

**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 21<sup>ST</sup> DECEMBER 2016**

**LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL**

**A G E N D A – P A R T 1**

Ref.	Item	Lead presenter	Attachment
12-1	To receive apologies for absence	Chairman	Verbal
12-2	To declare interests relevant to agenda items	Chairman	Verbal
12-3	Minutes of the Part 1 meeting of 30 <sup>th</sup> November 2016	Chairman	1
12-4	To note progress with previous actions	Chairman	2
12-5	Safety moment	Chief Nurse	Verbal
12-6	Chairman's report	Chairman	Verbal
12-7	Chief Executive's report	Deputy Chief Executive	3
12-8	Integrated Performance Report for October 2016 (to incl. an update on the "Trauma & Orthopaedics 2020" programme) <ul style="list-style-type: none"> <li>Safe / Effectiveness / Caring</li> <li>Safe / Effectiveness (incl. HSMR)</li> <li>Safe (infection control)</li> <li>Well-Led (finance)</li> <li>Effectiveness / Responsiveness (incl. DTOCs)</li> <li>Well-Led (workforce)</li> </ul>	Deputy Chief Executive  Chief Nurse Medical Director Dir. of Inf. Prev. and Control Director of Finance Chief Operating Officer Director of Workforce	4
<b>Quality items</b>			
12-9	Planned and actual ward staffing for November 2016	Chief Nurse	5
<b>Reports from Board sub-committees (and the Trust Management Executive)</b>			
12-10	Charitable Funds Committee, 28/11/16 (incl. approval of: revised Terms of Reference; Annual Report & Accounts of the NHS Trust Charitable Fund, 2015/16; Letter of Representation)	Committee Chair	6
12-11	Workforce Committee, 01/12/16	Committee Chair	7
12-12	Patient Experience Committee, 02/12/16	Committee Chair	8
12-13	Trust Management Executive, 14/12/16	Committee Chair	9
12-14	Finance Committee, 19/11/12 (incl. approval of the Business Case to replace a Linear Accelerator at Maidstone Hospital)	Committee Chair	10 (to follow) & 11
<b>Other matters</b>			
12-15	Response to the Board's suggestions to raise patients/visitors' awareness of the activity undertaken by the Trust	Deputy Chief Executive	Verbal
<b>Presentation from a Clinical Directorate</b>			
12-16	The "Home First" model	Director of Operations, Urgent Care (& colleagues)	Presentation
12-17	<b>To consider any other business</b>	Chairman	Verbal
12-18	<b>To receive any questions from members of the public</b>	Chairman	Verbal
12-19	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
<b>Date of next meetings:</b> <ul style="list-style-type: none"> <li>25<sup>th</sup> January 2017, 10.30am, The Academic Centre, Maidstone Hospital</li> <li>22<sup>nd</sup> February 2017, 10.30am, The Education Centre, Tunbridge Wells Hospital</li> <li>29<sup>th</sup> March 2017, 10.30am, The Academic Centre, Maidstone Hospital</li> <li>26<sup>th</sup> April 2017, 10.30am, The Education Centre, Tunbridge Wells Hospital</li> <li>24<sup>th</sup> May 2017, 10.30am, The Academic Centre, Maidstone Hospital</li> </ul>			

**Anthony Jones,**  
Chairman

**MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING  
(PART 1) HELD ON WEDNESDAY 30<sup>TH</sup> NOVEMBER 2016, 10.30A.M AT  
MAIDSTONE HOSPITAL**

**FOR APPROVAL**

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Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Hannah Alland	Communications Officer	(HA)
	Annemieke Koper	Staff Side representative (until item 11-15)	(AKo)
	Rob Parsons	Risk and Compliance Manager (from item 11-18)	(RP)

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**11-1 A patient's experiences of the Trust's services**

The Trust Board approved the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from item 11-1 by reason of the confidential nature of the business to be transacted.

*[N.B. The minute of item 11-1 will be submitted to the 'Part 2' meeting of the Trust Board, 21/12/16]*

**11-2 To receive apologies for absence**

Apologies were received from Alex King (AK), Non-Executive Director; and Kevin Tallett (KT), Non-Executive Director. It was also noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

**11-3 To declare interests relevant to agenda items**

No interests were declared.

**11-4 Minutes of the Part 1 meeting of 19<sup>th</sup> October 2016**

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

**11-5 To note progress with previous actions**

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

- **9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director")**. JL reported that there had been a discussion about Medical productivity at the Finance Committee on 28/11/16, and it was acknowledged that progress had not been as hoped, but a more holistic approach would now be adopted, involving a monthly standing item (and report) at the Finance Committee. PS also reported that in relation to the new Junior Doctors' contract, only 8 Doctors were on the new contract to date, but approximately a further circa 50 would move to the new contract in the coming weeks. PS added that the Trust's Medical Workforce Manager had undertaken much preparatory work. KR noted that the Trust Board was being asked to agree to close the action as worded. AJ confirmed that he wished to keep the action open until the Board was completely satisfied.

- **9-21ii (“Arrange for the incoming Risk and Compliance Manager to be introduced to the Trust Board after they commence in post”).** It was noted that it was intended to introduce the individual to Trust Board Members during the lunch break after today’s ‘Part 1’ meeting.
- **10-8iii (“Submit a report to the Trust Board, in November 2016, with a considered response to the suggestions made at the meeting on 19/10/16 to raise patients’ and visitors’ awareness of the level of activity undertaken by the Trust”).** It was noted that JL was not initially intending to be at today’s meeting, so it had been agreed to defer the report until the December meeting.

#### **11-6 Safety moment**

AB reported the following points:

- The topic for the month was falls, which was the Trust’s number one patient safety priority
- Much work had been undertaken over the last 6 months, using the same methods applied for Infection Control i.e. the application of enhanced monitoring if falls reached a certain threshold.
- There were now only 2 Wards with falls above their set threshold, which was reflected in the Trust’s falls rate, which had reduced markedly
- Safety Messages were now intended to be shown on PC screensavers across the Trust. This was commonplace at other Trusts, and this had commenced on some PCs, including those at the Academic Centre at Maidstone Hospital (MH)

AJ noted that the difficulty of balancing the actions to prevent falls with patients’ desire to maintain their independence had been discussed at the Finance Committee on 28/11/16. AB agreed this was an issue.

#### **11-7 Chairman’s report**

AJ reported that the GD’s report under item 11-8 included the list of those receiving awards at the Annual Staff and Long Service Award ceremonies, and added that both events had been very well received. AJ continued and emphasised the large range of services recognised at the Ceremonies, which he believed was a tribute to the way the Trust functioned. AJ added that this had left him with the conviction that the Trust had very good staff, which should not be underestimated.

#### **11-8 Chief Executive’s report**

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

- Winter had arrived, and the first increase in activity had already been seen. The most worrying aspect was not the increase (which happened each year), but the fact that staff were tired, and had had much respite from recent pressures. This should be recognised.
- The Trust remained in Financial Special Measures, and this would permeate everything the Trust did for the future, in terms of its future financial viability

AJ emphasised the need for pace of change in relation to addressing the Trust’s financial issues. GD agreed this was a key factor.

GD then continued, and reported that Maternity services in West Kent had been the only service in the country as “top performing”, even though NHS England had not recognised the providers of such services within its publicity. GD stressed that it was a major achievement to be rated as the best in the country, given the dire consequences that some perceived would occur as a result of previous service changes. AJ concurred, and suggested that a formal letter of congratulations be sent, on behalf of the Board, to the Clinical Director for Women’s and Sexual Health and the Head of Midwifery. This was agreed.

**Action: Arrange for a letter of congratulations to be sent, on behalf of the Trust Board, to the Clinical Director for Women’s and Sexual Health and the Head of Midwifery, following West Kent CCG being the only area to achieve a “Top performing” rating on the CCG Improvement and Assessment Framework baseline maternity assessment for 2016/17 (Trust Secretary, November 2016 onwards)**

SDu asked whether the achievement had been promoted within the Trust’s Maternity areas, via digital display screens. GD confirmed this had not been done, but AJ noted a press release had

been issued. Following a discussion it was agreed JL should arrange for the achievement to be publicised within Maternity.

**Action: Arrange for the “Top performing” rating on the 2016/17 CCG Improvement and Assessment Framework baseline maternity assessment to be publicised within the Trust’s Maternity areas (Deputy Chief Executive, November 2016 onwards)**

#### **11-9 Review of the Board Assurance Framework, 2016/17**

KR referred to the circulated report and highlighted that:

- This was the second time in 2016/17 that the Board Assurance Framework (BAF) had been submitted to the Board for review
- The BAF had already been reviewed in full at the Audit and Governance Committee and Trust Management Executive (TME) in November, whilst objectives 4.a and 4.b had been reviewed by the Finance Committee on 28/11/16
- As part of its review, the Finance Committee had felt that objective 4.b, which was currently stated as “To improve on the Trust’s Income and Expenditure plan for 2016/17”, should be replaced with an alternative, “To deliver the control total for 2016/17”. The Trust Board was therefore asked to approve this change

The Trust Board duly approved the proposed change of wording for objective 4.b.

KR then continued, and pointed out that the prompts for Trust Board Members to consider were listed on page 1. Questions were then invited. None were received.

#### **11-10 Integrated Performance Report for October 2016**

GD referred to the circulated report and highlighted that there was continued pressure, and the number of Delayed Transfers of Care (DTOCs) remained high. GD continued that he had been surprised that Social Care was not mentioned in the Chancellor’s Autumn Statement, given the consistent problem in accessing Social Care placements. GD clarified that he did not however blame Social Services for the predicament, as this was a product of the current environment.

SDu referred back to the comments made by the patient under item 11-1 in relation to their contact with a Clinical Nurse Specialist (CNS), and asked whether proactive contact was being made with patients to ensure they were taking care during the winter, and thereby avoiding deterioration which required hospital admission. GD confirmed that such support services did exist, including in the community, where Community Matrons were in place, but acknowledged that such services were not as coordinated as they could be. PS remarked that he understood issues such as this would be addressed via the Sustainability and Transformation Plan (STP). AJ acknowledged the point, but stated it was important for the Trust to take action where it could. GD agreed.

SD asked whether the number of DTOCs had risen in the last month. AG confirmed this was the case. SD asked for details of the number. AG confirmed that the proportion of inpatients meeting the strict criteria for being classified as a “DTOC” was 8% for October. SD asked how many inpatients were therefore in the Trust that did not need acute care. GD replied that a bed audit across the local area had identified 200 patients at the Trust (27% of admissions) who were “Medically fit for discharge”, although this was not the same as being a “DTOC”.

SD pointed out that the Trust had a high number of CNSs, and asked whether they were part of coordinated teams. AG corrected SD that benchmarking showed that the Trust did not have particularly higher levels of CNSs compared to others, but confirmed that each CNS was linked with a coordinated team. AB concurred, and declared that CNSs were a ‘lifeline’ for patients with long-term conditions. SD asked whether the model for CNSs was working. AB and AG gave assurance to this effect. It was also reported that detailed monitoring of CNS’ performance was in place.

AJ then invited colleagues to highlight any issues arising from the Integrated Performance Report.

*[N.B. The order of the following domains within the Integrated Performance Report reflects the order they were discussed at the meeting, which differs from the order listed on the agenda]*

### **Effectiveness / Responsiveness (incl. DTOCs)**

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

- A&E attendances had increased, and performance on the A&E 4-hour waiting time target had suffered. Medway NHS Foundation Trust and East Sussex Healthcare NHS Trust had experienced 12-hour trolley waits, but the Trust was continuing to try to maximise its ambulatory pathways. Quality of care remained very high
- It was disappointing to see DTOCs continue to rise, particularly following the support provided to Social Services earlier in the year. However the Hilton enablement model would be reintroduced in December 2016. The "Home First" model was also being introduced
- The latest Cancer 2-week wait initiatives had now been embedded. There had been 2 months of improvement, and November's performance was also as required. AG believed the changes made would have sustainable benefit. The performance predictor for the Breast Tumour Group showed that the required level of performance should be delivered in December
- Performance on the 62-day Cancer waiting time target was at 80%, but a new Colorectal CNS had been appointed, and Macmillan had confirmed that two further CNSs would be funded

SDu asked what the 62-day Cancer waiting time target performance was solely for Colorectal patients. AG replied that approximately half of such patients were offered a first definitive treatment within 62 days. SDu asked whether such patients were offered alternative treatment. AG explained that no adverse consequences had been reported as a result of patient waiting times, but the CNSs managed such patients, and were within close contact with each. AG continued that 31-day waiting time target was however being met, and therefore the focus of attention would be on the particular part of the pathway that would lead to improvement on the 62-day target performance.

AJ stated that he still did not understand why the 62-day Cancer waiting time target performance had deteriorated. In the ensuing discussion, it was noted that a range of factors were involved, including a change in the monitoring 'rules' which meant that patients that did not accept the first appointment they were offered were no longer excluded from the performance; and including the fact that most of the Trusts in the country had not achieved the 62-day target for the past 18 months. AG added that the Trust had worked to understand the root causes of each breach of the target, and gave assurance that the teams involved had a strong desire to improve performance.

AJ asked that a chart of the performance on the 62-day waiting time target be included in the 'Story of the month' section within future Integrated Performance Reports. This was agreed.

**Action: Arrange for a chart of the Trust's performance on the 62-day Cancer waiting time target to be included in the 'Story of the month' section within future Integrated Performance Reports (Chief Operating Officer, December 2016 onwards)**

SD then asked for a more detailed explanation of the delays within the Colorectal Tumour Group. AG provided the explanation.

SDu asked for an update on the implementation of the Bowel Cancer screening programme. AG confirmed that this was fully implemented & no increase in patient activity was therefore expected.

AG then continued, and highlighted that there had been issues for both inpatients and outpatients in relation to the Referral to Treatment (RTT) waiting time targets. AG added that such issues included the Junior Doctors' strike, but recovery plans were in place in each area, to enable the required level of performance (92%) to be met by January 2017.

### **Safe / Effectiveness / Caring**

AB reported that complaints response performance for November had improved, but she had identified the causes of the poor performance in the previous 2 months, and a combination of factors were involved, including complex complaints, sickness within the central Complaints team, and delays in receiving some Directorate responses.

AJ asked for a comment about the 'red' rating on the "Maternity Combined FFT % Positive" indicator on page 5. AB explained that the completed Friends and Family Test (FFT) cards had

been reviewed, and it had been found that for the post-natal period, many women had replied “don’t know” to most of the questions. AB elaborated that “don’t know” responses received a negative score, but no negative remarks had been made in free-text. AB continued that the questions could not be changed, so the challenge was now to understand why mothers had responded in that way.

### **Safe / Effectiveness (incl. HSMR)**

PS referred to the circulated report and reported that the Quality Committee ‘deep dive’ into mortality had been delayed to January 2017, due to his commitments. PS continued that 2 aspects were related to the increased Hospital Standardised Mortality Ratio (HSMR): 7 day services (the Trust was now identified as an outlier for weekend mortality) and the Clinical Coding of comorbidities. PS noted that he was scheduled to meet the Trust’s Assistant Director of Business Intelligence in the near future to discuss the latter issue.

AJ asked whether there was a difference in the mortality between MH and Tunbridge Wells Hospital (TWH). PS replied that he did not have this data, but this would be discussed during the aforementioned meeting with the Assistant Director of Business Intelligence.

AJ confirmed the Trust Board was concerned at the issue, but proposed to defer further discussion until the Quality Committee ‘deep dive’ meeting on 04/01/17. This was agreed, but GD emphasised the importance of not waiting until that meeting before taking action. PS agreed, and noted that the weekend mortality issue had prompted queries as to what was being done differently at weekends and/or what needed to be done differently, and this was being explored.

### **Safe (infection control)**

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

- The Trust was still below the trajectory for Clostridium difficile, but there had been 5 more cases for the year-to-date than the same point in the previous year
- One MRSA bacteraemia case had occurred (in November 2016) and the early indications were that the patient that had not been screened for MRSA. If screening had occurred, this would have identified the patient as having MRSA colonisation

AJ referred to the latter point and asked why the patient had not been screened. AB replied that the reasons were not yet known definitively.

### **Well-Led (finance)**

SO then referred to the circulated report and reported that the Trust had a deficit of £0.5m for the month, whilst the year-to-date deficit was £11.9m, which varied from Plan by £0.6m. SO explained that the variance related to the non-receipt of the Sustainability and Transformation Fund (STF), which reflected non-performance against the NHS Constitution access targets. SO confirmed that the STF monies not received equated to £0.2m for the month, and £0.6m for the year-to-date.

AJ asked SO to quantify the financial impact of the Trust not agreeing to the control total at the start of the year. SO confirmed that this was close to £4m, and then continued by highlighting the following points:

- The Trust was delivering the financial performance that had been committed to NHS Improvement (NHSI), but continuing to achieve this for Quarter 4 would be very challenging
- Nursing staffing improvements had been successful, and AB and the operational teams should be given credit for this

AJ observed that there had been a 25% increase in the “Medical Locum & Agency Spend” indicator (page 5), and asked for an explanation. SO answered that he understood a number of vacancies had to be covered. AJ queried how many posts this related to, noting that vacancy levels were not high. PS confirmed that this related to a small number of posts, but the need to provide the cover had a considerable impact. GD highlighted that the “Agency & Locum Staff (WTE)” indicator had reduced by 26.9% (from the previous year). The point was acknowledged.

AJ then noted the other workforce metrics and asked for confirmation that shifts would always try to be covered via the Trust Bank, before engaging Agency staff. This was confirmed.

SD asked which area used the most Medical locums. PS confirmed that the majority of Medical Agency usage was in the Urgent Care Division, but there was usage across the Trust. RH declared that a number of permanent Medical appointments were expected to be made in the near future, which would reduce the use of Medical Agency staff. RH also reported that he and SO had met with other local Trusts to consider concerted action regarding the use of Agencies. SO added that the meeting had heard lessons from Trusts in London. RH noted that a further meeting was scheduled for the following month.

### **Well-led (workforce)**

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

- “Sickness Absence” was an area of focus, and was currently at 4%
- The rate of “Appraisal Completeness” had increased, but RH did still not believe the reported rate was an accurate reflection of the true performance

### **Quality Items**

#### **11-11 Supplementary Quality and Patient Safety report**

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

- Falls and FFT already discussed under item 11-10
- A Trust bereavement survey had started in September. This had been considered very carefully and been discussed at the Ethics Committee. Fifteen responses had been received so far and the survey would cease once 100 responses had been received. No adverse issues had been reported in relation to the survey
- Following comments from a Junior Doctor about the readability of staff name badges, it was proposed to change the background colour from white to yellow

AJ referred to the latter point, and asked whether increasing the size of name badges had been considered. AJ also asked for details of the evidence that a yellow background was better, and of the costs involved in the change. AB replied that the change would operate via a rolling programme, and would therefore just be applied for new staff, so there were no cost implications. AB also stated that the new badge had been shown to Ophthalmology staff, who confirmed that a yellow background was easier to see for patients with any form of visual impairment. AB also confirmed that badge size had been considered but it had been decided not to change this.

AJ asked for comments on the proposed colour change. SDu observed that not all staff wore their name badge, and opined that this should be a condition of employment, but added that she believed name badges should be considered within a wider cultural context, and be used with other initiatives, such as the “Hello, my name is...” concept. AJ agreed, but noted that visibility of staff badges also played a part. AB reminded SDu that communication was the theme of the Safety Message for September, and the importance of the “Hello my name is...” campaign had been emphasised during that month.

PS commented that there must be a scientific answer as to which colour background was the most visible. AJ confirmed he was content to rely on the conclusion from Ophthalmology reported by AB.

The Trust Board approved the proposal to change the colour of staff name badges, as described. AJ asked however that the issue be reviewed at some future point, to assess whether the intended effect had been achieved. AB agreed.

#### **11-12 Planned and actual ward staffing for October 2016**

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

- The report had been challenging to produce this month, as October saw the transition to the new Nursing establishments
- There had been no deterioration seen in the quality profile, despite the changed establishments

AJ remarked that some areas, such as Cornwallis Ward, showed fill rates far above 100%, and asked for an explanation. AB explained that Cornwallis Ward usually showed fill rates slightly above 100%, as a reflection of the need for additional Nurses for enhanced care. AJ retorted that the chart did not reflect such agreements, and queried whether that Ward's rating should therefore be 'green'. AB replied that the rating was not 'green' as the fill rate was above the agreed establishment. AJ queried whether other Trust Board Members were content with the chart as presented. AB pointed out that NHSI had stated that the Trust's report was the best 'planned versus actual' report they had seen. The point was acknowledged.

### **11-13 The "Trauma & Orthopaedics 2020" programme**

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

- The "Trauma & Orthopaedics 2020" programme had been established earlier in the year, as a result of capacity issues, feedback from the Trauma review, and other concerns
- The bed reconfiguration had been completed, and the recommissioning of the Maidstone Orthopaedic Unit (MOU) was underway. The Unit was due to open on 19/12/16
- JL chaired the "Trauma & Orthopaedics 2020" meeting, which met monthly
- The Directorate's Clinical Director and Management Team had found the Programme very useful, as it provided the infrastructure for action
- A new Clinical Director for Trauma & Orthopaedics would start on 05/12/16. A new General Manager and new Assistant General Manager were also in place, along with a relatively new Matron. There was therefore renewed optimism regarding the Directorate's improvement

SDu welcomed the optimism, but stated that she did not believe this had been reflected in the report's Appendix. AG acknowledged the point, but emphasised the importance of the MOU being used to full capacity. JL added that the Directorate had held an 'away day' recently which had been very positive. JL continued that the "2020" approach could be applied to other specialities, perhaps most notably Cardiology, and added that the query as to whether the current configuration was the correct one was also applicable to other areas.

AJ proposed that a further update be received in 3 months. SDu proposed that this be received each month instead. This was agreed, but GD proposed that the monthly update be included within future Integrated Performance Reports. This was also agreed.

**Action: Arrange for a monthly update on the "Trauma & Orthopaedics 2020" programme to be included within future Integrated Performance Reports (Chief Operating Officer, December 2016 onwards)**

AJ referred to the statement on page 2 of the report that "At this time T&O have not achieved the level of ring-fencing anticipated however this has not impacted on activity due to lack of beds", and asked for a comment. AG confirmed that there no patients had been cancelled due to lack of beds per se, despite the capacity challenges.

### **11-14 Update on IT-related issues within Ophthalmology**

PS referred to the circulated report and gave assurance that Ophthalmology and IT were now communicating. AJ acknowledged the point, but expressed concern that the issue had to be escalated in the first place. AJ also asked for confirmation that the issues would therefore be resolved. PS clarified that he was not able to give such an assurance, as there would be a long-term need for continued communication between the departments. GD added that the demands of the Ophthalmology service needed to be moderated, to reflect the developments that could actually be delivered. In the ensuring discussion, the positive contribution of the Clinical Director (Carole Jones) to the Directorate's desire to introduce new technology was acknowledged.

### **Planning and strategy**

#### **11-15 2016/17 Winter & Operational Resilience Plan (final)**

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

- The national thresholds regarding the risk/escalation status were listed, including the 'escalation ladder'



- No Wards had been 'mothballed' for future use, so the intention was to transfer the allocation of beds from Surgery and Orthopaedics to Medicine, as required, to ensure Ambulances were able to drop off patients; and ensure Cancer patients were able to receive treatment

AJ asked for details of the size of bed-base for the previous year. AG confirmed that 120 escalation beds had been available, from Whatman Ward and from the use of other areas.

AJ asked Trust Board Members whether they were content with the Plan. GD replied that the circumstances would dictate what occurred. The point was acknowledged.

AJ asked what training the "Associate Director of the Day" received. AG replied that an in-house programme was in place to ensure such individuals were conversant with relevant requirements. SDu asked for confirmation that such individuals were therefore fully competent and empowered. AG confirmed this was the case.

#### **11-16 Review of the Trust's draft Planning submissions for 2017/18 and 2018/19 (including the budgets)**

SO referred to the circulated report and reported the following points:

- The narrative "Operational Plan 2017/18- 2018/19" document had been submitted, but a highly complex template also had to be completed and submitted to NHSI
- The content of the document had been discussed at the Trust Board 'Away Day' on 18/11/16, and included how activity had been planned, the approach to quality, the approach to workforce planning, and financial aspects
- The document aimed to reflect the content of the Kent and Medway STP
- This was the draft submission. The final submission was required by 23/12/16, and an update on that would be given to the Finance Committee and Trust Board in December 2016

AJ observed that a large reduction in workforce was not planned. SO noted that there was a large level of unidentified CIP, and some of this was expected to be related to workforce reductions.

AJ commended the work undertaken to produce the Plans.

#### **11-17 The Kent and Medway Sustainability and Transformation Plan (STP)**

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

- The document had been made public in the previous week, and broadly speaking, had been positively received. There had been considerable media interest in some aspects, particularly in East Kent, which had focused on the future of Kent and Canterbury Hospital (even though the STP document did not include much detail on that particular issue)
- There was nothing in the Plan regarding the long term future of MH, despite the beliefs held by some parts of the media and public regarding that future
- The principal piece of work relating to the STP, the clinical case for change, was expected to be completed by the end of January 2017. This would not describe the proposed locations of any changes, but would set the framework for the future public consultation on, for example, the number of acute hospitals in Kent and Medway in the future. All potential permutations needed to be considered as part of the formal process

AJ referred to the latter point, and emphasised that the involvement of Trust Boards was also important. GD noted that Boards were partial, but agreed that it was important for Boards to agree on the criteria, and stated that in this respect, Medical Directors would be the persons charged with ensuring Boards were kept informed.

The Trust Board confirmed its support for the 'direction of travel' described in the Sustainability and Transformation Plan.

#### **Assurance and Policy**

**11-18 Ratification of Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation (annual review)**

KR referred to the Standing Orders (Attachment 13) and highlighted that all proposed changes were 'tracked' in the document. KR continued that the majority of the proposed revisions reflected national changes as well as local 'housekeeping', but the major change was the proposed removal of the Foundation Trust Committee. KR elaborated that Committee had been 'dormant' since 2013, and AJ, who chaired that Committee, had confirmed he was content with the proposal. KR also noted that the revised document had been reviewed and approved at the Audit and Governance Committee on 03/11/16.

The Trust Board ratified the revised Standing Orders as circulated.

KR then referred to the Standing Financial Instructions (Attachment 14) and highlighted that all proposed changes were 'tracked' in the document, which had been reviewed and approved at the Audit and Governance Committee on 03/11/16. KR did however point out that since that meeting, the need for a number of additional amendments had been identified. KR noted that these amendments were described on page 2, whilst the other proposed changes were listed on page 1.

The Trust Board ratified the revised Standing Financial Instructions as circulated.

KR then referred to the Reservation of Powers and Scheme of Delegation (Attachment 15) and highlighted the following points:

- The revised document had been reviewed and approved at the Audit and Governance Committee on 03/11/16. However, since that meeting, the need for a number of additional amendments has been identified. KR noted that these amendments were described on pages 1 and 2 of the report, whilst the other proposed changes were listed on page 1
- Some further amendments were however still required, in relation to the "Waiving of quotation or single tender action"; "Authorisation or Orders, tenders and competitive quotations"; and "Approval of Contracts and SLAs" sections. These additional amendments reflected the need for further consideration as to the most appropriate governance arrangements, and KR and the Deputy Director of Finance (Financial Governance) had commenced work to establish the processes in place at other NHS Trusts, to inform future proposals on these sections
- In the meantime, the wording of these sections was proposed to be left as currently stated (with the exception of 'housekeeping' changes)

The Trust Board ratified the revised Reservation of Powers and Scheme of Delegation as circulated.

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

**11-19 Audit and Governance Committee, 03/11/16 (incl. approval of revised Terms of Reference)**

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

- Outstanding high priority actions from previous Internal Audit reviews had been discussed, and the owners of some outstanding recommendations would be invited to the meeting in February
- The efforts that resulted in the "Fully Comprehensive – NHS Connecting for Health conclusion" for the Internal Audit review of "NHS In-House Information Governance Toolkit: Training Material Checklist" were acknowledged
- Revised Terms of Reference were agreed, and these had been submitted for approval

AJ asked whether the Committee was content with the review of the outstanding high priority actions. SDu confirmed this was not the case, which was why the aforementioned invitations to attend the next meeting would be made. SO emphasised the importance of using such invitations to ensure actions were implemented in accordance with the relevant management response.

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

### **11-20 Quality Committee, 09/11/16 (incl. SIs)**

SDu referred to the circulated report and highlighted that the latest Stroke performance was included in the Appendix. SDu also noted that it had been agreed to highlight to the Board the concerns raised by the Clinical Director for Children's Services regarding the appropriateness of the Recruitment Panel's response to requests to extend the term of some fixed-term Medical posts. RH referred to latter point and clarified that the Panel had merely asked for clarification of some information within the request, which had then been provided 1 week later, to enable the request to be approved. RH stated that the concerns therefore seemed to arise from a misunderstanding on behalf of the Clinical Director. SDu stated that the impression was given that the matter was an ongoing concern. RH confirmed that this was not the case.

AJ commended the Stroke performance for MH, and reminded Trust Board Members that they had an open invitation to attend meetings of the Quality Committee, Finance Committee and other Board sub-committees.

### **11-21 Trust Management Executive, 16/11/16**

JL referred to the circulated report and highlighted that NHS England had commenced a process to replace existing Linear Accelerators (LinAcs), but clarified that the contact with the Trust was more akin to an indicative programme than a firm offer of replacement. JL added that the Trust had been asked to submit an expression of interest, which it had done. AJ asked whether the funding could be used for the proposed LinAc at TWH. JL replied that this was unlikely, but discussions were continuing.

JL then continued, and highlighted that TME's Terms of Reference had been revised, to reflect the intention for the Committee to become less of a performance management meeting.

AJ referred to page 5, and asked for an explanation of the role of TME in reviewing Business Cases. SO replied that TME would continue to be notified of Business Cases that had been approved. KR added that TME would only be asked to review Business Cases that were required, by virtue of value, to be approved by either the Finance Committee or Trust Board.

AJ asked whether the outcome of post-project evaluation of Business Cases was reported to TME. SO and GD confirmed that these were not reported at TME, but were undertaken as part of the performance management process.

### **11-22 Finance Committee, 28/11/16**

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

- A report of a post-project review of the Business Case for the Crowborough Birth Centre was reviewed, and it was agreed to consider the full review report in January 2017
- A report was also received on the process for undertaking post-project review of Business Cases, and it was agreed to schedule 6-monthly reports on this subject
- As was noted under item 11-9, the Committee agreed that objective 4.b within the BAF should be replaced with an alternative objective

### **11-23 Charitable Funds Committee, 28/11/16**

SDu pointed out that a written summary would be submitted to the Trust Board in December 2016, but reported that the Committee had discussed the following issues:

- The Annual Report and Accounts for 2015/16 were reviewed, along with the Audit Findings Report, which confirmed that the Auditor's anticipate providing a unqualified audit opinion
- The fund finances to month 7 were reviewed, and it was noted that income had been poor in comparison with that for 2015/16
- A presentation was received on a proposal to introduce a fundraiser post, and it was agreed to undertake some further work before considering the matter again at the next meeting. The Committee agreed that that any post should be self-funding

AJ welcomed the last point, but noted the previous experience of introducing a fundraiser at the Trust needed to be borne in mind. SD concurred. The point was acknowledged.

SDu then continued, and highlighted that some proposed revisions to the “Policies and Procedures for Charitable Funds” were approved; the processes in place to prevent fraud in relation to the Charitable Fund were noted; and revised Terms of Reference were agreed.

**11-24 Ratification of approval of “Uncommitted Single Currency Interim Revenue Support Facility Agreement”**

KR referred to the circulated report and stated that the Board was being asked to ratify the decision to approve the Agreement that had been made earlier in November, using the Board’s Emergency powers and urgent decisions” provisions.

The Trust Board formally ratified the approval of the “Uncommitted Single Currency Interim Revenue Support Facility Agreement”.

**11-25 To consider any other business**

The Trust Board delegated the authority to approve the appointment of the Trust’s External Auditor from 2017/18; and to approve the content of an ‘Agency self-certification checklist’ (which was required to be submitted to NHSI) to the ‘Part 2’ Trust Board meeting scheduled for later that day.

**11-26 To receive any questions from members of the public**

There were no questions.

**11-27 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted**

The motion was approved.

## Trust Board Meeting – December 2016

12-4	Log of outstanding actions from previous meetings	Chairman
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## Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress <sup>1</sup>
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	<div></div> The Finance Committee has agreed that a report on medical productivity should be submitted to the Committee each month. Any issues arising from the latest such report will be raised at the Trust Board meeting by exception
9-14ii (28 <sup>th</sup> Sept 16)	Arrange for the Quality Committee to consider the findings and responses to the two Orthopaedic implant related Never Events that occurred in May 2014 and August 2016 respectively	Trust Secretary / Chief Nurse / Medical Director	September 2016 onwards	<div></div> The latest Never Event had not been considered by the Learning & Improvement (SI) Panel by the time of the November 'main' Quality Committee, so the item has now been scheduled for the 'main' Quality Committee in January 2017
10-11 (Oct 16)	Liaise to consider how Non-Executive Directors could be incorporated into the formal framework for Ward/Departmental visits recently developed for Executive Directors	Trust Secretary / Deputy Chief Executive / Chairman of the Trust Board	October 2016 onwards	<div></div> Liaison has occurred, and it is proposed that the linkage for Non-Executive Directors (NEDs) be based on the principle of linking the Chair of the relevant Board sub-committee to the relevant Executive Director (i.e. so that the NED adopts the same Ward/Departmental links as that Executive). The following links are proposed: <ul style="list-style-type: none"> <li>▪ Chair of Finance Committee linked with Director of Finance</li> <li>▪ Chair of Quality Committee linked with Medical Director</li> <li>▪ Chair of Patient Experience Committee linked with Chief Nurse</li> <li>▪ Chair of Workforce Committee linked with</li> </ul>

1

Not started

On track

Issue / delay

Decision required

Ref.	Action	Person responsible	Original timescale	Progress <sup>1</sup>
				<p>Director of Workforce</p> <ul style="list-style-type: none"> <li>▪ Chair of Trust Board linked with Chief Executive and Chief Operating Officer</li> <li>▪ Chair of Audit and Governance Committee linked with Deputy Chief Executive (N.B. although the most obvious link would be the Director of Finance, this link is also taken by the Chair of the Finance Committee)</li> </ul> <p>The Trust Board is asked to consider the above proposals and agree a position</p>
11-8ii (Nov 16)	Arrange for the “Top performing” rating on the 2016/17 CCG Improvement and Assessment Framework baseline maternity assessment to be publicised within the Trust’s Maternity areas	Deputy Chief Executive	November 2016 onwards	<p>A verbal update will be given at the December Trust Board meeting</p>

### Actions due and ‘closed’

Ref.	Action	Person responsible	Date completed	Action taken to ‘close’
9-21ii (28 <sup>th</sup> Sept 16)	Arrange for the incoming Risk and Compliance Manager to be introduced to the Trust Board after they commence in post	Trust Secretary	November 2016	The individual was introduced to Trust Board Members on 30/11/16
10-8iii (Oct 16)	Submit a report to the Trust Board, in November 2016, with a considered response to the suggestions made at the meeting on 19/10/16 to raise patients’ and visitors’ awareness of the level of activity undertaken by the Trust	Deputy Chief Executive	December 2016	A verbal report will be given at the December Board meeting (a specific item has been added to the agenda)
11-8i (Nov 16)	Arrange for a letter of congratulations to be sent, on behalf of the Trust Board, to the Clinical Director for Women’s and Sexual Health and the Head of Midwifery, following West Kent CCG being	Trust Secretary	December 2016	A letter was issued on 01/12/16

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	the only area to achieve a "Top performing" rating on the CCG Improvement and Assessment Framework baseline maternity assessment for 2016/17			
11-10 (Nov 16)	Arrange for a chart of the Trust's performance on the 62-day Cancer waiting time target to be included in the 'Story of the month' section within future Integrated Performance Reports	Chief Operating Officer	December 2016	The requested chart has been included in the 'Story of the month' section in the Integrated Performance Report submitted to the December 2016 Board
11-13 (Nov 16)	Arrange for a monthly update on the "Trauma & Orthopaedics 2020" programme to be included within future Integrated Performance Reports	Chief Operating Officer	December 2016	The Integrated Performance Report submitted to the December Board includes the requested update

**Actions not yet due (and still 'open')**

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

## Trust Board meeting - December 2016

12-7	Chief Executive's update	Chief Executive
<p>I wish to draw the points detailed below to the attention of the Board:</p> <ol style="list-style-type: none"> <li>1. We have shared the draft Health and Social Care Sustainability and Transformation Plan (STP) both internally and externally which sets out our thinking on how services need to change over the next five years to achieve the right care for people for decades to come. In the New Year along with more detailed information about the STP, we will publish a timetable for engaging with the public in Kent and Medway in 2017.</li> </ol> <p>The HSJ published an article in early December saying that Kent and Medway STP has been selected as one of four pathfinders to look at ways of making significant savings in relation to back office functions. We are at a very early stage of this work and it will take time to get it right – we can only do that by listening and working with our staff to design the future of support services, as we are with the redesign of clinical services. We can decide how best to do this and we will explore many different options with a range of organisations, to choose the models we think are right for our staff and patients.</p> <ol style="list-style-type: none"> <li>2. Linked in to this is a new scheme which has been launched to help patients in our hospitals get home sooner. 'Home First' relies on us working alongside Kent Community Health NHS Foundation Trust and Kent County Council, more closely, as well as involving our voluntary and community sector partners more effectively. Home First aims to make home the first choice for all patients who are medically stable.</li> <li>3. We submitted our draft two year operational plan and the executive team met with NHS Improvements (NHSI) to provide an update on our progress against our Financial Recovery Plan. This was our second progress meeting and NHSI were again grateful for the efforts we have made and recognised the progress that had been delivered. They were, however, disappointed with the rate of progress and the pace with which some actions had been implemented. NHSI would like to meet with us again in the new calendar year to further assess our progress and delivery and as such, we remain in Financial Special Measures. Members of the executive team presented update sessions for staff at the very end of November to keep everyone informed of our latest position.</li> <li>4. MTW has been awarded £1.8 million of national funding to help modernise radiotherapy. MTW is one of only 15 Trusts across England to benefit from the first wave of investment by NHS England which was announced at the 'Britain Against Cancer' conference this week. This funding will ensure we continue to provide optimum treatment, care and support to cancer patients.</li> <li>5. The inquest into the death of Mrs Edna Thompson, who died in Maidstone Hospital in September 2015, took place on the 5/6/7 December. The coroner entered a narrative conclusion at the end of the case. Our statement expressed that we are very sorry Mrs Thompson did not receive the high standards of care we would expect at our hospital and we have offered our deepest condolences to her family and friends. We have thoroughly investigated the care and treatment Mrs Thompson received and as a result, we have implemented a number of improvements to our systems and processes to improve patient care. These include (but are not limited to): improvements to channels of communication between different teams and departments within the hospitals, the introduction of a medicine handover sheet and a review of how inpatients attending our ophthalmology clinics are cared for while they wait.</li> </ol>		



6. It's so important that we learn from this situation and ensure we alter processes and approaches, where necessary, so we can provide the highest quality care to patients and their families.
7. MTW has shared key learnings from the way we have transformed our approach to fighting the 'superbug', C.difficile, with around 850 delegates from over 30 countries, including a large group from Finland. Sara Mumford, Director of Infection Prevention and Control, delivered a presentation in November at the Healthcare Infection Society (HIS) International Conference in Edinburgh, entitled: '*From zero to hero*'. The conference attracted a wide range of experienced practitioners and newcomers in the field, including infection control specialists and consultant microbiologists.
8. Recent flu vaccine data released by Public Health England (PHE) ranks MTW well within the 20 top performing Trusts across the South Region and highlights MTW as the most improved Trust within Kent & Medway in the last year. MTW has increased uptake of our flu vaccine by 14% from 15/16 to 16/17 and is ranked 2<sup>nd</sup> in Kent for workforce uptake of the flu vaccine at 40.5% by the end of October. (Currently around 60%.)
9. I am delighted to be able to announce the appointment of Dr Peter Maskell as our new Medical Director. Peter is one of our consultant stroke physicians and is currently also the Medical Director of Kent Community Healthcare NHS FT. He will be an excellent addition to our Executive team and will formally take up post early in February, though he will begin spending time with us from very early in the New Year. We will have the opportunity after Christmas to properly welcome Peter and also to thank Paul Sigston for his years of service in the role and for the fantastic contribution he has made and will continue to make as one of our most senior clinicians.

While on the issue of clinical leadership we have had a close look during the last few months at the way we run the Trust. We have made excellent progress in moving to a more robust model of clinical, and particularly medical, leadership through the establishment of robust clinical directorates. We are fortunate to have a highly skilled and experienced cadre of Clinical Directors. The next step in ensuring that we have that strong medical voice in every part of the structure is to build in a clear role at divisional level, alongside the Directors of Operations.

On this basis I can now confirm that we are establishing three new roles of Deputy Medical Directors. I am very pleased to say that Laurence Maiden has agreed to take on the role for Urgent Care, Wilson Bolsover will do likewise for Women's, Children's & Sexual Health and Paul Sigston will cover Planned Care on an interim basis in addition to his role as Medical Director for the Trust. Given the scale of the operational and financial challenges that we face it has never been more important that we are able to build the strongest clinical leadership possible. I am confident that these appointments will move us firmly in the right direction and where necessary I will confirm permanent arrangements in due course.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**

Information and assurance

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

**Trust Board meeting – December 2016****12-8 Integrated performance report for November 2016****Chief Executive**

The enclosed report includes:

- The 'story of the month' for November 2016
- An update on the "Trauma and Orthopaedics 2020" programme
- A quality exception report
- A Workforce update
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts

**Which Committees have reviewed the information prior to Board submission?**

- Trust Management Executive, 14/12/16 (performance dashboard)

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Discussion and scrutiny

<sup>1</sup> 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 November 2016

### Responsiveness

At the end of month 7 the Trust is underperforming against the constitutional standards for emergency 4 hour standard, RTT and cancer 62 day first definitive treatment.

#### 1. Four-hour standard, non-elective activity and LOS

Performance for the Trust for November fell to 86.5% (including MIU) which is below the Trust recovery plan of 94.2% for Nov, and well below the 95% national target. The target for December comes down to 92.2% - this is the time of year when performance scores generally start to drop as winter pressures kick in.

- A&E Attendances are still running high – they seem to have settled down to a 'new normal', as they are again conforming very closely to the model. YTD attendances are 7.4% higher than last year, and A&E admissions 18.5% higher.
- Non-Elective Activity was 15.9% higher than plan for Nov and 19.6% higher than Nov last year. YTD activity is 11.2% higher than plan.
- There were 1,359 bed-days lost – 6.39% of occupied beds in Nov due to delayed transfers of care, an improvement on Oct.
- Non-elective LOS dropped marginally to 7.60 days in November. Average occupied bed days increased from 704 in October to 722 in November.

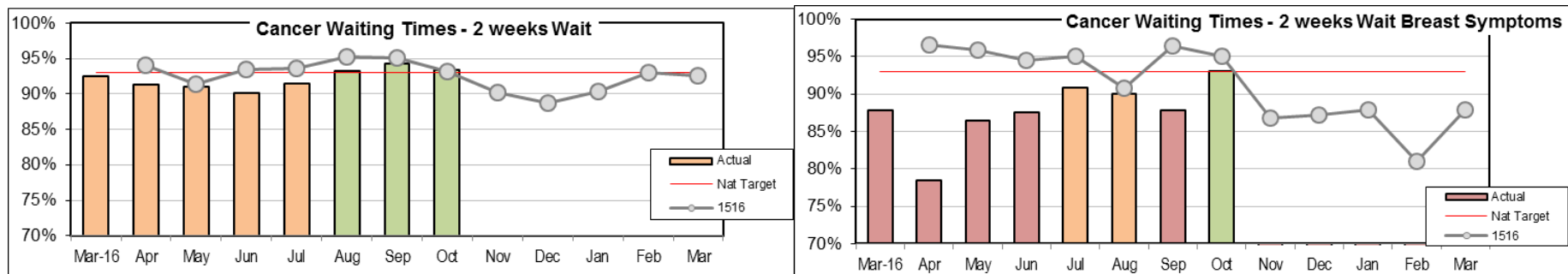
Along with the focus on the internal professional standards for the Emergency Department there is a clear focus on LOS improvement as a key enabler to improve capacity and flow of patients to achieve safe and effective admission and discharges of patients. The level of Delayed Transfers of Care (DTC) has dropped from 7.97% in October to 6.39% in November (percentage of delayed of occupied bed-days). The number of bed days lost fell from 1,673 in October to 1,359 in November.

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Grand Total	133	94	116	119	162	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180
Trust DTC	4.2%	3.6%	4.1%	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.4%

#### 2. Cancer 2 week waits (N.B. data runs one month behind)

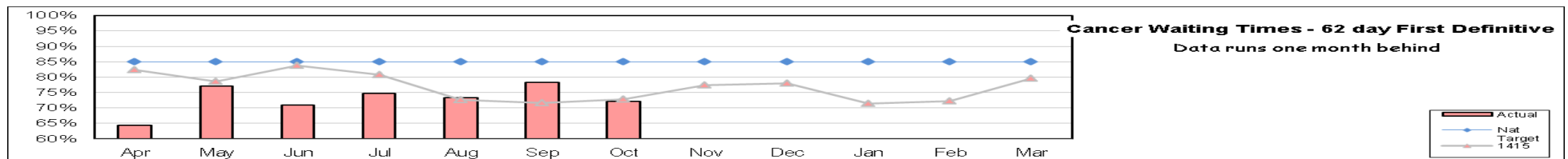
The standard for 2ww standard and breast symptomatic referrals was met in October:

- Performance for 2 Week Wait for October was 93.4% (Last year: 95.2 %.)
- Performance for 2 Week Wait Breast Symptoms for October was 93.1%, (Last Year: 90.8%)



### 3. Cancer 62 day First Definitive Treatment (FDT) (N.B. data runs one month behind)

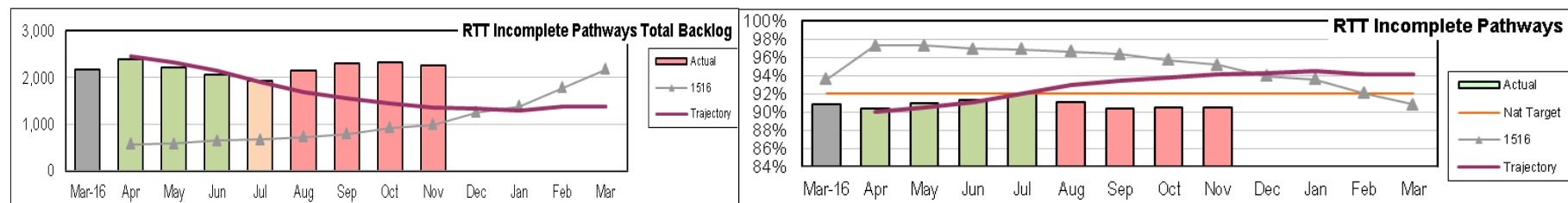
Performance for 62 day FDT for October was 72.1% (73.8% using new breach allocation policy) which is below both the national target of 85% and Trust Recovery Trajectory of 85% for October. The focus internally remains on addressing all the issues that are to do with MTW processes and clear actions have been agreed and are in place for each tumour group. The cancer delivery plan is monitored on a weekly basis with the relevant managers and clinical leads. An upgrade to the electronic patient tracking system is now available across all MDTs. A short term action plan has been compiled and the actions are being implemented and any benefits monitored. The recovery plan is focusing on the high volume tumour sites to achieve the recovery target. A revised pathway for all LGI referrals will be fully implemented as soon as the additional CNSs are in post (November – January). The revised pathway which will have intense concentration on the diagnostic period is expected reduce the overall waiting time by up to 2 weeks once fully established.



### 4. RTT and elective activity

November performance shows the Trust continues to be non-compliant with the Incomplete RTT standards at an aggregate level – 90.6%. This is due to a continued increase in non-elective demand resulting in a number of surgical cancellations as well as a significant increase in a number of specialist medicine outpatient backlogs. The Trust is now non-compliant at a speciality level for T&O, Gynae, Rheumatology, Cardiology, Respiratory, Endocrinology and ENT, but the majority of the backlog is concentrated to three specialities (T&O, Gynae, ENT).

There is a directorate & specialty level improvement plan in place, monitored via weekly performance meetings. The improvement in performance is dependent on treating more patients who have already waited over 18 weeks



## T&O 2020 Programme Update

### 1. Overview

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

- Consultant Away Day update
- Bed reconfiguration
- Trauma Review
- Theatre Utilisation
- Virtual Fracture Clinic Pilot

There are weekly update meetings chaired by the Deputy Chief Executive, the meetings are attended by the CD, Director of Operations, Associate Director of Nursing, GM, Matron, PMO. Appendix A is the updated project plan which staff are monitored on.

### 2. Consultant Away Day

On the 23<sup>rd</sup> November T&O consultants took part in an away day to review and develop a vision for the future of the service. The consultants discussed key areas during the morning and were joined by the management team in the afternoon.

The key areas discussed were:

- Business Planning and dashboards
  - Overview of the current dashboards and areas of focus for T&O
  - Agreement to review medical spend and rota management
  - GM and Head of Performance and Delivery for Planned Care agreed to organise additional sessions on the dashboard giving detail on the services position and areas of focus.
  - Agreement to review all patients over 14 weeks
  - Audit of IP coding as felt comorbidities are not being captured.
- MSK
  - Identification of lead consultants to work alongside the CCG to develop the plans for T&O MSK
  - Consultants to review the MSK pilot proposals and provide feedback
- VFC
  - Agreement that VFC will continue to be managed by the on-call consultant.
  - Review of the role of hand therapists and ESP for therapy led clinics
- Trauma List provision
  - Review of the long term plan for trauma – link to the Theatre master-schedule review and job planning. The short term provision will be implemented with the opening of MOU where elective sessions will be converted into specialist Trauma sessions
- Junior Doctors
  - The service will explore the use of recruiting to a post CCT for shoulders
  - To support the Orthopaedic geriatrician further discussions with Medicine are required to look at the recruitment of orthopaedic geriatric staff grades.
- GIRFT

- Review of volumes of procedures to be undertaken to rationalise low volumes. An overview of this work will be presented at the next Directorate meeting
  - Next step is to benchmark the services infection rates with other providers
- MOU
  - An overview of concerns and proposals of options to support the ward

### 3. Bed Reconfiguration

Since the initial bed reconfiguration on wards 20/30/31 and PPU on the 15<sup>th</sup>, SAU moved out of SSSU at the start of November to assist in securing the elective day case activity.

At this time T&O have not achieved the level of ring-fencing anticipated however this has not impacted on activity until mid December. Once the MOU is open the speciality will continue to aim to have 10 beds ringfenced at TWH to protect the cases that cannot be done at Maidstone. This will be monitored closely by the T&O 2020 weekly update group.

Next steps:

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

#### Maidstone

The opening of MOU is still on track to be the 19<sup>th</sup> December which will assist in the delivery of elective activity throughout the winter.

Next steps:

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

#### Chaucer Update.

Following the Go Live to the updated Chaucer Operational Policy Orthopaedic Rehabilitation Beds on the 17<sup>th</sup> October, there has been an increase in TWH patients receiving rehabilitation at Maidstone.

There continues to be issues regarding patients refusing to transfer to Chaucer and the following actions have been taken to manage this:

- Patient communication has been updated.
  - Patient letter
  - Introduction of a patient pack on the ward.
- Implementation of a clear escalation pathway for nurses when patients refuse.
- Chaucer Issues and Resolution meetings in place to identify and resolve issues.
- Project Review and Lessons learned - 3 month review booked for mid January 2017

### 4. Trauma Review

The specialist trauma sessions will come into place on the 19<sup>th</sup> December to coincide with the opening of MOU. This ensures that specialist Trauma will be managed within the converted session per day and recorded accurately.

The Trauma Coordinator Key to the improvement of the Trauma pathway is the introduction of an end to end coordinator. The consultation process is still underway and will be completed by mid Jan 2017.

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

## 5. Theatre Utilisation

As a part of the Divisional programme meetings are being arranged to review Theatre Utilisation. A project group has been established to review the process for getting a patient to theatre highlighting the reasons for delays.

Key outcomes from this work are to:

1. Improve theatre Start times
2. Improve cases per session
3. Reduce on the day cancellations

The first meeting took place on the 8<sup>th</sup> December reviewing the following areas:

- Patient Preparation Criteria,
  - Prepping patient
  - Clinics / theatre time – consultants
- Timelines for delivery
- Agreement and sign off

## 6. Virtual Fracture Clinic

The Virtual Fracture clinic pilot started on the 4<sup>th</sup> July and has been running for 4 months. A detailed review of the service has been undertaken and report was taken to the execs on the 12<sup>th</sup> December.

Next Steps:

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

T&amp;O 2020

Page 7 of 29



Page 8 of 29

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### **Quality Exception Report**

There were 3 cases of C difficile for November which brings the total YTD 23 cases. The limit for the year is 27 cases. There was one case of MRSA bacteraemia. This was the first case in 17 months and learning has already been identified.

12 mixed sex breaches have been reported and these occurred in SAU. Although this area was initially mixed to maintain site and patient safety the area was not 'unmixed' quickly enough.

Complaints response times improved to 80%.

### **Workforce**

As at the end of November 2016, the Trust employed 5,125.0 whole time equivalent substantive staff. While bank and agency use has reduced further from October and September levels, dependence upon temporary staff remains higher than planned. Comparison with the same period last year shows an overall reduction in temporary staffing use as well as a proportional shift from Agency to Bank. Further work will continue to reduce agency expenditure.

Sickness absence in the month has increased to 4.3%. A detailed analysis was presented to the Workforce Committee in November in order to review trends and identify root causes. Sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance has risen modestly by 0.5% from September. Actions are in place to improve compliance further.

Appraisal levels are reported for non-medical staff have increased significantly since October, representing a 4.0% rise as appraisals are returned and processed. Particular improvements have arisen following targeted activity within the Urgent Care division. Work continues with directorates and managers in order to improve return rates.

TRUST PERFORMANCE DASHBOARD

Position as at:

30 November 2016

Safe	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
*Rate C-Diff (Hospital only)	10.37	14.1	9.6	13.2	3.6	2.3	11.5	11.5	
Number of cases C.Difficile (Hospital)	3	3	15	23	8	4	27	27	
Number of cases MRSA (Hospital)	0	1	1	1	0	1	0	1	
Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%		1.0%	98.0%	99.0%	
% Non-Elective MRSA Screening	98.0%	96.0%	98.0%	96.0%		1.0%	95.0%	96.0%	
**Rate of Hospital Pressure Ulcers	4.2	2.6	2.6	2.7	0.1	- 0.3	3.0	2.7	3.0
***Rate of Total Patient Falls	7.1	6.2	6.9	5.8	- 1.1	- 0.4	6.20	6.20	
***Rate of Total Patient Falls Maidstone	6.7	6.2	6.1	5.2	- 0.9			5.5	
***Rate of Total Patient Falls TWells	7.7	6.2	7.3	6.2	- 1.1			7.0	
Falls - SIs in month	3	1	30	21	- 9				
Number of Never Events	1	1	1	2	1	2	0	2	
Total No of SIs Open with MTW	28	22			- 6				
Number of New SIs in month	9	7	66	72	6	- 8			
**Serious Incidents rate	0.47	0.33	0.42	0.41	- 0.01	0.35	0.0584 - 0.6978	0.41	0.0584 - 0.6978
Rate of Patient Safety Incidents - harmful	0.73	0.56	1.25	0.63	- 0.63	- 0.60	0 - 1.23	0.63	0 - 1.23
Number of CAS Alerts Overdue	0	0			0	0	0		
VTE Risk Assessment	95.5%	95.0%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
Safety Thermometer % of Harm Free Care	95.7%	97.3%	96.7%	96.5%	-0.2%	1.5%	95.0%		93.4%
Safety Thermometer % of New Harms	3.73%	2.39%	2.52%	3.29%	0.78%	0.3%	3.00%	3.29%	
C-Section Rate (non-elective)	11.7%	10.3%	11.7%	12.9%	1.13%	-2.1%	15.0%	12.9%	

Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
Hospital-level Mortality Indicator (SHMI)*****	Prev Yr: Oct 13 to Sept 14		102.0	109.0	7.0	9.0	Lower confidence limit to be <100		100.0
Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		104.0	107.0	3.0	7.0			100.0
Crude Mortality	1.1%	1.2%	1.2%	1.2%	0.0%				
****Readmissions <30 days: Emergency	11.3%	11.4%	11.5%	11.7%	0.2%	-1.9%	13.6%	11.7%	14.1%
****Readmissions <30 days: All	10.8%	10.6%	10.7%	10.9%	0.2%	-3.8%	14.7%	10.9%	14.7%
Average LOS Elective	2.86	3.08	3.17	3.31	0.14	0.11	3.20	3.20	
Average LOS Non-Elective	7.18	7.49	7.33	7.59	0.26	0.75	6.84	7.59	
*****FollowUp : New Ratio	1.27	1.53	1.27	1.58	0.31	0.06	1.52	1.58	
Day Case Rates	84.9%	85.9%	83.9%	85.1%	1.3%	5.1%	80.0%	85.1%	82.2%
Primary Referrals	8,640	9,237	70,857	73,396	3.6%	4.1%	104,825	109,231	
Cons to Cons Referrals	3,631	3,717	28,174	29,109	3.3%	3.7%	40,698	43,321	
First OP Activity	12,153	14,561	94,236	101,209	7.4%	3.8%	145,879	145,099	
Subsequent OP Activity	23,611	27,400	182,677	192,644	5.5%	3.3%	278,923	277,471	
Elective IP Activity	621	642	5,348	5,251	-1.8%	-5.3%	8,097	8,337	
Elective DC Activity	3,334	3,728	26,475	27,601	4.3%	0.1%	41,046	41,028	
Non-Elective Activity	3,549	4,308	30,161	33,093	9.7%	1.0%	49,350	49,006	
A&E Attendances (Inc Clinics. Calendar Mth)	12,491	12,557	103,450	108,652	5.0%	1.2%	164,376	164,376	
Oncology Fractions	6,060	6,383	45,864	47,630	3.9%	-2.4%	72,901	72,617	
No of Births (Mothers Delivered)	435	484	3,854	4,054	5.2%	3.3%	5,888	6,081	
% Mothers initiating breastfeeding	72.0%	83.2%	79.7%	82.5%	2.7%	4.5%	78.0%	82.5%	
% Stillbirths Rate	0.5%	0.20%	0.43%	0.34%	-0.1%	-0.1%	0.47%	0.34%	0.47%

Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
Single Sex Accommodation Breaches	0	12	0	12	12	12	0	12	
****Rate of New Complaints	1.71	1.55	1.69	1.26	-0.4	- 0.06	1.318-3.92	1.26	
% complaints responded to within target	88.3%	80.0%	71.9%	68.5%	-3.4%	-6.5%	75.0%	75.1%	
****Staff Friends & Family (FFT) % rec care	82.2%	82.7%	82.6%	86.6%	4.0%	7.6%	79.0%	86.6%	79.2%
*****IP Friends & Family (FFT) % Positive	96.7%	95.8%	96.6%	95.4%	-1.2%	0.4%	95.0%	95.4%	95.8%
A&E Friends & Family (FFT) % Positive	88.2%	88.9%	88.8%	90.4%	1.6%	3.4%	87.0%	90.4%	85.5%
Maternity Combined FFT % Positive	93.0%	93.5%	94.6%	93.6%	-1.0%	-1.4%	95.0%	95.0%	95.6%
OP Friends & Family (FFT) % Positive	81.1%	83.5%	79.5%	82.7%	3.2%			82.7%	

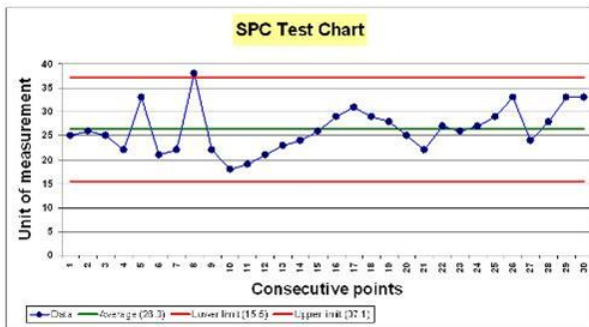
\* Rate of C.Difficile per 100,000 Bed days, \*\* Rate of Pressure Sores per 1,000 admissions (excl Day Case), \*\*\* Rate of Falls per 1,000 Occupied Beddays, \*\*\*\* Readmissions run one month behind, \*\*\*\*\* Rate of Complaints per 1,000 occupied beddays.  
\*\*\*\*\* New :FU Ratio is only for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

Delivering or Exceeding Target			Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains						
Underachieving Target									
Failing Target			*****A&E 4hr Wait monthly plan is Trust Recovery Trajectory						
Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
*****Emergency A&E 4hr Wait	89.6%	86.5%	91.6%	89.1%	-2.4%	-1.2%	95.0%	91.1%	85.8%
Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	
Ambulance Handover Delays >30mins	New	294	New						
Ambulance Handover Delays >60mins	New	47	New						
RTT Incomplete Admitted Backlog	640	1382	640	1382	742	480	916	916	
RTT Incomplete Non-Admitted Backlog	350	855	350	855	505	403	459	459	
RTT Incomplete Pathway	95.2%	90.6%	95.2%	90.6%	-4.6%	-3.6%	92%	92.3%	
RTT 52 Week Waiters	0	1	5	3	- 2	3	0	3	
RTT Incomplete Total Backlog	990	2237	990	2237	1,247	560	1,375	1375	
% Diagnostics Tests WTimes <6wks	95.33%	99.8%	98.8%	99.8%	1.0%	0.8%	99.0%	99.0%	
*Cancer WTimes - Indicators achieved	6	3	4	3	- 1	- 6	9	7	
*Cancer two week wait	93.1%	93.4%	94.6%	93.4%	-1.1%	0.4%	93.0%	92.3%	
*Cancer two week wait-Breast Symptoms	95.0%	93.1%	94.4%	93.1%	-1.3%	0.1%	93.0%	93.0%	
*Cancer 31 day wait - First Treatment	96.2%	98.5%	97.1%	98.5%	1.3%	2.5%	96.0%	96.0%	
*Cancer 62 day wait - First Definitive	72.9%	72.1%	75.2%	72.1%	-3.1%	-7.8%	85.2%	80.9%	
*Cancer 62 day wait - First Definitive - MTW	78.6%	78.7%	80.7%	78.7%	-2.1%		85.0%		
*Cancer 104 Day wait Accountable	6.5	9.5	43.5	62.5	19.0	62.5	0	62.5	
*Cancer 62 Day Backlog with Diagnosis	New	82	New	82					
*Cancer 62 Day Backlog with Diagnosis - MTW	New	60	New	60					
Delayed Transfers of Care	6.6%	6.4%	6.5%	6.5%	0.0%	3.0%	3.5%	6.5%	
% TIA with high risk treated <24hrs	92.3%	85.7%	72.4%	82.4%	10.0%	22.4%	60%	82.4%	
*****% spending 90% time on Stroke Ward	88.1%	96.8%	85.0%	81.1%	-3.9%	1.1%	80%	81.1%	
*****Stroke:% to Stroke Unit <4hrs	47.4%	57.6%	47.4%	51.9%	4.5%	-8.1%	60.0%	51.9%	
*****Stroke: % scanned <1hr of arrival	53.2%	64.4%	53.1%	55.9%	2.8%	7.9%	48.0%	55.9%	
*****Stroke:% assessed by Cons <24hrs	70.1%	79.7%	72.6%	64.5%	-8.1%	-15.5%	80.0%	64.5%	
Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	0	0	
Patients not treated <28 days of cancellation	0	1	0	21	21	21	0	21	
RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory									
*CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory									
*** Contracted not worked includes Maternity /Long Term Sick **** Staff FFT is Quarterly therefore data is latest Quarter									
Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
Income	33,171	36,072	266,096	284,065	6.8%	-0.5%	440,817	440,303	
EBITDA	(322)	1,607	6,712	8,835	31.6%	-8.4%	37,717	37,191	
Surplus (Deficit) against B/E Duty	(3,096)	(1,177)	(15,902)	(13,120)			4,675	4,249	
CIP Savings	1,862	2,298	14,146	13,236	-6.4%	2.4%	32,065	32,065	
Cash Balance	4,497	4,125	4,497	4,125	-8.3%	320%	1,000	1,000	
Capital Expenditure	1,895	534	7,721	2,402	-68.9%	-61.3%	15,188	6,949	
Establishment (Budget WTE)	5,642.1	5,755.3	5,642.1	5,755.3	2.0%	0.0%	5,837.3	5,837.3	
Contracted WTE	5,051.0	5,125.0	5,051.0	5,125.0	1.5%	-4.1%	5,427.1	5,427.1	
***Contracted not worked WTE	(104.2)	(130.6)	(104.2)	(130.6)	25.3%		(100.0)	(100.0)	
Bank Staff (WTE)	277.5	273.6	277.5	273.6	-1.4%	7.4%	254.8	254.8	
Agency & Locum Staff (WTE)	281.5	243.1	301.0	243.1	-19.2%		155.3	155.3	
Overtime (WTE)	65.0	55.5	65.0	55.5	-14.6%		50.0	64.4	
Worked Staff WTE	5,570.7	5,566.6	5,570.7	5,566.6	-0.1%	-3.3%	5,801.7	5,801.7	
Vacancies WTE	591.1	551.2	591.1	551.2	-6.7%	34.4%	408.6	408.6	
Vacancy %	10.5%	9.6%	10.5%	9.6%	-0.9%	31.5%	8.5%	8.5%	
Nurse Agency Spend	(767)	(581)	(6,846)	(5,837)	-14.7%				
Medical Locum & Agency Spend	(757)	(1,069)	(8,052)	(10,175)	26.4%				
Temp costs & overtime as % of total pay bill		14.1%		14.1%					
Staff Turnover Rate	10.4%	10.3%	9.8%	10.3%	0.0%	-0.2%	10.5%	10.3%	11.05%
Sickness Absence	4.1%	4.3%	3.9%	4.1%	0.2%	1.0%	3.3%	4.1%	4.1%
Statutory and Mandatory Training	89.0%	89.8%	89.0%	89.8%	0.8%	4.8%	85.0%	89.8%	
Appraisal Completeness	79.6%	85.8%	62.9%	85.8%	6.2%	-4.2%	90.0%	85.0%	
Overall Safe staffing fill rate	101.9%	98.3%	101.5%	99.1%	-3.5%		93.5%	99.1%	
****Staff FFT % recommended work	56.9%	60.2%	56.9%	60.2%	3.3%	-1.8%	62.0%	60.2%	62.9%
***Staff Friends & Family -Number Responses	253	98	253	98	-155				
*****IP Resp Rate Recmd to Friends & Family	27.9%	25.6%	27.1%	23.0%	-4.1%	-2.0%	25.0%	25.0%	25.7%
A&E Resp Rate Recmd to Friends & Family	17.4%	18.6%	14.8%	15.7%	0.8%	0.7%	15.0%	15.0%	12.7%
Mat Resp Rate Recmd to Friends & Family	33.1%	20.8%	18.6%	23.7%	5.1%	-1.3%	25.0%	25.0%	24.0%



## Explanation of Statistical Process Control (SPC) Charts

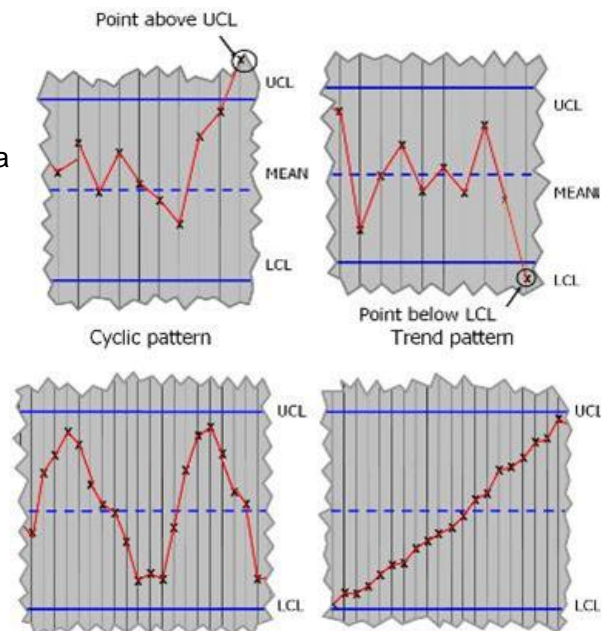
In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. An SPC chart looks like this:



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

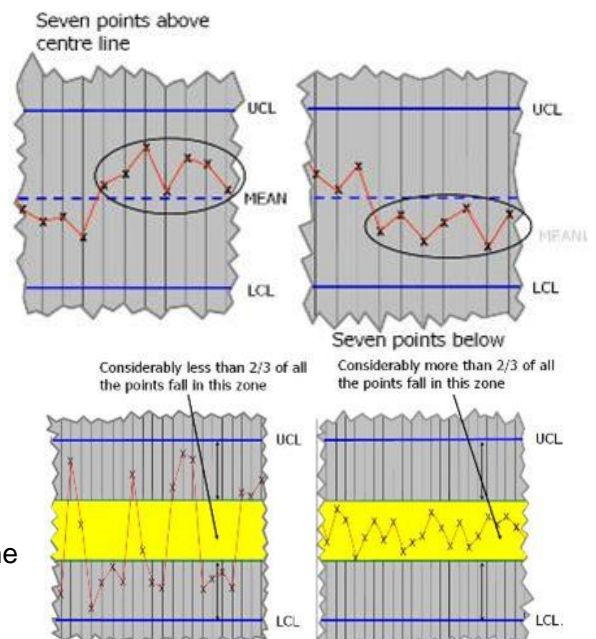
**Rule 1:** Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change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

**Rule 2:** Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.



Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

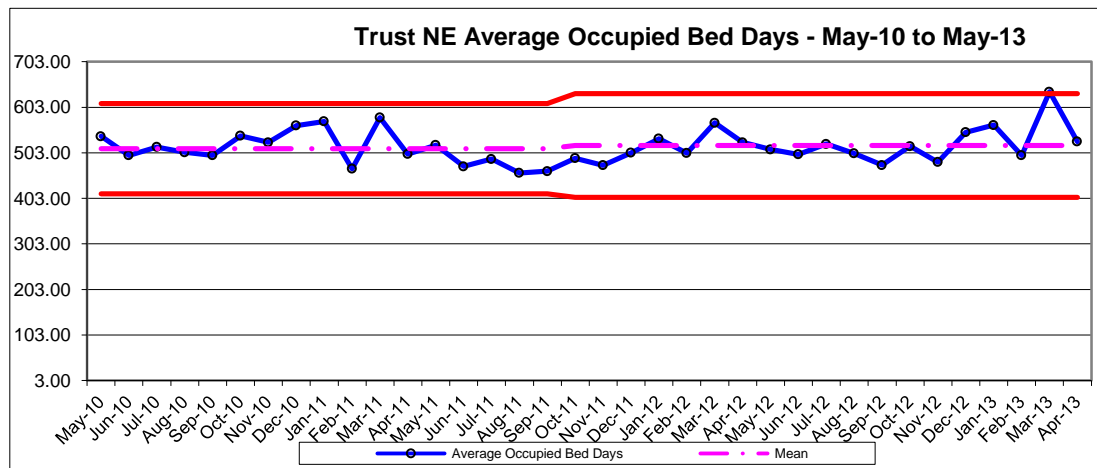
**Rule 3:** A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.



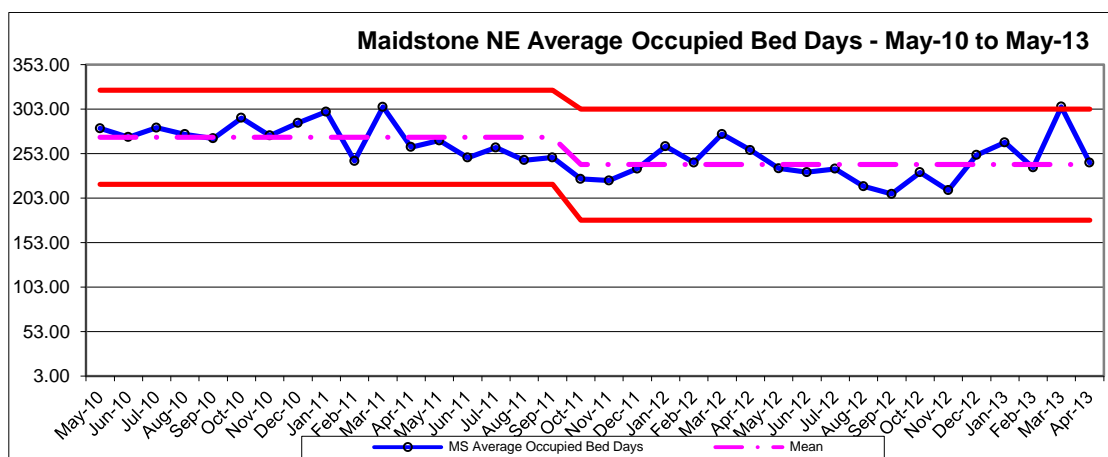
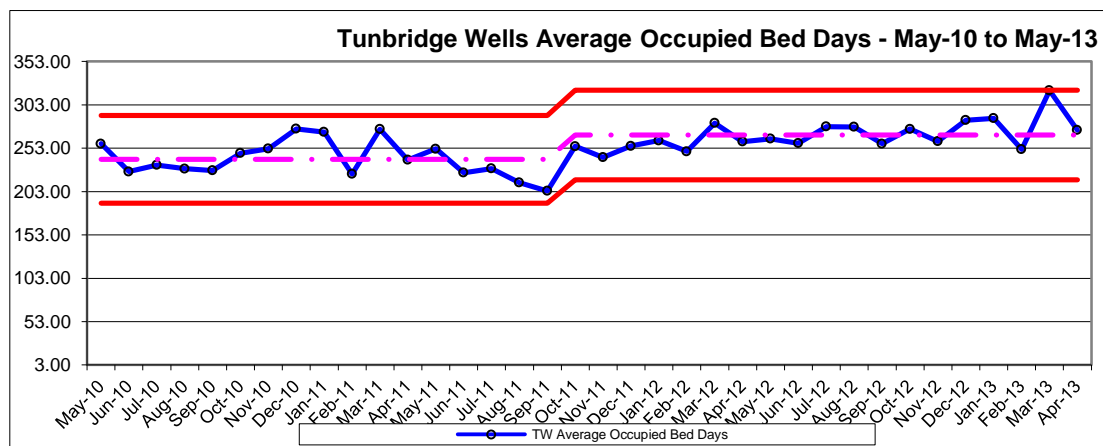
**Rule 4:** The number of points within the middle third of the region between the control limits differs markedly from two-thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

### Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



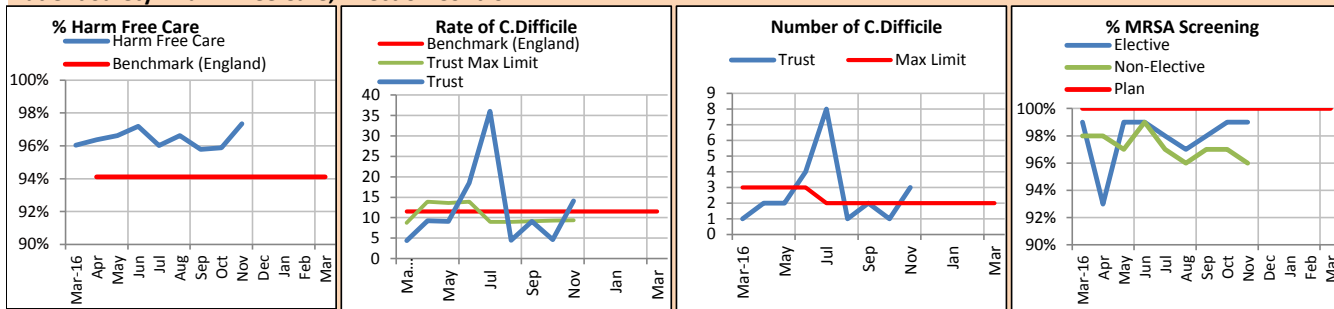
The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:



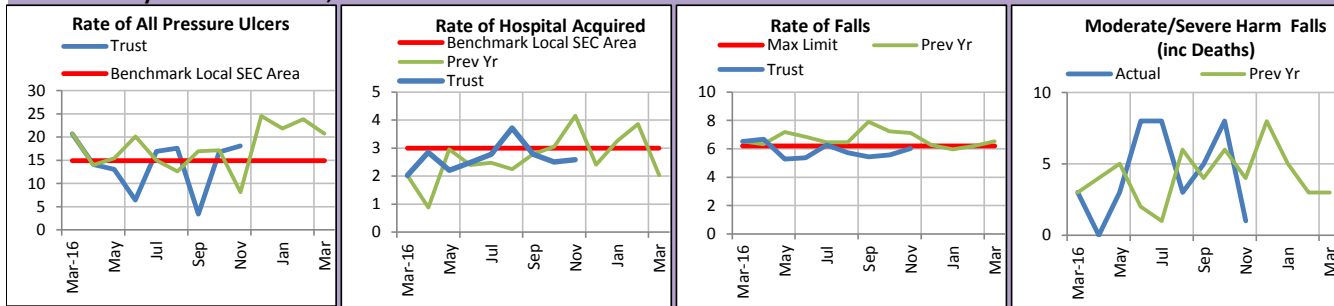
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

# INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

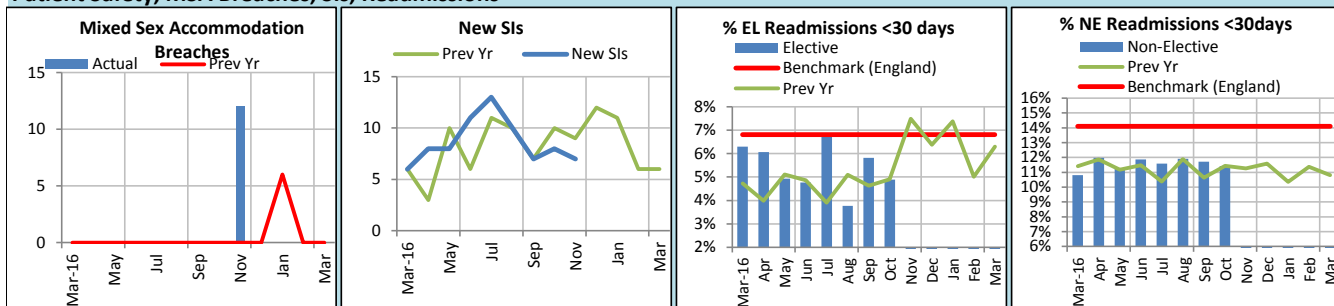
## Patient Safety - Harm Free Care, Infection Control



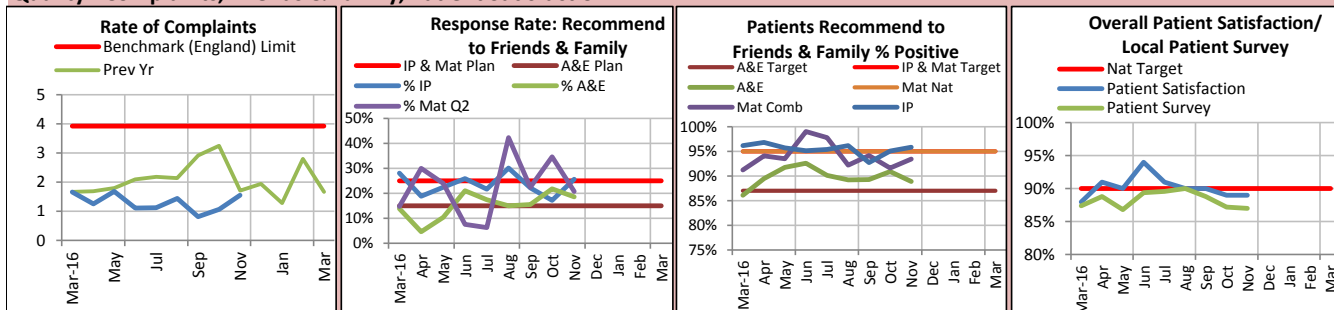
## Patient Safety - Pressure Ulcers, Falls



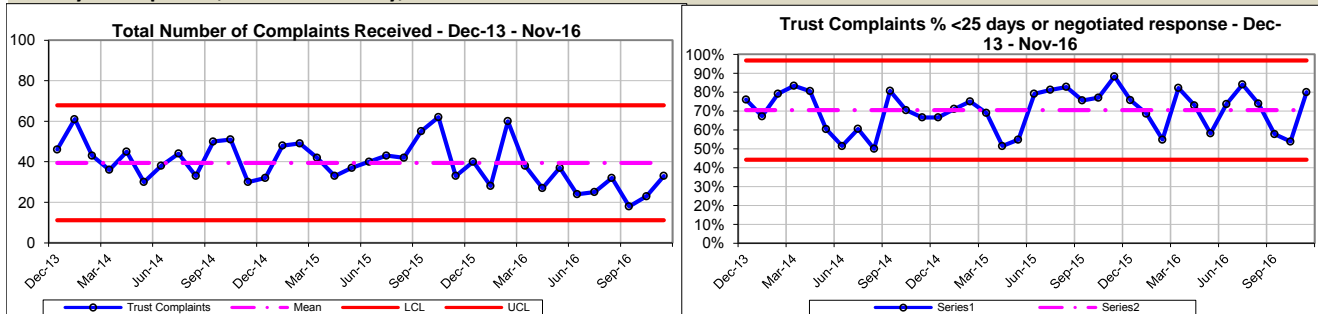
## Patient Safety, MSA Breaches, SIs, Readmissions



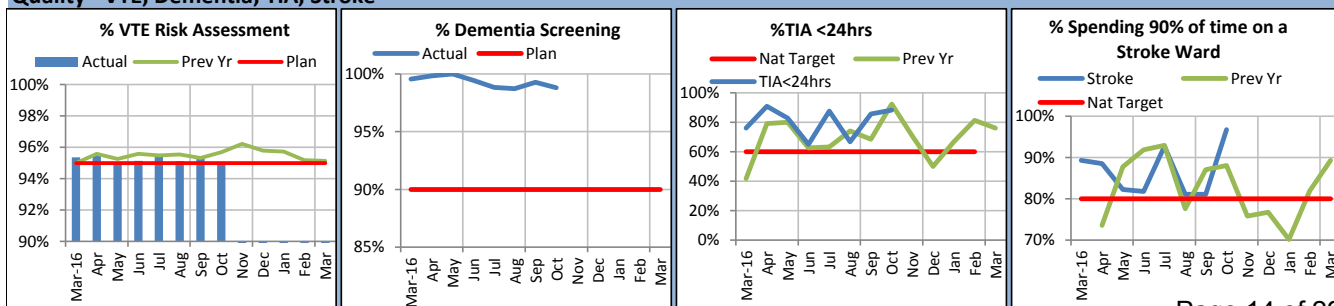
## Quality - Complaints, Friends & Family, Patient Satisfaction



## Quality - Complaints, Friends & Family, Patient Satisfaction

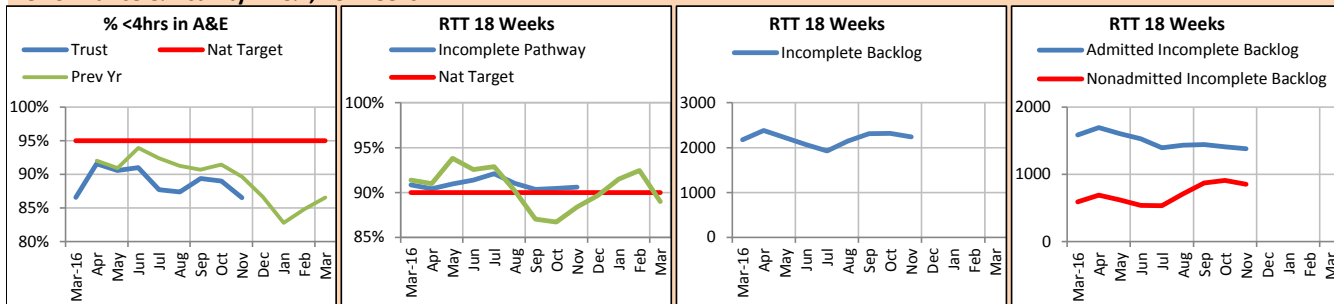


## Quality - VTE, Dementia, TIA, Stroke

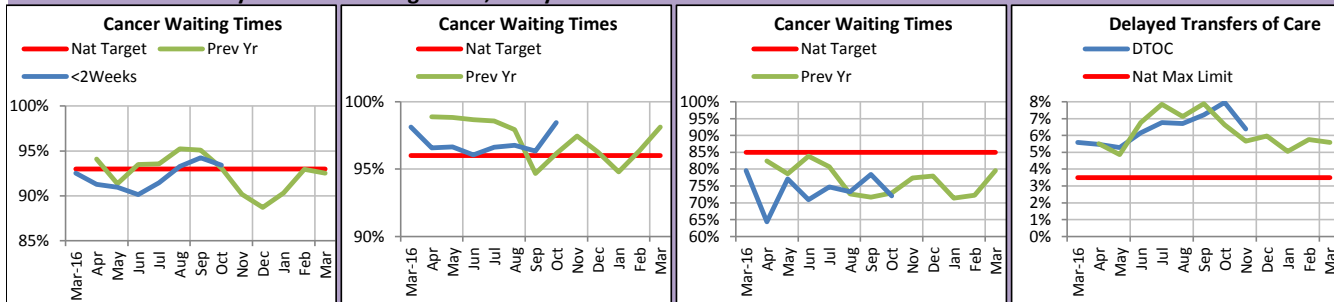


# INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

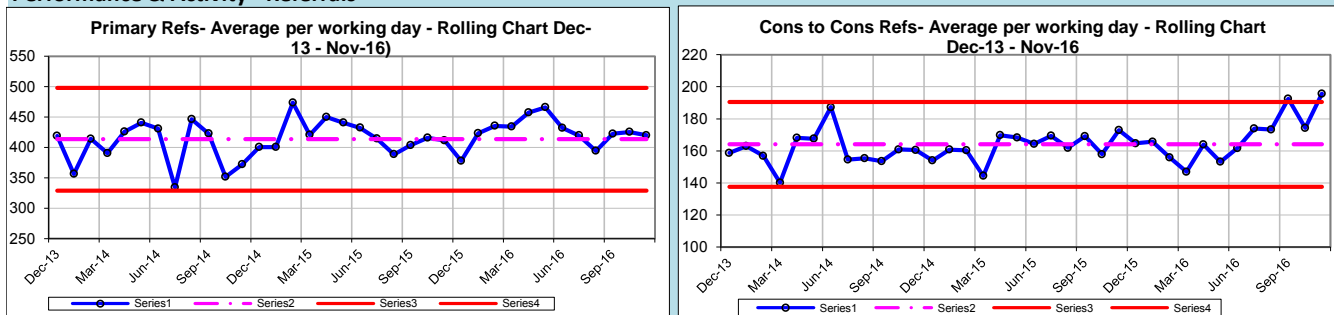
## Performance & Activity - A&E, 18 Weeks



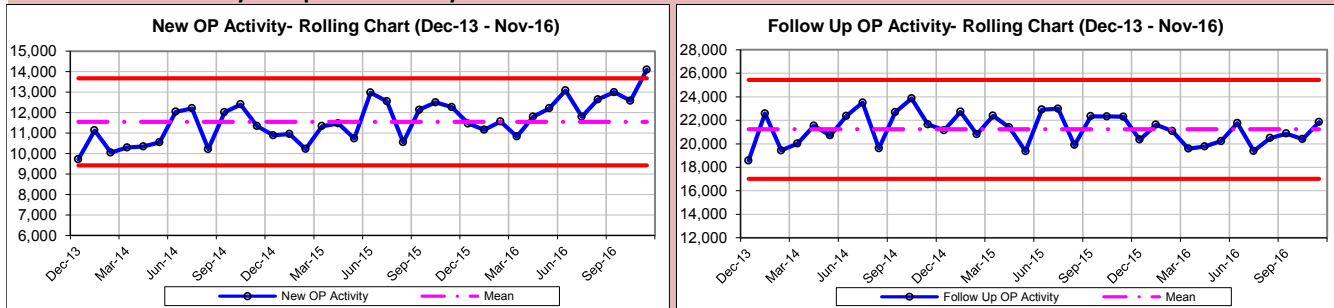
## Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



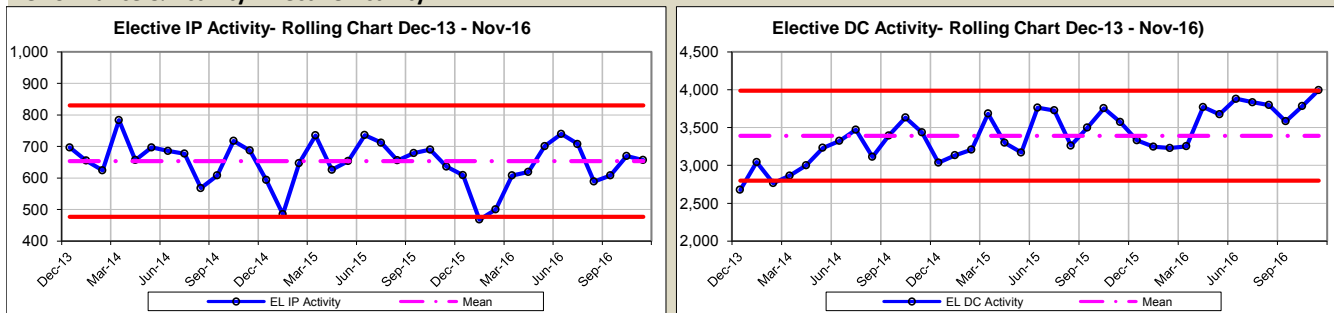
## Performance & Activity - Referrals



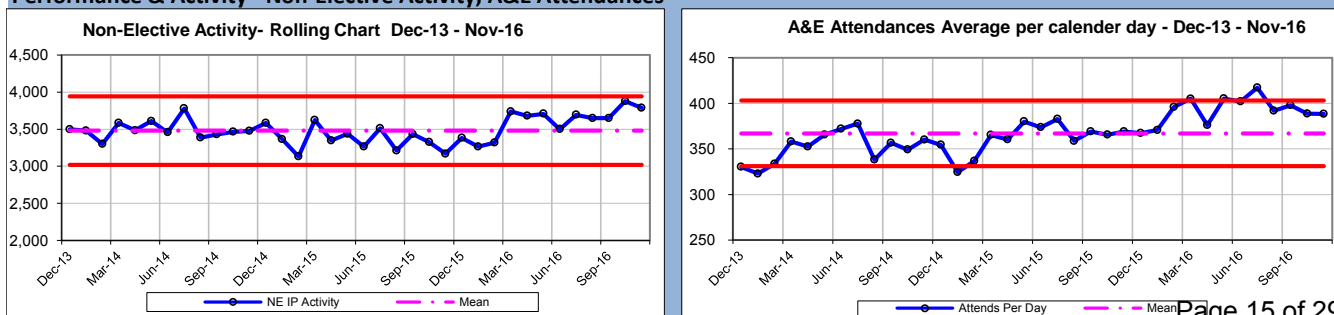
## Performance & Activity - Outpatient Activity



## Performance & Activity - Elective Activity



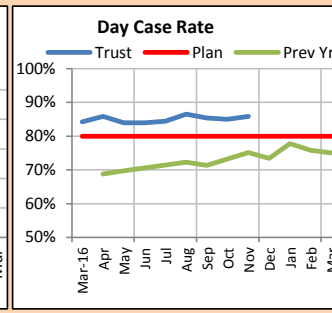
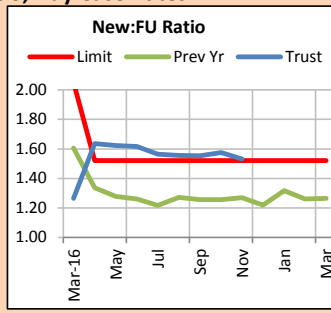
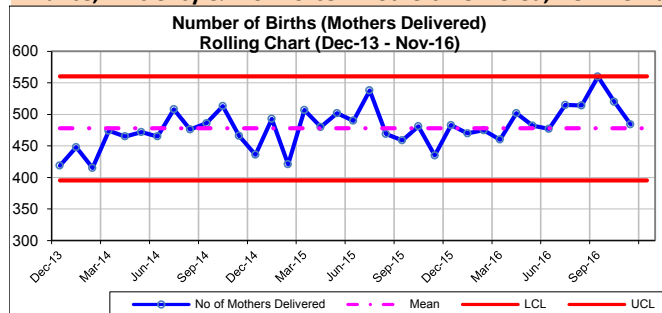
## Performance & Activity - Non-Elective Activity, A&E Attendances



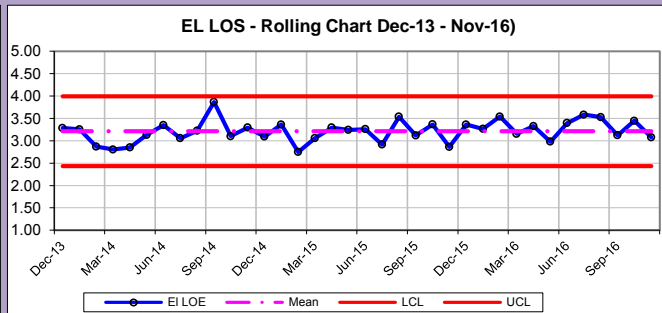
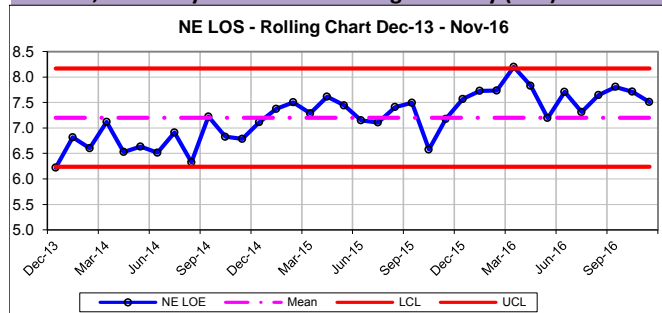


# INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

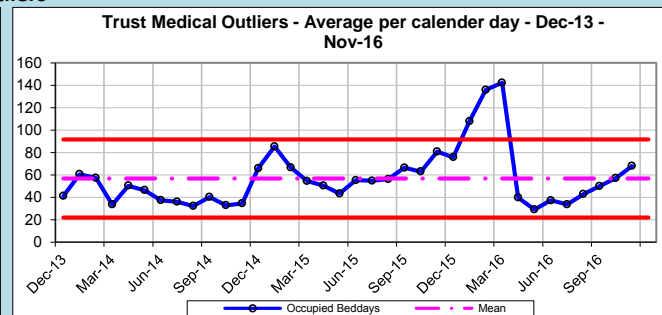
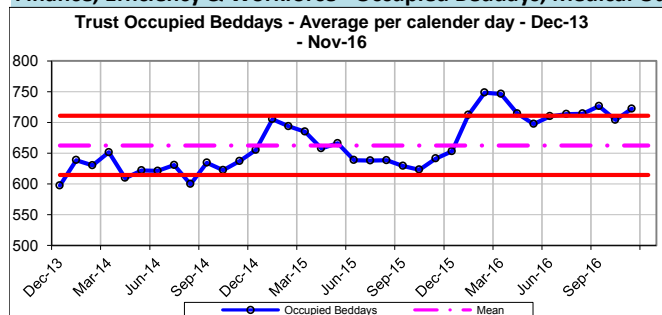
## Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates



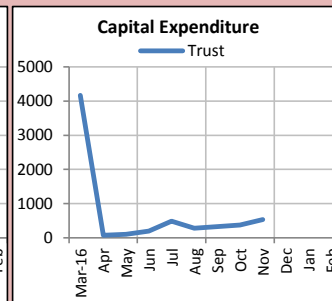
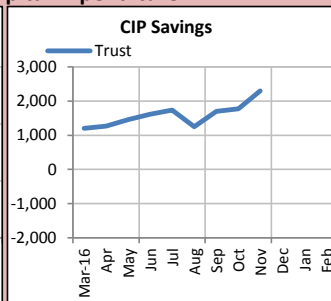
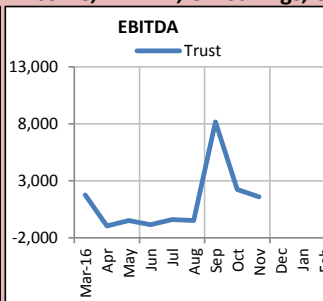
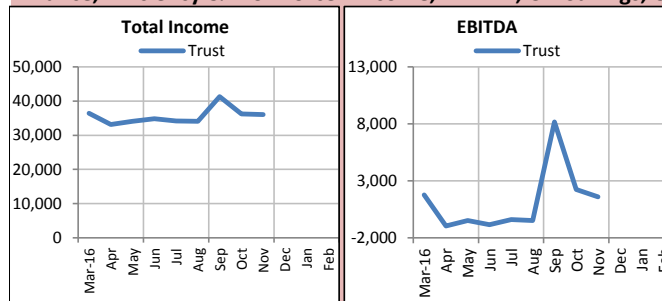
## Finance, Efficiency & Workforce - Length of Stay (LOS)



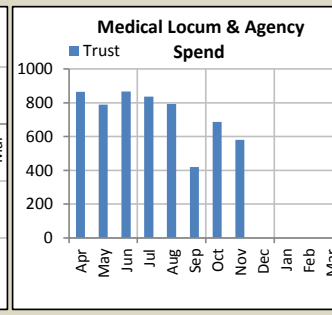
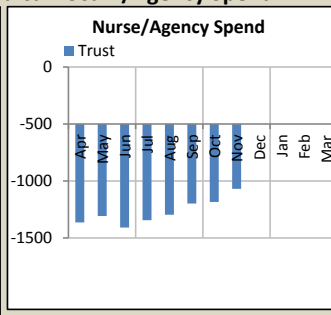
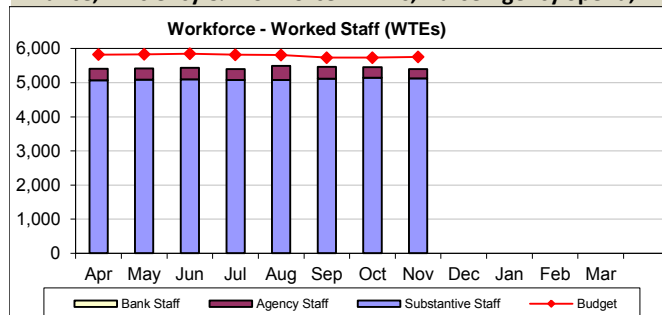
## Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers



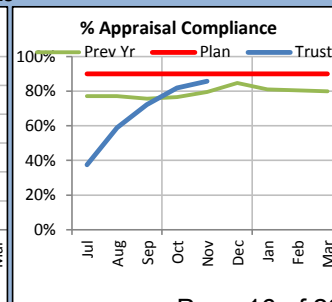
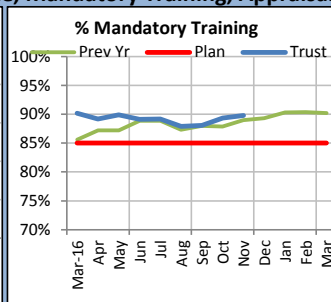
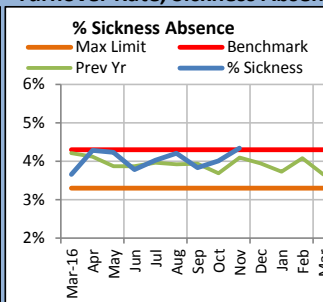
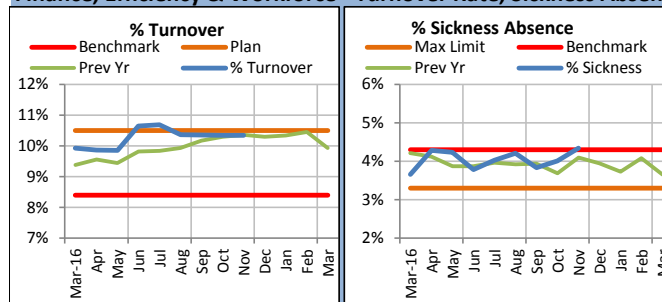
## Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



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



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



**Trust Board meeting – December 2016**

12-8	Review of Latest Financial Performance	Director of Finance
<p><b>Summary / Key points</b></p> <ul style="list-style-type: none"> <li>▪ The Trust in November 2016 broke even against the plan with a deficit of £1.2m</li> <li>▪ The Trust's net deficit to date (including technical adjustments) is £13.1m against a planned deficit of £12.5m, therefore £0.6m adverse to plan. The driver of the adversity to plan is the Trust only achieved 83% of the STF YTD. The Trust fully achieved the element relating to financial performance but failed RTT and Cancer performance trajectories.</li> <li>▪ In November the Trust operated with an EBITDA surplus of £1.6m which was in line with the plan</li> <li>▪ The key variances in the month are as follows: <ul style="list-style-type: none"> <li>○ Total income was breakeven in the month, Clinical income was £0.1m adverse in the month, £0.3m adverse for Daycase activity partly offset with Non Elective over performance (£0.2m net of non-elective threshold), STF funding was £0.3m adverse due to failure to meet A&amp;E, RTT and Cancer trajectories agreed at the beginning of the financial year. Other Operating income over performed within the month by £0.4m, this was mainly due to £0.5m relating to STP which is offset by a corresponding increase in expenditure.</li> <li>○ Pay was £0.6m favourable to plan in the month, temporary staffing costs reduced by £0.3m between months which was the lowest level over a 13 month period.</li> <li>○ Non Pay was overspent by £0.6m, this was mainly due to an overspend on drugs by £0.7m, a review of HCD expenditure and income is underway. STP costs of £0.5m were incurred in the month which is offset by income, an Energy rebate of £0.3m was incorporated within the position, this ward part of the FRP for Estates and Facilities.</li> </ul> </li> <li>▪ The CIP and FRP performance in November delivered efficiencies of £2.3m which was £0.3m favourable to plan. The main benefit within November relates to the Energy rebate of £0.3m.</li> <li>▪ The Trust held £4.1m of cash at the end of November. The Trust received £2.708m uncommitted loan facility in November which £250k is planned to be repaid in December. The remaining £2.458m is forecast to be repaid once the Trust receives quarter 3 STF funding, currently forecast for March.</li> <li>▪ The Trusts plan has been set to deliver the Control total for 2016/17 of a £4.7m surplus including STF, £4.7m deficit excluding STF. The Trust is aiming on delivering this plan and has identified mitigating actions of £25.2m to reduce the run rate to a projected year end deficit of £12.5m including STF however there remains a risk of £16.7m. NHSI has informed the Trust that an improvement of £3.5m is expected to be made by the 3<sup>rd</sup> progress meeting which is scheduled for the 30<sup>th</sup> January.</li> </ul>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>▪</li> <li>▪</li> <li>▪</li> </ul>		
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p>		

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

# Trust Board Finance Pack

**Month 8  
2016/17**

## Trust Board Finance Pack for November 2016

### 1. Executive Summary

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

### 2. Financial Performance

- a. Consolidated I&E

### 3. Expenditure Analysis

- a. Run Rate Analysis £

### 4. Cost Improvement Programme / Financial Recovery Plan

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

### 5. Balance Sheet and Liquidity

- a. Cash Flow
- b. Balance Sheet

### 6. Capital

- a. Capital Plan

# 1.Executive Summary

## 1a. Executive Summary November 2016

### Key Variances £m

	November	YTD		Headlines
<b>Total Surplus (+) / Deficit (-)</b>	(0.0)	(0.6)	<b>Adverse</b>	The reported Trust position for November is a deficit of £1.2m which is breakeven to plan  The main drivers were: Clinical Income (Excluding STF) was £0.1m adverse to plan in month (£1.5m adverse YTD), Daycase income was £0.3m adverse to plan, Non Elective activity net of threshold was £0.2m favourable in the month, Out Patients £0.2m favourable in month and Challenges were £0.6m adverse to plan mainly due to provision for Non Elective Threshold challenges. Sustainability Transformation Funding (STF) was £0.3m adverse due to non delivery of A&E, Cancer 62 days and RTT trajectories.
<b>Pay</b>	0.6	1.1	<b>Favourable</b>	Pay was £0.6m underspent in the month. The level of pay spend has reduced between months by £0.2m, A&C was the only staff group where costs increased between months (£0.1m), this was mainly within T&O which increased by £50k due to a catch-up in agency invoices (Agency has now ended) . All other staff groups reduced the level of spend between months by £0.1m each.
<b>Non Pay</b>	(0.6)	(0.6)	<b>Adverse</b>	Non Pay was £0.6m overspent within the month, Drugs net of pass through costs were £0.6m adverse to plan, a review of HCD expenditure and income is underway. Premises underspent by £0.3m in the month, this was due to an Energy rebate included within the FRP plan.
<b>Non Elective threshold</b>	0.0	0.7	<b>Favourable</b>	The non-elective threshold has been adjusted in line with the Financial Recovery plan. Negotiation and agreement with commissioners is required and therefore remains a risk to achievement of the Trust control total for 2016/17
<b>Sustainability and Transformation Fund</b>	(0.3)	(0.9)	<b>Adverse</b>	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards access targets (12.5% A&E, 12.5% RTT and 5% Cancer). The Trust achieved the financial plan however has not fully achieved the access trajectories for RTT and Cancer
<b>CIP / FRP</b>	0.2	(0.6)	<b>Adverse</b>	£0.2m over performance in the month relates to Energy rebate

### Financial Forecast

#### Risks:

Unidentified FRP (£8.3m) phased from 1st January 17 equating to a reduction in budget of £3.1m per month.

Ability to deliver elective activity due to non elective activity levels

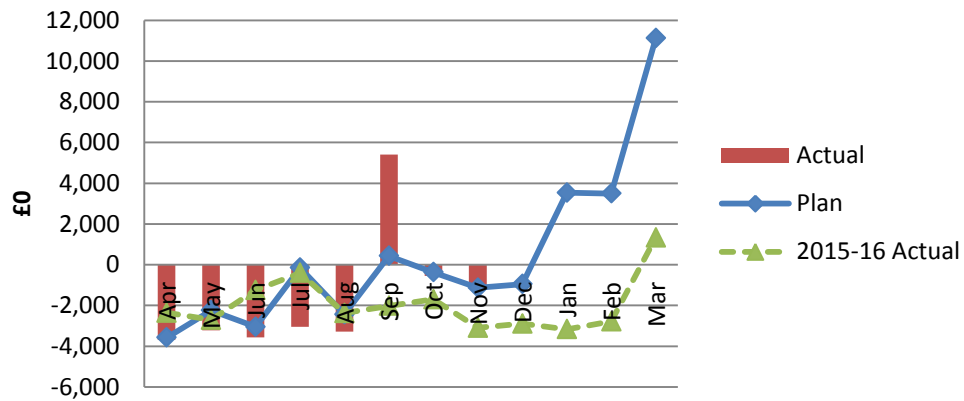
CQUINs are finalised with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing. CQUIN performance is forecasted to achieve 90% for the year.

#### Opportunities:

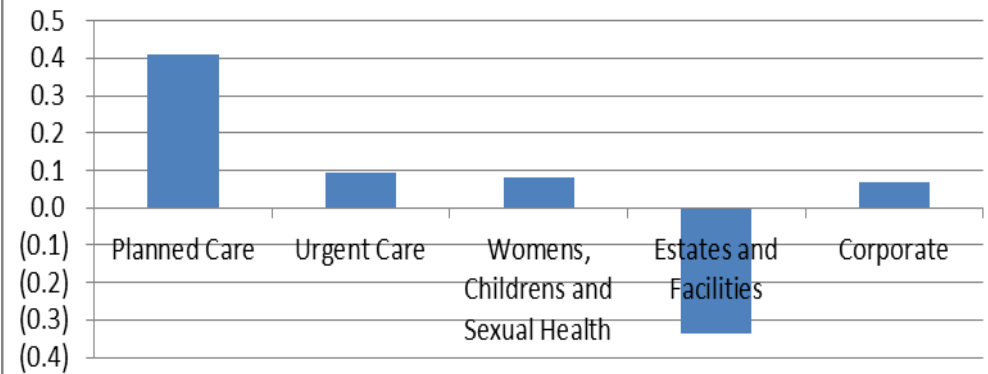
Work ongoing to identify further opportunities as part of the FRP. New FRP governance process in place. Top down savings have been developed as part of the Carter programme. These will be fast tracked over the coming months to ensure early delivery.

## 1b. Executive Summary KPI's November 2016

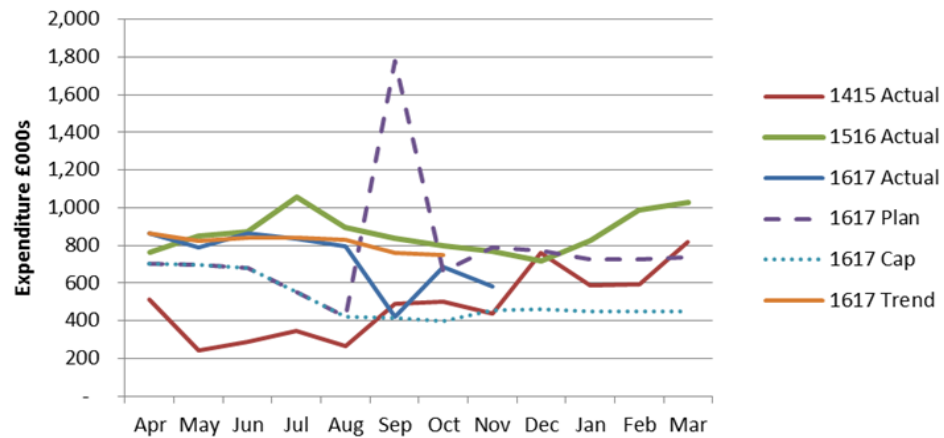
### Monthly Surplus / Deficit (-)



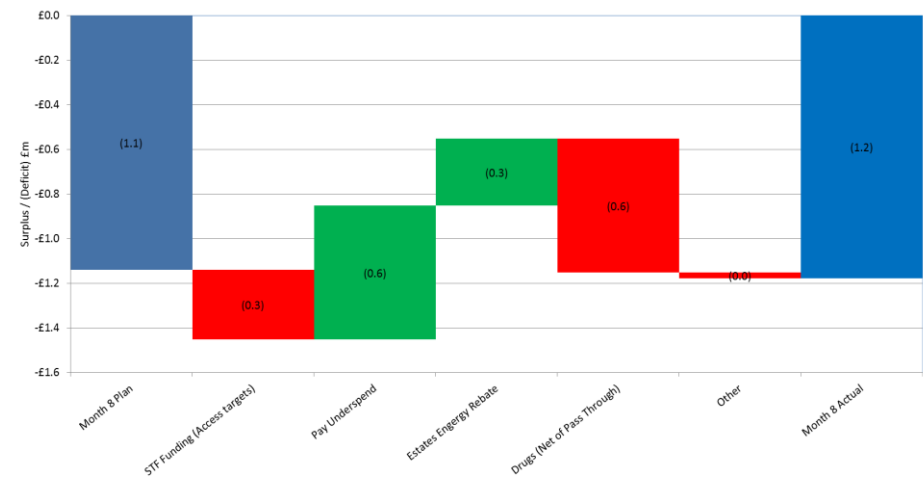
### YTD Variance £m



### Agency Nurse Expenditure



### Bridge between Monthly Plan and Actual



## 2. Financial Performance

### 2a. Consolidated Income & Expenditure

Income & Expenditure November 2016/17

	Current Month			Year to Date			Annual Forecast		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Forecast £m	Plan £m	Variance £m
<b>Revenue</b>									
Clinical Income	28.6	28.8	(0.1)	227.2	228.7	(1.5)	344.6	348.3	(3.8)
STF	0.7	1.0	(0.3)	4.3	5.2	(0.9)	5.1	9.4	(4.3)
High Cost Drugs	2.8	2.7	0.1	22.2	21.7	0.4	32.6	32.6	0
Other Operating Income	3.9	3.5	0.4	30.4	29.7	0.6	50.3	50.5	(0.2)
<b>Total Revenue</b>	<b>36.1</b>	<b>36.1</b>	<b>(0.0)</b>	<b>284.1</b>	<b>285.4</b>	<b>(1.3)</b>	<b>432.6</b>	<b>440.8</b>	<b>(8.3)</b>
<b>Expenditure</b>									
Substantive	(18.1)	(18.5)	0.4	(143.8)	(144.4)	0.6	(218.8)	(214.3)	(4.5)
Bank	(0.8)	(0.8)	(0.0)	(6.4)	(6.1)	(0.3)	(9.1)	(8.9)	(0.3)
Locum	(0.5)	(0.8)	0.4	(7.5)	(8.0)	0.5	(11.3)	(10.8)	(0.6)
Agency	(1.6)	(1.4)	(0.1)	(11.6)	(11.8)	0.2	(17.3)	(16.4)	(0.9)
Pay Reserves	0.0	(0.0)	0.0	0	(0.2)	0.2	0	0	0
<b>Total Pay</b>	<b>(20.9)</b>	<b>(21.5)</b>	<b>0.6</b>	<b>(169.3)</b>	<b>(170.5)</b>	<b>1.1</b>	<b>(256.7)</b>	<b>(250.4)</b>	<b>(6.3)</b>
Drugs & Medical Gases	(4.8)	(4.1)	(0.7)	(33.8)	(33.0)	(0.8)	(49.4)	(48.3)	(1.1)
Blood	(0.2)	(0.2)	0.0	(1.6)	(1.6)	0.0	(2.4)	(2.4)	0.0
Supplies & Services - Clinical	(2.6)	(2.6)	0.0	(21.3)	(20.8)	(0.5)	(31.2)	(30.5)	(0.7)
Supplies & Services - General	(0.5)	(0.5)	0.0	(3.7)	(3.7)	(0.0)	(5.4)	(5.5)	0.1
Services from Other NHS Bodies	(0.6)	(0.8)	0.2	(5.3)	(5.8)	0.5	(8.9)	(8.6)	(0.2)
Purchase of Healthcare from Non-NHS	(0.7)	(0.8)	0.1	(6.1)	(6.5)	0.4	(9.0)	(9.5)	0.5
Clinical Negligence	(1.5)	(1.5)	0.0	(12.2)	(12.2)	0.0	(18.3)	(18.3)	0
Establishment	(0.3)	(0.3)	(0.0)	(2.6)	(2.3)	(0.2)	(3.4)	(3.3)	(0.1)
Premises	(1.4)	(1.7)	0.3	(13.4)	(14.1)	0.7	(20.8)	(20.5)	(0.2)
Transport	(0.1)	(0.1)	(0.1)	(1.2)	(1.0)	(0.2)	(1.3)	(1.3)	(0.1)
Other Non-Pay Costs	(0.9)	(0.3)	(0.6)	(3.5)	(3.1)	(0.5)	(4.4)	(4.2)	(0.2)
Non-Pay Reserves	0.0	(0.0)	0.0	(1.3)	(1.3)	0.0	(0.3)	(0.3)	0
<b>Total Non Pay</b>	<b>(13.6)</b>	<b>(12.9)</b>	<b>(0.6)</b>	<b>(105.9)</b>	<b>(105.3)</b>	<b>(0.6)</b>	<b>(154.7)</b>	<b>(152.7)</b>	<b>(2.0)</b>
<b>Total Expenditure</b>	<b>(34.5)</b>	<b>(34.4)</b>	<b>(0.0)</b>	<b>(275.2)</b>	<b>(275.7)</b>	<b>0.5</b>	<b>(411.3)</b>	<b>(403.1)</b>	<b>(8.2)</b>
<b>EBITDA</b>	<b>1.6</b>	<b>1.6</b>	<b>(0.0)</b>	<b>8.8</b>	<b>9.6</b>	<b>(0.8)</b>	<b>21.2</b>	<b>37.7</b>	<b>(16.5)</b>
<b>Other Finance Costs</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>3.1%</b>	<b>3.4%</b>	<b>61.0%</b>	<b>4.9%</b>	<b>8.6%</b>	<b>200%</b>
Depreciation	(1.4)	(1.4)	(0.0)	(11.0)	(11.0)	0.0	(16.4)	(15.7)	(0.7)
Interest	(0.1)	(0.1)	(0.0)	(0.7)	(0.7)	(0.0)	(1.3)	(1.1)	(0.2)
Dividend	(0.3)	(0.3)	(0.0)	(2.1)	(2.2)	0.0	(3.1)	(3.4)	0.3
PFI and Impairments	(1.1)	(1.1)	(0.0)	(9.0)	(9.0)	(0.0)	(27.0)	(27.0)	(0.0)
<b>Total Finance Costs</b>	<b>(2.9)</b>	<b>(2.9)</b>	<b>(0.0)</b>	<b>(22.8)</b>	<b>(22.9)</b>	<b>0.0</b>	<b>(47.9)</b>	<b>(47.2)</b>	<b>(0.6)</b>
<b>Net Surplus / Deficit (-)</b>	<b>(1.3)</b>	<b>(1.3)</b>	<b>(0.0)</b>	<b>(14.0)</b>	<b>(13.2)</b>	<b>(0.8)</b>	<b>(26.7)</b>	<b>(9.5)</b>	<b>(17.1)</b>
<b>Technical Adjustments</b>	<b>0.1</b>	<b>0.1</b>	<b>0.0</b>	<b>0.9</b>	<b>0.7</b>	<b>0.2</b>	<b>14.2</b>	<b>14.2</b>	<b>0</b>
<b>Surplus/ Deficit (-) to B/E Duty</b>	<b>(1.2)</b>	<b>(1.1)</b>	<b>(0.0)</b>	<b>(13.1)</b>	<b>(12.5)</b>	<b>(0.6)</b>	<b>(12.5)</b>	<b>4.7</b>	<b>(17.1)</b>
<b>Surplus/ Deficit (-) to B/E Duty Excl STF</b>	<b>(1.9)</b>	<b>(2.2)</b>	<b>0.3</b>	<b>(17.4)</b>	<b>(17.7)</b>	<b>0.3</b>	<b>(17.5)</b>	<b>(4.7)</b>	<b>(12.8)</b>

#### Commentary

The Trusts deficit including STF was £1.2m which was breakeven to plan with a YTD deficit of £13.1m (£0.6m adverse to plan). Income included for STF relates to the delivery of the Financial plan, the access trajectories were not delivered in November.

Clinical Income (Excluding STF) was £0.1m adverse to plan in month (£1.5m adverse YTD), Daycase income was £0.3m adverse to plan which was mainly within Diagnostic (£0.2m and T&O £0.1m), Non Elective activity net of threshold was £0.2m favourable in the month, Out Patients £0.2m favourable in month and Challenges were £0.6m adverse to plan mainly due to a provision for a Non Elective Threshold challenge from West Kent CCG. Sustainability Transformation Funding (STF) was £0.3m adverse due to A&E, Cancer 62 days and RTT below trajectories.

Other Operating Income includes £520k STP funding offsetting expenditure incurred in the month, additional £120k associated with E Prescribing (YTD adjustment relating to split of charges). Private Patient income in the month was adverse to plan by £334k in the month, £150k of the reduction was within Diagnostics and is offset by corresponding reduction within non pay, this is due to a change in reporting of Private Radiology fees.

Pay was £0.6m favourable in the month. Temporary Staffing costs reduced between months by £280k, Medical Temporary staffing £114k reduction, Nursing £126k reduction and STT £76k reduction, £50k reduction with Specialist Medicine, £30k within Therapies and £20k within Cardio Respiratory)

Non Pay was overspent by £0.6m, Drugs adverse to plan by £0.7m, a review of HCD expenditure and income is underway. STP costs (offset by income) £0.5m adverse partly offset by energy rebate (£0.28m).

The Trust is forecasting a year end deficit of £12.8m with mitigating actions of £16.7m to deliver a year end surplus including STF of £4.2m which is £0.4m adverse to plan.

### 3. Expenditure and WTE Analysis



#### 3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Change between Months
Revenue	Clinical Income	26.3	26.4	25.5	25.7	26.9	26.6	27.7	28.4	27.6	27.8	32.0	28.5	28.6	0.2
	STF											2.7	0.9	0.7	(0.1)
	High Cost Drugs	2.8	2.8	2.7	2.6	3.1	2.8	2.6	2.8	2.6	2.7	2.9	2.9	2.8	(0.1)
	Other Operating Income	4.1	4.0	4.0	4.6	6.5	3.8	3.8	3.6	4.0	3.6	3.7	4.0	3.9	(0.1)
	<b>Total Revenue</b>	<b>33.2</b>	<b>33.2</b>	<b>32.2</b>	<b>33.0</b>	<b>36.4</b>	<b>33.2</b>	<b>34.1</b>	<b>34.8</b>	<b>34.2</b>	<b>34.1</b>	<b>41.3</b>	<b>36.2</b>	<b>36.1</b>	<b>(0.2)</b>
Expenditure	Substantive	(17.5)	(17.4)	(17.3)	(17.7)	(18.1)	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(0.1)
	Bank	(0.8)	(0.8)	(0.9)	(0.9)	(1.1)	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	0.0
	Locum	(0.6)	(0.9)	(1.0)	(0.7)	(0.6)	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	0.4
	Agency	(1.6)	(1.6)	(1.4)	(1.7)	(1.9)	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.2)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<b>Total Pay</b>	<b>(20.4)</b>	<b>(20.6)</b>	<b>(20.6)</b>	<b>(21.0)</b>	<b>(21.8)</b>	<b>(21.2)</b>	<b>(21.2)</b>	<b>(21.6)</b>	<b>(21.3)</b>	<b>(21.2)</b>	<b>(20.9)</b>	<b>(21.1)</b>	<b>(20.9)</b>	<b>0.2</b>
Non-Pay	Drugs & Medical Gases	(4.0)	(4.1)	(4.1)	(3.9)	(4.0)	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(0.9)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(3.0)	(2.8)	(2.5)	(2.3)	(2.3)	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	0.2
	Supplies & Services - General	(0.5)	(0.4)	(0.6)	(0.4)	(0.7)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	0.1
	Services from Other NHS Bodies	(0.5)	(0.6)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	0.1
	Purchase of Healthcare from Non-NHS	(0.6)	(0.7)	(0.3)	(0.7)	(1.1)	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	0.2
	Clinical Negligence	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0
	Establishment	(0.4)	(0.3)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	0.0
	Premises	(1.9)	(1.8)	(1.4)	(1.0)	(1.1)	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	0.3
	Transport	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.3)	(0.4)	(0.5)	(0.8)	(0.8)	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.5)
	Non-Pay Reserves	0	0	0	0	0	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	0	(0.0)
	<b>Total Non Pay</b>	<b>(13.0)</b>	<b>(12.8)</b>	<b>(12.0)</b>	<b>(11.8)</b>	<b>(12.9)</b>	<b>(12.9)</b>	<b>(13.4)</b>	<b>(14.1)</b>	<b>(13.3)</b>	<b>(13.4)</b>	<b>(12.3)</b>	<b>(12.9)</b>	<b>(13.6)</b>	<b>(0.7)</b>
	<b>Total Expenditure</b>	<b>(33.5)</b>	<b>(33.4)</b>	<b>(32.6)</b>	<b>(32.8)</b>	<b>(34.7)</b>	<b>(34.1)</b>	<b>(34.6)</b>	<b>(35.7)</b>	<b>(34.6)</b>	<b>(34.6)</b>	<b>(33.1)</b>	<b>(34.0)</b>	<b>(34.5)</b>	<b>(0.5)</b>
	<b>EBITDA</b>	<b>(0.3)</b>	<b>(0.2)</b>	<b>(0.4)</b>	<b>0.2</b>	<b>1.8</b>	<b>(1.0)</b>	<b>(0.5)</b>	<b>(0.8)</b>	<b>(0.4)</b>	<b>(0.5)</b>	<b>8.2</b>	<b>2.2</b>	<b>1.6</b>	<b>(0.6)</b>
Other Finance Costs		-1%	-1%	-1%	1%	5%	-3%	-1%	-2%	-1%	-1%	20%	6%	4%	
	Depreciation	(1.3)	(1.3)	(1.3)	(1.4)	0.9	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	(0.2)	(0.4)	(0.4)	0.1	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	PFI and Impairments	(1.1)	(1.2)	(1.1)	(1.4)	(14.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	0.0
		<b>(2.9)</b>	<b>(2.8)</b>	<b>(2.9)</b>	<b>(3.2)</b>	<b>(13.2)</b>	<b>(2.9)</b>	<b>(2.8)</b>	<b>(2.8)</b>	<b>(2.8)</b>	<b>(2.8)</b>	<b>(2.9)</b>	<b>(2.9)</b>	<b>(2.9)</b>	<b>(0.0)</b>
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(3.2)	(3.1)	(3.3)	(3.0)	(11.5)	(3.8)	(3.3)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(1.3)	(0.7)
Technical Adjustments	Technical Adjustments	0.1	0.2	0.1	0.2	12.8	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.7)	(3.2)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(1.3)	(0.7)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.7)	(3.2)	(3.7)	(3.2)	(3.3)	2.6	(1.5)	(2.0)	(0.5)

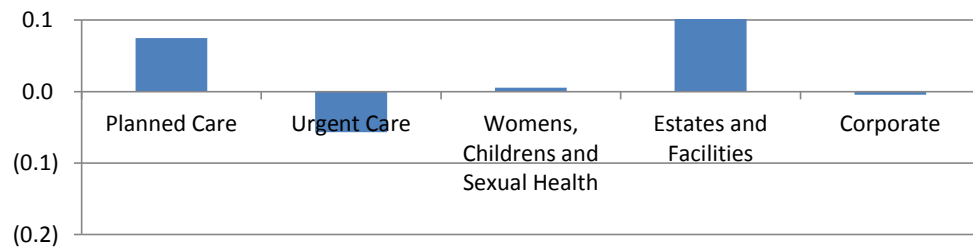


## 4. Cost Improvement Programme and Financial Recovery Plan

### 4a. Current month savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	0.1	0.1	0.0	0.1	0.1	(0.0)	0.2	0.2	(0.0)
Critical Care	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Diagnostics	0.1	0.1	0.0	0.2	0.1	0.1	0.3	0.2	0.1
Head and Neck	0.1	0.1	(0.0)	0.0	0.0	0.0	0.1	0.1	(0.0)
Surgery	0.1	0.1	(0.0)	0.1	0.1	0.0	0.2	0.1	0.0
Trauma and Orthopaedics	0.1	0.1	0.0	0.0	0.0	(0.0)	0.1	0.1	(0.0)
Patient Admin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)
<b>Total Planned Care</b>	<b>0.6</b>	<b>0.6</b>	<b>0.0</b>	<b>0.4</b>	<b>0.3</b>	<b>0.1</b>	<b>1.0</b>	<b>0.9</b>	<b>0.1</b>
Urgent Care	0.2	0.2	(0.0)	0.3	0.3	(0.0)	0.5	0.6	(0.1)
Womens, Childrens and Sexual Health	0.1	0.1	(0.0)	0.1	0.0	0.0	0.2	0.2	0.0
Estates and Facilities	0.1	0.1	(0.0)	0.4	0.1	0.2	0.4	0.2	0.2
Corporate	0.1	0.1	(0.0)	0.1	0.1	0.0	0.2	0.2	(0.0)
<b>Total</b>	<b>1.1</b>	<b>1.1</b>	<b>(0.1)</b>	<b>1.2</b>	<b>0.9</b>	<b>0.3</b>	<b>2.3</b>	<b>2.0</b>	<b>0.2</b>

### Current Month Variance £m



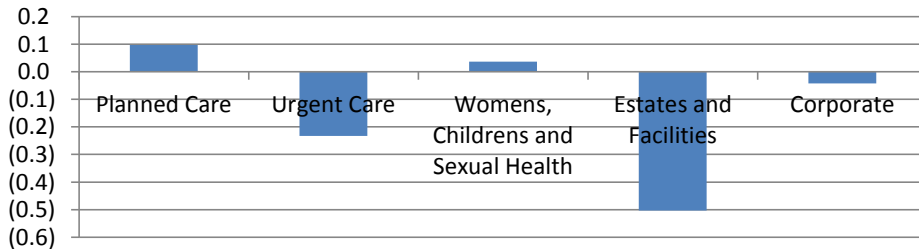
**Estates and Facilities:** Overperformance against the FRP target for November is due to a Energy rebate of £280k

**Diagnostics:** Overperformance of £0.1m against the FRP Target, this is mainly due to Histopathology Medical agency being less than plan (£62k)

#### 4b. Year to Date Savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	<i>Actual</i>	<i>Plan</i>	<i>Variance</i>	<i>Actual</i>	<i>Plan</i>	<i>Variance</i>	<i>Actual</i>	<i>Plan</i>	<i>Variance</i>
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	1.8	1.8	0.0	0.2	0.2	(0.0)	1.9	1.9	(0.0)
Critical Care	0.8	0.8	0.0	0.1	0.0	0.0	0.8	0.8	0.0
Diagnostics	0.9	0.9	0.0	0.5	0.3	0.2	1.4	1.2	0.2
Head and Neck	0.6	0.6	(0.0)	0.0	0.0	0.0	0.6	0.6	(0.0)
Surgery	0.9	0.9	0.0	0.1	0.1	(0.0)	1.0	1.0	(0.0)
Trauma and Orthopaedics	0.8	0.9	(0.1)	0.0	0.1	(0.0)	0.8	0.9	(0.1)
Patient Admin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Patients Unit	0.1	0.1	0.0	0.0	0.0	(0.0)	0.2	0.1	0.0
<b>Total Planned Care</b>	<b>5.9</b>	<b>5.9</b>	<b>(0.0)</b>	<b>0.9</b>	<b>0.8</b>	<b>0.1</b>	<b>6.8</b>	<b>6.7</b>	<b>0.1</b>
<b>Urgent Care</b>	<b>2.5</b>	<b>2.5</b>	<b>(0.1)</b>	<b>0.5</b>	<b>0.6</b>	<b>(0.2)</b>	<b>2.9</b>	<b>3.1</b>	<b>(0.2)</b>
<b>Womens, Childrens and Sexual Health</b>	<b>0.7</b>	<b>0.7</b>	<b>0.0</b>	<b>0.2</b>	<b>0.2</b>	<b>0.0</b>	<b>0.9</b>	<b>0.9</b>	<b>0.0</b>
<b>Estates and Facilities</b>	<b>0.9</b>	<b>1.6</b>	<b>(0.7)</b>	<b>0.5</b>	<b>0.3</b>	<b>0.2</b>	<b>1.4</b>	<b>1.9</b>	<b>(0.5)</b>
<b>Corporate</b>	<b>0.6</b>	<b>0.7</b>	<b>(0.0)</b>	<b>0.6</b>	<b>0.6</b>	<b>(0.0)</b>	<b>1.2</b>	<b>1.3</b>	<b>(0.0)</b>
<b>Total</b>	<b>10.6</b>	<b>11.4</b>	<b>(0.8)</b>	<b>2.6</b>	<b>2.5</b>	<b>0.2</b>	<b>13.2</b>	<b>13.8</b>	<b>(0.6)</b>

#### YTD Variance £m



**Estates and Facilities:** Overperformance against the FRP target for November is due to a Energy rebate of £280k

**Diagnostics:** £0.2m YTD overperformance due to £0.1m of new schemes and overperformance of existing schemes £0.1m. New schemes added mainly relate to procurement changes.

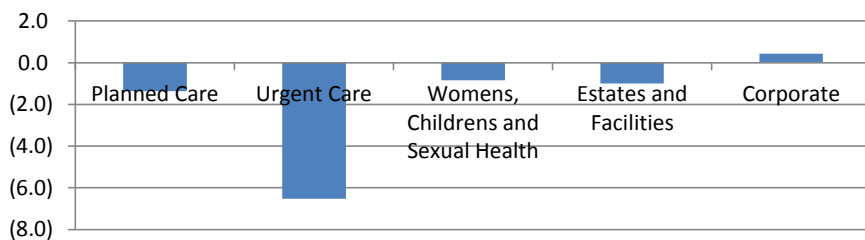
The YTD slippage in CIP is due to Energy and rates rebate which was included in the CIP forecast however were not included within the I&E.

## 4c. Forecast savings by Directorate

### Directorate Performance

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	2.2	2.2	0.0	0.8	0.5	0.3	3.0	2.7	0.3
Critical Care	1.0	1.1	(0.0)	0.2	0.4	(0.1)	1.3	1.5	(0.2)
Diagnostics	1.4	1.4	0.0	1.2	1.4	(0.2)	2.6	2.8	(0.2)
Head and Neck	0.8	0.9	(0.1)	0.1	0.5	(0.3)	0.9	1.3	(0.4)
Surgery	1.2	1.2	0.0	0.4	1.0	(0.6)	1.6	2.2	(0.6)
Trauma and Orthopaedics	0.9	1.0	(0.1)	1.0	1.2	(0.2)	1.9	2.2	(0.3)
Patient Admin	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Private Patients Unit	0.2	0.2	0.0	0.0	0.0	(0.0)	0.2	0.2	0.0
<b>Total Planned Care</b>	<b>7.8</b>	<b>8.0</b>	<b>(0.1)</b>	<b>3.8</b>	<b>5.0</b>	<b>(1.2)</b>	<b>11.6</b>	<b>13.0</b>	<b>(1.4)</b>
<b>Urgent Care</b>	<b>3.5</b>	<b>3.7</b>	<b>(0.2)</b>	<b>1.7</b>	<b>8.1</b>	<b>(6.4)</b>	<b>5.3</b>	<b>11.8</b>	<b>(6.5)</b>
<b>Womens, Childrens and Sexual Health</b>	<b>1.1</b>	<b>1.1</b>	<b>0.0</b>	<b>0.4</b>	<b>1.3</b>	<b>(0.9)</b>	<b>1.6</b>	<b>2.4</b>	<b>(0.8)</b>
<b>Estates and Facilities</b>	<b>1.4</b>	<b>2.1</b>	<b>(0.7)</b>	<b>0.9</b>	<b>1.2</b>	<b>(0.3)</b>	<b>2.3</b>	<b>3.3</b>	<b>(1.0)</b>
<b>Corporate</b>	<b>1.0</b>	<b>1.0</b>	<b>(0.1)</b>	<b>1.1</b>	<b>0.6</b>	<b>0.5</b>	<b>2.0</b>	<b>1.6</b>	<b>0.4</b>
<b>Total</b>	<b>14.8</b>	<b>15.9</b>	<b>(1.0)</b>	<b>7.9</b>	<b>16.2</b>	<b>(8.3)</b>	<b>22.8</b>	<b>32.1</b>	<b>(9.3)</b>

### Forecast Variance £m



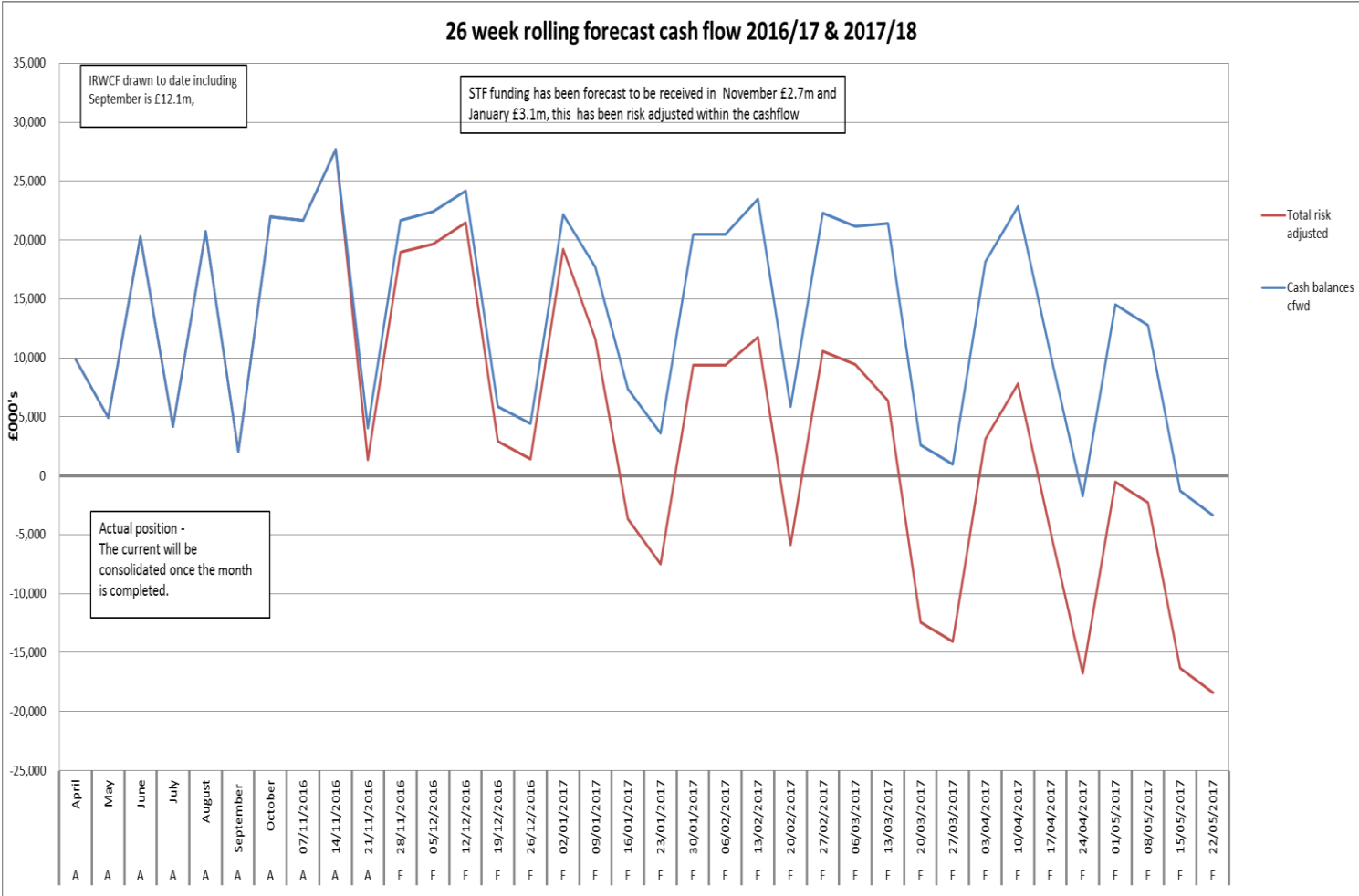
The annual savings plan for the Trust incorporating CIP and FRP equates to £32.1m for 2016/17.

The CIP forecast which was used for the resubmitted plan included savings for energy and rates. However this was not included in the I&E forecast therefore has no bottom line impact, this will be a £0.75m shortfall at the year end.

The current year end forecasted FRP gap is £8.3m. To deliver the control total of £4.7m surplus additional savings need to be identified.

NHSI has informed the Trust that an improvement of £3.5m is expected by the 3rd progress meeting in January.

5a. Cashflow



Commentary

For 2016/17 the Trust has drawn IRWCF of £12.132m to assist the cash position. Additionally the Trust drew in November £2.708m against the uncommitted loan facility, in respect to the quarter 2 STF funding. In December the Trust is planning to repay £0.25m reducing the balance to £2.458m. This balance is forecast to be repaid in March, once the quarter 3 STF funding has been received.

The cash forecast has been amended to reflect the I&E position after agreeing to the control totals. It assumes receiving in cash, overperformance of c£10m and receipt of STF funding of £5.3m. Both these values have been risk adjusted on the red line of the graph.

The Trust is currently stretching supplier payments by 14 days, which therefore means we are paying them to 44 day payment terms. This will also have a negative impact on the Trusts BPPC target as invoices are paid.

The finance team are focusing on reducing Debtor balances primarily over 90 days.

The Trust is also in discussions with local NHS organisations and to ensure a reduction in debtor/creditor balances, the Trust is paying on "like for like" arrangements where the Trust receives a cash benefit.

## 5b. Balance Sheet

### November 2016

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

£m's	November			October		Full year	
	Reported	Plan	Variance	Reported	Plan	Forecast	
Property, Plant and Equipment (Fixed Assets)	342.4	344.3	(1.9)	343.3	335.3	330.2	
Intangibles	2.6	1.3	1.3	2.7	1.5	2.0	
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0	
Debtors Long Term	1.0	1.2	(0.2)	1.0	1.2	1.2	
<b>Total Non-Current Assets</b>	<b>346.0</b>	<b>346.8</b>	<b>(0.8)</b>	<b>347.0</b>	<b>338.0</b>	<b>333.4</b>	
<b>Current Assets</b>							
Inventory (Stock)	8.1	8.3	(0.2)	8.8	8.3	8.3	
Receivables (Debtors) - NHS	44.6	19.8	24.8	44.9	20.6	21.5	
Receivables (Debtors) - Non-NHS	13.7	7.8	5.9	13.2	10.0	9.4	
Cash	4.1	1.0	3.1	4.0	1.0	1.0	
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0	
<b>Total Current Assets</b>	<b>70.5</b>	<b>36.9</b>	<b>33.6</b>	<b>70.9</b>	<b>39.9</b>	<b>40.2</b>	
<b>Current Liabilities</b>							
Payables (Creditors) - NHS	(4.1)	(5.0)	0.9	(4.4)	(5.0)	(5.0)	
Payables (Creditors) - Non-NHS	(63.7)	(30.9)	(32.8)	(65.5)	(21.8)	(21.7)	
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)	
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0	
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.1)	(5.0)	
Provisions for Liabilities and Charges	(1.8)	(2.3)	0.5	(1.9)	(1.1)	(1.0)	
<b>Total Current Liabilities</b>	<b>(76.6)</b>	<b>(45.2)</b>	<b>(31.4)</b>	<b>(78.8)</b>	<b>(35.2)</b>	<b>(34.9)</b>	
<b>Net Current Assets</b>	<b>(6.1)</b>	<b>(8.3)</b>	<b>2.2</b>	<b>(7.9)</b>	<b>4.7</b>	<b>5.3</b>	
Finance Lease - Non- Current	(199.7)	(200.0)	0.3	(200.2)	(198.2)	(198.2)	
Capital Loan - (interest Bearing Borrowings)	(13.4)	(13.4)	0.0	(13.4)	(16.4)	(12.4)	
Interim Revolving Working Capital Facility	(31.7)	(29.0)	(2.7)	(29.0)	(29.0)	(29.0)	
Provisions for Liabilities and Charges	(1.2)	(1.4)	0.2	(1.2)	(0.7)	(0.7)	
<b>Total Assets Employed</b>	<b>93.9</b>	<b>94.7</b>	<b>(0.8)</b>	<b>95.3</b>	<b>98.4</b>	<b>98.4</b>	
Financed By							
<b>Capital &amp; Reserves</b>							
Public dividend capital	(203.3)	(203.3)	0.0	(203.3)	(203.3)	(203.3)	
Revaluation reserve	(53.8)	(53.8)	0.0	(53.8)	(53.8)	(53.8)	
Retained Earnings Reserve	163.2	162.4	0.8	161.8	158.7	158.7	
<b>Total Capital &amp; Reserves</b>	<b>(93.9)</b>	<b>(94.7)</b>	<b>0.8</b>	<b>(95.3)</b>	<b>(98.4)</b>	<b>(98.4)</b>	

#### Commentary:

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

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

**Current Assets** Inventory has remained consistent as the reported October position, with pharmacy stock at £3.7m, cardiology stocks £1.0m, materials management £1m and all other stock including theatres of £2.5m. Inventory reduction is a cash management and potential CIP being discussed.

**NHS Receivables** have decreased since October but still remain significantly higher than the plan value. Of the £44.6m balance, £15.2m relates to invoiced debt of which £5.7m is aged debt over 90 days. This has decreased significantly from the October's position of £8.2m. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned. The additional interim resource has ended but the Finance Team are working collaboratively to ensure the reduction of debtors, introducing effective processes and working closely with the CCGs and other NHS organisations.

**Trade receivables** is also above plan (by £5.9m), included within this balance is trade invoiced debt of £2.3m and private patient invoiced debt of £0.8m (consistent with £0.9m in October).

**Current Liabilities:** NHS trade payables has remained consistent with the October reported position and is below plan. Non-NHS trade payables has decreased by £1.8m but still remains significantly above plan. At present the Trust has a policy to pay approved invoices within 30 days but there are £6.3m of unapproved invoices, and £11.4m approved invoices at month end, due to cash being restricted during November. Work is being undertaken to improve this and reduce balances over 90 days.

## 6. Capital

### 6a. Capital Programme

#### Capital Projects/Schemes

	Year to Date			Annual Forecast			Committed
	<i>Actual</i>	<i>Plan</i>	<i>Variance</i>	<i>Plan</i>	<i>Forecast</i>	<i>Variance</i>	
	£000	£000	£000	£000	£000	£m	£000
Estates	292	2,700	2,408	9,384	2,478	6,906	878
ICT	1,475	1,987	512	2,671	2,045	626	1,652
Equipment	635	1,520	885	2,581	1,868	713	1,321
PFI Lifecycle (IFRIC 12)	0	0	0	553	553	0	553
Donated Assets	127	300	173	800	800	0	375
<b>Total</b>	<b>2,529</b>	<b>6,507</b>	<b>3,978</b>	<b>15,989</b>	<b>7,744</b>	<b>8,245</b>	<b>4,779</b>
Less donated assets	-127	-300	-173	-800	-800	0	-375
Contingency Against Non-Disposal	0	0	0	0	0	0	0
<b>Adjusted Total</b>	<b>2,402</b>	<b>6,207</b>	<b>3,805</b>	<b>15,189</b>	<b>6,944</b>	<b>8,245</b>	<b>4,404</b>

#### Commentary:

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

A detailed review of uncommitted capital projects was undertaken by the each category lead for Estates, IT and Equipment to determine the list of projects to be deferred, in order to make it possible to reduce our outturn capital by this figure. The main projects proposing to be deferred are Estates Electrical Upgrades totalling £2.7m. Given discussions with Specialist Commissioners around the Radiotherapy Development at TWH this scheme has been deferred into 17/18. It would still require approval through the NHSI process.

The Estates projects include significant investment for Backlog Maintenance of £2m, the majority of which relates to deferred 2015/16 schemes. The replacement equipment business cases were approved at the September TME meeting. The Plan of £15.988m is therefore reduced by £4.188m and £4.056m to £7.744m for 16/17. The Trust has been successful in a bid for PDC funding to support the purchase of a Linac in 16/17, as part of the NHSE investment in radiotherapy modernisation.

## Trust Board meeting – December 2016

### 12-9      **Planned and Actual Ward Staffing for November 2016**      **Chief Nurse**

#### **Summary / Key points**

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

#### **Care Hours Per Patient Day**

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

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13. Overall CHPPD for Maidstone Hospital was 7.2 compared to 7.8 for October. For Tunbridge Wells Hospital the overall CHPPD was 10.0 compared to 9.8 for October.

Staffing establishments undertaken during August and September are now implemented with two areas in the final stages of full implementation. This is evidenced by a variance in their actual hours worked compared against plan that is not explained by changes in acuity, dependency or additional capacity.

#### **Planned vs. Actual**

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

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

Wards in this category during November were Acute Stroke Maidstone, Cornwallis, Mercer, Wards 10 and 11.

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

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

A number of areas had a reduced fill rate, most notably CCU at Maidstone. This unit is co-located with Culpepper Ward, and as such staff move between the two areas as required.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife. The non-registered fill rate is an improving position.

Neonatal unit fill rates for non-registered staff continues improve, with the reduced fill rate at night a considered approach, as a greater level of support is required during the day.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels Maidstone had a low CSW fill rate at night, which was an accepted risk. TWH accepted a low fill rate for CSWs during the day, to give priority to covering the nights when need for support staff is greatest.

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

The RAG rating for the fill rate is rated as:

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

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

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

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

- The ward maintained a nurse to patient ratio of 1:6 – 1:8
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

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

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

RAG	Details
	<p><b>Minor or No impact:</b></p> <p>Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix.</p> <p>RN to patient ratio of 1:8 or better  Skill mix within recommended guidance  Routine sickness/absence not impacting on safe care delivery  Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time.</p> <p>OR</p> <p>Staffing numbers not as expected but reasonable given current workload and patient acuity.</p>



	<p><b>Moderate Impact:</b> Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level.</p> <p>OR</p> <p>Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required.</p> <p>Requires redeployment of staff from other wards RN to Patient ratio &gt;1:8 Elements of clinical care not being delivered as planned</p>
	<p><b>Significant Impact:</b> Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix.</p> <p>Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met.</p> <p>Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio &gt;1:9</p> <p>Need to instigate Business Continuity</p>
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>n/a</li> </ul>	
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>Information and assurance</p>	

<sup>1</sup> 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

November '16		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate register d nurses/m idwives	Average fill rate care staff (%)	Average fill rate register d nurses/m idwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	96.0%	99.2%	121.1%	100.0%	7.2	44.7%	100.0%	13	0		Enhanced care needs for 9 nights.	118,487	118,266	221
MAIDSTONE	Foster Clark	97.8%	100.0%	96.7%	98.3%	5.8	64.9%	94.6%	5	0			98,543	96,748	1,795
MAIDSTONE	Cornwallis	108.9%	103.3%	100.0%	150.0%	7.2	60.6%	93.7%	2	0		7 nights additional CSW required to support care for a bariatric patient. 3 CSW nights as a 'cost pressure' post staffing review.	62,109	84,761	-22,652
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	76.7%	100.0%	N/A	10.0	104.0%	96.2%	0	0		CSW fill rate for CCU reduced as in process of recruitment following staffing review. Impact on care mitigated with cross-cover from Culpepper ward, as co-located.	92,404	94,876	-2,472
MAIDSTONE	Culpepper	100.0%	100.0%	100.0%	100.0%	7.2	68.0%	100.0%	2	0					
MAIDSTONE	John Day	95.5%	102.2%	103.3%	98.3%	6.5	61.8%	91.2%	5	1			105,241	141,071	-35,830
MAIDSTONE	Intensive Treatment Unit (ITU)	95.4%	100.0%	93.8%	N/A	29.4	50.0%	100.0%	0	0			169,797	159,208	10,590
MAIDSTONE	Pye Oliver	110.0%	75.5%	100.0%	98.9%	6.1	54.0%	92.6%	6	1		16 CSW shifts not covered by bank	105,943	103,592	2,351
MAIDSTONE	Chaucer	100.0%	94.7%	100.0%	99.2%	5.7	33.3%	100.0%	2	2			110,176	126,604	-16,428
MAIDSTONE	Lord North	99.3%	107.9%	101.1%	96.7%	7.2	67.4%	96.8%	3	0			87,270	93,738	-6,468
MAIDSTONE	Mercer	113.3%	93.3%	100.0%	121.7%	6.5	0.0%	0.0%	4	0		8 nights requiring enhanced care, CSW moved from neighbouring ward on 1 night. RN fill rate reflects supernumerary shifts x 7 which were available for direct patient care.	95,500	93,969	1,531
MAIDSTONE	Edith Cavell (MOU)	98.7%	95.8%	100.0%	100.0%	4.5	0.0%	0.0%	3	0			115,874	73,876	41,998
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAUI)	96.4%	93.8%	127.8%	200.0%	10.3	7.2%	100.0%	5	2		Escalated at night.	87,799	125,610	-37,811
TWH	Stroke/W22	90.0%	81.3%	98.7%	103.3%	9.6	130.8%	100.0%	6	0		CSW x 6 shifts not covered (vacancy) and 3 shifts not covered due to short-notice sickness.	172,191	121,049	51,142
TWH	Coronary Care Unit (CCU)	98.8%	44.2%	100.0%	96.7%	14.5	215.2%	100.0%	1	0		28 CSW shifts unfilled due to vacancy, as part of staffing review to cover cath lab recovery bay. Mitigated by movement of staff between cath labs and other wards	59,083	53,418	5,665
TWH	Gynaecology/ Ward 33	94.0%	88.3%	98.3%	100.0%	8.4	30.8%	98.0%	1	0		CSW x 7 shifts unfilled by bank	71,114	78,872	-7,758
TWH	Intensive Treatment Unit (ITU)	98.8%	96.7%	99.2%	93.3%	29.2	75.0%	100.0%	0	0			179,174	173,285	5,889
TWH	Medical Assessment Unit	93.3%	114.2%	120.7%	100.0%	8.3	41.5%	96.3%	9	0			147,016	173,700	-26,684
TWH	SAU	91.7%	90.0%	103.3%	96.7%	11.5			0	0			86,565	91,738	-5,173
TWH	Ward 32	100.5%	97.8%	103.3%	101.7%	7.6	41.0%	70.5%	5	1			115,279	127,795	-12,516
TWH	Ward 10	96.7%	98.3%	88.3%	148.3%	7.3	38.5%	93.6%	3	1		13 nights requiring enhanced care, of these 6 nights additional CSW supporting a cohort of 3, decreasing to 2 for 4 nights, then 1 for 3 nights	109,719	116,330	-6,611
TWH	Ward 11	99.5%	98.9%	95.8%	145.0%	7.0	52.4%	100.0%	3	0		22 nights need enhanced care for 3 patients at significant risk of falls.	111,956	119,192	-7,236
TWH	Ward 12	94.8%	90.0%	101.1%	93.3%	6.9	39.4%	100.0%	11	0			119,125	120,925	-1,800
TWH	Ward 20	105.0%	82.7%	100.0%	100.0%	6.2	9.4%	100.0%	8	0		21 CSW shifts not covered during the day. Mitigated with cohort nursing and support from MDT.	112,926	109,852	3,074
TWH	Ward 21	102.8%	96.7%	90.0%	118.3%	6.3	29.0%	100.0%	6	0		Increased CSW fill rate to ensure core observation over-night to mitigate reduced RN fill rate. This was a considered risk.	126,492	127,326	-834
TWH	Ward 2	95.8%	86.7%	97.8%	94.2%	6.5	83.0%	90.9%	10	1		20 CSW day shifts unfilled by bank	81,865	109,888	-28,023
TWH	Ward 30	93.1%	94.6%	101.8%	96.8%	6.2	26.8%	100.0%	2	0			103,382	120,817	-17,435
TWH	Ward 31	96.1%	93.0%	99.2%	96.7%	7.3	70.3%	84.6%	5	2			103,145	128,848	-25,703
Crowborough	Birth Centre	91.7%	103.3%	100.0%	100.0%		20.8%	93.5%	0	0			86,691	52,496	34,195
TWH	Ante-Natal	98.3%	90.0%	98.3%	80.0%				0	0		Decreased fill rate for CSW at night on Post-natal an accepted risk. Staff work as a 'floor' and cross-cover during the course of a shift.			
TWH	Delivery Suite	103.3%	90.0%	94.8%	90.0%				0	0					
TWH	Post-Natal	100.0%	80.0%	97.5%	76.7%				0	0					
TWH	Gynae Triage	98.3%	93.3%	95.0%	76.7%				0	0		An accepted risk. Covered by Ante-natal.	12,407	11,684	723
TWH	Hedgehog	97.8%	80.0%	108.7%	106.7%	8.1	9.9%	94.6%	0	0		CSW/unregistered support fill rate an accepted risk for the day, as priority given to cover nights.	218,771	181,595	37,176
MAIDSTONE	Birth Centre	98.3%	100.0%	100.0%	96.7%				0	0			62,135	63,046	-911
TWH	Neonatal Unit	95.0%	100.0%	103.3%	50.6%	15.9			0	0		Fill rate at night an accepted risk. Need is during the day. Overall fill rate for un-registered staff improving.	162,825	152,531	10,294
MAIDSTONE	MSSU	124.3%	77.1%	100.0%	N/A		0.0%	0.0%	0	0		RN:CSW ratio to ensure overall numbers of staff available. Within existing establishment currently.	42,569	42,739	-170
MAIDSTONE	Peale	121.1%	58.3%	125.0%	46.7%	7.9	31.3%	92.3%	1	0		Change of planned establishments not yet fully implemented.	61,123	70,350	-9,227
TWH	SSSU	103.3%	62.5%	136.4%	145.5%		0.0%	0.0%	1	0		Additional capacity/escalation over night. Priority for CSW fill rate given to ensuring coverage for nights.	22,983	37,699	-14,716
MAIDSTONE	Whatman	98.3%	94.2%	100.0%	103.3%	5.6	0.0%	0.0%	3	2			114,975	110,782	4,193
MAIDSTONE	A&E	102.1%	90.0%	100.0%	83.3%		21.1%	86.8%	1	0		Low CSW fill rate for Maidstone, an accepted risk.	202,541	188,136	14,405
TWH	A&E	96.7%	83.3%	98.1%	156.7%		16.2%	91.6%	3	0		Need for CSW support is greater at night for TWH so priority given to covering the nights.	294,413	334,013	-39,600
Total Establishment Wards												4,826,316	4,965,273	(138,957)	
Additional Capacity beds												40,245	38,012	2,233	
Other associated nursing costs												3,033,324	2,441,040	592,284	
Total												7,899,885	7,444,326	455,559	

RAG Key

Under fill

Over fill

**Trust Board meeting – December 2016**

12-10	<b>Summary report from Charitable Funds Committee, 28/11/16 (including approval of: Revised Terms of Reference (ToR); Annual Report &amp; Accounts of the NHS Trust Charitable Fund 2015/16 and the Management Letter of Representation)</b>	<b>Committee Chair (Non-Executive Director)</b>
<p>The Charitable Funds Committee met on 28<sup>th</sup> November 2016.</p> <p><b>1. The key matters considered at the meeting were as follows:</b></p> <ul style="list-style-type: none"> <li>▪ The External Audit Plan 2015/16 was formally ratified (the Plan had been approved after the previous meeting, under the Committee's "Emergency powers and urgent decisions" provisions)</li> <li>▪ The draft Annual Report and Accounts 2015/16 were reviewed and agreed subject to minor amendments. Subject to these amendments, the Committee recommended the Annual Report and Accounts (Appendix 2) for approval by the Trust Board</li> <li>▪ The Management Letter of Representation (Appendix 3) was agreed by the Committee as circulated and recommended for approval by the Trust Board</li> <li>▪ The External Audit Findings Report 2015/16 was reviewed and it was noted that: <ul style="list-style-type: none"> <li>○ There had been no adjustments affecting the Charity's net movement in funds and</li> <li>○ One minor deficiency in internal controls had been identified, and an unqualified audit report was expected</li> </ul> </li> <li>▪ The income, expenditure and balance sheet, as at Month 7, 2016/17, were reviewed, along with fund transactions over £1k and the balances by individual fund</li> <li>▪ Income for the year to date (£53k) was noted as disappointing when compared to the overall income for the prior year (£1.474m)</li> <li>▪ It was reported that there had been no items of expenditure refused in the period, and only one purchase of equipment over £50k in year</li> <li>▪ There were three funds with balances over £100k at 31/10/16, and it was confirmed that 16 of 38 spending plans for 2016/17 had been received to date. A draft letter to fund-holders reminding them of the requirement to submit plans was considered. The letter has subsequently been finalised for circulation</li> <li>▪ Progress with a review of the performance of the investment portfolio, which included a benchmarking exercise, was noted and it was agreed that further benchmarking should take place to identify a rate of return percentage for each benchmarked fund</li> <li>▪ Some proposed amendments to the "Policies and Procedures for Charitable Funds" were approved, including agreement that revenue expenditure of Charitable Funds in excess of £150k should be approved by the Charitable Funds Committee</li> <li>▪ The Committee noted the processes in place to prevent fraud in relation to the Charitable Fund and reviewed the latest guidance from the Charity Commission on reporting Serious Incidents. The Committee agreed that responsibility for reporting Serious Incidents should be delegated to a named individual within the Trust, and included in the Policies and Procedures for Charitable Funds</li> <li>▪ The Committee reviewed some minor proposed changes to the Committee ToR (Appendix 1) and agreed that they be recommended for approval by the Trust Board</li> <li>▪ A presentation was given on proposals to introduce a fundraiser post (and it was agreed to undertake some further work, to review the role's context within a wider community engagement strategy, prior to further consideration at the next meeting)</li> </ul> <p><b>2. In addition to the actions noted above, the Committee agreed that:</b></p> <ul style="list-style-type: none"> <li>▪ Liaison should take place between the Communications and Finance functions and the Trust Secretary in the preparation of the 2016/17 Annual Report and Accounts to achieve a more accessible and interesting Report</li> <li>▪ The Director of Finance would submit the outcome of a review of expenditure for the current year, with a view to identifying items that might be retrospectively classified as</li> </ul>		

- Charitable Funds expenditure, to the Trust Board in January 2017
- The Deputy Chief Executive would engage the Executive Team on the proposed Fundraiser role and agree the nature and scope of potential future fundraising appeals for the Trust

**3. The issues that need to be drawn to the attention of the Board are as follows:**

- Revised Terms of Reference (Appendix 1) are enclosed for approval by the Trust Board. Proposed changes are shown as 'tracked'
- The Annual Report and Accounts for the Charitable Fund 2015/16 (Appendix 2), subject to minor amendments, were recommended to the Trust Board for approval. The Management Letter of Representation (Appendix 3) is also enclosed for approval. The Annual Accounts of the Fund are legally required to be submitted to the Charity Commission within 10 months from the financial year-end (i.e. by the end of January 2017). The Trust Board is therefore asked to approve the enclosed documents, to enable the required submission to take place
- The Director of Finance will report to the Trust Board in January 2017 on the findings from his review of expenditure for the current year, with a view to identifying items that might be retrospectively classified as Charitable Funds expenditure

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**

- To approve the revised Terms of Reference for the Charitable Funds Committee
- To approve the Annual Report and Accounts for the Charitable Fund 2015/16
- To approve the Management Letter of Representation for 2015/16

<sup>1</sup> 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

## CHARITABLE FUNDS COMMITTEE MEETING - NOVEMBER 2016

11-12	REVIEW OF THE TERMS OF REFERENCE FOR THE CHARITABLE FUNDS COMMITTEE	TRUST SECRETARY
	<p>The Terms of Reference (ToR) for the Charitable Funds Committee were last reviewed in detail in July 2015, and a routine annual review is therefore due.</p> <p>The ToR have duly been reviewed, and a number of changes are proposed, as follows:</p> <ul style="list-style-type: none"> <li>▪ Change to “Chairman” to “Chair”. Although this reverses the change agreed when the Terms of Reference were last reviewed, this follows the changes that have since been made to other Board sub-committees</li> <li>▪ The inclusion of the Deputy Director of Finance (Financial Governance) to the membership</li> <li>▪ Inclusion of text to provide context to the ‘applications for support’ that may be received by the Committee (i.e. so that these are linked to a judgement call from the Head of Financial Services)</li> <li>▪ Inclusion of additional clauses are to clarify that the documents listed in the “Policy matters” section may not necessarily be required</li> </ul> <p>A ‘track changes’ version is enclosed, which shows the specific proposed revisions.</p> <p>The Committee is asked to review and agree the revised ToR, which will then be forwarded to the Trust Board (in December 2016) for formal approval.</p> <p>The proposed changes do not inhibit any further changes that may be required in-year, should these be considered necessary.</p>	
	<p><b>Reason for submission to the Charitable Funds Committee</b> (decision, discussion, information, assurance etc.)</p> <p>Review and agreement</p>	

**CHARITABLE FUNDS COMMITTEE****Terms of Reference****1. Purpose**

The Charitable Funds Committee has been established as a sub-committee of the Trust Board to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors.

**2. Membership**

Membership of the Committee is as follows:

- The Committee ~~Chairman~~ – a Non-Executive Director appointed by the Trust Board
- The Committee ~~Vice-Chairman~~ - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Director of Workforce ~~and Communications~~
- The Head of Financial Services
- The Deputy Director of Finance (Financial Governance)
- The Trust Secretary

**3. Quorum**

The Committee shall be quorate when one Non-Executive Director and one Executive Director are present.

**4. Attendance**

The Committee ~~Ce~~Chairman may invite other staff or Non-Executive Directors ~~or Managers~~ to attend, ~~including Clinical Directors and Directorate Managers,~~ as required, to meet the objectives of the Committee.

**5. Frequency**

The Committee shall meet at least three times per year (and more frequently if required to meet the objectives of the Committee).

**6. Duties**

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop and approve the strategy and objectives of the Charitable Fund
- Ensure that the Charitable Fund complies with relevant law, and with the requirements of the Charity Commission as regulator; in particular ensuring the submission of Annual Returns and accounts
- Oversee the development and delivery of the Trust's fundraising strategy
- Oversee the Charitable Fund's expenditure and investment plans, including:
  - Approving relevant policies and procedures
  - Agreeing approval and authorisation limits for expenditure from charitable funds
  - Considering applications for support (as recommended by the Head of Financial Services)
  - Approve and monitor investment strategies

The specific duties of the Committee in relation to Charitable Funds are to:

**Policy matters**

- To approve, on behalf of the corporate Trustee:
  - A Reserves policy (if considered by the Committee to be required)
  - An Investment strategy (and to formally review the strategy annually)

- A Grant Making policy (if considered by the Committee to be required)
- Guidance for fund raising activities (if considered by the Committee to be required)

### **Operational matters**

- Approve the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Approve proposals regarding the establishment of any new funds
- Authorise financial procedures and financial limits
- Receive details of any expenditure refused
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To authorise expenditure in accordance with the Trust's Reservation of Powers and Scheme of Delegation

### **Internal and External control**

- Seek assurances that all income is secured and that expenditure is within the objects of the Fund
- Ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- Ensure there is adequate provision for the independent monitoring of investment activity
- Receive all relevant internal and external audit reports, and ensure compliance with any recommendations

### **Financial reporting**

- Review income and expenditure reports for each of the reporting periods
- Review and agree the Principal Accounting Policies to be adopted
- Review, and agree the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive, where appropriate, the annual investment report
- Ensure the Director of Finance is compliant with the reporting requirements of the Committee and the Trustee
- To review Fundholders' spending plans, on an annual basis

## **7. Parent committees and reporting procedure**

The Charitable Funds Committee is a sub-committee of the Trust Board.

A summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chair~~man~~ of the Charitable Funds Committee will present the Committee report to the next available Trust Board meeting.

## **8. Sub-committees and reporting procedure**

The Charitable Funds Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

## **9. Emergency powers and urgent decisions**

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

## **10. Administration**

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair~~man~~ on:

- The Committee's Forward Programme, setting out the dates of key meetings and agenda items
- The meeting agenda
- The meeting minutes and the action log

**11. Review**

The Terms of Reference of the Committee will be reviewed annually, and approved by the Trust Board

Agreed at Charitable Funds Committee, July 2014

Approved at Trust Board, September 2014

Agreed at Charitable Funds Committee, July 2015

Approved at Trust Board, September 2015

Agreed at Charitable Funds Committee, November 2016





## Charitable Fund



Vital signs monitors donated by the Maidstone Hospital League of Friends

# Annual Report and Accounts for the year ended 31<sup>st</sup> March 2016

## Charity Number 1055215



*Charitable Fund*

## **Contents**

Annual Report for the year ended 31 <sup>st</sup> March 2016	3
Trustee Statement	3
Information about the charity	3
The Corporate Trustee	4
Principal Advisors	5
Governance and Management of the Charity	6
Aims and Objectives for the Public Benefit	8
Investment Performance	9
Achievement of Public Benefit	10
Expenditure	11
Income	12
Looking Forward	15
Statement of Trustee Responsibilities in Respect of the Trustee Annual Report and the Financial Statements	16
Independent Auditors' Report to the Trustee of Maidstone and Tunbridge Wells NHS Charity	17
Statement of Financial Activities for the Year Ended 31 <sup>st</sup> March 2016	19
Balance Sheet as at 31 <sup>st</sup> March 2016	20
Statement of cash flows as at 31 <sup>st</sup> March 2016	21
Notes to the Financial Statements for the Year Ended 31 <sup>st</sup> March 2016	22
Maidstone and Tunbridge Wells NHS Trust Charity Donation form	33

## **Annual Report for the year ended 31 March 2016**

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds ('the Charity's') annual report and the audited financial statements for the year ended 31<sup>st</sup> March 2016.

The financial statements set out on pages 19 to 32 comply with the charity's trust deed, applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015).

### **Trustee Statement**

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

### **Information about the Charity**

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

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

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

Within the Umbrella there were a total of 39 individual funds at the 31<sup>st</sup> March 2016 with a total value of £1,726k. The number of funds in each category is as follows:-

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

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

## The Corporate Trustee

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

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

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

<b>Executive Directors</b>	<b>Non-Executive Directors</b>	<b>Other Directors</b>
Glenn Douglas – Chief Executive	Anthony Jones – Chairman of the Trust Board	Sara Mumford – Director of Infection Prevention and Control
Stephen Orpin – Director of Finance	Steve Tinton – Chair of the Charitable Funds Committee	Richard Hayden – Director of Workforce (from March 2016)
Jim Lusby – Deputy Chief Executive (from April 2015)	Sarah Dunnett OBE (Vice Chair of the Charitable Funds Committee)	Paul Bentley – Director of Workforce and Communications (to February 2016)
Paul Sigston – Medical Director	Kevin Tallett	Stephen Smith (Associate Non-Executive Director) (to July 2015)
Angela Gallagher – Chief Operating Officer	Sylvia Denton CBE	
Avey Bhatia – Chief Nurse	Alex King MBE	

None of the Trust Board Members have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee. (2014/15 none)

The principal office of the Charity is:

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

**Principal advisors:**

External Auditor Grant Thornton UK LLP Grant Thornton House Melton Street London NW1 2EP	Bankers Citibank Citibank NA, London Branch 25 Canary Wharf London E14 5LB
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Lloyds TSB 2 <sup>nd</sup> Floor 11 Earl Grey Street Edinburgh EH3 9BN
	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB
	Bankers National Westminster Bank PLC 2nd Floor 280 Bishopsgate London EC2M 4RB

## **Governance and Management of the Charity**

### **Governance**

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

The Charitable Funds Committee plans to meet at least three times a year, and in 2015/16 met in July 2015, October 2015 and February 2016.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chair of the Committee and circulated to all members. A written summary report of each Charitable Funds Committee is also formally submitted to the Trust Board.

### **Recruitment and Training of Board and Committee Members**

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

### **Management of the Charity**

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

### **Risk Management**

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

To mitigate the risk of investment performance the Corporate Trustee has adopted a relatively low risk policy, but 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £75,000 per banking institution operating under a separate banking licence. The policy is that the maximum investment is up to £85,000 in each banking institution outside the Government banking Scheme and therefore the maximum risk on each investment is £10,000.

## Investment Powers

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

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

- a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;*
- b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures and traded options);*
- c) shall not have power under this clause to engage in trading ventures; and*
- d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.”*

## Investment strategy

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

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

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

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

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

## Professional Advisors

The External Audit is performed by Grant Thornton UK LLP. For the 2015/16 financial year, a full audit is required as a result of the charity's gross income exceeding £1m.

In addition, TIAA Ltd, the Internal Auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee (although the Internal Auditors are not directed to focus specifically on the application of such systems to the Charitable Fund).

## Aims and Objectives for the Public Benefit

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

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

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

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

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

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

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

## Strategy for Achieving its Objectives

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

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

## Reserves and Commitments

Charity Reserves as defined by Charities SORP (FRS 102) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

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

Major items of expenditure for both goods and services are agreed in advance in order that the



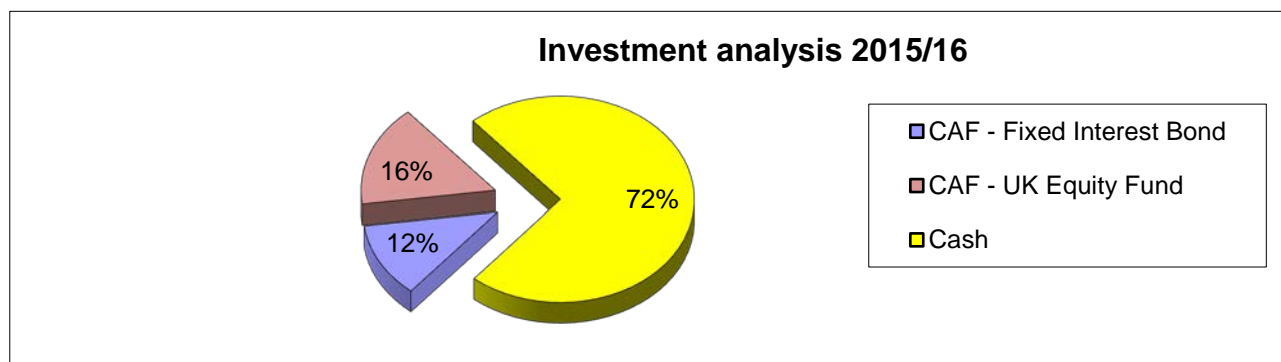
necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible,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

## Investment Performance

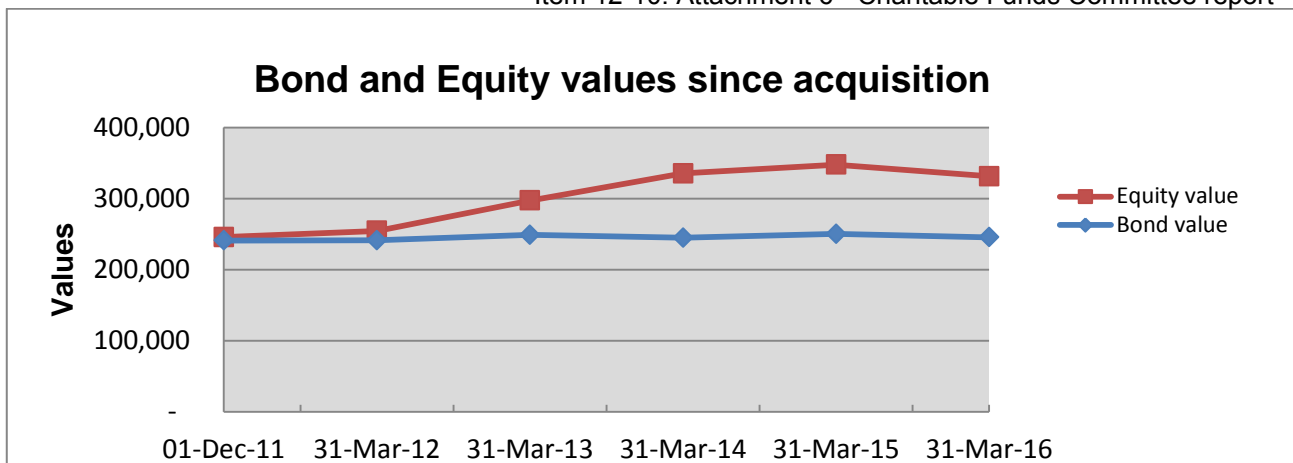
Investment income for the year was £23k (2014/15 £21k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The total performance return on the portfolio of the investments (equity and bond) was a loss of £21k which equates to a 3.49% on the opening portfolio value (2014/15 1.15% surplus). This reflects the downturn in the market, where interest rates have decreased and investment portfolios have not performed as well as anticipated. Discussions with fund managers are ongoing, to mitigate further loss on capital investments and to review the most effective future investment strategy. The Investment manager's report from CAF states *'it was a difficult year for the portfolio, performance was hampered by market volatility, in particular from funds invested in small – and medium-sized companies'. As a reflection of this, we have reduced our exposure to small – and medium-sized companies slightly. Instead we prefer companies within the FTSE 100'.*

The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio decreasing in market value to £577k at 31 March 2016 (£598k at 31 March 2015). The cash investment at 31 March 2016 was £1,514k (£542k at 31 March 2015).

The current asset portfolio of cash and investment allocation totalling £2,091k at 31 March 2016 is shown in the following graph:



The cash allocation at 72% exceeds the strategy of Cash 50% due to the high level of legacy received in 2015/16 with matching plans to spend it in 2016/17. Consequently, the mix of bonds (16%) and equities (12%) is lower than the planned strategy. This has to some extent, limited the loss on investments in the period. The bond and equity investments have not performed as expected during the year, although equity investments continue to perform better than bond investments over time. The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

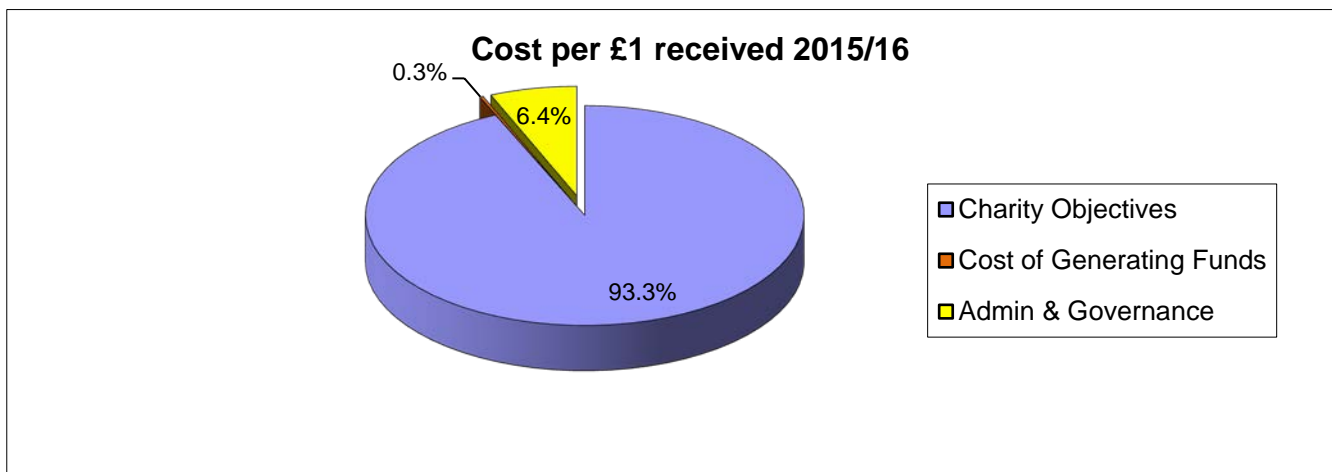


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee and the investment strategy is under review for 2016/17.

### Achievement of public benefit

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

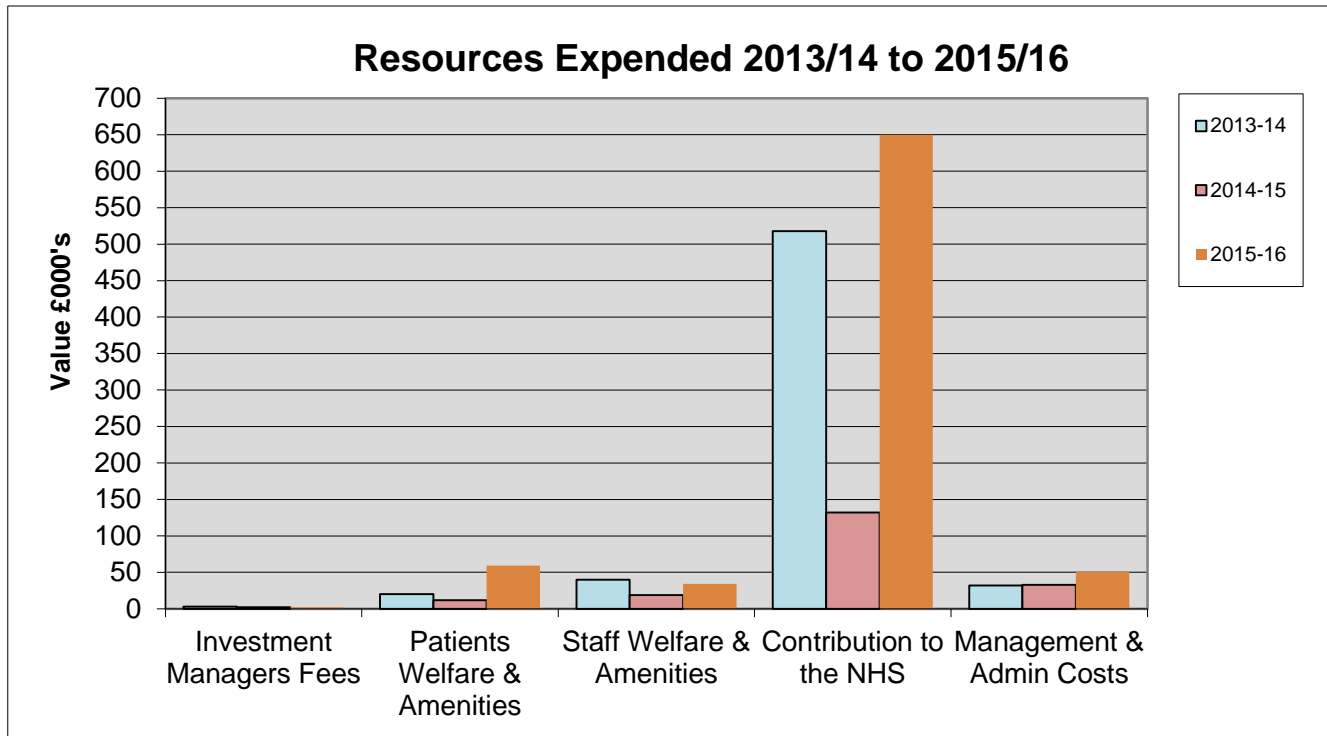
The graph below shows that in this financial year for every £1 raised, 93 pence was spent in achieving the objectives of the charity. This is higher than the equivalent ratio for 2014/15 (82 pence) primarily due to the higher level of donations and legacies received in 2015/16 with administration and governance costs decreasing to 6% (2014/15 17%). Although a 'cost-per-pound' raised ratio can be misleading as many factors can affect the analysis, it can be a useful guide to both donors and the Corporate Trustee.



## Expenditure

Total resources expended by the Charity within this financial year were £795k (2014/15 £197k), of which £700k (88%) was a contribution to Maidstone and Tunbridge Wells NHS Trust (2014/15 £164k 83%), £58k spent on patient welfare, and £35k on staff benefits. Note governance cost of £52k is included in total contribution to NHS.

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



Charitable expenditure for the year is detailed below.

### Medical Equipment – Total spend £608k (2014/15 £77k)

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

The most significant purchases were:

- Tomosynthesis machine funded by 'Breast Cancer Kent' (£144k)
- Echo Machine funded by Mollie Hayling Legacy (£115k)
- Echo Machine funded by David Crow Legacy (£90k)
- Scalp Coolers funded by 'Walk the Walk' charity (£114k)
- 4 microscopes and associated items (£88k)
- Flat Lift Kit x 2 (£14k)
- Tecotherm Neo Basic Unit (13k)

### Patient Welfare and amenities – Total spend £58k (2014/15 £12k)

The most significant spends were:

- Infusomat Space pumps (£29k)
- SafePresence sensor pads (£7k)
- Complementary therapy (£12k)

### Staff Amenities and Welfare – Total spend £35k (2014/15 £19k)

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

53% of expenditure in this category is as support for additional training, allowing staff to develop within their roles and allowing them to enhance patient care and experience.

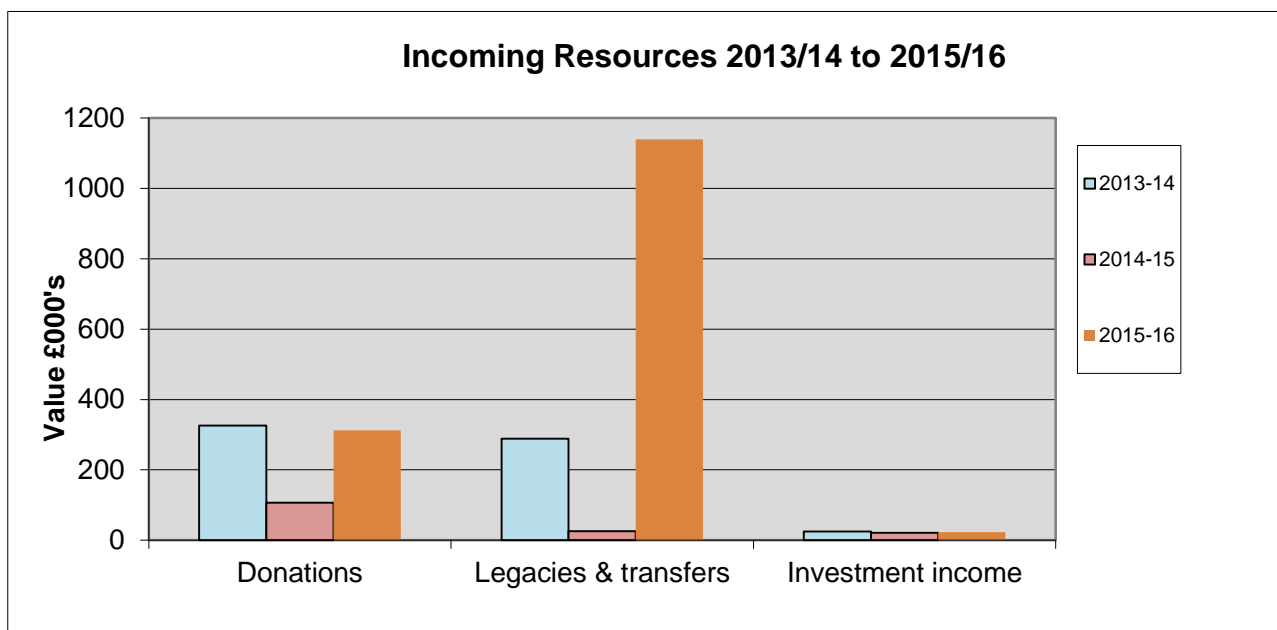
### Other Direct Contributions to the NHS – Total spend £40k (2014/15 £55k)

50% of expenditure in this category has supported the purchase of fixtures and fittings. The most significant purchases were:

- Replacement Chairs for Oncology Outpatients Area (£8k)

### Income

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



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

A total of £312k was received from donations (£107k 2014/15) and £1,139k from legacies (£26k 2014/15). We have immense appreciation of the generosity of all donors and their families. Significant donations and legacies over £10k are highlighted below.

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

	£000's
Breast Cancer Care Kent	144
'Walk the Walk' charity	114





A Scalp Cooler donated by 'Walk the Walk' charity.

## Legacies

Legacies were received from the estates of the following:

	£000's
Mollie Hayling Legacy	808
David Crow Legacy	270
Frances Gibson Legacy	25
Roma Isabel Petty Legacy	15
Special Care Baby Unit Legacy	10
Peter B Ward Legacy	10
Estate of the late GWD	1
<b>Total legacy funding received</b>	<b>1,139</b>

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

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

## Fundraising

The Trust has an active 'just giving' page that received donations of £10k this year compared to £13k last year. The Trust did not undertake any other fundraising activity during 2015/16.

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

## **Intangible Income**

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

## **Looking Forward - our plans for the future**

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

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

The charity received higher levels of voluntary income in 2015/16, thanks to the generosity of various donors, some of which are highlighted above. The Trust has plans to review its investment income strategy in 2016/17.

## **Making donations**

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

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

If you would like to find out more about the work of the Charity, make a donation, or raise funds, please contact the Trust at the principal office (details on page 4), via our website at [www.mtw.nhs.uk](http://www.mtw.nhs.uk) or complete the attached form at the end of the report and send it to us.



## **Statement of Trustee Responsibilities in Respect of The Trustee Annual Report and The Financial Statements**

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

In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the charity hence taking reasonable steps for the prevention and detection of fraud and other irregularities. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

### **Statement as to disclosure to our auditors**

In so far as the trustees are aware at the time of approving our trustees' annual report:

- there is no relevant information, being information needed by the auditor in connection with preparing their report, of which the auditor is unaware, and
- the trustees, having made enquiries of fellow trustees that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a trustee in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

By Order of the Trustee

Signed:

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

Date: .....



## **Independent Auditor's Report to The Trustees of Maidstone and Tunbridge Wells NHS Charitable Fund**

We have audited the financial statements of Maidstone and Tunbridge Wells NHS Charitable Fund for the year ended 31 March 2016 which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

This report is made solely to the charity's trustees, as a body, in accordance with the Charities (Accounts and Reports) Regulations 2008 made under Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

### **Respective responsibilities of trustees and auditor**

As explained more fully in the Statement of Trustee Responsibilities set out on page 15, the trustees are responsible for the preparation of the financial statements which give a true and fair view.

We have been appointed as auditor under section 149 of the Charities Act 2011 and report in accordance with the Charities (Accounts and Reports) Regulations 2008 made under section 154 of the Charities Act 2011. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### **Scope of the audit of the financial statements**

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at [www.frc.org.uk/auditscopeukprivate](http://www.frc.org.uk/auditscopeukprivate).

### **Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2016 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

### **Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements; or
- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

**[signature]**

Darren Wells  
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

xx November 2016

Grant Thornton UK LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

**Statement of Financial Activities for the year ended 31 March 2016**

					2015/16	2014/15
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
		£000	£000	£000	£000	£000
<b>Income</b>	2					
Donations		308	4	-	312	107
Legacies		25	1,114	-	1,139	26
<b>Total Donations and Legacies</b>		<b>333</b>	<b>1,118</b>	<b>-</b>	<b>1,451</b>	<b>133</b>
Investment income		10	13	-	23	21
<b>Total income</b>		<b>343</b>	<b>1,131</b>	<b>-</b>	<b>1,474</b>	<b>154</b>
<b>Expenditure</b>	3					
Costs of generating funds	3.1	(1)	(1)	-	(2)	(2)
<b>Charitable Activities</b>						
Activities in furtherance of Charity's objectives	3.2	(425)	(368)	-	(793)	(195)
<b>Total expenditure</b>		<b>(426)</b>	<b>(369)</b>	<b>-</b>	<b>(795)</b>	<b>(197)</b>
Gains / (losses) on investments	4	(6)	(15)	-	(21)	17
<b>Net income/expenditure</b>		<b>(89)</b>	<b>747</b>	<b>-</b>	<b>658</b>	<b>(26)</b>
Fund transfer	4	(25)	25	-	-	-
<b>Net movement in funds</b>	4	<b>(114)</b>	<b>772</b>	<b>-</b>	<b>658</b>	<b>(26)</b>
Fund balances brought forward at 31 March 2015		524	535	9	1,068	1,094
<b>Fund balances carried forward at 31st March 2016</b>		<b>410</b>	<b>1,307</b>	<b>9</b>	<b>1,726</b>	<b>1,068</b>

The notes at pages 22 to 32 form part of these financial statements

**Balance Sheet as at 31 March 2016**

					2015/16	2014/15
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
		£000	£000	£000	£000	£000
<b>Fixed Assets</b>	5					
Investments	5.1	138	439	-	577	598
<b>Total Fixed Assets</b>		<b>138</b>	<b>439</b>	<b>-</b>	<b>577</b>	<b>598</b>
<b>Current Assets</b>	6					
Cash at bank and in hand	6.1	359	1,146	9	1,514	542
Debtors due within one year	6.2	-	-	-	-	-
<b>Total current Assets</b>		<b>359</b>	<b>1,146</b>	<b>9</b>	<b>1,514</b>	<b>542</b>
<b>Liabilities</b>						
Creditors due within one year	7.1	(87)	(278)	-	(365)	(72)
<b>Net Current Assets / (Liabilities)</b>		<b>272</b>	<b>868</b>	<b>9</b>	<b>1,149</b>	<b>470</b>
<b>Total Net Assets</b>		<b>410</b>	<b>1,307</b>	<b>9</b>	<b>1,726</b>	<b>1,068</b>
<b>Funds of the Charity</b>	8					
Endowment Funds				9	9	9
Restricted Funds			1,307		1,307	535
Unrestricted Funds		410			410	524
<b>Total Funds</b>		<b>410</b>	<b>1,307</b>	<b>9</b>	<b>1,726</b>	<b>1,068</b>

For purposes of splitting assets / liabilities by category, restricted and unrestricted funds are categorised by transactions, whilst endowment funds are categorised only as cash.

The notes at pages 22 to 32 form part of these financial statements

**Signed on behalf of the Trustee:**

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

**Date:**

**Statement of cash flows**

Cash flow as at 31 March 2016		
<b>Cash flows from operating activities:</b>	<b>2015/16</b>	<b>2014/15</b>
	£000	£000
<b>Net cash provided by (used in) operating activities</b>	<b>949</b>	<b>(94)</b>
<b>Cash flows from investing activities:</b>		
Dividends, interest and rents from investments	23	21
Proceeds from the sale of property, plant and equipment	-	-
Purchase of property, plant and equipment	-	-
Proceeds from sale of investments	-	-
Purchase of investments	-	-
<b>Net cash provided by (used in) investing activities</b>	<b>23</b>	<b>21</b>
<b>Cash flows from financing activities:</b>		
Repayments of borrowing	-	-
Cash flows from new borrowing	-	-
Receipt of endowment	-	-
<b>Net cash provided by (used in) financing activities</b>	<b>-</b>	<b>-</b>
<b>Change in cash and cash equivalents in the reporting period</b>	<b>972</b>	<b>(73)</b>
<b>Cash and cash equivalents at the beginning of the reporting period</b>	<b>542</b>	<b>615</b>
<b>Cash and cash equivalents at the end of the reporting period</b>	<b>1,514</b>	<b>542</b>
<b>Net income / (expenditure) for the reporting period (as per the statement of financial activities)</b>	<b>658</b>	<b>(26)</b>
<b>Adjustments for:</b>		
(Gains) / losses on investments	21	(17)
Dividends, interest and rents from investments	(23)	(21)
Loss / (profit) on the sale of fixed assets		
(Increase ) / decrease in debtors	-	1
(Increase ) / decrease in creditors	293	(31)
<b>Net cash provided by (used in) operating activities</b>	<b>949</b>	<b>(94)</b>
<b>Analysis of cash and cash equivalents</b>		
Cash in hand	1,514	542

The notes at pages 22 to 32 form part of these financial statements

## Notes to the financial statements for the year ended 31<sup>st</sup> March 2016

### 1. Principal accounting policies

#### 1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective 1 January 2015 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

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

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts.

#### 1.2. Reconciliation with previous generally accepted accounting practices

In preparing these accounts the Trustees have considered whether any restatement of comparatives was required to comply with FRS 102 and the Charities SORP FRS 102. No restatements were required although there has been a change in the analysis of governance and administration costs and inclusion of a cash flow statement.

Governance and administration costs: previously these had been separately identified on the face of the Statement of Financial Activity. These are now classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities on a cost basis (see note 3). The Trustees consider this is a more equitable treatment to avoid disadvantaging funds with high volume low value transactions. All funds attract administrative costs even without any expenditure as these have to be monitored, fund managers approached for future plans, investment transactions and overhead charges. The cost of the transaction does not necessarily reflect on the work involved to achieve that expenditure and therefore consistency is maintained by working with an activity cost based apportionment.

#### 1.3. Income

##### *Donations, grants, legacies and gifts in kind (voluntary Income)*

All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, and then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is provable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is disclosed as a contingent asset.

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

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods.

#### *Intangible Income*

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

#### *Investment Income*

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

### **1.4. Expenditure**

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. All expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

#### *Irrecoverable VAT*

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

*Allocation of support costs*

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads from Maidstone and Tunbridge Wells NHS Trust and are apportioned on an average fund balance monthly across all funds.

*Charitable activities*

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

*Exceptional Items*

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

*Costs of generating funds*

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

*Recognition of liabilities*

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

*Analysis of grants*

The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of its charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and further analysis in relation to activity is provided in note 3.

**1.5. Structure of funds**

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

Where there is a legal restriction or a binding agreement with a donor, on the purpose for which a donation may be used, the fund is classified in the accounts as a restricted fund.

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

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

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

**1.6. Finance and Operating Leases**

The Charity has no finance or operating leases



## **1.7. Fixed Assets**

### *Tangible Fixed Assets*

The Charity held no tangible fixed assets during the year.

### *Investments Fixed Assets*

Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 7 for further information.

### *Investment properties*

The Charity held no investment properties during the year

## **1.8. Stocks**

The Charity held no stocks during the year

## **1.9. Gains and losses**

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

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

## **1.10. Cash and Cash equivalents**

Cash is represented by the balance maintained in the charity bank accounts and is used to meet the operational costs of the charity as they fall due.

Cash equivalents are short term liquid investments held for a period of 3 months or less in interest bearing accounts that are readily convertible to cash with no risk of change in value.

As a requirement of FRS 102, a statement of cash flows has been included in the accounts to provide information about the ways in which the charity uses the cash generated by its activities and about changes in cash and cash equivalents held by the charity.

## **1.11. Financial Instruments**

The Charity only has financial assets and financial liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value.

## **1.12. Pensions**

The Charity has no employees.

## **1.13. Prior Year Adjustments**

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

## 2. Income

				2015/16	2014/15
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
	£000	£000	£000	£000	£000
Donations	298	4	-	302	94
Donations - website	10	-	-	10	13
Legacies	25	1,114	-	1,139	26
<b>Total Donations and Legacies</b>	<b>333</b>	<b>1,118</b>	<b>-</b>	<b>1,451</b>	<b>133</b>
<b>Investment income</b>					
Dividends from investment portfolio	8	10	-	18	7
Interest from investment portfolio	1	2	-	3	14
Bank Interest	1	1	-	2	-
<b>Total Investment income</b>	<b>10</b>	<b>13</b>	<b>-</b>	<b>23</b>	<b>21</b>
<b>Total incoming resources</b>	<b>343</b>	<b>1,131</b>	<b>-</b>	<b>1,474</b>	<b>154</b>

## 3. Expenditure

				2015/16	2014/15
3.1. Cost of generating funds	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
	£000	£000	£000	£000	£000
Investment managers fees	(1)	(1)	-	(2)	(2)
<b>Total cost of generating funds</b>	<b>(1)</b>	<b>(1)</b>	<b>-</b>	<b>(2)</b>	<b>(2)</b>

				2015/16	2014/15
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Total Funds
	£000	£000	£000	£000	£000
<b>Patients welfare and amenities</b>					
Hospitality	-	-	-	-	-
Other	(46)	-	-	(46)	-
Complimentary Therapies	-	(12)	-	(12)	(12)
<b>Total patients welfare and amenities</b>	<b>(46)</b>	<b>(12)</b>	<b>-</b>	<b>(58)</b>	<b>(12)</b>
<b>Staff welfare and amenities</b>					
Training	(8)	(11)	-	(19)	(14)
Hospitality	-	-	-	-	-
Christmas Events	(4)	(2)	-	(6)	(5)
Other	(10)	-	-	(10)	-
<b>Total staff welfare and amenities</b>	<b>(22)</b>	<b>(13)</b>	<b>-</b>	<b>(35)</b>	<b>(19)</b>

<b>3.2. Charitable Activities continues</b>					
Medical and Rehabilitation Equipment	(315)	(293)	-	<b>(608)</b>	<b>(77)</b>
Furniture and Fittings	(11)	(9)	-	<b>(20)</b>	<b>(33)</b>
Other	(4)	(16)	-	<b>(20)</b>	<b>(22)</b>
IT	-	-	-	-	-
Nursing Staff Salary Support	-	-	-	-	-
Governance - Salaries & overheads	(25)	(24)		<b>(49)</b>	<b>(29)</b>
Governance - Audit Fees (external)	(2)	(1)		<b>(3)</b>	<b>(3)</b>
<b>Total contribution to Maidstone and Tunbridge Wells NHS Trust</b>	<b>(357)</b>	<b>(343)</b>	-	<b>(700)</b>	<b>(164)</b>
<b>Total cost of charitable activities</b>	<b>(425)</b>	<b>(368)</b>	-	<b>(793)</b>	<b>(195)</b>
<b>Total resources expended</b>	<b>(426)</b>	<b>(369)</b>	-	<b>(795)</b>	<b>(197)</b>

### Employee Information

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

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

#### 4. Net Movements in Funds

	Unrestricted Funds	Restricted Funds	Endowment Funds	2015/16 Total Funds	2014/15 Total Funds
	£000	£000	£000	£000	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	(83)	762	-	679	(43)
Gains/Losses on Investments	(6)	(15)	-	(21)	17
<b>Total net movement in funds</b>	<b>(89)</b>	<b>747</b>	<b>-</b>	<b>658</b>	<b>(26)</b>
Funds transfers	(25)	25	-	-	-
<b>Total net movement in funds after transfers</b>	<b>(114)</b>	<b>772</b>	<b>-</b>	<b>658</b>	<b>(26)</b>
<b>Fund balances at 1 April 2015</b>	<b>524</b>	<b>535</b>	<b>9</b>	<b>1,068</b>	<b>1,094</b>
<b>Fund balances carried forward at 31 March 2016</b>	<b>410</b>	<b>1,307</b>	<b>9</b>	<b>1,726</b>	<b>1,068</b>

##### 4.1 Unrestricted funds amalgamated following review in 2015/16

Following the reclassification exercise in 2014/15, the Charity undertook another extensive review of all unrestricted funds in 2015/16 in respect of the number of funds in each directorate. Consequently, a number of unrestricted funds were amalgamated to reduce the number of funds.

Total fund value amalgamated was £392k, and we now have 21 unrestricted funds reduced from a previous total of 151.

#### 5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/15	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	Carrying value at 31/03/2016
	£000	£000	£000	£000	£000
CAF Bond Income Fund (UK)	250	-	-	(5)	245
CAF Equity Growth Fund (UK)	348	-	-	(16)	332
<b>Total Fixed Asset Investments</b>	<b>598</b>	<b>-</b>	<b>-</b>	<b>(21)</b>	<b>577</b>

## 6. Current Assets

6.1. Cash and cash investments	2015/16	2014/15
	Total Funds	Total Funds
	£000	£000
<b>Cash Investments:</b>		
Santander	82	82
Clydesdale	86	83
CAF	80	80
Nat West	-	-
<b>Operational Bank Accounts:</b>		
GBS bank account	1,219	214
Nat West bank account	47	83
<b>Total Cash and Cash Investments</b>	<b>1,514</b>	<b>542</b>

6.2. Debtors	2015/16	2014/15
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year	-	-
<b>Total Debtors due within one year</b>	<b>-</b>	<b>-</b>

## 7. Current Liabilities

7.1. Creditors	2015/16	2014/15
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year		
Trade Creditors	(68)	(8)
Other Creditors	-	-
Owed to Maidstone and Tunbridge Wells NHS Trust	(291)	(56)
Accruals	(6)	(8)
<b>Total Creditors due within one year</b>	<b>(365)</b>	<b>(72)</b>

## 8. Details of Funds

Endowment Fund	Fund number	Balance 01-Apr-2015	Incoming Resources	Resources Expended	Balance 31-Mar-2016
		£000	£000	£000	£000
A. Haines - Cip	67020	7	0	0	7
E.C. Beedle Fund - Cip	67010	2	0	0	2
<b>Total Endowment Funds</b>		<b>9</b>	<b>-</b>	<b>-</b>	<b>9</b>

Restricted Funds	Fund number	Balance 01-Apr-2015	Incoming Resources	Resources Expended	Funds Amalgamation & Transfers	Balance 31-Mar-2016
		£000	£000	£000	£000	£000
Cancer Services Dir Fund	61350	35	-	-		35
Cardiac Equip Fd Ms Crow Legacy	65450	-	271	(92)		179
Cardio Equip Tw Hayling Legacy	65460	-	813	(131)		682
E&M Dir Diabetes Fund Tw	65410	54	1	(3)		52
Gastrointestinal Fund	65340	12	-	(1)		11
Mh Med Equip Fund	61040	36	1	(2)		35
Neurology Fund	65990	30	-	(13)		17
Oncology Centrifuge Fund	61490	-	0	(1)	25	24
Oncology Equipment Fund	67170	261	3	(107)		157
Oncology Prostate Equip Fund	61310	-	10	-		10
Pierre Fabre Grant Fund	61720	70	1	(6)		65
E&M Directorate - Francis Gibson Legacy	65180	-	25	-		25
Other Restricted Funds (closing balances <£10,000)		37	6	(28)		15
<b>Total Restricted Funds</b>		<b>535</b>	<b>1,131</b>	<b>(384)</b>	<b>25</b>	<b>1,307</b>

Unrestricted Funds	Fund number	Balance 01-Apr-2015	Incoming Resources	Resources Expended	Funds Amalgamation & Transfers	Balance 31-Mar-2016
		£000	£000	£000	£000	£000
Oncology Centre Fund	61350	20	(0)	(26)	33	27
Critical Care Dir Fund	61060	4	1	(4)	14	15
Emergency & Medical Dir Fund	61020	1	1	(42)	97	57
Paediatric Directorate Fund	61540	5	1	(0)	4	10
Pathology Fund	62560	24	0	(1)	5	28

<b>Unrestricted Funds</b>	<b>Fund number</b>	<b>Balance 01-Apr-2015</b>	<b>Incoming Resources</b>	<b>Resources Expended</b>	<b>Funds Amalgamation &amp; Transfers</b>	<b>Balance 31-Mar-2016</b>
Radiology Fund	61590	13	1	(1)	59	72
Special Care Baby Unit Fund Tw	65660	16	24	(24)	1	17
Surgery Directorate Fund	61140	2	1	(2)	63	64
Trust Management Dir Fund	61000	3	277	(273)	50	57
Women's/Sexual Health Dir Fund	61320	0	0	(0)	21	21
Other Unrestricted Funds (closing balances <£10,000)		436	37	(59)	(372)	42
<b>Total Unrestricted Funds</b>		<b>524</b>	<b>343</b>	<b>(432)</b>	<b>(25)</b>	<b>410</b>

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

<b>Restricted Funds</b>	<b>Nature and purpose of Fund</b>
Medical Equipment Maidstone	Supports Maidstone Hospital
Haematology Fund	Supports the Haematology Department at Maidstone Hospital
E&M Directorate Diabetes Fund TW	Supports the Diabetes Unit at Tunbridge Wells Hospital
Oncology Equipment Fund	Supports the Oncology Centre for the purchase of Equipment.
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures.
Oncology Centrifuge Fund	Supports the Oncology Department at Maidstone Hospital
Oncology Prostate Equip Fund	Supports the Oncology Department at Maidstone Hospital
Gastrointestinal Fund	Supports the Gastrointestinal Unit at Maidstone Hospital
Cancer Services Directorate Fund	Supports the Oncology Centre at Maidstone Hospital
Cardiac Equip MS Crow Legacy	Supports the Cardiac Department at Maidstone Hospital
Cardio Equip TW Hayling Legacy Fund	Supports the Cardio Respiratory Unit at the Tunbridge Wells Hospital
Neurology Fund	Supports the Neurology Department at Tunbridge Wells Hospital
<b>Unrestricted Funds</b>	
Oncology Centre Fund	Supports the Oncology Centre at Maidstone Hospital
Critical Care Directorate Fund	Supports the Critical Care units of Maidstone and Tunbridge Wells NHS Trust
Emergency & Medical Directorate Fund	Supports the Emergency & Medical Departments of Maidstone and Tunbridge Wells NHS Trust
Paediatric Directorate Fund	Supports the Paediatric Departments of Maidstone and Tunbridge

<b>Restricted Funds</b>	<b>Nature and purpose of Fund</b>
	Wells NHS Trust
Pathology Fund	Supports the Pathology Units of Maidstone and Tunbridge Wells NHS Trust
Radiology Fund	Supports the Medical Imaging and Ultrasound Departments of Maidstone and Tunbridge Wells NHS Trust
Surgery Directorate Fund	Supports the Surgical Departments at Maidstone and Tunbridge Wells NHS Trust
Trust Management Directorate Fund	Supports the Maidstone and Tunbridge Wells NHS Trust
Women's /Sexual Health Directorate Fund	Supports the Women's and Sexual Health Departments at Maidstone and Tunbridge Wells NHS Trust
Special Care Baby Unit Fund	Supports the Special Care Baby Unit at Tunbridge Wells Hospital

## 9. Charity Tax

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

## 10. Related Parties

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

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

The Charity has made revenue and capital payments, in the form of grants, to the Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition £49k (2014/15 £29k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration of the Charity. The amount due at the balance sheet date to Maidstone and Tunbridge Wells NHS Trust was £291k.

## 11. Events after the reporting year

The Trustees have not been advised of any potential significant legacies to be received in 2016/17.





**Donation Form**  
**Registered Charity Number 1055215**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Post Code: \_\_\_\_\_

Email: \_\_\_\_\_

Whilst recognising that this does not form a binding trust I would wish my donation of

£.....to be used for: (please tick one of the following)

☐ Wherever it will be most useful within the whole Trust to benefit patients and staff as determined by the Charity (This will be the default if no additional information is provided)

☐ The Directorate fund that supports .....Ward / Department.

**Payment Methods**

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

**Gift Aid**

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

☐ YES, I am a UK taxpayer and would like MTW to reclaim tax on this and any future donations

Date...../...../..... Signature.....

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

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

**Please return to:**

**Maidstone and Tunbridge Wells NHS Trust, Financial Services, Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ. Telephone 01622 224500 Website: [www.mtw.nhs.uk](http://www.mtw.nhs.uk)**

**THANK YOU FOR YOUR SUPPORT**

Appendix 3

Letter of representation



*Charitable Fund*

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

Financial Services  
Maidstone Hospital  
Hermitage Lane  
Maidstone  
Kent. ME16 9QQ

Tel: 01622-224500

30<sup>th</sup> November 2016

Dear Sirs

**Maidstone and Tunbridge Wells NHS Charitable Fund Financial statements for the year ended 31 March 2016**

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Charitable Fund ('the charity') for the year ended 31 March 2016 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with section 154 of the Charities Act 2011.

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

**Financial statements**

We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 12 September 2016, for the preparation of the financial statements in accordance with the regulations made under the Charities Act 2011 and the Charities Statement of Recommended Practice (FRS102) (the 'SORP'), issued by the Charity Commission and any subsequent amendments or variations to this statement, in particular the financial statements give a true and fair view in accordance therewith.

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

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

Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the SORP (FRS 102).

All events subsequent to the date of the financial statements and for which the SORP (FRS 102) requires adjustment or disclosure have been adjusted or disclosed.

We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of the SORP (FRS 102).

We can confirm that:

- a. all income has been recorded;
- b. the restricted funds have been properly applied;
- c. constructive obligations for grants have been recognized; and

**Information provided**

We have provided you with:

- d. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- e. additional information that you have requested from us for the purpose of your audit; and
- f. unrestricted access to persons within the charity from whom you determined it necessary to obtain audit evidence.

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

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

We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

- g. management;
- h. employees who have significant roles in internal control; or
- i. others where the fraud could have a material effect on the financial statements.

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

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

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

We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

We confirm that we have made available to you all correspondence with regulators and that we are aware of our responsibilities in respect of the guidance 'Reporting Serious Incidents – guidance for trustees' issued by the Charity Commission in December 2013. We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

**On behalf of Maidstone and Tunbridge Wells NHS Trust  
(the corporate Trustee of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)**

### Trust Board meeting – December 2016

#### 12-11 Workforce Committee report

#### Committee Chair (Non-Executive Director)

This report provides a summary of the issues discussed at the Workforce Committee on 1<sup>st</sup> December 2016.

##### Trust Payroll Provider Compliance and Medical Study Leave

A verbal update was provided to the Committee in relation to the Trust Payroll performance in response to a query raised by the November 2016 Audit and Governance Committee. The process for medical study leave approval was also explained.

##### Culture and Leadership Programme

The Committee received a copy of phase one of the NHS Improvement (NHSI) Culture and Leadership Programme resource toolkit. The Programme has been designed to contribute to the “culture and capability” domain of the well-led framework. There are three phases to the toolkit with the first stage being the diagnostic stage. The Committee received a report outlining the resources required and plan to complete phase one.

##### Equality and Diversity Update

The Workforce Committee were provided with a detailed update of the equality and diversity work that had been undertaken in the organisation, including: launch of the Diversity Network Group, Transgender Awareness in the workplace training and disability confident scheme. The Committee noted the work that had been undertaken and Trust commitment to creating a culture that promotes equality and embraces diversity in all its functions as both an employer and service provider.

##### Apprenticeship Update

A report to the Workforce Committee in September 2016 outlined the Governments introduction of an apprenticeship training levy and the implications for the Trust. An update was provided to the Committee in relation to the Trust response and approach to apprenticeships. The Committee requested that a detailed action plan be presented to the next Workforce Committee and that the Trust explore all opportunities for apprenticeships within the Workforce.

##### Medical Education Update

The Committee were shown Trust junior doctor promotional videos which have been developed and are now being used to promote the Trust as a place for medical education. The Committee requested that the short clips be used as much as possible to promote the Trust as a place to work. The Director of Medical Education presented the Committee with the detailed action plan in relation to the GMC Survey and an update of progress in areas. The Committee requested that the action plan be monitored to monitor progress more frequently and to also ensure that specific leads are assigned to each action.

##### Junior Doctors – the New 2016 Contract

The report provided an update on the implementation of the new contract, pay protection, exception reporting and information on the decision by the British Medical Association (BMA) to suspend industrial action in relation to the new contract.

##### Dementia Training

The Committee reviewed a request from the Dementia Steering Group around training. The Committee supported the direction of travel but requested more work to be conducted on the proposal.

**NHSI Workforce Plan – 1<sup>st</sup> Submission**

The Committee received a report providing the summary of the first submission of the Workforce Plan to NHSI. Further work was continuing to refine the plan and the final submission will be presented to the March 2017 Workforce Committee with a clear bridge explaining the changes by staff group and area. The Committee requested that workforce numbers continue to be refined in line with feedback received by the Trust from NHSI

**Sickness Absence**

The Committee received a detailed report on sickness absence within the Trust for the 12 month period October 2015 to September 2016. Throughout the last 12 reporting months (October 2015 to September 2016), sickness absence has consistently exceeded the Trust's stated target. As at the end of September 2016, the overall organisational sickness absence rate was 3.98% against a target of 3.3%. Although this is higher than the target, the figure has typically remained lower than the 'Large Acute NHS Trust in England' comparator group that is used as a relevant benchmark. The most recent comparator figure available relates to July 2016 at 4.09%. Sickness absence management remains a key area of focus for the HR and operational management teams.

**Health and Wellbeing Update**

The Committee received a report detailing the activity that had been undertaken in relation to staff health and wellbeing. The Committee were informed of the Flu Campaign and vaccination performance to date compared to both the national and local picture. The Committee noted the work that had been done and in particular the significant increase in uptake. Work will continue through December to drive update further.

**Rostering Update**

The report provided an update on the deployment for the replacement rostering system. The Committee were informed that the pilot stage was going well and the overall project timeline would be reviewed with the intention to accelerate deployment based on the pilot. The Committee requested that the finalised deployment timetable be presented to the next meeting.

**Workforce Performance Dashboard**

The Committee received a report on the workforce dashboard which highlighted the issues of temporary workforce, vacancies and provided an update in relation to the overall Trust compliance with Disclosure and Barring Scheme (DBS) checks.

The Workforce Committee were informed of the low response rate for the national staff survey which was due to close on 2<sup>nd</sup> December 2016. The same approach had been adopted as in previous years to encourage participation. It was acknowledged that the survey may have been impacted upon by conflicting agendas and engagement priorities. However a revised approach would be adopted for next year's survey including all staff being surveyed and local management teams charged with driving participation.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Information and Assurance

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

**Trust Board Meeting - December 2016**

12-12	<b>Summary report from Patient Experience Committee, 02/12/16</b>	<b>Committee Chair (Non-Executive Director)</b>
	<p>The Patient Experience Committee (PEC) met on 2<sup>nd</sup> December 2016.</p> <p><b>1. The key matters considered at the meeting were as follows:</b></p> <ul style="list-style-type: none"> <li>▪ An update on the key issues arising from implementation of the Trust's new translation service (launched 1<sup>st</sup> June 2016), including the latest statistics of usage by division</li> <li>▪ The latest performance of the Trust's Stroke services, including reference to the scope of the Sustainability and Transformation Plan (STP) and the Kent and Medway NHS Joint Health Overview and Scrutiny Committee's (JHOSC) activity in this field. The reports considered under the "Kent and Medway Hyper Acute and Acute Stroke Services Review" item at the Kent and Medway JHOSC held on 28<sup>th</sup> November 2016 were circulated to Committee members after the meeting</li> <li>▪ A report from the Lead Nurse for Dementia Care on the Trust's Dementia Strategy, 2017-20</li> <li>▪ An update on Complaints and PALS contacts for the period July to September 2016</li> <li>▪ A report from Healthwatch, including short updates on the status of its review of MTW's Engagement and of the Enter &amp; View report for Outpatients (which had taken place in September 2016)</li> <li>▪ A review of the Quality Accounts priorities for 2015/16</li> <li>▪ Review of the Patient Led Assessments of the Care Environment (PLACE) Action Plan</li> <li>▪ A report from the 'Patient and their Medicines Working Group', including a review of the Terms of Reference, membership and action plan for this new group formed to review the medication related issues in the NHS Inpatient Survey 2015</li> <li>▪ Notification of recent/planned service changes, which included updates on the STP, the launch of Home First and the Trust's Winter Bed Reconfiguration</li> <li>▪ An update on work from the West Kent Clinical Commissioning Group (WKCCG), which included notification that the CCG's representative on the Committee was due to leave her current post at the end of January 2017. The Associate Director, Quality Assurance agreed to liaise with the CCG to confirm the identity of its new representative and encourage his/her attendance at PEC meetings</li> <li>▪ An update on Communications and Membership, including notification of upcoming Inquests</li> <li>▪ A report on the Trust's response to matters not previously addressed from the NHS Inpatient Survey 2015</li> <li>▪ An update from the Macmillan Lead Cancer Nurse on the progress with the action plan from the National Cancer Patient Experience Survey 2015</li> <li>▪ Findings from the local patient survey (including Friends and Family). It was noted that the results for assistance at mealtimes were disappointing, notwithstanding the recent relaunch of the Protected Mealtimes Policy, and confirmed that this issue would be subject to audit by Patient Representatives in early 2017</li> <li>▪ An update on the work of the Patient Information and Leaflets Group (PILG)</li> <li>▪ A report from the Quality Committee meetings on 01/08/16; 14/09/16, 05/10/16 and 09/11/16</li> <li>▪ A report from the Patient Representative Working Group, which had been established following the last meeting as a forum to: consider feedback and share experiences of patient representatives; propose improvements in practice; request additional support for emerging programmes; discuss progress / actions from monthly PLACE audits and from Enter and View visits. The Committee heard that Patient Representatives were involved with each of the monthly CQC audits and would shortly join the Trust's PLACE group</li> <li>▪ Reflections from a Junior Doctor-the meeting was attended by a Junior Doctor representative (Specialist Training 3, Theatres &amp; Anaesthetics), who raised the management / scheduling of patients awaiting emergency surgery as an area for consideration &amp; potential improvement</li> <li>▪ The Committee noted that, although he was unable to attend, this would have been the last PEC meeting during Tony Jones' term as Chairman of the Trust Board, and acknowledged the significant support that he had provided to the Committee.</li> </ul>	

**2. The Committee agreed that:**

- The Trust Secretary would provide an update for the Committee meeting in March on progress with the installation of new parking payment machines, with credit/debit card payment facilities, at Maidstone Hospital and also clarify the likely timescale for Trust car parking machines to accept the new design of £5 note
- The Head of Staff Engagement and Equality should submit a further report on the Trust translation service for the Committee meeting in March, which should include:
  - An updated analysis of service usage, differentiating between foreign language and British Sign Language sessions in the breakdown of Face to Face minutes;
  - Inclusion of data for all months (even where the value was 0);
  - Identification of trends in languages requested;
  - Details of any evaluation process in place to verify patient understanding at the conclusion of the session
  - Clarification of whether it would be possible to record which health professional had used the service (as distinct from the individual who had processed the request)
- The Associate Director, Quality Assurance should highlight to the WKCCG contact / representative the Committee's concern that dementia no longer appears as a strategic topic area for 2017 for the CCG
- The Deputy Chief Nurse (CO'B) should liaise with the Junior Doctor who attended the meeting to consider the options for improving the process by which patients awaiting emergency surgery are managed in terms of scheduling, including reviewing that appropriate communications are in place between ward and theatre staff to prevent unnecessarily prolonged starvation
- The Trust Secretary was to identify if it was possible for the automated teller machine (ATM) at Maidstone Hospital to dispense £5 and £10 notes, rather than defaulting to £20 notes for withdrawals of £20 and above

**3. The issues that need to be drawn to the attention of the Board are as follows:**

None

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Information and assurance

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



## Trust Board meeting – December 2016

**12-13 Summary of the Trust Management Executive (TME) meeting, 14/12 Dep. Chief Exec.**

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Chief Nurse highlighted the need for staff to undertake proper checking processes, following the 2 most recent Never Events, and some near misses
- The latest situation regarding the **Financial Recovery Plan and Financial Special Measures (FSM)** was reported, following the second review meeting with NHS Improvement (NHSI)
- **Performance for month 8, 2016/17** was discussed, and the issues raised included 12 Mixed Sex Accommodation breaches on the Surgical Assessment Unit; the action being taken in response to the current Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR); and performance on the Cancer waiting time targets
- A report on the Trust-wide actions planned to ensure delivery of the **A&E 4-hour waiting time target** was also received, and the deterioration in performance against that target that occurred on the previous weekend was acknowledged
- The **infection prevention and control** position for November was reported, which included the occurrence of the first case of MRSA bacteraemia for 17 months; and the occurrence of 3 cases of Clostridium difficile. It was also noted that the Trust had only seen 1 case of Norovirus, despite other local hospitals experiencing major Norovirus-related problems
- This was the first meeting at which **reports were received from Divisions**, rather than Directorates. The key issues highlighted were as follows:
  - Urgent Care: The need to improve the number of completed Mortality Reviews had been added to the risk register, and retired Consultants had been approached to identify whether such individuals could be engaged to undertake such reviews
  - Planned Care: There remained a number of key vacancies in Critical Care and Trauma & Orthopaedics, and the Division still had unidentified schemes against its savings targets
  - Women's, Children's & Sexual Health: Elective Paediatric activity had reduced in recent weeks, due to increasing demand for emergency care. Maternity was also continuing to see an increase in births, and work was underway to assess how the ratio of midwives to births compared to Medway NHS Foundation Trust. It was also noted that a meeting was scheduled directly after the TME meeting to aim to resolve the continuing concerns regarding Obstetrics and Gynaecology Consultant hours on the Labour Ward. The TME made it clear that a resolution to that issue was expected to be reached at that meeting.
- The Medical Director reported the issues from the latest **Clinical Directors' Committee**, which included the new operational structure, new bed reconfiguration, and White Card referral system
- The **key issues from recent Executive Team meetings** were reported, which were noted to be focussed specifically on the response to FSM
- The recently published Kent and Medway **Sustainability and Transformation Plan (STP)** was presented, and Clinical Directors were encouraged to participate fully in the discussions that would need to take place regarding collaboration with other local Trusts
- The latest report from the **Trust Clinical Governance Committee** was noted, and an update on the planned **implementation of the SAcP (replacement PAS+)** was given, which noted a likely 'go live' date by the end of 2016/17 (although a formal decision had not yet been made)
- Formal updates were received on the work of the TME's main **sub-committees** (Clinical Operations & Delivery Committee, Health & Safety Committee, and Informatics Steering Group)

**Which Committees have reviewed the information prior to Board submission?**

N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**

Information and assurance

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



**Trust Board Meeting – December 2016****12-14 Summary report from Finance Committee, 19/12/16** **Committee Chair (Non-Executive Director)**

The Finance Committee met on 19<sup>th</sup> December 2016.

**1. The key matters considered at the meeting were as follows:**

- Under the “Safety Moment”, the Trust Secretary reported that the Chief Nurse had recently highlighted the need to undertake proper checking processes, following the 2 most recent Never Events, and some near misses
- An update on progress in implementing the Financial Recovery Plan (FRP) was given, following the second review meeting with NHS Improvement (NHSI), and ahead of the next review meeting, on 30/01/17. The update prompted a detailed discussion, which focused on the action taken in relation to the 7 key action areas identified in the letter the Trust had received from NHSI. The month 8 financial performance for 2016/17 was also reviewed
- The Deputy Chief Executive submitted a report on the approach the Trust will be taking on Medical productivity. It was agreed that the incoming Medical Director should be asked to own the development of the “Project Brief”, and report their views at the Committee in January 2017. It was also agreed to ensure that NHSI was informed of the Trust’s approach
- The Director of Finance gave an overview of the 2017/18 contract discussions, and agreed to ensure that NHSI were informed of the risks relating to the 2017/18 contracts with NHS West Kent CCG and NHS England
- The financial aspects of the Trust’s draft Planning submissions for 2017/18 and 2018/19 were reviewed, noting that the Plans would be submitted to NHSI on 23/12/16
- An update on the national planning initiatives/focus areas; and Lord Carter efficiency review, was received, and it was agreed to schedule a detailed consideration of the outcome of the Service Line Reporting ‘deep dive’ reviews at the Committee in early 2017
- The Business Case to replace a Linear Accelerator (LinAc) at Maidstone Hospital was reviewed, and it was agreed to recommend that the Board approve the Case
- A proposal to dispose of the “Hillcroft” and “The Springs” Trust properties was considered, and it was agreed to recommend that the Board approve the disposals, subject to book value being obtained
- A review of the findings from (and response to) the Reference Costs Assurance Programme, 2015/16 was noted
- The usual report on breaches of the external cap on the Agency staff pay rate was noted, as was the 6-monthly update on recent findings from relevant Internal Audit reviews
- The Committee evaluation findings for 2016 were discussed, and it was agreed that the Chief Operating Officer and Director of Workforce should be invited to participate in the ‘monthly performance’ item at the Finance Committee meetings in January, February and March 2017 (and to then review the situation at that point). The Chair of the Workforce Committee was also asked to submit some proposals to the Trust Board, in January 2017, to improve the degree of unison between Executive and Non-Executive Directors

**2. In addition the agreements referred to above, the Committee agreed that:**

- Future “Progress against the FRP” reports to the Committee would include progress against the 7 action points identified in the letter sent by NHSI on 30/11/16
- Committee (& Board) Members would be provided with an explanation of the planned reductions in “Clinical Supplies” shown on the “Summary I&E – Best Case” slide submitted to the Committee; and also identify the extent of contribution from Medical productivity efficiencies within the “CIP Programme by Division” information submitted to the Committee

**3. The issues that need to be drawn to the attention of the Board are as follows:**

- The Committee reviewed the Business Case to replace a LinAc at Maidstone Hospital, and agreed to recommend that the Board approve the Case (this is a separate item on the agenda of the ‘Part 1’ Board meeting on 21/12)

- The Committee agreed to recommend that the Board approve the disposal of the “Hillcroft” and “The Springs” Trust properties, subject to book value being obtained (this is a separate item on the agenda of the ‘Part 2’ Board meeting on 21/12)

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

Information and assurance

**Trust Board meeting – December 2016**

12-14	<b>Business Case to replace a Linear Accelerator at Maidstone Hospital</b>	<b>Director of Finance</b>
<p><b>Summary / Key points</b></p> <p>NHS England recently announced a fund of £130m had been made available to support replacement of ageing or technologically obsolescing linear accelerators. They identified a number of machines that fitted the criteria for MTW, and invited bids in the first place for capital PDC funding in 2016/17. The Trust submitted a bid and has received confirmation that the funding has been allocated to the Trust for 2016/17 for one machine at Maidstone Hospital. There is potential for the replacement of further machines to be funded in 2017/18 and 2018/19.</p> <p>The attached Business case sets out the preferred option for replacing linear accelerator LA1 at Maidstone Hospital, explains the rationale for the selection of this particular machine, the financial implications, the arrangements for ensuring that SLA patient activity is maintained during the replacement phase, and the overall project management.</p> <p>The Trust's Reservation of Powers and Scheme of Delegation (2.6) stipulate that "Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of £1,000,000" is a function reserved for decision by the Trust Board. The case will therefore be reviewed by the Finance Committee on 19/12/16 and the outcome of this review will be reported to the Board as part of the summary report of the meeting (Attachment 10).</p>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Finance Committee, 19/12/16</li> </ul>		
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>Consideration of the Finance Committee's recommendation on Business Case and, if appropriate, approval.</p>		

<sup>1</sup> 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

# Business Case

## *Continuing with the Linac Replacement Program in 2016/17*

Issue date	January 2016
Department	Kent Oncology Centre
Directorate	Cancer & Haematology
Author	Stephen Duck
Clinical lead	Dr Sharon Beesley
Executive Sponsor	Jim Lusby
ID reference	

Approved by	Name	Signature	Date
General Manager	David Fitzgerald		
Finance manager	Gemma Paling		
Clinical Director	Dr Sharon Beesley		
Executive sponsor	Jim Lusby		
Supported by	Name	Signature	Date
Director Estates & Facilities	Jeanette Rooke		
Director of Informatics	Donna Jarrett		
HR Business Partner	Angie Collison		
Approved by	Name	Minute	Date
Directorate Board			
Investment Appraisal Group			
Trust Management Executive			
Finance Committee			
Trust Board			

# The Business Case Summary

## Strategic context

*Improvements in patient outcomes are being driven by the advances in radiotherapy technology that is now available on the modern generation linear accelerators, which is why it is a national recommendation that treatment units should be replaced once they reach 10 years<sup>12</sup>.*

*NHS England has recently announced a capital fund to support the modernisation of radiotherapy services by replacing obsolete and aged (10 years or older) equipment as a priority<sup>3</sup>. Maidstone and Tunbridge Wells NHS Trust has 5 linacs that fit the above criteria for obsolescence (by the end of this year) out of a complement of 9 across the Maidstone and Canterbury sites and NHS England commissioners have indicated that the Trust may be allocated access to this fund to replace an obsolete linac this financial year (16/17) with a further two linac replacements in 2017/18 and one more in 2018/19 being possible – but not guaranteed at this time.*

*Failure to take advantage of this funding to install the latest generation of radiotherapy treatment units into the Trust will significantly impact not only the potential outcomes for our patients but also the Kent Oncology Centre's radiotherapy income as commissioners choose to use those providers who are able to offer better access to modern treatments<sup>1</sup>. The Trust's capital funding is constrained so this presents an ideal opportunity to access scarce central capital funding through nationally provided PDC.*

*The proposed satellite centre at TWH may not come on-line until 2018/19 at the earliest and there may, therefore, be an opportunity to divert a later linac from the NHSE modernisation program to the TWH satellite. Alternatively, the linac replacements, currently scheduled to take place in 2017 and 2019 (and which are not covered by this modernisation program) could complete the proposed satellite configuration and achieve the objectives of the TWH MTW Radiotherapy Bunker Capacity Outline Business Case.*

## Objectives of the investment and the problems with the status quo

1. *Replace an end-of-life, obsolete, radiotherapy linear accelerator (linac) at Maidstone Hospital, which is not compliant with the NHSE specification for the provision of radiotherapy, with a modern unit that provides a safer, higher-quality treatment that will deliver better patient outcomes and which meets the radiotherapy specification.*
2. *Take advantage of the Transforming Radiotherapy Services Capital Investment Programme that has been recently allocated to Maidstone and Tunbridge Wells NHS Trust for the financial year 2016/7 to develop our services.*
3. *Maintain radiotherapy activity during the replacement programme.*

<sup>1</sup> NHS Standard Contract for Radiotherapy (all ages)

<sup>2</sup> Transforming Radiotherapy Services – letter from NHS England

The main benefits expected from the investment	
<ol style="list-style-type: none"> <li>1. <i>Improve access to modern radiotherapy techniques for our patients – increasing access to dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT).</i></li> <li>2. <i>Provide continuity for the radiotherapy service, maintaining standards for patients living in Kent, Medway and parts of East Sussex.</i></li> <li>3. <i>Improve patient care through better treatment outcomes.</i></li> <li>4. <i>Improve capability for transferring patients between linacs during breakdowns and servicing which could otherwise result in patient delays and additional staff overtime.</i></li> <li>5. <i>Protect market share.</i></li> </ol>	
The main risks associated with the investment	
<ol style="list-style-type: none"> <li>1. <i>The loss of 11% of linac capacity during the replacement of the treatment unit and the need to maintain business continuity.</i></li> <li>2. <i>The aging linac at Canterbury (LA3) is prone to high failure rates that may result in extended down-times that would reduce linac capacity by a further 11%.</i></li> <li>3. <i>Timescales for NHS England Business Case approval is not known, which may impact on availability of the preferred contractors to undertake the bunker enabling works for the linac supplier to provide a linac (time from order to supply is around 12 weeks) in this financial year.</i></li> <li>4. <i>Failure to install the linac within the financial years proposed in the Transforming Radiotherapy Services Capital Investment Programme may potentially impact the Trust's access to future funding and may incur storage charges.</i></li> </ol>	
Available options	
<ol style="list-style-type: none"> <li>A. <i>Do nothing – do not replace a linac at the KOC in 2016/17.</i></li> <li>B. <i>Replace LA3 at Canterbury.</i></li> <li>C. <i>Replace LA4 at Maidstone.</i></li> <li>D. <i>Replace LA1 at Maidstone Hospital.</i></li> </ol>	
Preferred Option	
<u>Option D Replace a linac at Maidstone Hospital</u> <ol style="list-style-type: none"> <li>1. <i>Replace an obsolescent linac at Maidstone General Hospital with a state-of-the-art Varian Truebeam linear accelerator similar to that which was installed at Canterbury in 2015. The linac will provide additional dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT) in accordance with modern radiotherapy delivery.</i></li> <li>2. <i>The linac proposed for replacement at MGH is LA1M because it is 10 years old and it is the least capable unit within the fleet – considering the x-ray energies and imaging modalities that are available.</i></li> </ol>	
Funding, affordability	Revenue    £88,500 (recurrent revenue excluding capital charges)
	Capital      £2,560,320

## Management arrangements

*The project will be managed by an internal MTW team from Procurement, Estates & Facilities and Medical Physics. Work-streams to manage the various tasks will be formed under an umbrella Project Group that will report into the Maidstone Program Board and the Cancer and Haematology Directorate Board (see below for further details).*

## The Business Case

Strategic Context	Strategic Case
<p><b><u>Current status</u></b></p> <p><i>The Maidstone and Tunbridge Wells NHS Trust manages the regional Kent Oncology Centre that provides specialised cancer services – including radiotherapy – to the 1.9M population in Kent, Medway and parts of East Sussex.</i></p> <p><i>The KOC radiotherapy service is based at Maidstone General Hospital (MGH) and the Kent and Canterbury Hospital (KCH). Delivering over 69,000 fractions/year, the service is one of the top 5 Cancer Centres in England for radiotherapy delivery.</i></p> <p><i>The radiotherapy department at MH is relatively new and purpose built while the facilities at KCH are older and were not originally designed for linacs (being built in 1937), albeit the area has been recently refurbished.</i></p> <p><i>NHSE have published, in conjunction with Cancer Research UK, a vision for radiotherapy services<sup>4</sup> where “All patients will receive advanced and innovative radiotherapy that has been shown to be clinically and cost effective” and that “aging equipment prevents centres from keeping pace with innovation and provide advanced techniques to agreed levels of good practice...Trusts should have appropriate replacement plans for these machines to ensure they continue to meet national standards<sup>5</sup>.”</i></p> <p><i>The centre has a fleet of 9 linacs (6 at MGH and 3 at KCH). Of the 9 linacs, 4 are in need of replacement in 2016/17 because they already are or would be at the end of their 10-year lifetime. Being older generation linear accelerators they are unable to meet the current minimum specification for radiotherapy treatment delivery and are not capable of meeting the future developments envisaged by the KOC in its 5 year plan.</i></p> <p><i>There is a published linac replacement program for the Kent Oncology Centre that calls for a replacement of a linac every year (Appendix A) but this program already extends the lifetime of each linac significantly beyond the recommended 10 years and any delay in the replacement program would push all of the linear accelerators even further beyond the recommended lifetime (unless there are options to replace 2 linacs in a single year over a number of years) and would, therefore, place significant strain on the KOC’s ability to provide modern radiotherapy.</i></p> <p><i>Access to the recently announced central funding to support the replacement of obsolete and aged (10 years or older) equipment as a priority<sup>6,7</sup> would significantly improve the position and NHS England</i></p>	

<sup>4</sup> Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014

<sup>5</sup> NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013

<sup>6</sup> Transforming Radiotherapy Services – letter from NHS England



*commissioners have indicated that the Trust may be allocated access to this fund to replace an obsolete linac this financial year (16/17) with a further two linac replacements in 2017/18 and one more in 2018/19 being possible – but not guaranteed at this time. Allocation of this level of funding could allow the KOC to partially catch-up on a delayed replacement schedule.*

*Failure to take advantage of this funding to purchase the latest generation of radiotherapy treatment units into the Trust will significantly impact not only the potential outcomes for our patients but also the Kent Oncology Centre's radiotherapy income as commissioners choose to use those providers who are able to offer better access to modern treatments<sup>1</sup>.*

*Regarding the proposed satellite centre at TWH, this may come on-line until 2018/19 at the earliest and there may, therefore, be an opportunity to divert a later linac from the NHSE modernisation program to the TWH satellite. Alternatively, the linac replacements, currently scheduled to take place in 2017 and 2019 (and which are not covered by this modernisation program) could complete the proposed satellite configuration and achieve the objectives of the TWH Radiotherapy Bunker Capacity Project Outline Business Case<sup>8</sup>.*

*The oldest linac in the fleet is LA3C at Canterbury and this would appear to be the first candidate for replacement, however this is not currently scheduled for imminent replacement because of the uncertainties around the future of the Kent and Canterbury Hospital. The commissioners are aware of this position and have indicated that a replacement of an obsolete linac at Maidstone instead is acceptable.*

*The position regarding the disposition of linacs at TWH and at Canterbury will need to be reviewed throughout the on-going linac replacement program.*

#### **Advances in radiotherapy technology**

*Significant technological progress has been made in both treatment unit design and radiotherapy techniques that have contributed to improved patient outcomes since the older generation units were installed over 10 years ago, including:*

- *RapidArc for dose painting that concentrates the dose on the target lesion whilst minimising the dose to surrounding critical structures.*
- *On-board imaging that provides near diagnostic quality images with the patient in the treatment position on the linear accelerator to improve the accuracy of dose delivery,*
- *Image acquisition during treatment to monitor target position in real-time which is important when targeting lesions that can vary position throughout treatment,*
- *High-dose rate modes for stereotactic radiotherapy techniques to significantly reduce treatment times and improve accuracy when irradiating small, highly mobile, lesions.*

*The first 2 of these advances opens the way for 4D image guided adaptive radiotherapy that should be the standard of care for many patients<sup>9,10</sup> and the last 2 would improve the accuracy of the techniques*

<sup>7</sup> It should be noted that the funding is Public Dividend Capital for equipment only – monies for any bunker enabling works would need to be allocated from Trust capital.

<sup>8</sup> Outline Business Case: MTW Radiotherapy Bunker Capacity Project, 2015

<sup>9</sup> NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013



such as stereotactic ablative radiotherapy/stereotactic body radiotherapy ( SABR/SBRT) which are in the KOC business plan and significantly reduce treatment delivery time and improve outcomes for some patients.

### **The current situation**

The table below lists the current location of the linac fleet within the Kent Oncology Centre and indicates whether they meet the NHS specification for maximum age (in 2015) and the ability to deliver modern radiotherapy, including 4D Adaptive and SABRE/SBRT.

The table shows that the Kent Oncology Centre has 6 linacs that need replacing over the next 2 years if the Centre is to remain compliant with the NHS specification.

The table also indicates the anticipated replacement dates for the linacs, assuming access to the recently announced Modernising Radiotherapy fund (see Appendix A for further details on the replacement program) – even with access to this funding, the KOC will not meet the NHS Specification for equipment replacement without additional investment in both linacs and decant bunker capacity.

### **Current status of the treatment units at the Kent Oncology Centre.**

Location	Linac	Within 10y Age (2016)	Capable of modern RT	Replacement date		Anticipated age at replacement	Comments
				Due	Expected		
Canterbury	LA1C	Yes	Yes	2020	2022	12	
Canterbury	LA2C	Yes	Yes	2025	2025	10	
Canterbury	LA3C	No	No	2014	2018	14	Delayed due to uncertainty of the east Kent site.
Maidstone	LA1M	No	No	2017	2017	10	
Maidstone	LA2M	Yes	Yes	2019	2021	13	
Maidstone	LA3M	Yes	No	2017	2020	13	
Maidstone	LA4M	No	No	2015	2017	12	
Maidstone	LA5M	No	Yes	2016	2017	11	
Maidstone	LA6M	No	Yes	2016	2019	13	Upgraded to 4D adaptive in 2013 under government "Innovations" program.

<sup>10</sup> National Radiotherapy Implementation Group Report Image Guided Radiotherapy (IGRT) Guidance for implementation and use, 2012

### **The case for the replacement of a treatment unit**

*The drivers for replacing a radiotherapy treatment unit include: equitability of access to modern radiotherapy facilities for our patients, improving patient care through improved outcomes<sup>11</sup> and the protection of market share.*

*Providing the best care for our patients requires providers to keep up with technological advances that improve outcomes by replacing treatment units regularly. The NHS standard contract for radiotherapy states that “The provider should ensure that each Linear Accelerator is in operation for a maximum of 10 years and that the replacements are planned in a timely manner.” This is echoed through the Modernisation of Radiotherapy Services Program<sup>12</sup> where priority is given to “Replacement of linacs that have reached or are reaching the age of ten years or older, as these are considered obsolete”.*

*The NHS standard contract for radiotherapy also identifies “Access to technologies such as Image Guided Radiotherapy (IGRT), which together with intensity modulated therapy forms the basis of 4-D Adaptive Radiotherapy, should be the standard of care for many patients”. These techniques require imaging equipment that is not available on older generation treatment units.*

*The delivery of the best care to our patients also requires providers to increase access to IMRT. The current national target of 24% has been achieved by the Kent Oncology Centre (currently access to IMRT at the KOC is around 34%), but the latest national guidance recommends 50% by 2020<sup>13</sup> and there is already an expectation that “incentives to promote IMRT being driven through tariff<sup>14</sup>. In order to meet future targets and increase income the Kent Oncology Centre will need the additional dose-painting and on-board imaging capability that comes as standard on modern units.*

*The proposed linac would be the make and model (Varian, Truebeam recently installed at Canterbury), with the same standard features necessary to deliver innovative radiotherapy including IMRT, IGRT and SABR/SBRT.*

*Market share will be at risk if the Kent Oncology Centre does not replace their older generation treatment units because the NHS radiotherapy contract specifies that commissioners are free to engage with other suppliers, who presumably are able to provide a modern radiotherapy service, where the provider has not agreed a timely replacement program, “Commissioners may divert activity where this is breached without agreement”.*

### **Case for Change - Business Needs**

*The objective/s of the proposed investment*

- *To improve access to modern radiotherapy techniques and better outcomes for our patients,*
- *To provide continuity of the radiotherapy service,*
- *To protect income and market share.*

<sup>11</sup> Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014

<sup>12</sup> Specialised Services Circular, £130m capital fund to modernise radiotherapy services in England – Next Steps, 2016

<sup>13</sup> Radiotherapy Board – Intensity Modulated Radiotherapy (IMRT) in the UK: Current access and predictions of future access rates, 2015

<sup>14</sup> Improving outcomes: a strategy for cancer, Department of Health, January 2011

**Case for change -Benefits***The Economic Case*

*The measurable benefits associated with the investment objectives listed above are summarised below.*

**To improve access to modern radiotherapy techniques and better outcomes for our patients**

- *Provide additional capacity to deliver more advanced radiotherapy so that more patients are offered innovative radiotherapy techniques that will contribute to better outcomes.*

**To provide continuity of the radiotherapy service**

- *Maintain the radiotherapy service activity during subsequent linac replacements and minimise patient delays and gaps in treatment by offering an additional x-ray energy to support the transfer of patients between linacs during failures and downtime.*

**To protect income and market share**

- *Provide additional capacity to deliver advanced radiotherapy that meets the National Standard Contract for Radiotherapy, assuring commissioners and patients that the KOC should remain the Cancer Centre of choice within Kent.*

**Case for change –Risks***The Economic Case*

*List and description (category and grading) of the potential risks associated with the investment*

<i>Risk</i>	<i>Category</i>	<i>Grading (Consequence x Likelihood)</i>	<i>Mitigation</i>
<i>Loss of linac capacity during the replacement resulting in loss of activity and patient delays.</i>	<i>Financial, Clinical Outcome, Quality</i>	<i>4 x 2= 8 Green</i>	<i>The KOC has recently undertaken a similar project successfully with no loss of activity. Select an obsolescent linac for replacement that is least able to support the activity of the KOC during the replacement project (and not necessarily the oldest). Business continuity arrangements will be in place. Major servicing and quality assurance will be undertaken out of hours and, where possible, before the project starts.</i>
<i>Incomplete knowledge of bunker structure and supporting services resulting in additional costs and delay in the project.</i>	<i>Financial</i>	<i>3 x 3 =9 Green</i>	<i>The bunker is a purpose built facility. Services/bunker inspected as part of developing the Contractor's proposals and contingency costs allocated where appropriate. Advice from the Estates Department is that HVAC is sufficient. Core samples (which are standard) will be required for additional assurance.</i>
<i>Insufficient staffing or expertise to successfully commission the linac resulting in project delays.</i>	<i>Workforce</i>	<i>4 x 2= 8 Green</i>	<i>The team have successfully commissioned a similar unit at Canterbury in 2015 and this expertise is still available within the centre. Maintenance of the routine service during the replacement may require staff to agree to work overtime. Commissioning times are expected to be shorter because the replacement linac will match the Canterbury linac and, therefore, data collection and analysis will be a sub-set of what is undertaken normally.</i>

## Constraints

1. To maintain activity during the replacement program any enabling works that may affect the operation of the other linacs will need to be carried out outside of the radiotherapy service working hours.
2. To meet our obligations under the Modernising Radiotherapy Services program, the Trust must take ownership of the linac by 31<sup>st</sup> March 2017 – either delivered to site or to a bonded warehouse.

## Dependencies

1. Timescales for the delivery of the project are dependent on the following external factors:
  - a. Confirmation of allocation of funding for the linac from NHSE – so that an order can be provided for the enabling works and the linac.
  - b. Availability of the Turn-key contractors to carry out the enabling works (the Modernisation Program has already significantly increased demand for their services).
2. Trust capital funding is required for the bunker enabling works, commissioning costs and additional equipment to support the clinical use of the linac.

## The short list of options *The Economic Case*

### Option A. The do nothing option - Discounted.

Do not replace a linac in 2016/17 and delay the KOC replacement program.

#### SWOT Analysis – Do minimum

<b><u>Strengths</u></b>	<p>Lower capital costs in the short term.</p> <ol style="list-style-type: none"> <li>a. No loss of radiotherapy capacity during the linac replacement.</li> <li>b. Sweating high value capital assets.</li> </ol>
<b><u>Weaknesses</u></b>	<p>Increased failure rates on aging equipment will result in delays in patient treatments.</p> <ol style="list-style-type: none"> <li>a. Increase in revenue in the instance of major breakdown as staff will need to work overtime at weekends to meet demand.</li> <li>b. There is an increased risk that a catastrophic failure will remove an older unit from clinical use for an extended period at very short notice, resulting in significant disruption, local and national media interest and consequent loss of income and reputation.</li> <li>c. Managing capacity during unscheduled long-term catastrophic breakdowns will not always be possible without compromising the outcome of treatment for some patients.</li> <li>d. Increasing pressure on other IMRT capable units to meet demand – extended working days and weekend working to cope – increase in revenue.</li> <li>e. Recruitment difficulties as it would be more attractive to work at other centres providing better facilities, working hours and advanced treatment techniques.</li> <li>f. Higher staff turnover due to unsatisfied staff.</li> <li>g. Increased staff stress and poorer morale due to workload and overtime with the potential of increased clinical incidents.</li> </ol>

<b><u>Opportunities</u></b>	<i>None identified given the age profile of the linac fleet.</i>
<b><u>Threats</u></b>	<p><i>Increasing loss of MTW market share and income:</i></p> <ul style="list-style-type: none"> <li><i>a. commissioners may choose to redirect patients to other centres who are able to meet the NHS standard contract for radiotherapy delivery,</i></li> <li><i>b. patients may choose to have their treatment elsewhere where the provider is able to offer a modern radiotherapy service, and,</i></li> <li><i>c. other providers may be encouraged to enter the market and secure the business given the age of most of the KOC fleet at replacement will be significantly outside the 10 years specified in the NHSE Radiotherapy standard contract.</i></li> </ul>
<b>Option B Replace LA3 at Canterbury - Discounted.</b> Replace LA3 at Canterbury which is over 14 years old.	
<b>SWOT Analysis – Replace LA3 at Canterbury</b>	
<b><u>Strengths</u></b>	<p><i>Replaces the oldest linac in the Kent Oncology Centre's portfolio.</i></p> <p><i>Provides additional capacity to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT on the Canterbury site.</i></p>
<b><u>Weaknesses</u></b>	<p><i>LA3 may be the oldest linac but it has more functionality than an obsolete unit at Maidstone General Hospital (LA1 – see option C).</i></p> <p><i>Inequitable disposition of linacs capable of advanced radiotherapy to the benefit of east Kent (66% IMRT/IGRT capable) versus west Kent (50% IMRT/IGRT capable). All SABRE/SBRT would be located on the Canterbury site until a Maidstone linac is replaced.</i></p> <p><i>Reduction in linac capacity of 11% during the commissioning program.</i></p>
<b><u>Opportunities</u></b>	<i>Additional capacity to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT on the Canterbury site.</i>
<b><u>Threats</u></b>	<i>EKHUFT is currently undertaking a strategic review of the location of their hospital services and, therefore, the future of the Kent and Canterbury site is unclear which could impact on the future delivery of radiotherapy services and the disposition of linacs in east Kent.</i>
<b>Option C Replace LA4 at Maidstone - Discounted.</b> Replace LA4 at Maidstone which is over 11 years old.	
<b>SWOT Analysis – Replace LA4 at Maidstone</b>	
<b><u>Strengths</u></b>	<p><i>Replaces the oldest linac in the Kent Oncology Centre's portfolio at Maidstone.</i></p> <p><i>Provides additional capacity to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT on the Canterbury site.</i></p>
<b><u>Weaknesses</u></b>	<p><i>LA4 may be the oldest linac at Maidstone but it has more functionality than another obsolete unit at Maidstone General Hospital (LA1 – see option D).</i></p> <p><i>Replacing LA4 before LA1 would significantly limit the KOC's ability to support activity during the replacement project because LA1 has limited clinical utility. It is unable to treat a significant number of radical radiotherapy patients and some palliative patients - already it cannot support an extended treatment day. Maintaining activity during the replacement of LA4 would, therefore, require the remaining 3 linacs at MGH to work even longer extended days but the service would have limited options</i></p>

	<p><i>for managing unscheduled breakdowns and patient delays.</i></p> <p><i>Continued service reliance on LA3 at Canterbury – which is over 14 years old.</i></p> <p><i>Reduction in linac capacity of 11% during the commissioning program.</i></p>
<b><u>Opportunities</u></b>	<i>Additional capacity to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT on the Canterbury site.</i>
<b><u>Threats</u></b>	<i>Perceived service inequity from east Kent service users who may feel that the oldest linac in the fleet, which is based at Kent and Canterbury Hospital, should be replaced.</i>
<b>Option D Replace a linac at Maidstone Hospital - The preferred option.</b> Replace LA1 at Maidstone which is over 10 years old.	
<b>SWOT Analysis – Replace LA1 at Maidstone</b>	
<b><u>Strengths</u></b>	<p><i>Replaces the least useful of the obsolescent linacs within the fleet at Maidstone.</i></p> <p><i>Maximises the KOC's capacity for maintaining activity and minimising patient delays during the replacement project because the other linacs in the fleet are more capable than LA1 of supporting activity during the replacement project.</i></p> <p><i>Provides for an equitable disposition of linacs capable of advanced radiotherapy (66% across both sites).</i></p> <p><i>Additional x-ray energy will improve the service's ability to reduce patient delays and cancellations by more effectively managing downtime on the other linacs due to servicing and breakdowns.</i></p>
<b><u>Weaknesses</u></b>	<p><i>Continued service reliance on LA3 at Canterbury – which is over 14 years old.</i></p> <p><i>Reduction in linac capacity of 11% during the commissioning program.</i></p> <p><i>As this linac is less aged than the alternative options, and will be replaced before reaching the 13 year depreciable life that the Trust moved to for the fleet in 2015/16, a larger depreciation charge adjustment will arise upon disposal.</i></p>
<b><u>Opportunities</u></b>	<i>Additional capacity to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT on the Maidstone site.</i>
<b><u>Threats</u></b>	<i>Perceived service inequity from east Kent service users who may feel that the oldest linac in the fleet, which is based at Kent and Canterbury Hospital, should be replaced.</i>

## Maintenance options – Truebeam Linac

*Potential options for managing the maintenance of the Truebeam after the 2 year warranty include:*

- 1. No maintenance contract from the linac manufacturer – support would be chargeable when required, spares not included.*
- 2. Limited maintenance contract – telephone support and access to diagnostic tools but spare parts are not included.*
- 3. Full-service maintenance contract, including all spares except “high-vacuum” items.*

*The provision of manufacturer support and access to diagnostic tools is considered essential to ensuring that delays due to breakdowns are minimised. Proceeding without maintenance cover is, therefore, not recommended because the risks to the service are too high.*

*Selection of the most appropriate maintenance contract from the remaining options (limited cover and full-service cover) is essentially a question of the financial risk that the Trust wishes to take around the cost of the spare parts: all parts are chargeable under the limited contract but under a full-service contract spares are included – except items identified as “high vacuum” items which are typically x-ray tubes, and high energy valves etc.*

*Unfortunately, given that the Truebeam is a relatively new linac platform, with the Canterbury unit still to come out of warranty (early in 2017), it is difficult to predict the spare-parts costs at this stage and therefore the relative merits of these options – except that the full-service contract places an upper limit on the likely spend on spare parts in a year.*

*We may be in a better position to identify the best service contract option when this linac is due to come out of warranty in 2 years because we will have several years of (non-warranty) maintenance experience on the Truebeam at Canterbury.*

### Summary of maintenance options.

Maintenance options	Advice	Diagnostics	Spares	Service contract cost/year (£)	Comments
No cover	X	X	X	£0	Not recommended – business continuity risks are too high.
Limited cover	✓	✓	X	£18,000	
Full-service	✓	✓	✓	£85,000	All spares covered excluding “high vacuum” items.



## The Preferred Option *The Economic Case*

Costs	Description	Category	Costs (inc. VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac which operates at a higher energy.		
	Enabling Works	Estate Capital	£348,000
	SK2 Shielding Option	Estate Capital	£147,600
	Lighting Control	Estate Capital	£3,600
	Additional Lighting	Estate Capital	£2,520
	Entrance Alterations	Estate Capital	£2,520
	Sky Art	Estate Capital	£4,680
	Contingency	Estate Capital	£30,000
	<b>Total incl VAT</b>		<b>£538,920</b>
	Estates Consultancy	Estate Capital	£34,000
	<b>Total incl VAT</b>		<b>£572,920</b>
Commissioning equipment	Plotting tank and detectors	Equipment Capital	£120,000
	Verification phantoms	Equipment Capital	£18,000
	(these items will be used for subsequent linac commissioning too)		<b>£138,000</b>
Dosimetry equipment	Dosimetry PC	IT Capital	£1,200
	Instrumentation cabling	IT Capital	£1,000
	In-vivo dosimetry diodes	IT Capital	£5,400
Patient equipment	Patient communications system		£2,400
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7	Other Capital	£23,000
	Overtime to meet the 12 week commissioning program	Other Capital	£8,000
<b>TOTAL</b>	<b>Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)</b>		<b>£751,920</b>
<b>Linear accelerator</b>	<b>Varian Truebeam, operating at 6MV and 10MV x-rays only.</b>	Equipment Capital	<b>£1,806,000</b>
<b>Total CAPITAL COST</b>			<b>£2,557,920</b>
Storage of linac	Modernising Radiotherapy services program requires linac to be purchased by 31 <sup>st</sup> March 2017. Bunker will not be ready until the end of July. Linac will be stored in the interim for 4 months at £650/month.	Non Recurrent Revenue Non Pay	£2,600
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends.		



	Additional OEM costs	Non Recurrent Revenue Non Pay	£9,750
	Additional Physics-engineering staffing costs	Non Recurrent Revenue Non Pay	£12,500
	Additional Physics staffing costs	Non Recurrent Revenue Non Pay	£3,000
	Additional travel costs	Non Recurrent Revenue Non Pay	£3,000
	<b>Total Pay</b>		<b>£28,250</b>
Maintenance requirements	Description		Costs
Linac maintenance contract	A maintenance contract for the linac and spares (excluding high-vacuum) will be required at the end of the 2 year warranty period.	Recurrent Non Pay	£85,000
Dosimetry maintenance contract	An extended maintenance contract for the dosimetry equipment will be required at the end of the warranty period.	Recurrent Non Pay	£3,500

#### Services and/or assets required

1. *This is a linac replacement into an existing bunker and will, therefore, connect into the existing services already being supplied to the current unit.*

#### Activity and service level agreement (SLA) implications. Commissioner involvement and input.

1. *There are no anticipated implications on activity and SLAs because the service will maintain business as usual during the linac replacement by extending the service's operating hours on other machines.*
2. *The replacement is supported by NHSE through the Modernising Radiotherapy program.*
3. *Radiotherapy services are fully commissioned for the 2016/17 financial year.*

#### Workforce impact

1. *The service will extend operating hours during the replacement program which will require staff to work different shift patterns and some occasional weekend working and overtime –but additional staff will not be required to support the extended working day.*
2. *The linac commissioning will be undertaken utilising existing Radiotherapy Physics staff – this approach was successful when commissioning LA2 at Canterbury in 2015 and has been shown to be the most cost-effective approach<sup>15</sup>.*
3. *Additional clinical staff will not be required to maintain existing activity once the linac facility has been returned to clinical use.*

#### Estates impact

1. *Enabling works are required within the bunker to increase the protection levels to meet the demands of the replacement machine and to bring the facility up to modern standards.*
2. *The enabling works and installation will be a turn-key project using the team that completed LA2 at Canterbury.*
3. *The Estates and Facilities team will be involved in the project management and delivery of the enabling works.*

<sup>15</sup> Business Case – Replacement linear accelerator at Canterbury (October 2014)

4. *We are advised by Estates that there is sufficient power on-site to support the linac.*
5. *During the enabling works, noisy working and the movement of materials into and out of the work area will be undertaken out of hours to minimise any disruption.*

#### Impact on other directorates

1. *No impacts are anticipated on other directorates at any stage of the replacement process.*
2. *The Project Management arrangements described below will be used to manage communications should a problem arise that may impact on other directorates.*

## Funding and affordability *The Financial Case*

### Capital costs of investment option

Capital	Year 1 (16/17)	Year 2 (17/18)	Year 3 (18/19)	Year 4 (19/20)	Year 5 (20/21)	Total
Equipment	1,806,000	138,000	0	0	0	1,944,000
Estate	0	572,920	0	0	0	572,920
IT	0	10,000	0	0	0	10,000
Other	0	31,000	0	0	0	31,000
Total Capital	1,806,000	751,920	0	0	0	2,557,920
Funding - Ext PDC	-1,806,000	0	0	0	0	-1,806,000
Trust CRL	0	751,920	0	0	0	751,920

#### Notes on capital costs:

- Funding - Ext PDC in Year 1 is NHS England external funding received for Linac machine purchase
- 'Other' in Year 2 is Commissioning Physicists to be capitalised during the commissioning works
- Year 2 costs assume commission of Linac in Quarter 4 (3 Months Year 2)

### Revenue changes associated with the investment option

	Year 1	Year 2	Year 3	Year 4	Year 5
Pay	0	28,250	0	0	0
Non Pay expenditure	0	2,600	3,500	88,500	88,500
Capital charges & depreciation	0	101,700	278,917	272,070	265,224
Write off NBV LA1	0	234,608	0	0	0
Total costs	0	367,158	282,417	360,570	353,724
Current Costs					
Current Maintenance Changes	0	-8,979	-8,979	-8,979	-8,979
Current Capital Charges	0	-78,540	-78,540	-78,540	-78,540
Net Change in Costs	0	279,639	194,898	273,051	266,205
Net Change in Recurrent Costs	0	16,781	194,898	273,051	266,205

#### Notes on revenue changes:

- PDC is included on capital charges @ £3.5%.
- Equipment incl the Linac Machine, Commissioning Equipment and Patient Communications System (assumed 13 yrs life)
- Estate Capital are the enabling works for the upgrade and refurb of the Linac bunker and control area (13 years life in line with Linac)
- IT Includes Dosimetry Equipment (assumed 5 years useful life)
- Year 2 costs assume commission of Linac in Quarter 4 (3 Months Year 2);
- Year 2 Revenue Pay costs are to maintain the existing Radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends.
- Year 2 revenue Non Pay costs is 1 quarter of the £85k Maintenance contracts for the Linac and the Dosimetry Equipment

### Affordability *The Financial Case*

1. The new machine has significantly higher functionality than the existing LA1 which is the lowest functionality machine in the fleet. When it was purchased it cost £780k, compared with LA3 purchased at the same time for £1.4m. Therefore the costs of capital charges and maintenance costs on the new machine are higher than the existing machine. This generates an additional cost to the Trust of c £270k from Year 4. The additional functionality and capacity of the new machine will provide the opportunity to undertake additional activity/respond to growth, if commissioned, and therefore recoup this cost.
2. The existing machine will be 9.5 years old at the time of planned disposal in terms of its depreciable life (this is lower than its actual age as it required 9 months to commission and bring the asset into use). The Trust changed its asset lives for linacs to 13 years last financial year to recognise the increasingly aged status of the fleet, and the constraints on available capital making it likely that the assets would be in operational use for a longer life. The consequence of disposal of this asset before the 13 years is reached is a non-recurrent write off to I&E in 2017/18 of the remaining value on the asset when disposed, c. £235k. This cost affects the break-even duty and the control total performance so will need to be balanced by additional CIP efficiencies. Replacing the alternative older LA4 would result in a write off of c £153k.

### Procurement Route *The Commercial Case*

3. The linac and associated equipment will be procured through the NHS Supply Chain Framework with the supplier then providing a turn-key solution to the bunker upgrade and linac installation.
4. This approach has been implemented successfully on the previous linac replacements.

### Quality Impact Assessment *The Management Case*

#### Clinical Effectiveness

Have clinicians been involved in the service redesign? If yes, list who.

*Dr Sharon Beesley, Clinical Director for Cancer and Haematology and Clinical Oncologist and Dr Mathilda Cominos, Lead Clinician for Radiotherapy and Clinical Oncologist.*

*Full discussion at the Cancer and Haematology Care Group meetings attended by all Consultants in oncology.*

*This has also been discussed at the Cancer and Haematology departmental governance meetings and is included in the Annual Business Plan.*

Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)

*Yes, the national predicted patient demand for radiotherapy activity levels (known as MALTHUS modelling Actual activity levels achieved in the last 5 years.*

*National trends in growth in oncology patients from a variety of sources including Macmillan and the Royal Colleges.*

*MTW has been nationally benchmarked with other radiotherapy centres in the UK.*

Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no,

specify additional outcome measures where appropriate.	
<p><i>The radiotherapy department monitors a number of key performance indicators including efficacy of treatment, number of fractions of radiotherapy per patient, incidence of side effects (minimal).</i></p> <p><i>The Directorate regularly audits radiotherapy practise and there are a number of regular annual clinical audits on radiotherapy treatments.</i></p> <p><i>Complication rates are audited on a regular basis and discussed at the clinical governance meetings and monitored on the Trust Dashboards.</i></p> <p><i>The directorate participates in Mortality and Morbidity meetings continually learn and improve on clinical outcomes.</i></p> <p><i>Both the Radiotherapy and Physics departments are ISO 9001:2008 certified and CHKS accredited. Clinical Quality is a large part of the accreditation process.</i></p>	
Are there any risks to clinical effectiveness? If yes, list	
Yes – 11% loss in capacity during the replacement program, potential failure of one of the remaining treatment units during this time – reducing capacity further.	
Have the risks been mitigated?	
Yes – there is a business continuity plan in place to manage the 11% loss in capacity during the linac replacement and to manage breakdowns during this period.	
Have the risks been added to the departmental risk register and a review date set?	
Yes.	
Are there any benefits to clinical effectiveness? If yes, list	
Yes – the replacement treatment unit will contribute to improved patient outcomes by supporting advanced radiotherapy techniques, including dose painting of the target lesion and improved treatment accuracy through better image guidance.	
<b>Patient Safety</b>	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y/ <del>N</del>
Safeguarding vulnerable adults/ children?	Y/ <del>N</del>
Current quality indicators?	Y/ <del>N</del>
Quality Account priorities?	Y/ <del>N</del>
CQUINS?	Y/ <del>N</del>
Are there any risks to patient safety? If yes, list	
There are no known risks to patient safety at the time of writing as the radiotherapy service is highly governed and there are a number of inherent patient safety checks that are performed prior to administration of radiotherapy.	
Have the risks been mitigated?	
Yes, all of the existing risks have been mitigated appropriately.	
Have the risks been added to the departmental risk register and a review date set?	
Yes.	
Are there any benefits to patient safety? If yes, list	

<i>Yes. Improved access to image guided, intensity modulated radiotherapy (IGRT/IMRT- dose painting) which may improve outcomes and reduce side-effects.</i>
<b>Patient experience</b>
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
<i>Yes, the impact of the redesign has been assessed. There should be no impact on the patients/ carers or members of the public apart from the radiotherapy patients being offered a superior service to the one that is currently available within the existing resources.</i>
Has the impact of the change been considered in relation to:
<ul style="list-style-type: none"> <li>• Promoting self-care for people with long-term conditions?</li> <li>• Tackling health inequalities?</li> </ul>
<i>Patients treated and consulted at the new radiotherapy centre will be managed by current MTW staff who will always promote self-care when applicable in addition to their treatment.</i>
<b>Tackling health inequalities?</b>
<i>The radiotherapy department is open to all patients who access health services and can accommodate all types of patients as per the Trust's Access Policy.</i>
Does the redesign lead to improvements in the care pathway? If yes, identify
<i>Yes, patients will be seen in a location closer to home and meet unmet patient need for treatment.</i>
Are there any risks to the patient experience? If yes, list
<i>No.</i>
Have the risks been mitigated?
<i>N/A.</i>
Have the risks been added to the departmental risk register and a review date set?
<i>N/A.</i>
Are there any benefits to the patient experience? If yes, list
<i>Yes – see above.</i>
<b>Equality &amp; Diversity</b>
Has the impact of redesign been subject to an Equality Impact Assessment?
<i>Yes.</i>
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
<i>No.</i>
Has any negative impact been added to the departmental risk register and a review date set?
<i>N/A.</i>
<b>Service</b>

What is the overall impact on service quality? – please tick one box					
Improves quality	<input checked="" type="checkbox"/>	Maintains quality	<input type="checkbox"/>	Reduces quality	<input type="checkbox"/>
Clinical lead comments					

Management Arrangements

The Management Case

Project management arrangements

1. The technical leadership and project management will be provided internally by MTW NHS Trust.

2. The project governance arrangements are covered by the Trust’s Governance arrangements whereby the project group (see below) will report into the Cancer and Haematology Directorate Management Meeting which is chaired by the General Manager for the Directorate and the Maidstone Program Board which is chaired by the COO.

The main aims are to:

Ensure the decision making can be integrated with MTW normal management processes as much as possible,

Clinical leadership and project management support can be targeted effectively and efficiently,

Best practice is applied in terms of project management and governance,

As part of the project, business assurance and benefits realisation key performance indicators along with risk and contingency plans have been developed and will be updated as the project develops.

3. The project group will ensure that the replacement of the linear accelerator is successfully delivered and the benefits realised and will oversee 4 work-streams that will manage contractor and site liaison, the team commissioning the unit and the associated treatment planning systems, the operational plan to maintain the service during the replacement period and the implementation of the new technology into routine clinical use.

Group	Role	Chair	Reporting to
Project Group	Oversee the implementation of the project, including the business planning process.	Director of Medical Physics	Cancer and Haematology Directorate Management Meeting  Maidstone Program Board
Operations work stream	Implementation of the operational plan for maintaining business continuity during the replacement program	Cancer & Haematology Operations Manager	Project Group
Contractor and site liaison team	To ensure that the design meets the user’s requirements and those of the wider Trust.  To liaise with builders, Varian, MTW, operations and commissioning teams.	Estates Project Manager	Project Group
Commissioning team	To commission the treatment unit and the treatment planning systems	Lead Physicist	Project Group
Radiotherapy Technique group	To ensure that new treatment techniques/technology are introduced safely into clinical use.	Head of Radiotherapy Physics	Project Group



Timetable		
Milestone		Indicative date
Submission to Finance Committee.		19 <sup>th</sup> Dec 2016
Submission to the Trust Board.		21 <sup>st</sup> Dec 2016
Linac ordered (minimum 12 week lead time, purchase required before 31 <sup>st</sup> March 2017)		22 <sup>nd</sup> Dec 2016
Formal instructions issued by the Trust to the Turn-key contractors		30 <sup>th</sup> Jan 2017
Linac placed in storage until enabling works are completed.		31 <sup>st</sup> March 2017
Close machine, move to business continuity arrangements.		10 <sup>th</sup> April 2017
Enabling building works completed (12 week program).		30 <sup>th</sup> Jun 2017
Linac delivered, installation and acceptance commences (4 week program).		1 <sup>st</sup> July 2017
Treatment unit is accepted by the Trust and commissioning begins (12 week program).		31 <sup>st</sup> July 2017
Commissioning completed, staff training begins.		9 <sup>th</sup> October 2017
Staff training completed and the treatment unit enters into clinical use. Centre returns to normal operating hours. Completion of the project.		16 <sup>th</sup> October 2017
Business assurance and benefits realisation arrangements		
<p>1. The business benefits that will be realised upon the installation of the Truebeam linear accelerator include:</p> <ul style="list-style-type: none"> <li>improved access for patients to modern radiotherapy techniques,</li> <li>no additional loss in market share.</li> </ul> <p>2. The benefits will be realised as soon as the replacement treatment unit is fully commissioned and put into routine clinical use.</p>		
Training arrangements		
<p>1. A Truebeam linear accelerator has recently been commissioned by the Medical Physics team and introduced into clinical use within the KOC at Canterbury. There is, therefore, scientific, clinical and technical expertise within the centre to successfully commission, operate and maintain the replacement Truebeam unit.</p> <p>2. Additionally, to ensure that expertise is developed within the teams, Varian will provide on-site clinical training in the week leading up to go live and a radiotherapy engineer will attend the appropriate maintenance training courses.</p>		
Risk Management and Contingency plans		
<p>1. The Centre will maintain activity throughout the replacement program following the business continuity arrangements that were implemented successfully during the recent replacement of LA2 at Canterbury.</p> <p>2. The plan was developed by a multi-disciplinary team from the Kent Oncology Centre to ensure that it is robust and the necessary infrastructure will be in place to support the continuity arrangements.</p>		

3. *The workload will be redistributed across the remaining Maidstone linacs by starting the treatment day a little earlier and continuing through until 8pm. To ensure that there are sufficient resources to meet the requirements for RapidArc and to deal with the inevitable fluctuations in patient numbers, some patients in the Ashford corridor may be transferred to Canterbury when there is cu spare capacity.*
4. *To manage the extended working days, some servicing and quality assurance of the treatment units will move to the weekends for which the costs have been readily identified because these are scheduled tasks that are normally completed regularly throughout the year.*
5. *It is likely that a treatment unit will break down occasionally during the replacement program. If the breakdown exceeds 1 hour (breakdowns totalling 1 hour is the most that can be tacked onto an already extended day) then patients may need to be treated during the weekends to catch up (for many patients a gap in radiotherapy must be avoided). Weekend planned maintenance and quality assurance programs may need to be moved to a subsequent weekend when a breakdown necessitates weekend working.*
6. *The business continuity planning team have estimated a contingency element to cover the staffing costs required to cover unscheduled weekend working using the current breakdown statistics for the units that will be treating during the replacement. These costs are obviously subject to variability because breakdowns can be unpredictable.*
7. *To mitigate the requirements for extended servicing on the linacs, the engineering team is arranging for the OEM servicing on the Maidstone linacs to be completed before the replacement program gets underway.*
8. *The business continuity plan is being discussed with staff in readiness for a February 2016 project start.*
9. *The contingency plan assumes that radiotherapy activity will not increase significantly during the replacement period – this assumption is supported by the activity data from previous years and there being no evidence to suggest that a significant increase in 2016/17 is anticipated.*
10. *The business continuity plan does not provide a model for managing activity across the Kent Oncology Centre on fewer linacs in the longer term because the extended working day is not sustainable (patient acceptance, staff good-will, recruitment and retention, over-reliance on equipment and staff support), the Centre will not be able to replace future linacs because capacity will be insufficient, limited access to IMRT, IGRT and SABR/SBRT will affect patient outcomes and choice which could impact on the Trust's market share.*

#### Arrangements for post project evaluation

1. *Post project evaluation will be monitored through the Cancer and Haematology Directorate Management Meeting and include;*
  - a. *RPA reports from a critical examination of the radiation facility,*
  - b. *Linac acceptance and commissioning reports,*
  - c. *Treatment planning system commissioning reports,*
  - d. *External dose audit reports,*
  - e. *Monitoring of activity, including patient delays and IMRT uptake.*

## Version history

Version	Issue date	Brief Summary of Change	Owner's Name

## Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes/no
Revenue breakdown completed	Yes/no
Capital breakdown completed	Yes/no
Supporting statements from stakeholders attached	Yes/no
Quality impact assessment completed	Yes/no
Commissioner support agreed	Yes/no
Appendices attached	Yes/no
	Yes/no

## Appendix A

### Linac replacement program

### The Strategic Case

1. The table below outlines the revised current proposed linac replacement program, taking into account potential funding from the Modernisation of Radiotherapy Services program, and reducing the impact on the Trust's capital program by extending the age of the majority of the linacs to 12-14 years which is significantly beyond the 10 years recommended in the NHS specification.

#### Linac replacement programme

Site	Equipment	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Age replaced	Note
Canterbury	LA1									R		12	1
Canterbury	LA2										R	10	2
Canterbury	LA3				R							14	3
Maidstone	LA1			R								10	4
Maidstone	LA2							R				13	5
Maidstone	LA3						R					13	6
Maidstone	LA4			R								12	7
Maidstone	LA5			R								11	8
Maidstone	LA6					R	R					13	9
	Build bunker/s			✓									10

#### Notes relating to linac replacement programme

Note 1: Canterbury LA1 10 years old in 2020

Note 2: Last replaced in 2015.

Note 3: LA3 moved back from 14/15 as a consequence of earlier LA2 delay (completed 11/2015) and now delayed due to discussions over the future of the KCH site.

Note 4: Replacement linac purchased in 2016/17 but existing unit will come out of service at the beginning of 2017/18

Note 5: 10 years old in 2019/20

Note 6: 10 years old in 2017/18

Note 7: 10 years old in 2015/16

Note 8: Delayed, due to knock-on from Canterbury. 10 years old 2016/17

Note 9: Extended replacement from 2016 due to Innovations upgrade.

Note 10: Option for bunker development which would allow the replacement program at Maidstone to continue whilst maintaining a full complement of treatment units in west Kent.

2. There are a number of complexities with this replacement program that need to be managed:

- There is no bunker in which to house a replacement unit (at Maidstone or Canterbury) -which means that an existing linac would need to be removed from clinical use, reducing capacity by 11%.
- There is currently significant uncertainty within EKHUFT and the local healthcare economy

regarding the future of the Kent & Canterbury site that houses the KOC at Canterbury – closure of the KCH site appears to be a real possibility.

- c. Additional investment is required on the KOC at Canterbury site because the KCH is not designed to provide the infrastructure and shielding requirements of modern linear accelerator and the fabric of the building is also deteriorating, with water leaks throughout the department becoming common.
- d. Each linac replacement is time-consuming, taking around 6-12 months to complete depending on the complexities of the estate (and involves removing the existing linac, upgrading the bunker, installing and commissioning the replacement unit and training the staff).
- e. There is very little slack in the program which means that a delay in one replacement has a knock-on effect on the whole replacement program, pushing the age of the linacs ever upwards (as has already been exhibited by the delay to LA2 at Canterbury – see notes 2,3 and 8 above).
- f. The timetable below shows the key installation and commissioning dates along with the key assumptions if the Trust is to install the linacs funded through the Modernising Radiotherapy Services program in a timely manner.

Linac	Linac removed from clinical use	New linac installed and accepted	New linac Commissioned	Returned to clinical service	Comments
LA1	10 <sup>th</sup> Apr 2017	31 <sup>st</sup> Jul 2017	23 <sup>rd</sup> Oct 2017	6 <sup>th</sup> Nov 2017	Installation and acceptance timescales provided by Turn-key contractor and assumes formal instructions are issued by the Trust before 20 <sup>th</sup> Jan 2017. Assumes a 12 week commissioning program (confirmatory measurements only).
LA4	20 <sup>th</sup> Nov 2017	26 <sup>th</sup> Feb 2018	18 <sup>th</sup> Jun 2018	2 <sup>nd</sup> July 2019	Assumes a 9 week build program (bunker shielding is up to specification) and a 16 week commissioning program (additional modalities require data collection).
LA5	16 <sup>th</sup> Jul 2018	22 <sup>nd</sup> Oct 2018	17 <sup>th</sup> Dec 2018	21 <sup>st</sup> Jan 2019	Assumes a 9 week build program (bunker shielding is up to specification) and a 12 week commissioning program).
PAUSE: to account for potential delays and to complete treatment planning commissioning for LA4M 15MV and electrons on LA4M and LA5M before removing LA6M from clinical use.					
LA3C	6 <sup>th</sup> May 2019	2 <sup>nd</sup> Sep 2019	2 <sup>nd</sup> Dec 2019	16 <sup>th</sup> Dec 2019	Assumes a 12 week build program and a 12 week commissioning program (confirmatory measurements only).

Appendix B
Linac costs



NHS SC quote-  
Maidstone- Varian- 11

Appendix C
Cost proposal – enabling works



Maidstone LA1 Draft CP for budget.pdf



2186. MAIDSTONE  
BUNKER LA1 UPDATE

## Appendix B

Pricing Schedule

Modality: Linac

Supplier Name: Varian Medical UK

Trust Name: Maidstone & Tunbridge Wells NHS Trust

Hospital Name: Maidstone

Date: 11th November 2016

Supplier Quotation Reference: 2016-65321



NHS Supply Chain

The price is based on a commitment deal via the Department of Health Capital Equipment Trading Fund and as such has limited availability. Once all goods are sold from the particular commitment deal, pricing will revert as per the standard framework agreement not withstanding any prices quoted on this quotation.

Quote Valid To:

THIS QUOTE IS VALID UNTIL 10/02/17 OR UNTIL ALL STOCK IS EXHAUSTED , WHICHEVER DATE IS SOONER.

Core Spec	System Name	Product Code	Warranty (in yrs)	Qty
Linac	TrueBeam linear accelerator	MBS001001002	2	1

Total Number of Systems

1

Total Framework Price to compare against Supplier (Excl. VAT) price, including Any Multi System Discounts Applicable

£1,731,691.00

Total Framework Price to compare against Supplier (Inc. VAT) price including Any Multi System Discounts Applicable

£2,078,029.20

Trust Cash Saving

£233,346.25

Total Price to compare against Supplier (Excl. VAT) price, Including Any Additional Savings

£1,498,344.75

Final Invoice Cost Including Any Additional Savings  
(No VAT will be added to this final Invoice cost)

£1,798,013.70

Additional Information

PLEASE NOTE: NHSSC is in the same VAT division as all English Trusts and therefore transactions between the two parties are 'Out of Scope' for VAT purposes. No VAT will therefore be added to the final invoice cost shown above. As VAT cannot be reclaimed by an English Trust for payments

Indicative Lease costs for this quote are available upon request.

## Appendix B

### Pricing Schedule

<b>Modality:</b>	<b>Linac</b>
<b>Supplier Name:</b>	<b>Varian Medical UK</b>
<b>Trust Name:</b>	<b>Maidstone &amp; Tunbridge Wells NHS Trust</b>
<b>Hospital Name:</b>	<b>Maidstone</b>
<b>Date:</b>	<b>11th November 2016</b>
<b>Supplier Quotation Reference:</b>	<b>2016-65321</b>



## NHS Supply Chain

The price is based on a commitment deal via the Department of Health Capital Equipment Trading Fund and as such has limited availability. Once all goods are sold from the particular commitment deal, pricing will revert as per the standard framework agreement notwithstanding any prices quoted on this quotation.

**Quote Valid To:**

**THIS QUOTE IS VALID UNTIL 10/02/17 OR UNTIL ALL STOCK IS EXHAUSTED , WHICHEVER DATE IS SOONER.**

Core Spec	System Name	Product Code	Warranty (in yrs)	Qty
Linac	TrueBeam linear accelerator	MBS001001002	2	

### TrueBeam linear accelerator

[illegible]

Optional Items Not Included in Quote Price			
Accessories	Product Code	Qty	Price per unit
Upg. LOW-X IMAGING at 2.5MV	LBU001040007	1	£17,050.00
TrueBeam Developer Mode	DEV001001001	1	£28,350.00
UPG. PERFECTPITCH™ 6DoF COUCH	LBU001040018	1	£166,290.00

This price is discounted based on the couches we currently have available on bulk deal



## Appendix B

TrueBeam Package	MBS001001002
New Universal Baseframe 52" Fixed Floor	MBX001028001
Rapid Arc Treatment Delivery License	LRA001001001
6/6 MV (BJR 11/17)	MBX001009003
10/10 MV (BJR 11/17)	MBX001009005
6 MeV, 0-1000 MU/min	MBX001011003
9 MeV, 0-1000 MU/min	MBX001011005
12 MeV, 0-1000 MU/min	MBX001011007
15 MeV, 0-1000 MU/min	MBX001011008
18 MeV, 0-1000 MU/min	MBX001011010
STD TRNG: TrueBeam On-Site Support	IAB001001008
STD TRNG: TrueBeam Ops (on-site)	IAB001001009
INCL ED: TrueBeam Physics and Admin	IEB001011031
INCL ED: VAI IGRT/RPM Clinical School	IEB001011017
NLS: English	ISB001002002
120 Multileaf Collimator	MBX001019001
6X High Intensity Mode	MBS001009004
10X High Intensity Mode	MBS001009006
Advanced IGRT & Motion Package	MBS001005002
Respiratory Motion Mgmt Pkg	MBS001006001
STD TRNG: RPM Respiratory Gating	IAB001011012
Integrated IGRT Couch Top	MBX001012004
Education FlexCredits	PEC001001001
Heatherose Limited - TB Interface Panel	VAR001001011
REFCOOL Style Hybrid Chiller	VAR001001011
2nd year Warranty - HW	VAR001001016

Appendix C

**Draft Contractor's Proposals for budget**

**CONTRACTOR'S PROPOSALS**

for

**BUILDER'S WORK IN CONNECTION WITH  
LINEAR ACCELERATOR INSTALLATIONS**

at

**MAIDSTONE HOSPITAL ROOM LA1**

on behalf of

**VARIAN MEDICAL SYSTEMS (UK) LIMITED**



## **Draft Contractor's Proposals for budget**

### **CONTENTS**

<b>Section No</b>	<b>Title</b>	<b>Page No</b>
<b>ONE</b>	<b>SCOPE OF WORK IDENTIFIED BY EMPLOYER'S REQUIREMENTS</b>	<b>2</b>
<b>TWO</b>	<b>CONTRACTOR'S PROPOSALS</b>	<b>3-11</b>
<b>APPENDIX A:</b>	<b>INDICATIVE PROGRAMME</b>	<b>12</b>
<b>APPENDIX B:</b>	<b>DRAWINGS</b>	<b>13</b>
<b>APPENDIX C:</b>	<b>PROPOSED BUDGET</b>	<b>14</b>
<b>APPENDIX D:</b>	<b>DESIGN TEAM AND PROFESSIONAL INDEMNITY INSURANCE</b>	<b>15-16</b>

## **Draft Contractor's Proposals for budget**

### **SECTION ONE**

#### **SCOPE OF WORK IDENTIFIED BY EMPLOYER'S REQUIREMENTS**

- 1) The scope of works for the project is all as detailed below and is based on Drawings 2186/254/SK1, SK2 and SK3
- 2) The Proposals relate to the building works and fitting out only and do not include the supply or installation of the Linear accelerator or its associated specialist equipment which is the subject of a separate order from the Hospital
- 3) The Contractor's Proposals in the following section two have been based upon the drawn information referred to above and visual survey carried out on the 15<sup>th</sup> January 2016, expanded upon as necessary to produce the Contractor's Proposals and budget cost. If the Employer requires a change in the Employer's requirements or Contractor's Proposals then costs may be required to be adjusted.
- 4) The core budget is based on the layout indicated on drawing SK1 with additional cost options shown separately for radiation protection as noted on drawings SK2 and SK3

## Draft Contractor's Proposals for budget

### SECTION TWO

#### CONTRACTOR'S PROPOSALS

- 1) The Contractor's Proposals whilst acknowledging the contents of Section One have made the following assumptions which have formed the basis of these draft proposals, the anticipated scope of work and overall budget
- 2) Building Control Requirements. The work will be carried out in accordance with the Building Regulations current at the time of tender and the proposals include for the necessary fees for obtaining the building control approvals
- 3) Extent of information. The following indicative drawings form the basis of the Contractor's Proposals: Felce and Guy drawing 2186/254/SK2 LA1 Replacement Linac Sketch Plans; 2186/254/SK2 LA1 Replacement Linac Shielding Option 1 and 2186/254/SK3 LA1 Replacement Linac Shielding Option 2

Further details will be prepared to amplify the information contained therein upon placing of the order

- 4) The Employer, prior to the start on site is to advise the actual extent of radiation protection necessary to satisfy the Hospital's appointed Radiation Protection Officer. Any revision required to satisfy the Radiation Protection Officer's criteria will be deemed a change and the tender will be required to be adjusted. The Contractor takes no responsibility for the radiation protection assumptions. All requirements for radiation protection are to be provided by the Radiation Protection Officer in writing and the Contractor's drawings must be stamped as approved by the Radiation Protection Officer prior to work commencing. Additional shielding is allowed in the budget as indicated on the above drawings
- 5) Proposed budget. The draft budget is included in Appendix C which also indicates any options which may need to be taken into account to compile an overall cost
- 6) Working space. The costs are based upon the Employer providing convenient and adequate storage space at a reasonable distance from the site entrance for the site compound facility which will consist of space for two vehicles, a covered skip and a twenty foot container.
- 7) Indemnity insurance. See Appendix D for members of Design Team and Indemnity Insurance carried by each
- 8) Insurance to existing structures will be the responsibility of the Employer

## **Draft Contractor's Proposals for budget**

- 9) Varian Medical Systems (UK) Limited does not have specific professional indemnity insurance for the building works as all design work is carried out by appointed consultants who all carry indemnity cover as referred to above. Copies of the relevant policies can be provided on request
- 10) Cost of machine and its associated specialist equipment is not contained within the building contract sum. See main machine order
- 11) Commissioning to Varian standard acceptance test protocol. See main machine order
- 12) Out of hours working – the proposals allow for out of hours working to cover elements such as services installations, structural alterations and noisy working and removal and movement of materials into and out of the work area We have made a further allowance in the form of a provisional sum for possible additional out of hours working for any additional restrictions that may be imposed by the Hospital to suit working arrangements or for any unforeseen works that may be required Any works falling under this category will be agreed in advance and the hours recorded and adjusted at the rate of £29.75 Per hour.
- 13) The buildin programme for the works is shown in Appendix A. Should the contract period overlap statutory holidays then the programme will be required to be extended to reflect this. The design work will be executed during the lead-in period from placing contract order to the contractor's start on site. The indicative overall programme is included in Appendix A which may be subject to review should the scope of works change;
- 14) Pit location and baseframe – Our proposals include a Provisional Sum allowance for alterations to the existing flooring that will be necessary for the installation of the new base frame. We do not have any structural details available so core holes will be taken and issued to Varian Structural Engineers for analysis and design. The provisional sum value has been allowed on the basis of previous installations carried out and will be adjusted to the amount of works required. Any savings in cost will be taken into account in the Final Account.
- 15) Radiation Shielding – all as shown on the drawings. The budget is based on the use of steel but subject to investigation it may be possible to offer a more competitive cost for the use of lead
- 16) Existing Linac – Our proposals allow for the removal of the existing Clinac machine by a Specialist Contractor to be taken for scrap.
- 17) General - No allowance for clinical clean. This work to be carried out by the Hospital.
- 18) General – Costs assume free use of electricity, water supplies and the use of sanitary facilities for welfare. The site would have its own office within the work area (normally

## **Draft Contractor's Proposals for budget**

the control area). Our contractor's operatives will carry clean sets of clothing, and will change into them prior to use of the hospital public canteens and toilets. They are well briefed that work clothes and boots are not to be worn outside the works area.

- 19) Liquidated damages are not included
- 20) A bond is not included
- 21) Tender Offers - All tender offers will remain open for acceptance for a period of three months from submission. The final offer once agreed is a lump sum fixed price tender that is only adjustable if there is a change in the Employers Requirements or scope of works or where works are covered by a PC or Provisional sum. In the event of a change the contractor will advise the Hospital of the variance providing where possible a quotation or if it is not possible to fully define the change an assessment of the costs for acceptance in principal before the works proceed.
- 22) Scope of Works - the following is a list of inclusions in the Contractors Proposals and indicative budget

## **Treatment Room**

### **Alterations**

Strip out and remove, existing fittings and fixtures remaining following removal of Linac; clear away from site; make good all works disturbed left ready to receive decorations or final finish

Take up existing floor coverings and associated skirtings and remove from site;

Strip any applied coverings to walls including tiling; remove from site; make good all works disturbed left ready for new decorations or final finish

Take down existing ceilings and bulkheads and remove from site; make good all works disturbed left ready for installation of new

Carry out floor alterations for installation of new base frame; receive base frame from Varian and grout in position

Construct New Plinth for Modulator to standard detail

### **Internal Walls**

Line out treatment room walls with plasterboard finished with taped and filled joints to receive decorations where required

Build out the walls where indicated using timber or proprietary metal studwork system at the contractor's option and cover with plasterboard finished with taped and filled joints to receive decorations

## **Draft Contractor's Proposals for budget**

### **Internal Doors**

Supply and install new double doorset to the electrical cupboard

Supply and install new bunker entrance doors and screens as elevation shown

### **Finishes**

Prepare wall surfaces and apply two full coats of eggshell finish

Redecorate all other previously decorated items

Prepare existing floors, apply latex and vapour barrier and lay new vinyl flooring all to standard specification; to include cutting and fitting into covers and around items of equipment; All abutments to have cove former and vinyl floors turned up to form skirtings

Supply and fit new lay in grid suspended ceiling system all to standard specification including all accessories hung from existing soffit; allow to incorporate all necessary ceiling grilles and modular light fittings, detectors and the like and working around services in ceiling void

Include for forming any bulk heads and making good at wall junction

### **Fittings**

Supply and install all items of purpose made joinery to detail; All units to be to the approval of infection control

Form all necessary laser housings in matching construction

Fix only all items from pre installation kit provided by Varian; in conjunction fix only sundry items provided by the hospital (but not any Hospital equipment)

Provide fully accessible Venesta or similar laminated preformed housing for basins including any necessary alterations or adaptations to existing risers or boxings

Supply and fix handrail buffer system to maze walls and supply matching corner protectors as required

### **Control Area**

### **Alterations**

Strip out existing items not required for the new works and clear away; make good all works disturbed left ready to receive decorations or final finish



## **Draft Contractor's Proposals for budget**

### **Finishes**

Prepare existing floors, apply latex and lay new vinyl flooring and vapour barrier all to standard specification; to include all necessary including cutting and fitting into covers and around items of equipment; All abutments to have cove former and vinyl floors turned up to form skirtings

Allow to carry out minor modifications to ceiling area to allow for erection of site hoarding and reinstate on completion

Supply and fit new lay in grid suspended ceiling system all to standard specification including all accessories hung from existing soffit; allow to incorporate all necessary ceiling grilles and modular light fittings, detectors and the like and working around services in ceiling void

Include for forming any bulk heads and making good at wall junction

### **Fittings**

Provide new purpose made joinery to profiles shown

Provide and fix as required sundry items to include coat hooks mirrors handbag shelves etc

### **Mechanical and Electrical Services**

#### **Mechanical Services**

Please note the following clarifications or qualifications to the mechanical installation included in the Contractors Proposals that seek to identify any assumptions made in the pricing or highlight items that may require further survey and inspection; A number of items will need to be executed by Hospital Nominated Contractors and we have identified PC sums based on previous experience of similar installations. Similarly where we have allowed provisional sums this is to identify items of work that cannot at this stage be fully ascertained and again the allowances made reflect Varian's experience of similar items executed on previous projects

1) The existing HVAC systems serving the treatment room are in good working order and will meet the requirements for the new Varian equipment in respect of achieving the correct air exchange rate together with the ability to maintain the correct treatment room environmental conditions. Within our costs we have allowed for alterations only to the existing ductwork within the ceiling to accommodate the new room layout and Varian components.

2) Within the option costs we have allowed for all necessary alterations to the mechanical installation to allow for the installation of additional radiation shielding

3) Within the control area we have assumed all existing HVAC systems are in good working order and will meet the requirements.

4) In both the treatment room and control area after undertaking design should it become apparent that the existing services cannot meet the cooling/heating requirements we have provided option costs subject to further surveys for installing independent DX air conditioning systems.

5) We have assumed that the new Varian chiller will be installed externally therefore within our

## **Draft Contractor's Proposals for budget**

costs we have allowed to extend the existing pipe work to the agreed location. Please note that since the existing pipe work between the treatment room and the chillers previous location will remain we would need to undertake a design to verify its suitability to reuse, no costs have been included to replace this section of pipe work. In addition any existing chiller pipe work will be subject to a pressure test prior to any commissioning; no costs have been included for replacing any existing defective pipe work should it be necessary.

6) It is assumed all existing domestic services currently serving the treatment room can accommodate the proposed new domestic services layout. Within our cost we have allowed for alterations to existing only, no costs have been allowed for any upgrades.

### **Mechanical scope of works**

Preliminaries design and supervision

Air flow measurements and verification

Ductwork alterations within ceiling void to accommodate the new layout and associated Varian equipment

Alterations to chilled water pipe work

Alterations to hot and cold water services and installation of basins and sinks

Chlorination of domestic water services

Test and commission

O&M information and certification

### **Exclusions**

- 1) Any remedial works or alterations on main HVAC equipment
- 2) Any upgrades to any HVAC systems to accommodate proposed works
- 3) Replacement of defective chiller pipe work.
- 4) Any works in linking and combining two chillers to operate in run / standby mode.
- 5) Any upgrades to BMS controls including any monitoring
- 6) Fire Stopping
- 7) Any works to medical gases

### **Electrical services**

Please note the following clarifications or qualifications to the Electrical installation included in the Contractors Proposals that seek to identify any assumptions made in the pricing or highlight items that may require further survey and inspection; A number of items will need to be executed by Hospital Nominated Contractors and we have identified PC sums based on previous experience of similar installations. Similarly where we have allowed provisional sums this is to identify items of work that cannot at this stage be fully ascertained and again the allowances made reflect Varian's experience of similar items executed on previous projects

- 1) The existing power supply currently serving the existing medical equipment is derived from

## **Draft Contractor's Proposals for budget**

the control panel situated within the Control area, in addition this panel also serves the Power and Lighting circuits within treatment and control rooms. From the initial survey and discussions on site the proposed new works will involve removal off this panel and re-terminating the existing supply cable into a new main switch. From this point we have allowed to install a new sub-main supply to serve the new Heatherose panel which is to be located within the treatment room. Please note that from initial site survey we have assumed that this existing supply is 100amp rated and the switch panels have sufficient electrical capacity to meet the requirements of the new Varian TrueBeam equipment. No costs have been included for any electrical upgrades.

2) Since the proposed alterations will remove the existing electrical supply which served the existing small power and lighting services within the treatment room, we have as agreed during the survey provided a Provisional Sum for the installation of a new single phase sub-main from the main switch panel to serve a new single phase distribution board location to be agreed which will then serve new power and lighting circuits. At present there is an existing distribution board located within control room however since the origin or the supply capacity are unknown further investigation and verification will be required to establish if this supply can be utilised. In addition we have assumed the existing switch panel can accommodate the new supply therefore since the scope of works are unknown we have also provided a Provisional Sum should there be any panel modifications required.

3) Within our costs we have allowed for replacing the existing lighting within the treatment room with new digital dimming LED fittings complete with localised switching. A separate option cost is also shown for the replacement of control room lighting should this be required. Please note prior to finalising costs we would need to obtain approval on both the proposed type of light fittings and its intended method of installation/operation. This will include emergency light fittings complete with standard 3hr self-contained battery backup.( excludes any addressable emergency lights ).

4) In respect of earthing arrangements within the room we have included for the installation of an earth reference bar and associated cabling from this reference point to the required items within the treatment room. Also included within the cost is an allowance for a new main earth reference cable back to a suitable connection point no more than 50 metres in distance..

5) A Provisional Sum has been indicated for possible additional works required to services as a result of the introduction of the new entrance doors

### Electrical scope of works

Preliminaries including design and supervision

Mains Distribution

Containment Installation

Small power Installation

Lighting Installation

Control Room Lighting

Heatherose and Interlock Wiring

Fire Alarm and data containment

Mechanical Wiring

## Draft Contractor's Proposals for budget

PIK Installation

Earthing requirements

Mechanical supply alterations

Test & Commission

O&M Manuals and Certification

### Exclusions to Electrical Installation

- 1) Any upgrades to electrical infrastructure
- 2) Any new generators, essential power services or any associated equipment
- 3) Any upgrades to existing Fire Alarm, Data or Nurse call Systems
- 4) Any upgrades to IT Networks of Infrastructure
- 5) Dosimetry Panels
- 6) Door Access controls
- 7) Security Systems
- 8) PA or Tannoy Systems
- 9) Supply and installation of any IPS/UPS systems
- 10) Supply and installation of Voltage Stabilisers
- 11) Nurse Call system

- 23) Generally in addition to items above, there are no allowances in the builder's work for:

Value Added Tax which will be charged at the rate prevailing at the point of invoice

Any provision for Legionnaires disease protection to existing DHHWS system

Any improved security provisions whilst works in progress.

Removal of any depleted uranium or Beryllium or any other hazardous waste requiring particular treatment. This will include asbestos. The Hospital will be required to provide an R & D survey prior to commencement to identify any ACM's

- 24) Schedule of PC and Provisional sums Included in budget cost.

PC Sum for Fire Alarm Installation executed by a Hospital nominated Sub contractor  
**£3,500.00**

PC Sum for Data Installation executed by a Hospital Nominated Sub Contractor  
**£2,800.00**

PC Sum for BMS connections executed by a Hospital Nominated Sub Contractor  
**£2,800.00**

## **Draft Contractor's Proposals for budget**

Provisional sum for three phase site temporary supplies for concrete cutting equipment **£1,150.00**

Provisional Sum for Structural floor alterations **£14,000.00**

Provisional Sum for Out of Hours working **£5,000.00**

## Draft Contractor's Proposals for budget

### APPENDIX A: INDICATIVE PROGRAMME

#### LA1 Basic Refurbishment Works

Duration in working weeks	13
Design Period and approval	4
Builder's Work to Treatment Room and maze	9
Installation, Test & commissioning of machine by Varian for compliance with Varian Standard Acceptance Test Protocol	tbc

#### LA1 Works Including Additional Radiation Protection Option 1 (Scheme SK2)

Duration in working weeks	16
Design Period and approval	4
Builder's Work to Treatment Room and maze	12
Installation, Test & commissioning of machine by Varian for compliance with Varian Standard Acceptance Test Protocol	tbc

#### LA1 Works Including Additional Radiation Protection Option 2 (Scheme SK3)

Duration in working weeks	16
Design Period and approval	4
Builder's Work to Treatment Room and maze	12
Installation, Test & commissioning of machine by Varian for compliance with Varian Standard Acceptance Test Protocol	tbc

## **Draft Contractor's Proposals for budget**

### **APPENDIX B: DRAWINGS FORMING CONTRACTOR'S PROPOSALS**

Felce & Guy Drawings 2186/254/SK1, SK2, SK3

## Draft Contractor's Proposals for budget

### APPENDIX C: PROPOSED BUDGET BUILDERS WORK IN CONNECTION WITH LINEAR ACCELERATOR INSTALLATION

Varian budget to design, execute and construct the enabling works necessary to install the new linear accelerator within the programme indicated from commencement to handover of room for Varian machine installation and inclusive of all necessary Consultants Fees and Statutory charges for the sum of **£290,000.00 (Two Hundred and Ninety Thousand Pounds) excluding VAT**

#### Cost Options

The following are items offered as below line budget cost options. Please note that these are **not included** in the above sums. Before establishing an overall cost the Employer can instruct any or all of the items listed to be incorporated into the total sum or leave them excluded.

Additional Cost for inclusion of radiation protection works as indicated on Drawing SK2 **£123,000.00**

Additional cost for inclusion of radiation protection works as indicated on Drawing SK3 **£130,000.00**

Control area lighting **£3,000.00**

Additional lighting to newly formed entrance **£2,100.00**

Sky Art panel **£3,900.00**

Treatment Room DX Air Conditioning **£6,500.00**

Control room DX Air conditioning **£6,000.00**

Installation of new single phase sub – main **£3,500.00**

Switch panel modifications **£1,800.00**

Service alterations around proposed new room entrance **£2,100.00**

#### Payment terms

Payment to Varian is on the basis of 100% on completion of the works inclusive of any agreed variations. Varian reserve the right to request interim payments should the programme of works be delayed for reasons outside of their control or where there is a significant change in the scope of works due to instructed variations



## **Draft Contractor's Proposals for budget**

### **APPENDIX D: DESIGN TEAM AND PROFESSIONAL INDEMNITY INSURANCE**

#### **TEAM MEMBERS**

- 1 Architect and Principal Designer  
Felce and Guy Partnership  
Studio 5  
English Close  
Hove  
East Sussex  
BN3 7ET  
  
Professional Indemnity Insurance £10,000,000.00
  
- 2 Quantity Surveyor and CDM Advisor  
Julian Church and Associates Ltd  
12 Bath Place  
Worthing  
West Sussex  
BN11 3BA  
  
Professional Indemnity Insurance £2,000,000.00
  
- 3 Structural Engineers  
Hemsley Orrell Partnership  
HOP House  
41 Church Road,  
Hove  
BN3 2BE  
  
Professional Indemnity Insurance £2,000,000.00
  
- 4 Mechanical and Electrical Consultants  
Air Conditioning Engineers Limited  
Unit 7  
Mill Industrial Estate  
Kings Caughton  
Nr Alcester  
Warwickshire B49 5QG  
  
Professional Indemnity Insurance £2,000,000.00
  
- 5 Principal Contractor  
Rocare Building Services Ltd  
Rossland House  
Headlands Business Park  
Salisbury Road

## **Draft Contractor's Proposals for budget**

Blashford  
Ringwood  
BH24 3PB

Professional Indemnity Insurance £5,000,000.00

## Appendix C1

**From:** [Paul Hampton](#)  
**To:** [John Chapman <john.chapman@felceandguy.co.uk>](#) ([john.chapman@felceandguy.co.uk](#))  
**Subject:** 2186. MAIDSTONE BUNKER LA1 UPDATED CONTRACTORS PROPOSALS  
**Date:** 16 November 2016 14:45:50  
**Attachments:** [image001.gif](#)  
**Importance:** High

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Hi John

I am just writing following the request from the Hospital for refreshed costings and update following the e mail from Stephen Duck indicating that the preferred scheme would be to go with the SK2 option

I have reviewed the previous draft set of contractors proposals issued in March 2016 and as you will appreciate this was a draft document and as such contains a number of items that need to be firmed up and that are subject to further testing and survey in order to confirm if the assumptions made in our draft apply or if further works may be required to provide compliance with the DDR

In terms of the room cost I can confirm that our indicative figure of £290,000.00 will still apply but subject to the following

### PC and Provisional sums

The following allowances are included as noted under item 24 of the CP. All will need to be adjusted or omitted if not required I have noted each of the items and included a risk analysis next to each one

PC Sum for Fire Alarm Installation executed by a Hospital nominated Sub contractor  
**£3,500.00** the cost of these works is normally established once works start on site; the amounts we have allowed are based on historical data and are therefore considered to be low risk

PC Sum for Data Installation executed by a Hospital Nominated Sub Contractor  
**£2,800.00** - ditto

PC Sum for BMS connections executed by a Hospital Nominated Sub Contractor  
**£2,800.00** - ditto

Provisional sum for three phase site temporary supplies for concrete cutting equipment  
**£1,150.00** - ditto

Provisional Sum for Structural floor alterations **£14,000.00** we do not have any details on the existing floor structure so cores will need to be taken to establish the construction and the works designed accordingly; this is considered to be a medium risk as the costs allowed are based on previous historical costs for similar installations

Provisional Sum for Out of Hours working **£5,000.00** again this is considered as a medium risk due to the extent of the floor works not yet being established

The following items are noted in the CP as requiring confirmation and are based on assumptions currently and are therefore subject to survey ; The results of the survey could require upgrades or additional works

Existing HVAC it has been assumed that the existing HVAC systems are capable of providing

the correct environmental conditions required. This is considered to be a high risk item until such time as the systems have been tested surveyed and the capabilities verified

Chiller location and pipework. CP currently allows for external location with existing pipework extended to suit actual location; costs therefore assume that the existing pipework is suitable to be reused. This is considered to be a medium risk until such time as the systems have been tested surveyed and the capabilities verified

Domestic water service pipework. CP allows for connections to existing pipework ; costs therefore assume that the existing pipework is suitable to be reused. This is considered to be a medium risk until such time as the systems have been tested surveyed and the capabilities verified

Power supplies CP assumes that there is sufficient power available to service the new equipment this is considered to be high risk item until such time as the systems have been tested surveyed and the capabilities verified

Radiation shielding WE are aware that the Hospital wish to go ahead on the basis of the option shown on drawing SK2. The figure given of £123,000.00 is a below line budget and will be subject to final confirmation at which point it can be added to the CP value. This will be low risk unless the specification of the rating or materials to be used are amended

#### Cost options

The CP indicates a number of cost options and budgets for additional works. All the figures are below line and not included in the CP total. Further instructions to be given as to whether any of these options are to be taken up in which case the budget figures can be firmed up

Radiation protection works as drawing SK2 **£123,000.00** see above

Control area lighting **£3,000.00**

Additional lighting to newly formed entrance **£2,100.00**

Sky Art panel **£3,900.00**

Treatment Room DX Air Conditioning **£6,500.00**

Control room DX Air conditioning **£6,000.00**

Installation of new single phase sub main **£3,500.00**

Switch panel modifications **£1,800.00**

Service alterations around proposed new room entrance **£2,100.00**

I hope that this will assist but let me know if you have any queries or require any additional information

Kind regards

Paul



**Paul Hampton**

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