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 21ST OCTOBER 2015

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
10-1	To receive apologies for absence	Chairman	Verbal
10-2	To declare interests relevant to agenda items	Chairman	Verbal
10-3	Minutes of the Part 1 meeting of 30th Sept. 2015	Chairman	1
10-4	To note progress with previous actions	Chairman	2
10-5	Safety moment	Medical Director	Verbal
10-6	Chairman's report	Chairman	Verbal
10-7	Chief Executive's report	Chief Executive	3
10-8	Integrated Performance Report for September 2015 ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-led (workforce)	Chief Executive Medical Director Medical Director Dir. of Infection Prevention and Control Director of Finance Chief Executive Director of Workforce and Communications	4
	Quality items		
10-9	Progress with the Quality Improvement Plan	Medical Director	5
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10-11	Approval of compliance oversight self-certification	Trust Secretary	7
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10-12	Quality Committee, 05/10/15	Committee Chairman	8
10-13	Trust Management Executive, 14/10/15	Committee Chairman	9
10-14	Finance Committee, 19/10/15 (to include approval of the Trust's application for an Interim Revolving Working Capital Facility)	Committee Chairman	10 (to follow) & 11
10-15	Charitable Funds Committee, 19/10/15	Committee Chairman	Verbal
	Other matters		
10-16	Proposal regarding the appointment of a "Freedom to Speak up Guardian"	Director of Workforce and Communications	12
10-17	**To consider any other business**		
10-18	**To receive any questions from members of the public**		
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	Chairman	Verbal
	Date of next meeting: 25th November 2015, 10.30am, The Academic Centre, Maidstone Hospital		

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 30TH SEPTEMBER 2015, 11.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive (from item 9-7)	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director (from item 9-7)	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications (from item 9-7)	(PB)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Gianna Pollero-Payne	Communications Manager	(GPP)
	Mark Holland	General Manager, Pathology	(MH)
	Nadir Ratanshi	FY1 Doctor	(NR)
	David Gazet	Reporter, Kent Messenger (until item 9-15)	(DG)

9-1 To receive apologies for absence

No apologies were received.

9-2 To declare interests relevant to agenda items

There were no declarations of interest.

9-3 Minutes of the Part 1 meeting of 22nd July 2015

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

9-4 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").** AG reported that work to reformat the Dashboard was continuing, and meetings had been held with the Information Team. It was hoped to finalise this soon.
- **Item 7-7 ("Schedule a regular item for future Trust Board meetings to enable any awards and recognition issued to Trust staff to be reported").** AJ added to the update provided, by noting that the winners of recent awards had been included in the Chief Executive's report
- **Item 7-9 ("Arrange for a 'deep dive', involving a representative from Dr Foster Intelligence, to be held into the Trust's Hospital Standardised Mortality Ratio (HSMR")).** AJ noted that this would be the sole item of the Quality Committee 'deep dive' meeting on 05/10/15, and that a representative from Dr Foster would be in attendance.

SD referred to item 7-9 in the minutes of 22/07/15, and asked whether numbers of Delayed Transfers of Care (DTOCs) could be provided to the Trust Board. It was pointed out that numbers of DTOCs were contained on page 2 of the Performance Report (Attachment 4). AJ asked whether the numbers could be reported by patient age group. AG agreed to provide such details.

Action: Provide the Trust Board with details of the numbers of Delayed Transfers of Care by patient age group (Chief Operating Officer, October 2015)

9-5 Safety moment

PS highlighted that there were a number of changes affecting the other Trusts within the local area, which in turn may have an impact on patient safety at the Trust. AJ recognised the difficulties involved in providing support to other Trusts.

9-6 Chairman's report

AJ noted that he had nothing to report.

9-7 Chief Executive's report

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

- The Trust was assisting in the efforts to improve system-wide processes for the benefit of the local health economy, and continued to work closely with colleagues in Kent and Medway
- There had been some recent examples of innovation, which were outlined in the report
- A very positive Long Service Awards event had been held at Maidstone Hospital (MH)
- The recipients of the most recent 'Employee of the Month' Awards had both been surprised and delighted to receive recognition for their work, which reinforced the benefit of such Awards

[At this point, GD, PB and SO joined the meeting]

GD then highlighted that although the Trust had demonstrated its willingness to work with other partners, the willingness of such partners to work with the Trust had been less demonstrable. JL concurred, and acknowledged that partnership working had suffered from recent structural changes in health and social care, and would take time to recover.

9-8 Integrated Performance Report for August

Effectiveness / Responsiveness (incl. DTOCs)

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

- DTOCs were the main contributor of the Trust's inability to effectively manage the flow of patients through its hospitals
- The Clinical Commissioning Group (CCG) had set a target for DTOCs of 3.5%, but during August, the level seen at the Trust was as high as 9%.
- The report contained the reasons for the DTOCs

AJ asked Trust Board Members whether they had any comments on the DTOC data on page 2 of Attachment 4. ST remarked that the difference between the number of DTOCs in August 2014 compared to August 2015 illustrated the scale of the current problem. AG agreed, and noted that the current issues were affecting the west part of Kent in particular. AG added that although initiatives were being developed to address the problem, these would take time to have an impact.

KT then referred to Home Care Assessments, and commented that he was aware that these could sometimes be sub-standard, and lead to patients' swift return to hospital. KT also asked whether Kent County Council (KCC) had been charged for DTOCs. GD replied by firstly stating that KCC were currently consulting on the closure of their Nursing Homes, which illustrated the lack of resources available in the system, which was seemingly heading towards a 'perfect storm', and therefore a collective view of how the Trust should respond was warranted at some point. GD then referred to KT's query, and answered that although the Trust had written to KCC giving notice of its intention to seek reimbursement for DTOCs, the Trust was subsequently asked to rescind the intention. GD continued that the Trust duly obliged, but clarified that the matter had only been

paused at present. GD also pointed out that there was however improved engagement with KCC, which had been the Trust's aim in issuing notice to seek reimbursement.

AG then referred to KT's comment regarding Care Assessments, and noted that the Trust was aware of the problems outlined by KT.

SD emphasised that DTOCs were a significant issue for patients. GD agreed, but noted that although an acute hospital bed was not an ideal place for a person awaiting long term care, it was also not ideal for patients to have to wait longer in A&E, nor have their elective operation cancelled. GD continued that a solution needed to be identified, and it was likely that NHS funding would have to be used to support the Social Care system.

AK emphasised the need for the Trust to continue to escalate the current situation, to inform the Government's spending review, which was due in November. AK continued that the Trust had an opportunity to lobby Greg Clark MP, the Secretary of State for Communities and Local Government, and appealed for such lobbying to be undertaken. GD replied that he had recently met with Greg Clark, and the meeting had resulted in the establishment of a forum which would take place in the next few weeks, involving Mr Clark. GD added that AK was welcome to attend. AK reiterated his earlier point that Mr Clark needed to be asked to raise the current issues as part of the Government's forthcoming spending review. GD acknowledged the point.

AJ then asked for an explanation of "Patient of [sic] Family Choice", page 2 of the report. AG explained that this related to a patient or their family's preference to stay in hospital until a place at the particular Nursing/Care Home of their choice became available. AG added that in such circumstances, and given the sensitivities involved, the Trust was reluctant to use its powers to insist that a patient moves to an alternative Home.

AG then continued, and highlighted the following points:

- The increase in elective activity had continued
- The rules regarding Referral to Treatment (RTT) had changed, which affected the order in which the Trust treated patients on pathways
- The Trust had agreed a target with the NHS Trust Development Authority (TDA) to meet the 62-day wait Cancer target for the Trust as a whole by March 2016. However, the target was being met for patients that were exclusively treated by the Trust (i.e. who had not been referred from another Trust)

SDu referred to the latter point, and asked whether, given the situation, patients would be likely to choose another Cancer provider, such as Guy's and St Thomas' NHS Foundation Trust. GD replied that this was unlikely, as the data would suggest that patients should have their full Cancer treatment undertaken by the Trust, rather than being referred after having their initial treatment elsewhere. GD added that at present, the Trust could not influence the first stage of patients' pathways. SDu asked what efforts were therefore being made with the referring Trusts. AG confirmed that discussions were being held by herself and the Associate Director Operations - Surgery and Cancer, and clarified that although the Trust had some internal challenges, the key issue at present rested with other providers.

AG then continued, and highlighted the following points:

- There had been some breaches of the 104-day Cancer waiting time target during August, although some of these originated from other Trusts, including Medway NHS Foundation Trust (MFT). The main reason for the delays that had originated at the Trust was that certain patients had a complicated pathway, involving a primary of unknown diagnosis. A separate Patient Tracking List (PTL) was now therefore in place for patients whose delays were considered unavoidable due to the complexity of their care
- There had also been 180 breaches of the non-Obstetric Ultrasound target. A risk assessment had been undertaken earlier in the year, and although a number of contingencies had been agreed, these were unable to be implemented as planned during August. However, the breaches would be managed over the coming weeks, via the appointment of overseas staff, and the securing of external capacity. The reliance on temporary staff due to Annual Leave in August had also been a factor.

AJ then invited SM, PB, AB, and SO to highlight any key issues.

Safe (infection control)

SM referred to the report and highlighted that there had been 3 cases of Trust-attributable Clostridium difficile in August. SM added that in response, there had been increased educational efforts regarding prescribing by Doctors in Training; and prescribing errors were being corrected when identified. KT queried the methods used to deliver the prescribing education. GD gave assurance that the Doctors were informed of all the key issues, and added that Non-Executive Directors were welcome to observe the educational sessions. KT stated that he would be happy to be involved in the development of alternative approaches to such education.

GD pointed out that this was the first year where the number of Clostridium difficile cases had increased nationally. SM confirmed this was the case, and added that the Trust was one of only two in the region that was still meeting its Clostridium difficile trajectory.

Well-led (workforce)

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

- There had been some recruitment successes, and the number of substantive vacancies had therefore reduced
- August was another month in which there was a net increase of Nurses, and this was also expected for September, following the arrival of new Nurses from Italy
- The graphs in the report relating to sickness absence had not been updated, but sickness absence remained stable below 4%
- Levels of Statutory and Mandatory training had reduced slightly, but action was being taken

KT remarked that despite previous discussions regarding the need to triangulate finances, activity and workforce data, he was unconvinced that the presented data had been triangulated. ST noted that the issue had been discussed at the Finance Committee on 28/09/15 and SO had provided a response. SO explained that capacity was calculated on discharge, and therefore although activity appeared to be static, non-elective activity had reduced in the month, and when combined with a peak in DTOCs, the Trust had had to use a lot more of its capacity to manage the situation.

ST then noted that the Finance Committee also discussed the fact that Medical Staff had seen the greatest proportional increase in staffing, and noted that PS would be reviewing Medical rotas in detail. KT expressed his interest in seeing the outcome of the review. AJ asked that the conclusions also be shared with the Trust Board.

Action: 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)

Safe / Effectiveness / Caring

AB referred to the circulated report and highlighted that there had been one Grade 4 and one Grade 3 Pressure Ulcer, both of which had been subject to Root Cause Analysis (RCA). AB continued that the Grade 4 case involved a patient with considerable mobility issues and complex morbidity, and although exceptional Pressure Ulcer care had been provided, nothing could have been done to prevent the Ulcer. AB added that the Grade 3 case had revealed opportunities for learning, relating to communication by staff about the length of time the patient had spent on trollies. AB did however point out that the management of the patient had also been exceptional.

AJ referred to the latter case, and asked whether all staff had received the learning AB had described. AB replied that there were a number of actions arising from the RCA, and these would be implemented in the near future. SDu then challenged AB's assertion that one of the cases could not have been prevented, and asked that if this was so, why other Trusts did not have such cases. AB replied that other Trusts did see such cases, and added that for some, the conclusion would be that they were unavoidable. AJ proposed that AB 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. This was agreed.

Action: 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)

AB then continued, and reported that the scores for the Friends and Family Test (FFT) had been positive, and the Trust was now above the national average. AB also commended the A&E Department for improving the FFT response rate. AJ added his own commendation to both improvements.

AJ then asked whether Trust Board Members had any further queries on the Safe / Effectiveness / Caring aspects of the report. SDu referred to the decline in "% MRSA Screening", as shown by the graph on page 5 of 18, and asked for an explanation. SM stated that in relation to elective screening, this referred to 3 patients who had "timed out" i.e. the 8 weeks allowed for their screening to be valid had expired. SDu confirmed that she had been assured by SM's response, given the small number of patients involved.

Well-Led (finance)

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

- There had been an in-month deficit of £2.5m, and the year to date deficit was now £9.1m
- Income was ahead of plan (by just under £2m), but expenditure was adverse to plan
- Agency Nursing expenditure had reduced in the month, from a peak in July. The Trust's trajectory regarding this had been submitted to the TDA, and although a similar expenditure pattern was expected for September, a reduction for the remainder of 2015/16 was anticipated (though an increase was likely once the new Ward opened at Tunbridge Wells Hospital (TWH))
- In terms of cash, an application for an Interim Revolving Working Capital Facility would be submitted to the Trust Board in October 2015, as this required a formal resolution from the Board. The Facility, in effect, acted as a Government-backed overdraft, and lasted for 2 years
- For the forecast out-turn, the original plan was to achieve a deficit of £14.1m, but this had now been revised to £12.1m. However, to achieve this, the CCG would need to provide funding for the Trust's costs relating to its Care Quality Commission (CQC) action plan, and such funding had been requested from the CCG

ST added that the Finance Committee had discussed the performance in detail on 28/09/15, and summarised by stating that a number of reviews were taking place, relating to: Medical rota efficiency; cost reduction; and a focus on trying to improve processes. ST added that the Committee had been very impressed by the efforts being made, and significant assurance had been taken by such efforts. AJ concurred with ST's summary, but cautioned against complacency.

KT then asked whether the Trust always took advantage of using generic medication once intellectual property protection had expired. SM confirmed this was part of the Medicines Cost Improvement Plan.

KT also asked whether there was any financial benefit from the Trust's recent support to MFT. GD confirmed there was no such benefit.

AJ then highlighted that there were a high level of debt from the Medway area, and asked whether this indicated a particular problem. SO replied that MFT had a significant deficit, but noted that discussions continued to be held with MFT. SO added that some of the debt with MFT was long-standing, but he expected this to reduce by the next Trust Board meeting. SO also confirmed that discussions were taking place with Medway CCG regarding the funds it owed the Trust.

Quality items

9-9 Progress with the Quality Improvement Plan

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

- There were no 'red' or 'amber' rated items, but the focus was now on obtaining comprehensive evidence of compliance
- It had been confirmed that the final report on the water quality testing would be arriving from the CQC later that week

KT remarked that some of the actions had taken a long time to complete, such as "CA6" and "CA9". PS replied that the completion of the actions for "CA6" relied upon the opening of the new Ward at TWH. KT challenged this, but PS explained that the increased capacity that would then be available at TWH would help to improve discharges from ICU.

AB then referred to "CA9" (i.e. that care and treatment was provided to service users with due regard to their cultural and linguistic background…), and stated that the required changes would take time. PB agreed that the timescale in the report was prudent. KT queried why two of the actions were still "under assessment". PB confirmed that some support had already been provided.

AJ then asked for an update on the changes for the Trust's translation service. AB confirmed that the Trust had changed its processes soon after the CQC inspection report had been issued, and gave assurance that all patients requiring translation were receiving this.

GD then remarked that the end point for the Quality Improvement Plan (QIP) should be agreed, to avoid the Trust Board continuing to receive similar reports. AJ asked that the reports continue to be provided, to ensure that more actions be rated 'blue'. AJ also asked when the CQC would be reviewing the action taken. AB replied that the CQC received the monthly QIP update reports, and had not raised any concerns. AJ asked whether the CQC had confirmed this in writing. AB noted this was not part of the process. AJ acknowledged this, but asked whether the Trust could request formal confirmation from the CQC to this effect. KT instead proposed that the Trust write to the CQC, stating that it was the Trust's understanding that there were no concerns. This was agreed.

Action: 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, September 2015 onwards)

9-10 Clinical Quality and Patient Safety Report

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

KT & SDu commended the recent performance on complaints response. SDu also referred to the PLACE assessment for Tonbridge Cottage Hospital, and asked whether this was an improvement from 2014. AB confirmed this was the case. SDu therefore commended the achievement.

9-11 Annual Report from the Director of Infection Prevention and Control

SM referred to the circulated Annual Report and highlighted the following points:

- Fig 1. on page 4 demonstrated the improvement made in reducing Clostridium difficile cases
- Extensive plans had been put in place during the year in response to the Ebola virus
- The Trust was working with a company developing Ultraviolet light decontamination, and it was hoped to introduce this during 2015/16. If implemented, the system would reduce the time required to decontaminate clinical areas, and therefore help improve patient flows

KT remarked that he found the Annual Report more readable than in previous years, and also asked for further details regarding Carbapenem resistant/Carbapenemase producing Enterobacteriaceae (CRE/CPE). SM explained that these were fast-spreading organisms that were resistant to a wide range of antibiotics. SM continued that there had been outbreaks within the UK (including at Hastings) and internationally, and a Safety Alert had been issued. SM added that patients arriving at the Trust from abroad were now screened, as were patients being transferred from other healthcare facilities. SM explained that extended Infection Control measures were applied to such patients until 3 negative results had been obtained from such screening.

ST commended the achievements referred to in the Report, particularly given the Trust's history. AJ agreed, but encouraged continued achievement towards 'upper quartile' performance.

9-12 Planned v actual ward staffing for July & August 2015

AB referred to the circulated reports (Attachments 8, 8a & 8b), and highlighted the following points:

- In August, the "Average fill rate – registered nurses/midwives" for Foster Clark Ward had been 80%, but this related to that Ward's high use of Clinical Support Workers rather than Registered Nurses. If this was related to dependency rather than acuity, this represented good practice, but AB did not want to see this pattern continue in the long-term, as it reduced the overall Nurse to patient ratio
- There had been some areas where the Trust had to engage staff above budgeted establishments, but such occurrences were in response to specific reasons, and had been authorised

SDu asked who determined the "RAG" rating definitions i.e. were these set externally or internally. AB explained that the overall "RAG" rating was a judgement applied by the Trust.

AJ then referred to Attachment 8b, and asked for an explanation of the low percentages in "Average fill rate - care staff (%)" for "Ante-Natal" and "Post-Natal". AB clarified that this related to recent appointments of staff that had not yet started in post, and she therefore expected the percentages to increase in the near future.

SD asked how acuity and dependency data was recorded. AB explained that this was collected at 12pm each day, according to a strict methodology, and the results were used to inform the number of staff required, which was then balanced against Nurse to patient ratios. AB continued that acuity and dependency altered shift by shift, and day by day, and the report outlined the specific details.

9-13 Board members' hospital visits

AJ referred to the circulated report and highlighted that all Trust Board Members needed to record the visits they made; and also increase the number of such visits, including undertaking visits at weekends and evening. AJ added that he did not wish the report to include every visit made by AB, PS, AG etc., but the report should capture any 'special' visits made by such individuals.

Assurance and policy

9-14 Review of the Board Assurance Framework, 2015/16

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

- The Board Assurance Framework (BAF) had been updated with each Responsible Director during September
- The content of each section had been refreshed, and ratings for September had been given for the two questions requiring this
- Objective 4.a. had been reviewed at the Finance Committee on 28/09/15, and it was agreed that the content of the "What actions have been taken in response?" section should be amended, to better reflect the full range of actions that had been taken. KR would therefore liaise with SO to make the requested amendments

ST referred to the latter point, and opined that the principle of capturing the full range of actions taken could be expanded to other areas on the BAF. KR acknowledged the point.

ST then referred to the "amber" rating in objective 2.a (capacity) for "Are the actions that have been taken sufficient to achieve the objective at year-end?", and asked for an explanation. AJ referred ST to the comment in the report that "The actions undertaken by the Trust are sufficient, but there is dependency on the wider system (where failure is occurring)".

AJ then referred to the "Quality" objectives (1.a and 1.b), and queried the "amber" ratings. AJ also queried whether the BAF should be populated with ratings for "Nov. 2015" and "Feb. 2016". KR replied that these ratings were not intended to be forecasts, but assessments at a point in time.

ST challenged the 'amber' rating for the staffing objectives (3.a and 3.b), and queried whether these contradicted the message the Trust had provided to the TDA. PB replied that he did not regard the rating as being contradictory.

SDu then referred to the objective relating to culture (5.a), and observed that there was a tension between the 'green' rating for "Are the actions that have been taken sufficient to achieve the objective at year-end?", and the 'amber' rating for "How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?". SDu added that there was no reference to culture as perceived by the staff and/or the local population. PB replied to the first point by stating that he was unsure the Trust would ever get to a 'green' rating for the stated objective. AJ stated that he did not believe the first 'green' rating was therefore correct. ST surmised that he understood the rating to mean that PB had confidence in the actions taken, but there was some uncertainty as to whether these would be sufficient. PB confirmed this was his intention.

SD declared that there would continue to be uncertainty as to whether objective 5.a. had been achieved until the Trust was able to effectively measure its culture. AJ noted that this had been covered within Attachment 18, under item 9-21, and asked PB to comment. PB explained that previously, the Trust Board had not approved a request to commission a bespoke cultural tool. AJ asked whether there were any objections to such a tool being commissioned. No objections were raised. The proposal, as stated in Attachment 18, was therefore agreed.

KT then referred to objective 7.a, which related to succession planning for the Trust's senior workforce, and challenged the 'green' rating for "Are the actions that have been taken sufficient to achieve the objective at year-end?". AJ agreed that more could be done to meet the objective.

The enhanced level of discussion prompted by the revised BAF format was commended, but AJ suggested that the format be reviewed, to consider, for example, his earlier comments as to whether ratings for "Nov. 2015" and "Feb. 2016" should be given in advance. AJ proposed that he meet separately with KR to consider this. This was agreed.

Action: 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, September 2015 onwards)

9-15 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 was the Trust's application to have the Regulated Activity of "Assessment or medical treatment for persons detained under the Mental Health Act 1983" added to its registration with the CQC.

The submission was approved as circulated.

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

9-16 Charitable Funds Committee, 20/07/15 (to include approval of revised Terms of Reference)

ST referred to the circulated report & the proposal to revise the Committee's Terms of Reference.

The Terms of Reference were approved as circulated; however GD queried the rationale for changing "Chair" to "Chairman". KR explained that "Chairman" was a generic term, à la "mankind" (i.e. it was not intended to imply gender), and represented an attempt to standardise terminology within Terms of Reference. KR confirmed that he would not proceed with the proposed change if there were any fundamental objections. AJ requested any Trust Board Member with such objections to make these known to KR, for him to consider.

9-17 Audit and Governance Committee, 06/08/15

KT referred to the circulated report, noted that PB would be attending the next meeting in November, in relation to the reported absence of an "up to date policy/procedure for requesting, booking and approving temporary medical staff". KT also noted that the draft "Gifts, hospitality,

sponsorship and interests policy and procedure" had been reviewed and it had been agreed that an upper limit of £25 for the acceptance of gifts should be set.

9-18 Quality Committee, 10/08/15 and 09/09/15

SDu referred to the circulated report and highlighted that the meeting was not quorate, as there was only one Non-Executive Director present. The Trust Board duly ratified the decisions made at the meeting, as per the request within Attachment 14.

SDu also highlighted that a continuing improvement in Stroke care had been reported, and asked whether the Trust Board wished to continue to receive the Stroke care update reports that were submitted to the 'main' Quality Committee. The Board agreed to continue to receive such reports.

AJ referred to the Stroke care report, and asked for an explanation of the different performance between MH and TWH. PS confirmed that as far as he was aware, this did not reflect the application of different standards at the two hospitals.

9-19 Trust Management Executive, 19/08/15 and 16/09/15

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

9-20 Finance Committee, 24/08 and 28/09/15

Attachment 16 was noted. ST then referred to Attachment 17 and invited questions or comments. KR pointed out that although it was not referred to in the report, the Committee had reviewed the Strategic Outline Case (SOC) for a Linear Accelerator (LinAc) at TWH, and gave its approval to develop and take forward an Outline Business Case (OBC). AJ repeated the offer he had made at the Finance Committee, for the Trust Board to consider approving the OBC as soon as the management wished to submit it. ST added that the only outstanding issues from the SOC were the provision of car parking, and the need to obtain Commissioner support. AJ also noted that the strategic considerations at East Kent Hospitals University NHS Foundation Trust were also important. GD asserted that this latter point was not of fundamental importance to the consideration of the Case.

KR also highlighted the proposed minor change to the Terms of Reference, as described in Attachment 17. The proposed amendment to the Terms of Reference was approved as circulated.

9-21 Workforce Committee, 15/09/15 (to include approval of the Workforce Strategy, 2015-20)

SD referred to the circulated report and invited questions or comments, noting that a decision regarding the introduction of a suitable cultural barometer had already been taken under item 9-14.

PB highlighted that the Trust Board's approval was being sought for the Workforce Strategy.

The Workforce Strategy 2015-20 was approved as circulated.

9-22 Patient Experience Committee, 21/09/15

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

AB commended the presentation given by the Paediatrics department on their response to the National Children's patient survey, adding that it was an excellent presentation.

Other matters

9-23 Proposal regarding the appointment of a "Freedom to Speak up Guardian"

PB referred to the circulated report and stated that it was proposed that the Associate Director of Workforce be the appointed Guardian, as PB did not regard it appropriate for the role to be undertaken by a Trust Board Member.

AJ queried whether the post of Associate Director of Workforce would be seen as sufficiently independent from the Executive Team by staff, noting that his comment was unconnected to the individual currently in that post. PB replied that he believed the individual would be seen as independent, and added that a number of contacts were already received by the individual concerned, as part of the Trust's 'Speak Out Safely' Policy.

SD asked whether the role could be undertaken by an individual from outside the Trust. PB replied that the view from the 'Francis report' was that the role should be undertaken from within the Trust, and pointed out that the equivalent national post would be based within the newly-created organisation, 'NHS Improvement'.

AJ stated that the proposed role holder may have difficulty distinguishing their operational workforce responsibilities from the "Freedom to Speak up Guardian" role. ST agreed that he did not believe that the post of Associate Director of Workforce was sufficiently independent. AK concurred, and stated that it represented a potential conflict of interest.

PS however remarked that he believed the proposal to be a fair compromise.

KT suggested that to satisfy the expressed concerns, it may be beneficial to ask the proposed role-holder to present to the Trust Board, outlining how they expected to fulfil the role. PB reiterated the point that the "Freedom to Speak up Guardian" role was, in effect, an extension of the role the Associate Director of Workforce already held under the current "Speak Out Safely" Policy. SDu queried whether staff were taking the opportunity to raise concerns via the "Speak Out Safety" Policy, as well as to the Senior Independent Director (SID). KT confirmed that, as SID, he had not been contacted with any such concerns. PB explained that a number of concerns had been reported under the "Speak Out Safety" Policy, and these covered a wide range of subjects, but none of the concerns had required the involvement of the SID.

AJ proposed that PB consider whether the "Freedom to Speak up Guardian" role would be better undertaken by KT, as an extension to his existing SID role. This was agreed. AJ asked PB to therefore re-submit the proposal to the Trust Board in due course.

Action: Consider whether the role of the Trust's "Freedom to Speak up Guardian" would be more appropriately undertaken by the Senior Independent Director; and re-submit a proposal to the Trust Board regarding the appointment to the role (Director of Workforce and Communications, September 2015 onwards)

KR then referred to the comment in the circulated report that PB would provide the Trust Board with a report on activity from the anonymous reporting system every 12 months, pointing out that the Board had previously agreed to receive such reports every 6 months. It was agreed that the 6-monthly anonymous reporting frequency should be maintained.

9-24 To consider any other business

There was no other business.

9-25 To receive any questions from members of the public

There were no questions.

9-26 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – October 2015

10-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
6-8ii (June 15)	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	Chief Operating Officer	September 2015	The necessary changes require further discussion, as although the target is set quarterly for performance monitoring purposes (and the "forecast" column has therefore been amended to be a quarterly forecast), performance against the monthly target is important in terms of the CCG contract. It is therefore likely that both monthly and quarterly performance will be reported.
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
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 will be provided to the Trust Board meeting in November 2015
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	The QIP report reviewed at the Trust Board on 30/09/15 has been sent to CQC. The next scheduled telephone discussion with the CQC is set for 26/10/15, and the CQC will be asked whether they have any concerns. The discussion will be followed up by an email from the Associate Director of Governance, Quality & Patient Safety, to confirm the

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

Ref.	Action	Person responsible	Original timescale	Progress [1]
				Trust's understanding of the CQC's view
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	September 2015 onwards	A meeting is being arranged

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-4 (Sep 15)	Provide the Trust Board with details of the numbers of Delayed Transfers of Care by patient age group	Chief Operating Officer	October 2015	The performance report submitted to the October Trust Board contains the requested information
9-23 (Sep 15)	Consider whether the role of the Trust's "Freedom to Speak up Guardian" would be more appropriately undertaken by the Senior Independent Director; and re-submit a proposal to the Trust Board regarding the appointment to the role	Director of Workforce and Communications	September 2015 onwards	The matter has been considered, and a proposal has been re-submitted to the October 2015 Trust 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 - October 2015

10-7	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 review the quality, safety and effectiveness of our services from the experience of our patients and clinical colleagues and partners within the wider local health community. From this I can see that despite continuing demand for, and pressure on our services, we are maintaining high standards of care and are focused on areas in which we require improvement. We are continuing to work closely with our partners where improvement requires external support.

2. Looking ahead, we are working with the Department of Health to ensure our organisation, and those around us, have and are continuing to develop robust winter plans that are fit for purpose. This shared understanding enables us all to see how the whole system works together to support patient care.

   As part of our own plan, we are working hard to ensure our new 38-bed ward at Tunbridge Wells Hospital is ready to open this winter to support an anticipated increase in patients requiring hospital assessment and treatment. The new ward will have an ambulatory care area, a rapid assessment area and a short stay area for patients with an expected length of stay of less than 48 hours. By having these three areas contained in one ward, medical and nursing staff will be able to work more efficiently; improving patient flows throughout the unit and hospital as a whole.

   Our new respiratory ward at Maidstone is due to open at the end of November with additional beds for patients with respiratory conditions. This is again in preparation for winter. The ward includes a new area for patients with higher dependency and acuity.

3. We have offered jobs to 100 nurses following our latest and on-going efforts to fill vacant posts and reduce costly agency use. Many are due to start between November and March 2016. We have recently welcomed a group of Italian nurses to our Trust and look forward to colleagues from Spain joining us in November.

4. We are now running a critical care outreach service in both our hospitals 24/7. Staff caring for critically ill and deteriorating patients on our wards will now have access to experienced critical care nurses for assistance, support and advice 24 hours a day.

5. Our outpatient booking teams have improved outpatient attendance through a new text messaging reminder service. More patients are now attending their appointments, saving over £50,000 a month.

6. Our Estates and Facilities department has gained an internationally-recognised standard for business continuity. We are only the second Trust in the country to achieve this accolade.

7. Our Radiology department has won the Society of Radiographers South East Radiography Team of the Year Award 2015 and Christine Richards, Radiotherapy Services Manager, has won the South East Radiographer of the Year Award 2015. The team and Christine Richards will now be put forward for the SOR's national awards, which take place at the House of Commons in November.

8. Our Viral Hepatitis Team were national finalists in the National Quality Care Awards for their outstanding work in helping diagnose and treat people, through our prison outreach scheme.

9. Congratulations to our latest employee of the month, Helen Francis. Helen is a member of the domestic services team and she was nominated for her excellent standards of cleaning in the Intensive Care Unit at Tunbridge Wells Hospital. Linen Services has been awarded our latest team of the month award following their recent success in achieving national recognition for professional linen standards. Well done to all the team for delivering high quality services.

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 – October 2015

10-8 Integrated Performance Report for September 2015	Chief Executive/Executive Team

The enclosed report includes:

- The 'story of the month' for September 2015, which includes the latest position on Delayed Transfers of Care (DTOCs);
- The Trust performance dashboard;
- Integrated performance charts; and
- Financial performance overview. This was discussed, and accompanied by a presentation, at the Finance Committee on 19/10/15.
-

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 13/10/15
- Finance Committee, 19/10/15

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

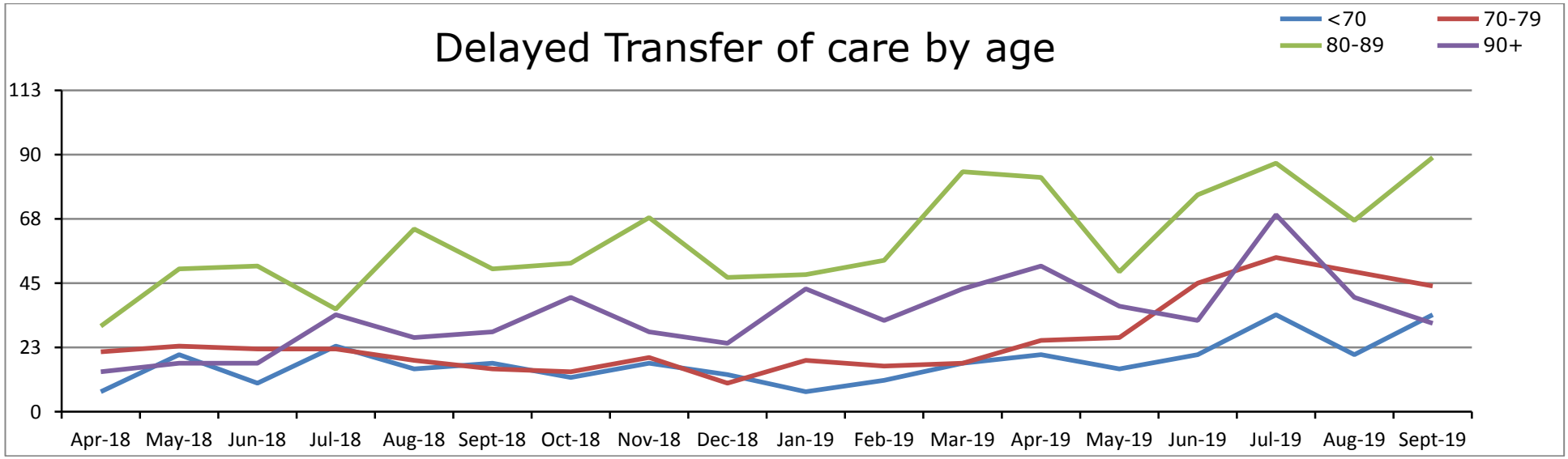
'Story of the month' for September 2015

The key issues for the month are

- Continued high level of Delayed Transfers of Care
- A&E 4 hour standard
- Cancer 62 day time to first definitive treatment
- Non-obstetric ultrasound breaches.
- Increased rate of falls

The level of delayed Transfers of Care: the level increased in September to 7.9% against the threshold of 3.5% caused by a combination of nursing home capacity, and access to care packages. We continue to work with health and social care partners to manage and resolve the contributory causes, but have not yet seen the benefits of any initiatives that are in place. The Trust has reorganised the patient discharge team to create and integrated discharge team which includes nursing, therapy and social care staff and this team will manage the complex discharges from the beginning to end. This model is well established elsewhere and provides a good governance framework for discharge planning and management. The charts below outlines the numbers of DTOCs and the age range of patients affected.

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	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	170
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	8	47
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	563
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	26	159
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	433
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	231
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	88
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	773
H : Disputes						1							2	1			1	3	8
I : Housing		2	6	2				2		2		1	3	4	3	1		1	27
Grand Total	76	111	106	119	123	110	119	133	94	116	119	162	180	129	173	250	181	198	2499



The A&E performance for September is 89.2% and 90.1% for quarter 2 and the bulk of the delays occur for patients requiring admission to an impatient bed and this issue is predominately on the TWH site, largely due to the inflexibility around bed capacity. The September performance was 96% at Maidstone and 82% at Tunbridge Wells. The MTW recovery action plan is focused on creating additional capacity, further developing the ambulatory pathways, and achieving the lowest possible length of stay for all patients.

The performance on Cancer targets in August (reported a month in arrears) shows a continued underperformance on the 62 day target, but with a drop this month in MTW only performance. This drop is largely due to a smaller than planned number of treatments whilst trying to treat a greater number of breached patients. The drop in activity was a combination of August leave and patient cancellations/postponements. It is expected that the MTW performance will recover for the quarter.

There are 5 accountable breaches over the 104 day standard in August , this is 8 patients of which 2 were attributable to MTW and 6 patients who were referred in from other centers with a combination of reasons relating to complex pathways and late referrals.

The Trust incurred a further 220 breaches of the 6 week standard for non-obstetric ultrasound in August, largely due to the issues with capacity identified in July and August and there is now a recovery plan underway which expects to get this back on track in October and remains dependent on external capacity. September has seen an increased rate of falls particularly at Maidstone site. There is no single explanation for the significant increase at Maidstone at this point but the analysis continues particularly within the medical directorate. There has been an increase in repeat fallers despite actions being taken. The feedback from the falls team, ward managers and matrons is that the complexity and frailty of the patients together with delayed transfers of care is having an impact on the overall rate.

Work is underway to implement ‘Safety Huddles’ in ward areas as a methodology for reducing falls and other harms. These have proven to be successful in other Trusts.

In relation to the workforce issue which should be drawn to the Boards attention for the month of September, the key issues are the continued reliance on temporary staff, the reduction in the number of vacant posts and an update on the nurse recruitment activity.

The month saw an increase compared to the previous month in the use of locum and agency staff (3 wte and 26 wte retrospectively) and increase in the levels of overtime used (10 wte) the bank was also unable to fill as many temporary slots as previously which a reduction of twenty while time equivalent reduction when compared with the previous month.

This increase in the use of temporary staff is not a result of the levels of vacancies which has reduced when compared to earlier in the year, the board will note the level of vacancies running at 7.6% for the month, in part this is a reflection of a significant success in the recruitment of both registered and non-registered nursing staff, the month saw a net increase in nursing of 43 whole time equivalents of which 19 are registered nurses.

The recruitment initiatives continues in the month of September with successful nurse open events taking place at Maidstone on the day of the Trust AGM, and a further overseas recruitment initiate in Europe. The nursing recruitment pipeline is strong.

Although the other workforce metrics are reported to the Board, and are important to note I do not wish to draw them to particular attention this month.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30th September 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)	0.00	15.9	16.9	10.2	-6.7	- 2.6	11.5	10.1	
'1-02	Number of cases C.Difficile (Hospital)	0	3	19	12	-7	- 3	27	24	
'1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
'1-04	Elective MRSA Screening	97.0%	99.0%	97.0%	99.0%		1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	96.0%	98.0%	96.0%	98.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.6	2.8	2.1	2.3	0.2	- 0.7	*3.0*	2.3	3.0
'1-07	***Rate of Total Patient Falls	5.6	7.9	5.9	6.8	0.9	0.6	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	5.0	8.5	5.3	6.1	0.8			6.0	
'1-09	***Rate of Total Patient Falls TWells	6.0	7.5	6.4	7.1	0.8			7.1	
'1-10	Falls - SIs in month		5		21	21				
'1-11	Number of Never Events	1	0	2	0	-2	0	*0*	0	
'1-12	Total No of SIs Open with MTW	37	28			- 9				
'1-13	Number of New SIs in month	18	7	66	47	- 19	- 13			
'1-14	**Serious Incidents rate	0.95	0.37	0.59	0.40	- 0.19	0.34	*0.0602 - 1.0634*	0.40	*0.0602 - 1.0634*
'1-15	Rate of Patient Safety Incidents - harmful	0.87	1.68	1.24	1.35	0.11	- 0.34	*0 - 1.698*	1.35	*0 - 1.698*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.5%	95.7%	95.6%	95.3%	-0.3%	0.3%	95.0%	95.3%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	96.1%	96.7%	96.7%	96.8%	0.2%	1.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	1.51%	2.54%	2.40%	2.36%	-0.04%	-0.64%	*3.00%*	2.36%	
'1-20	C-Section Rate (non-elective)	16.9%	15.3%	14.9%	13.1%	-1.76%	-1.90%	*15.0%*	13.1%	

	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	104.0	0.6	4.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	106.0	-0.9	6.0			100.0
2-03	Crude Mortality	1.0%	1.2%	1.1%	1.1%	0.0%				
2-04	****Readmissions <30 days: Emergency	11.4%	11.8%	11.9%	11.3%	-0.6%	-2.3%	*13.6%*	11.3%	14.1%
2-05	****Readmissions <30 days: All	10.6%	10.9%	10.9%	10.5%	-0.4%	-4.2%	*14.7%*	10.5%	14.7%
2-06	Average LOS Elective	3.9	3.2	3.2	3.23	- 0.0	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.2	7.5	6.7	7.4	0.7	0.9	*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%	83.6%	83.4%	83.6%	0.2%	3.6%	80.0%	83.6%	82.2%
2-10	Primary Referrals	8,929	8,629	51,195	52,669	2.9%	2.3%	102,995	105,338	
2-11	Cons to Cons Referrals	3,380	2,788	20,691	19,855	-4.0%	0.3%	39,585	39,710	
2-12	First OP Activity	12,747	11,987	71,731	69,039	-3.8%	0.5%	137,412	138,078	
2-13	Subsequent OP Activity	22,166	22,185	128,602	128,324	-0.2%	-1.6%	260,800	256,648	
2-14	Elective IP Activity	605	674	3,879	4,046	4.3%	1.3%	7,988	8,092	
2-15	Elective DC Activity	3,184	3,279	18,692	19,550	4.6%	1.4%	38,556	39,100	
2-16	Non-Elective Activity	3,880	3,838	23,853	22,918	-3.9%	-5.1%	48,289	45,836	
2-17	A&E Attendances (Calendar Mth)	10,827	11,258	67,853	68,859	1.5%	1.3%	135,922	137,718	
2-18	Oncology Fractions	5,853	6,108	34,856	33,712	-3.3%	-6.0%	71,761	67,424	
2-19	No of Births (Mothers Delivered)	486	459	2,872	2,938	2.3%	2.9%	5,708	5,876	
2-20	% Mothers initiating breastfeeding	85.6%	80.0%	82.0%	80.6%	-1.4%	2.6%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.0%	0.85%	0.10%	0.40%	*0.3%*	*-0.1%*	*0.47%*	0.40%	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	2.65	2.92	3.98	2.13	-1.85495	0.81	*1.318-3.92*	2.10	
3-03	% complaints responded to within target	80.6%	75.6%	80.6%	72.1%	-8.6%	-2.9%	75.0%	73.5%	
3-04	****Staff Friends & Family (FFT) % rec care	New	82.2%	New	83.3%	New	8.3%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	95.9%	New	96.7%	New	1.7%	95.0%	95.0%	95.9%
3-06	A&E Friends & Family (FFT) % Positive	New	89.0%	New	89.0%	New	2.0%	87.0%	87.0%	88.2%
3-07	Maternity Combined FFT % Positive	89.4%	95.2%	91.1%	94.7%	3.6%	-0.3%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	New	79.2%	New	79.0%	New			79.0%	

* 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	94.3%	89.2%	95.1%	90.1%	-5.0%	-4.9%	95.0%	95.0%	92.5%
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	93.5%	87.5%	89.7%	91.3%	1.6%	1.3%	90%	91.3%	
4-06	18 week RTT - non admitted patients	96.4%	97.3%	96.3%	97.9%	1.6%	2.9%	95%	97.9%	
4-07	18 week RTT - Incomplete Pathways	96.1%	96.3%	96.1%	96.3%	0.2%	4.3%	92%	96.3%	
4-08	18 week RTT - Specialties not achieved	-	6	14	27	13	27	*0*	27	
4-09	18 week RTT - 52wk Waiters	0	0	0	5	5	5	*0*	5	
4-10	18 week RTT - Backlog 18wk Waiters	319	635	319	635				635	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	96.56%	100.0%	96.56%	-3.4%	-2.4%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	8	4	8	6	- 2	- 3	9	9	
4-13	*Cancer two week wait	95.1%	95.3%	95.1%	94.3%	-0.8%	1.3%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	95.4%	90.8%	95.4%	93.3%	-2.1%	0.3%	93.0%	93.3%	
4-15	*Cancer 31 day wait - First Treatment	100.0%	97.9%	100.0%	98.2%	-1.8%	2.2%	96.0%	98.2%	
4-16	*Cancer 62 day wait - First Definitive	85.4%	72.8%	85.4%	76.2%	-9.2%	-8.8%	85.0%	85.0%	
4-17	*Cancer 62 day wait - First Definitive - MTW	90.8%	78.0%	90.8%	81.3%	-9.5%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	5	New	28	New	28.0	-	28	
4-19	Delayed Transfers of Care	4.4%	7.9%	4.1%	6.6%	2.6%	3.1%	3.5%	5.0%	
4-20	% TIA with high risk treated <24hrs	53.8%	68.6%	70.2%	70.8%	0.6%	10.8%	60%	70.8%	
4-21	% spending 90% time on Stroke Ward	89.3%	88.1%	82.3%	83.1%	0.8%	3.1%	80%	83.1%	
4-22	Stroke:% to Stroke Unit <4hrs	38.1%	59.2%	38.4%	52.6%	14.1%	-2.4%	55.0%	55.0%	
4-23	Stroke: % scanned <1hr of arrival	50.8%	58.0%	46.1%	54.5%	8.4%	11.5%	43.0%	54.5%	
4-24	Stroke:% assessed by Cons <24hrs	78.5%	68.0%	74.1%	72.8%	-1.4%	-12.2%	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*

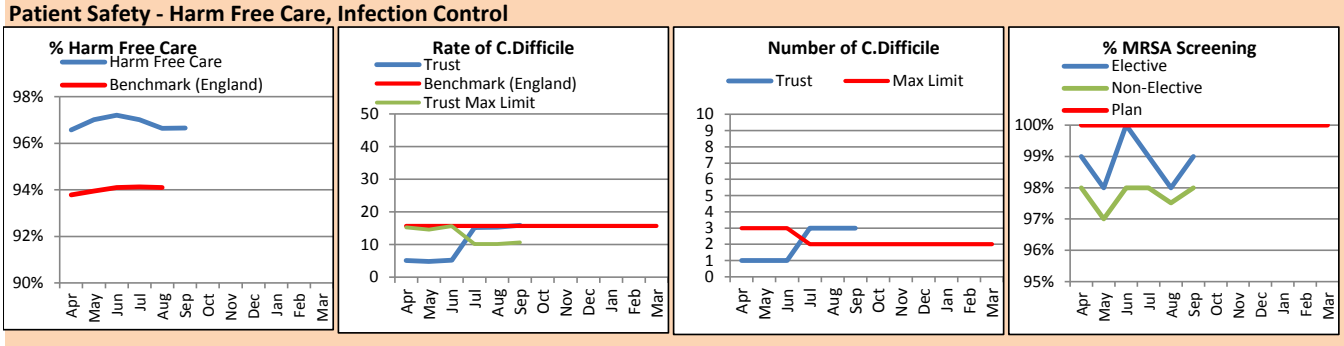
**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

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

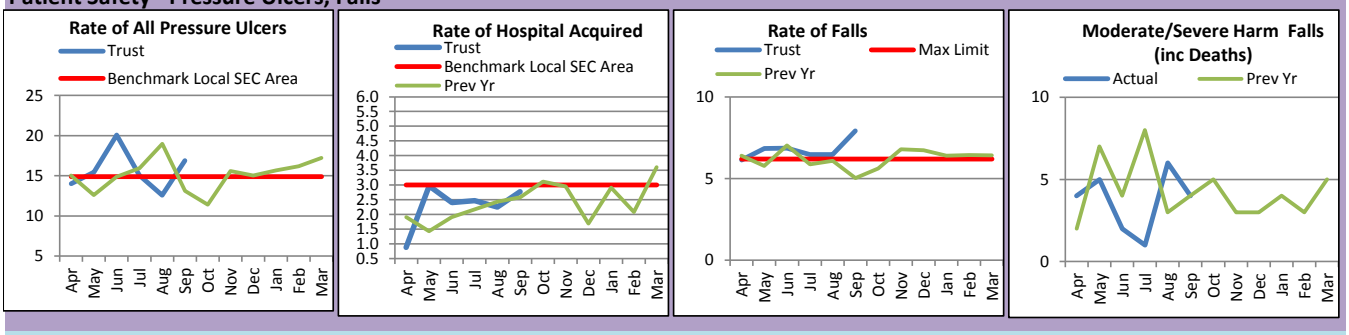
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	32,507	34,384	189,045	198,888	5.2%	1.5%	400,777	404,410	
5-02	EBITDA	2,177	731	9,209	5,929	-35.6%	-33.3%	23,821		
5-03	Surplus (Deficit) against B/E Duty	(734)	(2,002)	(8,714)	(11,092)			(12,132)		
5-04	CIP Savings	2,855	1,812	11,282	10,184	-9.7%	-5.4%	21,496	20,463	
5-05	Cash Balance	7,162	12,295	7,162	12,295	71.7%	-13.1%	2,127	2,127	
5-06	Capital Expenditure	277	1,150	1,453	4,284	194.8%	-9.4%	*16,163*	16,163	
5-07	Establishment (Budget WTE)	5,403.9	5,381.5	5,403.9	5,381.5	-0.4%	0.0%			
5-08	Contracted WTE	4,931.8	4,974.6	4,931.8	4,974.6	0.9%	-2.4%			
5-09	***Contracted not worked WTE	(111.4)	(103.8)		(103.8)					
5-10	Locum Staff (WTE)	29.7	53.9	29.7	53.9	81.3%				
5-11	Bank Staff (WTE)	303.5	295.6	303.5	295.6	-2.6%				
5-12	Agency Staff (WTE)	172.7	304.8	172.7	304.8	76.5%				
5-13	Overtime (WTE)	87.1	79.8	87.1	79.8	-8.4%				
5-14	Worked Staff WTE	5,418.3	5,588.0	5,418.3	5,588.0	3.1%	3.8%			
5-15	Vacancies WTE	472.0	406.9	472.0	406.9	-13.8%				
5-16	Vacancy %	8.7%	7.6%	8.7%	7.6%	-13.4%				
5-17	Nurse Agency Spend	(491)	(839)	(2,151)	(5,280)	145.5%				
5-18	Medical Locum & Agency Spend	(913)	(1,102)	(4,522)	(6,322)	39.8%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.5%	10.2%		9.8%	0.7%	-0.3%	*10.5%*	9.8%	8.4%
5-21	Sickness Absence	3.9%	3.9%		3.9%	0.1%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	85.1%	88.0%		88.0%	2.9%	3.0%	85.0%	85.0%	
5-23	Appraisal Completeness	81.0%	75.6%		75.6%	-5.4%	-14.4%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	101.0%	100.5%	100.4%	101.6%	-0.5%		92.7%	101.6%	
5-25	****Staff FFT % recommended work	New	56.9%	New	58.0%		-1.1%	58.0%	58.0%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	253	New	253					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	26.8%	New	27.3%		-2.7%	30.0%	30.0%	27.6%
5-28	A&E Resp Rate Recmd to Friends & Family	New	20.0%	New	13.5%		-6.5%	20.0%	20.0%	15.2%
5-29	Mat Resp Rate Recmd to Friends & Family	17.5%	10.2%	20.6%	14.5%	-6.0%	-0.5%	15.0%	15.0%	22.4%

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

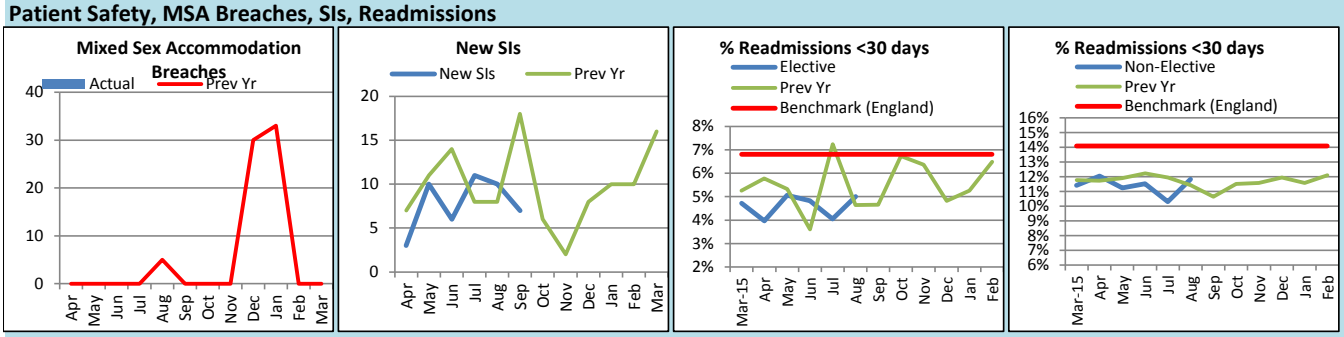
Patient Safety - Harm Free Care, Infection Control



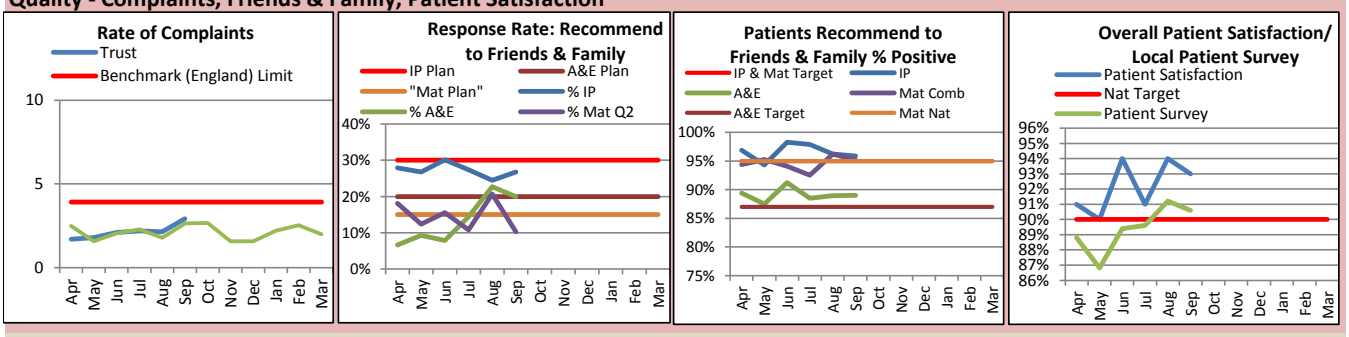
Patient Safety - Pressure Ulcers, Falls



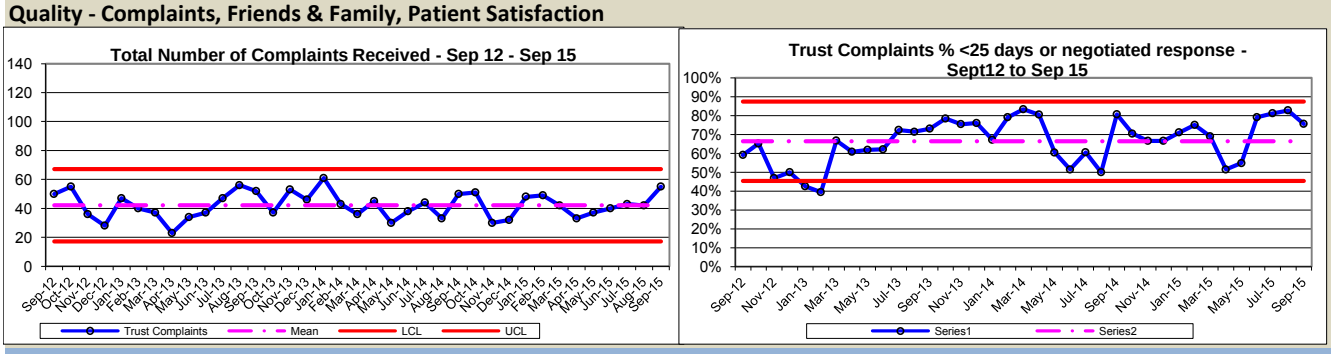
Patient Safety, MSA Breaches, SIs, Readmissions



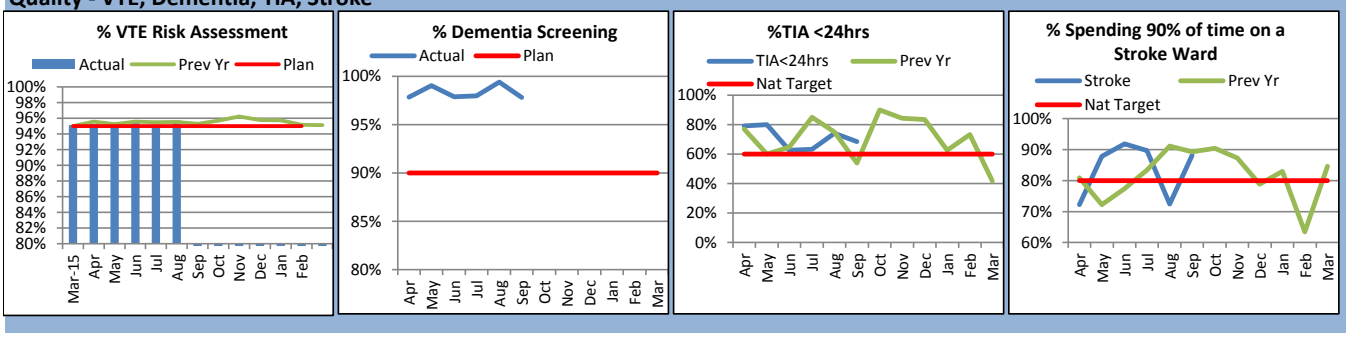
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

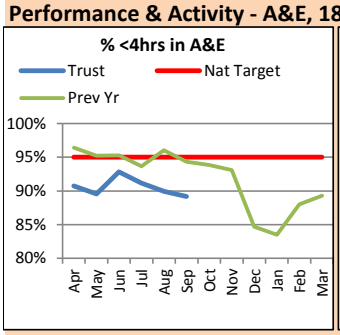


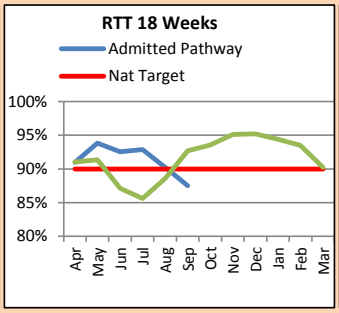
Quality - VTE, Dementia, TIA, Stroke

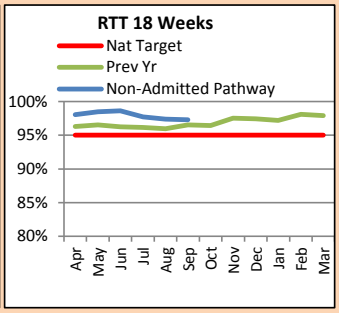


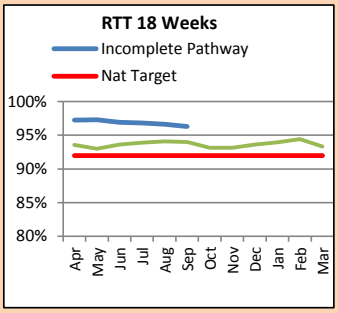
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

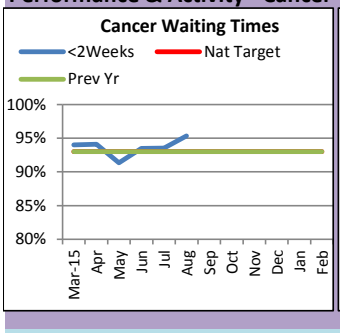


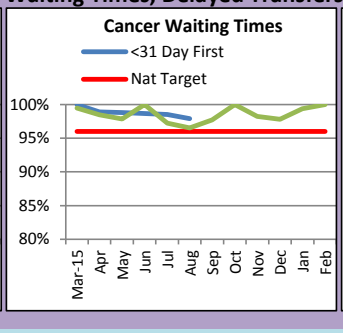


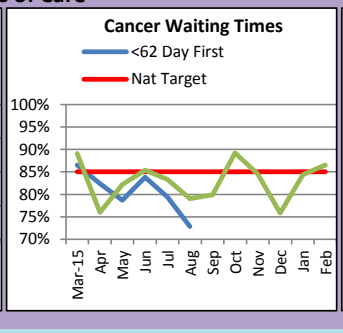


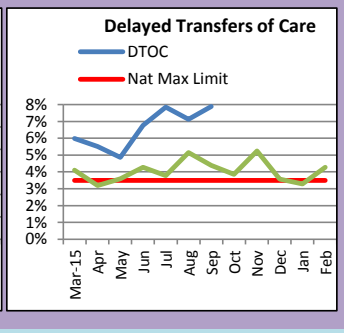


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

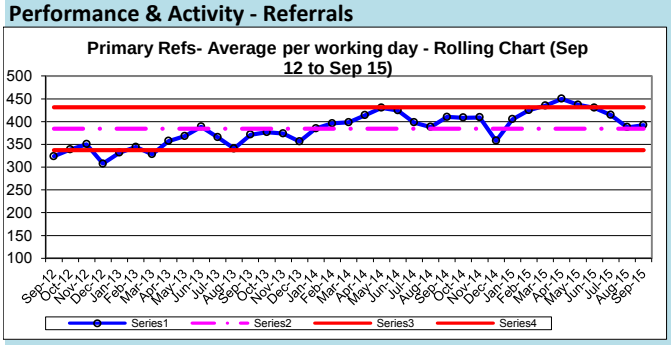


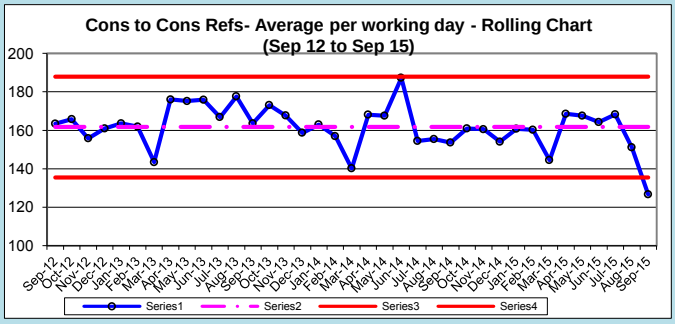




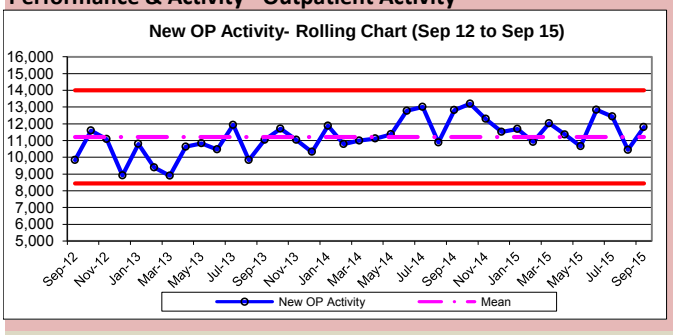


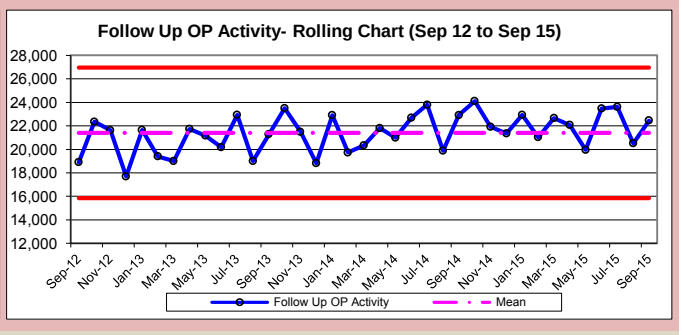
Performance & Activity - Referrals



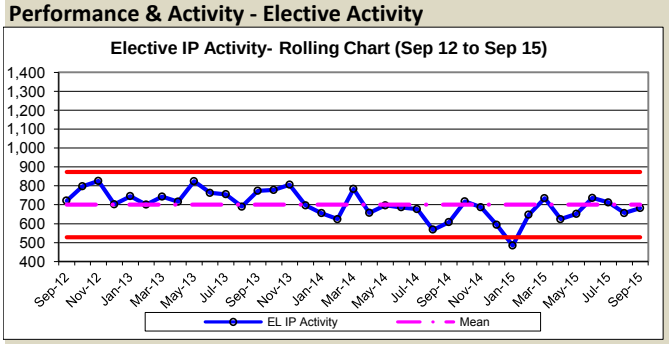


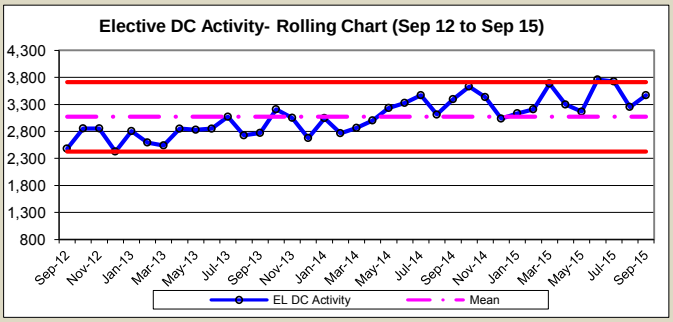
Performance & Activity - Outpatient Activity



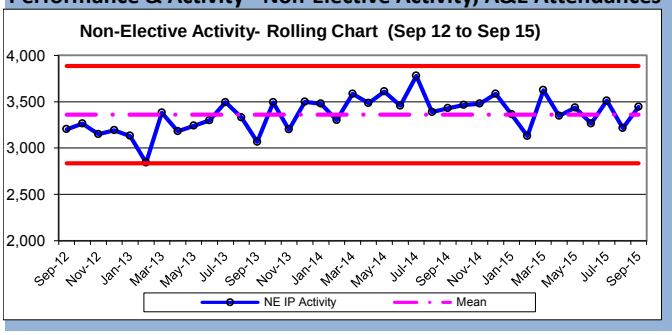


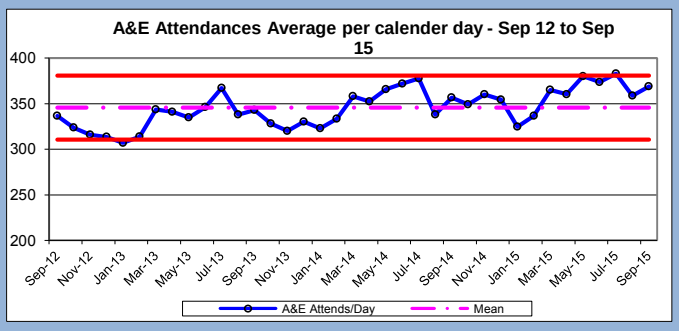
Performance & Activity - Elective Activity





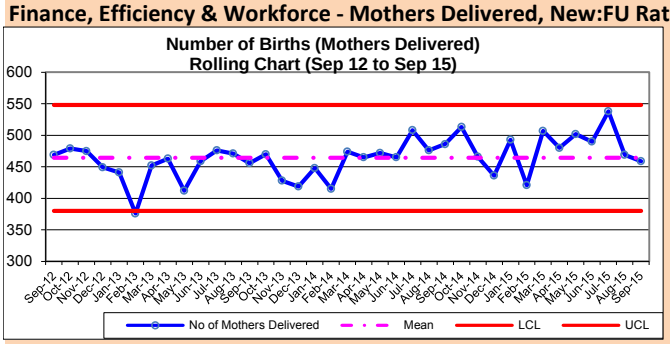
Performance & Activity - Non-Elective Activity, A&E Attendances

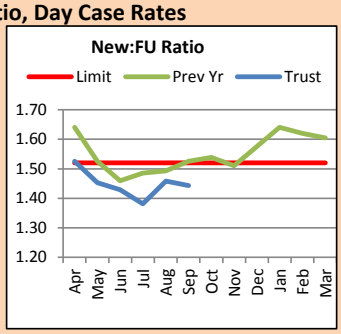


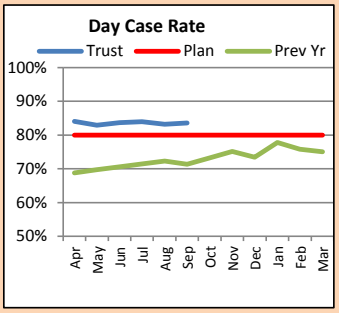


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

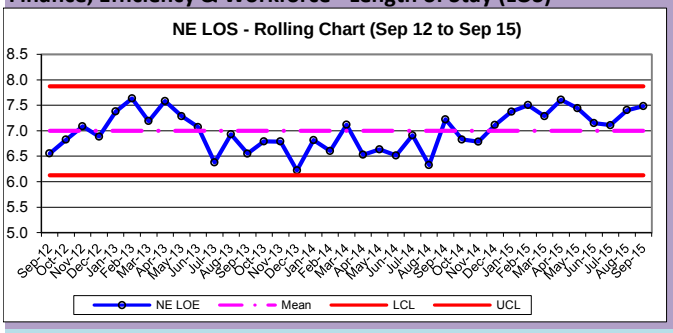
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

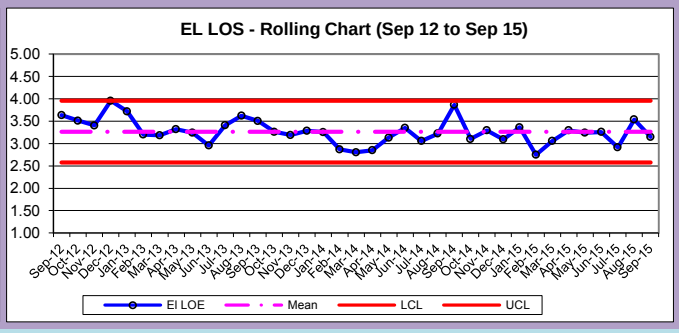




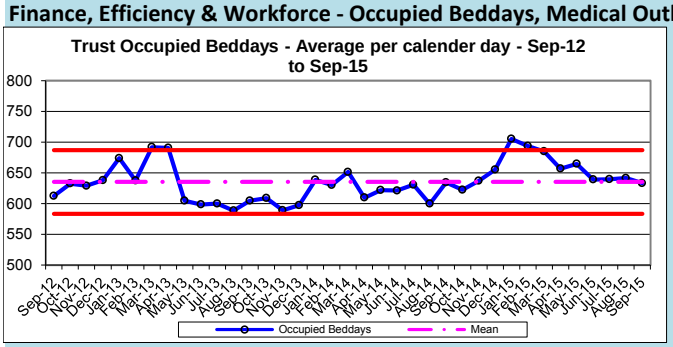


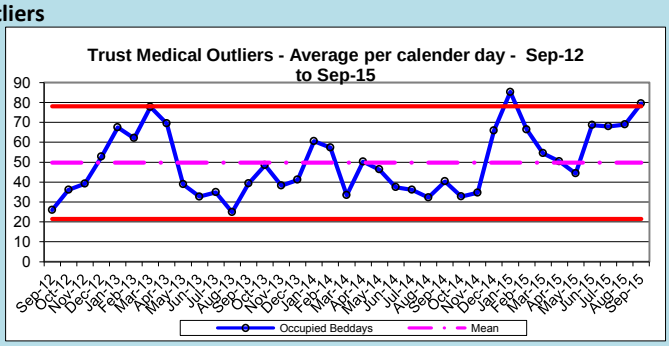
Finance, Efficiency & Workforce - Length of Stay (LOS)



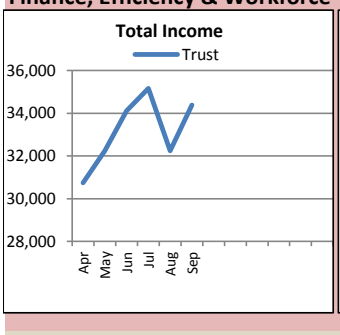


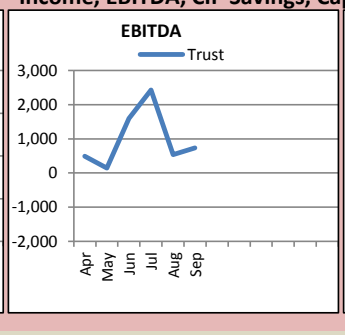
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

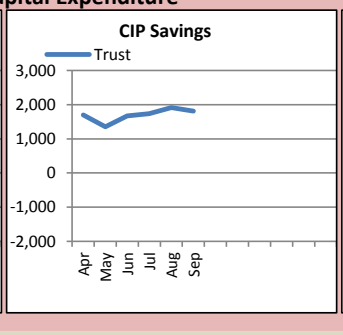


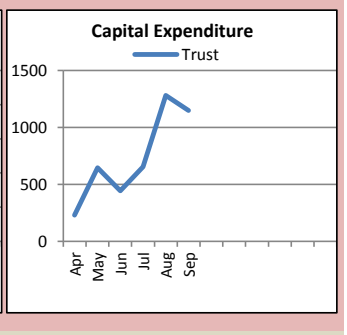


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

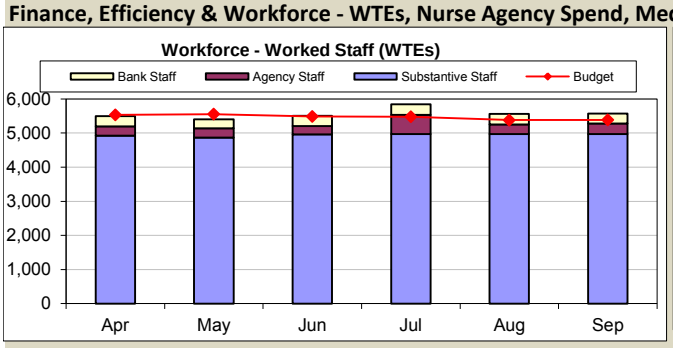


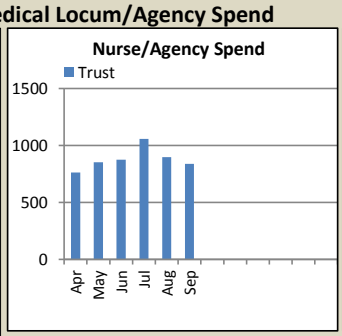


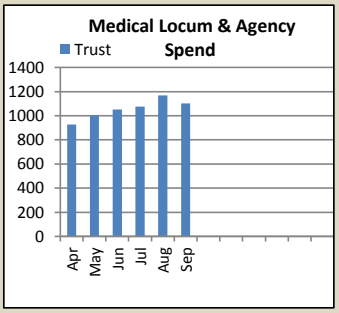




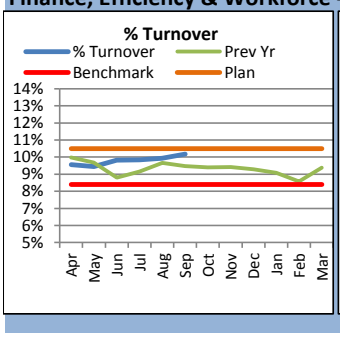
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

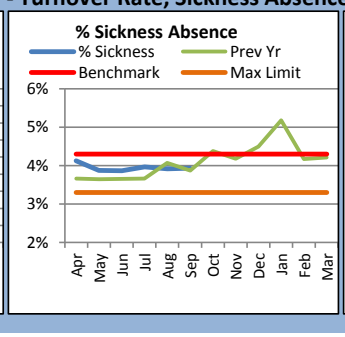


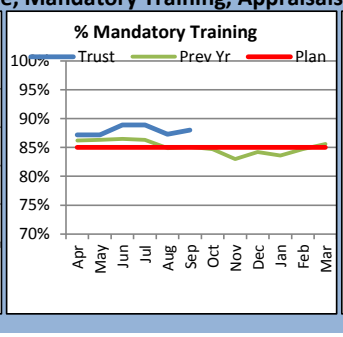


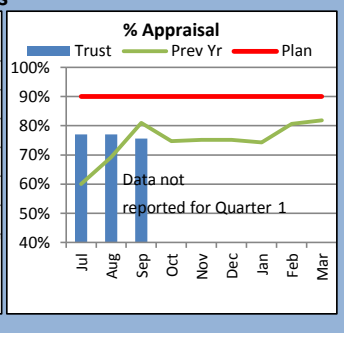


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting– October 2015

10-8 Review of Latest Financial Performance — Director Of Finance

Summary / Key points

- The Trust had an adverse variance against plan at the end of September 2015 of £1.98m, an increase of £1.1m in the month.
- The Trust's net deficit to date (including technical adjustments) is £11.09m against the planned deficit of £9.11m. In the month the Trust operated at a deficit of £2.0m against a plan of £0.9m deficit for September.
- There are a number of key risks to the Trust's year end position which are reflected in the forecast outturn of £18.6m. This is £6.5m adverse to the revised "stretch" plan of £12.1m, and £4.5m higher than the original plan deficit of £14.1m. 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, areas of Best Practice Tariff and other income related CIPs. High levels of income in previous months mitigated this slippage.
- In September the Trust operated with an EBITDA surplus of £0.7m which was £1.4m adverse to plan.
- The Trust held £12.3m of cash at the end of September, a reduction of £2.9m from the end of August.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

[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

Briefing paper – Trust Board

M6 Financial Performance overview

1. Overview of the Financial Position at M6 2015/16

1.1. This written summary provides an overview of the financial position at M6 of 2015/16. It should be read alongside the finance pack, which has also been circulated to Board members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 6. The Finance pack shows for month 6 the Trust moved out adversely by £1.1m against its in-month deficit plan of £0.9m resulting in a year to date deficit of £11.09m against a planned deficit of £9.11m. This is an adverse year to date variance of £1.98m. These figures include the full utilisation of reserves available for the first six months of 2015/16.

1.3. Planned financing to support the Trust's liquidity is being 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 IRWCF documentation requires a Board resolution which is on the agenda for the October Trust Board for approval.

Income

1.4. Total income for the year to date is £198.9m against a budget of £195.9m. Income for the month is £34.4m compared to the £33.3m plan for the month.

1.5. The income headlines are outlined below:

- Total income is £1.1m 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 £3.3m provisions/deductions and £2.0m threshold adjustments are included in the year to date position with £9.97m provisions/deductions and £4.4m threshold adjustments in the forecast outturn.
- A&E attendance activity remains higher than in the corresponding period of last year.
- Conversion rate remains unchanged from June 2015 level

1.6. Elective inpatient and day case activity have increased from the previous month's level but not by as much as planned given the extra two working days (£4.84m in M6 compared to £4.76m in M5, with YTD under performance of £0.2m). The closure of Whatman ward towards the end of the month has reduced the level of escalation capacity, and there was also an increase in medical outliers into surgical beds, with the greatest impact in Tunbridge Wells. Whilst reportable cancellations reduced from August to September (42 Aug vs 26 Sept), there was an increase in "patient induced" cancellations (198 in Aug vs 233 in Sept) along with an increase in trauma patients. This combined with laser equipment breakdown, Locum Consultant last minute withdrawal, staff shortages in theatre and the inability to put on extra sessions resulted in the loss of activity across various specialties and lower than expected level of elective income.

1.7. A&E attendances increased slightly in September, while the rate of conversion from A&E admission remained static at 25% resulting, in an increased level of Non - Elective admissions between August and September, particularly in Elderly Care where lengths of stay tend to be longer. Overall Non-Elective activity continues to be lower than in 2014/15. Delayed Transfers of Care in September reached 7.9% matching the record level reported in July this year.

1.8. As a result, Non Elective income increased from £6.8m in M5 to £7.6m in M6 and the YTD performance is now £0.1m below plan. The increase in income reflects a combination of

increased A&E attendances, increased discharges, and a more complex casemix for those patients that were discharged in the month and therefore a higher average income per spell.

1.9. Outpatient activity has increased marginally from last month's level (£4.8m in M6 compared to £4.7m in M5). However this is a lower increase than expected from the additional two working days in September, which would have suggested a value of c£5.2m. Year on year, the income from Outpatients was 4% higher than in M6 of the previous financial year.

1.10. Readmissions, A&E waits and RTT penalties (relating only to incomplete pathways) were £1.8m in September compared to the £1.5m performance in August.

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

1.12. Non recurrent transitional support of £1.8m 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.

Expenditure

1.13. Operating costs are £6.6m adverse YTD against a plan of £186.4m. Pay deteriorated against plan by £1.4m in September generating a year to date adverse variance of £5.2m. This sustains the upward pressure on overall pay costs seen in the first half of the financial year.

1.14. Non pay overspent by £1.7m in September and is £1.4m overspent year to date.

1.15. Substantive staffing was underspent year to date by £1.7m due to prior period vacancies in Scientific posts (£0.3m), medical staffing (£0.8m), clerical (£0.2m) and nursing (£0.4m). In the month substantive pay costs were marginally over budget (£0.1m).

1.16. At the end of September agency Nursing (£3.6m), Medical agency (£1.6m), Scientific/Therapeutic agency (£0.6m) and Admin & Clerical (£0.6m) are the major overspends to plan year to date. In the month there was a small reduction from August's level in nurse agency spend (£839k compared with £891k), while support service agency costs increased. Locum costs remained high and are £0.4m overspent to date, whilst Bank staff costs were lower than the average level of the year to date and are £0.15m underspent.

1.17. The trajectory plan submitted to the TDA last month 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 September the agency nursing reduced to £839k which was £57k lower than the September trajectory target.

1.18. Non pay overspent by £1.7m in September and is £1.4m overspent year to date.

1.19. Significant overspends for the year to date are:

- Drugs and medical gases £1.8m adverse (offset in the position by the over performance in HCD income to date of £1.6m)
- Clinical Supplies is £1.2m 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 £1.5m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income.

1.20. 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 £2.9m underspent to date.

1.21. Premises is £0.7m 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 October.

1.22. EBITDA is a £5.9m surplus and is now adverse to plan by £2.9m.

1.23. The financing costs including those related to the PFI and deprecation total £17.5m year to date which is underspent against the plan by £0.98m. The plan was agreed prior to the finalisation of the revaluation in year-end accounts, which reduced planned levels of deprecation. In addition, the in-year capital plan reprioritisation and "capping" to provide funding for the new TWH ward development has slowed down originally planned spend, and diverted it from shorter life, higher depreciating assets such as medical and IT equipment into build assets.

Forecast Outturn & Risks on delivery

1.24. The performance in September, particularly around elective income and on the sustained level of pay costs including agency reliance, is putting increased 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.

1.25. 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.

1.26. There has also been slippage on the delivery of a number of Directorate and Strategic plans intended to increase market share, areas of Best Practice Tariff and other income related CIPs. In previous months high levels of income mitigated this slippage.

1.27. 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.

1.28. 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.

1.29. The forecast outturn submitted to the TDA in month 6 will therefore recognise an assessment of these key risks to the Trust's year end position reflected in the revised forecast outturn of £18.6m. This is £6.5m adverse to the revised "stretch" plan of £12.1m, and £4.5m higher than the original plan deficit of £14.1m.

Balance Sheet & Capital

1.30. Cash balances of £12.3m were held at the end of September (£15.2m at the end of August). 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 £32.7m, £11.7m higher than the reported August figure. This includes a technical adjustment of £15.8m made to reclassify the advance SLA payments from WK CCG as deferred income rather than debt adjustment. The corresponding adjustment is reported now in NHS creditors. Debt over 90 days has reduced by £0.2m to £4.2m at the end of September. Debtors in excess of a £1m are;

- WKCCG £7.5m
- EK Hospitals FT £2.0m
- Medway FT £1.1m

90 day invoiced debt for private patients billed through Compucare is currently £0.3m (£0.9m 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 £54.9m. This includes the £15.8m adjustment to the advance WK CCG SLA payment now reclassified as deferred income. Against the 95% target for payments made within 30 days the Trust achieved in value 87.4% in September for Trade creditors (81.3% in March 2015) and 80.7% in September for NHS creditors (66.6% in March 2015).

1.33. Planned financing to support the Trust's liquidity is being 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 IRWCF documentation requires a Board resolution which is on the agenda for the October Trust Board for approval. The Trust's facility is limited to £12.132m initially, in line with the stretch plan total.

1.34. Capital expenditure to month 6, net of donated assets, was £4.3m against the original TDA profiled plan of £4.6m for the first half of the year. The Trust has revised its planned outturn to the TDA in line with its Finance Improvement response, reducing its request for capital loans (or PDC) by £3m to £3.5m.

1.35. As a result of the relative Business Case approval progress on the TWH ward and satellite radiotherapy business cases, and the need for the latter to be reviewed and approved at OBC and FBC stages by the TDA, the Trust has agreed with the TDA that the £3.5m loan will be sought wholly against the TWH ward project in this financial year. Loan funding for the radiotherapy satellite project will be sought in full in the 2016/17 financial year in line with the likely spend profile, assuming the case is approved.

1.36. 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. Pending approval of the loan, the Trust has "capped" its original programme, and paused a number of schemes to ensure the Trust has sufficient resource to finance the new ward if a loan is not agreed. However there is a risk that emergency capital requests will put the delivery of the Capital Resource Limit (CRL) at risk.

1.37. If the loan is not agreed in full or in part, the Trust will need to reduce planned spend further than the current cap by c.£2.4m, to a level of £12.8m for the year. The combination of spend pressure on agreed schemes and the deferral of the planned residence disposal makes this a high risk target for the Trust to achieve in the eventuality of the loan not being agreed. Therefore an additional control has been introduced for the period until the loan decision is known requiring Finance Director sign off on all capital purchase orders (Estates, IT and Equipment) prior to any commitment being placed.

2. CIP Delivery

2.1. The month 6 position shows a CIP delivery of £10.2m against the target that was included in the TDA plan of £10.8m, so under-performing by £0.6m to date.

2.2. The schemes identified are forecast to deliver £20.5m by year end which is £0.2m more than the forecast reported at month 5, and leaves £1.0m of schemes that the Trust is working to identify.

2.3. Against the year to date total CIP expectation of £10.8m, shortfalls in Medical Efficiency (-£0.3m), Length of Stay (-£0.6m) and Drugs (-£0.2m) are offset by overachievement in Contract Management (+£0.9m) and Financial Management efficiencies (+£0.1m).

3. Conclusion

3.1. September elective and outpatient performance was higher than the corresponding month in 2014/15, but nonetheless lower than planned for this year. Various issues including an influx of trauma cases, patient determined cancellations, and equipment failure, led to cancelled elective activity. A&E attendances increased slightly over the previous month, whilst non-elective discharges and income increased. The picture on non-elective capacity is mixed in the month: escalation bed usage reduced at Maidstone, however medical outliers increased at TWH; delayed transfers of care returned to the peak level of July. Overall the financial impact was c. £1m less than planned (excluding service developments).

3.2. Overall Staffing costs were the highest of the year to date, with the Trust both spending more on establishment staffing and remaining reliant on high levels of temporary staffing. Action to reduce both the use of temporary staffing and the cost of agency has been implemented with Directorates having trajectory targets 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 are requested note this report.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M6 - September 2015

September 2015

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 5 2015/16

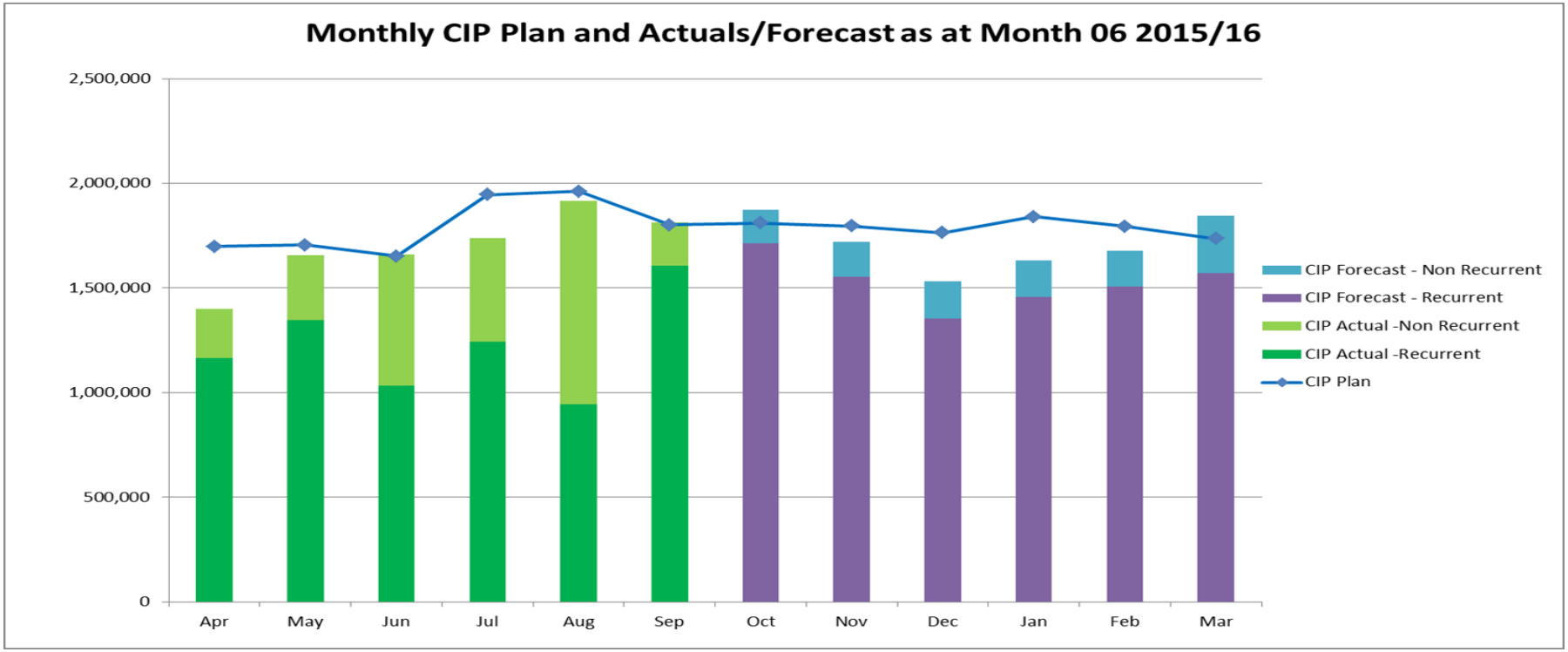
(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

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)	(18,579)	(6,447)	RED
1b) Year to Date, Actual compared to Plan	(9,104)	(11,092)	(1,987)	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	7,942	7,509	(433)	
- Recurrent Efficiencies for Year to Date compared to Plan	7,942	4,665	(3,277)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	18,274	128	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	13,269	(4,877)	
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	16,163	16,163	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	2.00	0.00	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

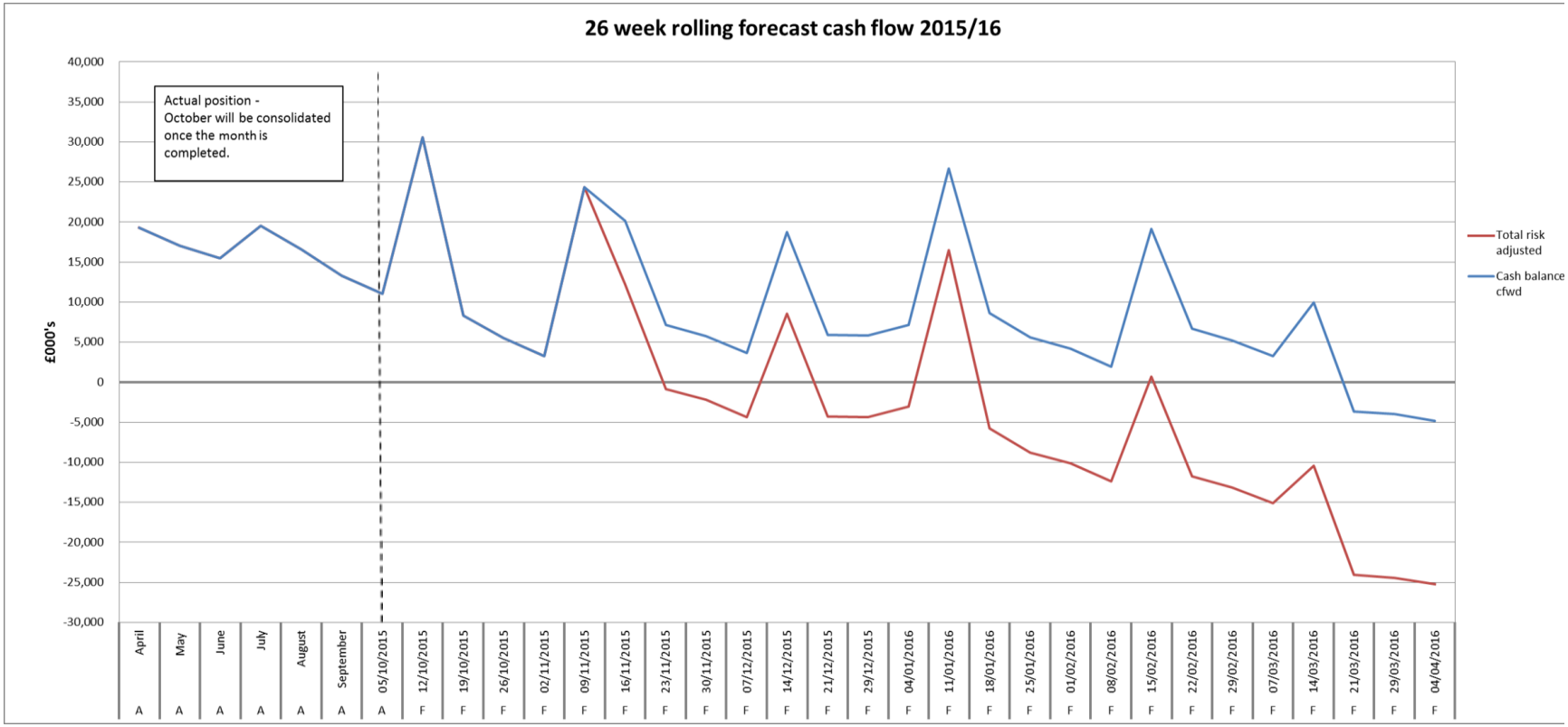
Maidstone and Tunbridge Wells NHS Trust



Recurrent Analysis	**£'000**	**£'000**
Recurrent	7,340	16,491
Non Recurrent	2,844	3,972
Total	**10,184**	**20,463**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of forecast cash balances up to w/c 4th April 2016, actuals at 9th October 2015



	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	05/10/2015	12/10/2015	19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015
Cash balances cfwd	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**11,054**	**30,566**	**8,294**	**5,480**	**3,214**	**24,373**	**20,178**	**7,150**	**5,767**	**3,604**	**18,765**	**5,887**
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	8,000	8,000	8,000	8,000	8,000	8,000
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	0	0	0	2,219	2,219
Total risk adjusted	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**11,054**	**30,566**	**8,294**	**5,480**	**3,214**	**24,373**	**12,178**	**-850**	**-2,233**	**-4,396**	**8,546**	**-4,332**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	29/12/2015	04/01/2016	11/01/2016	18/01/2016	25/01/2016	01/02/2016	08/02/2016	15/02/2016	22/02/2016	29/02/2016	07/03/2016	14/03/2016	21/03/2016	29/03/2016	04/04/2016
Cash balances cfwd	**5,817**	**7,178**	**26,673**	**8,609**	**5,572**	**4,214**	**1,946**	**19,141**	**6,664**	**5,226**	**3,288**	**9,953**	**-3,645**	**-4,005**	**-4,835**
Debtors carry forward in 15/16	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	2,000	2,000	2,000	2,000	4,000	4,000	4,000	4,000
External Financing - Revenue	8,000	8,000	8,000	12,132	12,132	12,132	12,132	12,132	12,132	12,132	12,132	12,132	12,132	12,132	12,132
External Financing - capital	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
NHD Support	2,219	2,219	2,219	2,219	2,219	2,219	2,219	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292
Total risk adjusted	**-4,402**	**-3,041**	**16,454**	**-5,742**	**-8,779**	**-10,137**	**-12,405**	**717**	**-11,760**	**-13,198**	**-15,136**	**-10,471**	**-24,069**	**-24,429**	**-25,259**

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 – October 2015

10-9 CQC Quality Improvement Plan **Chief Nurse**

Summary / Key points

The October QIP report shows continued good progress.

Areas to note:

- The water testing at Maidstone Hospital Enforcement notice has been lifted by the CQC
- There are continued challenges with patent flow particularly at Tunbridge Wells Hospital where there were 5 ITU transfers out of hours in September (compared to 1 in August and 8 in July).
- The Critical Care outreach service commenced a 24/7 service from 9th October.
- The Trust-wide paediatric early warning system (PEWS) is now in place in all relevant areas and required staff training has been completed.
- A Standard Operating Procedure for care of children on a surgical pathway on paediatric wards has been implemented with an audit commenced to assess compliance. Results are expected towards the end of the year.
- Equality and Diversity: Good progress has been made with the second meeting of the Black and Minority Ethnic forum taking place in September with the South East Coast BME Chair in attendance. Healthwatch and other Patient and Carers groups are engaging with the improvement plan and will be part of the approval process for EDS2.

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

CQC Quality Improvement Plan

Assurance Report October 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 will be updated. The report will be submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be 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

Enforcement action – Water testing Maidstone Hospital

The trust has received confirmation from the CQC that it is compliant with the warning notice and they have lifted the enforcement notice.

Compliance actions – Paediatrics

The Trust-wide paediatric early warning system (PEWS) is now in place in all relevant areas and required staff training has been completed.

A Standard Operating Procedure for care of children on a surgical pathway on paediatric wards has been implemented with an audit commenced to assess compliance. Results are expected towards the end of the year.

Compliance actions – Critical care

The Standard operating Procedure for ITU admission and discharges has been ratified and is in place. Work is ongoing to complete the documented pathway for patients in escalated areas. The intensivist rota is compliant with Intensivist Care Society core standards.

There are continued challenges with patent flow particularly at Tunbridge Wells Hospital where there were 5 ITU transfers out of hours in September (compared to 1 in August and 8 in July).

The critical care outreach service commenced a 24/7 service from 9th October.

Compliance Action – Equality and Diversity

Good progress has been made with the second meeting of the Black and Minority Ethnic forum taking place in September with the South East Coast BME Chair in attendance. Healthwatch and other Patient and Carers groups are engaging with the improvement plan and will be part of the approval process for EDS2.

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.
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Continued good progress with rota compliance now in place. Recruitment September 2015 of substantive intensivists.
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 under development and consultation
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During September 5 patients, all at TWH were transferred out of hours Incident report raised. This compares with 1 in August and 8 in July all TWH. ***Red over 5, Amber 5 or less. Green less than 3.***
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		The Trust has commenced 24/7 critical care outreach Completed compliance action

	Operational lead	Progress rating	Issues / Comments
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		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		Main audit completed with action plan. Record keeping audit as part of case reviews still to be 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		Focus on development of information on website and education / update programme.
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Standard Operating Procedure completed and disseminated to staff. Audit underway to evidence compliance
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		Ongoing work to improve processes
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		Awaiting audit results to be presented and shared to demonstrate compliance.

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
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 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	
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 staff ongoing (currently >80%) Presented at Paediatric Directorate board (Sept 15) Audits underway to provide evidence of implementation: PEWs audit Inpatients completed 25th September PEWs audit Ambulatory due w/b 28th September PEWS audit ED due w/b 5th October			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	New PEWs charts submitted for building onto the nerve centre system Provisional launch nerve centre 9th November, Live by 23rd November 2015	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
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	Interviews for recruitment September 2015. Recruitment will be ongoing		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 to be 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. Meeting to discuss version 3 pathway is being held on `14th October 2015. Policy and procedure drafted.		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).				

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 September 5 patients, all at TWH were transferred out of hours Incident report raised. This compares with 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 by Jan 2016 with the aim to ease patient flow across the trust.		1/3/15 New date 1/2/16	
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 and admissions.				

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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 Job Description for substantive post holder developed with post to be advertised as part of review of HR dpt 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		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	Trust Executive agreed governance proposals in July 15.		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:				

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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		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	

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

Compliance action 13				CA13
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	Leaflet completed Distribution completed	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1/5/15 Distribution excepted to be completed 1/9/15	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet completed. Bolder reporting incident button already changed on intranet front page Work on website underway		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 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	External Governance report presented at Trust Board 30th September. From this a new clinical governance framework will be developed.		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				

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

Compliance action 16 CA16

Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*

Lead: *Avey Bhatia, Chief Nurse*

Operational Lead: *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*

Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Assc. Director Quality Governance and Patient Safety attended Anaesthetic Clinical Governance meeting in May 2015 to discuss the Trust Incident reporting system in place and take questions.	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed, distribution due for completion 1/9/15		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	

Action Plan running to time: **Yes**

Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes

Assurance statement :

This compliance action has been completed

Areas of concern for escalation:

None

Compliance action 17 CA17

Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*

Lead: *Paul Sigston, Medical Director*
Avey Bhatia, Chief Nurse

Operational Lead: *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*

Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Full review undertaken between April and July 2015 External Governance report presented at Trust Board with a plan on 30th September. Action plan / response under development	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	Will commence once report and recommendations considered and plan made		1/7/15 New date: 31/12/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	MTW mortality review process has been reviewed and strengthened with work continuing at Trust and directorate level. Agreement with IT/ health informatics to implement e-form with plans to set up working group to ensure consultant engagement. 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	Will follow on from action taken above.		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. This will drive many of the required changes over the coming months.

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 Audit completed and will be presented Paediatric directorate board in October		1/6/15 Audit completed	
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 :				
Running to schedule, audit completed				
Areas of concern for escalation:				
None				

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10-10 Safe Staffing: Planned V Actual September 2015 Chief Nurse

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of September 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.

For September there has been a significant increase in falls particularly on the Maidstone site. When reviewing the wards with high number of falls (greater than 10) against the actual staffing it can be concluded that there is no direct correlation.

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 acuity and/or 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 some cases this is a managed risk. This may be due to decreased activity or dependency. Maidstone ICU would be an example where they are below the planned rate of 100%. However staff were redeployed to TWH ICU where acuity was higher than planned.

Financial data is included to provide potential indicators of actual spend versus planned. Consideration needs to be made for new starters who are paid above mid-point of band (budgets generally set at mid-point of band for vacant posts) and for late presentation of invoices for temporary staff usage.

Decrease in overspend is noted in a number of areas; including Maidstone Stroke Unit, where the staffing skill mix has been managed differently to allow for increased RN presence at night. This has resulted in a decrease in reliance for temporary staffing. Another key area is Foster Clarke, following recruitment to a number of posts, the budget for temporary staffing has be rebased to reflect staff in post.

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.

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.

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

September '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	90.0%	105.8%	97.2%	100.0%	43.2%	100.0%	9	0			107,868	128,361	(20,493)
MAIDSTONE	Romney	93.3%	105.6%	105.0%	86.7%			5	0		Minimal impact on care	66,973	81,684	(14,711)
MAIDSTONE	Cornwallis	95.0%	135.0%	103.3%	106.7%	43.3%	97.6%	3	0		Named pt special required 24/7 for 8 days. Night cover filled by bank/framework agency.	93,344	73,434	19,910
MAIDSTONE	Coronary Care Unit (CCU)	94.4%	N/A	100.0%	N/A	54.2%	100.0%	0	0			104,551	103,315	1,236
MAIDSTONE	Culpepper	100.0%	96.7%	100.0%	100.0%	58.6%	97.1%	0	0					
MAIDSTONE	Foster Clark	94.7%	121.1%	102.5%	100.0%	34.3%	82.6%	6	0		Increased dependency on 5 days. 8 vacancies of which 4 now have a start date, and 3 at pre-employment checks stage.	105,534	110,584	(5,050)
MAIDSTONE	Intensive Treatment Unit (ITU)	86.7%	80.0%	86.0%	N/A	0.0%	NA	0	0		12 days with decreased dependency. Recommended nurse to patient ratios maintained. Staff redployed to TWH where required/appropriate.	152,539	159,610	(7,071)
MAIDSTONE	Pye Oliver	84.7%	124.4%	105.6%	123.3%	11.5%	100.0%	12	1		13 RN shifts not covered in month. RN:CSW split a risk. High number of falls. Directorate now have a supportive improvement plan in place.	95,666	137,650	(41,984)
MAIDSTONE	Chaucer	100.7%	120.8%	103.3%	147.8%	14.0%	100.0%	10	0		28 days of special required of which 6 required an RMN. High number of falls but no link observed	79,298	77,878	1,420
MAIDSTONE	Lord North	96.7%	97.6%	92.2%	96.7%	86.2%	100.0%	2	0			97,051	89,786	7,265
MAIDSTONE	Mercer	94.2%	105.6%	98.9%	118.3%	13.3%	100.0%	7	1		11 specials required (named patients).	91,166	120,244	(29,078)
MAIDSTONE	MOU	80.5%	116.7%	98.3%	118.3%	166.7%	96.4%	2	2		A number of wandering patient requiring additional nusing presence on 7 days/nights. Redueced RN fill rate had minor impact.	139,941	42,122	97,819
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	95.1%	92.0%	125.6%	150.0%	13.0%	96.7%	2	0		Trolleys converted to beds at night for capactiy/escalation.	119,337	148,124	(28,787)
TWH	Acute Stroke	97.8%	100.0%	102.2%	106.7%	42.9%	100.0%	3	0			76,565	69,804	6,761
TWH	Coronary Care Unit (CCU)	97.8%	86.7%	97.8%	N/A	115.6%	98.1%	0	0		4 days where CSW shifts were unfilled. Minor risk as RN cover for those days was adequate for acuity and dependency.	57,300	68,195	(10,895)
TWH	Gynaecology	100.0%	95.5%	96.7%	113.0%	50.0%	93.5%	3	0			66,261	69,708	(3,447)
TWH	Intensive Treatment Unit (ITU)	98.3%	100.0%	99.6%	N/A	0.0%	NA	0	0			172,575	172,523	52
TWH	Medical Assessment Unit	98.1%	107.5%	99.4%	101.1%	11.3%	100.0%	13	0		High number of falls despite required staffing levels.	151,252	198,597	(47,345)
TWH	SAU	118.9%	166.7%	135.0%	183.3%			0	0		Escalated in Short Stay. Establishment revised to reflect anticipated increased demands, but not yet reflected in planned numbers.	65,750	80,662	(14,912)
TWH	Ward 32	96.7%	100.0%	96.7%	100.0%	22.0%	71.8%	0	0			119,911	124,814	(4,903)
TWH	Ward 10	94.3%	101.7%	110.8%	106.7%	31.5%	96.6%	0	1			124,165	125,721	(1,556)
TWH	Ward 11	92.9%	130.0%	85.8%	125.0%	69.7%	97.0%	7	0		Additional CSW required to support two patients at high/increased risk of falls. 5.6 wte RN vacancy, of which 4.0wte in pipeline.	125,584	117,371	8,213
TWH	Ward 12	86.7%	110.0%	80.0%	138.3%	7.0%	100.0%	15	2		RN:CSW ratio shift due to vacancy. Ward has 10 vacancies, of which 8 are in pipeline. High number of falls. Directorate have a supportive improvement plan	108,139	143,564	(35,425)
TWH	Ward 20	99.4%	118.3%	100.0%	163.3%	0.0%	NA	13	2		Cohort nursing for patients requiring increased supervision. 6 nights 1 patient required 121 nursing.	122,805	131,678	(8,873)
TWH	Ward 21	100.0%	117.8%	91.3%	133.3%	15.6%	100.0%	0	0		Increased dependency during the month. RN:CSW ration shift at night an accepted risk in line with dependency.	121,898	134,180	(12,282)
TWH	Ward 22	91.7%	107.8%	95.6%	110.0%	77.8%	100.0%	11	0		High number of falls not related to staffing short fall.	93,043	125,249	(32,206)
TWH	Ward 30	97.0%	85.7%	79.2%	138.3%	27.8%	95.2%	1	2		Decrease in RN and increase in CSW at night is an accepted risk to manage elective flow during the day. Despite staffing chanllenges only 1 fall.	121,746	126,153	(4,407)
TWH	Ward 31	107.0%	98.7%	116.7%	90.0%	37.8%	70.6%	6	2	⇧		136,057	174,087	(38,030)
TCH	Stroke Rehab	88.9%	98.3%	105.0%	100.0%	116.7%	100.0%	3	0		RN fill rate b elow 90% due to unscheduled absence on 2 occaisons. Both during the week. Risk minimal, as AHP presence on ward.	57,413	60,116	(2,703)
TWH	Ante-Natal	100.0%	53.3%	100.0%	76.7%	10.2%	96.2%	0	0		Midwifery care met 1:1 care for women in established labour. CSW recruiment: 4 wte in pipeline with 2 at advert stage and 2 with agreed start date.	596,956	668,336	(71,380)
TWH	Delivery Suite	97.0%	88.3%	97.8%	93.3%			1	0					
TWH	Post-Natal	99.3%	63.3%	96.4%	82.4%			0	0					
TWH	Gynae Triage	93.3%	90.0%	100.0%	100.0%			0	0			14,085	10,713	3,372
TWH	Hedgehog	93.9%	90.4%	98.9%	100.0%	3.1%	100.0%	0	0			186,190	204,323	(18,133)
MAIDSTONE	Birth Centre	100.0%	93.3%	100.0%	96.7%			0	0			65,392	66,784	(1,392)
TWH	Neonatal Unit	106.7%	80.0%	104.4%	96.7%			0	0			160,641	152,319	8,322
MAIDSTONE	MSSU	134.8%	93.2%	105.3%	N/A	0.0%	0.0%	0	0		Escalated beds over 2 weekends plus 1 night.	42,528	47,535	(5,007)
MAIDSTONE	Peel	103.3%	81.7%	101.1%	N/A	23.2%	100.0%	0	0			80,271	80,762	(491)
TWH	SSSU	96.8%	123.8%	N/A	N/A	0.0%	NA	0	0			36,096	31,483	4,613
												4,155,891	**4,457,468**	**(301,577)**

RAG Key

RAG Key

Underfill

Over fill

Movement in overall RAG rating

⇧ indicates an postive move compared to previous month

⇩ indicates a negative move compared to previous month

no arrow indicates no change compared to previous month

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10-11 Oversight Self-Certification, Month 6, 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 30th September. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of October (i.e. by 30th).

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. Monitor licence conditions; and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "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.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Foundation Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. As had been agreed previously at the Board, the Trust will continue to declare non-compliance with such items, and the date by which the Trust will become compliant is proposed as 31/03/2017.

The evidence has been refreshed and updated from that reviewed at the Board in September 2015. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~.

No change in compliant status is proposed from that agreed by the Board in September 2015.

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 self-assessment for the forthcoming submission to the TDA

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

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

General conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. 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 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	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 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?
	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.	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant 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 foundation trust application trajectory.**	No Compliant by 31/03/2017
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities 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 assessor	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	will be visiting the Trust in October to consider the Trust's application.	
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2015 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	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).	No Compliant by 31/03/2017
P2 – **Provision of information** to Monitor about the cost of service provision	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**	No Compliant by 31/03/2017
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant 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 appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
Monitors need to set a modified tariff.		

Competition conditions

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

Integrated care conditions

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

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 ▪ 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" ~~Clinical Governance~~, the findings of which were ~~will be~~ discussed by the Board in September 2015 The final report of the Trust's inspection by the Care Quality	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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.	
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'. 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.	Yes
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The May 2015 Trust Board received the 2014/15 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations 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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	approved the 2014/15 Accounts in May 2015.	
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the Plan (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions (iv) Development – the Trust will embrace the development model as appropriate (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which take place each month) and both external &, internal communications channels; a growing Membership ▪ making better care easy to achieve – the Trust's stated 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.	Yes
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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.	Assurance Framework and risk register, supported by an overall Risk Management Policy, are established and scrutinised by various Committees ▪ Risks receive regular scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The Trust is currently being evaluated against the Well-Led Framework via an external Governance Adviser (see 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 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 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	Compliant
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 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.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The 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 step 3 of the agreed process ('due diligence checks') is in progress). It is proposed that the process agreed by the Board be formalised	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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.	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – October 2015

10-12 Summary report from the Quality Committee meeting, 05/10	**Committee Chairman (Non-Exec. Director)**

A Quality Committee 'deep dive' meeting was held on 05/10, and was solely devoted to reviewing **Hospital Standardised Mortality Ratio** (HSMR). Representatives from Dr Foster limited attended the meeting, and gave a presentation (which has been circulated to all Trust Board members). The key points covered were as follows:

- A myriad of factors affected Mortality, including age, the month of the year, and the admission type (i.e. the vast majority of deaths arise from non-elective admissions)
- Standardised mortality rates were calculated by dividing the number of observed deaths by the expected deaths, and then multiplying by 100. The number of expected deaths was calculated using a Model which predicted the number of deaths that would be expected, given the patient population. This allowed differences between populations to be taken into account
- HSMR was a type of relative risk calculation used to monitor mortality at NHS Trusts, and was based on a subset of 56 diagnoses which gave rise to over 80% of inpatient hospital deaths. There was no "correct" method of standardisation, and others were available, including Summary-level Hospital Mortality Indicator (SHMI)
- If the number of in-hospital deaths was higher than would be expected, given the case mix in the population being studied, the HSMR would be greater than 100
- HSMRs were placed into one of three bandings, based on 95% Confidence Intervals: Higher than expected (red); As expected (blue); and Lower than expected (green).
- The HSMR risks included (in no particular order): Age on admission (in 5-year bands up to 90+); Sex; Diagnosis subgroup; Comorbidities (based on the Charlson score[1]): Palliative Care received; Socioeconomic deprivation quintile of the area of residence of the patient; Number of previous admissions in the preceding 12 months; Admission method; Source of admission; Year of discharge (financial year); Month of admission; and Interaction between age on admission and the Charlson comorbidity score
- The 3-year trend data for the Trust's own mortality showed peaks in Quarters 1 & 2 of 2013, and Quarter 3 in 2014. All of these peaks had a "high relative risk" i.e. higher than expected mortality, but all other Quarters in the period were within the expected range
- In Quarter 4 of 2014, there was a higher national mortality associated with Pneumonia, but this had been accounted for in the Dr Foster Model
- For 2014/15, the Trust had a higher proportion of non-elective patients compared to the national average; and had higher proportions of elderly (aged 85+) and female patients, compared to the national average
- The Trust also had a lower proportion of Palliative Care deaths compared to the national average. This pertained to patients being seen by the Palliative Care Team and being allocated the correct Clinical Code (ICD Code "Z515")
- The Trust had more patients with no comorbidities coded compared to the national average. This related to the presence of Secondary Diagnoses that were within the Charlson list of relevant diagnoses, and not the presence of Secondary Diagnoses per se

In summary, the indication was that further Clinical Coding analysis was required, with a focus on comorbidities. The Medical Director duly identified the following 6 areas for further review:

1. The relatively low level of Palliative Care Coding (i.e. patients coded with Z515)
2. The relatively low level of patients allocated Comorbidities pertinent to the Charlson score
3. The relatively high level of Residual Coding
4. The higher risk for "Aspiration pneumonitis, food/vomitus" patients
5. The higher risk for "malignant neoplasm without specification of site"; and
6. The increased risk for patients with LOS between 1 to 6 days

[1] The Charlson comorbidity index predicts the 10-year mortality for patients across a range of 22 comorbid conditions

The Medical Director therefore agreed to:

- Give a presentation to the November 2015 'main' Quality Committee on HSMR and the issues discussed at the Quality Committee 'deep dive' meeting;
- Provide an update, to the 'main' Quality Committee in January 2016, on progress with addressing the non-clinical care-related issues discussed at the 'deep dive' (i.e. the level of Palliative Care coding; the coding of comorbidities; the use of Residual coding; and the association between HSMR and Length of Stay between 1 and 6 days)
- Provide an update, to the 'main' Quality Committee in January 2016, on progress with addressing the non-clinical care-related issues discussed at the 'deep dive' (i.e. the higher risk for "Aspiration pneumonitis, food/vomitus" patients; and the higher risk for "malignant neoplasm without specification of site")

Future 'deep dive' meetings

- It was confirmed that the focus of the Quality Committee 'deep dive' meeting in December 2015 should be "Update on Cancer Multidisciplinary Team (MDT) meetings"; "Review of plans for 7-day services"; "Review of Pharmacy"; and also include a brief verbal update on the latest situation regarding Women's Services
- It was also agreed that the Quality Committee 'deep dive' meeting in February 2016 should focus on the findings from the National Clinical Audits relating to Cancer

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – October 2015

10-13 Summary of the TME meeting, 14/10/15 **Chief Executive**

This report provides information on the Trust Management Executive (TME) meeting held on 14/10/15. The meeting was not a 'usual' TME, and all Trust Board members were invited. The meeting focused on the latest position for each Directorate with their plans for 2015/16 (following up on the TME meeting held on 18/03/15, at which such plans were presented).

Presentations on such plans were given for the all Clinical Directorates, and for Estates and Facilities Management and Health Informatics.

Each presentation covered the following themes:

- Summary of progress against 2015/16 Business Plan, for the year to date;
- Key issues for the year to date in relation to demand and capacity (compared to plan);
- Key issues for the year to date in relation to finances (compared to plan); and
- The current status on key risks

Copies of the presentations have been circulated to all Board members.

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 - October 2015

10-14 Application for an Interim Revolving Working Capital Facility Director Of Finance

This report requests the Board's approval for the Trust's application for a working capital facility. The application is scheduled to be reviewed at the Finance Committee on 19/10/15. An update on the outcome of the Finance Committee's review and recommendation will be contained within the summary report of the Finance Committee meeting, which will be issued after the meeting.

1. The Trust has received the draft documentation (Appendix 1), as requested from the Department of Health (DH) for the Interim Revolving Working Capital Facility (IRWCF)
2. The facility has been set by the DH at £12,132,000, which reflects exactly the reduced Income & Expenditure deficit plan, following the 'stretch' target adjustments. The minimum cash balance the Trust is expected to hold is £2,032,000, and there is also a maximum limit of £10,159,000, which is tested against the lowest balance that the Trust holds during the period the facility is used. In other words it does not restrict normal peaks of income flow (e.g. when CCG contract payments are received), but the Trust cannot continuously hold a greater balance than the maximum limit. Schedule 3 of Appendix 1 holds the defined facility limits).
3. The potential loan has not yet been granted final approval by the DH. This will be considered once the documentation is returned by the Trust. The date that a representative of the Secretary of State at the DH signs the agreement becomes the agreement date.
4. No withdrawals of cash can be made until the agreement has been signed, direct debit mandate completed and Trust Board resolution minute has been received by the DH.
5. The Board of Directors' resolution must include the following information (see Schedule 1)
   (A) "Approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;
   (B) Authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and
   (C) Authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request) and to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party
   (D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions"
6. Resolution (D) above refers to a long list of additional terms and conditions which must be met as a condition of the facility. The full details are in Schedule 8 of the agreement (Appendix 1) and require compliance under the following headings:-
   - Deficit Targets and Capital Controls
   - Nursing agency expenditure
   - Professional Services Consultancy Spend
   - Very Senior Manager Pay Costs
   - Estate Costs
   - Surplus Land
   - Procure 21
   - Financial and Accounting and Payroll
   - Bank Staffing
   - Procurement
   - Crown Commercial Services
   - EEA and non-EEA Patient Costs Reporting
7. The agreement must then be signed in BLUE ink by the officer named in Resolution (B) above. It is proposed that the Board authorises the Director of Finance to execute the documents.

8. Utilisation requests to drawdown cash will only be accepted if they are signed by a person duly authorised to do so in part (C) of the Board resolution. It is proposed that the Trust Board authorises the Director of Finance and the Deputy Directors of Finance to sign on its behalf
9. It is also however proposed that the Direct Debit form (which form part of the documents referred to in Part (C)) be signed by two signatories from the current Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems).
10. A monthly cashflow must be provided with each Utilisation request to ensure that funds are not drawn in advance of need.
11. Based on the latest cashflow, as included in the M6 financial reporting, assuming that income and expenditure expectations continue to be realised broadly in line with the plan, the first requirement for a drawdown of a working capital facility will be in November 2015 (circa £8m) with a further requirement of the balance available in January 2016.
12. This facility can be held across the year end into 2016/17 and the Trust can continue to draw against it. It possible for the Trust, with NHS Trust Development Authority (TDA) approval, to increase beyond the initial limit to the 30 day maximum, as and when the Trust requires access to more cash within the year.
13. Interest will be payable on the IRWCF at 3.5% per annum calculated on a daily basis and based on actual funds drawn. For 2015/16 this charge is estimated to be £132k.

Additional Risks

14. Although the documentation from the DH was received with a limit of £12,132,000, the Trust will be making the case that £0.2m of the gain is non-cash (depreciation) and £1.7m relates to CCG income that may be agreed but not paid in this year. There is no guarantee that the DH will increase the facility limit for 2015/16.
15. In order to mitigate a potential cash shortfall, the Trust may apply in writing, authorised by the signatories nominated in the Board resolution, to have its minimum balance reduced from £2m to £1m however the TDA cash team have advised that once lowered this minimum balance may not be able to be reversed in year.
16. Whilst there is potential to extend creditors there is a risk that to mitigate the assumptions above would have a detrimental effect on operational activities due to the delays to supplier payments. This would in turn impact on Better Payment Practice Code (BPPC) performance.

Process for accessing the Interim Revolving working capital facility

17. The Board will need to nominate officer/s to sign the agreement as required by Part (B) of the resolution, and nominate officers to sign/despatch further notices or documents as required by Part (C) of the resolution
18. For drawdown on 16th November, allowing the Trust to continue to settle creditors as due, the Trust will need to complete and submit the facility agreement, direct debit mandate, utilisation request and Trust Board Resolution minute by 30th October 2015.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 19/10/15

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

1. Approve the resolution to support the financing application (as written in para 5. above)
2. Authorising a person/s to execute the Finance Documents on its behalf (the Director of Finance is proposed)
3. Authorising a specified person/s, on its behalf, to sign and/or despatch all documents and notices and to be signed and/or despatched by it under or in connection with the Finance Documents (the Director of Finance and Deputy Directors of Finance are proposed, though additional signatories, as listed above, will be authorised to sign the Direct Debit form)
4. Confirm the undertaking to comply with the Additional Terms and Conditions (as listed in Schedule 8)

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

DATED 2015

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£12,132,000

SINGLE CURRENCY INTERIM REVOLVING WORKING CAPITAL SUPPORT FACILITY AGREEMENT

REF NO: DHPF/ISRWF/RWF/2015-10-02/A

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THIS AGREEMENT is dated 2015 and made between:

(1) **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST** of**, Hermitage Lane Maidstone, Kent ME16 9QQ** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Control" means the overall maximum net inflow/outflow from investing activities that may be incurred by the Borrower in any relevant financial year as determined by the Lender

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Control" means the Surplus/Deficit outturn limit for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the working capital facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means the amount set out in Schedule 3 as may be amended from time to time.

"Final Repayment Date" means the 12/10/2020, as may be amended from time to time by the Lender.

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

“Government Banking Service” means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 3.5% per annum.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"Maximum Cash Balance" shall be the amount defined in Schedule 3

"Minimum Cash Balance" shall be the amount defined in Schedule 3

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"NHS Body" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 31 March 2014.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Date" means the repayment date set out in Schedule 6 (*Repayment Schedule*).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means either the NHS Trust Development Authority and/or Monitor.

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower a sterling revolving working capital facility in an aggregate amount equal to the Facility Amount.

2.2 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower may deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only be obliged to comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 **Completion of a Utilisation Request**

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 **Currency and amount**

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 **Payments**

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 **Repayment**

6.2.1 The Borrower shall repay each Loan and all other amounts outstanding under the Finance Documents in full on the Repayment Date; and

6.2.2 Where the available Cash Balance is greater than the Maximum Cash Balance for the period from the Monday preceding the 18th day of any Month to the Monday preceding the 18th day of the following month, the borrower shall additionally repay the lesser of the minimum amount by which the Cash Balance exceeds the Maximum Cash Balance during this period or, the aggregate of each Loan and all other amounts outstanding under the Finance Documents.

6.3 **Re-borrowing**

The Borrower may re-borrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 **Illegality**

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 **Voluntary cancellation**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 **Interest Payment Dates**

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 **Shortening Interest Periods**

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A **Payment Start Date**

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 **Non-Business Days**

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 **Consolidation of Loans**

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. NOT USED

11. INDEMNITIES

11.1 **Currency indemnity**

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1 (Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in

relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 **Cashflow Forecast**

The Borrower shall supply to the Lender a Cashflow Forecast for each month that Loans remain outstanding, on dates which will be advised by the Lender from time to time.

15.2 **Financial statements**

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.3 **Requirements as to financial statements**

15.3.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.3.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.4 **Information: miscellaneous**

The Borrower shall supply to the Lender:

15.4.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.4.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.4.3 details of any breaches by the Borrower of the Compliance Framework;

15.4.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.4.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.4.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.4.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.4.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.4.9 any change in the status of the Borrower after the date of this Agreement

15.5 **Notification of default**

15.5.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.5.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.6 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the Relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 **Non-payment**

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 **Compliance Framework and Negative Pledge**

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 **Other obligations**

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 **Misrepresentation**

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 **Cross default**

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 Assignments and transfers by the Lender

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 Conditions of assignment or transfer

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 Disclosure of information

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 Payments

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 Distributions to the Borrower

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 Partial payments

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 No set-off

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 Business Days

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 Currency of account

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 **Communications in writing**

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 **Addresses**

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 **Delivery**

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 **Electronic communication**

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 **Accounts**

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 **Certificates and Determinations**

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 **Day count convention**

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

[ ] – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
[ ]

SCHEDULE 3: DEFINED FACILITY LIMITS

Defined Term	Amount £'000
Facility Amount	12,132,000
Minimum Cash Balance	2,032,000
Maximum Cash Balance	10,159,000

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

NOT USED

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 Without Prejudice/Confidentiality

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be entitled to request the President for the time being of the Chartered Institute of

Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
12th October 2020	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Deficit Targets and Capital Controls

   1.1. The Borrower must not exceed Deficit Target and/or Capital Control Limits set by the Lender. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body. Performance against these limits will be monitored by the relevant Supervisory Body. For the avoidance of doubt, as at the date of this Agreement, the Deficit Target Limit is £12,132,000 and the Capital Control Limit is not applicable.

2. Nursing agency expenditure:

   2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

      2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.
      2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.
      2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

   2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

   3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

   4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
   4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
   4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and

Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service

provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services (“CCS”)

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

By:

Name:

Position:

Address: Hermitage Lane
Maidstone
Kent
ME16 9QQ

Email: stuart.doyle@nhs.net

Attention: Stuart Doyle

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
4th Floor,
Skipton House,
80 London Road,
London SE1 6LH

Email: dhloanscentralinbox@dh.gsi.gov.uk

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - October 2015

10-16	Recommendation of Speak Out Safely Guardian	Director of Workforce and Communications

Purpose of the paper

This paper makes recommendation to the Board of how to address one of the recommendations identified in the Freedom to Speak Up review undertaken by Sir Robert Francis, QC and published in February 2015. During our September 2015 Board meeting, the Board debated the most appropriate structures to allow all staff to raise concerns in a safe and supportive environment, particularly as they relate to patient safety.

After debate I was asked to explore alternate or iterated possibilities and I am now in a position to make a recommendation to the Board. The Freedom to Speak Up review identified that there should be an ability and a mechanism for members of staff to raise concerns and to have them investigated, if necessary, by Board members under the direction of the Chief Executive. If necessary, these could then be escalated to a national Speak Out Safely Guardian who is to be appointed by the CQC on behalf of the Arm's-Length Bodies and with a mandate to act across the service in England. Having examined the review and considered the observations of the Board, I recommend that the most appropriate Board member to consider any concerns is the Senior Independent Director and Vice-Chairman. I would propose that this post holder works in conjunction with the Deputy Director of Workforce to ensure that all concerns raised are appropriately investigated and reviewed and actions taken accordingly to ensure that patient safety is maintained. This approach is consistent with the Freedom to Speak Up review and as previously suggested, a regular report will be produced to the Board identifying concerns raised, actions taken and any recommendations to change either process or structures to ensure that all our staff have an opportunity to raise concerns.

Recommendation

That the Senior Independent Director / Vice-Chairman is the authorised Board post to receive concerns and to ensure a regular report is made to the Board of any and all such concerns.

Which Committees have reviewed the information prior to Board submission?

- None

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

Decision

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