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 25TH NOVEMBER 2015

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
11-1	To receive apologies for absence	Chairman	Verbal
11-2	To declare interests relevant to agenda items	Chairman	Verbal
11-3	Minutes of the Part 1 meeting of 21st October 2015	Chairman	1
11-4	To note progress with previous actions	Chairman	2
11-5	Safety moment	Chief Nurse	Verbal
11-6	Chairman's report	Chairman	Verbal
11-7	Chief Executive's report	Chief Executive	3
11-8	A patient's experiences of the Trust's services	Medical Director[1]	Verbal
11-9	Review of the Board Assurance Framework, 2015/16	Trust Secretary	4
11-10	Integrated Performance Report for October 2015 ▪ 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		
11-11	Progress with the Quality Improvement Plan	Chief Nurse	6
11-12	Clinical Quality and Patient Safety Report	Chief Nurse	7
11-13	Staffing (planned & actual ward staffing for Oct '15; and 6-monthly review of Ward and non-Ward areas)	Chief Nurse	8 & 9
11-14	'Safe staffing and efficiency' letter from the NHS TDA etc. (and Trust response)	Chief Nurse	10
	Assurance and policy		
11-15	The Computer Aided Facilities Management system	Director of Estates and Facilities	Presentation
11-16	Fit & Proper Persons' (Directors) Regulations update	Trust Secretary	11
11-17	Approval of compliance oversight self-certification	Trust Secretary	12
11-18	Ratification of Standing Fin. Instructions (ann. review)	Director of Finance	13
	Reports from Board sub-committees (and the Trust Management Executive)		
11-19	Charitable Funds Committee, 19/10/15 (incl. approval of the 2014/15 Ann. Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)	Committee Chairman	14
11-20	Audit and Governance Committee, 04/11/15	Committee Chairman	15
11-21	Quality Committee, 11/11/15 (including SIs)	Committee Chairman	16
11-22	Trust Management Executive, 18/11/15	Committee Chairman	17
11-23	Finance Committee, 23/11/15 (incl. OBC for adoption of GS1 and implementation of PEPPOL)	Committee Chairman	18 (to follow) & 19
	Other matters		
11-24	Stroke Therapy Assisted Discharge Service: Approval	Chief Nurse	20
11-25	**To consider any other business**		
11-26	**To receive any questions from members of the public**		
11-27	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 16th December 2015, 10.30am, venue TBC		

Anthony Jones,
Chairman

[1] A patient's relative 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 21ST OCTOBER 2015, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jane Rademaker	Associate Director of Operations, Surgical Services and Cancer	(JR)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Claire Baigent	Communications & Marketing Officer	(CB)
	David Gazet	Reporter, Kent Messenger (from item 10-8)	(DG)
	John Moynihan	Head of Learning and Skills Delivery, Home Office	(JM)

10-1 To receive apologies for absence

Apologies were received from Avey Bhatia (AB), Chief Nurse; Angela Gallagher (AG), Chief Operating Officer; Alex King (AK), Non-Executive Director; and Steve Tinton (ST), Non-Executive Director.

AJ welcomed JR to the meeting, noting she was attending to represent AG.

10-2 To declare interests relevant to agenda items

There were no declarations of interest.

10-3 Minutes of the Part 1 meeting of 30th Sept. 2015

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

- List of those "Present", Page 1 of 10: transfer "(from item 9-7)" from after "Medical Director" to after "Director of Finance".

Action: Amend the minutes of the Part 1 meeting of 30th Sept. 2015 (Trust Secretary, October 2015)

10-4 To note progress with previous actions

The circulated report was noted. The following action was discussed in detail:

- **Item 6-8ii ("Arrange for the Trust Performance Dashboard to be amended to reflect the fact that the A&E 4-hour waiting time target was required to be achieved on a quarterly, rather than annual, basis").** KR noted that the Performance Dashboard now contained data for the month and for the Quarter, and therefore the action had been closed.
- **Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director").** The update was acknowledged.
- **Item 9-8ii ("Provide the Trust Board with comparative data on the occurrence of Grade 3 and 4 Pressure Ulcers at other acute NHS organisations in the South East area").** The update was acknowledged.

- **Item 9-9 ("Write to the Care Quality Commission, stating that it was the Trust's understanding that the Commission had no concerns regarding progress in implementing the Trust's Quality Improvement Plan").** The update was noted, but AJ asked for further comments. GD highlighted that the Care Quality Commission (CQC) had now issued another inspection report on Maidstone Hospital (MH), and lifted the Enforcement Notice relating to water quality testing. AJ noted he had invited the Director of Estates and Facilities and her Deputy to attend the Trust Board, to apprise the Board on the monitoring dashboard that was referred to in the CQC's report. KR confirmed that the item had been scheduled for the Trust Board meeting in November 2015.

10-5 Safety moment

PS referred to the previous winter period, and the significant contribution that Junior Doctors had made to the Trust's patients during that time. PS suggested that Trust Board Members therefore pay particular attention to the Trust's Junior Doctor staff, who may be feeling demoralised at present, given the national situation regarding their contract. AJ agreed with PS's request, emphasised the importance of Junior Doctors to the Trust, and appealed for Trust Board Members to make further efforts to engage with such staff.

10-6 Chairman's report

AJ noted that he had nothing to report.

10-7 Chief Executive's report

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

- Work was continuing regarding the creation of the new Ward at Tunbridge Wells Hospital (TWH) and the refurbishment at MH. GD acknowledged that further communication regarding the latter was warranted, as this was positive news
- GD had visited the ICU at TWH, with the purpose of testing their response to the CQC action plan, and gauging the general atmosphere within the ICU. GD commended Dr Lawton's appointment as Clinical Director, and reported that positive feedback had been given regarding the introduction of the new Consultant rota system. GD appealed for Trust Board Members to visit the ICU, and view the notice board, which contained data that showed that the Trust's ICUs were the best performing in the South East region.

  PS declared that the Units were the best in England, not just the South East. AJ asked whether the latest South East Coast Critical Care Network (SECCCN) report had been circulated to all Trust Board Members. PS confirmed that the report had been circulated to all Board Members as part of the reports for the last 'main' Quality Committee meeting.

- Following a visit to A&E on 21/10/15, GD had observed that the one major difference between this Trust and other Trusts facing similar capacity pressures was the Trust's ability to demonstrate its plans to improve the situation, by, for example, the new Paediatric A&E which was planned. GD emphasised that seeing the area in person had 'brought the plans to life'

SDu asked what assurance could be provided that the new Ward at TWH would open on time, and deliver the expectations of both patients and A&E staff. GD highlighted that the new Ward would have a beneficial effect, but would not be a panacea, and emphasised that other improvements would be required, in terms of reducing the number of Delayed Transfers of Care (DTOCs), and improving theatre efficiency.

SD referred to paragraph 3 on page 1, and asked how many of the 100 Nurses had accepted the job offers. PB replied that the net gain of Registered Nurses was 20, whilst for Clinical Support Workers (CSWs), this was 75. GD added that the recently announced temporary hiatus on recruitment from staff outside of the EU would help the situation, but the requirement that non-UK staff pass a Level 7 English language examination would likely prove challenging for some staff.

AJ then referred back to paragraph 3, and pointed out that the reference to 100 Nurses was not in the context of a net gain. PB clarified that the current recruitment pipeline would lead to a net gain

of 100. SD asked for confirmation that such changes would therefore lead to a reduction in Agency Nurse usage. SO confirmed this was the intention, and noted that some reduction had already occurred.

SM gave assurance that new overseas staff were being coached by Infection Control Team staff, to ensure that they had the required level of knowledge and skills regarding Healthcare Associated Infections.

GD then referred to paragraph 7, and commended the Radiology Department on their recent awards. SM clarified that the awards were actually won by the Radiotherapy Department.

SD referred to paragraph 4, and asked whether outcomes were being monitored for the Critical Care Outreach service. GD confirmed that audit data would be collected and outcomes would be reported, and suggested that it may be beneficial to invite the Critical Care Outreach team to present such data to the Quality Committee.

SDu then referred to paragraph 1, and asked GD to clarify his intended meaning. GD stated that his intention was to highlight that an acute hospital bed was not necessarily a safe place for all of the patients the Trust was currently being asked to treat i.e. those patients that had been determined to be “Medically Fit For Discharge”, but who were then subject to a DTOC.

10-8 Integrated Performance Report for September 2015

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

- Performance against the A&E 4-hour waiting time target for patients that did not require admission was 95%, and the non-compliant aspect of the target was related to those patients requiring admission
- The outsourcing of elective activity was continuing, and although this was cost neutral, it prevented the Trust from achieving a surplus on such activity
- DTOCs were continuing, and the fundamental ‘story of the month’ was, in turn, having an adverse impact on the Trust’s finances, and on the Trust’s middle management staff. GD elaborated that the immediate pressures were preventing such managers from planning ahead, even in the very short term i.e. for the next month

AJ referred to the chart that showed the age distribution of DTOCs, and noted that the main problem manifested within those aged 80 - 89. GD concurred, adding that media reports from that day contained a suggestion that the NHS provide funding for Care Homes, and stated that the Trust Board may wish to consider whether this should be pursued by the Trust. AJ queried whether there was funding for such a step. GD replied that despite the lack of funding, it may be beneficial for the Trust to consider the option, as part of a long-term approach.

AJ then queried the latest position for non-Obstetric Ultrasound scans. SM confirmed there had been no breaches for October, and gave assurance that the current issues were being managed effectively.

GD then invited PS, SM, SO and PB to highlight any key issues.

Safe / Effectiveness / Caring

PS referred to the circulated report and highlighted that Patient Falls had increased. SDu proposed that “Patient Falls” be the subject of a Quality Committee 'deep dive' meeting. This was agreed.

Action: Arrange for “Patient Falls” to be reviewed at a future Quality Committee ‘deep dive’ meeting (Trust Secretary / Chief Nurse, October 2015 onwards)

Safe / Effectiveness (incl. HSMR)

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

- The Hospital Standardised Mortality Ratio (HSMR) was slightly outdated, as the data for July had now been loaded into the system. The Trust’s HSMR for the previous 12 months was 103 as of that week

- Further actions arising from the Quality Committee 'deep dive' meeting in October were being progressed, and a report would be provided to the next 'main' Quality Committee.

AJ noted that the Trust Board would therefore be apprised of further information via the summary report from the Quality Committee.

Safe (infection control)

SM referred to the report and highlighted that there were two main current issues:
1. There had been an increase in community acquired MRSA bacteraemia, with 3 recent cases. The cases were not linked, but 2 of the 3 had arisen from tertiary centres
2. Clostridium difficile had now breached the monthly trajectory for 3 consecutive months, and although the number of cases was still in accordance with the trajectory for the year, there appeared to be an issue relating to Orthogeriatric patients. Action was being taken, including a letter from PS to all Doctors. Eight of the first 10 cases reviewed at Panel had been related to Tazocin, so further education regarding the appropriate use of this was being introduced.

AJ asked whether an additional control could be introduced regarding the use of Tazocin. PS stated that Trauma & Orthopaedics had not been used to having increased cases of Clostridium difficile, and he had attended their Clinical Governance meeting and received a positive response. PS elaborated that additional controls regarding further doses of Tazocin would be introduced, but initial doses would not be subject to any additional controls.

KT queried whether anything had therefore changed in practice, given PS's comment that the increase in cases was a new phenomenon within Trauma & Orthopaedics. PS replied that it appeared that Trauma & Orthopaedics had increased its use of Tazocin, as a result of non-compliance with Trust Policy, but the issue had not previously been at the forefront of clinician's thoughts. SM added that the issues relating to Nursing had improved, and the focus was now on improving prescribing. SM added that no Trauma & Orthopaedics cases had been seen for October thus far. AJ commended the actions being taken and pointed out that if any assistance was required by either the Trust Board or Quality Committee, this only need be requested.

KT queried whether any IT-related alerts could be issued at the point of prescribing Tazocin. SM replied that this was difficult, as the Trust did not have a generic ePrescribing system, but noted that Pharmacy staff were intervening in the prescribing process. SM elaborated that such interventions were occurring more at MH than at TWH, so efforts would now be focused on improving the consistency at TWH.

KT asked for details of the plans regarding ePrescribing. PS replied that he believed this was part of the long-term strategy, but an introduction date had not been set. KT queried whether this could be reconsidered. AJ concurred.

Action: Reconsider the appropriateness of the planned timescale for the introduction of ePrescribing at the Trust (Medical Director, October 2015 onwards)

KT commended the 'Safety moment' at the Trust Board, but suggested that further thought could be given to making the process more structured, in terms of, for example, wider dissemination, and introducing safety messages on a weekly basis. AJ agreed that the matter would benefit from further thought.

Well-Led (finance)

SO then referred to the circulated report and highlighted the following points:
- The Trust's cumulative financial position was adverse to plan by circa £2m, which had been affected by the aforementioned DTOCs
- Income had been adverse to plan in the month

AJ asked for clarification that DTOCs were the main factor in the Trust's deteriorating financial position. SO confirmed this was the case, but added that the level of medical patient outliers was also a contributory factor. GD added that this equated to circa 30 beds being unavailable for use.

AJ asked GD to comment on his recent discussions with Social Services. GD confirmed that he and JL held discussions, and although engagement with Social Services had improved, this had only translated into fleeting improvements in the situation i.e. there had been no systemic improvement. GD added that he had also met with Greg Clark MP, but had little confidence that the situation would change, and the Trust therefore needed to plan to manage during the coming winter.

SD asked for a prediction, in terms of the winter period. SO replied that it was difficult to predict what would happen, and although the Trust had agreed a Winter & Operational Resilience Plan, with increased capacity, the fact that the number of DTOCs at the Trust equated to another full Ward was a key factor. SO added that the continued use of outsourcing would also have a negative effect on the Trust's financial position. GD added that the main consideration was how the Trust could survive through to March 2016, and added that he believed this was possible, but would require some sacrifices.

KT queried West Kent Clinical Commissioning Group's (CCG) funding of the Trust's Winter & Operational Resilience Plan. SO explained that the CCG had agreed to continue to fund the schemes introduced in 2014/15 i.e. the High Impact Team (HIT) and Therapy Assisted Discharge (TAD) team, but no funding for additional capacity had yet been agreed. GD highlighted that the position was therefore worse than the previous year, and noted that the Trust would receive payment for clinical activity, but would not be paid for the 'tail' of DTOCs.

AJ asked about the Better Care Fund. SO stated that the Trust had not received any funding from the Fund, and although some funding had been directed towards assisting DTOCs, the effectiveness of this investment was not apparent. GD added that he understood that the CCG had significant influence in the direction of the Fund. SO stated that he could provide details of the local healthcare economy schemes being financed via the Fund. This was agreed.

Action: 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)

SDu opined that no option should be discounted in relation to the Trust finding a solution to its current problems, including the introduction of temporary Ward capacity. KT agreed. GD acknowledged the point.

Effectiveness / Responsiveness (incl. DTOCs)

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

- The A&E 4-hour waiting time target data was unsatisfactory, but the Trust was not atypical in relation to national performance
- This was the first month that the Cancer 62-day waiting time target had not been met for the Trust's patients, which related to the significant efforts made regarding 'long-wait' patients

AJ referred to the latter point, and asked for clarification that performance against the Cancer 62-day waiting time target would therefore recover. GD confirmed this was the case.

Well-led (workforce)

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

- The number of vacancies had reduced, from just under 500 to just above 400 for the comparative period. Much of this related to Registered Nurse and CSW posts
- The reliance on temporary staff still remained, albeit at a reduced level

KT noted that "Appraisal Completeness" had reduced. PB agreed, but stated that he expected this to recover, and he was therefore not concerned. KT expressed concern at latent indicators, in terms of support being provided to staff. PB acknowledged the point, but reiterated that he did not regard this as a significant problem.

SDu commended compliance with "Statutory and Mandatory Training", and stated that the Training and Education department should be particularly commended.

SDu then queried whether the Trust was intending to provide training for new Nursing recruits. PB clarified that the Trust provided a range of in-house training, but did not provide training for those wishing to become Registered Nurses. GD added that discussions had been held regarding the introduction of bursaries for local individuals, but noted that obstacles had been encountered with the external funders of education. GD added that he did not however believe these obstacles were insurmountable, and understood the government was planning to introduce tuition fees for Nurse training, which may therefore present an opportunity for the Trust.

PB noted that there were some plans to introduce Nurse Cadet schemes in the country. AJ requested that PB keep the Board apprised of the development of such schemes.

GD then referred to the "OP Friends & Family (FFT) % Positive" indicator, and reported that the score indicated that there was a problem in Outpatients. GD added that the indicator had not been 'RAG' rated as there was no comparative benchmark, but it had been acknowledged that work was warranted in this area.

Quality items

10-9 Progress with the Quality Improvement Plan

PS referred to the circulated report and highlighted that the main issues rated as 'amber' related to capacity, and these were expected to improve with the creation of the new Ward at TWH.

Questions or comments were invited. AJ asked whether there was sufficient capacity in ICU at both hospital sites. PS replied that this was not considered to be a problem at MH, but at TWH, the emergency surgery workload was vast, which had prompted calls to consider whether ICU capacity needed expansion. PS continued that such discussions were ongoing, but gave assurance that patients were not currently experiencing problems in accessing ICU due to capacity constraints.

SDu then referred to "Compliance action 17", and queried whether the "Green" rating was correct, given the outstanding action regarding the external review of "Good Governance and Culture Review". SDu proposed that the rating should be "Amber". This was agreed.

Action: Arrange for the "Progress rating" for "Compliance action 17" in the October 2015 CQC Quality Improvement Plan to be amended from "Green" to "Amber" (Medical Director, October 2015 onwards)

10-10 Staffing (planned v actual ward staffing for Sep 2015

PS referred to the circulated reports and highlighted that AB had considered whether there was a correlation between the increase in falls at MH and staffing, but had concluded that there was no such correlation. KT queried whether the analysis should have been undertaken by an independent source. PS clarified that the Patient Safety team, and not the Wards, had undertaken the analysis. SDu remarked that "Patient Falls" still warranted a 'deep dive' review, as had been agreed earlier in the meeting.

SDu then stated she wished to challenge the myth that patients with increased Length of Stay required further Nursing numbers, noting that such patients should not require in-depth clinical care. GD clarified that being classified as "Medically Fit For Discharge" did not mean that patients did not require Nursing care. SDu acknowledged the point, and suggested that it would therefore be beneficial for the proportion of DTOCs that were "Medically Fit For Discharge" but who still required Nursing care to be provided. PS referred SDu to the chart on page 2 of 19 of Attachment 6. GD added that further detail existed regarding DTOCs, and proposed that this be shared with the next Quality Committee. GD elaborated that it would be beneficial for the Quality Committee to review a 'snapshot' of individual cases, at that point in time, and review the exact circumstances involved. SDu acknowledged the suggestion, but pointed out that her point was to challenge whether the level of Nursing staff was warranted by the level of DTOCs.

PB then highlighted that a letter had been issued by the NHS Trust Development Authority (TDA) relating to safe staffing, and this may affect the RAG ratings used in future 'planned v actual ward staffing' reports. The point was acknowledged.

KR then asked for confirmation of how GD's earlier proposal regarding the Quality Committee was to be considered. SDu expressed concern that the Quality Committee would be provided with too much information. GD clarified that his proposal related to the Quality Committee reviewing a small selection of cases, to provide an insight into the issues involved in each case. This was agreed.

Action: Arrange for the 'main' Quality Committee to review a small selection of patients who are the subject of a Delayed Transfer of Care, to provide an insight into the issues involved in each case (Trust Secretary / Chief Operating Officer, November 2015)

Assurance and policy

10-11 Approval of compliance oversight self-certification

KR referred to the circulated report and explained that there had been no change to the compliance status of any statement, but there had been some developments in terms of the evidence, which were highlighted. KR continued that the main development related to Condition G7 ("Registration with the Care Quality Commission"), where the Trust had applied to have the Regulated Activity of "Assessment or medical treatment for persons detained under the Mental Health Act 1983" added to its registration. KR continued that representatives from the CQC were scheduled to visit the Trust on 22/10/15 to consider the application.

Questions or comments were invited. KT referred to Board Statement 1, on page 6 of 11, and queried the label of the "Good Governance and Culture" review. KR explained that this was the verbatim wording used by the external adviser that undertook the review.

SDu also referred to Board Statement 1, and queried whether the evidence provided was sufficient, given that the Trust Board had agreed that a further response to the review be prepared. AJ proposed that further information (i.e. an additional bullet point) be included, to reflect the Trust Board's decision. This was agreed.

Action: Include further information, in the "Evidence of Trust compliance" section for Board Statement 1 in the Oversight Self Certification, regarding the Trust's Board's request that a considered response to the external "Good Governance and Culture" review be submitted to the Board in December 2015 (Trust Secretary, November 2015)

PB then referred to Condition G4 ("G4 – Fit and proper persons as Governors and Directors") and queried whether the absence of completed Disclosure and Barring Scheme (DBS) checks for all Trust Board Members required further action. KR clarified that the wording he had used in the report was not intended to imply that there was a problem with processing the DBS check of any individual Trust Board Member, nor that further action was required. Following further questioning, KR agreed to clarify the status of the DBS checks being undertaken, and provide a definitive position to the Trust Board in November.

Action: Clarify the status of the Disclosure and Barring Scheme (DBS) checks being undertaken for Trust Board Members (Trust Secretary, November 2015)

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

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

10-12 Quality Committee, 05/10/15

SDu referred to the circulated report and highlighted that there were a number of actions arising from the meeting, which involved a very good presentation from Dr Foster.

KT remarked that he was struck by the benefit of the dashboards used by Dr Foster, and asked why these were not being adopted by the Trust. SDu noted that PS would be considering the information presented during his discussions with Clinical Directorates, with the intention of

improving the process of exception reporting. PS added that the aforementioned "Good Governance and Culture" review covered many of the relevant actions required.

AJ then asked about Clinical Coding. PS explained that further work was needed, but the initial action would be focused on Palliative Care Coding. SO added that an audit was scheduled to be undertaken by CHKS, who would review 250 sets of Healthcare Records, to consider whether the clinical activity had been coded correctly, and whether the Trust had been appropriately recompensed. SO added that the review would be completed in the near future.

SD then referred to the "Aspiration pneumonitis, food/vomitus", and "malignant neoplasm without specification of site" issues, and asked PS for details of his intended actions. PS replied that he expected individual patient care to be reviewed for "malignant neoplasm without specification of site", but further investigative work was required for "Aspiration pneumonitis, food/vomitus".

KT reiterated his view that Dr Foster's approach to data should become a model for the Trust's approach, given the level of resource that Dr Foster had invested, and queried whether the Trust was making maximum use if its subscription to Dr Foster. PS acknowledged that the Trust could make further use of its subscription, and once considered, would be able to report proposed actions to the Board.

10-13 Trust Management Executive, 14/10/15

GD referred to the circulated report, highlighted that the meeting was jointly held between the Trust Management Executive and Trust Board, and added that he believed it had been very good.

AJ agreed, and stated that he thought all of the Clinical Directors demonstrated ownership of their 'business', noting that they were not accompanied by other staff from within their Directorate.

KT stated that he concurred, but the meeting had left him feeling somewhat deflated that despite all of the efforts being made, the Trust was facing extreme difficulty. KT added that further discussion at Trust Board would be warranted. GD agreed, and suggested that discussion before Christmas would be beneficial.

10-14 Finance Committee, 19/10/15 (to include approval of the Trust's application for an Interim Revolving Working Capital Facility)

SDu referred to the circulated report and highlighted the following:

- The key issues referred to in the "Review of Latest Financial Performance" section of Attachment 4 had been discussed in detail
- The Committee had agreed to recommend that the Trust Board approve the Trust's application for an Interim Revolving Working Capital Facility
- The Full Business Case for the new Ward at TWH was approved
- Agency expenditure was reviewed, but the Committee agreed to leave the controls as they were at present

AJ also reported that the Committee had reviewed the Trust's usage of external Consultancies, which had reduced. SDu agreed, and added that the Committee had also recognised the need to ensure that the engagement of external Consultants provided value for money.

SO then referred to Attachment 11 and highlighted the following points:

- The Trust's plans for 2015/16 had always included an intention to request such a Facility
- The Facility had been set at £12.1m, which reflected exact value of the Trust's reduced Income & Expenditure deficit plan, following the 'stretch' target adjustments
- The full documentation relating to the Facility had been enclosed within Attachment 11

AJ invited questions or comments. None were received.

The application for an Interim Revolving Working Capital 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 Revolving Working Capital 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 Revolving Working Capital 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 Revolving Working Capital 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 Revolving Working Capital 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 Revolving Working Capital Support Facility Agreement"

10-15 Charitable Funds Committee, 19/10/15

SDu reported the following points:

- The Committee had reviewed and agreed the Annual Report and Accounts for 2014/15, and it was noted that no concerns had been raised from the External Auditors. The Finance team that had prepared the Accounts had also been commended.
- The Committee reviewed the latest financial position, and commended the progress that had been made in respect of the Funds amalgamation exercise
- The Committee had also noted the progress regarding the changes to the process of appointing auditors to NHS charities (following the abolition of the Audit Commission)

Other matters

10-16 Proposal regarding the appointment of a "Freedom to Speak up Guardian"

PB referred to the circulated report and invited questions or comments. None were received.

The proposal was approved as circulated.

10-17 To consider any other business

GD referred to the future of the Trust's 12 beds at Tonbridge Cottage Hospital, and noted that the Trust had written to the CCG stating that the Trust was considering the option of repatriating Stroke Rehabilitation patients to TWH, and highlighting that further work was required in terms of the future of the 12 beds. JL added that he had met with Kent Community Healthcare NHS Foundation Trust regarding this, noted that there would be some further joint work regarding the future bed base in West Kent (which would include the beds at Tonbridge Cottage Hospital), and stated he would update the Board on progress.

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

There were no questions.

10-19 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

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

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards	The most appropriate date to schedule the outcome will be identified in the near future, but it is expected that this is likely to not be until 2016
10-8i (Oct 15)	Arrange for "Patient Falls" to be reviewed at a future Quality Committee 'deep dive' meeting	Trust Secretary / Chief Nurse	October 2015 onwards	A separate meeting of the Quality Committee 'deep dive' meeting, which will focus solely on patient falls, is being scheduled for January 2016
10-8iii (Oct 15)	Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund	Director of Finance	October 2015 onwards	A request has been made to West Kent Clinical Commissioning Group, and a response is awaited

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-8ii (Sep 15)	Provide the Trust Board with comparative data on the occurrence of Grade 3 and 4 Pressure Ulcers at other acute NHS organisations in the South East area	Chief Nurse	October 2015	The information has been submitted to the November 2015 Trust Board meeting, as part of the Clinical Quality and Patient Safety Report
9-9 (Sep 15)	Write to the Care Quality Commission, stating that it was the Trust's understanding that the Commission had no concerns regarding progress in implementing the Trust's Quality Improvement Plan	Chief Nurse	October 2015	A telephone discussion was held with the CQC on 26/10/15, and the CQC was asked whether they had any concerns regarding the implementation of the QIP. None were raised. The discussion was then followed up by an email from the Associate Director of Governance, Quality &

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				Patient Safety, to confirm the Trust's understanding of the CQC's view to this effect
9-14 (Sep 15)	Meet with the Chairman of the Trust Board, to consider whether the format of the Board Assurance Framework for 2015/16 should be amended (and if so, agree what amendments should be made)	Trust Secretary	October 2015	A meeting was held, and the matter discussed, but it was agreed to keep the format of the Board Assurance Framework unchanged for the time being.
10-3 (Oct 15)	Amend the minutes of the Part 1 meeting of 30th Sept. 2015	Trust Secretary	October 2015	The minutes were amended
10-8ii (Oct 15)	Reconsider the appropriateness of the planned timescale for the introduction of ePrescribing at the Trust	Medical Director	October 2015 onwards	The planned timetable is 2016/17, but with the awareness of the time taken to enable chemo – ePrescribing and the PAS change, we are looking to other Trusts to await high quality solutions prior to embarking down this route
10-9 (Oct 15)	Arrange for the "Progress rating" for "Compliance action 17" in the October 2015 CQC Quality Improvement Plan to be amended from "Green" to "Amber"	Medical Director	October 2015 onwards	The rating has been changed to 'Amber' (this is reflected in the QIP report to the November Trust Board)
10-10 (Oct 15)	Arrange for the 'main' Quality Committee to review a small selection of patients who are the subject of a Delayed Transfer of Care, to provide an insight into the issues involved in each case	Trust Secretary / Chief Operating Officer	November 2015	The issue featured as part of the 'main' Quality Committee on 11/11/15.
10-11i (Oct 15)	Include further information, in the "Evidence of Trust compliance" section for Board Statement 1 in the Oversight Self Certification, regarding the Trust's Board's request that a considered response to the external "Good	Trust Secretary	November 2015	The Oversight Self Certification report submitted to the November 2015 Trust Board contains the requested further information.

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Governance and Culture" review be submitted to the Board in December 2015			
10-11ii (Oct 15)	Clarify the status of the Disclosure and Barring Scheme (DBS) checks being undertaken for Trust Board Members	Trust Secretary	November 2015	The status has been clarified within a "Fit and Proper Persons' Regulations: Update" report that has been submitted to the November 2015 Board meeting

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - November 2015

11-7 Chief Executive's update **Chief Executive**

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

1. I have continued to seek assurance about the quality and safety of the care we provide and are planning to provide our patients. Since our last Board meeting I have visited a number of clinical areas including ICU and our A&E departments. ICU discussed with me the need for HDU beds in addition to the ICU to cope with increasing demand and that a plan was being worked on to achieve this. I felt assured that our new consultant rotas are working in ICU and that we are seeing improvements to patient care and consistency of patient care as a result. Overall, I was impressed with the pride colleagues are taking in all areas and was left with a sense of colleagues having a real can do attitude in our A&E departments. This is exemplified by the emergency department's `Meet the Matron' sessions where the public have been able to come along and speak with our clinical staff about the improvements they'd like to see. As an example we are going to train our staff in basic sign language after one visitor explained it can be difficult for deaf individuals to communicate with staff in hospital.

2. As part of an on-going commitment to improving local maternity services, started under the Better Beginnings programme in 2013/14, we have agreed in principle with High Weald Lewes Havens CCG and East Sussex Healthcare NHS Trust, that the management of maternity services provided within the High Weald area, including Crowborough Birthing Centre, and related community care, should move to our Trust.

2.1 The move will help provide a seamless maternity service for women in the High Weald area and is another example of how our close partnership working is helping positively improve patient experience. We have seen an overwhelmingly positive public response to this news which reflects well on the quality of care women have come to associate with our maternity services.

2.2 Once the transfer has occurred, we will need to apply to the Care Quality Commission (CQC) to have Crowborough Birthing Centre added to the Trust's list of "Locations" on its CQC Registration. The application will note that the Trust intends to provide "Maternity and midwifery services" from the Centre, under the same management / clinical leadership of the existing maternity and midwifery services that are provided at the Trust's existing registered locations. The application will also note that the property itself is anticipated to be managed by NHS Property Services Ltd (who will be responsible to the maintenance of the building); and that food at the Centre will be provided from Crowborough War Memorial Hospital (which is operated by Sussex Community NHS Trust, and is already registered with the relevant Environment Health Department (Wealden District Council).

3. On a related theme, three members of our maternity department are in China this month, at the request of their regional health authorities, to share the best practice we have developed in ante natal care. This includes helping them develop the better care outcomes we have seen for women and babies through the use of kangawraps. We are immensely proud of these achievements.

4. Our new 31-bed respiratory ward at Maidstone is on schedule to open at the end of this month. The refurbished ward area provides an impressive environment for our patients. It includes an enhanced care bay for patients requiring more intensive monitoring or intervention and a negative pressure room for patients with airborne transmitted diseases such as Tuberculosis, who require isolation. The improved ward layout has five 4-bed bays and one 3-bed bay, all with shower rooms and toilet facilities. There are also seven single rooms with en-suite facilities. Work is continuing at pace on the development of our new 38-bed ward at Tunbridge

Wells Hospital. This priority scheme, which is part of our detailed winter planning, will provide ambulatory care, rapid assessment and a short stay area for patients.

5. We have worked in partnership with Hever Castle to help mark World Diabetes Day. Congratulations to Dr Masud Haq, Consultant and Clinical Lead in Diabetes and Endocrinology and Hever Castle for turning the castle blue to mark the event.

6. I have circulated the Care Quality Commission's latest reports on two neighbouring hospital trusts (Brighton and Sussex University Hospitals NHS Trust and East Kent Hospitals University NHS Foundation Trust), to colleagues throughout our Trust through my weekly Update to support shared learning. I linked these reports to our own capacity constraints and the actions we are collectively taking to offer more fast-track ambulatory care and the work we are doing with our partners in community and social care to reduce delayed transfers of care. I also shared some of the key points from our last Trust Board meeting with colleagues through Update to support our efforts to be open and transparent.

7. Congratulations to our latest employee and teams of the month. Margaret Gurney form the eye department at Maidstone was employ of the month for July and Rebecca Higgins from Ward 30 at TWH was employee of the month for August. A&E receptionists at TWH and Maidstone A&Es were joint teams of the month for July.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-9 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 by the Trust Board
This is the third time during 2015/16 that the Board has seen the populated BAF, following the discussions regarding key risks, objectives and BAF format that were held in April, May and June. When the BAF was last reviewed, in September, it was agreed that the Trust Secretary and Chairman should meet, to consider whether the format of the BAF should be amended. A meeting was duly held, but it was agreed to keep the format of the BAF unchanged for the time being. However, it was agreed that the BAF should be reviewed earlier on the Board agenda.

The content has been updated from the BAF reviewed at the Board in September. 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
The BAF that was received at the September Trust Board was also reviewed at the Audit and Governance Committee on 04/11/15. Details of the review are provided in the summary report from the Committee, which has been submitted to the November Board under a separate agenda item.

Review by the Trust Management Executive (TME)
The BAF that was received at the September Trust Board was also reviewed at the TME on 18/11/15.

Which Committees have reviewed the information prior to Board submission?
- Finance Committee, 23/11/15 (objective 4.a only)

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

Maidstone and Tunbridge Wells NHS Trust

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 and the CQC); and 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 and response was discussed at the Trust Board on 30/09/15, and will be discussed further at the Board 'away day' in November (and the Trust Board, in December)

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. 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
2. The revised Governance Structure will be implemented, once agreed

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 TME, Quality Cttee, Patient Exp. Cttee & Trust Board (which includes a wide range of information on quality, incl. patient 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? [3]

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

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

1. The "amber" rating reflects the confidence in the efforts to improve the clinical governance arrangements, and the in-house CQC monitoring programme, but a 'Green' rating cannot be given until the CQC rates the Trust as "Good"

[2] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [4] *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 11/01/16
b. A System-wide action plan has been developed, following a review by the Emergency Care Intensive Support Team (ECIST), and is overseen by the System Resilience Group
c. An internal Capacity and Flow improvement Plan has been developed, and has become part of the operational resilience plans
d. A fortnightly recruitment and retention group (Chaired by the Chief Nurse / Director of Workforce and Communications) is overseeing progress against recruitment plans
e. Winter & operational resilience plans are finalised

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. The actions undertaken by the Trust are sufficient, but there is dependency on the wider system (where failure is occurring)

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? [5]

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

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

1. There are still some unresolved dependencies i.e. staffing and DTOC numbers

[4] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[5] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [6] *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 the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. Medical Director Staffing Assurance Report
2. Introduction of 'refer a friend' recruitment payment for agreed clinical posts
3. Development of new roles

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	**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? [7]

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [8] *Main risk*

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 performed
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 in detail the risks on the range of forecast outturn scenarios, identify and agree actions to mitigate risks
b. Complete review of Acute and Emergency Directorate nurse rotas
c. Close gap on CIP outturn delivery
d. Escalate CQC , 7 day working, safer staffing funding requests with CCG
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

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. A Financial Recovery Plan is in the process of being developed and implemented

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. External audit of accounts ('Value for Money' conclusion)
4. Internal audit reviews: "Financial Accounting and Non Pay" (Reasonable Assurance); "Budgetary Control" (Reasonable Assurance) "Payroll" (scheduled for Q3)
5. The winter and operational resilience plan (reviewed by the Trust Board in May and July 2015)

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? [9]

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 2. Achieving the financial plan will be contingent on the construction of an appropriate Financial Recovery Plan
2. The trend on temporary staffing has been partially offset by increased income. This has not continued through Quarter 2

[8] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[9] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [10] *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 the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. Continue with the cultural change programme already underway
2. Following approval of the Workforce Strategy, the action plan for the Strategy contains a number of elements which seek to change the culture
3. Following the reversal of the Board decision, the acquisition of a cultural barometer will better enable measurement

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? [11]

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

[10] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[11] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [12] *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 the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. The greatest area of uncertainty relates to broader strategic thinking
2. Opportunities to shape and influence thinking
3. Scenario planning to generate MTW views

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)
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	**Committee/s responsible for oversight**
Deputy Chief Executive	Trust Management Executive / Trust Board

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 greatest risks lie in factors beyond the Trust's direct control – continuing external engagement and influencing will be crucial

[12] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[13] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [14] *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 the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

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

If "Unsure" or "No", what other actions are planned?

1. The Workforce Strategy identifies actions which address the issue of succession planning, however as with long term cultural change, we should be aware of the length of the lead times

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? [15]

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

[14] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[15] "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 – November 2015

11-10	Integrated Performance Report for October 2015	Chief Executive / Executive Team

The enclosed report includes:

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

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

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 17/11/15
- Trust Management Executive, 18/11/15

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 October 2015

The key issues for October remains the overall increase in A&E attendances compared to plan with a steady rise in activity on the Maidstone site over the past number of months. The initiatives in place to prevent admissions where this is appropriate are now becoming embedded and reflected in the lower than plan level of non-elective admissions. We have seen an improvement in the overall length of stay for patients admitted through a non-elective pathway including a reduction in the level of DTOCs, particularly at the Tunbridge Wells site. The length of stay in October is the lowest it has been since October 2014 and was driven by reduced bed occupancy at Maidstone reflecting the closure of Whatman Ward.

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	Grand Total
Health	68	104	97	103	111	97	110	111	60	87	95	130	133	90	92	134	92	110	107	1931
SS	8	6	3	15	11	6	8	20	23	26	23	29	42	31	78	113	85	83	91	701
Health/SS		1	6	1	1	7	1	2	11	3	1	3	5	8	3	3	4	5	7	72
Grand Total	**76**	**111**	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**2704**
Delayed by Health	89.5%	93.7%	91.5%	86.6%	90.2%	88.2%	92.4%	83.5%	63.8%	75.0%	79.8%	80.2%	73.9%	69.8%	53.2%	53.6%	50.8%	55.6%	52.2%	
Delayed by Social Services	10.5%	5.4%	2.8%	12.6%	8.9%	5.5%	6.7%	15.0%	24.5%	22.4%	19.3%	17.9%	23.3%	24.0%	45.1%	45.2%	47.0%	41.9%	44.4%	
Delayed by both parties	0.0%	0.9%	5.7%	0.8%	0.8%	6.4%	0.8%	1.5%	11.7%	2.6%	0.8%	1.9%	2.8%	6.2%	1.7%	1.2%	2.2%	2.5%	3.4%	

The Referral to Treatment (RTT) remains on trajectory for the revised standards although the levels of elective activity remain below the plan.

The performance on Cancer targets in September (reported a month in arrears) shows a continued underperformance on the 62 day target whilst performance for the cancer 2 week-wait target improved to 95.3%. There were 9 breaches of the 104 day target [11 patients]. The 62 day position for patients managed entirely by MTW is currently at 81.3% for the year to date, against a target of 85%.

There were 3 Clostridium difficile cases in October bringing the year to date figure to 20 and only allowing for 2 cases per month from November onwards. There were no MRSA cases and the rate of readmissions reduced further.

The number of falls reduced in October and the rate also reduced despite the drop in occupied bed days. Whilst the numbers of falls resulting in harm remain low this is an area that the Trust is focusing on, particularly for the wards and Tunbridge Wells Hospital.

Complaints received by the Trust increased further to 62 and has been on an upward trend since April 2015. The proportion open >25 days remained stable despite the increased numbers.

During the month the Trust reached the target of employing 5000 whole time equivalent substantive staff, this is the highest number of substantive staff employed by the Trust since reporting to the Board became the norm, the month continued to see a net increase in the numbers of substantive registered nurses, albeit that the recruitment of clinical support workers was balanced by the numbers of those leaving. The 'pipeline' of recruitment

for registered nurses also appears strong so the trend of monthly net increases is likely to continue. Despite the recruitment success the dependence upon temporary staff remained higher than planned and as reported elsewhere represents one plank of the financial position.

Sickness absence in the month was below 4% 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.

The Trust is also taking steps to comply with the requirement of the TDA to reduce our dependence upon expensive agency and interim workers with the usage being reviewed weekly and reduction being seen.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31st October 2015**

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

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

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	5.23	15.7	15.2	11.0	-4.2	- 1.5	11.5	10.5	
'1-02	Number of cases C.Difficile (Hospital)	1	3	20	15	-5	- 2	27	25	
'1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
'1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%		1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	97.0%	98.0%	97.0%	98.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	3.1	3.0	2.2	2.4	0.2	- 0.6	*3.0*	2.4	3.0
'1-07	***Rate of Total Patient Falls	6.8	7.2	6.0	6.8	0.8	0.6	*6.2*	6.8	
'1-08	***Rate of Total Patient Falls Maidstone	5.0	6.2	5.2	6.1	0.9			6.0	
'1-09	***Rate of Total Patient Falls TWells	6.0	7.8	6.7	7.2	0.6			7.1	
'1-10	Falls - SIs in month		6		27	27				
'1-11	Number of Never Events	1	0	2	0	-2	0	*0*	0	
'1-12	Total No of SIs Open with MTW	36	22			- 14				
'1-13	Number of New SIs in month	6	10	72	57	- 15	- 13			
'1-14	**Serious Incidents rate	0.31	0.52	0.55	0.42	- 0.13	0.36	*0.0602 - 1.0634*	0.42	*0.0602 - 1.0634*
'1-15	Rate of Patient Safety Incidents - harmful	0.80	1.17	1.18	1.33	0.15	- 0.37	*0 - 1.698*	1.33	*0 - 1.698*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.5%	95.4%	95.6%	95.3%	-0.3%	0.3%	95.0%	95.3%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	96.3%	96.8%	96.6%	96.8%	0.2%	1.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	1.99%	2.24%	2.34%	2.34%	0.00%	-0.66%	*3.00%*	2.34%	
'1-20	C-Section Rate (non-elective)	14.6%	12.5%	14.8%	12.9%	-1.97%	-2.14%	*15.0%*	12.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.4	102.0	- 1.4	2.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	103.0	-3.9	3.0			100.0
2-03	Crude Mortality	1.1%	0.9%	1.1%	1.1%	0.0%				
2-04	****Readmissions <30 days: Emergency	10.6%	10.0%	11.7%	11.2%	-0.5%	-2.4%	*13.6%*	11.2%	14.1%
2-05	****Readmissions <30 days: All	9.9%	9.3%	10.8%	10.3%	-0.5%	-4.4%	*14.7%*	10.3%	14.7%
2-06	Average LOS Elective	3.1	3.4	3.2	3.3	0.0	0.1	*3.2*	3.2	
2-07	Average LOS Non-Elective	6.8	6.6	6.7	7.3	0.6	0.8	*6.5*	6.5	
2-08	New:FU Ratio	1.53	1.44	1.52	1.45	- 0.07	- 0.07	*1.52*	1.52	
2-09	Day Case Rates	84.8%	84.4%	83.4%	83.7%	0.3%	3.7%	80.0%	83.7%	82.2%
2-10	Primary Referrals	9,303	8,859	60,498	61,904	2.3%	2.2%	102,995	105,279	
2-11	Cons to Cons Referrals	3,701	2,643	24,392	23,498	-3.7%	1.0%	39,585	34,967	
2-12	First OP Activity	13,155	12,326	84,886	81,365	-4.1%	0.7%	137,532	138,376	
2-13	Subsequent OP Activity	23,234	21,823	151,836	150,148	-1.1%	-2.1%	260,920	255,353	
2-14	Elective IP Activity	716	678	4,595	4,724	2.8%	0.6%	7,988	8,034	
2-15	Elective DC Activity	3,412	3,507	22,104	23,057	4.3%	1.7%	38,556	39,213	
2-16	Non-Elective Activity	3,959	3,756	27,812	26,674	-4.1%	-5.5%	48,289	45,620	
2-17	A&E Attendances (Calendar Mth)	10,634	11,493	78,487	80,352	2.4%	1.1%	135,922	137,424	
2-18	Oncology Fractions	6,432	6,038	41,288	39,750	-3.7%	-5.3%	71,761	67,984	
2-19	No of Births (Mothers Delivered)	513	481	3,385	3,419	1.0%	2.7%	5,708	5,861	
2-20	% Mothers initiating breastfeeding	81.7%	No data	81.9%	81.0%	-0.9%	3.0%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.2%	0.61%	0.12%	0.43%	*0.3%*	*0.0%*	*0.47%*	0.43%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	5	0	-5	0	0	0	
3-02	*****Rate of New Complaints	2.67	3.24	4.11	2.28	-1.83112	0.97	*1.318-3.92*	2.24	
3-03	% complaints responded to within target	70.5%	77.1%	70.5%	73.1%	2.6%	-1.9%	75.0%	73.9%	
3-04	****Staff Friends & Family (FFT) % rec care	New	82.2%	New	83.2%	New	8.2%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	95.7%	New	96.5%	New	1.5%	95.0%	95.0%	95.6%
3-06	A&E Friends & Family (FFT) % Positive	New	88.9%	New	89.0%	New	2.0%	87.0%	87.0%	87.8%
3-07	Maternity Combined FFT % Positive	86.8%	96.1%	90.6%	94.98%	4.4%	0.0%	95.0%	95.0%	95.1%
3-08	OP Friends & Family (FFT) % Positive	New	80.0%	New	79.2%	New			79.2%	

* 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 Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	93.9%	90.2%	94.9%	90.2%	-4.7%	-4.8%	95.0%	95.0%	90.1%
4-02	Emergency A&E >12hr to Admission	0	0	2	0	-2	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	95.1%	86.6%	90.6%	90.5%	-0.1%	0.5%	90%	90.5%	
4-06	18 week RTT - non admitted patients	97.5%	97.8%	96.5%	97.9%	1.4%	2.9%	95%	97.9%	
4-07	18 week RTT - Incomplete Pathways	96.0%	95.7%	96.0%	95.7%	-0.3%	3.7%	92%	95.7%	
4-08	18 week RTT - Specialties not achieved	1	7	15	34	19	34	*0*	34	
4-09	18 week RTT - 52wk Waiters	0	0	0	5	5	5	*0*	5	
4-10	18 week RTT - Backlog 18wk Waiters	340	655	340	655				655	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	99.83%	100.0%	99.83%	-0.1%	0.8%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	8	4	8	6	- 2	- 3	9	9	
4-13	*Cancer two week wait	96.5%	95.1%	95.7%	94.6%	-1.2%	1.6%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	93.3%	96.4%	94.6%	94.4%	-0.3%	1.4%	93.0%	94.4%	
4-15	*Cancer 31 day wait - First Treatment	97.2%	94.7%	98.7%	97.1%	-1.6%	1.1%	96.0%	97.1%	
4-16	*Cancer 62 day wait - First Definitive	83.3%	71.7%	84.4%	75.2%	-9.2%	-9.8%	85.0%	85.0%	
4-17	*Cancer 62 day wait - First Definitive - MTW	85.7%	77.3%	88.4%	80.7%	-7.6%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	9	New	37	New	37.0	-	37	
4-19	Delayed Transfers of Care	3.9%	6.6%	4.0%	6.6%	2.6%	3.1%	3.5%	5.0%	
4-20	% TIA with high risk treated <24hrs	90.0%	92.3%	72.1%	72.4%	0.3%	12.4%	60%	72.4%	
4-21	% spending 90% time on Stroke Ward	90.4%	89.1%	83.4%	84.3%	0.8%	4.3%	80%	84.3%	
4-22	Stroke:% to Stroke Unit <4hrs	44.6%	48.2%	39.4%	52.5%	13.0%	-2.5%	55.0%	55.0%	
4-23	Stroke: % scanned <1hr of arrival	40.6%	51.8%	45.2%	53.4%	8.2%	10.4%	43.0%	53.4%	
4-24	Stroke:% assessed by Cons <24hrs	76.9%	73.2%	74.6%	73.0%	-1.6%	-12.0%	85.0%	85.0%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*	0.0%	

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

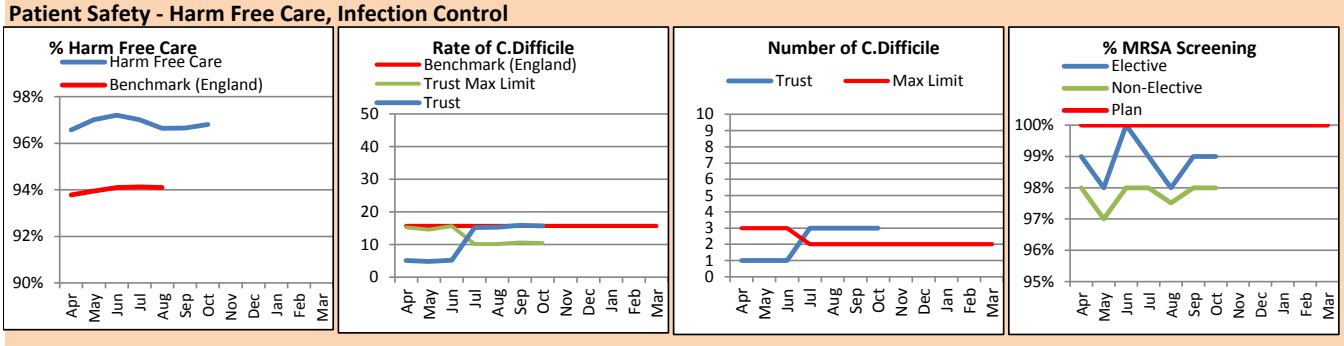
*** Contracted not worked includes Maternity /Long Term Sick **** Staff FFT is Quarterly therefore data is latest Quarter

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

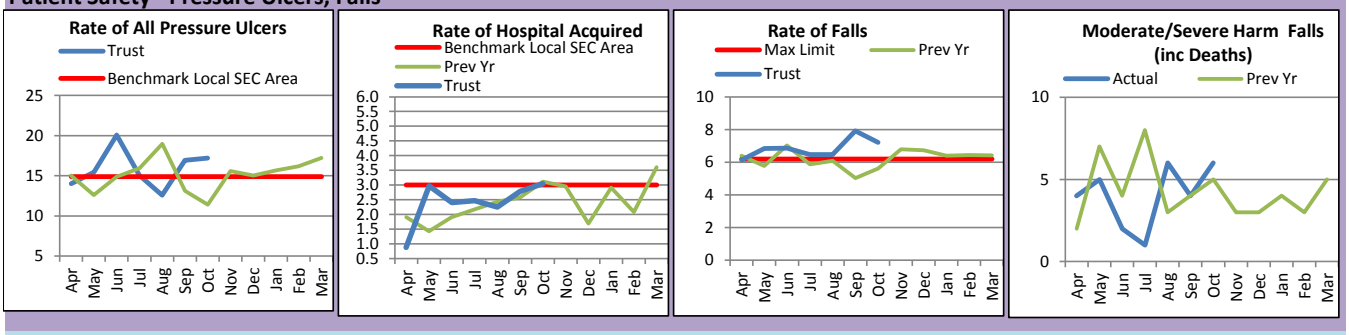
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	40,962	34,037	230,006	232,925	1.3%	1.5%	400,765	407,849	
5-02	EBITDA	10,274	1,104	19,483	7,033	-63.9%	-39.3%	23,821		
5-03	Surplus (Deficit) against B/E Duty	7,380	(1,695)	(1,334)	(12,787)			(12,132)		
5-04	CIP Savings	2,225	2,008	13,507	12,192	-9.7%	-3.1%	21,496	20,579	
5-05	Cash Balance	4,170	7,226	4,170	7,226	73.3%	16.7%	2,127	2,127	
5-06	Capital Expenditure	629	1,403	2,082	5,827	179.9%	-12.5%	*16,163*	14,998	
5-07	Establishment (Budget WTE)	5,421.5	5,643.4	5,421.5	5,643.4	4.1%	0.0%			
5-08	Contracted WTE	4,952.1	5,003.3	4,952.1	5,003.3	1.0%	-6.4%			
5-09	***Contracted not worked WTE	(108.3)	(109.1)	0.0	(109.1)					
5-10	Locum Staff (WTE)	25.7	56.4	25.7	56.4	119.2%				
5-11	Bank Staff (WTE)	301.3	293.0	301.3	293.0	-2.7%				
5-12	Agency Staff (WTE)	186.4	275.9	186.4	275.9	48.0%				
5-13	Overtime (WTE)	78.0	62.9	78.0	62.9	-19.4%				
5-14	Worked Staff WTE	5,453.4	5,575.8	5,453.4	5,575.8	2.2%	-1.2%			
5-15	Vacancies WTE	469.4	640.1	469.4	640.1	36.4%				
5-16	Vacancy %	8.7%	11.3%	8.7%	11.3%	31.0%				
5-17	Nurse Agency Spend	(499)	(799)	(2,650)	(6,079)	129.4%				
5-18	Medical Locum & Agency Spend	(972)	(974)	(5,494)	(7,296)	32.8%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.4%	10.3%		9.9%	0.9%	-0.2%	*10.5%*	9.9%	8.4%
5-21	Sickness Absence	4.4%	3.7%		3.9%	-0.7%	0.4%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	84.7%	87.9%		87.9%	3.2%	2.9%	85.0%	85.0%	
5-23	Appraisal Completeness	74.7%	76.7%		76.7%	2.0%	-13.3%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	101.4%	100.5%	100.6%	101.4%	-0.9%		92.7%	101.4%	
5-25	****Staff FFT % recommended work	New	56.9%	New	57.9%		-1.1%	58.0%	57.9%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	253	New	253					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	25.2%	New	27.0%		-3.0%	30.0%	30.0%	25.1%
5-28	A&E Resp Rate Recmd to Friends & Family	New	20.5%	New	14.5%		-5.5%	20.0%	20.0%	14.1%
5-29	Mat Resp Rate Recmd to Friends & Family	16.0%	30.1%	19.9%	16.7%	-3.2%	1.7%	15.0%	15.0%	22.7%

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

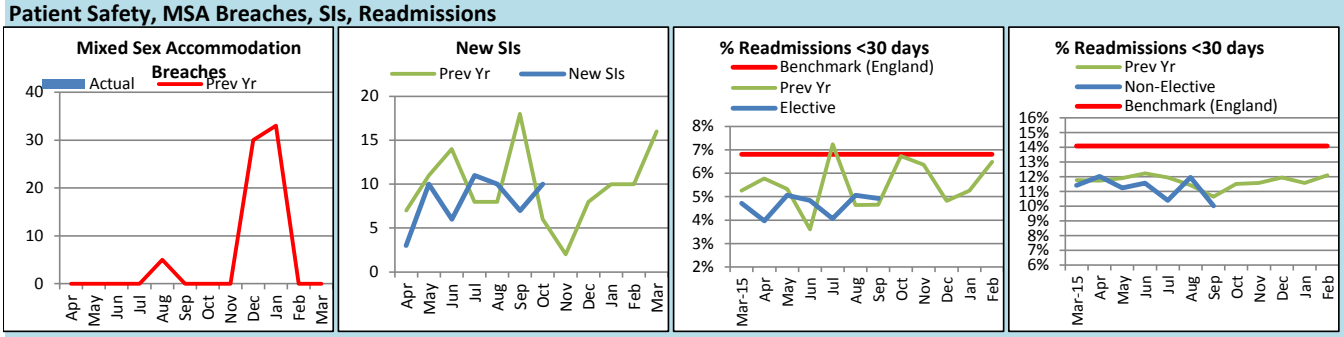
Patient Safety - Harm Free Care, Infection Control



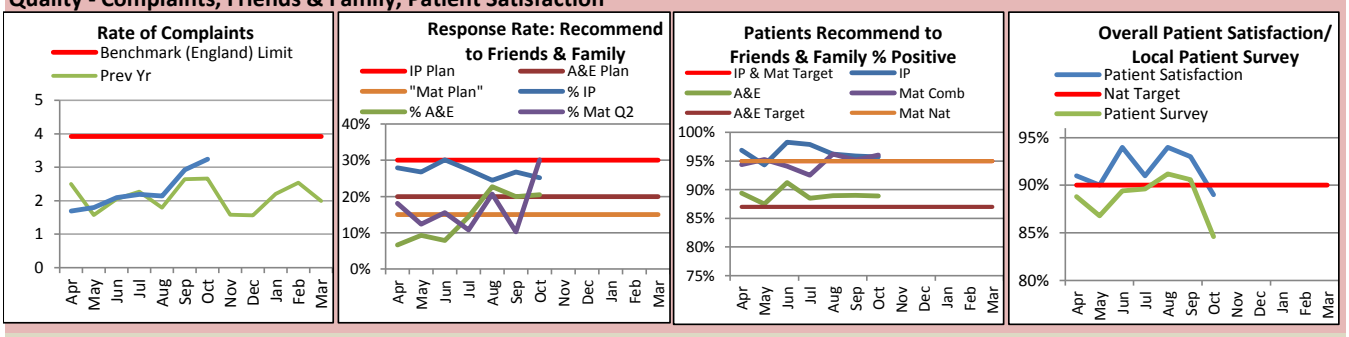
Patient Safety - Pressure Ulcers, Falls



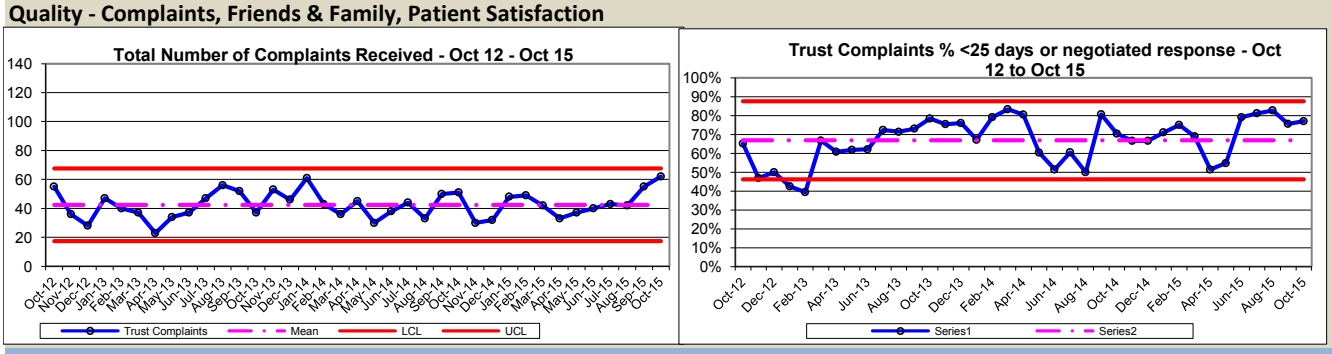
Patient Safety, MSA Breaches, SIs, Readmissions



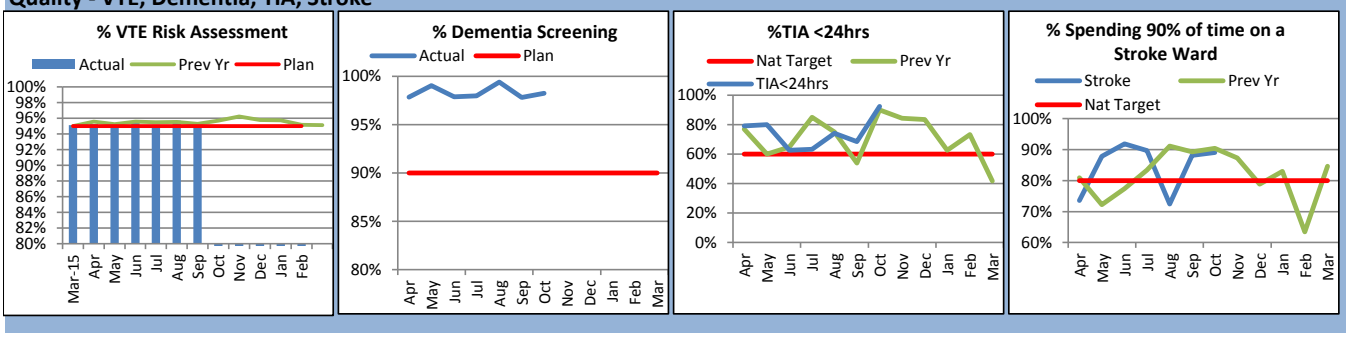
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

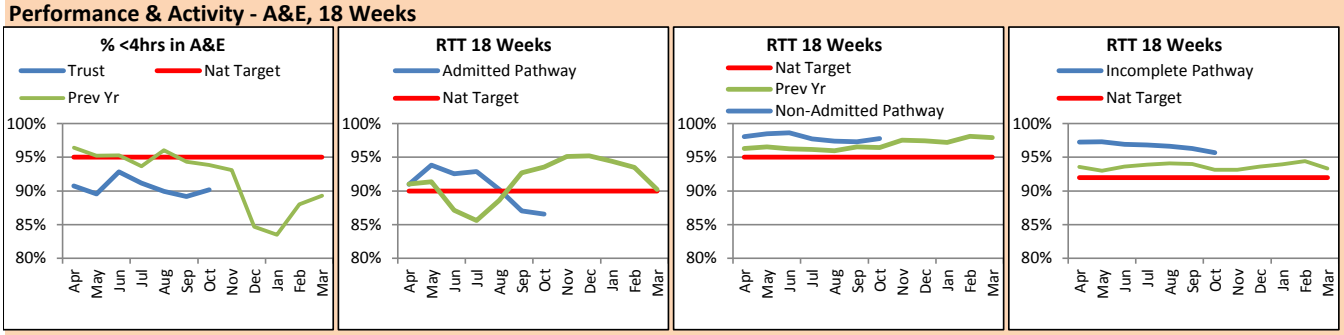


Quality - VTE, Dementia, TIA, Stroke

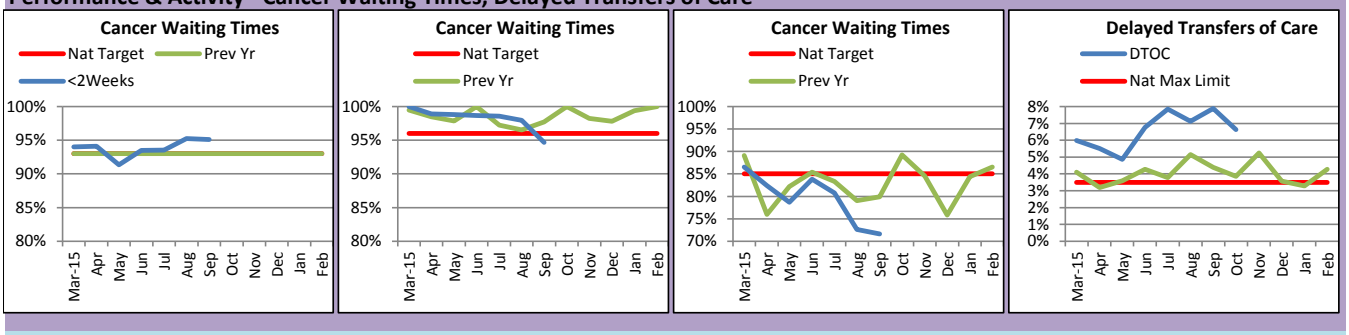


INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

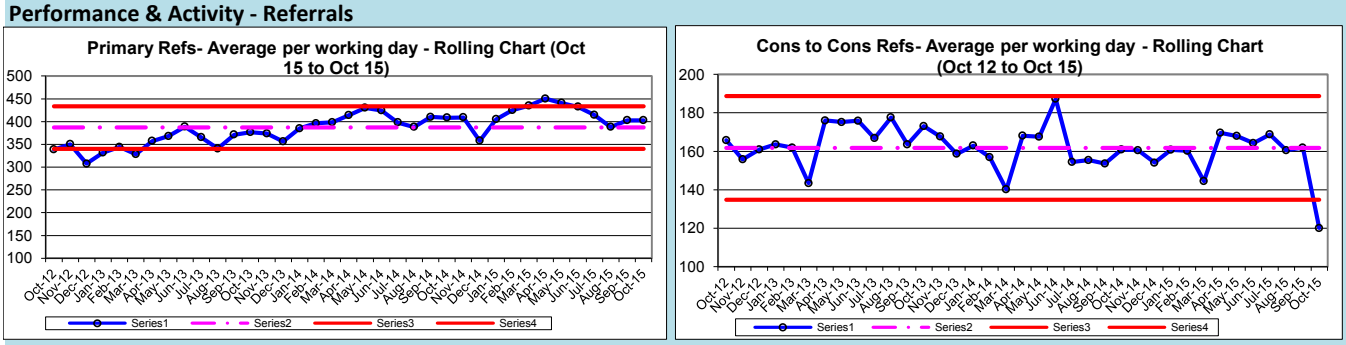
Performance & Activity - A&E, 18 Weeks



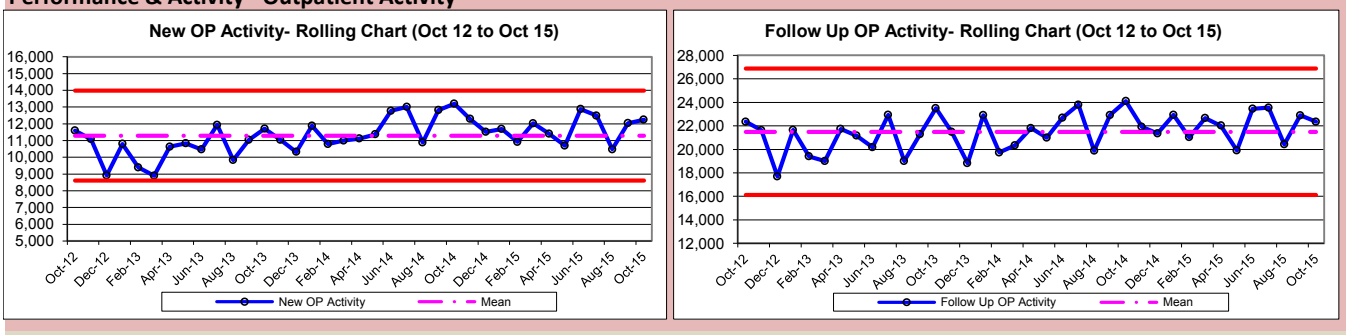
Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



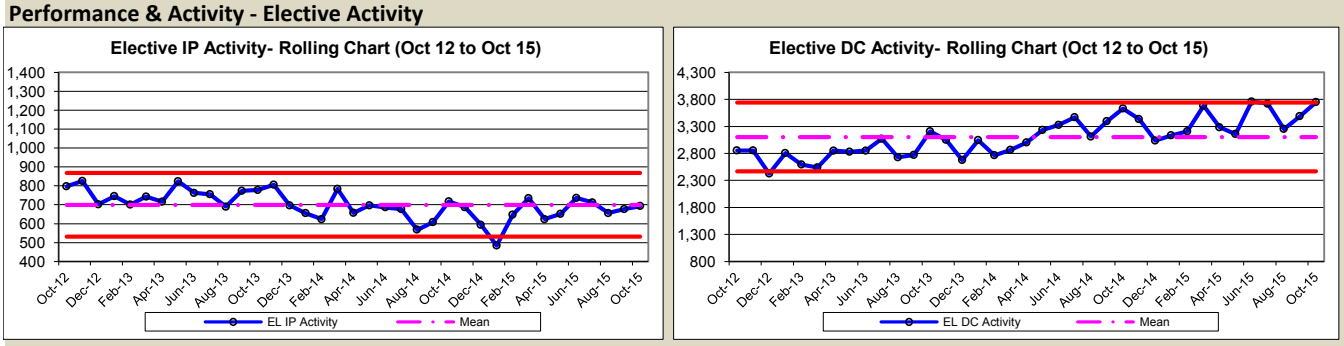
Performance & Activity - Referrals



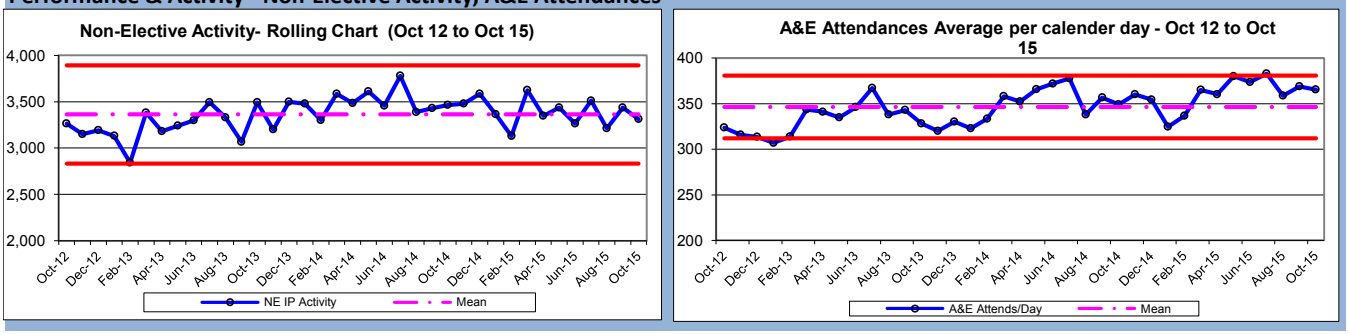
Performance & Activity - Outpatient Activity



Performance & Activity - Elective Activity

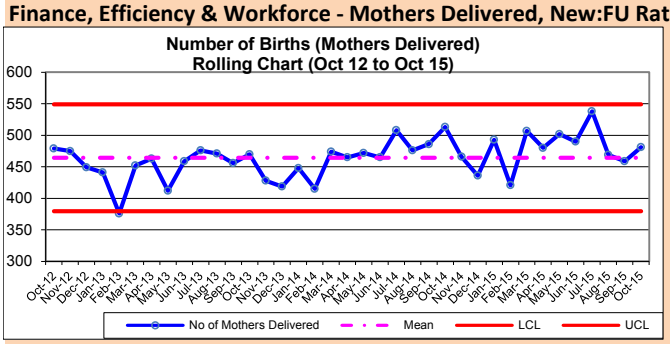


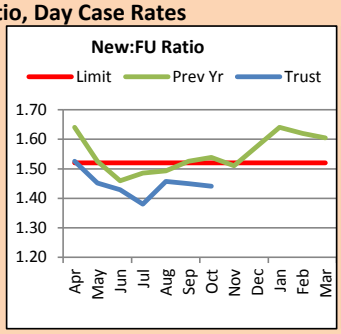
Performance & Activity - Non-Elective Activity, A&E Attendances

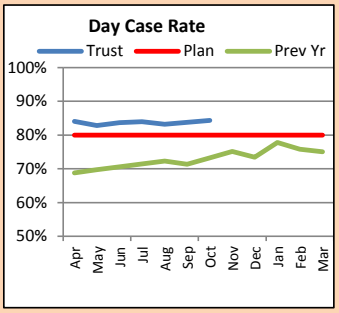


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

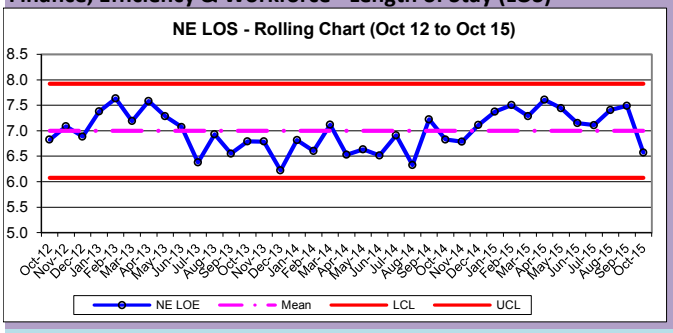
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

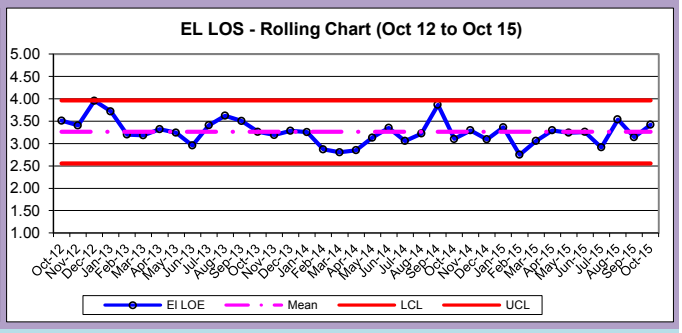




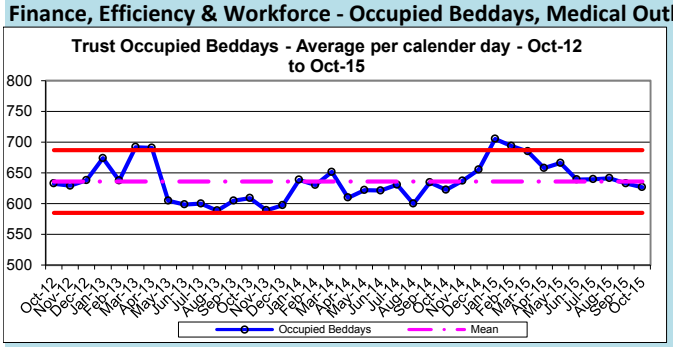


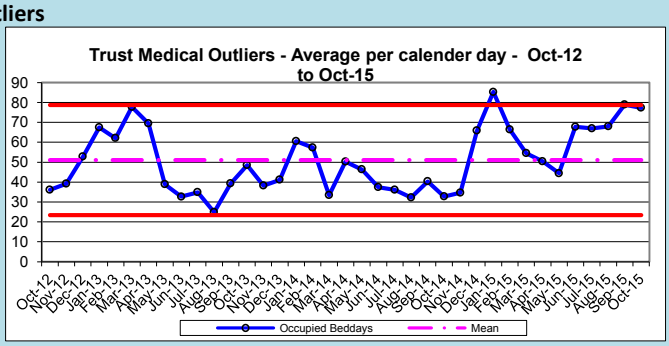
Finance, Efficiency & Workforce - Length of Stay (LOS)



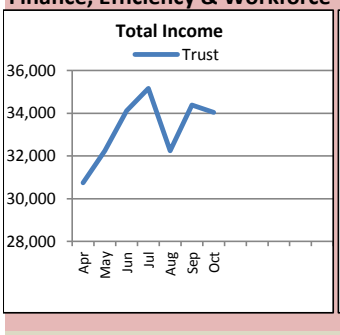


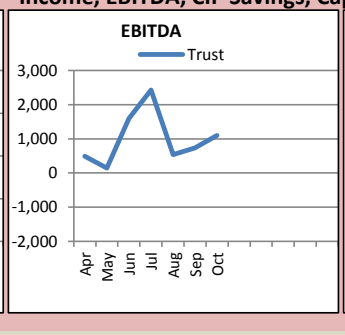
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

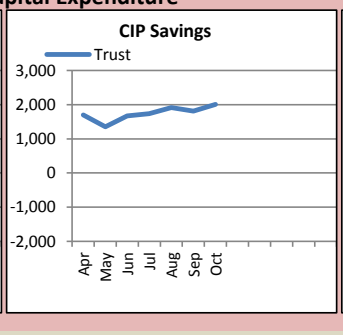


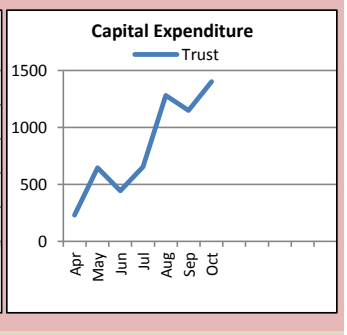


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

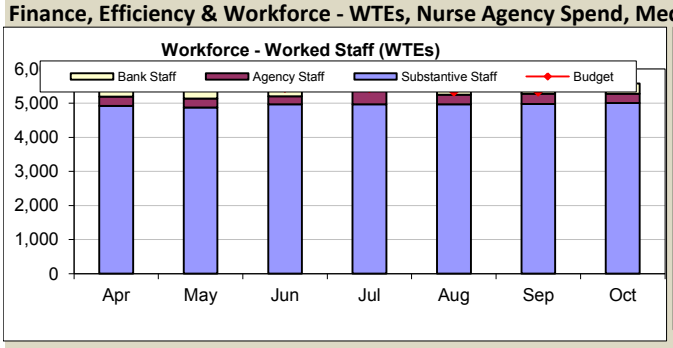


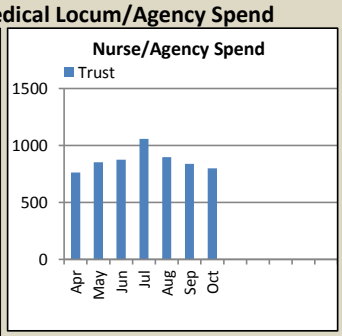


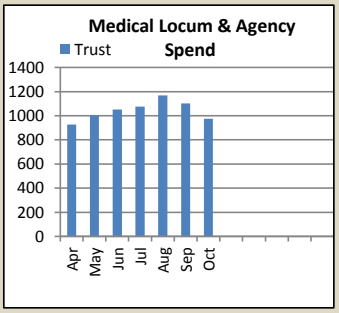




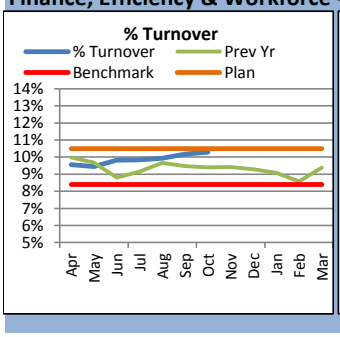
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

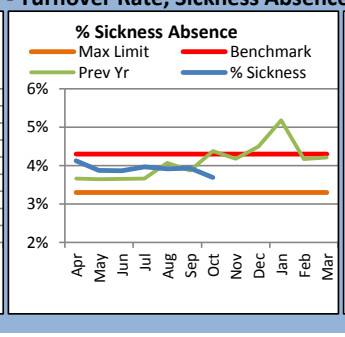


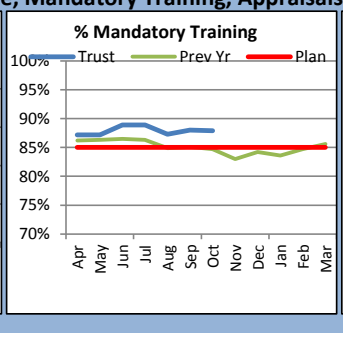


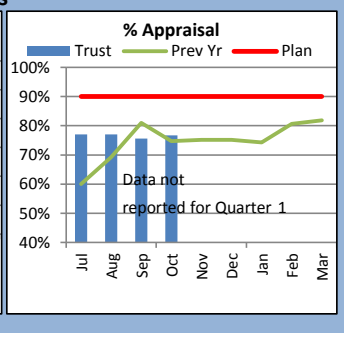


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting– November 2015

11-10 Review Of Latest Financial Performance **Director Of Finance**

Summary / Key points

- The Trust had an adverse variance against plan at the end of October 2015 of £3.4m, an increase of £1.41m in the month.
- The Trust's net deficit to date (including technical adjustments) is £12.79m against the planned deficit of £9.39m. In the month the Trust operated at a deficit of £1.7m against a plan of £0.28m deficit for October.
- There are a number of key risks to the Trust's year end position. The risks are:
  - The Trust's ability to deliver its elective workload to planned levels;
  - The impact of staffing costs over plan, albeit with the plans in place to reduce agency reliance and increase substantive staffing;
  - The CCG's ability to provide the finance requested and included in the Trust's plans to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors;
  - Slippage on the delivery of a number of Directorate and Strategic plans intended to increase market share relating to East Sussex and Medway non elective workload, E Sussex maternity developments, areas of Best Practice Tariff and other income related CIPs. High levels of income in previous months mitigated this slippage.
- In October the Trust operated with an EBITDA surplus of £1.1m which was £1.6m adverse to plan.
- The Trust held £7.2m of cash at the end of October, a reduction of £2.9m from the end of September.

Reason for receipt at Trust Board

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

Briefing paper – Trust Board

M7 Financial Performance overview

1. Overview of the Financial Position at M7 2015/16

1.1. This written summary provides an overview of the financial position at M7 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 7. The Finance pack shows for month 7 the Trust moved out adversely by £1.4m against its in-month deficit plan of £0.28m resulting in a year to date deficit of £12.79m against a planned deficit of £9.39m. This is an adverse year to date variance of £3.4m. These figures include the full utilisation of reserves available for the first seven months of 2015/16.

1.3. Financing to support the Trust's liquidity through an Interim Revolving Working Capital facility (IRWCF) was approved by the Trust Board in October and signed off by the DH. This facility may be converted into a more formal loan or PDC product in 2016/17. The initial drawdown of £6.5m against this facility has been made in November.

Income

1.4. Total income for the year to date is £232.9m against a budget of £229.2m. Income for the month is £34.0m compared to the £33.6m plan for the month.

1.5. The income headlines are outlined below:

- Total income is £3.4m favourable to plan year to date.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges. A total of £4.0m provisions/deductions and £3.2m threshold adjustments are included in the year to date position with £7.3m provisions/deductions and £5.6m threshold adjustments in the forecast outturn.
- A&E attendance activity remains higher than in the corresponding period of last year.
- The Conversion rate for October is 25% which compares to 27.5% for the same month last year. The conversion rate has remained at the same level since June this year.

1.6. There was an increase in Elective inpatient and day case activity compared to last month's level (£5.3m in M7 compared to £4.9m in month 6, with a YTD under performance of £0.4m), however overall this remains below planned levels, and is dependent on outsourced activity. Day activity is now on plan for year to date, while electives are £0.4m under achieved. Even though there was some benefit realised from better bed management, there were also unutilised weekday theatre sessions, and reliance on outsourcing and additional weekend waiting list sessions.

1.7. A&E attendances increased marginally in October in line with the normal seasonal trend. However, the Month 7 A&E income was 14% higher than the corresponding month of the last financial year level. The rate of conversion from A&E to admission fell from 27.5% to 25% over the same period.

1.8. Whilst Non - Elective admissions remained flat from September to October, there was a reduction in activity over the same period in some specialties particularly in General Medicine and General Surgery. However, this was compensated by an increase in activity in Paediatrics, Obstetrics and Elderly Care. The income per spell decreased across most of the Non elective specialities suggesting a reduction in the acuity of patients being seen. Overall Non-Elective activity continues to be lower than in 2014/15. The levels of DTOC activity remain high though there was a reduction in the month from 7.9% to 6.6%.

1.9. Outpatient activity remains unchanged from last month's level of £4.8m. Year on year, the income from Outpatient activity was 14% higher the corresponding period of the previous financial year but is still lower than planned levels.

1.10. Readmissions, A&E waits and RTT penalties (relating only to incomplete pathways) were £2.2m in October compared to the £1.8m performance in September.

1.11. An 85% achievement rate for CQUINs has been assumed in the income position. This is unchanged since Month 5.

1.12. Non recurrent transitional support of £2.1m year to date for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Outsourcing

1.13. The value of income related to outsourced activity increased to a 2015/16 record level of £0.34m in October, with a cumulative total of £1.8m. The average for the year is c. £260k per month. 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.

1.14. The fewer discharges experienced in October, combined with escalation pressures, led to the intermittent opening and closing of Whatman ward which was initially closed in September. While Medical Outliers reduced slightly in the month (79 in Sept vs 77 in Oct), there was an increase in Surgical Outliers (27 in Sept vs 29 in Oct). Even though there was a reduction in all cancellations (reportable cancellations Sept 42 vs 18 in Oct and "patient induced" cancellations 74 in Sept vs 70 in Oct), there was loss of potential activity from unutilised weekday theatre sessions due to staff absences where not all the sessions were replaced.

Expenditure

1.15. Operating costs are £7.97m adverse for the year to date against a planned budget of £217.9m. Pay was over plan by £1.0m in October generating a year to date adverse variance of £6.2m. This was the second lowest pay cost month for the year to date.

1.16. Non pay overspent by £1.0m in October and is £1.8m overspent year to date.

1.17. Substantive staffing is underspent for the year to date by £1.9m due to (primarily prior period) vacancies in Scientific posts (£0.4m), medical staffing (£0.9m) and nursing (£0.5m). In the month substantive pay costs were underspent by £0.2m.

1.18. The year to date major overspends on agency usage are in Nursing (£4.2m), Medical agency (£1.7m), Scientific/Therapeutic agency (£0.7m) and Admin & Clerical (£0.7m). In the month there was a small reduction from September's level in nurse agency spend (£799k compared with £839k), while overall agency costs were the lowest for the year (£1.68m). Locum costs remained high and are £0.56m overspent to date, whilst Bank staff costs were on budget and remain £0.14m underspent.

1.19. The trajectory plan submitted to the TDA set out a reduction in agency costs (for trained nursing) of £0.5m through to the end of March with an overall reduction, including additional permanent staffing, of £0.3m. In October the total agency nursing (qualified and unqualified)

reduced to £799k which was £50k greater than the total October trajectory target (qualified and unqualified).

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

- Drugs and medical gases £2.5m adverse (offset in the position by the over performance in HCD income to date of £2.3m)
- Clinical Supplies is £1.5m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs.
- Purchase of Healthcare from non NHS is adverse to plan by £1.9m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income.

1.21. The main areas of under-spending in non-pay are in “other non-pay costs” which includes the reserves and contingencies released into the position. This is now £4.08m underspent to date.

1.22. Premises is £0.5m underspent to date; it includes the budget for the PAS replacement costs which are included in the budget to date but the costs are expected to occur later than planned, in November.

1.23. EBITDA is a £7.0m surplus year to date and is now adverse to plan by £4.56m.

1.24. The financing costs including those related to the PFI and deprecation total £20.4m year to date which is underspent against the plan by £1.16m. 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

1.25. The performance in October particularly around elective income and on the sustained level of pay costs including agency reliance, is putting a high degree of pressure on the Trust’s ability to deliver the original planned deficit of £14.1m as well as the additional stretch target of £12.1m.

1.26. In addition the CCG is signalling that it is unlikely to provide the finance requested and included in the Trust’s plans to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors.

1.27. There has also been 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, East Sussex maternity developments, areas of Best Practice Tariff and other income related CIPs. In previous months high levels of income mitigated this slippage.

1.28. CQUIN performance is currently assessed at 85% outturn delivery. There are risks around delivery of some of the individual schemes which might reduce the eventual performance and consequent income attainment.

1.29. The Trust needs to deliver on its CIP programme and achieve the planned reduction in agency spend, while maintaining control over substantive staffing and non-pay costs, and at the same time manage its non-elective flows, reducing length of stay and DTOCs, so as to optimise its ability to deliver its elective and OP activity. The Trust is considering further actions to support increased levels of delivery and generate additional income.

Balance Sheet & Capital

1.30. Cash balances of £7.2m were held at the end of October (£12.3m at the end of September). The Trust still has the benefit of the advance of one month's contract payment from CCGs along with its normal April payment.

1.31. Total debtors are £36.7m, £4m higher than the reported September figure. Debt over 90 days has increased by £0.8m to £5m at the end of October. Debtors in excess of a £1m are;

- WKCCG £8.5m
- EK Hospitals FT £2.4m
- NHS England £2.0m
- Medway FT £1.2m

90 day invoiced debt for private patients is currently £0.2m (£1.2m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.2m (£1.3m in total).

1.32. Total creditors are £56.4m. Payments to creditors have been slightly stretched in that only those falling due at the payment date are being paid, rather than those falling due prior to the next scheduled payment run. This means that potentially some invoices may be one to six days past their due date when they are paid. This action contributed to a reduced borrowing requirement for November c.£1m, but will adversely impact the Trust BPPC performance. Against the 95% target for payments made within 30 days the Trust achieved in value 88.1% in October for Trade creditors (81.3% in March 2015) and 81.9% in October for NHS creditors (66.6% in March 2015).

1.33. Financing to support the Trust's liquidity has been applied for through an Interim Revolving Working Capital facility (IRWCF), which may later be converted into a more formal loan or PDC product in 2016/17. The Trust's facility is limited to £12.132m initially, in line with the stretch plan total. The first drawdown on this facility was made on 16th November for a value of £6.5m.

1.34. 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.

1.35. Capital expenditure to month 7, net of donated assets, was £5.7m capital expenditure against the Trust's original plan of £6.6m for the same period. The forecast net outturn is £4.1m lower than the original plan, which is mainly accounted for by the agreement to reduce its loan request by £3m, and the decision not to proceed at this stage with the disposal of the Hillcroft residence (£0.9m, matched by reduction in spend).

1.36. In the month the TDA confirmed that the Trust under-spending on depreciation, due in part to the new ward project replacing previously planned equipment/ICT schemes, and the capping control that the Trust implemented prior to agreement to the external loan, would necessitate a reduction in capital resource limit. Therefore if the loan is not agreed the Trust would be likely to overshoot its capital resource limit as it would need to reduce its planned spend by a further c. £3m (the loan is £3.5m but there is some flexibility remaining around timing of equipment purchases).

1.37. The loan case is planned for submission to the TDA in November, and if agreed by the TDA will then go forward to the Independent Trust Financing Facility (ITFF) for decision in January 2016.

2. CIP Delivery

2.1. The month 7 position shows a CIP delivery of £12.2m against the target that was included in the TDA plan of £12.6m, so under-performing by £0.4m to date.

2.2. The schemes identified are forecast to deliver £20.6m by year end which is £0.1m more than the forecast reported at month 6, and leaves £0.9m of schemes that the Trust is working to identify.

2.3. Against the year to date CIP expectation of £12.6m, shortfalls in Medical Efficiency (-£0.3m), Length of Stay (-£0.6m) and Back office (£-0.5m) are in part offset by overachievement in Contract Management (+£0.9m) and Financial Management efficiencies (+£0.2m).

3. Conclusion

3.1. October elective performance was higher than in September but remains lower than planned for this year and includes significant levels of outsourced activity, especially in orthopaedics, where the Trust does not earn a margin. Outpatient activity is higher than last year, but is also behind the plan for this year, and there are issues in ensuring outpatient clinic capacity is fully utilised while referral rates rise and waiting lists are growing. Non elective activity is lower than last year, and LoS has reduced in the month, along with DTOCs (although these remain at a high level). The challenge for the Trust is how to ensure maximum activity is undertaken in house to bring the Trust back to, and above, planned levels of activity whilst contributing the financial margin required.

3.2. Overall Staffing costs were the lowest since April across all categories except bank usage. However this remains the most significant area of pressure on the Trusts' budgets, and is currently not being covered off by income at or above planned levels. Action to reduce both the use of temporary staffing and the cost of agency has been implemented with Directorates and the downward trajectory needs to be sustained to progressively reduce reliance on agency staffing, and to convert to framework contractors, along with strengthened controls over rota management.

3.3. The risks identified in the previous months remain and have increased, as lower levels of activity than planned, together with sustained staffing costs at higher than plan levels, and some significant elements of income support or developments becoming less likely to be realised in-year, impacting on the delivery of the forecast outturn figure.

3.4. The Trust Board is requested note this report.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M7 - October 2015

October 2015

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 7 2015/16

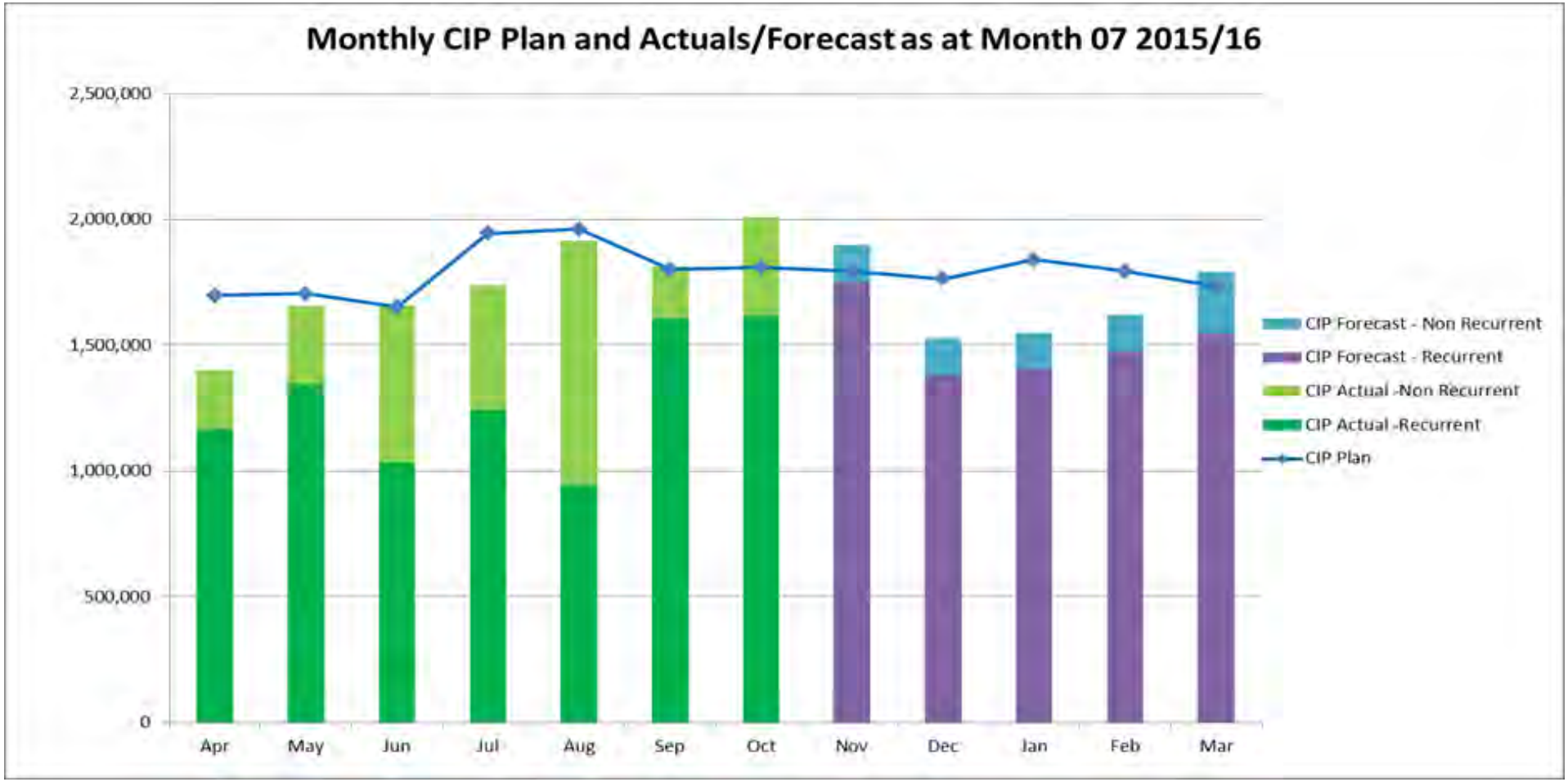
(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

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)	(12,132)	0	RED
1b) Year to Date, Actual compared to Plan	(9,387)	(12,787)	(3,400)	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	9,546	9,302	(244)	
- Recurrent Efficiencies for Year to Date compared to Plan	9,546	7,065	(2,481)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	17,357	(789)	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	14,296	(3,850)	
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		0		GREEN
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	2.00	0.00	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

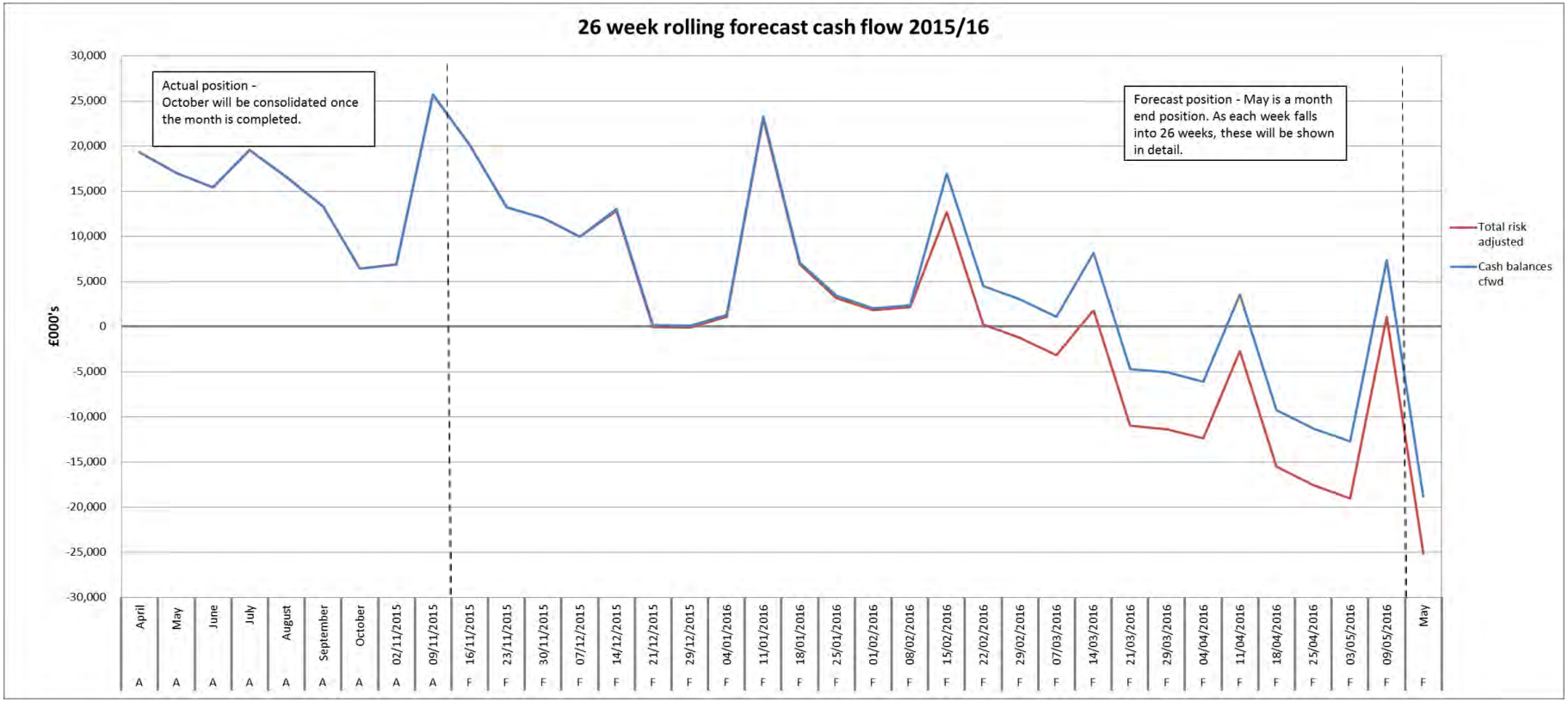
Maidstone and Tunbridge Wells NHS Trust



Recurrent Analysis	YTD £'000	FOR £'000
Recurrent	8,956	16,518
Non Recurrent	3,236	4,061
Total	**12,192**	**20,579**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of forecast cash balances up to w/c 9th May 2016, actuals at 13th November 2015



Week commencing	A April	A May	A June	A July	A August	A September	A October	A 02/11/2015	A 09/11/2015	F 16/11/2015	F 23/11/2015	F 30/11/2015	F 07/12/2015	F 14/12/2015	F 21/12/2015	F 29/12/2015	F 04/01/2016	F 11/01/2016
Cash balances cfwd	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**6,871**	**25,690**	**20,159**	**13,256**	**11,998**	**9,960**	**13,030**	**152**	**82**	**1,283**	**23,278**
Debtors carry forward into 15/16	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	0	0	0	0	0	0
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	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	0	219	219	219	219	219
Total risk adjusted	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**6,871**	**25,690**	**20,159**	**13,256**	**11,998**	**9,960**	**12,811**	**-67**	**-137**	**1,064**	**23,059**

Week commencing	F 18/01/2016	F 25/01/2016	F 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	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 May
Cash balances cfwd	**7,082**	**3,395**	**2,037**	**2,344**	**16,965**	**4,487**	**3,049**	**1,111**	**8,135**	**-4,712**	**-5,072**	**-6,115**	**3,552**	**-9,220**	**-11,303**	**-12,736**	**7,355**	**-18,827**
Debtors carry forward in 15/16	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	2,000	2,000	2,000	2,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	219	219	219	219	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292	2,292
Total risk adjusted	**6,863**	**3,176**	**1,818**	**2,125**	**12,673**	**195**	**-1,243**	**-3,181**	**1,843**	**-11,004**	**-11,364**	**-12,407**	**-2,740**	**-15,512**	**-17,595**	**-19,028**	**1,063**	**-25,119**

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-11 CQC Quality Improvement Plan Chief Nurse

Summary / Key points

The November 2015 Assurance Report for the CQC Quality Improvement Plan (QIP) is enclosed.

The key points of note are:

- The Enforcement Notice has now been lifted by the CQC.
- 9 of the 18 compliance actions have been completed and closed, with 9 still in progress.
- Of those compliance actions still to be fully completed there has been significant and reassuring progress demonstrated, with some awaiting final audits to demonstrate full compliance / change in practice

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 18/11/15

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

CQC Quality Improvement Plan

Assurance Report November 2015

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 has now been lifted by the CQC. 9 of the 18 compliance actions have been completed and closed, with 9 still in progress. Of those compliance actions still to be fully completed there has been significant and reassuring progress demonstrated with some awaiting final audits to demonstrate full compliance / change in practice.

Compliance actions – Paediatrics

There has been good progress with the electronic solutions (Nervecentre) for PEWS and escalation with Paediatric inpatients and day case going live in November. This will further support staff to identify deteriorating patients requiring review.

Compliance actions – Critical care

There are continued challenges with out of hours transfers from ITU. During October 4 patients, all at TWH were transferred out of hours. This compares with 5 in September, 1 in August and 8 in July all TWH. All mitigation is in place and each case is reviewed for learning. The opening of the new 38 bed ward in February 2016 will ease capacity challenges and thus improve our ability to further reduce any discharges out of hours from ITU.

Compliance Action – Equality and Diversity

The Diversity Management group met for an inaugural meeting in October to provide appropriate organisational governance and provide assurance to the Trust Board in relation to Equality and Diversity.

Compliance Action – Trust wide Governance

Following the external governance review that included broad staff engagement, a proposed new governance framework has been developed. This will include a clear ward to board and board to ward structure for clinical governance. The intention is to for the new framework to be in place by the end of December 2015.

Status of plan

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

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

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

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

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Enforcement notice lifted. Completed compliance action
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		PEWS in place in all required areas, training completed and rolling program for new starters. Audit to provide evidence of implementation underway. PEWS being added to NerveCentre November 2016.
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Completed compliance action
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Standard Operating Procedure now in place. Just awaiting the additional pathway for patients in escalation areas which is nearly completed
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During October 4 patients, all at TWH were transferred out of hours Incident report raised. This compares with 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	Siobhan Callanan Associate Director of Nursing		The Trust has commenced 24/7 critical care outreach Completed compliance action

service provision			
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		In progress, no concerns raised
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Completed compliance action
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Integration with medical records review as part of Directorate Clinical Governance meetings being implemented
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		Website being updated and due to be completed by end of November
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Audit outstanding
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		New Governance framework proposed and expected to be implemented by the end of December 2015
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		Most of the audit has been completed and shows compliance, final area to be audited outstanding.

Maidstone and Tunbridge Wells NHS
NHS Trust

Enforcement Notice

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria	Delivery RATING
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 and Ambulatory completed **PEWS audit ED due to be completed November 2015**			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	New PEWs charts being added to nerve centre system Plan to go live across Inpatient and Daycase only on 24th November	6. Compliance audit from Nervecenter	31/12/15	
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				
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)	SOP ratified at Standards committee in August 2015. Task and finish group of all stakeholders working on pathways for patients in escalation areas formulated and draft pathway disseminated for comment. Second meeting to discuss version 3 pathway arranged in November. Policy and procedure drafted and circulated for comment.		30/4/15 New date: 30/11/15	
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 :				
There was an improvement in delayed admissions in September with no delayed admission over 4hrs (compared 6 over 4hrs in August).				
Areas of concern for escalation:				
Long term solution planned for 2016 with further bed-stock being available (New Ward).				

Maidstone and Tunbridge Wells NHS
NHS Trust

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:				
Continue challenges meeting required performance targets due to patient flow issues				

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 October 4 patients, all at TWH were transferred out of hours Incident report raised. This compares with 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 New date 31/03/16	
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.				

Maidstone and Tunbridge Wells NHS
NHS Trust

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, expected in post early 2016 Chief Nurse appointed as 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	
2. Develop an E&D awareness programme for all staff	E&D training 89% compliant against 85% target (April 2015) Benchmarking and intelligence from partner Trust to inform awareness programme and roll out plan		1/10/15	
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 on 4 September		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated July 2015		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		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, anticipated publishing 1/10/15. Comprehensive review will be undertaken when substantive postholder in post (see 1)		1/4/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Development of new Diversity Management Group. First meeting 30 October 2015.		1/9/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): Approved business case for E&D lead				
Assurance statement :				
In progress				
Areas of concern for escalation:				

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

Compliance action 11 CA11

Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*

Lead: *Paul Sigston, Medical Director*

Operational Lead: *Wilson Bolsover, Deputy Medical Director*

Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) Discussed with Clinical Directors 7/10/15 b) This has been considered. Decision following audit is to not pursue this at this time c) Audit completed with staff involvement. Action plan developed	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15 new date 1/9/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Not commenced as yet, communication going out in November to establish this process		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 developed

Areas of concern for escalation:

None

Maidstone and Tunbridge Wells NHS
NHS Trust

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:				

Maidstone and Tunbridge Wells NHS
NHS Trust

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 due to be compelted on website in November		Intranet 1/6/15 Website 1/10/15 New date 1/12/15	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	Datix upgrade completed. Datix review group established. Reporting page streamlined and quicker. DATIX app now loaded on the new Ipad's to be used in clinical practice		1/6/15 New date for completion of all actions: 1/8/15	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	Identified within team and included in Governance team strategy Revised RCA training identified but not planned until January 2016. Incident reporting and patient safety included in induction training for new staff		1/9/15 Revised RCA training 28/2/16	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Monthly articles in Governance Gazette		Monthly	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is well underway with good progress.				
Areas of concern for escalation:				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned and awaiting results		1/8/15 New date for completion of audit 1/1/16	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	New Governance framework developed with implementation by 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				

Maidstone and Tunbridge Wells NHS
NHS Trust

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

Maidstone and Tunbridge Wells NHS
NHS Trust

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 developed with implementation by December 2015	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	Under development alongside the new Governance framework		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 guidelines drafted and out for comment Agreement with IT/ health informatics to implement e-form. Working group met in October. NTDA reviewed process in August, awaiting report. CCG invited to Trust Mortality Review Group		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 :				
Continued work in this area				
Areas of concern for escalation:				
Delay due to waiting for the external Governance report that has now been presented. Full Implementation expected by the end of December 2015				

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	Topical anaesthetic cream now prescribed at all pre-assessment clinics TWH ambulatory and inpatient areas audited Nov 15 and compliant MH ambulatory unit to be audited by end of November		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): competency and training list				
Assurance statement :				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

11-12 Clinical Quality And Patient Safety Report **Chief Nurse**

Summary / Key points

This exception report provides the board with an update on the following 4 issues:

- Pressure Ulcer category 3 & 4 incidents at MTW
- Investigating ward safety climates and the effects of interventions on preventable patient falls - A Pilot Project
- Complaints rate and response times
- Complaints, Legal, Incidents and PALS – triangulation

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

Quality & Patient Safety Report

November 2015

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

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

Review of category 3 & 4 pressure ulcers

Pressure ulcer prevention has been, and remains, a key focus for nursing. Significant improvements have been made over the last 4 years with particular focus on hospital acquired damage. A pressure ulcer review group was established in October 2010, chaired by the Deputy Chief Nurse. In December 2010 there were 22 cases of pressure ulcer damage under review, all hospital acquired category 3 or 4. Of these, 10 were reported in month. The Trust's overall prevalence at this time was 22%

Over the following year significant reductions were seen as a result of multi-disciplinary working, raised awareness and incorporating pressure ulcer prevention awareness into all aspects of clinical education and update (including moving and handling training). As a result the Trust has seen a sustained reduction in pressure damage and has been free of hospital acquired category 3+ pressure damage for 10 months. The Trust's overall hospital acquired prevalence in February was 4.4%

Between July and September of this year, three patients sustained category 3 and/or 4 pressure damage. Of these 1 one was considered avoidable, 1 unavoidable with the third case still under review. These events triggered a further review of systems and processes at ward level, including a review of mattress stock (completed November). A trust-wide pressure ulcer prevalence audit was undertaken in September and is now at the report writing stage. This local review did not raise any significant concerns, with overall good compliance with pressure relieving strategies, appropriate use of mattresses which were all in good condition.

In order to get some more meaningful triangulation and comparison data, neighbouring trusts were asked if they could provide their most recent pressure ulcer incidence data, specifically in relation to category 3 and 4.

The European Pressure Ulcer Advisor Panel (EPUAP) and the Tissue Viability Society advise that any ulcer which has necrotic tissue or scab should be classified as un-gradable. The rationale for this is that the wound bed needs to be visible before accurate classification and subsequent management decisions can be made. It is possible for a scab to reveal a wound that would be categorised as a 4, or indeed a 2. Maidstone and Tunbridge Wells NHS Trust follows this guidance for classification and reporting.

Local context:

Medway and East Kent Hospital supplied information from April – October 2015. Medway are averaging 1 category 3 pressure ulcers per month, with 6 reported between April and October, and

1 category 4 pressure ulcer in 2014/15. Medway use the EPUAP methodology for classification and reporting.

East Kent Hospitals do not use EPUAP methodology for classification and reporting. East Kent Hospitals report their ungradable ulcers as Category 3. This makes any direct comparison impossible. However, East Kent has reported 5 category 3s and 1 category 4 between April and September 2015.

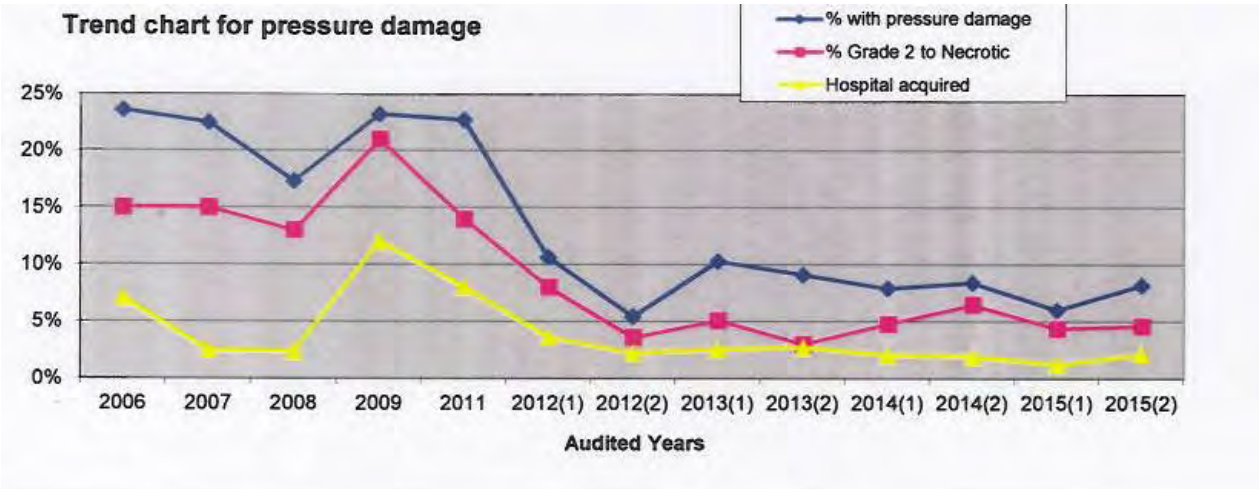
National Safety Thermometer data provides data (as a point prevalence or 'snap shot' audit) for 'Old' pressure damage and 'new' pressure damage. New pressure damage being damage that manifests at or after 72 hours following admission.

The data for 2014 for acute providers with in Kent was looked at. Acute providers were identified by searching Clinical Commission Groups (CCGs). The search range included Dartford & Gravesham, Medway, Canterbury and West Kent. Ashford and South East Kent were excluded as these CCGs do not directly commission acute care provision.

For all new damage, Maidstone and Tunbridge Wells NHS Trust was similar to peers with higher incidence of damage (Category 2 -4) during the summer months and reducing towards the winter. The exception was East Kent whose numbers were higher throughout the year. As noted previously, this may be due to variation in case mix and methodology used for categorisation.

Maidstone and Tunbridge Wells NHS Trust was lower than peers for incidence of Category 3 pressure damage and significantly lower than peers for Category 4, having last had a category 4 pressure ulcer in October 2014.

Chart – MTW pressure ulcer prevalence (hospital acquired and non hospital acquired



The chart demonstrates an upward curve, however overall numbers are small. The average incidence is 11 -12 category 2 per month. We had a high of 14 in May 2015 which decreased to 11 and has held until September where we saw an increase to 13. October was 12.

National Context:

There has been no published national data for prevalence or incidence in the UK for over a decade. Quality Observatories have attempted to collate data, with the HSCI National Safety Thermometer now collecting incidence data nationally. Previous studies have indicated that there

is a 13% prevalence (Category 2 and above) in the UK (EPUAP cited in Dealey 2012). Maidstone and Tunbridge Wells NHS Trust prevalence audit suggests a prevalence of 4.4% (Feb 2015).

There is a general consensus in the literature that incidence of pressure damage is an indicator of good nursing care, despite incidence remaining static until recently (Samuriwo 2012). This can lead to the view that all pressure damage is avoidable.

The National Pressure Ulcer Advisory Panel (NPUAP) held a consensus conference in America in 2010 to review all the available literature. They concluded that there were times when pressure damage may occur despite all appropriate measures being put in place. The consensus conference cites a number of scenarios and conditions where this is likely (Black et al 2010). Further work on this subject was undertaken by NPUAP and arrived at similar conclusions (Edsberg et al 2014).

Investigating ward safety climates and the effects of interventions on preventable patient falls - A Pilot Project

Maidstone and Tunbridge Wells NHS Trust has seen a small increase in the number of preventable harms over the past 5 months, with falls being the main trigger. Patient falls have been above the maximum limit (6.2per 1000 occupied bed days) since May 2015. In October the rate was 7.2 and September 7.9 per 1000 occupied bed days. Many interventions have already been implemented to reduce the rate of falls overseen by the Falls Prevention Practitioner and multidisciplinary Falls Group. An intensive training and competency programme has been in place for some time and the Trust uses appropriate risk assessment processes and available equipment for falls prevention.

Current research promotes the use of interventions and investigations into staff behaviours and attitudes regarding the safety climate of the ward and how this can have a positive impact on the reduction of preventable harms occurring. A pilot project aims to adapt and investigate this hypothesis within the inpatient environment onsite.

The project aims are:

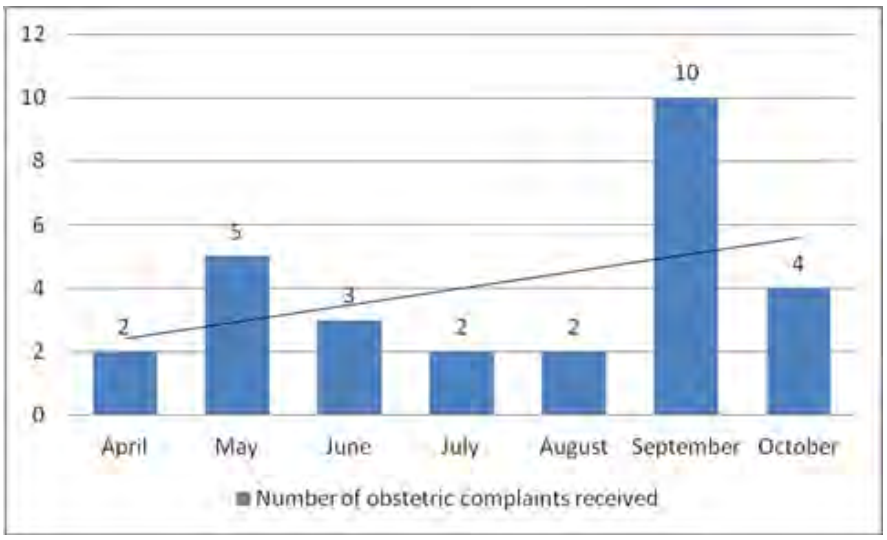
- To investigate staff culture, attitudes and concerns when considering preventable harms in the inpatient ward environment
- To analyse the effectiveness of low level interventions in reducing the number of preventable harms quantified as patient safety indicators. The indicators for this project are; pressure ulcers, falls, medication errors and reports to complaints/PALS

Wards identified for this pilot project are Mercer Ward at Maidstone Hospital and Ward 20 at Tunbridge Wells Hospital. The project will commence on 1st December 2015 and run for 3X30day improvement cycles.

Results will be considered and published with a view to extend effective practice and analyse further with future research.

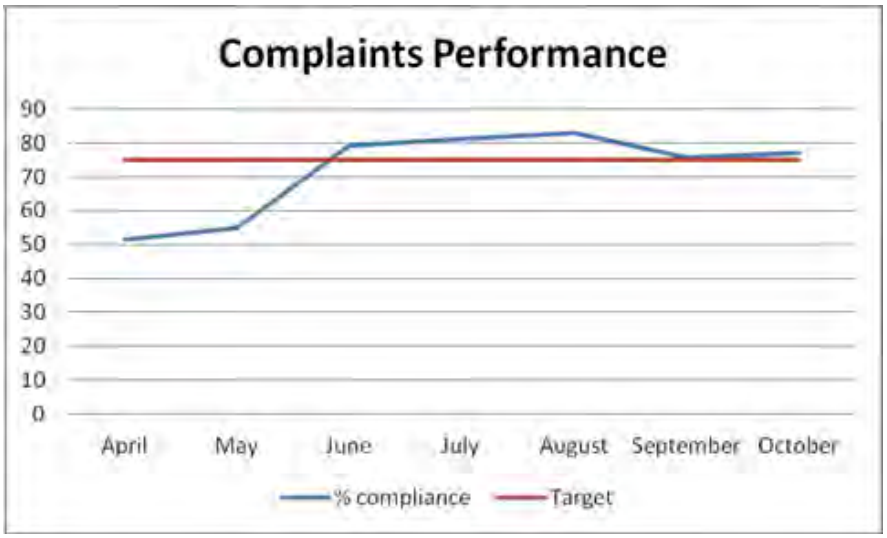
Complaints

MTW received 139 new complaints between July and September 2015 (quarter 2). Of these, 51 related to inpatient services, and 53 related to outpatients. Of note, the Trust has seen a rising trend in the number of Women's Services complaints being received, as illustrated below:



In view of this increasing number of Women's Services complaints, discussion has been initiated with the senior directorate management team to identify and address the causes of these complaints. The complaints are varied across the directorate and focus on a range of issues. Furthermore, early extension of the pilot programme (lead by the central complaints team) to the Women's' and Sexual Health Directorate is under consideration to support them in this.

Despite an increase in the number of complaints received as compared to the previous quarter and high activity levels, the Trust has continued to consistently achieve the complaints performance target of 75%, as illustrated below:



Roll out of the pilot programme is being planned with the next phase of implementation due to incorporate Women's and Sexual Health, Paediatrics, Cancer & Haematology, Diagnostics, Therapies and Pharmacy Directorates and Corporate Service. We are launching a new complaints satisfaction survey to review the quality of the service being provided and as part of this, we are seeking earlier feedback from complainants.

For complaints closed in September and October, 52% were upheld or partially upheld following investigation. Outcomes and actions taken in light of these complaints include:

- Review of practice around requesting leave
- Decision made not to rebook an agency nurse
- Alert added to the drug chart for patients continuing on supportive therapy without chemotherapy

- Changes made to the consent process to make specific risks in relation to diabetic patients more explicit; changes to administration practice to limit the amount of anaesthetic and iodine used/left in contact with the eye.
- Staff reminded of need to remove tourniquets via staff meeting
- Change in practice agreed around providing copies of medical records
- Nurse to attend customer care training
- Knowledge gap audit undertaken around management of hand wounds
- New process introduced around the management of Nomad boxes in pharmacy
- Checklists revised to ensure any iodine allergies are specifically recorded
- Departmental best interest meeting processes being reviewed
- Additional training to be delivered to ward team around management of NG tubes
- Session in local anaesthesia to be added to the middle grade doctors teaching programme
- Teaching to be delivered to ENP's by orthopaedics; learning from case shared via regional ED Deanery meeting

Complaints, Legal, Incidents and PALS

The Complaints, Legal, Incidents and PALS (CLIP) meeting has been resurrected to improve triangulation of data, communication and shared learning. The Patient Safety Manager, Complaint and PALS manager, Trust Solicitor and Associate Director Quality Governance & Patient Safety meet weekly and share updated information from their areas. Any cross over data or cases are identified and themes and trends considered. This group will enable a more timely review of any emerging themes and trends through these indicators which they will share appropriately. A monthly report will be produced to share learning across the Trust.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

11-13 SAFE STAFFING: PLANNED V ACTUAL OCTOBER 2015 CHIEF NURSE

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of October 2015. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

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

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'.

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

Other areas, most notable UMAU and SAU where trolley bays have been converted to beds to provide 24 hour care to meet increased urgent care demand – i.e. escalation.

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

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

A number of wards have had a shift in RN: CSW ratios, notably Cornwallis, Foster Clark, and Ward 11. In these areas this was a considered action based on professional judgement, available skill mix and patient acuity and dependency.

Financial data is included to provide a comparison of actual spend versus planned. The financial data will be a mixture of actual payments to substantive staff and temporary staff, and also accruals for expected expenditure where requests for payment have not been presented.

Decrease in overspend is noted in a number of areas; including Cornwallis and Ward 31.

The RAG rating for the fill rate is rated as:
Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

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

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

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

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

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

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

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

	Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at 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

Oct-15		Day		Night		Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	96.8%	101.6%	99.2%	100.0%	88.9%	100.0%	10	0			107,868	111,683	(3,815)
MAIDSTONE	Romney	98.9%	100.6%	96.8%	100.0%			2	1			66,973	86,783	(19,810)
MAIDSTONE	Cornwallis	79.8%	148.4%	87.1%	106.5%	26.3%	100.0%	1	0		RN Reduction was an accepted risk based on clinical needs. CSW increase reflects this as Bank CSWs were utilised to support RN rather filling with bank/agency RNs; reviewed by Ward Manager & Matron.	93,344	84,250	9,094
MAIDSTONE	Coronary Care Unit (CCU)	96.8%	N/A	83.9%	N/A	42.1%	100.0%	0	0		CCU is co-located with Culpepper and staff cross-cover as required. Fill rate was an accepted risk.	104,551	141,233	(36,682)
MAIDSTONE	Culpepper	100.0%	96.8%	100.0%	100.0%	49.0%	100.0%	1	0					
MAIDSTONE	Foster Clark	87.1%	117.2%	102.4%	108.1%	34.5%	95.0%	6	0		RN reduced fill rate, complimented by increase in CSWs as acuity was within acceptable limits.	105,534	134,091	(28,557)
MAIDSTONE	Intensive Treatment Unit (ITU)	93.1%	90.9%	88.3%	N/A	20.0%	100.0%	0	1		RN fill rate acceptable as acuity and dependency was low. 1;1 and 1;2 ratios maintained for Level 3 and level 2 patients respectively.	152,538	154,478	(1,940)
MAIDSTONE	Pye Oliver	94.8%	104.3%	99.2%	138.7%	16.5%	100.0%	3	1		18 nights of increased dependency with identified patient/s requiring 1:1 care: Improvement plan in place	95,666	144,236	(48,570)
MAIDSTONE	Chaucer	116.1%	106.5%	116.1%	160.2%	105.4%	97.4%	9	1		12 nights of increased dependency with identified patients requiring 1:1 care.	79,299	172,395	(93,096)
MAIDSTONE	Lord North	106.0%	119.0%	111.1%	100.0%	69.4%	100.0%	3	0		1 patient requiring special/enhanced support for mental health reasons.	97,050	96,872	178
MAIDSTONE	Mercer	100.0%	119.4%	98.9%	135.5%	1.5%	100.0%	10	1		Covering escalated beds: escalated by 1 bay (annexed to Whatman Ward) which requires a constant nursing presence.	91,166	112,257	(21,091)
MAIDSTONE	MOU	100.0%	111.3%	96.8%	122.3%	NA	NA	1	0		Increased CSW requirement overnight for cognitively impaired patients.	134,418	78,886	55,532
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	92.2%	93.9%	130.1%	190.3%	13.1%	98.2%	2	0		Escalation beds overnight throughout month.	119,337	134,634	(15,297)
TWH	Acute Stroke	97.8%	98.4%	100.0%	100.0%	88.9%	100.0%	2	0			76,565	70,206	6,359
TWH	Coronary Care Unit (CCU)	97.8%	77.4%	100.0%	N/A	35.9%	92.9%	1	0		Reduced CSW fill rate mitigated with support from neighbouring ward as required.	57,300	61,061	(3,761)
TWH	Gynaecology	99.1%	97.5%	100.0%	100.0%	18.5%	85.7%	1	0			66,262	65,194	1,068
TWH	Intensive Treatment Unit (ITU)	102.8%	100.0%	106.0%	N/A	0.0%	0.0%	0	0			172,576	160,005	12,571
TWH	Medical Assessment Unit	90.7%	104.8%	91.4%	100.0%	4.7%	100.0%	14	2			151,252	174,485	(23,233)
TWH	SAU	104.3%	158.1%	130.6%	200.0%			0	0		Escalated beds overnight (overflow into Short Stay Surgery which also impacts on SSSU staffing requirements	65,750	76,629	(10,879)
TWH	Ward 32	93.5%	96.8%	100.0%	100.0%	19.0%	97.0%	2	0			119,911	126,447	(6,536)
TWH	Ward 10	94.0%	109.7%	102.4%	122.6%	24.1%	96.3%	3	1		6 nights of 1:1 nursing required for agitated patient/s	124,165	127,286	(3,121)
TWH	Ward 11	100.0%	122.6%	88.7%	143.5%	33.3%	97.7%	5	0		Risk assessed change in RN:CSW ratio at night as 3pts requiring 1:1 for 6 nights, and 2pt requiring 1:1 for 14 nights	125,584	126,355	(771)
TWH	Ward 12	81.4%	109.7%	77.4%	108.1%	5.2%	100.0%	17	0		RN:CSW ratio shift due to vacancies; 10 with 8 in pipeline - now with start dates. Improvement plan in place.	108,139	119,190	(11,051)
TWH	Ward 20	93.2%	84.7%	100.0%	125.8%	26.7%	100.0%	14	4		2 cohorted areas (rooms 1-10 & 22-31) combined for 4 nights.	122,805	126,532	(3,727)
TWH	Ward 21	105.3%	101.1%	92.9%	137.1%	3.7%	100.0%	8	0		Increased dependency at night, CSWs used where acuity allowed.	121,898	132,735	(10,837)
TWH	Ward 22	96.8%	114.0%	97.8%	103.2%	68.8%	90.9%	9	0			93,043	107,583	(14,540)
TWH	Ward 30	95.2%	101.7%	87.9%	145.2%	14.4%	94.7%	5	1		11 nights of 1:1 care required for cognitive impairment.	121,746	135,900	(14,154)
TWH	Ward 31	88.7%	83.9%	112.9%	87.1%	22.9%	90.9%	2	2		Recruitment plans starting to impact positively. Skill mix acceptable for acuity & dependency. Increased RN at night to reflect acuity requirements.	136,057	144,986	(8,929)
TCH	Stroke Rehab	93.5%	96.8%	100.0%	96.8%	50.0%	100.0%	1	0			57,413	54,948	2,465
TWH	Ante-Natal	100.0%	93.5%	93.5%	93.5%	30.1%	96.1%	0	0		1:1 care for women in established labour maintained. CSW recruitment 2 commenced, 2 in pipeline.	596,961	536,441	60,520
TWH	Delivery Suite	96.4%	90.3%	97.5%	87.4%			0	0					
TWH	Post-Natal	100.7%	82.3%	98.4%	83.9%			0	0					
TWH	Gynae Triage	98.4%	96.8%	98.4%	93.5%			0	0			14,086	10,514	3,572
TWH	Hedgehog	92.5%	81.1%	99.5%	83.9%	13.6%	97.8%	0	0		Minimal impact on care delivery. Recruitment plans in place to cover both vacacny and maternity leave.	186,191	173,300	12,891
MAIDSTONE	Birth Centre	100.0%	90.3%	100.0%	96.8%			0	0			65,394	62,445	2,949
TWH	Neonatal Unit	102.7%	87.1%	104.8%	83.9%			0	0		Minimal impact on care, as good levels of RN presence.	160,644	157,268	3,376
MAIDSTONE	MSSU	118.2%	95.5%	100.0%	N/A	NA	NA	0	0		Additional activity at weekend	42,528	39,166	3,362
MAIDSTONE	Peel	94.3%	119.5%	98.9%	N/A	0.0%	0.0%	0	0			80,270	76,422	3,848
TWH	SSSU	118.2%	109.1%	N/A	N/A	0.0%	0.0%	0	0		Area escalated.	36,096	25,475	10,621
												4,150,380	**4,342,370**	**(191,990)**

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-13 Ward Staffing Review **Chief Nurse**

Summary / Key points

The National Quality Board stipulates that nurse / midwifery staffing reviews should be presented to Trust Boards twice a year. These reviews are comprehensive, reviewing the methodology used to set establishments and the national guidance for the specific areas.

The areas reviewed in detail for this specific review are:

- Paediatric services
- Maternity services
- Pye Oliver Ward
- Haem-oncology Day Unit (HODU)
- Ward 30

The review has **not highlighted any immediate changes required**. Areas that may require changes / investment (linked to activity) will be considered through directorate business planning.

All staffing considerations are in line with national guidance, where this exists, and in keeping with the strategic views expressed by the Trust Development Authority, NHS England and the Care Quality Commission regarding triangulation and use of professional judgement. All ward areas staffing ratios and skill mix will be reviewed again over the coming months to ensure we are considering different roles and disciplines to support wards and not focussing disproportionately on trained nurse to patient ratios.

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

Reason for receipt at 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

1. Introduction:

This paper set outs to provide an update to the board on the on-going staffing reviews for nursing and midwifery. It provides the board with an update on the recommendations made earlier in the year, and provides assurance that nursing skill mix is a key consideration at directorate level, subject to oversight by the Chief Nurse.

2. National Guidance

There has been no new guidance of note issued in relation to safe staffing within the last year. The most recent guidance issue by the National Institute for Health & Care Excellence (NICE) relates to maternity care, and was published in February 2015. This document broadly supports the principles set out within Birth Rate Plus developed by the Royal College of Midwives. NICE does not set out to recommend specific midwife to mother ratios as there is wide variation in the type, level and geographical set up of maternity services nationally. However NICE does endorse the principle of 1 to 1 care for women in established labour.

The National Quality Board (NQB: 2013) sets out the requirements for regular reviews of staffing levels every 6 months and reports to Trust Boards.

3. Skill mix and nurse to patient ratios

The NQB 'How to ensure the right people, with the right skills, are in the right place at the right time (2013) is very clear that setting safe staffing levels is not just about numbers. Safe staffing also needs to take into account the skills of the available workforce and the nursing care demands.

The Trust sets nursing establishments based on the current evidence base combined with the professional judgement of the Ward Managers and Matrons. The current approach is to have a ward level workforce with a ratio of Registered Nurse (RN) to Clinical Support Worker (CSW) of 60/40 as the starting point.

There a number of variations, such as Romney Ward, where a different RN to CSW ratio is adopted. This is because the case mix in this area is more aligned to a community hospital level of dependency than an acute hospital ward.

The same approach is used for RN to patient ratios. There is a national consensus that a base point should be an RN to patient ratio of between 1:5 and 1:8.

This approach is also applied to paediatric ward settings; however the ratios vary according the age of the child. The Royal College of Nursing (RCN) in their document 'Defining staffing levels for children and young people's services (2013) recommend a ratio of 1:3 for children less than 2 years of age, increasing to 1:4 for older children. As with adult settings, this is dependent on skill mix, work patterns and geography of the clinical area.

4. Methodology

Methodology for reviewing staffing levels has remained unchanged, and is in line with the guidance set out by the RCN (2012) NQB (2013), and NICE (2014).Some key principles are kept in mind when agreeing staffing levels these include:

- Supervisory time for ward managers to be built into establishments
- Number of Band 6's per ward
- RN to patient ratio (between 1:5 and 1:8)
- RN to Clinical Support Worker ratio (aim for 65/35 split)
- Headroom allowance (to cover leave, sickness, study)
- Practice Educator support and supervision
- Specialty specific requirements recommended by relevant College (e.g.: 1:1 care for women in established labour).

5. Areas reviewed in October 2015

Paediatrics

Paediatric services are predominantly provided on the Tunbridge Wells Hospital site, with a day care/assessment service provided on the Riverbank Unit at Maidstone. The service is managed as a single service with staff rotating across both sites. This provides an opportunity to flex the skill mix according to demand, provide opportunities for staff development and reduce the potential for 'professional isolation' on the Maidstone site.

Riverbank provides a 5 day service on the Maidstone site with a bed capacity of 13.

The unit provides an assessment service to Accident & Emergency and day case care. There is planned day case care provided for 4 days per week (was previously 3 days). This is sometimes increased to 5 days per week. During this time there is an additional RN (Child) on duty to ensure that there is always an experience children's nurse available.

There is generally a nurse to child ratio of 1:4, increasing to a ratio of 1:3 when unit undertakes planed care for children less than 2 years of age. This is in keeping with the national view for safe staffing within this setting.

Hedgehog provides a full range of inpatient paediatric care. The unit is currently 23 beds with plans to increase by 5 beds. This forms part of the Directorate Business Planning process which is now underway.

The ward has 2 HDU beds, which are currently unfunded. As part of the business development work currently underway, discussions are being had with the Clinical Commissioning Group (CCG) to fund these beds as Level 2 care beds and thus attracting the appropriate tariff for this level of care in 2016/17. Staffing for these beds is currently not included as funding is yet to be agreed.

Woodlands provides both elective day case and pre-assessment/ambulatory care in 10 beds. The directorate is submitting a business plan to extend the operational hours of the unit. It is planned to have the unit open from 07.00 – 12.00 midnight in-line with paediatric consultant cover in Accident & Emergency. This will enable safe and efficient flow of children through the hospital in line with the current capacity and demand planning.

The current establishment provides for a ratio of RN to Child of 1:4.6 with the current funded bed base. Business planning for additional beds will include associated nursing requirements for consideration.

The current establishment, based on national guidance and professional judgment, is considered to be safe.

Neonatal Unit provides level 2 intensive care. If a neonate requires extended ventilation or is of low gestation s/he will be transferred to a level 3 unit.

The unit is staffed for 18 cots however this is often flexed upwards due to a lack of capacity across the network. The RN to Cot ratios is in line with the recommendations stated by the British Association of Perinatal Medicine.

The cot base is determined by the Neonatal Network based on network capacity and staffing profiles. Increases in birth rates are having and an adverse impact on capacity. Neonatal nurses are difficult to recruit to, however the overall vacancy for Tunbridge Wells is low.

Community Children's nursing services are provided by Tunbridge Wells under a block contract from the CCG. The service is provided 5 days per week during day time hours. Out of hours provision is made by the Eleanor Hospice.

Plans are in development with the CCG to extend this service to 7 days per week.

Current community service caseloads are generally within acceptable limits, however this is supported by a number of Clinical Nurse Specialists who also provide community care time.

Recent appointments to the Clinical Nurse Specialist cohort include the appointment of a Respiratory Nurse whose work on asthma pathways and admission avoidance is now attracting best practice tariff at 60% (previously only getting 45%).

Other appointments include a diabetes nurse specialist and an epilepsy nurse specialist who will also enable the service to attract best practice tariff.

Maternity Services

The methodology used for setting safe staffing levels for maternity services is based on Birthrate Plus. NICE published guidance on safe midwifery staffing in February 2015. However they did not prescribe any specific model for care delivery or make recommendations on maternity care outside of a labour ward. This is due to the wide national variation in the way maternity services, other than labour ward care, are managed and delivered. There is a consensus view, supported by the Royal College of Midwives, regarding the key principles for safe care.

The Local Supervisory Authority sets out standards for good practice in relation to midwife to woman ratios and supervisor to midwife ratios.

Midwifery staff rotate through the service to provide consistent cover, within a specific locality.

There are 3 ward manager type roles covering antenatal ward, labour ward and post-natal ward. One of these post-holders will take operational bed management responsibility for the maternity unit between 08.00 and 20.00.

Delivery suite coordinator is supervisory but will often take a case load. This role is staffed 24/7.

The ratio for midwife to woman in established labour is 1:1 which is met.

HDU (2 beds) require a ratio of 1:1 however the dependency is frequently such that this can be flexed either to cover labour ward or to cover HDU as appropriate.

Birthrate Plus indicates an acuity and dependency ratio of 1:28.5 locally against a national benchmark of 1:28. Acuity and dependency is recorded daily and staffing is flexed accordingly.

Ante-natal ward provides 17 beds plus 4 triage beds open 24/7. The staffing ratio for ante-natal 1:8.5

Post-natal ward provides care in 31 single rooms. The Unit has a 24% section rate meaning that potentially 1 in 4 women will require surgical nursing care.

The Post-natal ward shift coordinator is supervisory for 5 days. The ratio based on 4 RMs for 31 beds is 1:7.5

Maidstone Birth Centre provides a midwifery led service in a ‘stand-alone’ building on the Maidstone site.

It is staffed by 2 RMs and 1 support worker 24/7.

Additional support is provided by the Community Midwifery team if a transfer to Tunbridge Wells is required. It should be noted the transfer rate for the Maidstone Birth Centre is lower than the national average.

Community Teams – the majority of work in the community is ante-natal care with some home deliveries. There is an on-call system which covers home births, birthing centre and Tunbridge Wells labour ward.

Midwives are aligned to GP practices, however all community care is provided by midwives.

The national benchmark for midwife to woman ratio is 1:30. There is an option to include maternity support staff in this ratio, providing the midwife to support worker ratio is maintained at 90:10; this means 90% of care must be provided by a Registered Midwife.

The Trust ratio is 1:32. If the 90:10 rule is applied the ratio is 1:29.

Maternity services had an uplift of 15 wte midwives earlier in the year to reflect the increased birth rate locally. The unit had 5,700 deliveries in 2014/15 and is predicted to have 5,900 for the current year.

The maternity day unit will extend the opening hours for planned admissions to relive pressure on the maternity triage service. This is currently being recruited to, and is included in the 15 wte uplift noted previously.

The establishment review undertaken earlier in the year has enabled the service to review and modify working practices. As a result the service intends to establish a 24/7 maternity site cover role, which will include gynaecology services. This role will support the current clinical site manager role, and provide an onsite senior midwifery presence to support the services during peak, but often short-lived, pressures.

The service will introduce 3 maternity discharge coordinators, based on the post-natal ward. These posts will ensure a smooth and timely discharge of mother and baby, resulting in a better experience for the mother and a reduction in discharge delays.

The Critical Care directorate and Women's and Sexual Health Directorate are reviewing the provision of obstetric theatres and staffing in view of the increasing numbers of births.

Supervision of midwives is currently a statutory requirement and this standard is currently being met. National changes currently being debated will herald changes in both provision of 24/7 supervision and the wider midwifery rules. As yet outcome is uncertain, however the service is considering how senior level support out of hours can be provided if and when supervision ceases. The Implications of disbanding the Local Supervisory Authority of midwives will need to be fully understood and worked through

Pye Oliver Ward

Pye Oliver is a 28 bedded ward providing acute elderly and gastroenterology care. This cohort of patients was previously accommodated on John Day Ward. The ward decanted to Pye Oliver earlier in the year to facilitate the redevelopment of John Day and Jonathon Saunders wards. At the same time the ward leadership changed, as the substantive ward manager left the Trust.

Case mix remained unchanged, with an addition of two beds. The view was that two additional beds would not require any additional resource.

Recently the ward has had a number of clinical challenges resulting in a supportive improvement plan being implemented. Part of the discussion included a review of staffing levels.

Staffing levels are such that an RN to patient ratio of between 1:5.6 and 1: 7 is maintained throughout the 24 hours period of care.

Debate has been had around the night time skill mix, where the ward has 4 RNs and 1 CSW. Consideration has been given to whether or not the CSW numbers should increase with a subsequent decrease in RNs at night.

Discussion with the Ward Manager and the Matron arrived at the view that further work needs to be done with the team overall to review working practices. There is some disquiet about reducing the number of RNs at night, given the overall complexity of the case mix.

As the ward remains under enhanced supervision and watching brief is proposed with further review in the next quarter.

Haem-oncology Day Unit (HODU)

The Haem-Oncology Day Unit (HODU) is based at Tunbridge Wells Hospital and is primarily a nurse led service, open Monday to Friday.

It was established for 10 chairs with 10 wte nursing staff.

During the early part of 2015 there was an increase in activity including the requirement to support medical transfusion therapy requiring additional sessions to be operated on Saturdays. Since the establishment of the acute ambulatory unit at Tunbridge Wells, this additional medica l work has been repatriated to the medical teams.

In line with professional judgment with peers who provide similar services, the unit has seen an increase of 1 wte RN to enable the unit to have an overall nurse to patient ratio of 1:1.6 – 1:2.

The increase by 1 wte RN was included in the Directorate business planning intentions and accepted earlier in the year, based on current and project workloads.

Ward 30

Ward 30 is an elective orthopaedic ward also supporting trauma and some medical patients.

The ward previously had challenges with increased dependency during the night as a result of patients returning from theatres in the later part of the afternoon. This was addressed by altering the skill mix at night to allow for an additional CSW to support with evening drinks, post-operative washes and general observations

Reviews of workloads and attempts to ensure the availability of surgical beds to manage elective caseloads has shifted the acuity to the afternoons. Within the existing budgets, the RN reduction at night has been utilised to provide an increase in RN cover in the afternoons.

6. Conclusion

Overall the areas reviewed are safely staffed with no recommendations for changes or investment. Staffing levels are monitored on a daily basis by the operational teams. Changes in service delivery, service improvements and activity levels are fed into directorate business planning intentions. All wards will be reviewed again (starting with Maidstone) to ensure full consideration is given to different roles and disciplines in supporting trained nursing staff. Any changes to staffing establishments or alterations in RN skill mix have oversight from the Chief Nurse.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

11-14 Safe Staffing & Efficiency **Chief Nurse**

Summary / Key point

A joint letter from Monitor, NHS Trust Development Authority (NTDA), NHS England, Care Quality Commission (CQC) and the National Institute for Health and Clinical Excellence (NICE) was published on 13th October 2015; providing further guidance on the processes for setting safe staffing levels for nursing (Appendix A) The background to this was the publication in 2014 by NICE of methodologies for setting safe staffing levels for wards. This drew on the available research and literature and set out to provide some parameters within which wards would be deemed safe.

In 2015 the responsibility for describing the framework for safe staffing was passed from NICE to NHS England

The subsequent letter issued on the 13th October broadly supports the findings of NICE in that the key factors for determining safe staffing were professional judgement supported by knowledge of acuity and dependency and other local factors (such as line of sight, time of day).

The communication draws attention to the fact that the 1:8 ratio is a guide, not a requirement.

In terms of the methodology used to set staffing levels on wards within Maidstone and Tunbridge Wells NHS Trust, there is nothing within this communication that is contrary to the approach taken. When setting staffing levels, the views of the Ward Manager, Senior Nurses and relevant college or association are taken into account, along with ward geography, co-location to other services and known (or predictable) variations in case load or case mix. This is evidenced by a range of nurse to patient ratios ranging between 1:5 and 1:9 for wards delivering community level care. In the latter case the split between Registered Nurses and Clinical Support Workers is 50/50, whilst acute care wards the split is close to 65/35.

A systematic approach is taken to assessing acuity, using the Safe Staffing Acuity & Dependency Scoring System validated by the Shelford Group of University Hospitals. This is triangulated against a number of key nurse sensitive outcomes including incidence of pressure ulcers, falls (including time of occurrence) and complaints related specifically to nursing care.

Further guidance is awaited from the work on the Model Hospital led by Lord Carter which will develop acuity assessment further to include care hours per patient. In the meantime it would be prudent to review all our ward establishments again (especially those with a 1:5 / 1:6 ratio) to ensure we do have the staffing right with the right skills to deliver safe care and are not reliant on ratios alone.

Work to underpin safe staffing in relation to temporary staffing solutions is well underway, with migration plans in place to enable the safe use of framework agencies in specialist or hard to recruit to areas. This combined with the methodology described above will assist in ensuring that wards and departments are both safely and efficiently staffed.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 18/11/15

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

For 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

To: NHS foundation trust and NHS trust Chief Executives
Cc: NHS foundation trust and NHS trust Nurse Directors, Medical Directors, Finance Directors and Operations Directors

13 October 2015

Dear colleague

Safe staffing and efficiency

We know that many organisations have taken a systematic and thoughtful approach to staffing wards and services safely over the past two years, by responding positively to the guidance issued by the National Quality Board and by NICE, embracing transparency about their planned versus actual staffing, and focusing on how to make services as safe as possible within available resources. We are also aware that recent messages to the system on safe staffing and on the need to intensify efforts to meet the financial challenge have been seen as contradictory. We recognise that it is important to offer clarity to the system as we work together to close the gaps in health and wellbeing, care and quality, and funding and efficiency identified in the Five Year Forward View.

The current safe staffing guidance has been designed to support decision makers at the ward/service level and at the Board to get the best possible outcomes for patients within available resources. The guidance supports - but does not replace - the judgements made by experienced professionals at the front line. The responsibility for both safe staffing and efficiency rests, as it has always done, with provider Boards.

As set out in the guidance, it is important for providers to take a rounded view of staffing. Providers should be able to demonstrate that they are able to ensure safe, quality care for patients and that they are making the best use of resources. This should take account of patient acuity and dependency, time of day and local factors, such as line of sight for those caring for patients. In some cases, these factors will mean a higher number of nurses per patient, and in other cases it will mean a lower number or different configuration of staff can be justified. Some trusts have taken innovative approaches whereby Allied Health Professionals are included in their ward based teams, and this can have a positive impact on patient outcomes. We support this approach where appropriately implemented.

It is therefore important to look at staffing in a flexible way which is focused on the quality of care, patient safety and efficiency rather than just numbers and ratios of

staff. We would stress that a 1:8 ratio is a guide not a requirement. It should not be unthinkingly adhered to: achieving the right number and balance of clinical and support staff to deliver quality care based on patient needs in an efficient way that makes the best possible use of available resources is the key issue for provider Boards. Where trusts are able to maximise the proportion of time spent by clinical staff focusing on care that contributes most directly to patient outcomes (including through the use of innovation and technology) there are likely to be benefits for both patient care and for efficiency.

Trusts are responsible for ensuring that they get the balance right by neither under-staffing nor over-spending, and are able to secure the right complement of clinical staff to meet local patient need and circumstances.

CQC always assesses staffing levels as part of rating a service on safety in its programme of comprehensive inspections. These assessments include observation of care delivery, listening to staff and patients, assessing outcomes of care and discussions with nurse managers about assessment of acuity levels and achievement of planned staffing levels. Staffing ratios are never the sole determinant of a rating.

We will continue to work with and support trusts to secure both safe staffing and greater efficiency. This will include:

- further progress on the Model Hospital led by Lord Carter, who will be working with providers to develop a way to use data on the nursing and care hours per patient, so that staffing arrangements remain safe across a range of different times and situations. Lord Carter's team will be working closely with front-line staff to put in place a more sophisticated approach to measurement of nursing time and its connections with outcomes, costs and other critical measures; and

- development of further safe staffing guidance. We are currently reviewing the responses we had to the letter dated 4 August 2015 and will confirm further details on the development of the guidance and timescales in due course.

In order to support your efforts to manage your agency staffing costs, the mandatory use of approved frameworks for procuring nursing agency staff will come into effect from 19 October. Further work is being taken forward at pace by Monitor and the NHS TDA to introduce a national rate-cap for all agency staff, to include medical and other agency staff later this autumn.

As we collectively work on both the efficiency and the safe staffing agendas, we recognise the need for clarity and consistency across the work of all teams in the arm's length bodies in this area. We will be working hard across the national organisations and in close partnership with providers and all clinicians to ensure these are delivered in the next phase of work.

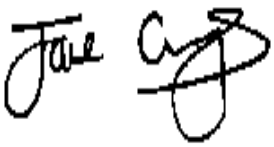
The financial and quality challenges that you are grappling with are unprecedented, and we thank you for all you are doing for patients and their families.

Yours sincerely

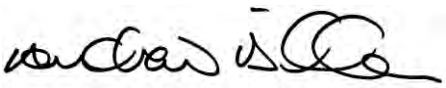
Ed Smith, Chairman-Designate NHS Improvement

Sir Mike Richards, Chief Inspector of Hospitals

Dr Mike Durkin, National Director of Patient Safety, NHS England



Jane Cummings, Chief Nursing Officer for England



Sir Andrew Dillon,
Chief Executive, National Institute for Health and Care Excellence

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-16 Response to the Fit and Proper Persons Regulations — Trust Secretary

In December 2014, the Trust Board approved the Trust's response to the "Fit and Proper Persons" Regulations (FPPR).

Progress on implementing the response has been provided to each Board meeting since then, as part of the evidence in the monthly "Oversight Self-Certification" reports. However, in October 2015, the Board agreed that the status of the Disclosure and Barring Scheme (DBS) checks being undertaken for Trust Board Members should be clarified.

In response, this report provides:

- A comprehensive update on the implementation of the Trust's response to the FPPR, including the outcome; and
- Information on the national situation regarding the FPPR

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Assurance

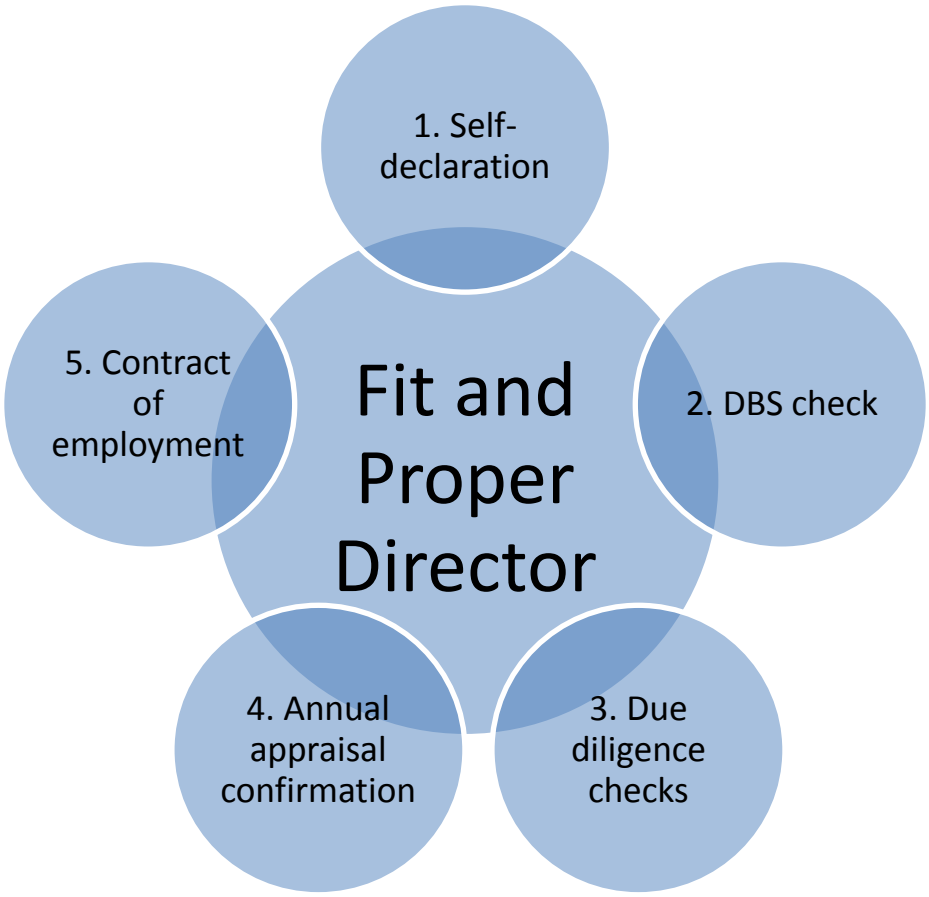
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; 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

Introduction

- The "Fit and Proper Persons" Regulations (FPPR) for Directors of health service bodies[2] came into force on 27/11/14. The specific requirements of the FPPR are enclosed in Appendix 1
- In December 2014, the Trust Board approved the process by which the Trust would response to the FPPR.

The approved process

- The approved process is illustrated by the diagram below:



- In specific terms…
  1. Each Director should be asked to sign a declaration covering the specific aspects of the FPPR.

  2. An "Enhanced with list checks" Disclosure and Barring Service (DBS) check should be undertaken for each Director (only an "Enhanced with list checks" check includes a check of the DBS barred lists, which is one of the FPPR criteria for being "unfit" (See Appendix 1).

  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)

[2] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- 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 include (but is not 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 should be undertaken on appointment, and annually thereafter. Ad-hoc checks should also be undertaken if any information is received that warrants such checks being made.

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.

5. The contracts of employment of Directors who are employed by the Trust should be reviewed, and if necessary amended, to take into account the fact that an individual cannot continue within the role should they meet any of the criteria for being "unfit" (as listed in Appendix 1).

Progress with implementation, and the outcome

1. Self-declaration

- Implementation: All Trust Board Members have been asked to sign a declaration covering the aspects with Appendix 1
- Outcome: All Trust Board Members have signed an appropriate declaration

2. DBS check

- Implementation: Enhanced DBS checks of all Trust Board Members have been processed in 2015, and all DBS certificates have been issued and reviewed by the Trust Secretary.
- Outcome: None of the DBS certificates reveal any cause for concern, in that all state "None recorded" for all of the categories listed[3]

3. Due diligence checks

- Implementation: Due diligence checks were undertaken on all Trust Board Members during the summer of 2015 (as per the details within step 3 above)
- Outcome: The due diligence checks did not reveal any cause for concern

[3] (i.e. "Police Records of Convictions, Cautions, Reprimands and Warnings"; "Information from the list held under Section 142 of the Education Act 2002"; "DBS Children's Barred List information"; "DBS Adults' Barred List information"; & "Other relevant information disclosed at the Chief Police Officer(s) discretion")

4. **Annual appraisal confirmation**
   - Implementation: The annual appraisal confirmation is intended to be implemented as part of the next appraisal cycle (i.e. between 1st April and 30th June 2016). The Trust Secretary will liaise with the Chief Executive and Chairman of the Trust Board ahead of the next scheduled appraisals for each Executive and Non-Executive Director respectively.
   - Outcome: This step is not yet complete. See comment above.

5. **Contract of employment**
   - Implementation: The Director of Workforce and Communications has confirmed they will initiate the required review of the employment contracts of the Directors who are employed by the Trust, and arrange for the contracts to be amended, after consultation with the post-holder, as required.
   - Outcome: This step is not yet complete. See comment above.

The national situation re FPPR

- The CCQ assesses a provider's processes for ensuring compliance with the FPPR (though the Regulations were not in force at the time of the Trust's CQC inspection, in October 2014)
- The CQC's report "The state of health care and adult social care in England" (which was published on 15/10/15) states: "To date we have not identified a breach of this regulation. There is emerging evidence on the impact the requirement is having, both directly and indirectly, particularly a deterrent effect. The evidence that we have available both from hospital inspections and dialogue with the sector suggests that the requirement is starting to drive culture change. Trusts have reviewed their processes and tightened them where necessary. We believe this may have deterred certain individuals from applying for director posts and it may have deterred trusts from appointing individuals about whom concerns may have been raised. However, it is not yet possible to assess this objectively. Information about how the fit and proper person requirement is working in other sectors will be included in next year's report, once we have a more comprehensive picture of how services are implementing this requirement".

Appendix 1: Specific requirements of the "Fit and Proper Persons" Regulations

- The FPPR apply to all Directors and "equivalents", which includes Executive Directors of NHS Trusts (as well as Foundation Trusts & Special Health Authorities[4]). The CQC guidance makes it clear that the FPPR will apply regardless of a Director's voting rights on a Board, and will apply to permanent, interim & associate[5] positions (providing they are members of the Board)
- In the case of NHS bodies, the Chairman of the Trust Board has responsibility to ensure that the FPPR are adhered to, in general terms. However, for Chairman and Non-Executive Directors of NHS Trusts, the duty to ensure compliance with the FPPR falls to TDA, as the appointing authority.
- The CCQ will assess a provider's processes for ensuring compliance with the FPPR, under their 'well-led' domain. Specifically, the CQC will confirm that the provider has undertaken appropriate checks and is satisfied that, on appointment and subsequently, all new and existing Directors are "of good character" and are not "unfit" (see below), which may involve (at inspection) checking personnel files and records about appraisal rates for Directors. The CQC will also require the Chair of the NHS provider to declare that appropriate checks have been undertaken in reaching a judgement that all Directors are deemed to be fit and none meet any of the unfit criteria. The CQC will report on the FPPR under the 'well-led' section in their inspection reports, and as part of this, will consider whether the FPPR have been breached. If this is concluded, the CQC will be able to take enforcement action. The CQC will not have the authority to remove individual Directors from their posts, though in effect, they can insist that NHS bodies do this, via their enforcement action, & via liaison with the TDA and Monitor.
- The CQC was not asked to investigate individual fitness, maintain a list of those found unfit (in effect, a 'blacklist'), or replace existing employment and legal processes.
- The FPPR state that Directors cannot be "unfit". The criteria for being "unfit" are absolute i.e. if any of the criteria apply, the individual should not hold a post as a Director. The criteria are that the individual cannot…
  - be an undischarged bankrupt;
  - have sequestration awarded in respect of their estate;
  - be the subject of a bankruptcy restrictions order;
  - be a person to whom a moratorium period under a debt relief order applies;
  - have made a composition or arrangement with, or granted a trust deed for, creditors;
  - be included in the children's barred list or the adults' barred list; and
  - be prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[6].
- Directors also need 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. This requirement is not absolute, and involves an element of judgement.
- Directors also need to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Again, this requirement is not absolute, and involves an element of judgement. Although the FPPR make no differentiation between 'qualifications', 'competence', 'skills', and 'experience', the CQC guidance makes it clear that providers may consider appointing an individual to a role based on their 'qualifications', 'skills' and 'experience' with the expectation that they will develop specific 'competence' to undertake the role within a specified timeframe.

[4] The Regulations do not therefore apply to Clinical Commissioning Groups

[5] The Regulations will not therefore apply to those staff who have "Associate Director" in their job title but who are not members of the Board

[6] 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.

- In addition Directors need to be "of good character". This requirement is also not absolute. However, in determining whether a Director is "of good character", the FPPR state that consideration should be given as to whether:
  - the person has been convicted in the UK of any offence[7]; or
  - the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals
- 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 applies to any previous misconduct or incompetence in a previous role for a service provider, even if the individual was working in a more junior capacity at that time (or working outside England). Again, judgement is required, though the CQC guidance provides definitions of "Serious misconduct or mismanagement", "Responsible for, contributed to or facilitated", and "Privy to", to assist such judgements.
- The FPPR make no reference to convictions, bankruptcies or similar matters that have been 'spent'. However, the CQC's guidance states that they will have regard to such considerations.
- The FPPR also make no distinction between the severity an "offence", and therefore a providers' considerations should not automatically exclude "minor" offences, including motoring offences

[7] "Conviction" in the UK by definition means an admission of guilt or a finding of guilt in a criminal court, whether by Judge, Jury, Magistrate or certain tribunal Chairman conducting criminal cases. In the UK fixed penalty notices and speeding fines are not convictions. Other RTA offences from careless to dangerous driving would be convictions if pleaded or found guilty.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

11-17 Oversight Self-Certification, Month 7, 2015/16 Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 6, 2015/16, based on performance as at 31st October. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of November (i.e. by 27th).

As Board members are aware, each month the Trust Board is required to self-assess against the questions contained in two self-certification documents under the TDA oversight process:
1. The NHS Provider licence conditions (although NHS Trusts are exempt from the requirement to hold an NHS Provider license); and
2. Board statements

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

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

There are 4 changes in compliance status proposed from that agreed by the Trust Board in October 2015, as follows:
1. Condition G5 ("Monitor guidance")
2. Condition P1 ("Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information")
3. Condition P2 ("Provision of information")
4. Condition P3 ("Assurance report on submissions to Monitor")

Since the oversight self-certification process began, the Trust had reported its compliance status with these 4 Conditions as "No", with the rationale that as an aspirant Foundation Trust, the conditions did not apply. However, following a recent review by the Trust Secretary, it is believed that the Trust's previous conclusion that these Conditions were "Not Applicable" was erroneous (though this had not resulted in any challenge from the TDA), as the subject matter of the Conditions is not exclusive to NHS Foundation Trusts.

It is now therefore proposed that the Trust change its compliance status, and declare "Yes" for compliance with all of these Conditions. Further details of the rationale for this (and the associated evidence) are provided in the relevant sections below.

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

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to:
1. Review the evidence presented to support the self-assessment (and amend if required); and
2. Approve the "Latest assessment – Compliant?" status for the forthcoming submission to the TDA

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

Oversight Self Certification – NHS Provider Licence Conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
General Condition 1 (G1 - "Provision of information") This condition contains an obligation for all licensees to provide Monitor with any information they require for their licensing functions	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 2 (G2 - "Publication of information") This licence condition obliges licensees to publish such information as Monitor may require.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 3 (G3 - "Payment of fees to Monitor") The Act gives Monitor the ability to charge fees and this condition obliges licence holders to pay fees to Monitor if requested.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 4 (G4 - "Fit and proper persons as Governors and Directors") This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions).	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. The Regulations introduced a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". ~~The Care Quality Commission (CQC) will be able to insist on the removal of Directors that fail this test.~~ 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	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?
	health, qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". 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. ~~Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper".~~ A proposed approach to the new Regulations was approved at the December 2014 Trust Board, ~~and implementation has commenced (DBS checks are currently being processed for all Board members, and step 3 of the agreed process ('due diligence checks') is in progress)~~. 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 ~~issued for consultation~~ will be submitted for ratification to the Trust Board in 2016. A report on the latest position regarding implementation of the approved approach has also been submitted to the November 2015 Trust Board meeting.	
General Condition 5 (G5 - "Monitor guidance") This licence condition requires licensees to have regard to any guidance that Monitor issues.	~~Monitor guidance is at varying degrees of progress through the consultation process.~~ ~~Trust response~~: ~~**As an aspirant Foundation Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its**	~~No~~ ~~Compliant by 31/03/2017~~

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?
	~~**foundation trust application trajectory.**~~ 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) This licence condition requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	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 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. ~~A~~ CQC assessors ~~will be visiting~~ visited the Trust in October to consider the Trust's application, and in November the CQC confirmed that the application had been accepted.	Yes
General Condition 8 (G8 - "Patient	The Referral and Treatment Criteria (RATC) which apply from 1st April 2015 are	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
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	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").	
General Condition 9 (G9 - "Application of Section 5 (Continuity of Services)") This condition applies to all licence holders. It sets out the conditions under which a 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.	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)	
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.	~~Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**~~ ~~An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).~~ The Trust records information regarding its costs in accordance with Monitor's "Approved costing guidance".	~~No~~ ~~Compliant by 31/03/2017~~ 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	~~Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**~~ The Trust submits the relevant information regarding its costs to Monitor, in accordance with Monitor's "Approved costing guidance".	~~No~~ ~~Compliant by 31/03/2017~~ Yes
Pricing condition 3 (P3 - "Assurance report on submissions to Monitor") When collecting information for price setting,	~~Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time**	~~No~~ ~~Compliant by~~

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
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.	~~**appropriate to its foundation trust application trajectory**~~ 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.	~~31/03/2017~~ Yes
Pricing condition 4 (P4 - "Compliance with the national tariff") The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for 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.	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
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")	The Trust complies with the philosophy of patient choice, with regards to choice of provider.	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
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 has not taken any actions to inhibit patient choice.	
Competition condition 2 (C2 - "Competition oversight") This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	The Trust does not seek to inhibit competition.	Yes
Integrated care condition 1 (C3 - "Provision of integrated care") The 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.	The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Yes
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	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)	

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
financially distressed or insolvent.		
NHS Foundation Trust Conditions (FT1 to FT4) The NHS foundation trust licence conditions translate the well-established core of Monitor's previous oversight of NHS foundation trust governance into Monitor's licence-based system of regulation.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding these Conditions, as they are only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	

Oversight Self Certification – Board Statements

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

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal ▪ The Trust has commissioned an external review of "Good Governance and Culture", the findings of which were discussed by the Board in September 2015. It was agreed at the Board meeting the Chief Executive should "Coordinate a considered response to the recommendations arising from the external "Good Governance and Culture Review" (involving the Executive Team and Trust Management Executive), and submit the outcome to the Trust Board". This response is in process (the report was reviewed and discussed at the Trust Management Executive on 18/11/15), and a report is scheduled to be submitted to the Trust Board in December 2015. 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.	
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'; ~~and~~ 'Family planning'; and "Assessment or medical treatment for persons detained under	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	the Mental Health Act 1983". 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 (refer to the evidence for General Condition G7 above)~~. 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.	
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 governing appraisal and revalidation.	Yes
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	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	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 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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	▪ 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 ~~is currently being~~ recently evaluated against the Well-Led Framework via an external Governance Adviser (see Statement 1 above)	
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, ~~2015 and~~ September, and November 2015.	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 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.	Yes
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

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	The Trust Board monitors compliance with existing targets, and actions to address any issues, at each meeting, 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 will be submitted to the Trust Board, for ratification, in ~~issued for consultation. It has been agreed that the Policy should be ratified by the Trust Board, and this has therefore been scheduled for~~ December 2015. All formal Board positions are filled substantively.	Yes
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA conducted a review of the Trust Board in 2013/14 ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and implementation has commenced ~~(DBS checks are currently being processed for all Board members, and~~	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	~~step 3 of the agreed process ('due diligence checks') is in progress)~~ – Refer to General Condition 4 above. ~~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 issued for consultation.~~	
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 - November 2015

11-18 Standing Financial Instructions Director Of Finance

The Trust has committed to reviewing the Trust's Standing Financial Instructions (SFIs) each year, to ensure they remain relevant. The review took place earlier in 2015, and a revised version was duly submitted to the Audit and Governance Committee on 6th August, and has since been subject to consultation. The revised post-consultation version of the SFIs was then submitted to the Audit and Governance Committee on 5th November, and "approved". The Trust Board is now asked to "ratify" the document, which is enclosed.

The major proposed changes are summarised below.

- Expansion and strengthening of the 'definitions' section in line with changes to Standing orders (to cover the fact that Boards now have 'Members' that don't have voting powers etc.)
- Update for the External Audit arrangements post Audit Commission
- 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.
- Inclusion of reference to the budget holder manual in the "Budgetary control" section 4, and clearer statement to reflect revenue business case requirements
- Reflection of the new NHS Trust Development Authority (TDA) consultancy usage processes
- Strengthening of petty cash controls
- Updated section on External Borrowing regime, to reflect the TDA Interim support and financing guidance
- Reflecting the Security Management requirements on asset records for critical assets under £5k (i.e. not included in the Trust fixed asset register)
- Changes to reflecting the agreed Charitable Fund policy
- Gifts section to be removed, as this will be covered in the proposed new "Gifts, hospitality, sponsorship and interests policy and procedure"
- Updating of financial limits to reflect the above changes
- Revision of the delegated limits for approval of business cases by increasing the level for Trust Board-approved business cases to £1m, while retaining the £0.5m level for Finance Committee approval
- Inclusion of detail in respect of electronic tendering processes
- Inclusion of references to guidance in respect of Agency controls, consultancy controls and off payroll arrangements
- Strengthening of SLA review and authorisation requirements
- Requirement for further authorisation where orders are amended
- Clarification in retention of records section

The 'sister' documents to the SFIs, the Standing Orders and Scheme of Delegation, will be submitted to the Trust Board, for ratification, in early 2016

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 06/08/15 & 04/11/15
- Finance Committee, 28/09/15 (notification of proposed changes, via a summary report)

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 Financial Instructions

Requested/ Required by:	Trust Board
Main author:	Head of Financial Services
Other contributors:	Consultation list contributors (Appendix Two)
Document lead:	Director of Finance Contact Details: 01622 226422
Supersedes:	Standing Financial Instructions (with effect November 2014)
Approved by:	Audit and Governance Committee, date 4th November 2015
Ratified by:	Trust Board, Date 25th November 2015
Review date:	Date TBA

With Effect from November 2015

Document History

Requirement for document:	• Trust (Functions) Directions 2000 issued by the Secretary of State • Code of Accountability • Bribery Act 2010 and associated Government guidance
Cross References / Associated Documents:	• Standing Orders[RWF-OPPCS-NC-TM23] • Reservation of Powers and Scheme of Delegation[RWF-OPPCS-NC-TM21] • Department of Health's Commercial Sponsorship – Ethical standards in the NHS • Records Management: NHS Code of Practice • Trust Procurement Strategy • Code Of Conduct/ Code of Accountability in the NHS (NHS Appointments' Commission / Department of Health) • Board of Directors Code of Conduct • Bribery Act 2010 • Standards of Business Conduct for NHS Staff(HSG (93)5) • Gifts, hospitality, sponsorship and interests policy and procedure [RWF-XXX-XXX] • Data Protection Act 2010 • International Financial Reporting Standards • Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts (NHS Trust Development Authority) • Overpayments Policy and Procedure [RWF-OPPPCS-NC-WF74] • Anti Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • NHS Audit Committee Handbook (2014) • Managing Public Money (HM Treasury) • The Accountability Framework for NHS Trust Boards (NHS Trust Development Authority) • Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, Department of Health (2006) • NHS Trust Development Authority consultancy spending controls guidance • Charitable Fund Policy and Procedure • Patients Property Policy (RWF-OPPPCS-NC-NUR1) • NHS Protect Standards for Providers

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Standing Financial Instructions (with effect from 1 April 2008)	February 2008
2.0	Standing Financial Instructions (with effect from 1 April 2009)	March 2009
3.0	Standing Financial Instructions (with effect from 1 April 2010)	March 2010
4.0	Standing Financial Instructions (with effect from 1 April 2011)	March 2011
4.1	Standing Financial Instructions (with effect from July 2012)	July 2012

4.2	Standing Financial Instructions (with effect from Sept 2013)	Sept 2013
4.3	Standing Financial Instructions (with effect from November 2014 – Definitions amended to ensure consistency, and to more accurately describe the circumstances at the Trust; authority of Remuneration Committee amended to accord with current practice)	Nov 2014
5.0	Standing Financial Instructions updated	Nov 2015

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SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING FINANCIAL INSTRUCTIONS

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

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

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

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

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

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

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

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

"Chairman of the Trust Board" is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust Board" shall be deemed to include the Vice-Chairman of the Trust Board if the Chairman is absent from the meeting or is otherwise unavailable.

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

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

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

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

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

"Director" means an Executive or Non-Executive Director of the Board as the context permits. The inclusion of the word "Director" in a staff member's job title does not mean that they automatically meet the definition of being a "Director" for the context of these SFIs.

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

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

"Executive Director" means a member of the Trust Board who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) of The National Health Service Trusts (Membership and Procedure) Regulations 1990 (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust Board member). Executive Directors are expected to be present at, and participate in, meetings of the Trust Board.

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

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

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

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

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

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

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

"Senior Information Risk Owner (SIRO)" is an Executive Director or Senior Management Board Member who will take overall ownership of the Organisation's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control in regard to information risk. The SIRO implements and leads the Information Governance (IG) risk assessment and management processes within the Organisation and advises the Board on the effectiveness of information risk management across the Organisation. The SIRO for this Trust is the Chief Nurse.

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

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

"SD" means Scheme of Delegation

"SFIs" means Standing Financial Instructions.

"SLA" means Service Level Agreements

"SOs" means Standing Orders.

"Standing Orders Set" means the Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation. Unlike NHS

Foundation Trusts, NHS Trusts do not have a "Constitution", but the "Standing Orders Set" can be considered as the closest equivalent to such a Constitution.

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

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

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

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

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

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

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

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

SECTION B - STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

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

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

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

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

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

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

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

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

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

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

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

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

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

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

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

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

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

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

1.2.5 **The Director of Finance**

The Director of Finance is responsible for:

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

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

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

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

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

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

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

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

1.2.6 **Trust Board Members and Employees**

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

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

(b) avoiding loss;

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

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

1.2.7 **Contractors and their employees**

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

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

2. AUDIT

2.1 Audit and Governance Committee

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

(a) overseeing Internal and External Audit services;

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

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

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

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

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

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

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

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

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

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

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

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

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

(ii) major internal control weaknesses discovered;

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

(iv) progress against plan over the previous year;

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

(vi) a detailed plan for the coming year.

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

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

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

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

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

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

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

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

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

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

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

2.3.3 The Head of Internal Audit will normally attend Audit and Governance Committee meetings and has a right of access to all Audit and Governance

Committee members, the Chairman of the Trust Board and Chief Executive of the Trust.

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

2.4 External Audit

2.4.1 The External Auditors were previously appointed by the Audit Commission. With its abolition from 1st April 2015, arrangements have been put into place to transfer its functions. The management of the existing audit contracts have transferred to Public Sector Audit Appointments Ltd as a transitional body prior to the establishment of Local Auditor Panels who will in future advise on auditor appointments. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the PSAA Ltd if the issue cannot be resolved. Health bodies will move to the new audit framework in 2017/18 under the Local Audit and Accountability Act 2014. NHS Trusts will select and appoint their own auditors and directly manage their contracts for the audits for the financial year starting 1st April 2017, with the legislation requiring that the auditors are appointed by 31st December 2016. The Audit and Governance Committee must ensure a cost-efficient service.

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

2.5 Fraud and Corruption

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

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

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

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

2.6 Security Management

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

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

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

2.7 Health Informatics Service (HIS)

2.7.1 Following the change in status of the HIS so that it is no longer a separate hosted service, the HIS Management Board is a normal part of the Trust's corporate management structure and is therefore subject to all the standard requirements of the Trust.

3. SECTION NOT USED

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

4.1 Preparation and Approval of Plans and Budgets

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

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

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

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

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

(b) accord with workload and workforce plans;

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

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

(e) identify potential risks.

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

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

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

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

4.1.7 The Director of Finance will publish annually a budget holder guidance manual to ensure all budget holders understand their responsibilities and to provide practical guidance.

4.2 Budgetary Delegation

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

(a) the amount of the budget;

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

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

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

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

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

4.3 Budgetary Control and Reporting

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

(a) monthly financial reports to the Finance Committee and Trust Board in a form approved by the Finance Committee and Board containing:

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

(ii) movements in working capital;

(ii) Movements in cash and capital;

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

(iv) explanations of any material variances from plan;

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

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

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

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

(e) arrangements for the authorisation of budget transfers.

(f) holding a record of authorised budget holders (see section 12.2.5 d(i))

4.3.2 Each Budget Holder is responsible for ensuring that they:

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

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

(c) Ensure that they operate within their agreed budgets

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

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

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

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

(h) All developments, services changes, investments (revenue, capital or funded through charitable funds), or other proposals that increase the Trust's costs or incomes must be tested and approved through the Trust's business case process. This includes adherence to the relevant delegated limits which are currently:

a. Cases up to £500k require approval by the TME

b. Cases of £500k or over require approval by the Trust Finance Committee

c. Cases of £1million or over require Trust Board Approval

d. Cases of £5m or over require Trust Development Authority approval for capital investments, or equivalent managed service or leased equipment, IT or Property arrangements (where the whole life cost is the determinant).

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

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

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

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

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

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

4.4 Capital Expenditure

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

4.4.2 Capital Assets should not be purchased from revenue funding.

4.5 Monitoring Returns

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

5. ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

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

6. BANK AND GOVERNMENT BANKING SERVICE

6.1 General

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

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

6.2 Bank and Government Banking Service

6.2.1 The Director of Finance is responsible for:

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

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

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

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

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

6.3 Banking Arrangements

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

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

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

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

6.4 Tendering and Review

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

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

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

7.1 Income Systems

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

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

7.2 Fees and Charges

7.2.1 The Trust shall follow the Department of Health's and Monitor's established costing guidance in setting prices for NHS Service Level Agreements.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Monitor/NHS England jointly published national tariffs or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust code of Conduct Policy and the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed (see also Appendix 6 of Standing Orders).

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

7.3 Debt Recovery

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

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

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

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

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

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of

safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

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

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

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

7.4.4 Cash receipts over £1,000 must receive authority from the finance department prior to their acceptance in order to reduce risk of accepting fraudulent currency or potentially supporting money laundering.

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

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

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

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

8.2 EU Directives Governing Public Procurement

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

8.3 Reverse eAuctions and other e procurement techniques

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

8.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply, as far as is practicable with the requirements of the Department of Health 'Capital Investment Manual', 'Estatecode' and the Trust Development Authority Capital Regime and Investment Business case approvals guidance' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply with the Trust Development Authority guidance on Consultancy spending controls to NHS Trusts (see Annex C)

8.5 Formal Competitive Tendering

8.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

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

8.5.2 Health Care Services

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

8.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

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

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

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

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

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

arrangements must comply with TDA and Trust guidance if the payment arrangement is 'off payroll'.

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

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

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

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

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

8.5.6 Fair and Adequate Competition

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

8.5.7 Building and Engineering Construction Works

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

8.5.8 Items which subsequently breach thresholds after original approval

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

8.5.9 Splitting Orders

Orders may not be split for administrative or other purposes to avoid the tendering thresholds. The requirement for quotation or tender should be based, in all cases for the life of the arrangement as proposed at the outset. When determining the value of the expenditure, Budget holders must consider

the aggregation of entire spend of the arrangement, as planned, which may cover more than one financial year

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

Orders which, following investigation are found to have been split to avoidtendering processes shall be recorded in an appropriate Trust record and reported to the next available Audit and Governance Committee.

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8.6 Contracting/Tendering Procedure

8.6.1 Invitation to tender

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

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

(iii) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word “tender” followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager; (b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer. All procurement instigated Tenders will be issued via the electronic tendering system administered by the London Procurement Partnership (LPP) ‘Due North’ or Crown Commercial Solutions (CCS) All bid submissions will be submitted via these systems with no manual tenders accepted.

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

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

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

These documents shall be modified in accordance with Department of Health guidance and, in minor respects, to cover special features of individual projects. Tender based on other forms of contract may be

used only after prior consultation with the Director of Estates & Facilities Management.

8.6.2 Receipt and safe custody of tenders

All procurement generated tenders are received via the electronic portal and cannot be accessed until the deadline for receipt has passed. For manual tenders the Chief Executive, or his nominated representative not from the originating department, will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

8.6.3 Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic portal will be accessed by nominated officers within the procurement team who will download all tenders received within the deadline. For manual tenders they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department. One of these senior officers should be the Head of Procurement or their nominated deputy

(ii) The electronic tendering portal closes at the deadline and will not accept any attempt to file a tender after this deadline. For manual tenders rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

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

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

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

(vi) Every tender received via the electronic tendering portal shall be automatically marked with the date of opening and who has accessed the tender. For manual tenders these will be initialled by those present at the opening.

(vii) The system will hold a full record of all tender activity for electronic tenders. For manual tenders, a register shall be maintained by a person authorised by the Chief Executive' to show for each set of competitive tender invitations despatched:

- the name of all suppliers invited or expressed an interest;
- the names of suppliers from which tenders have been received and those that have opted out;
- the date the tenders were received;

- the date the tenders were opened and for manual tenders, the persons present at the opening;

for manual tenders, the price shown on each tender;

for manual tenders, a note where price alterations have been made on the tender.

For manual tenders, each entry to this register shall be signed by those present.

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

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt will not be permitted by the electronic system., but for manual tenders, prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SFI No. 8.6.5 below).

8.6.4 Admissibility

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

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

8.6.5 Late tenders

(i) The electronic tendering system will not allow late submission of any tender under any circumstances. Written Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

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

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

8.6.6 Acceptance of formal tenders

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

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

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

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

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

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

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

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

(b) that best value for money was achieved.

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

8.6.7 Tender reports to the Trust Board

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

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

(a) Responsibility for maintaining list

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

via the electronic tendering process the approved supplier framework forms part of the tendering portal.

(b) Approved list of contractors

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction. For tenders managed via the electronic tendering process the approved supplier framework forms part of the tendering portal.

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

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

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

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

8.6.9 Exceptions to using approved contractors

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

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

8.7 Quotations: Competitive and non-competitive

8.7.1 General Position on quotations

Written quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is

reasonably expected to exceed £10,000, but not exceed £49,999 excluding VAT. Where three written quotations cannot be obtained then a single tender waiver form will be required to be completed and authorised in line with the Scheme of Delegation. These should be reported to the next Audit and Governance Committee.

8.7.2 Competitive Quotations

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

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

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

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

8.7.3 Non-Competitive Quotations

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

8.7.4 Quotations to be within Financial Limits

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

8.8 Authorisation of Tenders and Competitive Quotations

8.8.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the officers detailed in the Scheme of Delegation

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

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

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

Where competitive tendering or a competitive quotation is not required where expenditure is genuinely expected to be below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance. Designated Budget Managers are expected to secure value for money.

8.10 Private Finance for capital procurement (see overlap with SFI No. 15)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a major capital procurement, or as in accordance with current TDA and Department of Health guidance. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.11 Compliance requirements for all contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants; and with the Trust Development Authority guidance on Consultancy spending controls to NHS Trusts (see Annex C)

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The

Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Procurements in this category must adhere to the Trust and Trust Development Authority (TDA) guidance on Consultancy spending controls and Agency spending and price capping controls and Trust off payroll guidance where applicable

8.13 Healthcare Services Agreements (see overlap with SFI No. 9)

8.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.

8.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with the Trust's agreed policy.

8.14 Disposals (See overlap with SFI No. 17)

8.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement strategy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £10,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH and TDA guidance has been issued but subject to compliance with such guidance.

8.14.2 Prior to any decision on disposal the book value of the asset should be obtained from the Financial Services Department. In the event that a loss on disposal is expected, this must be approved by the Director of Finance prior to disposal

8.14.3 Disposals of fixed assets, whether by sale, exchange, scrapping, loss or otherwise, shall be notified to the Director of Finance as soon as they take place and must follow the arrangements set out in Section 17 of the SFIs.

8.15 In-house Services

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine that in-house services should be market tested periodically by competitive tendering.

8.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance Representative. For services having a likely contract expenditure exceeding £500,000, a non-Executive Director should be a part of the evaluation team.

8.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.15.4 The evaluation team shall make recommendations to the Board.

8.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.16 Applicability to Trust and to Funds held on Trust and Other Private Resources

These Instructions shall apply to Exchequer funds and to works, services and goods purchased from the Maidstone and Tunbridge Wells NHS Trust Charitable fund and other private resources.

9. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 8.13)

9.1 Service Level Agreements (SLAs)

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS TDA Accountability Framework;
- Information Governance requirements;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

9.1.2 The Finance Director will ensure that all SLAs will be reviewed annually to ensure that they remain fit for purpose taking into consideration any notice periods for changes.

9.1.3 All SLAs must be signed by all parties.

9.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue with clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Reports to Board on SLAs

The Chief Executive as the Accountable Officer will ensure that regular reports are provided to the Board detailing actual and forecast income from commissioner SLAs through the finance reporting. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

9.4 Partnerships

The Director of Finance is responsible for ensuring that any partnerships that the Trust may have are identified through an annual review and that partnership agreements are put in place reflecting the arrangements. These arrangements should be routinely monitored by senior management to ensure they are operating as intended and meeting their objectives. The

Director of Finance will maintain a register of partnerships, which will be reviewed by the Audit and Governance Committee annually. The financial performance of partnerships will be monitored by the Director of Finance and the results shared with partners and acted upon.

9.5 Hosting of Services

9.5.1 The Director of Finance will ensure a business case is prepared, for review by the Finance Committee, and approval by the Trust Board, to support any proposed hosting of services to other organisations. The business case should include a cost benefit analysis and identify financial and operational risks to Maidstone and Tunbridge Wells NHS Trust, together with any legal implications. Following approval, hosted services should only be provided once a signed Service Level of Agreement is in place with all member organisations. All costs incurred by the Trust in hosting a service shall be recoverable from member organisations, including corporate overhead.

9.5.2 The hosted service(s) should fully comply with the Trust's Standing Financial Instructions/Standing Orders and other core procedures established within the Trust unless specifically agreed in writing by the Trust Chief Executive. Contracts will be signed with other organisation members of the hosted service(s) which should stipulate the members financial and other responsibilities/commitments, both whilst a member of the hosted service(s) and if they leave following termination of the agreement.

9.5.3 The Trust currently has no hosted service to which 9.5.1 and 9.5.2 apply.

9.5.4 Services used by the Trust but hosted by another body will follow the Standing Financial Instructions / Standing Orders and other procedures as set by the host body.

10 SECTION NOT USED

This section is not currently applicable to Maidstone and Tunbridge Wells NHS

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

11.1 Remuneration and Terms of Service (see overlap with SO No. 4 appointment of committees and sub committees)

11.1.1 In accordance with Standing Orders the Trust Board shall establish a committee to consider remuneration and terms of service, with clearly defined Terms of Reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. For this Trust this is the "Remuneration and Appointments Committee".

11.1.2 The Committee's duties, membership and authority will be described in Terms of Reference, which will be reviewed annually, and approved by the Trust Board (also annually). This will include the requirement to review the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies

11.1.3 The Committee shall record in writing the basis for its decisions. The Trust Board shall however remain accountable for the Committee's decisions on the remuneration and terms of service covered under its Terms of Reference

11.1.4 The Trust Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration and Appointments Committee (and which are not covered by nationally agreed Terms and Conditions.

11.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

11.2 Funded Establishment

11.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive via delegated authority.

11.3 Staff Appointments

11.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) within their approved budget and funded establishment,

(b) authorised to do so by the Chief Executive via the scheme of delegation and in accordance with the agreed approval process (e.g. Recruitment panel authorisations); and

c) managed through the Trust's recruitment or staff bank departments

d) compliant with DH, TDA or other relevant regulatory guidance

11.3.2 The Remuneration and Appointments Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

11.4 Processing Payroll

11.4.1 **The Director of Workforce and Communications** is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

(e) appropriate (contracted) terms and conditions

11.4.2 **The Director of Workforce and Communications in conjunction with the Director of Finance** will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

(n) ensuring that pay information is accurately reflected in the financial records of the Trust.

11.4.3 **Appropriately nominated managers** have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with local instructions and in the form prescribed by the Director of Workforce and Communications**;**

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation,

termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Communications must be informed immediately.

(d) see overlap with budget holder responsibilities SFI section 4.3.

11.4.4 **Individual Employees / Officers** have responsibility for checking their payslips and ensuring that any discrepancies of over or underpayment are reported to their line manager immediately. See also section 7.3.3

11.4.5 Regardless of the arrangements for providing the payroll service, **the Director of Workforce and Communications in conjunction with the Director of Finance** shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.5 Contracts of Employment

11.5.1 The Trust Board shall delegate responsibility to the Director of Workforce and Communications for:

(a) ensuring that all employees are issued with a Contract of Employment in a form which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

11.6 Redundancy and Early Retirements

11.6.1 The Remuneration and Appointments Committee will approve individual non-Board redundancy packages up to £100,000. Approval must be sought prior to any formal communication being made with an employee.

11.6.2 Individual non-Board redundancy packages in excess of £100,000 will be approved by the Trust Remuneration and Appointments Committee and will require additional approval from the Trust Development Authority's Remuneration and Appointments Committee in accordance with the TDA 2015-16 Accountability Framework.

11.6.3 All contractual severance payments to the Chief Executive or Executive Directors shall be approved by the Trust's Remuneration and Appointments Committee and the NHS Trust Development Authority's Remuneration Committee.

11.6.4 All non-contractual severance payments will require Treasury approval in addition to that of Trust and TDA Remuneration Committees.

11.6.5 In the event that severance payments are considered to include "novel or unusual" elements. These will normally require Treasury approval, in addition to the Trust and TDA Remuneration Committees.

11.7 Agency Procurement

11.7.1 The use of agency staffing should be kept to the minimum required to maintain agreed operational capacity. Any agency requests must be made in accordance with Trust procedures and using recognised framework agencies.

11.7.2 Agency procurement must comply with nationally published regulations eg. Guidance from the Trust Development Authority

12. NON-PAY EXPENDITURE

12.1 Delegation of Authority

12.1.1 The Trust Board will approve the level of non-pay expenditure (Revenue, Capital and Charitable Funds) on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for approval above that level.

12.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 8)

12.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's procurement department or other specialist advisor (e.g. IT or estates) shall be sought.

12.2.2 All purchases (NHS and trade) should have a purchase order made with the formal involvement of the Procurement Department (for goods and services), the Estates Department (for specialised maintenance and services and capital items), Chief Pharmacist for Pharmacy supplies and the Human Resources department for Agency staff and other recruitment related expenditure.

12.2.3 A list of any authorised exceptions to the requirement to raise a purchase order is held within the procurement department

12.2.4 System of Payment and Payment Verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

12.2.5 The Director of Finance will:

(a) agree with the Trust Board the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) Authorised Signatory Register - A list of Board Directors and budget holders (including specimens of their signatures) authorised to approve orders and certify invoices. See overlap with SD section 3.3.4(f)

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 12.2.6 below.

12.2.6 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform

the appropriate Director or Chief Executive if problems are encountered.

12.2.7 Official orders

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

12.2.8 Purchases from Petty Cash

Purchases from petty cash are restricted in value to less than £25.00 per claim unless advance authority is given by the Financial Services Team. There are also restrictions in respect of the type of purchase and Petty cash may be used for specified or emergency use only subject to the following:-

a. minor emergency purchases approved in advance by procurement

b. Emergency spending as part of the Emergency planning and business continuity standards authorised by the Emergency Planning team

c. reimbursement of Patient travel

d. reimbursement of small balances of patient monies (see patient property policy)

e. no reimbursement of expenses for staff (including uniforms) or volunteers may be made from petty cash under any circumstances

f. no reimbursement for any electronic or electrical items may be made from petty cash as these items could form a health and safety risk if procured outside official channels

g. Instances where expenditure has been split to fall below petty cash thresholds will be reported to the Director of Finance

h. failure to adhere to the requirements of section 12.2.8 may result in claims being refused

12.2.9 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement (see section 8.2)

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with the Trust Development Authority guidance on Consultancy spending controls to NHS Trusts.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 7.4 and the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff” (SO Appendix 6) and the Bribery Act 2010 and associated Government guidance); More detailed guidance is available in the Trust Code of Conduct policy.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract or purchases from petty cash (see k below);

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order at the earliest opportunity and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or delegated limits See overlap with section 8.5.9;

(i) Where orders are amended, authorisation at the appropriate level must be sought in advance of the amended order being issued

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are held in an appropriate record.

12.2.10 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estatecode and other Department of Health Guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

12.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

12.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

13. EXTERNAL BORROWING, FINANCING AND INTERIM SUPPORT

13.1 Borrowing & Interim support

13.1.1 The Director of Finance will advise the Trust Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital; and likewise its ability to repay principal and interest on any proposed new borrowing or interim support, whether Capital Support Loan, Revolving Working Capital Support Facility, or Interim Revenue Support Loan, within the borrowing limits set by the Trust Development Authority (TDA) and the Department of Health (DH). The Director of Finance is also responsible for reporting periodically to the Finance Committee and Trust Board concerning the PDC debt and all loans, support and overdrafts.

13.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and / or the Director of Finance.

13.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for interim support and overdrafts.

13.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the TDA and Department of Health.

13.1.5 Any short-term borrowing drawdown must be with the authority of two members of an authorised panel, one of which must be the the Director of Finance or authorised deputy. The Revolving Working Capital Facility must be set up in accordance with the requirements of the TDA. The Finance Committee and Trust Board must be made aware of all short term borrowings at their next - available meetings.

13.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board, and meet the requirements as currently set out by the Trust Development Authority and Department Health.

13.2 Investments

13.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

13.2.2 The Director of Finance is responsible for advising the Trust Board on investments and shall report periodically to the Finance Committee and Trust Board concerning the performance of investments held.

13.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained

14. SECTION NOT USED

15. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Investment

15.1.1 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, where applicable, and the availability of resources to finance all revenue consequences, including capital charges.

15.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the regulatory guidance contained within the Capital Investment Manual, the Treasury Green book, International Financial Reporting Standards, TDA Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts and other applicable guidance) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Trust Management Executive, Finance Committee and/or Trust Board has approved the business case in accordance with delegated limits after suitable review and challenge;

(c) that any other external requirements have been fulfilled e.g. NHS TDA authorisation limits including temporary changes to delegated limits;

(d) for projects over £500k the relevant Business Case requires Finance Committee approval; Trust Board approval is required for projects of £1million and over; for projects over £5m Trust Development Authority approval is required.

15.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

15.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised capital budget.

15.1.6 The approval of a capital programme shall not constitute approval for expenditure on any specific scheme.

15.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance, TDA Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts and the Trust's Standing Orders.

15.1.8 The Chief Executive shall issue through delegation to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 8.5);

(c) approval to accept a successful tender (see overlap with SFI No. 8.8).

15.1.9 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

15.1.10 Prioritisation of the capital programme will take account of the Trust's commitment to the sustainable use of resources and look favourably on any plans that reduce the use of energy and other natural resources, minimise the production of waste and contribute to the sustainable development of the wider community.

15.2 HIS Capital Projects

15.2.1 Following the change in arrangements regarding the status of the HIS as a "hosted" service within MTW, it will now be subject to the same process of capital bidding, review, prioritisation and approval processes as any other Directorate within the Trust. The Managing Director of the HIS will be responsible for ensuring that a project programme incorporating HIS's capital expenditure requirements is drawn up each year for agreement by the HIS Management Board as part its business planning submission within the Trust overall process.

15.2.2 Before work can commence on any HIS project the Director will ensure that:

a) Capital and revenue funding has been fully agreed by the Trust and SLA partners as appropriate;

b) Where assets are to be procured and owned, a business case must be submitted in accordance with the Trust policies for approval in the agreed format. Approval will be in accordance to the Trust and TDA delegated limits (see 15.1.2(d))

15.3 Private Finance (see overlap with SFI No. 8.10)

15.3.1 The Trust should normally test for PFI when considering major capital procurement, or as directed by current Department of Health guidance. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically approved by the Trust Board.

15.4 Asset Registers

15.4.1 The Trust's asset register is an integral part of the Trust's asset management information and along with relevant financial information will be used in actively managing the asset base of the Trust. The Chief Executive is responsible for the maintenance of up to date registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical verification of assets against the asset register to be conducted once a year.

15.4.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the guidance issued by the Department of Health.

15.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and timesheets for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

15.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

15.4.5 A sales invoice must be raised in respect of all disposals by sale, to ensure correct VAT accounting

15.4.6 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.4.7 The value of each asset shall be indexed, if appropriate, to represent current values in accordance with guidance issued by the Department of Health and TDA.

15.4.8 The value of each asset shall be depreciated using appropriate methods and rates with reference to Department of Health and TDA guidance.

15.4.9 The Director of Finance of the Trust shall calculate and pay capital charges as specified in guidance issued by the Department of Health and TDA.

15.4.10 An annual housekeeping exercise of the asset register should be undertaken in respect of fully depreciated assets

15.5 Security of Assets

15.5.1 The overall control of Trust assets is the responsibility of the Chief Executive

15.5.2 Each department and ward is responsible for establishing and maintaining registers of its high risk and business critical assets under £5,000 in value, and periodically reviewing and updating the records. Evidence of these registers and the processes of maintaining them will be required to comply with the requirements of the Standards for Providers (Security Management).

15.5.3 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, remaining useful life, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

(h) all disposals or losses of assets must be recorded and reported in line with the requirements set out in SFI section 17.

15.5.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

15.5.5 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

Where practical, assets should be marked as Trust property

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subject to annual stock take processes;

(c) valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

16.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store, that are classified as 'stock', at least once a year, in accordance with agreed processes.

16.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

16.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 17 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by NHS Supply Chain

16.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note notifying Procurement of any discrepancies.

16.4 Consignment Stock

16.4.1 Consignment Stocks are those items that remain the property of the supplier until used, but that are available on site for practical reasons

16.4.2 Any consignment stock held must have been approved in accordance with the delegation of authority and must be kept to an agreed minimum level. Consignment stock held must not be included in the Trust's stock values but separate detailed records must be kept

16.4.3 It is the responsibility of the Clinical Director to ensure that SFI 16.4.2 is followed.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS (see overlap with SFI 8 and SFI 2.5 Fraud & Corruption)

17.1 Disposals and Condemnations

17.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate and the net book value at the time of proposed disposal.

17.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

17.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance or Deputy Directors of Finance of all the details relating to the loss. . Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant Local Counter Fraud Service in accordance with Secretary of State for Health's Directions.

17.2.3 The Director of Finance must notify the Local Counter Fraud Specialist and the External Auditor of all frauds.

17.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Trust Board (at its next available meeting),

(b) the External Auditor.

17.2.5 Within limits delegated to it by the Department of Health, the Audit and Governance Committee shall approve the writing-off of losses on behalf of the Board.

17.2.6 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations

17.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made.

17.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

17.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

17.2.10 Compensation payments to Chief Executives or Directors reporting to the Chief Executive require approval of the Trust's Remuneration and Appointments' Committee and the Trust Development Authority's Remuneration Committee. In the event the payment includes novel of unusual elements it may require Treasury approval (see SFI 11.6)

17.2.11 All losses and special payments must be reported periodically to the Audit and Governance Committee.

18. INFORMATION TECHNOLOGY

18.1 Responsibilities and duties of the Senior Information Risk Owner (SIRO)

18.1.1 The Senior Information Risk Owner, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

18.1.2 The Senior Information Risk Owner shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

18.2.1 In the case of computer systems which are proposed for general applications and those applications which the majority of Trusts in the TDA South area wish to sponsor jointly, all responsible directors and employees will send to the Trust's Director of Health Informatics for submission and approval by the ICT Steering Group the following:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.2.2 The Director of Health Informatics shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority and compliance to this is a statutory requirement. It describes the classes or types of information about our Trust that we make publicly available.

18.3 Contracts for Computer Services with other health bodies or outside agencies

18.3.1 The Director of Health Informatics shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Health Informatics shall periodically seek assurances that adequate controls are in operation.

18.4 Risk Assessment

The Director of Health Informatics shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

18.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as a Health Informatics Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(b) such computer audit reviews as are considered necessary are being carried out.

18.6 Standard of Non-Financial Records

The Director of Health Informatics shall be responsible for ensuring that non-financial records are adequate for contractual and management purposes.

18.7 Security and Integrity of Records

The Director of Health Informatics shall be responsible for implementing all necessary systems to ensure the security and integrity of the records in which this data (Financial and Non-Financial) is held. Records will be maintained in accordance with the Records Management: NHS Code of Practice.

19. PATIENTS' PROPERTY

19.1 Safe Custody of Patients' Property

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

19.2 Liability for Patients' Property

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets (notices are subject to sensitivity guidance);
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

19.3 Procedures for Patients' Property

19.3.1 The Chief Nurse must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

19.3.2 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients

19.4 Bank accounts for Patients' Property

Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.5 Restricted Use of Patients' Property

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.6 Deceased Patients

19.6.1 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the

property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.6.2 Where a patient, dying intestate and without lawful kin, leaves property in the hands of the Trust, the Director of Finance shall report the facts to the Treasury Solicitor. Where the net estate after payment of all known liabilities and collection of all known assets amounts to £200 or less, the money can be retained as a contribution towards expenses. The Trust will not accept responsibility for any assets in the hands of any other person or organisation.

19.6.3 The burial or cremation of deceased patients for whom no other arrangements are possible shall be undertaken by the Trust and the cost thereof recovered as a first charge against the patient's property, if any.

20. FUNDS HELD ON TRUST (INCLUDING CHARITABLE FUNDS)

20.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust,

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

(3) The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

(4) All Fund Holders are required to comply with the Charitable Fund Policy and Procedure

20.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 8.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. ACCEPTANCE OF GIFTS BY STAFF (see overlap with Trust Gifts, hospitality, sponsorship and interests policy and procedure and SO No. 7, SO Appendix 6

21.1 Detailed guidance on the acceptance of gifts by staff is contained in the Trust Gifts, hospitality, sponsorship and interest's policy and procedure (see Annex D)

22. SECTION NOT USED

23. RETENTION OF RECORDS

23.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

23.2 The records held in archives shall be capable of retrieval by authorised persons.

23.3 Information Asset Owners, as delegated by the Chief Executive, are responsible for ensuring the appropriate retention and subsequent disposal of records in line with Records Management: NHS Code of Practice.23.4 Detail shall be maintained of records destroyed.

24. RISK MANAGEMENT AND INSURANCE

24.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Trust Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement that is published with the Annual Report and Accounts as required by current Department of Health guidance.

24.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Trust Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical,

property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.3 Insurance arrangements with commercial insurers

24.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

24.4 Arrangements to be followed by the Trust Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Nurse shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Nurse shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Nurse shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Nurse will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Annex A

Procedures supporting the Standing Financial Instructions

CE= Chief Executive; DoF= Director of Finance; DWC=Director of Workforce and Communications; CN=Chief Nurse

Paras.	Procedure	Lead
1.2.5 (b)	Ensuring detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions.	DoF
6.3.1	Prepare detailed instructions on the operation of bank and GBS accounts	DoF
7.3.2	Bad Debts to be dealt with in accordance with Losses and Special payments procedures	DoF
7.4.1.(c)	The security of keys, and for coin operated machines;	DoF
7.4.1 (d)	Prescribing systems and procedures for handling cash and negotiable securities	DoF
Section 8	Tendering and Contracting	DoF
9.4	Development and maintenance of a register to monitoring Partnerships	DoF
9.5	Development of a Business case supporting any proposed hosting of services provided to other organisations	DoF
11.3.2	Determination of starting pay rates, condition of service, etc., for employees.	DWC
11.4.2 (h)	Procedures for payment by cheque, bank credit or cash	DWC/DoF
11.4.2 (i)	Procedure for the recall of cheques and bank credits	DWC/DoF
11.4.5	Payroll: Audit Review Procedures	DWC/DoF
12.1.3	Professional Advice for the supply of goods and services	DoF
12.2.4	Instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds	DoF
12.2.4 (d) (iv)	Instructions to employees regarding the handling and payment of accounts within the Finance Department	DoF
12.2.7.(k)	Instructions Restrictions of purchases from petty cash in terms of value and by type of purchase.	DoF
12.3.1	Payments to Local Authorities & Voluntary Organisations under Section 28A	DoF
13.1.3	Applications for loans and overdrafts.	DoF
13.2.3	The operation of investment accounts and on the records to be maintained.	DoF
15.1.3	Capital Projects: Stage payments	CE
15.1.5	Regular reporting of Capital expenditure and commitment against authorised expenditure	DoF
15.1.6	Issue a scheme of delegation for capital investment management	CE
15.1.9	The financial management, including variations to contract, of capital investment projects and valuation for accounting purposes	DoF
15.4.5	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers	DoF
15.5.2	Asset Control	DoF
15.5.3	Reporting of breaches of agreed security practices	DoF
16.2.3	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.	DoF
16.2.6	Procedures for the disposal of obsolete stock shall follow the	DoF

Paras.	Procedure	Lead
	procedures set out for disposal of all surplus and obsolete goods.	
17.1.1	Detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers	DoF
17.2.1	Prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers	DoF
18.1.1 (a)	Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware	CN
19.3.1	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises)	CN
19.4	Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under agreed arrangements.	DoF
24.4.(1)	Use the risk pooling schemes administered by the NHS Litigation Authority	CN
24.4 (2)	Management of any claims arising from third parties and payments in respect of uninsured	CN
24.4 (3)	Ensure documented procedures to cover the management of claims and payments below the deductible in risk pooling schemes	DoF

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Annex B

Financial Limits contained within the Standing Financial Instructions

Section B Para.	Limit	£
4.3.2(h)	For revenue developments over £500k the relevant Business Case requires Finance Committee approval.Trust Board approval is required for cases of £1million and over. For revenue developments or investments over £5m whole life costs involving managed service or lease arrangements (for equipment, IT, property), the relevant Business Case requires the approval of the Trust Development Authority	Up to £500,000 TME £500,000 & over FC £1,000,000 & over Trust Board £5,000,000 & over TDA
8.9	Local procurement procedures will operates for items requisitioned and expected to be below £10,000 (Purchase Orders required for all purchases see para. 12.2). Designated Budget Managers are expected to secure value for money	10,000 exc VAT
8.7.1	3 Written Quotations are required where intended expenditure/income is reasonably expected to be between	10,001 and 49,999 exc VAT
8.5.3 (a)	Formal Tendering is required if income or expenditure is reasonably expected to exceed	49,999 exc VAT
8.8.1	Authorisation of Tenders or Competitive quotations Head of Procurement and one of Deputy Director of Finance Above plus one Executive Director Above plus Chief Executive or Trust Board	(exc VAT) Up to 49,999 50,000 – 249,999 250,000 – 500,000 Greater than 500,000
8.14.1 (c)	Competitive Tendering not required if income from disposal is expected to be less than	10,000
8.15.2 (c)	Where tenders include in-house submissions, Non-Executive Director should sit on evaluation teams if contract expenditure is likely to exceed	500,000
11.6.1	The Trust Remuneration Committee approve individual non Board contractual redundancy packages up to	100,000
11.6.2	Trust Remuneration Committee and Trust Development Authority (TDA) Remuneration Committee to approve individual non Board redundancy packages in excess of	100,000
11.6.3	All contractual severance payments to the Chief Executive or Executive Directors must be approved by the Trust's Remuneration Committee and the NHS Trust Development Authority's Remuneration Committee.	
11.6.4/5	Non contractual severance payments and payments of a novel or unusual nature require the approval of the Trust and TDA Remuneration Committees as above and will require Treasury approval.	
12.2.5	Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate	NLF + 2%
12.2.8	Purchases from petty cash are restricted in per claim unless advance authority is given by the Financial Services Team	25.00
15.1.2d	For projects over £500k the relevant Business Case requires Finance Committee approval; if £1million or over Trust Board approval is required.	£500,000 & over FC £1,000,000 & over Trust Board
15.1.2 (d)	For projects over £5m the relevant Business Case requires the approval of the Trust Development Authority	5,000,000

Section B Para.	Limit	£
19.6.1	Value above which Probate or Letters of Administration required if patient property held exceeds	5,000
19.6.1	Forms of indemnity required if deceased patients property fall below	5,000
19.6.2	A contribution to expenses not exceeding £200 may be retained in cases where a patient, dying intestate and without lawful kin, leaves property in the hands of the Trust	200.00

Annex C

TDA Consultancy spending controls: Executive Summary (July 2015)

Spending by NHS providers on management consultants was £420 million in 2014/15 and given the current level of provider deficits the NHS cannot continue to spend on this scale without getting maximum value for money. The TDA are therefore putting in place support and controls at a national level to ensure that only good value for money consultancy is commissioned and, where, possible generic technical advice is widely shared within the NHS.

Effective 2nd June 2015, NHS Trusts are required to secure advance approval from the NHS TDA before:

- Signing new revenue contracts for consultancy projects over £50,000 including irrecoverable VAT and expenses; this includes contracts where contractual negotiations were in place prior to 2nd June. These controls do not currently apply to capital contracts, interim management and day rate contractors.

- Extending or varying existing revenue contracts or incurring additional expenditure to which they are not already committed (where the total contract value exceeds £50,000 including irrecoverable VAT and expenses).

Important notes:-

- Consultancy is as defined in the NHS Manual for Accounts (see overleaf)

- Interim management and day rate contractors are currently outside these controls but in accordance with Agency controls contractors must be procured from a 'framework' agency.

- Under HMRC current guidance, VAT is recoverable on the professional services of managers, advisers, experts, specialists and consultants for advice or information on how to affect something but not on the implementation of the new process / initiative. Contracts that include research / information gathering / provision of advice or recommendations AND support in implementing those regulations are not VAT recoverable. It is important that contracts and project specifications only claim implementing if they are really going to affect something. If they are in an advisory or supportive capacity but not implementing this changes the VAT treatment under current guidance.

- During 2015/16, the NHS TDA will collect detailed financial data on consultancy contract procurement as part of the regular collection process.

- NHS Trusts are expected to comply with this controls process. A failure to do so may indicate to the NHS TDA that a trust does not have adequate expenditure controls in place which may result in the TDA requesting that the NHS Trust obtains prior approval before committing to other discretionary expenditure items.

- Evidence suggesting organisations are seeking to avoid these controls through splitting contracts, manipulating contract scope or substituting contracts with high cost interims or secondees from consultancies will be subject to follow up by the TDA.

Approval Process – For revenue contracts over £50,000 (including irrecoverable VAT & expenses)
NHS Trusts must complete the TDA business case approval form, available from Procurement, which will allow the NHS TDA Consultancy Control panel to assess each case. The key areas of focus for the template are:-

- Ambition to deliver something of value, importance and relevance that supports the trust's strategic and operational objectives
- Clear scope developed with engagement with patients, clinicians, commissioners and suppliers
- Robust contract management – that the Trust can manage supplier, control spend and ensure VFM
- Capacity for the Trust to implement findings / recommendations
- Timeline of work – with details on when expected outcomes will be delivered
- Robust implementation review proposal – focus on benefits and value added
- Value on price – options appraisal, evidence of sourcing best value supplier
- Wider use of findings – expectation that the results will be made available for wider benefit of NHS, particularly if technical advice which is likely to be generic; right of access to be written into contracts.

On completion of approved consultancy projects, NHS Trusts will be required to submit to the NHS TDA a report detailing benefits of the work and value added.
Extract from draft NHS Manual for Accounts 2015-16 : Consultancy (chapter 4 annex 5)

The provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation, in pursuit of its purposes and objectives. Such assistance will be provided outside the "business as usual" (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions.

The consultancy category will include areas such as:
• **Strategy**: The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management

• **Finance**: The provision of objective advice and assistance relating to corporate financing structures, accountancy, control mechanisms and systems. This does not include "auditor's remuneration", this is reported separately. It will include:
- Strategic Finance: Providing specialist services and support in the form of financial, legal, insurance advice to develop a Public Private partnership/Private Finance Initiative deal for procurement requirement.
- Operational Finance: Procurement advice on risk management and internal control systems including audit arrangements. Advice on the commercial viability of grant recipients, suppliers and partners; solvency checks

• **Organisation and Change Management**: Provision to management of objective advice and assistance relating to the strategy, structure management and operations of an organisation in pursuit of its purposes and objectives. Long range planning, re-organisation of structure, rationalisation of services, general business appraisal of organisation

• **IT/IS**: The provision of objective advice and assistance relating to IT/IS systems and concepts, including strategic studies and development of specific projects. Defining information needs, computer feasibility studies and making computer hardware evaluations. Including consultancy related to e-business

• **Property and Construction**: The provision of specialist advice relating to the design, planning and construction, tenure, holding and disposal strategies. This can also include the advice and services provided by surveyors and architects

• **Procurement**: the provision of objective advice and assistance when establishing procurement strategies

• **Legal Services**: The provision of external specialist legal advice and opinion in connection with the policy formulation and strategy development particularly on commercial and contractual matters

• **Marketing and Communication**: The provision of objective advice, assistance and support in the development of publicising and the promotion of the entity's Business Support programmes, including advice on design, programme branding, media handling and advertising

• **Human Resource, training and education**: The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies

• **Programme and Project Management**: The provision of advice relating to ongoing programmes and one-off projects. Support in assessing, managing and or mitigating the potential risks involved in a specific initiative; work to ensure expected benefits of a project are realised

• **Technical**: The provision of applied technical knowledge. This can be sub-divided into:
- Technical Studies: Research based activity including studies, prototyping and technical demonstrators.
- Project Support: Project based activities including technical consultancy, concept, development and in-service support activities.
- Engineering Support: Task based support including Post Design Services, repair, calibration, analysis testing and integration.

Maidstone and Tunbridge Wells NHS
NHS Trust

Annex D

Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Policy subject to agreement

APPENDIX ONE
Process Requirements

1.0 Implementation and Awareness

1.1 Once approved the Document Lead or Author will send this policy/procedural document to the Clinical Governance Assistant who will publish it on the Trust intranet.

1.2 All staff will have access to a copy of the policy and procedure through the Trust's intranet site. A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and a notification email circulated Trust wide by the Communications team

1.3 On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

The Standing Financial instructions will be reviewed annually.

3.0 Archiving

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

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX TWO

CONSULTATION ON: Standing Financial Instructions

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Head of Financial Services (wmaher2@nhs.net)

By date: Wednesday 30th September 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	28/08/15			
Chief Internal Auditor	28/08/15	28/09/15	Y	Y
Director of Finance	28/08/15	throughout	Y	Y
Deputy Director of Finance	28/08/15	throughout	Y	Y
Executive Directors	28/08/15			
Non-Executive Directors	28/08/15	Audit committee		
Risk Manager	28/08/15			
Head of Information Governance	28/08/15	01/09/15	Y	Y
Human Resources Business Partner	28/08/15			
Head of Employee Services	28/08/15			
Head of Finance Systems	28/08/15	01/09/15	Y	Y
Head of SLA & Income	28/08/15	throughout	Y	Y
Head of Financial Management	28/08/15	throughout	Y	Y
Head of Procurement	28/08/15	throughout	Y	Y
Financial Services Manager	28/08/15	throughout	Y	Y
Service agreements manager	28/08/15	throughout	Y	Y
Technical Team Leader and team	28/08/15	throughout	Y	Y
Debt Management Team Leader and team	28/08/15	throughout	Y	Y
Payables Team Leader and team	28/08/15	throughout	Y	Y
Associate Directors	28/08/15			
HIS Managing Director	28/08/15			
Head of R&D	28/08/15			
Associate Director of Governance, Quality and Patient Safety	28/08/15			
EME Services Manager	28/08/15			
Capital Planning Manager	28/08/15	throughout	Y	Y
Local Security Management Specialist	28/08/15			
Staff side representative	28/08/15			
Trust Secretary	28/08/15			
General Managers / Heads of department	28/08/15	01/09/15 (1)	Y	Y
Director of Estates	28/08/15			
Director of Health Informatics	28/08/15			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX THREE

Equality Impact Assessment

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

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

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	**Standing Financial Instructions**
What are the aims of the policy or practice?	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust.
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	Yes (May have difficulty in understanding document, support / interpretation can be provided on request)
People who have a physical disability	Yes (Sight impaired may have difficulty in reading document, a braille version can be provided on request)
People who have a mental disability	Yes (May have difficulty in understanding document, support can be provided on request)
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	At the same time as the Standing Financial Instructions document (annually)
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of the Standing Financial Instructions document on the Trust Intranet

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2015

11-21	**Summary report from Charitable Funds Committee, 19/10/15 (incl. approval of the 2014/15 Ann. Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)**	**Committee Chairman (Non-Executive Director)**

The Charitable Funds Committee met on 19th October 2015.

1. **The key matters considered at the meeting were as follows:**
   - The draft Annual Report and Accounts 2014/15 were reviewed and agreed subject to minor amendments. Subject to these amendments, the Committee recommended the Annual Report and Accounts for approval by the Trust Board
   - The income, expenditure and balance sheet, at quarter 2 2015/16 were reviewed, along with fund transactions over £1k and the balances by individual fund. The one occasion of expenditure refused was also notified to the Committee
   - Progress with the previously-agreed action to amalgamate the current list of designated Funds by Directorate was reviewed
   - The Statement of Recommended Practice (SORP) to be adopted for 2015/16 Charitable Fund Accounts was reviewed and the Committee agreed to adopt the Financial Reporting Standard (FRS102) SORP.
   - A letter from the Department of Health was received regarding the requirement for NHS Charities to appoint their own Auditors, from 2017/18
   - A proposed lottery scheme initiative was reviewed and further investigation regarding the validity of the scheme was requested

2. **The Committee agreed…**
   - The Annual Report and Accounts 2014/15, subject to minor amendments, be recommended to the Trust Board for approval
   - A request for the Haematology Development Fund to be reclassified as "restricted" as it resulted from a bequest
   - The Trust adopt the Financial Reporting Standard (FRS102) Statement of Recommended Practice which would apply for the accounts prepared for 2015/16

3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Annual Report and Accounts 2014/15, subject to minor amendments, be recommended to the Trust Board for approval. It should be noted that due the value involved, the 2014/15 were only subject to an "independent examination" (rather than a full external audit), and therefore there is no separate report from the Auditors. The Auditor's findings from the examination are contained with the Annual Report. Similarly, there is no Management Representation Letter (as would be the case with a full audit). The Annual Accounts of the Fund are legally required to be submitted to the Charity Commission within 10 months from the financial year-end (i.e. by the end of January 2016). The Trust Board is therefore asked to approve the enclosed documents, to enable the required submission to take place.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. Assurance
2. To approve the enclosed 2014/15 Annual Report and Accounts for Maidstone and Tunbridge Wells NHS Trust Charitable Fund

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

mtw.nhs.uk

Charitable Fund

Charity Number 1055215

View of tub chairs purchased for 'Hayley's Room'

Annual Report and Accounts for the year ended 31st March 2015

Contents

Annual Report for the year ended 31 March 2015

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds ("the Charity's") annual report and the audited financial statements for the year ended 31 March 2015.

The financial statements set out on pages 19 to 28 comply with the charity's trust deed, applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" issued in October 2005, and the Charities Act 2011.

Trustee Statement

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

Information about the Charity

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

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

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

Within the Umbrella there were a total of 164 individual funds at the 31st March 2015 with a total value of £1,068k. The number of funds in each category is as follows:-

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

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

The Corporate Trustee

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

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

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

Executive Directors	Non-Executive Directors	Other Directors
Glenn Douglas – Chief Executive	Anthony Jones – Chairman of Trust Board	Sara Mumford – Director of Infection Prevention and Control
Stephen Orpin – Director of Finance (from 14th April 2014)	Steve Tinton – Chair of Charitable Funds Committee	Jayne Black – Director of Transformation (to November 2014)
Ian Miller – Interim Director of Finance (to 11th April 2014)	Sarah Dunnett OBE	Terry Coode – Director of Corporate Affairs (to 11th April 2014)
Paul Sigston – Medical Director	Kevin Tallett	Paul Bentley – Director of Workforce and Communications
Angela Gallagher – Chief Operating Officer	Sylvia Denton CBE	Stephen Smith (Associate Non-Executive Director)
Avey Bhatia – Chief Nurse	Alex King MBE (from 1st September 2014)	

None of the Board Directors have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee. (2013/14 none)

The principal office of the Charity is:

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

Principal advisors:

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

Governance and Management of the Charity

Governance

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

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

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

Recruitment and Training of Board and Committee Members

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

Management of the Charity

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

Risk Management

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

To mitigate the risk of investment performance the Corporate Trustee has adopted a relatively low risk policy, but 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85,000 (This reduces to £75,000 from 1st January 2016) per Banking institution operating under a separate banking licence. The maximum investment in each banking institution outside the Government banking Scheme will be £85,000 and therefore the maximum risk on each investment is £15,000 (£10,000 from 1st January 2016).

Investment Powers

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

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

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

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

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

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

Investment strategy

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

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

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

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

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

Professional Advisors

The External Audit review is performed by Grant Thornton UK LLP. For the 2014/15 financial year this will be an independent examination as permitted by the charities act. In addition, TIAA, the internal auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

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

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

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

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

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

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

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

Strategy for Achieving its Objectives

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

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

Reserves and Commitments

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

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

Major items of expenditure for both goods and services are agreed in advance in order that the

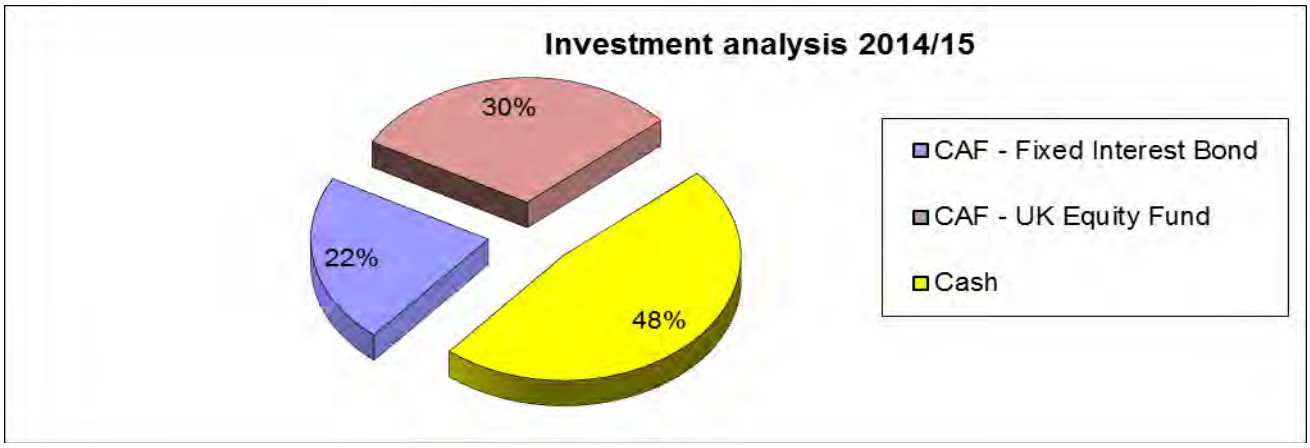
necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible,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

Investment Performance

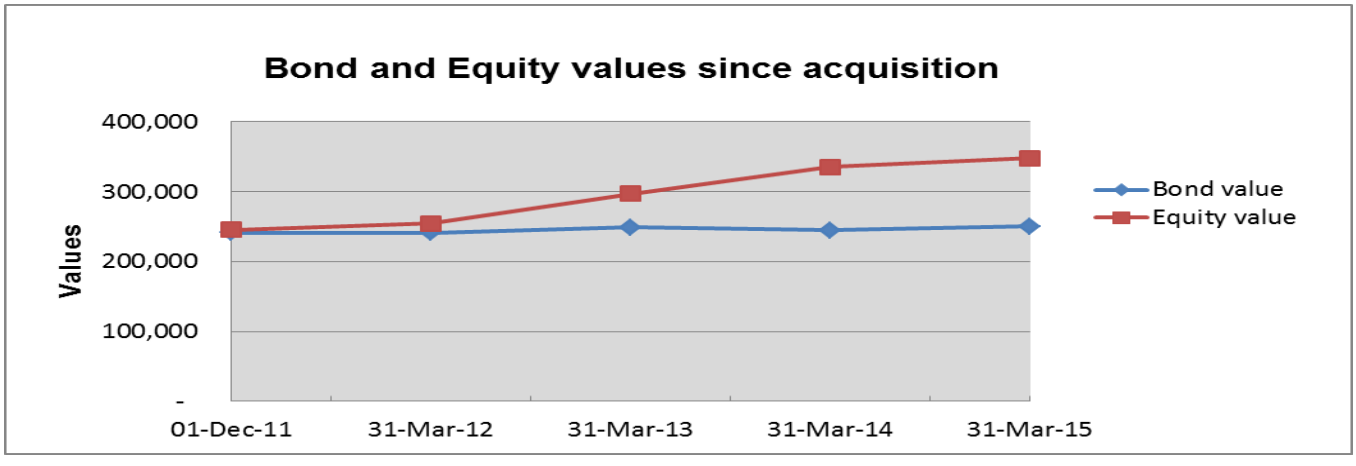
Investment income for the year was £21k (2013/14 £25k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The total performance return on the portfolio of the investments (equity and bond) was £7k which equates to a 1.15% on the opening portfolio value (2013/14 1.12%).

The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio increasing in market value to £598k at 31 March 2015 (£581k at 31 March 2014). The cash investment at 31 March 2015 was £542k (£615k at 31 March 2014).

The current asset portfolio of cash and investment allocation totalling £1,140k at 31.03.15 is shown in the following graph:



Although the cash allocation at 47.5% is broadly in line with the strategy of Cash 50%, Bonds 25%, Equities 25%, the mix of bonds (22%) and equities (30.5%) is not completely in line due to the fact that the equity investments have performed better over time. The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

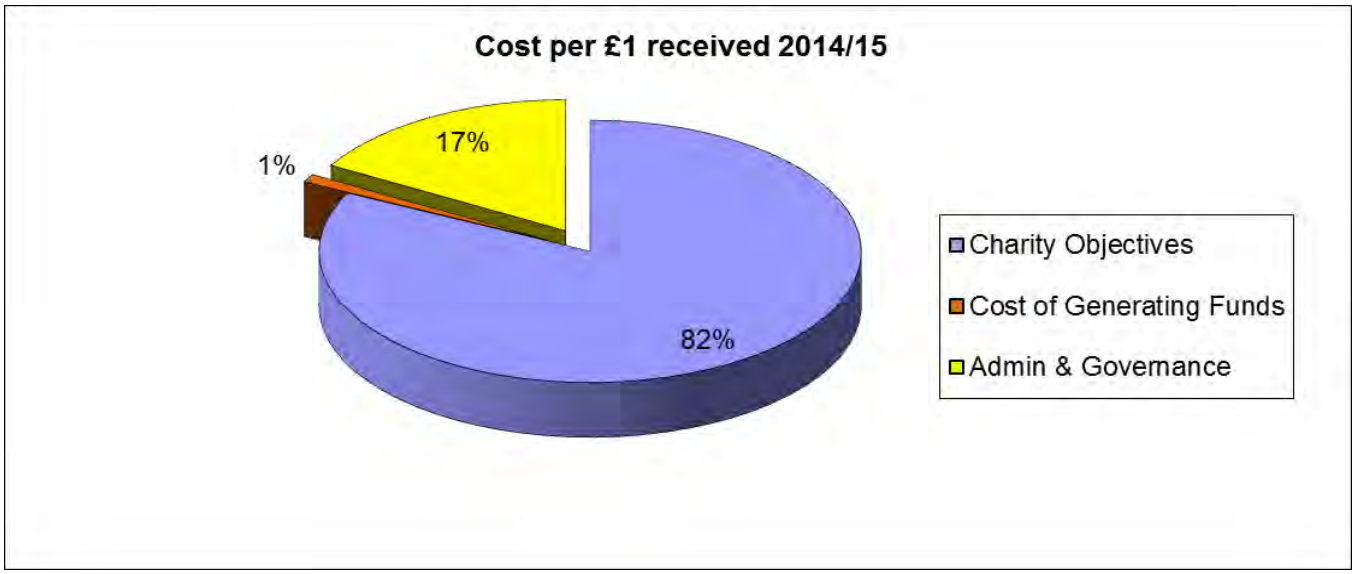


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

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

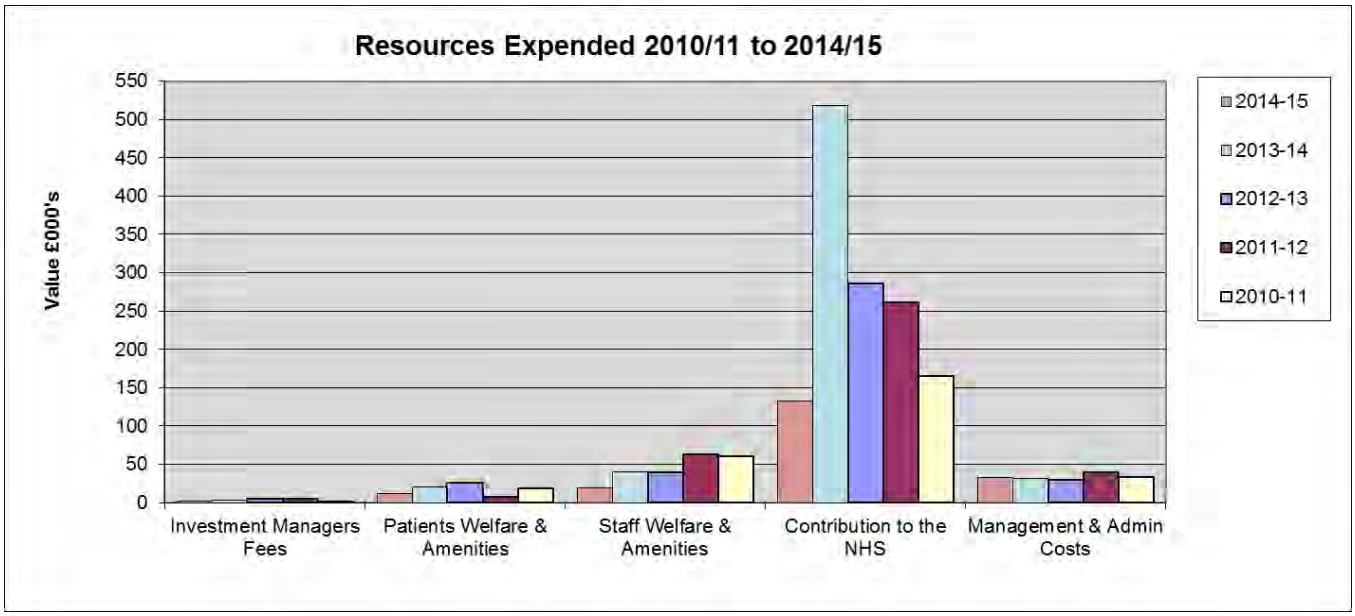
The graph below shows that in this financial year for every £1 raised, 82 pence was spent in achieving the objectives of the charity. This is lower than the equivalent ratio for 2013/14 (94pence) primarily due to the lower level of donations and legacies received in 2014/15 with administration and governance costs staying the same. Although a 'cost-per-pound' raised ratio can be misleading as many factors can affect the analysis, it can be a useful guide to both donors and the corporate trustee.



Expenditure

Total resources expended by the Charity within this financial year were £197k (2013/14 £613k), of which £163k (83%) was a direct contribution to the Trust (2013/14 £578k 94%).

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



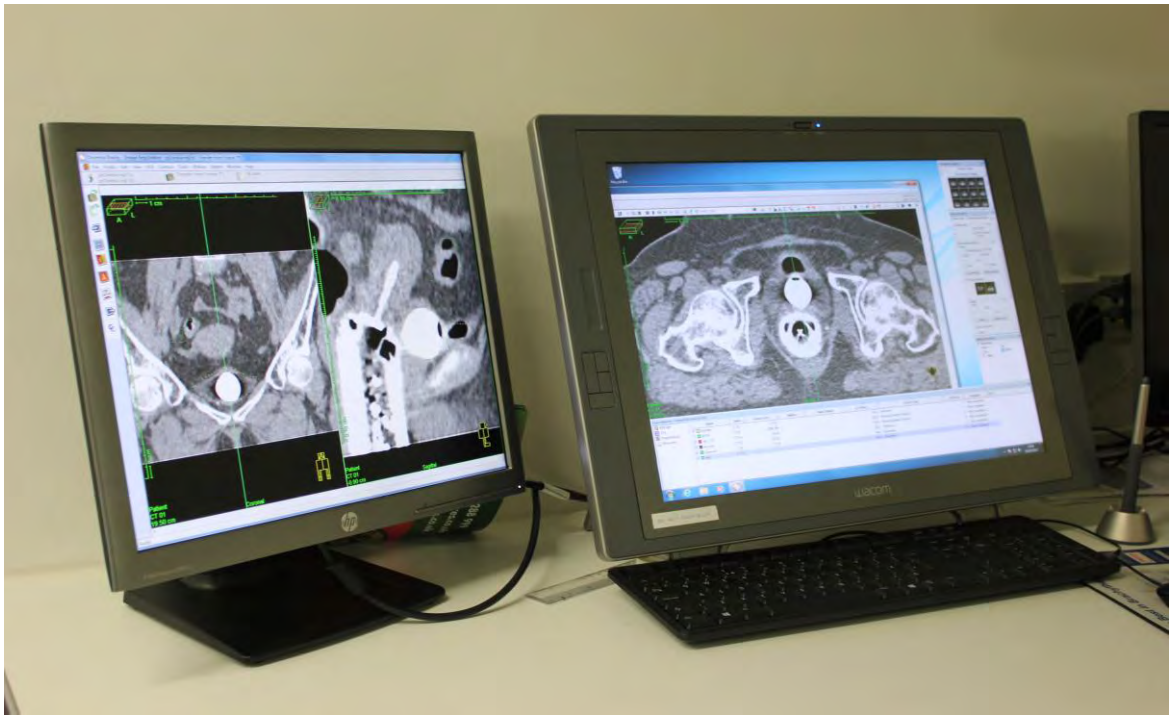
Charitable expenditure for the year is detailed below.

Medical Equipment – Total spend £77k (2013/14 £429k)

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

The most significant purchases were:

- Oncentra Platform to aide in the treatment of brain cancers (£45k)
- 3 x Body Box (£11k)
- Cerebral Function Monitor (£12k)



Oncentra platform in action

Patient Welfare and amenities – Total spend £12k (2013/14 £22k)

92% (£11k) of the expenditure in this category provides complementary physiotherapy service for patients with multiple sclerosis to enable patients to maintain higher levels of ability.

Staff Amenities and Welfare – Total spend £19k (2013/14 £40k)

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

74% of expenditure in this category is as support for additional training, allowing staff to develop within their roles and allowing them to enhance patient care and experience.

Other Direct Contributions to the NHS – Total spend £55k (2013/14 £41k)

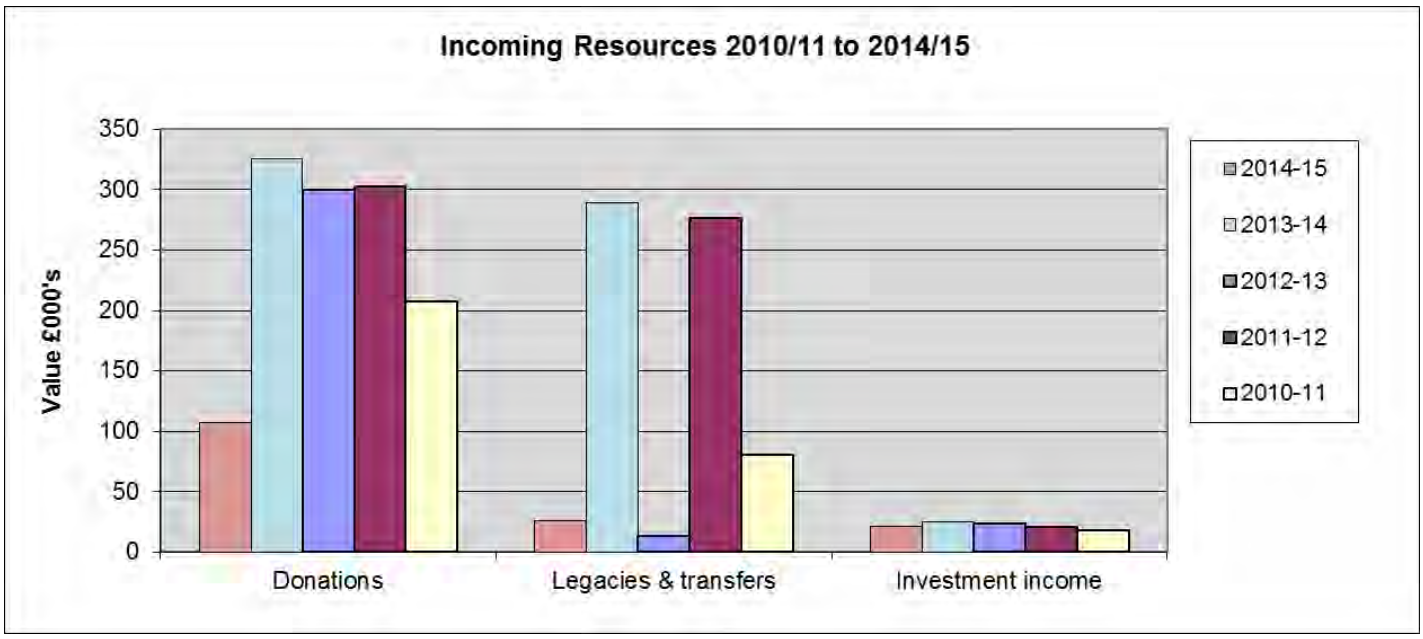
27% of expenditure in this category has supported the purchase of fixtures and fittings. The most significant purchases were:

- 32 x E-Clean Hygiene Centres (Barrier Nursing Trollies) for use across the Trust (£12k)
- 12 x tub chairs for 'Hayley's Room' providing a safe environment for children's cancer support group to meet (£3k)

View of tub chairs purchased for 'Hayley's Room'

Income

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



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

The total voluntary income received from all sources was £133k.

A total of £107k was received from donations (£326k 2013/14) and £26k from legacies (£289k 2013/14).

The Trust did not undertake fundraising activity during 2014/15 and therefore the lower levels of income received may be explained by the voluntary nature of this income

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

	£000's
Kent & Sussex Hospital Fund Darts League – 32 barrier nursing trollies for use in infection prevention	10

Four members of the Kent and Sussex Hospital Fund Darts League committee visited the Tunbridge Wells Hospital to hand over 32 barrier nursing trolleys, collectively worth over £10,000.

In the past, the League has donated a huge range of vital and costly equipment, including oximeters, ventilators and an incubation fibre scope. In recent years, they have purchased the Giraffe incubator (at a cost of £16,500), optical equipment and almost £15,000 worth of specialist pressure cushions. In total, the league has raised around £100,000 for the Trust.

Legacies

Legacies were received from the estates of the following:

	£000's
The late Tony McCambridge for the Maidstone Hospital Oncology ward funds	25
The late Winifred George for the general funds of Maidstone Hospital	1

For 2015/16 the Trust has been advised of 2 potentially significant legacies in favour of the Cardiology Departments at both sites.

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

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

Fundraising

The Trust has an active 'just giving' page that received donations of £13k this year compared to £19k last year.

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

Intangible Income

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

Looking Forward

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

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

The charity received low levels of voluntary income in 2014/15. For 2015/16 the Trust has been advised of 2 potentially significant legacies in favour of the Cardiology Departments at both sites. The committee is considering options to increase fundraising activity for the charity.

Following the categorisation review of administrative funds carried out in 2014/15, the charity is undertaking a piece of work to establish where administrative unrestricted funds may be amalgamated to ensure that these monies are more available to be spent in accordance with donor wishes. The results of this work will be reported in 2015/16.

Making donations

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

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

If you would like to find out more about the work of the Charity, make a donation, or raise funds, please contact the Trust at the principal office (details on page 4), via our website at www.mtw.nhs.uk or complete the attached form at the end of the report and send it to us.

The following pages show the financial accounts for the year ended 31 March 2015.

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

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

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

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

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

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

As far as the trustee is aware, there is no relevant audit information of which the charity's auditors are unaware and the trustee confirms that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 17 – 18 attached have been compiled from and are in accordance with the financial records maintained by the trustee.

By Order of the Trustee

Signed:

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

Date: ……

Independent examiner's report to the trustees of Maidstone and Tunbridge Wells NHS Charitable Fund

I report on the accounts of Maidstone and Tunbridge Wells NHS Charitable Fund for the year ended 31 March 2015, which are set out on pages 18 to 31.

This report is in respect of an examination carried out under section 149(3) of the Charities Act 2011 (the Act). This report is made solely to the charity's trustees, as a body, in accordance with the regulations made under section 154 of the Act and any directions given by the Charity Commission under subsection 149(5) of the Act. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees, as a body, for my work, or for this report.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year (under section 149(2) of the Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 149 of the Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 149(5) of the Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

i) which gives me reasonable cause to believe that in any material respect, the requirements:
   - to keep accounting records in accordance with section 130 of the Act;
   - to prepare accounts which accord with the accounting records; and
   - to comply with the accounting requirements specified in regulation 8 of the Charities (Accounts and Reports) Regulations 2008, with the exception of the requirement to show a true and fair view;

have not been met, or

to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Darren Wells
Grant Thornton UK LLP
Chartered Accountants
Fleming Way, Manor Royal
Crawley RH10 9GT

Date:

Statement of Financial Activities for the year ended 31 March 2015

					2014/15	2013/14
	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Incoming resources	2					
Donations		46	61	0	**107**	**326**
Legacies		0	26	0	**26**	**289**
Total Donations and Legacies		**46**	**87**	**0**	**133**	**615**
Investment income		5	16	0	**21**	**25**
Total incoming resources		**51**	**103**	**0**	**154**	**640**
Resources expended	3					
Costs of generating funds	3.1	(1)	(1)	0	**(2)**	**(3)**
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(70)	(93)	0	**(163)**	**(578)**
Governance and administration	3.3	(8)	(24)	0	**(32)**	**(32)**
Total resources expended		**(79)**	**(118)**	**0**	**(197)**	**(613)**
Net incoming / (outgoing) resources		**(28)**	**(15)**	**0**	**(43)**	**27**
Gains / (losses) on revaluation and disposal	4	4	13	0	**17**	**30**
Net Movement before category Review	4	(24)	(2)	0	**(26)**	**57**
Funds transferred between categories following category review	4	271	(271)	0	**0**	**0**
Net movement in Funds after category review	4	**247**	**(273)**	**0**	**(26)**	**57**
Fund Balances brought forward at 31 March 2014		277	808	9	**1094**	**1037**
Fund balances carried forward at 31st March 2015		**524**	**535**	**9**	**1068**	

The notes at pages 20 to 31 form part of these financial statements

Balance Sheet as at 31 March 2015

					2014/15	2013/14
	Note	**Unrestricted Funds £000**	**Restricted Funds £000**	**Endowment Funds £000**	**Total Funds £000**	Total Funds £000
Fixed Assets	5					
Investments	5.1	296	302	0	598	581
Total Fixed Assets		**296**	**302**	**0**	**598**	581
Current Assets	6					
Cash at bank and in hand	6.1	264	269	9	542	615
Debtors due within one year	6.2	0	0	0	0	1
Total current Assets		**264**	**269**	**9**	**542**	616
Creditors due within one year	7.1	(36)	(36)	0	(72)	(103)
Net Current Assets / (Liabilities)		**228**	**233**	**9**	**470**	513
Total Net Assets		**524**	**535**	**9**	**1068**	1094
Funds of the Charity	8					
Endowment Funds					9	9
Restricted Funds					535	808
Unrestricted Funds					524	277
Total Funds					**1068**	1094

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

The notes at pages 20 to 31 form part of these financial statements

Signed on behalf of the Trustee:

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

Date:

Notes to the financial statements for the year ended 31 March 2015

1. Principal accounting policies

1.1. Accounting Convention

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

Basis of preparation

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

1.2. Incoming Resources

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

Legacies are accounted for upon receipt.

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

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

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

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

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

1.3. Resources expended

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

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

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

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

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

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

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

1.4. Structure of funds

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

Where there is a legal restriction or a binding agreement with a donor, on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. There were a number of funds classified as restricted where there was no evidence to support this classification. The Trust has completed its work to correct this classification where appropriate, reviewing receipt documentation back to April 2009, where this was available. This resulted in a net reduction of restricted funds of £271k and a corresponding increase in unrestricted funds.

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

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

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

1.5. Finance and Operating Leases

The Charity has no finance or operating leases

1.6. Fixed Assets

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

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds.
Please see investment strategy on page 7 for further information.

Investment properties
The Charity held no investment properties during the year

1.7. Stocks

The Charity held no stocks during the year

1.8. Gains and losses

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

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

1.9. Cash and Cash equivalents

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

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

1.10. Pensions

The Charity has no employees.

1.11. Prior Year Adjustments

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

2. Incoming Resources

				2014/15	2013/14
Voluntary Income	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Donations	46	61	0	**107**	326
Legacies	0	26	0	**26**	289
Total Donations and Legacies	**46**	**87**	**0**	**133**	**615**
Investment income					
Dividends from investment portfolio	3	4	0	**7**	19
Interest from investment portfolio	2	12	0	**14**	18
Bank Interest	0	0	0	**0**	1
Total Investment income	**5**	**16**	**0**	**21**	**25**
Total incoming resources	**51**	**103**	**0**	**154**	**640**

3. Resources Expended

3.1. Cost of generating funds	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds	**2014/15 Total Funds £000**	2013/14 Total Funds £000
Investment managers fees	(1)	(1)	0	**(2)**	(3)
Total cost of generating funds	**(1)**	**(1)**	**0**	**(2)**	(3)

3.2. Charitable Activities	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds	**2014/15 Total Funds £000**	2013/14 Total Funds £000
Patients welfare and amenities					
Hospitality	0	0	0	**0**	(2)
Other	0	0	0	**0**	0
Complimentary Therapies	(12)	0	0	**(12)**	(18)
Total patients welfare and amenities	**(12)**	**(0)**	**0**	**(12)**	(20)
Staff welfare and amenities					
Training	(10)	(4)	(0)	**(14)**	(25)
Hospitality	(0)	(0)	(0)	**(0)**	(7)
Christmas Events	(2)	(3)	(0)	**(5)**	(7)
Other	(0)	(0)	(0)	**(0)**	(1)
Total staff welfare and amenities	**(12)**	**(7)**	**(0)**	**(19)**	(40)

Note 3.2 continued					
Contributions to the NHS					
Medical and Rehabilitation Equipment	(24)	(53)	0	**(77)**	(429)
Furniture and Fittings	(5)	(28)	0	**(33)**	(10)
Other	(17)	(5)	0	**(22)**	(20)
IT	(0)	(0)	0	**(0)**	(48)
Nursing Staff Salary Support	(0)	(0)	0	**(0)**	(11)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(46)**	**(86)**	**0**	**(132)**	(518)

3.3. Governance & Administration Costs	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**2014/15 Total Funds £000**	2013/14 Total Funds £000
Governance – Salaries and overheads	(7)	(22)	0	**(29)**	(27)
Governance – Audit Fees (external)	(1)	(2)	0	**(3)**	(5)
Total governance & admin costs	**(8)**	**(24)**	**0**	**(32)**	(32)
Total resources expended	**(79)**	**(118)**	**0**	**(197)**	(613)

3.4. Employee Information

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

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

4. Net Movements in Funds

				2014/15	2013/14
	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Net Incoming/(outgoing) resources before other recognised gains and losses	(28)	(15)	0	(43)	27
Gains/Losses on Investments	4	13	0	17	30
Total net movement in funds before category review	**(24)**	**(2)**	**0**	**(26)**	57
Funds transferred between categories following category review	271	(271)	0	(0)	57
Total net movement in funds after category review	**247**	**(273)**	**0**	**(26)**	57
Fund balances at 1 April 2014	277	808	9	1094	1094
Fund balances carried forward at 31 March 2015	**524**	**535**	**9**	**1068**	

4.1 Details of Funds that have been recategorised following review in 2014/15

The Charity undertook an extensive review of all funds in 2014/15 in respect of the categorisation between 'Restricted' and 'Unrestricted' funds. This entailed referring back to any original documentation where this was available for all receipts 2009/10 – 2014/15.

As a result of this exercise 77 funds were reclassified from Restricted to Unrestricted (£312k) and 2 reclassified from Unrestricted to Restricted (£42k) resulting in a net increase in Unrestricted funds of £271k with a corresponding decrease in Restricted Funds.

The categorisation transfers were transacted at 31st March 2015 after all other transactions for the year. The funds impacted with over £10k balance at 31st March 2015 are detailed in the table following. Details of the purposes of these funds is disclosed in note 8.1

Note 4.1 continued

Fund	Restricted to Unrestricted £000	Unrestricted to Restricted £000
Maidstone Patients Amenity Fund	11	
Maidstone Stroke Unit Fund	15	
Gynaecological Oncology Fund	12	
Jefferson Day Suite Fund	14	
CT Scanner Fund	13	
Medical Imaging – Ultrasound Fund	25	
CT Scanning Fund	29	
Cellular Pathology Fund	24	
Cardiorespiratory Fund	20	
Oncology Centre Fund	20	
Peggy Wood Breast Care	11	
Funds < £10k (66 funds)	119	
Gastrointestinal Fund		12
Neurology Fund		30
Total	**313**	**42**

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/14 £000	Additions to investment at cost £000	Disposals at carrying value £000	Net gain / (loss) on revaluation £000	**Carrying value at 31/03/2015 £000**
CAF Bond Income Fund (UK)	245	0	0	5	**250**
CAF Equity Growth Fund (UK)	336	0	0	12	**348**
Total Fixed Asset Investments	**581**	**0**	**0**	**17**	**598**

6. Current Assets

6.1. Cash and cash investments	2014/15	2013/14
	Total Funds £000	Total Funds £000
Cash Investments:		
Santander	**82**	82
Clydesdale	**83**	82
CAF	**80**	80
Nat West	**0**	85
Operational Bank Accounts:		
GBS bank account	**214**	189
Nat West bank account	**83**	97
Total Cash and Cash Investments	**542**	615

6.2. Debtors	2014/15	2013/14
	Total Funds £000	Total Funds £000
Amounts falling due within one year	**0**	1
Total Debtors due within one year	**0**	1

7. Current Liabilities

7.1. Creditors	2014/15	2013/14
	Total Funds £000	Total Funds £000
Amounts falling due within one year		
Trade Creditors	**(8)**	(57)
Other Creditors	**0**	(8)
Owed to Maidstone and Tunbridge Wells NHS Trust	**(56)**	(30)
Accruals	**(8)**	(8)
Total Creditors due within one year	**(72)**	(103)

8. Details of Funds

	Balance 01-Apr 2014	Incoming resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance before Reclassification 31-Mar-15	Reclassification	Balance after Reclassification
	£0	£0	£0	£0	£0	£0	£0
Permanent Endowment Funds							
Endowment Funds	9	0	0	0	9	0	9
Total Endowment Funds	9	0	0	0	9	0	9
Restricted Funds							
DGH Patients Amenity Fund - 61010	11	0	0	0	11	-11	0
Maidstone Hospital Medical Equipment Fund - 6104	31	1	3	1	36	0	36
CT Scanner Pembury - 61590	13	0	0	0	13	-13	0
Haematology Fund - 61190	27	1	-1	0	27	0	27
Maidstone Hospital Stroke Unit Fund - 61240	11	4	0	0	15	-15	0
Oncology Equipment Fund - 67170	265	4	-12	4	261	0	261
Medical Imaging Ultrasound - 61600	20	7	-3	1	25	-25	0
Gynaecology Oncology - 61430	11	0	0	0	11	-11	0
CT Scanning Fund Maidstone - 61660	30	0	-1	0	29	-29	0
Pierre Fabre Grant Fund - 61720	69	2	-2	1	70	0	70
Cellular Pathology Fund - 62560	24	0	0	0	24	-24	0
Cardio Respiratory Fund - 65300	20	0	0	0	20	-20	0
Diabetes Centre Fund - 65410	54	1	-2	1	54	0	54
Oncology Centre Fund - 61350	70	35	-51	1	55	-20	35
Gastrointestinal Fund - 6534	0	0	0	0	0	12	12
Neurology Fund - 65990	0	0	0	0	0	30	30
Other Restricted Funds (closing balance <£10,000) 71 funds	152	48	-49	4	155	-145	10
Total Restricted Funds	808	103	-118	13	806	-271	535
Unrestricted Funds							
Lung Function Fund - 65260	15	0	0	0	15	0	15
Haematology Development Fund - 65600	16	1	-1	0	16	0	16
Special Care Baby Unit TWH - 65660	22	11	-17	0	16	0	16
Pembury General Fund - 64050	11	0	0	0	11	0	11
Neurology Fund - 65990	57	1	-28	0	30	-30	0
Gastrointestinal Fund - 6534	12	0	0	0	12	-12	0
DGH Patients Amenity Fund - 61010	0	0	0	0	0	11	11
Maidstone Hospital Stroke Unit Fund - 61240	0	0	0	0	0	15	15
Oncology Centre Fund - 61350	0	0	0	0	0	20	20
Gynaecology Oncology - 61430	0	0	0	0	0	11	11
CT Scanner Pembury - 61590	0	0	0	0	0	13	13
Medical Imaging Ultrasound - 61600	0	0	0	0	0	25	25
CT Scanning Fund Maidstone - 61660	0	0	0	0	0	29	29
Cellular Pathology Fund - 62560	0	0	0	0	0	24	24
Cardio Respiratory Fund - 65300	0	0	0	0	0	20	20
Jefferson Day Suite Fund - 61450	5	10	-1	0	14	0	14
Peggy Wood Breast Care Fund - 67160	10	1	0	0	11	0	11
Other Unrestricted Funds (closing balance < £10,000) 70 funds	129	27	-32	4	128	145	273
Total Unrestricted Funds	277	51	-79	4	253	271	524
Total Funds	1094	154	-197	17	1068		1068

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

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

9. Charity Tax

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

10. Related Parties

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

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

The Charity has made revenue and capital payments, in the form of grants, to the Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition £29k (2013/14 £27k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration of the Charity. The amount due at the balance sheet date to Maidstone and Tunbridge Wells NHS Trust was £56k.

11. Events after the reporting year

The Trust has been advised of two potentially significant legacies in favour of the Cardiology Departments at both hospital sites that may be received in 2015/16.

mtw.nhs.uk

Charitable Fund

Donation Form

Registered Charity Number 1055215

Name: _____

Address: _____ Post Code: _____

Email: _____

Whilst recognising that this does not form a binding trust I would wish my donation of

£……..……..to be used for: (please tick one of the following)

☐ Wherever it will be most useful within the whole Trust to benefit patients and staff as determined by the Charity (This will be the default if no additional information is provided)

☐ The Directorate fund that supports ……..…Ward / Department.

Payment Methods

1 Cheques made payable to **Maidstone and Tunbridge Wells NHS Trust Charitable Fund**

2 Standing Order - Please call us on 01622 224500 to arrange for documentation to be sent

3 Make A Donation By Phone – If you would prefer to make a donation over the phone, please call 01622 224500. If you have an email address, we can send you bank details for electronic payments. We will require a remittance advice to enable us to receipt your donation. We currently accept the following cards: Maestro UK; MasterCard; Visa;

4 Visit our 'just giving' page www.justgiving.com/mtwnhscharitablefund

Gift Aid

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

☐ YES, I am a UK taxpayer and would like MTW to reclaim tax on this and any future donations

Date……../……./…… Signature……..…….……

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

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

Please return to:

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

THANK YOU FOR YOUR SUPPORT

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-20	Summary report from Audit and Governance Committee, 04/11/15	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 4th November 2015

1. The key matters considered at the meeting were as follows:

- Revised Terms of Reference were agreed (their annual review was due), and have been submitted to the Trust Board for approval (see Appendix 1)
- The Board Assurance Framework that was reviewed at the Trust Board in September was discussed, & some changes to the content were requested, as part of the next review
- The Risk Register was reviewed, and the Trust Secretary outlined his initial thoughts for revising the Risk Register process. A number of suggestions were made by Committee members as to the aspects any revised process needed to take into account. The Trust Management Executive's review of 'red' rated risks was also discussed, and it was agreed that further information would be circulated to Committee members in relation to the 'red' risk regarding compliance with the statutory Duty of Candour. It was further agreed that the Chairman of the Committee should review that information, and consider whether to recommend that the Quality Committee reviewed compliance with the Duty of Candour
- The Director of Workforce and Communications attended, to respond to the point raised in the "Use of Temporary Medical Staff" Internal Audit review that "The Trust did not have an approved and up to date policy/procedure for requesting, booking and approving temporary medical staff". Assurance was given that although the review findings were accurate (in that the Trust did not have an approved and up to date policy and procedure when the audit was conducted), the Trust did have a Temporary Staff Booking Principles and Controls Policy which had been previously approved (although this was also slightly out of date). The Committee was also informed that the correct processes for requesting, booking and approving temporary staff had been circulated Trust-wide on a number of occasions over the past 4 years; and the finalisation of the new Policy and Procedure had been consciously delayed in order to ensure that the national changes made by TDA and Monitor in the use of agency and temporary staff were able to be included.
- An update on progress with the 2015/16 Internal Audit plan was received, which included some recent reviews relating to the Kent & Medway Health Informatics Service (see below)
- An update on Counter Fraud was received, along with a report of the outcome and response to the "Focussed Assessment" undertaken by NHS Protect in August. The areas in need of improvement were acknowledged, and it was agreed that an update on the actions being taken in response should be submitted to the next meeting
- A 'Progress and emerging issues report' was received from external audit
- A verbal summary of the latest financial issues was provided
- The latest Losses and Compensations and Single Tender Waivers data was reviewed, and it was agreed that the next reports for both should include trend data
- Revised Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation were reviewed and approved, subject to one further amendment (relating to the Patient Experience Committee's role in public engagement and consultation). All 3 documents will be submitted to the Trust Board for ratification in due course (the SFIs have been submitted to November)

- Notification was given of the Trust's selection for inclusion in Monitor's 2015/16 Reference Costs Assurance Programme. It was agreed that the response to the Programme should be overseen by the Audit and Governance Committee (rather than the Finance Committee)
- The latest "Guidance to help health bodies meet their statutory duties" regarding "Auditor Panels" was considered. This relates to the fact that with the closure of the Audit Commission, NHS Trusts must appoint their own external auditors from 2017/18 onwards, via an "Auditor Panel". Such Panels would advise on the selection, appointment and removal of external auditors, and on maintaining an independent relationship with them (though the responsibility for the actual procurement and appointment of external auditors rests with the Trust Board). The Committee was informed that as appointments for 2017/18 must be made by 31/12/16, "Auditor Panels" needs to be in place early in 2016 (see below)
- The Committee agreed the method by which it would undertake its next self-assessment

2. The Committee received details of the following Internal Audit reviews:

- "Cost Improvement Plans" (which received a "Reasonable Assurance" conclusion)
- "Assurance Framework and Risk Management Processes" (which received a "Reasonable Assurance" conclusion)
- "NHS In-House Information Governance Toolkit: Training Material Checklist Follow Up" (which received a "Fully Comprehensive" conclusion)
- "Review of Windows 7 Arrangements" (which received a "Reasonable Assurance" conclusion)
- "Assurance Review of the K&M HIS IT Business Intelligence System Arrangements" (which received a "Limited Assurance" conclusion)
- "K&M HIS Review of Controls Assurance - Network Management and Security" (which received a "Limited Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- "Application Management Policies & Procedures" (1 action)
- "Data Centre Facilities Review (Frame Server Room Assessment)" (1 action, which has been partially implemented)

A further "Urgent" action, relating to "Local Registration Authority Management", was reported as no longer being applicable, as the relevant project had been put on hold until at least 16/17 (but the action will continue to be monitored & be taken into account once the project resumes)

4. The Committee agreed that (in addition to any actions noted above):

- It should be appointed as the Trust's "Auditor Panel"
- The Director of Finance should coordinate the process for the procurement of the Trust's external auditor from 17/18 (in accordance with normal procurement processes), & provide the Trust's designated "Auditor Panel" with the information it requires to fulfil that role.
- The Trust Secretary should support the designated "Auditor Panel", and the Trust Board, in meeting its duties under the new requirements
- An update on actions being taken in response to red risks should be included as part of the risk report to the February 2016 Audit and Governance Committee
- The Head of Internal Audit and Director of Finance should meet to discuss the focus and timing of the next Internal Audit review of the Cost Improvement Plan
- The Director of Finance should confirm whether temporary staff were able to authorise the use of other temporary staff (and if so, describe the controls in place)
- The Director of Finance should arrange for a report to be prepared on the future of

the KMHIS' functions & outstanding Internal Audit actions, and consider the most appropriate forum for the report to be received (i.e. the Finance or Audit and Governance Committee)
- A report on the Kent Oncology Centre partnership should be submitted to the February 2016 Audit and Governance Committee meeting
- The Director of Finance and Trust Secretary should liaise, to identify the key partnerships to be reviewed at future meetings, and propose a schedule for such reviews

5. The issues that need to be drawn to the attention of the Board are as follows:
- The Board is asked to approve the Audit and Governance Committee's recommendation that it be appointed as the Trust's "Auditor Panel", and that the Committee's Terms of Reference be amended accordingly (in addition to including the "Auditor Panel" role, the quorum needs to change so that 3 (not 2) Non-Executive Directors will be required at meetings that consider "Audit Panel" matters)

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. Information and assurance
2. To approve the Committee's revised Terms of Reference (Appendix 1)
3. To approve the Audit and Governance Committee's recommendation that it be appointed as the Trust's "Auditor Panel", and that the Committee's Terms of Reference be amended accordingly

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

Appendix 1: Revised Terms of Reference (with proposed changes 'tracked')

Maidstone and Tunbridge Wells NHS
NHS Trust

AUDIT AND GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive committee of the Board. ~~-~~The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chairman of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chairman of the Committee will be appointed by the Trust Board, together with a Vice-Chairman~~Deputy~~. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting.

3.2 Other individuals may be co-opted to attend to address issues of specific concern at the discretion of the C~~c~~ommittee Chairman.

4. Quorum

4.1 The C~~c~~ommittee shall be quorate when two Non-Executive members are present (including either the C~~c~~ommittee Chairman or Vice~~deputy~~ Chairman).

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Director of Finance
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives

- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to attend all meetings of the Committee

5.3 The Chief Executive and other members of the Executive TeamDirectors will be invited to attend when the Committee is discussing areas of risk or assurance that are the responsibility of that Director and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive maywill be invited to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chairman.

5.5 The Committee will meet privately with the External and Internal Auditors regularly, at the start of each meetingnot less than once per year.

5.6 The Trust Secretary will provide appropriate support to the Chairman and Ccommittee members, and will be responsible for the administration of the Committee (see section 10)ensuring that minutes of the meeting are taken.

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chairman of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may put a request in writing to the Chairman of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chairman of the Committee.

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

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

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from member of the Executive Team~~Directors~~ and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.7.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.7.2 Review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

7.7.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.7.4 Ensuring that the Internal Audit Function is adequately resourced and has appropriate standing within the organisation

7.7.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor ~~appointed by the Audit Commission~~ and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses~~.~~
- Ensuring that there is in place a clear framework~~policy~~ for the engagement of external auditors to supply non audit service

Other Assurance Functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. ~~7.9~~ These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies

or Regulators/Inspectors (e.g. Care Quality Commission~~, NHS Litigation Authority,~~ etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Protect's standards and shall review the outcomes of Cc~~c~~ounter Ff~~f~~raud work.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team~~Directors~~ and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- T~~t~~he wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- C~~c~~hanges in, and compliance with, accounting policies and practices
- U~~u~~nadjusted mis-statements in the financial statements
- S~~s~~ignificant judgements in preparation of the financial statements
- S~~s~~ignificant adjustments resulting from the audit
- T~~t~~he letter of Management Representation
- E~~e~~xplanations for significant variances
- Q~~q~~ualitative aspects of financial reporting

Whistleblowing ("Speaking Out Safely")

7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

8. Parent committee and reporting procedure

8.1 The C~~c~~ommittee is a sub-committee of the Trust Board.

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chairman of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance

arrangements.The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed.

8.4 The Committee shall undertake an annual self- -assessment to ensure the objectives of the Terms of Reference are being met.

9. Sub-committees and reporting procedure

9.1 The Cecommittee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items.
- Agreement of agenda for next meeting with Chairman, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward.
- Advising the Committee on all pertinent areas.

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chairman of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chairman shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – November 2015

11-21	Summary report from the Quality Committee meeting, 11/11/15 (incl. update on the latest Stroke performance)	Committee Chairman (Non-Exec. Director)

A 'main' Quality Committee was held on 11/11. Unfortunately, the meeting was not quorate for certain items, as there was only one Non-Exec. Director present. This summary should therefore be regarded as a request to ratify the decisions made. The following issues were covered:

- The latest **Stroke care performance** was reported. The report that was received is enclosed at Appendix 1, and has been included as a result of a previous request from the Board.
- The **Clinical Directorates** presented their reports. The key issues raised were as follows:
  - **Emergency & Medical Services** reported that performance against the A&E 4-hour waiting time target had been challenging, but there were signs for optimism, in terms of the new Ward at TWH. Staffing challenges also remained, although there had been some recent Consultant appointments. Patient falls had increased, and there was concern regarding the levels of Clostridium difficile infections (following which the importance of appropriate antibiotic usage had been emphasised to staff)
  - **Surgery** reported that a Standard Operating Procedure for escalation of the Short Stay Surgical Unit at Tunbridge Wells Hospital had been approved, and Guidelines for pre-operative fasting had been circulated. Nurse vacancies were improving, but expenditure on Locum staff remained high. Actions plans regarding the 62-day waiting time target for Cancer were being devised by each speciality, following the failure to meet the target; and there had been an increase in patient falls in September. The Directorate was also asked to provide further detail of the action taken in response to the number of "Unplanned Returns to Theatre" in its future Directorate reports
  - **Trauma & Orthopaedics** reported that the latest National Joint Registry report had identified the Trust as an outlier for Hip Revisions, which was suspected to be related to metal-on-metal hip implants. The latest National Hip Fracture Database data showed that the Trust was performing above the national average in terms of Best Practice Tariff performance, but there had been a decline in performance in July & August for the previous two years, and the reason for this was not definitively known. The data also revealed a concerning trend in relation to the "Hours to op." for which the Trust's performance was below average
  - **Women's & Sexual Health** reported that there was one key action outstanding from the CQC action plan, which related to the Gynaecology Outpatient department 'quiet' waiting area kiosk calling screen (which had been ordered and was awaiting installation); and noted that the Trust had announced that it would be taking over the management of the Crowborough Birthing Centre and Community Midwifery for that population. The new E3 data system had been implemented, and the "Nerve Centre" system had been implemented in Gynaecology (and was about to commence within Maternity). An external Quality Assurance visit in June 2016 would focus on the Antenatal Screening service
  - **Cancer & Haematology** reported that Chemotherapy ePrescribing had now gone 'live'; and the situation regarding the availability of Baxter pump consumables had now been resolved (only Baxter equipment was now being used). Confirmation had been received from Macmillan to fund a Macmillan Lung Clinical Nurse Specialist for a fixed period of 24 months. Agency usage for Nursing was increasing, as a percentage of WTEs, but the 'red' rated risk relating to Radiotherapy Physics staff at Maidstone Hospital was hoped to be resolved (and removed) in the near future. An increase in extravasations in Chemotherapy was also reported, but no particular trend had been identified.
  - **Children's Services** reported that all inpatients now had shared care between the Paediatricians & the Surgeons, & work on the emergency pathway was continuing. There had been a review of staffing in relation to overnight bed capacity in the Woodlands Unit a a Business Case had been completed. The Paediatric Early Warning System (PEWS) charts had been finalised and implemented, and the "Sepsis Six" bundle would be

implemented. A Cystic Fibrosis Specialist Nurse was in post, a a there was a permanent advertisement for a vacant Special Reg. post (but there had been little interest)
    - **Critical Care** reported that a Locum in Chronic Pain started in post on 16/11, and this was expected to result in improvements in the service in the coming months. WHO safety checklist audit compliance had improved enormously, and delayed discharges and admissions to ICU had reduced. Some decontamination issues, and the major sewage leak in the operating department at TWH were reported (it was noted that the latter had been dealt with very effectively). The latest Intensive Care National Audit & Research Centre (ICNARC) data was submitted, as was the outcome of investigation as to whether delay in admissions to ICU affected patient's clinical outcome (the analysis had not revealed any cause for concern). An SI involving an unexpected death after Surgery was noted as still being 'open', and the Clinical Director for Critical Care was asked to provide assurance that the learning had been shared with other Clinical Directorates.
    - **Diagnostics, Therapies & Pharmacy** reported that the general trend in terms of reporting delays in Cellular Pathology showed improvement; and a new process for reporting Radiology (to ensure that scans were always available when needed) had been agreed with Oncology. It was noted that the Trust had agreed not to enter into the Any Qualified Provider process for GP Direct Access MRI (as it would cost the Trust money every time a GP Direct Access scan was performed). There had been 5 community acquired (i.e. pre-48 hours) MRSA bacteraemia cases recently, but 1 of the cases may be re-assigned to the Trust. A new SI had been declared regarding Antenatal screening, and the 'red' risk regarding implementation of the Intelligent Fridge system had been closed, but reopened as 'amber' for the residual risk. It was also reported that a patient had suffered a fractured neck of femur injury in the Breast Screening Unit, and efforts had been made with the staff to promote learning from the incident
- A discussion was held regarding the best method for including details of **Directorate Clinical Governance meetings** within the Directorate reports to the Committee, and it was agreed that future Directorate reports should include the minutes and "actions log" from the main Directorate Clinical Governance meeting
- The Medical Director gave a presentation on **HSMR** and the issues discussed at the Quality Committee 'deep dive' meeting on 05/10/15
- An update on the external **"Good Governance and Culture"** review was provided, and reference was made to the TME discussing the report at its November 2015 meeting
- The circumstances of a small sample of the patients subject to a **Delayed Transfer of Care** was received, following the request made at the Trust Board in October
- The latest **SIs** were considered, & the Medical Director reported that on reading all of the falls-related SIs, there did not appear to be any particular common issue.
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was noted (performance to date was in accordance with the plan)
- Reports on the latest findings from relevant **Internal Audit reviews**, and latest media coverage/**reputational risk** issues were noted. An update on **visits from external agencies** was also received, and changes to the content of future reports were agreed.
- The minutes of the **Quality Committee 'deep dive'** held on 05/10/15 were received, along with reports from the latest meetings of the **sub-committees** i.e. Mortality Review Group, Standards, Safeguarding Adults, Infection Prevention & Control, Patient Environment Steering Group, and Safeguarding Children. Revised Terms of Reference for the Safeguarding Adults and Infection Prevention & Control Committees were approved

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Appendix 1: Stroke care update report received at the 'main' Quality Committee on 11/11/15

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality & Safety Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing stroke headlines was requested to replace the full paper. This is the third short headline paper to be presented to the Quality Committee.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP). The Trust has also recently reviewed it's own targets to continue to drive improvements within stroke care, adhere to national standards and drive excellence in stroke care.

2.1 CT scan performed in under an hour:

- September data for scanning within 1 hour is encouraging with TWH scanning 56.5% within the hour and Maidstone scanning 59.3%. The national average remains 46.2% with a SSNAP "A" Level requiring 48% of patients to be scanned with an hour. Both sites are significantly above this target.
- 12 hour scanning indicates a further welcomed improvement in performance with TWH scanning 95.7% within 12 hours and Maidstone 96.3%. National average currently sits at 90.1%, with a Level A consisting of 95% of patients being scanned within 12 hours. Both sites have achieved this for the month of September.
- SSNAP results covering data collected April-June 2015 has now been reported. Both sites obtained a Level "B" with TWH marginally missing an "A" by 1.7 points.

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- September data indicates that once again there was an improvement in thrombolysed patients at TWH at 21.7%. Retrospectively August had a lower number at 4.8% (which equated to one patient). August's patient was thrombolysed in under an hour, and September saw 3/5 patients (60%) thrombolysed within 60 minutes.
  At Maidstone 7.4% of patients were thrombolysed, which equated to 4 patients. Only one of whom achieved the 60 minute target.
- Thrombolysis rates and the 60 minute door to needle target remains a challenge with fluctuating results. A repeat audit looking at the delays in achieving the 60 minute target will be carried out by the specialist nurses.
- SSNAP Results covering data April – June 15 gave a mixed picture cross site with TWH achieving a level "C" due to an increase in patients being thrombolysed and being admitted to a stroke unit within the 4 hour target. Maidstone however, saw a reduction in performance obtaining a Level E due to multiple domain factors which now have an action plan in place to address.

2.4 Proportion of Patients admitted to the stroke unit within four hours:

- September data within this performance indicator shows that MGH had admitted 63% of stroke patients to the stroke unit within 4 hours. TWH has maintained a steady improvement at 54.5%. TWH currently sits just below national average within this Key indicator which is a great accomplishment, considering the constraints currently faced with the current number of acute stroke beds at TWH.

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from September indicates specialist assessments were completed within 24 hours in 78.3% of cases at TWH and 59.3% at MGH, which shows a stable performance throughout the year at TWH, with a decrease at Maidstone. Consultants have been approached for potential route causes but none have yet been identified.

2.6: Current 80/90 Performance

- September data is currently 87.7% with a current YTD performance of 84.9%. The national average for this indicator is 84%.

2.7: CQUIN achievement for 15-16

- The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS). A working party has been formed to identify steps to assist in achieving the required outcome.

3. Conclusion

Data above is generally encouraging as it shows that the majority of Key Performance Indicators continue to either improve or maintain performance, especially in access to a stroke unit and scanning. Work continues locally with site specific action plans and meetings taking place to improve performance and drive up standards of care. The Kent Stroke Review continues to progress, with both nursing and medical clinical leads attending the Clinical Reference group to represent the Trust. Options are currently being identified, in addition to a clinical workshop being held for senior clinicians in mid November to discuss the process and progress. SSNAP results for April – June 2015 have shown a significant improvement at TWH with almost achieving a Level C (missing this by 2.1 points) after a deduction of points for a Level B within audit compliance. Maidstone has maintained a “C” rating as expected.

Below shows Kent’s SSNAP results for April – June 2015 which is encouraging for benchmarking. This placed Maidstone as the second highest performing unit in Kent just under Queen Elizabeth, with TWH close to entering the SSNAP Level C band (60 points required).

- Queen Elizabeth SSNAP Level C (64.1 points)
- Maidstone SSNAP Level C (63.7 points)
- Darenth Valley SSNAP Level C (62.3 points)
- William Harvey SSNAP Level C (60.8 points)
- TWH SSNAP Level D (57.9 points)
- Kent and Canterbury SSNAP Level D (47 points)
- Medway Maritime SSNAP Level D (43.7 points0

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – November 2015

11-22 Summary of the Trust Management Executive (TME) meeting, 18/11 Chief Executive

The TME met on 18/11/15. The key items covered at the meeting were as follows:

- In the **safety moment**, the Chief Nurse highlighted that the Trust had been under increasing pressure in recent weeks, and the winter period had now started
- The Head of the Programme Management Office (PMO) attended, to lead a session on the **CIP for 2016/17 and lessons learned**, and it was agreed to discuss this again, in more detail, at the TME meeting in December 2015
- The key issues highlighted via the **reports from the Clinical Directors** were as follows:
  - Staffing issues were a theme in several Directorates, in relation to recruitment to specific posts and/or the continued usage of temporary staff
  - Performance against key access targets continued to be a challenge, but efforts to resolve the current obstacles were being made
  - The monthly trajectory for Clostridium difficile cases had been breached again, & it was agreed that in future, the DIPC would notify the Consultant of any carriers & confirmed cases
  - Risks were discussed, which included those associated with the implementation of Chemotherapy ePrescribing; and the level of Obstetric anaesthesia provision. Efforts to resolve the former were being led by the Clinical Reference Group for the project, whilst for the latter, it was agreed that the Clinical Directors for Critical Care and Women's and Sexual Health should liaise in the first instance, and report back to Trust Management Executive
  - The backlog of CT & MRI reporting had reduced significantly as a result of a recent 'purge'
- A proposal to **cease sending paper copies of Pathology reports for inpatients** was approved
- The Chief Nurse gave a presentation on the **response to the Good Governance and Cultural Review**, which focused on a proposed new Committee Structure (which was supported)
- The Deputy Chief Executive gave an update on the transfer of **Crowborough Birthing Centre and Community Midwifery** to the Trust (from East Sussex Healthcare NHS Trust)
- The latest **performance, for month 7**, 2015/16 was reported (including the latest position regarding infection prevention and control)
- The Chief Operating Officer submitted a report on the **Cancer Action Plan 2015/16**, which had been developed to ensure compliance with the 62 day Cancer waiting time standard by March 2016, and which had been submitted to the NHS Trust Development Authority (TDA)
- The Director of Workforce and Communications provided an update on a proposed **indicator to monitor nursing staff numbers against clinical activity** and submitted a report on **temporary staffing controls** (which related to a letter sent jointly by the TDA and Monitor)
- The Chief Nurse reported on a **"Safe staffing and efficiency" letter** which had been sent jointly from a number of national NHS organisations, and the Trust's response (a report has been submitted to the Trust Board regarding this)
- The latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection was reported
- The Director of Workforce and Communications reported the **follow-up of the issues discussed at the TME 'away seminar' held in March 2015**, and it was agreed that the issues would be discussed in more detail at the TME meeting in December
- The Deputy Chief Executive gave an update on the development of the **clinical strategy**, and the key milestones involved in the **business planning process for 2016/17** were also reported
- The Chief Operating Officer gave an update on progress with the various **projects overseen by the MTW Programme Board**, including the new Wards at Tunbridge Wells and Maidstone Hospitals; & updated on progress in implementing the **Winter and Operational Resilience Plan**
- The recently-approved **business cases** were noted, and the **Outline Business Case (OBC) for GS1 and PEPPOL** (now termed "Programme TILT" – "Track, Identify, Locate, Transact) was also reviewed, and supported. The OBC will be reviewed by the Finance Cttee & Board in November
- A request for a **replacement Consultant Clinical Oncologist** (with a specialist interest in Head and Neck) was approved
- The **Board Assurance Framework** received at the September Board was reviewed, as was the

latest version of the **Trust Risk Register**. Plans to revise the Risk Register process were noted

- An update on the **Internal Audit reviews** within the 2015/16 plan was provided, and updates were received on the work of the **TME's sub-committees** - Capital meetings; Private Patient Board; Clinical Operations & Delivery C'ttee; Health & Safety C'ttee (which included assurance on water quality testing); Informatics Steering Group; and Policy Ratification Committee. It was also agreed that the Procurement Strategy Committee become a sub-committee of TME.
- The **PET/CT Operational Policy and Procedure** and **Gifts, Hospitality, Sponsorship and Interests Policy and Procedure** were approved

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2015

11-23	Outline Business Case for Programme TILT – adoption of GS1 & PEPPOL standards	Director of Finance

Introduction

In June 2015, the Trust Board approved a Strategic Outline Case (SOC) to adopt GS1 and PEPPOL standards. The Trust since submitted an application to the Department of Health (DH) to be considered as a demonstrator site for the related changes to our processes. The DH has shortlisted the Trust as one of 12 Trusts to be considered and have tasked each of the 12 to develop a robust plan detailing the costs and benefits of the programme in the form of an Outline Business Case (OBC).

The DH intends to fund the six best bids. To be selected, the Trust must submit a business case that shows that the Trust's plans for the adoption of GS1/ PEPPOL are supported by stakeholders, financially viable and achievable.

Approval

The enclosed OBC seeks approval to invest £1.79m (excluding depreciation and capital charges) over 5 years to adopt GS1 and PEPPOL standards as mandated by the DH. If successful in our application, the DH will provide £1.72m of funding over a two year period. The programme will return £1.8m in cash releasing benefits over a five year period, with a net benefit to the Trust of £1.28m.

It is recommended that the Board should bid for DH demonstrator funding on the basis of this business case, understanding that in doing so it is committing to:

a. Actively support and take all steps necessary to ensure the delivery of the demonstrator capabilities within the Trust according to the four phase programme within 2 years;
b. Assign a Board Level Executive Sponsor to drive the Trust's programme forward and be an active member of the national Steering Group, helping shape the national adoption programme;
c. To host visits from, and provide information to, other Trusts developing their adoption programmes;
d. Approve the release of funds attributed to the Trust as detailed in the Financial Case.

The OBC has been reviewed by the Chairman of the Investment Appraisal Group (IAG), via the IAG's exceptional procedure, and support was given to the Case (see signature 4 on Page i below). The OBC was also reviewed at the Trust Management Executive meeting on 18/11/15 and was supported.

The Finance Committee is also being asked to review and support the OBC, ahead of the Trust Board being asked to approve the Case. The outcome of the Finance Committee's review will be provided to the Trust Board as part of the Committee's summary report to the November Board, which will be issued after the Finance Committee meeting (23/11/15).

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 18/11/15
- Finance Committee, 23/11/15

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

Approval

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

Maidstone and Tunbridge Wells NHS Trust

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Programme *TILT*

Track | Identify | Locate | Transact

Outline Business Case - Adoption of GS1 and PEPPOL Standards

9 November 2015

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Business Case

Programme *TILT*

Outline business case for the adoption of GS1 and PEPPOL standards

Issue date	Nov 2015
Department	Health Informatics
Directorate	Health Informatics
Author	Dr Andy Evason / David Walach
Directorate Lead	Donna-Marie Jarrett
Executive Sponsor	Steve Orpin
ID reference	412

Approved by	Name	Signature	Date
1 Executive sponsor	Steve Orpin		12/11/15
2 Clinical Lead	Dr Paul Sigston		12/11/15
3 GS1 Lead / SRO	Donna Marie-Jarrett		12/11/2015
4 Finance manager	Stuart Doyle		12/11/2015
Supported by	Name	Signature	Date
Deputy Chief Exec	Jim Lusby		
Director Estates & Facilities	Jeanette Rooke		
Head of Pharmacy	Simon Badcott		
Head of Category Management	Lesley Martin		12/11/2015
Approved by	Name	Minute	Date
Informatics Steering Group	Jim Lusby		
Executive Meeting	Glenn Douglas		
Trust Management Executive	Glenn Douglas		
Finance Committee	Steve Tinton		
Trust Board	Anthony Jones		

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1 Executive Summary

1.1 Introduction

This Outline Business Case (OBC) seeks approval to invest £1.79m (excluding depreciation and capital charges) over 5 years to adopt GS1 and PEPPOL standards as mandated by the Department of Health (DH).

The DH is seeking bids from 12 Trusts, including MTW, to act as demonstrator sites for the adoption of GS1 and PEPPOL, and intends to fund the six best bids. To be selected, the Trust must submit a business case that shows that the Trust's plans for the adoption of GS1/ PEPPOL are supported by stakeholders, financially viable and achievable. The DH also requires a clear commitment from the Trust Board to:

a. Actively support and take all steps necessary to ensure the delivery of the demonstrator capabilities within the Trust according to the four phase programme within 2 years;

b. Assign a Board Level Executive Sponsor to drive the Trust's programme forward and be an active member of the national Steering Group, helping shape the national adoption programme;

c. To host visits from, and provide information to, other Trusts developing their adoption programmes.

1.2 Strategic case

GS1 is a global, not-for profit, organisation that has defined standards and corresponding barcodes to enable clear and unique identification of people, items and locations. PEPPOL provides messaging standards enabling business documents (eg purchase orders and invoices) to be electronically exchanged without manual intervention between buying and selling organisations.

Compliance with GS1 standards and the eProcurement strategy is part of the NHS Standard Contract, with trusts being required to comply fully by 2021/22. The DH target is for 80% of Trusts to have 80% of relevant transactions complying with GS1 and PEPPOL by 2018. In addition, EU directive 2014/55/EU stipulates that, by the end of 2018, all public organisations must be capable of receiving electronic invoices from suppliers.

Regulation is also expected shortly from the EU relating to Unique Device Identification and Falsified Medicines. Both will rely on trusts having mechanisms to accurately read and record information contained within bar coded labels, and for UDI, automated linking of product information with patient records.

Adoption of GS1 / PEPPOL will also support the Trust in meeting its strategic objectives, namely:

a. **'To transform the way we deliver services so that they meet the needs of patients'** by improved data accuracy and availability, better patient safety though improved patient identification ensuring 'right treatment, right patient, right time', and by improved availability of medicines and devices.

b. **'To deliver services that are clinically viable and financially sustainable'** through better understanding of costs associated with services and benchmarking from common data standards and costs savings from improved inventory management and automated ordering and invoicing.

c. **'To actively work in partnership to develop a joint approach to future local healthcare provision'** through the adoption of global standards enabling better sharing of information with partners.

The vision for the GS1 & PEPPOL programme is for GS1 standards to be used to positively identify and link product, place and patient at every step throughout the patient pathway, providing a consistent and detailed record of every interaction with each patient. The strategy is outlined in a diagram in Section 2.1.

The scope of the Demonstrator programme and this business case include three core enablers (GS1 location identifiers, GS1 item identifiers and GS1 patient identifiers) and three use cases (inventory management, purchase to payment and product recall).

Keys problems and difficulties associated with the existing arrangements that adoption will address include:

- **Location**: There is a need to move to a standard way of representing and capturing locations within the Trust so that they can be used for a wide range of purposes, eg to keep track of patient location to reduce consultant time wastage or delay operations when a patient cannot be found.
- **Catalogue management**: product data is entered manually into procurement and pharmacy stock control systems. This is manually intensive and susceptible to data entry errors. There is a need to capture data automatically and in a way that maintains the currency and accuracy of the data.
- **Patient Identification**: patient identity is read from the wrist band and manually entered, which is susceptible to errors. There is a need to capture and record patient identity faster and more reliably.
- **Inventory management**: Improved inventory management processes will reduce stock levels, reduce wastage, improve stock visibility and availability and free clinical staff time.
- **Purchase to Payment**: The Procurement department is currently procuring a product to enable PEPPOL messaging to be used for the procurement of medical supplies and devices. This needs to be extended to cover Pharmacy to reduce the costs of medicine order creation and invoicing payment.
- **Product recall**: Current recall processes are manual and costly. New processes are needed to identify unused items of recalled stock or patients that have been treated with recalled medicines or devices.
- **Service level costing**: The Trust needs to be able to understand the costs of services or procedures, ideally to patient level, so it can identify major cost drivers and progressively reduce costs.

Consultation with clinical and management colleagues has been carried out and the following related stories were shared:

"Better inventory management and an ability to electronically track our implants at patient level will greatly support our patient's safety and our clinical governance - an area we need to improve upon." ***Guy Slater, Clinical Director, Trauma & Orthopaedics***

"Better inventory management would strengthen our controls and help us avoid potential incidents where expired stock is opened and used on a patient in Theatres." ***Daniel Gaughan, General Manger, Critical Care***

"About 8-10 adverse drug incidents a month could be avoided with improved 'right drug - right patient' initiatives." ***Jim Reside, Chief Pharmacist***

"We recently had a serious incident where equipment was used and resulted in a patient being injured. This carried significant damage to the Trusts reputation and litigation costs. Better tracking information linking equipment, staff, patients and training would have supported our investigation." ***Stephen Orpin, Director of Finance***

"From a costing perspective we have always had issues with knowing which prosthesis have been used on which patient. Detailed information linking products to patient would be really beneficial to the costing process." ***Angela Double, Finance Manager – Costing & SLR***

1.3 Economic case

Short-listed options are as follows:

a. Option 1 – do nothing - the trust would not seek to adopt GS1 standards beyond current plans.

b. Option 2 – adopt standards in accordance with the DH Demonstrator Programme requirements;

c. Option 3 – Trust funded adoption programme.

With Option 1 the Trust would not be compliant with the NHS Standard Contract, UDI, FMD and EU electronic invoicing regulations. This option has therefore only been used for comparison purposes.

Options 2 and 3 have the same scope, covering the three enabling capabilities and three use cases. The main difference is that Option 2 is driven by the need to deliver within 2 years, whereas with option 3 the timing can aligned with the Trust's wider change programme, so long as adoption is completed by 2021/22 and the adoption programme fits within Trust financial constraints.

The costs and benefits of each of the options have been considered with extensive involvement from and consultation with stakeholders. The summary of the costs and quantitative benefits is shown below.

Option	Description	Overview				
		NPC (£)	Cash benefit	Non cash benefit	Cash benefits - costs	All benefits - costs
1	**Do nothing**	£0	£0	£0	£0	£0
2	**DH funded**	-£1,615,784	£2,888,432	£1,007,913	£1,272,648	£2,280,561
3	**Trust funded**	-£1,633,215	£2,275,298	£637,287	£642,083	£1,279,370

In addition, the qualitative benefits of options 2 and 3 are broadly similar. Option 2 has a higher level of risk than Option 3 because of the shorter timescales, but the risks are assessed to be manageable. Taking the investment appraisal, qualitative benefits and risk profiles together, the preferred option is Option 2, DH demonstrator funding of the adoption of GS1 and PEPPOL.

1.4 Commercial case

This business case is primarily for business transformation supported by small scale changes to existing systems. The majority of the focus of the programme will be on organisational and process change and as such the commercial case is relatively straightforward. Items to be procured are potentially as follows:

- **Project and change management services** – the majority of project and change management will be undertaken by internal staff, to maximise value for money. Where staff need to be back-filled, use will be made of existing contract frameworks in place with the Trust's own procurement function, the London Procurement Partnership or Crown Commercial Services.
- **Systems developments** – where it is necessary to change existing systems operated by the trust it is expected that these will be covered through the existing contracts of supply and maintenance.

1.5 Financial case

The capital and revenue costs are shown below. The costs include VAT where it is non-recoverable. Capital items are depreciated over 5 years in accordance with the Trust's standard accounting practices. Only the first quarter of the programme falls into FY 2015/16.

Total costs	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Capital (inc VAT)	£39,813	£826,036	£88,640	£0	£0	£0	£954,488
Revenue (inc VAT but excl depreciation & capital charge)	£37,381	£449,364	£280,273	£22,800	£22,800	£22,800	£835,417
Total	£77,193	£1,275,400	£368,913	£22,800	£22,800	£22,800	£1,789,906

Funded by:	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
DH	£77,193	£1,275,400	£363,213	£0	£0	£0	£1,715,806
Trust (excluding depreciation & capital charges	£0	£0	£5,700	£22,800	£22,800	£22,800	£74,100
Total	£77,193	£1,275,400	£368,913	£22,800	£22,800	£22,800	£1,789,906

Revenue	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Costs							
Revenue(ex-VAT)	-£37,081	-£421,910	-£269,141	-£19,000	-£19,000	-£19,000	-£785,132
Non-recoverable VAT on revenue items	-£300	-£27,453	-£11,132	-£3,800	-£3,800	-£3,800	-£50,285
Capital depreciation	£ -	-£60,284	-£186,466	-£190,898	-£190,898	-£190,898	-£867,167
Capital charge	£ -	-£9,934	-£27,317	-£20,804	-£14,749	-£8,067	-£82,469
Sub-total costs	**-£37,381**	**-£519,582**	**-£494,055**	**-£234,501**	**-£228,446**	**-£221,765**	**-£1,785,054**
Income							
Revenue payments from DH	£37,381	£449,364	£ 274,573				£761,317
Cash benefits	£ -	£ 58,468	£ 409,275	£ 444,943	£ 444,943	£ 444,943	£ 1,802,572
Sub-total income	**£37,381**	**£507,831**	**£683,848**	**£444,943**	**£444,943**	**£444,943**	**£2,563,889**
Total (income minus costs)	**£0**	**-£11,750**	**£189,793**	**£210,442**	**£216,497**	**£223,178**	**£778,835**

As can be seen, the revenue payments by the DH (shown as income in the table above) mean that the costs to the Trust's revenue account are relatively small, at less than £12k in FY2016/17. Thereafter the impact is net income to the Trust of around £200k pa.

Given the positive income after the first two years, the relatively small revenue costs in the initial years, and the large non-cashable and non-financial benefits, it is recommended that this is highly affordable and should be a priority for funding.

Delivering this OBC will require DH and TDA agreement for the capital spend and use, where necessary, of external manpower to backfill or provide the core programme team including the adjustment of the Trust's capital resource limits. The TDA is aware of this OBC.

1.6 Management case

The GS1/PEPPOL adoption programme will report through the Trust's Informatics Steering Group and Corporate System Programme Board and hence into the Trust's Management Executive and Trust Board. The Clinical Lead will be the Trust's Medical Director, reflecting the importance of the programme and its clinical rather than purely technical focus.

The programme will be managed using the Managing Successful Programmes (MSP) methodology. A core team will be established including:

a. Programme Manager, responsible to the programme board for the delivery of the programme;

b. Clinical Engagement Lead, responsible for delivering cultural embedded change, including recruiting and managing ward level change agents in support of the various projects;

c. Informatics Lead, to drive IT changes required by individual projects within the programme;

d. Logistics Lead, to manage and lead on the logistics elements of the programme.

Individual projects will be managed in accordance with PRINCE 2. The following projects will be established:

- Location project, to deliver the location core capability;

- Logistics project, responsible for delivery of catalogue management, inventory management and purchase to payment (subdivided in Procurement and Pharmacy sub-projects);
- Clinical project, responsible for delivery of the patient ID core capability and product recall use case.

In line with the Trust's management approach, project leads will be assigned from IT, Finance, Procurement, Pharmacy, Estates & Facilities and HR to ensure coordination of activities and approaches.

Each area of benefits will be assigned to a benefits owner who will be responsible for reporting to the programme board at the end of each Phase and six months beyond the end of Phase 4 on the achievement of benefits for which they are responsible.

Financial benefits will be integrated into the Trust's Cost Improvement Programme and will be tracked on a monthly basis. Deviations from the benefit forecast will be managed through the Executive Recovery Committee.

In the event that this programme fails, there will be no immediate impact on the delivery of services by the Trust. The impact will be on the Trust's ability to meet the mandates set by the DH which are intended to improve patient safety, efficiency and effectiveness. The programme is working to ambitious timescales for the achievement of the DH demonstrator timescales mandates. Even if difficulties are encountered the Trust will be able to meet the more relaxed DH mandated timescales.

If the Trust is not successful in its bid for DH demonstrator funding, then the Trust will re-assess its options and a new business case will be developed for GS1 / PEPPOL adoption and re-submitted to the Trust Board.

1.7 Recommendation

It is recommended that the Board should bid for DH demonstrator funding on the basis of this business case, understanding that in doing so it is committing to:

a. Actively support and take all steps necessary to ensure the delivery of the demonstrator capabilities within the Trust according to the four phase programme within 2 years;

b. Assign a Board Level Executive Sponsor to drive the Trust's programme forward and be an active member of the national Steering Group, helping shape the national adoption programme;

c. To host visits from, and provide information to, other Trusts developing their adoption programmes;

d. Approve the release of funds attributed to the Trust as detailed in the Financial Case.

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2 The Strategic Case

2.1 Introduction

This OBC is for a programme to implement the recommendations of the NHS eProcurement Strategy (May 2014) within the Trust relating to the consistent adoption of GS1 and PEPPOL standards.

GS1 is a global, not-for profit, organisation that has defined standards and corresponding barcodes to enable clear and unique identification of people (such as patients and staff), places (such as sites, departments, rooms, and suppliers) and items (such as products, documents and assets).

GS1 standards are widely adopted globally in the retail and pharmaceutical industries where barcodes with unique product identifiers are mandated on all consumer products and commonly used at point of sale to speed up the "checkout" process. PEPPOL (Pan European Public Procurement OnLine) is the culmination of a multi-year project co-funded by the European Commission and 11 member states. It provides a set of messaging standards that enable business documents (such as purchase orders and invoices) to be electronically exchanged without manual intervention between buying and selling organisations.

The Trust approved the Strategic Outline Business Case (SOBC) for the adoption of GS1 and PEPPOL in May 2015. The SOBC defined the strategic context and the approach to GS1 and PEPPOL implementation. It recommended that a single programme should be established operating across all relevant departments, with a Trust nominated GS1 lead heading the programme and reporting progress to the board.

The SOBC was approved on the basis that further more detailed business cases would be submitted for approval identifying the specific actions and investments required and the associated financial and other benefits. This OBC is the first such detailed business case and has been developed to be used as the Trust's bid for demonstrator funding. It is expected that further business cases covering the use of GS1 identifiers for other use cases will be developed in the future.

2.2 Structure and content of the document

This OBC has been prepared using the Five Case Model. It comprises the following key components:

a. Strategic case: this sets out the strategic context and case for change, with supporting investment objectives for the scheme;

b. Economic case: this demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM);

c. Commercial case: this outlines the content and structure of the proposed deal;

d. Financial case: this confirms funding and affordability and explains any balance sheet impact;

e. Management case: this demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

There are six core changes within scope of the DH Demonstrator programme and thus of this business case. These are the three core enablers (use of GS1 compliant location identifiers (GLNs), catalogue management based on item identifiers (GTINs) and patient identifiers (GSRNs)) and three use cases (inventory management, purchase to payment and product recall). More detailed descriptions of how the core enablers and use cases will be adopted / implemented are provided in appendices A to F respectively.

Part A: The strategic context

2.3 Organisational overview

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust. It provides a full range of general hospital services to around 500,000 people living in the south of west Kent and parts of north east Sussex. In addition, the Trust provides specialist cancer services, through its flagship cancer centre at Maidstone and unit at Kent & Canterbury Hospital, for the whole of Kent, Hastings and Rother, about 1.8 million people.

The Trust primarily currently works from two main clinical sites: Maidstone Hospital, and the new Tunbridge Wells Hospital at Pembury (which was procured via PFI). It also provides cancer services at the Kent Oncology Centre at Maidstone Hospital.

The Trust employs a team of approximately 4,750 whole time equivalent staff and provides services to:

- Accident and Emergency: 119,000 per year;
- Inpatients: 84,000 per year;
- Outpatients: 387,500 per year.

The Trust, like the rest of the NHS in England is going through a period of unprecedented challenge, due to:

- Ageing population with increasing care requirements;
- Increasingly costly and complex technology;
- Increasing pharmaceuticals costs;
- Growing levels of litigation.

The adoption of GS1 and PEPPOL will contribute towards the mitigation of the last three of these challenges by standardising data (and hence reducing complexity), improving procurement practices (and hence reducing pharmaceutical costs) and reducing the risk of patient misidentification (and hence reduce the risk of litigation).

2.4 Business strategies

National strategies

The use of GS1 standards for the clear and consistent definitions including location, product and patient, has been stated within numerous policies and publications across NHS for some years. These include Coding for Success (DH 2007), ISB1077: AIDC for patient identification (2012) and most recently the NHS eProcurement Strategy (2014) and the Personalised health and care 2020: a framework for action (2014).

Compliance with GS1 standards and with the recommendations of the eProcurement strategy is now part of the NHS Standard Contract, with commissioners requiring acute trusts to comply fully by 2021/22. The DH target is for 80% of Trusts to have 80% of relevant transactions complying with GS1 and PEPPOL by 2018.

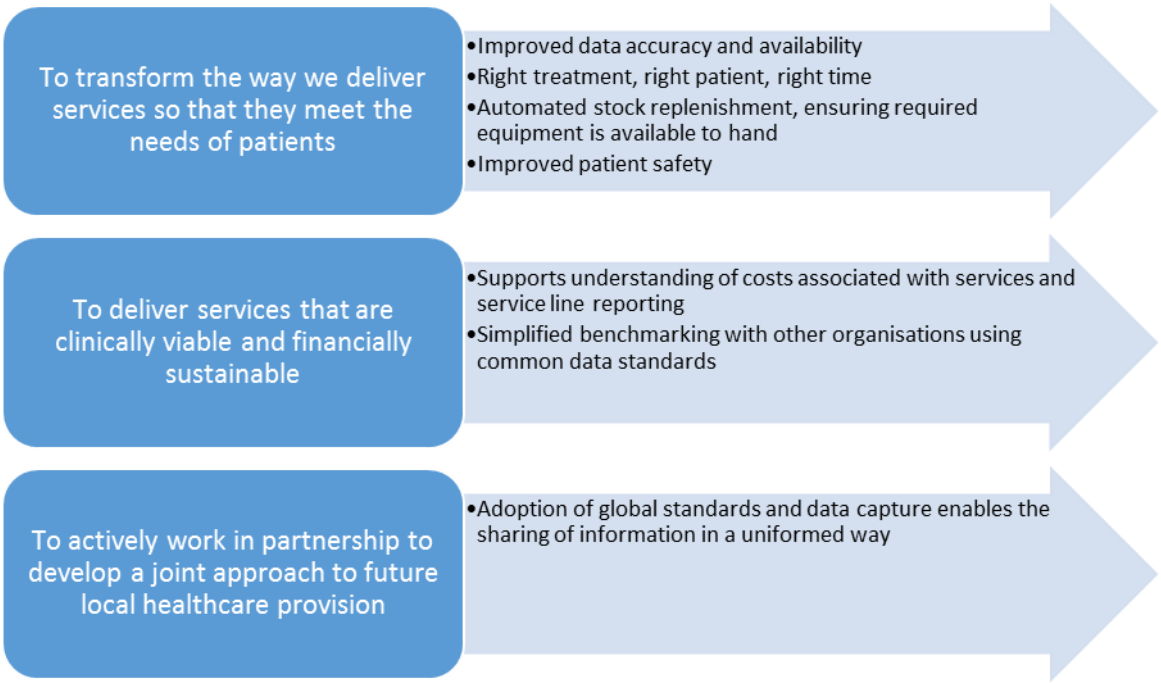
Regulation is expected shortly from EU relating to Unique Device Identification (a mechanism to accurately identify different types of medical device through distribution and use with a patient) and Falsified Medicines. Both will rely on trusts having appropriate mechanisms in place to accurately read and record

information contained within bar coded labels, and in the case of UDI, automated linking of product information with patient records.

Another key driver is EU regulations relating to the increased use of electronic procurement and invoicing (EU directive 2014/55/EU) which stipulates that, by the end of 2018 all public organisations must be capable of receiving electronic invoices from suppliers.

Local context

MTW has set out its key strategic objectives (as published in the Trust Strategy – "Moving Forward 2015/16 to 2019/20") which has been linked to the key benefits of the adoption of the core enablers and primary use cases in the following figure.



2.5 Other organisational strategies

There are a number of Trust strategies that set the context for the adoption of GS1 and PEPPOL. The most relevant of these are described below.

2.5.1 Procurement strategy:

This sets out a strategy for improving the efficiency and effectiveness of the Procurement Department through the introduction of business and organisational change and supporting technical changes, including the move to the use of a GS1 compliant catalogue management tool, GS1 compliant inventory management capability and GS1 / PEPPOL compliant purchase to payment capability. The strategy is currently being implemented and is scheduled for completion in FY 2016/2017. This strategy does not include Pharmacy within its scope.

2.5.2 Health Informatics strategy

Health Informatics is a key element and foundation to supporting the delivery of the Trust's vision. Through the creation, shaping, sharing and application of patient data and the deployment of appropriate

technologies, health informatics supports service planning, the delivery of the clinical strategy, and decision making to achieve desired outcomes for the quality of treatment and patient experience.

A key focus of the Trusts Informatics Strategy is the delivery of a basic Electronic Patient Record by 2018, based on the 'Clinical 5' core areas; these are:

a. A patient administration system (PAS) with integration with other systems and sophisticated reporting. A new GS1 compliant PAS is due for delivery by June 2016.

b. Order Communications and diagnostics reporting (including all pathology and radiology tests and tests ordered in primary care). This is due for delivery by April 2016.

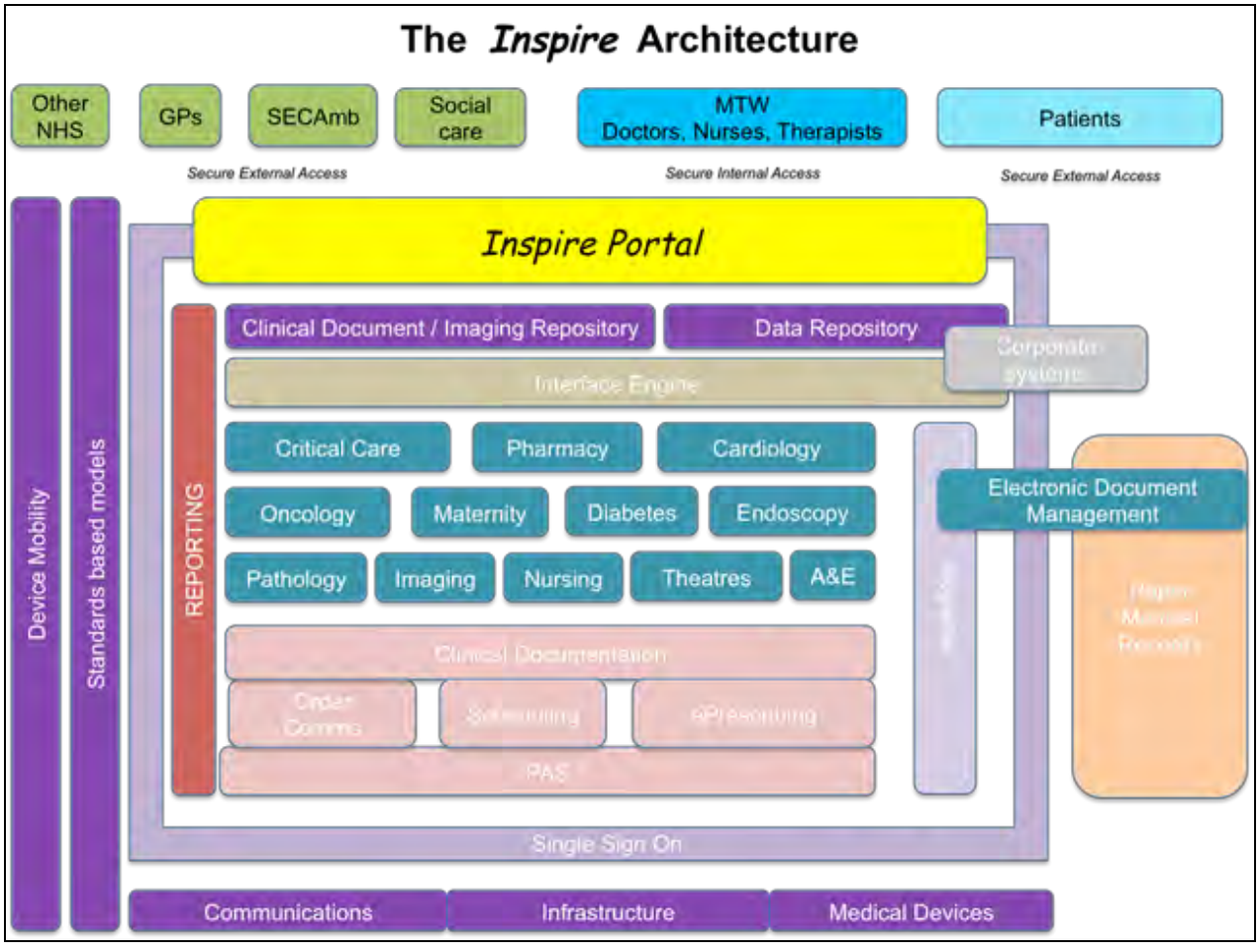
c. Clinical documentation (eg discharge summaries, transfers, clinic and A&E letters). This is scheduled for delivery by late 2016.

d. Scheduling (for beds, tests, theatres, etc). This is already in place.

e. e-Prescribing (including 'to take out' medicines), planned for completion in FY 2017/18.

The Informatics strategy is based on the use of best of breed applications with a shared repository being used to join data from the different applications so that it can be presented to a range of different stakeholders in ways that are relevant to them. The adoption of GS1 standards will ensure that consistent identifiers are used, enabling information to be linked more easily.

The Inspire strategy is supported by the Inspire technical architecture, which is shown below. This identifies a number of general capabilities (clinical 5 applications, workflow, document and imagery management, mobile platform, repository and portal) together with 12 specialist functional areas (critical care, pharmacy, cardiology, etc) which are supported by specialist line of business applications used only by the particular functional area.



Mobility strategy & Nerve-centre: As part of the Trust's wider Informatics strategy, it is currently rolling out mobile devices for use by all clinical staff as part of its 'Nerve-centre' initiative. The devices will be used initially for the recording of patient readings (temperature, heart rate, blood oxygen level, etc), for accessing patient information from the Patient Administration System and other applications, for recording handover notes for use when nurses change shift, and for doctors to record clinical notes. The mobile devices have a scanning capability which can be used in the future for a variety of applications.

Part B: The case for change

2.6 Our vision

To improve patient safety and outcomes, drive efficiency and reduce risk by interfacing with the Trusts clinical systems to provide visibility of the full patient pathway through GS1 standardisation.

By connecting patient, product, event, location, medical record and equipment through a global standard we will connect information in a way that is not currently possible. We will create a new ability to identify improvements for our Patients, our Trust and our Suppliers, integrating information and enabling our clinically-led organisation.

From the moment a patient requires healthcare through to discharge, we will, at the touch of a button, be able to see their complete pathway. Where they have been, who treated them, what products were used, which products were implanted, which equipment they used, the drugs they took, where they were located, their movements around the hospital and their interaction with clinical staff.

In the event of a problem, we'll be able to identify the patients affected in minutes and commence any remedial action. We'll be able to identify counterfeit drugs and stop them entering our pharmacy.

This vision won't be delivered by the current adoption programme alone, but the programme will put in place the fundamental foundations that will enable the Trust to deliver its vision progressively over time.

The target operating model that reflects the Trust's vision is shown in Figure 2-1.

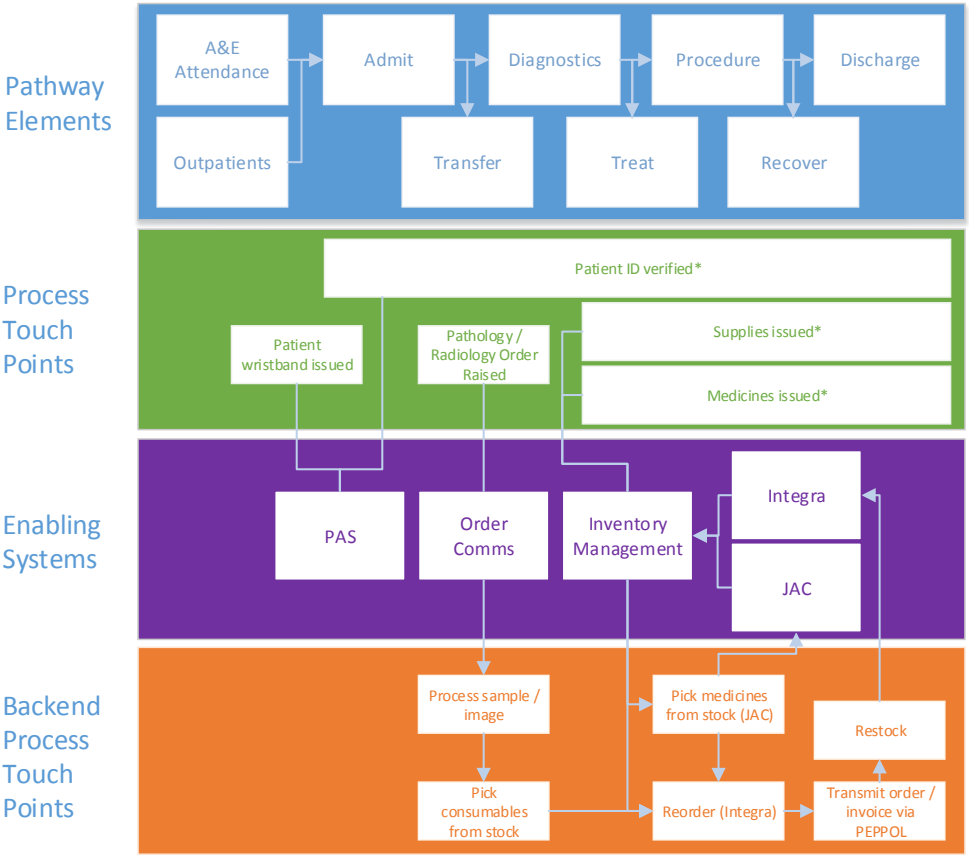


Figure 2-1: GS1 and PEPPOL Target Operating Model

The key features of the target operating model are that:

a. Patient interactions throughout the patient pathway are validated and recorded at each step, automating data capture using GS1 standards that are embedded into every process and system;

b. At each process step, patient, caregiver and location is recorded;

c. Information supporting product recall and service line reporting is stored in the inventory management solution. Diagnostic requests at patient level are recorded in order-comms with point of care interactions recorded in the PAS.

2.7 Investment objectives

The investment objectives are as follows:

a. To improve the Trust's understanding of the inputs to (including staff, equipment, medicines and devices, facilities and estate) and outcomes of its activities and the associated inputs so that it can improve patient safety, effectiveness and efficiency.

The adoption of GS1 identifiers for all locations, items and people consistently across the Trust's systems means that it will be possible to link up data captured in different systems and so get a full picture of the inputs (including staff, equipment, medicines and devices, facilities and estate) and outcomes from all activities. This will enable the Trust to identify what works well and where costs arise, so that best practice can be identified and costs reduced progressively over time.

b. To improve the Trust's management of inventory, such that the right item is always available when needed while driving average stock levels to three weeks or less within two years.

This will help the Trust to meet the requirements of the NHS eProcurement Strategy (2014) and at the same time meet the Trusts strategic objective to 'deliver services that are clinically viable and financially sustainable' by reducing stock holding and reducing wastage where items go out of date.

c. To improve the efficiency and cost-effectiveness of purchase to payment processes, such that less than 0.5% of items on the catalogue are manually ordered within two years.

This will help the Trust to meet the requirements of the NHS eProcurement Strategy (2014) and at the same time meet the Trusts strategic objective to 'deliver services that are clinically viable and financially sustainable' by freeing up staff time, particularly clinical staff time, that is used for ordering and managing medical devices and medicines.

d. To capture more accurate and detailed information on the use of items consumed, to the level of the patient treated, for at least 50% of items consumed within 2 years.

By tracking items consumed to the level of the individual patient, and recording the information in an easily searchable format, the Trust will be able to drastically reduce the staff time required for product recalls and build up statistics on the full cost of different treatment options.

e. To put in place the enabling capabilities for GS1 & PEPPOL adoption, namely:

1. GS1 Global Location Numbers (GLNs) for identifying all locations;
2. GS1 Global Trade Item Numbers (GTINs) for identifying all items procured or consumed;
3. GS1 People identifiers (GSRNs) for identifying patients, and in time, staff and other people.

This objective supports and enables the other four objectives and more generally will enable the Trust to better link information from different systems and therefore to understand better its activities and the associated costs.

These objectives are based on the national mandate to achieve GS1 and PEPPOL compliance, but with a particular focus on those areas identified by the Department of Health for its GS1 and PEPPOL adoption demonstrator programme.

2.8 Existing arrangements

Full details of the current arrangements for the three enabling capabilities and the three use cases are provided in Appendices A to F. The summary is as follows:

- **Location Identifiers**: The Trust's Estates and Facilities department maintains spreadsheets with details of around 7000 Trust locations, with all of these locations being assigned a unique identifier and being physically identified by a non-GS1 compliant bar-code label. A number of other location schema are used within the Trust, including 'Requisition points', which are used when ordering supplies via the NHS Supply Chain, and cost centre codes used when requisitioning medicines from the Pharmacy department.
- **Catalogue management**: There is currently no catalogue management solution in place. A GS1 compliant catalogue management solution is currently being procured to be used by the Procurement Department and this will also be used for procurement activities by Pathology and by Estates and Facilities once it is in place. Pharmacy procures a large volume of medicines but does not currently use any catalogue capability, with the details of medicines having to be manually entered in the JAC Pharmacy stock control system. In addition Procurement has incorporated the requirement for suppliers to adopt GS1 and PEPPOL standards into standard terms and conditions of contract.
- **Patient ID**: The Trust has been printing GS1 compliant barcodes since 2012 but the barcodes are not currently used. This will change with the delivery of the new Patient Administration System in mid-2016 which is able to capture patient identity from the wrist band via a barcode reader. The Trust is currently in the process of rolling out 1200 tablet devices for use by nursing and other medical staff and these have the capability to scan and read GS1 bar codes when suitable application software is installed.
- **Inventory management**: Currently there are no automated inventory management systems in use within the Trust although several departments have stock control systems (eg JAC is used by Pharmacy and Trident by Pathology). The Trust's Procurement Strategy includes the implementation of a patient level inventory management system for inventory management of medical supplies at ward level and work is underway to select a suitable product. Pharmacy on the Maidstone site has embarked on a pilot of a medicines inventory management system (Omnicell) which is GS1 compliant and provides greater security, verification and promotes patient safety – a key element in the Trusts CQC action plan, but there is no plan for the deployment of such a capability once the pilot is over.
- **Purchase to Payment**: The Trust does not currently use automatic purchase to payment capabilities. However, the Procurement department is currently procuring the GHX exchange product which will enable PEPPOL based messaging to be used for the procurement of medical supplies and devices. There are currently no plans to extend this capability to support the procurement of medicines by the Pharmacy department.
- **Product recall**: Currently product recall is a manual process, based on manually captured theatre records (for devices such as artificial joints implanted into patients) and a review of which wards received medicines during the time that a specific batch was being issued from JAC combined with a manual review of ward records. As a consequence product recall is a slow and expensive process with significant risk that products are missed.

2.9 Business needs

This section provides a detailed account of the problems, difficulties and service gaps associated with the existing arrangements in relation to future needs and changes since submission of the SOC.

- **Location**: There is a need to move to a standard way of representing and capturing locations within the Trust so that they can be used for a wide range of purposes, including for example:

- it is difficult to know the current location of all patients and this can waste consultant time or delay operations when a patient cannot be found – this information could be captured by scanning room barcodes when a patient is moved and recording patient ID, location and time;
- there is a need to collect and maintain information about the physical locations in which a patient has stayed, which is important for infection control purposes;
- suppliers that need to deliver to a Trust location for the first time must contact the Trust to obtain details, this would be avoided by publishing the information to a national registry.

- **Catalogue management**: product data is entered manually into procurement and pharmacy stock control systems. This is manually intensive, susceptible to data entry errors, and as a result much of the data is incomplete and out of date. There is a need to capture product data automatically and in a way that maintains the currency and accuracy of the data.
- **Patient Identification**: Currently patient identity is obtained by a person reading the wrist band and either selecting or typing in details, which is susceptible to data entry errors. There is a need to capture patient identity in a way that is faster and not susceptible to human error.
- **Inventory management**: Inventory management is predominantly manual and not always effective. Even with six weeks stock, operations are sometimes cancelled because of item non-availability (though often items are subsequently found to have been in other parts of the Trust). Improved inventory management arrangements will reduce average stock holdings, reduce wastage, improve stock visibility and availability and free clinical staff from inventory management activities.
- **Purchase to Payment**: The Trust does not have automatic purchase to payment capabilities. The Procurement department is currently buying the GHX exchange product which will enable PEPPOL based messaging to be used when procuring medical supplies and devices. This capability needs to be extended to cover Pharmacy to reduce the costs of order creation and invoicing payment.
- **Product recall**: More efficient and effective processes and tools are required to allow the Trust to identify the specific location of any unused items of stock covered by a product recall or any patients that have been treated with medicines or devices covered by a recall notice.
- **Service level costing**: There is a need to be better able to understand the costs (including the consumption of medicines and medical devices) associated with specific services or procedures, ideally to the individual patient level. This will enable the Trust to better understand what its major cost drivers are so that it can seek to optimise them.

Stakeholders have particularly stressed the need for near real time tracking of patients (from scanning locations and patient identity) and for reducing missed doses due to non-availability of medicines such as antibiotics (from improved inventory management).

During consultation with clinical and management stakeholders, the following related stories were shared:

"Better inventory management and an ability to electronically track our implants at patient level will greatly support our patient's safety and our clinical governance - an area we need to improve on. We already have the national joint registry, but data collection is manual and time consuming, there is also a three month lag in availability of the data.

We have had instances where products have been out of date when they are about to be used, which is a huge risk to the patients and cost tens of thousands of pounds to replace and a few instances where the implant required just hasn't been available, both of which is significant waste and can be avoided through better stock control.

We had a never event last year where the wrong size head was attached to a stem, which turned out to be human error and would probably not be avoided through this, but the time spent investigating the issue would be greatly reduced with electronic records" ***Guy Slater, Clinical Director, Trauma & Orthopaedics***

"Better inventory management would strengthen our controls and ensure that incidents where expired stock was opened and could be used on a patient in Theatres are avoided." ***Daniel Gaughan, General Manger, Critical Care***

"About 8-10 adverse drug incidents a month could be avoided with improved 'right drug - right patient' initiatives. Whilst the majority of incidents have a low impact, the cost increases enormously if the incidents are subject to complaints, serious incident review and perhaps even litigation" ***Jim Reside, Chief Pharmacist***

"We recently had a serious incident where equipment was used and resulted in a patient being injured. This carried significant damage to the Trusts reputation and litigation costs. Better information on where the equipment had been used, which staff had been trained to use it and which patients it had been used on would have greatly helped the investigation." ***Stephen Orpin, Director of Finance***

"From a costing perspective we have always had issues with knowing which exact prosthesis has been used on which patient. For example we know that a patient has come in and had a knee replacement because the clinical coding tells us. However we do not have information that tells us which type of knee the patient had or what other consumables have been used in theatre or on the ward once they are recovering. Detailed information linking products to patient would be really beneficial to the costing process." ***Angela Double, Finance Manager – Costing & SLR***

"The ability to track where our patients are at a glance alongside electronic data about their condition would help from a bed management perspective and GS1 could help with this." ***Sarah Overton, Head of Strategy***

2.10 Potential business scope and key service requirements

Summary of business scope

The scope for the initial adoption of GS1 and PEPPOL covered by this outline business case is limited to the three core enablers and three primary use cases, namely:

a. Core enablers:

   1. Location Identifiers: to simplify trade and internal processes using consistent location numbers across the trust based on the GS1 Global Location Number (GLN).

   2. Catalogue Management: to ensure consistent product master data and pricing is used across the trust and the NHS as a whole based on the GS1 Global Trade Item Number (GTIN).

   3. Patient Identity: to be able to positively identify a patient through point of care scanning of a patient's wrist band using the GS1 Global Service Relationship Number (GSRN).

b. Use cases

1. Inventory Management: to maintain stock at appropriate levels at point of use and to be able to electronically trace products and medicines to a specific location or patient.
2. Purchase to Pay: all purchase orders, advanced shipping notes and invoices to be exchanged between trusts and suppliers via a PEPPOL compliant access point.
3. Product Recall: to be able to trace products and medicines to a specific location or patient to allow safe and efficient recall.

The DH has identified minimum criteria for the implementation of each of these core enablers and use cases and set them within a four-phase timeline. This business case is for a programme to implement GS1 and PEPPOL across the Trust in a way that meets all of the criteria defined within the DH guidance.

Key Service Requirements

The service requirements for each core enabler and use case as follows:

Core enabler / use case	Service Requirements
Global Location Numbering	Assignment and management of GLN for all Trust physical locations Export of Trust's GLN repository to national GLN repository Use of GLN for all processes and systems where location is required
Catalogue Management	Establish catalogue and organisation to administer and manage it Design / roll-out of policies and procedures for procuring products via the catalogue
Patient Identity	Printing of ISB1077 compliant wrist band for 100% of inpatients on admission Design / roll-out of processes and procedures to capture patient identity via wrist-band scanning at point of care and recording of identity in all relevant systems
Inventory Management	Development and implementation of policies, processes and procedures and supporting technology for the effective / efficient inventory management of stock with automatically replenish stock without manual intervention
Purchase to Pay	Development and implementation of policies, process and procedures to enable purchase orders to be issued and for invoices to be received electronically, enabling automatic matching and payment
Product Recall	Development and implementation of policies, processes, procedures and tools to enable efficient and effective product recall

Further Use Cases

Six further use cases have been identified by DH and will be considered separately when the initial scope of the programme has been delivered. These further use cases include:

- eMedicines – provision of more accurate product information and enable process controls to ensure the efficient management of pharmaceuticals and the tracking of individual medicines to patients.
- Surgical Instrument Management – identification of all surgical instruments and trays so that accurate records can be kept when they are used and they can be tracked through sterilisation.
- Medical Equipment Management – tracking all individual items of medical equipment, enabling it to be located quickly and ensure that the records can be maintained of where the equipment has been used and on which patients.
- Community Equipment Management – tracking all loan stock items through their full life cycle to improve efficiency and ensure that records can be maintained of when the asset has been issued, to whom, when it was returned, decontaminated and taken back into stock.

- Medical Records Management – enabling accurate tracking of medical records throughout the estate to improve patient care through reducing time taken to locate specific records.
- Pathology Sample Management – enabling accurate tracking of samples from patient to laboratory, reducing the incidence of lost samples and helping to make results available as quickly as possible.

2.11 Main benefits criteria

This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs.

Investment objectives	Main benefits criteria by stakeholder group	
To improve the Trust's understanding of the inputs to (including staff, equipment, medicines and devices, facilities and estate) and outcomes of its activities and the associated inputs so that it can improve patient safety, effectiveness and efficiency.	**Patients** will receive safer and more effective treatment because of the improved evidence and information captured	**Clinicians** will have better data from which to assess the effectiveness of their actions and therefore will be able to optimise their actions to improve safety and outcomes for patients.
	Trust managers will have a better understanding of cost drivers and will therefore be able to progressively reduce costs and/or to negotiate more appropriate prices with the CCG.	
To improve the Trust's management of inventory, such that the right item is always available when needed while driving average stock levels to three weeks or less within two years	**Patients** • operations cancelled less often due to item non-availability • missed doses of medicine less often due to non-availability, hence stays extended less often	**Clinicians** will have • greater confidence that items will be available when they are needed • less time wasted due to cancelled operations due to non-availability • less time wasted treating patients relapsing due to missed medicine doses due to poor availability • spend less time on managing stock levels and ordering items • spend less time trying to find items that are out of stock in local stores
	Trust managers will see • reduced capital tied up in stock • reduced stock wastage • reduced storage space • reduced clinical staff time used to manage inventory • reduced average length of stay	
To improve the efficiency and cost-effectiveness of purchase to payment processes, such that less than 0.5% of items on the catalogue are manually ordered within two years	**Trust managers** will see a reduction in the cost of raising orders and paying invoices.	**Clinicians** will have more time for patient care as they will spend less time on ordering items, dealing with record discrepancies and authorising payment of invoices.
		Suppliers will be able to deal with the Trust more efficiently and therefore can offer better prices.

<table>
<tr><th>Investment objectives</th><th colspan="2">Main benefits criteria by stakeholder group</th></tr>
<tr><td rowspan="2">To capture more accurate and detailed information on the use of items consumed, to the level of the patient treated, for at least 50% of items consumed within 2 years.</td><td>Patients can be identified more quickly when devices that they have had implanted in them are recalled, reducing their risk of harm</td><td rowspan="2">Clinicians will gain a better understanding of how the outcomes from procedures vary depending on the items used and hence will be able to optimise future outcomes.</td></tr>
<tr><td>Trust managers will have
better understanding of the outcomes / cost drivers for particular procedures
greater ability to progressively optimise costs
better ability to reconfigure services because of robust evidence base</td></tr>
<tr><td>To put in place the enabling capabilities for GS1 & PEPPOL adoption, namely:
Global Location Numbers;
Global Trade Item Numbers;
GS1 Patient identifiers.</td><td colspan="2">Increased patient safety by reducing the risk of patient misidentification
Reduced cost to maintain multiple location schema
Reduced cost due to a single process for identifying all items (currently items have a variety of barcode types and none, requiring manual work rounds in some cases)</td></tr>
</table>

A potential dis-benefit, in the early stages of implementation, is that staff time may be taken away from patient care if scanning of items and patient wrist bands takes significantly longer than the current processes for recording item usage and for confirming patient identity.

2.12 Main risks

The main business and service risks associated with the potential scope for this project are shown below, together with their counter measures.

Description of risk	Countermeasure
There is a risk that new processes for inventory management are not embedded, so that the issue of stock is not recorded consistently, resulting in loss of stock control, availability failures and consequent delayed operations / treatment.	Ensure that clinical staff are fully involved in the development of the ward / clinical area processes. Ensure that the roll out of the new processes is comprehensively planned with senior stakeholder support and extensive training and a high level of compliance monitoring and re-training where required.
There is a risk that suppliers do not adopt GS1 and PEPPOL on the same timescale as the Trust, so that the Trust takes longer to achieve that potential benefits	Extensive supplier engagement is included within the scope of the plan to encourage and facilitate supplier adoption of these standards.
There is a risk that information system suppliers do not move to make their applications GS1/PEPPOL compliant on the timescale that the Trust needs, so that the Trust either has to pay suppliers to adopt GS1/PEPPOL faster or the delivery of benefits will be delayed.	Engage with information system suppliers early, ideally with other demonstrator trusts, to stress the importance of these standards.

2.13 Constraints

The adoption of GS1 and PEPPOL is subject to the following constraints:

a. **Availability of funding**: The availability of funding from the DH is subject to competition, with the Trust being one of twelve trusts bidding with the expectation being that six will be successful. If DH Demonstrator funding is not available, then funding will need to be sought from within the Trust's own resources at a time when there are many competing priorities.

b. **System provider readiness**: The Trust operates a number of information systems which hold patient ID, item information and location information in non-GS1 compliant formats. While many suppliers will in time be driven to upgrade their systems to GS1 compliance by market pressures, few suppliers have yet identified when GS1 compliance will be achieved on their product roadmaps. It is unlikely that the majority of the Trust's suppliers will achieve GS1 compliance within the timescales defined by DH for the demonstrator trusts.

c. **Supplier readiness for GTIN and PEPPOL**: The Trust will only be able to move fully to the use of GS1 and PEPPOL when the suppliers and other organisations with which it interacts have also adopted these standards, including:

    1. Medicine and medical device suppliers using GS1 compliant bar codes on their packaging;

    2. NHS Supply Chain accepting GLNs to specify delivery points rather than requisition points.

d. **Availability of skilled staff**: The Trust has a limited number of staff that are able to support business and technical change of the scale and scope required by GS1 / PEPPOL adoption. These staff are already working on the Trust's existing change programmes.

e. **Ability to absorb change**: The Trust is undergoing a number of major changes, for example the roll out of the new Patient Administration System and of Nerve-centre, both of which entail significant business as well as technology change. There is a limit to the rate of business change that the Trust can manage, and therefore care will need to be taken to ensure that the adoption of GS1 / PEPPOL is aligned with other change initiatives.

2.14 Dependencies

While the adoption of GS1 and PEPPOL within the Trust is to a great extent under the control of the Trust, the achievement of the full benefits of adopting these standards will only be achieved when a number of external parties have also fully adopted them. Specifically:

a. The Trust is required to export a subset of its GS1 compliant location database to a national GLN register. This will only be possible once the register is available.

b. Suppliers will need to provide GS1 compatible product data into a central data pool by December 2016.

c. The Trust is required to move to the use of GS1 item barcodes and identifiers (GTINs) for all items. The Trust will put in place the mechanisms to work with appropriately barcoded items, but there will be a period between the Trust being fully GS1 enabled and all suppliers providing items which are labelled in a GS1 compliant way and during this period, probably of several years, the Trust will need to be able to work with both GS1 and non-GS1 compliant items.

d. The Trust operates a large number of information systems which hold information about locations, items and patients. Currently the majority of these systems are not GS1 compliant. While it is expected that commercial pressures will mean that in time all suppliers release versions of their

products that are GS1 compliant, the majority of suppliers do not yet have clear roadmaps and timelines for achieving such compliance.

e. Suppliers are required to join a certified PEPPOL access point by December 2015 with full capability to send and receive invoices by December 2016. The Trust will need to have a connection to a certified access point and the ability to transact via PEPPOL electronically for purchase orders, purchase invoices and sales invoices when each supplier is ready.

f. The Department of Health and Trust Development Authority are able to increase the Trust's capital resource limits in line with the levels stated in this business case.

g. Capital funding will need to be released for other dependant programmes such as the Procurement Transformation which incorporates funding for the Inventory Management Solution.

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3 The Economic Case

3.1 Introduction

This section identifies the options considered and their economic cases, based on HM Treasury guidance.

3.2 The options

The options shown within the SOC were as follows:

a. Do nothing - continue as current without adopting GS1 standards.

b. Responsibility for adoption of the standards is distributed to individual departments and directorates.

c. Establish a centrally coordinated programme of activities to oversee the adoption of standards consistently across all aspects of the trust.

These have been re-visited in the context of the OBC and remain valid. The preferred option within the SOC was to establish a centrally coordinated programme of activities to adopt the standards consistently across all aspects of the trust. The short-listed options are based on this preferred way forward:

d. Option 1 – do nothing - continue as current without adopting GS1 standards;

e. Option 2 – adopt GS1 standards in accordance with the DH Demonstrator Programme requirements with DH funding;

f. Option 3 – Trust funded adoption programme.

3.3 Short listed options

Option 1 – do nothing - continue as current without adopting GS1 standards

This option provides the benchmark for value for money (VFM) and is predicated upon the following parameters:

a. **Scope:** the trust would not seek to adopt GS1 standards beyond current plans, with local solutions to the identification of patients, products and locations continuing to be used. The trust would not be fully compliant with the NHS Standard Contract nor UDI, FMD or EU electronic invoicing regulations.

b. **Solution:** no solution would be required to implement this option.

c. **Service delivery:** no service delivery impact.

d. **Implementation:** no implementation impact.

e. **Funding:** no funding impact.

Option 2 – adopt GS1 standards in accordance with the DH Demonstrator Programme requirements with DH funding

This option provides an outline of the 'preferred way forward' (not preferred option) at SOC stage and is predicated upon the following parameters:

a. **Scope**: Implementation of the three Core Enablers and three Primary Use Cases as described by the DH within a two year timeframe and across all affected areas of the trust.

b. **Solution**: Adoption of the GS1 and PEPPOL standards within the existing technology capabilities of the trust, namely:

   1. CE1: The creation of the Trust GLN registry, the physical re-labelling of all rooms across both sites and changing location references in all Trust systems to use the new location references.

   2. CE2: Catalogue management: The procurement of a catalogue management system that interfaces with the national data pools so that the Trust is always working from the best data on medicines, medical devices and other supplies.

   3. CE3: Patient Identification: The printing of GS1 compliant bar codes on all patient wrist-bands with wrist bands being scanned to confirm patient identity each time care is provided, requiring changes to the Trust's relevant systems so that they can use and store the scanned identities.

   4. UC1: Inventory management: The provision of inventory management software combined with controlled storage and inventory management terminals at 48 locations within the Trust, covering all wards, theatres groups and clinical areas, together with the development of new processes and training of relevant staff. This will allow stock levels to be managed automatically, enabling stock levels to be reduced, reduced stock wastage and reduced staff time on manual inventory management processes.

   5. UC2: Purchase to Payment: The introduction of a purchase to pay capability such that the vast majority of orders and payments are handled automatically, reducing the cost of order and invoice handling.

   6. UC3: Product recall: The development of new processes which exploit the improved data on ward/theatre level item location and patient level consumption to substantially automate product recall, together with training staff in the new processes.

c. **Service delivery**: A central programme team with accountability to deliver the outcomes required by the Department of Health, delivering to the Trust's GS1 Lead and governed by the Informatics Steering Group, which reports via the Trust Management Committee to the Trust Board.

d. **Implementation**: Adoption of the GS1 and PEPPOL standards will be implemented in a phased programme in order to meet the outcomes required by DH. Each use case will be implemented in four distinct phases, each of which are subject to acceptance processes.

e. **Funding**: Fully funded by Department of Health GS1 and PEPPOL Adoption Programme.

Option 3 – trust funded adoption programme

This option provides an outline of an alternative option, delivering the outcomes required over a longer timeframe based on the Trust's existing Health Informatics strategies.

a. **Scope**: Implementation of the three Core Enablers and three Primary Use Cases within a planned timescale of five years, subject to changing trust priorities for trust resources.

b. **Solution**: Adoption of the GS1 and PEPPOL standards will be undertaken in the same way as for Option 2, except that key programme activities will be aligned with related programmes of work. The extent of adoption will be reduced and phasing amended to focus on areas returning the greatest

benefit and aligning with dependant programmes. Due to the Trust's financial position and significant constraints on funding from both Capital and Revenue, the Trust would not be in a position to fund the scale and speed of deployment of the programme – with the capital elements being subject to prioritisation and deferral in line with other investment cases. Currently there is no capital available in FY2016/17, and the capital costs of the programme will need to be spread across FYs 2017/18 and 2018/19, effectively delaying the roll out by around 18 months compared with Option 2.

c. **Service delivery**: A central programme team with accountability to deliver the outcomes required by the Department of Health, delivering to the Trust's GS1 Lead and governed by the Informatics Steering Group, which reports via the Finance Committee to the Trust Board.

d. **Implementation**: Adoption of the GS1 and PEPPOL standards will be implemented in a phased programme to meet the priorities of the trust in respect of quality, clinical and financial improvement. Standards will be adopted by the end of 2018/19.

e. **Funding**: Funded from within existing resources.

The main difference between options 2 and 3 is thus primarily one of timing rather than scope or ambition, as the scope of the change required has been defined by the DH. Option 2 will deliver the core enablers and use cases more quickly, but at the cost of requiring the Trust's plans in other areas to be changed.

These options each include three core enablers and three use cases, and there are different ways in each of these can be delivered. The number of potential sub-options is therefore very large. To avoid making this business case over-complex, the sub options for the individual core enablers and use cases are discussed in Appendices A to F and the body of the report only discusses the three top level options.

3.4 Economic appraisal

3.4.1 Introduction

This section provides a detailed overview of the main costs and benefits associated with each of the selected options. More detailed information is shown for each cost and benefit line within the detailed discussions of the enabling capabilities and use cases in Appendices A to F.

The **benefits** associated with each option were identified through the following process:

- The starting point for the benefits assessment was the benefits model developed for Trust's to use in developing their Strategic Outline Cases;
- The benefits identified from the DH benefits model were modified taking into account the specific details of the Trust's starting point and plans;
- Benefits where discussed with key stakeholders for each element of the case and evidence gathered to firm up assumptions and provide more accurate benefit projections.
- These firmer benefits were circulated for consultation widely across the remaining stakeholder base for challenge and refinement.
- A workshop was held to challenge the assumptions made around each benefit.

The **costs** associated with each option were identified by a combination of the following approaches:

- Bottom up estimation of the level of effort;
- Discussion of costs with potential suppliers and benchmarking with other Trusts;
- Developing the cost model and submitting it for stakeholder review.

3.4.2 Net present cost findings

The detailed economic appraisals for each option are discussed at core enabler or use case level in Appendices A to F. These are then aggregated into the option level summaries presented here.

The following table summarises the key results of the economic appraisals for each option. Note that given the relatively small scale of the programme and the focus on business rather than technology, optimism bias has not been included.

Option 1 – Do Nothing		
	Undiscounted (£)	Net Present Value (£)
Capital	£0	£0
Revenue/ current	£0	£0
Risk retained	£0	£0
Total costs	£0	£0
Less cash releasing benefits	£0	£0
Costs net cash savings	£0	£0
Non-cash releasing benefits	£0	£0
Total	£0	£0

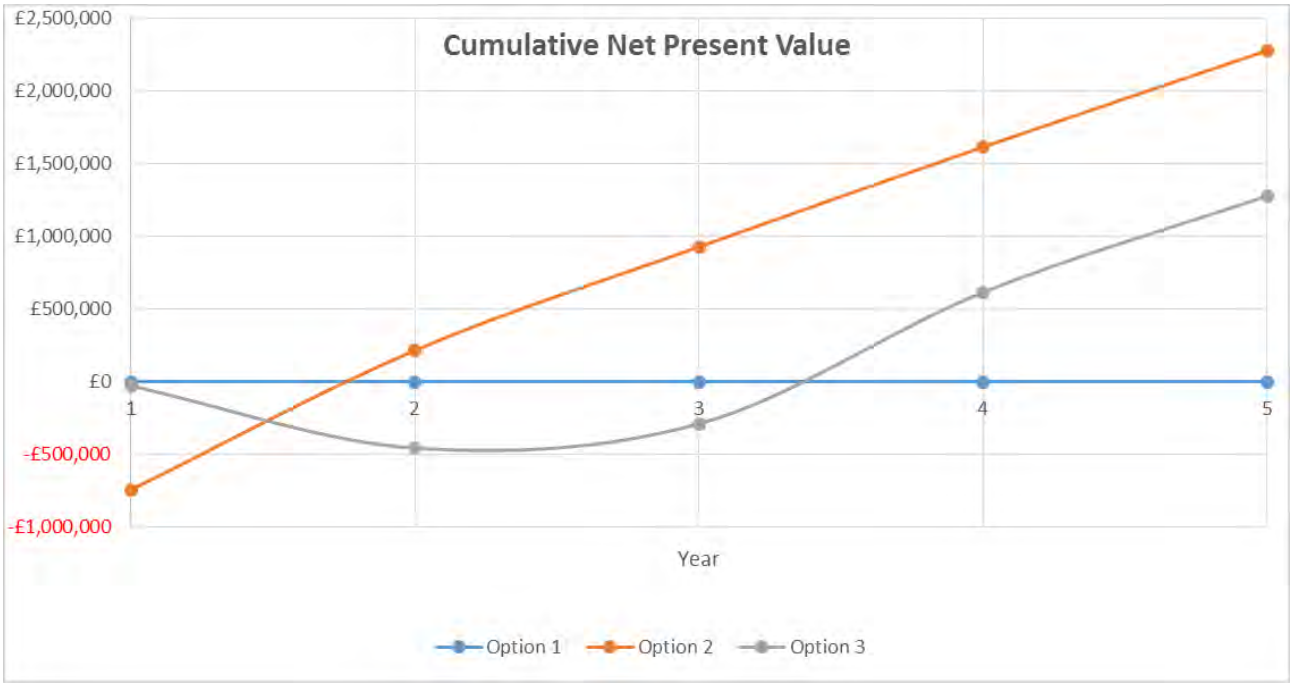
Option 2 – DH demonstrator funded implementation of GS1 and PEPPOL		
	Undiscounted (£)	Net Present Value (£)
Capital	-£820,209	-£816,244
Revenue/ current	-£818,024	-£799,540
Risk retained	£0	£0
Total costs	-£1,638,233	-£1,615,784
Cash releasing benefits	£3,076,101	£2,888,432
Cash savings minus costs	£1,437,868	£1,272,648
Non-cash releasing benefits	£1,109,500	£1,007,913
All benefits minus costs	£2,547,368	£2,280,561

Option 3 – Trust funded implementation of GS1 and PEPPOL		
	Undiscounted (£)	Net Present Value (£)
Capital	-£883,459	-£833,184
Revenue/ current	-£845,194	-£800,031
Risk retained	£0	£0
Total costs	-£1,728,653	-£1,633,215
Cash releasing benefits	£2,491,422	£2,275,298
Cash savings minus costs	£762,769	£642,083
Non-cash releasing benefits	£717,250	£637,287
All benefits minus costs	£1,480,019	£1,279,370

3.4.3 Option ranking

3.4.3.1 The results are summarised in the following table, with a graph of cumulative net present value following.

Option	Description	Ranking: 2, 3, 1				
		Discounted costs	Cash benefit	Non cash benefit	Cash benefits - costs	All benefits - costs
1	**Do nothing**	£0	£0	£0	£0	£0
2	**DH funded**	-£1,615,784	£2,888,432	£1,007,913	£1,272,648	£2,280,561
3	**Trust funded**	-£1,633,215	£2,275,298	£637,287	£642,083	£1,279,370



3.4.4 Option appraisal conclusions

The key findings are as follows:

- **Option 1 – do nothing**: This option has only been included to provide a baseline for comparison purposes as it does not meet the strategic mandate to implement GS1 and PEPPOL by 2021/22. It does not have any costs but has no financial benefits and has the highest (ie worst) net present cost.
- **Option 2 – DH demonstrator funding of GS1 / PEPPOL adoption**: This option will achieve the DH demonstrator requirements, delivering the three core enablers and the three use cases within 2 years. This option provides the best Net Present Cost, with discounted costs of £1.6m generating discounted savings of about £3.9m and giving a net present value of just almost £2.3m.
- **Option 3 – Trust funding of GS1 / PEPPOL adoption**: This option will broadly deliver the same changes in terms of GS1 and PEPPOL adoption as Option 2, but the benefits are reduced because the implementation of inventory management is delayed by a year to align with other programmes, reducing the benefits. There are also additional costs because of the need to keep the team in place for longer. This option has an NPV of £1.3m, around £1m less than the equivalent value for Option 2.

Based on the economic case, Option 2 is clearly the best option.

3.5 Qualitative benefits appraisal

This section discusses the qualitative benefits that the various options will provide. In the table a single ✓ means that the option partially achieves the benefit, two ✓✓ means that it substantially achieves the benefit and three ✓✓✓ means that it fully achieves the benefit.

Benefit description	Option 1	Option 2	Option 3
Patients will be safer because of reduced risk of misidentification	-	✓✓✓	✓✓✓
Patients will receive more effective treatment because of the improved evidence base captured	-	✓✓✓	✓✓✓
Clinicians will have better data from which to assess the effectiveness of their actions and therefore will be able to optimise their actions to improve outcomes for patients	-	✓✓✓	✓✓✓
Trust managers will have a better understanding of cost drivers and will therefore be able to progressively reduce costs and/or to negotiate more appropriate prices.	-	✓✓✓	✓✓✓
Patients will have operations cancelled less often due to item non-availability	-	✓✓✓	✓✓✓
Clinicians will have greater confidence that items will be available when they are needed and will have more time for patient care as they will spend less time on managing stock levels and ordering items.	-	✓✓✓	✓✓✓
Trust managers will see a reduction in the capital tied up in stock, a reduction in stock wastage, a reduction in required storage space and a reduction in staff time required to manage inventory.	-	✓✓✓	✓✓✓
Patients can be identified more quickly when devices that they have had implanted in them are recalled, reducing their risk of harm	-	✓✓✓	✓✓✓
Clinicians will gain a better understanding of how the outcomes from procedures vary depending on the items used and hence will be able to optimise future outcomes.	-	✓✓✓	✓✓✓
Trust managers will have a better understanding of the outcomes and cost drivers for particular procedures and therefore will be able to progressively optimise costs.	-	✓✓✓	✓✓✓

The qualitative benefits provided by options 2 and 3 are effectively the same, though with Option 3 they are delivered more slowly. Option 1 does not provide any benefits compared to the existing situation.

3.6 Risk appraisal

3.6.1 Methodology

Risk appraisal has been undertaken and involved the following distinct elements:

- identifying all the possible business and service risks associated with each option;
- assessing the impact and probability for each option;
- calculating a risk score.

3.6.2 Risk scores

In keeping with our bottom-up approach, the detailed assessment of the risks is provided with the discussion of the core enablers and use cases to which they apply in Appendices A to F. In each area, the relevant team members assigned risk scores using the Trust's standard risk methodology on the basis of the participants' judgment and assessment of previous transformation programmes.

3.6.3 Assessment of comparative risks

Option 1 does not involve any activities and therefore it is the least risky option. Options 2 and 3 have the same scope and are based on the same delivery technologies and methodologies. The elapsed timescale for both is roughly the same, except that with Option 2 the aim is to complete the work within the two year period starting on 1 January 2016, which with Option 3 the aim is to complete the work within 24-30 months starting in April 2017. This means that:

a. Risks that depend on the pace of delivery, such as the risk that new processes will not be embedded, will broadly have the same probability and impact for options 2 and 3;

b. Risks that depend on when an activity takes place will be different. In particular, the patient Id use case requires a number of clinical and other IT systems to be either upgraded or configured to use GS1 patient, location and Item Ids. It is expected that suppliers of these systems will progressively make their products GS1 compatible, so that as time passes it will become less risky/costly from an IT perspective for the Trust to make its systems GS1 compliant. This means that Option 2, with its more aggressive timescale, will have a higher IT related risk than option 3. As this is one of the larger risks for the programme, it means that Option 2 has a higher risk than option 3.

This means that in terms of ranking for risk:

- Option 1 is ranked first for risk (ie it has the lowest risk);
- Option 3 is ranked second for risk;
- Option 2 is ranked third for risk (ie it is the most risky).

3.7 The preferred option

The results of investment appraisal are as follows:

Evaluation Results	Option 1	Option 2	Option 3
Economic appraisals	3	1	2
Benefits appraisal	3	1	2
Risk appraisal	3	2	1
Overall Ranking	3	1	2

The preferred option is Option 2 because it provides the best balance of economic and other benefits while having a manageable risk profile.

3.8 Sensitivity analysis

The two substantive options are similar in terms of the changes to be made, they differ in terms of timing. With option 3 the lack of available capital funding means that implementation does not start substantially until 2017/2018 and is extended to fit within capital spending limits. This means that with option 3 the programme team costs will be higher because the programme takes longer to deliver, but there will be compensating savings because there is no need to prepare interim and final case studies. As such all the main assumptions as to costs and benefits are common and there are no assumptions or scenarios under which the order of ranking of the options would change between options 2 and 3.

There are circumstances under which the net present value of Option 2 could go negative, so that it becomes difficult to justify the programme on economic grounds. The major benefits are as follows:

Area	Benefit	Total value over 5 years
UC1	Clinical staff time freed up	£280,000
UC1	Reduce emergency restock	£170,951
UC1	Reduced cancelled operations	£352,800
CE2	Reduce data management cost	£56,000
CE3	Reduction of Adverse Drug Incidents	£315,000
UC1	Missed doses	£178,850
UC1	Inventory reduction	£1,439,000
UC1	Inventory waste reduction	£654,500
UC2	Invoice processing cost reduction	£700,000
UC3	Reduce recall processing costs	£38,500

There is no single area of benefits that alone could take the NPV negative. The UC1 (Inventory Management) benefits account for a high proportion of the programme benefits, so a major failure of this area of the programme could mean that the programme as a whole becomes non-viable, but this is unlikely as the technologies and processes concerned are all mature and in use in a number of other Trusts.

3.9 Preferred option

3.9.1 The preferred option remains Option 2, DH demonstrator funding for GS1 / PEPPOL adoption.

4 The Commercial Case

This business case is for business transformation supported by a number of relatively small technology changes. The majority of the focus of the programme will be on organisational and process change and as such the commercial case is relatively straightforward.

Items to be procured are potentially as follows:

- **Project and change management services** – the majority of project and change management will be undertaken by internal staff, backfilled as necessary, to maximise value for money. Where this is not possible, because niche skills are required or to meet peaks of workload, then use will be made of existing contract frameworks in place with the Trust's own procurement function, the London Procurement Partnership or Crown Commercial Services.
- **Systems developments** – where it is necessary to effect updates to existing systems operated by the trust it is expected that these will be covered through the existing contracts of supply and maintenance. Should that not be the case, for example where new technology or systems are required to be purchased then use should be made of existing frameworks of supply.

Where procurement is necessary then:

- Standard contract terms and contract terms will be applied;
- Charging mechanisms will ensure that payment is only made following acceptance, with risk being transferred to suppliers where appropriate;

There are no TUPE implications from this business case.

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5 The Financial Case

5.1 Introduction

The purpose of this section is to set out the forecast financial implications of the preferred option.

5.2 Impact on the organisation's income and expenditure account

The anticipated payment stream for the project over its intended life span is set out in the following table:

Total costs	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Capital (inc VAT)	£39,813	£826,036	£88,640	£0	£0	£0	£954,488
Revenue (inc VAT but excl depreciation & capital charge)	£37,381	£449,364	£280,273	£22,800	£22,800	£22,800	£835,417
Total	£77,193	£1,275,400	£368,913	£22,800	£22,800	£22,800	£1,789,906

Funded by:	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
DH	£77,193	£1,275,400	£363,213	£0	£0	£0	£1,715,806
Trust (excluding depreciation & capital charges	£0	£0	£5,700	£22,800	£22,800	£22,800	£74,100
Total	£77,193	£1,275,400	£368,913	£22,800	£22,800	£22,800	£1,789,906

Cost benefit assessment	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Total costs inc VAT (but ex depreciation and capital charges)	£77,193	£1,275,400	£368,913	£22,800	£22,800	£22,800	£1,789,906
Cashable benefits	£ -	£ 58,468	£ 409,275	£ 444,943	£ 444,943	£ 444,943	£ 1,802,572
Cashable benefits minus costs (cumulative)	-£ 77,193	-£ 1,294,125	-£ 1,253,763	-£ 831,620	-£ 409,477	£ 12,666	
Non-Cashable benefits	£ -	£ 39,625	£ 277,375	£ 317,000	£ 317,000	£ 317,000	£ 1,268,000
All benefits minus costs (cumulative)	-£ 77,193	-£ 1,254,500	-£ 936,763	-£ 197,620	£ 541,523	£ 1,280,666	

Preferred way forward:	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Capital spend (ex VAT)	£35,813	£709,447	£79,138	£0	£0	£0	£824,397
Non-recoverable VAT on capital items	£4,000	£116,589	£9,503	£0	£0	£0	£130,092
Full year depreciation	£7,963	£406,343	£763,591	£190,898	£190,898	£190,898	
Depreciation in period	£1,991	£101,586	£190,898	£190,898	£190,898	£190,898	£867,167
Opening Value	£39,813	£1,931,191	£3,117,301	£660,014	£469,117	£278,219	
Closing Value	£37,822	£1,829,606	£2,926,403	£469,117	£278,219	£87,321	
Capital Charge	£340	£16,453	£26,441	£19,760	£13,078	£6,397	£82,469

Revenue	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	Total
Costs							
Revenue(ex-VAT)	-£37,081	-£421,910	-£269,141	-£19,000	-£19,000	-£19,000	-£785,132
Non-recoverable VAT on revenue items	-£300	-£27,453	-£11,132	-£3,800	-£3,800	-£3,800	-£50,285
Capital depreciation	£ -	-£60,284	-£186,466	-£190,898	-£190,898	-£190,898	-£867,167
Capital charge	£ -	-£9,934	-£27,317	-£20,804	-£14,749	-£8,067	-£82,469
Sub-total costs	**-£37,381**	**-£519,582**	**-£494,055**	**-£234,501**	**-£228,446**	**-£221,765**	**-£1,785,054**
Income							
Revenue payments from DH	£37,381	£449,364	£ 274,573				£761,317
Cash benefits	£ -	£ 58,468	£ 409,275	£ 444,943	£ 444,943	£ 444,943	£ 1,802,572
Sub-total income	**£37,381**	**£507,831**	**£683,848**	**£444,943**	**£444,943**	**£444,943**	**£2,563,889**
Total (income minus costs)	**£0**	**-£11,750**	**£189,793**	**£210,442**	**£216,497**	**£223,178**	**£778,835**

As can be seen, the payments by the DH mean that the costs to the Trust's revenue account are relatively small, at less than £12k in FY2016/17. Thereafter the impact is increased income of around £200k pa.

(Note that depreciation and capital charges show in the revenue account in the quarter after they arise)

5.3 DH payment profile

The funding requirement by Phase from the Department of Health is shown in the table below:

	Funding Required	Financial Year
Phase 1	£ 215,079	FY15/16 or FY16/17
Phase 2	£ 738,686	FY16/17
Phase 3	£ 608,319	FY16/17 or FY17/18
Phase 4	£ 153,722	FY17/18
Total	£ 1,715,806	

The Trust may request that part of the Phase 1 funds are provided in FY15/16 with the remainder in FY 16/17 to simplify budget management around the end of the FY 15/16. A similar arrangement may be required for Phase 3 which straddles the FY2016/17, FY2017/18 boundary.

Additionally, there will be a dependency that TDA and DH agree to adjust the Trust's capital resource limits.

5.4 Impact on the balance sheet

The proposed expenditure will have the following impact on the balance sheet.

Preferred way forward:	2015/16	2016/17	2017/18	2018/19	2019/20	2010/21	
Balance sheet closing asset value	£37,822	£1,829,606	£2,926,403	£469,117	£278,219	£87,321	

5.5 Overall affordability

Given the initial cash income from DH in years one and two, positive net benefit from year three, the relatively small revenue costs in the initial years, and the large overall non-cashable and non-financial benefits, this programme is highly affordable and should be a priority for funding.

Delivering this OBC will require TDA agreement for the capital spend and use including an increase in the Trust's Capital resource limit. Additionally, where necessary, approval of external manpower to backfill or provide the core programme team. The TDA is aware of this OBC.

6 The Management Case

6.1 Introduction

This section of the OBC addresses the 'achievability' of the scheme.

6.2 Programme governance

Currently the adoption of GS1 and PEPPOL is a project within the Corporate Systems Programme, which is one of four major programmes running within the Health Informatics department. It will become a fifth major programme within the Informatics Department, as shown in Figure 6-1 below.

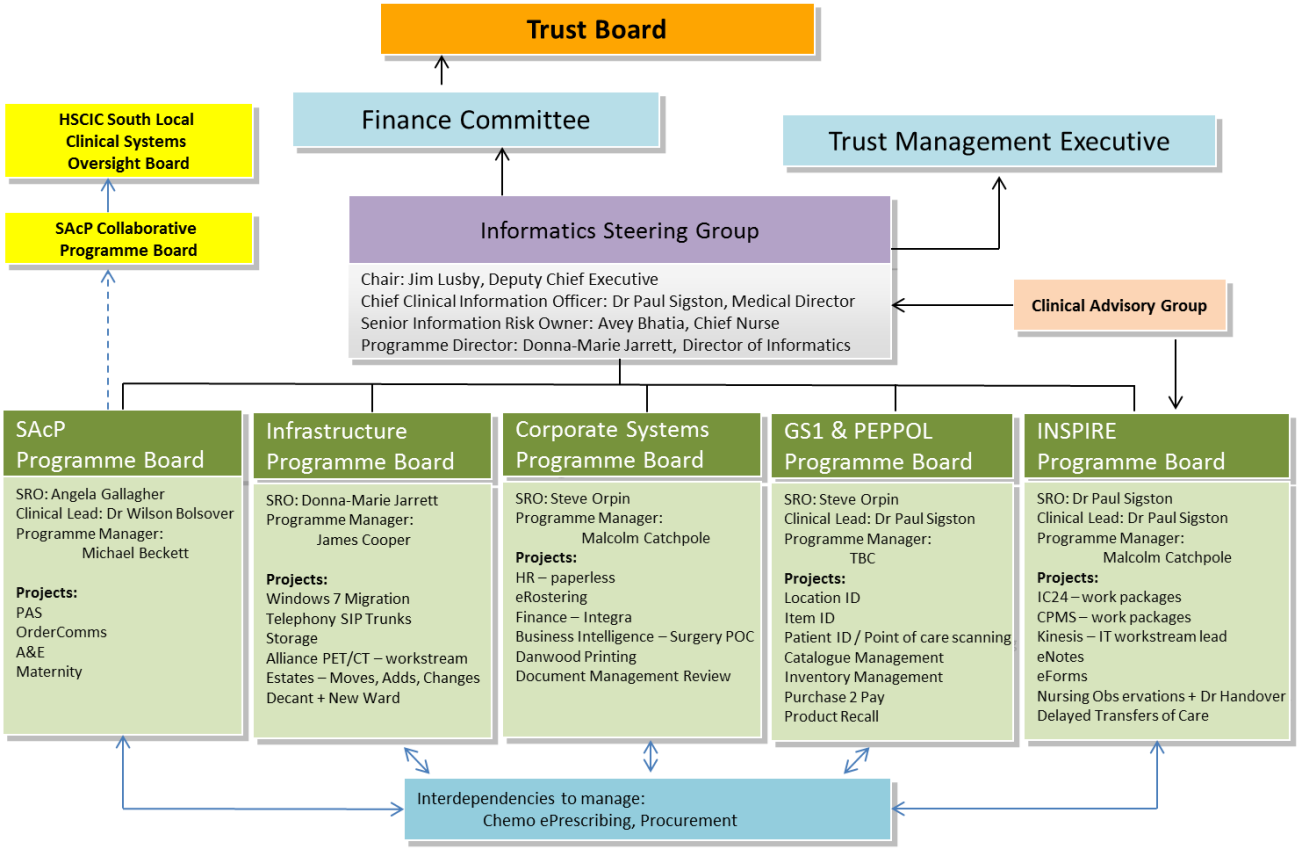

Figure 6-1: Programme governance arrangements

The adoption programme will be managed through the Trust's Informatics Steering Group and the Corporate System Programme Board, which reports to the Trusts Management Executive.

6.3 Programme and project management arrangements

6.3.1 Programme structure and responsibilities

The programme will be managed using the Managing Successful Programmes methodology with projects being managed using the PRINCE2 methodology.

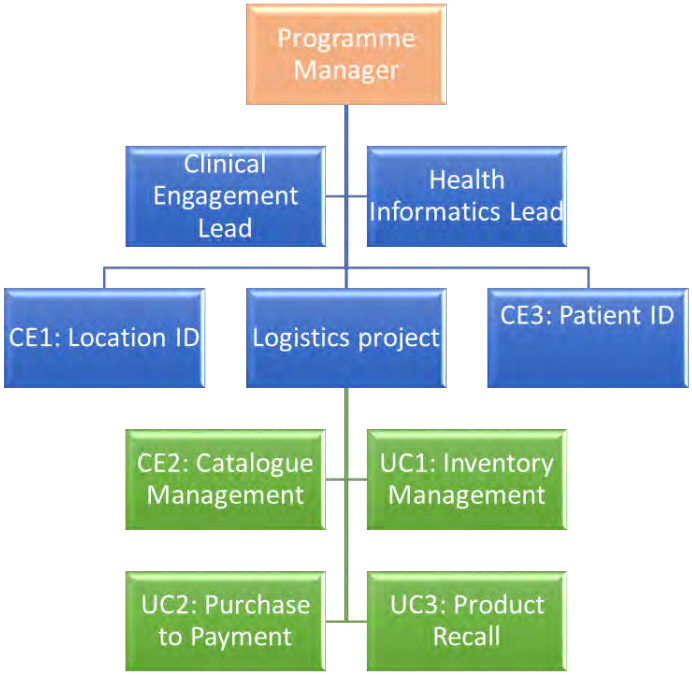

Figure 6-2: Programme structure

A core programme team will be established consisting of the Programme Manager, Clinical Engagement Lead, Health Informatics Lead and Logistics Lead.

- The Programme Manager will be responsible for the coordination of the individual projects of work across departments and directorates. In line with that centralised management approach nominated leads will be assigned from IT, Finance, Procurement, Pharmacy, Estates & Facilities and HR to ensure coordination of activities and approaches.
- The Clinical Engagement Lead will be responsible for clinical engagement and delivering cultural embedded change across the Programme. The Clinical engagement lead will be responsible for recruiting and managing ward level change agents in support of the various projects.
- The Health Informatics Lead will be responsible for supporting and coordinating the IT related aspects of all of the projects within the Programme.
- The Logistics Lead will be responsible for leading the logistics aspects of the wider programme.

The core programme team will, where possible, be formed by secondment of existing Trust staff, with their existing roles being backfilled for the duration of their secondment by the use of new staff recruited on fixed term appointments in order to minimise cost.

6.3.2 Project roles and responsibilities

As well as a project manager, each project will have a project sponsor who is responsible for the department that will be most affected by the change delivered by the project once it is brought into operational use. The project executives will generally be the relevant benefit owners.

Project	Project management undertaken by:	Business sponsor / project executive	Comment
Location ID	Programme Manager	Jeanette Rook, Estates & Facilities	This is a relatively small project and will be mainly managed by the Programme Manager working with the Estates team
Patient ID	Clinical Engagement Lead	Dr Paul Sigston, Medical Director	This project will have the greatest impact on clinical staff, hence the Clinical Engagement Lead managing it. Extensive support will also be required from the Health Informatics Lead because of the number of systems that will be affected.
Logistics projects • Catalogue Management • Inventory Management • Purchase to Payment • Product Recall	Logistics Lead	Joint between Pharmacy and Procurement Pharmacy: Simon Badcott, Head of Pharmacy Procurement: Lesley Martin, Head of Category Management Dr Paul Sigston, Medical Director will be engaged where ward/theatre processes are impacted	The Clinical Engagement Lead will need to support these projects where they require changes to process at ward and theatre level, eg scanning items when removing from ward/theatre level stores.

6.3.3 Project plan

A comprehensive project plan has been developed covering all phases and activities. The subset of the plan that relates to each enabling capability and use case is provided in the appendix that relates to the enabling capability or use case concerned (ie Appendices A to F for location, catalogue management, patient Id, inventory management, P2P and product recall respectively).

6.4 Use of special advisers

Special advisors were used to support the planning and development of this business case:

- The Trust has funded the GS1 / PEPPOL OBC programme manager role on a part time basis. The advisor concerned previously supported the development and implementation of the Trust's procurement strategy which is a key enabler for the Trust's adoption of GS1 and PEPPOL.
- The DH provided professional services support from Actica Consulting to assist the Trust in preparing this OBC.

6.5 Outline arrangements for change management

Change management at a programme level will be the responsibility of the GS1 Programme Lead and managed via the governance structure identified in Section 6.2.

As noted in the Commercial Case in Section 4, the GS1 / PEPPOL adoption programme is primarily a business transformation programme. It is expected that there will be some procurement activity, primarily of the Patient Level Inventory Management System:

- All such procurements will be via established framework contracts which include provisions for change management;
- The relevant project manager will be responsible for contract management until acceptance.

6.6 Outline arrangements for benefits realisation

The benefits outlined in the Economic Case cover a range of aspects including cash releasing, financial non-cash releasing and quality improvements.

Quality improvements include:

- Increased data accuracy and reliability enabling improved analytics and decision making;
- Patient safety and experience improvements through “right patient, right product, right treatment”; and
- Increased automated data transfer between systems and organisations reducing potential errors and time delays.

Each area of benefits will be assigned to a benefits owner who will be responsible for reporting to the programme board at the end of each Phase and six months beyond the end of Phase 4 on the achievement of benefits for which they are responsible. The benefits owners will be as follows:

Benefit area	Description	Owner
UC1	Clinical staff time freed up (theatre staff managing inventory)	Chief Operating Officer
UC1	Reduce emergency restock	Pharmacy and Procurement
UC1	Reduced cancelled operations	Medical Director
CE2	Reduce data management cost	Director of Health Informatics
CE3	Reduction of Adverse Drug Incidents	Pharmacy and Chief Operating Officer
UC1	Missed doses	Pharmacy and Chief Operating Officer
UC1	Inventory reduction	Pharmacy and Procurement
UC1	Inventory waste reduction	Pharmacy and Procurement
UC2	Invoice processing cost reduction	Finance
UC3	Reduce recall processing costs	Pharmacy and Procurement

Benefits will be tracked using the Trust’s standard benefit tracking model and performance monitored and reported via the programme governance. Cash releasing financial benefits that positively affect the Trust’s

Income & Expense position will be reported and monitored within the Trust's central cost improvement programme and variance against plan managed through the Executive Recovery Group.

6.7 Outline arrangements for risk management

It will be the responsibility of the Trust's GS1/PEPPOL Programme Manager and governance boards to ensure that, throughout the duration of the programme, appropriate regular reviews are undertaken of the programme risk register and that significant or strategic risks are raised to the Trust's board in accordance with the Trust's standard risk management approach.

Risks associated with each of the core enablers and use cases are provided in the relevant appendices based on the Trust's standard approach to risk management.

6.8 Outline arrangements for post project evaluation

Post implementation review (PIR): These reviews ascertain whether the anticipated benefits have been delivered and will take place at the end of each Phase, with a final PIR being prepared six months after the completion of Phase 4.

Project evaluation reviews (PERs): PERs appraise how well the project was managed and delivered compared with expectations. A PER will be prepared for each project on completion of Phase 4.

Case studies: In addition to the PIRs and PERs, interim and final case studies will be prepared for each enabling capability and use case. These will summarise the activities undertaken to deliver the capabilities or use cases, the costs and benefits, lessons learned and recommendations for additional activities building on the capability or use case.

6.9 Gateway review arrangements

The limited scale and scope of the programme means that it does not warrant formal gateway reviews. The Trust will submit a Phase completion report to the DH at the end of each Phase and in developing these completion reports will address the areas that would be covered in a gateway review in addition to the specific criteria defined by the DH.

6.10 Contingency plans

In the event that this programme fails, there will be no immediate impact on the delivery of services by the Trust. The impact will be on the Trust's ability to meet a number of mandates set by the DH which are intended to improve patient safety, efficiency and effectiveness. The programme is working to ambitious timescales for the achievement of these DH mandates and even if difficulties are encountered will be able to meet the DH required timescales.

In the event that the Trust is unsuccessful in obtaining DH demonstrator status and related funding, this case will be reviewed and additional options considered before being represented to the Board for consideration.

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A Location identifiers /GLN

A.1 Introduction

The aim of this core enabler is to move to a position where there is a single GS1 compliant schema used for the identification of locations within the Trust that is used by all systems and processes that relate to locations.

A.2 Current situation

The Trust operates from two main sites, namely Maidstone and Tunbridge Wells hospitals. The Maidstone site is owned and maintained by the Trust. The Tunbridge Well's site was procured under the Private Finance Initiative (PFI) and maintenance is the responsibility of the PFI provider.

The Trust's Estates and Facilities department maintain registers of all Trust locations in several spreadsheets. There are around 7000 identified locations across the two sites. All of these have a location identifier label which includes a non-GS1 barcode and a human readable location identifier.

The Estates and Facilities department operates five information systems for building and facilities management purposes, namely:

- Shires (Procurement);
- ElVis (Contractor control);
- Synbiotix (Cleaning Audit and Health & Safety Audits);
- Portertrac;
- Kronos (Time and Attendance).

These all use the location identifiers defined within the spreadsheet registers.

In addition a number of other Trust systems include location related information. These include:

- Procurement systems, which use the 'Requisition Point' as the location to deliver items to.
- Patient Administration Systems, which need to know where the patient is, and any locations that they are scheduled to move to.
- Theatre management systems.

A.3 Target operating model

The target operating model for location identifiers is as follows:

a. A GS1 Registry will be developed from the two existing site specific location registries. This will identify the GRN for the approximately 7,000 locations currently identified within the Trust.

b. The existing bar code labels at each location will be replaced with GS1 compliant bar codes.

c. The Estates Team will take responsibility for managing GLNs for the Trust, including:

1. Entering GLNs for new locations into the GLN registry and ensuring that appropriate GS1 compliant bar code labels are placed at the locations;
2. Maintaining the GLN registry and uploading changes to the national GLN registry;
3. Providing advice and guidance to the Trust and suppliers on the Trust's use of GLNs.

A.4 Approach to meeting DH criteria

A.4.1 Phase 1

The Phase 1 criteria are as follows:

a. A single organisational GLN prefix in place;

b. Trust GLN registry in place;

c. 50% of trust locations allocated a GLN.

The Trust already has an allocated GS1 prefix and has a registry of all locations within the Trust to room level. The existing registry is in a spreadsheet form and it would be very simple to add an additional column and allocate a GLN to each existing record. Allocating GLNs to all Trust locations can therefore be achieved very quickly.

A.4.2 Phase 2

The Phase 2 criteria are as follows:

a. A sustainable organisational structure is in place to administer GLNs;

b. Trust GLN registry 50% populated;

c. 100% of trust locations have been assigned GLNs.

The Estates and Facilities department currently manages the location registry and has agreed to take responsibility for management and administration of GLNs. The approach of re-purposing the existing location registry as the GLN registry means that it is already fully populated and that 100% of trust locations will have been assigned GLNs in Phase 1.

A.4.3 Phase 3

The Phase 3 criteria are as follows:

a. Inventory management systems using GLN identifiers;

b. Trust GLN registry 100% populated;

c. 50% of trust locations (Level 5 rooms and spaces) have GS1 barcodes affixed;

d. Interim case study including costs and benefits produced.

The Trust is planning to procure new inventory management systems and as such these will use GLN identifiers from the time that they are brought into operational use, which is planned to be in the second half of calendar year 2016.

Currently all Trust level 5 rooms and spaces are physically labelled using non-GS1 compliant barcodes and identifiers. Labelling all of the 7000 rooms and spaces required around 30 person-days previously and it is assumed that a similar amount of time will be required to apply GS1 compliant barcodes. This is not a major activity and can be scheduled as required.

The initial case study will be developed based on the actual costs incurred by this point and from discussions with Estates and Facilities staff and other Trust staff as to the benefits and any lessons learned from the implementation of GLNs.

A.4.4 Phase 4

The Phase 4 criteria are as follows:

a. All in-trust systems using GLN identifiers;

b. Trust GLN data is populated into GS1 UK GLN registry;

c. 100% of trust locations (Level 5 rooms and spaces) have GS1 barcodes affixed;

d. Final case study including costs and benefits produced.

The first of these criteria is the most difficult and costly to achieve. Two approaches have been considered:

a. To manually update the location identifiers used in the Trust's systems on a system by system basis.

b. To leave the information in the individual systems as at present and put in a middleware solution to map between the different location schemas.

While the second option was initially attractive, there is uncertainty about the integration capabilities of the various systems and the initial estimates of the cost of this approach appear larger than the cost of updating the systems individually. As such, the proposed approach is to manually update each of the affected systems, though this will be confirmed at the start of the work.

As to the other criteria, population of Trust GLN data into the GS1 UK GLN directory should be straightforward once the formats and upload mechanisms are understood and the labelling of all Trust level 5 locations should have been completed during Phase 3. The final case study will be an update of the interim case study taking into account further experience of updating the various Trust systems and of operating using the GLNs.

A.5 Plan

A project will be defined within the GS1/PEPPOL Adoption Programme to manage the implementation of GS1 compliant location identifiers. The project sponsor will be the Director of Estates and Facilities.

Key tasks will include:

a. Phase 1 (Jan 16 – June 16):

   1. Identify / confirm approach to achieve aim of all Trust systems using GLN identifiers;

   2. Consolidation of the Trust's two site location registries into a single GLN registry, including allocation of GLNs to all Level 5 rooms and spaces;

   3. Support inventory management project to import location information from the GLN registry;

b. Phase 2: (July 16 – Dec 16):

   1. Agreement of terms of reference for GLN administration activities and allocation of these to a role within the Estates and Facilities department;

c. Phase 3: (Jan 18 – Jun 17):

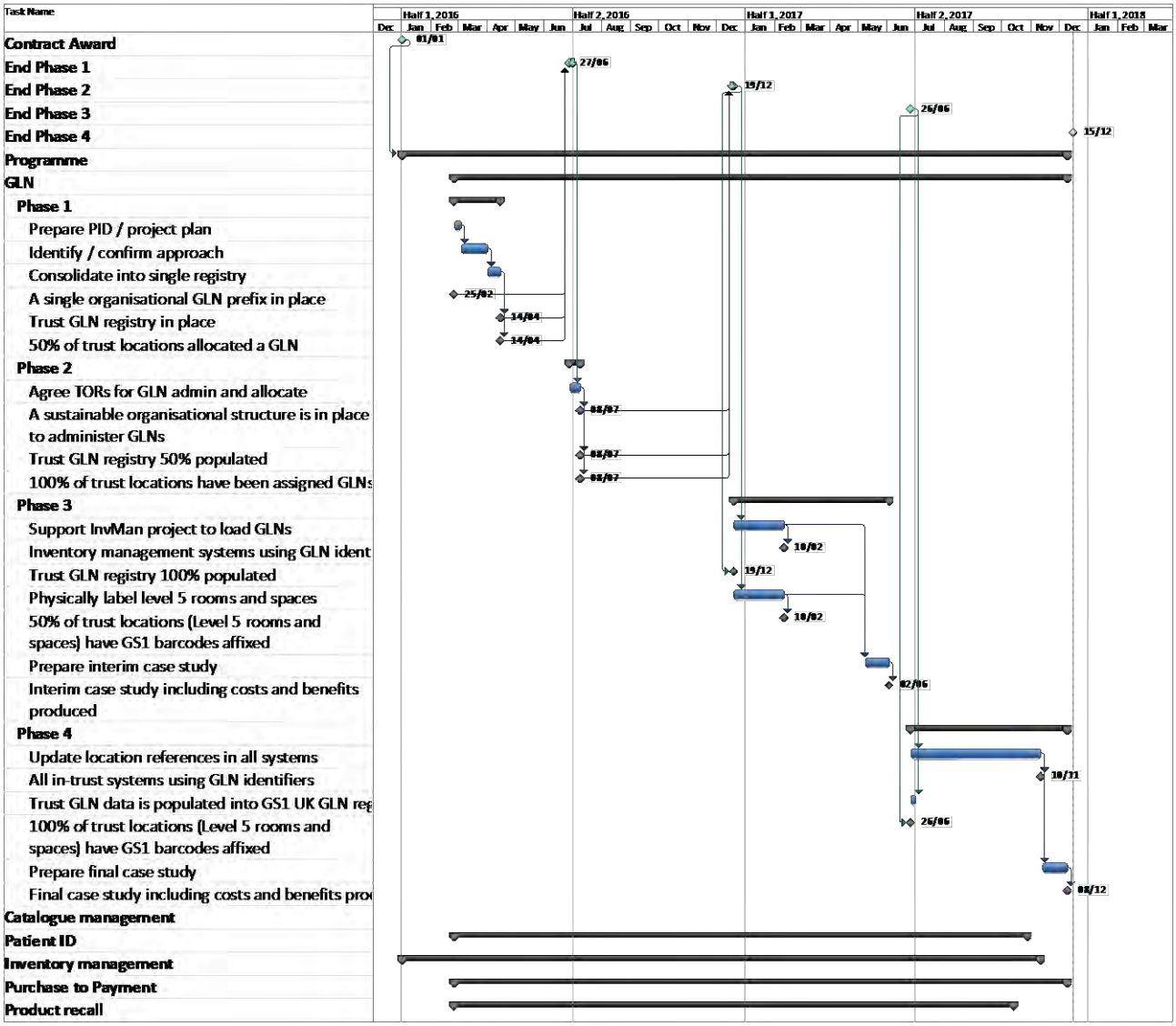
   1. Physically label the 7000 level 5 rooms and spaces across both Trust sites;

   2. Prepare interim case study;

d. Phase 4: (Jul 17 – Dec 17):

1. Update location reference data in all Trust systems, using approach confirmed in Phase 1;
2. Establish process for exporting GLN registry information to the GS1 UK GLN registry and export data for the first time;
3. Prepare final case study.

The Gantt chart for the project is shown below:



A.6 Costs

The costs are estimated as follows:

Description of cost	Estimate	Basis for estimate
Project Lead	£0	Relatively simple task so no Project Manager required (Programme Manager can coordinate)
Confirm approach to system update	£5,000	Small study
Re-do bar codes, effort required	£3,409	Up to 30 person days.
Recode locations in Estate systems	£24,858	Assumes up to 5 systems, each with 7000 locations identified and requiring 3 minutes to change each location.
Recode locations in other systems	£8,878	Assumes up to 25 systems, each with 500 locations identified and requiring 3 minutes to change each location.
Interim case study	£2,500	
Final case study	£2,500	
	£47,145	

A.7 Benefits

The move to the use of GLNs within the Trust puts in place an enabling capability and does not itself provide direct benefits.

A.8 Risks

The main risk with the implementation of GLN's within the Trust is that the cost of changing the location schema in the Trust's various systems has been underestimated because either there are more systems to update than anticipated or that the manual effort required per system is higher than that estimated. The current assumption is that adding a new GLN based location record or modifying an existing location record to use a GLN identifier will take 5 minutes or less and that most systems will have less than 1000 location entries that need to be updated, and that there are 25 systems or less. These assumptions are likely to err on the high side, so there risk of significant under-estimation of the cost is expected to be small.

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B Catalogue management

B.1 Introduction

The aim of this core enabler is to move to a position where there all items procured by the Trust are identified by a GS1 barcode (GTIN), with data on the items being obtained via a single catalogue from an authoritative external source.

B.2 Current situation

Three Trust departments handle the catalogue management of products and services within the Trust: Pharmacy, for pharmaceutical products; Estates, for engineering consumables and services; and Procurement for all others goods and services. All catalogue data is maintained in five disparate systems currently managed by each department internally where data is collected and inputted manually or via upload.

For Pharmacy maintained products, product identifiers are created by the Pharmacy team and data is managed within the JAC system. An external tool is in place that translates purchase orders from the JAC system into the product identifiers recognised by suppliers and wholesalers.

Plans are in place at the Trust to rationalise the systems that the Procurement and Estates departments use for catalogue management. The project will provide a single catalogue management system (GHX Nexus) for all products and services (currently excluding Pharmaceuticals) which is connected to the national Product Information Management (PIM) and GS1 data pool and will provide core, consistent product data to the Trust. The catalogue management tool enables the Trust to select which products and services from the data pool are in use and link Trust specific, regional and national contract information ensuring that all feeder systems are populated with all relevant information.

Pharmacy

Pharmacy catalogue data within JAC does not include or make use of GTIN barcodes. However, a Pharmacy robotic dispensing system is in place that reads barcode labels to put away and pick stock. The majority of pharmaceutical packaging contains a machine readable barcode as a product identifier, but not many are making use of the GS1 GTIN standard. Forthcoming EU legislation called the falsified medicines directive will mandate that all medicine manufacturers place a 2 dimensional barcode, based on the GS1 GTIN standard which holds additional information regarding the provenance of pharmaceuticals. The robot solution at MTW is not currently capable of reading 2 dimensional barcodes.

Estates

Estates catalogue data held within the Shires system does not record or make use of GTIN barcode identifiers. Individual product identifiers, based on the supplier's orderable item code are used instead.

Procurement

Catalogue data held in the Marrakesh (purchase to pay) and EDC (stock management) solutions managed by Procurement do not currently record or make use of GTIN barcode identifiers. Barcodes are in use within the EDC system, which are generated by the application and based on the supplier's orderable item code. An increasing number of manufacturer's products and outer packaging contain a machine readable

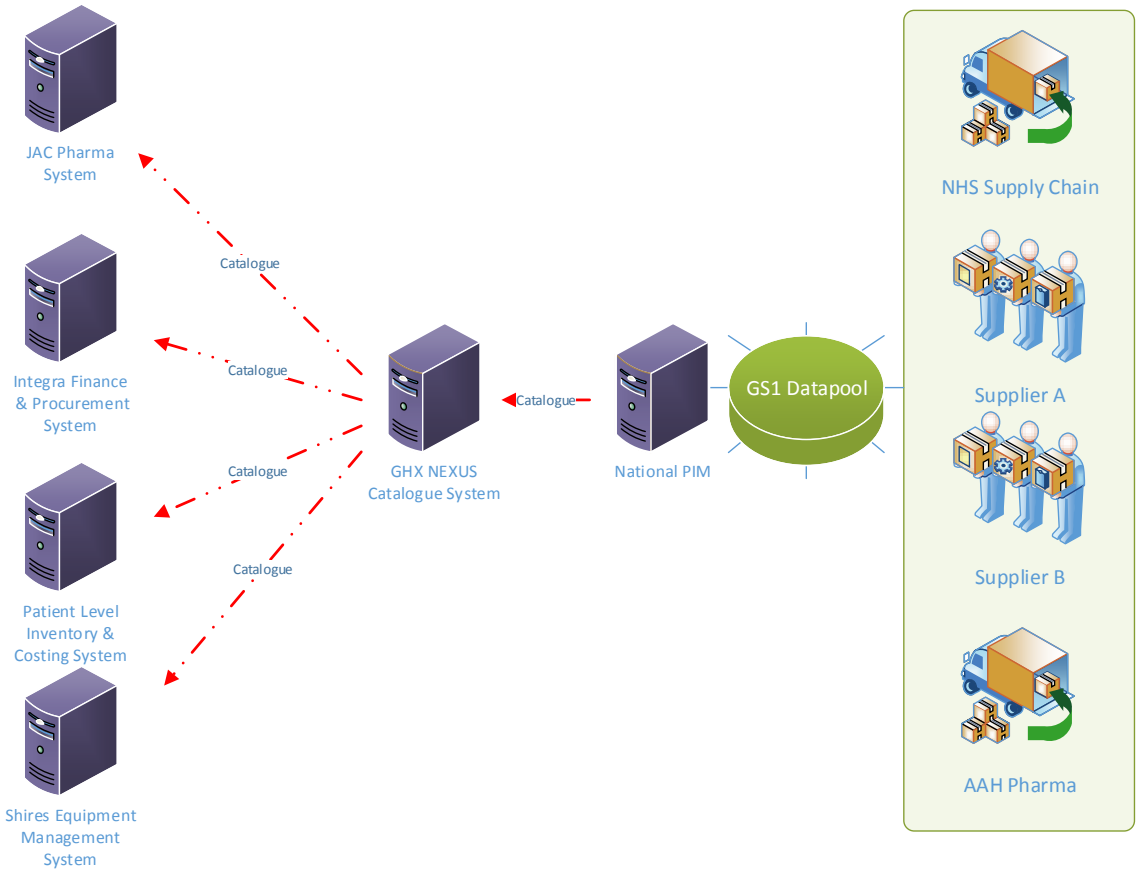
barcode, but not all are using the GS1 GTIN standard. Plans are in place to work with suppliers to identify, record and make use of their own barcode identifiers during the transitional phase to full GS1 adoption in the industry.

The plans to implement a new catalogue management system which will feed individual purchasing systems and processes will include GTIN (and initially, other barcode identifiers) to facilitate the primary use cases. These plans are already in progress, fully funded and scheduled to deliver by the end of 2015/16.

B.3 Target operating model

The target operating model for catalogue management will extend the plans in place to Pharmacy, ensuring that all catalogue data used within the Trust is managed in a central system regardless of product or service category. A single connection to the PIM will exist and subset catalogues including GTIN and other core information will be fed into each primary system with the requirement to hold product information. This will initially include the Purchase to Pay System (Integra), JAC (Pharmacy), and the Trust's Inventory management system which is being selected during 2015/16.

The below diagram demonstrates the flow of information and interoperability between the supplier catalogue data and the Trust systems.



Catalogue data will be managed by the Procurement and Pharmacy departments using existing resources. Their role will be to ensure that all information is kept up to date, accurate and is matched to contract pricing. Performance and strategy will be managed through a single existing organisational committee that is responsible for overseeing the execution and performance of the Trusts Procurement and eCommerce strategy.

B.4 Approach to meeting the DH criteria

B.4.1 Phase 1

The Phase 1 criteria are as follows:

a. A catalogue management system is in place;

b. A detailed as-is to be gap analysis has been carried out.

As discussed in the previous sub-section, the Trust will be extending the GHX Nexus Catalogue system which has been procured under the Trust's Procurement strategy to also support Pharmacy, finance and equipment management systems. It has already carried out a detailed as-is / to-be gap analysis as part of the procurement strategy development and the approach to filling the gaps is discussed in the previous sub-section. As such, the Trust will have satisfied both Phase 1 criteria before the start of the demonstrator period.

B.4.2 Phase 2

The Phase 2 criteria are as follows:

a. 50% of products purchased are listed in the catalogue system;

b. Where appropriate data is sourced from 'provisional central PIM'.

c. Relevant trust systems have been modified to utilise GTINs, GLNs and associated attributes;

The Trust plans to have 80% of all products purchased listed in its catalogue by March 2016. The current scope excludes Pharmacy – which would be the focus of the additional work. As to sourcing data from the 'provisional central PIM', this will be provided by the GHX service once the provisional central PIM becomes available.

The relevant Trust systems that need to utilise GTINs, GLNs and associated attributes include:

a. JAC Pharmacy Stock Control system;

b. Integra finance / procurement system;

c. The Patient Level Inventory Management System (PLIMS) which is currently being procured.

Integra and the PLIMS solution are or will both be GS1 compliant. The JAC supplier has stated that JAC is not GS1 compliant currently but that future versions will be, but without providing a roadmap that explains when GS1 compliance will be achieved and what JAC understands by compliance.

A supplier adoption programme will be carried out to engage with the Trust's supplier community and highlight its ambitions for catalogue management and use of GTIN information. Suppliers will be encouraged to label their products with full GTIN information and upload to the central PIM when available. This will be supported by clear evaluation criteria based on this during procurement exercises and incorporating into KPI's under new and existing contracts where applicable.

B.4.3 Phase 3

The Phase 3 criteria are as follows:

a. Integration of PIM to relevant in-trust systems is in place;

b. 90% of products purchased are listed in the catalogue system;

c. 50% of available master data is taken from the national PIM;

d. Interim case study including costs and benefits produced.

As discussed in Section B.3, the Trust will connect to the PIM via GHX, and the transition from the 'provisional central PIM' to the final PIM will be undertaken by GHX.

The initial case study will be developed based on the actual costs incurred by this point and from discussions with Pharmacy and Procurement staff on the benefits as they see them.

B.4.4 Phase 4

The Phase 4 criteria are as follows:

a. 30% of services purchased are listed in the catalogue system;

b. A sustainable organisational structure is in place to administrate Trust master data;

c. 100% of available master data is taken from the national PIM;

d. Final case study including costs and benefits produced.

The final case study will be an update of the interim case study taking into account further experience of using the catalogue and master data derived from the PIM.

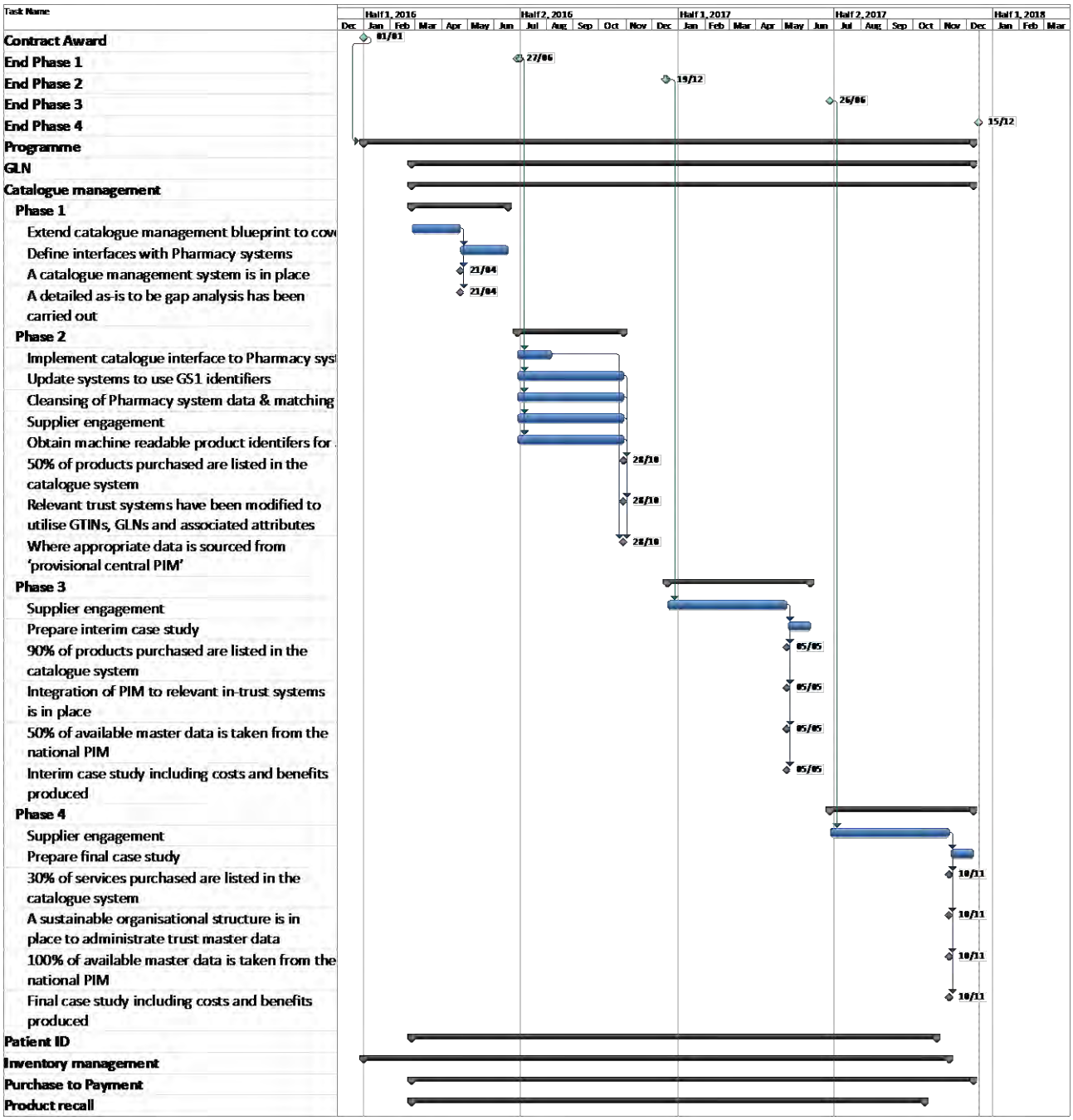
B.5 Plan

Much of the work required to achieve the target operating model is in progress already and set to be delivered by the end of 2015/16. This includes:

- Implementation of catalogue management solution – GHX Nexus
- Development of interfaces between GHX Nexus and trust systems
- Cleansing of current catalogue information and matching to supplier content
- Engagement with suppliers to understand their GS1 adoption roadmap
- Collect machine readable product identifiers for all products in use in the hospital

Under the GS1 and PEPPOL adoption programme, the scope of the above activity will be extended to Pharmacy workflows and systems including any connectivity. The adoption programme will measure progress against:

- Connectivity of enabling solution and systems in place
- % of products and services in catalogue with machine readable identifiers
- % of products and services in catalogue with GS1 compliant GTIN identifier
- % of products and services purchased are listed in the catalogue


Task Name
Half 1, 2016
Half 2, 2016
Half 1, 2017
Half 2, 2017
Half 1, 2018
Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Contract Award
End Phase 1
End Phase 2
End Phase 3
End Phase 4
Programme
GLN
Catalogue management
Phase 1
Extend catalogue management blueprint to cov
Define interfaces with Pharmacy systems
A catalogue management system is in place
A detailed as-is to be gap analysis has been carried out
Phase 2
Implement catalogue interface to Pharmacy syst
Update systems to use GS1 identifiers
Cleansing of Pharmacy system data & matching
Supplier engagement
Obtain machine readable product identifers for
50% of products purchased are listed in the catalogue system
Relevant trust systems have been modified to utilise GTINs, GLNs and associated attributes
Where appropriate data is sourced from 'provisional central PIM'
Phase 3
Supplier engagement
Prepare interim case study
90% of products purchased are listed in the catalogue system
Integration of PIM to relevant in-trust systems is in place
50% of available master data is taken from the national PIM
Interim case study including costs and benefits produced
Phase 4
Supplier engagement
Prepare final case study
30% of services purchased are listed in the catalogue system
A sustainable organisational structure is in place to administrate trust master data
100% of available master data is taken from the national PIM
Final case study including costs and benefits produced
Patient ID
Inventory management
Purchase to Payment
Product recall
01/01
27/06
19/12
26/06
15/12
21/04
21/04
28/10
28/10
28/10
05/05
05/05
05/05
05/05
10/11
10/11
10/11
10/11

B.6 Costs

The costs for introducing GS1 / PEPPOL compliant catalogue management are estimated as follows:

Description of cost	Estimate	Basis for estimate
Project manager	**£0.00**	Relatively simple task so no Project Manager required (Programme Manager can coordinate)
Catalogue implementation	£15,000	JAC integration / implementation
Cat man revenue costs	£3,000	Annual cost to connect JAC
Interim case study	£2,500	
Final case study	£2,500	
Total	**£20,000 plus £3,000 recurring**	

B.7 Benefits

Catalogue management enables benefits in other areas but does not itself deliver direct benefits. The enabled benefits are accounted for against the use cases to which they apply, in this case Purchase to Payment.

B.8 Risks

Catalogue management is a mature activity with off-the-shelf services available. As such the primary risk in this area is around the connection of the Pharmacy system (JAC) to the catalogue. It is assessed that the costs identified will be sufficient and that not additional budget for risk is required.

C Patient Identifier

C.1 Introduction

The aim of this core enabler is to move to a position where all of the Trust's systems use a common identifier for any patient and the patient identity is verified by scanning the GS1 compliant bar code on the patient wrist band prior to the delivery of care.

C.2 Current situation

Currently the Trust prints GS1 compliant bar codes on all patient wrist bands but does not use the bar codes for patient identification. There are many clinical and other information systems that hold patient identifiers and these generally use a mix of NHS numbers and locally generated 'Hospital numbers'.

C.3 Target operating model

The future vision is that:

- All patients will be given a GS1 compliant bar-coded wrist band on admission (as at present);
- The bar code will be used to confirm patient identity for all POC interactions, including for example:
  - taking measurements (eg blood pressure, temperature, heart rate);
  - administering medicine or taking a sample for diagnostic purposes (eg blood, urine, etc);
  - taking an x-ray or other image.
- The wrist band bar-code will be read using a variety of devices, including:
  - tablets used by medical staff (nurses, doctors, etc), running applications, including PAS client;
  - barcode readers attached to static terminals, eg X-ray and ultra-sound machines;
- The Trust's information systems will all be able to relate information captured to the specific patient based on the GS1 identifier captured when scanning the patient wrist-band.

To deliver this vision the following changes need to be made:

People All clinical staff trained to scan the wrist band to identify the patient prior to delivery of any care. All new staff trained as part of their induction / initial training on joining the Trust	**Process** Point of care processes designed to include scanning to confirm patient ID prior to care delivery. Fall back processes designed to ensure continuity of care if systems are not available
Technology Wrist-band scanning enabled from mobile platforms and scanners connected to medical equipment and pcs System integration enables relevant systems to capture patient ID from wrist band scanner and record the ID with the action carried out	**Information** automatically captured to include: • Patient Identity via GS1 barcode • Care-giver (via logged-on identity) • Observations captured in 'Nerve-centre' with time • Medicines or devices associated with patient

Achieving the target operating model will build on a number of the Trust's existing strategies and initiatives.

C.4 Approach to meeting the criteria

C.4.1 Phase 1

The Phase 1 criteria are as follows:

- Criteria 1.1: 50% of appropriate in-patients have GS1 wristbands given on admission

  The Trust already has barcodes printed on all patient wrist-bands on admission. The current wrist band printing solution will be updated when the new GS1 compliant PAS is brought into use in mid-2015.

- Criteria 1.2: AIDC scanning technology & hardware provider agreed

  The Trust has been working on the provision of mobile devices for use by all nursing and medical staff for nearly two years under its Project 'Gladstone', which is aimed, inter-alia, at reducing and, in time, eliminating the use of paper records. Some 1200 devices are being deployed, covering all patient care interactions for in-patients. Currently devices have been rolled out to the Tunbridge Wells site, with the roll-out to the Maidstone Hospital site being scheduled for completion by the end of 2015 (calendar) year. The initial deployment is limited to in-patients because it relies on accessing patient care information from the PAS. The business case includes budget to provide bar-code scanner peripherals for use with all of these devices. The option of scanning using the device cameras was considered but was not thought to be fast or reliable enough.

  Scanning hardware is only a part of the solution and it is equally important to consider the applications aspects. Applications are required that are able to drive the scanning process and make appropriate use of the captured identity. The two applications that most users will interact with most often are:

  - the Patient Administration System;
  - the 'Nerve-centre' application which is used for recording observations, nursing handover, medical handover, 'hospital at night' and task management.

  These two applications are then able to interface to other clinical systems.

  A PAS client will be developed to run on the Trust's mobile devices that is capable of scanning patient wrist bands. Discussions have been initiated with the Nerve-centre application provider and the supplier is currently trialling scanning solutions for patient identification.

- Criteria 1.3: Detailed processes and training plans in place to roll out point of care scanning including patient identification.

  Patient identification is currently a standard step within the processes and training for the use of the Nerve-centre application and it will be a step within the use of the new PAS, for which the training has to be developed. The team responsible for training users in the use of Nerve-centre have commented that the full training for Nerve-centre requires about 15 minutes per user and is delivered using videos stored on the mobile devices themselves. It was commented that training an existing Nerve-centre user to scan the patient wrist-band to identify the patient should require only a few minutes as the devices and the application were very intuitive and it is only a single step that is changing. It was also commented that the same approach to training, ie providing training videos on the device itself, would be suitable.

C.4.2 Phase 2

The criteria for this Phase are as follows:

a. 100% of appropriate in- patients have GS1 wristbands given on admission

This will be completed in Phase 1, subject to the replacement of the PAS in mid-2015.

b. Relevant in-trust systems ready to store, receive and transmit to point of care scanners, EPR etc

The focus of this requirement is the use of wrist band scanning for patient identity confirmation at point of care. Care in this context can take a variety of forms, including for example:

1. Admitting the patient;
2. Recording basic details (name, address, age, height, weight, next of kin, etc);
3. Recording of symptoms or details of conditions for which they have been admitted;
4. Recording of observations (blood pressure, heart rate, temperature, blood oxygen level, etc);
5. Recording of notes / completion of forms;
6. Administering medicines (and recording of the administration);
7. Taking samples for diagnostic purposes (eg blood, swab, urine and other samples);
8. Diagnostic imaging (ultra-sound, x-ray, CT scan, etc);
9. Other treatment (surgical, radio-therapy, etc);
10. Transferring the patient between locations (eg wards);
11. Handover of the patient from between nurses or doctors on change of shift or change of ward;
12. Discharge.

The majority of these point of care scenarios will be managed using the PAS (items 1, 2, 3, 10, 12) or Nerve-centre (4, 6, 7, 11), both of which are planned to be able to verify the patient identity by scanning the barcode. Notes and forms will be accessible from within the PAS and Nerve-centre application contexts (due to integration between the PAS and Nerve-centre applications and the underpinning e-Notes and e-Forms services) and as such will not need to capture the patient ID directly. It is expected that the PAS and Nerve-centre will between them account for the vast majority of instances of care, since items (8) and (9) above will not happen very often for any patient. As such, it is expected that once the PAS and Nerve-centre use wrist band scanning for patient ID, the patient ID will be confirmed by scanning in more than 90% of patient care instances.

In addition to the PAS and Nerve-centre, there are 25 systems used in specific specialist areas, though not all are used with the patient present, with around 15 being used at point of care with in-patients. The majority of the systems are commercial off the shelf (COTS) and as such their suppliers will have a commercial interest in making them GS1 / PEPPOL compliant in time, but not necessarily on the timescale of the demonstrator programme. The Trust therefore has a number of options:

1. To replace all of the systems with equivalent systems that have been designed to be GS1/PEPPOL compliant within the 2 year demonstrator period;
2. To contract with the system suppliers for them to modify their systems to be GS1/PEPPOL compliant earlier than they would otherwise do and, where appropriate, to add any necessary scanning capabilities;
3. To re-purpose existing fields within the systems to hold information as required to make the systems GS1 compliant;
4. To identify middleware or other system integration based approaches to deliver the required benefits (eg patient ID validated by scanning the wrist band, common patient identifier allowing patient data held in different systems to be linked up) with the minimum necessary change to existing systems.

Options 1 and 2 above would be prohibitively expensive and the scale of the change would in any case by too large to achieve within a two year period. A pragmatic combination of options (3) and (4),

taking a portfolio approach where systems are planned for near-term replacement, combined with the implementation of the scanning capability within the new PAS client and Nerve-centre, is therefore the planned way forward to meeting this criteria.

c. Point of care scanning for patient identification in place in 50% of the trust

This will be achieved when the Nerve-centre and PAS scanning processes have been brought into use across one of the main sites.

C.4.3 Phase 3

The criteria for this Phase are as follows:

a. Scanned information is stored in relevant systems. EPR etc

For this enabling capability, the core information scanned is the GSRN, which consists of an organisational identifier combined with the patients NHS number and a checksum. There is additional information encoded in the 2d barcode, but it is only the NHS number encoded in the GSRN that is needed to enable patient attribute information to be pulled from the PAS as this is the primary identifier used across the Trust's information systems.

b. Point of care scanning for patient identification in place in 100% of the trust

This will be achieved when the Nerve-centre and PAS scanning processes have been brought into use across both sites.

c. Interim case study including costs and benefits produced

The case study will be developed based on the actual costs incurred by this point and from discussions with users and clinical managers as to the benefits and any lessons learned from the implementation of point of care scanning.

C.4.4 Phase 4

The criteria for this Phase are as follows:

a. Sustainable organisational structure in place to administer trust systems and processes

The systems aspects of the GS1/PEPPOL adoption are the responsibility of the Health Informatics Department who will include GS1/PEPPOL compliance as part of the approvals process when considering the procurement of new information systems and major changes to existing ones.

Processes will remain under the ownership of the relevant professional discipline, so for example the Trust's Clinical Director will be responsible for patient of care scanning processes, though implementation of training once the processes are agreed will be undertaken by the project team delivering the change.

b. Final case study including costs and benefits produced

This requires the interim case study produced during phase 3 to be updated to take into account the full costs of the implementation and a more informed assessment of the benefits and lessons learned from the completion of the roll out.

C.5 Plan

Based on the assessment above, the activities to be undertaken are as follows:

a. Phase 1:
   1. Confirm approach to implementation of point of care scanning;
   2. Develop architecture / high level design and plan for implementation;
   3. Agree future point of care scanning 'business' processes;
   4. Specify and procure changes to Nerve-centre to provide scanning capability;
   5. Specify and procure any changes needed to the PAS to provide integral scanning capability;

b. Phase 2:
   1. Roll out of Nerve-centre and PAS scanning capability;
   2. Undertake system integration / upgrade activities in accordance with the high level design;
   3. Develop training material;
   4. Deliver training and implement POC scanning processes at one site <<which site>>

c. Phase 3:
   1. Monitor the POC scanning processes, identify improvements and update training material;
   2. Deliver training and implement revised POC scanning processes at second site;
   3. Implement any improvements to POC processes at initial site;
   4. Continue with any further system integration / upgrades;
   5. Conduct interviews and workshops with delivery teams and users of POC scanning processes to identify costs, benefits and lessons;
   6. Prepare interim Case Study;

d. Phase 4:
   1. Agree and implement any further improvements;
   2. Conduct second round of interviews and workshops with delivery teams and users of POC scanning processes to identify costs, benefits and lessons after longer period of use and following improvements responding to previous feedback;
   3. Prepare final Case study.

Assuming four six-month phases, project timing is shown in the following Gantt chart.

C.6 Costs

The costs for patient identification from a GS1 barcode on the patient wrist band are estimated as follows:

Description of cost	Estimate	Basis for estimate
Project manager	£0	Assume done by programme Clinical Engagement Lead so no additional cost.
Cost of additional bar code readers	£360,000	Assume 1200 bar code readers at £300 each for use with mobile platforms
Develop design / integration plan	£25,000	Up to 50 days work from Informatics lead
Upgrade to Nerve Centre	£60,000	Assume £50k for supplier and £10k to specify
Upgrade to PAS for scanning	£0	Not needed as hardware scanners now being used
Integration costs	£150,000	15 applications at £10k each
Agree new processes	£5,000	Assume Clinical Engagement Lead does this
Prepare training material	£5,000	Assume Clinical Engagement Lead does this
Ward training costs	£160,000	40 wards / clinical areas @ 10 days each at £400/day
Other training costs (medic groups)	£20,000	
Prepare interim case study	£2,500	Clinical Engagement Lead
Prepare final case study	£2,500	Clinical Engagement Lead
Total	**£790,000**	

Of this £360k is for hardware, £50k to software suppliers to extend their applications to better support scanning, £150k for system integration and related activities to make the other clinical applications work from the GS1 patient ID and £180k for training. The remaining tasks will be undertaken by the Clinical Engagement Lead and the Informatics Lead.

C.7 Benefits

Implementation of point of care scanning will provide a number of benefits:

- Increased patient safety by reducing the risk of patient misidentification;
- Improved traceability of medicines and devices to the individual patient, enabling:
    - Reduced cost and timescale to identify what medicines and devices have been used on a specific patient;
    - Reduced cost and timescale to identify patients that have received a specified batch or Lot of medicines or devices in a product recall situation;
    - Better ability to cost the medicines and devices used in treating a particular patient. When combined with information about the procedures undertaken, this will provide a better understanding of the cost of different procedures / treatments. When combined with information about other patients with similar conditions treated with different medicines or devices and their respective outcomes, it will enable the Trust to identify the treatments that provide the best outcome and so improve the treatment provided to future patients as part of the Trust's continuous improvement approach.

C.8 Risks

The main risks to the delivery of this capability are as follows:

Risk	Owner	Likelihood	Impact	Score	Mitigation
1. There is a risk that some systems cannot make use of the mobile scanners	Patient ID project	Possible (21%-50%)	Minor (2-20k)	6	Buy a small number of dedicated wired scanners for use with particular systems. Cost likely to be limited to a few tens of scanners at a few £100 each, so < £10,000.
2. There is a risk that ward and other clinical staff require more training or follow up to embed the use of POC scanning	Patient ID project	Unlikely (6-20%)	Moderate (repeated failure to follow procedures)	6	Recruit ward level change agents / champions and extend training / monitoring period.
3. There is a risk that the cost of upgrading systems to GS1 compliance is significantly higher than budgeted for	Patient ID project	Possible (21%-50%)	Moderate (20k – 1m)	9	Budget is £150k, based on up to 15 systems at £10k average cost. The uncertainty in this will be reduced early in Phase 1. If it is found that the cost if higher then the Trust could choose to postpone upgrades to systems with few users.

D Inventory management

D.1 Current situation

D.1.1 Pharmaceuticals

Drugs are purchased, stored and managed centrally in the Pharmacy department in each main trust site on behalf of all wards and clinical departments. This central stock is then issued as stock to individual departments or specific patients based on prescription.

Pharmaceutical inventories in the central store are managed through the core JAC system, supported by Pharmacy robots which are used for storage and picking of product. JAC is not currently fully GS1 compliant, but is able to use product barcode identifiers to capture demand and use location identifiers to issue stock to wards and departments, linking patient identifiers to prescriptions is also possible. The robots within each Pharmacy department utilise barcodes printed on drug packaging to identify the product, and store within the robot storage compartment. This barcode is then used to retrieve the correct product upon request.

JAC has the functionality to capture and record LOT numbers and expiry of products held within the central inventory, but this functionality is not currently used. Suppliers currently utilise a mixture of barcoding standards for their products, namely GS1 and HBIC standards. There are still a number of manufacturers who do not place a machine readable code on their packaging. Workarounds are in place to handle this.

Unique Device Identification standards and forthcoming Falsified Medicines legislation will require that GS1 standard barcodes are used on all packaging with extended information held within a 2-dimensional barcode. Currently, the pharmacy robots have linear scanners and require an upgrade to read the new standard identifiers.

Pharmaceutical stock held in wards and departments is managed by a team of pharmacy technicians who use a manual top-up process to check stock against pre-agreed levels and enter a replenishment order onto the JAC system for products below the required level. It is not clear how much stock or the value of stock held at any one time and there are risks around security and misuse of this stock.

D.1.2 Clinical Supplies

General clinical supplies are managed by the Procurement Department at the point of use in each Ward and clinical department. This stock is managed using an electronic top-up system, based on agreed minimum and maximum stock levels which uses barcodes (produced by the system) as the data collection method for demand. Visits are made to each area on a regular basis and stock on hand is counted to identify which product lines are below agreed re-order levels. Requisitions for products requiring replenishment are processed electronically and purchase orders are sent to the relevant suppliers. There is no capturing of expiry date information and the process does not currently make use of barcode product identifiers on manufacturer's packaging. Current stock holding can be estimated, but does not provide an accurate value without a full stocktake being carried out which is extremely labour intensive.

Specialist and high cost consumables are often managed directly by senior clinical staff (band 6 and 7). This includes implantable devices such as orthopaedic implants and cardiac stents, ICD's and Pacemakers. Stock levels are monitored by these clinical staff manually, often taking up to 3 days of their week to monitor

stock and place orders, diverting them away from patient focussed activity. Orders are placed directly with suppliers using pre-authorised call-off orders placed with the supplier.

As part of the Trust's Procurement Transformation Programme, plans are in place and deployment has started to procure and implement a full inventory management solution for clinical supplies. Deployment will commence in April 2016 and will conclude by March 2018. The solution will be fully GS1 compliant and will use GS1 barcodes to track the usage and consumption of products to individual patient. Inventory will be measured and tracked in real time and replenishment will trigger automatically as stock on hand reached pre-defined re-order levels. The new solution will cover all items held in stock within the organisation and will free up clinical time spent on checking and managing stock. The solution will also ensure that the right product is available for the right patient at the right time and will reduce costly cancellations of operations and other procedures that have previously been caused by lack of product availability. Expiry dates for products will be tracked with triggers and reports being raised where stock is nearing expiry and requires rotation or sending back to the supplier, avoiding costly wastage and risks to patient and caregiver through the use of expired product.

Whilst this solution meets the requirement for the inventory management use case, its scope is limited to clinical supplies and devices used by wards and clinical areas.

D.1.3 Catering

Provisions are stored by the Catering department for consumption and processing. Stock levels are maintained manually and are controlled by catering supervisors. Inventory is confined to use by the catering department and represents a small amount of the total inventory held within the Trust.

D.1.4 Engineering parts

Spare parts for engineering and medical devices are held within two stores within the Trust. These inventories are managed closely within the Shires system and are reserved for use by the Electro-Medical Engineering and Estates Departments. Inventory levels are maintained manually and orders are placed as items are used. This represents a small amount of the total inventory held at the Trust.

D.1.5 Blood

In 2014 the Trust implemented phase 1 of its electronic blood management system (Bloodhound) which incorporated controlled access to blood storage fridges that included inventory management and validation that the correct blood is being issued to the patient requiring it and checking integrity of the unit. Alerts are configured in the event that

- A unit has expired
- A unit of blood has been out of the fridge longer than allowed
- The incorrect unit is removed

The system does not currently extend to validation and tracking to the point of administration (transfusion), which introduces risks from when the blood leaves the fridge until administered. The extension of this solution to bedside would meet an MHRA requirement that 100% traceability of blood is available and, with modification, will meet the GS1 & PEPPOL adoption requirement for inventory management and product recall on this category of inventory.

D.2 Target operating model

D.2.1 Single Patient Level Inventory Management System

A single solution will be implemented in all clinical areas for the management of inventory for pharmaceuticals and clinical consumables. All consumables required for use by clinical departments (with the exception of Blood) will be held and stored within the solution in each area, with pre calculated reorder levels (ROL) and reorder quantities (ROQ). Inventory that requires a high degree of control and security, such as high cost or controlled pharmaceuticals and implantable devices, will be stored in a "closed" environment with access control and in some cases secondary validation. Items picked from closed systems will recorded as issued to a specific patient with LOT (or in some cases Serial) numbers tracked to the issue to enable product recall and itemised patient / service level costing.

General, or bulky consumables such as gloves, needles, syringes, fluids and uncontrolled drugs will be stored within an "open" environment enabling fast, unrestricted access to products. Usage will be captured via hand held devices and in some cases linked to patient used, and others to "floor stock". For example, a box of gloves may be taken from stock to replenish a dispenser on a ward – single gloves would not be recorded as used on a patient. Bulky products that are consumed by a patient such as fluids would be tracked to a patient level using the hand held devices.

The solution would monitor real time inventory levels and stock on hand in each area, automatically triggering replenishment requisitions when stock levels reach the predefined reorder levels. Requisitions would then be automatically routed to the supply source which could include;

- Central stores / parent inventory location via picking tickets;
- Pharmacy central inventory via replenishment request to JAC;
- Supplies requisition via electronic request to Integra.

GLN extensions would be assigned to each storage location and bin location which would be grouped to a GLN indicating the room that the store is held. This GLN information would be used as the identification of which area a product was used, where it is held and where to deliver / replenish to.

Caregiver information will be tracked through the logged in user, or in the case of operations, the assigned surgeon.

Functionality will exist within the solution for staff to quickly locate product in other areas in the event of stock out. Stock on hand will continually be monitored by inventory teams responsible for the product range – low levels of product will trigger alerts and proactive action will be undertaken to replenish the levels outside of scheduled replenishment visits. Transfers of stock between locations will be captured electronically and budgets and usage history updated accordingly.

Expiry dates of certain products will be monitored within the system, with locations with expiring product being flagged up with enough time to redistribute to other areas of the hospital, other hospitals or return to the supplier; avoiding wastage. Wastage will be recorded electronically enabling a clear understanding of costs at a patient level and wastage that could be targeted for reduction.

Central stores and warehouses, including those products held by catering, domestic and engineering stores will be stored in an "open" environment with access control on the door to the store room. Issues would be either direct to patient or floor stock or be based on a picking request from a secondary store.

Inventory levels would be continuously reviewed based on historical trends, actual usage and economic purchase quantities. Stock on hand would be audited through regular cycle counts and physical counts

which would update the solution – variances would be written off as wastage. Stock levels will be reduced the requirement to keep buffer stocks related to infrequent stock checks and replenishment reduces due to automatic replenishment. Less space will be required for storage as a result as product is ordered little and often and demand is managed closely.

Product information including GTIN product identifier will be populated from the central catalogue management solution which will make updates to product information whenever there is a change.

Patient information will be fed into the solution from the Trusts PAS HL7 feed and patient identification will be through scanning of GS1 barcode (where handheld devices are used) or selection from a list of patients assigned to the area.

Replenishment orders would be fed through to the relevant system, either JAC for pharmaceuticals and Integra for supplies which would generate an automated purchase order, sent via the PEPPOL Access Point to Suppliers. Order details would then be fed back to the inventory system ready to match receipts when the goods are delivered.

D.2.2 Tracking of bloods to patient

The Bloodhound tracking and inventory solution will be extended to bedside where administration of blood will be captured at patient level by scanning the barcode of the blood (issued from the intelligent fridge) and scanning of the patient wristband and location barcode. The solution will validate that the correct blood type and serial number has been issued to the patient to avoid incorrect blood transfusions.

D.2.3 Supply Chain Consolidation

As the Single PLIMS and blood tracking solutions are implemented, a review will be carried out in each area by a multi-disciplinary team responsible for the management of the internal supply chain to review where logistics and supply processes could be consolidated and rationalised. This would include:

- Delivery consolidation and scheduling
- Consolidation of internal central stores and external deliveries
- Review of who checks and verifies stockholding at the point of use

D.3 Approach to DH criteria

D.3.1 Phase 1

The criteria for this Phase are as follows:

a. A detailed plan is in place to manage inventory across all trusts departments

b. Review of existing technical solutions for inventory management undertaken

The Trust has recently completed a Procurement Strategy during which a full review was undertaken of all aspects of procurement and inventory management across the Trust. The Procurement Department is currently leading the procurement of a new inventory management solution for the Trust, supported by Pharmacy and Estates and Facilities, the other departments which procure and manage inventory.

As part of preparing this business case, a range of possible approaches to ward level inventory management have been considered, These all included the use of scanning when stocking the local storage

areas and when removing items from these local stores, but differed in the way that access to medicines is controlled. Options for such access control considered included:

a. Open storage for all medical supplies and drugs;

b. Use of existing secure cabinets for controlling access to controlled drugs, combined with open storage of other items;

c. Improved access control using existing secure cabinets (eg by using electronic key fobs issued to individuals with locks on individual containers that control which staff can access which containers and also record such access) for controlled drugs, combined with open storage of other items;

d. The purchase of specialist medicine cabinets that are integrated with the inventory management system, providing a high degree of control over access to controlled drugs, again combined with open storage of other items.

Option (a) was discounted because it does not meet requirements for manging access to controlled drugs. Option (d) was investigated, with the 'Omnicell' solution being piloted in one ward, but this was found to be prohibitively expensive, with a cost of over £1.5m for the Trust. In the short term the decision has been taken to adopt option (b), as it maintains the current level of security, while allowing inventory management to move forward at pace. In parallel the Pharmacy department is exploring option (c) which has a number of benefits over option (b) (in terms of more granular access control, improved accountability and reduced risk of keys being taken off-site) but at a much lower cost than option (d). As well as identifying the option to be procured, the Trust has identified how the new PLIMS capability will need to be integrated with other Trust systems, including Integra for ordering and JAC for Pharmacy.

This means that these criteria have already been met.

D.3.2 Phase 2

The criteria for this Phase are as follows:

a. A sustainable organisation is in place to manage inventory across all trust departments

b. Implementation of inventory management processes commenced

c. Creation of web requisitions has reduced by 50%

d. Investment case produced to upgrade technical solution set where needed

The Procurement and Pharmacy departments will develop joint ways of working as the new PLIMS and associated working practices are identified and hence meet the sustainable organisation criteria. It is expected that during this Phase the new processes will be rolled out to one site, as the PLIMS implementation at that site is completed. The investment case for the new PLIMS solution has already been made within the Trust's Procurement Strategy and this is the only technical solution set required.

D.3.3 Phase 3

The criteria for this Phase are as follows:

a. Business case produced for the creation of a single in-trust logistics function

b. Implementation of auto-replenishment of inventory using GLNs and GTINs commenced

c. Creation of web requisitions has reduced by 75%

d. 25% of relevant products can be tracked by batch or serial number to the patient record

e. Full technical solution set available for deployment across the whole trust

f. Interim case study including costs and benefits produced

As the single PLIMS and blood tracking solutions are implemented, a review will be carried out in each area by a multi-disciplinary team responsible for the management of the internal supply chain to review where logistics and supply processes could be consolidated and rationalised. The required business case will be prepared based on the outcome of this work and is expected to cover:

- Delivery consolidation and scheduling
- Consolidation of internal central stores and external deliveries
- Review of who checks and verifies stockholding at the point of use

It is expected that the use of auto-replenishment of inventory using GLNs and GTINs will have started in Phase 2, when the PLIMS solution was rolled out to the first site. During this Phase these processes will be rolled out to the second site. It is also expected that tracking of products by batch or serial number will have been started in the previous phase, in line with the roll out of the PLIMS, and that by end of this phase the full technical solution will have been deployed, rather than just being available for deployment.

D.3.4 Phase 4

The criteria for this Phase are as follows:

a. Business case for the creation of a single in-trust logistics function agreed by the trust board

b. Trust-wide inventory levels represent an average of less than 3 weeks cover

c. Less than 0.5% of purchase orders are generated by web requisition

d. 50% of relevant products can be tracked by batch or serial number to the patient record

e. Deployment of technical solution commenced

f. Final case study including costs and benefits produced

The achievement of these criteria will generally occur based on the activities that have already occurred during the previous phases. Measures will be in place from phase 1 to track performance and progress against the key criteria. Relevant products from tracking by bath or serial number to patient are defined by the Trust as “implanted, invasive or physically consumed products” such as ICD’s, Prosthesis, Pharmaceuticals and X-Ray detectable swabs amongst others.

D.4 Plan

Based on the assessment above, the activities to be undertaken are as follows:

a. Phase 1:

   1. Complete procurement of PLIMS and Blood Hound 2;
   2. Finalise Inventory Management / logistics blueprint and plan, covering Procurement, Pharmacy and also clinical staff (who will be required to scan items when taking them from store and for tracking at patient level);
   3. Develop training plans and materials;
   4. Establish baseline stock holdings and web requisition volumes, to enable benefit tracking, and identification of products to be tracked at patient level and / or LOT / Serial level

5. Supplier engagement, including ensuring that contracts enforce GS1 compliance and, where relevant, agree any options for return of excess stock;

b. Phase 2:

1. Roll-out PLIMS / Blood Hound 2 to initial areas. The decision as to whether to roll out by site or by type of area (eg wards, clinical areas, theatres) will be made in Phase 1;
2. Integrate PLIMS with other systems (eg Integra, JAC), including all necessary testing of interfaces and end-to-end processes;
3. Train affected staff in new processes;
4. Compliance monitoring and support as new systems and processes are brought into use;
5. Further Supplier engagement as required;

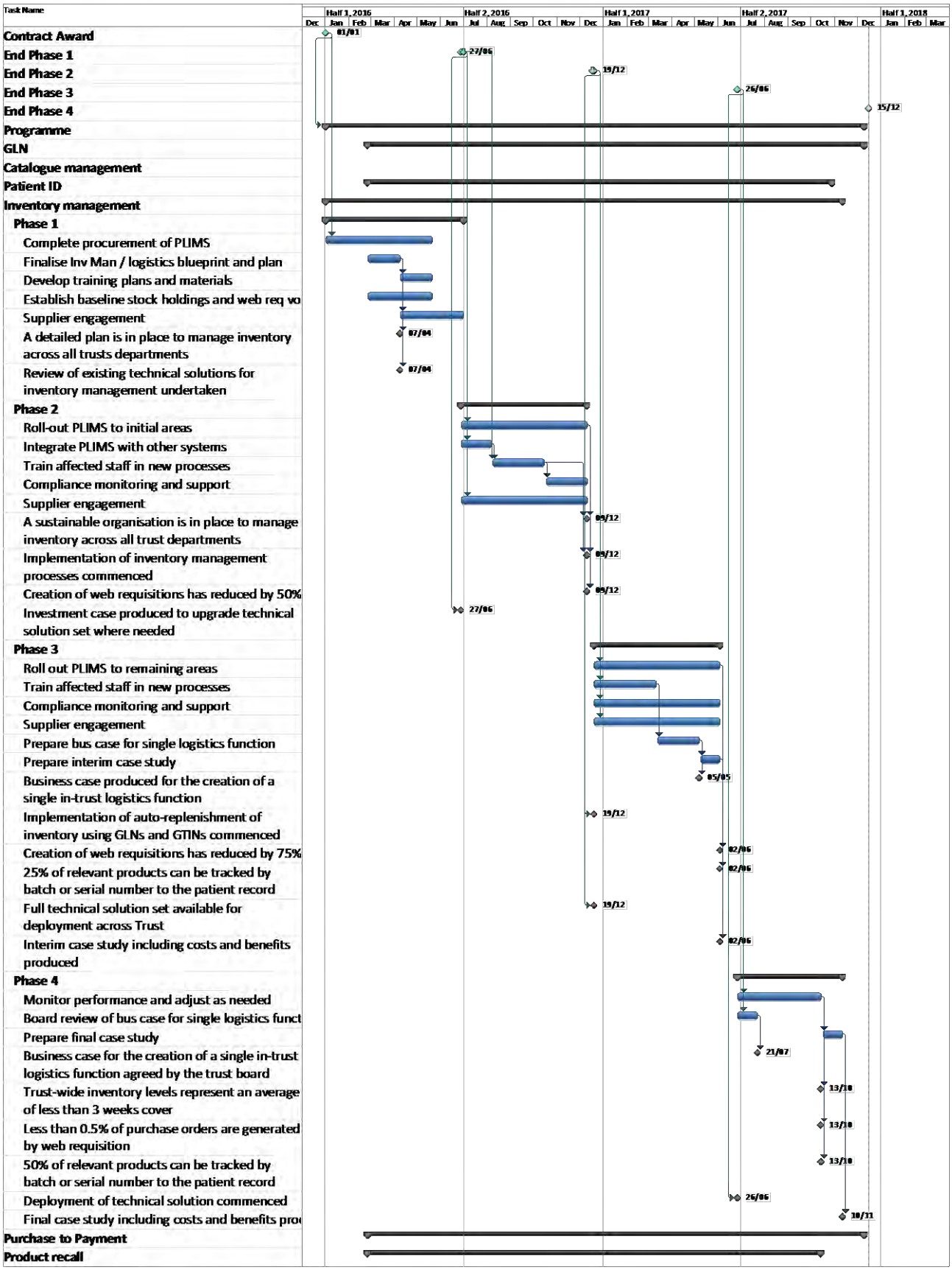
c. Phase 3

1. Roll out PLIMS to remaining areas;
2. Train affected staff in new processes;
3. Compliance monitoring and support;
4. Supplier engagement;
5. Develop operating model and prepare business case for single logistics function;
6. Prepare interim case study;

d. Phase 4

1. Monitor performance and adjust as needed;
2. Board review of business case for single logistics function;
3. Prepare final case study.

Assuming four six-month phases, project timing is shown in the following Gantt chart.



D.5 Costs

The following costs have been estimated for Inventory Management:

Description of cost	Estimate	Basis for estimate
Cost of PLIMS system / maintenance and associated procurement and implementation costs	£0	This is already funded by the Procurement Strategy
Finalise Inventory Management / logistics blueprint and plan	£10,000	Will be undertaken by Logistics lead supported by managers within the Procurement and Pharmacy departments.
Develop training plans and materials	0	Covered by funding of Logistics lead and Clinical Engagement Lead
Establish baseline stock holdings and web requisition volumes	0	Use existing Trust resources within Procurement and Pharmacy
Supplier engagement	0	Will be undertaken by Procurement and Pharmacy staff as part of regular supplier engagement activities
Integrate PLIMS with other systems	£10,000	This is to fund the interface with Pharmacy systems as other interfaces are funded by the Procurement Strategy implementation.
Train affected staff in new processes	0	Training of staff within Procurement and Pharmacy will be undertaken by Logistics lead.
Compliance monitoring and support	0	As the processes become business as usual for the Procurement and Pharmacy departments, compliance monitoring will be a line management responsibility with additional support from the Logistics and Clinical Engagement leads.
Prepare business case for logistics function	£5,000	
Prepare interim case study	£2,500	Standard cost assumed for interim case study
Prepare final case study	£2,500	Standard cost assumed for final case study
BloodHound 2 Capital	£51,000	Supplier quote
BloodHound 2 Revenue	£13,000	Supplier quote

Note that the costs of the logistics and clinical engagement leads are presented at the programme level rather than at the use case / project level.

Note also that the costs of improved inventory management are relatively low because a patient level inventory management system is being procured under the Trust's Procurement Strategy and therefore these costs do not fall within this business case.

D.6 Benefits

The following benefits have been identified in discussions with Trust staff and used in the business case.

Benefit	Value	Justification
Clinical staff time freed up	£80,000 pa	Currently the equivalent of two full time equivalent Band 6 clinical staff are doing inventory management tasks which they will not need to do in the future.
Reduce emergency restock	£48,843 pa	Reduced manpower required by eliminating emergency requests for items out of stock at ward / theatre level (1 FTE at Band 4 in Procurement and 1 FTE at Band 2 in Pharmacy)
Reduced cancelled operations	£100,800 pa	112 operations cancelled pa due to item non-availability. Average loss due to cancelled operation is £1.8k. Assume 50% avoided by better inventory management, so £100,800 pa benefit.
Missed doses	£51,100 pa	720 ADE pa. 30% are missed doses. Assume 50% result in 1 extra day stay (~100 days). Double to 200 because of wide scale under-reporting. Cost of day £255 (from NHS).
Inventory reduction	£1,439,000	This is the excess stock that can be run down based on the difference between current average 6 week stock holdings and the target of 3 weeks. This is a one-off saving
Inventory waste reduction	£187,000.00	Sampling shows around £150k pa avoidable wastage in Procurement and £37k pa in Pharmacy.
Total	£467,743 pa plus £1,439,000 non-recurring	

D.7 Risks

The main risks to the delivery of this capability are as follows:

Risk	Owner	Likelihood	Impact	Score	Mitigation
There is a risk that the cost of interfacing the PLIMS to the JAC Pharmacy system is larger than estimated	Inv Man project	Possible	Minor (£10k)	6	Engage early with supplier and try to pass risk to the supplier (ie try to agree firm price)
There is a risk that it takes longer to embed process and cultural changes and this benefits realisation takes longer than planned, undermining the business case	Inv Man project	Possible	Moderate (£250k for 6 month delay)	9	Monitor situation carefully and provide additional training / support if needed to recover

E Purchase to Payment

E.1 Current situation

The Trust currently transacts with on an annual basis with 2,300 suppliers and 1,210 customers.

E.1.1 Purchases

Purchase orders are currently raised from four key sources:

a. Procurement – for goods and services;

b. Pharmacy – for drugs and medical gasses;

c. Estates & Facilities – for construction, engineering parts and equipment maintenance;

d. Human Resources – for agency staff.

Purchase orders are currently raised using eight systems, with varying levels of integration with suppliers.

System	Used by	No of Suppliers	Level of integration
Marrakech	Procurement	1,144	Emailed or Faxed PDF
NHS Supply Chain – EDC	Procurement	1	Fully Integrated
NHS Supply Chain – SOLO	Procurement	1	Fully Integrated
Bates online	Procurement	1	Fully Integrated
Collector Set Printers	Procurement	1	Fully Integrated
JAC	Pharmacy	132	Mix of Email and integrated through Medecator
Shires	Estates & Facilities	487	Emailed PDF
Roster Pro	Human Resources	437	Manual booking requests

In 2014/15, the Trust processed 85,350 accounts payable invoices with the majority being received through the postal system. Paper invoices (with the exception of Pharmacy) are scanned into the Finance System (Integra) where data entry is automated using Optical Character Recognition (OCR) at the header level. There is no current link or match between Invoice, Purchase Order and Receipt.

For Pharmacy invoices (30%), documents are entered manually into JAC and matched against Purchase Order and Receipt. Once fully matched, the pharmacy data is interfaced to the Integra Finance system.

Invoices from NHS Supply Chain (0.01%) are interfaced into Integra via a weekly transactional feed.

Advanced shipping notices are not currently in use within the organisation.

E.1.2 Sales

The Trust has an active customer base of 1,210, with 8,700 invoices raised each year within the Integra system. All invoices sent in PDF format either through email, fax or post. There is no integration currently with any customer systems and sales orders are not received or entered into Integra.

NHS SBS have contacted the Trust requesting that it connects to its Tradeshift exchange service for sales invoices for any of its members that the Trust transacts with. It is envisaged that as PEPPOL adoption grows, more organisations will request direct connections.

E.1.3 Procurement Transformation Programme

The Trust is progressing with a fully funded programme to rationalise the number of systems used to purchase goods and services and to automate the transmission, receipt and processing of purchase orders and invoices through a single PEPPOL access point.

The programme rationalises the number of systems used for ordering from eight down to three, with Pharmacy and Agency remaining out of scope. GHX Exchange has been selected as the Trusts PEPPOL access point and full integration of the exchange with Integra will be completed by February 2016.

Purchase invoices will be integrated into Integra and a 3 way match will occur to automate the approval and processing of invoices.

E.2 Target operating model

The scope of the current purchase to pay project within the Procurement Transformation Programme will be extended to include Pharmacy and Sales transactions. All transactions including Purchase Orders, Advanced Shipping Notes, Invoices and Credit Notes will be transmitted and received through a single PEPPOL access point (GHX Exchange).

Figure E-1 represents the data connections and information flows between systems under the new model.

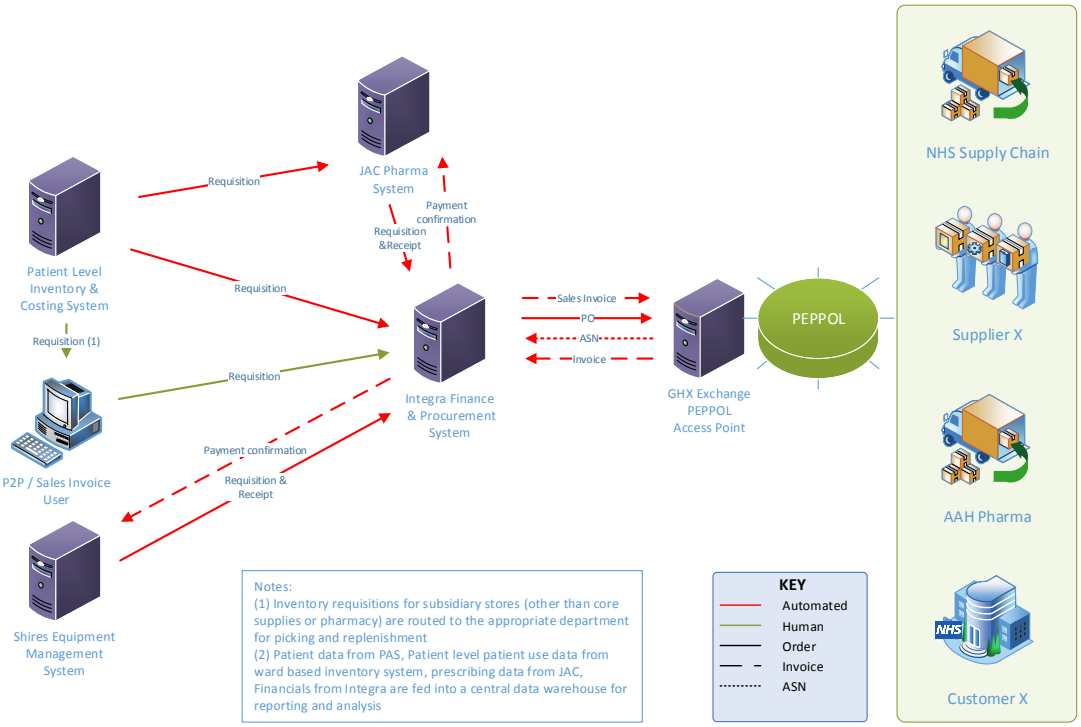


Figure E-6-3: Future P2P connections and data flows

A supplier adoption project will be initiated to communicate the Trust's strategy for electronic trading and to raise the profile of the PEPPOL programme. All suppliers will be required to transact with the Trust via

their own PEPPOL access point by December 2017. There will be no requirement for suppliers and customers to directly engage with the Trust's chosen access point as their requirements will be unique to them. Documents will be exchanged between access points via the PEPPOL Open Network. For example, NHS SBS has chosen Tradeshift as their PEPPOL access point. Sales invoices will be transmitted from Integra to GHX, and then on to Tradeshift via the PEPPOL network. There will be no requirement for either organisation to connect to multiple access points.

E.3 Approach

E.3.1 Phase 1

The criteria for this Phase are as follows:

a. Organisational review of policies and processes completed

This review has already been undertaken as part of the Trust's procurement strategy development and implementation.

E.3.2 Phase 2

The criteria for this Phase are as follows:

a. Updated P2P policies and processes agreed;

b. Technical development path identified and agreed;

c. Plan for the trust to adopt machine to machine processing agreed;

d. Access point provider selected and live.

The Trust has already entered into a contract for the GHX Exchange product and this will be in place and integrated with the Trust's finance system (Integra) by the end of FY 2015/16. Some work will be required however to define and implement the interface between the JAC system used within the Pharmacy department and Integra.

E.3.3 Phase 3

The criteria for this Phase are as follows:

a. Training of relevant staff in new P2P processes completed

b. Technical solution set deployed in one department (eg supplies; pharmacy etc)

c. Updated P2P processes implemented

d. 30% of trusts purchase orders and invoices are exchanged via access points

e. Purchase orders and invoices exchanged via the trusts access point carry GS1 GLN keys and, where available, GTIN keys

f. Interim case study including costs and benefits produced

Training of staff will be limited to technical staff managing each connecting system and interface failures and those staff processing invoices that fail to automatically complete. All connections to the PEPPOL access point and source systems to Integra will be in place and operating fully across all departments. P2P processes including a "No-PO, No-Pay" policy and "Business Integration" policy for suppliers will be fully implemented. Continued engagement with suppliers will be carried out to ensure adoption of PEPPOL standards are in place to schedule and relevant connections are tested and implemented. Extrinsic data

will be added by design in phase 1 for all documents to carry GLN and GTIN identifiers as they become available.

E.3.4 Phase 4

The criteria for this Phase are as follows:

a. Technical solution set deployed in all departments (eg supplies; pharmacy etc)

b. A sustainable organisational structure is in place to manage P2P processes

c. 60% of trusts purchase orders and invoices are exchanged via access points

d. Final case study including costs and benefits produced

Technical solution will be in place and fully operational across all connecting systems and departments by the end of Phase 3. Primary connections and responsibility for successful transmission will be with the Financial Systems team. Procurement will be responsible for supplier adoption processes and business change. Performance and progress will be monitored by the Trusts Procurement Strategy Committee which oversees other Procurement performance indicators.

E.4 Project plan

Based on the assessment above, the activities to be undertaken are as follows:

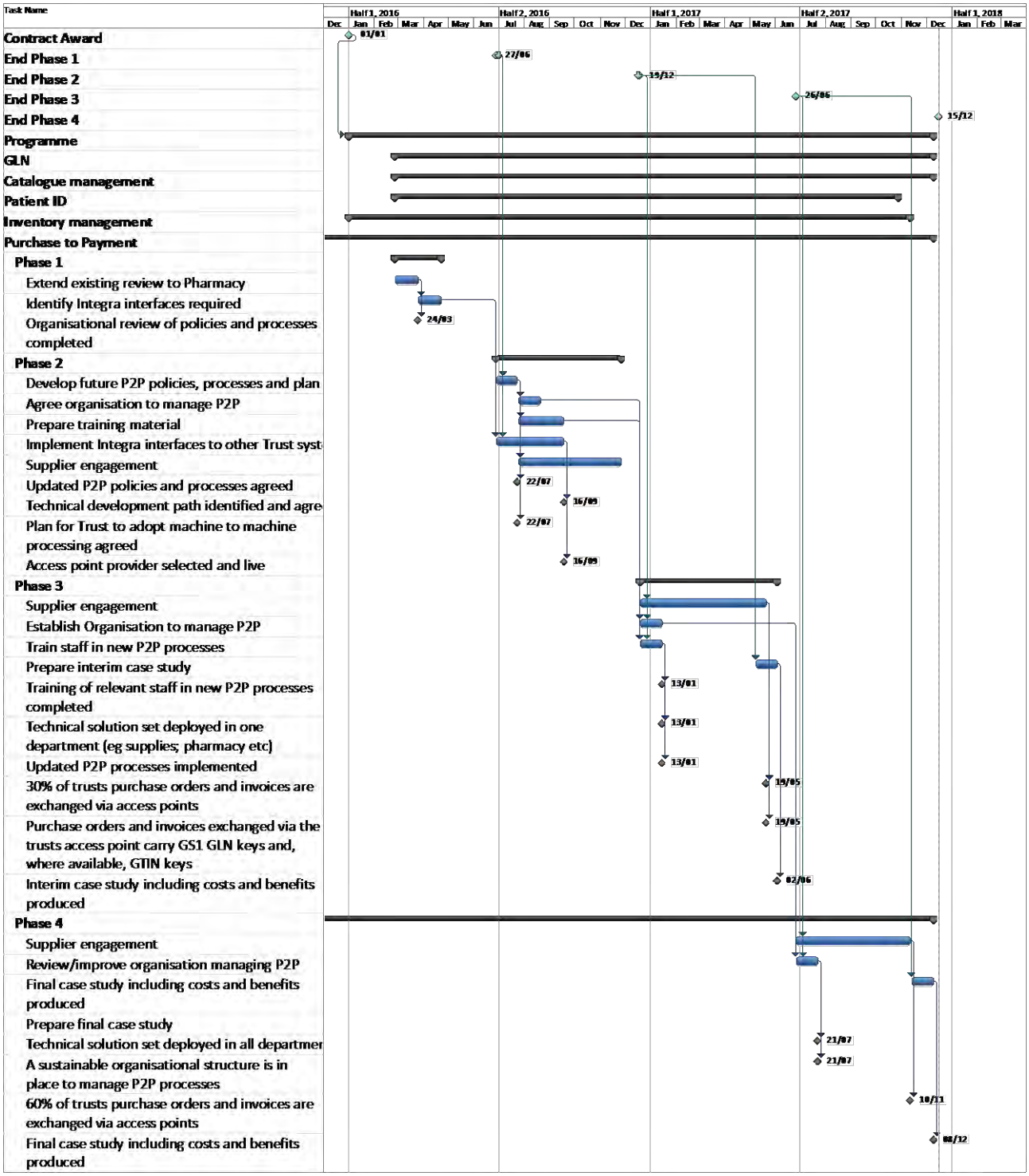
a. Phase 1:
   1. Extend existing review to Pharmacy
   2. Identify Integra interfaces required

b. Phase 2:
   1. Develop future P2P policies, processes and plan
   2. Agree organisation to manage P2P
   3. Prepare training material
   4. Implement Integra interfaces to other Trust systems
   5. Supplier engagement

c. Phase 3:
   1. Supplier engagement
   2. Establish Organisation to manage P2P
   3. Train staff in new P2P processes
   4. Prepare interim case study

d. Phase 4:
   1. Task Name
   2. Supplier engagement
   3. Review/improve organisation managing P2P
   4. Final case study including costs and benefits produced
   5. Prepare final case study

Assuming four six-month phases, project timing is shown in the following Gantt chart.



E.5 Costs

The following costs have been estimated:

Description of cost	Estimate	Basis for estimate
Process changes	£10,000	
Identification and implementation of interfaces	£20,000	Several interfaces at average of £10k each
Pharmacy interface costs – recurring	£3,000	If GHX cannot be interfaced as planned with Pharmacy systems, then funding is required for a separate connection.
Prepare interim case study	£2,500	Standard cost assumed for interim case study
Prepare final case study	£2,500	Standard cost assumed for final case study

E.6 Benefits

The following benefits have been identified in discussions with Trust staff and used in the business case.

Benefit	Value	Justification
Invoice processing cost reduction	£200,000 pa	Based on the volume of invoices and the DH indicative cost savings per invoice, the cost saving is calculated to be £406k pa. This does not seem realistic given the Trust team sizes and therefore the benefit has been estimated at £200k pa.

E.7 Risks

The main risks to the delivery of this capability are as follows:

Risk	Owner	Likelihood	Impact	Score	Mitigation
There is a risk that suppliers will not develop EDI capability in line with plans	P2P Project	Possible	Moderate	9	Strong supplier engagement and adoption. Support suppliers with adoption plans. Develop consistent messaging from collaborative partners
There is a risk that initial EDI transactions will cause greater inefficiencies whilst data is being improved through catalogues and better transactional processes causing delays in payment and additional workload	P2P Project	Unlikely	Minor	4	Manage dependencies with Catalogue Management project and Procurement Transformation Programme, prioritising suppliers in line with transactional and data match rates

F Product recall

F.1 Current situation

Product recall is currently a predominantly manual process that occurs within Pharmacy, Procurement or Theatres. In each case when an item or batch is identified as needing to be recalled, the team concerned:

a. identifies if the items / batch concerned have been procured and issued and which locations (ward, clinical area or theatre) they were issued to;

b. arranges for a manual check to be undertaken of any stores in these locations to identify whether any of the relevant items are still in stock, and withdraws them for return or disposal if this is the case;

c. if there are no items in local stores, seeks to identify who they were used to treat, for example by reviewing the paper records maintained within theatre of which medical devices where used in operations and on what patient.

The volumes of recalls are not large, amounting to under 50 per year with the procurement department and similar numbers within Pharmacy. The time taken to handle a recall depends upon the item concerned but ranges between a few hours and a few tens of hours, with an average of perhaps 10 hours. So across the Trust this probable amounts to of order 1000 hours per year, or about 0.5 FTE, and a cost of perhaps £15k pa. The workload is spread across many people, so that even if this workload was eliminated, there would not be a cashable benefit.

F.2 Target operating model

Once the Trust has achieved an effective inventory management capability across all areas, so that the contents of local level (ie ward, clinical area or theatre) stores are visible via the inventory management system, then in the case of a product recall the Trust would be able to immediately identify where any items for recall are located. In addition, it will be possible to identify which items had been administered to and/or fitted to which patient. This will rely upon the patient identity and the identifier of any medicine being administered or medical device being fitted being captured at the time of administration or operation. This is summarised below.

People Clinical staff trained to capture patient ID and details of any medicine being administered or device being implanted using scanners and GS1 compliant bar codes. Pharmacy / Procurement staff trained in new processes for product recall	**Process** Point of care processes designed to include scanning to confirm patient ID prior and record items administered or implanted. New processes developed for product recall.
Technology Scanner technology able to capture patient ID and identifiers of medicines being administered or devices implanted and to record captured information against the patient. Search capability to identify which patients have had specific medicines administered or devices implanted	**Information** automatically captured to include: • Patient Identity via GS1 barcode • Medicines or devices used with patient • Care-giver (via logged-on identity)

F.3 Approach to meeting DH criteria

F.3.1 Phase 1

The Phase 1 criteria are: Organisational review of policies and procedures completed.

This will take the form of a workshop attended by staff that undertake product recalls currently from Pharmacy and Procurement. The output will be a summary of the current policies and procedures with a commentary on what works well and what needs to be improved.

F.3.2 Phase 2

The Phase 2 criteria are as follows:

a. Updated product recall policies and procedures agreed;

b. Technical development path identified and agreed.

To achieve these criteria we need to develop a blueprint which shows how people, process, information and technology will be used together to provide a more efficient and effective product recall process. It is anticipated that the solution may be based around:

a. enhancement of Nerve-centre (or an equivalent application running on the mobile devices) to support scanning of the patient wrist band and the bar code on the item being dispensed or implanted and recording of the administration / implantation event;

b. development of simple reporting tools to record the link between items and patients and vice-versa;

c. new processes for scanning and for using the reporting tools in support of product recall.

Once the requirements for such technology components have been confirmed then they will need to be procured or implemented.

F.3.3 Phase 3

The Phase 3 criteria are as follows:

a. Training of relevant staff in new product recall procedures completed;

b. Technical solution set deployed in one department (eg supplies; pharmacy etc);

c. Updated product recall procedures implemented;

d. 50% of product recalls are being done using the new processes;

e. Interim case study including costs and benefits produced.

Once the technology components have been accepted and rolled out, then training can be designed and implemented. Two groups of staff will need to be trained:

a. Ward and clinical staff who administer medicines or implant medical devices. They will need to be trained to scan medicines / devices prior to their use. This should be a fairly simple and therefore short process, particularly since they will have been trained to scan patient wrist bands by this point.

b. Staff involved in recall processes currently who will need to be trained in the new processes. These will be within the Procurement and Pharmacy departments.

Preparation of the interim case study will require interviews and discussions with staff using the new processes to identify lessons learned, costs and benefits.

F.3.4 Phase 4

The Phase 4 criteria are as follows:

a. Technical solution set deployed in all departments (eg supplies; pharmacy etc);

b. A sustainable organisational structure is in place to manage product recall procedures;

c. 100% of product recalls are being done using the new processes;

d. Final case study including costs and benefits produced.

The sustainable organisational structure to manage product recall processes will have been identified in the blueprint developed in Phase 2. During this phase the terms of reference for the organisational will be confirmed and responsibility for managing the recall process assigned to an appropriate role.

During this phase further information will be gathered to enable the preparation of the final case study.

F.4 Plan

Based on the assessment above, the activities to be undertaken are as follows:

a. Phase 1: Undertake workshop to identify and document current recall processes;

b. Phase 2:

   1. Develop blueprint for capture of medicine / medical device and product recall;
   2. Agree future point of administration / implantation scanning and product recall processes;
   3. Specify and procure changes to Nerve-centre to provide capability to capture items administered or implanted;
   4. Specify and implement / procure capability to report on items administered to / implanted into patients and associated search capabilities;

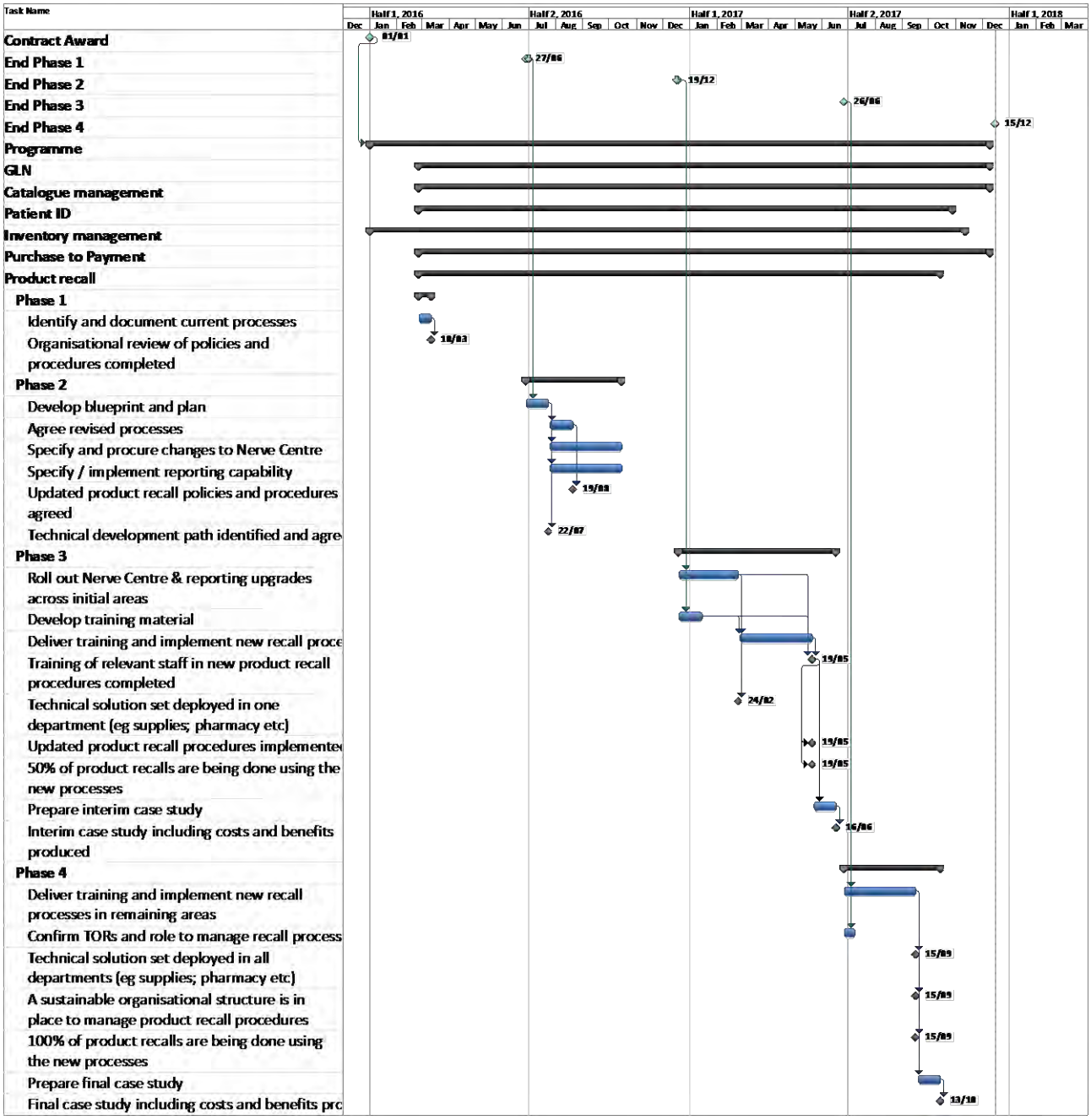
c. Phase 3:

   1. Roll out of Nerve-centre upgrades and reporting upgrades;
   2. Develop training material;
   3. Deliver training and implement new recall processes within Procurement;
   4. Conduct interviews and workshops with delivery teams and users of new product recall processes to identify costs, benefits and lessons;
   5. Prepare interim Case Study;

d. Phase 4:

   1. Confirm the Terms of Reference for the management of the product recall process and allocate these responsibilities to a role;
   2. Implement any improvements to product recall processes at initial site;
   3. Conduct interviews and workshops with delivery teams and users of product recall processes to identify costs, benefits and lessons after longer period of use and following improvements responding to previous feedback;
   4. Prepare final Case study.

Assuming four six-month phases, project is shown in the following Gantt chart.



F.5 Costs

The costs for developing and implementing new product recall processes are as follows:

Description of cost	Estimate	Basis for estimate
Project manager	-	Assume programme manager will project manage this activity
Develop blueprint for capture of administration of medicines / implantation of devices and product recall (includes process and technical aspects)	£5,000.00	Up to 10 days at £500/day
Upgrade to Nerve-centre	£20,000.00	Assume relatively limited change (simple screen with few buttons to enable scanning of item and patient).
Cost of preparing training material	£5,000.00	Assumes external analyst
Training costs	£15,000.00	1 day each for 24 wards plus 6 days for non-ward based clinical staff.
Prepare interim case study	£2,500.00	
Prepare final case study	£2,500.00	
Total	**£50,000**	

F.6 Benefits

Benefits to be provided by this use case include:

a. Qualitative benefits:

   1. Improved traceability of medicines and medical devices to patients and vice versa;
   2. Improved ability to relate outcomes to the treatment provided;
   3. Improved ability to relate cost of medicines and medical devices to a procedure;

b. Quantitative benefits: Current cost of product recall estimated at £15k per year, based on around 50 recalls/year for Procurement and a similar number for Pharmacy and an average of 10 hours effort for each one. This benefit is not cashable as the time saved is spread over many individuals.

F.7 Risks

There are no major risks to the delivery of this use case as it depends on the development of technology for scanning patient ID and item ID which will be developed under other core enablers / use cases. Risks associated with scanning patient ID and item ID are addressed in the discussion of the relevant core enablers.

G Quality Impact Assessment

Clinical Effectiveness
Have clinicians been involved in the service redesign? If yes, list who.
Dr Paul Sigston is Clinical Lead for the programme and has drafted this QIA
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)
Yes, Department of Health eProcurement Strategy and guidance from the Department of Health on adoption of the standards
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.
N/A
Are there any risks to clinical effectiveness? If yes, list
A potential dis-benefit, in the early stages of implementation, is that staff time may be taken away from patient care if scanning of items and patient wrist bands takes significantly longer than the current processes for recording item usage and for confirming patient identity.
Have the risks been mitigated?
Yes, extensive training and support will be provided to clinicians during the early stages of the programme
Have the risks been added to the departmental risk register and a review date set?
No risks identified
Are there any benefits to clinical effectiveness? If yes, list

Yes:
• Clinicians will have better data from which to assess the effectiveness of their actions and therefore will be able to optimise their actions to improve safety and outcomes for patients
• Clinicians will have
  • greater confidence that items will be available when they are needed
  • less time wasted due to cancelled operations due to non-availability
  • less time wasted treating patients relapsing due to missed medicine doses due to poor availability
  • spend less time on managing stock levels and ordering items
  • spend less time trying to find items that are out of stock in local stores
• Clinicians will have more time for patient care as they will spend less time on ordering items, dealing with record discrepancies and authorising payment of invoices.
• Clinicians will gain a better understanding of how the outcomes from procedures vary depending on the items used and hence will be able to optimise future outcomes.

Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Yes - Reduced inventory levels in clinical areas (gathering dust, which acts as locus for infection)
Safeguarding vulnerable adults/ children?	N/A
Current quality indicators?	N/A
Quality Account priorities?	N/A
CQUINS?	N/A

Are there any risks to patient safety? If yes, list
None identified
Have the risks been mitigated?
Yes, one of the projects in the programme addresses inventory management
Have the risks been added to the departmental risk register and a review date set?
Yes – risks have been logged in the programme register and will be managed as detailed in the management case
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Yes
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
N/A
Does the redesign lead to improvements in the care pathway? If yes, identify
• Patients will receive safer and more effective treatment because of the improved evidence and information captured • operations cancelled less often due to item non-availability • missed doses of medicine less often due to non-availability, hence stays extended less often • Patients can be identified more quickly when devices that they have had implanted in them are recalled, reducing their risk of harm • Increased patient safety by reducing the risk of patient misidentification
Are there any risks to the patient experience? If yes, list
None identified
Have the risks been mitigated?
N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
As above
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	

Approval			
Signature	**Name**	**Designation**	**Date**
	Dr Paul Sigston	Medical Director	
	Avey Bhatia	Chief Nurse	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – November 2015

11-24	Stroke Therapy Assisted Discharge Service	Chief Nurse

Summary / Key points

The enclosed report provides information on:

- Background on the Stroke Therapy Assisted Discharge Service (STARS)
- Performance against STARS associated measures
- Proposed future staffing
- Current and proposed indicative finances
- Care Quality Indicator (CQUN)
- Expected benefits

Which Committees have reviewed the information prior to Board submission?

- None

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

Decision – the Board is asked to:

- support this proposal pending completion of a business case
- support the recruitment of staffing on a temporary contract initially until 31 March 2016 and thereafter until 31 March 2017, pending further CCG CQUIN funding.

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

1 Background

The aim of this service is to deliver early supported discharge for patients who have suffered a stroke, reducing length of stay (LOS) in an acute stroke unit and other inpatient stroke rehabilitation units for newly diagnosed people following a stroke.

Stroke Therapy Assisted Discharge Service (STARS) will reflect evidence based outcomes, and maximise opportunities for care at home in the person's usual place of residence for the first 6 weeks following discharge from hospital.

There are 3 elements essential to an early supported discharge service for stroke:

- Early intervention by therapists within the acute setting, 7 days per week
- Proactive planning of discharge, working with clients to identify any opportunities for interventions being provided in a non-acute setting
- Community continuation of a therapy plan

The service will provide people who have experienced a stroke or TIA with residual functional impairment (and their carer's) with inter-disciplinary coordinated specialist stroke rehabilitation, advice, social and emotional support, offered during the transition from hospital to home, for the first 6 weeks.

The service will be delivered as an integrated pathway; the community stroke pathway links closely with the in-patient provision, to ensure coordinated transfers. In supporting early discharge from in-patient settings, the service will establish clear and seamless discharge plans that meet the person's individual needs, supporting carers when appropriate, giving intensive and person centred rehabilitation. These plans will be identified at the earliest opportunity in the patient's pathway.

It is intended that this service will reflect the wider South East Coast Stroke Network vision for Stroke Therapy Assisted Discharge Service (STARS) and rehabilitation and provides inter-disciplinary co-ordinated specialist stroke rehabilitation. The expectation is that the pathway, the associated protocols and processes support and meet best practice and evidence as detailed in the National Stroke Strategy and the National Clinical Guidelines for Stroke.

This scheme was first introduced via MRET funding from 2013/14 to 2014/15 in partnership with KCHFT and provided additional support to therapy teams for weekend working and additional support to community services.

Table 1 provides a comparison of 13/14 and 14 /15 data for this patient cohort which shows improvement against national performance in relation to length of stay (LoS) and early supported discharge against admissions, contributable to the STARS team being in place. Although LoS increased nationally by 8%, LoS at MTW reduced by 5%; in respect of early supported discharge as a percentage of admitted patients, TWH improved by over 7% and MH improved over 27%, compared to a national improvement of 3.5%.

Table 1: MTW & National Performance Relation to STARS Patient Cohort

Measure	April 2013 - March 2014	April 2014 - March 2015
Length of stay (J8.4)		
National	17.3	18.7
Maidstone	17.4	16.6
TWH	21.3	20.2
Early supported discharge as % patients admitted (J10.3)		
National	24.7%	28.2%
Maidstone	15.2%	42.5%
TWH	21.2%	28.4%

(Source: National SSNAP)

This service was provided at a cost of £211k as detailed in Table 2 below:

Table 2: Current ESD Financial Summary

Community Resources	**WTE**	**Cost £000**
OT Band 7	0.69	30
SALT	0.4	14.4
Physio	1.00	36
OT band 6	1.00	36
Acute Resources	**WTE**	**Cost £000**
Discharge co-ordinator	0.6	22
Weekend working		53
Admin support		10
Non pay		10
Total		**211**

2 Proposal

This proposal case seeks to build on previous success and to use the model as already developed to further improving the percentage of patients being directed to an early supported discharge service and reducing the length of stay. Evaluation of the scheme by the clinicians providing the services has identified further enhancements that would contribute to reducing LoS, these enhancements are detailed below.

2.1 In-patient Increased Therapy

Physiotherapy already has a 6 day service and it is proposed to uplift this service to 7 days and bring staffing levels in line with national guidelines; Table 3 below details associated staffing and costs:

Table 3: Increased Physiotherapy Staffing & Costs

Additional PT staffing required to maintain seven day service to stroke TWH based on RCP guidelines	
0.37 wte Band 6 XR06/02	12,077
Additional PT staffing required to maintain seven day service to stroke services at MGH based on RCP Guidelines	
0.86wte Band 6 XR06/02	28,071
1.00wte Band 7 XR07/03	39,806

Occupational therapy does not have a 7 day service and therefore would require additional staff to provide a 7 day service:

Table 4: Increased Occupational Therapy Staffing & Costs

Additional OT staffing required to maintain seven day service to stroke TWH	
1.0 wte band 6	42,350
1.0 wte band 3	23,000
Additional OT staffing required to maintain seven day service to stroke services at MGH	
1.0 wte band 6	42,350
1.0 wte band 3	23,000

The total investment required to provide a 7 day inpatient therapy service is **£ 210,654**

2.2 Improved discharge planning

At present there is no dedicated social services support to stroke patients, who are frequently complex discharges requiring high levels of support. At present the community hospital care manager supports patients at Tonbridge cottage stroke unit. It is proposed to recruit an additional care management resource.

Table 5: Increased Care Manager Staffing & Costs

Additional Care Manager staffing required to support complex stroke patients	
1.0 wte care manager	42,350

The total investment required to improved discharge planning is **£42,350**

2.3 Community Support for Discharges

Table 6: Increased Community Support for Discharge Staffing & Costs

Additional OT staffing required to increase community follow up allowing earlier discharge	
2.0 wte band 6	85,000
1.0 wte band 3	23,000
Additional PT staffing required to increase community follow up allowing earlier discharge	
2.0 wte band 6	85,000
1.0 wte band 3	23,000
Additional SALT staffing required to increase community follow up allowing earlier discharge	
0.4 Band 7	14,500

The total investment required to increase community support to facilitate discharge planning is **£230,500**

3 Financial Summary

The total investment required to continue and improve this service is **£483,504.** This is an increase on the previous investment of £211k, mainly due to increasing the provision of weekend therapy for both physiotherapy and occupational therapy (additional investment of approximately £150k) and additional community therapy provision (additional £115k).

The CCG have agreed a local Early Supported Discharge Care Quality Indicator (CQUIN) to the value of **£1,191,689** because it is recognised that that it is an effective alternative to continued in-patient stroke unit management. In order for the Trust to receive these funds, certain measures must be achieved:

Table 7: CQUN Measures

Quarter	Measure	Value	Achieved
1	Written proposal in place for Early Supported Discharge Team attached to both MTW sites	£297,922	✓
2	MTW Board approval	£297,922	
3	Both teams recruited and working operationally	£297,922	
4	Reduction of LoS for all stroke patients by 10% from baseline of 1 April 2015.	£297,922	

4 Expected Benefits

It is anticipated that adoption of this proposal will improve our patient's experience due to:

- Earlier discharge to home environment
- Integrated therapeutic intervention with minimal handoff
- Increased level of therapeutic intervention within acute setting
- Focused discharged planning to support safe & timely discharge
- Reduced LoS within acute hospital

In respect of the Trust, the following benefits are expected:

- Reduction in stroke LoS (target 10%) and consequently reduction in overall LoS, creating extra capacity
- SSNAP ESD target met
- Increased income of £1,191,689 (net £708,185)

5 Conclusion & Recommendations

STARS has a proven track record over the last 18 months using a model of increasing inpatient therapy, planning for discharge and providing additional and faster community intervention on discharge. The nationally accredited SSNAP data shows a significant improvement in performance over the last year for early supported discharge.

The proposed investment of £483k will provide:

- A weekend occupational therapy service to stroke patients
- Raise physiotherapy levels to Royal college of Physicians guidance
- Dedicated social services support for the complex patients
- Community clinicians to support patients earlier in their pathways to support earlier discharge

It is recommended that the Board:

- support this proposal pending completion of a business case
- support the recruitment of staffing on a temporary contract initially until 31 March 2016 and thereafter until 31 March 2017, pending further CCG CQUIN funding