

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

Thu 28 July 2022, 09:45 - 13:00

Virtually, via Webconference

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-3FLrluzYSc29211EQ).

07-1

To receive apologies for absence

David Highton

07-2

To declare interests relevant to agenda items

David Highton

07-3

To approve the minutes of the 'Part 1' Trust Board meeting of 30th June 2022

David Highton

 Board minutes, 30.06.22 (Part 1).pdf (11 pages)

07-4

To note progress with previous actions


David Highton

 Board actions log (Part 1).pdf (2 pages)

07-5

Report from the Chair of the Trust Board

David Highton

 Report from the Chair of the Trust Board.pdf (1 pages)

07-6

Report from the Chief Executive

Miles Scott

 Chief Executive's report July 2022.pdf (3 pages)

Reports from Trust Board sub-committees

07-7

Quality Committee, 13/07/22

Maureen Choong

 Summary of Quality C'ttee, 13.07.22.pdf (2 pages)

07-8

Finance and Performance Committee, 26/07/22

Neil Griffiths

N.B. The report will be issued after the meeting on 26/07/22.

07-9

People and Organisational Development Committee, 22/07/22 (incl. quarterly report from the Guardian of Safe Working Hours)


Richard Finn

 Summary of People and Organisational Development Cttee, 22.07.22 (incl. quarterly update from the Guardian of Safe Working Hours).pdf (4 pages)

07-10

Audit and Governance Committee, 20/07/22 (incl. the External Auditor's Annual Report for 2021/22)


David Morgan

 Summary of Audit and Governance Committee, 20.07.22.pdf (2 pages)

07-11

Charitable Funds Committee, 18/07/22

David Morgan

 Summary of Charitable Funds Cttee, 18.07.22.pdf (1 pages)

Integrated Performance Report

07-12

Integrated Performance Report (IPR) for June 2022


Quality Items

07-13

Safeguarding update (Annual Report to Board, including Trust Board annual refresher training)

Joanna Haworth, Karen Davies and Alison Jupp

N.B. This item has been scheduled for 11:20am.

 Safeguarding update (Annual Report to Board, including Trust Board annual refresher training).pdf (34 pages)

07-14

Quarterly Maternity Services report

Joanna Haworth


 Quarterly Maternity Services report.pdf (11 pages)

Systems and Place

07-15

Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP)

Bob Cook

 Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP) V2.pdf (4 pages)

Planning and strategy

07-16

To approve an updated Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity

Lynn Gray

 To approve an updated Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity.pdf (149 pages)

07-17

To approve the Business Case for the development of a community Diagnostic Centre (CDC) - Phase 2

Lynn Gray

 To approve the Business Case for the development of a community Diagnostic Centre (CDC) - Phase 2.pdf (48 pages)

07-18

To approve a Business Case for the establishment of a Tier 4 Bariatric Surgical Service at MTW Trust

Lynn Gray

 To approve a Business Case for the establishment of a Tier 4 Bariatric Surgical Service at MTW Trust.pdf (39 pages)

Assurance and policy

07-19

Quarterly report from the Freedom to Speak Up Guardian

Christian Lippiatt and Natalie Howard

N.B. This item has been scheduled for 12:30pm.

 Quarterly report from the Freedom to Speak Up Guardian.pdf (7 pages)

07-20

To consider any other business

David Highton

07-21

To respond to any questions from members of the public

David Highton

Questions should relate to one of the agenda items above, and be submitted in advance of the Trust Board meeting, to Daryl Judges, Assistant Trust Secretary, via daryl.judges1@nhs.net.

Members of the public should also take note that questions regarding an individual's patient's care and treatment are not appropriate for discussion at the Trust Board meeting, and should instead be directed to the Trust's Patient Advice and Liaison Service (PALS) (mtw-tr.palsoffice@nhs.net).

07-22

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 30th JUNE 2022, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE**

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control (from item 06-20)	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Divisional Director of Midwifery, Nursing & Quality (for item 06-24)	(SBS)
	Mark Hope	Director of Estates (for item 06-27)	(MHo)
	Stu Meades	Energy and Sustainability Consultant (for item 06-27)	(SMe)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

06-11 To receive apologies for absence

Apologies were received from David Morgan (DM), Non-Executive Director; and Emma Pettitt-Mitchell (EPM), Non-Executive Director.

06-12 To declare interests relevant to agenda items

No interests were declared.

06-13 To approve the minutes of the meeting of 26th May 2022 and 16th June 2022

The minutes of the meeting of 26th May 2022 were approved as a true and accurate record of the meeting, subject to the following amendment:

- Item 05-11, page 6 of 10: Replace "EPM asked where the accountability resided for ensuring a long-term sustainable change to communication." with "EPM asked where the accountability resided for ensuring a long-term sustainable change."; and replace "EPM then requested further details of the mechanisms which would ensure the success of the revised approach to communications. JH replied that an in-depth review into the challenges associated with communication had been conducted to ensure the contributing factors were addressed and noted that Director of Quality Governance would support for the programme of work." with "EPM then requested further details of the mechanisms which would ensure the success of the revised approach. JH replied that an in-depth review into the challenges had been conducted to ensure the contributing factors were addressed and noted that Director of Quality Governance would support for the programme of work."

Action: Amend the minutes of the Trust Board meeting on 26th May 2022 to reflect the corrections that were agreed at the Trust Board meeting on 30th June 2022 (Trust Secretary, June 2022 onwards)

The minutes of the meeting of 16th June 2022 were then approved as a true and accurate record of the meeting.

06-14 To note progress with previous actions

The content of the submitted report was noted and the following actions were discussed in detail:

- **Action 05-11c (“Liaise with the Chair of the Finance and Performance Committee to consider whether the quarterly “Analysis of Consultancy use” report should be reinstated”).** SO reported that he had discussed the issue with NG and had agreed that a quarterly report should be submitted to the Finance and Performance Committee, from July 2022. SO continued that the first report should cover quarter 1 of 2022/23 and also include retrospective performance, to enable trends to be monitored. DH added that the report was related to the fact that consultancy expenditure over £50k needed to be approved externally. SO confirmed that was correct. It was therefore agreed that the action could be closed.
- **Action 05-14 (“Ensure that the Trust’s corporate objectives for 2022/23 appropriately reflected that a proportion of the Trust’s patients resided in East Sussex”).** SO reported that the objectives would be considered under item 06-26 but SO believed the point had been captured within the work. It was therefore confirmed the action could be closed.

06-15 Report from the Chair of the Trust Board

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

- That day’s meeting was RJ’s first full Trust Board meeting, although RJ had attended the extraordinary Trust Board meeting held on 16th June 2022.
- EPM had been reappointed for a further three-year term of office.
- There had been no consultant Advisory Appointments Committee (AAC) panels held since the last Trust Board meeting.

JW referred to the last point and stated that an AAC panel for consultant radiologists had been held on 28/06/22 and the outcome would be reported in DH’s next report. The point was acknowledged.

06-16 Report from the Chief Executive

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

- The operational context in which the Trust worked continued to be the record levels of clinical activity, which were significantly above the levels prior to the pandemic. There had also been very high activity levels, and high numbers of complex cases, seen by the maternity service.
- The fourth wave of COVID-19 had led to 49 COVID-19 positive inpatients currently being treated in the Trust’s hospitals, with several staff members absent with COVID-19. However, PM had seen data that indicated the position would soon reach a plateau, after experiencing a recent sharp increase. The Trust had removed the requirement to wear face masks in much of the hospitals’ areas, and visiting restrictions had been lifted.
- SB would give further details of the Trust’s continued recovery, but the remainder of MS’ report was focused on a series of individual achievements by members of staff; as well as on the work taking place across the Kent and Medway Integrated Care System (ICS) and Health and Care Partnership (HCP). The Trust Board would have a “Systems and place” section on the agenda at future meetings.

DH asked for clarification whether visiting was still restricted on the COVID-19 wards. JH confirmed there were some restrictions for such areas, but visiting was allowed on compassionate grounds, and visitors could attend for short periods.

Reports from Trust Board sub-committees

06-17 Quality Committee, 08/06/22

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

- Some of the Committee’s oversight was being delegated to its sub-committees, and some helpful reports had been submitted to provide assurance regarding health and safety, and on how learning could occur, to enable improvement.

- The work to reduce the risk of a “failure to learn” was ongoing, and although the Committee was not yet fully assured, the good work undertaken to date was commended.
- The Continuity of Care plans for maternity had been discussed.

DH noted that some of the items referred to by MC would be covered under other agenda items.

06-18 Finance and Performance Committee, 28/06/22

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

- Patient flow-related challenges continued, and SB and his colleagues were working to develop some options to be considered at the Committee’s meeting in July 2022.
- There were some emerging pressures regarding financial performance, which included the delivery of the Cost Improvement Programme (CIP) and staffing costs, and it had been agreed to undertake “deep dives” in certain areas.
- The assessment of previously-agreed Business Cases had been discussed and the Committee considered the work in some detail. Further information would be provided at the next meeting.
- SB gave an update on the Business Case for increasing elective orthopaedic capacity i.e. the ‘barn theatre’, but that would be covered under item 06-28.

DH again noted that some of the items considered at the Committee would be covered elsewhere on the Trust Board agenda.

06-19 People and Organisational Development Committee, 24/06/22

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

- A major investment had been made in recruitment, and the area that was discussed at some length was retention, to ensure the Trust kept as many of its good staff as it could. A retention Programme Board had been established, and details of that forum’s work would be considered by the Committee.
- The meeting discussed the role of the Human Resources (HR) Business Partners, which were all now in place, and it was agreed that the Committee should hear more about the workshops that had been held with the HR Business Partners.
- The main discussion was regarding leadership development, and the Exceptional Leaders programme, which had also been subject to a major investment. The main development was to extend the programme to all leaders, not just senior leaders, while there would also be Continuing Professional Development (CPD) for those that had been through the programme.
- Employee relations cases were discussed and SS and her colleagues had been asked to undertake some benchmarking.
- RF and EPM both considered the reports that were now being submitted to the Committee to be very high quality, and very insightful, so SS and her colleagues should be commended.

DH echoed RF’s commendation to SS regarding the quality of the reports.

06-20 Patient Experience Committee, 09/06/22

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

- An excellent presentation had been given on the Paediatric Emergency Department (ED) at Tunbridge Wells Hospital (TWH).
- An update on the Trust’s visiting arrangements was given, which included the use of assistive technology to communicate with patients, which was very important given the visiting restrictions that had been in place over the past two years, and the challenges had been discussed openly.
- The Complaints and PALS Manager had briefed the Committee on the compliance with the new national complaints framework.
- The Trust’s response to the findings from the Care Quality Commission Maternity survey 2021 was discussed.

MS acknowledged the feedback the Trust had received regarding communicating with patients and noted that JH had wanted to incorporate that at the centre of the relevant objectives for 2022/23. JH elaborated on the rationale for that inclusion, and explained the intention to shift from focusing on the Friends and Family Test (FFT) response rate to the underlying themes affecting communication.

DH stated that there was no doubt that there would be benefit from identifying more qualitative aspects of patient feedback.

06-21 Audit and Governance Committee, 16/06/22

MC referred to the submitted report and highlighted that it just confirmed the issues that had been reported verbally to the Trust Board meeting on 16th June.

Integrated Performance Report

06-22 Integrated Performance Report (IPR) for May 2022

MS referred to the Executive Summary and drew attention to the new “Assurance Stacked Bar Charts by Strategic Theme” section on page 7 of 41, which complemented the “Assurance RADAR Charts by Strategic Theme” section. MS then asked each member of the Executive Team to highlight the key themes for escalation within their remit that were listed on page 5 of 41.

SS referred to the “People” strategic theme and explained that she would not discuss the “Climate Survey Responses” metric as the next climate survey was about to be issued, so new data would be available soon. SS then referred to the “Vacancy Rate” metric and highlighted the following points:

- Retention within the NHS was a key workforce issue across the country, and it had national and regional attention. Some of the data suggested that flexibility was a key factor in deciding to leave the NHS, although flexibility could mean different things, given the new ways of working.
- The Trust was involved in the local Provider Collaborative work that was focusing on retention, which included the procurement of a new starter feedback platform, which would try and capture information on why staff wanted to join, and their ‘onboarding’ process. There had been an increase of staff leaving within the first 12 months of starting in post, which indicated that their ‘onboarding’ process was less than optimal. There was also a need to focus on the shift patterns being offered to available to staff.
- Turnover was currently at 14.2%, which was above the internal maximum limit of 10%, and some areas were far higher than the overall 14% level.
- The Trust only had about a 20% response of the exit surveys of those who were leaving, so improvement was required, as was the need to triangulate the data with other sources.
- The Breakthrough objectives for 2022/23 were proposed to focus on vacancies, as that needed to be main priority. The Trust had healthy recruitment pipelines, and there had been lots of activity on recruitment campaigns, with work continuing to ensure that all current vacancies were being advertised.
- JH was leading on work in nursing, and also exploring whether anything different needed to be done for TWH as compared to Maidstone Hospital.

DH commended the fact that the Trust had over 399 staff going through pre-employment checks or with start dates booked, but asked whether benchmarking data was known regarding the process, to establish whether more staff could complete such checks more quickly if the Trust had better processes. SS noted that no benchmark data was available on ‘time to fill’, but a workstream was in place to monitor the Key Performance Indicators (KPIs) for the recruitment process, as well as considering whether some activities could operate in parallel, rather than operate separately.

WW asked whether exit interviews were held via face-to-face/in-person means rather than via written surveys. SS stated that both methods were used, and some changes were being made to the exit survey, as “Unknown” was selected as one of the main reasons for leaving. SS added that exit interviews were held with members of her team, although these were usually only done on specific request. WW asked whether there would be better feedback from exit interviews being done by someone who was not the individual’s line manager. SS acknowledged that may be the case and noted that such aspects could be explored.

SS then explained the latest position in relation to the “Sickness Rate” metric, which included that benchmarking data had revealed that the Trust’s rate was very similar to other organisations in Kent and Medway, while the national sickness absence levels were also similar.

PM then referred to the “Patient Safety & Clinical Effectiveness” strategic theme and explained the latest position in relation to the “Incidents Resulting in Harm”, “Falls Rate”, and “Safe Staffing” metrics which included the following points:

- The “Incidents Resulting in Harm” had increased by 30%, but the numbers involved were low, so it was difficult to judge the significance of that increase.
- The falls rate had, as predicted, decreased over the past three months, as the number of staffing vacancies had decreased.
- The number of medically optimised for discharge (MOFD) patients remained high, and that was a factor in the falls rate.

Questions were invited. None were received.

SM then explained the latest position in relation to the and "Infection Control" metrics and reported the following points:

- There had been a small reduction in Clostridioides difficile cases recently, but that had not continued in June, so a Trust-wide incident meeting had been held to develop an action plan to reduce the number of cases. The local increase reflected a national trend, but the reasons were not definitively known.
- COVID-19 outbreaks and deaths were still being seen, but most of the latter had died with a COVID-19 infection, rather than because of a COVID-19 infection. Patients who had been in contact with a COVID-19 positive patient were still being quarantined. The Omicron variant spread very easily, so there was a high ‘hit’ rate among those who had been exposed, although the vast majority of the infections were very mild.

SB referred to the “Patient Access” strategic theme and explained the latest position in relation to the “RTT Performance”, “Diagnostics <6 weeks”, “A&E Performance”, “Outpatient Calls answered <1 minute”, “Outpatient Clinic Utilisation”, “Ambulance Handovers >30 minutes”, “Super-Stranded Patients”, “% Emergency Admissions to Assessment Areas”, and “Ensuring Activity Levels Match those Pre-Covid – Inpatients & Outpatients, MRI & NOUS” metrics and reported the following points:

- SB continued to be proud of the teams’ efforts to cope with pressures, and the ED 4-hour waiting time target performance had improved recently, so the Trust was the fifth best in the country for May, and the third best for June.
- Efforts continued to try and reduce the number of MOFD patients, but the demand through the EDs continued to be at very high levels.
- The cancer access targets had been met again.
- Diagnostic access performance had improved to be the best performance for several months.
- Elective activity had suffered from the response required to the emergency demand in March and April, and that had been discussed further at the Finance and Performance Committee meeting on 28/06/22. The relevant teams continued to prioritise the recovery of the position, acknowledging the positive impact that would have on the achievement of the Referral to Treatment (RTT) standard and the financial position. This area would be the focus of SB and his team’s efforts for the future.

DH referred to page 21 of 41 and the statement that “Managed service business case approved by NHSE – working towards 3 month implemenations [sic]”, and asked how confident SB was that the three month implementation could be achieved. SB stated that he would like to report to the next Trust Board meeting with a more detailed assessment of his confidence, as he would prefer for the implementation to take slightly longer if that resulted in a better implementation.

Action: Provide the Trust Board with a more detailed assessment of the Trust’s confidence in the ability to meet the intended three-month implementation timescale for the managed MRI service (Chief Operating Officer, July 2022)

WW remarked that the IPR did not provide much information about SB’s confidence on the areas that had been identified for escalation, such as “Transformation: CAU Calls answered <1 minute”; “Ambulance Handovers >30 minutes”; “Super-Stranded Patients”; and “% Emergency Admissions to Assessment Areas”, but WW was aware that some of these were affected by factors from other areas, so asked whether the Trust Board could provide further support to SB. SB replied that he believed some of the escalation reflected an ambitious target being set; and also provided further

context on the relevant factors, which included the aforementioned work that NG had referred to, and the work PM was leading in relation to virtual wards. SB also noted the staffing challenges in primary care which had influenced the record levels of ED activity. SB continued that he hoped the discussion at the next Finance and Performance Committee meeting would help with the challenge. WW encouraged SB and his teams to focus on the areas that would have the largest impact. MS added that it was important to make the connection between WW's challenge and the corporate objective under the "System" Strategic Theme, which would be considered under item 06-26.

JW asked how much intelligence the Trust had about the social care sector, including home care, and the difficult position nursing homes currently faced. MS noted that previous Trust Board meetings had acknowledged the need to replicate the demand and capacity data that was used for internal hospital purposes to community services, and that had not yet been achieved. MS added that the Integrated Care Board (ICB) would however promote change. RJ added further context on the focus on the proposed corporate objectives, and the changes RJ believed could be made to make domiciliary and care home posts more attractive. RJ however also challenged the myth that there was no capacity in social care, as there was such capacity, the issue was how the situation could be made financially sustainable. JW acknowledged that the challenges seemed to be more about the viability of the system rather than capacity.

DH noted that there were a material number of MOFD patients at TWH from East Sussex and asked whether the Trust had the same level of connection with the relevant agencies in East Sussex than for patients in North Kent. RJ acknowledged that more work was required on that aspect.

JH then referred to the "Patient Experience" strategic theme and explained the latest position in relation to the "Friends & Family Response Rates" and "Complaints" metrics, which included the following points:

- The FFT response performance remained static, but the responses received remained positive. The text messaging reminder service was due to 'go live' soon, and the level of engagement with the FFT system provider had improved. Some initiatives were planned to improve the priority given to the issue by staff, but the position was closely dependent on staffing levels.
- The complaints response position had started to recover following the application of the interventions that had been referred to at the Trust Board meeting in May 2022. The challenge was to sustain that improvement and that may be problematic for June. It had however been agreed that the additional resources would remain in place at present. The Director of Quality Governance was overseeing the position and leading the work to respond to the themes arising from complaints. There had though been some challenges to the process changes that had been made.

MC referred to the final point and asked JH to elaborate on the challenges to the process. JH stated that she believed these were more related to a resistance to change per se, and the challenges had largely been raised by junior staff, so JH was confident the issue would be resolved.

WW asked JH when she felt the complaints target would be met, given that 75% was not a particularly ambitious target. JH agreed that the 75% target should probably be higher, but stated that she was hopeful of a sustained improvement within the next three months.

RJ referred to the "Systems" strategic theme and explained the latest position in relation to the "Reduction in non-elective bed days" metric, and reported the following points:

- The reduction in non-elective bed days was not where the Trust wanted it to be, so further work was required, some of which was related to the issues discussed earlier in the meeting.
- Work to support patient flow was a theme that would feature across the corporate objectives that would be discussed under item 06-26.

DH noted the materiality of the number of MOFD patients, and acknowledged that although the number would never be reduced to zero, given the complexity of the discharge process required for some patients, the number had increased significantly over the past few months. RJ agreed and acknowledged that it had been one of the most significant pressures faced by the Trust. DH also highlighted the importance of identifying common terminology, noting that NHS England/Improvement (NHSE/I) now referred to 'patients who did not meet the criteria to reside',

which was not particularly easy for the public to understand. RJ acknowledged the point and noted that the Trust's chosen terminology would endeavour to be accessible to the public.

JW noted the number of anecdotal comments that MOFD patients that remained in hospital were not being deconditioned before their discharge. PM however gave assurance that such deconditioning was taking place and stated that the virtual ward programme would help the position. PM also gave some further context.

SO then referred to the "Sustainability" strategic theme and reported the following points in relation to the overall financial position:

- The Trust was on target with its financial plan, which was a break-even plan.
- The Trust was also on track with its CIP target for the year to date, but that target would increase markedly over the next few months, and it would be a challenge to achieve that increased target.
- There was increasing pressure in the Medicine & Emergency Care and Women's Children's and Sexual Health divisions, and Facilities departments, and those would be the first three areas subjected to an aforementioned Finance and Performance Committee "deep dive".

SO then explained the latest position in relation to the "Use of Agency" metric and noted that a reduction in temporary staffing expenditure was expected for June 2022.

RF welcomed the move to allocate additional resources to the divisions to support the delivery of their financial targets, but asked why the overall financial position had not been escalated, given the risks identified by SO. SO referred to the difficulty of forecasting future performance, so although SO was concerned, it was not yet clear whether the risks would materialise. SO continued that he expected to submit more forecast data to the Finance and Performance Committee and Trust Board. SO therefore stated that his highlighting of the issues reflected a 'soft escalation' of the issues.

WW welcomed the intended work on the forecast but asked for a comment on the financial risk associated with revenue from elective activity. SO acknowledged the significance of the risk and noted that the Trust could 'lose' 75% of the value of elective activity that was not delivered, so although June's performance would be better than in May, more improvement was required. SO also stated that the issues were considered in detail at the Finance and Performance Committee, but SO could consider providing more detailed information to the Committee and/or Trust Board, should that be considered beneficial.

Quality Items

06-23 Quarterly mortality data

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

- The Hospital Standardised Mortality Ratio (HSMR) position had increased slightly, although the one-month rolling was inaccurate and was expected to reduce.
- The Summary Hospital-level Mortality Indicator (SHMI) was normal.
- There remained some issues regarding depth of clinical coding, and in coding patients with a sign or symptom rather than a diagnosis, and that may have been affected by the engagement of some temporary clinical coders. Work therefore continued to educate junior doctors to support the coders work.
- There had been no CUMulative SUM (CUSUM) alerts.
- The "Medical Examiner Service" section noted that the Trust was being under-funded compared to the service that was expected to be provided.
- The backlog of Structured Judgment Reviews (SJRs) was being reduced.

SO referred to PM's remarks about clinical coding and stated that he understood the issue was not related to the clinical coders' work, but with the information available to the coders. PM elaborated that when the issue had been reviewed, the increased coding of signs and symptoms was related to an increase in the use of temporary coders, but it was feasible that clinicians had not been as clear in their record-keeping. PM added that the issue regarding the depth of coding was likely to be caused by clinicians.

MC stated that the Trust seemed to consistently lag in relation to the quality of clinical coding, so asked how active the Trust had been to learn from other organisations, and consider what could be done differently. MC also asked whether the variance was with the substantive clinicians, given that junior doctors tended to move between hospitals regularly. PM agreed that the rotation of the junior doctors meant that their practice would likely be reflected similarly in all the Trusts they worked at. PM also noted that he had not engaged with other organisations, but the Trust compared very well with local organisations on the HSMR and SHMI. PM also noted that the Executive Team Meeting (ETM) had approved the recruitment of a new mortality lead, that would enable the current lead, the Chief of Service, Medicine & Emergency Care, to focus on his Divisional responsibilities.

DH stated that most Trusts had found that, over time, an Electronic Patient Record (EPR) would improve the quality of clinical coding. SO also pointed out that the Trust's clinical coding function was audited regularly, and had just achieved a Level 3 rating; while the Head of Clinical Coding and PbR Assurance was leading on work to achieve a more consistent approach across local organisations. SO however noted that such work did not address MC's point about sharing of best practice, so agreed to ask the Head of Clinical Coding and PbR Assurance to explore such aspects.

Action: Ask the Head of Clinical Coding and PbR Assurance to explore what could be learned from sharing best practice across other local NHS organisations (Deputy Chief Executive/Chief Finance Officer, June 2022 onwards)

06-24 To approve the Trust's long term plan for Maternity Continuity of Carer

DH referred to the submitted report and confirmed that it had already been considered at the Quality Committee. SBS then highlighted the following points:

- The plan had been submitted for approval, and once approved, there was a requirement for updates to be submitted at the Trust Board each quarter.
- The Trust's plan did not comply with NHSE/I's default position, which required implementation by March 2024, but the Trust's recruitment position, current turnover rate, midwifery student position, and the national shortage of midwives had led to a proposal to implement Continuity of Care by March 2030. The plan was to implement the initiative over eight years, and increase the workforce by growing a local workforce rather than taking staff from other providers.
- A risk assessment had been undertaken and the Continuity of Carer arrangements at Crowborough Birth Centre in response to operational pressures.
- The rollout plan prioritised the Black and Asian Minority Ethnic (BAME) population and deprived areas, by specific postcodes.
- The current workforce was 196.49 Whole Time Equivalent (WTE), and an uplift of 42.61 WTE would be required to achieve the default Continuity of Carer arrangements. The current recruitment strategies just covered the turnover rate, so the service was working with local universities to increase student numbers and support the long-term plan.

MS asked whether other local Trusts had adopted a similar approach to the Trust. SBS stated that the ICB understood the rationale for the Trust's eight-year plan, but East Kent Hospitals University NHS Foundation Trust (EKHUFT) had opted for the default model, although they had had a significant investment in midwifery workforce and midwifery leadership. SBS added that there would likely be a focus on leadership once the Kirkup review report (of the Independent Investigation into East Kent Maternity Services) was published in September 2022. SBS also reported that both Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust had submitted a default plan, but they had acknowledged that they did not have the funding to implement that approach, so SBS expected their plans to change. SBS added that she believed the Trust's plan was realistic.

MS noted that one of the principles the Trust had committed to in other areas, was asking how developments could demonstrate how the required additional staff would be recruited from new staff, and avoid just shifting existing staff from other services within the ICS. MS therefore suggested that SBS may wish to discuss that principle with her counterparts at other local Trusts. SBS confirmed that she had held such discussions, but the principle to which MS had referred had not been universally accepted, particularly with regards to EKHUFT. The point was acknowledged.

DH asked whether the Local Maternity & Neonatal System (LMNS) primary responsibility was assurance or leadership. SBS explained that the LMNS was a partnership of organisations working together, with long terms theoretical goals about sharing staff etc.

KR noted the need for quarterly updates to be submitted to the Trust Board and stated that he presumed such updates would be able to be included in the existing "Quarterly Maternity Services report" that was received by the Trust Board. SBS confirmed that was the intention, if that was acceptable. DH confirmed that approach was acceptable.

The Trust's long-term plan for Maternity Continuity of Carer was approved as submitted.

06-25 Infection prevention and control board assurance framework

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

- SM hoped it would be the last Infection prevention and control board assurance framework that needed to be submitted to the Trust Board.
- The changes from previous versions had been highlighted, and there had been some significant changes since the last report to the Trust Board, following the issuing of guidance in April and June 2022.
- The Trust had stepped down many of its COVID-19 restrictions. Temperature checks were no longer being done at the ED, while the 'green' (non-COVID-19), 'amber' (suspected COVID-19) and 'red' (confirmed COVID-19) pathways had been changed to respiratory and non-respiratory pathways. The intention was to delineate according to symptoms and have rapid testing during the winter.
- Universal face mask wearing had also been stood down, although anyone that wished to continue to wear a mask could do so. However COVID-19 restrictions and mask wearing continued in some higher risk areas, including areas which contained vulnerable patients. Staff would also be required to continue to wear face masks on wards that had confirmed COVID-19 cases and had patients in quarantine, to protect the staff from contracting COVID-19.
- Visiting times had been extended, and two birth partners had now been allowed in maternity.
- COVID-19 testing arrangements had also been changed. PCR tests would no longer be conducted on elective patients who were awaiting admission and lateral flow tests would be used instead. A negative lateral flow test for three days was required for three days up to and including the date of admission, which was a slight variation on the national guidance.
- Social distancing had also been reduced to pre-pandemic levels, including face-to-face/in-person meetings, waiting areas and the canteens.

DH asked whether patients and visitors would be allowed back into the Trust's canteens, as that restriction had been applied during the COVID-19 pandemic. SM confirmed there were no plans to return to that previous arrangement. MS elaborated that the main concern was ensure staff had a dedicated space outside their work environment. MC highlighted the needs of the small number of long-term carers, and asked MS to consider such needs when making a longer-term decision on the canteens. MS acknowledged the point and agreed that would be considered, but noted that much of the pre-pandemic footfall had been members of the public attending the canteens to obtain an inexpensive meal, which could not be supported in the future. JH supported MC's point and highlighted the need to consider the needs of carers, and the range of food that was available for such individuals. The point was acknowledged.

Planning and strategy

06-26 To approve the corporate objectives for 2022/23

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

- The work related back to the organisational vision, and the report contained "corporate service projects" for the first time.
- Work had been undertaken with each member of the Executive Team to consider the six strategic themes and develop the proposed breakthrough objectives and corporate projects, and the 'filter' process had been applied.

- The ETM has considered the Divisional Improvement Projects, and the 'catchball' process, which focused on a 'bottom-up' approach.
- The three key themes that had been considered were recruitment and retention (including at partner organisations); improving flow (internally and externally) and financial sustainability.
- Some of the objectives had continued from 2021/22, but some had been reframed.
- The major proposed targets were "To reduce the number of incidents or concerns relating to communication each month"; "Reduction in incidents resulting in harm by 7.5% by June 2023"; "Achieve the Trust RTT Trajectory by March 2023"; "Decrease the number of occupied bed days relating to delayed discharges from our hospitals"; "Delivery of 2022/23 financial plan, including operational delivery of capital investment plan"; and "Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3".
- The five proposed cross-cutting corporate projects were "Outstanding Care", "Safer Better Sooner", "Out patient [sic] pathways and procedures", "EPMA" and "PFIS".
- The proposed "corporate service projects" were "Hybrid & Remote Working", "Leadership Development" and "Staff Rostering".
- Some further work was required to finalise the Divisional Improvement Projects.
- If the objectives were approved, the next steps included working with divisions to agree their goals, targets and objectives by mid-July 2022; finalising the complete organisational list of goals, targets and objectives using the catch ball process by the end of July; ensuring delivery capacity requirements could be met; and updating the integrated score card.
- Draft divisional scorecards would also be created, before the work moved into the implementation phase.

RJ also emphasised that the objectives may need to be changed, in response to exceptional circumstances, such as potential industrial action, so the Board should be aware of that potential.

DH then noted that the work was still in progress and asked whether it was intended to submit further information to the Trust Board once the Divisional work had been completed. RJ confirmed that would be sensible, but clarified that the Trust Board was asked to approve the other aspects. The completed aspects of the corporate objectives for 2022/23 were duly approved as submitted.

Action: Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed (Director of Strategy, Planning and Partnerships, June 2022 onwards)

06-27 Annual approval of the Trust's Green Plan

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

- The plan was aspirational, and focused on eight key areas of focus: Workforce and System Leadership; Sustainable Models of Care; Digital Transformation; Travel and Transport; Estates and Facilities; Medicines; Food and Nutrition; and Adaption.
- The document was essentially a manifesto.
- It was intended to establish a Green Committee, to be chaired by a senior person, to help embed the work beyond being Estates-focused.
- The intention was to undertake further work and develop a revised version by April 2023.

RF welcomed the Plan, but challenged the use of the word "Achieving" in relation to the "Related Targets and Current Progress" section. SMe explained that he intended the Green Committee to engage with particular areas, and develop a more detailed action plan that could be developed, which could include SMART objectives. RF welcomed that, but noted that the document was called a "Plan", so it needed to include the expected content of a plan. SMe acknowledged the point.

RF also welcomed the inclusion of social value in the Plan. SMe confirmed he had tried to include such references throughout the document and gave assurance that that aspect would be driven.

WW stated that one of the key issues was the financial cost of achieving change and how that could be captured in the plan. WW also encouraged SMe to focus on the initiatives that would provide a cost-saving or revenue-generating benefit to the Trust. SMe agreed and stated that he believed the Green Committee would be vehicle to explore the financial aspects, including the options for external funding, and the work taking place across the ICB to try and achieve economies of scale.

The Green Plan was approved as submitted.

06-28 To receive an update on the updated Outline Business Case (OBC) for Increasing Elective Orthopaedic Capacity

DH noted that the team were still working on the OBC, and there had been a lengthy discussion at the Finance and Performance Committee on 28/06/22. SB then reported the following points:

- The Trust was working with local partners to ensure the plans met the ICS' requirements.
- The main challenge at present was the cost of the project, which had increased in recent months, and the cost was now outside of the financial envelope the Trust had available.
- SB hoped to conclude the OBC soon, and hopefully by the date of the next Trust Board meeting.

DH noted that the OBC may need to be approved before the next scheduled Trust Board meeting, so asked the Trust Board to delegate the authority to approve the OBC to the Finance and Performance Committee, to enable it to make a decision before the Trust Board meeting. DH added that the invitation to the Finance and Performance Committee's consideration of the OBC could be extended beyond the membership of the Committee. The Trust Board duly agreed to delegate the authority to approve the updated OBC to the Finance and Performance Committee.

Assurance and policy

06-29 To approve the Trust's proposed submission for the Data Security and Protection Toolkit (DSPT) for 2021/22

DH noted that the submission needed to be approved, but the Trust Board would have the opportunity to review some further details in the 'Part 2' Trust Board meeting scheduled for later that day. JH then referred to the submitted report and highlighted the following points:

- The submission was required annual, and it was a self-assessment against the National Data Guardian's 10 data security standards.
- 108 of the 109 mandatory standards had been able to be declared as compliant, so it was proposed to declare a "Standards Not Met" submission, supported by an improvement plan for the mandatory assertion that has not been met.

MC stated that the confidentiality of patient information was fundamental to the Trust's business, but she could not see any assurance in the report regarding that, so suggested JH liaise with colleagues to provide further assurance on that aspect. JH agreed,

Action: Provide the Trust Board with assurance regarding the confidentiality of patient information, in light of the 'Standards Not Met' submission on the Data Security and Protection Toolkit for 2021/22 (Chief Nurse, June 2022 onwards)

The Trust Board confirmed that it supported the recommendation that the Trust made a "Standards Not Met" submission on 30/06/22, supported by an improvement plan for the mandatory assertion that had not been met.

06-30 To consider any other business

There was no other business.

06-31 To respond to questions from members of the public

KR confirmed that no questions had been received.

06-32 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.

Trust Board Meeting – July 2022

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
06-26	Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed.	Director of Strategy, Planning and Partnerships	June 2022 onwards	The work is not due to complete until early August, so an item has been scheduled for the Trust Board's meeting in September 2022.
06-29	Provide the Trust Board with assurance regarding the confidentiality of patient information, in light of the 'Standards Not Met' submission on the Data Security and Protection Toolkit for 2021/22.	Chief Nurse	June 2022 onwards	A "To receive assurance regarding the confidentiality of patient information, in light of the 'Standards Not Met' submission on the Data Security and Protection Toolkit for 2021/22" item was originally scheduled for the Trust Board's meeting in July 2022; however, was subsequently deferred to the Trust Board's meeting September 2022 due to the further work required to ensure sufficient assurance was provided.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
06-13	Amend the minutes of the Trust Board meeting on 26 th May 2022 to reflect the corrections that were agreed at the Trust Board meeting on 30 th June 2022.	Trust Secretary	July 2022	The minutes were amended.
06-22	Provide the Trust Board with a more detailed assessment of the Trust's confidence in the ability to meet the intended three-month implementation timescale for the managed MRI service.	Chief Operating Officer	July 2022	The Chief Operating Officer is confident that the three-month plan now looks realistic.
06-23	Ask the Head of Clinical Coding and PbR Assurance to explore what could be learned from sharing best practice across other local	Deputy Chief Executive / Chief Finance Officer	July 2022	The Head of Clinical Coding has been working with colleagues across the local system for some time, sharing practice and approaches. All

1

Not started

On track

Issue / delay

Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	NHS organisations.			potential learning points will continue to be identified and implemented within the Trust.

Actions not yet due (and still 'open')

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

Report from the Chair of the Trust Board

Chair of the Trust Board

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?
28/06/22	Consultant Interventional Radiologist	Ashley	Wheeler	Radiology	TBC	Replacement
28/06/22	Consultant Interventional Radiologist	Bhavin	Kawa	Radiology	TBC	Replacement
01/07/22	Consultant Benign Hepatobiliary and General Surgeon	Jeffrey	Lordan	Surgery	TBC	New
12/07/22	Consultant Gynae-oncologist	Michelle	Godfrey	Gynaecology Oncology	TBC	New

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

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

Report from the Chief Executive

Chief Executive

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

- I would like to personally thank all the staff across the Trust who continue to work tirelessly to deliver the best possible care for our patients – especially in the recent extreme temperatures. We put plans in place to support our patients and staff during the heatwave, including: installing air conditioning units and fans in wards and departments most affected by the heat; temporarily changing the uniform policy to ensure staff are comfortable; bringing in extra staff on 18 and 19 July to deal with any increase in people needing hospital care; supplying ice lollies and ice creams to staff across the organisation, delivering directly to wards, outlying facilities and clinical areas where it is difficult for colleagues to visit the staff restaurants to collect them; and installing fridges in ambulance bays to ensure ambulance crews have cold water.

In addition to the continued operational pressures, the Trust is currently managing a fourth wave of Covid and caring for around 60 positive patients on our hospital wards and in our ICU. Thankfully this wave feels very different to those we have responded to before. The vast majority of patients are not coming into hospital because of the virus. They are attending for other medical reasons and we are picking this up during admittance testing procedures. We continue to run red and green care pathways to ensure our patients, staff and visitors are protected.

- We continue to work closely with community and social care partners on system flow and I want to thank them all for their ongoing support. We are currently looking at new ways of working as part of our winter planning and the introduction of virtual wards in the coming months is one scheme which will provide extra capacity. The number of patients in our hospitals who are medically fit for discharge remains high but we are partly dependent on care homes, social care and GP practices – all of whom are working incredibly hard and dealing with their own challenges.

The Safer Better Sooner programme continues to work with teams to get patients home, or to the best place for their ongoing care, as quickly and safely as possible. Developments include:

- A continued focus on safe and speedy assessment at triage within our Emergency Departments, using established pathways such as Urgent Treatment Centres, Mental Health and Same Day Emergency Care to provide appropriate care.
- At the other end of the pathway the Discharge Lounge continues to work hard to complete the discharge process, including a new module within our automated bed management to improve efficiency and pick-ups from the wards.
- Last week the team ran a winter planning system-wide event looking at some of the obstacles we face in terms of capacity and demand. The event involved external partners including KCC, KCHFT, KMPT and West Kent CCG.
- Supporting more weekend discharges is the main drive for the team in the next three months, working with each Medicine and Orthopaedic ward to understand from front line staff how we can improve things.
- Our new Patient Pledge poster has been developed with patient and multi service input – letting our patients and carers know what we expect of them and what they can expect of us.
- We recently launched our new People and Culture Strategy, which outlines our commitment over the next three years to create an environment at MTW where everyone can thrive. This strategy has been co-designed with our people, through survey results, focus groups and engagement sessions following a very challenging period highlighting more than ever the need for a focus on wellbeing. It outlines our commitment to six key themes that staff have told us

matter the most: Staff engagement and growth; Supportive team behaviours; Recruitment and resourcing; Health and wellbeing; Equality, diversity and personalisation and collective and compassionate leadership. The People and Culture Strategy is one of our strategic foundations in our strategy triangle which supports the delivery of our vision of 'Exceptional people, outstanding care'.

- To support the ongoing pressures our focus on workforce planning remains a priority. I'm delighted that MTW is seen as a good organisation to work for and this is reflected in both the quality and number of applicants applying for jobs with us. We currently have nearly 400 people going through the pre-employment phase. In addition, 70 international nurses have joined the Trust in the last five months.
- As part of celebrations to mark the 74th birthday of the NHS (Tuesday 5 July), we officially opened our new Intensive Care Unit (ICU) garden at Tunbridge Wells Hospital. This new space offers critically ill patients and their families a safe, tranquil place to help with their recovery. As well as opening the garden, I unveiled the "lasting impressions" tree artwork – marking the work of the community during Covid-19 and consisting of leaves sewn by members of the public – and was delighted to welcome to join me, the Mayor of Tunbridge Wells, Godfrey Bland, and William Benson, Chief Executive of Tunbridge Wells Borough Council. Trees were also planted at Tunbridge Wells Hospital and in Tunbridge Wells to commemorate Amelia Scott, one of the first women town councillors and a guardian of the workhouse which later became Pembury Hospital. Amelia played a key role in improving healthcare in the town, and the trees celebrate the lasting connection between Tunbridge Wells Borough and the Hospital. You can read more [here](#).
- A new international stroke rehabilitation trial which aims to identify best practice in reducing disability after stroke, has recently launched at the Trust. Four evidence-based mobility therapies will be delivered by physiotherapists and nurses to patients within the first few days following a stroke, as part of the AVERT DOSE trial, which has recruited its first participants. Thank you to our colleagues in the Stroke Physiotherapy team and Research team for all their hard work on this important project help ensure the best possible outcomes for our stroke patients. Full details about the trial can be found [here](#).
- Our staff networks continue to work to support our colleagues across the Trust with our LGBT+ Network currently awaiting our action plan from the NHS Rainbow Badge Assessment Scheme, with a restart meeting set for September. We also have our first 'network of network' meetings planned for September. This will be hosted quarterly and is a chance for all networks to come together and share learning and updates – especially for our staff members who want to belong to multiple groups but are unable to attend lots of separate meetings.
- The 'Messenger review' (i.e. the "Health and social care review: leadership for a collaborative and inclusive future") was published on 8 June. General Sir Gordon Messenger was commissioned, in October 2021, by the then Secretary of State for Health and Social Care to examine the state of leadership and management in the health and social care sector. The review report makes recommendations in seven areas (targeted interventions on collaborative leadership and organisational values; positive equality, diversity and inclusion (EDI) action; consistent management standards delivered through accredited training; a simplified, standard appraisal system for the NHS; a new career and talent management function for managers; effective recruitment and development of non-executive directors; and encouraging top talent into challenged parts of the system). The Department of Health and Social Care has confirmed that all seven recommendations have been accepted by the government and that the publication of the report will be followed by a plan committing to implementing the recommendations. Locally, the review findings will, in the first instance, be considered by the People and Organisational Development Committee at its 'deep dive' meeting in September 2022.

- Congratulations to the joint winners of the Trust's Employee of the Month scheme for June, Karen Smart, Domestic Assistant, and Stacey Davis, Senior Phlebotomist, (a mother and daughter team). They were nominated for their work in the community where they were recognised for going above and beyond by recently supporting a vulnerable missing person. On behalf of the Trust Board I would like to say thank you to both Karen and Stacey for the kindness they showed to support this individual – demonstrating the Trust's PRIDE values in every way.

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

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Summary report from Quality Committee, 13/07/22

Committee Chair
(Non-Executive Director)

The Quality Committee met on 13th July (a 'main' meeting), via virtual means.

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

- The reports from the Committee's sub-committees (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; The Infection Prevention and Control Committee; The Drugs, Therapeutics and Medicines Management Committee; the Health and Safety Committee (which included a Report on the Water Steering Group and a verbal update on the next steps for the management of health and safety within the Trust); and The Joint Safeguarding Committee) were considered, and revised Terms of Reference were approved for the latter
- It was agreed under the summary report from the CLIPAM group that the Director of Quality Governance should consider inclusion of heightening public / patient awareness re risks re button batteries within the button battery ingestion serious incident action plan, and also consider opportunities for MTW to raise awareness of this issue via Twitter/social media
- The issues raised from the **reports from the clinical Divisions** highlighted the challenges associated with staffing levels at the Trust; and the continued impact of increased operational pressures. The Women's, Children's and Sexual Health Divisional Governance report included the latest "Quarterly Maternity Services report" which has been submitted via a separate report to the Trust Board. It was agreed under the Surgery Division Quality report for the division to clarify in its next divisional report to the committee re the nature of the risk relating to Optometrists, i.e. if the high MTW vacancy rate amongst optometry staff was due to resignations within a small group of individuals carrying out the role. It was also agreed under the Women's & Children's Division Quality Report that the issue of mitigation for the growing backlog of paediatric MRIs be referred to the Core Clinical Services Division for further update
- The Associate Chief of Surgery provided an **Update on harm reviews for patients who have waited a long time**, which confirmed new responsibility adopted by the surgery division for reviewing a subsection of patients across the organisation to provide assurance re clinical and operational assessment of harm
- Members of the Outpatient management team provided an **Update on the outpatient transformation programme** which included details of the new outpatient pledges that had been developed to improve patient experience. It was agreed that a further update on the programme should be scheduled for the committee to receive an update on the issues raised at the meeting
- The Deputy Chief Nurse (Quality and Experience) gave an update on the latest work to achieve an 'Outstanding' CQC rating
- The latest **update on mortality** included confirmation of the extension of medical examiner scrutiny to non-coronial deaths in the community
- The Chief Nurse presented the **annual review of Quality Impact Assessments (QIAs)**; it was agreed that amendments be made to reflect observations by the Chief of Service, Medicine and Emergency Care
- The Complaints & PALS Manager presented the Complaints Annual Report 2021/22 and gave an update on the new NHS Complaints Standards due for launch nationally in December 2022
- The Deputy Chief Nurse (Quality and Experience) provided the **update from the Enteral feeding and Nasogastric tube (NGT) placement working group** and agreed to circulate the detailed SMART action plan, developed in response to NG tube never events, to the committee
- The latest **Serious Incidents (SIs)**, which included the report from the Learning and Improvement (SI) Panel, were reported by the Director of Quality Governance. It was agreed that the Chair and Vice Chair of the Quality Committee should consider out of meeting if a more formal process was required for reporting of outstanding CAS alerts (to the Quality Committee). It was also agreed that the Director Quality Governance would liaise with Divisions/Chiefs of Service re how best to manage and address outstanding Datix actions to ensure that opportunities to learn and identify trends from reports were not missed

- The Committee reviewed the **Joint Safeguarding Annual Report for 2021/22**, which was pending review by the Safeguarding Committee, prior to finalisation by the Chief Nurse and Chair of the Quality Committee for Trust Board consideration (the report has been submitted to the Trust Board under a separate agenda item)
- The final version of the **Quality Accounts for 2021/22** was noted
- The Clinical Director, Pharmacy and Medicines Management provided an **update on the safe use of medical oxygen training for staff across the Trust**
- The Director Quality Governance presented **key themes of the final Ockenden report and the Southern Health NHS Foundation Trust Pascoe Review**; it was agreed that a further report to the committee would be scheduled reflecting on the observations made at the meeting
- The report from the last **Quality Committee ‘deep dive’ meeting** held on 08/06/22 was noted.
- The **summary report from the Patient Experience Committee** meeting held on 09/06/22 was noted.

2. In addition to the agreements referred to above, the meeting agreed that: N/A

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

Summary report from the People and Organisational Development Committee, 22/07/22 (Incl. Quarterly update from the Guardian of Safe Working Hours (covering April to June 2022))
**Committee Chair
(Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on the 22nd July 2022 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings** and supported the inclusion of expected completion dates.
- The Committee reviewed the **monthly update on the latest People Key Performance Indicators (KPIs)** which included updates on recruitment and retention; the retention programme board; and the development of a Trust-wide retention programme board; wherein the impact of increased mental health presentations on the Trust's bank and agency expenditure was discussed in detail and It was agreed that the Deputy Chief Executive / Chief Finance Officer should circulate the "Strategic Theme: Sustainability" breakthrough objective and associated action plan to Committee members to enable consideration of what, if any, further measures were required to achieve the delivery of the breakthrough objective. It was also agreed that the Deputy Chief People Officer, People and Systems should ensure that future "Monthly update on the latest People Key Performance Indicators (KPIs)" reports included forecasting of the Trust position against key metrics for 2022/23.
- The Deputy Chief People Officer, Organisational Development provided a comprehensive **update on plans to reduce the Trust's gender pay gap** wherein the Committee noted the further work that was required throughout the NHS, and the additional support which was required to increase the pay negotiation skills of those that were disproportionately impacted and it was agreed that the Deputy Chief People Officer, Organisational Development should develop a proposal regarding the additional support which could be provided by Non-Executive Directors for Trust staff in relation to the Gender Pay Gap.
- The Deputy Chief People Officer, Organisational Development provided the latest **update on Equality, Diversity and Inclusion (EDI)**, which included review and approval of the Trust's action plans and proposed national data submissions for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)) subject to further discussion of the action plans by the Cultural and Ethnic Minorities Network and the Disability Network respectively. The Committee held an in-depth discussion on the findings of the Trust's WRES and WDES data and the further work that was required wherein the following actions were agreed:
 - The Deputy Chief People Officer, Organisational Development should consider, and confirm to the Assistant Trust Secretary, the scheduling of an "update on the measures to improve the Trust's culture (incl. any further support required)" item at a future People and Organisational Development Committee meeting.
 - The Deputy Chief People Officer, People and Systems should consider what, if any, amendments could be made to the Trust's recruitment process to increase the application rate of candidates with disabilities.
 - The Deputy Chief People Officer, Organisational Development should ensure that the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans were circulated to Committee members once agreed by the Cultural and Ethnic Minorities Network and Disability Network respectively.
 - The Vice Chair of the People and Organisational Development Committee should liaise with the Chair of the Trust Board to consider the scheduling of a discussion at the Trust Board regarding the representation of disabled and Black, Asian and Minority Ethnic (BAME) demographics on the Trust Board.
- The Committee received the latest **update on employee engagement**, which include details of the progress with the Divisional Development plans and the initial findings from the latest 'Climate Survey' wherein it was agreed that the Deputy Chief People Officer, Organisational

Development should circulate the in-depth analysis of the findings from the latest 'Climate survey' to Committee members, once available, for review and comment.

- The Committee reviewed an **update on the new Senior Nursing Team and their associated roles** wherein the working dynamics were commended.
- The first **update from the Wellbeing Committee** was reviewed wherein the proposed reporting arrangements were discussed and it was agreed that the Assistant Trust Secretary should liaise with Chair of the Trust Board to check and confirm their support for the inclusion of the Wellbeing Guardian Non-Executive Director within the "membership" of the 'main' People and Organisational Development.
- The latest **quarterly update from the Guardian of Safe Working Hours** (covering April to June 2022) was noted (and this is enclosed in Appendix 1, for information and assurance).
- The **Director of Medical Education** attended for the latest **quarterly update** wherein the Committee commended the programme of work which had been implemented by the Medical Education Fellows and thanked the Director of Medical Education for their continued focus on the development of the Trust's Medical Education programme.
- The Committee conducted a comprehensive **review of the relevant aspects of the Risk Register** as part of the bi-annual process wherein the Committee was informed of the new and emerging risks which had been identified.
- The **recent findings from relevant Internal Audit reviews** and the **Committee's forward programme** was noted.
- Under the **evaluation of the meeting** the Committee commended the quality of the discussions which had been facilitated by the submitted reports.

In addition to the actions noted above, the Committee agreed that: The Chief People Officer should ensure that, where feasible, the "Strategic Theme: People" section of the Integrated Performance Report (IPR) was submitted as part of future "Monthly update on the latest People Key Performance Indicators (KPIs)" reports.

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

- The quarterly update from the Guardian of Safe Working Hours (covering April to June 2022) is enclosed in Appendix 1, for information and assurance

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

**‘MAIN’ PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE –
JULY 2022**



**QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE
WORKING HOURS (COVERING APRIL TO JUNE 2022)**

GUARDIAN FOR SAFE WORKING HOURS

The enclosed report covers the period April 2022 to June 2022:

- A total of 53 Exception Reports were raised during this period relating to extra hours worked.
- 4 reports were for educational opportunities missed.
- The majority were raised in General Medicine (17), General Surgery (13) and Orthopaedics (18).
- Following a change in medical staffing personnel, issues had been raised by trainee doctors relating to timely payments for extra hours worked, this issue is now in hand.

Reason for circulation to People and Organisational Development Committee

Assurance

Reporting Period: April - June 2022

Exception Reports-table of results

Specialty	Grade	No. exceptions raised
Orthopaedics	FY2	18
Haematology	CT	3
General Medicine	FY1	17
Emergency Medicine	ST1	1
ENT	FY2	1
Surgery	FY1	13
Total		53

Missed educational opportunities

Specialty	Grade	No. exceptions raised
Trauma and Orthopaedics	FY2	3
General Medicine	FY1	1
Total		4

Report Commentary:

For the period April – June 22

During this three-month period there were 53 Exception Reports received.

There were also 4 exceptions reports relating to missed educational opportunities..

The majority of ERs were generated by FY1 in general medicine/surgery and FY2 in trauma and orthopaedics.

During this period reasons for ERs being raised included;

- Increased staff sickness resulting in staff shortages
- Excessive workload
- Unwell patients taking a long time to treat.

The main issue during this period has been understanding the frustration of our junior doctors relating to not being paid appropriately in a timely manner for extra hours worked. This is due to a change in medical staffing. (Andrea Stephens has taken a secondment and Vivian Ogunsipe has taken on the role of head of medical staffing whilst Andrea is on secondment). I have discussed this issue with Rob Henderson, Deputy Chief People Officer who has assured me that all junior staff leaving in August 2022 will be paid at the appropriate rate for these extra hours before they leave.

The Audit and Governance Committee met, virtually via web conference, on 20th July 2022.

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

- The **actions from previous meetings** were reviewed and it was agreed that the Audit Manager for Tiaa Ltd should ensure that as part of the planning meeting for the “Complaints, Serious Incidents and PALs” Internal Audit Review that discussions are held with the Director of Quality Governance regarding a review of the Trust’s processes for addressing national guidance.
- The Risk and Compliance Manager attended for a **review of the Trust’s red-rated risks** wherein an in-depth discussion was held regarding the further alterations required to the report to provide additional assurance to Committee members and consideration was afforded to whether any further ‘deep dives’ in specific red-rated risks were required. It was agreed that the Risk and Compliance Manager should ensure that future “Review of the Trust’s red-rated risks” reports reflect the comments received at the July 2022 Audit and Governance Committee meeting (i.e. outline the alignment of each red-rated risk to the associated Strategic Theme; provide a graphical representation of the age of each red-rated risk; and provide a recommendation of what, if any, further ‘deep dives’ should be commissioned into specific red-rated risks).
- An **update on progress with the Internal Audit plan for 2022/23** (incl. progress with actions from previous Internal Audit reviews) was reported which included details of Outstanding Audit Recommendations; wherein a comprehensive discussion was held regarding the Outstanding Audit Recommendations for the Internal Audit Review of “Payroll”, which included details of the mechanisms by which the actions to prevent further salary payments would be monitored. The list of recent Internal Audit reviews is shown below (in section 2) and details of the “Urgent” priority outstanding actions from Internal Audit reviews is also shown below (in section 3).
- The Committee reviewed the latest **Counter Fraud update** wherein the requirement for the Trust Board to be aware of bribery-related best practice was highlighted and it was agreed that the Senior Anti-Crime Manager should ensure that the “Counter Fraud update” report to the Committee’s meeting in November 2022 (and annually thereafter) included details of any changes to bribery and corruption laws and regulations, which could be submitted to the Trust Board as part of the Committee’s summary report, to ensure Trust Board members were made aware of bribery-related best practice.
- The **External Audit Annual Report for 2021/22** was reviewed (Appendix 1).
- The Medical Director and two of the Trust’s Business Change Leads attend for the Committee’s first “**Spotlight on...**” item which focused on **the findings of the Internal Audit review of “Consent”** wherein a detailed demonstration of the eConsent system was provided and the Medical Director provided further assurance regarding the measures which would be implemented to validate the findings of the Internal Audit review and ensure that the necessary improvements had been implemented.
- The Deputy Chief Executive / Chief Finance Officer provided a verbal **summary of the latest financial issues** wherein it was noted that the Trust was forecast to achieve the financial plan for month 3 of 2022/23.
- The **latest losses and compensation data** was reported; the **latest single tender / quote waivers data** was reviewed and the **details of gifts, hospitality and sponsorship** were noted.
- The Director of Emergency Planning and Response attended for the first **Security issues** report to the Committee wherein it was agreed that the Director of Emergency Planning and Response should liaise with the Trust Secretary to ensure that the Trust’s Security Committee and sub-committees were reflected in the Trust’s committee structure chart. It was also agreed that the Director of Emergency Planning and Response should ensure that the “Security issues” report to the Committee’s meeting in November 2022 included details of

the process by which members of the Executive Team discharged their responsibilities in relation to security management and the associated governance arrangements.

- The Committee approved the revised **Anti-Fraud, Bribery and Corruption Policy and Procedure** for submission to the Policy Ratification Committee, for formal ratification, however it was agreed that the Senior Anti-Crime Manager should amend the “Anti-Fraud, Bribery and Corruption Policy and Procedure” to reflect the comments received at the July 2022 Audit and Governance Committee meeting (i.e. ensure the job title for the Deputy Chief Executive / Chief Finance Officer was correct; and ensure that section 4.0 “Training and competency requirements” provided details of the annual bribery awareness raising for Trust Board members).
- The Committee’s **forward programme** was noted.
- The Committee undertook an **evaluation of the meeting** which included consideration of any future “Spotlight on...” items wherein it was confirmed that “Spotlight on...” items would be scheduled for the Committee’s meeting in November 2022, however there would be an enhanced focus on the “review of the Trust’s red-rated risks” item.

2. The Committee received details of the following completed Internal Audit reviews:

- “Data Quality of KPIs – Emergency Department 4 hour wait and Referral to Treatment” (which received a “Reasonable Assurance” conclusion)
- “Data Security and Protection Toolkit Part 2” (which received a “Moderate Assurance” conclusion (as per NHS Digital Strengthening Assurance Guidance)

3. The Committee was also notified of the following “Urgent” priority outstanding actions from Internal Audit reviews:

- “Management to ensure that appropriate action has been taken to recover the salary overpayments outlined in the finding.”

4. The Committee agreed that (in addition to any actions noted above): N/A

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

- The External Audit Annual Report for 2021/22 is enclosed under appendix 1 for assurance

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

Charitable Funds Committee, 18/07/22

Committee Chair (Non-Executive Director)

The Charitable Funds Committee (CFC) met on 18th July 2022 virtually, via webconference.

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

- The **actions from previous meetings** were noted
- The Committee **reviewed the draft Charitable Fund Annual Report and Accounts for 2021/22** wherein it was agreed that the Trust Secretary should provide the Head of Financial Services with his proposed amendments to the “Charitable Fund Annual Report and Accounts for 2021/22”, to enable the Head of Financial Services to ensure that such amendments were incorporated prior to circulation to Committee members, for review.
- The **financial overview at Month 3** was considered and it was noted that:
 - The total income received up to month 3 was £12.1k with expenditure of £30.1k
 - The main donation of £5k was for Cancer Services and there were several additional £1k donations
 - The main expenditure was £11.8k for a Video processor/illuminator (VPI), Camera Head and surgical display and no expenditure requests had been refused for 2022/23
 - There were two funds with a balance over £100k as of 30/07/22
- A **proposal for the management and administration fee for 2022/23** was reviewed and the Head of Financial Services agreed to liaise with the Chair of the Charity Management Committee to conduct a benchmarking exercise against other NHS Trusts’ Charitable Funds; it was also agreed that as part of this exercise they should investigate the approach adopted by the other Trusts regarding dispersal of Charitable funds. Furthermore, it was agreed that the Chair of the Charitable Funds Committee should liaise with the Chair of the Trust Board to confirm the appropriate point of contact at Demelza to enable the Trust to investigate the lessons learned from their fundraising approach; and the Chair of the Charity Management Committee should liaise with the Chief Operating Officer to develop an interim approach to fundraising at the Trust until such time as a substantive fundraising officer could be appointed.
- The Chair of the Charity Management Committee outlined the **proposals to simplify the Charitable funds spending** wherein the Chief Operating Officer agreed to investigate the issues experienced by the Lead Nurse for Falls Prevention during the development of the “Business Case for the Replacement of Fall Alarm Monitor Device”.
- There was a **discussion on the policy on spending charitable funds on staff long service** in which the Chief Operating Officer and Chair of the Charity Management Committee agree to develop a proposal in relation to the provision of long service awards and the associated funding approach, for consideration at a future Committee meeting, having first been considered by the Executive Team Meeting.
- The Chair of the Charity Management Committee provided the latest **update on the proposed partnership with Maggie’s Centres** wherein the Committee was informed that the Heads of Terms would be submitted to the Trust Board for approval, which were provisionally scheduled for the September 2022 ‘Part 1’ Trust Board meeting.
- The Chair of the Charitable Funds Committee confirmed that the **findings from the Committee’s evaluation** did not highlight any areas that required substantial improvement.

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: N/A

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

Trust Board meeting – July 2022

Integrated Performance Report (IPR) for June 2022

**Chief Executive / Members
of the Executive Team**

The IPR for month 3, 2022/23, 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?

Executive Team Meeting, 26/07/22, Finance and Performance Committee, 26/07/22

Reason for submission to 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

Integrated Performance Report

June 2022














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

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	Consistent (P)assing of Target - Upper control limit is below the target line or Lower control limit is above the target line (depending on the nature of the metric)	Metric has (P)assed the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Inconsistent passing and failing of the target	Metric has (F)ailed to meet the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Consistent (F)ailing of Target - Lower control limit is below the target line or Upper control limit is above the target line (depending on the nature of the metric)	Data Currently Unavailable or insufficient data points to generate an 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.



Escalation Rules:

Please see the Business Rules for the five areas of Assurance: Consistently Failing, Not achieving target >=6 months, Hit or Miss, Consistently Passing and Achieving target >=6 months (three slides in the last Appendix)

Escalation Pages:

SPC Charts that have been escalated as have triggered the Business Rule for Full Escalation have a Red Border

Scorecards explained

Name of Metric/KPI	Latest			Previous			Assurance			
	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Variance / Driver	Variation	Assurance	CM Action
A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	159	Oct-21	100	159	Sep-21	Driver			Verbal CMS

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>



Executive Summary

Executive Summary

The report has been updated this month to include the Vision and Breakthrough objectives as agreed at the June Board. As a number of these objectives are new or have changed significantly, SROs are in the process of developing the associated A3s and completing the analysis required to fully populate the Counter Measure Summary templates, therefore, please note that the completeness of these reflects this position in this month's report. Executive leads (SROs) are being supported by Improvement and Delivery and BI colleagues to have completed this work in time for the next Board meeting.

The Trust Turnover Rate is a new SDR metric and is consistently failing the target. It is in special cause variation of a concerning nature. Vacancy Rate is now experiencing common cause variation and variable achievement of the target and has moved to an SDR metric for focussed improvement. Agency use and spend is consistently failing the target. Sickiness is in variable achievement and Safe Staffing levels remain in escalation as have not achieved the target for more than six months which is impacting on key quality indicators.

The rate of inpatient falls continues to experience common cause variation. Both the Hospital on-set of COVID and C.Difficile indicator have not achieved the target for more than six months and have therefore been escalated. These indicators also impact the Incidents resulting in harm indicator which is experiencing variable achievement of the target.

Diagnostic Waiting Times continues to experience special cause variation of an improving nature at 95.6% for June 2022. RTT performance is experiencing common cause variation and has not achieved the trajectory target for more than six months. We continue to be a Trust with no 52 week waiters (one of the first Acute Trusts to have cleared these long waiters). Elective, first outpatient and diagnostic activity levels have failed the trajectory target for the last six months but are showing signs of improvement with the elective activity currently forecasting to achieve plan in July. The high level of emergency admissions and delayed discharges continues to put pressure on the bed capacity.

A&E 4hr performance is experiencing common cause variation at 87.3% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers also remains in full escalation. The Trust continues to achieve the National Cancer 62 Day Standard (85.3%) and the national 2 Week Wait (2WW) Standard (93.3%) in May 2022. Achievement of these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and the number of patients on the 62 day backlog.

Escalations by Strategic Theme:

People:

- Turnover Rate (P.8)
- Sickiness Rate (P.9) *

Patient Safety & Clinical Effectiveness:

- Safe Staffing (P.12)
- Infection Control (P.12)*

Patient Access:

- RTT Performance (P.13)
- Planned levels of new outpatients activity (P.14)
- A&E Performance (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- Ambulance Handovers >30 minutes (P.15)
- % Emergency Admissions to Assessment Areas (P.15)
- Planned levels of Elective inpatients activity (P.17)
- Planned levels of Diagnostics activity (P.17)

Patient Experience:

- Complaints responded within target (P.19)
- FFT Response Rates - all areas (P.20)

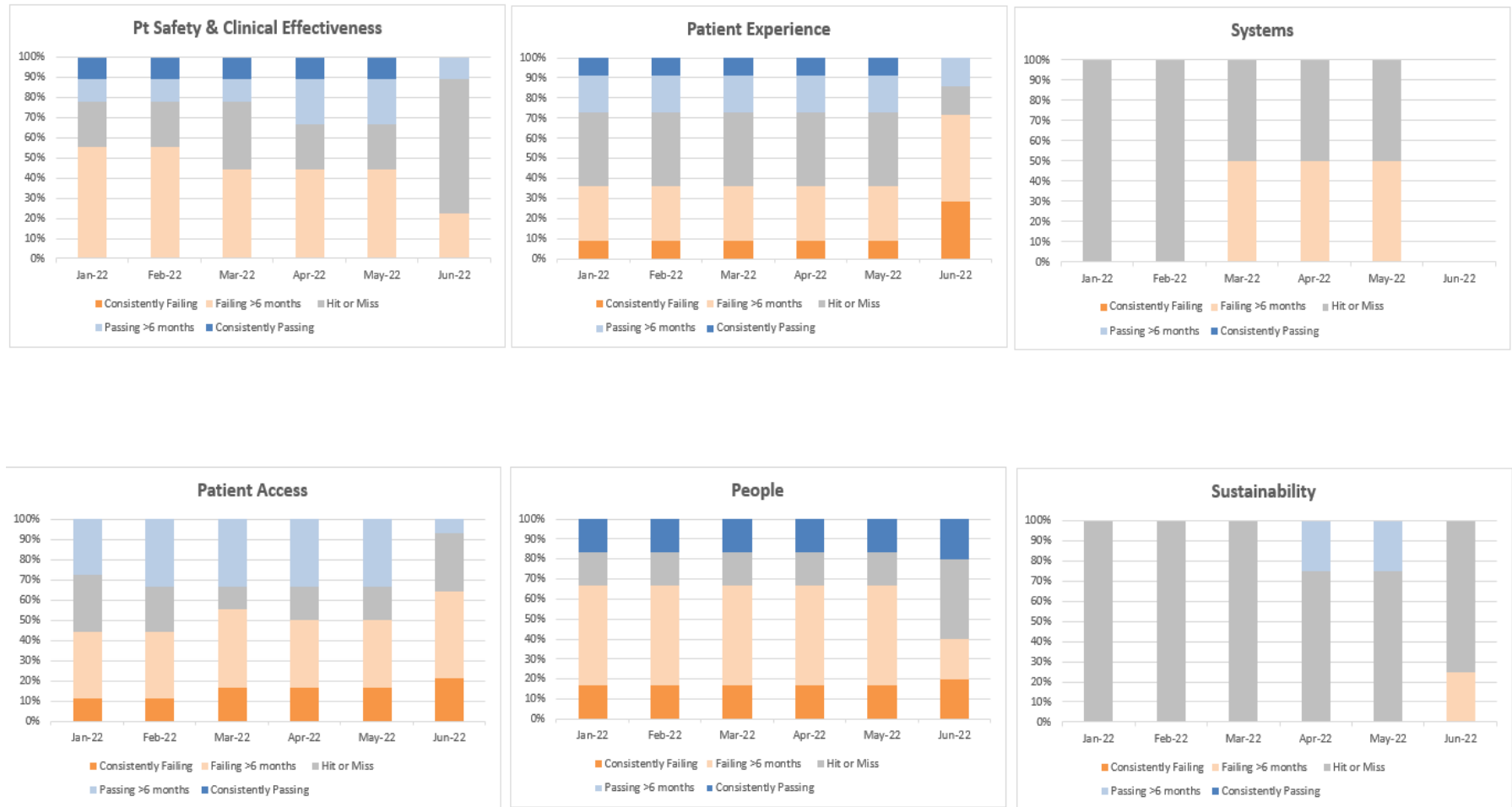
Systems: None

Sustainability

- Agency Spend (P.23)

*Escalated due to the *rule* for being in Hit or Miss for more than six months being applied

Assurance Stacked Bar Charts by Strategic Theme









Please note the metrics for each Strategic Theme have been amended in the June report following a review of the Vision and Breakthrough Objectives and an Executive review of the other metrics included in the report. These changes are reflected in the latest position reported in the charts above, hence the changes in assurance for some of the Strategic Themes



Matrix Summary

June 2022

		Assurance				
		Pass★ 	Pass 	Hit and Miss 	Fail 	Fail - 
Variance	Special Cause - Improvement 		Never Events	Access to Diagnostics (<6weeks standard)		Transformation: CAU Calls answered <1 minute
	Common Cause 	Summary Hospital-level Mortality Indicator (SHMI), Statutory and Mandatory Training	Cancer 62 Day, Complaints Rate	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3, Reduction in incidents resulting in harm by 8.2% by March 2023 RTT Patients waiting longer than 40 weeks for treatment Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023, Number of New SIs in month, Cancer - 2 Week Wait, Cancer - 31 Day, Vacancy Rate, Sickness Absence , % VTE Risk Assessment, C-Diff Rate, Activity Levels - FUP Outpatients, Cash Balance, Capital Expenditure	RTT Trajectory, FFT Response -Inpatients, Activity Levels - Total Elective, Outpatients, A&E 4 Hour Performance, Safe Staffing Levels, Hospital Acquired Covid, Complaints responded within target, Ambulance Handover Delays over 30mins, % Emergency Admissions to assessment areas	Diagnostic Activity Levels, Clinic Utilisation, FFT Response Rate - Outpatients
	Special Cause - Concern 			Delivery of Financial Plan, HSMR, MRSA	Agency Spend, Appraisal Completeness, FFT Response Rate - Maternity	Turnover Rate, FFT Response - A&E



Strategic Theme: People

	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	12%	12.9%	Jun-22	12%	13.5%	May-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12% by March 2023	12%	13.9%	Jun-22	12%	13.6%	May-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	4.1%	May-22	4.5%	5.2%	Apr-22	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	15.4%	Jun-22	95.0%	15.3%	May-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	86.1%	Jun-22	85.0%	86.2%	May-22	Driver			Not Escalated

Breakthrough Objective: Counter Measure Summary

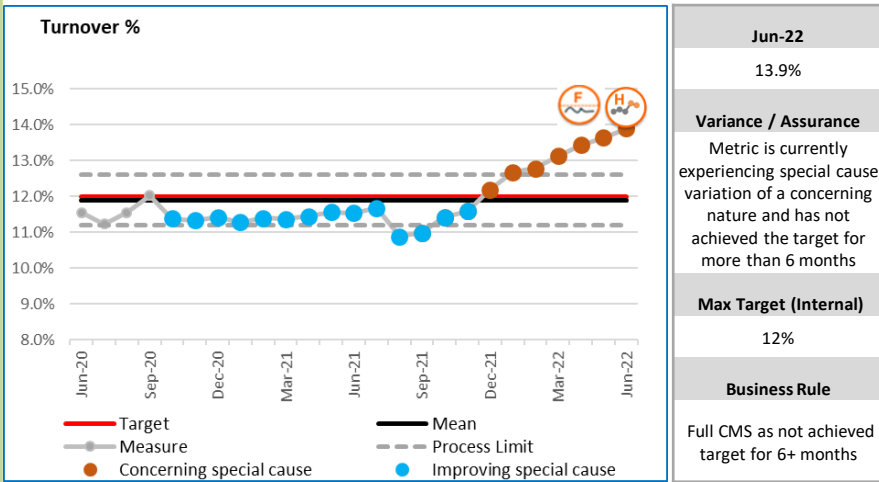
Metric Name – Reduce Turnover Rate to 12% by March 2023

Owner: Sue Steen

Metric: Turnover Rate

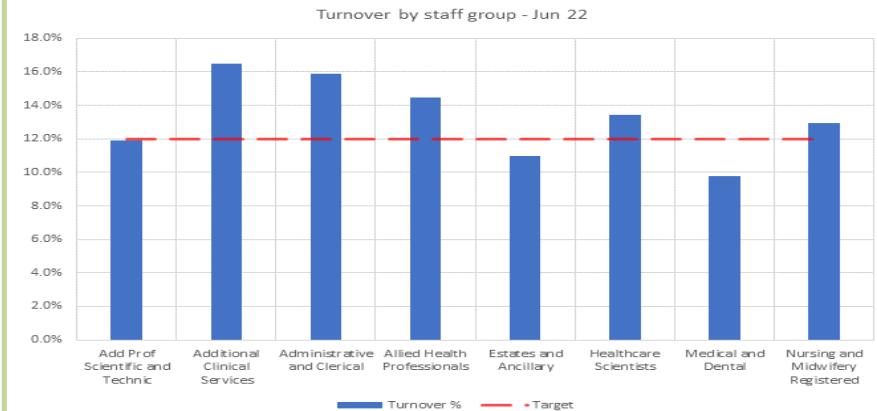
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



2. Stratified Data

** This is an early view and further analysis will be undertaken



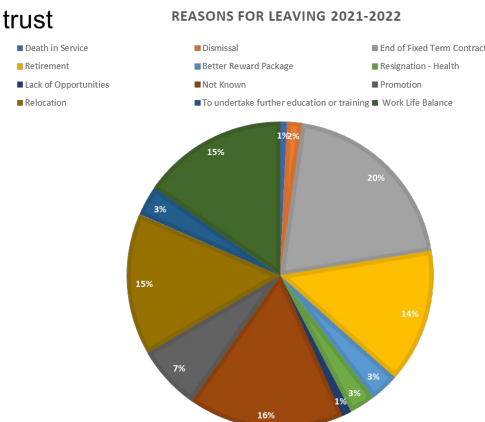
3. Top Contributors

** This is early analysis and full analysis will be undertaken shortly as part of the A3

Reasons for leaving across the trust

Aside from the reasons of 'End of FTC' (20%), 'Unknown' (16%) and 'Retirement' (14%)

The most common reasons for leaving were 'Relocation' at 15% (It should be noted that Relocation has been used even for staff moving to neighbouring trusts) and 'Work Life Balance' also making up 15%. This value also includes staff that have left to support Adult or Child dependants.

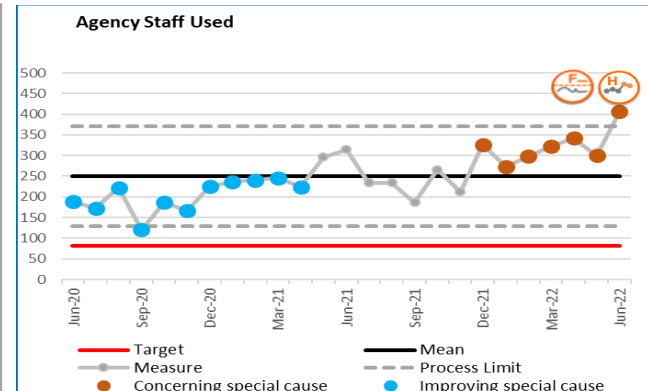
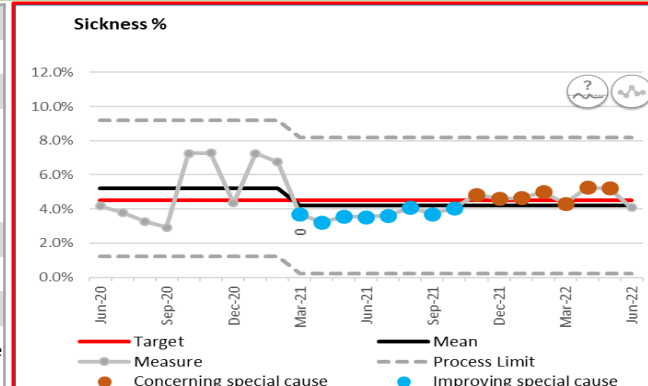
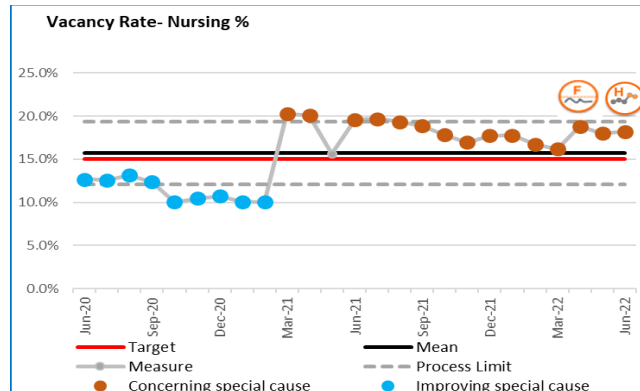
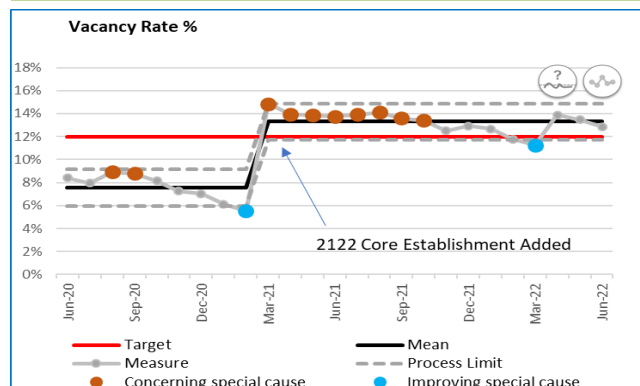


4. Action Plan

A new A3 is being developed, with countermeasures identified and to be implemented.

Define	Jul-Aug-22	Define objectives for Reduced Turnover	In progress
Measure	Jul-Aug-22	Review existing data	In progress
Analyse	Aug-22	Analyse data and define reduction trajectory	Not yet started
Improve	Aug-22-Mar-23	Working Groups reducing turnover rate with interventions	Not yet started
Control	Sep-22	Governance structure to encompass improvement framework	Not yet started

People – Workforce: CQC: Well-Led



Summary:

Vacancy Rate % - This metric is in common cause variation, and variable achievement of the target (with the new target of 12%)

Sickness % - This metric is experiencing Common Cause Variation and variable achievement of the Target for over 6 months

Nursing Vacancy Rate: Shown for information as linked to Vacancy Rate and has failed the target for more than six months.

Agency Staff Used: Shown for information as linked to Vacancy Rate and is consistently failing the target. The Medical and Emergency and ICT Directorates have the highest Agency Spend.

Actions:

Vacancy Rate: Currently over 359 candidates going through pre-employment checks or have start dates booked in the next three months. International Recruitment: 53 International educated nurses and 23 AHP candidates going through pre-employment checks. The corporate nursing teams are going to the Philippines on 17th July to hopefully recruit 60 International Educated Nurses.

Attraction and Marketing: We have Staff Nurse and Health Care support worker events scheduled for July. The recruitment team have a full calendar of events for the year which include Recruitment, PR and educational events. The recruitment microsite has proven successful with over 60,247. Our non digital advertising is in graphic design stage and will be live soon including (Billboards, Trains, ad vans and many more) Our marketing focus for July is HCSW, Staff Nurses and Pathology

Turnover: The retention team leads have analysed the leaver data over the last year and broken this down per divisions and staff groups. The main reason for people leaving last year was due to "work life balance" this could be due to the pressures of covid however there also needs to be more flexibility throughout the trust.

Assurance & Timescales for Improvement:





















Vacancy Rate % - Recruitment pipeline shows high level of recruitment activity and due to the increase of recruitment activity with international recruitment, marketing campaign and events etc we expect this metric will continue to improve.

Sickness: June absence has reduced and is ahead of target. Ongoing monitoring of sickness absence will continue (including for covid as a reason)

Turnover: Leaver data is now being analysed on a monthly basis and will be feed back to the HRBP's and divisions to design and implement strategies to improve retention.

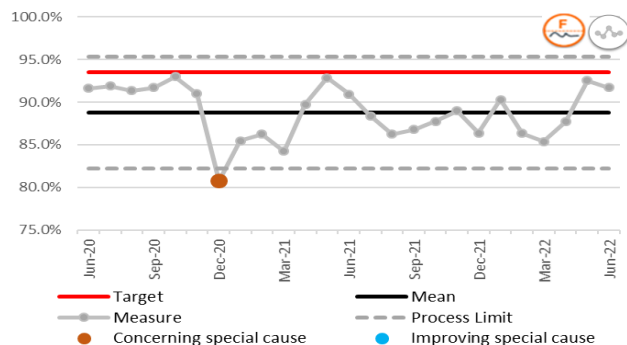
Agency Staff Used: Increasing focus on reduction in Agency Spend across the NHS and Regionally. This is directly linked to the Agency Spend Breakthrough Objective for Sustainability. Further analysis of Agency staff used compared to Agency Spend is currently being undertaken.

Strategic Theme: Patient Safety & Clinical Effectiveness

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	Reduction in incidents resulting in harm by 8.2% by March 2023	132	120	Jun-22	133	162	May-22	Driver			Verbal CMS
Breakthrough Objectives	Safe	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	7.00	7.16	Jun-22	7.07	6.87	May-22	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	11	Jun-22	11	13	May-22	Driver			Not Escalated
	Safe	Standardised Mortality HSMR	100.0	100.6	Mar-22	100.0	97.1	Feb-22	Driver			Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	95.7	Jun-22	100.0	94.0	May-22	Driver			Not Escalated
	Safe	Never Events	0	0	Jun-22	0	0	May-22	Driver			Not Escalated
	Safe	Safe Staffing Levels	93.5%	91.7%	Jun-22	93.5%	92.5%	May-22	Driver			Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	41	Jun-22	0	33	May-22	Driver			Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	50.8	Jun-22	22.7	39.0	May-22	Driver			Not Escalated
	Safe	IC - Number of Hospital acquired MRSA	0	1	Jun-22	0	0	May-22	Driver			Not Escalated

Patient Safety and Clinical Effectiveness: CQC: Safe

Overall safe staffing fill rate



Jun-22

91.7%

Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months

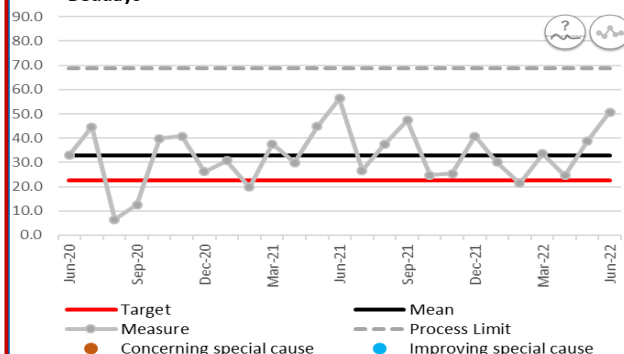
Target (Internal)

93.3%

Business Rule

Full Escalation as has not achieved the target for > 6 months

Rate of Hospital Acquired C.Difficile per 100,000 Occupied Beddays



Jun-22

50.8

Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target

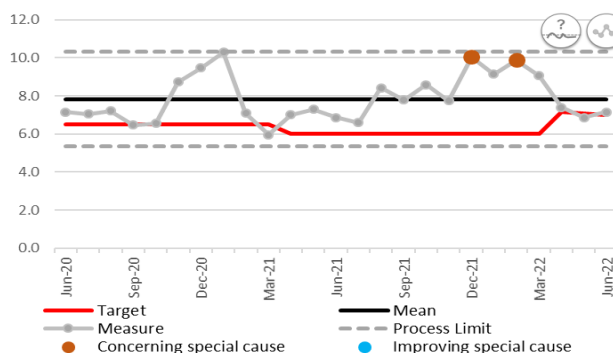
Max Target (Internal)

22.7

Business Rule

Full Escalation as Hit or Miss > 6 months

Rate of Total Patient Falls per 1,000 occupied beddays



Jun-22

7.2

Variance / Assurance
Metric is currently experiencing Common Cause and variable achievement of the target

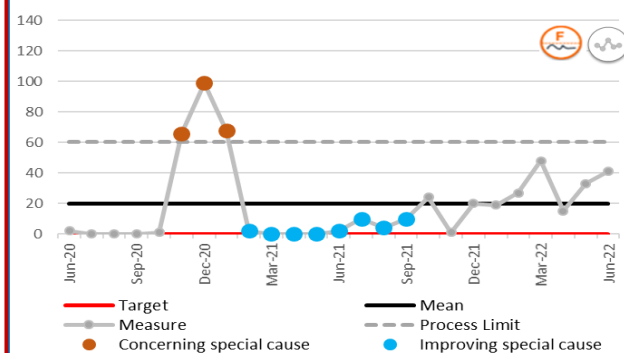
Max Target

0

Business Rule

For information as target has changed resulting in a de-escalation from CMS

Number of Hospital On-set COVID



Jun-22

41

Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6 months

Max Target (Intern)

0

Business Rule

Full Escalation as has not achieved the target for > 6 months

Summary:

Safe Staffing Fill Rate: The level reported continues to experience common cause variation and has not achieved the standard for more than six months.

Rate of C.Difficile: continues to experience common cause variation and variable achievement of the target.

Hospital on-set COVID: This indicator is experiencing common cause variation and has failed to achieved the target of zero for more than six months.

Rate of Patient Falls: is experiencing common cause variation and variable achievement of the new trajectory target

Falls Action: 'Think Yellow' 3 month trial recommenced on 21/05/22 following resolution of stock issues. ED specific assessment documents being drawn up. Leads on Working Group A has completed the ward equipment audit on the six target wards. Meeting to be held to determine next steps.

Actions:

Safe Staffing Fill Rate: Daily staffing huddles review nursing and midwifery rosters. The temporary staffing team continue to attend site meetings. The Matrons afternoon staffing huddles are supported by the Bank team to ensure the staffing allocations mitigate any safety risks. There is ongoing focus on recruitment activity, including International Recruitment. We are currently in the Philippines recruiting 60 IENs and have plans to do the same in the Caribbean for 30 IENs. We have introduced a monthly HCSW Open Day which has proven to be successful and also have quarterly RN/RM Open Days where fewer numbers have attended. The Retention Programme is progressing with working groups in place continue to focus on the reduction of Nursing, Midwifery and Clinical Support Workers (CSWs) turnover rates.

Infection Control: The Trust continues to see an increase in numbers of Trust attributable C.difficile cases, and has breached our trajectory of 58 cases. A large proportion of were deemed to be unavoidable on RCA, those cases that were deemed to be avoidable were largely due to inappropriate antimicrobial prescribing which has been feedback to teams. During June we held C.difficile incident meeting to identify areas for improvement and opportunities to drive antimicrobial stewardship further. The Trust is experiencing a number of Covid outbreaks which has seen a fairly high transmission rate in bays where a Covid positive patient has been identified, this is reflective of increasing community Covid rates and staff positives. Outbreaks are managed through Trust wide outbreak meetings which identify areas for action.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. This is now recorded through a share point to ensure accuracy of data however, requires some improvement in accuracy/completion. The Trust continues to roll out SafeCare and the next stage is to introduce the Red Flag mechanism and redeployment.. Recruitment activity continues to move at pace with a focus on international recruitment. Projected mapping up until December 2022 is underway to inform recruitment numbers required. Face to face recruitment events have recommenced and have had good attendance. It is expected that the vacancy rate will reduce to 10% by December 2022.

Infection Control: The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising, RCA scrutiny will continue for alert organisms including C.difficile. Covid-19 outbreak management meetings continue to be a high priority in the Trust, and we continue with precautions to help minimise the spread of infection such as restricted visiting, patients screening and staff LFD testing.

Rate of Patient Falls: Appointment of Falls Prevention Practitioner to support the falls prevention agenda and focus work. Confirmed to start on 18th July 2022.



Strategic Theme: Patient Access

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	We will achieve the RTT Submitted Trajectory	75.2%	70.9%	Jun-22	73.8%	71.1%	May-22	Driver			Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	118.1%	108.7%	Jun-22	114.0%	100.0%	May-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	532	713	Jun-22	541	584	May-22	Driver			Not Escalated
	Responsive	Access to Diagnostics (<6weeks standard)	88.6%	95.3%	Jun-22	85.6%	95.9%	May-22	Driver			Not Escalated
	Responsive	A&E 4 hr Performance	93.1%	87.3%	Jun-22	91.3%	84.0%	May-22	Driver			Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	93.3%	May-22	93.0%	89.5%	Apr-22	Driver			Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.3%	May-22	85.0%	85.7%	May-22	Driver			Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	61.1%	Jun-22	85.0%	60.4%	May-22	Driver			Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	3.5%	Jun-22	1.5%	3.2%	May-22	Driver			Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	70.0%	Jun-22	90.0%	69.9%	May-22	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	7.0%	7.9%	Jun-22	7.0%	11.8%	May-22	Driver			Escalation
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	62.8%	Jun-22	65.0%	62.3%	May-22	Driver			Escalation
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	99.8%	98.8%	Jun-22	91.5%	90.0%	May-22	Driver			Escalation
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	99.6%	107.8%	Jun-22	93.1%	107.0%	May-22	Driver			Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	200.4%	125.9%	May-22	198.8%	102.0%	Apr-22	Driver			Escalation

Vision: Counter Measure Summary

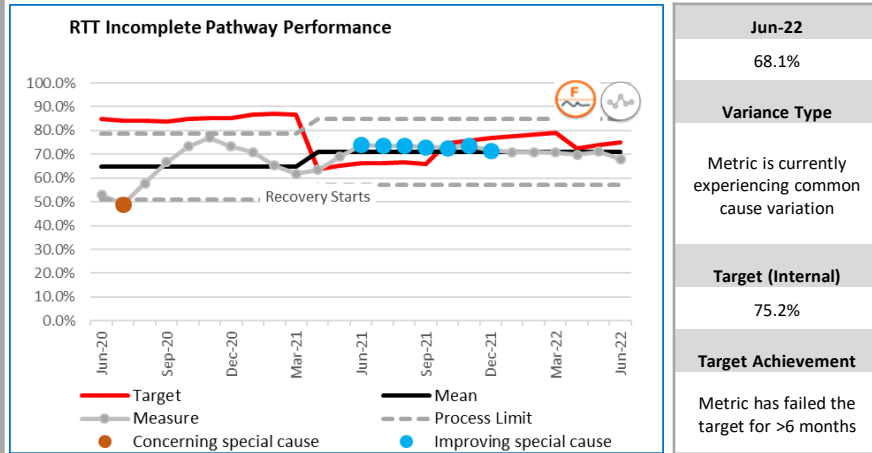
Project/Metric Name – We will achieve the submitted RTT Trajectory

Owner: Sean Briggs

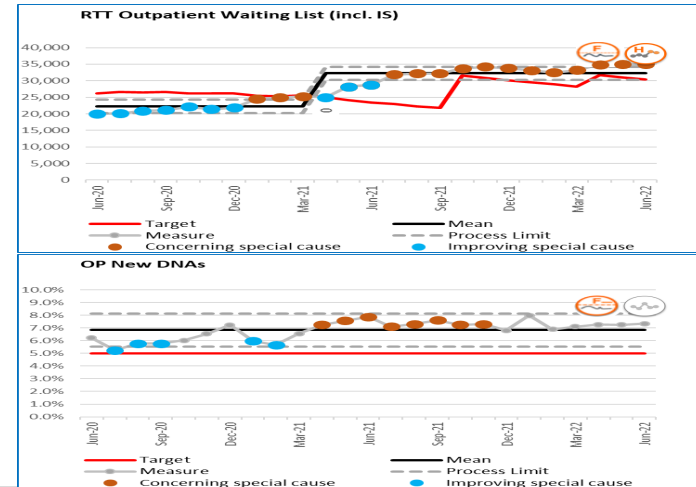
Metric: Referral to Treatment time Standard

Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data



3. Top Contributors

- General managers have undertaken bi-weekly PTL reviews to ensure that the next step in every patient's pathway is booked within the agreed timeframe.
- Weekly escalation of any capacity issues. For example; clinic, diagnostic and theatre capacity.
- Data validation to ensure all the patient's are tracked accurately on the PTL.

N.B. A detailed action plan is to follow pending a full A3 in the next month.

4. Action Plan

Breakthrough Objective delivered using Lean Six Sigma Improvement methodology and DMAIC framework

Action	Timeline	Progress
Define	July/August	In Progress
Measure	August/September	TBC
Analyse	September	TBC
Improve	TBC	
Control	TBC	

Breakthrough Objective: Counter Measure Summary

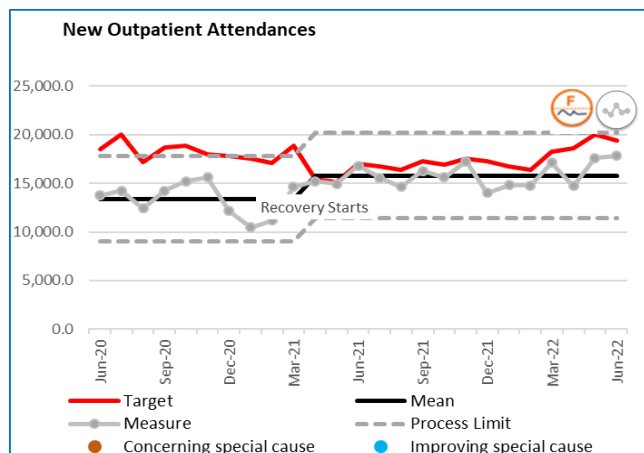
Project/Metric Name – To achieve the planned levels of new outpatients activity (shown as a % 19/20)

Owner: Sean Briggs

Metric: Elective Activity: New Outpatients

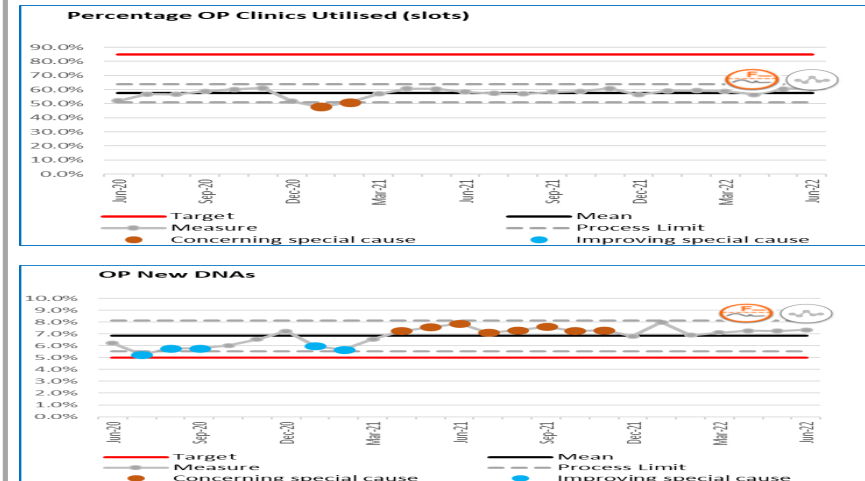
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Jun-22
17,849
Variance Type
Metric is currently experiencing Common Cause Variation
Target
19,394
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

- General managers have conducted weekly reviews down to clinic level to ensure that new capacity is fully utilised.
- Room utilisation has significantly improved through improved scheduling meetings and information sharing of available ad hoc rooms.
- Increased number of consultant-run Saturday clinics with new appointments only.

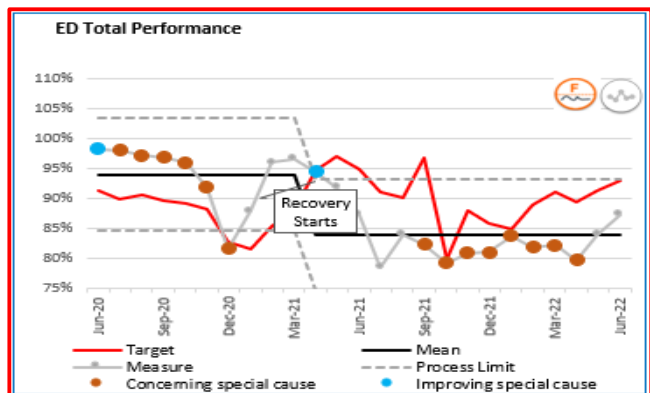
N.B. A detailed action plan is to follow pending a full A3 in the next month.

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Define	July/August	In Progress
Measure	August/September	TBC
Analyse	September	TBC
Improve	TBC	
Control	TBC	

Patient Access – Hospital Flow: CQC: Responsive

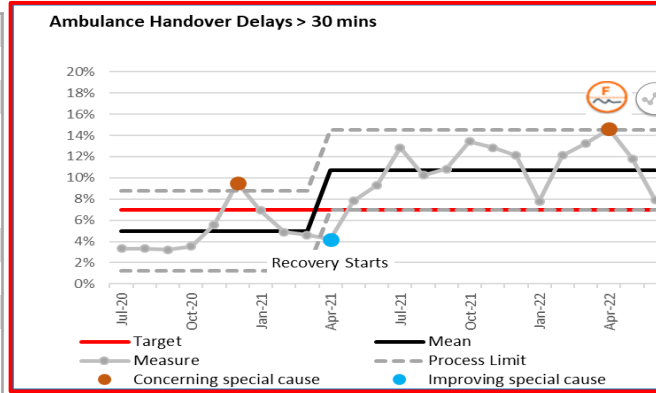


Jun-22
87.3%

Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months

Target (Internal)
93.1%

Business Rule
Full Escalation as has failed the target for >6 months

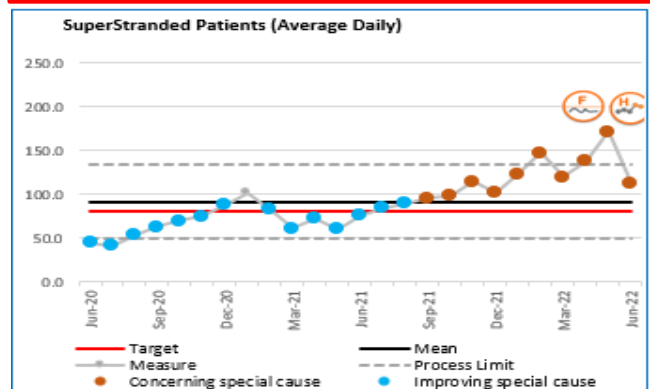


Jun-22
7.9%

Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for more than six months

Max Limit (Internal)
7%

Business Rule
Full Escalation as has failed the target for more than six months

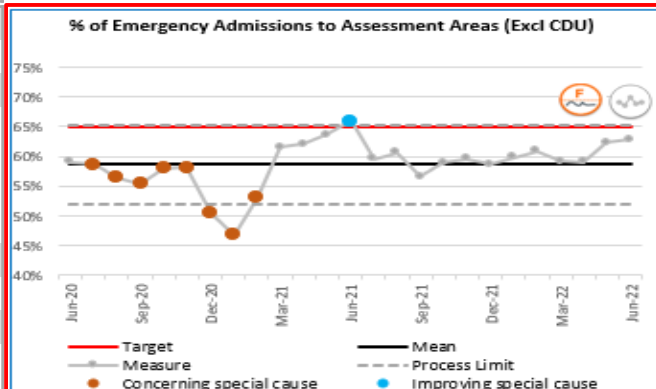


Jun-22
113

Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months

Max Limit (Internal)
80

Business Rule
For Information as linked to ED Performance



Jun-22
62.8%

Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for >6 months

Target
65%

Business Rule
Full Escalation as has failed target for >6 months

Summary:

ED 4hr performance (inc MIU): This indicator is now experiencing common cause variation and has failed the target for more than six months. Despite this, the Trust is in the top 3 performing Trusts in the country during this time.

Ambulance Handover Delays of >30 minutes is experiencing common cause variation and has failed the target for more than six months.

% of Emergency Admissions to Assessment Areas: is experiencing common cause variation of an improving nature but has failed the target for >6 months. SAU emergency admission rates have reduced due to site escalation restricting flow and lack of ability to open 24hours due to staffing constraints. Performance varies depending on escalation and complexity of patients in A&E.

Actions:

ED 4hr performance (inc MIU): The trust has maintained a strong position regionally and nationally. Improved work in SDEC areas will support sustained improvement.

Ambulance handover delays: Process of PIN entry now embedded, capacity issues remain in TW ED. Ambulance handovers undergoing an A3 approach, discussions in progress regarding digital solution. Quote received for ambulance window at TW

% of Emergency Admissions to Assessment Areas: 4 suitable candidates arranged for interview in January in order to resume 24/7 opening hours. 3 x ACP's are training to help improve flow and length of stay.

Assurance & Timescales for Improvement:

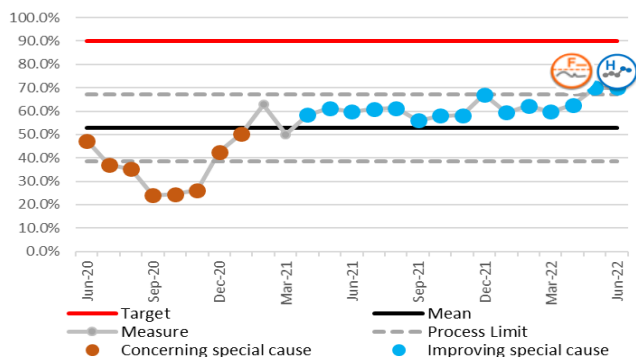
ED 4hr performance (inc MIU): Continue with ED improvement huddles. Late shifts undertaken by senior team to understand delays out of hours, A3 to be presented.

Ambulance handovers delays: Maidstone performed at 93.9% and TW 91.1% again Improved performance in June compared with May particularly at TW. Daily review of breaches maintained.

% of Emergency Admissions to Assessment Areas: Ongoing recruitment programme and introduction of the Physicians Associate role to pull from A&E so patients are not placed in a ward beds before being assessed by the SAU team

Patient Access – Transformation: Outpatients: CQC: Responsive

Calls Answered in under 1 min



Jun-22

70%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

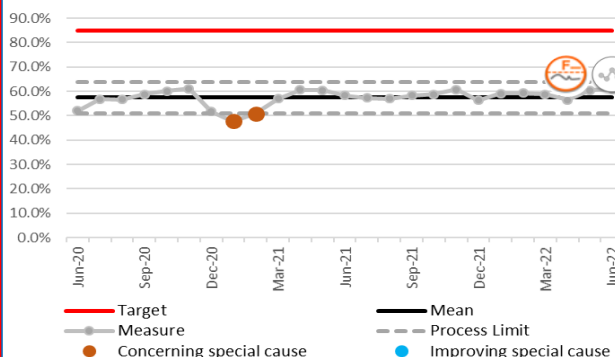
Target (Internal)

90%

Business Rule

Full Escalation

Percentage OP Clinics Utilised (slots)



Jun-22

61.1%

Variance / Assurance

Metric is currently experiencing Common Cause Variation and consistently failing the target

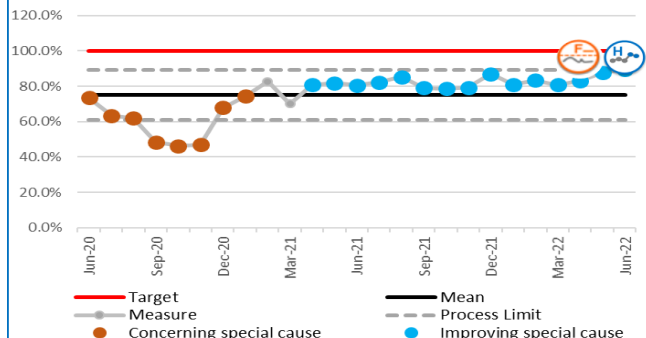
Target (Internal)

85%

Business Rule

Full Escalation

Calls Answered in under 3 minutes



Jun-22

89.6%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

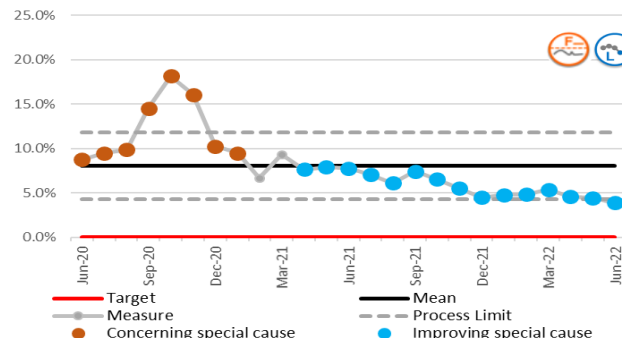
Target (Internal)

100%

Business Rule

For Information as linked to Calls <1min

Percentage of Calls abandoned



Jun-22

3.9%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

Target (Internal)

0%

Business Rule

For Information as linked to Calls <1min

Summary:

Calls Answered: The number of calls answered in less than 1 minute is improving (experiencing special cause variation of an improving nature), however it is not yet at the target level of 90%.

Outpatient Utilisation: This remains relatively steady at 60% (the indicator continues to experience common cause variation), still consistently failing the target, however there are a few remaining clinic templates skewing this data.

Actions:

Calls Answered: Investigating spacing options in which to house call operatives for the outpatient communication centre pilot to improve this. Continuous monitoring of the CAU's. Pilot with T&O- two bank staff to support the T&O CAU acting as first point of contact to screen calls is being implemented and other CAUSs are being contacted to discuss the option of extra support. July 2022. Looking to introduce a web-based patient outpatient appointment form for re-booking/cancelling appointments to reduce CAU call volume – July 2022

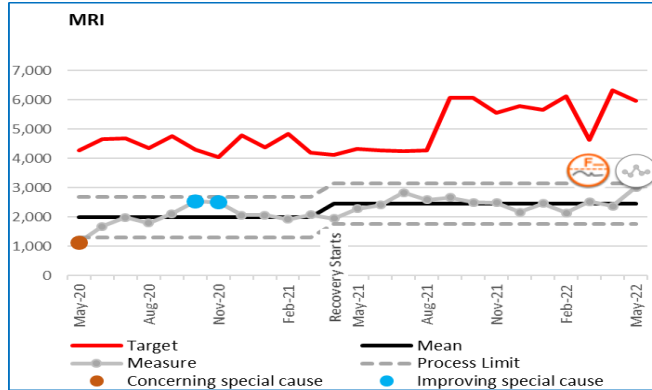
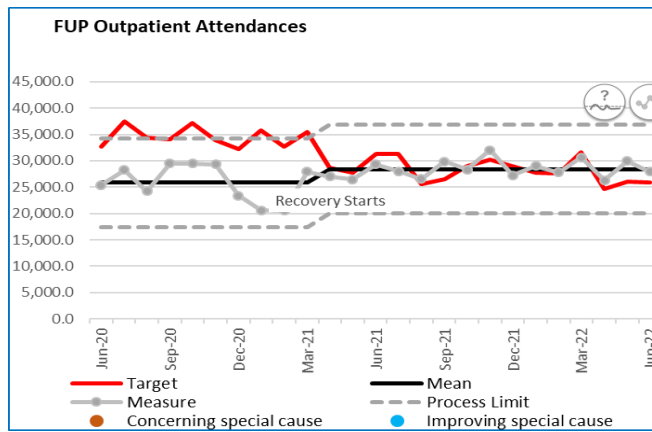
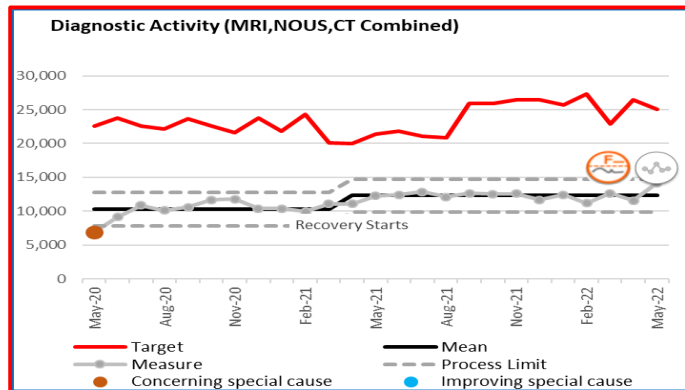
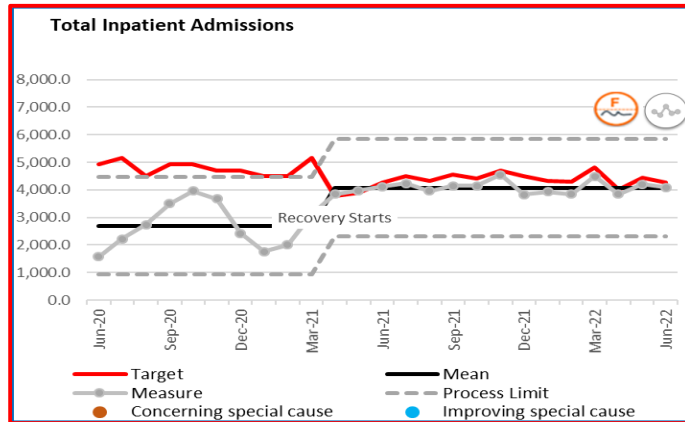
Outpatient Utilisation: The Clinical System Development Managers reviewed over 99% of the clinic templates on Allscripts, and removed historic clinics that were no longer required. Following the completion of the work above a review of nurse led clinics across specialities will be undertaken which have been identified as having low utilisation rates. August 2022

Assurance & Timescales for Improvement:

Weekly meeting with specialties are undertaken to go through call KPIs to understand areas for improvement and reasonings for poor performance. Further actions are being progressed, detailed in the Escalation Page

Outpatient Utilisation: Further analysis of utilisation is being completed to understand reasonings and a number of options are being explored and actioned by the Clinical System Development Managers to improve utilisation. Comprehensive plan to be developed to address clinic slot utilisation. July 2022

Patient Access –Activity Levels: CQC Responsive



Summary:

Elective Activity (DC/EL): Activity is experiencing common cause variation, remaining slightly below target but the gap to achieve the plan is closing month on month. Performance is slightly below plan for Quarter 1 2022 due to a change in coding for Paediatrics, which has led to a reduction in expected levels of day cases and this is currently being investigated. The Trust would have achieved planned levels overall for Quarter 1 without the impact of the reduction in day case levels for Paediatrics and we expect this to be corrected.

Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS but are experiencing common cause variation and consistently failing the target. **MRI:** is experiencing common cause variation and consistently failing the target (however MRI is at 141% of 1920 levels).

Actions:

Elective Activity (DC/EL): Activity is monitored weekly and day case activity has since increased. Coding of Paediatric activity being investigated to ensure that activity data is fully representative going forward.

Diagnostic Activity: MRI Managed service FBC now approved by NHSE/I; contracting progressing with target go live at the beginning of Q3. Work underway with Temporary staffing team and recruitment to support NOUS team.

Assurance & Timescales for Improvement:

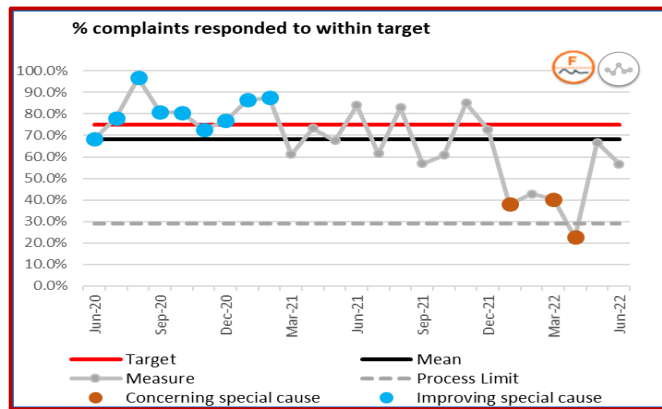
Elective Activity (DC/EL): Weekly focus on submitted activity plans with the speciality teams and directorate teams. Directorate teams to review efficiency and productivity within the theatre lists. 6-4-2 scheduling meeting revised to ensure more robust. Extra capacity identified by theatre team and is being offered to speciality teams. Weekly focus on theatre utilisation and productivity continues via trust performance meetings

Diagnostic Activity: Setting up of new Community Diagnostics Centre (CDC): Capacity meetings with both providers to improve throughput, Recruitment of bookers and helpers to improve flow, new MRI Scanner delivered on 6th June will improve TATs, AAT Software being loaded onto in-house Scanners – 40% efficiency forecasted by NHSE

Strategic Theme: Patient Experience

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month	TBC	TBC	Jun-22	TBC	TBC	May-22	Driver	No SPC	No SPC	-
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	TBC	TBC	Jun-22	TBC	TBC	May-22	Driver	No SPC	No SPC	-
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.8	Jun-22	3.9	3	May-22	Driver			Not Escalated
	Caring	% complaints responded to within target	75.0%	56.7%	Jun-22	75.0%	66.7%	May-22	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.2%	May-22	95.0%	95.7%	Apr-22	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	19.2%	Jun-22	25.0%	14.3%	May-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	1.4%	Jun-22	15.0%	0.5%	May-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	10.1%	Jun-22	25.0%	9.4%	May-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	11.9%	Jun-22	20.0%	3.6%	May-22	Driver			Escalation

Patient Experience: CQC: Caring (Hit or Miss >6 months)

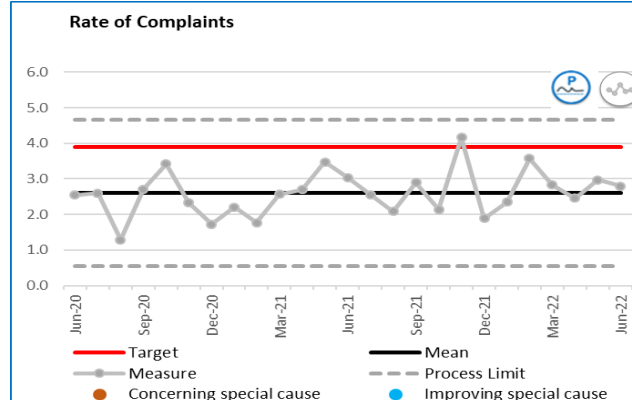


Jun-22
56.7%

Variance / Assurance
Metric is currently experiencing Special Cause
Variation of a concerning nature and variable achievement of the target

Target (Internal)
75%

Business Rule
Full Escalation failed the target 6+ months

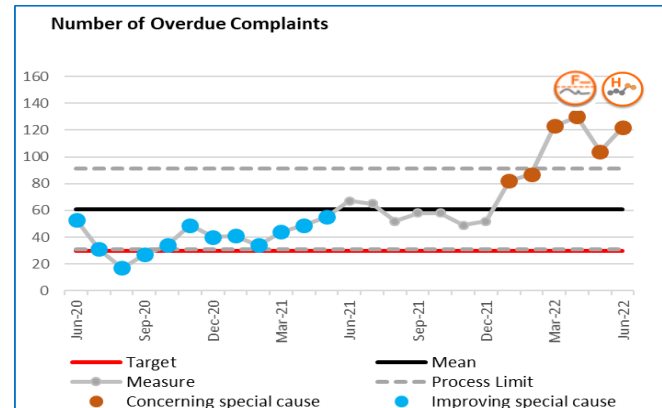


Jun-22
2.8

Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target

Max Limit (Internal)
3.9

Business Rule
For information as is now passing the target for 6+ months

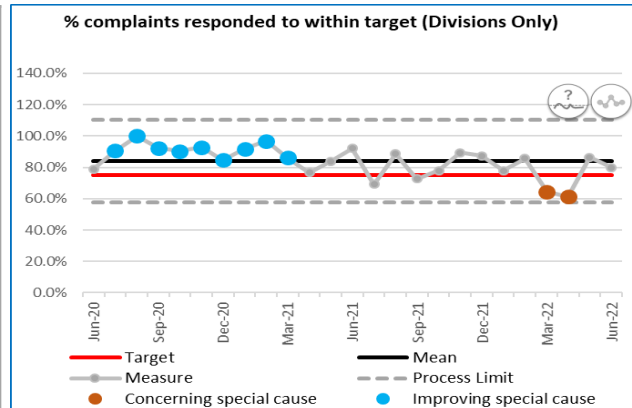


Jun-22
122

Variance / Assurance
Metric is currently experiencing Special Cause
Variation of a concerning nature and variable achievement of the target

Max Limit (Internal)
30

Business Rule
For Information as linked to % Complaint Responded



Jun-22
80.0%

Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target

Max Limit (Internal)
75%

Business Rule
For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within Target: this indicator is experiencing common cause variation but has failed the target for 6+ months

Rate of Complaints: This indicator has passed the target threshold once

Actions:

% Complaints responded to within Target:
Complaints performance recovery and stabilisation actions include;

- Interim performance monitoring reported weekly to CN
- Additional temporary resource in place up to mid Sept 2022
- Complaints leads have weekly meetings with directorates / divisions who have the biggest outstanding volume
- Business case for revised complaints model (meeting new 2022 National framework) to be finalised by July 2022
- Targeted work plan in place with daily monitoring by management team
- Appointment to PALS Team Leader role and additional secondment role in PALS to be recruited to

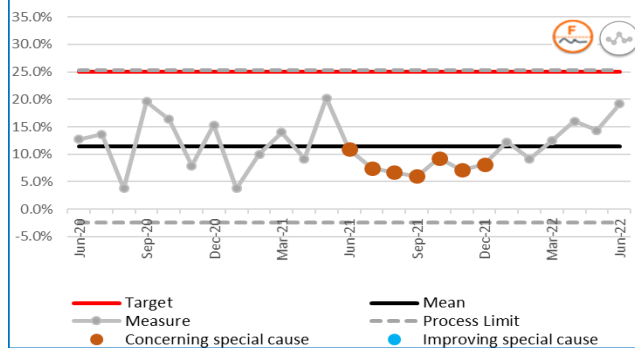
Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Expect upward shift in performance from June and stabilised performance from September 2022 (dependent on resourcing)

Patient Experience: CQC: Caring

Inpatients Friends and Family (FFT) Response Rate



Jun-22

19.2%

Variance / Assurance

Metric is currently experiencing Common cause variation and has failed the target for >6 months

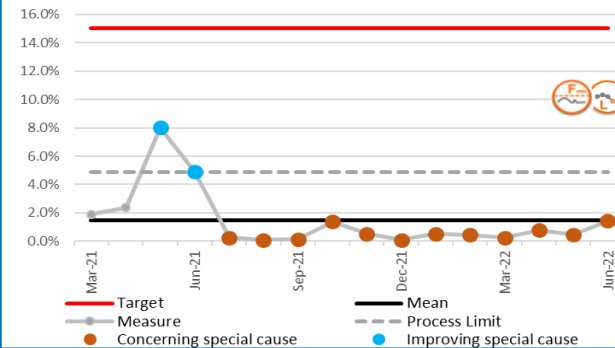
Target (Internal)

25%

Business Rule

Full Escalation failed the target 6+ months

A&E Friends and Family (FFT) Response Rate



Jun-22

1.4%

Variance / Assurance

Metric is currently experiencing Common Cause Variation and variable achievement of the target

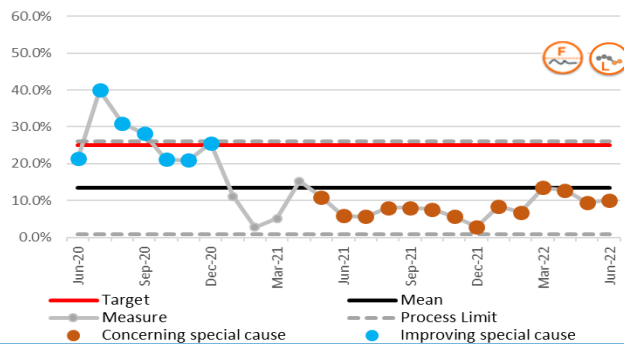
Target (Internal)

15%

Business Rule

Full Escalation as consistently failing the target

Maternity Friends and Family (FFT) Response Rate



Jun-22

10.1%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for >6months

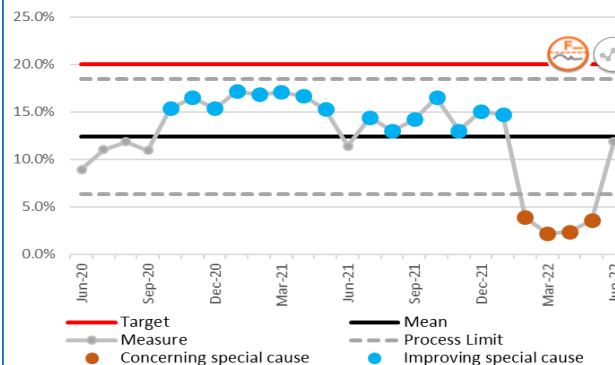
Target (Internal)

25%

Business Rule

Full Escalation as not achieved target for >6months

OP Friends and Family (FFT) Response Rate



Jun-22

11.9%

Variance / Assurance

Metric is currently experiencing Common Cause Variation and is consistently failing the target

Target (Internal)

20%

Business Rule

Full escalation as is consistently failing the target

Summary:

FFT Response Rate Inpatients: Inpatients is experiencing common cause variation but has failed the target for more than six months

FFT Response Rate A&E: A&E is experiencing special cause variation of a concerning nature and is consistently failing the target

FFT Response Rate Maternity: Maternity is experiencing special cause variation of a concerning nature and has failed the target for more than six months

FFT Response Rate Outpatients: Outpatients is experiencing common cause variation but is consistently failing the target.

Actions:

FFT Response Rate Inpatients: Push reporting has been requested however the PDF document is not appropriate / accessible. Patient Outcomes lead has generated an in-house replacement which can be accessed by divisions.

FFT Response Rate A&E: SMS text messaging commenced on 5th July in ED's / AEC areas which has elicited a large response in submissions to date. This will be reflected in the next reporting period.

FFT Response Rate Outpatients: SMS text messaging commenced on the 5th July, this has now replaced all phone call surveys.

Assurance & Timescales for Improvement:

FFT Response Rate Inpatients: Interim Push reports will be available on the 15th working day of each month. FFT responses have improved, they will be monitored fortnightly. Further action has been taken with IQVIA to improve reporting.

FFT Response Rate A&E: To continue to monitor July's data in response to the SMS campaign weekly with the AGM for ED.











FFT Response Rate Outpatients; to monitor the OPD data response rate over the next 2 months post SMS / Phone call transition with the BI and OPD Leads.



Strategic Theme: Systems

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge.	TBC	1385	Jun-22	TBC	1324	May-22	Driver	No SPC	No SPC	-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	TBC	16.9%	Jun-22	TBC	15.7%	May-22	Driver	No SPC	No SPC	-

Strategic Theme: Sustainability

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus+)/net deficit (-) £000)	-1,075	-1,073	Jun-22	-2,604	-2599	May-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000	1609	2304	Jun-22	1580	2253	May-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	298	465	Jun-22	298	497	May-22	Driver			Not Escalated
	Well Led	Cash Balance (£k)	23328	28464	Jun-22	23328	25375	May-22	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	1971	418	Jun-22	1971	176	May-22	Driver			Not Escalated

Vision: Counter Measure Summary

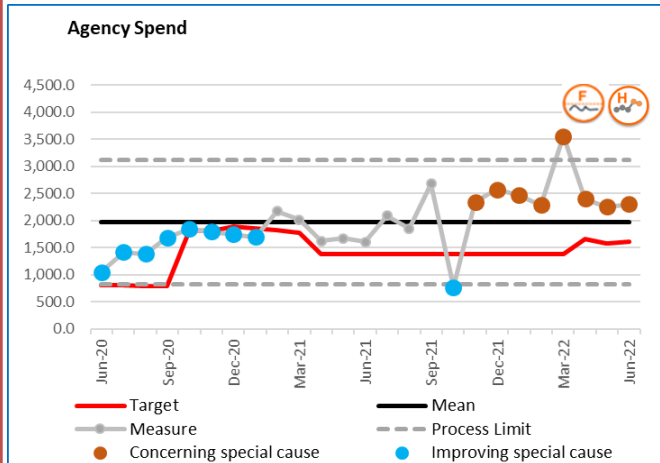
Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000

Owner: Steve Orpin

Metric: Premium Workforce Spend

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

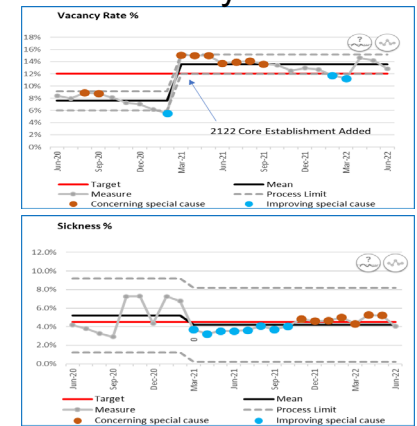


Jun-22
2,303
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
1,654
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data

**** This is an early view and further analysis will be undertaken**

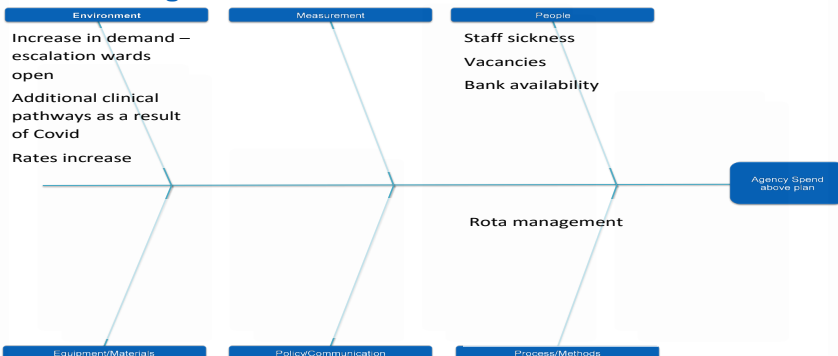
Reason	
Vacancy	48%
Back Filling	23%
Escalation / Demand	13%
COVID-19 Related	5%
Patient Special / Escort	5%
Other	4%
Sickness	3%



3. Top Contributors

**** This is early analysis and full analysis will be undertaken shortly as part of the A3**

Fishbone diagram for:



4. Action Plan

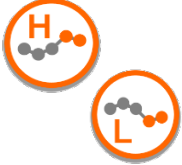



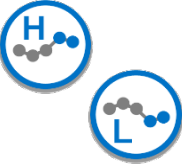

A new A3 is being developed, with countermeasures identified and to be implemented.

Contributor	Potential Root Cause	Owner	Due by?
Increase in demand	Root cause to be identified using data	MEC leadership team	16/6/22
Rota Management	Specialties not all on same roster system	Nicky Sharpington	30/6/22
People	Root cause to be identified using data	MEC leadership team	16/6/22
Rates Increase	Shortage in staff leads to higher rates from agencies		

Appendices





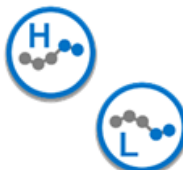

SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		<p>Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p>	<p>Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement</p>	<p>Metric is Failing the Target and is showing a Special Cause for Concern. A full CMS is required to support actions and delivery of a performance improvement. Consider escalating to a driver metric</p>
		<p>Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.</p>	<p>Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement</p>	<p>Metric is Failing the Target and is in Common Cause variation. A verbal CMS is required, but do not consider escalating to a driver metric</p>
		<p>Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p>	<p>Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement</p>	<p>Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric</p>

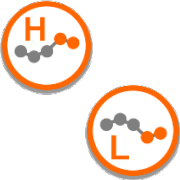



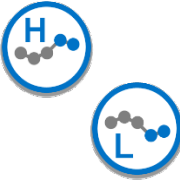

SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss


Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern . A <u>verbal CMS</u> is required to support ongoing actions and delivery of a continued / permanent performance	Metric is in Common Cause , but is showing a Special Cause for Concern . <u>Note performance</u> , but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A <u>verbal CMS</u> is required to support ongoing actions and delivery of a continued / permanent performance	Metric is Hitting & Missing the Target and is in Common Cause variation. <u>Note performance</u> , but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target and blue outline indicates this has continued for 6 months or more.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement . <u>Note performance</u>	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement . <u>Note performance</u>

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		<p>Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.</p>	<p>Metric is Passing the Target, but is showing a Special Cause for Concern. A <u>verbal CMS</u> is required to support continued delivery of the target</p>	<p>Metric is Passing the Target, but is showing a Special Cause for Concern. <u>Note performance</u>, but do not consider escalating to a driver metric</p>
		<p>Common Cause - no significant change. Assurance indicates consistently (P)assing the target.</p>	<p>Metric is Passing the Target and is in Common Cause variation. <u>Note performance</u>, consider revising the target / downgrading the metric to a 'Watch' metric</p>	<p>Metric is Passing the Target and is in Common Cause variation. <u>Note performance</u></p>
		<p>Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.</p>	<p>Metric is Passing the Target and is showing a Special Cause of Improvement. <u>Note performance</u>, consider revising the target / downgrading the metric to a 'Watch' metric</p>	<p>Metric is Passing the Target and is showing a Special Cause of Improvement. <u>Note performance</u></p>

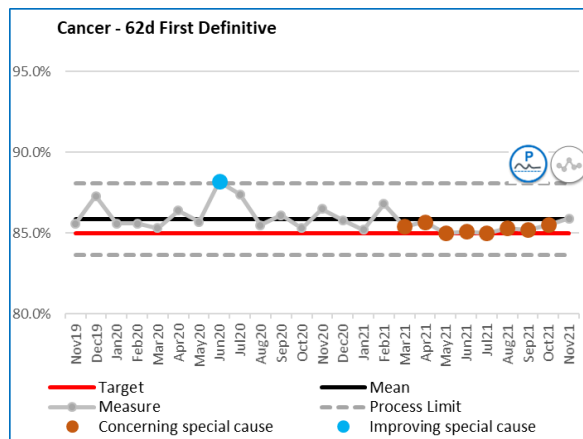
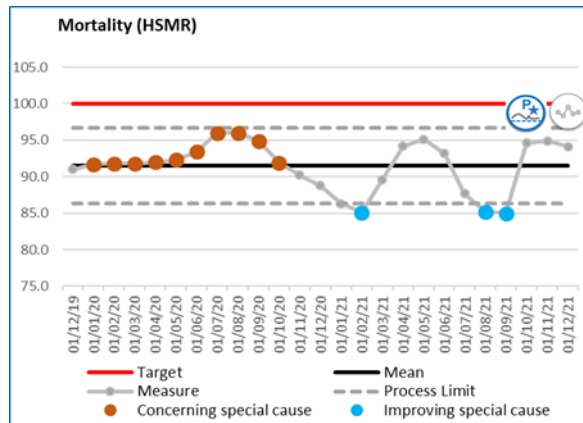
Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass**  have:

The **upper** control limit **below** the target line for metrics that need to be **below the target**

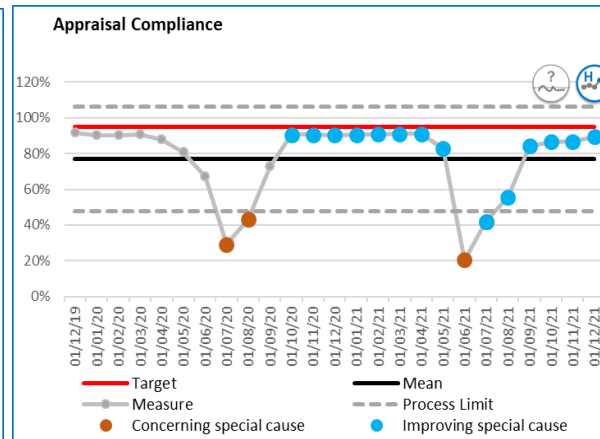
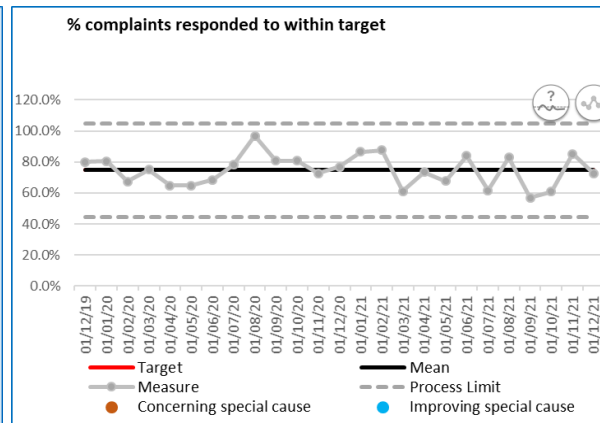
The **lower** control limit **above** the target line for metrics that need to be **above the target**


A metric achieving the target for 6 months or more will be flagged as passing 



Metrics that are **hit and miss**  have:


The **target** line **between** the **upper** and **lower** control limit for all metric types

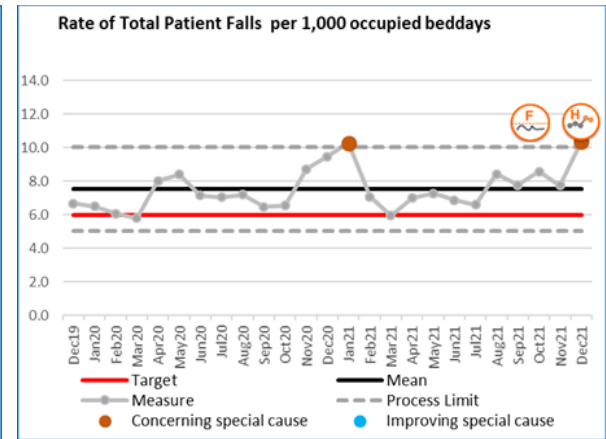
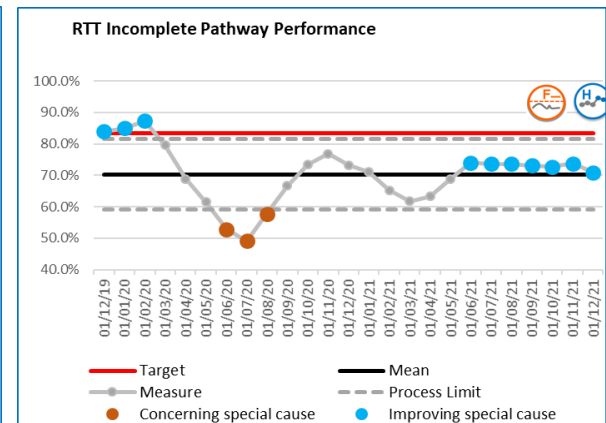


Metrics that consistently **fail**  have:

The **lower** control limit **above** the target line for metrics that need to be **below the target**

The **upper** control limit **below** the target line for metrics that need to be **above the target**

A metric not achieving the target for 6 months or more will be flagged as failing 



Executive Summary

- The Trust has delivered the June Plan and the Year to Date plan by delivering a deficit of £1.1m in month and £5.2m year to date.
- The key pressure is within pay budgets which are adverse to plan by £1.7m, this is driven by overspends within Emergency Medicine medical staffing (£1.7m) and facilities staffing (£0.7m).
- The Trust has had to release £0.9m from reserves to help to part offset the pay pressures incurred.
- Cost Improvement Plans (CIP) are slightly ahead of plan with a year to date favourable position of £0.5m. The CIP plans are phased with further stepped increases required in July and October which is detailed in more depth within the finance report.
- There is a risk of £3.6m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April to June was below 104% of 2019/20 levels. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore, the month 3 position does not assume any ERF clawback.
- The Trust is forecasting to deliver a breakeven position however this requires close to full delivery of the CIP plan.

Year to Date Financial Position

- The Trust was on plan, generating a £5.2m deficit.
- The Trust has released £0.3m of the general contingency reserve to offset the agreed continuation of enhanced bank rates.
- In line with NHSE/I guidance additional income (£1.1m) has been included in the position to offset additional costs for PCR swabbing and Rapid testing.
- The key year to date variances is as follows:
 - **Adverse Variances**
 - Pay budgets overspent by £1.7m. The main pressures continue to be within Emergency Medicine medical staffing (£1.7m) and facilities staffing (£0.7m). These pressures were partly offset by underspends within support to clinical staff (£0.5m) and Nursing (£0.3m).
 - Drugs £0.3m adverse to plan (net of passthrough related costs)
 - **Favourable Variances**
 - Release of £0.9m from reserves. The following reserves have been released: £0.4m from growth reserve to offset unfunded waiting list initiatives incurred, £0.3m from contingency and £0.2m from service developments to part offset some pay pressures in April.
 - Underspends within Clinical supplies (£0.9m) and Elective outsourcing due to Elective activity below budget (£0.5m)

Risks

- Elective Activity in April to June was below 104% of 2019/20 levels which could result in an Elective Recovery Fund clawback of c£3.6m. However, the baselines and methodology have not been confirmed or the interaction with the K&M ICS and NHSEI. Therefore, the month 3 position does not assume any ERF clawback.

Current Month Financial Position

- The Trust was on plan generating a £1.1m deficit in the month.
- The key current month variances are as follows:
 - Pathology Trade and provider to provider income overperformed by £0.1m in the month

- Pay budgets overspent (net of passthrough related costs) by £0.3m. The main pressures continue to be within Emergency Medicine medical staffing (£0.5m), and £0.2m pressure within facilities, these pressures are partly offset by underspends within nursing (£0.3m) and support to clinical staff (£0.1m).
- Drugs overspent in the month (net of HCD income) by £0.4m, this pressure was offset by underspends within use of independent sector (£0.3m) and reduction in doubtful debt (£0.2m)
- Financing Costs underspent by £0.1m in the month due to favourable positions relating to depreciation (linked to an IFRS 16 lease being less than planned), interest receivable being higher than expected and a non-recurrent profit on disposal of an asset.

Cashflow

- The closing cash balance at the end of June 2022 was £28.5m which is an increase by £3.1m from the May's cash position of £25.4m, the increase is primarily due to K&M CCG paying slightly more than the agreed SLA income value, this will be corrected by the CCG from month 4.
- The cash flow is updated daily to ensure that the Trust can meet all its commitments as well as working towards ensuring prompt payment is made to suppliers. The Trust is retaining producing two payment runs a week and are paying all invoices when they are approved to ensure all non-NHS suppliers are paid as soon as possible.

Capital Position

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICS for 2022/23 is £41.3m comprising:
- Net Internal funding (£8.6m):
 - £19.5m depreciation
 - less £2.5m in-year cash surplus (balancing to ICS control total)
 - less £8.4m of PFI finance and capital investment loan repayment
- PFI lifecycle per Project model of £1.3m - actual spend will be notified periodically by the Project Company.
- Donated Assets of £0.4m relating to forecast donations in year.
- System PDC of £1.95m for HASU (to be approved) and
- National PDC of £29m for Barn Theatre (to be approved)
- The Plan figure of £41.3m includes:
 - Estates: Estates Enabling and Backlog schemes include contractual commitments from 21/22 relating to enabling works for Linacs and SPECT CT equipment, as well as MRI enabling/build works at MGH and TWH (relating to In-Health proposed contract). They also include carry forward spend from projects that were planned for completion in 2021/22 but have overrun e.g. Annexe and Oncology OPD.
 - ICT: ICT schemes include EPMA costs relate to contractual commitments, IT for KMMS, iPro Anaesthetics, EPR infrastructure upgrade, eChemo prescribing, PACS replacement and devices replacement.
 - Equipment: Includes contractual commitments from 21/22 relating to schemes that could not be delivered by 31st March due to supplier issues. Other equipment schemes have been prioritised and business cases are in development.
 - Externally Funded schemes: Includes £1.9m for the HASU and £29m for the Barn Theatre (includes estates, ICT and equipment), both are waiting for the business cases to be approved.
- The Year to date spend on capital is £0.8m which is in line with in the overall plan. The majority of this spend relates to Estates and Equipment Backlog carry forward spend from projects commenced in 2021/22 e.g. Annexe & Oncology OPD and kitchen dishwasher.

Finance Report

Month 3
2022/23

1a. Dashboard

June 2022/23

	Current Month					Year to Date				
	Actual	Plan	Variance	Pass-through	Revised Variance	Actual	Plan	Variance	Pass-through	Revised Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	53.5	52.9	0.5	0.0	0.5	156.4	156.6	(0.2)	(0.7)	0.5
Expenditure	(50.9)	(50.2)	(0.6)	(0.0)	(0.6)	(150.5)	(150.5)	0.0	0.7	(0.6)
EBITDA (Income less Expenditure)	2.6	2.7	(0.1)	0.0	(0.1)	5.9	6.1	(0.2)	0.0	(0.2)
Financing Costs	(3.8)	(3.8)	0.1	0.0	0.1	(11.3)	(11.5)	0.2	0.0	0.2
Technical Adjustments	0.1	0.1	(0.0)	0.0	(0.0)	0.2	0.2	0.0	0.0	0.0
Net Surplus / Deficit (Incl Top Up funding support)	(1.1)	(1.1)	0.0	0.0	0.0	(5.2)	(5.2)	0.0	0.0	0.0
Cash Balance	28.5	23.3	5.1		5.1	28.5	23.3	5.1		5.1
Capital Expenditure (Incl Donated Assets)	0.4	2.0	1.6		1.6	0.8	2.4	(1.6)		(1.6)
Cost Improvement Plan (Internal £30m target)	0.5	0.3	0.2		0.2	1.4	0.9	0.5		0.5

Summary Current Month:

- The Trust was on plan generating a £1.1m deficit in the month.

The Trusts key variances to the plan are:

- Pathology Trade and provider to provider income overperformed by £0.1m in the month
- Pay budgets overspent (net of passthrough related costs) by £0.3m. The main pressures continue to be within Emergency Medicine medical staffing (£0.5m), and £0.2m pressure within facilities, these pressures are partly offset by underspends within nursing (£0.3m) and support to clinical staff (£0.1m).
- Drugs overspent in the month (net of HCD income) by £0.4m, this pressure was offset by underspends within use of independent sector (£0.3m) and reduction in doubtful debt (£0.2m)
- Financing Costs underspent by £0.1m in the month due to favourable positions relating to depreciation (linked to an IFRS 16 lease being less than planned), interest receivable being higher than expected and a non recurrent profit

Year to date overview:

- The Trust was on plan generating a £5.2m deficit year to date.
- The Trust has released £0.3m from the general contingency to offset the agreed continuation of enhanced bank rates.
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay budgets overspent by £1.7m. The main pressures continue to be within Emergency Medicine medical staffing (£1.7m) and facilities staffing (£0.7m). These pressures were partly offset by underspends within support to clinical staff (£0.5m) and Nursing (£0.3m).
- Drugs £0.3m adverse to plan (net of passthrough related costs)

Favourable Variances:

- Release of £0.9m from reserves. The following reserves have been released: £0.4m from growth reserve to offset unfunded waiting list initiatives incurred, £0.3m from contingency and £0.2m from service developments to part offset some pay pressures in April.

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2022/23 of £20m but a internal savings requirement of £30m. Against the £30m internal target the Trust has delivered £1.36m savings year to date which is £0.5m favourable to plan. The main areas of overperformance relates the Surgery Division which includes the reduction in independent sector and the non recurrent benefit due to the delay in fully recruiting into the ITU bed expansion.
- The CIP phasing increased to £1.5m from July and then increases further to £4.1m from October.

Risks

- ERF Clawback (£3.6m). The Trust has underperformed against the Elective Recovery Fund (ERF) baseline (104% of 19/20 activity) which equates to £6.3m. The Trust has not reflected this clawback in the YTD position because the baselines and methodology has not been confirmed or the interaction with the K&M ICS and NHSEI.

Forecast

- The Trust is forecasting to deliver a breakeven position however this requires close to full delivery of the CIP plan.

Jun-22		DAY				NIGHT				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	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					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance (£ (overspend))
MAIDSTONE	Stroke Unit (M) - NK551	94.8%	85.1%	-	100.0%	103.4%	113.3%	-	-	38.4%	30.2%	264	18.41	47	6.7	0.0%	0.0%	9	1	293,327	306,757	(13,430)
MAIDSTONE	Cornwallis (M) - NS959	87.5%	103.4%	-	-	130.0%	250.0%	-	-	75.3%	39.4%	205	14.26	53	7.5	0.0%	0.0%	7	0	89,426	121,781	(32,355)
MAIDSTONE	Culpepper Ward (M) - NS551	131.9%	83.4%	-	-	161.6%	210.0%	-	-	58.3%	49.0%	98	6.99	23	6.8	0.0%	0.0%	0	0	109,875	147,183	(37,308)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	92.2%	101.5%	-	-	116.1%	125.2%	-	100.0%	44.8%	53.8%	211	14.91	56	6.5	0.0%	0.0%	6	0	153,133	180,634	(27,501)
MAIDSTONE	Intensive Care (M) - NA251	98.5%	84.0%	-	-	95.0%	78.1%	-	-	6.1%	5.2%	65	3.48	19	39.7	700.0%	100.0%	0	0	259,600	232,281	27,319
MAIDSTONE	Pye Oliver (Medical) - NK259	105.7%	91.7%	-	-	107.8%	115.6%	-	-	27.2%	58.3%	89	6.06	16	6.2	6.9%	100.0%	6	0	126,255	127,300	(1,045)
MAIDSTONE	Whatman Ward - NK959	123.8%	97.0%	-	-	150.0%	217.2%	-	100.0%	94.4%	57.8%	240	16.68	49	7.4	0.0%	0.0%	13	0	101,328	150,146	(48,818)
MAIDSTONE	Lord North Ward (M) - NF651	96.2%	76.2%	-	-	95.6%	100.0%	-	-	11.6%	25.9%	39	2.90	9	8.1	0.0%	0.0%	1	2	111,138	96,234	14,904
MAIDSTONE	Mercer Ward (M) - NJ251	94.2%	78.7%	-	100.0%	118.9%	111.9%	-	-	33.6%	51.5%	113	7.72	31	5.8	0.0%	0.0%	1	1	108,840	127,817	(18,977)
MAIDSTONE	Edith Cavell - NS459	106.5%	77.6%	-	100.0%	111.4%	108.5%	-	-	49.2%	37.2%	86	6.10	12	6.3	4.3%	100.0%	4	1	112,597	111,740	857
MAIDSTONE	Acute Medical Unit (M) - NG551	89.5%	96.2%	-	-	141.5%	204.8%	-	-	38.2%	42.4%	140	9.99	53	8.9	100.0%	100.0%	4	0	164,368	175,626	(11,258)
TWH	Ward 22 (TW) - NG332	73.5%	66.1%	-	100.0%	113.6%	112.9%	-	-	42.2%	46.3%	147	10.78	70	5.1	37.3%	95.5%	11	1	139,368	158,845	(19,477)
TWH	Coronary Care Unit (TW) - NP301	76.9%	64.9%	-	-	79.1%	-	-	-	14.8%	31.2%	61	4.37	39	10.4	127.3%	100.0%	1	0	70,950	69,338	1,612
TWH	Ward 33 (Gynae) (TW) - ND302	100.1%	94.6%	-	-	93.0%	100.0%	-	-	24.9%	7.1%	50	3.23	10	7.8	27.2%	96.4%	0	0	112,268	110,092	2,176
TWH	Intensive Care (TW) - NA201	104.0%	99.5%	-	-	102.2%	95.0%	-	-	10.9%	0.0%	134	8.33	19	37.6	50.0%	100.0%	0	0	389,871	350,684	39,187
TWH	Acute Medical Unit (TW) - NA901	68.8%	57.1%	-	100.0%	90.8%	68.6%	-	100.0%	25.4%	35.2%	242	17.81	142	7.4	1.6%	100.0%	6	0	233,790	193,797	39,993
TWH	Surgical Assessment Unit (TW) - NE701	106.4%	135.1%	-	-	65.0%	90.0%	-	-	22.4%	12.2%	58	3.90	20	23.1	0.0%	0.0%	1	0	73,332	67,222	6,110
TWH	Ward 32 (TW) - NG130	80.0%	89.2%	-	100.0%	59.2%	87.8%	-	-	16.9%	37.9%	121	8.57	74	7.4	46.2%	100.0%	2	1	140,429	118,584	21,845
TWH	Ward 10 (TW) - NG131	75.8%	122.3%	-	-	96.7%	134.7%	-	-	44.8%	37.1%	193	12.37	76	6.2	6.3%	100.0%	5	0	138,874	152,229	(13,355)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	71.0%	76.5%	-	-	133.4%	96.4%	-	-	74.8%	38.3%	276	18.46	94	5.6	29.7%	100.0%	8	0	136,616	131,672	4,944
TWH	Ward 12 (TW) - NG132	93.1%	100.6%	-	100.0%	103.6%	95.3%	-	-	36.1%	25.9%	148	8.97	59	6.1	0.0%	0.0%	10	1	139,267	162,317	(23,050)
TWH	Ward 20 (TW) - NG230	83.0%	76.7%	-	-	150.1%	95.0%	-	-	27.9%	51.7%	161	11.63	72	6.3	0.0%	0.0%	12	1	164,050	162,803	1,247
TWH	Ward 21 (TW) - NG231	83.4%	96.7%	-	-	100.7%	111.7%	-	-	28.8%	46.0%	208	14.36	115	6.3	26.9%	100.0%	5	0	142,009	155,839	(13,830)
TWH	Ward 2 (TW) - NG442	57.9%	87.1%	-	100.0%	114.1%	144.3%	-	-	42.4%	45.9%	200	14.53	126	6.1	80.0%	90.6%	13	1	171,153	158,514	12,639
TWH	Ward 30 (TW) - NG330	91.9%	69.4%	-	100.0%	91.1%	131.0%	-	-	43.7%	36.4%	200	13.36	89	5.7	10.9%	100.0%	3	0	119,248	147,753	(28,505)
TWH	Ward 31 (TW) - NG331	86.6%	76.7%	-	-	91.4%	124.4%	-	-	33.2%	25.0%	172	11.35	70	5.9	60.0%	93.3%	7	7	132,279	163,319	(31,040)
Crowborough	Crowborough Birth Centre (CBC) - NP775	61.4%	85.5%	-	-	58.3%	83.3%	-	-	9.1%	0.0%	29	1.56	0	136.0	0.0%	0.0%		0	140,259	89,573	50,686
TWH	Midwifery (multiple rosters)	74.9%	60.9%	-	-	81.2%	88.6%	-	-	14.4%	4.5%	712	41.38	228	10.5	10.1%	100.0%	0	0	760,430	827,916	(67,486)
TWH	Hedgehog Ward (TW) - ND702	101.0%	182.9%	-	-	124.8%	-	-	-	56.7%	67.5%	228	15.96	44	10.8	0.4%	100.0%	0	0	143,266	200,697	(57,431)
MAIDSTONE	Maidstone Birth Centre - NP751	88.2%	96.1%	-	-	99.6%	93.3%	-	-	17.1%	0.0%	29	1.36	2	36.2	63.6%	100.0%	0	0	72,788	90,471	(17,683)
TWH	SCBU (TW) - NA102	84.5%	-	-	100.0%	90.9%	-1400.0%	-	100.0%	26.4%	2.7%	136	7.77	8	10.3	0.0%	0.0%	0	0	194,672	202,327	(7,655)
TWH	Short Stay Surgical Unit (TW) - NE901	73.9%	68.3%	-	100.0%	58.3%	93.3%	-	-	12.2%	31.4%	43	2.95	12	11	0.0%	0.0%	0	0	77,966	74,117	3,849
MAIDSTONE	Accident & Emergency (M) - NA351	96.7%	100.7%	-	-	96.7%	86.0%	-	-	36.3%	35.6%	391	27.63	43		0.6%	97.5%	0	0	367,872	380,181	(12,309)
TWH	Accident & Emergency (TW) - NA301	95.0%	75.2%	-	100.0%	96.2%	83.3%	-	100.0%	38.4%	48.4%	454	31.67	50		0.3%	87.0%	3	0	394,618	487,635	(93,017)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	84.3%	79.6%	-	100.0%	90.0%		-	-	13.5%	11.8%	21	1.40	2	14.1	26.8%	95.5%	0	0	56,166	56,489	(323)
MAIDSTONE	Peale Ward COVID - ND451	91.7%	92.6%	-	100.0%	98.9%	107.4%	-	-	23.4%	29.3%	52	3.71	16	8.3	0%	0%	4	1	119,714	93,377	26,337
MAIDSTONE	Foster Clark - NS251	86.2%	89.4%	-	100.0%	107.5%	88.9%	-	-	16.8%	37.3%	88	6.11	39	7	20%	100%	1	0	153,036	151,027	2,009
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	87.3%	97.7%	-	-	68.2%	-	-	-	13.7%	9.9%	20	1.19	4	31.5	0%	0%	0	0	54,433	57,691	(3,258)
Total Established Wards																				6,468,611	6,792,006	(323,395)
Additional Capacity beds																				54,288	36,293	17,995
Cath Labs																				0	388	(388)
Chaucer																				5,279,400	4,649,777	629,623
Other associated nursing costs																				11,802,299	11,478,464	323,835

Under fill

Overfill

Green: equal to or greater than 90% but less than 110%
Amber Less than 90% OR equal to or greater than 110%
Red equal to or less than 80% OR equal to or greater than 130%

Safeguarding update (Annual Report to Board, including Trust Board annual refresher training)
Chief Nurse / Matron for Safeguarding Adults / Named Nurse for Safeguarding Children

The Safeguarding Annual Report provides the Trust Board with an overview of all safeguarding adults and children activities within Maidstone and Tunbridge Wells NHS Trust (The Trust).

The purpose is to Inform the Committee on how the Trust is meeting its statutory duties to safeguard patients by preventing and responding to concerns, or risks of abuse, harm or neglect of patients, visitors and staff from April 2021- March 2022. The report also highlights best practice and identifies the extent to which the Trust in partnership with the local authority, police and other agencies are effectively discharging their statutory safeguarding functions both children and adults.

The day to day delivery of the safeguarding patient's agenda is delivered by the Named Nurse for Safeguarding Children, the Named Midwife and the Named Nurse for Safeguarding adults. Oversight is provided by the Deputy Chief Nurse Quality and Patient experience working together with the divisional director of Midwifery and Nursing Services. The Chief Nurse is the named person at board level with executive responsibility for all safeguarding agenda.

The report has been prepared by the named nurses for safeguarding adults and children and compiled by the deputy chief nurse. This report has had oversight of the Safeguarding and the Quality Main committees.

The report will also provide assurance that Safeguarding activities were maintained during the national and local 'lockdowns' from 2020 to present. All individuals working for the Trust, or engaged by the Trust, have a statutory responsibility for the safety and wellbeing of patients, colleagues and visitors (of all ages) to the Trust. This is a statutory responsibility enshrined in the 'Safeguarding is Everyone's Responsibility' agendas and the Children Act 1989 and the Care Act 2014.

Section 1 report: Children's safeguarding (incorporating maternity safeguarding).
Section 2 report: Adult safeguarding.

Maidstone and Tunbridge Wells NHS Trust is fully committed to ensuring that all patients are cared for in a caring safe and, secure environment.

Key concerns identified are:

- Independent Domestic Violence Advisor service provision - The Trust has been successful in securing funding for a HIDVA service to be based across both sites. It is anticipated that the service will be in place by late 2022.
- The advent of the Liberty protection Safeguards where roles and responsibilities shift from the Local Authority to Responsible Bodies – such as Hospital Trusts.

Key priorities for 2022/2023 are:

- Continue planning for the implementation of the new Liberty Protection Safeguards
- Complete audits in key service areas; including Mental Capacity Assessment (MCA) training and restraint and restrictive procedures
- Focus on disseminating lessons learned from local and national multi-agency reviews
- Continue to work on the Learning Disability Benchmarking Strategy
- Continue to promote the work of the integrated adult and children's safeguarding service
- Ensure that there is provision for a hospital independent domestic violence advocate to work across the Trust.
- Continue to monitor the change to online/ digital safeguarding concern form.

Recent Changes July 2022:

- Concerns regarding the digital safeguarding forms where Trusts were not automatically copied

into the referrals has been resolved. Mechanism has now been implemented by adding three new questions to enable safeguarding leads to have a copy of the referral.

- The Domestic Abuse Act 2021 Statutory Guidance has now been published setting out a statutory legal definition of domestic abuse, recognising that domestic abuse can encompass a range of abuse including physical or sexual violence and threatening behaviour, emotional or psychological abuse, controlling or coercive behaviour and economic abuse. The statutory definition also recognises that children can be victims in their own right, if they see, hear or experience domestic abuse.

The key message from the Safeguarding team is that Safeguarding Adults and Children is everyone's responsibility within the Trust.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 13.07.22

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

Information and assurance

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

Section One.

Safeguarding Children Annual Report 2022.

Key points

The Trust is an active participant within the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and their constituted sub-groups. Both Named Nurses sit within sub-groups; the Named Nurse Safeguarding Children sits on the Emerging Themes and Joint Exploitation Sub-groups. The Named Nurse Safeguarding Children will take over chairing the Health Reference Group (HRG) in late 2022.

The Trust has a joint Safeguarding Committee which was formed in October 2019 bringing the separate Safeguarding Children and Safeguarding Adults Committees together. It has strategic responsibility to provide assurance to the Trust Board that the Trust fulfils its statutory responsibilities, highlighting any areas of risk, consider emerging themes and trends, along with national/regional updates in relation to both safeguarding agendas. It promotes a more streamlined approach to Safeguarding and advances the 'Think Family' agenda within the Trust.

The Integrated Care Board [formerly the Clinical Commissioning Group (CCG)] Designated Safeguarding Nurses for both children and adults are represented on this committee along with Trust senior nurses/matrons, AHP's and medical leads in the Trust.

The committee has a named Non-Executive Director to champion, support and challenge both safeguarding agendas.

Safeguarding activity is underpinned by a suite of learning and development opportunities, in line with national and local guidance. The Trust has access to multi-agency training via the KMSAB and KSCMP's, and on-line training provided by the e-Learning for Health platform. Due to the COVID restrictions no face to face training was delivered in the 2020/21 time period. As the UK (and the NHS) has moved out of national restrictions the opportunities for more bespoke face to face training have arisen; we continually review our training offer and deliver a range of virtual and face to face sessions to all staff groups.

Safeguarding supervision was provided to the Safeguarding Leads via the Psychology Service at KCHFT on a quarterly basis; this service has now been de-commissioned and the Named Nurse Safeguarding Children (with her counterparts in other provider organisations) is actively pursuing a new range of opportunities for supervision. Managerial supervision for both Named Nurses is provided by the Deputy Chief Nurse. The Named Nurse Safeguarding Children also has close contact with the Named Midwife who provides oversight on Safeguarding Midwifery issues.

Supervision is provided to front line staff involved in significant or complex cases by the Named Nurses or members of their team. All Safeguarding team members (including the Named Nurses) have access to mandatory Supervision.

Maidstone and Tunbridge Wells NHS Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment. The Trust has in place a requirement for all staff to have a repeat 3 yearly DBS check.

The Trust has Named Safeguarding Professionals who lead on issues in relation to the safeguarding of children and adults. They are clear about their roles, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. This complies with the current Working Together Guidelines (2018) and the Intercollegiate Documents (2018 and 2019).

The Trust has an audit programme to provide assurance that safeguarding systems and processes are working. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.

The Trust continues to review and challenge its arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to any changing guidance and national reviews.

1. INTRODUCTION

This annual report is to inform the Trust Board about how the Trust is meeting its statutory duties to safeguard children by identifying, preventing and responding to concerns of abuse, harm or neglect of patients, visitors and staff from April 2021 to March 2022. Useful information outside of these time frames will inform the report.

All individuals working for the Trust, or engaged by the Trust, have a statutory responsibility for the safety and wellbeing of patients, colleagues and visitors to the Trust.

The NHS Accountability and Assurance Framework (2019) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Maidstone and Tunbridge Wells NHS Trust Boards assurance processes in respect to its statutory duties and responsibility around safeguarding. A revised Accountability and Assessment Framework is due for publication in 2022.

The Section 11 audit (for Safeguarding Children services) submitted in November 2020 recognised that the Trust was able to evidence that it meets all its statutory responsibilities in a robust and accessible manner. A revised Section 11 audit will be submitted in September 2022.

The Statutory requirements for Safeguarding include The Care Act 2014, Children's Act (1989/2004), Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and PREVENT (under the Counter-Terrorism and Security Act 2015). The new Domestic Abuse Act 2021 also places responsibilities on staff to ensure that children are safeguarded where all incidents of Domestic Abuse are known or recorded.

2. GOVERNANCE & SAFEGUARDING STRUCTURES

The Trust is accountable to the NHS Kent and Medway Integrated Care Board – the ICB (formerly the Clinical Commissioning Group) and reports direct to the Trust Performance & Quality Committee. *Additionally, quality and monitoring for East Sussex CCG, is captured on the Safeguarding Metrics submitted to their commissioners as a quarterly report; accordingly.*

The ICB Designated Nurses for Safeguarding are members of the Trust's Safeguarding Committee.

The Trust Executive Lead for Safeguarding is the Chief Nurse, who delegates responsibilities to the Deputy Chief Nurse (DCN) in relation to both adults and children. The Divisional Director of Midwifery and Nursing Services (DDMNQ) has additional responsibility for Safeguarding within Midwifery services.

Operational oversight of the Safeguarding Children's agenda is delegated to the Named Nurse for Safeguarding Children (NNSGC).

The Trust Board has a responsibility to ensure that there are policies and processes in place that details the processes to protect both children and adults at risk. The Trust Safeguarding Children Policy is due for a full review in 2024, and is updated regularly to take in to account new/revised legislation and national guidelines.

The Domestic Abuse Policy was published in April 2021 highlights new legislation on Domestic Abuse (Domestic Abuse Act 2021). This policy covers all patients, staff and visitors. The Safeguarding Children team attend MARAC where high risk victims of Domestic Abuse are discussed. The Local Authority is undertaking a review of the MARAC process as it currently felt to be not fit for purpose. The Named Nurse Safeguarding Children is part of the review and co-chairs the health review sub-group.

Safeguarding Committee

The Board receives assurance via the Trust Quality Committee, which receives reports, risks and plans to mitigate via the Trust's Safeguarding Committee.

The Trust Safeguarding Committee is a constituted sub-committee of the Trust Quality Committee. It is chaired by the Chief Nurse and has core representation from the Named professionals, senior leaders from the directorates (including therapies), Lead Nurse for Dementia Care, Learning Disability Liaison Nurse, Learning & Development and the ICB Designated Safeguarding Nurses.

The Committee has a Named Non-Executive Director (NED) to support and champion both safeguarding agendas.

The committee meets quarterly, in line with the required Safeguarding Quality quarterly reporting mechanisms to the ICB. New Terms of Reference (TORS) were agreed in 2021. Committee members agree that a joint approach to Safeguarding removes the (perceived) divide between adults and children and highlights the close working relationship between adults and children, and the impact that one has on the other.

The purpose of the Safeguarding committee is to implement and monitor the Safeguarding Frameworks and agendas. It has a remit to ensure that Safeguarding training is available for all staff to equip them with the knowledge and skills required to identify adults and children (and the unborn) that may need safeguarding. Training gives staff the skills to take all appropriate steps in response to concerns identified, and to assist in any investigations of those concerns with learning outcomes identified.

The Trust Safeguarding Committee draws its work plan and objectives from both local and national Safeguarding objectives. It is a forum for the review of practice and learning from incidents. Work streams are identified from themes and action plans arising from serious (Safeguarding) incidents, Safeguarding Adults Reviews, Domestic Homicide Reviews and Child Safeguarding Practice Reviews. The committee provides a forum to support and facilitate feedback and discussion between clinicians, divisions and directorates, and the commissioners. It promotes closer working between the Trust and the CCG and will wish to have a view on the development of Integrated Care Partnerships and Integrated Care Systems.

Although the Named Nurses work in close partnership they have individual work streams that are pertinent to their areas and expertise.

They have joint responsibility for:

- Design and delivery of training for both Safeguarding Adults and Safeguarding Children with an emphasis on the 'Think Family' agenda; also includes training on the principles of the Care Act (2014), the role of the lead agency, application of the Mental Capacity Act (2005), Domestic Abuse, PREVENT (under the Counter-Terrorism and Security Act 2015), Exploitation and FGM
- PREVENT – both Named Nurses are Home Office approved trainers for the PREVENT agenda
- Domestic Abuse – includes training, policy updating and support of staff & patients who are victims of Domestic Abuse; also includes developing the links with ED and local Domestic Abuse services

The Named Nurse Safeguarding Adults has individual responsibility for:

- Policy and procedure development and review, ensuring that Trust policies are in line with both the Care Act (2014) and the Kent & Medway Safeguarding Adults Policy and Procedures; also - MCA, Consent, DOLS (to include Liberty Protection Safeguards) and Physical Restraint.
- Mental Capacity Act Lead for the Trust, which includes the Deprivation of Liberty Safeguards/LPS agenda.
- Internal Management Review (IMRs) - author of IMRs in response to requests for the preparation of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)
- Represents the Trust at KMSAB sub-groups
- Attends and chairs the Adult Health Reference Group meetings
- Attends the Mental Capacity Act Local Implementation Network (MCA LIN).

- Oversees the Learning Disability agenda and line manage the Disability Liaison Nurse
- Safeguarding supervision: provides supervision to staff involved in complex or serious safeguarding cases.

The Named Nurse for Safeguarding Children leads on the key areas of work necessary to safeguard children at risk. These include:

- Named Nurse for Children in Care – responsible for ensuring that the Trust recognises the uniqueness of a child who is (or has been) in care and ensures that the appropriate support is available, and that local and national policies and guidelines are followed
- Policy and procedure development and review in line with the current legal frameworks applicable to children
- Agency Author for Child Safeguarding Practice Reviews and Domestic Homicide Reviews that involve a child
- Represents the Trust at (amongst others) Kent and Medway Joint Exploitation Group, Health Reference Group, and the Emerging Themes Sub-group. the Named Nurse will also deputise for the Executive Lead for Safeguarding as requested.
- Safeguarding supervision: provides mandatory supervision to those staff identified as requiring it (e.g., Midwifery staff, Paediatric staff, NICU and ED staff); also provides supervision and debriefs to staff involved in complex or serious safeguarding cases.
- Ensures that all processes for reviewing Child Death are adhered to (in conjunction with the Named Doctor for Child Death and the Lead Paediatric matron)
- Line manages the Safeguarding Children Nurse Specialists,
- Safeguarding Audits in the Paediatric Department
- Coordinates the discharge of children who have complex and/or Mental Health needs within the trust

3. COVID AND SAFEGUARDING

The COVID pandemic and subsequent government restrictions meant that the Trust had to develop new and creative ways of working to ensure that business continuity was maintained. Safeguarding was no different and had to adapt very quickly to an ever-changing NHS environment. No staff were redeployed during the pandemic and the Safeguarding Children remained visible in the Trust.

The Safeguarding Children team faced a number of challenges in its own right with team members on long term sick leave and staff shielding at home. This continued until March 2022. The team established a plan to prioritise work streams with the safety of all patients being the highest priority. The Safeguarding team were very proactive in understanding the huge challenges that staff faced and implemented a plan to support staff across the two main sites. The Safeguarding Children team continues to support non-Paediatric areas where children are admitted and reviews all 16/17- year-old admissions to ensure that all Safeguarding processes are followed (as appropriate).

As the Trust moves out of restrictions and moves into a new normal way of working the Safeguarding Children team will continue to support departments as before. Training will remain on-line (see below) with some face to face as required.

4. INTERAGENCY PARTNERSHIP WORKING

The Named Nurses for Safeguarding Children is proactive in working with a variety of external partners in delivering the Safeguarding agenda across Kent and Medway. We have close ties with our partners in other provider and commissioner organisation and the Local Authority. As the NHS moves towards Integrated Care Partnerships (ICP) and Integrated Care Systems (ICS), alongside established Primary Care Networks (PCN) the need for closer working will be self-evident. It is

noted that the NHS Kent and Medway Integrated Care Board came into existence on 1.7.22. No longer can individual teams work within narrow confines; we all need to have a view on the bigger picture and how we can contribute to that world view. Safeguarding needs to be joined up between partners with clear information sharing and an understanding of the role of partners. Kent has a clear vision of what partnership working looks like and clear procedures for challenging any deviation from this normal. The Kent Safeguarding Children Multi-Agency Partnership (KSCMP – the Partnership) has been in existence since 2020 and has a clear vision on priorities for the coming 12-24 months. These include Youth Violence, Complex Needs in the Adolescent, Sexually Inappropriate Behaviours, and Harm to the under 2's. The Trust will align its own priorities to match these.

The Local Authority (Kent County Council - KCC) is the lead agency for investigations into Safeguarding concerns. KCC (and East Sussex County Council - ESCC) assume responsibility for triaging all referrals and ensuring learning outcomes are shared as needed.

Health providers and commissioners in Kent and Medway attend the Health Safeguarding group (HSG) to enable debate and information sharing between organisations. This attended by the Chief Nurses from across Kent. The Kent and Medway Health Reference Group feeds into the HSG. These fora are for Named Nurse Professionals to meet and share information, develop guidelines and raise concerns to the HSG. The HRG (Children) is chaired by the CCG currently with the Named Nurse Safeguarding Children taking over the chair in late 2022.

- The Named Nurse Safeguarding Children Represents the Trust at (amongst others) the Kent and Medway Joint Exploitation Group, Health Reference Group, and the Emerging Themes sub-group of the KSCMP the Named Nurse will also deputise for the Executive Lead for Safeguarding as requested

Safeguarding Adults

The Named Nurse Safeguarding Children and wider team work closely with the Safeguarding Adults team to provide a seamless and robust Safeguarding service. As agreed they will deputise for each other.

Safeguarding Children

The Safeguarding Children team has a close relationship with our Local Authority partners in both Kent and Medway and East Sussex. The Safeguarding Children team (including Safeguarding Midwives) attend Child Protection Conference's and Strategy Meetings across the Local Authority areas and are a key partner in developing Child Protection Plans for our most vulnerable children and the unborn child.

The Named Nurse Safeguarding Children has close working relationship with her counterparts in KCHFT, EKHFT, MFT, KCHFT, DGS and ESCH and regularly meets with them to share information and learning. The Named Nurse works closely with the ICB Designated Nurses. The Trust has a single point of access ICB Designated Nurse who can support the Trust as appropriate.

The Named Nurse Safeguarding Children supports practitioners to challenge decisions made by the Local Authority if there is professional disagreement. The Kent and Medway escalation process are clearly laid out and staffs are encouraged to use this framework if they feel an inappropriate decision has been reached. It is important that staff feel able to challenge decisions as this empowers staff in their decision making and serves to highlight the important role that health has in Safeguarding. It has been highlighted in recently published Safeguarding reviews that practitioners (across Kent and Medway) feel disempowered in challenging decisions made by the Local Authority. The Partnership is looking at barriers to challenge and will publish recommendations alongside a Local Safeguarding Practice Review

5. OVERSIGHT AND SCRUTINY

a. Disclosure and Barring (DBS) checks.

The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with

adults at risk and children undergo an enhanced level of assessment. All staff are currently having their DBS checks renewed as per national policy

b. Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The S.11 report for Maidstone and Tunbridge Wells NHS Trust was submitted in November 2020; the KSCMP noted that there was nothing to query the Trust on and no concerns identified. A revised Section 11 audit will be submitted in September 2022.

c. Was Not Brought

The Trust has a process in place for following up children who are not brought to outpatient appointments within any speciality to ensure their care and health is not affected in any way. The Named Nurse Safeguarding Children follows up on children not brought to appointments and liaises with Health Visitor team, GP's and the Local Authority (if needed). A new 'Was Not Brought' policy is currently going through the Trust ratification process.

d. Flagging Systems in Place for:

- Children who are subject to a child protection plan. The Trust has implemented the national Child Protection Information Sharing System (CP-IS) in the ED. The trust has further implemented the national FGM-IS.
- Children who are designated as a Child in Care

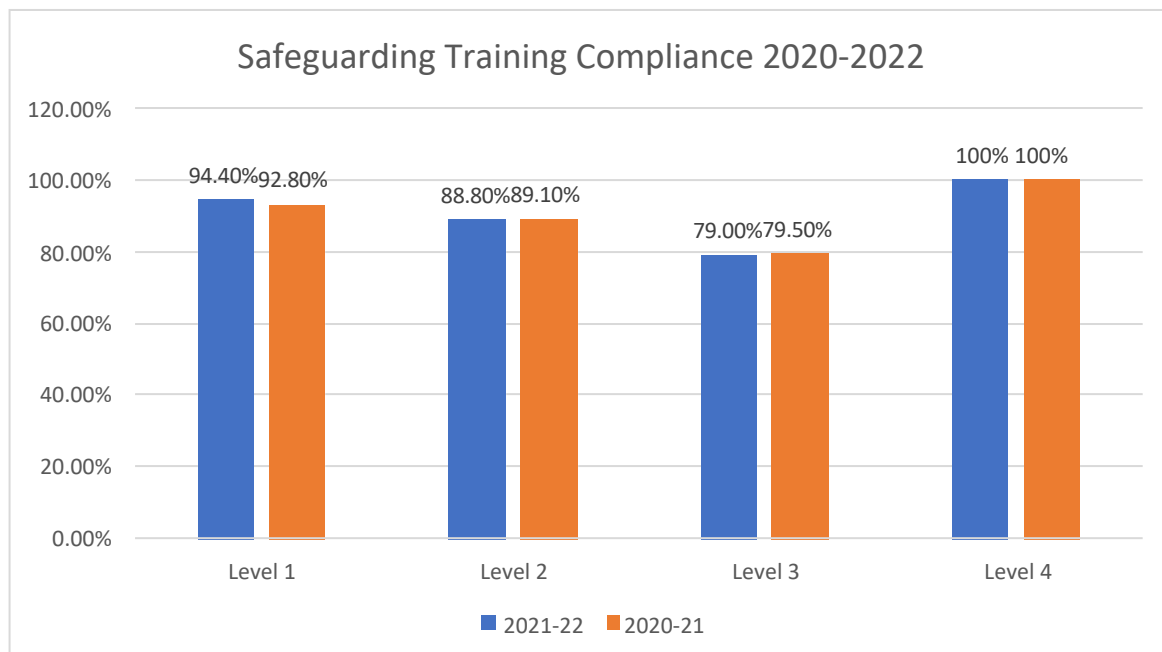
e. Training Design and Delivery

All eligible staffs are required to undertake relevant Safeguarding training; this is regularly reviewed to ensure it is up to date and fit for purpose. The Trust has a training strategy in place with regard to delivering safeguarding training. All Safeguarding Children training is in line with the current Intercollegiate Document (2019) and highlights emerging themes as highlighted by NHSE. All Safeguarding Adults training is commensurate with the Adult Intercollegiate Document (2018).

The Safeguarding team have adopted a more collaborative approach to training with joint training delivered by the Safeguarding Adults and Safeguarding Children specialists. This approach has focussed on the 'Think Family' agenda recognising the overlap between the adult and children safeguarding agenda.

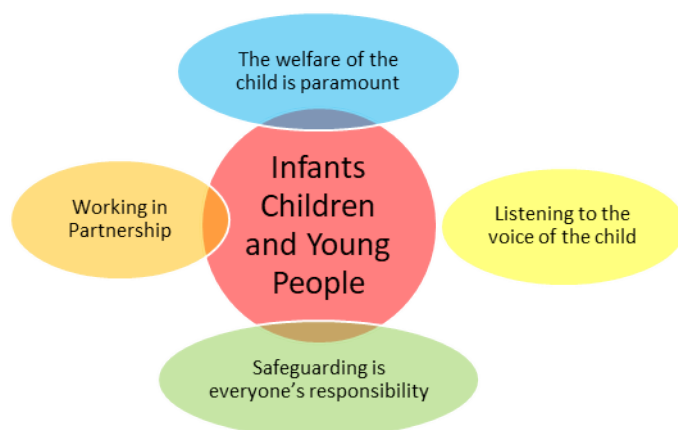
6. Training and COVID

Due to the constraints imposed by the lockdowns the Safeguarding team developed new ways of delivering training. As no face to face training was available there was a greater reliance on using on-line or e-learning training. Staffs have provided positive feedback on this way of delivering training and the aim is to continue to offer this with bespoke Safeguarding masterclasses for staff and small class sessions for discreet staff groups. Despite the absence of face to face training it is encouraging that training compliance was maintained or raised. The set target for the Trust is at 95%.



7. Care Quality Commission

The last full inspection was in 2017/18. It is likely the Trust will be subject to a CQC inspection in 2022. As with all services within the Trust Safeguarding will contribute to this event. Our ethos puts CYP at the centre of all our work



The Safeguarding Children team has taken the 5 CQC domains and uses these as our framework.

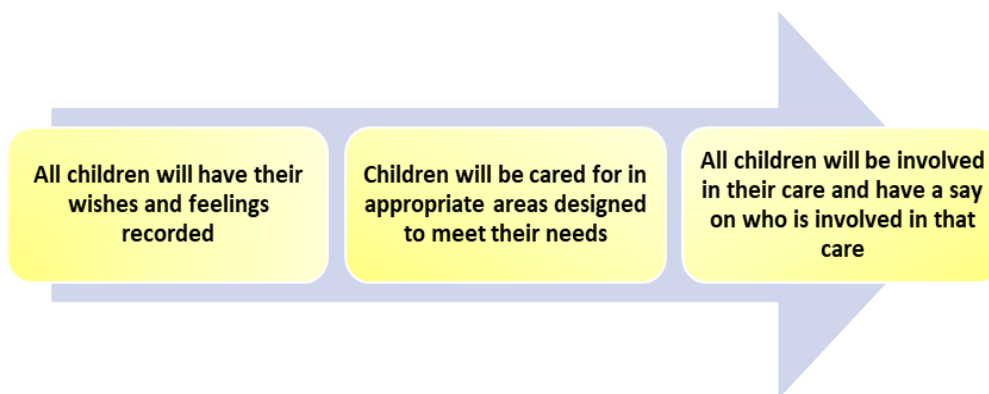
A. Caring - Putting CYP at the Centre of our Work



B. Safe – the Welfare of the Child is Paramount



C. Responsive – Listening to The Voice of the Child



D. Well-Led – Safeguarding is Everyone's Responsibility



E. Effective Partnership Working



8. QUALITY AND SAFEGUARDING

8.1 Mental Capacity Act, DOLS and LPS

The current legislation is applicable to 16 and 17 year who fall within the definition of a child. The Named Nurse Safeguarding Children provides expert advice on a range of consent issues for children and the application of legal frameworks around consent (especially the Fraser Guidelines and Gillick competence). The Named Nurse Safeguarding Children in conjunction with the Named Nurse Safeguarding Adults is part of a working group looking at the implementation of the new Liberty Protection Safeguards.

8.2 DOLS ORDERS

Due to the legal complexity of some admissions to Hedgehog Ward, and the delay in discharges the Trust has sought legal advice to ensure that we are not depriving children of their liberty, and are using the least restrictive options when discharges are delayed. Between April and June 2022, the Trust obtained 2 DOLS orders for children who were inpatients on Hedgehog Ward. The hearings in the High Court sought to provide the Trust with a safety net to keep children on Hedgehog Ward whilst alternative placements were found within Mental Health settings or Local Authority foster/residential settings. The High Court has been clear that The Trust has gone 'above and beyond' in what would be considered our usual care pathways. It is hoped that all legal processes will be concluded by the beginning of July 2022.

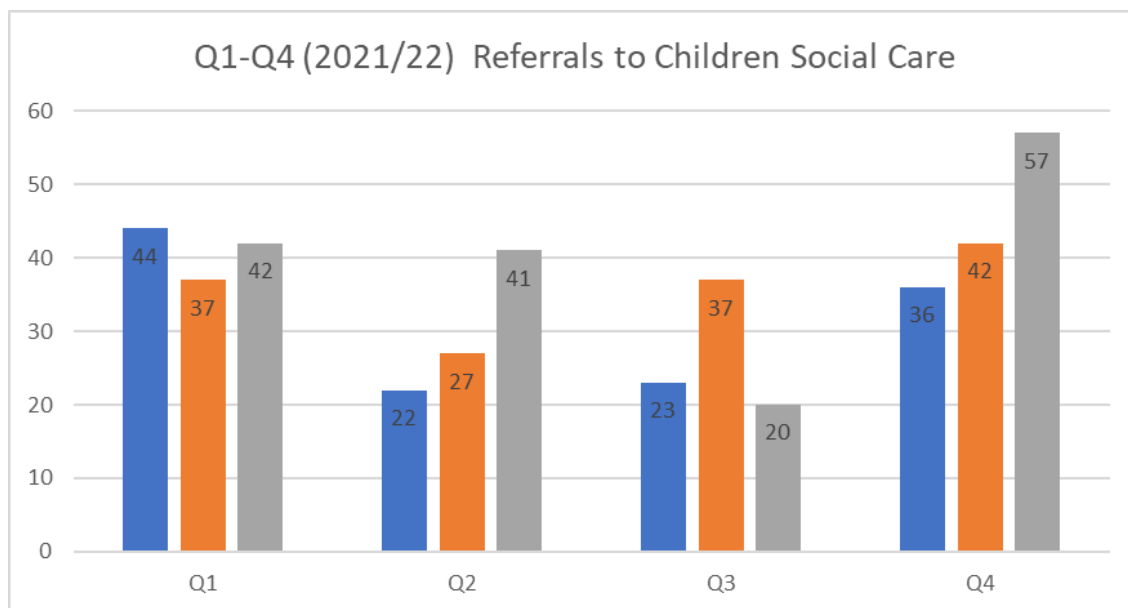
A request for an external review of the two above admissions is being considered due to the complexity of these admissions and the multiple organisations involved. The Named Nurse Safeguarding Children is Directorate Lead on an SI for one of the admissions.

8.3 Safeguarding Children Audits

There are no current Safeguarding Children audits in progress at the time of writing the report.

9. SAFEGUARDING REFERRALS AND INVESTIGATIONS - CHILDREN

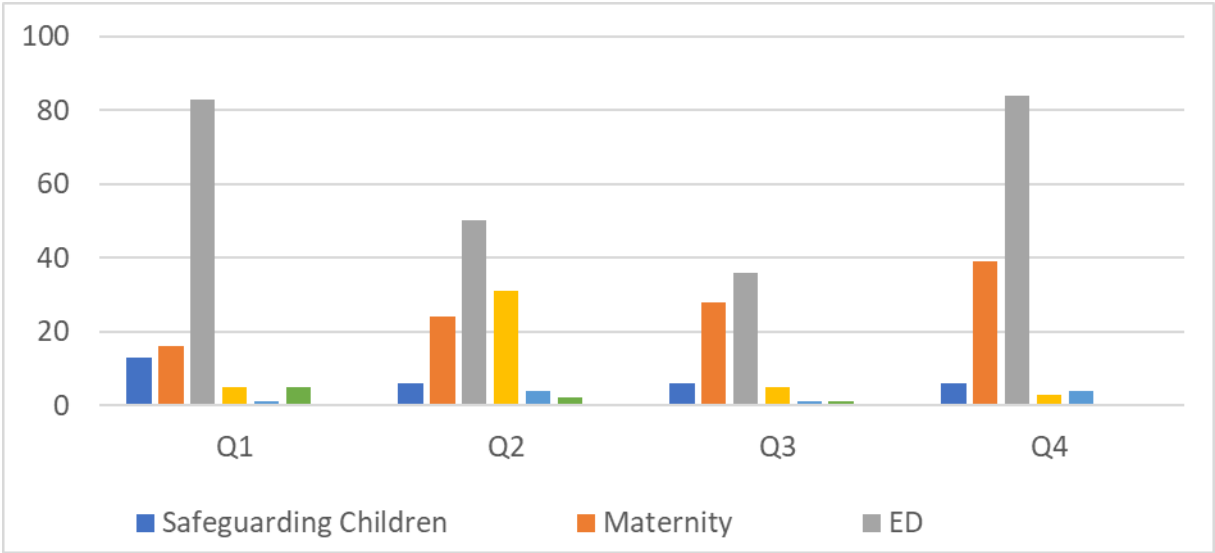
Safeguarding Children activity has been maintained in the 2021-2022 reporting period. This is despite national lockdowns and a rise in Paediatric ED admissions.



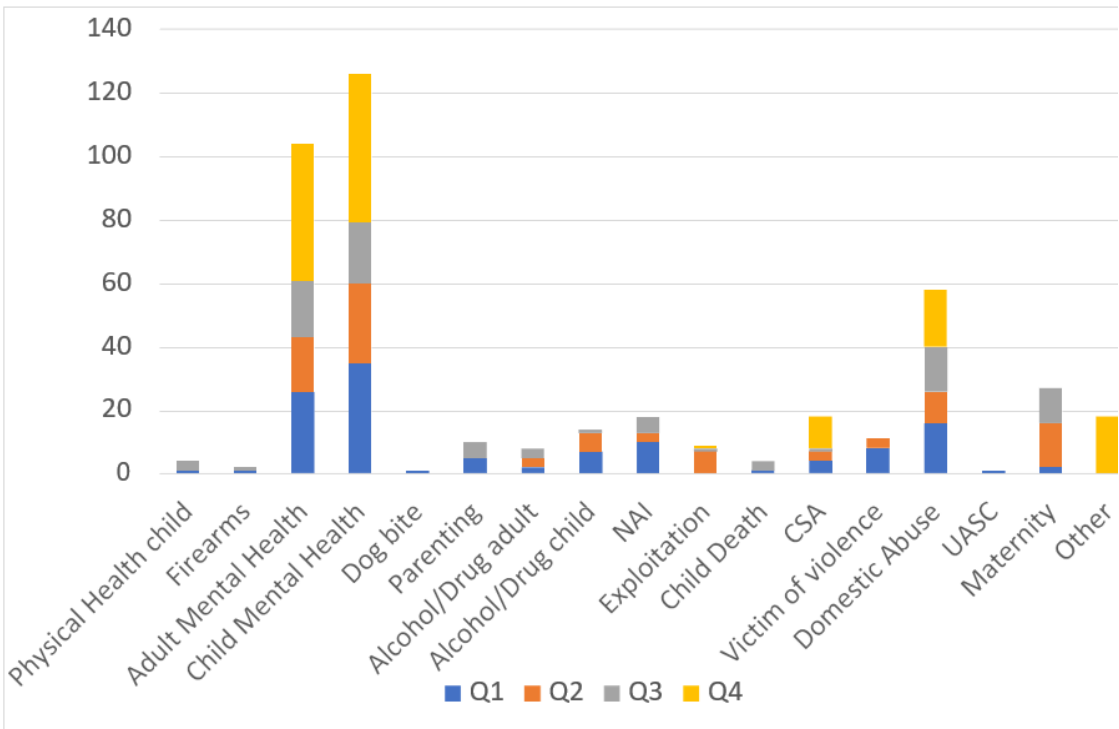
- Blue – 1st month of the quarter
- Orange – 2nd month of the quarter
- Grey – 3rd month of the quarter

Maidstone and Tunbridge Wells NHS Trust submitted 418 referrals to Children's Specialist Services (Kent and East Sussex) in the 12 months from April 2021 to March 2022. This represents a 21% decrease from the previous 12 months. It is unclear why the rate has dropped. Staff have been reminded to ensure that they inform the Safeguarding Children team of all referrals made; the Safeguarding Children team review all ED records to ensure that information is complete.

Who is making the referrals?



Reason for the referral



An analysis of why referrals are being made shows that the majority are related to the Mental Health concerns of both adults and children (see narrative below).

As a team the quality of the referrals are reviewed. Training is provided on 'how to make a quality referral' and staff are encouraged to get referrals reviewed by safeguarding practitioners prior to submission.

The Safeguarding Children team attend Child Protection Conference's for high risk children known to the Trust to support staff whose experience in Safeguarding may be limited. We support staff to provide high quality reports for Child Protection Conference's; the Named Nurse will also attend conferences as time permits.

Currently the Local Authority (Kent) has 1269 children subject to a Child Protection Plan – the Trust flags these children on our IT systems. We also flag known Children in Care and other high-risk children, including those that are frequently missing or display high risk behaviours.

Serious Case Reviews/Child Safeguarding Practice Reviews –

In the current reporting period the Trust has been notified of 27 Rapid Reviews and we have contributed to 4 of these reviews.

The Trust has further submitted IMR's for 2 Local Safeguarding Practice Reviews which are on-going. Both cover serious injuries to children under 6 months of age. The Trust provided both Paediatric and Maternity Services to the children and action plans and recommendations have been produced.

Recommendations include –

- Documentation, - ensuring that documentation is clear and contemporaneous; to ensure that it is accessible to all practitioners
- Domestic Abuse – ensuring that all conversations about Domestic Abuse are recorded and disclosures are acted upon
- Training for staff on Adverse Childhood Experiences
- Highlighting to Midwifery staff the process to follow when a woman/pregnant person books 'late' in their pregnancy for maternity services

Both Local Safeguarding Practice Reviews will be published after the conclusion of all criminal processes and will be shared with the Trust. The Named Nurse Safeguarding Children has been working closely with the Named Midwife in ensuring our processes are robust and fit for purpose.

10. CHILD DEATHS

The new Child Death Review Guidance set out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in the Working Together Guidelines (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidelines place a responsibility on all organisations to improve the experience of bereaved families, and professionals involved in caring for children. They also ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths. The new arrangements are in place in Kent.

The Trust is fortunate in that there are very few child deaths. Sadly 14 children known to our services passed away in the reporting period 2020-2022. The majority were due to complex health needs or life limiting conditions.

10.1 Safe Sleep Advice

Despite national 'back to sleep' campaigns on average 196 babies die from Sudden Infant Death Syndrome (SIDS) in the UK. Every under 12-month-old baby who has passed away at The Trust in the last two years has been found to have been co-sleeping prior to the event.

The following useful infographic explains the risks –



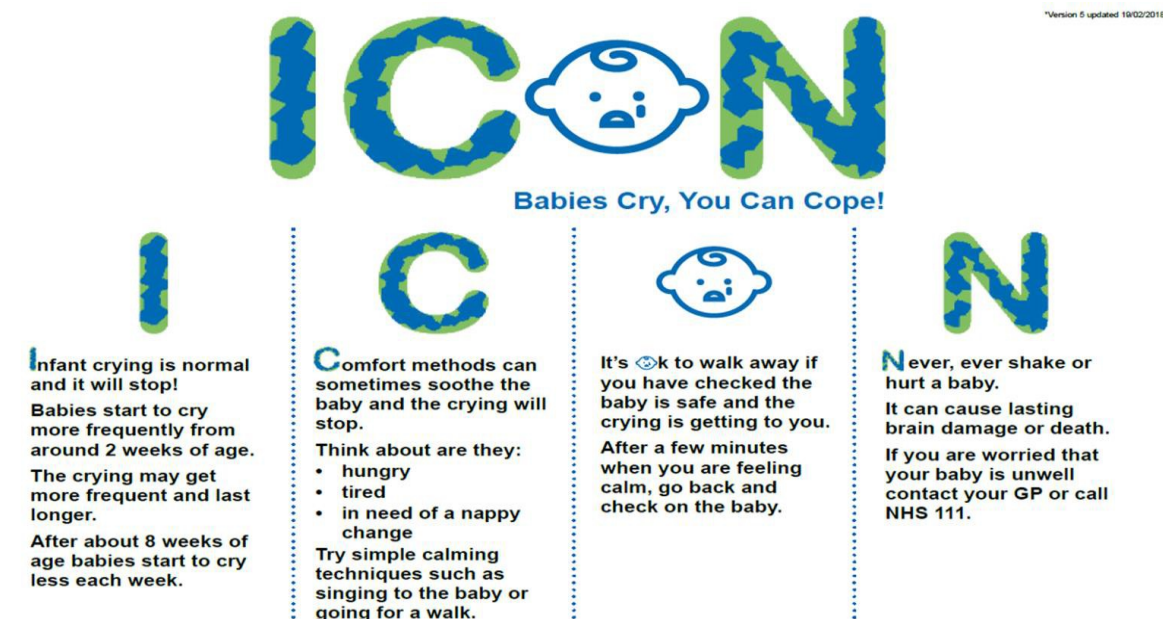
The Named Nurse Safeguarding Children and Safeguarding Midwives continue to work with the maternity teams, and external partners to raise the profile of 'safe sleeping' advice and reduce the risks to babies.

Abusive Head Trauma (AHT) and ICON –

During the national lockdowns a picture emerged of a rise in presentations in AHT; this was not replicated in the Trust. AHT is a form of child abuse and usually occurs in infants aged 6 months and younger. Shaking or blunt trauma can cause catastrophic injuries, with up to 75% of injuries caused by men. Crying is a key trigger.

A national campaign – ICON- was launched in 2021 to highlight the growing issues of AHT and its association with crying.

ICON focuses on 4 simple steps to help parents and carers to cope with crying and help reduce the incidence of AHT. The maternity teams in the Trust signpost new parents to this information and safe sleeping advice.



Speak to someone if you need support such as your family, friends, Midwife, Health Visitor or GP.

© Hampshire Clinical Commissioning Groups Safeguarding Children Services

Sadly, we have seen 2 deaths of 17-year olds from suicide. The Safeguarding Children Partnership has highlighted the effects of COVID on the Mental Health of adolescents and has established a Suicide Prevention Network which is co-chaired by the Named Nurse Safeguarding Children.

11. DOMESTIC ABUSE

In April 2021 The Domestic Abuse Act received Royal Assent and became law. There is a revised definition of Domestic Abuse –

‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members regarding of gender or sexuality’.

Throughout the Covid 19 public health emergency, domestic abuse was recognised as an issue through the Equality Impact Assessment carried out by NHS Safeguarding – this is highlighted in forms of domestic abuse such as honour based abuse and adolescent to parent/carer abuse. It is clear that NHS Safeguarding need to further explore these nuanced forms of domestic abuse in order to recognise, respond and refer appropriately. They will be producing ‘rapids reads’ on the types of domestic abuse to address this issue.

The Trust ratified a new Domestic Abuse policy in 2021 which takes into account the new legislation. We have a cohort of staffs who are trained to carry out DASH assessments and they make timely referrals to MARAC.

11.1 Hospital Based Independent Domestic Abuse Advisor (HIDVA)

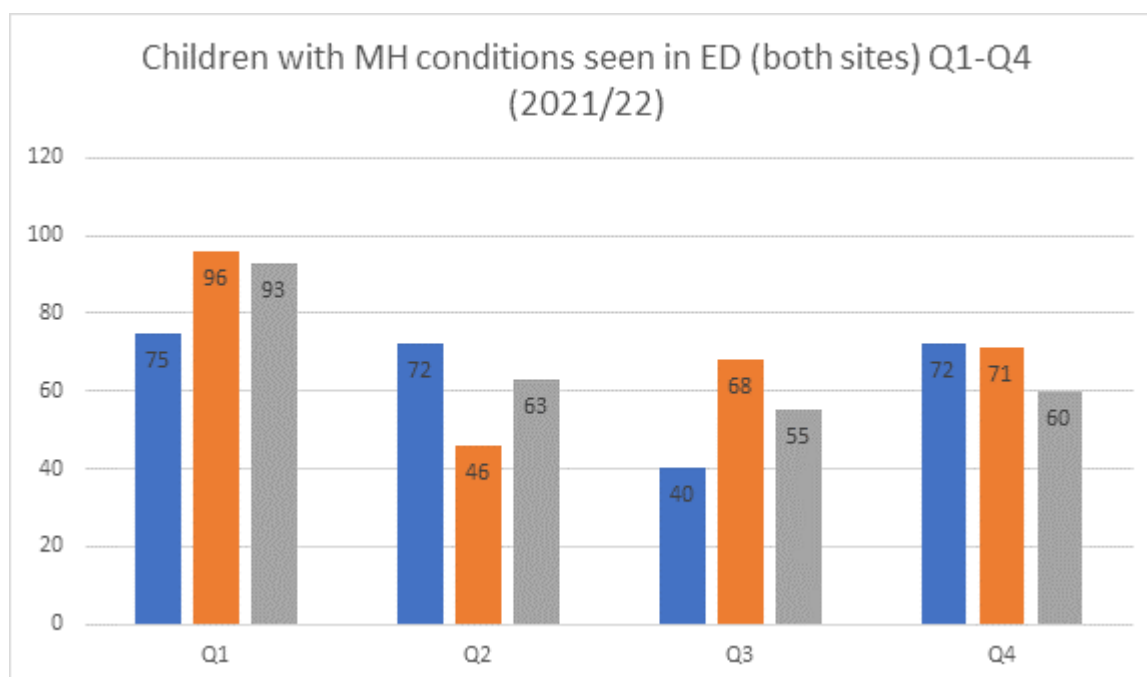
The role of the HIDVA is -

- To provide immediate support and advice to victims of domestic violence within hospital
- To link individuals and families to longer-term community-based support
- To provide hospital staff with expert training so that they have the confidence to ask about domestic abuse

The Trust has been successful in securing funding for a HIDVA service to be based across both sites. Initially the service will be rolled out at Tunbridge Wells Hospital with Maidstone Hospital having access to the service. The Trust recognised that we had a gap in our service provision in support offered to victims of Domestic Abuse. This service will bolster the current training and support given to staff and empower them to become more proactive in recognising and acting on Domestic Abuse. It is anticipated that the service will be in place by late 2022.

12. CHILDREN WITH MENTAL HEALTH NEEDS

Within this Trust it is apparent that an increasing number of children are being admitted with Deliberate Self-Harm (DSH) and overdoses. Staffs are ill-prepared for the risk that these children pose to themselves and struggle with the limited services provided by CAMHS. There are huge challenges in supporting admission to a tier 4 Mental Health bed; often this can take up to 4 weeks. This leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff.



In the current reporting period 159 children were admitted to Hedgehog Ward with Mental Health needs – the admissions were for a variety of reasons including Overdose, suicide ideation, Eating Disorder, self-injurious behaviours and anxiety.

14 children were detained under Mental Health Act [Sections 2, 3, 136 and 5(2)] – the majority of which were placed in a tier 4 setting or were discharged home after the detention period expired.

Children with multiple co-morbidities (ASC/ LS/Mental Health) are the most challenging in terms of coordinating care pathways and safe discharges. The complexities have resulted in the Trust seeking legal remedies under the Inherent Jurisdiction framework and obtaining DOLS orders. The orders have allowed the Trust to legally keep children at Tunbridge Wells Hospital whilst the Local Authority seeks a discharge placement.

The Trust has a robust care pathway and risk assessments for these children. Staffs are supported by both the Lead Paediatric Matron and the Named Nurse Safeguarding Children. Both work closely with the ICB, CAMHS, NHSE (as the 'bed manager' for tier 4 beds) and the Local Authority to ensure appropriate care for these children is given.

For all children admitted in a Mental Health crisis receive a daily CAMHS assessment. A weekly meeting is held with CAMHS to ensure that there are robust care plans in place and a Discharge Planning Meeting is held for the majority of children. The Lead Paediatric Matron and Named Nurse Safeguarding Children meet with the Chief Nurse and DCN weekly to update on admissions and discharge plans.

The Named Nurse Safeguarding Children holds multi-agency case reviews for a small number of children who require extended admission due to Mental Health concerns. These have highlighted the lack of adolescent Mental Health beds available for children (particularly in the south-east) and the lack of 'joined up' working. As described above we now hold weekly meetings with our CAMHS provider (NELFT) and are proactive (from day 6 of admission) in raising to Senior Trust Managers, NELFT and the ICB children who may find themselves 'stranded' on Hedgehog due to a lack of appropriate services. This has resulted in a much closer partnership between Community and acute services and creative ways of looking after these very sick children. We place a high emphasis on treating Mental Health needs in the same way as physical needs. A second CAMHS Liaison Nurse has been appointed providing more intensive support to the Trust.

A new volunteer service to support children in ED with Mental Health started in autumn 2021. This is provided by a charity called EMERGE. They have vast experience of supporting children in an ED environment and aim to prevent admission. They work with the CAMHS crisis team to build a plan of support for the child and will follow up in the community for up to 3 months after presentation.

13. MIDWIFERY SAFEGUARDING.

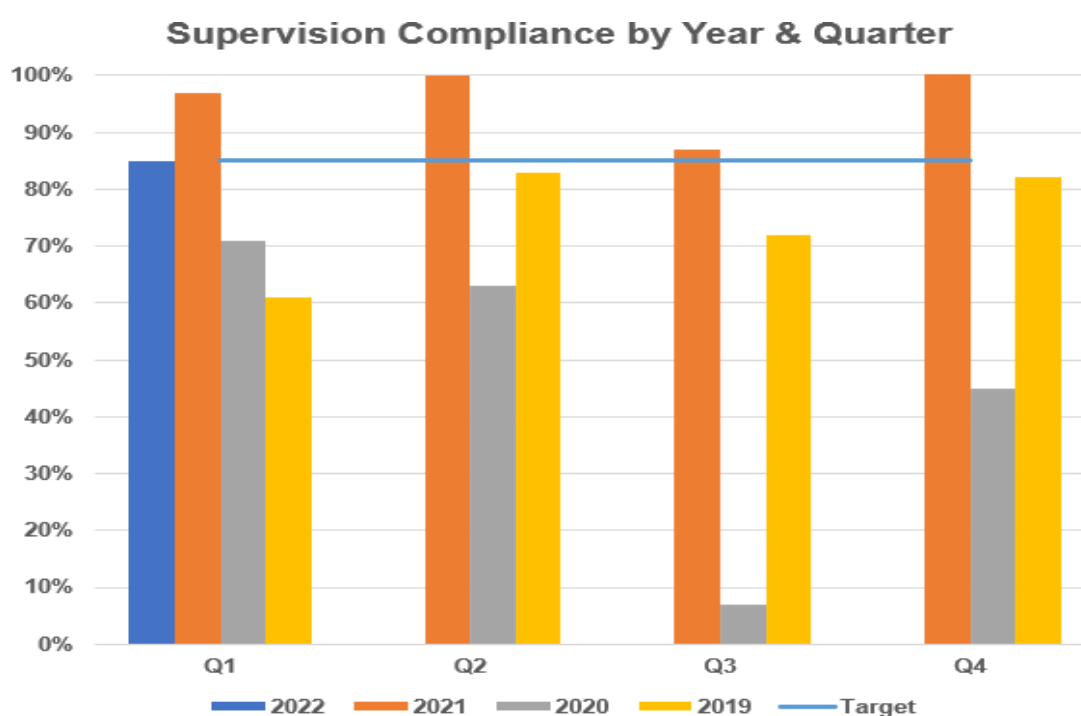
The Named Midwife line manages the deputy Named Midwife, who manages the day to day operational caseload, and together support in the identification and implementation of service improvement initiatives, staff training and supervision. Working collaboratively to ensure there is effective, high quality safeguarding frameworks in place to support expectant parents, safeguarding the unborn and their siblings, and providing expert knowledge and support to all maternity staff involved in the family's care.

The Covid 19 pandemic, resulting government restrictions, increasing safeguarding workload coupled with changes within the Safeguarding Midwifery team has meant that the team has had to adapt and respond dynamically to these challenges in order to continue to maintain a safe and effective service. Despite the ongoing challenges faced over the last 12 months, the maternity safeguarding service has continued to maintain focus on the importance of providing a safe, informed, evidenced based service which places Maternity Safeguarding and the voice of the child as paramount. The Trust has continued to evaluate our service provision, start and deliver on a number of high-profile service improvement initiatives,

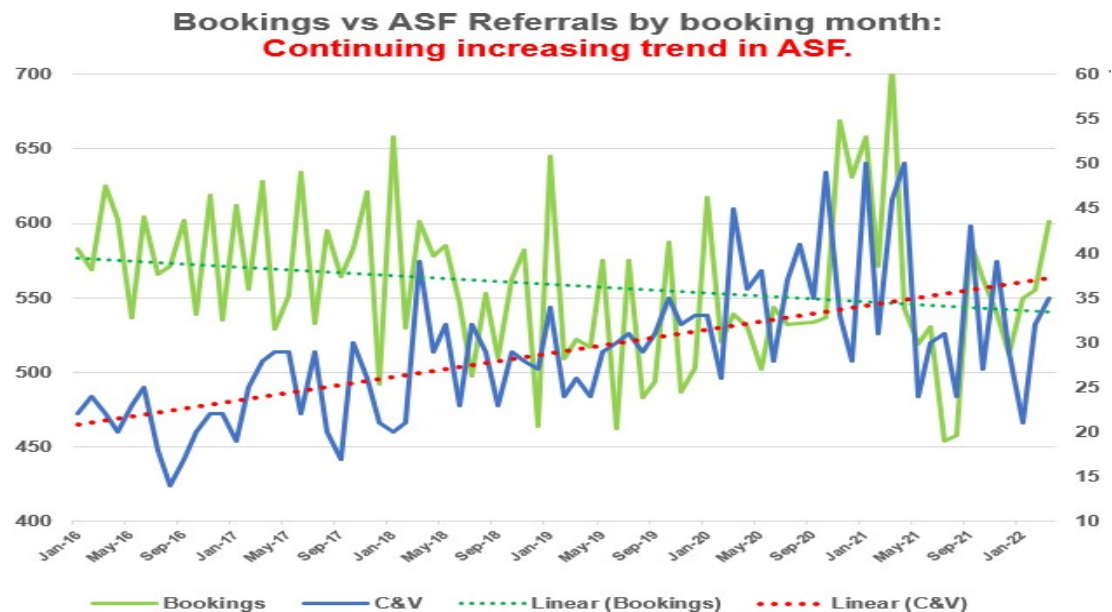
In addition to these the maternity safeguarding team have continued to:

- Chair the maternity MDT Safeguarding Hubs which run twice monthly.
- Reinstated safeguarding champions in every community team and ward department.
- Reinstated complex case reviews detailing all high-risk clients due each month.
- Launched an accessible online booking process for community midwifery supervision increasing our supervision capacity to 120 available slots per month.
- Safeguarding visibility in clinical areas has continued.
- Developing a joint Safeguarding Midwifery training programme with the Kent Children's services department to standardise and inform practice across safeguarding teams, improving working relationships and communication.

For the report year, Midwifery Safeguarding Team's time was spent in direct support of Midwives, face to face or virtually. Compliance with Trust supervision targets has been achieved despite ongoing high acuity within Maternity. Headcount of midwives eligible for supervision has also risen increasing the number of supervisions required to achieve target. Overall for 2021, 31% of the Midwifery Safeguarding Team's time was spent in direct support of Midwives, face to face or virtually.

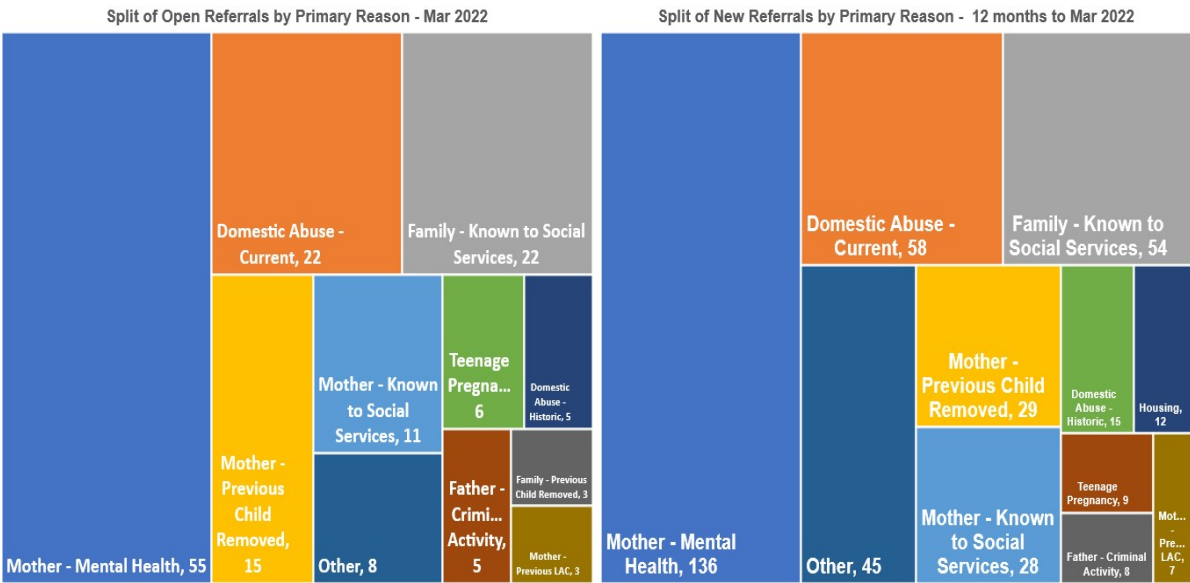


Midwives generate a Concern and Vulnerability Form (C&V) for all women with a known or perceived vulnerability; this could be because of Domestic Abuse, Mental Health needs, historical Children Social Services involvement, or a history of being a Child in Care. These forms are uploaded to the maternity IT system (E3) and are shared with the Community Health Visitor teams. They are a valuable source of information for all professionals working with these families.



The proportion of primary referral reasons relating to social services involvement (including removal of previous children) (30.4%), mental health (37.4%) and domestic violence (12.9%) related C&Vs YTD account for 80.7% of cases for the year (up from 79% YTD at the end of quarter 3).

Open and YTD cases by primary referral reason



14. PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter- terrorism and Security Act 2015 which sets out duties for specific authorities. The revised PREVENT Duty will be published by the Government in late 2022. It is unclear what the implications for the Trust will be at this stage.

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

The Trust has met the PREVENT training standard for Basic Awareness and achieved 93.5%. Face to face WRAP Training has not been delivered to staff in the last year.

The Trust made no referrals to the Prevent process in the reporting year.

15. SERIOUS INCIDENTS (SI)

A Serious Incident (SI) is defined by NHS England as an event in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Whilst there is no definitive list of events or incidents that constitute an SI there are a number of descriptors that contribute to the classification of an incident as an SI; this includes

Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery, all of which were: healthcare did not take appropriate action / intervention to safeguard against such abuse occurring; or abuse occurred during the provision of NHS- funded care

Two SI's have been declared (June 2022) to focus on the extended admissions of children with co-existing complex needs. The Named Nurse Safeguarding Children will be the Paediatric Directorate Lead for one of the reviews.

16. PRIORITIES FOR 2022 - 2023

We recognise that there will be new and differing priorities for the coming 12 months and we see Safeguarding as being central to business continuity for the Trust.

Our priorities will be focused on the following –

- Education and Training – increasing compliance on mandatory training by offering creativity in delivering training; increased use of on-line platforms
- Strengthening the joint working between the Named Nurses
- Complex Needs – developing a more streamlined process for escalation of children who may have complex needs that need robust discharge planning
- Domestic Abuse – rolling out the HIDVA service and developing training packages for staff
- NAI in the under 2's – highlighting in training the complexity of AHT, NAI's and care pathways
- Mental Health – strengthening the Safeguarding support for children with Mental Health needs

It is recognised that there have been unique challenges in the previous 12 months. The Safeguarding team has recognised and risen to the challenge to support all staff during this difficult time. We will continue to build on the positive work started in the previous 12 months.

Appendices

Appendix 1: Safeguarding Children Structure



Section 2

Safeguarding Adults Annual Report

Safeguarding Adults Activity

The Adult service has supported 223 cases relating to safeguarding concerns, (113 relating to alleged hospital incidents and 110 relating to alleged community incidents). The alleged hospital safeguarding incidents have decreased from last year by 4 cases. The alleged community safeguarding incidents have also decreased by 7 cases in the last year.

The information below gives data about safeguarding adult referrals raised about alleged incidents that have occurred in the Trust. There is a relatively even split across both hospitals of referrals received.

The data also highlights where the allegations of abuse have occurred but the Trust Board should note that out of the 113 Trust incidents received only eight incident involving Trust staff were upheld. Two of those upheld led to a disciplinary process. The remaining 6 cases were as a result of failure of teams to follow processes involving pressure ulcer management, discharge processes, one missing patient and one was in relation to unexplained bruising.

Overall Activity over 2021/2022

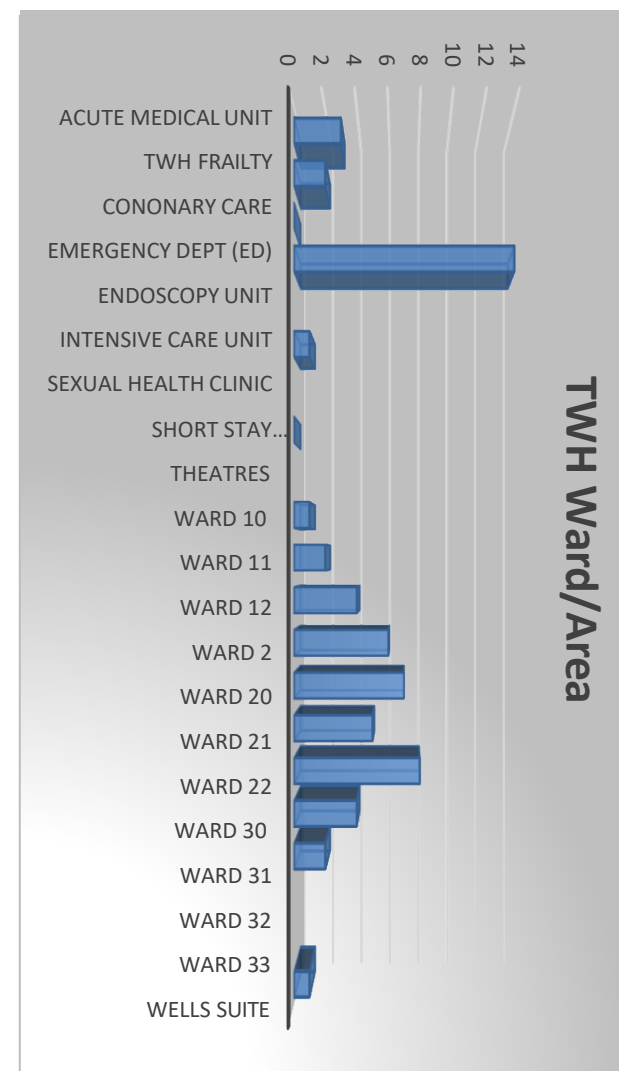
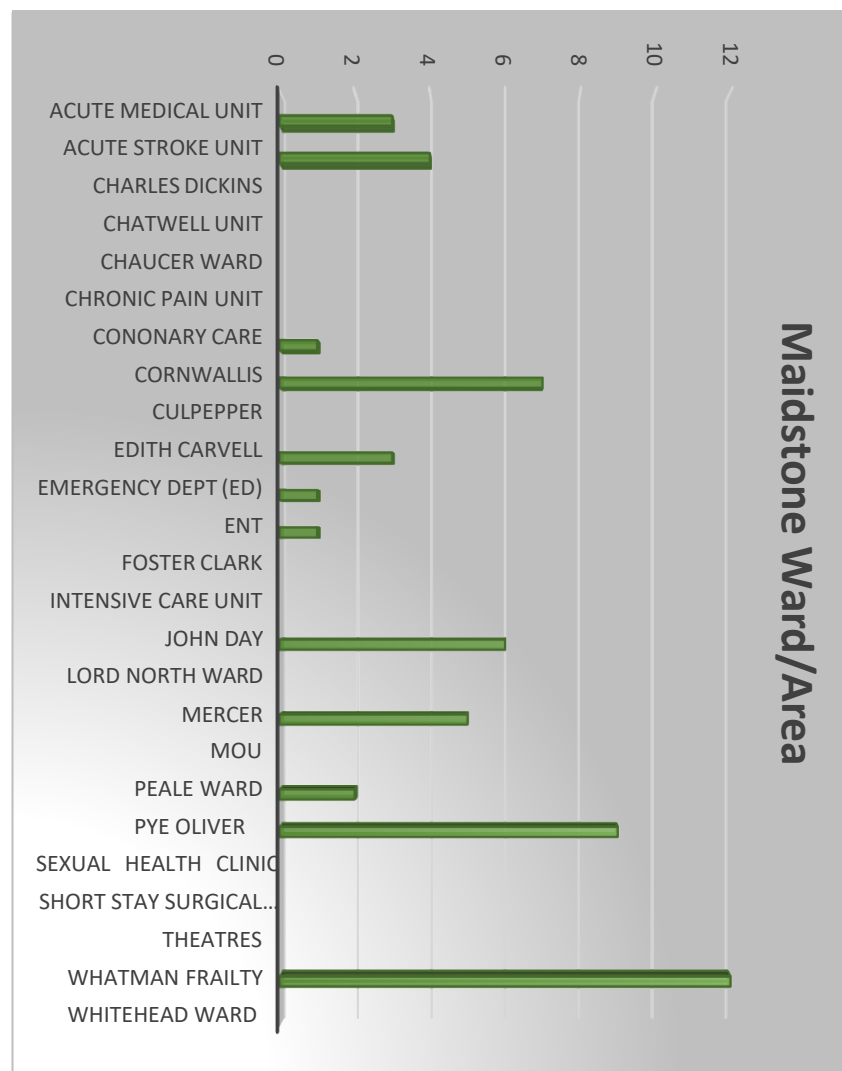
Number of cases	113
TWH	60
MH	53

Reported by	
Reported by Trust staff	36
Reported Externally	77

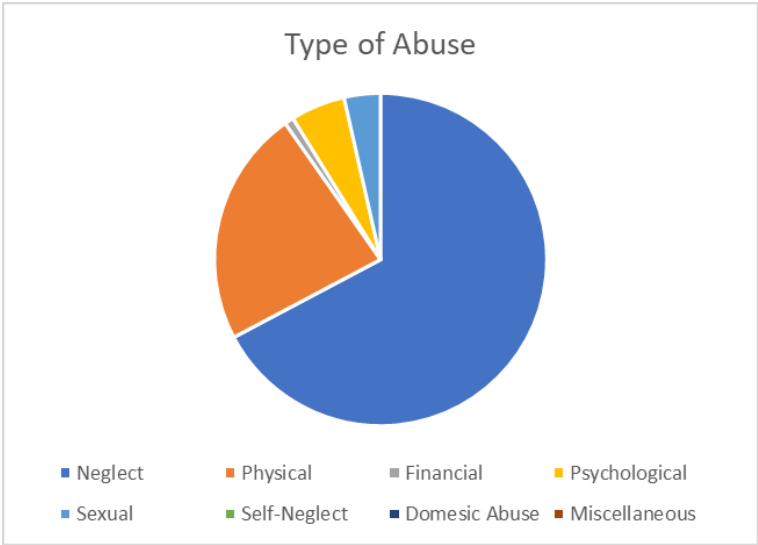


Where Trust staff have reported concerns about issues of abuse within the Trust this shows an open and transparent approach to safeguarding, noting that abuse can happen anywhere.

Activity by Area or Department over 2021/2022



Types of Alleged Abuse

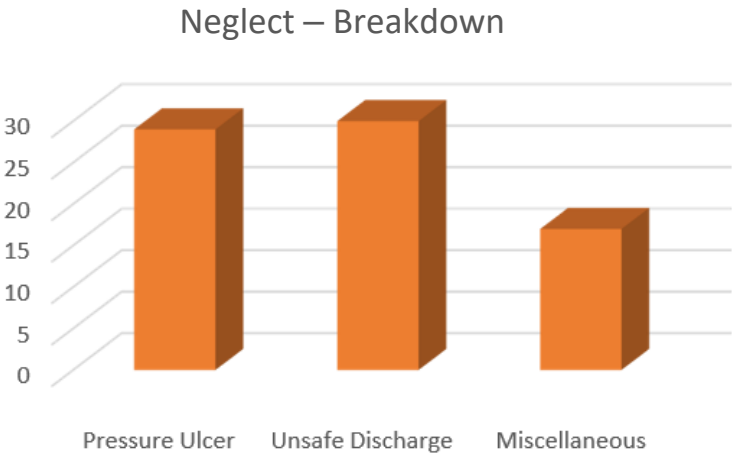


Type of Alleged Abuse	
Neglect	76
Physical	26
Financial	1
Psychological	6
Sexual	4

The highest category of alleged abuse was neglect and this has been further split to show the types of neglect (see chart below). The Board should note that of these cases described below only two were upheld, 1 for a hospital acquired pressure ulcer and the other in relation to an unsafe discharge. It is recognised that safeguarding concerns have been raised in the past in relation to poor communication upon discharge and that Nursing Homes and Community Nursing staff were not using the national guidance ‘Safeguarding Adults Protocol: Pressure Ulcer and the Interface with a Safeguarding Enquiry Decision Tool’ that was adopted by the Kent and Medway Safeguarding Adults Board (KMSAB) for use across Kent. Some care homes openly stated that they had been told to use the Safeguarding Concern form as a way to log Pressure Ulcer acquisition rather than using an incident reporting mechanism. The Named Nurse for Safeguarding Adults (NNSA) has worked closely with the West Kent Safeguarding Team and with care home managers to promote the use of this decision tool.

In relation to hospital discharges we continue to promote with staff the use of the Transfer of Care form and this has been requested to be placed onto Sunrise system as part of the safer better sooner work to improve discharge processes.

The following chart gives the breakdown of the neglect safeguarding concerns raised about Hospital practice:



Neglect	
Pressure Ulcers	29
Unsafe Discharge	30
Miscellaneous	17

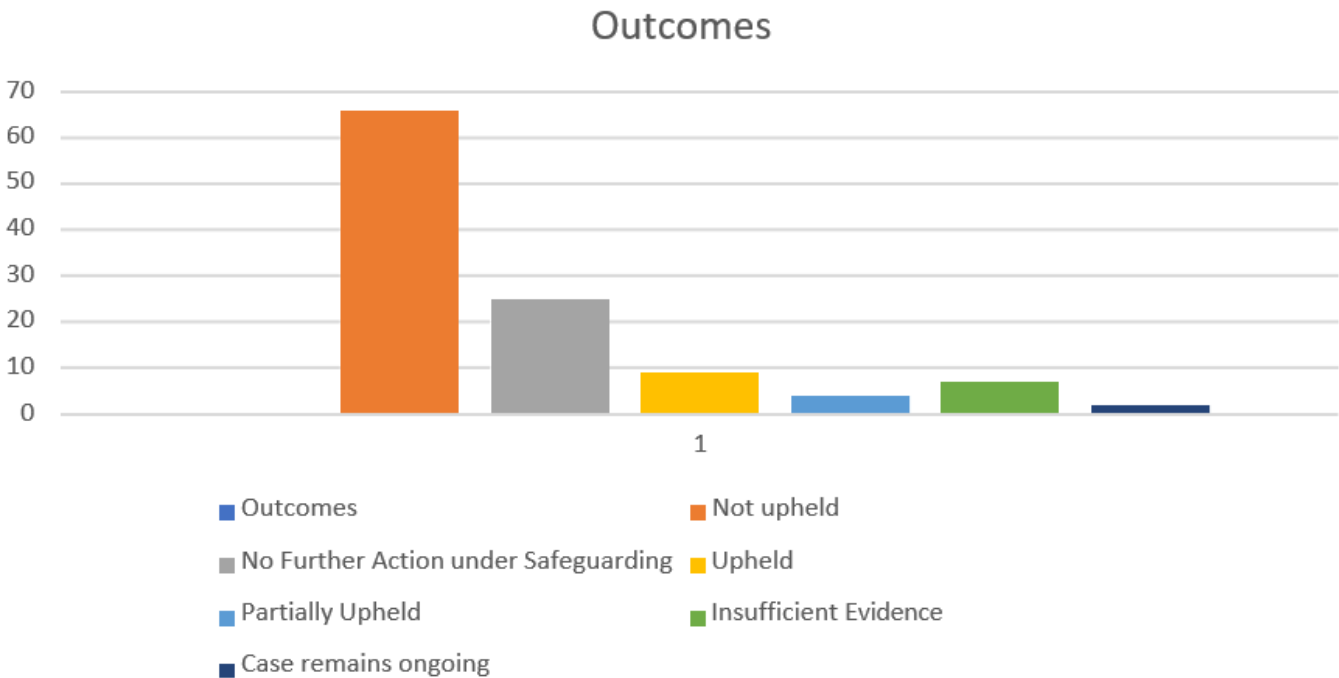
In relation to physical abuse these have been disaggregated between Restraint, Assault Misdiagnosis and Miscellaneous. The following chart gives this breakdown:

Physical	
Restraint	7
Misdiagnosis	2
Assault	13
Miscellaneous	4
Sexual	4

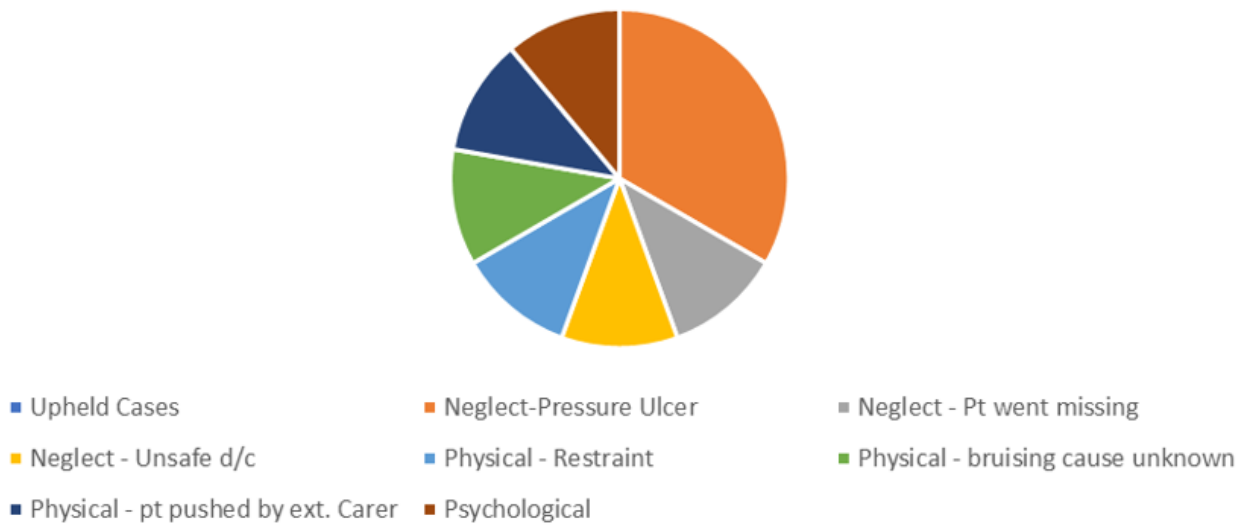
The following charts give a breakdown of the outcomes of alleged incident of abuse in the hospital setting:

Percentage of outcomes	
Not Upheld	58%
No Further Action under safeguarding adults	22%
Upheld	8%
Partially upheld	4%
Insufficient Evidence	7%
Case remains ongoing	2%

Outcomes	
Not upheld	66
No Further Action under Safeguarding	25
Upheld	9
Partially Upheld	4
Insufficient Evidence	7
Case remains ongoing	2



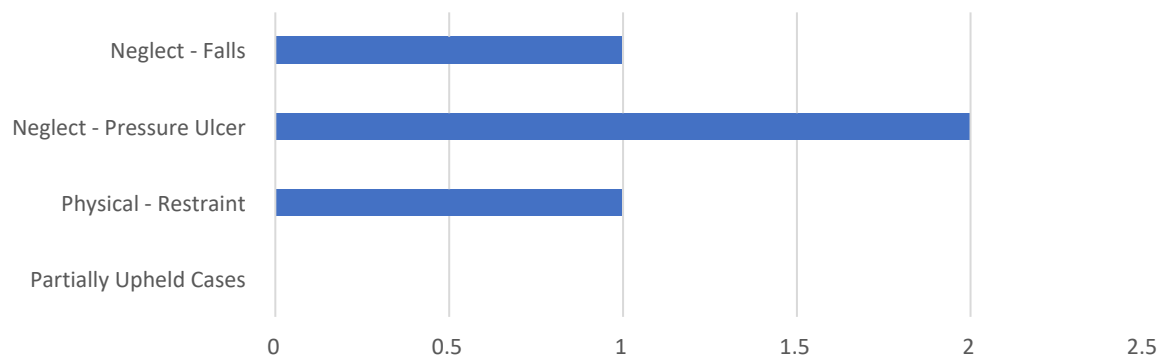
Upheld Cases



Upheld Cases		
Neglect- Pressure Ulcer	3	
Neglect - Pt went missing	1	
Neglect - Unsafe discharge	1	
Physical - Restraint	1	Trust staff
Physical -bruising cause unknown	1	
Physical assault	1	Not Trust staff
Psychological	1	Trust staff

Of the eight incidents that were upheld about hospital practice, the above breakdown gives the type of incident that occurred. To note one was upheld in relation to physical restraint resulting in a disciplinary process, one was upheld as a patient had sustained bruising but it was unclear how this occurred, the one upheld in relation to psychological abuse resulted in a disciplinary action.

Partially Upheld Cases



Partially Upheld Cases	
Physical - Restraint	1
Neglect - Pressure Ulcer	2
Neglect - Falls	1

These outcomes have all been agreed by the Local Authority who have the statutory duty to lead on safeguarding matters and make decisions about safeguarding cases, in line with the Care Act 2014.

Domestic Abuse advice has been given throughout the year by both the Adult and Children's Safeguarding services. The level of advice given has not been collated through the year but upon discussing both named nurses have agreed that a shared database to collect this data going forward is required and will be developed.

The NNSA's has also given advice to staff on a number of occasions about patients with mental health decline or suicidal ideation. It is recognised that going forward the level of advice given should be collated and NNSA's plans to collect this data in the forthcoming year.

Making Safeguarding Personal

One duty under safeguarding adults is the duty called 'Making Safeguarding Personal' (MSP). This is a duty under the Care Act 2014 to liaise with the patient and/or their family about what they would want to happen as an outcome of the safeguarding concern being raised. We have audited this process by reviewing all safeguarding concerns forms completed by Trust staff and the outcome is the following:

Hospital MSP



Hospital Cases	
Yes	31
No	1

Community MSP



Community Cases	
Yes	80
No	19

Reason contact not made (Community Cases)

Unsafe to disclose	12
Known to Social Services	1
Staff did not complete	1
Lacked capacity and spoke to the relative	5



This is a good outcome and shows that Trust staff are talking with patients about the concerns that they are raising to the Local Authority.

Training and Compliance

Training is offered on a mandatory basis for all staff and this is aligned to the level that they are identified as needing, in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff (Intercollegiate Document 2019).

Delivery of training in this year has remained as online e-learning and virtual face to face training via webinars and Teams. There have been limited face to face training delivery for some staff.

The NNSA's has redesigned the training offer in relation to Safeguarding Adults Level 3, Mental Capacity Act and Deprivation of Liberty Safeguards Level 3, into separate Webinar Modules so that these can be accessed with ease by staff. They have available to them the following: -

Safeguarding Adults Level 3

1. The Challenges in Managing Complex Safeguarding Adult (SA) Concerns followed by a quiz
2. The Care Act 2014 and Safeguarding Responsibilities followed by a quiz
3. How Effective Communication and Information Sharing contributes to SA Processes followed by a quiz
4. Reflective Practice and Shared Decision Making followed by a quiz

Mental Capacity Act and Deprivation of Liberty Safeguards Level 3

1. The Basics followed by a quiz
2. Assessing Mental Capacity followed by a quiz
3. Best Interest Processes followed by a quiz
4. Restraint/DOLS and Court of Protection Approaches and NICE Standards followed by a quiz

To support staff, they have had the opportunity to discuss and debate issues and cases with the NNSA's via a Teams meeting to further their understanding and exploration of the subject matter in both Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards. These 'talk with the expert' sessions are offered monthly from March through to November each year and are proving popular for practitioners to discuss particular cases, learning from the Webinars or learning from practice.

The E-Learning for Health (ELfH) MCA/DOLS resources have been placed onto the Learning and Development platform and advertised out for staff to access to count towards the current training offer. These modules have been split into basic, intermediate and advanced learning opportunities for staff to access, with clear guidance as to which levels staff should access.

MCA and DOLS learning requirements have been mandated for staff to complete every 3 years as opposed to being a 'one off' requirement within the Trust. In the drive to improve competence and confidence amongst staff to apply MCA/DOLS into their practice, the Trust has taken the decision to reset the training compliance for this subject back to zero and all relevant staff have been notified that they need to complete their MCA/DOLS training in the near future to become compliant. We expect compliance rates to be on an upward trajectory over the next year with the Trust reaching the compliance target of 85% by July 2023. Staff will then be required to refresh this training every 3 years. This is seen as especially important due to the changes in relation to Liberty protection Safeguards going forwards.

All staff commencing in the Trust have to undertake their Level 1 e-learning prior to commencement of employment.

Training compliance remains good within the Trust with the latest report indicating that Trust staff overall are: -

Safeguarding Adults Training Compliance (Target 95%)

Level 1 End of Year = 94.5% compliance

Level 2 End of Year = 92% compliance

Level 3 End of Year = 61.9% compliance – upward trajectory after redesign and reset of training

Mental Capacity Act (MCA) includes Deprivation of Liberty Safeguards – (Redesigned and compliance reset to zero)

Level 2 = 9.2% Compliance

Level 3 = 4.2% compliance

MCA compliance has been reset across the Trust due to the change from MCA being one off training to now being required to be completed every 3 years. Also due to the redesign of training and training being split into levels 2 and 3 to assist with the Trusts drive to reinvigorate the MCA Agenda and competency for staff.

PREVENT

Basic Awareness End of Year = 94%

WRAP End of Year = 89.7%

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. There have been no Prevent referrals made by the Trust in 2021/22.

Policies and Procedures

The Trust has a developed suite of Safeguarding Adults policies and procedures that are published on the Trusts document retrieval system. There are links provided to staff via the Safeguarding Adults Intranet pages for ease of access to these policies and procedures.

These include up to date policies on: -

Safeguarding Adults at Risk

The Mental Capacity Act

Deprivation of Liberty Safeguards

The Domestic Abuse policy for patients, staff and visitors

Guidance for Making Reasonable Adjustments to Provide Individualised Care to Patients

Enhanced Care to Adult Inpatients (use of 1:1 nursing, specials)

Consent Policy and Procedure

Missing Adult Patient Policy and Procedure

Physical Restraint (Adults)

Venepuncture and Oral Sedation Guidance

The NNSA's has been working on a 'Was Not Brought' policy that will cover both children and adults with care and support needs. This will give guidance to staff about what to do if a patient should have been brought to an appointment, either by a parent or a carer, but was not brought for some reason. The Did Not Attend (DNA) approach should not be used for this category of patient as they need support to access healthcare.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

There have been 563 Deprivation of Liberty Safeguards (DOLS) applications completed by hospital staff. This is an increase on the previous year's applications by 26 cases applied for. Of note there has been a year on year increase in relation to DOLS applications since the Cheshire West Supreme Court judgement.

The Trust has had an MCA project group so as to aid staff to improve their practice in relation to documenting their assessments of mental capacity for patients for everyday decisions and this continued throughout the pandemic.

This group was changed to the Liberty protection Safeguarding Operational Working Group in December 2021. Actions completed from this working groups are as follows:

- NNSA's has built the MCA E-Hub on the MTW Learning Platform
- Redesigned the MCA/DOLS Level 3 training offer
- Reset the compliance numbers back to zero
- Made MCA and DOLS Level 3 compulsory for all clinically registered, patient facing staff and insisted that they refresh every 3 years
- Reset to zero MCA/DOLS Level 2 training for all clinical staff to complete with a refresher every 3 years
- Commissioned Best Interest Assessor training in an attempt to upskill more staff across the Trust as advised by national expert
- Advocated the use of the Deciding Right APP in clinical areas
- Completed a Trust wide audit of all adult inpatients and have developed an Action plan as a result of this audit
- NNSA's has presented the outcome of the MCA/DOLS audit at Clinical Governances, Ward Manager's meetings and asked them how they will ensure practice is improved, or how we can assist
- Have employed a Mental Capacity Nurse Specialist to assist with the programme of work to ready the Trust for LPS.

At Best Interest Meetings we saw an upturn in GP attendance, Social Care and internal colleagues' attendance. This was thought to be due to no travel time involved and busy practitioners could leave a meeting if required at a click of a button. This enhanced practitioners' abilities to really think about the person, their wishes, values and beliefs when making complex decisions on behalf of the person who lacked capacity to make such decisions for themselves.

Liberty Protection Safeguards will be a new way of managing the deprivation of liberty safeguards processes with key responsibilities switching from the Local Authority to the Responsible Body. Some of the key changes are outlined in appendix one.

The Trust has a Liberty Protection Safeguarding Operational Working Group, chaired by the Director of Operational Nursing, to plan how the Trust will put this into operational working going forward. There have been discussions about whether or not a Health Hub with shared resources could be resourced across Kent. These discussions are in early stages and it is not yet clear if this will happen or not or what the implications for the Trust will be in relation to assisting to resource this if it does happen.

The Trust has employed a Mental Capacity Clinical Nurse Specialist to assist with this programme of work.

NNSA's and the Mental Capacity Clinical Nurse Specialist are responding to the MCA Draft Code of Practice consultation on behalf of the Trust. Views from Trust staff have been sought to assist with providing this feedback. Consultation due to close on the 14th July 2022. There is no new projected date for implementation of the new LPS system however it is thought this may come into force in Spring 2023.

External Partnership working

The Chief Nurse, Executive Lead for Adult Safeguarding attends the KMSAB board meetings or delegates this responsibility to the Deputy Chief Nurse.

The KMSAB has a number of sub-groups to ensure a consistent approach across Kent in relation to quality assurance, learning & development, practice, policy & procedures and Safeguarding Adults Reviews which the Named Nurse for Safeguarding Adults (NNSA's) attends on behalf of the Trust.

Health services have a separate strategic group (Health Safeguarding Group) to enable debate and information sharing, which also acts as a conduit for communication between health organisations and the board; this is attended by the Chief Nurses from across Kent and MTW's Chief Nurse is a regular attendee to this. The Kent wide Health Reference Group (A) is chaired by MTW's NNSA's and feeds information and ideas, by report and attendance to the above HSG.

MTW are a keen participant of all the KMSAB Board meetings and subgroup meetings and this has remained the case throughout the year. The Trust welcomed a new Chief Nurse into role in August 2021 and the safeguarding, agenda continues to be upheld as being of paramount importance within the Trust.

The Trust works collaboratively with the Local Authority Safeguarding Teams and CCG Designated Nurses. This is borne out with the work that had been completed at the Trusts Safeguarding Learning and Improvement Panels which were set up as multi-agency panels, reviewing the investigation reports into hospital safeguarding incidents, and making decisions together in relation to outcomes.

Learning from this panel is shared both Trust-wide and locally within directorates. The Local Authority has the opportunity to share learning wider with our community colleagues such as Care Homes, Domiciliary Provider agencies etc. These panels have continued throughout the pandemic.

The Trust NNSA's, continues to focus on triaging the safeguarding alerts received from the Local Authority to ensure that alerts are being raised for concerns relating to allegations of abuse and safeguarding issues as opposed to being used as an incident reporting mechanism by the referrer. By collaboratively working with the local safeguarding team and also more strategically in the sub-groups of the KMSAB; the Trust has been involved in effecting change in practice and policy and procedures for such issues as use of the Decision Tool within National Guidance – Pressure Ulcers and the interface with a safeguarding enquiry and within the Self-neglect policy and procedure.

The Trust has completed the Self-Assessment Framework (SAF) developed by the KMSAB, which was peer reviewed last June. The Trust were amber for 4 areas within the SAF in relation to the following:

- 1) How does your agency disseminate and promotes policy updates from KMSAB?
- 2) How does the agency introduce staff to the work of KMSAB and alert them to the website and information provided by the Board that is pertinent to their area of work?
- 3) How does your agency identify people who may have challenges in transitioning between services and what is in place to manage and support this?
- 4) How does your agency take into account the potential increased vulnerability of previously looked after children in provision of care?

The action plan agreed for this SAF is being worked on and is on track for completion by year end 2022.

The Trust has provided an Annual Report to the KMSAB.

Safeguarding Adults Reviews (SAR's)

Safeguarding Adults Reviews (SAR's) are a process that is used to review cases where someone has died as a result of abuse or come to serious harm and agencies feel that if there were better multi-agency working this may have prevented the death or serious harm. The Trust is a proactive member of the SAR processes and currently we have an active role in seven SARs where the Trust needs to produce an Independent Management Review (IMR).

In year 2021-2022, 4 SAR's were published (Robert, Douglas, Mark and James) and although the Trust was not involved in these reviews, the safeguarding team have looked at the learning and recommendations. The following points are pertinent to the practice in the Trust:

- Promote the effective use of the KMSAB Self-neglect and Hoarding policy
- How can we promote vulnerable people to engage with services?
- Improve communication between agencies when concern is raised about an individual
- Safeguarding (SG) not to be closed without proper checks across agencies being made
- SG not to be closed without the offer of a Care Needs assessment
- Promote the notion of professional curiosity as being positive
- Agencies to ensure ability to communicate with people who have literacy and communication difficulties
- Promote KMSAB protocol for Modern Slavery and Human Trafficking
- Develop clear pathways for people who need support with alcohol or substance misuse
- Ensure pre-discharge co-ordination for people with long term care, especially between Acute and Community Healthcare Trusts
- Care Packages to support client and families to be person centred
- Learning Disability annual health checks to be quality assured CCG and NHSE
- Ensure carers needs assessments are offered
- Agencies to work together to prevent suicide ideation is expressed

A further 6 SAR's have been published on the KMSAB since April and the recommendations and learning from these will again be disseminated by the NNSA's for the Trust to review and put learning into practice.

The Trust has also been involved in one Domestic Homicide Review and have completed an individual management report (IMR) for this. All reviews have not yet been published and any learning for the Trust will be shared out to appropriate practitioners and areas.

The Trust meets its statutory requirements in relation to the Disclosure and Barring (DBS) checks. All staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment. The Trust has in place a requirement for all staff to have a repeat three yearly DBS check.

The Trust is accountable to the NHS Kent and Medway Clinical Commissioning Group (the CCG) and reports to the Trust Performance & Quality Committee. Additionally, quality and monitoring for East Sussex CCG, is captured on the Safeguarding Metrics submitted to the CCG as a quarterly report; it is shared with East Sussex accordingly.

The CCG Designated Nurses for Safeguarding are members of the Trust's Safeguarding Committee. The Adult Designated Nurse attends the Safeguarding Learning and Improvement Panels (sub-panel to the Serious Incident panel) in an advisory capacity.

Learning Disability (LD) Service

The Learning Disability Liaison Nurse (LDLN) has continued supporting people with a learning disability (PWLD) throughout the pandemic whilst also furthering this agenda.

The LDLN continues to support the LeDeR process on behalf of the Trust and has set up an Acute Hospitals LeDeR group to discuss processes, cases and outcomes. There is Kent wide Acute Trust LeDeR action log where a list of 8 actions against good practice or areas for improvement for MTW have now been completed. These were:

- Good evidence of reasonable adjustments for people while inpatients in hospital. E.g. side rooms offered to ease persons anxiety and this also enabled family and carers to visit.
- Good evidence of multi-disciplinary working which has led to continuity of care for the person.
- Increase use of Treatment Escalation Plans (TEP), advanced care planning and End of Life Care (EOLC) plans enabling people to have good deaths.
- Emphasis on the important role of the Acute Hospital LD Liaison Nurse to support reasonable adjustments and ensure good communication between services.
- Evidence of Mental Capacity Act (MCA 2005) being followed and best interest meetings/discussions to discuss active treatment vs conservative care
- Developed Visitor and Carer Cards to support patients with learning disabilities in the emergency department or on wards from the beginning of their admission.
- Link Structured Judgement Reviews (SJR)- with the Mortality Surveillance Group (MSG). SJR backlog is now a standing item on the MSG agenda.
- Consultation with an IMCA as part of the Best Interest process in absence of a next of kin when decisions on do not attempt cardiopulmonary resuscitation are taking place.

The LDLN has been involved in piloting the new Mandatory Oliver McGowan Learning Disability and Autism training and awaits to hear further updates on the progress of this.

The LDLN has shared the current MTW Learning Disability and Autism training slides with HEE (Health Education England) as an example of current provision.

The Trust recognises that LD Training will be mandatory going forward.

The LDLN has assisted PWLD in paediatric services and is now assisting with the Transition of children to adult services. This work is ongoing and a scoping paper is being written to highlight the requirements and resources that might be required.

A good patient experience is key for PWLD when they access our services and the LDLN is forging good partnership working with the Patient Experience Lead within the Trust. Alongside this there has been a lot of work completed with our Community LD Nursing colleagues especially in relation to complex patients and development of individual complex care plans for PWLD. This has helped our community colleagues to understand pathways into the Acute Trust.

The LDLN devised and presented Learning Disability training to partners at South East Coast Ambulance (SECamb) service in conjunction with the Kent Community Health Foundation Trust (KCHFT) community learning disability team. The aim of the presentation was to aid front line paramedic practitioners' in their assessments of people with learning disabilities and/or autistic people; with the overall aim of reducing inappropriate emergency department (ED) attendances and raising awareness of diagnostic overshadowing.

Work continues on the NHS Improvement and NHS England LD Benchmarking project. In November 2021 the LDLN presented at the National Learning Disability Improvement Standards Learning and Sharing Conference, on the topic of Oral Sedation for people with learning disabilities. The participants and the senior program managers at NHS Improvement and NHS England were all highly complementary of the work and were keen to replicate this guideline across other Trusts.

The LDLN provides a full report inclusive of action plan to the Safeguarding Committee in relation to the learning disability standards and how the Trust benchmarks against other Trusts.

Accessible Information is key for PWLD and as such the LDLN has been involved with the Accessible Information Committee and has formed a sub-group with PWLD and their carers to check through developed Accessible information to ensure it truly is accessible.

A safeguarding incident was raised in 2021 whereby a patient with learning disabilities was physically restrained in the emergency department (ED) for a medical intervention, the level of restraint was found to be potentially inappropriate. As a result of learning from this safeguarding incident the LDLN is working closely with ED matrons and community LD practitioners to devise a one-page ED care plan for people with a learning disability.

These care plans will be issued to individuals with highly complex needs requiring specialised care or those who are frequent attenders. The care plan acts as a quick reference guide for ED staff to ensure that the most important information to support the person, is conveyed. This care plan will then be uploaded to the clinical system e-notes which can be accessed by ED staff via Sunrise.

The LDLN has continued to offer advice and support to patients with autism but no Learning Disability, however, this is not within her remit.

The LDLN prepared a presentation for the Quality Main Committee about Learning Disability incidents, complaints, serious incidents, LeDeR, LD Business Intelligence, NHS LD Improvements Standards, Safeguarding Alert Forms. This was well received by the committee.

Activity for the year

There was a total of 792 LD patient contacts with the LD service at MTW:

- 134 contacts from the total involved complex cases that required contact with external parties.
- 60 contacts were referred internally.
- 30 initial LeDeR reviews were completed by MTW
- 1 focused LeDeR review under MTW and the learning from this is still pending as panel meeting scheduled for August 2022
- Initial LeDeR review learning - Kent wide themes:
 - Did not attend (DNA) outpatient appointments contributing to avoidable deaths was identified as a theme. MTW's LDLN, formulated an action plan with all acute Trusts across Kent to ensure all LD DNA's are followed up by the Acute LDLN service.
 - Unsafe discharges were identified as a theme across Kent. The LDLN refers all complex patients with LD to the IDT (Integrated discharge teams) to ensure safe discharges.

The Venepuncture Pathway has been revised to make these reasonable adjustments to assist PWLD who may struggle to access hospital services for procedures such as blood tests, CT Scans and diagnostic testing.

Impact of Covid

Business continuity has been maintained throughout the pandemic. No staff from the service were permanently redeployed. The team adapted to a mix of remote and on site working, maintaining a presence on site. To support frontline staff the service used technology effectively to hold Best Interest Meetings and training, we also assisted with authoring safeguarding alerts and Deprivation of Liberty Safeguards applications for staff.

Conclusion

The Adult Safeguarding Service has concluded another busy year complicated in parts by the pandemic. The service has clear priorities for 2022/23.

The Adult Safeguarding Service faces the challenge of increasing areas of work as the speciality continues to develop nationally at a fast-moving pace, however the service remains committed to supporting all staff to uphold their responsibilities to safeguard adults at risk.

Appendices

Appendix one:

Some of the key LPS changes

1. LPS will **now** apply to 16- and 17-year olds, along with 18 + years as usual.
2. Acute Trusts will be responsible for assessing for and authorising LPS in hospital settings as opposed to the Local Authority.
3. The ACID Test remains i.e. a deprivation of liberty will occur when a Person (P) is unable to consent to remain in a place for care and treatment, staff have continuous supervision and control of P AND P would not be free to leave.
4. The Trust will be responsible for carrying out pre-authorisation reviews and this will need to be someone who is expert in the application of the Mental Capacity Act and not involved in the care delivery for the patient.
5. Parental Consent is NOT enough to authorise a Deprivation of Liberty for 16 and 17 yr. olds, although the Children's Act could be used – staff would need to be clear which act of law they are using
6. An authorised LPS, from another care environment **may** be able to transfer with the P to the Acute Setting – therefore lessening duplication however, after reviewing the new draft Code of Practice this is less likely to be the case
7. Any authorised DOLS when LPS comes into force, will continue until they are reviewed, but at least within 12 months
8. The Acute NHS Hospitals become Responsible Bodies for authorising Liberty Protection Safeguards
9. If the P or family/friends object a referral to an Approved Mental Capacity Practitioner (AMCP) will be required and the Responsible Body will need to refer onto this service
10. P will have access to be supported either by family member or friend OR IMCA if there is no appropriate person to support them. The Responsible Body will need to inform patients and carers about the situation
11. Applications to the Court of Protection can still be made for arbitration.
12. LPS can be in place for 1 year for the first application and then be renewed for a further year, then for up to 3 years for well-established stable placements
13. Although Best Interests Assessor's will no longer exist, practitioners with this qualification will be in a good position to requalify to become an AMCP
14. There is no longer a dual process of Urgent and Standard authorisations. Trusts will be able to act to carry out life-sustaining treatment or prevent serious deterioration in the urgent emergency situation. Thereafter, they will need to consider if P meets the requirements for an LPS.

Quarterly Maternity Services report**Chief Nurse**

The enclosed report provides information about safety issues in Maternity, the themes and trends and the identified learning and action plans, including:

- The number and summary of Serious Incidents declared for Maternity Services **
- The number of Health Service Investigation Bureau (HSIB) cases reported **
- The number of Perinatal Mortality Review Tool (PMRT) case reviews*
- The key themes
- Learning
- The recommendations and actions
- The progress in implementing Saving Babies Lives Care Bundle v2*
- A Maternity staffing review summary*
- The training report

The report also provides assurance of progress in meeting the requirements of the Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme which each recommend that this information is shared with the Trust Board on at least a quarterly basis

*Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme requirement

**Ockenden recommendation requirement

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 13.07.22, Executive Team Meeting, 19.07.22

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

Information and assurance

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

Report to: Trust Board

Report from: Maternity Services

Date: July 2022 (reporting period April 2022 to June 2022)

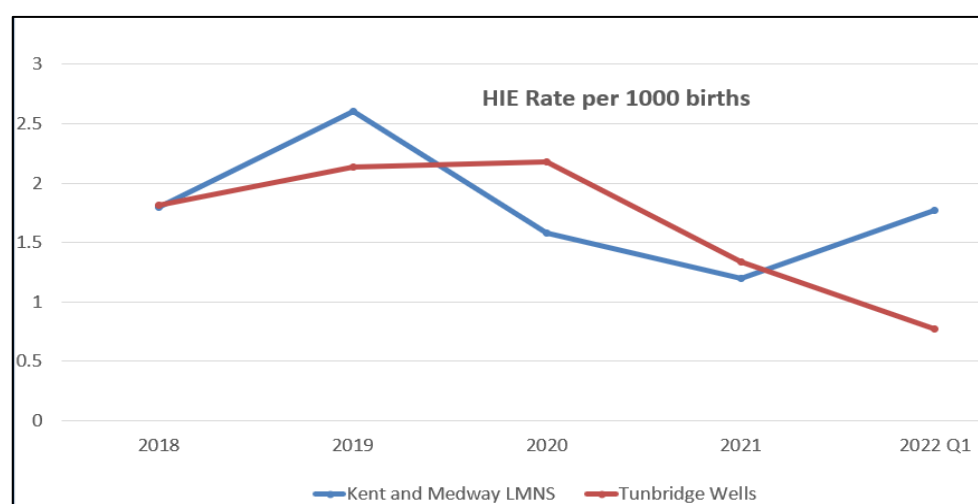
Subject: Maternity Services Quarterly Update Report

Summary	<p>This report provides an overview of the following for April to June 2022:</p> <ul style="list-style-type: none">• Number and summary of Serious Incidents (SIs) declared for Maternity Services **• Number of Healthcare Safety Investigation Branch (HSIB) cases reported **• Number of Perinatal Mortality Review Tool (PMRT) case reviews*• Key themes• Learning• Recommendations and actions• Progress in implementing Saving Babies Lives Care Bundle v2*• Staffing review summary*• Training report <p>*Clinical Negligence Scheme for Trusts (CNST) requirement</p> <p>**Ockenden recommendation requirement</p>																				
Number of Internal SI's Declared	<p>5 cases - see summary in the table below:</p> <table><tr><th>STEIS Ref</th><th>Clinical Area</th><th>Synopsis</th></tr><tr><td>2022/8524</td><td>Delivery Suite, TWH</td><td>HSIB investigation – see below Immediate learning identified at 72 hour review Learning actions shared</td></tr><tr><td>2022/13192</td><td>Ward 33, TWH</td><td>Maternal death – referred to HSIB and MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK) No care issues identified at 72 hour review</td></tr><tr><td>2022/13608</td><td>Delivery Suite, TWH</td><td>Unexpected/potentially avoidable Neonatal Unit admission following resusciataion – under investigation Immediate learning identified at 72 hour review Learning actions shared</td></tr><tr><td>2022/13783</td><td>Delivery Suite, TWH</td><td>HSIB investigation – see below No care issues identified at 72 hour review</td></tr><tr><td>2022/13789</td><td>Maidstone Birth Centre, MGH</td><td>HSIB investigation – see below No care issues identified at 72 hour review</td></tr></table>			STEIS Ref	Clinical Area	Synopsis	2022/8524	Delivery Suite, TWH	HSIB investigation – see below Immediate learning identified at 72 hour review Learning actions shared	2022/13192	Ward 33, TWH	Maternal death – referred to HSIB and MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK) No care issues identified at 72 hour review	2022/13608	Delivery Suite, TWH	Unexpected/potentially avoidable Neonatal Unit admission following resusciataion – under investigation Immediate learning identified at 72 hour review Learning actions shared	2022/13783	Delivery Suite, TWH	HSIB investigation – see below No care issues identified at 72 hour review	2022/13789	Maidstone Birth Centre, MGH	HSIB investigation – see below No care issues identified at 72 hour review
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MI-010152	Maternity Triage, TWH	Stillbirth, diagnosed on admission in early labour No care issues identified at 72 hour review HSIB investigation in progress
MI-010647	Maidstone Birth Centre, MGH	Required extensive resuscitation following vaginal birth with shoulder dystocia, transferred to NNU and then on to tertiary unit for cooling No care issues identified at 72 hour review Parents declined HSIB investigation

Comparative data for Hypoxic Ischemic Encephalopathy (HIE) rates MTW & Kent and Medway LMNS:



Dr Park, Consultant Neonatologist, undertook a thematic review with KMCCG and HSIB to review all cases identified as meeting HIE criteria. This concluded that there were no clear themes identified, however, some recommendations were made. This was presented at a joint Obstetric/Paediatric Clinical Governance meeting in July 2022.

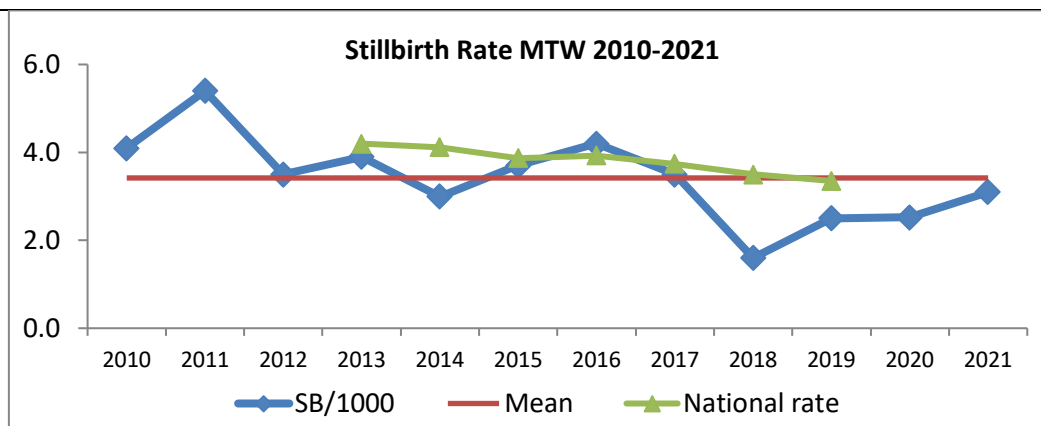
Local rate compares well with regional data for year to date.

HSIB reports received – findings and actions	Ref and summary	HSIB Recommendations	Trust Actions
	MI-005631 First pregnancy Low risk pregnancy Attended birth centre in early labour. Fetal	1. The Trust to ensure that when a mother is transferred into the maternity unit following an ambulance transfer, a multidisciplinary team is present to receive handover, to enable assessment and ongoing care planning in a timely manner.	1. & 2. Review of Maternal Transfer guideline regarding timing of medical review

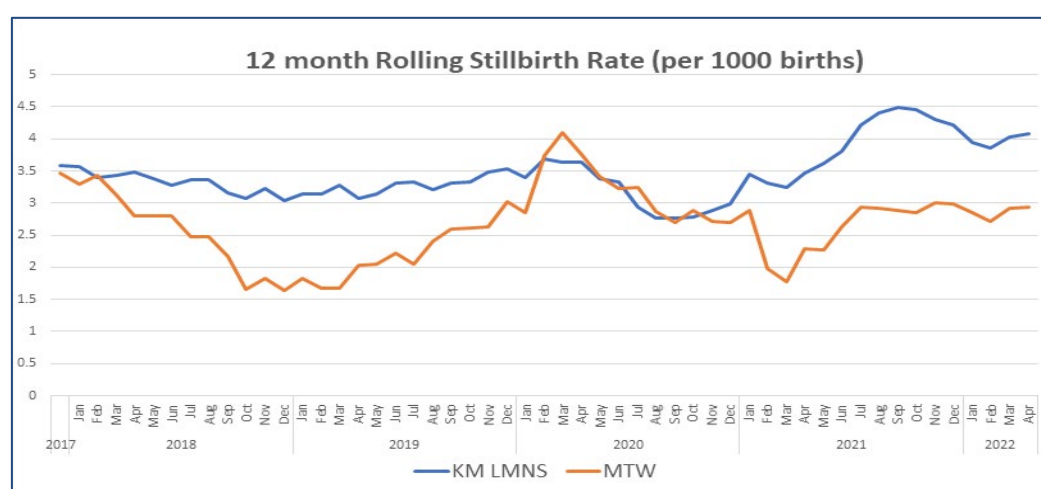
	<p>heart decelerations heard and thin meconium noted. Transferred to TWH.</p> <p>Suspicious then pathological CTG – not escalated</p> <p>Absent fetal heart on scan by Reg – instrumental delivery</p> <p>Resuscitation stopped at 28 mins – stillbirth</p>	<p>2. The Trust to ensure that mothers transferring from any setting to a high risk pathway of care during labour receive a face to face holistic review by an obstetrician and that oversight of care is maintained.</p> <p>3. Key management decisions should not be based on CTG interpretations alone. Healthcare professionals must take into account the full clinical picture, including the mother's history, stage and progress in labour, any risk factors and any other signs the baby may not be coping with labour.</p> <p>4. The Trust to ensure that for mothers having continuous CTG, when an adequate trace of a baby's heart rate cannot be accurately obtained during labour; this is escalated immediately.</p> <p>5. The Trust to ensure staff are supported to recognise, escalate and act upon a pathological CTG in a timely manner, and that there is a process of continual risk assessment in the second stage of labour</p>	<p>3. Fetal surveillance study day in progress, introduced in 2022, competency document updated with a pass mark of 90%. Weekly multidisciplinary case reviews held on Teams</p> <p>4. As per current guideline, FSE to be applied and escalated for assistance if no improvement, include on fetal surveillance training.</p> <p>5. As per current guideline, escalation policy followed if assistance is required. Discuss looking at the whole clinical picture as part of fetal surveillance study day</p>
	<p>MI-004850</p> <p>G2P1</p> <p>Low risk pregnancy</p> <p>Spontaneous labour at birth centre</p> <p>Shoulder dystocia at birth</p> <p>Neonatal resuscitation required</p> <p>Cooling therapy required</p>	<p>1. The Trust to support staff to follow local guidance for the management of reduced fetal movements in order to ensure that mothers receive the correct pathway of care.</p> <p>2. The Trust to support staff to recognise the warning signs of delay in the first stage of labour</p>	<p>1. Guideline review to make the flow chart more user friendly and add Registrar review if reduced fetal movements reported during labour into flow chart</p> <p>Take 5 and GLOW reminding staff that reduced fetal movements in previous 24hrs should be offered continuous fetal monitoring and birth at Tunbridge Wells Hospital</p> <p>Updated flow chart available for reference in Triage and MDU for management of reduced fetal movements</p> <p>2. Staff educated to use clear vaginal examination ranges and not use</p>

		<p>to ensure that mothers receive the correct pathway of care.</p> <p>3. The Trust to ensure that staff working within a free-standing midwifery unit environment are equipped with the skills in ongoing neonatal resuscitation, whilst awaiting support from the ambulance service, in line with local guidance.</p> <p>4. The Trust to review the local processes in place at the free-standing midwifery unit to ensure staff are supported to respond to an emergency situation in line with local guidance.</p>	<p>approximate measurements, i.e.: 3-4cms</p> <p>Care in Labour guideline clearly outlines the expected progress of labour and accessible to staff</p> <p>Skills Drills scenario outlining this case for learning at Free-standing Birth Centres and Home Births services</p> <p>3. All staff must attend annual PROMPT training</p> <p>Birth Centre skills drills programme in partnership with community teams which has a dedicated week on a rolling basis for neonatal resuscitation</p> <p>To review the possibility of core birth centre and community staff to attend NLS training</p> <p>4. Processes are being reviewed with senior exec team regarding discussions ongoing</p> <p>Birth Place Options Assessment in circulation to ensure that information given to patients is clear about emergency situations</p>								
Number of PMRT case reviews	6 – please see summary in the table below: <table border="1"> <thead> <tr> <th><i>Number of stillbirths and late fetal losses (For review)</i></th><th><i>Reviews completed</i></th><th><i>Number of cases with care likely to have made a difference to the outcome for the baby</i></th><th><i>Cause of death</i></th></tr> </thead> <tbody> <tr> <td>6</td><td>6</td><td>1</td><td>2 – undetermined</td></tr> </tbody> </table>			<i>Number of stillbirths and late fetal losses (For review)</i>	<i>Reviews completed</i>	<i>Number of cases with care likely to have made a difference to the outcome for the baby</i>	<i>Cause of death</i>	6	6	1	2 – undetermined
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			2 – placental insufficiency 1 – hypoxia 1 – hypoxia secondary to placental abruption
Number of neonatal deaths (For review)	Reviews completed	Number of cases with care likely to have made a difference to the outcome for the baby	Cause of death
0	0	0	
Top 5 contributory factors relevant to details reviewed			
Task Factors – Procedural or Task Design		Fundal height measurements not plotted correctly Referrals for scans not undertaken when required Baby was small, scans were indicated and performed but baby was not identified as growth restricted	
Staff Factors – Cognitive Factors		There were concerns about baby’s growth but they were not acted upon appropriately Baby was small, scans were indicated and performed but baby was not identified as growth restricted	
Actions planned to share learning and mitigate risk			
Individual support and learning plans Case presentation at Multi-disciplinary Team (MDT) forum Guidance to be recirculated and shared via various forums and media Implementation of electronic Growth Assessment Programme within maternity IT system			
Trends in stillbirths since 2010:			



Trends in stillbirths since 2018 in LMNS:



Themes and Trends from investigations and case reviews

- Poor compliance with growth assessment protocol – on risk register and targeted approach to increasing compliance with update training. The team are hoping that sonographer staffing will remain stable over coming months so that we do not need to change the guidance due to lack of capacity.
- Rise in swab incidents for maternity (cases not related to theatre). MDT working and learning shared. Compliance with guideline audit completed by governance team in April will be repeated in July 2022
- Staff shortages impacting services. Home birth service suspended during times of high activity within acute unit. Specialist midwives and managers diverted to support clinical activity during periods of high staff absence

Risk Register

- 1 red risk – lack of maternity training days to meet mandatory training requirements – escalated through SDR, currently a cost pressure to division
- 0 new risks
- 4 risks closed

Complaints

Number of new and themes from new formal complaints

- 8 amber complaints received
- Main themes:

	<ul style="list-style-type: none">▪ Communication about care planning▪ Incorrect treatment / procedures not followed▪ Lack of support in postnatal period <p>Key themes identified from closed complaints</p> <ul style="list-style-type: none">▪ 15 Complaints closed▪ 4 partially upheld, 11 not upheld <p>Themes:</p> <ul style="list-style-type: none">▪ Ensure good communication and explanations, in both planned and emergency procedures and contacts▪ Concerns about lack of support and choices due to staffing pressures and covid restrictions																																																									
Friends and Family feedback	<ul style="list-style-type: none">• The number of responses averaged 220 per month with good response rates being achieved despite recent staffing challenges. Positive feedback range 87-99%• Work continues on the action plan developed following analysis of CQC Maternity Survey 2021 <p>Trends in FFT feedback:</p> <div><p>Maternity Friends and Family Feedback</p><table border="1"><thead><tr><th>Month</th><th>Number of IQVIA (FFT) responses</th><th>% positive responses</th></tr></thead><tbody><tr><td>Jan-21</td><td>270</td><td>98%</td></tr><tr><td>Feb-21</td><td>280</td><td>99%</td></tr><tr><td>Mar-21</td><td>240</td><td>96%</td></tr><tr><td>Apr-21</td><td>260</td><td>99%</td></tr><tr><td>May-21</td><td>250</td><td>97%</td></tr><tr><td>Jun-21</td><td>250</td><td>97%</td></tr><tr><td>Jul-21</td><td>240</td><td>96%</td></tr><tr><td>Aug-21</td><td>180</td><td>92%</td></tr><tr><td>Sep-21</td><td>180</td><td>92%</td></tr><tr><td>Oct-21</td><td>160</td><td>91%</td></tr><tr><td>Nov-21</td><td>150</td><td>90%</td></tr><tr><td>Dec-21</td><td>270</td><td>86%</td></tr><tr><td>Jan-22</td><td>280</td><td>99%</td></tr><tr><td>Feb-22</td><td>180</td><td>92%</td></tr><tr><td>Mar-22</td><td>210</td><td>94%</td></tr><tr><td>Apr-22</td><td>250</td><td>97%</td></tr><tr><td>May-22</td><td>100</td><td>87%</td></tr><tr><td>Jun-22</td><td>280</td><td>99%</td></tr></tbody></table></div>	Month	Number of IQVIA (FFT) responses	% positive responses	Jan-21	270	98%	Feb-21	280	99%	Mar-21	240	96%	Apr-21	260	99%	May-21	250	97%	Jun-21	250	97%	Jul-21	240	96%	Aug-21	180	92%	Sep-21	180	92%	Oct-21	160	91%	Nov-21	150	90%	Dec-21	270	86%	Jan-22	280	99%	Feb-22	180	92%	Mar-22	210	94%	Apr-22	250	97%	May-22	100	87%	Jun-22	280	99%
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Recommendations and Actions	<ul style="list-style-type: none">• Annual “deep-dives” – rolling programme of areas to review• Report to MDT following thematic review of HIE cases, led by neonatologist Dr Park• Roll out of fetal surveillance training to support learning and decision making• Collaboration with LMNS project to review fetal monitoring and induction of labour guidance and develop system wide guidelines• Contribution to LMNS peer review group to provide mutual assurance and support with Ockenden and CNST actions• Project planned to implement integrated Growth assessment charts into the maternity information system, to support staff with accurate plotting and prompts for decision making																																																									

Progress with Implementation of Saving Babies Lives Care Bundle version 2	Element	Compliance data		Actions
	Smoking in pregnancy	CO monitoring at booking	95%	SiP midwife working with community and ANC teams to improve compliance
		CO monitoring at 36 weeks	88%	
	Fetal growth restriction	Pregnancies where a risk status for fetal growth restriction is identified at booking and 20 week scan	100%	
	Reduced fetal movements	Women who receive information about reduced FMs by 28 weeks	100%	
		Women attending with RFM who have a computerised CTG	100%	
	Fetal monitoring	Staff attended annual MDT fetal monitoring training	66%	Training challenges due to staffing issues and high activity – action plan in place
		Lead midwife (0.6 wte) and Lead obstetrician (0.1 wte) appointed	100%	Obstetrician appointed Midwife appointed
	Preterm births	Live births <34 weeks having full dose of steroids within 7 days of birth	53%	All cases reviewed to ensure steroids given appropriately
		Live births occurring more than 7 days after first course of steroids	0%	
		Singleton live births < 30 weeks receiving MgSO4 within 24 hours before birth	88%	All cases reviewed to ensure MgSO4 given appropriately
		Women giving birth in an appropriate care setting for their gestation	98%	All cases reviewed to ensure transferred considered appropriately
Progress with maternity multidisciplinary staff training	Compliance with maternity specific training			March 2022
	Fetal monitoring			66%
	Neonatal resus (PROMPT*)			73%
	Practical Obstetric Multi-professional Training (PROMPT)			77%
	Gap & Grow- E learning (annual update)			66%
	Gap & Grow workshop			94%
	Avoiding Term Admissions to Neonatal Unit (ATAIN)			92%
	Staffing challenges have led to a fall in compliance across a number of topics. Management team taking a focused approach to releasing staff for mandatory training. The team are also looking at ways to improve the re-booking process when training days are cancelled.			
Progress with clinical workforce planning	Workforce	Latest review	Progress with actions	

	Maternity workforce	Senior management safety review October 2021 Workforce review, H O'Dell, Maternity Clinical Advisor Clinical Delivery and Networks, Maternity NHS England and NHS Improvement-South East, March 2022	<i>Ockenden money is supporting some of the identified shortfall with a further business case being developed to support remaining shortfall</i>
	Obstetric medical workforce	Review September 2021	<i>New consultants in post and job plans provide increased weekend cover</i>
	Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations	
	Neonatal medical workforce	Neonatal medical cover meets national recommendations	
	Neonatal nursing workforce	Nursing and Midwifery Staffing Review April 2021	<i>Business case in progress for NNU BCP to meet BAPM recommendations</i>
Perinatal Quality & Safety Dashboard	Included in appendices		
Related Regulatory Requirements	Response to the Ockenden Report, December 2020 & April 2021 CNST Maternity Incentive Scheme – year four, May 2022 Transforming perinatal safety, December 2020		
Author:	Sarah Blanchard-Stow, Divisional Director of Midwifery, Nursing and Quality Rachel Thomas, Deputy Head of Midwifery and Gynaecology Susan Powley, Matron for Governance, IT & Projects Sarah Flint Chief of Service		
Paper reviewed by:	Maternity Board		
Action Required by the Trust Board			

Update on the Kent and Medway Integrated Care Board (ICB) and West Kent Health and Care Partnership (HCP)

**Deputy Director of Strategy,
Planning and Partnerships**

The enclosed report provides information and updates on the establishment of the Kent & Medway Integrated Care Board (ICB) and the West Kent Health Care Partnership (WKHCP).

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 discussion, to facilitate feedback between MTW, the HCP and the wider system.

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

Kent & Medway ICB

The Kent and Medway ICB replaced the Clinical Commissioning Group on 1st July 2022. The majority of posts are confirmed (below). The 2 representatives from Primary Care have been confirmed as Dr Susie Marsden and Dr Satvinder Lall.

The board of NHS Kent and Medway



The Executive Director structure has also been confirmed and is in the process of being recruited to (below). The following posts have been substantively recruited to:

- Chief Finance Officer – Ivor Duffy
- Chief Medical Officer – Dr Kate Langford
- Executive Director Corporate Governance – Mike Gilbert
- Chief of Staff – Natalie Davies

The following posts have been recruited to on an interim basis with formal recruitment processes underway:

- Chief Nurse
- Chief Strategy Officer
- Chief Digital Officer
- Chief People Officer
- Chief Delivery Officer

The Executive Director of Communications and Engagement is vacant.

Executive team for NHS Kent and Medway



Updates

Both MTW and the WKHCP have had oversight meetings during July. The intention going forward is to run them concurrently to avoid duplication and support place governance as we move towards in defining delegation from 1st April 2023. Both meetings were positive and we await formal feedback.

Over the past few months the HCP Development Board has diversified its membership to include the CEO of Involve Kent and has welcomed public health representation.

It is proposed, and generally supported, that the HCP infrastructure will include a formal subcommittee of the ICB to oversee any delegations from the ICB this will be called the HCP Committee. The Terms of Reference for this meeting and, specifically the ICB representation, is being discussed but is expected to be proportionate to any delegation. In respect of delegations from the ICB to date, we have been successful in securing:

- Engagement/Co-production - ICB agreed delegation of funding for lay member post continuation £20K annually. Leading SEAG and supporting PPG chairs group and strategic approach to engaging residents
- Population Health Management - ICB agreed use of HI funding for PHM post for each HCP approx. £70k)
- Health Inequalities resource £308K to be used as outlined below.

In addition, we will be working with WK stakeholders and other HCPs to identify areas for delegation and will develop a process for agreeing the Memorandum of Understanding with the ICB by September 2022. The delegations are expected to be agreed by the end of the year and a formal MOU will be signed to confirm the T & Cs.

WKHCP Highlights

- **Maidstone Health Inequalities:** This initiative led by Maidstone Council has taken an evidence-based approach, responding to data and feedback from the community. Through active engagement residents have identified issues relating to the wider determinants of: food and income insecurity, housing and safety issues, all having a negative impact on their health. Local HCP partners have responded by targeting their response on food and income insecurity in the first instance. This will start with the development of a community larder service providing regular healthy food for an affordable contribution from residents. This work will link local supermarkets and other food providers with a community-based outlet in the most deprived areas of Maidstone. This initiative will also inform the development of a dynamic blueprint approach to tackling health inequalities that can be replicated elsewhere.
- **Weald Neighbourhood development:** The multiagency team drawn together by the Weald Primary Care Network (PCN is a partnership of practices) have identified a shared interest in more effectively addressing the needs of people who are frequent users of primary care but do not seem to be making progress in their health and well-being. A data search by practices has revealed about 60 patients across Weald PCN area that fit this description (frequent users of primary care) and a common theme this group are presenting are emerging or untreated mental health presentations. The multiagency neighbourhood group are working with the West Kent Mental Health clinical lead to develop a multi-agency MDT response for this group of patients which they will introduce using a QI methodology and evaluate for its impact on patient's health and well-being and their use of primary care.
- **Health Inequalities Funding 2022/2023.** The Integrated Care Board (formerly the CCG) has allocated £308k Health Inequalities monies to West Kent to be spent in 2022/23. Funding has now been agreed to support the following health inequality initiatives: Weald PCN leading development of Mental Health MDT for high users of primary care services, involve to develop social prescribing with the Acute Trust in support of people with mental ill health notably in relation to effective discharge and preventing avoidable A&E attendances, Malling PCN to provide pop up clinics to support isolated and marginalised groups receive health checks, Maidstone borough council leading on the development of a community larder in a deprived area of Maidstone to support people with food insecurity.

WKHCP Risks and Challenges

The 2 top rated red risks are:

Workforce - All providers are identifying capacity issues with staffing core services and 2022 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue. Nursing capacity pressures in secondary care.

Demand pressures - Pressures across WK system arising from range of sources including: planned care backlog; COVID/Post COVID related demand; new ways of working i.e. VCA/remote consultations, COVID vaccination/booster programme; patient contact increase post covid measures and K&MCCG/ICB developments.

**To approve an updated Outline Business Case (OBC) for
Increasing Elective Orthopaedic Capacity**

Deputy Chief Operating Officer

Please find enclosed the updated Outline Business Case (OBC) 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 26/07/22, 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, 26/07/22
- Finance and Performance Committee, 26/07/22

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

OBC for Additional Elective Orthopaedic Capacity for Kent & Medway

JULY 2022



1. Introduction

The Outline Business Case for 'Increasing Elective Orthopaedic Capacity' was discussed and reviewed in December 2021 by our Finance and Performance Committee and Trust Board. It was highlighted at the time that the next reiteration of the business case would reflect the wider ICS context.

The OBC for 'Additional Orthopaedic Elective Capacity for Kent and Medway' has now been developed and reflects a system business case, whereby the facility will be hosted by MTW. The revised OBC was to be presented through Trust / ICB governance in May 2022, however following the appointment of a new Quantity Surveyor, the capital estimate/cost plan was still in the process of being reviewed and validated.

The capital estimate for the original brief (4 Theatres, 20 IP beds and 16 Day Case trolleys) has now been finalised at £47.3m, which far exceeds the TIF funding earmarked for the project. The project team looked at all options to significantly reduce this capital estimate. This included reviewing the scope of the project, together with consideration of the build type (Modular vs Traditional).

The lowest cost plan of the options reviewed, and which has been approved by the clinical project team, is £39.1m and is a 3 Theatres, 14 IP beds and 10 Day Case trolley facility. The 3 theatres would be fully allocated for Sector capacity to support elective recovery. The transfer of TWH elective orthopaedic activity still forms part of the overarching clinical strategy and would be delivered predominantly through extended hours/days in MOU and MSSSU.

This paper provides an overview to the new option, highlights the key assumptions and risks in the OBC and talks through the operational and financial impacts of the 3 Theatre option.

2. Key Assumptions of Updated OBC

	Original 4 Theatre Option	New 3 Theatre Option
Scope	<ul style="list-style-type: none"> • 4 laminar flow Theatres, in a 'barn' theatre block • 20 IP Beds, 16 DC Trolleys, 8 Recovery beds • Modular Building 	<ul style="list-style-type: none"> • 3 Theatres flow Theatres, in a 'barn' theatre block • 14 IP Beds, 10 DC Trolleys, 6 Recovery beds • Modular Building <p><i>(To note: a Traditional build was considered and costed, however the saving in size of footprint/plant space was offset by redesign fees, re-work of substructure and inflationary increase (as delayed go-live date).</i></p>
Cost	£47.3m (Final estimate)	£39.1m
Activity	<p>6,286 Total Elective Orthopaedic cases</p> <p>Less 1,004 TWH transferred activity</p> <p>5,282 Sector Elective Orthopaedic capacity</p>	<p>5,030 Sector Elective Orthopaedic capacity</p> <p>TWH activity to transfer to MOU/MSSSU on the Maidstone Hospital site through extended working hours/days/other specialty sessional swops with TWH e.g. Gynae and ENT</p>
Footprint	4,280 sq.m	3,472 sq.m
Go live date	<p>September 2023</p> <p>(If OBC went through June 2022 Governance)</p>	<p>February 2024</p> <p>(Due to delay in concluding preferred option and redesign required for new option. This timeline also assumes £1.4m of professional fees is approved and funded by Trust prior to the early capital release of funds from NHSEI at OBC approval stage)</p>

3. Capital Estimate of new preferred option

The 3 Theatre option capital estimate of £39.1m is broken down as follows. To note, work will continue during the redesign stage to try and reduce this capital estimate further within the new re-defined scope (3 Theatres, 14 IP Beds, 10 DC Trolleys).

<u>Capital estimate</u>	<u>£m</u>
Building	£28.5
Enabling works (Incl substation)	£4.2
Professional fees	£1.9
Inflation	£2.0
Medical Equipment	£2.1
ICT Equipment	£0.4
TOTAL	£39.1

Cashflow by year and the corresponding shortfall by year is as follows. To note: the funding shortfall is required in 2022/23.

<u>Phasing of cashflow</u>	<u>£m</u>
2021/22 (Spent)	£3.7
2022/23 (Forecast)	£16.4
2023/24 (Forecast)	£19.0
TOTAL	£39.1

Further breakdown of phasing:

2021/22	<u>Spent:</u>	£m
	Enabling works / Prof Fees	£2.4
	Equipment / IT	£1.2
	TOTAL	£3.7
2022/23	<u>Forecast :</u>	
	Professional fees	£1.5
	Advance orders - steel etc	£11.9
	Enabling works (Incl substation)	£3.0
	TOTAL	£16.4
2023/24	<u>Forecast :</u>	
	Balance of spend	£17.0
	Inflation	£2.0
	TOTAL	£19.0

Phasing of cashflow required compared to current funding allocation

<u>£m</u>	<u>Current funding</u>	<u>Required funding</u>	<u>Difference</u>
2021/22 - TIF	£2.5	£2.5	£0.0
2021/22 - ICS	£1.2	£1.2	£0.0
2022/23	£9.3	£16.4	£7.1
2023/24	£19.7	£19.0	-£0.7
TOTAL	£32.7	£39.1	£6.4

4. Funding of new Preferred option

The financing gap against the National TIF funding for this new preferred option is £6.4m, as follows:

Capital Estimate for 3 Theatre Option		£39.1m
<u>Less:</u>		
TIF Funding (including £2.5m advanced in 2021/22)	£31.5m	
Equipment/ICT funded from ICS slippage 2021/22	<u>£1.2m</u>	£32.7m
Funding Shortfall		£6.4m

The initial approach to funding the gap is to revisit our Internally funded capital programme. As 2022/23 is already mostly committed, the bulk of the funding is likely to need to come from reducing availability in 2023/24 and 2024/25.

Existing capital plan funded from internal resource, capped by ICS control totals up to 2024/25. 2025/26 onwards may be subject to future control total limits.

Linac replacements relate to Canterbury site with oldest machines. No NHSE funding available in future as deemed to be part of ICS allocations.

Barn theatre funding released from deferring one linac replacement (or ICS funded) & reducing 3 main functional budgets over two years.

Adjusted budgets may need recalibration to reflect prioritisation of risks under each functional area.

MTW Capital plan - adj for release of Barn funding	2022/23	2023/24	2024/25	2025/26	2026/27
Internal Resource	£'000	£'000	£'000	£'000	£'000
Estates total capital	2,995	2,000	2,015	3,964	3,547
ICT total capital	2,931	2,345	2,435	4,000	3,699
Equipment total capital	2,706	1,933	1,828	4,376	3,826
Linear Accelerator replacement programme		3,000	3,000		
Total internal resource	8,632	9,278	9,278	12,340	11,072
Adjust to release £6.4m additional Barn funding					
1. Earmark estates unallocated funding 2022/23	250				
2. Defer linac replacements/seek ICS funding			3,000		
3. Reduce Estates/ICT/Equipment 2023/24 & 2024/25		1,275	1,875		
Total reallocated internal funding to Barn project	250	1,275	4,875		
Adjusted Capital budgets - internal funds					
Estates total capital	2,745	1,600	1,390	3,964	3,547
ICT total capital	2,931	1,870	1,810	4,000	3,699
Equipment total capital	2,706	1,533	1,203	4,376	3,826
Linear Accelerator replacement programme	0	3,000	0	0	0
Barn Theatre allocation from internal funds	250	1,275	4,875	0	0
Total internal resource	8,632	9,278	9,278	12,340	11,072

4. Funding of new Preferred option cont.: Options to mitigate Internal Funding Approach

Reducing the forward internally funded programme by £6.4m has significant impact on the Trust's ability to renew/replace key infrastructure across Estates, ICT and Equipment areas. Although the Trust's internal capital increases from 2025/26 within the plan, these years do not yet have a published "control total" which might further limit the Trust's ability to spend its resource (the Trust's current control total of £9.2m is c. £2m less than available resource from depreciation).

Therefore the Trust will need to look at other potential approaches to mitigate the impact of releasing £6.4m from internal funds. Such approaches will include:

Mitigation	Estimate
Slippage from capital system / regional / national	? £2m - £3m
Contingency from Regional TIF ER Fund (not agreed but could be framed for build cost inflation)	? £1m - £2m
Sponsorship / Corporate Donation	? £0.5m
Charitable funds / league of friends funding	? £0.5m
National funding bids e.g. Diagnostic/Digital	?
Any alternative funding routes for equipment – would need to be IFRS16 compliant	?
Secure brokerage over a longer period	?
Total:	? £4m – £6m

5. Transfer of TWH Adult Elective Orthopaedic activity to Maidstone Hospital

The 3 theatres in the new facility would be fully allocated for Sector capacity to support elective recovery. The transfer of TWH Adult Elective Orthopaedic activity still forms part of the overarching clinical strategy and would be delivered as follows:

	<u>Hours</u>
<u>To move:</u> 11 sessions x 4 hours	44
<u>Solution</u>	
MOU - Move to extended 10 hour operating days - 2 additional hours/day x 6 days	12
MSSSU - Move to extended 10 hour operating days - 2 additional hours/day x 4 days	8
MSSSU - Saturday operating – 1 all-day session/week	8
Sessions to be swapped with TWH e.g. Gynae and ENT (4 x 4 hour sessions)	16
TOTAL	44

This would result in all Adult Elective Orthopaedic activity being centralised on the Maidstone Hospital site, but would result in MOU and the Orthopaedic element of MSSSU moving to 10 hour operating days and 6 day weeks. This would pose the following risks:

- Although Adult Orthopaedic activity would become centralised, Orthopaedic activity would be undertaken across several theatres in different locations and may not produce the efficiency gains as expected.
- Workforce impact, as orthopaedic activity undertaken in several theatres in different locations.
- Surgical specialities agreeing to swap operating sessions to TWH from MH.
- MSSU does not have laminar flow so would be utilised for day case surgery only.
- Longevity of MOU, infrastructure, regular maintenance etc.

6. Revenue Implications of 3 Theatre option - Assumptions

- **Go live date** of 1st February 2024. This:
 - Incorporates a 3 month NHSE approval period for OBC and a 3 month NHSE approval period for FBC.
 - Assumes capital funding for long lead items and enabling works is released following OBC approval. NHSE have set up a process for early fee requests, with a template to be completed and submitted alongside the OBC.
 - Assumes £1.4m of professional fees is approved and funded by Trust (April 2022 to January 2023), prior to the early capital release of funds from NHSE at OBC approval stage, to allow the project to continue to progress the OBC to FBC, including redesign relating to the new preferred option. To note: £0.6m of this had already been committed to by the Trust for the 4 Theatre option. As our 2022/23 internal capital programme is already mostly committed, the Trust would need to go at risk with this capital spend until it is funded by NHSE. A decision to not proceed with this project would result in the writing off of all costs incurred to date to Revenue.
- **Operating model:** The 3 theatre facility will operate 60 hours a week, 48 weeks a year, in line with GIRFT recommendations. This has currently been modelled at 2.5 session days (10 hour operating days), 6 days a week.
- **Activity levels:**
 - These have been modelled at 5 IP cases per 2.5 session day, and 7.1 DCs per 2.5 session day, with 93% of lists running, and totals 5,030 elective cases per annum.
 - To note: Activity for 4 Theatres submitted as part of the TIF submission was 6,640 elective cases. If we simply pro-rata'd this down to 3 Theatres, it totals 4,980. Activity levels are therefore in line with the Sector offering in the 4 Theatre option, however requires further productivity as TWH was only utilising 44hours/60hours of the 4th theatre.
 - OP conversion allows for 1 New, 1 Follow-Up, 1 POA, 1 Physio (2 from Year 3 assuming MTW only activity then) and 30% will have an Anaesthetic review.

6. Revenue Implications of 3 Theatre option - Assumptions cont.

- Workforce:** The total workforce requirement is as follows:

The temporary staffing assumption is as follows:

	Year 1-2	Year 3	Year 4+
% of staff substantively recruited	70%	85%	90%
Temporary staffing	30%	15%	10%
Temporary staffing premium	100%	100%	100%

Staff Group	Total Requirement
Medical	25.00
Nursing	90.09
AHP	31.60
Admin	20.93
Other Support Staff	17.29
TOTAL	184.91

- Working assumption of substantive staff in post 3months ahead of go-live date included in modelling.
 - Saturdays have been costed at Waiting List Initiative rates, at this stage.
- Non-recurrent costs:** These have been costed and included as follows:

	Year 0	Year 1	Year 2	Year 3	TOTAL
£000	2022-23	2023-24	2024-25	2025-26	
Recruitment fees		£800	£240	£120	£1,160
Project Team Costs	£539	£539			£1,078
Non-capital equipment (incl IT)		£607			£607
Consultant Relocation fees		£113			£113
Legal fees	£72				£72
Total	£611	£2,059	£240	£120	£3,030

- Other**
 - The income assumption has been modelled at the ERF rate (75% of tariff) for 2023/24 and 2024/25, with full tariff from 1/4/25.
 - An 8% contribution to MTW Corporate Overheads has been included.

6. Revenue Implications of 3 Theatre option - SOCI

The impact on Income and Expenditure over the first 5 years is as follows. The deficit in Years 1 and 2 is as a result of the 75% tariff income assumption, non-recurrent set up costs, temporary staffing premium and lead time in recruitment to go-live. The OBC states MTW will require non-recurrent revenue support in 2022/23 to 2024/25 to cover these deficits. The revenue requirement for 2022/23 (predominantly project teams costs) has not yet been discussed with the ICB.

£000	Year 0 2022-23	Year 1 2023-24	Year 2 2024-25	Year 3 2025-26	Year 4 2026-27	Year 5 2027-28
Pay		£5,787	£14,459	£13,324	£12,845	£12,845
Non Pay		£1,268	£7,611	£7,611	£7,611	£7,611
MTW Corporate Overhead		£576	£1,800	£1,708	£1,669	£1,669
Non Recurrent Setup	£611	£2,058	£240	£120		
Depreciation		£96	£995	£995	£995	£995
PDC dividends payable	£414	£1,033	£1,348	£1,313	£1,279	£1,245
Total Cost	£1,025	£10,818	£26,453	£25,071	£24,399	£24,365
Income @ 75%		(£3,174)	(£19,041)			
Income @ 100%				(£25,680)	(£25,680)	(£25,680)
Total Income	£0	(£3,174)	(£19,041)	(£25,680)	(£25,680)	(£25,680)
Total Surplus (+) / Deficit (-)	(£1,025)	(£7,645)	(£7,411)	£610	£1,281	£1,315
% Profit (+) / Loss (-)		-241%	-39%	2%	5%	5%

7. Top Project Risks

There are 3 red risks after mitigations and these are as follows:

Category	Description	Likelihood	Impact	Current Grade	Mitigation Action(s)	Likelihood	Impact	Residual Grade
FBC	Increase to Capital Costs	5	5	25	The project team have reviewed scope reduction and value engineering to reduce the capital cost. Approval from Execs to complete and progress OBC for 3 Theatre option at £39.1m. T&T cost plan is based on RIBA Stage 2, and includes the corresponding contingencies for the stage of design.	4	5	20
Approvals	Delay to OBC and FBC approval periods impacting go-live date	5	4	20	Unmitigated as dependent upon NHSEI approval times lines to review and approve OBC/FBC. Trust to ensure swift response to any queries raised by NHSE.	5	4	20
Construction	Extended lead-times for IT equipment impact technical and operational commissioning	5	4	20	Monitor issue and place orders as soon as funding is available. Review alternative suppliers to identify equipment that is more readily available or on a shorter lead time	4	4	16

The full risk register is included in Appendix 15 in the OBC. The risk log contains the risks from each workstream including construction, workforce, patient pathways and System RTT.

A risk review workshop was held in June 2022 to review the Construction risks in detail. This workshop will be replicated for the other workstreams.

8. Conclusion

The OBC assesses all options to assist with elective recovery across Kent & Medway including using the independent sector, and concludes that the preferred option is to build a new orthopaedic unit based on the Barn theatre concept, consisting of three open theatres separated by laminar flow canopy, with 14 inpatient beds and 10 trolleys for day surgery.

This paper seeks approval for the OBC to be presented to the Trust Board, noting:

- The preferred option is now a 3 Theatres, 14 IP beds and 10 DC trolley facility. The 3 theatres would be fully allocated for Sector capacity to support elective recovery, delivering 5,030 adult elective orthopaedic cases per annum. This activity level is in line with the Sector offering in the 4 Theatre option, however requires further productivity.
- The transfer of TWH Adult Elective Orthopaedic activity still forms part of the overarching clinical strategy and would be delivered predominantly through extending to 2.5 session days in MOU/MSSSU and Saturday operating in MSSSU.
- The £6.4m shortfall in capital funding will require re-prioritisation of our internally funded capital programme, whilst mitigations are progressed.
- In order to achieve the February 2024 go live date, capital funding of £1.4m for professional fees will need to be funded by the Trust ahead of the early capital release of funds from NHSEI at OBC approval stage. £0.6m of this had already been committed to by the Trust for the 4 Theatre option. As our 2022/23 internal capital programme is already mostly committed, the Trust would need to go at risk with this capital spend until it is funded by NHSEI. If these fees are not funded and work is delayed until after OBC approval/release of funding from NHSEI, it will add another 3-4 months onto the programme/go-live date (and an additional inflationary pressure of c.£0.3m to the overall Project cost).
- The Trust will require non-recurrent revenue support in 2022/23 to 2024/25 to cover the deficits caused by the 75% tariff income assumption, non-recurrent set up costs, temporary staffing premium and lead time in recruitment to go-live. The revenue requirement for 2022/23 (predominantly project teams costs) has not yet been discussed with the ICB.

Outline Business Case for Additional Orthopaedic Elective Capacity for Kent and Medway



July 2022

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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 4 th 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	Draft issued to Trust executives
1.1	26 Nov 2021	Sarah Davis	Final issued for NHSEI
2.0	11 Jan 2022	Andy Whiting	Updated for NHSEI (Region) comments
2.1	12 Jan 2022	Andy Whiting	Revised revenue costs
2.2	Jan 2022	Sarah Davis	Revision to Exec Team
2.3	17 Mar 2022	Andy Whiting	Updated for NHSEI feedback
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2.6	02 May 2022	Andy Whiting	Strategic, commercial and management cases circulated to project team for review
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2.8	12 May 2022	Andy Whiting	Issued to MTW for final review
2.9	20 May 2022	Andy Whiting	Issued to Finance and Performance Committee for review
3.0	13 July 2022	Julie Wells	Updated to Three Theatre preferred option
3.1	20 July 2022	Andy Whiting	Economic case updated for 3 Theatre option
3.2	22 July 2022	Julie Wells	Issued to Finance and Performance Committee and Trust Board for review and approval

1 Executive Summary

1.1 Introduction

This outline business case (OBC) proposes an investment of £39.1m to create the West Kent Elective Orthopaedic Unit (the name is TBC) on the Maidstone Hospital site. The new facility will open in February 2024 and will consist of:

- Three laminar flow theatres, in a 'barn' theatre block
- A 14-bed inpatient ward
- A 10-trolley day case ward.

The WKEOU will be ring-fenced for orthopaedic green pathway elective day case and inpatient activity. The new unit will be a Kent and Medway (K&M) system resource to help with elective recovery and will have the capacity to deliver 5,030 elective orthopaedic cases per annum. The elective activity will also generate 21,629 corresponding outpatient appointments (new, follow-up, pre-assessment, physiotherapy and anaesthetic review), increasing to 26,659 outpatient appointments from year three.

The facility will operate 60 hours a week, 48 weeks a year, in line with GIRFT recommendations.

As part of the supporting strategy, MTW also proposes to centralise all elective orthopaedic activity (excluding Paediatrics) on the Maidstone Hospital site. This will provide an opportunity for other surgical specialities to refine their planned theatre sessions.

The structure of this business case is consistent with NHS Improvement (NHSI) guidance¹ from on the development of business cases and uses the Five Case Model.

Statements of support for the investment proposed, have been received from Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust and West Kent Integrated Care Partnership. A statement has also been requested and is anticipated from East Kent Hospitals University Foundation Trust.

Engagement with the Health Overview and Scrutiny Committee (HOSC) has been productive and they are supportive of this case. The HOSC have confirmed their view that the proposal does not require a public consultation.

The business case is being submitted to the MTW Board of Directors and Integrated Care Board's Governing Body for approval. If approved it will then be submitted to NHS England (NHSE) with the request that:

- Capital investment for the proposed orthopaedic centre is predominantly supported from the Elective Recovery Fund (ERF) together with Trust/System capital contributions.
- Capital funding for advance orders of long lead items is released following OBC approval

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

- The Kent and Medway system is supported via national recovery monies, to fund the tariff costs associated with recovery from 2022/23 to 2024/25.
- Non-recurrent revenue support is provided in 2022/23 to 2024/25 to cover the deficits caused by the 75% tariff assumption and non-recurrent set up costs.

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 system-wide need to recover elective performance
- The ambition to create a centre of excellence for orthopaedics to ensure that people across Kent and Medway benefit from best practice in orthopaedic surgery
- Anticipated medium-term growth in demand which will require an expansion in elective capacity.

MTW's vision is to provide *outstanding hospital services* which means its orthopaedic 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 and other providers in Kent and Medway fail to comply with best practice in two key respects:

- There is limited ring-fenced orthopaedic theatre and bedded capacity
- Elective and non-elective activity is not separated.

The result is that operational performance is compromised as demonstrated by all Kent and Medway providers falling short against a number of GIRFT and Sentinel targets. Creating an elective orthopaedic centre of excellence with dedicated radiology and physiotherapy resource for post-operative care, and consistent team of nurses and theatre staff, would allow Kent and Medway to develop pathways that reflect best practice.

Following the pandemic recovering the system's referral to treatment (RTT) position and reducing the number of patients waiting more than a year to zero, are key priorities. Providers have worked hard to recover the 52-week breach position, but 1,300 remain across Kent and Medway and the position regarding the 18 week 92% RTT target has not improved to the same extent. To mitigate these issues the system has commissioned waiting list activity from the independent sector however, private hospitals are not able to operate on the full range of patients as is the case with NHS providers.

More capacity is also needed because demand is growing. Orthopaedics is a speciality skewed towards treating older people and the number of people aged 65 and over is expected to increase by 36% in Kent and 23% in Medway, over the next 15 years. The number of revisions is also rising as people live longer.

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 additional theatre capacity of 5,030 elective orthopaedic cases per annum and increased productivity in order to reduce the size of the Kent and Medway system orthopaedic waiting list and the time people waiting in line with national expectations.
- **Investment objective two** - to deliver year on year recurrent cost savings to the Kent and Medway system by fully utilising additional NHS orthopaedic capacity thereby reducing the number of orthopaedic patients outsourced to the independent sector.
- **Investment objective three** – to release MTW theatre capacity and provide an opportunity for other surgical specialities to refine their planned theatre sessions to enable improvement in non-surgical waiting list and RTT performance.
- **Investment objective four** – to fully utilise additional theatre capacity by improving theatre efficiency to achieve upper quartile performance across as measured by Model Hospital, GIRFT and HVLC metrics for orthopaedic day and inpatient activity.
- **Investment objective five** – to strive to become an outstanding organisation through the development of an orthopaedic centre of excellence to serve the Kent and Medway system.

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 1: Benefits

Group benefitting	Benefit
Patients, families and wider society	<ul style="list-style-type: none"> • 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 be able to choose to access orthopaedic best practice-based services without needing to travel outside the area. • The additional capacity created will enable waiting times to be reduced bringing forward the health benefits resulting from orthopaedic procedures • The additional capacity proposed would be located at Maidstone rather than Tunbridge Wells Hospital meaning more orthopaedic capacity would be close to the most deprived areas served by MTW and more accessible to people living in the more deprived parts of the wider Kent and Medway sector
Kent & Medway ICB	<ul style="list-style-type: none"> • Additional theatre capacity within the system to allow other providers to reduce their post-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, EKHUFT has a 52 week+ backlog of over 1,100 orthopaedic patients waiting for surgery. MTW has commenced discussions with EKHUFT, DGT and MFT regarding patient transfers of care to MTW.
Orthopaedics service	<ul style="list-style-type: none"> • Improved theatre staff recruitment and retention; specialised orthopaedic surgery is an attractive place to work. To also note, recruitment for theatre staff is currently easier on the Maidstone site. • Improved post-operative care for elective patients, with a specialised physiotherapy team on site. • Improved day case rates linked to the provision of dedicated day case space within the new facility, run by trained T&O teams. • 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

Group benefitting	Benefit
	<p>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.</p> <ul style="list-style-type: none"> • 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 through the super green ward within the WKEOU • Improved recruitment for surgical trainees and other clinical roles. • Reduced infection rates, as a result of the facility providing ringfenced, green elective pathways. • Reduction of further patients (backlog) being sent to the IS, as creates additional elective surgery theatre capacity.
Financial benefits	<ul style="list-style-type: none"> • Creating a separate elective orthopaedic centre will 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 three-barn theatre.
- Clinical buy in and commitment to change job plans/base location for consultants, including anaesthetists.
- Ability to recruit the workforce required for the WKEOU.

Delivery is dependent on:

- Capital investment, predominantly through central funding, 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 2: 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 and income with commissioners	The business case will need to confirm that activity performed in the 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	Offer capacity to other trusts
Unforeseen increase in capital cost	Ongoing development of detailed plans (currently at RIBA Stage 2) and early engagement with suppliers
Ability to recruit the required workforce to staff the new facility	Recruitment process to commence in advance for international and student recruitment, to ensure there is sufficient time for training and embedding.

1.3 The economic case

A shortlist of four options was appraised:

- 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 modular build barn theatre block with 3 theatres, 14 inpatient beds and a 10-trolley day case 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 3: Summary of risks and benefits by option

Option	Benefits and risks	Option benefit and risk score and/or rank
Option 1 BAU/ Do nothing	<p>Currently NHSE paying for outsourcing of backlog via ERF so no financial impact to Trust, however future finance agreements are not clear on impact</p> <p>Risk of backlog /RTT due to cancelled electives and limited theatre utilisation</p> <p>Lack of theatre capacity for emergency trauma/CEPOD/service changes</p> <p>Continued ad-hoc planning to meet RTT, >52W and activity plans</p> <p>Inability to meet gap between demand and capacity</p> <p>No ability to significantly improve GIRFT metrics whilst operating on hot site with no ring-fenced beds</p>	3
Option 2 Do Minimum - increase outsourcing	<p>MTW have no long-term commitment to IS usage</p> <p>Independent sector not able to meet full capacity gap</p> <p>High transaction costs</p> <p>Patients can be returned to NHS providers by independent sector with no notice</p> <p>Independent sector have long waiting lists</p> <p>Patients in the backlog often don't meet the independent sector patient criteria.</p>	4

Option 3 Modular 3 barn theatre plus 14 inpatient beds and 10-trolley day care unit	Increases theatre capacity for the ICB	1
	Creates super green ring-fenced capacity	
	Site development of cutting-edge clinical service to showcase MH site	
	Barn approach allows for improvements in GIRFT metrics	
Option 4 3 traditional theatres plus 14 inpatient beds and 10-trolley day care unit	Increases theatre capacity for the ICB	2
	Creates super green ring-fenced capacity	

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

Net present social value - total	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital	£0	£0	-£40,578,381	-£45,442,777
Revenue	-£77,956,419	-£642,129,318	-£562,467,809	-£561,452,871
Costed risks	-£6,280,193	-£53,104,647	-£742,750	-£782,500
Non-cash releasing benefits	£0	£0	£63,053,640	£55,449,362
Societal benefits	£4,939,770,907	£7,957,066,847	£7,999,376,200	£7,991,915,229
Net present societal value	£4,855,534,294	£7,261,832,882	£7,458,640,899	£7,439,686,443

The three “do something” options have similar levels of societal benefit (£8bn over 62 years), however only the in-house options (options 3 and 4) also deliver non-cash releasing benefits to MTW. The cost of delivering benefits is highest for Option 2 (£642m) compared to £603m (Option 3) and £607m (Option 4); Option 2 also carries significantly higher costed risks than the two in-house options (£53m versus £0.7 – 0.8m).

The incremental NSPV is then calculated for each “do something” option compared to the BAU to derive the cost benefit ratio.

Table 5: Incremental NPSV and cost benefit ratio

Net present social value - incremental from BAU	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital		£0	-£40,578,381	-£45,442,777
Revenue		-£564,172,898	-£484,511,390	-£483,496,452
Costed risks		-£46,824,454	£5,537,443	£5,497,693
Non-cash releasing benefits		£0	£63,053,640	£55,449,362
Societal benefits		£3,017,295,940	£3,059,605,293	£3,052,144,322
Net present societal value	£0	£2,406,298,588	£2,603,106,605	£2,584,152,149
Cost benefit ratio	0.00	4.94	5.92	5.85

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 1:5.92 and a net societal incremental value of £2.6bn over the life of the facility. The second-best value option is Option 4.

Sensitivities were run to understand the switching points at which the preference would move away from Option 3 in favour of options 2 or 4. The conclusion of this exercise was that the gap between Option 3's NPSV and the other options is too great for there to be a credible change in costs, risks or benefits for the switch to occur.

Taking both the non-financial and financial assessments 'in the round', the preferred option is to build a new elective orthopaedic unit based on the Barn theatre concept consisting of three open theatres separated by laminar flow canopy with 14 inpatient beds and 10 trolleys for day surgery. Following commissioning, the three elective operating theatres would open 1st February 2024 and would have a total capacity to deliver 5,030 elective orthopaedic cases per year.

1.4 The commercial case

The WKEOU will be a ring-fenced orthopaedic 3-barn theatre and ward modular complex (with 14 overnight beds and 10-day case trolleys). The facility will be a system facility initially dedicated to the clearing of the elective backlog. All three theatres will be available for Kent and Medway patients with patients sent across to the unit prior to surgery, mimicking the prime provider model. Theatre staffing will be consistent across all theatres, as will standard operating procedures, kit supplies and other consumables to ensure standardisation. MTW surgeons will receive patients from other trusts to aid backlog clearance across Kent and Medway. Patients would be seen and pre-assessed to ensure the surgery is still necessary and they are fit, then operate on, mimicking the prime provider model.

The flow and design of the facility is based on best practice and existing barn theatre complexes and has currently been developed to architectural design RIBA stage 2 (Concept Design). The Trust's Lead Nurse for Infection Prevention Control and the Head of Fire and Safety have both also reviewed the design of the unit and have confirmed their sign-off of the plans.

In order to meet the challenging timelines associated with elective recovery two decisions were made:

- The facility is to be of modular construction since modular construction is up to 50% faster to deliver than onsite construction
- Some aspects of the build programme were procured early i.e. before the primary contract is in place.

The trust also had a series of choices to make in determining its approach to the procurement and tendering of this scheme. The choices were:

- The choice of procurement route – 'design and build' was selected since this enables design risk transfer to the contract, integrated supply chains and early contractor involvement and a shorter overall programme due to the ability to overlap design, procurement and construction
- The choice of tendering approach - a two-stage tendering was selected as this enables early contractor and supply chain input into the design and a shorter overall programme

- The choice of which framework to use - the SBS Modular Building framework has been selected. This decision was reviewed by Gardiner & Theobald LLP, the trusts' chartered surveyors, who concluded that, *"it is our considered opinion that the selected procurement strategy, tendering strategy, and framework is appropriate given the size, value and complexity of this project and is aligned to the project's overall programme objectives. We consider that an appropriate building contract risk profile is achievable through the selected route and that appropriate management of quality can be achieved"*.

Premier Modular were selected as preferred bidder by way of mini-competition under the NHS SBS Modular Building Framework. Premier Modular are now engaged for pre-construction services under a Pre-Construction Services Agreement (PCSA). Following completion of the design, Premier Modular will market test the sub-contract packages on an open-book basis and provide a fixed price commercial offer. This is anticipated to occur by January 2023.

The planning application was validated by Maidstone Council on the 8th June 2022, with a current target determination date of the 7th September 2022. To date there have been consultation comments by various statutory consultees addressing matters such as ecology, drainage, environmental health and archaeology. None of those consultee comments have raised any fundamental points of objection; some raise minor issues of clarification but otherwise seek conditions as appropriate on those specific matters.

The WKEOU 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 workforce. 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 overseas 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 is 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 in the first few years post-opening.

1.5 The financial case

The initial capital investment required is £39.1m. This would be funded by:

Table 6: Capital Funding streams

£000	
TIF Funding	£31,489
ICS Slippage 2021/22	£1,200
Trust funded / System slippage / TIF Contingency	£6,410
Total	£39,099

The additional £6.4m of capital funding will require re-prioritisation of MTW's internally funded capital programme, whilst mitigations, such as slippage from System capital and Contingency from Regional TIF Elective Recovery Fund are progressed.

The theatres will provide capacity to carry out 5,030 elective orthopaedic cases for the Kent and Medway system to reduce the elective backlog. The impact of the scheme on the trust's cost base for years one to ten, is set out in the table below.

Table 7: SOCI impact

£000	Year 0 2022-23	Year 1 2023-24	Year 2 2024-25	Year 3 2025-26	Year 4 2026-27	Year 5 2027-28	Year 6 2028-29	Year 7 2029-30	Year 8 2030-31	Year 9 2031-32	Year 10 2032-33
Pay		£5,787	£14,459	£13,324	£12,845	£12,845	£12,845	£12,845	£12,845	£12,845	£12,845
Non Pay		£1,268	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611
MTW Corporate Overhead		£576	£1,800	£1,708	£1,669	£1,669	£1,669	£1,669	£1,669	£1,669	£1,669
Non Recurrent Setup	£611	£2,058	£240	£120							
Depreciation		£96	£995	£995	£995	£995	£995	£995	£995	£995	£995
PDC dividends payable	£414	£1,033	£1,348	£1,313	£1,279	£1,245	£1,216	£1,188	£1,191	£1,193	£1,159
Total Cost	£1,025	£10,818	£26,453	£25,071	£24,399	£24,365	£24,336	£24,308	£24,311	£24,313	£24,279
Income @ 75%		(£3,174)	(£19,041)								
Income @ 100%				(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)
Total Income	£0	(£3,174)	(£19,041)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)
Total Surplus (+) / Deficit (-)	(£1,025)	(£7,645)	(£7,411)	£610	£1,281	£1,315	£1,344	£1,372	£1,369	£1,367	£1,401
% Profit (+) / Loss (-)		-241%	-39%	2%	5%	5%	5%	5%	5%	5%	5%

The Trust has assumed that the additional activity will be funded at ERF rates (75% of tariff) for 2023/24 and 2024/25 and then full tariff from 1st April 2025.

The gross additional cost of the WKEOU will be approximately £24.4m per annum including depreciation and PDC, and an 8% contribution to MTW trust overheads.

Non-recurrent set-up costs and PDC lead to a £1,025k deficit in 2022/23 (Year 0). In year 1, the assumed 1st February 2024 opening date means that income will only be generated for two months (at the ERF tariff). This together with non-recurrent set-up costs, the working assumption that staff are in post three months ahead of go live (due to the need to recruit from overseas and for familiarisation with the facility), commissioning and handover results in a loss in 2023/24 (Year 1). A loss is also made in 2024/25 (Year 2) because the underlying assumption remains funding at the ERF 75% tariff until 31st March 2025. Once full tariff is received (Year 3 onwards), MTW would expect to be generating a surplus of approximately 5% (£1.3m per annum).

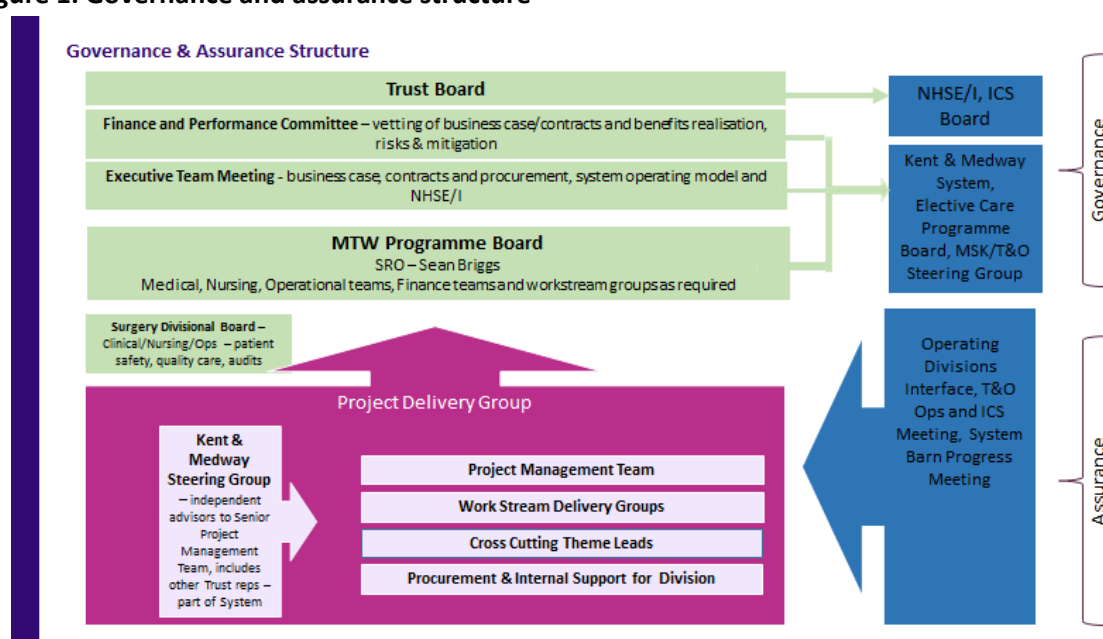
The investment will create new assets on the trust's balance sheet. The calculation of depreciation in the financial model does not assume an impairment in net book value on opening; if this were to occur there would be a one-off impairment charge to the SOCI followed by lower capital charges.

In the medium to long-term, the preferred option represents an affordable option to MTW assuming commissioners fund the trust at full tariff. MTW will need non-recurrent support in the period 2022/23 to 2024/25 due to a combination of non-recurrent revenue costs, staff being employed ahead of opening and the ERF tariff not covering total costs.

1.6 The management case

Project governance arrangements reflect the Kent and Medway system involvement in the project as well as delivery being focused on MTW.

Figure 1: Governance and assurance structure



The MTW governance structure is headed by the programme board, which is directly accountable to the MTW Trust Board, the Executive Management Team, Surgery Divisional Board and relevant committees. The MTW Programme Board consists of a senior responsible owner (SRO), operational, clinical, nursing and quality, system and finance leads, and a programme director. The SRO is Sean Briggs, MTW's Chief Operating Officer.

The key milestones associated with implementation are set out below.

Table 8: Project milestones

Milestone	Date
RIBA Stage 2 Design complete	September 2022
OBC approval – MTW & K&M ICB and submitted to NHSE for approval	End July 2022
OBC approval – NHSE	August - October 2022
Materials procurement	October 2022 to April 2023

Milestone	Date
RIBA Stage 3 and 4 complete	November 2022
Market testing	November 2022 to January 2023
FBC approval – MTW & K&M ICB and submitted to NHSE for approval	January 2023
Enabling works	October 2022 to February 2023
FBC approval – NHSE	February 2023 to May 2023
Manufacture and Construction period	May 2023 to December 2023
Handover to Trust and operational commissioning	January 2024
Opening of new Facility to patients	1 st February 2024

The desired benefits were described in the strategic case; delivery will be measured through ongoing monitoring of GIRFT and other performance metrics. Performance will also be measured through use of the annual the data submitted to the National Joint Registry.

The Project Board ensures that suitable and sufficient assessments of risks to staff and those affected by its activities are undertaken and oversees the management of the risk register. Stakeholder engagement is ongoing and plans have reflected engagement done to date.

Service changes have the potential to create uncertainty for staff, they also have opportunity to enhance recruitment and retention with the opportunity to work in new clinician and patient designed facilities. We are working to provide opportunities for staff to raise their concerns and provide opportunity to allay fears and worries. A detailed people and workforce plan is in development to ensure that the trust recruits the staff needed ahead of the new facility becoming operational. The plan will factor in the workforce changes needed to deliver the new models of care and successfully meet patient demand including:

- Recruitment and retention strategy to ensure operation from Day One – supporting wellbeing and succession planning, inclusion and leadership to promote healthy workplace cultures
- Embedding new professional roles
- Designing and evaluating roles to maximise specialist skills and knowledge of clinically qualified staff.

There are no TUPE arrangements necessary for this project.

The project involves the transfer of patients on partner trusts' waiting lists to the MTW waiting list, and centralising adult elective orthopaedic services on the Maidstone Hospital site.

In the weeks leading up to handover and service transfer 'safe transfer' activities will be undertaken to ensure any risks to patients and staff are minimised. The impact of the proposal on quality and equality has been assessed; both assessments confirm that the project does not have a negative impact.

1.7 Conclusion

This business case sets out the optimal way to develop an orthopaedic centre of excellence at Maidstone Hospital. The proposed WKEOU will be a Kent and Medway resource available to all Kent and Medway providers to assist with elective recovery and expansion. In the medium-term the WKEOU will also 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*.

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

- The ICB will benefit from having capacity available 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 close to the most deprived areas within West Kent and readily accessible to the wider Kent and Medway population.
- 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.

The trust requires capital funding from NSHE to deliver this development; failure to obtain funding is the main risk associated with the proposal. 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

Summary of this section of the OBC

- The purpose of this business case is to make the case for investing £39.1m to create an elective orthopaedic centre of excellence for the Kent and Medway system
- The capital funding would predominantly come from NHSE's Elective Recovery Fund (ERF) together with Trust/System capital contributions.
- The new centre's proposed name is the West Kent Elective Orthopaedic Unit (WKEOU)
- Once delivered the system would have an additional three elective theatres at Maidstone Hospital which will provide additional capacity to meet elective recovery targets and to meet longer-term predicted growth.
- The proposal has the full support of stakeholders.

2.1 Purpose of this business case

This outline business case (OBC) proposes an investment of £39.1m to expand Kent and Medway (K&M) elective orthopaedic surgical capacity by creating the West Kent Elective Orthopaedic Unit (WKEOU) on the Maidstone Hospital site operated by Maidstone and Tunbridge Wells (MTW) NHS Trust. The new facility will open 1st February 2024 and will consist of:

- Three laminar flow theatres, in a 'barn' theatre block, with a modelled capacity of 5,030 elective orthopaedic cases per annum.
- Supported by a 14-bed inpatient ward
- And a 10-trolley day case ward.

The WKEOU will be ring-fenced for orthopaedic green pathway elective day case and inpatient activity, and will make a significant impact on the sector demand and capacity gap, together with creating capacity to help with elective recovery across the whole Kent and Medway system. The new capacity will assist in system-wide elective recovery. This elective activity will also generate 21,629 corresponding outpatient appointments (new, follow-up, pre-assessment, physiotherapy and anaesthetic review), increasing to 26,659 outpatient appointments from Year Three.

The facility will operate in line with GIRFT recommendations to increase overall available capacity by operating at 60 hours a week, 48 weeks a year.

2.2 Barn theatres

The 'barn theatre' concept is central to the proposed unit. The term 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. Barn theatres have adjoining anaesthetic rooms and traditional recovery areas.

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 benefits²:

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

2.3 The Kent and Medway Integrated Care System

In April 2021 NHS England formally accredited the Kent and Medway integrated care system (ICS) which brings together eight NHS providers, NHS Kent and Medway Clinical Commissioning Group (CCG), Kent County Council, Medway Council, NHS England (NHSE) South East Region, the Kent Local Medical Committee and Healthwatch with the core purpose of:

- Improving outcomes (population health and care)
- Tackling inequalities in outcomes and access
- Enhancing productivity and value for money
- Supporting broader social economic development.

Figure 2: The Kent and Medway system



² <https://www.operatingroomissues.org/the-rise-of-the-barn-operating-theatre/>

The Kent and Medway ICS became the Kent and Medway Integrated Care Board (ICB) in July 2022. The ICS had agreed six strategic priorities:

1. **Restart and Recover** – a systematic approach to restarting services that were disrupted during the first COVID-19 peak and in transforming to the system we want to be. Elements of the programme include: a focus on the enablers and levers for lasting change; addressing the impact of COVID-19 on BAME communities; clinical input to the plans for restarting and recovery; recognising the importance of impact of COVID-19 on staff and the need to support staff resilience; supporting meaningful development of out-of-hospital care for the longer term; preparing for any further surge in COVID-19.
2. **System leadership and development** – ICS development and approval moving to deeper system working including ICP and Primary Care Network (PCN) development and assurance and effective interactions between the layers of the ICS in terms of accountability, responsibility, support and facilitation.
3. **Strategic change** – starting the process for review of service delivery across Medway, north Kent and west Kent with a focus on development of organisational alliances and clinical networks.
4. **Performance** – developing a revised performance improvement approach in challenged organisations with better alignment of energies and activities across CCG/ICS and regulators; system approaches to improvement beyond single organisational boundaries; and incorporation of local system support from other organisations to support improvement.
5. **Develop a clear approach to improvement** – commitment to, and adoption of, single methodology and philosophy; develop capacity and capability at all levels of the ICS; change in culture for increased focus on experimentation and rapid improvement cycles.
6. **Ensure a focus on key system enablers** – strategic attention to digital and workforce aligned to focused initiatives within priority development areas to ensure this is translated into real change and moves beyond strategic intent.

The investment proposed in this business case will make a significant contribution to delivering against 'restart and recover' (strategic priority one); provide an excellent example of a new organisational alliance and clinical network (strategic priority three); and help improve performance across organisational boundaries (strategic priority four).

2.4 Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (MTW) is a large acute hospital Trust in the south east of England. The Trust provides a full range of general hospital services and some areas of specialist complex care to around 600,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population. The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs over 6,900 full and part-time staff, has a turnover in excess of £360m and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations.

The trust's **vision** is *exceptional people, outstanding care*.

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 3: Trust strategies



2.5 Other Kent and Medway acute providers

The other Kent and Medway based providers who will benefit from this business case are:

- East Kent Hospitals University NHS Foundation Trust (EKHUFT)
- Dartford and Gravesham NHS Trust (DGT)
- Medway NHS Foundation Trust (MFT).

2.6 Scope of the business case

The service scope of this business case is NHS commissioned day case and inpatient elective orthopaedic surgery, together with corresponding adult orthopaedic outpatient appointments, provided for people living in Kent and Medway.

Out of scope of this business case are non-elective orthopaedics (trauma) and paediatric orthopaedics.

2.7 Structure of the OBC

The structure of this business case is consistent with NHS Improvement (NHSI) guidance³ from on the development of business cases and uses the Five Case Model 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.

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

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

2.8 Consultation and support

Statements of support have been received from Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust and West Kent Integrated Care Partnership. A statement has also been requested and is anticipated from EKHUFT.

Engagement with the Health Overview and Scrutiny Committee (HOSC) has been productive and are supportive of this case, with the agreement that this represents a significant opportunity to enhance patient access and the patient experience. The following statement has been made by the Chair of the HOSC, *“Pre-conversations between the Trust and the Chair of HOSC have been positive. There is a recognition that this scheme could provide significant enhancements to patient care. Albeit we cannot prejudice the formal view of HOSC. Based on our discussions the initial view is this change would be of similar impact to the Digestive Diseases Unit scheme which HOSC formally reviewed and did not feel reached the threshold for a significant variation”* – a ‘significant variation’ would require a public consultation.

The Trust’s senior management team, architects and planners met and presented the scheme to councillors at a briefing meeting on Monday 25th April 2022 and the proposal was discussed at the Kent and Medway HOSC on 11th May 2022 at which members agreed that a public consultation would not be needed.

2.9 Approvals

The business case is being submitted to the MTW Board of Directors for approval, together with the Integrated Care Board’s Governing Board. If approved it will then be submitted to NHS England (NHSE) with the request that the:

- Capital investment for the proposed orthopaedic centre is predominantly supported from the Elective Recovery Fund (ERF) together with Trust/System capital contributions.
- Capital funding for advance orders of long lead items is released following OBC approval
- The Kent and Medway system is supported via national recovery monies, to fund the tariff costs associated with recovery from 2022/23 to 2024/25.
- Non-recurrent revenue support is provided in 2022/23 to 2024/25 to cover the deficits caused by the 75% tariff assumption and non-recurrent set up costs.

3 The Strategic Case

Summary of this section of the OBC

- The national context for elective orthopaedics is described with a focus on the unprecedented levels of waiting list backlog caused by the Covid-19 pandemic
- Orthopaedic best practice, as set out by the British Orthopaedics Association and as reflected in the GIRFT programme, is described and the link made to creating an elective orthopaedic centre of excellence
- The Kent and Medway system's orthopaedic backlog and current MTW performance is detailed to highlight the pressures currently facing the system
- Factors influencing current and future demand for elective care are discussed including the likely impact of significant ageing within the Kent and Medway population
- The case for change concludes and the following investment objectives covering both MTW and the Kent and Medway system, are explained in detail:
 - Investment objective one - to deliver additional theatre capacity of 5,030 elective orthopaedic cases per annum and increased productivity in order to reduce the Kent and Medway system orthopaedic waiting list, thereby meeting national targets for reducing the backlog and increasing capacity.
 - Investment objective two - to deliver year on year recurrent cost savings to the Kent and Medway system by fully utilising additional NHS orthopaedic capacity thereby reducing the number of orthopaedic patients outsourced to the independent sector.
 - Investment objective three – to release MTW theatre capacity and provide opportunity for other surgical specialities to refine their planned theatre sessions to enable improvement in non -surgical waiting list and RTT performance.
 - Investment objective four - to fully utilise additional theatre capacity by improving theatre efficiency to achieve upper quartile performance across as measured by Model Hospital, GIRFT and HVLC metrics for orthopaedic day and inpatient activity.
 - Investment objective five - to strive to become an outstanding organisation through the development of an orthopaedic centre of excellence to serve the Kent and Medway system.
- The investment will bring benefits to patients and their families, the Kent and Medway system, MTW as a provider and the orthopaedic service. Benefits flow from the additional capacity provided, the complete separation of elective from non-elective flows and the creation of an orthopaedic centre of excellence.

3.1 Introduction to the strategic case

The strategic case demonstrates that the proposed investment to expand orthopaedic capacity is aligned to national policy, in particular elective recovery and that the proposed approach of creating an elective centre of excellence is driven by best practice. The strategic case also sets out the investment objectives, desired 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 year⁴. 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 2016-17⁵.

3.2.2 Elective orthopaedic backlog

The Covid pandemic placed considerable strain on planned service delivery including elective orthopaedics, services that were already under pressure before the pandemic and by February 2022 there were six million people are now on the waiting list across England, an increase of 1.6 million compared to the period before the pandemic⁶. Recovering elective performance is therefore a priority for the NHS.

Lessons learned during the pandemic include:

- The benefit to elective services of separating elective care facilities from those for urgent and emergency care because this reduces disruptions to care and helps build resilience
- The need to increase collaboration across the NHS and beyond including the sharing of resources.

The 2022/23 Priorities and Operational Planning Guidance⁷ places an emphasis on restoring services, meeting new care demands and reducing backlogs that are a direct consequence of the pandemic. One of the objectives outlined is for systems to work in partnership to make the most effective use of resources available across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity. This objective is reflected in the aim of maximising elective activity and reducing long waits, whilst taking full advantage of opportunities to transform the delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved. In 2022/23 systems are asked to:

- Eliminate waits of over 104 weeks (two years) as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer)
- Eliminate waits of over 78 weeks (18 months) by April 2023, except where patients choose to wait longer or in specific specialties, and conduct three-monthly reviews for this cohort of

⁴ <https://www.good-governance.org.uk/wp-content/uploads/2019/04/MSK-BAP-draft-commissioners-AW-AR-GW.pdf>

⁵ As above.

⁶ Delivery Plan for Tackling the Covid-19 Backlog of Elective Care, February 2022.

⁷ <https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf>

patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022

- Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties
- Accelerate the progress already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible.

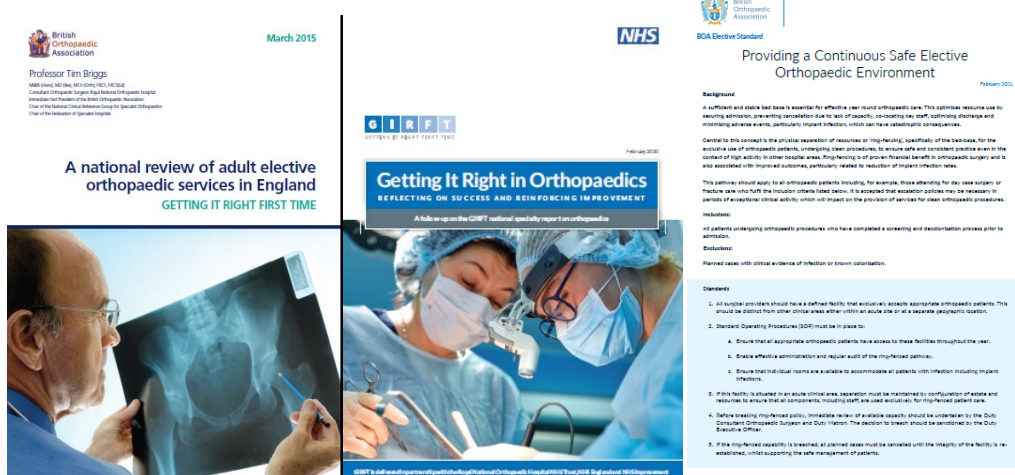
Looking further ahead, to the period when the orthopaedic unit proposed in this business case will be open, the national imperative is that elective activity is at 130% of pre-pandemic levels by 2024/25. These national targets are reflected in the Kent and Medway system's 'Restart and Recover' strategic priority.

Elective recovery is being supported through ERF capital and revenue funding. The ERF capital funding is a £1.5 billion capital allocation above that funded within core envelopes, which is available over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems have been asked to demonstrate how their capital proposals, such as this business case, support a material quantified increase in elective activity, e.g. through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day care units or increased bed capacity. New surgical hubs should be focused on providing high volume low complexity surgery, as recommended by the Royal College of Surgeons of England⁸.

3.2.3 Orthopaedic best practice

MTW's vision is to provide *outstanding care* 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.



⁸ Delivery Plan for Tackling the Covid-19 Backlog of Elective Care, February 2022

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 1.

An earlier GIRFT report⁹ 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 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

- Recovering orthopaedic elective performance across Kent and Medway is a ‘must do’. As per Royal College of Surgeons recommendations and national strategy, the optimal way to recovery performance is through the development of a surgical hub.
- The ERF capital allocation creates an immediate opportunity for the Kent and Medway system to develop a surgical hub to support local recovery.
- Any projects funded by the ERF must add to total capacity and should be facilities shared cross systems.
- 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 TWH is particularly hit by emergency bed pressures, with non-elective patients taking up bed space earmarked for green elective orthopaedic patients.
- Centralising all adult elective orthopaedics at Maidstone Hospital, 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 Kent and Medway system case for change

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

- The Kent and Medway system’s orthopaedic backlog
- MTW’s operational performance
- MTW’s adherence to best practice in orthopaedics.

3.3.1 The Kent and Medway system backlog

Recovering both the Kent and Medway referral to treatment (RTT) position to meet the national standard of 92% of patients receiving treatment within 18 weeks of referral and reducing the

⁹ A national review of adult elective orthopaedic services in England, GIRFT, March 2025.

number of patients waiting more than a year to zero, are key priorities for the system. As at the end of March 2022 there were approximately 1,300 orthopaedic patients across Kent and Medway who have waited over a year for surgery – the position for each of the four local providers is described in turn, below.

3.3.1.1 Dartford and Gravesham NHS Trust backlog

DGT operates:

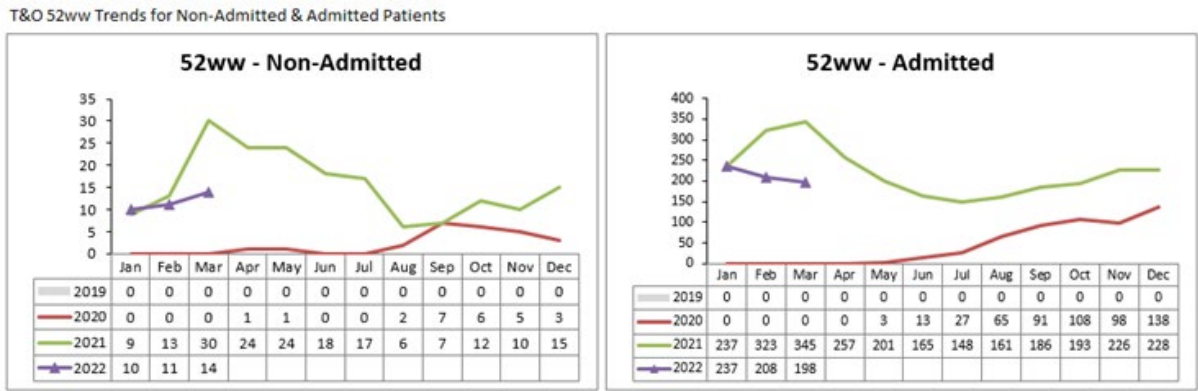
- Five theatres at Queen Marys Hospital (QMH) which provide an average of 20 sessions a week for all surgical specialities
- Nine theatres at Darent Valley Hospital of which six are dedicated to elective serving all surgical specialities.

The average number of orthopaedic lists each week is 18; split eight at QMH and ten at Darent Valley. The service employs:

- Ten adult orthopaedic surgeons
- Three clinical fellow trainees (one post Certificate of Completion of Training and two pre-CCT)
- Three trust doctors including one associate specialist.

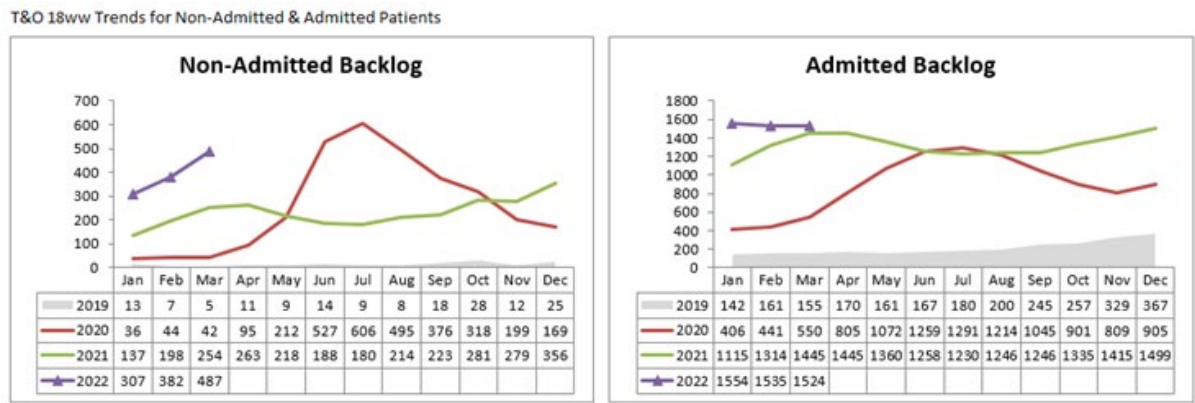
The trust has worked hard to recover the 52-week breach position as shown below.

Figure 4: DGT orthopaedic 52-week wait trends



The peak of almost 400 people was in March 2021; this has been reduced to a total of 212 people in March 2022. The trend for 18-week waits is shown below.

Figure 5: DGT orthopaedic 18-week wait trends



Recovering RTT performance has been and continues to be constrained by a lack of theatre capacity at both sites.

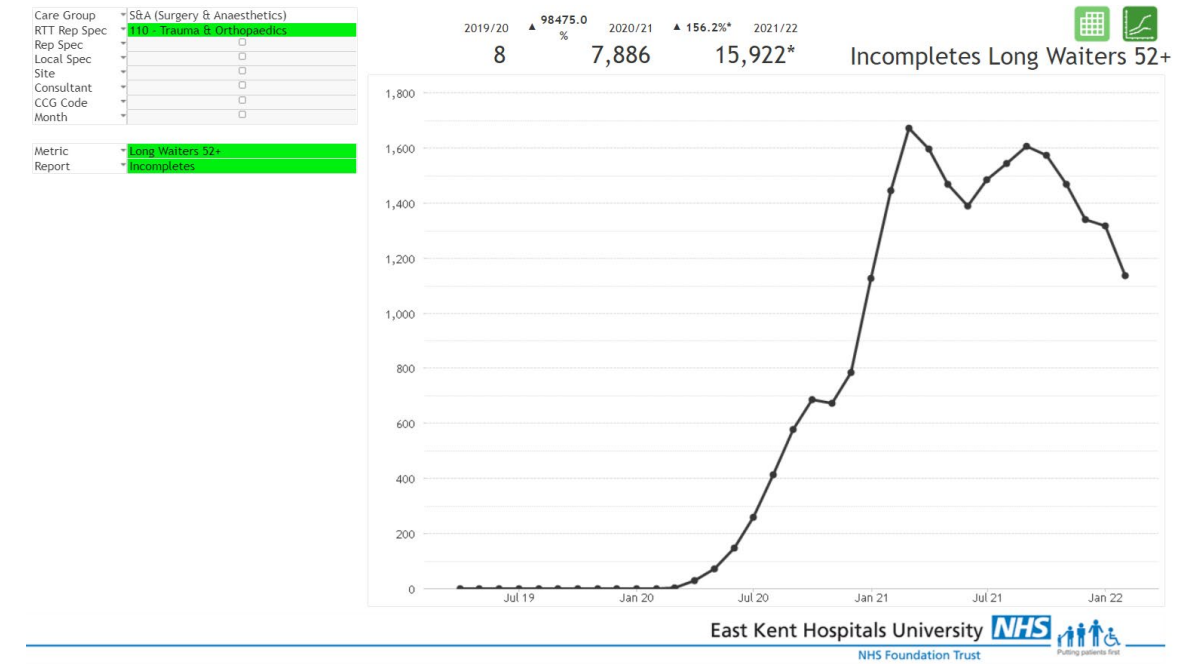
3.3.1.2 East Kent Hospitals University Foundation Trust backlog

The trust runs an average of 56.5 orthopaedic theatre sessions each week. Forty of these sessions are provided from the elective orthopaedic hub, consisting of four new operating theatres and 24 beds, at the Kent and Canterbury Hospital site. This is a new elective care facility opened in spring 2021. In addition, the trust runs orthopaedic day surgery:

- Elsewhere at KCH three sessions a week
- At the William Harvey Hospital nine sessions a week
- At the Queen Elizabeth The Queen Mother Hospital an average for four and a half sessions a week.




The EKHUFT 52-week waiters' trend is shown below.

Figure 6: EKHUFT orthopaedic 52-week wait trends



The overall backlog trend can be seen from the breach table below.

Figure 7: EKHUFT orthopaedic breaches March 2021 to February 2022

KPI	SPC	Thres.	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
RTT 104w Breaches	 0		0	1	2	1	3	3	13	18	14	12	23	29
RTT 78w Breaches	 0		189	273	284	291	431	562	555	413	309	280	268	249
RTT 52w Breaches	 Traj.		1,672	1,597	1,467	1,388	1,485	1,543	1,605	1,574	1,468	1,339	1,316	1,136

The highest number of 52+ waits was seen in March 2021 with 1,672; as of February 2022, this had reduced to 1,136 people waiting. The trust is currently working hard to reduce the number of 104-week breach patients.

3.3.1.3 Medway Foundation Trust backlog

The MFT elective orthopaedic service operates from:

- Two dedicated main theatres
- One day case theatre in the MFT day surgery unit (DSU)
- One all day trauma theatre.

The average number of orthopaedic lists per week is:

- Main theatre – elective = 20 sessions
- MFT DSU – elective = 5 sessions
- Trauma – 14 sessions.

Historically an average of 150 patients receive elective surgery each month at full capacity including an average of ten cases each weekend.

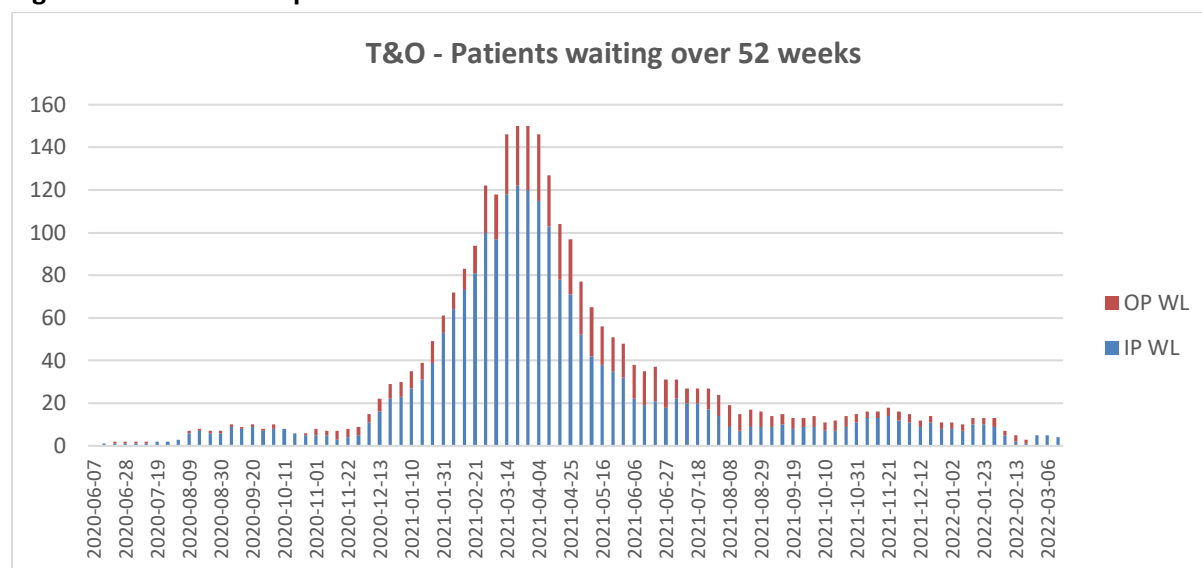
The service employs 12 adult full-time orthopaedic surgeons; three spine, three upper limb, five lower limb and one foot and ankle. Together with one full-time clinical fellow (upper limb).

Access to treatment at MFT is through a primary care-based triage and assessment service managed by Medway Community Health. The amount of activity that can be done in the local independent sector is limited due to complexity of case mix and independent sector capacity.

Medway Maritime Hospital does not have the estate to build a new complex so are reliant on increasing the utilisation of existing theatres to reduce patients waiting a long time for treatment.

Across all pathways (inpatients and outpatients), orthopaedics accounts for 7% of patients on trust's waiting list. The trust has worked hard to recover the 52-week breach position as shown below.

Figure 8: Elective orthopaedic 52-week wait trends



There were no people waiting over 52 weeks at the end of March 2022. However, the position regarding the 18 week 92% RTT target has not improved to the same extent.

3.3.1.4 Maidstone and Tunbridge Wells backlog

The MTW elective adult orthopaedic service currently operates from:

- Maidstone Orthopaedic Unit (MOU). 10 sessions/week. MOU is a standalone theatre, with a ring-fenced 12 bedded ward and specialist theatre team, dedicated to elective orthopaedic surgery.
- Maidstone Short Stay Surgical Unit (MSSSU). 8.5 sessions/week.
- TWH for elective (11 sessions/week) and non-elective surgery (Trauma surgery is only carried out at TWH through 18 sessions each week).

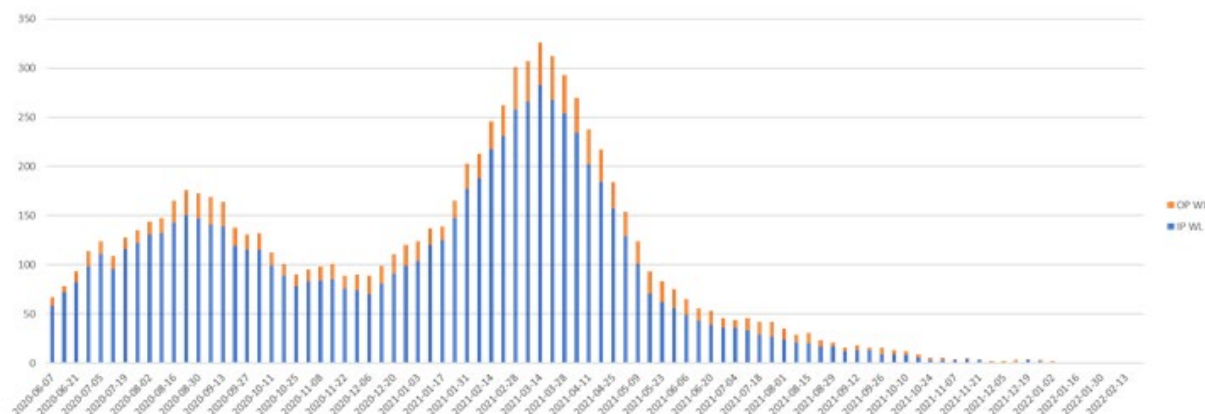
Historically an average of 248 patients receive elective orthopaedic surgery each month at full capacity.

The service employs:

- 13 substantive adult orthopaedic surgeons and 2 locum orthopaedic surgeons, together with 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.

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 breach position as shown below.

Figure 9: MTW - elective orthopaedic 52-week wait trends – June 2020 to Feb 2022

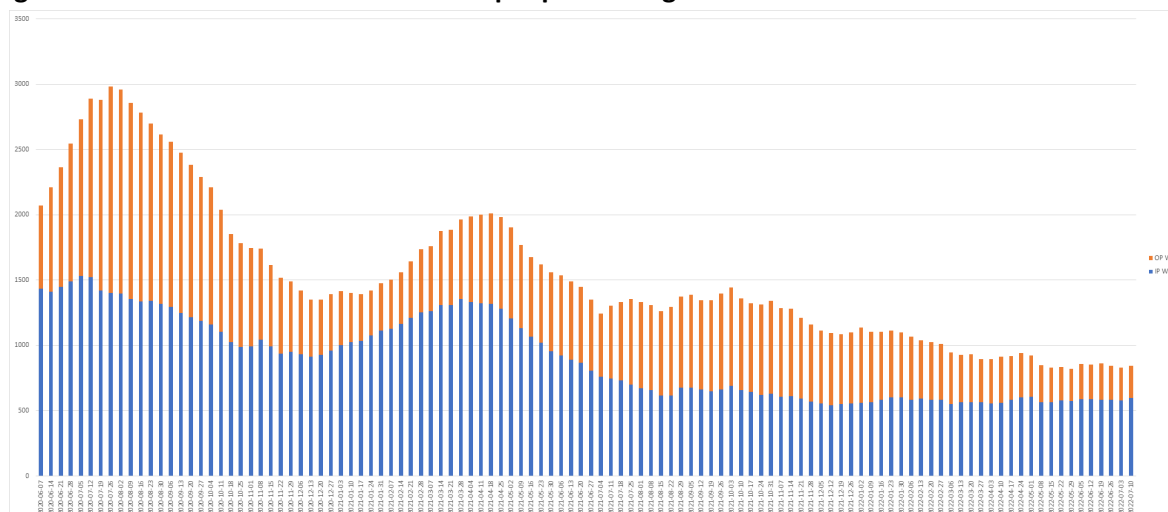


To note, the trust has remained at zero >52 week waits since February 2022.

The peak seen in March 2021 when over 250 patients had been waiting more than 52 weeks for surgery has been eliminated and currently there are no patients waiting over 52 weeks. It is, however, important to recognise that although over 52-week waits have been eliminated, activity is growing (at 4.4% per annum) which means that without new capacity average waiting times will rise.

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

Figure 10: MTW - 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, 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) in 2021/22.

The number of patients on the orthopaedics non-admitted (outpatient) waiting list (approximately 1,825) exceeds the admitted (elective surgery) waiting list (approximately 1,100), however due to the conversion rate and time taken to see a patient in clinic compared to an operation, the biggest capacity constraint relates to elective (inpatient and day case) activity; for example, one consultant might see 20 new patients in a full day clinic and list half of them for surgery, but will take two full

days to operate on these 10 patients. Nevertheless, the outpatient waiting list has been reducing in line with the inpatient waiting list. The trust is undertaking a number of initiatives to increase outpatient capacity in response to the need to meet Kent and Medway system-wide demand; these include:

- Moving to a system of 'Patient Initiated Follow Ups' (PIFU) to reduce the number of follow up appointments required.
- Increasing the number of one stop clinics, including knee clinics with same day MRI and clinics with pre-assessment on the same day, for those patients requiring surgery. This reduces the number of appointments each patient has with a consultant, thereby increasing the availability of consultant slots to see new patients.
- As clinic capacity is limited in main outpatients on both MTW main hospital sites, the trust has worked with the system to run orthopaedic clinics in the community diagnostic centre and at Sevenoaks Hospital.
- Mapping annual leave, clinics and theatres six weeks ahead to ensure maximum utilisation and backfill if a surgeon is on leave. Consultants have flexible job plans to allow clinics to be converted to theatre sessions and vice versa as required, depending on patient demand.
- Saturday clinics to increase capacity for new appointments.
- A business case to increase outpatient capacity on the Maidstone site has recently been approved. While this new build is not planned to be used by orthopaedics directly, it will release capacity to orthopaedics as other specialities move.
- A strong foundation of physiotherapists, physician associates and surgical care practitioners to follow up patients for wound checks post-operation, in order to save the consultant appointments for new referrals.

3.3.2 MTW's operational performance

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

Table 9: Snapshot of MTW theatre performance indicators

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 Increasing capacity to GIRFT recommendations (60-hour weeks, 48 weeks/year)
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
Number of patients waiting over 40 weeks for treatment	N/A	N/A	N/A	46 (April 2022)	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% (Aug-21) 65.7% (April-22)	80% 6 months after opening 86% 9 months after opening 92% 1 year after opening	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, with extended working days Increased medical presence

3.3.3 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 orthopaedics 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 below.

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

Table 10: Snapshot of MTW 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
BADS ¹⁰	Day case rate for unicompartmental knee replacement (benchmark)	40.0%	0%		No

¹⁰ The British Association of Day Surgery

	Metric/Recommendation	Top Decile/Best practice performance	Service Performance	Current service provision	Has the service met top decile performance or recommendation? (Yes/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

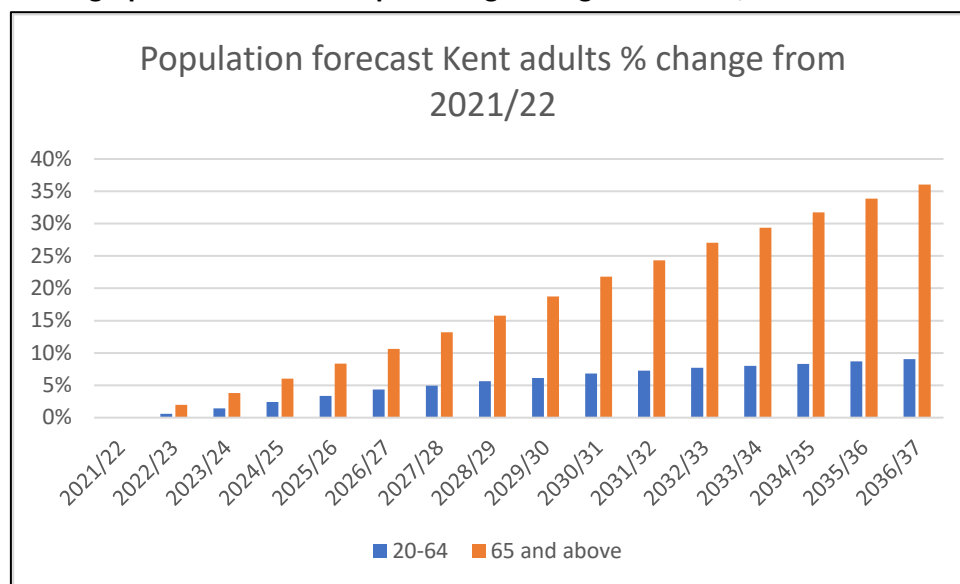
The pandemic experience has reinforced the need to separate elective and non-elective pathways to ensure that 'Green' (Covid negative) pathway activity can continue in the event of future spikes in the infection rate.

3.4 Demand and capacity forecast

3.4.1 Demographic change

The population of Kent and Medway is predicted to both grow and age rapidly over the next 15 years. Ageing is of particular relevance given that 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. The chart below shows the predicted percentage increase across the Kent County Council area from the 2021/22 base for adults under 65 and separately people aged 65 and over.

Figure 11: Demographic forecast Kent – percentage change from 2021/22 base¹¹

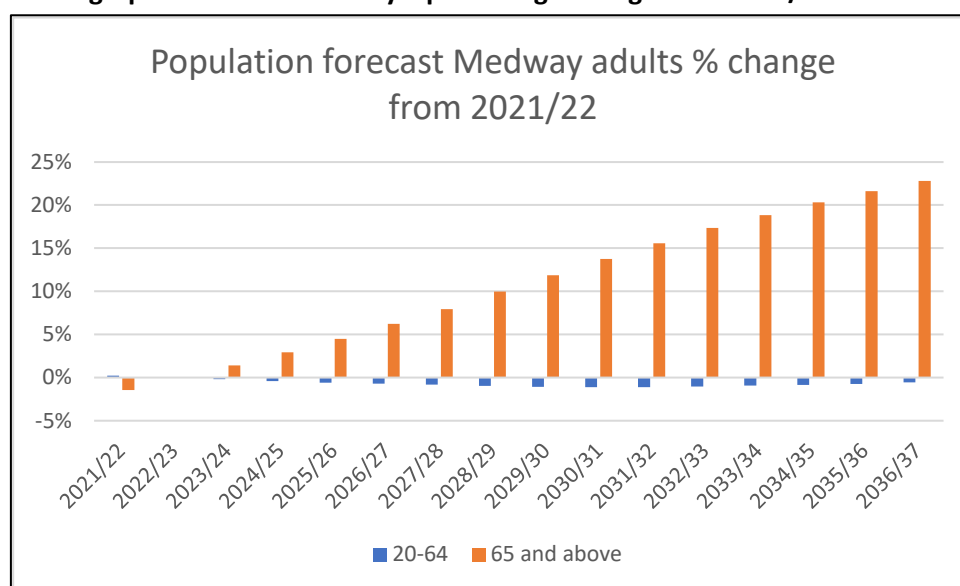


Over the 15-year period forecast by Kent County Council, the number of people aged 65 and over living in Kent is forecast to increase by 36% from 294k to almost 400k. The working age adult population will also increase, but by a much lower 9%.

The equivalent chart for Medway is below.

¹¹ Kent County Council

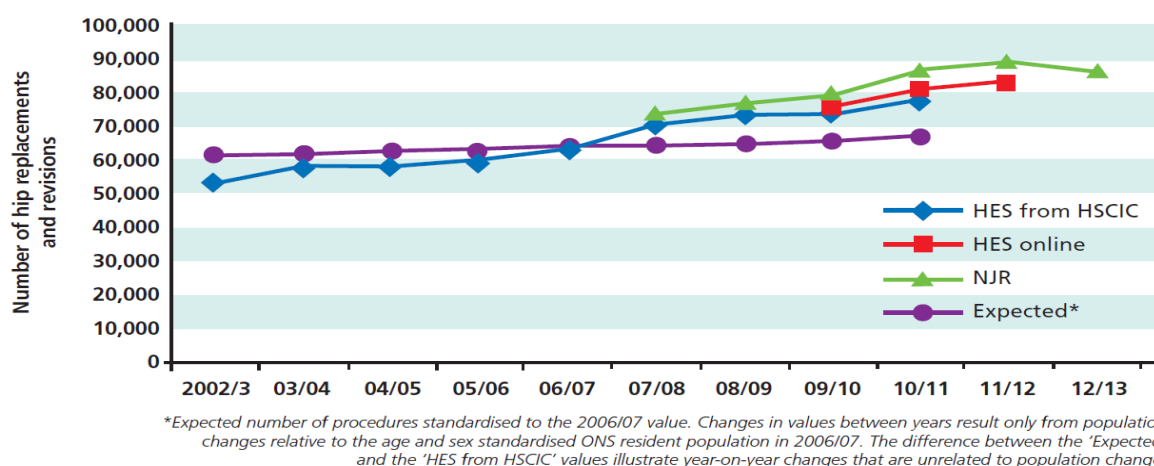
Figure 12: Demographic forecast Medway – percentage change from 2021/22 base¹²



Over the 15-year period to 2036/37, the number of people aged 65 and over living in Medway is forecast to increase by 23% from 46k to almost 57k. The working age adult population will remain at more or less current levels.

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 13: Hip replacement revisions¹³



3.4.2 Health inequalities

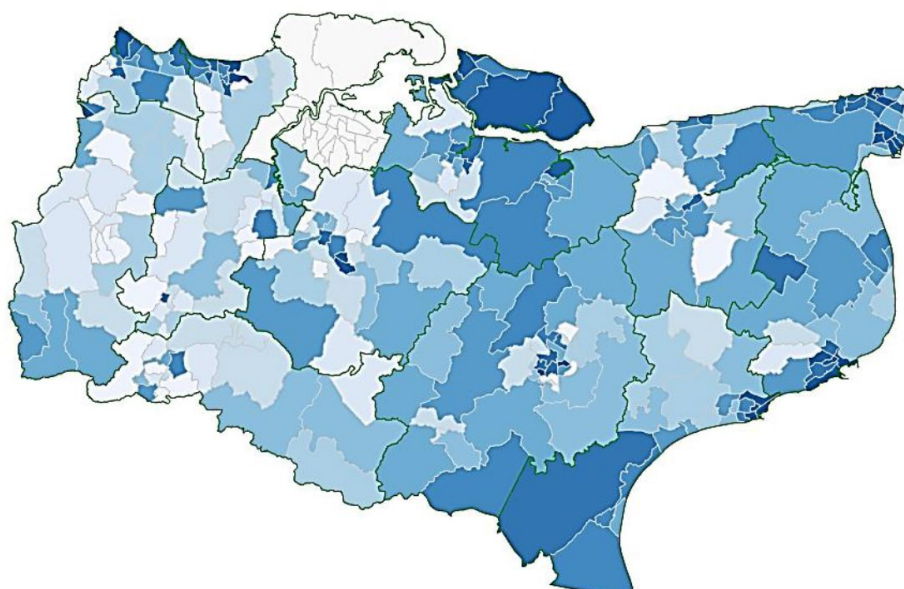
Although Kent and Medway as a whole has better health outcomes than the English average, health inequalities exist between different areas within the ICB. Inequalities can be linked to deprivation, age, gender and ethnicity.

¹² Office of National Statistics

¹³ A national review of adult elective orthopaedic services in England, GIRFT, March 2015.

Deprivation is a known driver of health inequality with people living in more deprived areas having higher health needs (estimated at between 30% and 40% more than average for orthopaedics), but often accessing healthcare at lower than expected rates. For example, work by the Strategy Unit¹⁴ looked at health inequalities in relation to the hip pathway and found lower secondary care surgical rates amongst more deprived populations and concluded that *“for every 10 additional elective spells, we estimate that one emergency spell will be avoided. The effect accumulates over two years. Increasing access to elective care for those in the most deprived areas is likely to lead to reductions in emergency care overall and to inequalities in levels of emergency care”*. It is therefore important that services are provided from accessible locations close to areas of most need. Kent is ranked 100th out of all 152 local authority areas in England, meaning it is in the least deprived 50 per cent of the country. By contrast deprivation is worse in Medway which ranks 81st. The map below shows deprivation level across Kent (darker shades = more deprived).

Figure 14: Deprivation map of Kent¹⁵



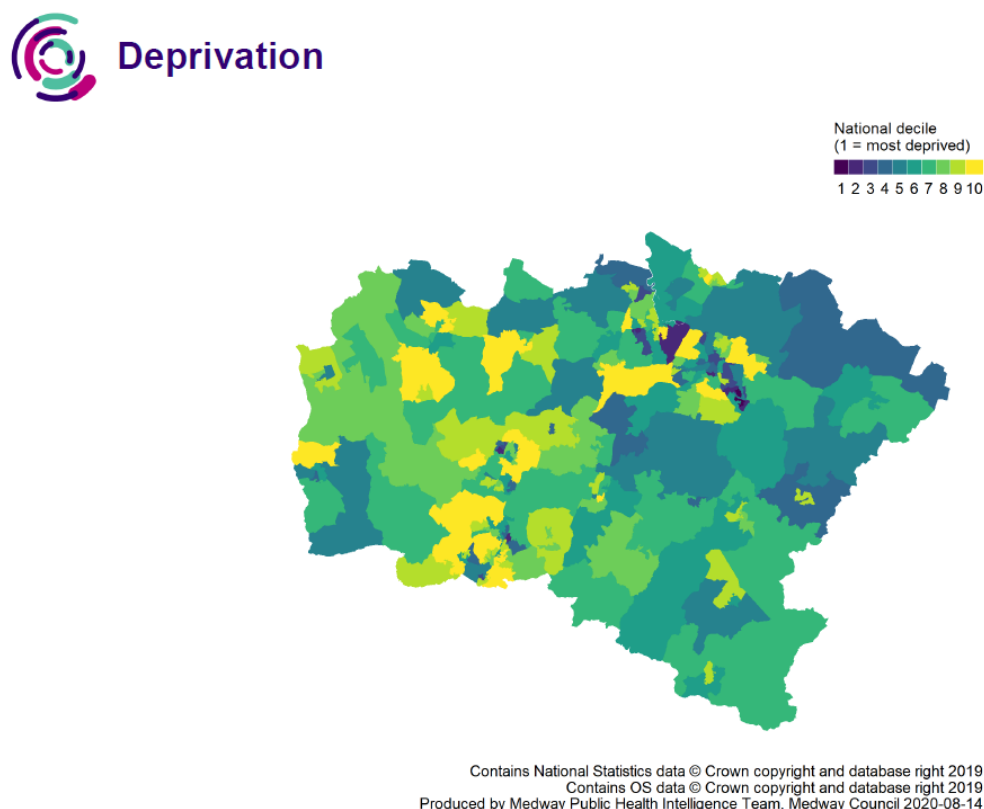
Deprivation is worse in the east of the county than the west, but East Kent is already served by the new dedicated elective orthopaedic hub at Canterbury. Medway Maritime Hospital, whilst in an area of relatively high deprivation, does not have the available estate to build a new unit; the choice is therefore between MTW and DGT locations. After consideration, all Kent and Medway providers support the proposed orthopaedic centre being within MTW's estate, in part due to the accessibility of Maidstone to the areas of Kent and Medway not served by the Canterbury hub i.e. north and west Kent.

In deciding which of the two main MTW sites to construct the orthopaedic hub at, a factor is that the more deprived areas of West Kent are typically closer to Maidstone Hospital as indicated on the map below.

¹⁴ Socio-economic inequalities in access to planned hospital care: causes and consequences, The Strategy Unit, 2021

¹⁵ Kent Annual Public Health Report 2015, Kent County Council

Figure 15: Deprivation map of West Kent¹⁶



The table below uses population and lower super output area (LSOA) deprivation data for the four West Kent local authority districts, to provide a more granular illustration of how deprivation varies across the districts. LSOA are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. There are 278 across West Kent (95 in Maidstone, 43 in Sevenoaks, 72 in Tonbridge & Malling and 68 in Tunbridge Wells) and an index of multiple deprivation (IMD) score is allocated to each. If these IMD scores are grouped into deciles for Kent (rather than England) an assessment of relative deprivation across the four districts, can be formed.

Table 11: Deprivation and population at super output area by local authority district

Kent deprivation decile	Tonbridge &				Total
	Maidstone	Sevenoaks	Malling	Tunbridge Wells	
1	100%	0%	0%	0%	100%
2	58%	0%	25%	17%	100%
3	50%	6%	31%	13%	100%
4	50%	9%	18%	23%	100%
5	38%	21%	17%	25%	100%
6	33%	26%	19%	22%	100%
7	26%	10%	32%	32%	100%
8	28%	9%	41%	22%	100%
9	19%	19%	19%	43%	100%
10	31%	21%	30%	18%	100%
Population aged 18 & over	32%	22%	24%	22%	100%
Population aged 65 & over	31%	24%	23%	22%	100%

¹⁶ West Kent Integrated Care Partnership Profile, Medway Council Public Health Intelligence Team and Kent Public Health Observatory

The assessment indicates that whilst Maidstone has just under one third of the adults over 65 (the age group most associated with planned orthopaedic activity) for West Kent, the Maidstone district has 100% of the most deprived decile LSOA, 58% of the second most deprived decile LSOA and 50% of the third and fourth decile most deprived LSOA etc.

Demographic factors also impact on demand and can be the source of health inequalities. The table below compares the demographic profile of people receiving hip and knee replacements across England as a whole with the local population.

Table 12: Demographic comparison of orthopaedic patients – MTW catchment versus England

Primary hip and knee replacements	Catchment Area			
	National ^{17 18}	Maidstone Hospital	Tunbridge Wells Hospital	Narrowed Catchment ¹⁹
% Female	60%	57%	61%	59%
% Male	40%	43%	39%	41%
Average Age Females	69.1	70.5		
Average Age Males	66.7	73.1		
% Observed BAME	1.5%	-	-	1.5%
% Expected BAME	6.2%	-	-	1.8%

The gender split of MTW patients is consistent with national averages with a procedure rate at MTW of 112 per 100k for males and 161 per 100k for females.

MTW has a marked difference in the average age of patient having hip or knees replacements compared to the national average - the national average of 69.1 for females and 66.7 for males is lower than the average for MTW which is 70.5 and 73.1 respectively. The charts below show the age profile of patients and indicates that the highest proportion of MTW patients are in the 80 to 84 age range as opposed to 75 to 79 nationally.

¹⁷ National Joint Registry Annual Report 2021 Reports, Publications and Minutes (njrcentre.org.uk) Accessed 22/12/2021

¹⁸ M.C. Smith et al. 2017 Rates of hip and knee joint replacement amongst different ethnic groups in England: an analysis of National Joint Registry data. Osteoarthritis and Cartilage 25 (2017) pp448 -454
<http://dx.doi.org/10.1016/j.joca.2016.12.030>

¹⁹ Narrowed catchment area of patients living in the boroughs of Maidstone, Tonbridge and Malling and Tonbridge Wells as patients are more likely to visit MTW for their treatment. Data run from 2016 – 2021 to increase activity numbers for a better analysis.

Figure 16: Male age prevalence rate distribution

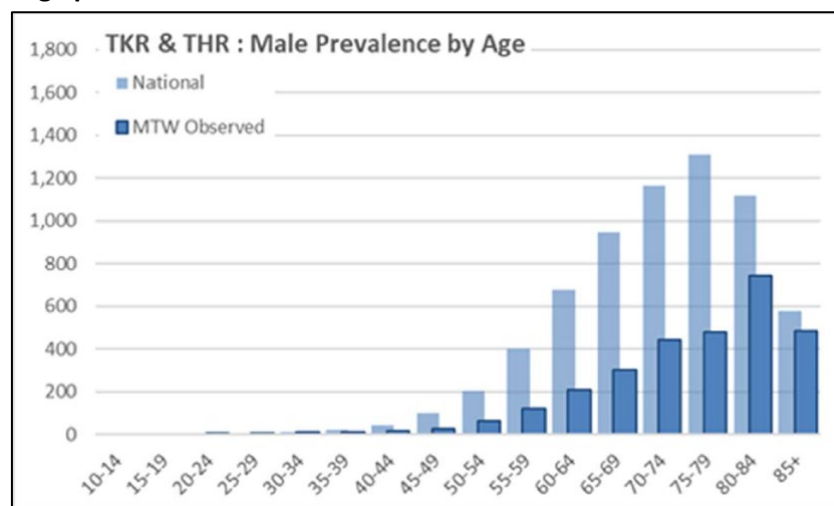
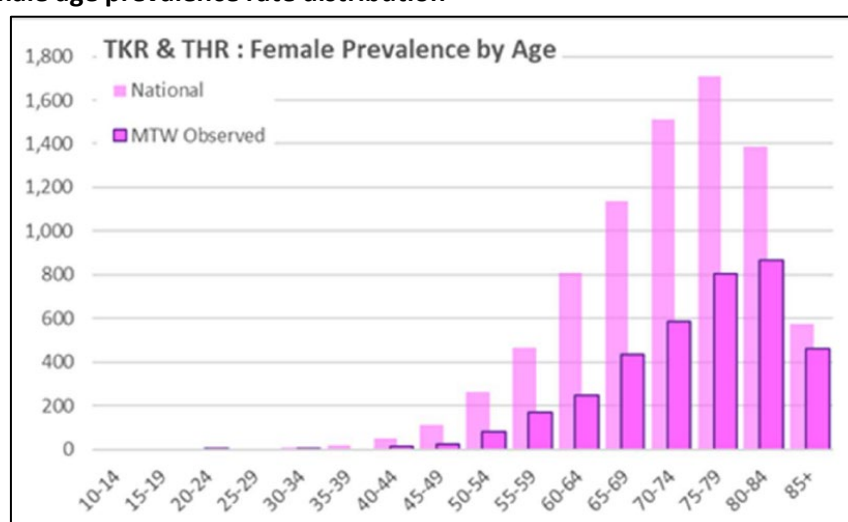


Figure 17: Female age prevalence rate distribution



There is evidence that ethnic minorities present for orthopaedic treatments at a lower rate than expected. Smith et al²⁰ calculated a national expected rate of all hip and knee replacements of 6.2% for people from Black and Minority Ethnic (BAME) groups, but observed, via the National Joint Registry, a rate of just 1.5%. Comparatively, MTW would expect to see 1.8% of the total hip and knees procedures to be performed on BAME patients, but only 1.5% is observed. At MTW therefore BAME patients are 20% under-represented for hip and knee replacements (BAME patients are around 7.5% over-represented in the totality of elective activity).

3.4.3 Impact on demand and capacity

3.4.3.1 MTW catchment

Demographic change, increasing revision rates and the need to tackle health inequalities have been assessed as being the key factors driving forecast average growth of 4.4% per annum for orthopaedic day cases and elective inpatients. Using this information, the MTW informatics team

²⁰ As above

have modelled demand from MTW's catchment population through to 2026/27 and mapped this against current available capacity across both sites and the independent sector.

Although the 52-week backlog at MTW was eliminated before the start of 2022/23 growth means that there will be a substantial shortfall in capacity (even after assuming that the independent sector can increase capacity by 4.4% per year). Demand by the end of the period modelled (to 2026/27) will have risen by a compound 19% leading to a shortfall against existing MTW and local independent sector capacity of over 1,000 cases.

If growth beyond 2026/27 continues at the current 4.4% per annum, by 2036/37 (the year to which Kent County Council population forecasts extend) compound growth from the 2021/22 base will be +75%. The theatre capacity needed to meet growth will similarly increase subject to efficiency improvements (e.g. theatre throughput) and the implementation of interventions to reduce demand for elective surgery (e.g. enhanced musculoskeletal services); a +75% in elective orthopaedic sessions equates to +22 more sessions a week.

3.4.3.2 Other Kent and Medway

Given that demographic growth and ageing is predicted to run at more or less the same rate across the rest of Kent and Medway as within MTW's catchment area, system-wide forecasts of demand would show a similar increase.

3.5 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. Currently much of the resulting demand is met through local private hospitals such as the Horder Centre in Crowborough.

3.6 Summary of the case for change

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

- Meet the national 'must do' of clearing the elective backlog across Kent and Medway
- Create ring-fenced 'Green' secure facilities in order to protect elective pathways from the risk of disruption due to emergency activity, winter pressures and further pandemic waves
- Adhere to best practice as per the British Orthopaedic Association and GIRFT
- Provide additional capacity to meet the anticipated growth in demand.

3.7 Response to the case for change

3.7.1 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 proposed investment will benefit both MTW and the wider Kent and Medway system, and as such the investment objectives reflect both perspectives. The objectives are:

- **Investment objective one** – to deliver additional theatre capacity of 5,030 elective orthopaedic cases per annum and increased productivity in order to reduce the size of the

Kent and Medway system orthopaedic waiting list and the time people waiting in line with national expectations.

- **Investment objective two** - to deliver year on year recurrent cost savings to the Kent and Medway system by fully utilising additional NHS orthopaedic capacity thereby reducing the number of orthopaedic patients outsourced to the independent sector.
- **Investment objective three** – to release MTW theatre capacity and provide an opportunity for other surgical specialities to refine their planned theatre sessions to enable improvement in non-surgical waiting list and RTT performance.
- **Investment objective four** – to fully utilise additional theatre capacity by improving theatre efficiency to achieve upper quartile performance across as measured by Model Hospital, GIRFT and HVLC metrics for orthopaedic day and inpatient activity.
- **Investment objective five** – to strive to become an outstanding organisation through the development of an orthopaedic centre of excellence to serve the Kent and Medway system.

The table below makes each objective SMART by describing the targeted outcomes and benefits linked to each.

Table 13: SMART objectives

Investment objective	Targeted outcomes	Benefits
To deliver additional theatre capacity of 5,030 elective orthopaedic cases per annum and increased productivity in order to reduce the size of the Kent and Medway system orthopaedic waiting list and the time people waiting in line with national expectations.	<p>Ring-fenced orthopaedic theatres</p> <p>Increase in elective theatre capacity within Kent and Medway</p> <p>Increase in day case and inpatient bedded capacity</p> <p>Improvement in theatre efficiency metrics such as cancellations</p>	<p>Elimination of elective orthopaedic 52-week backlog across Kent and Medway by the end of March 2025</p> <p>Delivery of 130% of Kent and Medway's pre-pandemic orthopaedic capacity by 2024/25</p> <p>Reduction in orthopaedic waiting times to within national standard as per national timescales</p> <p>Achieving upper quartiles GIRFT and HVLC procedure metrics such as day case rates, cancellations and average length of stay within 12 months of opening the WKEOC</p>
To deliver year on year recurrent cost savings to the Kent and Medway system by fully utilising additional NHS orthopaedic capacity thereby reducing the number of orthopaedic patients outsourced to the independent sector	<p>The Kent and Medway elective backlog reduced and eliminated in the most economically beneficial way</p> <p>The growth in elective activity arising from demographic change, met in the most economically beneficial way for the Kent and Medway system</p> <p>Enhanced workforce productivity while retaining improved quality of care and patient experience</p> <p>Optimal facilities management cost per square metre for space</p>	<p>By bringing activity in-house, costs to the Kent and Medway system will reduce from the second half of 2023/24</p> <p>Average cost per procedure reduces compared to the amount paid to the independent sector</p> <p>Achieving upper quartiles GIRFT and HVLC procedure metrics such as day case rates, cancellations and average length of stay within 12 months of opening the WKEOC</p>

Investment objective	Targeted outcomes	Benefits
To release MTW theatre capacity and provide an opportunity for other surgical specialities to refine their planned theatre sessions to enable improvement in non-surgical waiting list and RTT performance.	Transfer of 1.1 theatres worth of orthopaedic elective work from the TWH site to the Maidstone site	Contribute towards the elimination of elective backlog for other specialities across Kent and Medway as per national timescales To increase elective orthopaedic capacity by the equivalent of 5,030 extra operations per annum (by Q1 2024)
To fully utilise additional theatre capacity by improving theatre efficiency to achieve upper quartile performance across as measured by Model Hospital, GIRFT and HVLC metrics for orthopaedic day and inpatient activity	Ring fence theatre, day case and ward capacity for elective orthopaedics Three laminar flow theatres 60-hour operating weeks, in line with GIRFT recommendations	Achieving upper quartiles GIRFT and HVLC procedure metrics such as day case rates, cancellations and average length of stay within 12 months of opening the WKEOC
To strive to become an outstanding organisation through the development of an orthopaedic centre of excellence to serve the Kent and Medway system	Orthopaedic centre of excellence in place at Maidstone Hospital	MTW achieves CQC 'outstanding' in the 'responsive' category Improved recruitment and retention rates

The following sections take each investment objective in turn and for each describe:

- The current situation
- The problems and risks associated with the current situation
- The gaps from where the Trust and system wants to be
- The expected benefits of achieving the change.

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

3.7.1.2 Current situation

Demand for orthopaedic surgery is rising and the pandemic has led to a backlog of elective work. The rate of demand increase means that in the medium-term MTW will need 75% more capacity (including independent sector capacity via patient choice) by the end of 2036/37 (assuming no productivity gains).

Orthopaedic surgery is carried out in Maidstone Orthopaedic Unit (MOU), the Maidstone Short Stay Surgical Unit (MSSSU) and at Tunbridge Wells Hospital (TWH). Current (March 2022) Trust wide RTT performance is 69% compared to the 92% target with 37,675 people on the waiting list including 1,118 adults waiting for orthopaedic 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. This higher productivity is due to consistency of the MOU team and their specialist orthopaedic knowledge and experience.
- TWH theatres have twice the rate of on the day cancellations than the MOU. 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 other surgical or medical patients occupying beds required for elective orthopaedic patients. This lack of beds is most pronounced over the winter when elective activity often averages just half of the annual average.

Comparing elective orthopaedic efficiency between the MOU and TWH demonstrates how ring-fencing a theatre and ward on a cold elective site avoids same day cancellations and increases theatre utilisation.

3.7.1.3 Problems / risks of current situation

Delivery against orthopaedic activity and performance targets is compromised by winter bed pressures and/ or increased trauma activity. This results in cancellations leading to patients being left in pain for longer and staff becoming demoralised due to the idle time wasted.

The lack of ring-fenced elective capacity poses a significant risk to the RTT recovery plan with orthopaedics accounting for one in five MTW patients awaiting surgery. With a growth in emergency surgery pressures previously confined to the winter are increasingly impacting the summer months. Although elective recovery in orthopaedics has been positive so far, with the

number of 52-week breaches reducing from 350 to 0 and RTT performance increasing by 25% between April 2021 and March 2022, there's a risk that this will plateau due to increasing referrals.

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

Theatre productivity needs to improve. The table below shows the most common cancellation reasons, listed in order of priority.

Table 14: 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 for surgery / pre-op	Currently the Clinical Administration Unit (CAU) and pre-op team can 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 – an 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 kit for patients with nickel allergies.	CAU to enter kit requirements on theatre man and chase. NCR form to become electronic.	Yes – ability to stock more kit on the shelf 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 lists start on time Consultants signing off theatre lists	Yes – if new theatres mimic MOU performance

3.7.1.5 The expected benefits of achieving the change

The new facility will operate in line with GIRFT recommendations to increase overall available capacity by operating at 60 hours a week, 48 weeks a year. This will help improve the System's waiting list and RTT.

3.7.2 Investment objective two - deliver system-wide cost savings

3.7.2.1 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 independent sector hospitals after initial referral to MTW
- Backlog patients who are referred to MTW, are seen in MTW outpatient clinics, but whose operations are carried out by MTW surgeons at independent sector hospitals due to the lack of capacity in MTW.

Backlog patients could be repatriated to MTW if additional in-house capacity were made available. Backlog cases are not covered by pre-existing contracts, so are charged on a case-by-case basis by the independent sector - MTW sent a total of 1,236 elective cases to the independent sector in 2021/22 at a cost of £6.2m.

Funding for this case is predominantly from the ERF. If the non-recurrent ERF ended, without additional MTW theatre capacity in place, the backlog will increase and RTT performance will drop.

3.7.2.2 Problems / risks of current situation

The problems and risks which this business case seeks to address are:

- 25% of patients do not fit the independent sector patient criteria due to existing co-morbidities. This important constraint means the independent sector can only ever be a partial solution to meeting demand. Patients not fitting independent sector criteria therefore wait longer for surgery
- Furthermore, independent sector providers are limited in the case mix they can offer due to lack of specialist equipment
- Physiotherapy and post up care are variable between hospitals and patients can be 'lost' between MTW and the independent sector provider
- The process of outsourcing involves significant administrative support
- Reduced learning opportunities for MTW medical and other trainees.

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

Most of the backlog surgery can be brought in house if we have adequate theatre capacity. MTW would require an additional 0.82 theatres to repatriate this activity.

3.7.2.4 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.

3.7.3 Investment objective three – to release theatre capacity and provide an opportunity for other surgical specialities to refine their planned theatres sessions to enable improvement in on-surgical waiting list and RTT performance

3.7.3.1 Current situation

There are nine operating theatres on the Maidstone site operating complex five-week rolling timetable:

- Four theatres in the main theatre block used for 40 sessions a week (no sessions used by orthopaedics)
- Two theatres in the eye unit (EEMU) used by ophthalmology for 19 sessions per week
- Two theatres in the MSSSU used for 20 sessions per week (8.5 sessions used by orthopaedics)
- One theatre in the MOU providing ten sessions a week solely for orthopaedics.

Not included in the numbers of sessions above are regular Saturday lists in the MSSSU and MOU run as part of the trust's waiting list initiative.

The table below highlights how many sessions per week are used by each speciality, using week one of the rota, as an example.

Table 15: 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

There are a further eight 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 16: 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	
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.

3.7.3.2 Problems / risks of current situation

There is unmet demand for theatre sessions from general, orthopaedic, breast and urological surgeons for example:

- There are newly appointed orthopaedic surgeons who only have a half-day allocated each week rather than a whole day (two sessions).
- Paediatric orthopaedics is developing a business 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 and 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 physical option for an increase in theatre space at TWH meaning any expansion must be at Maidstone Hospital.

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

The trust would benefit from releasing orthopaedic capacity at TWH to meet new demand for other specialties and enable new services to be developed.

3.7.3.4 The expected benefits of achieving the change

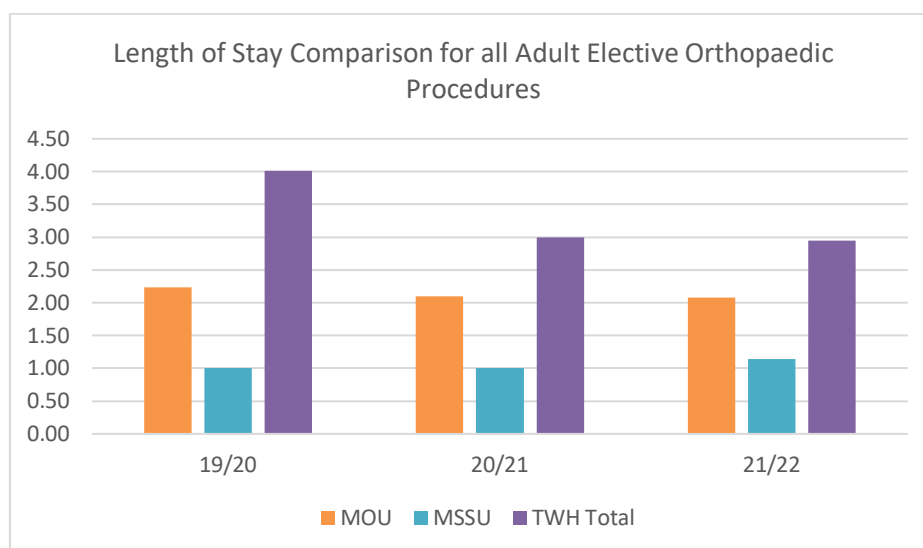
The overarching strategy involves transferring 1.1 theatres worth of orthopaedic elective work from TWH to Maidstone Hospital thereby providing an opportunity for other surgical specialties to refine their planned theatre sessions. Releasing capacity for other directorates would provide benefits such as enabling MTW to become a specialist bariatric centre with more theatre space for the general surgeons.

3.7.4 Investment objective four – to improve theatre efficiency

3.7.4.1 Current situation

GIRFT recommends ring-fencing theatres and beds for orthopaedics. The benefits of this approach were discussed above and can also be seen by comparing MOU inpatient length of stay with equivalent orthopaedic patients who are treated elsewhere across TWH.

Figure 18: Elective orthopaedic length of stay by unit



The main reasons MOU has a shorter length of stay than the trust average are:

- Better nursing to patient ratios
- Being less vulnerable to staffing moves due to site pressures
- More thorough pre-admission planning to forecast any additional needs as the focus is elective planning rather than emergency flow
- Focus on criteria led discharge in MOU with key milestones each half day/day.

3.7.4.2 Problems / risks of current situation

MTW is not compliant in several areas monitored by GIRFT – see Section 3.3.1 above.

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

Currently MTW is not achieving its aspiration of GIRFT top decile performance for day case rates and productivity. Whilst length of stay for elective knee replacements is currently 'good', this varies between sites with MOU performing better than TWH. GIRFT's key recommendation of centralising elective inpatient care for high volume low complexity (HVLC) work using laminar flow theatres and ring-fenced elective beds, cannot be achieved with the trust's current configuration.

3.7.4.4 The expected benefits of achieving the change

The benefits expected from adopting GIRFT recommendations are an:

- Improvement in productivity, with the average number of cases per list increasing.
- Increase in the overall available capacity by operating at 60 hours a week, 48 weeks a year.

- Improvement in day cases rates with MTW achieving top quartile performance
- Reduced length of stay for all procedures and MTW achieving top quartile performance
- Reduced same day cancellation rate.

3.7.5 Investment objective five - striving to become an outstanding organisation

3.7.5.1 Current situation - T&O beds at TWH are not ring fenced

MTW patients receive a good standard of care with good surgical outcomes, 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 impact on surgical outcomes and leads to poor patient satisfaction for trauma patients.

3.7.5.2 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.

3.7.5.3 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.

3.8 Benefits

The benefits associated with the investment are summarised below.

3.8.1 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 be able to choose to access orthopaedic best practice-based services without needing to travel outside the area.
- The additional capacity created will enable waiting times to be reduced bringing forward the health benefits resulting from orthopaedic procedures

- The additional capacity proposed would be located at Maidstone Hospital rather than Tunbridge Wells Hospital meaning more orthopaedic capacity would be close to the most deprived areas served by MTW and more accessible to people living in the more deprived parts of the wider Kent and Medway sector

3.8.2 Benefits to the Kent and Medway system

There are also benefits to the system:

- Additional theatre capacity within the system to allow other providers to reduce their post-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, EKHUFT has a 52 week+ backlog of over 1,100 orthopaedic patients waiting for surgery. MTW has commenced discussions with EKHUFT, DGT and MFT regarding patient transfers of care to MTW.

3.8.3 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. To also note, recruitment for theatre staff is currently easier on the Maidstone site.
- Improved post-operative care for elective patients, with a specialised physiotherapy team on site.
- Improved day case rates linked to the provision of dedicated day case space within the new facility, run by trained orthopaedic teams.
- 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 through the super green ward within the WKEOU
- Improved recruitment for surgical trainees and other clinical roles.
- Reduced infection rates, as a result of the facility providing ringfenced, green elective pathways.
- Reduction of further patients (backlog) being sent to the IS, as creates additional elective surgery theatre capacity.

3.8.4 Benefits to other surgical services

The benefits anticipated to other surgical services are:

- Released theatre capacity at TWH.

3.8.5 Financial efficiency savings

Creating a separate elective orthopaedic centre will 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.

3.9 Constraints and dependencies

The constraints and dependencies that could impact on the project have been examined.

3.9.1 Constraints

- Site space to develop a three -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.

3.9.2 Dependencies

- Capital investment, predominantly through central funding, 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.

3.10 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
- 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 17: 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 and income with commissioners	The business case will need to confirm that activity performed in the Barn is cheaper than outsourcing

Risk	Mitigation plan
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	Offer capacity to other trusts
Unforeseen increase in capital cost	Ongoing development of detailed plans (currently at RIBA Stage 2) and early engagement with suppliers
Ability to recruit the required workforce to staff the new facility	Recruitment process to commence in advance for international and student recruitment, to ensure there is sufficient time for training and embedding.

4 The Economic Case

Summary of this section of the OBC

- A review of service scope, location and delivery options concluded that a shortlist based on MTW or independent sector delivery of extra orthopaedic capacity, were the options most likely to achieve project investment objectives
- Three do something options were compared to the baseline ('business as usual') position. This economic appraisal concluded that the creation of three new theatres plus day case and inpatient facilities at Maidstone Hospital represents better value for money than outsourcing to the independent sector.
- A 'barn theatre' model was assessed as being preferable to a traditional orthopaedic theatre model because of service efficiencies associated with the barn approach and the opportunity to use a modular build approach to keep capital costs contained.

4.1 Introduction to the economic case

The economic case demonstrates that the trust and Kent and Medway (K&M) system has selected the option that represents best value for the taxpayer.

4.2 Longlist to shortlist

The trust used the options framework approach to review which dimensions of choice were applicable to this project and to derive a shortlist of options capable of meeting the investment objectives.

The choices considered and the summary outcome, are shown below.

Table 18: Longlist choices

	Option 1	Option 2	Option 3	Option 4
Service scope	Orthopaedics only	Orthopaedics plus other surgical specialties		
Service solution (location)	Maidstone Hospital	Independent sector	Tunbridge Wells Hospital EKHUFT DGT	Another K&M trust
Service delivery	By MTW in partnership with other K&M trusts	Outsourced to independent sector	Other K&M providers	
Implementation	Big bang	Phased		
Funding source	Trust capital	Central funds	Operating lease	

The outcome of the evaluation was:

- **Service scope – the scope of this development was agreed as being orthopaedics only** after having ruled out the option of also including other surgical specialties. Although other specialties have elective backlogs to clear, an immediate focus on orthopaedics only would have the added benefit of freeing-up existing orthopaedic theatre slots to assist other specialties to also tackle their elective backlog.
- **Service solution** – this dimension of choice relates to location. **The options shortlisted were Maidstone Hospital and the local independent sector.** EKHUFT was ruled out as there is already a dedicated elective orthopaedic hub on the Kent and Canterbury Hospital site which opened in Spring 2021. Medway Maritime was ruled out as there is not enough estate to build on. TWH was ruled out because there is no developable space on the site and the Maidstone Orthopaedic Unit already provides the nucleus of a centre of excellence at Maidstone and there is developable space at Maidstone. Maidstone is also geographically central and easily accessible by motorways to the areas of Kent and Medway without recently opened orthopaedic capacity i.e. west and north Kent. The local independent sector was included as an additional option recognising that the trust is currently utilising local independent sector providers.
- **Service delivery – the options shortlisted were provision by MTW and provision by the independent sector.** Outsourcing activity to other NHS providers is not a deliverable solution because other local providers also have elective backlogs to clear.
- **Implementation – a single phase (big bang) approach to the project was the only option shortlisted.** A phased option would be less likely to deliver the required capacity quickly enough to meet national target timescales for elective recovery.
- **Funding** – capital departmental expenditure limit (CDEL) constraints, which from April 2022 will impact lease options as well as NHS capital options, mean **the project needs to be funded predominantly from central NHS monies.**

4.3 Shortlist of options

Based on the options framework approach discussed above, the final 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 – Do Minimum: increased outsourcing to reduce waiting list and improve and then maintain RTT, over 52 week and activity performance.
- Option three – construct a modular barn theatre block with 3 theatres, 14 inpatient beds and a 10-trolley day case area at Maidstone Hospital
- Option four – as per option three but with a traditional build and theatre layout.

4.4 Appraisal of the options

The options available were appraised to identify the preference.

4.4.1 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 2021/22 activity levels, indicative activity would continue to be in line with the table below.

Table 19: Option one indicative in-house activity

2021/22 Activity	
<u>TWH</u>	
Day Case	1,091
Elective	873
<u>Maidstone</u>	
Day Case	449
Elective	397
TOTAL ANNUAL ACTIVITY	2,810

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 20: 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 Waiting List Initiative (WLI) sessions (however bed capacity and long-term staff resilience a significant barrier)	4	GM
Continuing risk of on the day cancellations at the TWH 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

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
MOU theatre is over 15 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	Planned downtime in order to carry out maintenance works within the theatre departments	3	Director of Estates
Reliant on independent sector theatre capacity and funding	4	Continued discussions with IS and commissioners to fund IS	3	DDO Surgery
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 21: Option one non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
No disruption	x	x	x	Short term	DDO Surgery

4.4.2 Option 2 – Do Minimum: increase outsourcing to meet current and future demand

Option 2 is the ‘Do Minimum’ under which 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 22: Option two Do Minimum 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 23: Option two Do Minimum non-financial benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
No disruption	x	x	x	Short term	DDO Surgery

4.4.3 Option 3 – Create a Kent and Medway system ring-fenced orthopaedic unit with 3 barn theatres, 14 beds and a day case area with 10 trolleys

The Trust would build a ring-fenced super green three -barn theatre orthopaedic unit which would be available to clear the Kent and Medway system elective orthopaedic backlog. The unit will have 14 inpatient beds and 10 trolleys for day cases which together with the theatres deliver an assumed capacity of 5,030 elective orthopaedic cases per annum. The facility would operate 48 weeks a year, allowing for downtime due to bank holidays, audit, theatre downtime and planned maintenance - this is in line with practice at other surgical hubs.

Key activity and financial assumptions

The theatres would be available to clear the Kent and Medway system elective backlog in the most cost-effective way possible.

Table 24: Total recurrent staffing requirement for the facility – option three

Staff Group	Total Requirement
Medical	25.00
Nursing	90.09
AHP	31.60
Admin	20.93
Other Support Staff	17.29
TOTAL	184.91

Non-financial risk associated with the option

Table 25: 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 Maidstone Hospital, may impact Recruitment & Retention	3	Consultation needed to identify staff who would be willing to move to Maidstone Hospital 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
When maintenance needs to be carried out this means the entire barn theatre must be closed down	3	Explore option to 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 26: 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
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 interesting cases / do parallel operating lists.			Improvements in efficiency KPIs	Within 3 months	GM and CD

4.4.4 Option 4 – Create 3 traditional theatres, 14 beds and a day area with 10 trolleys

The Trust would build a three -theatre complex with individual theatres to create a super green ring-fenced orthopaedic unit. This will also incorporate 14 inpatient beds and 10 trolley for day cases, and has an assumed capacity of 5,030 elective orthopaedic cases per annum. The facility would operate 48 weeks a year allowing for downtime due to bank holidays, audit, theatre downtime and planned maintenance - this is in line with practice across at other surgical hubs.

Key activity and financial assumptions

The medium-term plan for the three new theatres would be as per Option 3.

The option also requires the following additional staff.

Table 27: Total recurrent staffing requirement for the facility – option four

Staff Group	Total Requirement
Medical	25.00
Nursing	91.70
AHP	31.60
Admin	20.93
Other Support Staff	17.29
TOTAL	186.52

Non-financial risk associated with the option**Table 28: 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 TWH to MH, may impact Recruitment & Retention	3	Consultation needed to identify staff who would be willing to move to MH 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	Alternate efficiency schemes	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	None	4	CD

Non-financial benefits associated with the option**Table 29: 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

4.4.5 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 30: Summary of risks and benefits by option

Option	Benefits and risks	Option benefit and risk score and/or rank
Option 1 BAU/ Do nothing	<p>Currently NHSE paying for outsourcing of backlog via ERF so no financial impact to Trust, however future finance agreements are not clear on impact</p> <p>Risk of backlog /RTT due to cancelled electives and limited theatre utilisation</p> <p>Lack of theatre capacity for emergency trauma/CEPOD/service changes</p> <p>Continued ad-hoc planning to meet RTT, >52W and activity plans</p> <p>Inability to meet gap between demand and capacity</p> <p>No ability to significantly improve GIRFT metrics whilst operating on hot site with no ring-fenced beds</p>	3
Option 2 Do Minimum - increase outsourcing	<p>MTW have no long-term commitment to IS usage</p> <p>IS not able to meet full capacity gap</p> <p>High transaction costs</p> <p>Patients can be returned to Trust by IS with no notice</p> <p>IS have long waiting lists</p> <p>Patients in the backlog often don't meet the IS patient criteria.</p>	4
Option 3 Modular 3 barn theatre plus 14 inpatient beds and 10 trolley day care unit	<p>Increases theatre capacity for the ICB</p> <p>Creates super green ring-fenced capacity</p> <p>Site development of cutting-edge clinical service to showcase MH site</p> <p>Barn approach allows for improvements in GIRFT metrics</p>	1

Option 4 3 traditional theatres plus 14 inpatient beds and 10 trolley day care unit	Increases theatre capacity for the ICB Creates super green ring-fenced capacity	2
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4.5 Economic appraisal of costs

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 two and three. The period assessed is 62 years being two years for the project period and 60 years for the assessed life of the new building.

The economic benefit of orthopaedic procedures is summarised in the quote below²¹.

“

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.

”

The economic appraisal for this proposal builds upon the work of the GIFT team by assessing costs and benefits associated with the investment proposal – these are described in detail below.

4.5.1 Opportunity costs

There are no opportunity costs under any option.

4.5.2 Capital costs

The initial capital investment requirement together with the reconciliation between total initial capital costs and CIA costs, is shown below by option.

²¹ Source: A national review of adult elective orthopaedic services in England, GIRFT, March 2015

Table 31: Initial capital costs by option

Capital Cost	Option 1 Do nothing	Do Minimum Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Building	£0	£0	£36,622,353	£41,747,554
Medical Equipment	£0	£0	£2,085,742	£2,085,742
ICT Equipment	£0	£0	£390,850	£390,850
Total	£0	£0	£39,098,945	£44,224,146

Capital Cost for CIA	Option 1 Do nothing	Do Minimum Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Total capital	£0	£0	£39,098,945	£44,224,146
Exclude sunk costs (pre 2022/23)	£0	£0	-£3,653,697	-£3,653,697
Exclude inflation	£0	£0	-£1,659,247	-£1,891,447
Exclude VAT	£0	£0	-£5,907,541	-£6,761,742
Total for CIA	£0	£0	£27,878,460	£31,917,260
Split:				
Initial capital			£27,213,139	£30,528,880
Optimism bias			£665,321	£1,388,380
Total	£0	£0	£27,878,460	£31,917,260

The BAU and Do Minimum (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.

4.5.3 Lifecycle costs

Lifecycle costs are included in the economic appraisal to reflect the need to replace some of the new assets created under options 3 and 4 during the course of the 60-year total building life assessed.

The lifecycle cost assumptions are that:

- A sum equivalent to 60% of the initial building capital will need to be spent every 25 years to refurbish the building – this assumption has not been tested in detail, but is based on other approved business cases
- The medical equipment assets are replaced every seven years
- ICT equipment is replaced every three to five years.

The whole life undiscounted lifecycle costs for each option are shown below; once again options 1 and 2 do not require investment.

Table 32: Lifecycle costs by option

Lifecycle costs	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Building	£0	£0	£31,378,529	£35,357,419
Medical equipment	£0	£0	£6,796,247	£6,796,247
ICT equipment	£0	£0	£3,000,400	£3,000,404
Total	£0	£0	£41,175,176	£45,154,069

4.5.4 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). Options 3 and 4 have been costed on the basis of three theatres; Option 2 assumes the same quantum of activity as options 3 and 4, but provided by the independent sector. The BAU (Option 1) assumes current activity levels only.

The table below shows the revenue costs included in the CIA based on an indicative steady state year (2026/27).

Table 33: Annual revenue costs (indicative steady state year and undiscounted)

Annual revenue costs (2026/27)	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
In-house theatres	£0	£0	£22,124,914	£22,177,811
Outsourcing	£2,799,615	£25,680,137	£0	£0
Total	£2,799,615	£25,680,137	£22,124,914	£22,177,811

4.5.5 Costed risks

The trust has allowed for contingency and optimism bias in the estimate of capital costs – see capital cost forms.

A risk costing exercise was carried out by the trust's cost advisors to test allowances for options 3 and 4, and the results are incorporated into the CIA model.

Option 1 includes a cost for outsourcing 1,300 patients who have waited more than 52 weeks.

Option 2 includes a costed risk to account for premium prices being demanded by the independent sector to treat the estimated one third of orthopaedic patients with co-morbidities not currently accepted by independent sector providers. Under Option 2 no additional NHS capacity would be available for this work, so the trust has assumed a premium of 25% above tariff would need to be paid to find independent sector providers willing to carry out this more complex activity.

The table below shows total undiscounted costed risks for the whole life of the project and the new unit.

Table 34: Costed risks

Costed risks (whole life)	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Risks	£6,280,193	£53,104,647	£742,750	£782,500

4.5.6 Non-cash releasing benefits

The following non-cash releasing benefits to the system have been assessed:

- The benefit of adhering to evidence-based design standards. This benefit is based on meta research which values the benefit at approximately £30,000 per bedroom with factors included covering healthcare acquired infections, patient falls, staff sickness and turnover, and patient length of stay/ recovery. The benefit would only apply to the options involving a new build at Maidstone (options 3 and 4) and the benefit has been calculated based on 14 inpatient beds (x £30,000 per annum) and 10-day case trolleys (valued at 50% of the inpatient benefit i.e. £15,000 per annum).
- A collection of five benefits relating to staff training, recruitment and team working accruing due to the creation of an orthopaedic centre of excellence under options 3 and 4. The maximum benefit in this category is £1.98m to Option 3, with a smaller amount, £1.716m applying to Option 4.

In summary the non-cash releasing benefits apply to the different options as per the table below.

Table 35: Non-cash releasing benefits

Benefit	Option 1 BAU	Option 2 outsourcing	Option 3 Barn theatres	Option 4 Traditional theatres
Evidence-based design of bedrooms	×	×	✓	✓
Staff recruitment & training	×	×	✓	✓
Freed-up capacity	×	×	✓	✓

4.5.7 Societal benefits

The societal benefits expected are summarised in the table below.

Table 36: Wider societal benefits

Benefit to	Benefit
"UK PLC" – the economy	"Gross Value Add" (GVA) – 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

Benefit to	Benefit
Patients	Positive health impacts Reduced waiting times

In line with 2020 NHSEI guidance, the GVA benefit has not been monetised, however monetary values have been estimated for other benefits, as summarised below:

- Evidence based design - benefits to patients from adherence to evidence base for healthcare buildings. This benefit is based on the same research as trust Non-CRB from University of Texas (see above) and applies to options 3 and 4.
- Patient outcomes health benefits from orthopaedic procedures. The benefit is based on research for hip and knee replacement surgeries, and treatment for carpal tunnel syndrome (used as a proxy for all other procedures). Benefits were applied to all options but vary depending on the number of patients expected to be treated.
- A collection of other more minor societal benefits linked to the centre of excellence, travel and sustainability. These total £1.457m per year for Option 3 and £1.207m for Option 4, but do not apply to options 1 and 2.

In summary the societal benefits apply to the different options as per the table below.

Table 37: Societal releasing benefits

Benefit	Option 1 BAU	Option 2 outsourcing	Option 3 Barn theatres	Option 4 Traditional theatres
Evidence-based design of bedrooms	×	×	✓	✓
Patient outcomes – hips, knees and other procedures	✓	✓	✓	✓
Freed-up space patient outcome benefits	×	×	✓	✓
Centre of Excellence	×	×	✓	✓

Further details of the calculations behind the values included in the CIA can be found in Appendix 3. The monetised benefits are in Appendix 4.

4.5.8 Net present value and cost benefit

Bringing capital and revenue costs together with costed risks and monetised benefits 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	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital	£0	£0	-£40,578,381	-£45,442,777
Revenue	-£77,956,419	-£642,129,318	-£562,467,809	-£561,452,871
Costed risks	-£6,280,193	-£53,104,647	-£742,750	-£782,500
Non-cash releasing benefits	£0	£0	£63,053,640	£55,449,362
Societal benefits	£4,939,770,907	£7,957,066,847	£7,999,376,200	£7,991,915,229
Net present societal value	£4,855,534,294	£7,261,832,882	£7,458,640,899	£7,439,686,443

Option 1 has the lowest lifetime (62 year) discounted cost (£84m including costed risks), but also delivers the lowest monetised benefits (£4.9bn) mainly because fewer patients are treated under this option.

The three “do something” options have similar levels of societal benefit (£8bn over 62 years), however only the in-house options (options 3 and 4) also deliver non-cash releasing benefits to MTW. The cost of delivering benefits is highest for Option 2 (£642m) compared to £603m (Option 3) and £607m (Option 4); Option 2 also carries significantly higher costed risks than the two in-house options (£53m versus £0.7-£0.8m).

The incremental NSPV is then calculated for each “do something” option 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	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Capital		£0	-£40,578,381	-£45,442,777
Revenue		-£564,172,898	-£484,511,390	-£483,496,452
Costed risks		-£46,824,454	£5,537,443	£5,497,693
Non-cash releasing benefits		£0	£63,053,640	£55,449,362
Societal benefits		£3,017,295,940	£3,059,605,293	£3,052,144,322
Net present societal value	£0	£2,406,298,588	£2,603,106,605	£2,584,152,149
Cost benefit ratio	0.00	4.94	5.92	5.85

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 1:5.92 and a net societal incremental value of £2.6bn over the life of the facility. The second-best value option is Option 4.

4.5.9 Sensitivity analysis and switching points

Sensitivity testing has been undertaken to determine the point at which the preference would switch from Option 3 to the next best ranked option (Option 4) and to the outsourcing option (Option 2).

The first test applied related to an increase in the capital costs of Option 3 – the result is that these costs would need to increase by £42.2m to switch the preference. This level of increase is not considered credible and it is probable that factors influencing any increase in capital costs for Option 3 would also apply to Option 4 e.g. cost inflation.

Table 40: Capital cost switching point (Option 3 to option 4)

Capital cost increase

£42,200,000

Cost sensitivity	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Opportunity cost				
Capital	£0	£0	-£81,351,328	-£45,442,777
Revenue	£0	-£564,172,898	-£484,511,390	-£483,496,452
Costed risks	£0	-£46,824,454	£5,537,443	£5,497,693
Non-cash releasing benefits	£0	£0	£80,508,672	£55,449,362
Societal benefits	£0	£3,017,295,940	£3,063,917,916	£3,052,144,322
Net societal value	£0	£2,406,298,588	£2,584,101,313	£2,584,152,149

The amount by which the annual revenue costs of Option 3 would need to increase by to switch the preference to Option 4 is £1.6m annual increase which is an increase of 7.3% over forecast costs. Although a more credible value, there is no obvious reason why the costs of Option 3 (Barn theatres) would increase whilst the cost of Option 4 (traditional theatres) would remain static – the ongoing revenue costs of both options are similar (£22.2m for Option 3 versus £22.3m for Option 4).

Table 41: Annual revenue cost switching point (Option 3 to option 4)

Annual revenue cost increase

£1,610,000

Cost sensitivity	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Opportunity cost	£0	£0	£0	£0
Capital	£0	£0	-£40,578,381	-£45,442,777
Revenue	£0	-£564,172,898	-£525,365,558	-£483,496,452
Costed risks	£0	-£46,824,454	£5,537,443	£5,497,693
Non-cash releasing benefits	£0	£0	£80,508,672	£55,449,362
Societal benefits	£0	£3,017,295,940	£3,063,917,916	£3,052,144,322
Net societal value	£0	£2,406,298,588	£2,584,020,092	£2,584,152,149

The two top rated options are both MTW in-house options, so the trust's project team also considered sensitivities that would switch the preference to the outsource option (Option 2):

- The gap in NPSV between options 3 and 2 is £197m which is too great to mean there's a credible increase in capital costs that would result in Option 2 becoming the preference.
- Option 2's costed risks are £53.1m compared to £0.7m for Option 3, so even removing all risks would only close approximately 1/4 of the NPSV gap.
- Option 2's societal benefits are lower than those of Option 3. If the two were made the same, the preference would not switch because Option 2 would still have higher revenue costs and costed risks, and it does not deliver any non-cash releasing benefits.
- An increase of £8.62m in the annual revenue costs of Option 3 would switch the preference to Option 2 (outsourcing). This would be an increase of 38.9% which again, is not credible.

Table 42: Annual revenue cost switching point (Option 3 to option 2)

Annual revenue cost increase

£8,620,000

Cost sensitivity	Option 1 BAU	Do Min Option 2 Outsource	Option 3 Barn Theatres	Option 4 Traditional Theatres
Opportunity cost	£0	£0	£0	£0
Capital	£0	£0	-£40,578,381	-£45,442,777
Revenue	£0	-£564,172,898	-£703,246,127	-£483,496,452
Costed risks	£0	-£46,824,454	£5,537,443	£5,497,693
Non-cash releasing benefits	£0	£0	£80,508,672	£55,449,362
Societal benefits	£0	£3,017,295,940	£3,063,917,916	£3,052,144,322
Net societal value	£0	£2,406,298,588	£2,406,139,523	£2,584,152,149

The conclusion of the comparison of options 2 and 3, is that there are no credible scenarios under which Option 2 becomes the preference.

In summary having looked at the second and third ranked options, there is no credible scenario under which the preference would switch away from Option 3.

4.6 Identification of the preferred option

The preferred option is to build a new elective orthopaedic unit based on the Barn theatre concept consisting of three open theatres separated by laminar flow canopy with 14 inpatient beds and 10 trolleys for day surgery. Following commissioning, the unit would open 1st February 2024. The new building will be located at the back of the Maidstone Hospital site and would be a ring-fenced Covid secure facility.

The new facility will have a total capacity to deliver 5,030 elective orthopaedic cases per year.

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

Summary of this section of the OBC

- The new facility will be a Kent and Medway system facility
- The design is currently at RIBA Stage 2 (Concept Design) and a contract has been appointed under a pre-construction services agreement (PCSA) through the NHS SBS Modular Building framework
- The NHS SBS Modular Building framework has been selected as the preferred procurement route because this provides a tried and tested route to market for modular buildings. The contracting and tendering strategy has applied the best practice of the NHS ProCure22 Framework.
- Pre-application planning engagement indicates a high likelihood of a successful planning outcome
- The new facility will be modular and is being designed to minimise environmental impact; a BREEAM excellent rating is being targeted
- A recruitment plan has been developed to ensure the trust can staff the WKEOU from opening
- The unit will be on the trust's balance sheet.

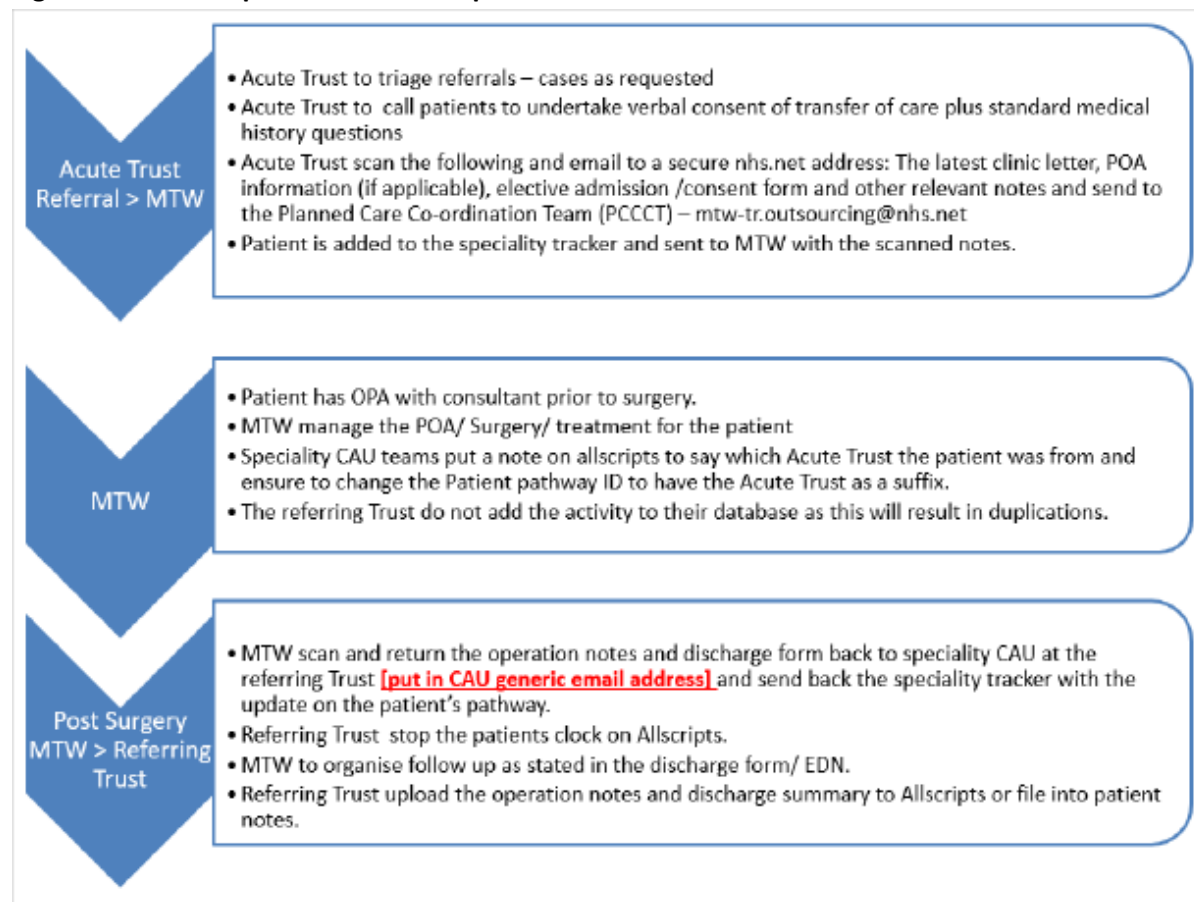
5.1 Introduction to the commercial case

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 open the new facility (West Kent Elective Orthopaedic Unit - WKEOU - name is TBC) at Maidstone Hospital. WKEOU will be a ring-fenced orthopaedic 3-barn theatre and ward modular complex. The facility will be a system facility initially dedicated to the clearing of the orthopaedic elective backlog. All three theatres will be available for Kent and Medway patients with patients sent across to the unit prior to surgery, mimicking the prime provider model. Theatre staffing will be consistent across all theatres, as will standard operating procedures, kit supplies and other consumables to ensure standardisation. MTW surgeons will receive patients from other trusts to aid backlog clearance across Kent and Medway. Patients would be seen and pre-assessed to ensure the surgery is still necessary and they are fit, then operate on, mimicking the prime provider model. Referrals for patients to be treated in the Barn facility will follow the following process.

Figure 19: Referral process non-MTW patients



The operational and planned care co-ordination policies for WKEOU can be found at Appendix 5.

MTW have an embedded weekly theatre 6-4-2 scheduling meeting (this supports delivering the 48 weeks per year plan) and also fortnightly operational theatre performance meetings (identifying and challenging, utilisation, cut times, cancellations, cases per session etc.). This is supported by a monthly Theatre Utilisation Board (TUB) chaired by the Clinical Director for Critical Care and is attended by the speciality clinical directors. The Barn theatres, once commissioned, will form part of this process.

The usage of each theatre and activity will be monitored down to surgeon and patient level, so that data on how many patients from each trust have been operated on, as well as how many sessions each surgeon has used each theatre, will be routinely available. The main measure of success will be the activity levels through the theatres and the backlog clearance. In time backlog work will be replaced with growth linked to the growing and ageing population.

As part of the elective recovery plan, MTW have been developing a pre-operative assessment (POA) expansion plan off site. The WKEOU increase in activity will form part of the expansion which will include consultant delivered POA sessions for higher risk patients.

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.

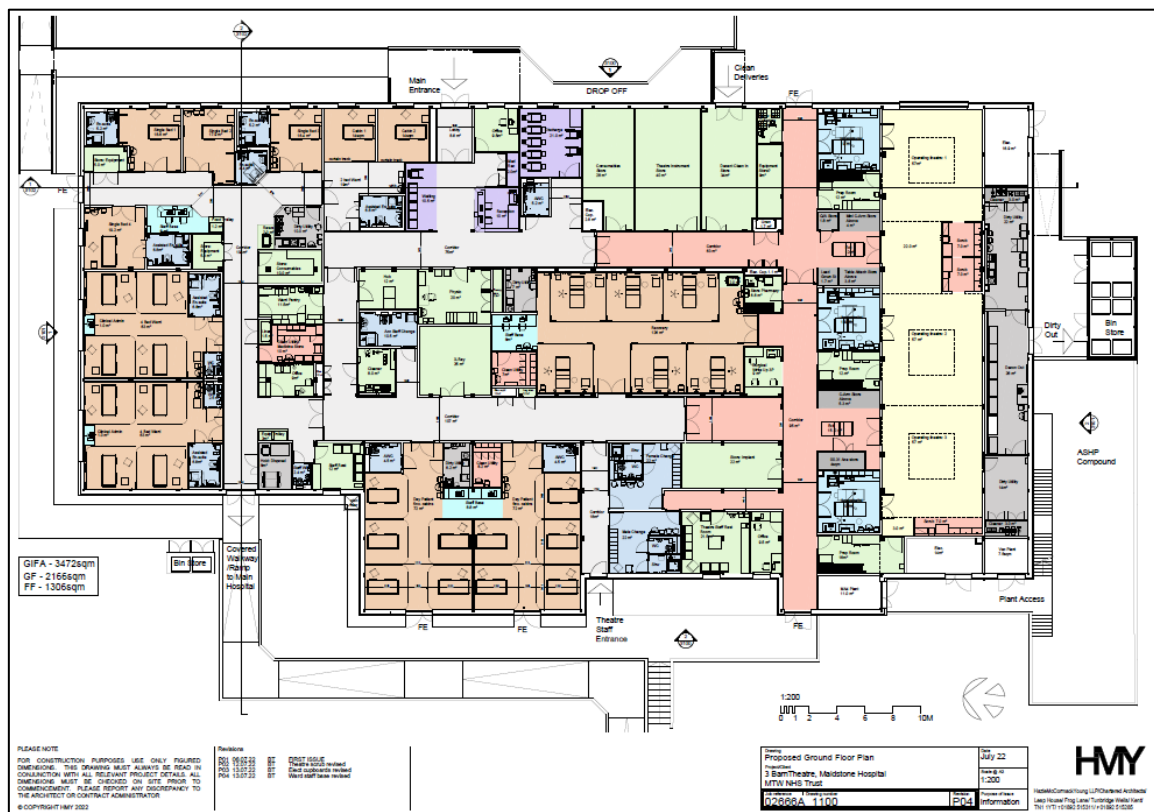
The new facility will contain:

- A three-station barn theatre
- Three 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 14 beds (6 in single rooms and 8 in four-bed bays) and 10-trolley day case area 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, in accordance with HTM guidance.

The capital equipment required is listed in Appendix 8; IT equipment required is listed in Appendix 9.

The design has been developed to RIBA Stage 2 (Concept Design) with 1:200 floor plans prepared. The layouts have had detailed services and structural input to ensure that they are feasible. The building is modular, and therefore applies the benefits of Modern Methods of Construction (MMC). The modular contractor, engaged under a Pre-Construction Services Agreement, has provided detailed input into the plans, delivery programme and estimated capital costs.

Figure 20: Plan of the facility



The 1:200 GA Plans and Concept Design Drawings can be found in Appendix 6. The summary schedule of accommodation can be found in Appendix 10.

The new building will be entirely clinical in nature so will improve the trust's performance against the Carter and Long Term Plan admin to clinical space metric. The Trust's backlog maintenance position will not be impacted by the development. During the life of the asset, the facilities management requirements of the building will be met as per the existing arrangements for facilities management across the wider MTW estate at Maidstone Hospital (it will not form part of the trust's PFI arrangements for TWH).

The Trust's Lead Nurse for Infection Prevention Control and the Head of Fire and Safety have both also reviewed the design of the unit and have confirmed their sign-off of the plans.

5.3 Procurement and tendering strategy and approach

MTW, as the site owner, has taken the lead in procuring the services required to deliver the scheme. In order to meet the challenging timelines associated with elective recovery two decisions were made:

- The facility is to be of modular construction since modular construction is up to 50% faster to deliver than onsite construction
- Some aspects of the build programme were procured early i.e. before the primary contract is in place (most of these arrangements will then novate into the primary contract in order to maintain continuity and the integrity of the design).

The trust also had a series of choices to make in determining its approach to the procurement and tendering of this scheme. The choices were:

- The choice of procurement route
- The choice of tendering approach
- The choice of which framework to use.

These choices are discussed in turn below.

5.3.1 Procurement strategy

This section analyses the available procurement strategies, with reference to *Developing a Construction Procurement Strategy and Selecting an Appropriate Route*²².

Table 43: Procurement route assessment summary

Procurement Route	Assessment
Traditional	A traditional procurement route was discounted as the strategy does not facilitate design risk transfer to the contractor, integrated supply chains, early contractor involvement. A traditional procurement route would also result in a longer programme.

²² Royal Institution Of Chartered Surveyors, 1st Edition, 2013.

Procurement Route	Assessment
Construction Management	A construction management procurement route was discounted as the strategy does not facilitate design risk transfer or provide for a fixed price lump sum contract.
Management Contracting	A management contracting procurement route was discounted as the strategy does not facilitate design risk transfer or provide for a fixed price lump sum contract.
Design and Build	A design and build procurement route was selected since this enables design risk transfer to the contract, integrated supply chains and early contractor involvement and a shorter overall programme due to the ability to overlap design, procurement and construction.

Design and build was the option selected.

5.3.2 Tendering approach

The second choice considered was the approach to tendering for the required services. Once again guidance published by the Royal Institution of Chartered Surveyors was used to determine the correct approach²³.

This section analyses the available tendering strategies, with reference to RICS Guidance Note Tendering Strategies 1st Edition.

Table 44: Tendering approach assessment summary

Tendering approach	Assessment
Single-Stage Tendering	Whilst the most common type of tendering, this approach was discounted as did not facilitate the early contractor and supply chain involvement required by the modular form of construction and the overall programme objectives of the project.
Negotiation	A negotiated tender with a single contractor was discounted since this would not comply with the Trust's standing financial instructions and would not provide the competitive advantage of a formal bidding process.
Two-Stage Tendering	A two-stage tendering was selected as this enables early contractor and supply chain input into the design and a shorter overall programme. In a two-stage procurement, the preferred contractor is chosen based on the quality of their bid, preliminaries and overheads and profit allowances. The preferred contractor then joins the design team on a consultancy basis using a pre-construction services agreement (PCSA). The preferred contractor works with the professional team to complete the design, before presenting a commercial offer.

In light of the choice to select a two-stage tendering approach a number of services were procured early. These are discussed below.

²³ RICS Guidance Note Tendering Strategies, 1st Edition, 2014.

5.3.2.1 Professional services

The Trust has engaged a full design team through the NHS Shared Business Services Framework. The Design Team is appointed to complete the design to RIBA Stage 4 (Technical Design) and will be novated to the modular contractor following agreement of the contract sum.

5.3.2.2 Enabling groundworks

These works would normally form part of the primary contract, but because of the challenging project timetable needed to affect elective recovery, these works have been contracted for separately. Following competitive tender, WW Martin Civils has been appointed on an NEC4 Engineering & Construction contract in order to maintain progress against the timescale. Enabling groundworks will be concluded in time for the primary contractor to take possession of the site once funding has been agreed. It is not therefore, intended that the groundworks contractor novates to the primary contract.

The enabling works that have commenced are valued at £2.5m and include:

- Site security fencing
- Footpath diversion
- Site compound set-up and cabins
- Site strip of vegetation
- Tree surgery
- Waste acceptance criteria testing and ground penetrating radar survey
- Reduced level dig
- Link walkway earthworks/foundation
- Contractor preliminaries
- Renal unit temporary car park move.

No work has commenced on permanent foundation construction at this stage.

5.3.3 Choice of framework

The final choice is which framework to use given the choices made above. Given that the facility will be a modular unit in addition to the frequently used NHS ProCure23 Framework, the NHS Shared Business Services (SBS) Modular Building Framework Agreement was also considered. The table below summarises the comparison of the two frameworks.

Table 45: Summary comparison of frameworks

	NHS Shared Business Services Modular Building Framework Agreement	NHS ProCure23 Framework	Difference
Procurement Strategy	Design and Build	Design and Build	No difference.
Tendering Strategy	Two-Stage	Two-Stage	No difference.
Early Contractor Involvement and Integrated Supply Chain	Yes, achieved through two-stage tendering.	Yes, achieved through two-stage tendering.	No difference.
Form of Contract	NEC ECC Option A or NEC ECC Option C	NEC ECC Option A	No difference. The Trust is being advised by Birketts, Gardiner & Theobald and Turner & Townsend to see that appropriate terms are agreed
Cost	Direct appointment of a modular contractor as the main contractor, avoiding the overheads and profit of a general building contractor.	The NHS ProCure23 Framework would result in a higher overall cost since the PSCP would apply the PSCP fee % to the modular contractor's costs.	The NHS SBS Modular Building Framework Agreement is advantageous compared to NHS ProCure23.
Time	The procurement has already been completed and Premier Modular Limited are engaged under a PCSA	If the NHS ProCure23 Framework was used it would be necessary to pause the current pre-construction activities to undertake a PSCP selection process, which typically takes around 8 weeks. The PSCP would then need to select a modular builder.	The NHS ProCure23 Framework would introduce a minimum delay of 8 weeks.
Quality	A competent contractor is engaged through the framework. The Contractor, Design Team and NEC Supervisor are responsible for	A competent contractor is engaged through the framework. The Contractor, Design Team and NEC Supervisor are responsible for	The NHS ProCure23 Framework would provide an additional layer of checking, as the PSCP would be responsible for checking the work of the modular building. We do not consider this to be a

NHS Shared Business Services Modular Building Framework Agreement		NHS ProCure23 Framework	Difference
	checking the quality and compliance of the work.	checking the quality and compliance of the work.	material benefit since additional assurance may be provided under the chosen route through additional technical monitoring resource.
Risk	The risk profile of the building contract is determined through the second-stage negotiation.	The risk profile of the building contract is determined through the second-stage negotiation.	It is our considered opinion that the risk profile of the eventual building contract will not differ between the two routes. The objective of both is full design risk transfer and appropriate site condition risk transfer. The Trust is being advised by Birketts, Gardiner & Theobald and Turner & Townsend to see that an appropriate risk profile is achieved.

The trust's evaluation conclusion was that the SBS Modular Building framework is the preferred framework. This decision was reviewed by Gardiner & Theobald LLP, the trust's chartered surveyors, who concluded that, *"it is our considered opinion that the selected procurement strategy, tendering strategy, and framework is appropriate given the size, value and complexity of this project and is aligned to the project's overall programme objectives. We consider that an appropriate building contract risk profile is achievable through the selected route and that appropriate management of quality can be achieved"*.

5.3.4 Primary modular contractor

Premier Modular were selected as preferred bidder by way of mini-competition under the NHS SBS Modular Building Framework. Premier Modular are now engaged for pre-construction services under a Pre-Construction Services Agreement (PCSA). Following completion of the design, Premier Modular will market test the sub-contract packages on an open-book basis and provide a fixed price commercial offer. This is anticipated to occur by January 2023. Following agreement of the fixed price, the Trust will enter into an NEC4 Option A construction contract with Premier Modular to complete the design, manufacture and construction of the facility.

5.4 Land and infrastructure issues

There will be no acquisition of land or any land disposals. The new unit will be located 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 land is owned by the trust; MTW therefore has the right to use this land subject to planning consent – see below.

Figure 21: 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.

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.

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 46: 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	✓		
Financing risks	✓		
Legislative risks			✓
Other project risks			✓

5.6 Contractual issues

Premier Modular were selected as preferred bidder by way of mini-competition under the NHS SBS Modular Building Framework. Premier Modular are now engaged for pre-construction services under a Pre-Construction Services Agreement (PCSA). Following completion of the design, Premier Modular will market test the sub-contract packages on an open-book basis and provide a fixed price commercial offer. This is anticipated to occur by January 2023. Following agreement of the fixed

price, the Trust will enter into an NEC4 Option A construction contract with Premier Modular to complete the design, manufacture and construction of the facility.

5.7 Planning

The planning application was validated by Maidstone Council on the 8th June 2022, with a current target determination date of the 7th September 2022. To date there have been consultation comments by various statutory consultees addressing matters such as ecology, drainage, environmental health and archaeology. None of those consultee comments have raised any fundamental points of objection; some raise minor issues of clarification but otherwise seek conditions as appropriate on those specific matters.

The project team are continuing to discuss the scheme with Kent Highways, who have yet to respond. However, there is no indication from those discussions to date that Kent Highways would have a fundamental objection to the proposed scheme.

To date no formal or informal feedback has been received since the submission of the application from the Planning Case Officer, and an update from the Officer is therefore being sought at present. The Case Officer assigned to the application is the same Officer who conducted the pre-submission Member's Briefing on behalf of the Council, and who indicated a positive approach to the scheme during that process and in separate pre-submission informal discussions with the Trust.

The Trust met at an early stage prior to the submission of the application with the two local Ward Members for the area, both of whom were very positive regarding the scheme. Those two Members suggested that a wider Members briefing be held, which took place in April 2022. That meeting was also positive overall with Members recognising the clear need for the scheme, whilst seeking clarification on elements such as energy efficiency, use of renewable technologies and landscaping. Some minor changes to the scheme were made after the Member's briefing to address the comments made.

The position regarding the application therefore remains positive at the current time. The project team are continuing to review consultation responses as those are submitted to the Council and are providing the necessary clarification to consultees where required. At present, only very minor alterations to the scheme itself are anticipated as arising from that process.

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 advantages 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 current BREEAM pre-assessment for the project shows targeted credits of 77.95% (BREEAM ‘Excellent’). Please see Appendix 7 for further detail of this pre-assessment.

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 will 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 overseas 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 47: Recruitment assumption

	Year 1-2	Year 3	Year 4+
% of staff substantively recruited	70%	85%	90%
Temporary staffing	30%	15%	10%
Temporary staffing premium	100%	100%	100%

5.12 Impact on other site users

5.12.1 During the works

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.

5.12.2 Travel assessment

The WKEOU will generate more activity at the Maidstone Hospital site. The Trust commissioned a travel assessment in connection of the planning application to understand the likely impact (see Appendix 11). The conclusion of the assessment was that the new unit would generate 362 vehicle movements each working day. The report also states that the proposed unit is not in conflict with any local or national policies on accessibility, sustainability or highway safety.

5.13 Accountancy treatment

The build and equipping proposals have been reviewed for their treatment as either capital or revenue costs. The build will be owned by MTW and is assessed in the main as capital in nature against the trust's policies and the DHSC Group Accounting manual guidance (relating to IAS 16). The building will be initially recognised at cost and then become subject to the annual revaluation reviews that the trust commissions from its independent valuers on the basis of depreciated replacement cost, using the modern equivalent asset methodology. The equipment schedules have been reviewed and those items meeting the trust's capital policies will be on balance sheet; other equipment or furniture below the capital threshold is treated as non-recurrent revenue expenditure in the business case financials.

6 The Financial Case

Summary of this section of the OBC

- The financial appraisal has been undertaken in line with HM Treasury requirements and focuses on the incremental impact of the proposed scheme
- An initial capital investment of £39.1m is required to construct and equip the WKEOU
- 5,030 elective orthopaedic cases will be undertaken per annum at the WKEOU
- The incremental revenue cost impact is an annual increase of approximately £24.4m at steady state.
- Once steady state is achieved and the backlog has been cleared (April 2025), the unit will generate a surplus of approximately £1.3m per annum.
- In the years leading up to 2025/26, the unit will record a deficit due to a combination of start-up costs and backlog activity being funded at 75% of tariff. MTW will require revenue support to cover these early year deficits.

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*²⁴. 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 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. The costs that vary are the direct costs of the three theatres, day care unit, inpatient ward and outpatient clinics making up the WKEOU.

²⁴ Capital regime, investment and property business case approval guidance for NHS providers, NHS Improvement, November 2016.

- Capital costs have been worked up by the Trust's cost advisers 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.

6.3 Capital investment and source of funding

Capital costs have been worked up by the trust's cost advisers Turner & Townsend working with the trust's project team. The initial capital investment required is shown below. The Capital OB Forms can be found in Appendix 2.

Table 48: Initial capital costs

Asset group	Total capital cost £000
Building	£36,622
Equipment	£2,086
ICT	£391
Total	£39,099

This would be funded via the following capital funding streams.

Table 49: Capital Funding Streams

	£000
TIF Funding	£31,489
ICS Slippage 2021/22	£1,200
Trust funded / System slippage / TIF Contingency	£6,410
Total	£39,099

The additional £6.4m of capital funding will require re-prioritisation of MTW's internally funded capital programme, whilst mitigations, such as slippage from System capital and Contingency from Regional TIF Elective Recovery Fund are progressed.

The forecasted capital spend by financial year is as follows. The 2022/23 expenditure relates to professional fees, enabling works and advance orders for long lead items. The Trust will request an early release of capital funds following OBC approval from NHSE to ensure the programme can achieve the expected go-live date.

Table 50: Forecasted Capital Spend by Financial Year

£000	
2021/22 (Spent)	£3,653
2022/23 (Forecast)	£16,354
2023/34 (Forecast)	£19,092
Total	£39,099

6.4 Activity impact

The theatres will all be open from day one and between the three theatres will provide capacity to carry out 5,030 elective orthopaedic cases per annum. The elective activity will also generate 21,629 corresponding outpatient appointments (new, follow-up, pre-assessment, physiotherapy and anaesthetic review), increasing to 26,659 outpatient appointments from Year Three.

Table 51: Activity years one to three

	Year 1 2023-24 (2 months) Total Capacity	Year 2 2024-25 Total Capacity	Year 3+ 2025-26 Total Capacity
<u>Elective</u>			
Day Case	571	3,423	3,423
Inpatients	268	1,607	1,607
TOTAL ELECTIVE CASES	838	5,030	5,030
<u>Outpatients:</u>			
New	838	5,030	5,030
Follow-Up	838	5,030	5,030
Other (POA, Physio etc)	1,928	11,569	16,599
TOTAL OUTPATIENT APPTS	3,605	21,629	26,659

6.5 Impact on the trust's statement of comprehensive income

The detailed impact of the scheme on the trust's cost base, is set out in the table below.

Table 52: Recurrent direct cost impact

£'000	Annual Recurrent Cost
<u>Pay</u>	
T&O Medical Staff	£1,431
Anaesthetists	£1,205
Theatre Staff	£1,432
Barn Ward	£1,531
Day Care Area	£793
Pre Operative Assessment	£387
Out Patients	£748
Therapies	£528
Pharmacy	£169
Radiology	£521
Pathology	£36
Estates and Facilities Staffing	£393
T&O Admin (CAU)	£265
Reception	£45
EME / IT	£91
Temporary Staffing Premium	£958
Waiting List Initiatives for Saturdays	£1,839
Backfill Consultant Leave (48 week operating)	£473
Total Pay	£12,845
<u>Non Pay</u>	
Theatre Consumables	£4,681
Drugs	£455
Barn Ward	£90
Day Care Area	£20
Diagnostic Non Pay	£300
CT and MRI Outsourcing	£62
Out Patients Non Pay	£107
Energy	£253
Catering	£59
Domestics	£60
Decontamination	£103
Waste disposal	£50
Laundry	£103
Maintenance and Other Estates Costs	£516
Water and Sewerage	£24
Rates	£167
Security	£51
CNST	£512
Total Recurrent Non Pay	£7,611
Total Direct Expenditure	£20,456
MTW Corporate Overhead Contribution	£1,669
Depreciation and PDC	£2,240
Total Recurrent Cost	£24,365

The gross additional cost of the WKEOU will be approximately £24.4m per annum including depreciation and PDC, and an 8% contribution to MTW trust overheads. £12.8m relates to the cost of the additional 184.91 WTE staff required.

Table 53: Staff WTE

Staff Group	Total Requirement
Medical	25.00
Nursing	90.09
AHP	31.60
Admin	20.93
Other Support Staff	17.29
TOTAL	184.91

Recruiting to this number of posts will be challenging, so the financial modelling prudently allows for a temporary staffing premium (as well as recruitment costs) as follows.

Table 54: Temporary staffing assumptions

	Year 1	Year 2	Year 3	Year 4+
% of staff substantively recruited	70%	70%	85%	90%
Temporary staffing	30%	30%	15%	10%
Temporary staffing Premium	100%	100%	100%	100%
Temporary staffing Premium £000	£1,164	£2,803	£1,436	£958

Non-pay costs incurred will include drugs, theatre consumables and facilities costs (utilities, business rates etc). Non-recurrent costs of £3m are forecast for the period 2022/23 to 2025/26 with the largest non-recurrent cost being recruitment fees (£1.2m – see table 56 below).

The Trust has assumed that the additional activity will be funded at ERF rates (75% of tariff) for 2023/24 and 2024/25 and then full tariff from 1st April 2025. The net impact on the trust's statement of comprehensive income (SOCi) is therefore as below.

Table 55: SOCi impact

£000	Year 0 2022-23	Year 1 2023-24	Year 2 2024-25	Year 3 2025-26	Year 4 2026-27	Year 5 2027-28	Year 6 2028-29	Year 7 2029-30	Year 8 2030-31	Year 9 2031-32	Year 10 2032-33
Pay		£5,787	£14,459	£13,324	£12,845	£12,845	£12,845	£12,845	£12,845	£12,845	£12,845
Non Pay		£1,268	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611	£7,611
MTW Corporate Overhead		£576	£1,800	£1,708	£1,669	£1,669	£1,669	£1,669	£1,669	£1,669	£1,669
Non Recurrent Setup	£611	£2,058	£240	£120							
Depreciation		£96	£995	£995	£995	£995	£995	£995	£995	£995	£995
PDC dividends payable	£414	£1,033	£1,348	£1,313	£1,279	£1,245	£1,216	£1,188	£1,191	£1,193	£1,159
Total Cost	£1,025	£10,818	£26,453	£25,071	£24,399	£24,365	£24,336	£24,308	£24,311	£24,313	£24,279
Income @ 75%		(£3,174)	(£19,041)								
Income @ 100%				(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)
Total Income	£0	(£3,174)	(£19,041)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)	(£25,680)
Total Surplus (+) / Deficit (-)	(£1,025)	(£7,645)	(£7,411)	£610	£1,281	£1,315	£1,344	£1,372	£1,369	£1,367	£1,401
% Profit (+) / Loss (-)		-241%	-39%	2%	5%	5%	5%	5%	5%	5%	5%

Non-recurrent set-up costs and PDC lead to a £1,025k deficit in 2022/23 (Year 0). In year 1, the assumed 1st February 2024 opening date means that income will only be generated for 2 months (at the 75% ERF tariff). This together with non-recurrent set-up costs, the working assumption is that staff are in post three months ahead of go live because of the need to recruit from overseas and for familiarisation with the facility, commissioning and handover, and a higher temporary staffing assumption, results in a loss in 2023/24 (Year 1). A loss is also made in 2024/25 because the Trust has assumed that activity continues to be funded at the ERF 75% tariff until 31st March 2025. Once full tariff is received (Year 3 onwards), MTW would expect to be generating a surplus of approximately 5% (£1.3m per annum).

The non-recurrent revenue costs of the project are detailed below.

Table 56: Non-recurrent costs

£000	Year 0 2022-23	Year 1 2023-24	Year 2 2024-25	Year 3 2025-26	TOTAL
Recruitment fees		£800	£240	£120	£1,160
Project Team Costs	£539	£539			£1,078
Non-capital equipment (incl IT)		£607			£607
Consultant Relocation fees		£113			£113
Legal fees	£72				£72
Total	£611	£2,059	£240	£120	£3,030

The impact on the trusts' statement of comprehensive income including this investment is as follows.

Table 577: SOCI – Trust position after investment

STATEMENT OF COMPREHENSIVE NET INCOME		2022/23	2023/24	2024/25
Whole Trust Position INCLUDING the Investment over the Appraisal Period		£'000	£'000	£'000
Gross employee benefits		(372,686)	(389,025)	(399,022)
Other operating costs		(237,465)	(248,183)	(255,132)
Revenue from patient care activities		589,985	583,606	601,796
Other operating revenue		40,605	41,162	41,985
Operating surplus/(deficit)		20,439	(12,439)	(10,373)
Investment revenue		50	50	50
Other gains and losses		0	0	0
Finance costs		(16,550)	(17,093)	(18,451)
Surplus/(deficit) for the financial year		3,939	(29,482)	(28,774)
Dividends payable on public dividend capital (PDC)		(6,180)	(6,954)	(7,429)
Net gains/(loss) on transfers by absorption		0	0	0
Retained surplus/(deficit)		(2,241)	(36,437)	(36,203)
Adjustments (including PPA, IFRIC 12 adjustment)		1,216	1,216	1,216
Adjusted financial performance retained surplus/(deficit)		(1,025)	(35,221)	(34,987)

6.6 Impact on cash flow

The most significant cashflow linked to the investment will be the £39.1m capital spend up to February 2024. Cashflows thereafter relate to operating expenses.

The trust is applying for central capital funding for this scheme which would be provided as PDC.

The impact on the trust's cash flow position including this investment is as follows.

Table 58: Cashflow – Trust position after investment

	2022/23 £000's	2023/24 £000's	2024/25 £000's
<u>CASH RECEIPTS:</u>			
NHS SLA Income	588,475	585,432	587,754
Debtors cfwd	300	1,000	1,000
NHS revenue	25,003	25,400	25,600
Other revenue - VAT	10,379	10,500	10,750
Other revenue - car parking (cash/card taken from machines)	204	204	529
Other revenue - catering	76	76	76
Other Income - CRU (RTA)	699	700	700
Other revenue - Private Health Insurers	2,282	2,300	2,300
Other Income (GBS) NON NHS includes Horder SLA/R&D money	11,800	12,000	12,500
External financing - PDC	30,934	7,886	2,300
Total Cash Receipts	670,152	645,498	643,509
<u>CASH PAYMENTS:</u>			
Payroll (monthly, weekly, Tax, NI & Pension)	340,264	355,339	356,497
Agency 247	6,242	6,242	6,242
Agency Other	20,645	20,645	20,645
Revenue Payments - Drug Suppliers	58,524	60,000	62,000
Revenue Payments - Rates & Council	3,407	3,600	3,800
Other Revenue Payments:	115,188	121,578	123,962
Supplier restrictions	0	-32,356	-36,050
NHSLA payments	19,287	20,000	21,000
NHS Supply Chain Payments	10,526	10,800	11,200
NHS - Blood and Transplant	2,637	2,700	2,700
Other NHS Payments	8,321	8,500	8,500
Prime Provider	9,660	9,000	9,000
Capital Payments	43,291	21,687	13,390
Account charges	13	13	13
Dividends paid	5,766	5,922	6,082
Repayment of Salix Loan	453	453	453
Loan repayments (inc interest)	1,175	1,175	1,175
PFI Unitary Charge	31,592	32,200	32,900
Total Cash Payments	676,990	647,498	643,509
OPERATIONAL CASH INFLOW/(OUTFLOW):	(6,838)	(2,000)	0
CASHBOOK BALANCES B/F:	11,838	5,000	3,000
CASHBOOK BALANCES C/F:	5,000	3,000	3,000

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.

The impact on the trust's statement of financial position including this investment is as follows.

Table 59: Statement of Financial Position – Trust position after investment

£000	2022/23	2023/24	2024/25
Non-Current Assets			
Property, Plant and Equipment (Fixed Assets)	378.9	400.1	413.3
Intangibles	10.1	7.6	5.8
IFRS 16 - Right to Use Asset	79.0	69.5	60.2
Debtors Long Term	2.9	2.9	2.9
Total Non-Current Assets	470.9	480.1	482.2
Current Assets			
Inventory (Stock)	9.2	9.2	9.2
Receivables (Debtors) - NHS	8.9	8.2	7.9
Receivables (Debtors) - Non-NHS	19.8	19.5	19.3
Cash	5.0	3.0	3.0
Total Current Assets	42.9	39.9	39.4
Current Liabilities			
Payables (Creditors) - NHS	(3.8)	(3.6)	(3.2)
Payables (Creditors) - Non-NHS	(35.6)	(62.2)	(91.8)
Deferred Income	(2.1)	(2.1)	(2.1)
Capital Loan	(1.0)	(1.0)	(1.0)
Other loans	(0.4)	(0.1)	(0.1)
Borrowings - PFI	(6.0)	(6.3)	(6.2)
Borrowings - IFRS 16	(5.9)	(5.9)	(5.9)
Provisions for Liabilities and Charges	(4.3)	(2.7)	(2.7)
Total Current Liabilities	(59.1)	(83.9)	(113.0)
Net Current Assets	(16.2)	(44.0)	(73.6)
non-current liabilities: Borrowings - PFI > 1yr	(165.2)	(158.8)	(152.5)
Capital Loans	(4.0)	(2.6)	(1.6)
Other loans	(0.1)	0.0	0.0
IFRS 16 - Lease Liability	(73.5)	(64.9)	(56.4)
Provisions for Liabilities and Charges- Long term	(2.4)	(2.4)	(2.4)
Total Assets Employed	209.5	207.4	195.7
Financed By:			
Capital & Reserves			
Public dividend capital	304.9	312.8	315.1
Revaluation reserve	63.1	81.9	101.9
Retained Earnings Reserve	(158.5)	(187.3)	(221.3)
Total Capital & Reserves	209.5	207.4	195.7

6.8 Affordability conclusion

In the medium to long-term, the preferred option represents an affordable option to MTW assuming commissioners fund the trust at full tariff. MTW will need non-recurrent support for the period 2022/23 to 2024/25 due to a combination of non-recurrent revenue costs, staff being employed ahead of opening and the ERF tariff not covering total costs.

7 The Management Case

Summary of this section of the OBC

- The trust and wider system have in place programme governance arrangements that reflect the need to report into the ICB and the trust. The governance structure also includes appropriate working groups
- Risk management and benefits realisation plans are in place to ensure successful project delivery
- Extensive engagement has been carried out
- Impact assessments have also been undertaken.

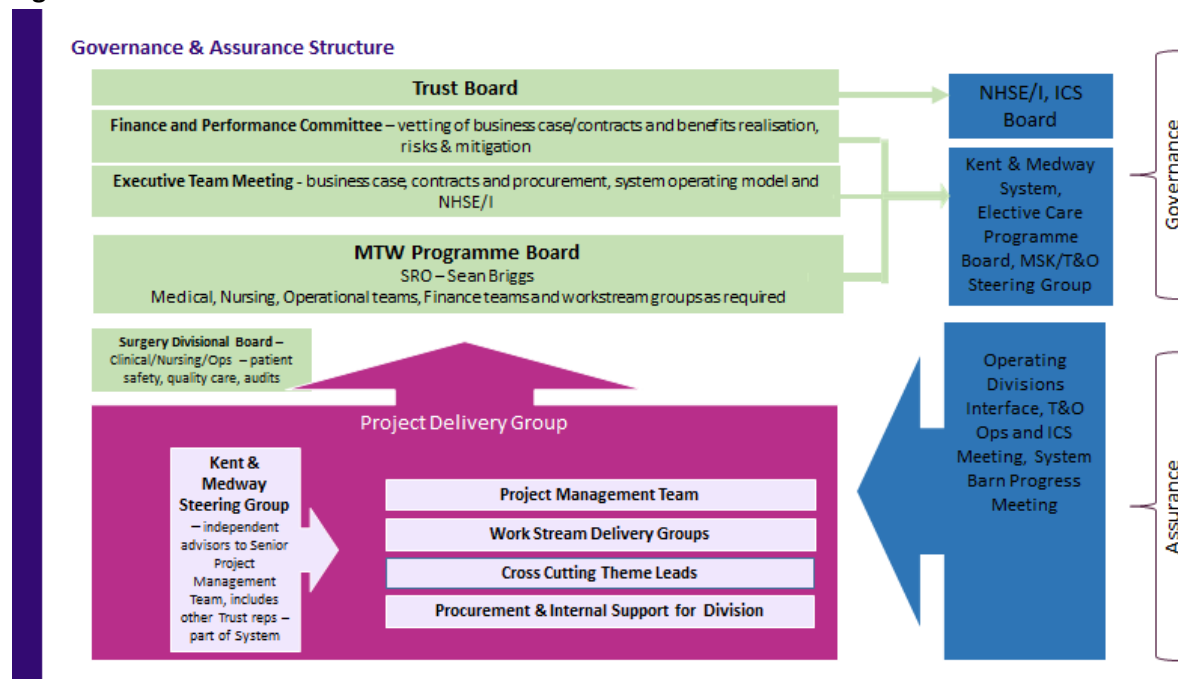
7.1 Introduction to the management case

This section of the business case describes how the project will be managed.

7.2 Governance arrangements

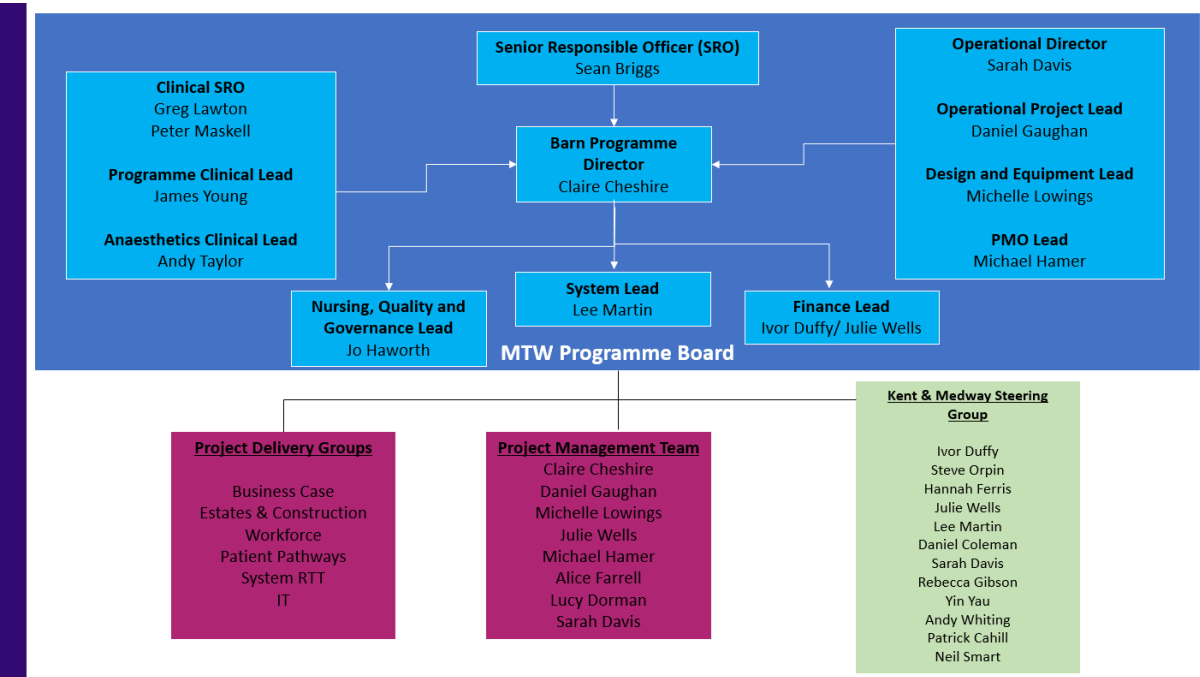
The project governance arrangements reflect the Kent and Medway system involvement in the project as well as delivery being focused on MTW.

Figure 22: Governance and assurance structure



The MTW governance structure is headed by the programme board, which is directly accountable to the MTW Trust Board, the Executive Management Team, Surgery Divisional Board and relevant committees.

Figure 23: MTW governance structure



The MTW Programme Board consists of a senior responsible owner (SRO), operational, clinical, nursing and quality, system and finance leads, and a programme director. The SRO is Sean Briggs, MTW’s Chief Operating Officer. The programme director, who will oversee the implementation and delivery of the project and who will be responsible for reporting weekly to the MTW executive team, is Claire Cheshire. The Clinical SRO is Greg Lawton, Chief of Service Surgery, who will ensure that the clinical pathways are agreed, signed off and who will undertake a quality impact assessment. The Operational Director is Sarah Davis, MTW’s Deputy Chief Operating Officer who is responsible for the delivery of the project operationally.

The programme board oversees the work of project delivery groups and the project delivery and progress teams. Daniel Gaughan is the dedicated operational project manager assigned to the project and has over 20 years of theatre experience both at a clinical and senior management level and has been involved in previous theatre projects. He will be supported by a project assistant and 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.

Harry Pluckrose is the dedicated contracting manager from Gardiner & Theobald LLP. This role oversees the contracted works and construction, and provides weekly progress reports.

Membership of the project workstreams is described below.

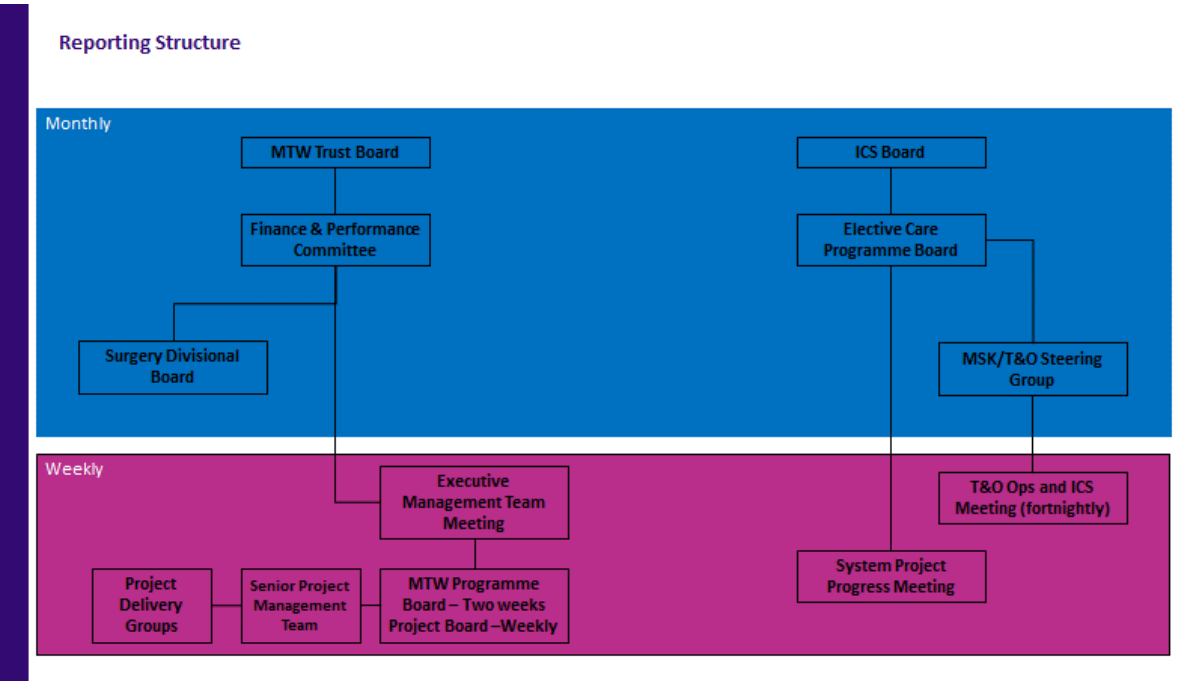
Figure 24: Project workstreams



Terms of reference for the project delivery groups, project team and programme group can be found in Appendix 12.

The programme spans MTW and the Kent and Medway ICB reporting into both organisations as per the reporting structure and frequency shown below.

Figure 25: Reporting structure



The control of changes (or variations) within a project and each phase, is vital to enable suitable control of the scope and budget. The project manager will maintain a log of all potential and instructed changes to the project. Divergence from the design brief or tendered design, or the increase or decrease in monies required to fund the design or construction of the works, will

constitute a change to the project. All changes to the project required by the users or any officer of the Trust will need to be authorised by the project director and project manager. The project manager in turn communicates changes to the PSCP.

The Trust is using a project management methodology which is fully aligned to PRINCE 2.

7.3 Project plan

The key milestones associated with implementation are set out below.

Table 60: Project milestones

Milestone	Date
RIBA Stage 2 Design complete	September 2022
OBC approval – MTW & K&M ICB and submitted to NHSE for approval	End July 2022
OBC approval – NHSE	August - October 2022
Materials procurement	October 2022 to April 2023
RIBA Stage 3 and 4 complete	November 2022
Market testing	November 2022 to January 2023
FBC approval – MTW & K&M ICB and submitted to NHSE for approval	January 2023
Enabling works	October 2022 to February 2023
FBC approval – NHSE	February 2023 to May 2023
Manufacture and Construction period	May 2023 to December 2023
Handover to Trust and operational commissioning	January 2024
Opening of new Facility to patients	1 st February 2024

The project timeline is based around achieving a number of ‘gateways’ and a continuous assurance process covering the period from opportunity identification to handover of the new facility.

Please see Appendix 13 for a more detailed Project plan.

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.

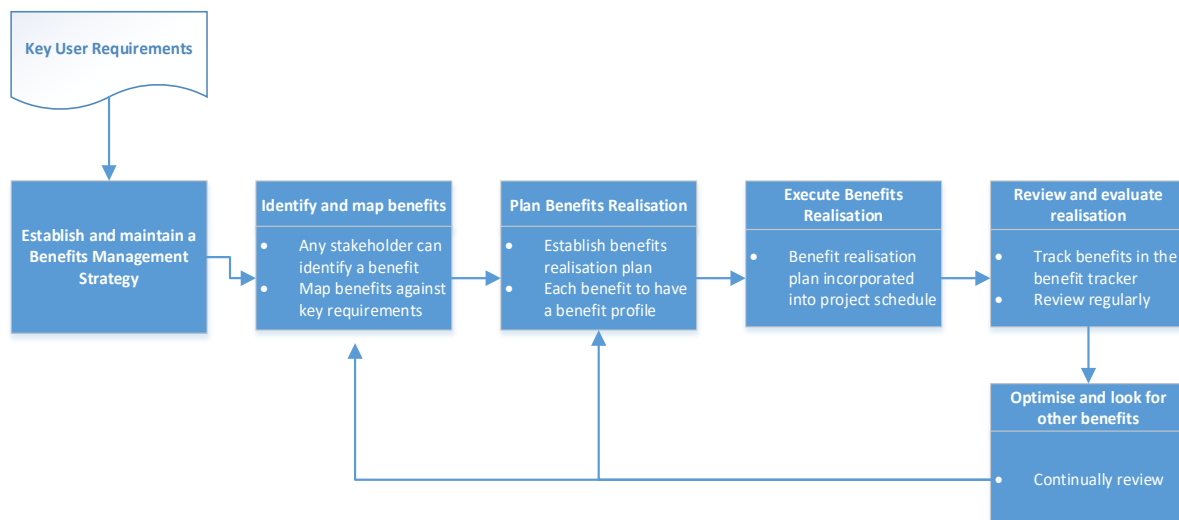
7.4 Benefits realisation

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 installation of the unit are aligned, and contribute fully, to the achievement of the benefits, both clinical and financial.

Figure 26: 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.

The desired benefits were described in the strategic case; delivery will be measured through ongoing monitoring of GIRFT and other performance metrics such as those listed in Appendix 14.

Performance will also be measured through use of the annual the data submitted to the National

Joint Registry (NJR) which is publicly available via the NJR website. This data can be filtered to be viewed either by hospital or surgeon to view 90-day mortality, revision rates and patient outcomes.

MTW already runs weekly theatre 6-4-2 scheduling and fortnightly theatre performance meetings to continuously monitor and improve performance; the barn theatres, once commissioned will be included in this process.

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 is appended as Appendix 15 and the top 3 risks, post mitigation, are reproduced below.

Table 61: Top 3 project risks

Category	Description	Likelihood	Impact	Current Grade	Mitigation Action(s)	Likelihood	Impact	Residual Grade
FBC	Increase to Capital Costs	5	5	25	The project team have reviewed scope reduction and value engineering to reduce the capital cost. Approval from Execs to complete and progress OBC for 3 Theatre option at £39.1m. T&T cost plan is based on RIBA Stage 2, and includes the corresponding contingencies for the stage of design.	4	5	20
Approvals	Delay to OBC and FBC approval periods impacting go-live date	5	4	20	Unmitigated as dependent upon NHSEI approval times lines to review and approve OBC/FBC. Trust to ensure swift response to any queries raised by NHSE.	5	4	20
Construction	Extended lead-times for IT equipment impact technical and operational commissioning	5	4	20	Monitor issue and place orders as soon as funding is available. Review alternative suppliers to identify equipment that is more readily available or on a shorter lead time	4	4	16

7.6 Change management

7.6.1 Communications and engagement

The trust recognises that the project will only achieve its objectives if the project is developed with an engaged set of staff and stakeholders. 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. 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. An engagement plan has been drawn-up and can be found, together with a write up of initial feedback, in Appendix 16.

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 other Kent and Medway providers have been engaged with and pledged support for utilising the Barn facility for their activity.

Engagement with the HOSC has been productive, with the agreement that this represents a significant opportunity to enhance patient access and the patient experience and are supportive of this case.

7.6.2 Workforce change

Service changes have the potential to create uncertainty for staff, they also have opportunity to enhance recruitment and retention with the opportunity to work in new clinician and patient designed facilities. Understandably staff may have concerns about

- New ways of working and new models of care
- Learning new skills
- Familiarising with a new environment in a live situation
- Impact on future career and development opportunity.

We are working to provide opportunities for staff to raise their concerns and provide opportunity to allay fears and worries.

A detailed people and workforce plan is in development to ensure that the trust recruits the staff needed ahead of the new facility becoming operational. The plan will factor in the workforce changes needed to deliver the new models of care and successfully meet patient demand including:

- Recruitment and retention strategy to ensure operation from Day One – supporting wellbeing and succession planning, inclusion and leadership to promote healthy workplace cultures
- Embedding new professional roles
- Designing and evaluating roles to maximise specialist skills and knowledge of clinically qualified staff.

The trust is committed to ensuring that all staff have the skills, behaviours, values and attitudes to deliver high quality services and have a healthy workplace culture. The workforce plan for the new unit will include measures to:

- Maximise the potential workforce by enhancing the practice of key support workers through vocational education and apprenticeships
- Ensure student and newly qualified practitioners are adequately supported in practice education and in situ training
- Provide a framework to develop advanced practice opportunities to support these new models of care
- Simulation training ahead of occupying the new facilities.

There are no TUPE arrangements necessary for this project.

7.6.3 Safe transfer

The project involves the transfer of patients on partner trusts' waiting lists to the MTW waiting list, and centralising adult elective orthopaedic services on the Maidstone Hospital site.

In the weeks leading up to handover and service transfer the following activities will be undertaken to ensure any risks to patients and staff are minimised:

- Date and time established for the move and the process for keeping services operational for during the transfer.
- Four weeks ahead of service operational, detailed clinical scenario testing to ensure that all staff are familiar with the layout, where items are located and how items work. There will also be practice runs of emergency situations, for example a cardiac arrest, not only ensuring the staff in the department but also first responders can access the department and identify where the emergency is.
- Training and competency assessments will be carried out for all staff on new or updated equipment once the equipment has been commissioned, early access has been requested to the clinical engineering room to support the commissioning.
- Other departments who provide support services to the areas will undertake familiarisation exercises in the facilities and ensure areas are stocked in preparation for becoming operational.
- Four to six weeks ahead of service operational patient representatives will be encouraged to provide feedback on the wayfinding and signage for the new facilities.

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: ACHIEVEMENT 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 Impact on health inequalities

As set out in the strategic case, health inequalities across the trust's catchment area can be linked to relative deprivation and there is a known under-presentation for orthopaedic treatment amongst BAME groups. By expanding the capacity of orthopaedic elective activity at Maidstone, MTW will be focusing this activity closer to the more deprived part of its catchment. The trust will also focus on schemes to understand the drivers for under-presentation in some communities to put in place ways of improving equity of access.

The other key driver of need for orthopaedic procedures is age and there is little difference across the catchment in the population's age profile meaning that the transfer from TWH to Maidstone should not negatively impact on older people.

7.9 Quality impact

The project's quality impact assessment can be found as Appendix 17.

7.10 Equalities impact

The equality impact assessment for the project can be found as Appendix 18. The project was assessed as having no overall negative impact on any group and a positive impact in four areas.

8 Conclusion

This business case sets out the optimal way to develop an orthopaedic centre of excellence at Maidstone Hospital. The proposed WKEOU will be a Kent and Medway resource available to all Kent and Medway providers to assist with elective recovery and expansion. In the medium-term the WKEOU will also 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*.

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

- The ICB will benefit from having capacity available 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 close to the most deprived areas within West Kent and readily accessible to the wider Kent and Medway population.
- 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 the theatre capacity freed-up by the transfer of elective orthopaedics.

The trust requires capital funding from NSHE to deliver this development; failure to obtain funding is the main risk associated with this proposal. 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 1 – GIRFT case studies

Appendix 2 – Capital OB Forms

Appendix 3 – Comprehensive Investment Appraisal (CIA) Model

Appendix 4 – Monetised benefits

Appendix 5 – WKEOU Operational and Planned Care Coordination Operational policies

Appendix 6 – 1:200 GA Plans and Concept Design Drawings

Appendix 7 – BREEAM Pre-assessment

Appendix 8 - Medical equipment schedule

Appendix 9 – List of IT equipment

Appendix 10 – Schedule of Accommodation

Appendix 11 – Travel assessment

Appendix 12 – Project groups terms of reference

Appendix 13 – 3 Theatre project plan

Appendix 14 – Performance metrics

Appendix 15 – Risk Register

Appendix 16 – Engagement Plan

Appendix 17 – Quality Impact Assessment

Appendix 18 – Equality Impact Assessment

Appendix 1 – GIRFT case studies

CASESTUDY 7

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 the 14 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.

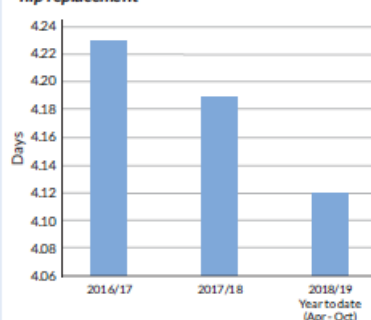
Thanks to the protection of the ring-fenced ward, it was possible to maintain elective activity throughout the winter period whilst having the flexibility to manage an increased emergency workload. As a result, the orthopaedic team only had to cancel two electives in the winter of 2018/19 in comparison 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.

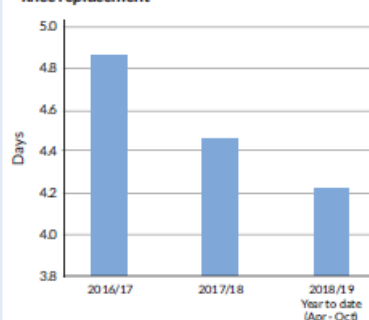
CASESTUDY 9

Benefits resulting from hot and cold site split at Royal Cornwall NHS Foundation Trust

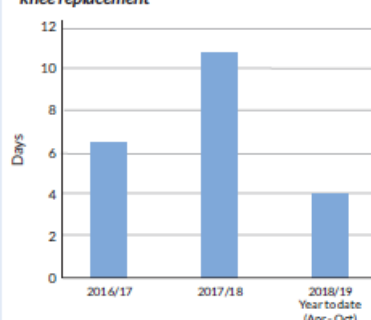
LOS for patients receiving elective primary hip replacement



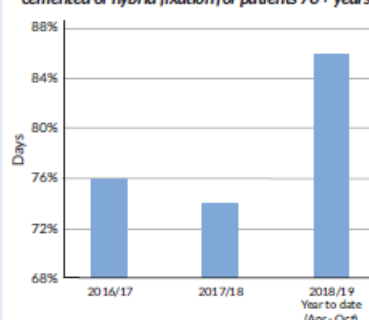
LOS for patients receiving elective primary knee replacement



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 2 – Capital OB Forms



MTW BT OBC Forms
1-4.pdf

Appendix 3 – CIA model



CIA_Barn Theatres
July 2022.xlsx

Appendix 4 – Monetised benefits



Benefits monetisation
for July OBC.xlsx

Appendix 5 – Operational policies



Operational Policy -
West Kent Elective Or



Planned Care
Coordination Operati

Appendix 6 – 1:200 GA Plans and Concept Design Drawings



02666A 3 Barn
Theatre drawings.pdf

Appendix 7 – BREEAM Pre-Assessment



X116 - Barn Theatre
Maidstone Hospital - (

Appendix 8 – Medical equipment



Equipment Barn.xlsx

Appendix 9 – IT equipment



IT Equipment
Barn.xlsx

Appendix 10 - Schedule of accommodation



3 Barn
Theatre_SoA.xlsx

Appendix 11 – Travel assessment

Available under separate cover

Appendix 12 – Project groups terms of reference

Available under separate cover

Appendix 13 – 3 Theatre Project Plan



220712 Barn
Theatres Strategic Pro

Appendix 14 – Performance metrics

<https://www.gettingitrightfirsttime.co.uk/bpl/orthopaedics/>

Key Performance Indicator (KPI)	Target
Productivity equivalent to 4 total hip or knee joint replacements in all-day list (8 hours)	4
Percentage of cemented or hybrid hip replacements for patients aged 70+	99.5%
Average length of stay for elective primary hip replacements	3.00
Emergency readmission following primary hip replacement within 30 days	3.2%
Average length of stay for elective knee replacements	3.0
Emergency readmission following knee replacement within 30 days	3.7%
Surgical site infection rate for elective primary arthroplasty	<1%
Orthopaedic surgery – day case rates (all procedures excluding total joint replacements)	93%
Orthopaedic surgery – Conversion from day case to inpatient stay	1.5%
On the day cancellation rate for elective orthopaedics for non-clinical reasons (benchmark)	0.8%

How will the performance of the different surgeons and other clinicians be monitored (in terms of e.g. re-admission rates, revision rates), particularly for those coming from other trusts – will this be done by the hub?

Annually, the data submitted to the National Joint Registry (NJR) is publicly available via the NJR website. This can be filtered to be viewed either by hospital or surgeon to view 90-day mortality, revision rates and patient outcomes (as displayed below). The quality of the data is also submitted and published to ensure the data is truly representative. All surgeons operating in the unit will need to be registered on the NJR under Maidstone Hospital.

<https://surgeonprofile.njrcentre.org.uk/HospitalProfile?hospitalName=Maidstone%20District%20General%20Hospital>

Furthermore, emergency readmission within 30 days will be monitored and benchmarked against the GIRFT target of 3.2% for primary hip replacements and 3.7% for knee replacements.



Hospital: Maidstone District General Hospital

Maidstone and Tunbridge Wells NHS Trust

► SURGEONS WITH ACTIVITY RECORDED IN NJR



► 12-MONTH PRACTICE PROFILE (1 YEAR)



► 36-MONTH PRACTICE PROFILE (3 YEAR)



▼ HIPS



▼ PATIENT IMPROVEMENT AND OUTCOMES



This information display shows you how this hospital compares to the national rates for a range of patient improvement and outcomes measures used to demonstrate quality in joint replacement surgery. Against each measure you will be able to see whether this hospital is performing better than expected, within the expected range or worse than expected for this type of surgery. This hospital is represented on the chart by the black marker.

It is important to note that the types of patients a hospital treats and the procedures it carries out can explain variation in patient outcomes after surgery. Please click on the "How to interpret this chart" button for further information.

Patient improvement

Patient improvement, featured in this chart, looks at three measures of patient-reported outcomes that are routinely assessed following hip/knee replacement in England. This information is not currently collected in Wales, Northern Ireland, the Isle of Man, Guernsey or the independent sector and as a result, no data is available to display.

The measures are referred to using their technical names 'Oxford hip/knee score', 'EQ-5D' and 'EQ-VAS' [click here](#) for a non-technical introduction to these.

Data for 1 April 2020 - 31 March 2021

Click on the to find out more about the quality measure and its source data

HOW TO INTERPRET THIS CHART

Patient Reported Improvement Measure	This Trust	Patient Records Analysed	Trust Avg Health Gain	National Avg Health Gain	Worse than Expected EXPECTED RANGE Better than Expected NATIONAL AVERAGE
Oxford hip Score	As Expected	56	24.83	23.01	
EQ-5D	As Expected	51	0.482	0.475	
EQ-VAS	As Expected	52	17.38	15.06	

Appendix 15 – Risk Register



Barn Theatre Project
Risk Register.xls

Appendix 16 – Engagement Plan and Feedback

Responsible	Who to engage	What for	How and when	Comments
Miles Scott/Sean Briggs	Wider MTW Trust,	To familiarise MTW with the proposal and design To check meets standards. Obtain evidence of support. To learn of any matters arising To keep the board up to date with progress.	Discussion at Executive Board and Trust Board obtaining written support, if possible, with relevant contact. CEO Trust wide communication weekly newsletter plus drop-in sessions Commenced (Jan 22)	Note: The engagement plan for specifically impacted MTW teams is detailed below.
Alice Farrell / James Young / James Nicholl	Orthopaedic directorate, including surgeons and nursing teams	Ensure design meets the required standard. Obtain evidence of support. To plan operational requirements including staffing. To learn of any matters arising.	Face to face meeting and via TEAMS followed up by written correspondence with regular monthly (min) updates on progress at directorate board. Commenced (Aug 21).	
Miles Scott / Amanjit Jhund/Sarah Davis	Kent & Medway ICP, including ops teams	To familiarise K&M ICP with the proposal and design To obtain written assurance the scheme meets expectations. Obtain written assurance of activity and pathways. To learn of any matters arising.	Phased series of discussions with relevant contact. Commenced (Dec 21)	Note: MTW Finance department will also be engaging with ICP on financial issues
Steve Orpin	Kent & Medway ICP	Financial flows arising from the shared activity.	Phased series of discussions with relevant contact including written evidence of allocation / timing/ flexibility if possible. (Jan 22)	
Amanjit Jhund	Clinical Commissioners	Notify CCG of intention and seek written statement of support and advise of progress of scheme	Discussion followed by written communication to CGG Strategy Director (Jan 22)	

Responsible	Who to engage	What for	How and when	Comments
Sarah Davis / Daniel Gaughan	Supporting teams within MTW, including theatres, radiology, decontamination, pharmacy and physiotherapy	To assess cross-divisional impact To familiarise MTW with the proposal and design To check meets standards. Obtain evidence of support. To learn of any matters arising. To plan operational requirements including staffing.	Task and finish groups for specific patient pathways e.g. admissions, theatres pathway and post-op care on the ward. Presentation at Clinical Ops and Directorate Boards (April 22)	
Daniel Gaughan	Patients	Keep patients up to date with progress of scheme. To learn of any matters arising.	Patient forums (April 22)	Note: Involvement from the patient experience team.
Sean Briggs	Members of Kent County Council	To update on the Barn Project and to seek support for the planning permission submission	Sean Briggs, Sarah Davis, Dan Gaughan and Michelle Lowings attended meeting on 22/04/22	Verbal support and submission advice given by Members of the Board
Bob Cook	HOSC	To familiarise HOSC with the proposal and design.	James Nicholl, Andy Taylor, Sarah Davis, Mark Atkinson and Rachel Jones attended HOSC on 11/05/22	Written confirmation given that the project does not necessitate a public consultation

Elective orthopaedic capacity needs to provide quality environment to allow surgical teams, in theatres and on the wards, to operate safely and efficiently in order to provide the best patient care.

Small task and finish groups were formed and a consultation exercise took place to identify the needs of surgical teams and their requirements for theatre and ward space. The design and layout of other recently built orthopaedic theatre facilities were reviewed in terms of what has worked well and what has worked less well.

Contact was also made with the estates project team and clinical colleagues at the Royal Free NHS Trust in London to learn from their experience on elective orthopaedics using a system wide model, design and the build of a new space and utilising barn theatres in practice.

From engagement and benchmarking, the key needs in the accommodation were identified as follows:

Review of Plan	Issue Identified	Outcome
Storage	The very strong message from both the ward and theatres team was that current storage was not sufficient and how this had a significant impact on patient flow and ability to optimise activity. The MTW theatres team emphasized that current storage was not sufficient. The Royal Free team had not planned enough storage and had to convert two recovery bays into extra storage.	Extra storage has been worked into the revised plan
Physiotherapy	Sufficient support staff on a 7-day rota would be crucial for ensuring our patients have a minimal length of stay following surgery. A physio room next to the ward was essential for supporting reduced length of stay.	Physio requirement has been revisited and wte confirmed
Radiology	Current staff timetables in some theatres don't match the full length of the theatre lists. The Royal Free also highlighted how the plan the lists to have lists requiring intense radiology to be at either end of their 4-theatre barn to minimise cross-radiation.	Radiology requirement revisited and wte confirmed
T&O Consultants feedback	Sufficient computer access to write up op notes etc. especially with a move away from paper notes is essential to reducing delays.	Plans reviewed and adjusted
Configuration of patient areas	Visibility of patients from a central nursing station was highlighted as essential.	Plans reviewed and adjusted. Although bays were preferred by clinical teams, HDM01 recommendations include to increase the number of single patient rooms to 50% as per updated guidelines. Patient flow considered with feedback from the nursing team, anaesthetics, theatres and surgeons.
Infection rates in barn theatres	The Royal Free stated verbally that their audits show no increased level of post-op infections (in fact post-op infection rate had decreased).	Communication with the T&O Consultants and this feedback given.
Location of the Barn Theatre complex	Advise from the Royal Free team was that the location should not be a long way from the acute site.	Advise considered when considering long options and TWH site not deemed a suitable estate for a Barn Theatre complex plus there are greenbelt limitations.

Appendix 17 – 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 08/09/21.	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes with feedback from Chase Farm.	
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:	

<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <input checked="" type="checkbox"/> Maintains quality Reduces quality
Clinical lead comments

Appendix 18 – Equality impact assessment



EIA
Assessment.docx

**To approve the Business Case for the development of a
community Diagnostic Centre (CDC) - Phase 2**

Deputy Chief Operating Officer

Please find enclosed the Business Case for the development of a community Diagnostic Centre (CDC) - Phase 2. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 26/07/22, 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, 12/07/22
- Finance and Performance Committee, 26/07/22

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

**Community Diagnostic Centres
Short Form Business Case Template
£5 to £15m Capital Schemes**

Note –there is one approval process for the capital & revenue allocations and this is the ‘Capital Delivery Oversight Committee’ CDOG.

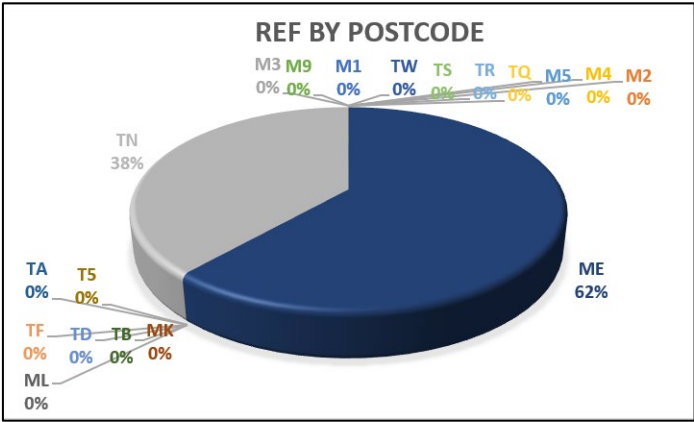
This purpose of this document is to provide the information required by the Capital Delivery Oversight Committee (CDOG) to approve CDC capital & revenue spend incurred in 2022/23 – 24/25

SECTION 1 - SCHEME DETAILS

PROJECT DESCRIPTION	Region Name	South East Region	
	ICS Name	Kent & Medway ICS	
	Lead organisation for the scheme	Maidstone & Tunbridge Wells NHS Trust (MTW)	
	What is this CDC to be called / named? <i>(name will be used as a unique identifier and should be XXX CDC)</i>	West Kent CDC – H7SOB	
	Full Name and Address of the Standard, Large and/or Hub site, to include postcode	Unit A, Hermitage Court, Hermitage Lane, Maidstone, Kent ME16 9NT	
	Name of the Spoke if this is a Hub and Spoke model, to include full address and postcode (if site identified). Add all Spokes on separate lines with full details	N/A	
		Postcode:	
Brief descriptor / overview of the scheme	<p>The West Kent CDC was successful in 2021/22 in gaining Early Adopter status, and has been active since 30th September 2021, offering cross-sectional radiology (MRI and CT) capacity, from Hermitage Court in Maidstone, using a staffed mobile scanner provision. Bridging funding has been awarded in 2022/23 to continue the activity already in place at the CDC site, and to galvanise the structure around this.</p> <p>This business case describes the on-going development of the West Kent CDC for Phase 2, from Years 2 (2022/23) to 5 (2025/26) to extend the scope of service provision at our existing CDC site at Hermitage Court in Maidstone to meet the full requirement of a standard model CDC, in line with guidance. West Kent CDC will deliver a comprehensive selection of radiological, cardio-respiratory and pathological diagnostics and will ensure that West Kent is able to provide the best standard of care for our patients and service users by meeting our associated targets.</p> <p>The additional capacity provided at the West Kent CDC site will allow for improvement against DM01 national diagnostic and cancer 28-day FDS standards, also allowing for sustainability by the additional capacity provided within the modalities proposed for inclusion into the site over the next 3 years.</p>		

The Hermitage Court site was identified as a preferred site in Summer 2021 and work has been undertaken to progress and finalise the lease whilst the cross-sectional activity has been online. Whilst considering site selection the following data was considered:

- Volume of referral per p/code
- Transport links for patients and staff
- Parking availability and cost
- Resource attached to estates costs



Location	Area	Population	% of ICP
Maidstone	Maidstone	113,137	24%
Royal Tunbridge Wells	Tunbridge Wells	57,772	12%
Tonbridge	Tonbridge and Malling	38,657	8%
Sevenoaks	Sevenoaks	29,506	6%
Ditton	Tonbridge and Malling	25,982	5%
Swanley	Sevenoaks	16,226	3%
Hartley	Sevenoaks	16,029	3%
Southborough	Tunbridge Wells	11,138	2%
Snodland	Tonbridge and Malling	10,211	2%
Edenbridge	Sevenoaks	8,172	2%
Paddock Wood	Tunbridge Wells	7,840	2%
6 Towns	All	4,000-7,500	9%
Other	Other	95,966	21%
Total		464,000	

The information above demonstrates population guide and referral information of CDC imaging modalities broken down by patient postcode. This confirmed that Maidstone (ME) is by far the largest user of the services.

Hermitage Court is well located, close to Maidstone Hospital, but on a completely separate Non-NHS site. It is superbly positioned in an area of comparative deprivation, having very good road access, dedicated parking, a station 5 minutes' walk away and a, soon to be, extended bus service linking Maidstone and Tunbridge Wells hospitals with Hermitage Court.

The expansion of the West Kent CDC will use the ground floor of Unit A at Hermitage Court (Initial 5-year lease has been signed), which is being designed to ensure we provide highly efficient facilities that can maximise the throughput. This facility is 6,125 sq.ft and will provide 12 clinical rooms, which will be allocated as follows:

- 2 x X-Ray rooms
- 3 x Ultrasound rooms
- 1 x DEXA room
- 1 x Echo room
- 2 x Phlebotomy rooms
- 2 x Spirometry and Phys Measurement rooms
- 1 x POCT room

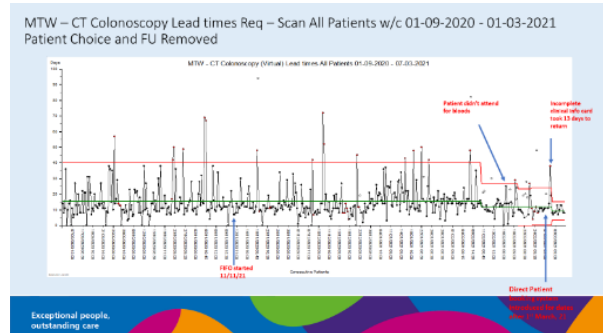
The refurbishment work is underway and due to complete in Summer 2022.

The cross-sectional provision (CT and MRI) will be housed within a modular building on the Hermitage Court site, owing to the size of the units; the modular build will also contain a cannulation area and sub-wait to ensure good flow and allow for efficiency of use. Work will commence on this transition in Q3 and in 2023/24 the modular space will also provide additional space for consultation clinic rooms, dedicated reporting facilities and staff areas.

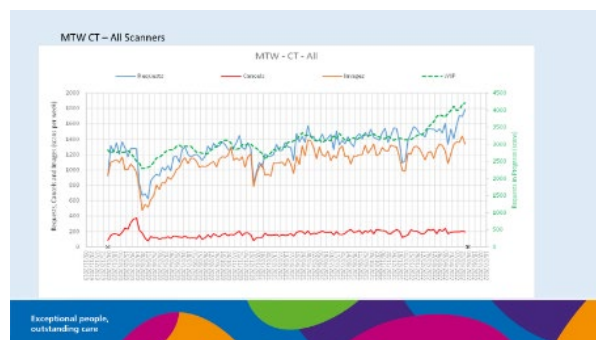
In addition to the clinical space, West Kent CDC at Hermitage Court will also house the Kent Imaging Academy hub which will provide facilities to train Radiologists, Radiographers and Sonographers (advanced practice) and also RDA's and Assistant Practitioners. The Academy's remote training systems/facilities will also allow for the provision of education for referring clinicians and possible MDT for one stop shop pathways. Staff will be able to actually see the impact of their part of the diagnostic pathway more clearly as more pathways are delivered from the facilities. It is relevant to note however that this is separately funded and therefore linked but out of the formal scope of this case.

The West Kent CDC will:

- achieve the 6 primary aims above by:
 - allowing patients access to planned diagnostic care nearer to home without the need to attend acute hospital sites.
 - separating these planned services to the urgent diagnostic scan facilities, patient waiting times for diagnostics will be shorter, together with a reduced risk of cancellation which can happen when more urgent cases take priority. Therefore, leading to improved patient experience and outcomes.
 - improving acute flow by removing the competing pressure of elective work
 - improving patient's environment and experience
 - improving staff facilities
 - improving IT integration
- provide services 12 hours a day, 7 days a week, 48 weeks per year
- provide a dedicated booking service to ensure efficiencies and consistency supported by the work undertaken using HCSE methodology
- Extend the excellent HCSE work undertaken within CT (detailed below) across diagnostic modalities to maximise efficiency
- CT Colonoscopy:
- Improved Flow : by reduced mean lead times from 15 days to 9 days for all patients irrespective of priority
- Improved Safety: all patients get diagnosis earlier leading to earlier treatment.
- Improved quality: Provided patient choice (Radiology GIRFT Recommendation 2)
- Improved Productivity: reduced cancellations and DNA's



- CT MTW:
- Diagnosed poor flow in CT, Measured Utilisation and Capacity & Demand
- Reduced the number of IP waiting for CT from 40 / week to 4 / week
- Reduced lead times for acute patients 30% 1 hour, 60% 2 hours, 95% 24hours



- Work to support and deliver new workforce models by extending the advanced practice within our AHP workforce, developing the reporting radiographer roles
- deliver additional, digitally connected, diagnostic capacity, providing all patients with a coordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways.
- have the capacity to deliver the following activity levels once fully operational (12 hours a day, 7 days a week, 48 weeks per year):

Modality	Activity per annum
X-Ray	54,835
Ultrasound	22,848
DEXA	8,568
MRI	15,137
CT	30,274
Phlebotomy	3,315
Echo (Cardiology)	5,100

To note:

- The West Kent CDC will be a standard CDC and therefore no endoscopy work will be undertaken on site.
- Activity levels are a combination of displaced elective activity in line with the recommendations within the Richards Review and additional capacity
- There will also be additional cardio respiratory capacity available at the CDC which is being modelled
- Phlebotomy activity is an area we expect to significantly grow; at the current stage we have only included a very basic level of information around specific primary care referrals; this is linked to ensuring we do not make patient pathways more difficult by removing access in either primary or acute settings. However when activity at the CDC grows, we expect the phlebotomy activity to increase at pace.

West Kent CDC and MTW as lead organisation are committed to working with the Kent and Medway Imaging Network Board and systems colleagues to ensure robust planning and progression which supports the our population and develops services.

This business case describes the on-going development of the West Kent CDC for Phase 2 - from Years 2 (2022/23) to 5 (2025/26) including the extension of services to meet the minimum service specification for CDCs.

The business case is requesting £9.9m capital in 2022/23 and a total of £30.6m of revenue for the next 3 years (2022/23 – 2024/25) from NHSEI. The revenue funding requested is in addition to the bridging funding received in 2022/23.

SECTION 1 - LEAD ORGANISATION DETAILS		
PROVIDE SENIOR RESPONSIBLE OFFICER (SRO) INFORMATION FOR THE SCHEME	Title	Executive Director - Strategy, Planning and Partnerships
	Name	Rachel Jones
	Organisation	Maidstone & Tunbridge Wells NHS Trust
	Office tel.	07826 531754
	Mobile tel.	07826 531754
	e-mail	Rachel.jones22@nhs.net
LEAD COMMISSIONER	Title	Director of Integrated Care Commissioning
	Name	Mark Atkinson
	Organisation	NHS Kent and Medway CCG
	Office tel.	07909 996993
	Mobile tel.	07909 996993
	e-mail	markatkinson@nhs.net
LEAD CLINICIAN	Title	Chief of Service for Core Clinical Services
	Name	Richie Chalmers
	Organisation	Maidstone & Tunbridge Wells NHS Trust
	Office tel.	01622 477579
	Mobile tel.	07887 870354
	e-mail	clairechalmers@nhs.net

Section 2: APPENDICES CHECKLIST	
APPENDIX	COMPLETED / ATTACHED (Y/N)
Appendix 1 – Estates	Y
Appendix 2 – Capacity Benefit of CDC Investment	Y
Appendix 3 – Planned Activity	Y
Appendix 4 – Digital & Connectivity	Y
Appendix 5 - Workforce	Y
Appendix 6 – Equipment Order & Cost	Y
Appendix 7 - Pathways	Y
Appendix 8 – Project Risk Log	Y
Appendix 9 – West Kent CDC Programme Timelines	Y
Appendix 10 – Post-Project Evaluation template	Y
Appendix 11 – Governance and Quality Impact Assessment	Y

SECTION 3: PROJECT DELIVERY OVERVIEW

DELIVERABILITY ASSESSMENT

DELIVERY AND TIMETABLE

Please set out the anticipated commercial and procurement route, and provide a simple timeline with key milestones for the procurement and delivery of the scheme

Please give a go live date for each modality you are asking to be funded

A timeline with key milestones is as follows:

Milestone	Date
Early adopter funding award	July 2021
Go live of cross-sectional activity at Hermitage Court	September 2021
Bridge funding awarded for 2022/23	March 2022
Works to be completed on Unit A	September 2022
Extension to MRI capacity	April 2022
Submission of Phase 2 BC to BCRP > F&P > Trust Board	July 2022
Submission of funding application to NHSE (via Network)	End July 2022
Outcome of SFBC	August 2022
Approval of FBC based on final capital quotes	September 2022
Orders placed for equipment	End of September 2022
IT items lead times (estimate – as unknown)	Until March 2023
X-Ray, US, DEXA live onsite	April 2023
Pathology Diagnostics, Echo (Cardiology) live onsite	April 2023
CDC fully operational 8am-8pm 7 days/ week	January 2024

The current assumption is that the extension of services in the West Kent CDC will come online April 2023. This is largely driven by the long lead time on IT items including CISCO Data Centre Switches; this is a global supply chain issue which is already escalated to government level with agreement that blue light industries such as health will be prioritised.

It is relevant to note that the refurbishment of Unit A will be complete by Q3 and the clinical facilities will be ready with the exception of IT support. Work is ongoing to mitigate risk and if this is possible, we will look to draw in some activity as recruitment allows.

Taking into account both the equipment and IT lead times, and the recruitment challenges, the plan for the first year of operation is:

Go live date	April 2023
Monday to Friday 9am – 5pm	April – June 2023 (Q1)
Monday to Sunday 9am – 5pm	July – September 2023 (Q2)
Monday to Friday 8am – 8pm, Saturday and Sunday 9am – 5pm	October – December 2023 (Q3)
Monday to Sunday 8am – 8pm	From January 2024

RISKS TO DELIVERY

Please set out the main potential risks to delivery and mitigating actions to address these.

Also please complete the standard Risk Matrix for the proposed scheme and attach as an appendix.

The key risks to delivery are as follows:

Staffing availability - There is a national shortage in Radiology workforce. We have mitigation plans including overseas recruitment, apprenticeships etc. We are securing our apprenticeship schemes for medium to long term staffing solutions and for short term we are working with a recruitment partner in India to identify and train radiographers. Overseas recruitment is ongoing with the first cohort of staff in the pipeline and further progression and interviews with our recruitment partner planned for July and August 2022.

Availability of IT equipment - There are significant global supply chain issues for certain IT equipment, such as the data centre switches, which is causing significant lead times. The shortage specifically relates to the chips required and has been further impacted by the conflict in the Ukraine, where 90% of the neon gas used in the production of the chips is produced. Whilst mitigation work is underway and the potential delays have been factored into our phasing, the risk remains.

Please see Appendix 8 for the full risk register.

SECTION 4: FINANCIAL OVERVIEW. NOTE THAT REPORTING BACK MONTHLY ON PROGRESS AGAINST CAPITAL FUNDING WILL BE EXPECTED MONTHLY

FUNDING SOURCES		
PLEASE SET OUT ALL FUNDING SOURCES FOR THE PROJECT	DHSC PDC £	£9,872k
	Other (please specify) £	-
	Total £	£9,872k

CAPITAL EXPENDITURE PROFILE								
FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
DHSC PDC funded capital expenditure				£9,872	£9,872			£9,872
Other (<i>specify</i>)								
Total				£9,872	£9,872			£9,872

BREAKDOWN OF SCHEME CAPITAL COST (using OB Form headings)								
FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
Works Costs				£3,616	£3,616			£3,616
Fees								
Non-Works Costs								
Equipment Costs				£3,863	£3,863			£3,863
Optimism bias								
Planning contingency				£748	£748			£748
Inflation Adjustment								
VAT				£1,645	£1,645			£1,645
Total				£9,872	£9,872			£9,872

Please provide a narrative on the basis of the costs e.g. tendered costs, PUBSEC indices, cost advisor reports. Please STATE the following:	
1) PUBSEC Indices used:	N/A
2) Basis of the costs: HPCG / benchmark rates from cost advisor / tendered costs / schedules of rates / previously tendered rates.	Equipment costs currently based on estimates.
3) Cost advisor Review of the vfm / procurement process.	N/A

The capital requirement is currently based on estimates and is as follows:

	Cost	VAT	Total	Number required	Total inc VAT	Expected Economic Life
Building						
MRI & CT Modular building	£3,616,000	20%	£4,339,200	1	£4,339,200	25
Equipment						
Canon CT 160 slice mid specification	£434,800	20%	£521,760	1	£521,760	10
Canon CT ONE slice high specification	£855,124	20%	£1,026,149	2	£2,052,298	10
CT Injector	£25,000	20%	£30,000	3	£90,000	10
Pre-installation costs (Unit A) inc professional fees	£700,000	20%	£840,000	1	£840,000	5
Siemens X-ray	£155,000	20%	£186,000	2	£372,000	10
AGP/Spirometry room - Spirometry booths	£50,000	20%	£60,000	2	£120,000	7
Samsung US/Echo system	£70,000	20%	£84,000	2	£168,000	5
Radiologist workstations	£15,000	20%	£18,000	4	£72,000	5
Unit A IT equipment	£232,360	20%	£278,832	1	£278,832	5
Access control/nurse call/fire/alarm estimate - supply and installation of systems	£100,000	20%	£120,000	1	£120,000	5
Contingency (Costs based on estimates - Inflation impact)					£897,409	
TOTAL CAPITAL					£9,871,498	

To note:

- Based on current quoted lead times and SFBC approval timescales, we would require all of this capital funding in 2022/23.
- The MRI service will be provided via a managed service. The MRI Managed Service business case was approved by NHSEI South East Region in June 2022. Therefore, there is no capital requirement for MRI equipment.
- A third CT scanner has been included to ensure adequate capacity throughout Trust sites and CDC to support acute / elective split and to ensure complex scanning and clinical changes of practice can be supported.
- The lease of Unit A, Hermitage Court falls under the new IFRS 16 accounting treatment. This has been included as part of the Trust's 2022/23 planning submission to NHSEI and the capital impact has therefore been excluded from this business case.
- The current lease of Unit A, Hermitage Court is for 5 years. The Modular building has a longer life than 5 years, but can be moved or repurposed if required.
- A 10% contingency has been included as these are currently estimated costs, and noting the current inflationary pressures being seen nationwide.

STATEMENT OF COMPREHENSIVE INCOME				
Incremental impact of scheme on the SOCI of lead organisation				
	2022/23 £'000	2023/24 £'000	2024/25 £'000	Total £'000
Revenue costs				
Pay & Non-Pay	(£1,076)	(£13,061)	(£13,453)	(£27,589)
Transport costs				
Depreciation	(£202)	(£1,071)	(£1,071)	(£2,344)
PDC dividends	(£9)	(£339)	(£309)	(£657)
Other				
Cash-releasing benefits				
Incremental impact on I&E surplus/ (deficit)	(£1,286)	(£14,471)	(£14,833)	(£30,590)

To note:

- The revenue funding requested in 2022/23 is in addition to the bridging funding received.
- 3.5% inflation (in line with NHSEI recommendations) has been applied in the financial modelling, though this is currently unpredictable and therefore a risk in the financial modelling.
- Non-pay in 2022/23 includes non-recurrent expenditure for non-capital set up costs and recruitment fees.
There is also some non-recurrent non-pay in 2023/24 for recruitment fees and the CT staffed service charge (which from January 2024 will convert to a trust-run (and staffed) service)
- A 11.20% contribution to Corporate overheads has been included.

A further breakdown of the revenue implications is as follows:

REVENUE COST SUMMARY					
£000s	Rec/Non-Rec	2022/23	2023/24	2024/25	Comment
Pay costs	Recurrent	£212	£4,925	£6,832	Staffing requirement – calculated by room, by modality plus admin, management and support staff
Pay Costs - Agency Premium	Recurrent		£764	£1,059	
TOTAL PAY		£212	£5,689	£7,891	
Consumables	Recurrent		£901	£1,001	Based on forecasted activity
MRI Managed Service	Recurrent		£1,687	£1,746	Business case approved by NHSEI June 2022. CDC activity will be additional activity to that included in the MRI MSA Business Case.
CT Staffed Service	Non-Recurrent		£2,012		Until December 2023 then transfer to Pay/Consumables cost
Maintenance Contracts	Recurrent		£20	£467	Estimated at this stage
Printing/Stationery/Postage	Recurrent		£159	£201	Based on forecasted activity
Recruitment Costs	Non-Recurrent	£77	£569	£59	Estimated costs associated with recruiting 50% of staff from Overseas
Set-up costs (non-capital)	Non-Recurrent	£373			Includes furniture, IT and other equipment <£5k
Heat/Light/Power	Recurrent	£250	£569	£589	Estimated at this stage
Other (Training, IT, Unit A insurance etc)	Recurrent	£55	£139	£144	Minor categories of spend
TOTAL NON PAY		£755	£6,056	£4,207	
Capital Charges	Recurrent	£211	£1,410	£1,380	
Contribution to Overheads	Recurrent	£108	£1,316	£1,355	11.20%
GRAND TOTAL		£1,286	£14,471	£14,833	

STATEMENT OF COMPREHENSIVE NET INCOME				
Whole Trust Position including the Investment over the Appraisal Period				
	2022/23 £'000	2023/24 £'000	2024/25 £'000	Total £'000
Gross employee benefits	(£372,383)	(£388,552)	(£392,159)	(£1,153,094)
Other operating costs	(£238,232)	(£252,027)	(£251,338)	(£741,597)
Revenue from patient care activities	£589,985	£580,432	£582,754	£1,753,172
Other operating revenue	£40,605	£41,162	£41,985	£123,752
Operating surplus/(deficit)	£19,974	(£18,984)	(£18,757)	(£17,767)
Investment revenue	£50	£50	£50	£150
Other gains and losses	£0	£0	£0	£0
Finance costs	(£16,752)	(£18,068)	(£18,527)	(£53,348)
Surplus/(deficit) for the financial year	£3,272	(£37,002)	(£37,234)	(£70,965)
Dividends payable on public dividend capital (PDC)	(£5,774)	(£6,261)	(£6,390)	(£18,426)
Net gains/(loss) on transfers by absorption	£0	£0	£0	£0
Retained surplus/(deficit)	(£2,502)	(£43,263)	(£43,625)	(£89,390)
Adjustments (including PPA, IFRIC 12 adjustment)	£1,216	£1,216	£1,216	£3,648
Adjusted financial performance retained surplus/(deficit)	(£1,286)	(£42,047)	(£42,409)	(£85,742)

SECTION 5: FIVE CASE MODEL PROJECT DETAIL

STRATEGIC CASE (MAX 1000 WORDS IN EACH SECTION)

a) Please set out the strategic rationale and case for change and local strategic context taking into account digital strategy.

Approximately 85% of patient pathways include a diagnostic investigation and the provision of timely access to these services are pivotal to the majority of diagnostic and treatment pathways across the Trust in both elective and non-elective settings, and underpins the diagnosis and staging of cancer(s). With the introduction of the 28-day diagnostic standard, the ability to access diagnostic investigations with much shorter turnaround times than we have historically provided is required. The diagnostic services have a significant demand and capacity deficit which has increased over recent years, driven by increased demand and a challenged staffing provision. This has result in a significant volume of outsourcing to independent sector providers at significant cost and significant growth in backlog.

The creation of CDCs was recommended following Professor Sir Mike Richards' review of NHS diagnostic capacity. CDCs are created in free standing locations away from main hospital sites, and will allow patients to access planned diagnostic care closer to home without the need to access acute hospital sites. These services would be separate to urgent diagnostic scan facilities, which means shorter waiting times, easier access to tests and a reduced risk of cancellation which can happen when more urgent cases take priority. Therefore leading to improved patient experience and outcomes.

The West Kent CDC was an Early Adopter (EA) site and has been active since 30th September 2021, offering cross-sectional radiology (MRI and CT) capacity, from Hermitage Court in Maidstone, using a staffed mobile scanner provision. This business case describes the on-going development of the West Kent CDC to extend the scope of service provision at our existing CDC site at Hermitage Court in Maidstone to meet the full requirement of the CDC in line with guidance. This will ensure that West Kent is able to provide the best standard of care for our patients and service users by meeting our associated targets.

The West Kent CDC will deliver additional digitally connected, diagnostic capacity, providing all patients with a coordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of a clinical pathways.

Success of CDCs is dependent on the digital connectivity between diagnostic IT systems and organisations across health systems to allow the appropriate sharing of information. Work is underway with partners to ensure seamless connectivity between the West Kent CDC and Primary and Secondary Care.

The key objectives of the investment are:

- Improve access for patients to diagnostic services by providing earlier access
- Improve flow for patient by separating acute and elective flow
- Support the integration of care between primary, secondary and community care
- Improve and sustain national diagnostic targets against the 99% standard for recovery.
- Reduction in the amount of patient long waiters above 6 weeks awaiting their scan.
- Improvement in national cancer standards against 28-days FDS.

<p>b) Please explain how this scheme will contribute to the delivery of the CDC overall programme aims.</p>	<p>CDCs have six primary aims, as follows. An explanation of how our investment will contribute to achieving these aims is also included:</p> <p>To <u>improve population health</u> outcomes by reaching earlier, faster and more accurate diagnoses of health conditions. <i>Separating the acute and elective flow for diagnostics, together with dedicated additional diagnostic capability, will allow earlier and faster diagnosis for the patients of West Kent.</i></p> <p>To <u>increase diagnostic capacity</u> by investing in new facilities, equipment and training new staff, contributing to recovery from COVID-19 and reducing pressure on acute sites. <i>The West Kent CDC programme is investing in new additional diagnostic equipment and facilities in order to increase diagnostic capacity. We are developing the radiology academy on site to develop among other things post graduate radiography e.g. reporting and assistant practitioner training. We are also engaged in a significant level of international recruitment (The Trust have a very successful track record in recruiting nursing staff from India). The dedicated facilities in the CDC will support Covid 19 recovery and help in the plan to bring activity to 120% of pre-pandemic levels, thus relieving the pressures on both the Maidstone and Tunbridge Wells acute sites. The Trust will be able to monitor this activity against DM01 national standards and cancer 28-days FDS.</i></p> <p>To <u>improve productivity and efficiency</u> of diagnostic activity by streamlining provision of acute and elective diagnostic services where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication. <i>A key focus in West Kent will be to streamline the processes and improve the efficiency of the pathways, reducing the number of visits a patient has to make to ultimately gain their diagnosis. We are developing several key pathways that will help us demonstrate the methodology and scale up this process (eg breathlessness, long covid, targeted lung health check, shoulder pain, acute knee pain). The site will have the range of diagnostic test in the one location that will allow for multiple tests on one visit and ultimately leading to one stop services in some pathways where appropriate. For example, our CT and MRI facility is being designed in a modular format and will allow maximum efficiency and throughput whilst also focussing on patient and staff comfort.</i></p> <p>To <u>contribute to reducing health inequalities</u> driven by unwarranted variation in referral, access, uptake, experience and outcomes of diagnostic provision. <i>The CDC programme will utilise iRefer as its referral decision making tool linked with a networked order comms solution allowing clear correct and appropriate referrals from all referring clinicians and a key part of the service will be education for referring clinicians to further improve the quality of referrals and therefore reduce inequalities and provide a better diagnostic experience.</i></p> <p>To <u>deliver a better and more personalised diagnostic experience</u> for patients by providing a single point of access to a range of diagnostic services in the community. <i>The CDC service will deliver a better more planned and 'joined up' diagnostic service than is currently delivered, as the new service will centre on Hermitage Court. Pathway redesign focused on symptoms (breathlessness/pain/MSK) to drive better patient experience and joined up care via localised service delivery, close to home with minimal appointments.</i></p> <p>To <u>support integration of care</u> across primary, community and secondary care. <i>To be successful the CDC programme must integrate primary and secondary care much further than is achieved currently. IT systems will play a major part in this integration but a significant lever in integrating the services across all parts of the health landscape will be better more efficient pathways and improved communication between clinicians. Clinical pathway redesign being developed with engagement from all system partners, overseen by West Kent CDC Task & Finish group driven jointly by Trust and Primary Care clinical leadership.</i></p>
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<p>c) Provide confirmation of stakeholders e.g. support from clinicians, commissioners and ICS accountable officers (formal letters of support to be appended to this business case template).</p>	<p>The West Kent CDC scheme is supported across the locality, Maidstone and Tunbridge Wells NHS Trust, West Kent ICP, Kent ICS, ICS Imaging Board, local consultants and GP's.</p> <p>The West Kent network has undertaken due diligence on the diagnostic requirements/gaps/innovation required in the West Kent locality.</p> <p>The proposed model has been developed following stakeholder engagement, which included a workshop with representatives from; West Kent providers, including the independent sector, Commissioners, IT specialists, K&M Imaging Network, Regional NHSE/I team, and Estates specialists, together with the current operational experience we have gained from our Early Adopter service.</p>
ECONOMIC CASE	
<p>a) Please submit a VFM template with this business case template.</p>	<div data-bbox="598 568 654 631" data-label="Image"> </div> <p>CDC SFBC Template VFM Model FINAL.xls</p>
<p>b) Please provide an incremental VFM analysis that shows the VFM ratio (Net Present Social Value) for Business As Usual and the preferred option and provide an explanatory narrative on the VFM analysis.</p>	<p>The VFM template above articulates the financial and economic cases for the West Kent CDC.</p> <p>The analysis sets out the costs and benefits of the preferred option, and shows a VFM ratio of 1.06 reflecting a saving to the public purse over the 25 year life of the project.</p> <p>A Business as Usual case has not been analysed in the VFM template as this proposal describes an increase in diagnostic capacity. Without this, the system would have to increase outsourcing in order to deliver the activity described, or would continue with just cross-sectional provision at Hermitage Court and become a 'spoke' for a larger alternative CDC.</p> <p>The monetisable benefits are currently based on a comparison to if we provided the equivalent CDC capacity as a Staffed service (CT), Managed service (MRI) and outsourced all other modalities. It is difficult to quantify other economic benefits of providing additional capacity at the West Kent CDC at this stage.</p> <p>Unmonetisable benefits and risks are also clearly articulated in the template.</p>

<p>c) Provide a narrative on:</p> <ul style="list-style-type: none"> - The options considered to achieve the scheme's objectives, including business as usual. - The process through which the long-list of options was narrowed down to the preferred option. - The main costs, benefits and risks for the Business As Usual and preferred option. - The appraisal period for the scheme. 	<p>The options considered were:</p> <ul style="list-style-type: none"> • Option 1 - Continue with the cross-sectional (CT and MRI) provision at Hermitage Court and become a 'spoke' for a larger, alternative CDC. • Option 2 - Extend scope of the CDC at Hermitage Court, to meet full requirements of a CDC, in line with guidance. <p>The option to close the CDC was considered and discussed with both Executive colleagues within the Trust and Network colleagues. However, it was agreed that this should not be considered an option owing to the significant demand concerns and national picture.</p> <p>The risks and benefits associated with the 2 options considered are as follows:</p> <p><u>Option 1: Continue with just cross-sectional provision at Hermitage Court:</u></p> <p>Risks:</p> <ul style="list-style-type: none"> • Unused space within Unit A due to inability to house CT and MRI • Inability to meet 120% 2019/20 activity and DMO1 without extension to NOUS and DEXA • Loss of full CDC potential • Potential loss of academy <p>Benefits:</p> <ul style="list-style-type: none"> • More flexibility associated with 'spoke' – minimum service specification does not apply • Supports cross sectional recovery, leading to a reduction in outsourcing <p><u>Option 2: Extend scope of CDC to cover full service provision</u></p> <p>Risks:</p> <ul style="list-style-type: none"> • Staffing levels within broader diagnostics sector outside of radiology • Staffing within radiology and overseas timeframe <p>Benefits:</p> <ul style="list-style-type: none"> • Staff development and retention • Clinical / pathway development opportunity • Activity level compliance 120% • DM01 performance improvement • Improvement in national cancer 28-day FDS standards for patients awaiting a diagnostic scan within the CT/MRI modalities. • Improved TaT to scanning • Opportunity to support 'network' approach to excess capacity • Elective / non-elective split supports flow • Improved DNA rate • Patient experience – reduced on site delays from interruption • Patient experience – improved privacy and dignity • Patient experience – extended hours give greater flexibility • Opportunity to cohort tests <p>The preferred option is to extend the scope of service provision at our existing CDC site at Hermitage Court in Maidstone to meet the full requirement of the CDC in line with guidance. As it stands, the current service provision at the West Kent CDC does not comply with the minimum diagnostic set as laid out in the Richards review; as such the options would be to close the service completely or become a 'spoke' for a different/alternate 'Hub'.</p> <p>If we do not extend the scope of the West Kent CDC, the impact is:</p> <ul style="list-style-type: none"> • Inability to meet the recovery target of 120% of 2019/20 activity without significant outsourcing • Inability to meet DM01 compliance owing to increased demand on private providers who provide outsourced capacity • Increased number of long waiters (>6 weeks) awaiting a diagnostic scan.
<p>d) Confirm inflation, VAT, depreciation, PDC are excluded from the economic analysis.</p>	<p>Confirmed</p>

COMMERCIAL CASE	
a) Please set out the commercial and procurement route, e.g. P22.	<p>MTW's Procurement Department are supporting the development of the West Kent CDC. The Medical equipment will be procured via the NHS Supply Chain Managed Equipment and Clinical Service Solutions (MECSS) Framework.</p> <p>The MRI / CT Modular building will be procured through the SBS - Modular Buildings framework. This framework supports modern premanufactured building methods that reduce waste on site and have a shorter construction time.</p>
b) Set out the basis of the negotiated position, including the final price for the works.	A capability assessment will be undertaken for the modular build to ensure the potential suppliers have the capability to deliver the project on time. The framework also offers the option of direct award or mini competition.
c) Confirm status of any legal documentation or processes required for the scheme to be delivered in full and what (if anything) remains to be agreed.	<ul style="list-style-type: none"> • 5 year lease has been signed and agreed on Unit A, Hermitage Court • Managed MRI contract is being progressed but not yet signed; likely timeframe 3 - 4months.
d) We assume that Modern Methods of Construction (MMC) will be used for new builds. Please provide details of how MMC will be utilised.	<p>Yes, MMC will be utilised for the Modular Building that will home CT and MRI and also where possible in the refit of Unit A.</p> <p>The superstructure and finishes, including the fit-out, of the prefabricated modular building will be undertaken by a specialist modular contractor. MMC will be a requirement in the tender for our Modular Building. The fabrication is predominantly undertaken off site, to reduce construction time, promote sustainability and reduce costs. It also reduces the time on site, allows for more stringent quality control and reduces waste. The modular building sections will be transported to site by truck, and lifted into place, followed by a period for installation, finishing and commissioning.</p>
e) Confirm contribution to carbon reduction plan (if applicable). (net zero, Greener NHS etc)	<p>The West Kent CDC will aim to contribute to the NHS Net Zero in a number of different areas. On a broad scale, refurbishing an existing facility rather than building new will limit the carbon footprint of the scheme relative to that option. It does however introduce challenge in creating a carbon efficient environment and this challenge has been considered during the design process; with efforts made to progress green efficient options.</p> <p>In addition, consideration is also given to direct interventions within estates and facilities, travel and transport, supply chain and medicines by way of minimising transport and travel both for staff and equipment utilising existing routes, keeping extension of transport to a minimum and using shared transport methods such as staff bus services which is supported by the location of the West Kent CDC. We also have the aim, in line with CDC guidance, to reduce patient journeys by cohorting diagnostic testing in a supportive way.</p> <p>It is recognised that as part of the CDC development, there is also a need for improved waste and recycling facilities to be implemented such as reduced use, improved waste management, sorting, reusing and recycling, with some suggestions relating to clinical and non-clinical equipment. Ideas include ensuring multi-use equipment where possible, such as reusable sharps bins. Applying circular economy principles to waste management was also proposed, by fixing, rather than replacing, broken equipment (non-clinical) such as chairs, flooring and office equipment.</p> <p>In addition by working towards negotiated bookings, the opportunity to go paperless is also being progressed, with suggestions around a digital-first approach and stopping paper letters.</p>

FINANCIAL CASE

a) Please provide narrative to support the detail provided in Section 4 (above).

Capital requirements

The estimated capital requirement is £9.9m. Based on current quoted lead times from suppliers, and subject to a rapid approval process, we would require all of this capital funding in 2022/23. Orders would need to be placed by the end of September 2022 to ensure delivery by the end of March 2023 and the capital spend incurred in 2022/23.

An itemised breakdown is provided in both Section 4 and Appendix 6.

Key assumptions:

- A 10% contingency has been included as these are currently estimated costs, and noting the current inflationary pressures being seen nationwide.
- There is no capital requirement for MRI equipment as the MRI service will be provided via a managed service (MRI Managed Service business case was approved by NHSEI South East Region in June 2022).
- The lease of Unit A, Hermitage Court falls under the new IFRS 16 accounting treatment. This has been included as part of the Trust's 2022/23 planning submission to NHSEI and the capital impact has therefore been excluded from this business case.

The Trust was successful in receiving Early Adopter status for the West Kent CDC in 2021/22, with associated revenue funding. Bridging revenue funding has also been received in 2022/23. It should be noted that there has been no capital funding allocated or capital spend incurred to date for West Kent CDC.

b) Please explain any incremental revenue consequences of the investment and how they can be mitigated.

Revenue implications

The revenue requirement for the West Kent CDC for the next 3 years (2022/23 – 2024/25) is £30.6m. The revenue funding requested is in addition to the bridging funding received in 2022/23.

Key assumptions include:

- 3.5% inflation (in line with NHSEI recommendations) has been applied in the financial modelling, though this is currently unpredictable and therefore a risk in the financial modelling.
- Pay costs are based on the staffing requirement for each modality to deliver the activity levels stated in the business case. Management, administration and support staffing costs have also been included. Modelling has been based on 90% substantive, 10% temporary staffing.
- Non Pay costs include consumables (activity related), equipment maintenance, MRI Managed Service costs and Heat/Light/Power. It also includes non-recurrent costs. These are as follows:

£000s	2022/23	2023/24	2024/25	Comment
CT Staffed Service		£2,012		Until December 2023 then spend converts to Pay
Recruitment Costs	£77	£569	£59	Costs of recruiting 50% of staff from Overseas
Set-up costs (non-capital)	£373			Includes furniture, IT and equipment <£5k
TOTAL	£450	£2,581	£59	

- Capital charges relating to the capital investment have been included.
- A 11.20% contribution to Corporate overheads has been included.

The revenue implications have been reviewed and challenged (where required) by the Divisional Management Team.

Bridging funding: £5.7m of bridging funding was awarded to the Trust in 2022/23 to continue with activity already in place at the CDC site (cross-sectional radiology) and to galvanise the structure around this; including stabilising the onsite contrast cover with an RMO rotation. No further development of CDC activity is supported by the bridging funding. Activity and costs relating to MRI and CT in 2022/23 has


	been excluded from this business case, as they are covered by this bridging funding. Revenue costs requested for 2022/23 are in relation to extending the West Kent CDC to other modalities beyond CT/MRI.
c) Are there any cash flow issues, such as fees, enabling works, that require early funding?	Owing to the significant delays associated with the global supply chain issues experienced specifically with IT equipment such as the Cisco Data Switches, it would be supportive to place these orders as soon as possible to ensure that the timeframes are mitigated.
d) Confirm that the project can be managed within existing funding envelopes.	Given the constraints on internal capital, the implementation of this scheme depends fully upon external funding.
e) Confirm and demonstrate that the recurrent revenue cost of the scheme is affordable.	<p>The business case assumes all the revenue costs of West Kent CDC will be offset via external revenue funding or a future CDC tariff.</p> <p>Completion of this SFBC template is to request the capital and revenue funding for the period 2022/23 - 2024/25. Subject to approval of this business case and confirmation of the associated funding for this period, it should be highlighted that the process for the on-going revenue funding after 2024/25 has not yet been confirmed.</p> <p>The National Strategic Finance team, issued the following statement, giving reassurance on future funding for CDCs : <i>'Given we only have a Spending Review settlement for 3 years, we cannot confirm the revenue funding beyond 2024/25, however we can confirm our intent to ensure there is future revenue to continue to support the diagnostic programme which will need to form part of the next SR bid. CDCs are seen as a government priority which further strengthens the requirement to provide on-going revenue funding. Over time revenue costs should also be supported by system growth funding, and specifically growth funding expected to cover diagnostic LTP growth, and also efficiencies that CDCs should bring to a system overall.'</i></p>
f) Confirm the system has assessed and is able to fund lifecycle costs to keep the facility in good working condition (condition B)	Not applicable.

MANAGEMENT CASE

a) Confirm the arrangements for the management and delivery of the scheme and that activity will be monitored and uploaded weekly in the required format	<p>The scheme will be managed by MTW, specifically the Core Clinical Services Division. The SRO and executive team leading this project have a wealth of experience and a proven track record of delivering projects and they are supported by highly experienced diagnostic professionals.</p> <p>To maintain robust management and governance arrangements throughout the programme, a Project Team is in place consisting of:</p> <ul style="list-style-type: none"> • Ritchie Chalmers, Chief of Service for Core Clinical Services (Clinical Lead) • Jelena Pochin, Lead Deputy DDO for Core Clinical Services (MTW Ops Lead) • Julie Wells, Associate Director of Finance - Financial Projects (Finance Lead) • Simon Oates, Senior Management Advisor • Susan White, Head of Service for Radiology • Antony Gough Palmer, Clinical Director for Radiology • Steve Hockney, Procurement and Delivery Lead • Antony Harris, Associate Director, Integrated Health Care Commissioning <p>A CDC operational site lead is to be appointed and will sit as part of the MTW Core Clinical Services Division but with specific responsibility for the community delivery.</p> <p>Please see Governance & Quality Impact Assessment undertaken in Appendix 11.</p> <p>Activity will be monitored and uploaded weekly in the required format via the CDC operational team. Additional data collection/report resource has been incorporated within the workforce, in order to ensure we meet the increased data collection and analysis requirements.</p>
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b) Set out the benefits realisation strategy and how the Trust intend to monitor and report on benefits.	Under the Trust's governance and assurance processes, business cases set out clear and measurable details of benefits realisation, providing a baseline condition and a set of Key Performance Indicators and timescales for the associated benefits of the investment. Benefits realisation is monitored and tracked through both investment implementation and post project delivery. Performance is reported regularly through project and Trust governance forums, allowing escalation and decisions on mitigation/corrective actions to achieve the benefits set out in the business case.
c) Set out the expectations for Post-Project Evaluation, and the expected timescales for the review of delivery.	As part of our approach to Project Assurance, Monitoring and Evaluation, we have appropriate arrangements for post project evaluation in place – to ensure we capture and document lessons learnt throughout the project implementation phase, ensure robust review of core considerations and expectations such as modelling and EDI and share and disseminate those lessons post-delivery. The Trust's post project evaluation form is included in Appendix 10. Post Project Evaluation is a key requirement of project close out.
d) Provide a Gantt chart/ timeline, as an Appendix, with key milestones for the procurement and delivery of the scheme to meet the go live dates given	See Appendix 9.

HEALTH INEQUALITIES

a) Has an EHIA been completed?	 EIA CDC.doc <p>Equality and Diversity review is fully embedded in practices at MTW, with specific consideration expected and monitored both as part of the peoples strategy and as part of the development of services, business cases etc.</p> <p>MTW has a dedicated team embedded within the Engagement and Equality Team to support this and strong support to comprehensively review issues is available. In addition, EDI is robustly consider within the wider ICP and network throughout service development and planning as a core value.</p>
b) Has due attention been paid to digital inclusion	<p>Considerable consideration has been given to digital inclusion and this has been reviewed at a network level, as part of the working group between MTW and the CCG and as part of patient / public engagement.</p> <p>Review continues to be ongoing in recognition of the fact that not all service users will have suitably access to digital provision such as the ready access to reliable internet, tablets or smart phones. Links with Healthwatch to gain additional support and development ongoing.</p>
c) Will the data & modelling of access to the service be dis-aggregated by deprivation, ethnicity & other health inequalities lenses to surface any emerging inequalities in access, experience & outcomes?	<p>Full consideration of health inequalities, areas of deprivation and impact have pathways has been considered throughout the development of the CDC, closely linking with works undertaken within the ICS, CCG and Cancer Networks.</p> <p>This will be an area which requires ongoing review throughout the development of the CDC owing to emerging changes and the potential to support.</p>
d) Will the service be communicated in a culturally competent way to ensure equitable access for marginalised communities?	<p>The service will be delivered in line with Maidstone and Tunbridge Wells NHS Trust current guidelines to ensure there is equitable access for marginalised communities.</p>

e) Will the service design incorporate a Health Equity Audit once the service has been fully operational for 12-18 months?	Yes, a Health Equity Audit will be undertaken once the expanded service has been fully operational for at least 12 months. This review forms part of the standard project review within MTW as EDI is embedded within practices.
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Section 6: PROGRAMME SPECIFIC INFORMATION REQUESTS

Also detail the impact on and the future model for: Workforce

Provide information on the impact and model for Workforce within your scheme. What ways do you envisage mitigating any risks you have over workforce, how does your plan for workforce guarantee meeting the activity you state?

The Additional WTE requirements of the West Kent CDC are as follows (shown incrementally at each stage of ramping up). In total, an additional 129.45WTE will be required when fully operational 8am-8pm, 7 days/week, 48 weeks/year.

	April- June 2023	July - Sept 2023	Oct - Dec 2023	From Jan 2024	TOTAL WTE Requirement
Consultant	2.22	0.88	1.06	0.46	4.63
RMO	1.25	0.49	0.60	0.26	2.60
Band 8B	1.00	0	0	0	1.00
Band 8A (Sonographer)	3.66	1.45	1.75	0.76	7.62
Band 8A (Echo)	3.66	1.45	1.75	0.76	7.62
Band 8A (POCT)	1.00	0.00	0.00	0.00	1.00
Band 8A (HSCE Tech)	0.87	0.34	0.42	0.18	1.82
Band 8A (Medical Physics)	0.24	0.10	0.12	0.05	0.50
Band 8A (Admin)	3.00	0.00	0.00	0.00	3.00
Band 7 (Radiographer)	3.44	0.97	2.17	0.51	7.08
Band 7 (Radiation Physics)	0.24	0.10	0.12	0.05	0.50
Band 7 (Admin)	1.00	0.00	0.00	0.00	1.00
Band 6 (Radiographers)	4.88	6.93	7.50	1.02	20.33
Band 6 (AHPs)	4.88	1.93	2.34	1.02	10.16
Band 6 (Admin)	1.00	0.00	0.00	0.00	1.00
Band 5 (POCT)	1.22	0.48	0.58	0.25	2.54
Band 4 (Asst Practitioner)	2.44	0.97	1.17	0.51	5.08
Band 4 (Admin)	2.22	0.48	0.58	0.25	3.54
Band 3 (RDAs)	6.10	2.41	2.92	6.35	17.79
Band 3 (AHPs)	2.44	0.97	1.17	0.51	5.08
Band 3 (HSA)	1.22	0.48	0.58	0.25	2.54
Band 3 (Admin)	9.42	3.73	4.51	1.96	19.62
Band 2 (Cleaners)	2.42	0.00	0.00	0.97	3.39
TOTAL	59.81	24.15	29.35	16.13	129.45

The modelling assumption is that 90% will be staffed using substantive staff and 10% will be via temporary staffing.

Recruitment of staff remains a key constraint for rapid progression of CDC projects nationally. Many of the diagnostic specialities are hard to recruit areas and therefore the extension of services is likely to be challenging.

Discussions have been held at the Imaging Network Board regarding a system approach to the workforce challenges to ensure that no specific CDC is disadvantaged; this work continues and the West Kent CDC (incorporating MTW and the West Kent ICC) are committed to supporting this work.

West Kent ICP have started to consider workforce planning, acknowledging the need for:

- Appropriate trained and competent staff to support the service
- A flexible multidisciplinary workforce
- Focus on recruitment, retention, teaching, training and development.
- Consistent and appropriate professional structures in place for all aspects of the service
- Modern and effective workflows to maximise workforce efficiency and productivity

	<p>This includes:</p> <ol style="list-style-type: none"> 1. Core rotational teams. 2. Staffing skill mix appropriate to deliver the full range of CDC services and should drive the effective use of new roles that provide development opportunities, including consideration of apprenticeships, physicist and practitioner roles etc 3. Workforce modelling in line with broader demand and capacity to consider growth and deliverability of extended services. Broader workforce solutions including a rolling programme of overseas recruitment, graduate training and apprenticeships is being worked through. 4. Work with ICP and network partners to consider alternate staffing models 5. Continuation of home reporting through broader project workforce to support development 6. Analysis of non-clinical support workforce need including administrative and ancillary 7. Training and development opportunities considering skill mix and network need. <p>For West Kent CDC specifically, we are addressing/mitigating the risks by the following:</p> <ul style="list-style-type: none"> • International recruitment. We have agreements with HEE for their international recruitment programme and with a private company Aryavrat from India. MTW has a long standing and highly successful partnership with Aryavrat, part of the ClearMedi group, who have already successfully supplied nursing staff to the Trust (over 200 in the last 2 years) with a +90% retention rate. The Trust is now looking to develop this relationship further with radiographer recruitment. This recruitment strategy is already underway and we hope to recruit radiographers into the Trust prior to being needed in the CDC to ensure they are properly inducted into the NHS and the Trust. • The CDC will form part of the rotation of staff from MTW and as such offers a fantastic opportunity for staff to work in the CDC whilst also retaining an acute rotation – best of both worlds. We believe this will make working at MTW an attractive option. • We have already started our apprenticeship programme and hope to further increase this programme over the next few years. • We are looking to extend the capabilities of our current staff e.g. more radiographer reporting, an internal programme for sonography training and more assistant practitioners. <p>Alongside expansion, other initiatives are also urgently being reviewed, including:</p> <ul style="list-style-type: none"> • Development of new ways of working, with a different balance of practitioners taking on different parts of the work (e.g. for acquisition of CT and MRI scans) • Training for advanced practitioner radiographers to take on reporting of images with appropriate back filling of existing workloads. • Provision of imaging simulators to facilitate training of different staff groups. • Support for existing staff to take on additional responsibilities (e.g. micro credentialing) • Recognition of sonographers as a regulated profession. • Recognition of the impact of non-clinical support staff HCA (Health Care Assistant and Administrative staff) have on improving patient throughput. • Full development of imaging networks with the connectivity to enable image sharing and flexible working, i.e. home reporting by radiologists/radiographers. • Introduction of artificial intelligence (AI) to support reporting as soon as it has been evaluated in different areas of imaging (e.g. screening mammography), thereby reducing radiologist/radiographer reporting time.
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	<p>The West Kent CDC will house the Kent Radiology Academy which will form a key part of our longer term recruitment strategy providing:</p> <ul style="list-style-type: none"> • Dedicated training facilities and options to work and specialise across modalities • Continuous professional and personal development opportunities • Development programmes across <ul style="list-style-type: none"> • Radiographer post graduate training • Training for non radiographers across (Mammography, DEXA, X-Ray and even CT&MRI) • Supporting the current apprenticeship schemes • RDA training • Cannulation training <p>The academy will also form a critical part of the radiologist training programme across Kent, with US simulation and dedicated reporting and teaching facilities.</p> <p>A key focus of our staffing strategy is retention, we must be able to hold onto the staff we recruit and we plan to achieve this through a combination of</p> <ul style="list-style-type: none"> • Training and development opportunities • CPD support • Creating an interesting and rewarding clinical rotation • Ensuring we are competitive in terms of salary etc • Career progression <p>Much like radiology, the physiological multi-professional model is challenged by workforce shortages, recruitment and seasonal pressures which directly impact respiratory teams. To address this, we must move towards a sustainable healthcare system by working toward a skilled, sustainable workforce capable of delivering holistic multi-professional care. This will require:</p> <ul style="list-style-type: none"> • Investment in retention and support for current respiratory multi-professional teams. • A renewed focus on expansion and recruitment of respiratory professionals across the multi-professional team, including review and consideration of overseas recruitment recognising training needs. • Improved training and career development, with a view of developing advanced care models • Continuing to build sustainability and resilience into the respiratory workforce through optimising the roles and career pathways available to specialist nurses, physiotherapists, physiologists, advanced clinical practitioners and physician associates, within primary, secondary and integrated care. <p>Commissioning</p> <ul style="list-style-type: none"> • Wider adoption of a joined up approach to service planning, similar to that used in sub-specialist services. • Using data on patient need, health inequalities and standards of care to design services, determine workforce needs and deliver innovative holistic care targeted to patient needs. <p>There is ongoing work with both colleagues within the Medical Divisions at MTW who manage the physiological services and with ICP colleagues to progress opportunities.</p> <p>Another important, but often overlooked, area of staffing centres around adequate support staff; key work on efficiencies supported by the Imaging Network has clearly indicated the vital importance of having sufficient booking and administrative provision and portering and support. This has been duly considered and actioned to support maximum efficiency throughout the CDC.</p> <p>Discussions are also commencing around the option and opportunities and risks associated with a system wide centralised booking service. Whilst these discussions are in their infancy, West Kent CDC is fully engaged with the discussions and</p>
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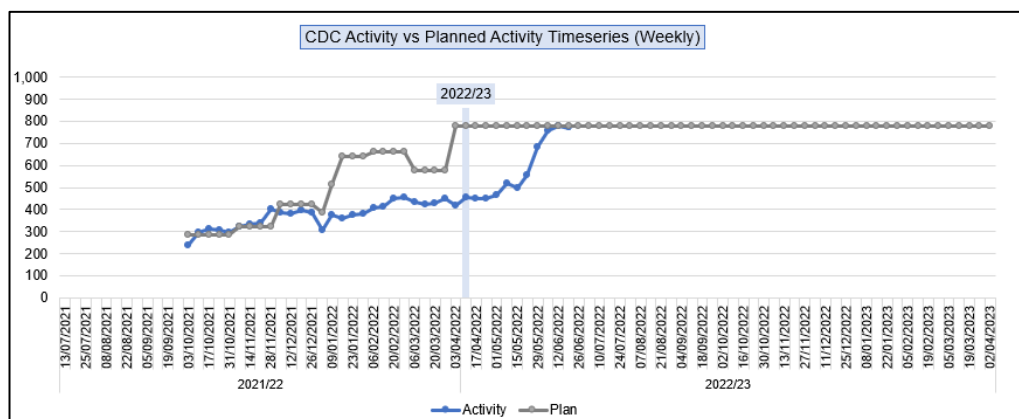
	<p>committed to ensuring robust service delivery and maximum efficiency for CDCs across the system.</p>
<p>Digital integration Provide information on your Digital strategy within your scheme. Do you have a system way forward, if so what is this and is it also supporting CDC interactions with secondary and primary care.</p> <p>(You may also want to add examples of digital inclusion with regards to the patient adaptations, visual impairment, accessibility?)</p>	<p>IT connectivity is a key dependency. Success of CDCs is dependent on the digital connectivity between diagnostic IT systems and organisations across health systems to allow the appropriate sharing of information and this review and consideration is supported at a Network level.</p> <p>Work is underway with partners to ensure seamless connectivity between the West Kent CDC and Primary and Secondary Care including:</p> <ul style="list-style-type: none"> Assessment of need for HSCN network connections or point to point connection. Review of necessary infrastructure to connect sites such as firewalls, UPS, wireless, power, networks plus associated hardware <p>Kent & Medway Digital IT Strategy: Home reporting, iRefer, Order Comms, PACS Image sharing</p> <p>West Kent ICP will also be taking the following considerations for IT, digitisation and connectivity:</p> <ul style="list-style-type: none"> Mechanism and responsibility for long-term storage of patient information Aim to evolve towards a unified system solution for radiology image sharing Ability to receive and process referrals Use of digitally enabled diagnostic equipment should be prioritised to facilitate efficiency and reduce the demand on staff Information sharing between CDC and NHS provider using relevant NHS standards (e.g. DICOM, HL7, National Interim Clinical Imaging Procedures code-set) Patient identification using the NHS number must be used including for all (clinical) data transfers. Consideration of integration of multiple IT systems, care settings and providers (including NHS and independent sector providers) Systems and solutions must comply with all NHS guidance on security and access control. All requests/referrals* should be received electronically, although capability to receive paper requests/referrals may be required as a form of back-up system only and to provide for patients that do not use digital booking channels. Ability to receive and report on cancer referrals through connection to NHS e-referral system (ERS), with system in place to book the referrals as well as

	<p>receive them, along with cancer tracking systems in place so that they can record and submit data on Cancer Waiting Times</p> <ul style="list-style-type: none">• The IT capability to maximise CDC efficiency is critical. IT solutions to identify patients not attending appointments, or to facilitate the pre-appointment process (e.g. automated distribution of instructions the patient must follow prior to a test) should be explored• Appropriately coordinate multiple tests to minimise the number of locations and appointments a patient attends• Reporting: Accessing results of tests conducted in NHS and independent sector setting will be crucial to enable a seamless patient experience including flagging of urgent results/reports.• IT infrastructure to enable offsite working (home reporting) for radiologists and radiographer reporting. <p>Enabling GP direct access is a key priority to ensure improved experience for primary care colleagues and patients alike. Work is underway at a network level and West Kent is fully engaged with this. We aim to progress GP Direct Access with the current CDC provision with the aim to extend in line with the development growth in 2023/24.</p> <p>There is a new PACS/RIS being deployed across Kent but this is likely to not be embedded until 2023. In the interim period, this presents risks to the potential efficiency gains available in and the ability to 'link in' AQP/IS providers to the service delivery.</p> <p>In addition, there are significant global supply chain issues for certain IT equipment, such as the data centre switches, which is causing significant lead times. The shortage specifically relates to the chips required and has been further impacted by the conflict in the Ukraine, where 90% of the neon gas used in the production of the chips is produced. Whilst mitigation work is underway and the potential delays have been factored into our phasing, the risk remains.</p>																																																																																																							
<p>Activity and Benefits Provide outline of how you propose to monitor and feedback on the following:</p> <ul style="list-style-type: none">• Activity as per plan- this must be activity that is directly done on the CDC site or its hub and funded by the CDC programme or continued system operational funding.• Are your activity levels at the agreed national minimum productivity rates? If not please state why not and what time frame it will take to get there. Minimum anticipated planned activity rates are: <p>1. MRI- 2-3 scans per hour 2. CT – 3-4 scans per hour 3. US – 3 scans per hour 4. Endoscopy -10 points per service list, 8 points per training list</p>	<p>Activity The West Kent CDC will have the capacity deliver the following activity levels when open 8am-8pm, 7 days/week, 48 weeks/year:</p> <table><tr><th></th><th>Per 8-8</th><th>Per hour</th><th>Minutes per scan</th><th>Per 48 week annum</th><th>Activity per annum @ 85% occupancy (incl DNA/Canx)</th></tr><tr><td rowspan="2">X-Ray</td><td>120</td><td>10</td><td>6</td><td>40,320</td><td>34,272</td></tr><tr><td>72</td><td>6</td><td>10</td><td>24,192</td><td>20,563</td></tr><tr><td>TOTAL X-Ray</td><td>192</td><td>16</td><td></td><td>64,512</td><td>54,835</td></tr><tr><td rowspan="3">Ultrasound</td><td>30</td><td>2.5</td><td>24</td><td>10,080</td><td>8,568</td></tr><tr><td>30</td><td>2.5</td><td>24</td><td>10,080</td><td>8,568</td></tr><tr><td>20</td><td>1.7</td><td>36</td><td>6,720</td><td>5,712</td></tr><tr><td>TOTAL Ultrasound</td><td>80</td><td>6.7</td><td></td><td>26,880</td><td>22,848</td></tr><tr><td>DEXA</td><td>30</td><td>2.5</td><td>24</td><td>10,080</td><td>8,568</td></tr><tr><td rowspan="2">MRI</td><td>36</td><td>3</td><td>20</td><td>12,096</td><td>10,282</td></tr><tr><td>17</td><td>1.4</td><td>42</td><td>5,712</td><td>4,855</td></tr><tr><td>TOTAL MRI</td><td>53</td><td>4.4</td><td></td><td>17,808</td><td>15,137</td></tr><tr><td rowspan="2">CT</td><td>60</td><td>5</td><td>12</td><td>20,160</td><td>17,136</td></tr><tr><td>46</td><td>3.8</td><td>16</td><td>15,456</td><td>13,138</td></tr><tr><td>TOTAL CT</td><td>106</td><td>8.8</td><td></td><td>35,616</td><td>30,274</td></tr><tr><td>Phlebotomy</td><td></td><td></td><td></td><td>3,900</td><td>3,315</td></tr><tr><td>Echo</td><td></td><td></td><td></td><td>6,000</td><td>5,100</td></tr><tr><td></td><td></td><td></td><td></td><td>TOTAL</td><td>140,077</td></tr></table> <p>Of note:</p> <ul style="list-style-type: none">• Activity is a combination of displaced elective activity in line with the recommendations of the Richards Review and additional capacity (as detailed on Page 34).• Activity in individual rooms have been planned to take into account complexity of scan, use of contrast and considering patient/staff experience. This is a baseline assessment and will be reviewed regularly to ensure capacity is maximised.		Per 8-8	Per hour	Minutes per scan	Per 48 week annum	Activity per annum @ 85% occupancy (incl DNA/Canx)	X-Ray	120	10	6	40,320	34,272	72	6	10	24,192	20,563	TOTAL X-Ray	192	16		64,512	54,835	Ultrasound	30	2.5	24	10,080	8,568	30	2.5	24	10,080	8,568	20	1.7	36	6,720	5,712	TOTAL Ultrasound	80	6.7		26,880	22,848	DEXA	30	2.5	24	10,080	8,568	MRI	36	3	20	12,096	10,282	17	1.4	42	5,712	4,855	TOTAL MRI	53	4.4		17,808	15,137	CT	60	5	12	20,160	17,136	46	3.8	16	15,456	13,138	TOTAL CT	106	8.8		35,616	30,274	Phlebotomy				3,900	3,315	Echo				6,000	5,100					TOTAL	140,077
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<p>5. Echo- 1 scans =45 mins to scan and report</p> <ul style="list-style-type: none">Benefits to be tracker by systems and returned quarterly – please include how you :Demonstrate efficiency over time and value for money / return on investment. Specify over what period of time this will be realisedHow will your CDC will be measured in terms of performance compliance. When will this impact be felt and howHow will you measure and report staff feedback and improvements to staff satisfaction and retention (including primary and secondary care staff)How will you capture and report on patient experience and the impact the CDC has had here?	<ul style="list-style-type: none">Phlebotomy activity is an area we expect to significantly grow; at the current stage we have only included a very basic level of information around specific primary care referrals; this is linked to ensuring we do not make patient pathways more difficult by removing access in either primary or acute settings. However when activity at the CDC grows, we expect the phlebotomy activity to increase at pace. <p>In response to the minimum anticipated planned activity rates:</p> <p>MRI: Scan per hour rates have been assessed considering existing activity, referral patterns, contrast need, complexity of scans, patient experience and significant discussion and potential clinical developments. Stretch targets will be reviewed and considered after year 1 activity review.</p> <p>CT: Scans per hour targets have been stretched in line with HCSE efficiency review work; we are confident we will be able to achieve this activity.</p> <p>US: Scan per hour rates have been considered based on referral patterns and existing activity, both elective but through the acute site and AQP. Of note, we anticipate the West Kent CDC activity will manage a significant volume of cancer pathway scanning and to ensure as positive as possible patient experience, additional time has been factored. Once again, stretch targets will be reviewed at regular intervals. It is also relevant to note that GP feedback has confirmed a positive view on the provision of USS via AQP providers and this information will continue to be reviewed and considered.</p> <p>Echo: Activity has been considered in line with AQP provision across the patch and discussions with cardiology team and initial concerns re: lack of onsite cardiology consultant cover. Stretch targets will be reviewed and considered after Year 1 activity review.</p> <p>Phlebotomy: Phlebotomy activity has been the most difficult to plot and we anticipate the rates to increase significantly. We will manage this via a rotation of staff through the acute sites. We initially anticipate running hard to bleed clinics specifically and supporting other activity working through the CDC.</p> <p>There is significant focus on activity levels within the CDC and how this will support performance, recovery against national standards and sustainability of compliance within the modalities providing additional capacity at the Hermitage Court CDC site. It is recognised that prompt access to elective diagnostics supports positive cancer and RTT performance and therefore there is significant focus on DM01 performance.</p> <p>MTW, as lead organisation for the West Kent CDC, has a primary focus on DM01 compliance and is on a trajectory of recovery following the pandemic. CT performance has improved as a direct result of CDC activity and has allowed draw in of activity which has improved both clinician and patient experience by ensuring a more joined up approach and ensured increased capacity within the private sector for system partner organisations and AQP. MRI has undoubtedly been more challenging owing to issues surrounding aged equipment and resultant downtime, but it has allowed MTW to provide stability in service even after the catastrophic failure of the TWH MRI.</p>
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May 2022 DM01	Under 6 weeks	6 weeks and over	Total	Pass %
PAS categories	1,866	21	1,887	98.9%
Imaging categories	6,587	337	6,924	95.1%
TRUST	8,453	358	8,811	95.9%

Community Diagnostic Centre (CDC) Activity Report			Region Name		System Name		CDC Parent Hub		Diagnostic Group		Diagnostic Test		FY	
Latest Position			Toggle View		SOUTH EAST		KENT AND MEDWAY STP		BUCKLAND COMMUNITY HOSPITAL CDC		Imaging		FY 2021/22	
Week Ending: 19/06/2022			Use buttons below to switch between weekly values and cumulative position						MAIDSTONE AND TUNBRIDGE WELLS HO				FY 2022/23	
Current Week: 42,481											Computed Tomography			
Cumulative Position: 1,256,394											Magnetic Resonance Image			
Select first week to display in table:			Weekly		Cumulative									
2003/2002			Current view: Weekly											
</														



Activity for 2022/23 is currently behind plan due to issues with aging equipment provided and implementation of full contrast cover; both issues have been progressed and will continue to be monitored closely by the project team as part of the CDC development.

The planned CDC activity within NOUS and DEXA will continue to support compliance with DM01 and extension of support available for a network approach to excess capacity.

The West Kent network has undertaken due diligence on the diagnostic requirements/gaps/innovation required in the West Kent locality.

The proposed pathways have been developed following stakeholder engagement, which included a workshop with representatives from West Kent providers including MTW, Commissioners, GP reps and some patient feedback.

Discussion have been held at K&M Imaging Network to ensure a system approach to pathways, making certain that the needs of our patients are fully considered and that efficiencies are maximised across the system.

Benefits

Performance review: All activity will be monitored both via weekly activity submission and via specific performance review lead by the Core Clinical Services Divisional Team with an ongoing and evolving action plan to ensure compliance and stretch targets.

Impact on cross-sectional (MRI and CT) will be felt from Q3 in 2022/23 with the other modalities seeing rapid improvement through 2023/24.

Staff feedback: The CDC staff will be employed by Maidstone and Tunbridge Wells NHS Trust and therefore general feedback will be gained via climate survey, staff surveys, peoples forums alongside staff meetings, 1:1 etc. However, we recognise the complexity and potential impact of working within a 'new' service therefore a specific staff feedback forum is planned in conjunction within the Peoples Division and Wellbeing Teams.

Patient Experience: Patient experience and feedback is a key factor in the development of the CDC; a robust plan of patient surveys available in multiple forms including paper based sent with letters or available on site, QR and via a social media campaign in underway alongside on-site opportunities to provide feedback face to face.

	<p>This has been discussed and agreed with CCG colleagues and will be undertaken on a ongoing basis.</p>
<p>Commissioning (NHS or collaborative with IS) model moving forwards – is the ICS planning on block contract or other model for commissioning in the longer term?</p>	<p>The K&M ICB is currently scoping the contracting and commissioning options to support the ongoing commissioning of CDCs. It is anticipated that the system will seek to utilise a lead provider model or operate a provider collaborative to support commissioning of the CDC programme. This will allow for maximum flexibility in securing capacity from a range of providers. It will also support maximum utilisation of workforce, estate and services (including equipment) across the provider landscape. This will mitigate risk of competition across providers, allow for flexible deployment of resources and support optimum productivity.</p> <p>The West Kent CDC expansion assumes the majority of the service will be provided by the NHS (Maidstone and Tunbridge Wells NHS Trust) with the MRI currently planned to be delivered by Inhealth through a managed service (contracted to MTW). The MRI Managed Service business case was approved by NHSEI South East Region in June 2022, and is due to go live in Q3 2022/23. CDC activity will be additional activity to that included in the MRI Managed Service Business Case.</p> <p>Contracting options remain under discussion to ensure robust process and effective value for money, linking in with the AQP activity within the system.</p>
<p>Patient engagement: Your approach to developing an engagement plan and how you will involve communities in your governance structures. Include seldom heard groups e.g. inclusion health groups, 20% most deprived population by IMD and your local PLUS groups e.g. those with poorer than average access, experience and outcomes e.g. ethnic minority communities, coastal communities, those with multi-morbidities, inclusion health groups</p>	<p>West Kent CDC is committed to undertaking robust patient engagement. Recognising that minimal engagement was undertaken prior to our Early Adopter activity, we have worked closely with our Patient Experience and Engagement colleagues to ensure a robust plan for feedback and engagements recognising the need to consider health inequalities, hard to reach groups etc. This includes:</p> <ul style="list-style-type: none"> • Patient surveys available in a multiple format including paper based, online via QR code and on social media • Ensuring documentation and feedback opportunities is EDI compliant • Onsite surveys and feedback sessions • Links with local patient and public groups and forums • Links with healthwatch • Feedback at patient experience committee <p>The project group has presented on CDC at the West Kent Stakeholder Engagement Group on a regular basis and also feeds in to the MTW Patient Experience and Engagement Group.</p> <p>A joint comms release has also been produced reviewed by ICC, MTW and the Imaging Network to ensure an aligned approach across Kent and Medway.</p> <p>Kent & Medway Imaging Network (KMIN) has developed a draft Communications and Engagement Plan in partnership with the ICS Communications and Engagement Team, inclusive of all system stakeholders. This plan provides a framework for KMIN communications and engagement to help ensure that plans developed by each HCP/ICC area in Kent & Medway, ie, West Kent, East Kent, Medway & Swale and Dartford, Gravesham & Swanley. This will reflect the wider strategic aims and objectives of the ICS and KMIN and to enable maximised utilisation of CDCs and to allow shared learnings across the system from year 2 (22/23) from the patients who use this service.</p>

Please fill in key information about your location and if your model is a hub and spoke one then clear information about all components of the scheme should be entered (you cannot have a spoke site in a system without first having a CDC hub site). Copy and paste the whole section if you need to record multiple sites

We have completed 2 of the Estates key information templates:

1. Unit A, Hermitage Court
2. Modular Building to house CT and MRI, Hermitage Court

Estates Key Information – Unit A, Hermitage Court

Size of development m²	6,125sq.ft (Unit A Hermitage Court)	
Indicate archetype:	Large <input type="checkbox"/> Standard <input checked="" type="checkbox"/> Hub & Spoke <input type="checkbox"/>	
Site ownership	NHS <input type="checkbox"/> Public <input type="checkbox"/> Private Estate <input checked="" type="checkbox"/>	
Site Location	High St <input type="checkbox"/> Industrial / Business <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Community <input type="checkbox"/> Primary Care <input type="checkbox"/> Other <input type="checkbox"/> <i>If Other, then please provide further information here: N/A</i>	
Demonstrate how you have made best use of existing NHS estates as part of your location deliberations.	Not applicable – CDCs are to be located away from acute hospital sites and no suitable existing NHS estates were identified during search. Hermitage Court is a non-NHS site, located close to Maidstone Hospital.	
Is this an owned or leased facility – provide details if leased?	Owned	
	Leased	<input checked="" type="checkbox"/>
	Details if leased:	Initial 5 year lease, from Gallaghers, a private landlord. Lease agreed and signed; option to extend covered in lease and discussed with Gallaghers, who would be very happy to progress at any stage.
New or refurbishment or % of each (enter % in each row)	New	0%
	Refurbished	100%
Description and application of and percentage use of modern methods of construction by value	Not applicable	
Any temporary accommodation required – please provide details	No	
Is land purchase required – provide details	No	

On what basis was the site chosen as a CDC location?	<p>The data considered during site selection was as follows:</p> <ul style="list-style-type: none"> • Volume of referral per postcode • Transport links for patients and staff • Parking availability and cost • Resource attached to estates costs <p>Hermitage Court was the preferred location. It is a well located site, close to Maidstone Hospital, but on a completely separate Non-NHS site. It is superbly positioned, having very good road access, dedicated parking, a station 5 mins walk away and a, soon to be, extended bus service linking Maidstone and Tunbridge Wells hospitals with Hermitage Court. The expansion of the West Kent CDC will use the ground floor of Unit A at Hermitage Court, which is being designed to ensure we provide highly efficient facilities that can maximise the throughput.</p>
Wider considerations (achieving VFM, coordination with local & region priorities, net zero, local engagement & consultations)	<p>Work has been undertaken with a multi-disciplinary team to assess the wider considerations of CDC implementation. This has ensured key areas of focus around pathways, such as the breathlessness pathway.</p> <p>In addition, discussions are being held at a network level regarding the approach to mutual aid and a network approach where there are areas of both over and under performance.</p> <p>No specific consultation has been undertaken regarding CDC however, patient and public engagement is ongoing.</p>
Stage of design development and trust approval (please attach design drawings)	See below
Estimated average lifecycle costs £/m2 over asset life	Not applicable
Has your system considered if the CDC estate can be linked up to other NHS/elective recovery investment e.g. hospitals new build, surgical hubs, Cavell centres, Mental Health hubs etc.	Consideration is being given to how the CDC could potentially support the pre-operative pathway of the Elective Orthopaedic (Barn) Theatre development on the MTW site
Is this in line with local Estates Strategy?	<p>The West Kent CDC at Hermitage Court fits within the parameters laid out in the Richards Report namely:</p> <ul style="list-style-type: none"> • Not located on an acute hospital site • Good transport links • Car parking • Supports all the functions of a Standard CDC

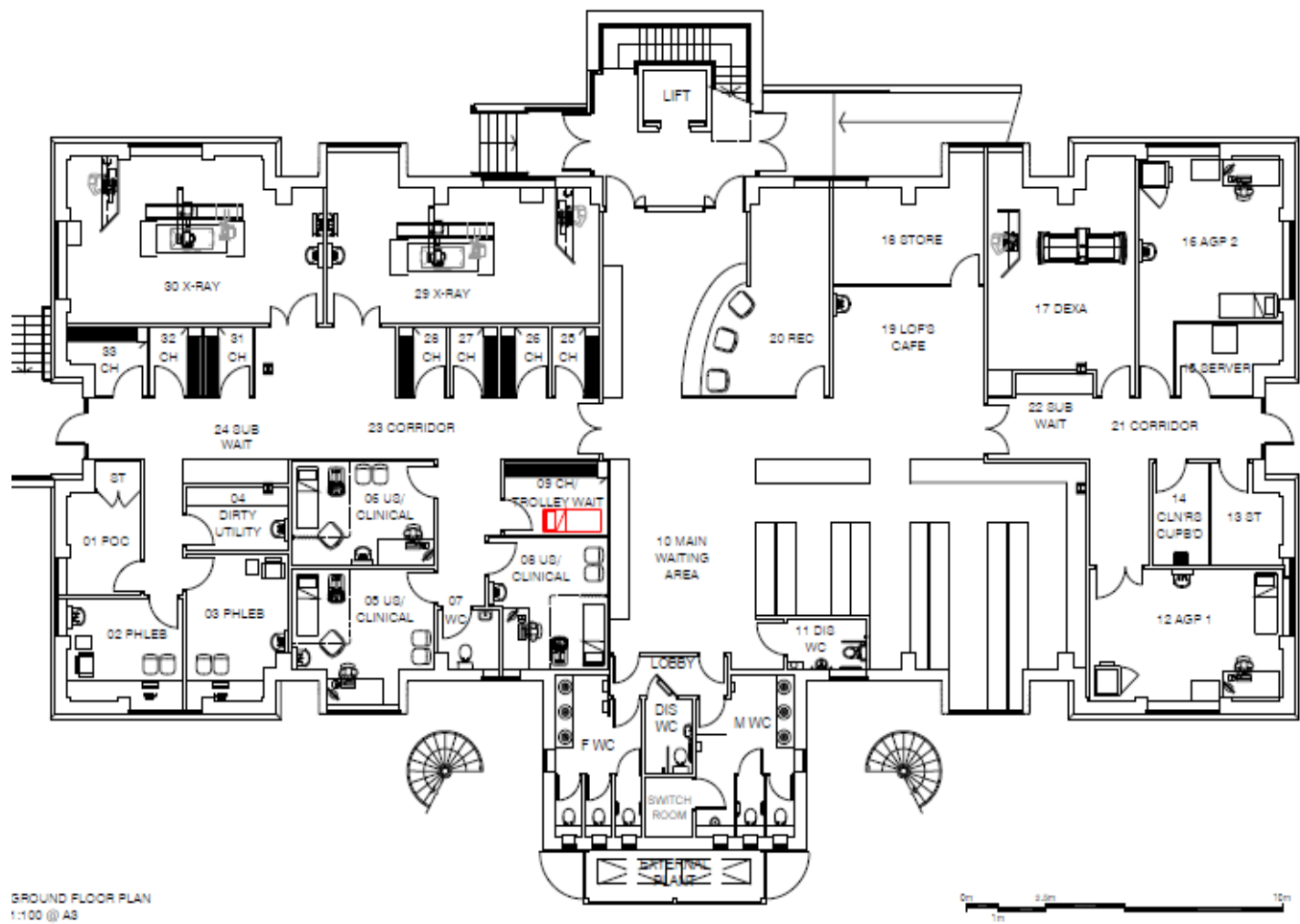
Hermitage Court – Unit A



UNIT LOCATION AND PARKING



Proposed layout:

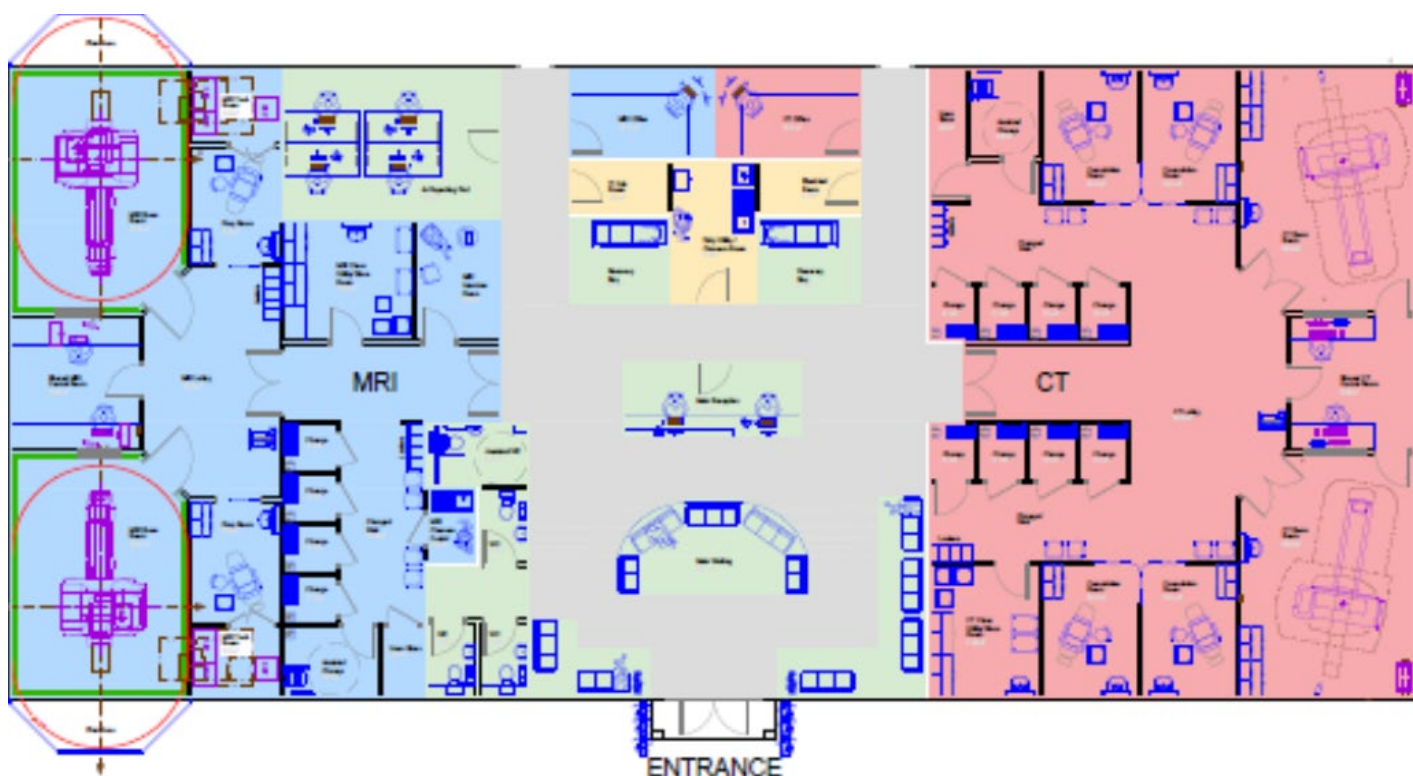


Estates Key Information – Modular Building to house CT and MRI, Hermitage Court

Size of development m²	Approx 7,500 sq.ft (Modular Build to house CT and MRI)	
Indicate archetype:	Large <input type="checkbox"/> Standard <input checked="" type="checkbox"/> Hub & Spoke <input type="checkbox"/>	
Site ownership	NHS <input type="checkbox"/> Public <input type="checkbox"/> Private Estate <input checked="" type="checkbox"/>	
Site Location	High St <input type="checkbox"/> Industrial / Business <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Community <input type="checkbox"/> Primary Care <input type="checkbox"/> Other <input type="checkbox"/> <i>If Other, then please provide further information here:</i> N/A	
Demonstrate how you have made best use of existing NHS estates as part of your location deliberations.	Not applicable – CDCs are to be located away from acute hospital sites and no suitable existing NHS estates were identified during search. Hermitage Court is a non-NHS site, located close to Maidstone Hospital.	
Is this an owned or leased facility – provide details if leased?	Owned	
	Leased	<input checked="" type="checkbox"/>
	Details if leased:	Forms part of the lease on Unit A – detail given above.
New or refurbishment or % of each (enter % in each row)	New	100%
	Refurbished	0%
Description and application of and percentage use of modern methods of construction by value	Not applicable	
Any temporary accommodation required – please provide details	Cross-sectional imaging (MRI and CT) will be housed in a modular build with a 25 year lifespan. Whilst not temporary in the traditional sense, included as not a permanent structure	
Is land purchase required – provide details	No	
On what basis was the site chosen as a CDC location?	The data considered during site selection was as follows: <ul style="list-style-type: none"> Volume of referral per postcode Transport links for patients and staff Parking availability and cost Resource attached to estates costs Hermitage Court was the preferred location. It is a well located site, close to Maidstone Hospital, but on a completely separate Non-NHS site. It is superbly positioned, having very good road access, dedicated parking, a station 5 mins walk away and a, soon to be, extended bus service linking Maidstone and Tunbridge Wells hospitals with Hermitage Court. The expansion of the West Kent CDC will use the ground floor of Unit A at Hermitage Court, which is being designed to ensure we provide highly efficient facilities that can maximise the throughput.	

Wider considerations (achieving VFM, coordination with local & region priorities, net zero, local engagement & consultations)	<p>Work has been undertaken with a multi-disciplinary team to assess the wider considerations of CDC implementation. This has ensured key areas of focus around pathways, such as the breathlessness pathway.</p> <p>In addition, discussions are being held at a network level regarding the approach to mutual aid and a network approach where there are areas of both over and under performance.</p> <p>No specific consultation has been undertaken regarding CDC however, patient and public engagement is ongoing.</p>
Stage of design development and trust approval (please attach design drawings)	See below
Estimated average lifecycle costs £/m2 over asset life	Not applicable
Has your system considered if the CDC estate can be linked up to other NHS/elective recovery investment e.g. hospitals new build, surgical hubs, Cavell centres, Mental Health hubs etc.	Consideration is being given to how the CDC could potentially support the pre-operative pathway of the Elective Orthopaedic (Barn) Theatre development on the MTW site
Is this in line with local Estates Strategy?	<p>The West Kent CDC at Hermitage Court fits within the parameters laid out in the Richards Report namely:</p> <ul style="list-style-type: none"> • Not located on an acute hospital site • Good transport links • Car parking • Supports all the functions of a Standard CDC

CT and MRI Modular Unit



Capacity benefit of CDC Investment- data will be required weekly

Appendix 2

Modality	Diagnostic Test	Additional capacity provided in 2022/23 Financial year (part yr. effect PYE)	Additional capacity provided in 2023/24 Financial year	Additional capacity provided in 2024/25 Financial year	Additional capacity (full year effect FYE)
Imaging	MRI	Included in Bridging funding	15,137	15,137	15,137
	CT	Included in Bridging funding	30,274	30,274	30,274
	Ultrasound		17,422	22,848	22,848
	X-ray		41,812	54,835	54,835
	DEXA Scan		6,533	8,568	8,568
	Other (please specify)				
Physiological measurement	Audiology – Audiology Assessments				
	Cardiology - echocardiography		3,889	5,100	5,100
	Cardiology - electrophysiology				
	Neurophysiology - peripheral neurophysiology				
	Respiratory physiology – FENo Lung function tests sleep studies				
	Urodynamics - pressures & flows				
	Other (please specify)				
Endoscopy	Colonoscopy				
	Flexi sigmoidoscopy				
	Cystoscopy				
	Gastroscopy				
	Other				
Pathology	Phlebotomy		2,528	3,315	3,315
	Other (please specify)				

To Note:

- The West Kent CDC will be a standard CDC and therefore no endoscopy work will be undertaken on site. This has been fully discussed and agreed as part of the multi-disciplinary team.
- Work continues in respect of working through physiological measurement activity beyond echo including spirometry and extended pathways in the same envelope.
- Activity included is a combination of displaced elective activity in line with the recommendations within the Richards Review and additional capacity.

USS:	50% additional capacity	X-ray:	60% additional capacity
DEXA:	20% additional capacity	ECHO:	25% additional capacity (under review)
Pathology:	100% additional capacity		
- Phlebotomy activity is an area we expect to significantly grow; at the current stage we have only included a very basic level of information around specific primary care referrals; this is linked to ensuring we do not make patient pathways more difficult by removing access in either primary or acute settings. However when activity at the CDC grows, we expect the phlebotomy activity to increase at pace.

Based on this additional capacity, we are assured of a positive impact on backlog and waiting times ; further analysis into the specifics is ongoing.

Planned Activity April 2022 – March 2023 (breakdown by month, will be required weekly operationally) Appendix 3

	Diagnostic Test		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Imaging	Magnetic Resonance Imaging	Planned	-	Not applicable – activity delivered in 2022/23 is funded separately via the bridging fund and does not form part of this business case											
	Computed Tomography	Planned	-												
	Non-obstetric ultrasound	Planned	-	-	-	-	-	Activity commences April 2023 for these modalities							
	General Xray	Planned	-	-	-	-	-								
	DEXA Scan	Planned	-	-	-	-	-								
Physiological Measurement	Audiology - Audiology Assessments	Planned	-	-	-	-	-								
	Cardiology - echocardiography	Planned	-	-	-	-	-								
	Cardiology - electrophysiology	Planned	-	-	-	-	-								
	Neurophysiology - peripheral neurophysiology	Planned	-	-	-	-	-								
	Respiratory physiology	Planned	-	-	-	-	-								
	Urodynamics - pressures & flows	Planned	-	-	-	-	-	-	-	-	-	-	-	-	-
Endoscopy	Colonoscopy	Planned	-	-	-	-	Not Applicable – West Kent CDC is a standard CDC. There will be no endoscopy provision delivered on-site.								
	Flexi sigmoidoscopy	Planned	-	-	-	-									
	Cystoscopy	Planned	-	-	-	-									
	Gastroscopy	Planned	-	-	-	-									
Pathology	Phlebotomy	Planned	-	-	-	-	Activity commences April 2023								-

Planned Activity 2023 & 2024 (breakdown by year)

	Diagnostic Test		2023/24	2024/25
Imaging	Magnetic Resonance Imaging	Planned	15,137	15,137
	Computed Tomography	Planned	30,274	30,274
	Non-obstetric ultrasound	Planned	17,422	22,848
	General X ray	Planned	41,812	54,835
	DEXA Scan	Planned	6,533	8,568
Physiological Measurement	Audiology - Audiology Assessments	Planned	-	-
	Cardiology - echocardiography	Planned	3,889	5,100
	Cardiology - electrophysiology	Planned	-	-
	Neurophysiology - peripheral neurophysiology	Planned	-	-
	Respiratory physiology	Planned	-	-
	Urodynamics - pressures & flows	Planned	-	-
Endoscopy	Colonoscopy	Planned	-	-
	Flexi sigmoidoscopy	Planned	-	-
	Cystoscopy	Planned	-	-
	Gastroscopy	Planned	-	-
Pathology	Phlebotomy	Planned	2,528	3,315
Other (please add)	Other	Planned	-	-

The following digital specifics must have been considered as part of the CDC proposal and firm plans must be in place to ensure that specifics are achieved. Please tick to show that plans are available. (If not then why not?)

Digital Specifics for Consideration	Plans YES/NO
All digital plans have been cross-referenced with ICS & Regional digital roadmaps/plans	Yes
Local Pathology and Imaging Networks have been explicitly consulted.	Yes
All clinical information transfers into and out of the CDC will use validated NHS Numbers for every interaction/test	Yes
The impact of additional data generation, transfer, storage and user access requirements on NHS IT systems have been discussed with local IT services.	Yes
If the use of Image Exchange Portal is proposed, due regard has been given to required levels of performance and impact for local imaging services.	Yes
All long and short term repositories of clinical and operational data have been identified, investigated with respect to required performance, maintenance and support, data lifecycle management etc.	Yes
Are arrangements in place to manage urgent and/or unexpected findings and have these been endorsed by Medical Directors of all participant organisations.	Yes
<i>Enter comments / planning details into this box if required and particularly if NO is ticked to any of the above:</i>	

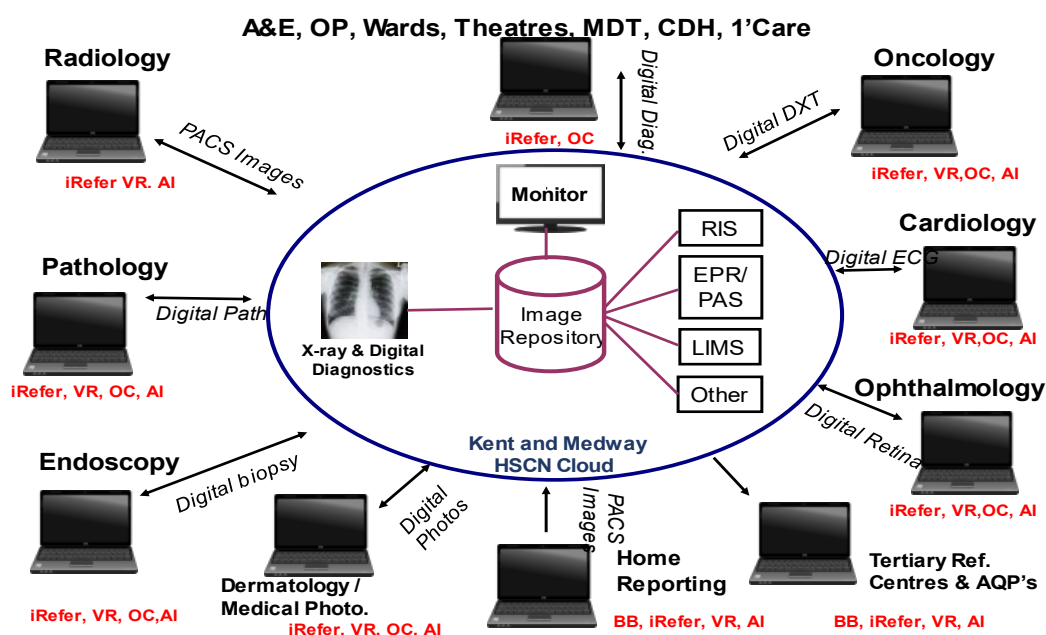
The following digital questions require more explanation and / or evidence. Please fill in as fully as possible

All NHS standards for data and transfer must be complied with. If this is not immediately possible then an indication of when compliance will be achieved must be given:

All data and data transfer is in line with current NHS standards under the direct control of Maidstone and Tunbridge Wells NHS Trust. All applications which will be implemented within the CDC will complete clinical safety sign off by the organisation, data security will align to our DSP toolkit submission, and all interfacing between applications will align to FHIR standards where applicable.

Our data transfer/interoperability will align to the wider Kent and Medway vision for digitally enabled transformation of pathology/ diagnostic imaging across the system:

Kent & Medway Digital IT Strategy:
Home reporting, iRefer, Order Comms, PACS Image sharing



Mechanisms for transport layer IT network infrastructure to CDC premises and facilities e.g. mobile scanners e.g. broadband, HSCN connections, wi-fi have been identified and costed (costings should also be entered as part of Table 2 & Table 3 on page 3):	
Has this been done?	Yes
The CDC and the interim mobile scanners are fully connected to the Maidstone and Tunbridge Wells NHS Trust network and falls under its IG governance. The facility will be connected to a large HSCN connection which has been scoped and specified by MTW IT department with appropriate orders in progress to support development.	
All technical integration requirements have been identified and costed, and a delivery plan developed involving all relevant parties.	
Device integration has been identified and costed. For clinical and administrative IT systems the CDC will be directly linked to MTW PACS, RIS and PAS and further links within the system in line with the the PACS Procurement will extend to support the new service. As a result, a complete systems review has been completed.	
Process mapping, aligning this back to applications, identifying configuration changes required and any additional integration needs has been undertaken with CCG colleagues including clinical leads and this is being considered and progressed. This will ensure that the IT solutions meet the requirements of the clinicians, supporting efficiency and aiding the overall patient experience.	
All clinical pathways and individual tests to be supported by the CDC have been identified, documented and agreed. Documentation must identify which organisations, teams and IT systems are responsible for each stage of the referral/request to result/discharge pathway and how transfers across organisational and system boundaries will be made e.g. FHIR messaging, API etc Documentation should also include appropriate safety measures, monitoring and audit arrangements.	
Has this been done?	Yes
A full review of clinical pathways has been undertaken in line with service need, referral patterns and health inequalities data. These discussions have been undertaken on a cross-organisational, multi-disciplinary capacity which has ensured comprehensive consideration of clinical needs, patient engagement consideration and digital connectivity to support successful implantation. Key pathways under development include Breathlessness and MSK conditions.	
Extensive MDT discussions regarding cancer pathways have been undertaken and it has been decided that improving access would be the preferred approach initially but this will remain under review.	
Work will continue across the network to standardise systems where possible across the Kent and Medway ICS to aid data convergence across the system supporting in provided safety and patient outcomes.	
Set out your referral plan e.g. how will GPs, secondary care clinicians be able to refer into the CDC, and any future plans for self-referral (if known)	
The West Kent CDC is connected to Maidstone and Tunbridge Wells NHS Trust PACS and RIS systems which in turn feed into the Trusts PAS system and ensures integration with the acute sites; greater assurance will also be offered as part of the system wide PACS programme roll out.	
Additional configuration is required to the existing order comms/referral systems within the Trust and CCG and this work is ongoing. This maintains existing processes which clinicians are familiar with, reducing training requirements and making implementation similar. Referrals will then electronically be sent for triage and bookings. A full SOP will be developed during the implementation of the CDC.	
Enabling GP direct access is a key priority to ensure improved experience for primary care colleagues and patients alike. Work is underway at a network level and West Kent is fully engaged with this. We aim to progress GP Direct Access with the current CDC provision with the aim to extend in line with the development growth in 23/24.	
Options for electronic self-referral are being considered in line with the wider ICS digital strategy which is currently being developed.	
Outline when and how co-ordinated scheduling or patient appointments across diagnostic modalities and services are to be achieved? This should include an explanation of linkage where pathway tests might be split between a CDC and another site i.e. Acute.	

Owing to the IT systems at the CDC being directly linked to the acute site, there will be no segregation of information. Work is ongoing within West Kent, linking in with the Imaging Network, to integrate seamlessly with primary care and we are also undertaking significant work on efficiencies which centre around bookings.
How will clinical staff in the CDC become aware of and have secure access to previous test results and images (i.e. should a patient be returning for a repeat scan or if testing was at a different location)?
A single Order Communications service across Kent and Medway is currently being installed, which includes pathology and radiology testing. This will provide results and images for all tests which have been carried out within Kent and Medway, both supporting clinicians with access to the full patient record (in combination with the KMCR), while reducing the amount of unnecessary tests on patients. The solution also supports this objective by providing decision support to ordering clinicians if tests have been completed recently.
Provide outline plans for technological innovation during the expected lifespan of the CDC
<p>Throughout radiology services, there is a need to integrate AI solutions to provide decision support assistance, with the view of aiding an overstretched workforce and assist in productivity. Some of the Trusts within the system already utilise Brainomix for assistance in the stroke service, and greater use of AI technology in the future can only be beneficial. AI developments will expand significantly over the next few years as the Royal College of Radiologist become more comfortable with the testing undertaken and the West Kent CDC will look to test, assess and embrace the different opportunities this will provide.</p> <p>Voice Recognition is already in place within MTW and licences have been purchased to support this within the CDC. Voice recognition tools combined with AI to aid reporting and support follow up requirements.</p> <p>Interoperability In line with NHS England's vision for data and system convergence across regions we will look further to both integrate and consolidate IT systems to support improved clinical support through digital tools, and availability of data, improving performance and aiding patient care.</p> <p>Integration with the Kent and Medway Care Record (KMCR) which will provide patient access to both results and services.</p>
Please provide narrative on how you will mitigate against digital exclusion & ensure equitable access for all communities including seldom heard groups e.g. But not limited to inclusion health groups, those from most deprived communities who may be experiencing digital poverty
<p>One of the developments achieved as part of the pandemic response has been that NHS trusts have had to adapt approaches and develop new ways of working to meet the needs of patients and service users. This has developed into system wide discussions around digital inclusion and as part of the working group between MTW and the CCG and as part of patient / public engagement.</p> <p>Review is ongoing in recognition of the fact that not all service users will have suitably access to digital provision such as the ready access to reliable internet, tablets or smart phones. Links with Healthwatch to gain additional support and development ongoing with review of how public access to PCs / tablets could be supported.</p>

Workforce

Appendix 5

Please complete the following grid with roles and numbers required around workforce planning. **Extra rows, roles and descriptions should be added as required.**

Roles (WTE)	As at March 2023	As at March 2024	As at March 2025
Radiologist		4.62	4.62
RMO		2.60	2.60
Reporting Radiographers		5.08	5.08
Radiographers	3.66	22.33	22.33
Assistant Practitioners	1.22	5.08	5.08
Sonographers	3.66	7.62	7.62
Echocardiographers		7.62	7.62
Clinical/Healthcare Scientists	1.00	19.06	19.06
Other clinical staff (RDAs)		17.79	17.79
Other clinical staff (HCAs)		5.08	5.08
Admin. Mgt and Support Staff	14.64	32.55	32.55
Total	24.18	129.45	129.45

To note : Healthcare Scientists include Respiratory Physiology staffing, POCT staffing and additional roles such as healthcare science technicians/assistants and support staff for the scanners (Medical Physics/Radiation Physics). These roles will support the development of both the physiological measurement and pathology diagnostic services which will support additional activity and ensure a robust staff development and retention opportunity.

PoCT is an area of significant potential within the CDC which will support the development of clinical pathways and grouping of test which fully support the ambition of the CDC.

Please continue into the following grid with costs around the identified staff planning above. **Extra rows, roles and descriptions should be added as required.**

Roles (£000)	2022/23	2023/24	2024/25
Radiologist	£0	£470	£638
RMO	£0	£147	£200
Reporting Radiographers	£0	£260	£353
Radiographers	£34	£838	£1,323
Assistant Practitioners	£7	£139	£188
Sonographers	£81	£402	£545
Echocardiographers	£0	£402	£545
Clinical/Healthcare Scientists	£5	£784	£1,045
Other clinical staff (RDAs)	£0	£348	£584
Other clinical staff (HCAs)	£0	£123	£167
Admin. Mgt and Support Staff	£75	£1,012	£1,243
Total	£202	£4,925	£6,832

To note : This table includes inflation

Equipment Order & Cost

Appendix 6

CDC / Spoke (Name)	Modality (Imaging, Phys Meas etc)	Equipment (CT, US etc)	Supplier (Name of supplier) model name and any specifications requested	Cost Including VAT	TOTAL Cost Including VAT	Lead in Time	Enabling Works? (Y/N)
West Kent CDC	Imaging	CT	Canon CT 160 slice mid specification x 1	£521,760	£521,760	8-30 weeks	Y circa £150k inc in Modular costs
	Imaging	CT	Canon CT ONE slice high specification x 2	£1,026,149	£2,052,298	8-30 weeks	Y circa £150k inc in Modular costs
	Imaging	CT	CT Injector x 3	£30,000	£90,000	Within CT lead time	N
	Imaging	X-Ray	Siemens X-Ray x 2	£186,000	£372,000	4-16 weeks	Y £45k per room included in Unit A costs
	Imaging	Ultrasound	Samsung US system x1	£84,000	£84,000		N
	Imaging	MRI and CT	Modular Building x1	£4,339,200	£4,339,200	16-30 weeks	Y inc in the modular building costs
	Imaging	Other	Radiologist workstations x 4	£18,000	£72,000	10 weeks	N
	Cardiology	Echo	Samsung Echo system x1	£84,000	£84,000	12-14 weeks	N
	Spirometry	Spirometry	Spirometry Booths x 2	£60,000	£120,000	12-14 weeks	N
	Other	Unit A	Pre-installation costs (Unit A) including professional fees	£840,000	£840,000	12 weeks	N this is the cost of the fitout (inc the xray pre-installation costs above)
	Other	Unit A	IT Equipment (Includes data cabling, fibre links, network/wifi connections, switches etc)	£278,832	£278,832	Unknown – assumed 7 months with April go live date	N
	Other	Unit A	Access control/nurse call/fire/alarm - supply and installation of systems	£120,000	£120,000	24 weeks	N
	Other	Contingency	10% allowance as based on estimates + inflationary pressure unknown		£897,409		
				TOTAL	£9,871,499		

Pathway	Do you have this pathway agreed? (Y/N)	If Y then are you happy for it to be shared with other regions? (Y/N)	If N then would you like NHSEI to support you developing a pathway? (Y/N)	Date to Start	Comments
Symptoms of possible cancer <ul style="list-style-type: none"> Upper and Lower GI Lung - cough, weight loss and haemoptysis Skin / Dermatology Prostate 	N	NA	N		Focus on improving access has been the outcome of MDT discussions re: Cancer pathways
Cardiac Symptoms <ul style="list-style-type: none"> Heart Failure Atrial Fibrillation Chest Pain Heart Valve Disease Breathlessness 	Y	Y	N	April 23	Discussions held with CCG and shared with network
Respiratory Symptoms <ul style="list-style-type: none"> COPD Asthma Breathlessness Sleep Symptoms 	Y	Y	N	April 23	Discussions held with CCG and shared with network
Ophthalmology <ul style="list-style-type: none"> Glaucoma Medical Retina Cataract 	N	NA	N		
Gynaecological Symptoms <ul style="list-style-type: none"> Abnormal Bleeding Abdominal Bloating Pelvic Pain Pelvic Mass eg vaginal examination 	N	NA	N		
MSK/Neurological Symptoms <ul style="list-style-type: none"> Orthopaedics – soft tissue and joint pain OA Spinal conditions (neck and back pain) Rheumatology - Inflammatory Arthritis Osteoporosis and fragility fractures 	Y	Y	N	April 23	Discussions held with CCG and shared with network
Diabetes <ul style="list-style-type: none"> Annual Checks 	N	NA	N		
Head and Neck/Audiology <ul style="list-style-type: none"> Hearing Loss Tinnitus and Balance 	N	NA	N		
Upper and Lower GI Symptoms <ul style="list-style-type: none"> Weight loss 	N	NA	N		

<ul style="list-style-type: none"> PR Bleeding 					
Urological Tract Symptoms <ul style="list-style-type: none"> Male Lower Urinary Tract Symptoms Overactive Bladder Recurrent UTI Raised PSA Haematuria Scrotal pain & Scrotal Pathology 	N	NA	N		
Tests for Liver Disease <ul style="list-style-type: none"> Non Alcoholic Fatty Liver Disease (NAFLD) 	N	NA	N		
Long Covid	TBC	TBC	TBC		
Renal <ul style="list-style-type: none"> CKD F/U Transplant Clinic AKI 	N	N	N		
Other – Please Add					
Other – Please Add					
Information on what other symptom-based pathways you are developing	Pathway Redesign <ul style="list-style-type: none"> Recent improvement projects have been discussed with K&M Imaging Board and will be subject to ongoing review. Review and redesign of processes and pathways to ensure right first time, minimal waste, maximum flow design and throughput for patients and clinical staff. Ensure support staff and all aspects of aspects of IT capabilities, enhance the flow of patients through the CDH. The Vitals Charts© and work undertaken with HCSE methodology will provide an ongoing measure of Demand, Activity, Backlog and Lead times and will be shared across the ICP to assess the impact and progression.. 				
Information on any other symptom-based pathway that is a priority in line with your local population health needs (If there is any)	<p>There will be ongoing review of symptoms based pathways, specifically regarding the potential for cancer pathways.</p> <p>Following initial discussions with a multi-disciplinary team including cancer clinicians, GP rep, Cancer Alliance Programme Director and the West Kent CDC Project team, it was decided that the initial focus would be on improving access times as this would be the most beneficial initially but this will be reviewed at a regular basis.</p>				

As detailed in section 6, the West Kent network has undertaken due diligence on the diagnostic requirements/gaps/innovation required in the West Kent locality.

The proposed pathways have been developed following stakeholder engagement, which included a workshop with representatives from West Kent providers including MTW, Commissioners, GP reps and some patient feedback.

Discussion have been held at K&M Imaging Network to ensure a system approach to pathways, making certain that the needs of our patients are fully considered and that efficiencies are maximised across the system.

Full Description of Risk	Current Impact	Current Likelihood	Current Risk Rating	Key current mitigation / controls already in place	Target Impact	Target Likelihood	Target Risk Rating
Workforce							
Staff availability: Inability to recruit the workforce required in key groups (radiographers/sonographers, cardiac technicians) due to national shortage which means the CDC can not operate to the requirements of the CDC service spec (meeting wait times, KPIs etc) resulting in a reduction in the capacity/the service underperforming and the benefits of CDC approach not being realised	4	4	16	Detailed workforce plan being drafted. A combination of international and UK recruitment to address short term requirements, with other schemes working to address long term issues e.g. apprenticeships. Use of agency/temporary staffing, where available Extension of staffed service for CT	4	3	12
Staff retention: Inability to retain staff due to attraction of London based Trusts and increase in salary from Independent sector providers.	3	5	15	Retention framework will be developed by steering group to retain students in Trusts across the network.	3	4	12
Reporting capacity: There is a risk of insufficient radiologist reporting capacity (including WLI reporting) which leads to additional high costs for external outsourcing resulting in a service that may not be sustainable in the long term.	4	4	16	Potential for a network wide insourcing programme and use of international (GMC registered radiologists), discussions are also underway with the international recruitment partner Aryavrat re using GMC registered radiologists who are now back in India Ongoing conversations with local system to best utilise existing workforce across providers	3	4	12
Equipment							
Availability of Equipment: Delay in the delivery of equipment / extended lead times for delivery impacting on go live date	4	4	16	Place orders as soon as confirmation of funding is received from NHSE/I and final quotes approved. Orders must be placed by end of September 2022 to ensure delivery by the end of March 2023.	3	3	9
IT							
Availability of IT Equipment: Global supply chain issues re: CISCO IT Data supply switches (escalated to government level) causing extended lead time for these items and a potential delay to go live of additional activity.	4	4	16	Go live date amended and review ongoing with Trust IT leads re: mitigations	4	3	12
Future PACs solution: There is a risk of centres being open without new Kent wide PACS solution, thus perpetuating lack of connectivity between sites, radiologists and primary care resulting in fragmented service which could impact negatively on patient experience.	4	4	16	Gain full understanding of how PACS procurement programme operates and put a robust project plan in place to set all sites up with PACS, including training etc.	3	3	9
Finance							
Inflationary Pressures: Capital and revenue costs come in higher than estimated and exceed the allocations, due to inflationary pressures and other global events affecting prices	4	4	16	Rapid procurement that will reduce the potential inflationary pressure, and will minimise delays between pricing and purchase. A 10% contingency has been included in the financial modelling for capital. Inflation of 3.5% (per NHSEI recommendation) per annum has been built into the revenue financial modelling, together with an additional 5% contingency (for inflation and other estimates revenue implications)	3	3	9
Revenue funding uncertainty: Funding for the next 3 years (2022/23 to 2024/25) will be confirmed following SFBC approval. There is still no clear indication of the revenue funding for the West Kent CDC after 2024/25.	4	4	16	Risk is unmitigated as confirmation of revenue funding is required from the national team beyond 2024/25. Continue to work closely with regional team and contracting teams	4	4	16
Contracting and Governance: There is a risk of formal contracting and Governance still not agreed and therefore leading to inability to finalise governance structures and overall accountability. Lack of an agreed contracting model resulting in delays in decision making and continued fragmentation of diagnostic provision.	3	4	12	Short term measure, Lead is putting a medium term an options plan together Continue to work closely with regional team, contracting and governance teams	3	3	9
Risk to spending in year capital allocation: Delay in lead times for IT and Equipment may risk being able to spend the allocated capital funding in year.	4	3	12	Current lead times have been reviewed with suppliers and are all by 31/3/23 hence funding all requested in 2022/23. Regular updates required from suppliers once equipment has been ordered. Early communication to Network Board if any risk on capital spend.	3	3	9
Operational							
Delay in refurbishment of Unit A by the landlord / contractor impacting on the go live date, resulting in significant activity continuing in a non CDC approach, and continued fragmentation of provision.	3	3	9	Long lead time to go live (caused by IT supply chain issues) means Unit A should all be completed by 1/4/23 even with any unforeseen delays in refurbishment	2	2	4
AQP contract specification does not meet the CDC Framework specification. This could lead to significant activity continuing in non-CDC approach, resulting in lack of realisation of benefits of CDC and continued fragmentation of provision	2	4	8	Gap analysis of differences between AQP and CDC service spec and put in place to engage with AQP providers about this and work with them to meet meet the longer term contract specifications.	1	4	4
Access issues: There is a risk that south and east parts of the West Kent patch will not experience improved access to diagnostics in a community setting with a Maidstone based CDC as a "Large" or "Standard" CDC model, leading to inequity across West Kent patch and resulting in negative impact on patient experience	4	4	16	Consider how to utilise current providers as "spokes" and survey other possible sites Current site is good for public transport links for much of the patch	4	3	12
Demand outweighs capacity available in Unit A Hermitage Court. Whilst currently this is not an issue, if demand continues to grow at significant rates then there is potential for demand to outstrip capacity in a matter of a few years	2	3	6	Not an issue currently, will keep under review and work with CCG to identify options	2	2	4

Went Kent CDC Programme Timelines

Appendix 9

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24				
Submit NHSEI 'Short Form Business Case' - OBC - for approval - MTW Trust Board, Imaging Network Board. Then submission to NHSEI																									
NHSEI Approval period (Taking into account holiday season) - Assumed 2 month period																									
Approval of FBC based on final capital quotes																									
Orders placed for capital equipment - and associated lead times																									
IT lead time (Could be longer)																									
Services coming online at Hermitage Court (Month & %)																									
Room 1: X-Ray										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 2: X-Ray										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 3: Ultrasound										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 4: Ultrasound										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 5: Ultrasound										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 6: DEXA										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 7: Phlebotomy										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 8: Phlebotomy										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 9: Spirometry & Phys Measurement										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 10: Spirometry & Phys Measurement										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 11: Echo										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
Room 12: POCT										48% Mon - Fri 9-5	48% Mon - Fri 9-5	48% Mon - Fri 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	67% Mon-Sun 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	90% M-F 8-8, S/S 9-5	100% Mon- Sun 8-8	100% Mon- Sun 8-8	100% Mon- Sun 8-8				
MRI										Managed Service from April 2023															
MRI										Managed Service from April 2023															
CT										Equipment lead time and installation. Staff recruitment. Continue with staffed service until end of December 2023.															
CT										Equipment lead time and installation. Staff recruitment. Continue with staffed service until end of December 2023.															

To note: The percentage represents the percentage of 8am-8pm, 7 days a week capacity that is operational.

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: Core Clinical Services
 Evaluation manager: Jelena Pochin / Ritchie Chalmers
 Project title & reference: West Kent Community Diagnostics Centre
 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: ACHIEVEMENT 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 were such resolved?

What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

Clinical effectiveness		
Project Group:		
To maintain robust management and governance arrangements throughout the programme, a Project Team is in place consisting of: <ul style="list-style-type: none"> Ritchie Chalmers, Chief of Service for Core Clinical Services (Clinical Lead) Jelena Pochin, Lead Deputy DDO for Core Clinical Services (MTW Ops Lead) Julie Wells, Associate Director of Finance - Financial Projects (Finance Lead) Simon Oates, Senior Management Advisor Susan White, Head of Service for Radiology Antony Gough Palmer, Clinical Director for Radiology Steve Hockney, Procurement and Delivery Lead Antony Harris, Associate Director, Integrated Health Care Commissioning Danielle O'Sullivan, Programme Manager, West Kent ICC Dr Andrew Roxburgh, GP Rep Jo Garrity, Head of Staff Engagement and Equality 		
Have clinicians been involved in the service redesign? If yes, list who.		
Yes. Ritchie Chalmers Andrew Roxburgh Richard Fairie	Antony Gough Palmer Emma Ince Mark Garrad	Natalie Ryan Susie White
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)		
Richards Review Diagnostics recovery info		
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.		
DMO1, TaT, Acute flow KPIs		
Are there any risks to clinical effectiveness? If yes, list		
N/A		
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 clinical effectiveness? If yes, list		
Yes, Improved flow for acute patients and more timely access for elective patients		

Patient safety	
Has the impact of the change been considered in relation to:	
Infection prevention and control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality account priorities?	Y
CQUINS?	Y
Are there any risks to patient safety? If yes, list	
N/A	
Have the risks been mitigated?	
Have the risks been added to the departmental risk register and a review date set?	

Are there any benefits to patient safety? If yes, list					
Patient experience					
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.					
Patient experience has been at the centre of the project with key objectives centring around improving access from a timeliness and convenience perspective. CCG have undertaken engagement around community provision of services					
Has the impact of the change been considered in relation to:					
<ul style="list-style-type: none"> • Promoting self-care for people with long-term conditions? • Tackling health inequalities? 					
 Health Equity.pdf					
Does the redesign lead to improvements in the care pathway? If yes, identify					
Yes, redesign of elective diagnostics					
Are there any risks to the patient experience? 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 the patient experience? If yes, list					
Improved privacy and dignity by separating acute and elective work					
Equality & diversity					
Has the impact of redesign been subject to an Equality Impact Assessment?					
Informal review					
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?					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	x	Maintains quality		Reduces quality	
Clinical lead comments					
<ul style="list-style-type: none"> • Improved opportunities for staff upskilling and knowledge sharing • Improved IT connectivity brings primary care diagnostics into the CDC setting so avoiding delays or lost images and reports. • Improved privacy and dignity for patients • Streamlined patient pathways • Reduced waiting times due to increased capacity and activity 					

**To approve a Business Case for the establishment of a
Tier 4 Bariatric Surgical Service at MTW Trust**

Deputy Chief Operating Officer

Please find enclosed the Business Case for the establishment of a Tier 4 Bariatric Surgical Service at MTW Trust. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 26/07/22, 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, 12/07/22
- Finance and Performance Committee, 26/07/22

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

BUSINESS CASE

Establishment of a Tier 4 Bariatric Surgical Service at MTW Trust

Issue date/Version number	V8 July 2022		
ID reference	ID:786		
Division	Surgery		
Directorate	General Surgery		
Department/Site	Surgery Tunbridge Wells Hospital		
Author	Julia McGinley, Divisional Business Manager		
Clinical lead	Mr D Lawes, Clinical Director, General Surgery		
Project Manager	Lucinda Hill, General Manager, General Surgery		
Approved by	Name	Signature	Date
General Manager/Service Lead	Lucinda Hill	Via email	9 th June
Finance manager	D Wood	Via email	9 th June
Clinical Director	D Lawes	Via email	9 th June
Executive sponsor	S Briggs	Via email	9 th June
Division Board	Formally discussed on 4 th May 2022, financial updates have been discussed at Bariatric Steering Group (most recently on 13 th June 2022). Divisional Board were updated on progress on 6 th July 2022.		
Supported by	Name	Signature	Date
Estates and Facilities Management (EFM)	L Gray	Via email	9 th June
ICT	S Forsey	Via email	9 th June
Deputy Chief Operating Officer	S Davis	Via email	9 th June
Diagnostics and Clinical Support Services (DCSS)	K Goodwin	Via email	9 th June
Emergency Planning	J Weeks	Via email	9 th June
Human Resources (HR) Business Partner	L O'Neil	Via email	9 th June
Procurement	B Murray	Via email	9 th June
EME Services Manager	M Chalklin	Via email	9 th June

Further stake holders consulted on 9th June 2022: Clinical Director Therapies, Head of Dietetics, Head of CSMT, Head of Contracts, Head of Finance, Deputy Director of Finance – Performance, Clinical Director Medicine, Lead Endocrinologist, Lead Diabetologist, Clinical Director Anaesthetics

Business Case Summary

Strategic background context and need

Obesity is high on the national agenda, in 2018 67% of men and 60% of women were overweight or obese. In 2018/19 11,117 hospital admissions were directly attributable to obesity, an increase of 4% on 2017/18. The pandemic and resulting lockdowns have also contributed to levels of obesity nationwide.

The UK has the second highest rate of obesity in Europe, and ranks sixth internationally. However, it ranks 13th out of 17 for EU countries and sixth in the G8 countries for rates of bariatric surgery. (BMJ 2016).

- In England in 2018/19; 11,117 admissions to hospital per year are directly related to obesity
- In the same period, there are 876,000 admissions to hospital in England where obesity was a factor
- Obesity is strongly linked to increase incidence of diabetes
- It is estimated 10% of the NHS budget is used to treat diabetes and its complications alone
- 26% of men and 29% of women are classified as obese
- 20% of y6 children are classified as obese

Obesity surgery is approved by NICE. In 2016 commissioning responsibility changed so that the service no longer falls under Specialist Commissioning.

Obesity is referenced in The NHS Planning Guidance 2022/23 which states “There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. *Obesity is the next biggest preventable risk factor*”

There is no full Tier 4 bariatric surgery service within Kent. Annually approximately 300 K&M residents have had to travel to London, Sussex or Surrey for their surgery, commissioned by Kent and Medway (K&M) CCGs.

Professional bodies including NICE advocate nationally that there is a trebling the amount of obesity surgery provided per head of population.

Objectives

- To improve the delivery of Tier 4 bariatric services for the residents of Kent and Medway within Kent
- To set up and develop a multi-disciplinary team (MDT) and integrated pathway for the surgical management of obesity, linked to the Tier 3 service and compliant with NICE and NHS England Guidance for Clinical Commissioning Groups (CCGs): Clinical Guidance: Surgery for Severe and Complex Obesity (2016)
- After the 2nd full year to provide a cost-effective service at less than the current cost of the service provided

The preferred option.

The preferred option is to develop a bariatric service; in Year 1 seeing and assessing 156 new patients with a BMI less than 50 and operating on 108 patients.

The service will develop and in Year 3 (2024/25) using a collaborative approach with the Tier 3 service (TBC Healthcare formerly The Bariatric Consultancy) and University College London Hospitals NHS Foundation Trust (UCL) will see over 350 new referrals and undertaking 20 operations per month on patients with a BMI less than 55.

MTW, uniquely in K&M, has an established team of Upper GI Consultants with the expertise and experience who can provide a local bariatric surgery service for Kent. The role of the UGI surgeon is multifaceted and involves supporting the emergency admissions and surgical procedures 24 hours a day 7 days a week, assessing cancer diagnostics (surgery is carried out in a neighbouring Trust), supporting the development of the Digestive Diseases Unit (DDU), education and development of junior doctors and medical students via the Medical School as well as routine elective outpatients and surgery.

The MTW Bariatric team will work in close collaboration with the local Tier 3 service. In the first years of service a clinician from UCL has agreed to support the bariatric services at MTW in providing high quality and efficiently run services for our patients. In line with NICE guidance patients will be followed up by the team until 2 years post-surgery.

This proposal has been discussed with the CCG and an outline proposal has been discussed at the CCG Clinical Cabinet in February 2022. MTW Head of Contracts and Director of Strategy. Planning and Partnerships have had discussions with the Director of Strategy at the CCG to gather support for the development of this case. As patients are seen and treated in non-K&M providers the activity will be part of a block contract in 22/23, K&M CCG cannot therefore plan repatriating referrals from London in the short-term. However, they can establish a pathway for new referrals from the Tier 3 providers. Tier 3 volumes have significantly increased so K&M CCG have indicated that they will need to commission additional capacity for the future with Health Inequalities funding, after this point funding used to fund services outside of Kent and Medway will be transferred to MTW.

Main benefits associated with the investment

Patients having surgery within K&M	Baseline Position	Future Outcome
Reduction in the need for K&M residents to travel to London for bariatric surgery	Approximately 300 residents per year travel outside of Kent for Surgery	By the end of year 3 only patients with a BMI in excess of 55 will need to travel outside of K&M for bariatric surgery.

Main risks associated with the investment

Risk of not doing it: -

- K&M residents continue to face journey to London for treatment.
- Competing priorities and a lack of local control may leave the patients facing unnecessary delay.
- A fragmented local service may be less prepared to respond appropriately to increased demand
- Increase in obesity related conditions

Delivery risk: -

- No specific bariatric OP tariff currently
- Adjustments to block values may need Regional agreement and signoff

- Additional pressure on RTT waiting time standards arising from pressure on outpatient / ward/ operating theatre/ critical care capacity. As at 29th June 2022 General Surgery has 4966 incomplete RTT pathways, with 873 patients on the in-patient waiting list, no patients waiting more than 52 weeks and a RTT pass of 67.54% .

Residual Risk: -

- Pressure on local capacity. However, local control allows local management and prioritisation of demand supported by local investment.

Financial impact of the preferred option – full year effect – include VAT unless recoverable

Summary of financial impact	Sum(£)	
CAPITAL COSTS for 3 years		
ICT- Identified in the Trust capital plan	£13,980	
Equipment- Identified in the Trust capital plan	£47,280 (ONLY £19,339 IN YEAR 1)	
Total Capital cost of project	£61,260	

Assumptions:

- Year 1 there is no additional theatre and consultant anaesthetist costs as theatre lists are already staffed. Costs are included after April 2023 on the assumption that the theatre capacity review will allow capacity to be released on the TWH site which will be unfunded.
- Theatre staff costs calculated at +35% to allow for the use of agency theatre staff from April 23 to March 24 (whilst the Trust significantly expands theatre capacity). In Year 3 there is 20% additional funding for some agency staff as a contingency.
- Standard hospital beds take patients up to 250kg, therefore no rental of new beds included.
- Patients will be ambulant and suitable for day case surgery. Minimal use of CT, echo and sleep studies required.
- All patients required group and save, additional costs for blood transfusion included.
- UCL mentor support will be needed for 3 sessions a week in Year 1 and 2, reducing from April 2024.
- Bariatric fellow will be required in Year 3.
- Contribution to overheads @20% (for pay and non-pay only)
- There are no additional costs for the bariatric surgeons in all years as their costs are already funded.
- Case mix will be consistent with current case mix at tertiary centres

Although there is a deficit in year 2 direct costs are fully covered and there is a 20% contribution to overheads in all years.

OPTION 5 - phased costing

	Year 1 - Sept 22 to March 23		
	£ 000	Year 2 23/24 £ 000	Year 3 24/25 £ 000
PAY COSTS	326	805	1,051
NON-PAY COSTS	99	394	584
REVENUE SET UP COSTS	42	16	16
Depreciation and PDC	9	14	15
Contribution to overheads @20% for pay and non-pay only	85	240	327
Expenditure Total	560	1,468	1,992
Income	-560	-1,379	-2,054
Revenue Surplus (-) / Deficit (+)	0	89	-62
<i>Memo: Tariff x activity</i>	<i>376,559 -</i>	<i>1,378,743 -</i>	<i>2,053,687</i>

Timetable

Include at a minimum the expected key milestone e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date
Divisional Board	4th May 2022
BRCP	June 2022
Execs	July 2022
Finance and Performance Meeting	July 2022
Trust Board approval	July 2022
K&MCCG approval given	August 2022
MTW Internal working group set up	Established Q3 21/22
Start of recruitment to new posts; dietitian, CNS and psychologist key milestones	July 2022
Service starts to accept new patients	September 22

Clinical timetable

Clinical pathway to be finalised and reviewed via Governance structure:

- Bariatric Steering Group 13th June,
- Surgical Directorate Board 14th June,
- DDU Steering Group 15th June,
- Surgical Governance Board 15th June

August 2022 Latest – place orders for clinical equipment to ensure delivery for September 2022

September 2022 – Service open to new referrals, first clinic held at TWH

October 2022 – First patient receives surgery at TWH

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.

1.1 National

Obesity is high on the national agenda, in 2018 67% of men and 60% of women were overweight or obese. In 2018/19 11,117 hospital admissions were directly attributable to obesity, an increase of 4% on 2017/18.

The UK has the second highest rate of obesity in Europe, and ranks sixth internationally. However, it ranks 13th out of 17 for EU countries and sixth in the G8 countries for rates of bariatric surgery. (BMJ 2016)

- In England in 2018/19, 11,117 admissions to hospital per year are directly related to obesity
- In the same period, there are 876,000 admissions to hospital in England where obesity was a factor
- Obesity is strongly linked to increase incidence of diabetes
- It is estimated 10% of the NHS budget is used to treat diabetes and its complications alone
- 26% of men and 29% of women are classified as obese
- 20% of y6 children are classified as obese

Obesity surgery is approved by NICE. In 2016 commissioning responsibility changed so that the service no longer falls under Specialist commissioning. The service is now commissioned by the local CCG.

Obesity surgery is approved by NICE and NHSE guidance is for a 4-tier model approach to obesity services.

Professional bodies advocate nationally, a trebling the amount of obesity surgery provided per head of population.

Obesity is strongly linked to increase incidence of diabetes. "Diabetes", the UK's leading charitable funder of diabetes research, estimates that 10% of the NHS budget is used to treat diabetes and its complications alone.

Different tiers of weight management services cover different activities. Definitions vary locally but usually:

- tier 1 covers universal services (such as health promotion or primary care);
- tier 2 covers lifestyle interventions;
- tier 3 covers specialist weight management services; and
- tier 4 covers bariatric surgery.

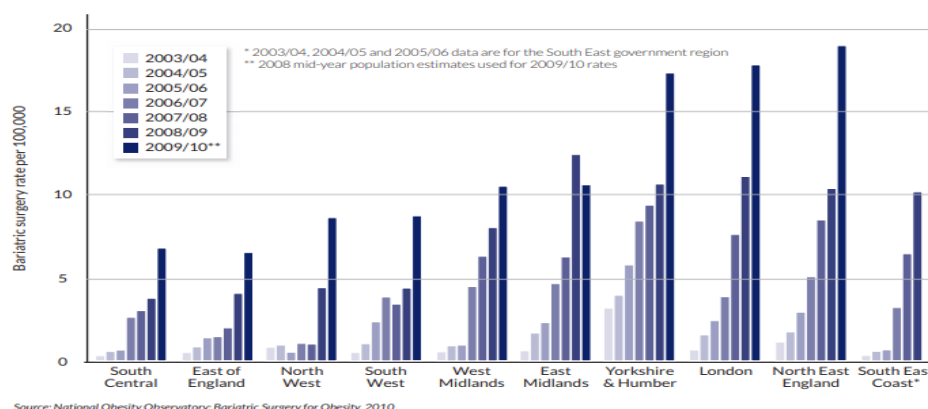
General Surgery GIRFT report references bariatric surgery and states: Demand for some surgical procedures is hard to predict. However, there are areas where there is clear evidence of unmet need. The most obvious of these is bariatric surgery, where despite a 300% increase in surgical activity over the last six years, due to the prevalence of obesity, only 0.6% of potential surgical activity is currently delivered. Evidence has shown that access to surgery varies widely between regions, and that provision is not necessarily higher in areas that have the greatest prevalence of obesity. This has led to sizeable variations in demand at present that will increase if current patterns do not change. Given the high levels of childhood obesity in the UK, NHS England is now collating evidence to support a proposal 2 for the routine commissioning of bariatric surgery for those aged 18 and under. If this was introduced, it would clearly have a substantial impact on demand.

1.2 Local

PHE report that the obesity rate in Kent is 63.2% and 69.4% in Medway, compared to the national rate of 63.5%.

In 2016 the commissioning of bariatric surgery in adults moved from being the responsibility of Specialised Commissioning to become the responsibility of the local CCG.

The South East has a low level of hospital episodes for bariatric surgery per 100,000 population.



The annual cost for bariatric surgical cases from Kent and Medway was £2.1M in 18/19 and £1.89M in 19/20 (reducing to £686K during the pandemic in 20/21 based upon eleven months of data, forecast for a full year effect).

	2017/18	2018/19	2019/20	2020/21*
Activity (count of surgical procedures)	224	320	267	94
Surgery cost (with actual HRG tariff and provider MFF applied by year)	£1,297,117	£2,007,726	£1,813,193	£658,533
1x First outpatient attendance (proxy cost of £173+1.2MFF)	£46,502	£66,432	£55,429	£19,477
1x Follow-up outpatient attendance (proxy cost of £72+1.2MFF)	£19,354	£27,648	£23,069	£8,106
Surgery & Outpatient Combined Total	£1,362,973	£2,101,806	£1,891,691	£686,115

NHS obesity surgery is commissioned for the Kent and Medway population from providers outside the area as shown in the table below. No NHS obesity surgery is provided in East Kent, West Kent or Medway. In the last 4 years K&M CCG has sent patients to 16 different providers across the UK. The top 3 providers Kings, Ashford and St Peters and Western Sussex (St Richard's Hospital in Chichester) undertook 407, 132 and 118 episodes respectively in the last 4 years, a further 13 providers undertook 248 cases in the same period. There is a hub of the King's Service with Inpatient and day surgery provided at the Princess Royal with outpatient clinics at the Princess Royal, Orpington Hospital and Beckenham Beacon.

Within MTW the development of bariatric surgery aligns with Trust's strategic plan to develop a Digestive Diseases Unit.

The CCG have supplied MTW with details of bariatric surgery undertaken in previous years, unfortunately this does not indicate BMI of patients nor current wait times. The mix of these patients was as below, there appears to be no explanation for the reduction in activity in 2019/20 which is probably not explained by Covid:

	2017/18	2018/19	2019/20	2020/21
Day Case	24	18	14	4
Elective	194	298	244	87
Emergency	6	4	9	2
TOTAL	224	320	267	93

Providers are under contract to provide bariatric surgery and K&MCCG will need to give notice. However, during the pandemic significant backlogs have built up and it is understood that there are currently significant patients waiting more than 52 weeks. The full number and waiting time for patients is not known by the CCG.

Surgery attendances:

	2017/18	2018/19	2019/20	2020/21	Total
Kings	101	154	119	33	407
Ashford and St Peters	17	44	40	31	132
Western Sussex	25	33	51	9	118
Chelsea and WM	19	15	10	9	53
UCL	18	22	10	2	52
Lewisham and Greenwich	6	9	15	2	32
Homerton	7	11	8	1	27
Imperial	9	11	4	2	26
St George's	9	10	4	2	25
GSTT	10	4	1	0	15
Luton and Dunstable		2	3	2	7
Whittington	2	4	1	0	7
Bournemouth and Christchurch		1			1
North Midlands	1	0	0	0	1
Heart of England	0	0	1	0	1
Surrey and Sussex	0	0	0	1	1
	224	320	267	94	905

In the past the CCG had put bariatric surgery onto the list of procedures where Referral and Treatment Criteria (RATC) apply and individual approval is required subject to the criteria below.

Kent and Medway CCG Referral and Treatment Criteria (RATC) for bariatric surgery (abridged)

- Prior approval is required for this procedure
- Bariatric surgery in adults is not routinely funded by CCGs except where all of the following criteria are fulfilled:
 - The patient has either:
 - a BMI of ≥ 40 , OR
 - a BMI of 35–40 and other significant obesity related disease (e.g. type 2 diabetes mellitus or high blood pressure) that could be improved if they lost weight, (see note) OR
 - Asian family origin, recent onset* type 2 diabetes mellitus and a BMI of >32.5
- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The individual has recently received and complied with a local specialist weight management programme (tier 3) for a duration considered appropriate by the multi-disciplinary team (MDT).
- The person is generally fit for anaesthesia and surgery and commits to the need for long-term follow-up.
- A formalised MDT led process for the screening of co-morbidities and the detection of other significant diseases has been completed.
- The specialist hospital bariatric MDT agrees surgery is indicated

Prior approval is no longer needed and designated providers have been able to undertake surgery on patients **who fit the above criteria** without prior approval.

In order to deliver a complete bariatric surgery service at MTW K&M CCG will need to designate MTW as one of their named providers.

2. Objectives and case for change of the proposed investment

The objectives of this proposal are:

1. To improve the delivery of Tier 4 bariatric services for the residents of Kent and Medway within Kent
2. To set up and develop a multi-disciplinary team and integrated pathway within Kent for the surgical management of obesity, linked to the Tier 3 service and compliant with NICE and NHS England Guidance for Clinical Commissioning Groups (CCGs): Clinical Guidance: Surgery for Severe and Complex Obesity (2016)
3. In the medium and long term to provide a cost-effective service at less than the current cost of the service provided

Objective 1 To improve the delivery of Tier 4 bariatric services for the residents of Kent and Medway within Kent

Current situation:

The model for managing obesity has been defined by NHS England as follows:

- Tier 1: Preventative programmes/ health promotion
- Tier 2: Lifestyle weight management advice provided in primary care
- Tier 3: Specialist care provided by qualified specialists in obesity
- Tier 4: Management provided by specialist obesity medical and surgical multi-disciplinary team

In East and West Kent and Medway there is no local Tier 4 service

Problems / risks of current situation:

Patients need to travel to London or West Sussex for treatment commissioned by K&M CCG.

Local commissioners are unaware of the number of patients waiting for bariatric surgery

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

Approximately 270 patients per annum currently travel outside the area for their treatment

The expected benefits of achieving the change:

Local service integrated with local lower Tiers.

The cost to the health economy is likely to be lower outside of a London/Teaching Hospital environment.

Local knowledge and control of the bariatric surgery service

Objective 2 To set up and develop a multi-disciplinary team and integrated pathway for the surgical management of obesity, linked to the Tier 3 service and compliant with NICE and NHS England Guidance for Clinical Commissioning Groups (CCGs): Clinical Guidance: Surgery for Severe and Complex Obesity (2016)

Current situation: Patients are referred out of our area for Bariatric surgery to Kings College Hospital Trust, Kings and Western Sussex Hospitals Trust (see table bottom of page 8)

Problems / risks of current situation:

Expense and practical difficulties for travel for severely obese patients to tertiary centres

CCG pay for transport for patients to have surgery outside of Kent and Medway

A reduction in local integration with lower Tiers and reduction in control over access and priority

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

A local service integrated with local Tiers 1-3, managing increasing demand in line with CCG priorities and guidance.

The expected benefits of achieving the change:

A local service for the residents of Kent and Medway

The opportunity to have improved continuity of care through four tiers of locally managed and delivered bariatric services

Objective 3: In the medium and long term to provide a cost-effective service at less than the current cost of the service provided

Current situation: All income for bariatric services is outside of Kent and Medway

Problems / risks of current situation:

Income leaves our area to the London providers on treatment that can be made available locally and invested in local capacity

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

A local service integrated with local Tiers 1-3, managing increasing demand in line with CCG priorities and guidance

The expected benefits of achieving the change:

A bariatric service where specialist trained and experience bariatric surgeons work closely with local surgery, endocrinology and gastroenterology specialist services to provide the patient with a holistic service.

An inpatient service located in a fully single room hospital giving patients the best environment to enhance privacy, dignity and infection control.

3. Constraints and dependencies

- Must be integrated with local Tiers 1-3 who have existing referral pathways
- New governance arrangements to be put in place to assure that processes at every stage are robust
- Existing patients' referrals pathways to remain to reflect the incremental nature of the developing and expanding clinical service.
- CCG will need to manage different waiting times at different providers
- Collaboration required with clinician from UCL in first years to support the surgical teams and development of service
- Commissioners will need to give notice to current providers about changes in service.
- Fundamental changes to block contract agreement change may need Regional approval
- Requires a clearly documented and agreed institutional weight limit, taking equipment, (outpatient, diagnostic, surgical, manual handling, ward care & hygiene) into account on a locally agreed treatment pathway
- Must adhere to local CCG commissioning guidelines including the 'Referral and Treatment Criteria' (RATC)
- Will need to create a culture of team working and partnerships that transcends roles.

3.1 Governance

The UGI service was the subject of a clinical review in October 2013, resulting in a change in clinical service. Although many years have passed and there have been significant changes in managerial, clinical and surgical staff within UGI since this review, it is of critical importance that robust governance processes are at the heart of this service change.

The prospective pathway has been designed to ensure that all patients undergo multidisciplinary assessment and are operated on only if they fulfil the appropriate national and local guidelines and have completed the designated pre-operative work up. All patients will be discussed at a dedicated MDT meeting to ensure that this occurs and only proceed with surgery if all members of the MDT agree.

The Team will create a database to ensure that all outcomes are audited and accurate real results can be shared (with both stakeholders and nationally). In this regard further oversight is provided by BOMSS with regard to the NBSR (National Bariatric Surgery Registry) to which all cases would be added.

The Team have agreed in the initial phase to dual consultant operating and have an agreement with a clinician from the Bariatric Unit at UCLH to provide mentorship in the early phase. Under any option the team do not propose to take on the higher risk profile patients initially until the processes and pathways are fully established. The service will be limited even in year 3 to patients with a BMI of less than 55.

Proposed Supervision for the first two years:

- Two teams of the local surgeons would be created with surgeons linked together for six months.
- Members of the two teams will change every six months to allow each surgeon to operate with the other colleagues during the initial two-years phase of establishing the service. This will allow optimum exchange of experiences and techniques.
- The aim would be to individually operate by the third year to accommodate the expected expansion of the service by that time.
- Each team is expected to attend the one-stop MD clinic review as well as the MDT to discuss the specific cohort of patients that they reviewed on the day.
- These patients would have their operations done by the team who reviewed them at the OP clinic and MDT. This is to optimise continuity of care as well as management of post-operative complications if required.
- Monday is the day that is suitable for the Supervising Consultant to provide local supervision at Tunbridge Wells Hospital. Consequently, it would be the recommended day for theatre. Furthermore, operating early in the week would facilitate optimum post-operative care.
- The on call general surgical consultant would be expected to provide emergency cover.
- The Supervising Consultant from UCL will provide support and advice in theatre as well as the MDT.
- The UCL surgeon is expected to provide a second opinion if required. If not available, the MTW bariatric lead is the next point of contact.
- The decision of site of post-operative care either on the ward or HDU/ITU should be preoperatively agreed with the operating surgeons and the Bariatric Lead anaesthetist.

4. Short list of options

Option 1 Title: The do-nothing option

Description – K&MCCG to continue to commission the service from other providers, MTW will not be involved in the surgical treatment of bariatric patients.

Key activity and financial assumptions – 270 + patients /year sent to other providers outside of Kent

Non-financial risk associated with the option

- Loss of local control as the CCG do not know where and how many patients are referred
- Long journeys for Kent patients to access Tier 4 services
- Difficulty integrating with local Tiers 1-3

Non-financial benefits associated with the option

- Surgical capacity available to treat local patients for routine general surgery elective cases

Option 2:

Description – Provide Tier 3 and 4 bariatric services at MTW

Key activity and financial assumptions –

- 270 plus patients /year have surgery locally
- 600 patients have Tier 3 intervention in Kent
- Minimal patients travel outside of Kent for surgery

Non-financial risk associated with the option

- Not enough space and capacity on the MTW sites
- Delivery and governance of CBT supported weight loss is not currently delivered within MTW

Non-financial benefits associated with the option

- MTW is a centre of excellence and the sole provider of bariatric services in Kent

Option 3:

Description - Develop hub and spoke model with current provider

Key activity and financial assumptions –

- 50 patients /year have surgery locally
- Remaining patients © 220 pa remain in London/Sussex

Non-financial risk associated with the option

- Some loss of local control, difficult access for local patients
- Possible reluctance of tertiary centre to provide support to competing service.
- Long term reliance and additional cost from tertiary centres
- MTW clinical teams keen to develop whole pathway service rather than just act as surgical spoke

Non-financial benefits associated with the option

- Allows the service to develop slowly with the support of existing experienced service to provide governance and clinical advice and mentorship

Option 4 :

Description - Provide a standalone Tier 4 bariatric service at MTW

Key activity and financial assumptions

- Up to 300+patients /year
- Remaining patients remain in London/Sussex for their surgery

Non-financial risk associated with the option

- Limited opportunity for support from tertiary centres
- Service development requiring significant management and clinical leadership time
- Capital and equipment requirements are not likely to be funded

Non-financial benefits associated with the option

- A local service for the residents of Kent and Medway
- Reduction in BMI for patients who have received surgery
- After the service has been set up the costs per patient are more affordable than treatment in London due to reduced MFF
- Support and commitment from MTW General Surgical Team
- Improved retention of trained staff
- The opportunity to have improved continuity of care through four tiers of locally managed and delivered bariatric services
- A bariatric service where specialist trained and experience bariatric surgeons work closely with both the multi-disciplinary team, dietitians, obesity nurses, psychologist and consultant diabetologist/metabolic physician to provide the patient with a holistic service.
- An inpatient service located in a fully single room hospital giving patients the best environment to enhance privacy, dignity and infection control.
- MTW seen as the sole "Kent Bariatric Surgery Centre"

Option 5:

Description - Develop staggered model of service with support and mentorship from a practising bariatric surgeon. In the first year focussing on patients with a BMI of less than 50 with an expectation of operating on around 100 patients based on a 70% conversion rate from referral. This will increase to 200 procedures in year 2 with the increase in BMI < 55 and up to 300 procedures in years 3-5 with no further increases to BMI. There is an expected 70:30 split between sleeve and bypass surgery.

Clinical criteria for surgery:

- BMI<50, first year.
- ASA 3 or better.
- Not immune compromised.
- No end stage organ failure, or end stage metabolic syndrome.
- Not requiring long term psychological support. As patients would be preoperatively screened as Green or Red by the psychologist.
- Able to consent
- Not < 25 years of age.

Exclusion criteria:

- BMI >50,
- Weight > 150 kg,
- Bore size > 60 cm. This is related to the diameter of the current available CT scan.

This would comply with the following K&MCCG criteria for bariatric surgery:

- a BMI of 35–40 and other significant obesity related disease (e.g. type 2 diabetes mellitus or high blood pressure) that could be improved if they lost weight, (see note) **OR**
- Asian family origin, recent onset* type 2 diabetes mellitus and a BMI of >32.5

Key activity and financial assumptions –

In year one 100 patients have surgery locally, Year two 200 procedures with an increase in BMI <55 and up to 300 procedures in years 3-5 with no further increase in BMI

Conversion rate from new OP to surgery is 70%

Remaining patients, expected to be approximately 250 to have surgery in London/Sussex

Non-financial risk associated with the option

Difficulty in assessing demand

Service may be overwhelmed with patients

CCG to commit to a service beyond year 1

Non-financial benefits associated with the option

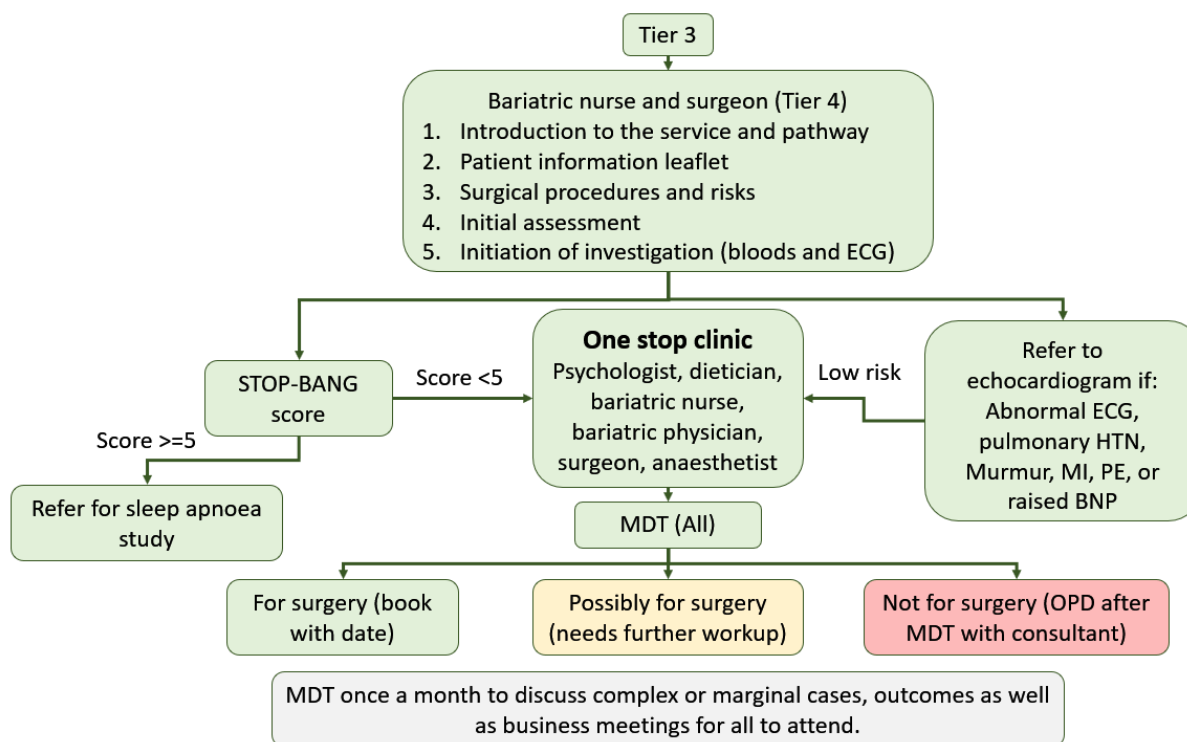
Supports developing governance and operational policies

The patient pathway

Patients will be referred by eRS from the local Tier 3 services in Kent and Medway into the MTW tier 4 Bariatric surgery service.

The service will be run from 3 identified clinic rooms (9,10 and 11) in main OP at Tunbridge Wells Hospital.

The pre-op pathway for patients is:



The Team aims to carry out this surgery via an operating session at Tunbridge Wells, in the short term due to the resignation of one of the Surgeons there is capacity for this in the UGI Surgeon's job plans.

Post-operatively patients would be treated within Ward 32 at TWH. During Spring 2022 average bed occupancy at TWH is 113.9 surgical patients per night, bed base is 119 so there is a small potential opportunity to do additional elective work on the TWH site. Patient expectations will be set that 90% of patients will have a 23-hour length of stay in our SSSU.

It is anticipated that less than 10% of patients will need HDU care and 1% of patients (i.e. less than one per year) will require ICU care post operatively. At the current providers percentage of bariatric surgery requiring critical care in the past 4 years has been 12, 9, 6 and 2% respectively. Average length of stay over the last 4 years is 2.4 days; however, one patient stayed 39 days. MTW intensivists support this as an expected clinical scenario based on their experiences elsewhere.

Patients are seen regularly for follow up by the dietitian, CNS and surgeon up to 2 years post-operatively as recommended by NICE.

Risk register at Planning stage

Risk type	Description	Mitigation	Remaining risk
Reputational risk	Adverse clinical event leading to local scrutiny of service	Pathway design to support appropriate patients for surgery Database and continuous audit process in place Support from bariatric surgeon mentor	
Design risk	Risk that the pathway design does not deliver the required quantity of appointments required	Regular review of pathway as part of operational meetings	
Planning risk	Unable to recruit to posts required to run service	None of the posts needed to deliver this service are standalone, therefore with the possible exception of dietitians it is planned to release staff from the existing service and backfill if could not recruit substantively	
Demand risk	Number of patients seeking service may be far greater than capacity creating unforeseen backlogs and inability to meet RTT targets and inability to meet objectives and CSFs	Set up regular communication with CCG and Tier 3 service	
Demand risk	Number of patients seeking emergency treatment from ED and requiring admission might increase number of medical outliers in surgical wards	Theatre list scheduled at the beginning of the week. Day surgery planned for this cohort of patients, with expectations set with patients early on in the clinical pathway	
Procurement risk	Potential risk from breakdown in contract with Bariatric Surgeon support	If required the Surgeons can be self-supporting from approximately 6 months onwards. There is currently a vacancy for an UGI surgeon and if required this post could be focussed on additional bariatric surgery support	
Procurement risk	Risk that CCG priorities change and there is no commitment to fund the service in Year 1 and beyond	Exec support to ensure that service stays on priority list for funding	
Procurement risk	Funding for Year 1 has verbal agreement from CCG but not confirmed with contract variation	Set up Bariatric Steering Group with CCG involvement	
Operational risk	Costs vary from budget causing performance to slip	Operational groups to manage project implementation	
Operational risk	In the medium term there is no capacity in surgeon's job plans	Theatre schedule to be reviewed to ensure additional sessions and capacity are available	
Operational risk	Inability to recruit theatre staff	Costings include an additional	

Funding risk	Availability of funding for Years 2 and beyond is reduced leading to delays and reductions in scope of service.	Set up Bariatric Steering Group with CCG involvement	
External risk	Increase in covid19 cases leading to reduction in elective operating	No local mitigation	
Policy risk	Potential for local and national priorities to change	No local mitigation although Obesity is referenced in The NHS Planning Guidance 2022.	

Benefits associated with the option

- The creation of a local service for the residents of Kent and Medway would mean that local residents would have access to bariatric surgery without the need to travel outside the area.
- Reduction in BMI and health inequalities for patients who have received surgery and consequent improvements in overall health
- Support and commitment from MTW General Surgical Team
- Improved retention of trained staff across subspecialties
- Incremental start to service allows for more robust support to the clinical team with set up of governance, audit and clinical infrastructure
- The opportunity to have improved continuity of care through four tiers of locally managed and delivered bariatric services
- A bariatric service where specialist trained and experience bariatric surgeons work closely with both the multi-disciplinary team, dietitians, obesity nurses, psychologist and consultant diabetologist/metabolic physician to provide the patient with a holistic service.
- An inpatient service located in a fully single room hospital giving patients the best environment to enhance privacy, dignity and infection control.
- After the service has been set up the costs per patient are more affordable than treatment in London due to reduced MFF

Critical success factors

Local Strategic fit and business need

- Development of a bariatric surgical service fits the organisation's vision of Exceptional People, Outstanding Care (EPOC)
- The bariatric surgery service forms part of the Trust's Clinical Strategy to establish a Digestive Diseases Unit (DDU) at TWH. Surgeons and physician will work together to provide in house multidisciplinary care for all patients with digestive diseases. This enables the highly skilled and experience team to provide high quality care for the local populations
- The vision for General Surgery is to provide an exceptional level of care to the people of west Kent.

Potential value for money

- This development optimises public value (social, economic and environmental) in terms of the potential costs, benefits and risks by moving highly complex work from tertiary providers to west Kent.
- After the service has been set up the costs per patient are more affordable than treatment in London due to reduced MFF

Potential affordability

- The proposal can be funded from available sources of finances, in year 1 as part of the Improving Health Inequalities workstream and thereafter from Trust wide elective contract.

Potential Achievability

- There is exceptional clinical leadership and commitment to this proposal both from within the Division and Directorate. The clinical and managerial skills within the team are well matched to ensure successful delivery of the project. A staggered approach to service delivery would allow the service to develop clinically with the support of an appropriate mentor.

Key performance indicators (KPIs)

These are specific KPIs relating to the bariatric service derived from The UK National Bariatric Surgery Registry

	Metric	Goal
Conversation rate	% of referred patients who are suitable for surgery	70%
Type of surgery	Split between sleeve and bypass surgery	70:30 split
Complication rate	2.18% reported nationally in Third registry report 2020	Less than 2.18%
% patients admitted to ICU	Patients transferred to ICU post-surgery	Less than 1 in 100
% patients admitted to HDU	Patients transferred to HDU bed post-surgery	Less than 1 in 10
Reoperations	Revision of surgery	Less than 10.2%
Readmission	Admission for bariatric related issue within 30 days of discharge	Less than 1%
Length of stay	Less than 24 hours	90% of patients
% excess weight lost	One-year post op excess weight loss	Bypass – 71.5%, Sleeve gastrectomy 62.9%
Reduction in type 2 diabetes	Reduction from 30% to 14% nationally in Third registry report 2020	14%

KPIs relating to theatre utilisation, clinic productivity, income and expenditure for the service will be managed via the Surgical Division BAU processes.

Capacity review

The team have reviewed capacity in the first year.

- The list identified on a Monday is allocated to UGI on weeks 1,3,4 and 5 is staffed by a locum consultant (formerly Mr Hamouda). The original planning assumption for 2022/23 business planning was to operate on 6 patients per day for 32 weeks = 192 episodes

With this plan we expect that the locum will carry out their current work plan from April to September; 16 weeks at 6 patients per list = 96 patients.

- With the start of the bariatric service the bariatric surgeons would use the list on weeks 1 and 3, leaving the locum to operate on weeks 4 and 5.
- Capacity created would be 40 bariatric cases (10 sessions of 4 cases) plus locum activity of approximately 48 episodes. Total revised capacity for H2 = 88 cases
- Total revised capacity is therefore – $96 + 88 = 184$
- Total capacity for the Monday list would therefore reduce from 192 to 184 cases.

This would be mitigated by using the locum to backfill vacated lists from other surgeons. We expect this to have no impact on our Elective Recovery Fund plans, as in the first year (up to March 23) this is a change of use of clinical capacity.

As at 29th June 2022 General Surgery has 4966 incomplete RTT pathways, with 873 patients on the in-patient waiting list, no patients waiting more than 52 weeks and a RTT pass of 67.54% . The change to the capacity as outlined above would result in 40 general surgery cases not being operated on, as these will be substituted for bariatric cases. This is less than 5% of the total in-patient waiting list and would have a minimal impact on total waiting list and RTT%.

From year 2 there will be a requirement for more theatre capacity. If the bariatric team were to operate on W1,3,4 and 5, assuming 2 cases per session, they could operate on a maximum of 163 patients per year. However, in order to treat more patients, there is opportunity to create additional sessions with the planned theatre review. This would require job plan review and the requirement for additional costs for anaesthetists and theatre staff.

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 BAU Do nothing	<p>Risks</p> <ul style="list-style-type: none"> Loss of local control, difficult access for local patients Difficulty integrating with local Tiers 1-3 <p>Benefits</p> <ul style="list-style-type: none"> None 	Rank: low
Option 2 Develop Tier 3 and 4 service at MTW	<p>Non-financial risk associated with the option</p> <ul style="list-style-type: none"> Not enough space and capacity on the MTW sites Delivery and governance of CBT supported weight loss is not currently delivered within MTW <p>Non-financial benefits associated with the option</p> <ul style="list-style-type: none"> MTW is seen as THE Prime Provider of bariatric services in Kent 	Rank: Low REJECTED no further financial analysis/development undertaken
Option 3 Hub and spoke	<p>Non-financial risk associated with the option</p> <ul style="list-style-type: none"> Some loss of local control, difficult access for local patients Possible reluctance of tertiary centre to provide support to competing service Not clear if tertiary centres will provide service for free or at what cost Surgeons keen to develop whole pathway service rather than just act as surgical spoke Difficulty integrating with local Tiers 1-3 <p>Non-financial benefits associated with the option</p> <ul style="list-style-type: none"> Allows the service to develop slowly with the support of existing experienced service to provide governance and clinical advice and mentorship 	Rank: Low REJECTED no further financial analysis/development undertaken
Option 4: MTW only service for Kent residents offering full range of service	<p>Risk</p> <ul style="list-style-type: none"> Collaboration with St Georges / UCL clinician in first years Significant additional pressure on waiting time standards arising from pressure on outpatient / ward/ operating theatre/ critical care capacity, Service may be overwhelmed with referrals Not enough capital funding to resource service properly Big service development requiring significant management and clinical leadership time Risk of breakdown of governance and operational policies if increase capacity too quickly <p>Benefits</p> <ul style="list-style-type: none"> A local service for the residents of Kent and Medway delivered by one Trust The opportunity to have improved continuity of care through four tiers of locally managed and delivered bariatric services A bariatric service where specialist trained and experience bariatric surgeons work closely with both the multi-disciplinary team, dietitians, obesity nurses, psychologist and consultant diabetologist/metabolic physician to provide the patient with a holistic service. An inpatient service located in a fully single room hospital giving patients the best environment to enhance privacy, dignity and infection control. 	Rank: Medium
Option 5: Develop staggered model of service starting with patients up to 50 BMI	<p>Risk</p> <ul style="list-style-type: none"> Collaboration with St Georges / UCL clinician in first years Pressure on waiting time standards arising from pressure on outpatient / ward/ operating theatre/ critical care capacity, Service may be overwhelmed with referrals <p>Benefits</p> <ul style="list-style-type: none"> Allows for incremental growth to a new service whilst pathways are developed A local service for the residents of Kent and Medway for patients with a BMI up to 50, who fulfil the K&M RAT Criteria The opportunity to have improved continuity of care through four tiers of locally managed and delivered bariatric services A bariatric service where specialist trained and experience bariatric surgeons work closely with surgical and gastroenterology specialist services to provide the patient with a holistic service. An inpatient service located in a fully single room hospital giving patients the best environment to enhance privacy, dignity and infection control. 	Rank: High

Summary of options:

	BAU	Develop Tier 3 and 4	Hub and Spoke	Full service	Staggered model
OBJECTIVES					
Improve the delivery of Tier 4 bariatric services for the residents of Kent and Medway within Kent	X				
To set up and develop an MDT and pathway for K&M	X				
To provide a cost-effective service at less than the current cost of the service provided	X	?	?	?	
Retain Upper GI surgeons as part of General Surgical workforce	X				
Critical Success Factors					
Local Strategic fit and business need	X				
Potential value for money					
Potential affordability		?	?	?	
Potential Achievability		X	?	x	
Summary		Discounted	Possible	Discounted	Preferred

4b. Summary of information on each option

Category (summarised 3 yr costs and income)	Option 1 do nothing	Option 2 Tier 3 and 4	Option 3 Hub and spoke	Option 4 Full service	Option 5 BMI 50 and under Year 1
Capital costs (<i>One off upfront costs</i>)	£0				£25,039
A) Revenue income – part year	£0				£560,426
B) Costs/ expenses (pay and non-pay) part year	£0	Financial assessment not worked up	Financial assessment not worked up	Similar costs to Option 5	£560,426
Net annual income = (A –B)	£0				Zero impact
Benefits/Risk (<i>non-financial</i>) rank of option	Low benefit	High risk	Clinically unacceptable	Medium Risk	High benefit/low risk
<i>Summary of option (Preferred / discounted/ deferred)</i>	Discounted	Discounted	Discounted	Discounted in short term	Preferred

Note the expectation is that, as agreed with the CCG, this service will be funded in the short term from Health Inequalities funding at cost, thereby creating a cost neutral financial position.

4c. Directorate decision on which option is preferred and why

The preferred option is to develop a local Tier 4 bariatric surgery service at MTW based on treating patients with a BMI less than 50 in Year One.

This offers a significant improvement in local access for patients.

It will enable development and investment in local services, whilst the CCG give notice to other providers about changes to their services.

During Year One the service will work with the Tier 3 service and local commissioners to further develop locally accessible Tier 4 bariatric service pathways.

NOTE: From this point onwards, the sections should be completed for the preferred option only.

5. Commercial considerations (preferred option)

Further specifications will be refined in operational planning but changes include additional investment in a multi-disciplinary clinic with surgeon/s, endocrinologist, clinical nurse specialist, dietitian and counsellor, who will also meet as an MDT to discuss the outcome of the clinic and plan for surgery.

Suitable patients will need a pre-operative work up with POA nursing staff and anaesthetic input prior to surgery in existing timetabled sessions. In line with NICE guidance patients need follow up at 2 weeks, 6 weeks, 6 months, 1 year and 2 years. In between these appointments they will need educational support from the CNS, dietitian and counsellor.

A key part of planning for the new service is establishment of robust governance arrangements; these will be put in place to provide assurance that there are strong processes at every stage in the patient pathway.

The prospective pathway has been designed to ensure that all patients undergo multidisciplinary assessment and are operated on only if they fulfil the appropriate national guidelines and have completed the designated pre-operative work up. All patients will be discussed at a dedicated MDT meeting to ensure that this occurs and only proceed with surgery if all members of the MDT agree.

The Bariatric Team will create a database to ensure that all outcomes are audited and accurate real results can be shared (with both stakeholders and nationally). In this regard further oversight is provided by BOMSS with regard to the NBSR (National Bariatric Surgery Registry) to which all cases would be added. In the initial phase the department will run dual consultant operating and have an agreement from one of the Bariatric Surgeons from UCLH to provide mentorship in the early phase. The team will not take on the higher risk profile patients initially until the processes and pathways are fully established.

The department aims to carry out this surgery via an operating session at Tunbridge Wells, in the short term there is capacity for this in the UGI Surgeon's job plans. There is one consultant surgeon vacancy currently and we will use these vacated sessions as an opportunity to reconfigure the surgeons job plans, this will move some of their current routine surgical activity to be undertaken by non-consultant grade medical staff, thereby improving their exposure to surgical activity.

Post-operatively patients would be treated within Ward 32 at TWH, we anticipate that 10% of patients will need HDU care and 1% of patient ICU care post operatively. The Chief of Service for Surgery is confident that these patients can be managed within the expanded Critical Care and Enhanced Care bed base.

The following non-pay items will be required as part of the 3 year set-up, in order to manage delivery lead times they will need to be order at least 2 months prior to the start of operating starting.

Item – revenue set up	Y1	Y2	Y3	Item value
Fast clamps	2	2	2	£2,747
Needle holders and baskets	4			£4,018
10mm 30 degrees ultra telescope	2			£9,996
10mm 30-degree long telescope	2			£7,472
Ward set up - 2x waiting room chairs, winged chairs, commodes				£2,484
Hovermatt air supply	1			£1,234
Bariatric scales	2			£678
Surgical care practitioner course fee				£4,000
IT screens, keyboards, mouses, docking stations (incl. VAT)				£4,184

Set up - capex (incl. VAT)	Y1	Y2	Y3	Total
IT costs - laptops CAPITAL	7	4	5	£13,980
Theatre table CAPITAL		1		£27,942
Theatre accessories CAPITAL	1			£19,339
				£61,260

The Surgeons require the use of a C-MAX operating table with bariatric accessories to accommodate the width, weight and operating position of their patients. 6 suitable tables have been purchased as part of another planned development and one has been transferred to TWH for use in the first year. The attachments will be fully trialled to ensure suitability and compliance, it is likely that these will need to be purchased before the end of March 2023. However, it is possible that a new table will not be needed until other developments are in place.

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

The current number of patients being treated in London / out of area is c. 300/yr. The CCG are required to give a year's notice to the top 5 providers.

	2017/18	2018/19	2019/20	2020/21	Total
Kings	101	154	119	33	407
Ashford and St Peters	17	44	40	31	132
Western Sussex	25	33	51	9	118
Chelsea and WM	19	15	10	9	53
UCL	18	22	10	2	52
Lewisham and Greenwich	6	9	15	2	32
Homerton	7	11	8	1	27
Imperial	9	11	4	2	26
St George's	9	10	4	2	25
GSTT	10	4	1	0	15
Luton and Dunstable		2	3	2	7
Whittington	2	4	1	0	7
Bournemouth and Christchurch		1			1
North Midlands	1	0	0	0	1
Heart of England	0	0	1	0	1
Surrey and Sussex	0	0	0	1	1
	224	320	267	94	905

The MTW service plans to start a service in Year 1 seeing and assessing 156 new patients with a BMI less than 50 and operating on 108 patients.

5.d RTT impact

As this is a new Service MTW would only accept new referrals.

The following would be excluded from the service:

- Patients referred to other providers who are still waiting for their first OPA
- Patients who have already been seen by the MDT at another provider

5.e Workforce impact

Bariatrics is an expanding sub specialism which is new to MTW. The financial model includes the phasing of additional staff as the service expands over the next 3 years. These will be recruited to as and when the additional activity is planned. We plan to recruit admin staff locally in our normal manner. Historically we have not had any issues in recruiting this type of staff.

The surgeons currently have capacity and have given commitment to absorb this activity within their current job plans.

The Matron for General Surgery has identified suitable nurses who could be seconded into the CNS role as a development opportunity. Existing senior nurses have been trained in bariatric nursing at UCL in April 2022.

Dietitians and psychologist are hard to recruit specialist areas, a psychologist who is known to the private bariatric surgeons locally has been approached to help set up the service and is willing to see patients on a regular basis.

Bariatric trained Dietitians are hard to source and in the first instance the Dietetic service will try local requirement in the hope of attracting an established practitioner, however it may be that an in-house training programme will be needed to develop the skills required internally.

There is incremental growth in staff to support additional activity, the Service Manager will be responsible for advertising and recruiting staff to ensure that they are available and orientated in time to support this activity.

Staff are costed at permanent staff costs. However, it is realised that in the short-term theatre staff may be difficult to recruit and therefore their costs include an additional 35% to allow for the possibility of agency staff in year 2 as we rapidly increase theatre capacity across the system. In year 3 these additional costs are reduced to 20% as a contingency.

These additional staff can be accommodated on site at TWH in the short term, however by Year 3 additional space may be required. There would be service benefits to the staff being co-located with a suite of "Bariatric Team" office accommodation being the preferred solution. This will require planning and funding in Year 3.

The additional WTE required are:

			Y1	Y2	Y3	
Additional Direct Pay	Staff group	Grade	WTE/unit	WTE	WTE	Cost/ WTE
Service Manager	Admin	Band 6	1.00	1.00	1.00	£50,126
MDT co-ordinator	Admin	Band 5	1.00	1.00	1.00	£40,234
Health records support	Admin	Band 3	0.25	0.50	0.70	£27,353
Support Secretary	Admin	Band 3	1.00	1.50	2.00	£27,353
Booker	Admin	Band 3	1.00	1.50	2.00	£27,353
Audit co-ordinator/clinical	Admin	Band 7	0.50	0.50	1.00	£59,119
CNS - Bariatric	Clinical team	Band 7	1.00	1.50	2.00	£59,119
Dietician	Clinical team	Band 8a	1.00	1.00	1.00	£60,818
Dietician	Clinical team	Band 7	0.60	1.00	2.00	£59,119
Surgical Care Practitioner - trainee	Clinical team	Band 7	1.00	1.00	1.00	£59,119
Physiotherapist	Clinical team	Band 7	0.10	0.20	0.30	£59,119
Occupational therapist	Clinical team	Band 7	0.10	0.20	0.30	£59,119
Blood transfusion - group and save	Clinical Support	Band 5	1hr per IP	1hr per IP	1hr per IF	£40,234
Endocrinologist	Clinical team	Cons	0.00	0.00	0.00	£0
Respiratory Consultant	Clinical team	Cons	0.00	0.00	0.00	£0
Psychologist	Clinical team	Band 8a	0.50	0.50	1.00	£60,818
Outpatient nurse	OP team	Band 5	0.10	0.20	0.30	£20,117
CSW	OP team	Band 3	0.10	0.20	0.30	£27,353
Consultant anaesthetist - specialist pre-op	Pre-Op	Cons	0.10	0.20	0.30	£125,000
Consultant anaesthetist - theatre list	Clinical team	Cons		0.25	0.37	£125,000
Consultant Surgeon - theatre list and OP	Clinical team	Cons		0.25	0.37	£125,000
Anaesthetic practitioner	Theatres	Band 6		0.31	0.47	£65,164
Scrub Nurse x 2	Theatres	Band 6		0.62	0.94	£65,164
TSW	Theatres	Band 2		0.31	0.47	£35,559
Recovery Nurse	Theatres	Band 6		0.31	0.47	£65,164
Professor - UCL SLA time	Medical	cost per session	0.30	0.30	0.15	£337,500
Bariatric Fellow	Medical	MG	0.00	0.00	1.00	£57,701

6. Financial impact of the preferred option – Full year effect – include VAT unless recoverable

MTW Head of Contracts and Director of Strategy. Planning and Partnerships have had discussions with the Director of Strategy at the CCG to gather support for the development of this care. As the activity goes to non-K&M providers and will be part of a block contract in 22/23 K&M CCG cannot plan repatriating referrals from London. However, they can establish a pathway for new referrals from the Tier 3 providers. Tier 3 volumes have significantly increased so K&M CCG have indicated that they will need to commission additional capacity for the future with Health Inequalities funding.

In terms of year 2 and beyond the CCG will need to commit to the service long term and will need to divert funds from the existing Provider contracts to fund the new local service.

The pathway for bariatric patients requires regular follow up of patients to ensure that their nutritional and clinical needs are met whilst they lose weight. There is a national and local drive to reduce the number of follow up patients seen in the acute setting, it will therefore be necessary for the Trust and CCG to reset KPIs and activity levels to allow for these patients to have appropriate follow up care.

There will be an initial financial risk to the CCG of having to fund multiple providers but as backlogs are cleared with existing providers, this should gradually shift the funds to MTW as MTW grow the service. This will be possible to be done within the current and expected contract arrangements, but MTW will need to be proactive with the CCG in ensuring sufficient notice is given to the existing Providers.

The CCG will then need to establish funding agreements with MTW and their existing Tier 3 providers from April 2023 onwards.

The above agreement will affect Kent and Medway residents only. In the short-term referrals will not be accepted from Sussex and Surrey residents, eRS will be set up to exclude them. However, the service could be expanded to take patients from the rest of the country once established.

The CCG will need to manage the Tier 3 service to ensure there is no massive influx of referrals to MTW, which will create unmet need and potential waiting time issues.

Table for section 6 - Financial Impact

	Year 1 - Sept 22 to March 23 £ 000	Year 2 23/24 £ 000	Year 3 24/25 £ 000
Pay			
Admin	106	216	278
Clinical team	150	353	499
Clinical Support	1	3	5
OP team	3	9	14
Pre-Op	7	25	38
Theatres	0	98	109
Medical	59	101	108
Pay Total	326	805	1,051
Non Pay			
Theatres	72	296	444
E&F	8	33	49
Clinical Support	7	27	40
Surgery	4	16	25
Medicine	1	2	3
QVH	1	3	4
Endoscopy	6	17	20
Non Pay Total	99	394	584
Set Up Costs	42	16	16
Contribution to overheads	85	240	327
Expenditure Total	552	1,454	1,976
Income	-560	-1,379	-2,054
Depreciation and Capital Charges	9	14	15
Revenue Surplus (-) / Deficit (+)	0	89	-62

7. Quality Impact Assessment (preferred option)

Clinical Effectiveness
Have clinicians been involved in the service redesign? If yes, list who.
Yes UGI leads; Mr Y Abdul Aal, Mr. H Ali, Mr. W Lynn
Clinical Directors Mr. D Lawes
Head of Dietetics, Moving and Handling Lead
Mr Mohamed Elkalaawy, MBBCh, MS, MRCSd, MD. Bariatric Surgeon. UCLH Centre for Weight Loss, Metabolic and Endocrine Surgery. UCLH NHS Trust, Associate Professor, Division of Surgery and Interventional Sciences. University College London, UK.
Consultant Endocrinologist and Cardiologist, MTW
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)
Kent and Medway individual funding request criteria Kent and Medway CCG referral and treatment criteria for Bariatric surgery NICE guidance on identification, assessment and management of obesity
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.
The Bariatric Team will sent up a comprehensive database for auditing all clinical outcomes including; complications, mortality, length of stay and readmissions
Are there any risks to clinical effectiveness? If yes, list
Yes, risk of harm to patients, reputational risk
Have the risks been mitigated?
<p>The prospective pathway has been designed to ensure that all patients undergo multidisciplinary assessment and are operated on only if they fulfil the appropriate national guidelines and have completed the designated pre-operative work up. All patients will be discussed at a dedicated MDT meeting to ensure that this occurs and only proceed with surgery if all members of the MDT agree.</p> <p>The Team will create a database to ensure that all outcomes are audited and accurate real results can be shared (with both stakeholders and nationally). In this regard further oversight is provided by BOMSS with regard to the NBSR (National Bariatric Surgery Registry) to which all cases would be added.</p> <p>The Team have agreed in the initial phase to dual consultant operating and have an agreement with a Bariatric Surgeon from UCLH to provide mentorship in the early phase. Under any option the team do not propose to take on the higher risk profile patients initially until the processes and pathways are fully established.</p>
Have the risks been added to the departmental risk register and a review date set?
No
Are there any benefits to clinical effectiveness? If yes, list
Locally managed and clinically prioritised access to surgery
Patient Safety
Has the impact of the change been considered in relation to?

Infection Prevention and Control?	Y Managed through standard trust processes
Safeguarding vulnerable adults/ children?	Y Managed through standard trust processes
Current quality indicators?	Y Managed through standard trust processes
Quality Account priorities?	Y Managed through standard trust processes
CQUINS?	Y Managed through standard trust processes
Are there any risks to patient safety? If yes, list	
This is a new service undertaken in a department which has previously been the subject of Royal College of Surgeons review. Although there are believed to be no additional risks to surgery, it is prudent that we proceed with caution.	
Have the risks been mitigated?	
Yes - The prospective pathway has been designed to ensure that all patients undergo multidisciplinary assessment and are operated on only if they fulfil the appropriate national guidelines and have completed the designated pre-operative work up. All patients will be discussed at a dedicated MDT meeting to ensure that this occurs and only proceed with surgery if all members of the MDT agree.	
We have also agreed to create a database to ensure that all outcomes are audited and accurate real results can be shared (with both stakeholders and nationally). In this regard further oversight is provided by BOMSS with regard to the NBSR (National Bariatric Surgery Registry) to which all our cases would be added.	
We have agreed in the initial phase to dual consultant operating and have an agreement with the Bariatric Surgeon from UCLH to provide mentorship in the early phase. We do not propose to take on the higher risk profile patients initially until the processes and pathways are fully established and have been audited.	
Have the risks been added to the departmental risk register and a review date set?	
No	
Are there any benefits to patient safety? If yes, list	
Locally managed and clinically prioritised access to surgery	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
Yes, local access for local patients integrated with Tiers as per NHSE / CCG guidance	
Has the impact of the change been considered in relation to?	
<ul style="list-style-type: none"> Promoting self-care for people with long-term conditions? Tackling health inequalities? 	
Yes, local access for local patients integrated with Tiers as per NHSE / CCG guidance	
Does the redesign lead to improvements in the care pathway? If yes, identify	
Yes, local access for local patients integrated with local Tiers as per NHSE / CCG guidance	
Are there any risks to the patient experience? If yes, list	
None identified	
Have the risks been mitigated?	
N/A	
Have the risks been added to the departmental risk register and a review date set?	
N/A	
Are there any benefits to the patient experience? If yes, list	
Yes, local access for local patients integrated with local Tiers as per NHSE / CCG guidance	

Equality & Diversity			
Has the impact of redesign been subject to an Equality Impact Assessment?			
No, but managed in line with standard trust processes			
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?			
N/A			
Service			
What is the overall impact on service quality? – please tick one box			
Improves quality	<input checked="" type="checkbox"/>	Maintains quality	<input type="checkbox"/>
Clinical lead comments			

8. Project management arrangements

The service will be managed by the General Manager for General Surgery Directorate.

We anticipate that there will be a need for:

- MTW led operational task and finish group
- Exec led Strategic Steering Group involving Tier 3 to set up and develop the service
- Multi-disciplinary clinical governance and pathway review group

Timetable –

Milestone	Date
MTW Internal working group set up	Established Q3 21/22
Divisional Board	4th May 2022
BRCP	June 2022
Execs	July 2022
Finance and Performance Meeting	July 2022
Trust Board approval	July 2022
K&MCCG approval given	Aug 2022
Start of recruitment to new posts; dietitian, CNS and psychologist key milestones	July 2022
Service starts to operate on patients	October 22

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: ACHIEVEMENT 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 were such resolved?

What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

10. Appendices

Appendix 1 - NHSE guidance for CCG Surgery for Severe and Complex Obesity

CCG Pack - Guidance for Clinical Commissioning Groups (CCGs): Clinical Guidance: Surgery for Severe and Complex Obesity

Guidance for commissioning obesity surgery

Version number: Final Appendix 7

First published: 2016

Prepared by: Ursula Peaple

Classification: OFFICIAL

Appendix 2

West Kent CCG Referral and Treatment criteria related to Bariatric Surgery

https://www.kentandmedwayccg.nhs.uk/application/files/9415/8756/1256/Schedule_of_policy_statements_and_referral_and_treatment_criteria.pdf

7.1 Bariatric surgery in adults (primary surgery)

Category Restricted (prior approval required)

Background

Weight loss surgery, also called bariatric or metabolic surgery, is sometimes used as a treatment for people who are very obese. The most common types of weight loss surgery are gastric bypass, sleeve gastrectomy and gastric banding.

Bariatric surgery in adults became the commissioning responsibility of CCGs in April 2017.

Commissioning of specialist morbid obesity services for children, including bariatric surgery and associated care, remains the responsibility of NHS England.

Policy

Prior approval is required for this procedure (see Appendix A).

Bariatric surgery in adults is not routinely funded by Kent and Medway CCG except where all of the following criteria are fulfilled:

The patient has either:

- a BMI of ≥ 40 , OR
- a BMI of 35–40 and other significant obesity related disease (e.g. type 2 diabetes mellitus or high blood pressure) that could be improved if they lost weight, OR
- Asian family origin, recent onset* type 2 diabetes mellitus and a BMI of >32.5
- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The individual has recently received and complied with a local specialist weight management programme (tier 3) for a duration considered appropriate by the multidisciplinary team (MDT)**.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

A formalised MDT led process for the screening of co-morbidities and the detection of other significant diseases has been completed. These should include identification, diagnosis, severity/ complexity assessment, risk stratification/ scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.

The specialist hospital bariatric MDT agrees surgery is indicated; for each patient a risk: benefit evaluation should favour bariatric surgery. In addition the bariatric surgery team must satisfy themselves that there are no contraindications for surgery, risks have been minimised and the patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure.

*Consistent with NICE CG189, recent onset is defined as diagnosis within the previous 10 years.

** Note additional eligibility criteria are in place for access to tier 3 specialist weight management services across Kent and Medway. See separate policy on tier 3 specialist weight management services.

Where applicable, refer to Section 1 for overarching policies on smoking status and weight loss prior to non-urgent surgery, and referrals to local care in preference to secondary care for non-urgent interventions.

Rationale

The eligibility criteria stipulated in this policy are broadly consistent with the eligibility criteria used by NHS England prior to April 2017 and those recommended in NICE Clinical Guideline (CG) 189.

NICE CG189 also recommends extending the availability of bariatric surgery to people with new onset type 2 diabetes mellitus and a BMI of 30–35. However, NICE made this recommendation with less certainty than their other recommendations on bariatric surgery, reflecting the less compelling evidence base supporting it. In the context of the quality of the underpinning evidence, the strength of the NICE recommendation and the limited resources available, funding bariatric surgery for people with new onset type 2 diabetes mellitus and a BMI of 30–35 is not currently a priority for Kent and Medway CCG.

The separate BMI criterion on people of Asian family origin reflects the observation that diabetes tends to occur at lower BMIs in this population due to greater abdominal adiposity. It may therefore be appropriate to consider bariatric surgery at lower thresholds in these individuals.

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
V1	Nov 2020	First edition	NB/JP
V2	April 2021	Update finances based on contract changes and update options	JM
V3	26 th April 2021	Additional options added	JM
V4	May 2021	Removal of I&E view and additional info on commissioner involvement	JM
V5.1	March 2022	Updated following Clinical Cabinet 3/2/22 and DDU Away Day 7/2/22	JM
V5.4	May 2022	Finances reviewed	JM
V6	9 th June 2022	Final draft version for circulation to stakeholders	JM
V7	20 th June 2022	Revised with all Stakeholder comments	JM
V8	6 th July 2022	Revised following BCRP on 28/6/22	JM/HF

Trust Board meeting – July 2022

Quarterly report from the Freedom to Speak Up Guardian	Freedom to Speak Up Guardian / Deputy Freedom to Speak Up Guardian
The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.	
Which Committees have reviewed the information prior to Board submission? N/A	
Reason for receipt at the Board (decision, discussion, information, assurance etc.) ¹ Discussion	

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q1 (April – June 2022)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the first quarter report for 2022 presented to the board by the Freedom To Speak Up Guardian (FTSUG). The purpose of this report is to identify trends, issues; and provide a progress report on the Freedom to Speak Up function.

An interim Deputy Freedom To Speak Up Guardian, Natalie Hayward, has been appointed as maternity cover for a period of one year commencing in April 2022.

The Freedom to Speak Up Guardian received **Twenty-three** concerns raised in the last quarter with a large proportion, **circa forty percent**, of the concerns relating to staff feeling unfairly treated or harassed at work. Concerns were received through various routes including; direct contact with the FTSUG, anonymous portal logs and speaking up through the exit interview process.

Author: Natalie Hayward, Interim Deputy Freedom To Speak Up (FTSU) Guardian

Date: July 2022

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian	Christian Lippiatt
Deputy Freedom To Speak Up Guardian	Ola Gbadebo-Saba
Deputy Freedom To Speak Up Guardian	Natalie Hayward (Maternity Cover for Ola Gbadebo-Saba)

The FTSU Agenda is to:

- Protect patient safety and quality are
- Improve experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as an opportunity for learning and development

2022/23 year to date data collection

Quarter	Month/Year	MGH	TWH	Satellite Sites	Unknown	No. of Contacts
Q1	April-June 2022	7	9	2	5	23

Twenty-three cases were logged in the first quarter of 2022 with **seven** cases relating to Maidstone General Hospital and **nine** cases relating to Tunbridge Wells Hospital. There were **two** cases received from satellite sites and **five** further cases from an unknown location. The breakdown in cases received between Maidstone and Tunbridge wells this quarter is more proportionately balanced compared to previous quarters. However, it should be noted that of the **nine** cases from Tunbridge Wells, **five** are individuals who have raised concerns relating to the same issue, whereas the Maidstone cases (on the whole) are unrelated to each other.

Of the **twenty-three** total cases for the YTD; **nine** are currently open cases and **three** cases are open from the previous year.

When reviewing the data submitted it shows that the majority of the concerns received have been raised by staff working in nursing and midwifery. See appendix A.

A comparison analysis on data from the same quarter (Q1) in previous years shows an upward increase on total number of cases from **five** in 2020 to **seventeen** in 2021 and **twenty-three** in 2022. This also shows an increase in cases being reported in Tunbridge Wells from **zero** in 2020 to **four** in 2021 and **nine** in 2022. In comparison with other staffing groups there is larger increase in concerns being raised from the Nursing and Midwifery staff. See appendix B.

Themes/Issues

Theme	Number
Patient Safety	4
Bullying/ Harassment	9
Fraud	0
Health & Safety	3
*Other	7
Total	23

*Breakdown of 'Other' category	Number
Team Dynamics	1
Line management	1
TUPE Process	3
Car Park Security	1
Concern about colleague	1
Total	7

The themes identified above continue to demonstrate that the majority of concerns raised are around bullying and harassment. However, this quarter, over half of the concerns received under the bullying and harassment category were due to feelings of being harassed at work and staff had raised concerns to their safe space champion about not feeling safe at work. The Guardian immediately brought this to the attention of the HRBP and the Safe Guarding lead and appropriate steps were taken to ensure the safety of staff. There are **three** ongoing cases where staff have raised concerns of feeling undermined and unfairly treated at work by their management team. The individuals who have raised these concerns have all asked to remain anonymous as they fear that they may suffer a detriment to their career for speaking up. The Guardian is working with colleagues to address these concerns without compromising confidentiality.

The cases that relate to patient safety concerns were all escalated to the appropriate channels. **One** case has been closed which identified a lapse in infection control processes which has been addressed by the management team and Freedom To Speak Up Guardian Board Report. July 2022

corrective action taken. The remaining cases have been escalated to senior leaders and remain open whilst we await assurances that the concerns have been addressed.

Three concerns have been raised by staff who are experiencing stress and anxiety in response to a lack of communication from their management team on a TUPE situation. As it was evident that the levels of anxiety being discussed would have an impact on the staff's ability to perform and their wellbeing, the Guardian escalated the concerns to the HRBP and a Wellbeing Partner to offer support to the staff and provide more open communication on the process.

When comparing 2022 data with themes arising in Q1 in previous years, the data shows that more staff are speaking up in areas such as patient safety and health & safety. This may show more understanding in the Freedom to Speak Up role and the types of concerns that can be raised to the Freedom to Speak Up Guardian. Concerns around bullying and harassment show an upward trajectory with **five** concerns being raised in 2020, **eight** in 2021 and **nine** in 2022. This is worrying as it appears that staff continue to experience situations where they feel bullied and harassed at work and is an area that MTW should continue to focus on to provide a culture where staff feel safe. See appendix C.

Staff survey results

In the previous board report, the results of the staff survey for the questions which related to Speaking Up were shared. Having further analysed the results, we have provided some additional information as to where MTW sits in relation to other Trusts which are similar benchmarking groups. See appendix D. With this information we aim to reach out to FTSU guardians at organisations that are geographically close to MTW and who have performed better in the survey results to discuss best practices and how FTSU has been promoted.

Safe Space Champions

Safe Space Champions play a vital role in creating spaces for staff to raise concerns and help to promote a Speaking Up culture at MTW. There are currently **thirty-one** trained safe space champions. Working collaboratively with EDI we will be completing another cohort of Safe Space Champion training in September to increase our Safe Space Champion team thus providing more opportunities for staff to engage and Speak Up.

Currently, the network of Safe Space Champions spans across all divisions at MTW, however, we have identified gaps in certain areas where there is less representation than others. For example: at Tunbridge Wells, where we are seeing an increase in cases, there are currently **three** Safe Space Champions who are based on site compared to **twenty** Safe Space Champions based at Maidstone. Furthermore, there is only **one** Safe Space Champion who works at a community site. With this in mind, when promoting the Safe Space Champion training there will be a focus on recruiting Champions from staff who are based at Tunbridge Wells and Community Sites. We will also aim to increase the number of Safe Space Champions who are working on wards.

There has been an expression of interest to become a Safe Space Champion from **five** individuals based at Tunbridge Wells and Community Sites, including **three** ward-based staff. We hope to increase these numbers prior to the training commencing in September.

National Guardians Office (NGO) Update

On the 23rd June 2022 NHS England has published new and updated national Freedom to Speak Up policy, which is applicable to primary care, secondary care and integrated care systems. The NGO has provided updated guidance and a Freedom to Speak Up reflection and planning tool to support organisations in implementing the new policy.

NHSE is asking all Trust Boards to be able to evidence by the end of January 2024;

- An update to local Freedom to Speak Up policy to reflect the new national policy template

- Results of their organisations assessment of its Freedom to Speak up arrangements against the revised guidance and;
- Assurance that it is on track implementing its latest Freedom to Speak Up improvement plan

The results for the Freedom to Speak Up Guardian survey are now available. The report looks in more detail at the responses from Guardians about their wellbeing and the support available to them, whether from their leaders, their Guardian peers or the National Guardians office.

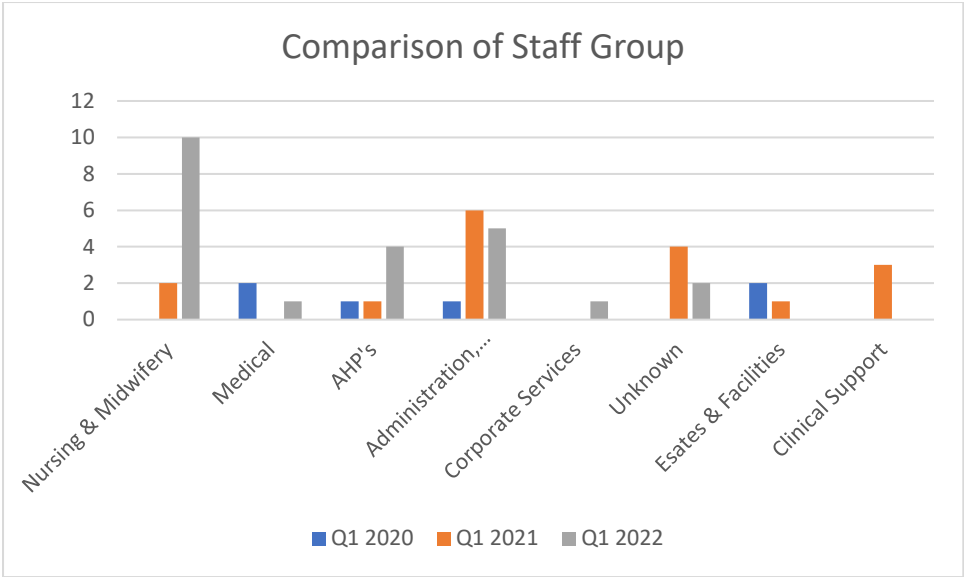
A key message from the results highlights, again, the importance of adequate ring-fenced time to carry out the Freedom to Speak Up Guardian Role.

Appendix A: Staff Group who have raised concerns

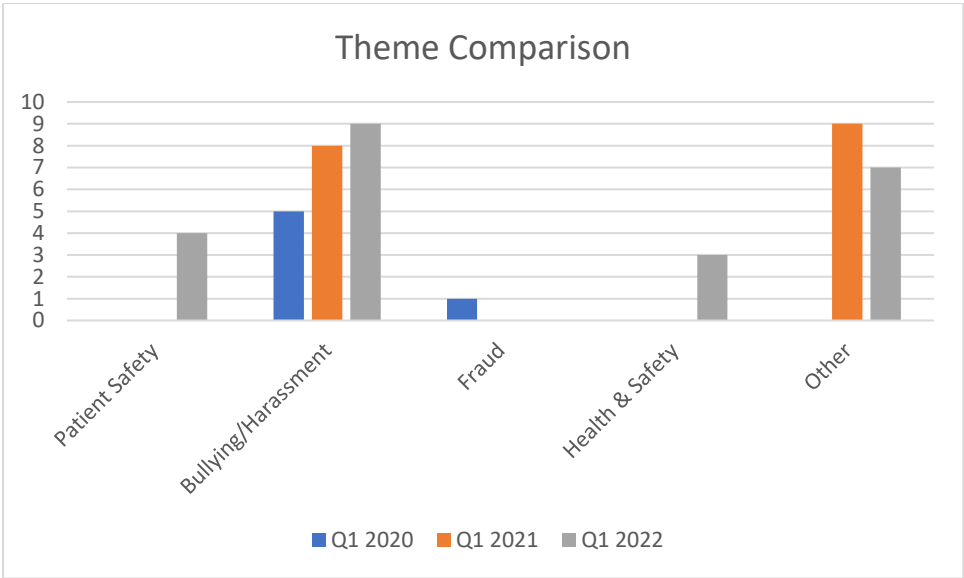
Staff Group	Number
Nursing & Midwifery	10
Medical	1
Unknown	2
AHP's	4
Corporate Services	1
Administration, Clerical & Maintenance/Ancillary	5
Total	23

Appendix B: Comparison of concerns logged and staff group

Total concerns logged	Q1 2020	Q1 2021	Q1 2022
Maidstone	6	9	7
Tunbridge Wells	0	4	9
Satellite Sites	0	0	2
Unknown	0	4	5
Total	6	17	23



Appendix C: Comparison of themes being reported



Appendix D: Survey Results Comparison

Q17a: Would I feel secure raising concerns about unsafe clinical practice

Benchmarking Group: Acute and Acute & Communities

Organisation name	% agree/strongly agree	Base
1 Northumbria Healthcare	82.90%	892
2 Chesterfield Royal Hospital	82.50%	2419
3 Yeovil District Hospital	80.40%	1235
4 Alder Hey Childrens	80.80%	2008
5 South Warwickshire	79.50%	2176
6 Northern Devon Healthcare	79.20%	1791
7 Gateshead Health	79.20%	1855
8 Somerset	79.10%	4303
9 Sheffield Childrens	79.00%	1567
10 Bolton	78.70%	2171

Guys & St Thomas	78.50%	10092
Surrey & Sussex	77.80%	2988
Portsmouth Hospital	76.70%	3828
Royal Surrey County Hospital	76.10%	2435
East Sussex Healthcare	74.80%	3641
Ashford & St Peters Hospital	73.20%	2338
Homerton University	73.40%	1870
Dartford and Gravesham	73.40%	1649
MTW	72.70%	3356
University Hospital Sussex	71.80%	8009
Chelsea & Westminster	71.40%	2887
Medway	71.30%	1824
Epsom & St Helier	71.30%	3851
Lewisham & Greenwich	71.00%	3144
Croydon Health Services	70.90%	1742
Royal Free London	70.80%	4085
Kings College	70.20%	4993
St Georges Hospital	70.10%	4848
East Kent Hospitals University	69.90%	4386
Barts	68.80%	7723
London Northwest	68.00%	4480
Queen Elizabeth	67.60%	1606

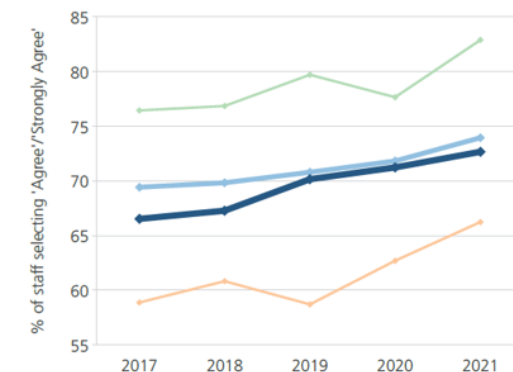
Q17b: I am confident that my organisation would address my concern

Benchmarking Group: Acute and Acute & Communities

Organisation name	% agree/strongly agree	Base
1 Northumbria Healthcare	75.70%	890
2 Yeovil District Hospital	70.20%	1236
3 Sherwood Forest Hospitals	68.80%	3319
4 Chesterfield Royal Hospital	68.00%	2427
5 Royal Surrey County Hospital	67.50%	2435
6 Alder Hey Children's	66.90%	2006
7 University Hospital Southampton	66.80%	6724
8 Surrey and Sussex Healthcare	66.70%	2992
9 Gateshead Health	66.20%	1850
10 St Helens and Knowsley Teaching	66.10%	2365

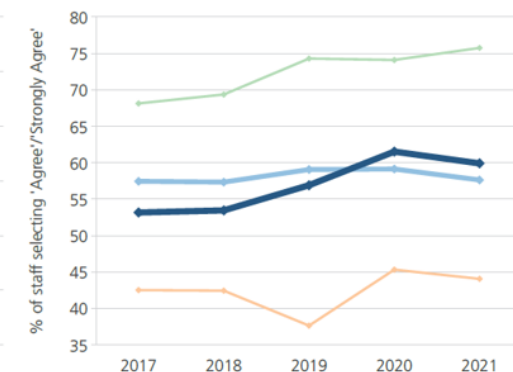
Royal Surrey County Hospital	67.50%	2435
Surrey & Sussex	66.70%	2992
Guys & St Thomas	65.50%	10074
Portsmouth Hospital	62.50%	3830
Homerton University	61.50%	1871
Ashford & St Peters Hospital	60.50%	2339
MTW	59.90%	3344
Dartford and Gravesham	59.90%	1640
East Sussex Healthcare	58.80%	3631
Chelsea & Westminster	58.80%	2889
Epsom & St Helier	56.40%	3844
Royal Free London	56.10%	4078
London Northwest	55.90%	4483
Lewisham & Greenwich	54.60%	3134
Croydon Health Services	54.80%	1739
Barts	54.30%	7715
St Georges Hospital	53.50%	4845
Kings College	52.90%	4983
University Hospital Sussex	52.60%	7988
Medway	51.40%	1816
East Kent Hospitals University	48.50%	4388
Queen Elizabeth	46.90%	1605

Q17a
I would feel secure raising concerns about unsafe clinical practice



Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	66.5%	67.3%	70.2%	71.2%	72.7%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	391	1,822	2,930	3,152	3,356

Q17b
I am confident that my organisation would address my concern



Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	53.2%	53.4%	56.9%	61.5%	59.9%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	389	1,825	2,924	3,144	3,344