Trust Board Meeting ('Part 1') - Formal meeting, which is open to members of the public (to observe)

Wed 22 December 2021, 09:45 - 13:00

Virtual Meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrIuzYSc29211EQ).

12-1
To receive apologies for absence

David Highton

12-2
To declare interests relevant to agenda items

David Highton

12-3
To approve the minutes of the 'Part 1' Trust Board meeting of 25th November 2021

David Highton

Board minutes, 25.11.21 (Part 1).pdf (9 pages)

12-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (1 pages)

12-5
Update on the issues relating to Kent Police's Operation Sandpiper

David Highton and Steve Orpin

Update on the issues relating to Kent Police’s Operation Sandpiper - December 2021.pdf (3 pages)

12-6

Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

12-7
Report from the Chief Executive

Steve Orpin

Chief Executive's report - December 2021.pdf (2 pages)

Reports from Trust Board sub-committees

12-8
Quality Committee, 08/12/21

Sarah Dunnett

Summary of Quality C'ttee, 08.12.21.pdf (2 pages)

12-9
Finance and Performance Committee, 20/12/21

Neil Griffiths

N.B. The report will be issued after the meeting on 20/12/21.

12-10
People and Organisational Development Committee, 17/12/21

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 17.12.21.pdf (2 pages)

12-11
Patient Experience Committee, 02/12/21 (incl. approval of revised Terms of Reference)

Maureen Choong

Summary of Patient Experience Committee, 02.12.21 (incl. revised terms of reference).pdf (5 pages)

12-12
Charitable Funds Committee, 23/11/21 and 15/12/21 (incl. approval of revised Terms of Reference and approval of Annual Report and Accounts of the Charitable Fund, 2020/21))

David Morgan

Summary of Charitable Funds Cttee, 24.11.21 (incl. revised terms of reference).pdf (5 pages)
Summary of Extraordinary Charitable Funds Cttee, 15.12.21 (incl. ARA 2020-21).pdf (40 pages)

Integrated performance report

12-13
Integrated Performance Report (IPR) for November 2021

Steve Orpin and colleagues

Integrated Performance Report (IPR) for November 2021.pdf (32 pages)

Planning and strategy

12-14
The impact of the potential growth in COVID-19 positive cases on the Trust's winter plan

Sean Briggs

The report will follow.

12-15
U pdate to capital programme funding and expenditure approvals 2021/22

Steve Orpin

Update to capital programme funding and expenditure approvals, 2021-22.pdf (3 pages)

12-16
To approve a Business Case for Increasing Elective Orthopaedic Capacity

Sean Briggs

To approve a Business Case for Increasing Elective Orthopaedic Capacity.pdf (108 pages)

12-17
To approve a Business Case for an Oncology Modular Building

Sean Briggs

To approve a Business Case for an Oncology Modular Building.pdf (34 pages)

Quality items

12-18

Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds

Peter Maskell and Joanna Haworth

Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds.pdf (6 pages)

12-19
Quarterly mortality data

Peter Maskell

Quarterly Mortality report - December 2021.pdf (20 pages)

12-20
To consider any other business

David Highton

12-21
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960,representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH NOVEMBER 2021, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director (until item 11-26)	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Naomi Butcher	General Manager, Cancer Performance (for item 11-23)	(NB)
	Katie Goodwin	Divisional Director of Operations, Cancer Services (for item 11-23)	(KG)
	Henry Taylor	Consultant Clinical Oncologist - Cancer Services (for item 11-23)	(HT)
	Charlotte Wadey	Director of Nursing and Quality, Cancer Services / Lead Cancer Nurse (for item 11-23)	(CW)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

[N.B. Some items were considered in a different order to that listed on the agenda]

11-6 To receive apologies for absence

There were no apologies, but it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

11-7 To declare interests relevant to agenda items

SDu declared that she was a Non-Executive Director at East Kent Hospitals University NHS Foundation Trust.

11-8 To approve the minutes of the meetings of 28th October 2021 and 11th November 2021

The minutes of the meetings of the 28th October 2021 and 11th November 2021 were approved as true and accurate records of the meetings.

11-9 To note progress with previous actions

The content of the submitted report was noted.

Monthly performance

11-10 Update on the issues relating to Kent Police's Operation Sandpiper

DH firstly expressed on behalf of the Trust Board the revulsion felt at David Fuller's activities, and repeated the apology that MS had expressed to the families of the victims when they had been

informed of such activities. DH continued that he was deeply sorry that the events had happened at the Trust, and although the catalogue of Fuller's crimes extended well beyond the Trust, DH's main concern was that the Trust learned all the lessons that could be learned, and did everything in its power to support the victims' families in any way it could.

MS then referred to the submitted report and highlighted the following points:

- The Secretary of State for Health and Social Care had announced that an independent inquiry would be established, to be chaired by Sir Jonathan Michael. An interim report from the inquiry was expected to be produced early in 2022, which would focus on what happened at the Trust, while the second phase would address the national questions more fully. The Trust would cooperate fully with the inquiry.
- NHS England/Improvement had asked all Trusts to submit a form relating to mortuary security, & the Trust had submitted a return that confirmed it was fully compliant with all the requirements.

MC asked for further clarification on what the independent inquiry would mean, as the Trust had already commissioned Sir Jonathan Michael to undertake an internal investigation. DH replied that the Secretary of State had effectively taken over the investigation that the Trust Board had commissioned, so the Trust Board would no longer receive a report directly from Sir Jonathan Michael. DH continued that there would inevitably be some delay, as the inquiry would need to establish and agree its own Terms of Reference and practical arrangements, while the scope would be wider, and may include, for example, Local Authority mortuaries and funeral directors.

RF welcomed the inquiry and the support being given to the victims' families by the Trust but asked when the Trust would be able to speak publicly about the matter. MS confirmed that, as a principle, the Trust would speak publicly whenever it could, but two important constraints were in place. MS continued that the first constraint was the fact that the Police investigation into Fuller's activities was ongoing, and there may be further charges brought in 2022, so the Police had asked the Trust not to do anything that would compromise that investigation. DH added that the aforementioned independent inquiry would also prevent the Trust from commenting publicly at that stage.

SDu asked whether it was possible to give more detail about the Trust's engagement with the victims' families, and the support to Trust staff. MS firstly replied that the support to the families had been, and remained, the Trust's number one priority. MS then reported that the Police Family Liaison Officers had visited the families and made available a wide range of support that had been commissioned from Victim Support; while the Trust had established a telephone call back team who had contacted the families that had given their consent for such contact. MS continued that the support was ongoing and would remain in place for as long as the families wanted it; and there had been a wide range of responses from families, although one of the main themes had been the need for the families to maintain their anonymity, so the support provided had been designed with that in mind. MS then stated a range of support had been made available to the Trust's staff more generally, as well as the staff who had been most affected by the case.

JW asked how the Trust had liaised with external regulators in relation to the case. DH explained that DH and MS had met with the Chief Inspector of Hospitals at the Care Quality Commission (CQC) to notify them, very soon after the Trust had been notified, and they had been kept informed throughout. DH added that the mortuary was licenced by the Human Tissue Authority (HTA), and the Trust had been subject to HTA inspections in 2015 and 2018, and on both occasions the licence had been renewed. DH then confirmed that all regulators had been kept informed throughout.

11-11 <u>Report from the Chair of the Trust Board</u>

DH referred to the submitted report and highlighted the key points therein, which included that Cedi Frederick had been appointed as the Chair Designate of the Kent and Medway NHS Integrated Care Board (ICB), while Paul Bentley had been appointed as the Chief Executive Designate. DH continued that the 'designate' label reflected the fact that the legal Act that would formally establish ICBs had not yet been passed. DH noted that Mr Bentley had previously been the Director of Strategy and Workforce at the Trust, so knew the organisation well. DH then noted that the ICB would have implications for the Trust, although NHS Trusts would remain sovereign bodies, and ICB governance would be discussed at the next Trust Board 'Away Day', which was scheduled for w/c 29/11/21.

11-12 Report from the Chief Executive

MS referred to the submitted report and highlighted the key points therein, which included that the Secretary of State for Health and Social Care had announced that Kent and Medway would have three Hyper-acute Stroke Units (HASUs)/Acute Stroke Units. MS noted that SB would report further details under item 11-20, but MS wanted to thank all those involved in the stroke service, which had achieved an 'A' rating under the Sentinel Stroke National Audit Programme (SSNAP).

MS then gave further details of the staff support being made available during the current pressures; reported the current status of the staff vaccination programme; and highlighted that the Trust's Community Diagnostic Centre had now opened at Hermitage Lane, Maidstone, close to Maidstone Hospital (MH).

EPM asked whether the Trust's vaccination programme included Bank and Agency staff and also staff from the third-party companies that worked in the hospitals. MS replied that the programme applied to all those who worked on site.

Reports from Trust Board sub-committees

DH explained that the order of agenda items had been changed from previous meetings, to enable the reports from the Trust Board sub-committee to be considered first.

11-13 Quality Committee, 10/11/21

SDu referred to the submitted report and highlighted the following points:

- The five clinical divisions had given their reports and there had been common themes of staffing challenges; the flow of patients through the hospitals; and increased violence and aggression from patients and visitors not wearing face masks. SDu understood that for the latter point, a case was being developed by the Surgery Division for the use of body cameras; and while SDu welcomed the joint communication on "Abuse: Not in a day's work" that had been issued by MS and the other Chief Executives in the health economy on 15/11/21, she wondered whether that message had gone far enough, as the Trust needed to be clear that abuse would not be tolerated in any form, and the action to be taken by the Trust needed to be clear.
- More work would be undertaken in relation to nasogastric tube placements.
- Sepsis would be included as a separate standing agenda item at the Committee in the future, in response to the delays in the sepsis programme that had arisen due to the COVID-19 pandemic.

MS referred to the violence and aggression point, and noted that the Trust had 'zero tolerance' policies and procedures, and would not tolerate violence and aggression, but it was also important to deal with patients and families in a way that accorded with the Trust's values, and that kindness was used in interactions. SDu acknowledged the point but noted that, for example, sonographers often worked in confined environments, and faced a risk when those in the same room refused to wear a mask. MS acknowledged the point.

11-14 Finance and Performance Committee, 23/11/21

NG referred to the submitted report and highlighted the following points:

- The Trust continued to perform very well in the face of continuing increased clinical demand, however the increasing number of Medically Fit for Discharge (MFFD) patients was becoming a problem.
- The format of the Integrated Performance Report (IPR) had been discussed and it was noted that the new format would be introduced in January 2022.
- An update on the Electronic Patient Record (EPR) implementation was given, which included the outage that had occurred in October 2021.
- The latest position on the work regarding the future of the laundry services was reported, and it was noted that further work was required before a proposal was submitted to the Committee.
- The Committee had recommended that the Trust Board approve the paediatric Emergency Department (ED) Business Case that had been submitted under item 11-22, although the revenue costs would be reviewed further, to consider whether these could be reduced.

11-15 People and Organisational Development Committee, 18/11/21 (incl. Guardian of Safe Working Hours Annual Report 2020/21)

EPM referred to the submitted report and highlighted the following points:

- Some new methods had been tried to increase the completion rate for the NHS Staff Survey.
- SO and SS had given a helpful update on the strategy deployment/catchball process.
- A Business Case for investment in the People and culture structure and operating model had been discussed.
- The Guardian of Safe Working Hours report was included in the summary report.

11-16 Audit and Governance Committee, 03/11/21 (incl. approval of revised Terms of Reference

DM referred to the submitted report and highlighted the following points:

- The main topic of discussion had been the risk register, and the red-rated risks, and it was noted that the process worked well and there was good documentation, but some assurance was required on the discussion of the risks. It was therefore agreed that the lead for each red-rated risk would give further details of where the risk had been discussed and debated. However, the Committee had no specific areas of concern.
- The external auditor's progress report did not raise any areas of concern.
- There had been previous issues with estates procurement, but the Committee had heard that the position had much improved.
- The Committee's revised Terms of Reference need to be approved, and the main change reflected the previously agreed position regarding the Board Assurance Framework (BAF).

EPM asked for an update on the development of the IPR and the link with the BAF. DM stated that the new version of the IPR was being developed, and would be submitted to the Trust Board in January 2022. KR then clarified that the Trust Board had agreed that the BAF would be replaced by the Strategy Deployment process, so asked SO to give an update on that process. SO pointed out that the Strategy Deployment process was very closely linked to the new IPR, so suggested it would be sensible for the Trust Board to reassure itself on its previous decision regarding the BAF once the new IPR had been considered. DH agreed that would be sensible.

The revised Terms of Reference were then approved as submitted.

11-17 Charitable Funds Committee, 24/11/21

DH noted that the Committee had only met on 24/11/21, and a written report would be submitted to the Trust Board in December 2021. DM therefore just reported that the entire fundraising strategy needed further work, and would probably be submitted to the Trust Board in January 2022.

Integrated Performance Report

11-18 Integrated Performance Report (IPR) for October 2021 (incl. response to the issues in the letter sent by NHS England / Improvement on 26/10/21 regarding ambulance handover delays; and the latest position on inpatients waiting to be discharged)

JH firstly referred to the "Safe" domain and highlighted the following points:

- Staffing levels had adversely affected many of the metrics.
- There had been four COVID-19 outbreaks, in four separate areas, but the situation was now under control, and areas for action had been identified in relation to patient swabbing.
- C-Diff rates had reduced in October 2021 & November 2021. This reflected the national position.
- Falls continued to be higher than the target, and the majority of falls were unwitnessed falls at Tunbridge Wells Hospital (TWH). A Falls Task Force had now started to meet and had agreed to progress some initiatives, which related to improving the management of delirium, the Mental Capacity Act, and additional aids and enhanced care.

PM then referred to the "Effective" domain and highlighted the following points:

- The actual data for the "Stroke: Best Practice (BPT) Overall %" metric on page 7 of the submitted report should be the figures stated on page 10 rather than the 20% stated on page 7.

- The Hospital Standardised Mortality Ratio (HSMR) was stable, and the Trust's physicians were in the process of introducing a new rota to ensure the service provided at the weekend was as good as that provided during the week.

SDu noted that several outpatient Key Performance Indicators (KPIs) were listed in the "Consistently Failing" section and asked for a response. PM gave his initial response but then deferred to SB, who explained that the outpatient transformation programme had been adversely affected by the wider pressures experienced by the Trust, so SB had asked the programme team to focus on a smaller number of KPIs, and the original timescale for improvement would be delayed. MS however emphasised the negative impact that the COVID-19 pandemic had had & pointed out that the Trust had made significant progress, given that context. MS also however noted that SDu's question had provided a timely reminder of the need to focus on the areas that were important for patients.

JH then referred to the "Caring" domain and highlighted the following points:

- Complaints response performance had improved for October 2021, but there had been a large number of complaints in November 2021, and that would likely have an adverse impact on response rate performance for that month.
- A working group had been established to explore the performance on Friends and Family Test (FFT) response, and a problem had been identified with the provider's data, so once that had been addressed the Trust's response rate should improve. JH was also undertaking work to consider whether the target for the FFT response for outpatients should be reduced, to reflect the performance targets of other Trusts within the Kent and Medway Integrated Care System (ICS).

SB then referred to the "Responsive" domain, as well as the "the latest position on inpatients waiting to be discharged" and "Improvement on 26/10/21 regarding ambulance handover delays" reports, and highlighted the following points:

- The 62-day cancer waiting time target had now been passed for 27 months in a row, and the Kent and Medway Cancer Alliance had been invited to parliament to discuss how that success had been achieved.
- The Trust's 52-week waiting time recovery had been one of the best in the country, and it was hoped that the Trust would have no patients waiting more than 52 weeks during w/c 29/11/21.
- Diagnostic performance had been affected by some problems in equipment and other issues, but a task force had been established to improve performance on diagnostics.
- The Trust's performance on the ED 4-hour waiting time target continued to be one of the best in the country.
- Despite the Trust's comparative performance, the current period was very challenging, particularly as the number of inpatients waiting to be discharged had increased (and was the highest in the region) and had a wider impact on patient flow, which was a factor in the current level of ambulance handover delays.

SB then referred to the latter points and elaborated on the actions being taken by the Trust to address the issues, which included the major drive to optimise the use of the Ambulatory Emergency Care (AEC) service, that had started to reap some benefit. SB however emphasised that December and January would be very challenging for the Trust.

SDu noted that the latest monthly performance was identical to the year to date performance for several KPIs in the "Responsive" domain of the IPR, such as "Reset and Recovery Programme - Elective Care" and "Reset and Recovery Programme – Cancer Services", so queried whether that was correct. SB agreed to check.

Action: Check whether the reporting of identical data for the "Latest" and "YTD" performance for several KPIs in the IPR that was submitted to the Trust Board meeting on 25/11/21 (such as "Reset and Recovery Programme - Elective Care" and "Reset and Recovery Programme – Cancer Services") was correct or an error (Chief Operating Officer, November 2021 onwards)

SDu then referred to the access to diagnostics, and stated that it was not clear what the timescale was for the recovery. SB stated that he had set a timescale to recover by the end of March 2022, although there were some particular problems, such as with DEXA scanning, and it may be optimistic to expect the position to be recovered by that date, so the deadline may need to be extended.

DH asked about ambulance diverts and asked whether the decision was a hospital-to-hospital discussion or a decision made by the Bronze Commander at South East Coast Ambulance Service NHS Foundation Trust (SECAmb). DH also asked whether dynamic conveyancing would make a difference. SB confirmed that at present, divert decisions were being made collectively through the ICS, but expressed concern that dynamic conveyancing, under which SECAmb would make decisions regarding the destination of ambulances, and diverts, would not provide the full context of the position at each hospital, as SECAmb did not have access to all the relevant information. PM added that the real risk associated with ambulance handover delays was undifferentiated and unassessed patients waiting at home for a response from an ambulance, not patients waiting slightly longer outside a hospital, although PM accepted that the latter reduced SECAmb's capacity in relation to the former. PM then also concurred with SB's views regarding dynamic conveyancing.

SO then referred to the financial aspects of the "Well-led" domain & highlighted the following points:

- There was a technical 'blip' in the expenditure data, as a result of an accounting change, but that would be corrected in the future.
- The Trust was behind on the delivery of its internal Cost Improvement Programme (CIP) target, although it was delivering the national requirement, so the CIP was not having an adverse impact on the overall financial position.
- The cash position was good.

SS then referred to the workforce aspects of the "Well-led" domain & highlighted the following points:

- The top priority was on staffing resourcing levels, and although the staffing establishment had increased as a result of investment into expanded services, the vacancy rate was higher than the plan, although the Trust's rate was aligned with the rates at other local NHS Trusts.
- A range of work was underway to recruit additional staff, including some recently-launched programmes for specific areas of risk.
- The staff turnover rate was an area of concern, so work was underway to increase staff retention.
- The year to date actual rate for sickness was circa 4.1% rather than 0% that had been erroneously reported on page 20 of 32.

DM acknowledged the importance of retaining staff, but emphasised the difference between staff that left the Trust to obtain promotion at other NHS organisations, and those that left the NHS completely i.e. regretted losses. SS confirmed that it was feasible to categorise the staff leaving in such a way and confirmed that was undertaken.

MC referred to the "Executive Summary Scorecard" on page 7 of 32 and asked whether there was a timeline for having Statistical Process Control (SPC) data for all KPIs. SS confirmed that she would expect the projections to be able to be reported in the next IPR, but SO clarified that some of the KPIs had deliberately not had SPC data included, such as "Surplus (Deficit) against B/E Duty", as they did not align with the SPC process, although the aforementioned new format of the IPR would contain fewer such KPIs.

Planning and strategy

11-19 <u>Nursing and Midwifery staffing review (mid-year update)</u>

JH referred to the submitted report and highlighted the following points:

- There had been an increase in establishment of circa 200 Whole Time Equivalents (WTEs) in response to service developments and adaptation to pathways. This had therefore resulted in an increase in vacancies.
- The guidance recommended a full review at the mid-year point, but JH had, in consultation with colleagues, decided that a desktop review would be the best option, given the current challenges with vacancies and operational demands.
- The review had showed that establishments were broadly were they needed to be, but there were some concerns in relation to night-time staffing at TWH. A shortened establishment review would therefore be undertaken for such areas, using established methodologies, before the next scheduled full review in April 2022.
- The nursing vacancy rate across areas ranged between 9% and 30%, so work was underway with the 'hot spots', and a range of initiatives had been implemented in response.

- The primary focus over the next six months would be on recruitment initiatives and clinical skills facilitation for new and existing nurses.
- JH wanted to also develop a safe staffing policy over the next six months, to encompass escalation, rostering and individuals' expected roles and responsibilities.

DH asked about the 32-day target for the employment checks and asked whether additional resources were required to ensure the target was met. JH noted that an individual's notice period was set although the Trust negotiated these with external employers; and added that some metrics had been set for each stage of the recruitment process, which had helped improve the position.

RF referred to the statement on page 5 of 10 that "Plans are being developed to recruit to turnover" and asked for further details. JH elaborated on the details and gave assurance on the underlying work. DH also gave his support for recruiting to turnover.

NG asked what impact the aforementioned larger number of MFFD patients had had on staffing. JH replied that the largest impact would likely be on staff morale.

JW asked whether there had been much movement of staff from social care to the NHS because of the mandatory vaccination programme in social care. JH stated that the data would need to be monitored, but noted that the NHS would itself require a mandatory vaccination in the future.

11-20 Update on stroke services

DH firstly pointed out the East Kent HASU would be at the William Harvey Hospital in Ashford, not the Kent and Canterbury Hospital, as the submitted report had stated. SB then referred to the submitted report and highlighted the key points therein. PM then again commended the Trust's stroke team for their response to the challenging circumstances they had faced and their work in delivering an 'A' rating on the SSNAP.

11-21 The Trust's planning submissions for the second half (H2) of 2021/22

AJ referred to the submitted report and highlighted the following points:
- A Referral to Treatment (RTT) trajectory was not required to be submitted, but this had been included for the Trust Board's information.
- The only aspect that was non-compliant with the requirements was endoscopy activity, as lower levels of colonoscopy and flexi sigmoidoscopy activity were expected because of the introduction of the Quantitative Faecal Immunochemical Test (qFIT) in the community, as well as the already-known impact of the Trust now not providing a bowel scope service.
- The key risk to the plan was the potential disruption to elective activity during the winter period. However, the plan represented a good balance between ambition and deliverability.

SO then highlighted the following points:
- The targets within the plan would be included in the aforementioned revised IPR.
- A balanced financial plan had been submitted, although that balance had been achieved by the inclusion of non-recurrent income, so SO was aiming to secure further recurrent funding.
- The Trust had now secured agreement of £1m for H2 and £2m for non-elective activity, and SO would liaise with SB and AJ regarding that funding, some of which would be allocated to the Business Case for the paediatric ED at TWH.
- The Trust still however had some contingency available to respond to unforeseen developments.

EPM asked about the link between current recruitment and the financial plan. SO explained the approach and noted that the £5.1m of "Pay Increase" shown on page 13 of 15 included the additional staff that were expected to be recruited. DH added further context.

11-22 To approve the Business Case for the reconfiguration of the paediatric Emergency Department at Tunbridge Wells Hospital

DH referred to the submitted report and reiterated, as NG had stated under item 11-14, that the Finance and Performance Committee had recommended that the Business Case be approved by

the Trust Board, on the understanding that the revenue costs would be reduced. The Trust Board duly approved the Case subject to that condition.

DM queried whether the "Build – Handover", which was listed in the report as being for 18/01/22 was achievable. SO confirmed that would be achievable and explained that the programme had been in progress for some time, and the delay had been in the development and submission of the Business Case, not in the building project.

DM also asked whether the Case would be affected by the introduction of International Financial Reporting Standards (IFRS) 16 (Leases). SO confirmed there would be no effect, as the Case was an outright capital purchase.

11-23 <u>Kent and Medway Cancer Services: Oncology Review</u>

HT referred to the submitted report and highlighted following points:

- HT would like to thank the Executive Team for their support to oncology over the years.
- The Trust Board was asked for support in relation to the region-wide Service Level Agreement (SLA) review with individual providers, and the overall funding allocation for oncology in the region. The Trust Board was also asked to help drive and steer the region-wide actions in Appendix 4, across Kent, via the ICS and Cancer Alliance; and to agree the funding requested in Appendix 3.

DH noted that the Cancer Alliance and the ICS were coterminous, which was not the same in other parts of the country, so wondered whether that had been beneficial. HT confirmed that had been the case.

DH also noted that the Trust provided chemotherapy for the Trust's patients so asked whether patients waiting longer for treatment at other Trusts was considered by the Cancer Alliance. HT replied that the Cancer Alliance had not, to date, taken responsibility for performance, although that may change in the future, depending on the relationship with the ICS and ICB.

SDu commended the report, which she stated was one of the best she had ever read, but asked why there were apparently different access opportunities for patients based on different contractual arrangements. HT explained that there were differences in workforce among Trusts and geographical areas; and also in service provision, as radiotherapy was overseen by the cancer centre, but individual Trusts in the ICS were responsible for the provision of chemotherapy. HT continued that there may be an argument for a common SLA to help ensure there was equity across geographical areas.

MC asked whether anything in the report required consultation, and if so, whether anything could be said to reassure patients and the public. HT confirmed that no services were intended to be withdrawn, although there would be a desire to address inequity of access.

RF referred to the 14% growth in clinical demand, and remarked that although the Trust had continued to deliver the cancer access targets despite such growth, the resources identified in Appendix 3 of the report would only enable the Trust to return to baseline levels, so RF would strongly support the recommendations. RF also noted that the success of cancer treatments had led to patients surviving longer, which would require additional funding, so queried whether that had been covered within Appendix 3. HT stated that it had been recognised that the shift towards cancer being a chronic disease represented a funding challenge, and further discussions would be required at a national level.

RF also accessed about equity of treatment, particularly with regards to East Kent, and queried whether enough was being done to address that. HT stated that the main issue related to radiotherapy and there was a balance between offering centralised expertise and the associated travel times, but the ambition was to offer the best quality radiotherapy treatment at both MH and the Kent and Canterbury Hospital.

MS welcomed the Trust Board's support in prioritising the securing of the investment that was required in the Trust's cancer service, and noted the need to make further steps in relation to

workforce; but emphasised the need for the ICS as a whole to secure significant additional funding to realise the ambition described in the submitted report, and that would therefore be the focus of future work. The point was acknowledged.

DH then noted that it would be helpful for DH to liaise with HT to better understand the "IT and systems" section of the report, as DH was the 'critical friend chair' for the ICS-wide digital strategy. DH therefore suggested he liaise with HT outside the Trust Board meeting and HT agreed.

Quality Items

11-24 Care Quality Commission (CQC) State of Care 2020/21 – Key findings and implications for the Trust

JH referred to the submitted report and highlighted the following points:

- The report highlighted the importance of health inequalities related to the impact of the COVID-19 pandemic; as well as increased demand for mental health services, particularly in young people. The report also highlighted the slow pace of improvement in maternity services, and the work that was required in relation to Deprivation of Liberty Safeguards.
- The next steps including discussing the report at the Trust's Quality Improvement Committee and with the Divisional triumvirates; and evaluating the Trust against the report to consider the immediate actions and 'quick wins'.

SDu stated that the content of the report felt like an agenda for a wider audience than an acute Trust, so asked how the ICS was addressing such issues. JH replied that she and PM had been working with the Integrated Care Partnership (ICP), to consider what the ICP's quality priorities should be, and although such discussions were in their infancy, the State of Care report would provide a useful platform for such discussions.

Assurance and policy

11-25 Update from the SIRO (incl. the current position on the Data Security and Protection Toolkit for 2021/22)

JH referred to the submitted report and highlighted the key points therein, which included that the Trust was meeting its obligations regarding information governance, as JH had taken over the role as the Trust's Senior Information Risk Owner (SIRO). JH also noted that the Trust had made a 'Standards Met' Data Protection and Security Toolkit submission for 2020/21.

11-26 Six-monthly update on Estates and Facilities

MS referred to the submitted report and highlighted that given the scale of the work required on the Trust's various Estates schemes, MS had transferred the responsibility for Facilities to SB, to enable the Director of Estates and Facilities to focus solely on Estates. DH asked whether a single facilities manager oversaw the facilities functions. MS confirmed that all the facilities functions would report directly to one of the Deputy Chief Operating Officers, apart from security, which would be overseen by the Director of Emergency Planning & Communications.

11-27 To consider any other business

KR asked the Trust Board to delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to make decisions regarding the Kent and Medway Medical School (KMMS) accommodation. The requested authority was duly granted.

11-28 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Log of outstanding actions from previous meetings **Chair of the Trust Board**

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
11-18	Check whether the reporting of identical data for the "Latest" and "YTD" performance for several KPIs in the IPR that was submitted to the Trust Board meeting on 25/11/21 (such as "Reset and Recovery Programme - Elective Care" and "Reset and Recovery Programme – Cancer Services") was correct or an error.	Chief Operating Officer	December 2021	The data was reported correctly.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
10-14	Review the categorisation of the themes included in the "Other" category in the "Data Collection; Concerns Raised" section of future quarterly reports from the Freedom to Speak Up Guardian	Deputy Freedom to Speak Up Guardian	January 2022 onwards	This will be addressed when the next quarterly report from the Freedom to Speak Up Guardian is submitted to the Trust Board (in January 2022).

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the issues relating to Kent Police's Operation Sandpiper	**Chair of the Trust Board; and Chief Executive**

The enclosed report provides an update on the issues relating to Kent Police's Operation Sandpiper

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Update on Operation Sandpiper

Background

David Fuller received two whole life prison sentences at Maidstone Crown Court on 15 December for the murders of Wendy Knell and Caroline Pierce in Tunbridge Wells in 1987. He also received a concurrent 12-year term for a number of other crimes, including sexual offences carried out in the mortuaries at the Kent and Sussex Hospital and Tunbridge Wells Hospital. These were committed while Fuller worked as an NHS maintenance supervisor and then as an employee of Interserve/Mitie.

Family support

Our priority has been to work with the Police and Victim Support to offer whatever help or assistance the families of Fuller's victims may need. We have put in place a substantial package of support and have been in contact with all the families and met with a number of relatives. The support we are offering to families is open-ended and we will offer help for as long as they may need it.

Inquiry

In February the Trust commissioned an investigation, independently chaired by Sir Jonathan Michael, into the mortuary offences. Last month the Secretary of State for Health and Social Care, Rt Hon Sajid Javid MP, announced that a non-statutory inquiry will replace the Trust commissioned investigation and will report directly to the Secretary of State. The inquiry will continue to be led by Sir Jonathan Michael. Phase one will focus on what happened in our hospital mortuaries and then determine any questions that arise for the NHS more widely and for other settings such as undertakers and non-NHS mortuaries. Phase two will address those broader national questions. The Trust has already shared all the material from our own internal inquiry with Sir Jonathan and we will continue to give his inquiry our full support and co-operation and allow him to publish his interim report before making any further public comment.

Compensation scheme

The Trust has told the families we will work with them to establish a fair and proper process for compensation and we are keen to progress this quickly. The Secretary of State for Health has now asked MTW to work with the families and NHS Resolution to agree the compensation scheme.

Public comment

Following the sentencing hearing on 15 December the Trust issued the following statement to the media.

Miles Scott, Chief Executive, said:

"Today in court we heard many deeply distressing accounts of the impact that David Fuller's crimes have had on the families of his victims. I would like to apologise once again for the hurt that has been caused to families as a result of these appalling crimes.

We have been in contact with the families affected in recent weeks and our priority continues to be to provide them with any help or assistance they may need for as long as they may need it.

As requested by the Secretary of State, we will work with the families and NHS Resolution to agree a compensation scheme without the pain and delay that may be caused by individual claim action.

We remain committed to complete openness and transparency around the criminal activities committed by Fuller, as we support Sir Jonathan Michael's investigation. We will make any further improvements recommended from the Independent Inquiry, and we have undertaken a risk assessment of our mortuary including assuring ourselves against existing Human Tissue Authority guidance."

While the Trust wants to make public as much as we can when we can there are two important considerations that limit what we can say at the present time. We have a duty to support Sir Jonathan

Michael's independent inquiry and to allow him to publish his interim report before making any further public comment. Additionally, the Police investigation into Fuller is ongoing and we cannot do or say anything that may prejudice future legal proceedings."

Report from the Chair of the Trust Board **Chair of the Trust Board**

Non-Executive Director (NED) developments

Trust Board members will be aware that Sarah Dunnett leaves the Trust Board at the end of December, when her period of office expires. Sarah joined the Trust Board in January 2014 and has been at the forefront of the Trust Board's improvement work over the past eight years, most notably as the Chair of the Quality Committee, but also via a range of other roles, including Vice Chair of the Trust Board. Sarah will be greatly missed, but I would like to thank her, on behalf of the Board, for her significant contribution to the Trust, and wish her well in her role as Non-Executive Director at East Kent Hospitals University NHS Foundation Trust.

The process to appoint a new NED is progressing well, and interviews are scheduled for early January 2022. However, Sarah's departure has required some changes to NED roles, and following liaison with colleagues, I can confirm the following arrangements will now apply:

- Neil Griffiths will become the Vice Chair of the Trust Board and Vice Chair of the Remuneration and Appointments Committee.
- Maureen Choong will become the Senior Independent Director (SID)[1] and the Chair of the Quality Committee.
- Jo Webber will become the Vice Chair of the Quality Committee.
- David Morgan will become the Vice Chair of the Finance and Performance Committee.

The roles of Vice Chair of the Charitable Funds Committee and the third NED member of the Quality Committee will be confirmed in due course.

Trust Board members will also be aware that NHS England/Improvement published new guidance, "Enhancing board oversight: a new approach to non-executive director champion roles" on 07/12/21. The guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures; and also describes the five lead Non-Executive Director roles which should be retained. Discussions regarding the guidance are in progress and a report will be submitted to the Trust Board in January 2022 that will confirm the Trust's response.

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants. The Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
10/12/21	Consultant Breast Radiologist	Elizabeth	Lephoi Musgrave	Radiology	TBC	Replacement
15/12/21	Consultant in Diabetes & Endocrinology	Maliha	Iqbal	Diabetes & Endocrinology	TBC	Replacement

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [2]
Information

[1] The SID role originated in Foundation Trusts in 2006, as part of Monitor's "Code of Governance". Many aspects of the SID role in Foundation Trusts do not apply to NHS Trusts, but the role is defined in the Trust's Standing Orders as "…to be available to listen to concerns which contact through the normal channels of the Chair, Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate".

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

Report from the Chief Executive **Chief Executive**

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

1. As you can read via the separate report on the Trust Board agenda the sentencing in the David Fuller murder trial took place on 15 December. Fuller received two whole life sentences for the murders of Wendy Knell and Caroline Pierce in 1987. He also received a concurrent 12-year term for a number of other crimes, including sexual offences carried out in the mortuaries at the Kent and Sussex and Tunbridge Wells hospitals. We continue to offer the families of Fuller's victims any help or assistance they need and are ensuring staff at our hospitals are also supported.

2. There continues to be ongoing pressure across the Trust, due to the combination of winter demands, increasing local COVID-19 community transmission rates, the emergence of the Omicron variant and an increasing number of COVID-19 admissions at both our sites. We continue to encourage staff to undertake twice weekly lateral flow tests to enable early detection of COVID-19, including the Omicron variant. Our COVID-19 booster programme for staff continues at both sites to help keep both our staff and patients safe this winter. We want everyone to have a safe and happy Christmas and with community transmission rates rising, and the Government's introduction of Plan B, we took the decision to recommend that our staff reconsider attending Christmas parties this year. Guidance has also been provided to staff as to how to stay safe and well over the festive period. I would like to reiterate a personal message of thanks to all our staff who continue to work tirelessly across the Trust, despite the ongoing COVID-19 pandemic and winter pressures.

3. We are continuing to make fantastic progress within elective care and have reduced the amount of long waiting patients (over 52 weeks) – down from almost 1,000 in February to now just 9 patients. This reduction represents our commitment to ensuring patients receive timely care and taking into consideration the national figure of 53,000 long waiting patients, it illustrates the progress made on a wider scale. A huge thank you and well done to all the teams involved in delivering this.

4. On Tuesday 7 December we were delighted to welcome Integrated Care Board Chair Designate, Cedi Frederick for a visit at Maidstone Hospital. Cedi met with the Trust's Director of Strategy, Planning and Partnerships, Dr Amanjit Jhund, and Medical Director Dr Peter Maskell. Discussions included the Trust's current pressures and our clinical strategy. Cedi also viewed our TeleTracking system in action and visited our Care Coordination Centre, and witnessed how it could be expanded for further gain across the wider Kent system.

5. The 12-week engagement period for our Cardiology services continues to understand what patients, the public, staff and stakeholders think about proposed changes (this will close at midnight on 14 January 2022). Over the last month, we have held a number of remote staff and public engagement events to ensure all stakeholders are able to help shape the future of cardiology services.

6. The ongoing COVID-19 pandemic has highlighted the need for increased clinical space across the Trust. Our Paediatric Emergency Department is seeing an increase in attendance in all areas and we are anticipating a further increase with respiratory and viral illnesses as part of the winter surge. A new project making good progress at the Trust is the new Paediatric Emergency Department at Tunbridge Wells Hospital. Groundwork has commenced and next steps are the internal fit out of the building, with opening planned for early next year. It will be sited next to the Tunbridge Wells Hospital adult Emergency Department to ensure ease of support from staff and close proximity to our Radiology Department and theatres. There will be separate entrances for COVID-19 and non COVID-19 patients and it will include separate

COVID red and green waiting areas for children, carers and parents. On the subject of Emergency Departments, I am delighted to report that last week, once again, our Emergency Departments were the top performing in the South of England and in the top 10 across the country – a testament to the hard work and dedication of the staff working in these teams.

7. 197 senior leaders in phases 1 and 2 have now completed our Exceptional Leaders Programme, with 126 colleagues signed up for phase 3 which starts in March 2022. Exceptional Leaders is a crucial foundation for helping us to create a culture of compassion and inclusion, innovation and improvement within MTW. We have designed the Exceptional Leaders Programme with compassion at its centre and have been working with Professor Michael West, a world leader in leadership and culture in health and social care.

8. Recruitment activity continues across the Trust. Over the last month we have been promoting return to practice nursing opportunities, Oncology vacancies and roles within our Pharmacy Team, via social media campaigns and through the production of directorate specific job packs. Our Recruitment and Communications colleagues are working hard to support recruitment campaigns across the Trust and fill all current vacancies. A huge thank you to colleagues from our staff network groups who recently volunteered to take part in a recruitment video to share their thoughts on what it's like to work for MTW and the support the Trust offers to minority groups. This is part of our recruitment drive to attract potential employees from a range of diverse backgrounds to actively promote equality, diversity and inclusion. You can watch the video here https://youtu.be/8N6ohcl3zeo

9. Our Networks continue to be very active across the Trust, supporting our staff. Our Disability Network has been busy celebrating Disability History month (18 November – 18 December) and a recent event focused on hidden disabilities – a workshop for staff run by the Kent Supported Employment Service. We have now launched our Staff Health Passport, providing a framework to discuss a staff member's health, how it influences their work life and how we can work together to make changes to improve their work life. Our LGBT+ Network recently submitted an Expression of Interest application to the national NHS Rainbow Badge – phase 2 scheme. I am pleased to report that the application was successful and a meeting will take place shortly to progress this programme within the Trust. The Rainbow badge was introduced at the Trust in 2019 and aims to promote a message of LGBT+ inclusion and show that participating organisations are open, non-judgemental and inclusive places for LGBT+ people. Phase 2 focuses on the assessment of LGBT+ inclusivity within our organisation in order to establish where we now and put improvement measures in place for the future if needed.

10. The annual national NHS survey closed on 26 November and I am pleased to report that we achieved a 52% response rate – matching last year's response rate and compared with a national average for acute trusts of 45%. This is a fantastic achievement, especially against a backdrop of the ongoing Covid-19 pandemic and focus on recovery. The data from our responses has now been submitted to the coordination centre for full analysis to take place and a detailed report will be made available in spring 2022.

11. Congratulations to the winner of the Trust's Employee of the Month scheme for November, Theresa Welfare, Service Manager, Cellular Pathology. On behalf of the Trust Board I would like to say thank you to Theresa for her fantastic work to help support our colleagues and patients.

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

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

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

Summary report from Quality Committee, 08/12/21 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 8th December 2021 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **progress with previous actions** was reviewed.
   - The Chief of Service, Women's, Children's & Sexual Health; Divisional Director of Midwifery, Nursing and Quality; and the Deputy Head of Midwifery and Gynaecology attended for a **further review of maternity services** wherein the Committee the commended the continued focus on quality improvement initiatives throughout significant operational pressures and acknowledged the assurance which had been provided.
   - The Director of Quality Governance presented a **review of the adverse patient outcomes for 2020-21 (Serious incidents and complaints).** The presentation provided a comprehensive thematic overview of the Trust's adverse events within the reporting period and associated next steps, wherein it was agreed that the Director of Quality Governance should ensure that future "Review of the adverse patient outcomes" reports, to the Quality Committee 'deep dive', included details of the quality improvement initiatives which had been implemented in response to the areas of concern which had been identified. It was also agreed that the Director of Quality Governance should consider the method, and frequency, by which the Divisional Governance reports to the 'main' Quality Committee should include a response to the findings of the "Review of the adverse patient outcomes for 2020-21 (Serious incidents and complaints)" report. Furthermore, it was agreed that the Director of Quality Governance should ensure that future "Review of the adverse patient outcomes" reports, to the Quality Committee 'deep dive', included benchmarking data for individual Divisions against comparable Trusts.
   - A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein the following agreements were made:
     - That the Chief Nurse and Director of Quality Governance should consider, and confirm to the Trust Secretary's Office, the future reporting arrangements for "Review of the adverse patient outcomes" items to the Quality Committee 'deep dive' (i.e. whether a mid-year review should be scheduled, or whether the Committee should receive assurance on an annual basis).
     - That the Chief Nurse should ensure that the "Review of impacts of health inequalities and equality of access to services on patient outcomes" report to the Quality Committee 'deep dive' meeting in February 2022 included a brief overview of the lessons learned from patients with learning disabilities, prior to the submission of an "In-depth review of the lessons learned from patients with learning disabilities" report to the Quality Committee 'deep dive' meeting in April 2022.
     - That the Chief Nurse and Director of Quality Governance should consider, and confirm to the Trust Secretary's Office, the future scheduling of a "Review of the lessons learned from patient deaths related to nosocomial COVID-19 infections" item at a future Quality Committee 'deep dive' meeting.
     - That the Assistant Trust Secretary should schedule a "Review of the response to the rate of falls, and associated fractures, at the Trust" item at the Quality Committee 'deep dive' meeting in April 2022.
   - Under **Any Other Business** the Chief Nurse, on behalf of the Committee, commended the Chair of the Committee on exemplary contribution during their tenure at the Trust

2. **In addition to the agreements referred to above, the meeting agreed that:** The Assistant Trust Secretary should remove the "Update on the management of Sepsis at the Trust" item from the Quality Committee 'deep dive' forward programme for February 2022, as future Sepsis assurance would be provided at the 'main' Quality Committee meetings.

3. **The issues from the meeting that need to be drawn to the Board's attention are:** N/A

Which Committees have reviewed the information prior to Board submission? N/A
Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1] Information and assurance

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 17/12/21	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 17th December 2021 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed and it was agreed that the Deputy Chief People Officer, Organisational Development should submit an "update on the Gender Pay Gap for 2021" to the 'main' People and Organisational Development Committee in January 2022.
- The Deputy Chief People Officer, People and Systems provided a comprehensive **update on recruitment and retention** wherein it was agreed that the Deputy Chief People Officer, People and Systems should provide Committee members with details of the variation, within Divisions and Directorates, in relation to the percentage of unfilled bank and agency shifts at Maidstone Hospital in comparison to Tunbridge Wells Hospital. It was also agreed that the Chief People Officer, People and Systems should consider, and confirm to Committee members, the measures which could be implemented to support the engagement of bank staff at the Trust.
- The Committee conducted an **in-depth review of the relevant aspects of the risk register** and it was agreed that the Chief People Officer should check, and confirm to Committee members, whether volunteers that work at the Trust, but are not employed by the Trust, are currently included within the Trust's COVID-19 vaccination plan in response to vaccination as a condition of deployment (VCOD). It was also agreed that the Chief People Officer should consider what, if any, risk entries within the "In-depth review of the relevant aspects of the risk register" report should be amended to reflect the impact of the potential failure to progress the Business Case for the People and Culture Structure and Operating Model.
- The Deputy Chief People Officer, Organisational Development; Head of Staff Engagement and Equality; and Interim Head of Learning and Development attended to present an extensive **review of the Trust's approach to succession planning and talent management** which highlighted the importance of ensuring a transparency and equitable approach to recruitment and career progression and it was agreed that the Deputy Chief People Officer, Organisational Development should submit an update on the Trust's approach to succession planning and talent management, which incorporated the feedback received at the People and Organisational Development Committee 'deep dive' meeting on the 17th December 2021, and the progress with the actions outlined within the presentation, to the 'main' People and Organisational Development Committee in March 2022.
- The Committee **confirmed the items to be scheduled for the future 'deep dive' meeting**, in February 2022 (i.e. "Review of the future approach to the Trust's appraisal process"; and "Review of the proposals for the digitisation of the Trust's Human Resources (HR) function") and it was agreed that the Chief People Officer should liaise with the Trust's Communications Team to investigate what, if any, further initiatives could be implemented to improve the response rate to the various surveys that were provided to Trust staff. It was also agreed that the Assistant Trust Secretary should schedule a "Proposals for the future of the Trust's 'Pulse' survey" item at the People and Organisational Development Committee 'deep dive' meeting in February 2022.
- The Committee conducted an **evaluation of the meeting** which highlighted the importance of ensuring that the report generators attended the meeting, as the subject matter experts

In addition to the actions noted above, the Committee agreed that: The Chief People Officer should submit an update on the Trust's COVID-19 Vaccination plan (including vaccination as a condition of deployment (VCOD)) to the 'main' People and Organisational Development Committee in January 2022

The issues from the meeting that need to be drawn to the Board 's attention as follows: N/A

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 02/12/21 (incl. approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 2nd December 2021, virtually, via webconference

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Chief Nurse outlined the initial proposals and next steps for the **what does it feel like to be in our care environment** programme of work and it was agreed that the Assistant Trust Secretary should ensure that the Committee's 'lay members' were provided with a hardcopy of the "What does it feel like to be in our care environment" report to enable the submission of any feedback, to the Chief Nurse, prior to the 25th December 2021. It was also agreed that the Chief Nurse should ensure that the "What does it feel like to be in our care environment" report to the Committee's meeting in March 2022 included details of the mechanisms by which the programme of work would be resourced.
- The Committee reviewed the **findings of the national inpatient survey 2020** wherein the importance of ensuring robust triangulation of data to highlight areas of improvement was emphasised.
- The Deputy Director of Strategy, Planning and Partnerships attended for an **update on Cardiology Consolidation and Gastroenterology Centralisation** wherein the range of engagement mechanisms for Cardiology Consolidation were noted and it was agreed that the Deputy Director of Strategy, Planning and Partnerships should submit a further update on Cardiology Consolidation, which was informed by the Trust Board's response to the feedback received from the 12-week engagement period, to the Committee's meeting in March 2022.
- The Patient Experience Lead provided a detailed **update on steps to improve the trust's volunteer provision** which included a targeted recruitment approach**.**
- The Patient Experience Lead provided an in-depth **review of carer access** (including a focus on access for carers of dementia patients) wherein it was agreed that the Divisional Director of Nursing and Quality for Surgery should liaise with the Matrons within the Surgery and Medicine and Emergency Care Divisions to highlight the flexibility in visiting arrangements for carers afford by the Trust's revised visiting policy. It was also agreed that the Chief Nurse and Patient Experience Lead should submit an "update on the Trust's Visiting Policy and provision of enhanced access for carers" to the Committee's meeting in March 2022.
- The Committee reviewed the **lessons learned from the management of patient property during COVID-19** wherein the recommendations proposed by the Interim Deputy Chief Nurse were supported.
- The Complaints and PALS Manager provided a comprehensive **review of complaints** wherein it was agreed that the Complaints and PALS Manager should ensure that the "Review of Complaints" report to the Committee's meeting in March 2022 included details of the process for determining whether a complaint was up-held
- The Committee considered its **Forward Programme** and the following actions were agreed:
  - That the Chief Nurse should submit a comprehensive evaluation of the Trust's performance against the objectives outlined within the "Patient Experience Strategy – 'Making It Personal'" and the next steps for the development of the revised Patient Experience Strategy to the Committee's meeting in March 2022.
  - That the Assistant Trust Secretary should ensure that future Committee meetings were facilitated using Microsoft Teams as the web conferencing platform.
  - That the Assistant Trust Secretary should schedule an "Informal Patient Experience Committee" meeting for six weeks' time, to test the user accessibility of Microsoft Teams for the Committee's 'lay members'
- Under **Any Other Business** the Chair of the Committee thanked members for their continued contribution throughout COVID-19.

In addition to the actions noted above, the Committee agreed: N/A

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

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To approve the Committee's revised Terms of Reference (see appendix 1)

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

Appendix 1 – Revised Terms of Reference (for approval)

PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Committee's purpose is to consider the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations

2. Membership

From the Trust:

- Non-Executive Director or Associate Non-Executive Director (Chair)
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)
- Chief Nurse
- Director of Strategy, Planning and Partnerships
- Deputy Chief Nurse (x 1)
- ~~Deputy~~ Director of Quality Governance
- Complaints & PALS Manager
- Patient Experience Lead
- Patient Experience Lead for Maternity Services

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

3. Attendance and quorum

The Committee will be quorate when 3 members from the Trust (including 1 Non-Executive Director or Associate Non-Executive Director) and 3 members external to the Trust are present. Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum.

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and members of the Executive Team are entitled to attend any meeting of the Committee.

Any Trust staff member, including trainees, who request the opportunity to observe the meeting are welcome, subject to capacity.

The Chair/s of the Patient Experience Committee's sub-committee will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the Committee's duties.

4. Frequency of meetings

The Committee shall, generally, meet quarterly, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings).~~Meetings will be generally held quarterly.~~

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

5. Duties

- To positively promote the Trust's partnership working with its patients.

- To aim to capture the perspective of patients and present their experience of the Trust's services.
- To consider the standard and accessibility of patient and/or carer information within the Trust, via any relevant forum, including the Patient Information Leaflet Group (PILG).
- To consider the impact of Trust Policies, procedures, and strategies in so far as they relate to patient experience.
- To advise on priorities for patient surveys, methods for obtaining local patient feedback and identify exemplar practice.
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Complaints and PALS contacts information
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
- To review the work being undertaken by the Trust's Divisions in relation to improving patient and service user experience.
- To receive reports on the outcome of the patient partner teams.
- To maintain awareness of the developments with the Kent and Medway Integrated Care System (ICS).
- To support the work by the Trust to consult with patient and public on:
  - The planning and provision of services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services in particular with regard to inclusion and service user confidence in services.

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members (including Associate Non-Executive Directors) to each meeting of the Committee, by exception.

The Committee's relationship with the Quality Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:
- Patient Information Leaflet Group (PILG)
- Patient Representative Group

The frequency of reporting will depend on the frequency of sub-committee meetings.

Quality Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

A summary report of the Patient Experience Committee will be submitted to the Quality Committee, for information/assurance and to help prevent any unnecessary duplication of work (the summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose).
~~The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee. The summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose.~~

8. 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 on:

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

9. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted with either the Chief Nurse or ~~Director of Finance~~Director of Strategy, Planning and Partnerships. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

10. Review of Terms of Reference

The Terms of Reference of the Committee will be reviewed and agreed by the ~~Patient Experience~~ Committee at least annually, and then formally approved by the Trust Board. ~~They will be reviewed annually or sooner if there is a significant change in the arrangements.~~

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2016
- Terms of Reference (amended) approved by the Trust Board, 23rd March 2016
- Terms of Reference (amended) agreed by the Patient Experience Committee, 8th March 2017
- Terms of Reference (amended) approved by the Trust Board, 29th March 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2018
- Terms of Reference (amended) agreed by the Patient Experience Committee, 5th July 2018
- Terms of Reference (amended) approved by the Trust Board, 26th July 2018
- Terms of Reference (amended) agreed by the Patient Experience Committee, 1st December 2020
- Terms of Reference (amended) approved by the Trust Board, 17th December 2020
- Terms of Reference (amended) agreed by the Patient Experience Committee, 2nd December 2021
- Terms of Reference (amended) approved by the Trust Board, 22nd December 2021

Summary report from the Charitable Funds Committee, 24/11/21 (incl. approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

The Charitable Funds Committee (CFC) met on 24th November 2021, virtually, via webconference.

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

- The **actions from previous meetings** were noted
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Committee undertook a **review of the risk register entries relevant to the Charitable Fund** wherein the increased focus on recovery within the risk register entries was noted.
- The **financial overview at Month 7** was considered wherein the Committee emphasised the importance of the development of a timing profile for the disbursement of existing funds to inform the Trust's investment strategy and it was noted that:
  - The fund balance stood at £1,104k, an increase of £19.8k since 1st April 2021
  - Twenty specific donations had been received exceeding £1k totalling £73.8k. The largest single donation was £36.5k from "EEMU legacy donation" in relation to Bartlett.
  - No requests for expenditure had been refused during the period
- The Committee undertook an **annual review of the Investment Strategy** wherein the recommendations were agreed as submitted, however it was also agreed that the Head of Financial Services should submit a "further review of the investment strategy" to a future Committee meeting, which had been informed by the outcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust, specifically in relation to the intended disbursement of existing funds.
- The Associate Director of Fundraising provided the latest **Fundraising update** which included an in-depth update on the Trust's submission to NHS Charities Together, the key fundraising activity within the reporting period and the focus on the development of collaborative working relationships.
- The Director of Strategy, Planning and Partnerships provided an update on the O**utcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust** wherein the scope and focus of the work was noted and it was agreed that the Associate Director of Fundraising and Director of Strategy, Planning and Partnerships should liaise with the Chair of the Committee, and the Trust Secretary's Office to consider, and confirm, the approach which should be adopted to inform Committee members of the outcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust, prior to submission to a future 'Part 1' Trust Board meeting
- The Committee received an update on the **future of fundraising at the Trust** wherein the Committee welcomed the Associate Director of Fundraising and it was agreed that the Trust Secretary should liaise with the Associate Director of Fundraising to consider and confirm the scheduling of an "outcome of the review of the Trust's fundraising approach and proposals for the future of fundraising at the Trust" item at a future 'Part 1' Trust Board meeting, having first been considered by the Committee.
- The Divisional Director of Operations for Cancer Services and the Assistant General Manager for Cancer Performance provided an update on the **proposed partnership with Maggie's Centres** wherein the Committee was informed of the further work required prior to the submission of the Heads of Terms to the Trust Board for approval.
- Under **the Committee's forward programme** it was noted that an extraordinary meeting had been scheduled for the 15th December 2021.

2. In addition to the actions noted above, the Committee agreed that: N/A

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

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
1. Information and assurance 2. To approve the Committee's revised Terms of Reference (see appendix 1)

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

Appendix 1 – Revised Terms of Reference (for approval).

CHARITABLE FUNDS COMMITTEE

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

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 Chair – a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- A further Non-Executive Director or Associate Non-Executive Director
- The Deputy Chief Executive / Chief Finance Officer
- The Director of Strategy, Planning and Partnerships
- The Head of Financial Services
- The Deputy Director of Finance (Financial Governance)
- The Trust Secretary

If a member cannot attend a meeting, they may send a representative in their place.

3. Quorum

The Committee shall be quorate when one Non-Executive Director (or Associate Non-Executive Director) and three other members are present. Deputies representing members will count towards the quorum.

4. Attendance

The Committee Chair may invite other staff, Non-Executive Directors (or Associate Non-Executive Directors) to attend, as required, to fulfil the Committee's purpose and/or meet its duties.

5. Frequency

The Committee shall meet at least twice per financial year (and more frequently if required to fulfil its purpose and/or meet its duties.

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; 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)
  - Approving and monitoring investment strategies

The specific duties of the Committee in relation to the Charitable Fund 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 fundraising activities (if considered by the Committee to be required)

Operational matters

- To 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 at the limits reserved for the Committee (as stated in the Trust's Reservation of Powers and Scheme of Delegation)

Internal and External control

- To seek assurances that all income is secured and that expenditure is within the objects of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- To ensure there is adequate provision for the independent monitoring of investment activity
- To receive all relevant internal and external audit reports, and ensure compliance with any recommendations

Financial reporting

- To review income and expenditure reports for each of the reporting periods
- To review and agree the Principal Accounting Policies to be adopted
- To review, and agree the Annual Report and Annual financial accounts for the Charitable Fund, for approval by the Trust Board
- To receive, where appropriate, the annual investment report
- To ensure the Chief Finance Officer is compliant with the reporting requirements of the Committee and the Trust Board (as the agent of the Trustee)
- To review Fundholders' spending plans

7. Parent committees and reporting procedure

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

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

8. Sub-committees and reporting procedure

The Committee has the following sub-committee:

- The Charity Management Committee

A written summary report from each sub-committee will be received at each meeting of the Charitable Funds Committee. The Terms of Reference of each sub-committee will be reviewed, and approved, at the Charitable Funds Committee every year.

The Charitable Funds Committee may also establish fixed-term working groups, as required, to support the Committee in meeting its duties as it, or the Trust Board, sees fit.

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 either the Deputy Chief Executive / Chief

Finance Officer or Director of Strategy, Planning and Partnerships. 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 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

History

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
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017
Agreed at Charitable Funds Committee, 27th November 2018 (annual review)
Approved at Trust Board, 20th December 2018
Agreed at Charitable Funds Committee, 29th October 2019 (annual review)
Approved at Trust Board, 28th November 2019
Agreed at Charitable Funds Committee, 24th March 2020 (to include the Charity Management Committee as a sub-committee)
Approved at Trust Board, 30th April 2020
Agreed at Charitable Funds Committee, 24th November 2020 (annual review)
Approved at Trust Board, 17th December 2020
Agreed at Charitable Funds Committee, 24th November 2021 (annual review, and to add a further Non-Executive Director or Associate Non-Executive Director to the membership)

Extraordinary Charitable Funds Committee, 15/12/21 (incl. approval of Annual Report and Accounts of the Charitable Fund, 2020/21)	**Committee Chair (Non-Executive Director)**

An extraordinary meeting of the Charitable Funds Committee was held on 15th December 2021 (virtually, via webconference).

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

- The **Charitable Fund Annual Report and Accounts for 2020/21** were reviewed and agreed, subject to the following actions:
  - The Head of Financial Services should amend "Sofa" to "Statement of Financial Activities" within the "Exceptional Items" section of the Charitable Fund Annual Report and Accounts for 2020/21, prior to submission to the December 2021 'Part 1' Trust Board meeting, for approval.
  - The Head of Financial Services should liaise with the Independent Examiner to request a draft version of the "Independent examiner's report to the trustees of Maidstone and Tunbridge Wells NHS Charitable Fund" for inclusion within the "Charitable Fund Annual Report and Accounts for 2020/21", prior to submission to the December 2021 'Part 1' Trust Board meeting, for approval.
  - The Associate Director of Fundraising should provide the Head of Financial services with expanded content for the "Making Donations" section of the "Charitable Fund Annual Report and Accounts for 2020/21"
  - The Head of Financial Services should Amend the "Making Donations" section of the "Charitable Fund Annual Report and Accounts for 2020/21" to reflect the content provided by the Associate Director of Fundraising, prior to submission to the December 2021 'Part 1' Trust Board meeting, for approval

The Charitable Fund Annual Report and Accounts for 2020/21 are enclosed in Appendix 1 (with the requested amendments incorporated) (the management representation is also enclosed) and the Trust Board is asked to approve these, to enable submission to the Charity Commission.

2. In addition to the actions noted above, the Committee agreed that:

- The Head of Financial Services should provide the Associate Director of Fundraising with the formal account name of the Trust's Charitable Fund

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

- The Charitable Fund Annual Report and Accounts for 2020/21 were agreed, subject to the requested amendments, and are enclosed in Appendix 1 (with the requested amendments incorporated) (the management representation is also enclosed), for approval

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

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

Information, assurance, decision

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

MTW Charity
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts

For the year ended 31st March 2021

Charity Number 1055215

Contents

Fundraising Foreword

This year the Trust has been responding to a further wave of COVID-19 and our staff have worked heroically under difficult conditions to care for our patients and their loved ones. The charity has worked with the staff wellbeing team to use monies raised for supporting staff to maximum effect especially as we move to the recovery phase of the pandemic.

Every donation is important and many people have been inspired to donate as a result of excellent care which either they, or their loved ones, have received from the Trust.

This year the Charitable Fund received total income of £522,000 from individuals, groups and organisations. This included monies from national fund raising as a member of NHS Charities Together.

This year our fund raising manager Laura Kennedy left to take up a new role and recruitment for a new manager is now underway.

Thank you to all our fantastic fundraisers and supporters.

Laura Kennedy
Fundraising Manager

Our performance

The charity aims to strategically grow its income and supporter base to add value to the patient and staff experience. Significant progress has already been made to develop corporate fundraising which has been identified as a key area for growth.

Our achievements

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 31st March 2021.

The financial statements set out on pages 20 to 34 comply with the charity's trust deed, 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 (FRS) applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019).

Trustee Statement

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

The Trustees and the Trust wish to extend our thanks for the kind generosity that we have received since the start of the COVID-19 pandemic in March 2020. Since the start of the pandemic members of the public donated gifts in kind to Maidstone and Tunbridge Wells NHS Trust. Where these donations are not material and were immediately distributed to and consumed by staff and patients these have not been recorded individually within the annual report and accounts; these include items such as meals, Easter eggs, food hampers and skin care products.

The role of the Charity

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 Commission under charity number 1055215, and includes funds in respect of the hospitals of Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites in Kent: Maidstone Hospital and Tunbridge Wells Hospital.

The Charity is an '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 42 individual funds at the 31st March 2021 with a total value of £1.1m. The number of funds in each category is as follows:

- 19 restricted funds[1].

[1] Restricted funds are the funds of the charity that are required to be expended in a certain way, or limited to expenditure for a particular purpose.

- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 21 unrestricted[2] or designated[3] 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 sole 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 therefore not trustees under Charity Law.

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

Executive Directors	**Non-Executive Directors**	**Other Directors**
Miles Scott – Chief Executive	David Highton – Chair of the Trust Board	Sara Mumford – Director of Infection Prevention & Control
Stephen Orpin – Deputy Chief Executive / Chief Finance Officer	David Morgan	
Peter Maskell – Medical Director	Sarah Dunnett	
Sean Briggs – Chief Operating Officer	Maureen Choong	
Claire O'Brien – Chief Nurse	Neil Griffiths	
Simon Hart – Director of Workforce (left Trust Board on 13th August 2020)	Emma Pettitt-Mitchell	
Amanjit Jhund – Director of Strategy, Planning and Partnerships	Jo Webber – Associate Non-Executive Director	
Cheryl Lee – Director of Workforce (from 7th September 2020 to 31st March 2021)	Karen Cox – Associate Non-Executive Director	
	Richard Finn – Associate Non-Executive Director	

None of the Members of the Trust Board 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 (in 2019/20 this was also none)

The principal office of the Charity is:
Trust Headquarters,
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital, Hermitage Lane,
Maidstone
Kent, ME16 9QQ

[2] Unrestricted funds are the funds of the charity that may be spent entirely at the discretion of the Trustee
[3] Designated funds are funds set aside for designated purposes. Designated funds are unrestricted as the Trustee can remove the designation at any time

Principal advisors:

Independent Examiner Grant Thornton UK LLP 110 Bishopsgate London EC2N 4AY	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Solicitors Capsticks Solicitors LLP 1 St George's House East St George's Road Wimbledon, London SW19 4DR	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB

Governance and Management of the Charity

Governance

The Board of Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1st April 2000, following the merger of Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells, and Mid Kent Healthcare NHS 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, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee operates according to Terms of Reference that are approved annually by the Trust Board, and plans to meet at least three times a year; for the financial year 2020/21 the Committee met three times.

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 of each Charitable Funds Committee is also submitted to the Trust Board.

Recruitment and Training of Trust Board and Charitable Funds Committee Members

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

Management of the Charity

The management of the Charity is operated in accordance with the Trust's "Policies and Procedures for Charitable Funds", which are approved by the Charitable Funds Committee. There is a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised Fund Holders. The Fund Holders consist mainly of 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, but it was agreed at the Charitable Funds Committee meeting in July 2020 that a proposal should be developed as to how the Committee could take a more robust approach to the risk management of the Trust's Charitable Funds. It was subsequently agreed, In November 2020, that a separate section of the Trust's risk register should be created (using the Trust's existing risk assessment process and framework) to register risks that are relevant to the Charitable Fund; that an "Annual review of the risk register entries relevant to the Charitable Fund" item be scheduled for consideration at the Committee; and that the outcome of that review be included in the "Risk Management" section of this Annual Report

The first annual review of risks was duly considered at the Charitable Funds Committee's meeting in March 2021; and three high-level risks were identified, which were informed by the Charity Commission's "NHS charities guidance" and "Managing your charity…" guidance; and the charitable fund risk registers at several other NHS Trusts:

1. Governance arrangements and management of charitable funds (i.e. that a lack of sufficient governance arrangements and resources within the corporate Division to adequately manage the raising, allocation and financial management of Charitable Funds could result in adverse outcomes);
2. Potential, actual or perceived misuse/misallocation of charitable funds (i.e. that damage could be caused should charitable funds be misappropriated, not allocated with due governance; not used for their intended purpose; or not used optimally within the bounds of Trust policy and procedure); and
3. The response to COVID-19 and other business continuity incidents COVID-19 (and other similar outbreaks) can impact the Trust's ability to manage its charitable funds (i.e. that decreased on site staffing resource could affect day to day running of charitable activities, that the inability to undertake normal charitable activities could impact earning potential, and that a significant increase in donations could result in funds being unallocated for specific or intended purposes).

The Committee was apprised of the control measures in place to reduce these risks, and requested some amendments to the risk register entries. Further reports on the charitable fund risk register will be considered during 2021/22.

One aspect of the management of charitable funds relates to investment performance the Corporate Trustee has adopted a relatively low risk policy regarding this, although 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85,000 per banking institution operating under a separate banking licence. The adopted policy is that the maximum investment is up to £85,000 in each banking institution outside the Government banking Scheme. Therefore there is no risk on these investments.

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 trustees:*

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 or 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

Grant Thornton UK LLP is the Trust's appointed External Auditors and they act as the charitable fund's independent examiner. For the 2020/21 financial year, an independent examination will be carried out as the charity's gross income falls below £1m.

In addition, TIAA, the Internal Auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust. The Trustees therefore consider that the charity clearly falls within the definition of a public benefit entity under the terms of FRS 102.

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 Charity are stated in the Trust deed as follows:-

"*The Trustees 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 Trustees think fit.*"

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

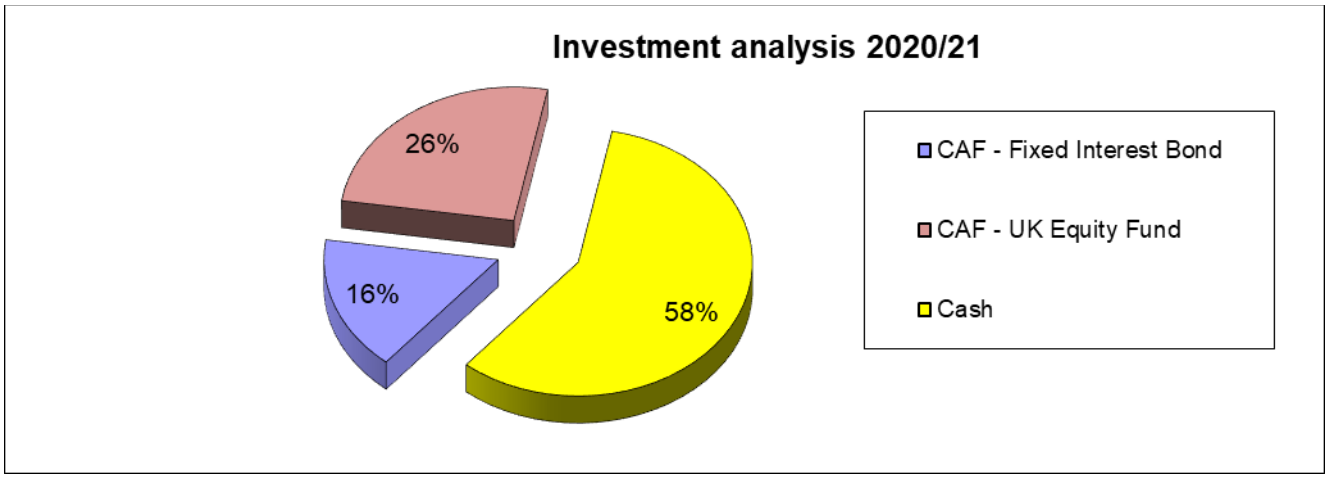
reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

Investment income for the year was £20k (in 2019/20, £22k). 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 value of investments was low on 31 March 2020 but has steadily risen and is back at pre-pandemic levels by 31st March 2021; the total performance return on the portfolio of the investments (equity and bond) was a profit of £104k. This reflects a significant upturn in market performance compared with the previous year (loss of £89k). The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

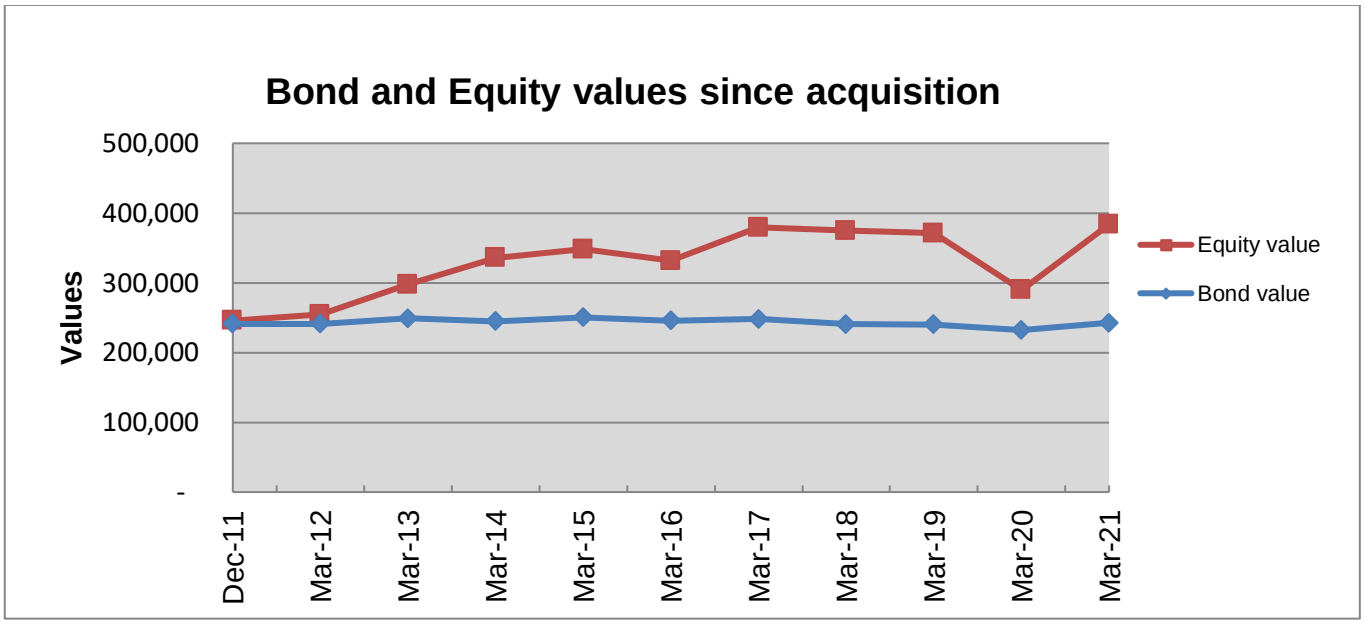
The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio increasing in market value to £626k at 31 March 2021 (£522k at 31 March 2020). The cash investment at 31 March 2021 was £865k (£830k at 31 March 2020).

The current asset portfolio of cash and investment allocation totalling £1,491k at 31 March 2021 is shown in the following graph:



The cash allocation at 58% is currently higher than the strategy of Cash of 50%. The bonds investment of 16% is lower than the 25% bond strategy; and the equities investment is slightly higher at 26% than the planned strategy of 25%. The bond investments have not performed well this year due to the influence of the COVID-19 pandemic on the money markets so the valuation has fallen, reducing their proportion of the total.

The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

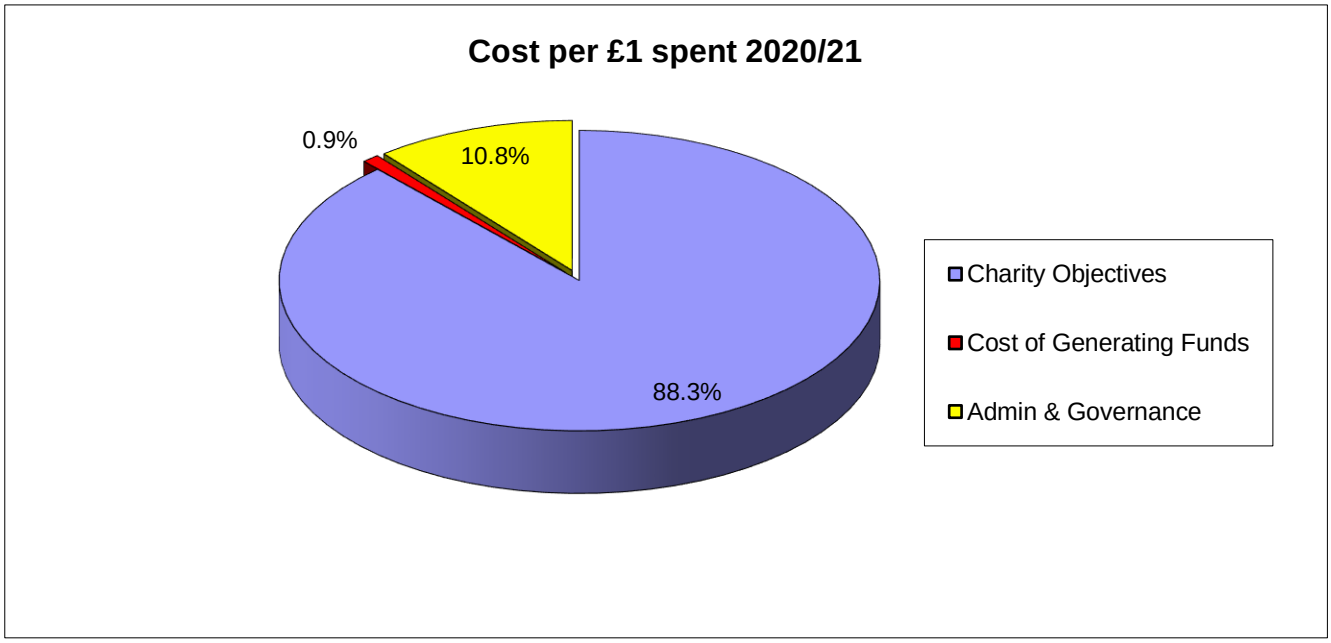


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

The Trust applies its charitable funds 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 of expenditure, 88 pence was spent in directly achieving the objectives of the charity. This has changed compared to equivalent ratio for 2019/20 (91 pence).



Expenditure

Total resources expended by the Charity within this financial year were £326k (in 2019/20, £1,041k), breakdown as follows:

Contribution to NHS:
- £129k Medical Equipment (in 2019/20, £549k)
- £0k Construction of Helipad (in 2019/20, £301k)

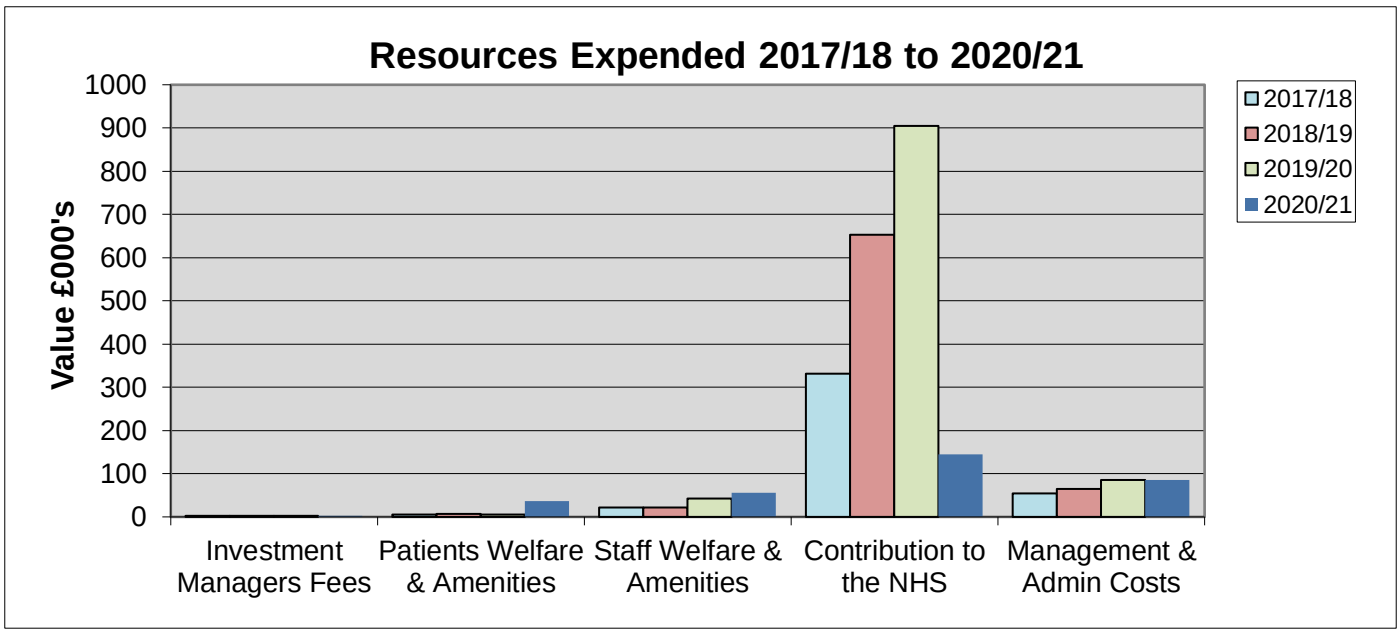
Support and fundraising cost:
- £86k Support and fundraising costs (in 2019/20, £86k)

Staff Welfare:
- £56k Staff Welfare and amenities (in 2019/20, £43k)

Patients Welfare:
- £36k Patients welfare and amenities (in 2019/20, £5k)

Included within the governance cost of £86k are the internal management fees for financially administering the funds and the costs of the Fundraiser Manager. The fees are agreed each year by the Trustees. These costs are charged proportionately across the unrestricted funds whose balance is greater than £1k on a quarterly basis.

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



Charitable expenditure for the year is detailed below.

Medical Equipment – Total spend £129k (in 2019/20, £549k)

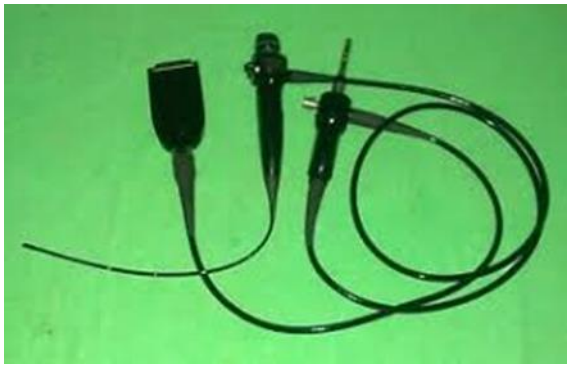
Medical equipment has been purchased within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities within the Trust.

The most significant purchases were:

- Olympus Rhinolaryngo System TWH (£27.5k)
- 2 SonoSite S II Ultrasound System for ICU (£48k)
- Verathon Bladder scanner for Oncology (£6k)

Verathon Bladder Scanner

Olympus Rhino-Laryngo scope



SonoSite S II Ultrasound System

Wingman Bus at Maidstone Hospital

Patient Welfare and amenities – Total spend £36k (in 2019/20, £5k)

The most significant spends were:

- Recliner chairs for patients undergoing chemotherapy (£11.5k)
- Licence fee for V-Create (allows parents to view babies in Neonatal) (£9k)
- Ecomax – Dishwasher (£2k)

Staff Amenities and Welfare – Total spend £56k (in 2019/20, £43k)

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.

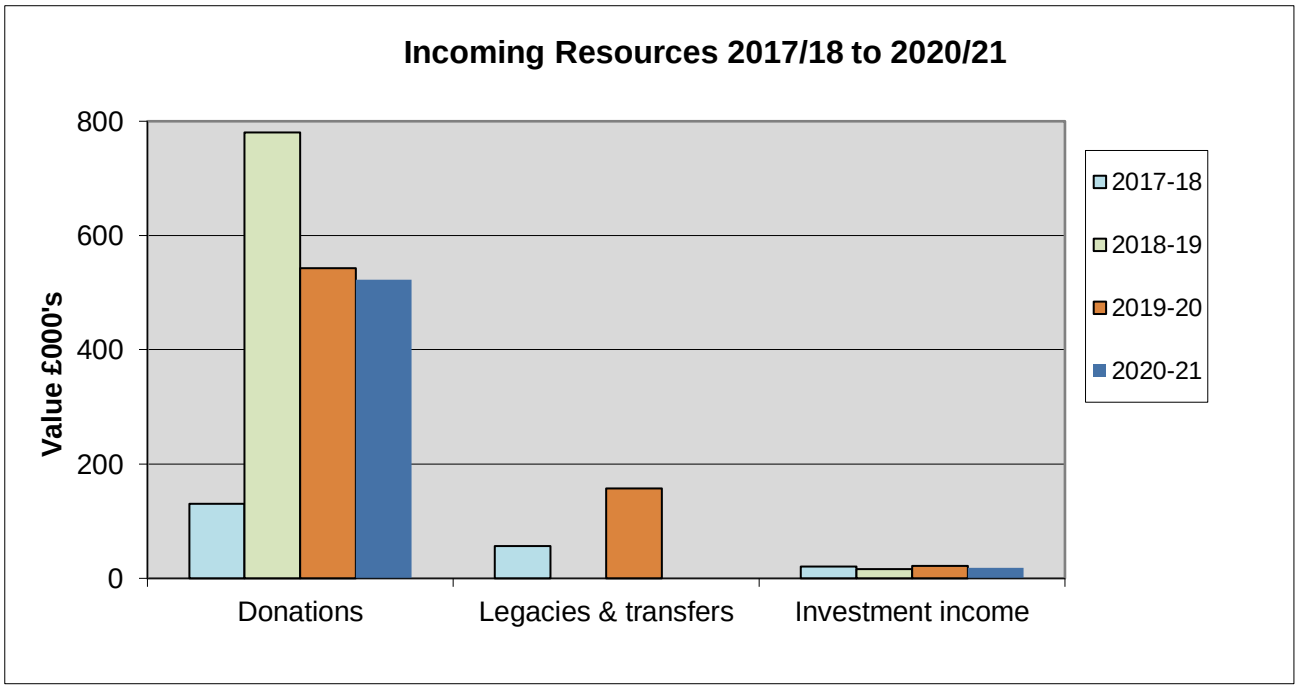
Of the £56k; £38k related to items such as - funding hampers for seriously ill staff, advent calendars and portraits of staff to celebrate black history, £12k related to furniture and fittings for the wobble rooms which the Trust provided for a quiet space for staff to go during the pandemic and £5k on training for staff.

Other – Total spend £16k (in 2019/20, £356k)

The most significant spend was Furnitures and Fittings (£11k) which was various items to benefit wards.

Income

The graph below shows an analysis of income sources for the current and two 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 £522k was received from donations (in 2019/20, £543k) and £0k from legacies (in 2019/20, £157k).

The Trust received 5 significant (>/= £10k) donations from NHS Charities Together (Sir Tom Moore) £177.5k; from Province of East Kent Freemasons & Province Grand Lodge Master £11.6k; from The Hollick Family Foundation £10k; from BNP Paribas for TWH £10k; from Caroline May for ICU/Critical Care at TWH £14.7k.

Legacies

The Trust did not receive any donation from legacies this year. (£157k in 2019/20)

We will continue to promote gifts in wills as a way for people to support the Charity.

Online fundraising
The Charity's 'Just Giving' page received donations of more than £247k this year (£19k 2019/20), of this £45k related to various donations from local residences to support staff during the pandemic.

This year we continued to extend the choice of online platforms to include Virgin Money Giving.

Intangible Income

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

Looking Forward - our plans for the future

Work is continuing at pace to develop the Charity and make it a more vibrant and proactive organisation than ever before. The Trustee is dedicated to strengthening the Charity, working in partnership with the Trust to achieve their aim to deliver an outstanding healthcare service for our patients.

The Trust is currently a member of NHS Charities Together and continues to work in partnership with members to ensure best fundraising practice.

We look forward to working with new and existing supporters to enhance the patient, carer and staff experience.

Making donations

There are several ways people can donate including making online donations via www.justgiving.com/mtwnhscharitablefund. Please make cheques payable to Maidstone and Tunbridge Wells Hospital Charity. Payments can also be made via Bacs on request or via the cashiers at our hospitals.

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 trustee is required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the SORP FRS 102 have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the Trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepares 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 and the rules 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 where any statements of accounts are prepared by the trustee under section 132(1) of the Charites Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustee has general responsibility for taking such steps as are reasonably open to the trustee to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustee is 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 Independent Examiner

In so far as the trustee is aware at the time of approving its Annual Report:

- there is no relevant information, being information needed by the Independent Examiner in connection with preparing their report, of which the Independent Examiner is unaware, and
- the trustee, having made enquiries of fellow directors and the Independent Examiner that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a director 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:

David Highton,
Chair of the Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date: 22nd December 2021

Independent examiner's report to the corporate trustee of Maidstone and Tunbridge Wells NHS Charity

I report on the accounts of Maidstone and Tunbridge NHS Trust Charity (the "charity") for the year ended 31 March 2021, which are set out on pages 21 to 36.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011;
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met, or

- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Basis of independent examiner's statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as corporate trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement above.

Respective responsibilities of corporate trustee and examiner

The charity's corporate trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 149(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 149 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 149(5) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice 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 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

This report is in respect of an examination carried out under section 149(3) of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the

regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and

for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

Darren Wells,

CPFA

Grant Thornton UK LLP
Chartered Accountants

London

Date:

Statement of Financial Activities for the year ended 31st March 2021

					2020/21	2019/20
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	£000	£000	**£000**	£000
Income	2					
Donations		236	286	0	**522**	543
Legacies		0	0	0	**0**	157
Total Donations and Legacies		**236**	**286**	**0**	**522**	700
Investment income		9	11	0	**20**	22
Total income		**245**	**297**	**0**	**542**	722
Expenditure	3					
Costs of generating funds	3.1	(3)	0	0	**(3)**	(2)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(349)	26	0	**(323)**	(1,039)
Total expenditure		**(352)**	**26**	**0**	**(325)**	(1,041)
Gains / (losses) on investments	4	34	70	0	**104**	(89)
Net income/expenditure		**(72)**	**393**	**0**	**321**	(408)
Fund transfer	4	0	0	0	**0**	0
Net movement in funds	4	**(72)**	**393**	**0**	**321**	(408)
Fund balances brought forward at 31 March 2020		433	321	8	**762**	1,170
Fund balances carried forward at 31st March 2021		**361**	**714**	**8**	**1083**	762

The notes at pages 22 to 33 form part of these financial statements.
Please note there may be some rounding's within the numbers

Balance Sheet as at 31st March 2021

					2020/21	2019/20
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	**£000**	**£000**	**£000**	£000
Fixed Assets	5					
Investments	5.1	211	416	0	**626**	522
Total Fixed Assets		**211**	**416**	**0**	**626**	522
Current Assets	6					
Cash at bank and in hand	6.1	288	568	8	**864**	830
Total current Assets		**288**	**568**	**8**	**864**	**830**
Liabilities						
Creditors due within one year	7.1	(137)	(270)	0	(407)	(589)
Net Current Assets / (Liabilities)		**151**	**298**	**8**	**458**	**241**
Total Net Assets		**362**	**714**	**8**	**1084**	**762**
Funds of the Charity	8					
Endowment Funds		0	0	8	**8**	8
Restricted Funds		0	714	0	**714**	322
Unrestricted Funds		362	0	0	**362**	432
Total Funds		**362**	**714**	**8**	**1084**	**762**

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 charitable funds financial statements were approved by the Trust Board on the 22nd December 2021 and signed on its behalf as Trustee by:

_____ 22nd December 2021

David Highton, Date

Chair of the Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows at 31st March 2021

	Note	**2020/21 £000's**	**2019/20 £000's**
Cash flows from Operating activities:			
Net Income /(Expenditure) for the reporting period	4	321	(408)
Adjustments for:			
(Gains)/losses on investments	4	(104)	89
Dividends, interest and rents from investments	2	(20)	(22)
(increase)/Decrease in debtors	6.2	0	146
Increase/(decrease) in creditors	7.1	(182)	589
Net Cash provided by (used in) operating activities		**14**	**394**
Cash flows from investing activities:			
Dividends, interest and rents from investments		20	22
Net Cash provided by (used in) investing activities		**20**	**22**
Cash flows from financing activities		0	0
Change in cash and cash equivalents in the reporting period		34	416
Cash and cash equivalents at the beginning of the reporting period		830	413
Cash and Cash equivalents at the end of the reporting period	6.1	864	830
Cash in hand		**864**	**830**

Notes to the financial statements for the year ended 31st March 2021

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 1st January 2019 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. The charity ended the year with £1,084k in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

Whilst the COVID-19 pandemic has had a negative impact on our charity's ability to generate income from fundraising plans and investment income, this has not made a material impact in the 2020/21 financial year.

1.2. Reconciliation with previous generally accepted accounting practices

These accounts are continued to be prepared in accordance with FRS 102 and the charities SORP FRS 102.

Governance and administration costs are 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 an 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 probable 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 of 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, costs of fundraising, 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 Statement of Financial Activities under the category to which they relate with further detail, where appropriate, provided in the notes. For the financial year 2020/21 there were no Exceptional Items.

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, Fundraising staff 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 it charitable aims. The total cost of making grants, including support costs, is presented 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 use, 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

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 9 for further information.

1.8. Gains and losses

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

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

1.9. Cash and Cash equivalents

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.

1.10. 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.

A financial asset is derecognised when it is settled, or when the contractual rights to the cashflows expire. If substantially all the risks and rewards are transferred, the financial asset is derecognised. If substantially all the risks and rewards are retained, the financial asset is not derecognised. A financial liability is derecognised only when it is cancelled, expired or discharged.

1.11. Pensions

The Charity has no direct employees but does charge costs relating to finance support staff and the full costs of the fundraiser. These employees are contracted by the Trust and pension liabilities are charged as part of the recharge.

1.12. Prior Year Adjustments

The Charitable Fund has not made any prior year adjustments

Due to the following tables being reported in thousands there may be some rounding differences but the overall totals are correct

2. Income

				2020/21	2019/20
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Donations	173	102	0	**275**	524
Donations – website	63	183	0	**247**	19
Legacies	0	0	0	**0**	157
Total Donations and Legacies	**236**	**286**	**0**	**522**	**700**
Investment income					
Dividends from investment portfolio	8	10	0	**18**	18
Interest from investment portfolio	1	1	0	**3**	2
Bank Interest	0	0	0	**0**	2
Total Investment income	**8**	**11**	**0**	**20**	**22**
Total incoming resources	**245**	**297**	**0**	**542**	**722**

3. Expenditure

3.1. Cost of generating funds				**2020/21**	2019/20
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Investment managers fees	(3)	0	0	**(3)**	(2)

				2020/21	2019/20
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	0	0	0	0	0
Other	(24)	(12)	0	(36)	(5)
Complementary Therapies	0	0	0	0	(0)
Total patients welfare and amenities	**(24)**	**(12)**	**0**	**(36)**	**(5)**
Staff welfare and amenities					
Training	(5)	0	0	(5)	(34)
Hospitality	0	0	0	0	0
Christmas Events	(1)	0	0	(1)	(6)
Other	(16)	(34)	0	(50)	(3)
Total staff welfare and amenities	**(22)**	**(34)**	**0**	**(56)**	**(43)**
Medical and Rehabilitation Equipment	(221)	92	0	(129)	(549)
Furniture and Fittings	(10)	(1)	0	(11)	(40)
Other	(9)	4	0	(5)	(15)
Building Costs	0	0	0	0	(301)
Governance - Salaries & overheads	(63)	(21)	0	(84)	(84)
Governance - Audit Fees (external)	(1)	(1)	0	(2)	(2)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(303)**	**73**	**0**	**(230)**	**(991)**
Total cost of charitable activities	**(349)**	**26**	**0**	**(323)**	**(1039)**
Total resources expended	**(352)**	**26**	**0**	**(325)**	**(1041)**

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 and a full time Fundraiser is employed by the Trust and recharged in full to 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

				2020/21	2019/20
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	(107)	323	0	**216**	(319)
Gains/Losses on Investments	34	70	0	**104**	(89)
Total net movement in funds	**(72)**	**393**	**0**	**320**	(408)
Funds transfers	0	0	0	**0**	0
Total net movement in funds after transfers	**(72)**	**393**	**0**	**320**	(408)
Fund balances at 1st April 2020	433	321	8	**762**	1,170
Fund balances carried forward at 31st March 2021	**361**	**714**	**8**	**1,083**	762

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/2020	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	**Carrying value at 31/03/2021**
	£000	£000	£000	£000	**£000**
CAF Bond Income Fund (UK)	232	0	0	11	**243**
CAF Equity Growth Fund (UK)	290	0	0	94	**384**
Total Fixed Asset Investments	**522**	**0**	**0**	**104**	**626**

6. Current Assets

6.1. Cash and cash investments	**2020/21**	2019/20
	Total Funds	Total Funds
	£000	£000
Cash Investments:		
Santander	**82**	82
Clydesdale	**87**	87
Operational Bank Accounts:		
Government Banking Service (GBS) bank account	**680**	540
Nat West bank account	**14**	120
Total Cash and Cash Investments	**864**	**830**

7. Current Liabilities

7.1. Creditors	**2020/21**	2019/20
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year:		
Trade Creditors	**(0)**	(0)
Other Creditors	**(0)**	(0)
Intercompany creditor between the charity and the Trust exchequer account	**(406)**	(587)
Accruals	**(1)**	(2)
Total Creditors due within one year	**(407)**	**(589)**

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2020	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2021
			£000	**£000**	**£000**	**£000**	**£000**
A.Haines – Capital in perpetuity	67020	Endowment	7	0	0	0	7
E.C.Beedle Fund - Capital in perpetuity	67010	Endowment	1	0	0	0	1
Total Endowment Funds			**8**	**0**	**0**	**0**	**8**

Please note that there may be some rounding's within the following numbers:

Description	Fund number	Fund Type	Balance 01-Apr-2020	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2021**
			£000	£000	£000	£000	**£000**
Cardiac Equip Fd Ms Crow Legacy	65450	Restricted	18	0	(1)	2	**19**
Cardio Equip TW Hayling Legacy	65460	Restricted	95	2	(3)	10	**104**
E&M Dir Diabetes Fund Tw	65410	Restricted	46	1	(2)	5	**50**
Oncology Centrifuge Fund	61490	Restricted	20	0	(1)	2	**21**
Oncology Equipment Fund	67170	Restricted	0	1	47*	2	**49**
Oncology Prostate Equip Fund P Ward Legacy	61310	Restricted	9	14	(3)	2	**21**
Pierre Fabre Grant Fund	61720	Restricted	47	1	(2)	5	**51**
E&M Directorate - Frances Gibson Legacy	65180	Restricted	19	0	(1)	2	**21**
Maskell Equipment Legacy Fund	69702	Restricted	27	2	41**	11	**81**
COVID-19 Trust Fund	69900	Restricted	0	276	(41)	25	**260**
Other Restricted Funds (closing balances <£10,000)			43	0	(8)	2	**38**
Total Restricted Funds			**323**	**297**	**26**	**69**	**715**

* The value of £47k appears as a positive balance in expenditure instead of a negative as the Trust was accruing for expenditure that was planned for at the end of 2019/20 but this never happened so the accrual was released within 2020/21.

**The other debit balance of £41k relates to a VAT refund.

Description	Fund number	Fund Type	Balance 01-Apr-2020	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2021
			£000	**£000**	**£000**	**£000**	**£000**
General Fund	61000	Unrestricted	21	83	(19)	6	**91**
Emergency & Medical Directorate	61020	Unrestricted	6	13	(11)	1	**10**
Critical care Dir Fund	61060	Unrestricted	21	31	(20)	4	**35**
Surgery Directorate Fund	61140	Unrestricted	11	0	(3)	1	**10**
Cancer Services Fund	61350	Unrestricted	36	37	(18)	7	**61**
Sutcliffe Fund	61370	Unrestricted	25	0	(4)	2	**23**
Paediatric Dir Fund	61540	Unrestricted	5	2	(2)	1	**6**
Radiology Fund	61590	Unrestricted	23	0	(13)	2	**12**
Cardiac Fund	65400	Unrestricted	26	1	(11)	2	**18**
Haematology Development Fund	65600	Unrestricted	8	0	(2)	1	**7**
Special Care Baby Unit Fund	65660	Unrestricted	20	8	(12)	2	**17**
Peggy Wood Breast Care Centre	67160	Unrestricted	215	3	(217)	0	**1**
Equality + Diversity Fund	68900	Unrestricted	0	51	(2)	5	**54**
Other Unrestricted Funds (closing balances <£10,000)		Unrestricted	16	15	(16)	2	**16**
Total Unrestricted Funds			**433**	**245**	**(351)**	**34**	**361**

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

Restricted Funds	**Nature and purpose of Fund**
Oncology Prostate Equipment Fund	Supports the purchase of prostate equipment for Cancer Services
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures
Oncology Centrifuge Fund	Supports the purchase of a centrifuge for the Oncology Centre
Cardio Equip Hayling Legacy Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Cardiac Equip Crow Legacy Fund	Supports the Cardiac Unit at Maidstone Hospital
E&M Dir Diabetes Fund TW	Supports the Diabetic Unit at Tunbridge Wells Hospital
E&M Directorate Gibson Legacy	Supports the emergency & Medical Directorate
Oncology Equipment Fund	Supports the purchase of equipment for Cancer Services
Maskell equipment Legacy	Supports equipment purchases at Tunbridge Wells Hospital
COVID-19 Trust Fund	Donation from NHS Charities Together from money raised by Sir Tom Moore to support staff
Unrestricted Funds	**Nature and purpose of Fund**
General Fund	Supports Maidstone and Tunbridge Wells NHS Trust
Critical Care Fund	Supports the Critical Care Directorate
Cancer Services Fund	Supports the Cancer Services department
Radiology Fund	Supports the Radiology Department at Maidstone Hospital
Cardiac Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Surgery Directorate Fund	Supports the Surgery Directorate
Women’s Directorate Fund	Supports the Women's Directorate
Special Care Baby Unit Fund TW	Supports the Special Care Baby Unit at Tunbridge Wells Hospital
Equality & Diversity Fund	Donation from NHS Charities Together from money raised by Sir Tom Moore to support staff
Sutcliffe Fund	Supports the purchase of medical equipment for the Haematology and Oncology departments

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 Maidstone and Tunbridge Wells NHS Trust.

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

The Charity has made revenue and capital payments, in the form of grants, to Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition, £86k (in 2019/20, £86k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration and fundraising activities of the Charity. The amount owed at the balance sheet date to the Charity by the Trust was £0k, (in 2019/20, £0k). Total amount owed by the charity to the Trust for 2020/21 £407k (in 2019/20, £589k).

11. Events after the reporting year

The Charitable Fund does not have any events after the reporting period.

Our Ref: SO/jr

Steve Orpin
Deputy Chief Executive / Chief Finance Officer
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

Dear Sirs

Maidstone and Tunbridge Wells NHS Trust Charitable Funds accounts for the year ended 31 March 2021

This representation letter is provided in connection with the independent examination of the accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund for the year ended 31 March 2021 for the purpose of making of an independent examiner's report 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:

Accounts

i We have fulfilled our responsibilities, [as set out in the terms of our engagement letter/contract dated [**enter engagement letter date**], for the preparation of accounts in accordance with section 132 of the Charities Act 2011 and comply with the Statement of Recommended Practice for accounting and reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) ('Charities SORP (FRS 102)'), effective 1 January 2019, in particular the accounts give a true and fair view in accordance therewith.

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

iii The methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

v Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi All events subsequent to the date of the financial statements and for which the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii We have not adjusted the misstatements brought to our attention on the audit differences and adjustments summary, attached to this letter, as they are [**immaterial to the results of the company and financial position at the year-end / for the reasons noted on the schedule / other reasons**]. The financial statements are free of material misstatements, including omissions.

ix 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 recognised; and

d. we consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

x The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the accounts in the event of non-compliance.

xi We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the accounts.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

xiii The charity meets the conditions for exemption from an audit of the accounts as set out in section 145 of the Charities Act 2011.

Information Provided

xiv We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the accounts such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your examination; and

c. unrestricted access to persons from whom you determine it necessary to obtain evidence.

xv We have communicated to you all deficiencies in internal control of which we are aware.

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

xvii All transactions have been recorded in the accounting records and are reflected in the accounts.

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

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the accounts.

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

xx 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 accounts.

xxi 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.

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

xxiii We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including the guidance 'How to report a serious incident in your charity' issued by the Charity Commission (updated in June 2019) and the specific guidance on 'Reporting serious incidents to the Charity Commission during the coronavirus pandemic', issued in June 2020.

. 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 date of signing of the balance sheet.

Yours faithfully

Name……

Position……..

Date……..

Signed on behalf Maidstone and Tunbridge Wells NHS Trust Charitable Fund

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for November 2021	Chief Executive / Members of the Executive Team

The IPR for month 8, 2021/22, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 20/12/21 (IPR)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

November 2021

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 23 onwards)

Note: Detailed dashboards and a deep dive into each CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

MTW
exceptional people, outstanding care

Key to KPI Variation and Assurance Icons

Variation			Assurance			
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low(L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

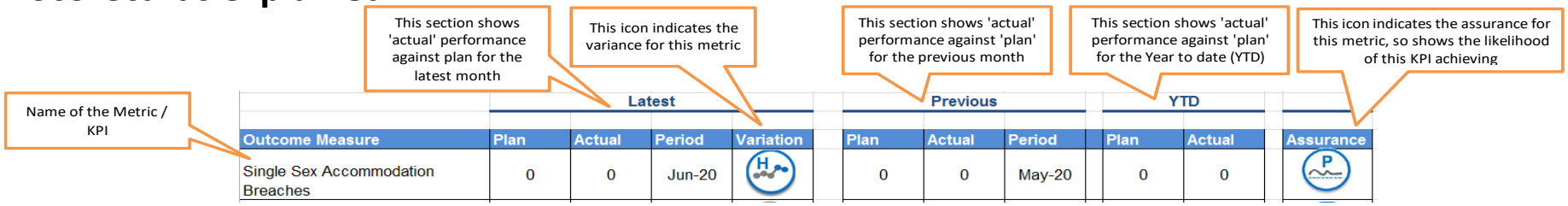
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

- They have special cause variation (positive or negative) in their performance
- They have a change in their assurance rating (positive or negative)

Scorecards explained



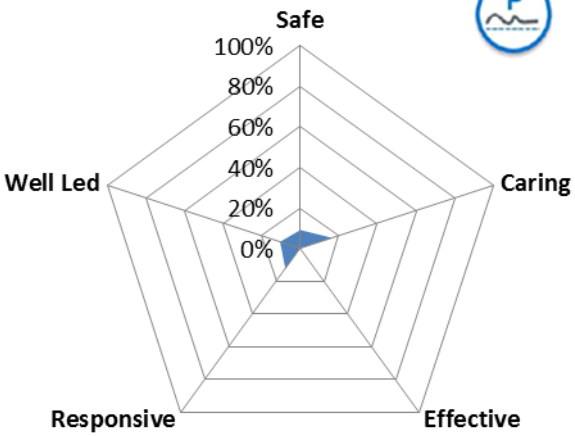
Further Reading / other resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

MTW exceptional people, outstanding care

Executive Summary

Consistently Passing



Consistently Passing:
The following Key Performance Indicators are all consistently achieving the target:

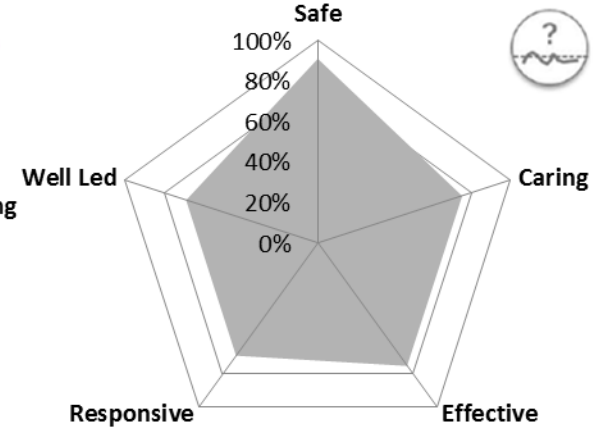
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance
- % VTE Risk Assessment

Responsive:
- Cancer 62 Day Waiting Times Standard
- Cancer 2 week Waiting Times Standard

Well-Led:
- Mandatory Training Compliance
- Number of Advanced Practitioners

Hit and Miss



Hit and Miss:
The following Key Performance Indicators are experiencing inconsistency (passing or failing target)

Safe:
- Safe Staffing, Infection Control Indicators, Incident Reporting, Harm Free Care Indicators, Never Events

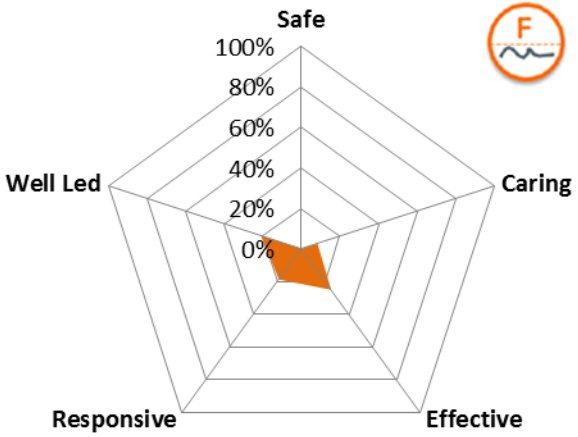
Effective:
- Hospital Cancellations, Readmissions & Stroke Indicators,

Caring:
- Complaints Indicators, Friends & Family Percentage Positive, Friends & Family Response Rates – Inpatients & Maternity

Responsive:
- RTT Number of >52 week Waiters, Cancer 31 Day Standard, A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NE LOS, Cancer PTL – size of Backlog

Well-Led:
- Capital Expenditure, Agency Spend, Sickness Rate, Appraisals and Health and Well-Being

Consistently Failing



Consistently Failing:
The following Key Performance Indicators are all consistently failing the target:

Caring:
- OP Friends & Family Response Rate
- A&E Friends & Family Response Rate

Effective:
- Outpatient Utilisation
- Outpatient –Calls answered within 1 min
- Outpatient – Calls Abandoned
- Outpatients DNA Rates

Responsive:
- RTT performance
- RTT Number of >40 week Waiters
- Diagnostics Waiting Times
- Theatre Utilisation

Well-Led:
- Agency Staff used
- Turnover Rate
- Vacancy Rate
- Number of Specialist Services to London
- Percentage of Trust policies within review date
- Staff FFT Recommended Care or Work

Matrix Summary

November 2021	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Variance: Special Cause - Improvement	Stat and Mandatory Training (W)	Sickness Rate - Covid (S), Infection Control - Number of Hospital acquired MRSA (S), Outpatient Hospital Cancellation (E) Outpatient Cancellations < 6 weeks (E) 52 week breaches (including those reported last month) (R) Capital Expenditure (£k) (W)	Calls Answereed in under 1 min '(E) Number of patients waiting over 40 weeks (R) Percentage of Trust policies within review date (W),
Variance: Common Cause	Single Sex Accommodation Breaches (C), Stat and Mandatory Training (W) Number of advanced practitioners (W)	**See box (right)**	Percentage OP Clinics Utilised (slots) (E), Percentage of Calls abandoned (E), A&E Resp Rate Recmd to Friends & Family (C), RTT (Incomplete) performance against trajectory (R), Theatre Utilisation (R), Number of specialist services (W), Turnover (W), Vacancy Rates (W), Use of Agency (WTE) (W)
Variance: Special Cause - Concern	% VTE Risk Assessment '(C) Cancer - 2 Week Wait (R) Cancer - 62 Day '(R)'	Mat Resp Rate Recmd to Friends & Family (C) A&E 4 hr Performance '(R)' Bed Occupancy (R) Size of backlog (R), Cancer - 31 Day (R) Nursing vacancies (W)	OP New DNAs '(E), OP Follow UP DNAs '(E), OP Resp Rate Recmd to Friends & Family (C), Access to Diagnostics (<6weeks standard) '(R), Staff Friends and Family % recommended work (W), Staff Friends and Family % recommended care (W)

Hit & Miss /

Safe Staffing Levels (S, Infection Control - Hospital Acquired Covid (S), Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays (S), Infection Control - Rate of Hospital E. Coli Bacteraemia (S), Number of New SIs in month (S), Rate of Total Patient Falls per 100,000 occupied beddays (S), Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions (S), Never Events (S), Percentage of Virtual OP Appointments (E) Total Readmissions <30 days (E), Non-Elective Readmissions <30 days (E), Elective Readmissions < 30 Days (E), Stroke Best Practice Tariff (E), Rate of New Complaints (C), % complaints responded to within target (C), IP Resp Rate Recmd to Friends & Family (C),	IP Friends & Family (FFT) % Positive (C), A&E Friends & Family (FFT) % Positive (C) Maternity Combined FFT % Positive (C), OP Friends & Family (FFT) % Positive (C), Average for new appointment (R), Super Stranded Patients (R), Ambulance Handover Delays Rate > 30mins (R) NE LOS (R), 28 day Target (R), Health and Wellbeing: How many calls received (W) Health and Wellbeing: What percentage of Calls related to Mental Health Issues (W), Covid Positive - number of patients (W), Agency Spend (£k) (W) Elective Spells in London Trusts from West Kent (W) Research grants (£) (W) Sickness (W) Appraisal Completeness (W)

Items for escalation based on those indicators that are Failing the target or are unstable ('Hit & Miss') and showing Special Cause for Concern by CQC Domain are as follows:

Safe:

Caring: OP Response Rate Recommended to Friends and Family, Maternity Response Rate Recommended to Friends and Family

Effective: OP Follow Up DNAs, OP New DNAs

Responsive: Diagnostics <6 weeks, A&E 4 hr Performance,Bed Occupancy, Cancer 31 Day, Size of 62 day Cancer backlog

Well-Led: Nursing Vacancies, Staff FFT % recommended work, Staff FFT % recommended care

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains		L	H	L	H	P	F	?	No SPC	
CQC Domain Safe										
Infection Control	3			1				4		4
Harm Free Care	2							2		2
Incident Reporting	2							2		2
Safe Staffing	1			1				2		2
Mortality				1		1				1
Safe Total	***8***	***0***	***0***	***3***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	3		2	2	1		5	3		8
Quality & CQC	4							4		4
Strategy - Estates									5	5
Effective Total	***7***	***0***	***2***	***2***	***1***	***0***	***5***	***7***	***5***	***17***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3	1				2		2		4
ED Care	2						1	1		2
Maternity Care	1	1						2		2
Outpatient Care	1	1					1	1		2
Caring Total	***9***	***3***	***0***	***0***	***0***	***2***	***2***	***8***	***0***	***12***
CQC Domain Responsive										
Elective Access	3			2			2	3		5
Acute and Urgent Access	3	1						4	1	5
Cancer Access	1	3	1			2		3		5
Diagnostics Access		1					1			1
Bed Management			1					1		1
Responsive Total	***7***	***5***	***2***	***2***	***0***	***2***	***3***	***11***	***1***	***17***
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts	1			1				2	4	6
Leadership		2					2		1	3
Strategy - Clinical and ICC	5		1		1	1	2	4	1	8
Workforce	6					1	3	2		6
Well-Led Total	***14***	***2***	***1***	***1***	***1***	***2***	***7***	***10***	***10***	***29***
Trust Total	***45***	***10***	***5***	***8***	***2***	***7***	***17***	***46***	***16***	***86***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	4		?
S6	Rate of Total Patient Falls	6.00	7.76		?
S7	Number of Never Events	0	0		?
S8	Number of New SIs in month	11	9		?
S10	Overall Safe staffing fill rate	93.5%	89.0%		?

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	95.0%	80.9%	L	?
R4	RTT Incomplete Pathway	86.7%	73.7%		F
R6	% Diagnostics Tests WTimes <6wks	99.0%	70.6%	L	F
R7	Cancer two week wait	93.0%	93.1%		P
R10	Cancer 62 day wait - First Definitive	85.0%	85.5%		P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	85.0	L	P
E3	% Total Readmissions	14.6%	14.8%		?
E6	Stroke: Best Practice (BPT) Overall %	50.0%	0.0%	L	?
R11	Average LOS Non-Elective	6.50	7.70		?
R12	Theatre Utilisation	90.0%	84.2%		?

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	0	6	No SPC	No SPC
W2	CIP Savings (£k)	483	240	No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	12.5%		F
W8	Total Agency Spend (£k)	1,333	2,277		?
W10	Sickness Absence	3.3%	4.8%		?

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		P
C3	% complaints responded to within target	75.0%	85.1%		?
C5	IP Friends & Family (FFT) % Positive	95.0%	97.8%		?
C7	A&E Friends & Family (FFT) % Positive	87.0%	100.0%		?
C10	OP Friends & Family (FFT) % Positive	84.0%	82.7%		?

Variation			Assurance			
H / L	H / L		P	?	F	No SPC
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low(L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Safe - CQC Domain Scorecard

Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	89.0%	Nov-21		93.5%	87.7%	Oct-21	93.5%	88.9%	
Sickness Rate - Covid	0.0%	0.3%	Oct-21	L	0.0%	0.2%	Sep-21	0.0%	0.3%	
Infection Control - Hospital Acquired Covid	0	1	Nov-21		0	24	Oct-21	0	51	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	20.3	Nov-21		22.7	24.8	Oct-21	22.7	28.2	
Infection Control - Number of Hospital acquired MRSA	0	0	Nov-21	L	0	0	Oct-21	0	0	
Infection Control - Rate of Hospital E. Coli Bacteraemia	19.0	25.3	Nov-21		19.0	24.8	Oct-21	19.0	21.5	
Number of New SIs in month	11.0	9	Nov-21		11	8	Oct-21	88	64	
Rate of Total Patient Falls per 1,000 occupied beddays	6.0	7.8	Nov-21		6.0	8.6	Oct-21	6.0	7.6	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	2.2	Nov-21		2.3	2.4	Oct-21	2.3	2.1	
Standardised Mortality HSMR	100.0	85.0	Aug-21	L	100.0	85.0	Jul-21	100.0	85.0	P
Never Events	0	0	Nov-21		0	0	Oct-21	0	4	

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Virtual OP Appointments	30.0%	25.0%	Nov-21		30.0%	23.7%	Oct-21	30.0%	28.0%	?
Percentage OP Clinics Utilised (slots)	85.0%	52.8%	Nov-21		85.0%	52.1%	Oct-21	85.0%	53.2%	F
OP New DNAs	5.0%	7.3%	Nov-21	H	5.0%	7.2%	Oct-21	5.0%	7.4%	F
OP Follow UP DNAs	5.0%	8.1%	Nov-21	H	5.0%	8.1%	Oct-21	5.0%	7.8%	F
Outpatient Hospital Cancellation	20.0%	21.4%	Nov-21	L	20.0%	22.4%	Oct-21	20.0%	22.4%	?
Outpatient Cancellations < 6 weeks	10.0%	16.7%	Nov-21	L	10.0%	17.3%	Nov-21	10.0%	17.0%	?
Calls Answereed in under 1 min	90.0%	58.2%	Nov-21	H	90.0%	58.1%	Nov-21	90.0%	49.6%	F
Percentage of Calls abandoned	0.0%	5.5%	Nov-21		0.0%	6.5%	Nov-21	0.0%	9.8%	F

Organisational Objectives: Quality and CQC

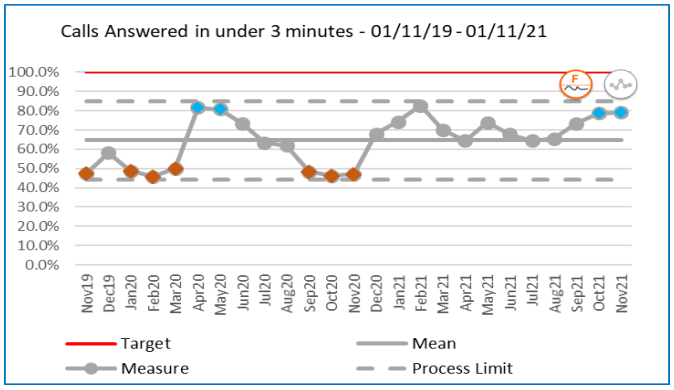
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	14.8%	Oct-21		14.6%	14.6%	Sep-21	14.6%	15.3%	?
Non-Elective Readmissions <30 days	15.2%	15.2%	Oct-21		15.2%	15.2%	Sep-21	15.2%	15.9%	?
Elective Readmissions < 30 Days	7.8%	8.8%	Oct-21		7.8%	6.9%	Sep-21	7.8%	8.2%	?
Stroke Best Practice Tariff	50.0%	No data	Nov-21		50.0%	No data	Oct-21	50.0%	54.2%	?

Effective - CQC Domain Scorecard

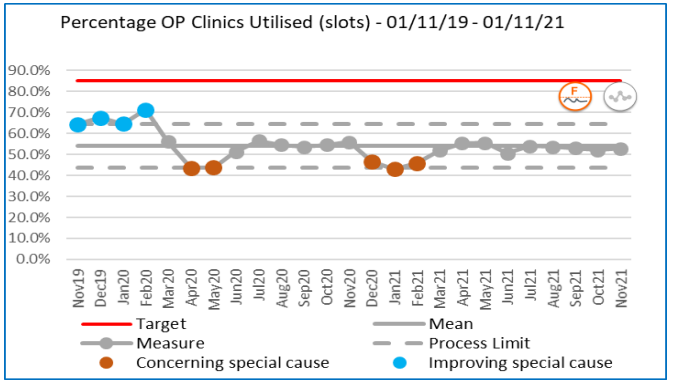
Organisational Objectives: Strategy - Estates

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100	Nov-21	No SPC	Under review	100	Oct-21	Under review	100	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Nov-21	No SPC	Under review	4.4:1	Oct-21	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Nov-21	No SPC	Under review	5808	Oct-21	Under review	5808	No SPC
Staff occupancy per m2	Under review	18.7	Nov-21	No SPC	Under review	18.9	Oct-21	Under review	18.9	No SPC
Energy cost per staff	Under review	£ 699.21	Nov-21	No SPC	Under review	£ 414.46	Oct-21	Under review	£5,040.6	No SPC

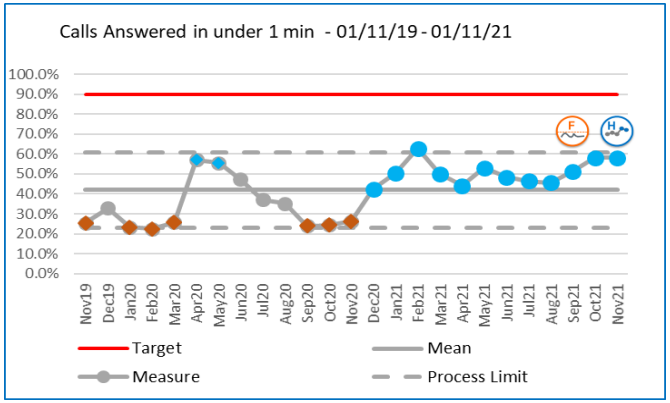
EFFECTIVE- Reset and Recovery Programme: Outpatients



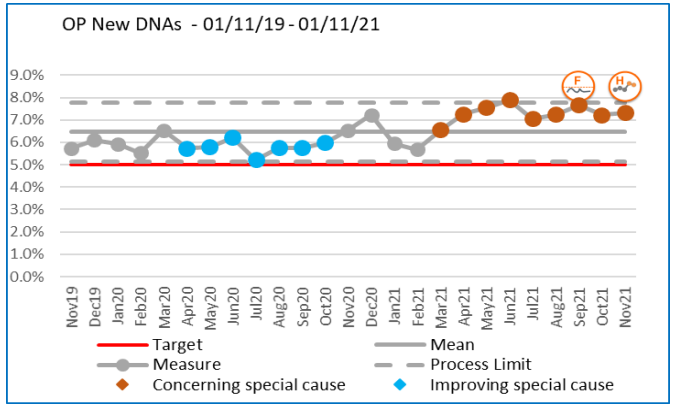
Nov-21
79.2%
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
100%
Target Achievement
Metric is consistently failing the target



Oct-21
52.8%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target



Oct-21
58.2%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
90%
Target Achievement
Metric is consistently failing the target



Oct-21
7.3%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Limit (Internal)
5%
Target Achievement
Metric is consistently failing the target

Summary:

Outpatient Utilisation: This indicator continues to experience common cause variation and is consistently failing the target

Calls Answered: The number of calls answered in less than 1 minute continues to experience special cause variation of an improving nature but remains consistently failing the target.

Calls answered in under 3 minutes is in common cause variation but is consistently failing the target.

DNA Rates: DNA rates for New Appointments continue to be in special cause variation of a concerning nature and is now consistently failing the target. This is the same for Follow Up appointments also. There has been an increase in DNAs for General Surgery (Meant of 8.8 for all and 12.0 for New only this financial year). Urology (mean of 8.8) and T&O (including Fracture Clinics) also have a high DNA Rate (mean of 6.3) along with Paediatrics (as expected) but this has seen an improvement.

Actions:

Hospital Cancellations: This is being monitored weekly and ensuring specialties are sticking to 6.4.2 model. Due to site pressures last minute cancellations have occurred.

Outpatient Utilisation: The Clinical System Development Managers have reviewed over 99% of the clinic templates on Allscripts, this includes viewing the individual microsession templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection. Once complete the utilisation figures will be correct to do further analysis on how to improve this.

Calls: Currently investigating spacing options in which to house call operatives for the outpatient communication centre pilot which will improve this.

DNA Rates: Currently reviewing cases to understand cause. Text reminders are being organised to switch on to reduce this.

Assurance:

Outpatient Utilisation: Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Further analysis of utilisation is being completed to understand reasonings.

Weekly meeting with specialties are undertaken to go through all of our KPI's to understand areas for improvement and reasonings for poor performance. This includes calls, DNA's and Cancellations.

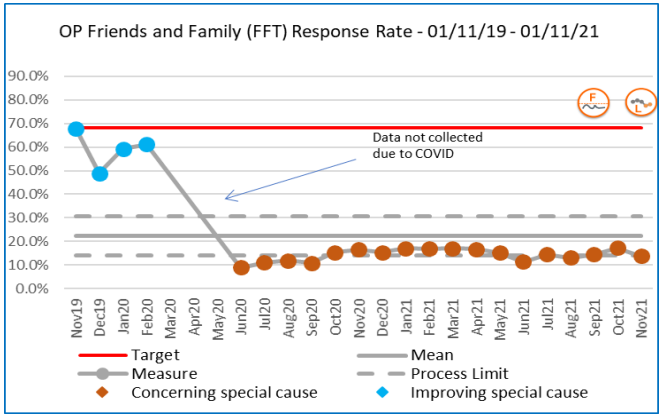
Two way text reminders are being explored and implemented to ensure our patients are informed of their appointment and have the opportunity to cancel prior to DNA.

Caring - CQC Domain Scorecard

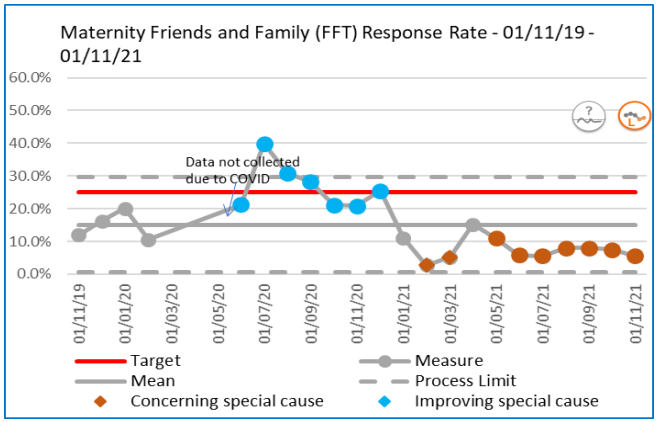
Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Nov-21		0	0	Oct-21	0	0	P
Rate of New Complaints	3.9	4.2	Nov-21		3.9	2.1	Oct-21	3.9	2.9	?
% complaints responded to within target	75.0%	85.1%	Nov-21		75.0%	60.9%	Oct-21	75.0%	71.3%	?
IP Resp Rate Recmd to Friends & Family	25.0%	7.1%	Nov-21		25.0%	9.3%	Oct-21	25.0%	9.8%	?
IP Friends & Family (FFT) % Positive	95.0%	97.8%	Nov-21		95.0%	97.4%	Oct-21	95.0%	97.9%	?
A&E Resp Rate Recmd to Friends & Family	15.0%	0.5%	Nov-21		15.0%	1.4%	Oct-21	15.0%	2.1%	F
A&E Friends & Family (FFT) % Positive	87.0%	100.0%	Nov-21		87.0%	96.0%	Oct-21	87.0%	96.0%	?
Mat Resp Rate Recmd to Friends & Family	25.0%	5.6%	Nov-21	L	25.0%	7.6%	Oct-21	25.0%	8.7%	?
Maternity Combined FFT % Positive	95.0%	100.0%	Nov-21		95.0%	95.2%	Oct-21	95.0%	99.0%	?
OP Friends & Family (FFT) % Positive	84.0%	82.7%	Nov-21		84.0%	83.0%	Oct-21	84.0%	82.7%	?
OP Resp Rate Recmd to Friends & Family	68.0%	13.8%	Nov-21	L	68.0%	17.2%	Oct-21	68.0%	14.6%	F
VTE Risk Assessment	95.0%	94.2%	Nov-21	L	95.0%	96.3%	Oct-21	95.0%	96.5%	P

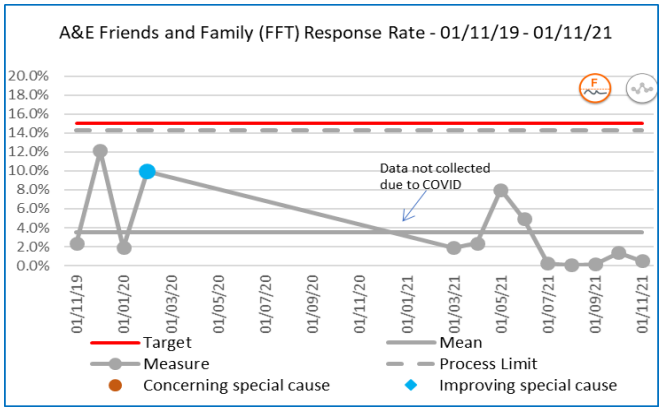
Caring - Organisational Objective: Quality and CQC



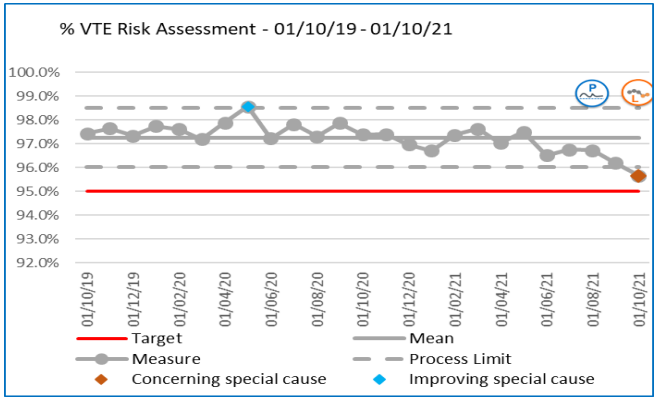
Nov-21
13.8%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
68%
Target Achievement
Metric is consistently failing the target



Nov-21
5.6%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
25%
Target Achievement
Metric is experiencing variable achievement



Nov-21
0.%
Variance Type
Metric is currently experiencing common cause variation
Target
15%
Target Achievement
Metric is consistently failing the target



Nov-21
95.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (National)
95%
Target Achievement
Metric is consistently achieving the target

Summary:

Outpatient Friends and Family Response Rate continues to experience special cause variation of a concerning nature and consistently failing the target.

Maternity Friends and Family Response Rate: The rate of responses remain low and this lower level has now become the new norm with this indicator experiencing common cause variation and variable achievement of the standard.

A&E Friends and Family Response Rate:. The level of those responding remains significantly lower than expected levels (Average of 0.1%) and this indicator is now experiencing special cause variation of a concerning nature.

VTE: VTE performance has returned to special cause variation of a concerning nature, however this indicator continues to consistently achieve the national target.

Actions:

OP FFT: The Trust will be implementing SMS text messaging

FFT: Reliance on paper remains an issue, patient experience lead is undertaking a detailed review with the patient experience assistant in each area. 500 FFT QR posters have been received and now being distributed. 6 patient partners onboarded week commencing 6.12.21 to assist with the collection of FFT.

FFT A&E: Multiple issues with setting up SMS Text to send out the FFT link. A working group is being set up to rectify this. The implementation of SMS text will increase the uptake to meet the target.

Assurance:

OP FFT: SMS text messaging in the final stages of implementation. This service will also be utilised within ED and ophthalmology pathways which will support their FFT submission rates.

FFT: The Patient Experience assistant is in the early stages of a full ward / area audit to review the resources and issues in each area.

VTE: There is a data lag in the information being coded which means the latest month is not always fully coded and once refreshed next month the performance usually improves. Performance is still consistently achieving the national 95% target.

Responsive - CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
RTT (Incomplete) performance against trajectory	86.7%	73.7%	Nov-21		86.7%	72.7%	Oct-21	86.7%	73.7%	F
Number of patients waiting over 40 weeks	222	327	Nov-21	L	222	440	Oct-21	222	327	F
52 week breaches (including those reported last month)	0	10	Nov-21	L	0	17	Oct-21	0	10	?
Access to Diagnostics (<6weeks standard)	99.0%	70.6%	Nov-21	L	99.0%	73.8%	Oct-21	99.0%	70.6%	F
Average for new appointment	10.0	9.1	Nov-21		10.0	8.6	Oct-21	10.0	9.1	?
Theatre Utilisation	90.0%	84.2%	Nov-21		90.0%	86.3%	Oct-21	90.0%	84.2%	?

Reset and Recovery Programme – Acute & Urgent Care

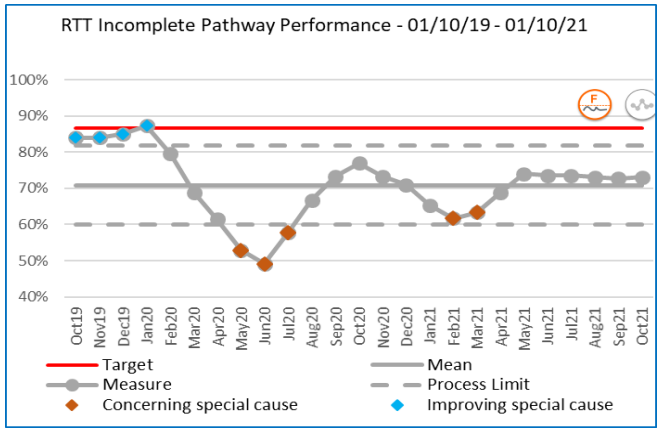
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	TBC		Nov-21	No SPC	TBC		Oct-21	TBC		No SPC
A&E 4 hr Performance	95.0%	80.9%	Nov-21	L	95.0%	79.3%	Oct-21	95.0%	84.8%	?
Super Stranded Patients	80	96	Nov-21		80	96	Oct-21	80	82	?
Ambulance Handover Delays Rate > 30mins	7.0%	12.8%	Nov-21		7.0%	13.4%	Oct-21	7.0%	10.1%	?
Bed Occupancy	90.0%	92.6%	Nov-21	H	90.0%	94.4%	Oct-21	90.0%	89.9%	?
	6.5	7.7	Nov-21		6.5	7.2	Oct-21	6.5	7.7	?

Responsive - CQC Domain Scorecard

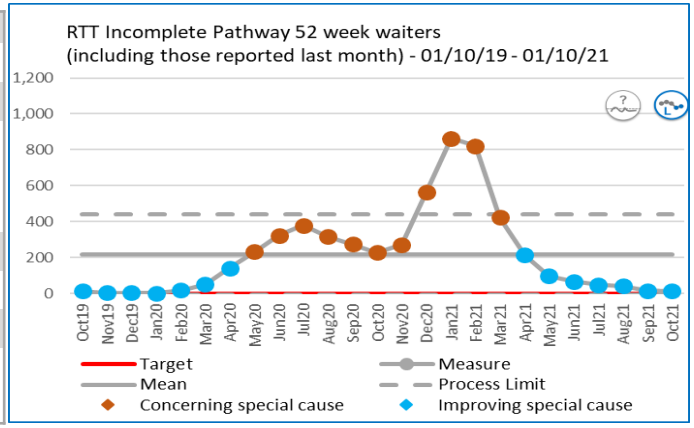
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	93.1%	Oct-21		93.0%	94.5%	Sep-21	93.0%	93.1%	
Cancer - 31 Day	96.0%	92.9%	Oct-21		96.0%	97.8%	Sep-21	96.0%	92.9%	
Cancer - 62 Day	85.0%	85.5%	Oct-21		85.0%	85.2%	Sep-21	85.0%	85.5%	
Size of backlog	30	96	Nov-21		30	96	Oct-21	30	96	
28 day Target	75.0%	80.0%	Oct-21		75.0%	75.6%	Sep-21	75.0%	80.0%	

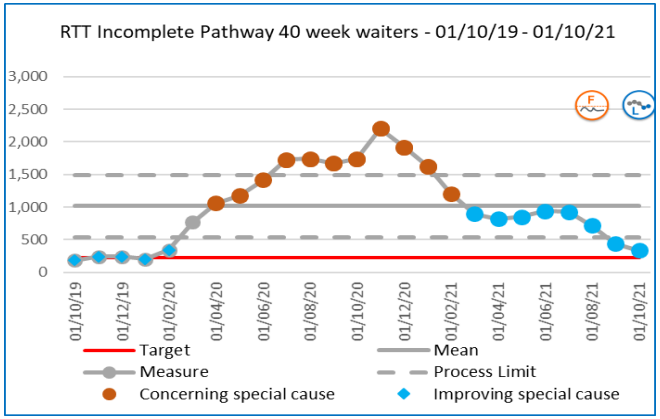
Responsive - Reset and Recovery Programme: Elective



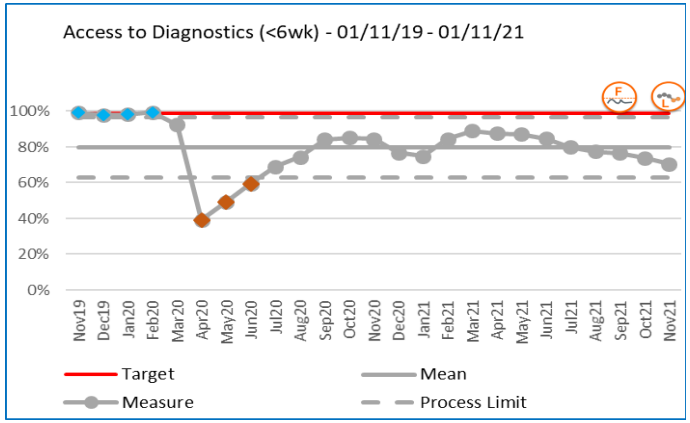
Nov-21
73.7%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



Nov-21
10
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
0
Target Achievement
Metric is experiencing variable achievement



Nov-21
337
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)
222
Target Achievement
Metric consistently failing the target



Nov-21
70.6%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

RTT: Performance has remained steady, with November's provisional performance sitting at 73.7%.

RTT 52 wk waiters: There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 854 waiters over the last 9 months to 10 patients.

Elective Activity: 96% of October's elective activity levels were achieved. The current estimate for November is 91% of November 2019 elective activity levels as endoscopy activity is not at the 1920 levels due to a change in the service. Outpatients are at 100% of 1920 levels overall with first outpatients estimated to be at 90% for November (excluding IS activity). This activity has been affected by a changing in coding for Paediatric Ward Attenders (now recorded as Day Case) which equates to a 3.5% reduction in OP New Activity.

Diagnostic Activity: CT Scans in October were at 126% of 2019/20 Activity levels, MRI is at 106% of 2019/20 Activity levels and NOUS is at 95% of 2019/20 Activity.

Diagnostic Waiting Times performance has been affected by Echocardiography staffing shortages and a lack of DEXA capacity.

Actions:

RTT: Continued focus on long waiting patients, pre operative assessment performance, patient cancellations, scheduling and utilisation.

Efficiency: Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity. HVLC action plan has been implemented across Ophthalmology, ENT, T&O and General Surgery.

Diagnostics:
A data quality issue has been identified within the DEXA waiting list whereby patients had not pulled through the system due to the way they were recorded. This has now been rectified following a full review of the waiting list and appropriate patients have been re-added to the waiting list ensuring an accurate position.

Assurance:

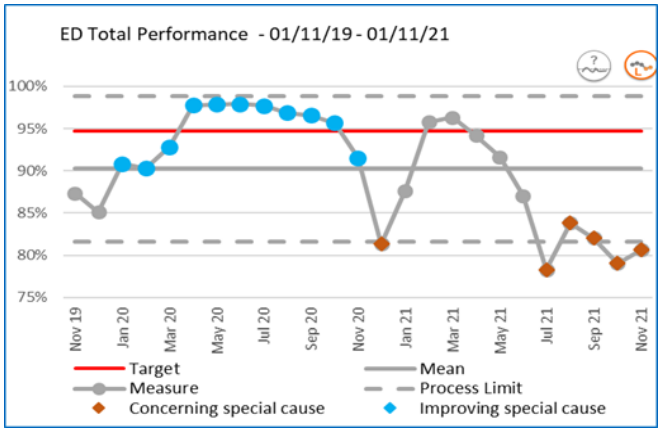
RTT and Elective Activity: Weekly performance meeting in progress, 6-4-2 and scheduling meetings, cancellations RCA's completed to identify trends. TUB in progress.

RTT Long Waiters: Clinical Prioritisation of waiting lists continues in line with national recommendations . P5 and P6 priorities have now been removed. Long waiting patients are in the process of being treated or are being scheduled for treatment.

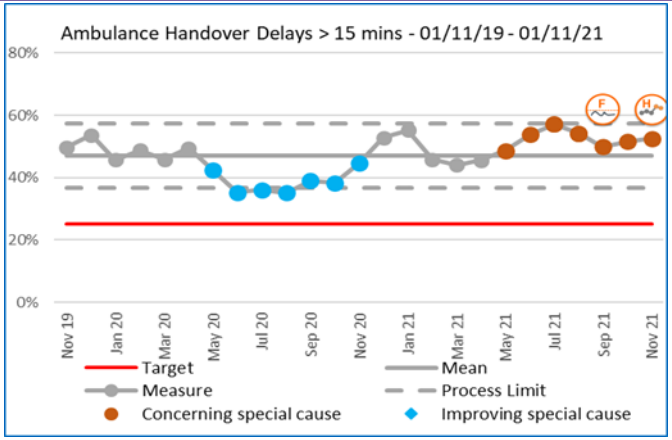
Elective Activity: We continue to work closely with ISP partners. Work continues to streamline the process and link with ISP where appropriate. The at risk long waiting patients are with the IS so are being monitored weekly.

Diagnostics:
- Recovery paper in progress
- Action plan and revised trajectory to be monitored weekly
- Revised operational structure to be implemented in radiology to support the recovery trajectory

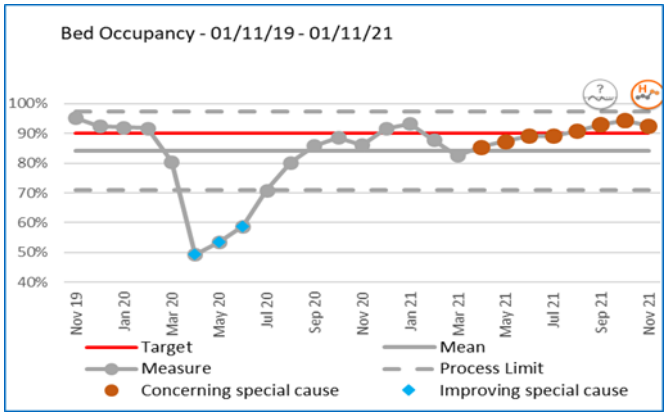
Responsive - Reset and Recovery Programme: Emergency Care



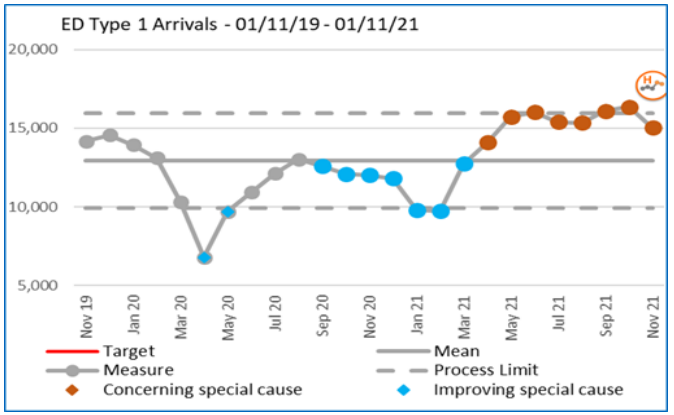
Nov-21
80.93%
Variance Type
Metric is currently experiencing special Cause Variation of a concerning nature
Target
95%
Target Achievement
Metric is experiencing variable achievement



Nov-21
52.5%
Variance Type
Metric is currently experiencing special Cause Variation of a concerning nature
Max Limit (Internal)
25%
Target Achievement
Metric is experiencing variable achievement



Nov-21
92.6%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Nov-21
15,030
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Model
15,578
Target Achievement
For Info

Summary:

ED 4hr performance (inc MIU): This indicator continues to experience special cause variation of a concerning nature at 80.93% in November, partly due to the implementation of the new Sunrise System and the continued high level of attendances. It should be noted that MTW sits 2nd in the latest regional benchmarking and 8th nationally for Type 1 4 hour performance.

Type 1 ED Attenders were 3.5% down on model in November. The sustained higher level in October dropped suddenly on 25th Oct, and have been consistently below model since then.

Ambulance Handover Delays of >15minutes continue to experience special cause variation of a concerning nature.

Bed Occupancy remains in special cause variation of a concerning nature at 92.6%. Patients with a long length of stay (LOS) is impacting on this partly due to a lack of social care and community beds.

Actions:

Flow Coordinators to be developed into cover until 2am. Business Case to be submitted for 24/7 cover to support minors flow in addition to majors flow.

111/ UTC – development of direct referral to SDEC pathways

New ED standards – to be reported from beginning of December.

Increased staffing for Minors/ GP on both sites including change in shift pattern.

3 new ED consultants in post. Paramedic recruitment for Resus/ RAP. Development of Band 2/3 Housekeeper post to support nursing workforce.

PIN input earlier in ambulance handover at clinician handover.

Assurance:

Focus on flow across organisation being led by Safer, Better Sooner Programme

Directorate/ Divisional meetings to review figures, with appropriate escalation. New Divisional Governance Matron lead in post. 5th Rota Coordinator appointed to support ED nursing rota

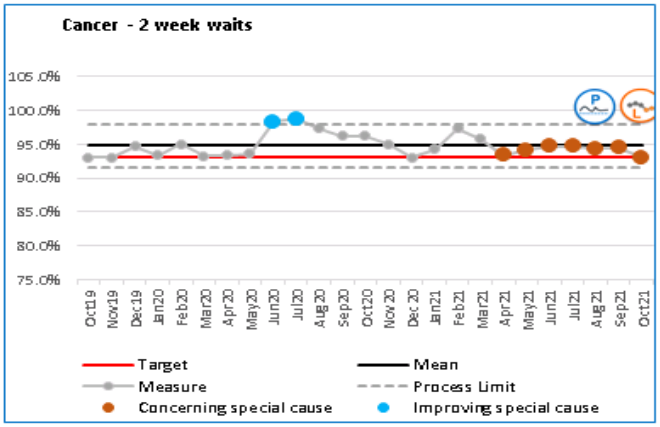
A3 project underway – key areas incl. R&R/ Staff Wellbeing; demand and capacity; Front Door; onward referrals for admitted patients

Good working relationship with SECAmb and Site Management team

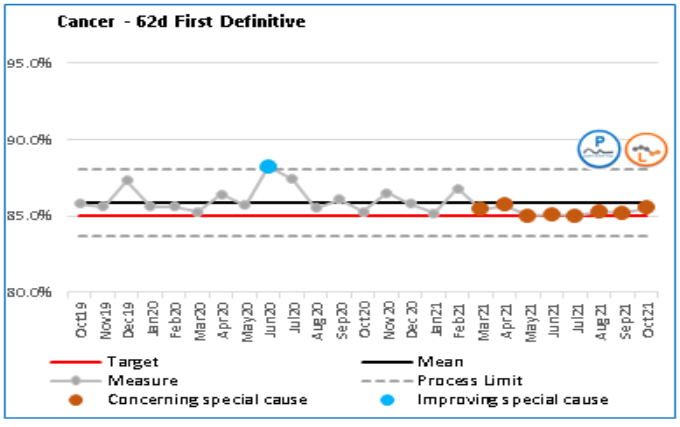
Consultants leading on transformation of referral process

Governance in place to support Sunrise changes where required

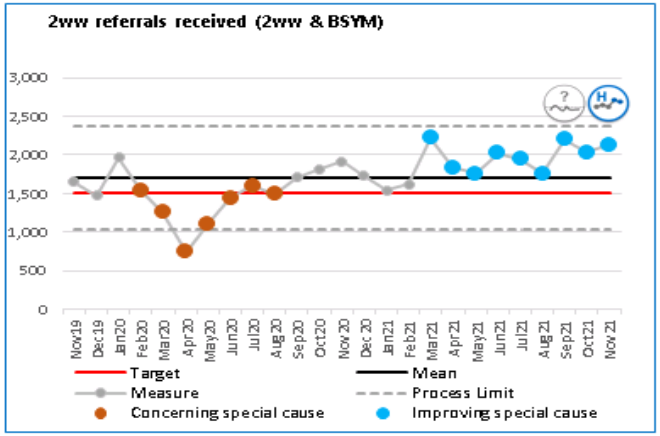
RESPONSIVE- Reset and Recovery Programme: Cancer



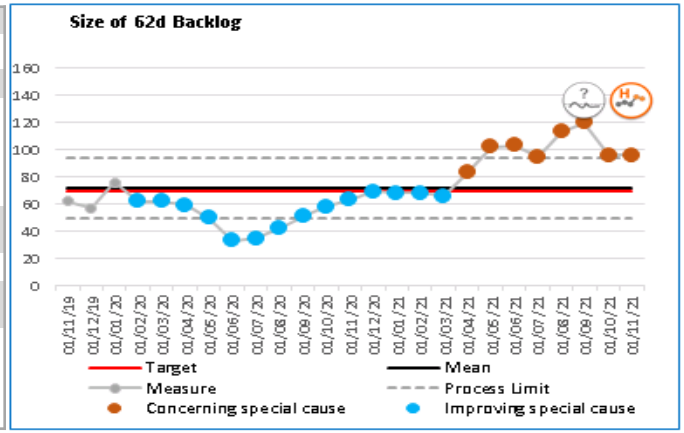
Oct-21
93.07%
Variance Type
Special cause variation as last 7 months below the calculated mean of 94.8%
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Oct-21
85.5%
Variance Type
Special Cause variation as last 8 months below the calculated mean of 85.85%
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Nov-21
2130
Variance Type
Improving Special cause – numbers with 9 months above the mean
Max Target
1500
Target Achievement
Metric is experiencing variable achievement of locally set target



Nov-21
96
Variance Type
Concerning Special Cause variation with last 8 points above the upper process limit
Max Target (Internal)
70
Target Achievement
Metric is experiencing variable achievement of locally set target

Summary:

2ww: The 2ww standard has continued achievement for the past 25 months – reporting 93.07% for October 2021

Referrals: The Trust is receiving higher numbers of 2ww referrals than pre-Covid and is showing improving special cause due to the last 9 months with numbers above the calculated mean.

62 day: The Trust has continued achievement of the 62 day standard for 2 years (from Aug 2019) reporting 85.5% this month.

62 day PTL Backlog: As the numbers on the 62d PTL continue to grow, the backlog has seen an increase in the past 8 months. Overall the process is showing concerning special cause variation, with May to November sitting at the upper process limit due to unprecedented 2ww referral numbers. The backlog has reduced to 96 in October & November, which is 5.0% of the total PTL

Actions:

Cancer PTL: 1.) Increased focus on backlog patients on a daily basis. **2.)** Introduction of F2F PTLs on a Monday afternoon to support services further.

3.) Validation of all backlog and tip-over patients this week in order to ensure all patients in the backlog are appropriate referrals and on the right pathway.

4.) Training with coordinators and teams to ensure prioritisation and recording of 'risk' patients for demand management within our supporting services.

Referrals: Services are reviewing baseline 2ww provision in line with trajectory of demand and implementing various models to support. The CCG and Cancer Alliance have supported in prioritising patient referrals and ensuring we are appropriately appointing those at highest risk of cancer within the national guidelines.

Assurance:

Cancer Performance and PTL: Management of the daily PTLs continues to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day.

28 Day FDS Standard: 28 day FDS meetings have been implemented to manage data completeness and ensure we are submitting a representative view of our performance.

Weekly triumvirate meetings help to support key areas of concern and give clinical guidance across services. Daily Cancer Performance huddles with the teams and weekly senior MDT coordinator huddles to support the team working.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	473	Aug-21	No SPC	Improving Quarterly	634	Jun-21	Improving Quarterly	473	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		52.2%	Aug-21	No SPC		56.4%	Jun-21		52.2%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		53.4%	Aug-21	No SPC		61.9%	Jun-21		53.4%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being placed on		52.2%	Aug-21	No SPC		54.0%	Jun-21		52.2%	No SPC
Health and Wellbeing: How many calls received	40	48	Oct-21		40	79	Jun-21	480	450	?
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	33%	Oct-21		44%	42%	Jun-21	44%	46%	?

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	4.8%	Oct-21		3.3%	4.1%	Sep-21	3.3%	0.0%	?
Turnover	10.0%	11.6%	Nov-21		10.0%	11.4%	Oct-21	10.0%	11.6%	F
Vacancy Rates	9.0%	13.4%	Nov-21		9.0%	13.4%	Oct-21	9.0%	13.4%	F
Use of Agency (WTE)	81	273	Nov-21		81	326	Oct-21	81	273	F
Appraisal Completeness	95.0%	86.7%	Nov-21		95.0%	86.6%	Oct-21	95.0%	86.7%	?
Stat and Mandatory Training	85.0%	92.2%	Nov-21		85.0%	92.1%	Oct-21	85.0%	92.2%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty (£k)	0	6	Nov-21	No SPC	-	5	Oct-21	0	69	No SPC
CIP Savings (£k)	483	240	Nov-21	No SPC	483	328	Oct-21	3569	1682	No SPC
Cash Balance (£k)	30,841	26,719	Nov-21	No SPC	31,432	33,821	Oct-21	30,841	26,719	No SPC
Capital Expenditure (£k)	1,060	388	Nov-21	L	1,134	965	Oct-21	6,203	3,261	?
Agency Spend (£k)	1,333	2,277	Nov-21		1,333	750	Oct-21	10,662	14,209	?
Use of Financial Resources	No data		Nov-21	No SPC	No data		Oct-21	No data		No SPC

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Nursing vacancies	13.5%	17.0%	Nov-21	H	13.5%	17.8%	Oct-21	13.5%	17.0%	?
Covid Positive - number of patients	0	129	Nov-21		0	150	Oct-21	0	591	?

Well Led - CQC Domain Scorecard

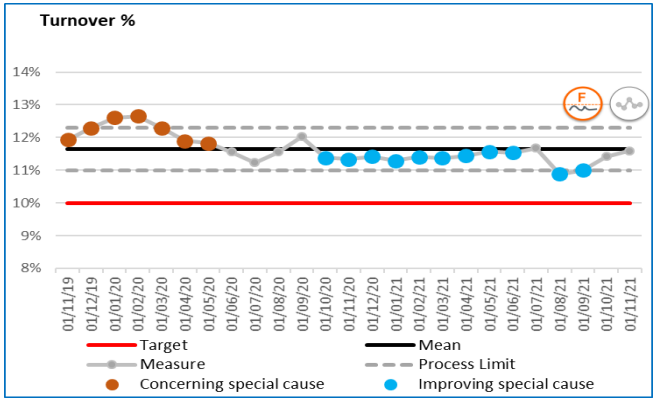
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Nov-21		35	30	Oct-21	35	35	F
Elective Spells in London Trusts from West Kent	329	365	Nov-21		329	365	Oct-21	329	365	?
Service contribution by division	TBC		Nov-21	No SPC	TBC		Oct-21	TBC		No SPC
Research grants (£)	124	107	Nov-21		124	111	Oct-21	124	107	?
Number of advanced practitioners	25	31	Nov-21		25	31	Oct-21	25	31	P
Percentage of Trust policies within review date	90.0%	79.0%	Nov-21	H	90.0%	73.4%	Oct-21	90.0%	79.0%	F

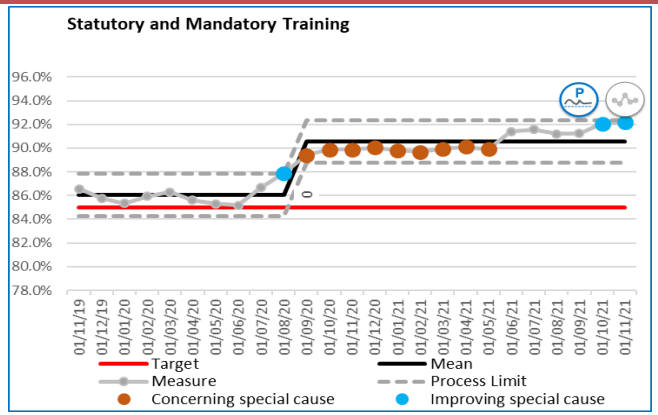
Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	70.0%	62.1%	Nov-21	L	70.0%	62.1%	Oct-21	70.0%	62.1%	F
Staff Friends and Family % recommended care	80.0%	72.8%	Nov-21	L	80.0%	72.8%	Oct-21	80.0%	72.8%	F
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	TBC		Nov-21	No SPC	TBC		Oct-21	TBC		No SPC

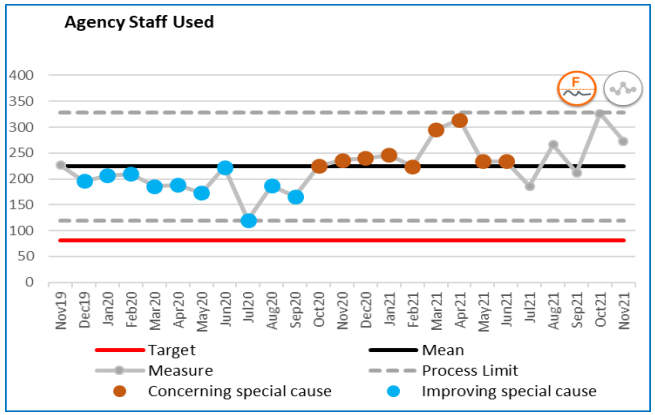
Well Led - Operational Objective: Workforce



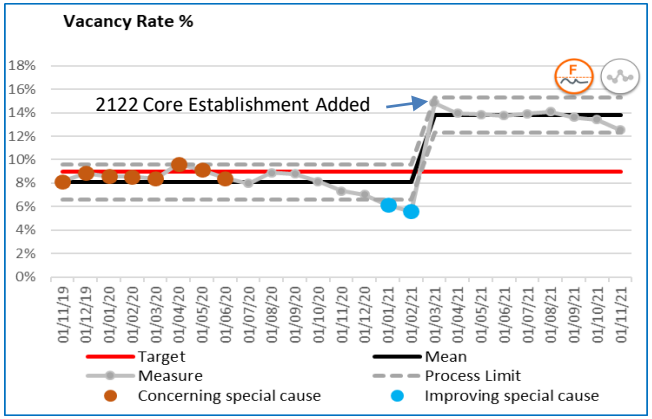
Nov-21
11.6%
Variance Type
Metric is currently experiencing Common Cause Variation.
Max Target (Internal)
10%
Target Achievement
Metric is consistently failing the target



Nov-21
92.2%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
85%
Target Achievement
Metric is consistently passing the target



Nov-21
273
Variance Type
Metric is currently experiencing Common Cause Variation
Target (Internal)
81
Target Achievement
Metric is consistently failing the target



Nov-21
12.5%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
9.0%
Target Achievement
Metric is consistently failing the target

Summary:

Turnover: The Turnover rate remains in Common Cause Variation and continues to consistently fail the target.

Statutory and Mandatory Training: This indicator continues to perform well and is consistently achieving the target.

Agency Staff Used: The level of Agency staff used dropped in November. However, this indicator continues to experience Common Cause Variation and consistently fail the target

Vacancy Rate : With a step change applied from the beginning of 2021/22, vacancy rate is now in common cause variation, but consistently failing the target

Actions:

Turnover : There has been a marginal movement bring the KPI closer to the mean average this month. This will continue to be monitored.

Agency / Vacancy Rate: In November we saw a slight decrease in supply for Temporary Staffing c.1%. Nursing saw a decrease of 4% compared to the previous month, the demand level remains higher than the same period last year (c.16%), the demand levels for CSW's decreased by 1% compared to the previous month but just under 15% compared to the same time last year. Medical demand increased by c.10% but is comparable to the same period last year. In the last 12 month period we have seen the temporary staffing demand increase by just under 40% compared to the same period the year before, with bank fill increasing by 22.9%. A further update will be provided in the next IPR.

Assurance:

The Recruitment and Communication leads are still working with "Alcatica" in preparation for the MTW recruitment campaign to go live January 2022. A bespoke Recruitment logo and strapline has been designed. We will be receiving the PR plan and first draft for social media content, micro site etc in the next few weeks. We still have ongoing campaigns with Pharmacy and ED which includes (Social media advertising, External advertising, Radio adverts, Head hunting and many more). The recruitment team are also meeting with Midwifery, Stroke, Respiratory, Cardiology, Radiotherapy, Therapies, ITU and Facilities to create content for recruitment campaigns in the near future. We are attending the London Nursing Times event on Saturday 11th December to promote Staff Nurse vacancies at MTW. We are also in discussions with two suppliers who will be supporting us to run a Staff Nurse recruitment campaign in Ireland. Job Packs are being created for each directorate to assist in attracting staff, these are in the final stages so should be completed within a few weeks. Funding has been offered to support trusts to decrease there HCSW vacancies, our EOI will be submitted next week. We have submitted our International Nursing bid for next year (140)- awaiting confirmation. We currently have 44 International nurses in the pipeline and a further 17 with start dates booked. Predicted circa 200 between now and Next December. In addition to paying enhanced rates for Bank staff working within areas with staffing concerns to mitigate staff shortages an early booking bonus in also in place for bank staff over Christmas.

NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 85.5% and 93.1% respectively, however achievement of the these standards is becoming increasingly challenging with the continued high number of 2ww referrals and increasing 62 Day Backlog . A&E 4hr performance remains in special cause variation of a concerning nature at 80.9% which has been impacted partly by the implementation of the new Sunrise System as well as the continued high level of attendances. However, the Trust's performance remains one of the highest both Regionally and Nationally. RTT performance has remained similar in November as elective activity continues to recover. Activity levels (which include the activity being undertaken in the Independent Sector) have been above the national target for April to July (just under for first outpatient attendances in July), August, September and October were just below the target and the estimate for November is currently showing 91% of 1920 levels for Elective Activity and 97% for Total outpatients. The high level of non-elective emergency admissions as well as the high level of elective activity being undertaken is therefore putting pressure on the bed capacity across with Trust. Total Bed Occupancy continues it's increasing trend back to pre-Covid levels and is now experiencing special cause variation of a concerning nature (92.6% for November 2021). Following the record level of Mothers Delivering reported in the last three months, the numbers decreased in November back to previous levels (482 for November which remains above the average over the last two years of 473). Patient safety and quality indicators remain in common cause variation despite the high bed occupancy and challenges in staffing levels.

Key Performance Items:

- **Infection Control:** Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The volume of C.Diff cases has dropped below mean levels in November. The Trust admitted 129 patients with Covid-19 infection during November, with 1 case of probable or definite hospital acquired infection (0.8%). Assurance of compliance continues through the IPC BAF.

- **Falls:** The overall rate of falls continues to experience common cause variation and variable achievement of the target. Two SI relating to Falls were reported. Following the Stakeholder Event held on 19th October 2021 three working groups were set up. The First working groups meetings were held on week commencing 29/11/21 to identify the priority for focus of top contributors to Falls. The next meeting is to outline the approach and method for the countermeasure to be implemented.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers remains in common cause variation and variable achievement of the target. Total pressure ulcers (including inherited) also remains in common cause variation. The Pressure Ulcer group continue to discuss learnings from recent incidents to ensure that they are shared across Directorates. The Trust continues to monitor patients admitted with pressure ulcers and liaise with the local community and neighbouring acute trusts to identify themes and trends.

- **Incidents and SIs:** The level of SIs reported increased to 9). Senior members of the Patient Safety Team continue to carry their own caseload of SIs to ensure that investigations are completed thoroughly and in a timely manner to support our staff, patients and their families. The team continue to work with the divisions to allocate investigators to these SIs.

- **Stroke:** The overall Best Practice Indicator continues to experience common cause variation and variable achievement of the target (no data available yet for November due to delays in coding).

- **A&E 4 hour Standard and Flow:** Overall A&E performance has increased by 1.6% in November but remains in special cause variation of a concerning nature (80.9% in November) driven by continued high attendance volumes and the rollout of Sunrise. Good progress is being made with the Trust routinely within the top 3 of the Region and top 10 Nationally. Action plan in place and focus on recruitment and retention. Physical capacity in A&E is the greatest challenge to achieving this metric. There is a focus on flow across the organisation being led by the Safer, Better Sooner Programme. Emergency admissions remain high and are experiencing special cause variation. The level of Same Day Emergency Care (SDEC) attenders continues to rise and is experiencing special cause variation.

- **Ambulance Handover Delays:** have returned to common cause variation but remain in variable achievement of the target (12.8% in November).

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** Performance remained similar at 73.7%. Elective activity continues to recover. The estimate for November is 91% for Elective and 97% for total outpatients. Day case activity is being affected by the reduction in endoscopy demand. The number of 52 week waiters has reduced by **854** waiters over the last 10 months. Diagnostics waiting <6 weeks decreased further to 70.6% mainly due to Echocardiography staffing shortages and a lack of DEXA Capacity.

- **Cancer 62 Day:** From August 2019 the 62 day standard has shown an improved performance, consistently achieving the 85% standard (reporting 85.5% for October 2021). This process is currently showing special cause variation of a concerning nature because the last 7 months have reported below the calculated mean. With the previous higher % performance achievement up to February 2021 the calculated mean across the past 25months is 85.8%. Although the target of 85% has been achieved, the last 8 months have reported performance below 85.8%. This could indicate a future risk to achievement of this standard

- **First Seen Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement, achieving the target. Despite the pressure experienced from the increased numbers of 2ww referrals from March 2021, the Trust has continued to achieve this standard (93.1% for October). This metric is now in special cause variation of a concerning nature. Although the target is being achieved, the current performance is below the calculated mean, which could indicate a future risk to the continued achievement of this standard

- **Size of 62 day Backlog**: The numbers on the 62 day PTL have continued to increase. This is impacting on the number of patients being managed with pathways over 62 days. Overall the size of the 62d backlog is in concerning special cause variation, with the last 6 months reporting numbers above the upper process limit. As at October month end, the backlog averaged at 96 patients (5.27% of the overall PTL). The 62d PTL has risen to 1954 patients as at 10th November 2021. A continuation of this backlog increase will impact the sustainability of cancer performance

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April 2020 due to COVID-19, the incoming referral numbers have increased through the remainder of 2020, into 2021. Following the significant increase in numbers seen in March 2021, referral numbers have remained high, experiencing special cause variation. 2130 referrals were received in November 2021 (on average 126% above the 2019 numbers).

- **Finance:** The Trust is £0.1m favourable to plan generating a Surplus of £0.1m. The Trusts key favourable variances to the plan are: Independent Sector usage (£4.7m), Pay underspends (£2.7m), non recurrent benefits / release of contingency (£2.2m) , underspends within clinical supplies and drugs (£1.2m) due to lower activity than funded levels, Elective recovery fund (£0.6m) and Pathology trade income overperformance (£0.4m). These underspends are offset by the following key adverse variances:- Re-phasing of top up and non recurrent income support (£6.6m), expenditure incurred relating to Kent and Medway Medical school (£3.9m) and CIP slippage to internal plan (£1.3m) .

- **Workforce**: The Safe Staffing Nursing Fill Rate reported remains in common cause variation, which impacts the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue to ensure safe staffing levels across the Trust. professions representation are on the wards to help support the nursing staff. The Recruitment and Communication leads are still working with “Alcatica” in preparation for the MTW recruitment campaign to go live January 2022. A bespoke Recruitment logo and strapline has been designed. We still have ongoing campaigns which include Social media advertising, External advertising, Radio adverts, Head hunting and many more. We are attending the London Nursing Times event on Saturday 11th December to promote Staff Nurse vacancies at MTW. We are also in discussions with two suppliers who will be supporting us to run a Staff Nurse recruitment campaign in Ireland. Job Packs are being created for each directorate to assist in attracting staff, these are in the final stages so should be completed within a few weeks. In addition to paying enhanced rates for Bank staff working within areas with staffing concerns to mitigate staff shortages an early booking bonus in also in place for bank staff over Christmas. Sickness levels increased by 0.7% in October. As we have enough data post wave 2 of Covid, a step change has been applied from March 2021. Sickness is now within common cause variation with variable achievement of the target at 4.8% Of the 4.8% reported 0.3% was COVID related sickness. Non-Covid Sickness remains at expected levels.

Implementing a Revised Perinatal Tool

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA (?)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	2 cases Themes: - Extreme prematurity x 1 - HSIB case x 1	1 case Themes: - HSIB case x 1	3 cases Themes: - HSIB case x 2 - MTOP - fetal anomaly x 1	5 cases Themes: - MTOP fetal abnormalitiy x 2 - Unexplained death x 2 - fetal cardiac anomaly x 1	1 case Themes: - MTOP fetal anomaly x 1	3 cases Themes: - Prematurity x 4 - Unexplained death x 1	2 cases Themes: - Prematurity x 2 - Unexplained death x 2	3 cases Themes: - Extreme prematurity x 1 - Unexplained stillbirth x 1 - Term stillbirth - placental	1 case Themes: - Covid infection at 23 weeks - IUD at 24 weeks	1 case Themes: - IUD at 36+6 weeks - placental abruption	1 case Themes: - Difficult birth at MBC - Extensive neonatal resuscitation required	
Findings of review of all cases eligible for referral to HSIB	2 cases Themes: Case 1 - Escalation during neonatal resuscitation Case 2 - No safety concerns	1 case Themes: Patient information - fetal movements in labour Guideline for risk	2 cases Themes: Guideline for obstetric / MDT review in Triage Review process for identifying indication for	0 cases	1 case Themes: GAP pathway not followed (incidental finding) No safety recommendations	0 cases	1 case Themes: GAP pathway not followed (incidental finding) No safety	0 cases	1 case Investigation in progress	1 case Investigation in progress	1 case Investigation in progress	
Report on:												
*The number of incidents logged as moderate or above and what actions are being taken	4 moderate incident 1 serious incident Learning shared: - MDT Communication - Guidelines updated	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - situational awareness	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - obstetric cover for Triage - review of guideline for care in latent phase of labour	0 moderate incident 1 serious incident Learning shared: - reminder to staff to follow fetal growth assessment programme	5 moderate incident 2 serious incident Learning shared: - reminder to follow ED pathway for unwell maternity patients - review of process for follow up of investigation results - review of pathway for booking caesarean section - 1:1 feedback	1 moderate incident 1 serious incident Learning shared: - importance of timely follow up of urgent investigation results - importance of MDT working and clinical overview - failure to follow swaab count policy in theatre	2 moderate incidents 2 serious incident Learning shared: - assess risk of bladder injury at LSCS - ensure staff with appropriate experience available for complex surgery - growth assessment policy not followed	0 moderate incident 0 serious incident	1 moderate harm 0 serious incident Learning shared: - consider FSE if loss of contact on CTG - rotate from OP to OA, if possible, for instrumental births - provide 1:1 care in labour in any location. Document and escalate if not possible - always connect CTG to	0 moderate incident 1 serious incident Learning shared: No learning idenitifed IUD of unknown cause in latent phase of labour - reported for investigation by HSIB	1 moderate incident 1 serious incident Learning shared: -Skills drills for community based midwives to be reinstated - Clear pathway for neonatal resuscitation at MBC required - Importance of acting on abnormal findings (urinalysis)	
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	66%	73%	82%	91%	98%	99%	98%	89%	84%	76%	81%	
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in	50%	56%	53%	53%	69%	74%	68%	67%	65%	55%	55%	
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service User Voice Feedback - number of IQVIA (FFT) responses	179	74	282	254	243	191	145	106	82	55	154	
Service User Voice Feedback - % positive responses	98%	99%	96%	99%	97%	97%	96%	92%	92%	91%	90%	
HISB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	HSIB quarterly engagement meeting	CQC engagement meeting	Letter from HSIB requesting additional support for staff involved in investigations - action	HSIB quarterly engagement meeting	No	No	No	No	No	HSIB quarterly engagement meeting
Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No	No	
Progress in achievement of CNST 10							Declaration of compliance submitted 22/07/2021	Maternity Incentive Scheme - Year 4 guidance published. Action planning commenced	Kick off and planning meetings arranged with leads for each safety action and project lead	Planning and progress meetings arranged with leads for each safety action and	Planning and progress meetings continue with leads for each safety action and	

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%
Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported	78%

REVIEW OF LATEST FINANCIAL PERFORMANCE

Year to Date Financial Position

- The Trust has generated a year to date surplus of £0.1m which is £0.1m favourable to plan.
- The Trust delivered a breakeven position in November which was on plan.
- In line with NHSE/I guidance additional income (£4.1m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £3m to cover the full costs incurred in quarter one and two.
- The year to date position includes £13.1m associated with the Elective Recovery Fund (ERF), which is £0.6m favourable plan. This includes unconfirmed ERF income of £2.2m reported within the year to date which relates to Infectious Diseases challenge (£1.7m) and missing independent Sector activity (£0.5m). The Trust has a mitigation for this risk which will involve reinstating Top-Up income.
- The key year to date variances is as follows:
  - **Favourable Variances**
    - Independent Sector usage (£4.7m),
    - Pay underspends (£2.7m)
    - Non-recurrent benefits / release of contingency (£2.2m)
    - Clinical supplies and drugs (£1.2m) due to lower activity than funded levels
    - Elective recovery fund overperformance (£0.6m).
    - Pathology trade income (£0.4m)
  - **Adverse Variances**
    - Rephasing of top up and non-recurrent income support (£6.6m)
    - Expenditure incurred relating to Kent and Medway Medical school (£3.9m)
    - CIP slippage to stretch target (£1.3m)

Current Months Financial Position

- The key current month variances are as follows:
  - Income overperformed by £0.1m in November. The main overperformance is within other operating income (£0.4m) which relates to Pathology services (£0.2m), Injury recovery income (£0.1m) and extension to Laundry contract (£0.1m). This overperformance is partly offset by £0.3m adverse variance within clinical income associated with a one-off year to date correction.
  - Expenditure budgets overspent by £0.2m, both pay and non-pay budgets overspent in the month by £0.1m. The key overspends to plan were: Costs associated with Kent and Medway Medical School (£1.35m) and Drugs (£0.2m). These pressures were partly offset by the following key favourable variances: Release of contingency (£0.5m), Independent sector (£0.4m) and non-recurrent benefits (£0.3m).

Cashflow

- The closing cash balance for November was £26.7m compared to the cash balance for September of £33.8m. H2 System funding envelopes, including system top-up and Covid-19 fixed allocation have been calculated based on the H1 2021/22 envelopes adjusted for inflation, efficiency requirements and policy priorities. The system funding envelope is comprises of growth funding (including 3% pay uplift), system top up (funding for free car parking and H1 efficiencies) and Covid-19 allocation.
- The capital programme for the year is currently c.£15.4m (including c£5m National funding); the majority of the capital spend with the cash flow forecast is within Qtr4 c£10.8m. The phasing of the capital spend is back ended but will be revised when projects are confirmed and approved. The balance sheet is assuming a reduction in capital creditors carried forward from c£6m to closing creditors of £2m within the cash flow - therefore the capital cash spend overall in the cash flow is c£19.4m.
- The Trust is continuing to pay all invoices once they are approved and are maintaining the twice a week payment runs. NHSEI continue to make the Better Payment code targets a key priority. The cash flow forecast is closely linked to the I&E position, therefore any adverse movement or amendments to the H2 planning position which includes a risk to the I&E position, will have a negative impact on the trust's cashflow so cash management strategies will need to be implemented.

Capital Position

- The Trust's capital plan agreed with the ICS/STP for 2021/22 is £10.57m comprising of net internal funding £8.9m, PFI lifecycle per Project model of £1.2m and donated assets of £0.4m.
- In addition to the Plan, an Emergency System PDC bid has been made to NHSE/I for £1.9m, this includes £1.1m for Linac enabling and ancillary equipment, as well as funding for additional equipment and HASU design costs. The STP has agreed to finance £411k of Diagnostic Equipment and £669k of Digital Diagnostics for Radiology and Pathology IT from the National Diagnostic Fund, over which they have discretion. The Trust has also received confirmation of national NHSE funding for 2 core Linacs (£3.73m) in 21/22,to be delivered by 31st March. The national Target Investment Fund (TIF) bids for £1.6m have been approved for schemes including a SPECT CT and Dexa scanner for Radiology, as well as IT equipment including Audio Visual.
- The forecast outturn including additional funds is therefore £18.7m, including donated and PFI Lifecycle.
- There are other national funding bids outstanding including a bid for a Barn Theatre development at Maidstone to provide additional elective recovery capacity.
- The Plan includes;
    - **Estates:** The Backlog schemes include contractual commitments from 20/21 relating to enabling works for CT Simulator, Pharmacy Robot, MRI, Interventional Radiology and Mammography equipment. Development schemes include the Annex/Kabin Modular Development, KMMS enabling work, Paeds ED modular build and Oncology Outpatients.
    - **ICT**: The EPR costs relate to contractual commitments. Other ICT schemes include wireless controllers replacement, over-age laptops/PCs, switches, hubs and servers.
    - **Equipment:** The Linac machine was delivered to the Canterbury site at the end of March, this year's costs include ancillary equipment and commissioning. Trustwide equipment has been prioritised and some emergency cases have been approved.
- The year to date capital spend is £3.2m compared to the Plan of £6.2m. The majority of the spend relates to: Estates - the completion of the MRI and Interventional Radiology installation, ongoing works to The Annex/Kabin, KMMS enabling and Paeds ED; Equipment - the completion of the Canterbury Linac and other various equipment; IT - the ongoing EPR project. There were also elements of carry forward spend from projects commenced in 2020/21. The YTD variance relates to schemes that have either been delayed or are waiting for final business case approval.

Year and Forecast

- The Trust is forecasting to deliver the planned breakeven position however the Trust has the following risks:
    - Additional costs associated with Kent and Medway Medical School above £3.9m incurred YTD
    - Increase in spend to support winter pressures and COVID increase.

Maidstone and Tunbridge Wells NHS

1. Dashboard

November 2021/22

	Current Month			Year to Date			Annual Forecast / Plan		
	Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Income	52.0	51.9	0.1	398.2	405.4	(7.2)	606.2	611.9	(5.7)
Expenditure	(49.4)	(49.2)	(0.2)	(376.5)	(383.7)	7.3	(573.2)	(578.8)	5.6
EBITDA (Income less Expenditure)	2.7	2.7	(0.1)	21.7	21.6	0.1	33.0	33.0	(0.0)
Financing Costs	(2.7)	(2.8)	0.1	(22.1)	(22.0)	(0.0)	(34.2)	(34.2)	(0.0)
Technical Adjustments	0.0	0.0	0.0	0.4	0.4	0.0	1.2	1.2	0.0
Net Surplus / Deficit (Incl Top Up funding support)	**0.0**	**0.0**	**0.0**	**0.1**	**(0.0)**	**0.1**	**0.0**	**(0.0)**	**0.0**
Cash Balance	26.7	30.8	(4.1)	26.7	30.8	(4.1)	5.0	5.0	0.0
Capital Expenditure (Incl Donated Assets)	0.4	1.1	0.7	3.3	6.2	(2.9)	18.7	10.6	(8.2)

Summary Current Month:

- The Trust was on plan generating a breakeven position.
- Income overperformed by £0.1m in November. The main overperformance is within other operating income (£0.4m) which relates to Pathology services (£0.2m), Injury recovery income (£0.1m) and extension to Laundry contract (£0.1m). This overperformance is partly offset by £0.3m adverse variance within clinical income associated with a one off year to date correction.
- Expenditure budgets overspent by £0.2m, both pay and non pay budgets overspent in the month by £0.1m. The key overspends to plan were: Costs associated with Kent and Medway Medical School (£1.35m) and Drugs (£0.2m) . These pressures were partly offset by the following key favourable variances: Release of contingency (£0.5m), Independent sector (£0.4m) and non recurrent benefits (£0.3m).
- In line with NHSE/I guidance additional income (£0.5m) has been included in the month 8 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

Year to date overview:

- The Trust is £0.1m favourable to plan generating a Surplus of £0.1m.
- The Trusts key variances to the plan are:

Favourable Variances:

- Independent Sector usage (£4.7m), Pay underspends (£2.7m), non recurrent benefits / release of contingency (£2.2m) , underspends within clinical supplies and drugs (£1.2m) due to lower activity than funded levels, Elective recovery fund (£0.6m) and Pathology trade income overperformance (£0.4m).

Adverse Variances:

- Rephasing of top up and non recurrent income support (£6.6m), expenditure incurred relating to Kent and Medway Medical school (£3.9m) and CIP slippage to internal plan (£1.3m) .
- In line with NHSE/I guidance additional income (£4.1m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £1.44m in November to cover the full costs incurred in quarter two.

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2021/22 of £3.7m which consists of £0.8m in H1 (April to September) and £2.9m in H2 (October to March 22).
- Year to date the Trust has identified savings of £1.6m which is £0.1m adverse to plan.

Risks within reported financial position:

- **KMMS Accommodation -** Issues around the building contract mean that this development will not be completed by the end of this financial year, and a s the accounting rules on leases change from April, the provision of such accommodation would have to be charged to capital (whether as conventional build across two financial years, or an IFRS 16 lease in 2022/23). The Trust has no agreed source of funding for a capital solution at present. Further work is being undertaken to consider the options available including discussion with the STP and Regional NHSEI.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Expenditure

Breakdown by Allowable Cost Type	£000s
Segregation of patient pathways	4,568
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	399
Backfill for higher sickness absence	1
Remote working for non-patient activities	18
Existing workforce additional shifts to meet increased demand	85
PPE associated costs	12
Additional Sick pay at full pay for all staff policy - full pay for COVID-related	16
Other -Not detailed on NHSI return	829
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	2,399
Long COVID	568
Total 'In Envelope'	**8,895**
COVID-19 virus testing- rt-PCR virus testing	3,687
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	52
COVID-19 virus testing - Rapid / point of care testing	350
COVID-19 virus testing (NHS laboratories)	0
NIHR SIREN testing - research staff costs	12
NIHR SIREN testing - antibody testing only	5
Total 'Out of Enevelope'	**4,107**
Total Expenditure (£000s):	**13,002**

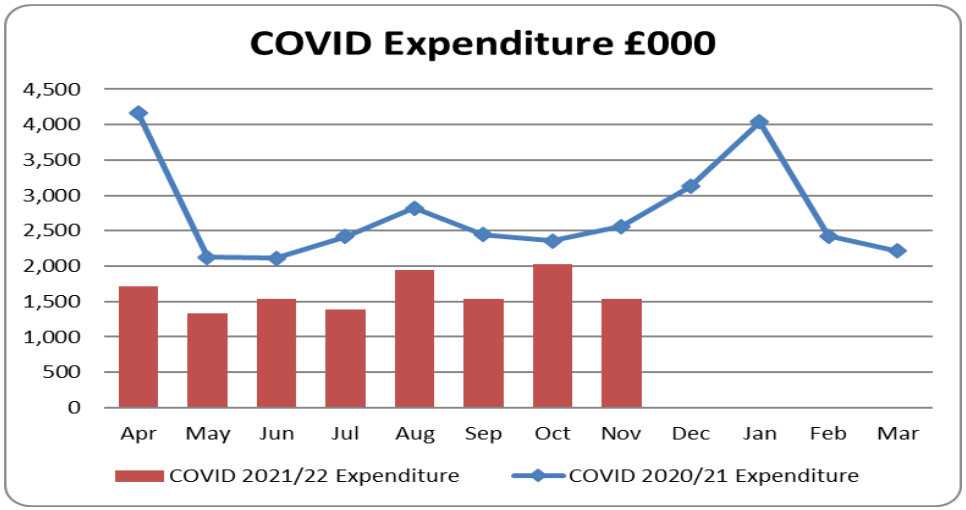
Income

Free staff car parking	379
Catering - Income loss	23
Total Income	**402**
Grand Total (£000s):	**13,404**

Commentary:
The Trust has identified the year to date financial impact relating to COVID to be £13.4m.

The main cost includes costs associated with virus testing , staff welfare such as providing meals, additional shifts required in ED to support patient flow and escalation of Edith Cavell and Peale Wards and the expansion of ITU.

The Trust has included £4.1m income in the position to offset the costs for 'Out of envelope' which include COVID swabbing , rapid testing and vaccination programme. NHSE/I has paid in full the costs identified relating to quarter 1 and 2, the remainder is expected to be confirmed over the next few months.



May-21		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	84.7%	102.6%	-	100.0%	91.5%	110.1%	-	-	27.6%	32.3%	445	18.49	168	7.0	2.3%	100.0%	15	1	275,288	264,177	11,111
MAIDSTONE	Cornwallis (M) - NS959	98.9%	77.4%	-	-	125.6%	295.5%	-	-	75.0%	40.2%	315	11.34	73	7.4	0.0%	0.0%	3	1	0	71,718	(71,718)
MAIDSTONE	Culpepper Ward (M) - NS551	110.1%	79.8%	-	-	128.6%	96.7%	-	-	37.1%	47.7%	126	4.75	36	5.0	20.8%	100.0%	4	0	111,333	110,457	876
MAIDSTONE	John Day Respiratory Ward (M) - NT151	97.5%	98.5%	-	-	107.7%	132.9%	-	-	29.9%	42.7%	256	7.90	99	6.9	25.8%	100.0%	10	0	145,571	163,976	(18,405)
MAIDSTONE	Intensive Care (M) - NA251	106.5%	100.2%	-	-	85.2%	101.6%	-	-	16.6%	7.4%	204	9.09	79	37.9	150.0%	100.0%	0	0	252,851	217,965	34,886
MAIDSTONE	Pye Oliver (Medical) - NK259	103.3%	96.5%	-	-	114.4%	98.9%	-	-	21.4%	59.5%	145	6.22	41	6.4	7.7%	100.0%	6	0	123,301	140,738	(17,437)
MAIDSTONE	Whatman Ward - NK959	86.1%	112.3%	-	-	124.3%	146.7%	-	-	62.8%	40.3%	283	12.91	90	6.4	0.0%	0.0%	1	2	91,695	117,671	(25,976)
MAIDSTONE	Lord North Ward (M) - NF651	96.6%	76.4%	-	100.0%	93.3%	100.0%	-	-	7.3%	0.0%	40	1.61	16	8.3	34.5%	100.0%	0	0	112,254	106,999	5,255
MAIDSTONE	Mercer Ward (M) - NJ251	106.3%	94.4%	-	-	117.2%	116.4%	-	-	36.1%	60.8%	245	9.92	89	6.3	0.0%	0.0%	2	2	109,816	131,269	(21,453)
MAIDSTONE	Edith Cavell - NS459	102.5%	78.6%	-	100.0%	97.0%	98.8%	-	-	39.0%	25.5%	215	6.48	82	6.5	33.3%	100.0%	2	0	118,411	95,200	23,211
MAIDSTONE	Acute Medical Unit (M) - NG551	112.2%	75.4%	-	-	140.0%	220.0%	-	-	39.0%	31.1%	273	9.82	84	10.6	0.0%	100.0%	4	0	163,153	182,416	(19,263)
TWH	Ward 22 (TW) - NG332	72.9%	95.5%	-	-	141.0%	113.2%	-	-	50.7%	56.6%	465	17.39	216	6.0	3.8%	100.0%	20	1	130,587	144,855	(14,268)
TWH	Coronary Care Unit (TW) - NP301	88.9%	51.6%	-	-	76.0%	-	-	-	12.2%	7.6%	96	4.52	69	10.7	4.8%	100.0%	1	0	69,560	61,925	7,635
TWH	Ward 33 (Gynae) (TW) - ND302	88.1%	93.8%	-	-	76.7%	100.0%	-	-	28.9%	3.7%	84	4.42	27	8.9	49.5%	95.7%	1	0	114,771	103,535	11,236
TWH	Intensive Care (TW) - NA201	100.9%	108.3%	-	-	102.1%	96.7%	-	-	11.1%	1.9%	133	7.51	12	35.5	0.0%	0.0%	0	0	383,197	320,060	63,137
TWH	Acute Medical Unit (TW) - NA901	81.7%	52.5%	-	100.0%	91.0%	61.8%	-	-	13.4%	32.5%	275	10.96	168	7.6	0.7%	0.0%	9	0	218,161	198,574	19,587
TWH	Surgical Assessment Unit (TW) - NE701	108.7%	135.0%	-	-	18.3%	40.0%	-	-	24.5%	16.5%	121	6.33	68	25.0	0.0%	0.0%	0	0	71,341	42,954	28,387
TWH	Ward 32 (TW) - NG130	76.7%	64.2%	-	100.0%	57.7%	73.9%	-	100.0%	12.7%	26.9%	133	6.84	71	6.4	4.3%	100.0%	1	0	141,037	103,626	37,411
TWH	Ward 10 (TW) - NG131	86.3%	86.6%	-	100.0%	99.2%	118.1%	-	-	48.0%	44.7%	393	14.52	154	5.9	0.0%	0.0%	7	0	137,398	123,895	13,503
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	59.3%	71.3%	-	-	105.6%	89.9%	-	-	64.5%	27.6%	546	16.90	189	5.1	0.0%	0.0%	7	1	0	98,029	(98,029)
TWH	Ward 12 (TW) - NG132	92.3%	102.0%	-	100.0%	103.5%	98.1%	-	-	36.4%	49.1%	354	11.85	161	6.1	0.0%	0.0%	15	0	139,447	129,913	9,534
TWH	Ward 20 (TW) - NG230	104.9%	98.6%	-	-	152.2%	116.7%	-	-	40.0%	46.1%	391	15.81	187	8.0	5.7%	50.0%	7	2	163,355	186,745	(23,390)
TWH	Ward 21 (TW) - NG231	75.6%	100.9%	-	100.0%	78.3%	113.3%	-	-	26.2%	35.0%	282	11.23	149	5.8	11.3%	100.0%	4	0	147,063	128,805	18,258
TWH	Ward 2 (TW) - NG442	72.0%	87.5%	-	100.0%	108.9%	126.9%	-	-	40.3%	33.0%	427	13.62	241	6.2	14.9%	85.7%	11	1	162,959	228,209	(65,250)
TWH	Ward 30 (TW) - NG330	73.6%	87.2%	-	100.0%	96.7%	103.1%	-	-	20.4%	12.2%	196	5.94	86	5.3	0.0%	0.0%	4	2	125,393	127,794	(2,401)
TWH	Ward 31 (TW) - NG331	85.4%	86.8%	-	100.0%	68.1%	143.0%	-	-	30.0%	9.4%	294	8.26	124	6.1	32.4%	100.0%	6	0	138,962	144,247	(5,285)
Crowborough	Crowborough Birth Centre (CBC) - NP775	56.0%	87.5%	-	-	0.0%	0.0%	-	-	3.8%	0.0%	24	0.54	2					0	71,415	44,956	26,459
TWH	Midwifery (multiple rosters)	78.9%	49.8%	-	-	90.9%	90.9%	-	-	14.0%	5.2%	951	36.61	259	14.2	32.0%	98.1%	0	0	741,539	777,245	(35,706)
TWH	Hedgehog Ward (TW) - ND702	83.7%	36.8%	-	-	84.3%	-	-	-	26.3%	69.6%	306	15.50	98	9.9	0.6%	100.0%	0	0	143,328	219,380	(76,052)
MAIDSTONE	Maidstone Birth Centre - NP751	103.8%	79.9%	-	-	97.1%	95.8%	-	-	23.1%	0.0%	59	1.92	2	43.2	33.3%	100.0%	0	0	72,115	86,999	(14,884)
TWH	SCBU (TW) - NA102	81.5%	-704.3%	-	100.0%	90.5%	-	-	-	22.7%	0.0%	126	6.55	4	13.4	33.3%	100.0%	0	0	177,929	185,765	(7,836)
TWH	Short Stay Surgical Unit (TW) - NE901	72.6%	61.4%	-	-	50.0%	96.6%	-	-	7.6%	19.4%	54	1.72	20	10.8	12.4%	97.6%	0	0	75,794	73,130	2,664
MAIDSTONE	Accident & Emergency (M) - NA351	93.1%	64.9%	-	-	100.9%	78.7%	-	-	39.0%	40.1%	522	29.75	111		1.0%	100.0%	2	0	283,070	386,279	(103,209)
TWH	Accident & Emergency (TW) - NA301	79.7%	82.5%	-	100.0%	91.1%	60.3%	-	-	42.0%	54.7%	791	40.37	260		0.1%	100.0%	3	0	389,304	449,867	(60,563)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	92.1%	91.3%	-	100.0%	93.3%	-	-	-	26.0%	15.9%	59	2.62	10	10.7	50.5%	100.0%	2	0	67,488	57,352	10,136
MAIDSTONE	Peale Ward COVID - ND451	82.9%	105.5%	-	100.0%	132.7%	121.9%	-	-	42.3%	68.3%	222	11.66	100	9.9	0.0%	0.0%	4	1	110,447	108,696	1,751
MAIDSTONE	Foster Clark - NS251	91.0%	96.7%	-	100.0%	93.3%	97.8%	-	-	19.1%	18.8%	132	3.97	31	7.5	33.3%	100.0%	2	0	151,283	138,029	13,254
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	111.1%	112.0%	-	-	113.6%	-	-	-	32.5%	6.0%	71	2.38	10	12.4	26.0%	98.1%	0	0	52,988	57,752	(4,764)
																				5,983,604	**6,333,151**	**(349,547)**
																				56,065	54,375	1,690
																				0	0	0
																				0	0	0
																				4,581,538	4,203,225	378,313
																				10,621,207	**10,590,751**	**30,456**

Total Established Wards
Additional Capacity beds — Cath Labs; Chaucer; Foster Clarke Winter Escalation 2
Other associated nursing costs

RAG Key

Under fill

Overfill

Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

NHS
Maidstone and Tunbridge Wells NHS Trust

Update to capital programme funding and expenditure approvals, 2021/22	Deputy chief executive/chief finance officer

The Trust initial capital resource level, agreed with the Integrated Care System (ICS) and NHS England/Improvement (NHSE/I) as part of the planning process for 2021/22, was a total of £10.6m including PFI lifecycle and donated asset expenditure. As at month 8 SOME additional resources have either been recently formally approved from ICS or national funding sources or are approved in principle awaiting final formalisation. As a result of the application processes and short turnaround of different tranches of funding bids, there are a number of elements of the bids that will require formal business case approval. This report sets out the main component elements of the bid funding and highlights those cases which are most significant financially, requiring Finance and Performance Committee/Trust Board approvals

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 20/12/21

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

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

1. CAPITAL RESOURCES (Month 8 2021)

1.1 The Trust initial capital resource level, agreed with the ICS and NHSEI as part of the planning process for 2021/22, was a total of £10.6m including PFI lifecycle and donated asset expenditure.

1.2 As at month 8 the following additional resources have either been recently formally approved from ICS or national funding sources or are approved in principle awaiting final formalisation:

Additional Funding area	£m	Note
ICS Emergency System PDC	1.95	Approved by ICS, submitted to NHSEI
National Linac Replacement PDC	3.73	Approved by NHSEI
National Diagnostic Fund PDC	0.41	Approved by NHSEI
National Digital Diagnostic PDC	0.67	Approved by NHSEI
National TIF PDC	1.67	Approved by NHSEI
ICS System Slippage - CRL (not PDC)	1.00	Approved by ICS, after M8 NHSEI submission
ICS A&E Slippage re-allocation - PDC	1.03	Approved by ICS, and agreed in principle by NHSEI
Total	**10.47**	

1.3 As a result of the application processes and short turnaround of different tranches of funding bids, there are a number of elements of the bids that will require formal business case approval. This paper sets out the main component elements of the bid funding and highlights those cases which are most significant financially, requiring FPC/Trust Board approvals.

2. ADDITIONAL RESOURCE PROJECTS

2.1 The ICS has an allocation of emergency PDC at its disposal to support system capital investment and strategic projects such as the HASU business case. MTW's share in 2021/22 is £1.95m. This includes funding to support the replacement of two linear accelerator machines at Maidstone where the machines are nationally funded, but the enabling works and ancillary equipment is not. The business case for the replacement machines is due to be submitted to the January FPC and Trust Board by the Division. The related national funding for the machines is £3.73m.

ICS Emergency PDC schemes	£000's	Note
Linac Ancillary equipment	720	Linac replacement BC due for FPC/Trust Board Jan 2022
CCTV and Control Room	300	BC in development
Replace Mobile X-ray x 2	130	BC due from Division
Tissue Processors x 2	150	BCs - one submitted and approved by Exec Team
Obstetric Ultrasound	62	BC approved by Executive Team
Diagnostic US balance from emergency fund	19	balance for Diagnostic fund shortfall
Linac 3 M - enabling works	452	Linac replacement BC due for FPC/Trust Board Jan 2022
HASU design costs	120	HASU OBC approved by DHSC
EMERGENCY PDC TOTAL	**1,953**	

2.2 National Diagnostic equipment and Digital Diagnostic funds have been agreed through the ICS bids:

Diagnostic National PDC	£000's	Note
Breast screening ultrasounds x 2	163	BC completed, ready for submission to Business Case Panel
General ultrasounds x 2	248	BC due from Division
DD Radiology - Home Reporting	425	BC due from ICT/Division
DD Radiology - iRefer	201	BC due from ICT/Division
DD Pathology - POCT & Digital Path	44	BC due from ICT/Division
PDC TOTAL	**1,081**	

2.3 The Trust bid via the ICS system for Transformation funds and has the following direct awards. There are in addition some system wide digital schemes which are still being confirmed by the system ICT Directors. The SPEC CT (gamma camera) replacement case will be over the £1m

limit for Trust Board approval as it will include significant enabling works that will take place in 2022/23. The equipment will be delivered to site by the end of the financial year.

TIF national PDC	£000's	Note
SPECT/Gamma Camera	610	BC due from Division:Trust Board approval as will incl. enabling works and be > £1m
Maidstone DEXA scanner replacement	142	BC approved by Executive Team
Colonoscopy insufflator	20	BC due from Division
Patient Flow module, interface and infrastructure	500	BC due from IT Diector, will need FPC approval
TWH Audio Visual System	400	BC approved by Executive Team
PDC TOTAL	**1,672**	

2.4 Some of the provider Trusts within the ICS system have reported slippage on major schemes and therefore the capital resource has been offered up for other providers to utilise. As the resource is part of internal funding there is no external PDC allocation, and utilising Trusts will need to provide the cash to finance the investments, but NHSEI will transfer the capital resource cover. MTW's share of the resource is £1m, and has been identified against key priorities capable of delivery by the end of the financial year.

System slippage CRL only	£000's	Note
Maidstone Hospital Staff Showers	345	BC due from Division
Replacement Defibrillators	341	BC due from EME Lead
Cardiac Monitors	24	BC due from Division
UBM Reichert Machine	11	BC completed, ready for submission to Business Case Panel
TW UIU Diathermy machine	10	BC completed, ready for submission to Business Case Panel
CTG Machines [Doors Redman x 2]	10	BC due from Division
Dishwasher in main Maidstone Kitchen	30	BC due from Division
Contrast Injector for K&C CT sim	27	BC completed, ready for submission to Business Case Panel
Laptops	162	BC due from ICT Director
PCs	40	BC due from ICT Director
£1m slippage agreed	**1,000**	

2.5 Additionally, a provider in the ICS has slippage on a nationally funded A&E development. The ICS agreed to support cross year brokerage via a redeployment of the current year funding to other system providers in order to bring forward priority investments from 2022/23, with a view to the reimbursement of the funding to the provider concerned in the next financial years. MTW agreed to advance £1m of equipment that was ranked in the top priority for replacement and which could be purchased for delivery by the year end. The largest element of replacement is the first year of a multi-year case for replacement of patient monitors for critical and emergency care.

EK ED Slippage Bids (Bring forward)	£000's	Note
Maternity beds x 12	120	BC due from Division
Transfer ventilators - ICU&Paeds	53	BC completed, ready for submission to Business Case Panel
Patient Monitoring for NNU/ICU/CCU/ED	490	Overall BC is for 3 year programme, will need FPC/Trust Board approval
Flexi Cystoscopes x 9	280	BC completed, ready for submission to Business Case Panel
Laundry Washer/Dryer	30	BC approved by Executive Team
Cardiac Stress Machine	27	BC due from Division
Central Monitoring Station	32	BC completed, ready for submission to Business Case Panel
PDC TOTAL	**1,032**	

2.6 The Trust has also submitted a major "Barn Theatre" business case to NHSEI for providing elective recovery capacity for the system and is awaiting potential confirmation of additional funding within 2021/22.

3. RECOMMENDATION

It is recommended that the additional allocations of capital are reviewed and approved in principle, noting the requirement for finalising business cases and in particular the larger cases requiring FPC and Trust Board approval in the final quarter of 2021/22.

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve a Business Case for Increasing Elective Orthopaedic Capacity

Chief Operating Officer

Please find enclosed the Business Case for Increasing Elective Orthopaedic Capacity. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 20/12/21, to consider the Business Case and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

The embedded documents are available, upon request, from the Trust Secretary's Office.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 14/12/21
- Finance and Performance Committee, 20/12/21

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

Information and assurance

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

Barn Theatre Update

Executive Team Meeting November 2021

Introduction

The outline business case (OBC) proposes an investment of £31.3m to expand orthopaedic surgical capacity by creating a 'barn theatre block' on the Maidstone Hospital site. The new facility would consist of four laminar flow theatres, a 20-bed inpatient ward and a 16-bed day case ward.

The facility would be ring-fenced for orthopaedic Covid Green elective day case and inpatients. The new facility will create theatre capacity for the Kent and Medway integrated care system (ICS), to help tackle the backlog of patients awaiting surgery following the Covid pandemic.

The development would be introduced as follows:

- Two theatres that will be available for the Kent and Medway ICS which could provide capacity for an estimated 2500 patients per annum. The theatres will be fully equipped to use for orthopaedic surgery.
- Two theatres to provide capacity for the transfer of most planned adult orthopaedic operations from Tunbridge Wells Hospital (TWH). The move of activity from TWH will enable other surgical specialities to grow activity at that site. These theatres will also allow for the repatriation of outsourced activity from the independent sector

This business case focuses on the use of the first two theatres, although the capital cost included covers the construction and equipping of all four theatres. Out of scope of this business case are non-elective orthopaedics (trauma), adult orthopaedic outpatients and paediatric orthopaedics.

The structure of this business case is consistent with the latest guidance[1] from NHS Improvement (NHSI) on the development of business cases using the Five Case Model.

The business case is being submitted to NHS England and Improvement (NHSEI). Once funding has been agreed the business case will be submitted to the Board of Maidstone & Tunbridge Wells NHS Trust (MTW) for approval.

Progress to Date

- Business case submitted to NHSE/I week commencing 29/11/21
- Business case presented to BCRP on 30/11/21
- Business case presented to regional operational team on 01/12/21
- 1:1 meeting with operational teams from DGT, MFT and EKUFT week commencing 06/12/21
- Barn capital costs list produced as requested by NHSE/I for discussion on 10/12/21 - £6.7m

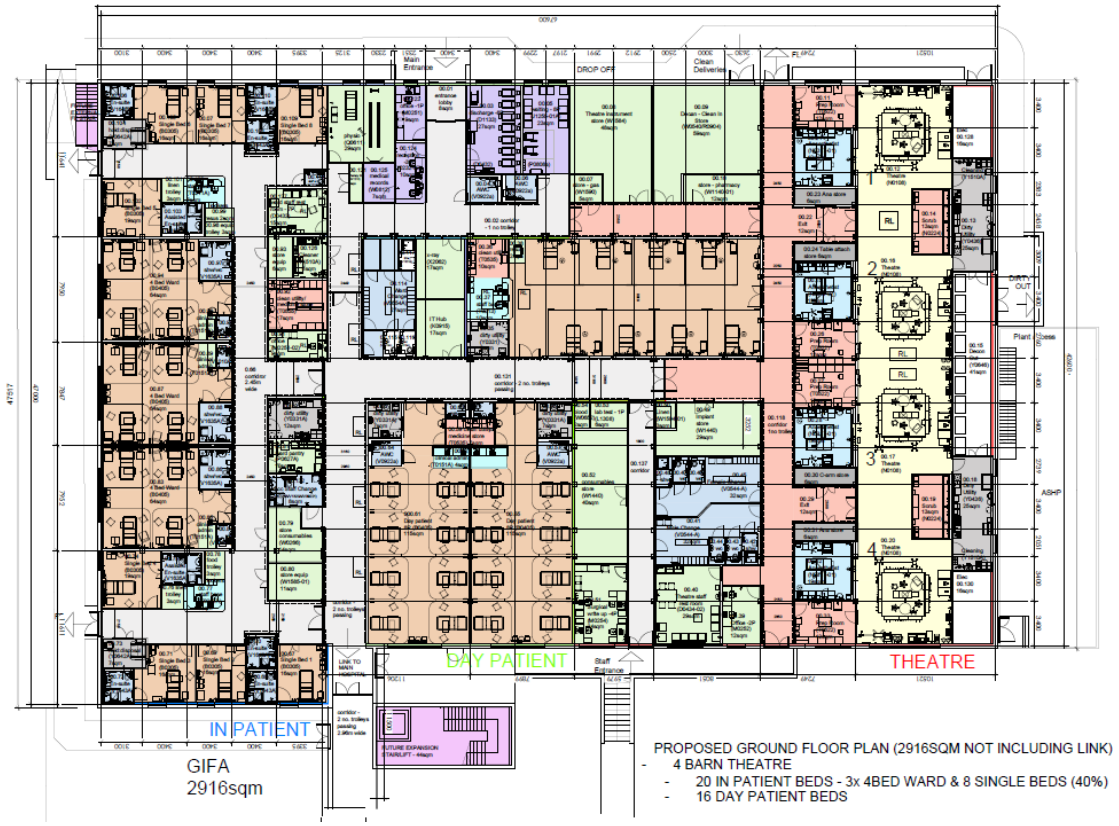
Next steps

- Operational, Estates and procurement teams on standby to place capital orders by 20 Dec if given the go ahead to proceed.
- Business case to F&P – December 21
- Business case to Trust Board – December 21

[1] Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, NHSI, 2016.

Maidstone and Tunbridge Wells NHS Trust

Business Case for Increasing Elective Orthopaedic Capacity



November 2021

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Version control

Version	Date	Author	Details
0.1	8 Nov 2021	Andy Whiting	Template set-up
0.2	10 Nov 2021	Andy Whiting	Initial draft incorporating Trust draft business case and gap analysis
0.3	17 Nov 2021	Andy Whiting	Updated with 4th option
0.4	18 Nov 2021	Andy Whiting	Updates throughout – circulated for comment
0.5	19 Nov 2021	Andy Whiting	With detail from architects – sent to Alice Farrell for review
0.6	21 Nov 2021	Andy Whiting	Incorporating feedback
0.7	23 Nov 2021	Andy Whiting	Including QIA, financials, management case and project plan
0.8	24 Nov 2021	Andy Whiting	Further updates on numbers
1.0	24 Nov 2021	Andy Whiting	Final issued for NHSEI
1.1	26 Nov 2021	Sarah Davis	Incorporating feedback

1 Executive Summary

1.1 Introduction

This outline business case (OBC) proposes an investment of £31.3m to expand orthopaedic surgical capacity by creating a 'barn theatre block' on the Maidstone Hospital site. The new facility would consist of four laminar flow theatres, a 20-bed inpatient ward and a 16-bed day case ward.

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The development would be introduced as follows:

- Two theatres that will be available for the Kent and Medway ICS which could provide capacity for an estimated 2500 patients per annum. The theatres will be fully equipped to use for orthopaedic surgery.
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This business case focuses on the use of the first two theatres, although the capital cost included covers the construction and equipping of all four theatres. Out of scope of this business case are non-elective orthopaedics (trauma), adult orthopaedic outpatients and paediatric orthopaedics.

The structure of this business case is consistent with the latest guidance[1] from NHS Improvement (NHSI) on the development of business cases using the Five Case Model.

The business case is being submitted to NHS England and Improvement (NHSEI). Once funding has been agreed the business case will be submitted to the Board of Maidstone & Tunbridge Wells NHS Trust (MTW) for approval.

1.2 The strategic case

Elective Orthopaedics is an essential service for communities with a significant positive impact on quality of life. According to Department of Health definitions musculoskeletal (MSK) conditions include over 200 different problems and affect 1 in 4 of the adult population. They are the biggest cause of the growing burden of disability in the UK, and cost the NHS £5 billion each year.

The strategic case for change is based on:

- The need to support the wider Kent and Medway ICS to recover elective performance
- Current performance on waiting times and the size of the waiting list
- The trust's ambition of adhering to best practice

[1] Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, NHSI, 2016.

- Anticipated medium-term growth in demand.

MTW's vision is to provide *outstanding hospital services* which means its clinical services must always strive to operate in accordance with best practice as set out by the British Orthopaedics Association and through the national Getting It Right First Time (GIRFT) programme. Key best practice recommendations are:

- Ring-fenced beds for orthopaedics.
- Hot and cold sites to separate 'hot' unplanned emergency work from 'cold' planned elective work.

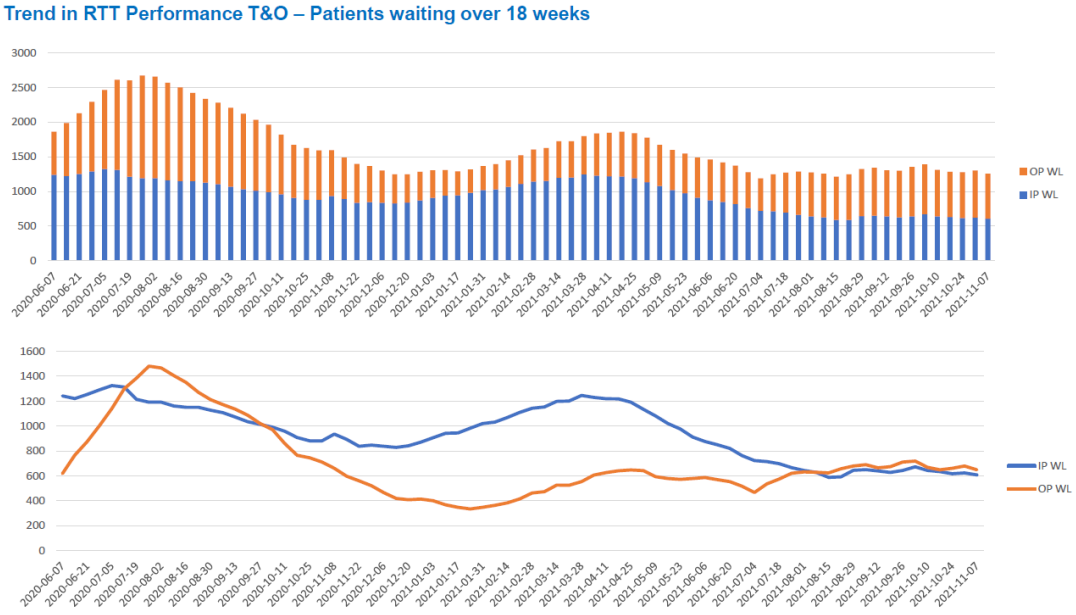
The trust fails to comply with best practice in two key respects:

- MTW only has one ring-fenced orthopaedics theatre and inpatient unit in the Maidstone Orthopaedic Unit (MOU).
- Elective and non-elective activity is not separated at TWH.

The result is that operational performance is compromised as a system as there is limited green elective capacity for orthopaedic activity and the result for MTW is that operational performance is often compromised due to planned electives being cancelled due to emergency activity and much of the planned work being done away from the MOU centre of orthopaedic excellence – the trust falls short against a number of GIRFT and Sentinel targets as a result. Moving adult elective orthopaedics to a single site in Maidstone, with dedicated radiology and physiotherapy resource for post-operative care and consistent team of nurses and theatre staff, would allow MTW to develop a more patient focussed pathway which reflects best practice.

Following the pandemic recovering MTW's referral to treatment (RTT) position and reducing the number of patients waiting more than a year to zero, are key priorities for the trust. The trust has worked hard to recover the 52-week breech position and has just six orthopaedic patients waiting more than 52 weeks (compared to 1,700 across the Kent and Medway system), although the position regarding the 18 week 92% RTT target has not improved to the same extent.

Figure 1: Trend in the number of people waiting more than 18 weeks



In order to mitigate the capacity shortfall and meet the RTT targets in the first quarter of 2021/22 170 elective backlog orthopaedic cases were outsourced to the independent sector at a cost of £0.7m (£0.23m per month).

Additional capacity is also needed because demand is growing. Orthopaedics is a speciality skewed towards treating older people and according to Kent County Council, the number of people aged 65 and over living in West Kent will increase by 35% over the next 15 years. The number of revisions is also rising as people live longer. The increasing rate of revisions adds to the baseline demographic pressures and taken together they are the key factors in the modelled average growth of 4.4% per annum for orthopaedic day cases and elective inpatients. The table below shows demand mapped this against available capacity (MTW theatres and the independent sector) to 2026/27.

Table 1: Demand and capacity model without additional capacity

	Total annual demand				Capacity			
	New demand	Backlog	IS choice	Total	Existing MTW @ 90% utilisation	IS	Total	Shortfall
2021/22	2,914	630	1,060	4,605	2,539	1,060	3,599	-1,005
2022/23	3,043	400	1,107	4,550	2,539	1,107	3,646	-904
2023/24	3,177	0	1,156	4,332	2,539	1,156	3,695	-638
2024/25	3,316	0	1,207	4,523	2,539	1,207	3,746	-777
2025/26	3,462	0	1,260	4,722	2,539	1,260	3,799	-923
2026/27	3,615	0	1,315	4,930	2,539	1,315	3,854	-1,076

The table above clearly demonstrates that there will be a substantial shortfall in capacity throughout the period modelled.

The response to the case for change set out above, is the proposed investment in new orthopaedic elective surgical capacity described in this business case. The investment objectives are:

- **Investment objective one** – to deliver a reduced waiting list and an improved RTT position for the system by increasing elective orthopaedic activity by increasing theatre productivity and efficiency including reducing theatre cancellations.

- **Investment objective two** – to deliver cost savings by reducing the number of orthopaedic patients outsourced to the independent sector.
- **Investment objective three** – to release theatre capacity on both trust sites to create additional capacity for other specialities thereby helping the system to improve its waiting list and RTT performance.
- **Investment objective four** – to improve GIRFT metrics and HVLC metrics, with the aim for MTW orthopaedics to be in the upper quartile of Model Hospital for day case and inpatient activity.
- **Investment objective five** – to strive to become an outstanding organisation.

Each investment objective is discussed in detail together with current and desired performance, in the strategic case.

The benefits associated with the investment are summarised below.

Table 2: Benefits

Group benefitting	Benefit
Patients, families and wider society	• The hot/ cold split and centre of excellence approach is associated with shorter lengths of stay and fewer cancellations resulting in better patient outcomes • The creation of a centre of excellence for orthopaedic surgery would mean that local residents would have access to orthopaedic best practice-based services without needing to travel outside the area • The additional capacity proposed would be located at Maidstone rather than TWH meaning more orthopaedic capacity would be close to the most deprived areas served by MTW. • Local people would no longer need to travel to independent sector providers for some treatments resulting in improved continuity of care for these patients who would receive pre-assessment and outpatient follow-up from the same multi-disciplinary team at MTW; patient outcomes are expected to be better as a direct result
Orthopaedics service	• Improved theatre staff recruitment and retention; specialised orthopaedic surgery is an attractive place to work and currently recruitment for theatre staff is easier on the Maidstone site. • Improved post-operative care for elective patients, with a specialised physiotherapy team on site. • Improved day case rates. • Reduced length of stay for hip and knee arthroscopies, as the length of stay in MOU is 1-3 days compared to 3-5 days at TWH. This is partly due to case mix but mainly due to the nursing support, physiotherapy support and the fact that electives are the main focus, rather than at TWH where they have to prioritise emergency flow and trauma patients. With a specialised orthopaedic centre, the aim will be to be within the upper quartile for length of stay following arthroscopic surgery. • Improved patient experience of the admission process, managed by a dedicated team for elective patients.

Group benefitting	Benefit
	• Improved teaching for orthopaedic surgery, with the ability to run parallel lists for the same sub-specialty. • Improved Covid pathways by moving all elective orthopaedic patients to a super green ward (currently ward 30 at TWH is not super green). • Improved recruitment for surgical trainees and other clinical roles. • Reduced infection rates. • Reduction of patients (backlog) sent to the IS from its current level of 170 in Q1 2021/22, in H1 this was funded non-recurrently from the ERF.
Kent & Medway ICS	• Reduced costs of ad-hoc independent sector referrals to commissioners • Offer to other providers within the system two theatres to allow them to reduce their covid backlog. This would be of benefit as there are significant numbers of patients who have been waiting over 52 weeks for surgery following the pandemic. As an example of need, East Kent Hospitals University Foundation Trust (EKHUFT) has a 52 week+ backlog of over 1,500 orthopaedic patients and a further 220 people have been waiting over a year at Kent & Medway's other two acute trusts. MTW has started discussions with EKHUFT regarding using theatres 3 and 4 to clear their elective orthopaedic backlog; currently two options are being discussed: • EKUHFT surgeons operating from the new facility or • The patients being transferred to MTW. • The expansion of theatre capacity will free-up space in existing TWH theatres currently used by orthopaedics. This space will initially be available to other MTW specialities (see above), but would also be offered to other trusts for non-orthopaedic specialties again to help with clearing the backlog.
Other MTW services	• Releasing ward space at Tunbridge Wells (10 beds in Ward 30).

Group benefitting	Benefit
	• Released theatre capacity at TWH.
Financial benefits	• Building a barn theatre will allow MTW to stop outsourcing backlog patients which is currently costing over £2.8m per annum. However, this level of outsourcing has only been funded through non-recurrent ERF income. The cost of outsourcing backlog patients is separate to the prime provider contract, where patients are referred to the independent sector from the beginning of their pathway. • Creating a separate elective orthopaedic centre will also reduce the average length of stay which as well as contributing to an improved patient experience, would generate a non-cash releasing benefit to the system.

The constraints that could impact on the project are:

- Site space to develop a four-barn theatre.
- Clinical buy in and commitment to change job plans/base location for consultants, including anaesthetists.
- Ability to recruit to theatre and nursing staff.

Delivery is dependent on:

- Capital investment for new building and theatres
- Planning permission.
- Radiology, therapies and critical care departments being able to facilitate increased capacity at Maidstone to support this change

The risks associated with the business case are summarised below.

Table 3: Summary of key risks

Risk	Mitigation plan
Ability of Estates and engineering to deliver build in the given timeframe e.g. due to planning issues and supply chain disruption	Early engagement with local authority planners Early engagement with potential supply chain partners
Negotiating increase in activity alongside increase in income with commissioners	The business case will only go ahead if Barn is more cost effective than outsourcing
Lack of Consultant ownership to move electives to a single site	Consultants have been continuously engaged through the planning process and buy-in has been achieved (it is worth noting all consultants already work at both sites)
Risk of not being able to fully utilise the theatres	Expanding surgeon numbers (three Fellows) who can operate alongside consultants Elective Flow co-ordinator post created Offer capacity to other trusts
Unforeseen increase in capital cost	Ongoing development of detailed plans (currently at RIBA Stage 3) and early engagement with two potential suppliers

1.3 The economic case

The economic case has appraised four options:

- Option one – business as usual which is effectively a 'do nothing' option of continuing with current theatre capacity and outsourcing

and three potential solutions, any of which would provide the capacity needed to meet modelled demand:

- Option two - increased outsourcing to reduce the waiting list and improve and then maintain RTT, over 52 week and activity performance
- Option three – construct a barn theatre block with 4 theatres, 20 inpatient beds and a day case trolley area
- Option four – as per option three but with a traditional build and theatre layout.

The following table summarises the benefits and risks of each option together with the resulting non-financial ranking of options.

Table 4: Summary of risks and benefits by option

Option	Benefits and risks	Rank
Option 1 **BAU/ Do nothing**	Currently NHSE paying for outsourcing of backlog via ERF so no financial impact to Trust, however future finance agreements are not clear on impact Risk of backlog /RTT due to cancelled electives and limited theatre utilisation Lack of theatre capacity for emergency trauma/CEPOD/service changes Continued ad-hoc planning to meet RTT, >52W and activity plans Inability to meet gap between demand and capacity No ability to significantly improve GIRFT metrics whilst operating on hot site with no ring-fenced beds	3
Option 2 **Increase outsourcing**	MTW have no long-term commitment to IS usage IS not able to meet full capacity gap High transaction costs Patients can be returned to Trust by IS with no notice IS have long waiting lists Patients in the backlog often don't meet the IS patient criteria.	4
Option 3 **4 barn theatre plus 20 inpatient beds and day case unit**	Creates super green ring-fenced capacity Increases theatre capacity for the Kent and Medway ICS. Site development of cutting-edge clinical service to showcase MS site Allows for improvements in GIRFT metrics Creates spare capacity at TWH for other clinical services	1

Option	Benefits and risks	Rank
Option 4 **4 traditional theatres plus 20 inpatient beds and day case unit**	Creates super green ring-fenced capacity Increase theatre capacity for the Kent and Medway ICS. Creates spare capacity at TWH for other clinical services	2

The economic appraisal was carried out according to HM Treasury's Green Book using the comprehensive investment appraisal (CIA) model. The results are set out below.

Table 5: Summary of Net Present Societal Value (NPSV) by option

Net present social value - total	Option 1 BAU	Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital	£0	£0	£25,226,149	£27,443,005
Revenue	£77,956,419	£182,397,105	£143,936,246	£148,190,934
Costed risks	£104,440,686			
Net present societal value	£182,397,105	£182,397,105	£169,162,395	£175,633,940

Incremental NSPV is then calculated compared to the BAU to derive the cost benefit ratio.

Table 6: Incremental NPSV and cost benefit ratio

Net present social value - incremental from BAU	Option 1 BAU	Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital		£0	£25,226,149	£27,443,005
Revenue		£104,440,685	£65,979,826	£70,234,515
Costed risks		-£104,440,686	-£104,440,686	-£104,440,686
Net present societal value	£0	-£0	-£13,234,710	-£6,763,166
Cost benefit ratio	0.00	1.00	1.15	1.07

A cost to benefit ratio of above 1.0 means an option represents better value than the BAU (doing nothing in this instance). Option 3 (barn theatres) is best value with a cost benefit ratio of 1: 1.15 and a net societal benefit (excluding to date, unmonetised non-cash releasing and societal benefits) of £13,234k over the life of the facility.

Based on both the non-financial appraisal and the economic assessment, the preferred option is the construction of a barn theatre facility consisting of four open theatres separated by laminar flow canopy with 20 inpatient beds and 16 trolleys for day surgery. The new building will be at the back of the Maidstone Hospital site and would be a ring-fenced Covid secure facility. Following theatres being commissioned, two elective operating theatres (1.12 transferred from TWH and the balance from repatriated independent sector work) would be immediately opened and used by orthopaedics with 12 inpatient and 8-day case beds functioning and will open in September 2022. The other two theatres will be available for the Kent and Medway ICS and will be fully equipped to use for orthopaedic surgery

The table below illustrates how each theatre will be utilised (MTW shaded).

Table 7: Utilisation of barn theatres 1 to 4

Barn 1	Barn 2	Barn 3	Barn 4
Transfer from TWH = 1 theatre's worth of elective orthopaedics	Transfer from TWH = 0.12 theatres worth of orthopaedic electives Current outsourced capacity = 0.53 theatre Current shortfall between demand and capacity = 0.35 theatre	*This theatre would be available for K&M ICS use*	*This theatre would be available for K&M ICS use*

The theatre time released at TWH (1.12 theatres) will be available to increase capacity in trauma, gynaecology (including c-section lists), ENT and emergency general surgery.

The first two barn theatres will provide capacity equal to 1,680 cases. This additional capacity will not be fully utilised meeting new demand for the first few years post-opening, so will be available for the wider system to use to clear waiting lists.

Table 8: Demand and capacity – barn theatres one and two

	Total annual demand				Capacity				
	New demand	Backlog	IS choice	Total	Existing MTW	IS	Barn (2 theatres)	Total	Shortfall
2021/22	2,914	630	1,060	4,605	2,539	1,060	0	3,599	-1,005
2022/23	3,043	400	1,107	4,550	2,539	1,107	840	4,486	-64
2023/24	3,177	0	1,156	4,332	2,539	1,156	1,680	5,375	1,042
2024/25	3,316	0	1,207	4,523	2,539	1,207	1,680	5,426	903
2025/26	3,462	0	1,260	4,722	2,539	1,260	1,680	5,479	757
2026/27	3,615	0	1,315	4,930	2,539	1,315	1,680	5,534	604

In 2023/24 MTW will be able to make available theatre lists sufficient to operate on 1,042 patients from the wider Kent and Medway system reducing to 604 case in 2026/27.

The preferred option also builds and equips (but does not staff) two more Barn theatres which would be offered to the Kent and Medway ICS for orthopaedic activity.

1.4 The commercial case

The scope of works to be procured to deliver the preferred option is summarised below together with the procurement route.

Table 9: Works and services required

Task	Supplier	Procurement Route
Enabling works	TBA	Tender by SS via LPP/CCS
Architect design	HMY	Direct award SS to put on NEC3
Modular build	Darwin, Premier, ModuleCo	Direct award by BM under SBS
M&E	BSP or Horley	Frameworks (TBD)
C&S	CTP	Frameworks (TBD)
Planning	DHA Planning	Direct award
Specialist air-flow fit-out	MAT or Howarth	Direct award under framework
Medical equipment	Various	
F&F	Various	
IT	Various	
QS		Tender by SS via LPP/CCS
Project Manager		Tender by SS via LPP/CCS
Landscaping	Allen Scott Landscape	
BREEAM	XDA	
Fire Engineering	Innovation Fire Engineering	
Accoustics	Adrian James Accounstics	
High Voltage Power Supply		Tender by SS via LPP/CCS
Legals	BLP, Glovers, Beechcroft	Direct award under framework

The trust has entered into non-binding dialogue with three potential contractors to select a preferred bidder subject to the business case being approved. The development of the project is at RIBA Stage 3 which means the framework modular construction companies can provide accurate information in respect of construction periods and likely outturn cost. The construction contract used will be a NEC contract as used across the public sector.

The relevant planning authority is Maidstone Borough Council. The trust has engaged with the Head of Planning at the council and the two ward councillors representing the electoral ward within which the hospital is situated. The two councillors have been exceptionally supportive of the project and have concurred that, subject to the permitted development arrangements of the Covid 19 pandemic being extended beyond 31st December 2021, the project could proceed as a permitted development with a full planning consent being submitted in parallel once the construction programme commence.

The new facility will adhere as closely as possible to NHS requirements for the use of modern methods of construction (it is a modular build) and for the building to contribute towards reducing the NHS' carbon footprint.

The new facility will be a standalone Covid secure Green facility. The standalone nature of the building will minimise the risk of disruption to other site users during the enabling works and construction phase.

The preferred option requires additional clinical and support staff to be recruited- the project team is developing a staff recruitment plan to ensure that the planned opening of the new unit is not delayed by a lack of staff.

1.5 The financial case

The initial capital investment required is shown below.

Table 10: Initial capital costs

Asset Group	Total £
Building	28,067,028
Equipment	2,731,646
ICT	532,203
Total	**31,330,877**

MTW is applying for central NHS funding to provide the capital investment needed.

The impact of the scheme on the trust's statement of comprehensive income (SOCI) position is set out in the table below.

Table 11: Revenue impact

	Annual revenue costs											
	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25	Year 4 2025-26	Year 5 2026-27	Year 6 2027-28	Year 7 2028-29	Year 8 2029-30	Year 9 2030-31	Year 10 2031-32	Year 11+ to Year 60 2038+	Total Costs
Pay	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Barn Ward	840	1,440	1,440	1,440	1,440	1,440	1,440	1,440	1,440	1,440	71,985	85,783
Day Care Area	212	363	363	363	363	363	363	363	363	363	18,134	21,610
T&O Medical	73	125	125	125	125	125	125	125	125	125	6,250	7,448
Anaesthetists	166	284	284	284	284	284	284	284	284	284	14,187	16,906
Theatre Staff	162	277	277	277	277	277	277	277	277	277	13,846	16,500
Theatre Porter	21	36	36	36	36	36	36	36	36	36	1,778	2,118
Therapies	189	325	325	325	325	325	325	325	325	325	16,229	19,340
Pharmacy	37	64	64	64	64	64	64	64	64	64	3,176	3,784
Radiology	124	212	212	212	212	212	212	212	212	212	10,608	12,642
Pathology	10	17	17	17	17	17	17	17	17	17	828	986
EME / IT	68	117	117	117	117	117	117	117	117	117	5,850	6,971
Catering	31	53	53	53	53	53	53	53	53	53	2,627	3,130
Domestics and Portering	151	259	259	259	259	259	259	259	259	259	12,974	15,461
T&O Admin (CAU)	27	46	46	46	46	46	46	46	46	46	2,301	2,741
Reception	28	47	47	47	47	47	47	47	47	47	2,362	2,815
Temporary Staffing Premium	641	549	366	183	183	183	183	183	183	183	9,157	11,995
											0	0
Total Pay	**2,778**	**4,212**	**4,029**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**192,290**	**230,229**
Barn Ward	72	144	144	144	144	144	144	144	144	144	7,199	8,566
Day Care Area	18	36	36	36	36	36	36	36	36	36	1,813	2,158
Theatre Consumables	571	1,142	1,142	1,142	1,142	1,142	1,142	1,142	1,142	1,142	57,110	67,961
Diagnostic Non Pay	30	60	60	60	60	60	60	60	60	60	3,000	3,570
Utilities	71	142	142	142	142	142	142	142	142	142	7,100	8,449
Catering	15	29	29	29	29	29	29	29	29	29	1,470	1,749
Domestics	5	10	10	10	10	10	10	10	10	10	500	595
Decontamination	25	50	50	50	50	50	50	50	50	50	2,500	2,975
Waste disposal	10	20	20	20	20	20	20	20	20	20	1,000	1,190
Laundry	25	50	50	50	50	50	50	50	50	50	2,500	2,975
Maintenace Costs	131	261	261	261	261	261	261	261	261	261	13,054	15,534
Legal fees	72	0	0	0	0	0	0	0	0	0	0	72
Non Recurrent Setup costs	495	0	0	0	0	0	0	0	0	0	0	495
Non Recurrent Setup costs - E&F	28	0	0	0	0	0	0	0	0	0	0	28
Consultant Relocation fee	26	0	0	0	0	0	0	0	0	0	0	26
Total Non Pay	**1,594**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**97,245**	**116,343**
											0	0
Depreciation and PDC	1,024	2,031	1,997	1,964	1,930	1,905	1,881	1,895	1,909	1,876	72,153	90,565
											0	0
Total Cost	**5,395**	**8,188**	**7,971**	**7,754**	**7,721**	**7,696**	**7,671**	**7,686**	**7,700**	**7,666**	**361,688**	**437,137**
											0	0
Less											0	0
reduction of 10 beds at TWH	-249	-498	-498	-498	-498	-498	-498	-498	-498	-498	-24,905	-29,637
Total Cost Reductions	**-249**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-24,905**	**-29,637**
											0	0
Total Investment	**5,146**	**7,690**	**7,473**	**7,256**	**7,223**	**7,198**	**7,173**	**7,188**	**7,202**	**7,168**	**336,783**	**407,500**
Income - 50% Depreciation and PDC cross charge to system for 2 Theatres and 50% of Ward / day area	-512	-1,015	-999	-982	-965	-953	-940	-948	-955	-938	-36,076	-45,282
Income - Assume system will bund at cost	-4,634	-6,674	-6,474	-6,274	-6,258	-6,245	-6,233	-6,240	-6,247	-6,230	-300,707	-362,217
Total Income	**-5,146**	**-7,690**	**-7,473**	**-7,256**	**-7,223**	**-7,198**	**-7,173**	**-7,188**	**-7,202**	**-7,168**	**-336,783**	**-407,500**
Grand Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The detail of the staffing numbers is shown below.

Table 12: Staffing detail

	WTE											
Pay	Consultants	Other Medical	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	**Total WTE**
Barn Ward			7.28	1.00	0.00	6.61	3.00	1.00	1.00	0.00	0.00	**19.89**
Day Care Area			2.00	0.00	0.00	5.00	1.00	0.00	0.00	0.00	0.00	**8.00**
T&O Medical	1.00											**1.00**
Anaesthetists	2.27											**2.27**
Theatre Staff			0.00	1.42	1.42	2.13	2.13	0.00	0.00	0.00	0.00	**7.10**
Theatre Porter			1.42									**1.42**
Therapies					1.08	2.00	1.62		2.00			**6.70**
Pharmacy			1.00			1.00		0.00				**2.00**
Radiology				2.00			3.25					**5.25**
Pathology				0.62								**0.62**
EME / IT						1.00	1.00					**2.00**
Catering			1.00	1.00								**2.00**
Domestics and Portering			6.03									**6.03**
T&O Admin (CAU)				0.00	1.50							**1.50**
Reception			1.84									**1.84**
Temporary Staffing Premium												
Total Pay	**3.27**	**0.00**	**20.56**	**6.04**	**4.00**	**17.74**	**12.00**	**1.00**	**3.00**	**0.00**	**0.00**	**67.62**

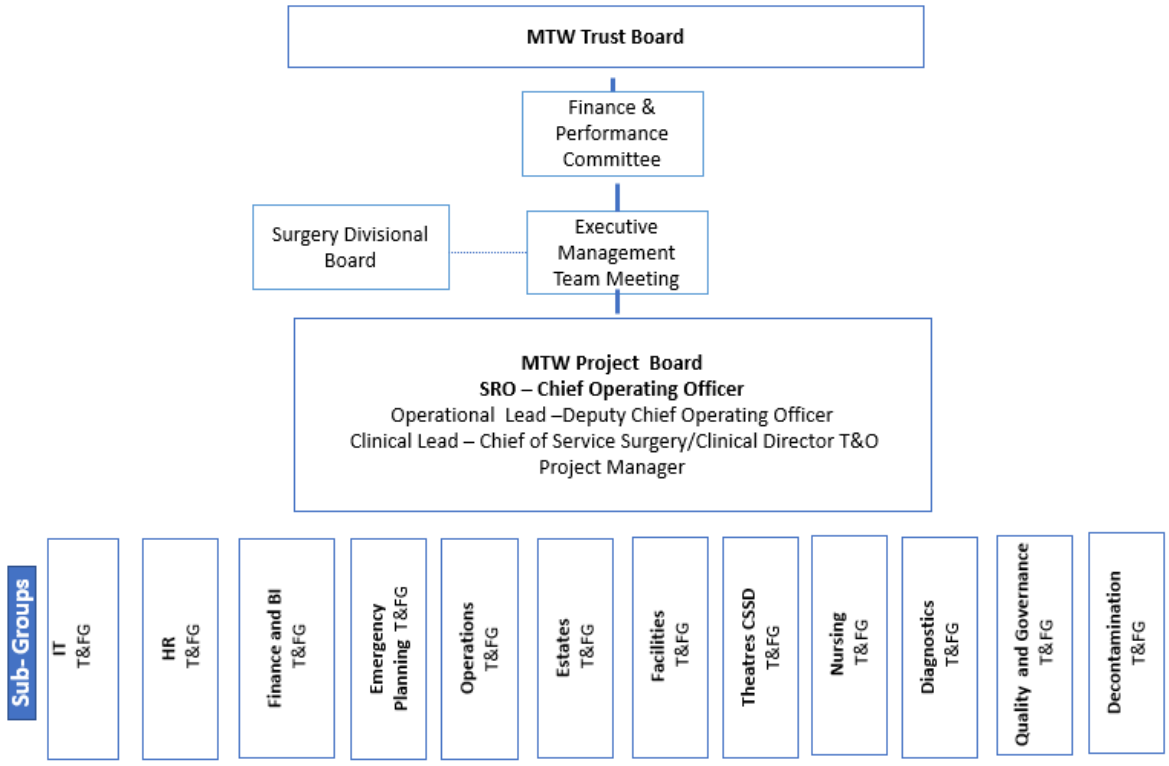
The preferred option represents:

- A cheaper option (Appendix 3) for the Kent and Medway ICS than the ongoing outsourcing of elective orthopaedic activity to the independent sector
- An affordable option to MTW assuming commissioners fund the trust at the cost of delivery.

1.6 The management case

The governance structure for the project is shown below.

Figure 2: Barn Theatre project governance structure



The senior responsible owner (SRO) for the scheme is Sean Briggs, the trust's Chief Operating Officer. The operational lead for the scheme is the Deputy Chief Operating Officer. This role will oversee the implementation and delivery of the project both from an operational and governance perspective and will be responsible for reporting weekly to the Trust Executive Team. The clinical leads for the scheme are the Chief of Service for Surgery and the Clinical Director for Trauma and Orthopaedics. These roles will ensure that the clinical pathways are agreed, signed off and undertake a quality impact assessment.

There will be a dedicated project manager assigned to the project supported by a project manager officer who will oversee the project on a daily basis and who will provide weekly progress reports and will highlight risks/concerns regarding delivery of the project.

The task and finish groups will consist of speciality leads and will lead the delivery of their areas.

The key milestones associated with implementation are set out below.

Table 13: Project milestones

Milestone	Date
Planning permission process started	Complete
Architectural design drawn up with clinical input	Complete
Procurement work to secure large capital items	Ongoing (started October 2021)
Foundation building work – levelling out the ground near MOU	Before end of year 2021
Installing the modular build and theatre equipment	Q1 2022
Building a team to staff the unit (including physiotherapy, nursing, theatre staff, surgeons, radiotherapy, anaesthetics)	To start immediately when business case approved (estimated time 6 months)
Theatre commissioning (deep clean and certification)	29th August 2022 (for 2 weeks)
Opening new build to patients	12th September 2022

Recognising the importance of rapid delivery of the new facility, the trust has carried out five strands of pre-construction planning and enabling works, each of which will save time from the project should the business case be approved.

The trust recognises that the project will only achieve its objective if there is an engaged set of staff and stakeholders throughout all project phases. The project team has identified the key stakeholders:

- The Kent and Medway system
- Surgeons
- Anaesthetists
- Theatre and recovery nursing staff
- Control of infection team
- Managers within the surgical directorate
- Managers within support services (estates and hotel services)
- Patient representatives.

Staff have been closely involved in developing the design for the proposed new barn theatre facility.

Operational stakeholders from East Kent, Darenth Valley and Medway Maritime have been engaged with and pledged support for utilising the Barn facility for their activity. Further meetings have been scheduled week commencing 6th Dec 21.

Consideration has been given to the patient communication of how the project would provide an improved patient pathway for elective care within the Kent and Medway system. For information purposes only the planning, provision and operation of the project could be taken to the Health Overview and Scrutiny Committee (HOSC).

A quality impact assessment has been carried out and can be found as Appendix Nine.

1.7 Conclusion

This business case sets out the optimal way for MTW to develop an orthopaedic centre of excellence at Maidstone Hospital. In the medium-term the proposed centre of excellence would support delivery of the trust's mission *to be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community* and the vision of providing *outstanding hospital services delivered by exceptional people*. The capacity delivered by this investment will enable the trust to reduce the orthopaedic elective waiting list and waiting times. Initially two of the four new theatres would be used, leaving the two remaining theatres available to the rest of the ICS to tackle their elective backlog.

This case is about delivering benefits as well as financial savings:

- The ICS will benefit from having capacity available in the short-term to support elective recovery, lower costs of delivery and lower waiting times.
- Benefits to local people who will be treated in an orthopaedic centre of excellence delivering evidence-based best practice which will optimise their chances of a good outcome and minimise the risk of their operation being cancelled. Waiting times will also reduce and the new unit will be closer to the most deprived areas within West Kent.
- The centre of excellence approach is expected to improve staff recruitment and retention by allowing staff to work from purpose-built facilities designed with best practice in mind.
- Other specialties at MTW will benefit from having access to theatre capacity freed-up by orthopaedics.

The trust requires capital funding from NSHEI to deliver this development; failure to obtain funding is the main risk associated with these proposals. The other key risk is inability to recruit the additional staff needed quickly enough – the orthopaedic team is developing its recruitment plan to mitigate this risk, noting that the centre of excellence will in itself be attractive to potential recruits.

2 Introduction

2.1 Purpose of this business case

This outline business case (OBC) proposes an investment of £31.3m to expand orthopaedic surgical capacity at Maidstone and Tunbridge Wells (MTW) NHS Trust by creating a 'barn theatre block' on the Maidstone Hospital site behind the Maidstone Orthopaedic Unit (MOU). The new facility would consist of:

- Four laminar flow theatres
- A 20-bed inpatient ward
- A 16-bed day case ward.

The facility would be ring-fenced for orthopaedic Covid Green elective day case and inpatients. The new facility will create theatre capacity for the Kent and Medway system, to help tackle the backlog of patients awaiting surgery following the Covid pandemic.

The development would be introduced as follows:

- Two theatres that will be available for the Kent and Medway system which could provide capacity for an estimated 2500 patients per annum. The theatres will be fully equipped to use for orthopaedic surgery.
- Two theatres to provide capacity for the transfer of most planned adult orthopaedic operations from Tunbridge Wells Hospital (TWH). The move of activity from TWH will enable other surgical specialities to grow activity at that site. These theatres will also allow for the repatriation of outsourced activity from the independent sector.

2.2 Barn theatres

The term 'barn theatre' refers to the open-plan design of the main surgical area, where each patient is treated in a dedicated space alongside the next patient, with a specialised air canopy over each station to prevent the spread of infection. The barn theatres have adjoining anaesthetic rooms and traditional recovery areas. Benefits of barn theatres include lower infection rates, improved safety and enhanced team working. Barn theatres have recently been developed at Chase Farm Hospital (which the orthopaedic and estates team have visited), Leighton Hospital in Crewe and Broadgreen Hospital in Liverpool.

The barn theatre built at Broadgreen Hospital (an exemplar build) showed the following key benefits[2]:

- Patient throughput increased by 40%
- Opportunities for enhanced team working
- Peer awareness of contemporary surgical practice and standards
- Improved supervision of non-consultant surgeons
- Reduced level of staffing requirement
- Opportunities to develop non-Doctor Anaesthetists in a safe environment

[2] https://www.operatingroomissues.org/the-rise-of-the-barn-operating-theatre/

- Reduced infection rates through improved theatre discipline
- Reduced cost per operation
- Higher quality environment
- Efficient space utilisation.

2.3 Maidstone and Tunbridge Wells NHS Trust

MTW is a large acute hospital trust in the south east of England which provides a full range of general hospital services and specialist complex care to around 590,000 people living in the south of West Kent and the north of East Sussex. The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding areas. The Trust operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The Trust also offers services at Sevenoaks, Tonbridge, Crowborough, Uckfield and Hawkhurst community hospitals, and Abbey Court. The Trust employs a team of over 5,000 and operates within the Kent and Medway Integrated Care System (ICS).

Figure 3: The Kent and Medway system

The trust's **vision** is *outstanding hospital services delivered by exceptional people*.

The **mission** is *to be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community.*

This business case is entirely consistent with the trust's suite of supporting of supporting strategies, including the clinical strategy and estate strategy.

Figure 4: Trust strategies

2.4 Scope of the business case

This business case covers day case and inpatient elective orthopaedic surgery provided by MTW. The facility will provide four theatres for adult orthopaedics – this business case focuses on the initial use of the first two theatres, although the capital cost included covers the construction and equipping of all four theatres.

The non-financial benefits of increasing theatre capacity for elective orthopaedics across the Kent and Medway system is within the scope of this business case (no financial value has been ascribed to this benefit).

Out of scope of this business case are non-elective orthopaedics (trauma), adult orthopaedic outpatients and paediatric orthopaedics. Also, out of scope are the potential financial benefits of backfilling freed-up theatre capacity across the trust – these benefits will feature in a separate business case.

2.5 Structure of the OBC

The structure of this business case is consistent with the latest guidance[3] from NHS Improvement (NHSI) on the development of business cases using the Five Case Model and is structured as follows:

- The **strategic case** sets out the strategic context and the case for change together with the supporting investment objectives for the scheme.
- The **economic case** demonstrates that the Trust has selected the option which best meets the existing and future demands of the service and optimises value for money.
- The **commercial case** outlines procurement and contractual issues associated with the development.
- The **financial case** confirms the funding arrangements and affordability, and summarises the impact on the balance sheet.

[3] Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, NHSI, 2016.

- The **management case** demonstrates that the scheme is achievable and can be delivered successfully to time, cost and quality.

2.6 Support

[DN: statements of support to follow]

2.7 Approvals

The business case is being submitted to NHS England and Improvement (NHSEI). Once funding has been agreed the business case will be submitted to the Board of Maidstone & Tunbridge Wells NHS Trust (MTW) for approval.

3 The Strategic Case

3.1 Introduction to the strategic case

In the strategic case we set out the case for the investment with reference to the national and local context, before confirming the investment objectives, benefits and risks.

3.2 The national context

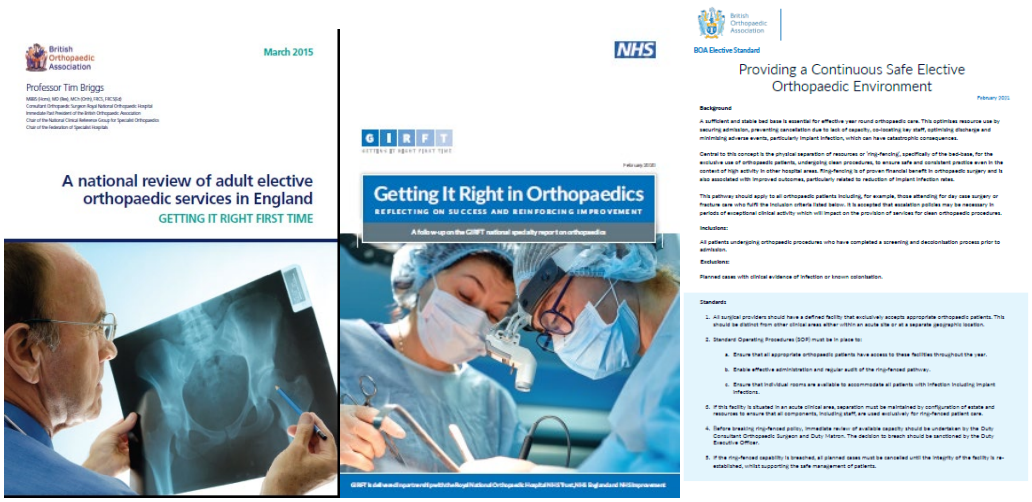
3.2.1 Musculoskeletal conditions and orthopaedics

Elective Orthopaedics is an essential service for communities with a significant positive impact on quality of life. According to Department of Health definitions musculoskeletal (MSK) conditions include over 200 different problems and affect 1 in 4 of the adult population. They are the biggest cause of the growing burden of disability in the UK, and cost the NHS £5 billion each year. MSK conditions can be progressive, meaning the impact can be profound though the importance is often underestimated since most are not immediately life threatening. MSK conditions comprise around 14% of all primary care consultations and 10% of all GP referrals to hospitals, resulting in approximately 1.36 million admissions to secondary care and 2.27 million bed days in England in 2016-17.

3.2.2 Orthopaedic best practice

MTW's vision is to provide *outstanding hospital services* which means its clinical services must always strive to operate in accordance with best practice. Best practice in orthopaedic service delivery is considered below with reference to:

- Recommendations from The British Orthopaedics Association
- The Getting It Right First Time (GIRFT) programme



The **British Orthopaedic Association's** elective standard recommends:

A sufficient and stable bed base is essential for effective year-round orthopaedic care. This optimises resource use by securing admission, preventing cancellation due to lack of capacity, co-locating key staff, optimising discharge and minimising adverse events, particularly implant infection, which can have catastrophic consequences. ***Central to this concept is the physical separation of resources or***

'ring-fencing', specifically of the bed-base, for the exclusive use of orthopaedic patients, undergoing clean procedures, to ensure safe and consistent practice even in the context of high activity in other hospital areas. *Ring-fencing is of proven financial benefit in orthopaedic surgery and is also associated with improved outcomes, particularly related to reduction of implant infection rates.*

The **GIRFT programme** published its report "*Getting It Right in Orthopaedics, Reflecting on success and reinforcing improvement*" in February 2020, in which the main themes are:

- **Minimum volumes** - evidence in the journals has continued to show that operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications and cost, and this evidence has now been incorporated into the guidance published by the professional bodies and specialty or sub-specialty associations. **Many trusts are working as part of networks or implementing occasional dual operating, which enable surgeons to deliver sufficient volumes of operations** (as well as providing mechanisms for training and professional development). The National Joint Registry (NJR) data shows a significant reduction in low-volume operations in most operation types, but also showed significant opportunity for further improvement, particularly in understanding the number of surgeons performing very small numbers of operations.
- **Service design: ring-fenced beds** - an increasing number of trusts report rigorously enforcing the ring-fencing of beds and, anecdotally, orthopaedic service managers have reported using the GIRFT recommendation to underline the importance of maintaining the ring-fence in their trust. This is despite the increasing pressures on trusts to make more beds available to deal with winter pressures. Surgical site infection rates are influenced by a number of factors, but it is likely that the maintenance of ring-fencing has contributed to the decreasing infection rates in the orthopaedics specialty.
- **Service design: hot and cold sites** - the implementation of a 'hot and cold' site split has proved transformative for several trusts. By separating their 'hot' unplanned emergency work from their 'cold' planned elective work, these trusts have seen reductions in average length of stay, reductions in cancellations of surgery and increased elective activity despite winter pressures. The GIRFT programme supported these hot and cold site splits and is continuing to work with a number of other trusts who are seeking to implement similar changes.
- **Training** - The GIRFT report highlighted concerns about the numbers of senior and experienced consultants approaching age of retirement and combined with the growing demand and pressure on surgeons, there was a risk of a capacity gap increasing if the numbers and experience of trainees could not be increased sufficiently.

A selection of case studies demonstrating the benefits of adopting the recommendations made by GIRFT that are most relevant to this business case, are included at Appendix One.

An earlier GIRFT report[4] recommend that ***a genuine elective orthopaedic ring-fence is one that is rigidly enforced, and this is essential if best outcomes are to be achieved.*** *If there is a breach of the ring-fence of any kind – including supposedly 'clean' surgical patients – then surgeons are advised to*

[4] A national review of adult elective orthopaedic services in England, GIRFT, March 2025.

cancel their lists and require that the ward is closed and deep cleaned before joint replacement can begin again. It is worth remembering that when infections do occur, as is more likely in a non-ringed circumstance, it is necessary to go through the same deep clean procedures.

In GIRFT's February 2020 update report, they reported that 40.3% of trusts had adopted this recommendation – MTW risks being 'left behind' if it does not act to rigidly enforce ring-fencing across orthopaedics.

This is supported by the release of the Elective Recovery High Volume Low Complexity (HVLC) guide for systems in May 2021 with one of the programme principles being – drive for 'top decile' GIRFT performance of clinical outcomes, productivity and equity of access.

The implications for this business case

- Currently at MTW there is only one theatre, within the Maidstone Orthopaedic Unit (MOU), that complies with the recommendation to ring-fenced orthopaedic capacity. The service at Tunbridge Wells is particularly hit by bed cancellations due to emergency bed pressures, with non-elective patients taking up bed space earmarked for green elective orthopaedic patients.
- Moving adult elective orthopaedics to a single site in Maidstone, with dedicated radiology and physiotherapy resource for post-operative care and consistent team of nurses and theatre staff, will allow MTW to develop a more patient focussed pathway which reflects best practice as described above.

3.3 The local context

The MTW elective orthopaedic service operates from:

- One theatre at the MOU. MOU is a standalone theatre, with a ring-fenced 12 bedded ward and specialist theatre team, dedicated to only elective orthopaedic surgery.
- Maidstone Short Stay Surgical Unit (MSSSU)
- TWH for elective and non-elective surgery (trauma surgery is only carried out at TWH through 18 sessions each week).

The average number of orthopaedic lists per week is:

- MOU – 10
- MSSSU – 11
- THW – 29 (including trauma and paediatric orthopaedics).

Historically an average of 248 patients receive elective surgery each month at full capacity.

The service employs:

- 15 adult orthopaedic surgeons (13 full-time and two part-time), one locum vacancy and 3.5 paediatric orthopaedic surgeons
- 4 clinical fellowship trainees (2 post Certificate of Completion of Training and 2 pre-CCT).
- 3 trainee surgical care practitioners

MTW contracts with commissioners using a 'prime provider' model whereby the trust is the 'prime' or main provider of services, but through which West Kent elective patients can choose to have their operation at an independent sector provider (for example, the Horder Centre in Crowborough) if the patient meets the independent sector provider's criteria for surgery. The contractual relationship with the independent sector will not alter as a result of the investment proposed in this business case because patient choice[5] will continue to apply. However, in addition to patient choice activity flowing to the independent sector, MTW outsources elective work to the independent sector to maintain waiting list performance – **it is this outsourced activity that the trust wishes to repatriate to the new capacity being proposed in this business case**. This activity is currently funded by non-recurrent elective recovery fund (ERF) funding, the level of backlog outsourcing is approximately £0.23m per month (£2.8m per annum).

3.3.1 The local case for change

The case for change is made with reference to the following factors, each of which is discussed in turn below:

- Adhering to best practice
- Operational performance
- Demand and capacity forecasts

3.3.2 MTW's adherence to best practice

The trust fails to comply with best practice in two key respects:

- As noted above MTW only has one ring-fenced orthopaedics theatre and inpatient unit (in the MOU)
- Elective and non-elective activity is not separated at TWH.

The result is that operational performance is often compromised due to planned electives being cancelled due to emergency activity and much of the planned work being done away from the MOU centre of orthopaedic excellence – see performance metrics in 3.3.3 below.

The GIRFT assessment of MTW's orthopaedic service has highlighted the areas shown below where the trust is not meeting recommendations.

[5] Patients have a legal right to choose which hospital or service they go to. The Trust will offer an appointment or treatment to the patient with a suitable clinician, at a suitable site and within agreed timeframes as documented in the Trust's Patient Access to Elective Care Policy (2020).

Table 14: GIRFT and other metrics

	Metric/Recommendation	Top Decile/Best practice performance	Service Performance	Current service provision	Has the service met top decile performance or recommendation? (Yes/No)
Sentinel metrics	**Productivity** equivalent to 4 total hip or knee joint replacements in all-day list (8 hours)	4	Trust to respond	5.2 MOU 4.2 TWH	Yes
Sentinel metrics	Average length of stay for elective **knee replacements**	3.00	3.1	Good	No
Sentinel metrics	Orthopaedic surgery - **day case rates** (all procedures excluding total joint replacements)	93.0%	65.00%		No
Sentinel metrics	Orthopaedic surgery - Conversion from **day case to inpatient stay**	1.50%	11.0%		No
Sentinel metrics	**On the day cancellation rate** for elective orthopaedics for clinical reasons		10.1% at TW and 5.7% at MS		No
GIRFT clinical metrics	Average length of stay for elective **hip revisions**	4.4	7.1		No
GIRFT clinical metrics	Average length of stay for elective **knee revisions**	4.1	4.5		No
GIRFT clinical metrics	Average length of stay for a **shoulder replacement**	1.9	2.1		No
GIRFT clinical metrics	Day case rate for **ankle or wrist fusion** procedures	36.9%	75.00%	20% ankle; 75% wrist	No

	Metric/Recommendation	Top Decile/Best practice performance	Service Performance	Current service provision	Has the service met top decile performance or recommendation? (Yes/No)
BADS[6]	Day case rate for **unicompartmental knee replacement** (benchmark)	40.0%	0%		No
BADS	Day case rate for **arthroscopy of knee** procedures (benchmark)	99.0%	77%		No
BADS	Day case rate for **therapeutic arthroscopy of shoulder** procedures (benchmark)	90.0%	75%		No
Ortho service/ clinical networks	A centralised elective inpatient orthopaedic centre in place for low dependency high volume work with laminar flow theatres, ring-fenced elective beds and full comprehensive staffing. Network in place to follow national guidance from the British Orthopaedic Association and Specialist societies regarding centralise low volume, complex procedures e.g. total elbow / ankle replacements, major revision arthroplasty surgery including periprosthetic joint infections				No

[6] The British Association of Day Surgery

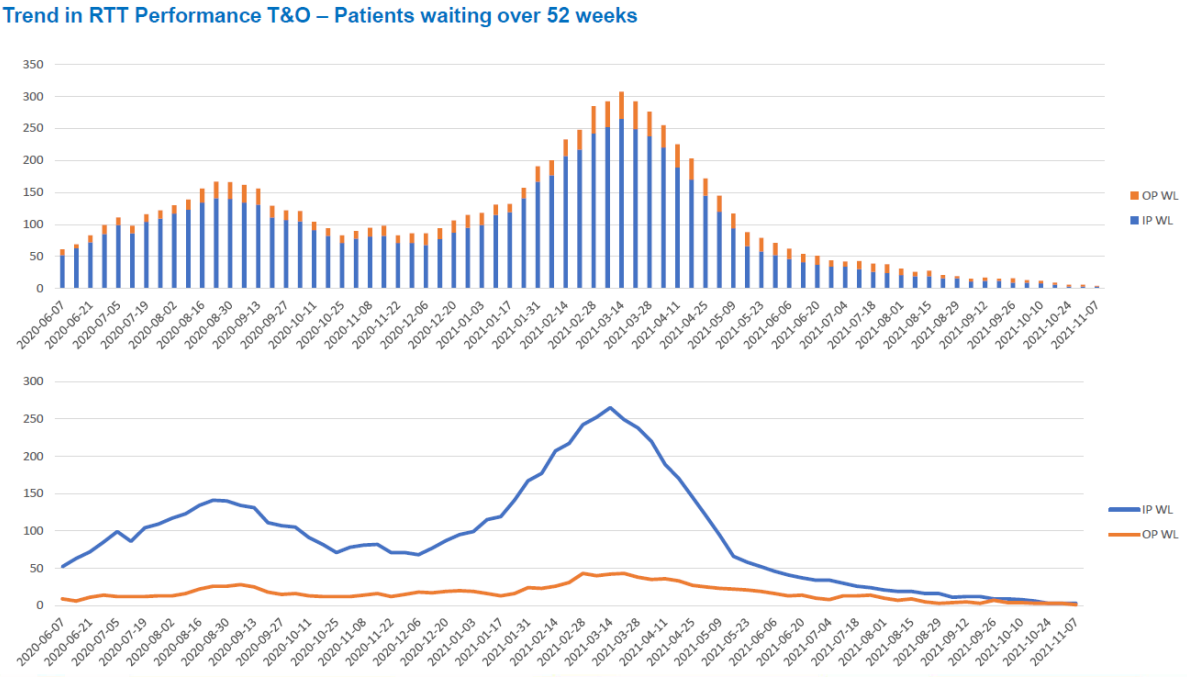
The pandemic experience has reinforced the need to separate elective and non-elective pathways to ensure that 'Green' Covid negative activity can continue in the event of future spikes in the infection rate.

3.3.3 MTW's operational performance

Following the pandemic, recovering MTW's referral to treatment (RTT) position to meet the national standard of 92% of patients receiving treatment within 18 weeks of referral and reducing the number of patients waiting more than a year to zero, are key priorities for the Trust. Currently adult orthopaedic patients represent one in five patients awaiting surgery on an RTT pathway and orthopaedics has largest inpatient surgical waiting list within the trust. Across all pathways (inpatients and outpatients), orthopaedics accounts for 10% of patients on trust's waiting list being second only to ophthalmology.

The trust has worked hard to recover the 52-week breech position as shown below.

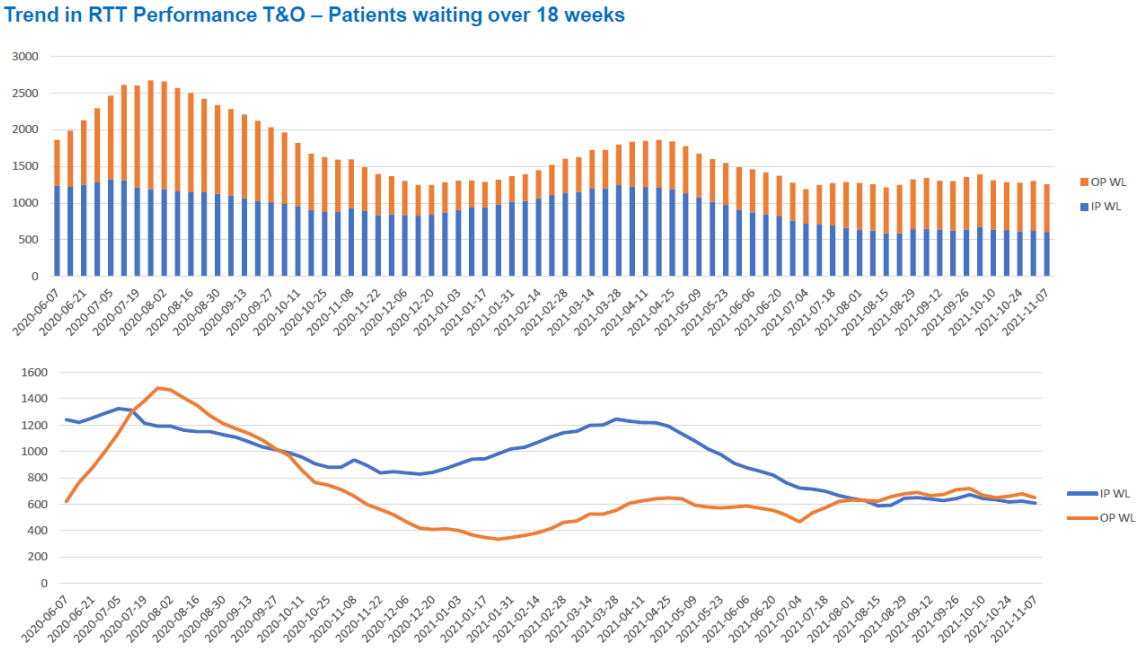
Figure 5: Elective orthopaedic 52-week wait trends



The peak seen in March 2021 when over 250 people had been waiting more than 52 weeks for surgery has been eliminated and currently there are just six people over 52 weeks. The position has not been recovered so quickly elsewhere and across the Kent and Medway there are over 1,700 orthopaedic patients who have waited over a year for surgery.

The position regarding the 18 week 92% RTT target has not improved to the same extent.

Figure 6: Trend in the number of people waiting more than 18 weeks



Recovering RTT performance is constrained by a lack of theatre capacity as evidenced by the 18-week performance and also new consultants struggling to find theatre capacity at either site.

In order to mitigate the capacity shortfall and meet the RTT targets in the first quarter of 2021/22 170 elective backlog orthopaedic cases were outsourced to the independent sector (in addition to patient's who chose to have their operation at the Horder Centre). This outsourcing was funded through the ERF; the trust understands the quarter one cost to have been £0.7m (£0.23m per month).

The table below summarises historic key performance indicators (KPIs) together with future targets and plans about how performance can be improved.

Table 15: Theatre performance indicators as at August 2021

Key Performance Indicator	MOU	MSSU	TWH	Baseline position (both sites)	Future outcome	How will these improvements be achieved?
Session utilisation (without TAT / with TAT)	79.7% 84.2%	78.0% 86.4%	83.9% 94.2%	80.4% 87.6%	85% 90%	See below actions for increasing cases per list, reducing cancellations and improving start times
Start times	8:50 44% within 15 mins	09:00 58% within 15 mins	08:59 28% within 15 mins	08:56 44% within 15 mins	08:35 1<10% late starts over 15 mins	Dedicated, consistent orthopaedic theatre and ward team. All day theatre lists with the same consultant and anaesthetist
Same day hospital cancellation rate	3%	5.7%	10.1%	4.6%	3%	Ring fenced ward to avoid cancellations due to bed capacity Improving pre-op pathway to reduce key cancellation reasons
Number of adult's electives per month	100	86	62	248 / month	340 / month	Increasing number of cases per list Increasing capacity of theatres with laminar flow (replacing MSSU) Increasing Saturday capacity Backfilling lists with fellow lists 1 extra theatre for orthopaedics
Average no. of cases per whole day list	4.7	4.0	3.0	4.2	5.2	Theatre efficiencies (start times, turnaround times etc.) Consistent staffing throughout lists
Current cost of outsourcing backlog patients (excludes prime provider)*	N/A	N/A	N/A	170 cases costing £700k per quarter	£0	Increasing internal capacity via theatre efficiencies Increased backfilling 1 extra theatre for orthopaedics
Number of patients waiting over 40 weeks for treatment	N/A	N/A	N/A	390	0	Booking in order Avoid cancelling long waiters Improved pre-op pathway

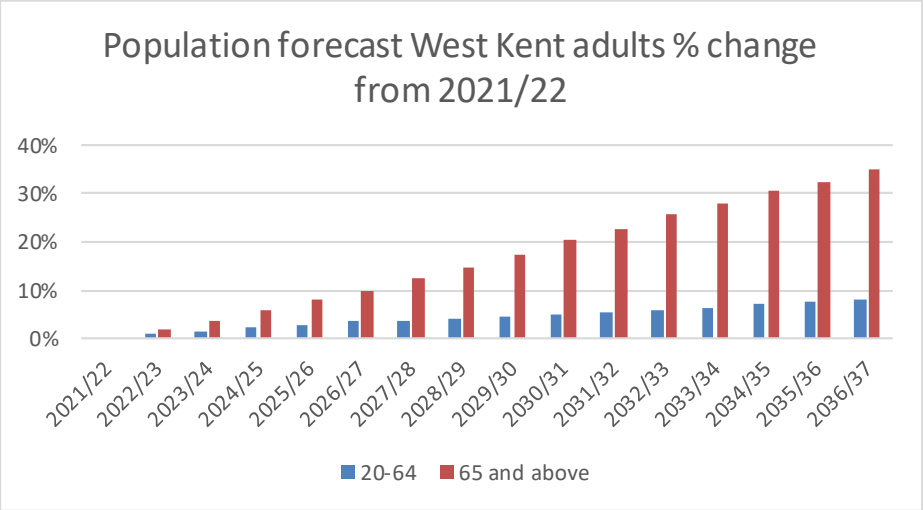
Key Performance Indicator	MOU	MSSU	TWH	Baseline position (both sites)	Future outcome	How will these improvements be achieved?
RTT (% treated within 18 weeks)	N/A	N/A	N/A	51.2%	80% June 22 86% Nov 22 92% Mar 23	Maintaining activity over the winter period / despite site pressures 6 day / week operating
Length of stay in top quartile of the country	2.07	1.14	2.95	2.5 days	2.1 days	Improved pre-admission planning Physiotherapy 7 days per week Increased medical presence

3.3.4 Demand and capacity forecast

The Office of National Statistics have predicted a precited population change from 2018-2028 of Ashford 10.3%, Dover 10.2%, Maidstone 10%, Swale 9.7%, Tonbridge and Malling 9.2%, Canterbury 5.2%, Thanet 5.1% and Tunbridge Wells 3.1%.

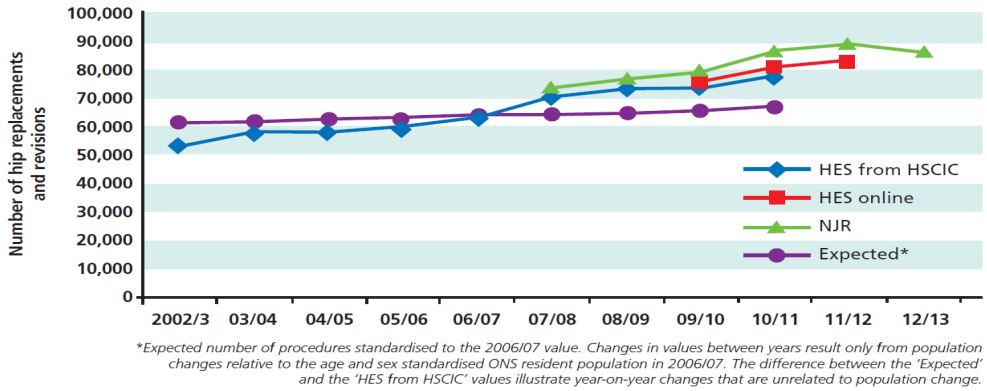
Orthopaedics is a speciality skewed towards treating older people so the forecast growth in the older population locally will have a substantial impact on demand for orthopaedic elective operations everything else being equal.

Figure 7: Demographic forecast – percentage change from 2021/22 base[7]



Over the 15-year period forecast by Kent County Council, the number of people aged 65 and over living in West Kent's four districts authority areas is forecast to increase by 35% from 110k to almost 149k. The working age adult population will also increase, but by a much lower 8%. As people live longer and as advances in orthopaedics continue, demand for elective work will also rise because more individuals will return to the trust for a revision - the figure below is taken from GIRFT's 2015 report and shows how the number of hip replacement revisions increased in the ten years to 2012/13.

Figure 8: Hip replacement revisions[8]



[7] Kent County Council

[8] A national review of adult elective orthopaedic services in England, GIRFT, March 2025.

The increasing rate of revisions adds to the baseline demographic pressures and taken together they are the key factors in the modelled average growth of 4.4% per annum for orthopaedic day cases and elective inpatients. The informatics team have modelled demand to 2026/27 and mapped this against available capacity (MTW theatres and the independent sector).

Table 16: Demand and capacity model without additional capacity

	Total annual demand				Capacity			
	New demand	Backlog	IS choice	Total	Existing MTW @ 90% utilisation	IS	Total	Shortfall
2021/22	2,914	630	1,060	4,605	2,539	1,060	3,599	-1,005
2022/23	3,043	400	1,107	4,550	2,539	1,107	3,646	-904
2023/24	3,177	0	1,156	4,332	2,539	1,156	3,695	-638
2024/25	3,316	0	1,207	4,523	2,539	1,207	3,746	-777
2025/26	3,462	0	1,260	4,722	2,539	1,260	3,799	-923
2026/27	3,615	0	1,315	4,930	2,539	1,315	3,854	-1,076

The table above clearly demonstrates that there will be a substantial shortfall in capacity throughout the period modelled (and the modelling assumes the independent sector can increase capacity by 4.4% per year).

3.4 Private patients

Not included within the demand modelling is a medium-term opportunity to undertake private patient activity at MTW. The MTW catchment area is an area of relatively high private medical insurance penetration.

3.5 Summary of the case for change

The case for 'doing something' is based on the need to:

- Clear the elective backlog across the wider ICS and within MTW
- Protect elective pathways by providing 'Green' Covid secure facilities
- Adhere to best practice as per Orth Assoc and GIRFT
- Meet the anticipated growth in demand that exists in addition to the backlog.

3.6 Response to the case for change

3.6.1 The investment objectives

The response to the case for change set out above, is the proposed investment in new orthopaedic elective surgical capacity described in this business case. The investment objectives are:

- **Investment objective one** – to deliver a reduced waiting list and an improved RTT position for the system by increasing elective orthopaedic activity by increasing theatre productivity and efficiency including reducing theatre cancellations.
- **Investment objective two** – to deliver cost savings by reducing the number of orthopaedic patients outsourced to the independent sector.
- **Investment objective three** – to release theatre capacity on both trust sites to create additional capacity for other specialities thereby helping the system to improve its waiting list and RTT performance.

- **Investment objective four** – to improve GIRFT metrics and HVLC metrics, with the aim for MTW orthopaedics to be in the upper quartile of Model Hospital for day case and inpatient activity.
- **Investment objective five** – to strive to become an outstanding organisation.

Each investment objective is discussed in detail below.

3.6.2 Investment objective one – deliver a reduced waiting list and improved RTT position

Current situation

Orthopaedic surgery is carried out in the ring-fenced MOU, other theatres at Maidstone (the MSSU) and at TWH. Current (October 2021) Trust wide RTT performance is 72.71% compared to the 92% target with the waiting list size at 38,781. There are currently 1,258 adults (and 128 paediatric) orthopaedic patients waiting for surgery.

Productivity varies significantly between the three settings. Because the MOU specialises in orthopaedic surgery and is for planned surgery only, the team can carry out 20% more activity per day than other theatres. For example, surgeons can complete five primary joint replacement cases in a list in MOU; a level of productivity not achieved in the other theatres. This is due to consistency of the team in MOU and their experience in orthopaedic surgery.

In comparison, TWH theatres experiences a much higher cancellation rate, often leaving a theatre time job planned to operate but with no patients or beds - less than half the total numbers of patients were cancelled on the day in MOU compared to TWH. This is mainly caused by a lack of beds at TWH arising because there are no ring-fenced beds for elective patients resulting in emergency trauma patients, or even surgical or medical patients, occupying beds required for elective orthopaedic patients. The most radical demonstration of pressure on TWH beds is demonstrated by elective activity over winter months dropping to 50% of the average in 2020 and even zero in previous years.

In summary, comparing the efficiency achieved by the ring-fenced MOU to TWH demonstrates how a theatre and ward on a dedicated cold elective site, avoids same day cancellations and increases theatre utilisation.

Problems / risks of current situation:

The delivery of orthopaedic activity and performance targets by MTW is vulnerable to interruption due to winter bed pressures and/ or increased trauma activity. This results in a poor experience for our patients and staff, with patients frustrated and in pain for longer waiting for their operation and staff becoming demoralised due to the idle time wasted.

The current configuration poses a significant risk to the RTT recovery plan, with orthopaedics accounting for 1 in 5 patients at MTW waiting for surgery and a backlog most effected by the pandemic, making up 60% of the outstanding 52-week breaches. With increasing emergency demand, elective surgery at TWH has been at risk over the last couple of months, despite the fact that it is 'summer'. Although elective recovery in orthopaedics has been positive so far, with the number of 52-week breaches reducing from 350 to 6 and RTT performance increasing by 15% in 5 months, there's a risk that this will plateau due to the increase in referrals.

The gaps from where we are to where we need to be:

There is a need to improve theatre productivity across the orthopaedic pathway. The table below shows the most common cancellation reasons, listed in order of priority.

Table 17: Reasons for cancellations

	Description	Actions to improve	Will this business case lead to improvement?
Lack of bed capacity	There are no ring-fenced beds at TWH, therefore elective beds depend on emergency flow and discharge profiles.	Daily board rounds, chasing discharges, ambulatory pathways (including SAU) to prevent admissions, use of Teletracking.	Yes – there will be ring-fenced beds.
Cancelled due to fitness / pre-op	Currently the CAU and pre-op team often miss key information in the pre-assessment pathway / only pick up information when it's too late to replace a patient on a list.	New iron-deficiency pathway Review pre-op capacity CAU checking pre-op outcomes weekly Moving to electronic notes	Yes – as elective booking coordinator in post.
Operation not needed	Patients turning up for surgery on the day but the surgeon (or patient) deciding that they don't need an operation. A significant reason with patients waiting so long for surgery.	The CAU are asking if symptoms remain the same and booking an urgent telephone appt with the consultant if required.	As above Likely limited impact
Covid-related	Either patients testing positive, having to isolate, not followed the isolation guidelines or not having a negative swab.	CAU ringing every patient to explain swab and isolation process pre-admission. Ability to rapid swab on admission.	As above.
Kit related	Not having appropriate loan kit available. Includes	CAU to enter kit requirements on theatre man and chase.	Yes – ability to stock more kit on the shelf

	Description	Actions to improve	Will this business case lead to improvement?
	kit for patients with nickel allergies.	NCR form to become electronic.	and avoid cross-site transfer
Running out of time	Mainly at TWH rather than MOU or MSSU, potentially due to lack of orthopaedic trained staff	Ensuring start time are followed Consultants signing off theatre lists	Yes – if new theatres mimic MOU performance

The expected benefits of achieving the change

The trust will improve the waiting list and RTT position and bridge the capacity gap by improving utilisation of the lists transferred from TWH to the proposed new Barn theatre facility. By improving utilisation, capacity will be made available to repatriate activity from the independent sector into the new Barn theatre facility – see objective two below.

3.6.3 Investment objective two - deliver cost savings

Current situation:

Since the restart of elective activity in March 2021, the independent sector has been carrying out one in three orthopaedic operations. These operations can be divided into:

- Patients who exercise their right to choose and elect to be treated in the independent sector
- Prime provider patients treated at the Horder Centre after initial referral to MTW
- Backlog patients whose operations are carried out by MTW surgeons at independent sector hospitals due to the lack of theatre capacity in MTW.

Backlog patients represent the group who could be repatriated to the trust if additional trust capacity were made available (these patients are referred to MTW, are seen in MTW outpatient clinics and are subsequently selected as suitable have their procedure in an independent sector hospital under the same consultant). Backlog cases are not covered by pre-existing contracts, so are charged on a case-by-case basis by the independent sector. The cost of this patient group in quarter one 2021/22 was as below.

Table 18: Outsourcing costs (quarter one 2021/22)

Type	Number of cases	Average Cost per case	Total cost
Day cases	68 cases	£2,023	£137,571
In patients	102 cases	£5,518	£562,829
Total	170 Cases		**£702,430**

Projected forward, this means MTW could spend up to £2.8m outsourcing orthopaedic cases in 2021/22. Funding from these cases is from the ERF which is on a non-recurrent basis. If the ERF is ended, without additional MTW theatre capacity, the backlog will increase and RTT performance will drop.

Problems / risks of current situation

The problems and risks associated with the current situation and which this business case seeks to address, are:

- Physiotherapy and post up care are variable between hospitals and sometimes patients are lost between MTW and the independent sector provider
- The process of outsourcing involves significant administrative support, as patients must be identified from the waiting list and all their details including case notes transferred
- Only very fit patients are suitable to be treated in the IS and patients can be bounced back from the IS as "unsuitable" and therefore wait longer for surgery
- Independent sector providers are limited in the case mix they can offer due to lack of specialist equipment
- Reduced opportunity for our trainees to see and support in theatres

The gaps from where we are to where we need to be:

Whilst most of the whole pathway patients are part of the prime provider contract, most of the backlog surgery can be brought in house if we have adequate theatre capacity. MTW would require an additional 0.88 theatres to repatriate this activity.

The expected benefits of achieving the change:

By bringing activity in-house MTW will be able to reduce costs to the NHS.

There are also non-financial benefits such as reduced administrative e.g. arranging loan kits, clearer pathways for patients, including pre-operative assessments and post-operative care and improved training opportunities for registrars by having more simple cases in house.

3.6.4 Investment objective three - release theatre capacity for other specialities

Current situation - Maidstone Hospital

There are nine operating theatres on the Maidstone site, which currently run a complex five week rolling timetable. There are:

- Four theatres in the main theatre block used for 40 sessions a week (no sessions used by orthopaedics)
- Two theatres in eye unit (EEMU) used for 19 sessions per week by ophthalmology.
- Two theatres in MSSSU used for 20 sessions per week (11 sessions used by orthopaedics)
- One theatre in the MOU offering 10 sessions a week solely for orthopaedics.

Both the MSSSU and MOU theatres also run Saturday lists as part of the waiting list initiatives.

The table below highlights how many sessions per week are used by each speciality, using week one as an example.

Table 19: Example theatres utilisation schedule – Maidstone theatres

Speciality	Main Theatres (4)	EEMU (2)	MSSU (2)	MOU (1)
Upper and Lower GI	8		2	
Urology	12		2	
Breast	8			
Gynae - oncology	6			
Gynaecology	5			
ENT			2	
Paeds endoscopy			2	
Orthopaedics (including paeds)			11	10
Ophthalmology		19	1	
Total sessions per week:	**40**	**19**	**20**	**10**

Current situation – Tunbridge Wells Hospital

There are eight main operating theatres at TWH, as well as a local anaesthetic suite in ophthalmology outpatients. Again, using week one as an example the 80 sessions are allocated as below.

Table 20: Example theatres utilisation schedule – Tunbridge Wells theatres

Speciality	TWH	OP LA suite
Upper and Lower GI	15	
Vascular	2 (once per month)	
Gynaecology	13	
CEPOD	10	
ENT	10	
Orthopaedics (including paeds)	11	
Orthopaedics (Trauma)	18	

Speciality	TWH	OP LA suite
Ophthalmology	N/A	7
Total sessions per week:	**79**	**7**

In addition, there is one vacant session that is used flexibly as extra trauma / CEPOD if needed (or closed down due to staffing). The outpatient local anaesthetic suite is used for cataracts, injections and oculoplastic surgery only.

Problems / risks of current situation:

There is unmet demand for theatre sessions from general surgery, other orthopaedic consultants, breast and urology, for example:

- There are newly appointed orthopaedic surgeons who only have a half day allocated per week, rather than a whole day (two sessions).
- Paediatric orthopaedics is currently developing a case to attract specialist commissioning, but this case is constrained by theatre space for paediatric surgery being extremely limited.
- The Trust and the CCG share an ambition to create a Tier 4 bariatric service at MTW, although this can be managed within existing capacity in the short term, additional theatre sessions will be required as the service builds up more demand.

There is no option for an increase in theatre space on the TWH site limiting the ability for services to expand on this site meaning any expansion must necessarily be at Maidstone Hospital.

The gaps from where we are to where we need to be:

The trust needs to release capacity on the TWH theatre site to meet the demand from other specialties both relating to demographic and other growth, and ambitions to develop new services.

The expected benefits of achieving the change:

The proposed development of the barn theatres would:

- Enable the transfer of 1.12 theatres worth of orthopaedic elective work from the TWH site thereby freeing-up space for other specialities to expand in to

Releasing capacity for other directorates would provide benefits such as:

- Potential to become a specialist bariatric centre with more theatre space for the general surgeons
- Release 10 beds on ward 30 at TWH.

Within the trauma and orthopaedic directorate freed-up theatre capacity at TWH could provide:

- Increased capacity for trauma surgery thereby reducing the wait for trauma surgery and consequently improving patient outcomes

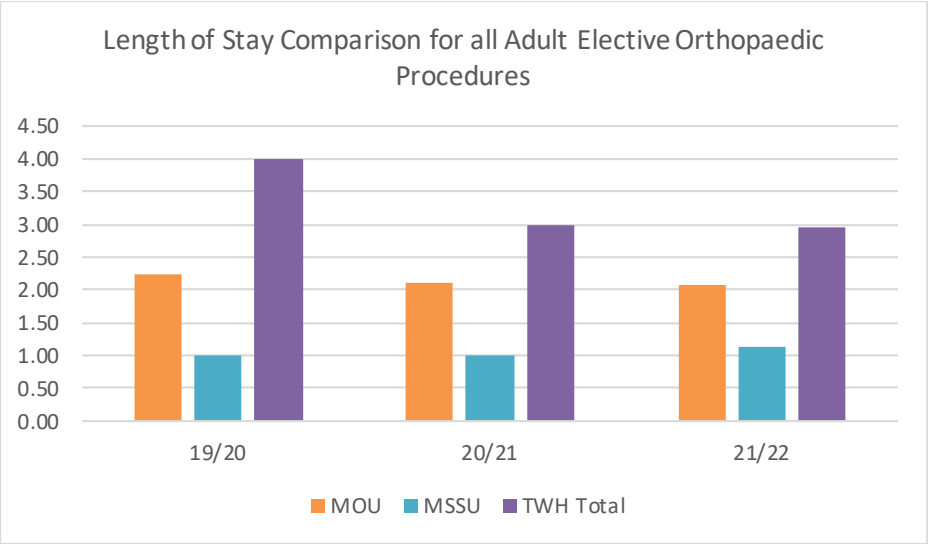
- The ability to expand and develop paediatric orthopaedic services and become the Kent & Medway specialist centre.

3.6.5 Investment objective four – improve metrics

Current situation

GIFT recommends ring-fencing theatres and beds for orthopaedics. The benefits of this approach can be seen by comparing MOU inpatient length of stay with equivalent orthopaedic patients who are treated elsewhere across TWH – MOU is one day less.

Figure 9: Elective orthopaedic length of stay by unit



The main reasons MOU has a shorter length of stay are:

- Better nursing to patient ratios and less vulnerable to staffing moves due to site pressures
- More thorough pre-admission planning to forecast any additional needs as ward manager and sister's main focus is elective planning rather than emergency flow
- Focus on criteria led discharge in MOU, with key milestones each half day/day
- TWH must prioritise emergency flow and trauma patients, therefore elective discharge planning is not the main focus.

Problems / risks of current situation:

The Trust is not compliant in several areas monitored by GIRFT – see Section 3.3.2 above.

The gaps from where we are to where we need to be:

As shown in the table above there are variations between day case rates and productivity between MTW performance and GIRFT top decile. Whilst length of stay for elective knee replacements is currently 'good', this varies between sites with MOU performing better than TWH. In particular, the final recommendation with regards to a centralised elective inpatient orthopaedic centre in place for

low dependency high volume work with laminar flow theatres and ring-fenced elective beds cannot be achieved with the trust's current configuration.

The expected benefits of achieving the change:

The benefits expected from adopting GIFT recommendations are:

- Improvement in productivity, with the average number of joints per lists increasing.
- Day cases rates to match GIRFT best practice and MTW to meet the top quartile performance
- A centralised orthopaedic centre for High Volume Low Complexity surgery, with laminar flow theatre and ring-fenced beds
- Improving length of stay for all procedures, with MTW to meet the top quartile performance
- Reducing same day cancellation rate, bringing the average in line with MOU

3.6.6 Investment objective five - striving to become an outstanding organisation

Current situation

MTW patients receive a good standard of care, and surgical outcomes are good, however patient experience is variable. This is heightened by the fact that Ward 30 at TWH is mainly centred around emergency care rather than elective care. Lack of theatre space at TWH can lead to delays for trauma patients awaiting surgery, with some patients waiting longer than the NICE recommendation to receive their operation to repair their fractured neck of femur on, or the day after the admission. Furthermore, as inpatients are often prioritised for trauma surgery, patients sometimes wait at home for two or more weeks for their surgery and may even have to have a more radical operation due to the wait. This can lead to worse surgical outcomes and poor patient satisfaction for trauma patients.

Problems / risks of the current situation:

There is a CQC action plan in place within the trauma and orthopaedic directorate, however the potential to meet the criteria to become an outstanding organisation are limited without an elective orthopaedic centre. For example, patients have to be transferred between wards post-operatively depending on their physiotherapy needs as the team is split across two sites.

Deterioration of estates and outdated wards and theatres are often mentioned in CQC reports as reasons that the Trust requires improvement and elective orthopaedics is currently dependent on MOU as its only space for ringfenced capacity on a cold site.

The gaps from where we are to where we need to be:

Whilst individuals involved work extremely hard to provide the best patient care, the whole orthopaedic elective care patient pathway is disjointed. Furthermore, theatre capacity limits RTT performance which compromises the trust's ability to become CQC 'outstanding' in the 'responsive' category.

3.7 Benefits

The benefits associated with the investment are summarised below.

3.7.1 Benefits to patients and society

The benefits to patients, their families and wider society are:

- The hot/ cold split and centre of excellence approach is associated with shorter lengths of stay and fewer cancellations resulting in better patient outcomes
- The creation of a centre of excellence for orthopaedic surgery would mean that local residents would have access to orthopaedic best practice-based services without needing to travel outside the area
- The additional capacity proposed would be located at Maidstone rather than TWH meaning more orthopaedic capacity would be close to the most deprived areas served by MTW.
- Local people would no longer need to travel to independent sector providers for some treatments resulting in improved continuity of care for these patients who would receive pre-assessment and outpatient follow-up from the same multi-disciplinary team at MTW; patient outcomes are expected to be better as a direct result

3.7.2 Benefits to orthopaedics

The benefits to the trauma and orthopaedic service are:

- Improved theatre staff recruitment and retention; specialised orthopaedic surgery is an attractive place to work and currently recruitment for theatre staff is easier on the Maidstone site.
- Improved post-operative care for elective patients, with a specialised physiotherapy team on site.
- Improved day case rates.
- Reduced length of stay for hip and knee arthroscopies, as the length of stay in MOU is 1-3 days compared to 3-5 days at TWH. This is partly due to case mix but mainly due to the nursing support, physiotherapy support and the fact that electives are the main focus, rather than at TWH where they have to prioritise emergency flow and trauma patients. With a specialised orthopaedic centre, the aim will be to be within the upper quartile for length of stay following arthroscopic surgery.
- Improved patient experience of the admission process, managed by a dedicated team for elective patients.
- Improved teaching for orthopaedic surgery, with the ability to run parallel lists for the same sub-specialty.
- Improved Covid pathways by moving all elective orthopaedic patients to a super green ward (currently ward 30 at TWH is not super green).
- Improved recruitment for surgical trainees and other clinical roles.
- Reduced infection rates.
- Reduction of patients (backlog) sent to the IS from its current level of 170 in Q1 2021/22, in H1 this was funded non-recurrently from the ERF.

3.7.3 Benefits to the Kent and Medway system

There are also benefits to the system:

- Reduced costs of ad-hoc independent sector referrals to commissioners
- Two theatres would be offered to other providers within the system to allow them to reduce their covid backlog. This would be of benefit as there are significant numbers of patients who have been waiting over 52 weeks for surgery following the pandemic. As an example of need, East Kent Hospitals University Foundation Trust (EKHUFT) has a 52 week+ backlog of over 1,500 orthopaedic patients and a further 220 people have been waiting over a year at Kent & Medway's other two acute trusts. MTW has started discussions with EKHUFT regarding using theatres 3 and 4 to clear their elective orthopaedic backlog; currently two options are being discussed:
  - EKUHFT surgeons operating from the new facility or
  - The patients being transferred to MTW.
- The expansion of theatre capacity will free-up space in existing TWH theatres currently used by orthopaedics. This space will initially be available to other MTW specialities (see above), but would also be offered to other trusts for non-orthopaedic specialties again to help with clearing the backlog.

3.7.4 Benefits to other MTW services

The benefits anticipated to other MTW services are:

- Releasing ward space at Tunbridge Wells (10 beds in Ward 30).
- Released theatre capacity at TWH.

The charts below provide an indication of the extent of possible benefit by presenting ICS providers' RTT and 52-week performance (for all specialties).

Figure 10: ICS providers RTT trajectories

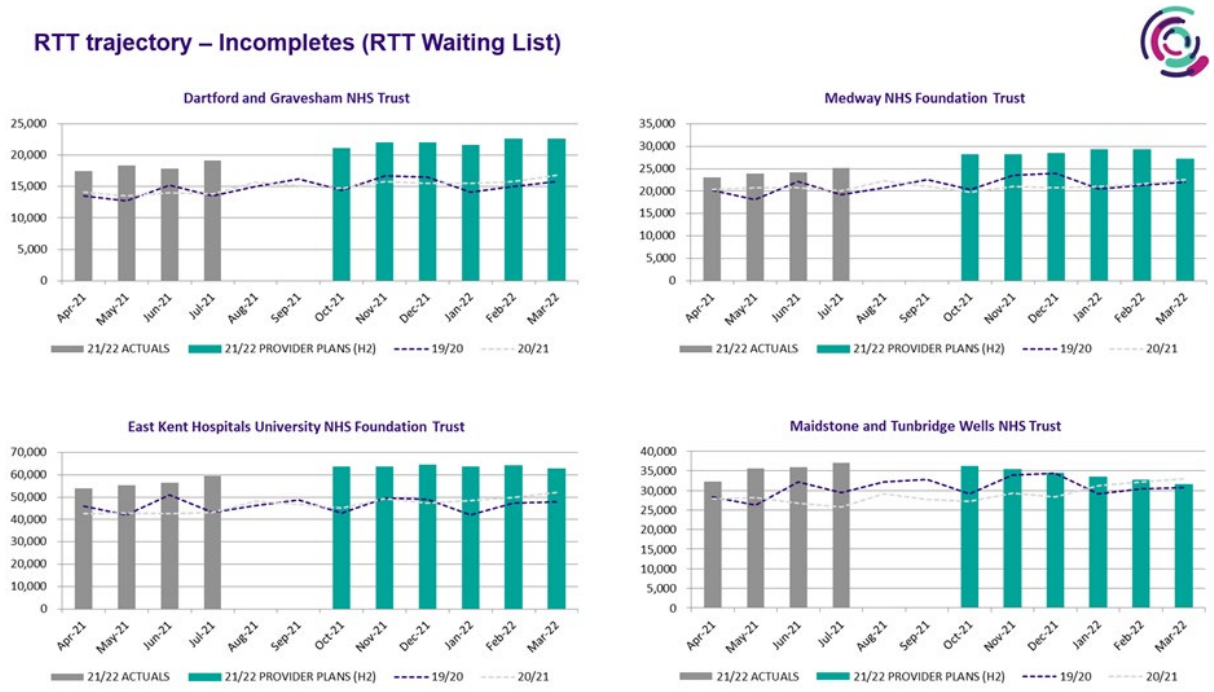
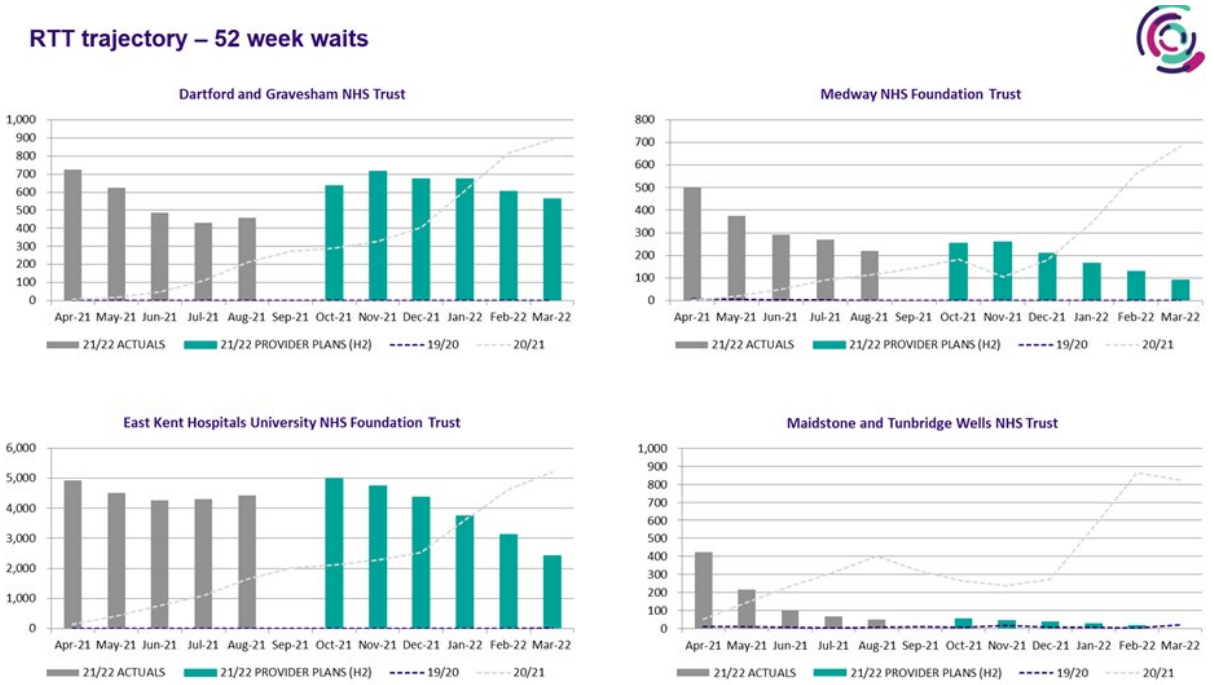
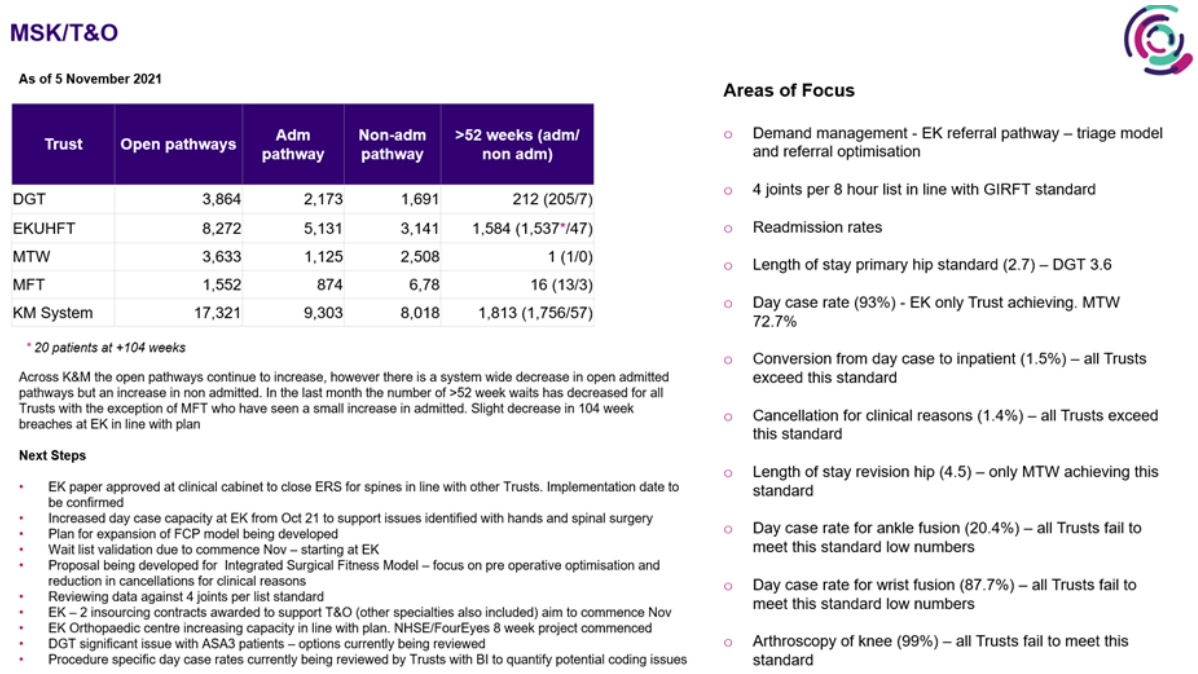


Figure 11: ICS providers 52 week wait trajectories



A summary of the system position for orthopaedics is reproduced below.

Figure 12: System position - orthopaedics



MSK/T&O

As of 5 November 2021

Trust	Open pathways	Adm pathway	Non-adm pathway	>52 weeks (adm/ non adm)
DGT	3,864	2,173	1,691	212 (205/7)
EKUHFT	8,272	5,131	3,141	1,584 (1,537*/47)
MTW	3,633	1,125	2,508	1 (1/0)
MFT	1,552	874	6,78	16 (13/3)
KM System	17,321	9,303	8,018	1,813 (1,756/57)

20 patients at +104 weeks

Across K&M the open pathways continue to increase, however there is a system wide decrease in open admitted pathways but an increase in non admitted. In the last month the number of >52 week waits has decreased for all Trusts with the exception of MFT who have seen a small increase in admitted. Slight decrease in 104 week breaches at EK in line with plan

Next Steps

- EK paper approved at clinical cabinet to close ERS for spines in line with other Trusts. Implementation date to be confirmed
- Increased day case capacity at EK from Oct 21 to support issues identified with hands and spinal surgery
- Plan for expansion of FCP model being developed
- Wait list validation due to commence Nov – starting at EK
- Proposal being developed for Integrated Surgical Fitness Model – focus on pre operative optimisation and reduction in cancellations for clinical reasons
- Reviewing data against 4 joints per list standard
- EK – 2 insourcing contracts awarded to support T&O (other specialties also included) aim to commence Nov
- EK Orthopaedic centre increasing capacity in line with plan. NHSE/FourEyes 8 week project commenced
- DGT significant issue with ASA3 patients – options currently being reviewed
- Procedure specific day case rates currently being reviewed by Trusts with BI to quantify potential coding issues

Areas of Focus

- Demand management - EK referral pathway – triage model and referral optimisation
- 4 joints per 8 hour list in line with GIRFT standard
- Readmission rates
- Length of stay primary hip standard (2.7) – DGT 3.6
- Day case rate (93%) - EK only Trust achieving. MTW 72.7%
- Conversion from day case to inpatient (1.5%) – all Trusts exceed this standard
- Cancellation for clinical reasons (1.4%) – all Trusts exceed this standard
- Length of stay revision hip (4.5) – only MTW achieving this standard
- Day case rate for ankle fusion (20.4%) – all Trusts fail to meet this standard low numbers
- Day case rate for wrist fusion (87.7%) – all Trusts fail to meet this standard low numbers
- Arthroscopy of knee (99%) – all Trusts fail to meet this standard

3.7.5 Financial efficiency savings

Building a barn theatre will allow MTW to stop outsourcing backlog patients which is currently costing over £2.8m per annum. However, this level of outsourcing has only been funded through non-recurrent ERF income. The cost of outsourcing backlog patients is separate to the prime provider contract, where patients are referred to the independent sector from the beginning of their pathway.

Creating a separate elective orthopaedic centre will also reduce the average length of stay which as well as contributing to an improved patient experience, would generate a non-cash releasing benefit to the system.

3.8 Constraints and dependencies

The constraints and dependencies that could impact on the project have been examined.

3.8.1 Constraints

- Site space to develop a four-barn theatre.
- Clinical buy in and commitment to change job plans/base location for consultants, including anaesthetists
- Ability to recruit to theatre and nursing staff

3.8.2 Dependencies

- Capital investment for new building and theatres
- Planning permission.
- Dependent on radiology, therapies and critical care departments to be able to facilitate increased capacity at Maidstone to support this change

3.9 Risks

There are a number of risks of not proceeding with this proposed investment:

- The impact on elective orthopaedic waiting list.
- Potential increase in number of patients outsourced to the independent sector rising from its current level of 170 per quarter
- Impact on theatre space across all surgical specialties
- Inability to implement GIRFT recommendations and provide for future development of the service
- Continued poor cancellation rates at the TW site giving a negative impact on patient experience and wasted theatre space

The risks associated with the business case are summarised below.

Table 21: Summary of key risks

Risk	Mitigation plan
Ability of Estates and engineering to deliver build in the given timeframe e.g. due to planning issues and supply chain disruption	Early engagement with local authority planners Early engagement with potential supply chain partners
Negotiating increase in activity alongside increase in income with commissioners	The business case will only go ahead if Barn is cheaper than outsourcing
Lack of Consultant ownership to move electives to a single site	Consultants have been continuously engaged through the planning process and buy-in has been achieved (it is worth noting all consultants already work at both sites)
Risk of not being able to fully utilise the theatres	Expanding surgeon numbers (three Fellows) who can operate alongside consultants Elective Flow co-ordinator post created Offer capacity to other trusts
Unforeseen increase in capital cost	Ongoing development of detailed plans (currently at RIBA Stage 3) and early engagement with two potential suppliers

4 The Economic Case

4.1 Introduction to the economic case

The economic case appraises the economic costs, benefits and risks for the short-listed options and identifies the preferred option i.e. the option most likely to offer the best overall social value for delivery of the project.

4.2 Shortlist of options

The shortlist of options is:

- Option one – business as usual which is effectively a 'do nothing' option of continuing with current theatre capacity and outsourcing.
- Option two - increased outsourcing to reduce waiting list and improve and then maintain RTT, over 52 week and activity performance.
- Option three – construct a barn theatre block with 4 theatres, 20 inpatient beds and a day case trolley area.
- Option four – as per option three but with a traditional build and theatre layout.

4.3 Appraisal of the options

The options available were appraised to identify the preference.

4.3.1 Option 1 – Business as Usual

The trust would continue to:

- Run theatre lists at the MOU, MSSSU and TWH.
- Run an additional two lists each weekend to tackle the waiting list
- Outsource some activity.

Key activity and financial assumptions

MTW would continue to run the existing number of orthopaedic lists. Based on April to July 2021 indicative activity would continue to be in line with the table below.

Table 22: Option one indicative in-house activity

	April 2021	May 2021	June 2021	July 2021
TWH – scheduled electives	70	59	66	78
Maidstone – scheduled electives	135	149	153	126
TWH – WLIs	0	0	0	0
Maidstone – WLIs	9	21	33	22

	April 2021	May 2021	June 2021	July 2021
TOTAL MONTHLY ACTIVITY	**214**	**229**	**252**	**226**

The capital investment required would be ongoing routine replacement of equipment and the cost of resolving backlog maintenance issues in the MOU.

Non-financial risk associated with the option

Table 23: Option one risks

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Not enough capacity to meet current demand for orthopaedic surgery	5	Use of weekend and evening WLI sessions (however bed capacity and long-term staff resilience a significant barrier)	4	GM
Continuing risk of OND cancellation at the TW site	4	Cancellation reduction action plan Daily management of emergency flow and discharges	3	GM
No space for expansion of surgeon's job plans due to lack of available capacity	5	Review of theatre schedule Exploring all potential space options	4	DDO Surgery / COO
All sites log jammed and no capacity for service developments	5	Continue to outsource activity Limit service developments	4	DDO Surgery
MOU theatre 15 plus years old	4	Assessment and review of longevity of MOU and timescales and impact required	3	Director of Estates
Backlog maintenance on the amber risk register	3		3	Director of Estates
Reliant on independent sector	4	Continued discussions with IS and commissioners to fund IS	3	DDO Surgery

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
theatre capacity and funding				
Independent sector failure to flex capacity to cope with backlog	4	Independent sector currently cannot provide enough capacity to fill gap between demand and capacity	4	GM PCCT
Long-term availability of independent sector due to their desire to revert to treating private patients	4	None – decision is with the independent sector providers	4	GM PCCT

Non-financial benefits associated with the option

Table 24: Option one non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
No disruption	x	x	x	Short term	DDO Surgery

4.3.2 Option 2 – Increase outsourcing to meet current and future demand

MTW would increase outsourcing to meet all current and future demand for elective orthopaedic surgery.

Key activity and financial assumptions

The level of activity forecasted to be outsourced would increase from 680 cases per annum (current backlog activity) to 1,680 cases per annum at an anticipated cost of £6.9m per annum. The number of cases assumed to be outsourced is consistent with the extra capacity to be built within the remaining options and therefore assumes the trust will support the system in increasing orthopaedic capacity. Based on the demand and capacity modelling this would equate to 1,042 cases from 2023/24.

There would be no additional capital investment needed except routine replacement of equipment.

Non-financial risk associated with the option

Table 25: Option two risks

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Lack of future proofing for surgical theatre capacity	5	Estates team review of site to look at other options for additional capacity	4	Director of estates
Lack of sufficient capacity in the independent sector to meet the shortfall in demand	4	Review of other independent sector options	4	GM for PCCT
Does not address GIRFT and key performance metric issues	5	Internal review and performance management processes	4	General Manager for Orthopaedics
Independent sector failure to flex capacity to cope with backlog	4	Independent sector currently cannot provide enough capacity to fill gap between demand and capacity	4	GM PCCT
Long-term availability of independent sector due to their desire to revert to treating private patients	4	None – decision is with the independent sector providers	4	GM PCCT

Non-financial benefits associated with the option

Table 26: Option two non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
No disruption	x	x	x	Short term	DDO Surgery

4.3.3 Option 3 – Create barn theatre with 4 theatres, 20 beds and a day area with 16 trolleys

The Trust would build a four-barn theatre to replace displaced theatre activity from TWH and create super green ring-fenced orthopaedic unit. This will have the capacity for 20 inpatient beds and 16 spaces for day cases.

Key activity and financial assumptions

The medium-term plan for the barn theatre is as below - this business case focusses on Barn 1 and 2.

Table 27: Plan by barn theatre

Barn 1	Barn 2	Barn 3	Barn 4
Transfer from TWH = 1 theatre's worth of elective orthopaedics	Transfer from TWH = 0.12 theatres worth of orthopaedic electives Current outsourced capacity = 0.53 theatre Current shortfall between demand and capacity = 0.35 theatre	*This theatre would be available for K&M ICS use*	*This theatre would be available for K&M ICS use*

In addition to the capital cost of the new building, the following capital costs would be incurred:

- Additional theatre equipment & specialist orthopaedic instrumentation £2,160k
- Anaesthetic room £108k
- Other £464k
- **Total** **£2,732k**

Full details of the additional equipment required can be found in Appendix Two.

The option also requires the following additional staff.

Table 28: Staffing requirement – option three

Staff group	WTE increase
Barn Ward	19.89
Day Care Area	8.00
T&O Medical	1.00
Anaesthetists	2.27
Theatre Staff	7.10
Theatre porter	1.42
Therapies	6.70
Pharmacy	2.00

Staff group	WTE increase
Radiology	5.25
Pathology	0.62
EME and ICT	2.00
Catering	2.00
Domestics and Portering	6.03
T&O Admin (CAU)	1.50
Reception	1.84
TOTAL	**67.62**

Non-financial risk associated with the option

Table 29: Option three risks

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Clinical buy in to change in service	5	Ensure all consultants are bought in by discussing options and concerns at directorate	3	GM and CD
Staff to transfer from TWH to MS, may impact Recruitment & Retention	3	Consultation needed to identify staff who would be willing to move to MS from TWH	2	GM, MM and CD
Significant equipment and instrumentation considerations	4	Review of equipment, dedicated PM support	2	GM and PM
Infected patients cannot be treated in a barn theatre	5	An audit has been undertaken and there's sufficient capacity at TWH (less than 1 patient per week)	2	CD and GM

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
When maintenance needs to be carried out this means the entire barn theatre must be closed down	3	Explore option create two separate air flow streams to allow at least one theatre to stay open	3	Director of Estates

Non-financial benefits associated with the option

Table 30: Option three non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
Cold ringfenced site for elective orthopaedics	10.1%	<2%	On the day cancellations reduced	Immediate	GM and CD
Will create unused theatre at TWH which can be used to facilitate theatre upgrade or additional service		1.12 theatre released	Theatre utilisation reports	Immediate	GM
Ultra-clean air canopy over each station to prevent the spread of infection.			Post-operative infection rate (elective surgery)		
Opportunity to raise awareness of contemporary best practice and standards, to improve supervision and teaching opportunities for non-consultant surgeons, and to increase efficiency			Improvements in efficiency KPIs	Within 3 months	GM and CD
Becoming an orthopaedic centre of excellence as it will be easier to observe			Improvements in efficiency KPIs	Within 3 months	GM and CD

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
interesting cases / do parallel operating lists.					

4.3.4 Option 4 – Create 4 traditional theatres, 20 beds and a day area with 16 trolleys

The Trust would build a four-theatre complex with individual theatres to replace displaced theatre activity from TWH and create super green ring-fenced orthopaedic unit. This will have the capacity for 20 inpatient beds and 16 spaces for day cases.

Key activity and financial assumptions

The medium-term plan for the four new theatres would be as per Option 3.

The additional equipment capital costs would also be the same as Option 3 (the build cost would be higher).

The option also requires the following additional staff.

Table 31: Staffing requirement – option four

Staff group	WTE increase
Barn Ward	19.89
Day Care Area	8.00
T&O Medical	2.00
Anaesthetists	2.27
Theatre Staff	7.1
Theatre porter	2.84
Therapies	6.7
Pharmacy	2.00
Radiology	5.25
Pathology	0.62
EME and ICT	2.00
Catering	2.00
Domestics and Portering	6.03

Staff group	WTE increase
T&O Admin (CAU)	1.5
Reception	1.84
TOTAL	**70.04**

Non-financial risk associated with the option

Table 32: Option four risks

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Clinical buy in to change in service	5	Ensure all consultants are bought in by discussing options and concerns at directorate	3	GM and CD
Staff to transfer from TW to MS, may impact Recruitment & Retention	3	Consultation needed to identify staff who would be willing to move to MS from TWH	2	GM, MM and CD
Significant equipment and instrumentation considerations	4	Review of equipment, dedicated PM support	2	GM and PM
Lack of theatre efficiency savings	4		3	Theatres GM
Would require increased consultant workforce as no parallel lists available	4	Recruitment for T&O consultants has a high success rate / there is high demand	3	CD and GM
Lack of future proofing for the development of the orthopaedic department going forwards	4		4	CD

Non-financial benefits associated with the option

Table 33: Option four non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
Cold ringfenced site for elective orthopaedics	10.1%	<2%	On the day cancellations reduced	Immediate	GM and CD
Will create unused theatre at TWH which can be used to facilitate theatre upgrade or additional service		1.12 theatre released	Theatre utilisation reports	Immediate	GM

4.3.5 Summary of non-monetary benefits and risks of each option

The following table summarises the benefits and risks of each option together with the resulting non-financial ranking of options.

Table 34: Summary of risks and benefits by option

Option	Benefits and risks	Option benefit and risk score and/or rank
Option 1 **BAU/ Do nothing**	Currently NHSE paying for outsourcing of backlog via ERF so no financial impact to Trust, however future finance agreements are not clear on impact Risk of backlog /RTT due to cancelled electives and limited theatre utilisation Lack of theatre capacity for emergency trauma/CEPOD/service changes Continued ad-hoc planning to meet RTT, >52W and activity plans Inability to meet gap between demand and capacity No ability to significantly improve GIRFT metrics whilst operating on hot site with no ring-fenced beds	3
Option 2	MTW have no long-term commitment to IS usage IS not able to meet full capacity gap	4

Increase outsourcing	High transaction costs Patients can be returned to Trust by IS with no notice IS have long waiting lists Patients in the backlog often don't meet the IS patient criteria.	
Option 3 **4 barn theatre plus 20 inpatient beds and day case unit**	Increases theatre capacity for the ICS Creates super green ring-fenced capacity Site development of cutting-edge clinical service to showcase MS site Allows for improvements in GIRFT metrics Creates spare capacity at TWH for other clinical services	1
Option 4 **4 traditional theatres plus 20 inpatient beds and day case unit**	Increases theatre capacity for the ICS Creates super green ring-fenced capacity Creates spare capacity at TWH for other clinical services.	2

4.4 Economic appraisal of costs

> It is clear that one of the reasons for the rising demand for orthopaedic procedures is the significant life-enhancing impact of the procedures. It is the swift return for patients to good or enhanced function and to work and normal family life, which makes orthopaedics such a high demand service. It is this financial benefit to the economy, of re-enabling people, that should also be kept in mind when considering the cost and scale of the provision.

Source: A national review of adult elective orthopaedic services in England, GIRFT, March 2025

The Economic Appraisal has carried out according to HM Treasury's Green Book using the comprehensive investment appraisal (CIA) model which, together with the underpinning economic and financial modelling, can be found at appendices three and four.

4.4.1 Opportunity costs

There are no opportunity costs under any option.

4.4.2 Capital costs

The initial capital investment requirement is shown below by option.

Table 35: Initial capital costs by option

Capital cost	Option 1 BAU	Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Building	£0	£0	£28,067,028	£30,820,363
Medical equipment	£0	£0	£2,731,646	£2,731,646
ICT equipment	£0	£0	£532,203	£532,203
Total	**£0**	**£0**	**£31,330,877**	**£34,084,212**

The BAU and Option 2 do not require an initial capital investment. In due course the trust will need to invest capital in resolving backlog maintenance issues within the MOU but this cost has been ignored for the purpose of this business case.

4.4.3 Revenue costs

The revenue costs included in the CIA are the direct pay and non-pay costs of the orthopaedic service (including outsourcing where applicable) and support services such as pathology, catering and portering (see workforce tables for options 3 and 4 above). Under options 3 and 4 a saving is included relating to the work transferred from TWH to the new facility in Maidstone. The costs of options 1 and 2 are based on the historic average orthopaedic tariff for outsourced activity.

4.4.4 Costed risks

The trust has allowed for contingency and optimism bias in the estimate of capital costs to cover risk in options 3 and 4.

Option 1 includes a cost for outsourcing the difference between historic levels of outsourced work and the actual required level (to manage waiting times and the waiting list) as a risk.

4.4.5 Non-cash releasing benefits

Non-cash releasing benefits have not been monetised at this stage of the business case process. The benefits that are expected which could be classified as non-cash releasing are:

- Improved staff recruitment due to the creation of an orthopaedic centre of excellence – lower recruitment costs
- Reduced staff turnover due to the creation of an orthopaedic centre of excellence – lower recruitment and agency/ bank costs

4.4.6 Societal benefits

Societal benefits have not been monetised at this stage of the business case process. The benefits that are expected which could be classified as societal benefits are summarised in the table below.

Table 36: Wider societal benefits

Benefit to	Benefit
"UK PLC" – the economy	"Gross Value Add" – the economic impact of the construction and wider project Tax revenues Employment
Local people	Employment Improved environment Additional capacity close to areas of most deprivation e.g. shift in capacity from TWH to Maidstone
Patients	Positive health impacts Reduced waiting times Improved continuity of care

4.4.7 Net present value and cost benefit

The table below summarises the financial appraisal at current costs i.e. undiscounted. The modular build barn theatre option (Option 3) has the lowest cost per case (£4,200).

Table 37: Summary of financials

			Based in Year 4 once 95% recruited	
	Business as usual (170 per Qtr)	Outsourcing Option	Traditional Build	Modular Buid
Activity per annum	680	1,680	1,680	1,680
Activity of 60 years	40,800	100,782	100,782	100,782
Cost over 60 Years £000	167,977	414,928	423,213	407,500
Average Cost per annum £000	2,800	6,915	7,054	6,792
Average cost per case £000	4.12	4.12	4.20	4.04

Option 3 (barn theatre) has the lowest annual revenue cost and therefore, lowest cost per case. The traditional build (Option 4) has a capital cost which is £2.75m (including VAT) more than the Option 3. The ongoing revenue cost is also more expensive as staffing efficiencies of c£160k per annum won't be delivered.

Bringing capital and revenue costs together and discounting values, gives the following net present societal values (NPSV) for the whole life of the project.

Table 38: Summary of NPSV by option

Net present social value - total	Option 1 BAU	Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital	£0	£0	£25,226,149	£27,443,005
Revenue	£77,956,419	£182,397,105	£143,936,246	£148,190,934
Costed risks	£104,440,686			
Net present societal value	£182,397,105	£182,397,105	£169,162,395	£175,633,940

Incremental NSPV is then calculated compared to the BAU to derive the cost benefit ratio.

Table 39: Incremental NPSV and cost benefit ratio

Net present social value - incremental from BAU	Option 1 BAU	Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital		£0	£25,226,149	£27,443,005
Revenue		£104,440,685	£65,979,826	£70,234,515
Costed risks		-£104,440,686	-£104,440,686	-£104,440,686
Net present societal value	£0	-£0	-£13,234,710	-£6,763,166
Cost benefit ratio	0.00	1.00	1.15	1.07

A cost to benefit ratio of above 1.0 means an option represents better value than the BAU (doing nothing in this instance). Option 3 (barn theatres) is best value with a cost benefit ratio of 1: 1.15 and a net societal benefit (excluding to date, unmonetised non-cash releasing and societal benefits) of £13,234k over the life of the facility.

4.5 Identification of the preferred option

The preferred option is the Barn theatre build consisting of four open theatres separated by laminar flow canopy with 20 inpatient beds and 16 trolleys for day surgery. The new building will be at the back of the Maidstone Hospital site and would be a ring-fenced Covid secure facility. Following theatres being commissioned, two elective operating theatres (1.12 transferred from TWH and the balance from repatriated independent sector work) would be immediately opened and used by orthopaedics with 12 inpatient and 8-day case beds functioning and will open in September 2022. The other two theatres will be available for the Kent and Medway ICS and will be fully equipped to use for orthopaedic surgery

The table below illustrates how the theatres will be utilised (MTW shaded).

Table 40: Utilisation of barn theatres 1 to 4

Barn 1	Barn 2	Barn 3	Barn 4
Transfer from TWH = 1 theatre's worth of elective orthopaedics	Transfer from TWH = 0.12 theatres worth of orthopaedic electives Current outsourced capacity = 0.53 theatre Current shortfall between demand and capacity = 0.35 theatre	*This theatre would be available for K&M ICS use*	*This theatre would be available for K&M ICS use*

The theatre time released at TWH (1.12 theatres) will be available to increase capacity in trauma, gynaecology (including c-section lists), ENT and emergency general surgery.

The first two barn theatres will provide capacity equal to 1,680 cases. This additional capacity will not be fully utilised meeting new demand for the first few years post-opening, so will be available for the wider system to use to clear waiting lists.

Table 41: Demand and capacity – barn theatres one and two

	Total annual demand				Capacity				
	New demand	Backlog	IS choice	Total	Existing MTW	IS	Barn (2 theatres)	Total	Shortfall
2021/22	2,914	630	1,060	4,605	2,539	1,060	0	3,599	-1,005
2022/23	3,043	400	1,107	4,550	2,539	1,107	840	4,486	-64
2023/24	3,177	0	1,156	4,332	2,539	1,156	1,680	5,375	1,042
2024/25	3,316	0	1,207	4,523	2,539	1,207	1,680	5,426	903
2025/26	3,462	0	1,260	4,722	2,539	1,260	1,680	5,479	757
2026/27	3,615	0	1,315	4,930	2,539	1,315	1,680	5,534	604

In 2023/24 MTW will be able to make available theatre lists sufficient to operate on 1,042 patients from the wider Kent and Medway ICS reducing to 604 case in 2026/27.

The preferred option also builds and equips (but does not staff) two more Barn theatres which would be offered to the Kent and Medway system for orthopaedic activity.

This proposal improves efficiency targets and will assist in infection control rate improvement and puts MTW at the forefront of orthopaedic theatre innovation in Kent.

The key delivery risk is recruiting the addition staff needed. This and other risks, will be mitigated with clinical input to the project development and the development of a workforce plan. Whilst some staff can migrate over from TWH, there will be an increase in staffing requirement, particularly

in terms of theatre, nursing, radiology and physiotherapy staff as many of the staff do not solely provide services just to orthopaedic elective theatres.

5 The Commercial Case

5.1 Introduction to the commercial case

The commercial case sets out procurement and contractual issues associated with the preferred option.

5.2 Description of the preferred option

The preferred option is to build a 4-barn theatre and ward complex. This will be located on the current grassed area at the rear of Maidstone Hospital between MOU and the Breast Screening car park. The site has direct road access and the build can be achieved without impact on the acute hospital areas.

The build will contain:

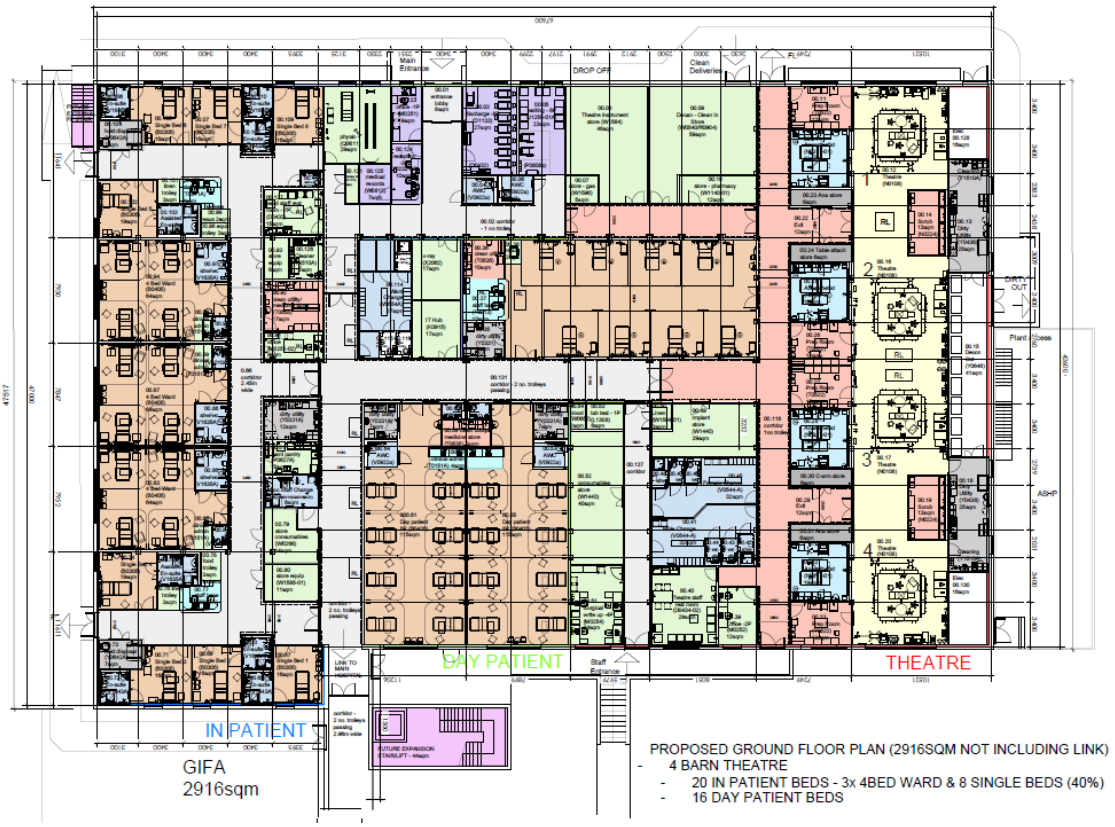
- 4 station barn theatre
- 4 x Anaesthetic rooms
- Admissions/ waiting area for day cases
- Recovery suite
- IT hardware (computers, printers, telephones) and software (unlikely to exceed current licencing arrangements)
- Ward area with 20 beds and 16-day case areas configured to provide suitable accommodation for day case, short stay and complex patients with a mix of bays and side rooms
- Physiotherapy room
- X-ray room
- Substantial storage facilities
- Large plant room to contain air handling unit for barn theatre area.

The capital equipment required is listed in Appendix Two.

The IT equipment required is listed in Appendix Five.

The project has been developed to architectural design RIBA stage 3. This advanced design has allowed the trust's Procurement Directorate working in conjunction with estates to obtain pre-commencement time lead on the overall project of ten weeks. In addition to this the early design works on the architectural building has allowed potential bidding modular build contractors to establish the suitability of their frames under modern methods of construction (MMC) to minimise the construction period and meet the design requirements of MTW. The latest plans are shown below.

Figure 13: Plan of the facility



The flow and design of the facility is based on best practice and existing barn theatre complexes such as those at Chase Farm and Poole hospitals. The summary schedule of accommodation is shown below (further details are provided in Appendix Six).

Table 42: Schedule of accommodation

Barn Theatre_Maidstone Hospital: Schedule of Accommodation - Summary					
Department	Functional Unit	Functional Content	NDA (m2)	Departmental Uplift	GDA (m2)
Theatres	Theatres	4	1,095.0	42%	1,555
Day Surgery Unit	Beds	16	374.8	42%	532
Ward 1 (24 beds)	Beds	20	512.0	42%	727
Ward Support			130.5	35%	176
Total			2,112.3	42%	2,990
Circulation/Internal partitions (30%)			804.0		870
Allowance for plant	TBC by design team				
Total GIA (m2)			2,916		3,860

5.3 The scope of works to be procured

The scope of works to be procured to deliver the preferred option is summarised below together with the procurement route.

Table 43: Works and services required

Task	Supplier	Procurement Route
Enabling works	TBA	Tender by SS via LPP/CCS
Architect design	HMY	Direct award SS to put on NEC3
Modular build	Darwin, Premier, ModuleCo	Direct award by BM under SBS
M&E	BSP or Horley	Frameworks (TBD)
C&S	CTP	Frameworks (TBD)
Planning	DHA Planning	Direct award
Specialist air-flow fit-out	MAT or Howarth	Direct award under framework
Medical equipment	Various	
F&F	Various	
IT	Various	
QS		Tender by SS via LPP/CCS
Project Manager		Tender by SS via LPP/CCS
Landscaping	Allen Scott Landscape	
BREEAM	XDA	
Fire Engineering	Innovation Fire Engineering	
Accoustics	Adrian James Accounstics	
High Voltage Power Supply		Tender by SS via LPP/CCS
Legals	BLP, Glovers, Beechcroft	Direct award under framework

5.4 Land and infrastructure issues

There will be no acquisition of land or any land disposals. The facility will be located to the rear of Maidstone Hospital in the centre of the site.

Figure 14: Location on the Maidstone Hospital site

The full survey of the intended construction site ground works has now been completed along with topographical study and geotechnical study that is included testing for contaminated land on the build site. This pre-commencement programme of works, which would normally be run in parallel with the architectural programme, has save a concurrent period of six weeks with the architectural design, that would have followed under normal circumstances on the commencement of the project approval.

The Maidstone hospital site utilises an 11KV (Kilo volt) ring main electrical power supply to the hospital. A detailed analysis of energy consumption for the proposed Barn theatre design (which has been clinically signed off by stakeholders and infection control) has been undertaken. This programme of engineering studies has been undertaken in conjunction with extending the high voltage ring main on the Maidstone Hospital site. The extended ring main will be provided with two 1.5 MVA (mega volt amperes) transformers that will serve the facility. Subject to the approval of the business case, the modification and extension to the ring main will then proceed immediately, so saving approximately six weeks on the building programme.

A study is being carried out on interconnection to the existing foul water and surface water sewage capacity and interconnection of the Barn theatre drainage systems into the existing Maidstone Hospital sewer network. This study will enable six weeks to be reduced on the overall construction programme, had it not been included in the pre-construction programme initiative to minimise the construction period of the proposed barn theatre at Maidstone Hospital.

5.5 Risk transfer

Each risk has been allocated to the party best able to manage it. This is indicated in the table below and will be reviewed in detail at FBC stage.

Table 44: Risk Transfer

Risk Category	Potential allocation		
	Trust	Construction partner	Shared
Design risk			✓
Construction and development risk		✓	
Transition and implementation risk			✓
Availability and performance risk			✓
Operating risk	✓		
Variability of revenue risks	✓		
Control risks	✓		
Residual value risks	✓		

Risk Category	Potential allocation		
	Trust	Construction partner	Shared
Financing risks	✓		
Legislative risks			✓
Other project risks			✓

5.6 Contractual issues

Expressions of interest and capability statements have been issued by the Trust Procurement Directorate working in conjunction with the Estates and Facilities Directorate to obtain capability statements and financial bids from eight NHS Shared Business Services modular building framework registered contractors. Of the eight approached, six companies submitted expressions of interest (EOI) and capability statements to the trust. On review, four expressions of interest and capability statements were found to be compliant with the trust's offer. The EOI and capability statements were also analysed by the trust's external chartered quantity surveyors working on the scheme, Betteridge and Milsom who concurred with the trust's assessment of compliance.

The trust has now entered into non-binding dialogue with three of the respective bidders to narrow the process to one preferred bidder subject to the business case being approved. The development of the project is at RIBA Stage 3 which means the framework modular construction companies can provide accurate information in respect of construction periods and likely outturn cost.

Government policy means that the construction contract used will be a NEC contract as used across the public sector. The Trust shall be utilising an NEC4: Engineering and Construction Contract Option A Price Contract with activity schedule. The contract shall be subject to drafting of "Z" clauses by construction solicitors acting on behalf of the Trust. The construction contract will be subject to negotiation with the main contractor for the provision of a lump sum and guaranteed not to exceed price.

5.7 Planning

The relevant planning authority is Maidstone Borough Council. The trust has engaged with the Head of Planning at the council and the two ward councillors representing the electoral ward within which the hospital is situated. The two councillors have been exceptionally supportive of the project and have concurred that subject to the permitted development arrangements of the Covid 19 pandemic being extended beyond 31st December 2021, the project could proceed as a permitted development with a full planning consent being submitted in parallel once the construction programme commence (the Covid 19 Planning Emergency arrangements remain in force until 1st January 2022. Planning stipulations of the Emergency Covid 19 Planning Act allow NHS organisations to proceed with buildings that have an impact or assist with NHS patient care during the duration of the pandemic).

The planning application and associated environmental, biodiversity, geotechnical, arboricultural ground water and foul water drainage studies have now been completed. An archaeological

consultant has been appointed and the archaeological requirements of the planning consent are now being assessed. Flood plain studies are proceeding for the area. This advanced work will save between six- and eight-weeks' time on the overall programme of the Barn theatre development.

The proposed site for the construction of the Barn theatre is in the centre of the site and is not overlooked by any neighbour. The building is low level with a height of 8.3m in the clinical areas and 18.3m for the plant room. These heights do not project above the building line of the existing hospital infrastructure. The proposed location of the building does not conflict with the helicopter landing pad flight path which is in the opposite direction to the location of the proposed facility.

5.8 Compliance with NHS/ government standards and guidance

An external specialist in compliance with health technical memoranda (HTM) and health building notices (HBN) was appointed who recommended some changes to the design to ensure HTM and HBN compliance. These changes also informed changes to ventilation, lighting and piped medical gas and vacuum requirements. The amended architectural drawings have been subject to review and signed off by infection control and the other major stakeholders in the development.

5.9 Modern Methods of Construction

The Barn theatre would be a modular building with the major percentage of internal fittings and design manufactured in factory and brought to site. MMC requirements specify that 65% of the building should be constructed off site to reduce construction time, promote sustainable development and reduce costs. The offsite construction of the modular building allows for the construction techniques to be undertaken in the factory under mass production and assembly techniques - this process has been described as a way "to produce more better-quality buildings in less time".

The Barn theatre would be constructed on a three-dimension volumetric construction involving the production of the three-dimension units in controlled factory conditions prior to the transport to site. The advantage are:

- Creating panellised units for the Barn theatre in factories, which can be quickly assembled creating 3D structures.
- The pre-cast concrete foundations of the building are pre-formed with fitted electrical wiring looms.
- The prefabricated floor and roof cassettes are fitted in place as panel.

Following the aftermath of the Grenfell tragedy the fire rating of the modular building would be A2 standard for walls and internal structure and a B rating for the roof (at present there is no A2 rating for modular building roofs.

5.10 Net Zero and sustainability

The NHS is committed to a net zero carbon emissions target to become carbon neutral by 2045. Recognising this, the design of the proposed Barn theatre is centred on achieving a BREEAM 'Excellent' rating and the building would be constructed to current building regulation thermal emission limits.

The lessons learnt out of the Covid pandemic with respect to ventilation in clinical areas would be applied in the design to meet lowest energy use and the high level of infection control required with HTM 03-01 Specialised Ventilation for Health Care Buildings and the HSE guidance of ventilation and air conditioning during the Coronavirus pandemic.

In respect of moving to carbon reduction and carbon net zero the Barn theatre would be all electric for heating and cooling (steam heating has been rejected) and the heating of the ventilation and theatre canopy laminar flow systems would utilise air source heat pumps.

The building would be fitted with photo voltaic solar panels to maximise electrical power generation from the sun in the building.

The design philosophy of the building would also utilise a building management system that would optimise energy demand by sophisticated control of thermal ventilation systems and lighting. In addition to this, controls would be utilised on hydraulic lift electric motors which would close down when not in use.

Other innovative net zero energy options would be explored to reduce the carbon footprint of the building in line with NHS policy.

5.11 Workforce

As noted in the economic case the preferred option requires additional clinical and support staff to be recruited. The trust is developing a staff recruitment plan to ensure that the planned opening of the new unit is not delayed by a lack of staff.

The easiest staff group to recruit to will be the surgeons, with high demand and competition for new fellowships and consultant posts. A time period of six months is required to complete the full recruitment process for a new, permanent consultant. For the anaesthetic consultant posts, there is a stream of senior trainees who are likely to have passed their consultant exam in the next six months.

Administrative posts will also be one of the most secure to fill, and could be filled within two months. Whilst nursing vacancies across the trust are high, orthopaedics are currently overrecruited in the nursing establishment so filling these roles is achievable, however dedicated recruitment support will be required to ensure the high volume of administration is complete within a suitable timeframe.

Theatre staffing are notoriously difficult to recruit to, especially following the Covid pandemic, however, to mitigate this, the service will run a dedicated recruitment campaign to recruit a new, specialised team and expand the current oversees recruitment. These posts will be attractive due to the specialist focus on orthopaedics and new barn style design that is unique in the South East. Some of the posts will be internal staff, but there's also potential to draw people in from private hospitals.

The most difficult group to recruit are likely to be radiology staff as there's a national shortage of trained radiographers.

The financial case modelled includes an assumption for the use of temporary staffing driven by the following recruitment assumptions.

Table 45: Recruitment assumption

	Year 1	Year 2	Year 3	Year 4 +
% of staff substantively recruited	70%	85%	90%	95%
Temporary staffing	30%	15%	10%	5%
Temporary staffing premium	100%	100%	100%	100%

5.12 Impact on other site users

The new facility will be a standalone Covid secure Green facility. The standalone nature of the building will minimise the risk of disruption to other site users during the enabling works and construction phase.

5.13 Accountancy treatment

The assets and liabilities associated with this investment will be on the trust's balance sheet.

6 The Financial Case

6.1 Introduction to the financial case

The financial case considers the affordability of the project to the trust.

The financial appraisal has been undertaken in line with HM Treasury Guidance set out in the 2020 update of the Green Book and the NHSI publication*, Capital regime, investment and property business case approval guidance for NHS providers*[9]. The financial case differs from the economic case in several important aspects:

- It only considers the preferred option unlike the economic appraisal which considered all short-listed options.
- The focus of the financial case is affordability as measured by the impact on the Trust's statement of comprehensive income (SOCI), balance sheet and cashflow, as opposed to net present values.
- Depreciation and interest on public dividend capital (PDC) are included.
- VAT is included.
- Non-cash releasing and, monetised risks and societal benefits are excluded.

6.2 Financial appraisal methodology

The following assumptions and factors underpin the financial appraisal:

- The appraisal is only based on staffing two theatres; however, the capital assumption is that the four theatres would be fully equipped i.e. the two phase two theatres are equipped, but are not staffed in the financial model.
- The appraisal has been undertaken only on costs that vary because of the scheme to clearly show the overall impact of the preferred option on the trust's overall financial position.
- Capital costs have been worked up by the Trust's cost advisers (see OB forms in Appendix Seven) and include an allowance optimism bias.
- The following asset lives have been used to calculate depreciation and assess when lifecycle capital costs are incurred; new build 60 years; equipment seven years, IT five years apart from laptops and IPADs which have been based on three years.
- Interest has been charged at 3.5% on the assumption that the investment utilises PDC.

For cash flow purposes it is assumed:

- That capital costs fall as per the OB forms.
- Expenditure falls in the financial year to which it pertains.

[9] Capital regime, investment and property business case approval guidance for NHS providers, NHS Improvement, November 2016.

6.3 Capital investment and source of funding

Capital costs have been worked up by the trust's cost advisers B&M working with the trusts project team. The initial capital investment required is shown below.

Table 46: Initial capital costs

Asset Group	Total £
Building	28,067,028
Equipment	2,731,646
ICT	532,203
Total	**31,330,877**

The cost estimate is based on a 2,916m^2 modular build. Allowances have been made for external works, preliminaries, risks (contingency), 4.5% optimism bias and 15% fees. The risk allowances are based on:

- Design Development risks – an allowance for use during the design process to provide for the risks associated with design development, changes in estimating data, third party risks (e.g. planning requirements, legal agreements, covenants, environmental issues and pressure groups), statutory requirements, procurement methodology and delays in tendering.
- Construction risks – an allowance for use during the construction process to provide for the risks associated with site conditions (e.g. access restrictions/limitations, existing buildings, boundaries, and existing occupants and users), ground conditions, existing services and delays by statutory undertakers.

6.4 Activity impact

The two theatres will provide capacity sufficient for 1,680 cases per annum as built-up below.

Table 47: Barn theatre capacity – Two theatres open

	No Theatres required	Ave cases per session	No Sessions in 1 theatre (Mon to Fri)	Increase in cases per week	No Weeks per month	Extra Activity per month	Extra Activity per annum	No Weeks operational	Total
Transfer existing activity sent to ISP	0.54	2.6	10	14.04	4.34	60.9	731	48	675
Increase in sessions (maximise 2 theatres in barn)	0.33	2.6	10	8.58	4.34	37.2	447	48	412
Productivity gain on existing sessions	1.12	1.1	10	12.32	4.34	53.5	642	48	592
Total	**1.99**					**152**	**1,820**		1,680

The scheme enables 0.54 theatres worth of activity to be repatriated from the independent sector; 0.33 theatres worth of additional activity from maximising the use of the theatres and 1.12 theatres worth of productivity gain.

The other two theatres would increase the capacity available to the system by a further 2500 cases per annum.

Table 48: Barn theatre capacity – Further two theatres open

	No Theatres required	Ave cases per session	No Sessions in 1 theatre (Mon to Fri)	Increase in cases per week	No Weeks per month	Extra Activity pr month	Extra Activity per annum	No Weeks operational	Total
Utilise empty theatres	2	2.6	10	52	4.34	225.7	2,708	48	2,500
Total	**2**					**226**	**2,708**		2,500

6.5 Impact on the trust's statement of comprehensive income

The impact of the scheme on the trust's statement of comprehensive income (SOCI) position is set out in the table below.

Table 49: Revenue impact

	Annual revenue costs											
	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25	Year 4 2025-26	Year 5 2026-27	Year 6 2027-28	Year 7 2028-29	Year 8 2029-30	Year 9 2030-31	Year 10 2031-32	Year 11+ to Year 60 2038+	Total Costs
Pay	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Barn Ward	840	1,440	1,440	1,440	1,440	1,440	1,440	1,440	1,440	1,440	71,985	85,783
Day Care Area	212	363	363	363	363	363	363	363	363	363	18,134	21,610
T&O Medical	73	125	125	125	125	125	125	125	125	125	6,250	7,448
Anaesthetists	166	284	284	284	284	284	284	284	284	284	14,187	16,906
Theatre Staff	162	277	277	277	277	277	277	277	277	277	13,846	16,500
Theatre Porter	21	36	36	36	36	36	36	36	36	36	1,778	2,118
Therapies	189	325	325	325	325	325	325	325	325	325	16,229	19,340
Pharmacy	37	64	64	64	64	64	64	64	64	64	3,176	3,784
Radiology	124	212	212	212	212	212	212	212	212	212	10,608	12,642
Pathology	10	17	17	17	17	17	17	17	17	17	828	986
EME / IT	68	117	117	117	117	117	117	117	117	117	5,850	6,971
Catering	31	53	53	53	53	53	53	53	53	53	2,627	3,130
Domestics and Portering	151	259	259	259	259	259	259	259	259	259	12,974	15,461
T&O Admin (CAU)	27	46	46	46	46	46	46	46	46	46	2,301	2,741
Reception	28	47	47	47	47	47	47	47	47	47	2,362	2,815
Temporary Staffing Premium	641	549	366	183	183	183	183	183	183	183	9,157	11,995
											0	0
Total Pay	**2,778**	**4,212**	**4,029**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**3,846**	**192,290**	**230,229**
Barn Ward	72	144	144	144	144	144	144	144	144	144	7,199	8,566
Day Care Area	18	36	36	36	36	36	36	36	36	36	1,813	2,158
Theatre Consumables	571	1,142	1,142	1,142	1,142	1,142	1,142	1,142	1,142	1,142	57,110	67,961
Diagnostic Non Pay	30	60	60	60	60	60	60	60	60	60	3,000	3,570
Utilities	71	142	142	142	142	142	142	142	142	142	7,100	8,449
Catering	15	29	29	29	29	29	29	29	29	29	1,470	1,749
Domestics	5	10	10	10	10	10	10	10	10	10	500	595
Decontamination	25	50	50	50	50	50	50	50	50	50	2,500	2,975
Waste disposal	10	20	20	20	20	20	20	20	20	20	1,000	1,190
Laundry	25	50	50	50	50	50	50	50	50	50	2,500	2,975
Maintenace Costs	131	261	261	261	261	261	261	261	261	261	13,054	15,534
Legal fees	72	0	0	0	0	0	0	0	0	0	0	72
Non Recurrent Setup costs	495	0	0	0	0	0	0	0	0	0	0	495
Non Recurrent Setup costs - E&F	28	0	0	0	0	0	0	0	0	0	0	28
Consultant Relocation fee	26	0	0	0	0	0	0	0	0	0	0	26
Total Non Pay	**1,594**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**1,945**	**97,245**	**116,343**
											0	0
Depreciation and PDC	1,024	2,031	1,997	1,964	1,930	1,905	1,881	1,895	1,909	1,876	72,153	90,565
											0	0
Total Cost	**5,395**	**8,188**	**7,971**	**7,754**	**7,721**	**7,696**	**7,671**	**7,686**	**7,700**	**7,666**	**361,688**	**437,137**
											0	0
Less											0	0
reduction of 10 beds at TWH	-249	-498	-498	-498	-498	-498	-498	-498	-498	-498	-24,905	-29,637
Total Cost Reductions	**-249**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-498**	**-24,905**	**-29,637**
											0	0
Total Investment	**5,146**	**7,690**	**7,473**	**7,256**	**7,223**	**7,198**	**7,173**	**7,188**	**7,202**	**7,168**	**336,783**	**407,500**
Income - 50% Depreciation and PDC cross charge to system for 2 Theatres and 50% of Ward / day area	-512	-1,015	-999	-982	-965	-953	-940	-948	-955	-938	-36,076	-45,282
Income - Assume system will bund at cost	-4,634	-6,674	-6,474	-6,274	-6,258	-6,245	-6,233	-6,240	-6,247	-6,230	-300,707	-362,217
Total Income	**-5,146**	**-7,690**	**-7,473**	**-7,256**	**-7,223**	**-7,198**	**-7,173**	**-7,188**	**-7,202**	**-7,168**	**-336,783**	**-407,500**
Grand Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The key factors driving the revenue impact are:

- When the unit is staffed to 95% with substantive staff (estimated from year four) the ongoing revenue cost is estimated to be c£7.3m. This cost is to staff two theatres and 50% of the available ward and day case capacity. This increase is the net increase as this assumes the staff / budget for the theatre sessions closed at TWH (1.12 theatres) will transfer to the Barn theatre.
- Staffing costs have been assumed will be incurred from September 2022 and non-pay from October 2022 which the unit becomes operational.
- The depreciation and PDC cost is based on building and equipping four Theatres and the full ward and day case capacity. As a result, there is an assumption that 50% of this cost would be charged and funded by commissioners to support system activity increase.
- The income included within the case is based on funding 'at cost' rather than funding at a tariff-based option - this assumption needs to be confirmed by commissioners.
- Temporary staffing premium costs have been included within the case based on the following assumptions

Table 50: Temporary staffing assumptions

	Year 1	Year 2	Year 3	Year 4 +
% of staff Substantively recruited	70%	85%	90%	95%
Temporary Staffing	30%	15%	10%	5%
Temporary Staffing Premium	100%	100%	100%	100%
Temporary Staffing Premium £000	641	549	366	183

- Theatre consumable costs have been based on the average cost per orthopaedic case, this therefore assumes the backlog and future demand growth is in line with current internal activity seen.
- Non-recurrent setup costs of £0.5m has been included in 2022/23 to fund for one off revenue setup costs which can't be capitalised.

The detail of the staffing numbers is shown below.

Table 51: Staffing detail

	WTE											
Pay	Consultants	Other Medical	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	**Total WTE**
Barn Ward			7.28	1.00	0.00	6.61	3.00	1.00	1.00	0.00	0.00	**19.89**
Day Care Area			2.00	0.00	0.00	5.00	1.00	0.00	0.00	0.00	0.00	**8.00**
T&O Medical	1.00											**1.00**
Anaesthetists	2.27											**2.27**
Theatre Staff			0.00	1.42	1.42	2.13	2.13	0.00	0.00	0.00	0.00	**7.10**
Theatre Porter			1.42									**1.42**
Therapies					1.08	2.00	1.62		2.00			**6.70**
Pharmacy			1.00			1.00		0.00				**2.00**
Radiology				2.00			3.25					**5.25**
Pathology				0.62								**0.62**
EME / IT						1.00	1.00					**2.00**
Catering			1.00	1.00								**2.00**
Domestics and Portering			6.03									**6.03**
T&O Admin (CAU)				0.00	1.50							**1.50**
Reception			1.84									**1.84**
Temporary Staffing Premium												
Total Pay	**3.27**	**0.00**	**20.56**	**6.04**	**4.00**	**17.74**	**12.00**	**1.00**	**3.00**	**0.00**	**0.00**	**67.62**

6.6 Impact on cash flow

The most significant cashflow linked to the investment will be the £31.3m capital spend in quarter four 2021/22 and the first half of 2022/23. Cashflows thereafter relate to operating expenses.

The trust is applying for central capital funding for this scheme which would be provided as PDC.

6.7 Impact on the statement of financial position

The investment will create new assets on the trust's balance sheet. The calculation of depreciation in the financial model does not assume an impairment in net book value on opening; if this were to occur there would be a one-off impairment charge to the SOCI followed by lower capital charges.

6.8 Affordability conclusion

The preferred option represents:

- A cheaper option for the Kent and Medway ICS than the ongoing outsourcing of elective orthopaedic activity to the independent sector.
- An affordable option to MTW assuming commissioners fund the trust at the cost of delivery.

7 The Management Case

7.1 Introduction to the management case

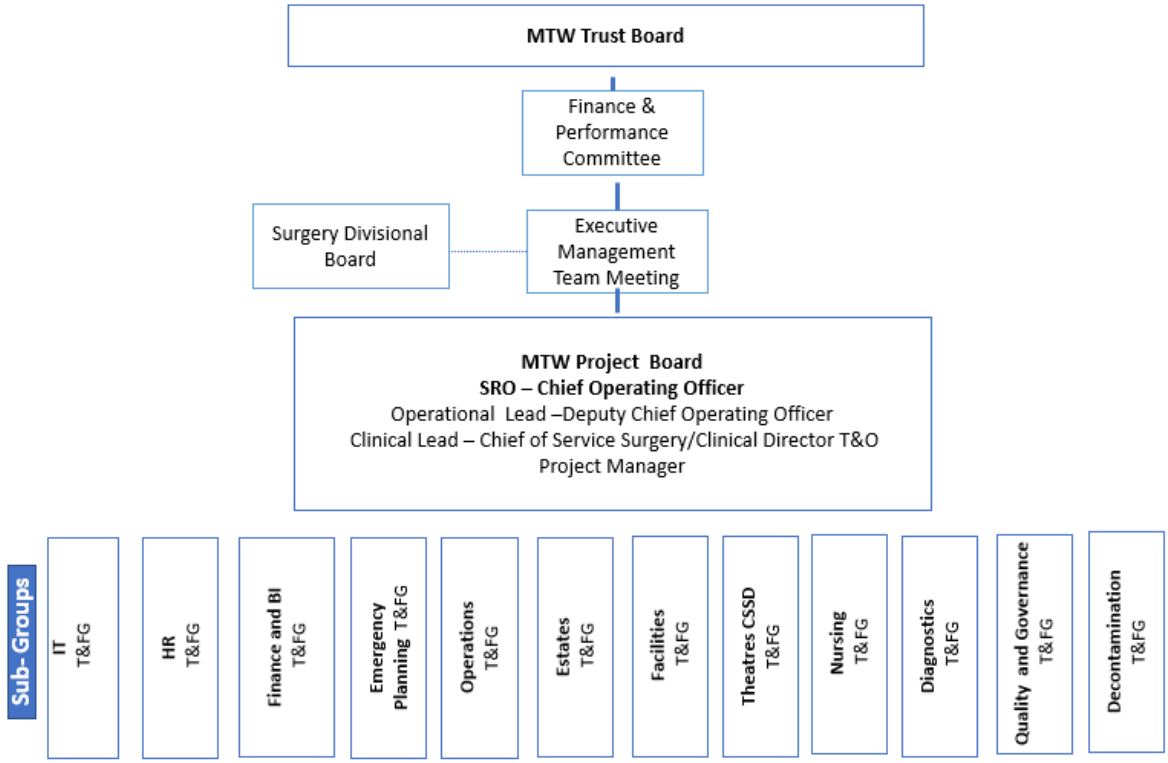
This section of the business case describes how the project will be managed.

7.2 Programme and project governance arrangements

7.2.1 Project structure

The governance structure for the project is shown below.

Figure 15: Barn Theatre project governance structure



The role and responsibilities of the various groups are as follows:

- MTW Project Board - to evaluate, direct and where applicable, agree recommendations from the project groups regarding:
  - Operational model / design solution
  - HR process & staffing
  - Communication & stakeholder engagement
  - Legal & Risk management
  - Financial control
- Task & Finish Groups – deliverables:
  - Service model & pathways
  - Theatre design
  - Operational policies
  - HR and staff Recruitment plan– clinical, nursing, therapy, pharmacy soft FM,

  - Fully Equipped unit
  - Operational risk management
  - Associated other unit and ward specialty relocation
- Estates Task & Finish Group – deliverables:
  - Design and build
  - IT solutions
  - Fixed equipment.

There are agreed terms of reference for a project working group which are separately documented. The project will be managed in accordance with good practice principles and processes, such as application of the PRINCE 2 methodology. Approvals for the project and the required investment lie with the MTW Trust Board.

7.2.2 Roles and responsibilities

The senior responsible owner (SRO) for the scheme is Sean Briggs, the trust's Chief Operating Officer.

The operational lead for the scheme is the Deputy Chief Operating Officer. This role will oversee the implementation and delivery of the project both from an operational and governance perspective and will be responsible for reporting weekly to the Trust Executive Team.

The clinical leads for the scheme are the Chief of Service for Surgery and the Clinical Director for Trauma and Orthopaedics. These roles will ensure that the clinical pathways are agreed, signed off and undertake a quality impact assessment.

There will be a dedicated project manager assigned to the project who will be supported by a project manager officer who will oversee the project on a daily basis and who will provide weekly progress reports and will highlight risks/concerns regarding delivery of the project.

The task and finish groups will consist of speciality leads and will lead the delivery of their areas.

The project team membership is below.

Table 52: Project team

Name	Role
Sarah Davis	Deputy Chief Operating Officer (Chair)
Greg Lawton	Chief of Service, Surgery (Deputy Chair)
Sharon Page	Divisional Director of Nursing and Quality
Doug Ward	Director of EFM
Bilal Wahid	Director of Improvement and Delivery
Anita Friday	IT Project Manager
Darren Palmer	Director of Operations, Diagnostics
Julie Elphick	Lead for Emergency Planning
Hannah Ferris	Deputy Director of Finance

Name	Role
Richard Sykes	Head of Financial Management
Lindsey Reynolds	Lead Matron Critical Care
Darren Bulley	Associate Director of Facilities
Tracey Jardine	Head of Performance and Business Intelligence
Joana DaSilva	Deputy General Manager Theatres & Critical Care
Dan Gaughan	General Manager of Theatres and Critical Care
James Nicholl	Clinical Director T&O and Consultant Surgeon
Jamie Young	Consultant Surgeon T&O
Alice Farrell	General Manager T&O
Tina Cooper	T&O Matron
Michelle Lowings	General Manager Decontamination & Laundry Services
Lucy O'Neill	HR Business Partner, Surgery

7.3 Project plan

The key milestones associated with implementation are set out below.

Table 53: Project milestones

Milestone	Date
Planning permission process started	Complete
Architectural design drawn up with clinical input	Complete
Procurement work to secure large capital items	Ongoing (started October 2021)
Foundation building work – levelling out the ground near MOU	Before end of year 2021
Installing the modular build and theatre equipment	Q1 2022
Building a team to staff the unit (including physiotherapy, nursing, theatre staff, surgeons, radiotherapy, anaesthetics)	To start immediately when business case approved (estimated time 6 months)
Theatre commissioning (deep clean and certification)	29th August 2022 (for 2 weeks)
Opening new build to patients	12th September 2022

A more detailed project plan is available in Appendix Eight.

Recognising the importance of rapid delivery of the new facility, the trust has carried out five strands of pre-construction planning and enabling works, each of which will save time from the project should the business case be approved. The five strands are:

- Planning – see Section 5.7
- Architectural design – see Section 5.2

- Ground works – see Section 5.4
- Electrical power infrastructure – see Section 5.4
- Foul water and drainage – see Section 5.4

These pre-planning initiatives significantly reduce the overall construction design development and timeline of the Barn theatre by some six weeks aiding the overall reduction of the construction programme of the Barn theatres from conceptual approval to commissioning and hand over.

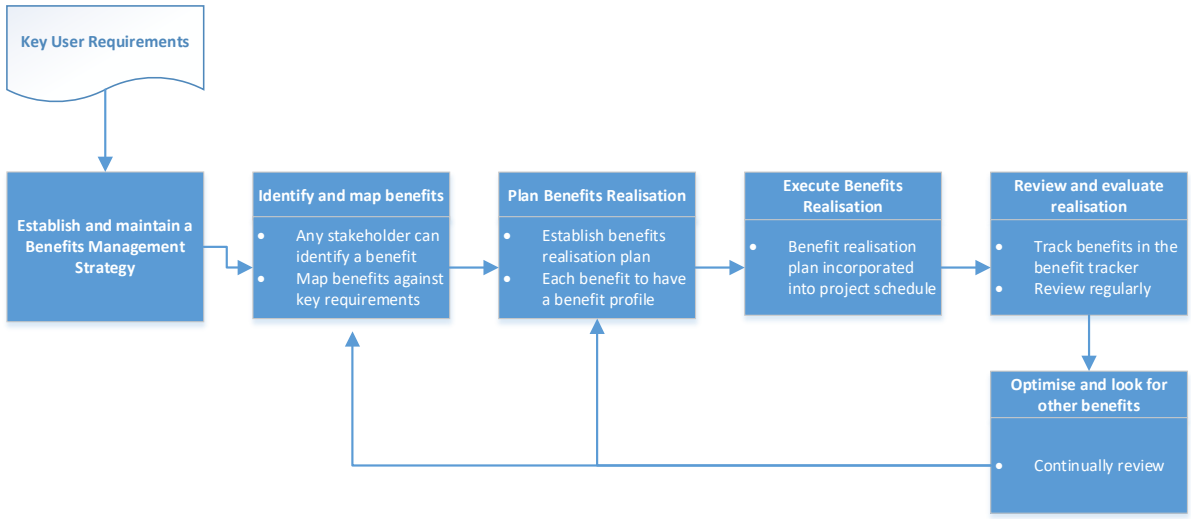
7.4 Benefits realisation

Benefits realisation is concerned with putting in place the management arrangements required to ensure that the desired benefit. A detailed benefits realisation plan will be developed as part of this programme. The high-level benefits realisation plan is designed to:

- Identify the benefits and responsibility for their delivery
- Establish baseline measurement where possible
- Quantify benefits
- Assign responsibility for the actual realisation of benefits throughout the key phases of the programme
- Periodically assess realisation and initiate any actions required
- Record further expected benefits identified during the project
- Measure outcomes.

The Barn theatre facility is a catalyst for change that will transform the orthopaedic surgical services at MTW. Utilising a benefits realisation cycle (see below) a benefits plan will be overlaid on project delivery to ensure healthcare planning, design, specification, construction and equipment instillation of the unit are aligned, and contribute fully, to the achievement of the benefits, both clinical and financial.

Figure 16: Benefits realisation cycle



The benefits tracking spreadsheet will be used to track the realisation of benefits across the project, and also set review and management controls. It will provide a planning and control tool for the project to track progress on delivery and the realisation of benefits. The benefits realisation plan will detail the appropriate benefit review milestones as agreed by the project board. It will provide dates

for when specific outcomes will be realised and highlights the dependencies on delivering the benefits. A significant aspect of the project success will lie in the new building being able to facilitate the desired benefits summarised in set out below.

7.5 Risk management

The project board will ensure that suitable and sufficient assessments of risks to staff and those affected by its activities are undertaken. Risks will be monitored and updated by the project board and any significant risks will be highlighted to the executive team and recorded on the trust's risk register and, if unacceptable, an action plan developed to mitigate the risk. The risk register as at the end of November 2021, is reproduced below.

Table 54: Project risks

Category	Risk	Baseline risk score *Consequence / likelihood*	Summary mitigation/ contingency	Mitigated risk score *Consequence / likelihood*
External/ environmental	Delay procuring concrete, steel and other core building materials due to market	4*4=16	Completed comprehensive list of supplies and commenced procurement process, contacting key suppliers.	3*3=9
Service delivery	Delay procuring theatre and medical equipment	4*4=16	High demand items have been identified so that procurement process can commence early (as soon as capital approved). Existing equipment could be transferred short term from TWH	3*3=9
External / environment	Delay to contact approval, leading to inflation costs increasing (4.2% at present)	4*4=16	Seeking approval for contractors this month to avoid increased inflation costs	4*3=12
Service delivery	Recruited delays leading to lack of fully establishment workforce in time for opening	4*3 =12	Ongoing recruitment campaigns for staff group with highest vacancies (theatres) has demonstrated success.	3*3 =9

Category	Risk	Baseline risk score *Consequence / likelihood*	Summary mitigation/ contingency	Mitigated risk score *Consequence / likelihood*
			Temporary staffing factored into costings	
Service delivery	Efficiency gains cannot be realised	4*3=12	Efficiency gains already achieved in MOU therefore aren't unrealistic. Elective flow coordinator included to support. Clinical buy in to set up efficiency work groups prior to build. Sensitivity analysis included.	2*3=6
Business strategy	Region wide reconfiguration of services, may impact unexpectedly on demand	3*3=9	Strategic case to be shared with senior strategic leads in health community. Facility suitable for private practice if NHS demand decreases.	2*3=6

7.6 Communications and engagement

The trust recognises that the project will only achieve its objective if there is an engaged set of staff and stakeholders throughout all project phases.

Business engagement is defined as the framework that enables effective stakeholder engagement and communication throughout the life of the project. It is recognised as integral and critical success. The project team have developed a communications strategy and engagement charter to facilitate messaging (what will be communicated, by whom, how and when) as a key vehicle for delivering the engagement strategy.

It is important to note that business/stakeholder engagement, communications and the stakeholder landscape itself will evolve throughout the life of the project and it is therefore essential that the project establishes a flexible approach to business engagement and communications that is maintained and re-visited at each phase of the project.

The project team has identified the key stakeholders:

- The Kent and Medway System
- Surgeons
- Anaesthetists
- Theatre and recovery nursing staff
- Control of infection team
- Managers within the surgical directorate
- Managers within support services (estates and hotel services)
- Patient representatives.

Staff have been closely involved in developing the design for the proposed new barn theatre facility.

Operational stakeholders from East Kent, Darenth Valley and Medway Maritime have been engaged with and pledged support for utilising the Barn facility for their activity. Further meetings have been scheduled week commencing 6th Dec 21.

Consideration has been given to the patient communication of how the project would provide an improved patient pathway for elective care within the Kent and Medway system. For information purposes only the planning, provision and operation of the project could be taken to the Health Overview and Scrutiny Committee (HOSC).

7.7 Post-project and programme evaluation

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

Complete the following section now

Name of Directorate
Evaluation manager
Project Title & Reference
Total Cost
Start date
Completion date
Post project evaluation Due Date

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues …
Project execution issues…
Project governance issues…
Project funding issues…
Human resource issues…
Information issues…

What worked well in developing case? …
What could be improved in developing a case? …
Summary of recommendations for developing a case…

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS

Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how where such resolved?
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

7.8 Quality impact

The project's quality impact assessment can be found as Appendix Nine.

8 Conclusion

This business case sets out the optimal way for MTW to develop an orthopaedic centre of excellence at Maidstone Hospital. In the medium-term the proposed centre of excellence would support delivery of the trust's mission *to be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community* and the vision of providing *outstanding hospital services delivered by exceptional people*. The capacity delivered by this investment will enable the trust to reduce the orthopaedic elective waiting list and waiting times. Initially two of the four new theatres would be used, leaving the two remaining theatres available to the rest of the ICS to tackle their elective backlog.

This case is about delivering benefits as well as financial savings:

- The ICS will benefit from having capacity available in the short-term to support elective recovery, lower costs of delivery and lower waiting times.
- Benefits to local people who will be treated in an orthopaedic centre of excellence delivering evidence-based best practice which will optimise their chances of a good outcome and minimise the risk of their operation being cancelled. Waiting times will also reduce and the new unit will be closer to the most deprived areas within West Kent.
- The centre of excellence approach is expected to improve staff recruitment and retention by allowing staff to work from purpose-built facilities designed with best practice in mind.
- Other specialties at MTW will benefit from having access to theatre capacity freed-up by orthopaedics.

The trust requires capital funding from NSHEI to deliver this development; failure to obtain funding is the main risk associated with these proposals. The other key risk is inability to recruit the additional staff needed quickly enough – the orthopaedic team is developing its recruitment plan to mitigate this risk, noting that the centre of excellence will in itself be attractive to potential recruits.

9 Appendices

Appendix One – GIRFT case studies

Appendix Two – Medical equipment schedule

Appendix Three - Comprehensive Investment Appraisal (CIA) Model

Appendix Four – Financial modelling

Appendix Five – List of IT equipment

Appendix Six – Schedule of Accommodation

Appendix Seven – Capital costs (OB Forms) and optimism bias calculations

Appendix Eight – Project plan

Appendix Nine – Quality Impact Assessment

Appendix One – GIRFT case studies

CASESTUDY7

Ring-fenced elective orthopaedic ward moved to protect against winter pressures

St Richard's Hospital in Chichester, part of Western Sussex Hospitals NHS Foundation Trust, avoided a significant number of elective operation cancellations by maintaining a ring-fenced elective ward. This was possible by relocating the ward during winter to mitigate the impact of operational pressures.

The trust usually provides orthopaedics from its ring-fenced 22-bed Chilgrove ward. It can be problematic having a large number of beds on this site ring-fenced during winter pressures when emergency admissions rise and space is at a premium.

To guard against having to cancel elective activity because of having to use the ring-fenced ward for emergency patients, it was decided that the elective activity would temporarily be moved to a lesser number of ring-fenced beds on the Chichester Suite (a 26-bedded ward normally used for private and bariatric patients).

This was possible due to the configuration of the Chichester Suite, which is 'U-shaped', and could be split using a fire curtain. Private and bariatric patients could continue to be seen using the14 beds on one side of the suite whilst elective orthopaedic patients could be seen using the 12 beds on the other side, without any cross-over.

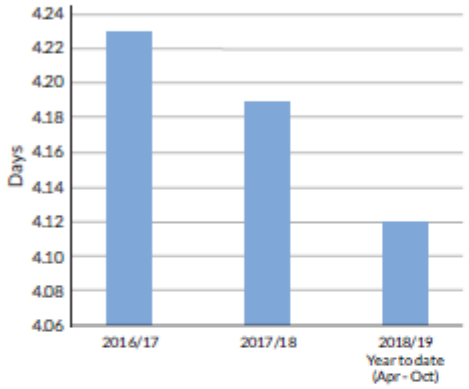
Thanks to the protection of the ring-fenced ward, it was possible to maintain elective activity throughout the winter period whilst having the flexibility to manage an increased emergency workload. As a result, the orthopaedic team only had to cancel two electives in the winter of 2018/19 in comparison to the 210 electives cancelled in the winter of 2017/18.

It is envisaged that the ward move will take place on an annual basis.

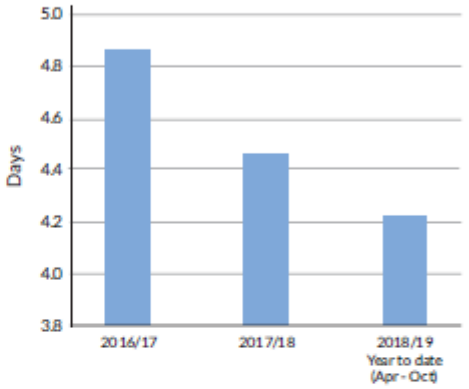
CASESTUDY 9

Benefits resulting from hot and cold site split at Royal Cornwall NHS Foundation Trust

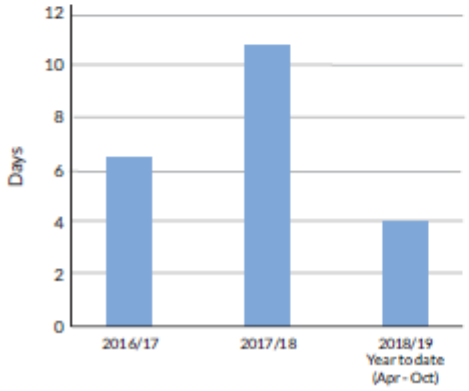
LOS for patients receiving elective primary hip replacement



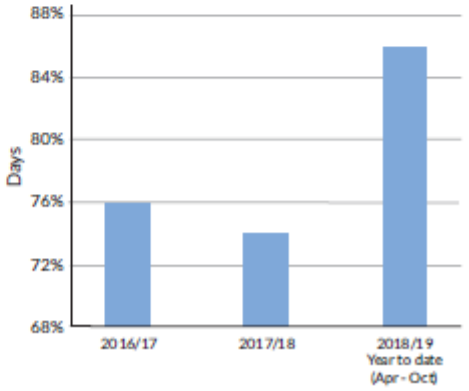
LOS for patients receiving elective primary knee replacement



LOS for patients receiving elective revision knee replacement



% of elective primary hip replacement with cemented or hybrid fixation for patients 70+ years



Source: Data provided by Royal Cornwall NHS Foundation Trust

Appendix Two – Equipment

Appx 2 - Barn Equip V6.xlsx

Appendix Three – CIA

Appx 3 - CIA_Barn Theatres 221101.xlsx

Appendix Three – Financial model

Appx 4 - Financial model - Barn Theatre

Appendix Five – IT equipment

Appx 5 - Barn Theatres - IT Equipm

Appendix Six – Schedule of accommodation

Theatre suite

Barn Theatre_Maidstone Hospital: Schedule of Accommodation - Summary

Department Level 1	Department Level 2	Department Level 3	Room Description	S, U, LR	QTY	Area (m2)	Net Area (m2)	Dept Net Total	ADB Code	Comments	SINK-TAP	WC	SHW
Theatres Suite	Orthopaedic Theatres	Entrance, reception & waiting facilities	Lobby: entrance, controlled access	S	1		0.0			Provided in DP Beds			
Theatres Suite	Orthopaedic Theatres	Entrance, reception & waiting facilities	Reception/staff base: 2 person	S	0	11.0	0.0			Provided in DP Beds			
Theatres Suite	Orthopaedic Theatres	Entrance, reception & waiting facilities	Porter's: 2 person	S	0	5.0	0.0			not required			
Theatres Suite	Orthopaedic Theatres	Entrance, reception & waiting facilities	Bay: holding	U	0	12.0	0.0			not required			
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Operating theatre standard	S	4	55.0	231.0		N0108	MTW to confirm Equipment layout - not as shown on ADB			
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Anaesthetic room	S	4	16.0	64.0		N0317-01	HBN 19 - ADB - 19sqm - MTW to confirm if room size to be increased.	4		
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Scrub-up / gowning room	S	2	12.0	24.0		N0224	HBN 11. ADB - 7sqm (3P)x2 - 6P between 2 theatres	12		
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Preparation room	S	4	12.0	48.0		T0522	HBN 12			
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Exit bay:	LR	2	12.0	24.0		G0407				
Theatres Suite	Orthopaedic Theatres	Operating theatre suites	Dirty utility	S	2	25.0	50.0		Y0436 + Y1510A	ADB	4		
Theatres Suite	Orthopaedic Theatres	Recovery	Bay: recovery	U	8	13.5	168.0		B2425	14sqm per bed + circulation.			
Theatres Suite	Orthopaedic Theatres	Recovery	Staff base	S	1	10.0	10.0		T0213		1		
Theatres Suite	Orthopaedic Theatres	Recovery	Clean utility	S	1	10.0	10.0		T0535		1		
Theatres Suite	Orthopaedic Theatres	Recovery	Dirty utility	S	1	8.0	8.0		Y0331	ADB - 12sqm	2		
Theatres Suite	Orthopaedic Theatres	Support facilities	Office: 2 person	S	1	12.0	12.0		M0252				
Theatres Suite	Orthopaedic Theatres	Support facilities	Bay: blood bank refrigerator	S	1	2.0	2.0		W0652				
Theatres Suite	Orthopaedic Theatres	Support facilities	Near patient testing / status laboratory (1 person)	S	1	6.0	6.0		L1308	ADB - 8sqm (2person)	1		
Theatres Suite	Orthopaedic Theatres	Support facilities	Service room: equipment	LR	4	8.0	32.0		W0131	Ana, table att, C-arm stores. ADB - 11qm			
Theatres Suite	Orthopaedic Theatres	Support facilities	Parking bay: imaging	S	0	5.0	0.0			not required			
Theatres Suite	Orthopaedic Theatres	Support facilities	Bay: resus trolley	S	1	2.0	2.0		G0180-01				
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: pharmacy	U	1	12.0	12.0		W0274	ADB - 12sqm			
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: sterile instrument trays	S	1	54.0	54.0		W1594	Theatre instrument Store - ADB-12sqm (x5)			
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: sterile	S	1	48.0	48.0		W0540/R0904	Decan Clean In (ADB-20sqm) x2.5			
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: bulk	S	1	40.0	40.0		W1440	Consumables			
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: implant	U	1	29.0	29.0		W1440				
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: linen	S	1	3.0	3.0		W1594				
Theatres Suite	Orthopaedic Theatres	Support facilities	Store: gas cylinders	U	1	5.0	5.0		W1590				
Theatres Suite	Orthopaedic Theatres	Support facilities	Hold: disposal	S	1	41.0	41.0		Y0646	Decon ADB-12sqm (x3.5)			
Theatres Suite	Orthopaedic Theatres	Support facilities	Cleaner's room	S	1	8.0	8.0			Part of Theatre Dirty Utility			
Theatres Suite	Orthopaedic Theatres	Support facilities	UPS & IT hub	U	0	10.0	0.0			Provided in IP Beds			
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Rest room and beverage bay: 15 person	S	1	29.0	29.0		D0434-02		1		
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Utility: footwear washing	U	0	4.0	0.0			Confirm if required?			
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Office: 4 person	S	1	24.0	24.0		M0254	Surgical Write Up - 4 person			
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Workstations	S	0	4.5	0.0			Theatre & anaesthetics - confirm no. and where required			
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Change: staff (20 places)	S	2	32.0	64.0		V0554-A	Includes 2no. WC & 1no. shower	4	4	2
Theatres Suite	Orthopaedic Theatres	Staff support facilities	Seminar room	S	0	35.0	0.0			not required			
Theatres Suite	Orthopaedic Theatres		Sub total					1,068.0			30	4	2

Day surgery unit

Barn Theatre_Maidstone Hospital: Schedule of Accommodation - Summary

Department Level 1	Department Level 2	Department Level 3	Room Description	S, U, LR	Qty	Area (m2)	Net Area (m2)	Dept Net Total	ADB Code	Comments	SINK-TAP	WC	SHW
Day Surgery Unit		Reception and waiting	Lobby: entrance	S	1	11.0	11.0			Includes entrance Canopy			
Day Surgery Unit		Reception and waiting	Self check in screens	S	0	2.0	0.0			not required			
Day Surgery Unit		Reception and waiting	Reception: 3 person	S	1	15.0	15.0		J0232-02				
Day Surgery Unit		Reception and waiting	Office: 1 person	S	1	9.0	9.0		M0251				
Day Surgery Unit		Reception and waiting	Store: medical records	S	1	8.0	8.0		W0612	ADB - 12sqm			
Day Surgery Unit		Reception and waiting	Waiting: per person	S	10	1.8	18.0		J1255-01A	ADB - 15sqm			
Day Surgery Unit		Reception and waiting	WC: ambulant	S	0	2.5	0.0						
Day Surgery Unit		Reception and waiting	WC: assisted	S	1	4.5	4.5		V0922A		1	1	
Day Surgery Unit		Reception and waiting	Refreshment: vending machine	S	0	3.0	3.0		P0808A				
Day Surgery Unit		Reception and waiting	Bay: Wheelchair parking	S	1	5.0	5.0						
Day Surgery Unit		Reception and waiting	Consultation and examination room	S	0	18.0	0.0			not required			
Day Surgery Unit		Prep Recovery area	In Patient Ward (BP)	S	2	115.0	230.0		B0405	9.5sqm bed area	4		
Day Surgery Unit		Prep Recovery area	WC: ensuite ambulant	S	2	2.5	5.0		V1010A		2	2	
Day Surgery Unit		Prep Recovery area	WC: ensuite assisted	S	2	4.5	9.0		V0922A		2	2	
Day Surgery Unit		Prep Recovery area	Lobby: isolation	S	0	6.0	0.0			TBC isolation requirement			
Day Surgery Unit		Prep Recovery area	Staff base: 1 person	S	2	4.0	8.0		T0211a	ADB- 11sqm 2person	2		
Day Surgery Unit		Prep Recovery area	Medicine management room	S	0	12.0	0.0			included within clean utility			
Day Surgery Unit		Prep Recovery area	Clean utility	S	1	7.0	7.0		T0535	ADB-16sqm	1		
Day Surgery Unit		Prep Recovery area	Dirty utility	S	2	7.0	14.0		Y0331A	ADB-12sqm	4		
Day Surgery Unit		Discharge	Discharge lounge:	U	8	1.8	14.4		D1133				
Day Surgery Unit		Discharge	WC: assisted	S	1	4.5	4.5		V0922A		1	1	
Day Surgery Unit		Discharge	Bay: beverage	S	1	6.0	6.0		D0432	ADB - Beverage Bay only	1		
Day Surgery Unit		Discharge	Staff base: 1 person	S	1	5.0	5.0		T0211A	ADB- 11sqm 2person	1		
Day Surgery Unit		Clinical support	Bay: resus	S	0	2.0	0.0			Confirm if required?			
Day Surgery Unit		Clinical support	Bay: linen	S	0	3.0	0.0			Share with ward or theatres			
Day Surgery Unit		Clinical support	Bay: equipment	S	0	4.0	0.0			Share with ward or theatres			
Day Surgery Unit		Clinical support	Cleaner's room	S	0	8.0	0.0			Share with ward			
Day Surgery Unit		Clinical support	Hold: disposal	S	0	10.0	0.0			Share with ward?			
Day Surgery Unit		Clinical support	IT hub	S	0	10.0	0.0			Provided in IP Beds			
Day Surgery Unit		Staff facilities	Staff change	S	0	15.0	0.0			Share with ward or theatres			
Day Surgery Unit		Staff facilities	WC: ambulant	S	0	2.5	0.0			Share with ward or theatres			
Day Surgery Unit		Staff facilities	Shower: ambulant	S	0	3.0	0.0			Share with ward or theatres			
Day Surgery Unit		Staff facilities	Staff rest and beverage bay	S	0	20.0	0.0			Share with ward or theatres			
Day Surgery Unit		Staff facilities	Office: 1 person	S	0	9.0	0.0			Share with ward or theatres			
Day Surgery Unit		Staff facilities	Workstations	S	0	4.5	0.0						
Day Surgery Unit								376.4			19	6	0

Inpatient ward

Barn Theatre_ Maidstone Hospital: Schedule of Accommodation - Summary												
Department Level 1	Department Level 2	Department Level 3	Room Description	S, U, LR	Qty	Area (m2)	Net Area (m2)	Dept Net Total	ADB Code	Comments	SINK-TAP	WC	SHW
Inpatients Department	Ward 1 (24 Beds)	Reception and waiting	Staff base: 2 person	S	0	8.0	0.0			Provided in DP Beds			
Inpatients Department	Ward 1 (24 Beds)	Reception and waiting	Interview room	S	0	9.0	0.0			Provided in DP Beds			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Bedroom: single	S	6	16.0	96.0		B0305	HBN 19sqm 16sqm if nested ensuite			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Ensuite: ambulant	S	6	4.5	27.0		V1643A	HBN 4.5sqm	6	6	6
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Bedroom: isolation	S	0	16.0	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Ensuite: assisted	S	2	7.0	14.0		V1635A		2	2	2
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Lobby: isolation	S	0	6.0	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Bedroom: single bariatric	S	2	19.0	38.0		B0305	HBN 20sqm if no nested ensuite			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Ensuite: dual assistance	S	0	7.5	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Breakout space	S	0	6.0	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Bedroom: 4 person	S	3	64.0	192.0		B0405	HBN 64sqm	6		
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Ensuite: assisted	S	3	6.5	19.5		V1635A		3	3	3
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	WC: ambulant	S	3	2.5	7.5		V1010A		3	3	
Inpatients Department	Ward 1 (24 Beds)	Patient accommodation	Treatment/procedure room	S	0	22.0	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Medicines management	S	0	12.0	0.0			Provided within clean utility			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Clean utility	S	1	17.0	17.0		T0535	Includes medicine management	1		
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Dirty utility	S	1	12.0	12.0		Y0331A		2		
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Bay: pneumatic tube	S	0	2.0	0.0			Not provided.			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Staff base: 2 person	S	2	7.0	14.0		T0211A	ADB- 11sqm			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Cleaner's room	S	1	8.0	8.0		Y1510A		1		
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Kitchen	S	1	10.0	10.0		P0627A	Ward Pantry (ADB - 12sqm)	1		
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Bay: food trolley	S	1	4.0	4.0			3sqm required			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Bay: linen trolley	S	2	3.0	6.0			2 provided 1 at each end of ward			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Bay: resus trolley	S	1	2.0	2.0						
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Bay: equipment	S	1	3.0	3.0						
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Store: equipment	S	1	15.0	15.0		W1585-01	ADB x4 (4sqm)			
Inpatients Department	Ward 1 (24 Beds)	Clinical support	Store: Consumables	S	1	14.0	14.0		W0266	ADB - 16sqm			
Inpatients Department	Ward 1 (24 Beds)	Staff facilities	Office: 1 person	S	1	9.0	9.0		M0251-02				
Inpatients Department	Ward 1 (24 Beds)	Staff facilities	Touchdown:1 person	S	3	2.0	6.0		T0151A	Clinical admin - 4bed ward			
Inpatients Department	**Ward 1 (24 Beds)**		**Sub total**					514.0					
Inpatients Department	Ward Support	Reception and waiting	Waiting: per person	S	0	1.8	0.0			Provided in DP Beds			
Inpatients Department	Ward Support	Reception and waiting	WC: assisted	S	0	4.5	0.0			Provided in DP Beds			
Inpatients Department	Ward Support	Physio	Physio	LR	1	30.0	30.0		Q0611	24sqm - 10 spaces			
Inpatients Department	Ward Support	Clinical support	Store: therapies	LR	1	3.0	3.0		W1210	6sqm ?			
Inpatients Department	Ward Support	Clinical support	Room: x-ray	S	1	17.0	17.0		X2062	30sqm ? Control room req'd	2		
Inpatients Department	Ward Support	Clinical support	Hold: disposal	S	2	7.0	14.0		Y0642A				
Inpatients Department	Ward Support	Clinical support	IT hub	S	1	17.0	17.0		K0915	9sqm - area to be confirmed.			
Inpatients Department	Ward Support	Staff facilities	Staff rest and beverage bay	S	1	15.0	15.0		D0434-01A	(10staff - 20.50?) 7 staff	1		
Inpatients Department	Ward Support	Staff facilities	Staff Change - Female		0	0.0	0.0			Multi sex required.			
Inpatients Department	Ward Support	Staff facilities	Staff Change - Multi sex	S	1	35.0	35.0		V0554A/V1010A/V1321A	Includes 2 WCs, 2 change and 1no. Shw (15P)	2	2	1
Inpatients Department	Ward Support	Staff facilities	Accessibe staff change	S	1	8.0	8.0		V0726A/V1320A/V0922A		1	1	1
Inpatients Department	Ward Support	Staff facilities	WC: ambulant	S	1	2.5	2.5		V1010A	On ward	1	1	
Inpatients Department	Ward Support	Staff facilities	Bay: staff lockers	S	1	1.5	1.5		V0653	Confirm location			
Inpatients Department	Ward Support	Staff facilities	Meeting: MDT	S	0	30.0	0.0			Not provided.			
Inpatients Department							0.0						
Inpatients Department	**Ward Support**		**Sub total**					143.0			32	18	13

Appendix Seven – Capital costs

Available under separate cover

Appendix Eight – project plan

Project Plan 23.11.21.pdf

Appendix Nine – Quality impact assessment

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Yes – site visit to barn theatre at Chase Farm Hospital undertaken by Greg Lawton and James Nicholl 1/9/21 Involvement from James Nicholl, Clinical Director and all consultant orthopaedic surgeons at Consultant meeting held on	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Surgical Site submissions to PHE on a quarterly basis for elective THR, TKR & #Nof's	
Are there any risks to clinical effectiveness? If yes, list	
No	
Have the risks been mitigated?	
NA	
Have the risks been added to the departmental risk register and a review date set?	
NA	
Are there any benefits to clinical effectiveness? If yes, list	
Improvements in on the day cancellations	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Yes
Safeguarding vulnerable adults/ children?	Yes
Current quality indicators?	Yes
Quality Account priorities?	Yes
CQUINS?	MA
Are there any risks to patient safety? If yes, list	
No	
Have the risks been mitigated?	
NA	
Have the risks been added to the departmental risk register and a review date set?	
NA	
Are there any benefits to patient safety? If yes, list	
Yes – improvements to efficiency, throughput and infection rates	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
Yes	

Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
No
Does the redesign lead to improvements in the care pathway? If yes, identify
Care pathway will be unchanged
Are there any risks to the patient experience? If yes, list
Yes, on call cover /ITU cover due to location of the building from the main site
Have the risks been mitigated?
Yes, design includes covered access corridor to main hospital site Orientation to resus and ICU teams will include access arrangement to the new building
Have the risks been added to the departmental risk register and a review date set?
NA
Are there any benefits to the patient experience? If yes, list
Yes • Reduced last minute theatre cancellations due to running out of time or bed capacity • Reduced length of stay post op • Super green ward, completely isolated from Covid and acute site enabling ring fenced beds
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
No
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No
Has any negative impact been added to the departmental risk register and a review date set?
No
Service
What is the overall impact on service quality? – please tick one box

Improves quality	☑	Maintains quality		Reduces quality	

Clinical lead comments

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve a Business Case for an Oncology Modular Building **Chief Operating Officer**

Please find enclosed the Business Case for an Oncology Modular Building. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 20/12/21, to consider the Business Case and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 14/12/21
- Finance and Performance Committee, 20/12/21

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Title: **Oncology Modular Building**

Issue date/Version number	1
ID reference	ID 854
Division	Cancer Services
Directorate	Oncology
Department/Site	KOC, Maidstone Hospital
Author	Summer Herron
Clinical lead/Project Manager	Henry Taylor/ Justin Waters

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead	Naomi Butcher	NJButcher	15/10/21
Finance manager	Gemma Paling/ Steve Orpin		
Clinical Director	Justin Waters		07/12/21
Executive sponsor	Sean Briggs		10/12/21
Division Board	Katie Goodwin	KJGoodwin	14/11/21
Supported by	**Name**	**Signature**	**Date**
Estates and Facilities Management (EFM)	Doug Ward	(email to LP)	11/10/21
ICT	Sue Forsey		
Deputy Chief Operating Officer	Sarah Davis		11/12/21
Diagnostics and Clinical Support Services (DCSS)	Darren Palmer		
Emergency Planning	John Weeks	(email to SH)	15/10/21
Human Resources (HR) Business Partner	Angela Collinson		
Procurement	Bob Murray	(email to NB/SH)	13/10/21
EME Services Manager	Michael Chalklin		10/12/21

Executive summary

This business case sets out the need for additional outpatient clinic and administrative space in the Kent Oncology Centre at Maidstone Hospital. In the last 5 years we have seen growth in outpatient appointments of c25% - 400% since the Centre was first opened in 1994 with 9 clinic rooms.

This business case sets out in detail the need for this space and the related cost implications – 9 additional clinic rooms and administrative offices for c30 people.

This is a capital case forc£1.2 million, including a 5% optimism bias).The annual running costs are c£375k including staffing, consumables and equipment.

Conversations are currently taking place with the CCG around financing this cost. We are aware that the 17% increase in outpatient attendances. since the move to a block contract arrangement in March 2020 (based on 2019/20 activity, is unlikely to be funded in full. As such, our argument is instead for the run-rate to increase by £375k per annum in order to cover the costs of the additional clinic space, helping elective and, in particular, cancer recovery following the global pandemic.

Funding to date

It is important to be clear at this stage that when we talk about "oncology provision", whilst intrinsically linked with cancer provision, we are not talking about the same thing. MTW has delivered the national cancer standards for over two years in a row, throughout the course of the pandemic, receiving significant investment to help turn performance around, having failed the standards for five years, prior to this. Investment has been made in a number of different areas of cancer provision including, diagnostic capacity, staffing, equipment and administration but oncology has not been a priority area for this funding.

To illustrate this further, a patient who is referred in by their GP on a two-week wait pathway for breast cancer would firstly be seen by a combination of diagnostic and breast surgery clinicians. Their first treatment (for cancer standard purposes) may well be surgical – for example, a mastectomy. It will be further along in their treatment for cancer that a patient will be seen by an oncologist and not all patients will require this. As such, and rightly so in order to ensure prompt treatment, investment has been prioritised at the beginning (surgery / diagnostic) rather than the end (oncology) of cancer pathways.

Increases in oncology financing to date have therefore been largely inflationary / tariff increase based.

Should the CCG not agree to the increase in run-rate being proposed, we would take the following actions:

1) Take recruitment down to an absolute minimum to reduce costs.

2) Explore revenue streams in research. From Feb 2018 to Feb 2020 oncology and haematology trials brought in £758,000 income from 19 commercial studies and £355,000 from 17 non- commercial studies. The net effect was approximately £556,000 per annum of additional income for the Trust, while working in a constrained environment (ie consenting patients in corridors / not being able to use clinic rooms). The research team estimate that an additional 12 research studies per year can be accommodated in a research oncology dedicated outpatient space, spanning all tumour groups.

Extra clinic space would allow us to host more lucrative investigator-led studies. Study income ranges from £500 to £80,000 per study. A prudent estimate, based on £10,000 per study would therefore bring in an approaching £100,000 additional commercial research income per year. The expectation is that the additional income would be realised without additional staffing costs. This would also improve the recruitment and retention of our clinicians, as they are keen to become more heavily involved in research and hosting their own trials.

3) Explore revenue streams in private patients. Since the Covid19 pandemic began in early 2020, we have ceased almost all private care activity. Now that our reset and recovery has begun, we have been looking at how we can best revive this service.

   The newest product we have procured to re-launch private care is SpaceOAR Vue, a hydrogel which reduces the effects of toxicity poisoning in prostate brachytherapy patients. The overall price of the product is £2250, and combined with the cost of the local anaesthetic, clinician's time and an additional 40% mark-up, we are look at charging each patient approximately £4550 (excl. VAT) – ie £2,300 net income.

   In Y1, we anticipate administering this treatment to 4 patients a week privately, both MTW patients and those receiving treatment elsewhere (as we are the only Trust in the region to offer this treatment option). Optimistically, if we were to run this service based on the predicted demand, and a 42 working- week year, this would generate a potential £305,760 net income per annum.

Whilst all of the above would require further work and scoping, and is by no means guaranteed, we trust it goes some way in providing assurance over the risk to this case, should the CCG not agree to fund the additional revenue costs of procuring this building.

Business Case Summary

Strategic background context and need

Summarise the background to the proposal including its relevance to strategic aims and objectives identified in Division business plan. Identify the key stakeholders. Summarise the needs or demands that are to be addressed and deficiencies in existing service.

The Kent Oncology Centre (KOC) was built at the Maidstone site in 1993, including 9 clinic rooms and a treatment room. In the near three decades that have since passed outpatient appointments have changed significantly: from c10,000 a year delivered exclusively by consultant oncologists in 1993, to c60,000 appointments a year delivered by the whole multi-disciplinary team in 2021, out of the same 9 clinic rooms.

In the last four years, activity has grown, on average, by 7% per annum. Since moving to a block funding arrangement in 2020/21 (based on 2019/20 activity), the forecast outturn for 2021/22 shows a total increase in activity during that period of 17%. Note that, whilst Dartford and East Kent KOC activity has been excluded from the below table, the trends remain similar.

Outpatient activity at the Maidstone and Medway sites (virtual and face to face):

Site	FY16-17*	FY17-18	FY18-19	FY19-20	FY20-21	FOT 21-22
Consultant-led activity						
Medway	**3,604**	**4,075**	**4,218**	**3,818**	**4,592**	**5,178**
Follow Up	2,879	3,167	3,251	3,127	3,850	4,310
New	725	908	967	691	742	868
Maidstone KOC	**21,816**	**20,297**	**21,189**	**21,830**	**23,739**	**26,222**
Follow Up	18,154	16,957	17,407	17,943	19,963	22,054
New	3,662	3,340	3,782	3,887	3,776	4,168
Total	**47,642**	**46,580**	**47,146**	**49,445**	**54,649**	**59,632**
Other non-consultant led outpatient activity						
Maidstone KOC	**22,761**	**21,299**	**23,434**	**25,899**	**25,337**	**30,764**
Follow Up	19,382	18,398	20,426	23,270	23,591	28,538
New	3,379	2,901	3,008	2,629	1,746	2,226
Grand total	**70,403**	**67,879**	**70,580**	**75,344**	**79,986**	**90,396**
Difference fromprevious year		*- 2,524*	*2,701*	*4,764*	*4,642*	*10,410*
% difference fromprevious year		*-4%*	*4%*	*6%*	*6%*	*12%*

**with the switch to Allscripts in this financial year, we are not assured on the accuracy of the 2016/17 activity figures.*

It is to be noted that, unlike in other specialties where reducing follow-ups and discharging patients is key to managing demand, oncology follow-up numbers will only continue to increase. Life expectancy for patients diagnosed with cancer continues to improve and many patients will remain under the care of their oncologist for a significant period (in some instances a decade or longer), undergoing varying degrees of treatment during that time. We note that, at a minimum, demand for oncology services is anticipated to continue growing at a minimum rate of c2% per annum, comprising 0.2% for incidence growth and 1.8% for normal population growth.

The above activity includes virtual and face to face activity. During the height of the pandemic, virtual consultations accounted for c80% of outpatient activity. At present this has fallen to 60%, still too high to provide consistently high-quality and efficient care for this extremely vulnerable patient group. Whilst, given the continued prevalence of covid-19 in the community, there is a necessity to limit face-to-face contact for immunocompromised patients at present, space is the main limiting factor here. In addition, we are experiencing increasing inefficiencies, with patients having duplicate appointments for the same matter because the virtual appointment is insufficient. During the pandemic, 80% of oncology clinics were run virtually. That figure has now dropped to 60% (varying from tumour site to tumour site) however this is still significantly higher than the national target of 25%. Due to the nature of oncology clinics, i.e. the need for thorough physical examinations, the delivery

of bad news and the need for regular bloods, it is far from ideal that we are running such a large number by virtual means.

It should be noted that most clinicians are running "mixed" clinics of virtual and face-to-face appointments. With all clinicians sharing offices, in some cases up to 4, clinic rooms are at present the only space available to run clinics, virtual or otherwise.

Whilst the continual growth in activity is the main driver for this case, there are a number of other strategic and qualitative issues that also require addressing:

1) Flexibility

The lack of space, and corresponding lack of flexibility this results in, impacts on patient experience, staff morale and, ultimately, recruitment and retention, in the following ways:

- inability to provide flexible job-plans and corresponding work-life balance for clinical staff;
- silo working and difficulties in communication between professions because they can't all work together in the same area / clinic session (ie multi-disciplinary outpatient clinics); and
- registrars unable to run their own clinics concurrently with their consultant, impacting on their learning and overall satisfaction, directly impacting on succession planning.

2) Kent and Medway Medical School (KMMS)

At present we are unable to provide sufficient space for our existing registrars. From Sept 2024 (year 4 for the first KMMS intake) we are expecting 4-6 students to be allocated to KOC as part of their degree. The ability to accommodate these students at present is severely limited and, as such, is not conducive to providing a high-quality training experience.

3) Research

KOC currently turns down approximately 3-5 research trials per year as many commercial trials specify research space as a pre-requisite to participating. Where we are undertaking trials, staff often have no choice but to often consult, consent and sometimes provide study treatment in discrete sections of public areas (including corridors) due to lack of space.

Our inability to facilitate trials of any scale at present has repercussions for recruitment and retention and our ability to provide cutting edge treatments to our patients. With the prospect of a Kent and Medway tissue bank also on the horizon, the ability to begin investigator-led studies, properly integrated into the oncology department, would be a "game-changer" for recruitment, retention and patient care.

4) Administrative space

Separate from clinical activity, the division as a whole is very short of space for administrative and nursing staff. The two week wait office and MDT coordinators are currently housed in a number of offices, dotted around KOC and there is insufficient space to have them all on site at once. Both teams are absolutely critical to the continued achievement of the cancer standards and much of their roles are taken up with talking to clinical staff and ensuring cancer patient pathways are expedited.

Whilst home working is an option for a proportion of these staff on any given day, we have noted a significant improvement to morale, team work, and cancer performance, when staff are located on site. The issue at the moment is that it's largely impossible to do, without hot-desking in consultant offices and other, less than appropriate, spaces as they become available throughout the day. This arrangement is less than ideal for staff welfare or team building.

In freeing up existing office space, we would be able to accommodate our CNS and straight to test nursing teams, allowing them to return to site (in many instances they have been entirely displaced during the pandemic), hold confidential patient conversations and be available in person to support their various clinical teams.

5) Breaking bad news

In terms of providing a good patient experience, we presently do not have a 'breaking bad news' room within the department. A diagnosis of cancer can turn someone's life upside down and be incredibly frightening. The quality of care that patients and their families receive is pivotal and it is important that outstanding care is provided when delivering bad news. There have been a number of Datix incidents (see Appendix 1, 2 & 3) whereby not only regular consultations, but consultations where difficult news is being delivered to our cancer patients, is being conducted in corridors, and patients and their clinicians have been asked to vacate rooms due to lack of space. It is vital that we provide comfort and support to our patients in a private and calming area where they can discuss the implications of this news and next steps with their clinicians. This should not be done in a public setting, and should not be interrupted by others.

6) Phlebotomy

Phlebotomy wait times are frequently reaching c2hrs as there is only one phlebotomy room in KOC, which is keeping patients in the department much longer than necessary. Chemotherapy patients, in particular, require multiple blood tests throughout the course of their treatment, and many are very ill (either due to cancer symptoms or chemotherapy side-effects) when they attend our sites. The one chair / one phlebotomy room set-up currently provides no flexibility to increase capacity at the beginning and end of the day, our busiest times.

We currently give c4-500 patients a blood test per week, with many requiring multiple vials, increasing the duration and administration required.

7) Reducing pressure on main outpatients

At present main outpatients has c30 outstanding clinic room requests. Whilst not all of these are oncology / outpatient related, if we were to be able to repatriate the c12 oncology clinics a week that take place in main outpatients, space would be released to accommodate other specialty teams, further assisting the Trust's elective recovery.

Medway NHS Foundation Trust (MFT)
We note that, separate to the above, there is currently an SLA in place with MFT for the provision of c16 consultant-led oncology clinics a week at Medway Maritime Hospital. Medway struggle to provide sufficient clinic space to service current activity levels and have asked if this activity could be moved to Maidstone Hospital, ending the SLA. With current clinic capacity at the Maidstone site it is currently not possible to facilitate this. Whilst the financial argument for this case stands separately from this repatriation of activity, and there has been no formal agreement with either MFT or commissioners, if this was to become a reality there is no space currently to facilitate this.

Objectives - *List the project objectives. (What you wish to achieve for patients, not what you wish to purchase)*

1. To streamline our oncology clinics to ensure an efficient and outstanding service is provided to our patients and provide better team-working opportunities.
2. To provide space to run purely virtual clinics, taking pressure off clinic room space.
3. To improve overall patient experience at KOC. This includes reducing wait times in phlebotomy and providing a private and comfortable 'breaking bad news' space.
4. To better accommodate our multi-disciplinary clinical team, ensure appropriate training space and maximise PAs. This includes providing the best learning opportunities for our new doctors attending the Kent and Medway Medical School.
5. To properly co-locate and house our growing administrative teams.
6. To improve access to clinical trials and the latest treatments for our patients (currently dependent on dedicated clinic space).
7. Reduce and centralise outsourced clinics, specifically from Medway NHS Foundation Trust.

The preferred option. *List exactly what is required in terms of staff (WTE and band) / equipment/estate*

The preferred option is a two-storey modular building that will provide us with the following:

- An additional 9 clinic rooms on the ground floor
- A clinical hub, in order to allow consultants, registrars, nurses and other clinical staff to work together (also improving learning experience)
- The flexibility to provide 2 phlebotomy rooms hosting 2 chairs each, vital in weakening the pressure on our current phlebotomy service, reducing wait times reaching c2hrs and therefore improving overall patient experience. This would also allow us the facilities to take on more clinical trials, for which phlebotomy provision is normally a prerequisite.
- An open-plan administrative space to accommodate c30 staff on the first floor, as well as kitchen facilities, toilets and a break-out space.
- 4 private offices, to be used as hot-desking / confidential office space or to be used as virtual clinic (thereby reducing the pressure on clinic rooms as such clinics could be located to the 1st floor administrative space instead),
- The creation of a breaking bad news room in the existing oncology clinic area.

Main benefits associated with the investment *Include here the key benefits the investment would bring to the service.*

Benefits	Measurable Outcome
Improved recruitment and retention in all staff groups, in particular consultants.	Reduction in use of locum doctors, as per our divisional scorecard. Reduction in substantive vacancies in oncology (currently 5) hindered by our inability to create attractive job plans and / or accommodate research. Turnover in cancer performance reduced to the Trust target level – currently 14.9%.
Improved facilities for research patients who can be seen in a more co-ordinated, organised way across K&M thereby increasing the number of clinical trials.	Increased number of commercial, investigator-led, clinical trials taking place at KOC.
Reduced phlebotomy waiting times. Currently patients waiting in excess of 2 hours with an average wait time of 15 minutes.	Average waiting time for phlebotomy reduced to under 7.5 minutes, with no patient waiting more than 15.
Continue to be one of the top Trusts in the country for cancer treatment.	Continued achievement of all national cancer waiting time standards.
Supporting the new doctors from the Kent and Medway Medical School	Receipt of positive feedback from trainees from a staff survey, retention of new doctors, and recommendations to work at MTW

Main risks associated with the investment *Include here the key risks if the project is not undertaken, not undertaken in the timescale you outline and key risks associated with the delivery of the project*

Risk of not doing it:-

- We will not be able to accommodate the growth of patient activity, having a negative impact on cancer performance, patient experience and staff retention.
- Our administrative staff will continue to be displaced and morale remain low. Potential impact on cancer standards from continued high turnover (currently 14.9% for cancer performance), reduced face-to-face presence with clinical staff, and lack of team work.
- We will not be able to wholeheartedly support registrars and doctors who are learning with us (the number of which will increase as a result of the new Kent and Medway Medical School) as we do not have the space to accommodate them

- We will not be able to accept new clinical trials as we currently do not have the space to host them. This will limit our income and access to new treatments for our patients. This will likely deter potential applicants from expressing an interest in working at MTW because they will not have access to opportunities provided at other trusts with dedicated clinical trial space
- We will not be able to attract new consultants with enticing and flexible job plans, nor facilitate "super clinics", involving the whole multi-disciplinary team.

Delivery risk:-

- We will not be able to complete this project by the end of the financial year due to construction and product procurement constraints
- There will be temporary disruption to our service due to noise and reorganisation of the department

Financial impact of the preferred option – full year effect – include VAT unless recoverable
The preferred option is shown below as a conventional capital purchase.

Capital option

Monies from the internal Trust capital plan have been identified for this project, subject to approval at governance.

The total capital cost quoted for the 2-storey modular build, including the associated ground works and modular installation costs involved option is £1,028,201, inclusive of VAT. The building would have a useful economic life of 60 years and be depreciated accordingly.

Given that we are still at the early stages of agreeing the cost and in order to cover for any "unknown, unknowns", we have added a 5% optimism bias to this, giving a total of £1,079,611 inclusive of VAT.

In addition, there are £113,000, inclusive of VAT for IT costs (£118,649 incl Optimism Bias). The IT costs are assessed as capital whilst the furnishings are classed as revenue (room set up). It has been assumed these would need refreshing periodically.

The total capital cost, including optimism bias of 5%, would therefore be **£1,198,260.**

As set out in the executive summary, we are looking for the CCG to fund the increase in our run rate (c£375k), additional growth demonstrated in our summary.

		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Depreciation	Building and Installation	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994
	IT	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600
PDC	Building and Installation	37,471	36,842	36,212	35,582	34,952	34,323	33,693	33,063	32,433	31,804
	IT	3,109	2,418	1,727	1,036	345	3,109	2,418	1,727	1,036	345
Other Expenses	Pay	174,844	233,126	233,126	233,126	233,126	233,126	233,126	233,126	233,126	233,126
	Consumables	2,273	2,342	2,412	2,484	2,559	2,635	2,715	2,796	2,880	2,966
	Room Set up	61,000	0	0	0	0	0	0	0	0	0
	Hard & Soft FM	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979
	Diagnostics	12,240	16,319	16,319	16,319	16,319	16,319	16,319	16,319	16,319	16,319
	Total	**377,510**	**377,619**	**376,368**	**375,120**	**373,874**	**376,084**	**374,843**	**373,604**	**372,367**	**371,133**

Please see appendix 7 for detailed assumptions for all other costs.

Medway

Medway have made indications that they can no longer accommodate the 12 clinics a week running at their site – historically it was 16 but 4 have already been repatriated to Maidstone due to lack of clinic space at Medway. We have incorporated this separately, rather than making Medway income part of the case, as there is still a significant amount of work to do to agree the transfer of this activity, including gaining agreement from the CCG

Based on 2019/20 tariffs, and assuming minimum growth of 2% per annum, indicatively, this would generate c£900k of income per annum. Offset against this is the loss of the SLA income currently received, an increase in consumable costs, to which we have applied a prudent 6% growth, given the growth levels we have seen in reality in the past five years and CNS support costs (as CNS provision is currently provided by Medway).

As part of the negotiation, and the new NHS finance regime, we would need to review the below income assumptions, to ensure our costs were covered at a minimum.

Note that much of the pathology and diagnostic provision for these patients is already conducted at Maidstone and the diagnostic costs incorporated in the above will be sufficient to cover this repatriation.

Medway					
	Y0 (21/22)	Y1	Y2	Y3	Y4
Income	869,800	887,196	904,940	923,039	941,499
Loss of SLA	- 577,860	- 577,860	- 577,860	- 577,860	- 577,860
Increased consumables	7,880	8,353	8,854	9,385	9,948
CNS support to clinics	-	116,950	116,950	116,950	116,950
Total	299,820	434,639	452,884	471,514	490,538

Assumptions:	
Consumables	Based on 10% of £75279 current full-year spend (relative to Medway activity), then 6% growth added each year (average for the past 5 financial years)
Loss of SLA	We will lose this money if activity is returned to MTW
Income	Based on current FOT21/22 income, with 2% growth each year (minimum assumed - the average for the past 5 financial years has been 6%)
CNS support-	2 x B7 / B8a CNS support to the repatriated clinics (currently provided by Medway, albeit sporadically)

Timetable

Include at a minimum the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date
Planning complete	August/September 2021
Finance approved	November 2021
Building procured	December 2021
Staff recruited	February 2022
Installation commenced	January 2022
Installation completed	March 2022
Go live date (fully operational)	March 2022

The Business Case

1. Strategic context

Introduce the service as if to a layperson. Summarise the background to the case including its relevance to strategic aims and objectives identified in division business plan. Identify the key stakeholders.

National –

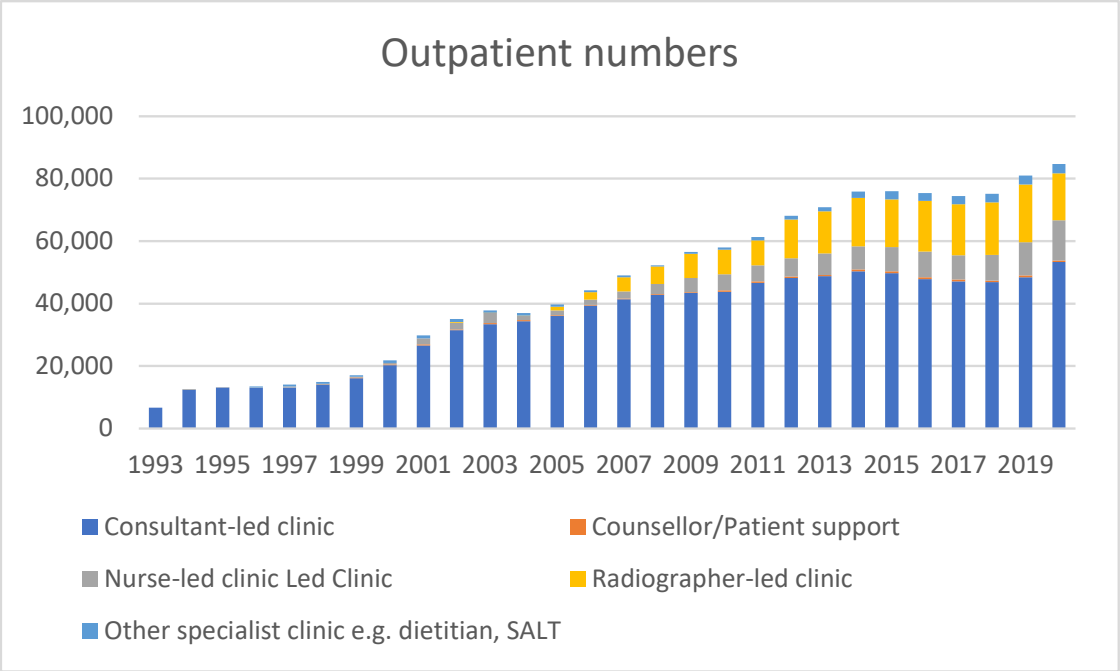
Since the Cancer Centre was built at the Maidstone site in 1993, we have outgrown our footprint. As the overall incident rate of cancer increases, and the number and duration of systematic treatments increases, we are struggling to accommodate all of our patients, and our ever-growing team of consultants, registrars and nurses. This business case addresses three demand and capacity-related needs:

- Providing consulting room capacity for demographic and incidence-related growth
- Providing consulting room capacity to repatriate some work back to the KOC
- Providing consulting room capacity to address quality issues.

All three aspects of the case are discussed in turn below but first discusses current baseline activity and provision locations.

Demand

The chart below shows the growth of outpatient appointments delivered by the service across all delivery locations, since opening in 1993.



The Maidstone KOC is the service's main delivery location. Patient numbers are increasing every year, and are predicted to rise to 742 cases per 100,000 people for all cancers combined (CRUK). A modest estimate of demographic and incidence-related activity growth adds 2% per annum growth to current numbers.

Moreover, in the past 5 years, we have seen on average 7% growth per annum, at the MTW and Medway sites, as follows:

Site	FY16-17*	FY17-18	FY18-19	FY19-20	FY20-21	FOT 21-22
Consultant-led activity						
Medway	**3,604**	**4,075**	**4,218**	**3,818**	**4,592**	**5,178**
Follow Up	2,879	3,167	3,251	3,127	3,850	4,310
New	725	908	967	691	742	868
Maidstone KOC	**21,816**	**20,297**	**21,189**	**21,830**	**23,739**	**26,222**
Follow Up	18,154	16,957	17,407	17,943	19,963	22,054
New	3,662	3,340	3,782	3,887	3,776	4,168
Total	**47,642**	**46,580**	**47,146**	**49,445**	**54,649**	**59,632**
Other non-consultant led outpatient activity- (Radiographers, nurse-led, CNS, etc.)						
Maidstone KOC	**22,761**	**21,299**	**23,434**	**25,899**	**25,337**	**30,764**
Follow Up	19,382	18,398	20,426	23,270	23,591	28,538
New	3,379	2,901	3,008	2,629	1,746	2,226
Grand total	**70,403**	**67,879**	**70,580**	**75,344**	**79,986**	**90,396**
Difference fromprevious year		*- 2,524*	*2,701*	*4,764*	*4,642*	*10,410*
% difference fromprevious year		*-4%*	*4%*	*6%*	*6%*	*12%*

It is to be noted that, unlike in other specialties where reducing follow-ups and discharging patients is key to managing demand, oncology follow-up numbers will only continue to increase. Life expectancy for patients diagnosed with cancer continues to improve and many patients will remain under the care of their oncologist for a significant period (in some instances a decade or longer), undergoing varying degrees of treatment during that time.

Clinic capacity

At the height of the pandemic 80-90% of outpatient activity was conducted virtually. Whilst this was a necessity at the time, given the nature of our patients and their high vulnerability to covid-19, it is not the service that we want to provide in the longer term and as we come out of the pandemic. Currently 50-60% of appointments remain virtual due to social distancing in waiting areas, lack of clinic space, and continued vigilance over covid-19. The ideal level of virtual activity will vary significantly from tumour site to tumour site, however, 25% (the national target) will be at the top end of this. Feeling for lumps and bumps and the overall health and welfare of the patient is not possible to replicate virtually. Currently, the clinical team have agreed that all new patients should be seen in person prior to chemotherapy being prescribed / new courses of chemotherapy.

We currently have 10 clinic rooms and 1 treatment room. Clinic rooms are also used for swabbing, blood tests and, on occasion, breaking bad news. This activity is not captured in the below, which shows that, assuming a 50 week year, 9 patients in a clinic, and 10 sessions a week, we need 13 rooms at a minimum to meet current demand (FOT 21/22). The gap at present is currently being managed through home working, use of inappropriate space (ie offices and corridors) to see patients, and over-running clinics.

In order to have sufficient clinic space, to meet current (forecast outurn) demand:		
At Maidstone in 21/22 forecast to see:	56,986	patients
Over 50 weeks this equates to (excluding bank holidays)	1,140	clinics
Number of clinics a week (assuming an average of 9 pts per clinic)	127	clinics
10 sessions a week	13	rooms required at a minimum

Quality

Linked to the above, there are a number of additional needs for clinic room space which constitute the quality case for more capacity:

- Unmet requests for consulting rooms. At the moment these clinic sessions are either not running, running on an ad hoc basis/virtually, running in corridors or using whatever room can be found vacant on the day.
- Unmet requests for outpatient clinic rooms from therapy radiographers. This is reduced activity as there are very few rooms for the radiographers at present, and the majority of this work is not being done in a clinic room. Sometimes doctors are picking up this activity even though it is a role that has been agreed for the radiographers to complete to take work off them. Some radiographers partake in specialist work so this would potentially bring in new patient activity if it were to be accommodated, for example HDR brachytherapy.
- Unmet requests for outpatient clinic rooms from CNS's, diatetics, supporting services. Again capacity constraints mean not all of the CNS are able to run their clinics at present or they rely on virtual clinics run from home. Some use main outpatient rooms, some use consultant rooms when they are not in use, or share ad-hoc vacant rooms on rotation.
- C12 oncology clinics to repatriate from main outpatients, allowing for considerably improved synergies - for example, allowing the medical and clinical lung oncologists to run a joint clinic – and freeing up space for other specialties to run clinics, contributing to the elective recovery effort. There are c30 outstanding clinic room requests currently in main outpatients which moving oncology would help to mitigate.

The total estimated weekly clinic session needed from the bullet points above, alone, equates to a minimum of 58 sessions a week (ie 6 rooms). This is before accommodating dedicated research clinics, a breaking bad news room, or new consultant timetables.

The additional demand for space is demonstrated below:

	Immediate Demand (sessions/week)	In clinic room terms / week
Population/incidence growth overall - reflected into number of cancer patients in **consultant clinics** likely to be seen (converted into clinics)	Both are set to increase by 2% per annum	
Population/incidence growth overall - reflected into number of cancer patients in **other clinics** likely to be seen (converted into clinics)		
Current utilisation of main outpatients for consultant clinics (and CNS clinics) at Maidstone	4	0.4
Current outstanding demand pending in main outpatients at Maidstone + TWH	14.5	1.5
Current outstanding demand for outpatient clinic rooms - Radiotherapy (radiographers)	13	1.3
Current outstanding demand for outpatient clinic rooms - CNS's, dietetics, supporting services	18	1.8
Current outstanding demand for outpatient clinic rooms - Research	10	1
TOTAL DEMAND (clinic rooms)		**6**

In addition to the 13 rooms that we need at the moment, the 6 noted above (prudently), give a requirement for 19 rooms in total.

Note that virtual working, better configured and more efficient clinics, and the use of evening and / or weekend clinics prevents the rise in clinic space required being exponential. However, after 30 years and a quadrupling of demand since the Centre first opened, the 10 clinic rooms we currently have are no longer sufficient.

Should there be any spare capacity, certainly initially, this will be used to support elective recovery, trust-wide and we will be making use of the corporate outpatient room booking system to best utilise the space.

It is also important to note that we do not anticipate that an expansion in clinic space will also require an expansion in waiting space, so long as social distancing measures end in the foreseeable future and patient calling is rolled out (plans underway with main outpatients). If this does not happen, we will need to look at our existing space and decide how best we can utilise.

CQC

Continue to work with the Trust to move CQC rating from good to outstanding. Continue to support and maintain our CHKS accreditation

KMMS

We currently do not have enough clinic space to be able to accommodate registrars for the 5/6 clinics a week they should be attending. More and more medical students will be starting to enter the division and we need to make sure that they are given the best learning opportunities possible, and this starts with offering them the space to be able to work.

With the development of the new Kent and Medway Medical School forming a key part of the Trust's strategic objectives, at present in KOC the outpatient space currently available is insufficient to be able to provide the high quality, professional clinical training required. We also know that many of our consultants have worked with us previously as trainees; this pipeline of future consultant oncology talent, with an affection for both the hospital and the local area, will only continue if we can increase the space we have available to accommodate them properly.

Staff Rostering

By providing a more flexible outpatient space and the ability to integrate investigator-led research into our clinician's job plans, we anticipate an improvement in substantive recruitment and retention. This in turn will reduce our reliance and spend on locums (forecasted spend for FY21/22 based on current establish and vacancies is £612,163, calculated in July 2021).

An open-plan office space would also allow us to properly co-locate administrative staff, in particular the MDT coordinators and 2WW teams, both essential to maintaining cancer performance. These teams are currently split between different offices and / or heavily reliant on working from home which is not ideal given the relationships and pace required to ensure patients move through their pathways as quickly as possible. An open-plan work space would encourage cohesive working and better relations, improving morale, performance and, ultimately, staff retention rates.

Space would also allow us to implement clinically-led innovation in patient care, such as 'super clinics'; this is something our consultants wish to facilitate in order to encourage better team working amongst tumour site specialities.

Health and Wellbeing/ Staff Welfare

The division is committed to supporting the health and wellbeing of staff within the division. OP space is an issue constantly fed back as a frustration amongst clinical teams as there is insufficient space for clinicians to see patients/ have face time with them and there is limited flexibility with job plans

- The new build plan incorporates four new staff toilets to support the guidance in welfare facilities for healthcare staff (NHS Staff Council, August 21). This will also provide space for staff lockers too. We would have the option to change one of these toilets into a changing room if deemed more appropriate once the business case is approved.
- The plans also include a communal staff area with kitchen facilities (will include space to prepare and eat food, and drinking water, fridge, microwave).
- There is a lift and non-stair access into the building (both floors) to accommodate disabled patients and/or staff.
- As part of a wider piece of work, we are working to refurbish our current staffing areas and enhance existing facilities (particularly in Lord North). The new building is just an extension of existing space and therefore has been included as part of this to improve the working environment and support staffing space during breaks. As a division, we have recently purchased a staff relaxation hut to provide additional space for staff.
- The clinic room plans have incorporated air conditioning in order to prevent overheating during hot summer days.

Outpatient Transformation

By developing this modular building we hope to contribute to positive outpatient transformation in the following capacities:

- Repatriating KOC clinics from main outpatient department will free up space for other specialties to utilise, reducing their reliance on outsourcing and increasing the number of face to face appointments – for example in trauma and orthopaedics.
- Being able to accommodate multi-disciplinary cancer "superclinics" to more efficiently and effectively consult, diagnose and treat this patient group.
- Making use of the new room booking system, kiosks and patient calling to improve patient flow and throughput in oncology outpatients.

Workforce Supply

The case will support the development of workforce planning within the division, ensuring new pathways are supported within the division in the following ways:

- Allow us to support registrar recruits into the directorate and increase amount of radiographer trainees in the department.
- Run clinics concurrently alongside experienced colleagues and provide a better educational experience for medical students.
- Many of our consultants have worked with us previously as trainees; this pipeline of future consultant oncology talent, with an affection for both the hospital and the local area, will only continue if we can increase the space we have available to accommodate them properly, bearing the new KMMS in mind.

2. Objective(s) and case for change of the proposed investment

*List the project objectives succinctly. (What you wish to achieve for patients **not** what you wish to purchase)*

1. To streamline our oncology clinics to ensure an efficient and outstanding service is provided to our patients and provide better team-working opportunities.
2. To provide space to run purely virtual clinics, taking pressure off clinic room space.
3. To improve overall patient experience at KOC. This includes reducing wait times in phlebotomy and providing a private and comfortable 'breaking bad news' space.
4. To better accommodate our multi-disciplinary clinical team, ensure appropriate training space and maximise PAs. This includes providing the best learning opportunities for our new doctors attending the Kent and Medway Medical School.
5. To properly co-locate and house our growing administrative teams.
6. To improve access to clinical trials and the latest treatments for our patients (currently dependent on dedicated clinic space).
7. Reduce and centralise outsourced clinics, specifically from Medway NHS Foundation Trust.

Relating to each objective; describe the current situation and problem and risks associated with the current situation, the gap from where we are to where *we need to be i.e. the required change and the benefits of achieving the change.*

Objective 1 – Title: Streamline Clinics

Current situation:
The lack of space, and corresponding lack of flexibility this results in, impacts on the morale and goodwill of our clinical body; consultants are having to request clinic rooms last minute and prolong a patient's care pathway, and are regularly working beyond their contracted hours due to clinics overrunning. It is also incredibly difficult to alter job plans due to a lack of space, meaning our staff do not have the flexibility that many require. Clinicians are currently working in silos, as there is no opportunity to run tumour-specific clinics alongside each other. We are outsourcing clinics to Medway and Darent Valley Hospitals, meaning the support to consultants varies significantly (in terms of administration, CNS's and radiographers) due to room availability being limited at KOC.

Problems / risks of current situation:

Our team of consultants, registrars, CNS' etc cannot work in cohesion due to a lack of space and inability to adapt job plans as a result. This does not provide a smooth and efficient patient experience as we are currently asking our patients to see specialists in different areas of the trust, and often at different times which increases how often they have to come to the hospital.

We are currently spending c£26k (net) per annum on a pod outside oncology to allow for spill-over swabbing and phlebotomy space, not currently budgeted for.

The gaps from where we are to where we need to be:
The gap needs bridging with more centralised clinic space in order to accommodate a change in job plan, and allow our consultants to run clinics alongside their registrars and CNS'. The management team will then be able to work with our clinicians to map a better way of delivering care that is beneficial for both patients and clinicians.

The expected benefits of achieving the change:

- A more cohesive service
- Greater opportunities for team working
- Retention of staff as a result of being a part of a happier and more supported tumour site team
- A smooth patient experience- it would allow them to see the right specialist at the right time in the right setting
- The possibility of running 'super clinics'- Consultants wish to facilitate 'super clinics', whereby a number of consultants of the same tumour site, their registrars, CNS' and radiographers all work together in concurrence in the same area of KOC, providing a smooth, quick and efficient service. They have explained that this would allow us to see more patients at a time, reduce wait times between appointments and reduce the amount of appointments a patient would need overall as there would be the possibility to see a number of specialists for different reasons on the same day, at the same time and in the same clinic space.
- No need for an external pod (cost c£26k per annum)

Objective 2 – Title: Virtual clinics

Current situation:

During the height of the pandemic, virtual consultations accounted for c80% of outpatient activity. At present this has fallen to 60%, still too high to provide consistently high-quality and efficient care for this extremely vulnerable patient group. Whilst, given the continued prevalence of covid-19 in the community, there is a necessity to limit face-to-face contact for immunocompromised patients at present, space is the main limiting factor here. In addition, we are seeing a significant number of Datix around virtual appointments and increased duplication, with patients having duplicate appointments for the same matter because the virtual appointment is insufficient.

Problems / risks of current situation:

Whilst the figure has now dropped to 60% (varying from tumour site to tumour site), this is still significantly higher than the national target of 25%. Due to the nature of oncology clinics, i.e. the need for thorough physical examinations, the delivery of bad news and the need for regular bloods, it is far from ideal that we are running such a large number by virtual means.
It should be noted that most clinicians are running "mixed" clinics of virtual and face-to-face appointments. With all clinicians sharing offices, in some cases up to 4, clinic rooms are at present the only space available to run clinics, virtual or otherwise.

The gaps from where we are to where we need to be:

- To increase the number of face-to-face appointments we need additional clinic space to accommodate these patients

- Private office space for consultants to host solely-virtual clinics would reduce the pressure on clinic rooms as such clinics could be located to the 1st floor administrative space

Objective 3 – Title: Improving Patient Experience

Current situation:
We currently do not have a 'breaking bad news' room within the department. The quality of care that patients and their families receive is vital and it is important that outstanding care is provided when delivering this news. Our wait time in phlebotomy also frequently reaches c2hrs.

Problems / risks of current situation:
There have been a number of Datix (see appendix) incidents whereby difficult news is being delivered to patients in corridors, and patients and their clinicians have been asked to vacate rooms during this delivery due to lack of space.

The gaps from where we are to where we need to be:
We ideally need a designated room for breaking bad news, and additional phlebotomy rooms and nurses to staff these in order to make our service more efficient and reduce wait times. An increase in patient activity is only going to put more pressure on the service and increase wait times if not expanded in proportion.

The expected benefits of achieving the change:
- To facilitate the increase in clinic capacity and address the current 2 hour wait times consistently being reached in oncology phlebotomy, we will increase our capacity by 3 phlebotomy chairs, reducing our wait times and improving overall patient experience. It would also allow us to offer a 7am-7pm service if required.
- The ability to run 'super clinics' would provide patients with a more efficient service, as explained above.

Objective 4 – Title: To better accommodate our multi-disciplinary clinical team, ensure appropriate training space and maximise PAs.

Current situation:
Since KOC opened in 1993 we have outgrown our footprint by more than 400%. There are not enough rooms to be able to provide registrars with clinic space to run alongside a consultant clinic or for our specialist trained radiographer team to run their own clinics. This is hindering their learning opportunities as they are not attending as many clinics as they should be in order to train effectively. Registrars should be attending 5/6 clinics a week, but currently can only attend 2/3. To run a multi-disciplinary effective clinic for oncology patients, supporting services such as dietetics and CNS's would also require space.

Problems / risks of current situation:
- Higher rates of medical staff turnover
- Reduced middle-grade workforce
- Limited ability to recruit new and vacant posts (nursing and medical)

The expected benefits of achieving the change:
- Allows us to accommodate the demand for the service
- Allows us to provide students with a comprehensive and immersive learning experience
- Allow enough clinic rooms to provide our consultants with ample space

Objective 5 – Title: To properly co-locate and house our growing administrative teams.

Current situation:

After a review was carried out of office space within the division, it was identified that a significant number of staff were displaced and would benefit from a 'hot desking' area. Staff are working in rooms that are not designated office space, such as cupboards and storage rooms. There is not enough space for staff to come back to site following the pandemic after working from home.

Problems / risks of current situation:

An open-plan office space would also allow us to properly co-locate administrative staff, in particular the MDT coordinators and 2WW teams, both essential to maintaining cancer performance. These teams are currently split between different offices and / or heavily reliant on working from home which is not ideal given the relationships and pace required to ensure patients move through their pathways as quickly as possible.

The gaps from where we are to where we need to be:

An additional 20 desks minimum would greatly improve the situation and allow the large majority of our admin staff body to return to site, at least on a part time rotation.

	Total team headcount	Number of people on site at any one time (needing space)	Number of people wfh at any one time	20% annual leave and sickness	Total desks required	
MDT coordinators	18	10	8	2	8	*Rotate through the office but on-site presence needed*
2WW office	8	8	0	1.6	6	*All admin, needed on site at all time*
STT nursing team	12	7	5	1.4	6	*9 nurses, 3 admin, (looking to recruit additional 5 nurses in next 6mths)*
CNS	70	21	1	4.2	17	*Many patient facing roles, but currently not enough admin space as is*
Total					37	

The expected benefits of achieving the change:

An open-plan work space would encourage cohesive working and better relations, improving morale, performance and, ultimately, staff retention rates. This relocation would also release a number of desks in our current administrative spaces, and reorganise the way clinical teams work within this space, for example for our CNS team who currently have a handful of desks (trust-wide) between them and acute oncology, who are currently located separately from the clinical areas.

We note that the areas released would not require any capital investment and minimal revenue. They would be repurposed as clinical office space in clinical areas.

Objective 6 – Title: Clinical Trials

Current situation:
KOC is currently the only cancer centre nationally without dedicated clinical trial clinic space; even centres smaller than ours have at least 1 room. We turn down 3-5 lucrative clinical studies a year as a result, losing out on a conservatively estimated income of £100,000.

Problems / risks of current situation:
A number of commercial research trials are stating that a dedicated research space is a pre-requisite to participating in the trial. We are limited in the number of patients we can recruit to trials as there is no guarantee of a clinic room/space being available. We have also yet to show that research is integral to KOC patient's treatment as they are not being seen in a KOC capacity, but as research patients when

participating in a trial. The aim is to integrate these and show that research is embedded in patient care. As part of the consultant recruitment drive we have recently launched, we have stressed the importance of clinicians getting involved in research and clinical trials integrating this in their job plans. In order to do this, we need to ensure that we can accommodate this increase in research activity with dedicated clinic space.

The gaps from where we are to where we need to be:
We need at least one research-dedicated clinic rooms to be able to accept new investigator-led clinical trials.

The expected benefits of achieving the change:
Our research and development department are trying to expand their scope in cancer research, and additional space would allow us to begin 'investigator-led studies', allowing us to facilitate up to 12 studies a year, with the potential to bring in an additional income of c£100K per/year (a conservative estimate, as trials can range from £500-£100K income each). As income is based on the amount of recruits, more clinic space to see participants will increase the number of recruits, and in turn increase income, staffing and access to drugs (all paid for by external companies facilitating these trials, but benefitting all KOC patients).

Objective 7 - Title: Reduce and centralise outsourced clinics, specifically at Medway.

Current Situation:

Due to a lack of space in outpatients at MTW:

- We outsource 12 clinic sessions per week to Medway
- MTW Main Outpatient departments hosts 25 oncology clinics a week

Problems / risks of current situation:

- We currently spend c£10,000/annum on staff travel to Medway from MGH
- We are asking our consultants to travel between sites when this is not always convenient for them, and consultants like to have a link with the Maidstone site, which some don't due to space constraints. This has been noted as a point deterring potential applicants from taking a role at MTW.
- Medway does not have sufficient space to accommodate these clinics in a sustainable way and offers little to no clinical support (ie CNS / CSW roles).

3. Constraints and dependencies

Describe any constraints and dependencies e.g. financial resources, ability to recruit and support from other departments etc.

- Coordination of project and delivery time is dependent on the capacity of the estates management team.
- The ability to pay for this project is dependent on securing surplus capital funds and being able to complete this project by the end of this financial year.
- The safe operation of an additional 9 clinic rooms and 4 phlebotomy chairs is dependent on the recruitment of additional nursing staff.
- The maintenance and cleaning of the additional space is dependent on the capacity of the estates and facilities team.

4. Short list of options

Show the short list of alternative ways to meet the objectives you have considered e.g. Variations in scale, quality, technique, location, timing

Option 1 Title: The do-nothing option

Description

This option would not require any additional investment. We continue to operate KOC at its current state and capacity, at no extra cost. There will be no estates input, project management or construction services required. A review and reorganisation of the department would not be needed, and therefore there would be no potential disruption to the service as a result. However, we would continue to have a growing backlog of patients waiting to be seen, our wait times for phlebotomy services would not decrease and overall patient experience will not improve, but likely get worse as a result of increasing patient activity.

Key activity and financial assumptions:

Based on assumptions outlined in the strategic summary there would be no impact on income or expenditure. However, the impact on cancer performance, patient experience and, ultimately, patient care is likely to be significant.

Non-financial risk associated with the option:

- There is a risk that the oncology directorate cannot meet demand, nor recruit and retain clinical staff due to inability to accommodate them.
  Mitigation: consultant recruitment drive, currently out to advert.
- There is a risk that there would be temporary disruption to the service and a result of building works and reorganisation of the department
  Mitigation: Identify areas most affected and relocate temporarily if able, or organise works to occur during OOH.
- There is a risk of being unable to meet patient activity increase due to lack of oncology outpatient clinic space, increasing wait list times.
- There is a risk that morale amongst our administrative staff will continue to diminish as a result of being displaced and teams fragmented
  Mitigation: we are trying to relocate teams offsite to allow cohesion, however this isn't always appropriate as staff are then moved away from clinicians and have limited access to resources and notes
- There is a risk that we will not be able to wholeheartedly support registrars and doctors who are learning with us (the number of which will increase as a result of the new Kent and Medway Medical School) as we do not have the space to accommodate them
- There is a risk that we will not be able to accept new clinical trials as we currently do not have the space to host them.
  Mitigation: currently a business case by the research department to renovate another room into an additional clinic room, yet to be approved.

Non-financial benefits associated with the option

- There would be no potential disruption to the service as a result of a review

Option 2 Title: Two Storey Building (clinic rooms and additional administrative space)

Description
The preferred option is a two-storey modular building that will host an additional 9 clinic rooms on the ground floor, 2 phlebotomy rooms hosting 2 chairs each which can also be turned in to clinic rooms as required depending on demand for clinic rooms and virtual space. We would be employing our own phlebotomists which would allow us to use them as healthcare assistants as well as phlebotomists and make them a properly integrated part of the nursing team.

We would also be able to host an open plan administrative space to accommodate c30 staff on an additional floor.

To facilitate the increase in clinic capacity and address the current 2/3 hour wait times consistently being reached in oncology phlebotomy, we will increase our capacity by 3 phlebotomy chairs, reducing our wait times and improving overall patient experience.

Finances – see appendix 9

Non-financial risk associated with the option

- There is a risk that there would be temporary disruption to the service and a result of building works and reorganisation of the department
  Mitigation: Identify areas most affected and relocate temporarily if able, or organise works to occur during OOH.

Non-financial benefits associated with the option

- We would be able to host and recruit more patients to clinical trials, including investigator-led studies
- We would be able to provide a more efficient phlebotomy service, reducing wait times and improving patient experience
- Our registrars could be provided with a room for 5/6 clinics a week rather than 2/3, improving their learning experience
- We would be able to accommodate 30 administrative staff in an open-plan space
- We would no longer need to rent the portacabin we have within department for pre-chemo swabbing/phlebotomy services, saving c£25K annually

Option 3- Title: Unit B, Hermitage Court

Description
This option differs from the previous, in that it would involve renting a unit that has already been built in Hermitage Court, Hermitage Lane. The unit, once fit-out to our spec, would allow us 9 clinic rooms and a phlebotomy room hosting two chairs on the ground floor. On the first floor it offers ample office space to accommodate the c30 displaced staff from KOC.

It provides us with almost all the benefits of installing an extension to the existing oncology outpatient structure, however it is a 5/10-minute walk from the main site and would require consideration for parking and transport arrangements. However, it does reduce the build costs and would allow us to move in much quicker than the previous options.

This would require all the same staffing, IT and equipment as the previous option.

Finances
The rent for this building is £128,400 per year.
The parking for x28 spaces on the site is £8700 per year.

The fit out of this building has yet to be costed.

Non-financial risk associated with the option

- There is a risk that there would be temporary disruption to the service and a result of building works and reorganisation of the department
  Mitigation: Identify areas most affected and relocate temporarily if able, or organise works to occur during OOH.
- There is a risk that the site won't be accessible to all patients as it is away from the main KOC
  Mitigation: Considerations for a shuttle bus service to go between HC and KOC. Parking at HC can also be procured.
- There is a risk that not all patients could be seen in this location if certain diagnostics would be required at the OP appointment

Mitigation: Patients requiring diagnostics can be placed in clinics at main KOC site. Could move clinics only needed consultation and no intervention. Diagnostics also looking to move down to HC so can link in service and synergies.

Non-financial benefits associated with the option

- We would be able to host and recruit more patients to clinical trials, including investigator-led studies
- We would be able to provide a more efficient phlebotomy service, reducing wait times and improving patient experience
- Our registrars could be provided with a room for 5/6 clinics a week rather than 2/3, improving their learning experience
- We would be able to accommodate at least 30 administrative staff in an open-plan space with communal space
- We would no longer need to rent the portacabin we have within department for pre-chemo swabbing/phlebotomy services, saving c£25K annually

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 Do nothing	Unable to meet demand in patient activity, diminish staff morale, not able to accommodate consultants/registrars, unable to accept new clinical trials. However, no disruption to service.	Low benefit. Ranked 3/3
Option 2 2-Storey Modular Build	Recruitment would be required for safe staffing, reorganise the current KOC layout to better our patient service, there may be temporary disruption to service. However, we would be able to accommodate growth in demand, be able to host more studies, run more efficient phlebotomy service and accommodate increase in consultants and registrars (improved flexibility). We would be able to accommodate admin staff and have a small communal space, improving staff welfare and efficient working for the cancer performance team.	Optimum benefits. Ranked 1/3
Option 3 The Oast	Recruitment would be required for safe staffing and risk that not all patients would be able to be seen at this site if diagnostics required. However, we would be able to accommodate growth in demand, be able to host more studies, run more efficient phlebotomy service and accommodate increase in consultants and registrars (improved flexibility). We would be able to accommodate admin staff and have a small communal space, improving staff welfare and efficient working for the cancer performance team.	Ranked 2/3

4b. Summary of information on each option.

Option 2

Financial impact of the preferred option – full year effect – include VAT unless recoverable

The preferred option is shown below as a conventional capital purchase option.

Costs are noted below.

Conversations are currently taking place with the CCG around financing this cost. We are aware that the 17% increase in outpatient attendances. since the move to a block contract arrangement in March 2020 (based on 2019/20 activity, is unlikely to be funded in full. As such, our argument is instead for the run-rate to increase by £380k per annum in order to cover the costs of the additional clinic space, helping elective and, in particular, cancer recovery following the global pandemic.

Capital option

Monies from the internal Trust capital plan have been identified for this project, subject to approval at governance.

The total capital cost quoted for the 2-storey modular build, including the associated ground works and modular installation costs involved option is £1,028,201, inclusive of VAT. The building would have a useful economic life of 60 years and be depreciated accordingly.

Given that we are still at the early stages of agreeing the cost and in order to cover for any "unknown, unknowns", we have added a 5% optimism bias to this, giving a total of £1,079,611 inclusive of VAT.

In addition, there are £113,000, inclusive of VAT for IT costs (£118,649 incl Optimism Bias). The IT costs are assessed as capital whilst the furnishings are classed as revenue (room set up). It has been assumed these would need refreshing periodically.

The total capital cost, including optimism bias of 5%, would therefore be **£1,198,260.**

		Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Depreciation	Building and Installation	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994	17,994
	IT	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600	22,600
PDC	Building and Installation	37,471	36,842	36,212	35,582	34,952	34,323	33,693	33,063	32,433	31,804
	IT	3,109	2,418	1,727	1,036	345	3,109	2,418	1,727	1,036	345
Other Expenses	Pay	174,844	233,126	233,126	233,126	233,126	233,126	233,126	233,126	233,126	233,126
	Consumables	2,273	2,342	2,412	2,484	2,559	2,635	2,715	2,796	2,880	2,966
	Room Set up	61,000	0	0	0	0	0	0	0	0	0
	Hard & Soft FM	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979	45,979
	Diagnostics	12,240	16,319	16,319	16,319	16,319	16,319	16,319	16,319	16,319	16,319
	Total	**377,510**	**377,619**	**376,368**	**375,120**	**373,874**	**376,084**	**374,843**	**373,604**	**372,367**	**371,133**

Please see appendix 7 for detailed assumptions for all other costs.

Medway

Medway have made indications that they can no longer accommodate the 12 clinics a week running at their site – historically it was 16 but 4 have already been repatriated to Maidstone due to lack of clinic space at Medway. We have incorporated this separately, rather than making Medway income part of the case, as there is still a significant amount of work to do to agree the transfer of this activity, including gaining agreement from the CCG

Based on 2019/20 tariffs, and assuming minimum growth of 2% per annum, indicatively, this would generate c£900k of income per annum. Offset against this is the loss of the SLA income currently received, an increase in consumable costs, to which we have applied a prudent 6% growth, given the growth levels we have seen in reality in the past five years and CNS support costs (as CNS provision is currently provided by Medway).

As part of the negotiation, and the new NHS finance regime, we would need to review the below income assumptions, to ensure our costs were covered at a minimum.

Note that much of the pathology and diagnostic provision for these patients is already conducted at Maidstone and the diagnostic costs incorporated in the above will be sufficient to cover this repatriation.

Medway					
	Y0 (21/22)	Y1	Y2	Y3	Y4
Income	869,800	887,196	904,940	923,039	941,499
Loss of SLA	- 577,860	- 577,860	- 577,860	- 577,860	- 577,860
Increased consumables	7,880	8,353	8,854	9,385	9,948
CNS support to clinics	-	116,950	116,950	116,950	116,950
Total	299,820	434,639	452,884	471,514	490,538

Assumptions:	
Consumables	Based on 10% of £75279 current full-year spend (relative to Medway activity), then 6% growth added each year (average for the past 5 financial years)
Loss of SLA	We will lose this money if activity is returned to MTW
Income	Based on current FOT21/22 income, with 2% growth each year (minimum assumed - the average for the past 5 financial years has been 6%)
CNS support-	2 x B7 / B8a CNS support to the repatriated clinics (currently provided by Medway, albeit sporadically)

4c. Directorate decision on which option is preferred and why

Has the cost, benefit and risk been identified?

Option 2 is the preferred option as it allows us to accommodate clinical and administrative staff in an appropriate setting. It would allow the Cancer Division to streamline oncology clinics to ensure an efficient and outstanding service is provided to our patients and provide better team-working opportunities for our clinicians. It would improve our ability to accommodate clinical trials and, as such, provide the latest treatment for our patients. It would improve the overall patient experience at KOC as a result of better flow, improved wait times, and greater efficiency – "*right person, right place, right time*". We would also be able to accommodate the growing consultant body and the new cohort of doctors coming through from the Kent and Medway Medical School in a flexible and efficient manner. A 'clinical hub' in the centre of these rooms that can also be reverted back into two when there is demand, will allow communal working between, consultants, registrars and the nursing team, further improving both the learning experience for new clinical staff, and patient experience.

The cost has been identified and a plan has been set out to illustrate how costs will be covered after a period of time.

The benefits greatly outweigh the risks, and this modular building would be a huge step in the right direction for the evolution of KOC. This facility would be the first step in increasing oncology capacity and capability and support the move towards incorporating research consultations into standard clinic templates.

The risk of moving forward with this project has been mitigated by working with the estates team to ensure that timescales are realistic and deliverable, and each deadline is being met.

NOTE: From this point onwards the sections should be completed for the preferred option only.

5. Commercial considerations (preferred option)

5.a. Services and/or assets required

Please see appendix 4, 7 & 8

5.b. Procurement route

Proposed sourcing option, with rationale for its selection; key features of proposed commercial arrangements (e.g. tendering, framework agreement, contract terms, contract length, payment mechanisms and performance incentives).

Following the identification for the need for additional clinic rooms we set about exploring options to procure a new building (in shell form) and obtained quotes. A quote for the modular building and installation and development was provided by Wernick Group Limited. The building will be sourced through a procurement framework which will allow a direct award.

The contents of the building were procured through companies that MTW have existing contracts with for office and clinic supplies. There were certain objects that several quotes were provided for, e.g. patient chairs, but considering they carry out the same option we chose the more cost-effective option whilst also making sure trust standards are met where necessary.

Anita Friday from MTW Trust IT provided the costing for all the additional IT equipment based on their existing contracts.

5.c. Activity and service level agreement (SLA) implications.

- It is not extremely unlikely that the additional activity we have seen over the past five financial years would be funded by commissioners under the previous payment by results (pbr) arrangement. However, if it were, the overall income figure would increase by £1.4million per annum in 21/22, based on the forecast outturn position and using the same tariff assumptions seen in 19/20. The below table sets out the detailed income movements in full.

Site	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FOT21-22
Consultant Led						
FUP	405,939	446,547	458,391	440,907	542,850	607,710
NEW	218,950	274,216	292,034	208,682	224,084	262,136
MED	**624,889**	**720,763**	**750,425**	**649,589**	**766,934**	**869,846**
FUP	2,559,714	2,390,937	2,454,387	2,529,963	2,814,783	3,109,614
NEW	1,105,924	1,008,680	1,142,164	1,173,874	1,140,352	1,258,736
MKOC	**3,665,638**	**3,399,617**	**3,596,551**	**3,703,837**	**3,955,135**	**4,368,350**
Total	**4,290,527**	**4,120,380**	**4,346,976**	**4,353,426**	**4,722,069**	**5,238,196**
Other Non-Consultant Led						
FUP	2,732,862	2,594,118	2,880,066	3,281,070	3,326,331	4,023,858
NEW	1,020,458	876,102	908,416	793,958	527,292	672,252
MKOC	**3,753,320**	**3,470,220**	**3,788,482**	**4,075,028**	**3,853,623**	**4,696,110**
Grand Total	**8,043,847**	**7,590,600**	**8,135,458**	**8,428,454**	**8,575,692**	**9,934,306**
Movement		*- 453,247*	*544,858*	*292,996*	*147,238*	*1,358,614*
% Movement		*-5.6%*	*7.2%*	*3.6%*	*1.7%*	*15.8%*

- Whilst we do not expect this level of reimbursement, given the current financial climate, it is clear from the table above that the implications of the increased activity are significant.
- Additional activity as a result of population/incidence growth has been included in our commissioning intentions letter. It should be considered that we have still been carrying out commissioned activity which has grown by an average 7% per annum since the pandemic.
- Note that the above does show the income implications of the Medway activity. If this were to be repatriated, it is important to note this would net off against the current income received of £577,860 from the Medway SLA.

5.d. Workforce impact:

Additional staffing requirements	Band	WTE	Total Cost
B5 registered nurses	B5	2.14	£81,183
B3 clinical support workers (CSW)	B3	8.46	£226,998
Upgrade of existing B2 (CSW) to B3		7.82	-
B3 phlebotomists	B3	2	£52,328
Less current bank costs (not in budget)			-£127,383
			£233,126

The table above explains how we will staff the additional clinic space and makes the following assumptions:

- The additional recruitment of 2.14 WTE band 5 registered nurses and 8,46 WTE band 3 CSWs is based on safe staffing levels aligning with the expansion of clinic space.
- The Saturday posts identified are currently an overspend on weekend nursing staff, and something we will incorporate into our run rate in order to continue to run Saturday clinics. Note that the total cost noted in the finance tables, deducts current bank spend of c£127k per annum, in order to staff weekends, evenings and other out of hour clinics.
- We have also assumed an upgrade of band 2 CSWs in oncology outpatients to band 3, to align oncology with main outpatients, which also sits within the cancer division.
- We have assumed the employment of our own phlebotomists (x 2 WTE B3 phlebotomists) in order to service the additional phlebotomy capacity in the new build, as discussed with pathology. This will ensure a reduction in waiting times (patients are regularly waiting over 2 hours for bloods) and make the phlebotomists part of the nursing team, thus allowing greater flexibility (ie to help as CSWs, with swabbing etc).

6. Financial impact of the preferred option –
Full year effect – include VAT unless recoverable

See section 4.2 for the financials of the preferred option.

7. Quality Impact Assessment (preferred option)

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Yes Charlotte Wadey (DDNQ) Henry Taylor (CoS) Justin Waters (CD) Rosalyn Yates (Matron) Andrew Brown (CNS) Russell Burcombe Joanne Green- sign off from IPC 12/10/21	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes- clinics based on NHS standard layout	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Yes- cancer performance standards are measured. The reduction in follow up patient waiting list is also monitored.	
Are there any risks to clinical effectiveness? If yes, list	
No, additional staffing has been factored into the case.	
Have the risks been mitigated?	
Yes	
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- please see outlined in main body of the case (e.g. improved consultant recruitment, time from referral to appointment, multi-disciplinary working)	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y/N
Safeguarding vulnerable adults/ children?	Y/N
Current quality indicators?	Y/N
Quality Account priorities?	Y/N
CQUINS?	Y/N
Are there any risks to patient safety? If yes, list	
No	
Have the risks been mitigated?	
N/A	

Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to patient safety? If yes, list
Improved consultation experience, more time for research patients to be seen, ad-hoc, emergency attendances better managed.
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Yes
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
Yes- equal access to all patients
Does the redesign lead to improvements in the care pathway? If yes, identify
Yes, streamlined clinics to provide convenience for patients, better flow, reduced wait times for appointments and phlebotomy
Are there any risks to the patient experience? If yes, list
No
Have the risks been mitigated?
N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
Yes- streamlined clinics to provide convenience for patients, better flow, reduced wait times for appointments and phlebotomy
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
Has any negative impact been added to the departmental risk register and a review date set?
Service
What is the overall impact on service quality? – please tick one box

Improves quality	✓	Maintains quality		Reduces quality	

Clinical lead comments

8. Project management arrangements

Timetable

Include at a minimum the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date
Planning complete	August/September 2021
Finance approved	September 2021
Building procured	October 2021
Staff recruited	February 2022
Installation commenced	November 2021
Installation completed	February 2022
Go live date (fully operational)	March 2022

9. Arrangements for post project evaluation (PPE)

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

Complete the following section now

Name of Division/Directorate
Evaluation manager
Project Title & Reference
Total Cost
Start date
Completion date
Post project evaluation Due Date

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS

Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

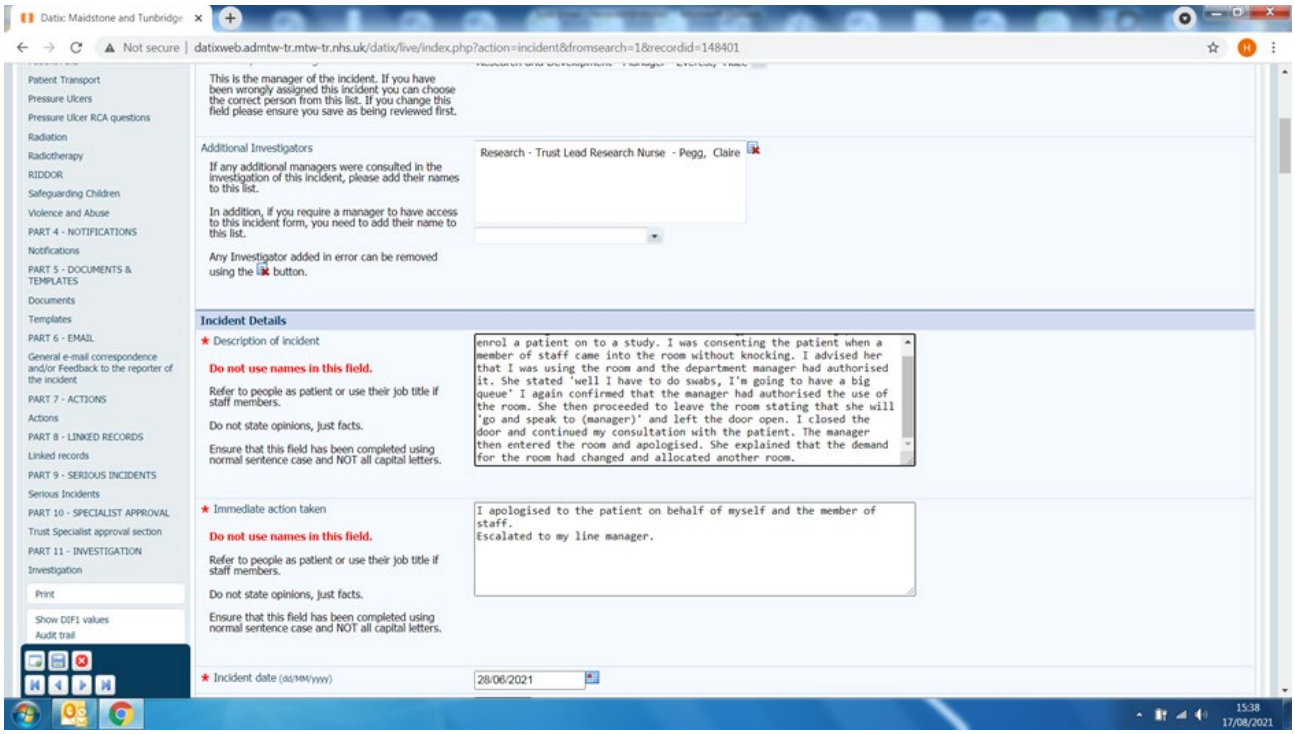
SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how where such resolved?
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

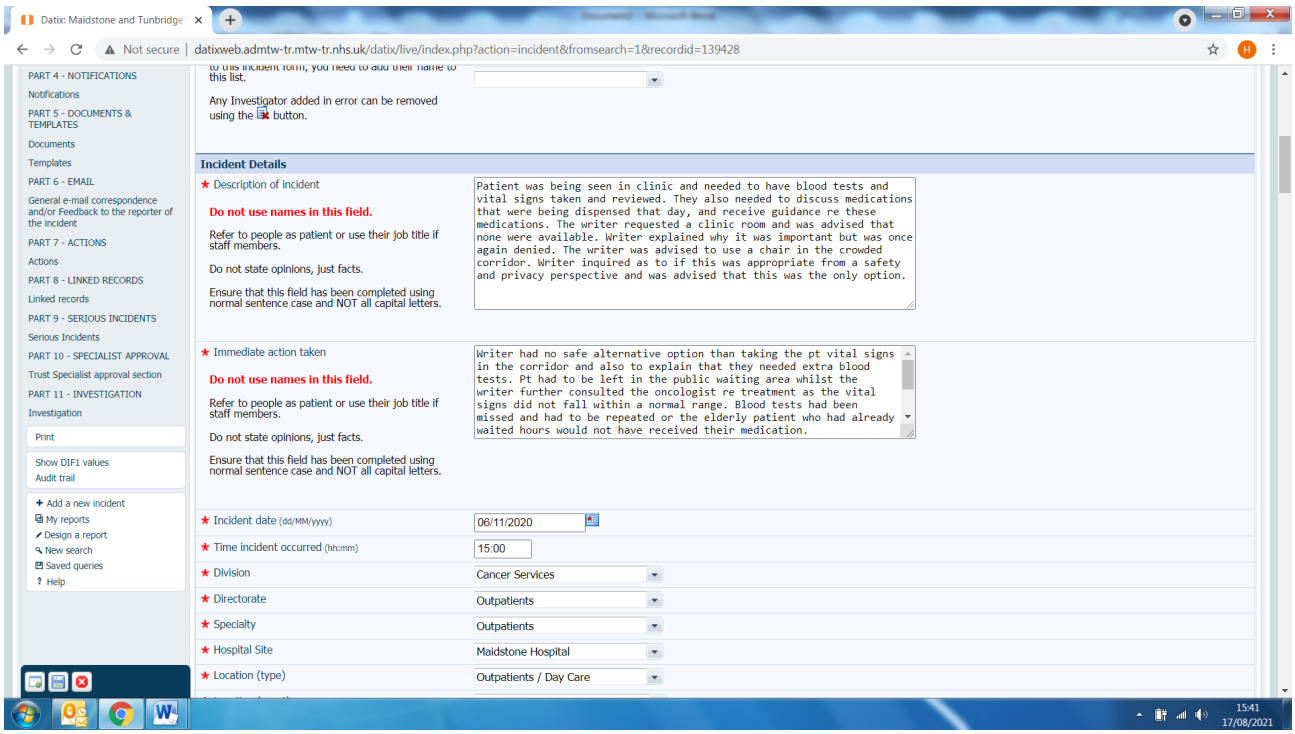
10. Appendices

Add any additional supporting information here. Include detail of activity and financial information as appropriate. Please do not embed files into this document.

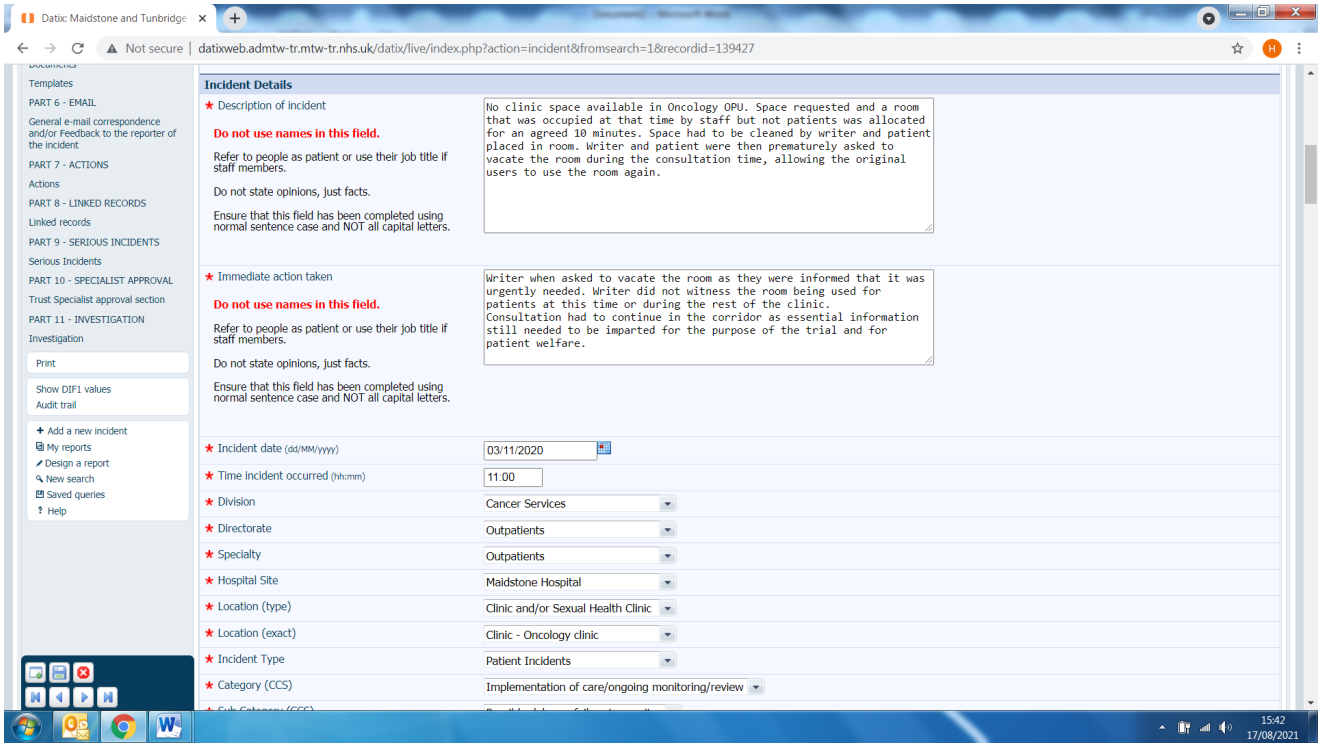
Appendix 1



Appendix 2



Appendix 3



Appendix 4 – IT costings (capital)

[Oncology Modular OPD IT Costs - Dec 6th 2021.pdf]

Appendix 5

VCA feedback from the FFT Survey

Neutral	Would you be happy to use the service again if offered? If No please specify why	still prefer seeing the consultant in person	29 Apr 2021	78857
Neutral	What disadvantages did you experience?	Due to significant hearing loss telephone and video calling is more difficult than face to face	29 Apr 2021	78804
Neutral	What disadvantages did you experience?	Due to hearing loss face to face is far better than video or telephone calls	16 Apr 2021	78103
Neutral	Would you be happy to use the service again if offered? If No please specify why	Would prefer to see someone in person	12 Apr 2021	77960
Neutral	What disadvantages did you experience?	i am not a tech person prefer to speak o someone face to face	12 Apr 2021	77960
Neutral	What disadvantages did you experience?	Nothing quite beats face to face interaction	01 Apr 2021	76927
Negative	Would you be happy to use the service again if offered? If No please specify why	If I had the option of a face to face appointment I would not accept a virtual call again.	27 Apr 2021	78681

Neutral	What benefits did you experience?	none of this apply as I would be happier with a face to face appointment	26 May 2021	80912
	We welcome any further suggestions you may have on how we can improve this service:	i hope after covid face to face consultations will return	30 Jun 2021	88198
Neutral	What disadvantages did you experience?	The technical difficulties made it more difficult so face to face would have been better to have a conversation about my condition.	09 Jun 2021	83214

Appendix 6

Copy of equipment schedule.xlsx

Appendix 7 – Financial Assumptions:

Assumptions:		
Revenue assumptions		
Pay-		*Assumed 1/2 required additional staffing in Y1 to allow time for recruitment to all necessary posts.* *New additional staffing requirements based on safe staffing levels to cater for 9 extra rooms: 1.6xB5, 7.38xB3, 2xB3, 0.54xB5, 1.08xB3, 7.82x B3 (upgrade from B2)* *Assumed 75% recruitment in year 1*
Consumables-		*Cost based on 6% increase in activity per annum (as seen on average since FY16/17).* *Added to current annual consumable expenditure of £75K per annum.*
FM Costs-		*Based on standard costs per square metre provided by estates for utilities. Installation costs included in fit-out*
Diagnostics-		*Costs incurred as a result of annual activity growth will be addressed at business planning year on year. Assumed 75% recruitment in year 1*
Capital assumptions		
Building-		*The building & installation valued at £703,000 has been depreciated over a 60 year useful economic life.*
IT-		*Estimation given to accommodate the 9 clinic rooms and admin space with IT equiptment, phones, wiring and installation costs- subject to a thorough review once plans and layout of building has been agreed. IT equipment has been depreciated over a 5 year useful economic life.*
Room set-up-		*Based on fitting out clinic space to standard spec, using established procurement routes and suppliers. Equipment has been depreciated over a 10 year useful economic life.*

NHS Maidstone and Tunbridge Wells NHS Trust

Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds	**Chief Nurse; and Medical Director**

It was agreed at the Trust Board meeting on 23/09/21 that an update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds should be scheduled at the Trust Board's meeting in December 2021. The report is enclosed.

The enclosed report provides information on the fact that the COVID-19 pandemic has had an enormous impact on the mental health of children and young people, and has led to an increased demand on services.

These young people attend the Trust with serious mental health needs, especially in crisis with eating disorders, self-harm and attempted suicide. They spend long periods of time (weeks to months) in an acute paediatric bed waiting for a CAMHS residential placement or a Tier 4 Psychiatric Intensive Care Bed.

Which Committees have reviewed the information prior to Board submission?

- None

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

- Information

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

Paediatric Report for Trust Board

Children and young people with Mental Health related Issues

December 2021

Background

The COVID-19 pandemic has had an enormous impact on the mental health of children and young people, and has led to an increased demand on services. These young people attend MTW with serious mental health needs, especially in crisis with eating disorders, self-harm and attempted suicide. They spend long periods of time (weeks to months) in an acute paediatric bed waiting for a CAMHS residential placement or a Tier 4 Psychiatric Intensive Care Bed.

This is not a good or appropriate setting for a child, young person or their family, as none of the therapies available in a specialist CAMHS unit are available on an acute paediatric ward. In addition, there has been an increase in children with serious behavioural difficulties presenting at acute hospitals, often being brought to A&E by place as it's the only 'safe' place for them. This is not ideal for a child or their family, for staff, or for general paediatric capacity. It frequently means general paediatric inpatient capacity is reduced (as the children require more intensive nursing than a general paediatric patient – 1:1 RMN support, security support / police depending on sectioning under mental health act and the need for restraint), and can be extremely stressful for staff and other patients and their families. Not only did this increase the risk of children and young people's symptoms worsening and reaching crisis point, it also led to them being cared for in unsuitable environments with extended length of stay on the acute paediatric wards.

There is a risk that due to increased demand for child and adolescent mental health services, that children and young people seeking referral via acute trusts may experience protracted waiting times to access these specialist services. This has the potential to result in patients finding themselves treated in inappropriately or inadequately staffed environments for their needs. This therefore could result in risk to patient safety and reduced outcomes for these patients.

Kent and Medway System Response (Sept 2021)

Key areas of most concern that were identified by the Kent and Medway partners in early June 2021 were:

- Access to Tier 4 beds including eating disorder beds
- Number of children and young people in emergency departments and paediatric wards who were waiting for a Tier 4 inpatient bed
- Number of children and young people in emergency departments and paediatric wards who were unable to access appropriate care or support within the community due to behavioural or social care needs
- The safety and safeguarding of children and young people within the pathways
- The acuity of physical, mental health and behavioural need of children and young people within the complex and crisis pathways
- The capacity of the acute trusts to manage the level of demand and acuity
- The capacity of the NELFT Crisis team to manage the level of demand and acuity

Impact at MTW

Reduction of inpatient bed capacity and ability to accept acute paediatric admissions when areas have to be restricted due to a child or young person in mental distress

Lack of appropriately trained staff to support and provide help/care as additional agency RMNs are required to ensure safety and maintain enhanced care observations of high-risk young people.

Environment not suitable accommodation for patients with mental health issues. Risk of self-harm, greater attention has to be paid to access to exits, ligature points etc. once ligature free rooms are full and all cubicles at MTW other than the low risk 16a/ 9a and 9b have the added risk of an ensuite bathroom

Increase in reported incidents involving physical and mental Harm to patients and staff due to violence, aggression and difficult behaviour, which are likely to increase due to patient's being together able to copy, or becoming more distressed by observing the behaviour of others.

Potential impact on other patients accommodated in the same area, if behaviours are violent / aggressive, or otherwise distressing for people to see.

Risk to patient dignity if the young person's behaviour is witnessed by other children and families also in the department who may have less of an understanding of the issues

Agency staffing has been seen to be provided with limited experience/knowledge/

Increase in need for security staff to remain on the unit to ensure able to de-escalate and restrain if required.

MTW data

82 children and young people were admitted to the paediatric inpatient ward with a mental health related issue between 1st April 2021 and 30th November 2021 utilising 879 bed days with the longest length of stay for one young person with an eating disorder, who remained on the ward for 146 days under section 2 before being discharged home with community support

Of these:

- 9 children awaited a tier 4 bed: The average length of stay for a Tier 4 bed was 19.5 days with the longest length of stay of 64 days.
- 8 required a residential mental health bed: The average length of stay for a residential bed was 19.25 days with the longest length of stay of 85 days.

New developments at MTW

While MTW paediatric directorate has been extremely proactive in the development of pathways, risk assessment and staff development / training it has been extremely difficult to ensure that there are enough staff with the right skills in the right place to meet demand. The trust does not employ any RMNs and therefore agency staff are required to support these young people.

There are a number of initiatives implemented at MTW which are being discussed with and some are now rolled out across the ICS.

- The mental health liaison role has been so successful that the CCG have taken this model and funded one wte in every paediatric inpatient unit in Kent and Medway for one year using MTW Job description and information to format the post.
- The youth worker role is being reviewed currently and MTW are out to advert as the pilot trust site
- The use of band 3 Mental Health Clinical Support Workers is proving very effective and MTW are leading on this pathway
- New task and finish group in place to review ambulatory care for young people with eating disorders who instead of being an inpatient for 10 days can ambulate to Woodlands Unit for daily tests and review from day 5 if compliant
- Development of low ligature rooms in Paediatric ED, Woodland Unit, Riverbank Unit and Hedgehog

The National audit for Children and Young People with mental health issues was completed in May 2021.

MTW Paediatric Mental Health Support for Children and Young People Action plan – December 2021

Actions	Leads	RAG	Governance
Paediatric inpatient mental health guideline in place with appropriate risk assessment forms.	Jackie Tyler / mental Health Liaison Nurses		Qpulse Training records
Monthly – 6/52 meeting reinstated between Directorate Leads	Jackie Tyler for MTW / Wayne Bennett for NELFT		Minutes
Weekly conference call with NELFT crisis team to review all CAMHS patients on Hedgehog in place Weekly CAMHS complex patient call in place weekly led by NELFT	Jackie Tyler / Mental Health Liaison Nurse/ Alison Jupp / NELFT		Documented in medical records Report of agenda items discussed across network
All NELFT reviews and action plans to be documented in medical records	Team leaders for Crisis team		Audit monthly
NELFT to change terminology as to what level of nursing care is required as they write RMN when they mean 1:1 which means we can staff more effectively and reduce delays in ED	Team leaders for Crisis team		Agreed with NELFT Feb 2021 Audit
Long term children who are sectioned and had a > 2 week wait for a tier 4 bed to have a Tier 4 review meeting with leads from all areas to ensure learning	Alison Jupp / Jackie Tyler		Weekly Complex crisis meeting in place led by NELFT lead
Information escalation pathway and on LEAP (local emergency area protocol) meetings and CETR (Common Education Treatment Reviews) with flow chart and time line to be circulated	CETR / LEAP Chair Mental Health Liaison nurse		Included in guideline on Qpulse
Team leader of crisis team to help with the writing of care plans for long stay patients to support care provision	Camhs Crisis Team/ Paediatric Mental Health Liaison nurses		Monthly audit Discussed at weekly meeting
Clear structure to be implemented for those deemed medically fit including liaison with schools and use of play team / nursery nurses to provide sessional activities	Paediatric Mental Health Liaison nurses / Play team		Documented in medical records
Information to be shared re Agency staff –Contact made with the agency NELFT uses regarding trained and untrained staff availability (Meditemp) Band 3 mental health staff now employed on agency line for paediatrics – agreed with Nicola Sharpington	Jackie Tyler		Contact in place for organising staff
Data analysis and contracts review for funding as admitted under paediatrics? camhs drop down on Allscripts	Jackie Tyler /Mark Pordage		Currently no additional funding

Actions	Leads	RAG	Governance
Complete national audit NECPOD	Jackie Tyler/ Dr Jay Halbert		Completed and action plan in place with NELFT
Current guideline to be circulated to Wayne Bennett, Peter Hyland and Ian Markin (Team leaders for crisis team) for review of ED assessment tool – ED assessment tool updated to allow use of ambulatory areas for low risk patients	Angela Clarke / Paediatric Educator		Breach data Monthly audit
Implementation of training to all staff including adult ED, paeds ED and SSPAU New STPN training and train the trainer for de-escalation implemented, we can talk training available on eLearning for all staff, bite size training provided by CCG	Margaret Trend / Mental Health Liaison Nurse / Jackie Tyler		Training records
Ensure ligature free room available and appropriate information is held in all ED areas on both sites – new ligature rooms on Woodlands and Riverbank in place alongside inpatient rooms.	Mental Health Liaison Nurse / Ward managers		Risk assessments and rooms in place
Update currently triage assessment tool to allow children to move to ambulatory care if applicable	Liz Kinnersley / Margaret Trend		To be reviewed Jan 2021 and audited
Safeguarding lead to be informed of any children who are admitted with CAMHS that are medically fit for discharge with no place to discharge to	Michelle Turton/ Mental health liaison nurse / Alison Jupp		Pathway in place
Task and finish groups in place to update mental health guidelines –focus on Eating disorders and possibility of ambulatory pathway from day 5 – national guidance currently being reviewed	Liz Kinnersley / Mental Health Liaison Nurse / Hilary Champion / Jay Halbert / Jackie Tyler / Ward managers		Q pulse Clinical Governance
Band 6 mental health liaison role – recruited to x 2 Amendment to JD in place for band 6 , role completed and shared with CCG CCG have agreed to fund one full time post for a year and have rolled this out across Kent– recruited second post utilising this funding to support increase to seven-day service as increased camhs attendance at weekends	Jackie Tyler /Rebecca Davies		In post currently, auditing outcomes
Paediatric consultant with specialist interest in mental health in post links with appropriate groups including tertiary centres and NHSE	Jay Halbert / Jackie Tyler		In place
We can talk mandatory for all paediatric staff-	Clinical Educators/ ward managers		Training record
Review of training availability for staff from NELFT	Jackie Tyler		Training record

Actions	Leads	RAG	Governance
Mental health liaison nurse to spend a day with the crisis team to develop working relationships and contact information to be provided on the team leaders to support her	Sarah Warnock / Peter Hyland		To recommence once lockdown lifted
Supervision agreed for Mental Health Liaison Nurse • Safeguarding in place with lead nurse for safeguarding • NELFT have band 7 in post to provide supervision for mental health liaison staff across Kent	Jackie Tyler		Reflective practice
Clear developmental action plan with objectives for mental health liaison role	Rebecca Davies		Audit date and survey of patients, parents and staff in place
Development of youth worker role	Jackie Tyler		JD approved AFC Out to advert
Trial of youth worker to be implemented in 'perfect week' plan	Jackie Tyler / Ward Manager		Completed
NCEPOD audit for children and young people with mental health issues to be completed for MTW	Jackie Tyler / Dr Jay Halbert		Completed

New areas under review / development

Actions	Leads	RAG	Governance
Review of learning disability / adult nurse role within paediatric wards raised with Workforce group • contact made with Canterbury University regarding students on LD pathway having placements within paediatrics or bank work at MTW • Discussions with HR underway regarding recruitment pathway for non- paediatric qualified staff	Jackie Tyler / Tammy Pike		
Band 3 agency workers with mental health training implemented • Discussion with staff bank completed and agency line approved by Nicola Sharpington • MHCSWs supplied on line of work to Hedgehog ward minimum of 1 per shift to support supervision of CAMHS patients	Jackie Tyler / Rebecca Davies		Monitor incidents, PALS and complaints
Communication team to be involved in publicising development of service • Article and review underway December 2021 – review for HSJ awards	Jackie Tyler / Comms Team		
De-escalation training for paediatric and security staff • Mental Health Liaison Nurse and ED sister have attended Train the trainer de-escalation training • Band 6 staff study days completed • Further training to be arranged	Jackie Tyler / Rebecca Davies /Paediatric educator		Training records
Task and finish group for ambulating eating disorders pathway – reduce LOS by approx. 5 days	Liz Kinnersley / Dr Jay Halbert / Jackie Tyler		Draft pathway under development

NHS
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Quarterly mortality data **Medical Director**

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 10/11/21 (a previous version)

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

Discussion and assurance

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

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Maidstone and Tunbridge Wells NHS Trust

Mortality Surveillance Group Report

October 2021

MTW
exceptional people, outstanding care

Contents

Note: Detailed analysis and a deep dive into specific areas are available on request - mtw-tr.informationdepartment@nhs.net

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

- T Health (Dr Foster) have resolved most of the issues with the new HES data feed. This means we now have data up to **June 2021.** There are some reporting streams yet to be published – notably deaths in low-risk diagnosis groups for this report
- HSMR has increased from previous month as we continue into wave 2 of Covid in the dataset – Rolling HSMR currently at **85.0** and still performing well against the standard ratio of 100. We continue to be in the "Low" bracket.
- Monthly HSMR shows an decrease in May 21 (**69.2**).
- As a Trust we continue to perform well amongst our local peers as well as those trusts rated Good or Outstanding by the CQC
- The latest reporting month saw **no** CUSUM alerts
- Deaths with no comorbidities on a rolling 12 month basis have increased from the last published dataset. Those deaths with no comorbidities focussed on Geriatric and General Medicine
- Covid HSMR for the Trust is higher than our Kent peers, with investigations as to the driver of this continuing
- Trust SHMI continues to perform in the green for the 11th month running

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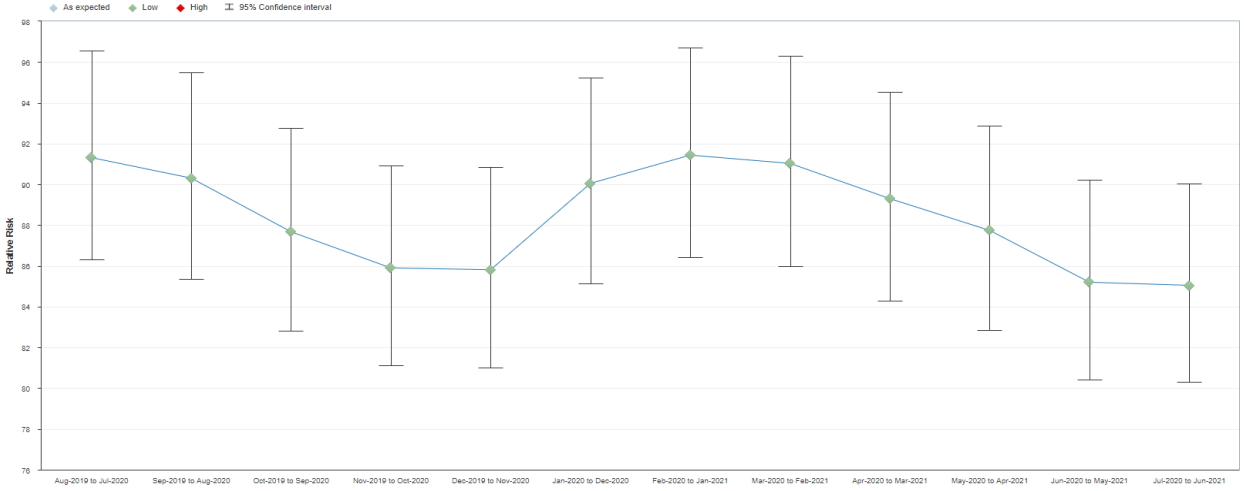
HSMR Overview

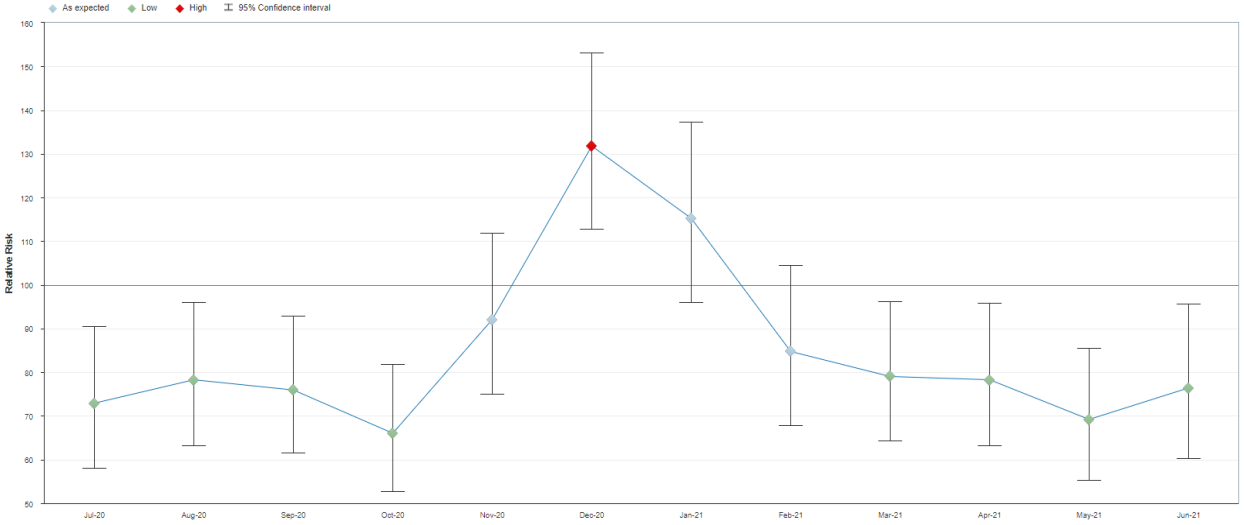
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Months



The 12 months **July 2020 to June 2021** show our HSMR to be **85.0**, which is lower than last month's figure of 85.2. We have consistently been in the low bracket of HSMR for 12 rolling months

Monthly View



The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so **May 2021** in this case, shows that the Trust's position has **decreased** to **69.2** from **78.3** in April 2021. Our HSMR is within the "low" bracket.

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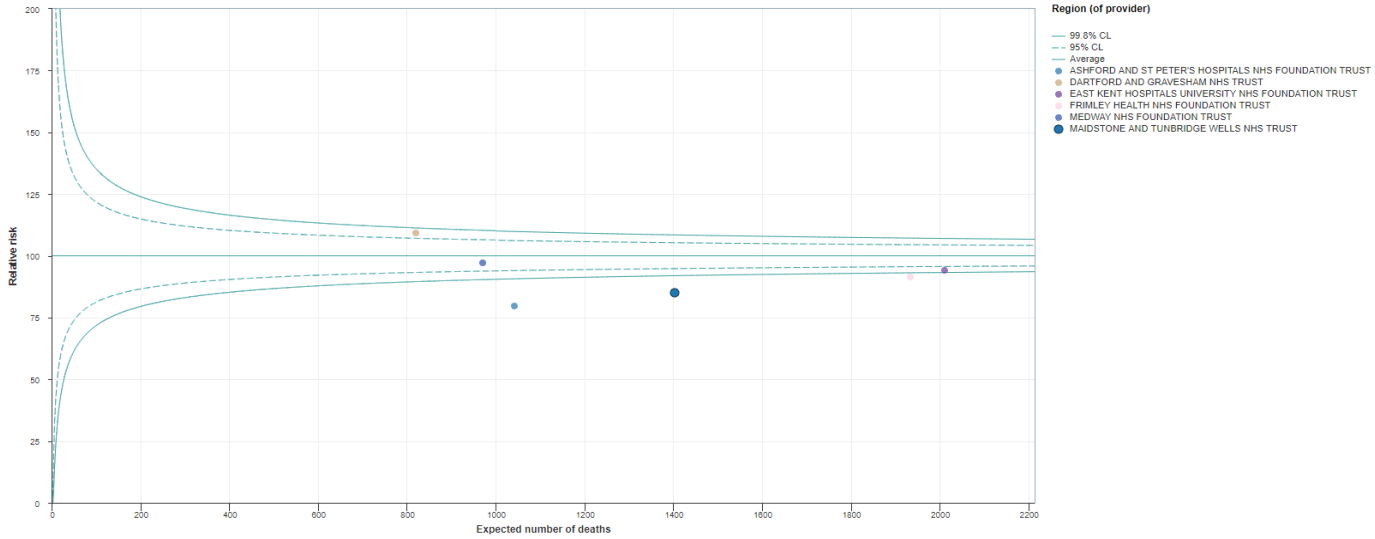
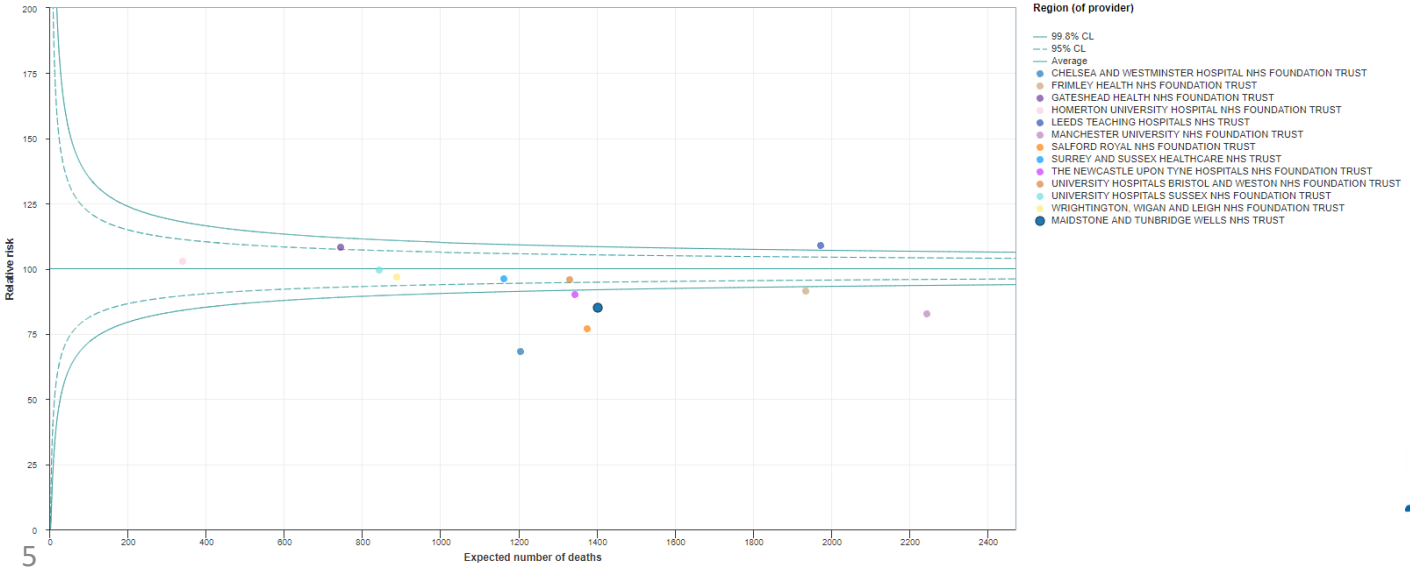
HSMR – Benchmarking

Maidstone and Tunbridge Wells NHS Trust

Kent Peers



Good & Outstanding Trusts



MTW continues to perform well both amongst it's local peers as well as with Good & Outstanding performing Trusts

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CUSUM Alerts - Overview

NHS Maidstone and Tunbridge Wells NHS Trust

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	2 6	104337	1811	1779.2	1.7	101.8				
HSMR (56 diagnosis groups)	9 2	42912	1133	1216.3	2.6	93.2				
Asthma	1	222	6	1.2	2.7	501.1				
Pneumonia	1 3	1106	183	150.5	16.5	121.6				
Septicemia (except in labour)	1	722	148	116.5	20.5	127.0				
Skin and subcutaneous tissue infections	1	1547	26	14.9	1.7	175.0				
Viral infection	18	1982	449	284.4	22.7	157.9				
All Procedures	1 7	76136	1270	1274.3	1.7	99.7				
Diagnostic imaging (except heart)	10 4	12877	450	479.9	3.5	93.8				
Extirpation of lesion of external ear	1	5	1	0.0	20.0	7820.3				
Other drainage of peritoneal cavity	1	336	27	19.2	8.0	140.6				
Rest of Upper GI	6	789	228	177.4	28.9	128.5				
Surgical arrest of bleeding from internal nose	1	51	1	0.4	2.0	263.6				
Total excision of kidney	1	8	1	0.0	12.5	2634.9				
Urethral catheterisation of bladder	1	1081	121	93.7	11.2	129.2				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Viral infection	157.9	1982	449	284.4	164.6
Rest of Upper GI	128.5	789	228	177.4	50.6
Pneumonia	121.6	1106	183	150.5	32.5
Septicemia (except in labour)	127.0	722	148	116.5	31.5
Urethral catheterisation of bladder	129.2	1081	121	93.7	27.3

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Amputation of leg	491.7	3	1	33.3
Rest of Upper GI	128.5	789	228	28.9
Cardiac arrest and ventricular fibrillation	51.6	26	7	26.9
Peripheral and visceral atherosclerosis	127.0	62	16	25.8
Rest of Respiratory (diagnostic/minor)	96.7	479	123	25.7

We continue to not experience any CUSUM alerts

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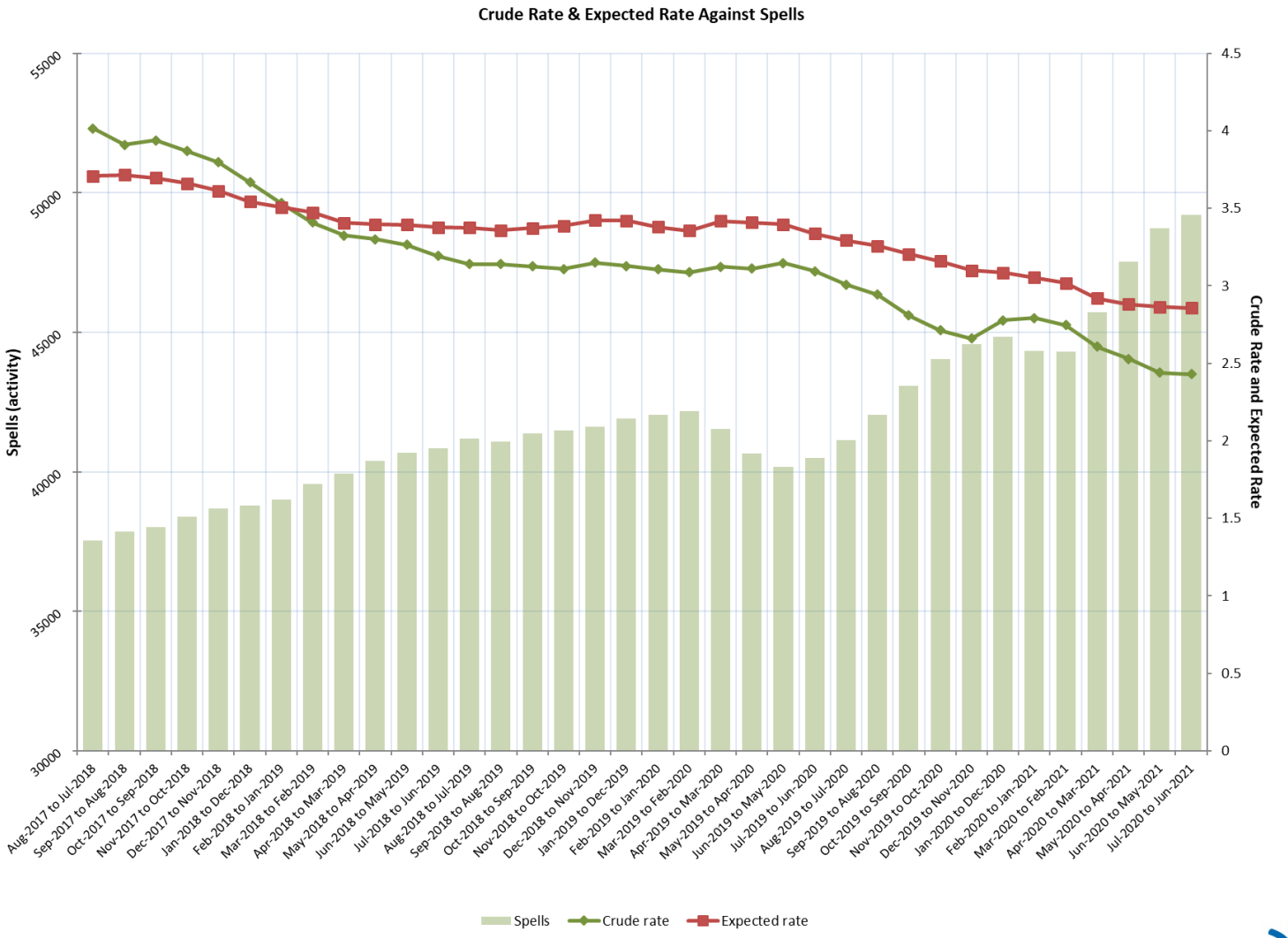
Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust



Crude and Expected Rates continue to improve even as volumes of spells increase.

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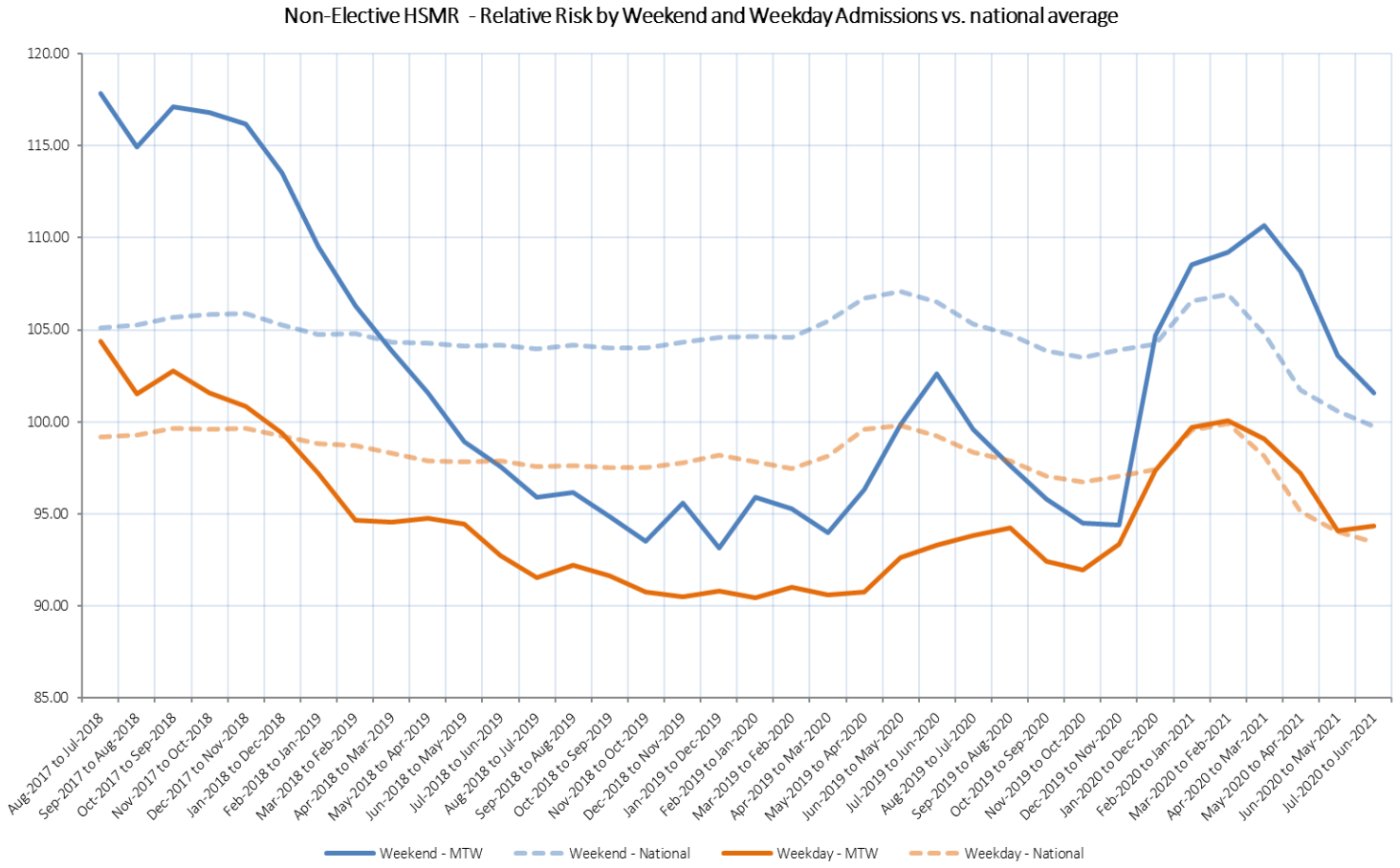
HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



Weekend and Weekday HSMR for non-elective care continue to be above the national average. **Weekend** figures in particular have a larger gap with the national average for the period of **Apr 20 – Mar 21** compared national figures with a relative risk of **116.47** vs **107.99** nationally, though the gap is closing.

As seen on the next slide, the driver of this gap continues to be Covid secondary diagnoses.

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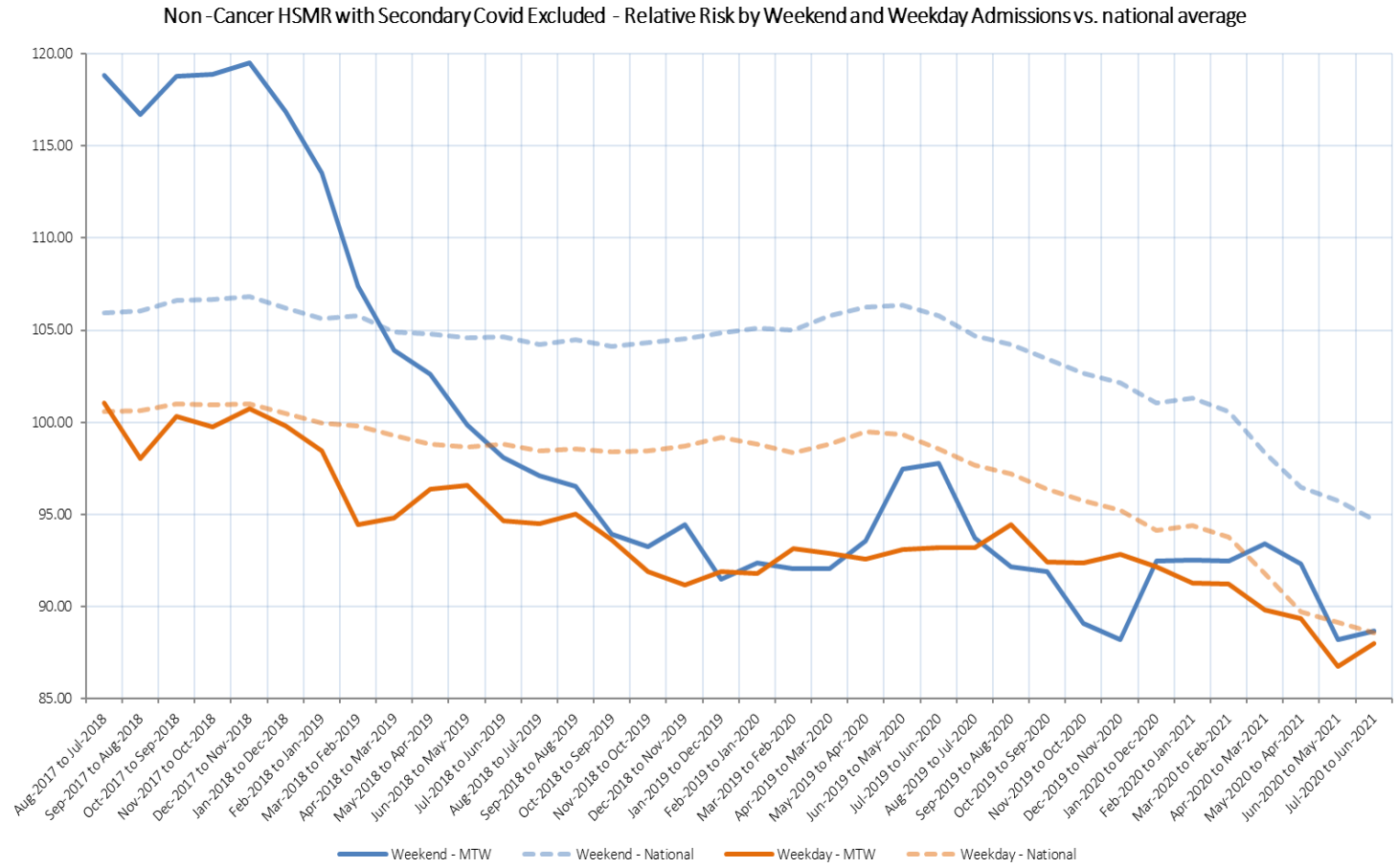
HSMR – Weekend & Weekday Comparison – Cancer & Covid Exclusions

Maidstone and Tunbridge Wells NHS Trust



A deep dive into the drivers behind Weekend HSMR revealed an impact from being an Oncology Centre as well as secondary Covid diagnoses.

Excluding cancer and secondary Covid diagnoses show the trust favourably against the national rate, though weekday mortality is closer to national average

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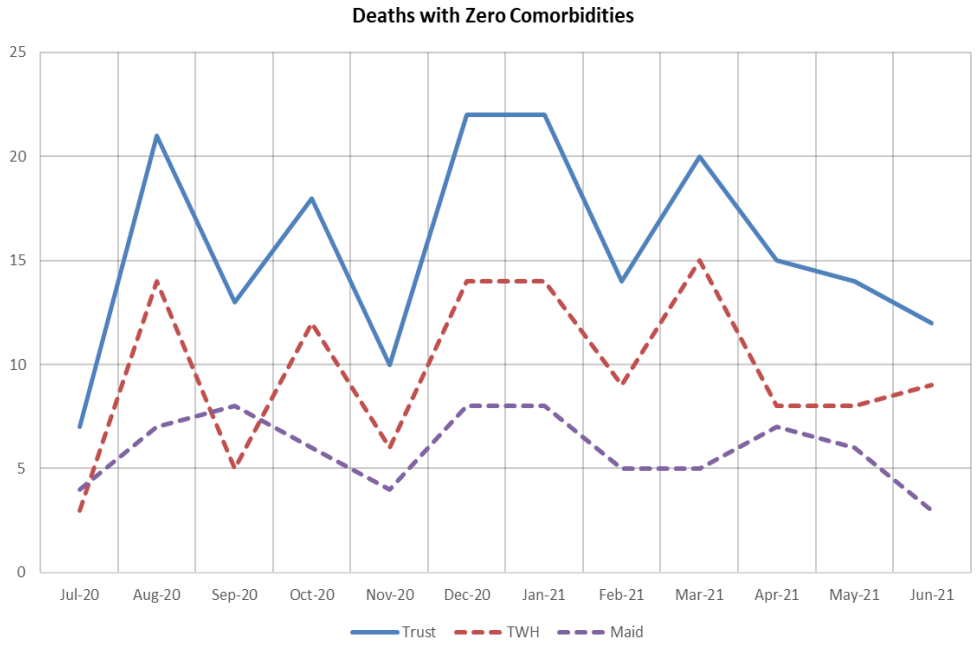
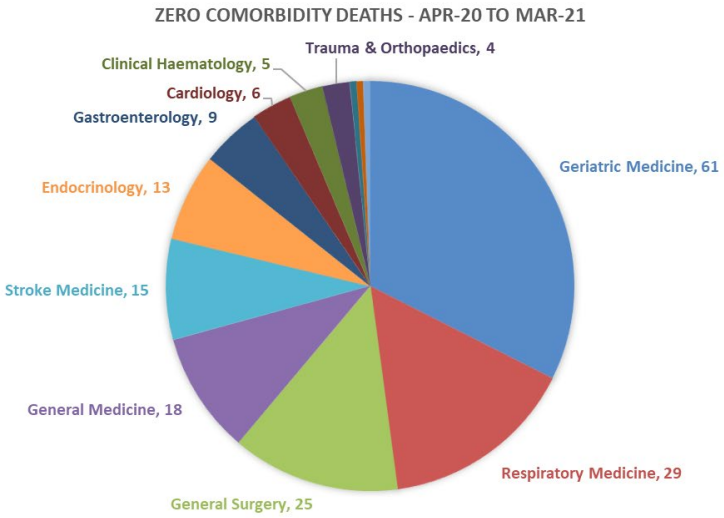
Deaths with Zero Comorbidities



Month	Trust	TWH	%	Maid	%
Jul-20	7	3	42.9	4	57.1
Aug-20	21	14	66.7	7	33.3
Sep-20	13	5	38.5	8	61.5
Oct-20	18	12	66.7	6	33.3
Nov-20	10	6	60.0	4	40.0
Dec-20	22	14	63.6	8	36.4
Jan-21	22	14	63.6	8	36.4
Feb-21	14	9	64.3	5	35.7
Mar-21	20	15	75.0	5	25.0
Apr-21	15	8	53.3	7	46.7
May-21	14	8	57.1	6	42.9
Jun-21	12	9	75.0	3	25.0
All	**188**	**117**	62.2	**71**	37.8

We can see that the number of deaths with zero comorbidities has reduced after moving out of wave 2 of Covid. Of the **1,193** deaths recorded in the period of **July 2020 to June 2021**, **188** had no comorbidities recorded (**15.76%**).

Deaths with Zero Comorbidities – By Specialty



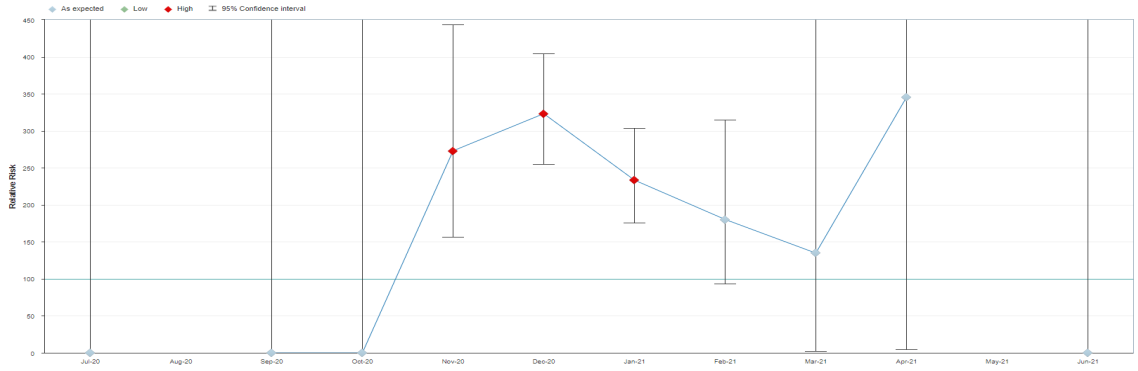
	Mar-20 Feb-21		Apr-20 Mar-21		Jul-20 Jun-21	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	53	33%	59	35%	61	32%
Respiratory Medicine	30	17%	26	15%	29	15%
General Medicine	20	15%	17	10%	18	10%
General Surgery	19	9%	20	12%	25	13%
Stroke Medicine	14	9%	11	7%	15	8%
Gastroenterology	9	5%	8	5%	9	5%
Endocrinology	13	3%	14	8%	13	7%
Cardiology	5	2%	5	3%	6	3%
Clinical Haematology	3	1%	2	1%	5	3%
Trauma & Orthopaedics	5	2%	4	2%	4	2%
Anaesthetics	1	1%	1	1%	1	1%
Accident & Emergency	0	1%	0	0%	1	1%
ENT	0	0%	0	0%	1	1%
Gynaecology	1	0%	1	1%	0	0%
Well Babies	0	0%	0	0%	0	0%
Urology	0	0%	0	0%	0	0%
Obstetrics	0	0%	0	0%	0	0%
All	173		168		188	

Trends continue month on month, with just under half of the deaths with zero comorbidities being in the **Geriatric and Respiratory Medicine specialties**. The overall rolling 12 month figures are showing an increase in volumes of deaths with zero comorbidities, however

Covid 19 Mortality

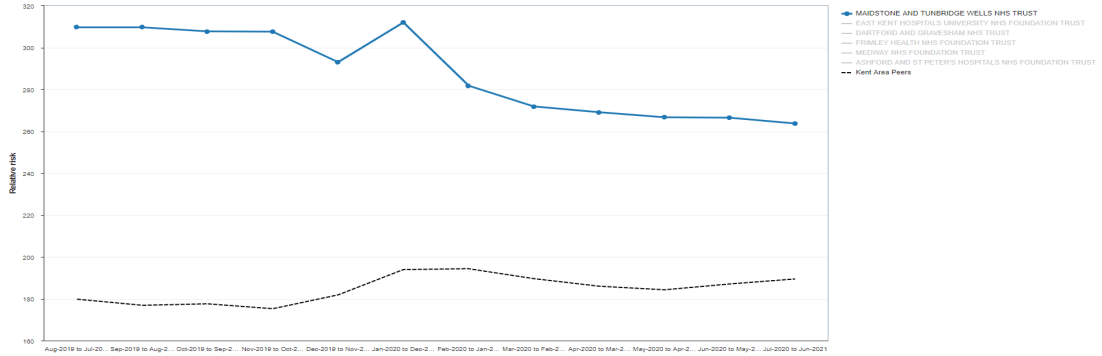
Maidstone and Tunbridge Wells NHS Trust

Monthly Relative Risk for Covid Diagnoses



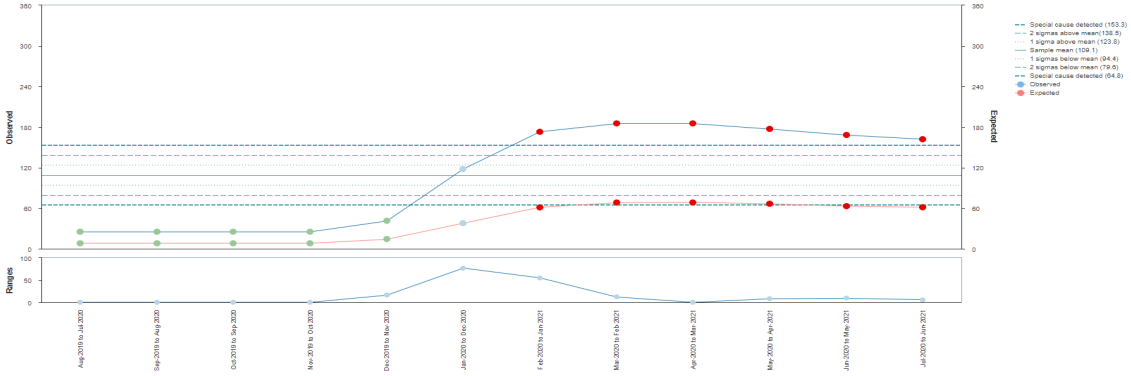
Relative Risk shows the Trust continuing to be "as expected" for Covid deaths post wave 2. The benchmark continues to be very unstable and is rebuilt each month by T Health

Relative Risk Compared to Kent Peers – Rolling 12 Months



Our Relative Risk continues to be higher than that of our Kent peers at **263.7** against 189.5. this gap is reducing over time, with our Relative risk reducing whilst peers increase.

Expected Deaths against Observed Deaths – Rolling 12 months



Our Observed Covid deaths continues to be higher than Expected deaths. The gap is gradually closing

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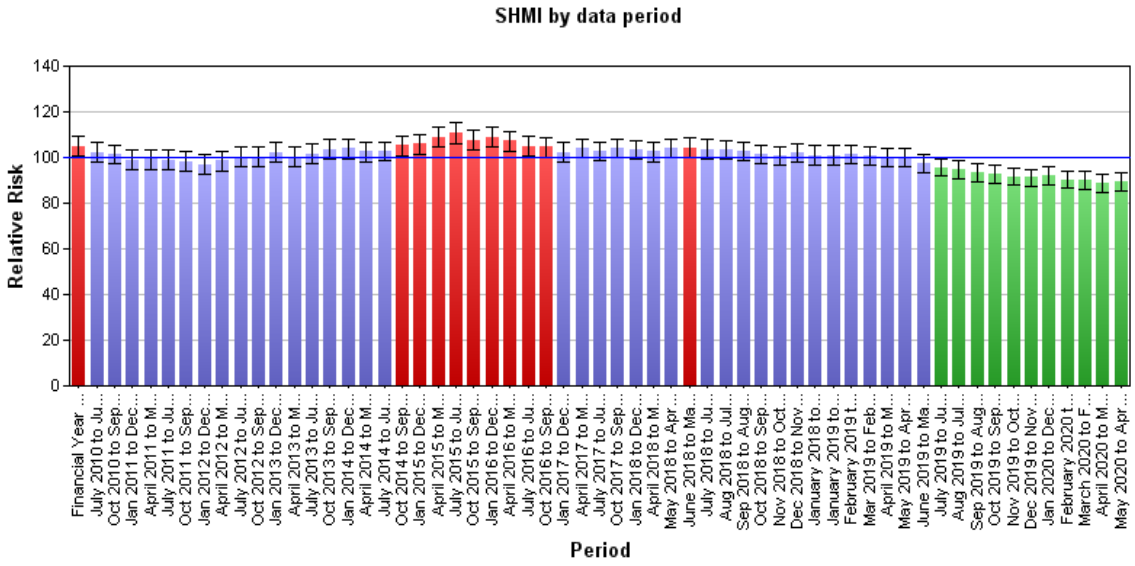
SHMI



SHMI contextual indicators

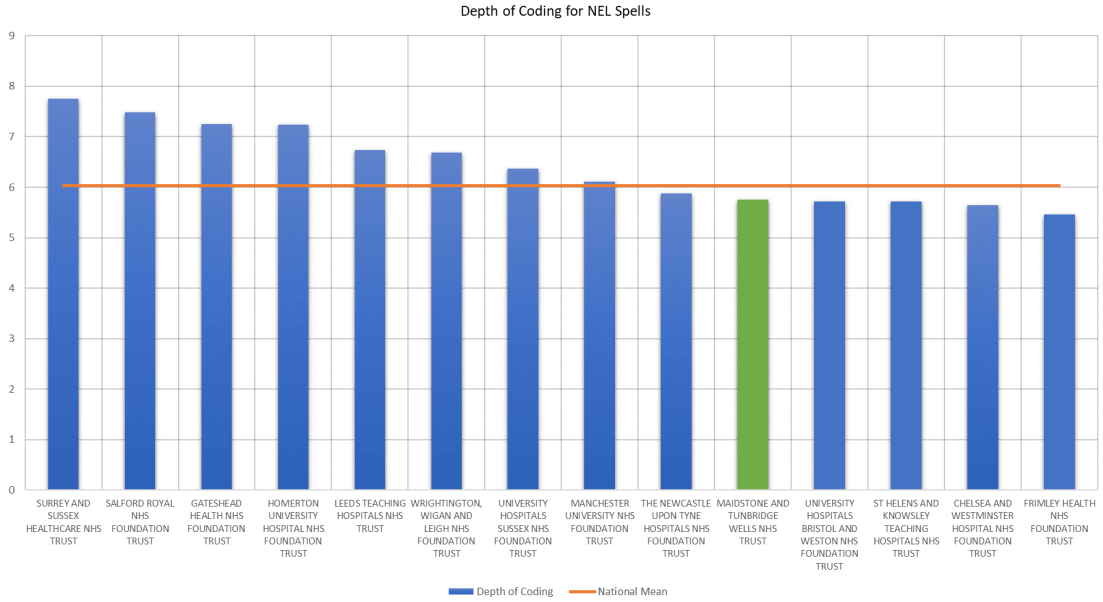
Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	1.9	1.8
Percentage of provider spells with palliative care coding	1.9	1.8
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	43.0	36.0
Percentage of deaths with palliative care coding	43.0	37.0
Admission method		
Crude percentage mortality rate for elective admissions	1.0	1.0
Crude percentage mortality rate for non-elective admissions	3.3	3.5
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	62.0	69.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	38.0	31.0

As a Trust, our SHMI continues to be favourable, with a 11th month running being a positive outlier for the period of May-20 to Apr-20.

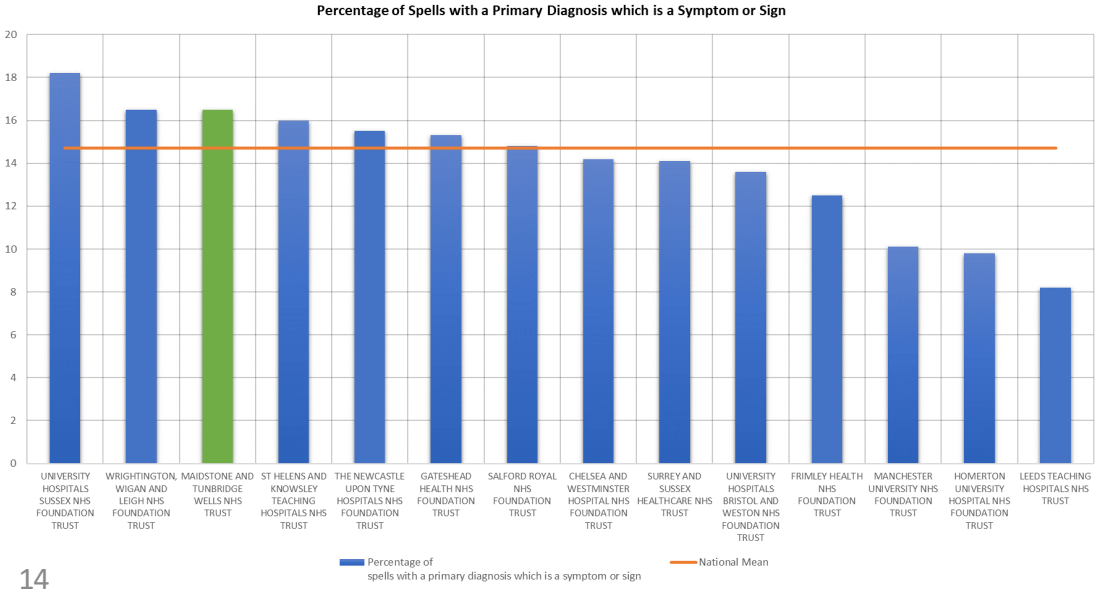
Within the contextual indicators, we continue to be an organisation with fewer deaths in hospital

SHMI Reporting Link

SHMI – Contextual Indicators

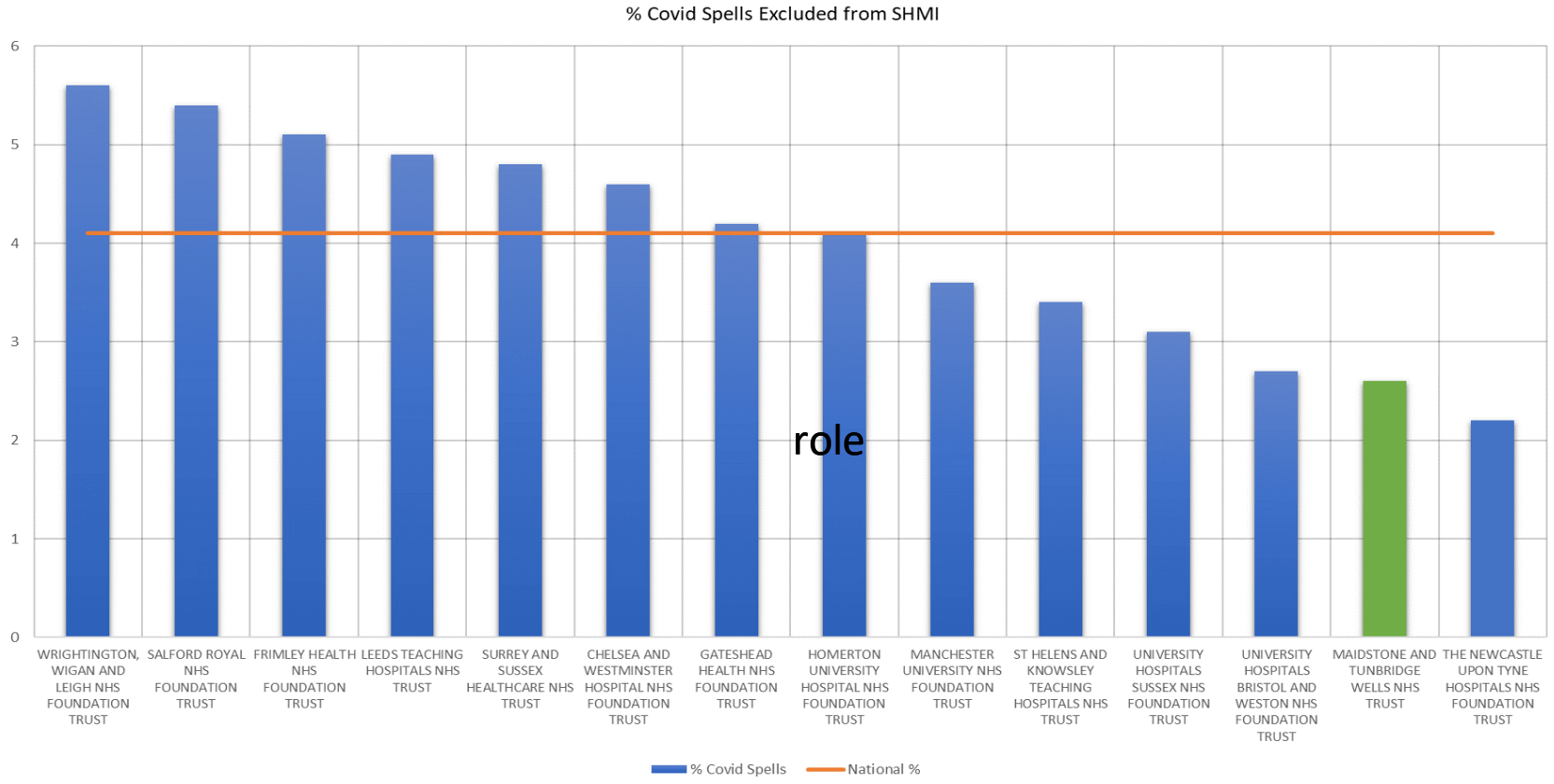


Depth of coding or the trust is below national average and in the lower half of our Outstanding and Good Rated peers.



The Trust's percentage of spells that have a Primary Diagnosis that is a symptom or sign is above the national average and in the top 3 amongst our Outstanding and Good rated peers and is a further improvement on previous months

SHMI – Contextual Indicators - Covid



SHMI excludes Covid Spells, but does track spells excluded due to Covid. We are an outlier on the number of spells excluded due to Covid – the 2nd smallest percentage amongst our Good and Outstanding peers. This points further to a recording issue to be resolved

Medical Examiners Service

ME Service Update

- There was a brief decline in the number of deaths scrutinised in August compared to July, however the number of deaths went back up to previous levels in September with the ME Service scrutinising 135 of the 138 deaths.
- The implementation of the ME Service had introduced consistency to the levels of deaths scrutinised, with performance between 98% and 100% month on month.
- 3 Medical Examiners have been recruited into the Service and vacancies within the Bereavement Team have also been filled. This should reduce the strain on the Service caused by reduced staffing levels.
- The roll out of the ME Service to the community temporary halted due to staffing issues in the current Service has now commenced. The South East Regional Medical Officer shared learning from 2 Trusts who have rolled out the Service to the Community. Shared learning from their experience be used to support the planning process for the roll out of the Service to the community

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Jan-21	353	347	98%	245	71%
Feb-21	149	147	99%	42	29%
Mar-21	127	125	98%	16	13%
Apr-21	122	122	100%	30	25%
May-21	99	99	100%	24	24%
Jun-21	112	108	96%	30	28%
Jul-21	137	136	99%	42	31%
Aug-21	103	103	100%	34	33%
Sep-21	138	135	98%	76	56%

Challenges faced by the ME Service

- Inability of the Service to complete scrutiny within 3 days continues to persist. The lead ME supported by the management team have developed a plan to raise awareness of the need for timely summary completions across the Trust.
- Some of the interventions planned include; representatives from the ME Service attending Clinical Governance meetings, walking the floor and creating a junior doctors peer group support system to address the issue of late summaries.
- The Service continues to communicate with consultants much earlier in the pathway to increase engagement with the process and improve the timeliness of death summary completions.

Mortality Surveillance Group (MSG)

The role of the Mortality Surveillance Group involves supporting the Trust to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary investigated. A further responsibility of the group is to ensure lessons learnt from Mortality reviews are disseminated appropriately and actions implemented to improve outcome for patients and quality of services provided.

The Mortality policy is due to go back to the Policy Ratification Committee in January 2021 with amendments recommended by the Committee in November 2021. The policy was approved at the August MSG meeting following changes to reflect the introduction of the Medical Examiners Service introduced in September 2020. The current policy outlines the current Mortality processes and pathways within MTW.

Learning from Mortality reviews identified the following needs:

- Sepsis was identified at the October MSG meeting as a recurring theme with some work required to raise awareness of this across the Trust. Failure to recognise sepsis by junior doctors coupled by poor senior input over the weekend was highlighted as an area of learning
- Risky discharge with no mitigation in place for care planning post discharge was a further area of learning discussed
- The impact of the pandemic on waiting lists and elective procedures resulting in harm was another area of learning discussed at MSG in October.

The following practice was highlighted in :

- Good documentation of care
- Early consultant involvement allowing for high level and appropriate decision making.
- Evidence of attempts to provide good care; Family and specialist involvement in decisions

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Structured Judgement Review (SJR)

An SJR is a standardised review of a patient's death undertaken by a trained clinician making safety and quality judgement of care phases. The SJR reviewer makes explicit comments about phases of care with scores attributed to each phase and the overall care received.

Year	Outstanding SJRs
Apr 17 to Mar 18	0
Apr 18 to Mar 19	5
Apr 19 to Mar 20	12
Apr 20 to Mar 21	13
Apr 21 to Mar 22	19
SJR Total backlog	49

- The SJR recovery plan implementation continues to positively impact the backlog position.
- The current SJR backlog position is 49, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4 week stipulated SJR turnaround time.
- There are 11 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 60.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Jul-21	MSG cancelled: quorate threshold not met		
Aug-21	12	4	1
Sep-21	18	4	1
Oct-21	12	3	0

- In September, there were 4s SJR with an overall assessment of 'Poor care' and 1 SJR with a 'Very poor care' rating discussed at MSG. The large number of cases reviewed at MSG in Sept. are as a result of the drive to clear the SJR backlog.
- In October, there were 3 SJRs with a 'Poor care' assessment and no SJRs with a 'Very poor care' assessment reviewed at the MSG meeting.
- Learning from both poor care and good practices highlighted from cases reviewed at MSG continue to be fed back to directorates

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Actions from 'Poor care' SJR Reviews

- All 8 SJRs with an overall assessment of 'Poor care' were discussed at MSG and with the Directorates
- 1 SJR discussed in September within the above cohort was referred to be reviewed at the Serious Incidents panel to determine if the Serious Incident(SI) threshold has been met to declare an SI
- Learning from these SJRs have been feedback to Directorates through Clinical Governance meetings.

Next steps

- Continue to work with SJR reviewers to implement the backlog trajectory plan.
- Implement a series of interventions to address the persistent issue of late summaries by QAP impacting the 3 day turnaround target for the Service to complete a scrutiny.
- Introduce learning from Trusts who have rolled out the ME Service to the community in the planning process to extend our current Service to the community.

MTW exceptional people, outstanding care