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

Thu 29 February 2024, 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).

02-1
To receive apologies for absence

David Highton

02-2
To declare interests relevant to agenda items

David Highton

02-3
To approve the minutes of the 'Part 1' Trust Board meeting of 25th January 2024

David Highton

Board minutes, 25.01.24 (Part 1).pdf (12 pages)

02-4
To note progress with previous actions

David Highton

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

The Independent Inquiry into the issues raised by the David Fuller case

02-5
Assurance statement on the implementation of the recommendations from the Phase 1 report of the Independent Inquiry into the issues raised by the David Fuller case

Miles Scott

Assurance statement on the implementation of the recommendations from the Phase 1 report of the Independent Inquiry.pdf

(12 pages)

Reports from the Chair of the Trust Board and Chief Executive

02-6
Report from the Chair of the Trust Board

David Highton

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

02-7
Report from the Chief Executive

Miles Scott

Chief Executive's report February 2024 - FINAL APPROVED.pdf (4 pages)

Reports from Trust Board sub-committees

02-8
Quality Committee, 14/02/24

Maureen Choong

Summary of Quality C'ttee, 14.02.24.pdf (1 pages)

02-9
Finance and Performance Committee, 27/02/24

Neil Griffiths

Summary of Finance and Performance C'ttee 27.02.24.pdf (2 pages)

02-10
People and Organisational Development Committee, 23/02/24

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 23.02.24.pdf (2 pages)

Integrated Performance Report

02-11
Review of the Integrated Performance Report (IPR) for January 2024

Miles Scott and colleagues

Jan 2024 IPR.pdf (41 pages)

Quality items

02-12
Proposals regarding the reinstatement of ‘patient stories’ at the Trust Board

Joanna Haworth

Proposals regarding the reinstatement of ‘patient stories’ at the Trust Board.pdf (8 pages)

Maternity Services

02-13
Review of the initial response to findings of the Care Quality Commission (CQC) inspection of the Trust's Maternity Services

Joanna Haworth

Review of the initial response to findings of the Care Quality Commission (CQC) inspection of the Trust's Maternity Services.pdf (7 pages)

02-14
Maternity establishment review

Joanna Haworth

Maternity establishment review.pdf (5 pages)

People

02-15
To approve the Trust Board’s High Impact equality, diversity and inclusion (EDI) objectives

Sue Steen

To approve the Trust Board’s High Impact equality, diversity and inclusion (EDI) objectives.pdf (27 pages)

Systems and Place

02-16
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 Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (5 pages)

Planning and strategy

02-17
Update on the Trust’s draft planning submission for 2024/25

Rachel Jones and Steve Orpin

Update on the Trust’s draft planning submission for 2024-25.pdf (9 pages)

02-18
To approve the Outline Business Case (OBC) for the reconfiguration of Cardiology services

Sean Briggs

Cardiology OBC.pdf (58 pages)

Assurance and policy

02-19
Emergency Planning Annual Report, 2023 and future emergency planning

Sean Briggs

Emergency Planning Annual Report, 2023 and future emergency planning.pdf (10 pages)

02-20
To consider any other business

David Highton

02-21
To respond to any questions from members of the public

David Highton

02-22
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH JANUARY 2024, 09.45AM, PENTECOST-SOUTH ROOM, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer (except items 01-12 to 01-15 and 01-18)	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Jim MacDonald	Deputy Medical Director	(JM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Ainne Dolan	Deputy Chief People Officer, Organisational Development (for item 01-18)	(AD)
	Sarah Flint	Chief of Service for Women's Children's and Sexual Health (for item 01-12)	(SF)
	Jack Richardson	Freedom to Speak Up Guardian (for item 01-18)	(JR)
	Rachel Thomas	Director of Maternity (for item 01-12)	(RT)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

01-1 To receive apologies for absence

Apologies were received from Emma Pettitt-Mitchell (EPM), Non-Executive Director; and Sara Mumford (SM), Medical Director, but it was noted that JM would be attending in SM's place. It was also noted that Alex Yew (AY), Associate Non-Executive Director, would not be in attendance.

01-2 To declare interests relevant to agenda items

No interests were declared.

01-3 To approve the minutes of the 'Part 1' Trust Board meeting of 21st December 2023

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

01-4 To note progress with previous actions

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

The Independent Inquiry into the issues raised by the David Fuller case

01-5 Monthly update on the implementation of the recommendations from the Phase 1 report of the Independent Inquiry into the issues raised by the David Fuller case

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

- The current assessment was that 14 of the 16 recommendations for the Trust were substantially complete, with further work required on the other two.
- The steps related to one of those recommendations would be considered at a Trust Board Seminar that had been scheduled for that afternoon.

- The intention to submit a more detailed assessment of the Trust's position, and the accompanying evidence, to the February 2024 Trust Board meeting, to enable any outstanding queries to be addressed prior to submission to the Department of Health and Social Care (DHSC) in March 2024.
- It was also hoped to provide the Department of Health and Social Care (DHSC) with a more formal assessment in March; which would include an update on the recommendation for Kent County Council and East Sussex County Council, to enable the Trust to inform the statement that the Secretary of State for Health and Social Care would make to the House of Commons.

Reports from the Chair of the Trust Board and Chief Executive

01-6 Report from the Chair of the Trust Board

DH firstly thanked all staff at the Trust that had ensured the continued provision of services during the latest six-day industrial action by junior doctors. DH then referred to the submitted report and highlighted the consultant appointments which had been made within the reporting period.

01-7 Report from the Chief Executive (incl. an update on the car parking position and future plans)

MS referred to the submitted report and highlighted the following points:
- SM had formally commenced as the Trust's Medical Director as of the 1st January 2024.
- The report included details of activity levels throughout year 2023, which illustrated the pressures experienced by the Trust, and the steps which had been taken to address such challenges; but, it was emphasised that the Trust had demonstrated a net productivity gain, which was a major achievement.
- One of the measures to that had been introduced to maintain productivity was the Patient First Improvement System (PFIS), which had now reached its first anniversary, and MS encouraged Trust Board members to visit 'shop floor' departments and observe one of the PFIS 'huddles'.
- The Secretary of State for Health and Social Care had visited to officially open the second phase of the Community Diagnostic Centre (CDC), and that the third phase was scheduled to be completed imminently.
- The current position in relation to car parking at the Trust and associated plans to improve the position; however, MS reminded Trust Board members of the significant investment which had been made into car parking three years ago, and that free bus travel was also provided to staff travelling between Tunbridge Wells Hospital (TWH) and Maidstone Hospital (MH).

WW asked what, if any, additional measures could be implemented to provide Trust Board members with additional specific details about the PFIS; and also ensure that the momentum was maintained. JH welcomed the opportunity to bring some examples from the PFIS to the Trust Board, and gave an example of a small change, whereby an area had stopped shredding confidential waste prior to placement in the confidential waste bin, which had delivered immediate time efficiencies. JH then gave her perspective on how the momentum could be maintained. SO added that a Trust Board report on a six-monthly basis could be beneficial, and suggested that those involved in the PFIS be invited to attend. SO also highlighted the importance of ensuring that the ideas from PFIS were followed, to provide confidence that other ideas would be listened to; whilst there was also work to introduce and standardise a 'go and see' concept whereby senior staff would visit areas to witness changes at first hand. SO added that further work was required in terms of leadership development. MS proposed that his report include a section on the PFIS every quarter, although, acknowledged that it was important for senior individuals to visit 'shop floor' areas. This was agreed.

Action: Arrange for future "Report from the Chief Executive" reports to include information on the Patient First Improvement System (PFIS) every quarter (including examples of improvements made) (Chief Executive, January 2024 onwards)

Reports from Trust Board sub-committees

01-8 Quality Committee, 10/01/24

MC referred to the submitted report and highlighted the key points therein, which included the importance of consideration the impact on health inequalities as part of any future proposed service

developments through an equality impact assessment; and that the Committee had agreed to consider the findings of the Committee evaluation as part of the response to the external governance review by Deloitte LLP.

01-9 Finance and Performance Committee, 23/01/24

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

- The challenges in terms of the Trust's financial position and associated risks to the delivery of the plan.
- A discussion had been held regarding the introduction of additional centralised controls during periods of financial challenges.
- The Committee had recommended the Full Business Case (FBC) for the reconfiguration of acute stroke services for approval, by the Trust Board.

MS informed Trust Board members of the progress which had been made in relation to the risks relating to the replacement of major radiology imaging equipment, which had been escalated following consideration at another Trust Board sub-committee. NG agreed that significant progress had been made, however, acknowledged that the risks currently remained.

01-10 People and Organisational Development Committee (incl. the Quarterly update from the Guardian of Safe Working Hours (covering October to December 2023)), 19/01/24

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

- Whilst the Committee was assured in regard to the progress which had been made in relation to premium agency expenditure, further assurance was required that a robust governance process would be in place for once the project returned to 'business as usual'.
- The NHS workforce plan had been discussed in detail, and the Committee had requested that the Deputy Medical Director explore what, if any, additional engagement mechanisms could be implemented for potential consultant candidates.
- The committee commended the progress which had been made in relation to the development of the draft Digital and Data strategy was reviewed; however, highlighted some additional areas of focus, such as consideration of ethical matters, including developments in AI.
- The latest quarterly report from the Guardian of Safe Working Hours was considered and that had been included as an appendix to the submitted report.

Integrated Performance Report (IPR)

01-11 Review of the Integrated Performance Report (IPR) for December 2023

MS referred to the submitted report and drew Trust Board members' attention to the "Executive Summary" section on page 6 of 38. SS then referred to the "People" Strategic Theme and highlighted the following points:

- The three areas for escalation were turnover rate; the percentage of staff in Agenda for Change (AfC) pay band 8c and above from a Black, Asian or Minority Ethnic (BAME) background, and statutory and mandatory training compliance.
- The range of initiatives which had been introduced to reduce staff turnover, which included further encouragement of line managers to allow flexible working arrangements.
- There was an enhanced focus on staff that left the Trust within the first 18 months of employment, to enable the root causes to be addressed.

DM commended the reduction in the Trust's vacancy rate; but asked whether there was a systemic issue with recruitment taking longer than a notice period. SS noted that the 'time to hire' indicator had reduced from 49 days to 25 days, as a result of implementation Robot Process Automation (RPA), and RPA was being considered for other tasks, to further expedite the process. SS continued that vacancy control panels had reduced the time taken to prepare advertisements for available posts.

DH referred to the RPA and noted that he was aware that some Trusts in other Integrated Care System (ICS) worked together on such processes, so asked whether the Trust had with other NHS providers in Kent and Medway on RPA. SS replied that the Trust had worked very closely with Kent

Community Health NHS Foundation Trust (KCHFT) who were considered to be 'trailblazers' in RPA, and the Trust was exploring the introduction of virtual Human Resources (HR) adviser 'bots'.

DH asked whether the training individuals had completed prior to commencing employment at the Trust was recognised within the Trust's training compliance data. SS confirmed that 'passporting' approach was adopted, but the acceptance of prior training was dependent on the specific circumstances associated with the training and appointment.

DH then welcomed the appointment of the Trust as a phase 2 exemplar organisation for the NHS People Promise national vanguard retention programme and outlined the impact that such an appoint had at Buckinghamshire Healthcare NHS Trust.

MS then highlighted the need to consider the staff turnover metric in the context of the significant recruitment progress that had been made over the last 18 months, rather than consider the non-delivery of the 12% target as wholly negative. MS also highlighted the need to consider whether the 12% target was appropriate, or whether it should be higher or lower. The point was acknowledged.

WW requested further details of the actions being taken to reduce turnover. SS duly explained the approach and noted that it was important to properly understand the reasons why staff had left the Trust, which were multi-factorial, as that would direct the more specific action. WW asked when an update on the programme of work would be available for consideration by the Trust Board. SS confirmed that the output of the programme of work would be submitted to the February 2024 'Part 1' Trust Board meeting.

Action: Arrange for the output of the further A3 analysis into the staff who leave the Trust within 24 months to be submitted to the Trust Board meeting in February 2024 (Chief People Officer, February 2024)

WW referred to the "Percentage of AfC 8c and above that are BAME" metric and asked whether there had been further development of the plan to achieve the target. SS outlined the discussions which had been held at the Executive Team Meeting on the 23rd January 2024 wherein it had been agreed that the area of focus would be expanded to include AfC Band 8b staff and above, and noted that all recruitment for AfC Band 8b would be managed through an internal consultancy approach, to ensure that any additional steps required were implemented, although the principle of recruiting on merit would continue to be applied.

SS then reported that the "Statutory and Mandatory Training" metric was on target, despite being escalated, and the main issue related to those training programmes which required a 'refresher' course.

JW asked whether SS had sufficient support and resources to recruit candidates into those to 'hard to recruit' roles, in-light of the national shortages within certain staff groups. SS replied that one of the key measures to support recruitment into 'hard to recruit' roles was the development of the Trust's Employee Value Proposition (EVP) which had been discussed previously by the Trust Board and People and Organisational Development Committee; although, SS noted that other factors such as the inability to offer London Weighting also contributed to the issue. SS added that the Executive had however just agreed to introduce a 'golden hello' process, which was hoped to attract 'hard to recruit' staff to the area. DH opined that the flexibilities afforded by apprenticeships could also help to fill 'hard to recruit' posts. The point was acknowledged.

JM then referred to the "Patient Safety & Clinical Effectiveness" Strategic Theme and reported the following points:

- Funding had been agreed for the Lead Nurse for the Deteriorating Patient role, to support the achievement of the "Number of Deteriorating Patients with Moderate+ Harm" Breakthrough Objective
- There had been no increase in the rate of Serious Incidents (SIs)
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) date remained stable.

DH asked whether there would be an overlap between the skills of the Lead Nurse for the Deteriorating Patient role and the skills contained within the Critical Care Outreach Team. JH explained that there was some overlap, but the Critical Care Outreach team did not have the capacity to cascade the lessons learned across the Trust, so the Lead Nurse would be expected to collate and circulate the learning.

WW asked whether the measures to prevent *Clostridiodes difficile* (C. Diff) cases were likely to result in a reduction on the rate of *Escherichia coli* and other infections. JM confirmed that such measures would likely result in a reduction in other infections due the underlying modalities and provided further details. WW asked what, if any, assurance could be provided that the number of C. Diff cases would not increase further. JH outlined the link between C. Diff rates and antibiotic usage and noted the potential impact of managing the increased prevalence of respiratory infections.

WW asked whether there had been any increase in 'long-covid' cases alongside the traditional respiratory infections. JH and JM confirmed that there had not been a discernible increase. MS however pointed out that although the rate of C. Diff infections had been escalated, there was a difference between special cause variation and common cause variation; therefore, there was no particular area of concern with in relation to the rate of C. Diff infections. MC added that the issue had been considered, in-depth, by the Quality Committee.

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

- 3-month Statistical Process Control (SPC) forecasts for the "Patient Access" Strategic Theme had been included as appendices
- The Trust's 18-week Referral to Treatment (RTT) performance had remained static, due to the adverse impact of industrial action.
- The Trust had been more conservative about the patients that had waited more than 40 weeks for treatment and, although the number of patients that had waited for more than 40 weeks was 681, further work was required. However, it was important to note the Trust's performance comparative to other NHS organisations.
- The 62-day cancer waiting time target had been met for all but one month over the last four years, so the Cancer Services team should be commended.
- Outpatient utilisation had dropped by 3% in December 2023 as a result of industrial action and a similar performance was expected for January 2024. However, the Trust had still performed above the outpatient and elective activity targets, so all staff, and the nursing staff in particular, should be thanked for their work.
- The programme of work by the Patient Flow Team to address the challenges in terms of Emergency Department (ED) four-hour waiting time target performance at Tunbridge Wells Hospital.

RF asked how the Patients Know Best (PKB) patient portal had performed in the initial months since 'go live'. SB firstly detailed the challenges associated with the implementation of the patient portal, as it was a significant undertaking involving a wide range of staff. SB then outlined the initial 'teething issues' which had been experienced, particularly for patients that shared their care between the Trust and other NHS Trusts and noted the further work required to fully embed the patient portal. DH queried whether the patient portal allowed patients to re-book their appointments directly, or whether it only enabled patients to cancel their pre-booked appointment currently. SB replied that there was currently insufficient flexibility within the patient portal to enable patients to re-book their appointments directly.

KC commended the continued performance which had been delivered; however, asked how motivation was maintained in response to the significant operational pressures. SB noted that sometimes improving a position was easier than maintaining the improved position and elaborated on his perspective, during which he acknowledged the difficulties in constantly striving to improve. A discussion was then held, during which KC, and DH gave their perspective, and WW highlighted the importance of obtaining positive feedback from patients. DH also noted that what was once considered to be poor performance in the NHS had become normalised, and DH believed that much of the Trust's motivation stemmed from not accepting that normalisation. The point was acknowledged.

JH then referred to the “Patient Experience” Strategic Theme and highlighted the following points:

- The total number of complaints received had started to decline, as had the number of complaints relating to communication.
- The action plan had been duly updated, following a previous request from the Trust Board.
- A programme of work had been developed to address the three top contributors to the Trust’s complaints rate (i.e. “Staff attitude and behaviour”; “Inconsistent communication”; and “Inaccurate communication”) with a focus on specific complaints, to use as examples.
- A training session had been scheduled in February on ‘compassion in the workplace’.
- Further work was being done with the InPhase tool, which included a focus on categorisation to ensure that communication complaints were accurately captured.
- The Trust was in the process of moving to a new Friends and Family Test (FFT) provider, which would ‘go live’ on the 28th February 2024 and would enable far more specific patient surveys to be introduced.

MC acknowledged the adverse impact of sickness absence in the central complaints team, but asked whether any work had been done to improve the efficiency and flow in terms of Divisional complaint responses. JH acknowledged that there was variation in terms of efficiency and flow in relation to the Divisional complaints processes; but provided assurance that a programme of work had been commissioned to develop a consistent approach, where appropriate.

MC welcomed the new FFT platform, and asked whether additional flexibility would be afforded to patients. JH confirmed it was more agile and enabled utilisation on a wider range of digital platforms, although noted non-digital platforms, such as paper forms and the use of volunteers would continue as well.

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

- The “Stratified data” provided a breakdown of patient discharge pathways and illustrated that the key opportunities for the Trust were in pathways 1 and 2
- Kent County Council (KCC) were considering procuring an alternative provider for pathway 1 capacity, which posed a risk for the wider Kent and Medway Integrated Care System as well as the Trust.
- Discussions had been held regarding capacity for the various pathways, and the utilisation of such capacity, to improve patient discharge
- The trajectory for the objective was progressing in the appropriate direction, although it was acknowledged that the position had started in special cause variation of a concerning nature.
- A series of Multi Agency Discharge Events (MADEs) had been held over the year, which had achieved several positive outcomes.
- A trajectory was being finalised with the Medicine and Emergency Care Division regarding non-elective patients, and it had been confirmed that there would not be a ‘one size fits all’ approach, so it was important to ensure lessons learned were disseminated across all clinical areas.
- Continued progress was expected; however, such progress was likely to be slow.

DH noted that the pilot in intensive care step-down/rehabilitation in East Kent had a significant impact on pathway 3 capacity and asked when the pilot would likely be extended to West Kent. RJ explained that the ‘one version of the truth’ work had identified that the West Kent community pathways had a longer length of stay (LOS) than other areas, so that work required prioritisation to support patient flow.

KC asked whether patients were referred to as “no longer fit to reside”. A discussion was then held during which MS stated that it was possible that some staff did use that phrase, due to the pace at which the terminology had changed. DH noted the intention to introduce the term ‘discharge ready’. MS added that the term “no longer fit to reside” was outdated, as the current official term was ‘no longer met the criteria to reside for inpatient care’.

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

- The Trust was 1 of only 12 Trusts that received an exemplary rating for the quality of the Integrated Performance Report (IPR), and the Business Intelligence Team had been invited to provide a presentation to other NHS Trusts in relation to how the data was used to inform discussions.

- The significant challenges to the financial position of the Trust, the Kent and Medway ICS and the NHS nationally and the potential consequences.
- The Trust was £1.8m adverse to plan year-to-date, of which circa £400k related to the industrial action prior to the Christmas period and circa 900k was related to the January 2024 industrial action; therefore, the Trust was circa £700k adverse to plan if the impact of industrial action was recognised.
- The Trust had been unable to reduce high-cost agency at a comparable rate to reduction in the vacancy rate; although, both the Estates and Facilities Directorates had completely eliminated their agency use as of the end of December 2023; however, Medical staffing remained a high use area for agency staff due the particular challenges in such areas.
- A range of discussions had been held regarding the importance of the delivery of the financial plan; which had been framed in the context of ensuring that the Trust could continue to deliver future service developments.
- It had been decided not to adopt additional controls and instead to encourage managers at the Trust to be held account for the decisions they made; although, it was acknowledged that the Executive Directors reserved the right to apply additional controls in the future, if required.
- Additional details of the 2024/25 Cost Improvement Programmes (CIPs) would be submitted to the February 2024 'Part 1' Trust Board meeting for review.
- There was a high spend in capital that would need to be shifted towards the end of the year, which included the frontline digitisation funding which involved £2.7m of capital funding which had not yet been confirmed, but which needed to be spent by the end of the financial year.

DH referred to the latter point and noted that potential challenges associated with supplier lead times, and asked whether the Trust Board was content to provide SO with the necessary support in his decisions, even if such decisions posed a risk that the Trust became overspent by £2.7m in the event that the required confirmation was not received. This was agreed.

NG asked when an alternative approach, such as the introduction of additional controls, would be taken if the current approach did not support an improvement in the Trust's financial position. SO stated that no timescale had been agreed, but felt that if the current worsening trend continued, that would trigger a discussion with the Executive Directors, but if there was an indication that the trend was improving, that may negate the need for such a discussion.

[N.B. The Trust Board took a brief recess at this point]

Quality Items

01-12 <u>To approve the NHS Resolution maternity incentive scheme submission</u>

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

- The NHS Resolution maternity incentive scheme submission was required by 12pm on 1st February 2024 and provided that an action plan had been developed for those areas which were non-compliant areas
- 7 out of the 10 Safety Actions had been achieved, which included Safety Action 6, which had involved achieving 70 specific actions.
- The 3 Safety Actions that were non-compliant were 5, 8 and 9.
- The evidence provided by the Trust had been reviewed by the Kent and Medway Integrated Care Board (KM ICB); who had confirmed their support for the evidence provided.
- Safety Action 5 required a six-monthly review of maternity staffing levels, which had been conducted, but had not been submitted to the Trust Board due to the publication of the Care Quality Commission (CQC) Section 29A Warning Notice, which had outlined additional staffing requirements.

SF anticipated that the Maternity Services staffing review would likely result in the development of a significant Business Case for additional staff. DH asked whether the Business Case would include medical staff. SF confirmed that would likely be the case, along with several other roles.

RT then outlined the further work which was required to achieve Safety Action 8; which included conducting a training needs analysis for maternity services which was aligned to the Maternity Services Core Competency Framework. SF provided assurance that the training requirements

related to areas such as smoking cessation, rather than the larger, safety-related training programmes. DH queried whether the Maternity Service was compliant with the requirement for a one-day multi-professional training. SF and RT confirmed that the Maternity Service was complaint; although, RT noted the requirement to increase the frequency of some areas of training at the Trust to ensure compliance.

RT then highlighted the requirement under Safety Action 9 for the Perinatal Quality Surveillance Model to be presented at each Trust Board meeting. DH noted that the "Quarterly Maternity Services" report had included details of SIs and Healthcare Safety Investigation Branch (HSIBs) reports and queried whether such information would also be supplied to each Trust Board meeting. RT and SF confirmed that was the case.

MC asked whether the standards for the NHS Resolution maternity incentive scheme had been amended for 2023/24. RT confirmed that was the case. SF then explained the complexity of the associated assessments and noted that the standard involved an element of interpretation, including via the Local Maternity & Neonatal System (LMNS).

KR queried whether the requirement for the Perinatal Quality Surveillance Model to be presented at each Trust Board meeting had been explicitly stated or was an interpretation of the NHS Resolution maternity incentive scheme. JH explained that it was an interpretation following a review by the LMN; and noted that other LMNS' had reach different conclusions; however, believed that the Trust should abide by the LMNS' interpretation. MC noted the variation in frequency with which Trust Boards met across the NHS. The point was acknowledged.

KC asked whether the action plan owners and "Lead executive director" sections in the action plans needed to be confirmed. RT and SF confirmed that some further clarification was required in relation to the action plans.

KC noted that the action plan included a request for funding and queried whether the funds requested were sufficient. SF explained that the Maternity service's approach, although noted that the funding request would be finalised once the aforementioned Business Case was developed. RT then provided further details.

KC then asked about the morale of the team, SF and RT, given that only 7 of the 10 Safety Actions had been achieved. RT and SF gave their perspectives.

DH observed that maternity services were under consistent pressure nationally, from NHS Resolution, the Care Quality Commission (CQC) and NHS England (NHSE); although acknowledged that the funding model for maternity Services did not reflect the significant increase in demands, so it was difficult for the Trust Board to reconcile the different pressures. SF commented that the key challenge was maintaining service provisions. MS stated that he believed it was a very good example of where the Trust needed to continue to determine its own destiny, and a key element of that was the delivery of the Trust's financial plan. SO emphasised the importance of continued prioritisation of those measures which would demonstrate a measurable impact on service provisions. DH also highlighted that the external requirements were primarily focused on inputs, on the basis that these would have a positive impact on outputs, and the Trust Board should not lose sight of the need to continue to focus on outputs i.e. the safety of those care for by the maternity service. The point was acknowledged.

The NHS Resolution maternity incentive scheme submission was approved as submitted.

People

01-13 <u>To commit to the implementation of the sexual safety in healthcare charter</u>

SS referred to the submitted report and highlighted the key points therein, which included the rationale for the submission of the report; the proportion of NHS staff which experienced inappropriate conduct of a sexual nature, both from patients and other staff; and that 7% of staff had reported in inappropriate behaviour from patients and 5% of staff had reported inappropriate

behaviour from colleagues as part of the findings of the national NHS Staff Survey, to which just over 3000 staff had responded.

DM noted that the figures in the report were higher than the Trust's local data that SS had reported, so asked whether there was a risk of under-reporting. SS acknowledged that was a possibility, and the survey was only completed by a certain proportion of staff. SS noted that it was therefore important to acknowledge that there was an issue, regardless of the extent.

SS continued that once the sexual safety in healthcare charter had been approved the Executive Team Meeting (ETM) and Trust Board would receive update reports, and proposed a frequency of every six-months. DH confirmed his support for the proposed reporting frequency.

Action: Schedule a "Six-monthly update on the implementation of the sexual safety in healthcare charter" at the Trust Board (Trust Secretary, January 2024 onwards)

The Trust Board confirmed its commitment to the implementation of the sexual safety in healthcare charter.

01-14 <u>Outcome of the review of the consultant interview and recruitment process (in light of the comments made at the 'Part 1' Trust Board meeting on 26/10/23)</u>

SS referred to the submitted report and highlighted the key points therein, which included the implementation of a line by line review of the Trust's vacancies to enable the provision of a tailored attraction programme and to consider which roles could be redesigned; the review of the Trust's recruitment processes to ensure candidates were aligned to the Trust's values; and the programme of work to improve onboarding processes. SS then invited any further suggestions from Trust Board members.

NG outlined the pragmatic approach which had been adopted at a recent Advisory Appointment Committee (AAC) based on the individual candidate's experience, and added that ACC had acknowledged the support which could be provided to candidates if they were appointed.

MC asked whether senior trainees had been asked for their views. JM confirmed that an engagement session had been held with senior trainees and such engagement would continue.

DH detailed the consultant recruitment process adopted by Buckinghamshire Healthcare NHS Trust which included stakeholder panel, which was held in the morning, and the interview, which was held in the afternoon utilised separate representatives from the Trust, which enabled to the interview to focus on the candidates values rather than their clinical acumen.

RF commended the programme of work to date; however, suggested that further emphasis could be placed on the Trust's Employee Value Proposition (EVP) and noted that he believed there were improvements which could be made in the Trust's induction processes to support candidate development needs. RF also stated that he was not sure whether there was sufficient contact between the Trust and potential candidates during the recruitment process, which may have been a factor in some candidates withdrawing their application. The points were acknowledged.

JH also commended the programme of work; however, stated that further emphasis on a multidisciplinary approach was required, which incorporated non-clinical staff such as representatives from the Finance Department and other corporate areas. The point was acknowledged.

DH noted that, due to changes in the way the deanery operated, senior trainees were under increased pressure to find a substantive position; however, such a position was likely to be a long-term commitment and therefore had to be sufficiently attractive. JM replied that there was additional engagement required to encourage senior trainees to pursue a career at the Trust. DH then outlined the alternative options which were available to senior trainees until such time a desirable position became available.

Systems and Place

01-15 Update on the West Kent Health and Care Partnerships (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- The operational planning guidance for 2024/25 had not yet been published; however, there continued to be a focus on financial recovery.
- The KM ICB had developed several engagement events, which would be available online.
- The £6.3m of investment in the HCP, which had previously been non-recurrent, had been made recurrent, so an assessment was underway, in conjunction with local authorities, as to what specific schemes should be funded.
- A session had been held at the HCP Board in January on financial sustainability; which had discussed the roles of the HCP and Provider Collaboratives, and MS had presented his views, which had been well-received.
- Involve gave a presentation on social prescribing, which had resulted in a reduction of Emergency Department attendances of up to circa 20% for some patient cohorts.

DH highlighted that three of the substantial organisations within the West Kent HCP (i.e. the Trust, Kent Community Health NHS Foundation Trust (KCHFT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT)) not in a financial deficit for 2023/24; therefore, the West Kent HCP should resist any request to participate in any programme to support other NHS providers which would be detrimental to the Trusts in West Kent. RJ supported the point and outlined the indication from the KM ICB that a review of health inequalities funding would be conducted, which would negatively impact funding for the Trust.

NG noted that although the operational planning guidance had not yet been published, the Finance and Performance Committee had been informed of some of the likely aspects such as the need to achieve financial balance for the Kent and Medway ICS and the potential 4% efficiency requirement; and requested RJ to provide further details. RJ duly provided additional detail, which included the expectations in regards to staffing levels obliged; although acknowledged the potential discussions which could be held regarding the Trust's productivity increases. DH opined that it was the role of the KM ICB to focus on resource allocation and rather than focus on individual decisions relating to, for example, recruitment, via Vacancy Control Panels. RJ agreed and gave her perspective on the delegation of responsibilities and the potential future development of such arrangements.

WW queried whether RJ was sighted on the financial pressures faced by Kent County Council (KCC) for 2024/25. RJ stated that she was closely involved with the borough and district councils rather than KCC, and that engagement with KCC occurred primarily at an KM ICB level, although expressed concerns over the potential re-procurement of a Pathway 1 provider.

Planning and strategy

01-16 To approve the Full Business Case (FBC) for the reconfiguration of acute stroke services

DH referred to the submitted report and noted that the Finance and Performance Committee had reviewed the FBC and recommended it for approval. Questions were invited. None were received.

The FBC for the reconfiguration of acute stroke services was approved as submitted.

Assurance and policy

01-17 Six-monthly review of the Trust's red-rated risks

JH referred to the submitted report and highlighted the key points therein which included that the Trust had 213 "finally approved" open risks, of which 45% were overdue for review; the Risk and Compliance Manager post was currently vacant; therefore, the risk management function was being provided by the Director of Quality Governance; an update on the development of a Business Case to improve the Trust's risk management function; the intended focus on those risks which had been open for over a year; the development of a robust training programme in relation to risk management; the alignment of risks to the Trust's strategic themes; six new red-rated risks had been added in

January 2024; and that five red-rated risks had been open since 2022, as such there was an outstanding question as to whether they should continue to be red-rated.

DM noted that the Trust's approach to risk management would be considered at the Trust Board Seminar later that day; however, suggested that it may be beneficial for feature red-rated risk items to include the term "risk management" in the title, to illustrate the key area of focus for the Trust Board. The point was acknowledged and it was noted that further discussions would be held at the Trust Board Seminar.

JW asked how the Trust's risk appetite compared with other NHS providers. JH stated further work was required to examine the Trust's risk appetite compared to other NHS providers within Kent and Medway. JW emphasised the importance of clearly defining the Trust's risk appetite. DM then explained the challenges in terms of determining an organisations risks appetite and noted that organisations often understated their risk appetite. DH commented that a further discussion on risk management would be held at the Trust Board Seminar; although, acknowledged that a further Trust Board Seminar on risk appetite and risk exposure may be required.

01-18 <u>Quarterly report from the Freedom to Speak Up Guardian</u>

DH congratulated JR on his appointment as interim Freedom To Speak Up Guardian (FTSUG) and welcomed JR and AD to the Trust Board. AD reported that JR had been appointed on an interim basis for a period of six-months, as an Agenda for Change (AfC) Band 8a lead; however, AD would continue to support the Freedom To Speak Up (FTSU) service to provide additional resilience and it was intended to train an additional FTSU Officer. AD then provided an update on the recruitment timeline for a substantive FTSUG.

JR then referred to the submitted report and highlighted the key points therein, which included that 19 reports had been received within the reporting period, which was low for an organisation of the Trust's size, so there was the potential for under-reporting; the increase in the number of anonymous reports and the associated challenges in terms of 'unknowns' within the data; the intended reinvigoration of the Safe Space Champions; the positive feedback which had been received, particularly in relation to service developments; and the observable changes which had been delivered to date. JR then invited suggestions from Trust Board members regarding any potential areas for inclusion in future reports.

SS informed JR that the Trust Board had confirmed its commitment to the sexual safety in healthcare charter, and noted that although relatively high numbers of staff had stated they had been subject to incidents of inappropriate sexual behaviour in the national NHS Staff Survey, however, that had not been reported via the FTSU service. SS then queried whether individuals could be encouraged to be part of a positive case study to illustrate the Trust's response to such issues. JR acknowledged the importance of the issue and elaborated on his intended approach.

MC acknowledged the importance of maintaining resilience within the FTSU service; and therefore, confirmed that a handover period, and ongoing support, would be afforded to WW during their transition to the role of Freedom to Speak Up NED champion.

JH outlined the original rationale for the establishment of the FTSU service and queried whether the Health and Safety category included clinical safety. JR confirmed that was the case and noted that those incidents which were covered multiple categories were recorded accordingly. AD then outlined the programme of work with the Director of Quality Governance to ensure there was appropriate triangulation between patient safety data, the FTSU service, and other 'People insights'.

RF asked how resolution of a concern was defined. AD explained that how resolution was determined would depend on the individual circumstances of the case and provided assurance that the FTSUG would work directly with the individual to understand their perspectives and ensure the Trust's response was tailored to the individual.

RF asked how further issues, following the resolution of the issue, would be identified. JR confirmed that he continued to liaise with the individuals concerned to ensure there was no deterioration in the resolution which had been achieved and provide any additional support as required.

WW highlighted the benefits of a 'fresh pair of eyes', and asked what two key themes were that, if addressed, would deliver a significant improvement. JR replied that the two key areas of focus were the method by which the key themes were collected from the backlog of FTSU data to ensure that no further issues had arisen, and the reinvigoration of the Safe Space Champions. AD then outlined the intention to increase the number of clinical staff appointed as Safe Space Champions. WW then asked how many Safe Space Champions there were at the Trust. JR replied that the Trust currently had circa. 50 Safe Space Champions, however, stated that the number of Safe Space Champions and the training provided would be reviewed.

MC commended AD's role in supporting the FTSU service, particularly during the absence of a substantive FTSUG.

01-19 To consider any other business

There was no other business.

01-20 To respond to questions from members of the public

KR confirmed that no questions had been received ahead of the meeting.

01-21 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
01-7	Arrange for future "Report from the Chief Executive" reports to include information on the Patient First Improvement System (PFIS) every quarter (including examples of improvements made).	Chief Executive	January 2024	The first update has been scheduled for inclusion in the report submitted to the Trust Board meeting in March 2024, and every quarter thereafter.
01-11	Arrange for the output of the further A3 analysis into the staff who leave the Trust within 24 months to be submitted to the Trust Board meeting in February 2024.	Chief People Officer	February 2024	The output of the further A3 analysis into the staff who leave the Trust within 24 months has been included as part of the "Review of the Integrated Performance Report (IPR) for January 2024" item.
01-13	Schedule a "Six-monthly update on the implementation of the sexual safety in healthcare charter" at the Trust Board.	Trust Secretary	January 2024 onwards	The item has been scheduled for July 2024, and every six months thereafter.

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 March 2024 due to the volume of work involved in the review (which is

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

Ref.	Action	Person responsible	Original timescale	Progress
				considerable, despite the light touch' label).
11-12a	Ensure that the next "Annual approval of the Trust's Green Plan" report to the Trust Board included details of what the Trust could do to generate renewable green energy.	Chief Executive	July 2024	The Director of Estates and Capital Development has been asked to ensure the content is included in the report submitted to the Trust Board meeting in July 2024 (which will be submitted to the Executive Team Meeting and Finance and Performance Committee beforehand).
12-18b	Ensure that the future "Review of the quality-related aspects of the Virtual Ward service" item at the Quality Committee 'deep dive' meeting contained details of any negative patient feedback that had been received about the service.	Medical Director (Integrated Care) at the West Kent Health and Care Partnership (HCP) (N.B. The individual was the Trust's Medical Director at the time the action was agreed)	December 2023 onwards	The requested content is expected to be included in the report, which is provisionally scheduled for the Quality Committee 'deep dive' meeting in April 2024.

NHS Maidstone and Tunbridge Wells NHS Trust

Assurance statement on the implementation of the recommendations from the Phase 1 report of the Independent Inquiry into the issues raised by the David Fuller case — **Chief Executive**

- The report from the Independent Inquiry into the issues raised by the David Fuller case was published on the 28th November 2023.
- A compliance status report was compiled to support evidencing the implementation of its recommendations.
- A Corporate Project was set up to ensure any remaining actions were completed in a timely manner.
- This enclosed report provides information on the actions taken and indicates the basis on which the Board can take assurance that the report's recommendations have been implemented.
- It is proposed that continuing compliance with these recommendations is subject to independent scrutiny by the Internal Auditors after 12 months and is then subject to annual reviews by the End of Life Committee and reported to the Quality Committee thereafter.
- Recommendation 12 is for Kent County Council and East Sussex County Council to respond to. The Trust has engaged with the councils and the Department of Health and Social Care (DHSC) will follow up compliance with regards to that recommendation.

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

- Fuller Inquiry Recommendations Implementation Corporate Project

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

- Assurance

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

Response to the recommendations following the independent inquiry into the issues raised by the David Fuller case

Recommendation 1

Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- The mortuary is only accessible using a swipe card. Only mortuary staff, the bereavement team, the security team and trained porters have a swipe card providing them access to the mortuary. This practice has been in place since 2021 and is formally documented[1].
- Porters require access to the mortuaries out-of-hours, to transfer deceased patients from inpatient areas to the mortuary fridges and to accept transfers of deceased persons from external sources (funeral directors, HM Coroner, the Police etc.). There would however always be at least two porters attending for this purpose. All porters are required to attend a 90-minute training session with mortuary staff, and be deemed competent, before they are authorised to access the mortuary with a swipe card. Porters' adherence to the policy is checked (see Recommendations 6, 7 and 9).
- Security staff need to be able to respond to calls relating to the Mortuary. Like porters they are required to attend in pairs if there is no member of the mortuary team on site. Their access is limited to the perimeter of the mortuaries and does not cover internal locked doors. Compliance with this policy is checked through the audit of swipe card access and CCTV.
- Estates staff (i.e. Mitie staff at Tunbridge Wells Hospital and the in-house team at Maidstone Hospital) and the Site Team are not given access to the mortuaries via their swipe cards. Contractors, including maintenance staff employed by the Trust's external facilities management provider, are therefore always accompanied by mortuary staff member when they visit the mortuary.

Recommendation 2

Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

[1] "The Mortuary General Policy and Procedures", August 2021

- The Human Tissue Authority (HTA) undertook a comprehensive inspection of the Trust's mortuaries in June 2022. The Trust retained its licence, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection. The HTA confirmed that it was satisfied that the Trust had completed the agreed actions in the corrective and preventative action (CAPA) plan and in doing so had taken sufficient action to correct all shortfalls addressed in the Inspection Report[2].
- The Designated Individual and Persons Designate maintain all standards and report through Governance to ensure they continue to meet standards.
- The practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, was ceased in early 2021. The prohibition of this practice has been formalised in a local policy[3].

Recommendation 3

Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.

Assurance statement:

The Trust now complies with this recommendation in full:

- A "Disclosure and Barring Service process proactive review" was undertaken by the Trust's Anti-Crime Service (formerly the Counter Fraud service) as part of the 2022/23 work programme, and the report was published in January 2023. That review concluded that "The Trust is compliant with NHS Employment Standards and Regulations for processing of DBS", and that the Trust's policy was "…robust and good compliance has been evidenced".
- Reports on the outcome of the Trust's internal compliance checks regarding the DBS checking process were considered at the Executive Team Meeting (ETM) in June and October 2023 and by the People and Organisational Development Committee in June and November 2023. These reports showed that no members of staff had a DBS check which was outstanding and had not actively engaged in renewing their check with the DBS team[4]. Annual reports are now scheduled to be presented at both ETM and People and Organisational Development Committee meetings.
- The Trust's contacts with service providers include the need to comply with the Trust's policy on DBS checks. Mitie (the contractor that provides Facilities Management and Estates services at Tunbridge Wells Hospital) has confirmed to the Trust that their policy renews DBS checks for all its employees every three years (which aligns with the Trust's policy for its staff). The Trust has also written to Kent and East Sussex Weald Hospital Ltd (KESWHL), the PFI Project Company that sub-contracts to Mitie, to confirm KESWHL and its agents and contractors, including Mitie, complies with the Trust's "Disclosure and Barring Service (DBS) checks" policy.
- The process for DBS checks for other contractors (apart from the Trust's security service provider – see below) has recently been transferred to the Compliance team within the People and Organisational Development function. 46 such contractors have been notified that the Trust requires them to comply with the Trust's "Disclosure and Barring Service (DBS) checks" policy & therefore renew the DBS Certificates of their eligible staff every three years.

[2] Inspection report on compliance with HTA licensing standards, Inspection date: 07-10 June 2022

[3] RWF-CAD-SOP4 Version 1.0 Post Mortem Examination

[4] 'Main' People and Organisational Development Committee – November 2023 Mid-Year Update on the Trust's Disclosure and Barring Service (DBS) Check Compliance

Recommendation 4

Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- A new Care After Death Directorate has been established, which separated the mortuary from the Cellular Pathology. The establishment of the new Directorate resulted in the existing Mortuary Manager being appointed as the Directorate's Head of Service[5]. A new Mortuary Manager was appointed from among the Trust's existing Anatomical Pathology Technologists.
- The essential requirements for the new Mortuary Manager post includes "RSPH Level 3 Diploma Anatomical Pathology Technology and Diploma Level 4 Diploma Anatomical Pathology Technology (or significant experience post level 3 qualification in an autopsy active DGH/public mortuary) or pre 2015 certificate and diploma in Anatomical Pathology Technology plus top up qualification or leadership certificate"[6].
- The Mortuary Manager role is subject to the Trust's standard appraisal process and has access to training opportunities, as required. Their job description includes a requirement "To maintain personal competency and develop records for the purpose of maintaining professional competency and compliance as part of ongoing CPD and training processes".

Recommendation 5

The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- Both the Head of Service and the Mortuary Manager are full-time dedicated roles and, as stated under Recommendation 4, are subject to the Trust's standard appraisal process with access to training opportunities, as required. Their job description includes a requirement "To maintain personal competency and develop records for the purpose of maintaining professional competency and compliance as part of ongoing CPD and training processes".

Recommendation 6

Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- All access points to the mortuaries at Tunbridge Wells Hospital and Maidstone Hospital are controlled by swipe card access.

[5] Management structure for the new Care After Death Directorate
[6] Mortuary Manager Job Description

- There are no longer any 'access all areas' access/swipe cards in circulation.
- The mortuary is one of the designated "restricted" areas in the Trust's current "Security policy and procedure"[7].
- In relation to the mortuary, the Head of Service for the Care After Death Directorate confirmed which roles should have the required access. Access is only granted to the mortuary staff, Bereavement team, the Bereavement Midwife, trained porters (see below), and security staff. Moreover, the security staff are not provided access to the doors within the mortuary that still have a digi-lock or key-lock in place (i.e. in addition to a swipe card activation). The porters are provided with the relevant digi-lock code in order to be able to access the fridges.
- At the Tunbridge Wells Hospital mortuary, there is differential access between the mortuary perimeter and the specific rooms within that perimeter. For example, portering staff cannot access the post mortem room.
- Estates staff (i.e. Mitie staff at Tunbridge Wells Hospital and the in-house team at Maidstone Hospital) and the Site Team are not given access to the mortuaries via their swipe cards. They are therefore expected to undertake any duties in the mortuary when mortuary staff are present[8], and can only access the mortuary out-of-hours if they attend with someone onsite who has been authorised to have swipe card access, or contact the on-call member of the mortuary team who would attend to authorise such access.
- All porters are required to attend a 90-minute training session with mortuary staff, and be deemed competent, before they are authorised to access the mortuary with a swipe card. The key aspects are as follows:
    - The training covers security; patients contact; 'do's and don'ts'; the Human Tissue Authority (HTA); HTA Reportable Incidents (HTARIs) and how to report an incident; moving and handling; and wellbeing.
    - The porter's competency is assessed at the end of the training (by an Anatomical Pathology Technologist (APT)) to ensure they have understood the requirements.
    - The training records are held by the mortuary
- When a porter is deemed competent, they are granted swipe card access to specific areas of the mortuary for 12 months. Their swipe card access will automatically deactivate after 12 months unless they receive the training again within that 12-month period. If they are deemed competent again, they will be granted swipe card access for a further 12 months. The mortuary team hold a record of each porter's training, and will prompt a porter to schedule their further training as their 12-month period is approaching.
- As a further security measure, in addition to the access control of entry points, the mortuary has an intruder alarm system in place. This requires those who access the mortuary to 'tap', upon entry, a pad located on the wall within the main entrance area of the mortuary with an electronic key fob, to deactivate the alarm. If the key fob is not deployed within a certain time period, the alarm is activated. The intruder alarm process is managed by the security team (who issue the key fobs to the required staff).
- Swipe card access has also been installed inside and out of the Snowdrop room at Tunbridge Wells Hospital. This room is used to store the bodies of any babies[9] that die on the delivery suite, in three refrigerated cots, and is therefore considered a 'satellite' to the main mortuary at Tunbridge Wells Hospital (and is thus covered by the Trust's HTA licence[10]).

[7] Security policy and procedure
[8] Routine duties would include a daily check of the external fire doors; twice-weekly flushing of the taps in the WC and post mortem room. Non-routine duties would include repairs that have been logged via the Estates helpdesk.
[9] This would include late miscarriages, stillbirths and terminations for foetal abnormalities.
[10] The HTA has previously been aware of the Snowdrop room, but it is expected that the HTA will formally inspect the room during the Trust's next HTA inspection.

Recommendation 7

Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- As referred to under Recommendation 6, the mortuary is a designated "restricted" area in the Trust's current "Security policy and procedure". Access to restricted areas may only be granted by the senior managers in the such areas.
- Any access/swipe card which has not been used on Trust premises for more than two months will be deactivated, with the ability to reactivate when required. Every week, Security Control Room staff conduct an audit on the respective sites' access control systems to review which access control cards have not been used for two months. Any access control cards identified are temporarily disabled.
- Once a month, the Operational Security Manager provides an electronic record to the managers of restricted areas of staff accessing those areas with the dates and times of those visits. This allows the manager to check that only authorised staff are accessing the area, and that this access is appropriate. The managers scrutinise these records and report any unusual or unauthorised activity to the Operational Security Manager for investigation.
- For the mortuary, this audit is undertaken by the Head of Service for the Care After Death Directorate (who was formerly the Mortuary Manager). The data provided by the Operational Security Manager includes details of the access to specific doors (each door has a reference number) i.e. the individual who has accessed the door, the date, time of entry, and time of exit. The data also includes details of individuals who have attempted to gain access (via their swipe card) but have failed. Although the Security policy and procedure contains a high-level description of the audit process for restricted areas, the audit process for mortuary access is further described in a local SOP. That SOP therefore needs to be reviewed, to confirm that it accurately reflects the current process, and revised if necessary.
- Retention period for CCTV images have been extended from 31 days to 38 days to enable the audits of restricted areas that relate to the review of CCTV footage to continue to be undertaken monthly.
- CCTV has also been installed outside and in the Snowdrop room at Tunbridge Wells Hospital (see Recommendation 6).

Recommendation 8

Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- The Trust has strengthened its security responsibility arrangements significantly since the Police informed the Trust of Fuller's mortuary-related crimes in December 2020. The changes made since then have been informed by, among other things, the findings from an external peer review of security arrangements that took place in October and November 2021 (and which was then followed up by a further peer review in 2023).
- The changes made include the following points:

- The revision of the Trust's Security policy and procedure[11].
- The implementation of the recommendations from the peer review of security arrangements[12].
- Transfer of the executive responsibility for security to the Chief Operating Officer (who is therefore the Trust's Security Manager Director[13]).
- The appointment of the Chair of the Audit and Governance Committee as the Trust's Security management NED champion[14].
- The addition of the oversight of security issues to the Audit and Governance Committee's remit[15], which includes the consideration of a standing "Security issues" item at each standard Committee meeting, and the consideration of a Security Annual Report.
- The submission of a Security Annual Report to the Trust Board[16].
- Transfer of the responsibility for security at a functional level to the Director of Emergency Planning & Response.
- The re-establishment of a Trust Security Committee (as a sub-committee of the Health and Safety Committee), chaired by the Director of Emergency Planning & Response. The Committee includes representatives from departments and areas across the Trust (and now includes the Head of Service for the Care After Death Directorate, who gave a report on Mortuary Security to the Committee in November 2023).
- The appointment of a Head of Security Management (a new role).
- The Deputy Chief Executive/Chief Finance Officer has confirmed that the Trust's security function can be allocated its own capital funding budget, rather than any security-related capital requirements having to be funded from the IT and/or Estates capital budgets.

- The Trust does however expect local departmental managers to retain some responsibility for security in their areas. They must therefore ensure their staff are aware of and comply with the Security policy and procedure; undertake security risk assessments of their own respective areas of responsibility; ensure that appropriate action is taken in respect of staff who are suspected of committing a criminal offence, misconduct or other breaches of security in contravention of the policies of the Trust; ensure that all staff are fully supported when making reports concerning fraud, violence, theft and damage or other security related incidents; ensure that all staff wear their Trust ID badges at all times; and investigate security breaches.

Recommendation 9

Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- CCTV cameras were initially installed in the Trust's mortuaries in the spring of 2020 (the installation at Maidstone Hospital was completed in March 2020 and the installation at Tunbridge Wells Hospital was completed in May 2020).

[11] Security policy and procedure

[12] Update on the response to the mortuary peer review and security peer review

[13] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004".

[14] This was confirmed at the Trust Board on 27/01/22, in response to the "Enhancing board oversight: a new approach to non-executive director champion roles" guidance from NHS England/Improvement.

[15] Audit and Gov. Committee Terms of Reference

[16] Audit and Governance Committee, 16.05.23 (incl. the Security issues annual report 2022-23)

- CCTV was installed in the post mortem room at the Tunbridge Wells Hospital mortuary in the autumn of 2021 (the mortuary at Maidstone Hospital does not have a post mortem room). The cameras were positioned to ensure they could not view post mortem examinations taking place (although this is not always feasible).
- There are eight CCTV cameras within the mortuary at Tunbridge Wells Hospital, including two within the post mortem room. There are five CCTV cameras within the mortuary at Maidstone Hospital.
- CCTV has also been installed outside and in the Snowdrop room at Tunbridge Wells Hospital (see recommendation 6), as this room, which is used to hold deceased babies, is a satellite to the mortuary and is covered by the HTA licence.
- A retention period for CCTV images has been extended to 38-day to enable the audits of restricted areas that relate to the review of CCTV footage to continue to be undertaken monthly.

Recommendation 10

Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- Once a month, the Operational Security Manager provides an electronic record to the Head of Service for the Care After Death Directorate with the dates and times of those visits, to enable them to check that only authorised staff are accessing the mortuaries. The data provided by the Operational Security Manager includes details of the access to specific doors (each door has a reference number) i.e. the individual who has accessed the door, the date, time of entry, and time of exit. The data also includes details of individuals who have attempted to gain access (via their swipe card) but have failed. Where anomalies are identified the Head of Service for the Care After Death Directorate reviews the CCTV footage of any particular dates.
- The Head of Service for the Care After Death Directorate also currently reviews CCTV footage from the mortuary of a random 24-hour period on a regular basis, within the CCTV control room.
- The retention period for CCTV images has been extended to circa 38-day to enable the audits of restricted areas that relate to the review of CCTV footage to continue to be undertaken monthly.

Recommendation 11

Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- The Trust's Chief Nurse and Director of Quality Governance share information regarding HTA inspections with the Kent & Medway Integrated Care Board (KM ICB) as part of their regular liaison with the ICB's Chief Nursing Officer and Director of Quality and Safety.
- HTA reports are also shared proactively with Kent County Council and East Sussex County Council

Recommendation 12

Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.

Assurance statement:

This recommendation is for KCC and ESCC. Some useful background follows:

- Separate contracts are in place between the Trust and KCC, and the Trust and ESCC. The Trust's latest contract with KCC covered the period 01/04/19 to 31/03/23. The contract was not officially extended beyond that date, but contract discussions commenced in April 2023, and the finalisation of the 2023/24 contract is almost complete.
- The Trust's current contract with ESCC covers the period 01/01/23 to 31/12/25, with the option for two further extensions of one year, if agreed (i.e. to 31/12/26 and 31/12/27).
- Discussions have been taking place to ensure that contracts are effective in protecting the safety and dignity of the deceased, including a requirement for the Trust to provide copies of HTA reports following inspections.

Recommendation 13

We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- The Trust commissioned an independent governance review by Deloitte in 2023.
- Feedback was provided to Trust Board by Deloitte on the 11th October 2023 with a final report issued to the Trust on 13/12/23 after the publication of the Inquiry recommendation report.
- The main proposed changes were considered at the Executive Team Meeting (ETM) on 16/01/24. The Trust Board then considered the proposals at a dedicated Trust Board Seminar session on 25/01/24, and a series of steps were agreed. The agreed changes are being implemented from February 2024.
- The Trust is making significant changes to its governance structures in response to detailed findings from the Fuller Inquiry Phase 1 report as well as the findings from the inspections that the CQC conducted at the Trust during 2023, and an independent review by Deloitte LLP in 2023 (the final report from which was issued to the Trust in December 2023[17]). The changes include measures to strengthen the functioning of the Quality Committee and its sub-committees.
- The Executive Team Meeting (ETM) held a 'time out' session in February 2024 to consider "Reflections on the Public Inquiry into the Fuller crimes: Identify individual and organisational learning from the public inquiry into the Fuller crimes". That session has been informed by the Phase 1 report of the Fuller Inquiry and other relevant information, which includes the "Out of sight, out of mind" report by The Guardian Service Ltd.

[17] MTW Governance Review - Final Report

Recommendation 14

Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- The Trust Board has received regular updates on the mortuary and HTA activity since the Police informed the Trust of the mortuary-related crimes of David Fuller in December 2020.
- The Trust Board received the first "Monthly update on the implementation of the recommendations from the Phase 1 report of the Independent Inquiry into the issues raised by the David Fuller case" report at its meeting in December 2023, and will continue to receive a "Six monthly update on mortuary issues" report for the foreseeable future. These reports will commence in May 2024. The report will be presented jointly by the Chief Operating Officer (who has the executive responsibility for the mortuary service), the Chief Nurse (who is responsible for assuring the Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased - see recommendation 16 below), the HTA DI and the Head of Service for the Care After Death Directorate. That report will also be considered by the Executive Team, and the Quality Committee, before being submitted to the Trust Board.
- It is proposed that ongoing compliance with the recommendations of the Independent Inquiry (not just those relating to the mortuary) is reviewed annually and reported to the Board. The first annual review, in 2025, should be undertaken as part of the internal audit programme and thereafter by the End of Life Committee.
- HTA inspection reports are received by the Board and Quality Committee. The End of Life Committee (which reports to the Quality Committee) proactively looks at Mortuary and HTA issues[18].
- The Trust's HTA DI has several routes to reporting to the Trust Board:
    - Via their line management structure through the Core Clinical Services Division. The HTA DI is also the Clinical Director for the Care After Death Directorate, and they have direct access to the Chief of Service for the Core Clinical Services Division, who is a member of the ETM (which is chaired by the Chief Operating Officer).
    - The DI will contribute to the "Care After Death (Security and Dignity of deceased patients)" workstream that has been established under the End of Life Care Steering Committee (which is chaired by the Chief Nurse) (see Recommendation 16).
    - The DI has direct access to the Trust's Chief Executive, who is the official representative for the Trust's HTA Corporate Licence, so they can escalate any matters they wish to via that route.

Recommendation 15

Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

[18] Instructions for Reporting Incidents to the HTA and Management of external agency visits, inspections and accreditations policy and procedure

- The Human Tissue Authority (HTA) inspected the Trust's mortuaries in June 2022 and confirmed that it was satisfied that the Trust had completed the agreed actions in the corrective and preventative action (CAPA) plan and in doing so had taken sufficient action to correct all shortfalls addressed in the Inspection Report[19].
- The Designated Individual and the Persons Designate maintain all standards and report through the governance structure outlined in this paper, to ensure they continue to meet these standards (see recommendations 2, 4, 11, 14 & 16).
- All recommendations from HTA inspections are implemented in full (see recommendations 2 and 14).

Recommendation 16

The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- In relation to making the responsibility explicit, the Chief Nurse's Job Description has been amended to state that they are "…responsible for assuring the Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.".
- In relation to implementing that responsibility, an additional "Care After Death (Security and Dignity of deceased patients)" workstream has been established under the End of Life Care Steering Committee (which is chaired by the Chief Nurse and meets every two months). The new workstream is led by the Head of Service for the Care After Death Directorate and involves liaison with a range of staff and departments, in addition to the mortuary i.e. security, the Divisional Directors of Nursing & Quality etc.
- The new workstream submits reports to the End of Life Care Steering Committee (as is the case with the Steering Committee's other workstreams), and some initial indicators have been agreed. These include Serious Incidents (SIs) and HTARIs; patient volumes; security audit findings; patient condition audit findings; family viewing numbers; complaints, feedback about the service (positive and negative) and Freedom of Information Act requests.

Recommendation 17

Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

Assurance statement:

The Trust now complies with this recommendation in full on the following basis:

- A definition of "Safeguarding" has been developed by the Trust's Chief Nurse that can apply to this context, given that the Safeguarding legislation excludes the deceased[20]. The following definition is as follows: "'Safeguarding ensures all staff are acting with compassion to protect deceased patients in our care, from harm and preservation of their dignity. This will be delivered in line with all relevant Trust policies".

[19] Inspection report on compliance with HTA licensing standards, Inspection date: 07-10 June 2022

[20] The UK government's Care and Support Statutory Guidance states that "Adult safeguarding means protecting an adult's right to live in safety, free from abuse and neglect"; whilst the Phase 1 report of the Independent Inquiry into the issues raised by the David Fuller case defines safeguarding as "Protecting those whose needs mean that they are more vulnerable to abuse and neglect".

- The work of the “Security and dignity of the deceased” workstream described under Recommendation 16 promotes the treatment of the deceased with the same due regard to dignity and safeguarding as it does its other patients. Examples of this practice in operation include: mortuary preparation packs; and developing enhanced links between the wards and the mortuary.

23 February, 2024

NHS Maidstone and Tunbridge Wells NHS Trust

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

It is with sadness that I announce the death of our friend and colleague Kevin Rowan, our Trust Secretary, who very sadly passed away on February 7th 2024.

My thoughts, and the thoughts of my fellow Board members and other colleagues across the Trust, are with his wife Odele and daughter, Adeana, and other members of Kevin's family at this difficult time.

Kevin's NHS career started in 1995 at what was then the East Kent Health Authority, and he joined MTW in November 2013, becoming a valued member of the Senior Management Team and supporting colleagues on a wide range of important projects.

On a personal note, Kevin was very supportive to me when I started as a new Chair in May 2017. I have chaired more than 70 meetings of the Trust Board since then and Kevin supported me and my Board colleagues in a totally professional manner to an extremely high standard. The commitment he gave to the performance of his role was particularly demonstrated over the last 2 years in acting as the Trust's liaison with the team from the Independent Inquiry into the issues raised in the David Fuller Case. Kevin was assiduous in responding to data requests from the Inquiry team, often searching back through historic records, to fulfil the commitment made by the Trust to fully support the work of the Inquiry and the Board specifically recorded their appreciation of his efforts. I am also aware that the Chair of the NHS Company Secretaries Network has noted the sadness of the whole Network at the news of Kevin's death, noting that Kevin had been such a key contributor over the last 10 years.

I know I speak for all the members of this Board when I say that we are devastated by the unexpected loss of such a great colleague. Kevin had a good sense of humour and could be relied on to provide a suitable corny joke when required. His dedication to Liverpool Football Club was very evident in all the football banter during breaks between Board meetings and he was regularly at the top of the management Fantasy Football League.

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?
17/01/2024	Consultant Microbiologist	Lara	Payne	Microbiology	22/04/2024	New
17/01/2024	Consultant Microbiologist	Simantee	Guha	Microbiology	April 2024	Replacement

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:

- Following their inspection of maternity services at MTW last year, as part of a wider national maternity inspection programme, the Care Quality Commission (CQC) have now published their findings. Maidstone Birth Centre and Crowborough Birthing Centre have been rated as 'requires improvement' and maternity services at Tunbridge Wells Hospitals have been rated as 'inadequate'.

  These ratings do not reflect the care we aim to provide and the Trust acknowledges both the seriousness of the CQC reports and the concerns of local people. We have taken the criticism of the CQC onboard and addressing their recommendations is our priority.

  We are proud of the maternity team's commitment to improving care and are working with them to give them the support they require to ensure we are delivering excellence in every domain.

  The reports made a number of recommendations which focused on governance, processes and documentation in the Trust's maternity units. Providing the highest levels of maternity care and robustly and quickly addressing all the issues raised by the CQC is our focus. Work to address the recommendations began in October, and the majority of these are now completed. These include:

  - the implementation of new guidelines on induction of labour;
  - additional training and new guidelines on the management of postpartum haemorrhage (PPH);
  - undertaking a multidisciplinary workforce review;
  - streamlining of the emergency theatre pathway;
  - improving use of the data we capture and report on, including the development of a maternity clinical dashboard.

  The Trust has also increased oversight of progress made against the recommendations with the introduction of a weekly operational improvement group, and a weekly maternity improvement oversight group chaired by the chief nurse reporting to the Trust Executive. In addition, regular oversight meetings with the Kent and Medway Integrated Care Board and NHS England have been on-going since November 2023.

  Our focus is very much on improvement, but nonetheless it is worth noting the CQC highlighted examples of good practice and care from their visits. These include:

  - a focus by staff on the needs of people using the service and caring for them with dignity and respect;
  - an open culture where service users and families could raise concerns;
  - staff feeling respected, valued and supported;
  - staff felt able to talk to departmental leaders about difficult issues.

  While the CQC report reflects themes and challenges facing maternity services across the country, the examples of good care and practice chime with the recent CQC 2023 Maternity Survey. This identified MTW as a positive outlier and a trust which received strongly positive feedback from users of the service.

Further information on the implementation of the CQC's recommendations is detailed in agenda item 02-13.

- At the time of writing this report the Trust is preparing for the latest round of industrial action by the British Medical Association (BMA). Junior doctors nationally are taking five days of action from 24 to 28 February. Ahead of the action detailed plans are being put in place across the Trust to ensure staff rosters are filled and senior clinical managers will be providing additional support at each hospital. In common with the rest of the NHS, we are expecting some disruption to normal services, including postponements to outpatient appointments and elective procedures. Patients affected will be contacted by staff and re-booked for the next possible date. Clinical and operational teams are continuing to work hard to ensure patient safety and urgent and emergency services, maternity and cancer care are provided.

- MTW has been formally recognised as 'Veteran Aware' by the Veterans Covenant Healthcare Alliance (VCHA). This is a group of NHS providers in England committed to providing the best standards of care for the Armed Forces community, based on the principles of the Armed Forces Covenant. The Armed Forces Covenant is a promise by the country to ensure those who serve, or who have served, in the armed forces, and their families, are treated fairly.

  We recognise this accreditation as a significant achievement for MTW and the start of a longer journey to embed 'veteran awareness' as business as usual within the Trust. This will ensure no disadvantage to our Armed Forces community service users and proper recognition of the skills and different perspectives that serving personnel, Reservists, and Veterans can bring to our workforce.

- Work to improve patient and staff parking at both Maidstone and Tunbridge Wells hospitals continues. A new car parking service contract will go live on 1 July, providing new barriers, number plate recognition technology and significantly improved management information. There will also be more car parking attendants at both sites. These developments will all enhance traffic flow. A further 20 visitor parking spaces have also opened at both hospitals this month. Our teams are also working as a priority to explore new opportunities to support more staff parking capacity.

- There is an ongoing outbreak of measles in the West Midlands and concern that this will spread to London and the south of England. We have now seen our first case this year at MTW. The diagnosis was not made on the attendance as the symptoms were very early. Contact tracing was done and two other children required treatment following their contact in the emergency department. Vaccination levels in west Kent are generally good and over 85% coverage, however there are pockets where the rate goes down to around 52%. Those most at risk are unvaccinated infants and those less than three years and four months who have not had their second dose of MMR. Some adults may also be unvaccinated and therefore at risk. We have published updated guidance on risk assessment for measles, and have put actions in place to isolate patients in all areas who have been risk assessed for the disease. Measures are also being taken to protect staff, including ensuring that staff have had their MMR vaccination and are up to date with fit testing.

- The Peggy Wood Breast Care Centre at Maidstone has been Highly Commended for its outstanding contribution to research. The Research Support Awards, run by NIHR Clinical Research Network Kent, Surrey and Sussex, recognise people and teams who do not work directly in research delivery but provide essential support to research activities:

- The Peggy Wood Breast Care Centre was Highly Commended in the Acute Trust category of the awards for supporting the three trust-sponsored trials in the unit, which have led to the establishment of an embedded research clinic week.
- The Critical Care Outreach team were shortlisted for their involvement with the AIRWAYS-3 project, for which they became the top recruiter in the region for the study.
- The Urology team were also shortlisted for supporting the TRANSLATE study, which looked into the use of two different biopsy methods. They were the second-highest recruiter in the country, second only to Oxford who were running the study.

On behalf of the Board, I offer my congratulations to all the teams involved for their hard work and dedication in ensuring we are supporting high-quality research which will serve to ultimately improve patient outcomes.

- Nominations for our Staff Star Awards are now open. Colleagues across MTW work incredibly hard and this is a wonderful opportunity to recognise the care and dedication they show every day. Members of the public are encouraged to nominate a member of staff, volunteer, team or service who they feel has made a real difference to patient care. There are eight categories to choose from which reflect the behaviours and values we see across the Trust every day. Nominations are open until midnight on 10th March and details of all the categories and a nomination form are available on the MTW website. A judging panel will have the very difficult task of choosing the winners who will be announced at the awards event in May. Last year we received over 400 nominations, so it would be fantastic to go beyond this number this year and ensure a wide range of colleagues are recognised - please do encourage staff and anyone who uses our services to make a nomination.

- Five years ago, 30% of posts in the Trust's Cardiology Department were vacant. Today, thanks to a new recruitment strategy coupled with a focus on training opportunities, only 10% of Cardiology posts are vacant across our main sites. The impact this has had on Cardiology services has been hugely significant. Waiting times for echocardiograms (echo) have been reduced from one year in 2021 to just six weeks currently, and 24hr electrocardiograms are now being analysed in 48hrs instead of three weeks, meaning any abnormalities are detected earlier and patients treated sooner. The improvement in Cardiology's staffing rates and waiting lists have been driven by the department's investment in developing the skillset of existing staff, while also focussing on recruiting new trainees every year.

- Our first cohort of apprentices who took part in a programme to become Operating Department Practitioners (ODPs) recently graduated at a ceremony in Rochester Cathedral. ODPs play a pivotal role in theatre, and clinical training takes place almost entirely in the department, providing high standards of skilled care and support during each phase of a patient's perioperative care (ie anaesthetic, surgery and recovery). Qualified ODPs also work in other areas from education and research to intensive care, and are a vital part of the NHS workforce. The Apprenticeship programme initially focussed on the career development of existing MTW staff but has now expanded to include external candidates. The Trust currently has nine apprentice ODPs completing their training. On behalf of the Trust, I extend my congratulations to our newly-graduated ODPs on their achievement.

- Our patient portal went live over three months ago, with more than 82,000 patients now registered on the platform. We are already seeing significant, measurable results displaying how the portal is helping staff and improving patient experience and access. These include:

  - More than 12,000 patients are now using the new platform on a weekly basis.

- In just three months, we have surpassed our six-month target for savings on postage by more than four times the estimated amount.
- Patients have now viewed more than 10,000 appointment letters via the portal, with the functionality of the platform helping to prevent over 1,200 calls into our teams.

Pop-up events to promote the portal were recently held at our hospitals in Maidstone and Tunbridge Wells, and patients spoke of the positive impact of receiving appointment information so quickly. Over the year ahead, we will continue to develop the functionality of the portal and encourage patients to sign up.

- Congratulations to the winner of the Trust's Employee of the Month award for January, Paediatric Orthopaedic Nurse, Julie Doherty. Julie always has an excellent rapport with patients and their relatives, and makes them feel completely safe and looked after. She has worked hard on developing patient information leaflets, setting up parent support groups and teaching colleagues about pain relief, traction and other paediatric orthopaedic conditions. Julie is invaluable to the team and has developed her role into one her team cannot do without. Switchboard Supervisor, Mary Rayner, also received the Highly Commended award for showing outstanding commitment to the Trust for 34 years, while taking on board all the changes in staffing and upgrades to the telephony system during this time.

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, 14/02/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (face-to-face / in-person, at Maidstone Hospital) on 14th February 2024 (a 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Committee reviewed the **actions from previous meetings** wherein the importance of robust oversight of the Ophthalmology recovery plan was reiterated and it was agreed that the Chief Nurse should consider, and confirm to Committee members, the assurance arrangements in relation to the Trust's Ophthalmology recovery plan.
   - The Director of Quality Governance and the Patient Safety Manager presented a **review of the Inphase Incident Reporting and Risk Management System** ('Inphase') which incorporated a live demonstration of Inphase and provided a comprehensive overview of the challenges which had been experienced due to the condensed timeline for the delivery of the programme of work and the further areas for improvement. It was however identified by the Committee that, due to the increased reliance on Inphase, the Trust Patient Safety Specialist and Director of Quality Governance should liaise with the Director of IT to develop a robust Business Continuity and Disaster Recovery plan, which included scheduled resilience testing, for the Trust's Inphase Incident Reporting and Risk Management System
     - ❖ The Committee was **assured** that there were robust plans in place to address the remaining challenges and to continue to improve Inphase
   - A presentation was given by the Chief Operating Officer and the Chief Nurse **to consider the key risk and areas for scrutiny by the Quality Committee 'deep dive' for 2024**, wherein the Committee supported a hybrid approach between the three-options which had been proposed, thereby maintaining the Committee's serendipity; however, it was acknowledged that the revised Quality Committee structure should first be implemented to enable an informed decision to be made.
   - A discussion was held on the **items for scrutiny by the Quality Committee at future 'deep dive' meetings**; wherein the Committee considered a number of potential areas for scrutiny in 2024 and the following actions were agreed:
     - o The Assistant Trust Secretary should schedule a "Review of End of Life Care" item at the April 2024 Quality Committee 'deep dive' meeting
     - o The Assistant Trust Secretary should liaise with the Chair of the Audit and Governance Committee to arrange for the Audit and Governance Committee to conduct a "Review of information systems failures and patients lost to follow-up" in place of the Quality Committee
     - o The Chief Nurse and Chief Operating Officer should develop a list of proposed topics for consideration at the June 2024 and August 2024 Quality Committee 'deep dive' meetings which was informed by the Trust's emerging risks and the Inphase dashboard
     - o The Assistant Trust Secretary should remove the "Further update on the management of pressure ulcers (incl. the progress with the implementation and embedding of the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T))" item from the Committee' forward programme

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:** N/A

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

Summary report from the Finance and Performance Committee, 27/02/24	**Committee Chair (Non-Exec. Director)**

The Committee met on 27th February 2024, face to face / in person.

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

- The findings of the Committee's 2023 evaluation were considered and it was agreed to implement the proposals to: promote/require improved executive summaries for the Committee's reports; and include a review at the end of each meeting to consider the assurance taken. The Chief Executive also agreed to discuss with the Chief People Officer how representation was best achieved at Finance and Performance Committee (FPC) meetings for matters of key common interest between the FPC and the People and Organisational Development Committees
- The Medical Director (WKHCP Integrated Care) attended for a 'deep dive' item focused on the **'utilisation of the Virtual Ward at the Trust'**, which included an update of progress on utilisation to date, the impediments to faster adoption and the plans to address these issues. It was a very helpful and informative presentation.
- The **Patient Access strategic theme metrics for January** were reviewed and the ongoing work by staff to ensure the Trust's continued strong performance in the face of increased demand and industrial action was acknowledged. It was agreed that progress with provision of senior clinician / consultant cover at front door (A&E) should be included as part of the standing Review of the performance on the metrics under the Patient Access Strategic Theme
- The review of **financial performance for January** highlighted that the Trust was forecasting to deliver the breakeven financial plan, but on the key assumption that the financial impact that industrial action in December and January would be fully funded (estimated at £1.2m). Significant risk to delivery of the plan was noted as it also assumed improved delivery of cost improvement plans for the remainder of the year.
- The latest **quarterly update on productivity (including the Model Health System Programme)** was reviewed and the impact of increased attendances and non-elective admissions over the past year was noted. The potential benefit of increased focus on speciality productivity was noted and encouraged including the provision of anonymised consultant productivity data to support local discussions.
- The Director of Strategy, Planning and Partnerships attended to give an **update on the Trust's draft planning submission for 2024/25** which noted that, although national planning guidance had not yet been received, the trust has provided an update for an ICB flash report to NHSE on 29/02/24. It was also noted that an extraordinary Trust Board meeting would be required in March to approve the Trust's final planning submission to the ICB.
- An **update on the financial risks regarding the Kent and Medway Medical School accommodation project**, was given; ongoing liaison was reported between all parties and it was noted that critical work on completion of external cladding was due by April 2024
- The **Business Case for Paediatric Orthopaedic Consultant changes** was reviewed and agreed; the need for consideration of patient experience as part of benefits evaluation was noted
- The **Business Case for development of a West Kent Sleep Service** was approved
- **The post project evaluation for the surgical reconfiguration Business Case** was reviewed and was considered indicative of a wider need for more structured benefits evaluation of business cases. It was therefore agreed to schedule review of the approach to business case / benefits evaluation, previously agreed by the FPC, for consideration at the FPC meeting in March 2024 (and ensure that patient experience was a part of the evaluation process)
- **The "Workforce efficiency programme" report submitted to the People and Organisational Development Committee (which relates to the "Reduce the amount of money the Trusts [sic] spends on premium workforce spend" Breakthrough Objective)** was noted.
- A verbal summary was given of the **People and Organisational Development C'ttee** meeting was given.
- The latest **use of the Trust Seal** was noted.
- 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 that Trust Board approve the **Outline Business Case for the reconfiguration of Cardiology Services** (this has been submitted to the Board under a separate agenda item).

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, 23/02/24 | **Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 23rd February 2024 (a 'deep dive' meeting).

The Chair of the Committee thanked the former Trust Secretary for their contribution and support, both to the Trust, and particularly in relation to the development of the Committee

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Committed reviewed the **Trust Board's High Impact equality, diversity and inclusion (EDI) objectives,** which have been submitted to the Trust Board under a separate agenda item, wherein the Committee supported the proposed objectives which had been developed; but, emphasised the importance of ensuring there were robust governance arrangements in place to monitor the progress with both the Trust Board, and individual Trust Board member objectives. The Committee also highlighted the importance of demonstrating tangible progress, to ensure that momentum was maintained for the programme of work. It was agreed that the Chief People Officer should explore the provisions of training for Trust staff on the completion of Equality Impact Assessments, to ensure that such assessments did not inappropriately list "no impact" as the outcome. It was also agreed that the Head of EDI and Engagement should explore what, if any, best practice was available within the NHS in terms of Trust Board focus on EDI, including the utilisation of case studies to demonstrate the lived experience of specific demographics
  - ❖ The Committee was **assured** that the appropriate high impact EDI objectives had been identified, and supported their consideration by the Trust Board, for confirmation of which objective/s should be pursued.
- The Committee considered the scope of the **Trust's management development training programme** wherein the progress to-date was commended; although, it was noted that further improvements could be made such as pursuing accreditation for the training programme, the inclusion of additional professional groups in the development of the training programme, and ensuring there were sufficient training modalities (e.g. face-to-face and e-learning sessions) to enable access for all staffing groups. It was agreed that the Deputy Chief People Officer, Organisational Development; and Head of Leadership Development should explore the creation of a holistic overview of the Exceptional Leaders programme and the Management Development training programme, to aid in the identification of any training needs that were not appropriately captured. It was also agreed that the Head of EDI and Engagement should liaise with the Head of Leadership Development to ensure that the Management Development training programme encompassed an EDI lens. The Deputy Chief People Officer agreed to liaise Deputy Medical Director to identify a cohort of medical staff to support with the development of the Trust's management development training programme.
  - ❖ The Committee was **partially assured** as, although a robust programme had been developed, further work was required to refine the programme to ensure the desired outcomes were achieved and enable accessibility for all staffing groups
- The Chief People Officer led an in-depth discussion on the topic of **Out of Sight Out of Mind and Curiosity in Leadership** wherein Committee members provided a wide range of reflections on the measures required to develop an open and just listening culture; the importance of visibility of senior managers to enable concerns to be raised; and the further work required to address subconscious biases and ensure that every member of staff had an equal voice, particularly those that faced additional barriers due to cultural differences. It was agreed that the Chair of the Committee and the Chief People Officer should liaise with the Chief Executive and Chair of the Trust Board to consider whether a face-to-face / in-person session on the topic of "Out of Sight Out of Mind and Curiosity in Leadership" should be scheduled for the Trust Board.
  - ❖ The Committee was **assured** that there was sufficient focus on the topic; although, acknowledged the complexities associated with delivering the required cultural change

- The Committee noted the latest **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR); and the Committee's forward programme.**
- The Committee conducted **an evaluation of the meeting** wherein the challenge which had been provided was supported.

In addition to the actions noted above, the Committee agreed that: The Chief People Officer and Head of EDI and Engagement should develop some initial guidance in terms of the questions which should be posed at the Trust Board, and associated sub-committees, to ensure there was sufficient consideration of EDI impacts

The issues from the meeting that need to be drawn to the Board 's attention as follows: The Trust Board should consider, as part of the discussion of High Impact EDI objectives, what monitoring arrangements should be implemented, both for the Trust Board objective and the individual Trust Board member objectives and whether the Trust Board should be informed of the individual Trust Board member objectives, once agreed.

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
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Integrated Performance Report (IPR) for January 2024	Chief Executive / Executive Directors

The IPR for month 10, 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, 27/02/24

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

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Integrated Performance Report

January 2024

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

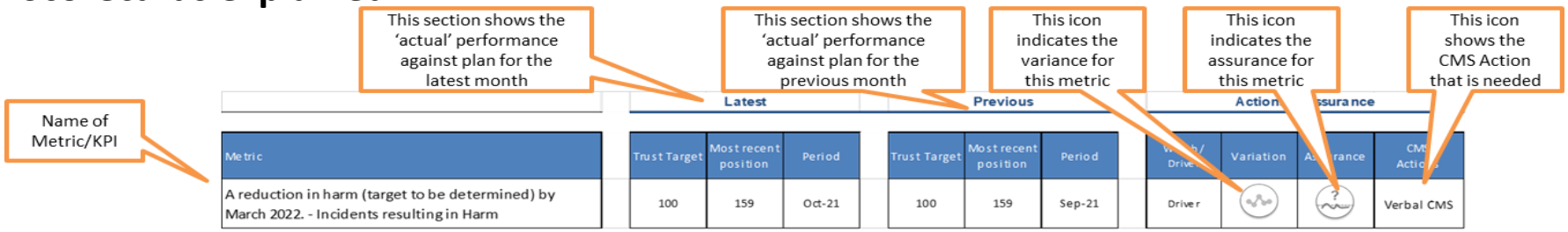
Escalation Rules:

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

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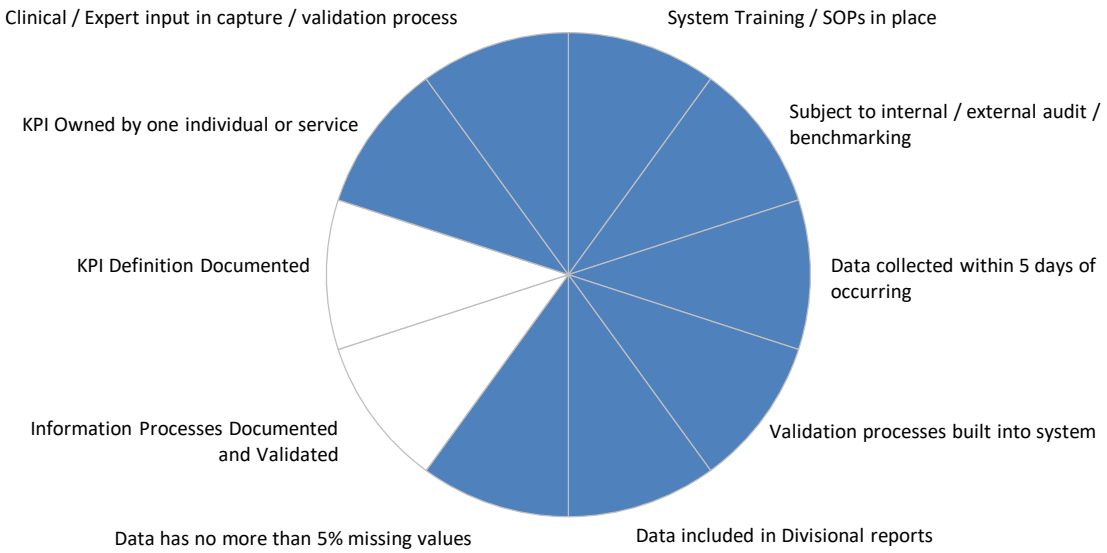
Forecasts

				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%		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: Vacancy Rate improved further to 5.6%. Turnover Rate continues to experience special cause variation of an improving nature and consistently failing the target. Agency spend did not achieve the target for January 24 but continues to experience special cause variation of an improving nature. The Nursing Safe Staffing Levels remains above target at 96.6% for January 24 and remains in common cause variation. Sickness levels increased in January 24 to above the maximum level. However this is in line with winter months in previous years. This metric is therefore now experiencing special cause variation of a worsening nature and variable achievement of the target. Statutory and Mandatory Training remains in common cause variation and variable achievement. 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 £0.4m in deficit in the month which was £0.7m adverse to plan. Year to Date the Trust is £1.8m in deficit which is £1.8m adverse to plan.

The rate of incidents causing patients moderate or higher harm 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, however the rate of E.Coli has now achieved the target 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 January 24 at 97%. It is now experiencing special cause variation of an improving nature and has achieved the recovery trajectory target for more than six consecutive months. RTT is now experiencing special cause variation of an improving nature and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters with no 52 week breaches reported at month end for January 24. Performance for First outpatient activity levels achieved above plan for January and continues to experience common cause variation and passing the target for six consecutive months. Outpatient Utilisation is experiencing common cause variation and has failed the target for more than six months. Diagnostic Imaging activity levels remain below plan for January 24, but remain above 1920 levels. Elective (inpatient and day case combined) activity was above plan for January 2024 and remains above plan year to date. This metric is now experiencing common cause variation and has now achieved the target for six consecutive months.

The number of patients leaving our hospitals before noon continues to experience common cause variation and consistently failing the target. The rate of patients no longer fit to reside has significantly improved in January, achieving the target and is therefore now experiencing special cause variation of an improving nature. A&E 4hr performance is experiencing common cause variation and variable achievement of the target and is no longer escalated. The Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers is now experiencing common cause variation and has failed the target for more than six months and is therefore escalated. The National Cancer Waiting Times (CWT) Standards have changed. The Trust has achieved the new combined 62 day First Definitive Treatment Standard as well as the 28 Day faster diagnosis compliance standard. The 31 day first definitive treatment is now a combined standard. The Trust did not achieve the National target for this standard in December but was above our internal recovery trajectory. 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.

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:
- Incidents resulting in Moderate + Harm (P.12)*
- Infection Control – Rate of C.Diff (P.13)
- Safe Staffing (P.13)*

Patient Access:
- RTT Performance (P.16)
- Outpatient Calls answered <1 minute (P.17)
- Outpatient Clinic Utilisation (P.17)
- Ambulance Handovers <30 minutes (P.17)
- Emergency Admissions in Assessment Areas (P.17)
- Cancer 31 Day Standard (Combined) (P.18)
- Planned levels of Diagnostics activity (P.18)

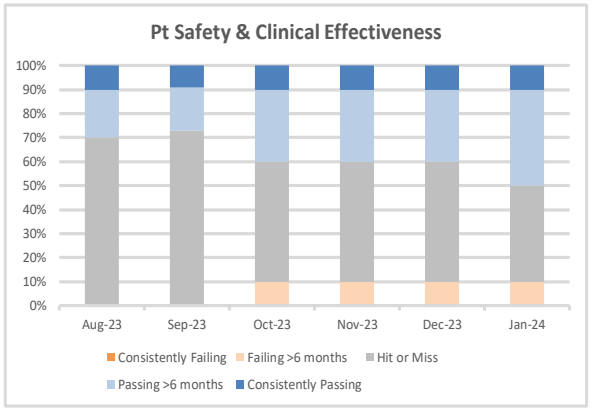
Patient Experience:
- New Complaints Received (P.20)*
- Complaints responded within target (P.21)
- FFT Response Rates: A&E, Outpatients, Maternity (P.21)

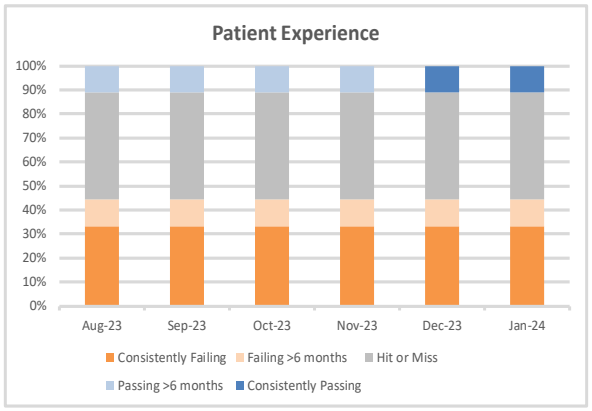
Systems:
- Discharges before Noon (P.23)

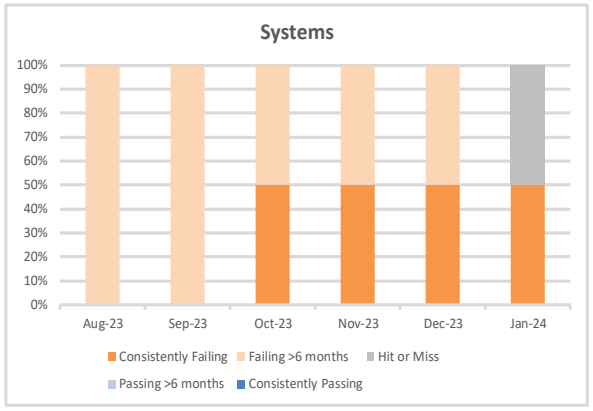
Sustainability:
- Agency Spend (P.25)

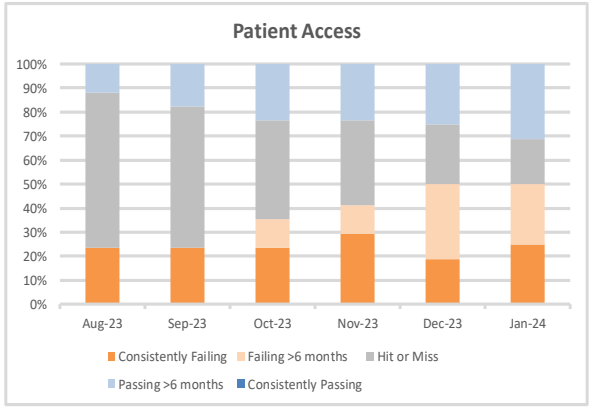
*Escalated due to the rule for being in Hit or Miss for more than six months being applied

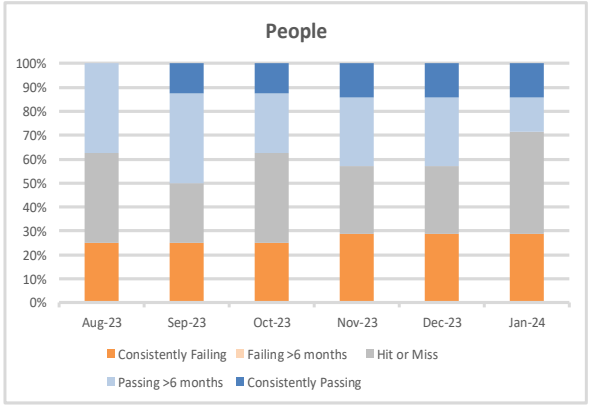
Assurance Stacked Bar Charts by Strategic Theme

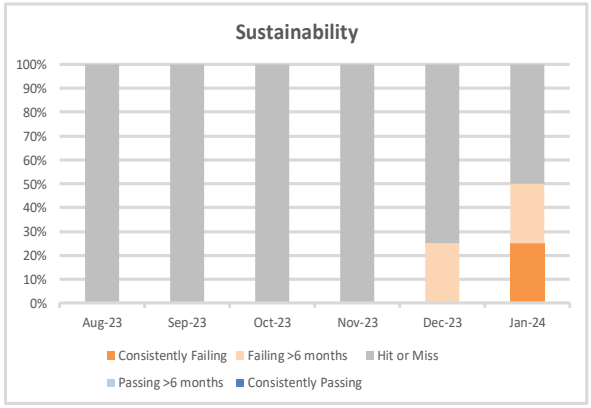












Matrix Summary

January 2024

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)	Percentage of AfC 8c and above that are Female Standardised Mortality HSMR Never Events Access to Diagnostics (<6weeks standard) Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)	Reduce the Trust wide vacancy rate to 12% To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR)	Cancer - 31 Day First (New Combined Standard) - data runs one month behind	Reduce Turnover Rate to 12% Percentage of AfC 8c and above that are BAME Achieve the Trust RTT Trajectory RTT Patients waiting longer than 40 weeks for treatment Transformation: CAU Calls answered <1 minute To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) Friends and Family (FFT) % Response Rate: A&E Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000
Common Cause	Complaints Rate per 1,000 occupied beddays	Number of New SIs in month IC - Rate of Hospital E.Coli per 100,000 occupied beddays To achieve the planned levels of new outpatients activity (shown as a % 19/20) Cancer - 62 Day (New Combined Standard) data runs one month behind To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	Statutory and Mandatory Training Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) Safe Staffing Levels IC - Number of Hospital acquired MRSA Rate of patient falls per 1000 occupied bed days A&E 4 hr Performance Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) 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 Friends and Family (FFT) % Response Rate: Inpatients Capital Expenditure (£k)	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays Transformation: % OP Clinics Utilised (slots) Flow: Ambulance Handover Delays >30mins Flow: Super Stranded Patients Flow: % of Emergency Admissions that are zero LOS (SDEC) Flow: % of Emergency Admissions into Assessment Areas % complaints responded to within target	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			Sickness Absence % VTE Risk Assessment (one month behind) Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	Cash Balance (£k)	

Strategic Theme: People

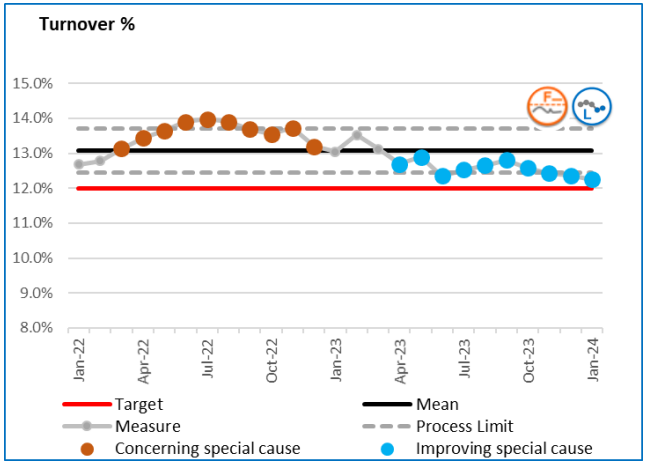
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		8%	5.6%	Jan-24	8%	6.5%	Dec-23	Driver			Note Performance	5.9%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.2%	Jan-24	12%	12.4%	Dec-23	Driver			Full CMS	12.2%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.7%	Dec-23	4.5%	4.3%	Nov-23	Driver			Not Escalated			
	Well Led	Statutory and Mandatory Training		85.0%	89.2%	Jan-24	85.0%	89.0%	Dec-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	72.1%	Jan-24	62.0%	70.1%	Dec-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	5.7%	Jan-24	3.2%	6.3%	Dec-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	7.1%	Jan-24	12.0%	7.6%	Dec-23	Driver			Escalation			

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

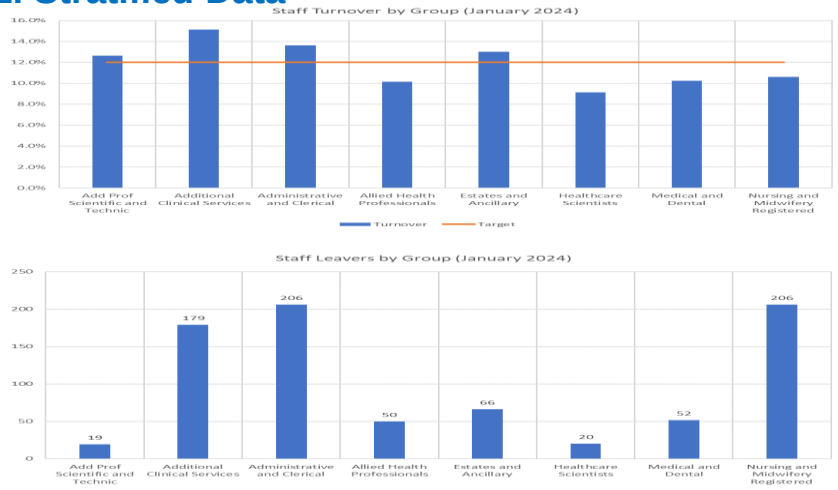
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Jan--24
12.25%
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 & Risks

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

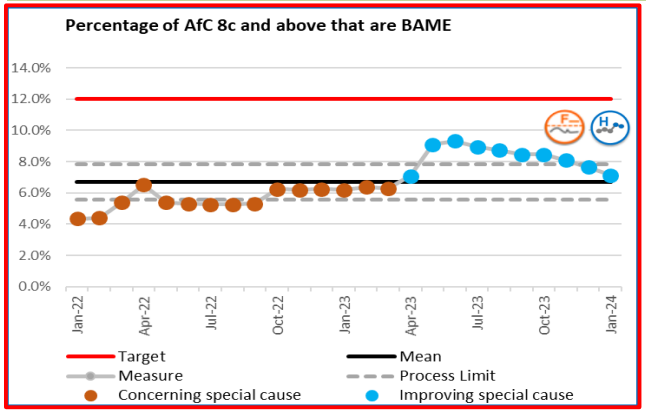
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership 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

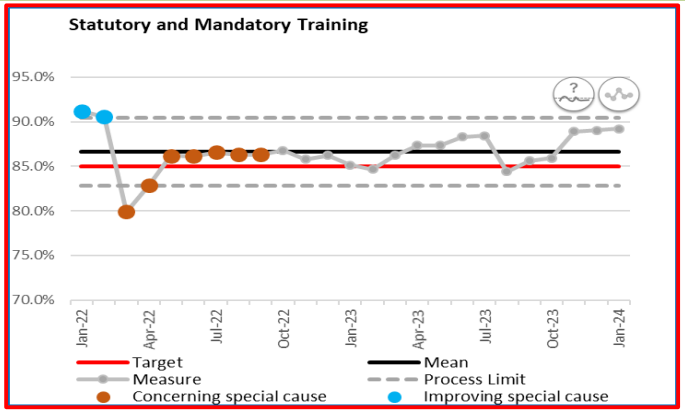
A full action plan by the working groups has been developed; some of the key actions shown:

Countermeasures	Target Completion Date
Develop a Media Attraction Campaign Dashboard to showcase successes / lessons learnt	Mar-24
Review every single step of the recruitment pathway, to reduce timings	Mar-24
Combine new starter, recruitment and induction surveys to create the onboarding survey	Feb-24
Develop outline structure of MTW Connect event, including speakers and networks	Mar-24
Develop A3 to target reducing the number of leavers who have been with the Trust for 24 months or less	Mar-24
Develop A3 to target reducing the number of admin and clerical leavers	Mar-24
Recruitment of People Promise Manager (12 month FTC from NHS England)	Mar-24

People – Workforce: CQC: Well-Led



Jan-24
7.1%
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



Jan-24
89.2%
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 are BAME:** (NB: These are not rapidly changing indicators). As at January 24 the current number of staff (WTEs) that are AfC 8c and above is 140. Of these 8 have a disability , 10 are BAME and 101 are female. **Actions:** Mandate for EDI recruitment reps to be on all interview panels of 8B and above. Second cohort of reverse mentoring launched in November with staff from ethnic minority backgrounds and those with long term health conditions as mentors Focus on recruitment of 8c and above: • Identifying potential turnover • Reviewing JD & creating recruitment campaign • Creating robust & equitable methods of shortlisting & interviewing • Scrutiny of recruitment decisions & provision of feedback to non successful candidates	**Statutory and Mandatory Training**: It was only in November 2023 that the methodology used to generate these numbers was aligned with L&D reporting. In addition to some legacy courses that shouldn't have been included, from August 2023 a new mandatory training course had been included in the numbers that produce this graph, explaining the three consecutive months below the mean line. Compliance against each separate statutory and Mandatory Training course is being undertaken. **% 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. EDI steering Board commenced October to drive improvement. Further discussions around the EDI strategy talking place The Trust Board are in the process of agreeing EDI objectives which will be measured in April 2024.

Strategic Theme: Patient Safety & Clinical Effectiveness

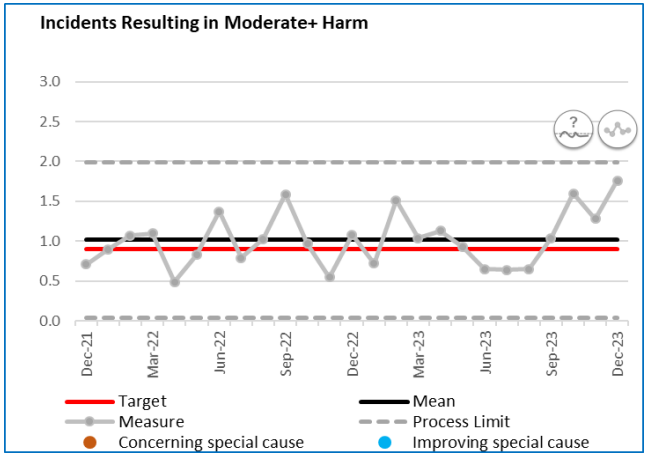
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.76	Dec-23	0.90	1.28	Nov-23	Driver			Verbal CMS	1.11 Mar 24		
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	5	Jan-24	11	11	Dec-23	Driver		P	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	90.9	Oct-23	100.0	93.8	Sep-23	Driver	L	P	Not Escalated			
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	91.8	Oct-23	100.0	92.8	Sep-23	Driver	L	P	Not Escalated			
	Safe	Never Events		0	0	Jan-24	0	0	Dec-23	Driver	L	P	Not Escalated			
	Safe	Safe Staffing Levels		93.5%	96.6%	Jan-24	93.5%	97.2%	Dec-23	Driver			Not Escalated			
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	19.9	Jan-24	32.6	5.3	Dec-23	Driver		P	Not Escalated			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	44.7	Jan-24	25.5	42.8	Dec-23	Driver		F	Escalation			
	Safe	IC - Number of Hospital acquired MRSA		0	0	Jan-24	0	0	Dec-23	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.9	Jan-24	6.4	7.0	Dec-23	Driver			Verbal CMS			

Vision: Counter Measure Summary

Project/Metric Name – Reduction in harm : Incidents resulting in moderate to severe harm and death

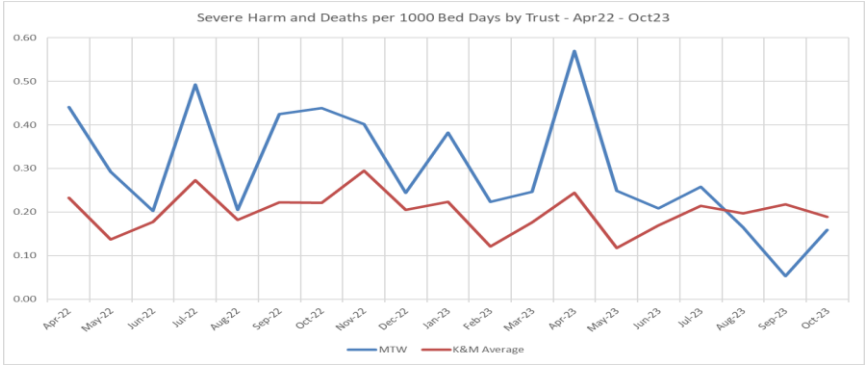
Owner: Sara Mumford
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



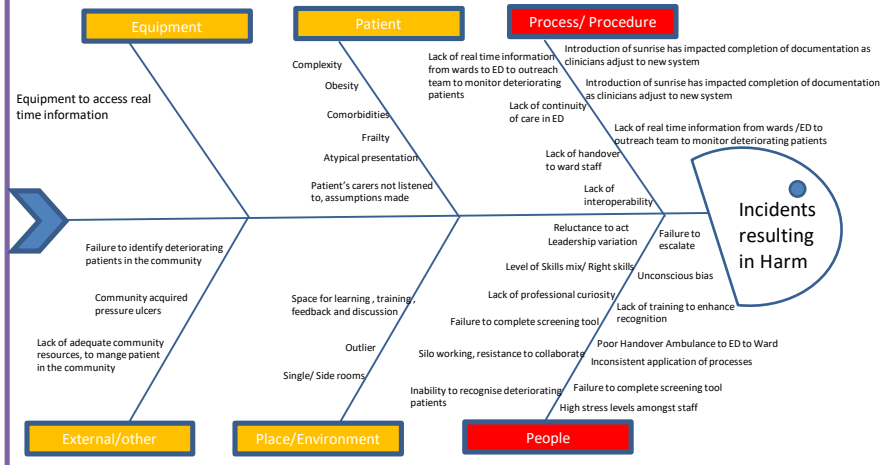
Dec-23 (1 month arr)
1.76
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric is in variable achievement of target for +6 Months

2. Stratified Data



When compared to peers in Kent and Medway for severe and catastrophic harm MTW is an outlier, recording more harm in this category. Indicating the severity of harm caused to patients at MTW is greater than the rest of Kent and Medway

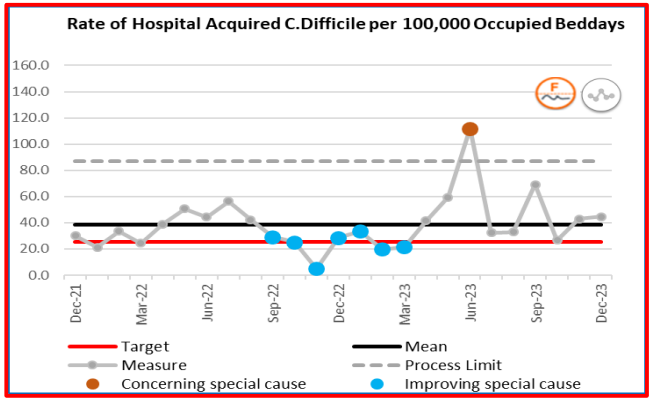
3. Top Contributors



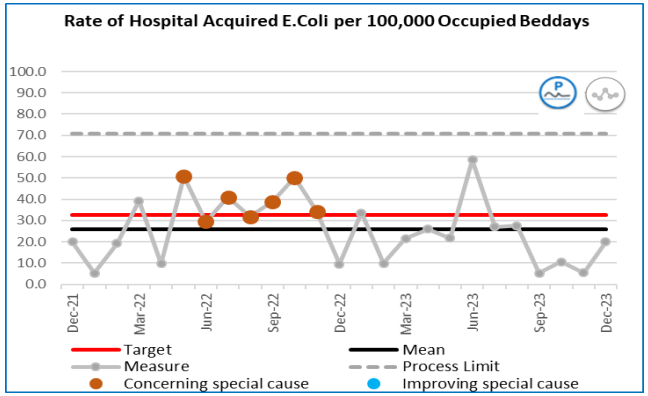
4. Action Plan

Contributor	solution /countermeasure	Owner	Due By
Patient Safety and Clinical Effectiveness	**Next Steps:** • Deep dive into the increase in moderate and above harm within the trust focusing on the data with the BI and Patient Safety team • A3 workshop session planned for the 21st of March with project team to finalise incidents category and determine interventions to address root causes and top contributors of deteriorating patients and sepsis. • Strategic Outline business case for Deteriorating Patient Nurse Specialist role approved to proceed to produce an Outline business case. • Deteriorating Patient Nurse Specialist JD to be submitted to the banding panel • Peri-arrest trial audit to commence as part of the work to include peri arrest information on InPhase in the audit section • Pull sepsis tool compliance data and understand what is the denominator data **Risks** • Delayed timeline for the implementation of the vital sign project Mar. end 2024 which will enable the outreach team to be automatically alerted of deteriorating patients. • Lack of robust education package to address the challenges associated with deteriorating patients.	Patient Safety /BI Project Team	Mar 2024

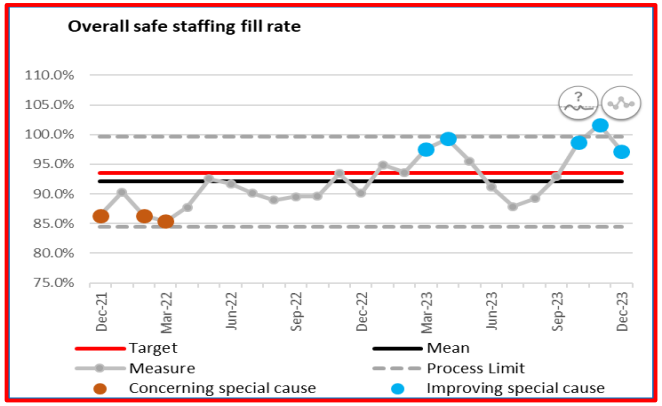
Patient Safety and Clinical Effectiveness: CQC: Safe



Jan-23
44.7
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



Jan-23
19.8
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has passed the target for >6months
Max Target (Internal)
32.6
Business Rule
For info now Passing target for 6+ Months



Jan-24
97.2%
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 passing the target for 6+ months

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

Actions:

The Cdiff rates exceeded the expected limits during January with 9 cases. Actions that continue to be undertaken include:

- Ongoing surveillance and monitoring of cases – All sample ribotyped to support surveillance monitoring, sub-typing requested where there is suspicion of transmission of infection
- Weekly review of patients with CDI by the IPC team and with the Consultant Microbiologist during the C diff round
- Timely feedback of lessons learnt from rapid review investigations
- E.coli rates remain within expected limits. An ongoing QIP is being undertaken to support an improvement in the management of peripheral cannulas

Safe staffing Fill Rate:

- The senior corporate nursing team have a focus on the continued reduction of temporary staffing usage and are meeting with Divisional Nursing Teams to support this.
- The senior corporate nursing team are supporting the Temporary staffing team with oversight of Nursing and Midwifery Temporary staffing. Live complaints are currently being reviewed, with meetings actioned to discuss issues within bank staff.
- Due to operation pressures and sickness, the soft go live for the reporting of Safe Staffing Red Flag incidents was delayed and will now occur in January/February. This will bring the Trust in line with National guidance for the management of Safe staffing. Training has been rolled out to clinical teams, which will provide governance for staffing concerns and risk mitigation.

Assurance & Timescales for Improvement:

Infection Control:

- Evidence of transmission of C diff infection (020 ribotype) on Mercer wards during January. After Action Review to be undertaken
- Learning from investigations are shared within the Directorate via the HCAI weekly status. Directorate IPC reports are presented to IPCC
- Commode cleanliness audit undertaken in December demonstrated improvement on the previous year
- Invasive devices QIP in progress – 11 wards audit and programme of re-audit

Safe Staffing Fill Rate:

- Oceans Blue system it currently being adapted to ensure the validity of data reporting.
- The establishment review paper was presented at Trust Board in December 2023. The October 2023 establishment review identified areas requiring an uplift. Planning for this is being explored with the Divisional teams
- SafeCare training will be rolled out to the Clinical site teams, so the live system can be utilised on a daily basis.

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		74.8%	71.0%	Jan-24	74.3%	68.7%	Dec-23	Driver			Full CMS	75.3% Year End FOT		
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		110.6%	122.3%	Jan-24	115.1%	116.6%	Dec-23	Driver			Note Performance	119.9% Year End FOT		
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment		615	544	Jan-24	621	681	Dec-23	Driver			Escalation	500		
	Responsive	Access to Diagnostics (<6weeks standard)		94.1%	97.0%	Jan-24	91.8%	97.4%	Dec-23	Driver			Not Escalated	98.4%		
	Responsive	A&E 4 hr Performance		84.0%	82.7%	Jan-24	82.0%	82.8%	Dec-23	Driver			Not Escalated	84.8%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	91.5%	Dec-23	96.0%	90.0%	Nov-23	Driver			Escalation	96.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.3%	Dec-23	85.0%	85.7%	Nov-23	Driver			Not Escalated	86.3%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	78.1%	Dec-23	75.0%	76.7%	Nov-23	Driver			Not Escalated	75.7%		
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		80.0%	85.9%	Dec-23	80.0%	86.7%	Nov-23	Driver			Not Escalated	87.6%		

- 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 and the position is expected to improve.

Strategic Theme: Patient Access (continued)

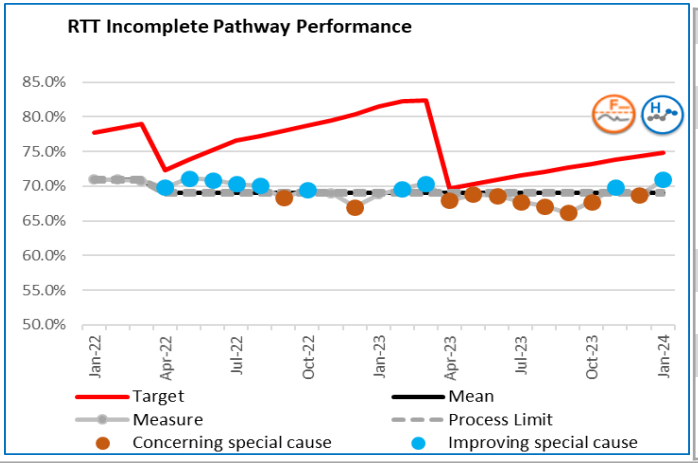
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	80.9%	Jan-24	85.0%	81.0%	Dec-23	Driver			Escalation	89.0%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		1.5%	6.0%	Jan-24	1.5%	5.7%	Dec-23	Driver	No SPC	No SPC	Not Escalated			
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	78.6%	Jan-24	90.0%	78.5%	Dec-23	Driver			Escalation	80.0%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	8.6%	Jan-24	5.0%	7.5%	Dec-23	Driver			Escalation	5.0%		
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	60.8%	Jan-24	65.0%	59.3%	Dec-23	Driver			Escalation	60.6%		
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		97.0%	104.7%	Jan-24	105.4%	113.3%	Dec-23	Driver			Not Escalated	106.9% Year End FOT		
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)		94.8%	106.8%	Jan-24	107.1%	105.4%	Dec-23	Driver			Not Escalated	109.3% Year End FOT		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		144.1%	141.1%	Jan-24	143.7%	139.1%	Dec-23	Driver			Escalation	140.5% Year End FOT		

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

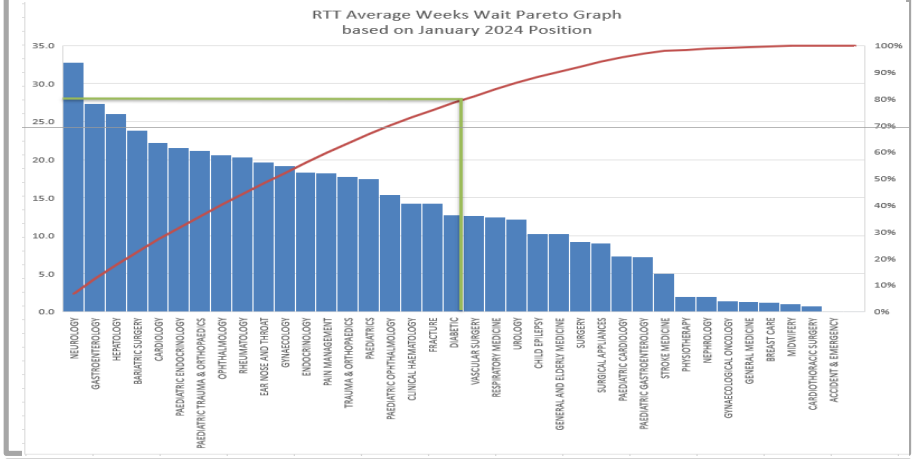
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Feb-24
71.0%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
74.8%
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 – average wait @19 weeks
- 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.

Review of New Breakthrough Objective by COO/DCOO/DDPA to be agreed

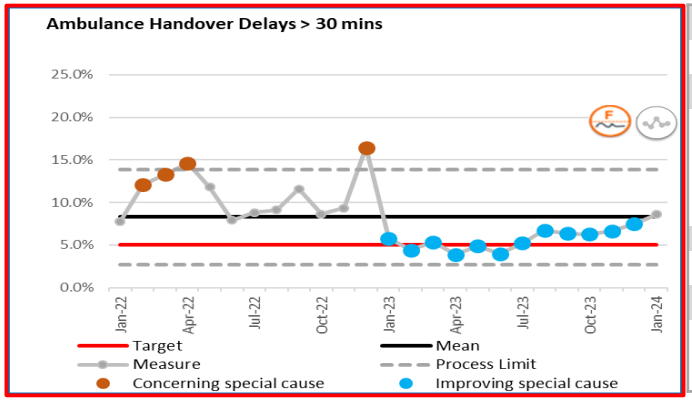
Key Risks:

- 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.
- Trajectory assumes that Additional activity continues until end financial year, this could be impacted by financial position

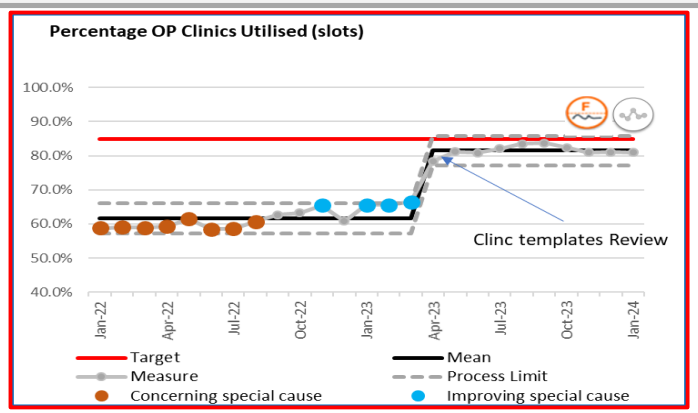
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots Reduction in FUPS and replacing with News in T&O following clinical validation	SC	Mar24
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	Full roll out May 24
	Trust STT pathways pilot in Gen Surg/Gastro to reduce long waits for 1st Appointments	SC/GM's	March 24
DNA Reduction	Two Way Text roll out for adults/paeds. Reduction of DNA 1% = 432 less missed appts	SC	Sept 23✓
	Failed text reminder report developed to improve DQ	SC	March 24✔
Monitoring of over 40 weeks	Tuesday PTL and Trust Access Performance meeting. Additional PTLs for Gastro, Neuro & Gen Surg	RTT Lead and PAT team	Weekly and in progress✔
Recovery Plan	Full RTT recovery plan by end March- Reduction of 40wks Percentage increase of RTT compliance RTT Training Plan	SC	March 24

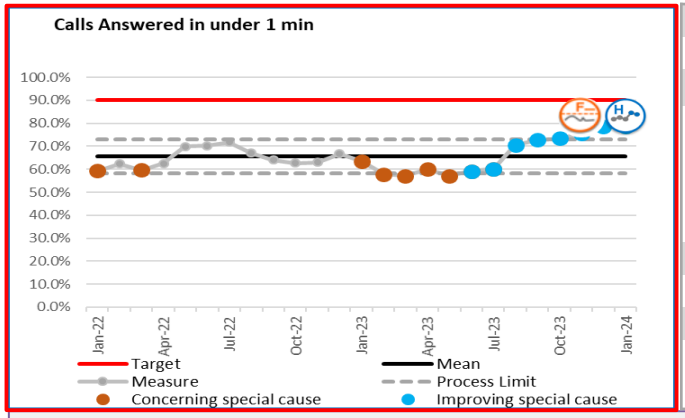
Patient Access: CQC: Responsive



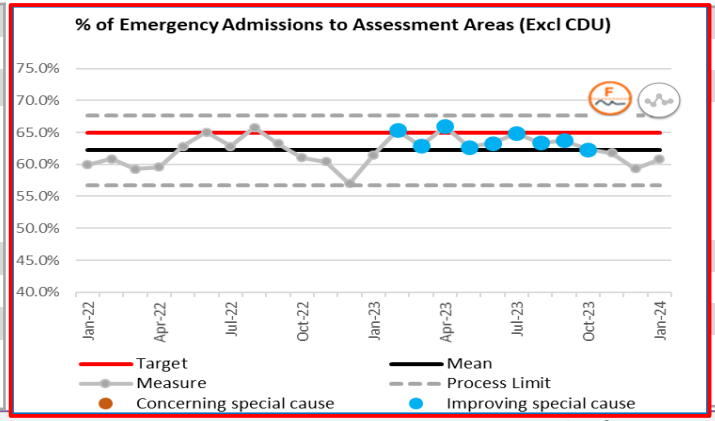
Jan-24
8.6%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Maximum Limit
5%
Business Rule
Full escalation as has failed the target for 6+months



Jan-24
80.9%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and failing the target for >6 months
Target (Internal)
85%
Business Rule
Full escalation as has failed the target for 6+months



Jan-24
78.6%
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



Jan-24
60.8%
Variance / Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (Internal)
65%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

Ambulance Handover <30mins: is experiencing common cause variation and has now failed the target for 6+months.

Outpatient Utilisation: is experiencing common cause variation and has failed the target for more than six months. All Divisions are now achieving above 80% utilisation.

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 T&O.

% of Emergency Admissions to Assessment Areas (Excl CDU): is experiencing common cause variation but has failed the target for 6+ months.

Actions:

Ambulance Handover <30mins: There has been a renewed focus on ambulance handovers as we need to achieve a minimum of 90% performance for quarters 3 & 4 as per the National Winter Incentive. A trust wide approach to this is underway and we are currently on track to deliver. Increase in hours of dedicated RAP admin support to improve compliance.

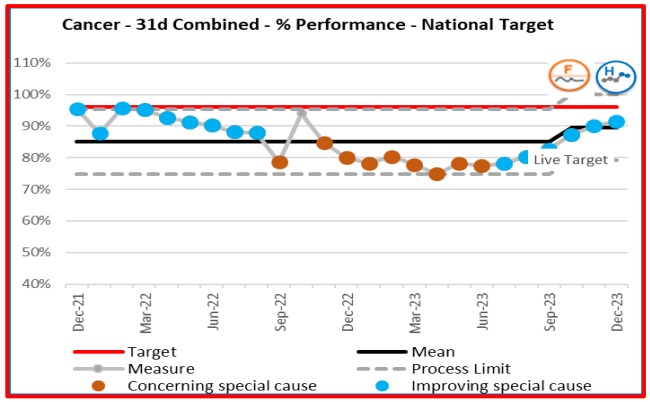
Outpatient Clinic Slot Utilisation: The OPD team continue to work with the CAUs on their clinic templates to improve utilisation by 20%. Next, the focus is on consultant led clinics under 80% and nurse led clinics.
Performance against the under 1 minute KPI:. Daily report by hour and by speciality are 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 SDEC 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:

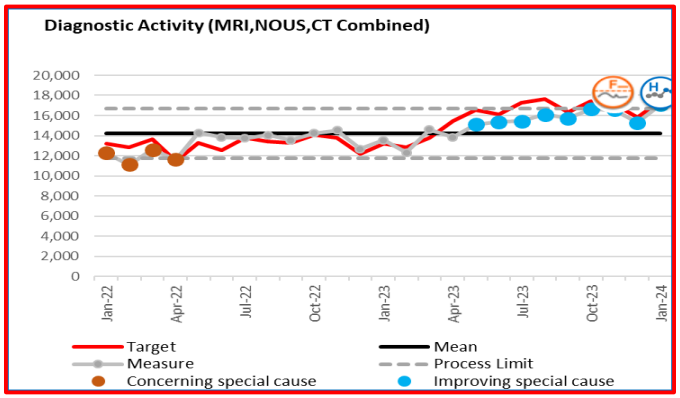
Ambulance Handover <30mins: We are on an upward trajectory and look to be achieving the target again in a month. Increase in admin staffing level to increase RAP support, increase in hours staffed from March. Training offered and delivered to SDECs to ensure compliance and understanding, any issues raised to be reviewed end of February.

Outpatient Slot Utilisation The aim is to ensure that no planned elective / consultant led clinic is under 85% utilised. Delay in cashing up impacting performance (December utilisation reached 80% w/c). The OPD team have worked to identify 'planned elective' vs. 'emergency / hot clinics'. Work required to improve utilisation of nurse led clinics. DNA working group and speciality based GIRFT work to support improvement. Action plan in development.
Calls Answered within 1 minute in the CAUs: Remain on upward trajectory, January reached new record high . New starters should help maintain that through further periods of Industrial Action / site pressures.
% of Emergency Admissions to Assessment Areas (Excl CDU): Outcomes from working group reviewed and action plan developed.

Patient Access: CQC: Responsive



Jan-24
91.5%
Variance / ,Assurance
Metric is currently experiencing special cause variation of an improving nature and failing the target for 6+ months
Target (National)
96%
Business Rule
Full escalation as has failed the target for 6+months



Jan-24
17069
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
17427
Business Rule
Full escalation as has failed the target for 6+months

Summary:	Actions:	Assurance & Timescales for Improvement:
Cancer 31 day First Definitive (Combined): This National Standard has now changed and is a combination of the previous targets. This indicator is experiencing special cause variation of an improving nature and has failed the target for 6+months (however new target only in place from October 2023).	**Cancer 31 Day First Definitive (Combined):** Detailed recovery plan in place to reduce waiting times for subsequent radiotherapy, as this is the area resulting in the most 31 day breaches. Additional staff in place in February and March to increase capacity and pathway transformation underway to decrease turnaround times	**Cancer 31 Day First Definitive (Combined):** Focus on implementation of detailed recovery plan.
Diagnostic Activity (MRI, NOUS, CT Combined): is experiencing special cause variation of an improving nature and is consistently failing the target.	**Diagnostic Activity (MRI, NOUS, CT Combined):** Ongoing review of activity levels against plan to maximise efficiency - improving position noted MRI position under review specifically as inefficiencies highlighted in service	**Diagnostic Activity (MRI, NOUS, CT Combined):** Continued improvement sustained across all modalities except MRI.

Strategic Theme: Patient Experience

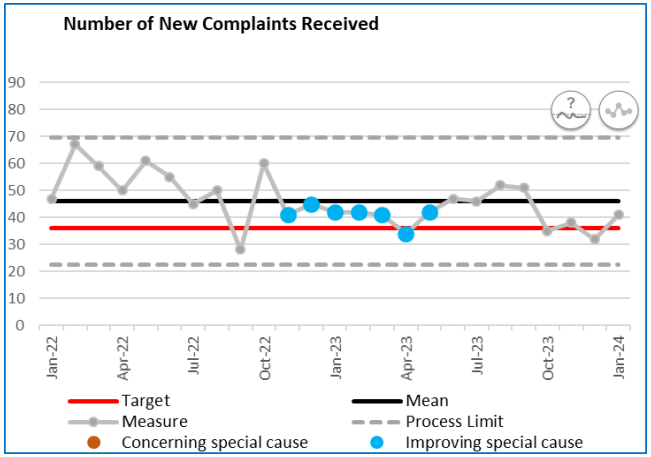
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month		36	32	Jan-24	36	38	Dec-23	Driver			Verbal CMS	36		
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	17	Jan-24	24	13	Dec-23	Driver			Note Performance	21		
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	1.6	Jan-24	3.9	2	Dec-23	Driver			Not Escalated			
	Caring	% complaints responded to within target		75.0%	62.5%	Jan-24	75.0%	70.6%	Dec-23	Driver			Escalation			
	Caring	% VTE Risk Assessment (one month behind)		95.0%	92.2%	Dec-23	95.0%	94.9%	Nov-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	24.5%	Jan-24	25.0%	18.5%	Dec-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	5.5%	Jan-24	15.0%	5.1%	Dec-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	14.1%	Jan-24	25.0%	5.1%	Dec-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	6.2%	Jan-24	20.0%	6.2%	Dec-23	Driver			Escalation			

Vision: Counter Measure Summary

Metric Name – To reduce the overall number of complaints or concerns each month

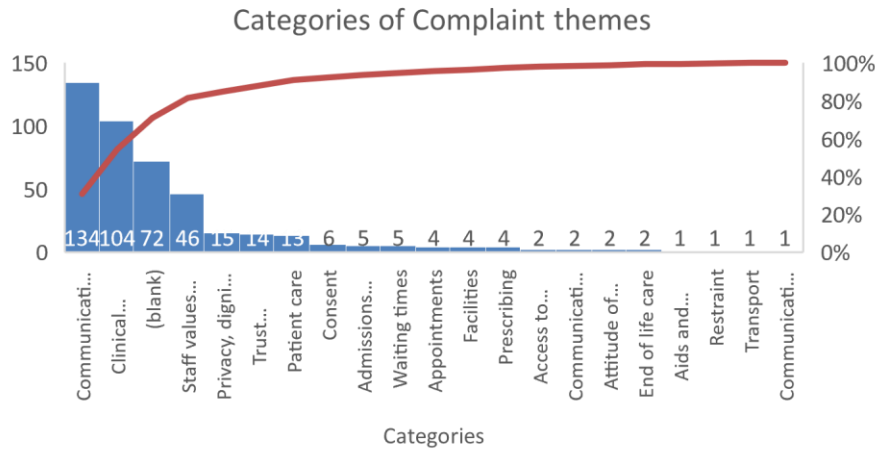
Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Jan-24
41
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

Using A3 Thinking, we have understood the themes of complaints received and poor communication was one of the main issues affecting patient experience. The key contributors are:

1. Staff attitude and behaviour
2. Lack of information for patients
3. Inconsistent communication
4. Inaccurate communication

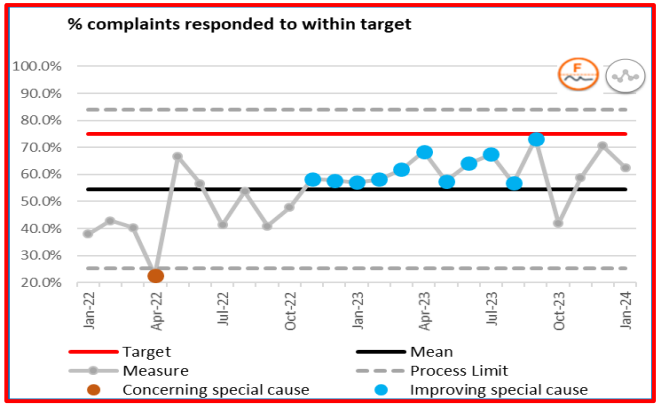
Key Risks:

1. The capacity to deliver the BO actions can be affected due to Industrial action and winter pressures
2. Accurate and consistent data capture for the complaints
3. Standardisation of measures about Divisional actions for complaints
4. Competing workloads for Divisional teams to execute actions related to feedback received.

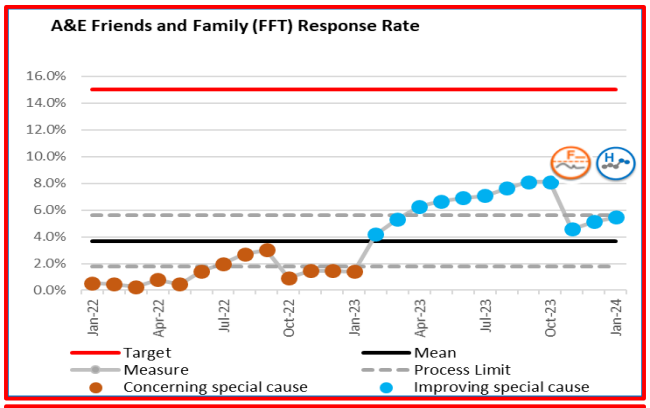
4. Action Plan

Counter-measure	Contributor	Action	Who	By when	Complete (Y/N)
Staff Communication – Oral	Lack of clear communication Breakdown in communication between clinicians and patients – lack of information sharing	Discuss themes from complaints in clinical governance meetings – Record Lessons learnt – Divisional/directorate Dataset available via directorate InPhase dashboards.	DDNQ, Chiefs of services, DDOs Heads of Nursing, GMs, CDs To confirm with Governance leads if this is in place	Feb-24	N
	Patient not being verbally told things – treatment planning, new medication, sharing with families				
	Test results not being communicated to patients				
	Unable to contact the right personnel for the right needs	Updating contact information display in wards for identifying the correct person to contact	Ward in charges per division	Feb-24	
Staff Communication - Written	Lack of clear explanation Breakdown in written communication to patients and between professionals including test results	Clarity in Electronic discharge notes and patient notes. Clarity	DDNQ, Chiefs of services, DDOs Heads of Nursing, GMs, CDs. CNIO	Mar-24	N
	Out of date information leaflets – lack of information clarity on procedures, discharge etc.	Update patient information leaflets Review PILG Policy	PILG Patient Information Leaflet group (Patient Exp Lead, Gina Knot)	Mar-24	
Staff attitudes and behaviour	Staff Attitude / Rudeness/Manner	Drama based learning – Role playing Training modules delivered by provider	Divisional Triumvirates, Nursing and Midwifery Education team (ENACT Training)	Mar-24	N
Capturing the correct Communication related categories on InPhase	Issues in identifying the correct category of complaints while reporting on InPhase, to identify Communication complaints accurately	Aligning complaints categories in InPhase. Mandatory questions to identify complaints relating to communications to be added	Complaints team/ Stuart Jones	Mar-24	N

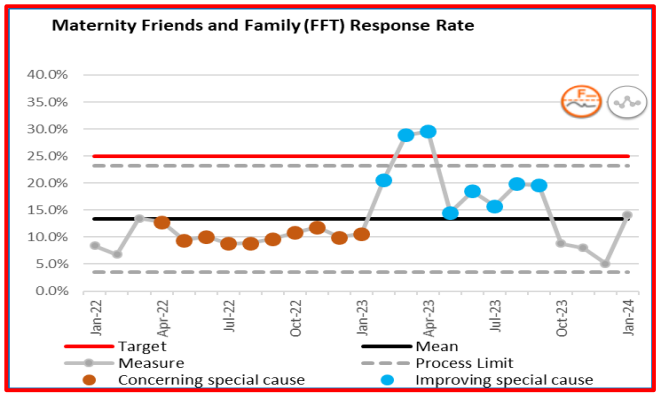
Patient Experience: CQC: Caring



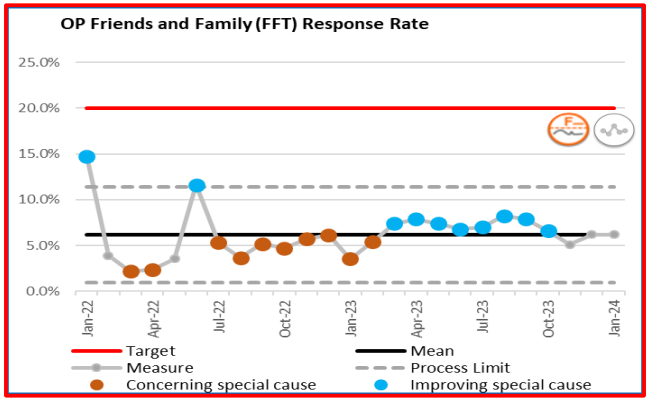
Jan-24
62.5%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Jan-24
5.5%
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



Jan-24
14.1%
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



Jan-24
6.2%
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 common cause variation 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 80.2%

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 95.1%

Word clouds being reviewed for key sentiments and shared with divisions.

Actions:

Complaints Response Rate: Complaints performance recovery and stabilisation actions include:

- Oversight meetings between complaints manager and DQG
- Weekly meetings between complaints leads and the directorates
- Business Case for revised complaints model/team submitted Jan24 and further discussions ongoing
- Recruitment ongoing to bolster the capacity of the Complaints team

A&E: Overall an improving picture.

Key themes are Positive – emotional support & information, communication and education

Negative – transition and continuity. England average for Dec 23 was 10.9%, MTW was 5.1% for Dec-23.

Maternity: Volunteers supporting with FFT collection.

FFT Recommendation key themes: Positive – emotional support

Negative – transition and continuity.

Outpatients: SMS text messaging still in use, QR Codes were available in Jan.

Key themes: Positive – respect for patient centred values

Negative – physical comfort & co-ordination and integration of care. England average for Dec 23 was 2.5%, MTW was 2.6% for Dec 23

FFT Response All: January was the last collection for our FFT cards for IQVIA. IQVIA contract ended 4th of Feb

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: Mobilisation of HCC is in progress. Expected start date is the beginning of March.

New reporting hierarchy with HCC has been developed and will consider whether internal targets will remain achievable or whether will require a review.

Risk: The embedding of HCC has the potential to affect the number or responses. This will also affect the National FFT Submissions for February and March 24. The BI have been informed to ensure NHSE will be aware of the change.

Mitigation:

We have created an FFT survey via Survey Monkey to capture FFT data while we are transitioning to the new provider. This link will be added to iPads, internet and intranet and shared with staff so data can be captured. It will also be added to social media and volunteers will be able to support with the FFT collection.

FFT data which has already been captured can be reviewed via the Power BI dashboard

Strategic Theme: Systems

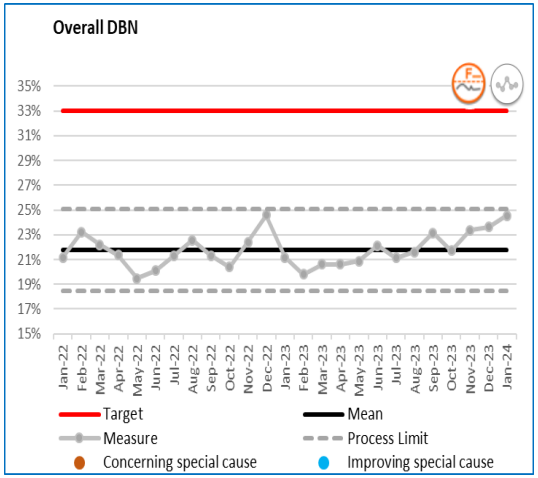
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)		3.5	2.5	Jan-24	3.5	5.4	Dec-23	Driver			Note Performance	2.7		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	24.6%	Jan-24	33.0%	23.6%	Dec-23	Driver			Full CMS	22%		

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%

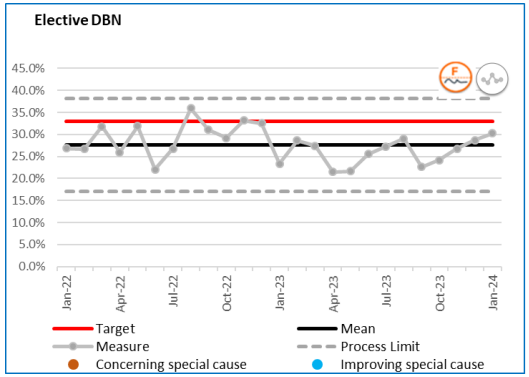
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

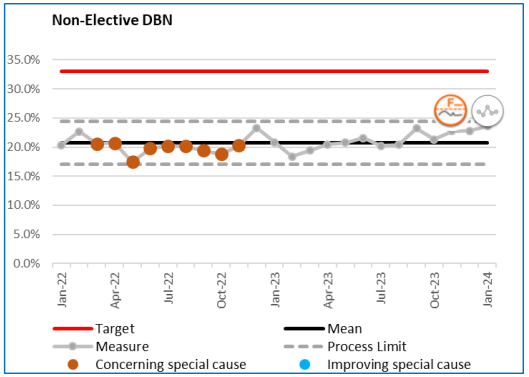
1. Historic Trend Data



Current Data Source: PAS
Jan-24
24.6%
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.
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. Currently a key issue is inability to pull accurate data to identify no. of Criteria led discharges

Key Risks:

1. Clinical buy-in to manage CLD processes differently
2. Changes in Sunrise required but team currently oversubscribed
3. Clinical capacity to prioritise EDNs
4. Clinical capacity to focus on discharge processes in times of severe operational pressures

4. Action Plan

Counter Measure	Action	Who	When	Complete
Governance	• The improvement trajectory for DBN is proving difficult to gain traction. In recognition we are strengthening the governance and focussing our improvement capacity through the SBS board. • New Pharmacy project group led by Directorate agreed with Chief Pharmacist/ Business Manager, to be agreed with DDO • Develop Perfect Week on one ward to incorporate EDN/ CLD following Board Round success on Pye Oliver.	RJ/SF MJ/ KT NP/ FR	20/2/24 29/2/24 18/03/24	Being set up In progress In progress
Criteria Led Discharge	• Paper to ETM on CLD approach on recommendations • Supporting CLD engagement at Board Rounds in key areas incl. Mercer, ECU, Peale, Pye, W33, backed up by E learning/ competency roll out • Changes in Sunrise to improve reporting capability	RJ NP Sunrise team	Dec 23 Rolling Dec 23	Feb-24 In Progress early 2024
EDN	• 3 ward EDN focus: ward 21, Cornwallis & Lord North • Testing of afternoon board rounds & EDN completion day before • Change EDN structure in Sunrise to align with clerking model- Change has been made, now in testing phase • Change EPMA & Sunrise TTO module to reduce time taken to complete medicines element of EDN (requires planned Sunrise upgrade completion first)- Drag and drop of TTOs in Sunrise enabled, now in testing	Registrars Wards & CI team Sunrise Sunrise Sunrise	1/11/23 6 week test 3/24	Complete In Progress In progress In Progress

Strategic Theme: Sustainability

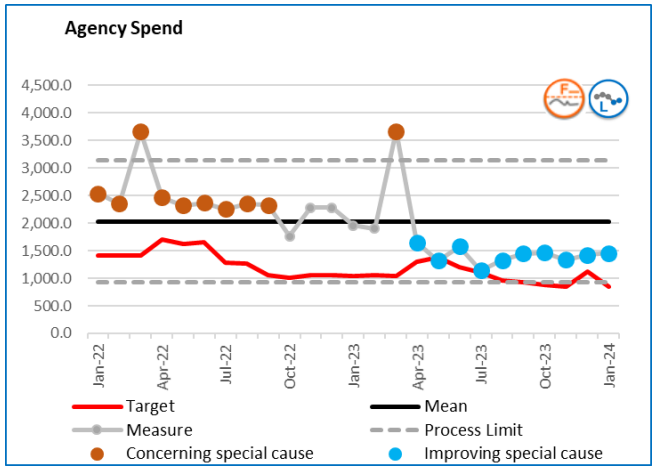
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)		-284	447	Jan-24	1,079	1,861	Dec-23	Driver			Verbal CMS	324 Year End FOT		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		848	1,455	Jan-24	1,114	1,423	Dec-23	Driver			Full CMS	1523 Year End FOT		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		3,684	1,351	Jan-24	3,666	1,607	Dec-23	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		11,024	4,397	Jan-24	15,869	13,473	Dec-23	Driver			Escalation			
	Well Led	Capital Expenditure (£k)		9,347	4,874	Jan-24	3,869	3,896	Dec-23	Driver			Not Escalated			
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		101,564	110,381	Jan-24	93,873	99,327	Dec-23	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		25,519	21,691	Jan-24	24,120	19,020	Dec-23	Driver			Not Escalated			

Breakthrough: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000

Owner: Steve Orpin
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Jan-24
1,455
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
1114
Target Achievement
Metric is consistently failing the target

Note the Oct 22 value is low due to a release of accruals from previous months

2. Stratified Data

3. Top Contributors/Risks

Contributing factors to premium workforce spend have been narrowed down to:

- Medical workforce gaps
- AHP workforce gaps
- Nursing workforce gaps
- Mental health and security support (skilled mental health workers are not currently available on the bank)
- Increased demand / ED attendances

- Increased demand to our ED adversely impact premium workforce spend
- Industrial action for junior doctors will require backfill with premium workforce
- Annual leave planning and sickness management.

4. Action Plan

Action	Status	By when
Increased controls over agency usage	Further escalation of authorisation to executive level (particularly around lines of work), "ban" on use of agency / certain agencies in specific areas (eg ED), reduction in automatic agency approval and executive level review of prospective agency bookings.	Will go to BAU when controls show process had been embedded
Data and reporting	Create dashboard (Oceansblue, Patchwork and Allocate) with the first divisional reports for performance meetings - manually pulled. Working with the provider collaborative and BI colleagues to develop a standard dashboard that covers all relevant KPIs, driving staff costs.	OceansBlue reporting implemented. March 24
Accountability and training	Managerial training programme for B5-9 managers – getting the basics right. This will include governance structures and data (as above).	Proposal to be presented to exec team Feb 24. Further Rostering and Finance training sessions in Jan-Mar 24
Medical rostering	Patchwork bank product implemented Trust-wide Rostering business case at BCRP stage to propose a single rostering provider for all medical rosters.	Feb 2024 Q1 2024/25
Review of A3	A review of A3 taking place to ensure we are still focused on the top contributors and remedial actions.	Q4 2023/24

	Booked on previous sessions	Attended	Booked on future sessions
Rostering Trainin	162	93	4
Finance Training	92	47	15

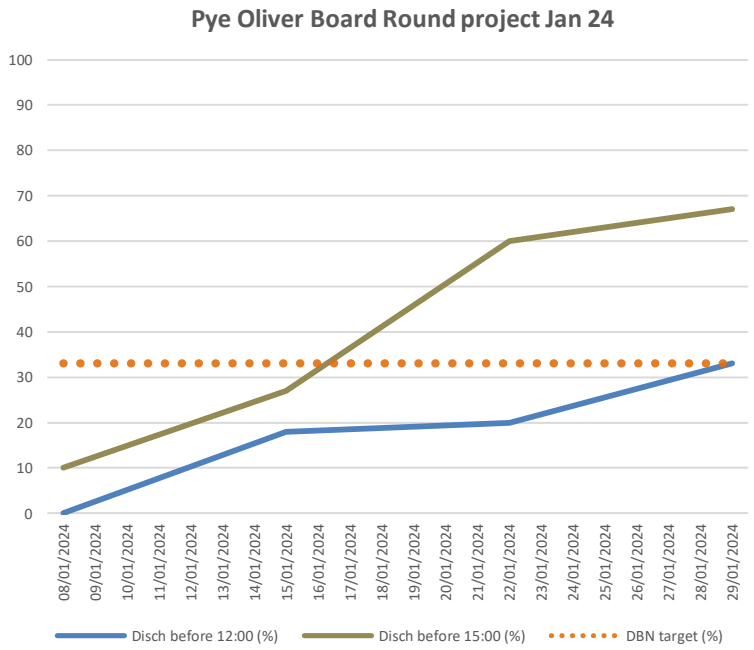
Appendices

Proposed Maternity Metrics

				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)	Proposed Metric	Registerable Births		477	509	Dec-23	477	461	Nov-23	Driver			Not Escalated
	Proposed Metric	Antenatal bookings		538	509	Dec-23	538	598	Nov-23	Driver			Not Escalated
	Proposed Metric	Elective Caesarean Rate		25.0%	21.3%	Dec-23	25.0%	21.1%	Nov-23	Driver			Not Escalated
	Proposed Metric	Emergency Caesarean Rate		25.0%	17.8%	Dec-23	25.0%	19.5%	Nov-23	Driver			Not Escalated
	Proposed Metric	Induction of Labour Rate		TBC	38.1%	Jan-24	0.0%	38.8%	Dec-23	Driver	No SPC	No SPC	
	Proposed Metric	Preterm Birth (<37 weeks) Rate		0.6%	4.1%	Jan-24	0.6%	5.6%	Dec-23	Driver			Escalation
	Proposed Metric	Unexpected term admissions to NNU		5.0%	4.1%	Dec-23	5.0%	5.0%	Nov-23	Driver			Not Escalated
	Proposed Metric	Stillbirth rate		0.4%	0.7%	Dec-23	0.4%	0.7%	Nov-23	Driver			Not Escalated
	Proposed Metric	PPH >=1500% Rate		3.3%	4.4%	Dec-23	3.3%	3.5%	Nov-23	Driver			Not Escalated
	Proposed Metric	Major Tear (3rd/4th degree Rate)		2.5%	1.5%	Jan-24	2.5%	1.6%	Dec-23	Driver			Not Escalated
	Proposed Metric	Breastfeeding Rate at Birth		78.0%	79.2%	Dec-23	78.0%	79.1%	Nov-23	Driver			Not Escalated
	Proposed Metric	Smoking at Delivery Rate		6.0%	8.0%	Dec-23	6.0%	5.3%	Nov-23	Driver			Not Escalated

Celebrations - Systems

Success Factors and Key Insights from Pye Oliver ward: Matron and Consultant Engagement Drive Results



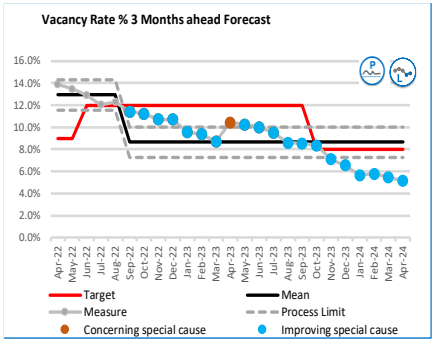
Factors Contributing to Success on Pye:

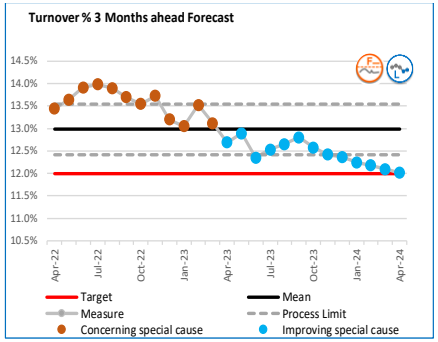
- Matron's excellent level of engagement in Pye Oliver ward
- Consultant's active involvement and willingness to incorporate feedback
- Consistent use of a prompt sheet, providing clarity and ensuring uniformity among B6's
- Implementation of Criteria Led Discharge (CLD) with support from both consultant and registrar.
- Operational Flow Project Manager's approach: reviewing board rounds against SAFER principles, fostering relationships, addressing gaps with ward support, and advocating for CLD integration.

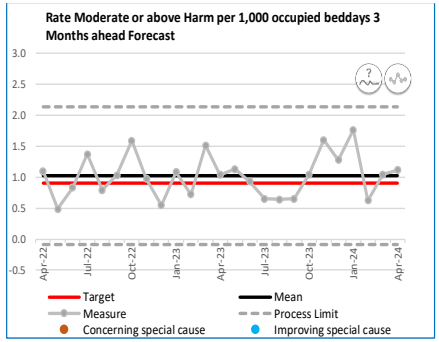
Key Lessons Learned:

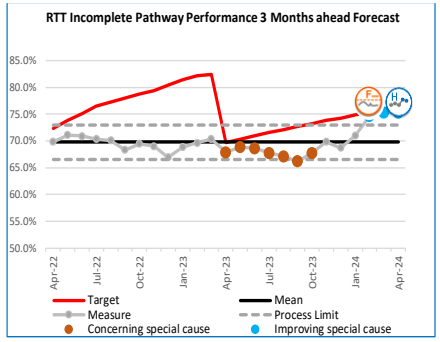
- Importance of daily attendance to familiarize with the prompt sheet
- Ensuring equal opportunity and support from the matron for all B6's
- Recognition that individual conversations yield deeper insights compared to group discussions.
- Embedding SAFER principles with the support of digital transformation promoted safe and timely discharges

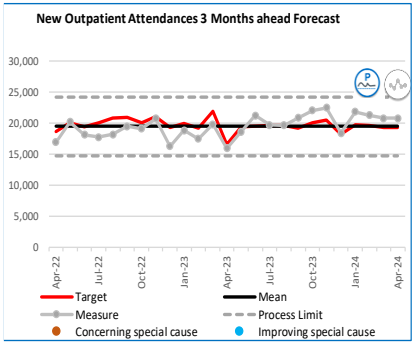
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

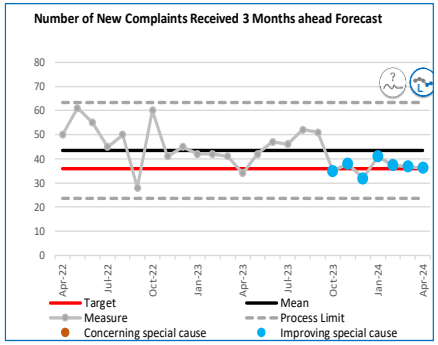


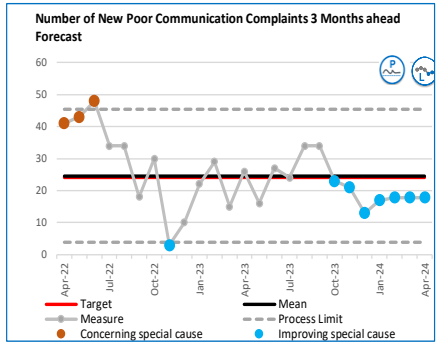


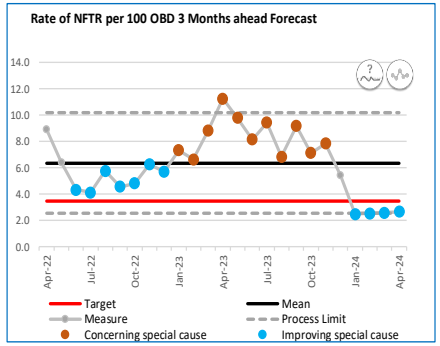


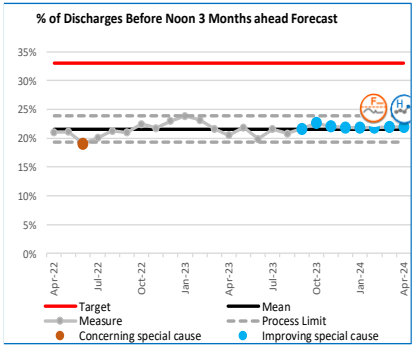


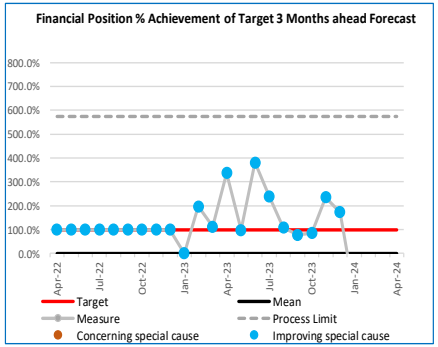


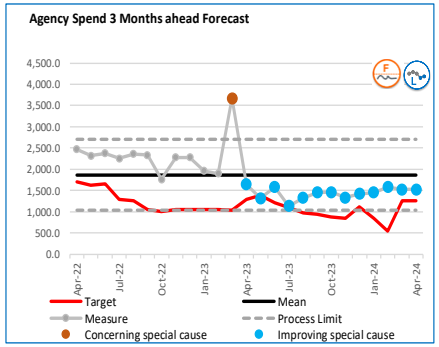




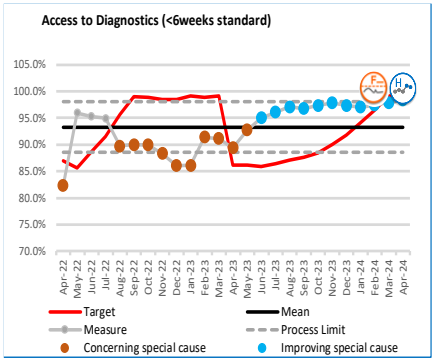


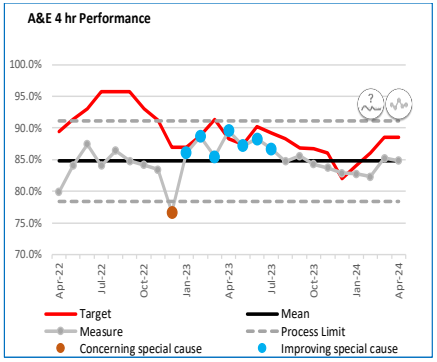


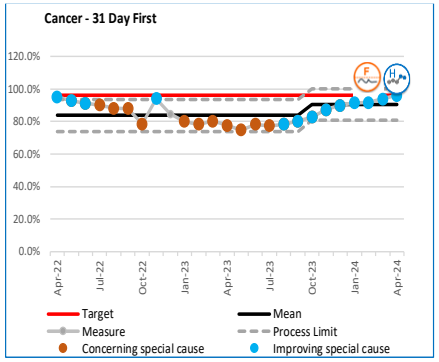


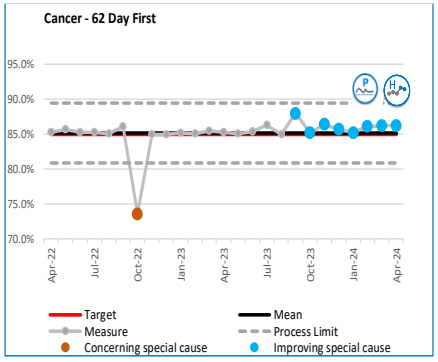


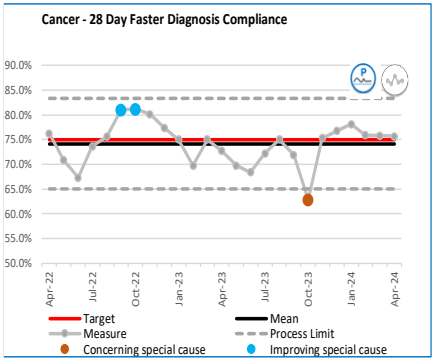
Forecast SPCs (3 month forward view) for Patient Access Indicators

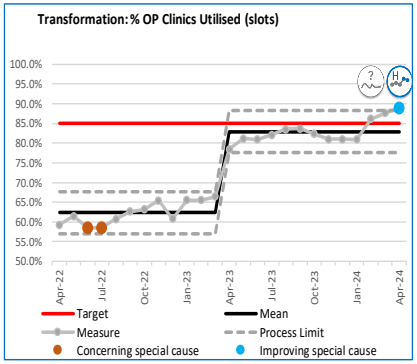


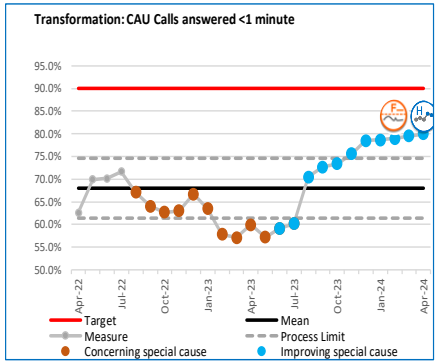


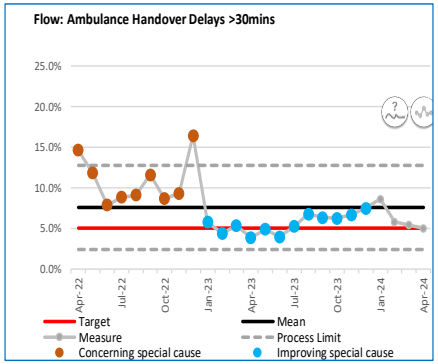


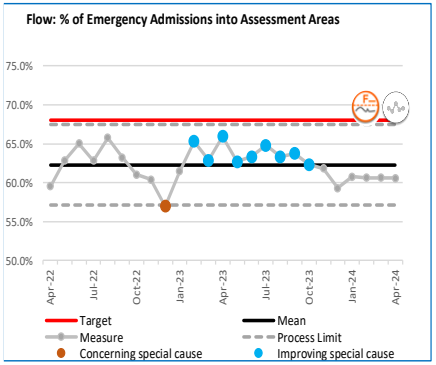


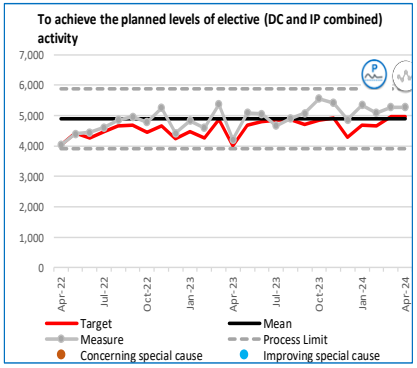


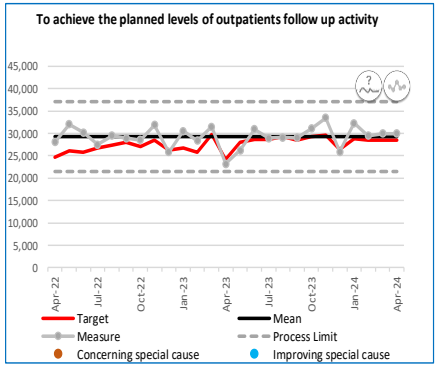


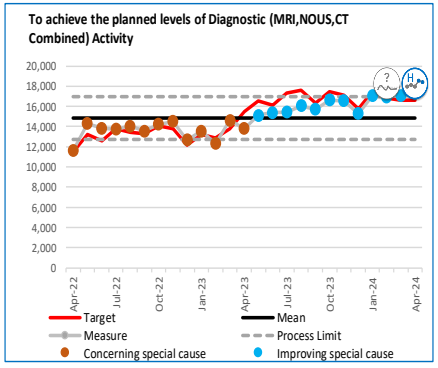






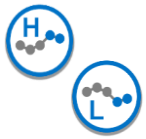






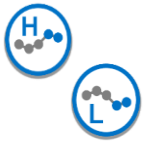
SDR Business Rules Driven by the SPC Icons

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

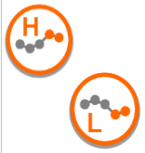
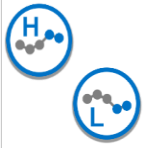
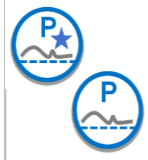
SDR Business Rules Driven by the SPC Icons

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:

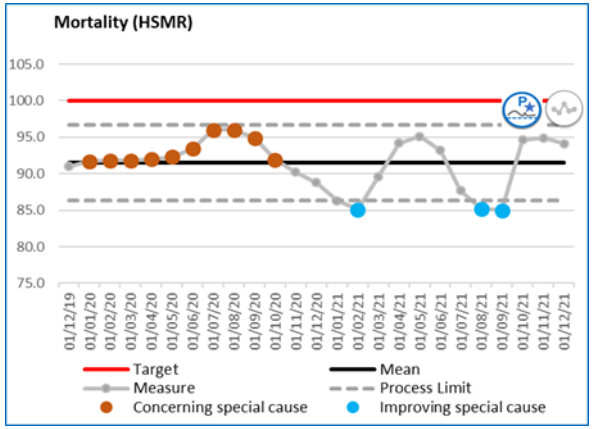
The **target** line **between** the **upper** and **lower** control limit for all metric types

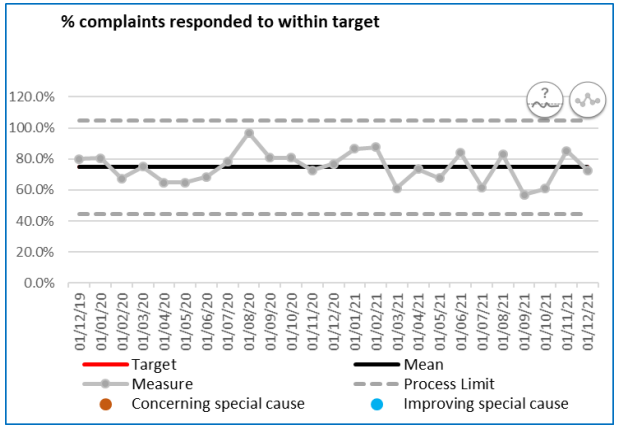
Metrics that consistently **fail** have:

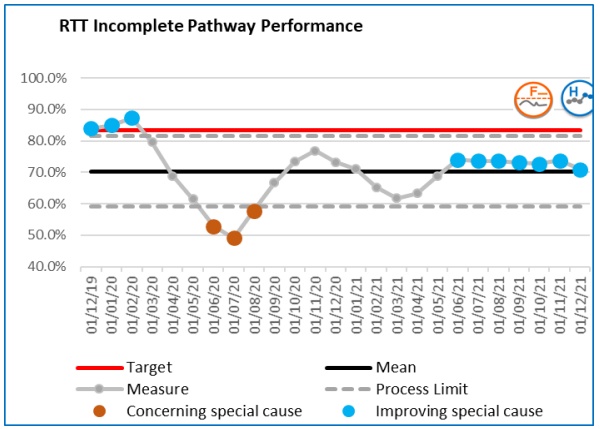
The **lower** control limit **above** the target line for metrics that need to be **below the target**

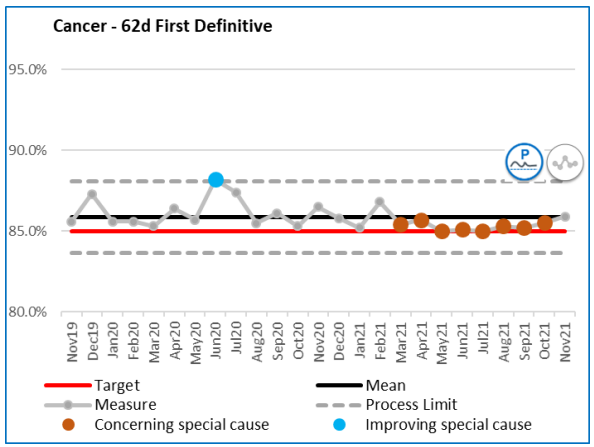
The **upper** control limit **below** the target line for metrics that need to be **above the target**

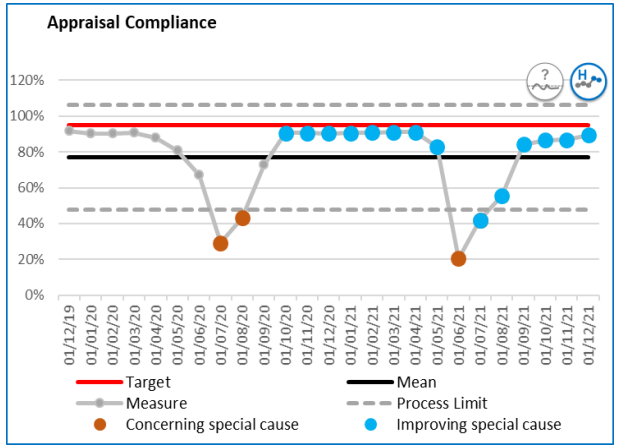
A metric not achieving the target for 6 months or more will be flagged as failing

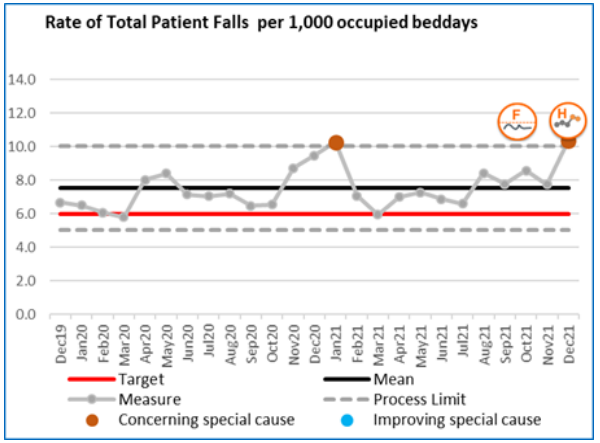












Executive Summary

- The Trust was £0.4m in deficit in January which was £0.7m adverse to plan. Year to date the Trust is £1.8m in deficit which is £1.8m adverse to plan.
- The key year to date pressures are; CIP slippage (£10.2m), CDC delay to fully opening and underutilisation of CT capacity (£2.8m), unfunded December and January industrial action impact (£1.2m), medical pay award pressure (£0.9m), overspend within patient transport (£0.5m) and Cardiology non pay (£0.5m). To mitigate these pressures the Trust has overperformed against variable income net of estimated spend (£8.9m) and had non recurrent benefits of £5.2m.
- Cost Improvement Plans (CIP) are behind plan by £10.2m year to date and are forecasted to be £14.8m adverse to plan at the year end
- The Trust is forecasting a deficit of £1.2m which is based on national guidance that Industrial action costs for December and January should be reported as an overspend. The Trust is expecting these to be funded and therefore the final year end forecast will still be on plan.
- The Trust is forecasting to deliver the breakeven financial plan however this requires £2.1m of run rate improvements and assumes the industrial impact for December and January will be fully funded (estimated at £1.2m). The increase in additional actions which are now necessary mean
  there is a significant risk to the delivery of the financial plan

Current Month Financial Position

- The Trust was £0.4m in deficit in the month which was £0.7m adverse to plan. The impact of industrial action in the month was £0.8m, this included £0.6m increase in additional costs and £0.2m reduction in income due to cancellations.
- **Key Favourable variances in month are:**
  - Overperformance against ERF activity (£1.3m) mainly within daycase activity (£0.8m) and out patients (£0.5m)
  - Non recurrent benefits of £1.8m in the month which included; a review of education expenditure (£0.8m), clinical income benefit through finalisation of previous year values (£0.5m), COS VAT rebate adjustment (£0.4m) and other one off benefits of £0.1m.
- **Key Adverse variances in month are:**
  - CIP Slippage (£2.3m)
  - Industrial Action (£0.8m)
  - Cardiology non pay was £0.5m adverse to plan in the month. The change to a managed service arrangement took place during December with the actual costs being received during January, these charges were higher than estimated and the costs for items outside of the MSA were also higher.
  - CDC delay to full capacity and also due to under utilisation of the CT capacity (£0.3m)

Year to Date Financial Position

- The Trust is £1.8m in deficit which is £1.8m adverse to plan
- The key year to date variances are as follows:
  - **Adverse Variances**
    - CIP Slippage (£10.2m)
    - CDC delay to full capacity and also due to under utilisation of the CT capacity (£2.8m)
    - Unfunded Industrial action impact (£1.2m)
    - Medical pay award pressures (£0.9m)
    - Overspend within Patient Transport budget (£0.5m) and Cardiology non pay (£0.5m)
  - **Favourable Variances**
    - Variable activity overperformance including change to ERF target (£8.9m) net of estimated spend.
    - Non recurrent benefits (£5.2m)

Risks

- **Industrial Action -** The forecast assumes any unfunded or loss in variable related income associated with future Industrial actions will be funded in full
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.
- **PFI** - The Trust has not yet applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in line with IFRS 16 principles. This must be completed by year end, using the new models released by DHSC in October and December. The impact will be to change the level of finance interest charged into the position. As this is a partly retrospective change, NHSE are treating it as a "technical" adjustment for 2023/24 that does not impact on performance measurement.

Cashflow position:

- The closing cash balance for January was £4.4m which is lower than the plan value of £11m. The cash balance is significantly reducing in the final quarter of the financial year which has a planned closing balance of £2m. Within February the Trust is forecasting receipt of capital PDC of £16.5m, this is to fund specific capital projects which are finishing towards the end of the financial year end. Within the cashflow for February and March are capital payments owed to suppliers totalling £18.8m which are expected to be paid due to the funding received.
- The Trust's cash flow is aligned to 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 Trust's 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, however local NHS organisations are also struggling with cash.
- The Trust is working with Suppliers, the 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 target of 95%. For January the percentages were for Trade suppliers by value 95.4%, and by volume 96.3%; for NHS suppliers by value 95.6% and by volume 91.0%.

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 is supporting related enabling works for the new MRI and CT at TWH.

- **Additional Funding**
  - **National Funding in addition to Plan – Total £8.498m**
    - CDC = £1.7m
    - Breast Screening Ultrasound = £95k
    - Interventional Radiology (IR) Suite at TWH = £535k
    - Cyber Security = £77k
    - Digital Pathology = 23/24 - £2.982m and 24/25 - £653k
    - LED Lighting (National Energy Efficient Fund) = £349k
    - Frontline Digitisation = £2.76m (will show on report in M11)

  - **System Funding in addition to Plan – Total £2.798m**
    - CDC = £2m
    - Ultrasound = £100k

- Image Intensifiers = £260k
- laptops = £200k
- IT switches = £6k
- Specialist lab benching = £76k
- Resuscitaires = £84k
- Ultrasound = £72k

- **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 **£250k** relating to forecast donations in year.

- **Month 10 Actuals (excluding IFRS16)**
  - The YTD spend at M10 is **£28.4m** against a YTD budget of **£37.7m**. 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 included £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 was for potential new lease capitalisations: the most significant being the KMMS accommodation with a value of £15.3m assuming completion by the end of 2023/24. The Trust adjusted its forecast outturn in month 6 to a reduced figure of £21.64m in line with instructions from NHSE that schemes not committed by that date would not be funded as a result of an overcommitment against the national resource made available. In consultation with NHSE regional office the Trust has now further moved its forecast down to £5.6m as it has become clear that the KMMS accommodation will not be complete by financial year end. The Trust will be including the capitalised value in its 2024/25 plans.

  - The Trust has not yet applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in line with IFRS 16 principles as work is ongoing on the new model. This must be completed by year end, using the new models released by DHSC in October and December 2023. The impact will be to change the level of finance interest charged into the position. As this is a partly retrospective change, NHSE are treating it as a “technical” adjustment for 2023/24 that does not impact on performance measurement.

Year end Forecast:

- The Trust is forecasting a deficit of £1.2m which is based on national guidance that Industrial action costs for December and January should be reported as an overspend. The Trust is expecting these to be funded and therefore the final year end forecast will still be on plan.
- The Trust is forecasting to deliver the breakeven financial plan however this requires £2.1m of run rate improvements and assumes the industrial impact for December and January will be fully funded (estimated at £1.2m).
- The forecast has been completed prior to the planned Industrial action in February and therefore excludes the impact of Februarys planned industrial action. If the industrial impact is the same as January this will adversely impact the forecast by a further £0.8m.
- The increase in additional actions which are now necessary mean there is a significant risk to the delivery of the financial plan

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 10
2023/24

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

January 2023/24

	Current Month					Year to Date					Annual Forecast / Plan		
	Actual	*Plan*	*Variance*	Pass-throu	*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	61.0	57.6	3.4	(0.1)	3.5	587.4	572.0	15.3	(0.4)	15.7	712.5	688.5	24.0
Expenditure	(57.2)	(52.9)	(4.3)	0.1	(4.4)	(546.8)	(529.3)	(17.5)	0.4	(17.9)	(662.4)	(636.4)	(25.9)
EBITDA (Income less Expenditure)	3.8	4.7	(0.9)	0.0	(0.9)	40.5	42.7	(2.2)	0.0	(2.2)	50.1	52.0	(1.9)
Financing Costs	(4.3)	(4.4)	0.1	0.0	0.1	(43.1)	(43.1)	0.0	0.0	0.0	(68.6)	(69.3)	0.7
Technical Adjustments	0.0	(0.0)	0.1	0.0	0.1	0.8	0.4	0.4	0.0	0.4	17.3	17.3	(0.0)
Net Surplus / Deficit	**(0.4)**	**0.3**	**(0.7)**	**0.0**	**(0.7)**	**(1.8)**	**0.0**	**(1.8)**	**0.0**	**(1.8)**	**(1.2)**	**0.0**	**(1.2)**
Cash Balance	4.4	11.0	(6.6)		(6.6)	4.4	11.0	(6.6)		(6.6)	2.0	2.0	0.0
Capital Expenditure (Incl Donated Assets and IFRS16)	4.9	9.3	4.5		4.5	30.8	46.7	(15.9)		(15.9)	52.5	68.0	15.5
Cost Improvement Plan	1.4	3.7	(2.3)		(2.3)	15.7	25.9	(10.2)		(10.2)	18.5	33.3	(14.8)

Summary Current Month:
- The Trust was £0.4m in deficit in the month which was £0.7m adverse to plan. The impact of industrial action in the month was £0.8m, this included £0.6m increase in additional costs and £0.2m reduction in income due to cancellations.

Key Favourable variances in month are:
- Overperformance against ERF activity (£1.3m) mainly within daycase activity (£0.8m) and out patients (£0.5m)
- Non recurrent benefits of £1.8m in the month which included; a review of education expenditure (£0.8m), clinical income benef it through finalisation of previous year values (£0.5m), Cost of Sales VAT rebate adjustment (£0.4m) and other one off benefits of £0.1m.

Key Adverse variances in month are:
- CIP Slippage (£2.3m)
- Industrial Action (£0.8m)
- Cardiology non pay was £0.5m adverse to plan in the month. The change to a managed service arrangement took place during Dece mber with the actual costs being received during January, these charges were higher than estimated and the costs for items outside of the MSA were also higher. This is being investigated further.
- CDC Phase 2 is now open but not yet operating at full capacity and under utilisation of the CT capacity (£0.3m)

Year to date overview:
- The Trust is £1.8m in deficit which is £1.8m adverse to plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£10.2m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£2.8m)
- Unfunded Industrial action impact (£1.2m)
- Medical pay award pressures (£0.9m)
- Overspend within Patient Transport budget (£0.5m) and Cardiology non pay (£0.5m)

Favourable Variances
- Variable activity overperformance including change to ERF target (£8.9m) net of estimated spend and Non recurrent benefits (£5.2m)

CIP (Savings)
- The Trust has a savings target for 2023/24 of £33.3m and has delivered £15.7m year to date which is £10.2m adverse to plan.

Forecast
- The Trust is forecasting a deficit of £1.2m which is based on national guidance that Industrial action costs for December and January should be reported as an overspend. The Trust is expecting these to be funded and therefore the final year end forecast will still be on plan.

Risks
- **Industrial Action** - The forecast assumes any unfunded or loss in variable related income associated with future Industrial actions will be funded in full
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.
- **PFI** - The Trust has not yet applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in lin e with IFRS 16 principles. This must be completed by year end, using the new models released by DHSC in October and December. The impact will be to change the level of finance interest charged into the position. As this is a part ly retrospective change, NHSE are treating it as a "technical" adjustment for 2023/24 that does not impact on performance measurement.

Jan-24		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RN/M (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	104.4%	120.2%	-	-	126.3%	140.3%	-	-	52.3%	53.6%	171	12.17	42	10.4	25.3%	91.7%	3	0		186,226	227,334	(41,108)
MAIDSTONE	Stroke Unit (M) - NK551	75.6%	66.6%	-	100.0%	87.3%	96.8%	-	-	25.6%	14.4%	254	17.95	64	9.5	127.3%	85.7%	6	0		365,782	369,373	(3,591)
MAIDSTONE	Cornwallis - NS251	196.7%	176.6%	-	-	98.9%	103.1%	-	-	12.1%	5.1%	76	5.27	18	15.0	79.5%	98.5%	1	1		123,283	128,261	(4,978)
MAIDSTONE	Culpepper Ward (M) - NS551	97.0%	88.8%	-	100.0%	107.1%	103.2%	-	-	32.3%	0.0%	32	2.08	4	4.5	0.0%	100.0%	0	0	CHPPD an anomoly for further investigation	118,416	137,493	(19,077)
MAIDSTONE	Edith Cavell - NS459	118.8%	94.5%	-	100.0%	105.5%	162.9%	-	-	40.4%	24.3%	50	3.41	3	7.0	17.1%	100.0%	6	3		121,085	153,205	(32,120)
MAIDSTONE	Foster Clarke Winter Escalation - NS959	75.9%	84.8%	-	100.0%	96.8%	93.5%	-	-	45.4%	7.9%	87	6.33	28	8.1	-	-	2	1		108,693	112,177	(3,484)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	101.7%	100.0%	-	-	114.3%	97.9%	-	-	31.7%	19.2%	149	10.45	39	6.5	10.6%	100.0%	2	3		156,436	189,367	(32,931)
MAIDSTONE	Intensive Care (M) - NA251	87.4%	86.3%	-	-	93.5%	91.7%	-	-	16.6%	0.2%	108	7.55	14	49.3	1200.0%	91.7%	0	1		240,066	261,611	(21,545)
MAIDSTONE	Lord North Ward (M) - NF651	90.6%	87.5%	-	100.0%	98.9%	93.5%	-	-	13.2%	0.0%	39	2.84	11	7.3	35.7%	100.0%	5	0		117,054	124,627	(7,573)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	111.0%	37.8%	-	100.0%	94.9%	-	-	100.0%	22.9%	0.0%	19	1.33	1	21.9	0.0%	100.0%	0	0		60,413	47,062	13,351
MAIDSTONE	Mercer Ward (M) - NJ251	109.9%	92.5%	-	100.0%	104.3%	130.6%	-	-	24.5%	41.4%	46	3.27	8	6.0	25.0%	100.0%	3	2		114,115	146,360	(32,245)
MAIDSTONE	Peale Ward COVID - ND451	93.9%	106.0%	-	-	96.8%	136.7%	-	-	26.7%	26.0%	52	3.74	10	8.4	68.2%	100.0%	6	1		124,265	99,554	24,711
MAIDSTONE	Pye Oliver (Medical) - NK259	129.8%	128.2%	-	100.0%	141.6%	164.5%	-	-	67.4%	49.5%	120	8.51	2	7.8	124.1%	97.2%	5	4		135,990	194,013	(58,023)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	92.9%	87.5%	-	-	87.8%	-	-	-	11.0%	0.0%	21	1.27	6	29.5	0.0%	-	0	0		59,953	58,707	1,246
MAIDSTONE	Whatman Ward - NK959	92.4%	116.6%	-	100.0%	104.6%	128.3%	-	100.0%	38.3%	28.4%	74	5.35	20	6.6	13.0%	100.0%	8	1		104,475	170,803	(66,328)
MAIDSTONE	Maidstone Birth Centre - NP751	105.3%	87.5%	-	-	102.6%	100.5%	-	-	18.3%	0.0%	30	1.78	0	48.8	0.0%	100.0%	0	0		77,570	95,535	(17,965)
TWH	Acute Medical Unit (TW) - NA901	100.2%	110.7%	-	100.0%	110.9%	131.3%	-	100.0%	37.2%	48.0%	211	15.18	63	9.5	34.7%	92.7%	5	0		254,957	286,300	(31,343)
TWH	Coronary Care Unit (TW) - NP301	94.4%	58.5%	-	-	93.5%	-	-	-	14.3%	3.1%	29	2.15	11	10.8	109.1%	100.0%	0	0		75,962	71,322	4,640
TWH	Hedgehog Ward (TW) - ND702	101.0%	130.9%	-	-	95.9%	151.6%	-	-	31.4%	30.3%	149	9.88	28	10.1	33.9%	96.9%	1	0		168,781	228,579	(59,798)
TWH	Intensive Care (TW) - NA201	109.8%	105.8%	-	-	107.7%	71.0%	-	-	7.6%	3.5%	80	5.19	5	32.4	0.0%	100.0%	0	0		381,661	416,228	(34,567)
TWH	Private Patient Unit (TW) - NR702	100.5%	87.3%	-	-	94.9%	95.6%	-	-	25.4%	0.0%	44	2.94	7	7.8	200.0%	96.2%	1	0		73,468	85,836	(12,368)
TWH	Ward 2 (TW) - NG442	90.2%	86.9%	-	100.0%	104.3%	136.8%	-	100.0%	32.3%	17.3%	104	7.44	44	6.4	28.0%	100.0%	8	0		183,318	201,090	(17,772)
TWH	Ward 10 (TWH) - NG144	66.7%	69.4%	-	100.0%	81.3%	90.3%	-	-	0.0%	No hours	0.00	0.00	0.00	5.1	-	-	7	1	Data missing for temporary staffing	182,965	49,298	133,667
TWH	Ward 11 (TW) - NG131	90.7%	104.4%	-	-	91.9%	119.4%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	7.0	4.8%	100.0%	10	0		149,847	159,121	(9,274)
TWH	Ward 12 (TW) - NG132	119.4%	98.0%	-	100.0%	128.3%	106.7%	-	-	49.1%	54.8%	245	17.01	69.00	7.5	17.0%	100.0%	2	0		149,950	192,675	(42,725)
TWH	Ward 20 (TW) - NG230	110.7%	117.4%	-	100.0%	117.8%	123.4%	-	-	44.3%	53.3%	181	12.08	31	7.8	30.0%	100.0%	8	4		176,689	218,060	(41,371)
TWH	Ward 21 (TW) - NG231	78.4%	97.4%	-	100.0%	88.4%	98.5%	-	-	19.5%	18.9%	130	8.31	65	5.4	9.4%	100.0%	7	0		152,563	167,909	(15,345)
TWH	Ward 22 (TW) - NG332	75.7%	118.3%	-	100.0%	88.7%	116.1%	-	-	34.4%	24.8%	133	9.50	53	6.2	75.0%	83.3%	6	2		150,276	196,851	(46,575)
TWH	Ward 30 (TW) - NG330	87.9%	87.9%	-	100.0%	91.8%	117.4%	-	100.0%	41.2%	0.5%	137	8.66	35	5.9	50.0%	92.6%	6	1		128,507	187,098	(58,591)
TWH	Ward 31 (TW) - NG331	90.3%	107.5%	-	100.0%	94.4%	139.7%	-	-	38.5%	5.5%	151	9.77	38	6.5	29.4%	90.0%	3	3		142,604	216,837	(74,233)
TWH	Ward 32 (TW) - NG130	88.3%	85.6%	-	100.0%	95.2%	112.8%	-	100.0%	23.2%	0.0%	68	4.45	24	9.4	0.0%	100.0%	2	2		151,293	156,858	(5,565)
TWH	Ward 33 (Gynae) (TW) - ND302	96.1%	93.8%	-	-	96.8%	93.5%	-	-	34.1%	14.8%	65	4.05	10	7.0	13.1%	100.0%	0	0		102,927	110,075	(7,148)
TWH	SCBU (TW) - NA102	101.4%	193.6%	-	-	119.3%	128.6%	-	-	31.4%	5.7%	135	8.10	2	9.2	35.3%	100.0%	0	0		212,704	223,594	(10,890)
TWH	Short Stay Surgical Unit (TW) - NE901	88.1%	94.8%	-	100.0%	103.2%	100.0%	-	100.0%	13.9%	0.0%	30	1.98	2	13.3	-	-	0	0		83,819	93,986	(10,167)
TWH	Surgical Assessment Unit (TW) - NE701	100.4%	91.9%	-	-	96.8%	100.0%	-	-	18.0%	0.0%	26	1.79	2	16.3	-	-	1	0		78,755	77,876	879
TWH	Midwifery (multiple rosters)	80.8%	65.6%	-	-	97.6%	88.0%	-	-	16.3%	6.4%	739	41.61	144	14.4	26.0%	100.0%	**0**	**0**		1,225,384	1,294,359	(68,975)
Crowborough	Crowborough Birth Centre (CBC) - NP775	53.3%	94.0%	-	-	48.5%	41.9%	-	-	13.3%	0.0%	77	4.85	27	1167.5	21.4%	100.0%	0	0	Elevated CHPPD due to the intermittant closure of the Unit	113,851	88,511	25,340
MAIDSTONE	Accident & Emergency (M) - NA351	102.3%	94.2%	-	100.0%	102.7%	84.9%	-	-	38.4%	30.9%	421	29.32	27	-	0.0%	76.7%	0	0		386,824	475,500	(88,676)
TWH	Accident & Emergency (TW) - NA301	100.0%	73.2%	-	100.0%	104.0%	84.5%	-	100.0%	41.5%	40.9%	471	32.71	31	-	6.1%	83.0%	6	0		418,955	495,271	(76,316)
																				Total Established Wards	**7,359,882**	**8,208,715**	**(848,833)**
																				Additional Capacity bed:Cath Labs	57,909	50,480	7,429
																				Other associated nursing costs	5,455,295	5,102,024	353,271
																				Total	12,873,086	13,361,219	-488,133

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

Proposals regarding the reinstatement of 'patient stories' at the Trust Board — Chief Nurse

Previously, patient stories had been an agenda item at the Trust board and the purpose was to provide Board members with a greater understanding of the services that the Trust provided and a more personalised connection with patients and carers.

The enclosed report provides information on the updated proposals for the potential reinstatement of patient stories at Trust Board.

The Board is asked to consider and approve the updated proposal.

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

- Executive Team Meeting, 14th November 2023

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

Decision 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

Patient Stories.

Maidstone and Tunbridge Wells NHS Trust

Patient stories are undeniably powerful in gaining an understanding of their experience and many Trusts nationally now use patient stories at Trust board meetings. The purpose of using stories to illustrate patient experience at Board level is to:

- Forge a connection between the experience of patients and the leadership of the Trust and its role in establishing the right strategic context for improvement and change
- To triangulate patient experience with reported data and information and provide insight into how this can influence improvements in quality and patient experience
- The voices and stories of patients are an effective and powerful way of making sure the improvement of services is centred on the needs of the people using those services
- To seek assurance that the organisation is learning from individual stories to benefit the wider patient experience
- For the board to gather insight into what happens between episodes of clinical care

The ambition to reinstate patient stories at Trust Board was broadly accepted at the Executive Team meeting (ETM).

Methodology

At Trust Board level:

- It is recommended that patient stories are considered in the ‘Part 1’ Trust board meeting unless the patient requests their story to be considered at the ‘Part 2’ Trust Board meeting
- It is recommended that each clinical division will have one story covered per year on the basis of five patient stories per year
- Consent will be required from the patient referred to in the story
- The Chief Nurse will be responsible for the patient story programme
- Trust board members will be encouraged to listen to patient stories with the intent to understand. It is recognised that some patient stories may evoke anxiety
- It is recommended that the Trust board will write to the patient or family to thank them for their contribution and outline, if any, steps being taken to address any concerns
- A guideline will be developed to support patients, divisional colleagues and the board to manage this effectively

Methodology

At Divisional level:

- The Divisional Triumvirates will be asked to attend the Board if the story relates to their division. Participation will be instrumental in helping to facilitate the session, respond to board members queries to the stories they hear, and help the Trust board identify the actions and learning from the story
- The Cancer division has already agreed to take the lead and present at the first Trust Board meeting once this process has been approved by the Board
- Divisions can choose any approach to identify a suitable patient or patient story to discuss. The intention is to have stories that reflect both positive and negative experiences
- Possible reasons for finding a patient story could include:
    1. Patients who have received care from a service
    2. Following incidents, compliments or complaints
    3. Suggestions from clinical or operational management staff
- The division will be responsible for reviewing action plans, if any, following the patient story. A copy of the plans will be shared with the patient experience lead

Methods of Presentation

There are multiple methods in which patient stories can be presented, these include

- Staff presenting a particular story relating to one of their patients
- Reading patient letters or written feedback,
- Thematic presentation of patient experiences
- Patients presenting in person/ via video link
- Patient audios / films

Stages of the Process

Divisional teams will be supported by the patient experience team and guidance will be provided on the key stages of this process:

- Identifying the patient
- Preparation for the Story
- The day at the Board
- After the Board

After the story

The Trust board may wish to consider the following areas/questions for further discussion:

- What additional support do board members need in hearing patient stories?
- Has the story evoked anxieties that members wish to talk through outside of the meeting?
- What does this story reveal about Trust staff?
- What does the story suggest about morale and organisational culture?
- What does the story reveal about the context in which clinicians work?
- How does the story relate to the information contained in the Trust's quality or performance reports?
- What does this story tell the board about progress towards quality improvement goals?
- What additional information does the board require to help it make sense of the story / put it in context?

Proposed draft schedule 2024

Month	Division
March	Cancer
May	Core Clinical Services
July	Medicine and Emergency Care
September	Surgery
November	Women's, Children and Sexual Health

References

- *Using stories to improve patient, carer and staff experiences and outcomes*, 2015, available at: https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/09/scht-storytelling-toolkit.pdf
- Creating a revolution in patient and customer service experience: Using patient Stories, 2015, available at: https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/08/using-patient-stories.pdf
- *Patient Stories (Trust Board Papers)*, 2023, The Leeds Teaching Hospitals, available at: https://www.leedsth.nhs.uk/patients-visitors/patient-and-visitor-information/patient-experience/involving-people/listening-to-our-patients/patient-stories/
- *Leadership for safety: 'how to guide' supplement using patient stories with board*, available at: https://qi.elft.nhs.uk/resource/using-patient-stories-with-boards/

NHS Maidstone and Tunbridge Wells NHS Trust

Review of the initial response to findings of the Care Quality Commission (CQC) inspection of the Trust's Maternity Services	**Chief Nurse**

The enclosed report provides the Trust Board with information related to the Maternity inspections that were carried out in August & November 2023, at the Tunbridge Wells site and Birth Centres. These inspections were part of the National Maternity CQC inspection programme, which focuses on two of the CQC domains – safe and well led.

An update on progress made in relation to the Section 29A CQC Warning Notice is provided within this report, with an update on the must do's and should do's alongside an overview of current improvement activity.

The report also outlines the resourcing challenges associated with delivering the required improvement whilst also delivering the Three-year plan for maternity and neonatal services

The Full CQC Maternity Reports are appended for information, which received the below ratings, and can be found at found on CQC website (https://www.cqc.org.uk/provider/RWF)

- Tunbridge Wells Hospital, Inadequate overall rating
- Maidstone Birth Centre, Requires Improvement overall rating
- Crowborough Birth Centre, Requires Improvement overall rating

The embedded documents, as described under appendices A – E, are available, to members of the public, upon request from the Trust Secretary's Office and have been uploaded to the "Documents" section of AdminControl (the Trust's board portal software) for Trust Board members.

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

- Executive Team Meeting, 20/02/24

Reason for submission to the Trust 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

Introduction

As part of their national maternity inspection programme, inspectors from the Care Quality Commission visited the Tunbridge Wells Maternity Services in August 2023 and the Birth Centres in November 2023. This programme aims to give an up to date view of hospital maternity care across the country, to understand what is working well and also to support learning and improvement at a local and national level. The inspections across the country have focused on two of the five CQC domains, safe and well-led.

Background

- Our three maternity sites were each inspected and rated individually, Maternity services at Tunbridge Wells Hospital (TWH) being rated 'inadequate', with Maidstone Birth Centre and Crowborough Birth Centre both being rated as 'requires improvement'.

	Safe	Well-led	Overall
Tunbridge Wells Hospital	Inadequate	Requires improvement	Inadequate
Maidstone	Requires improvement	Requires improvement	Requires improvement
Crowborough	Requires improvement	Requires improvement	Requires improvement

- The CQC also issued maternity services at TWH with a section 29a warning notice in late October 2023. This notice required the service to make significant improvements in five key areas. Work to make the necessary improvements commenced in November 2023. 26 key actions were identified, with the majority of these actions having now been addressed.
- The reports were published by the CQC on 16th February 2024. The Trust developed a comprehensive communications plan prior to the publication date that ensured service users, staff and other key stakeholders were aware of the improvement actions that have been taken to address the concerns.
- The trust accepts the findings of all the CQC inspections and has comprehensive action plans in place to address the concerns identified.
- Our priority continues to be the provision of safe and effective care for our service users and this is backed up by the CQC's own Maternity Survey results published on 9 February 2024, which identified MTW as one of just eight trusts nationally that exceeded service user expectations.
- The full reports can be found in Appendices A - C.

Inspection findings

A section 29A warning notice was issued on 31 October 2023 following the inspection of maternity services at to TWH in August 2023. The concerns raised are listed below:

1. The service does not have effective governance processes or accurate data collection to monitor, gain assurance and work to reduce the incidence and severity of post-partum haemorrhage (PPH)
2. The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for women, birthing people and babies.
3. The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored.
4. The service does not reduce the risks to women, birthing people waiting for induction of labour putting them at risk of harm.
5. The service does not always provide timely emergency caesarean sections putting women, birthing people, and babies at risk of harm.

Service Response

Following receipt of the 29a Warning notice an Improvement programme was urgently mobilised, with the employment of an improvement advisor. This postholder has been key in supporting the clinical leads from obstetrics and midwifery with the development and delivery of the required improvements.

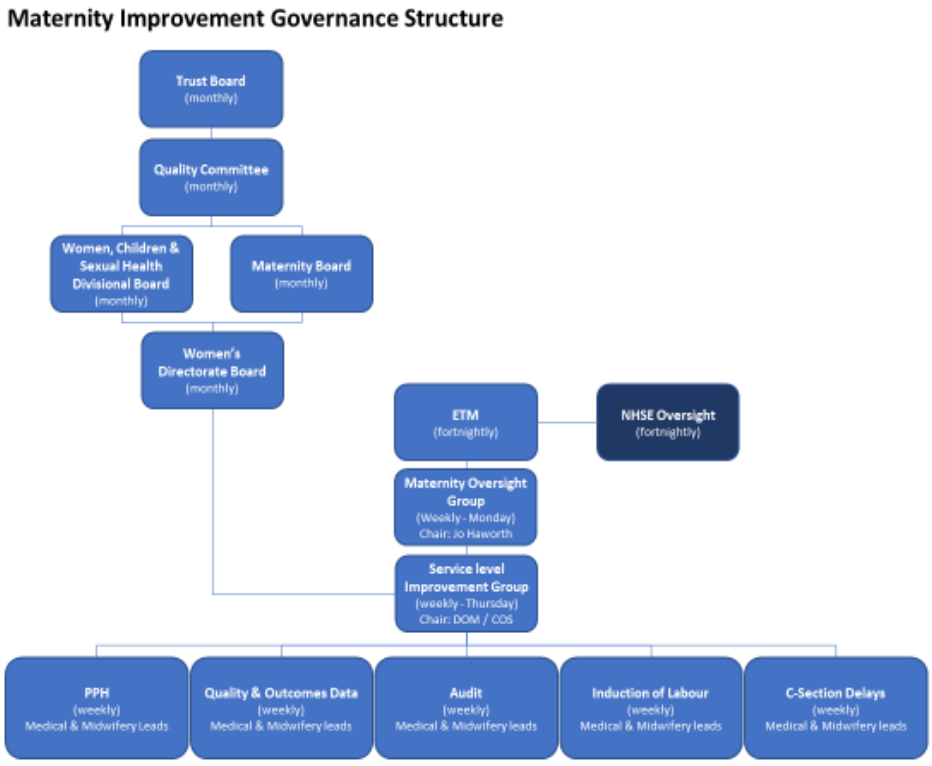
Oversight of the improvement implementation has been established through a weekly operational meeting, which supports delivery of the identified actions. The outputs of this meeting then report into a weekly Maternity Improvement Oversight Group, chaired by the Chief Nurse. The group receives clear reporting in respect of performance against agreed timescales and escalation of any challenges or concerns.

In addition, the trust is supported by external colleagues from NHSE, ICB and the Local Maternity and Neonatal System through fortnightly Maternity Oversight Meetings and site visits, which have been in place since December 2023.

The maternity service created 26 actions to address the concerns outlined in the 29a warning notice. However, following receipt of the full reports, the focus of some of the initial actions have now been expanded.

Going forward, reporting will be inclusive of the 29A warning notice concerns and the service response to the 'must do's' and 'should do's' in the respective inspection reports.

29A Notice Improvement Programme Governance structure



This reporting structure is currently under review. This is in response to the wider aspects of the CQC reports and the improvements required to meet the Three-year plan for maternity and neonatal services.

Progress against warning notice actions

The table below provides a comprehensive overview of the current status of the actions being taken to address the concerns

Maternity CQC action plan	Dec	Jan	Feb	Comments
29A Warning Notice Actions – significant progress				
Complete	**2**	**15**	**17**	Breached timescales relate to audit and it has been agreed to extend the timeline to the end of March 2024 and there is an ongoing conversation about additional resources
On track and on time	**23**	**11**	**3**	
Breached but progressing	**1**	**0**	**6**	
Breached at risk	**0**	**0**	**0**	

As a result of the completed actions the following improvements have been noted in January 2024:

Post-partum haemorrhage:

- January 2024 PPH > 1500ml Rate = 1.5% (national average 3.0)
- No PPH >1500mls related to operative delivery
- 91% of maternity staff compliant with MDT clinical skills training
- 100% PPH > 1500 ml incidents reported
- 100% of PPH reviews completed
- Dashboard PPH metric aligned to national rate

Governance and Audit

- 100% planned monthly reporting of dashboard and PQSM report achieved
- Maternity dashboard metrics updated to align with national KPIs
- Monthly PPH audit commenced
- Local spot checks in place to support risk assessment of induction of labour delays
- Emergency caesarean section audit commenced

Induction of Labour

- 84% compliance with use of new risk assessment tool and escalation for women experiencing delays in induction of labour
- IOL policy updated to include pathway for delays and escalation – awaiting ratification
- On-going audit of induction of labour commenced
- Data relating to IOL and delays reported on the maternity dashboard
- IOL delays added to Care Pathway Coordinator status updates and Site reports

Caesarean sections

- C-section delays data extracted from MIS to demonstrate trends on maternity dashboard

Further details of the desired outcomes, key performance indicators, plans for monitoring and the current position are detailed in Appendix D and E. The work to identify relevant outcome KPIs which provide assurance is ongoing, and being supported by the Patient Safety team, who are in the process of developing a digitalised dashboard to support oversight

Progress against the actions associated with the 29A warning notice and 'must do's and should do's will continue to be monitored and reported alongside the wider improvement plan.

Improvement Programme Resourcing

In recognising the importance and scale of the improvement work required to address the CQC concerns, the trust has supported the initial response to the 29A warning notice with additional resources, which has included:

- Interim Maternity Improvement Programme Lead Midwife – 1wte
- PMO Business Partner – 0.5wte
- Maternity Improvement Director – 0.4wte
- Additional Consultant time to support the risk team and delivery of the action plan

It is recognised that service leads and staff are key to delivering the overarching improvements and will have specific roles in leading key areas of work. This will inevitably increase the existing demands experienced by clinicians of all disciplines within maternity services. Therefore, an evaluation of resource requirements is currently being undertaken, and will outline the resources required to deliver the improvement programme alongside regular operational activity.

Maternity Site Based CQC Inspection Ratings

The maternity services received separate reports for each site. The reports for each site contain similar themes and are where appropriate being addressed as an improvement theme across all sites.

The ratings are as below:

	Must do	Should do
Tunbridge Wells Hospital	6	4
Maidstone	5	5
Crowborough	4	6

‘Must do and Should do’ Actions

The service has developed a draft overarching action plan to respond to the “Must do’s” and “Should do’s” identified in all the reports across the service, which can be dis-aggregated for reporting for each site.

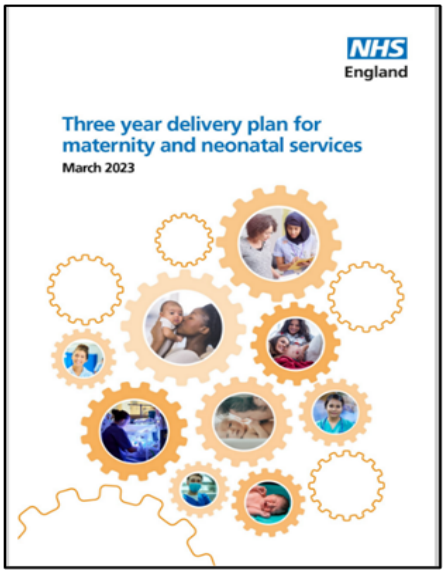
The improvement areas identified are:

Improvement area	Number of milestones identified	Current activities
Safe systems and processes for maternity triage	3	13
Robust medicines management	1	4
All women birthing at the stand-alone birth units should be added to the electronic maternity booking system	1	4
Women wishing to birth at the stand-alone birthing units will be accurately risk assessed for suitability	2	4
Safe clinical environment to underpin safe care and good patient experience	1	5
Enhance local systems to identify safety issues and support effecting learning to prevent recurrence	6	34
Develop systems that will better detect and mobilise responses to safety issues (e.g. sepsis, identification of deteriorating patient etc.)	6	29
Ensure staff understand the vision and values relating to the service and are supported to apply them to their work	1	2
Ensure staff have ongoing training to underpin effective technical skills to support maintain safe outcomes	3	11
The service must ensure there are sufficient number of suitably qualified midwives	4	17

Many of these activities have ongoing work and the maternity improvement programme team will be working with clinicians to agree specific actions, timescales and resource requirements for the wider improvements identified.

There is a robust communications plan which details a variety of methods of communication and engagement events to ensure that all staff are able to contribute to the improvement programme activities.

As part of the development of the Maternity Improvement Programme, the service has also reviewed the requirements of the Three-year plan for maternity and neonatal services. Actions required to meet the requirement of the Three-year delivery plan for maternity and neonatal services will be incorporated, to ensure there is a clear vision for future services.



Conclusion

This report provides assurance in regards to the actions being taken to address concerns raised in the three CQC maternity reports received by the Trust. Good progress is being made to deliver the required improvements, however the main risk to delivery at present, is the current resource available. As noted additional resource has been provided to mitigate this on an interim basis and a review of workforce is being undertaken to identify the long term requirements.

Appendices

Appendix A Tunbridge Wells Hospital CQC Report

20240206 The Tunbridge Wells Ho

Appendix B Crowborough Birth Centre CQC Report

20240206 Crowborough Birthi

Appendix C Maidstone Birth Centre CQC Report

20240206 Maidstone Hospital

Appendix D Key performance indicators and the current position

Maternity Improvement Progra

Appendix E Response to CQC Warning Notice (NHSE/LMNS presentation)

Response to warning notice.pptx

NHS Maidstone and Tunbridge Wells NHS Trust

Maternity Establishment review **Chief Nurse**

This report outlines the outputs and recommendations of the annual Midwifery establishment review and describes the current Trust wide Nursing and Midwifery staffing position and Midwifery staffing position.

The annual establishment review followed the format used in 2022, and was completed during November 2023 to ensure that there are the correct Midwifery staffing and skill mix to meet the needs of patients.

This reviewed all Midwifery clinical areas within the Trust, including antenatal clinics, postnatal ward, community services, delivery suite and both birthing centres (Crowborough and Maidstone).

The establishment review cycle is aligned with business planning taking into consideration any proposed workforce changes the recommendations of which are included in this report.

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

- Midwifery Board 21/02/24
- ETM 27/02/24

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

Information, assurance and decision

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

Nursing and Midwifery Staff Review (Annual review)

Midwifery Services

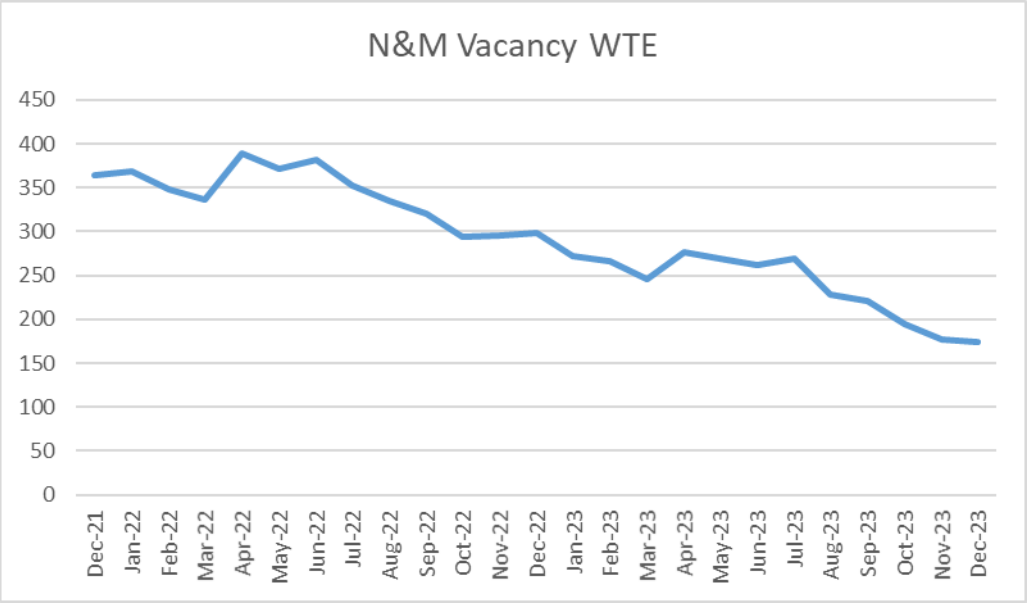
Introduction

This report presents a full annual review of the Midwifery workforce to assure the Board and the public regarding Midwifery safe staffing levels. In line with the Nursing and Midwifery Staff Review presented to the Board in December 2023, this is an additional separate report reviewing the maternity workforce as further work and consideration was required to ensure all CQC recommendations are met. The establishment reviews were undertaken in November 2023.

Current Nursing and Midwifery staff position- Trust wide

Registered Nursing & Midwifery Vacancies have reduced to 174.5 wte, resulting in an improved vacancy rate of 8.1% Currently, there are 72 wte IENs that are pending completion of the OSCE exam and subsequent Nursing and Midwifery Council (NMC) pin. Following receipt of their pin, vacancies will reduce to 103.5 wte. The current vacancy rate is 7.5 %.

Figure 1: Registered Nursing & Midwifery Vacancies (WTE)



Midwifery Staff position

The latest data (January 2024) demonstrates 16.9 wte vacancy with a current total establishment of 241.9 wte (figure 2) which equates to a vacancy rate of 7.0%. Compared to a year ago this is an increase of 2.7 wte however having reached the highest vacancy rate in July 2023 there has since been a positive improvement. The turnover rate currently sits at 10.4% and has steady decreased (figure 3).

The highest number of vacancies are in the Midwifery Services at Tunbridge wells which equates to 9.5 wte closely followed by the Community Midwifery Team (Tunbridge Wells) at 6.6 wte (figure 3).

Figure 2 Midwifery vacancies WTE

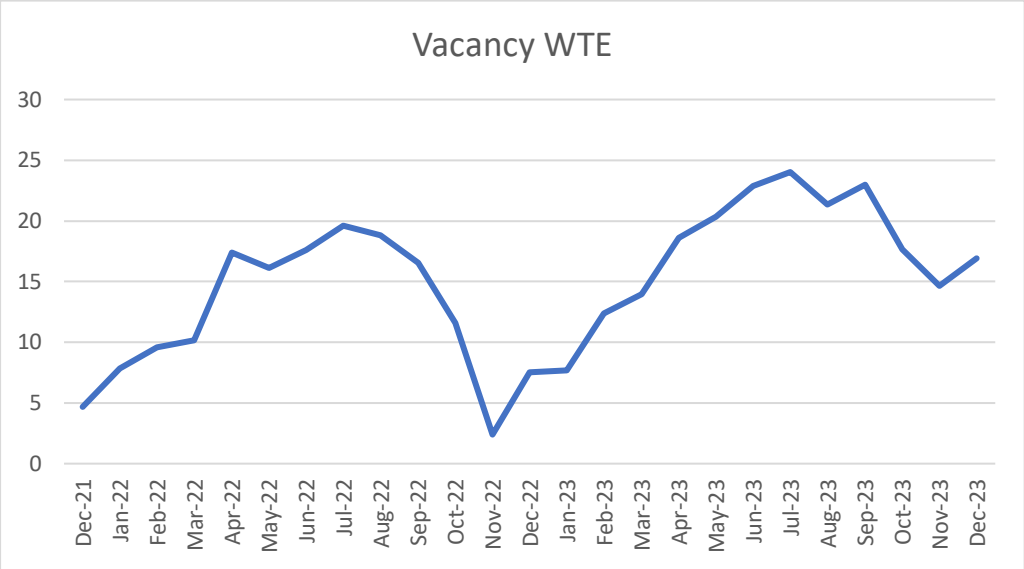


Figure 3 Midwifery turnover rate

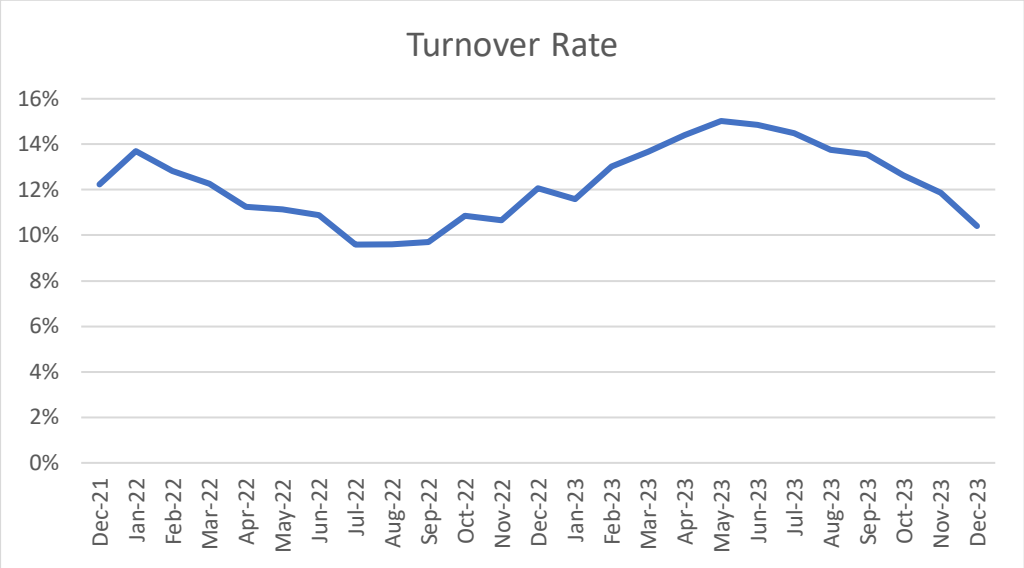


Figure 4 Areas with the highest Vacancies within Midwifery

Areas with highest vacancies WTE		**Areas with highest vacancies %**
Midwifery Services (TW)	9.5 wte	5.2%
Community Midwifery Services (TW)	6.6 wte	10.7%
Crowborough Birth Centre (CBC)	4.8 wte	19.2%
Community Midwifery Services (M)	0.8 wte	34.8%

Annual Establishment Review

The annual establishment review cycle was revised in 2022 to ensure alignment with the business planning cycle. Reviews for 2023 where were carried out using methodologies set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the Developing Workforce Safeguards (2018): using a triangulated approach to ensure the use of:

- Evidence based tools (where they exist)
- Professional Judgement
- Based on patients' needs, acuity, dependency and risks.

In line with RCM recommendations a systematic assessment of workforce requirements was implemented in June 2023 through the use of the Birthrate Plus® methodology the results of this were shared with the Maternity Board in November 2023. In summary it highlights that the case mix of difficult cases has increased, which is inline with national trend. In addition it notes that further work is required to review the headroom percentage uplift. This work will be undertaken between the division and corporate safe staffing team throughout 2024/25.

Key Recommendations of Workforce Changes following Establishment Review

The establishment review of each department within Midwifery was undertaken to ensure there are safe, effective and consistent establishments.

As noted previously, the recommendations of the 2022 establishment review were accepted and approved by the Trust Board and ICB in November 2023. Implementation of these recommendations (additional roles) is underway.

The subsequent recommendations have been made following the 2023 review and have been prioritised based on safety. The majority of the remaining additional requirements are recommended to be taken forward within the Division either via business planning, as these increased requirements are related to increases in activity or as part of the service review following on from the recent CQC inspection.

As in previous years the same methodology has been applied and these recommendations have been reviewed and prioritised by the Chief Nurse, Deputy Chief Nurse for Workforce and Education and Director of Midwifery. These have been split into four categories; recommended change safer staffing, Divisional lead high priority following on from safer staffing and service review, divisional review and on hold.

Women Children's & Sexual Health Division

Maternity

Area	Band	Recommended change safer staffing
Maidstone Birth Centre	7	Additional 0.5 WTE Band 7 for management
Community Midwifery	6	Additional 8 WTE band 6 to meet increase demand of service
Community Midwifery	7	Additional 1 WTE band 7 team lead
Postnatal	2	Additional WTE band 2 MSW on LD (2.71 WTE)
Postnatal	2	Additional WTE band 2 MSW on N (2.71WTE)
		Total 14.92 WTE

Area	Band	Recommend Change – Division to Lead
Antenatal Clinic:	7	Out of area Midwife
Antenatal Clinic	6	Cultural Safety Midwife
Antenatal Clinic	6/7	1 WTE RM for diabetes service
Antenatal Clinic	6/7	1 wte Registered midwife for Mental Health
Antenatal & Maternity Day Assessment Unit	7	Additional 1 WTE Band 7 Team Leader
Crowborough Birthing Centre	6	Additional 2.71 WTE band 6 LD, 7 days a week
Crowborough Birthing Centre	3	Increase MSW by 0.4 WTE to cover breast feeding café and GTT
Delivery Suite	7	Additional 0.5 WTE band 7 management to cover 8-6
Delivery Suite	6	1 WTE band 6 for elective section list
Postnatal	3	Additional 2.71 WTE band 4 in increase feeding service 08:00-22:00 7 days
Postnatal	7	Increase to 0.8 WTE band 7 for transitional care
Total		**13.12 WTE**

Area	Band	Division to consider with activity plans and on Hold
Delivery Suite	6	Additional 4.15 WTE band 6 for 24/7 care
Postnatel	4	Additional 1.69 WTE band 3 discharge coordinator 7 days a week
Postnatal	7	0.8 WTE band 7 for tongue tie service
Antenatal & Maternity Day Assessment Unit	3	Additional 2.24 WTE B3 MSW (8-8 service 7 days a week)
Antenatal & Maternity Day Assessment Unit	6	Additional 2.24 WTE B5/6 (8-8 service 7 days a week)
Total		**11.12 WTE**

In light of the recent CQC inspection and subsequent recommendations the division are preparing a business case for the Recommend change- Division to lead posts. It is the recommendation of this paper to include the recommended change safer staffing posts to be included as part of the divisional business case to ensure a consistence approach.

Conclusion

Following the 2023 establishment review, it is recommended that there is an increase of 14.92 WTE to ensure safety in the areas outlined above. In line with the recommendations of this paper it is recognised that in the current financial position further analysis is required to understand how these recommendations can be fully implemented. Therefore, next steps inclusive of the development of a business case would include a review of current skill mix, long term vacancies and analysis of temporary staffing spend.

A process for monitoring implementation will be agreed between the Corporate Nursing team and Finance, regarding recommendations associated with divisional business planning, where agreements are made.

Significant work has been undertaken over the last year in regard to the midwifery workforce to support safe staffing, further work is planned to embed this in 2024/2025

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Trust Board's High Impact equality, diversity and inclusion (EDI) objectives — **Chief People Officer**

Summary / Key points

On the 8th June 2023 the NHSE EDI Improvement Plan was launched, based on the NHS People Plan and the People Promise six high impact actions were identified.

High Impact Action 1: CEO, Chair and board members to have SMART objectives by March 2024. In response to the leadership responsibility of the Trust Board a development session was facilitated in September and a number of key actions have taken place since. The presentation for the session is attached for reference.

The Trust EDI Steering Board has now been established and is chaired by the Chief People Officer and attended by a cross representation from the Trust and also has attendance from the NEDs and other trust board members.

The delivery against the EDI Strategy are tracked and monitored at the Steering Board as well as key updates from all network groups, presentations from divisions on innovations and initiatives that have been introduced in response to improvements for staff and/or patient experience, as well as key updates on corporate and system level projects.

The EDI Steering Board reports formally to the Executive Team and also links through to formal reporting to the People and Organisational Development Committee on key areas of delivery such as WRES and WDES reporting and gender pay gap.

This paper is presented to bring together the feedback from the Trust Board development event, with some reflections from discussions at the EDI steering board and presents proposals for high impact objectives for each board member to individually and/or collectively promote.

The following suggestions have been developed from the feedback for the Trust Board to establish personal and group objectives.

Trust Board Collective Objectives:

To strengthen the process to review 'Equality Impact Assessments' an Equality Impact Assessment (EIA) is a systematic process used to assess how policies, procedures, services, and decisions may affect people differently based on their characteristics such as age, disability, gender, race, religion, sexual orientation, or socioeconomic status. The purpose of conducting an EIA is to ensure that the NHS upholds its commitment to equality and diversity, and that its actions do not unintentionally discriminate against any particular group or perpetuate existing inequalities.

To consider the development of a 'shadow board' - shadow boards in the NHS are typically created to provide a platform for aspiring leaders, particularly from underrepresented groups, to gain experience and exposure to the workings of NHS leadership roles. These boards are designed to mimic the structure and function of real boards within the NHS, allowing members to engage in decision-making processes, strategic planning, and policy development under the guidance of experienced mentors.

Develop a Trust Board programme for unconscious bias training to raise awareness and address the unconscious biases that individuals may hold, which can influence their perceptions, decisions, and behaviours towards others. Unconscious biases are implicit preferences or

stereotypes that people may unknowingly hold based on characteristics such as race, gender, age, ethnicity, sexual orientation, or disability.

To ensure diverse representation at all levels of leadership within the Trust - implementing robust data collection mechanisms to track diversity metrics, setting ambitious but achievable targets for increasing representation of underrepresented groups with clear timelines and accountability measures. Reviewing and revising recruitment and selection processes to minimise biases and promote diversity, such as using diverse panels for interviews and incorporating competency-based assessments.

Individual Objectives

Become an ally and champion for a network group in the Trust – this could include attending network events, sharing experience and mentoring experience and understanding the lived experience of people from an underrepresented group.

Be a member of the reverse-mentoring programme providing a platform for individuals from underrepresented groups or different backgrounds to share their perspectives and experiences with senior leaders, fostering greater understanding and empathy.

Increase personal understanding of diversity issues by attending workshops, seminars, or training sessions on topics such as unconscious bias, cultural competency, and inclusive leadership.

Conduct regular assessments of team composition and culture to identify areas for improvement and track progress over time. Use feedback from team members to inform initiatives aimed at promoting diversity and inclusion.

Recognise and celebrate the diversity of team members through events, newsletters, and other communications. This helps create a sense of belonging and fosters a positive team culture where everyone feels valued and respected.

Determine a personal objective which is agreed and documented to deliver over the year 2024/25.

The Trust Board are requested to feedback on the objectives and agree:

(1) A Trust board objective
(2) For each Trust Board member to reflect and set their own personal objective to be reviewed over 2024/25.
(3) To agree areas of further EDI development for the Trust Board.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 20th February 2024
People and Organisational Development Committee, 23rd February 2024

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

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

MTW Trust Board

September 2023

Making EDI Everyone's Business

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Time	Topic	
2.00pm	Welcome and introduction – 5 mins	**Sue Steen**
2.05pm	Leadership responsibility – 5 mins	**Sue Steen**
2.10pm	Why EDI is good for your health – 5 mins	**Jo Taylor**
2.15pm	Making EDI a Board priority – 5 mins	**Group discussion**
2.20pm	Hitting the Headlines – 10 mins	**Jo Taylor**
2.40pm	Case study - 20 mins	**Small group discussion and feedback**
3.00pm	MTW Key Priorities – 10 mins	**Sue Steen**
3.10pm	Board objectives – 20 mins	**Small group discussion and feedback**
3.50pm	Round up and close – 10 mins	**Sue Steen**

Welcome and Introduction

"The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms"

NHS People Plan 2020

Leadership Responsibility for the Trust Board

- Engaging in the reality of the challenges we face as a provider and the communities we serve
- Developing the critical connection between EDI and our core business, quality healthcare for all and national NHS strategic drivers such as the NHS England EDI Improvement Plan
- Increasing Board competence and confidence in individual and collective ability to lead on embedding EDI within MTW
- Reflecting the communities that you serve and the workforce you govern

NHS England EDI Improvement Plan

- On 8 June 2023, the NHS's first EDI improvement plan was launched. Based on the NHS People Plan and the People Promise and using the latest data and evidence, six high impact actions have been identified.

High Impact Action 1 : CEO, Chair and board members have SMART objectives

- SMART objectives assessed by March 2024
- Board to demonstrate how organisational data and lived experience have been used to improve culture by March 2025
- Boards review data to establish EDI areas of concern and prioritise actions by March 2024

Why EDI is good for your health

Health inequalities – "avoidable, unfair and systematic differences in health between different groups of people"

- Health status
- Access to care
- Quality and experience of care
- Behavioural risks to health
- Wider determinants of health

Black women are at a **greater risk of late cancer diagnosis** compared to white women

Black women are **4 times more likely to die** in childbirth than their white counterparts

(ONS data)

1 in 6 LGBT+ people **drank alcohol almost every** day (compared to 1 in 10 general population)

1 in 5 lesbian women who had not have cervical screening have been told by a health worker **they are not at risk and 1 in 50 have been refused screening**

(LGBT Foundation)

On average, the life expectancy of women with a learning disability is **18 years shorter** than for women in the general population – for men it is **14 years shorter**

Disable people are **3 times more likely** to be denied health care

(W.H.O)

Public Health Outcomes Framework - OHID (phe.org.uk)

Why EDI is good for your health

- **Innovation and problem solving** – approaching challenges from multiple angles, leading to novel solutions
- **Staff satisfaction and retention** – staff feel valued and respected for their unique contributions are more likely to be committed to their roles and the organisation

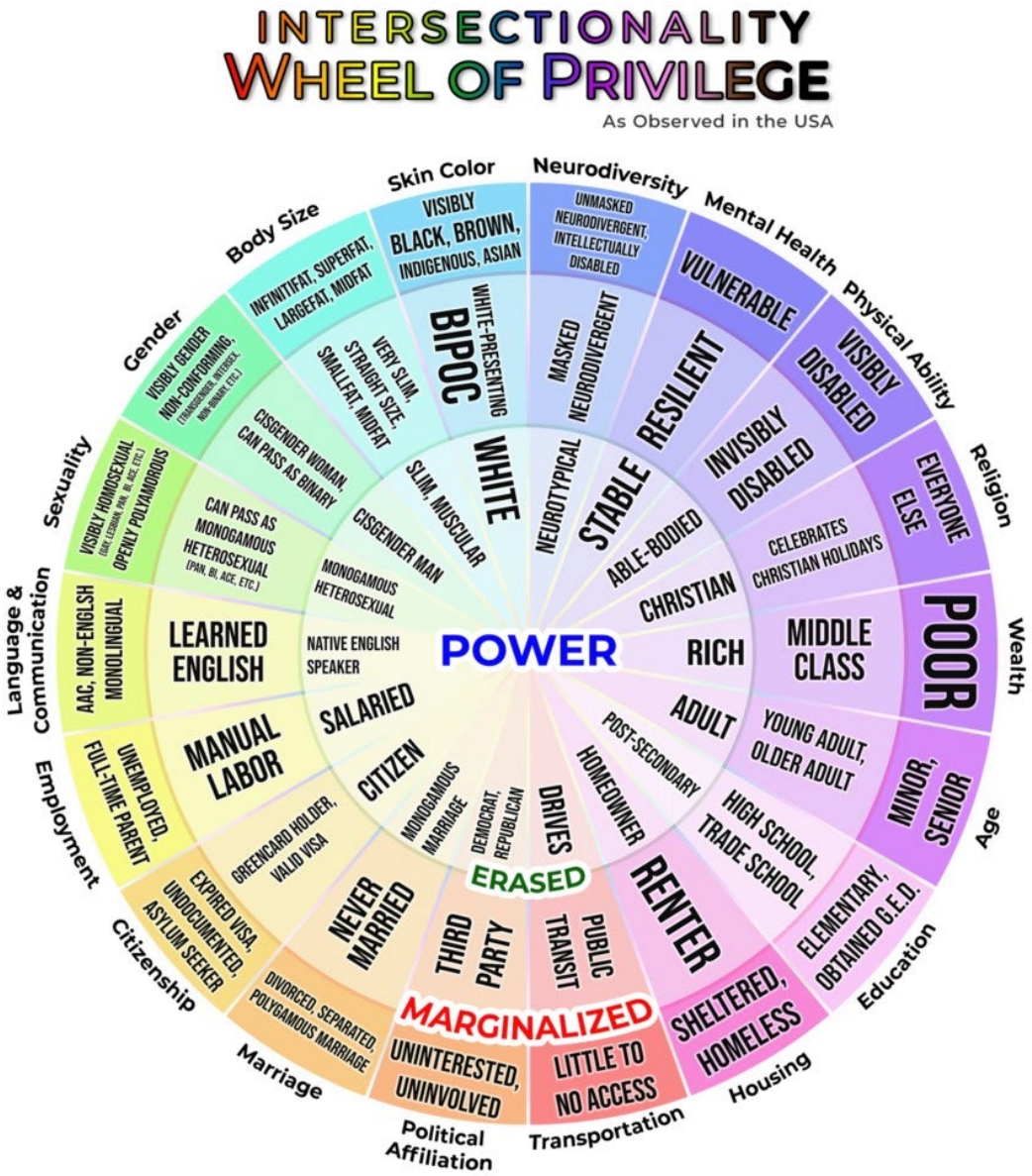
The Gender Equity Collective - Business case for greater board diversity demonstrates:

Profitability increased by 36%	Brand image up to 83%	Talent attraction at 76%	Innovation at 19%	Market responsiveness 70%

Employee retention (3.2 times more likely to retain staff)

Making EDI a Board priority

Privilege – “a special right, advantage, or immunity granted or available only to a particular person or group”



The Legal Framework for Equality in the UK

Equality legislation in the UK is primarily governed by the Equality Act 2010, which is a comprehensive piece of legislation that consolidates and strengthens previous equality laws. The Act covers a wide range of protected characteristics and aims to promote equality and eliminate discrimination in various areas of life, including employment, education, housing, and the provision of goods and services

Protected Characteristics: The Equality Act 2010 identifies nine protected characteristics, which are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Hitting the headlines

Cox v NHS England

Introduction

- Succeeds in direct race discrimination, harassment, victimisation and whistleblowing claims
- Cox was Continuing Healthcare Manager at 8B and a black woman
- Head of Continuing Healthcare, Director of Intensive Support and former Director of Nursing and Deputy Chief Nurse all gave evidence (5 witnesses in total including Cox) at 7-day hearing
- Manchester ET gave Judgment on 15 January 2023 after 3 days of deliberations

Allegations Upheld

- Exclusion of C from team away day and team event by scheduling them initially for times when C could not attend (not alleged whistleblowing)
- Not informing C that one of her team members had been promoted/acting up as a Band 8B
- Manager discussing C's mental health with one of C's team members (during which she encouraged Ms Luff to report concerns re C)
- Excluding C from recruitment for the new Band 8A posts that would have been part of her team
- The findings of the grievance outcome
- Failing to uphold C's grievance appeal

Hitting the headlines

Cox v NHS England

Additional Findings

- In "*the first version of the report … the surnames of the only 2 black nurses in the respondent were mixed up … which the claimant cites as disappointing, hurtful and humiliating further evidence of her experience in the workplace*"
- Email emerged re recruitment issue showing C's manager "*misleading and untruthful*"
- *"The Tribunal noted the lack of diversity in general at the respondent and in senior positions*"
- Reference to C eating bananas at meeting: "*shockingly poor example to give … it is a common metaphor and/or pejorative term used in relation to C's racial group and illuminative of the possibility of subconscious discrimination*"

Themes

- Investigation: "*The report from Dr Khan's investigation was compiled by the respondent's HR, due to Dr Khan's busyness at the time*"
- Grievance outcome: "*failed to deal with all the material issues raised nor set out its reasoning and instead was superficial … it simply reproduced large parts of the investigation report and then stated that a "case management review" had agreed with a number of conclusions*".
- "*does not address the underlying issue of race discrimination which C had specifically raised. Nor does the letter specifically state whether the grievance has been upheld or not"*

Hitting the headlines

Cox v NHS England

Themes

- *"any possibility of race discrimination is not addressed beyond a short statement to the effect that there was no evidence of any actions or behaviours having been deliberate or a deliberate attempt to discriminate against the claimant on grounds of race.* ***The Tribunal considered this … woefully inadequate – it fails to consider or address whether certain actions may have been subconscious bias or racially motivated".***
- *"no attempt to examine whether there was any pattern of behaviour…Nor did the grievance outcome draw any inferences from the material before it, instead setting a high bar, namely that it needed to see "deliberate" discrimination*".
- Appeal: "*The conclusions say that C has been negatively impacted by poor management and behaviour decisions.* ***There is then no attempt to examine the behaviour concerns identified or the reasons for it.***
- *"ET considered that … the grievance outcome was not effectively actioned and this failure …negated the purpose of the grievance process. When asked to explain this omission, Ms G told the ET that it was not within her remit and that feedback to Ms P was the responsibility of HR. It was apparent from the evidence that such feedback had never taken place"*.
- *"the outcome served as a way of placating C whilst failing to deal with the issue of discrimination*".

Hitting the headlines

Akinmeji v East Kent Hospitals University NHS FT

Introduction

- Akinmeji brought claims of direct race discrimination and victimisation – some claims were upheld, some were dismissed
- A was employed by the Respondent as an midwife (Band 6) between March 2018 and January 2020. She is black.
- 9 witnesses, in addition to the claimant, gave evidence at a 7 day hearing
- Ashford ET gave judgment on 12 October 2022

Factual Allegations

- Discrimination but out of time:
  - colleague asking C not to go near her patients
  - colleague stating to C: *"nobody likes you or wants you here"*
  - colleague telling the claimant that her help was not needed when they worked together
- Race discrimination/victimisation:
  - colleague stating to staff members "*its Kemi's last day everyone check your bags*" and repeating this in the hallway
- Majority of complaints not upheld but…
  - "*The evidence we heard reflected a toxic and difficult working environment generally where the claimant and colleagues were shouted and sworn at over differences of professional opinion*."

Hitting the headlines

Akinmeji v East Kent Hospitals University NHS FT

Themes

- Direct race discrimination complaints upheld
- Toxic culture well known and tolerated - nothing proactive done to break the cycle
- KC's treatment of A - "*the claimant's race was at least part of the reason for this treatment, consciously or unconsciously.*"
- KC's comment - "*extremely offensive", "It is not credible that this comment was made lightheartedly", "We find it more likely than not that she was motivated consciously or unconsciously by the claimant's race*."
- ET acknowledged that this was an unusual case with A relying on matters which she did not believe were race discrimination at the time but only with hindsight
- No "*direct apology [from KC], even though [A] expressly requested one*"
- "*There was no formal investigation by someone outside the department as the respondent had indicated was required, despite the claimant making clear she did want an investigation and found the account being given to be inadequate*"
- "[*A] was given a false explanation of what the respondent had done in consequence of her complaint. She was told [KC] had done unconscious bias training and reflected on her actions and had been warned about the possibility of disciplinary action if she repeated such conduct. The only unconscious bias training organised had been in response to an earlier grievance by another colleague. [KC] had not even attended it. She was not warned about any possible disciplinary action. She had been spoken to in order to get her account and that was all*."

Hitting the headlines

Walsh v London Borough of Islington

Disability Discrimination

- Claimant had Crohn's disease, made flexible working to reduce from full time to 2.5-3 days per week and slightly alter hours
- Request refused and suggestion of job-sharing rejected
- Disability referred to in request and OH advice recommended part time hours
- Tribunal found 3 days a week a reasonable adjustment
- Outcome – flexible working request supported and financial settlement

King v Tesco

- Submitted request for flexible working
- Had difficulty having the request received by an appropriate manager
- Request took 4.5 months to action
- At meeting, request declined outcome was predetermined (meeting set to "deliver the outcome")
- No appeal option given (part of company policy)
- Awarded compensatory award AND reconsideration of request – tribunal scathing of senior managers who appeared to have no/little knowledge of the flexible working policy

Hitting the headlines

Oliver McGowan

An avoidable death

- Oliver was born prematurely and developed bacterial meningitis at three weeks of age followed by a second episode of meningitis
- Oliver was left with mild hemiplegia, focal partial epilepsy, a mild learning disability and, later on, a diagnosis of high functioning autism
- He was expected to live an independent life with little support
- In October 15 Oliver was admitted to a children's hospital with partial focal seizures and was prescribed anti depressants though the family didn't feel this appropriate
- This affected his mood and increased his seizures and he was admitted and given antipsychotic medications – there was no diagnosis of psychosis or mental illness
- Oliver's seizures threshold and agitation deteriorated and he was held against his will under the mental health Act for assessment. His parents challenged the staff and his anti psychotic medication were removed and within days he was back to normal.
- In April Oliver was re-admitted to the same hospital with partial seizures and given anti psychotic medication – he began to hallucinate, had up to 30 seizures a day, problems urinating, extreme high blood pressure, sweating.
- It began obvious to Oliver's parents that the doctors and nurses had little to no understanding of autism and how autistic behaviours could present in a person with ongoing seizure.

Hitting the headlines

Oliver McGowan

An avoidable death

- At the request of his parents, Oliver was transferred to a specialist adult hospital but they were intolerant of his autistic and learning disabled behaviours and had no understanding of sensory crisis or overload. They refused to take any direction from the parents or the LD nurse.
- Physical restraint was increased and Oliver was not allowed privacy with his personal care and was kept in a darkened room.
- He was given different anti psychotic medications and detained against his will under section 2 for assessment and transferred to a specialist mental health PICU hospital.
- He improved almost immediately and was discharged home a few days later with a letter stating that he was sensitive to antipsychotic medications.
- He was well supported by the community LD team.
- In October 16, Oliver had cluster of partial seizures and was admitted to a different general hospital. Doctors were provided with the letters and advice was sought from previous doctors who had treated him.
- Oliver was intubated but later developed pneumonia. The safeguarding officer suggested the use of soft handcuffs and his parents to be present when reducing the sedation. This advice was not followed and despite denying permission from his parents, Oliver was prescribed antipsychotic medication.
- Over the next few days Oliver developed a temperature of 42 and doctors could not understand the decline in his condition as his pneumonia was improving and requiring far less oxygen.

Hitting the headlines

Oliver McGowan

An avoidable death

- Oliver was having tonic clonic seizures despite heavy sedation and paralysis drugs which he hadn't had before.
- He was sent for an MRI scan of his brain – Oliver's brain was badly swollen and doctors suspected neuroleptic malignant syndrome, a serious side effect of anti psychotic medications.
- Oliver's brain was so badly damaged, he would be profoundly disabled, no speech, no understanding of language, no way of communicating. He would be reliant on a tracheotomy and would be tube fed for the rest of his life. Oliver was now paralysed.
- A week later, the decision was made to turn Oliver's life support machines off and he passed away several days late on 11th November 2016.

[Oliver McGowan | Oliver's Campaign |]

Hitting the headlines

Female surgeons sexually assaulted while operating

September 2023

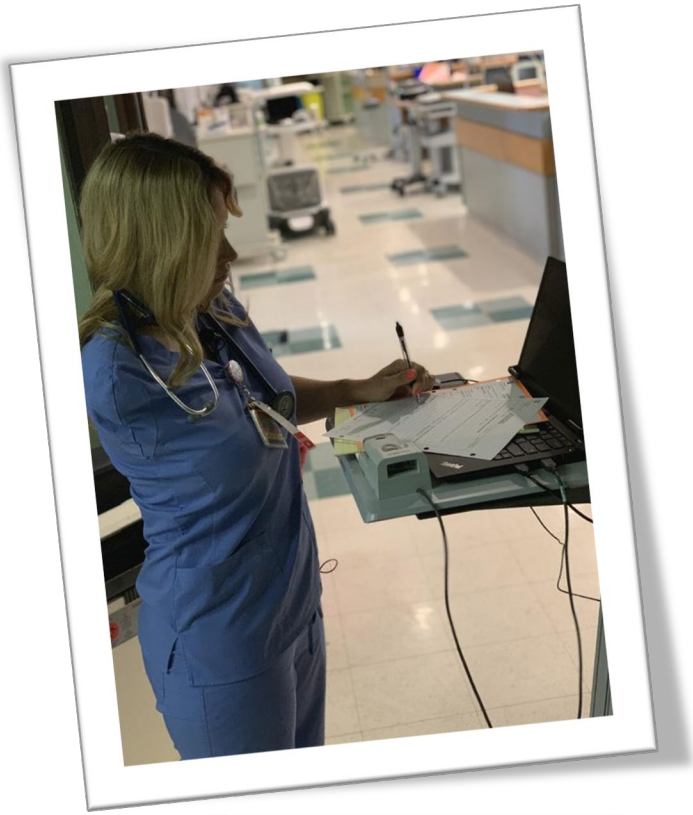
- Guardian publishes an article revealing that almost **one in three** female surgeons working in the NHS have been sexually assaulted in the past five years according to a study published in the British Journal of Surgery.
- Surgeons who took part in the study reported **11** instances of rape.
- The survey found the **30%** of female surgeons who responded said they had been sexually assaulted, **29%** of women had experienced unwanted physical advances at work, more than **40%** had received uninvited comments about their body and **38%** receiving sexual "banter" at work
- The report concludes: "Sexual misconduct occurs frequently and appears to go unchecked in the surgical environment owing to a combination of a deeply hierarchical structure and a gender and power imbalance. The result is an unsafe working environment and an unsafe space for patients."

- The BBC spoke to a surgeon who was sexually assaulted early in her career by a senior surgeon who pushed his face into her breasts in the middle of a procedure under the pretence of mopping sweat from his brow. When he did it for a second time, she offered to get him a towel, and he replied "no, this is much more fun".

Case study

Case Study 1

- Candidate applies for a role as a Maternity Support Worker declaring a disability and notifies the interview panel that they have dyslexia
- Pre-employment OCH assessment recommends ‘talk to write’ software to facilitate role
- Recommendation isn’t actioned and informal performance management begins
- Individual goes off sick and doesn’t return



Case Study 2

- Nurse in ED with one arm raises issues about discrimination from a patient
- The patient has refused treatment from them telling them “you’re disgusting, I can’t have you touching me – how can you do your job properly?”
- They have handed the patient over to another nurse and is visibly upset by the situation

Case study

Case Study 3

- A junior doctor talking in the mess about having a busy week coming up due to a friend's wedding
- A senior doctor asked why the wedding would last a week
- The junior explained that though his friend is from Essex, he is of Asian origin and it is customary for the wedding celebrations to last a few days
- The senior doctor responded with "A true Essex wedding would have been a two hour service in the morning following by a reception in the evening. They should go back to their own country to have their week long weddings where such weddings are the norm"

Case Study 4

- A member of staff has reported being subjected to inappropriate questioning by colleagues when she and her wife had children. Among the questions were "who is the man in their relationship", how did they decide which one of them would carry the child and other intimate questions about the process.
- Despite making several complaints, the manager felt the colleagues were just being curious and no further action should be taken. The member of staff felt they couldn't continue in their role and left the organisation.

MTW Key Priorities

- NHS England launches first EDI improvement plan. Six high impact actions identified:
- The plan:
  - Sets out why EDI is a key foundation for creating a caring, efficient, productive and safe NHS
  - Explains actions required to make the changes NHS staff and patients expect, who is accountable and responsible for their delivery
  - Describes how NHS England will support implementation
  - Provides a framework for ICBs to produce own local plans
- It supports the achievement of strategic EDI outcomes to:
  - Address discrimination
  - Increase accountability of all leaders
  - Support the levelling up agenda
  - Make opportunities for progression equitable

- Where diversity is underpinned by inclusion, staff engagement, retention, **innovation and productivity improve**. Inclusive environments create psychological safety and, in turn, support **efficient, productive and safe patient care**
- The plan is co-produced though engagement with staff networks and senior leaders with input from the Health and Care Women Leaders Network, the Race and Health Observatory, NHS Employers, NHS Providers, NHS Confederation and more

NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

EDI Improvement Plan – High Impact Actions

High Impact Action 1

CEO, Chair and board members have SMART objectives

- SMART objectives assessed by March 2024
- Board to demonstrate how organisational data and lived experience have been used to improve culture by March 2025
- Boards review data to establish EDI areas of concern and prioritise actions by March 2024

Measure
Annual chair and chief executive appraisals on EDI objectives – Board Assurance Framework

High Impact Action 2

Embed fair, inclusive recruitment processes & talent management strategies target under-representation & lack of diversity

- Implement talent management to improve diversity of executive and senior leaders teams (by June 2024) and evidence progress (by June 2025)
- Widen recruitment opportunities within local communities aligned to Long Term Workforce Plan – incl. career pathways into NHS eg apprenticeships, grad schemes (Oct 2024)

Measure
WRES, WDES
NHS Staff Survey
HEE NETS score

High Impact Action 3

Improvement plan to eliminate pay gaps

- Implement Mend the Gap review recommendations for medical staff (March 2024)
- Analyse data to understand pay gaps by protected characteristics plus improvement plan. (Sex and race by 2024, disability by 2025, other characteristics by 2026)

Measure
Pay gap reporting

High Impact Action 4

Improvement plan to address health inequalities within the workforce

- Line managers and supervisors to have regular effective wellbeing conversations with their teams (October 2023)
- Work with community organisations, facilitated by ICBs working with NHS orgs & arms length bodies eg NHS Race Health Observatory (April 2025)

Measure
NHS Staff Survey
NETS

High Impact Action 5

Comprehensive induction, onboarding & development programme for internationally recruited staff

- Provide guidance & support - conditions of employment (March 2024)
- Comprehensive onboarding programmes (March 2024)
- Cultural awareness for managers/teams (March 2024)
- Access to same development opportunities as wider workforce.

Measure
NHS Staff Survey

High Impact Action 6

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

- Review data by protected characteristic on B&H, D, V & set reduction targets (March 2024)
- Review disciplinary and ER processes (March 2024)
- Ensure effective policies are in place for staff affected by domestic abuse and sexual violence (June 2024)
- Create an environment where staff feel able to speak up and raise concerns (March 2024)
- Provide psychological support for all reporting they have been a victim of B&H, D or violence (March 2024)
- Protect staff who raise concerns

Measure
NHS Staff Survey

MTW EDI Strategy

Board Objectives

Be the difference between supporting and sponsoring – being engaged, entrenched in robust conversations and providing challenge

- Acting as allies, supporting staff networks, amplifying marginalised voices, using privilege, advocating for inclusive practices
- Attending training to build awareness and capability – spaces to learn and discuss
- Offering support as mentors or coaches to increase diversity in leadership roles
- Offering shadowing opportunities
- Creating dedicated time for people in their teams to work on their own inclusion objectives
- Committed to a Cultural Intelligence Programme
- Participating in Reverse Mentoring

Questions for consideration

- What is really working for us as a Board and how we lead on EDI?
- What do we need to focus our attention on?
- How will we hold each other to account?
- What are the barriers and how can they be addressed?
- How will success be measured?

Appendix

- EDI Project charter
- EDI Strategy
- NHS EDI Improvement Plan
- WRES
- WDES
- Gender Pay Gap

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)	**Director Strategy, Planning & Partnerships**

Summary of the background section

The report gives an overview of developments in West Kent Health Care Partnership and the Kent & Medway Integrated Care Board.

Summary of the analysis / conclusions section

The main focuses of the system are financial recovery, managing winter and the planning round for 24/25. The WK HCP is focussing on the review of discharge and flow schemes, with recommendations for funding, the development of Integrated Neighbourhood Teams and considering the roll out of the Better Use of Beds programme.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 20th February 2024

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

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

Maidstone and Tunbridge Wells NHS Trust

University Hospitals Sussex NHS Foundation Trust

ICB and West Kent HCP update

February 2024

Exceptional people, outstanding care

ICB/ System news

- The system remains focused on financial recovery for this financial year and work is now beginning to look at future years.
- The double and triple lock processes remain in place and further work on additional control measures are being considered.
- The ICB are working with partners to plan for the next junior doctors strike from7am on Saturday, 24 February to 11.59pm on Wednesday, 28 February.
- The ICB are coordinating business planning submissions although formal guidance is now significantly delayed.

West Kent HCP

The West Kent HCP Development Board took place on Thursday 15th February focussed on the better use of beds and short term services programme, discharge funding, the development of INTs and our health inequalities programme for 24/25.

The better use of beds programme will focus on 3 main areas:

- reduction in non elective length of stay,
- reduction in the number of patients who are no longer fit to reside in a bed
- identifying the correct pathway for patients on discharge.

The INT implementation approach (2024-2027) will focus on:

- Scaling the model to all PCN areas
- More intensive mobilisation in deprived areas
- Engage with the ICB enabler support offer
- Lessons learned and measuring impact
- Interfacing with urgent care, long term conditions, mental health and frail residents needs.

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.

NHS Maidstone and Tunbridge Wells NHS Trust

Update on the Trust's draft planning submission for 202425	**Director of Strategy, Planning and Partnerships; and Deputy Chief Executive / Chief Finance Officer**

The enclosed report provides an update in terms of the Kent and Medway Integrated Care System (ICS) planning approach for 2024/25 and internal business planning progress

Summary of position

- Full planning guidance has not been released, however templates for returns and some technical guidance is available
- There is a Kent and Medway Integrated Care Board (ICB) 'flash report' to NHS England (NHSE) on the 29th February, which the trust has provided an update for. At the time of the production of the report a response is awaited from the ICB Technical Planning Group review
- Executive led review & guidance meetings have been scheduled with each division.
- First full submission to NHSE on 21st March 2024, with the Trust's planning submission to the Kent and Medway ICB on 14th March 2024 (indicative) and further final Kent and Medway ICB submission scheduled for the 2nd May 2024

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

- Executive Team Meeting, 27/02/24
- Finance and Performance Committee, 27/02/24

Reason for submission to the Trust 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

24/25 Elective Activity, Workforce and Finance Plan

24/25 Elective Activity plan vs Actual 23/24 and Actual 1920

Our elective activity plan for 24/25 is based on our core capacity. A review of additional capacity opportunities will be undertaken before the first formal submission in March.

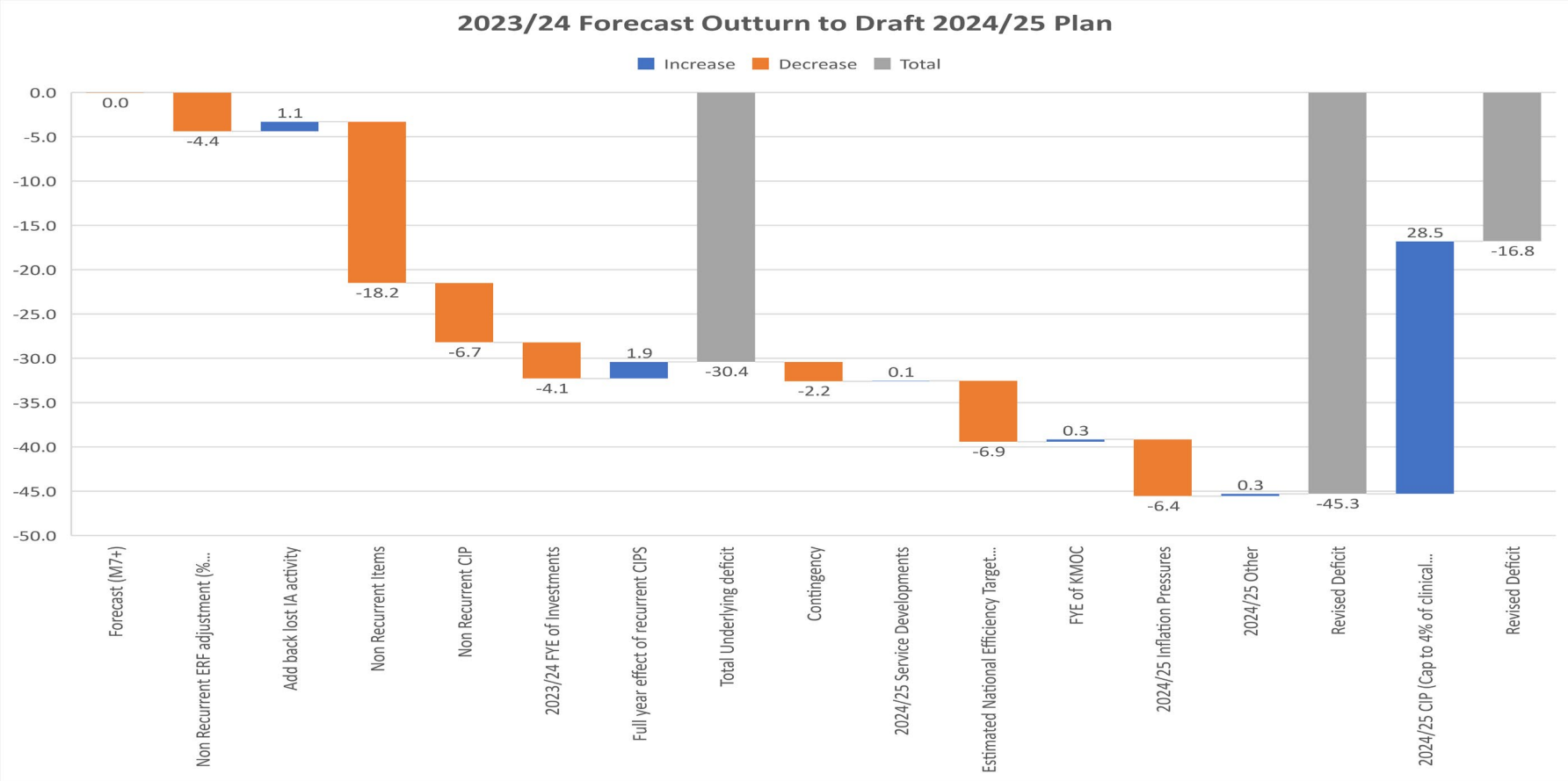
Total IP & DC Combined	Total
24/25 Plan as % of 1920	110%
24/25 Plan as % of 23/24 Actuals	**101%**
24/25 Plan as % of 23/24 Submitted Plan	**106%**

All Cons and Non-Cons First OP Total	Total
24/25 Plan as % of 1920	124%
24/25 Plan as % of 23/24 Actuals	**103%**
24/25 Plan as % of 23/24 Submitted Plan	**107%**

Total Elective (IP, DC and All First OP) - ERF	Total
24/25 Plan as % of 1920	121%
24/25 Plan as % of 23/24 Actuals	**102%**
24/25 Plan as % of 2324 Submitted Plan	**107%**

- Electives: Activity includes Inpatient overnight, day case and Endoscopy. Includes KMOC Activity.
- OP New Attendances include Tomcat activity (excluding insourcing), KMOC Activity and CDC Activity (Tomcat).

The Trust is forecasting a deficit in 2024/25 of c£45.3m before CIP. If the Trust delivers 4% CIP (£28.5m) this will reduce the deficit to £16.8m.



This is a 'top down' plan using month 7 as the baseline, further work with divisions is required to develop a 'bottom up' plan.

2024/25 Draft Financial Plan – Key position & issues

Income

The Trust has assumed income values are similar to 23/24 and that overperformance from 23/24 is included in the contract value. Contract values have not yet been confirmed with commissioners.
An income based on the activity plan is being calculated for the next submission.
The plan has been uplifted for the latest inflation and efficiency values.
There is additional funding for CNST and this will be worked through in the next submission.

Pay and Non Pay

This is a top down model which has not yet been triangulated with the workforce plan. This will be done in the next few weeks. There are inflationary pressures over and above national inflation assumptions for PFI Contract £1.4m, CNST £2.5m, Depreciation £1.8m and other items £0.7m.

CIP

The Trust currently has identified a significant proportion of the CIP target but further validation is required**.** Nearly 50% of identified savings relates to additional income and the rest is reduction in expenditure.

Underlying position

Slide 5 shows an underlying position of £30.4m, note for comparison within the ICB the Trust has removed some non-recurrent contract items such as ERF funding which gives an underlying position of £62.3m.

24/25 Workforce position & next steps

	Mar-24			Mar-25		
	Sub	Bank	Agency	Sub	Bank	Agency
Nursing & Midwifery	2067	207	84	2138	157	82
Sci tech therapy	671	27	37	711	25	37
supp clin	1091	148	30	1141	125	9
Medical	948	110	37	961	101	26
Infrastructure	2000	143	6	2035	84	2
Other	422	6	0	430	6	0
Sub Total	7198	640	194	7417	496	156
Total WTE		8032			8069	
Budget		7558			7831	
Variance		-474			-238	

- The 2025 substantive position reflects approved investments such as KMOC, FYE of CDC, safer staffing reviews and assumes a 5.5% vacancy factor (in keeping with current trust position)
- Reducing bank and agency expenditure is a key priority for us. We have work in progress relating to bank and agency which will be reflected in our next submission.

Appendix

Interim draft planning assumptions 24/25 (1/2)

These interim draft planning assumptions are not agreed with Government and are subject to change. Agreed expectations and priorities for 2024/25 will be set out in the published priorities and planning guidance document.

Use of Resources

- Deliver a balanced net system financial position for 2024/25.
- The cost uplift factor which reflects inflation is 1.9% and the efficiency factor has been set at 1.1% which means the ICB has a net uplift of 0.8%.

No further industrial action

- For the purposes of planning, we have been asked to assume there is no further industrial action.

General

- No industrial action in 2024/25.
- COVID-19 related demand continues at a similar level as experienced over 2023/24.

Maternity

- Continue to implement the Three-Year Delivery Plan for Maternity and Neonatal services Mental health
- Continue to improve access and quality in line with the priorities set out for 2023/24 and increase delivery of full annual physical health checks.
- Improve patient flow to reduce pressure in crisis and acute care and continue to improve the quality of care for patients, as set out in the Inpatient Quality Transformation Programme.

Elective care

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest
- System specific value weighted activity targets are the same as those agreed at the start of 2023/24, consistent with a national value weighted activity target of 107% for 2024/25.
- The ERF will operate in a similar way to how it has operated in 2023/24

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24.
- Prioritise the opening and maximisation of approved new capacity to deliver planned additional activity.

Interim draft planning assumptions 24/25 (2/2)

These interim draft planning assumptions are not agreed with Government and are subject to change. Agreed expectations and priorities for 2024/25 will be set out in the published priorities and planning guidance document.

Urgent and emergency care

- Improve on 2023/24 performance, with a minimum of 77% of patients seen within 4 hours in March 2025.
- Category 2 ambulance response times to average no more than 30 minutes across 2024/25.
- Maintain the peak increase in capacity agreed through operating plans in 2023/24. This includes acute G&A beds & virtual ward beds

Cancer

- Improve performance against the headline 62-day standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025.

Prevention and health inequalities

- Continue to increase the percentage of patients with hypertension treated to NICE guidance and with a CVD risk score greater than 20% on lipid lowering therapies.
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

Workforce

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise.
- Implement actions for 2024/25 from the Long-Term Workforce Plan, including the agreed increase in education places in 2024/25 for Nursing Associates, Advanced Clinical Practitioners and Physician Associates.
- System workforce numbers must be aligned to the financial resources available. Substantive staffing growth should come with commensurate and demonstrable reductions in temporary staffing use.

Digital and data

- Continue to level up the digital maturity of providers across all sectors, with a focus on deploying and upgrading electronic patient record systems in line with the What Good Looks Like guidance, as part of delivering the wider commitments set out in 'A Plan for Digital Health and Social Care', and 'Data Saves Lives'.
- Continue to connect services to and champion use of the NHS App and website as the digital front door to the NHS.

NHS Maidstone and Tunbridge Wells NHS Trust

Cardiology Reconfiguration Outline Business Case (OBC) **Chief Operating Officer**

The enclosed report provides information on the cardiology reconfiguration Outline Business Case and confirms:

- The current position and challenges with the current service in terms of service delivery, future service development and the ability to meet national performance and quality standards
- The build and funding options for the reconfiguration onto the Maidstone site (approved during the 14-week engagement and subsequent Board approval in February 2022
- The preferred option for the service configuration and funding
- An outline of the site profile and the benefits of the centralisation
- The impact and benefits on quality of service, capacity of service and activity
- The staffing requirement to deliver the activity and income to provide a breakeven financial position
- The financial risks associated with the OBC for exploration and clarification during the Full Business Case process

This is a key service development that will benefit the local community and will place MTW in a good position for development and expansion of the cardiology service in Kent and Medway.

The OBC presents a financial breakeven position alongside improvements in quality and patient experience. The Board are asked to approve the OBC to enable the detailed development of the preferred option in the Full Business Case.

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

- Divisional Board
- Business Case Review Panel
- Executive Team meeting, 13th February 2024
- Finance & Performance Committee, 27th February 2024

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

For information and support the decision to undertake the work to progress the preferred option to Full Business Case

[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

The report outlines the direction of travel as approved in the Strategic Outline Case (SOC) to develop the cardiology service to:

- deliver an improved service to the population
- to future proof the service to meet the growing population and national clinical recommendations
- to place the Trust in a favourable position to deliver the Clinical Strategy objective of becoming the second pPCI site in Kent and Medway.

The recommendation is to support the OBC and the reconfiguration options and approve the work to progress to FBC to:

- Confirm assumptions made in the OBC
- Confirm the capital and ongoing revenue assumptions
- Confirm the activity assumptions
- Clarify contractual arrangements with third parties
- To present a financially viable FBC
- Evidence a financially efficient and effective service model which supports cardiology development and growth, and cements the service profile in the local and wider cardiology community
- Present a timeline for delivery of the FBC and the service development
- Confirm ongoing ICB support for service development and financial changes to ensure ongoing system support

Introduction and Context:

The NHS Long Term Plan identified CVD as the single biggest area where the NHS can save lives over the next 10 years. To do this, services need to respond to the local population needs by delivering high quality, modern and responsive services.

A Strategic Outline Case for centralisation and reconfiguration of specialist cardiology service onto the Maidstone site was approved by the Board in October 2021, followed by a 14 week engagement period with all stakeholder. The direction of travel was agreed and approved.

A business case for the management of specialist equipment and consumables has been approved and implemented. The next phase is to develop the site and centralise the services which is the subject of the attached OBC by improving the facilities which will in turn improve the quality and responsiveness of the service, future proof the service by improving recruitment and retention opportunities and flexible use of available capacity to respond to future growth. Although not the subject of this case, the OBC will enable the delivery of the Trust strategy to be the second pPCI centre in Kent and Medway.

Current Position:

The cardiology service at MTW is fragmented and specialist work is undertaken on both the Maidstone and Tunbridge Wells sites. This provides: with each site taking on the management of different clinical disciplines in the labs which dilutes skills and reduces efficiency and flexibility. The service is non-compliant with seven GIRFT recommendations. The current service issues and risks are summarised as follows: -

- A disjointed and inefficient catheter laboratory service.
- Reduction in flexibility and efficiency with two Consultant of Week rotas and inefficient oncall arrangements
- The need for site to site transfers of unwell patients
- Lack of a dedicated specialist cardiology ward
- Non compliance with 7 of the GIRFT standards which cannot be delivered without centralisation
- Staff recruitment and retention is challenging as a direct result of the current configuration of the service
- Inability deliver the clinical strategy with current configuration due to GIRFT non compliance

Plan:

The plan outlined in the both the SOC (Oct 2021) and the OBC (attached) is to develop:

- 2 cath labs on the Maidstone site to cover all interventional sub specialties, with dedicated support services, clinical space and increase echocardiology capacity in a new build
- 12-14 bedded CCU on Cornwallis
- 23 bedded specialist ward on Culpepper
- An Acute Cardiology Assessment Unit (ACAU) in the current ward areas, to support he Divisions SDEC aspirations and plans
- Develop a staffing plan to enable the efficient use of the space which will reduce waiting times and increase activity and income

Plan (cont):

- The cath lab, recovery and CCU will be relocated from the TWH site, releasing space for other clinical service developments
- Outpatient and diagnostic services will remain on the TWH site with a consultant presence for cardiology opinions on inpatients.
- Robust pathways will be put in place for the appropriate transfer of patients for specialist cardiology care, working with local GPs and SECAMB

The plan is supported by the system and work is ongoing with the ICB regarding the impact of the service redesign and Kent and Medway impact.

Expected Benefits:

The development of the new build/refurbished and centralised specialist cardiology service will result in:

- Reduced fragmentation of the service
- Improved service continuity
- Improved efficiency and flexibility
- Improved patient experience and access
- Improved patient pathways
- Increased capacity to reduce waiting times and support increases in demand
- Increased income to resource an expanding and developing service
- Future sustainability of a patient centred and high performing service
- Improved recruitment and retention
- Improved compliance with national standards and recommendations enable a GIRFT complaint service to prepare to deliver the Trust clinical strategy of delivering pPCI

Build Options:

A number of build options have been considered, but in terms of value for money, longevity and future proofing, and provision of quality service an options that provides:-

- Refurbishment of Culpepper as a 23 bed specialist cardiology ward
- Refurbishment of Cornwallis as a 14 bed CCU and ACAU
- New 2 storey building for a cath lab and recovery, clinical office spaces, clinic rooms and 3 echo room

Finance Options:

The finance options considered for the capital development are:-

- System capital to fund both the refurbishment and the new build. The cost of this including costs, fees and VAT is c£17m, and would incur capital charges for 21 year on the refurbishment and 60 years on the new build.
- IFRS16 lease for the new build which would not require any capital outlay, but would incur capital charges for the subsequent revaluation on the whole cost at c£17m
- Addendum to the equipment MSA where Trust capital is used for the refurbishment and the equipment provider (Medtronic) pays for the new build. This will be a cost per case contract over 7-10 years. Medtronic would take the risk on costs and contingency, and would allow for the costs of the whole design (including refurbishment) so the whole programme can be progresses simultaneously. Although there is no initial capital impact the Trust's advisers believe a subsequent revaluation of the asset would be required, and this would then incur capital charges on the build costs, minus the contingency and design costs.

Finance (cont):

Finance Risks:

- The addition of the build element to the MSA equipment contract will require a new contract drafting. This will need to be reviewed by the Trust's advisers to ensure the fully variable cost per case approach is still valid within the IFRS 16 initial measurement of a liability, and that no initial capital impact is incurred from any newly introduced guarantees or minimum payments.
- The advisers will also need to confirm the approach to the subsequent valuation of the asset (building) within IFRS16 even though there is no initial capital impact.
- The working assumption is that the value of the build to depreciate is after deduction of the residual value at the end of the contract.
- The addition of the build element might change the position on the VAT recoverability of the contract as a whole. The new contract drafting will need to be reviewed by Trust advisers.
- The provision of the system capital for the refurbishment needs to be confirmed formally by the ICB.
- The case is financially viable on the basis of increase elective capacity and income increase. Any elective limit applied by the commissioner will be a potential risk.

Preferred Option:

The preferred option is as per the build option outlined above with funding from Trust capital for the refurbishment and an addendum to the equipment MSA to pay for the new build. Despite the financial risks that will be worked through in detail during the FBC process this option is considered the only viable way to progress the programme of work at the current time and in the current financial climate and shows a break even position against income at the OBC stage.

OBC Financial Assessment:

Detailed below is the high level financial assessment which shows a potential to deliver a £457k contribution to the cardiology bottom line.

Summary of financial impacts			
CAPITAL COSTS	**£000s**	**FUNDING SOURCE**	
Estates	-3,593	Identified in the Trust capital plan (System capital funding)	
IT		Identified in directorate revenue budget	
Equipment		Other *(tbc)*	
Total Capital Cost	**-3,593**	The capital funding for the refurbishment of Cornwallis will come from Trust/system capital. Confirmation of refurbishment costs will be detailed at RIBA 4. Non-Pay costs relate to the addendum to the Medtronic contract. This will be updated when full RIBA 4 costs are completed and the contractual impact confirmed. Capital Charges are based on 21-year Useful Economic Life left on the existing building for refurbishment costs, and are an average over this time. Capital charges are for the new build within the addendum	
REVENUE COSTS			
Pay	-852		
Non- Pay	-813		
Capital Charges Refurbishment	-234		
Capital Charges New Build Addendum	-266		
Total Revenue Cost per annum	**-2,165**		
INCOME			
SLA	**2,181**		
Other			
Surplus/Loss	**16**		

OBC Financial Assessment (cont):

The financial assessment is based on the revenue consequences as follows:-

- Capital charges for the refurbishment capital (£234k) and the new build (£266)
- Revenue impact of the MSA addendum cost per case model for the new build (£813k)
- The staffing costs to proved the capacity for increased activity to increase income (£852k)
- The SLA contribution including the increase in elective activity (£2,181k)
- Any anticipation of income from non elective growth has been excluded from this plan at the current time. This will be picked up in more detail during the FBC process
- Any financial impact and risk relating to the addendum costs due to the IFRS16 guidance will be explored in detail during contract development in the FBC process.

The increase in activity is essential to provide the income to pay for the revenue consequences of the build as well as the staffing to support delivery of the extra activity. This assumes variable growth depending on the type of activity as detailed below (table 1) and highlights the potential income impact (table 2). Detailed work has been undertaken with clinical staff to ensure the case mix and growth assumptions are realistic. 18% growth in activity drives 28% growth in income from high cost procedures – complex EP – which is in line with national picture. MTW anticipate further growth and development opportunities for increased income and these opportunities are being explored.

	Current	Impact of OBC	% growth
OP	38,616	46,214	20%
Day case	1,173	1,593	36%
Inpatient	139	167	20%
Echo	7,203	7,398	3%
Total	47,131	55,372	17%

	Current £000	Impact of case £000	% growth
OP	4,511	5,395	20%
Day case	2,303	3468	50%
Inpatient	321	425	32%
Echo	740	770	4%
Total	7,875	**10,058**	28%

Staffing:

An increase in staffing is required to deliver the increased activity to drive the increase in income. The staffing increase is detailed in the table below. This increase does not cover the ACAU, weekend cath lab working or return to lab out of hours. These are crucial developments as the service progresses and more granular work will be undertaken in the FBC to confirm affordability. In terms of the OBC the proposal is to increase staffing to increase activity and income sufficient to cover the cost of that staffing increase as well as the capital charges and revenue costs of the MSA. As per the financial summary an outlay of £852k will deliver a small positive financial contribution to the service.

	Current WTE		Revised		Difference	
Discipline	**WTE**	**£**	**WTE**	**£**	**WTE**	**£**
ACAU	0.00	0	0.00	0	0.00	0
Cath Lab & Recovery	15.31	694,906	18.10	809,287	-2.79	-114,381
Radiographers	4.00	232,554	5.49	305,837	-1.49	-73,283
Physiologists	31.29	1,740,910	28.24	1,740,910	3.05	0
CNS	14.05	714,171	15.34	808,745	-1.29	-94,574
Medical	13.00	2,345,822	18.00	2,914,910	-5.00	-569,087
Total	**77.65**	**5,728,363**	**85.17**	**6,579,688**	**-7.52**	**-851,325**

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE	Cardiology Inpatient & Interventional Service Reconfiguration

Stage of plan	Single stage "Justification" (J) ☐ Stage 1 - Strategic Outline Case (SOC) ☐	Stage 2 - Outline Business Case (OBC) ✓ Stage 3 - Full Business Case (FBC) ☐		
ID reference *mtw-tr.bcrp@nhs.net*	**ID 858**			
Division	Emergency and Medical Services			
Department/Site/ Directorate	Medical Specialties			
Author	Jo Cutting			
Clinical Lead/Project Manager	Laurence Nunn / Stephen Bundock			
Prioritisation has been agreed at	**Capital prioritisation group – in capital plan**	**Service development priority in divisional annual plan**	**Charitable funds group/s**	**Other (Specify)**

APPROVED by:	**Name**	**Date approved**
General Manager/Service Lead	Katie Cornwell	23.10.23
Finance Manager	Paula Susans	20.10.23
Clinical Director or their Clinical Deputy	Simon Webster	23.10.23
Medical Specialties Head of Nursing	Mansiri Gurung	23.10.23
Executive Sponsor	Sean Briggs	20.10.23
Division Leadership Team	Tim Hubbard/ Gemma Viner/ Laurence Maiden	January 2024
SUPPORTED by:	**Name**	**Date supported**
Estates capital development	David Pym	30.10.23
Facilities Management		tbc
(ICT / Clinical Systems & EPR) Team	Robert Stephenson	01.11.23
Core Clinical Services	Jelena Pochin	01.11.23
Emergency Planning	John Weeks	01.11.23
Human Resources (HR) Business Partner	Nicola Taylor	31.10.23
Procurement	Bob Murray	26.10.23
EME Services Manager	Michael Chalklin	30.10.23

Cardiology Reconfiguration Outline Business Case

Version 26

9th February 2024

Version control

Version	Date	Author	Details
1	July 2023	Jo Cutting	Template Set up
2	28.07.23	Jo Cutting	1st draft strategic case complete
	09.08.23	Jo Cutting	2nd draft strategic case – queries identified for directorate team
	09.08.23	JoCutting/Steve Williams	Longlist matrix/options criteria
3	18.08.23	Jo Cutting	Longlist to shortlist
4	21.08.23	Jo Cutting	Longlist to short list update
5	23.08.23	Jo Cutting	Longlist to shortlist completed/Management Case
6	25.08.23	Stephen Bundock	Updates to the management sections and appendix's
7	29.08.23	Jo Cutting	Updates
8	30.08.23	Jo Cutting	Options and options appraisal matrix
9	04.09.23	Jo Cutting	Update on engagement process
10	06.09.23	Jo Cutting	
11	25-09-23	Stephen Bundock	Added comments and updated from the project team across multiple sections.
12	16.10.23	Jo Cutting	Tidied up – started economic case
14	17.10.23	Jo Cutting	Detail economic case
15	18.10.23	Jo Cutting/Stephen Bundock	Tidy up, review economic case and update
16	20.10.23	Stephen Bundock	Tidy up,
17	23.10.23	JO Cutting	Update text and financial and activity presentation
18	24.10.23	Paula Susans	Populate financial charts
19	25.10.23	JO Cutting	Financial update/revision – update text, review activity
20	26.10.23	Jo Cutting/Paula Susans	Financial reviews and text for case. Jo further update.
21	27.10.23	Jo Cutting	Update to fully worked up draft for project team comments (emailed out for comments back asap, latest cop Monday 30th Oct)
22	31.10.23	Stephen Bundock	Updates from stakeholders. Full run through with project team
23	01.11.23	Jo Cutting / Stephen Bundock	Executive Summary, General organisation of the appendix / tables.
24	02.11.23	Jo Cutting	Final amendment – to BCRP
25	08.01.24	Jo Cutting/Steve Williams, Paula Susans	Updated with new modelling for activity and finance, and new Medtronic costs
26	30.01.24	Jo Cutting	Update financials

Executive Summary

Recommendation:

This Outline Business Case (OBC) seeks approval of the direction of travel for the development of the cardiology service to deliver: -

- 2 Cath labs on the Maidstone site with dedicated support services, clinical space and increase echocardiology capacity in a new build
- 12-14 bedded CCU on Cornwallis
- 23 bedded specialist ward on Culpepper

The OBC seeks support for as per the preferred service and funding options outlined, and approval to progress to Full Business Case (FBC) to evidence: -

- Improved compliance with national standards and recommendations
- To confirm the assumptions outlined in the OBC
- To evidence improvement in quality of service and patients experience
- To evidence capacity increase and resulting income generation
- To evidence on the ongoing revenue impact of the development
- To present a financially viable FBC
- Present a financially efficient and effective service model which supports cardiology development and growth, and cements the service profile in the local and wider cardiology community
- Present a Full Business Case to the Board for approval in May/June 2024 to enable site and service development

The investment will be funded by:

The refurbishment of the internal areas will be funded by Trust/System capital to update Culpepper and Cornwallis to become the CCU, specialist cardiology ward and ACAU.

The new build will be funded by Medtronic (IHS) as an addendum to the Cardiology Equipment Managed Service Agreement (approved by the Board in July 2023, go live December 2023). This will be funded on a cost per case basis. The Trust will have no need for capital investment as this is a full revenue solution although capital charges will apply and are consider in the financial evaluation.

The revenue impact in terms of capital charges and the cost per case in the MSA will aim to be funded by PbR activity as will staffing increases in specialist disciplines and other support services. The current financial assumption is a contribution to the baseline of c£400k. This will be further developed and crystallised in the FBC. There is a tangible link between the ability to increase capacity and the commensurate increase in income. Activity analysis, and income predictions, have been undertaken for the OBC and will be further refined in the FBC across as current assumptions on activity increases are cautious.

All costs outlined give tangible benefits to the service in terms of access, quality, demand management, growth and income maximisation. Whilst this OBC will not deliver full GIRFT (Getting It Right First Time) requirements for a cardiology unit, compliance will improve and the new development and changes in service efficiency will provide the platform for the next steps to ensure full compliance with 24/7 working.

Whilst acknowledging the work that needs to be undertaken to confirm the costs, firm up the income and clarify the financial impact of the new build within the IFRS16 guidance, the conclusion is that the preferred option for the build and the financial management of the case are the best options in terms of developing the service and the recommendation is that this OBC is supported proceeds to FBC to enable evidence of financial viability, service sustainability and quality improvement.

Strategic background context and need

The NHS Long Term Plan identified CVD as the single biggest area where the NHS can save lives over the next 10 years. To do this, services need to respond to the local population needs by delivering high quality, modern and responsive services and local populations in Kent and Medway are set to increase. Expansion of the pPCI service in Kent is recognised by the ICB who are actively working with Trust and Specialist Commissioning to determine the direction of travel.

The cardiology service at MTW is fragmented and specialist work is undertaken on both the Maidstone and Tunbridge Wells sites, with each site taking on the management of different clinical disciplines in the labs which dilutes skills and reduces efficiency and flexibility. The service is non-compliant with seven GIRFT recommendations. The current service issues and risks are summarised as follows: -

- A disjointed and inefficient catheter laboratory service.
- The need for site to site transfers of unwell patients
- The consultant workforce is split creating 1 in 4 Consultant of the Week (CotW) rota on the Maidstone site and a 1 in 5 rota on the TWH site. This is under the minimum 1 in 6 as recommended by GIRFT
- The on-call arrangement creates further inefficiency as when on-call all elective work (cath lab session, outpatients) for the on-call consultant is stood down leaving gaps in the service and putting a negative pressure onto waiting lists.
- There is no dedicated cardiology ward and although there are nominally allocated beds for cardiology patients the nature of the general medical flow means that very unwell cardiology patients may not be in the right bed.
- GIRFT compliance cannot be achieved without centralisation onto one site as outlined above, thereby compromising the delivery of the Trust clinical strategy
- Staff recruitment and retention is challenging as a direct result of the current configuration of the service

A Strategic Outline Case presented to the Board in October 2021 supported the progress of the development of the cardiology service and the reconfiguration of the specialist inpatient services and cardiac catheter labs onto one site. The following 14-week engagement process with all stakeholders in the heath and care community, confirmed the preference for the site is Maidstone Hospital.

The benefits of the change for the inpatient and cardiac catheter lab services has been driven by the service challenges outline above and is crystallised in the following:

- Enable the Trust to meet the GIRFT recommendations, particularly related to dedicated specialist facilities, COTW cover and access to rapid intervention
- To reduce the dilution of services due to current necessary duplication across two sites
- Reduce CotW frequency and release capacity for elective cath lab and outpatient work
- Increase elective activity to reduce waiting times and increase income
- To improve staff experience and impact recruitment and retention
- To improve efficiency of the cardiology service and the contribution to organisational inpatient flow
- To reduce and maintain low waiting times
- To improve the patient experience
- The changes will enable the delivery of the Trust clinical strategy

Objectives

The objective of the case is to reconfigure the cardiology inpatient and cardiac catheter laboratory and associated services and consolidate these elements onto one site to improve access, outcomes and experience for patients by:

- reducing fragmentation of the service
- improving service continuity
- improving efficiency
- improving patient experience and access
- ensuring future sustainability of a patient centred and high performing service

- improve positioning of the service to deliver a GIRFT compliant service over time. This case enables improvement on delivery against the current standards.eparing to deliver the Trust clinical strategy

The preferred option.

The preferred option for the cardiology development is Option 4. This comprises a new build cath lab, recovery, clinical space, clinical admin, echo cardiology capacity in a 2-storey new build adjacent to the current lab, with Cornwallis upgraded to a 12-14 bed CCU and Culpepper as the 23-bed specialist cardiology ward. This area will have a link corridor on the upper floor to the cardiology corridor between the ward areas and the current cath lab.

The consolidation onto one site will produce efficiencies and release capacity to increase activity. To enable this the following staffing increase is required, and the modelling assumptions so far show that increased capacity will enable increased income to cover these costs. Details of the banding and phasing of the staffing increase is in the body of the case.

Discipline	WTE	£
ACAU	excluded	
Cath Lab & Recovery	-2.79	-114,381
Radiographers	-1.49	-73,283
Physiologists	-3.05	0*
CNS	-3.99	-94,574
Medical	-7.00	-569,087
Total	**-29.17**	**-851,325**

- physiologists funded in baseline via case mix change

In terms of estate reconfiguration, the new build will be undertaken by a third party (Medtronic). This will provide the Trust with a revenue solution to the build which is advantageous in the current NHS financial environment where capital is currently scarce. Capital funding for the reconfiguration of the inpatient areas is from Trust/system capital specified for the cardiology development.

Having undertaken a robust options appraisal, this option is preferred as it is viable from a capital perspective, represents best value for money, will enable more efficiency and service growth and will provide an improved and sustainable service for patients as well as possibly paving the way for pPCI in the future.

Planned key benefits to come from the investment.

The development of the cardiology specialist service as outline will bring the following benefits: -

1. CotW rota improvement
2. Provide ring fenced inpatient specialist beds (CCU and ward)
3. Increased income to resource expanding and developing services Improved patient pathways for all interventions
4. Improved inpatient pathways
5. Improved cath lab efficiency
6. Increased capacity to reduce waiting time and support increases in demand
7. Improved recruitment and retention
8. Positive position for pPCI expansion in Kent*

Whilst the proposal in this OBC will not allow delivery of GIRFT compliance with regard to out of hours and weekend working (which will be the subject of a further case), the proposal outlined in this case will position the Trust well to reach compliance and therefore deliver pPCI

Measurable benefit Key Performance Indicator (KPI)	Baseline Position	Future Outcome

Waiting times	Tbc	All waits (OPD, diagnostic and procedure) and within the national standards
Improved GIRFT position	Tbc	Increase in the standards met with commensurate improvement in service delivery and the patient pathway
Recruitment and retention	Tbc	All disciplines have recruited to agreed establishments
Activity	Tbc	Increases in activity as capacity is released with improved rotas and improved staffing of released sessions
Income	Tbc	Income increases in line with activity increase and with improved coding and HRG payment

Main risks associated with the investment

Risk of not doing it: (mitigation is challenging)

- continued service challenges which will impact on recruitment, retention and service quality (access and waiting times)
- continued fragmented service
- continued GIRFT non-compliance impacting on ability to deliver pPCI, and no viable opportunity to deliver this
- undermined interventional service which could be at risk from other providers
- gradual erosion of the specialist cardiology service
- destabilisation of the local service
- poor staff and patient experience

Delivery risk: (all risks have a mitigation plan)

- cost of building and estates development continue to be unstable and may increase
- development of the FBC in this financial year and completion of the build in 2024/25 to stay ahead of other Kent providers looking to develop cardiology services
- recruitment and retention
- funding for RIBA 4/FBC development is not forthcoming
- capital is not available to complete the internal reconfiguration
- Trust Board do not approve of the OBC

Residual Risk: (all risks will be mitigated in the FBC)

- recruitment and retention (will be mitigated by a robust recruitment strategy in the FBC)
- income risk impacting affordability
- national accounting rules relating to a cost per procedure arrangement and IFRS16 rules interpretation, increases the revenue costs of the addendum

Summary of financial impacts			
CAPITAL COSTS	**£000s**	**FUNDING SOURCE**	
Estates	-3,593	Identified in the Trust capital plan (System capital funding)	
IT		Identified in directorate revenue budget	
Equipment		Other *(tbc)*	
Total Capital Cost	**-3,593**	The capital funding for the refurbishment of Cornwallis will come from Trust/system capital. Confirmation of refurbishment costs will be detailed at RIBA 4. Non-Pay costs relate to the addendum to the Medtronic contract. This will be updated when full RIBA 4 costs are completed and the contractual impact confirmed. Capital Charges are based on 21-year Useful Economic Life left on the existing building for refurbishment costs, and are an average over this time. Capital charges are for the new build within the addendum	
REVENUE COSTS			
Pay	-852		
Non- Pay	-813		
Capital Charges Refurbishment	-234		
Capital Charges New Build Addendum	-266		
Total Revenue Cost per annum	**-2,165**		
INCOME			
SLA	**2,181**		
Other			
Surplus/Loss	**16**		

TIMETABLE

Milestone	Date (by when)
Governance Structure and Terms of Reference created and approved	31st July 2023
Risk log created and scored	30th September 2023
QIA / EIA completed	24th October 2023
QIA/EIA Signed off	31st October 2023
High level analysis and baselining of Activity and Income	20th October 2023/5th January 2024
High level analysis and baselining of Financials	26th October 2023/5th January 2024
Outline business case approved by the Divisional Board	31st October 2023
OBC to BCRP to approve direction of travel and the development of the FBC	7th November, 2023 (for circulation 2nd November)
OBC to ETM, F&P and Board to approve direction of travel and the move to develop the FBC	16th, 23rd January and February Board
RIBA 4 work up, activity and financial confirmation and timeline of phasing for preferred option	30th June 2024
Full Business Case approvals process	July 2024
Full Business Case approved by Trust Board	July 2024

Table 1 - Project milestones

1. Strategic Case

1.1. The National Context - Cardiovascular Disease

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. CVD includes all heart and circulatory diseases, including coronary heart disease, angina, heart attack, congenital heart disease, hypertension, stroke and vascular dementia.

- CVD affects around seven million people in the UK and is a significant cause of disability and death
- CVD is responsible for one in four premature deaths in the UK and accounts for the largest gap in health life expectancy. Those in the most deprived 10% of the population are almost twice as likely to die as a result of CVD than those in the least deprived 10% of the population
- Atrial fibrillation (AF), high blood pressure and/or high cholesterol are 'high risk conditions' meaning that people with these conditions are at higher risk of developing CVD
- Other CVD risk factors include diabetes, smoking, family history of heart disease
- People from black, Asian, minority ethnic (BAME) background are at higher risk of developing CVD
- There are significant health inequalities for people living with severe mental illness (SMI). Life expectancy is 15-20 years lower than the general population. People with SMI have a 53% higher risk of having CVD and 85% higher risk of death from CVD

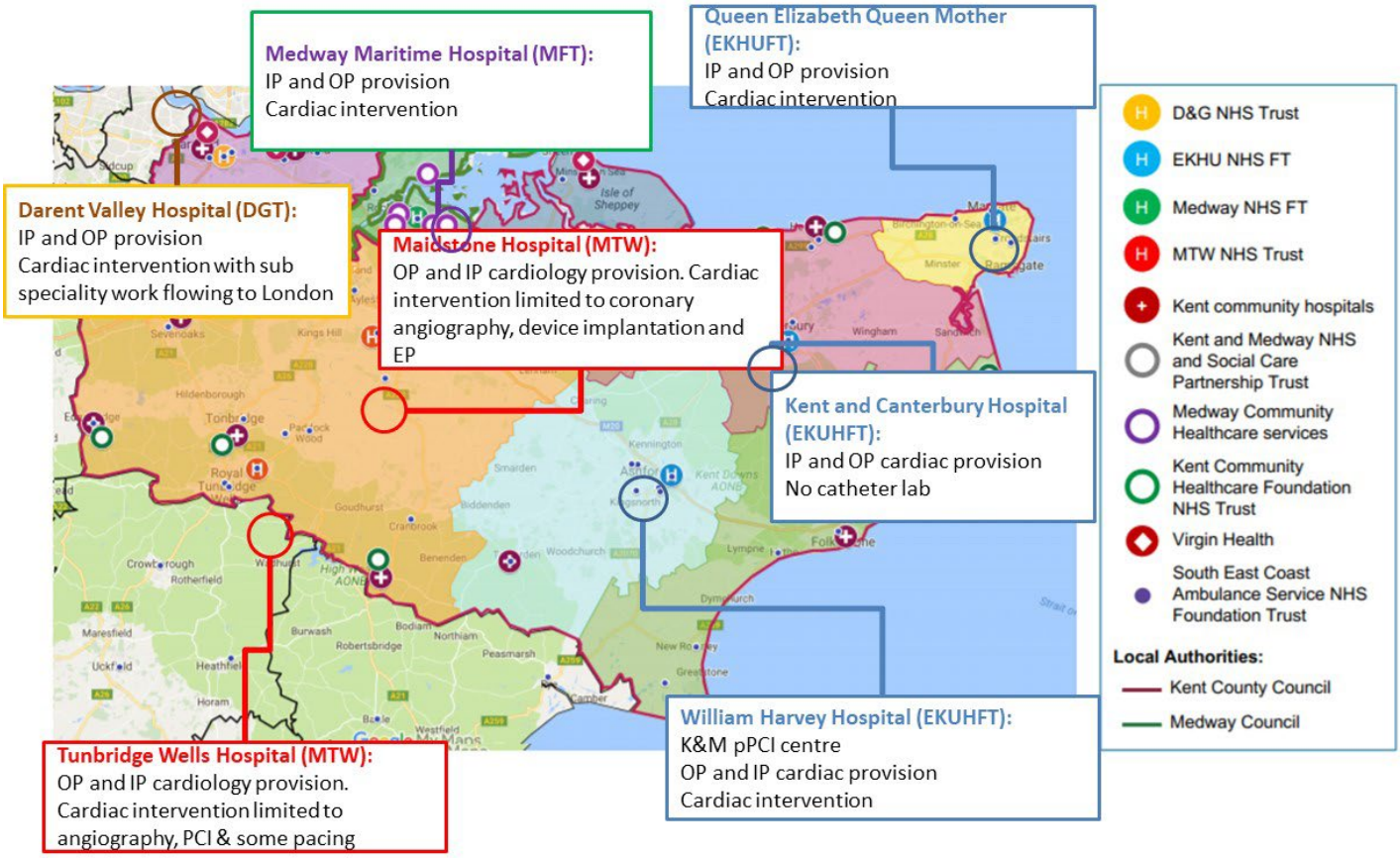
The NHS Long Term Plan identified CVD as the single biggest area where the NHS can save lives over the next 10 years.

1.2. The regional context

The four acute provider trusts in Kent and Medway are Maidstone and Tunbridge Wells NHS Trust, East Kent Hospitals University NHS Foundation Trust, Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust.

Each of the four provider trusts in Kent and Medway, provide outpatient care, non-elective inpatient care, cardiac catheter laboratory-based cardiology services and cardiology diagnostic services

Figure 1 Map of Kent Hospital Trusts



The Kent and Medway Primary PCI Service, an emergency service for patients who have had a heart attack, is located at a single site at the William Harvey Hospital (WHH) in Ashford, run by the East Kent Hospitals Trust. All heart attack patients in Kent and Medway deemed suitable for urgent PPCI are conveyed directly to The William Harvey Hospital (WHH) in Ashford. Consultant cardiologists from across Kent and Medway share in the on-call rota to cover the service 24/7. The PPCI service at WHH is one of the 6 largest in the country. Whilst performance at WHH in terms of 'door to needle' time is favourable, the 'call to door time' has challenges particularly from West and North Kent when due traffic and road congestion.

The numbers achieving a call to balloon (CTB) time within the 150minute target have continued to fall year on year with the most recent data (2021/2022) show only 40% reach this target (England mean 58% and best performing unit 90%).

There is an active Kent & Medway cardiac network which is developing options to support delivery of the Getting it Right First Time (GIRFT) network standards and the case for a second pPCI centre in Kent & Medway in order to manage demand and to manage the geographical challenges outlined above.

Population growth of 13-14% is forecasted for K&M over the next 10 years, which will be generated in part from the Government targets for new homes in Kent, which annually, exceeds 10,000 new houses to be built. An example of a large scheme is the Ebbsfleet Garden City, which will add approximately 15,000 new homes over the coming years and falls within the Darent Valley Hospital (DVH) area. This could increase the demand if DVH direct their complex caseload to MTW and not London Hospitals.

1.3. The West Kent context

Growth in the demand for cardiac services in West Kent area will be driven by increases in the percentage of people who are over the age of 50; the main age demographic for cardiac services, and the general increase in the number of people living in the West Kent area.

Area	Over 50's		
	2021	2031	% growth
Maidstone	69800	77500	11.0%
Sevenoaks	51700	57400	11.0%
Tonbridge & Malling	53400	60400	13.1%
Tunbridge Wells	49000	56600	15.5%
WKCCG only	223900	251900	12.5%

Table 2 - Population growth in the over 50's segment to 2031 from the data published by the KCC.

There are two large scale developments planned for the Maidstone area at [1]

- Heathlands (ME13) - 4,000 homes as part of Maidstone Borough Council's bid to hit its housing targets. A development of some 4,000 homes earmarked for land between Lenham and Charing.
- Lidsing (ME7) – 2000 homes on the opposite side of Maidstone is the proposed development.

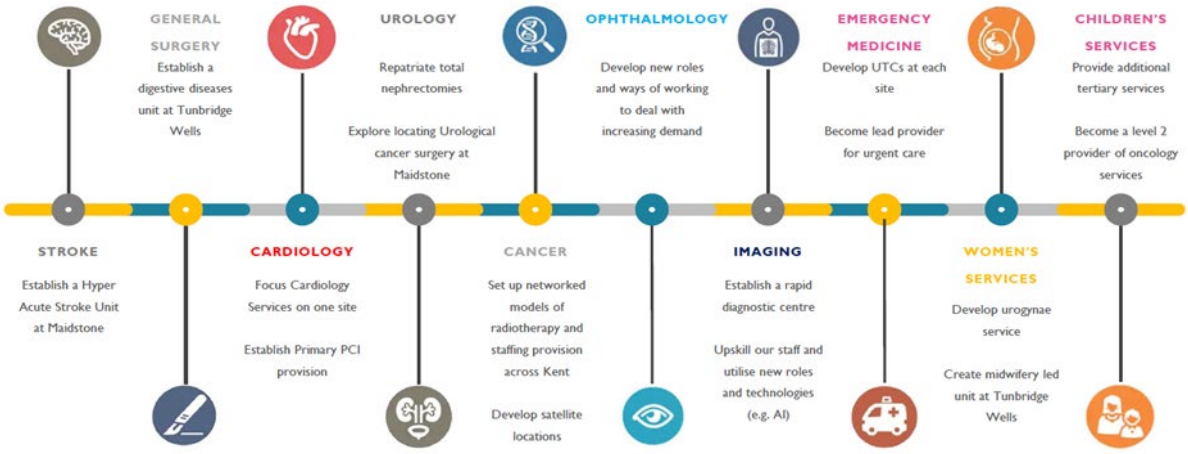
1.4. The local MTW Service

1.4.1. Cardiology Strategy

The Trust clinical strategy, as illustrated in figure 2 below, aims to focus the cardiology services onto one site, with future aspirations of becoming the second primary Percutaneous Coronary Intervention (pPCI) site in Kent and Medway. The current pPCI site for Kent and Medway is in Ashford, Kent which is part of East Kent Hospitals University NHS Foundation Trust (EKHUFT). As the only provider in Kent and Medway the service is regularly at capacity and patients from the north and west of the county are transferred to other providers in central London for pPCI if the Kent and Medway capacity is full. Repatriation of these cases would be welcomed by the London Trusts. Geographically, the Maidstone Hospital site would complement the current pPCI service at Ashford as it is at the other side of the county. Maidstone Hospital also has an excellent road network linking it to all areas of Kent, Medway and London.

To deliver pPCI, MTW aims to improve the efficiency and quality of the current service which is to improve current service delivery and a precursor to the Trust's ambition.

Figure 2 Trust Clinical Strategy



In October 2021, the MTW Trust Board approved a Strategic Outline case (SOC) to develop and reconfigure cardiology services in terms of staffing, facilities and equipment. The board approval initiated the creation of two separate cases:

[1] *Kent online (April 2021) https://www.kentonline.co.uk/kent-business/county-news/thousands-of-new-homes-coming-your-way-244679/*

- A business case to address the ageing cardiology equipment replacement and reduce consumables waste by improving stock management.
- A business case for the centralisation and development of cardiology services to improve quality and the enable the delivery of the Trust Clinical Strategy.

This FBC relates to the centralisation and development of cardiology services to improve quality and the enable the delivery of the Trust Clinical Strategy.

After agreement of the SOC MTW undertook a 14 week engagement process with all key stakeholders to determine the site preference for the service. The process ran from 22nd October 2022 until midnight on 14th January 2022. A wide variety of research, engagement, and involvement methodologies were used to elicit views, feedback, and ideas in response to the cardiology proposals:

1 Survey
2 Targeted engagement
3 Online public listening events
4 Telephone interviews
5 Pop-up stands x5 across geographies
6 Direct stakeholder feedback and individual responses
7 Staff feedback

Analysis of the engagement responses demonstrated a clear understanding of, and support for, the clinical case for change and agreement that the consolidation of services on a single site will bring benefits to patient care and outcomes. The importance of improving cardiology services at MTW had widespread and unequivocal support from respondents, with the majority favouring the consolidated service at the Maidstone hospital site. The engagement process was positively received by many of those who responded (including scrutiny committee colleagues) in terms of the clarity of the case for change and the efforts made by the Trust to raise awareness of the proposals and the opportunity to respond. The Trust has been nominated for a Healthwatch award for the thoroughness of the process undertaken to engage with the public and other key stakeholders.

The Board report from 22nd February 2022 is at Appendix 1 gives more detail regarding the engagement process and outcomes and supported the Board's decision to reconfigure the specialist cardiology service on the Maidstone hospital site.

1.4.2. The Current Cardiology Service

The Cardiology department serves the population of Maidstone, Tonbridge, Tunbridge Wells, Crowborough, Sevenoaks and Paddock Wood, as well as patients from the East Sussex border.

The inpatient cardiology service at MTW is currently provided at both the Maidstone (MH) and Tunbridge Wells (TWH) hospital sites. Both sites have a 6 bedded Coronary Care Units (CCU), and patients' inpatient stays outside of CCU are managed in the general medical wards on both sites. Nominally 6 beds are allocated on the MH site on Culpepper ward which is shared with endocrine medicine and 8 beds on ward 12 on the TWH site which is shared with general medicine. The current general bed need for cardiac patients is 28 beds, as such cardiology regularly uses more than the allocated beds which can result in outlying and safari ward rounds.

There is one cardiac catheter laboratory on each site, budgeted to operate Monday to Friday 9am to 5pm. No one laboratory provides the full range of cardiac procedures, with the Tunbridge Wells site providing diagnostic angiography & angioplasty intervention and simple pacing procedures, and the Maidstone site providing simple & complex cardiac pacing and electrophysiological intervention. Patients at Maidstone Hospital requiring angiography +/- angioplasty intervention will be transferred to Tunbridge Wells Hospital.

Patients at Tunbridge Wells Hospital require complex cardiac pacing or electrophysiological intervention will be transferred to Maidstone Hospital. Both sites also have outpatient services, including clinic and non-invasive diagnostic services (ECG, echocardiography, 24-hour monitoring). Out-patient services are also provided at Crowborough and Sevenoaks Hospitals.

1.4.3. MTW Service Strengths

The cardiology service at MTW delivers a high quality services against a number of key national standards as outlined below:

- Heart failure service
- Percutaneous coronary intervention (PCI) service
- Cardiac rhythm management (CRM) service

Heart failure service

Based on the NICOR National Heart Failure Audit (NHFA) 2023 report (2021-2022 data), Hospital care for patients admitted to both sites with heart failure under the care of cardiology is exceeding a number quality metrics for England and Wales with regard to diagnostic test and receiving prognostic medication as detailed below.

The NHFA standard is for >90% of patients to have undergone echocardiography based upon NICE Clinical guideline [CG187].

National average for England & Wales	85%
Maidstone Hospital	96.7%
Tunbridge Wells hospital	97.4%

Prescription of ACEI/ARB/ARNI, beta-blocker and MRA are associated with better survival, lower hospitalisation rates and improved quality of life. The target is ≥60% for the prescription of all three drug classes based on NICE guideline [NG 106], NICE Clinical guideline [CG 187] and ESC 2021 Heart Failure Guideline.

National average for England & Wales	46.2%
Maidstone hospital	65.7%
Tunbridge Wells hospital	62.9%

Percutaneous coronary intervention (PCI) service

Based on Myocardial Ischaemia National Audit Project (MINAP) and the National Audit of Percutaneous Coronary Intervention (NAPCI) 2023 report (2021-2022 data), hospital care for patients admitted to both sites with a heart attack is exceeding several quality metrics for England and Wales with regard to involvement of specialist care and access to angiography, prognostic medication and post-admission rehab.

All patients with non-ST elevation myocardial infarction (NSTEMI) should be reviewed by a cardiologist during their admission as they are more likely to receive guideline directed management and have better clinical outcomes.

National average for England & Wales	97%
Maidstone hospital	99.3%
Tunbridge Wells hospital	98.2%

With regard to coronary angiography during admission with NSTEMI, the NICE quality standard (QS 68) states that coronary angiography is important to define the extent and severity of coronary disease. Added to this the European Society of Cardiology Guidelines state coronary angiography allows confirmation of the diagnosis, identification of the culprit lesion in a coronary artery, establishment of suitability for PCI or CABG, and stratification of short term and long-term risk. No national standard has been published but the aim is for 100%

National average for England & Wales	83%
Maidstone hospital	99.3%
Tunbridge Wells hospital	98.2%

The ambition is for 90% of relevant patients to receive all secondary prevention drugs for which they are eligible at time of discharge from hospital following myocardial infarction as per NICE Guideline (CG 172).

National average for England & Wales	89%
Maidstone hospital	96.2%

Tunbridge Wells hospital	95.8%

Exercise-based cardiac rehabilitation programmes are associated with fewer cardiac deaths in patients with coronary artery disease. NICE quality standard (QS 99) states adults admitted to hospital with a myocardial infarction are referred for cardiac rehabilitation before discharge.

National average for England & Wales	85%
Maidstone hospital	87.1%
Tunbridge Wells hospital	89.6%

In the National Audit of Percutaneous Coronary Intervention (NAPCI) 2023 report (2021-2022 data) the BCIS Domain Expert Working Group have recommended that >75% of PCI procedures performed electively for stable symptoms should be discharged on the same day as the procedure to provide improved patient experience and cost savings.

National average for England & Wales	71.4%
Maidstone hospital	no PCI currently at Maidstone site
Tunbridge Wells hospital	78.6%

Cardiac rhythm management (CRM) service

International studies have demonstrated that outcomes tend to be poorer in hospitals undertaking low volumes of device and ablation procedures (NICOR National Audit of Cardiac Rhythm Management (NACRM) 2023 report (2021-2022 data)). The British Heart Rhythm Society publishes standards documents for hospitals and clinicians undertaking CRM procedures in adults. These include minimum recommended procedure volumes, which are stringent by international standards as follows:

Quality Standard 3 & 4 (Device Implantation)

BHRS Standards (2018) recommend that pacing centres undertake a minimum of 80 simple device implants per year and a minimum of 60 complex device implants (ICD and CRT implant/upgrades) per year. Maidstone hospital has the highest new device implant numbers in West Kent, exceeding the national threshold for simple devices (146), but below the threshold for complex device new implants at 45 (for reference 41% NHS hospitals are below threshold for complex device new implants). MTW are compliant with NICE guidelines regarding indication and device type for implants of pacemakers and primary prevention ICD implants.

Quality Standard 5 (Catheter Ablation)

BHRS Standards (2020) recommend that ablation centres undertake a minimum of 100 ablation procedures per year in total. Maidstone hospital is the highest volume centre for ablation in Kent and the only centre performing complex ablation in the county having performed 156 ablations in 2021-2022.

1.4.4. Service Challenges:

The service challenges are detailed below which undermine the service and have the potential to undermine the service and service development going forward:

- GIRFT non compliance with seven of the standards
- Fragmentation of cardiology service
- Gaps in continuity of care and poor patient experience
- Workforce, recruitment and retention issues
- Procedure volumes for coronary intervention
- Delivery of the Trust Clinical Strategy objective
- Escalation in to the recovery areas of the Cath Lab.

GIRFT Non-compliance:

A cardiology GIRFT report published in February 2021 recommended 25 standards for services to meet. MTW are non-compliant with 7 of these recommendations (detailed below):

Non-compliant MTW GIRFT requirements

	GIRFT Recommendation	MTW Position
1	All hospitals must deliver cardiology services as part of a defined and agreed network model.	**Essential services level 1 onsite – non-compliant** - 7/7 consultant ward review for all cardiology in-patients is only available for selected patients at weekends. - 7/7 elective/urgent echocardiography not available at weekends. **Level 2 (onsite/network level) – non-compliant** - 7/7 permanent pacing, 7/7 PCI with 24/7 on call for return to lab not available at weekends. In addition there is no on-site on call service available for PCI return to the lab during weekdays. There is an informal agreement for William Harvey hospital to provide this currently. **Workforce – non-compliant** - Consultant cardiologists 1 per 36,000 (currently 1 per 50,000). - Heart failure nurse specialists 3.5 per 100,000 (currently 1.8 in the hospital, 4.3 for West Kent, 1.5 for ES) **Chest pain & arrhythmia pathways 7.5 WTE per million** - currently chest pain clinic 1.2 WTE in post, rehab 4.24 in post & 0.6 vacancy and currently ANS 1.53 WTE in post for 500,000
2	All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned (note this may be the same consultant) to deliver 7/7 review of other inpatients, ensuring continuity of care.	**Non-compliant** - Current Consultant rota delivers 7/7 review of all cardiology patients on CCU and any acutely unwell patients & urgent referrals - Does not include all patients at weekends. - Consultant on call 24/7 is currently in place, however this is a 1 in 5 rota at each site (with Maidstone dropping to a 1 in 4 rota from November 2023). Minimum recommended rota in the GIRFT report is a 1 in 6.
4	All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including ACPs, specialist nurses and cardiac physiologists) are trained, accredited and authorised to prescribe medications relevant to their role.	**Non-compliant** Current hospital-based specialist nurses 3 out of 5 are prescribers. No other clinical staff are currently trained or accredited.
5	Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for the provision of 24/7 emergency temporary pacing and 7/7 permanent pacing.	**Non-compliant** - 24/7 emergency temporary pacing is provided at both sites by COTW - Cardiologist is only member of team trained in Cardiology when performing procedure (no cath lab nurses or physiologists available on call resulting in safety concerns) - Safety concerns with the current set-up which uses emergency theatres. - Permanent pacing is only available on weekdays.
8	Networks must ensure that all hospitals performing PCI have a 24/7 on-site rota for urgent return to the Cath lab.	**Non-complaint** - There are insufficient physiologists, cath lab nurses and radiographers to provide this. William Harvey hospital provides informal cover on a case-by-case basis resulting in fragmented care and safety concerns

10	For the acute chest pain pathway, all networks should provide 7/7 ACS lists, accessible to all hospitals in the network. Coronary angiography '?proceed' should be performed within 72 hours for patients without high risk features, within 24 hours for high risk patients and within 2 hours for the highest risk patients. Where cardiac surgery is required, this should by default be undertaken within seven days of coronary angiography.	**Non-compliant** - Coronary angiography is available Monday to Friday - There is no weekend / out of hours cover. - Currently non-compliant with targets for ACS.
15	Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review as required. Elective/urgent echo should be routinely undertaken 7/7. Urgent TOE should be available 7/7 and delivered on a network basis).	**Non-compliant** - 24/7 emergency echo is currently provided by the consultant on call (working a non-compliant rota). - Elective/urgent echocardiography is not currently available at weekends (there have been some elective ad hoc lists provided by out sourced service at weekends) - No formal 7/7 TOE cover. - 5/7 TOE cover is not consistently provided.

Table 3 - GIRFT summary

An MTW GIRFT virtual visit and subsequent report – at **Appendix 2** report dated October 2021 and **Appendix 3** report dated August 2023, endorsed the approach MTW is taking to resolving the challenges and meeting unmet standards to improve quality. Originally there were 9 unmet standards, and following implementation of service changes two standards have now been achieved, the remaining 7 detailed in the table above, require service reconfiguration, and this reconfiguration will deliver compliance on a further 3 standards. The second report references MTW and compares to a number of other trusts with a number of recommendations for good practice.

Fragmentation of the Cardiology Service:

Fragmentation of service provision means the service faces challenges with delivery, workforce requirements, sustainability, training and barriers to multi-disciplinary working.

GIRFT outline the essential base level services required on each site at each hospital admitting acute cardiology patients as detailed below, which MTW struggle to deliver:

- *Coronary care unit (CCU) or equivalent high dependency unit (HDU)* – whilst both sites have a CCU the configuration of each unit does not meet the required space standards
- *Dedicated (ring-fenced) inpatient beds* - The importance of cardiac patients being admitted to cardiology wards and benefitting from optimum cardiac monitoring and access to highly trained cardiac nursing staff has been highlighted in both the MINAP audit data and NCEPOD Failure to function report. European Society of Cardiology Guidelines advise that patients with NSTEMI should be admitted to a monitored unit and managed by personnel adequately trained to manage life-threatening arrhythmias. Whilst no national standard has been set for admission to a cardiac ward following a NSTEMI, MINAP has recommended a target of 80%. The proportion of NSTEMI patients admitted to a cardiac ward at Maidstone was 26% and Tunbridge Wells 63%. For reference, at least 80% of patients with NSTEMI were admitted to a cardiac ward in 69 hospitals and only 19 hospitals had fewer than 30% of NSTEMI patients admitted to a cardiac ward.
- Care in cardiology wards is associated with lower in-hospital and subsequent mortality, better treatment for patients with heart failure and reduced ejection fraction on discharge, and more access to specialist care. Whilst there is no official standard, the NICOR National Heart Failure Audit has recommended improved access to cardiology wards, as it is associated with better outcomes. Heart failure patients are among those at highest risk without this access (NICE Clinical guideline [CG 187]). The NICOR National Heart Failure Audit 2023 report (2021-2022 data) showed a national average for hospitals in England & Wales of 47% heart failure admissions cared for on a cardiac ward. Maidstone hospital was 39.8% and Tunbridge Wells hospital 34.6%.
- *24/7 consultant on-call (at a minimum 1 in 6 frequency)* - as both sites receive emergency cardiac patients a consultant of the week (CotW) model is required on each site, this results in a 1:4 (MH) and a (1:5) at TWH, which is unsustainable. Elective activity is cancelled due to staffing numbers and cover requirements for the CotW model.

- *7/7 cardiology consultant ward review for all cardiology inpatients* - weekend in-patient review is limited to CCU patients and urgent referrals, rather than a full ward round of cardiology patients due to the onerous nature of the CotW model being managed across two sites.
- *24/7 emergency echocardiogram provision and review (including virtual review) and 7/7 elective/urgent echocardiography* - there is no physiology echocardiography cover out of hours and at weekends. Consultants currently provide an emergency echocardiography provision only out of hours and the majority of on call consultants are not accredited with the British Society of Echocardiography.

Gaps in continuity of care and poor patient experience:

In the current configuration, patients requiring specialist cardiac input or interventional treatment can face delays and handovers between cardiologists and site(s). The arrythmia specialist cardiologists are based at MH, and all complex device and electrophysiology work is performed there, whilst percutaneous coronary intervention specialism and procedures are concentrated on the TW site. Given the elective commitments on both sites this creates challenges with provision of specialist care. In-patients are routinely moved between sites for procedures with associated delays and handover.

Workforce, Recruitment and Retention Issues:

As cardiac in-patients care is delivered on both sites there are inefficiencies in staffing requirements for all cardiac staff groups and has led to the inability to provide a number of core cardiac services, impacting on patient flow, experience and compliance with recognised good practice, for example:

- Inability to recruit to consultant posts as MTW is not an attractive proposition when proximity better staffed and equipped services particularly in London have available posts

- There is currently no provision for out of hours catheter lab nurses, catheter lab radiographers or cardiac physiologists, resulting in:
    - out of hours emergency temporary pacing procedures being performed in the emergency theatres. Emergency theatre staff are unfamiliar with these procedures and cases have to be fit around other emergency surgical work which can result in delays. Mandatory rest periods for theatre staff can mean that elective surgery maybe cancelled the following day if theatre staff have been called in for a cardiac procedure.
    - no out of hours return to laboratory provision for patients experiencing complications from PCI.
    - no provision for out of hours interrogation or programming of implanted devices (such as pacemakers and defibrillators) can lead to unnecessary admission to hospital over night and over weekends until a physiologist is available during normal weekday working hours to interrogate the device.

The current service configuration does not support the attraction of new staff or the retention of staff in post. Recruitment and retention continue to be an issue. Cardiac physiologists are a particular challenge to recruit due to a national shortage as outlined in the strategic review of cardiac physiology services in England. This makes it extremely difficult to recruit qualified and accredited staff. Such high demand had led to cardiac physiologists being able to secure high paid locum placements, which has made permanent contracts with NHS organisations less attractive financially. There have been several attempts to recruit with minimal success. MTW applied a recruitment and retention premia (RRP) for all band 6 and above cardiac physiologists to attract and retain staff to the trust in December 2020. This has improved the recruitment, however there continues to be vacancies and retention issues.

Procedure volumes for coronary intervention:

The British Cardiac Society recommends that a minimum of 400 PCI procedures are performed per year at a centre offering this service. In keeping with other non pPCI centres in Kent, MTW does not meet this level of activity, and is one of only 17 in the country who do not achieve the required numbers (see table below). In fact, the three intervention centres in West Kent (Tunbridge Wells, Darent Valley and Medway) are all in the bottom eight NHS hospitals in the country making them potentially vulnerable for a consolidation of activity to two sites in West Kent. Activity levels are low for three main reasons:

1. Lack of an agreed network NSTEMI service
2. A single pPCI centre and contribution of MTW consultants to that rota.

3. An onerous consultant of the week rota across both sites resulting in more frequent elective lists cancelled due to a lack of a consultant operator to accommodate the on call ward work.

The K&M Cardiac Network accepts that a second pPCI service in K&M is required. In the current configuration MTW would be vulnerable as provision of a pPCI service is not attainable.

There is the possibility that, due to low procedure volumes, a national or K&M review of PCI services would highlight that West Kent as an area that requires rationalisation. In the current configuration MTW would be vulnerable to this and risk losing services, which could have wider impacts for local cardiac services. A reconfigured service would be more robust to such a review and result in a more favourable outcome.

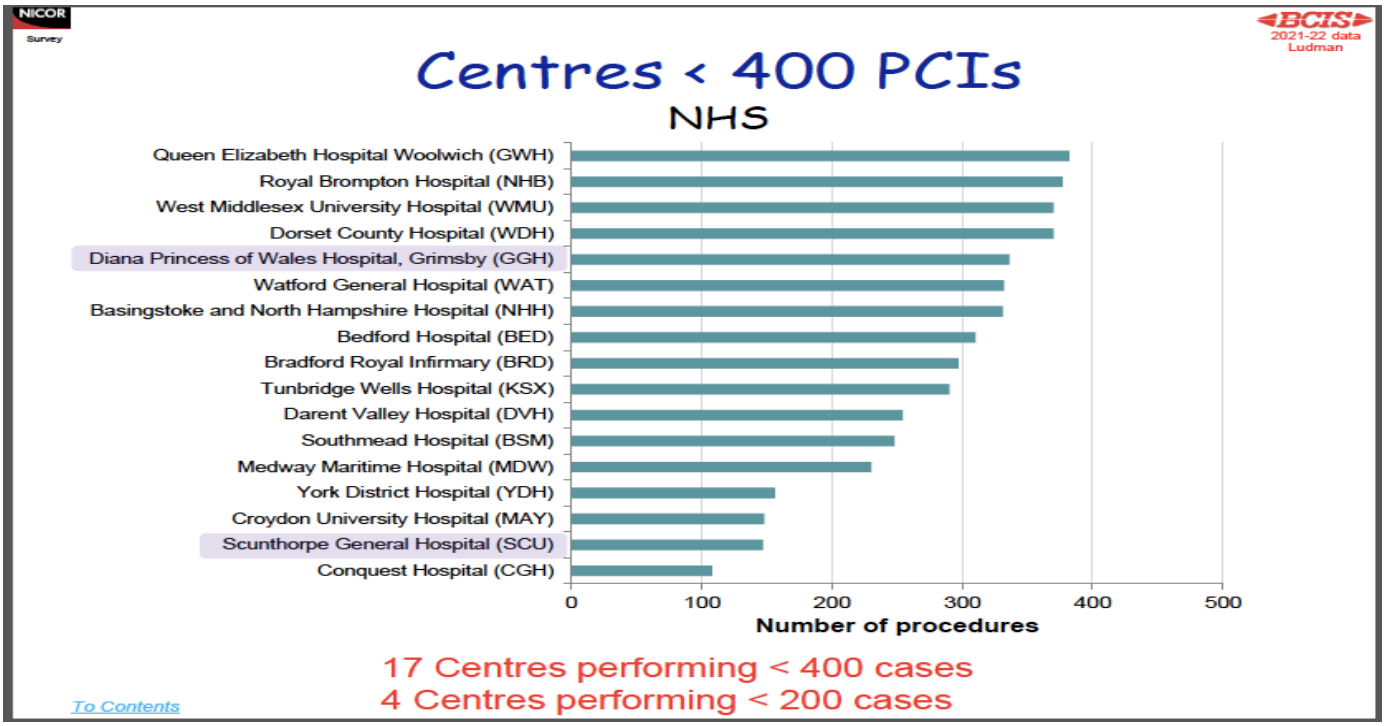


Figure 3 - BCIS National Audit Adult Interventional Procedures 2023 (2021-2022 data)

Delivery of the Trust Clinical Strategy Objective

The current configuration does not and cannot deliver GIRFT compliance and the fragmented nature of the service and staffing challenges will not enable the Trust to deliver the aspiration of becoming a second pPCI site in K&M.

Escalation in to the recovery areas of the Cath Lab

The recovery area for the cath lab at Maidstone is currently adjacent to Culpepper ward. The area is staffed 5 days per week. This makes the area vulnerable to escalation at times of bed capacity and challenges and whilst every effort is made to prevent escalation it is still a risk, which impact on elective activity if the recovery area is full with emergency medical patients. In the winter of 2022 31 cases were cancelled as a direct result of bed escalation.

2. The case for change

The case for change relates to the provision of inpatient and cardiac catheter laboratory services only. Currently cardiology outpatient services, rapid access clinics, heart failure clinics and non-invasive investigations such as ECG and echocardiography are provided on both the Maidstone and Tunbridge Wells Hospital sites. In addition, general cardiology clinics are provided at Crowborough and Sevenoaks Hospitals.

The case for change for the inpatient and cardiac catheter lab services has been driven by the service challenges outline above and is crystallised in the following:

- Progress to meeting the Getting It Right First Time (GIRFT) recommendations, particularly related to dedicated specialist facilities
- To reduce the dilution of services due to necessary duplication across two sites
- To improve recruitment and retention
- Enable delivery of the Trust clinical strategy
- To improve efficiency of the cardiology service and the contribution to organisational inpatient flow
- To improve the patient experience

2.1. Objective(s):

The objective of the case for change is to reconfigure the cardiology inpatient and cardiac catheter laboratory and consolidate these elements onto one site to reduce fragmentation of the service to:

- improve service continuity
- improve efficiency
- ensure future sustainability of a patient centred and high performing service
- to improve compliance against GIRFT standards
- to be prepared to deliver the Trust clinical strategy

2.1.1. Current position:

The specialist cardiology service is base on two sites with the cath lab on each site taking on the management of different clinical disciplines within the lab. This results in the following issues and risks:

- A disjointed and inefficient catheter laboratory service.
- The need for site to site transfers of unwell patients
- The consultant workforce is split creating a less than 1 in 6 consultants of the week on call rota.
- The on call arrangement creates further inefficiency as when on call all elective work (cath lab session, outpatients) for the on call consultant is stood down leaving gaps in the service and putting a negative pressure onto waiting lists.
- There is no dedicated cardiology ward and although there are nominally allocated beds for cardiology patients the nature of the general medical flow means that very unwell cardiology patients may not be in the right bed.
- GIRFT compliance cannot be achieved without centralisation onto one site as outlined above, thereby compromising the delivery of the Trust clinical strategy
- Staff recruitment and retention is challenging as a direct result of the current configuration of the service

2.1.2. The anticipated benefits of achieving the change:

- Improve the COTW rota to ensure compliance with national recommendations for cardiology on call rotas and by decreasing the frequency will release capacity to increase cath lab and out-patient activity
- Increase income and reduce waiting lists as a result of the release of consultant time
- Improved patient pathway for all interventions
- Improved efficiency of the cath labs, clinical support functions and specialist bed base (reduced LoS)
- Improve staff experience and impact on recruitment and retention
- Improved patient experience
- Well placed to bid for pPCI

2.1.3. Critical Success Factors:

The critical success factors (CSFs) share the attributes to the delivery of the programme against which success will be assessed. They have been designed to make sure the strategic objectives, constraints and dependences which are set out in this Strategic Case can be met. The CRFs are:

- **Optimise Value of Money and efficiency.** The preferred option must consider all aspects of VFM including:
  - Improve staff satisfaction to improve recruitment, retention and staff turnover
  - Maximise use of list capacity, scheduling and throughput
  - Increase PBR income
  - Management of waiting list to reduce and sustain low waiting times
  - Reduction in length of stay, improved patient turnover, reduce outliers and increase income
- **Financially Achievable - staffing**. The preferred option must secure sustainable revenue funding for any increase in staffing achieved through increased activity and resulting PBR income.
- **Financially Deliverable – capital**. The preferred option must consider all options to secure the capital/revenue streams to for the successful implementation of the site reconfiguration.
- **Supported by Staff**. The cardiology department is under considerable pressure due to challenges with recruitment and retention. The cardiac physiologist and consultant posts in particular and nationally recognised as difficult to recruit to and the nature of our current service has a negative impact which is affecting throughput and performance and is demoralizing.
- **Strategic Fit**. The preferred option must align with the clinical strategy regarding the provision of PPCI.

2.1.4. Constraints and dependencies on project delivery

The constraints and dependencies that could impact on the project have been examined and are as follows:

Constraints

- Capital availability
- Revenue availability
- Accounting rules

Dependencies

- Trust and ICB approval
- Auditor approval that the financial arrangements meet accounting regulation with relation to the build
- Income is sufficient to cover staffing revenue increase

2.1.5. Risks

There are a number of risks of not proceeding with this service reconfiguration:

- Continued fragmentation of the service
- Increasing recruitment and retention challenge resulting in service inefficiency and increased costs
- Increasing waiting list and waiting times
- Service unable to deliver GIRFT compliance and therefore not able to delivery pPCI service delivery
- Deterioration in the effectiveness and efficiency of the cardiology service
- Loss of the service to other providers
- Future loss of pPCI to another Kent Provider which further destabilises the local service

2.1.6. Assumptions

There are a number of working assumptions which will be fully tested as the case moves to the more detailed full business case. These are outlined in the table below:

	Assumptions
1	Demand for the service is in line with the expected level identified in the analysis and modelling.
2	The assumption is the data used for modelling is accurate and grouped correctly to support activity assumptions (the data used, predominantly from Tomcat is highly complex)
3	Tomcat activity has been mapped to the HRG codes as outlined in appendix 4
4	Where there has been any uncertainty with the HRG code classification, the lowest value has been used. This will provide opportunities for improved income to be achieved.
5	There are other diagnostics and procedures which will provide opportunities for improved income to be achieved may be charged. This will be worked through with the income team for the FBC.
6	The driver for the increased demand is the reduction in the intensity of the COTW rota and the extra capacity that this delivers for out patients, diagnostics and procedures.
7	Sufficient capacity, including physical space, equipment and staff, will be in place to meet demand in each phase
8	Increases in activity will fund the increases in staffing
9	The revenue associated with the build is driven by PBR
10	Unless otherwise stated, the income and costs are based on today's values (eg HRG codes) and do not factor any future increases.
11	That the implementation delivers- - consolidation onto 1 site with commensurate changes to the Consultant of the Week rota - increasing in staffing to improve capacity for EP to manage waiting lists and demand, and enable a procedure room to operate - increase in EP will increase income - other clinical interventions and activities will increase in line with usual growth assumptions…
12	Weekend lab working and 24/7 cover will be explored in the FBC process but if likely to be included in a pPCI case as this a requirement for a pPCI service

Table 4 - Project assumptions

3. Economic Case - The available options

3.1. Introduction to the Economic Case

The Economic Case demonstrates that the trust has selected the option that represents best value for the Trust and taxpayer. The economic case outlines:

- The estates options considered in the longlist process
- An evaluation of the options and development of the shortlist
- Funding for the estate development
- The preferred option in terms of both funding and the estate development

3.1.1 Longlist to shortlist

The Trust used the options framework approach to review which dimensions of choice were applicable to this project and to derive a shortlist of options capable of meeting the investment objectives, from the longlist which detailed in the table below, which outlines the choices considered and the summary outcome.

Option	1	2	3	4	5	6
Service scope (what)	Cath Labs	Cath Labs CCU beds	Cath labs Recovery CCU beds	Cath Labs Recovery CCU Ward beds Staffing review	Cath labs Recovery CCU Ward beds Clinic and clinical admin Develop ACAU Staffing review	Cath labs Recovery CCU Ward beds Clinic and clinical admin Develop ACAU Re site echocardiography service Staffing review
Service solution (where)	Both TWH and MGH sites	Maidstone Hospital		Tunbridge Wells Hospital	Off site	
Service Solution (build options)	SSSU, Culpepper and Cornwallis	Theatre 1 (cath lab) Culpepper and Cornwallis	Internal reconfiguration; fit in current Maidstone footprint; 2 new labs; upgrade of Cornwallis to larger CCU; Culpepper to be dedicated cardiology ward;	Internal reconfiguration ; 2 new labs; new build for recovery and clinic space; upgrade of Cornwallis to larger CCU; ACAU; Culpepper to be dedicated cardiology ward; staffing review	Internal reconfiguration; keep Maidstone lab; build for 2nd cath lab, recovery and clinic space; development of ACAU; upgrade of Cornwallis to larger CCU; Culpepper to be dedicated cardiology ward; staffing review	Internal reconfiguration; keep Maidstone lab; build for new lab, recovery and clinic space; development of ACAU; upgrade of Cornwallis to larger CCU; Culpepper to be dedicated cardiology ward; echocardiology rooms in new build; staffing review
Service delivery (who)	By MTW	Outsourced to Managed Service Provider				

Option	1	2	3	4	5	6
Funding and cost (how)	**Trust Capital**	**System Capital**		**Addendum to Managed Service Agreement**	**Hybrid – Trust (Teletracking) capital for refurbishment plus addendum to the MSA for the new build**	
Implementation (when)	**Full**	**Phased**				

Table 5 - Longlist choices

The outcome of the evaluation of the longlist to shortlist is as follows:

- **Service Scope (what)** – The service scope has considered a number of scenarios and their ability to centralise the clinical and support service to meet GIRFT compliance and the outcome is as follows:
  - Options 1 to 3 are discounted as they do not take account of the necessary movement of clinical staff and provision of space for them, the increased specialist bed requirement as a result of centralising the specialist inpatient service, or the required staffing review as a result of the centralisation.
  - Option 4 is a possible and although includes the ward beds does not take account of the increase in ambulatory activity and the provision of more clinic space or space for clinical staff
  - Option 5 – provides the majority of the requirement with the 2nd cath lab, CCU review, ward bed review, recovery and ambulatory cardiology unit to manage flow and the [provision of more clinical and clinical admin space.
  - Option 6 – the optimum option providing all items in option 5 plus the provision of echocardiography rooms on the ground floor of the new build. this co-locates a key diagnostic test to the labs and ambulatory areas and provides additional echocardiography capacity reducing outsourcing costs and helping with staff retention of cardiac physiologists.
- **Service Solution (where)** – whilst both the Maidstone and Tunbridge Wells sites have been considered, space availability, cost and extended timelines due to the nature of the PFI contractual arrangements ruled out the Tunbridge Wells site. Added to this, the preferred option was overwhelmingly the Maidstone site during the 14-week public engagement.
- **Service Solution (build options)** – a number of options have been considered with the options to build internally being discounted as follows:
  - Option 1 - SSSU (for cath lab, procedure room and recovery), Culpepper and Cornwallis as SSSU is still required for surgical services
  - Option 2 - Theatre 1 (for cath lab), Cornwallis and Culpepper as theatre 1 is too small and the patient pathway would not be optimal
  - Option 3 - The internal reconfiguration only of the cath labs, recovery, CCU and ward beds could be will not allow for the increased clinic and clinical admin space, and there is nowhere else on the site for these services, and does not allow the development of the CAU

  Option 4 will be carried forward as this option develops clinic, clinical admin and ACAU space. Options 5 and 6 will be carried forward as they provide the required space for the service to centralise with adequate space to develop to deliver the Trust strategy
- **Service Delivery (who)** - Option 1 is carried forward as an option with the Trust delivering the clinical service, however noting the constant capital constraint outsourcing the management of a new build to a managed service provider maybe optimal. Both options will be considered in the shortlist.
- **Funding (how)** – All options will be explored in the costing of each clinical option shortlisted to ensure a robust financial assessment, but a hybrid with the Trust taking on the capital for the refurbishment and an addendum to the equipment Managed Service Agreement for the new build is likely to be optimal.
- **Implementation (when)** – A full implementation will be required to deliver the provision of catheter lab and CCU services on one site. Benefit could come from staggering the development over two financial years by running the development of each phase concurrently.

The shortlisted build options are detailed below and labelled options 1 to 4. Option 2, 3 and 4 will include a review of staffing in the financial case, to the support the reconfigured service and activity growth.

Review of Options:

Option 1 – Do nothing

Option 2 – Internal reconfiguration, keeping the Maidstone lab with the development of an L-shaped new build for 2nd cath lab and recovery (first floor) and clinic space and clinical admin space and reception on the ground floor; development of ACAU (to include preassessment) to support increased flow and future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward.

Option 3 - Internal reconfiguration developing 2 new cath labs into the current single cath lab area, and a 2-storey new build to house recovery (upper floor) and clinic/clinical admin space on the ground floor. Allows the development of the ACAU (to include preassessment) to support increased flow and to future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward. This option would require a temporary mobile cath lab and recovery to be installed for the duration of the development, or arrangement with another provider

Option 4 (option 2+) - Internal reconfiguration, keeping the Maidstone lab with the development of an L-shaped new build for 2nd cath lab and recovery (first floor) and clinic space and clinical admin space, 3 echocardiography rooms and 1 reporting room and reception on the ground floor; development of ACAU (to include preassessment) to support increased flow and future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward

3.1.2 Shortlist Criteria

The shortlist criteria are detailed and scored in the table below for each of the options.

		Option 1		Option 2		Options 3		Option 4	
Quality Criteria	**weighting (1 to 3)**	**score**	**weighted score**	**score**	**weighted score**	**score**	**weighted score**	**score**	**weighted score**
FINANCIAL VIABILITY									
-evidence VFM	3	1	3	3	9	1	3	3	9
-income to positively impact revenue affordability	3	1	3	2	6	2	6	2	6
PATIENT PATHWAY									
- continuity of care	2	1	2	3	6	3	6	3	6
- reduce cross hospital transfers	2	1	2	3	6	3	6	3	6
WORKFORCE									
- ability to cover service commitments	3	1	3	3	9	3	9	3	9
- aid recruitment & retention	2	1	2	3	6	3	6	3	6
- support training & supervision	1	3	3	3	3	3	3	3	3
STRATEGY									
- deliver GIRFT compliance, develop cardiology services (local and network)	2	1	2	3	6	3	6	3	6
- strategic fit with ambition for second pPCI centre in K&M	2	1	2	3	6	3	6	3	6
-enables growth and development flexibility	2	1	2	2	4	2	4	3	6
OPERATIONAL									
- addresses barriers to efficient cath lab utilisation	3	1	3	3	9	3	9	3	9
- provides appropriate cover for 'cold' site	3	3	9	3	9	3	9	3	9

- supports inpatient bed efficiency improvements including winter resilience	2	1	2	3	6	3	6	3	6
QUALITY									
- improves patient experience &/or outcomes	3	1	3	3	9	3	9	3	9
- service sustainability	3	1	3	2	6	2	6	3	9
- clinician acceptability	2	1	2	2	4	2	4	3	6
TOTAL WEIGHTED SCORE			**46**		**104**		**98**		**111**

Table 6 - Shortlisted Options Appraisal

The short-listed estates options are detailed in table 6. The table outlines the weighting against each option for the following criteria:

- Financial viability
- The patient pathway
- Workforce
- Strategy
- Operational efficiency and management
- Quality

3.2 Detail of shortlisted options

The analysis of each option, including the financial overview, will be more refined and detailed at FBC, but gives a clear indication of the direction of travel, and has allowed an assessment of the most beneficial option to take forward to the FBC.

The high-level financial overviews of each option show the high-level cost assumptions for the capital and revenue expenditure as well as the income assumptions which are detailed in section 3.1.6. Whilst each option shows a potential annual revenue pressure, what it demonstrates is the increase in activity with commensurate increase income will offset the increased staffing costs at phase 4 as per the assumptions. The staffing costs are outlined in more detail in section 3.5. The increase activity assumptions are cautious at this stage. Further detailed analysis will be undertaken for the FBC to ensure the increased costs and income align through PBR. The figures below illustrate the cost at implementation of phase 4.

Option 1 – Do nothing

Description:

- The continuation of the cardiology service in its current dual site configuration and pathways of care.

Key activity and financial assumptions:

- No change in activity and financial performance.
- It is anticipated that due to demographic population growth demand will increase within a fixed and inefficient capacity context.

Strengths /Opportunities:

- Maintains status quo and will retain staff at TWH

Weaknesses/ Threats:

- Service will not meet GIRFT standards which will compromise delivery of clinical strategy
- Negative impact on recruitment and retention in difficult to recruit to disciplines
- Loss of pPCI service to another Kent and Medway provider
- Compromise service quality and patient experience
- Loss of specialist service to another provider

This option is rejected because it does not meet the service development needs, does not meet the GIRFT standards and will not support he delivery of the Trust Clinical Strategy. This option scored lowest against the options appraisal with an overall score of 47 (see options appraisal matrix in Table 5). Doing nothing is

in reality not an option. Aging equipment past UEL is becoming a challenge and adhoc consideration for replacement is not effective or economical.

Option 2 – L shaped Modular Build, maintain current cath lab, refurbishment of Cornwallis to ACAU and CCU

Description

Internal reconfiguration, keeping the Maidstone lab with the development of an L-shaped new build for 2nd cath lab and recovery (first floor) and clinic space and clinical admin space and reception on the ground floor; development of ACAU (to include preassessment) to support increased flow and future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward.

OPTION 2 - New build 2 storey L shaped extension for cath lab, recovery clinic and clinical admin space, with plant space on roof - development of ACAU and refurbishment of CCU. No temp cath lab required					
		Refurb and enabling	New build	TOTAL	
Construction costs		807,491	5,806,317	7,592,739	
Project Costs		1,261,538	4,252,442	5,513,980	
VAT		545,281	1,802,725	2,348,006	
TOTAL		**3,593,241**	**11,861,484**	**15,454,725**	
TOTAL CAPITAL COST				**15,454,725**	
Capital charges over lifetime of new build (60 years)					24,316,040
Annual capital charges of new build					405,267
Capital charges over lifetime of refurb (21 years)					4,913,760
Annual capital charges of refurb					233,988
Estimated increase staffing for increased capacity to meet demand and growth at phase 4					851,325
Total annual revenue cost					**1,490,580**
Increase in income at full implementation					-2,355,650
Annual revenue impact					**865,070**

Table 7 - Capital costs at RIBA 2.

Strengths

- Service reconfigured onto one site to support Trust strategy
- Bed base (beds 24 and CCU 14) as per the SOC
- Inpatient ward, cath lab, ACAU and CCU are colocated on one site
- Allows development of 7-day service
- Room for 5 bed ACAU to support flow
- Clinical offices and MDT space, reception and patient preassessment and interview rooms all co located on the ground floor of the new build
- Least operational disruption during the reconfiguration as there is no need to move or do work to the current cath lab space
- No movement of other services/offices in the adjoining corridor
- Clinical acceptability

Weaknesses

- No refurbishment of existing cardiology level one beds included in the scheme
- Diagnostic services, particularly echocardiography not included in the scheme

Opportunities

- Minimised service disruption
- Reduced risk of escalation

- Improved recruitment and retention
- Effective elective and non-elective pathways and movement between both
- Realisation of the clinical strategy
- Potential to develop 14 CCU beds to future proof for pPCI
- Provides required estate for future pPCI bid

Threats

- Not reconfiguring may give other local providers the chance to bid for pPCI
- Not including capacity for echocardiography will limit the service ability to deal with activity as this further becomes the diagnostic of choice and lead to inability to retain echo cardiac physiologists.

Option 3 – Internal reconfiguration of cath labs and 2 storey rectangular new build

Description:

Internal reconfiguration developing 2 new cath labs into the current single cath lab area, and a 2-storey new build to house recovery (upper floor) and clinic/clinical admin space on the ground floor. Allows the development of the ACAU (to include preassessment) to support increased flow and to future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward. No clinical new build but build for new air handling units and plant. This option would require a temporary cath lab during the development or an arrangement with another provider.

OPTION 3 - New build 2 storey rectangular extension for recovery, clinic and clinical admin space, with plant space on roof. Refurbishment of current cath lab space for two labs, development of ACAU and refurbishment of CCU. Temporary cath lab required. Not costed in this option.					
		Refurb and enabling	New build	TOTAL	Annual revenue impact
Construction costs		4,312,375	3,761,925	8,074,300	
Project Costs		3,149,039	4,734,525	7,883,564	
VAT		1,337,039	1,563,861	2,900,900	
TOTAL		**8,798,453**	**10,060,311**	**18,858,764**	
Estimated temp cath lab cost*				1,000,000	
TOTAL CAPITAL COST				**19,858,764**	
Capital charges of over lifetime of new build (60 years)					20,623,638
Annual capital charges of new build					343,727
Capital charges over lifetime of refurb (21 years)					12,031,884
Annual capital charges of refurb					572,947
Estimated increase staffing for increased capacity to meet demand and growth at phase 4					851,325
Total annual revenue cost					**1,767,999**
Increase in income at full implementation					-2,355,650
Annual revenue impact					**587,651**

Table 8 - Capital Costs at RIBA 2

This option has an initial cost of c£19.9m due to the high level of internal refurbishment of the current cath lab. This excludes the costs of a slab for a mobile cath lab and recovery and the hire of these modular building for the duration of the build which has been estimated at c£0.5m. The cost of the extensive internal refurbishment is likely to be brittle as work commence progresses on an old building.

Strengths

- Service reconfigured onto one site to support Trust strategy
- Bed base (beds 24 and CCU 14) as per the SOC
- Inpatient ward, cath lab, ACAU and CCU are colocated on one site
- Allows development of 7-day service
- Room for 5 bed ACAU to support flow
- Clinical offices and MDT space, reception and patient preassessment and interview rooms all co located on the ground floor of the new build, although smaller than option 2.
- No movement of other services/offices in the adjoining corridor
- Clinical acceptability but less than option 2

Weaknesses

- Less clinic space and clinical admin space available to support current and TWH staff move
- Mobile cath lab for the development of the cath labs will require a slab at circa £500k, other costs of infrastructure would be required as well as the mobile lab and recovery hire.
- Interim elective pathway risk as cath lab and recovery placed away from the CCU during build
- No refurbishment of existing cardiology level one beds included in the scheme
- Diagnostic services, particularly echocardiography not included in the scheme
- Less flexible space the space
- Higher capital costs than other options leading to a higher annual operational revenue cost

Opportunities

- Realisation of clinical strategy
- Potential for initial improved recruitment and retention
- Improved non-elective patient pathway
- Potential to develop 14 CCU beds to future proof for pPCI

Threats

- Refurbishment will take longer
- Capital requirement is substantially larger than option 2 for no tangible benefit
- Impact on the site and other developments of the interim lab and recovery arrangements while the two cath labs are being developed

Option 4 – option 2 plus provision on the ground floor for 3 echo rooms and a reporting room

Description:

This option is similar to option 2 with an internal reconfiguration, keeping the Maidstone lab with the development of an L-shaped new build for 2nd cath lab and recovery (first floor) and clinic space and clinical admin space, reception and the **addition** of 3 echocardiography rooms and 1 reporting room on the ground floor; development of ACAU (to include preassessment) to support increased flow and future proof the service. The development of 12-14 CCU beds on Cornwallis and the development of Culpepper to a 23-bed specialist cardiology ward

OPTION 4 - New build 2 storey L shaped extension for cath lab, recovery, 4 echo rooms, clinic and clinical admin space, with plant space on roof - development of ACAU and refurbishment of CCU. No temp cath lab required					
		Refurb and enabling	New build	TOTAL	Annual revenue impact
Construction costs		1,786,422	6,295,827	8,082,249	
Project Costs		1,261,538	4,610,950	5,872,488	
VAT		545,281	1,954,706	13,954,738	
TOTAL		**3,593,241**	**12,861,484**	**16,454,725**	
TOTAL INITIAL COST				**16,454,725**	

Capital charges over lifetime of new build (60 years)					24,723,628
Annual capital charges of new build					412,060
Capital charges over lifetime of refurb (21 years)					4,913,760
Annual capital charges per annum of refurb					234,036
Increase staffing for increased capacity to meet demand and growth					851,325
Total annual revenue cost					**1,497,241**
Increase in income at year 4 (full implementation)					-2,355,650
Annual revenue impact					**858,229**

Table 9 - Capital costs for option 4 (estimated from option 2 RIBA 2 costs)

The cost of this option is estimated from option 2 with the only difference being the inclusion of 3 echo room and 1 echo reporting room on a ground floor to create a single storey extension. An uplift of £1m on the total cost has been added while the costs are being confirmed.

Strengths

- Service reconfigured onto one site to support Trust strategy
- Bed base (beds 24 and CCU 14) as per the SOC
- Inpatient ward, cath lab and CCU located on one site
- Allows development of 7-day service
- Room for 5 bed ACAU to support flow
- Clinical offices and MDT space, reception and patient preassessment and interview rooms all co located
- Least disruption during the reconfiguration and no need to move or do work to the current cath lab space
- No movement of other services/offices in the adjoining corridor
- Clinical acceptability
- Co-location of echo rooms to support the rapidly increase in referrals as echo becomes the diagnostic of choice
- Future proofing the service

Weaknesses

- No refurbishment of existing cardiology level one beds included in the scheme

Opportunities

- Minimised service disruption
- Reduced risk of escalation
- Improved recruitment and retention
- Effective elective and non-elective pathways and movement between both sites
- Realisation of the clinical strategy
- Potential to develop 14 CCU beds to future proof for pPCI
- Provides required estate for future pPCI bid
- Provides increased echocardiography capacity

Threats

- Not reconfiguring may give other local providers the chance to bid for Ppci

The preferred option is option 4, as this will future proof service development and future growth in both procedures and diagnostics.

3.3 Funding Options for the Capital Estate Development

In terms of the funding for the development, the Trust has c£7m of capital from Teletracking which is currently held by the ICB. This will contribute to the development however, based on the costs outlined for the estate's options above, this this leaves a capital gap of between c£10m to c£14m based on the capital assumptions above. The use of the c£7m will reduce the initial capital requirement. This funding is however, subject to capital charges. Three funding options for the development have been considered and are outlined below.

3.3.1 Option A - System/Trust Capital

The capital position in the NHS is challenging and is likely to continue over the coming years. Whilst this is an approved development supported by the Health and Care System and stakeholder engagement, financial challenges remain. The lack of NHS capital will impact on the Trust ability to take the programme forward even after the Teletracking capital is added to the programme.

Added to this c£500k is required to get to RIBA 4 which is required to get to FBC. The Trust current lack of capital this will not be able to be delivered in 2023/24, which will constitute a delay to delivery even if build funding is available.

The majority of the costs of the capital will be subject to capital charges as revenue for 21 years for a refurbishment and 60 years for a new build.

Given the position with regard to NHS capital, and the ongoing capital charges this funding option is expensive and unrealistic with the lifetime costs making this prohibitive in the current NHS financial landscape.

3.3.2 Option B – IFRS16 operating lease

The benefit of an IFRS16 operating lease is there is no initial capital outlay. The total cost of the development will be revenue and the structure and duration of the lease will determine the annual revenue costs. An IFRS16 lease will incur capital charges for the duration of the assets expected use by the Trust under the lease agreement (length of lease). The Trust would need to fund the internal refurbishment and system capital will be allocated for this. This also subject to capital charges for the standard 21 years. To get from RIBA 2 to RIBA 4 drawing for the FBC will cost c£500k. The Trust does not have this resource in 2023/24 so progress to FBC would be delayed until 2024/25 unless Trust capital funding could be used in this financial year.

3.3.3 Option C - Addendum to the Equipment MES

The Trust finalised and Managed Service Agreement (MSA) in December 2023 with Medtronic for a 7-10-year period for the provision (renewal and replacement) of cardiology equipment and consumables. The provider can add an addendum to the agreement to include a new building if this is associated with the same service. On this basis the Trust can contract with Medtronic for the new build element of the reconfiguration. Whilst technically a lease, this is charged on a cost per case basis. The financial treatment of the arrangement and current advice puts this within IFRS16. Capital charges will apply and an estimate is included in the overall financial assumption. The capital sum is not as substantial as in other funding options due to the Medtronic financing arrangements where Medtronic take the risk on the project costs, fees and contingency which is over £30% of the overall development costs.

Medtronic would manage the costs of getting to RIBA 4 in 2023/24 for the new build and are prepared to support the Trust with getting to RIBA 4 for the refurbishment in the same timescale. The financial details will be clarified as the programme moves to RIBA 4 but this is an opportunity for the Trust to commence the work up of the FBC once the OBC is approved.

As the costs of any refurbishment of current MTW estate would fall to the Trust to fund, it is sensible to choose an option that optimises the new build. Capital charges will apply to the refurbishment over a 21-year period.

There are a number of issues and risks that need to be considered financially as follows:-

- The addition of the build element to the MSA equipment contract will require a new contract drafting. This will need to be reviewed by the Trust's advisers to ensure the fully variable cost per case approach is still valid within the IFRS 16 initial measurement of a liability, and that no initial capital impact is incurred from any newly introduced guarantees or minimum payments.
- The advisers will also need to confirm the approach to the subsequent valuation of the asset (building) within IFRS16 even though there is no initial capital impact. The working assumption is that the value of the build to depreciate is after deduction of the residual value at the end of the contract.
- The impact, if any, of the addition of the new build to the MSA on VAT recoverability.

Full details of the costs and the contractual arrangements including the building hand back to the Trust at the end of the contract term need full scrutiny and clarification at FBC, however this option has a financial and operational benefits to enable the development the reconfigured service.

Whilst this option has risks that will be worked through in the FBC this is considered the only viable financial options at the current time.

3.3.4 Other Considerations

- Whilst the OBC can progress to Board the FBC cannot be completed without RIBA 4 costs. This is likely to take three to four months and cost circa £500k of capital. Trust/system capital is not available for this in this financial year and has not been planned for in 2024/25
- Medtronic would take the new build to RIBA 4, and come to an arrangement to include the refurbishment costs to RIBA 4 so this stage can be commenced in this calendar year
- The addendum option will require more technical accounting input to assure the Trust that this meets current accounting standards.
- Confirmation of what happens to the building at the end of the contractual period and understand the financial implications

3.4 <u>The preferred options for the build and funding</u>

The preferred option is Option 4 funded by the addendum to the cardiology MSA for the following reasons: -

- **Value for money** – this option allows to expansion of the service to a level that can deliver current activity and future proof future growth both for procedures and diagnostics. The ability to use capacity flexibly will enable demand to be effectively managed to improve quality, reduce waiting times, manage demand and maximise income. On an annual basis, using the addendum option, the revenue costs are higher than the Trust building with NHS capital. However, lifetime costs are lowest for the addendum option. Added to this, securing more space for the footprint of the new cardiology build, makes economic sense at this stage and is using land which is not big enough for any other service development.
- **Economy** - the preferred option minimises the use of resources whilst having regard for the quality of service offered, for example co-locating the catheter labs provides the lowest in-laboratory staffing requirements. Improvement and investment in the service will improve recruitment and retention, resulting in lower bank and agency costs. The addendum option build cost is more cost effective due to the risk taken by Medtronic on project costs, fees and contingency.
- **Efficiency** - the preferred estates configuration and staffing rosters optimise catheter lab utilisation and expand the diagnostic ability of the service. The new consultant rota will enable more elective activity sessions to manage demand, flow and waiting times.
- **Effectiveness** - a scoring matrix (section 3.1.2) undertaken by the senior project group identified the preferred option as the most effective against the case objective

- **Capital Availability** - The likelihood of securing capital to for the new build from NHS system resources is very low meaning the funding option is the only viable solution to securing this development. This means lack of funds to get to FBC and lack of funds to be able to develop the service and reconfigure. With the ICB supporting the case for a second pPCI site in Kent by 2025/6 the Trust needs to be in a position to provide this service, or lose it to neighbouring Trusts. The further impact on recruitment and retention are likely to be substantial.

3.5 Staffing plans

The staffing impact is summarised in the table below. The changes relate only to the increased lab and diagnostic capacity and not to ward staffing which is being reviewed under a separate initiative with the Chief Nurse.

The increase in staffing is for medical staff (2 consultants), physiologists, radiographers, cath lab and recovery nursing to support an increase in cath lab work, enable a procedure room to function and increase outpatient activity. Specialist nursing increase will be required to run extra cardioversion lists and RACPC clinics and to provide the necessary pre-assessment & counselling for the extra procedures through the lab This is required to improve the quality of service to patients and allow sufficient activity to increase income to cover the build development revenue costs. The service expansion not only requires medical staffing but the support staff (cath lab nursing, radiology, physiologists) for the cardiac catheter labs and diagnostic growth and increase in available sessions.

At this stage the case does not include staffing the ACAU, however work will be undertaken to model the activity and income that could be managed through the unit, explore expansion opportunities and determine the necessary income to cover costs of running an ACAU alongside the service quality improvement this could enable.

As demonstrated above there is a tangible link between the ability to increase capacity and the commensurate increase income. Activity analysis, and therefore income predictions, will be further refined in the FBC across the phases as the current assumptions on activity are cautious.

All costs outlined below give tangible benefits to the service in terms of access, quality, demand management, growth and income maximisation.

The reduction in dedicated cardiology beds on the TWH site will release c£750k. Whilst these beds will still be in use by the Trust the costs should technically move to the cardiology budget and will reduce any increase in costs. This will be further explored during the FBC process.

Table 10 Staffing

	Current WTE		Revised		Difference	
Discipline	**WTE**	**£**	**WTE**	**£**	**WTE**	**£**
ACAU	0.00	0	0.00	0	0.00	0
Cath Lab & Recovery	15.31	694,906	18.10	809,287	-2.79	-114,381
Radiographers	4.00	232,554	5.49	305,837	-1.49	-73,283
Physiologists	31.29	1,740,910	28.24	1,740,910	3.05	0
CNS	14.05	714,171	15.34	808,745	-1.29	-94,574
Medical	13.00	2,345,822	18.00	2,914,910	-5.00	-569,087
Total	**77.65**	**5,728,363**	**85.17**	**6,579,688**	**-7.52**	**-851,325**

4 Commercial Case preferred option only

4.1 Services, assets and space required

The services the new development will provide will enhance the current provision on the Maidstone site and reprovide services that will be moving from the Tunbridge Wells site. In summary the new build will provide:

- 1 cardiac catheter lab and supporting space, freeing up the space on the TWH site
- 12 bedded recovery – releasing space on the TWH site and supporting the ward reconfiguration on the MH site
- Clinical office space – freeing up space on the MH site and allowing for staffing increases over the course of the phases. The clinical office space needs to be near service delivery and in reality, there is no where else on site to house up to 14 consultants and other critical clinical staff members.
- Clinic space for pre-assessment and pre-admission – freeing up space on both sites and allowing for increases in activity due to growth and increase in capacity
- 3 echocardiology rooms and reporting room – this will not free up space at TWH as this is an outpatient service which will continue on both site and it will allow refining of the current provision on the MH site which is very cramped and not fit for purpose. The dedicated rooms within the cardiology build will allow very flexible working across a 7day week which will support demand management as increasingly echocardiology becomes the diagnostic of choice

The reconfiguration will provide:

- A refurbished bed base sufficient for specialist cardiology non-elective work
- A refurbished area for a sufficiently sized CCU to manage on site increased specialist activity, and prepare for pPCI
- The second cath lab and current supporting space
- Space developed for the implementation of an ACAU

In terms of equipment the Trust equipment will continue to be managed and maintained by the Directorate, and the cardiac catheter lab and echocardiology equipment will be managed and maintained by the Managed Equipment Service with Medtronic.

In terms of viability the space is available for the new build adjacent to the current cath lab and this is confirmed by RIBA 2. The internal reconfiguration of the preferred options has been planned to create the minimum disruption but the maximum benefit to the clinical area.

The addendum to the MSA route for developing the new build will require the Trust to continue to work closely with Medtronic, with whom we have a robust working relationship. Medtronic will work in partnership with our estates team in terms of design and build, and the choice of contractors will be a joint decision which best meets the needs of the programme and delivers value for money.

4.2 Impacts on and interfaces with other services.

In terms of the impact on other services, this will impact a number of service both clinical and non-clinical on the Maidstone site. Whilst there will be am impact reduction on the TWH site, the space vacated by cardiology will be filled so the local impact at TWH is unlikely to change for some services. The main areas of impact are: -

- Radiology at Maidstone
- The Emergency Department at Maidstone
- Facilities Management at Maidstone
- Clinical Support Services at Maidstone – pharmacy, therapies
- EME at Maidstone
- IT for both the build infrastructure and the support for the larger clinical area once complete, including increased licences as staffing increases.

Whilst services are aware of the potential changes, they will be fully included in the FBC development to give clarity regarding the impact of the changes.

4.3 Activity, contractual and service level agreement implications. Commissioner involvement and input.

An analysis of activity and associated income has been undertaken and the table below shows the anticipated growth aligned to this case as a result of:

- releasing consultant capacity as a result of changes to the COTW rota enabled by single site working
- increasing consultant and support services establishment
- repatriating EP activity from London
- transferring Cath Lab work to the procedures room

For further details, please see **appendix 4** which shows the profile at HRG level as per SUS data. The activity assumptions are as follows:

	Current	Impact of case	% growth
OP	*38,616*	*46,214*	*20%*
Day case	*1,173*	*1,593*	*36%*
Inpatient	*139*	*167*	*20%*
Echo	*7,203*	*7,398*	*3%*
Total	***47,131***	***55,372***	***17%***

Table 11 - Build Option 4 – Estimated Activity

	Current £000	Impact of case £000	% growth
OP	***4,511***	***5,395***	***20%***
Day case	***2,303***	***3,468***	***50%***
Inpatient	***321***	***425***	***32%***
Echo	***740***	***770***	***4%***
Total	***7,875***	***10,058***	***28%***

Table 12 - Build Option 4 – Income

4.4 Procurement

During the FBC process the project team will work with the procurement team who will confirm the most appropriate National Framework run the process and meet compliance requirements. The procurement team will be critical in running the procurement process to ensure all governance requirements are met.

5 Financial Case – Funding and affordability

The financial analysis below shows the impact in terms of spend and income for the preferred option.

The capital costs are low as this reflects only the upgrade of Culpepper and Cornwallis at RIBA 2.

The pay costs are outlined in section 3. This does not include the c£750k to be 'pulled out' of the TWH site nursing for CCU and the ward area. Other Trust costs (e.g. IT) are not yet included in the case.

Whilst there is no capital implication for the new build there is a revenue implication as the contract is on a cost per case basis for catheter lab activity. The revenue impact is based on the RIBA 2 costs for the build and the activity set out in the MSA contract. Activity increases will change the percentage and basis of the charging with Medtronic and this detail, along with growth assumptions will be worked through in the FBC. The life time costs of the funding options will be spread over the contract term (7-10 years) whereas capital charges on a new build would be over 60 years if the Trust were to undertake this. More detail will be confirmed regarding the management of the building at the end of the contract term.

The figures quoted below are assumed as annual costs and income, although the latter may increase a with population growth and demand and the potential implementation of pPCI.

Breakdown of financial impacts	£
CAPITAL COSTS **Estates**	-3,593,243
IT	
Equipment	
VAT	
Total Capital Costs	-3,593,243
REVENUE COSTS **Pay**	-851,325
Non-pay	-812,591
Other	
Other (non- operating) expenditure	-266,000
Capital charges	-233,989
Total Revenue Costs	-2,163,905
INCOME **SLA**	2,181,000
Other (e.g. cash releasing benefits) Please specify and describe below)	
Surplus/Loss	17,095

Table 13: Year 1 financial assumptions

6. Management Case

The management case outlines the project management, monitoring and governance to give assurance regarding delivery of the project objectives and improved service.

- The Trust has in place programme governance arrangements that reflect the need to report into the trust. The governance structure also includes appropriate working groups
- Risk management and benefits realisation plans are in place to ensure successful project delivery
- Extensive engagement has been carried out
- Impact assessments (QIA and EIA) have been undertaken.
- Key clinical staff have been involved in the decision making and will continue to be involved in the implementation and ongoing evaluation of the programme

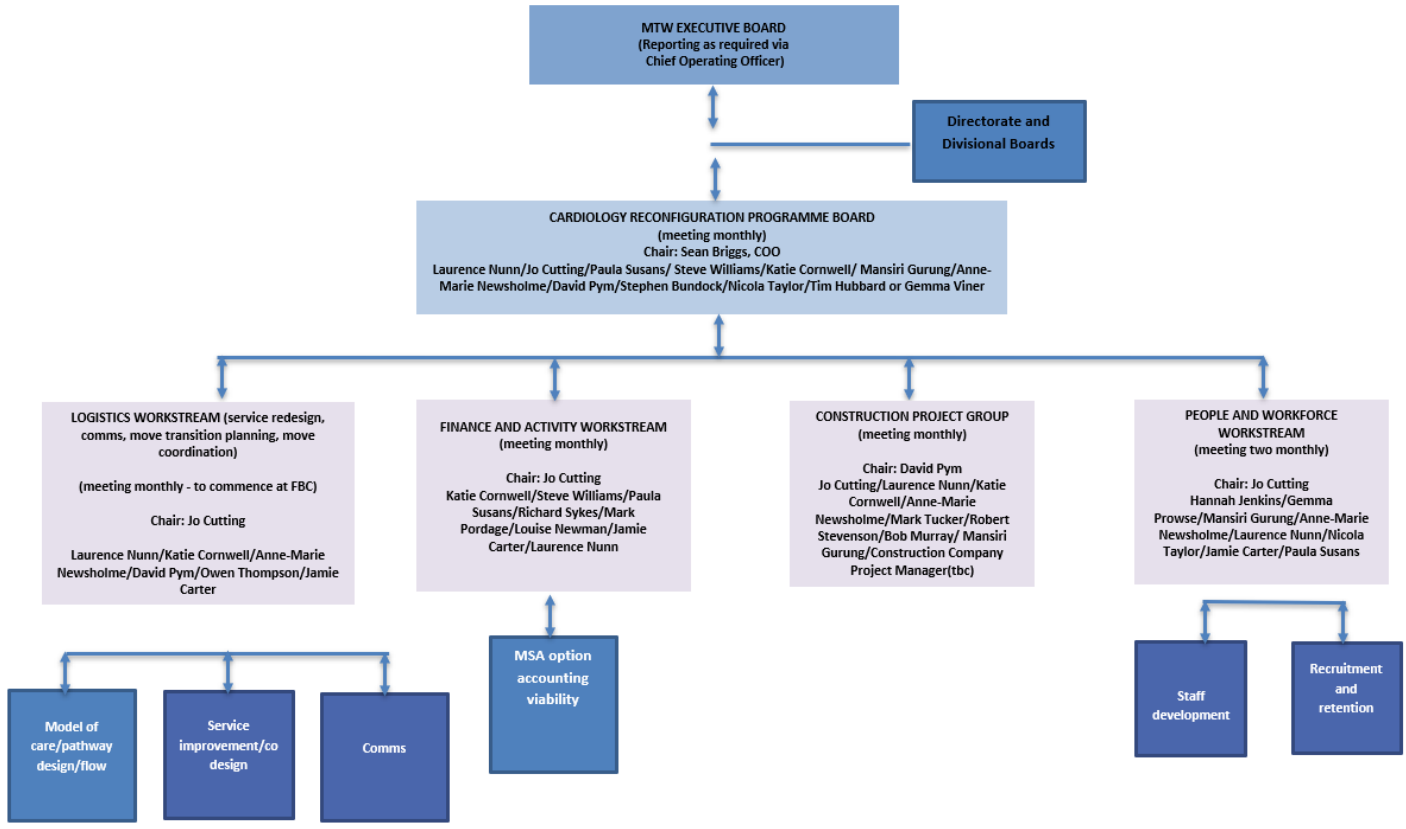
6.1 Introduction to the Management Case

This section of the business case describes how the project has and will be managed, demonstrating that robust arrangements are in place for the delivery, monitoring and evaluation of the initiative, including feedback into the organisation's strategic planning cycle.

6.2 Governance arrangements

The centralisation and reconfiguration of specialist cardiology services is an agreed Trust and Divisional priority and as such the project governance arrangements have been established as outlined in the diagram below. These have been regularly updated as the programme progressed and the structure below is considered to be the most robust to deliver the implementation at this stage but will be reviewed as the FBC develops.

Figure 4 - Cardiology Reconfiguration Governance structure



The programme is led by Sean Briggs SRO and COO and is directly accountable to the Executive Management Team, Medicine & Emergency Care Divisional Board and relevant committees. The programme team consists of:

- Clinical Lead and Chair – Dr Laurence Nunn
- Programme Director – Jo Cutting
- Deputy Director of Finance (capital) – Stuart Doyle
- Finance Lead – Paula Susans
- Divisional Business Planning Lead – Steve Williams
- Contracts/Procurement Lead – Bob Murray
- PMO Manager – Stephen Bundock
- General Manager – Katie Cornwall

Programme Team meetings have been held since June 2023, with outcomes recorded on email circulation. Details of the meetings and the programme management reporting is provided at **appendix 5.** Regular feedback through the Senior Programme Team to the Trust Executive Management Team (ETM) have been undertaken as requested to ensure senior management are appraised of progress.

The other workstreams as outlined in the diagram above are: -

- 1 – Finance and Activity workstream
- 2 – People and Workforce workstream
- 3 – Construction and Estates Project Group
- 4 – Logistic workstream

The meetings memberships and Terms of reference are detail at **appendix 6**

The senior clinical team have been kept appraised of progress and consulted on the options at the regular clinical governance meetings and more informally at staff meetings.

6.3 Project plan

The key milestones associated with implementation are summarised below and are detailed at **appendix 7** as a GANT chart from the beginning of the programme. The GANT chart is subject to updating as the programme progresses.

Milestone	Responsibility	Date	Status
Governance Structure and Terms of Reference created and approved	Jo Cutting & Stephen Bundock	August 2023	Completed
Risk log created and scored	Project Team	30th September 2023	Completed
QIA / EIA completed	Project Team	24th October 2023	Completed
QIA / EIA signed off	Project Board	31st October 2023	Completed
Analysis and baselining of Activity and Income	Laurence Nunn, Katie Cornwell, Jamie Carter, Steve Williams.	20th October 2023/5th January 2024	Completed
Analysis and baselining of Financials	Paula Susans, Steve Williams, Jo Cutting	26th October 2023/5th January 2024	Completed
Outline business case approved by the Divisional Board as correct direction of travel	Divisional Board	31st October 2023	Completed

Milestone	Responsibility	Date	Status
OBC to BCRP to approve direction of travel and the development of the FBC to approve direction of travel	BCRP	7th November, 2023 (for circulation 2nd November)	Completed
OBC to ETM, F&P and Board to approve direction of travel and the move to develop the FBC	ETM / F&P / Trust Board	16th, 23rd January 2024, and February Board	In progress
RIBA 4 work up, activity and financial confirmation and timeline of phasing for preferred option	Project Team / Estates/ Medtronic	30th June 2024	TBC
Full Business Case approvals process	April 2024	July 2024 Board meeting	TBC

Table 13 - Project milestones

6.4 Benefits realisation

Benefits realisation is concerned with putting in place the management arrangements required to ensure that the desired benefit and deliver the objectives. An overview of the benefits realisation against each of the objectives is outlined below and a detailed benefits realisation plan will be developed with measurable KPI metrics in the FBC.

Benefits	Metrics	Baseline	Target
GIRFT Standards	Increased compliance with GIRFT standards	Non-compliant with 7 standards	Completion of new build and service redesign as per FBC
Provide ring fenced beds (ward and CCU) on the Maidstone site	Delivery of centralised service as set out in the preferred option	Nominally allocated cardiology beds within general medicine on both site	Tbc
CotW rota improvement	Minimum 1 in 6-7 on one site	1 in 4 with a rota on MH site and 1 in 5 on the TWH site	Tbc
Improved patient pathways for all interventions, diagnostics and inpatient pathways	Robust elective pathways that deliver within agreed waiting time parameters, by the correct members of the multi professional team	Pathways are brittle and subject to change as the main driver for the service is the emergency demand	Tbc
Improved cath lab diagnostic, clinical support efficiency	Reduced downtime or labs, reduced cancelled lists, improved utilisation	Lists cancelled due to CotW rota, poor utilisation	Tbc
Increased capacity to reduce waiting times and support management of increased demand	Waiting list reduction and sustainability to national standards, effective waiting list management	Waiting list for procedures and some diagnostics outside of national standards, requiring extra (costly) resource to bring down	Tbc
Increased income	Extra staffing costs cover by extra income from extra activity	Little opportunity to expand the service with staffing	Tbc

Benefits	Metrics	Baseline	Target
		challenges and an onerous CotW rota	
Improved recruitment and retention	Fill all vacancies, robust staff development enables but expansion of service and increased income	Recruitment is challenging due to the service current configuration being unattractive	Tbc
Positioned for pPCI expansion in Kent	Service able to respond rapidly to outstanding GIRFT standards	Not currently GIRFT compliant	Tbc

Table 14 - Benefits Realisation

6.5 Risk management

The top risks are detailed in the table below which highlights the project as low risk for the Trust when considering the due diligence and governance that has been put in place. Risks will be monitored by the PMO manager in conjunction with the project members. Updates will be provided to the overall project board and any significant risks will be highlighted to the executive team and recorded on the trust's risk register and, if unacceptable, an action plan developed to mitigate the risk. The risk register is in **appendix 8**
The Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) are in **appendix 9&10.** No significant risks in any of the key areas (patient safety, clinical effectiveness, patient satisfaction, staff satisfaction, inequalities and data protection). The total risk score is 208 prior to mitigation, but after mitigating actions the total risk score is reduced to 140.

Ref	Risk	Baseline risk score (l x i)	Summary mitigation/ contingency	Mitigated risk score (l x i)	Lead
CRR1	Reconfiguration is unaffordable due to lack of Trust capital	25	"1. Review of options for funding and Identifying alternative sources of funding which are financially viable and beneficial, including:	12	Jo Cutting
CRR2	Clinical service development is unaffordable	16	a. Leasing options (IFRS16)	12	Katie Cornwell, Paula Susans, Mansiri Gurung
CRR4	The RIBA4 costs (c£500k) are unaffordable in the current climate and impact the development of the full business case (FBC)	15	b. Addendum to the existing MSA agreement (new build only)	12	Jo Cutting
CRR12	The staff phasing of the new service is unaffordable	12	c. Extend revenue solution 6 - 9 years	12	Paula Susans, Jo Cutting, Steve Williams, Mansiri Gurung
CRR8	Inability to access the site to commence required works.	15	Confirm the refurbishment costs, including capital charge and ensuring that the available capital from Teletracking are sufficient for initial outlay."	10	David Pym
CRR13	Recruitment delays caused by local or national issues and situations, including delays in the recruitment	16	Ensure that elective activity and growth are accounted for.	9	Jo Cutting, Steve William

	process or lack of supply in the network.				
CRR17	If the IFRS16 arrangements are not satisfactory to the Trust and do not align with future Trust strategies, then there is a risk of a delay, scope alteration or termination of the project.	15	1. On-going discussions between the Trust, KPMG and NHSE/I to agree IFRS16 reporting requirements. 2. Consideration from the project team of alternative funding arrangements.	12	Jo Cutting, Stuart Doyle

Table 15 - Key Project Risks

6.6 Change management

6.6.1 Communications and engagement

The Trust recognises that the project will only achieve its objectives if the project is developed with an engaged set of staff and stakeholders and a framework of communications and engagement with key stakeholders (mainly staff) has been in place throughout the duration of the project. It is important to note that stakeholder engagement, communications and the stakeholder landscape itself will evolve throughout the life of the project and it is therefore essential that the project establishes a flexible approach to engagement and communications that has been maintained and re-visited at each phase of the project.

As outlined above a robust 14-week engagement process was undertaken included all key stakeholders commencing in October 2021 and finishing in February 2022. This included an extensive list of all stakeholders **(appendix 1**). During the development of the case staff have been involved in updates about progress and have been involved in discussions regarding the options (**appendix 11**).

6.6.2 Workforce change

As a result of the centralisation of the cariology specialist services staff on the Tunbridge Wells site who work in these areas will be given the option to move over to the new service on the Maidstone site. Those staff not wishing to transfer will be offered suitable alternative employment on the Tunbridge Wells site.

6.7 Post-project and programme evaluation

A standard Trust evaluation template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved. The project will be evaluated by PMO within 6 months of implementation, with a full review at one year.

Name of Directorate	Specialist Medicine
Evaluation manager	PMO
Project Title & Reference	Specialist Cardiology Services Reconfiguration
Total Cost	TBC
Start date	TBC – once Business Case agreed
Completion date	TBC – once Business Case agreed
Post project evaluation Due Date	6 months, full review 1 year

Table 16 - Post project evaluation

6.8 Impact on health inequalities

6.8.1 Quality impact

The Quality Impact Assessment (QIA) at **appendix 9,** does not identify any significant risk in any of the key areas (patient safety, clinical effectiveness, patient satisfaction, staff satisfaction, inequalities). The risk score is TBC prior to mitigation, but after mitigating actions the risk score is down at TBC.

6.8.2 Equalities impact

The Equality Impact Assessment (EIA) for the project can be found at **appendix 10.** The project was assessed as having no overall negative impact on any group and a positive impact in four areas.

6.9 Timetable/ project plan:

A detailed project plan in the form of a GANTT chart is at **appendix 8** and highlights the whole programme history and forward plan. This is summarised with the key milestones below.

Milestone	Date (by when)
Governance Structure and Terms of Reference created and approved	31st July 2023
Risk log created and scored	30th September 2023
QIA / EIA completed	24th October 2023
QIA/EIA Signed off	31st October 2023
High level analysis and baselining of Activity and Income	20th October 2023
High level analysis and baselining of Financials	26th October 2023
Outline business case approved by the Divisional Board	31st October 2023
OBC to BCRP to approve direction of travel and the development of the FBC	7th November, 2023
OBC to ETM, F&P and Board to approve direction of travel and the move to develop the FBC	ETM 16th January 2024 F&P 23rd January 2024 Board February 2024
RIBA 4 work up, activity and financial confirmation and timeline of phasing for preferred option	30th June 2024
Full Business Case approvals process	July 2024
Full Business Case approved by Trust Board	July 2024

Table 17 - Project Milestones

6.10 Data Protection Impact Assessment (DPIA)

Not required as part of the MES contract with Medtronic ✓

6.11 Clinical Quality Impact Assessment (preferred option)

Clinical Effectiveness			
Have clinicians been involved in the service redesign?	Yes ✓	No ☐	N/A ☐
Has evidence been used in the redesign? (e.g. NICE guidance)	Yes ✓	No ☐	N/A ☐
Are relevant Clinical Outcome Measures already being monitored?	Yes ✓	No ☐	N/A ☐
Are there any risks to clinical effectiveness?	Yes ☐	No ✓	N/A ☐
Have the risks been mitigated?	Yes ☐	No ☐	N/A ✓
Have risks been added to departmental risk register review date set?	Yes ☐	No ☐	N/A ✓
Are there any benefits to clinical effectiveness?	Yes ✓	No ☐	N/A ☐
Notes on clinical effectiveness:			

Patient Safety. Has the impact of the change been considered in relation to: *(highlight as appropriate)*			
Infection Prevention and Control?	Yes ✓	No ☐	N/A ☐
Safeguarding vulnerable adults/ children?	Yes ✓	No ☐	N/A ☐
Current quality indicators?	Yes ✓	No ☐	N/A ☐
Quality Account priorities?	Yes ✓	No ☐	N/A ☐
CQUINS?	Yes ☐	No ☐	N/A ✓
Are there any risks to patient safety?	Yes ☐	No ✓	N/A ☐
Have the risks been mitigated?	Yes ☐	No ☐	N/A ✓
Have the risks been added to department risk register & review date set?	Yes ☐	No ☐	N/A ✓
Are there any benefits to patient safety?	Yes ✓	No ☐	N/A ☐
Notes on patient safety:			

Patient experience			
Has the impact of the redesign on patients/ carers/ members of the public been assessed?	Yes ✓	No ☐	N/A ☐
Does the redesign lead to improvements in the care pathway?	Yes ✓	No ☐	N/A ☐
Are there any risks to the patient experience?	Yes ☐	No ✓	N/A ☐
Have the risks been mitigated and / or added to the departmental risk register and a review date set?	Yes ☐	No ☐	N/A ✓
Are there any benefits to the patient experience?	Yes ✓	No ☐	N/A ☐
Notes on patient experience:			
Health inequalities			

What planned or potential positive or negative impacts will the development have on health inequalities? Consider who may have their service or access to service improved or compromised? Describe these impacts
Positive impact is that the consolidated service will be on one site negating the need for cross site travel for patients and their families. On the negative side there is further to travel for some patients at the TWH end of the catchment, but the improvement in quality with faster interventions and reduced length of stay will outweigh the negative.

Overall impact on quality					
What is the overall impact on service quality? – *please tick one box*					
Improves quality	✓	Maintains quality	☐	Reduces quality	☐
Clinical lead's comments:					

7. Appendix

Appendix 1 - Outcome of 14-week engagement – Board Report Feb 2022

Cardiology_Trust Board Report_Site R

Appendix 2

DRAFT GIRFT Cardiology_Maidsto

Appendix 3

20230830 Further Faster Handbook - (

Appendix 4 – SUS Data Activity and Income Modelling

Appendix 4 Cardiology OBC 09.(

Appendix 5 – Notes from the Programme Steering Group meetings

Cardiology - Meeting Notes & Ac

Cardiology Programme Team me

Appendix 6 – Meetings memberships and Terms of reference

ToR _Cardiology Reconfiguration Co

TOR Cardiology Reconfiguration Prc

TOR MSA CApital Addendum Sub Gro

TOR_Cardiology Reconfiguration - P(

TOR_Cardiology Finance and Activity

ToR Cardiology Reconfiguration Log

Appendix 7 - Project Gantt / Timeline (version 2)

Cardiology Reconfiguration Tin

Appendix 8 – Risk log (v3)

Cardiology Reconfiguration Ris

Appendix 9 – QIA

QIA Cardiology v1.xlsx

Appendix 10 - EIA

Cardiology Reconfiguration EIA

Appendix 11 – Staff updated for the progress

Staff QA Cardiology Reconfiguration 22

Staff QA Cardiology Reconfiguration 11t

Summary Information - Staff (

Summary Information - Staff (

Staff QA Cardiology Reconfiguration fin

NHS Maidstone and Tunbridge Wells NHS Trust

Emergency Planning Annual Report, 2023 and future emergency planning — **Chief Operating Officer**

This report highlights the work of the Emergency Planning Response and Recovery Team during 2023. It summarises:

- Incidents
- Training & Exercises
- Planning
- Infectious Diseases & Infection Control
- Partnerships

A video will also be played during the meeting to support the enclosed report.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 30th January 2024

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW EPRR
Annual Report
2023
Version 1.0

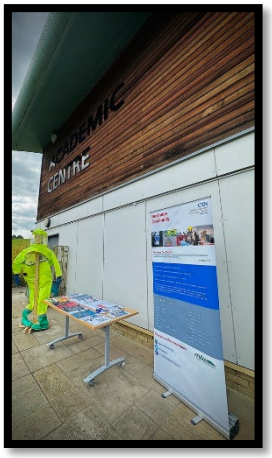
MTW Emergency Planning and Response

Contents

1. Introduction

In the dynamic landscape of healthcare, preparedness is paramount. This comprehensive overview will detail our proactive measures, strategic initiatives, and collaborative efforts undertaken to fortify our Trust against unforeseen challenges. Join us as we reflect on the past year's achievements and outline our commitment to ensuring the safety and well-being of our patients and staff in the face of emergencies.

2. Staffing



The team has thrived with new experience and diverse thinking as a direct result of embracing two Student Emergency Planning Officers. This has enabled the team to modernise its approach to work delivery and enhance the Trusts ability to continue to streamline its resilience approaches. Both of our students have now moved on from the Trust, with one completing their degree at University, and the other relocating back home to seek a career in Emergency Planning.

Furthermore, an internal restructure has allowed the team to enhance its approaches by utilising the range of experiences offered from clinical and non-clinical perspectives.

The team continue to showcase opportunities within the team by attending career fairs, new staff inductions and talking to local schools about the importance of a resilience organisation.

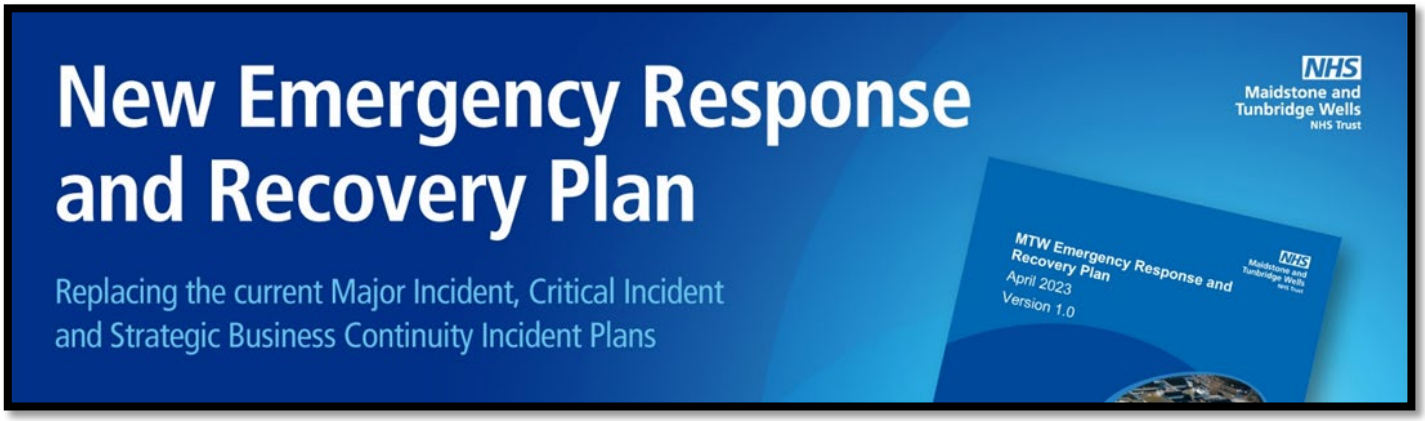
The EPRR Team at an Induction Day for Local Schools

3. New Plan Development

3.1. MTW Emergency Response & Recovery Plan

Keeping our patients and staff safe is paramount in everything we do. To enhance our ability to achieve this, the EPRR Team have completely redesigned the way in which it documents its responses to emergency situations. This new approach has been the catalyst for the creation of the new MTW Emergency Response and Recovery Plan. The main aim has been to streamline and modernise the way in which MTW responds to a multitude of incidents, embarking on a new approach of ‘out with the old, in with the new’.

MTW has become one of the first Trusts in the country to move towards this modern approach, a real leader in this field.



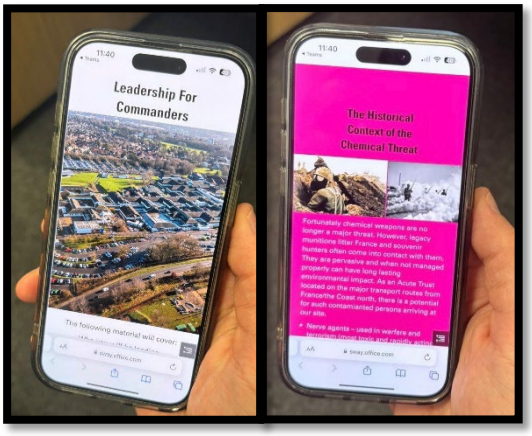
4. Technology Innovation – EPRR

With all of us living in a technologically advanced society, where the use of electronic devices is becoming the norm, it is no surprise that we have had to 'flow with the current' when it comes to new ways of working in modern world.

Innovation and modernisation at Maidstone and Tunbridge Wells NHS Trust is vital to enhance patient care, streamline operations, and keep pace with advancements in technology. Embracing innovation improves treatment outcomes, increases efficiency, and allows us to provide cutting-edge services, ultimately contributing to better healthcare delivery and patient satisfaction. Additionally, it helps the Trust adapt to evolving healthcare challenges.

4.1. Microsoft Sway

The EPRR Team have begun the rollout of Microsoft Sway products to enhance the sharing of key emergency response related material in an interactive digitalised format. This develops learning through easy to read layouts with improved accessibility. In short, this means MTW staff have training material in the palm of their hand, on the go, wherever they are.



Furthermore, staff can easily scan QR codes and immediately bring up step by step response guides.

4.2. Microsoft Forms

Furthermore, in the spirit of technology, the team is currently developing Microsoft forms to deliver:

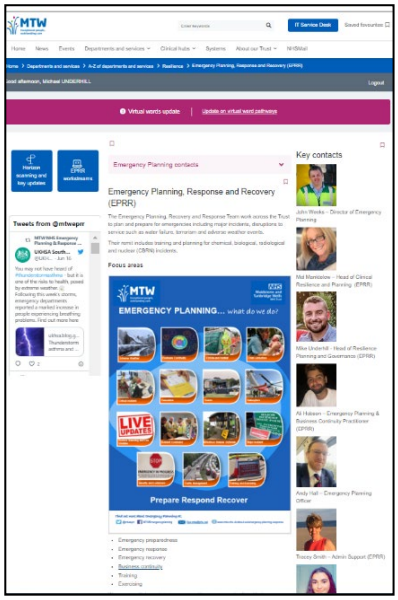
- Interactive training sessions to enhance learning experience through the use of live data
- Pre-reading and e-learning quizzes to identify knowledge gaps, and in turn tailor training to better suit the needs of recipients
- Evaluation of feedback to support the continuous professional development of our products

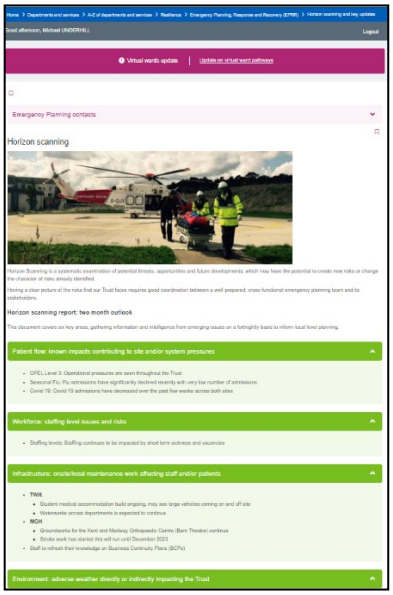
Finally, this allows us to reduce the use of paper within our team, ultimately reducing our carbon footprint as a service and in turn, making our Trust a resilient organisation for society in general.

4.1. Intranet

As the team continue to innovate, MTW EPRR now have a presence on the new Trust intranet, including areas for:

- General EPRR Team information
- Horizon Scanning – for Commanders to keep continually updated on current risks associated with emergency planning
- Commander Continuous Professional Development and Scenarios
- Key workstream information (e.g. Adverse Weather, Business Continuity etc.)





5. Business Continuity

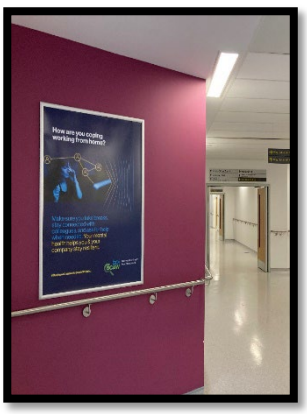
Business Continuity is a **must** within our organisation,

5.1. Business Continuity Awareness Week

Business continuity in at Maidstone and Tunbridge Wells NHS Trust is crucial to ensure uninterrupted healthcare services during unforeseen events like those overleaf. It safeguards patient care, maintains critical operations, and upholds the hospital's ability to respond effectively to emergencies, ultimately preserving public health.

MTW EPRR Team took part in the national Business Continuity Awareness Week by sending out daily communications and quizzes, including video interviews with various Directors, Chiefs and operational staff.

Furthermore, a Survey Monkey was shared to gather information on Business Continuity knowledge across the Trust, as well as imagery on electronic screens and screensavers on all Trust computer devices.



6. Incident Response & Recovery

The EPRR team have provided Tactical Advisor support to Tactical Commanders over the last year.

6.1. Ambulance Bay Flooding – Maidstone Hospital

As a result of sudden intense rainfall, we experienced flooding within our ambulance bays at Maidstone Hospital. This resulted in difficulties when offloading patients from emergency vehicles and into our departments.

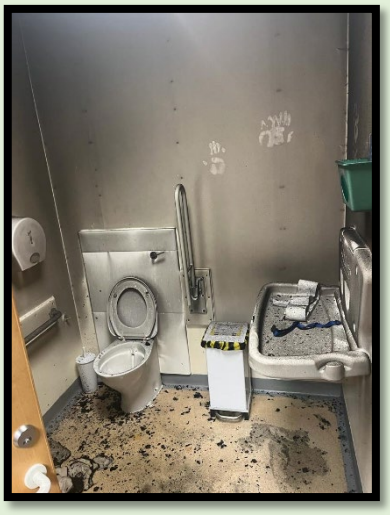
We were supported by Kent Fire and Rescue Service who safely pumped the water away from the location. A perfect example of working with our partners in the emergency services.

6.2. Car Fire – Maidstone Hospital

A member of the public was exiting the Hospital when their car suddenly caught fire. Fortunately, nobody was hurt but this caused challenges with staff and school children utilising the bus service on site, as well as ambulances leaving Maidstone Hospital.

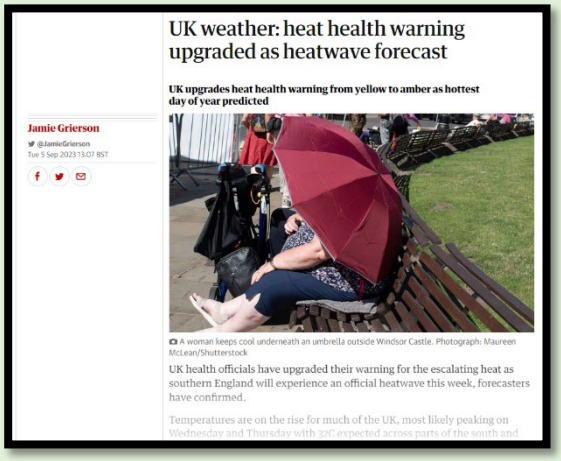
Temporary diversions had to be implemented. Coordinated multi-agency working in a collocated manner was essential to the success of returning to normality within hours.

6.3. Fire in our Oncology Centre – Maidstone Hospital



A fire was deliberately started within one of our toilets within the Oncology Department at Maidstone Hospital. As a result of swift action from our Security and Portering Teams, the fire was extinguished before it could spread, with multi-agency involvement from the likes of Police and Fire Service…a prime example of further strengthening our partnership working.

6.4. Amber Heatwave affecting Maidstone and Tunbridge Wells NHS Trust



UK weather: heat health warning upgraded as heatwave forecast

UK upgrades heat health warning from yellow to amber as hottest day of year predicted

Jamie Grierson

@JamieGrierson

Tue 5 Sep 2023 13.07 BST

A woman keeps cool underneath an umbrella outside Windsor Castle. Photograph: Maureen McLean/Shutterstock

UK health officials have upgraded their warning for the escalating heat as southern England will experience an official heatwave this week, forecasters have confirmed.

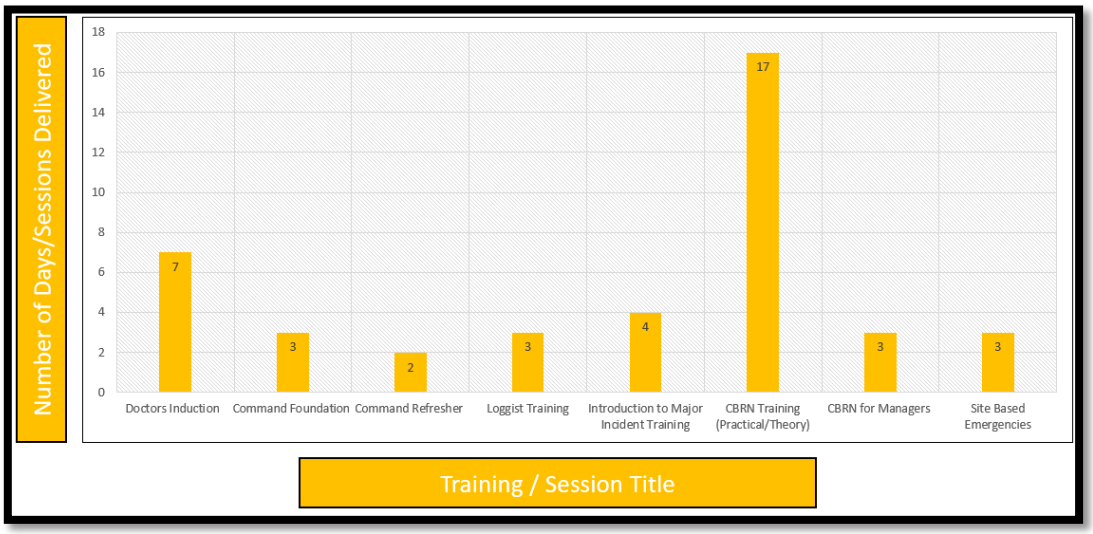
Temperatures are on the rise for much of the UK, most likely peaking on Wednesday and Thursday with 32C expected across parts of the south and

During heatwaves in the local area, we see increased admissions due to heat-related illnesses. Vulnerable people, particularly the elderly, may experience worsened health conditions during this time. Adequate preparation and resource allocation became crucial to ensure our hopsitals effectively managed the heightened demand during the heatwave.

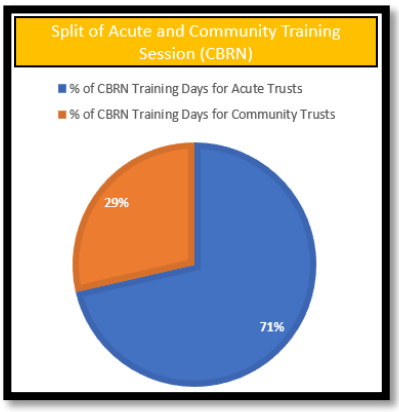
7. NHS Trust sites Training & Exercising

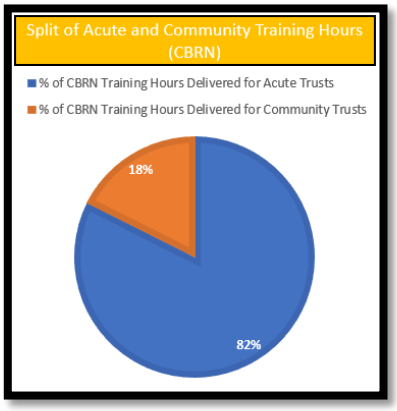
7.1. Training Delivery

MTW EPRR continue to roll-out multiple training sessions to its staff and surrounding Trusts. These include:



In addition to this, we have carried out Chemical, Biological, Radiological and Nuclear (CBRN) training for the Community Urgent Treatment Centres and we continue to deliver spontaneous training to departments in house, including supernumerary staff within clinical departments. The below graphs provide an overview of how we have split our CBRN training sessions across Acute and Community audiences, as well as the comparison of hours spent delivering these across both Trust types:





The future of training is that all deliverable material will be available on IT platforms for staff 24/7, whilst ensuring the target audience have confidence in accessing the necessary response documentation.

7.2. Exercising Delivery

Additionally, the EPRR Team have designed and delivered multiple exercises over the last year, including:

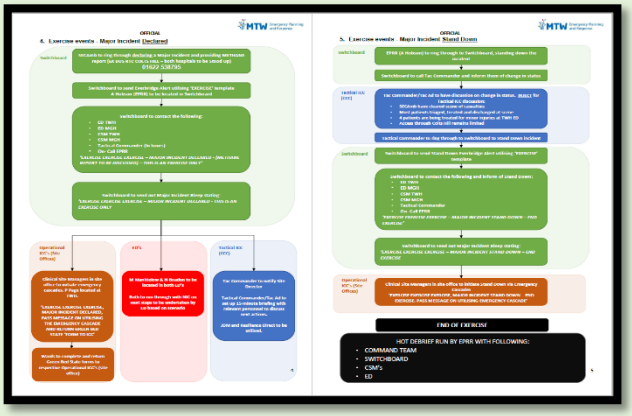
7.3. Exercise Neptune 2 – Water Outage Exercise

7.4. Exercise Springfield 1 – CBRN Exercise

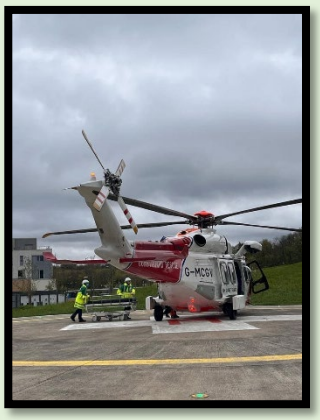
7.5. Exercise Polar 3 – Winter Preparedness Exercise

7.6. Industrial Action Exercise – To enhance preparedness during periods of Industrial Action

7.7. Mass Notification System Exercises – Everbridge…our electronic mass notification system



7.8. Coastguard Casualty Exercise



7.9. Department Evacuation Exercise (Live)

7.10. Wildfire Exercise (Table top)

7.11 Capital Projects

The opening of the new capital builds presents opportunity for multi-agency exercises and both the Kent & Medway Orthopaedic Unit at Maidstone and the New Medical School Building at Tunbridge Wells will both be used for multi-agency live exercises before being used operationally. This will allow our staff and emergency services to gain valuable experience prior to occupation.

8 Governance

The Trust received a full compliance rating in the NHS England core standards assurance process this year. The Trust was also received a peer review commissioned by NHS England looking at its Chemical and Radiological Incident Preparedness which the Trust passed with no issues highlighted.

9 Conclusion

The Trust continues to have high levels of resilience and enjoys a good reputation. Board members are encouraged to take part in exercises. The Trust continues to enjoy a good reputation for its Emergency Planning and resilience activities.