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

Thu 30 November 2023, 09:45 - 13:00

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ).

11-6
To receive apologies for absence

David Highton

11-7
The Phase 1 report from the Independent Inquiry into the issues raised by the David Fuller case

Miles Scott

Fuller Inquiry.pdf (5 pages)

11-8
To declare interests relevant to agenda items

David Highton

11-9
To approve the minutes of the 'Part 1' Trust Board meetings of 26th October and 20th November 2023

David Highton

Board minutes, 26.10.23 (Part 1).pdf (14 pages)
Extraordinary Board minutes, 20.11.23 (Part 1).pdf (4 pages)

11-10
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (4 pages)

11-11
Report from the Chair of the Trust Board

David Highton

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

11-12
Report from the Chief Executive

Miles Scott

Chief Executive's report - November 2023.pdf (4 pages)

Reports from Trust Board sub-committees

11-13
Quality Committee, 08/11/23

Joanna Webber

Summary of Quality C'ttee, 08.11.23 (incl. IR(ME)R) findings).pdf (10 pages)

11-14
Finance and Performance Committee, 28/11/23

Neil Griffiths

Summary of Finance and Performance C'ttee 28.11.23.pdf (2 pages)

11-15
People and Organisational Development Committee, 24/11/23 (incl. the Guardian for Safe Working Hours Annual Report 2022/23)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 24.11.23.pdf (4 pages)

11-16
Audit and Governance Committee, 09/11/23 (incl. approval of revised Terms of Reference)

David Morgan

Summary of Audit and Governance Committee, 09.11.23 (incl. revised Terms of Reference).pdf (9 pages)

11-17
Charitable Funds Committee, 22/11/23 (incl. approval of the revised Terms of Reference and approval of Annual Report and Accounts of the Trust's Charitable Fund, 2022/23)

David Morgan

Summary of Charitable Funds Cttee, 22.11.23.pdf (61 pages)

Integrated Performance Report

11-18
Integrated Performance Report (IPR) for October 2023

Miles Scott and colleagues

Integrated Performance Report (IPR) Oct 2023.pdf (36 pages)

Quality Items

11-19
Quarterly Maternity Services report

Rachel Thomas

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

Quarterly Maternity Services Report.pdf (47 pages)

Workforce

11-20
To approve the “Our nursing and midwifery strategy 2024 – 2027”

Joanna Haworth

To approve the Nursing and Midwifery strategy 2024-2027.pdf (21 pages)

Systems and Place

11-21
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent HCP and NHS ICB.pdf (12 pages)

Planning and strategy

11-22
To review the updated plan for the forthcoming winter period

Sean Briggs

Winter Plan.pdf (15 pages)

11-23
Update on the corporate objectives

Rachel Jones

Update on corporate objectives.pdf (5 pages)

11-24
To approve the Digital Pathology Full Business Case (FBC)

Rachel Jones

Digital Pathology FBC.pdf (71 pages)

11-25
The Trust’s response to the “Helping Queen Victoria Hospital (QVH) develop a vision for the future"

Miles Scott and Rachel Jones

Repsonse to 'Helping QVH develop a vision for the future'.pdf (5 pages)

11-26
Six-monthly update on the project to develop a Maggie’s Centre at Maidstone Hospital

Sean Briggs

Update on the project to develop a Maggie's Centre at Maidstone Hospital.pdf (1 pages)

11-27
To consider any other business

David Highton

11-28
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 Kevin Rowan, Trust Secretary, via kevinrowan@nhs.net.

However any questions relating to the "The Phase 1 report from the Independent Inquiry into the issues raised by the David Fuller case" item should be emailed to mtw-tr.fuller@nhs.net.

Members of the public should also take note that questions regarding an individuals 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).

11-29
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.

The Phase 1 report from the Independent Inquiry into the issues raised by the David Fuller case	**Chief Executive**

The enclosed report relates to the Phase 1 report from the Independent Inquiry into the issues raised by the David Fuller case, which was published on 28/11/23.

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

- N/A

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

To consider this report and to approve the proposed next steps detailed therein.

[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

Independent Inquiry into the issues raised by the David Fuller case

Background

In December 2020 David Fuller – a hospital maintenance supervisor at Tunbridge Wells Hospital – was arrested and charged with two historic murders that took place in 1987. He had been identified as the murderer through a chance DNA search. When the police searched his house they discovered video and photographic evidence of sexual offences involving 101 deceased victims in the hospital mortuaries at the former Kent and Sussex Hospital and Tunbridge Wells Hospital. Fuller pleaded guilty to a number of offences and in December 2021 he received two whole life prison sentences for the murders and concurrent sentences totalling 12 years in respect of the mortuary offences.

Maidstone and Tunbridge Wells NHS Trust (MTW) worked closely with the police during their lengthy enquiries into this case and Kent Police commended the work of Trust staff, recognising their role in the victim identification process and the support provided to the families of Fuller's victims.

Independent Inquiry

Shortly after Fuller's arrest the Trust commissioned Sir Jonathan Michael to conduct an investigation into the issues raised by Fuller's activities. On 8 November 2021, the Rt Hon Sajid Javid, then Secretary of State for Health and Social Care, incorporated this investigation into an Independent Inquiry to be chaired by Sir Jonathan.

The Independent Inquiry's investigation covered a period of over 30 years, from Fuller's initial NHS appointment in 1989 through to the present day. Most of this period precedes the existence of the Maidstone and Tunbridge Wells Trust.

Sir Jonathan Michael's report into the issues raised by the Fuller case was laid before Parliament and published on 28 November 2023. On the day of publication Sir Jonathan gave a briefing on his report to the families of Fuller's victims and a further briefing to local MPs. In addition, Sir Jonathan held a press conference for national and regional media and gave individual media interviews.

Media coverage of Sir Jonathan's report was extensive, and several different themes were highlighted in press reporting including, for example, the fact that in one year, according to swipe card records, Fuller visited the mortuary on no fewer than 444 occasions.

Maria Caulfield, Parliamentary Under Secretary of State in the Department of Health and Social Care (DHSC) said, in a Parliamentary statement, "We fully welcome the report, and will ensure that there is a full response to the recommendations in Spring 2024, and that lessons are learned across the wider NHS so that no family has to go through this experience again".

The eight MPs whose constituencies cover the catchment area of the Maidstone and Tunbridge Wells NHS Trust also issued a joint statement. They too welcomed Sir Jonathan's report and noted that Fuller's crimes had been committed over several decades. They said, "There was nothing unique about Maidstone and Tunbridge Wells NHS Trust during these decades, and the crimes took place under many different managements. That is why it is so important that these lessons are applied across the NHS."

On the day of publication, MTW issued a media statement repeating the sincere apology to the families of Fuller's victims that it made at the time of Fuller's trial. The Trust's Chief Executive, Miles Scott, said, "On behalf of the Trust, and on behalf of the previous NHS organisations that Fuller worked for, I am deeply sorry for the pain and anguish the families have suffered. I know how devastating it has been for them to learn the extent of his crimes."

In addition, Miles Scott gave a pooled broadcast interview which was aired both on national and regional television channels and the Trust communications team dealt with a number of media enquiries.

Trust response to the report

The Trust thanks Sir Jonathan Michael and his team for their detailed and comprehensive work and accepts Sir Jonathan's recommendations in full. The report clearly contains important lessons in a number of different areas, and we are committed to ensuring the implementation of all the recommendations.

The Trust accepts Sir Jonathan's contention that the families of David Fuller's victims trusted the NHS to take care of their loved ones after death, as well as in life. They had every expectation that the mortuary would be a place of safety, peace and protection for the deceased, but this was not the case.

Findings of the Inquiry team

Sir Jonathan has noted that responsibility for David Fuller's depraved, calculated and devious criminal behaviour rests with Fuller himself. That he murdered two young women in 1987 and went on to abuse his role in public service to pursue his criminal activities is truly shocking.

Sir Jonathan's report also notes that the Trust acted quickly when it learned of David Fuller's offending in the mortuary. It says the Trust fully cooperated with the police investigations into what had happened and commissioned reviews of both the mortuary and the Trust security services. Sir Jonathan also says, "It is fair to say that the Trust has demonstrated its intention to learn what went wrong by fully cooperating with and supporting the work of the Inquiry".

However, the report also references some serious failings here at MTW, and in the predecessor NHS organisations for which Fuller worked. Sir Jonathan makes 16 recommendations that address these failings (see below).

The key themes emerging from the report touch upon mortuary security, mortuary best practice, adherence to policies and procedures, criminal records checks, the monitoring of mortuary access, CCTV cameras, the sharing of information, Trust governance and oversight by regulatory bodies.

Sir Jonathan's report also contrasts the Trust's significantly improved performance in recent years with the findings of this report. MTW has been the only Trust in the country to deliver the 62-day cancer treatment standard every month for the past four years and is one of the top five best performing Trusts in the country when measured against the four-hour emergency care standard. But the findings of this Inquiry indicate some clear failings. This should serve as a stark reminder for us that even in a high performing Trust like MTW we must be constantly vigilant, curious and mindful of all risks.

Sir Jonathan also touches upon the issue of safeguarding and notes that while the deceased should be treated with dignity and respect, they are not included in safeguarding legislation and do not usually hold any legal rights after death. He says, "We heard from Trust employees that safeguarding training and policies did not include the deceased, which is in accordance with the legal position of the deceased and current safeguarding legislation" and he goes on to say, "the wider issue of safeguarding in relation to the deceased will be considered by the Inquiry in Phase 2 of its work".

Trust specific recommendations

Sir Jonathan's report makes 16 specific recommendations and these may be summarised as follows:

1. Non-mortuary staff must always be accompanied by another member of staff when visiting the mortuary.
2. The practice of leaving bodies overnight in the post mortem room, outside of fridges, must cease.
3. The Trust must ensure compliance with its own policy on criminal record checks.
4. Mortuary managers must be suitably qualified and experienced.
5. The role of Mortuary Manager must be a full-time dedicated role.

6. The Trust must review its security policies to ensure that only those with legitimate reasons are able to access the mortuary.
7. The Trust must regularly monitor access to restricted areas.
8. The Trust should treat security as a corporate responsibility rather than a local responsibility.
9. CCTV cameras must be installed in the mortuary post mortem room.
10. Footage from these cameras must be regularly reviewed and cross-checked with swipe card data.
11. HTA reports must be shared with organisations that require assurance of the service provided by the mortuary.
12. The Trust Board must review its governance structures.
13. The Trust Board must exert greater oversight of the mortuary.
14. The Trust should treat compliance with HTA standards as a statutory responsibility for the Trust.
15. The Chief Nurse should be made responsible for assuring the security and dignity of the deceased.
16. The deceased must be treated with the same due regard to dignity and safeguarding as the living.

Approximately 70% of these recommendations have already been actioned by the Trust with the remainder partially actioned or still to be actioned. The Trust notes that Sir Jonathan urges “the Trust and others to act quickly and decisively on these recommendations” and we will be implementing all of these recommendations as rapidly as possible.

The families of Fuller’s victims

Perhaps the most harrowing part of Sir Jonathan Michael’s report concerns the impact that Fuller’s crimes have had on the families of his victims. Typical comments from family members include:

- “It’s basically robbed me of 25 years of happy memories.”
- “Anything that reminds me of my wife also reminds me of what David Fuller did to her.”
- “Your mind doesn’t shut up. It just goes over and over and things.”
- “I really, honestly can’t give you the words to describe how this has affected us.”
- “This man … was put away for double murder … He got 12 years for the extent of his abuse to every single individual … Twelve years. I assure you that does not feel like justice at all.”
- “People die and you think about all the nice things and the good times that you had … this is just the very last thing that happened to her and that’s how like my memories are going to be now.”
- “I just guess that with the awareness that people have of it now, something would have to change because it clearly happens, and it probably isn’t the only place it’s happened.”
- “It was all too much to take in … absolutely shell shocked both trying to process the events and crimes but most alarmingly in the short-term trying to understand if my mum’s identity was going to be revealed.”
- “The crimes are so unspeakable and relate to someone that I so dearly loved that I know that it will take me the rest of my life to get over this … I am now being forced to carry the heavy weight of a dark secret on my shoulders for the rest of my life.”

The Trust was only able to make contact with family members after the Police had completed their investigations and we only contacted those family members who indicated they were content to be contacted. For entirely understandable reasons some family members simply wanted no contact and no discussion about Fuller’s horrendous crimes.

Where we have been in contact the Trust has been open with families about what happened to their loved ones and what we know about Fuller’s offending. In addition, we have taken responsibility for what happened and apologised to the families directly. Every family member we have been in contact with has a senior clinical contact and every family member who wished to speak directly to the Chief Executive has done so.

The Trust has also led on the establishment of a compensation scheme for the families of Fuller’s victims, working in partnership with NHS Resolution and senior counsel, and in December 2022 a

compensation scheme was approved by DHSC. The Trust involved families in the design of the scheme which is managed by NHS Resolution on behalf of the Trust.

The Trust is also considering ways in which it may share the lessons emerging from the Inquiry and how we might assist NHS organisations facing similar inquiries in the future.

Next steps

Sir Jonathan Michael's report covers a period of over 30 years. Fuller's crimes were horrific, and the impact of these crimes will stay with the families of his victims forever. We now have a duty to ensure the lessons are learned.

We will develop an action plan to ensure that all Sir Jonathan's recommendations are actioned by no later than 31 March 2024. We will prepare a full and comprehensive paper on the actions we have taken pursuant to Sir Jonathan's report in order that these can be incorporated into the full response referenced above by the Parliamentary Under Secretary of State at DHSC.

Meanwhile we will continue to support those families of Fuller's victims who want ongoing support. Our commitment to these families is ongoing and will be open-ended.

Conclusion

The Trust Board is invited to consider this report and to approve the proposed next steps detailed above.

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 26TH OCTOBER 2023, THE PENTECOST-SOUTH ROOMS, ACADEMIC CENTRE, MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Neil Griffiths	Non-Executive Director (Chair)	(NG)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

10-1 To receive apologies for absence

Apologies were received from David Highton (DH), Chair of the Trust Board. It was also noted that Karen Cox (KC), Associate Non-Executive Director, would not be in attendance.

10-2 To declare interests relevant to agenda items

NG declared that he was the Managing Director of TeleTracking UK, which was referred to in the summary report from the Finance and Performance Committee.

AY declared that he was a member of the NHS Kent and Medway Integrated Care Board's (ICB's) Productivity and Investment Committee.

10-3 To approve the minutes of the 'Part 1' Trust Board meeting of 28th September 2023

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

- Page 1 of 16, change the job title of "Rachel Thomas" from "Acting Director of Midwifery" to "Director of Maternity".

Action: Amend the minutes of the 'Part 1' Trust Board meeting of 28/09/23 to reflect the change agreed at the Trust Board's meeting on 26/10/23 (Trust Secretary, October 2023)

10-4 To note progress with previous actions

The content of the submitted report was noted and no further updates were given.

10-5 Report from the Chair of the Trust Board

The content of the submitted report was noted.

10-6 Report from the Chief Executive

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

- It was important to note that the Trust had managed to keep its services running through the recent industrial action; and the Trust's emergency care plan was on track going into the winter.

However, that position had only been achieved through a combination of hard work and innovative practice, and industrial action and winter pressures remained key risks for the Trust. It was positive that the British Medical Association had not announced any further dates for industrial action, to allow talks with the government, but the risk still remained.
- Getting the basics right, in quality or operational performance, was a key aspect and that would form the basis for the Winter Plan that would be considered under item 10-16.
- The Trust's plans for equality, diversity and inclusion (EDI) were important to achieve the vision of Exceptional People Outstanding Care, and EDI was a central theme for delivery of the Trust's objectives. The report contained details of the EDI activity that had taken place recently, which included the launch of the new reverse mentoring scheme. The work required effort but it was important to recognise that it would lead to genuine benefit, such as better staff engagement.
- The Kent & Medway Orthopaedic Centre (KMOC) was progressing well, and it would enable major joint replacements to be undertaken as day cases, which was a staggering development. The Trust was now able to perform seven major joints on a theatre list, despite the Getting It Right First Time (GIRFT) standard being five. A 'topping out' ceremony for the KMOC would take place on 03/11/23, with Greg Clark MP; and the opportunity would also be taken to show Mr Clark the new Community Diagnostic Centre development at Hermitage Court. Any Board member that wanted to take part in either event was very welcome and should contact MS.

SS added that a Senior Leaders' Forum meeting on anti-racism had been held on 25/10/23 with brap, and positive feedback had been received from attendees, so the Trust now needed to consider the next steps.

Reports from Trust Board sub-committees

10-7 Quality Committee, 11/10/23

MC referred to the submitted report and highlighted the following points:
- A comprehensive report had been received from the safeguarding team, and the Committee had heard about the significant challenges faced. MC however wanted to commend the team for the marked progress they had made, and for their engagement with the Trust's staff. MC felt there was now a genuine level of awareness and understanding.
- More work was however required, including on the safety dashboard through the InPhase system, which would enable live/real-time information to be viewed, on issues such as falls.

AY referred to the statement in the report that "…the Trust's safeguarding training compliance had been reset to zero following the publication of the revised Adult Safeguarding Intercollegiate Document in 2022" and asked what that meant. JH explained that a decision had been made to set the training compliance back to zero, as the content and requirements of the training had changed. JH however continued that compliance was now at circa 70%. AY asked whether the Trust had been exposed because of the approach. JH noted that most of the staff who had had their training reset had been in date with their training, so JH did not consider the approach to be a concern. JH did however acknowledge that more work was required in relation to Mental Capacity Act training.

10-8 Finance and Performance Committee, 24/10/23

NG referred to the submitted report and highlighted that a lively discussion had been held on financial performance and the Cost Improvement Programme (CIP); whilst the Committee had also reviewed its compliance with its Terms of Reference, which had led to some further actions.

DM added that there had been a detailed focus on the CIP, and the Committee had discussed the point at which a judgement would be made as to whether the CIP target would not be met, and therefore that different action would need to be taken. DM also stated that the Committee had agreed to request the removal of the duty, from its Terms of Reference "To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)".

RF also noted that a discussion had been scheduled on productivity and the Executive Directors had agreed to consider how productivity could be measured differently.

JW referred to SB having given a brief update on the plans regarding the non-emergency patient transport service and asked for further details. SB firstly pointed out that the service was not managed by the Trust, and the contract was held by the Kent and Medway ICB, although SB and SO had invested circa £600k of the Trust's own funds, to supplement the poor service being provided, and alternative options were being considered. SO added that he understood the contract was due for renewal within the next 12 to 18 months, but the Trust was hoping to be able to provide a service directly. SB did however acknowledge that the Trust needed to do more to help the current service be better delivered.

SB then highlighted that DH had highlighted, and the Committee had acknowledged, that the Trust's growth in non-elective activity over the last four years had not been properly recognised through the provision of appropriate financial resources, so it was important that that point was not lost. SO clarified that the Trust had received no additional funding at all for that growth, and in fact no provider had received such funding, which was a decision from the ICB. WW asked whether the reasons for that increase in activity were known. SB explained that there were a range of reasons, which included difficulties in accessing primary care. NG agreed that the issue was important, and should continue to be pursued.

The Trust Board duly approved the removal of the duty, from the Committee's Terms of Reference "To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)".

Action: Process the change to the Finance and Performance Committee's Terms of Reference that was approved by the Trust Board on 26/10/23 (Trust Secretary, October 2023 onwards)

The Trust Board also approved the Committee's recommendation that monitoring reports relating to the extended software and consultancy agreement with TeleTracking UK be received by the Trust Board, rather than by the Committee, given NG's conflict; and that a report be considered at the Trust Board every six months in the first instance. MS asked whether NG would be excluded from the Trust Board meeting for that item. KR confirmed that would be the intention.

Action: Schedule "Six-monthly update on the progress with implementing the extended software and consultancy agreement with TeleTracking UK" items at the Trust Board (Trust Secretary, October 2023 onwards)

10-9 <u>People and Organisational Development Committee, 20/10/23</u>

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

- The meeting was a 'deep dive' and had acknowledged the outstanding appraisal compliance performance, of 97%. All involved should therefore be commended for a magnificent achievement, but the Estates department, which had achieved 100% compliance, should be particularly thanked.
- The Exceptional Leaders programme had been discussed, and the wide range of activity had been acknowledged.
- The Committee however highlighted the need to consider the quality of the appraisals; and also highlighted the need to retain staff, particularly those who were internationally-educated, and there would therefore be some focused A3 work on the issue, given its importance to the Trust's future strategy.

SS referred to the latter point and clarified that the focus of the A3 work would be on the staff that had left the Trust within 12 to 24 months of their appointment. The point was acknowledged.

Integrated Performance Report

10-10 <u>Integrated Performance Report (IPR) for September 2023</u>

MS firstly asked SO to explain the changes that had been made to the format of the IPR. SO duly explained that the new innovations were described on page 5 of 32, and related to the addition of a "3 Month Forecast" for the metrics, which was based on a statistical extrapolation and did not currently involve any human judgement, although the latter would be considered in the future. SO continued that the second innovation was a "DQ Kite Mark", and most of the metrics had met eight

to ten of the ten criteria, which were listed on page 5, although some metrics were rated below that, so those would be the main area of focus.

MC asked whether the "DQ Kite Mark" had been developed internally or was external. SO replied that there was no national standard, so an internal standard had been developed, which was based on some other organisations that had a more advanced process. MC suggested that the Trust liaise with NHS England's (NHSE's) "Making data count" team. SO confirmed that the Trust was in active dialogue with that team, and that team had recently published some guidance on the use of Statistical Process Control (SPC) within finance and included the Trust as a case example.

MS also asked about the relationship between the solidity of the circular image in the "DQ Kite Mark" column and the ten specific "Data Quality Kite Mark Criteria" i.e. did it always mean that a score below ten did not involve "Clinical / Expert input in capture / validation process". SO agreed to check whether the order of the criteria matched the missing segments in the circular Kite Mark image, and if not, whether it was feasible to display such a relationship.

Action: Check whether the order of the "Data Quality Kite Mark Criteria" within the Integrated Performance Report was related to the missing segments in the circular Kite Mark image, and if not, check whether it was feasible to display such a relationship in the report (Deputy Chief Executive/Chief Finance Officer, October 2023 onwards)

AY asked whether the Kite Mark rating was obtained by allocating one point for each criterion that had been met. SO confirmed that was the case, and the criteria had not therefore been weighted, based on relative importance, but agreed to consider whether such a weighting should be applied.

Action: Consider whether a weighting should be applied to the Data Quality Kite Mark Criteria within the Integrated Performance Report (Deputy Chief Executive/Chief Finance Officer, October 2023 onwards)

DM observed that now the "DQ Kite Mark" tool had been applied, the presumed focus would be on the non-compliant criteria, which one would expect to improve over time. SO agreed but noted that he chaired the Trust's Data Quality Steering Group, which met every two months, and involved Divisional representation. SO also stated that missing documentation had been identified as the main issue that affected data quality. SO also stated that any further reflections from Trust Board members on the new additions would be very welcome.

SS then referred to the "People" Strategic Theme and highlighted the following points:

- The "Reduce Turnover Rate to 12%" Breakthrough Objective was in escalation. The target was 12% over a 12-month rolling average. Lots of actions had been taken, but the data showed that the key issue was staff leaving within the first 12 to 24 months of appointment. Staff survey data also showed that there were some issues regarding jobs not being as described or not being as expected; the environment and integration into the team; and the 'onboarding' process.
- It was recognised that reducing staff turnover was a major issue as the Trust needed to undertake significant recruitment activity to maintain its current level of workforce.

SB asked whether there was anything in the data that related to specific sites i.e. was the turnover more prevalent at Tunbridge Wells Hospital (TWH) than at Maidstone Hospital (MH), as SB had always felt. SS stated that there was no sufficient difference between the two hospital sites, but there was sometimes turnover when staff moved from Tunbridge Wells to Maidstone which was not reflected in the turnover data. SS also added that the work was exploring whether there were any 'hotspot' areas within the Divisions.

SS then continued and highlighted the following points:

- The "Statutory and Mandatory Training" metric was showing common cause variation, although the 85% target was being met. Additional mandatory training requirements had been introduced, which included the Oliver McGowan mandatory training on learning disability & autism. SS would therefore undertake a 'deep dive' into the specific training compliance i.e. beyond the overall headline figure.
- The "Percentage of AfC 8c and above that are BAME" metrics was in escalation. The Trust's EDI strategy had been launched, a Trust Board objective setting session had been held, and the objectives would be finalised by March 2024. As SS had noted under item 10-6, an anti-

racism session had been held on 25/10/23; whilst training was being introduced across Kent and Medway and the introduction of that training at the Trust was being explored. The objective would not likely be achieved but the Trust wanted to see progress being made.

AY referred to the Secretary of State for Health and Social Care's letter to ICBs regarding the appointment to senior EDI roles and asked for a comment. SS clarified that the letter had been aimed at ICB roles, not Trust roles, but the Trust had immediately issued a confirmation that the Trust Board valued the Trust's EDI support roles and Staff Networks. NG reiterated the Trust Board's commitment.

PM then referred to the "Patient Safety & Clinical Effectiveness" Strategic Theme and confirmed he had nothing to report, as no items were in escalation.

SM then referred to the Infection Prevention and control section of the "Patient Safety & Clinical Effectiveness" Strategic Theme and highlighted the following points:

- There had been an outbreak of *Clostridiodes difficile* in July, the cause of which the Trust had never entirely understood. There had however been a continued focus on mattress integrity, and that had seemed to be effective, as the number of cases had reduced to a more manageable level, so the outbreak meetings had been stood down. A deep clean programme was in progress at TWH, which had been able to utilise Ward 11 as a decant ward, whilst that ward remained closed. Three wards had been deep cleaned thus far.
- The number of *E.Coli* cases had also increased in June, although these had now also reduced. The Trust was also involved in a project that focused on cannular-site infections.

WW asked whether there were any actions arising from the *Clostridiodes difficile* outbreak that would be applied. SM confirmed that the definitive reason/s for the outbreak were not known, despite considerable investigation being conducted. SM then elaborated on the steps that had been taken in response, which included the aforementioned focus on mattress cleaning, and the difficulties of undertaking an audit on the issues, which SM and the Infection Prevention and Control (IPC) team were addressing with the relevant staff. WW asked whether a policy and process would therefore be in place by the next Trust Board meeting. SM clarified that there was already a mattress policy in place, but it was likely that that would need to be strengthened. SB acknowledged the difficulty in the issue, given the rarity of the Trust having idle beds to enable appropriate decanting. JH also emphasised the significant work involved and commended all the clinical and non-clinical teams for their engagement with the process of decanting patients to Ward 11. MC asked whether increasing the capacity of the bed turnaround team had been considered, even if that would involve additional resources. SM acknowledged the importance of ensuring that there were always two members of staff on that team. MC asked whether that team operated on a 24/7 basis and SM confirmed that was the case. JH added that discussions had also however been had to increase the nursing staff's support to the turnaround teams. JH also noted that the Trust had ordered additional mattresses, but would still need more. MC asked whether the Trust had adequate storage for the mattresses and MS confirmed that was the case.

NG asked whether the number of COVID-19 cases had increased. SM explained that TWH had had single figure cases and the number had been stable, but at MH, which had bays rather than single rooms, occasional cases had emerged with patients who had been admitted for other issues. SM also noted that there had been some small ward-based outbreaks at MH, and the number of cases had recently been as high as 25.

SB then referred to the "Patient Access" Strategic Theme and highlighted the following points:

- All the key cancer access standards continued to be met, but the current standards would only be reported for one further month, as there would be major national changes to such standards. The Trust would however continue to report the two-week waiting time standard, although that standard would be withdrawn nationally. The Trust would also continue to report the 28-day diagnosis standard, which was a new standard.
- The current three cancer standards associated with 31-days would be amalgamated into a single standard, and that would pose some significant challenges for the Trust, because of the size of the increased demand for radiotherapy. The different current 62-day standards would also be amalgamated into a single standard. The Trust's forecast of future performance did not

identify any problems apart from the 31-day standard, as that pertained to subsequent radiotherapy treatments.
- The Diagnostics Waiting Times and Activity (DM01) standard performance continued to improve, and the Trust was getting ever closer to delivering the required target.
- SB wanted to commend the booking staff and clinical teams, as the year to date position (to the end of September) for new outpatient activity was above plan by 3,003 patients, which was a major achievement, given the recent strikes; whilst elective activity was 1,054 cases above plan. For October, which was one of the first months without strikes, new outpatient activity was 1,464 patients above the plan, whilst the Trust was 355 cases above the plan for elective activity. Without the strikes, the position would obviously be far higher, so all involved should be thanked.
- Performance on the Emergency Department (ED) 4-hour waiting time target was around 85% which was the third highest in the country. SB had had two interactions with patients that week which illustrated the importance of the target, one of whom had waited for 12 hours in the ED; and one of whom had waited seven hours, so SB was keen for the Trust to continue to try and return to delivering the NHS Constitutional target, which was 95%.
- SB also noted the Trust's strong performance on ambulance handovers.

NG commended SB's description of the current performance, and the challenges.

WW asked how many patients would be seen in the ED each day. SB replied that between 600 to 700 patients attended the EDs each day, although there had been some recent occasions where that number had reached 800, which was a record for the Trust; and 80 to 120 of such patients would be admitted each day.

WW also asked whether there were further innovative steps that could be taken to ensure the ED was sustainable, given the continued increase in activity. SB elaborated on the various initiatives that could be taken, and noted that other Executive Directors had their own opinions, but one area being explored was a Patient Pathway Hub, which was important for the winter, as was Same Day Emergency Care (SDEC). SB also highlighted the importance of ensuring that the basic processes were performed effectively.

WW then asked whether there would be "3 Month Forecast" data for the "Constitutional Standards and Key Metrics…" in the IPR. SB confirmed that would be the case.

JH then referred to the "Patient Experience" Strategic Theme and highlighted the following points:
- The Breakthrough Objective for complaints was being reviewed, and the focus would be on complaints relating to communication. The introduction of InPhase would enable more detailed categorisation of the causes of communication-related complaints, although the main categories were information and staff attitude.
- The Trust was in the process of developing its patient experience strategy, which would infirm the work on complaints.
- The ambition was to achieve a 75% response complaints rate in September, and that had been narrowly missed at 73%, but the issues described earlier in the Trust Board meeting would mean that the achievement of the 90% target for December 2023 would be very challenging.
- The Friends and Family Test (FFT) response rates for ED and maternity continued to improve, but the response rate for outpatients remained static. The national average response rate would likely be achieved but JH did not think it would be feasible to achieve the response rates of circa 20% that had been achieved previously. The FFT satisfaction rate was however very high for all areas.
- The Trust was in the processing of transitioning to a new FFT provider, and that would enable more specific surveys to be undertaken, to obtain more valuable data about patient experience.

NG referred to SB's earlier comments regarding patients waiting in the ED and asked how that was reflected in the JH's work. JH replied that the patient surveys had highlighted that one of the key issues that patients raised was not having the opportunity to speak with someone about their care, and having a new FFT provider would support efforts to improve that position.

DM observed that the target for the Breakthrough Objective "To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients [sic] experience" was an absolute number, which was not being met, whilst the "Complaints Rate per 1,000 occupied beddays" metric was being met, so queried whether the target for the Breakthrough Objective was appropriate. JH agreed and explained that she had posed the same question to the Business Intelligence team and the issue was being explored.

RJ then referred to the "Systems" Strategic Theme and highlighted the following points:

- The target for the "To increase the number of patients leaving our hospitals by noon on the day of discharge" Breakthrough Objective was 30% and performance was still at 23% and difficult to improve. The Trust had usually delivered a performance of circa 28%, so there had been a decline.
- SB and RJ's team were working closely to address the issue. Electronic Discharge Notification (eDN) had been introduced into the Sunrise Electronic Patient Record (EPR), but this had not led to the anticipated improvement. There had however been good engagement with junior doctors, and as a result some steps were being explored to aim to make the discharge process simpler. RJ was also working closely with the team who were developing the Winter Plan.
- Some trajectories would be set to help deliver the target.
- A profile of the time of day that discharges occurred had been produced, and the first high-point was at 3pm, so RJ felt it was feasible to shift that forward three hours. However the next high-point was 6pm, so it would be difficult to achieve a shift of six hours.
- RJ could not identify any other Trust that was delivering the 33% target, which had called RJ to question the source of the target, although RJ believed that the 33% target should still be kept by the Trust.

MC opined that there should be a focus on the discharge of elective patients, and welcomed the engagement with the junior doctors, but asked whether there was sufficient engagement with the consultants and Chiefs of Service, given their leadership roles. RJ replied that the Chiefs of Service had discussed the performance at the Strategy Deployment Review (SDR) session at the Executive Team Meeting (ETM) on 24/10/23 and they had been very supportive. RJ also explained the relationship between the Breakthrough Objectives and the Patient First Improvement System (PFIS), and noted that Ward 21 at TWH had volunteered to support the delivery of the target.

SO then referred to the "Sustainability" Strategic Theme and highlighted the following points:

- The Trust had another good month, with another surplus. The year-to-date deficit was £2.9m against a planned deficit of £1.3m, and the £1.6m variance was essentially due to strike costs.
- The loss of activity had not been accounted for in the financial position, but it was known that the Trust had lost millions of pounds due to the recent strike action.
- The CIP position was still below target, but the work planned for the future had been discussed in detail at the Finance and Performance Committee, as NG had noted under item 10-8, and that had included the plans for the 2024/25 CIP.
- The forecast shown in the report was to December 2023, when the Trust's escalation capacity would be open.
- The Trust needed to continue to deliver the performance it had achieved during the first half of 2023/24 into the second half of the year, but that would be very challenging.

NG then concluded the item by thanking the Executive Directors for their continued hard work despite the circumstances, and also thanked the Trust's staff as a whole.

Quality Items

10-11 <u>Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)</u>

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

- The length of the report reflected the significant amount of work that had been undertaken on infection control across the year.

- The first part of the report covered the annual report for 2022/23, whilst the second part covered the Healthcare Associated Infection Reduction Plan for 2023/24, which was reviewed at the Infection Prevention and Control Committee (IPCC).
- The report covered compliance with The Code of Practice for the Prevention and Control of Healthcare Associated Infections i.e. the hygiene code, which had that year been reviewed and revised, to make it more functional. SM had been part of the group that conducted that review.
- The IPC team was now fully established, and the Personal Protective Equipment (PPE) and fit testing teams had been absorbed into the IPC team.
- Fit testing for FFP3 masks was now managed through the Learning and Development system, so update reminders were able to be issued to the relevant staff.
- The Trust still had an issue with peripheral cannular site infections.
- The *Clostridiodes difficile* outbreak had been discussed under item 10-10, but the Trust's maximum case limit for 2022/23 had been breached and the Trust's rate was higher than the England rate for the first time in several years. The Trust was therefore working hard to address the issue.
- The *E.Coli* position had also been discussed under item 10-10, but the Trust was working hard to deliver the five-year target and the Trust's rate was below the England rate.
- The flu position had differed from the previous year, as the season had started earlier, in October, whereas cases usually started to be seen in December. The peak had also been five times higher than the peak of the previous year.
- The COVID-19 data was shown from page 20 of 56 onwards, and the number of cases had remained lower than the previous year, which reflected the decreased acuity of COVID-19 patients.
- The Trust had been affected by the Group A Streptococcus issue.
- SM was very grateful to the Facilities team, who were always very helpful and responsive, which SM was aware was not always replicated at other Trusts.
- The water system at TWH was not balanced properly, so a major project had been conducted with the clinical operations team, IPC and Mitie working together, in relation to legionella control. There was however still some work taking place.
- The refresher training for Trust Board members started on page 34 of 56, and covered history, hygiene code compliance, and other aspects, but if any Trust Board member wanted a one-to-one session on IPC, SM would be delighted to oblige.

NG commended the comprehensive nature of the report.

JW asked whether the scarlet fever and Group A Streptococcus issue would likely be an annual occurrence. SM explained that Group A Streptococcus cases tended to be cyclical, but the key factor in the latest situation was that children had not mixed as they had done previously, whilst the media attention given to the situation had fuelled the increase in ED attendances. JW asked whether the data suggested a return to the normal situation. SM stated that she was not convinced that the children that had been seen in the ED were any sicker than the ED attendances in previous years.

SB then commended SM and her team and highlighted the high level of engagement that SM had with the operational teams.

10-12 <u>Findings of the national inpatient survey 2022</u>

JH referred to the submitted report and highlighted the following points:
- The survey related to inpatients in November 2022, and 1,250 questionnaires had been issued, which resulted in a 41% response rate. The methodology and questions had however changed, which made it very difficult to compare the latest performance with previous years.
- The demographic data of the respondents was as expected, given the local population.
- The Trust's best responses including being given enough to drink during an inpatient stay, privacy, and cleanliness.
- The Trust's worst performing responses included communication relating to discharge and medication. There were also concerns regarding access to food and noise at night. However the

data for the latter issue could not distinguish between TWH and MH, as JH would expect that to be more of an issue at MH. Nationally, the Trust was however within the main group of Trusts.
- In terms of the future, the aforementioned patient experience strategy would be important, but further work was required to understand the issues around noise, food and drink, and the Nutrition Steering Group would explore the latter in more detail. The Trust would also reinstate the annual Patient-Led Assessments of the Care Environment (PLACE) in November 2023.
- The Trust was developing a Quality Assurance Framework, which would support the Trust's efforts to understand the privacy and dignity elements of the survey better.
- The Trust wanted to utilise the patient engagement work taking place in the Divisions to respond to the communication elements of the survey.

SO referred to the "Bottom 5 Questions" section on page 10 of 16, and the "Were you ever prevented from sleeping at night by any of the following?" question in particular, and noted that that question had been included on previous year's surveys and SO did not believe it had been a concern, so asked whether further detail was available. JH pointed out that further details were provided on page 14 of 16, and it was clear that the Trust needed to focus on reducing noise from other patients, but that would be very difficult, and JH was not surprised at the survey finding, given the composition of patients that the Trust had treated over the past year.

MC commended the reinstatement of the PLACE and welcomed the involvement of patients in such assessments. MC also referred to the Trust's poor performance on the "Thinking about any medicine you were to take at home, were you given any information?" question, and pointed out that the Trust had performed poorly on that issue in previous years, so appealed for that issue to be addressed, given its importance. JH acknowledged the point but highlighted that it was a national issue. MC however stated that there were opportunities to utilise the written information that patients were given on discharge, provided that information did not conflict with what patients had been told verbally. The point was acknowledged.

DM referred to the point on page 3 of 16 that only 29 Trusts had taken part in the survey. JH however clarified that only 29 Trusts had used the same survey provider as the Trust (IQVIA), but all acute Trusts were mandated to conduct the survey.

MC noted that it would be helpful to understand the demographics of those who had complained, as there were differences in the willingness of particular patient groups to complain. JH acknowledged the point but stated that that would need to be considered through the complaints process rather than the inpatient survey.

RF commended the performance on many of the questions, but referred to question 47, "During your hospital stay, were you ever asked to give your views on the quality of your care?", and asked for a comment. JH confirmed that the Trust needed to improve its position on that aspect, and the aforementioned new FFT platform would enable the Trust to obtain more nuanced data to understand the specific issues in more detail. RF however asserted that the Trust's response needed to extend beyond just collecting more data. JH agreed.

JW then opined on the importance of the Trust improving its provision of information to an individual patient by using multiple communication channels, rather than just apply a 'one size fits all' approach. JH concurred and stated that she would expect the patient experience strategy to include that as one of its themes.

Workforce

10-13 <u>To approve the Medical Workforce Strategy 2024 – 2026</u>

PM referred to the submitted report and highlighted the following points:
- The draft strategy had been considered previously at various forums.
- The starting point for the Strategy had been the clinically-led management structure that had been introduced a few years ago.
- The Strategy included sections on EDI; recruitment and retention; data; driving improvement; medical and non-medical workforce; and building for the future. It was also important to stress

that one of the main comments received on the Strategy was the need for it to interlink with the Trust's various other workforce strategies, and with the workforce strategies outside the Trust.
- One of the most important practical aspects was the need to consider international recruitment earlier, and the Chiefs of Service were aligned with that need.
- The strategy covered consultants, Specialty and Associate Specialist (SAS) doctors, and the new roles of Advanced Clinical Practitioners (ACPs) and Physician's Associates.
- The Deputy Medical Director had engaged widely with the different Directorates and forums.

SS commended the strategy and noted it aligned with the Trust's People and Culture Strategy, which was important. SS also however noted that the NHS Long Term Workforce Plan had been published since the Medical Workforce Strategy had started to be developed, and there were some aspects of that Plan that would be beneficial to include in future versions of the Strategy.

JW referred to the Physician's Associates and asked for PM's views on how such roles would develop. PM stated that there had been some initial resistance, but the roles had now become more accepted, particularly given their potential to conduct eDNs. PM added that he also had great expectations for ACP roles.

JW also asked about developments in Artificial Intelligence (AI). PM gave his perspective, and highlighted the need for any developments at the Trust to align with the Trust's digital strategy.

RF noted that the section on page 7 was called "Recruitment", but as PM had highlighted, retention was also important, so suggested it would be appropriate to change the title. RF also remarked that he had participated in many consultant interviews, and he was disappointed that the final interviews still focused on clinical aspects, and did not give adequate time to leadership or values etc. PM explained the rationale for including at least one difficult clinical question in such interviews, and although PM acknowledged the limitations of a single 45-minute interview for a 'job for life', values-based questions were now part of the interview, and there was an EDI-representative. PM however agreed that some further thought was required for the future.

NG pointed out stated that the consultant interview panels he had attended had involved a leadership question. RF acknowledged that but opined that such questions seemed tokenistic. SB stressed that the Trust was often not in a position to attract multiple strong candidates for each post. SO also stated that the clinical questions posed at interview were often focused on leadership-adjacent issues. MS however confirmed that he would liaise with PM, SM and SS to review the consultant interview process, in light of the comments made. JH added that she was aware that other professions participated in consultant interview panels at some other Trusts. The point was acknowledged.

Action: Liaise with the Medical Director, Director of Infection Prevention and Control and Chief People Officer to review the consultant interview process in light of the comments made at the 'Part 1' Trust Board meeting on 26/10/23 (Chief Executive, October 2023 onwards)

RF also commended the inclusion of "We will strive to be the healthcare employer of choice…" as one of the five strategic priorities, and RF was aware that that had been the case in recent consultant appointments, but opined that the Trust needed to work more on its Employee Value Proposition. PM acknowledged the point and agreed to liaise with the Deputy Medical Director to consider what further action may be required.

Action: Liaise with the Deputy Medical Director to consider what further action may be required to strengthen the Trust's Employee Value Proposition in relation to medical staff (Medical Director, October 2023 onwards)

WW asked how the strategy would be implemented and monitored. PM explained that the Deputy Medical Director was meeting with all divisions to develop a scorecard that would then be considered at their SDR meetings, and PM would be content to submit a further report to the Trust Board or People and Organisational Development Committee, if required. EPM noted that the People and Organisational Development Committee would next meet at the end of November 2023. SS however cautioned against duplicating effort, given the workforce-related scorecards that were already produced and submitted to that Committee. The point was acknowledged.

The Trust Board approved the Medical Workforce Strategy 2024 – 2026, subject to the agreed amendment.

Action: Arrange for the title of the "Recruitment" section on page 7 of the "Medical Workforce Strategy 2024 – 2026" to be renamed "Recruitment and retention" (Medical Director, October 2023 onwards)

Systems and Place

10-14 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- The ICB had recently held a System Flow and Discharge Summit ahead of the forthcoming winter. The event had seen good engagement with the Local Authorities, but a stark message had been heard regarding the financial position of the Local Authority sector. It was therefore possible that local councils would prioritise their resources towards their statutory duties, to avoid the risk of having to issue a 'section 114 notice', as Birmingham City Council had done in September 2023. If such an approach was adopted there would be potentially significant implications. There was therefore a general feeling of disappointment at the Summit and RJ would liaise with MS. The actions agreed at the Summit had only been issued on 25/10/23, so RJ would circulate these in due course.
- The ICB had also held a Symposium on 20/10/23 on the Integrated Care Strategy refresh, and RJ had reiterated the comments the Trust had been made previously, namely that the Strategy was not sufficiently Kent and Medway-focused.
- The ICB's cost reduction programme was proceeding and that would have an impact on the West Kent HCP.
- Queen Victoria Hospital NHS Foundation Trust were engaging with stakeholders ahead of developing their strategy, and RJ would liaise with the relevant internal staff to obtain their views.
- A West Kent HCP away half-day had been held on 05/10/23 which was well attended by all partners, and which had focused on the creation of an Integrated Care Partnership Development Framework.

SO referred to the "Risks and challenges" section on page 6 of 6 and proposed that financial risks be reflected. RJ agreed to ensure that was reflected in future reports.

Action: Ensure that financial risks were reflected in the "Risks and challenges" section of future "Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)" reports (Director of Strategy, Planning and Partnerships, October 2023 onwards)

WW asked whether some time was required to model the worst-case scenario in relation to the financial position of Local Authorities. RJ confirmed that the risk had been identified as part of the Trust Board's previous 'horizon scanning' exercises, and such risks would now be added to the Trust's risk register, which would mean that appropriate mitigations would need to be developed.

MS then referred to the statement on page 3 of 6 that "QVH are engaging with stake holders [sic] ahead of developing their strategy…" and emphasised that the Trust needed to clearly articulate what it felt its position should be regarding Queen Victoria Hospital, so MS would liaise with the Executive Directors and submit something to the Trust Board in November or December 2023.

Action: Liaise with the Executive Directors to develop the Trust's response to the "Helping Queen Victoria Hospital (QVH) develop a vision for the future" programme, and submit further information to the Trust Board in November or December 2023 (Chief Executive, October 2023 onwards)

SS also referred to the "Risks and challenges" section and highlighted that the workforce changes being consulted on within the ICB could also pose a risk. RJ explained that the potential impact for West Kent was lower than for other areas within the ICB, but agreed to reflect on SS' point.

10-15 To approve the plans for the development of the Kent and Medway Provider Collaboratives

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

- The Provider Collaborative approach had been considered previously by the Trust Board, but the proposals were now being considered formally because the ICB Board intended to approve the arrangements.
- The Acute Provider Collaborative would be chaired by the Chief Executive at Medway NHS Foundation Trust; whilst RJ and the Associate Director of Business Intelligence would be the initial links from the Trust.
- The Acute Provider Collaborative would initially focus on service reviews for Ear, nose & throat (ENT) services and General Anaesthetic for dental services; and the service reviews would be significant programmes of work.

RF commented that he was shocked that something could be called 'integrated' but then divided into three separate areas. MS explained that although the Trust shared RF's view, all of the other Trusts in Kent and Medway felt differently, so the Trust was committed to try and make the arrangements work. SO added that the Trust wanted the ICB to adopt a standardised improvement methodology approach.

NG asked whether the Trust Board was being asked to approve the plans, despite the concerns that had been raised. RJ confirmed that was correct but noted that the Provider Collaboratives did not have any decision-making authority, so RJ would recommend that the best way of the Trust influencing the arrangements was from within. MS added that lots of discussion had been held and although the arrangements were not exactly as the Trust had wanted, they represented the best position that could be achieved.

MC asked whether the ICB genuinely believed that the plans would meet the health needs of the local population. RJ agreed to pose that question to the ICB.

Action: Check and confirm that the Kent and Medway ICB genuinely believed that the plans for Provider Collaboratives would meet the health needs of the local population (Director of Strategy, Planning and Partnerships, October 2023 onwards)

WW proposed, given the concerns, that the Trust Board approve the plans, "subject to…" certain conditions. MS agreed and confirmed that he would liaise with RJ to confirm such conditions, but emphasised that there were no major issues in the plans that the Trust should object to.

Action: Liaise to confirm the text that would accompany the Trust Board's decision that the plans for the development of the Kent and Medway Provider Collaboratives should be approved "subject to…" certain conditions (Chief Executive and Director of Strategy, Planning and Partnerships, October 2023 onwards)

The Trust Board therefore approved the plans for the development of the Kent and Medway Provider Collaboratives, subject to the conditions that MS and RJ would confirm.

Planning and strategy

10-16 Review of the draft winter plan for 2023/24

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

- The Trust had just been ranked in second place of all acute Trusts on The Telegraph's NHS Performance Tracker.
- The Plan would usually have been submitted to the Finance and Performance Committee and Trust Board meetings in October, but that had not been feasible.
- The plan was a draft and would be developed further, but the plan had been discussed at length at the Finance and Performance Committee meeting on 24/10/23.
- The bed modelling indicated that the Trust would be 114 beds short of the number required. That meant that in a worst scenario, that number of patients would need to be held in the EDs, or in an ambulance outside of the EDs, but that number would not be accepted. Efforts were therefore continuing to try and close the gap, which included working with partners, the expansion of the virtual ward service and other schemes.

- All the schemes in the “PRIORITY 1” list on page 12 of 14 had been funded, and SB and SO were reviewing the schemes in the other priority categories to consider if any of these could be funded. It was hoped that some of these schemes would be able to be funded.
- The Trust was in a better position this year than it had been in previous years in relation to escalation capacity, and there would be at least 1.5 wards to use for that purpose.
- 23/10/23 and 24/10/23 had been the most challenging days the Trust had faced that year, in terms of demand, which was not a good omen for the winter.

PM commended the plan, referred to the “Clinical Pathway Hub pilot from Sept 23” and pointed out that the Trust was very reliant on community services to implement that scheme, and also extend the virtual ward service. SB acknowledged the point.

EPM asked whether SB was concerned about anything that year compared to previous years. SB replied that he was concerned about the morale of the staff, given the strikes and other factors, and that needed to be recognised, although SB felt the position could be recovered.

EPM also asked whether SO was concerned with any financial aspects of the plan. SO explained his perspective and emphasised the difficultly of the situation, which meant the Trust was not able to implement some of the schemes that had been deployed in previous years. SO therefore shared SB’s concerns regarding the adverse impact on staff morale.

MC referred back to RJ’s comments under item 10-14 regarding the risks regarding Local Authority finances, and asked for a comment on the potential impact of that risk on the Winter Plan, given the Trust’s reliance on community and social services. SB confirmed there was a substantial risk, and elaborated on the specific details, but emphasised that there were some mitigating steps that could be taken by the Trust.

MC then asked about the maturity of the Trust’s Care Coordination Centre’s engagement with care homes and SB acknowledged that more needed to be done.

WW referred to the wellbeing aspects of the plan and emphasised the need to focus on such aspects. SS gave assurance that such issues would be considered.

MS then reflected on what the plan would mean for the Trust Board and emphasised the interconnectedness of the various aspects i.e. quality, patient access, performance and finance, and the need to avoid false choices between such aspects. MS continued that Trust Board members should therefore avoid focusing on ‘hobby horses’ at Trust Board and sub-committee meetings; and aim to be consistent, as it was likely that the Boards of the Trusts that were within the lower echelons of the aforementioned Telegraph’s NHS Performance Tracker would likely be focusing on one aspect per month, and not be allowed to consider their Trust’s consistent, overall performance. The point was acknowledged.

Assurance and policy

10-17 Quarterly report from the Freedom to Speak Up Guardian

SS referred to the submitted report and highlighted the following points:
- The Trust’s Freedom to Speak Up structure was being reviewed, so although an interim Guardian had been appointed for six months, the structure would be developed after that.
- MC, SS and the Guardian met every Friday afternoon to review the new cases that had been reported.
- Dignity and respect cases remained a concern, and some cases had emerged regarding sexual safety. An independent review had therefore been commissioned to identify learning.
- NHSE had issued a sexual safety in healthcare charter, and that would be submitted to the Trust Board’s meeting in November 2023.

Other matters

10-18 To consider any other business

There was no other business.

10-19 To respond to questions from members of the public

KR confirmed that no questions had been submitted prior to the meeting.

10-20 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.

MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1') HELD ON MONDAY 20TH NOVEMBER 2023, 12 P.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Hannah Ferris	Deputy Director of Finance (Performance)	(HF)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

11-1 To receive apologies for absence

Apologies were received from Maureen Choong (MC), Non-Executive Director; and Steve Orpin (SO), Deputy Chief Executive/Chief Finance Officer, although it was noted that HF was attending in SO's place. It was also noted that Karen Cox (KC), Associate Non-Executive Director; and Alex Yew (AY), Associate Non-Executive Director, would not be in attendance.

11-2 To declare interests relevant to agenda items

No interests were declared.

11-3 To approve the key finance, performance and capacity commitments relating to the "Addressing the significant financial challenges created by the industrial action in 2023/24" letter from NHS England (NHSE)

DH firstly explained the rationale for the scheduling of the extraordinary meeting, which related to the need to consider the Trust's financial position, as part of the operational reset required by NHSE. DH continued that the letter that had been issued by NHSE had requested formal approval by the Trust Board but the timescale did not allow that approval to take place at the next routine Trust Board meeting, which was scheduled for w/c 27/11/23.

MS then highlighted the following points:

- The Trust had a basis to deliver its plan for 2023/24, and therefore to deliver the commitments to quality, safety and patient experience, as per national agreements.
- Such delivery would however need additional funding to cover the the direct costs of the industrial action that had taken place for the year to date; and also need confirmation that the funding for elective activity would continue as planned.
- On that basis, it was believed that the Trust would be in a position to forecast the delivery of the 2023/24 plan by the year-end.

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

- The month 7 forecast had been reviewed, and the action required to achieve a breakeven position by year-end had been considered.
- It had been assumed that some additional funding would be received for the costs of industrial action. The Kent and Medway Integrated Care Board (KM ICB) had received an additional

£18m to support the funding for that action, and other pressures, and the Trust had been given confirmation that it would receive just over £1.9m of its direct costs relating to that action.
- It had also been confirmed that the Elective Recovery Fund (ERF) would continue, and the change in the baseline would lead to an additional benefit for the Trust of circa £2.2m.
- Further action had been taken to ensure that the accruals and provisions had not been over-estimated, and that work was expected to result in a benefit of circa £1.6m.
- That would therefore lead circa £3m of improvement to be achieved in the run-rate and Divisional forecasts, and work was continuing on that aspect. That extra delivery, if achieved, would result in a breakeven position without an adverse impact on the key performance metrics.

DM referred to the "Mitigations / Recovery Actions" section on page 8 of 15, and noted that the text referred to a £1.2m benefit from reducing accruals, but the table on that page listed "0.0" for "Accrual and Provision Review". HF confirmed that the content of the table was erroneous, as it should state "-1.6", whilst the "Divisional Recovery Actions" row should state "-3.0", instead of "-4.6". HF therefore confirmed she would amend the table and circulate a revised version.

Action: Amend the values in the table of the "Mitigations / Recovery Actions" section of the "H2 Financial and Operational Delivery" report submitted to the extraordinary Trust Board meeting on 20/11/23 (Deputy Director of Finance (Performance), November 2023 onwards)

DM also asked whether the £4.4m of benefit from the reduction in the ERF target would be achieved by the Trust continuing to undertake its current level of elective activity. HF confirmed that was correct in principle, and no additional activity had been assumed, although the benefit was over-stated, and would be closer to £2.2m. MS however stated that he had taken a decision on 17/11/23 to leave the data in the tables as had been submitted, on the basis that the circa £2m of difference was significantly below the Trust's materiality threshold, and although it was a risk that needed to be mitigated, it was believed that more could be done to mitigate that risk, particularly in relation to the accurate billing and data quality for income. MS continued that he had therefore confirmed that HF should not change the ERF benefit value in the submitted report.

DM then noted that the "Current Year end Forecast (before mitigations)" chart on page 7 of 15 had stated that the "Variable income performance" after seven months was £10m, so asked whether the new financial forecast had anticipated a reduction in the run-rate. HF clarified that the £10m on that chart was the year-end forecast value, not a year-to-date value, and confirmed that it had been assumed that the Trust's elective activity would continue at a similar rate, apart from the Kent & Medway Orthopaedic Centre activity, which would increase. DM therefore asked what the "Variable income performance" figure was after seven months. HF confirmed she did not have ready access to that figure, but stated that it had been a relatively straight line across the year.

WW asked whether any further work was planned in relation to increasing the delivery of the Cost Improvement Programme (CIP). HF explained that the current delivery of the CIP was already reflected in the forecast, and the pre-mitigation actions had already focused on the CIP, whilst any major recurrent CIP changes would require transformational change from 2024/25 onwards. WW also asked whether there was anything material in the CIP forecast about which the Trust Board should be concerned. HF confirmed there were no significant concerns.

WW also asked whether there was anything material in the list of provisions that would pose a particular risk. HF confirmed that none of the £1.6m of benefit arising from the "Accrual and Provision Review" was expected to reduce, and the benefit was likely to either stay at that level or increase, rather than reduce.

NG queried whether the £3m of improvement required for the "Divisional Recovery Actions" was related to cost reduction or increased income. HF confirmed it would cover both, but it was expected that action would be mainly needed on cost reduction. NG therefore asked about the confidence in delivering that outcome, given the challenge in delivering the CIP thus far. MS stated that the forecasts had been developed on a prudent basis and had been discussed with the relevant budget holders, so there were opportunities to improve on the forecast position, but the largest opportunity was within the five clinical divisions.

MS also pointed out, in relation to the elective out-turn position, that the Trust had not yet deployed all of its winter plan, as that would not be fully deployed until January 2024. MS continued that that position had been maintained despite the Trust experiencing some days in Operational Pressures Escalation Level (OPEL) 4, and the Trust continued to have the best patient flow in the south east.

MS also acknowledged the importance of the CIP, but emphasised that the current exercise was related to forecasting, and what would be delivered in the current financial year, rather than on future year's CIP, so the Trust Board should take assurance from all those elements. SB then acknowledged that the clinical divisions had not delivered their CIP targets for the year-to-date, but they had significantly overperformed on elective activity and reduced agency staffing expenditure, despite exceptional circumstances. SB continued that there was however much more that could be done to reduce agency expenditure further, particularly in the Medicine & Emergency Care and Core Clinical Services divisions, and both were committed to that aim. SB also stated that there was general confidence in the divisions' ability to deliver.

RF referred to agency expenditure, and noted that the Medicine and Emergency Care division accounted for circa half of that expenditure, so asked whether sufficient resource was being allocated to support a further reduction, as it felt like the position had plateaued. SB commended the work that SS and JH and their colleagues had done to reduce the agency expenditure and noted that the nursing staffing gaps had reduced markedly over the last 12 to 18 months. SB continued that the Trust understood that it had a shortfall of some specialist consultants, and had to cover such gaps with agency staff, and work was continuing to try and address such issues.

WW then referred back to MS' comments regarding non-recurring costs and cautioned against a blanket 'freeze' on recruitment. MS however clarified that although there was a system of vacancy controls, the Trust had not introduced a vacancy 'freeze'. HF added that the authorisation level of agency staff had been raised, which had had a beneficial effect; whilst the vacancy panels had only recently been introduced, so that would help with the longer-term position. HF also stated that NHSE had confirmed that it did not expect any agency staff to be engaged for non-clinical posts, so that was being reviewed at the Trust and alternative options were being explored.

SS also noted that the vacancy rate for medical and consultant staff had been 10.7% 12 months ago, but was now at 5.5%, so there had been a marked reduction. SS also reported that the Trust currently had 36 Whole Time Equivalent medical vacancies, and each post was reviewed in detail at a Medical Recruitment Steering Group. SS also reiterated that there had been no vacancy 'freeze', but the vacancy control panel considered how more agility could be applied to vacancies.

DH then clarified that the £800m of additional funding that NHSE had allocated was primarily to cover the direct costs of the industrial action, and the 2% ERF threshold change was to address the loss of activity due to the strikes. DH continued that if the Trust received the circa £1.9m of costs for the former, that would be less than the Trust's normal share of the Integrated Care System's (ICS') funding, which would equate to a further circa £2m, and the ICS had been grateful that the Trust was willing to adopt that position. DH also stated that if the winter plan allowed elective activity to continue at the current rate, the Trust would perform better in the second half of 2023/24 than it had done in the first half of the year, on the assumption that there would be no further industrial action.

DH therefore proposed that the Trust Board formally approve the key finance, performance and capacity commitments relating to the "Addressing the significant financial challenges created by the industrial action in 2023/24" letter from NHSE, as submitted. The requested approval was duly granted. DH then asked MS to communicate the Trust Board's decision to the KM ICB.

Action: Inform the NHS Kent and Medway Integrated Care Board of the Trust Board's approval of the key finance, performance and capacity commitments relating to the "Addressing the significant financial challenges created by the industrial action in 2023/24" letter from NHS England (Chief Executive, November 2023)

11-4 <u>To consider any other business</u>

There was no other business.

11-5 To respond to questions from members of the public

No questions were received.

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]
10-13a	Liaise with the Deputy Medical Director to consider what further action may be required to strengthen the Trust's Employee Value Proposition in relation to medical staff.	Medical Director	October 2023 onwards	Liaison has occurred, and the Deputy Medical Director is scheduled to meet with the Vice Chair of the People and Organisational Development Committee on 22/11/23 to discuss the issue further. A more detailed response will therefore be considered after that meeting.
10-13b	Liaise with the Medical Director, Director of Infection Prevention and Control and Chief People Officer to review the consultant interview process in light of the comments made at the 'Part 1' Trust Board meeting on 26/10/23.	Chief Executive	October 2023 onwards	A meeting has been scheduled to consider the matter.
10-15b	Liaise to confirm the text that would accompany the Trust Board's decision that the plans for the development of the Kent and Medway Provider Collaboratives should be approved "subject to…" certain conditions.	Chief Executive and Director of Strategy, Planning and Partnerships	October 2023 onwards	A verbal update will be given at the Trust Board meeting on 30/11/23.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
09-13	Submit a report on the further work being undertaken in relation to the corporate objectives to the Trust Board in October or November 2023.	Director of Strategy, Planning and Partnerships	November 2023	The item was scheduled for the Trust Board meeting in November 2023.
09-18a	Provide the Trust Board with details of how many additional induction of labour cases would need to be brought forward by one week to conform to the National Institute for Health and Care	Director of Maternity	November 2023	There would be a 16% increase in inductions of labour if the service adopted the NICE guidance (which would equate to an extra 1.7 inductions per day).

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Excellence's (NICE's) "Inducing labour" guideline.			
09-18b	Provide the Trust Board with details of the specific issues that had prevented the women who had declared an intention to breastfeed from not doing so.	Director of Maternity	November 2023	The requested information has been included in the "Quarterly Maternity Services report" submitted to the Trust Board meeting on 30/11/23.
09-18c	Ensure that the next "Quarterly Maternity Services report" to the Quality Committee and Trust Board included details of the mental health support available within the maternity services' team following the loss of a baby.	Director of Maternity	November 2023	The requested information has been included in the "Quarterly Maternity Services report" submitted to the Trust Board meeting on 30/11/23.
10-2	Amend the minutes of the 'Part 1' Trust Board meeting of 28/09/23 to reflect the change agreed at the Trust Board's meeting on 26/10/23.	Trust Secretary	October 2023	The minutes were amended.
10-8a	Process the change to the Finance and Performance Committee's Terms of Reference that was approved by the Trust Board on 26/10/23.	Trust Secretary	October 2023	The change was processed.
10-8b	Schedule "Six-monthly update on the progress with implementing the extended software and consultancy agreement with TeleTracking UK" items at the Trust Board.	Trust Secretary	October 2023	The items were scheduled at the Trust Board's meetings in April and October 2024 (and every six months thereafter).
10-10a	Check whether the order of the "Data Quality Kite Mark Criteria" within the Integrated Performance Report was related to the missing segments in the circular Kite Mark image, and if not, check whether it was feasible to display such a relationship in the report.	Deputy Chief Executive / Chief Finance Officer	November 2023	The kite mark has been ordered to show the missing segments matching to the ordering of the criteria. This has been changed for this months' IPR
10-10b	Consider whether a weighting should be applied to the Data Quality Kite Mark Criteria within the Integrated Performance Report.	Deputy Chief Executive / Chief Finance Officer	November 2023	With the change to the kite mark matching the criteria (see action 10-10a), a change to the individual weightings is not recommended at this time. We would suggest reviewing this again in the future once the current approach has had time to be embedded.
10-13c	Arrange for the title of the	Medical	November	The requested change

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	"Recruitment" section on page 7 of the "Medical Workforce Strategy 2024 – 2026" to be renamed "Recruitment and retention".	Director	2023	was made.
10-14a	Ensure that financial risks were reflected in the "Risks and challenges" section of future "Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)" reports.	Director of Strategy, Planning and Partnerships	November 2023	The report submitted to the Trust Board meeting on 30/11/23 reflects the request.
10-14b	Liaise with the Executive Directors to develop the Trust's response to the "Helping Queen Victoria Hospital (QVH) develop a vision for the future" programme, and submit further information to the Trust Board in November or December 2023.	Chief Executive	November 2023	A report has been submitted to the Trust Board meeting on 30/11/23.
10-15a	Check and confirm that the Kent and Medway ICB genuinely believed that the plans for Provider Collaboratives would meet the health needs of the local population.	Director of Strategy, Planning and Partnerships	November 2023	A discussion was held with the ICB but they were clear that the Collaboratives were being established by providers, although the ICB had supported the Collaboratives at the Transformation and Sustainability Board, which demonstrates that the ICB is supportive of the improvement agenda the collaboratives will be pursuing for the good of NHS services and better meeting population needs.
11-3a	Amend the values in the table of the "Mitigations / Recovery Actions" section of the "H2 Financial and Operational Delivery" report submitted to the extraordinary Trust Board meeting on 20/11/23.	Deputy Director of Finance (Performance)	November 2023	The report was amended and circulated to all Trust Board members (by the Trust Secretary) on 22/11/23.
11-3b	Inform the NHS Kent and Medway Integrated Care Board of the Trust Board's approval of the key finance, performance and capacity commitments relating to the "Addressing the significant financial challenges created	Chief Executive	November 2023	The Chief Executive of the NHS Kent and Medway Integrated Care Board was informed of the Trust Board's decision on 21/11/23.

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	by the industrial action in 2023/24" letter from NHS England.			

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
05-16	Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions.	Trust Secretary	October 2023	It was subsequently agreed with the Chair of the Trust Board to submit a report to the Trust Board meeting in September 2023 (having been reviewed at the Executive Team Meeting (ETM) beforehand). However the Chair of the Trust Board subsequently agreed to a deferral to December 2023due to the volume of work involved in the review (which is considerable, despite the light touch' label).

NHS Maidstone and Tunbridge Wells NHS Trust

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?
19/10/2023	Consultant Anaesthetics PAIN	Catherine	Cashell	Anaesthetist	January 2024	New
15/11/2023	Acute Consultant	Babiker	Babiker	Acute Medicine	December 2024	Replacement post
22/11/2023	Consultant Anaesthetist for Paediatrics	Srinivasan	Perumal	Anaesthetist	April 2024	New

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

Reason for submission to the Trust 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:

- The Independent Inquiry into the issues raised by the David Fuller case published a phase 1 report on Tuesday 28 November. Chaired by Sir Jonathan Michael, the report covers a period of 30 years and investigates the horrendous mortuary crimes committed by Fuller. The report contains important lessons for the Trust and makes 17 recommendations. These recommendations and the actions taken by MTW are detailed in the first agenda item. The Trust has repeated its sincere apologies to the families of Fuller's victims and issued a statement which you can read here. Fuller's crimes are deeply shocking and our continuing support to the families is ongoing and will be open-ended.

- The Trust has escalated to OPEL 4 on a number of occasions this month. OPEL is the NHS' Operational Pressures Escalation Levels framework and is rated from one to four. This level of escalation has been seen across the county and nationally, but despite this we have still managed to maintain flow across our Emergency Departments (EDs). Escalating to OPEL 4 can sometimes impact on those patients whose elective care will be delayed to enable us to administer emergency care. Despite the sustained pressures our teams have faced over the last few weeks, we have still provided an exceptional standard of care to our patients, with achievements including:
  - Maintaining a top three ranking out of over 120 acute trusts by *The Telegraph*'s NHS performance tracker. The tracker considers a number of measures including A&E waiting times and how quickly cancer treatment starts after diagnosis.
  - Our four-hour standard in ED remaining one of the highest in the country with a performance of 84%. The standard relates to the target time a patient should be seen in A&E and receive a definitive outcome by.
  - Ensuring ambulance handover delays are rarely ever above 60mins.

  On behalf of the Trust, I would like to thank our brilliant teams who have continued to work incredibly hard for our patients despite the recent increased site pressures.

- Ensuring our MTW estate and services are eco-friendly and more sustainable is a key priority for the Trust. We launched our Green Plan earlier this year which sets out how we will achieve a net zero carbon footprint by 2040. This will include reducing emissions we control directly such as our water, waste and fleet vehicles. Plans will then focus on achieving 'NHS carbon footprint plus' status by 2045 which covers other emissions we *can* influence such as freight transport, medicine, food and catering and medical devices. Work towards this is already well underway, and our teams are making small but important changes to install more energy efficient lighting, recycling returned medicines and bringing in electric fleet vehicles. But we have also put in place workstreams to target wider goals including:
  - Meeting the national ambition of 25% of outpatient appointments being offered virtually.
  - Upgrading technology to be more efficient and reduce our need for paper. We've already saved 1,400 trees just by cutting back on printing.
  - In Estates, completing upgrades to our systems so that heating and water are provided without the use of fossil fuels as a primary fuel source.
  - Doubling our recycling rate by 2026 and cutting down on single-use plastics.
  - Enabling more people to work flexibly, cutting business mileage, promoting eco-friendly transport options and replacing our entire Trust fleet with low or ultra-low emission vehicles by 2025.
  - Reducing the level of food waste to 5% and exploring more plant-based options.

  These targets will take a huge commitment from all colleagues, and the work will be supported by our Green Committee and Trust wide Green Champions.

- While we focus on providing sustainable services, we are continuing to expand to meet the needs of a growing population and two key large-scale projects are progressing well:
  - The first is the Kent and Medway Orthopaedic Centre (KMOC) at Maidstone Hospital, where we recently held a topping out ceremony to mark the completion of the building's highest point. I was joined at the event by the Rt Hon Greg Clark, MP for Tunbridge Wells, as well as two of our senior doctors who will treat patients from across Kent and Medway in the new centre from early spring next year. This new multimillion-pound orthopaedic hub will allow the Trust to significantly increase the number of additional routine orthopaedic operations that we carry out each year, including 2,000 extra knee and hip replacements. The new centre is part of a national scheme to deliver more than 50 new surgical hubs across England which will deliver almost two million extra routine operations to reduce waiting lists over the next three years.
  - The second is the expansion of the West Kent Community Diagnostic Centre (CDC) near Maidstone Hospital. We have now welcomed our first patients into the new Unit A, which houses x-ray, ultrasound and DEXA as well as cardiac and respiratory diagnostics. Across our sites, 98% of patients require diagnostic support and the new facility will significantly increase our capacity. Importantly for our patients, this means they will be able to get diagnostic tests and results more quickly, as we will be able to provide an additional:
    - 48,000 X-rays.
    - 35,000 ultrasound scans.
    - 8,500 DEXA scans.
    - 7,000 respiratory diagnostics.
    - 6,500 cardiac diagnostics.

- Our online patient portal, another important project to improve the patient experience, was successfully launched earlier this month. The portal is available to patients aged 18 and over, and enables them to manage their own hospital appointments. Over 70,000 patients have signed-up to the patient portal so far, meaning they can now use it to view, cancel and re-schedule appointments. A process has been put in place to ensure that any appointments which may involve sharing bad news are arranged so that the patient will not receive the news via the portal, but from a member of staff at the appointment. All our patient letters now include information on how to sign-up for the portal, to encourage patients to go digital if they haven't done so already. The portal not only benefits patients but also saves colleagues time and will help increase the productivity of our clinics. A key improvement area we hope the portal will help us deliver is the reduction of patients who do not attend (DNAs). Hospital trusts have reported a 30% drop in DNAs as patients use the amend/cancel options. Importantly, this means those appointments can be offered to other patients. Of course, anyone who does not want to use the new portal will continue to be contacted by the Trust in the usual way.

- The Care Quality Commission (CQC) recently visited our birth centres at Maidstone and Crowborough, as part of the national maternity inspection programme. The CQC have also been requesting feedback from patients who have used our maternity services between March 2022 and 31 May this year, to hear more about their experiences. Their recent visits follow their inspection of Maternity services at Tunbridge Wells Hospital in the summer, as well as a planned inspection of Radiotherapy services at Maidstone Hospital in September. We look forward to receiving the CQC report from their recent inspections in due course and I will provide a further update once their feedback has been received.

- This week we held our first Nursing and Midwifery Conference. The event's theme was 'Kindness and Compassion', and celebrated the good practice that is ongoing at the Trust. Key note speaker, Professor Michael West, who has extensive experience in working to improve staff experience, care quality and the development of compassionate leaders, led the conversations, and the event showcased current quality improvement projects. Discussion panels were also led by subject experts including Geraldine Walters and Jeni Caguioa. Our Chief Nurse, Jo Haworth, launched the new Nursing and Midwifery Strategy

during the conference, which provides a vision for nursing and midwifery at MTW for the future.

- The Trust is developing a new Patient Experience Strategy and throughout September and October we asked everyone who uses our services to share their feedback and help us shape the new strategy. More than 400 people took the time to respond to a survey and their feedback has provided us with key themes to explore with patient groups at workshops which have been running throughout this month.

- We recently celebrated one year since the Trust went live with Electronic Prescribing and Medicines Administration (EPMA) in Sunrise across our adult inpatient wards and Emergency Departments. The introduction of EPMA into our Sunrise Electronic Patient Record (EPR) system was an important part of our wider digital transformation strategy to support clinical services. The main advantage of EPMA is that it allows real-time prescribing, which includes the clinical information around prescribing and medicines administration, and has been shown to reduce errors. Since EPMA was introduced in November 2022, clinicians have ordered over 1 million medicines in Sunrise, including those validated and checked by pharmacy staff, and nursing staff have administered over 2.7 million medicines. On behalf of the Trust, I would like to thank all the teams who have been involved in implementing EPMA across MTW, and all colleagues who have undergone training and embraced this new system.

- Our Anaesthetic department recently received accreditation under the prestigious Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) scheme.

  ACSA is the RCoA's peer-reviewed scheme that promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, departments are expected to demonstrate high standards in patient experience, patient safety and clinical leadership.

  Working across our hospitals, the Anaesthetic department delivers anaesthesia for planned and emergency surgery, maternity, pre-operative assessments and the chronic pain service. They also provide support and training to the resuscitation service, as well as anaesthetic cover in the intensive care units for patients with life-threatening conditions.

  Their recent accreditation demonstrates the Trust's commitment to a high standard of practice, which includes providing reliable and high-quality services to patients, in line with the requirements set by RCoA.

- Earlier this year, the Trust was shortlisted for the Performance Recovery Award at the prestigious HSJ Awards 2023, and the awards ceremony was held earlier this month. Though we didn't win on the night, being shortlisted reflects and celebrates the dedication of all our teams who work so hard every day to provide the very best care to our patients. Our entry, 'Performance recovery driving improvements in patient care' reflected on the new ways of working MTW has introduced which ensure patients in the area are receiving some of the fastest access to treatment in the country. It highlighted the following achievements:
  - Our Emergency Departments – one of the top five performing trusts in the country.
  - Work on reducing waiting lists – MTW is one of the few organisations to have no long waiting patients.
  - Cancer performance – the Trust has delivered the 62-day cancer standard for almost four years.
  - Our top tier rating in NHS England's oversight framework – at the start of this year, MTW became just one of seven acute hospitals in the country to be rated at this level.

  This progress has been supported by the use of a real time electronic bed management system, the growth in Same Day Emergency Care which provides quick access to diagnostic tests and specialist care, and investments in staff training and service developments.

- Our teams have taken top spot at the Health Tech Newspaper 2023 Awards. Winning in the Health Tech Digital Pathway and Workflow Optimisation category, the achievement recognised the work of colleagues who have developed a Virtual Fracture Clinic (VFC) in MTW's Electronic Patient Record (EPR) system. The VFC aims to help patients in A&E access orthopaedic care more quickly. The innovative new system has enabled approximately 75% of all fracture referrals to become digital, meaning staff no longer need to rely on complex spreadsheets, collating information and manual data entry. This has saved up to eight days of administration time per month, meaning that processes are more efficient and patients are able to access care quicker. It has also supported the Trust's commitment to sustainability by reducing the number of printed documents, which has helped save just under £10,000 per year in printing costs.

- Local MP and former patient Tracey Crouch visited the Kent Oncology Centre last month to present a cheque for £153,000. The money was raised by a fundraising climb to Kilimanjaro in Africa and will fund new cancer technology to support patients across Kent and Medway. Tracey teamed up with six women, including Trust Consultant Breast Surgeon, Deepika Akolekar, who works in the Peggy Wood Breast Care Unit. The group reached the Uhuru peak in seven days – 5,895m above sea level. The money, donated to Breast Cancer Kent, will go towards purchasing a Faxitron, which will be based in the Pathology department at Maidstone Hospital. This state-of-the-art machine will speed up the diagnosis time for patients who are being tested for breast cancer.

- Congratulations to the winner of the Trust's Employee of the Month award for October, Joanne Yap Soldivillo, a Staff Nurse in the Surgery Division. Joanne's dedication and passion for her job inspires her colleagues, and she is always available to offer them help or advice when needed. She puts our patients first at all times by listening to their needs and also taking the time to explain procedures to them, so that they feel involved in their care every step of the 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

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

Quality Committee, 08/11/23 **Committee Chair (Non-Executive Director)**

The Quality Committee met on 8th November (a 'main' meeting), via virtual means.

1. **The key matters considered at the meeting were as follows:**
   - The Committee reviewed the **actions from previous meetings**.
   - The **reports from the Committee's sub-committees** (The Complaints, Legal, Incidents, PALS, Audit, Risk and Mortality (CLIPARM) group; the Infection Prevention and Control Committee; The Drugs, Therapeutics and Medicines Management Committee; the Health and Safety Committee; the Joint Safeguarding Committee; and the Sepsis Committee) were considered, wherein the Committee acknowledged the three key areas of focus to improve the management of sepsis at the Trust; and noted the key themes in terms of safeguarding concerns. It was agreed under the latter that the Deputy Chief of Service, Medicine and Emergency Care should liaise with the Learning and Development Team to ensure that Sepsis Training was included within the induction process for all relevant members of staff; including those staff where clinical duties were not the primary focus of their role at the Trust. The Committee approved the revised Terms of Reference for the Infection Prevention and Control Committee and the Sepsis Committee.
   - The summary report from the **Patient Experience Committee, 07/09/23**, which included the Complaints Annual Report 2022/23 was noted and it was agreed that the Assistant Trust Secretary should liaise with the Chief Operating Officer to ensure that an "Update on the plans in relation to car parking at the Trust" was submitted to the January 2024 'main' Quality Committee meeting.
   - The report from the last **Quality Committee 'deep dive' meeting** was noted.
   - The issues raised from the **reports from the clinical Divisions** included the further work required to improve patient flow in the Trust's Intensive Care Units (ICUs); the impact of the Dementia Key Worker vacancy on the rate of falls and the subsequent recruitment to resolve the issue; the impact of diagnostic delays; the support which had been provided by the Finance Department to replace key radiology equipment; the benefits associated with the utilisation of After Action Reviews (AARs); and an overview of the programme of work to improve breastfeeding rates. It was agreed that the Divisional Director of Nursing and Quality, Cancer Services should ensure that the Cancer Services Divisional Governance report to the January 2024 'main' Quality Committee meeting includes details of the outputs from the A3 Thinking process in response to diagnostic delays. The Cancer Services Divisional Governance report included the findings of the Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection, the full report is enclosed under Appendix 1. The Women's Children's and Sexual Health Divisional Governance report included an initial response to the CQC Warning Notice for Maternity Services.
   - The Women's, Children's and Sexual Health Divisional Governance report included the latest "Quarterly Maternity Services report" which has been submitted to the Trust Board under a separate agenda item.
   - The Deputy Chief Nurse, Quality and Experience provided the latest **update on the work to achieve an 'Outstanding' CQC rating** wherein the Committee was informed of the ongoing review of the "Outstanding Care" Corporate Project.
   - The Deputy Medical Director presented the latest **Mortality update** and it was agreed that the Deputy Medical Director should provide Committee members with clarification in regards to what a "superspell" represented within the "Morality Update" report.
   - The latest **Serious Incidents (SIs),** which included the report from the Learning and Improvement (SI) Panel, were reported by the Deputy Medical Director. The Committee supported the recruitment of a Patient Safety Partner.
   - The Director of Quality Governance provided an presented an **update on the implementation of the Quality Accounts priorities 2023/24** wherein the Committee noted the intention for a reduction in the total number of Quality Account priorities for 2024/25 to support the achievement of such priorities.

- The committee agreed to undertake its **evaluation for 2023** using the same methodology and survey used in 2022 and it was acknowledged that an electronic platform would be utilised to support the evaluation process.
- The Committee conducted an **evaluation of the meeting** wherein the improvement in the submitted information was commended.

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

3. The issues from the meeting that need to be drawn to the Board's attention are:
- The findings from the CQC IR(ME)R inspection have been enclosed under Appendix 1.

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

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

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

Maidstone Hospital

IR(ME)R inspection report

Date of inspection visit:

07 September 2023

This report sets out the key findings from our recent inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). We based this on a combination of what we found when we inspected and from all information presented, including previous statutory notifications and any other intelligence available to us.

How we inspected

CQC inspectors conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiotherapy service at Maidstone Hospital on 07 September 2023.

Prior to the inspection we requested and received copies of relevant documents, including the employer's procedures (EPs), equipment inventory, radiation protection governance documentation, clinical audit, study of risk and radiation incident information. We set out the programme for the day and we explained the post-inspection process at the end of the inspection.

During the inspection, we spent our time in discussion with the radiotherapy service lead, directorate quality manager, head of radiotherapy physics, director of core cancer services and various staff of all grades from radiotherapy. We also visited the department and spoke with clinical staff and collected both verbal and written evidence. We conducted a virtual meeting after the inspection on 11 September 2023 to discuss incidents and requested further evidence which was emailed to us shortly afterwards.

Summary of findings

Separate to this report an Improvement Notice was issued against Regulations 6(5)(b) as we found issues with the department's quality assurance procedures for documentation and Regulation 8(4) as we found inconsistencies in how incidents were managed.

The radiotherapy department had some examples of good practice, for example clinical audit, operator training management and equipment maintenance records. However, there were some areas that required improvements to maintain compliance with the regulations.

Staff we spoke with were engaged, open and cited a positive culture within the department with a supportive and visible senior leadership team.

What we found

Service Overview

The Kent Oncology centre radiotherapy service comprised of 2 geographical sites at Maidstone Hospital and Kent and Canterbury Hospital. The service delivered approximately 57000 radiotherapy treatments per year across both sites.

The radiotherapy department consisted of mould room/workshop areas and computed tomography (CT) scanners on both sites with access to a hospital led CT scanner on the Maidstone site, a high dose rate (HDR) brachytherapy theatre and 9 linear accelerators (linacs) with intensity modulated radiation therapy (IMRT) and volumetric modulated arc therapy (VMAT) capability. All linacs utilised advanced on-board imaging for image guided radiation therapy (IGRT) for external beam radiotherapy.

Management/Governance Structure

The IR(ME)R employer for the radiotherapy service was the Chief Executive Officer (CEO).

The service demonstrated the management arrangements for radiation protection matters with an organisational chart. This showed how risks relating to the delivery of ionising radiation were managed through the trust's risk and quality governance structure. This operated at directorate, divisional and trust level. The trust was in the process of an governance restructure and during inspection we discussed both the existing and proposed governance structures.

The radiation protection structure included regular staff group meetings, which fed into the local radiation committees, trust radiation advisory committee and the health and safety committee.

The service has historically had issues with staffing, and a recent surge in referrals meant that the service was operating under strained resources and below required establishment levels. This had directly impacted the number of notifiable incidents submitted by the trust.

The service had identified this risk and raised it to the executive team and a risk was lodged on the corporate risk register. Mitigations to address the risk initially included the implementation of concessions to streamline treatment set processes in order to improve efficiency and the use of locum staff. Long term the department has increased its recruitment processes and has now managed to recruit appropriately, although they would not be onboarded until 2024. We were advised that the staff were having to work overtime to complete mandatory training.

The service advised that they had used the governance structure effectively in order to address this risk, and felt well supported by the trust leadership team. The risk was monitored regularly using the above structure and was well managed.

Procedures, Protocols and Quality Assurance Programmes

The service had all required written procedures, which contained enough detail. The service utilised a compliance mapping document for its EPs to signpost duty holders to the relevant

procedure.

All duty holders could access written procedures via the use of a quality management system (QMS). All documents were held online and managers regularly audited practice to check that it was in line with the documented process. Protocols were available for all techniques and processes, and the service had a process in place to review documents in a timely manner involving the right people.

Although there was a process in place for the quality assurance of documentation, this did not appear to be effective as evidence gathered prior to, and post inspection demonstrated multiple errors. There were several references to outdated regulations and nomenclature, spelling mistakes and grammatical errors in both trust and departmental level documents. It was also noted that documentation relating to incident management referred to the use of a specific incident management system, which had been replaced by another incident management system in April 2023. These products had different operating and reporting processes and as such the documents were not reflective of practice.

We were not assured the radiotherapy service had effective quality assurance programmes for written procedures and written protocols. We issued an Improvement Notice on 14 September 2023 against Regulation 6(5)b which further detailed our concerns.

Referrals and Referral Guidelines

All patients were referred and reviewed at appropriate multi-disciplinary team (MDT) meetings. Patients were then referred to a consultant clinical oncologist with the intention of consent and referral for radiotherapy. Referrals were received electronically using an Electronic Action Sheet (EAS). All EAS were reviewed and triaged by a clinical specialist radiographer to ensure that the relevant information was present and then passed to the booking team to input onto the trust's patient information system.

All referrers could access referral guidelines which were written and reviewed regularly. Clinical guidelines were in place for each patient type, these were maintained and accessible in the QMS. Each guideline detailed and linked to the relevant work instructions that covered the key area for the delivery of radiotherapy.

Carers and Comforters

The use of carers and comforters to support patients undergoing radiotherapy examinations was not justified and this was appropriately documented in the EPs.

Pregnancy and Breastfeeding

Staff checked whether patients were breastfeeding or might be pregnant and raised awareness of the effects of ionising radiation in those circumstances. The current pregnancy checking policy was not gender neutral and we were advised that an updated version of the policy was in development. We were provided with a draft version of this policy which had updated inclusive terminology.

The department utilised a policy of asking patients to provide their own pregnancy tests if they were unsure if they were pregnant, and then self-declare. There was some discussion over this as there was some confusion over if this was reflective of practice, however

discussion with treatment floor staff confirmed that this was the case. The trust had taken this approach due to the risk of liability related to inadvertent exposure of a foetus due to a false negative result.

Research

The service had safe dose constraints for research participants and ethical approval for all studies. Staff were aware of active research trials and their requirements.

There were dedicated research radiographers based at the Maidstone site who coordinated and managed treatment bookings and trial patients. They liaised with trust research committees and ensured there was adequate resource to support new trials.

Patients on clinical trials had a separate EAS and this was flagged on the electronic patient record and in the radiotherapy record and verify systems to ensure that trials patients were adequately identified.

Clinical Audit

Members of different staff groups undertook clinical audits to assess and improve the quality of the service. EPs relating to clinical audit advised that audit progress was reported monthly by the Clinical Audit Facilitator to the divisional and directorate management team. We saw evidence of several examples of clinical audit which were tracked using a spreadsheet, however, several audits had not been completed within the stated timeframes. This was due to the staffing issues discussed above and was reviewed regularly at the Oncology Clinical Governance group.

The concession that was put in place to temporarily reduce tasks completed by treatment staff was audited to assess its impact. This showed that there were no increases in error rates and therefore the new process had been adopted as standard practice.

Staff were informed of the outcomes of clinical audits via reports that were sent to the clinical leads and by email through a weekly newsletter.

Incidents

The service had a system for recording the occurrence and analysis of radiation incidents. They had moved to a new incident management system in April 2023 and there were some issues with how this was embedded into the organisation. This meant that information relating to incident investigation was not readily available at inspection.

Level 1 incidents were analysed to identify trends and discussed at radiation governance meetings, however level 2-5 incidents were not reviewed to see if they required a dose assessment and relied solely on the incident handler to escalate if required.

We checked a sample of incident records and saw that, of those checked, several had not been appropriately investigated and or had enough detail. Where required, some incidents had not been reported to the enforcing authority, or the outcomes shared. Dose assessments were routinely undertaken during these investigations; however they were not documented appropriately and could not be evidenced. We were therefore not assured that the service had an effective incident management process. We issued an Improvement

Notice on 14 September 2023 against Regulation 8(4)a(iii) and 8(4)a(iv) which further detailed our concerns.

The service had systems to inform the referrer, practitioner and patient if a clinically significant unintended or accidental exposure occurred, and the outcome of the investigation. However, as above the process of how clinically significant unintended or accidental exposure are identified was not documented within either the patients record or the incident management system.

The service had a comprehensive study of the risk of accidental or unintended exposures to patients during radiotherapeutic exposures.

Duty Holders

Practitioners and operators were entitled appropriate to their role as part of the employer's procedures. Both groups understood their responsibilities and the need to cooperate with other professionals involved in medical exposures.

The department kept an up-to-date list of all duty holders in the department, along with their job title and role under the regulations. A competency matrix was held on the QMS which clearly identified who was entitled to carry out specific tasks.

When questioned, staff were able to demonstrate where this was located on the QMS.

Justification and Authorisation

The service had a documented process that defined who undertook justification and authorisation, and what factors must be considered. Audits of requests and referrals showed that the process was followed.

The service utilised consultant radiographers, who had a scope of practice which identified what they were entitled to justify and authorise. This was held on the QMS, and a separate entitlement matrix was available for this staff group.

Operators were entitled to act as practitioners to authorise additional imaging. This was carried out by Band 7 operators who had completed an internship which covered additional training to carry out this aspect of their role.

Non-Medical Imaging

The radiotherapy services did not accept referrals for any non-medical imaging exposures. This was documented within the EPs.

Optimisation

The service had a process for the optimisation of patient doses, all patients' treatments were individually planned and delivered in accordance with ALARP principles. Each individual exposure was optimised to the patient, with target volumes being individually planned.

Irradiation of non-target volumes, and tissues such as organs at risk (OAR), was consistent with the intended radiotherapeutic purpose. Established protocols were in place to support practitioners and operators and gave indications for treatment, accepted dose regimes and

OAR tolerances.

On-treatment verification imaging protocols were defined during equipment commissioning.

Patient doses were recorded in the service's information and image management system.

Clinical Evaluation

The service ensured clinical evaluations, including dose information, were recorded for every patient exposure, by staff trained to do so. Staff undertook weekly checks of all patients currently on treatment, and these were conducted in line with local administrative tasks checking procedures.

Assessment of patients' acute and long-term side effects were ascertained during treatment and at follow-up.

Operators conducted clinical evaluation of verification exposures following acquisition as specified within local procedures. This included assessment of image quality to inform subsequent treatment exposures.

National Dose Surveys

The service provided data on patient doses as part of national dose surveys.

Medical Physics Expert

The radiotherapy service had several entitled MPEs, each with specified job descriptions for appointment.

There was always close involvement of an MPE in all aspects of the radiotherapy service.

The expertise of MPEs was relevant to the scope of their support to the department and we were assured that they were appropriately involved in all matters set out in Regulation 14, as well as involvement with radiation safety committee meetings. We saw evidence of MPE audits of departmental compliance with the regulations, which highlighted any areas where practice could be improved.

The day-to-day involvement of physics in the service was well managed and clinical staff felt they were able to seek their support easily.

Equipment

The service regularly checked the performance of all radiological equipment, and records showed that this happened in line with professional guidance.

The quality assurance (QA) and quality control (QC) programme was managed by the lead physicist. All radiotherapy equipment QA was managed through the QMS and QC results were managed using spreadsheets. These spreadsheets showed performance over time so trends could be identified and flagged to the user any results outside tolerance.

All linacs and their associated imaging modalities had regular maintenance carried out by the radiation engineering service with basic level support from the manufacturers. CT scanners

were under a full manufacturer service level agreement. The engineers would document handover of equipment and post-maintenance QC checks using job sheets, logbooks and permit to work signage.

The service's inventory of radiological equipment was provided ahead of inspection. We noted that the recording and verification system and treatment planning systems were omitted, and therefore breached Regulation 15(2). However, this was amended immediately post inspection, and we were provided with an updated version on 11 September 2023.

All equipment was capable of reading out, recording and transferring dose information.

Training

The service had a procedure which detailed how training of operators was managed, and how competency was achieved and maintained. There was no associated training procedure for practitioners. However, we were advised that practitioners did attend an IR(ME)R training session that covered the use of the treatment planning system and recording and verification system. Evidence was provided that showed some, but not all, practitioners had completed this training. The service advised it was aware of national guidance relating to practitioner training records that had been released prior to the inspection and they intended to review the existing training process in response.

The service used training records to ensure that all practitioners and operators, including agency/bank/locum staff, were adequately trained and undertook continuing education and training. These records which were in both paper and electronic formats, with an online competency matrix used to log all operator competencies. All operators completed a workbook which quantitatively defined how competencies were achieved.

There was an internal programme that radiographers could complete that would entitle them to be able to authorise additional imaging.

The service ensured that trainee members of staff were supervised in line with their procedures and level of training.

Areas for improvement

The following areas are where a breach has been found which did not justify regulatory action. To prevent it failing to comply with legal requirements in future, or to improve the quality of services, the employer should take the following actions to comply.

Regulation	Action required
17(4) Training	The employer must keep and have available for inspection by the relevant enforcing authority an up-to-date record of all relevant training undertaken by all **practitioners** and operators engaged by the employer to carry out any exposures or any practical aspect of such exposures showing the date or dates on which training qualifying as

	adequate training was completed and the nature of the training

What happens next

In response to the actions required, as above, we require the employer, to provide an action plan to be **submitted within 6 weeks of the date** on this letter. This action plan should set out how the requirements are being addressed and within what time scale, and should be sent to irmer@cqc.org.uk. Where we have undertaken any enforcement action, this will be managed through separate correspondence.

If we are satisfied with the action plan submitted, we will write to you to confirm the inspection process has been concluded. We will continue to monitor compliance through our usual intelligence gathering.

Summary report from the Finance and Performance Committee, 28/11/23	Committee Chair (Non-Exec. Director)

The Committee met on 28th November 2023 via web conference.

1. **The key matters considered at the meeting were as follows:**
   - All due actions had been closed.
   - The 'deep dive' item focused on ongoing delivery of **the outpatients transformation programme** and progress with the three key workstreams. Monthly targets for call answering times and clinic utilisation had been met in October; the patient portal had been launched with over 300,000 records created and 72,000 patients registered; pathway transformation for ENT and Haematology was progressing. It was agreed to schedule a further update on progress for 6 months' time, which would include before and after reporting against the three key identified KPIs for the pathway transformation workstream. The Committee noted the very good progress and thanked all of the team.
   - The **Patient Access strategic theme metrics for October** were reviewed; continued strong performance against the Emergency Department 4-hour waiting time target was noted against unprecedented levels of demand in October. It was further noted that new outpatient activity stood at 116.7% against a target of 106.5%. The good Referral to Treatment (RTT) and performance against the cancer standards were also noted. The Committee also thanked everyone involved for the continued hard work in often very difficult circumstances.
   - The review of **financial performance for October** highlighted that the Trust was £0.9m in surplus in October, which was £0.1m adverse to plan, and £2.0m in deficit year to date which was £1.8m adverse to plan. Additional costs from Industrial action were a significant contributor to this position. It was agreed to extend the report on the Model Health System programme (and benchmarking), scheduled for January 2024, to include wider consideration of productivity (including the Trust's interpretation, approach to & measurement of productivity). The underlying performance against Cost Improvement Programme (CIP) targets continues to cause concern, although it was acknowledged that there had been an improvement over the last month.
   - The report on the **quarterly analysis of consultancy use** was noted.
   - The **plan for the forthcoming winter period** was noted, and the reviewed priority one list of schemes to be funded was considered. £1.7m had been included for Winter escalation within the financial forecast based on this priority list.
   - The Divisional Director of Operations for Surgery gave an update on **recruitment within facilities**. Further progress would be reported as part of the six-monthly update on the Facilities response to the external Estates and Facilities review, scheduled for December.
   - An update was given on **the options being pursued to manage the risk relating to the age of imaging equipment in Radiology,** which highlighted that agreement had been reached to prioritise the replacement of an x-ray room at MGH; work was underway to progress this. It was agreed that an update on the status of the red-rated risk register entries and likely timeline for mitigation should be provided in the next update to the committee.
   - The Director of Strategy, Planning and Partnerships gave an update on **the financial risks regarding the Kent and Medway Medical School (KMMS) accommodation project** and the Committee endorsed the proposed changes to the payment plan for the project.
   - The Committee reviewed the **Digital Pathology Full Business Case (FBC)** and it was agreed to recommend the case for approval by the Trust Board in November. The need for further development re benefits realisation was recognised, but did not preclude approval.
   - The Committee then reviewed the **Outline Business Case (OBC) for the Urology Investigation Unit,** and the proposal was endorsed to pursue further planning on the preferred option for a Urology Investigation Unit via a modular build at Maidstone Hospital through lease arrangement. The estimated risk of up to £100k +VAT for design and planning, payable in the event of the project not proceeding, was noted.
   - The **revision to the Cardiology Managed Equipment Service Business Case** was then reviewed by the Committee, and it was agreed to approve progression to contract completion

with the service provider, noting the additional risk in relation to the unconfirmed position re the accounting treatment for the service
- The content of the **summary report from the People and Organisational Development Committee** meeting in October 2023 was noted.
- The Committee agreed the **annual committee evaluation** process.
- The Committee's **forward programme** was noted.

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

3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Committee recommended the **Digital Pathology Full Business Case (FBC)** for approval by the Trust Board

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 24/11/23 (incl. the Guardian for Safe Working Hours Annual Report 2022/23)

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on 24th November 2023 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were reviewed.
- The **Guardian of Safe Working Hours** provided their **Annual Report** which covered October 2022 to September 2023 (the report has been enclosed under Appendix 1).
- The Programme Director, Premium Staffing Spend and Head of Temporary Staffing and eRostering attended for a **review of the findings of the Use of Temporary Staffing Internal Audit review** which included an **update on the workforce efficiency programme.** A lengthy discussion was held on the issues and it was highlighted that the Internal Audit review was carried out in February 2023, and so many of the 'limited' scores had improved and should continue to do so. The also confirmed that the Committee would monitor the actions when it discussed the performance on the associated Breakthrough Objective every two months.
- The Committee reviewed the **"Our nursing and midwifery strategy 2024 – 2027"**, which has been submitted to the Trust Board, for approval, under a separate agenda item. The Committee made several comments on the Strategy, but confirmed that it should be submitted to the Trust Board meeting as drafted. The Chief Nurse was also asked to confirm the frequency of the reports that would be submitted to future Committee meetings to monitor implementation of the Strategy.
- The Chief People Officer provided an u**pdate on the potential mechanisms which could be implemented to increase staff awareness of the Trust's Employee Value Proposition (EVP)**, and it was agreed that a 'persona' EVP should be piloted when recruiting to hard-to-recruit departments or staff groups, to assess the effectiveness of the approach and methodology. It was also agreed to schedule an update at the Committee's meeting in March 2024.
- The Head of Organisational Development and the Human Resources Business Partner for Cancer Services attended for a **review of the new Divisional People Plans**, and it was agreed that future progress would be monitored by the Committee annually.
- The Committee noted the latest **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR);** and the **mid-year update on the Trust's Disclosure and Barring Service (DBS) check compliance.**
- The Committee's **forward programme** was noted.
- The Head of Organisational Development gave a verbal report on the items considered at the latest **Wellbeing Committee** meeting.

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

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

- The Guardian for Safe Working Hours Annual Report 2022/23 is enclosed in Appendix 1, for information and assurance

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

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

Appendix 1

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – NOVEMBER 2023

NHS Maidstone and Tunbridge Wells NHS Trust

THE GUARDIAN OF SAFE WORKING HOURS ANNUAL REPORT (COVERING OCTOBER 2022 TO SEPTEMBER 2023)	**GUARDIAN OF SAFE WORKING HOURS**

It is outlined within "Schedule 06 – Guardian of Safe Working Hours" of the "Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016" that the Trust Board must receive a Guardian of Safe Working Hours report no less than once per quarter, which should include data on all rota gaps on all shifts. The required quarterly report is submitted via the People and Organisational Development Committee as part of the Committee's summary report to the Trust Board.

An internal decision was made to combine these quarterly reports into an Annual Report which covers each cohort of junior doctors and therefore does not follow the reporting schedule for the financial year, however covers a full year period of October to September. The latest report is enclosed which will be submitted to the November 2023 'Part 1' Trust Board meeting as an Appendix to the "Summary report from the People and Organisational Development Committee".

Key points:

There was a total of 515 exception reports during this period:

- 480 exception reports were filed due to work schedules/hours
- 18 exception reports were filed under patient safety issues
- 17 exception reports were filed due to missed educational opportunities
- The largest number of exception reports were from the medical division

Reason for submission to the 'Main' People and Organisational Development Committee

Information and assurance

Annual report for the period October 2022 - September 2023

During this period there was a total of **515** Exception Reports received.

- October 2022-December 2022 **177**
- January 2023-March 2023 **91**
- April 2023-June 2023 **98**
- July 2023-September 2023 **149**

The number of exceptions reports relating to missed educational opportunities were **17** during this period.

Comparison to the last annual report which covered Oct 21-Sep 22

	Oct 21 - Sep 22	Oct 22 - Sep 23	
Oct - Dec	107	177	65% increase
Jan - Mar	80	91	13% increase
Apr - Jun	53	98	84% increase
Jul - Sep	81	149	83% increase
Missed educational opportunities	12	17	41% increase
Total	**321**	**515**	

Commentary regarding annual comparison

There has been a large increase in the number of exception reports over the last year .This could well reflect difficulties around staffing and rotas, particularly in the medical division.
Some of the increase may also be due to the efforts that have ben made to make the reporting process more accessible and responsive.

Report Commentary for Oct 22- Sep 23

The largest number of exception reports were raised in the medical division. This was particularly the case at the end of 2022 and during the first half of 2023. There were many issues around the allocate (healthroster) rota allocation system which led to much unhappiness amongst the trainees. There were also a large number of vacancies on the rotas. This was recognised by the division and the allocate system was replaced by a system called patchwork. There has also been considerable work on recruitment in this division.

Overall there has been an improvement and the trainees seem much happier with patchwork, however I have been made aware by the Director of Medical Education, Dr Derek Harrington, that there have recently been **repeated human errors** which have created problems for many of the Junior Doctors. Tim Hubbard, General Manager for Medicine , has assured myself and Dr Harrington that he is aware and has put in place processes to reduce the errors.

The other specialities which have stood out over the year as having problems which have resulted in a **spike of exception reports are ophthalmology and haematology**. Ophthalmology had recurring over running clinics and haematology had a long running issue with the number of hours senior trainees were working at weekends. During the year I liaised with clinics and managers and I am glad to say that issues appear to have now been resolved.

Another problem at the start of the year was the **length of time consultant supervisors were taking to respond to the reports.** Myself and the Medical staffing team, led by Andrea Stephens have put in place some measures; these have included automated reminders and a link too a

guide to the reporting system. The response times have been improved. Many thanks to Andrea and the medical staffing team from me.

The delay in responses to exception reports had led to a delay of several months before trainees would receive financial compensation or time in lieu for extra work. Therefore after consultation the **cut off for payments has been reduced to one month**. This has been well received.

I was asked at the last JMCC what an appropriate number of exception reports is. This is a very difficult question to answer. On one hand a very large number may well represent problems within the Trust, however a very small number could just mean that there was not an open environment where trainees felt safe to make exception reports
It may be more useful to look at trends and spikes in particular specialities, something which I have tried to do over the year and then highlight to the division and executive team.

In my next report I will see if I can obtain figures from Kent and Sussex Trusts in order to see where we lie against other Trusts.

Finally I would like to thank all of the members of the various committees I report into for the manner in which they have received my report and asked questions.

Dr Tim Bell

Audit and Governance Committee, 09/11/23 (incl. approval of revised Terms of Reference) | **Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met, virtually via web conference, on 9th November 2023.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed.
   - The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference, are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
   - The Deputy Chief People Officer, People and Systems and Head of Temporary Staffing attended for the **limited assurance internal audit review: Use of temporary staffing** wherein a discussion was held regarding the importance of a robust approach to the utilisation of temporary staffing and assurance was provided regarding the progress which had been made in response to the internal audit recommendations. The following actions were agreed:
     - The Deputy Chief People Officer, Workforce and Systems should ensure that a discussion was held at the November 2023 'main' People and Organisational Development Committee regarding what, if any, roles and responsibilities the Committee should hold in relation to the monitoring of compliance with Trust's Temporary staffing policy.
     - The Director of Audit, Tiaa Ltd (Head of Internal Audit) should amend the implementation timetable for the use of temporary staffing key findings and management action plan (MAP) to reflect that the recommendations were not expected to be completed until the end of the 2023/24 financial year.
     - The Director of Audit, Tiaa Ltd (Head of Internal Audit) and Deputy Chief Executive / Chief Finance Officer should liaise to consider, and confirm, the scheduling of an Internal Audit review of eRostering.
   - The Director of Medical Physics attended for an **In-depth review of risk ID1269 Kent Oncology Management System (KOMS) server hardware** which included details of the installation and testing of the new virtual server infrastructure to enable the transition of the KOMS data.
   - The Chief Nurse outlined the **future development of risk management at the Trust** wherein the Committee acknowledged the additional resources which were required to support the Trust's risk management function and the importance of the development of a comprehensive education package. It was agreed that the Chief Nurse should investigate what, if any, guidance had been, or was due to be, issued by NHS England regarding the risk management process for NHSE providers and, if such guidance was available, what the implications were for the future of risk management at the Trust.
   - The Director of Emergency Planning and Response attended for the latest **update on security issues** which included an overview of the measures which had been developed to support the recruitment of additional Security staff at Tunbridge Wells Hospital and the direct involvement of the Trust's Security Team in the planning process for major capital projects to ensure the appropriate security measures were duly incorporated. It was agreed that the Director of Emergency Planning and Response should investigate what, if any, additional security arrangements were required in response to the implementation of Phase 2 of the Community Diagnostic Centre. It was also agreed that the Director of Emergency Planning and Response should ensure that future "Update on security issues" reports included details of the Trust's security equipment replacement programme; the "Did Not Attend" rate for face-to-face / in-person security training; and an organogram of the security department, showing the current and future staff (to see the extent of the further recruitment required).
   - The Committee received an **update on progress with the Internal Audit plan for 2023/24** (incl. progress with actions from previous Internal Audit reviews) wherein a discussion was held regarding the requirement for an internal audit review of the Trust's medical and non-medical eRostering.
   - The Committee reviewed the latest **Counter Fraud update** and it was agreed that the Anti-Crime Manager should check, and confirm to Committee members, whether the Cyber Security

e-learning training provided by Tiaa Ltd included sufficient education on the cyber security risks posed by Artificial Intelligence (AI).

- It was agreed under the latest "**Audit Progress Report and Sector Update" from External Audit** that the Director, Audit, Grant Thornton UK LLP should check, and confirm to Committee members whether the "But will lessons be learned this time?" statement in relation to the Lucy Letby inquiry required any specific action from the Trust.
- The Deputy Chief Executive / Chief Finance Officer provided a verbal **summary of the latest financial issues** which included an overview of the Trust's financial position as of month 6 2023/24 and the preliminary financial position as of month 7 2023/24.
- The Director of IT attended for the latest **update on Cyber Security** wherein it was agreed that the Assistant Trust Secretary should ensure that the Trust's Cyber Security Architect and Head of Information Governance were invited to attend the Committee for future "Update on cyber security" items.
- The Director of IT presented a **review of the lessons learned from the Trust's Storage Area Network (SAN) issues** which provided a comprehensive overview of the root cause for the SAN issues and the subsequent solutions which had been implemented.
- The **latest single tender / quote waivers data; latest losses & compensation data**; and **detail of interests declared under the Conflict of Interest policy and procedure** reports were noted; as was the **forward programme** and **reminder of the intended process for the review/survey of the Committee, External Audit Service, Internal Audit Service and Counter Fraud Service**.

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

- "Risk Management and Board Assurance" (which received a "Reasonable Assurance" conclusion)
- "ICT Asset Management" (which received a "Substantial Assurance" conclusion)
- "Financial Assurance – Payroll" (which received a "Reasonable Assurance" conclusion)
- "Use of Temporary Staff" (which received a "Limited Assurance" conclusion due to a lack of evidence of compliance with the Trust's processes)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews: N/A

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

- The Assistant Trust Secretary should schedule an "Education on the key areas for consideration in regards to Artificial Intelligence (AI)" item at the Committee's meeting in March 2023

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

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

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

Audit and Governance Committee

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive sub-committee of the Trust Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Trust Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control); and~~&~~ oversight of the Internal and External Audit, and Counter Fraud functions. The Committee has primary responsibility for ensuring compliance with the Trust's established governance structures.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of External Auditors, and on the maintenance of independent relationships with such Auditors.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.2 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Chair of the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to become formal members of the Committee, to address issues of specific concern, at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Committee Chair may require the affected member to withdraw at the relevant discussion or voting point.

4. Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[1].

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- Deputy Chief Executive / Chief Finance Officer
- Deputy Director of Finance (~~Financial~~ Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit ~~-~~Engagement Lead and/or other appropriate representatives
- Senior Anti-Crime Manager (formerly Local Counter Fraud Specialist)
- Trust Secretary

5.2 Members (listed above) are expected to be present at all meetings of the Committee. Those listed in section 5.1 are expected to be in attendance at all meetings of the Committee.

5.3 The Chief Executive, other ~~members of the~~ Executive Directors~~Team~~, or any other member of staff will be invited to attend if the Committee is discussing areas of risk or assurance that are the responsibility of that individual and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will, if requested by the External and Internal Auditors, meet privately with those Auditors at the start of each meeting. A private session with the External and Internal Auditors will however be held once a year, ahead of the first Audit and Governance Committee meeting following the completion of ~~that reviews the draft~~the audit of the Annual Report and Accounts, regardless of whether the Auditors have any issues to raise. Individual Committee members can however approach the External or Internal Auditors in private, should such members consider this necessary.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to fulfil the 'Committee's purpose and/or meet its duties.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may also put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

[1] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7. Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, risk management and internal control

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

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from ~~members of the~~ Executive ~~Team~~ Directors and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications & management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to 'those charged with governance' (TCWG), agreement of the Auditor's Annual Report (formerly the Annual Audit Letter) (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health and Social Care's Arm's Length Bodies or ~~R~~regulators/~~i~~inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of Counter Fraud work. The Committee will ensure that any suspicions of fraud, bribery and corruption are referred to the NHSCFA.

Management

7.11 The Committee shall request and review reports and positive assurances from ~~members of~~ the Executive Directors~~Team~~ and managers on the overall arrangements for governance, risk management and internal control.

7.12 The Committee~~y~~ may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance (in so far as they may affect the Trust's Annual Report and Accounts).

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board. This duty will usually be met via the commissioning of, and reviewing the outcome of, the Core Financial Assurance reviews within the annual ~~i~~internal A~~a~~udit programme.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The text of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The Letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Freedom to Speak Up

7.16 The Committee shall support the People and Organisational Development Committee and Trust Board in reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Security issues

7.17 The Committee shall support the Committee Chair in fulfilling their role as the Trust's Security Management Non-Executive Director (NED) Champion via the following methods:

- The consideration of a standing "Security issues" item at each standard Committee meeting.
- The consideration of a Security Annual Report.

Auditor Panel

7.18 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

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

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements. The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that

the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self-assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

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

12. Review of Terms of Reference and Monitoring Compliance

12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History
Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017
Terms of Reference agreed by the Audit and Governance Committee, December 2018
Terms of Reference approved by the Trust Board, December 2018
Terms of Reference agreed by the Audit and Governance Committee, November 2019
Terms of Reference approved by the Trust Board, November 2019
Terms of Reference agreed by the Audit and Governance Committee, November 2020
Terms of Reference approved by the Trust Board, November 2020
Amended Terms of Reference agreed by the Audit and Governance Committee, May 2021 (to reflect the Committee's primary responsibility for ensuring compliance with the Trust's established governance structures).
Amended Terms of Reference approved by the Trust Board, May 2021
Terms of Reference agreed by the Audit and Governance Committee, November 2021 (annual review)

Terms of Reference approved by the Trust Board, November 2021
Terms of Reference agreed by the Audit and Governance Committee, November 2022 (annual review, and the inclusion of content related to security issues)
Terms of Reference approved by the Trust Board, November 2022
Terms of Reference agreed by the Audit and Governance Committee, November 2023 (annual review)
Terms of Reference approved by the Trust Board, November 2023

Summary report from the Charitable Funds Committee, 22/11/23 (incl. approval of revised Terms of Reference and approval of Annual Report and Accounts of the Trust's Charitable Fund, 2022/23)	**Committee Chair (Non-Executive Director)**

The Charitable Funds Committee (CFC) met on 22nd November 2023, virtually, via webconference.

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

- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Committee reviewed and **agreed the Charitable Fund Annual Report and Accounts for 2022/23**, and these have been enclosed in Appendix 2, for the Trust Board's approval, along with the Management Representation Letter for 2022/23 (Appendix 3), which is a formal part of the Annual Accounts Process. The Letter is drafted by the Trust's External Auditors following the completion of their audit of the Annual Accounts, and then submitted to the External Auditors after it has been approved by the Trust Board.
- The **financial overview at Month 7** noted that the income received thus far was £267.5k, which was an increase on the same point last year; whilst expenditure was £241.5k, which was also an increase on last year. It was also noted that only two funds, "Covid 19" & "Cancer Services", had balances above £100k, and there were plans in place to reduce such balances.
- The Committee undertook an **annual review of the Investment Strategy** and agreed that the funds currently deposited with Santander (£82,719.48) and Virgin Money (£91,486.59) should be transferred to RBS, as RBS offered a far higher interest rate. It was also agreed that £85k should be invested with Metro Bank, as that amount was covered by the Financial Services Compensation Scheme. It was further agreed the Committee would receive details of any further recommendations relating to a potential investment with Cazenove and/or CCLA.
- The Head of Charity and Fundraising provided the latest **update on the progress of the Charitable Fund Fundraising Strategy** and the Trust Secretary agreed to liaise with the Head of Organisational Development regarding the formalisation of the food pantry service (which was funded through the Charitable Fund) via the development of a process/procedure.
- The Committee reviewed **a Business Case for support for the Trust's Charity**, and confirmed its support for a more formal Business Case to be developed, for consideration via the Trust's standard Business Case process.
- The Committee reviewed the benefits associated with **NHS Charities Together Membership** and confirmed that the membership should be renewed for 2024.
- The Head of Charity and Fundraising provided the latest **Fundraising update** and it was agreed that that report should be included in the Committee's summary report to the Trust Board, to draw the progress made to the attention of the Trust Board members that were not members of the Committee. That report is therefore enclosed in Appendix 4.
- The Head of Charity and Fundraising reported that work was still in progress on a **potential Customer Relationship Management (CRM) system**.
- The Committee was advised that a **raffle licence** had now been obtained and that would provide appropriate cover provided any income generated was not more than £250k per year.
- The Chair of the Charity Management Committee provided the latest update on the **proposed partnership with Maggie's Centres**, which noted that Maggie's had now identified a corporate fundraiser to manage the fundraising process.

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

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

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval
- The Charitable Fund Annual Report and Accounts for 2022/23 is enclosed under Appendix 2 for approval

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

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

[1] 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;

1. Information and assurance.
2. To approve the Committee's revised Terms of Reference (see Appendix 1).
3. To approve the Charitable Fund Annual Report and Accounts for 2022/23 (see Appendix 2).
4. To approve the Management Representation Letter for 2022/23 (see Appendix 3).

the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Appendix 1

CHARITABLE FUNDS COMMITTEE

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

1. Purpose

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

2. Membership

Membership of the Committee is as follows:

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

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

3. Quorum

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

4. Attendance

The Head of Charity and Fundraising will routinely attend meetings of the Committee (but will not be a member).

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

5. Frequency

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

6. Duties

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

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

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

Policy and other matters

- To approve, on behalf of the corporate Trustee:
  - The Ppolicy and procedures for Ccharitable funds.
  - Specific fundraising appeals (provided these align with the approved Charitable Fund strategy).
  - A Rreserves policy (if considered by the Committee to be required).
  - An iInvestment strategy (and to formally review the strategy annually).
  - A gGrant Mmaking policy (if considered by the Committee to be required).
  - Guidance for fundraising activities (if considered by the Committee to be required).

Operational matters

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

Internal and External control

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

Financial reporting

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

7. Parent committees and reporting procedure

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

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

8. Sub-committees and reporting procedure

The Committee has the following sub-committee:

- The Charity Management Committee.

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

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

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted either the Deputy Chief Executive / Chief Finance Officer or Chief Operating Officer. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

10. Administration

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

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

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

11. Review

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

History

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015
Agreed at Charitable Funds Committee, November 2016
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017
Agreed at Charitable Funds Committee, 27th November 2018 (annual review)
Approved at Trust Board, 20th December 2018
Agreed at Charitable Funds Committee, 29th October 2019 (annual review)
Approved at Trust Board, 28th November 2019
Agreed at Charitable Funds Committee, 24th March 2020 (to include the Charity Management Committee as a sub-committee)
Approved at Trust Board, 30th April 2020
Agreed at Charitable Funds Committee, 24th November 2020 (annual review)
Approved at Trust Board, 17th December 2020
Agreed at Charitable Funds Committee, 24th November 2021 (annual review, and to add a further Non-Executive Director or Associate Non-Executive Director to the membership)
Approved at Trust Board, 22nd December 2021
Agreed at Charitable Funds Committee, 17th November 2022 (annual review)
Approved at Trust Board, 24th November 2022
Agreed at Charitable Funds Committee, 22nd November 2023 (annual review)
Approved at Trust Board, 30th November 2023

MTW Hospitals Charity
Supporting your local hospitals

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts

For the year ended 31st March 2023

Charity Number 1055215

Contents

Fundraising foreword

The past twelve months has seen a resurgence of fundraising here at Maidstone and Tunbridge Wells NHS Trust. In October, we were please to welcome our new Head of Charity and Fundraising who has been working across the Trust to secure ongoing support for our patients, visitors and staff. She is assisted by our Charity Manager who has specific responsibility for fundraising for our incredible Kent Oncology Centre which has been open for 30 years this year.

In January this year the Trust Board agreed a new fundraising strategy, which will transform the charity over the next five years, focussing on supporting the Trust to be there for patients and their families in their time of need, providing additional equipment, services and amenities for patients, visitors and staff, improving the care received and health outcomes across the areas in which the Trust operates.

The Charity is grateful to everyone who has expressed their gratitude for the care received by them or their loved ones; be it with a donation, a gift in kind or simply a message of thanks and support for our amazing teams across the Trust. This gratitude enables the Trust to go further and support our local hospitals to grow and to truly become a household name and the charity of choice for support from our local community.

Over the past twelve months MTW Hospitals Charity has received £158K from our local community and NHS Charities Together, who campaign on a national level to support over 200 local NHS charities. Without the support of our local communities we would not be able to provide the trust with the additional resources for patients and staff; additional equipment that can make a real difference to patient care and additional opportunities for staff training and support.

The forecast for the next 12 months is unpredictable but under the leadership of our Head of Charity and Fundraising and the unwavering support, of you our supporters, we are sure we can continue to support our local hospitals to grow.

Our performance

The charity aims to raise vital funds to make Maidstone and Tunbridge Wells NHS Trust a truly outstanding, patient friendly provider for the patients and families cared for every year and to support the amazing staff who deliver exceptional care to those patients and their families.

We aim to promote understanding of and increase charitable giving to MTW Hospitals Charity and to demonstrate the difference this makes. We will support the Trust to meet its ambition of always providing exceptional healthcare and ensuring all patients have a positive experience of care and support.

We will use funds donated to us to provide additional resources above and beyond what the NHS can currently provide which will lead to an improved environment for patients and staff; additional equipment that can make a real difference to patient care and additional opportunities for staff training and support. We will also ensure that the Trust continues to be a leader of scientific research and treatment advances by raising funds to support the investment of latest technology and patient innovations.

Our achievements

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds (the Charity's) Annual Report and the audited financial statements for the year ended 31st March 2023.

The financial statements set out on pages 20 to 36 comply with the charity's trust deed, Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS) applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019).

Trustee Statement

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

The role of the Charity

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

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

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

Within the Umbrella there were a total of 35 individual funds at the 31st March 2023 with a total value of £0.874m. The number of funds in each category is as follows:

- 16 restricted funds[1].

- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 17 unrestricted[2] or designated[3] funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.
- The major funds within each of these categories are disclosed in Note 8 in the accounts.

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[1] Restricted funds are the funds of the charity that are required to be expended in a certain way, or limited to expenditure for a particular purpose.
[2] Unrestricted funds are the funds of the charity that may be spent entirely at the discretion of the Trustee
[3] Designated funds are funds set aside for designated purposes. Designated funds are unrestricted as the Trustee can remove the designation at any time

The Corporate Trustee

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

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

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

Executive Directors	**Non-Executive Directors**	**Other Directors**
Miles Scott – Chief Executive	David Highton – Chair of the Trust Board	Sara Mumford – Director of Infection Prevention & Control
Steve Orpin – Deputy Chief Executive / Chief Finance Officer	David Morgan	
Peter Maskell – Medical Director	Wayne Wright	
Sean Briggs – Chief Operating Officer	Maureen Choong	
Joanna Haworth – Chief Nurse	Neil Griffiths	
Sue Steen – Chief People Officer	Emma Pettitt-Mitchell	
Amanjit Jhund – Director of Strategy, Planning and Partnerships (left on 29.04.22)	Alex Yew – Associate Non-Executive Director (Joined on 27.03.23)	
Rachel Jones – Director of Strategy, Planning and Partnerships (Joined 30.05.22)	Jo Webber – Associate Non-Executive Director	
	Karen Cox – Associate Non-Executive Director	
	Richard Finn – Associate Non-Executive Director	
	Alex Yew - Associate Non-Executive Director	

None of the Members of the Trust Board have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee (in 2021/22 this was also none)

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

Principal advisors:

Independent Examiner Grant Thornton UK LLP 30 Finsbury Square London EC2A 1AG	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Solicitors Capsticks Solicitors LLP 1 St George's Road Wimbledon, London SW19 4DR	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB

Governance and Management of the Charity

Governance

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

The Charitable Funds Committee operates according to Terms of Reference that are approved annually by the Trust Board, and plans to meet at least three times a year; for the financial year 2022/23 the Committee met four times.

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

Recruitment and Training of Trust Board and Charitable Funds Committee Members

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

Management of the Charity

The management of the Charity is operated in accordance with the Trust's "Policies and Procedures for Charitable Funds", which are approved by the Charitable Funds Committee. That policy was reviewed and updated during 2021/22, approved by the Charitable Funds Committee on 28th July 2021, and then ratified by the Policy Ratification Committee on 10th September 2021. There is a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised Fund Holders The Fund Holders consist mainly of senior department managers. Each individual Fund Holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions that apply to Charitable Funds. Each Fund Holder receives a detailed financial statement of the fund each month. The Charitable Funds Committee agree the charitable fundraising strategy for year 2023 to 2027 on 20th January 2023.

Risk Management

The major risks to the Charity have been assessed, and in the opinion of the Corporate Trustee, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust also apply to the Charitable Funds, but it was agreed at the Charitable Funds Committee meeting in November 2020 that a separate section of the Trust's risk register should be created (using the Trust's existing risk assessment process and framework) to register risks that are relevant to the Charitable Fund; that an "Annual review of the risk register entries relevant to the Charitable Fund" item be scheduled for consideration at the Committee; and that the outcome of that review be included in the "Risk Management" section of this Annual Report

The third annual review of the three high-level risks that had been identified and assessed (which were informed by the Charity Commission's "NHS charities guidance" and "Managing your charity…" guidance; and the charitable fund risk registers at several other NHS Trusts) was duly considered at the Charitable Funds Committee's meeting in March 2023 The three high-level risks

were as follows:

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

The report considered by the Committee included details of the control measures in place to reduce these risks. The Committee was content with the risk register entries for the first two risks, but it asked that the third risk be amended to more explicitly focus on Business Continuity Incidents in general, rather than specifically the COVID-19 pandemic. The Committee also considered whether there were any omissions from the risk register and following a discussion it was agreed that a new risk register entry should be developed, for inclusion within the Trust's risk register, in relation to the risk of non-compliance with Charity Commission rules and regulations (and in particular in relation to the risks associated with over or under performance of the Trust's fundraising appeals). The Trust Secretary will discharge both actions during 2023/24.

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

Investment Powers

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

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

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.''

Investment strategy

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

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

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

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

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

Professional Advisors

Grant Thornton UK LLP is the Trust's appointed External Auditor and they act as the charitable fund's independent examiner. For the 2022/23 financial year, an independent examination was carried out as the charity's gross income falls below £1m.

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

Aims and Objectives for the Public Benefit

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

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

The purpose of the Charity is to raise vital funds to make Maidstone and Tunbridge Wells NHS Trust a truly outstanding, patient friendly provider for the patients and families cared for every year and to support the amazing staff who deliver exceptional care to those patients and their families. To achieve our purpose, we have four main strategic objectives:

- Promote understanding of and an increase in charitable giving;
- Supporting the Trust to always provide exceptional healthcare;
- Providing additional resources above and beyond what the NHS can currently provide; and
- Ensure the Trust continues to be a leader of scientific research and treatment advances.

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

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

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

the objects of the Charity.

Strategy for Achieving its Objectives

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

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

Reserves and Commitments

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

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

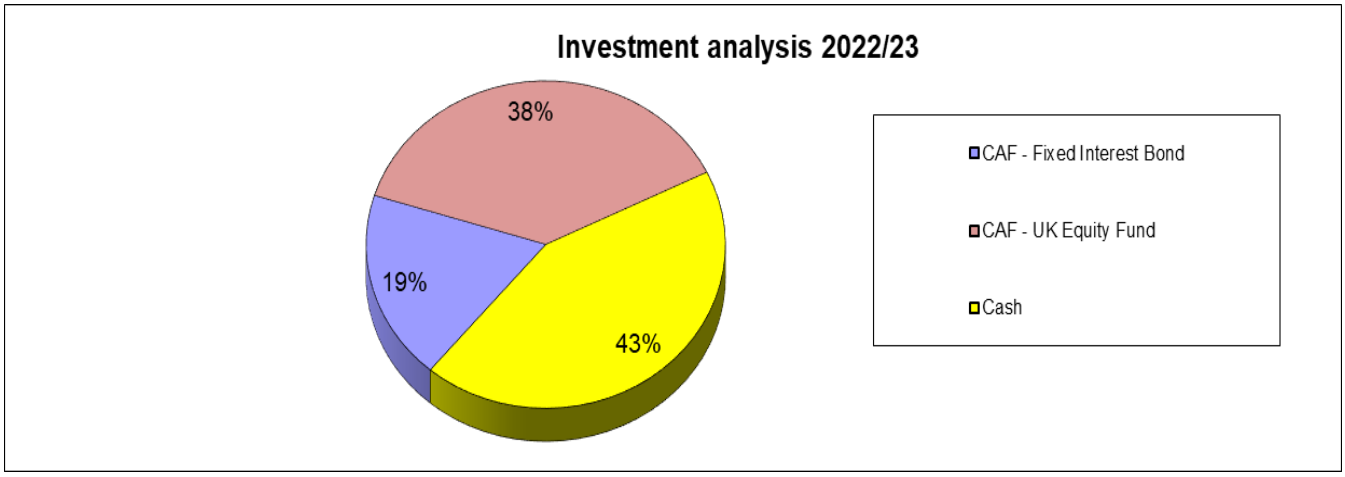
Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long-term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

Investment income for the year was £24k (in 2021/22, £24k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The value of investments was decreased as of 31 March 2023 compared to previous year. the total performance return on the portfolio of the investments (equity and bond) was a loss of £21k. This reflects a significant downturn in market performance compared with the previous year (profit of £7.4k). The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

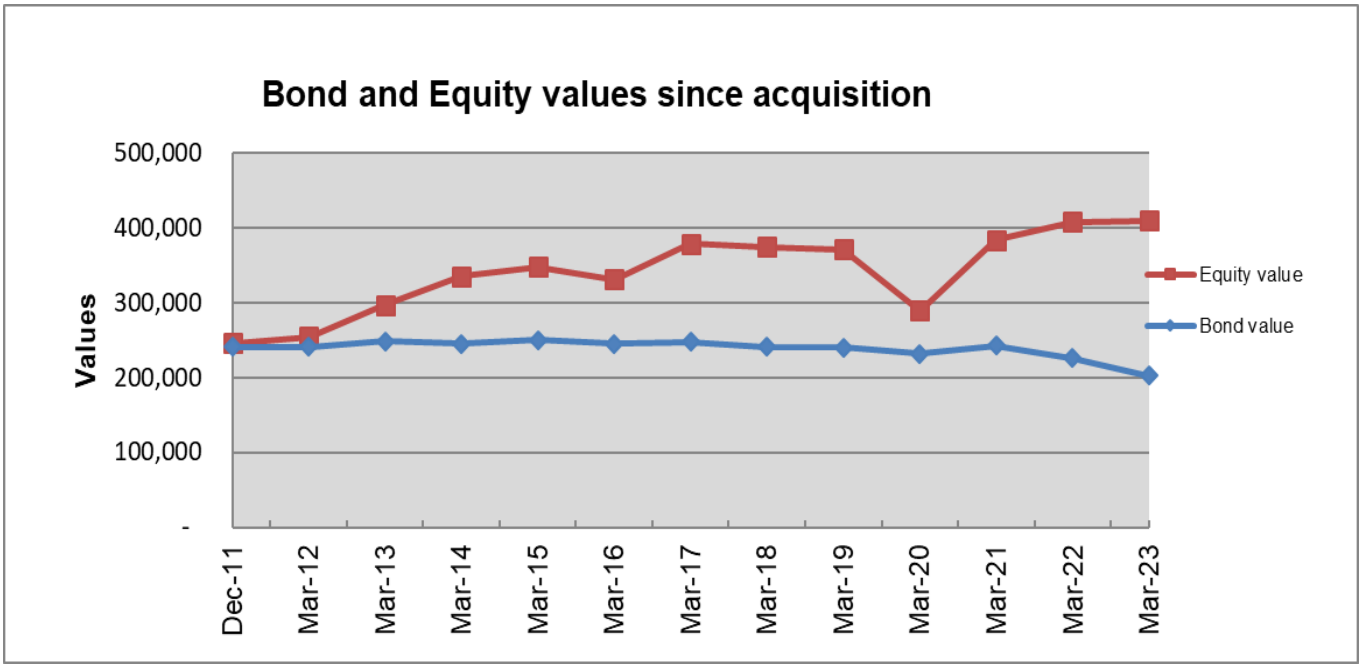
The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio decreasing in market value to £612k at 31 March 2023 (£633k at 31 March 2022). The cash investment at 31 March 2023 was £469k (£493k at 31 March 2022).

The current asset portfolio of cash and investment allocation totalling £1,081k at 31 March 2023 is shown in the following graph:



The cash allocation at 43% is currently lower than the strategy of Cash of 50%. The bonds investment of 19% is lower than the 25% bond strategy; and the equities investment is the most performing out them at 38% higher than the planned strategy of 25%. The bond investments have not performed well this year as well as last year. The massive impact of inflation all over the world is mainly due to the COVID-19 pandemic on the money markets, so the valuation has fallen, reducing their proportion of the total.

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

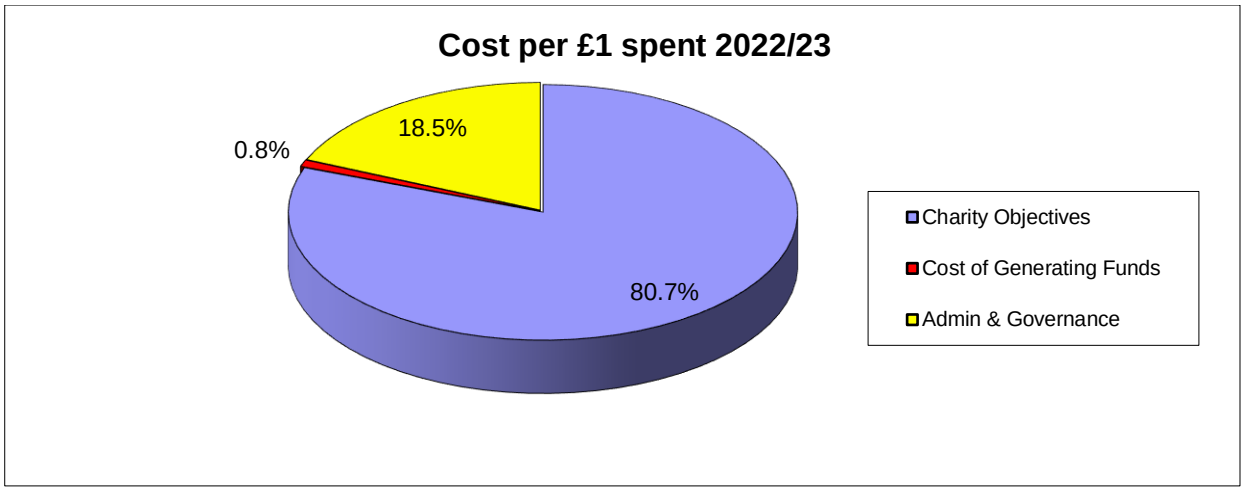


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

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

The graph below shows that in this financial year for every £1 of expenditure, 81 pence was spent in directly achieving the objectives of the charity. This has changed compared to equivalent ratio for 2021/22 (80 pence).



Charitable expenditure for the year is detailed below.

Expenditure

Total resources expended by the Charity within this financial year were £366k (in 2021/22, £213k), breakdown as follows:

Contribution to NHS:
- £199k Medical Equipment (in 2021/22, £89k)

Support and fundraising cost:
- £70k Support and fundraising costs (in 2021/22, £43k)

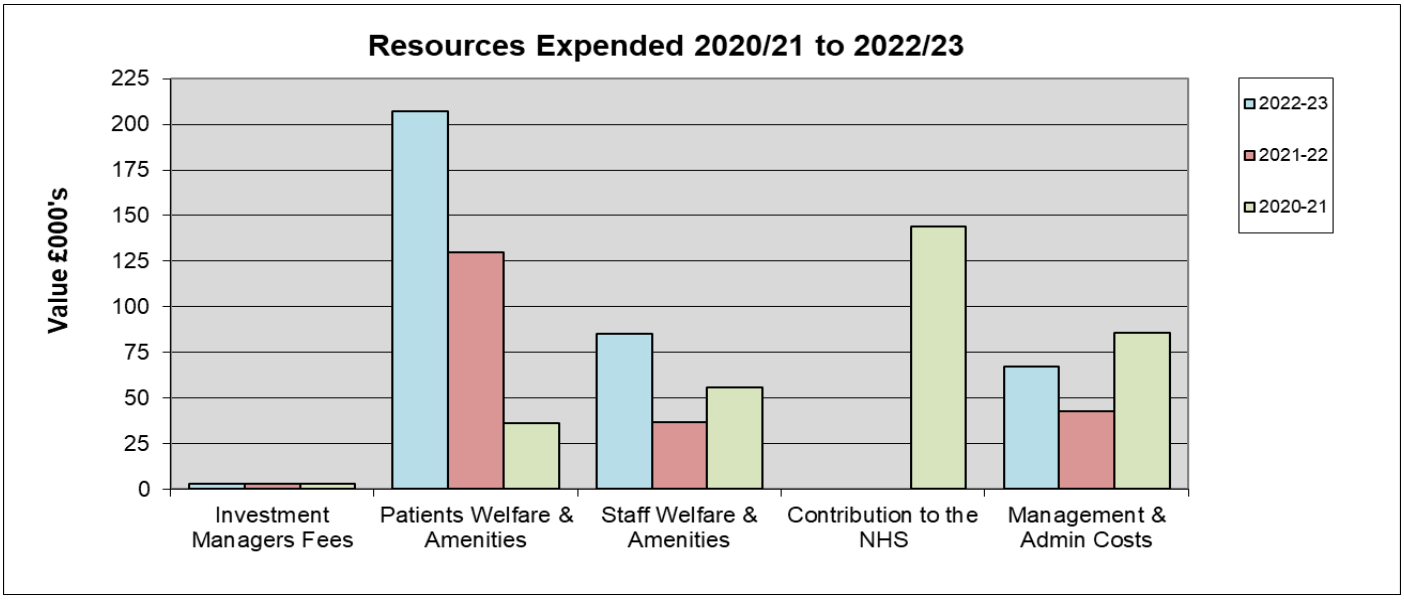
Staff Welfare:
- £85k Staff Welfare and amenities (in 2021/22, £40k)

Patients Welfare:
- £9k Patients welfare and amenities (in 2021/22, £23k)

Cost of Generating funds £3k (2021/22 £3k)

Included within the governance cost of £65k are the internal management fees for financially administering the funds and the costs of the Fundraiser Manager. The fees are agreed each year by the Trustees. These costs are charged proportionately across the unrestricted funds whose balance is greater than £1k on a quarterly basis.

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



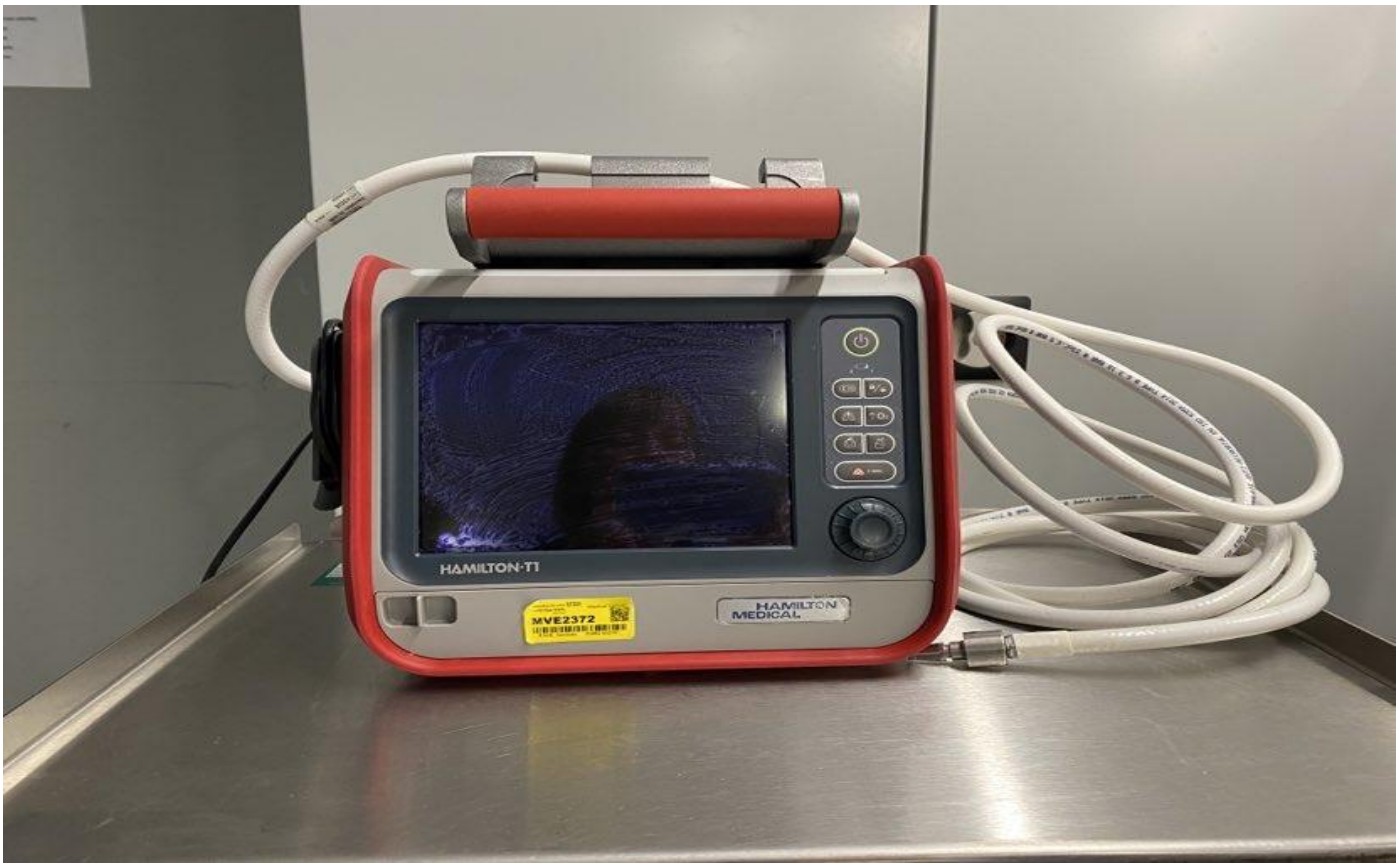
Medical Equipment – Total spend £199k (in 2021/22, £89k)

Medical equipment has been funded within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities. Of which the main items funded were: 10 cardiac output machines for theatres at TWH, 4 bladder scanners for Oncology at MGH, transfer ventilator for ITU at TWH, Echo Probes for Cardiology dept at TWH and for standing frame.

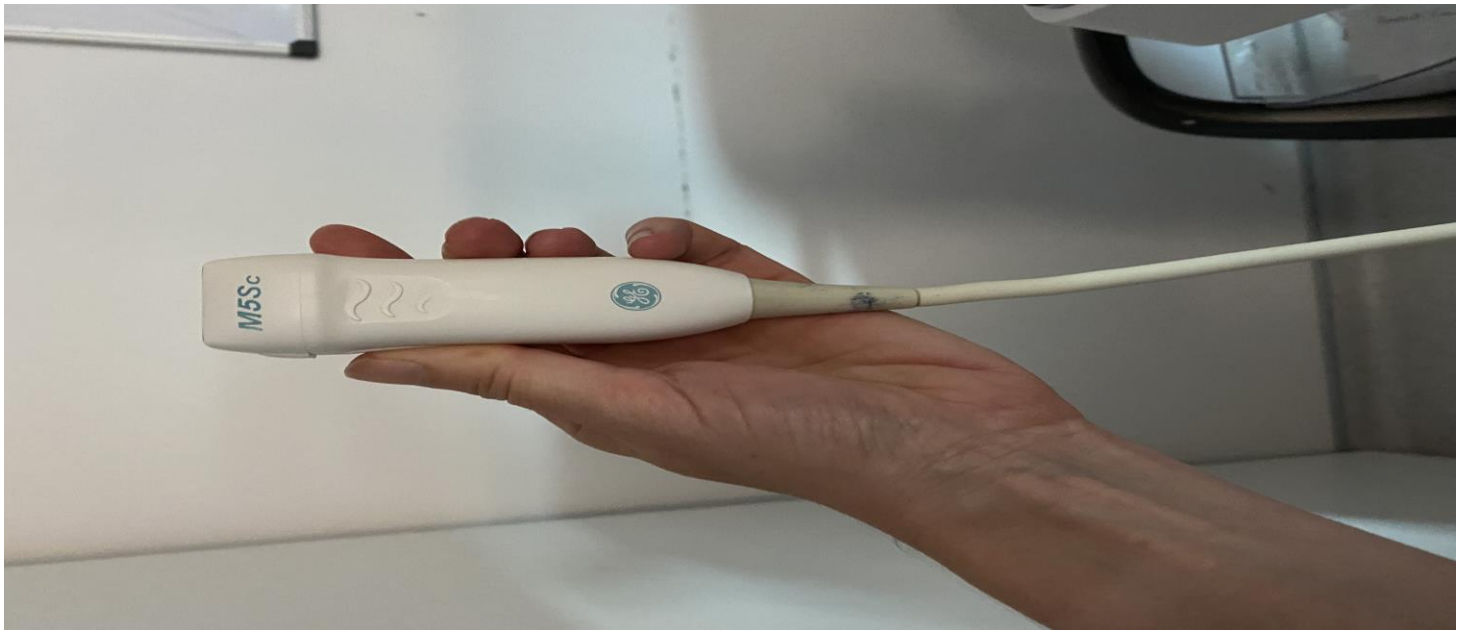
One of the cardiac output machines:

One out of four bladder scanner’s funded:

Transfer Ventilator:



Eco Probes:



Standing frame replacing quest 88 electric frame for stroke therapy

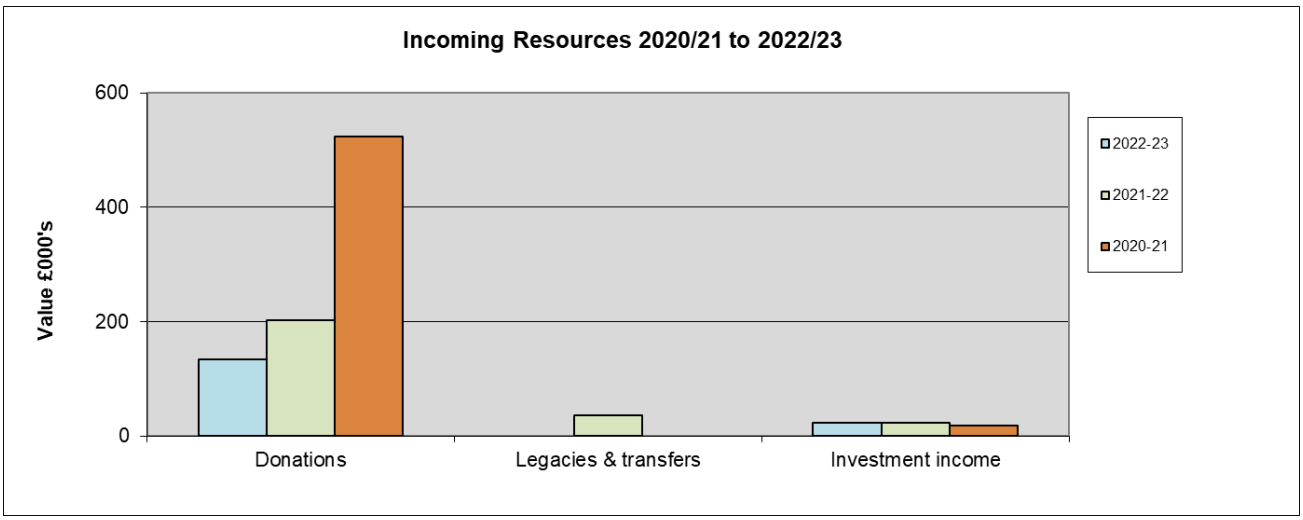
Staff Amenities and Welfare – Total spend £85k (in 2021/22, £40k)

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

Of the £85k; £29k related to various items - £79k Unrestricted funds and £6k Restricted funds, £38k for staff wellbeing, £11k on training and £7k for Christmas events.

Income

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



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

A total of £134k was received from donations (in 2021/22, £202k).

Legacies

The Trust has not received any legacies this year (£36.5k in 2021/22).

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

Online fundraising

The Charity's 'Just Giving' page received donations of £11k this year (£62k 2021/22).

Intangible Income

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

Looking Forward - our plans for the future

Over the next twelve months the Charity is looking to continue to increase our reach and scope across the whole of Maidstone and Tunbridge Wells NHS Trust. Working alongside all staff to raise awareness of the Charity through a Did You Know? campaign as well as establishing a regular giving scheme, to enable people to make a regular donation to the Charity.

In July, the NHS will celebrate its 75th birthday and a number of fundraising initiatives and community engagement activities are planned to commemorate this momentous occasion. Over the last 75 years, NHS Charities have been right alongside the NHS, providing vital extra support, helping staff, patient and communities and this will be recognised at several different events, to ensure we can continue to do this over the upcoming 75 years.

We will continue to work with all Wards and Departments, supporting them with their own fundraising initiatives, for example within the Special Care Baby Unit and our Oncology Centre. We will look to establish patient support groups, initially within Paediatric Gastroenterology and once proven will look to replicate this across the Hospital.

We will streamline the way in which wards and departments can apply for funding from charitable funds and we will put donor stewardship at the centre of all we do. We will ensure that we always have a consistent, open, honest and transparent approach to donations and fundraising activities.

We will also look to increase the presence of the Charity across the Hospitals with a customer facing hub that will make it easier for people to leave donations and pass on their gratitude for the care they have received at the Trust.

Making donations

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

Statement of Trustee responsibilities in respect of the Trustee Annual Report and the financial statements

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

In preparing these financial statements, generally accepted accounting practice requires that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the SORP FRS 102 have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the Trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepares the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity and the rules of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that where any statements of accounts are prepared by the trustee under section 132(1) of the Charites Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustee has general responsibility for taking such steps as are reasonably open to the trustee to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

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

Statement as to disclosure to our Independent Examiner

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

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

By Order of the Trustee

Signed:

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

Date: 30th November 2023

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

I report on the accounts of Maidstone and Tunbridge NHS Trust Charity (the "charity") for the year ended 31 March 2023.

Independent examiner's statement

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

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

  have not been met, or

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

Basis of independent examiner's statement

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

Respective responsibilities of corporate trustee and examiner

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

It is my responsibility to:

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

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

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

regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

John Paul Cuttle,

CPFA

Grant Thornton UK LLP
Chartered Accountants

London

Statement of Financial Activities for the year ended 31st March 2023

					2022/23	2021/22
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	£000	£000	**£000**	£000
Income	2					
Donations		78	56	0	**134**	165
Legacies		0	0	0	**0**	37
Total Donations and Legacies		**78**	**56**	**0**	**134**	202
Investment income		(1)	25	0	**24**	24
Total income		**77**	**81**	**0**	**158**	226
Expenditure	3					
Costs of generating funds	3.1	(3)	0	0	**(3)**	(3)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(244)	(120)	0	**(364)**	(210)
Total expenditure		**(247)**	**(120)**	**0**	**(367)**	(213)
Gains / (losses) on investments	4	(8)	(13)	0	**(21)**	7
Net income/expenditure		**(178)**	**(52)**	**0**	**(230)**	20
Fund transfer	4	0	0	0	**0**	0
Net movement in funds	4	**(178)**	**(52)**	**0**	**(230)**	20
Fund balances brought forward at 1st April 2022		485	611	8	**1104**	1084
Fund balances carried forward at 31st March 2023		**307**	**559**	**8**	**874**	1104

The notes at pages 22 to 36 form part of these financial statements.
Please note there may be some rounding's within the numbers

Balance Sheet as at 31st March 2023

					2022/23	2021/22
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	**£000**	**£000**	**£000**	£000
Fixed Assets	5					
Investments	5.1	217	395	0	**612**	634
Total Fixed Assets		**217**	**395**	**0**	**612**	634
Current Assets	6					
Cash at bank and in hand	6.1	163	298	8	**469**	493
Debtors due within one year	6.2	0	0	0	**0**	21
Total current Assets		**163**	**298**	**8**	**469**	514
Liabilities						
Creditors due within one year	7.1	(73)	(134)	0	(207)	(43)
Net Current Assets / (Liabilities)		**90**	**164**	**8**	**262**	470
Total Net Assets		**307**	**559**	**8**	**874**	1104
Funds of the Charity	8					
Endowment Funds		0	0	8	**8**	8
Restricted Funds		0	559	0	**559**	611
Unrestricted Funds		307	0	0	**307**	485
Total Funds		**307**	**559**	**8**	**874**	1104

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

The charitable funds financial statements were approved by the Trust Board on the 30th November 2023 and signed on its behalf as Trustee by:

David Highton,
Date: 30th November 2023
Chair of the Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows at 31st March 2023

	Note	2022/23 £000's	2021/22 £000's
Cash flows from Operating activities:			
Net Income /(Expenditure) for the reporting period	4	(230)	20
Adjustments for:			
(Gains)/losses on investments	4	22	(7)
Dividends, interest and rents from investments	2	(25)	(24)
(increase)/Decrease in debtors	6.2	21	(21)
Increase/(decrease) in creditors	7.1	164	(364)
Net Cash provided by (used in) operating activities		**(48)**	**(396)**
Cash flows from investing activities:			
Dividends, interest and rents from investments		24	24
Net Cash provided by (used in) investing activities		**24**	**24**
Cash flows from financing activities		0	0
Change in cash and cash equivalents in the reporting period		(24)	(372)
Cash and cash equivalents at the beginning of the reporting period		493	864
Cash and Cash equivalents at the end of the reporting period	6.1	469	493
Cash in hand		**469**	**493**

1. Principal accounting policies

1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective October 2019 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

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

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts. The charity ended the year with £874k in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

1.2. Reconciliation with previous generally accepted accounting practices

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

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

1.3. Income

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

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

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

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

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

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

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

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

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

1.4. Expenditure

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

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

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

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

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

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

Exceptional Items
Exceptional Items are shown on the face of the Statement of Financial Activities under the category to which they relate with further detail, where appropriate, provided in the notes. For the financial year 2022/23 there were no Exceptional Items.

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

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

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

1.5. Structure of funds

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

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

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

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

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

1.6. Finance and Operating Leases

The Charity has no finance or operating leases.

1.7. Fixed Assets

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 9 for further information.

1.8. Gains and losses

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

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

1.9. Cash and Cash equivalents

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

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

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

1.10. Financial Instruments

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

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

1.11. Pensions

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

1.12. Prior Year Adjustments

The Charitable Fund has not made any prior year adjustments Due to the following tables being reported in thousands there may be some rounding differences but the overall totals are correct

2. Income

				2022/23	2021/22
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Donations	43	56	0	**99**	103
Donations – website	35	0	0	**35**	62
Legacies	0	0	0	**0**	37
Total Donations and Legacies	**78**	**56**	**0**	**134**	**202**
Investment income					
Dividends from investment portfolio	(1)	11	0	**10**	21
Interest from investment portfolio	0	8	0	**8**	3
Bank Interest	0	6	0	**6**	0
Total Investment income	**(1)**	**25**	**0**	**24**	**24**
Total incoming resources	**77**	**80**	**0**	**158**	**226**

3. Expenditure

3.1. Cost of generating funds				**2022/23**	2021/22
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Investment managers fees	(3)	0	0	**(3)**	(3)

				2022/23	2021/22
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	0	0	0	0	0
Other	(7)	(2)	0	(9)	(23)
Complementary Therapies	0	0	0	0	(0)
Total patients welfare and amenities	**(7)**	**(2)**	**0**	**(9)**	**(23)**
Staff welfare and amenities					
Training	(10)	(1)	0	(11)	(3)
Wellbeing	(33)	(5)	0	(38)	(2)
Christmas Events	(6)	(1)	0	(7)	(4)
Other	(29)	0	0	(29)	(31)
Total staff welfare and amenities	**(78)**	**(7)**	**0**	**(85)**	**(40)**
Medical and Rehabilitation Equipment	(127)	(72)	0	(199)	(89)
Furniture and Fittings	0	0	0	0	(15)
Governance - Salaries & overheads	(28)	(37)	0	(65)	(41)
Governance - Audit Fees (external)	(3)	(2)	0	(5)	(2)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(158)**	**(111)**	**0**	**(269)**	**(147)**
Total cost of charitable activities	**(243)**	**(120)**	**0**	**(363)**	**(210)**
Total resources expended	**(246)**	**(120)**	**0**	**(366)**	**(213)**

Employee Information

The Charity does not employ any staff directly, although members of the finance team support the governance and administration function of the Charity and a full time Fundraiser is employed by the Trust and recharged in full to the Charity. Their costs have been included in the table above.

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

4. Net Movements in Funds

				2022/23	2021/22
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	(169)	(39)	0	**(208)**	13
Gains/Losses on Investments	(9)	(13)	0	**(22)**	7
Total net movement in funds	**(178)**	**(52)**	**0**	**(230)**	20
Funds transfers	0	0	0	**0**	0
Total net movement in funds after transfers	**(178)**	**(52)**	**0**	**(230)**	20
Fund balances at 1st April 2022	485	611	8	**1104**	1084
Fund balances carried forward at 31st March 2023	**307**	**559**	**8**	**874**	1,104

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/2022	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	**Carrying value at 31/03/2023**
	£000	£000	£000	£000	£000
CAF Bond Income Fund (UK)	226	0	0	(21)	205
CAF Equity Growth Fund (UK)	408	0	0	(1)	407
Total Fixed Asset Investments	634	0	0	(22)	612

6. Current Assets

6.1. Cash and cash investments	**2022/23**	2021/22
	Total Funds	Total Funds
	£000	£000
Cash Investments:		
Santander	**83**	83
Clydesdale	**91**	87
Operational Bank Accounts:		
Government Banking Service (GBS) bank account	**274**	304
Nat West bank account	**21**	20
Total Cash and Cash Investments	**469**	**493**

6.2. Debtors	**2022/23**	**2021/22**
	Total Funds	**Total Funds**
	£000	**£000**
Amounts falling due within one year	0	21
Total Debtors due within one year	**0**	**21**

7. Current Liabilities

7.1. Creditors	**2022/23**	2021/22
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year:		
Trade Creditors	**(8)**	(0)
Other Creditors	**(0)**	(0)
Intercompany creditor between the charity and the Trust exchequer account	**(191)**	(41)
Accruals	**(8)**	(2)
Total Creditors due within one year	**(207)**	**(43)**

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2022	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2023
			£000	**£000**	**£000**	**£000**	**£000**
A. Haines – Capital in perpetuity	67020	Endowment	7	0	0	0	7
E.C. Beedle Fund - Capital in perpetuity	67010	Endowment	1	0	0	0	1
Total Endowment Funds			**8**	**0**	**0**	**0**	**8**

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

Description	Fund number	Fund Type	Balance 01-Apr-2022	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2023**
			£000	£000	£000	£000	**£000**
Cardiac Equip Fd Ms Crow Legacy	65450	Restricted	19	1	(1)	0	**19**
Cardio Equip TW Hayling Legacy	65460	Restricted	53	2	(28)	(1)	**26**
E&M Dir Diabetes Fund Tw	65410	Restricted	48	2	(6)	(1)	**43**
Oncology Centrifuge Fund	61490	Restricted	21	1	(1)	(1)	**20**
Oncology Equipment Fund	67170	Restricted	25	1	(26)	0	**0**
Oncology Prostate Equip Fund P Ward Legacy	61310	Restricted	13	0	(13)	0	**0**
Pierre Fabre Grant Fund	61720	Restricted	48	2	(4)	(1)	**45**
E&M Directorate - Frances Gibson Legacy	65180	Restricted	21	1	(1)	(1)	**20**
Maskell Equipment Legacy Fund	69702	Restricted	86	4	(15)	(2)	**73**
COVID-19 Trust Fund	69900	Restricted	243	11	(20)	(6)	**228**
Staff Hardship Fund	61030	Restricted		25	(5)		**20**
Fundraiser Non Pay items	61130	Restricted		30	9		**39**
Other Restricted Funds (closing balances <£10,000)		Restricted	34	1	(8)		**27**
Total Restricted Funds			**611**	**81**	**(119)**	**(13)**	**559**

Description	Fund number	Fund Type	Balance 01-Apr-2022	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2023**
			£000	**£000**	**£000**	**£000**	**£000**
General Fund	61000	Unrestricted	181	4	(93)	(2)	**90**
Emergency & Medical Directorate	61020	Unrestricted	14	9	(3)	(1)	**19**
Critical care Dir Fund	61060	Unrestricted	47	3	(43)	(1)	**6**
Surgery Directorate Fund	61140	Unrestricted	46	3	(22)	(1)	**26**
Womens Directorate Fund	61320	Unrestricted	11	1	(1)	0	**11**
Cancer Services Fund	61350	Unrestricted	64	35	(47)	(2)	**50**
Sutcliffe Fund	61370	Unrestricted	23	1	(2)	(1)	**21**
Paediatric Dir Fund	61540	Unrestricted	21	2	(5)	0	**18**
Cardiac Fund	65400	Unrestricted	17	1	(1)	0	**17**
Special Care Baby Unit Fund	65660	Unrestricted	10	14	(2)	(1)	**21**
Equality + Diversity Fund	68900	Unrestricted	34	1	(25)	0	**10**
Other Unrestricted Funds (closing balances <£10,000)		Unrestricted	17	4	(2)	(1)	**18**
Total Unrestricted Funds			**485**	**78**	**(246)**	**(10)**	**307**

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

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

9. Charity Tax

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

10. Related Parties

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

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

The Charity has made revenue and capital payments, in the form of grants, to Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition, £191k (in 2021/22, £43k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration and fundraising activities of the Charity. Total amount owed by the charity to the Trust for 2022/23 £191k (in 2021/22, £43k).

11. Events after the reporting year

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

Appendix 3

Maidstone and Tunbridge Wells NHS Trust

Our Ref: SO/jr

Steve Orpin
Deputy Chief Executive/Chief Finance Officer
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

Tel: 01622 229002
Email: stephen.orpin@nhs.net

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

23rd June 2023

Dear Grant Thornton UK LLP

Maidstone and Tunbridge Wells NHS Trust Financial Statements for the year ended 31 March 2023

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust for the year ended 31 March 2023 for the purpose of expressing an opinion as to whether the Trust financial statements give a true and fair view in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2022/23 and applicable law.

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

Financial Statements

i. We have fulfilled our responsibilities for the preparation of the Trust's financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2022/23 ("the GAM"); in particular the financial statements are fairly presented in accordance therewith.

ii. We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii. The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

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

v. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include the valuation of land and buildings. We are satisfied that the material judgements used in the preparation of the financial

statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative, methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

vi. In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a. there are no unrecorded liabilities, actual or contingent

b. none of the assets of the Trust has been assigned, pledged or mortgaged

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have only accrued for items received before the year-end.

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

xiii. We have considered the unadjusted misstatements schedule included in your Audit Findings Report. We have not adjusted the financial statements for these misstatements brought to our

attention as they are immaterial to the results of the Trust and its financial position at the year-end. The financial statements are free of material misstatements, including omissions.

xiv. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

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

xvi. We have updated our going concern assessment. We continue to believe that the Trust's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

a. the nature of the Trust means that, notwithstanding any intention to cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements

b. the financial reporting framework permits the entry to prepare its financial statements on the basis of the presumption set out under a) above; and

c. the Trust's system of internal control has not identified any events or conditions relevant to going concern.

We believe that no further disclosures relating to the Trust's ability to continue as a going concern need to be made in the financial statements.

xvii. We have reviewed the remainder of leases for the findings in relation to IFRS16 and are satisfied that the adjustments made to the accounts are representative of all leases held by the Trust.

Information Provided

xviii. We have provided you with:

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

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

c. access to persons within the Trust via remote arrangements, where/if necessary, from whom you determined it necessary to obtain audit evidence.

xix. We have communicated to you all deficiencies in internal control of which management is aware.

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

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

xxii. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:

a. management;

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

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

xxiii. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

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

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

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

Annual Governance Statement

xxvii. We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Annual Report

xxviii. The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the Trust's financial statements.

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Governance Committee at its meeting on 22 June 2023.

Yours faithfully

Steve Orpin
Deputy Chief Executive/
Chief Finance Officer

Appendix 4

CHARITABLE FUNDS COMMITTEE MEETING – NOVEMBER 2023

NHS Maidstone and Tunbridge Wells NHS Trust

FUNDRAISING UPDATE (INCL. AN UPDATE FROM THE CHARITY MANAGEMENT COMMITTEE AND THE CARDIOLOGY CAPITAL CAMPAIGN COMMITTEE)	**HEAD OF CHARITY AND FUNDRAISING; AND DIRECTOR OF EMERGENCY PLANNING AND RESPONSE**

The attached report provides an update on the activities of the Fundraising Department.

A verbal update will be provided at the Committee meeting on the work of the Charity Management Committee and Cardiology Capital Campaign Committee.

Reason for submission to the Charitable Funds Committee (decision, discussion, information, assurance etc.)
For information and discussion

A review of my first year as Head of Charity and Fundraising for MTW Hospitals Charity

Claire Ashby – October 2023

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

What have we achieved?

- Approved Fundraising Strategy – January 2023
- Rebrand of MTW Hospitals Charity completed – April 2023
- Charity is now active member of Patient Experience Group and Business Case Review Panel
- Charity support is recognised by several Departments and is working closely with wards to increase fundraising and support – for example Paediatrics and Stroke Services
- Improved relationships with both Maidstone Hospital League of Friends and Tunbridge Wells Hospital League of Friends, Charity is now seen as a true partner and works with both League of Friends to establish support for wards and departments

Support from our local corporate organisations

£1,000 donation to our Staff Hardship Fund from Nisa Today

Morrisons

Regular donations of prizes for quiz nights, support groups and opportunities to fundraise in s[illegible]

BARRATT HOMES

DAVID WILSON HOMES
WHERE QUALITY LIVES

£2,000 donation to Maidstone Hospital, with further donations expected in the coming months

Thames Motor Group

Weekly grocery deliveries for Staff Food pantry at Tunbridge Wells Hospital

south east water

£5,000 donation to the Trust to support our work following water problems in December 22

Support from local voluntary organisations

Rotary Club of Kings Hill Kent

Donation to purchase interactive wall panels for Children's ED at Tunbridge Wells Hospital

KENT COMMUNITY FOUNDATION

£1,000 donation to HODU at Tunbridge Wells Hospital

LIONS 50 1970 - 2020 GILLINGHAM

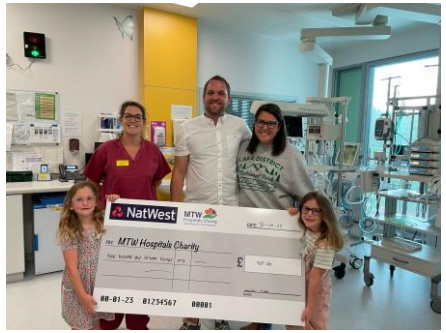
£2,000 donation for Oncology Centre

LIONS INTERNATIONAL

£5,000 from Malling Lions to fund bladder scanners

Supporting East Kent Freemasons with fundraising for new trolley for Paediatrics ED at Maidstone Hospital circa £10,000

Support from our local community



Mayor’s Charity of the Year

MTW Hospitals Charity has been named one of two charities for this year by Mayor of Tunbridge Wells, Hugh Patterson. This will give the charity a new presence in Tunbridge Wells and will be capitalised on in the following ways:

- Attendance at Mayoral events – clay pigeon shoot, civic dinner & dance, quiz nights
- Charity collections at Tunbridge Wells Pantomime during December
- Attendance at MTW events such as staff party and handing out Long Service awards
- Joint fundraising events with the Mayor’s office, for example It’s a Knockout
- Information giving events and awareness raising events with the Mayor at local Tunbridge Wells Council events

NHS 75th Birthday Celebrations

#75for75 campaign raised an incredible £3,727 from 7 fundraising pages

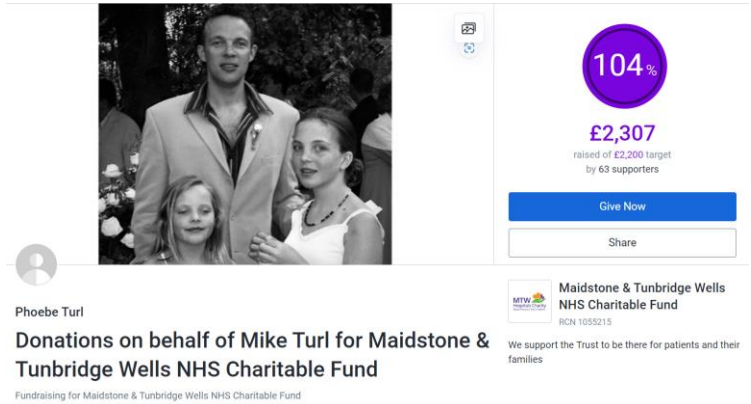
Supported the Trust on NHS75 publicity and civic receptions

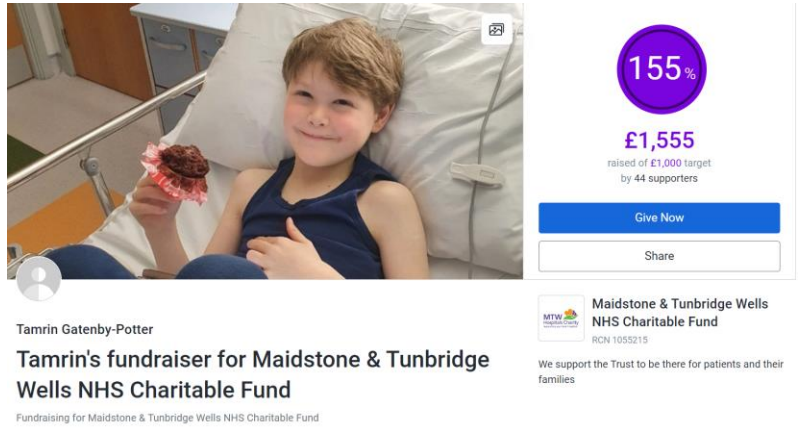
Worked with local primary and secondary schools to develop birthday cards and carried out assemblies on 75 years of the NHS. 15 assemblies were delivered in the month of June and July

Charity on tour at Pub in the Park Tunbridge Wells – raised over £200 and spoke to thousands of people over three days

Just Giving 2022 / 2023

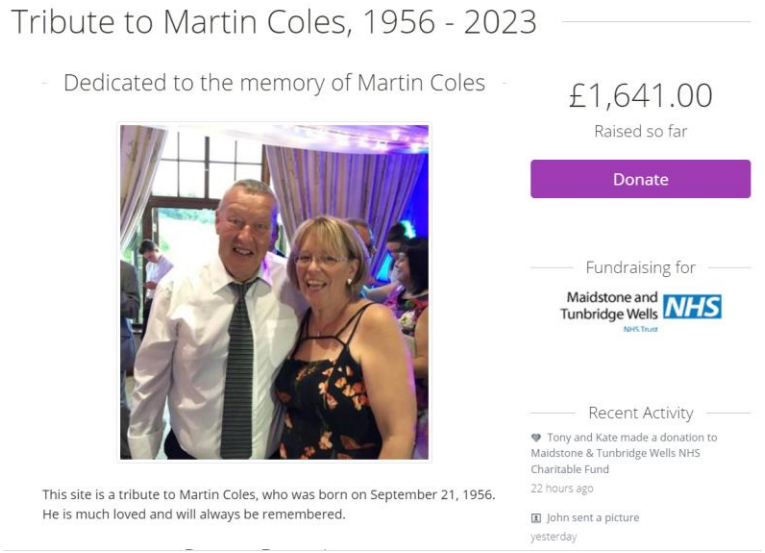
- Just Giving remains our biggest source of income into the Charity, raising £43,035 in the last twelve months.
- 23 Fundraising pages were created raising just under £20,000, remaining came from one off donations.





Much Loved 2022 / 2023

- Online In Memory portal to remember loved ones and make donations to the charity
- 14 Tributes created in the last 12 months, raising just over £6,000



Income October 22 – September 23

Month	Income		Month	Income
October 22	£9,770.11		April 23	£13,803.47
November 22	£11,966.89		May 23	£7,321.65
December 22	£9,905.27		June 23	£5,293.01
January 23	£37,582.13		July 23	£13,683.59
February 23	£5,165.49		August 23	£20,107.63
March 23	£46,004.68		September 23	£8,163.13
TOTAL INCOME - £188,767.05				
January and August include Investment Income Figures				

What have we funded?

Anne Robson Trust

Training for SWAN end of life volunteers

Recliner chairs for Special Care Baby Unit to help with kangaroo care

Wall vinyls for ITU Department with more to follow for ED at both hospitals

A LIFE IN A DAY

Immersive training for nursing staff to become the patient and experience the challenges, choices and impact that real patients face every day.

MTW | Staff Health and Wellbeing

Financial support to the MTW Staff Hardship Fund supporting staff who need extra help with a food pantry and supermarket vouchers

Windrush day celebrations for all staff with a steel band and Caribbean catering alongside speeches and a thought-provoking documentary

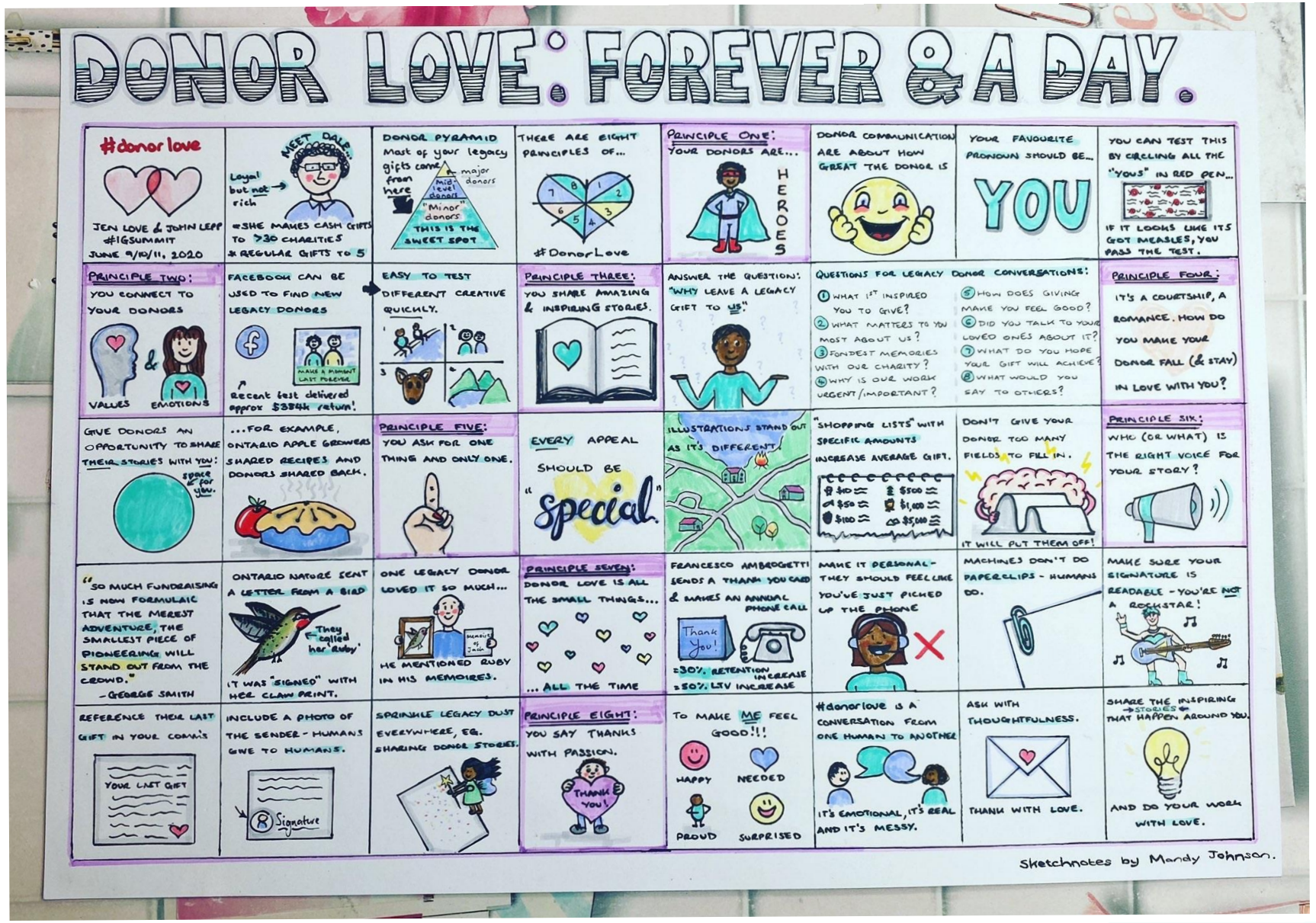
Strategy & Plans 2023

Although so much has been achieved in the last twelve months there is still so much more to be done, including:

- Rebranding and updating the Charity website
- Improving communications internally and externally
- Develop a Charity Newsletter
- Implement a CRM system
- Rewrite policy and procedure for charitable funds
- Improve the internal grant application process and give the charity more visibility of approved funding
- Become more strategic and proactive to funding opportunities

Next Steps

- Celebrate the successes of the last year
- Look forward to the next 12 months
- Grow the charity team
- Grow the charity standing within Maidstone and Tunbridge Wells NHS Trust
- Host our first in-person fundraising events in 2024
- Put our donors at the centre of everything we do and make them the reason why we able to make a difference


DONOR LOVE. FOREVER & A DAY.
#donor love
JEN LOVE & JOHN LEPP
#IGSUMMIT
JUNE 9/10/11, 2020
MEET DALE...
Loyal but not rich
=SHE MAKES CASH GIFTS TO >30 CHARITIES
& REGULAR GIFTS TO 5
DONOR PYRAMID
Most of your legacy gifts come from here
major donors
Mid-level donors
"Minor" donors
THIS IS THE SWEET SPOT
THERE ARE EIGHT PRINCIPLES OF...
#DonorLove
PRINCIPLE ONE:
YOUR DONORS ARE...
HEROES
DONOR COMMUNICATION ARE ABOUT HOW GREAT THE DONOR IS
YOUR FAVOURITE PRONOUN SHOULD BE...
YOU
YOU CAN TEST THIS BY CIRCLING ALL THE "YOUS" IN RED PEN...
IF IT LOOKS LIKE ITS GOT MEASLES, YOU PASS THE TEST.
PRINCIPLE TWO:
YOU CONNECT TO YOUR DONORS
VALUES
&
EMOTIONS
FACEBOOK CAN BE USED TO FIND NEW LEGACY DONORS
MAKE A MOMENT LAST FOREVER
Recent test delivered approx $38k return!
EASY TO TEST DIFFERENT CREATIVE QUICKLY.
PRINCIPLE THREE:
YOU SHARE AMAZING & INSPIRING STORIES.
ANSWER THE QUESTION:
"WHY LEAVE A LEGACY GIFT TO US"
QUESTIONS FOR LEGACY DONOR CONVERSATIONS:
1 WHAT IS IT INSPIRED YOU TO GIVE?
2 WHAT MATTERS TO YOU MOST ABOUT US?
3 FONDEST MEMORIES WITH OUR CHARITY?
4 WHY IS OUR WORK URGENT/IMPORTANT?
5 HOW DOES GIVING MAKE YOU FEEL GOOD?
6 DID YOU TALK TO YOUR LOVED ONES ABOUT IT?
7 WHAT DO YOU HOPE YOUR GIFT WILL ACHIEVE?
8 WHAT WOULD YOU SAY TO OTHERS?
PRINCIPLE FOUR:
IT'S A COURTSHIP, A ROMANCE. HOW DO YOU MAKE YOUR DONOR FALL (& STAY) IN LOVE WITH YOU?
GIVE DONORS AN OPPORTUNITY TO SHARE THEIR STORIES WITH YOU:
space for you.
...FOR EXAMPLE, ONTARIO APPLE GROWERS SHARED RECIPES AND DONORS SHARED BACK.
PRINCIPLE FIVE:
YOU ASK FOR ONE THING AND ONLY ONE.
EVERY APPEAL SHOULD BE "special"
ILLUSTRATIONS STAND OUT AS IT'S DIFFERENT
"SHOPPING LISTS" WITH SPECIFIC AMOUNTS INCREASE AVERAGE GIFT.
$10
$50
$100
$500
$1,000
$5,000
DON'T GIVE YOUR DONOR TOO MANY FIELDS TO FILL IN.
IT WILL PUT THEM OFF!
PRINCIPLE SIX:
WHO (OR WHAT) IS THE RIGHT VOICE FOR YOUR STORY?
"SO MUCH FUNDRAISING IS NOW FORMULAIC THAT THE MEREST ADVENTURE, THE SMALLEST PIECE OF PIONEERING WILL STAND OUT FROM THE CROWD."
-GEORGE SMITH
ONTARIO NATURE SENT A LETTER FROM A BIRD
They called her Ruby
IT WAS "SIGNED" WITH HER CLAW PRINT.
ONE LEGACY DONOR LOVED IT SO MUCH...
HE MENTIONED RUBY IN HIS MEMOIRES.
PRINCIPLE SEVEN:
DONOR LOVE IS ALL THE SMALL THINGS...
... ALL THE TIME
FRANCESCO AMBROGETTI SENDS A THANK YOU CARD & MAKES AN ANNUAL PHONE CALL
Thank You!
=30% RETENTION INCREASE
=50% LTV INCREASE
MAKE IT PERSONAL - THEY SHOULD FEEL LIKE YOU'VE JUST PICKED UP THE PHONE
MACHINES DON'T DO PAPERCLIPS - HUMANS DO.
MAKE SURE YOUR SIGNATURE IS READABLE - YOU'RE NOT A ROCKSTAR!
REFERENCE THEIR LAST GIFT IN YOUR COMMS
YOUR LAST GIFT
INCLUDE A PHOTO OF THE SENDER - HUMANS GIVE TO HUMANS.
Signature
SPRINKLE LEGACY DUST EVERYWHERE, EG. SHARING DONOR STORIES.
PRINCIPLE EIGHT:
YOU SAY THANKS WITH PASSION.
THANK YOU!
TO MAKE ME FEEL GOOD!!!
HAPPY
NEEDED
PROUD
SURPRISED
#donorlove IS A CONVERSATION FROM ONE HUMAN TO ANOTHER
IT'S EMOTIONAL, IT'S REAL AND IT'S MESSY.
ASK WITH THOUGHTFULNESS.
THANK WITH LOVE.
SHARE THE INSPIRING →STORIES← THAT HAPPEN AROUND YOU.
AND DO YOUR WORK WITH LOVE.
Sketchnotes by Mandy Johnson.

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for October 2023	Chief Executive / Executive Directors

The IPR for month 7, 2023/24, is enclosed, along with the monthly finance report and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 28/11/23

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

October 2023

MTW
exceptional people, outstanding care

Contents

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.

Maidstone and Tunbridge Wells NHS Trust

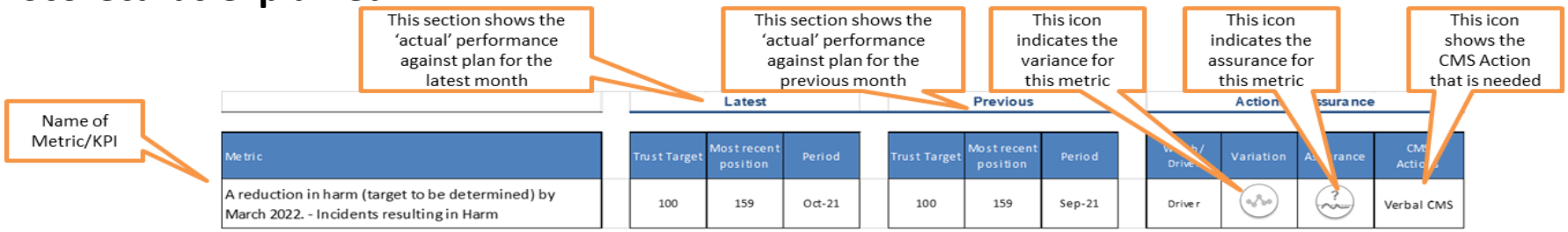
Escalation Rules:

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



Further Reading / other resources

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

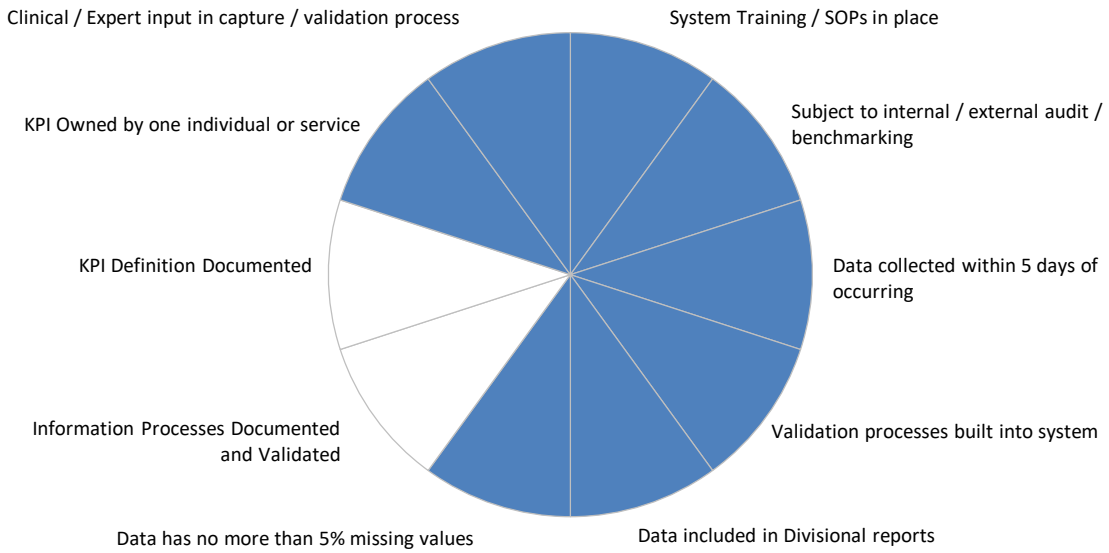
MTW exceptional people, outstanding care

Forecasts

	CQC Domain	Metric	DQ Kite Mark	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions	Forecast: 3 Month Forecast	Forecast: Variation	Forecast: Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		12%	8.5%	Sep-23	12%	8.6%	Aug-23	Driver			Note Performance	8.1%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.8%	Sep-23	12%	12.7%	Aug-23	Driver			Full CMS	12.7%		

A three month forward view forecast has been included in the IPR for the Vision and Breakthrough metrics. Variation and Assurance icons being generated for the forecasted position to give an indicative view of performance at that point. There are varying approaches being used to generate these forecasts. Some are statistical and others based on detailed plans and / or upcoming known events. These are signed off by Exec. SROs.

Data Quality Kite Marks



A Kite Mark has been assigned to each metric in the report. This has been created by assessing the source system against relevant criteria as well as the documentation and oversight associated with each metric.

A point has been assigned for each of the criteria met. The maximum score is ten. There are ten segments in the Kite Mark image and the corresponding segments are shaded blue based on those that have been met.

The ordering of the criteria has been kept consistent so users can see which criteria are met/unmet. So in the example shown, the 'KPI documentation' and 'Information Process documentation' are unmet.

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary: The Trust introduced a new stretch target of 8% for Vacancy Rate from this month. October was slightly above this target at 8.4% but this is still an improving position. Turnover Rate continues to experience common cause variation and consistently failing the target. Agency spend did not achieve the target for October 23 but is now experiencing special cause variation of an improving nature and variable achievement of the target. The Nursing Safe Staffing Levels has increased significantly in October, exceeding the target at 98.7% (the second highest level in the last two years). It is now in special cause variation of an improving nature and variable achievement of the target. Sickness levels continue to experience special cause variation of an improving nature and have achieved the target for more than six consecutive months. Statutory and Mandatory Training remains in common cause variation and variable achievement of the target for more than six months. The percentage of staff Afc 8a or above that are BAME is consistently failing the target but is in special cause variation of an improving nature. The Trust was £0.9m in surplus in the month which was £0.1m adverse to plan. Year to Date the Trust is £2m in deficit which is £1.8m adverse to plan.

The rate of incidents causing patients moderate or higher remains in common cause variation and variable achievement of the target. The breakthrough indicator for this strategic theme is currently being reviewed and therefore no data is shown this month until this has been confirmed. The rate of C.Difficile has failed the target for six months and the rate of E.Coli is escalated due to being in Hit or Miss for more than six months. Complaints response times have failed the target for more than 6 months and therefore remain escalated. Friends and Family Response rates remain challenging.

Diagnostic Waiting Times achieved the recovery trajectory target set for October 23 at 97.4% (+8.9%). It continues to experience common cause variation and has achieved the recovery trajectory target for more than six consecutive months. RTT performance improved in October but remains below the recovery trajectory, now experiencing special cause variation of a concerning nature and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters but have reported one month end breach in October 23. Performance for First outpatient activity levels achieved above plan for October and is now experiencing common cause variation and passing the target for six consecutive months. Outpatient Utilisation and Calls answered within 1 minute continue to experience special cause variation of an improving nature but remain consistently failing the target. Diagnostic Imaging activity levels remain below plan for September 2023, but remain above 1920 levels. Elective (inpatient and day case combined) activity was above plan for October 2023 and remains above plan year to date. This metric is now experiencing common cause variation and variable achievement of the target.

The number of patients leaving our hospitals before noon continues to experience common cause variation and consistently failing the target. A&E 4hr performance was below trajectory for October 23 at 84.3% and has now failed the submitted target for six consecutive months. The Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers remain in special cause variation of an improving nature and variable achievement. The Trust continues to achieve the Cancer Waiting Times (CWT) 62 Day and 2 Week Wait (2WW) standard and has achieved the 31 day first Definitive Treatment Standard in September. The CWT 28 day faster diagnosis compliance standard is experiencing special cause variation of a concerning nature and variable achievement of the standard. CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh, in January 2024. Initial results, following validation, suggest that the 31 day standard may achieve the target for July and August 23 and the CWT 28 day Faster Diagnosis compliance standard is likely to improve once the finalised positions are submitted in January 24.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.9)
- % of Afc 8c and above that are BAME (P.10)
- Statutory and Mandatory Training (P.10)*

Patient Safety & Clinical Effectiveness:
- Infection Control – Rate of C.Diff and E.Coli (P.12)*
- Safe Staffing (P.12)*

Patient Access:
- RTT Performance (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- A&E 4 hr Performance (P.16)
- Emergency Admissions in Assessment Areas (P.16)
- Planned levels of Diagnostics activity (P.16)

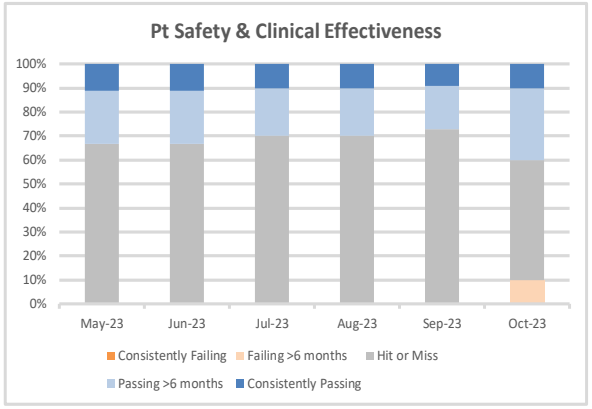
Patient Experience:
- New Complaints Received (P.18)*
- Complaints responded within target (P.19)
- FFT Response Rates: A&E, Outpatients, Maternity (P.19)

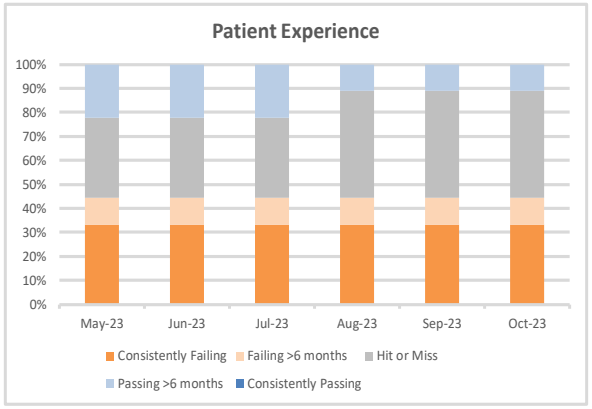
Systems:
- Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays) (P.21)
- Discharges before Noon (P.22)

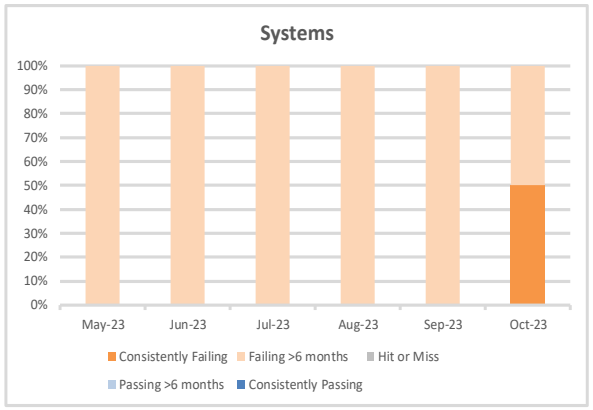
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

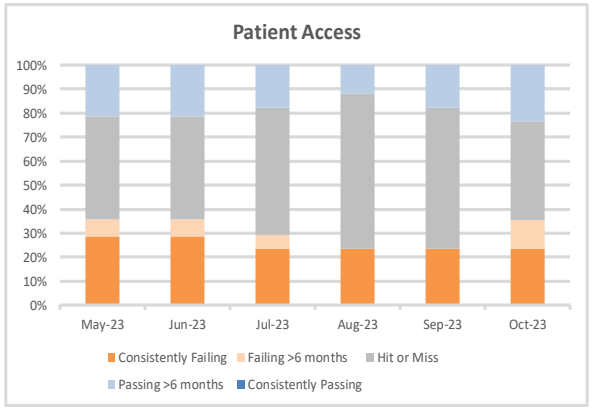
Sustainability: None

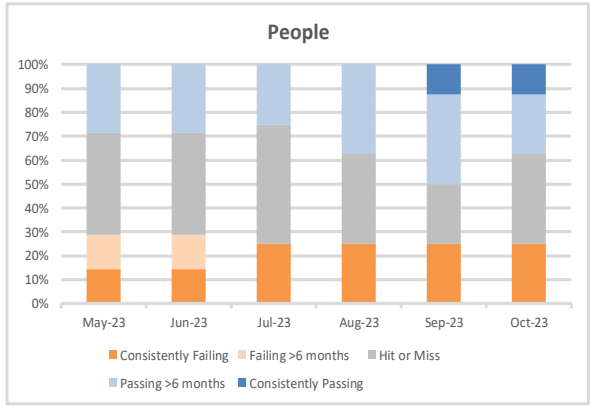
Assurance Stacked Bar Charts by Strategic Theme

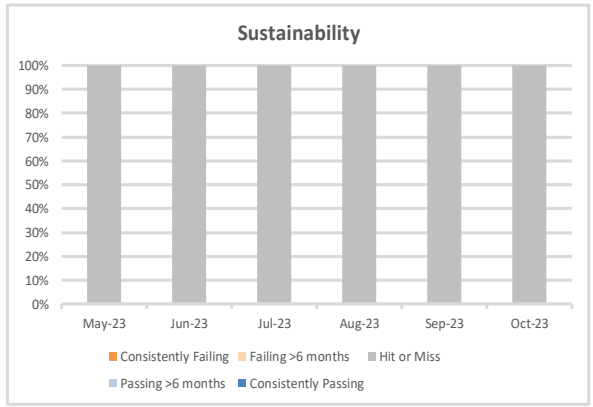












Matrix Summary

October 2023

Variance	Assurance: Pass★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Percentage of AfC 8c and above that have a Disability Summary Hospital-level Mortality Indicator (SHMI)	Sickness Absence Percentage of AfC 8c and above that are Female Never Events	Safe Staffing Levels	Flow: % of Emergency Admissions into Assessment Areas	Reduce Turnover Rate to 12% Percentage of AfC 8c and above that are BAME Transformation: % OP Clinics Utilised (slots) Friends and Family (FFT) % Response Rate: A&E
Common Cause		Number of New SIs in month Standardised Mortality HSMR To achieve the planned levels of new outpatients activity (shown as a % 19/20) Access to Diagnostics (<6weeks standard) Cancer - 2 Week Wait Cancer - 62 Day Complaints Rate per 1,000 occupied beddays	Reduce the Trust wide vacancy rate to 12% Appraisal Completeness Statutory and Mandatory Training Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Rate of patient falls per 1000 occupied bed days RTT Patients waiting longer than 40 weeks for treatment Cancer - 31 Day First Cancer - 28 Day Faster Diagnosis Completeness To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20) To achieve the planned levels of outpatients follow up activity (shown as a % 19/20) To reduce the overall number of complaints or concerns each month To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000) Capital Expenditure (£k)	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays A&E 4 hr Performance % complaints responded to within target Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)	Transformation: CAU Calls answered <1 minute Friends and Family (FFT) % Response Rate: Maternity Friends and Family (FFT) % Response Rate: Outpatients To increase the number of patients leaving our hospitals by noon on the day of discharge
Special Cause - Concern			Cancer - 28 Day Faster Diagnosis Compliance % VTE Risk Assessment (one month behind) Cash Balance (£k)		Achieve the Trust RTT Trajectory

Strategic Theme: People

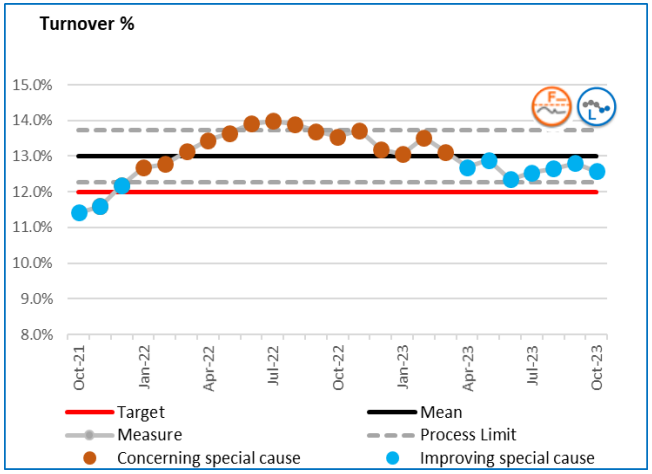
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		8%	8.4%	Oct-23	12%	8.5%	Sep-23	Driver			Verbal CMS	7.8%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.6%	Oct-23	12%	12.8%	Sep-23	Driver			Full CMS	12.7%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.0%	Sep-23	4.5%	3.9%	Aug-23	Driver			Not Escalated			
	Well Led	Appraisal Completeness		95.0%	96.4%	Oct-23	95.0%	96.8%	Sep-23	Driver			Not Escalated			
	Well Led	Statutory and Mandatory Training		85.0%	85.9%	Oct-23	85.0%	85.6%	Sep-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	70.0%	Oct-23	62.0%	68.5%	Sep-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	4.6%	Oct-23	3.2%	3.8%	Sep-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	8.5%	Oct-23	12.0%	8.5%	Sep-23	Driver			Escalation			

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

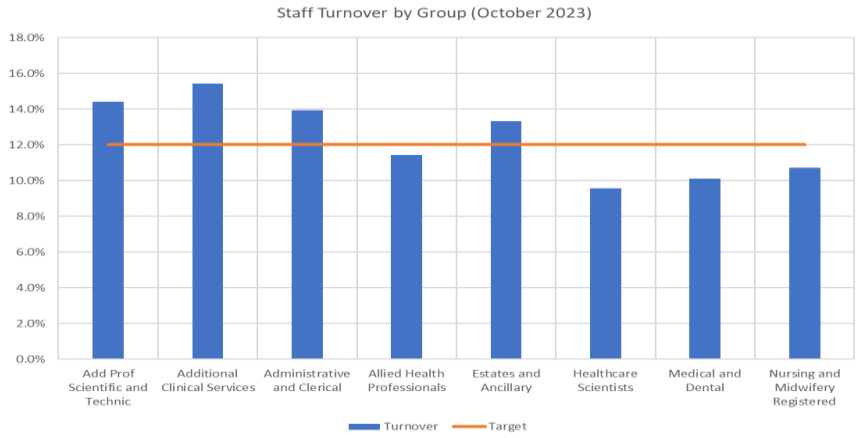
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Oct--23
12.58%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and is consistently failing the target
Max Target (Internal)
12%
Business Rule
Full CMS

2. Stratified Data



3. Top Contributors

These are some of the main contributors of focus for the working groups

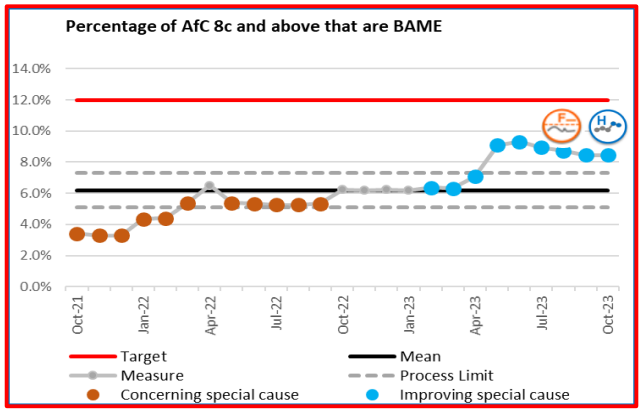
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership capability
	Not enough locally trained staff / Lack of staff development
Processes	**Retention**
Retire and return policy out of date, putting people off returning	Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action
TRAC process takes too long, leading to delays / lack of transparency in recruitment	No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere

4. Action Plan

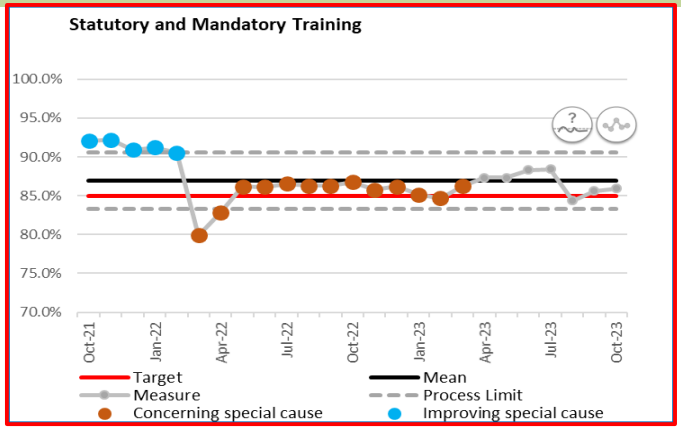
A full action plan by the working groups has been developed; some of the key actions shown:

Countermeasures	Target Completion Date
Showcase more internal development opportunities internally (Realworld data). Advertising more prominently on the Trust intranet	Nov-23
Decrease overall time to hire (conditional offer letter to sign off) to 25 working days by December 2023 - currently at 30 days (Sept), down from 43 days (July)	Dec-23
Deep dive into the average time candidates are in each stage of the recruitment process	Nov-23
Combining new starter, recruitment and induction surveys into one: the onboarding survey. Five touch points during the first year. Review data in six months to assess quality of responses	May-24
Develop new project specifically looking at reducing the number of leavers who have been with the Trust for 24 months or less	Mar-24
Admin and Clerical retention-deep dive	Dec-23
Focused Nursing & HCSW Retention Group & Plan led by Nursing (revised action plan and ensure actions fedback monthly)	Mar-24

People – Workforce: CQC: Well-Led



Oct-23
8.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (National)
12%
Business Rule
Full Escalation



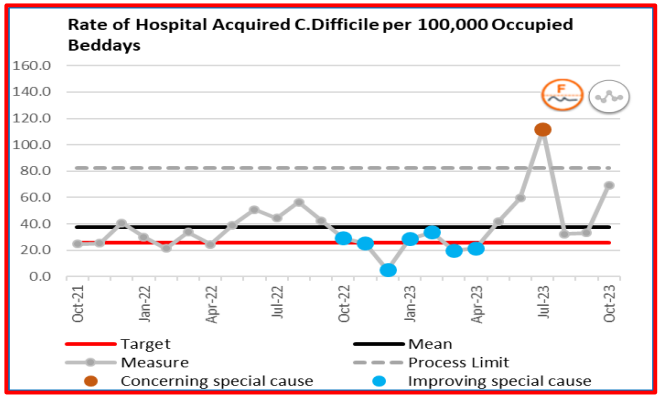
Oct-23
85.9%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (National)
85%
Business Rule
Escalated as in hit and miss for 6+ months

Summary:	Actions:	Assurance & Timescales for Improvement:
% of AfC 8c and above that are BAME: This metric is experiencing special cause variation of an improving nature and consistently failing the target. **Statutory and Mandatory Training:** This metric is experiencing common cause variation and variable achievement of the target for 6+ months.	**% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:** (NB: These are not rapidly changing indicators). As at October 23 the current number of staff (WTEs) that are AfC 8c and above is 130. Of these 6 have a disability , 11 are BAME and 91 are female. **Actions:** • Mandate for EDI recruitment reps to be on all interview panels of 8C and above • EDI steering Board commenced October to drive improvement • Second cohort of reverse mentoring launches in November with staff from ethnic minority backgrounds and those with long term health conditions as mentors and mentee pool being the Trust Board, including NEDs, plus Divisional triumvirates • Further discussions around the EDI strategy are also talking place in other forums eg Board and consultative committees	**Statutory and Mandatory Training**: A review of compliance against each separate statutory and Mandatory Training course and data reporting is being undertaken. **% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:** Develop and deliver values based recruitment training is being developed. This will initially target managers in Divisions with high turnover. Focus on anti racism took place for the senior leadership away day on 25/10/2023 The Trust Board are in the process of agreeing EDI objectives which will be measured in April 2024.

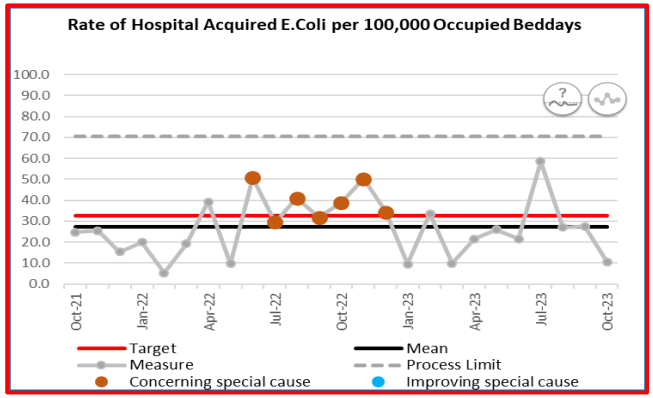
Strategic Theme: Patient Safety & Clinical Effectiveness

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.65	Sep-23	0.90	0.92	Aug-23	Driver			Verbal CMS	1.65		
Breakthrough Objectives	Safe	Number of Deteriorating Patients with Moderate+ Harm (data runs one month behind)		TBC	TBC	TBC	TBC	TBC	TBC	Driver	No SPC	No SPC	Verbal CMS	TBC	No SPC	No SPC
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month		11	11	Oct-23	11	8	Sep-23	Driver			Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	96.7	Jul-23	100.0	98.7	Jun-23	Driver			Not Escalated			
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	90.7	Jul-23	100.0	90.9	Jun-23	Driver			Not Escalated			
	Safe	Never Events		0	0	Oct-23	0	0	Sep-23	Driver			Not Escalated			
	Safe	Safe Staffing Levels		93.5%	92.9%	Oct-23	93.5%	89.2%	Sep-23	Driver			Not Escalated			
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	10.7	Oct-23	32.6	27.5	Sep-23	Driver			Not Escalated			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	69.2	Oct-23	25.5	33.0	Sep-23	Driver			Escalation			
	Safe	IC - Number of Hospital acquired MRSA		0	0	Oct-23	0	1	Sep-23	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	6.6	Oct-23	6.4	7.3	Sep-23	Driver			Note Performance			

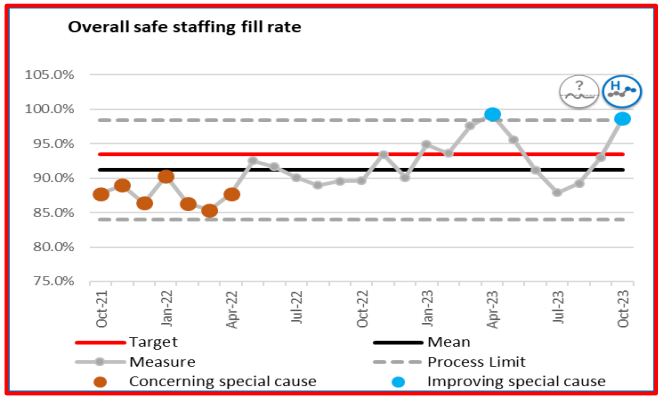
Patient Safety and Clinical Effectiveness: CQC: Safe



Oct-23
69.2
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Target
25.5
Business Rule
Escalated as failed target for 6+ months



Oct-23
10.7
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
32.6
Business Rule
Escalated as in Hit & Miss for 6+ months



Oct-23
98.7%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and variable achievement of the target
Target (National)
93.5%
Business Rule
Escalated as in Hit & Miss for 6+ months

Summary:

Rate of C.difficile: is experiencing special cause variation of a deteriorating nature and has failed the target for 6+ months.

Rate of E.coli:: is experiencing common cause variation and variable achievement of the target.

Safe Staffing Fill Rate - is experiencing special cause variation of an improving nature and variable achievement of the target.

Actions:

Infection Control:

After several months of declining rates, we saw a rise in C diff cases in October (13 cases). Actions that continue to be undertaken include:

- The ward deep cleaning programme continues at TWH
- Enhanced cleaning is being undertaken on wards at MH where possible
- Rapid C diff reviews are being undertaken by the IPC team with clinician involvement to support timely identification of learning
- Ongoing monitoring and surveillance of cases to identify and risk of transmission of infection. Further sub-typing found evidence of transmission of infection from 1 patient to 1 other on ward 10 which has been reviewed.

Safe staffing Fill Rate:

- Rostering confirm and support meetings are supporting the effective utilisation of nursing rosters. This has been further enhanced by the use of Oceans Blue reporting
- Critical staffing escalation cards are now live,
- Planning for the October SNCT audit is completed, with reporting now active to support nursing establishment reviews.
- The Establishment review business case has been approved by the board and will be presented to the ICB for final sign off and oversight.
- A focus on reduction of temporary staffing out of hours has seen an elevation in substantive staffing on these shifts.

Assurance & Timescales for Improvement:

Infection Control:

The Infection prevention team continue to monitor and escalate where infection and nosocomial rates are rising.

Post infection review and rapid review scrutiny will continue for alert organisms including C.difficile and gram negative blood stream infections.

Learning from investigations are shared within the Directorate and via the HCAI weekly status

Plans are being developed to transition to PSIRF for IPC post infection reviews. A system wide process is being written.

Recruitment of an invasive devises project nurse (funded by ICB) on a 1 year secondment to help support the gram negative reduction programme and prevent device related bloodstream infections

Safe Staffing Fill Rate:

- Full utilisation of the Oceans Blue reporting system will be shared with clinical teams, providing governance and oversight of rostering KPI compliance.
- Completion of the October SNCT audit, with provide data on the average acuity and dependency levels within the inpatient wards for 2023.
- Following full approval of the Establishment review business case by the ICB, mapping of the posts will be facilitated with the Divisions. This will support the safe staffing fill rate within the clinical areas.

Strategic Theme: Patient Access

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory		73.2%	67.8%	Oct-23	72.7%	66.2%	Sep-23	Driver			Full CMS	71.4%		
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		106.5%	116.7%	Oct-23	110.5%	120.5%	Sep-23	Driver			Note Performance	120.9%		
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment		632	829	Oct-23	637	1071	Sep-23	Driver			Not Escalated			
	Responsive	Access to Diagnostics (<6weeks standard)		88.5%	97.4%	Oct-23	87.6%	96.8%	Sep-23	Driver			Not Escalated			
	Responsive	A&E 4 hr Performance		86.7%	84.3%	Oct-23	86.8%	85.6%	Sep-23	Driver			Escalation			
	Responsive	Cancer - 2 Week Wait		93.0%	97.4%	Sep-23	93.0%	95.2%	Aug-23	Driver			Not Escalated			
	Responsive	Cancer - 31 Day First		96.0%	97.5%	Sep-23	96.0%	95.5%	Sep-23	Driver			Not Escalated			
	Responsive	Cancer - 62 Day		85.0%	85.2%	Sep-23	85.0%	88.0%	Aug-23	Driver			Not Escalated			
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance		75.0%	62.8%	Sep-23	75.0%	71.9%	Aug-23	Driver			Not Escalated			
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness		80.0%	84.2%	Sep-23	80.0%	86.5%	Aug-23	Driver			Not Escalated			

- CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh in January 2024 and the position is expected to improve.

Strategic Theme: Patient Access (continued)

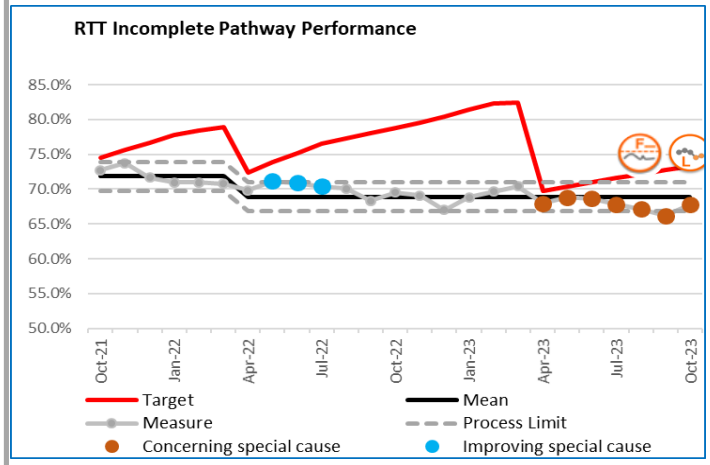
				Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	81.8%	Oct-23	85.0%	83.6%	Sep-23	Driver			Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		1.5%	5.2%	Oct-23	1.5%	5.4%	Sep-23	Driver			Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	72.2%	Oct-23	90.0%	72.7%	Sep-23	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.2%	Oct-23	5.0%	6.3%	Sep-23	Driver			Not Escalated
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	62.2%	Oct-23	65.0%	63.7%	Sep-23	Driver			Escalation
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		99.6%	111.7%	Oct-23	98.8%	106.4%	Sep-23	Driver			Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)		98.9%	103.8%	Oct-23	107.0%	108.7%	Sep-23	Driver			Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		136.0%	138.2%	Oct-23	156.5%	139.4%	Sep-23	Driver			Escalation

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

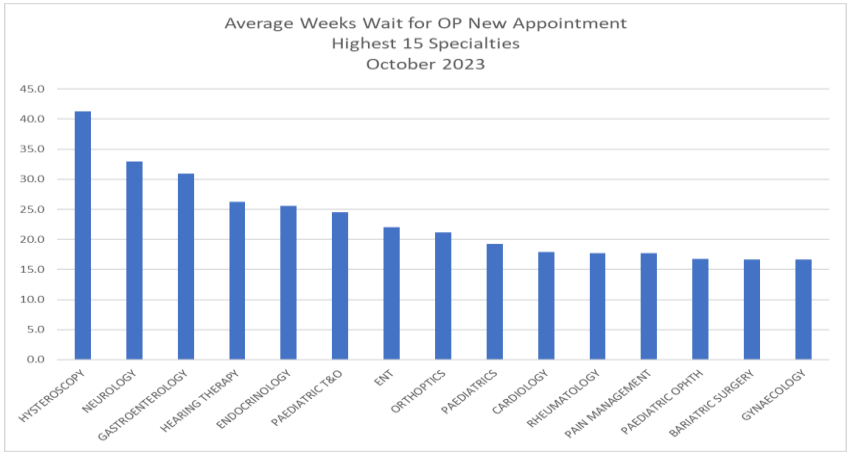
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Oct-23
67.76%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
73.2%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

Despite being above plan for our new outpatients. Although some of the key specialties with long waits are still under plan. The trust wide themes/top contributors are as follows:

- Long waits for 1st Outpatient appointment
- Achievement of activity targets for new outpatients and electives
- Follow ups without procedure above plan

BAU actions continue and focussed clinical engagement with Further Faster GIRFT Programme.

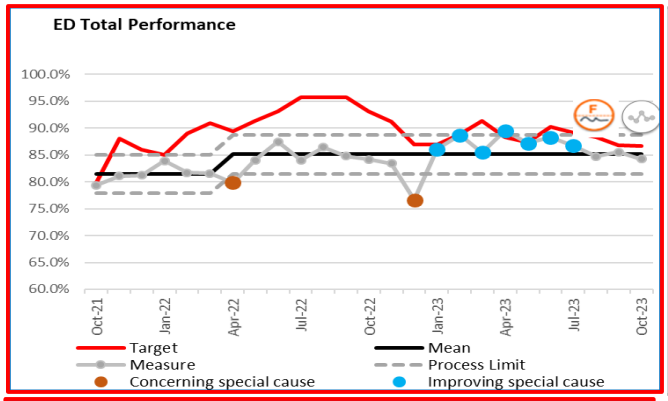
Key Risks:

- There is a risk that medical industrial action will affect achievement of the planned trajectory for activity affecting RTT.
- Waiting list growth could be affected due to increase in referrals and systems pressure.

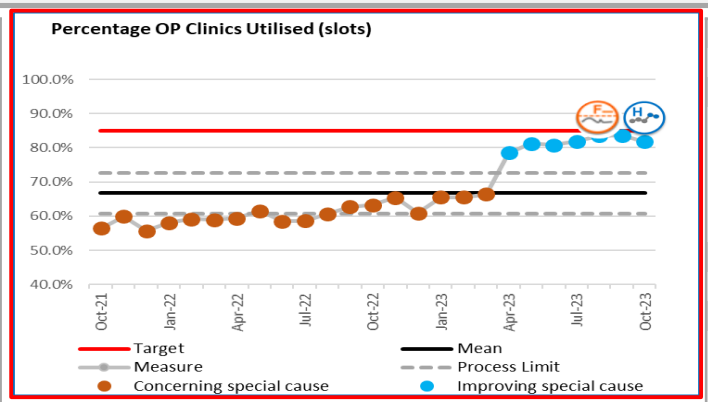
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots	SC	Oct/Nov
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	May 24
	Review of DOS with clinical teams	AC	Oct 23
DNA Reduction	Two Way Text roll out for adults and paeds	SC	Sept 23✓
	Trust wide DNA Task and Finish group looking at GIRFT recommendations and Patient Engagement	SC	March 24
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting Additional PTLs for Gastro, Gynae, Neurology and Surgery	RTT Lead and PAT team	Weekly and in progress

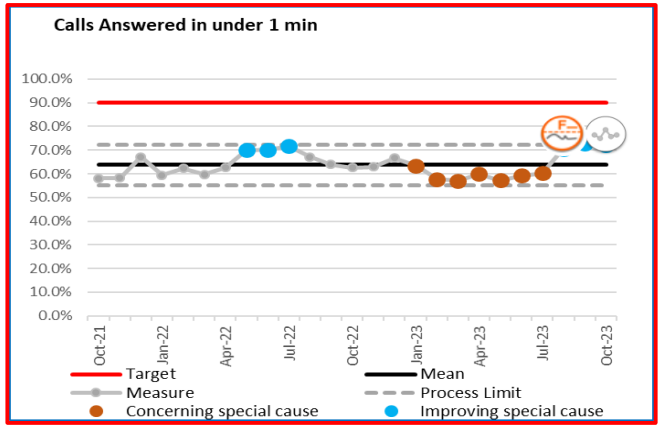
Patient Access: CQC: Responsive



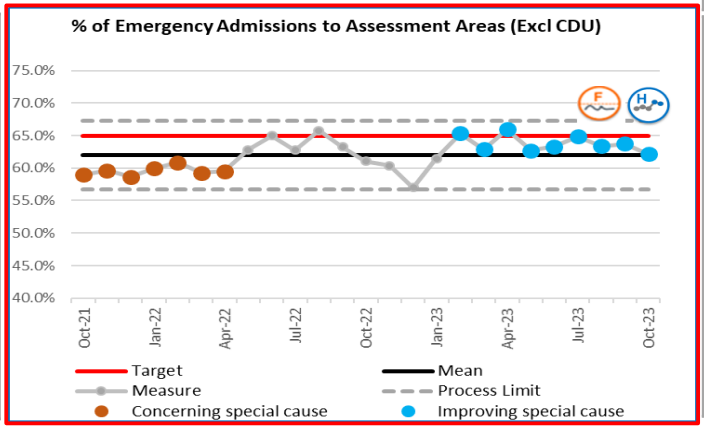
Sep-23
84.26%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (submitted)
86.75%
Business Rule
Full escalation as has failed the target for 6+months



Oct-23
81.8%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation as consistently failing the target



Oct-23
72.2%
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 as consistently failing the target



Oct-23
62.2%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and failing the target for 6+ months
Target (Internal)
65%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

A&E 4 hr Performance: is experiencing common cause variation but has failed the target for 6+months.

Outpatient Utilisation: is experiencing special cause variation of an improving nature and consistently failing the target. All Divisions are below the 75% target except Cancer Services.

Calls Answered <1 min: is experiencing special cause variation of an improving nature and remains consistently failing the target. The areas with the lowest rate is 2WW, Women & Children, Surgical Specialties and General Surgery.

% of Emergency Admissions to Assessment Areas (Excl CDU): is experiencing special cause variation of an improving nature but has failed the target for 6+ months.

Actions:

A&E 4hr Performance: Focus work and an action plan is in place focusing on improving delays to diagnostic breaches and out of hours ED performance.

Outpatient Clinic Slot Utilisation: The OPD team continue to work with the CAUs on their clinic templates to improve utilisation by 20%. Next, the focus is on planned elective clinics with utilisation below 85%.

Performance against the under 1 minute KPI:. Daily report by hour and by speciality are circulated to the General Managers and team leaders to highlight peaks and troughs of performance. The team are working with CAUs to review phone rotas and ensure all hours are covered - working with specialities to design a rota based on busiest call times.

% of Emergency Admissions to Assessment Areas (Excl CDU): Medical SDCE performance continues to be at above national standard of 33% of medical take with AFU and AEC taking over 50% of medical NE attenders. A trust wide working group for flow will have a focus on improvements in surgical SDEC including SAU pulling over night and OAU taking more patients from ED.

Assurance & Timescales for Improvement:

A&E 4hr Performance: A trust wide working group at DDO level, chaired by the COO to be set up focusing on flow to reduce the amount of bed breaches.

Outpatient Slot Utilisation The aim is to ensure that no planned elective clinic is under 85% utilised. The OPD team have worked to identify 'planned elective' vs. 'emergency / hot clinics'. Currently mapping a Trust wide trajectory to improve from 80% to 85%.

Calls Answered within 1 minute in the CAUs: Many speciality CAUs are reporting short staffing, however, new staff from an admin specific recruitment event are starting in post to support CAU recruitment. We achieved our interim target of 70% in Aug, Sep and Aug and new starters should help maintain that through further periods of Industrial Action / site pressures. OPD contact centre continues to support calls.

Strategic Theme: Patient Experience

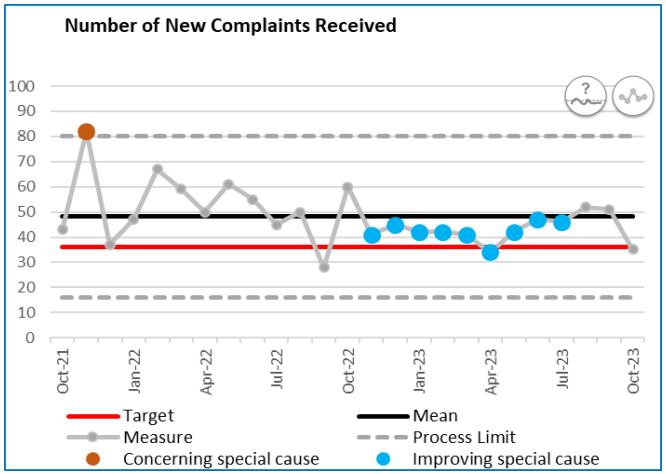
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month		36	35	Oct-23	36	51	Sep-23	Driver			Verbal CMS	39		
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.		24	23	Oct-23	24	34	Sep-23	Driver			Verbal CMS	30		
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	1.9	Oct-23	3.9	3	Sep-23	Driver			Not Escalated			
	Caring	% complaints responded to within target		75.0%	41.9%	Oct-23	75.0%	73.2%	Sep-23	Driver			Escalation			
	Caring	% VTE Risk Assessment (one month behind)		95.0%	95.0%	Sep-23	95.0%	95.5%	Aug-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	27.2%	Oct-23	25.0%	25.8%	Sep-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	8.1%	Oct-23	15.0%	8.1%	Sep-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	8.8%	Oct-23	25.0%	19.6%	Sep-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	5.7%	Oct-23	20.0%	6.7%	Sep-23	Driver			Escalation			

Vision: Counter Measure Summary

Metric Name – To reduce the overall number of complaints or concerns each month

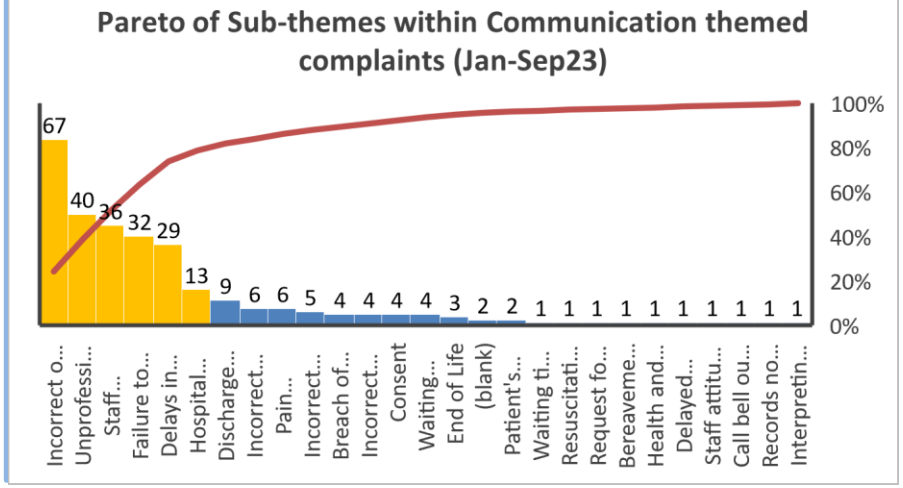
Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Oct-23
35
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric is in variable achievement of the target for 6+ months

2. Stratified Data



3. Top Contributors and Key Risks

A3 Thinking currently underway to understand the themes of complaints and concerns where poor communication is the main issue affecting patient experience

Incorrect or poor communication	67
Unprofessional conduct	40
Staff Attitude	36
Failure to meet communication needs	32
Delays in communication	29
Hospital acquired incidences	13

Key Risks:

1. Process risk: Moving from IQIVIA to HCC for FFT and local surveys

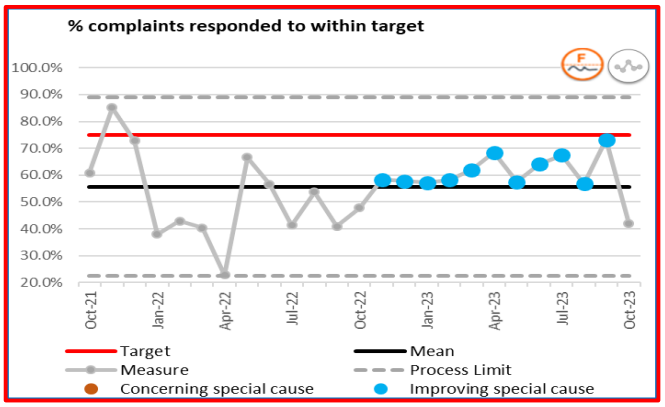
Horizon Events:

1. Impact of PKB once launched end of October – Briefly discussed at Patient experience workshop
2. Formulation of Patient Experience Strategy – Identifying key themes following patient experience workshop held on 16th of Nov.

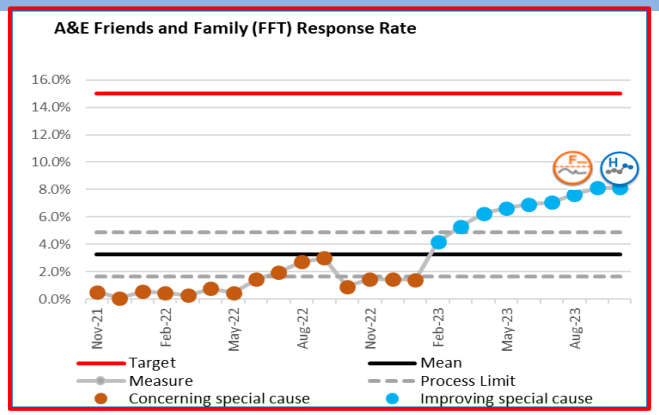
4. Action Plan

	Action for A3	Timeline	Progress
Define	Method to collect data from InPhase to be defined and agreed	August	Complete
	Current state of play being analysed	September	Complete
	Audit of complaints to be completed	October	Complete
Measure	Root Cause being identified	October	Complete
	Patient Voice being collected using an overall Patient Experience survey to inform part of Patient Experience Strategy	Nov-Dec	In Progress
Analyse	Analysed the sub themes and completed root cause analysis and to create a list of countermeasures	Dec-Feb23	In Progress
Improve			
Control			

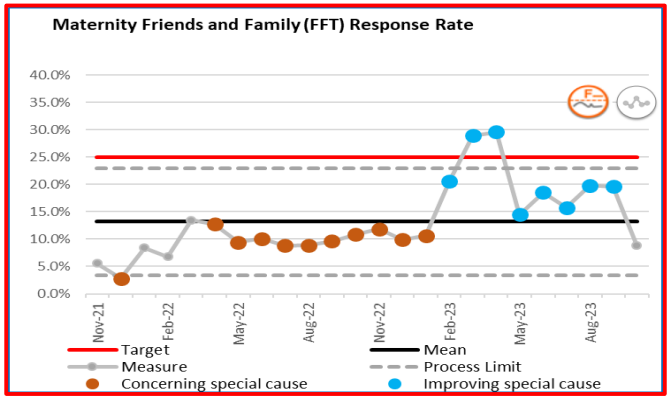
Patient Experience: CQC: Caring



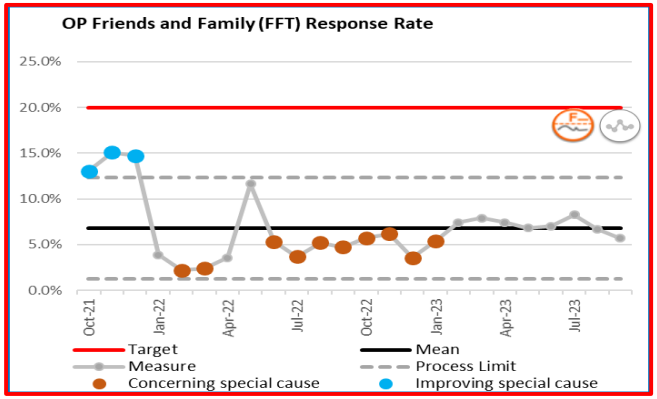
Oct-23
42%
Variance / Assurance
Metric is in special cause variation of an improving nature and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Oct-23
8.1%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Oct-23
8.8%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Oct-23
5.7%
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:

% Complaints responded to within target: this indicator is experiencing special cause variation of an improving nature and has failed the target for >6months, noting the target has not been met since November 2021

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.

Recommended Rate is 88.9%

Friends and Family Response Rate - Maternity: Is experiencing Common Cause Variation, but is consistently failing the target.

Recommended Rate is 100%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of a concerning nature and is consistently failing the target

Recommended Rate is 100%

Word clouds being reviewed for key sentiments and shared with Divisions.

Actions:

Complaints Response Rate: Complaints performance recovery and stabilisation actions include;

- Weekly oversight meetings led by CN and DQG
- Business case for revised complaints model submitted
- Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times
- Introduction of new 40 day target to support more complex cases

A&E: ED continues to be an improving picture, continuing with current methodology. Hybrid method using text, QR code and online. Consider change of reporting methodology to positivity rather than Response rate to match NHS England data.

Maternity: Continues to be a stable and improving picture. Volunteers supporting with FFT data collection

Outpatients: SMS text messaging still in use, QR Codes available. However, assurance on Text messaging and linked PAS outpatient clinic codes still not guaranteed. Further meeting with Netcall planned.

FFT Response All: Slight drop in FFT response rate in October (6800) as compared to 7300 in Sep-23. Word clouds being compiled between and feedback received and what good looks like

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: Continuing monthly review. Meetings with Netcall and OP planned to monitor and review SMS Text messaging for Outpatients. New contract with FFT provider (HCC) being reviewed by CEO pending sign-off. Current contract with IQUVIA ending Feb-2024. First meeting to plan mobilisation planned end of November -23.

FFT feedback is shared across all clinical areas as a visual template indicating total responses and positivity and negativity of patient experiences.

SDR to consider report amendment to show positivity rates rather than response rates to match NHS England. Of note, our positivity rate are above national average.

Strategic Theme: Systems

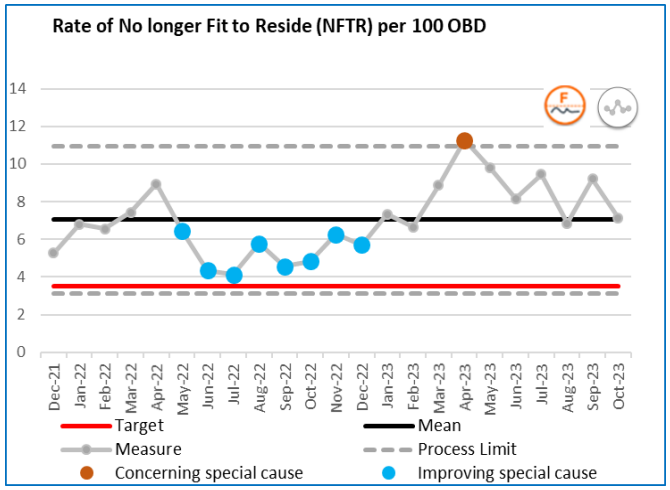
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)		3.5	7.1	Oct-23	3.5	9.2	Sep-23	Driver			Full CMS	7.6		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	22.1%	Oct-23	33.0%	22.7%	Sep-23	Driver			Full CMS	22%		

Vision: Counter Measure Summary

Project/Metric Name – Decrease the number of occupied bed days for patients identified as No longer fit to Reside

Owner: Rachel Jones
Metric: Rate of NFTR per 100 OBD
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Current Data Source: Teletracking
Oct-23
7.1
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
3.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data

Stratified data not yet identified until the analysis of the data has taken place

As part of the action plan there will be a review of relevant data including national submissions, numbers of patients no longer meeting the criteria to reside and external capacity

3. Top Contributors

Top contributors not yet identified

4. Action Plan

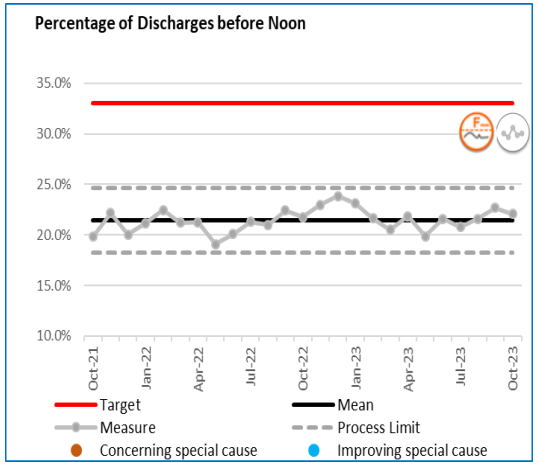
	Action	Who	When	Complete
Robust Data Flows	• Work with Key Stakeholders on reviewing data sources and statutory mandatory returns for No Longer Meeting the Criteria to Reside to NHSE, in order to improve quality of data to the system	FR/ RS/ AG	Dec23	
A3 Process	• Work with key stakeholders across the system through the West Kent HCP Discharge and Flow Group following agreement on the current work on one version of the truth for WK.	FJ/RC SP/ SM	Dec23	

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

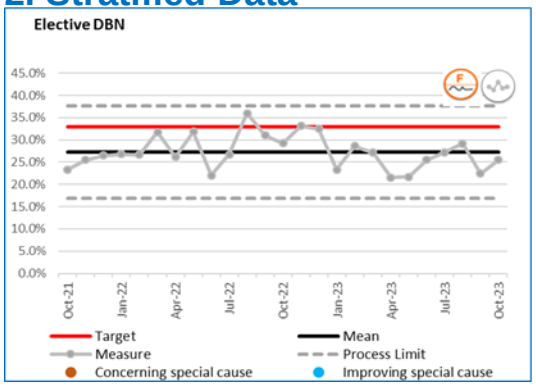
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

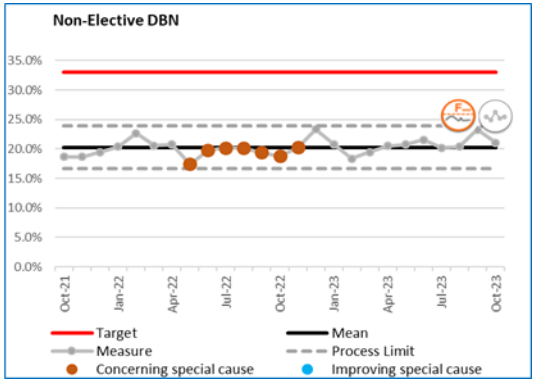
1. Historic Trend Data



Current Data Source: Teletracking
Oct-23
22.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data





3. Top Contributors and Key Risks

Area of Analysis	Considered a Top Contributor?
EDN	EDNs are a top contributor in delays in discharge time. There is a clinically led EDN project **group focusing on our ability to complete EDNs the day before planned date of discharge** A focus group working on **EDN content and alignment with clerking model to facilitate ease of completion of EDN**
Criteria Led Discharge	Data shows Criteria led discharge was only utilised 1.3% of all discharges – hence focus around identifying patients with CLD and recording them on Sunrise, have been identified.

Key Risks:

1. Continued disruption to a focus on EDN as a result of industrial action.
2. Clinical buy-in to manage EDN and CLD processes differently
3. Sunrise change freeze – Timeline will affect implementation of the changes and Sunrise data from HISBI – Report extraction

4. Action Plan

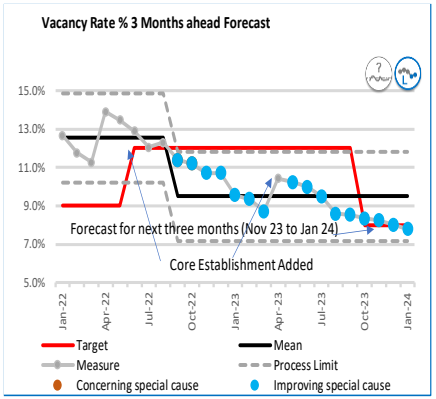
CM	Action	Who	When	Complete
Criteria Led Discharge	• Paper to ETM on clinical identification of patients for CLD • Clinical Engagement with Med Specialties and Surgery • Discharge policy to be updated to include CLD. • Competencies and E-learning uploaded to L&D (MTW learning) for Matrons and Band 7s to complete and training to be disseminated across all wards for CLD. • Changes in Sunrise to identify patients with CLD, on the taskbar and reports to be extracted from Sunrise (When the sunrise upgrade is completed)	RJ NP/SF/ Divisional CDs NP NP/RS/RT	28/11 End of Oct 23 Oct 23 Dec 23	In Progress Complete Complete In Progress In Progress Delayed – early 2024
EDN	• Trial different Jr Dr allocation model specifically to deliver EDNs on two wards (one medical base ward, one surgical)- Not Supported at CDs but agreed we could complete more EDNs the day before discharge • Agree ward and firms testing (meet ward 21 to confirm support w/o 23rd)- Ward 21, Lord North, waiting for surgical ward • Appoint clinical leadership to drive tests of change • Change EDN structure in Sunrise to align with clerking model • Change EPMA & Sunrise TTO module to reduce time taken to complete medicines element of EDN (requires planned Sunrise upgrade completion first)	BC CoS/DoO BC JS JS	1/11/23 13/11/23 3/24	Completed Completed Completed In progress In progress
Delay Reason	• Develop data export from Teletracking to BI warehouse to enable in house bespoke reporting • Develop data migration from Sunrise to Teletracking	RS JS		In Progress In Progress

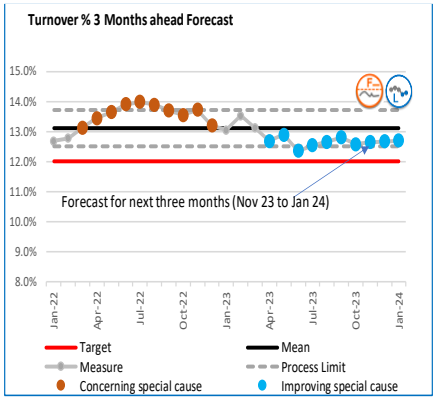
Strategic Theme: Sustainability

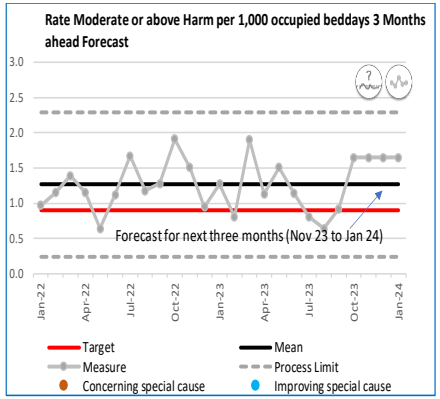
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)		-1,014	-873	Oct-23	-748	-588	Sep-23	Driver			Verbal CMS	1325		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		880	1,464	Oct-23	935	1,451	Sep-23	Driver			Note Performance	1298		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		3,567	1,659	Oct-23	2,851	2,688	Sep-23	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Cash Balance (£k)		19,691	18,533	Oct-23	18,277	15,756	Sep-23	Driver			Not Escalated			
	Well Led	Capital Expenditure (£k)		2,738	3,991	Oct-23	4,091	3,975	Sep-23	Driver			Not Escalated			
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		73,169	75,324	Oct-23	60,746	62,775	Sep-23	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		18,741	14,533	Oct-23	10,256	9,852	Sep-23	Driver	No SPC	No SPC	Not Escalated			

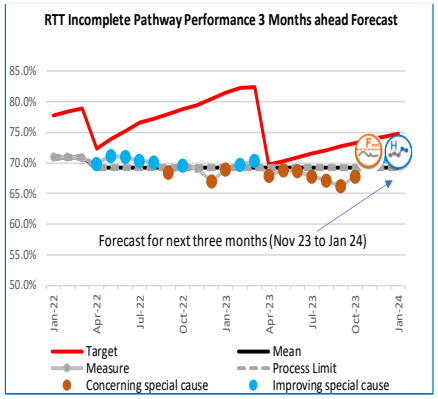
Appendices

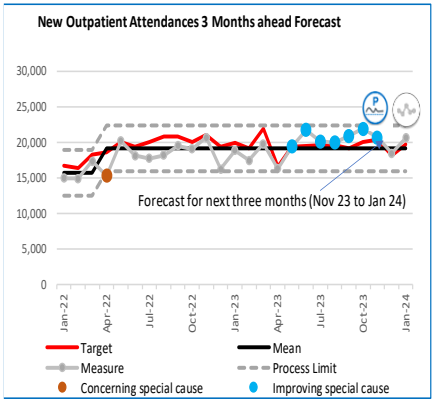
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

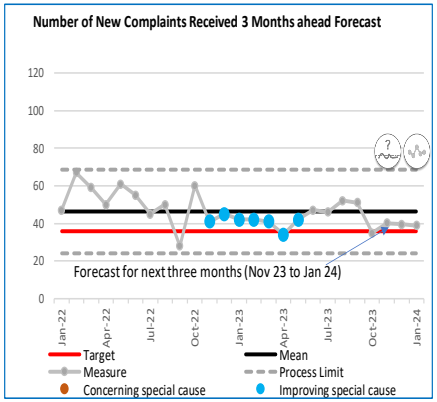


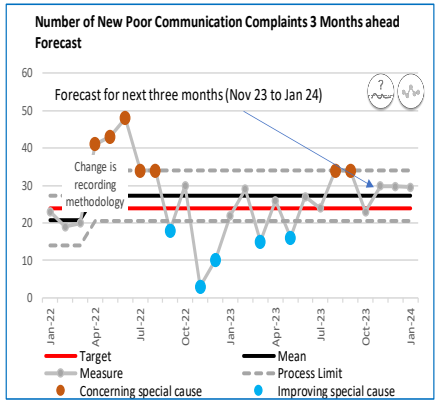


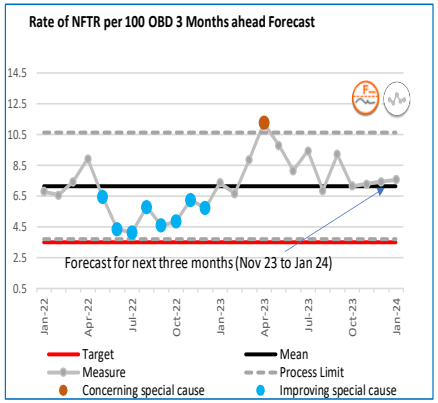


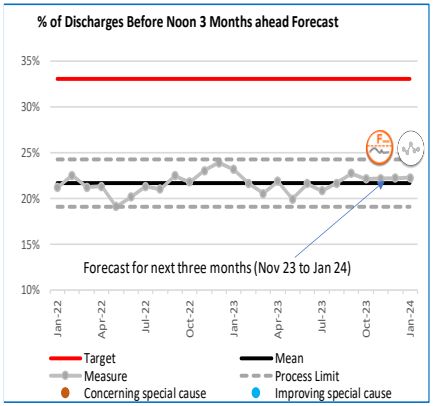


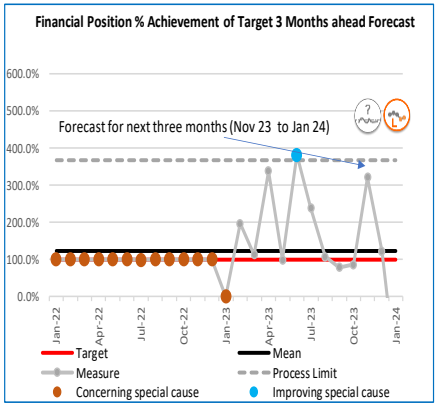


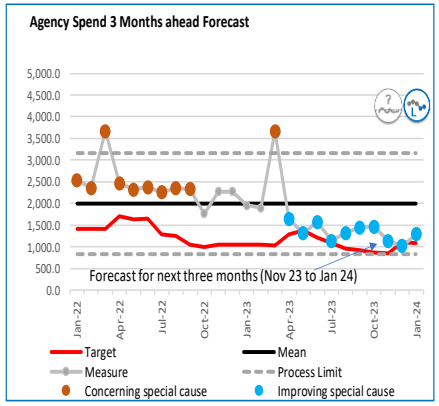






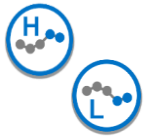






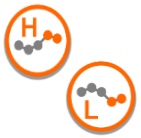
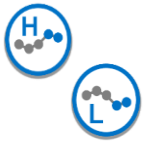
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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 consistently (F)ailing the target.	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	Metric is Failing the Target and is showing a Special Cause for Concern. Consider escalating to a driver metric.
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	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	Metric is Failing the Target and is in Common Cause variation. Consider next steps.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	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	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

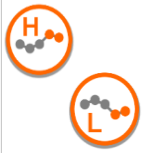
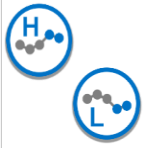
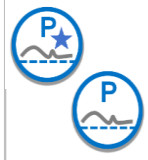
SDR Business Rules Driven by the SPC Icons

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 **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is in Common Cause, but is showing a Special Cause for Concern. **Note performance**, 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 **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is Hitting & Missing the Target and is in Common Cause variation. **Note performance**, 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.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**
Any		Assurance indicates inconsistently hitting or missing the target.	A Driver Metric that remains in Hit & Miss for 6 months or more will need to complete a **full CMS**	N/A

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

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:

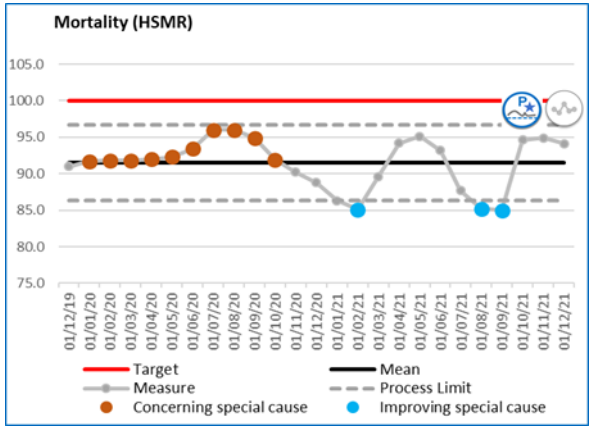
The **target** line **between** the **upper** and **lower** control limit for all metric types

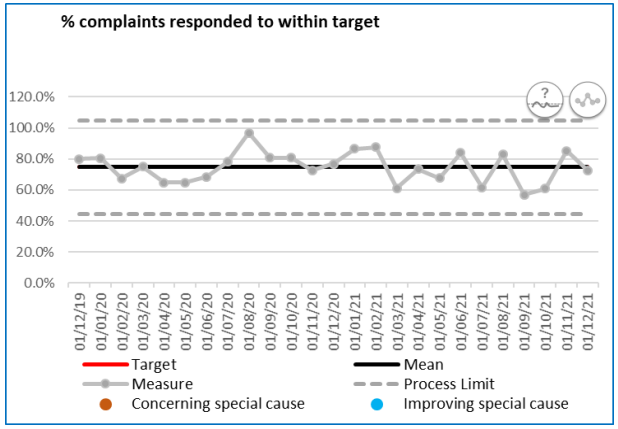
Metrics that consistently **fail** have:

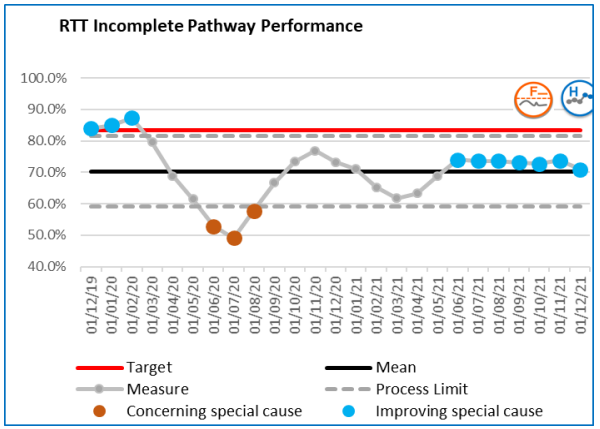
The **lower** control limit **above** the target line for metrics that need to be **below the target**

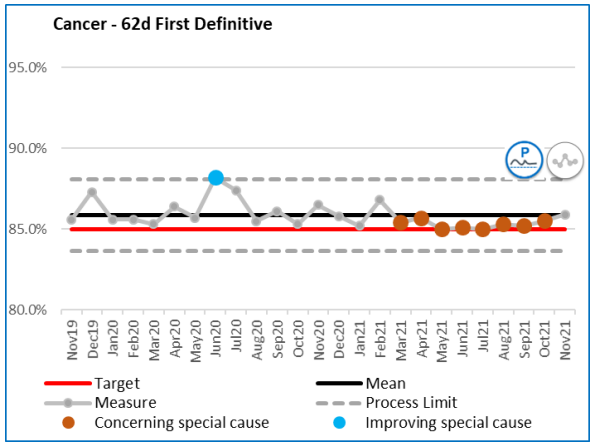
The **upper** control limit **below** the target line for metrics that need to be **above the target**

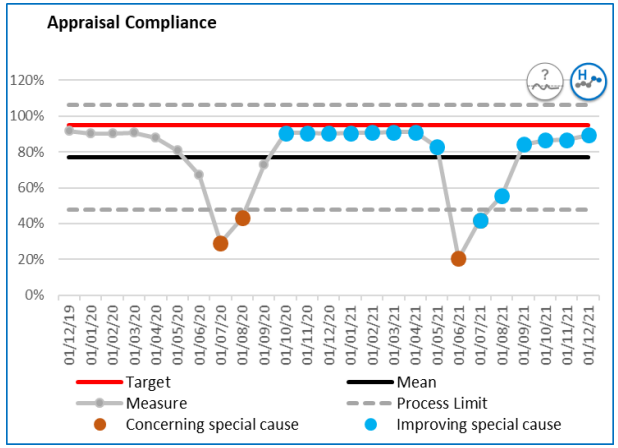
A metric not achieving the target for 6 months or more will be flagged as failing

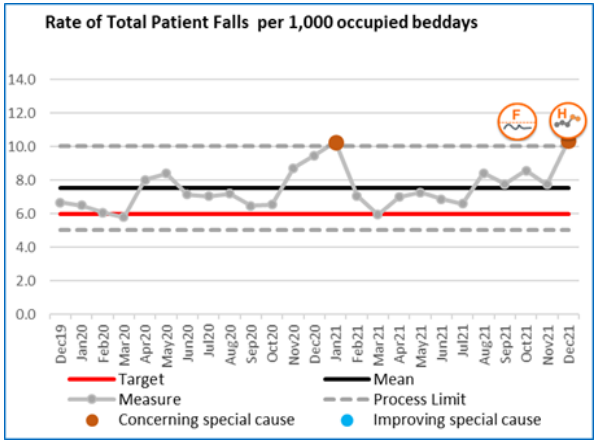












Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 7
2023/24

Maidstone and Tunbridge Wells NHS Trust

Summary

October 2023/24

	Current Month					Year to Date					Annual Forecast / Plan		
	Actual	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Forecast*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	62.0	58.4	3.5	(0.0)	3.6	405.5	399.7	5.8	(0.4)	6.2	707.7	687.9	19.8
Expenditure	(56.8)	(53.1)	(3.7)	0.0	(3.7)	(377.9)	(370.3)	(7.6)	0.4	(8.0)	(656.2)	(635.9)	(20.4)
EBITDA (Income less Expenditure)	5.1	5.3	(0.2)	0.0	(0.2)	27.6	29.4	(1.8)	0.0	(1.8)	51.4	52.0	(0.6)
Financing Costs	(4.3)	(4.3)	0.0	0.0	0.0	(30.0)	(30.0)	0.0	0.0	0.0	(68.7)	(69.3)	0.6
Technical Adjustments	0.1	0.1	0.0	0.0	0.0	0.4	0.3	0.0	0.0	0.0	17.3	17.3	(0.0)
Net Surplus / Deficit	**0.9**	**1.0**	**(0.1)**	**0.0**	**(0.1)**	**(2.0)**	**(0.3)**	**(1.8)**	**0.0**	**(1.8)**	**0.0**	**0.0**	**(0.0)**
Cash Balance	18.5	19.7	(1.2)		(1.2)	18.5	19.7	(1.2)		(1.2)	2.0	2.0	0.0
Capital Expenditure (Incl Donated Assets and IFRS16)	4.0	2.7	(1.3)		(1.3)	18.4	30.4	(12.0)		(12.0)	65.3	68.0	2.7
Cost Improvement Plan	1.6	3.6	(1.9)		(1.9)	11.1	14.9	(3.9)		(3.9)	19.0	33.3	(14.3)

Summary Current Month:
- The Trust was £0.9m in surplus in the month which was £0.1m adverse to plan. The Industrial action in October led to a £0.2m increase in temporary staffing and lost income due to cancelled elective activity of £0.3m.

Key Favourable variances in month are:
- Clinical income overperformance (£0.9m)
- Backdated education and training income to reflect medical pay award (£0.5m)

Key Adverse variances in month are:
- Impact of Industrial action (£0.5m)
- Revised doubtful debt estimate for Injury cost recovery income to provide in full for 2022/23 outstanding debt which is in line with the Trust policy (£0.4m)

Year to date overview:
- The Trust is £2m in deficit which is £1.8m adverse to plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£3.9m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£2m)
- Additional Costs associated with Industrial Action (£2m) and Medical pay award pressures (£0.6m)
- Other pressures mainly pay related (£0.8m)

Favourable Variances
- Variable activity overperformance including change to ERF target (£5.2m)
- Non recurrent benefits (£2.3m)

CIP (Savings)
- The Trust has a savings target for 2023/24 of £33.3m and has delivered £14.4m year to date which is £3.9m adverse to plan.

Risks
- **Community Diagnostic Centre (CDC) delay to full occupancy** – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan causing a net £2m pressure which is in part due to the delay to full capacity and also due to under utilisation of the CT capacity. There is a risk that costs won't be reduced to fully offset the loss in income.
- **CIP Delivery -** The Trust has a large CIP target for 2023/24 and there is £14.3m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions.
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.

Summary / Key points

Executive Summary

- The Trust was £0.9m in surplus in October which was £0.1m adverse to plan. Year to date the Trust is £2.0m in deficit which is £1.8m adverse to plan.
- The key year to date pressures are; CIP slippage (£3.8m), CDC delay to fully opening and underutilisation of CT capacity (£2m), additional costs associated with the Industrial action £2m, medical pay award pressure (£0.6m) and other pressures (mainly pay related) of £0.8m. To mitigate these pressures the Trust has overperformed against variable income (£5.2m) and had non recurrent benefits of £2.3m.
- Cost Improvement Plans (CIP) are behind plan by £3.9m year to date.
- The Trust is forecasting to deliver the breakeven financial plan. To deliver the forecast the trust has developed a recovery plan which includes: Additional Income associated with ERF change of national targets (£4.4m), income to fund costs incurred as a result of the industrial action (£2.0m), run rate improvements (£3m) and accruals and provision review (£1.6m)

Current Month Financial Position

- The Trust was £0.9m in surplus in the month which was £0.1m adverse plan.
- The Industrial action in October led to a £0.2m increase in temporary staffing and lost income due to cancelled elective activity of £0.3m.
- The Key variances to plan are:
    - Clinical Income Overperformance (£0.9m)
    - Backdated education and training income to reflect medical pay award (£0.5m)
    - Impact of Industrial action (£0.5m)
    - Revised doubtful debt estimate for injury cost recovery income to provide in full for 2022/23 outstanding debt which is in line with the Trust policy (£0.4m)
    - CDC delay to full capacity and also due to underutilisation of the CT capacity (£0.4m)

Year to Date Financial Position

- The Trust is £2m in deficit which is £1.8m adverse to plan.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - CIP Slippage (£3.9m)
        - CDC delay to full capacity and also due to underutilisation of the CT capacity (£2m)
        - Additional Costs associated with Industrial Action (£2m) and Medical pay award pressures (£0.6m)
        - Other pressures mainly pay related (£0.8m)
    - **Favourable Variances**
        - Variable activity overperformance including change to ERF target (£5.2m)
        - Non recurrent benefits (£2.3m)

Risks

- **Community Diagnostic Centre (CDC**) delay to full occupancy – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan causing a net £2m pressure which is in part due to the delay to full capacity and also due to underutilisation of the CT capacity. There is a risk that costs won't be reduced to fully offset the loss in income. Phase 2 has now been handed over to the Trust and patients are starting to be seen from mid November.
- **CIP Delivery** - The Trust has a large CIP target for 2023/24 and there is £14.3m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions, based on current rates this could equate to c£0.5m pressure per month if consultants and junior doctors both strike.
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.

Cashflow position:

- The closing cash balance for October was £18.5m which is slightly lower than the plan value of £19.7m. The main variance relates to the Medical Pay award that was paid out in September which was expected later in the cash flow forecast
- The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance Sheet. If the in-year I&E position moves adversely then this has a negative impact on the Trusts cash flow and the Trust would need to implement various strategies to ensure the Trust cash remains in balance whilst meeting its commitments. The Trust is working closely with local NHS organisations to improve receivables and payables aged balances.
- The Trust is working with Suppliers, Procurement Department and budget holders/authorised signatories to ensure invoices are receipted, approved and paid as promptly as possible, this is to assist with the Trust adhering to the BPPC (Better Payment Practice Code) target of 95% For October the percentages were for Trade suppliers by value 97% and by volume was 96.56; for NHS suppliers by value 95.1% and by volume 90%.
- Within October the Trust payed out commitments relating to Salix loan £0.2m, these are repaid twice a year in April and October.

Capital Position

- The Trust's capital plan, excluding IFRS16 leases, agreed with the ICB for 2023/24 is **£38.5m**. The Trust's share of the K&M ICS control total is **£14.016m** for 2023/24, including **£4.996m** from system funds for the Phase 3 HASU completion; and **£6.41m** of the costs of the K&M Orthopaedic Centre above the agreed national funding. The Trust has a net sum of **£2.6m** to cover all other capital spend for the year. The Trust has sold the MGH MRI for **£0.96m** (NBV) under the outsourced contract, which was planned to support related enabling works for the new MRI at TWH. The cost of the enabling works has increased since the plan was set, but remains to be finally confirmed. The Division (Core Clinical) and Estates are working to confirm the plan for enabling works for both the MRI and CT held in storage in relation to the TWH site

- **Additional Funding**
    - **£22.47m** of national funding for the Kent and Medway Orthopaedic Centre project is included. The FBC was approved at the NHSE/DHSC Joint Investment Scrutiny Committee on 12th June 2023. The Trust also received PDC of **£121k** for digital diagnostics (iRefer) for 2023/24. Additional National funding has been received for an additional Breast Screening Ultrasound of **£95k**, an Interventional Radiology (IR) Suite at TWH of **£535k** and Digital Pathology of **£242k**.

- Further National funding has become available in 23/24 (from National CDC slippage) and the Trust has been successful in their bid for **£1m in 23/25** and **£0.5m in 24/25**. This funding means that the equivalent System funding can be released back to the ICB. In addition the Trust has determined that the maximum spend on the CDC in 2023/24 will be **£3.7m**. The Trust will receive £2m from System funds in 2023/24. The overall project has therefore slipped into 2024/25 and the current assessment is for an additional £3.5m requirement (£2m slippage from 23/24 plus up to £1.5m additional cost pressure from tender returns). The source of this capital in 2024/25 needs to be agreed with the ICB. The Trust was successful in bids from ICB System funding, but on the basis that this funding is brokered back in 2024/25. The successful bids are for an Ultrasound **(£100k**), Image Intensifiers (**£260k**) and laptops (**£200k**).

- **Other Funds**
  - PFI lifecycle spend per the Project company model of **£1.5m** - actual spend will be notified periodically by the Project Company. Donated Assets of **£0.4m** relating to forecast donations in year.

- **Month 7 Actuals (excluding IFRS16)**
  - The YTD spend at M7 is **£17.7m** against a YTD budget of **£29.7m**. The main variance relates to the KMOC project where the phasing information provided for the plan was based on commitments rather than actual spend, so the plan year to date is ahead of expected delivery. Forecast outturn spend remains on plan.

- **Leased/IFRS16 capital**
  - The Trust included **£29.48m** of potential IFRS 16 liabilities in its 2023/24 plan. This includes **£4.3m** of expected lease remeasurements arising from increases to the rental agreements from inflation clauses, that now require to be capitalised. The remaining **£25.1m** is for potential new lease capitalisations: the most significant is the KMMS accommodation which is expected to be a value of **£15.3m** assuming completion by the end of 2023/24. NHSE regional office has indicated that nationally Trusts have planned for more resource than HMT has allocated. Expected commitments will be funded in 2023/24 but where schemes are not in a position to complete in the financial year, or there is no actual financial commitment as yet, Trusts have been asked to provide a realistic outturn projection that removes assumptions of this funding. The Trust therefore adjusted its Month 6 outturn to a figure of **£21.64m**.

Year end Forecast:

- The Trust is forecasting to deliver the breakeven financial plan. To deliver the forecast the trust has developed a recovery plan which includes: Additional Income associated with ERF change of national targets (£4.4m), income to fund costs incurred as a result of the industrial action (£2m), Run rate improvements (£3m) and accruals and provisions review (£1.6m).

Oct-23		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RN/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	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	111.6%	107.6%	-	-	113.6%	117.7%	-	-	32.4%	52.4%	118	8.43	34	9.7	17.9%	90.0%	6	0		186,226	198,527	(12,301)
MAIDSTONE	Stroke Unit (M) - NK551	81.4%	86.7%	-	100.0%	89.5%	95.2%	-	-	31.1%	13.7%	296	20.66	60	8.7	188.2%	100.0%	6	2		368,908	392,504	(23,596)
MAIDSTONE	Cornwallis - NS251	188.8%	201.5%	-	-	94.6%	106.5%	-	-	9.0%	17.7%	84	5.14	10	16.1	55.3%	94.7%	2	0		-26,822	109,946	(136,768)
MAIDSTONE	Culpepper Ward (M) - NS551	101.8%	99.2%	-	-	101.6%	158.0%	-	-	31.6%	36.8%	15	1.03	1	5.5	0.0%	100.0%	0	0		118,416	123,274	(4,858)
MAIDSTONE	Edith Cavell - NS459	118.0%	98.0%	-	100.0%	109.3%	138.7%	-	-	31.1%	38.1%	51	3.49	9	6.7	10.7%	100.0%	4	1		121,085	146,038	(24,953)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	97.6%	98.6%	-	-	103.3%	121.0%	-	-	33.3%	10.8%	105	7.48	25	6.6	50.0%	100.0%	5	2		156,436	182,533	(26,097)
MAIDSTONE	Intensive Care (M) - NA251	89.1%	89.1%	-	-	88.8%	83.5%	-	-	9.8%	0.0%	70	4.90	18	102.0	433.3%	100.0%	5	0		240,066	237,669	2,397
MAIDSTONE	Lord North Ward (M) - NF651	96.4%	105.6%	-	100.0%	92.4%	93.8%	-	-	11.1%	0.0%	29	2.17	8	9.1	25.9%	100.0%	2	0		117,054	110,340	6,714
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	100.2%	34.9%	-	100.0%	62.9%	-	-	-	11.6%	0.0%	8	0.55	0	22.4	0.0%	100.0%	1	0		60,413	53,398	7,015
MAIDSTONE	Mercer Ward (M) - NJ251	103.5%	102.8%	-	100.0%	108.6%	145.2%	-	-	32.4%	37.8%	58	3.92	8	6.3	70.0%	100.0%	3	2		114,115	145,060	(30,945)
MAIDSTONE	Peale Ward COVID - ND451	88.2%	124.2%	-	-	97.8%	126.0%	-	-	17.2%	16.2%	60	4.21	18	8.8	42.9%	100.0%	4	2		124,265	111,033	13,232
MAIDSTONE	Pye Oliver (Medical) - NK259	130.2%	125.7%	-	-	147.8%	158.1%	-	-	60.6%	53.2%	138	9.81	15	8.1	13.3%	100.0%	5	0		135,990	174,171	(38,181)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	93.0%	92.0%	-	-	87.5%	-	-	-	22.9%	0.0%	30	1.69	2	59.4	0.0%	100.0%	0	0		59,953	56,279	3,674
MAIDSTONE	Whatman Ward - NK959	92.7%	114.2%	-	100.0%	108.6%	166.7%	-	100.0%	41.7%	45.9%	56	4.04	15	7.0	2.9%	100.0%	5	1		104,475	146,369	(41,894)
MAIDSTONE	Maidstone Birth Centre - NP751	99.3%	100.1%	-	-	104.3%	96.8%	-	-	8.8%	0.0%	24	1.24	1	32.8	0.0%	100.0%	0	0		77,570	90,047	(12,477)
TWH	Acute Medical Unit (TW) - NA901	102.0%	96.4%	-	100.0%	116.1%	131.5%	-	100.0%	37.2%	48.4%	204	14.61	50	9.4	10.1%	92.9%	5	1		254,957	278,905	(23,948)
TWH	Coronary Care Unit (TW) - NP301	94.8%	94.0%	-	-	96.8%	-	-	-	14.0%	0.0%	30	2.16	5	11.0	114.3%	100.0%	1	0		75,962	75,287	675
TWH	Hedgehog Ward (TW) - ND702	96.2%	107.7%	-	-	98.9%	180.6%	-	-	44.1%	40.5%	202	13.58	31	8.5	55.7%	96.7%	0	0		153,164	209,291	(56,127)
TWH	Intensive Care (TW) - NA201	98.9%	90.5%	-	-	99.3%	68.0%	-	-	2.7%	0.0%	39	2.18	8	34.1	2200.0%	95.5%	1	1		381,661	389,054	(7,393)
TWH	Private Patient Unit (TW) - NR702	101.5%	102.0%	-	-	95.2%	96.8%	-	-	24.2%	0.0%	36	2.28	4	8.4	73.7%	100.0%	0	0		73,468	77,958	(4,490)
TWH	Ward 2 (TW) - NG442	88.8%	85.7%	-	100.0%	100.0%	144.7%	-	100.0%	33.1%	6.5%	92	6.49	34	6.5	139.3%	89.7%	4	0		183,318	174,090	9,228
TWH	Ward 10 (TW) - NG131	112.6%	103.6%	-	-	98.4%	146.3%	-	-	27.5%	0.8%	75	4.88	17	12.7	12.0%	100.0%	2	1		149,847	164,717	(14,870)
TWH	Ward 12 (TW) - NG132	91.0%	95.6%	-	100.0%	90.3%	96.0%	-	-	20.4%	0.0%	93	6.08	22.00	6.2	36.4%	100.0%	9	1		149,950	172,236	(22,286)
TWH	Ward 20 (TW) - NG230	111.8%	144.2%	-	100.0%	133.4%	148.4%	-	-	58.7%	46.0%	202	13.86	36	8.8	43.4%	95.7%	7	0		176,689	216,143	(39,454)
TWH	Ward 21 (TW) - NG231	95.9%	120.4%	-	100.0%	104.6%	109.8%	-	-	16.9%	31.1%	98	6.57	31	12.4	28.9%	100.0%	7	0		152,563	163,435	(10,872)
TWH	Ward 22 (TW) - NG332	87.2%	151.3%	-	-	96.9%	168.3%	-	-	58.1%	40.8%	134	9.49	38	7.5	51.0%	96.2%	19	6		150,276	195,718	(45,442)
TWH	Ward 30 (TW) - NG330	87.6%	83.1%	-	100.0%	93.5%	118.2%	-	100.0%	40.8%	0.5%	151	9.70	41	6.1	3.8%	100.0%	7	4		128,507	174,480	(45,973)
TWH	Ward 31 (TW) - NG331	92.4%	106.3%	-	100.0%	93.5%	139.8%	-	-	30.0%	0.0%	137	8.73	28	6.7	14.0%	100.0%	5	0		142,604	183,002	(40,398)
TWH	Ward 32 (TW) - NG130	88.4%	107.2%	-	100.0%	94.4%	114.3%	-	100.0%	27.8%	0.7%	99	6.75	19	9.5	0.0%	100.0%	2	0		151,293	159,174	(7,881)
TWH	Ward 33 (Gynae) (TW) - ND302	90.8%	98.1%	-	-	100.0%	100.0%	-	-	38.7%	5.4%	72	4.66	11	7.7	12.2%	100.0%	1	0		102,927	103,534	(607)
TWH	SCBU (TW) - NA102	104.2%	144.9%	-	-	110.5%	58.3%	-	-	24.9%	4.3%	119	7.18	4	10.8	100.0%	100.0%	0	0		212,704	221,444	(8,740)
TWH	Short Stay Surgical Unit (TW) - NE901	82.4%	104.2%	-	100.0%	101.5%	96.8%	-	-	15.5%	0.0%	41	2.92	5	11.6	11.1%	100.0%	1	0		83,819	96,562	(12,743)
TWH	Surgical Assessment Unit (TW) - NE701	98.4%	100.0%	-	-	100.0%	100.0%	-	-	18.8%	0.0%	24	1.58	2	19.5	2.9%	92.3%	0	0		78,755	75,822	2,933
TWH	Midwifery (multiple rosters)	80.7%	63.1%	-	-	89.7%	84.0%	-	-	15.6%	3.4%	676	37.64	143	**13.4**	30.7%	98.1%	**0**	**0**		**867,289**	**896,770**	**(29,481)**
Crowborough	Crowborough Birth Centre (CBC) - NP775	53.3%	88.6%	-	-	53.2%	93.4%	-	-	14.8%	0.0%	58	2.94	4	225.3	7.1%	100.0%	0	0		113,851	91,646	22,205
MAIDSTONE	Accident & Emergency (M) - NA351	100.2%	93.0%	-	100.0%	102.0%	97.7%	-	100.0%	40.1%	37.4%	456	31.15	32	-	0.0%	87.5%	5	0		386,824	461,715	(74,891)
TWH	Accident & Emergency (TW) - NA301	101.9%	87.7%	-	100.0%	102.1%	92.0%	-	100.0%	39.6%	33.8%	429	29.72	25	-	8.3%	90.2%	5	0		416,455	476,986	(60,531)
																				Total Established Wards	6,545,033	7,335,158	(790,125)
																				Additional Capacity bed Cath Labs	57,909	47,757	10,152
																				Ward 11 (TW) Winter Escalation 2019 - NG144	0	-5,027	5,027
																				Other associated nursing costs	5,325,476	5,262,337	63,139
																				Total	11,928,418	12,640,225	(711,807)

RAG Key

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%

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly Maternity Services report **Director of Maternity**

The Quarterly Maternity Services report is enclosed.

It should be noted that a supplementary report has been submitted to the 'Part 2 'Trust Board meeting, as that report contains confidential information that is not suitable for the public domain.

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

- 'Main' Quality Committee, 08/11/23
- Executive Team Meeting, 14/11/23

Reason for submission to the Trust Board

Assurance.

Executive Summary

Summary of the background section

This report provides the Trust Board with oversight and assurance with regards to requirements of:

- Ockenden (2020) Immediate and Essential Action 1 (IEA1) which requires Maternity and Neonatal services to provide the Board a locally agreed dataset in line with NHSE Guidance, “Implementing a Revised Perinatal Quality Surveillance Model”(2020).
- Supports the requirement of Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) in year 4 and year 5
- Saving Babies Lives Care Bundle Version 3 to track and demonstrate implementation to the Trust Board. ‘
- This report also provides assurance and oversight to the Board regarding all perinatal deaths as per the requirements of CNST Safety Action 1

Summary - This report provides an overview of the following for July – September 2023

- Summary of Serious Incidents (SIs) declared for Maternity Services, with full reports in appendix **
- Number of Healthcare Safety Investigation Branch (HSIB) cases reported **
- Number of Perinatal Mortality Review Tool (PMRT) case reviews*
- Themes and Trends from all investigations and case reviews**
- Staff engagement and feedback including Safety Champion Feedback
- Patient feedback and engagement
- Progress in implementing Saving Babies Lives Care Bundle v3*
- Progress with maternity staff training*
- Progress with clinical workforce planning*
- CQC Inspection Visit
- Responses to Trust Board requests for information

*Clinical Negligence Scheme for Trusts (CNST) requirement **Ockenden recommendation requirement

Number of Internal SI's Declared - 4 cases (3 HSIB cases)

STEIS Ref	Clinical Area	Synopsis
2023/13520	Community	HSIB case – see below
2023/13938	Delivery Suite, TWH	Maternal ITU admission following laparotomy and ischaemic bowel
2023/14538	Delivery Suite, TWH	HSIB case – see below
2023/11750	Delivery Suite, TWH	HSIB case – see below

Number of HSIB reported cases – 3 cases

HSIB Ref	Clinical Area	Synopsis
MI-029821	Community	Maternal death at 6 days post birth
MI-030942	Maidstone Birth Centre	Early neonatal death
MI-034671	Delivery Suite, TWH	Baby transferred to tertiary unit for cooling following category 1 caesarean section for abnormal CTG

Number of HSIB reports received - 3 cases (full reports available in appendices)

HSIB Ref & summary	HSIB recommendations	Trust actions
MI-021504 – Baby born in poor condition following shoulder dystocia, transferred to tertiary unit for cooling	• No safety recommendations	
MI-022824 – Intrapartum stillbirth	• The Trust to ensure that a robust system is in place to ensure that missed ultrasound scan appointments are rescheduled in a timely manner.	• Review and update USS DNA pathway to ensure it is robust
	• The Trust to ensure that systems are in place to support staff to complete a thorough and timely clinical risk assessment when a mother telephones maternity triage in early labour to inform care planning.	• Review Maternity Triage telephone protocol to ensure thorough clinical assessment
	• The Trust to ensure that staff are supported to follow local and national guidance, undertaking CTG assessment of fetal wellbeing if mothers report a reduction, change or uncertainty about fetal movements in any clinical context.	• Review guidelines and protocols to ensure thorough clinical assessment on attendance when mothers report a reduction, change or uncertainty about fetal movements in any clinical context

Number of HSIB reports received - 3 cases (full reports available in appendices)

HSIB Ref & summary	HSIB recommendations	Trust actions
MI-022299 – Fractured neonatal skull and haematoma, following impacted head at caesarean section	• The Trust to ensure that CTG interpretation is carried out as part of an in person holistic clinical review to support decision-making and achieve a timely birth.	• Learning shared with staff • Reminders displayed on centralised monitoring system monitors
	• The Trust should ensure that staff are supported to recognise a changing clinical picture by confirming maternal and fetal wellbeing. This will enable them to prioritise the urgency of the situation	• Risk of working to out of date guidance on risk register • LMNS project to develop new guideline in progress, supported by MTW team • Case review included in fetal surveillance training day

Summary of PMRT - no cases reviewed in this quarter – Management report in appendices

Stillbirths and late fetal losses– number of cases	*Neonatal deaths – number of cases*	*Parents informed of PMRT review and invited to contribute their perspective/ concerns/ questions*	
	0	( )	
	Grading of care of the mother and baby up to the point the baby was confirmed as having died	*Grading of care of the mother following confirmation of the death of her baby*	*Cause of death*
Case			

All cases of perinatal loss continue to be reviewed to identify learning. The maternity team are increasing the focus on cases involving families with health inequalities and those who may have difficulties in accessing care.

Work continues to meet the recommendations of the Saving Babies Lives Care Bundle v2 and benchmarking has begun to meet additional recommendations from the newly published SBLCB version 3.

Themes and trends identified from all investigations (SI / HSIB / PMRT)

- To **use proformas** for Shoulder dystocia, PPH, Sepsis, Severe PET, Eclampsia and Neonatal resuscitation
- To **escalate** concerns for senior review
- To **report (InPhase)** all incidents which meet the trigger list criteria. The list is orange and in all ward areas. We want to encourage a healthy reporting culture.
- Prevent **information governance** breaches by checking that only correct documents are given to patients and printing is checked when taken from the printer

Staff Engagement

- **Staffing Matters**
- Challenges with sonography vacancies
- Changes made to CAU team to improve leadership structure
- Women's consultant vacancies with RCOG – locum started 31 July
- Sickness – focus on the importance of return to work interviews to establish trends and support staff
- Vacancies and turnover rate have increased slightly. Exit interviews encouraged to identify trends, most due to relocation or seeking promotion in other organisations.
- Positive recruitment events and staff in pipeline.

- **Staff Engagement & Welfare**
  - Staff encouraged to attend and contribute to Nursing and Midwifery and HCSW strategy via on line meetings
  - Women's Directorate plan to repeat listening events
  - Support for maternity staff involved in recent incidents and challenging cases provided by Directorate staff, PMAs and OD team. Staff report feeling supported

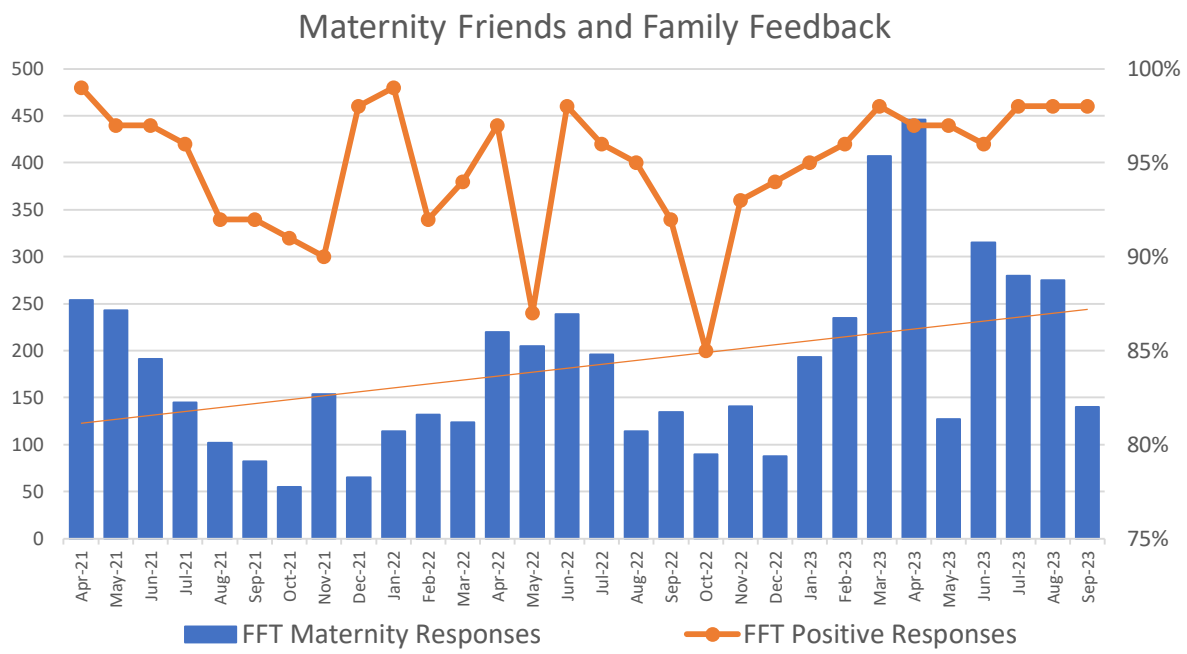
Safety Champion Feedback

- **Themes:**
  - Staff feel well supported by Matron and Band 7 at Crowborough Birth Centre (feedback to Matron and Band 7)
  - Acti-Prom needed for birth centres (this in currently being reviewed)
  - Collapsible stools for home births (purchased)
  - Staff feel well supported in Neonatal Unit (NNU)
  - Families feel well cared for in NNU

- **Actions:**
  - Positive feedback to Matron and B7 Team Lead at CBC
  - Use of POC for SROM being reviewed and birth centres will be included
  - Collapsible stools purchased
  - NNU matron received positive feedback

Patient Feedback and Experience

IQVIA – FFT total number and positive responses



Responses by ward/area

	April	May	June	July	Aug	Sep
Antenatal Ward	58	25	64	31	1	9
AN care TWH/MGH	29	5	21	16	34	9
AN care TWH/MGH	30	10	20	17	8	4
MBC	51	12	25	42	51	26
Community care AN	21	7	21	21	13	12
Community care PN	87	1	32	23	42	13
CBC	27	12	23	25	7	3
Delivery Suite	64	15	28	13	24	7
Triage	7	8	1	19	13	6
Homebirth	13	0	1	2	4	2
Postnatal Ward	56	31	44	38	25	48
W&C USS	27	1	35	33	53	1
Total	**470**	**127**	**315**	**280**	**275**	**140**

Patient Feedback and Experience

NHS Maidstone and Tunbridge Wells NHS Trust

Complaints summary: Jul – Sep 2023

First received	Current status	Subject	Sub subject	Nature of complaint
17 Jul 2023	Closed – Not upheld	Clinical treatment	Consent to second procedure	Concern that additional procedure was undertaken at time of caesarean section
31 Jul 2023	Closed – Not upheld	Consent	Patient care	Concern that epidural procedure continued after withdrawal of consent. Concern with monitoring during induction of labour and when wanting to push
09 Aug 2023	Closed - Upheld	Clinical treatment	Incorrect/ inappropriate clinical advice	Concern that CTG was misinterpreted which compromised the safety of the baby
11 Aug 2023	With directorate for investigation	Clinical treatment	Delayed / incorrect treatment / lack of information	Concerns raised with management of pregnancy given previous miscarriage and advice that a stitch would be placed, this was not. Concerns raised about antenatal care, whether scans were conducted at the correct intervals and what blood samples were being taken for. Concern that staff did not know the correct instructions for the use of the cold cot.
21 Aug 2023	Closed - upheld	Clinical treatment	Delayed investigations / tests	Concern raised that advice from the birth centre was not appropriate and that this lady was not listened to about her quick labour. This lady was not examined on two occasions and not offered admission. This lady went on to have her baby at home and was then blue lighted to TWH due to placenta complications. Relative feels that lack of examination was negligent.
22 Aug 2023	Awaiting signature	Clinical treatment	Inadequate pain management / Delayed investigations / tests / Infection risk/infection control / Discharge arrangements	Several concerns about maternity care provided, including that lack of monitoring resulted in category 1 emergency caesarean section. Concern that several member of theatres staff were not wearing masks. Delay and lack of pain and anti sickness medication. Contradictory information from postnatal staff and concern around discharge arrangements.
05 Sep 2023	With directorate for investigation	Communications	Lack of information provided (patient specific)	Numerous concerns with antenatal and labour and delivery which include lack of information provided, lack of pain relief, and long delays with midwives attending
05 Sep 2023	With directorate for investigation	Clinical treatment	Delayed treatment	Concern that delay with delivery of placenta prevented skin to skin contact. Concern that some placenta was retained which caused difficulties with bleeding post delivery and resulted in patient requiring antibiotics and D&C

Patient Feedback and Experience

CQC National Maternity Survey - 2023

- The Maidstone and Tunbridge Wells NHS Trust's scores are all positive, with the majority in the top-20% range of all Trusts surveyed by IQVIA.
- The highest score is for women having their partner, or someone close, being involved in their care as much as they would like during labour and birth.
- 26 scores are in the intermediate - 60% range and no scores are in the bottom-20% range.
- In particular, high scores are observed in Care in the hospital after birth.
- Compared to 2022, 40 scores have improved and 9 have declined.

Recommendation:
Share and celebrate the positive results from the survey with staff from the Trust and embed actions to continue positive performance.

Saving Babies Lives Care Bundle version 3 - oversight

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

- Element 1 – Reducing smoking in pregnancy
- Element 2 – Fetal Growth: Risk assessment, surveillance, and management
- Element 3 – Raising awareness of reduced fetal movement
- Element 4 – Effective fetal monitoring during labour
- Element 5 – Reducing preterm birth
- Element 6 – Management of pre-existing diabetes in pregnancy

Saving Babies Lives Care Bundle version 3 - oversight

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all Maternity and Neonatal services and is essential to achieving the National Safety Ambition. Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

Implementing Version 3 of the Care Bundle

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

A national Implementation Tool is now available on the Maternity Transformation Programme's Future NHS platform. The tool supports providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.

Saving Babies Lives Care Bundle version 3 - requirements

To reduce assurance burdens, national implementation surveys are being stepped down. Instead, to comply with Safety Action 6 of the CNST Maternity Incentive Scheme (Year 5), trusts are asked to use the Implementation Tool in 2 ways to ensure local oversight:

1. Track and demonstrate implementation to the Trust Board and ICBs. 'Full implementation' of the care bundle means completing all interventions for all 6 elements. Progress with implementation will therefore be expressed as a percentage of completed interventions for each element, and across all elements. To evidence adequate progress against this deliverable by the submission deadline for the CNST Maternity Incentive Scheme in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.

2. Holding quarterly quality improvement discussions with the ICB. These provider-commissioner discussions should include, at a minimum:
    - Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
    - Progress against locally agreed improvement aims.
    - Evidence of sustained improvement where high levels of reliability have already been achieved.
    - Regular review of local themes and trends with regard to potential harms in each of the six elements.
    - Sharing of examples and evidence of continuous learning by individual trusts with their local ICB and neighbouring Trusts.

Saving Babies Lives Care Bundle version 3 - preliminary assessment

MTW preliminary assessment

- The preliminary self-assessment for MTW was submitted on 25th September 2023 via the implementation tool, following benchmarking work by the leads for each element. The first quarterly review meeting with the LMNS is scheduled for the 10th October 2023.

- The summary below is based on the preliminary self-assessment, highlighting the gaps in current services at MTW and the level of impact relating to the interventions required. These represent those gaps which will have a higher level of impact and does not include those interventions that still require development though on a smaller scale (i.e. minimal pathway and guideline amendments)

- The bundle also has a significant increase in the requirement to provide assurance through new quarterly audits, rather than depend on reactive action to risk incidents. The data for some of these audits can be more easily extracted from E3. However, for those where the system is not up to date with capturing the field or not sophisticated enough to achieve complex nuances, manual audits will be required, demanding significant time and resource from the leads in post.

Saving Babies Lives Care Bundle version 3 impact analysis summary

Service / financial implication			
Element	Intervention	Description	Action required
2 - FGR	2.6 / 2.14	As part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy	Service wide procurement of validated digital BP monitors
2 - FGR	2.7 / 2.15	Women who are designated as high risk for FGR should undergo uterine artery Doppler assessment between 18+0 to 23+6 Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks	Implementation of alternate care pathway impacting, Obstetric risk assessment, fetal medicine and sonography service Training
2 - FGR	2.20	Opinion on timing of birth for foetuses with declining growth velocity and EFW >10th centile, where risk factors are present, should be made in consultation with specialist fetal growth services or fetal medicines services.	Implementation of alternate care pathway impacting fetal medicine service
3 - RFM	3.2	Women who attend with recurrent RFM to have USS by the next working day (unless has growth uss in previous 2 weeks)	Implementation of alternate care pathway impacting, Obstetric and sonography service
5 - Preterm	5.9	Symptomatic women for preterm birth require assessment using quantitative fetal fibronectin (qfFN) measurement	MTW currently use Partosure, pathway and procurement implication

Saving Babies Lives Care Bundle version 3 impact analysis summary

NHS Maidstone and Tunbridge Wells NHS Trust

Significant document reviews

Element	Intervention	Description	Action required
2 – FGR 5 - Preterm	2.17 / 5.6	Audit of guideline aligning to NICE guidance for risk assessment and management in multiple pregnancy.	NICE re-audit (round 3) of Antenatal care in twin pregnancies
2 - FGR	Multiple	Guideline pathways re: risk assessment, antenatal management and birth planning	GAP pathway review, guideline approval and roll out
5 - Preterm	Multiple	Guideline pathways re: risk assessment, antenatal management, birth planning and postnatal care	Preterm pathway review, guideline approval and roll out
6 - Diabetes	6.2 / 6.3	Women with type 1 diabetes should be offered real time continuous glucose monitoring. Method of objectively recording blood glucose level and pathways if glycaemic targets are not achieved	Pre-existing Diabetes guideline review, approval and roll out
6 - Diabetes	6.6	Guideline evidencing agreed pathways between maternity services and emergency departments and acute medicine for the management of women presenting with DKA during pregnancy	Maternity and Trust wide DKA guideline review, approval and roll out
Multiple	Multiple	Training Plan to align with Core Competency Framework Version 2 in relation to SBLCB version 3 training requirements	Review and approve updated training plan document

Saving Babies Lives Care Bundle version 3 impact analysis summary

Compliance with clinical care standards			
Element	Intervention	Description	Action required
1 - SiP	1.4	Percentage of smokers that have an opt-out referral at booking to an in-house tobacco dependence treatment service.	Minimum compliance 90% with action plan to meet stretch compliance 95% (current 86%)
1 - SiP	1.6	Percentage of smokers who set a quit date and are CO verified non-smokers at 4 weeks	Minimum compliance 50% with action plan to meet stretch compliance 60% (current 4%)
4 - FM	4.2 / 4.3 / 4.4	Percentage of women that had a risk assessment at onset of labour, hourly systematic review in labour and hourly 'Fresh Eyes' (4hrly for IIA)	Minimum compliance 80% with action plan to meet stretch compliance 95% Full audit in progress, preliminary results significantly lower that minimum standard

Saving Babies Lives Care Bundle version 3 impact analysis summary

Training compliance			
Element	Intervention	Description	Action required
1 - SiP	1.8 / 1.9	Annual very brief advice and CO monitor training	Minimum compliance 90% with action plan to meet stretch compliance 95% Compliance unknown, training requirement now annual
2 - FGR	2.11	Annual training compliance on the measurement of fundal height and recording and interpretation of result	Minimum compliance 90% with action plan to meet stretch compliance 95%
4 - FM	4.1	Annual training compliance on fetal monitoring	Minimum compliance 90% (current 60%, predicted 86% Dec '23)

The provision of this summary supports previous escalation of risk to achieving compliance with both the Three Year Plan objective and Maternity Incentive Scheme Year 5 target. It aims to support in the clear identification of the requirement and request of support for the MDT and specialists involved across varying aspects of the maternity service.

Sarah Mander-McGregor
Maternity Transformation Matron
3rd October 2023

Progress with Maternity Multidisciplinary Staff Training

Maternity specific training		Actions
Fetal surveillance	85%	Training plan in place to ensure all staff have had training and assessment and to ensure that all staff providing intrapartum care are up to date
Neonatal resuscitation (PROMPT)	92%	Training plan in place to ensure all staff have had training with predicted compliance 99% by end November
Emergency clinical skills update (PROMPT)	92%	Training plan in place to ensure all staff have had training with predicted compliance 99% by end November
GAP & Grow – e-Learning	68%	Targeted reminder to staff to complete annual updates (improvement on July)
GAP & Grow workshop	91%	Training plan in place to ensure all staff have had training (improvement on July)
Infant Feeding Annual Update	85%	

A robust schedule has been put in place to ensure compliance is maintained across the year with a new approach to booking staff for mandatory training for 2023.
The education team work closely with the governance team to ensure programmes are continually updated to reflect learning from incidents and good practice.
The Maternity service continues to find it challenging to support staff to fulfil the national training requirements, in addition to trust mandatory training, with an uplift of only 21% to meet training and other absence.
The education team find it difficult to book rooms in which to deliver training for the large groups which are required to fulfil all the training requirements for the MDT teams

Maternity Multidisciplinary Staff Training

Maternity Core Competency Training Plan October 2023

The following plan describes the training in place to meet the requirements of the Core Competency Framework Version 2

Training within the maternity department is coordinated by the Practice Development Midwives with training supported and delivered by a multi-disciplinary team including obstetricians, anaesthetists, neonatologists, fetal wellbeing and fetal surveillance midwives, clinical skills facilitators and specialist lead midwives.

Where applicable, training is offered to the multi-disciplinary team to ensure that those who work together, train together. This includes support workers and theatre staff who make a valuable contribution to the learning environment.

Maternity training is informed by local learning from incidents, audit, staff and patient feedback. The training teams work closely with the maternity governance team to ensure awareness of themes and trends. Training programmes are modified to include national updates and local outcome data is benchmarked against national and regional reports.

The table below describes how the requirements of each core module is met by the training currently offered.

Maternity Multidisciplinary Staff Training

NHS Maidstone and Tunbridge Wells NHS Trust

Core requirements must include training on:

Core Modules		Minimum Requirement	MTW Training
1	Saving Babies Lives Care Bundle v3	Smoking in pregnancy Fetal growth restriction Reduced fetal movements Fetal monitoring in labour Pre-term birth Diabetes in pregnancy	All staff required to access eLearning for Health on line SBLCB training programme. **Smoke free pregnancy**: All staff attend Very Brief Advice training annually CO monitoring training annually for all obstetricians, midwives and MSWs Enhanced NCSCT training for tobacco dependence advisors annually **Monitoring growth restriction**: GAP training delivered through workshops followed by completion of a competency document Annual updates included in Fetal Surveillance Training e-learning via Perinatal Institute website annually **Reduced fetal movements**: Element included in Fetal Surveillance Training Day to include local pathways/protocols **Fetal monitoring**: **Pre-term birth:** Included in Fetal Surveillance Multi-disciplinary Training **Diabetes:** e-learning for safe use of insulin (ELFH) (once only) e-learning: Diabetes in pregnancy (annually)

Maternity Multidisciplinary Staff Training

NHS Maidstone and Tunbridge Wells NHS Trust

Core Modules		Minimum Requirement	MTW Training
2	Fetal monitoring and surveillance	Risk assessment at start of and throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal monitoring- Electronic Fetal Monitoring EFM) Use of local case histories Be tailored for specific staff groups Multidisciplinary and scenario based Information about equipment Multiple pregnancies Psychological safety, civility and human factors	Fetal Surveillance Multi-disciplinary Training includes: Fetal Physiology Fetal monitoring, including Intelligent Intermittent Auscultation, Antenatal CTG, Intrapartum CTG and Risk Assessment Multi-disciplinary Case Reviews Fetal Monitoring Competency Assessment Staff have access to eLFH Fetal Monitoring modules to supplement their learning Multidisciplinary CTG case discussions are held weekly and are available for all staff to attend
3	Maternity Emergencies and multi-professional training – to include midwifery, obstetrics, anaesthetics, neonatal team as well as representatives from medical and critical care specialists	Locally identified training needs relating to emergency scenarios which might include: • Antepartum and Postpartum Haemorrhage • Impacted Fetal head • Pre-eclampsia/eclampsia severe hypertension • Uterine Rupture • Maternal collapse, escalation and resuscitation • Vaginal breech birth • Shoulder dystocia • Cord prolapse • Care of critically ill patient **Include:** - MEWS/NEWTT - SBARD - Structured review proformas - Deterioration and escalation thresholds	The Maternity Emergencies (PROMPT) Multi-disciplinary training is organised on a rolling 3 year programme to include each of the listed elements. These training sessions also cover: • sharing of local maternal and neonatal outcomes (including learning from in-situ simulation) including SIs • local data from Serious Incidents, Near Misses, Never Events or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others • learning from excellence case study • tailored learning for specific staff groups; including homebirth, birth centre teams/maternity support workers • principles of psychological safety, civility and human factors • in situ emergency scenario during PROMPT (on delivery suite)

Maternity Multidisciplinary Staff Training

Core Modules		Minimum Requirement	MTW Training
4	Personalised Care	Ongoing antenatal and intrapartum risk assessment with a holistic view from a woman's personal perspective, offering her informed choice • Maternal mental health • Vulnerable women and families - social factors requiring referral - families with babies on NICU • Bereavement care	The annual Maternity Mandatory Training day includes: • recognition, triage and care for women with mental health concerns in pregnancy delivered by the Mental Health Specialist Midwife • recognition, triage and care for women with safeguarding concerns in pregnancy delivered by the Safeguarding Lead Midwife • care for women and families following bereavement delivered by the Bereavement Specialist Midwife This includes information on local pathways and procedures to ensure face-to-face assessments and fast-track access to specialist perinatal mental health and safeguarding support services. Training also includes recognition of concerning 'red flags', particularly repeated referrals that should prompt urgent review. Staff are also required to complete the e-learning via the Personalised Care Institute which is available via the MTW-learning platform
5	Care during labour and the immediate postnatal period	• Management of labour • VBAC and uterine rupture • GBS in labour • Management of epidural anaesthesia • Operative vaginal birth – ROBuST • Perineal Trauma – prevention of and OASI pathway • Maternal Critical Care • Recovery Care after general anaesthetic	The Maternity Emergencies (PROMPT) Multi-disciplinary training is organised on a rolling 3 year programme to include each of the listed elements Additional workshops offer: • Operative vaginal birth • Focused workshops to support improved multi-disciplinary working and patient experience

Maternity Multidisciplinary Staff Training

Core Modules		Minimum Requirement	MTW Training
6	Neonatal Life Support	Identification of a baby requiring resuscitation after birth including: • Knowledge and understanding of the NLS algorithm • How to call for help within the organisation	The Maternity Emergencies (PROMPT) Multi-disciplinary training includes: • recognition of potential need for neonatal resuscitation • anticipation of risks and early communication between maternity and neonatal teams • recognition of the deteriorating newborn infant with actions to be taken Multidisciplinary simulation training opportunities encouraged, although currently limited In-situ skills drills held on delivery suite and birth centres to include neonatal resuscitation scenarios

Maternity specific training	Compliance Sept 2023	Actions
Fetal surveillance	**84%**	Training plan in place to ensure all staff have had training and assessment and to ensure that all staff providing intrapartum care are up to date
Emergency clinical skills update (PROMPT)	**70%**	Training plan in place to ensure all staff have had training with predicted compliance 95% by end November (new junior doctors and midwives have impacted compliance)

The Maternity service continues to find it challenging to support staff to fulfil the national training requirements, in addition to trust mandatory training, with an uplift of only 21% to meet training and other absence.
The education team find it difficult to book rooms in which to deliver training for the large groups which are required to fulfil all the training requirements for the MDT teams

Progress with clinical workforce planning

Workforce	Latest review	Progress with actions from Maternity incentive scheme Year 4	Additional requirements for Year 5
Maternity workforce	Nursing and midwifery workforce review June 2023	Requirements for increases in staffing have been identified and included in trust Nursing and Midwifery Staffing Business case. Report for 2023 BirthRate Plus assessment (funded by LMNS) received finalised	Recommendation to monitor midwifery red flags Consider raising the workforce uplift from 21%
Obstetric medical workforce	Audit of consultant attendance against Royal College of Obstetricians & Gynaecologists' recommended attendance in given clinical situations	Audit continues with work needed to improve data collection. Action required to improve evidence of evening attendance at MDT ward rounds	New standards for locum doctors and arrangements for compensatory rest following non-resident on call hours
Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations		
Neonatal medical workforce	Neonatal medical cover meets national recommendations		Workforce review between 30/5/2023 – 7/12/2023
Neonatal nursing workforce	Nursing and Midwifery Staffing Review – October 2022	Through safe staffing, agreement to staff and fund supernumerary B7 for neonatal Business case as part of business planning to meet Neonatal B6 neonatal nursing for BAPM recommendations	Workforce review between 30/5/2023 – 7/12/2023

CQC Maternity Inspection Visit

- The CQC inspection team visited the Maternity department at Tunbridge Wells Hospital on 23rd August. They met with a number of clinical maternity staff, specialist teams and senior leaders.

  The trust provided supporting evidence, as requested, relating to the safe and well led CQC domains.

  The service anticipates further visits to the Birth Centres at Maidstone and Crowborough.

- Following the inspection visit in August, the Trust was issued with a section 29a warning notice on 31 October 2023. The service is currently working through the details of this warning notice and developing improvement plans to address the concerns raised.

Additional information in response to Trust Board requests:

Mental Health Support following Pregnancy Loss:

There is currently one full time bereavement midwife position at MTW who will support any family who suffers pregnancy or baby loss >13 weeks gestation if they would like us to. This encompasses: late miscarriage, stillbirth and neonatal death.

Support for early miscarriage is managed by the team on Ward 33 – manager and bereavement midwife will do bereavement training for new nurses on the ward and refresher training. They signpost to support charities when meeting families experiencing early miscarriage.

We offer:

- Face to face support whilst an inpatient on W33 or Delivery Suite
- Phonecall support once discharged as often and for as long as the family wish (most commonly a few weeks but can extend to months or even a year)
- Offer referral to specialised baby loss counselling via charity funded projects (available for parents, extended family and other children via play therapy)
- Inform Parents of MH support available via GP referral and local support via self-referral
- Advise on local/national support charities/groups/forums/helplines
- Refer to MTW Thrive service if necessary
- Support through a pregnancy after a loss

Year	Number of families supported
2020	105
2021	91
2022	88
2023 (Jan - Oct)	69

Since January 2023, 20 families have been referred for specialist counselling

In line with the ambition of the Maternity & Neonatal 3 Year Plan, the maternity department are working on plans to extend the bereavement service to 7 days per week

Additional information in response to Trust Board requests:

Barriers to Breastfeeding

- A presentation about the barriers to breastfeeding among women who had chosen to is included in the appendices.

- The report identifies themes and describes the measures in progress or to be introduced to address them.

Summary of the recommendation/s section (incl. any action needed by the ETM)

- The report requests that the Board notes the detail of the report, the improvement actions in progress and the ongoing challenges
- The Board are requested to continue to offer their support to the maternity services to meet the safety actions for the Maternity incentive scheme, year 5, fully implement the Saving Babies Lives Care Bundle, version 3 and deliver the requirements of the Maternity and Neonatal Three Year Delivery Plan

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Report Identifying the barriers to continuation of breastfeeding

Sally Sidhu Infant feeding lead

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Method of Investigation

I wanted to discover the barriers to breastfeeding in a cohort of parents who have recently birthed with MTW's maternity service.

These parents expressed a wish to breastfeed but were unable to meet their goals.

In order to comply with IG, a post was placed on the maternity Facebook page requesting that parents who had intended to breastfeed, but not been successful in reaching their breastfeeding goals, could contact the infant feeding team to discuss.

Most of the parents interviewed were able to identify the contributing factors easily

Reason	Theme
Told my baby had a tongue-tie straight after the birth so I didn't feel it was going to be possible	Incorrect advice
I asked for help but was made to feel like it was a lost cause	Incorrect advice and lack of antenatal education to empower
Didn't like the sensation	Personal preference
Not told to express early or frequently enough, my baby was in NNU	Incorrect advice/ lack of support
Couldn't wait for TT appt on NHS, couldn't afford to go private	personal preference
Perceived insufficient milk supply	Incorrect advice
Sore nipples, milk not in at 5days old, weight loss of 12.5% day 5, baby incorrectly positioned at the breast	Lack of support and antenatal education
Person felt NCT Antenatal classes gave unrealistic goals, so gave up	Incorrect advice/ lack of support and access to NHS antenatal education
No free (NHS) antenatal classes available in the area, didn't have access to lap top for online class	Lack of support/ no access to antenatal education

Baby was at risk (TC) pathway, I had to give what seemed like lots of formula to try to make sure my baby didn't lose weight so that we could go home. I tried to hand express but felt so stressed as I was only getting small amounts, nowhere near enough to keep up with the amounts that my baby needed.	Lack of support
No sign posting to community support, didn't read the postnatal ward information e-mail (? Went to spam)	Lack of support antenatal education
Unable to breastfeed due to canula position, student midwife told me it was too late to try, so I moved to formula	Incorrect advice/ lack of support
Inconsistent advice as to when to feed in hospital and community	Incorrect advice/lack of antenatal education to empower
lack of support for feeding in general. UK needs standards to ensure tongue tie assessed early so that everyone has the opportunity to breast feed successfully.	Lack of support
No support at night on postnatal ward, I rang the buzzer no one came, next day infant feeding team came, but I'd already lost my confidence	Lack of support
My baby was born on Friday afternoon by C-section, no one from the infant feeding team works at nights or weekends	Lack of support

Judgemental attitude of staff	Cultural factors
Wasn't sure what to expect although midwives very helpful but busy. If I'd have an antenatal class to go to I would have felt better prepared maybe	Lack of support
I did an online class, but had a traumatic birth and didn't feel able to breastfeed as I felt shell-shocked and wanted to talk to someone about this first, but everyone was too busy	Birth trauma, lack of support
Staff were 'hands on' didn't use models to help teach me about how to breastfeed, I felt uncomfortable – it wasn't pleasant	Incorrect support
I had a PPH, felt exhausted, my milk didn't come 'in' when I expected, and my baby lost too much weight, I didn't know that this can happen after PPH, I felt very, very guilty at the time, like I'd starved my baby.	Lack of support, incorrect advice, poor access to antenatal education
I had an unsuccessful breastfeeding journey first time around and wanted to try this time, but felt too 'triggered by events, i.e. hand expressing was so difficult as it reminded me of my first experience and how traumatised I felt. I decided to bottle feed. I'm very glad I did	Past trauma affecting current experience, effect of recent pandemic
My partner felt left out and he felt that breastfeeding was tiring me out and stressing me	Cultural factors, lack of access to antenatal education

I felt uncomfortable feeding in public	Cultural factors
I found out at 2 weeks post birth that I was going to have to go back to work earlier than expected due to financial reasons and my place of work has no facilities for expressing and storing breast milk	Cultural/ workplace reasons

Identification of Causative Themes

The tables on the preceding slides represents the information elicited by the exercise. Consequently, I was able to identify themes, ranging from lack of support to cultural factors to unaddressed birth trauma, to being given incorrect advice and lastly to a lack of access to face to face antenatal education about breastfeeding

These themes also echo the themes of other similar studies carried out in recent years.

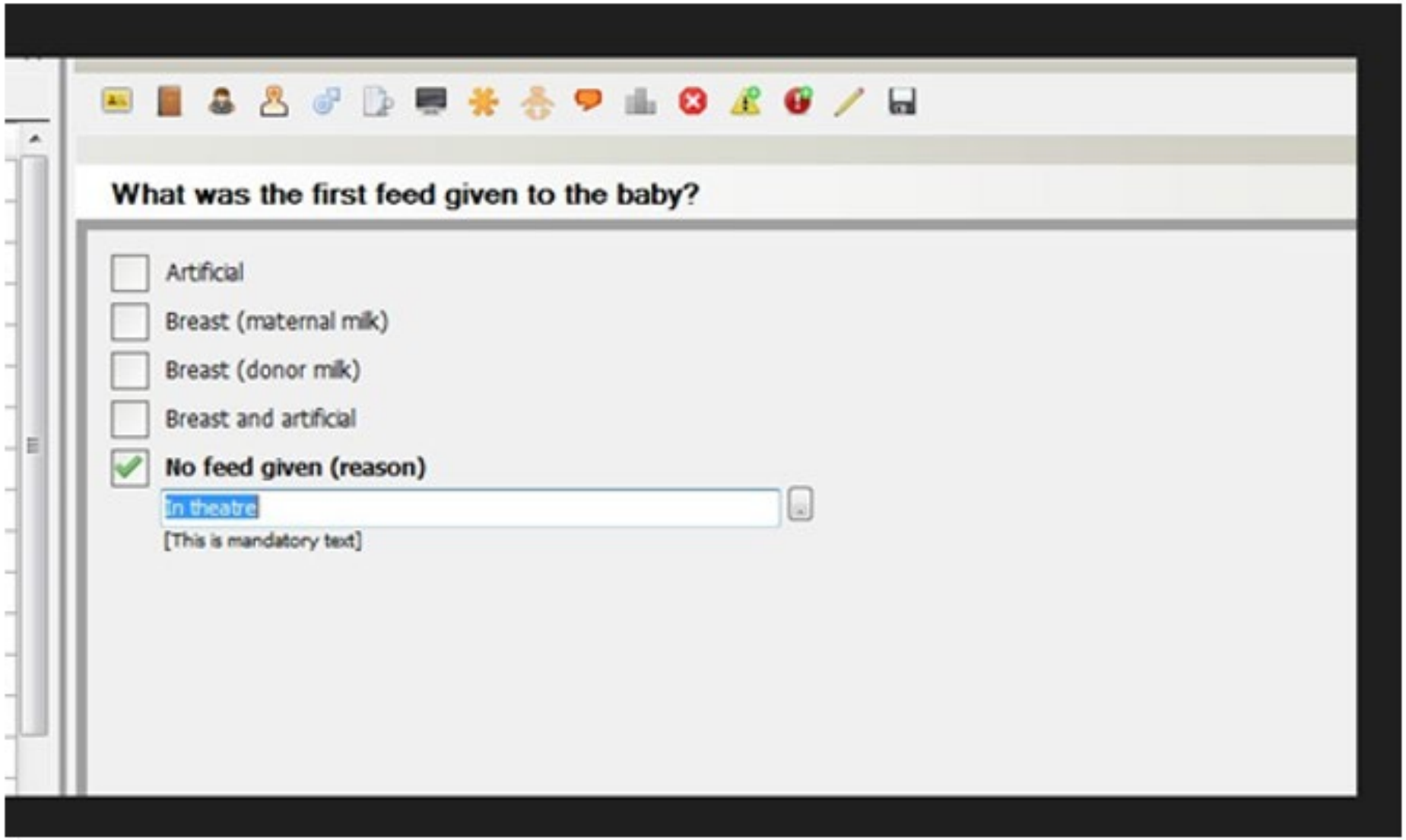
I have full confidence that following action plan will mitigate these barriers.

Putting the information Gathered into Context

To put this information in to context, I should explain that all the service user feedback in the table was taken from the 12 parents who have replied to an MTW Maternity Facebook post. Some parents were experiencing multiple issues, and some issues common to more than one parent.

Some issues highlighted by the group occurred in in a previous pregnancy, but in fact affected the more recent pregnancy as well.

The recording of first feed data is often incorrect by as much as 10% according to a national report mentioned at a recent NHS Long-term plan BFI meeting. Our own data from E3 may be somewhat inaccurate, as the first feed question on E3 requires staff to return to the questionnaire to change the answer once the baby has fed, if a first feed did not occur on delivery suite, see next slide


What was the first feed given to the baby?
Artificial
Breast (maternal milk)
Breast (donor milk)
Breast and artificial
No feed given (reason)
In theatre
[This is mandatory text]

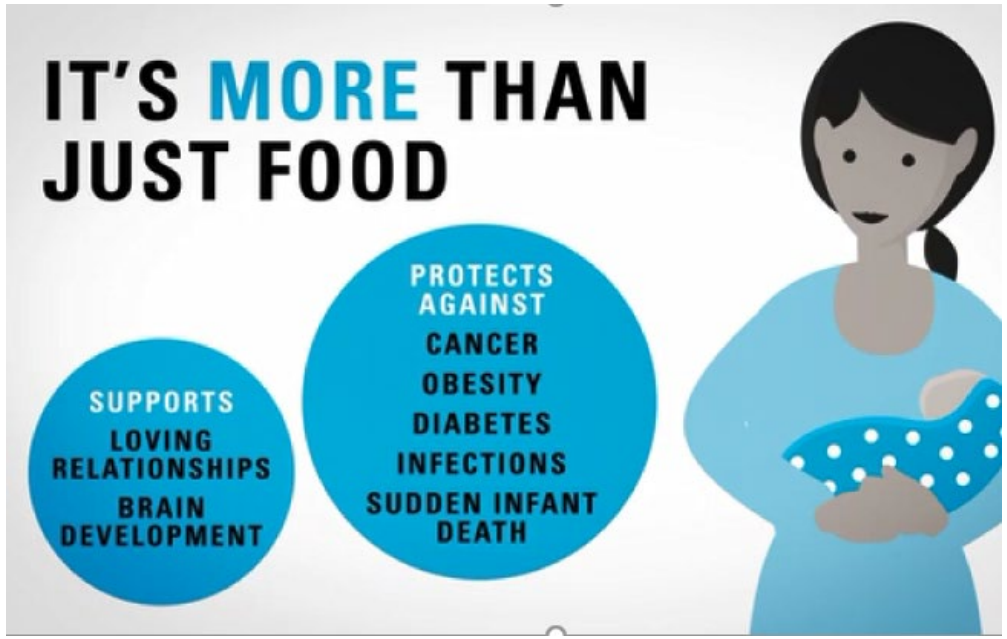
Barrier	Action
First feed data inaccuracies	• Ensure accurate record keeping on maternity IT system E3, by including reminders regarding this on mandatory staff training, trust social media pages & staff bulletins
Gaps in maternity staff knowledge leading to incorrect advice being given to parents	• Staff to repeat Infant Feeding and relationship building study day every 5 years • Staff identified as regularly giving incorrect advice by In Phase system or other, to repeat the above study day sooner. • Infant feeding team to conduct ad-hoc micro-teaching sessions when possible • Monitor staff compliance with all mandatory infant feeding monthly • Ensure that the PNU is staffed correctly at all times • Open door policy for Infant feeding team to support maternity staff who support infant feeding face to face and via telephone when on duty

Lack of breastfeeding support	• Recruit and train Breastfeeding peer supporters to support the infant feeding team. Peer supporter are people who have a special interest in breastfeeding and befriending new mothers to support them in learning about how breastfeeding works are able to encourage and build confidence as they have fewer time constraints that regular maternity staff • Expand the infant feeding team to enable 24 hours, 7 day per week cover in future to increase availability of expert support and advice • Ensure that at discharge all parents are reminded of the infant feeding support available in the community and to open the discharge email sent to every parent who births within or trust • Ensure all staff are equipped to sign post parents to all breastfeeding support available including antenatal education, postnatal drop ins, free e-learning resources etc by including this information on MTW social media, MTW website, on staff mandatory breastfeeding study day and yearly updates, using posters and barracudas in all maternity patient areas and highlighted to parents on discharge from hospital via email.

Minimal access to Breastfeeding Parent Education antenatally	• Continue to run virtual antenatal breastfeeding information classes for those who are unable to travel to face to face classes • Commence face to face antenatal breastfeeding information classes in each trust geographical area according to need i.e. weekly in TWH and MDG and monthly in CBC • Encourage CMWs to identify parents who have experienced an unsuccessful or traumatic breastfeeding journey and refer to the infant feeding team at MTW or the specialist lactation service at KCHFT • CMWs to use antenatal meaningful conversations to encourage parents to use the free breastfeeding parent education e learning, available on the MTW maternity website • Parents to be directed to LMNS Solihull antenatal online classes on Bump, Birth and Beyond website, by CMWs. Link to be added to Antenatal notes, hard copy or electronic.

Encourage a breastfeeding friendly culture at MTW	• Instigate Breastfeeding and New-born cafés – already running at MBC and CBC, we need locate a venue for a Tunbridge Wells café • Infant feeding team to continue to work with MTW Well-being team to install 'My pods' expressing and breastfeeding rooms for MTW staff to use on return from maternity leave. • Ensure that staff who go on maternity leave are aware that they must negotiate this with their line manager prior to their return – employment law • Continue to work towards BFI accreditation, sustainably with the support of BFI Guardian Chief Nurse Jo Haworth. • Ensuring that the entire trust, including the general wards are aware that mothers and babies of under a year of age should not be separated, instead viewed as a 'dyad'. Infant feeding team will work with Comms dept. to communicate this to wider trust using social media, intranet and celebration weeks. • The infant feeding policy is a trust wide policy, infant feeding team and Comms dept. to highlight this.

Lastly, the infant feeding team, postnatal unit and transitional care (TC) ward are working collaboratively with our neonatologist colleagues to reduce the large volumes of feed currently required by premature babies and SGA babies on TC pathway.
We fully expect that this step will help to increase our breastfeeding rates and increase parents' confidence in breastfeeding



To approve the 'Nursing and Midwifery strategy 2024-2027' **Chief Nurse**

The Trust Board is requested to review and, if appropriate, approve the Nursing and Midwifery Strategy for 2024 - 2027.

The report was discussed at the People and Organisational Development Committee on the 24th November 2023 and has been subsequently amended to reflect both the comments received at the People and Organisational Development Committee and the comments received at the Executive Team Meeting on the 7th November 2023.

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

- Executive Team Meeting, 07/11/2023
- People and Organisational Development Committee, 24/11/2023

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

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

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Our nursing and midwifery strategy 2024 - 2027

Skilled, kind and proud

Foreword

I am enormously proud of all your contributions. The commitment and care provided by our nurses, midwives, nursing associates, healthcare support workers and maternity support workers makes a huge difference to people's lives every day.

With the engagement of our workforce, this strategy has been developed to take us forwards, building on all that we have achieved in the last few years. It builds on our strengths and lays out our shared aspirations for the future.

It sets out the vision for the nursing and midwifery workforce and outlines how we will continue to contribute to the Trust's overall vision of 'Exceptional people, outstanding care.'

Whilst developing this strategy, our teams have identified a number of themes which will support our nursing and midwifery staff to be 'skilled, kind and proud'. This will be our framework for delivery.

Increasing demands on the NHS have created the need for strong leadership, innovation and resilience. This strategy and the associated ambitions aim to empower our nursing and midwifery professions to ensure there is a strong professional voice in the Trust, alongside a well-developed culture of professional accountability that delivers excellent care to patients and families.

To deliver this ambitious strategy, we will ensure our workforce are given the right tools to consistently be **'skilled, kind and proud'**, supporting us to provide outstanding care for our patients.

Skilled

We will maintain and develop our professional competencies to deliver safe, skilled and effective care.

Kind

We will be kind and compassionate to the patients and families we care for and be kinder to our colleagues and each other.

Proud

We will be proud of our professional voice and be empowered to speak with authority on matters that affect our patients and our professions.

Whatever your role in our nursing and midwifery workforce, this is **your strategy.**

Jo Haworth Chief Nurse

In writing this strategy, *when we refer to nursing, midwifery workforce or team we are including nursing associates, maternity support workers and healthcare support workers.

*When we use the term 'patients', we are including all service users.

Who we are

Maidstone and Tunbridge Wells NHS Trust provides a full range of general hospital services, alongside some specialist complex care to around 760,000 people living in West Kent and parts of East Sussex.

It also provides specialist care to a wider population including specialist cancer services to around 1.9 million people in Kent, Medway and East Sussex.

We are honoured to have a diverse workforce with a broad wealth of experience and working with the wider multi-disciplinary team, the Trust would not function without the contributions you make.

The commitment, dedication and resilience you demonstrate in response to the needs of our communities is truly valued.

Our nursing and midwifery workforce make up the largest part of our total workforce with a vast scope of practice, and have a significant impact on patient outcomes and experience.

Our nursing and midwifery team in numbers:

Correct as of 1 November 2023.

These numbers are a snapshot of our team and not a full dataset. In line with the Equality, Diversity and Inclusion Strategy and the People and Culture Strategy we will create an environment where our staff can develop, thrive and bring their whole selves to work.

What it means to be part of the nursing and midwifery workforce

As part of the nursing and midwifery workforce at MTW our expectations are:

We act in accordance with the NMC code of professional practice*

We are committed to delivering outstanding care through high standards of professional practice, trust and compassion

We are patient-centred ensuring a personalised and shared approach to care, listening to patients and their families and involving and empowering them in decisions about their care

We practise effectively, safely and safeguard against harm

We are patient-focused and person-centred ensuring our part in reducing health inequalities, promoting health and preventing illness

We seek feedback for continuous quality improvements

That you are accountable to others as professionals representing the organisation and working in accordance with Trust values

*The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates; Nursing and midwifery council.

Our commitments are:

- You will be supported with your personal development. We want everyone to reach their full potential
- We will embed a psychologically safe culture where staff feel safe to speak out and feel that their voices are heard
- You will be supported with your health and wellbeing
- You will experience an equitable and inclusive culture
- We will empower you to continuously improve the care we provide
- We will continuously improve practice through research and audit

Introduction and context

To deliver our clinical strategy, service developments and a sustainable workforce built for the future, we need to transform our nursing and midwifery workforce. We'll do this by continuing to introduce new and advanced roles, a strong pathway of succession through apprenticeship routes to practice and adopting new ways of working, including the use of advanced technology (such as patient apps and artificial intelligence).

Through clear leadership and a passion for excellence in professional practice, we will continue to improve service delivery, and deliver high-quality, safe care, meeting the changing needs of the communities we serve.

The commitment and investment to get the right combination of numbers and skills of nurses and midwives across services has been recognised and this will continue through increasing student placement capacity, ongoing workforce planning and a focus on retention. There will be ongoing support and investment in professional standards, valuing all roles and responsibilities in the wider workforce.

We are already delivering successful nurse-led clinics which is a clear strength, as well as presenting further opportunity to play a vital role in the future care of our patients. Within the nursing and midwifery workforce there are established roles in research and education which promotes advancement in clinical practice and influential roles for nurse and midwifery leaders across all disciplines.

In the lifecycle of this strategy, we will be working as a system, with pathways of care crossing organisational boundaries. This provides an opportunity for staff development and shared posts with our partners. As a major employer in the system (an anchor organisation), we will strengthen the pipeline of local recruitment and offer development posts to our local communities.

Our patients are presenting with increasing comorbidities and complexity, including both mental and physical health needs. We need to respond to ensure that our staff are confident and competent to meet these needs.

With the ambition to develop an academy of professional practice, we will offer more education and training internally and design competency frameworks that cover generic roles and specialised posts.

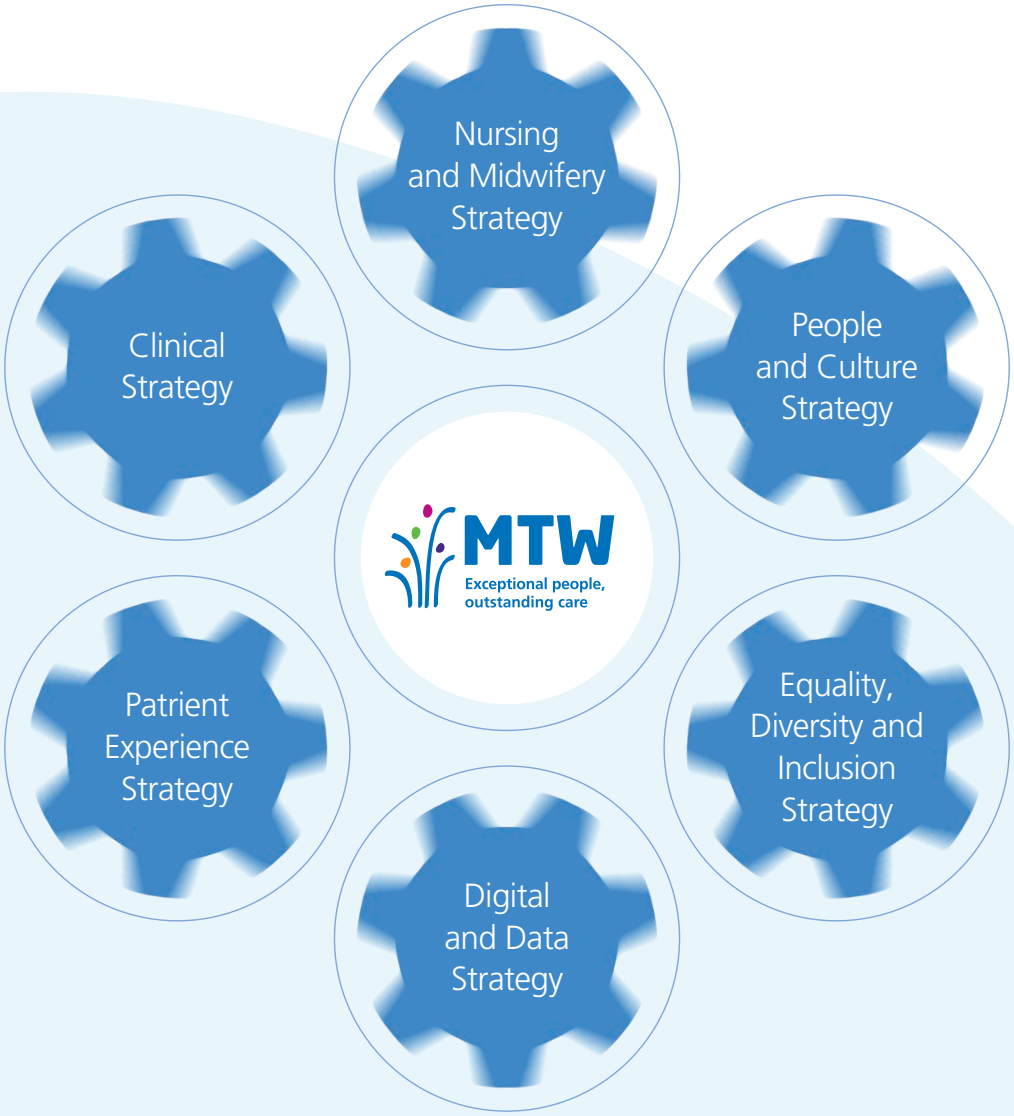
Our new nursing and midwifery strategy places importance on research and development, continuous improvement, digital literacy and innovation in practice, while continuing to champion the fundamentals of nursing and midwifery practice - including emotional care and acts of kindness that support our patient's recovery and wellbeing.

With your help we've created a strategy that identifies key areas of focus and improvement, that build on our current strengths and develops our people to ensure we provide the best care to patients.

Thank you to everyone involved and for your ongoing dedication to our patients, their families and our colleagues.

How this strategy aligns

The ambitions within this strategy are underpinned by our values and will support the delivery of the Trust vision and strategic themes. It interconnects with and supports other strategies as shown below:



This strategy is supported by the nursing and midwifery workforce plan, which details the deliverables to secure a healthy pipeline of new recruits and succession plans.

The workforce plan outlines how roles can be adapted to ensure people are working to their maximum potential within their scope of professional practice. This links to the medical workforce strategy and clinical strategy which recognise the valuable contribution of nursing and midwifery advanced roles in the future of healthcare.

We will work with the divisional triumvirates to align development priorities with service developments.

Our strategy is also aligned with current and emerging national strategies from the Chief Nursing Officer (CNO) and Chief Midwifery Officer for England, and our local workforce plan is consistent with the NHS Long Term Workforce Plan, which sets out our detailed plan to train, retain and reform.

What we are proud of

We asked you what you felt were our strengths and what you are proud of.

A culture of compassionate and safe care

With increasing demands on health and social care, alongside our patient needs and expectations, demonstrating compassion is more important than ever.

MTW strives to be an organisation from which our patients know they can expect high quality care and compassion, and one that our people are proud to be part of. Key to this is a culture of respect and inclusion.

To enable our people to provide compassionate, safe care, we must focus on creating a supportive environment that empowers our nursing and midwifery staff to consistently deliver in a person-centred way. We will do this with a culture of coaching, time for structured learning, and mindful and reflective practice.

By valuing diversity, experience and talent, we will ensure that the right capacity and capability is present for every shift. This will allow us to consistently deliver person-centred care by a team who are skilled, kind and proud.

All of our people are leaders in their own way, and take responsibility for ensuring that practice is safe and current. This involves 'looking up and out' by learning from others both inside and outside of the organisation, which will inform and improve professional standards of practice.

We will strive to embed a culture of psychological safety where staff feel safe to speak out and share their ideas for improvement. Engagement with our workforce is vital to ensure staff feel safe, listened to and are enabled to make improvements to care and their own work environments.

Through the development of a nursing and midwifery shared governance model, we will strengthen the professional voice in the care provided, enabling shared decision making between HCSWs, nurses, midwives and leaders. There will be an increased presence of nursing and midwifery leadership to observe practice, consider nurse and midwife sensitive indications (hard and soft data) and monitor patient experience and excellence in nursing and midwifery professional practice. We will develop a balance of widely recognised indicators, things that matter to patients and things that matter to staff.

All of our people are leaders in their own way, and take responsibility for ensuring that practice is safe and current.

Working together, we are skilled, kind and proud

Skilled

We maintain and develop our professional competencies to deliver safe, skilled and effective care

Kind

We are kind and compassionate to the patients and families we care for and we are kind to each other

Proud

We are proud of our professional voice and speak with authority on matters that affect our patients and professions

The strategic aims and priorities you identified for the next three years are:

Skilled

Enable a diverse, skilled, sustainable nursing and midwifery workforce

Deliver excellence and innovation in professional practice

Kind

Maintain high levels of positive patient experience and involvement

Embed Trust values and behaviours that foster psychological safety and kindness to one another

Proud

Celebrate the professions through accessible knowledge sharing and engagement

Promote excellence in nursing and midwifery leadership and be a respected professional voice

The actions and developments for each objective are detailed on the following pages. They are not independent of one another, and key activities will drive improvements across several themes.

The strategy will be implemented through annual delivery plans, and timelines will be informed by our strategic foundations, alongside the clinical strategy, people and culture strategy and professional priorities.

Skilled

Objective: | We will deliver this by: | The results will be:

2024 → 2027

Strategic theme 1: Enable a diverse, skilled, sustainable nursing and midwifery workforce

• Informed by the clinical strategy and models of care, we will deliver the workforce plan and adopt a strategic approach to workforce design along pathways of care to ensure a safe and productive skill mix	• Introducing advanced roles and new roles • Aligning with the medical workforce plan to increase the number of advanced clinical practitioners, including consultant practitioners • Reviewing the future pipeline and increasing the number of apprenticeships and student placements • Working with schools and colleges in our areas • Clarifying roles to ensure maximum time to care and a person-centred experience	• MTW is an employer of choice • Strong pipeline of nurses, midwives and advanced clinical roles • Improved patient experience • Safe staffing levels maintained • 10% of traditional medical roles filled with non-medical alternatives • Improved staff retention • Improved Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data in nursing and midwifery • A workforce that is responding to local health needs • More diverse and representative workforce • Inclusive values-based recruitment and talent management practices • Trained nurses and midwives to deliver the service developments in the clinical strategy • Improved student experience • Increased numbers of staff with qualification in specialty or similar
• We will deliver an inclusive approach to talent management including clear career pathways for all	• Introducing a professional practice framework of competencies from preceptorship, through to generic roles, specialist and advanced roles (with a new competency passport) • Introducing individual career conversations for all of the nursing and midwifery workforce • Developing a Chief Nurse fellowship offering rotational programmes for aspiring senior leaders. • Ensuring all staff have educational opportunities to support them in practice • Strengthening the current process of learning needs analysis. • Investing in the infrastructure for learning including practice development nurses • Delivering interview training and support for individuals in the recruitment process	
• Launch an academy of professional practice with partners, providing accredited programmes and courses for internal staff as well as develop commercial opportunities in partnership with others	• Increasing number of accredited courses we offer internally (balance of on-the-job and university learning) • Develop new partnerships with regional universities • Working across the Trust to develop multi-disciplinary learning and embedding our organisational culture • Focusing on profession's equality of opportunity	

Objective:	We will deliver this by:	The results will be:
2024 → 2027		
• Strengthen the enhanced care team support for patients with mental health and learning disabilities	• Designing and delivering a skills development programme to equip staff with the confidence and competence to support this patient cohort • Developing a head of mental health	• Improved patient experience for people presenting with mental health and learning disabilities
Strategic theme 2: Deliver excellence and innovation in professional practice through education and professional development		
• Increased level of nursing and midwifery research across inpatient and community	• Increase the awareness and accessibility of research, including training on research methodology • Creating a research forum to recognise good practice and build an evidence base • Developing a journal club to support staff with an interest in research • Exploring opportunities to develop clinical academic posts • Developing a framework to support staff to publish papers in journals, at conferences etc. • Working with the Quality Improvement (QI) team to implement key findings and high-impact outcomes	• Improved performance and outcomes • High-quality care • An organisation that is always learning • A dashboard that demonstrates nurse and midwife sensitive indicators • Improved reputation as a high-quality and, research-focused organisation • Shared governance will improve quality of care and experience and reduce risk • Patient-centred care
• Review of best practice and learning from others through QI and Innovation	• Reviewing the use of technology in practice including artificial intelligence and patient apps • Developing digital literacy and data analysis competencies • Embedding data quality principles to enable change	
• Focus on consistent quality of nursing care fundamentals and standards, such as infection prevention control	• Introducing a ward accreditation programme • Running bite-size masterclasses of learning and education for basic nursing care • Core competencies refined to include Nursing and Midwifery Council (NMC) code and skilled, kind and proud principles • Align clinical educators to drive high impact action for improvements and culture change	
• Introduce a shared governance model for the nursing and midwifery workforce	• Developing a dashboard of nurse and midwife sensitive indicators • Involving staff at the bedside in shared decision making about the care of the patient and improvement initiatives by building on 'patient first' • Using the professional voice to advise on standards and experiences	

Kind

Objective:	We will deliver this by:	The results will be:
Strategic theme 3: Maintain high levels of positive patient experience and involvement		
• Put the patient at the centre of the care we provide and deliver the patient experience strategy	• Continuing to implement the Patient First Improvement System (PFIS) i.e. letters to loved ones, protected meal times etc. • Consistently asking ourselves what matters to the patient and their family • Learning from compliments and complaints • Learning from how we communicate and inform our patients • Focusing on embedding personalised care in all areas of the organisation	• Empowering patients to make decisions about their care • Improved outcomes and recovery • Improved friends and family scores • Patients will be key partners in service improvements and quality governance • Reducing health inequalities • Choice and voice
• Improve our levels of co-production and patient engagement	• Embedding patient involvement and co-production in service development and new patient safety principles • Taking regular patient stories to the Nursing, Midwifery, AHP and Pharmacy Board • Introducing patient service training and patient experience roles	
• Recognise our volunteers as a key part of patient experience	• Providing training programmes and career opportunities targeted at volunteers • Holding engagement and inclusion forums to hear from this cohort of support in terms of nursing and midwifery practice	
• Support the health inequalities agenda through inclusive practice and system working	• Aligning with the people and culture strategy to embed inclusive cultures • Having a lead in the system networks for nursing and midwifery across partnerships • Recognising and celebrating religious festivals and adapting processes and practice respectful of an individual's beliefs and requests	• Open culture of providing feedback and sharing ideas • Pipeline for recruitment • Improved quality and experience

2024 → 2027

Objective:	We will deliver this by:	The results will be:
Strategic theme 4: Embed Trust values and behaviours that foster psychological safety and kindness to one another		
• Strengthen collaboration across multidisciplinary teams (MDT) with new and extended roles	• Multi disciplinary learning and reflective practice • Multi disciplinary decision making, huddles, handover and audit • Sharing understanding of roles and responsibilities through team sessions • Working with Medical Education to support multi-professional learning from novice to expert	• Collaboration and respect across MDT • Increased focus on health and wellbeing, improving staff experience • Improved retention • A just culture • Safe to speak out • Learning culture • Psychological safety
• Schedule a plan of staff listening and engagement events	• Building on existing listening forums, to ensure all voices are heard • Specific target groups and forums to understand and improve experiences and monitor safety	
• Strengthen the support framework for the nursing and midwifery workforce	• Working with People and OD colleagues to develop a structured approach to staff support using debrief tools and restorative and group supervision • Developing a plan to ensure sufficient mentorship opportunities are available • Strengthening the number of safe space champions in the workforce. • Increasing the numbers of trained Professional Midwifery Advocates and Professional Nurse Advocates by 2025 • Encouraging attendance at Schwartz rounds • Ongoing accessible wellbeing activities	
• Focus on inclusivity and respect of difference	• Cultural awareness training • Listening to the experiences of IENs and IEMs (and other staff network groups) • Embedding an IEN and IEM council	

2024 → 2027

Proud

Objective: | We will deliver this by: | The results will be:

2024 → 2027

Strategic theme 5: Celebrate the professions through accessible knowledge sharing and engagement

- Take a structured approach to sharing stories and successes, helping us all to develop and learn

- Holding an annual conference for the nursing and midwifery team
- Hosting an annual graduation event to celebrate all the successes of our workforce
- Developing a nursing app and intranet hub to share stories, successes and drive key educational messages and current topics of focus and priority
- Encouraging access to external learning and networks (e.g. membership to the Florence Nightingale Foundation)
- Developing an online welcome handbook for nursing and midwifery staff
- Holding nursing and midwifery grand rounds
- Celebrating our workforce by submitting entries to national awards e.g Nursing Times, HSJ
- Supporting staff to present at national and international onferences

- Increased professional pride and profile
- Empowered collective leadership culture
- Improved engagement scores, i.e. staff survey
- Sense of belonging
- Improved retention and lower vacancy rates
- Shared clinical decision making
- Reduction in HR cases relating to the Nursing and Midwifery Code

Strategic theme 6: Promote excellence in nursing and midwifery leadership and be a respected professional voice

- External awards and publications
- Internal awards within the organisation
- Embedding collective leadership principles where individuals take accountability for their roles and deliverables

- Promoting professional standards through role-modelling and visible leadership, both in and outside the Trust
- Strengthening professional understanding of the Nursing and Midwifery Code
- Increasing professional accountability
- Sharing stories from the front line, to be shared at board to empower nurse leaders to drive cultural improvements
- Development of specific nursing and midwifery forums (e.g. IENs and IEMs)
- Recognising our staff experiences, their motivations for work and individual needs for flexibility
- Ensuring all nursing and midwifery leaders are able to complete Exceptional Leaders training, or similar programmes
- Improving the uptake of external grants to improve practice

Delivering and monitoring success

The success of this strategy will be measured on its delivery. It will be implemented through a detailed annual plan for each strategic theme, with a named lead responsible for delivery.

Progress will be reported through the Nursing, Midwifery AHP and Pharmacy Board, where we will hold ourselves to account, reporting onwards to the Trust executive team and People and Organisational Development Committee.

We will keep the conversations going to ensure that the priority areas of focus remain current, impactful and meaningful for patients, families and our people.

With your help we've created a strategy that identifies key areas of focus and improvement, and that empowers our people. Thank you to everyone involved and for your ongoing dedication to our patients, their families and our colleagues.

Who was involved in this strategy

Senior nursing and midwifery leaders

The Nursing and Midwifery, Allied Health Professionals and Pharmacy Board

The Nursing and midwifery workforce, through seven focus group discussions

Survey responses

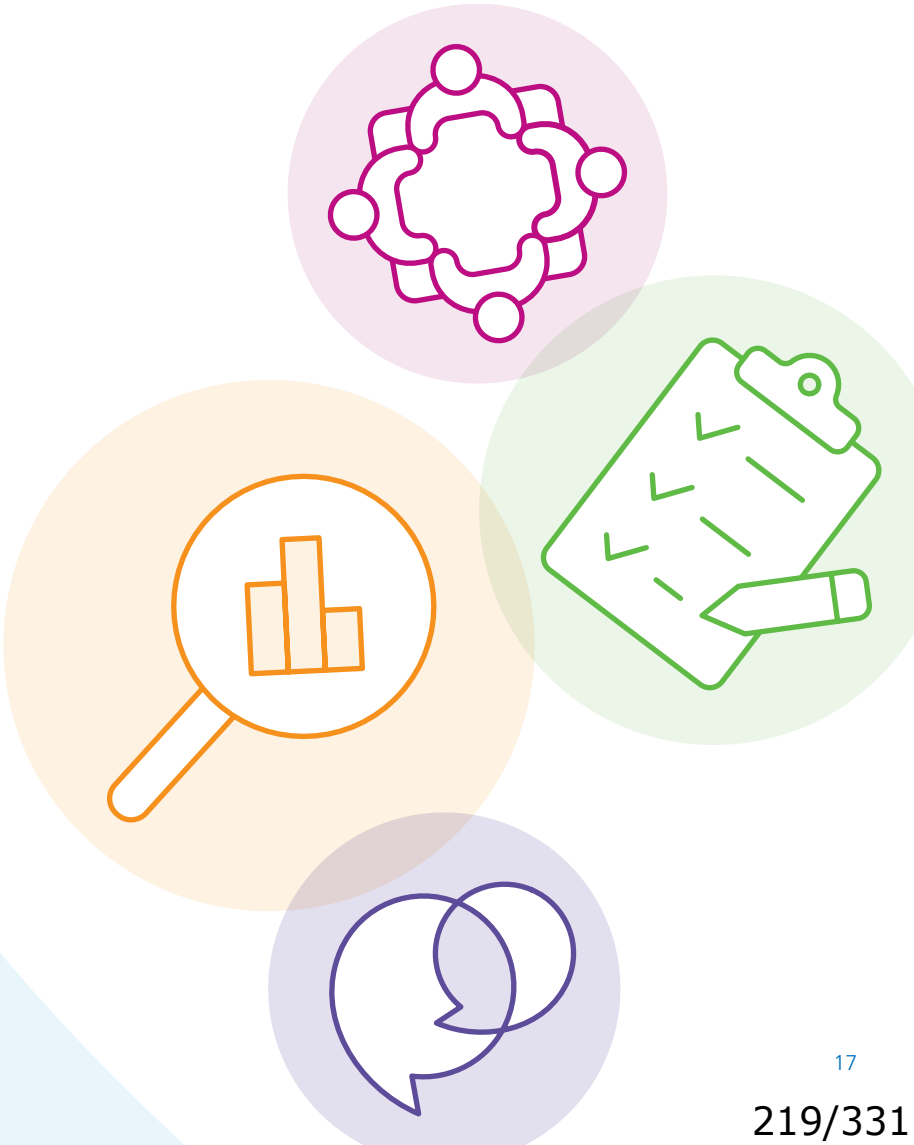
Chiefs of service

Executive and non-executive director input

Review of patient experience and family and friends' data

Patient representatives

EDI network



Quotes from our nursing and midwifery teams

Working together with an amazing team

A supportive environment which has allowed me to continue studying – the trust has been flexible with my working hours to allow me to do this

Compassionate and understanding everyday on the ward is an enjoyable experience and drives me forward

The Trust is supportive especially the education side of things. As an internationally recruited member of staff I have been well supported, this generates a positive attitude and I enjoy my role

Never a dull moment

Good environment to work in, organised and clean

Good health and wellbeing support for staff

Team work is dream work

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

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Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
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Kent, TN2 4QJ

01892 823535

11.2023 – 607-V9

NHS Maidstone and Tunbridge Wells NHS Trust

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	**Executive Director Strategy, Planning & 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) and includes details of the progress with the key programmes and projects.

Which Committees have reviewed the information prior to Trust Board submission?
- Executive Team Meeting, 21/11/23

Reason for submission to the Trust 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

NHS
Maidstone and Tunbridge Wells NHS Trust

ICB and West Kent HCP update

November 2023

Exceptional people, outstanding care

ICB/ System news

- The acute provider collaborative acute services review project group had its first meeting on 14th November. Timescales for the work are ambitious with the high level review of services due to be drafted by January 2024. Weekly meetings are being planned focussing on data reviews and agreeing the definition of sustainability.
- A letter from Julian Kelly has been sent to ICBs and Trust outlining the financial pressures and immediate actions focussing on efficiency and expected activity.
- The MTW safer staffing business case was approved by the ICB.

- The staff consultation with the HCP facing teams started on 19th October.
- The HCP is focussed on the delivery of Integrated Neighbourhood teams and the November Development Board heard from several of the schemes

West Kent HCP

- The ICB staff consultation with HCP facing staff has commenced. Sally and I will work with the team to support them and we are hopeful that previous work and utilising vacancies will minimise the impact on our team however some redeployment/redundancies are likely.
- The letter from Julian Kelly may impact the HCP in funding schemes that have not yet commenced. The digital front door is the most significant and clarity is being sought from the ICB.
- Dr Vijay Koshal and Dr Pete Maskell have outlined their HCP roles and priorities (attached).
- The HCP Development Board on 16th November focussed on the early outcomes of INT projects on mental health MDTs, social prescribing support for discharged patients, pop up health checks and well-being support. Case studies were used and were very insightful.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services and 2022/23 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 and 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, vaccination/booster programme and urgent care demand.
- *Finance pressures* – the system pressures and focus on financial balance is likely to have an impact on the development activities of the HCP for 23/24 and 24/25.

West Kent
Health and Care Partnership

West Kent
Clinical Leadership Priorities

Dr Vijay Koshal, WKHCP Medical Director (Primary Care)
Dr Peter Maskell, WKHCP Medical Director (Integrated Care)

November 2023

Clinical Leadership assumptions in the WKHCP

- The 2 Medical Director posts in WKHCP are funded by and therefore focused on the clinical leadership of WKHCP priorities although some liaison/engagement work with the K&MICB will be provided for.
- The WKHCP Medical Directors are both working 2 days a week (approx. 8 days a month).
- The WKHCP Medical Director (Primary Care) assumes 7 days a month is expected to be spent on WKHCP business, 1 day a month on K&MICB related activities.
- The WKHCP Medical Director (Integrated Care) will work for the WKHCP and will liaise with the ICB on WKHCP business
- Providers working as part of the partnership are contributing clinical and support staff time to support delivery of our shared priorities.
- The 2 WKHCP Medical Directors will not field all clinical queries or undertake all clinical leadership work across West Kent.

West Kent
Health and Care Partnership

WKHCP Medical Director (Primary Care) 2024-2026 Priorities

West Kent Health and Care Partnership

INTEGRATED NEIGHBOURHOOD TEAMS:

- Long term INT plan development 2024–2027 (V1 12/2023)/promote learning INT work
- Implementation support – INT Programme group/learning forum
- Monitoring impact/supporting outcomes framework

DEMAND & CAPACITY SYSTEM WIDE REPORTING/WINTER PLAN IMPLEMENTATION :

- Support implementation of same day access hub for winter
- Complete WK Demand and Capacity reporting framework
- Provide regular demand and capacity system reports at PCN and WKHCP level

DIGITAL FRONT DOOR (TUNBRIDGE WELLS):

- Agree DFD change programme with TW practices clinical leads and support staff
- Plan and implement modern GP workflow prep
- Introduce Anima and evaluate impact

KEY MEETINGS:

- WEST KENT: WKHCP Development Board; WKHCP Clinical Professional Quality Advisory Group (Co-Chair); WKHCP Primary & Community Care Transformation Group (Chair); WKHCP INT Programme Steering Group; Clinical Directors Group; WKHCP Population Health Management Group; MTW & PC Interface Group; Place Oversight meetings; Patient and Resident Engagement
- KENT & MEDWAY**:** Primary Care Team Delivery Unit Meeting and Associated Workstream Meetings.

KEY RELATIONSHIPS:

PCN Clinical Directors; LMC

WKPC; Community Provider;

Mental Health Provider;

WKHCP Chair, SRO & Director;

WKHCP Executive & Board

Members; K&MICB Primary Care Executive & Clinical Leaders, K&M HCP MDs (PC)

WKHCP Medical Director (Primary Care) Long Term Goals 2024/2026

- Integrated Neighbourhood Team (INT) implementation
- Digital Front Door Implementation (West Kent)
- Mental Health Community Framework integration with INT work
- West Kent Primary and Community prevention/health inequality initiatives – Long Term Conditions and social prescribing
- Outcomes Framework for WKHCP

West Kent
Health and Care Partnership

WKHCP Medical Director (Integrated Care) 2024-2026 Priorities

1) EXPLORATION OF SINGLE SHARED REAL TIME PATIENT RECORD INCLUDING PRIMARY CARE TO SUPPORT INTEGRATED CARE

- Supporting the frailty core INT development using shared system to share learning.
- Establish an understanding at HCP level how data sharing can work to develop services, understand our business and protect patients.

2) URGENT CARE HUB (UCH)/WINTER PLAN IMPLEMENTATION

- Winter plan implementation and response.
- Supporting the implementation of the UCH as part of the WK system wide response to urgent needs.
- Develop the UCH to support effective safe and equitable frailty signposting.
- Promoting effective links with other triage hubs across WK building key provider engagement.

3) VIRTUAL WARDS

- Roll out and expansion of Virtual wards including a robust safety, effectiveness and satisfaction framework.
- Evaluation of impact and value for money of current and future WK virtual ward offer.

4) INTERMEDIATE CARE

- At early development stage > Provide leadership and develop a clinical model that was congruent with other HCP areas and understand the role of CHs.

5) KEY MEETINGS:

- **West Kent HCP**: WKHCP Development Board; WKHCP Executive Group; WKHCP Clinical Professional Quality Advisory Group (Co-Chair); WK Urgent & Emergency Care Group (Chair); WKHCP Digital & Data Group; WKHCP Virtual Ward Steering Group; WKHCP Frailty/ACC Programme Steering Group (Chair)
- **Kent & Medway**: Improving Outcomes & Experience Board; Stroke Network Board (Chair)

6) KEY RELATIONSHIPS:

MDs all partners; WKHCP Executive & Board members; K&MICB MD and DMDs; WKHCP JPMO

West Kent
Health and Care Partnership

WKHCP Medical Director (Integrated Care) Long Term Goals 2024-2026

- WK Urgent & Emergency Care Work Plan implementation
- Urgent Care Hub
- WK Intermediate Care Strategy
- Data Sharing Agreements to support integrated working
- Workforce priority initiatives

West Kent
Health and Care Partnership

West Kent
Health and Care Partnership

NHS Maidstone and Tunbridge Wells NHS Trust

To review the updated plan for the forthcoming winter period	Chief Operating Officer

The updated winter plan is enclosed. This has been amended and refined since being considered by the Finance and Performance Committee, and the Trust Board, in October. The Trust Board is invited to review and discuss the plan.

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

- Executive Team Meeting, 14/11/23
- Finance and Performance Committee, 28/11/23

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

Discussion and Assurance.

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

Maidstone and Tunbridge Wells NHS Trust

Winter Plan 2023/24

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Contents

Executive Summary

Purpose

- The purpose of the Winter Plan is to identify activities across the Trust which relate to planning for winter 2023/24, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned and supporting the workforce.

Development of the Winter Plan

- The Plan is a live document that will be continuously updated, especially in light of demand and capacity modelling and is led by the Chief Operating Officer
- The Plan identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- NHS England has set out core objectives and key actions for operational resilience for winter in the 27 July letter outlining high impact interventions.

Data driven management:

- The Care Coordination Centre (CCC) will ensure centralised flow, optimizing resources supported by clear communication
- The principles of national Operational Pressures Escalation Levels (OPEL) framework will be employed to ensure a consistent approach
- Bed modelling from MTW B.I. and system wide data analysis from Lightfoot predicts a shortfall of acute beds. Schemes are developed or being developed to mitigate this to provide robust flow and patient safety

Finance:

- Schemes to support robust flow and offer increased capacity may require additional resource. This is being calculated and prioritised against realisation of benefits.

Emergency Department activity

Activity prediction

MTW B.I. have predicted lower ED attendances in 23/24 than last year. This is particularly noticeable in December, with a slight increase in January. It is thought that Nov and Dec 22 were outliers in activity due to the strep throat epidemic.

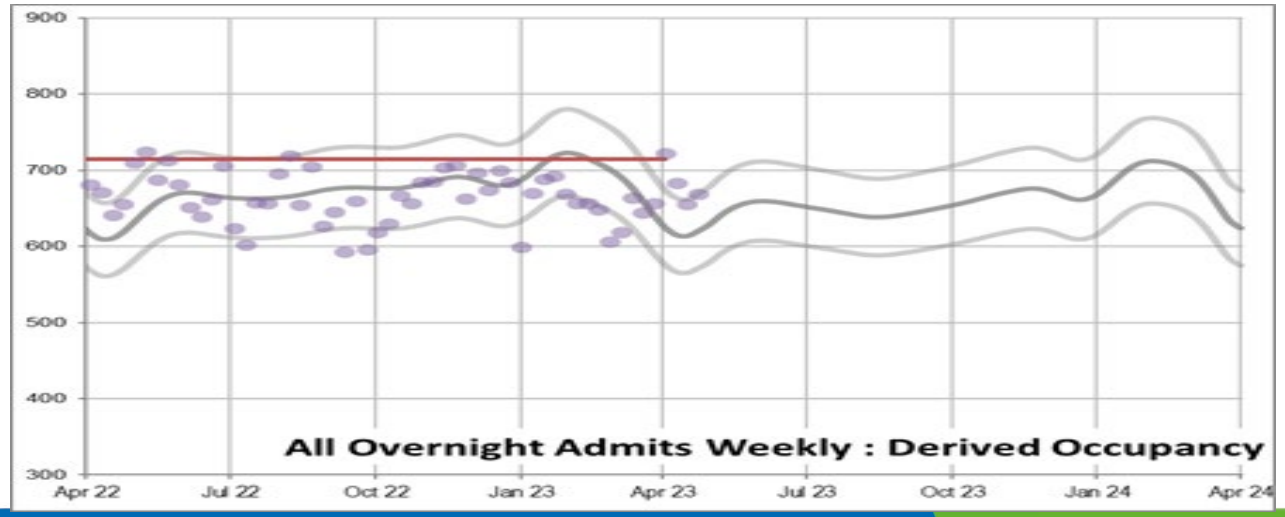
There is an underlying inflation of 1.5% to 2.0% per annum in demand for emergency care. Around half of this is driven by simple numerical population growth, and half from an ageing of our local population.

Month	2022/23 Actual	2023/24 Planning
Oct	17,835	17,792
Nov	17,625	17,238
Dec	19,440	17,793
Jan	16,163	16,983
Feb	15,554	16,310
Mar	18,313	18,120

Bed Modelling – MTW projections: peak 710 beds

Projections 23/24 (source: MTW B.I.) The peak for beds is estimated at 710 beds using medium projection – leaving a worse case scenario of a shortfall of 114 beds This figure will be updated later in the year.

- Bed occupancy projections this coming winter are similar to last winter, coming out as ***roughly the same or slightly less than last year***, based **entirely** on patterns of activity observed over the past 10 years. The assumption is that next winter will be 'average', i.e. without abnormal weather, epidemics or economic collapse. There are fairly broad confidence levels and do not take mitigation into account.
- Admissions are on track to be ***around the same or slightly higher*** but it is noted that LoS appears to be on a downward trajectory. The past 12 weeks has averaged 7.5 days against 8.4 for a similar period last year. This would lead to a reduction in bed occupancy.
- Non-elective length of stay (LoS) averaged 8.0 days in 2022/23. If schemes in place delivered a reduction of 0.5 days (continuing the trend), this would release around 45 beds
- These figures are likely to be offset by a 5% shifting of non-elective activity from overnight admissions to SDEC.



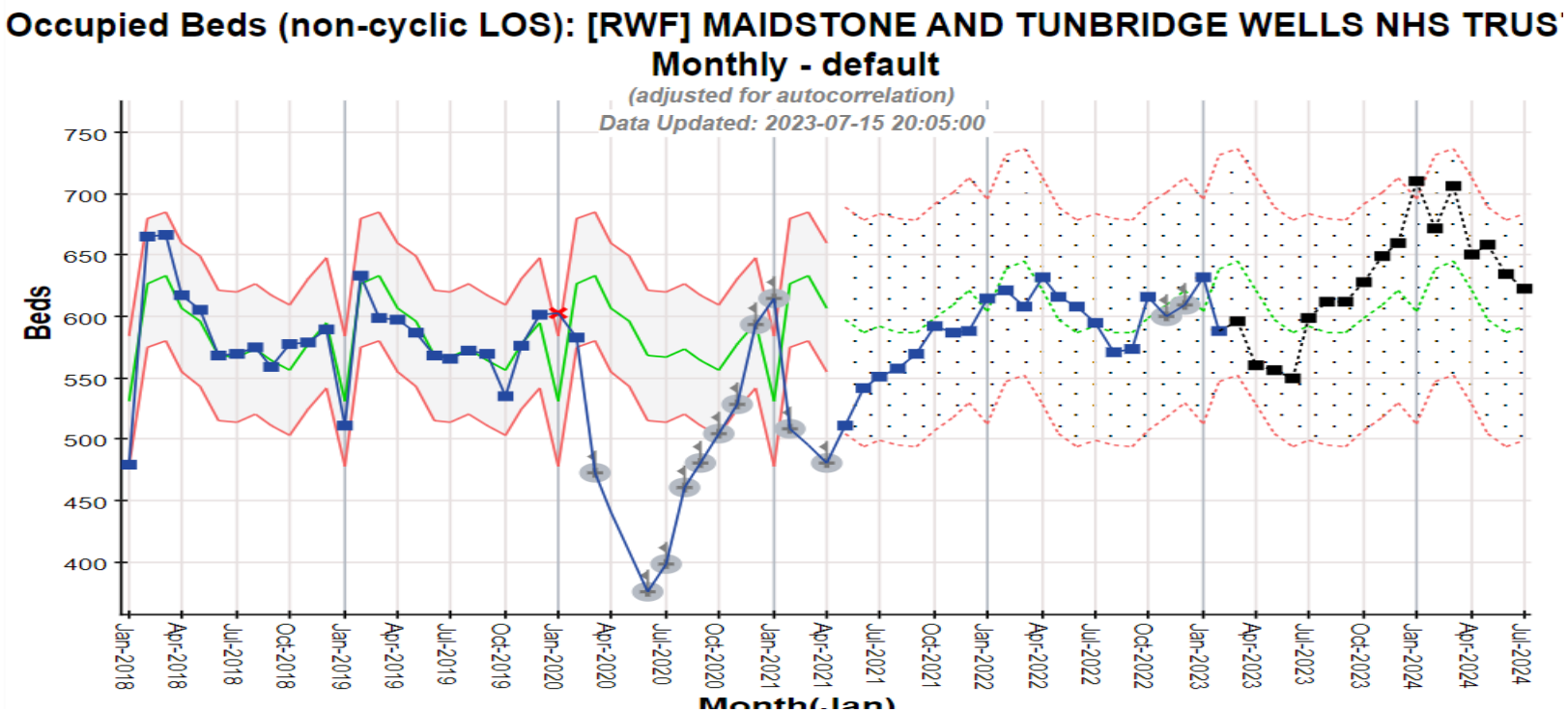
Graph shows patients admitted for a minimum of 1 night, giving overall bed occupancy

There is an increased risk of a severe winter this year – something in the order as twice as likely as normal.. A bad winter could add 50 -100 respiratory patients. 50 patients adds 7% increased bed occupancy.

Bed Modelling – HCP projections: 710 beds

Projections 23/24 (source: West Kent HCP/ Lightfoot data)

- The graph below indicates that the peak occupancy prediction for G&A beds (adult and pediatrics) is 710
- The peak in winter 22/23 was 6th January at 715.



MTW Core & escalation beds (Med/Surg): 596

Core and Escalation Bed Availability – the calculation below shows a total of 596 non elective core and escalation beds, including escalation wards but not elective capacity from SSSU/ SSU/ MOU. NB please note this includes only core medical and surgical beds.

Core Medical Beds				Core Surgical Beds			
Tunbridge Wells		Maidstone		Tunbridge Wells		Maidstone	
AMU	28	John Day	30	W10	30	Cornwallis	19
CCU	7	Culpepper	13	W32	20		
W2	26	CCU	6	W30	30		
W12	30	Mercer	26	W31	30		
W20	30	Pye Oliver	28				
W21	30	AAU*	22				
W22	32	Stroke Unit**	34				
		Foster Clark	12				
		Whatman	22				
		Edith Cavell	22				
		Peale	14				
TOTAL BEDS	**183**	**TOTAL BEDS**	**229**	**TOTAL BEDS**	**110**	**TOTAL BEDS**	**19**
Winter Escalation		**Winter Escalation**		**Winter Escalation**		**Winter Escalation**	
W11	**30**	**Foster (Stroke/ Med)*** **	**16**	**PPU**	**9**		
INPATIENT TOTAL	**213**	**INPATIENT TOTAL**	**245**	**INPATIENT TOTAL**	**119**	**INPATIENT TOTAL**	**19**
		*incl. A bay		**SSSU**	**25**	**SSU**	**18**
		** new plan				**MOU**	**12**
		*** need to move IR out					

NB Escalation beds available at MGH have been impacted by stroke building delays. The escalation numbers have been decreased from 28 – 16

Medicine non elective bed capacity	**458**
Surgical non elective bed capacity	**138**
total non elective bed capacity	**596**

Closing the gap 710 beds required Total Core/ Esc beds = 596 Total beds released = 90. Overall gap 24 beds

No.	Division	Bed Releasing Scheme	Benefits	Beds Released
OP FLOW/ CCC				
1	CCC	Extended CCC functionality	Expansion of CCC hours, oversight of milestones, outstanding issues, increased use of existing TeleTracking functionality	7
2	CCC	Clinical Pathway Hub pilot from Sept 23	Increased admission avoidance and diverting ambulances from ED	10
3	CCC	Expansion of Virtual Ward	Early supported discharge	15
4	Op Flow	P1, 2, repats, Transfer of Care Hub / discharge technology support	Early supported discharge	7
5	Op Flow	Additional out of hospital capacity (RBLI (4), Hawkhurst (5), spot purchase beds (5))	Additional OOH capacity	14
DIVISIONS				
6	MEC	Additional GP cover & respiratory med cover w/e for MGH	Clinical cover for walk ins and earlier discharges for respiratory patients	*1*
7	Paeds	Additional paediatric capacity	Paediatric escalation (Hedgehog to 27 beds/ Hoglets to 31 beds)	12
8	Haem	Provision of internal brace fitting	Reduction of LOS and improved patient experience	1
9	Cancer	Acute Oncology Service 7 days a week both sites	Admission avoidance, improved patient experience	2
10	SDEC	SDEC improvements incl. Ortho w/e opening / pull through	Admission avoidance, increased SDEC	10
11	Surgery/ MEC	ITU MGH – additional capacity requiring staffing	Medical escalation	6
12	ED	Additional consultant support in ED incl. acute physician, RAP consultant, w/e ED consultant	Senior decision making at front door	5

Flow Improvement Schemes

Admission Avoidance

- Clinical Pathway Hub
- GP in ED capacity
- SDEC optimised
  - Overnight pull ED
  - hours
- Senior decision maker front door

Central oversight driving quality

- 7 day Tactical cover covering evening surge
- Robust manager on call
- Transport/ Facilities/ IDT covering evening surge
- CCC weekend oversight
- R&R Site Team on floor
- Daily P0, milestone identification

Inpatient incl. seasonal surge

- SAFER bundle
  - Board rounds
  - EDN planning
  - Criteria Led
- Medicine w/e (respiratory)
- ED consultant (w/e and RAP evening)
- Paeds capacity
- Bank w/e Pharmacy
- Virtual Ward

Discharge

- Discharge checklist
- TTO delivery
- Transport actions
- Transfer of Care Hub
- Digitally enabled support
- P3 additional capacity
- P1, P2

Closing the gap – development of opportunities

- Review of SDEC capacity in all specialities increasing ED pull
- Increased front door senior decision making
- Scoping a dedicated junior team completing EDNs
- Urgent care plan for Gastroenterology and Cardiology
- CCC - Improved central oversight
- Increased out of hospital capacity
- Scoping safe delivery TTOs to patients to reduce time spent in hospital
- Improving flow basics as part of ongoing work

Winter monies required

Funding bids in priority order – total £2.405m (to be validated)

PRIORITY 1 Escalation wards W11 and Foster	30 beds/ 16 beds for 3 months	£733k plus £442k
MGH additional nursing (6 beds) (ITU space)	2 x B5 24/7	£135k
RN and med cover Paeds escalation		£93k
Additional mortuary capacity		£90k
TOTAL		**£1.5m**

PRIORITY 2		
Clinical Pathway hub		£25k
Tactical Commander	2.0wte 8b x 5 days	(£73k funded ICB)
EDN junior doctor team	1300 - 2000 5 days SHO	£30k
AEC Dr	13.00 – 2200 5 days a week TW = 40 hours x £50	£40k
ED cover (RAP consultant, Acute Phys, ED w/e consultant)	Acute Phy £5.5k per week for 12 weeks = £66k ED cons 20 hours x 26 w/e day @£133 p/hour £69k RAP cons 3 hours 7 – 10pm x 90 days £185 p/hr £50k	£185k
TOTAL		**£280K**

PRIORITY 3		
Ortho SDEC w/e plus Cancer AOS		£74k plus £15k
GP in ED	(8 hours x 7 days x 2 sites x £75) x 10 weeks	£67k
Additional Resp w/e cover (move to priority 2)	(1 x cons 4 hrs £130 both days every weekend	£21k
ED triage nurse TW B5/ B3 A&C in RAP	Triage 1400 – 2200 Mon/ Tues/ B3 2.0wte	Triage nurse £10k/ Admin £33k
TOTAL		**£220K**

PRIORITY 4		
OOH capacity (Hawkhurst/ RBLI) – funded by ICB confirmed so moved down priority list		£102k
External contractor support (Estates & Facilities) – gritting/ 4 x 4 adverse transport winter plan		£35k
Additional domestics and porters to support demand – review costs of this request		250k
TOTAL		**£405k**

Reviewed Priority One List To Be Funded

PRIORITY 1 Escalation wards W11 and Foster	30 beds/ 16 beds for 3 months	£1M
W&C: RN and med cover Paeds escalation		£80k
Core Clinical Services – HIT increase		£100k
Core Clinical – additional mortuary capacity.		£90k
Tactical commander	2.36wte 8b x 7 days (£70k funded ICB)	£25k
EDN junior doctor team	1300 - 2000 5 days SHO	£30k
ED cover (RAP consultant, Acute Phys, ED w/e consultant, AEC Dr, ED triage nurse TW B5/ Additional Resp w/e cover)		£300k
TW ddditional domestics and porters to support demand		100k
TOTAL		**£1.7M**

Workforce

https://padlet.com/staffwelfare/staff-health-wellbeing-jcklvvjnxgss3vwt
Wellbeing hub :: Kent & Medway ICS (kmstaffwellbeinghub.uk)
https://www.kmstaffwellbeinghub.uk/

Wellbeing support

MTW is able to offer the following support to staff as part of an extensive wellbeing approach:

- Continue current offer as Wellbeing Partners, Inreach and Bespoke Support, Employee Assistance and NHS Staff Support, Signposting to Welfare support for staff in Financial difficulties
- Continue to support our staff through the winter period with particular emphasis on signposting, cost of living crisis support, fuel poverty and seasonally affected loneliness and mental health
- Incident response support from Wellbeing and Staff Psychological Support Team
- Flu and Covid Vaccination schemes for staff are in place
- Imminent introduction of financial wellbeing platform WAGESTREAM to support staff, offering live visibility over pay, flexibility to access a percentage of earned pay ahead of payday, rainy-day pot to budget and save, access to a certified financial coach
- Free toast and breakfast cereals to be provided in the canteens throughout winter, organised by Facilities

Vacancy rate

- As part of the Strategic Theme for People within Strategy Deployment Review, the key metrics include sickness absence, appraisal completeness, training and EDI metrics. The vacancy rate for the Trust is 8.5% against target 12% for September 2023, with turnover at 12.8% against 12% target. Work continues on these objectives.
- Senior teams work closely with HR Business Partners and Recruitment to forecast and plan future turnover, gaps and a multi skilled workforce.

Data-driven flow and surge management

Care Coordination Centre

- The CCC will centralise all flow management through site meetings, review of discharge milestones and link in with the Flow Representatives from each Division.
- The Integrated Discharge Team will pilot management support in the CCC to streamline flow to external pathways and the CCC will be supported 24/7 by Site Management and Virtual Ward, and until 1800 by Transport and Tactical Command
- On call managers will be provided with winter training in autumn 2023 to support decision making

Industrial Action

- A standard plan is in place to support industrial action. It is expected that industrial action will continue and this will have a considerable impact on staff/ activity/ finance. As more information becomes available, plans will be coordinated by the CCC with actions being delivered by all clinical Divisions, supported by IT and Workforce. This is overseen by the Deputy COO.

Severe Weather

- The Care Coordination Centre will ensure both severe weather and flood warning information is cascaded to staff in a timely way to ensure maximum amounts of preparedness. The CCC will liaise with Kent Highways to ensure gritting & snow ploughing is carried to maintain essential access to sites.
- Estates & Mitie have plans to keep the access roads clear and the helipad de-iced.
- In the event of severe winter weather resulting in transport disruption the Trust can:
    - Use the existing 4WD vehicles the Trust has with Estates staff and deploy one to each main site at the disposal of the Clinical Site Manager
    - Use the MOU with Kent 4WD to use local trained volunteers with 4WD to assist in getting critical staff in
    - Access the Kent Surrey Sussex Air Ambulance, Children's Air Ambulance and HM Coastguard to transfer patients or emergency supplies
    - Utilise hotel accommodation for stranded staff / Provide hot food and drink for staff at no charge

Update on the corporate objectives	**Executive Director Strategy, Planning & Partnerships**

At its meeting in September 2023 the Trust Board confirmed the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects, but it was agreed that a report on the further work being undertaken in relation to the corporate objectives would be submitted to the Trust Board in either October or November, that report is now enclosed.

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

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

Corporate Objectives Update 2023/24

Rachel Jones
Executive Director Strategy, Planning & Partnerships

November 2023

To be successful we must deliver the breakthrough objective and target of each strategic theme for the year ahead, along with our corporate projects.

Strategic Theme	Goal	Target	Breakthrough Objective
Patient Experience	To reduce the number of complaints we receive each month.	To reduce the overall number of complaints or concerns each month to a target of 24 by March 2024.	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.
Patient Safety and Clinical effectiveness	No significant avoidable harm: 0.7 per 1000 beddays (eradicates all severe and above harm)	Reduce moderate and severe harm rate from a 12 month average of 1.0 per 1000 occupied bed days to 0.9 per 1000 occupied bed days by April 2024 and 0.85 per 1000 bed days by December 2024	Reducing Deteriorating patients and sepsis by 50%
Patient Access	To ensure we are achieving all constitutional patient access standards.	Achieve the Trust RTT Trajectory by March 2024	To achieve the planned levels of new outpatient activity shown as % 19/20
Systems & Partnerships	No patient resides in an acute hospital bed who needs care that can be provided in another setting.	Decrease the number of occupied bed days relating to delayed discharges from our hospitals	**Internal**- to increase the number of patients leaving our hospitals by noon on the day of discharge **External**- To provide appropriate care capacity to enable timely discharge of patients to other settings
Sustainability	Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure	Delivery of financial plan, including operational delivery of capital investment plan	Reduce the amount of money the Trusts spends on premium workforce spend
People	Achieve a Trust wide vacancy level of 7% over two years - by end financial year 2025-6. This would move MTW into one of the top performing NHS trusts in the South East.	Reduce the Trust wide vacancy rate to 8% by January 2024	Reduce turnover to 12% by March 2024

Our Corporate Projects enable delivery of our priorities, progress our corporate strategy and are aligned with the strategic themes

Proposed Corporate Projects 2023/24		1st Project Goal	Project SRO
	Workforce Supply	To agree, implement and cascade flexible working principles for clinical and non clinical staff • To better promote benefits of a range of flexible options • To educate line managers on the benefits, options and ways to operationalise flexible & hybrid working without impacting patient care (through job planning/ rostering) • To pilot fit for purpose hybrid working spaces in agreed non clinical sites & implement learning (may now be part of wider hybrid working strategy)	Sue Steen
	EDI Strategy Implementation	• To make the training programme listed in the EDI Strategy available to all MTW staff. • To ensure processes embed EDI best practice. • To enable the EDI Steering Group to review MTW EDI data against national targets and deliver NHS High impact actions.	Sue Steen
	Mental Health	Establish a Mental Health Committee. Develop a strategy document. Develop pathways and assess activities/work aligned within each division dedicated to care of patients with mental health needs. Establish the position of a Mental Health Lead within MTW.	Jo Haworth

Our Corporate Projects enable delivery of our priorities, progress our corporate strategy and are aligned with the strategic themes

	EPMA	The EPMA Project will ensure that the Trust has a robust system that delivers safe, high quality and cost-effective system to order prescriptions across MTW (excluding chemotherapy) .	Peter Maskell
	Patient Portal	To provide patients with a higher level of digital service, using modern technology to enable patients to take control of their health by giving them more control over managing their appointments, receiving and giving communications and information relating to their care. Improve efficiency and productivity. In line with our Trust Outpatients Transformation Programme, and with National priorities for elective recovery, the portal will drive patient engagement forward, provide cost efficiencies and enable more virtual consultation, patient initiated follow up and joined up care. Better waiting list management, fewer unnecessary follow ups, reduced DNA.	Sean Briggs
	Workforce Efficiencies	• Achieving budget for 2023/24 • Informing 2024/25 CIP programme	Steve Orpin

To approve the Digital Pathology Full Business Case (FBC)	**Executive Director, Strategy, Planning & Partnerships**

The Trust Board is requested to review and, if appropriate, approve the Digital Pathology Full Business Case (FBC).

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

- Executive Team Meeting, 07/11/2023
- Finance and Planning Committee, 28/11/23

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

For approval.

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

Summary of the report

Maidstone and Tunbridge Wells NHS Trust

Digital pathology is the digital capture, storage, and transfer of clinical images, replacing glass slides and microscopes.

The NHSE Diagnostics Digital Capability programme has been established to deliver four key objectives to:

- Support the development of Pathology & Imaging networks by improving connectivity within and between networks and to develop national shared learning and improvement opportunities.
- Increase system capacity and resilience of diagnostic services through enhanced digital capability.
- Level up access to diagnostic services across the NHS through the development of Digital capabilities for imaging and pathology.
- Improve safety and experience for patients and NHS staff, by reduced manual processes, turnaround times and greater flexible working, including remote working.

Expected benefits

- Increased number of slides available in digital form / Increased cases reviewed at MDTM meetings.
- Increased image sharing requests fulfilled using digital images / Reduced need to transport glass slides.
- Reduced administrative burden in sharing slides / Quicker clinical decision making.
- Reduced outsourcing / Reduced insourcing / Reduced equipment cost.

Summary of the report

Maidstone and Tunbridge Wells NHS Trust

High-level risks and mitigations

Securing the funding and ICB support – funding identified and ICB ETM have supported.
The capacity to implement LIMS and digital pathology – the teams have been preparing to do both and will manage any conflicts as part of operational planning
Embedding the change processes required – this is recognised and all departments are bought into the development. Implementation planning is key.
A lack of clarity on benefit realisation as raised by the CFO group. This will be developed by the Network.

Overall cost of the Business Case: £14.598m

The capital will be provided by NHSE and the revenue costs, including capital depreciation, will be covered by K&M ICB. The case has a nil impact on the financial position of the EKHUFT and MTW however will require dedicated resource from within pathology to implement. Details are on pages 9 and 10 of the short form business case attached.

Summary of the report

Has the funding been identified and agreed? Yes – the case does not require MTW or EKHUFT funding. £5.728m capital and 2023/24 and 24/25 £8.87m Revenue Investment is coming from NHSE.

Has the case been considered by the Business Case Review Panel? Yes on 24/10/23 subject to reviewing the financial appendix which has been done.

Does this case require ICB approval? Yes and it has been supported by the ICB ETM meeting so far. There are a schedule of meetings in MTW/EKHUFT and the ICB before final sign off at Board level.

Diagnostics Digital Capability (DDC)
Programme of Works Short Form Business Case
Projects for £5-25m
V1.1

SECTIONS TO COMPELTE / APPENDICES TO COMPLETE IN EXCEL – CHECKLIST		
Section / Appendix	**Completed by**	**Completed (Y/N)**
Section 1- Purpose of template [For information only]	**N/A**	**N/A**
Section 2 - DDC programme objectives [For information only]	**N/A**	**N/A**
Section 3 - Project Overview	Network	**N/A**
• Appendix A – Organisation Lead Contact Details	Trusts	Yes
Section 4 – Impact of Programme - tick boxes	Network	Yes
Section 5 – Project Delivery Overview	Network and Trusts	**N/A**
• Appendix B - Delivery and Timeframe by Project and Funding	Trusts	Yes
• Appendix C - Risks and Issues	Trusts	Yes
Section 6 – Financial Overview	Network and Trusts	**N/A**
• Appendix Front sheet – Comprehensive net income – total by Network	Network	Yes
• Appendix D - Trust Financial Overview	Trusts	Yes
Section 7 - Key stakeholders/ officers contact details	Trusts	**N/A**
• Appendix E: Key Stakeholder Communications Table	Trusts	Yes
Section 8 – Programme Governance Structure	Network	Yes
Section 9 - Procurement Checklist and Process • Appendix F: Procurement Checklist	Trusts	Yes
Section 10 - Financial Obligations	Network and Trusts	Yes
Section 11 – Benefits Metrics Data Collection • Appendix G: Benefits Data Collection	Trusts	Yes
Section 12 – Five Case Model • Appendix H: Five Case Model Information capture	Trusts	Yes
Section 13 - Counterpart Commitments [For information only]	NA	NA
Section 14 - Sign off	Network and Trusts	**N/A**
Section 15 - Long Term Plan Alignment [For information only	NA	NA

1 Purpose of template

The purpose of this NHSE template is for applicants to set out their digitisation funding requirements, which the diagnostics digital capability (DDC) programme can consider and, if appropriate, approve, and for the programme to set out the commitments required from recipients with respect to governance and reporting.

This document identifies the scope of work completed and yet to be completed, timescales for completion, key accountabilities and responsibilities for completion and key improvement indicators. In all cases, the trust(s) named in this agreement retain(s) responsibility and accountability for making the best use of the public funds provided to deliver a defined set of projects to the agreed scope, timeframes and to acceptable quality standards.

The template is to cover all Diagnostics Digital Capability projects that are asking for a financial envelope between £5-25 million capital up to 24/25. All business cases can be signed off by the programme SRO and go to the Capital Delivery Oversight Group (CDOG) for information.

Complete all sections, including the appendices populating the embedded spreadsheet where necessary.

Please note the word document requires completion at Network level, while the attached appendix within Excel needs information per Trust per tab as indicated in the section heading. The only exception to this is the front sheet on the Excel appendix that requires a 'statement of comprehensive income' to be completed by Network and is mandated by the NHS England 'Cash and Capital' team.

2 Diagnostics Digital Capability programme objectives:

The NHSE DDC programme has been established to deliver four key objectives to:

1. Support the development of Pathology & Imaging networks by improving connectivity within, and between networks and to develop national shared learning and improvement opportunities.
2. Increase system capacity and resilience of diagnostic services through enhanced digital capability
3. Level up access to diagnostic services across the NHS through the development of Digital capabilities for imaging and pathology
4. Improve safety and experience for patients and NHS staff, by reduced manual processes, turnaround times and greater flexible working, including remote working.

3 Project Overview – Network level

3.1 Project Details

NETWORK PROJECT DESCRIPTION (Covers all Network projects)	Project no	Not Applicable
	Region:	South East
	Network:	Kent and Medway Pathology Network (KMPN)
	ICS Name:	Kent and Medway Integrated Care System
	Lead organisation for the project:	Maidstone and Tunbridge Wells Trusts on behalf of KMPN
	Title of the project:	Digital Pathology
	Brief description of project:	The Digital Pathology project will deliver a modern digital pathology solution that will transform the review, analysis, and reporting processes of all Histopathology services provided by the relevant members of the Kent and Medway Pathology Network (KMPN). The digital workflow will introduce a new step –scanning the glass slide after processing and staining - to produce a high-resolution digital image – it's this digital image which then goes to the Histopathologist to review, analyse and report on.
	Total funding requested by network:	£5.728m NHSE Capital 2023/24 and 24/25 £8.87m Revenue investment
	Specific trusts drawing down project funds	East Kent Hospitals University Foundation Trust (EKHUFT) Maidstone and Tunbridge Wells NHS Trust (MTW)
	Other organisations impacted by the project:	Medway NHS Foundation Trust (MFT) Dartford and Gravesham NHS Trust (DGT) Kent and Medway Integrated Care Board (KM ICB) Investment only

BRIEF PROJECT OVERVIEW

Summarise the key dimension(s) of the network project, in relation to the outputs that will be delivered by the following funding workstreams

1. *Please select the project's funding workstream(s)*

☒ Digital Pathology
☐ LIMS and Interoperability
☐ Image Sharing
☐ Home Reporting
☐ iRefer

For information, a brief description of the funding workstreams is provided below.

- **Digital Pathology** - digital capture, storage, and transfer of clinical images, replacing glass slides and microscopes. Requiring the acquisition of slide scanners and application software, and integration between digital pathology and LIMS systems. Providing the access and capability of whole slide imaging for histopathology enabling improved access to clinical expertise and clinical specialities, enabling remote working and workload balancing

3.2 Organisation lead contact details – Trust level

Appendix A (Excel spreadsheet) provides details of lead organisation Senior Responsible Officer (SRO) and responsible officers/leads within all participating Trusts.

4 Impact of programme – Network level

4.1 Alignment to DDC programme objectives

Please use the table below to indicate which of the DDC programme spend objective(s) your Network project aligns to.

DDC Programme spend objective	*Project alignment*
1. Support development of Pathology & Imaging networks by improving connectivity within, and between networks, to allow for requests, tests, images, and results across wider geographical areas and provide seamless care pathways for patient crossing traditional boundaries	☒
2. Increase system capacity and resilience of diagnostic services through enhanced digital capability	☒
3. Level up access to diagnostic services across the NHS through the development of digital capabilities for imaging and pathology	☒
4. Improve safety and experience for patients and NHS staff, by reduced manual processes, turnaround times and greater flexible working, including remote working. With introduction of clinical decision support tools enhancing patient experience and safety through removal of inappropriate exams	☒

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4.2 Alignment to national reviews

Please use the table below to indicate which review recommendations, as referenced in **Diagnostics: Recovery and Renewal, Report of the Independent Review of Diagnostic Services for NHS England, 2020 (NHS England commissioned review)**[1] your project aligns to.

Recommendation	*Project alignment*
Equipment and facilities	
Recommendation 11: Pathology and genomics equipment and facilities should be upgraded to facilitate the introduction of new technologies, to support Covid-19 testing and drive efficiency.	☐
Digitisation and connectivity	
Recommendation 19: Improving connectivity and digitisation across all aspects of diagnostics should be prioritised to drive efficiency, deliver seamless care across traditional boundaries and facilitate remote reporting.	☒
Recommendation 20: NHS Digital's work on developing and implementing a standardised universal test list across all diagnostic disciplines (pathology, imaging, endoscopy and cardiorespiratory services) should be accelerated, as has been done for the National Genomic Test Directory.	☐
Delivering the change	
Recommendation 24: NHS England and NHS Improvement should ensure standardised data and information is collected across all diagnostic modalities to drive operational performance, improve business intelligence at a national and local level and inform service improvement.	☒

For reference, **Section 15** lists the priorities and improvements from the NHS Long term Plan (2019), as related to diagnostics. The majority of the priorities and improvement have been taken forward into the ***Independent Review of Diagnostic Services,*** so, for the purposes of efficiency, the NHS Long Term Plan priorities and improvements have not been referenced here.

[1] NHS England, 2020. *Diagnostics: Recovery and renewal, Report of the Independent Review of Diagnostics Service for NHS England* [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf [Accessed 12 Dec 2022]

4.3 Alignment to national service delivery standards

Please use the table below to indicate which national service delivery standards your project is expected to positively influence.

Operating standard	*National target*	*Oct 2022 national outturn*	*Project alignment*
6 weeks diagnostic wait. [2] • NHS target in England is that less than 1% of people should wait more than 6 weeks for a diagnostic test[3] • The *Delivery plan for tackling the COVID-19 backlog of elective care (2022)* has set an ambition of '95% of patients needing a diagnostic test receive it within six weeks by March 2025.'[4]	<1%	27.5%[5]	☒
28-day Faster Diagnosis Standard (FDS) - patients will be diagnosed or have cancer ruled out within 28 days of being referred urgently for suspected cancer • The *NHS Long Term Plan* (2019) states that 'we will begin introducing a new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening'.[6] • The *Delivery plan for tackling the COVID-19 backlog of elective care* (2022) has set an ambition of '75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.'[7]	75%[8]	68.5%[9]	☒
18-week maximum waiting time from referral to treatment (for consultant-led elective care)[10]. • 92% of patients should wait no longer than 18 weeks to start elective treatment[11]	92%	59.7%[12]	☒

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[2] The clock starts when the request for a diagnostic test or procedure is made. The clock stops when the patient receives the diagnostic test/procedure.
NHS England, 2015. Diagnostics waiting time and activity [Online] Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf [Accessed 13 Dec 2022] p.

[3] House of Commons, 2022 *NHS Key Statistics: England. November 2022 [Online]* Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf [Accessed 12 Dec 2022] p. 19

[4] NHS, 2022. *Delivery plan for tackling the COVID-10 backlog of elective care. Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf* [Accessed 12 Dec 20220] p.4

[5] NHS England, 2022. *Monthly Diagnostics – Provider – Oct 2022 XLS* [Online] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2022-23/ [Accessed 15 Dec 2022]

[6] NHS, 2019. *The NHS Long Term Plan* [Online] Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed 12 Dec 2022] p.59

[7] NHS, 2022. *Delivery plan for tackling the COVID-10 backlog of elective care* [Online] Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf [Accessed 12 Dec 20220] p.4

[8] NHS England, 2020. *National Cancer Waiting Ties Monitoring Dataset Guidance – Version 11.0 [Online] Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/national-cancer-waiting-times-monitoring-dataset-guidance-v11-sep2020.pdf [Accessed 12 Dec 2022] p.4*

[9] NHS England, 2022. *Cancer Waiting Times – National Time Series Oct 2009 – Oct 2022 with Revisions* XLSX [online] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/ [Accessed 18 Dec 2022]

[10] Patients referred for non-emergency consultant-led treatment are on RTT pathways. An RTT pathway is the length of time that a patient waited from referral to start of treatment, or, if they have not yet started treatment, the length of time that a patient has waited so far

[11] The Health Foundation, 2022. *Returning NHS waiting times to 18 weeks for routine treatment* [Online] Available at: https://www.health.org.uk/publications/long-reads/returning-nhs-waiting-times-to-18-weeks [Accessed 18 Dec 2022]

[12] NHS England, 2022. *Consultant-led Referral to Treatment Waiting Times Data 2022-23* [Online] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2022-23/ [Accessed 18 Dec 2022]

4.4 Expected outcomes

Please use the tables below to indicate which outcomes are expected to be realised, as a result of your project. Some outcomes have been included for validating the DDC programme's business case or identifying potential emergent benefits.

Digital pathology (digitisation of histopathology slides)		
Outcome ID	**Outcome**	**Project alignment**
DIP-O-010	**[Digitisation]** Increased number of slides available in digital form [DIP-006]	☒
DIP-O-020	**[Increased cases reviewed at MDTM meetings]:** Increased number of cases reviewed at MDTM meetings, enabled by instant/quicker access to (digital) slides (potentially leading to benefits, such as faster commencement of treatment, reduced inpatient admissions and reduced length of stay) [DIP-801]	☒
DIP-O-021	**[Reduced burden in MTDM slides preparation]** Reduced staff time burden in preparing slides for MDTM meetings [B3], [DIP-800 - 820]	☒
DIP-O-030	**[Increased image sharing requests fulfilled using digital images]** Increased number of internal and external histopathology slide sharing requests fulfilled using digital images [B12], [DIP-400 - 402]	☒
DIP-O-031	…leading to… **[Reduced need to transport glass slides]** Reduced need to package and transport glass slides for image sharing requests (leading to cost and staff time savings) [B5], [DIP-700, 710]	☒
DIP-O-032	…and… **[Reduced administrative burden in sharing slides]** Reduced administrative burden in fulling sharing requests [DIP-410 - 411]	☒
DIP-O-040	**[Quicker clinical decision making]** Reduced delays to clinical decision making, as a result of capability to share histopathology images with other clinicians in other trusts [B54]	☒
DIP-O-050	**[Reduced outsourcing]:** Reduced reliance on outsourced staff for histopathology reporting, enabled by capability to share histopathology slide images with clinicians in network [B1], [DIP-200, 240, 270]	☒
DIP-O-051	**[Reduced insourcing]** Reduced reliance on insourced staff (i.e. paying for additional capacity using in-house staff) for histopathology reporting, enabled by sharing of histopathology slide images [DIP-200, 240, 270]	☒
DIP-O-060	**[Reduced equipment cost]** Reduced costs associated with regular purchase of Microscope/camera equipment [B59]	☒

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5 Project delivery overview – Network and Trust Level

5.1 Deliverability assessment

DELIVERY AND TIMETABLE – BY TRUST

Please set out the anticipated delivery timescales in relation to the required reported project phases by Trust.

Project Ref	KMPN-DIGITAL PATH
Theme	Digital Pathology
Initiation	31/03/2023
Procurement	27/08/2023
Planning	30/12/2023
Detailed Design	30/12/2023
Delivery/implementation	30/09/2024
Testing/monitoring	31/01/2025
Live	28/02/2025
Benefits Realisation	30/06/2025

ALSO see Appendix B (Excel spreadsheet) *in each Trust tab -*

Please note that monthly Highlight Reports have and continued to be produced for updates in relation to phase baseline dates.

RISKS TO DELIVERY - BY TRUST

Please set out the key potential risks to delivery and mitigating actions to address these.

Please see Appendix C (Excel spreadsheet) *within each Trust tab -providing a high-level description of the Project key risks, dependencies, accountabilities or commitments with other Trusts and other organisations, which are critical to the delivery of the Project objectives.*

DELIVERY TO DATE - BY NETWORK

Did you deliver what your Trusts were awarded capital funding for in 20/21, 21/22 and 22/23?

If not – please explain why at a high level.

Digital diagnostic road map	2021/22	2022/23	2023/24	2024/25	Total 3yr plan	Grand total
	£'000	£'000	£'000	£'000	£'000	£'000
PACS/RIS replacement	69	1,091	0	0	1,091	1,160
iRefer CDS	779	130	340	0	470	1,249
Home reporting	1,696	239	0	0	239	1,935
POCT	103	0	0	0	0	103
Digital pathology	55	260	5,380	1,295	6,935	6,990
Order comms	2,367	246	276	140	662	3,029
AI	85	0	0	0	0	85
Order Comms - Acute	0	262	0	0	262	262
FISH		186	0	0	186	186
	5,154	**2,414**	**5,996**	**1,435**	**9,845**	**14,999**

	The above table demonstrates all the funding that we have had from the DDCP and digital initiatives. All funds prior to 2023/24 have been drawn down and spent. We have either completed e.g. Home reporting, or are in the process of completing e.g. Order Comms or are in the process of finalising the business case to secure the funding e.g. Digital pathology.

6 Financial overview

All VAT on capital has been treated as non-recoverable. VAT on the annual service change and cold storage charge has been assumed as recoverable. This has been reviewed and accepted by the Finance leads of MTW and EKHUFT. Funding can be drawn down in stages against the satisfactory confirmation of the achievement of the delivery / payment milestones to be defined in contractual agreements. Table 1 below provides the summary of the capital cost for the project. The detail is provided in Appendix D by Trust.

	21/22	22/23	23/24	24/25	TOTAL
	£'000	£'000	£'000	£'000	£'000
NHSE Approved - drawn down	55	260	-	-	315
NHSE approved - awaiting MOU (already spent)		-	400	-	400
Additional required	-	-	4,268	1,060	5,328
TOTAL	55	260	4,668	1,060	6,043
NHSE PROVIDED/EARMARKED IN ROADMAP	55	260	5,380	1,295	6,990

Table 1 Capital Cost of Digital Pathology

Organisations who receive capital investment must own any assets procured with the funding and will be responsible for any consequential costs arising from the funding award (including any ongoing costs arising from the initial investment). Such consequential costs may include capital charges and depreciation. Funding awards cannot be used to cover these consequential costs.

These consequential costs and all other revenue costs will be covered by investment from NHS Kent and Medway ICB. Therefore this case has a nil impact on the financial position of the provider Trusts. Below is a summary of the required investment from NHS K&M ICB. Table 2 below is a summary of the revenue costs of the project incurred by the Trusts. Pay costs cover the additional staff to run the scanner. Non pay is for the annual service charges and the 'cold' cloud based storage. Depreciation is the total capital cost and dividends are the return on capital that is required

MOVEMENT	Year 1 23/24	Year 2 24/25	Year 3 25/26	Year 4 26/27	Year 5 27/28	Year 6 28/29	Year 7 29/30	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital cash phasing								
Capital	4,268	1,060	0	0	0	0	0	**5,328**
Summary I&E impact								
Pay	0	11	104	68	68	68	68	390
Non pay	39	89	130	291	334	377	422	1,681
TOTAL PAY	39	100	234	360	402	446	490	2,071
Depreciation	0	288	1,151	1,151	1,151	1,151	1,151	6,043
Dividend	86	181	181	141	101	60	20	771
Total	**126**	**569**	**1,567**	**1,652**	**1,654**	**1,657**	**1,661**	**8,886**
Income								
MTW	**79**	**357**	**975**	**1,029**	**1,031**	**1,033**	**1,036**	**5,542**
EKHUFT	**46**	**212**	**591**	**622**	**623**	**624**	**625**	**3,344**
Total Additional income	**126**	**569**	**1,567**	**1,652**	**1,654**	**1,657**	**1,661**	**8,886**
Net Impact	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 2: Revenue impact of digital pathology on the provider Trusts.

UNINFLATED	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	
Revenue investment	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WEST	38	172	470	496	497	498	499	2,670
EAST	46	212	591	622	623	624	625	3,344
DGS	20	88	241	254	255	255	256	1,370
MEDWAY & SWALE	22	97	264	279	279	280	281	1,502
Total ICB investment	**126**	**569**	**1,567**	**1,652**	**1,654**	**1,657**	**1,661**	**8,886**

Table 3: K&M NHSE investment by HcP.

Table 3 reflects the total investment required by the K&M ICB by HCP area .
DHSC Cash and Capital has requested the following sections to be completed:

- Capital Expenditure profile – Outlining the funding source per quarter per Trust and totalled by Network
- Breakdown of Capital Costs – In project related categories by quarter per Trust and totalled by Network
- Statement of comprehensive income – Indicating the incremental Impact of the Project on the Lead Organisation (increased rev costs) per financial year, and a Whole Trust Position including the Investment over the Appraisal Period

These are provided in Appendix D (Excel spreadsheet) giving the financial overview as detailed above.

Since the proposal involves multiple trusts, the information in Appendix D has been completed for each Trust – there is a separate tab for each trust in the Excel spreadsheet (tabs Appendices MTW and Appendices EHUFT).

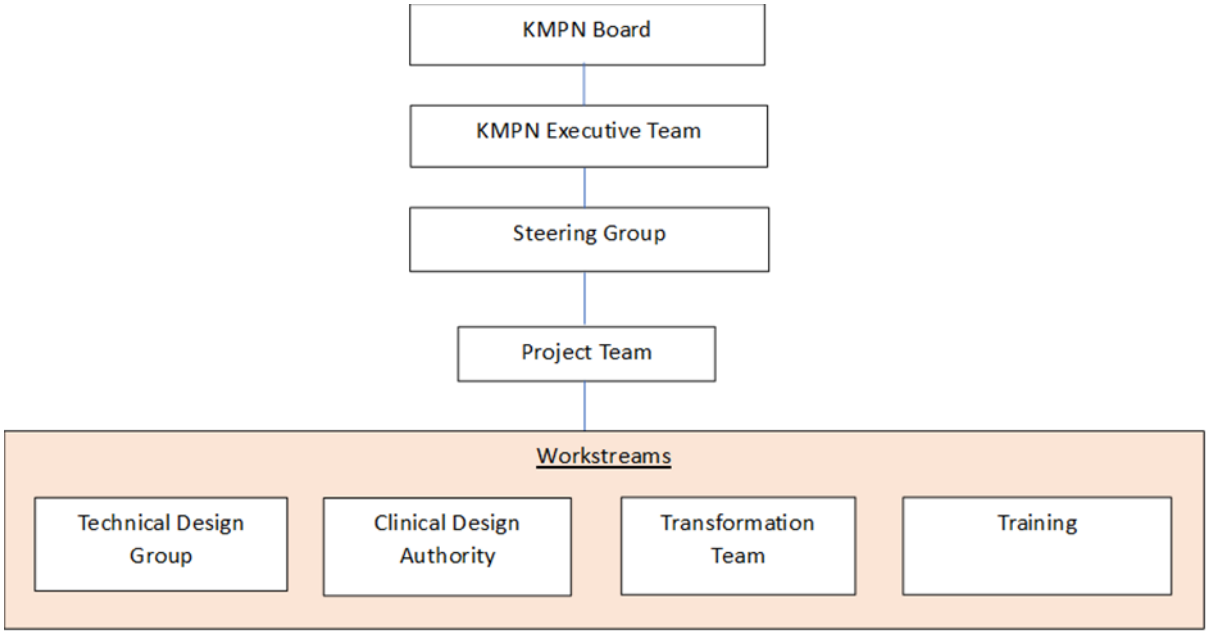
7 Key stakeholders/ officers contact details

Communications for Programme stakeholders

For communication purposes, please see **Appendix E** (Excel spreadsheet) to identify the key staff who will oversee this programme of work. These provide details, at Trust level, for each the following roles:

- Finance Director (mandatory field)
- Key Programme Contact (mandatory field)
- Senior Responsible Officer (SRO)
- Chief Information Officer (CIO)
- Chief Clinical Information Officer (CIO)
- Clinical safety officer (CSO)
- Programme Manager
- Business Change Lead

8 Programme Specific - Governance structure for network



The above diagram outlines the day-to-day governance for the project. A more detailed account of governance is given in *13.5 Management Case*.

9 Procurement

The section below describes the procurement strategy that has been adopted to procure the systems and services required to deliver the Project objectives.

Provision of central funding is dependent upon Trusts / Networks procuring solutions / services through the PTOM endorsed frameworks.

Pillar 3 covers Clinical Software / SaaS and Apps and includes implementation of Pathology / Radiology solutions. Details of the Pillar 3 endorsed frameworks are included below for ease of reference:

Pillar 3 – Software/SaaS/Apps – Clinical
- CCS: AI DPS RM6200
- LPP: Clinical Digital Solutions
- LPP: Health and Social Care Apps DPS
- NHSD: GP IT Futures
- NHSEI: HSSF

This programme used 2019/S212-519575 Pathology Point of Care Testing and the Atamis eCommercial platform framework.

How Suppliers were scored

The Project Team issued a Standard Operating Procedure (The SOP) to the DP Steering Group and to those invited to participate in the selection and procurement of a Digital Pathology solution. The SOP outlined the procurement process. Once the SOP was approved by the Steering Committee, the procurement process commenced.

The Procurement Team representing the two Trusts and led by MTW Procurement initiated the procurement process with the issuing of the Request For Information (RFI) through Supply Chain Framework 2019/S212-519575 Pathology Point of Care Testing and the Atamis eCommercial platform. Although the procurement is for a single solution that will be used by both Trusts, it is with MTW that the Supplier will contract. MTW will then recharge EKHUFT for their share. To facilitate, it will require a variation to the existing Kent & Medway Pathology Network Collaboration Agreement.

It should be noted that the Procurement Team led the process at every stage as described below to ensure compliance and integrity be maintained throughout.

Six suppliers registered an interest and were sent the Invitation To Tender (ITT) document. The ITT documentation included the Output Based Specification (OBS) which set out the explicit sets of criteria and requirements of a Digital Pathology solution needed by KMPN.

Scoring Matrix

The business requirements were agreed by the key stakeholders and documented in the Output Based Specification (OBS). They then agreed a MoSCoW priority for each requirement. This MoSCoW rating is used along with a response rating, to calculate a score for each requirement.

> **For example**: requirement A is a Must have requirement worth 5 points. The supplier indicates that their solution is partially compliant with this requirement, earning them 1 point. The total score for this requirement is 5*1 = 5. If the supplier had indicated that their solution was fully compliant with the requirement, they would have earned 3 points, and a total of score of 5*3 = 15.

Each requirement was given a MoSCoW rating and a response rating as detailed below;

Rating	Weighting
Must	5
Should	3
Could	1

Table 4: MoSCoW Rating

Response	Weighting
Fully Compliant	3
Partially Compliant	1
Not-Compliant	0
Future development (not in the current commercial release)	0

Table 5: Response Rating

The key stakeholders initially agreed the evaluation criteria would be based on two categories: business (70%) and Commercial (30%), but the Procurement team advised that Sustainability and Social values now needs to be evaluated for every public procurement, so the weighting were adjusted to business (60%), commercial (30) and sustainability (10%).

The following table shows the weightings of each section of the business requirements detailed in the OBS. So, for example, Whole Slide Scanner included 18 Must, 3 Should and 1 Could requirement, which if a supplier rated fully compliant for each would earn a maximum of 300 points.

Business Requirements (60%)	Maximum Points Available	Maximum Weighting %
1 Whole Slide Scanner	300	10
2 Pathologist Workstation	216	5
3 Virtual Image Management	240	20
4 Operational & Image Archiving	30	7
5 Backup & Business Continuity	15	5
6 Maintenance & Support	57	5
7 ICT Governance	438	2
8 Training	84	2
9 Project Management	45	2
10 Upgrades	60	2
Total Business Score	1485	60

Table 6: Nonfinancial Requirements Weightings

Each bidder then responded to each of the criteria, documenting their response in the OBS. The OBS criteria were categorised by areas of competencies. In other words, for example, Sustainability criteria were grouped, similarly Workstation and IMS useability had a separate group.

Expert panels were set up according to the groupings of criteria/requirements. Each panel consisted of Pathologists and Medical Physicists, IT Specialists, Trainers, Sustainability experts as appropriate, and were drawn from both MTW and EKHUFT for each of the panels.

Over several days each panel met and discussed the responses from each of the suppliers bidding for the contract. Scores as defined in the OBS were then applied according to the suppliers response. Each panel then scored according to the criteria set out in the ITT and presented their findings to the wider project team and to the Procurement team.

The seven bids were ranked by score. (*NOTE* – one supplier submitted two bids).

Legend: Wgt. = Weighting

			Supplier 1		Supplier 2		Supplier 3		Supplier 4		Supplier 5		Supplier 6		Supplier 7	
Business Requirements (60%)	Max points	Wgt. %	Points	Wgt. %	Points	Wgt. %	Points	Wgt. %	Points	Wgt. %	Points	Wgt. %	Points	Wgt %	Points	Wgt. %
1 Whole Slide Scanner	300	10	288	10	288	10	283	9	286	10	257	9	261	9	278	9
2 Pathologist Workstation	216	5	210	5	216	5	216	5	216	5	183	4	210	5	206	5
3 Virtual Image Management	240	20	231	19	225	19	240	20	219	18	162	14	225	19	240	20
4 Operational & Image Archiving	30	7	30	7	30	7	10	2	30	7	20	5	30	7	30	7
5 Backup & Business Continuity	15	5	5	2	15	5	15	5	15	5	5	2	15	5	5	2
6 Maintenance & Support	57	5	32	3	47	4	35	3	45	4	27	2	38	3	35	3
7 ICT Governance	438	2	325	1	412	2	432	2	432	2	403	2	432	2	402	2
8 Training	84	2	78	2	84	2	84	2	84	2	74	2	78	2	78	2
9 Project Management	45	2	5	0	45	2	35	2	45	2	25	1	25	1	45	2
10 Upgrades	60	2	20	1	60	2	50	2	60	2	40	1	60	2	50	2
Total Business Score	1485	60	1224	49	1422	57	1400	57	1432	58	1196	48	1374	56	1369	55
Sustainability & Social Values Requirements (10%)		10		10		10		10		10		10		10		10
Total Sustainability & Social Values Score		10		10		10		10		10		10		10		10
Commercial Requirements (30%)	30	30		24		13		30		14		15		18		12
Total Score (100%)		**100**	**1224**	**83**	**1422**	**80**	**1400**	**97**	**1432**	**82**	**1196**	**74**	**1374**	**83**	**1369**	**78**
				3		**5**		**1**		**4**		**7**		**2**		**6**

Table 7 Appraisal of Suppliers

Conclusion

Based on the evaluation supplier 3 was selected as the preferred supplier.
Procurement then advised those bidders who were unsuccessful, and engaged with the bidder with the highest score to complete the Procurement.

10 Financial obligations

- Trusts cannot rely upon any reduction in financial / contractual obligations if it wants to Exit any contractual arrangements early.

- Financial obligations on each Trust shall remain over the contract duration unless agreement to reduce charges can be reached with the supplier - this includes any post award contractual changes agreed through change control.

- Trust exits from contractual agreements entered for the benefit of the Network should be avoided, rather the service should be used as an archive service.

- Any internal dispute between Trusts in a Network that cannot be resolved locally shall be escalated to the Digital Diagnostics Programme SRO and the programme procurement lead for resolution. Trusts and networks acknowledge and accept that the outcome of such escalation shall be final.

- Each relevant Trust in the network commits that it will act as Lead Trust and allow the contract to be novated to it, if the initially appointed Lead Trust needs to step away from this role (e.g. because it is terminating early / reducing its service to an Archive solution, etc);

- Each applicable Trust commits to cover the cost of any impact on its go-live caused by any delay that it causes. The KMPN Collaboration agreement will commit to cover and identify who is liable, if it experiences delays as being part of the Network (i.e. if the delay is caused by another Trust in the Network).

- Each applicable Trust commits to allowing its slot in the deployment schedule to change to minimise the impact on the other network Trusts (should they be unable to achieve their original planned implementation dates).

- Each applicable Trust commits to an equitable proportion of shared resource costs based upon service / solution usage throughout the life of the contract.

11 Benefits metrics

Methodology

The benefits tables have been provided in the template. The group reviewed all those that were applicable and ensured the mandatory ones were applicable.

The benefits associated with each option were identified during several workshops, with the following key stakeholders:

Dominic Chambers – Consultant Histopathologist, MTW and Digital Pathology Lead
Theresa Welfare – Lead Bio-Medical Scientist, MTW
Stuart Turner – Lead Bio-Medical Scientist, EKHUFT
Furthermore, other Trusts who have implemented Digital Pathology were also consulted, including Oxford University Hospital Trust and Leeds Teaching Hospitals NHS Trust.

A conference call to obtain a histopathologist's perspective of benefits also took place with Alyn Cratchley, Consultant Histopathologist, Leeds Teaching Hospitals Trust, who is also the clinical Lead for Digital Deployment for National Pathology Imaging Cooperative (NPIC).

Benefits Assurance

The Benefits Register was reviewed during a series of meetings and audience members were requested to attest that the identified benefits of the Digital Pathology project are:

- Complete
- Deliverable
- Correctly identified as non-cash releasing.

Date	Group	Lead
June 14 2023	Pathology General Managers: Mark Holland (MTW), Marcus Coales (EKHUFT)	Dominic Chambers
June 14 2023	Cellular Pathology Consultants Meeting	Stuart Turner/ Nicola Chaston
June 21 2023	Cancer Board – MTW: Consultants involved in cancer care and one senior nurse practitioner in cancer care.	Theresa Welfare
June 23 2023	COOs: Sean Briggs (MTW), Dylan Jones (EKHUFT), Nick Sinclair (MFT) and Victoria Harrison (DGT).	Dominic Chambers /Steve Hives
June 8 2023	MTW Cellular Pathology Clinical Governance & Audit Meeting: Consultants, Consultant BMS/Clinical Scientist, Service Manager, Histology Quality Lead, (Histology) Laboratory Manager & Cut up Practitioners.	Dominic Chambers
August 2 2023	Cancer Board - Dartford & Gravesham: 6 Cancer Nurse specialists, 2 oncologists, Director of Ops for Medicine, Cancer and Emergency care, Lead for radiology, 2 x Macmillan nurses, Urology Consultant, Cancer performance team (x2), Chemo nurse, Breast Consultant, Deputy COO, Haematology Consultant, Ward Sister (nurse), Surgery lead Consultant.	Theresa Welfare
August 3 2023	Finance Leads: Julie Wells (EKHUFT), Viv Bertram (EKHUFT), Hannah Ferris (MTW) and Andrew Wills (ICB).	Ada Foreman

September 14 2023	Medway Cancer Board: Present Clinical Consultants, Cancer Pathway Managers, General Managers, MacMillan Nurses, Oncologists, Chief Delivery Officer, Director of R&I, Director of Operations	Julie Cooke (Cell path Head BMS)

Table 8: Benefit Assurance Meetings

See 13.5.11.3 for a detailed account of how Benefit Realisation will be managed.

See benefits metrics table and Register (**Appendix G** and **Appendix 2)**.

12 Counterpart commitments [for information only]

KMPN's counterpart commitments (as stipulated by NHSE)

To be eligible for this funding, the recipient agrees to the following commitments:

1. Delivering the programmes and projects defined in this SFBC

2. Producing light-touch reports to NHSE Regions to enable the production of high-level dashboards. This will be managed by the KMPN Network staff.

3. Ensuring the project is clinically led where appropriate, with sufficient dedicated resource to enable delivery

4. The network project team sharing progress with networks, NHSE Regions to enable wider learning

5. Conforming to national standards, including on cyber security, interoperability and IPR, open data and open source.

6. Confirms that all procurement related activity was conducted in accordance with the latest procurement regulations and use the procurement frameworks endorsed by PTOM.

7. The Recipient agrees to have a plan in place to reach the required standards as set out in the Data Security and Protection Toolkit (where their DSPT status is currently 'standards not met') and, where requested, engage on this issue with NHS Digital regional leads.

8. The Recipient agrees to have a plan in place to migrate off unsupported versions of Windows (including Windows 7 and unsupported Windows 10 versions where either are present on their estate) and, where requested, engage on this issue with NHS Digital's Trust System Support Model (TSSM) Team. This is because unsupported systems provide a relatively easy means by which cyber attackers can gain access to networks and services as such this is a risk to an organisation's operations and reputation and poses a potential threat to patient safety.

9. To document and agree any changes required by this service in the Kent and Medway Pathology Network Collaboration Agreement

10. If the funding received is greater than £5m the project agrees to complete mandatory blueprint documentation for NHSE, if requested. Details on blueprinting are available here: https://future.nhs.uk/GDEcommunity/grouphome NHSE/I reserve the right to implement Spend Controls, under the authority of the Cabinet Office, and to hold Trusts accountable to them.

By signing this business case , Recipients are agreeing to all commitments.

13 Five Case Model - Project detail

There is only one presentation of the strategic, commercial and management case in this business case because they are the identical for both Trusts.

13.1 STRATEGIC CASE

Part A: The strategic context

13.1.1 Introduction

Pathology is the study of disease, and it is estimated that it is involved in 70% of all diagnoses made in the NHS. Kent and Medway Pathology Network (KMPN) plays a crucial role in the local healthcare system, underpinning all clinical services, enabling the effective delivery of care to the community. Pathology is also a key enabler to Government health delivery plans, including cancer services, for which Histopathology plays a critical part.

Histopathology, a branch of Pathology, is the diagnosis and study of diseases of the tissues, with histopathologists responsible for making tissue diagnoses and helping clinicians determine and manage a patient's care. It therefore contributes hugely to the quality of care provided to patients and the success of any treatment. To enable this vital role to be performed, the histopathology service requires the tools and digital infrastructure to be available and adequate to match the ever-changing clinical landscape, and to enable progression towards emerging technologies, such as Artificial Intelligence (AI), as they evolve.

The evolving competitive pathology market introduces both opportunities and threats for Acute Trusts. The Kent and Medway Pathology Transformation Programme aims to establish a single, high quality, robust and sustainable Pathology service for the people of Kent and Medway, supported by systems and processes, resulting in the creation of an organisation which can thrive and grow within an evolving competitive market environment. A move to Digital Pathology will ensure that the Kent & Medway histopathology service remains in line with histopathology services provided nationally, of which many are either already on, or about to embark onto, the Digital Pathology journey.

Furthermore, with growing volumes of histopathology workload (c. 5% per annum) and increasing complexity of cases, alongside a chronic national shortage of histopathologists, it will not be possible to sustain, let alone improve on, the service provided to the patients of Kent and Medway, without significant investment in change. This poses a real threat to the future of the Kent & Medway Pathology Network.

13.1.1.1 Organisational overview

Histopathology is a service currently provided by Maidstone and Tunbridge Wells NHS Trust (MTW) and East Kent Hospitals University NHS Foundation Trust (EKHUFT) over 2 sites – Maidstone Hospital and William Harvey Hospital respectively.

13.1.1.1.1 Maidstone & Tunbridge Wells NHS Trust

MTW provides a full histopathology service on behalf of their own Trust, as well as on behalf of Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust, via a direct contract with each Trust. MTW also has contracts to provide services for external bodies, including Sussex Community Dermatology Service.

The Histopathology Department sits within the Pathology Directorate which forms part of the Core Clinical Services Division (formerly the Diagnostics & Clinical Support Services Division).

13.1.1.1.2 East Kent Hospitals University NHS Foundation Trust

EKHUFT provides a histopathology service solely on behalf of their own Trust. Cellular Pathology (including mortuary services) forms part of the Clinical Support Services Care Group.

13.1.1.2 Business strategies – the national context

13.1.1.2.1 National Pathology Networks

The NHS Long Term Plan committed the NHS to establishing pathology networks across England by December 2021, with the objective that they are more efficient, more digitally enabled, have greater resilience, and with reduced variation and reduced human error, through automation.

It was recognised that realising the benefits of a Pathology Network will take time and as networks adapt to the new way of working to deliver the expected transformation of Pathology services, they will need to progress along a maturity curve.

To assist networks, regions and the national team with this progression, the Pathology Network Maturity Matrix Tool was introduced to provide a means of objectively assessing maturity aligned to five progression stages from pre-emerging to thriving.

Against this model, the Kent & Medway Pathology Network was assessed as an 'emerging' network, with the CEOs of all 4 Trusts committing, in a letter to NHSE, to progress along the maturity curve to deliver a 'developing' network by the end of 2022/23 and become a 'maturing' network against all domains by the end of 2024/25.

In order to achieve this progression, a gap analysis was undertaken which included actions against the maturing key indicators, along with timescales to complete these actions.

Digital Pathology was included on the gap analysis, the maturing key indicator being 'A proportion of WSI (Whole Slide Imaging) are being analysed using computerised analysis', **with a target date of 31/03/2025 for** '**WSI used for primary diagnosis for at least 50% of services or investigations in each Trust**.'

In order to achieve this, implementation of Digital Pathology needs to commence early 2024, and failure to approve the required revenue funding will mean that this will not be achievable.

13.1.1.2.2 Cancer Pathways

Histopathology is a critical diagnostic activity within the cancer pathways[13], with targets set by NHS England, such as the FDS (Faster Diagnosis Standard)[14] and the maximum 62 day wait[15]. With the existing challenges faced in Histopathology detailed in this report, such as a chronic shortage of consultant pathologists, investment in change is essential to ultimately maintain and even improve Histopathology turnaround times (TaTs). The introduction of Digital Pathology in Kent & Medway would provide a firm foundation to support this going forward.

13.1.1.2.3 The Need for Interoperability

Interoperability is critical for Kent & Medway Pathology Network to work collaboratively, as a true network, in order to drive service efficiencies. The existing Histopathology reporting process centres around Histopathologists and microscopes in physical laboratory spaces, reporting on glass slides, which is not conducive to interoperability, whereas digitisation will help to balance workloads across the laboratory and between sites, streamline collaboration and broaden access to specialist expertise and secondary opinions, both nationally and internationally, so that patients can receive higher quality diagnoses faster.

13.1.1.2.4 Royal College of Pathologists recommendations

In response to the 2020 Cancer Research UK report[16] , the Royal College of Pathologists state, "*for the Histopathology workforce, the report findings show that without targeted action and investment, the number of Histopathologists is forecast to reduce from the existing shortfall".*

[13]The patient's journey from the initial suspicion of cancer, through clinical investigations, patient diagnosis and treatment
[14] FDS – Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently and from NHS cancer screening
[15] Maximum 2-month (62 day) wait to first treatment from urgent GP referral, consultant upgrade and NHS cancer screening
[16] Estimating cost of growing NHS Cancer workforce in England by 2029. CRUK - Sep 2020

In recognising that '*Digital Pathology has the potential to improve patient care and support the pathology workforce by making the diagnosis and monitoring of disease much more efficient'*, whilst acknowledging that '*in order to transform pathology services, we need investment to support IT infrastructure, staffing and training'*, they have developed a high-level strategy for the implementation of diagnostic digital pathology. This promotes adoption of digital solutions for the benefit of improved outcomes, increased productivity, and efficient working practices[17].

The below points are listed as the impact of Digital Pathology on the Royal College of Pathology website:

- **Benefits patients** by enabling the rapid referral of cases between organisations or across pathology networks, enhancing access to expert advice and opinion on diagnoses
- **Improves laboratory workflow** and connectivity and increases flexibility and efficiency of the workforce, helping create digital training resources that support the development of specialists in training
- **Increases our power to share** slides and more, making it easier for others to benefit from the fantastic expertise in our profession
- Provides the foundation for the use of **artificial intelligence** which will help bring advances to pathology services

A UK-wide survey[18] of Histopathologists was conducted in 2017, to provide the College with a comprehensive picture of Britain's pathology workforce. The survey found that there were serious shortages affecting departments across the country, as follows:

- Only 3% of Histopathology departments said they had enough staff to meet clinical demand, and this demand continues to grow.
- The cost of outsourcing services and using locum doctors is an estimated £27 million a year across the UK.
- There was an approaching retirement crisis as a quarter of all Histopathologists are aged 55 or over, with 9% aged at least 60, and there were insufficient trainee doctors in post to fill the gaps in the workforce.
- It can take up to 15 years to train a pathologist and experienced consultants typically report up to twice as much as newly qualified consultants.

13.1.1.2.5 2023/24 Priorities and Operational Planning Guidance

Published by NHSE, in Feb 2022 (v3), this document sets out the objectives and priorities for Trusts for 2022/23 and includes the following priority:

Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

Within this document, there are 2 sub-sections that are extremely relevant to this business case:

- C2: Complete recovery and improve performance against cancer waiting times standards
- C3: Diagnostics

C3 references the Kent & Medway Diagnostic Digital Roadmap submitted to NHSE in which the capital bid for Digital Pathology was included, and states that the implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

As a result of the submission of this roadmap, the capital funding for Digital Pathology was approved in principle by NHSE, subject to internal approval of the consequential revenue funding and capital charges, the subject of this business case.

[17] Digital Pathology Strategy 2019 – RC Path – Apr 2019
[18] Histopathology Workforce Survey 2018

13.1.1.3 Business strategies - regional and local priorities

13.1.1.3.1 Pathology vision

Published on 15th October 2020, the 'Vision for the Kent & Medway Pathology Service' set out the strategic objectives for the Kent & Medway Pathology Network, as follows:

Objective 1: The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative, and creative.

Objective 2: Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs.

Objective 3: Creating a workforce that feels valued, involved, and owns the single pathology service as partners in the service; and it is a great place to work.

Objective 4: Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential and meets the needs of the client Trusts and Commissioners.

Objective 5: Managing the transition to the new service in a creative and competent manner.
The below table demonstrates how Digital Pathology will contribute to the above objectives.

Network Strategic objective	*Specific to Digital Pathology*
The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative, and creative.	Ability to digitally share images between Trusts Single set of Standard Operating Procedures (SOPs) Workflow aligned between Trusts, where possible Use of proven, innovative technology
Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs	Will enhance accuracy and precision of reporting of cases. Will provide the foundation for the future adoption of Artificial Intelligence and other evolving technologies to further enhance accuracy and speed of diagnosis
Creating a workforce that feels valued, involved, and owns the single pathology service as partners in the service; and it is a great place to work.	More desirable for students and newly qualified histopathologists to work in an innovative digital environment that is ready to onboard AI and emerging technologies as they mature. Enabler for flexible/remote working. Facilitates collaborative working between Trusts and external partners.
Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential and meets the needs of the client Trusts and Commissioners.	Will digitise the existing histopathology process in order to create efficiencies and build a foundation for the adoption of AI and other evolving technologies.
Managing the transition to the new service in a creative and competent manner	Effective and efficient implementation of a Digital Pathology Solution across the histopathology departments at MTW and EKHUFT using proven methodologies and best practice from other Networks who have already implemented Digital Pathology

13.1.1.3.2 Regional Charter

The 'South-East Digital Diagnostics Charter' signed in May 2022, outlines the key principles that NHS England South-East asked all networks in the region, but principally Radiology and Pathology, to sign up to.
A network-wide implementation of Digital Pathology will contribute to several of the strategic aims included in this charter, as detailed below:

- All diagnostic results are available to clinicians at the point of care, irrespective of where the diagnostic test was undertaken, i.e. complete interoperability between diagnostic systems and any results' repository.
    - The Digital Pathology solution will include a 2-way interface between the Image Management System (IMS) and the Laboratory Information System (LIMS) which will associate patient data held in LIMS with the glass slide images held in IMS and also send the Consultant Pathologist reports, following analysis of the images, to LIMS. This is currently a manual entry process.

- All histopathology services to have the ability to share slide and specimen images digitally for reporting locally and in conjunction with specialist colleagues elsewhere
    - Slides of at least 70% of Histology cases to be available digitally
    - Digital images of macroscopic specimen dissection to be available in at least 50% of complex cases not cut by a reporting consultant

    - Only the implementation of Digital Pathology can achieve this.

- All clinical staff who provide specialist interpretation of clinical images (including histopathology) are enabled to work remotely

    - Digital Pathology will enable histopathologists to access, analyse and report from any location using a standard workstation and medical grade screen. It should be noted that the funding to purchase a second medical grade screen for the consultants to report at home is not included in this Business Case.

13.1.1.3.3 South-East Histopathology Forum

On 6th October 2022 the South-East Histopathology forum took place, attended by histopathology stakeholders from across the region to discuss current regional challenges, recovery plans and priorities. Amongst key themes impacting on performance against targets, the significant challenges around workforce recruitment and retention were discussed, with 48 histopathology positions currently vacant across the region. In response to this, it has been recognised, in Recovery Action Plans across the networks, the need in the medium term, to digitalise, automate, and enable remote reporting to offer flexible working, all of which Digital Pathology will support.

Part B: The case for change

13.1.1.4 Investment Objectives

The Investment Objectives for this project have been agreed by the Digital Pathology Steering Group, as follows:

Objective 1: Provide a quality, safe, effective, sustainable, and timely histopathology service for patients.
Objective 2: Improve recruitment and retention of current and future workforce to address the workforce shortage of Consultant Histopathologists within the Kent & Medway Pathology Network by making it a desirable place to work.
Objective 3: Contribute to Trust Cancer Pathway performance as workload and complexity of cases continue to grow, in order to provide the optimum result for the patient in a timely manner.
Objective 4: Future proofing **-** Provide a foundation for the introduction and exploitation of Artificial Intelligence and other emerging technologies in the future to further increase efficiencies and resilience.
Objective 5: Facilitate collaboration both within and outside of the network, improving patient pathway experience and collegiate working across the network.

The five Investment Objectives can be translated using the SMART approach as detailed in Table 9: Translating Investment Objectives to Digital Pathology. This approach helps to show how the implementation of digital pathology would contribute to these.

Investment Objective	*How?*	*Measurable*	*Achievable*	*Relevant*	*Time-bound*
Provide a quality, safe, effective, sustainable, and timely histopathology service for patients	Creation of efficiencies within the histopathology process Enhance the accuracy of reporting	Turnaround Times (TaTs) - Performance against cancer pathway targets and KPIs Patient outcomes	Proven at other Trusts who have implemented Digital Pathology	Addresses one of the key challenges for the K&M Pathology Service – maintaining TaTs as workload grows	Implementation plan will be agreed with the selected supplier and baselined
Improve recruitment and retention of current and future workforce to address the workforce shortage of Consultant Histopathologists within the Kent & Medway Pathology Network	Enabler for Remote/Flexible Working Opens a Wider recruitment net (potentially global) Use of innovative and emerging technology making it more desirable for medical students to train in this specialism	Recruitment performance e.g. Time to hire, no. of vacancies Employee retention performance e.g. average age of retirement	Moving from glass slides to digital images will be the enabler to achieve this objective	Addresses another of the key challenges for the K&M Pathology Service – the national shortage of Histopathologists	Will be implemented in a similar timescale as a number of other Trusts nationally who have also obtained capital funding from NHSE enabling K&M to be competitive from a recruitment perspective
Contribute to Trust Cancer Pathway performance as workload and complexity of cases continue to grow, in order to provide the optimum result for the patient in a timely manner	Creation of efficiencies within the histopathology process	Turnaround Times Performance against Cancer Pathway targets	The level of efficiencies required can only be achieved through the implementation of Digital Pathology	Critical to safeguard the future of histopathology at K&M	Implementation plan will be agreed with the selected supplier and baselined
Future proofing **-** Provide a foundation for the introduction and exploitation of Artificial Intelligence and other emerging technologies in the future to further increase efficiencies and resilience efficiencies to drive down TaTs	Moving from glass slides to digital images and storage/archiving of these images	Volume of images in archive	Bank of digital images will grow as the Histopathologists transition to digital pathology, a pre-requisite for the adoption of AI	The introduction of AI will ultimately deliver significant benefits, efficiencies, and improved accuracy	Implementation plan will be agreed with the selected supplier and baselined
Facilitate collaboration both within, and outside of, the network, improving patient pathway experience and	Ability to share digital images, negating the need to physically transport glass slides	Turnaround Times Preparation time for MDMs (Multidisciplinary Meetings)	Moving from glass slides to digital images will be the enabler to achieve this objective	Key to working as a true network as well as to maintaining or improving Turnaround Times	Implementation plan will be agreed with the selected supplier and baselined

Investment Objective	*How?*	*Measurable*	*Achievable*	*Relevant*	*Time-bound*
collegiate working across the network					

Table 9: Translating Investment Objectives to Digital Pathology

13.1.1.5 Existing arrangements

13.1.1.5.1 MTW

MTW provide a full histopathology service on behalf of their own Trust, as well as on behalf of Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust, via a direct contract with each Trust.

Based at Maidstone Hospital, all histopathology reported internally is conducted using the traditional microscope method, with some outsourcing of routine cases. In 2021/22 approximately 13,500 slides were outsourced for routine reporting, in response to the Covid backlog - prior to this there was no routine work outsourced. Additionally, there were 17,300 slides sent out in 2019/20 (pre-Covid) for external second opinion. There is currently no digitalisation of slides.

The team that reports on the cases consists of 20 Consultant Pathologists and 2 Consultant Biomedical Scientists. There are also up to 10 trainee Histopathologists.

In response to a shrinking workforce and increasing work volumes, a workload assessment was recently performed **based on current workload volumes**, which identified a shortage of 4.57 WTE consultant Histopathologists, for which a Business Case process is currently underway.

13.1.1.5.2 EKHUFT

EKHUFT provide a histopathology service solely on behalf of their own Trust. All histopathology reported internally is via microscope, however, there is also a scanning solution to produce digital images of slides, that was recommended and procured via their outsourcing partner.

The scanning solution was implemented, and is used, only for outsourced routine referrals to that partner, to accelerate the TaT of those results and decrease the administration, costs and risks associated with shipping out and receiving back physical slides. No reporting is done internally via digital images. Internal laboratory staff are therefore familiar with the scanning technology, but not with analysing and reporting digital images.

The contract allows for 10,000 routine cases per annum to be scanned and emailed to the outsourcing partner for reporting. An interface has been built between the provider's IT system and their LIMS system, Apex, which automatically populates the results into LIMs, instead of being emailed and manually entered.

EKHUFT currently has vacancies for 4.9 WTE consultant Histopathologists which they have been trying to recruit to for over 2 years. Due to this, they have become heavily reliant on outsourcing and use of locums and bank staff.

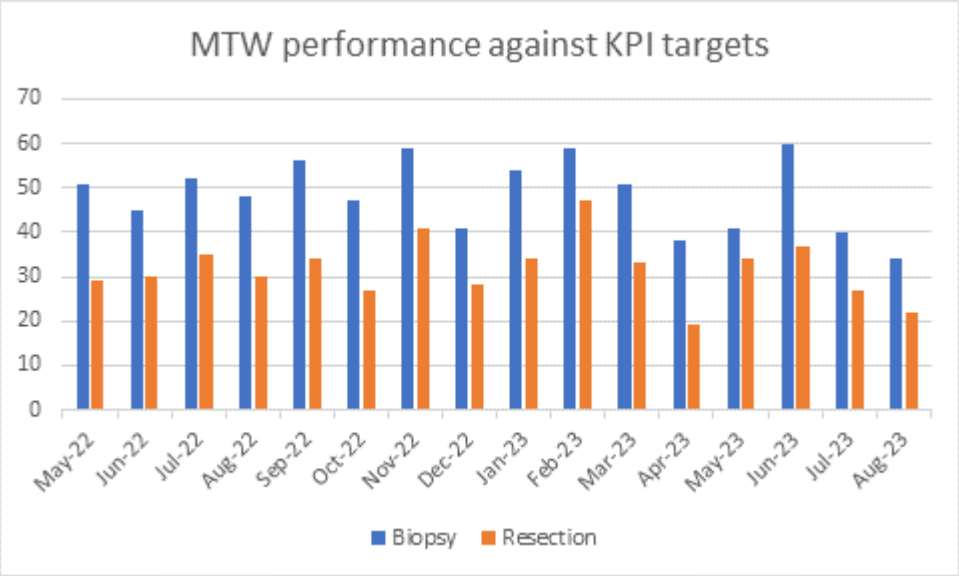
Both EKHUFT and MTW have completed a workload assessment, which established the resource availability versus demand.

13.1.1.6 Business Needs

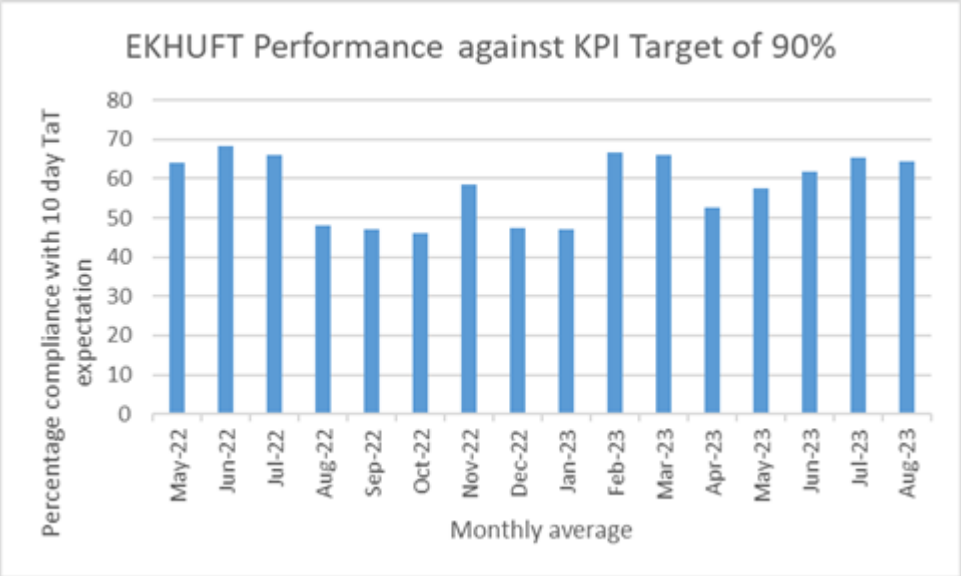
Like many clinical specialties, histopathology is facing the perfect storm of rising demand, increasing complexity of interpretation, an aging clinical workforce, and a decreasing number of trainee histopathologists.

The Kent and Medway histopathology service is already experiencing a degradation of performance as a result of having insufficient histopathologists to meet the current demand at both Trusts. This is demonstrated by their performance against their respective KPI targets. As shown in the below graphs, both Trusts are consistently underperforming against their targets, each target being 90%.

MTW performance against RCPath KPI targets



EKHUFT performance against RCPath KPI Target



As previously mentioned, a recent workload assessment performed by MTW identified a deficit of histopathologists of 4.57 WTE just to meet current demand.

Table 10 below details the age profile (as of 2022/23) of the substantive / retire and return Histopathologists at each Trust. This shows that in both Trusts there are more Histopathologists aged over 55 than under 45, and in the case of EKHUFT considerably more. This mirrors the situation nationally, as highlighted in Section 13.1.1.2.4 Royal College of Pathologists recommendations.

	No. of Histopathologists by age bracket				
Age Bracket	**Under 45**	**45 – 54**	**55 +**	**Retire & Return**	**Total**
MTW	4	9	4	2	19
EKHUFT	2	9	4	2	17

Table 10: Number of Histopathologist by Age Bracket as of 2022/23

On commenting on the NHS recovery plan, Professor Mike Osborn, President of The Royal College of Pathologists, quotes on the RCP website:
Without investment in pathology, it will not be possible to tackle the diagnostic backlog.'
'The announcement sets out how the COVID-19 backlog of elective care will be tackled and it is encouraging to see the focus on investment in areas such as digital pathology, imaging and Artificial Intelligence.'
'However, the pathology workforce is key to reducing the backlog, especially in cancer diagnosis and is also crucial to disease prevention, infection control and good antibiotic stewardship. It is vital that investment is targeted at pathology services to alleviate workforce pressure and meet increased demand.'

It is therefore recognised nationally that there is a critical need to invest in change in pathology, via digitalisation and automation, to optimise processes and maximise efficiencies. With a growth in histopathology workload in Kent and Medway of c.5% per annum, compounded further by the Covid elective care backlog, and the shortage of histopathologists, it will be impossible to maintain, let alone improve, current performance against local and national targets, without significant investment.

In fact, investment in change is essential to protect the future of the Kent & Medway Pathology Network and improve on the service provided to cancer patients in Kent. The introduction of Digital Pathology in Kent & Medway would provide a firm foundation to support this.

And ultimately, if investment is not made in this technology, with a number of Trusts and Networks nationally already well advanced on the Digital Pathology journey and others embarking, Kent & Medway will be left behind, as an undesirable place to work for histopathologists, with no opportunity to exploit Artificial Intelligence once it matures, which is where the significant efficiencies will be gained in the future.

13.1.1.6.1 Scope of preferred option

13.1.1.6.2 Potential business scope and key service requirements

For Digital Pathology the proposed investment is to digitalise the reporting of all Histopathology services provided by the 2 Trusts, with the exception of those outlined in Section 13.1.1.6.3 Out of scope services.

Though the overall objective is to ultimately achieve 100% digitalisation of the in-scope services, the adoption of Digital Pathology across all histopathology disciplines will be gradual, phased in by Histopathologist and further by specialism, and is likely to take several years.

The key service requirements for a digital pathology solution are as follows:

(1) High throughput automated **whole slide imaging scanners** capable of scanning high volumes of stained microscope slides. Must be located so as to not interrupt workflow and be of a size to fit in existing laboratory space.

(2) **Provision of image storage**: The size of any archive storage will depend on the final agreed scope of the investment, but the system should retain the images for a sufficient period of time in line with data retention policies to enable audit and case review as well as adhere to data retention policies. Archive storage architectures would need to be agreed with the supplier as would back-up/ system resilience plans.

(3) **Slide / Caseload software** that manages the clinical caseload and the digital slide images. This includes image creation, workload management, slide viewing, slide sharing, clinical annotation and measurements, report generation and case submission. The software also creates and holds audit trails relating to the activities undertaken for each case. Image analysis software can also be applied to slides to improve the effective quantitation of cell markers (e.g. HER2 in breast cases).

(4) A **Pathology workstation** set up comprising of a clinical grade screen to analyse the images, a standard screen to produce reports, a specialised precision mouse and a high-spec laptop.

(5) **2-way interface with LIMs**, to pull information relating to patient cases and push required results/report information back when the case is complete.

(6) **Implementation support** – to include supplier-side project management, installation, and training

(7) **Service Management contract** – providing hardware and software support and maintenance initially by phone, followed by a site visit where required

(8) **Information management and technology hardware** - The servers (locally or remotely hosted), host the application software described below and may provide short term storage for the images. A webserver can allow image access from any web-browser- enabled PC connected to the institutional network

13.1.1.6.3 Out of scope services

The following histopathology services are currently considered to be out of scope for digitalisation:

- Diagnostic Cytology – this should be noted for future consideration, but not for initial inclusion, as it is low volume and not suitable for the technology this project is procuring initially.

- Immunofluorescence for skin – the scanners to be procured initially do not cater for fluorescence which would require specialist scanners.
- Frozen sections - as they are very low volume but will require a dedicated specialist scanner. Being rapid pieces of work requiring a considerable level of validation, scanning would add little value and potentially incur more time.
- Home reporting - set up to be procured and implemented via a separate project. It would also require a significant level of information governance input.
- AI - the purchase and implementation of AI does not form part of this Business Case. Although they are not included in this Business Case, digital pathology is a key component of making both remote working and Artificial Intelligence (AI) possible. Histopathologists cannot report remotely without the use of digital pathology, and we cannot integrate AI diagnostic methods without a digital platform.

13.1.1.7 Constraints

Constraints, like dependencies, carry the potential to disrupt the smooth progress of any project and as such must be identified and managed proactively.

Constraint	Management Actions
Delivery of the project within the budget approved – NHSE (Capital), Contributing Trusts (Revenue) and spending funding within the constraint of the financial year.	Work closely with the supplier, monitoring expenditure regularly. Avoid delays by managing dependencies, issues, and risks effectively, as well as all activities on the critical path. Within the procurement process those suppliers who could meet our tight timelines were viewed more favourably.
Availability of critical resources such as subject matter experts, Clinicians, Trust IT Teams, pathology IT Teams, supplier resources and third-party resources, at a time when multiple pathology projects are being undertaken, involving the same resource.	Work closely with all parties contributing resources. Agreements at Programme Management / Trust Executive level will be required to ensure that the project will be supported as a priority. Funding built in to backfill key roles.
Limitations around the abstraction of laboratory staff for training on the new system and equipment being implemented so as to ensure Turnaround Times are not impacted.	Coordination of staff for training will need to be managed closely by each Trust. Weekend training (will incur overtime).
Estate space to accommodate scanners in the laboratory in suitable locations, and dual screens, alongside microscopes, in the histopathologist's offices.	Scanner dimensions to form part of the solution selection process. Work with the supplier to determine where scanners should be best placed to optimise workflow based on best practice. Audit of histopathologists office space.
Buy in and subsequent adoption of the solution by the histopathologists in order to become as fully digitised as possible.	Phased deployment to histopathologists starting with the 'enthusiasts' first. Facilitate engagement with histopathologists outside of Kent and Medway who are using digital pathology.

Table 11: Project Constraints

13.1.1.8 Dependencies

Within any complex programme of work dependencies between projects and workstreams are inevitable and must be closely managed. Failure to identify and manage key dependencies will lead to cost overruns and schedule slippage. Table 12 shows the dependencies for the implementation of Digital Pathology.

Dependency	Impact of delay or change	Key dates (as per current indicative timeline)
Dependent on the implementation of the new single LIMS system at each site to implement an interface with Digital Pathology.	Whilst it is technically possible to go live without the LIMS interface by updating digital pathology manually in line with current process, any delays to the LIMS project will delay the realisation of benefits of an active LIMS interface.	MTW – LIMS due to go live Aug 2024 EKHUFT – LIMS due to go live Nov 2024 NKPS – Jan 2025
Dependent on the approval of the Full Business Case (FBC) to secure the required consequential revenue.	Failure to secure the consequential revenue funding will mean that the project cannot proceed.	OBC was approved March 2023. Final approval of FBC planned Dec 2023.
Delivery of the project is dependent on the availability of some key resources that are critical to the implementation.	Successful implementation will be dependent on the ability to backfill some of the key project roles at the required time for the required duration.	From January 2024 Head of service 0.60 WTE IT Lead1.0 WTE Clinical Lead 0.50 WTE Biomedical Scientists:1.0 WTE

Table 12: Project Dependencies

13.1.1.9 Network Sensitivities

It is important to recognise sensitivities to any aspects of the proposed investment that may exist across the Kent and Medway Pathology Network.

(1) EKHUFT have already invested in a scanning solution. However, it should be noted that this is currently an outsourcing solution only, in conjunction with their outsourcing partner, and there is no internal reporting on digital slides. Therefore, there is no change to this service assumed in this business case.

(2) MTW have contracts in place, with strict SLA's, to provide the Histopathology service for Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust) and another large contract is with Sussex Community Dermatology Service. Therefore, consideration needs to be given with regard to any potential impact on the service provided during the transition.

13.2 ECONOMIC CASE

13.2.1 Introduction

This section of the SFBC documents the range of options that have been considered in response to the potential scope identified within the strategic case.

13.2.2 Critical Success Factors (CSFs)

The CSFs are the attributes essential to the delivery of the transaction against which the project success will be assessed. They have been designed to make sure that the strategic objectives, constraints and dependencies which are set out in the Strategic Case can be met.

Six critical success factors have been identified and are described in Table 13 below:

Critical success factor	Description
Strategic alignment	The preferred option will show strategic fit with the digital transformation ambitions of local, regional and national bodies for service improvements through digital innovation.
Quality	The preferred option will show improvements in qualitative standards, such as report turn-around times and staff recruitment/retention.
Costs	Over a 10-year period, the running service costs of the preferred option will be less than retaining microscopes and growing the team to absorb the increasing workload.
Supports the workforce	The preferred option will support: • Collaborative working • Improved workflows • Retention and recruitment of high-quality staff. • Delivery of positive patient experience by staff
Timetable	Effective project management, adherence with best practice and a sufficiently resourced implementation team will facilitate implementation to enable release of efficiencies and benefits at the earliest opportunity
Ability to meet increasing demand for pathology services	• A future-proofed solution able to support changes in local and national demand • Enables adoption of Artificial Intelligence in the future. • Creation of efficiencies to absorb workload as it grows • Increased automation and improved workflow

Table 13: Critical Success Factors

13.2.3 *Summary of Short Listed Options*

None of the identified options were discounted therefore all options were taken forward to the short list.

The short-listed options are as follows:

Option 1 This is the **Maintain Status Quo** option. Each Trust would continue to use microscopes for histopathology reporting. As workload grows, consultant histopathologists would be recruited, where possible, along with continued use of locums, bank workers and outsourcing for routine cases.

Option 2 Investment in a **Digital Histopathology solution** for the KMPN, with equipment located at both MTW and EKHUFT, transitioning from traditional microscopy to digital images for the analysis and reporting of cases.

Option 3 Each Trust would continue to use microscopes, with existing processes remaining as-is. As the workload volumes grow, there would be a need to rely increasingly on **outsourcing** cases to external providers.

13.2.4 Short List Criteria

13.2.4.1 Option 1 – Recruitment of additional histopathologists as the workload grows

This is the Maintain Status Quo option. Each Trust would continue to use microscopes for histopathology reporting and recruit consultant histopathologists, where possible, to absorb workload as it grows. There would be no change to the way the service is currently delivered, and funding for additional histopathologists would be subject to annual business cases for staff and required equipment.

While EKHUFT has approximately 36% less volume of work than MTW, EKHFT has received the same percentage increase in reporting demand as MTW over the last 6 months. Even allowing for outsourcing reporting (at least twice the level predicted in the contract) with external provider LDPath accounting for 1.5 WTE consultants and x3 consultant vacancies, EKHUFT are overspent on locum consultants and still failing to meet reporting expectations of both the Trust and the RCPath. This is wholly representative of the capacity gap between the performance expectation and the financed establishment of reporting staff. A more complete workload analysis is pending, using the same model as used at MTW to demonstrate their reporting capacity gap and as all other factors are comparable, it is highly likely to demonstrate similar results that have resulted in additional vacancies at MTW. Regardless of whether these positions can be filled, it will demonstrate to governing bodies the scale of the shortfall in reporting staff across the whole network and justifies the financial position, in the short term, regarding locum expenditure. In the interim, it is fairly safe to assume the reporting shortfall at MTW is mirrored at EKHUFT, therefore this has been factored into the estimates of additional histopathologists that will be required to support the 5% increase in workload, and therefore the costs of option 2 for EKHUFT.

In reality, this is not a feasible option due to the growing national shortage of histopathologists, which is already impacting on KPMN and will impact further as the existing histopathologists retire. However, it has been retained as an option to demonstrate the significant financial investment that would be required and highlight the serious risks associated with this approach.

13.2.4.2 Option 2 – Investment in a Digital Histopathology solution

This option would involve the procurement and implementation of a digital histopathology solution for the sites that provide this service; MTW and EKHUFT, using capital funding from NHSE and revenue secured via this Business Case.

Moving from glass slides to digital images would, in the longer term, realise significant efficiencies to cope with the growing workload, by removing the need to physically transport glass slides both internally and externally, improving workload allocation and case tracking, and facilitating archiving and retrieval. It would also be an enabler for histopathologists to work remotely and flexibly to improve recruitment and retention, and support

collaboration within the network, as well as externally. It would provide a foundation for the future use of Artificial Intelligence and other evolving technologies, thus increasing efficiencies further.

However, it should not be underestimated the cultural change that will be required to make this implementation successful, both by the histopathologists themselves and also by the teams working within the labs and supporting the service. Therefore strong change management and leadership will be critical. Implementation will need to be phased to support the level of change and to mitigate any temporary reductions in efficiencies as the solution is adopted. It is also important to note that there will not be a quick release of benefits and efficiencies due to the nature of the transition from microscopy to digital, so this would need to be considered as a long-term investment.

13.2.4.3 Option 3 – Extend the level of outsourcing to support the growing workload

Each Trust would remain using microscopes, with existing processes remaining as-is. As the workload volumes and their complexity grow, there would be a need to rely increasingly on **outsourcing** the reporting of cases to external providers, with its associated risks. Whilst only routine cases are currently outsourced, over time it would be necessary to outsource the more complex cases.

Over time, as the level of digitalisation of histopathology grows nationally, outsourcing options for KMPN would reduce, meaning a choice between investment in scanning technology and image storage, or outsourcing the entire histopathology service. It should be noted that EKHUFT already have one scanner used to outsource the reporting of routine cases.

This is an investment option, with minimal benefits/efficiencies to be gained other than to potentially maintain the existing level of service for the patients of Kent and Medway.

13.2.5 The Procurement Process

See the Commercial Case, Section 13.3.9 - The Procurement Process.

13.2.6 Economic Appraisal Ranking

Table 14 below shows the summary appraisal rankings, where 1 is the highest and 3 the lowest ranking.

Evaluation Results	Option 1	Option 2	Option 3
Economic appraisal ranking	3	1	2
Appraisal ranking	2	1	3
Overall Ranking	**5**	**2**	**5**

Table 14: The summary appraisal rankings

Option 2 was selected to continue to full business case.

13.2.6.1 Estimating Benefits

The benefits associated with each option were identified during several workshops, with the following key stakeholders:

Dominic Chambers – Consultant Histopathologist, MTW and Digital Pathology Lead

Theresa Welfare – Lead Bio-Medical Scientist, MTW

Stuart Turner – Lead Bio-Medical Scientist, EKHUFT

Furthermore, other Trusts who have implemented Digital Pathology were also consulted, including Oxford University Hospital Trust and Leeds Teaching Hospitals NHS Trust.

A conference call to obtain a histopathologist's perspective of benefits also took place with Alyn Cratchley, Consultant Histopathologist, Leeds Teaching Hospitals Trust, who is also the clinical Lead for Digital Deployment for National Pathology Imaging Cooperative (NPIC).

The benefits identified fell into the following main categories:

Type	Direct to Organisation(s)
Cash releasing	These are financial benefits – for example, avoided spend, reduced cost etc.
	The above are accounted for in the financial case appraisals
Non-cash releasing	These are economic benefits – for example, opportunity cost of staff time etc.
	All of the above are accounted for in the economic case appraisals
Qualitative (or non-quantifiable)	Non-measurable – for example, quality improvements such as patient well-being, improved morale etc

13.2.6.2 Qualitative Benefits

Benefits, risks and potential qualitative evaluation criteria were identified during the development and analyses of each option and were discussed with histopathology stakeholders.

It was agreed that the five Investment Objectives, identified, discussed and agreed at OBC stage, would be used to qualitatively evaluate the options. The Investment Objectives are:

1. Provide a quality, safe, effective, sustainable and timely histopathology service for patients.

2. Improve recruitment and retention of current and future workforce to address the workforce shortage of Consultant Histopathologists within the Kent & Medway Pathology Network by making it a desirable place to train and work.

3. Contribute to Trust Cancer Pathway performance as workload and complexity of cases continue to grow, in order to provide the optimum result for the patient in a timely manner.

4. Future proofing - Provide a foundation for the introduction and exploitation of Artificial Intelligence and other emerging technologies in the future to further increase efficiencies and resilience.

5. Facilitate collaboration both within and outside of the network, improving patient pathway experience and collegiate working across the network.

All 7 tender responses delivered to these qualitative benefits and therefore this was not a deferential factor.

13.2.6.3 Estimating Costs

The following assumption were used when determining the costs of the project;-

- Base year (Year 0) is 2022/23.
- Asset life 5 years - remaining contract life
- Assume Asset commencement date for depreciation April 2025
- All system capital VAT is non-refundable and for the revenue costs, all system VAT is assumed to be non-refundable
- Capital cost split based on activity - 63% MTW, 37% EKHUFT where not identifiable to a specific Trust

- Discount factor is 0.035 (3.5%).
- Scheme will be funded by Public Dividend Capital (PDC) via the Digital Diagnostic investment programme for initial set up
- Scheme will be funded internally by the system
- Pay inflation assumed as 3% for 24/25 implementation costs
- Go live' 1/3/25

13.2.6.4 Net Present Cost Findings

The comprehensive investment model (CIA) provided in Appendix 3 was used to calculate the Net Present Costs for each option. The CIA combines the costs, quantified benefits and quantified risks associated with each option. The undiscounted and discounted values for all options are shown in Table 15 below.

From CIA	Undiscounted (£'000)	Net Present Cost (£'000)
Option 1 – Do nothing		
Capital	315	315
Revenue	105,170	93,529
Risk retained	0	0
Optimism Bias	0	0
Total costs	**105,485**	**93,844**
Less cash releasing benefits	0	0
Costs net cash savings	**105,485**	**93,844**
Non-cash releasing benefits	0	0
Total	**105,485**	**93,844**
Option 2 – Preferred supplier		
Capital	6,459	5,059
Revenue	106,961	95,037
Risk retained		-
Optimism Bias	54	51
Total costs	**113,474**	**100,147**
Less cash releasing benefits		
Costs net cash savings	**113,474**	**100,147**
Non-cash releasing benefits	0	0
Total	**113,474**	**100,147**

Table 15: Undiscounted and Discounted values for all options:
The economic appraisal therefore ranks 'Do nothing' as the higher option however this does not deliver the benefits or mitigate the risks identified that cannot be financially valued.

13.2.6.5 Option Ranking

The table below shows the summary appraisal rankings, where 1 is the highest and 2 the lowest ranking

Evaluation Results	Do nothing	Digital pathology
Economic appraisal ranking	1	2
Qualitative appraisal ranking	2	1
Unquantifiable risk appraisal	2	1
Overall Ranking	**2**	**1**

13.2.6.6 Option Appraisal Conclusion

On November 22, 2022 an Options Appraisal workshop was held , during the OBC phase, The desired outcome of the workshop was to select either the Do Nothing – Maintain Status Quo option or the invest in digital pathology option.

- The purpose of the workshop was to :Gain a shared understanding of the options identified.
- Consider the benefits that each option would provide.
- Consider the risks associated with each option.
- Consider how each option might enable the Kent and Medway Pathology Network to achieve the 5 investment objectives.
- Consider the degree to which each option complies with the agreed evaluation criteria.

The preferred and agreed option at OBC stage was to invest in digital pathology and a competitive procurement exercise was undertaken on this option.

For the FBC, the outcome was reviewed, and the outcome was deemed to have not changed. There was no need to reassess because all the suppliers were the same solution, so quality and risk did not become a factor on which to assess our outcome

Procure and implement Digital Pathology remains the preferred option.

13.2.6.7 Option Risks – High Level Overview

The main business and service risks associated with each option are detailed in the following sections, along with their countermeasures.

13.2.6.7.1 Preferred Option – Procure and Implement Digital Pathology

Risk Description & Impact	Countermeasures
There is a risk that the required revenue funding is not secured which would result in the project not being taken forward and the Histopathology department not able to maintain Turnaround Times as workload grows.	This Business Case is being developed to demonstrate the opportunities and long-term efficiencies and benefits that could be realised, along with identifying key clinical stakeholders to promote the patient benefits.

Risk Description & Impact	Countermeasures
There is a risk that there will be insufficient space in the existing labs to accommodate the scanners required to support Digital Pathology. This could result in not being able to fully digitalise histopathology, without increasing estate space, leading to a reduction in benefits/efficiencies.	With the size of the scanners varying according to the supplier, this can be addressed as part of the supplier selection process during procurement.
It will be necessary to parallel run microscopes with digital imaging for training and validation, and until the consultants are comfortable with sole use of the solution. Therefore, there is a risk that there will be a temporary reduction in efficiency in terms of time taken to report cases which could result inability to maintain TATs.	(1) Phased deployment to reduce impact on productivity, onboarding the 'enthusiast' consultants first. (2) Secondary phasing by histopathologist i.e. start with a sub-set of each histopathologist's workload and slowly build up. (3) Each histopathologist's workload can also be phased in by speciality as they become comfortable with the technology. (4) Purchase consultancy to support the training and validation phase. (5) Increase outsourcing during this period.
There is the risk that network speeds are insufficient for a digital pathology solution which would result in unsatisfactory amount of time for histopathologists to retrieve images, thus impacting on efficiencies.	Costs have been factored into the business case for additional bandwidth at both sites to support the solution.
The delivery plan for tackling the Covid-19 backlog is predicting a 30% increase in elective NHS activity for 2024, which would significantly impact on workload volumes in digital histopathology. This could result in a limited capacity to transition new users to Digital Histopathology, particularly those consultants less comfortable with the technology.	Measure impact on efficiency during the initial phase to fully understand how this might impact ability to manage increased workload volumes, then consider for subsequent phases (Potential to increase outsourcing during this period).
The transition from diagnostic reporting via traditional microscopy to Digital Histopathology will require huge organisational cultural change and there is the risk that some consultants will be unwilling to adapt. This would result in a delay in the full realisation of benefits and efficiencies of Digital Histopathology.	(1) Early engagement with consultants - issue survey to consultants to understand their attitude towards Digital Histopathology. (2) Organise meetings/discussions with consultants from other Networks who are further along the journey and accustomed to the use of Digital Histopathology. (3) Include in Communication Plan.
There is the expectation that the implementation of Digital Histopathology will realise immediate benefits to sustain the growing workload volumes and reduce TaTs which could result in perceived failure of the project.	(1) Business Case to include likely timescales for the realisation of benefits. (2) Clear communication from the outset required to manage expectations around what this project will deliver and the likely timings and dependencies for, and risks to, the release of benefits.
Increasing histopathology workload, statutory/operational commitments and multiple pathology projects being delivered, means that key resources may not be available to support the project which would result in implementation delays.	(1) Careful planning required at programme level to avoid duplicate allocation of resources across projects/workstreams (PMO). (2) Obtain commitment at executive level to resourcing the project. (2) Backfill for key project roles where feasible.
Prolonged Business Case approval and procurement, beyond the currently planned dates, may result in a delay to implementation and therefore realisation of benefits	(1) Use an approved framework agreement for procurement. (2) Approval process identified, and meeting dates targeted.

13.2.6.7.2 Do Nothing Option – Maintain Status Quo

Each Trust would continue to use microscopes for histopathology reporting. As workload grows, consultant histopathologists would be recruited, where possible, along with continued use of locums, bank workers and outsourcing for routine cases.

Risk Description & Impact	Countermeasures
Nationally, the number of qualified histopathologists is shrinking and is already impacting recruitment at both trusts. Going forward, this option will become completely untenable, and it will be impossible to recruit, resulting in a continued increase in turnaround times, impacting on performance against cancer pathway targets and quality of service for patients.	Options 2 or 3 are the only way to mitigate this.
There is insufficient Estate space at both Trusts to accommodate the number of histopathologists that would be required to support the growing workload, resulting in the need to secure additional or alternative estate space for the growing team of Histopathologists at significant cost	Reporting of glass slides could be done remotely but there would be security implications and would requires funding to equip home offices (microscopes/servicing, IT). Also poses additional risk to quality due to lack of equipment maintenance and loss of control of clinical material/access to slides which would need to be carefully managed.
Recruitment already presents a real challenge (and threat) to both Trusts, with their proximity to London, where histopathologists can earn a higher salary. However, the geographical location of EKHUFT further impacts their ability to recruit, which will worsen as the national shortage of histopathologists grows. This could potentially lead to disparity within Kent, in terms of the availability/timeliness of the histopathologist service provided, according to where in Kent a patient lives.	(1) Central service - estate cost for alternative accommodation. (2) Balancing of workload between the 2 Trusts in accordance with workload demands, which would introduce additional risk without digitalisation, due to the requirement to transport glass slides and reduction of visibility / traceability of case status and slide location.

13.2.7 The Preferred Option

Investment in a **Digital Histopathology solution** for the KMPN, with equipment located at both MTW and EKHUFT, transitioning from traditional microscopy to digital images for the analysis and reporting of cases is the preferred option.

13.3 COMMERCIAL CASE

13.2.1 Introduction

This section of the FBC outlines the approach for the procurement process relevant to the preferred option outlined in the Economic Case.

The procurement is consistent with the NHSE mandated route for all digital procurements that have been nationally funded. It is supported by the MTW procurement team.

This OBC underwent a rigorous review process, reviewed by a 'Gateway Review' panel comprised of the Chief Executive Officers and the Chief Financial Officers from the four acute hospital Trusts in Kent and Medway, in order to ensure that the proposal is commercially feasible and deliverable. The OBC was approved.

This FBC will undergo a similar process. Furthermore prior to the signing of contracts, the proposed supplier contract will be reviewed by external legal advisors.

13.2.2 Required services

The supplier will be required to provide, and support the implementation and ongoing use of, a digital histopathology solution, that is accessible to all legitimate users.

This will comprise of:

Whole slide imaging scanners - Sited within the laboratory, high throughput automated slide scanners with associated PC workstations scan high volumes of stained microscope slides.

Pathology slide/caseload software and associated licences - The software manages the clinical caseload and the digital slide images. This includes image creation, workload management, slide viewing, slide sharing, clinical annotation and measurements, report generation and case submission. The software also creates and holds audit trails relating to the activities undertaken for each case. Image analysis software can also be applied to slides to improve the effective quantitation of cell markers (e.g. HER2 in breast cases).

Interfaces - To the main laboratory information management system (LIMs), pulling information relating to patient cases and providing an ability to push any required results/ report information back when the case is complete. It will also need to be future-proofed for A.I. insofar that it will be capable of supporting A.I. at some future date.

Implementation support – to include supplier-side project management, installation, and training.

Service Management contract – providing hardware and software support and maintenance initially by phone, followed by a site visit where required.

Information management and technology hardware - The servers (locally or remotely hosted), host the application software described below and may provide short term storage for the images. A webserver can allow image access from any web-browser- enabled PC connected to the institutional network.

Pathologist workstations – comprising of a medical grade screen, a standard screen, a specialist mouse, and a high-spec workstation. Installed into pathologist's offices, they allow the visualization of the slide images at high resolution. Dual monitors are used to allow simultaneous control of workflow/ case selection/ slide selection and the viewing of the chosen images.

Archive database storage solution - The system will retain the images for a sufficient period of time to enable audit and case review as well as adhere to data retention policies.

13.2.3 Assessment of Market Interest and Offering

Over the past few years there have been various engagements between the Kent & Medway Pathology Network stakeholders and market leading suppliers to understand the impact and benefits of implementing a digital histopathology solution. In addition, webinars and meetings have been attended by key stakeholders, facilitated by NPIC (National Pathology Imaging Co-operative), a collaboration between NHS, Academic and Industry Partners, who are running a deployment programme to deploy digital pathology across over 40 hospitals in England.

A scoping exercise was carried out in Spring 2022 to obtain a proposal and indicative costs from three market-leading suppliers, in order to inform the bid to NHSE/I for Capital Funding, as well as this Outline Business Case.

13.2.4 Development of Requirements

Ahead of Procurement, an OBS (Output Based Specification) was developed by an experienced Business Analyst, with input from laboratory staff, clinicians, Trust IT, Pathology IT, Information Governance and Procurement, via workshops and 1:1 meetings.

The OBS contains the functional requirements of the Digital Histopathology Solution and also provides information governance requirements.

The OBS was used to qualitatively evaluate the supplier's products and the provision of their services.

13.2.5 Potential for Risk Transfer

The general principle is that risks should be passed to 'the party best able to manage them,' subject to value for money.

This section provides an assessment of how the associated risks might be apportioned between the Network (shared responsibilities across all Trusts) and the Digital Histopathology supplier.

Risk Category	Potential Allocation		
	Network	Supplier	Shared
1. Design risk			✓
2. Construction and development risk			✓
3. Transition and implementation risk			✓
4. Availability and performance risk		✓	
5. Operating risk	✓		
6. Variability of revenue risks	✓		
7. Termination risks	✓		
8. Technology and obsolescence risks			✓
9. Control risks	✓		
10. Financing risks	✓		
11. Legislative risks	✓		
12. Other project risks	✓		
13. Price Increase above NHS Inflator			✓
14. Contract delivery penalties		✓	

Table 16: Risk Allocation Matrix

Contract clauses concerning pricing and risk transfer will enable effective mitigation of risks and the specific allocation of risks will be reviewed and agreed in conjunction with the supplier prior to contract award.

13.2.6 Proposed Contract Length

All costs have been produced and evaluated on the basis of an initial contract of 7 years with the Digital Histopathology supplier, with the option to extend on an annual basis.

A Collaboration Agreement between the 4 Trusts in the Kent and Medway Pathology Network has been established and the impact of the digital pathology contract will be covered by an amendment via the change control process.

13.2.7 Personnel Implications (including TUPE)

There is no requirement for TUPE – Transfer of Undertakings (Protection of Employment) Regulations 2014 – to apply to this business case.

13.2.8 Procurement Strategy and Timescales

The PTOM (Procurement Target Operating Model) is the NHSE mandated route for all digital procurements that have been nationally funded, and therefore will apply to this project. It has been developed to categorise and consolidate the multiple frameworks available and implement new standards and governance around them, in order to simplify the process, avoid duplication and reduce costs.

The successful supplier has been selected from a suitable PTOM framework, via a competitive tender process, supported by the MTW Procurement Team.

A digital histopathology strategy / brief has been developed and was posted on the framework. The initial stage of the procurement required that prospective suppliers to self-assess against the strategy / brief and pre-qualifying statements. The pre-qualification process centred on the need for suppliers to demonstrate proven experience, and examples of, implementing a digital histopathology solution, which included LIMS integration, working across organisational boundaries, within a network of more than one site/trust, in the UK.

13.2.9 The Procurement Process

The OBC went through a lengthy approval process through a series of Committees and Boards at both EKHUFT and MTW. As a result of accepting the Outline Business Case (OBC) by both EKHUFT and MTW Trust Boards in March 2023 the project was granted approval to proceed to tender for the implementation of Digital Pathology for Kent & Medway Pathology Network to be hosted and operational at MTW and EKHUFT Trusts.

The MTW Procurement Department led the procurement process on behalf of both Trusts and continued to be involved in that capacity throughout the selection process, from the development of the Invitation to Tender (ITT) through evaluation to recommendation to award.

The following process was adopted which enabled the project to identify the most appropriate supplier.

Tender submissions were sought under Supply Chain Framework 2019/S212-519575 Pathology Point of Care Testing. The framework has over 100 suppliers on the framework.

Fifteen suppliers responded to the Request for Information (RFI).

Suppliers were encouraged to conduct a site survey and had the opportunity to ask conformation questions.

The quality element of the of the ITT was scored on the MoScOw scoring template, Clinical and Technical departments developed the questions to be scored. Tenders were scored based on 60% quality, 30% financial and 10% social responsibility.

Six suppliers responded and submitted an Invitation to Tender (ITT). Note that one supplier submitted two differing bids. As such we received seven tenders in total.

The tender evaluations took place face to face over three days in Ashford. Twenty-one evaluators came together in person from both Trusts across a broad range of skillsets, from Pathologists, to IT specialists, to administrative staff. Evaluation of the tenders was undertaken over three days. Each of the evaluation days covered the Quality,

Technical (IT) and Social responsibility. Procurement were present during each of the evaluation days to ensure conformity to procurement protocols.

Financial evaluation was conducted by both Procurement and Finance

The final evaluation and scoring resulted in the winning tender being from **Leica Biosystems and Paige** with a final score of 97%. It is anticipated that the procurement stage activities will be as detailed in Table 17. Timescales for each activity will be determined during procurement planning, once a suitable framework has been identified, and included on a plan.

Milestone Activity
Stage 1: 17 July 2023
Digital Histopathology strategy document and mandatory questions released to suppliers
Bidders short-listed
Stage 2: 31 July 2023
Scoring of supplier submissions
Stage 3: 8 August 2023
Supplier Presentations
Stage 4: 15 August 2023
Evaluation period complete
Stage 5: 31 August 2023
Submission of supplier's Best and Final Offer (BAFO)
BAFO evaluation conclusion (FBC can now be finalised)
Stage 6: 22 Dec 2023
FBC Finalisation & Approval:
FBC complete including peer review
FBC Governance complete (Including Trust Boards' and NHSE approval)
Stage 7: 9 January 2024
Contract Award

Table 17: Overview of Procurement Activities

The system implementation time following contract award will be defined in a detailed Project Plan, which will be agreed with the contracted supplier. The Management Case of this document includes the indicative implementation milestone plan based on the template plan provided by NPIC.

13.2.10 Procurement Resource Requirements

The procurement exercise requires consistent and effective engagement from all Trusts involved to ensure that the best solution and provider are selected. The anticipated resource requirements, in addition to procurement support, are detailed in Table 18. Whilst some resources are dedicated to the project others will be required on an ad-hoc basis during the process, with some tasks, such as initial proposal response and OBS evaluation, on-site demonstrations and reference site visits requiring several days to complete. Where a single resource is required to lead on a discipline or speciality area, they will be required to communicate effectively with their counterparts in the other Trusts and to ensure that all views are considered and represented.

Table 18 outlines the resources consulted and who contributed to the procurement. Note – the quantities should not be interpreted as FTE.

Resource Requirement	Quantity
Histopathology Clinical Lead	1
Histopathology Management Lead (Lead Biomedical Scientist)	1 per Trust

Resource Requirement	Quantity
Histopathology Clinical Lead	1
Quality Management Lead	1 per Trust
Pathology IT Lead	1 per Service
Trust IT Lead	1 per Trust
Business Intelligence Lead	1 per Service
Information Governance Lead	1
Procurement Lead	1
Senior Project Manager	1
Business Analyst	1
Project Support	1

Table 18: Procurement Resource Requirements

13.2.11 Agreed Charging Mechanisms

At the time of writing arrangements for payments to the Digital Histopathology supplier have yet to be agreed.

13.2.12 Proposed Key Contractual Clauses

A Service Level Agreement (SLA) schedule will form an important part of the contract. This sets out the standards to which the supplier must deliver the services, the mechanism by which Service Failures will be managed, and the method by which the supplier's performance under this agreement will be monitored. The SLA details the following:

- Service Levels and Service Credits;
- Supplier System Maintenance;
- Performance Monitoring;
- Service Incident Reporting and Recording; and
- Responsibilities Matrix

The principles of the mechanisms employed are to give a well-defined boundary of what must be delivered, together with a fair mechanism to allow the deduction of points where this has failed to occur, and a clear and well-structured process that allows all parties to determine both what has happened, and the reasons and responsibilities where it has not been in line with the expectations of the contract. The actual SLA will be developed during the Contract Negotiation exercise.

13.4 FINANCIAL CASE

13.3.1 Introduction

The purpose of this section is to set out the forecast financial implications of the preferred option, Option 2.

- The financial model was quality assured via internal peer review which is in line with the National Audit Office (NAO) framework. The peer review was via a 'check and challenge' session whose membership consisted of senior finance for each acute Trust and the ICB. Supported by the Operations lead for histopathology of the Kent and Medway Pathology Network.

13.3.2 Assumptions

As stated in the Economic Case, the following assumptions and bases have been used to calculate the economic and financial impact of the proposed investment scheme:

- Base year (Year 0) is 2022/23.
- Asset life is 63 months from 'go live' of February 2025 with the option for rolling annual extensions.
- All system capital VAT is non-recoverable and for the revenue costs, VAT is assumed to be recoverable.
- Discount factor is 0.035 (3.5%).
- Effect of inflation has been included at appropriate published rates as identified below; there is a risk this will be insufficient. Non-pay inflation has been included net of a reduction of 1% for CIP.

Inflation Rates	2024/25	2025/26 to 2029/30
AFC pay deal	3.00%	3.00%
Pay and mix	2.10%	2.10%
Pay	**2.10%**	**2.10%**
Non-pay (net of 1% CIP)	2.00%	2.00%
Other – Tariff uplift	0.90%	0.90%

- Scheme will be funded by Public Dividend Capital (PDC) via the Digital Diagnostic Capability Programme (DDCP).
- 15% optimism bias has been added to the capital costs in 24/25 (excluding Trust project implementation cost) based on the Treasury green book approach.
- Revenue impact will be funded by the K&M system.
- Commencement of revenue charges assumed on purchase. During procurement phased costs will be negotiated.
- Existing costs are the 2022/23 budgeted costs for the Cell path service delivered by MTW and EKHUFT on behalf of the system.

13.3.3 Source of Costs

13.3.3.1 In-house Revenue Costs

All existing costs were obtained directly from the two Trusts. These are the recurrent costs for the running of the histopathology service in MTW and EKHUFT.

Ongoing internal staff support requirements (revenue) were obtained from the Histopathology departments.

13.3.3.2 Capital Costs

Prior to the FBC, all costs were estimated in the OBC. The justification of each is detailed below. Since the OBC, the procurement was put out to tender and the suppliers provided more detailed, accurate anticipated costs. The costs in the FBC are based upon those provided by the Preferred Supplier and represent the actual anticipated costs. They are not estimated.

The Trust-based implementation team costs (capital) were estimated by producing a high-level plan. This has been benchmarked against a plan provided by NPIC (National Pathology Imaging Co-operative) who have supported the implementation of Digital Pathology across a number of Trusts. The template plan provided indicative timescales for each phase. The high-level plan was then used to identify resource types required to undertake the work which were then costed.

Much of the work will be completed by existing Trust staff so has been costed at the appropriate band. These costs have been included on the basis that resources will need to be released to the project for the duration and will therefore need to be backfilled on most occasions.

Some Trust-based implementation team resources are deemed specialist (e.g Project Manager and Business Analyst), external Contractor rates were used in the cost calculations. Contractors will be replaced by fixed term contract when the business case is agreed.

Capital cost breakdown	Tendered	Estimate
Scanners, Implementation Costs, Hardware/Software	Y	
Pathologist Workstation	Y	
Infrastructure (Cloud)	Y	
Hot Storage	Y	
Trusts IT Infrastructure		Y
LIMS Interface		Y
Project costs	Y	
Implementation costs		Y

Capital costs by Trust	Year 0 22/23 £'000	Year 1 23/24 £'000	Year 2 24/25 £'000
MTW	158	2,982	653
EKHUFT	158	1,686	407
TOTAL	**315**	**4,668**	**1,060**

13.3.4 Future Financial Requirements

The total uninflated income and expenditure for the preferred option are shown in Table 19.

Preferred Option: Digital pathology	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital cash phasing									
Capital	315	4,668	1,060						**6,043**
Summary I&E impact									
Pay	11,077	11,077	11,089	11,182	11,146	11,146	11,146	11,146	89,008
Non pay	2,069	2,108	2,158	2,199	2,360	2,403	2,446	2,490	18,233
Depreciation	0	0	288	1,151	1,151	1,151	1,151	1,151	6,043
total non pay	2,069	2,108	2,446	3,350	3,511	3,554	3,597	3,642	24,277
Dividend	6	93	188	181	141	101	60	20	791
Total	**13,153**	**13,278**	**13,722**	**14,713**	**14,798**	**14,800**	**14,804**	**14,808**	**114,076**
Funded by:									
Existing	13,153	13,153	13,153	13,146	13,146	13,146	13,146	13,146	105,190
Additional	-	126	569	1,567	1,652	1,654	1,657	1,661	8,886
Total	**13,153**	**13,278**	**13,722**	**14,713**	**14,798**	**14,800**	**14,804**	**14,808**	**114,076**

Table 19: Uninflated Income and Expenditure

The total inflated income and expenditure for the preferred option are shown in Table 20 below.

INFLATED	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	
Option 2	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Costs									
Total Capital	315	4,668	1,060	0	0	0	0	0	6,043
Revenue Costs									
Pay	11,077	11,077	11,322	11,656	11,863	12,112	12,366	12,626	94,099
Non pay	2,069	2,108	2,201	2,288	2,505	2,601	2,701	2,805	19,277
Depreciation	0	0	288	1,151	1,151	1,151	1,151	1,151	6,043
Dividend	6	93	188	181	141	101	60	20	791
Total Revenue	**13,153**	**13,278**	**13,998**	**15,276**	**15,659**	**15,965**	**16,279**	**16,602**	**120,210**
Funded By									
Existing	13,153	13,153	14,142	13,700	13,986	14,277	14,575	14,878	111,863
New Investment	0	126	-144	1,576	1,674	1,687	1,704	1,724	8,347
Grand Total	**13,153**	**13,278**	**13,998**	**15,276**	**15,659**	**15,965**	**16,279**	**16,602**	**120,210**

Table 20: Inflated Income and Expenditure

13.3.5 Impact on the Income and Expenditure of the Organisations

Table 21 below describes the impact to I&E on the two service provider Trusts. The impact is nil due to he investment from the K&M ICB

Uninflated	Year 1 23/24	Year 2 24/25	Year 3 25/26	Year 4 26/27	Year 5 27/28	Year 6 28/29	Year 7 29/30	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MTW								
Income	**(79)**	**(357)**	**(975)**	**(1,029)**	**(1,031)**	**(1,033)**	**(1,036)**	**(5,542)**
Pay	0	6	57	34	34	34	34	200
Non pay	25	56	82	184	211	239	267	1,064
Capitral charges	54	296	836	811	786	760	735	4,278
Total Expenditure	**79**	**357**	**975**	**1,029**	**1,031**	**1,033**	**1,036**	**5,542**
Net surplus/deficit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
EKHUFT								
Income	**(46)**	**(212)**	**(591)**	**(622)**	**(623)**	**(624)**	**(625)**	**(3,344)**
Pay	0	6	47	34	34	34	34	190
Non pay	14	33	48	107	123	138	155	617
Capitral charges	32	174	496	481	466	451	436	2,536
Total Expenditure	**46**	**212**	**591**	**622**	**623**	**624**	**625**	**3,344**
Net surplus/deficit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 21: Uninflated Income and Expenditure by Trust

The investment required by NHS K&M ICB split by HcP area is provided in table 22 below

UNINFLATED	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	
Revenue investment	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WEST	38	172	470	496	497	498	499	2,670
EAST	46	212	591	622	623	624	625	3,344
DGS	20	88	241	254	255	255	256	1,370
MEDWAY & SWALE	22	97	264	279	279	280	281	1,502
Total ICB investment	**126**	**569**	**1,567**	**1,652**	**1,654**	**1,657**	**1,661**	**8,886**

Table 22: Proportionate Split of Additional Revenue Costs

Should the project not progress to the implementation stage, £715k of capitalised costs will be sunk costs, these have already been incurred and would need to be written off in 2023/24

13.3.6 Overview of Non-recurrent Costs

There is just one non-recurrent revenue cost – £20K in legal costs contingency which is included in 2023/24 capital costs to support contract negotiation.

13.3.7 Sensitivity Analysis

The majority of the costs have been tendered therefore the requirement for a sensitivity analysis has been deemed as not required. The main variable cost if the implementation team costs and these will be managed via the use of existing resources to ensure there is no increase in cost.

The cold storage costs have already been estimated with an expected growth in activity and the contract has been negotiated to be a variable contract so if this growth does not materialise the additional cost will not be incurred. Also, this enables the cost to be reduced if there is a decision to retain images for less time.

13.3.8 Impact on Balance Sheet

The capital assets comprising of equipment, system, hosted hot storage, infrastructure and implementation costs are on MTWs and EKHUFTs balance sheet and will be depreciated in line with the accounting policies of the Trust.

The contract with Paige will be for a remotely hosted cold storage solution. and the provision. No assets will be for the sole use of the network, so this is a service contract so not ‘on balance sheet’.

To ensure the liabilities committed by MTWs contract with the suppliers is met by EKHUFT, the KMPN Collaboration agreement will be amended to include this arrangement.

13.3.9 Overall Affordability

This is an investment case which delivers on one to the priorities of the digital capacity agenda.
This has been supported to date by the K&M ICB via approval of the Outline business case in March 2023 and the underwriting of the capitalised costs incurred to date.

13.5 MANAGEMENT CASE

13.5.1 Introduction

This section of the Short Form Business Case (SFBC) addresses the 'achievability' of the preferred option. Its purpose, therefore, is to set out in detail the actions that will be required to ensure the successful delivery of the project in accordance with best practice.

13.5.2 *Deliverability*

The implementation of a Digital Pathology solution across two Trusts will present a significant challenge, both technically and operationally, and will require strong transformational management and governance.

From a technical perspective, there will be a significant image storage implication with archiving capability, to adhere with data retention policies, as well as image-sharing considerations to enable collaborative working and resilience between the two Trusts. There will also be a requirement to interface with the new single LIMS system, WinPath Enterprise, which is being implemented in parallel. Sufficient network bandwidth from an infrastructure perspective must also be in place to ensure optimum solution performance for the histopathologists when retrieving images. The end technical solution will need to be architected jointly by both Trust IT departments, in conjunction with the supplier, to ensure it meets Trusts IT Department's requirements and principles.

From an operational perspective, strong change management is essential as this will represent an unprecedented change to the way cases are currently analysed and reported by the histopathologists, as well as adding an additional step into the existing lab process, to accommodate the scanning of the slides. Therefore, in line with best practice, a phased deployment approach will need to be taken to reduce the impact on workflow and efficiencies and to encourage buy-in from the histopathologists and laboratory staff. Early and ongoing engagement and involvement of histopathologists and laboratory staff has and will continue to be critical. This will include, but is not limited to:

- Engagement with consultants: issue survey to consultants to understand their attitude towards digital pathology.

- Organise meetings/discussions with consultants from other Networks who are further along the journey and accustomed to the use of digital pathology.

There are also potential estate-related implications to house the scanners and other components of the solution. The extent of this has already been estimated in collaboration with our preferred suppliers, Leica Biosystems and Paige. Furthermore, the scanners will need to be located so as to not interrupt the workflow and create inefficiencies. Another estates-related consideration will be the medical grade screens, which will need to be located alongside the existing microscopes in the histopathologist's offices, during the transitional period.[19]

The selection of the supplier and the approach to deploying Digital Pathology took into account the complexity of delivery. Stage 1 of the procurement ensured that the preferred supplier could demonstrate having successfully deployed a single Digital Pathology solution across a Network. The procurement process also considered their proposed approach to deployment in order that the Network can be satisfied that it is appropriate and fits in with local Trust implementation methodologies.

Excellent clinical leadership, effectively supported from the very highest levels of Trust, network and programme governance, has and will continue to be required to drive this change through.

13.5.3 Deployment Strategy

The deployment strategy defines the adoption of the solution by the histopathologists once the solution is live. In line with best practice, a phased deployment approach will need to be taken for the following reasons:

- To identify any issues in relation to processes/workflow and alleviate these before rolling out further
- To reduce impact of transition on efficiency/workflow and therefore Turnaround Times (TaTs)

[19] The Royal College recently (September 2023) announced that trainee Pathologists will continue to be trained using microscopes.

- To demonstrate the benefits whilst minimising operational impact
- To allow time to adapt and therefore encourage buy-in from histopathologists and laboratory staff

There are a number of ways to phase the deployment, but following consultation with Leica Biosystems and Paige, the preferred suppliers, and the clinical stakeholders from MTW and EKHUFT, current thinking is that the proposed deployment strategy would be as follows:

- Both sites would look to phase by groups of histopathologists, onboarding the 'enthusiasts' (early adopters)' first, with the 'sceptics' i.e. those more resistant or unsure of the change, later. The groups and sequencing will be decided by the clinical leads from each Trust and will need to be cross-speciality. Surveying the consultant body to identify likely early adopters may be beneficial, as well as use of the network stakeholder analysis template.
- It is likely to be divided into 3 – 4 deployment phases at each site, with the timeframe per phase to be defined during implementation planning.
- The majority of histopathologists are cross speciality (up to 4 specialisms) so there is likely to be secondary phasing of speciality by pathologist, enabling each speciality to be signed off following a period of validation.
- National Pathology Imaging Co-operative (NPIC) have advised, from experience, that for 'enthusiast' pathologists, a 2-month WTE period is generally enough to have covered the depth and breadth of cases encountered in real world pathology reporting. For those that are uncertain, 3-4 months may be more realistic, but if after 2 months they have identified parts of their work they are comfortable to do solely digitally, they could sign off their validation for these classes of specimen, then continue to validate other types of specimens on glass for a longer period.

13.5.4 *Programme Management Arrangements*

The project is an integral part of the Digital Diagnostic programme, which in turn is part of the Kent and Medway Pathology Transformation Programme, which comprises a portfolio of projects for the delivery of pathology initiatives.

The Programme will be managed within the Kent & Medway Pathology Network.

13.5.4.1 The Kent and Medway Pathology Network (KMPN) Board

The Pathology Transformation Board contains executive representation from all trusts including:

- Clinical, strategic, operational and finance management
- Pathology Clinical Directors and General Managers
- ICB leads
- PMO Directors

The Pathology Transformation Board has overall responsibility for the delivery of Kent & Medway's programme of pathology projects and the single accountable person will be the Programme's Senior Responsible Owner (SRO), the Chief Executive Officer of MTW, who chairs the Pathology Transformation Board.

In relation to this project, the main function of the Pathology Transformation Board will be to:

- Act on behalf of the Trusts and stakeholders within the Kent and Medway Pathology Network.
- Monitor progress on quality, cost, and time against baselined plans for all projects.
- Approve or reject change requests that have been escalated by the Steering Group.
- Provide the final point of arbitration and support the management of escalated risks.

- Monitor progress of any benefits scheduled to be realised during the life of the project.
- Monitor and approve progress against the strategic objectives.
- Facilitate the flow of information to and from the constituent trusts and other senior stakeholders.

13.5.4.2 Steering Group

The Steering Group will be run, in effect, as the Programme Board. Given that this project will impact more than one Trust, decisions on clinical and technical aspects that would otherwise be sovereign to a Trust will need to be delegated to the Steering Group that has representation from both Trusts.

The Digital Pathology Steering Group is accountable for the standardisation of pathology services, the harmonisation and optimisation of processes and workflow, adherence to the required clinical standards and the development of a single Quality Management System across both Trusts. It contains representatives from the two Trusts – MTW and EKHUFT – from clinical, scientific, and operational management fields, including IT and Finance drawing upon their experience to guide and to push through the project.

It is cognisant of all significant IT and Clinical projects and initiatives being undertaken across the whole health economy in order to ensure that risks and issues do not arise from aspects such as resource clashes and IT change freezes etc.

It will retain overall responsibility for the delivery of the project and the single accountable person will be the Project Executive (SRO), who will chair the Steering Group. The main function of the Steering Group will be to:

- Monitor progress on quality, cost, and time against baselined plans through regular highlight reports containing performance against agreed indicators.
- Authorise progression to the next project stage when required.
- Approve or reject change requests.
- Ensure that risks are proactively managed and that all risks have an owner and meaningful mitigating actions are identified and implemented.
- Support the management of escalated risks and escalate higher and/or wider, through other governance bodies as required.
- Monitor progress of any benefits scheduled to be realised during the life of the project.
- Facilitate the flow of information to and from the Pathology Executive Team.
- Act as critical friend to the Project Management Team, provide advice and guidance but hold them to account for the successful delivery of the project.

A Terms of Reference (ToR) has been published at the outset of the project.

13.5.4.3 Other Authorities

In addition to the Steering Group, specialist knowledge from both trusts will be required on an ad-hoc basis and will be accessed at every level. For example, advice and guidance on Information Governance.

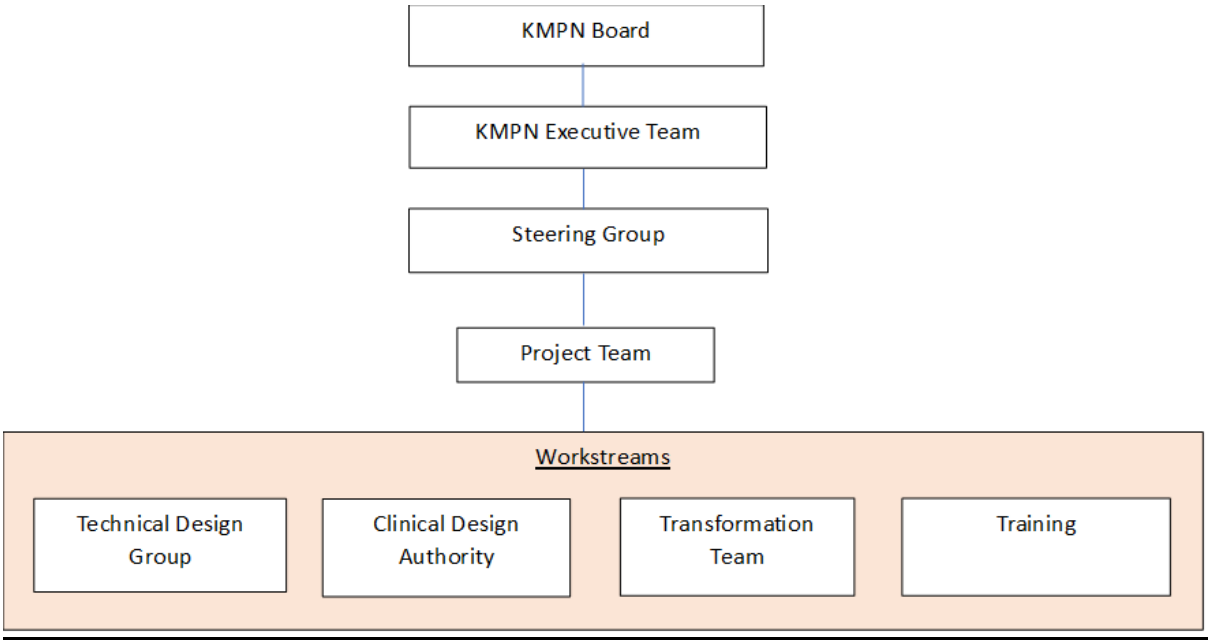
13.5.5 Project Management Arrangements

The project will be managed in alignment with PRINCE 2 methodology. Appropriate strategies and plans will be developed to ensure that the project is managed and controlled effectively with specific focus placed on quality, schedule, and cost.

13.5.5.1 Project reporting structure

Figure 2 shows the Programme's day-to-day governance.

Figure 2: Project Governance Arrangements



13.5.6 Project Roles and Responsibilities

13.5.6.1 The Project Team

Most of the project team will be dedicated and full-time. The project team is responsible for the day-to-day implementation of the project. Some of the key roles are dedicated to the project and financed through project funds.

13.5.6.2 The Senior Project Manager

The project is led by an experienced Senior Project Manager, who is full time. Once the business case is approved a fixed term contract project manager will be appointed to deliver the project. The Senior Project Manager will have day-to-day responsibility for the successful delivery of the overall project and will report to the Steering Group. They will be the main point of contact for the Steering Group and will represent the Project Management Team on the Steering Group. The Senior Project Manager will be PRINCE2 qualified will continue to ensure that they can deliver the project aligned to these standards and will have extensive experience of working within the NHS and/or partners, managing major projects, preferably within the pathology arena.

13.5.6.3 Clinical Lead

The overall Clinical Lead is Dr Dom Chambers, an MTW Histopathologist, who up to completion of Procurement has taken time out from his day-to-day job to fill the role of Project Clinical Lead. However, once the implementation commences the expectation is that the role will be partly backfilled via outsourcing, part-time. They will work closely with the Senior Project Manager, and be responsible for making decisions, managing risks, and resolving issues from a clinical and operational perspective. In addition, they will manage senior clinical stakeholders to ensure that the strong leadership that is required is in place.

13.5.6.4 Workstreams

The work of the project team will be managed and completed within focussed workstreams. Each workstream will be led by an appropriately skilled manager who will have the necessary experience and knowledge to ensure that all work undertaken by the workstream meets the required quality criteria. Work will be described in detail within work packages, following detailed planning, in which system users and workstream leads will be fully

involved. The work packages will contain all necessary information including quality expectations, reporting arrangements, agreements on timescales and risk management thresholds. Workstream Leads will be responsible for all the work within the workstream and will agree the work packages on behalf of the workstream. Workstreams will include IT, Testing & Validation and Training & Organisational Change. These are likely to be dedicated to the project (either full or part time), as required, but will not necessarily be required for the whole project duration.

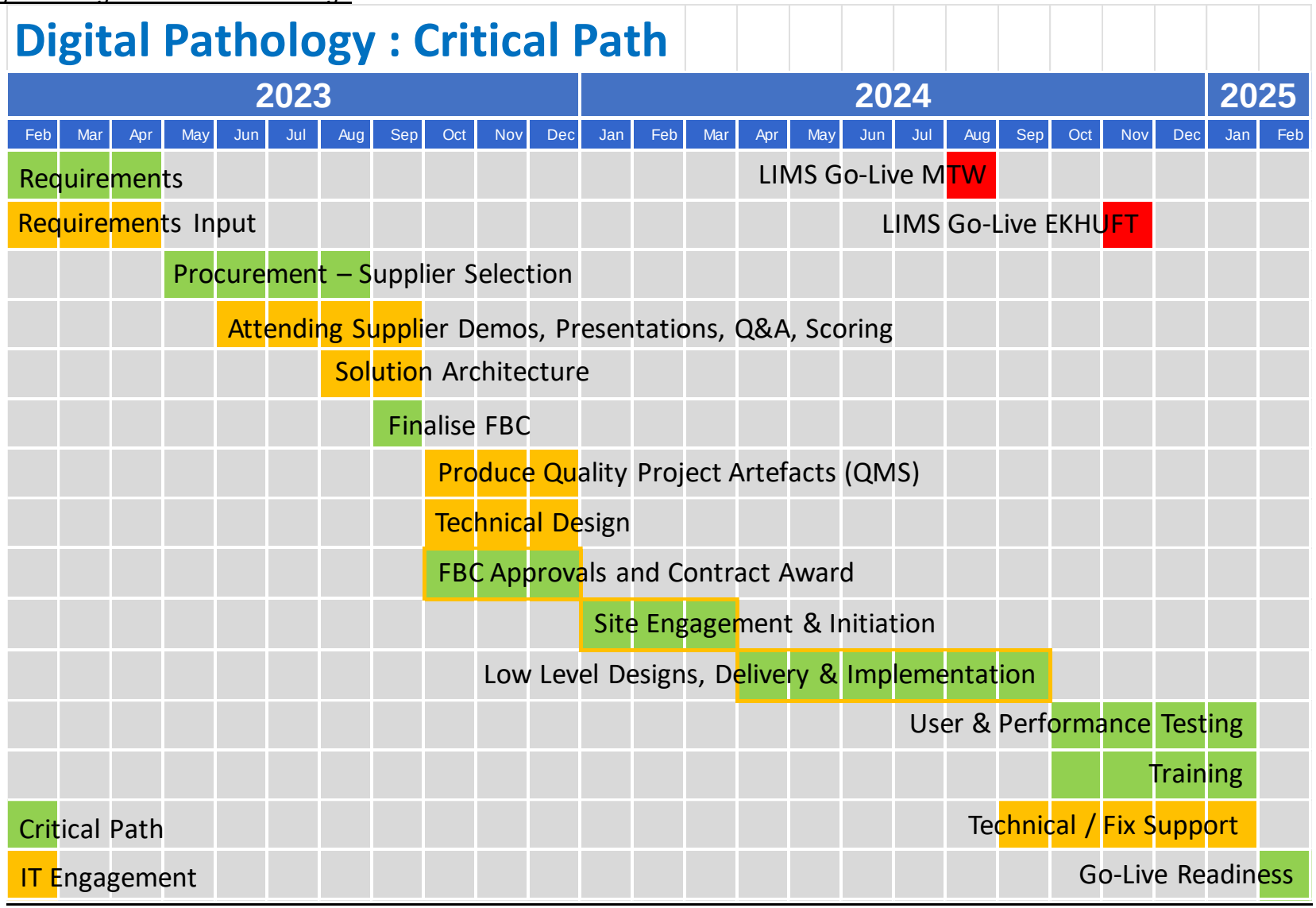
13.5.6.5 Leadership Responsibilities

As with any significant project, success or failure is dependent on multiple factors. Strong and supportive leadership is required by senior clinical and management representatives to oversee the delivery, who must accept their role willingly and demonstrate the values that will enable a successful implementation. The Senior Project Manager and the Clinical Lead will foster close relationships with stakeholders to ensure that all are kept appraised of developments; to ensure that there are no conflicts of interests or significant issues and to support the Project Team to deliver according to the project specification.

13.5.7 Project Planning and Timescales

Project planning will be undertaken in two distinct parts: Pre-contract award, and Post-contract award. Pre-contract planning will be the responsibility of the Snr Project Manager in collaboration with representatives of the Steering Group. It will run to end of December 2023 when it is expected that the contract will be awarded to the preferred supplier. Planning of the post-contract phase will be the responsibility of the Snr Project Manager but in collaboration with the Programme Manager of Leica Biosystems and Paige.

Figure 3: High-Level Plan on a Page



13.5.7.1 Reporting of Progress

During Pre-contract award, the Steering Group will meet monthly at which a **Highlight Report** will be presented along with an updated **Risk/Issues Log**. Where necessary, the Snr Project Manager will engage with members of the Steering Group to appraise, to action, to seek guidance as appropriate.

During Post-contract award the Steering Group will meet more frequently. It will also include representation from Leica Biosystems and Paige, the preferred supplier[20]. Given the scale and complexity of the implementation project, any tasks on the critical path will be very closely monitored. Detailed planning for the implementation stage of the Digital Histopathology Project will be undertaken by the project team, and in partnership with the Digital Histopathology provider, following authorisation to proceed into Project Initiation. Tasks on the critical path will be closely monitored and any that have slipped will be reported as an Issue to the Project Steering Group.

13.5.8 Management of Risk

Risks will be managed in accordance with the Programme-level risk management strategy and will continue to be managed on a daily basis under the direction of the Snr Project Manager using standard Prince2 principles. Identification of any severe risk or issue will be escalated up as appropriate through the Clinical Lead (SRO).

In principle, the approach to Risk Management can be described as follows:

- It will be the responsibility of the whole team for the identification and assessment of risk, and the Senior Project Manager will be responsible for management of those risks.

- Risks are recorded in a project risk register and evaluated using agreed Probability Vs Impact matrix to derive a risk priority number. The scale of the risk, determined by the risk priority number, will determine the actions required regarding escalation. Aspects such as proximity (when will the risk most likely occur) and opportunities to manage the risk will be established.

- All risks will be assigned an Owner and one or more actions will be assigned to actionees. The Risk Owner will be responsible for ensuring that mitigation actions are completed in accordance with the management plan.

13.5.9 Implementation of Lessons Learnt

Lessons from other Trusts who have implemented Digital Pathology has (as described above) and will continue to be investigated, documented, and shared, ahead of implementation. This will include consultation with NPIC, who have extensive experience in implementing Digital Pathology across NHS Trusts in the North-East of England. There is also a wealth of information and publications available on-line.

Some of the key lessons learned, that have already been collated specifically in relation to Digital Pathology, are as follows:

- The implementation of Digital Pathology must not be underestimated, being both transformational, in terms of significantly changing the way things are done, as well as having huge IT implications – both need equal emphasis when planning and resourcing the project.

- Pathologist engagement from the outset and training is absolutely key to the success of Digital Pathology

- For the reasons highlighted above, best practice is to adopt an incremental phased deployment.

- Pre-imaging factors (such as slide quality and careful calibration) are as important as the imaging itself.

[20] At the time of writing Leica Biosystems and Paige had yet to be awarded the contract

- Digital Pathology will reap benefits in the longer term, but is not a quick fix - expectations across the organisation need to be managed accordingly.

- Individual validation by each pathologist is essential as it allows them to decide which cases they are confident to diagnose digitally, and which need more practice or workflow modifications to ensure a confident and safe diagnosis.

In addition, key lessons identified for projects of similar size and complexity include:

- Governance arrangements must be established and fully integrated into respective Trusts governance structure to ensure key decisions and actions are discharged in a timely manner.

- There is a need to map as-is and to-be operational processes and data flows at a detailed level, including those impacting other service users.

- Proactive clinical leadership is critical, with a single accountable clinical lead.

- Adequate project resources must be allocated (and backfilled where required) across all required workstreams.

Lessons identified during the course of the project will be captured in a lessons log and will be reported via the Project Highlight Report. During the project closure stage, a lessons learned report will be compiled.

13.5.10 *Outline Arrangements for Change and Contract Management*

The approach to Change Management will be fully detailed within a Configuration Management Strategy, which will be developed during the Initiation Stage of the Project in accordance with the PRINCE2 methodology.

In principle however, the approach to Change Management can be described as follows:

13.5.10.1 Project Products

Any formally approved project product e.g. Project Plan, Project Initiation Document etc. must be subjected to a formal change control process. The Project Board will be responsible for the change control processes.

13.5.10.2 Systems Design

The Technical Design Group will have authority over design. Any formally approved systems artefact, e.g. design/configuration specification, interface specification etc must be subjected to a formal change control process. The Technical Design Group will be responsible for the change control processes and will advise and inform the Steering Group of decisions.

13.5.10.3 Clinical Design

The Clinical Design Authority will have authority over clinical design matters. Any formally approved clinical artefact, e.g. Workflow specifications, standard operating procedures, testing & validation method etc must be subjected to a formal change control process. The Clinical Design Authority will be responsible for the change control processes and will advise and inform the Project Board of decisions.

13.5.11 Contracts Management

The Procurement Department of MTW, who have agreed to lead, will be responsible for the establishment and initiation of any supplier agreement or contract.

Contract monitoring arrangements will be included within the supplier agreements and are likely to consist of quarterly review meetings at which supplier and system performance will be reviewed and any corrective actions agreed.

Changes to any contractual agreement will be managed by the Procurement Department in accordance with any pre-established contract change notification procedure.

13.5.11.1 Outline Arrangements for Benefits Realisation

The approach to Benefits Realisation Management will be fully detailed within a Benefits Management Strategy, which will be developed and refined during the Initiation Stage of the Project in accordance with the PRINCE2 methodology.

In principle however, the approach to Benefits Realisation Management can be described as follows:

13.5.11.2 Benefits Identification

In the economic case of the document, various options were discussed and high-level benefits and risks of each were identified.

Identified benefits specific to the preferred option, once agreed following the procurement stage, are detailed in the Benefits Register. The Benefits Register will be used to associate each benefit with specific Investment Objectives, establish how benefits will be measured, the owner of the benefit and, for measurable benefits, any current baseline performance data. Once baseline data is known, improvement targets can be set and associated with the relevant benefit.

Benefits can be identified at any stage of a project and a significant number are often defined during the business change analyses, where current processes are investigated in detail. The benefits register will be updated as emergent benefits arise.

13.5.11.3 Benefits Reporting

Overview

Benefits realisation allows organisations to plan, manage and monitor how time, effort and resources are invested into making desirable changes within the organisation. It is an essential part of project management, which invariably involves change for the better through a clearly defined, results-focused process. Planning for benefits realisation, however, involves a lot more than identifying which benefits should be delivered and to whom. It needs a clear timeline, a plan for implementation, and a way to assess how well the projects actual results match up to the outcomes intended.

The start point is the core data upon which to build the Benefits Realisation structure. See *Section 11 Benefits Metrics*, and Appendix G which provides a detailed core list of data.

The Process

Produce a Benefits Realisation Plan which details:

- Identify specific benefits (drawn from Appx G).
- Define in detail what each benefit will entail.
- Assign dates for the delivery of the benefits.
- Detail the necessary implementation procedures to ensure that benefits are delivered in full.
- Plan for change management as the processes to deliver new benefits are implemented.
- Method for tracking progress at every stage of the project lifecycle.
- The methodologies for comparing actual outcomes to planned outcomes.

Each benefit will be assigned an owner, and once into BAU this is typically the Operational Manager most impacted by the change and benefit. During the lifetime of the project, ‘in-flight’ benefits reporting will be to the Steering Group.

With the exception for producing the Benefits Plan much of the work for Benefit Realisation will be post go-live and the project moves to BAU. Arrangements will be made as part of the project closure to ensure Benefits Realisation Management remains a key focus of the operational management team.

As measurements are taken, reports will be submitted by the Benefit Owner to the KMPN Board.

The actual realisation of project benefits, as defined in the benefits realisation plan, can span a considerable period of time, often years. Throughout this period, individual benefits must be tracked, measured, managed and realised by the business.

The Project Manager in collaboration with the Senior Responsible Owner must put in place the necessary resource and structures to allow the benefit realisation plan to be monitored at regular intervals, ensuring that key benefits are being managed and are on target to be fully realised.

Tracking and Prompting

The benefits realisation plan must be monitored regularly to track the progress of each of the key milestones identified for each benefit profile. A pre-implementation baseline measurement should be followed by defined actual measurements at relevant points during, and post implementation.

The SRO will liaise with the benefit owner to ensure that all planned measurement and review activities are being implemented. It is recommended that specific benefit targets are built into well-established business planning processes.

The benefit owners may wish to include benefit targets in their operational and strategic business plans though this will depend on the level and priority of the benefit.

Review and Update

The SRO will own the benefits realisation plan. It is important that the plan is kept up to date and that established benefit management processes are flexible enough to react to changing circumstances.

Often, as information is reported back to the SRO, there may be instances where new, unexpected benefits and dis-benefits have emerged. It is important that there is the resource and facility to analyse these benefits.

This review should also ensure that:

- the benefit profile itself is up to date
- the actual measurement value has been included
- the benefit priority remains valid
- any new risks have been assessed

Communications

As programme or project benefits begin to be realised across the organisation, there may be opportunities to link successful benefits realisation to the programme, project or organisational communication channels.

Good news stories, emanating from benefits that have been achieved within the business, are particularly effective as they will have a robust evidence base.

Managing individual benefit profiles

The successful execution, management and realisation of individual benefit profiles is fundamental to the ultimate success or failure of the investment in change.

Analysis of progress following each actual measurement point to determine if the benefit is projected to achieve or even exceed the target defined in the profile. If a programme or project fails to prove it has realised the benefits on which it was initiated, then the business transformation and investment in change will be deemed a failure.

13.5.11.4 Outline Arrangements for Post Project Evaluation

During the closure stage of the project, arrangements will be made to transfer the system and all related artefacts such as the open risk register to the operational management team.

The project closure stage will be planned as per any other project stage; and such plans will include the approach to be taken to evaluate the performance of the project against the agreed success criteria, the benefits realisation plan and business case.

The project closure stage will include the completion of a final lessons report, which will compile all lessons identified throughout the life of the project and can be shared as required within and across the organisations.

It is anticipated that the project will be closed 3 – 6 months after the completion of the last Trust/lab deployment, after the final stabilisation period has come to an end. Prior to project closure, review milestones projected forward will be agreed within a post project review plan, which will also include benefits realisation reviews.

13.5.11.5 Contingency plans

In the event that this project fails, the following arrangements are in place for continued delivery of the required services and outputs.

- Microscopes will be retained for sufficient time for the consultants to fully transition to digital images. Business continuity will be maintained.

- Immediately following the point at which the project is deemed to have failed and has been stopped, an urgent review of the reasons for failure will be ascertained. Depending on the cause and how far the project has progressed, appropriate actions will be taken. Action might include:

    - A review of the business case to establish if a viable project remains and if so, what remedial action is required to bring the failed project back on track.

    - Decisions to change the project's scope and or approach.

    - The approval of additional funding if deemed appropriate.

    - The appointment of additional or replacement project management resources.

    - A further review of the original options to ascertain if anything has changed since the decision to proceed with the preferred option was made.

13.6 ADDITIONAL APPENDIXES

13.6.1 Appendix 1: Excerpt from 2022/23 Priorities and Operational Planning Guidance v3, 22 February 2022

Refer to: Appendix 1 - Excerpt from 2022_23 priorities and operational planning guidance

13.6.2 Appendix 2: Benefits Register

Refer to: Appendix 2 - DP Benefits Register with metrics mapped

13.6.3 Appendix 3: Comprehensive Investment Appraisal (CIA)

Refer to: Appendix 3 – The detailed costs discounted calculations

14 Sign off

The parties approving this Agreement are as follows

Area of Responsibility	Name	Position and organisation name	Signature
SIGNED by the Recipient Accountable Officer (CEO). **MTW By:** **EKHUFT By:** **K&M ICB**	 Miles Scott Tracey Fletcher Paul Bentley	CEO	**Date:**
SIGNED by Finance Director(s). **MTW By:** **EKHUFTBy:** **K&M ICB**	 Steve Orpin Michele Stevens Ivor Duffy	CFO/	**Date:**
SIGNED by Regional Digital Lead **By:**	Natasha Walton-natasha.walton1@nhs.net	RDD	**Date:**
SIGNED by Regional Digital or Diagnostics Director	Ewan Cameron-ewan.cameron2@nhs.net	**<insert>**	**Date:**
SIGNED by Director of Diagnostics & System Improvement, NHS England	Rhydian Phillips - rhydian.phillips@nhs.net	Director	**Date:**

15 NHS Long Term Plan (2019) alignment [for information only]

This section sets out a selection of key priorities and improvements from the NHS Long term Plan, as related to diagnostics and pathology, which projects are likely to align to. The information has been included as 'for information only', as the majority of the priorities and improvements stated below have been taken forward into the *Diagnostics: Recovery and Renewal, Report of the Independent Review of Diagnostic Services for NHS England,* 2020 (NHS England commissioned review), and so, to avoid duplication, trusts and networks will be expected to state the alignment to the Diagnostic Service Review report recommendations and efficiencies, within Section 4.

Alignment to national priorities: NHS Long term Plan

Priority/improvement
Chapter 1: A new service model for the 21st century
Reforms to hospital emergency care − Same Day Emergency Care: New diagnostic and treatment practices allow patients to spend just hours in hospital rather than being admitted to a ward. This also helps relieve pressure elsewhere in the hospital and frees up beds for patients who need quick admission either for emergency care, or for a planned operation.
Chapter 3: Further progress on care quality and outcomes
Better care for major health conditions: We will begin introducing a new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from screening.
Better care for major health conditions: The new faster diagnosis standard will be underpinned by a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer. From 2019, we will start the roll-out of new Rapid Diagnostic Centres (RDCs).
Better care for major health conditions: The NHS will use its capital settlement to be negotiated in the 2019 Spending Review in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests.
Chapter 5: Digitally-enabled care will go mainstream across the NHS
• By 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost. Mandated open standards in procurement will ensure that these networks are ready to exploit the opportunities afforded by AI, such as image triage, which will help clinical staff to prioritise their work more effectively, or identify opportunities for process improvement; • By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret.
Chapter 6: Taxpayers' investment will be used to maximum effect
Procurement savings by aggregation of volumes and standardising specifications: Delivering pathology and imaging networks to improve the accuracy and turnaround times on tests and scans will make best use of the expanding workforce, and reduce unit costs…By 2021, all pathology services across England will be part of a pathology network and, by 2023, we will have introduced new diagnostic imaging networks… The investment in a new digital diagnostic imaging service will enable clinical images from care settings close to the patient to be rapidly transferred to the relevant specialist clinician to interpret regardless of geography.

The Trust's response to the "Helping Queen Victoria Hospital (QVH) develop and vision for the future"	**Chief Executive / Executive Director Strategy, Planning & Partnerships**

The enclosed report provides information on the Trust's response to the 'Helping Queen Victoria Hospital (QVH) develop and vision for the future'.

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

- Executive Team Meeting, 21/11/23

Reason for submission to the Trust 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

Feedback to QVH vision for the future

Background

- Queen Victoria Hospital is a specialist NHS hospital providing reconstructive surgery, burns care and rehabilitation services for patients across Kent, Surrey and Sussex.
- They specialise in conditions of the hands and eyes (corneoplastics), head and neck cancer and skin cancer, reconstructive breast surgery, maxillofacial surgery and prosthetics.
- The previously explored merger with University Hospitals Sussex is not being further developed and QVH have commenced a period of local and external engagement on their future strategy.

- The newly appointed CEO, James Lowell, came to discuss the strategy development on 15th October

Discussion

- James described the engagement to date which had focussed on internal stakeholders with some external sessions held recently. MTW attended such a meeting in October.
- Currently there is not a strategy to consider and QVH are clear that they want to develop the strategy with stakeholders and partners
- We were clear that we believe QVH to have a strong and sustainable future however, with developing models of care and a focus on local delivery for K&M residents, flows of patients to the QVH sire were going to change over the coming 2 to 5 years.
- We felt there were 2 considerations for the strategy:
  - The services provided and model of delivery
  - The use of the buildings on the QVH site

Discussion

- We recognised some of the historic challenges and clinical relationship tensions and felt that we needed some joint work to focus on improving operational collaboration.
- Miles was clear that their future plans need to factor in a significant reduction in head and neck and breast activity from K&M based on current inequitable access and a desire for these services to be provided more locally.
- We recognise their role in burns and plastics more widely and confirmed our willingness to be an active partner and also to promote and support a K&M response to the strategy development.

NHS Maidstone and Tunbridge Wells NHS Trust

Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital — **Chief Operating Officer**

Introduction

Since May 2023 we have continued to engage with the Maggie's team on a regular basis to provide information as requested. The partnership between MTW and Maggie's has only grown in strength in the last year, and we continue to really appreciate the support of Maggie's.

Progress

- Project board established chaired by Maggie's, with senior representation from MTW.
- Maggie's have appointed a dedicated fundraiser to lead the main fund-raising campaign.
- Maggie's have now offered dates for the clinical teams and other interested staff to visit Maggie's projects around the South East**. The project has universal support from the MTW Oncology clinical team.**
- Maggie's attended the site for 2 days to engage interested parties including architects presenting their initial concepts for the centre. This makes use of the trees and other natural features of the site as well as respecting the history of MTW using natural materials like local stone.
- A key next step for us will be to consider relocation options for occupational health and grounds & gardens in the new financial year, to ensure the Maggie's project is not delayed.
- Maggie's hope that the groundwork could start in 2026 fundraising dependent.

Summary

Progress continues and is on track. There are excellent working relationships between the Trust and Maggie's who are working well together.

Which Committees have reviewed the information prior to Board submission?

- Charitable Fund Committee, 22/11/23

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

For information – to provide a six month update

[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