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

Thu 25 April 2024, 09:45 - 13:00

Pentecost/South room, Academic Centre, Maidstone Hospital

Maidstone and Tunbridge Wells NHS Trust

Agenda

09:45 - 09:45
0 min

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).

09:45 - 09:45
0 min

04-1
To receive apologies for absence

David Highton

09:45 - 09:45
0 min

04-2
To declare interests relevant to agenda items

David Highton

09:45 - 09:46
1 min

04-3
To approve the minutes of the 'Part 1' Trust Board meeting of 28th March 2024

David Highton

Board minutes, 28.03.24 (Part 1).pdf (10 pages)

09:46 - 09:50
4 min

04-4
To note progress with previous actions

David Highton

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

Patient experience

09:50 - 10:10
20 min

04-5
Patient experience story

Representatives from the Cancer Services Division

N.B. This item has been scheduled for 9:50am

Patient Experience Story - Cancer Services.pdf (3 pages)

Reports from the Chair of the Trust Board and Chief Executive

10:10 - 10:15
5 min

04-6
Report from the Chair of the Trust Board

David Highton

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

10:15 - 10:20
5 min

04-7
Report from the Chief Executive

Miles Scott

Chief Executive's report - April 2024.pdf (4 pages)

Reports from Trust Board sub-committees

10:20 - 10:24
4 min

04-8
Quality Committee, 10/04/24

Maureen Choong

Summary of Quality C'ttee, 10.04.24.pdf (2 pages)

10:24 - 10:28
4 min

04-9
Finance and Performance Committee, 23/04/24

Neil Griffiths

Summary of Finance and Performance C'ttee 23.04.24.pdf (2 pages)

10:28 - 10:32
4 min

04-10
People and Organisational Development Committee, 19/04/24

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 19.04.24.pdf (2 pages)

Integrated Performance Report

10:32 - 11:22
50 min

04-11
Review of the Integrated Performance Report (IPR) for March 2024

Miles Scott and colleagues

Integrated Performance Report (IPR) for March 2024.pdf (40 pages)

Systems and Place

11:22 - 11:32
10 min

04-12
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent HCP and NHS Kent and Medway ICB.pdf (6 pages)

Planning and strategy

11:32 - 11:42
10 min

04-13
To approve the Trust's Digital and Data Strategy

Steve Orpin

To approve the Trust's Digital and Data Strategy.pdf (25 pages)

11:42 - 11:52
10 min

04-14
To approve the Trust's Patient Experience Strategy

Joanna Haworth

Patient Experience Strategy.pdf (21 pages)

11:52 - 12:02
10 min

04-15
The final planning submissions for 2024/25

Rachel Jones and Steve Orpin

The final planning submissions for 2024-25.pdf (31 pages)

12:02 - 12:12
10 min

04-16
Update on the corporate objectives for 2024/25

Rachel Jones

Update on the corporate objectives for 2024-25.pdf (8 pages)

12:12 - 12:22
10 min

04-17
To approve the Outline Business Case (OBC) for the East Kent Oncology build

Rachel Jones

To approve the Outline Business Case (OBC) for the East Kent Oncology build.pdf (86 pages)

Assurance and policy

12:22 - 12:32
10 min

04-18
To review the Trust's NHS IMPACT self-assessment

Steve Orpin

To review the Trust's NHS IMPACT self-assessment.pdf (60 pages)

12:32 - 12:37
5 min

04-19
Quarterly report from the Freedom to Speak Up Guardian

Jack Richardson

N.B. This item ha been scheduled for 12:35pm

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

Other matters

12:37 - 12:37
0 min

04-20
To consider any other business

David Highton

12:37 - 12:37
0 min

04-21
To respond to any questions from members of the public

David Highton

12:37 - 12:37
0 min

04-22
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 28TH MARCH 2024, 08.45AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Davis	Deputy Chief Operating Officer (Representing the Chief Operating Officer)	(SD)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Medical Director	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director (from item 03-16)	(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)
	Sue Steen	Chief People Officer (from item 03-24 – refer to minute for specific details)	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Daryl Judges	Assistant Trust Secretary	(DJ)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

03-12 To receive apologies for absence

Apologies were received by Sean Briggs (SB), Chief Operating Officer; and Emma Pettitt-Mitchell (EPM), Non-Executive Director. It was also noted that Alex Yew (AY), Associate Non-Executive Director, would not be in attendance.

03-13 To declare interests relevant to agenda items

No interests were declared.

03-14 To approve the minutes of the 'Part 1' Trust Board meeting of 29th February 2024; 14th March 2024 and 27th March 2024

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

03-15 To note progress with previous actions

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

Reports from the Chair of the Trust Board and Chief Executive

03-16 Report from the Chair of Trust Board

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

- Four new consultant appointments had been made during the reporting period
- The Trust continued to deliver a strong operational performance during February 2024, so staff and People Leaders within the Trust should be commended for their continued focus on service delivery.

03-17 Report from the Chief Executive (incl. a quarterly update on the Patient First Improvement System (PFIS))

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

- The significant improvement in the Trust's National NHS Staff Survey results for 2023 reflection the culmination of a significant programme of work over several years, so it was important to

maintain the momentum and noted the changes which had been delivered to support and prompt staff engagement, which were supported by the Patient First Improvement System (PFIS).
- A new Chief of Service for Surgery had been appointed.
- The Trust had been shortlisted for the Health Service Journal (HSJ) Digital Awards 2024, in the in the 'Improving out of hospital care through digital' category, for the Virtual Award programme and the latest development of an Acute Virtual Ward programme.
- The Maidstone Hospital League of Friends (LoF) Annual General Meeting had celebrated the significant support provided by the LoF to the Trust.

Reports from Trust Board sub-committees

03-18 Quality Committee, 13/03/24 (incl. approval of revised Terms of Reference)

MC referred to the submitted report and highlighted the following points:
- The Committee Terms of Reference, which had been submitted for approval, had been revised to commence the establishment of the amended quality governance structure.
- Significant improvements had been made in terms of the utilisation of data to inform quality improves; although, the Committee had acknowledged that further work was required.

The revised Terms of Reference were approved as submitted and DJ confirmed that the Trust Board Terms of Reference would be amended to reflect the change of the "Parent" Committee of the Patient Experience Committee.

03-19 Finance and Performance Committee, 26/03/24

NG referred to the submitted report and highlighted the following points:
- The Committee had reviewed, and recommended for approval in April 2024, the Business Case for the East Kent Oncology Build and the Trust's Digital and Data Strategy.

03-20 People and Organisational Development Committee, 22/03/24

RF referred to the submitted report and highlighted the following points:
- Partial assurance had been received regarding the work to reduce the Trust's temporary expenditure; so, it had been agreed that the workforce efficiency programme should be extended for another three-to-six months.
- Assurance had been provided that the Trust's internal communications programme had continued to deliver improvements in the engagement rate at the Trust, which included the Patient Frist Newsletter.
- Further work was required to deliver the Trust's Statutory and Mandatory training compliance target of 85%; but, assurance had been provided that the target was expected to be achieved within the coming months.
- Although progress had been made in regards to the Equality, Diversity and Inclusion (EDI) strategy, further work was required, which included ensuring an EDI 'lens' was applied to all discussions within the Committee.

03-21 Patient Experience Committee, 21/03/24 (incl. an update on End of Life Care)

JW referred to the submitted report and highlighted the following points:
- Feedback had been provided on the draft Experience of Care Strategy, which was intended to be submitted to the April 2024 'Part 1' Trust Board meeting, for approval.
- Initial triangulation of Friends and Family Test (FFT) feedback, complaints and Patient Advice and Liaison Service (PALS) contacts had commenced, which would be developed further once the new FFT provider was sufficiently embedded.
- A comprehensive Maternity Services plan had been developed to in response to the patient-experience aspects of the Care Quality Commission investigation.
- The annual update on End of Life Care had been enclosed, under appendix 1, for the Trust Board's information.

03-22 Audit and Governance Committee, 06/03/24 (incl. an update on bribery-related best practice)

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

- The standing review of red-rated risks had identified several concerns in relation to the Trust's risk management process, as such the issue had been escalated to MS and the Executive Directors to ensure the issues were addressed and consideration would be afforded to the establishment of working group.
- The Committee had reviewed the Trust's response to the Limited Assurance internal audit review of the "Implementation of NICE Guidance and Safety Alerts" wherein the Committee was assured that the appropriate corrective action had been implemented.
- The Trust's Security provisions continued to improve; however, the initial the position had commenced from a relatively low base position, so further work was required.

03-23 Charitable Funds Committee, 20/03/24 (incl. approval of revised Terms of Reference)

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

- The Standard Operating Procedure had been approved for the Charity Management Committee, which would support the control and disbursement of charitable funds.
- Donations had significantly increased compared to 2023/24, so additional focus was required in relation to ensuring that such funds were appropriate disbursed.
- The Committee's Terms of Reference had been revised to reflect changes in the Committee's membership, so the Trust Board was required to approve Terms of Reference.

The revised Terms of Reference for the Charitable Fund Committee were approved as submitted.

Integrated Performance Report (IPR)

03-24 Review of the Integrated Performance Report (IPR) for February 2024

MS referred to the submitted report and drew Trust Board members' attention to the incorporation of the "Proposed Maternity Metrics" section. SO then referred to the "Proposed Maternity Metrics" section and highlighted the following points:

- The metrics had been developed using the making data count methodology and the Trust's Strategy Deployment Review (SDR) process rules for the escalation of any concerns.
- The two key questions for the Trust Board to consider where whether any additional metrics should be included, beyond the two additional metrics identified by the Finance and Performance Committee (i.e. the Trust's compliance with the target wait time for emergency Caesarean sections and induction of labour), and whether the proposed maternity metrics should be incorporated into each of the existing domains or whether they should be included as a separate section.

JH added that the Women's, Children's and Sexual Health Divisional triumvirate had been directly involved in the production of the proposed maternity metrics and noted the expectation for such data to be presented to the Trust Board, on a monthly basis.

[SS joined the meeting]

A discussion was then held wherein DM highlighted the importance of demonstrating how the maternity metrics would be monitored and how the targets had been established; WW supported the inclusion of the proposed metrics, although, queried whether there was sufficient confidence the metrics would enable the appropriate areas of concern to be identified prior to inspection by an external regulator; JW supported the inclusion of a separate "Proposed Maternity Metrics" section, but requested that the first iteration include details of "what good looks like" compared to the national position; and MC suggested that a six-month review of the metrics should be conducted and noted that metrics should reflect national 'best practice' such as the focus on prompting natural births rather than elective caesarean sections. SO agreed, based on the discussions which had been held, to ensure that the "Maternity Metrics" section of the April 2024 Integrated Performance Report included additional narrative regarding the methodology for the calculation of the metrics, how the target was developed and details of "what good looks like".

Action: Ensure that the "Maternity Metrics" section of the April 2024 Integrated Performance Report included additional narrative regarding the methodology for the calculation of the metrics, how the target was developed and details of "what good looks like" (Deputy Chief Executive / Chief Finance Officer, March 2024 onwards)

JH provided assurance that the proposed maternity metrics would have supported the identification of the areas of concern raised by the Care Quality Commission (CQC) inspection; however, noted that a number of the metrics were recorded manually; therefore, further work was required to ensure a consistent approach and noted the importance of ensuring the metrics considered by the Trust Board were meaningful. JH then noted that the Kent and Medway Integrated Care Board also required the Trust to utilise the Perinatal Quality Surveillance Model (PQSM) Report which introduced additional metrics, so consideration was required as to how the Trust's Maternity Services reporting could be streamlined.

DH suggested that the metrics should be separated into performance metrics and those which provided trend data, but were not necessary for performance management. MS acknowledged the point; however, emphasised the importance of adherence to the Statistical Process Control (SPC) methodology, to ensure the appropriate areas were escalated to the Trust Board.

MS then introduced the IPR and noted that the IPR to the 'Part 1' Trust Board meeting in April 2024 would include a forward view for 2024/25. SS then referred to the "People" Strategic Theme and highlighted the following points:

- The turnover rate had reduced to 11.8%, which was the first time the target turnover rate had been achieved.
- An in-depth review had been conducted into the Trust's short-term leavers, which had identified that the turnover rate for the first 12 months was 30.8%, rising to 49.4% within the first 24 months; so, an initial target had been set to reduce the turnover rate within the first 24 months by 10% by March 2025.
- Due to a change in employment the Trust performance against the "Percentage of AfC 8c and above that are BAME" metric had reduced to 6.5%; so assurance was provided the improving Equality, Diversity and Inclusion (EDI) at the Trust remained a key priority, supported by the Trust Board EDI objectives and the EDI Steering Group.

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

- The rate of Clostridioides difficile (C. Diff) infections per 100,000 occupied bed-days had breached the Trust's target for 2023/24, so additional 'deep cleans' would be implemented once the Trust's open escalation capacity was closed, to enable patients to be decanted.
- The "Reduction in rate of patient incidents resulting in moderate+ harm per 1000 bed days" metric illustrated an improving trend, but a further 'deep dive' was required into the associated data to establish a revised baseline position, which would be supported by the recategorization of all incident reporting categories on the InPhase incident reporting and risk management system.

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

- The Trust was on track to achieve the 96% performance target for the 31-day cancer standard.
- 83% of outpatient calls had been answered in less than 1 minute, but additional work was required to reduce the wait time for initial outpatient appointments, and noted that further updates would be included in future reports as the programme of work progressed.

DH requested an update on the Trust's performance in relation to the original urgent and emergency care capital incentive scheme and the revised urgent and emergency care capital incentive scheme which had been introduced due to the limited number of Trust's that had achieved the performance targets for the initial incentive scheme. MS replied that the Trust was on-track to receive the maximum amount (i.e. £5m) from the urgent and emergency care capital incentive scheme; although, noted that Trust's were only eligible for one incentive scheme, rather than both. SO then clarified that the Trust would receive £5m in capital resource, rather than capital resource and cash; so an additional focus would be required on the Trust's working capital to utilise the additional capital allocation.

WW stated that it would be beneficial for the "Patient Access" Strategic Theme to include additional narrative regarding the number of attendances at the Trust, to provide further context regarding the Trust's performance. SD replied that the volume of patients attending the Trust's Emergency Departments remained at high-levels with an average of 600-700 patients a day, with some days reaching levels of 700-800 patients per day. DM supported the inclusion of additional metrics to provide further context regarding the Trust's performance. MS however re-emphasised the importance of adherence to the SPC methodology. SD agreed to include additional supporting narrative in future reports.

Action: Ensure the "Patient Access" Strategic Theme included additional narrative regarding the number of attendances at the Trust, to provide further context regarding the Trust's performance (Deputy Chief Operating Officer, March 2024 onwards)

DH requested further details of the Trust's peak attendance times and whether there had been any changes. SD replied the period of peak activity was between 6pm and 2am and noted that several initiatives were being trailed in response to the changes in peak attendance times. DH acknowledged the potential impact on the way in which staff rostering was conducted. MS provided assurance that changes in Trust's attendance profile were closely monitored and that the Trust's Clinical Divisions had responded appropriately which had mitigated the requirement for escalation of the increase. DH noted that the Trust was one of a limited number of NHS Trusts that had demonstrated a positive productivity trend.

MC noted the changes which had been highlighted in terms of peak service provision times and queried whether the Trust's cleaning rotas had been adjusted to reflect the change in peak service provision times, to enable additional 'deep cleans' to be conducted in response to the increase in C. Diff cases. SD agreed to review, and if required adjust, the Trust's 'cleaning rotas'.

Action: Review, and if required adjust, the Trust's cleaning rotas to reflect the change in peak service provision times, to enable additional 'deep cleans' to be conducted (Deputy Chief Operating Officer, March 2024 onwards)

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

- Complaints performance had continued to declined and had been inconsistent throughout 2023/24 due to capacity challenges within the Complaints Team, so a Business Case had been developed to expand the complaints Team in 2024/25.
- The Cancer Services Division had implemented a new approach to complaints management whereby patients were contacted immediately after a complaint was received to facilitate a discussion with clinicians and other key staff members which had resulted in a positive improvement in terms of closure time and patient satisfaction.
- Friends and Family Test (FFT) performance had declined due to the transition between the Trust's current provider and the new provide despite the mitigations which had been implemented, but a significant improvement was expected for the April 2024 data.

KC requested clarification regarding the rationale for the deterioration of the Trust's FFT performance. JH replied that the issue was specifically related to the interval period between the cessation of the previous contract and the commencement of the new provider. DH then asked which company had been commissioned as the Trust's new FFT provider. JH confirmed that the contract had been awarded to Health Care Communications (HCC).

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

- Once the Electronic Discharge Notification (EDN) testing had been completed pilots, with six-month improvement trajectories, would be established within those areas which had received PFIS training.

DH referred to the "Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR)" metric and supported the utilisation of the cumulative metric and it prevented variances related to individual outliers.

WW asked what the key factors were, and if any support was required, to deliver significant improvements in relation to the metrics within the "Systems" Strategic Theme. RJ replied that there had been initial delays to the development of the EDN due to the required upgrade to the 'Sunrise'

Electronic Patient Record (EPR); however, noted that the upgrade had been completed and the testing of the EDN had commenced. RJ continued that when the breakthrough objective had been originally developed it had been anticipated that there would be consistent contributors across each service area; however, noted that had there was significant variation in top contributors between service areas. SD added that the revised governance arrangements, through the Better Safer Sooner workstream would enable consistent improvement.

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

- It had been agreed to extend the workforce efficiency programme to further drive reductions in premium staffing expenditure; however, it was noted that there had been a steady reduction in Medical Agency expenditure throughout 2023/24.
- There had been a slight expenditure in premium agency expenditure for February 2024, due to an outstanding invoice, which had prevented the achievement of the lowest level of premium agency expenditure to date.
- The Trust had reported a financial surplus of £10.5m for February 2023 against a revised financial plan due to additional funding which had been agreed with the Kent and Medway ICB which included additional cash resource.
- Cost Improvement Plan (CIP) delivery had underperformed for 2023/24; however, had been counteracted by the additional income achieved from the Trust's activity levels.

DH commented that the extended workforce efficiency programme should also consider similar controls for the utilisation of bank staff, as such controls would be required for a one-to-one reduction between the Trust's vacancy rate and temporary staff utilisation. SO supported the point and provided assurance that the programme of work would consider the totality of the Trust's temporary staffing workforce and the underlying processes (e.g. staff rostering).

Quality Items

03-25 <u>Quarterly mortality data</u>

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

- All mortality indicators were within the "lower-than-expected", with the exception of the Summary Hospital-level Mortality Indicator (SHMI); although, it was noted that the latest SHMI data indicated a value within the "lower-than-expected" range
- No cumulative sum (CUSUM) breaches had been reported within a six-month period
- The Hospital Standardised Mortality Ratio (HSMR) value was higher on a Monday following weekend admissions.
- 100% of on-site deaths had been reviewed by the Medical Examiners Service for February 2024 and there had been a slight increase in the number of Structured Judgement Reviews (SJRs) as it had been agreed that an SJR would be conducted for every sepsis related death.
- There were plans to rename the Mortality Surveillance Group to the Learning from Death Group, to better reflect the intended function of the group.
- The backlog of SJRs had been reduced to 7, all of which had been declared between April 2023 and March 2024.
- An audit, which had been previously cancelled due to the junior doctor's industrial action, had been scheduled to examine the appropriateness of requests for SJRs

DH asked whether the introduction of the 'Sunrise' Electronic Patient Record (EPR) had resulted in improvements in the quality of clinical coding. SM replied that due to the significant programme of work to improve clinical coding at the Trust it was difficult to determine the impact of any individual factor; however, it was acknowledged that the 'Sunrise' EPR had improved the legibility of clinical notes. SM noted that a key factor in improving clinical coding would be the provision of access to patients General Practice (GP) Medical Records, to indicate any existing or past morbidities.

KC asked how the lessons learned from Structured Judgement Reviews were disseminated into clinical practice. SM replied that the lessons learned were reported through the Trust's Clinical Governance meetings, and noted the method of implementation was the responsibility of the local clinical teams; however, any major lessons learned would be escalated to the relevant Committee. KC then asked whether there was a process for identifying any areas which had not responded to

the lessons learned. SM confirmed that was the case; and noted that a regular thematic review was conducted to identify any issues.

People

03-26 <u>The findings of the national NHS staff survey 2023</u>

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

- The Trust's response rate had increased from 42% in 2022 to 47% for 2023, which was a positive engagement indicator.
- 71% of staff recommended the Trust as a place to work, which ranked the Trust in 1st place Kent and Medway, 2nd in the South East region and 8th in the country
- Staff feeling that there are enough staff at the Trust for them to do their job properly had increased by 9.2%
- Although the return on investment on ensuring all staff received an appraisal had been demonstrated; further work was ongoing to improve the quality of the appraisals received by Trust staff.
- Additional focus was required on the areas identified for improvement to ensure alignment with the current programme of work; although, the areas of improvement were associated with areas of concern that had been identified for interventions by the People and Organisational Development Department.
- The feedback received would be triangulated with the feedback received from the Trust's CQC inspections
- An EDI Steering Group had been established to support the delivery of the Trust's EDI Strategy and support the reduction in health inequalities across all service areas.
- The questions related to inappropriate sexual behaviour indicated that 7% of Trust staff had experienced inappropriate sexual behaviour in the last 12 months from patients, families or relatives and that 5% of Trust staff had experience inappropriate sexual behaviour from other colleagues; which emphasised the importance of the Trust's commitment to the sexual safety in healthcare charter. Further work was required to empower Trust staff to speak up if they witnessed any inappropriate behaviour.
- The "Conclusion and Next Steps" section provided assurance that whilst the Trust had celebrated the areas of success there was also significant focus on those areas which required further improvement.

RF commended the improvement in the Trust's National NHS staff survey results and the format of the report which had been submitted, particularly the inclusion of the "so what" factor and identification of key themes. RF continued that RF continued that although a 47% response rate represented an achievement for the NHS, the Trust should consider a target response rate of over 50% for 2024 as additional feedback provided further assurance regarding the actions required by the Trust. RF added that PFIS also provided additional understand and insight regarding key areas of improvement and provided accountability to individual members of staff to deliver such improvements.

RF then highlighted the inconsistency in response rates across different service areas; but, noted that communication barriers had been identified consistently within the feedback received, which was often linked to the role of the line manager and emphasised the importance of encouraging line managers and middle manager to communication with their staff and listen to ideas and concerns of their staff, which would be supported by the new appraisal process.

DH noted that some ICBs had applied a mandate on the number of days in the office for staff within their Integrated Care Systems and noted the free text comments which had been received regarding the equitable allocation of home and flexible working and queried how any inequity within localised approaches could be identified. SS replied that a 'flexible working' Corporate Project had been established, which utilised 'soft intelligence' to identify key areas of concern and noted that as part of the Corporate Project the intention was to provide managers with guidance on how to identify and support appropriate flexible working arrangements. SS acknowledged the challenges in ensuring equity between clinical and non-clinical roles and noted the challenges in terms of space at the Trust were would be considered as part of the Estates Strategy. SS added noted the programme of work

with the Clinical Divisions to achieve a culture where the initial response to flexible working requests was "yes, let's see how it will work". MS emphasised the importance of the space review which had been commissioned and noted the commitment to provide clear principles to guide managers in relation to flexible working.

WW commended the development of the culture at the Trust and requested further details of the next steps in relation to bullying and harassment and the experiences of staff from protected demographics. SS replied that there were concerns in relation to underreporting as the feedback received via the National NHS Staff Survey did not reflect the data received through the Trust's reporting mechanisms; so, outlined the interventions which had been enacted such as the programme of work with A Kinder Life and the Trust's 'listening events' to support the Trust's understanding of the root causes for microaggressions. SS continued that the intention was to provide Trust staff with the required support to improve their resilience and ensure they were kind at work and noted the cultural change programmes which were aimed at increasing management competencies and confidence to deal with inappropriate behaviour.

SO noted that the National NHS staff survey results would enable further prioritisation of key areas which may not have previously been a key area of focus and acknowledged the importance of a consistent and competent management approach. SO highlighted that the Organisational Development Function at the Trust had been established within the previous three years, therefore, the improved feedback received illustrated part of the Trust's return on investment.

NG supported the importance of pursuing an increased response rate and requested further clarification regarding the "…some staff divulging that they have no intention on filling out any further surveys" statement. SS suggested that the comment may relate to survey fatigue within the NHS or to a lack of change within the individuals particular service area.

03-27 <u>To approve the Trust's updated Equality Delivery System (EDS) assessment</u>

SS referred to the submitted report and highlighted the Trust's performance against each of the domains contained therein, and the rationale for the performance ratings which had been allocated.

The Trust's updated EDS assessment was approved, for submission to NHS England, as submitted.

03-28 <u>Update on the Trust Board's High Impact equality, diversity and inclusion (EDI) objectives</u>

SS reported that:

- The intention was to ensure that all Trust Board members had individual high-impact EDI objectives confirmed by the end of March 2024; therefore, discussions would be held with any individual Trust Board members that had not yet confirmed their EDI objectives.
- The Trust Board EDI objective would focus on ensuring that Trust Board reports included an EDI 'lens' and that an Equality Impact Assessment (EIA) would be developed for utilisation as part of any service developments or policy changes at the Trust, to ensure an equitable approach.

DH asked whether the Non-Executive Directors were comfortable with the provision of the individual objectives to DH, as part of the appraisal process, as the appraisal process was intended to be completed prior to the end of DH's term of office. The Non-Executive Directors confirmed their support for the proposed approach.

Systems and Place

03-29 <u>Update on the West Kent Health and Care Partnerships (HCP) and NHS Kent and Medway Integrated Care Board (ICB)</u>

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

- The operational planning guidance for 2024/25 had been issued earlier that day, although had not yet been reviewed.
- The Trust's operational plan for 2024/25 was scheduled for submission to NHSE on the 2nd May 2024, with a draft currently scheduled for submission to the Kent and Medway Integrated Care

Board on the 18th April 2024, although, discussions were ongoing regarding the Kent and Medway ICB submission date.
- A draft report acute provider collaborative review of acute services was expected in April 2024, an update on which would be submitted to a future Trust Board meeting, once available.
- Initial work had commenced on the West Kent HCP Estates Strategy, which would consider the provision of shared facilities with local government and the charitable and voluntary sectors.
- Kent and Medway NHS and Social Care Partnership Trust had commissioned a significant programme of work to transform community mental health services, so JH would ensure engagement by the Trust, through the Mental Health Committee.

DH elaborated on the rationale for the delay in the publication of the operational planning guidance for 2024/25 and noted that the Trust currently exceeded the Emergency Department performance target; therefore, commended the Executive Directors on their continued focus on the delivery of operational performance and noted that it was important to consider the impact of the operational planning guidance on the Trust's budget setting for 2024/25, to prevent a detrimental impact on the Trust's performance for 2024/25.

Planning and strategy

03-30 Update on the Trust's planning submission for 2024/25

RJ reported that:
- Those long-waiting patients from across Kent and Medway which were supported by the Trust would not be included on the Trust's Patient Treatment List (PLT) and therefore would not adversely impact the Trust's performance.
- SB and SO had developed a process for service prioritisation, which would consider the allocation of funding to unfunded service developments, to ensure any available funding was optimally prioritised.

SO then reported that the Kent and Medway Integrated Care Board had confirmed the submission date for the Trust's planning submission for 2024/25 as the 22nd April 2024.:

DJ queried whether it would be beneficial for the Trust Board to delegate authority to MS, via the Executive Team Meeting (ETM), to approve the Trust's final planning submission for 2024/5, due to the revised submission timelines. DH replied that a decision would be made, external to the meeting, with SO and MS, as to whether an extraordinary Trust Board meeting was required, or whether the Trust's final planning submission could be circulated to Trust Board members, via e-mail.

Assurance and policy

03-31 To ratify the updates Standing Orders (to reflect the new Fit and Proper Persons Test Framework)

DH referred to the submitted report and highlighted that the Trust's Standing Orders had been amended to reflect the new NHS England (NHSE) Fit and Proper Persons Test Framework and the NHS Leadership Competency Framework; although, it was acknowledged that a pragmatic approach would be required to the Non-Executive Director appraisal process, as the competencies had not been available during the 2022/23 individual objective setting process, but would be utilised to inform the Non-Executive Directors objectives for 2024/25 onwards. DH then commended the work of DJ on the amendment of the Standing Orders to reflect the technical aspects of the Fit and Proper Persons Test Framework.

The updates to the Standing Orders to reflect the new Fit and Proper Persons Test Framework were ratified as submitted.

Annual Report and Accounts

03-32 Confirmation of the outcome of the Trust's 'going concern' assessment

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

- As part of the annual accounts, the Trust had to make a statement about the basis on which the accounts would be prepared.
- The Executive Team Meeting (ETM) and Finance and Performance Committee had considered the issue and confirmed their support for the Trust's annual accounts for 2023/24 being prepared under the going concern principle.

The Trust Board confirmed that the Trust's annual accounts for 2023/24 should be prepared under the going concern principle.

03-33 To consider any other business

There was no other business.

03-34 To respond to questions from members of the public

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

03-35 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]
03-24a	Ensure that the "Maternity Metrics" section of the April 2024 Integrated Performance Report included additional narrative regarding the methodology for the calculation of the metrics, how the target was developed and details of "what good looks like"	Deputy Chief Executive / Chief Finance Officer	March 2024 onwards	Due to time constraints, the additional narrative requested will be available for the May 2024 Integrated Performance Report.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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)	April 2024	The requested content was included within the presentation at the Quality Committee 'deep dive' meeting in April 2024.
03-24b	Ensure the "Patient Access" Strategic Theme included additional narrative regarding the number of attendances at the Trust, to provide further context regarding the Trust's performance	Deputy Chief Operating Officer	March 2024 onwards	The Chief Operating Officer will include additional narrative regarding the increase in ED attendance within his verbal performance update.
03-24c	Review, and if required adjust, the Trust's cleaning rotas to reflect the change in peak service provision times, to enable additional 'deep cleans' to be conducted	Deputy Chief Operating Officer	March 2024 onwards	Out of hours domestics are rostered routinely in order to manage the peaks in service provision. This is also reviewed daily in line with the CCC so that support services can be flexed to meet the demand.

Actions not yet due (and still 'open')

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

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 May 2024 due to the volume of work involved in the review (which is 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).

NHS Maidstone and Tunbridge Wells NHS Trust

Patient Experience Story **Representatives From The Cancer Services Division**

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

Patient stories will provide feedback, from patients themselves on what actually happened in the course of receiving care or treatment at the Trust, both the objective facts and their subjective views of it.

The Trust Board is asked to consider the following areas/questions for further discussion:

- What does this story reveal about Trust staff?
- 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?

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

Reason for submission to the Trust Board: 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

Patient Story

Name: Mr A	
Date of care experienced: **November 2023-January 2024**	**Services/wards experienced:** **Oncology Services**

Outline of experience:

Mr A is a 59-year gentleman with a diagnosis of melanoma with a lung metastasis in 2023. Mr A was referred to oncology for treatment.

Patient consented and started a drug combination of Ipilimumab and Nivolumab which are an immune checkpoint inhibitor and would be given 3 weekly and this is a total of 4 cycles, after which Mr A will move onto 4 weekly Nivolumab. Treatment duration is 2 years.

Mr A commenced treatment at end of November 2023 initially with no side effects. However, around the start of the 2nd cycle Mr A was experiencing some symptoms relating to swelling and itchiness of the skin in a part of the body, reviewed by medical team and treatment proceeded. Within 6 days, a call was made to your triage line with continuing swelling and itchiness, advised medication both oral antihistamine and topical treatments for itchiness.

Cycle three of treatment given early January 2024.

Day 10 post 3rd cycle:

Mr A contacted the triage phone as had itchiness, applied treatment that was previously suggested and had not made any difference. Advised to increase oral antihistamine medication treatment to three times a day.

Day 11 post 3rd cycle:

Mr A called the triage phone in the early hours of the morning, not able to sleep due to itchiness. Advised to call 111 and to call the chemotherapy unit the next day as it was a weekend.

Day 12 post 3rd cycle:

Mr A called the triage line, GP had prescribed sleeping tablets and stronger anti-histamines, checking to make sure medication could be taken with immune checkpoint inhibitors. It was confirmed by pharmacy that this was fine to take.

Day 15 post 3rd cycle:

Mr A wife called the triage line concerned about husband in the morning due to feeling very fatigued and sleepy. Later on, that evening, a call was received by paramedics who attended and assessed Mr A at home. Mr had had a raised temperature and was very sleepy. Mr A was taken to another local NHS Trust near Mr A for assessment and admitted as an inpatient for sepsis management.

Day 16 post 3rd cycle:

Subsequently Mr A was admitted to ICU having suffered a cardiac arrest at his local trust.

Mr A passed away 4 days later in ICU.

Family contacted the oncology team at Maidstone and Tunbridge wells a day after Mr A passed away regarding concerns raised about his care and treatment. A Local Resolution Meeting (LRM) held in March 2024 with the family together with oncology team including treating Oncology Consultant, Divisional Director of Nursing, Clinical Director and Complaints Lead. During the meeting the family was Mr A voice and talked through their concerns of the information and advice provided to Mr A on the triage phone assessment calls. From the LRM it became clear that were some learning opportunities that we needed to take forward. We advised the family that we would be in contact.

A week later we contacted Mr A wife to explain that we were going to be undertaking an After-Action Review (AAR) for learning opportunities and once this was completed we will meet with the family and go through the AAR and action plan.

Positive points to highlight:	**Negative points to highlight:**
Personalised approach with Local Resolution Meeting with the family. Family appreciated the offer of a face to face LRM to discuss their concerns. Mr A family were the voice for him and able to provide us with their experience Learning from Local Resolution Meeting to take back to improve experience and care for oncology patients. Importance of changing our practice with complaints, taking an LRM response vs written responses. Nurse Consultant post out to advert for Acute Oncology and also with a special interest in Immunotherapy	Delay period between family contacting and LRM held face to face. Incorrect advice given on the triage line. Lack of clear documentation on triage assessment forms. Lack of clinical review from oncology service post triage assessment calls. Difficult for staff to hear Mr A story and family. Hearing the family story of losing Mr A and the impact that this has had on them and the wider family.

Ongoing actions with case:

After Action Review taking place with an action plan to take forward learning.

Weekly Immune check point inhibitor task and finish group – number of actions being taken forward including changes to the triage assessments, re assessing competencies, setting up a dedicated triage team to manage assessments. This weekly meeting is chaired by divisional director of nursing.

Sharing and working other Kent and Medway Trusts to share learning from this incident.

NHS Maidstone and Tunbridge Wells NHS Trust

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

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
20/03/2024	Consultant Acute and General Physician	Orchid	Barua	Geriatrics	TBC – awaiting CCT / acting up from 11th May	New

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

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

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

Report from the Chief Executive **Chief Executive**

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

- With the financial year 2023/24 at an end, we have carried out a review of progress against each of our strategic objectives as we look ahead to our future plans.
    - **Patient experience**: We have achieved our target and reduced the number of complaints received during the last six months. Compared to two years ago we've also seen a 30% reduction in the number of complaints which mention poor communication with patients and their families. A dedicated programme board has been set up to oversee the Trust-wide action plan to further reduce complaints and we are continuing to engage with clinical divisions on their action plans.
    - **Patient access**: Work to achieve the national standard for referral to treatment (RTT) is ongoing and the number of patients on our surgical waiting lists has reduced by 2,500 compared to this time last year. The Trust also continues to be one of the best performing acute trusts in the country for long waiting patients, with no patients waiting over 52 weeks for elective treatment. Significant developments have also been made to increase new outpatient activity, achieving over 120% for the year (April 23 to March 24), compared to pre-pandemic levels. Other Trust-wide improvements include the introduction of the patient portal and progress under NHS England's Getting It Right First Time (GIRFT) programme. We are now looking at initiatives to reduce the time patients wait for a first outpatient appointment.
    - **Sustainability**: The objective is to reduce the amount of money spent on premium workforce and the Trust has made significant progress in this area. Agency staffing costs have reduced by £10.3m in the last financial year - down from £27.8m in 22/23 to £17.5m in 23/24. This is being supported by a Trust-wide programme to improve the use of rostering systems. We have also delivered our financial plan for the sixth year in a row and I would like to thank colleagues for their hard work and support which has enabled us to achieve this.
    - **People**: The target to reduce the Trust-wide vacancy rate has been achieved, and stands at 5% in March, reduced from 15% in April 2021. An additional target, to reduce staff turnover to 12%, has also been met in February and March this year, and is now at 11.5%. The priorities going forwards include further reductions in the turnover rate and improvements in retention, with a focus on hot spot vacancy areas, and staff who leave MTW within 24 months of joining the organisation.
    - **Systems and partnerships**: The Trust has improved flow through the hospitals by supporting patients ready to be discharged by noon and we saw an increase to 24% early in the year, with an ongoing focus to bring discharges further forwards during the day. This is thanks to more efficient processes including criteria-led discharges, electronic discharge processes and board rounds. However, further improvement towards this target has been challenging and therefore our teams continue to prioritise this issue. In addition, the Trust has reduced the rate of patients who are no longer fit to reside, achieving a position of 3.3 days (per 1,000 occupied bed days) against our target of 3.5.
    - **Patient safety and clinical effectiveness**: The Trust continues to focus on reducing patient falls, reaching our target (6.4 falls per 1,000 occupied bed days) last year and sustaining this with an end of year performance of 5.4. MTW has developed the incident reporting process on the Trust's incident reporting system, InPhase, to reduce the moderate and severe harm rate for patients in our care and supporting more accurate reporting of incidents going forwards.

- MTW has acquired Spire Tunbridge Wells Hospital, a private healthcare facility in Kent. The purchase will enable the Trust to develop clinical services in a number of areas and provide additional NHS capacity across Kent and Medway. The hospital at Fordcombe will provide MTW with additional facilities including two theatres, 28 inpatient and day care beds, diagnostics

including X-ray, MRI, CT and endoscopy, and a number of consultation and treatment rooms. This will increase NHS capacity and enable MTW to carry out more procedures for long waiting patients across Kent and Medway. Following a transition period some NHS patients will access care at the Spire Tunbridge Wells site and the new facility will free up capacity at both Maidstone and Tunbridge Wells hospitals, and additional patients will be seen at those sites. Following the acquisition there will be a transition period, which is expected to be around six months, while MTW works on the development and integration of services. The Spire Tunbridge Wells employs 173 staff and work will also begin on the transfer of their employment to MTW. The hospital currently treats both private and NHS patients and during the transition Spire management will continue to run the hospital and patient care will continue as normal. MTW will work with the Spire team to expand the use of the facility for NHS patients during this period and once the transition has completed the management will be taken over by MTW.

- The Patient Safety Incident Response Framework (PSIRF) was introduced at the Trust earlier this month. It has replaced the Serious Incident Framework and represents a significant shift in the way the NHS responds to patient safety incidents. Patient safety incidents are unintended or unexpected events or accidents (including omissions) in healthcare that could or did harm one or more patients. PSIRF makes no distinction between patient safety incidents and 'Serious Incidents', and removes the threshold that we based our previous serious incident decision-making on. The key change with PSIRF is that, as an organisation, we are able to decide on the most appropriate and proportionate response to learning from patient safety incidents. This means that we will create our own local incident profile at MTW that takes into consideration our patient safety priorities and risk areas, as well as acknowledging any existing improvement work that is taking place.

- The Trust has seen a steady reduction in its average annual mortality indicators, reflecting the hard work done by teams across MTW to learn from patient deaths and improve services. Mortality indicators measure the actual number of patients who die following hospitalisation, compared with the national number of patients expected to die. Nationally, the mortality indicators score for hospitals is set at 100, which indicates that the actual number of deaths is the same as the expected number. If the score is above 100, this means there are more deaths occurring at the hospital than expected. A score under 100 indicates that a trust has fewer deaths than expected, meaning it is performing better. The Trust's scores have been steadily decreasing over the past ten consecutive months, and our annual average is currently in the low 90s and so below expected. There are a number of reasons why the Trust's mortality indicators have improved, including the introduction of the Medical Examiner Service, Structured Judgement Reviews and the learning from the deaths process itself.

- MTW's Medical Director, Dr Sara Mumford, has been presented with a Senior Fellowship by the Faculty of Medical Leadership and Management (FMLM). The recognition demonstrates Dr Mumford's commitment to medical leadership and its importance in delivering outstanding care for patients. Fellowship of the FMLM is recognition for high performing and effective medical leaders, benchmarking them against the national Leadership and Management Standards for Medical Professionals. The Senior Fellowship is awarded to UK-based members of the Faculty who are established medical leaders with a least two years' experience at Board or system level, and have made a significant contribution to leadership and management in the health sector. Dr Mumford joins an elite group of just over 200 medical leaders who have been awarded Fellowships of FMLM at multiple levels since 2016.

- The Stroke Unit at Maidstone Hospital have retained their overall A-rating in the latest Sentinel Stroke National Audit Programme (SSNAP). This means the Unit have maintained their top tier performance for a full year, with patients receiving some of the highest quality stroke care in the country. Ten categories are individually scored as part of the SSNAP, ranging from scanning and specialist assessment to physio and discharge processes. The result for each category contributes to the overall score. The Stroke Unit rated higher than the national average in a number of areas, and this is testament to the team's hard work. The Unit are currently in the final phase of their refurbishment project, which is due to end in May and has involved the

development of an Acute Stroke Unit (ASU) and Hyper Acute Stroke Unit (HASU) at Maidstone Hospital.

- A strong performance in our Emergency Departments (ED) means that MTW will receive a share of a £150 million capital fund from NHSE. Last July, NHSE published an incentive scheme for providers with a Type 1 A&E to achieve even better performance in the second half of the year, in return for receiving a share of a capital fund for 2024/25. MTW exceeded the national targets which formed part of the criteria needed for the original capital incentive scheme:
  - Four-hour ED performance greater than 80% across the final quarter of financial year 2023/24.
  - 90% of ambulance handovers completed within 30 minutes across the second half of 2023/24.

  On behalf of the Board, I would like to thank all the teams involved across the Trust for their hard work and dedication in exceeding these targets and securing this additional funding for the MTW.

- The Trust's electronic bed and capacity management system won Gold and Silver awards in two categories of the national Health Service Journal (HSJ) Partnership Awards. Used in our Care Coordination Centre, the technology provides real time information about bed occupancy at both Maidstone and Tunbridge Wells hospitals, helping to maintain flow through our hospitals by reducing the amount of time a bed is empty. The HSJ received over 200 nominations for the awards, with MTW winning Gold in the 'HealthTech Partnership of the Year' category and Silver in the 'Best Acute Sector Partnership with the NHS' category, alongside healthcare tech company TeleTracking, who support the bed management system.

- The Trust has appointed two new Chief Clinical Information Officers (CCIO) with Sarj Athwal (Consultant Ophthalmologist and Oculoplastic Surgeon) and Dr Oliver Blightman (Consultant in Anaesthesia and Intensive Care Medicine) now stepping into the position. The role of the CCIOs is to lead the Trust with its use of digital technologies which are fit for the future, and provide safer clinical care and enhanced patient safety. Sarj and Oli will provide a critical bridge between clinical expertise and digital solutions. This joint appointment will allow us to benefit from the combined skills and experience in healthcare digital transformation of two senior consultants. A further level of expertise has been created at divisional level by the appointment of Dr Shehriyar Khan as Deputy Chief Clinical Information officer for our Women's, Children's and Sexual Health services.

- Gary Purdy, Chair of the Tunbridge Wells Hospital League of Friends (LoF), will be celebrating his 25-year tenure on 19 May. In the 2023 calendar year, the charity donated over £24,000 to the hospital, raising a further £20,000 since then for a variety of projects including new phlebotomy trolleys, the refurbishment of the paediatric ward playroom and support for end of life volunteers. On behalf of the Board, I would like to thank Tunbridge Wells Hospital LoF for all of their continued support, and recognise the incredible contribution that Gary has made during his quarter of a century as Chair of the charity.

- MTW has become one of the first trusts in the country to introduce the Noona app for cancer patients, which allows them to directly message our specialist teams and report symptoms. This helps to reduce unnecessary follow-up appointments and attendances at our hospitals. The new app went live to radiotherapy patients earlier this year, giving them an easy direct route to the Trust's Macmillan radiographers. Patients are able to upload any photos of symptoms that teams can then review and provide advice on. The app can also further increase capacity by only booking in follow-up appointments for those reporting serious ongoing symptoms, and helping our teams prioritise those with urgent needs for clinical treatment. As the app further develops, it will also soon be able to send through notifications to ensure patients have carried out specific pelvic preparations which can often cause delays in treatment when patients are on site.

- Work to strengthen our cardiology services is ongoing, following a stakeholder engagement process in 2022 which supported the development of the specialist inpatient cardiology service on the Maidstone Hospital site. An outline business case for the centralisation of the service and a preferred option for layout on the Maidstone site have been approved, and a full business case is now in progress. This will look at finances, the staffing and patient flow details of the new services, and the improvements and development opportunities it will bring. Once complete, the service at Maidstone will offer up to 12 coronary care unit beds, 22 specialist cardiology inpatient beds, two cardiac catheter labs with recovery spaces, a clinic room and dedicated echocardiology rooms, and an ambulatory area to support our Same Day Emergency Care services.

- Congratulations to the winner of the Trust's Employee of the Month award for March, Brittany Buckwell-Boomsma, Healthcare Records Multi Section Manager. As part of her work on the Exceptional Leaders programme, Brittany led on a project for Health Records' staff welfare. The project involved organising the department's first away day at the start of this year, bringing together over 100 staff from the Trust's sites at Maidstone, Tunbridge Wells and Paddock Wood.

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, 10/04/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (face-to-face / in-person, at Maidstone Hospital) on 10th April 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 key topics for consideration for June 2024 (i.e. "Review of the appropriateness of the assessment models within the Trust's Emergency Departments") and August 2024 (i.e. "Review of the Trust's Medicine Management incidents"; and "Review of the management of mental health presentations") were confirmed and it was agreed that the Chair of the Committee should discuss with the Chair of the People and Organisational Development Committee whether a 'deep dive' into violence and aggression against Trust staff should be scheduled at a future meeting.
   - The West Kent Health and Care Partnership, Medical Director for Integrated Care; Urgent Care Director and Hospital Avoidance Lead and Virtual Ward Matron presented a **Review of the quality-related aspects of the Virtual Ward service** which included details of the measures which had been introduced to monitor patients' conditions and ensure patient safety; and an initial draft proposal for the future governance arrangements for the virtual ward programme. It was agreed that the Hospital Avoidance Lead and Virtual Ward Matron should conduct an equality impact assessment in regards to the exclusion of patients in receipt of a Social Services package of care from eligibility for the virtual ward programme. It was also agreed that the West Kent Health and Care Partnership Medical Director, Integrated Care; and Urgent Care Director should provide a brief update on the development of the oversight dashboard and reporting structure for the virtual ward programme to the June 2024 Quality Committee 'deep dive' meeting.
     - ❖ The Committee was **partially assured** as although the appropriate information was being recorded further work was required to develop the associated governance arrangements
   - The Deputy General Manager, Medical Specialties and Assistant General Manager, Diabetes and Endocrinology presented a **further update on the management of Diabetes at the Trust** wherein the Committee commended the significant performance improvements in terms of key metrics such as Referral To Treatment (RTT); however, it was acknowledged that there were continued workforce challenges within the Trust's Diabetes Team, so it was agreed that the Chief Nurse and Chief Operating Officer should liaise with the Trust's Clinical Lead for Diabetes and the Medicine and Emergency Care Divisional Triumvirate to explore what, if any, alternative staffing models could be implemented to support the Trust's Diabetes Service. It was also agreed that Assistant General Manager, Diabetes and Endocrinology should provide clarification to Committee members as to what constituted a non-primary diagnosis of Diabetic Ketoacidosis (DKA) and confirm whether such cases were audited to improve the associated management.
     - ❖ The Committee was **partially assured** as significant improvements had been made in relation to service delivery; however, further work was required to develop and support the Diabetes Team.
   - Under **any other business** a brief update was provided on the development of the new quality governance structure and it was agreed that the Interim Trust Secretary should provide Committee members with the outputs of the initial mapping exercise for the new quality governance structure. It was also agreed that the Director of Quality Governance and Interim Trust Secretary should provide a briefing note to the May 2024 'main' Quality Committee meeting on the development of the new quality governance structure.

2. **In addition to the agreements referred to above, the meeting agreed that:** The Director of Quality Governance; and Trust Patient Safety Specialist should Liaise with representatives from the Virtual Ward Team to support the development of an oversight dashboard.

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, 23/04/24	Committee Chair (Non-Exec. Director)

The Committee met on 23rd April 2024, face-to-face / in-person at Maidstone Hospital.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted
   - The Chief of Service, Surgery; Divisional Director of Operations, Surgery and Divisional Director of Nursing and Quality, Surgery presented a 'deep dive' into **the ophthalmology service** which provided information on the progress with the associated recovery plan; an overview of the triangulation between Serious Incidents, Complaints and the risk register to support service improvements; and the continued challenges associated with the Did Not Attend (DNA) rate. A discussion was then held regarding the requirement to ensure improved productivity in response to the increased core establishment and the need to ensure Cost Improvement Programme (CIP) delivery for 2024/25.
   - The **Outline Business Case (OBC) for Robotic Assisted Surgery** was reviewed, which noted the impacts of robotic assisted surgery on patient outcomes and post-operative length of stay and the Committee emphasised the importance of ensuring the Full Business Case illustrated the impact on recruitment and retention and considered all options to minimise the capital implications, such as pursuing a lease arrangement, which would provide additional benefits due to the pace of technological innovation. The Committee agreed to recommend that the Trust Board approve the OBC, in May 2024.
   - The **Business Case for Oncology Consultant Recruitment** was reviewed, wherein the Committee acknowledged that the Business Case was necessary to support ongoing service delivery in response to increased demand for Cancer Services and it was agreed that the Director of Strategy, Planning and Partnerships should explore the anticipated impact of the Business Case for Oncology Consultant Recruitment on the Trust's productivity performance. The Committee agreed to recommend that the Trust Board approve the Business Case, in May 2024.
   - The Director of Strategy, Planning and Partnerships attended to give an **update on the Trust's final planning submissions for 2024/25**, which has been submitted to the Trust Board under a separate agenda item, wherein the Committee noted the requirement, given the national focus on productivity within the NHS, to demonstrate a continued positive productivity coefficient and it was agreed that the Deputy Chief Executive / Chief Finance Officer should consider, and confirm to the Trust Secretary's Office, the scheduling and frequency of an "Update on the Trust's productivity" item at future Committee meetings. A discussion was also held regarding the Trust's continued focus on the reduction of temporary staffing expenditure wherein it was recommended that a review of those areas with a significant reduction in vacancies should be conducted, to explore whether there was continued utilisation of temporary staff.
   - The **Patient Access strategic theme metrics for March** were reviewed.
   - The Chief Operating Officer provided the first **monthly update on the provision of mutual aid** which noted the initial discussions which had been held with partner organisations regarding the provision of system-wide support and it was agreed that the Chief Operating Officer should ensure that future "Monthly update on the provision of mutual aid" reports included details of the financial implications of the provision system support.
   - The review of **financial performance for March** highlighted that the Trust had, subject to external audit, achieved the financial plan for 2023/24; and the Committee acknowledged the technical adjustments required to the Private Finance Initiative (PFI) liability measurement under International Financial Reporting Standard (IFRS) 16.
   - The Deputy Chief Executive/Chief Finance Officer presented the latest **quarterly analysis of consultancy use.**
   - The **capital programme funding and expenditure approvals for 2023/24** were approved as submitted.
   - The Chair of the People and Organisational Committee provided a **summary report** from the Committee's meeting in March 2024, and presented the latest update on the **"Workforce efficiency programme"** to the Committee.

- The Committee received **notification of the use of the Trust Seal**.
- 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:** N/A

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 19/04/24	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (Face-to-face / in-person at Maidstone Hospital) on 19th April 2024 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Committed reviewed the **latest "Strategic Theme: People" section of the Integrated Performance Report (IPR),** wherein the Committee held a discussion regarding the retention of internally educated staff and the mechanisms which could be implemented to improve retention. The Committee also highlighted the importance of ensuring there was sufficient capacity within the People and Organisational Development Department to support the delivery of the current service levels and transformational changes. It was agreed that the Head of People Performance and Improvement should ensure that future "Monthly review of the "Strategic Theme: People" section…" reports included system-wide comparison data and a numerical value for long-term staff sickness absence rates. It was also agreed that the Chief People Officer; and Head of People Performance and Improvement should consider the frequency at which future "Monthly review of the "Strategic Theme: People" section…" reports should include an update on the findings from the NHS Customer Feedback Survey.
  - ❖ The Committee was **assured** that there was the appropriate focus on continued improvements.
- The Chief People Officer provided a verbal update on **the future governance and 'Business As Usual' (BAU) arrangements for the Workforce efficiency programme** wherein the next steps for the programme of work were outlined and the intended additional collaboration with the South East Collaborative was acknowledged; however, Committee members emphasised the importance of ensuring decision-making staff were empowered to support the programme of work and were actively involved. It was agreed that the Chief People Office should provide Committee members with details of the future governance structure for the workforce efficiency programme and the methods by which the involvement of decision-making staff would be maintained.
  - ❖ The Committee was **partially assured** as, although the next steps to ensure alignment between the Agency Team, Temporary Staffing Team and Recruitment Team had been identified, further work was required to develop the future governance structure.
- The Head of People Performance and Improvement, with input from the Interim Trust Secretary facilitated a **review of the Trust's People related risks** wherein the Interim Trust Secretary detailed the programme of work to improve the Trust's risk management processes and ensure alignment between the Trust's operational and strategic risks. The Committee noted the cultural change which was required to risk management and it was agreed that the Interim Trust Secretary would liaise with the Director of Quality Governance and Chief Nurse to provide Committee members with an update on the Trust's Risk Management improvement plan and key deliverables.
  - ❖ The Committee **did not allocate an assurance rating** as the report was intended to provide an update on the current position and the associated next steps.
- Under the **findings from the Committee's evaluation for 2024** it was agreed that the Assistant Trust Secretary should recirculate the Committee's evaluation for 2024 to enable additional feedback from Committee members to be captured, by the 26th April 2024.
- The Committee reviewed the **items for scrutiny at future People and Organisational Development Committee 'deep dive' meetings** and it was agreed that:
  - Schedule an "Update on the people-related aspects of the Kent and Medway Medical School" and "Update on the People and Organisational Development capacity to support the transfer of the Spire Tunbridge Wells to the Trust" at the June 2024 People and Organisational Development Committee 'deep dive' meeting.
  - The Assistant Trust Secretary should defer the "To review the Multi-professional Learning and Development Strategy" item to the Committee's meeting in September 2024.

- The Committee conducted **an evaluation of the meeting** wherein the additional focus on the IPR supported.

In addition to the actions noted above, the Committee agreed that: The Assistant Trust Secretary should amend the title of the future "Further review of the Pastoral Support requirements for Internationally Education staff (incl. International Medical Graduates (IMGs))" item to reflect the Committee's request for a wider focus Internationally Educated Professionals.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 12, 2023/24, is enclosed, along with the 'A3' for staff turnover, 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, 23/04/24

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

March 2024

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

Variation			Assurance					
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Consistent (P)assing of Target - Upper control limit is below the target line or Lower control limit is above the target line (depending on the nature of the metric)	Metric has (P)assed the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Inconsistent passing and failing of the target	Metric has (F)ailed to meet the target for the last 6 (or more) data points, but the control limits have not moved above/below the target.	Consistent (F)ailing of Target - Lower control limit is below the target line or Upper control limit is above the target line (depending on the nature of the metric)	Data Currently Unavailable or insufficient data points to generate an SPC

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

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

Maidstone and Tunbridge Wells NHS Trust

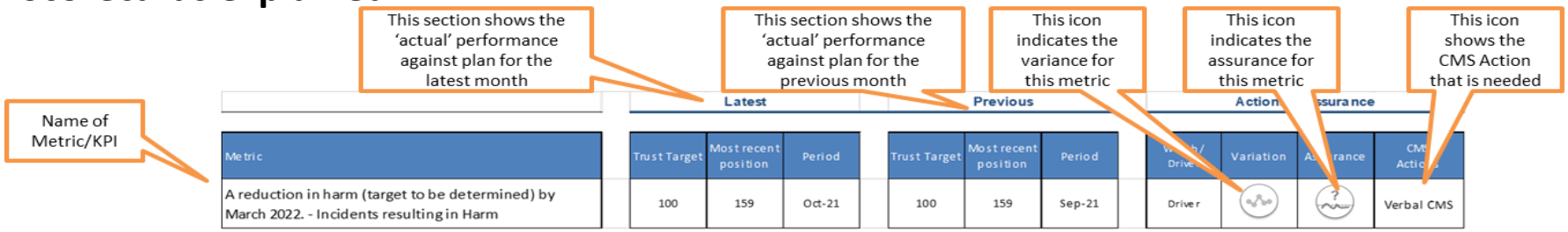
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

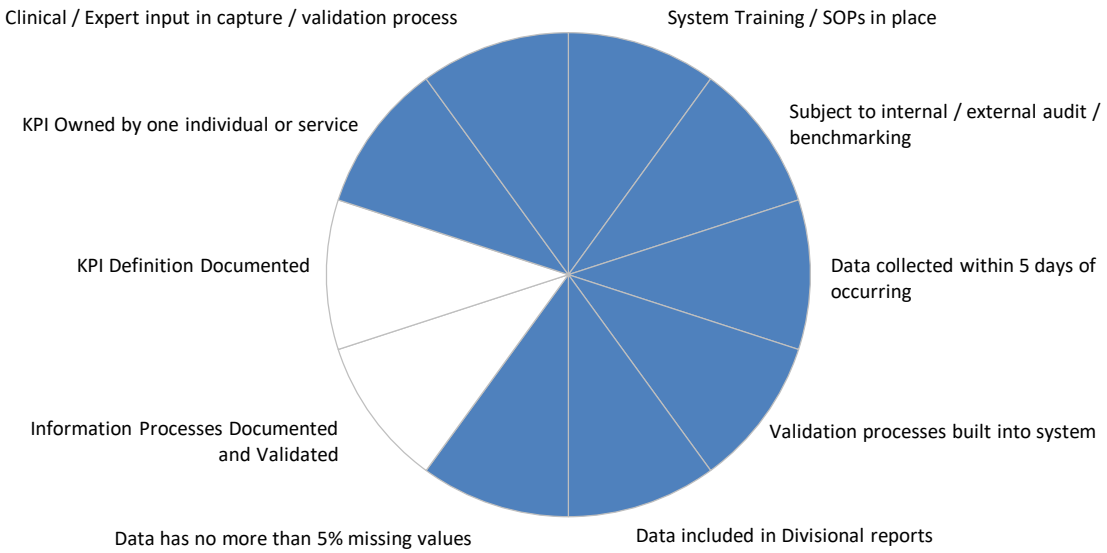
MTW exceptional people, outstanding care

Forecasts

				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: The Trust no longer has any metrics experiencing special cause variation of a concerning nature (except FTT Response Times due to the limited data issues). Vacancy Rate improved further to 5%. Turnover Rate improved, continuing to experience special cause variation of an improving nature. This metric continues to achieve the maximum level target at 11.5%. Agency spend did not achieve the target for March 24 but continues to experience special cause variation of an improving nature. The Nursing Safe Staffing Levels improved further to 98.2% and has now passed the target for six consecutive months. Sickness levels improved in March 24, achieving below the maximum limit. This metric is therefore now experiencing common cause variation and variable achievement of the target. Statutory and Mandatory Training improved further in March, now experiencing special cause variation of an improving nature and consistently passing the target. The percentage of staff Afc 8a or above that are BAME is consistently failing the target . The Trust continues to implement a number of actions to improve performance is this area. The Trust was £0.8m in surplus in the month which was on plan. Year to Date the Trust is £9.5m in surplus which was on 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 until this has been confirmed. The rate of C.Difficile improved but has failed the target for six months. Complaints response times have failed the target for more than 6 months and therefore remain escalated. Friends and Family Response rates have been adversely affected by the change in service provider for the collection of responses and there is limited data available as a consequence.

Diagnostic Waiting Times achieved 98.8% in March 24 and continues to experience special cause variation of an improving nature. RTT improved further in March at 75.1% which is an improvement of 4.67% over the year (March 23 compared to March 24). The total waiting list has reduced from 45,022 to 42,306 (-2,716) over the year. This indicator continues to experience 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 March 24. The Trust continues to achieve the internal target of less than 1.5% of total patients waiting having waited more than 40 weeks. Outpatient Utilisation improved further to 83.5%. This indicators is experiencing common cause variation and has failed the target for more than six months. Diagnostic Imaging activity levels were above plan and 1920 levels in March 24 and this indicator is no longer escalated, experiencing special cause variation of an improving nature and variable achievement of the target. Performance for both First Outpatient and Elective (inpatient and day case combined) activity levels were above plan and 1920 levels for both March 2024 and the 23/24 year overall. Both are now experiencing common cause variation and passing the target for more than 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 improved further in March 24 and is now experiencing special cause variation of an improving nature. Both A&E 4hr performance and Ambulance Handovers <30mins improved further in March 24 and are no longer escalated, experiencing common cause variation and variable achievement of the target. The Trust's performance for A&E 4hrs remains one of the highest both Regionally and Nationally. The Trust continues to achieve 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 February but did improve it's performance further to 92.9%. 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:

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

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

Patient Safety & Clinical Effectiveness:
- Incidents resulting in Moderate + Harm (P.12)*
- Infection Control – Rate of C.Diff (P.13)

Patient Access:
- RTT Performance (P.16)
- Outpatient Calls answered <1 minute (P.17)
- Outpatient Clinic Utilisation (P.17)
- Emergency Admissions in Assessment Areas (P.17)
- Cancer 31 Day Standard (Combined) (P.17)

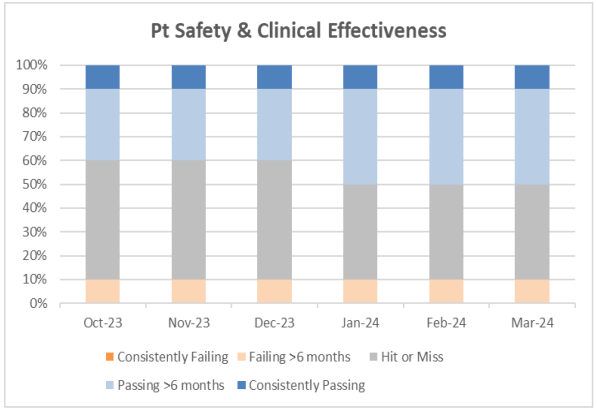
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.26)
- Women waiting for Induction of Labour <4 Hrs (P.26)

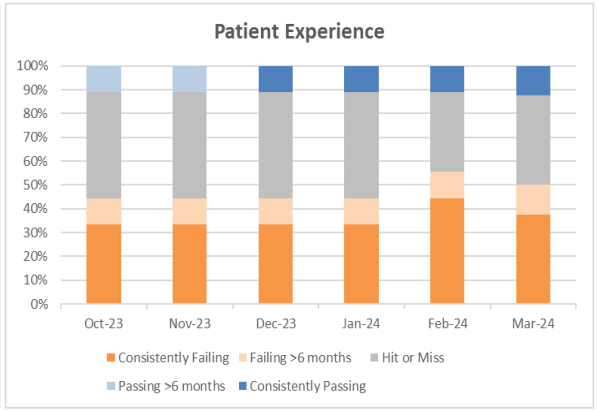
Patient Experience:
- New Complaints Received (P.19)*
- Complaints responded within target (P.20)
- FFT Response Rates: A&E, Outpatients, Maternity (P.20)

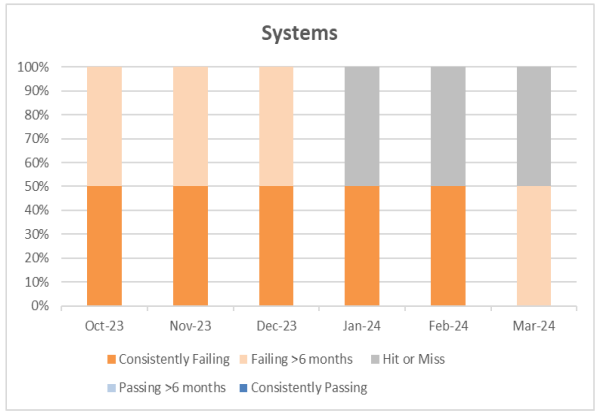
Systems:
- Discharges before Noon (P.22)

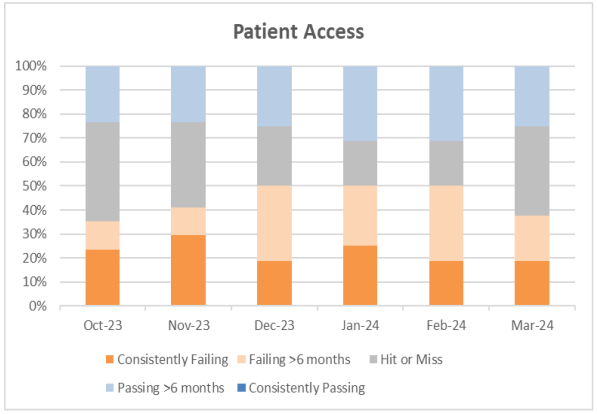
Sustainability:
- Agency Spend (P.24)

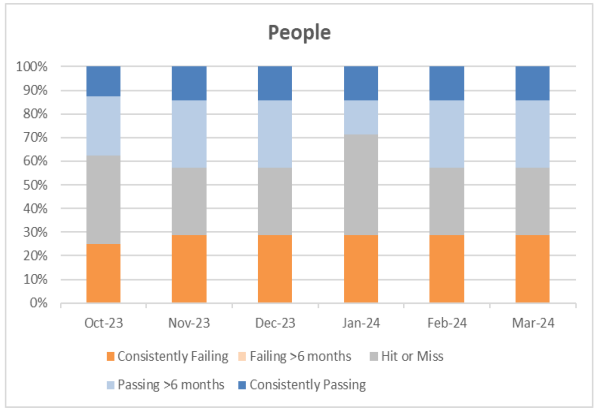
Assurance Stacked Bar Charts by Strategic Theme

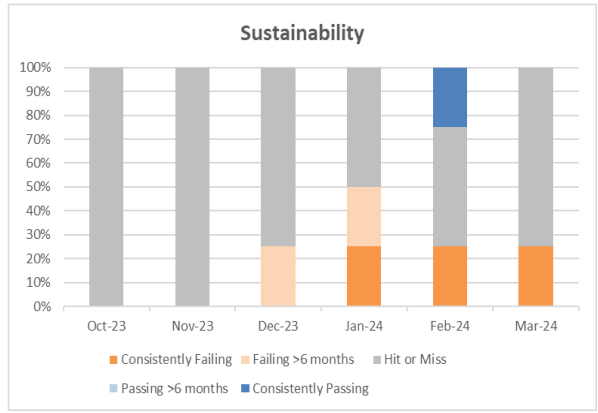












Matrix Summary

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

Strategic Theme: People

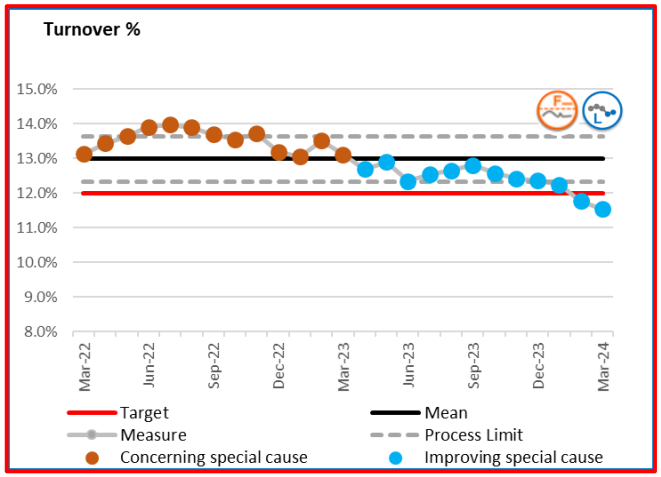
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 8%		8%	5.0%	Mar-24	8%	5.5%	Feb-24	Driver			Note Performance	5.0%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	11.5%	Mar-24	12%	11.8%	Feb-24	Driver			Full CMS	11.5%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.2%	Feb-24	4.5%	4.7%	Jan-24	Driver			Not Escalated			
	Well Led	Statutory and Mandatory Training		85.0%	89.7%	Mar-24	85.0%	89.1%	Feb-24	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	72.1%	Mar-24	62.0%	72.7%	Feb-24	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	5.7%	Mar-24	3.2%	5.8%	Feb-24	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	6.4%	Mar-24	12.0%	6.5%	Feb-24	Driver			Escalation			

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 8%

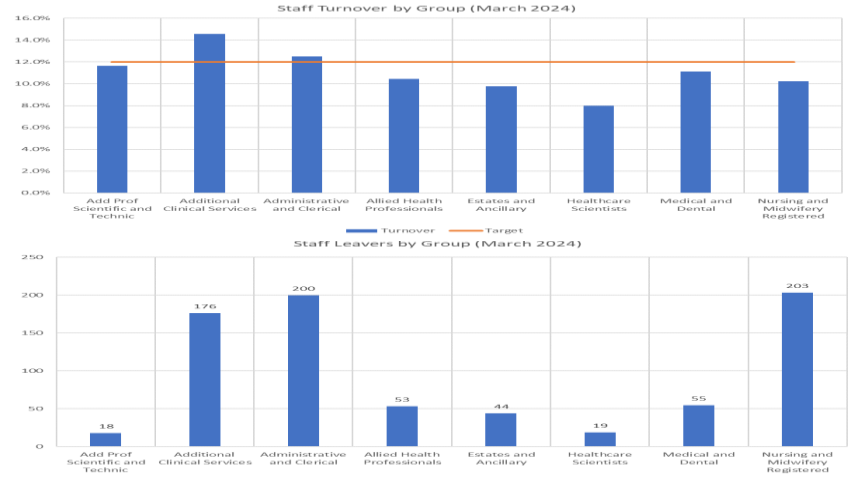
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar--24
11.54%
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

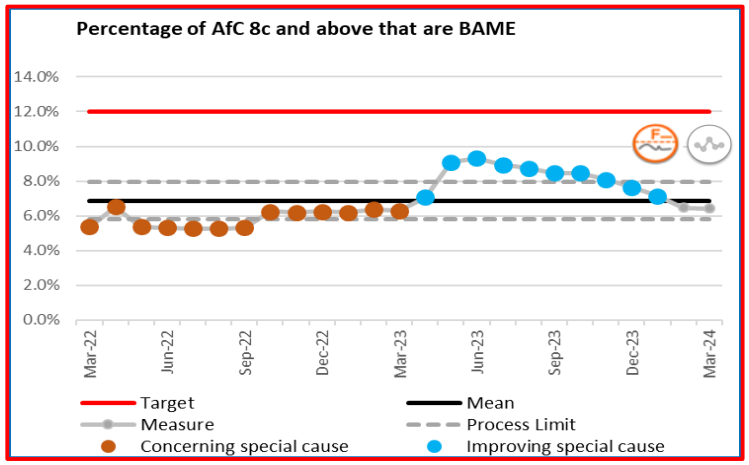
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership 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
Continuation of end to end Recruitment Transformation, to reduce time to hire metrics	Sep-24
Combined new starter, recruitment and induction surveys to create the onboarding survey, and data is now available on a monthly basis	Apr-24
Offer expanded work experience placements programme for nursing to commence in June to August.	Aug-24
Continue to develop A3 to target reducing the number of leavers who have been with the Trust for 24 months or less	Apr-24
Continue to develop A3 to target reducing the number of admin and clerical leavers	Apr-24

People – Workforce: CQC: Well-Led



Mar-24
5.8%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (National)
12%
Business Rule
Full Escalation

With regards to Turnover Rate (on the previous page) from next month, for 24/25 we will include more granular detail in relation to short term leavers (Staff in post for less than 12 months and between 12 to 24 months) as this is a key focus area we are accelerating in 24/25. This will also directly support sustaining our People corporate breakthrough objective of a turnover target of 12% or less.

Summary:	Actions:	Assurance & Timescales for Improvement:
% of AfC 8c and above that are BAME: This metric is experiencing common cause variation and consistently failing the target.	% of AfC 8c and above that are BAME: (NB: These are not rapidly changing indicators). As at March 24 the current number of staff (WTEs) that are AfC 8c and above is 140 (Feb 24: 13 9, Nov 23: 136). Of these 8 ((Feb 24:8, Nov 23: 7) have a disability , 9 (Feb 24: 9, Nov 23: 11) are BAME and 101 (Feb 24: 101, Nov 23: 96) are female. **Actions:** Various actions have been undertaken during 23/24. This included developing and delivering, initially targeting managers in Divisions with high turnover. A focus on anti racism took place for the senior leadership away day on 25/10/2023 and an EDI steering Board commenced October to drive improvement. Further discussions around the EDI strategy took place, including with Trust Board to agree EDI objectives which will be measured in April 2024. A more comprehensive end of year update on actions is provided in the next column, with relevant actions continuing in 24/25 to sustain performance and improvement:	% of AfC 8c and above that are BAME: The following is an end of year update, with relevant actions continuing in 24/25 to sustain performance and improvement. (These measures will also help with % of AfC staff below 8c that are BAME: • Developing and empowering our vibrant staff networks - MTWProud, Cultural and Ethnic Minorities Network, DisAbility Network, Parental Responsibility Network, Chronic pain support group, neurodiversity support group, clinically extremely vulnerable support network, menopause support group and recently re-launched Senior Women Leaders. • Representation from our staff networks on the EDI Steering Group, Health and Wellbeing Committee and various stakeholder interview panels ensuring the voices of our minority staff are heard. • Developing interactive workshops on inclusive recruitment and allyship. • Delivering interactive sessions on bias, micro aggressions and advancing cultural competence. • Increasing the number of EDI recruitment representatives to help raise awareness of and offer peer to peer support for inclusive recruitment. • Ensuring equality objectives are in place for the Trust Board. • A mentoring programme to help address the gap in representation of ethnic minority staff in senior roles • A focus on inclusive recruitment in bands 8b and above to address the gap in ethnic minority and disabled staff representation. • Participating in Step into Health programme which helps those leaving the Armed Forces to access employment opportunities in the NHS. • A second cohort of reverse mentoring which enables staff from ethnic minority backgrounds and those with long term health conditions share their experiences with senior colleagues including our Trust Board and Divisional Leaders

Strategic Theme: Patient Safety & Clinical Effectiveness

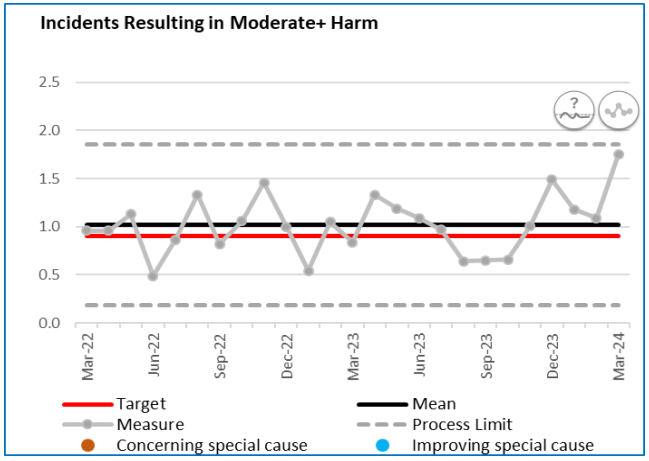
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.75	Feb-24	0.90	1.09	Jan-24	Driver			Verbal CMS	1.51 May 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	4	Mar-24	11	5	Feb-24	Driver			Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	85.6	Dec-23	100.0	89.1	Nov-23	Driver			Not Escalated			
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	93.8	Dec-23	100.0	94.3	Nov-23	Driver			Not Escalated			
	Safe	Never Events		0	0	Mar-24	0	0	Feb-24	Driver			Not Escalated			
	Safe	Safe Staffing Levels		93.5%	98.2%	Mar-24	93.5%	97.0%	Feb-24	Driver			Not Escalated			
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	15.4	Mar-24	32.6	21.2	Feb-24	Driver			Not Escalated			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	36.0	Mar-24	25.5	47.8	Feb-24	Driver			Escalation			
	Safe	IC - Number of Hospital acquired MRSA		0	0	Mar-24	0	0	Feb-24	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	0.0	Mar-24	6.4	5.4	Feb-24	Driver			Note Performance			

Vision: Counter Measure Summary

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

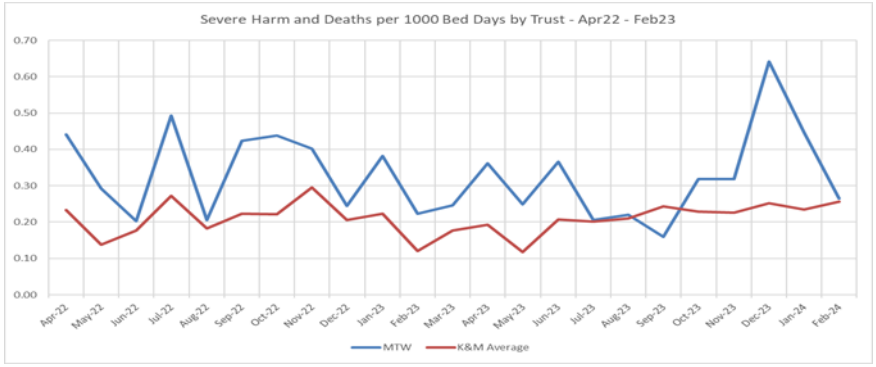
Owner: Sara Mumford
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



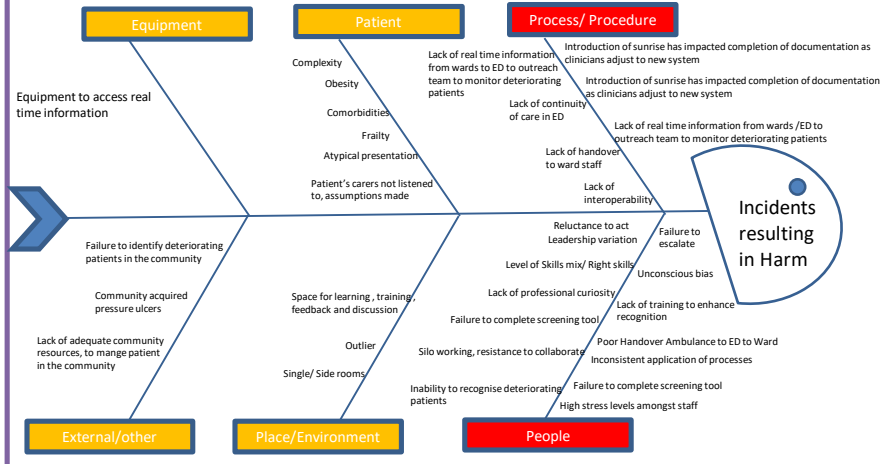
Feb-24 (1 month arr)
1.75
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric is in variable achievement of target for +6 Months

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. Improved in February 24.

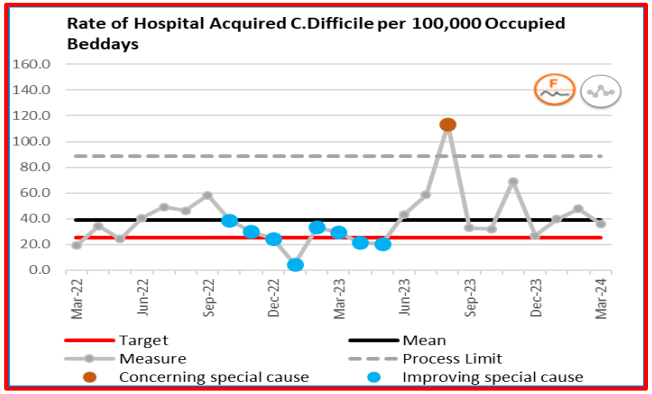
3. Top Contributors



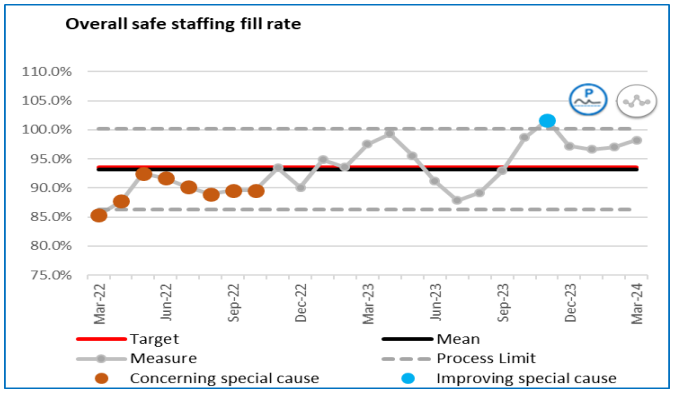
4. Action Plan

Contributor	solution /countermeasure	Owner	Due By
Patient Safety and Clinical Effectiveness	**Key Update:** • Revised incident reporting categories went live w/c 1st April 2024 • Audit completed of peri-arrest data following proposed changes to arrest form on Sunrise **Next Steps:** • Finalise JD and Business Case for Deteriorating Patients Nurse Lead • Launch (with Comms) of ITU Referral Form on EPR • Finalise data collection for deteriorating patients – sepsis, NEWS triggers/escalations • Update ED sepsis report template to ensure more information that is needed is included **Issue** • Slippage in timeline for the implementation of the vital sign project • Escalation process identified as contributor to avoidable 2222 calls **Risks** • Lack of robust education package to address the challenges associated with deteriorating patients	S. Mumford H. Boyle J. Kelly, A. Spyrka, BI J. Kelly, J. Wade	Apr-24 Apr-24 Apr-24 Apr-24 Apr-24

Patient Safety and Clinical Effectiveness: CQC: Safe



Mar-23
36.0
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



Mar-24
98.2%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and has achieved target for >6 months
Target (National)
93.5%
Business Rule
Shown for info as first month no longer escalated

Summary:

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

Safe Staffing Fill Rate - is experiencing special cause variation of an improving nature and has now passed the target for six consecutive months

Actions:

Infection Control: The C.diff rates exceeded the expected limits during March with 9 cases and an end of year total of 107. Actions taken include:

- Deep Cleaning planned as soon as escalation capacity becomes available
- Trust wide CDI incident meeting planned for April 24 to identify additional actions to help reduce rates
- Antimicrobial, IPC, PII audits undertaken to monitor compliance
- 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
- Enhanced cleaning undertaken on discharge and transfer of patients with CDI

Safe staffing Fill Rate:

- The senior corporate nursing team are meeting with Divisions as finance for the 2022/23 Establishment review business case has now been released. This will ensure that posts are advertised and budgets aligned.
- The SafeCare project is moving towards implementation in the CCC. This will provide Trust wide oversight of N&M staffing and patient acuity and dependency within the clinical areas.

Assurance & Timescales for Improvement:

Infection Control:

- No Evidence of transmission on C diff infection identified
- IPC team involvement in ICB CDI collaborative exploring local and regional interventions
- Rapid reviews of all cases provide timely feedback of learning from cases
- Learning from investigations are shared within the Directorate via the HCAI weekly status and IPC monthly newsletter.
- Directorate reports presented to IPCC

Safe Staffing Fill Rate:

- Oceans Blue system ward guardians reporting is currently being piloted for 11 inpatient areas. These are being reviewed in Rostering Confirm and Support meetings, giving oversight to compliance with Rostering KPI's.
- SafeCare training will be rolled out to the Clinical site teams, so the live system can be utilised on a daily basis.
- New Band six access profiles went live in March to provide governance and oversight of the finalisation of shifts within the clinical areas. This roll out is being monitored in collaboration with the Senior Nursing Teams to gauge any impacts and provide overview to the new process.

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		75.8%	75.1%	Mar-24	75.4%	72.4%	Feb-24	Driver	H	F	Full CMS	75.1% Year End FOT	H	F
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		133.6%	144.0%	Mar-24	118.0%	126.7%	Feb-24	Driver		P	Note Performance	120.0% Year End FOT		P
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment		605	477	Mar-24	610	475	Feb-24	Driver		?	Not Escalated	494		P
	Responsive	Access to Diagnostics (<6weeks standard)		99.1%	98.8%	Mar-24	96.5%	98.1%	Feb-24	Driver	H	F	Escalation	99.0%	H	F
	Responsive	A&E 4 hr Performance		88.6%	86.2%	Mar-24	86.0%	83.6%	Feb-24	Driver		?	Not Escalated	84.1%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	92.9%	Feb-24	96.0%	90.4%	Jan-24	Driver		F	Escalation	96.0%		F
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.3%	Feb-24	85.0%	85.4%	Jan-24	Driver	H	P	Not Escalated	85.5%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	80.1%	Feb-24	75.0%	77.0%	Jan-24	Driver		?	Not Escalated	79.9%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		80.0%	86.6%	Feb-24	80.0%	91.3%	Jan-24	Driver	H	P	Not Escalated	90.0%	H	P

- 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)

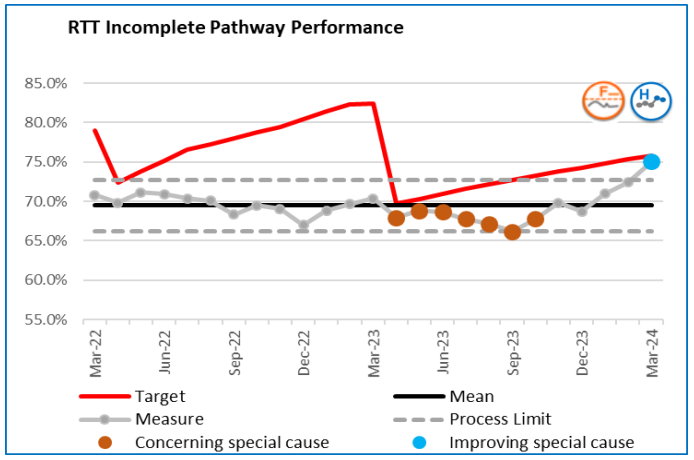
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	83.5%	Mar-24	85.0%	83.2%	Feb-24	Driver			Escalation	87.8%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		1.5%	6.7%	Mar-24	1.5%	6.1%	Feb-24	Driver	No SPC	No SPC	Not Escalated			
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	83.1%	Mar-24	90.0%	83.2%	Feb-24	Driver			Escalation	88.9%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	4.5%	Mar-24	5.0%	8.0%	Feb-24	Driver			Not Escalated	5.0%		
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	62.4%	Mar-24	65.0%	59.3%	Feb-24	Driver			Escalation	61.1%		
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		144.2%	139.3%	Mar-24	100.8%	106.0%	Feb-24	Driver			Not Escalated	107.6% Year End FOT		
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)		113.9%	117.6%	Mar-24	107.1%	114.7%	Feb-24	Driver			Not Escalated	109.5% Year End FOT		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		169.7%	179.1%	Mar-24	151.6%	149.4%	Feb-24	Driver			Not Escalated	144.8% Year End FOT		

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

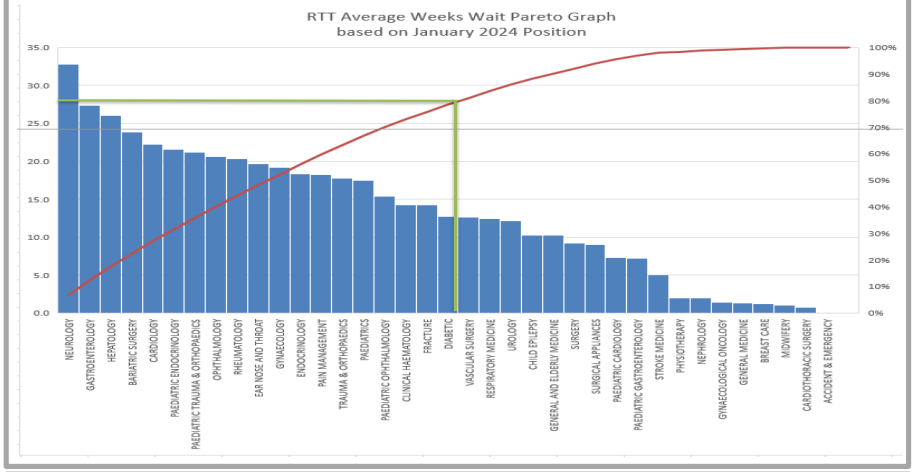
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Mar-24
75.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
75.8%
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

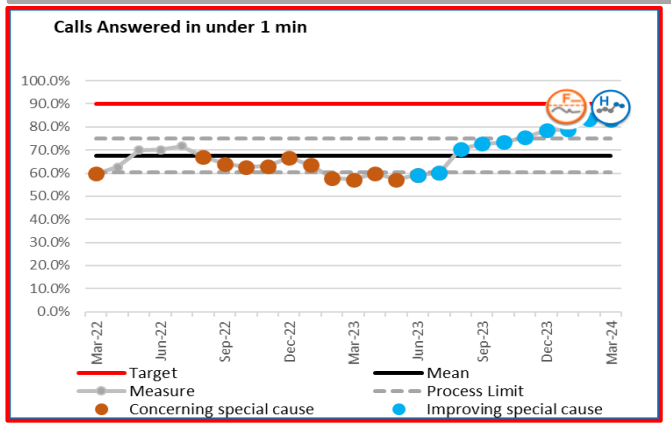
Key Risks:

- 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

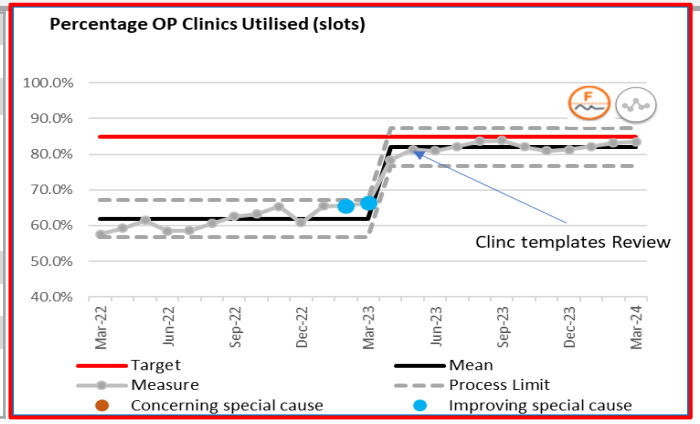
4. Action Plan

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	Data Assurance Lead	Weekly and in progress✔
Review of Breakthrough Objective	Complete new A3 , review of data to understand biggest contributors to waits for first appointments	SD/SC/JT	April 24
	Trust trajectory being developed by specialty to achieve max wait for 1st appointments no more than 8 weeks	SC/TJ/KE	May 24

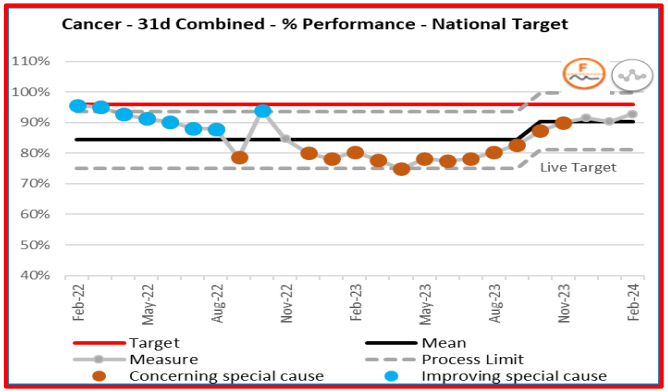
Patient Access: CQC: Responsive



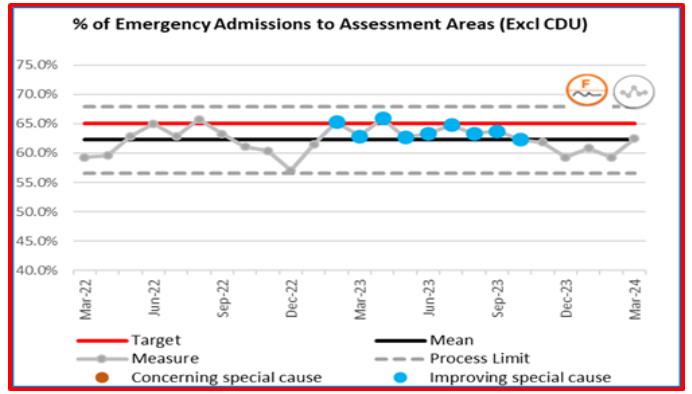
Mar-24
83.1%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target



Mar-24
83.5%
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



Feb-24 (one month behind)
92.9%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (National)
96%
Business Rule
Full escalation as has failed the target for 6+months



Mar-24
62.4%
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:

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.

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.

Cancer 31 day First Definitive (Combined): This National Standard has now changed and is a combination of the previous targets. This indicator is experiencing common cause variation and has failed the target for 6+months (however new target only in place from October 2023).

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

Actions:

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.

Outpatient Clinic Slot Utilisation: The OPD team continue to work with the CAUs on their clinic templates to sustain over 80% of clinics utilised across each division. OPD Team closely monitoring blocked slots and uncashed clinics. Continued work on CNS led clinics, specifically Medicine.

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 now in place to allow consistent increase in capacity. Ongoing clinically led review of urology and breast pathways to create efficiencies.

% 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 48% 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:

Calls Answered within 1 minute in the CAUs: Remain on upward trajectory, February new record performance achieved (83%). Focus on underperforming specialities to reach 90%.

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 but closely monitored and flagged to specialities. DNA working group and speciality based GIRFT work to support improvement. 24/25 year plan in development.

Cancer 31 Day First Definitive (Combined):
Focus on implementation of detailed recovery plan. Trajectory met consistently since set and on track to achieve the national target by March. Recent change in prostate protocol has seen an improvement in this area.

% of Emergency Admissions to Assessment Areas (Excl CDU): Outcomes from working group reviewed and action plan developed.

Strategic Theme: Patient Experience

				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
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month		36	38	Mar-24	36	43	Feb-24	Driver			Verbal CMS
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	29	Mar-24	24	25	Feb-24	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	2.0	Mar-24	3.9	2	Feb-24	Driver			Not Escalated
	Caring	% complaints responded to within target		75.0%	63.3%	Mar-24	75.0%	54.8%	Feb-24	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)		95.0%	TBC	Feb-24	95.0%	TBC	Jan-24	Driver	No SPC	No SPC	Escalation
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	2.3%	Mar-24	25.0%	2.3%	Feb-24	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	0.01%	Mar-24	15.0%	0.01%	Feb-24	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	3.3%	Mar-24	25.0%	0.6%	Feb-24	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	0.7%	Mar-24	20.0%	0.3%	Feb-24	Driver			Escalation

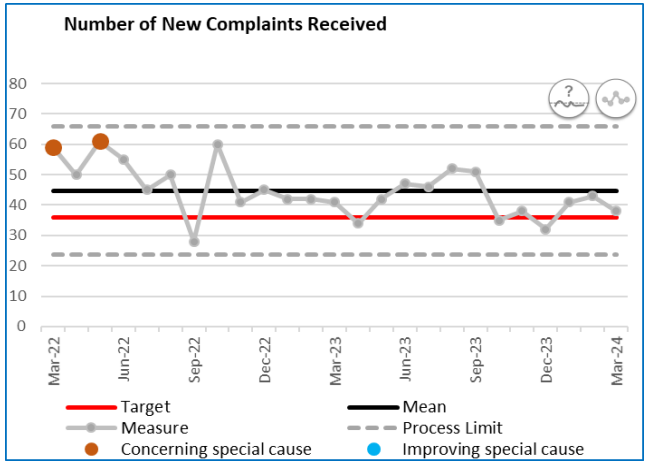
NB: There is no data available for VTE as there are some data quality issues that are been investigated. This metric will be reported again from next month once the issues have been resolved

Vision: Counter Measure Summary

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

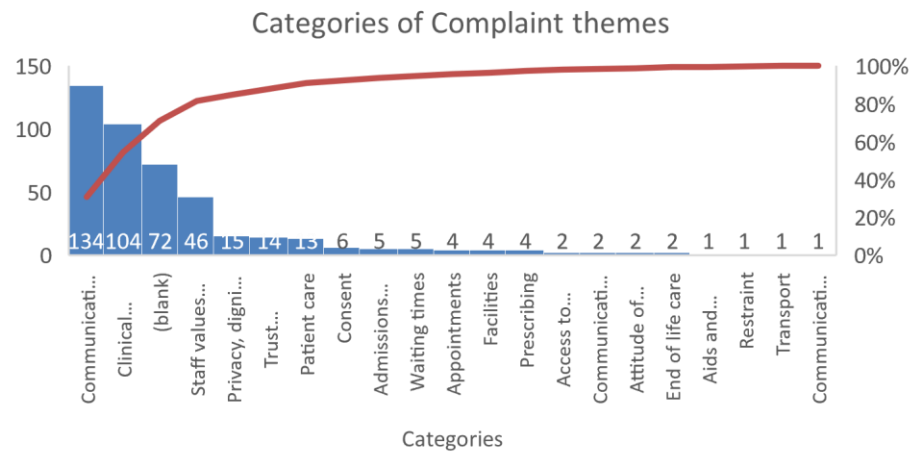
Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-24
38
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.

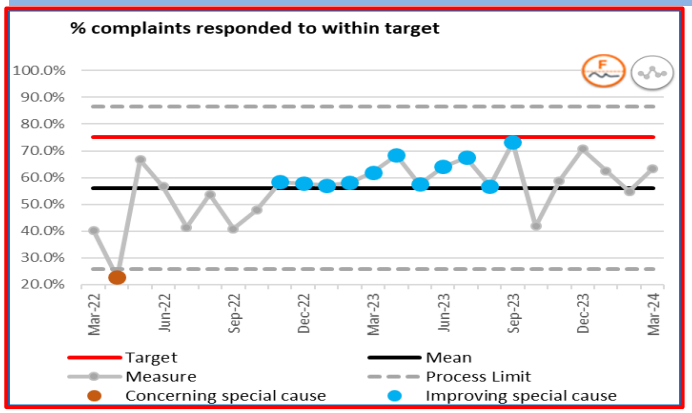
Key Risks:

1. The key risk to delivery of the breakthrough objective actions is primarily staff capacity.
2. Standardisation of measures about Divisional actions for complaints
3. Competing workloads for Divisional teams to execute actions related to feedback received.

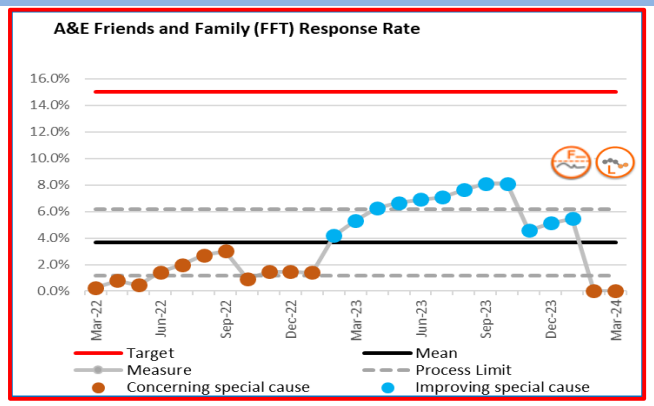
4. Action Plan

CM	Action	Who	Complete
Define	• Strategic A3 define and identify	JH, HC, SP, RS	Y
Measure	• Measure the data and identify stratified data by division and by them		Y
Analyse	• Analyse the root causes • Create breakthrough objectives	JH, RG, SP, SM	Y
Improve	• Breakthrough objectives identified as complaints with poor communication as the main theme - A3 developed for the breakthrough objective and action plan (attached in a separate CMS slide).	SM, RG, Divisional teams, Complaints Lead, BI, Workstream leads	In Progress
Control	• To put a control plan in place along with triggers and response plan	RG, SM,	N

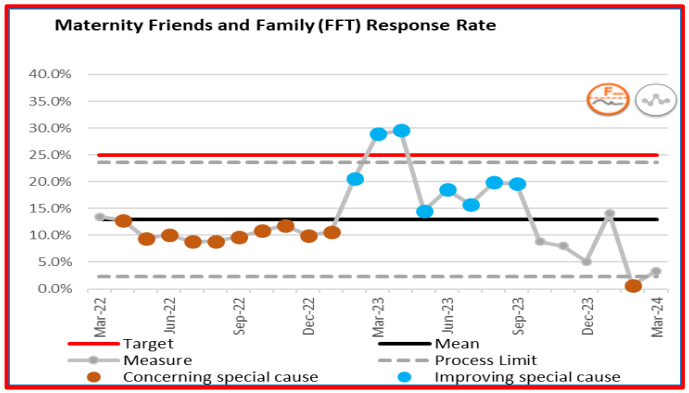
Patient Experience: CQC: Caring



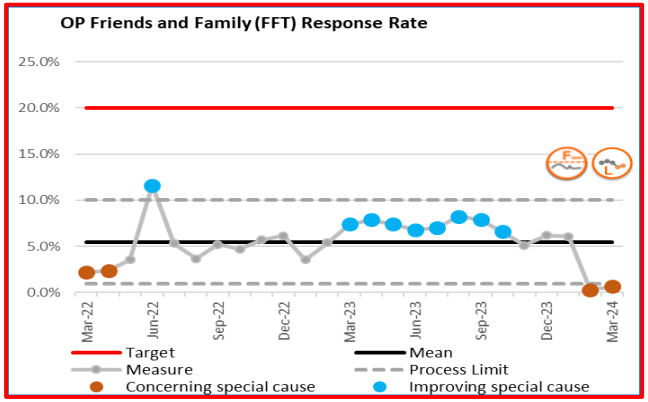
Mar-24
63.3%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Mar-24
0.01%
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



Mar-24
3.3%
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



Mar-24
0.7%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

% Complaints responded to within target: this indicator is experiencing 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. National Rate – 11.5%

Recommended Rate is 100%

Friends and Family Response Rate - Maternity: Is experiencing Common Cause Variation, but is consistently failing the target. National Rate – 12.2%

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. National Rate – 2.4%

Recommended Rate is 97.5%

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 provisionally approved
Recruitment ongoing to bolster the capacity of the Complaints team

A&E: No FFT data available as trust is in the transition process moving from IQVIA to HCC. Survey monkey links are still available for patients to complete. 2 responses – both Very good overall

Maternity: Minimal FFT data available as trust is in the transition process moving from IQVIA to HCC. 55 responses – 54 Very good and Good, 1 Poor. Negative theme includes: Information overload and lack of key contacts.

Outpatients: Minimal FFT data available as trust is in the transition process moving from IQVIA to HCC. 280 responses – 278 Very good and Good and 1 very poor. Negative theme was: Staff attitude and lack of communication in phlebotomy

Inpatients: Minimal FFT data available as trust is in the transition process moving from IQVIA to HCC. 62 responses – 57 Very good and Good, 3 Poor or Very poor. Negative themes include : Late discharge, poor nursing care, Noisy and crowded environment at night.

FFT Response All: Slight increase in responses via survey monkey link for March 2024. Stocktake in progress for all iPad for patients to complete FFT surveys. Positivity of responses (Very good . Good) currently at 98%

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: Mobilisation of HCC almost complete. Online survey build has been completed. SMS Text messaging has been completed. QR codes for online surveys have been developed and ready for deployment. Interactive voice messages (IVM) completed. Courier arrangement for FFT cards have been agreed. Awaiting final confirmation and system tests. Expected start date for HCC online surveys and FFT cards to be in place by May 2024.

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

Mitigation:
Interim measure for FFT survey are in place via Survey Monkey to capture FFT data while we are transitioning to the new provider.

Strategic Theme: Systems

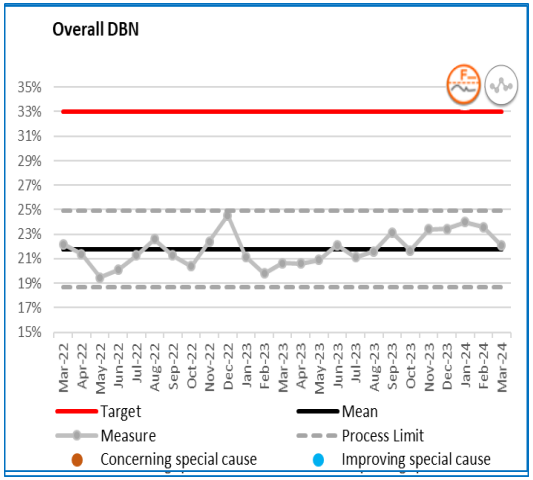
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)		3.5	3.3	Mar-24	3.5	2.5	Feb-24	Driver			Verbal CMS	3.5		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	22.1%	Mar-24	33.0%	23.6%	Feb-24	Driver			Full CMS	23%		

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%

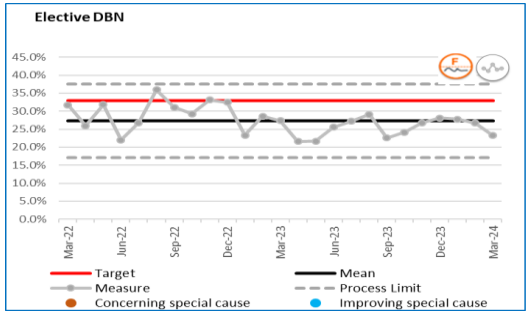
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

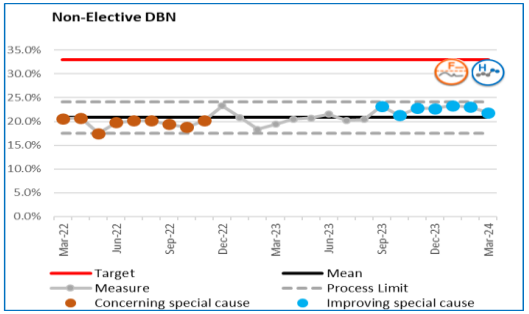
1. Historic Trend Data



Current Data Source: PAS
Mar-24
22.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data – improving special cause for Non-Elective DBN





The average time of day that patients are discharged was 3:05pm during 22/23. This has improved to 2.40pm throughout 23/24

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 capacity to prioritise EDNs
2. Clinical capacity to focus on discharge processes in times of severe operational pressures
3. Clinical buy-in to manage CLD processes differently

4. Action Plan

Counter Measure	Action	Who	When	Complete
Governance	• Power BI DBN dashboard established. Socialise & embed into improvement work	BC	Apr 24 Apr 24	Yes
	• Agree standard work for board rounds and discharge process escalation	NP/SM	Apr 24	Yes
	• Confirm pilot support arrangements and capacity	BC/FR/LB		Yes

	• Confirm pilot wards & timeline
	  • Surgery Wds 30/31/32
	  • MEC Wds Mercer, Pye Oliver, Whatman
		TH/SP	
			Apr 24
			Apr 24	

	• Agree Pharmacy projects to support DBN	RJ/JP	Apr 24	
	• Mapped current state P3 supported by Teletracking to review key drivers	FR		Yes
	• Medical engagement W20 developing flow education piece	NP		Yes
	• Bring DBN into MEC SDR	TH	May 24	Yes
Criteria Led Discharge	• Establish clinically led T&F group to develop CLD model • Supporting CLD engagement at Board Rounds in key areas incl. Mercer, ECU, Peale, Pye, W33, backed up by E learning/ competency roll out	NP NP	Apr 24 Rolling	In progress In progress
EDN	• Run pilot projects on wards 30/31/32 for 6 weeks • Change EDN structure in Sunrise to align with clerking model- Change has been made, now in testing phase. Roll out due May 24 • Change EPMA & Sunrise TTO module to reduce time taken to complete medicines element of EDN – Testing Drag and drop of TTOs in Sunrise	SP Sunrise Sunrise	1st May 24 04/04/24	In progress In progress In progress

Strategic Theme: Sustainability

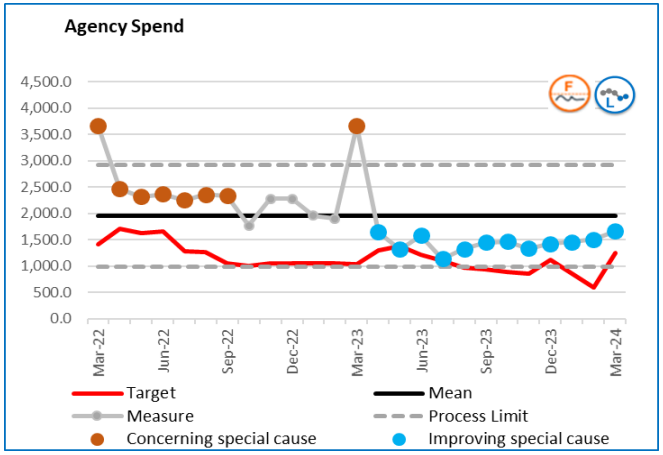
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-864	-830	Mar-24	-8,598	-10,449	Feb-24	Driver			Verbal CMS	-830 Year End FOT		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		1,255	1,664	Mar-24	597	1,512	Feb-24	Driver			Full CMS	1664 Year End FOT		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		3,694	1,446	Mar-24	3,684	1,583	Feb-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Cash Balance (£k)		2,000	11,947	Mar-24	7,661	21,493	Feb-24	Driver			Not Escalated			
	Well Led	Capital Expenditure (£k)		2,944	36,679	Mar-24	18,285	4,260	Feb-24	Driver			Escalation			
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		123,606	133,787	Mar-24	111,878	121,214	Feb-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		30,153	29,057	Mar-24	27,716	24,603	Feb-24	Driver	No SPC	No SPC	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



Mar-24
1,664
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
1255
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.

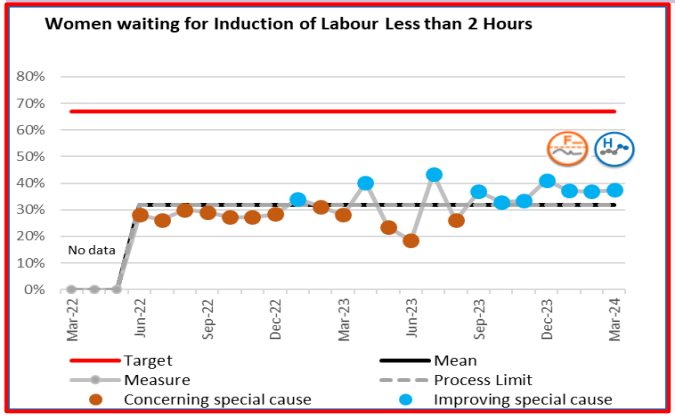
4. Action Plan

Action	Status	By when
Increased controls over agency usage	Process for agency usage is now BAU.	Now BAU
Data and reporting	Data reporting is BAU with Oceans Blue being used for Confirm and Support meetings etc.	Now BAU
Accountability and training	The rostering training is now BAU and provided by Amanda Timms' team. The Financial training is being incorporated in a managerial training by OD.	Now BAU
Medical rostering	The Business Case for Patchwork (medical rostering) was signed off by BCRP and a project manager to oversee the implementation is being recruited to deliver it.	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. Data pulled for review.	Q1 2024/25

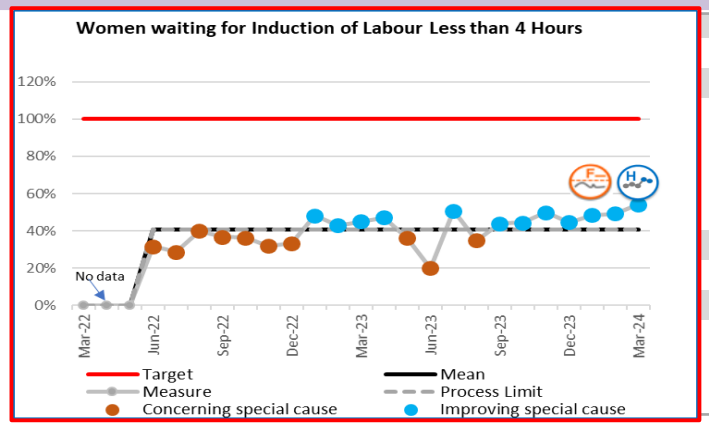
Maternity Metrics

				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)	Maternity Metric	Registerable Births		470	455	Mar-24	470	436	Feb-24	Driver			Not Escalated
	Maternity Metric	Antenatal bookings		545	508	Mar-24	545	546	Feb-24	Driver			Not Escalated
	Maternity Metric	Elective Caesarean Rate		No target	18.4%	Mar-24	No target	21.5%	Feb-24	Driver		No target	Not Escalated
	Maternity Metric	Emergency Caesarean Rate		No target	24.2%	Mar-24	No target	19.9%	Feb-24	Driver		No target	Not Escalated
	Maternity Metric	Induction of Labour Rate		36.0%	28.9%	Mar-24	36.0%	27.9%	Feb-24	Driver			Not Escalated
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	37.5%	Mar-24	67.0%	36.9%	Feb-24	Driver			Escalation
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	54.2%	Mar-24	100.0%	49.2%	Feb-24	Driver			Escalation
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	6.4%	Mar-24	6.0%	3.9%	Feb-24	Driver			Not Escalated
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	6.0%	Feb-24	4.0%	4.1%	Jan-24	Driver			Not Escalated
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Mar-24	0.4%	0.5%	Feb-24	Driver			Not Escalated
	Maternity Metric	PPH >=1500% Rate		3.0%	4.0%	Mar-24	3.0%	2.1%	Feb-24	Driver			Not Escalated
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	3.1%	Mar-24	2.5%	2.4%	Feb-24	Driver			Not Escalated
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	81.9%	Mar-24	75.0%	81.0%	Feb-24	Driver			Not Escalated
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	87.5%	Mar-24	95.0%	81.8%	Feb-24	Driver	No SPC	No SPC	Not Escalated
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	65.6%	Mar-24	95.0%	65.9%	Feb-24	Driver	No SPC	No SPC	Not Escalated

Maternity Metrics



Mar-24
37.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



Mar-24
54.2%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target

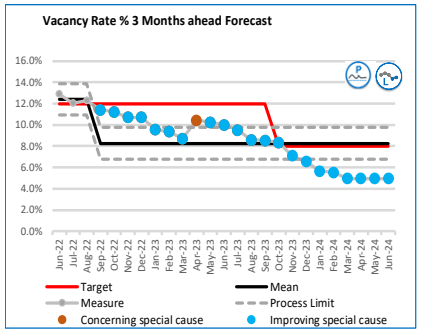
Summary:	Actions:	Assurance & Timescales for Improvement:
Women waiting for Induction of Labour less than 2 Hours: is experiencing special cause variation of an improving nature and consistently failing the target. **This is a new metric with data collection from June 22** **Women waiting for Induction of Labour less than 4 Hours:** is experiencing special cause variation of an improving nature and consistently failing the target. **This is a new metric with data collection from June 22**	**Women waiting for Induction of Labour less than 2 or 4 Hours:** The Maternity Service is working with the Business Intelligence Team and other stakeholders to review demand and capacity and to identify opportunities to improve flow throughout the department and reduce the occurrence of lack of bed or midwife capacity on Delivery Suite to enable timely transfer of women for ongoing induction of labour.	**Women waiting for Induction of Labour less than 2 or 4 Hours:** The process for robust risk assessment, daily obstetric reviews and prioritisation according to the latest clinical picture has been formalised and documented in an update to the Induction of Labour Guideline to ensure safety for those women who are delayed. Timescales for improvement will be dependent on the outcome of the demand and capacity project and any actions required as a result

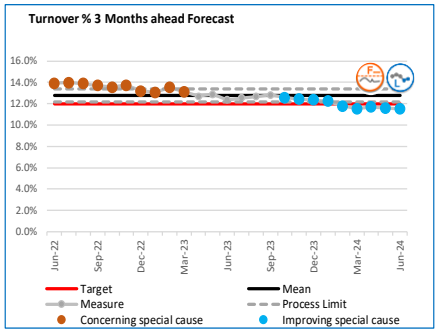
NHS
Maidstone and Tunbridge Wells NHS Trust

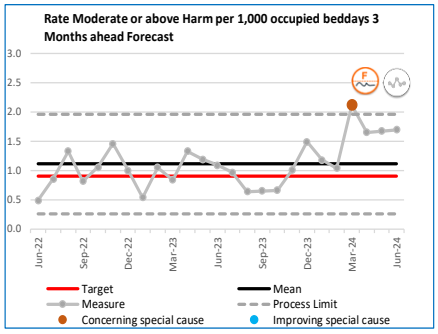
Appendices

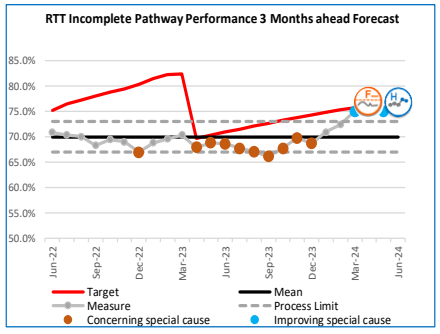
MTW
exceptional people, outstanding care

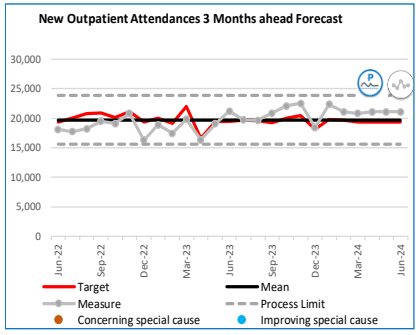
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

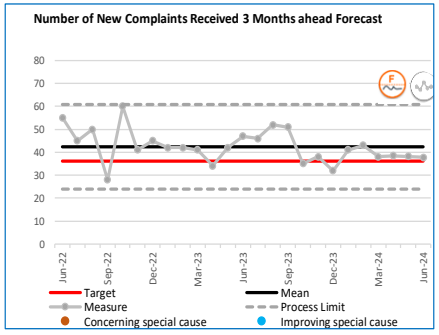


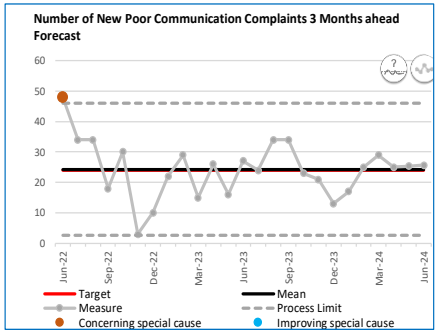


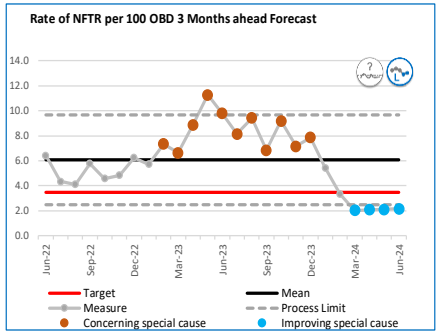


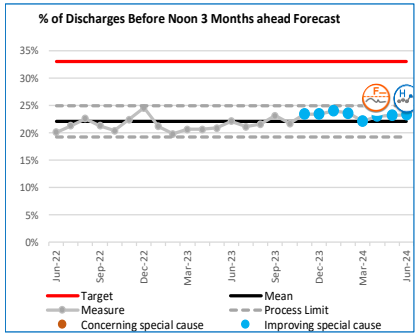


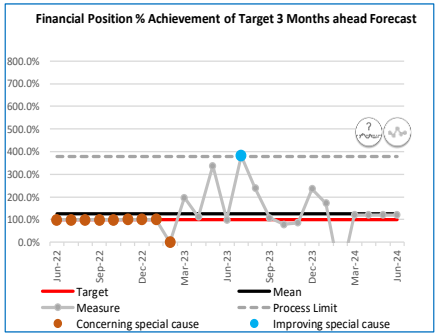


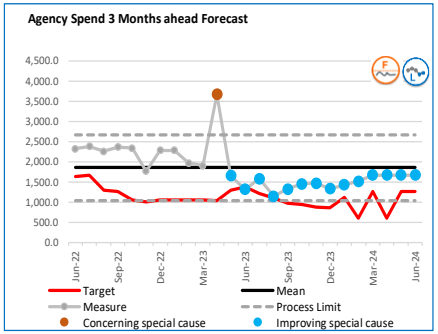




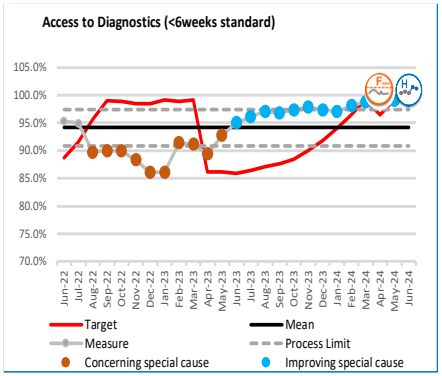


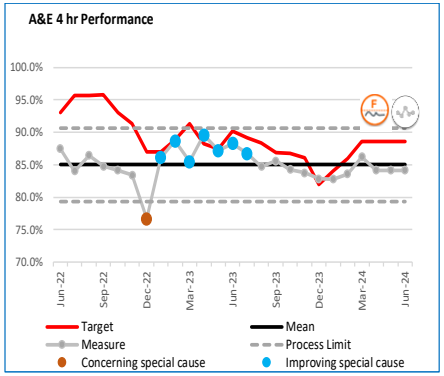


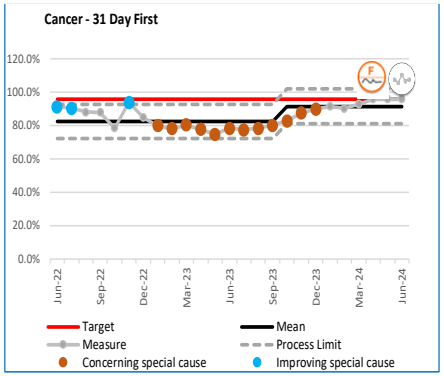


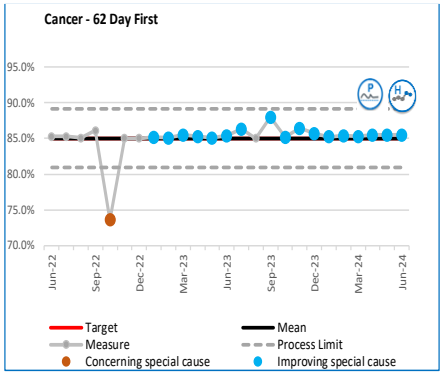


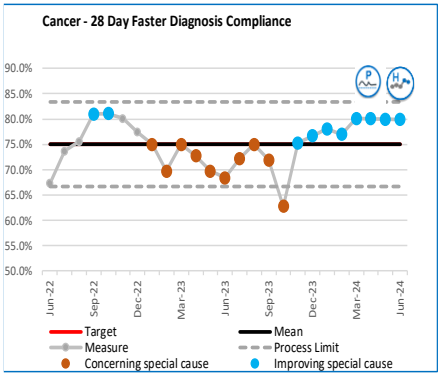
Forecast SPCs (3 month forward view) for Patient Access Indicators

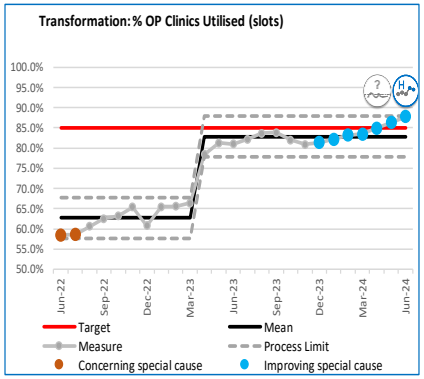


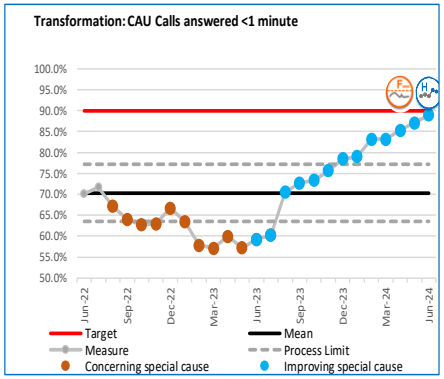


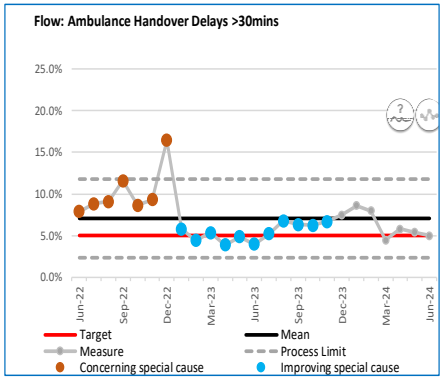


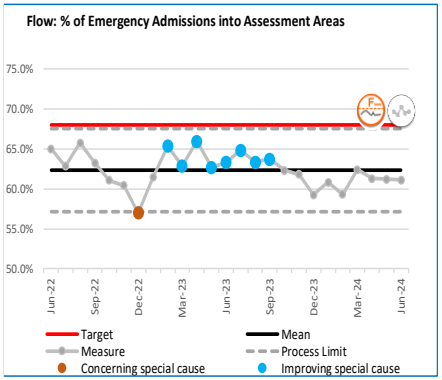


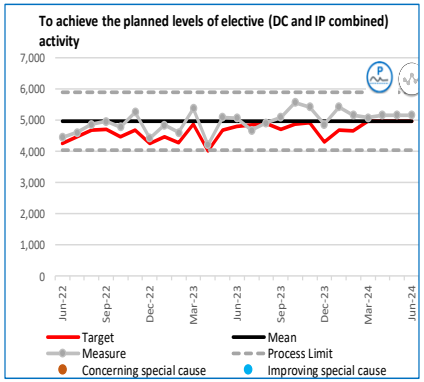


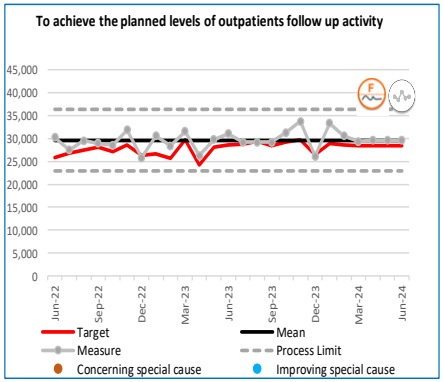


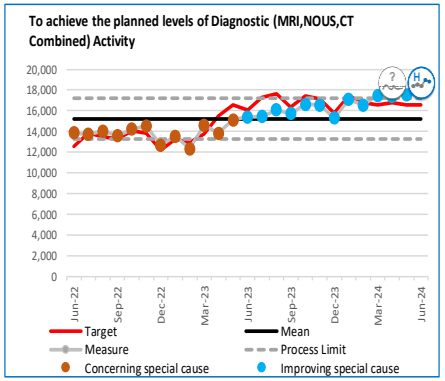






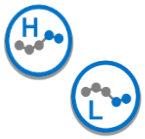






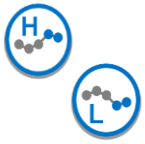
SDR Business Rules Driven by the SPC Icons

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

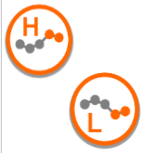
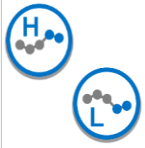
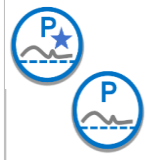
SDR Business Rules Driven by the SPC Icons

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:

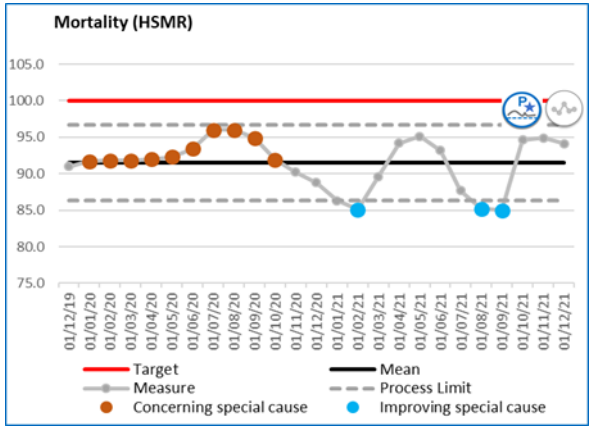
The **target** line **between** the **upper** and **lower** control limit for all metric types

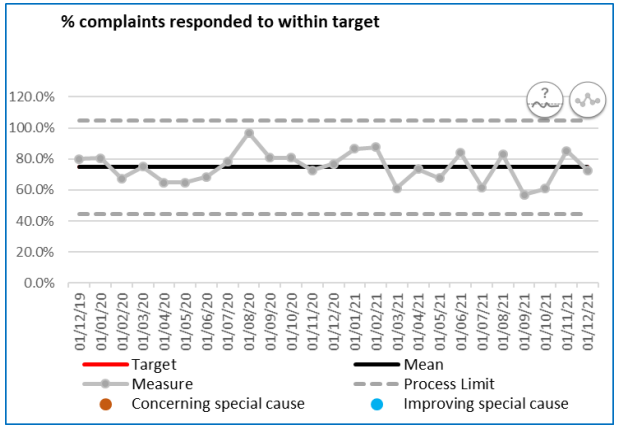
Metrics that consistently **fail** have:

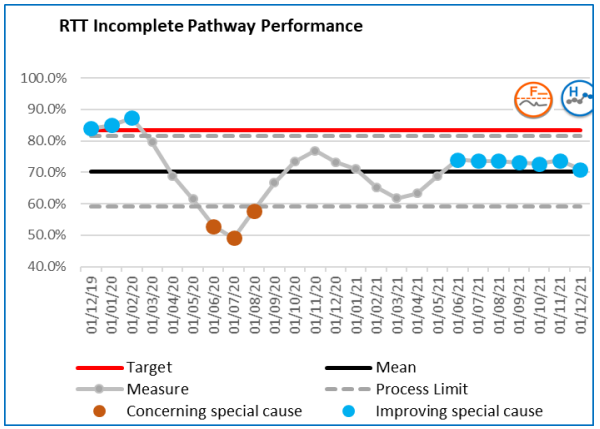
The **lower** control limit **above** the target line for metrics that need to be **below the target**

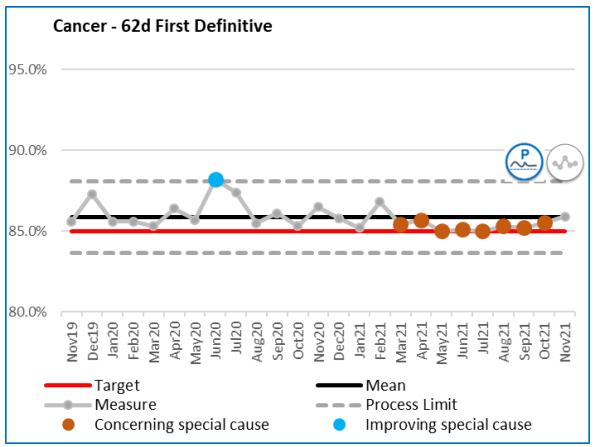
The **upper** control limit **below** the target line for metrics that need to be **above the target**

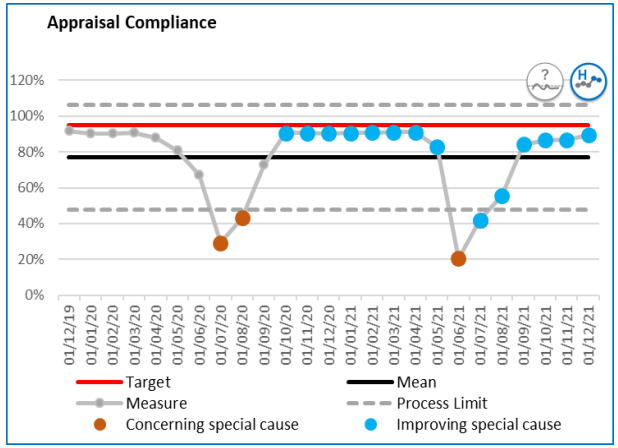
A metric not achieving the target for 6 months or more will be flagged as failing

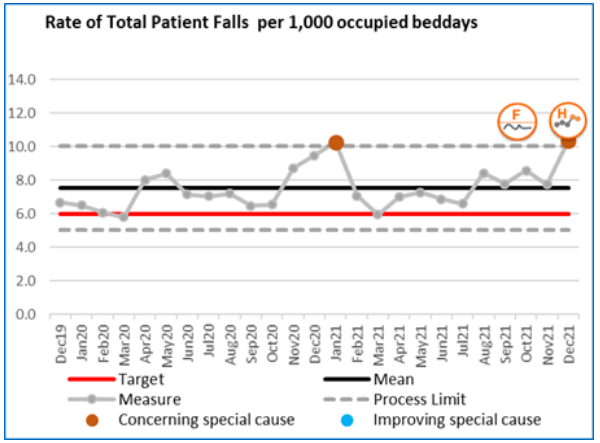












Executive Summary

- The Trust was £0.8m in surplus in March which was on plan. Year to date the Trust is £9.5m in surplus which is equal to the plan.
- The key year to date pressures are; CIP slippage (£14.5m), CDC delay to fully opening and underutilisation of CT capacity (£3.3m), medical pay award pressure (£1.1m), overspend within patient transport (£1.2m) and Cardiology non-pay (£0.4m). To mitigate these pressures the Trust has overperformed against variable income net of estimated spend (£9.9m), had non-recurrent benefits of £7m, overperformed against pathology service level agreements (£1.2m), benefited by £1.2m of interest receivable income and underspent against sexual health and medical education budgets (£1.1m)
- Cost Improvement Plans (CIP) was adverse to plan by £14.5m

Current Month Financial Position

- The Trust was £0.83m in surplus in the month which was on plan.
- **Key Favourable variances in month are:**
  - Clinical Income (£1.4m) overperformance in the month. The current month position included year to date adjustments to reflect notified ERF income values with commissioners and high cost drug income from specialist commissioning.
  - Underspend on Sexual Health and Medical education budgets to reflect final income and expenditure values (£1.1m)
  - Interest receivable favourable to plan in the month due to higher average cash balance (£0.2m)
- **Key Adverse variances in month are:**
  - CIP Slippage (£2.2m)
  - Costs associated with project dalmatian (£0.3m)
  - Increase in doubtful debt provision (£0.1m) and increase in bus and security costs linked to price changes (£0.1m)

Year to Date Financial Position

- The Trust is £9.5m in surplus which equal to the plan
- The key year to date variances are as follows:
  - **Adverse Variances**
    - CIP Slippage (£14.5m)
    - CDC delay to full capacity and also due to under utilisation of the CT capacity (£3.3m)
    - Medical pay award pressures (£1.1m)
    - Overspend within Transport budget (£1.2m) and Cardiology non pay (£0.4m)
  - **Favourable Variances**
    - Variable activity overperformance including change to ERF target (£9.9m) net of estimated spend.
    - Non-recurrent benefits (£7m)
    - Pathology NHS and trade contracts (£1.2m)
    - Interest receivable (£1.1m)
    - Underspends within Sexual Health and Medical Education budgets (£1.1m)

Risks

- **PFI** - The Trust has applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in line with IFRS 16 principles using the new PFI model, on a provisional basis in its initial year end Key Data submission. The model is not yet fully amortising the new calculation of the finance lease liability over the term, so support is being received from the DHSC GAM team that adapted the existing PFI model template to resolve the issues. 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 March was £11.9m which is higher than the revised value of £7.5m. The main reason that the cash balance is so high compare to the revised FOT is due to capital creditors of £4.9m where projects were completed but there was a delay in receiving the invoice. These invoices will be paid when they are approved, the expectation is that this will be in April
- Within 2023/24 the Trust received in total £38.5m in PDC funding and paid out capital payments of £47.9m. The Trust also paid PDC dividends of £6.2m and loan repayments of £1.5m. In March the Trust paid all authorised NHS invoices in accordance with the NHSE timetabled date of 21st March totalling £2.9m. The Trust purchased the Fordcombe Hospital (Spires TW) towards the end of March costing £9.75m.
- The cashflow is updated daily ensuring that the most up to date information is recorded. The Trust is continuing to have payment runs twice a week and we are paying all invoices up to the date of the next payment run which is in line with the Trust credit payment terms.
- 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 March the percentages were for Trade suppliers by value 95.8%, and by volume 96.3%; for NHS suppliers by value 89.3% and by volume 95%.

Capital Position

Year-end outturn (excluding IFRS16)

- The Trust reported £61.18m of capital spend at year-end. M12 alone saw a significant value of £27.5m being spent or accrued as equipment, ICT and building projects were completed. Some items are being held on the Trust's behalf offiste, the Trust has major projects as assets under construction e.g. KMOC and CDC modular developments.
- Both KMOC and CDC have had delayed completion dates, KMOC is now due to be completed at the end of May and CDC due in Dec 24. These delays had a significant impact on the 23/24 resources which required rescheduling of other schemes to bring the outturn back on plan. In turn this has had an impact on the 24/25 budget costs, KMOC has been funded from Internal sources and CDC is a mixture of Internal, System and National sources.

Fordcombe Hospital acquisition

- NHSE made available additional Capital Resource to enable the Trust to acquire the former Spire hospital at Fordcombe, Tunbridge Wells, at the end of March 2024. The overall capital impact of this acquisition is £16.5m, comprising £5.4m capitalised lease cost (IFRS 16), £5.8m of purchased fixed assets, £1.1m of Trust purchased ICT assets, and £4.2m of Goodwill (intangible asset). The balance of value between the purchased fixed assets and the goodwill value may be subject to change as a consequence of a fair value review of the purchased assets.

Other Funds

- PFI lifecycle spend at the year-end was notified by KESWHL to be £1.384m, with a prepayment of £124k carried forward. Donated Assets of £211k had been acquired by year-end.

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 further reduced its forecast to £5.6m in Month 10 as it had become clear that the KMMS accommodation will not be complete by financial year end. The Trust has included the capitalised value in its 2024/25 plans - this will be a key issue for , agreement with ICB and NHSE for funding.
- The final outturn spend for the year for IFRS 16 capital comprised £5,450k of Trust additional/renewal of leases plus remeasurements, plus the purchase of the Spire lease with a capital value of £5,391k, giving a total outturn of £10,841k. There was a surrender of a lease which led to a disposal credit of £33k, which nets off the spend total.
- The Trust has applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in line with IFRS 16 principles using the new PFI model, on a provisional basis in its initial year end Key Data submission. The model is not yet fully amortising the new calculation of the finance lease liability over the term, so support is being received from the DHSC GAM team that adapted the existing PFI model template to resolve the issues. 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.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 12
2023/24

Maidstone and Tunbridge Wells NHS

1a. Dashboard

March 2023/24

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-throu	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	82.8	59.8	23.1	0.2	22.9	742.8	698.0	44.8	(0.1)	44.8
Expenditure	(78.4)	(54.3)	(24.2)	(0.2)	(24.0)	(683.3)	(636.5)	(46.8)	0.1	(46.9)
EBITDA (Income less Expenditure)	4.4	5.5	(1.1)	0.0	(1.1)	59.5	61.5	(2.0)	0.0	(2.0)
Financing Costs	(28.6)	(21.7)	(6.9)	0.0	(6.9)	(75.8)	(69.3)	(6.5)	0.0	(6.5)
Technical Adjustments	25.0	17.1	8.0	0.0	8.0	25.8	17.3	8.5	0.0	8.5
Net Surplus / Deficit	**0.83**	**0.86**	**(0.03)**	**0.00**	**(0.03)**	**9.52**	**9.50**	**0.02**	**0.00**	**0.02**
Cash Balance	11.9	7.5	4.4		4.4	11.9	7.5	4.4		4.4
Capital Expenditure (Incl Donated Assets and IFRS16)	36.9	3.9	(33.0)		(33.0)	72.0	68.9	3.1		3.1
Cost Improvement Plan	1.4	3.7	(2.2)		(2.2)	18.8	33.3	(14.5)		(14.5)

Note: These figures are draft accounts and subject to audit approval

Summary Current Month:
- The Trust was £0.83m in surplus in the month which was on plan.

Key Favourable variances in month are:
- Clinical Income (£1.4m) overperformance in the month. The current month position included year to date adjustments to reflect notified ERF income values with commissioners and high cost drug income from specialist commissioning.
- Underspend on Sexual Health and Medical education budgets to reflect final income and expenditure values (£1.1m)
- Interest receivable favourable to plan in the month due to higher average cash balance (£0.2m)

Key Adverse variances in month are:
- CIP Slippage (£2.2m)
- Costs associated with project dalmatian (£0.3m)
- Increase in doubtful debt provision (£0.1m) and increase in bus and security costs linked to price changes (£0.1m)

Year to date overview:
- The Trust is £9.5m in surplus which is breakeven to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£14.5m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£3.3m)
- Medical pay award pressures (£1.1m)
- Overspend within Transport budget (£1.2m) and Cardiology non pay (£0.4m)

Favourable Variances
- Variable activity overperformance including change to ERF target (£9.9m) net of estimated spend.
- Non recurrent benefits (£7m), Pathology NHS and trade contracts (£1.2m), interest receivable (£1.1m) and underspend within Sexual health and medical education (£1.1m)

CIP (Savings)
- The Trust has a savings target for 2023/24 of £33.3m and has delivered £18.8m year to date which is £14.45m adverse to plan.

Risks
- **PFI** - The Trust has applied the change in accounting for PFIs relating to remeasurement of the PFI finance liability in line with I FRS 16 principles using the new PFI model, on a provisional basis in its initial year end Key Data submission. The model is not yet fully amortising the new calculation of the finance lease liability over the term, so support is being received from the DHSC GAM team that adapted the existing PFI model template to resolve the issues. 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.

Mar-24		DAY				NIGHT				TEMPORARY STAFFING					Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Overall Care Hours per pt per day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	120.1%	125.2%	-	-	129.8%	161.0%	-	-	57.0%	50.6%	125	8.26	13.3	-	-	4	0		186,226	271,533	(85,307)
MAIDSTONE	Stroke Unit (M) - NK551	88.6%	98.2%	-	100.0%	99.3%	103.8%	-	100.0%	32.1%	1.8%	79	5.48	9.2	0.0%	-	2	1		365,782	325,765	40,017
MAIDSTONE	Cornwallis - NS251	202.9%	187.4%	-	-	98.9%	98.4%	-	-	14.4%	3.9%	41	2.66	17.0	18.5%	93.3%	1	0		119,839	118,610	1,229
MAIDSTONE	Culpepper Ward (M) - NS551	100.0%	89.4%	-	-	100.1%	93.5%	-	-	27.8%	1.4%	21	1.46	4.7	0.0%	-	0	0		118,416	131,664	(13,248)
MAIDSTONE	Edith Cavell - NS459	108.0%	98.8%	-	100.0%	99.0%	156.5%	-	-	35.8%	28.9%	29	2.03	6.8	29.6%	100.0%	6	0		121,085	130,517	(9,432)
MAIDSTONE	Foster Clarke Winter Escalation - NS959	66.7%	63.8%	-	-	95.7%	78.1%	-	-	34.2%	20.2%	41	2.80	8.4	-	-	1	1		108,693	98,337	10,356
MAIDSTONE	John Day Respiratory Ward (M) - NT151	103.3%	96.7%	-	-	106.8%	108.1%	-	-	27.9%	13.5%	77	5.29	7.0	-	-	5	2		156,436	178,578	(22,142)
MAIDSTONE	Intensive Care (M) - NA251	84.0%	90.5%	-	-	87.0%	75.5%	-	-	9.1%	0.0%	47	3.24	51.4	0.0%	-	0	0		240,066	267,042	(26,976)
MAIDSTONE	Lord North Ward (M) - NF651	93.4%	96.7%	-	100.0%	101.8%	110.0%	-	-	24.2%	0.0%	34	2.47	7.2	20.0%	100.0%	3	0		117,054	124,833	(7,779)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	15.2%	2.8%	-	100.0%	16.4%	-	-	100.0%	4.9%	11.0%	3	0.21	1.9	0.0%	-	0	0		60,413	39,174	21,239
MAIDSTONE	Mercer Ward (M) - NJ251	100.9%	100.4%	-	100.0%	100.0%	120.7%	-	-	30.9%	21.0%	49	3.39	5.9	-	-	2	2		114,115	128,986	(14,871)
MAIDSTONE	Peale Ward COVID - ND451	100.0%	94.4%	-	-	110.8%	127.6%	-	-	35.1%	43.4%	73	5.05	9.9	-	-	0	0		124,265	103,358	20,907
MAIDSTONE	Pye Oliver (Medical) - NK259	127.5%	132.8%	-	-	145.1%	159.1%	-	-	61.5%	37.5%	93	6.57	8.1	-	-	5	0		135,990	207,163	(71,173)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	90.9%	85.1%	-	-	72.1%	-	-	-	13.6%	4.2%	15	0.94	44.3	0.0%	-	0	0		63,385	61,979	1,406
MAIDSTONE	Whatman Ward - NK959	102.0%	122.2%	-	100.0%	101.3%	171.6%	-	-	67.3%	36.4%	86	6.20	7.3	-	-	4	1		104,475	183,905	(79,430)
MAIDSTONE	Maidstone Birth Centre - NP751	104.8%	98.7%	-	-	100.7%	100.0%	-	-	15.6%	0.0%	22	1.33	47.6	0.0%	100.0%	0	0		77,570	98,719	(21,149)
TWH	Acute Medical Unit (TW) - NA901	108.4%	114.0%	-	-	114.6%	129.1%	-	100.0%	47.6%	39.9%	176	12.44	10.3	-	-	4	0		254,957	298,553	(43,596)
TWH	Coronary Care Unit (TW) - NP301	98.7%	82.9%	-	-	99.2%	-	-	-	16.2%	5.4%	23	1.64	12.1	-	-	0	0		75,962	75,642	320
TWH	Hedgehog Ward (TW) - ND702	107.8%	115.4%	-	-	111.5%	140.0%	-	-	47.7%	48.5%	196	13.03	10.4	-	-	0	0		168,781	260,955	(92,174)
TWH	Intensive Care (TW) - NA201	104.2%	89.7%	-	-	102.6%	77.4%	-	-	6.3%	5.8%	64	4.42	34.5	-	-	0	0		381,661	402,899	(21,238)
TWH	Private Patient Unit (TW) - NR702	99.3%	101.5%	-	-	95.2%	123.2%	-	-	44.1%	0.0%	42	2.64	8.9	-	-	3	0		73,468	94,398	(20,930)
TWH	Ward 2 (TW) - NG442	90.1%	96.5%	-	100.0%	101.1%	153.2%	-	100.0%	39.8%	9.3%	82	5.23	7.1	-	-	2	1		183,318	214,805	(31,487)
TWH	Ward 10 (TW) - NG144	106.4%	101.3%	-	-	101.6%	119.4%	-	-	61.3%	18.1%	181	12.24	8.5	-	-	6	1		182,965	80,384	102,581
TWH	Ward 11 (TWH) Nov 2019 - NG131	88.2%	89.5%	-	100.0%	113.7%	91.0%	-	-	27.2%	2.7%	86.00	5.72	6.6	#N/A	#N/A	8	0		149,847	166,505	(16,658)
TWH	Ward 12 (TW) - NG132	108.5%	89.6%	-	100.0%	118.4%	86.9%	-	-	29.3%	20.3%	96	6.34	6.8	-	-	14	0		149,950	175,904	(25,954)
TWH	Ward 20 (TW) - NG230	113.2%	124.8%	-	100.0%	123.6%	122.7%	-	-	45.5%	47.5%	150	10.11	7.9	-	-	2	0		176,689	219,326	(42,637)
TWH	Ward 21 (TW) - NG231	91.9%	99.9%	-	100.0%	93.5%	103.2%	-	-	27.7%	6.4%	94	6.08	5.9	-	-	7	2		152,563	178,875	(26,312)
TWH	Ward 22 (TW) - NG332	87.4%	104.1%	-	100.0%	93.5%	113.6%	-	-	32.2%	1.1%	93	6.39	6.2	-	-	8	2		150,276	205,769	(55,493)
TWH	Ward 30 (TW) - NG330	90.4%	105.7%	-	100.0%	97.6%	125.6%	-	100.0%	41.7%	0.9%	117	7.10	6.6	2.5%	100.0%	13	2		128,507	184,468	(55,961)
TWH	Ward 31 (TW) - NG331	97.1%	109.7%	-	-	96.8%	129.1%	-	-	40.1%	0.0%	122	7.37	6.6	15.6%	60.0%	7	9		142,604	220,538	(77,934)
TWH	Ward 32 (TW) - NG130	89.4%	90.5%	-	100.0%	99.2%	98.2%	-	100.0%	26.8%	0.0%	70	4.33	8.8	0.0%	-	0	0		151,293	170,014	(18,721)
TWH	Ward 33 (Gynae) (TW) - ND302	96.0%	93.8%	-	-	95.2%	100.0%	-	-	34.4%	0.0%	42	2.75	8.0	-	-	0	0		102,927	105,953	(3,026)
TWH	SCBU (TW) - NA102	90.9%	146.4%	-	-	105.2%	110.0%	-	-	17.0%	0.0%	74	4.49	12.8	-	-	0	0		212,704	191,187	21,517
TWH	Short Stay Surgical Unit (TW) - NE901	79.6%	93.2%	-	100.0%	106.5%	107.2%	-	100.0%	20.0%	0.0%	57	3.71	12.7	-	-	0	0		83,819	104,620	(20,801)
TWH	Surgical Assessment Unit (TW) - NE701	101.0%	96.8%	-	-	100.0%	100.0%	-	-	17.0%	0.0%	23	1.63	20.6	-	-	0	0		78,755	82,618	(3,863)
TWH	Midwifery (multiple rosters)	81.0%	63.6%	-	-	97.1%	82.1%	-	-	20.7%	2.5%	697	38.00	**14.0**	0.6%	100.0%	**1**	**0**		**1,225,381**	**1,302,980**	**(77,599)**
Crowborough	Crowborough Birth Centre (CBC) - NP775	62.1%	96.5%	-	-	84.3%	83.9%	-	-	19.0%	0.0%	60	3.59	205.5	-	-	0	0		113,851	114,251	(400)
MAIDSTONE	Accident & Emergency (M) - NA351	100.1%	96.2%	-	100.0%	102.7%	96.6%	-	-	39.4%	20.7%	400	27.13	-	0.0%	-	3	0		386,824	443,214	(56,390)
TWH	Accident & Emergency (TW) - NA301	95.8%	84.0%	-	100.0%	98.6%	89.0%	-	100.0%	41.1%	33.0%	427	29.30	-	0.0%	100.0%	3	0		418,955	508,322	(89,367)
																			Total Established Wards	**7,359,867**	**8,272,344**	**(912,477)**
																			Additional Capacity beds Cath Labs	57,909	49,616	8,293
																			Whatman			
																			Other associated nursing costs	5,771,536	5,352,048	419,488
																			Total	**13,189,312**	**13,674,008**	**(484,696)**

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

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	**Director of Strategy, Planning and Partnerships**

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

The report outlines the work the ICB are developing on the K&M NHS Strategy, the work of the Acute Provider Collaborative and the publication of the ICS Integrated Strategy alongside the WK HCP away day that took place on 15th April.

Which Committees have reviewed the information prior to Board submission?

Executive Team Meeting, 23rd April 2024

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

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

ICB and West Kent HCP update

March 2024

ICB/ System news

- We will be submitting the operational plan to the ICB on the 22nd April ready for our system submission to NHSE on 2nd May.

- The acute provider collaborative work on reviewing acute services is progressing with the first phase report now ready. The outputs of the data analysis have been reviewed with providers. Five top services have been identified as well as some additional quick wins focussed on variation. The next steps are being discussed at the APC meeting on 18th April.

ICB/ System news

- The ICB are leading the development of the K&M NHS strategy. An executive workshop took place on 21st March with 3 more planned on 19th and 26th April and 10th May.
- A continuous improvement approach is being utilised to develop the strategy, focussing initially on the case for change.

- The Integrated Care System has published the Integrated Care Strategy which can be found at *https://www.kmhealthandcare.uk/about-us/vision-and-priorities/kent-and-medway-integrated-care-strategy*. It has six outcomes:
  - *Given children and young people the best start in life*
  - *Tackle the wider determinants to prevent ill health*
  - *Support happy and healthy living*
  - *Empower people to best manage their health conditions*
  - *Improve health and care services*
  - *Support and grow our workforce*

West Kent HCP

The West Kent HCP Executive Group took place on Thursday 11th April with a Development Board away event on 15th April.
The Executive Group meeting focussed predominantly on an update of the implementation of Family Hubs presented by Kent County Council.

The Away Event celebrated the HCP successes over the last year and focussed on the coming year and how we take forward the development of Integrated Neighbourhood Teams and the Estates Strategy. The successes include the positive impact of our health inequalities programmes – a short video can be found at https://vimeo.com/920391859, the establishment of INT projects, success at the HSJ awards and focus a WK discharge and flow board.

We agreed next steps in both areas which will be written up and shared next month.

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

To approve the Trust's Digital and Data Strategy	Deputy Chief Executive / Chief Finance Officer

Summary of the background section

- The Digital and Data Strategy has been produced following consultation and engagement with colleagues across the Trust and uses the themes of the national What Good Looks Like (WGLL) framework.

Summary of the analysis, conclusions and key points for discussion section

- The digital and data strategy replaces the three separate strategies currently in situ.
- The strategy has been consulted upon in all Finance & Performance sub committees with comments incorporated into the final version.
- The increased use of digital technology and data led decision making will require a sustained level of funding. The anticipated funding profile is shown on page 22.
- Following approval of the strategy, a number of focus areas will be required to include: a workforce plan, detailed investment plans, governance structure, business case development, benefits profile and realisation, prioritisation matrix and restructuring of digital support teams.
-

Summary of the recommendation/s section (incl. any action needed by the Committee)

- Following review at Finance & Performance Committee, the Trust Board are asked to approve the Digital and Digital Strategy 2024 - 2029.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 16/01/24 and 30/01/24
- People and Organisational Development Committee, 23/01/24
- Finance and Performance Committee, 26/03/24

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

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

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Digital and data strategy 2024 - 2029

Digital and data supporting exceptional people and outstanding care

Foreword

Maidstone and Tunbridge Wells NHS Trust (MTW) provides a full range of general hospital services and some areas of specialist complex care to around **600,000 people** living in west Kent and East Sussex. Our Kent Oncology Centre provides complex radiotherapy and chemotherapy to almost **2 million people.**

Our Trust has over 7,000 staff and operates from two main hospital sites: Maidstone Hospital and Tunbridge Wells Hospital. Across the two sites we have a total of 620 beds. We also provide services at the Birthing Centre at Crowborough Hospital, sexual health services in Tunbridge Wells and Gravesend, oncology services at the Kent and Canterbury Hospital and outpatient clinics across a wide range of locations in Kent and East Sussex.

The services we provide to colleagues and patients are enabled by digital technology and effective use of data.

This strategy builds upon three, previously separate strategies that have helped us make so many developments in the last five years:

- MTW IT strategy 2018 - 2023
- MTW business intelligence strategy 2019 - 2022
- MTW digital transformation strategy 2020 - 2030

This new strategy outlines our commitment and aspirations for the Trust's digital and data roadmap from 2024 to 2029, aligning with the latest national guidelines. Our ability to harness digital innovation and data driven decision making will support the delivery of exceptional patient care and operational efficiency. With continuous improvement, our vision is to create exceptional digital and data services that enable staff to provide outstanding care.

Sue Forsey
Director of IT

James Jarvis
Associate Director of Business Intelligence

Contents

MTW digital

Our digital and data vision

Our vision is to create exceptional digital and data services that enable our people to provide outstanding care.

Our strategic goal

To provide digitally seamless, enhanced patient care.

Digital technology offers solutions to some of the most complex challenges facing the NHS and we plan to fully embrace these opportunities. Through the increased use of digital technology and the intelligent use of data, MTW is already seeing huge improvements to patient care, safety and quality.

To date, this has most notably been done through the launch of Sunrise Electronic Patient Record (EPR). We want to build on this using the latest technology and data, such as Artificial Intelligence (AI), Robotic Processing Automation (RPA), along with partnering with industry and acadaemia to support our clinical colleagues with earlier diagnosis, personalised treatment plans and population health management.

Our digital vision for the future

We aim to help treat patients more effectively by giving healthcare staff:

- Easier access to the right information in the right place at the right time with decision support tools to provide safer and more efficient care
- Opportunities for working differently across boundaries, to improve care and improve how our services are provided by different teams across organisations

All staff in every department of our Trust will see the benefits of digital technology. This will enable:

- Better use of the digital and data tools within the Trust, supported by continuous training and improvement
- Easy access to information at the point of care with reliable quality of data

It will also enable MTW to:

- Support the wider Kent and Medway vision by using digital and data to enable better research, innovation and improvement across the system
- Continue to collaborate with other provider organisations to converge systems where appropriate to support data driven decision making

As digital technology is constantly changing and evolving, we will be flexible and open to new opportunities. While we want to be ambitious in our use of technology, we are mindful that we need to prioritise investment in the infrastructure that will help to underpin successful deployment of the latest technologies. We will also commit to investing in developing and enhancing the skills of our workforce to keep up to date with innovations in technology.

Design principles

Our design principles guide our digital and data developments, help us make investment decisions and prioritise what we deliver. We will continue to invest in our core electronic patient record systems but will not introduce risk, workarounds or complex digital processes.

Principle	What it means
Simpler	✔ We will rationalise the number of systems in use ✔ We will not replicate or introduce complex processes digitally ✔ We will develop systems and solutions that are usable, easy to understand, easy to navigate, accessible and meet the needs our staff and patients
Connected	✔ We will create tools and systems that bring together information from disparate systems ✔ We will not create closed systems which create silos of information
Efficient	✔ We will develop digital solutions that streamline work for clinicians, improving their speed and efficiency, while enhancing the patient experience ✔ We will not develop inefficient solutions that detract from the patient experience
Enabling	✔ We will create digital solutions to transform care pathways ✔ We will not create solutions in isolation and will learn from others to accelerate implementation ✔ We will support staff by improving digital literacy and developing expertise where required
Secure	✔ We will develop digital solutions that are safe and secure, and meet our security standards ✔ We will not support any solutions that put our data at risk
Collaboration	✔ We will develop digital and data solutions in collaboration with staff and patients to support a patient first and clinically driven culture ✔ We will develop digital and data solutions to facilitate communication across health and social care boundaries enabling transformation of care pathways
Governance & Ethics	✔ We will develop simplified governance processes with an overarching Digital & Data Board ✔ We will utilise existing Trust governance processes to reduce duplication ✔ We will develop and strengthen our clinical safety capacity to support digital and data solutions

Key digital and data developments that we are proud of

Staff tell us that we are already doing great things. We have achieved many successes over the last two to three years, including:

- Deployment of Sunrise Electronic Patient Record (EPR) Electronic Prescribing and Medicines Administration (EPMA) and Electronic Discharge Notification (EDN) for adult patients
- Implementation of Teletracking (patient flow management)
- Windows 10 deployment to a refreshed PC and laptop estate
- Rapid expansion and implementation of hybrid working, and deployment of equipment including iPads for patients and increase in video consultations during COVID
- Significant network, server and system upgrades across the Trust
- Significant Patient Administration Systems (PAS) upgrade
- Implementation of new Radiology Information System
- Deployment of new Picture Archiving and Communicaiton System
- Deployment of Incident & Risk Management system
- Implementation of bereavement software solution
- Single Sign On implementation
- Adoption of Making Data Count methodology and use of Statistical Process Control charts
- Deployment of Power BI for close to real-time reporting

We have aligned our digital and data strategy with national guidance.

The aim nationally is to use digital technology to keep people well in their own homes, offer choice and improve overall life chances through healthcare at residents' fingertips.

At the same time, the NHS aims to address the challenges of demand and capacity across the system for the management of urgent and emergency care pressures, elective recovery, and the objectives set out in the Primary Care Strategy 2022, including virtual wards and hospital at home.

NHS England launched the 'What Good Looks Like' (WGLL) programme that builds on established good practice on how to digitise, connect and transform services safely and securely. From this a WGLL framework has been developed and used to assess our Kent and Medway Integrated Care System (ICS) and MTW digital maturity. Developing our own digital and data strategy in line with this framework ensures consistency with national strategy and regional strategy. It will help us improve the outcomes, experience and safety of our patients.

Our Trust

Our five-year digital and data Strategy 2024-2029 is one of the key foundations in supporting the delivery of our trust strategic objectives. This strategy aligns with our 'Exceptional people, Outstanding Care Strategy' and the national WGLL framework.

Our healthcare system

Our care pathways cross numerous boundaries within ICS as well as in Surrey, Sussex and London. As a member of the Kent and Medway Integrated Care Board (ICB) and the West Kent Health & Care Partnership (HCP), we collaborate with other health and care providers and our local community including the voluntary sector, to support the vision of enabling multidisciplinary teams to work effectively across organisational boundaries. We will continue to work with other providers towards integrating and consolidating IT systems, ensuring data can flow between them and importantly, access at the point of care. We will continue to consider convergence of digital and data systems where there is clear productivity and efficiencies to be gained and proactively contribute to system projects such as the KERNAL (integrated datasets), the Kent and Medway Shared Care Record and a number of county wide diagnostics projects including the Kent and Medway LIMS (laboratory information management system). We will work together across West Kent and the wider K&M system to support improved outcomes and enhanced productivity ensuring value for money.

We will continue to work with other providers towards integrating and consolidating IT systems, ensuring data can flow between them and importantly, access at the point of care

National digital guidance informs our strategy

Key guidance	Highlights
The NHS long term plan 2019	A significant drive to transform health care through better and widespread use of digital technologies. Emphasis on upskilling users at all levels in the NHS, particularly clinicians
What good looks like framework (WGLL) programme 2021	Provides clear guidance for health and care leaders to digitise, connect and transform services safely and securely
Who pays for what: Digitise, connect, transform NHS Transformation Directorate Aug 2021	Who Pays for What (WPfW) identifies the barriers faced by the system when it comes to investment in digital technology and proposes actions to overcome these barriers in 2021 to 2022 and beyond
A plan for digital health and social care GOV.UK June 2022	A plan for a health and social care system that will be faster and more effective and deliver more personalised care
Greening government: ICT and digital services strategy 2020-2025 GOV.UK Sept 2020	Strategy setting out how government can provide responsible and resilient ICT and digital services to all its end users and customers
Data saves lives: Reshaping health and social care with data GOV.UK June 2022	Plans the use of data to bring benefits to all parts of health and social care
Inclusive digital healthcare: A framework for NHS action on digital inclusion Sept 2023	Provides a framework to help NHS staff enable and encourage greater access to and improved experiences of healthcare, and increased adoption of digital approaches where appropriate
NHS long term workforcplan June 2023	The first comprehensive workforce plan for the NHS, putting staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside recruitment drive

MTW values

We do not compromise on our values. They aid our decision making and set an expectation of the behaviours that staff exhibit (and experience) in the workplace. These are implicit within our digital and data priorities identified in this strategy.

Patient First

Patients are at the centre of service design with access to a standard set of digital services that meet their needs

Respect

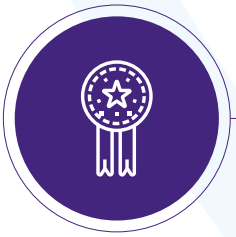
We respect and value our patients, visitors and staff and ensure that appropriate digital safety and data quality standards are in place to keep them safe

Innovation

We take every opportunity to improve services. Leaders across MTW collectively own and drive the digital transformation journey

Delivery

We embed digital and data within our improvement capability to transform care pathways. We aim to deliver high standards of quality and efficiency in everything we do using reliable, modern, sustainable and resilient solutions that capture data at source when required



Excellence

We take every opportunity to enable our staff to work optimally with data and technology. Digital and data tools and systems are fit for purpose, regularly validated and support staff to do their jobs well

How the strategy fits together

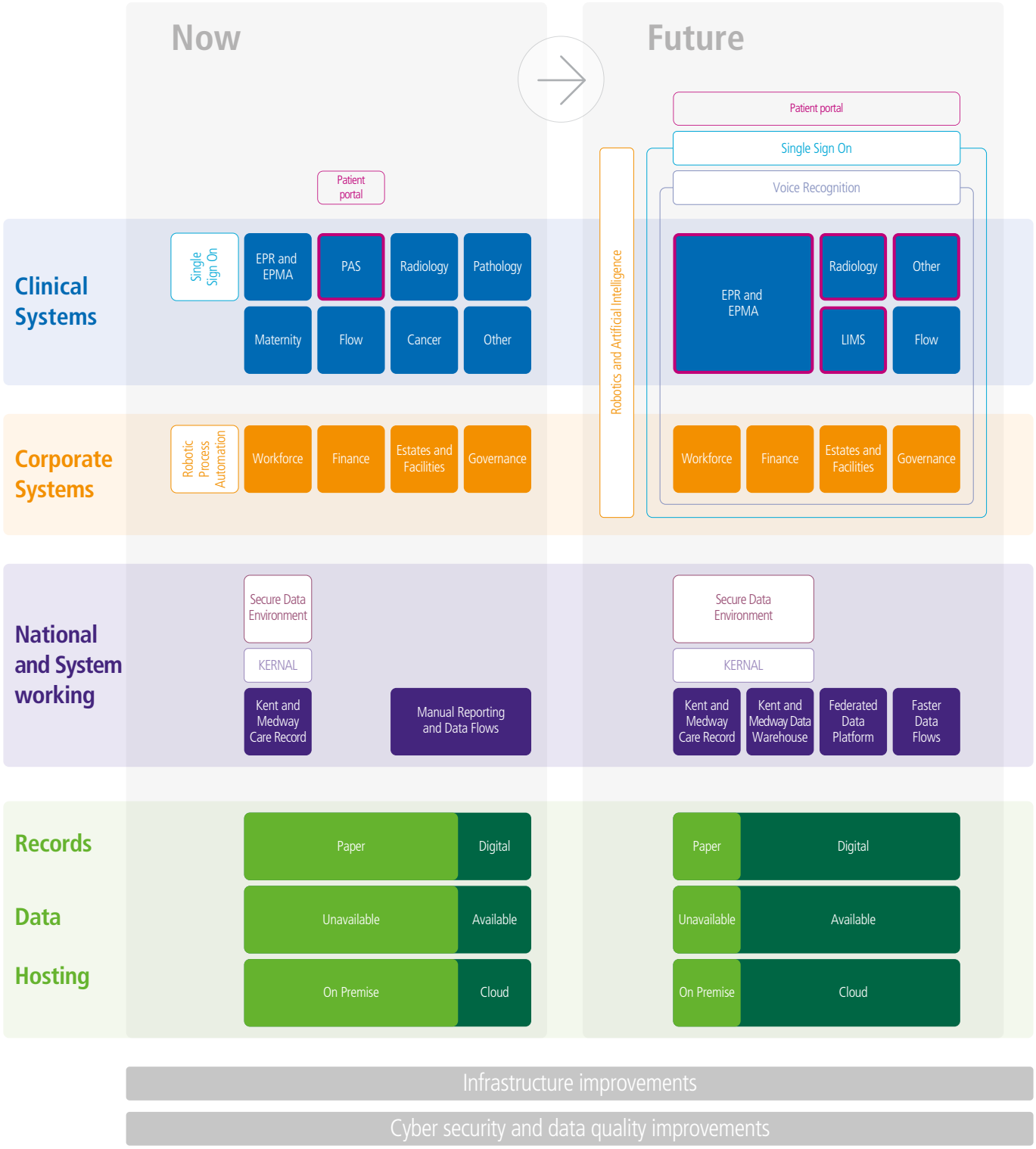
We have targeted our priorities for this strategy based on the feedback from staff. The Trust commits to supporting national and regional plans, and meeting the expectations of NHS England and NHS Digital.

Our strategy is designed to be actionable and is based on the themes of the WGLL framework:

This strategy provides high-level objectives. It will be revisited annually by the digital and data leadership team and appropriate committee to review progress and reset priorities and timelines, in order to maintain a relevant high-level plan and assist in the development of a sustainable financial plan.

Our digital maturity

The diagram below shows the transition through the Digital Capabilities Framework and the increase in the organisation's digital maturity based on the implementation of the strategy.



Well led

Our goals and measures of success

- MTW has a clear strategy for digital and data leadership and collaboration
- Leaders across all departments collectively own and drive the digital and data transformation journey, to support our staff and improve services for patients
- All leaders promote digitally enabled solutions, ultimately aiming to deliver safe, high-quality care, efficiently
- We will develop a set of metrics to provide assurance over the delivery of the strategy and the associated benefits
- The Trust will use assessment models such as Healthcare Information and Management Systems Society (HIMSS) and the Digital Maturity Assessment provided by NHS England

Our commitments

- Review the governance of our digital and data programmes
- Establish Board-level governance to regularly review and align all Trustwide digital and data programmes, procurements, services, capability and risks within the Trust against the delivery of the digital and data strategy
- Ensure projects are prioritised appropriately in line with the Trust's objectives with support and commitment from senior leadership
- Invest in regular Board and senior leadership development sessions to develop digital and data competence
- Support digital clinical leaders by developing a dedicated team of digital clinicians
- Combine all digital support services under one overarching leadership structure

Prioritising investment

Investment will be prioritised using a matrix that considers our corporate objectives, clinical strategy, risk, productivity, safety and sustainability. We will seek to expand our digital and data capability by investing in solutions that allow us to increase productivity in front line and back office functions. We will continue with our commitment to remove high cost agency staff and utilise local and national funding to expand our digital and data workforce.

New governance structures will be developed to ensure strategic oversight, clinical engagement and effective delivery in line with the Trust's business planning and business case development processes.

Our five year plan

2024-25	2025-26	2026-27	2027-29
Regular digital and data metrics which measure progress, improve scrutiny and monitor delivery will be introduced to the Trust Board agenda			
A digital and data engagement plan will be developed with the support of the Communications team			
Regional engagement and collaboration on digital, data and technology will be maintained along with participation in developing stronger digital clinical leadership across the region			
Enabling stronger links between central digital leadership teams and developing a Digital and Data Business partner model for Divisions to provide better coordination and more effective prioritisation, and avoid unnecessary duplication of effort			
Develop plans to strengthen the Trust's digital clinical leadership representation			
Develop a set of principles and scoring metrics for prioritising digital and data projects. Review and standardise the process for change management, implementation and operational support			
Ring-fenced digital and data resources and dedicated digital workforce will be promoted to deliver improved efficient ways of working across all areas of the Trust			
Develop an annual financial investment plan			

Smart foundations and safe practice

Our goals and measures of success

- Digital, data and infrastructure operating environments are reliable, modern, sustainable, resilient and meet national standards
- We have well-resourced and competent teams delivering modern digital and data services
- Demonstrate that digital systems store and process information in a safe, fair and lawful way.
- Trust-wide security, sustainability and resilience is reviewed annually
- We will maintain our focus on improving our data quality and ensuring compliance with national data standards

Our commitments

- Staff will be able to use MTW's digital and data resources efficiently whenever and wherever they are working
- Hardware, software and end user devices will be within the suggested supplier life cycle and fully supported
- Staff will have access to the technology and devices that best support their roles, including a clear process for replacing such equipment
- There will be a secure and well-tested back-up process, including a plan to move away from unsupported systems
- Robust business continuity processes will be implemented that are tested regularly for all our key digital systems
- Progress towards net zero carbon, sustainability and resilience ambitions by meeting the objectives of the Sustainable ICT and Digital Services Strategy (2020 to 2025)
- Investigate the benefits of moving to a cloud data hosting and management solution
- Maintain a robust and secure network
- Comply with the requirements of the Data Security and Protection Toolkit and Cyber Assessment Framework
- Regulatory compliance with the Data Protection Impact Assessment for all systems where personal or sensitive data is processed or stored
- Compliance with appropriate governance procedures for clinical systems and tools will meet clinical safety standards as set out by the DTAC and DCB0129 and DCB0160
- All projects and programmes will meet clinical safety standards and be cyber secure by design
- Our cyber security function will be adequately resourced with an established process for managing cyber risk
- A cyber improvement plan will be developed and reviewed regularly at Trust Board
- There will be a clear process for reviewing and responding to relevant safety recommendations, alerts, and monitoring, including those from NHS England Cyber Security team, NHS England, the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Healthcare Service Investigation Branch (HSIB)
- We will comply with NHS national contract provisions related to technology-enabled delivery of automated correspondence

We will understand the risks presented by the growth of AI technology in healthcare and how these may impact our systems, processes and security

Our five year plan

2024-25	2025-26	2026-27	2027-29
All new contracts will meet the published standards and embed the Technology Code of Practice			
Review and evaluate the purchase of end user devices via a service model			
	Undertake a strategic review of how cloud storage could be developed and introduced at MTW		
	A new integration strategy will include continuing investment in the technology ensuring that it can meet demand robustly for messaging between systems		
A Cyber Improvement Plan including training, awareness and targeted campaigns (such as Multi Factor Authentication) will be accompanied by an investment plan and proposal for monitoring progress and delivery of such projects			
Review the clinical safety officer structure at Trust and divisional level supported by a clinical safety policy to ensure all clinical systems undergo reviews before implementation, during their use and when decommissioned, to comply with DCB0160. This includes developing a plan to ensure all the current clinical systems have a safety review completed within the next 24 months			
Continue to measure and report our compliance against the national information governance and cyber compliance standards and frameworks			
Standardise role-based access for digital systems, including robust processes for temporary staff			
Work with the Trust Estates team to deliver 'A Green Plan for MTW – 2023-2028'			
Plan annually for the introduction of latest versions of operating systems and other core technology. Develop a prioritised plan of migration of unsupported operating systems with documented mitigating action where this is not immediately possible			
Continue optimisation of systems to get maximum benefit from them and develop a robust plan for the disinvestment of systems no longer required			
Robust business continuity processes and documentation for all digital systems will be tested regularly so that all departments know what to do during an outage			
	Develop asset management capability to enable robust device tracking		

Supporting staff and teams

Our goals and measures of success

- Our workforce is digitally literate and can work optimally with data and technology
- Digital and data tools and systems are fit for purpose and support staff to do their jobs well
- Equipment provided allows teams to work more efficiently and reduces manual data entry
- All staff in all areas will benefit from digital technology to enable continued improvement of services they provide within the Trust

Our commitments

- Multidisciplinary teams with clinical, operational, informatics, design and technical expertise will lead and deliver our digital and data ambitions
- Develop a Digital and Data Academy to undertake a gap analysis and develop digital skills and competency-based training for staff
- Develop plans and explore opportunities to improve digital inclusion for patients and staff
- Support specialist staff to enhance their existing skills including those in digital and data roles
- Create virtual and on-site digital hubs to support staff to develop and maintain data, digital and cyber security literacy
- Providing collaborative dedicated digital teams to support the daily management of core clinical systems and infrastructure
- Accessible digital support services that are quick to respond and have high first-time fixes
- Staff supported to work flexibly, remotely, and across multiple areas or sites
- Staff have the information they need to do their job safely and efficiently, reducing the need for manual intervention and duplication of work by integrating systems
- A simplified identity management system enabling staff to be given appropriate access to the systems they need via a streamlined process that captures all starters and leavers
- All staff can access and interact with the systems they need, wherever they are, supported by a single sign on process
- Systems optimised so that they are intuitive and easy to use
- Use of voice recognition and/or digital dictation for those who need it
- Staff can 'self-serve' to access the reporting they need from our clinical and corporate systems
- Promote the use of digital solutions to increase wellbeing through access to resources, facilitating connections, empowering staff to take proactive steps towards improving their mental, emotional and physical health
- Staff can provide feedback on the quality of digital and data services and suggest areas for improvement

Data is made available from our clinical systems to support the management of patient flow, ensuring our compliance with best practice guidance and the completion of clinical audits

Our five year plan

2024-25	2025-26	2026-27	2027-29
All MTW-provided devices will have email, chat, phone and, where appropriate, virtual meeting functionality and reliable connectivity			
	Develop our ability to manage stock, and track resources using wireless tag and reader technology, e.g. beds, caseloads, emergency department capacity, equipment, aligned with Scan for Safety guideline		
Develop voice recognition capability for all staff who need it to reduce manual typing and aid inclusion			
	Clinical systems (such as EPR) to have functionality enabling patient correspondence or forms to be automatically generated based on a validated clinician's typed or digitally-dictated notes		
	Engage and plan for digital hubs that can be used for digital drop-in sessions, training and safe space for digital literacy development		
Increase integration to reduce the complexity of systems in use across MTW and automate processes so that staff only enter information once			
	Continue investment in appropriate technology to support flexible working		
Enable staff in clinical education training labs to use the same digital systems in training that they will use in the real clinical environment			
	Develop a Digital Academy based on a digital literacy competency framework to support staff and provide training and mentoring		
Develop a strategic workforce plan to meet our digital and data ambitions, including digital career pathways to aid retention and development of our staff			
Provide a standardised identity management system enabling staff to be given appropriate access to the systems they need via a streamlined process which captures all starters and leavers correctly			
Promote the principles and learning from digital exemplar wards when implementing digital and data initiatives			

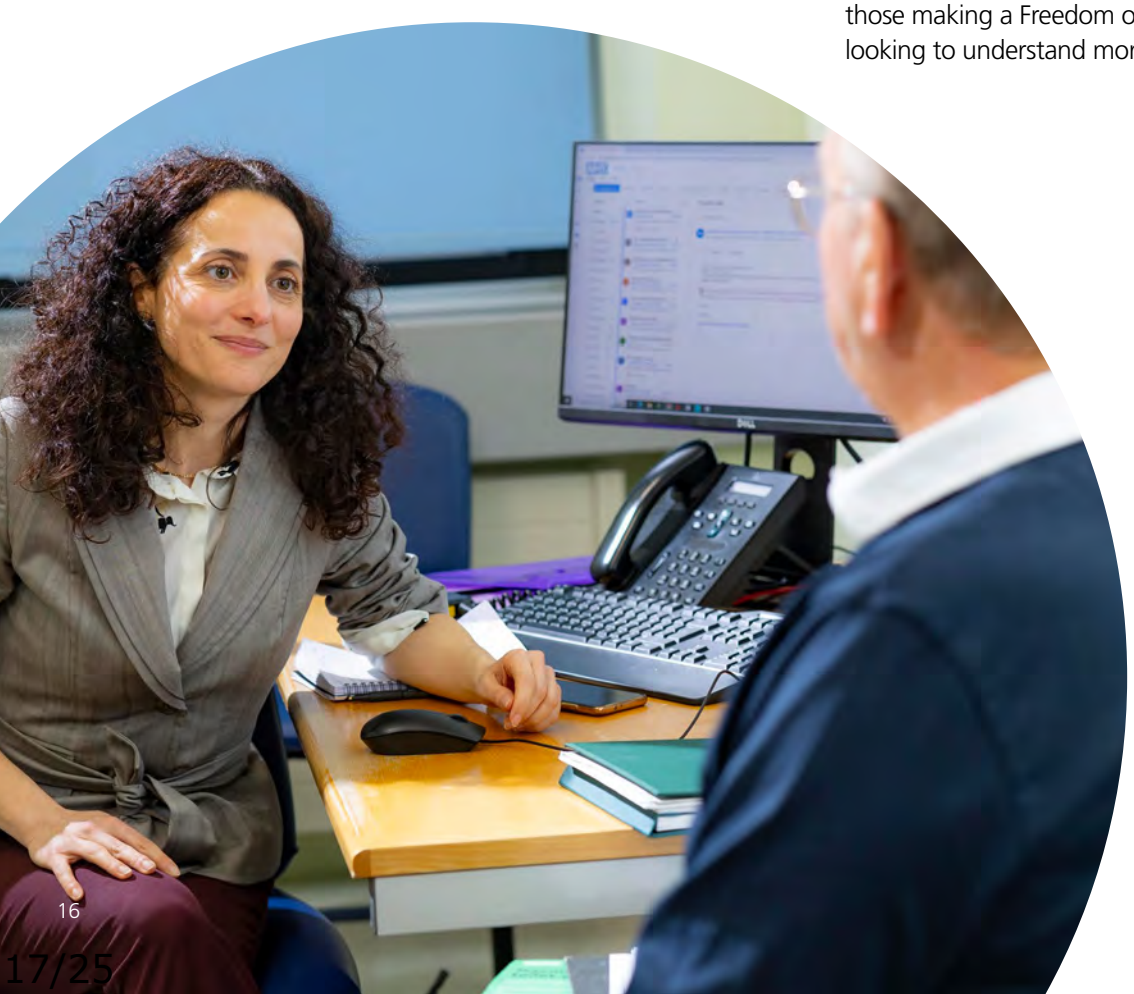
Empowering our patients

Our goals and measures of success

- Patients have access to a standard set of digital services that suit all literacy, cultural and digital inclusion needs
- Patients are central to the design of the digital services they use and will be engaged with for all patient facing systems being introduced
- Patients can take an active role in, and control of, their health, care and wellbeing through secure online access to clinicians, personalised health information, digital tools and advice. They are empowered to make choices around sharing their health data and their consent will be effectively recorded
- Patients can better manage their long-term conditions to avoid unnecessary visits to hospital

Our commitments

- Digital tools, e.g. our patient portal, will enable patients to take control of their health and care, with access to their healthcare records, results, medications and clinical correspondence, and the ability to manage appointments
- Technology will be used to support self-care such as triage, referral, condition management, advice and guidance, apps, and wearable devices for monitoring health
- New processes will allow patients to choose and update how much consent they give over their health data and record those preferences
- Digital systems for virtual wards and outpatient clinics will continue to support care to avoid unnecessary hospital visits
- Alongside our Patient Experience group we will ensure digital services are developed with their input including devising a clear digital inclusion strategy will address digital accessibility for all those that have potential to be excluded or left behind
- Improved collection and coordination of data and feedback, including friends and family, for departments to learn and enhance their digital services
- We will be involved in developing seamless digital services with our regional partners, led by patients
- We will make data available to the public to support those making an Freedom of Information request or looking to understand more about the work we do
- We will make data available to the public to support those making a Freedom of Information request or looking to understand more about the work we do



Our five year plan

2024-25	2025-26	2026-27	2027-29
Tailored digital engagement with our patients by capturing their communication preferences			
Continue to develop and empower our patients through targeted projects to have safe access to their health records, test results, and be able to enter relevant information and update their records through our patient portal			
A targeted project will continue to develop our maternity records and functionality, enabling service users to enter relevant information and hold their records digitally			
Trust-wide plan to tackle digital exclusion will draw on the guidance within 'The digital inclusion guide for health and social care' here			
Support the Patient Engagement Programme with accessibility requirements that define a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss			
	Enhancement of technology in place for virtual clinics and virtual ward services to ensure they support reduction of unnecessary visits to hospital		
	Working with the MTW Charity we will support the development of a Digital Pod on each Trust site, and potentially even in the community, for patients to go to for access to Trust services and to use technology (for example hub/s for remote digital assessment in Ophthalmology).		
		Empower patients to have controlled and safe access to test results and the ability to update their records via patient portal	

Digital care pathways

Our goals and measures of success

- We embed digital and data to transform care pathways for patients ensuring they get the right care, in the right place, at the right time
- Digital and data is used to standardise processes, reduce variation and manual data entry for our staff

Our commitments

- Our journey to become a paper-free organisation will continue through the increased use of digital technology
- Care pathways across departments and multidisciplinary teams will be redesigned taking a user-centred approach supported by the latest digital technology, giving patients the safest care in the most appropriate setting
- The use and scope of Sunrise EPR extended to all services, so it becomes the Trust's default EPR for managing patient care
- Extend use of decision support tools and implement AI technology to help clinicians follow best practice and eliminate variation across the care pathway
- Legacy bleep/pager systems will be removed and replaced with electronic messaging and rapid response alert systems for staff
- Where possible people will be offered remote and virtual services to keep well in their own homes
- Through further integration of systems, clinicians have the right information when they need it
- Contribute data to the implementation and expansion of regional shared care records
- We will integrate Sunrise EPR with bespoke systems with specialist functions such as Maternity, ITU and Opthalmology

The use of Artificial Intelligence (AI) has the potential to increase productivity and remove repetitive tasks. We will consider the use of AI technology on a case by case basis through robust governance processes, while developing an AI strategy in line with NHS England's objectives to strengthen the use of AI in healthcare. Examples of AI technology that we will explore include the use of AI technology in key diagnostic services such as Stroke and Cancer, assisted voice recognition, chat bots to assist call centres and wearable devices for our virtual wards.

Our five year plan

2024-25	2025-26	2026-27	2027-29
Enable multi-disciplinary teams to coordinate care more effectively for priority high-risk pathways, including discharge or transfer of care using integrated digital clinical systems			
	Increase the use of mobile handheld devices to allow clinical teams to review patient records by the bedside		
		Collaborate with regional partners to develop the Shared Care Record, enabling clinicians to request tests and procedures, and track progress across the county	
Further develop the automation of patient observations in our EPR, improving rapid response to deteriorating acute illness, alerting outreach teams for critically ill patients			
	Further develop the virtual ward and remote monitoring device technology for patients with long term conditions		
		Enable self-service access to close to real-time workforce data, including rostering and temporary staffing usage, to support resource scheduling, staff and budget management	
Support the integration capability of the patient flow management system with key clinical systems			
	Implement the Pathology Network-wide replacement Laboratory Information Management System (LIMS) ensuring integration with relevant MTW systems		
Collaborate with other local maternity and neonatal system (LMNS) trusts on a system-wide procurement of new Maternity Information System			
Develop a plan for the procurement and implementation of a specialist Clinical Information System for ITU			
Increase the level of patient pathway documents to be created electronically in line with the Trust's digital maturity ambitions			
Deliver the planned expansion of the EPR replacing relevant legacy systems			
Deliver integration priorities to reduce the data burden and increase the availability of data for clinicians			
Further reduce the need to scan and store paper records for all new and existing patients			
Support the national Scan4Safety initiative, using barcodes to enhance patient safety through point of care scanning, streamlining data entry and inventory management			
Procure and implement a new e-chemo prescribing system and extend EPR or ophthalmology			

Digital for a healthy population

Our goals and measures of success

- We use data to design and deliver service improvements to enable positive change in the health and wellbeing of our population
- Insights from data are used to improve health outcomes for our patients and address health inequalities
- Data and advanced analytics are used to increase our understanding of our services – and the patients accessing them – to ensure efficiency, effectiveness and control
- We will ensure data quality is at the centre of everything we do by promoting the capture of the right information at source, which is monitored for accuracy and assurance through regular validation to meet national standards.

Our commitments

- Bring together data, information, intelligence and essential connectivity to inform care planning and decision making
- Contribute data and resources to the regional and national population health management systems
- Use data to support the implementation of new pathways and personalised care models to coordinate care across settings
- Make data available to support clinical trials, real-world evidencing and the development of machine learning (ML) and artificial intelligence (AI) tools
- Drive digital and data innovation through collaboration with academia, industry and other partners
- Develop automation to reduce manual intervention, including use of robotic process automation (RPA) technologies
- Ensure compliance with existing and new national data standards, and maintain an ongoing focus on improving their data quality and completeness
- Review and assess the opportunities for the adoption of cloud-based data services and related tools
- Expand the use of SNOMED CT (coding) to enable clinicians to better document the needs of our patients and the care we provide and fully utilise this in our analysis
- Empower clinicians and patients to deliver and receive personalised care that is tailored to individual need and choice through the use of digital technology and targeted analysis

Insights from data are used to improve health outcomes for our patients and address health inequalities

Our five year plan

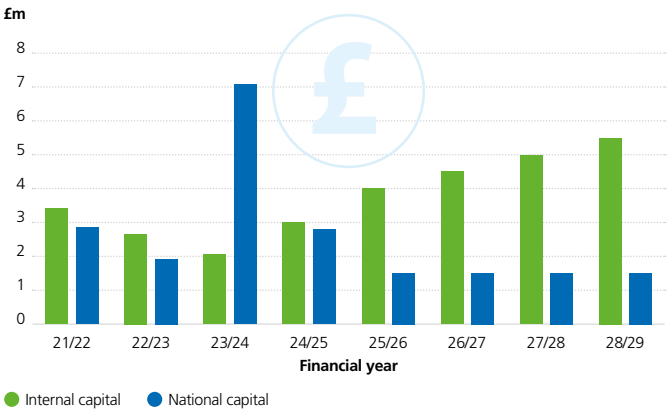
2024-25	2025-26	2026-27	2027-29
Use of dynamic speciality and ward-level reporting to show compliance with clinical policy and best practice			
	Collaborate with system partners to develop operational and financial reporting from the new Pathology system (LIMS)		
		Develop our predictive and prescriptive analytical capability	
Use data to support the development of new models of care, e.g. virtual wards, shared care record and patient portal inollaboration with regional ICS			
Integrate data sources to enable unified reporting across disciplines, e.g. workforce, finance, and performance			
Expand the use of Power BI software to allow colleagues to create reports more easily, automating analytics and reporting			
Enable staff to manipulate data directly and with ease, including data for Population Health analytics			
Use shared care records and data to inform care planning and decision making			
Use segmentation tools to predict future health needs and promote better health outcomes			
Monitor national NHS progress with development of a Federated Data Platform (FDP) and associated enablers of transformational improvements			
Look for opportunities to explore the use of new data tools and techniques in collaboration with other NHS partners and seek opportunities to learn from other industries			
Support research and innovation by working work with the Academic Health Science Network and the Kent and Medway Medical School			
Provide relevant information to support the Trust's central hub for innovation, research and clinical trials			
Develop our ability to fully automate data extraction from multiple sources into a dynamic data hub. This will enable near-real-time access to data, with quick onboarding of new data sources. Explore the automation of national clinical audits using Sunrise EPR and other clinical systems			
Develop step by step implementation plan for the development of the use of RPA for repetitive tasks in clinical and non-clinical processes			

Funding

The focus and increased use of technology and data led decision making will require sustained investment to deliver the ambitions of the digital and data strategy.

The graphic below shows the internal and national capital investment over the last three years along with assumed national funding and predicted internal capital requirements over the coming five years.

Digital and data capital investment



The predicted investment is based on the following:

Staff tell us that we are already doing great things. We have achieved many successes over the last two to three years, including:

- Continued investment in underpinning infrastructure based on three and five year replacement lifecycles
- Provision of modern and reliable computers, laptops and mobile clinical devices
- Development of the new hospital site for 24/25
- Continued clinical and corporate system consolidation and optimisation
- Expansion of the digital and data workforce
- Consideration of future EPR convergence and/or replacement in 27/28

In order to increase capital investment flexibility, we will continue to look at ways in which we can convert capital to revenue. For example, this includes looking at a managed service solution for computer and laptop replacements and moving to cloud hosted infrastructure.

Alongside this, we will be looking to find suitable benchmarks to provide context over the average or recommended level of investment in technology for public sector organisations. We will also seek to show investment alongside benefit realisation linked to the strategic aims of the strategy; this will be done in conjunction with developing the associated investment plan and required business cases which will be presented to Finance and Performance Committee.

Next steps

Detailed planning will be undertaken following the approval of the strategy, but the following actions will be taken forward as next steps.

- Develop a Resourcing Plan to deliver the strategy based on an assessment of current capacity and capabilities
- Build an Investment Plan and take this through the appropriate governance for trust approval
- Establish governance to oversee the strategy delivery with appropriate representation from the wider organisation
- Development of strategic business cases linked to the strategy
- Collation of a benefits profile and process for tracking benefit realise
- Creation and approval of a prioritisation matrix for digital and data projects to ensure alignment with trust priorities
- Restructuring of teams and recruitment to key roles

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

04.2024 – 673-V16

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Trust's Patient Experience Strategy 2024-2029 Chief Nurse

Patient Experience is one of the corporate strategic themes and remains a pillar to the PRIDE values and with a direct link to the Trust's vision of Exceptional People, Outstanding Care (EPOC).

The enclosed report provides information on the new 'Experience of Care' strategy 2024-2029.

This will replace the previous strategy 'Making it Personal strategy' which was extended to cover the period of 2018/2019 to April 2024.

Through engaging and listening to patient, carer, partner, external partners and staff feedback, the Trust has identified what is most important to those in our care. These invaluable insights have helped to define the new strategy objectives:

- Communication: We will improve how we communicate, listen and respond.
- Involvement: Patients and families will be central to decision-making.
- Partnerships: We will deliver locally-based and accessible services.
- Culture: We will deliver care with kindness and compassion.

The A work plan will be developed that will inform how the above objectives will be achieved within the time frame.

The monitoring and assurance will be provided at the Patient Experience Committee chaired by the Chief Nurse.

The Trust Board is asked to consider and approve the new strategy for wider communication.

Which Committees have reviewed the information prior to Trust Board submission?
Patient Experience Committee, 21st March 2024.(draft)
Executive Team Meeting, 23rd April 2024

Reason for submission to the Trust Board: decision, discussion, information, assurance. [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
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Experience of Care strategy 2024 - 2029

Contents

Foreword

I am very pleased to introduce our new Experience of Care Strategy for 2024 – 2029; this strategy outlines MTW's recognition of, and commitment to, the importance of the patient and carer experience. We want all our exceptional people to deliver outstanding care which treats each patient as an individual, recognises their needs and cares for them with compassion.

Everyone in our organisation has a role to play in contributing to a positive patient experience, and this strategy provides a foundation on how we will achieve this.

Through engaging and listening to patient, carer, partner and staff feedback we have identified what is most important to those in our care. These invaluable insights have helped to define our objectives:

- We will improve how we communicate, listen and respond.
- Patients and families will be central to decision-making.
- We will deliver locally-based and accessible services.
- We will deliver care with kindness and compassion.

I am proud to launch this strategy. It details a structured approach to improving the experience of care, how progress will be monitored and our ongoing partnership working with patients, carers and stakeholders.
By delivering against these commitments we will continually develop the care we provide and put the patient and their experience of care at the centre of everything we do.

Jo Haworth Chief Nurse

MTW employs a team of around **8,000** permanent staff and over 200 volunteers

Why we are doing this

We know compassionate, high quality care is safe and effective. Importantly it also gives our patients, and the people who support them, the best possible experience.

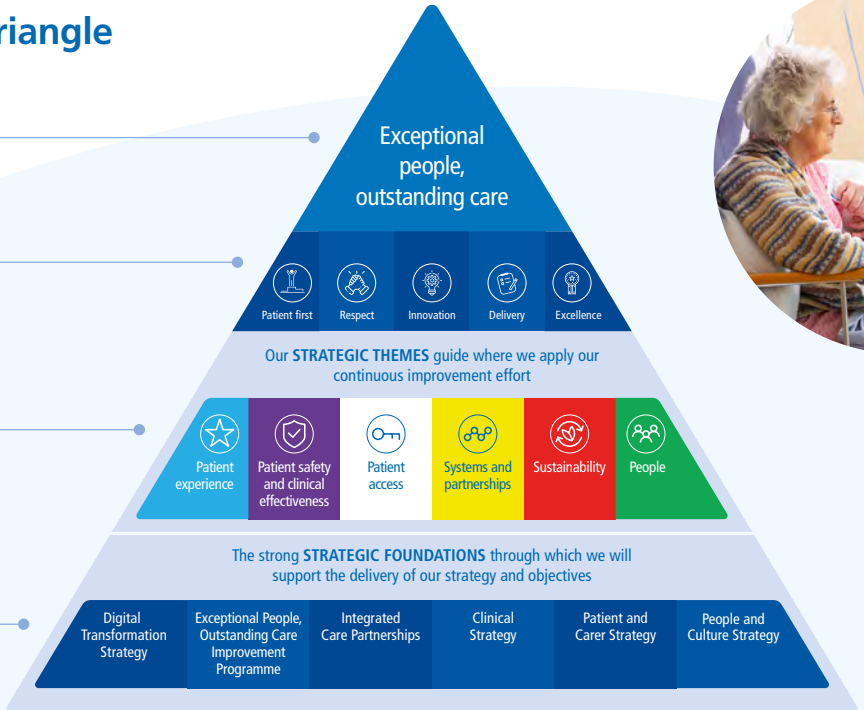
Each of us has a role to play and by working together we can ensure the experience of care at MTW is everyone's business.

A patient's experience of care matters to them. They want to feel heard and supported. By listening to their experiences of care received, from a single appointment to regular treatments, we can improve and develop what we provide. This is why our focus is on working together in decision making and the design of the service. This is known as 'co-production' and we are committed to making every effort to involve our patients and those that support them in what we do.

In NHS England's Experience of Care framework and guidance 'Working with people and communities[1]', learning for improvement and collecting feedback are considered key areas for reviewing patient experiences alongside leadership, culture and analyses. We have used theses areas to help design this new strategy.

Research has shown that a positive experience of care leads to better health outcomes and a shorter stay in hospital. Here at MTW, the importance is seen in our strategy triangle. Experience features as a core strategic theme supporting our Trust PRIDE values (Patients, Respect, Innovation, Delivery and Excellence) and delivering our vision of 'Exceptional people, outstanding care'.

Our strategy triangle



[1] https://www.england.nhs.uk/get-involved/involvementguidance/

Our local population

Our local population in Kent and Medway is changing and growing. People are living longer and with increasingly complex health needs.

By 2040, we expect the local population to have increased by an additional 110,000 people. The number of people over 65 is expected to grow by 45% and over 85s by 79%. We expect to see more patients experiencing falls and frailty, and people will live with single and multiple long-term health conditions for longer.

Inequalities in life expectancy also exist. These are a result of the differences in how care is accessed by different communities. We need to improve access for all, joining up services between Health and social care, and there is a growing trend for patients to manage their health through self-care and staying well.

Our Experience of Care strategy 2024-2029 outlines our ongoing commitment to improve the experience for all our patients and carers, and this includes a focus on addressing health inequalities over the next five years.

Our services

Ensuring our patients have access to the best possible care is a key priority and in recent years our teams have focussed on developing and improving our services.

The dedication from colleagues has resulted in key achievements such as our Kent Oncology Centre now providing some of the quickest access to cancer care in the country. We've also ensured that no patient has waited more than 52 weeks for elective surgery. Despite these improvements, we know there is more to do to meet the needs of local people, consider individuals and make it easier for them to share feedback.

In their most recent report, the CQC also said the Trust engaged well with patients and communities, working with partner organisations to improve services to patients and those that support them. They rated our delivery of care at MTW as 'good'.

To give a better understanding of the services we provide to patients over the course of a year, here is a snapshot of the services we provide across our hospitals and outpatient centres. This includes some of the less visible but important ways we provide care, including catering, dispensing prescriptions and reducing carbon consumption in response to the drive for environmentally sustainable ways of working.

237,008
Number of patients attending A&E

25,873
Number of planned and emergency surgeries performed

448
Patients discharged to virtual ward

78,430
Number of CT scans performed

84%
Diagnosed cancer patients receiving treatment within 62 days

5,566
Number of babies born

928
New carers identified by Involve Carers

30,450
Hours from volunteers including the hospital radio team[2]

3,000
tCO^2 reduction in total carbon emissions

267,800
Meals produced by the hospital kitchens for patients

713,251
Prescriptions dispensed by the hospital pharmaciess

[2]http://www.hrm.org.uk/

Our people

We have an exceptional workforce.

As a large acute trust in the south east of England, MTW employs almost 9,000 staff and 200 volunteers. We have over 1,500 different positions to support the delivery and experience of care. Here are the voices of a few of these people or teams, some with a specialist focus on the experience of our patients. We do however acknowledge that the experience of care is everyone's business.

Nursing and Midwifery

"Providing safe, quality care has a direct relationship with patient and carer experience and we will ensure our nursing and midwifery workforce are given the right tools to consistently be 'skilled, kind and proud', supporting us to provide outstanding care for our patients. At MTW, we will always make time to listen, learn and ensure we continue to improve."

Richard Gatune Deputy Chief Nurse

Medical workforce

"As doctors, ensuring our patients have safe and effective care is fundamental. One of my key priorities as Medical Director is to attract medical staff with the right skills to deliver the best care. Keeping our patients safe and using innovative ways to treat them. I'd like to see more research here at MTW and for us to be seen as leaders in providing outstanding care."

Sara Mumford Medical Director

Healthcare Professionals

"At MTW we have over 500 Healthcare Scientists and Allied Healthcare Professions who provide specialist care and support to our patients. We have contact with over 90% of the patients and work in collaboration our partners in the multi-disciplinary team. We are the third dimension of clinical care at MTW. I am also delighted that at MTW we are committed to being Veteran Aware, and providing special care for our Armed Forces communities."

Stacy Gough Chief of Healthcare Professionals

Patient Experience Team

"At MTW, our patients, families and carers are at the heart of everything we do. The Patient Experience Team supports our staff, patients and communities to provide the very best experience of care. We want to work in partnership with people who use our services and we are committed to listening to our patients, including our hard to reach groups, to understand what matters to and is important to them."

Sarah Eastwood Interim Patient Experience Lead

Patient Experience Committee

"As an NHS trust, our patients rely on us in times of need and we are committed to making their experiences with us the most effective, safe and supportive as we can. To do this, the Patient Experience Committee works with our patients, enabling services to fit their needs through prompt treatment and effective support."

Joanna Webber Associate Non-Executive Director

Voluntary Services

"The Voluntary Services Department at MTW leads a large team of volunteers ranging from 16-96 years old, who are a compassionate and supportive workforce. They complement our paid staff to enhance the experience of patients, carers, visitors and staff. Every volunteer is empowered to share their expertise, ranging from infant feeding volunteers supporting new parents to the nine enthusiastic pets as therapy volunteers providing comfort and support."

Anne-Marie Swain Voluntary Services Manager

Administrative Services

"None of the services delivering care to patients would function without the fantastic administration people and teams. We are committed to supporting our patients with managing their appointments, discharge paperwork or explaining plans for care. We appreciate this needs to be personalised, and that with the move towards paperless systems, we need to offer help to make this as easy as possible for everyone"

Sean Briggs Chief Operating Officer

League of Friends

We have two supportive League of Friends charities at both main hospital sites. The League of Friends of Tunbridge Wells Hospital[3] supports both patients and staff to provide those extras to make their time more comfortable and pleasant. Over the years the League has raised millions of pounds towards a wide range of projects, including the latest project, refurbishing the paediatric playroom. The League of Friends in Maidstone hospital[4] is also very active and continues to support the hospital, providing in excess of £100,000 each year to purchase items of equipment such as ECG machines and creative therapies for people with dementia.

MTW Hospitals Charity[5]

"MTW Hospitals Charity is the registered charity of the Trust, providing additional resources for patients, visitors and staff; improving the care received and health outcomes. Through the support of our local community, MTW Hospitals Charity uses kind gifts to make a real difference to life at MTW. Every penny we raise, and every penny given, makes a real difference to the hospitals and ensures we are here when our people need us the most."

Claire Ashby Head of MTW Hospitals Charity

Chaplaincy

"The MTW Chaplaincy Department exists to support and deliver inclusive, compassionate, person-centred pastoral, spiritual and religious care for patients, their loved ones, and our staff. Our team of substantive chaplains and supporting volunteers offer a regularly visible and attentive presence to staff and patients across our sites. Our multi-faith centres provide staff and patients with valuable space to find quiet refuge and to reflect or pray."

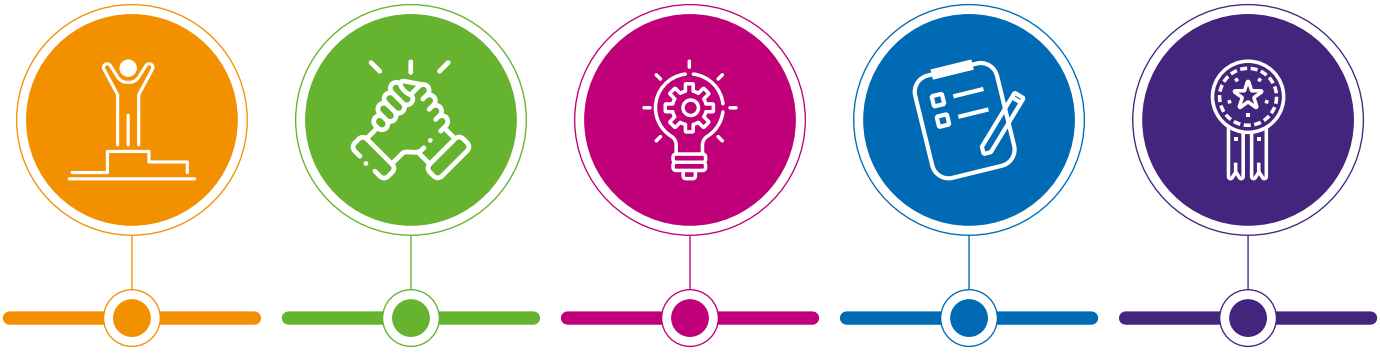
Amanda Pink Lead Chaplain

[3]www.friendsoftwhospital.org
[4]https://maidstoneleagueoffriends.co.uk/
[5]https://www.justgiving.com/mtwnhscharitablefund

What we have achieved so far

In 2018 we released our previous patient experience strategy titled ‘Making it personal’ and set out the plan to improve care against MTW’s PRIDE values.

Looking back over the past six years, we have delivered many successes across our hospitals and outpatient centres.



Patient first

- ✔ Implementation of Patient First Improvement System (PFIS)
- ✔ Patient partners in Maternity
- ✔ Accessible Information standards group
- ✔ Neurodivergent support project
- ✔ Car park expansion planning
- ✔ New Patient Safety partner

Respect

- ✔ Different not Less campaign
- ✔ Digital navigation systems
- ✔ iPads on wards for video calls
- ✔ Easy read Signage
- ✔ Translation software and bookable in-person facilitators
- ✔ Implementation of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in end of life care

Innovation

- ✔ Widespread completion of the Friends and Family Test (FFT)
- ✔ Individualised End of life care plans
- ✔ What Matters to Me boards
- ✔ Collaboration with Involve Carers
- ✔ Patients Know Best (PKB) portal Launched
- ✔ New Public Research champions

Delivery

- ✔ Public consultations to design new services
- ✔ Introduction of Community Diagnostic centre, Kent and Medway Orthopaedic Centre
- ✔ New personalised care role in Cancer
- ✔ Introduced SWAN volunteers to care for the dying patient
- ✔ Virtual wards

Excellence

- ✔ Adoption of the Veterans Awareness Charter
- ✔ Nutrition and Hydration Committee established
- ✔ Specialist Learning Disability liaison nurses
- ✔ New Green plan for sustainable healthcare launched
- ✔ Enhanced Supportive Care service working between acute and community in Cancer care


Giraffe

Where we are now

We know that while we often get it right in providing a good experience of care, further improvements are needed.

Quality care has never been more important to us. We are committed to listening to and acting on the feedback and experiences of everyone: patients, families, carers, local authorities, health and care system partners, voluntary sector colleagues and regulators.

In developing this strategy, we explored national and local policy and guidance, and performed a self-assessment. We analysed our existing feedback and complaints to look at the emerging themes. We conducted a survey of our services and held a series of engagement workshops.

We are incredibly grateful to everyone who has taken the time to be part of this process. We have listened and you told us:

What is a good experience of care?

- A service you feel confident in
- I want help navigating round the system
- Staff that own difficult information – including having to wait
- Involve my family
- Give me enough information and make it timely
- Staff who introduce themselves
- Telling me clearly what is wrong
- Give me time and really ask how I am feeling
- It's all joined up
- People know your story
- Use my preferred name
- I want to feel I have some control

How can we ensure you feel listened to and involved?

- Have an agreed point of contact or forum for families
- It helps to have options, but also get advice from the experts
- Allow enough time for the appointment
- Provide a clear contact number or email for questions
- See the 'whole person'
- Allow for follow up conversations to make sure I've understood
- Make eye contact, eyes off the screen
- Don't judge me or my family
- Encourage me to write down questions beforehand
- Sometimes you need time to process the information
- Demystify the process and prepare me
- Show me the ward or treatment area

How can we personalise your care?

- Treat me as a human being
- Empathy
- Know your patient
- Ask me how I like to be known
- Brush teeth
- Give me time
- Send porters instead of an elderly spouse with a wheelchair
- Involve my family
- Offer a full washdown after surgery
- Be kind to me
- Continuity in people and tasks
- Brush my hair

We have identified the following from our feedback.

Most commonly this related to the importance of good communication and being treated with kindness. Receiving a personal experience and feeling cared for, being listened to and involved all made a difference to our patients and carers.

There were also reports of challenges with access to and from the hospitals, including parking.

The experience of care is everyone's business

National inpatient survey results reveal low scores in preparing for discharge.

Friends and Family Test results tell us that families do not always feel involved or informed.

Care does not always feel personalised.

Information is not always accessible and presented in a way which can be understood according to survey results.

Making contact with clinical staff on the telephone is difficult.

Complaints show us that we do not always show compassion.

Engagement events tell us people do not always feel listened to and respected.

Parking on our sites is frequently reported as problematic.

Access on public transport can also be challenging.

*Transport arrangements will be further addressed via our Estates management forums

Where we want to be

These are our strategic objectives for the next five years:

Communication

We will improve how we communicate, listen and respond

Involvement

Patients and families will be central to decision-making

Partnerships

We will deliver locally-based and accessible services

Culture

We will deliver care with kindness and compassion

Following feedback, we know these are the key areas where we need to make improvements. This strategy sets out our commitment and ambition for these improvements. Against each we have identified priorities and an outline of actions, the success of which will be measured by the improvements we make. Progress will be reported through our established committees and forums.

NHS England's definition of co-production for working in partnership with people and communities.

Key domain 1 – **Communication**

Objective: We will improve how we communicate, listen and respond.

Why it matters

When communication is effective, people feel informed, supported and engaged. It gives carers confidence and people feel more satisfied, leading to better overall health and wellbeing.

Where do we want to get to?

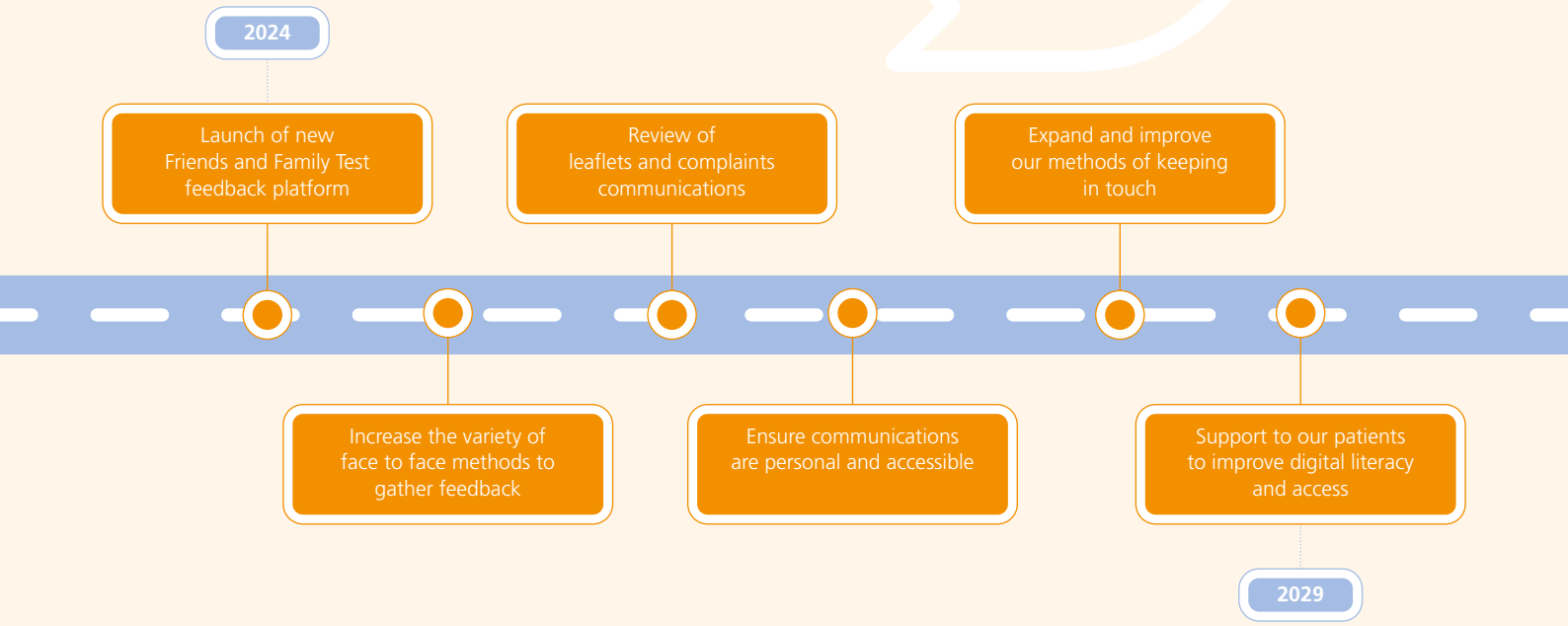
We want to ensure that no-one experiences barriers to care due to misinformation or poor communication. We will help you to navigate the system and do this by:

- Using your preferred methods for communicating.
- Ensuring we provide additional support when needed.
- Allowing time and listening to you.

What success will look like:

- Patients and their carers tell us they feel listened to and communicated with effectively.
- Information will be consistently personal and accessible.
- Divisional patient stories will be introduced and heard across the Trust.
- There will be more focus groups in place for feedback.
- Clearer signposting to PALS services and the complaints process will be visible.
- Support to ensure digital literacy will be offered.

How we will get there



Objective: Patients and families will be central to decision-making.

Why it matters

People will be able to make decisions based on knowledge and values. Being involved will bring a sense of ownership and improves participation in treatment. It will enable carers to be part of the experience and ensure they have a voice. It will enable us to jointly work on improvements in a co-produced way.

Where do we want to get to?

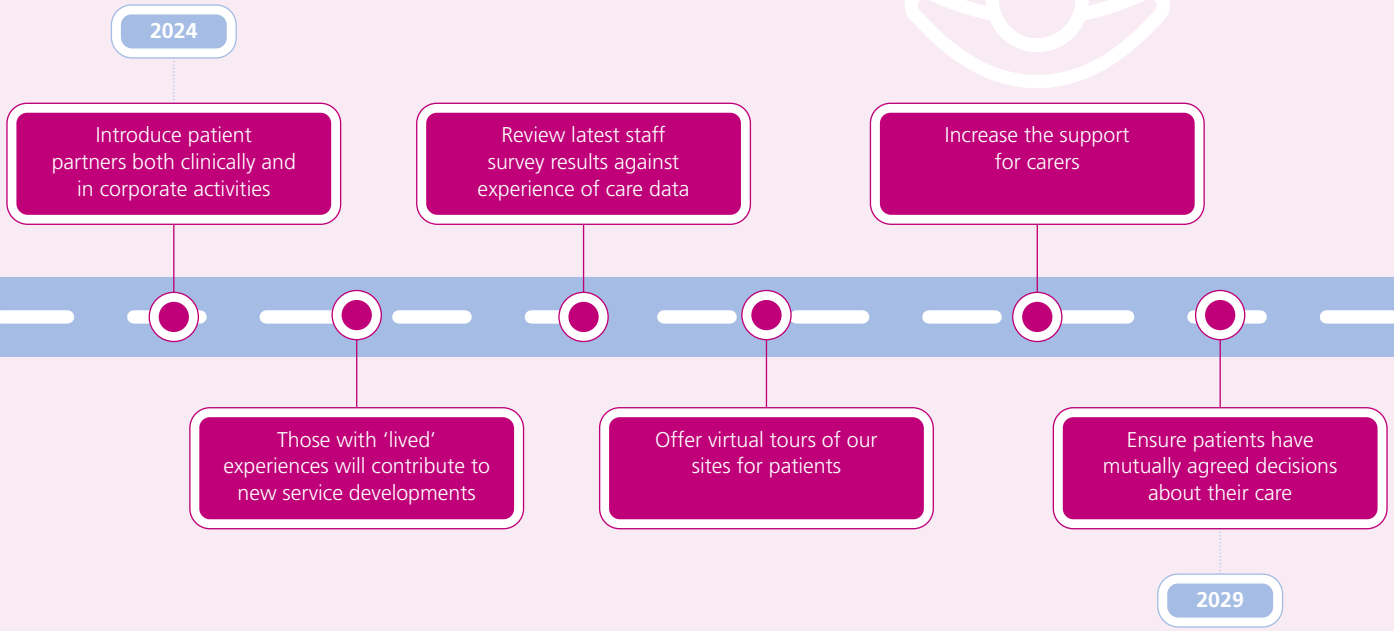
People and carers will be empowered to make decisions about care that is right for them at that time. Planning will be mutually agreed, and guidance will be given without being overly directive. People will feel connected and be given a choice. Carers will be supported to be involved. We will do this by:

- Creating opportunities for you to be involved.
- Asking for your opinion.
- Agreeing plans together.

What success will look like:

- Patient partners and representatives integrated across the organisation.
- Regular reporting on staff survey against performance in the experience of care.
- Relatives clinics across inpatient areas.
- Completion of fully co-produced service improvements and reconfigurations.
- Increase in the reporting of shared decision-making.

How we will get there



Key domain 3 – **Partnerships**

Objective: We will deliver locally-based and accessible services.

Why it matters

Broadening our links with the whole community will allow us tailor service to meet different needs. It will help overcome inequalities and reduce barriers to care.

Where do we want to get to?

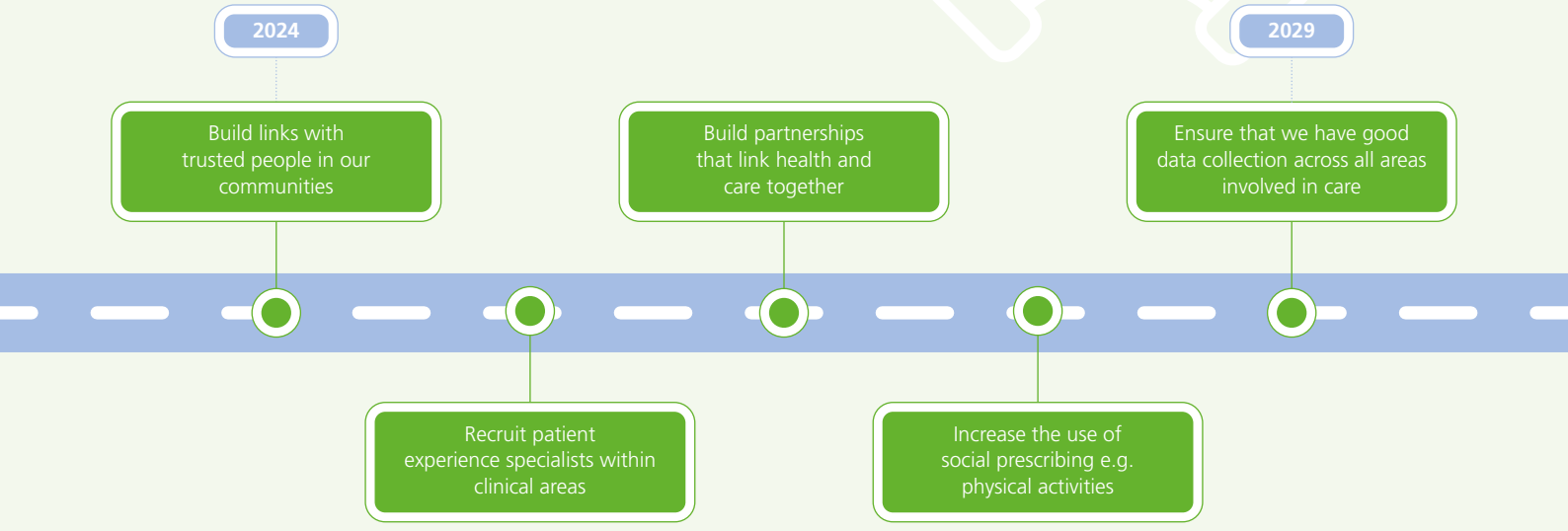
Care will feel inclusive and represent the whole community. It will feel seamless across settings and boundaries. Those with lived experiences will be equal partners in decisions. Care will be better planned. We will do this by:

- Making links with the people who are important to you.
- Thinking about the whole person.

What success will look like:

- We will develop further and strengthen working with voluntary, community and social enterprises.
- There will be an increased number of patients recruited into research.
- Links will be established with faith group leaders.
- There will be joined up working with Kent & Medway healthcare partners
- We will fulfil our Veterans Awareness charter commitments.
- We will have improved diversity in the workforce.

How we will get there



Key domain 4 – **Culture**

Objective: We will deliver care with kindness and compassion.

Why it matters

Feeling safe and valued will reduce stress and lead to better overall health and wellbeing. Kindness will build stronger relationships.

Where do we want to get to?

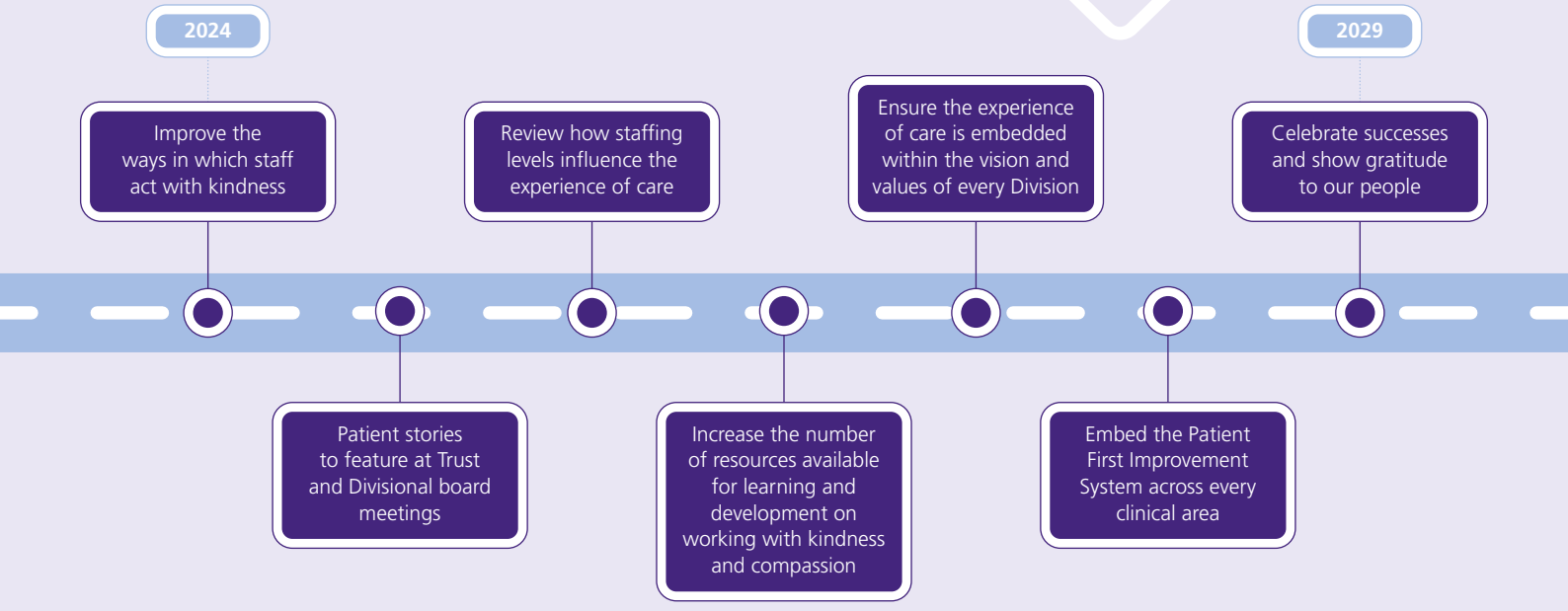
We will treat people and carers with dignity and respect. We will see the person and create a safe space. We want to know what matters to you and not just what is the matter with you. We will ensure care feels personalised and relatable. We will do this by:

- Using your preferred terms.
- Embedding positive values in our teams.
- Showing gratitude.

What success will look like:

- Staff will have completed learning and development on courses such as Kindness into action; Compassionate organisations or Exceptional leaders.
- Improved use of experience of care data in clinical and staff meetings.
- More staff to be trained to use the Patient First Improvement System, to strengthen the inclusion of experience of care within improvement programmes.
- Reduction in complaints linked to staff attitude.

How we will get there



MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

04.2024 – 702.V16

NHS Maidstone and Tunbridge Wells NHS Trust

The final planning submissions for 2024/25	Director of Strategy, Planning and Partnerships

This paper provides an update on the system planning approach for 24/25 and internal operational planning progress. This represents our final submission due to the ICB ahead of the central submission due 2nd May. Points to note:

- Activity, finance and workforce plans have been developed in line with the technical guidance with a series of exec led review meetings at divisional level.
- The workforce plan has improved by 118 WTE since first submission but forecasting to remain above core establishment by 49.5WTE in Mar 25.
- Financial plan is breakeven with £2M allocated to service developments. The Trust has several significant clinical priorities that are still to be agreed and therefore these aren't in the financial plan
- Cost pressure review meetings are scheduled to confirm divisional budgets.
- Activity plan is compliant in all domains in aggregate terms. There are two main risks:
    - New OP and OP follow up with a procedure target. NHSE proposed value for MTW is significantly higher (53%) than we recognise. Additionally, we have assumed Radiotherapy treatments will continue to be excluded.
    - Diagnostic performance for Ba enema and cystoscopy is non-compliant

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 16/04/24
Finance and Performance Committee, 23/04/24
Previous Trust Board meetings have all considered the development of the operational planning submission

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To support the submission of the operational plan to the ICB.
N.B. The Board delegated authority to approve to the ETM meeting as the submission had to be made on 22nd April. ETM reviewed this version on 16th April.

[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

2024/25 Operational Planning

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Exceptional people, outstanding care

Executive summary

Purpose of report: This paper provides an update on the system planning approach for 24/25 and internal operational planning progress.

Summary of position

- 24/24 Operational planning guidance was released on 28th March 2024. A summary of the guidance is in the appendix.
- The trust is asked to submit a board approved planning return to the ICB on 22nd March, in advance of an ICB full submission to NHS E on 2nd May.
- Activity, finance and workforce plans have been developed in line with the technical guidance with a series of exec led review meetings at divisional level.
- The workforce plan has improved by 118 WTE since first submission but forecasting to remain above core establishment by 49.5WTE in Mar 25.
- Financial plan is breakeven with £2M allocated to service developments. The Trust has several significant clinical priorities that are still to be agreed and therefore these aren't in the financial plan
- Cost pressure review meetings are scheduled to confirm divisional budgets.
- Activity plan is compliant in all domains in aggregate terms. There are two main risks:
  - New OP and OP follow up with a procedure target. NHSE proposed value for MTW is significantly higher (53%) than we recognise. Additionally, we have assumed Radiotherapy treatments will continue to be excluded.
  - Diagnostic performance for Ba enema and cystoscopy is non-compliant
- Project Dalmatian is not included within the plan at this stage
- **Recommendation**
- ETM is asked approve the proposed planning submission on behalf of the trust board.
- ETM is asked to note the issues and next steps

Elective Activity Plan

24/25 Elective Activity plan vs Actual 23/24 and Actual 1920 (inc. proposed WLIs)

Total IP/DC Combined	Total
24/25 Plan as % of 1920	116%
24/25 Plan as % of 23/24 Actuals	**105%**
24/25 Plan as % of 23/24 Submitted Plan	**111%**

All Cons and Non-Cons First OP Total	Total
24/25 Plan as % of 1920	129%
24/25 Plan as % of 23/24 Actuals	**106%**
24/25 Plan as % of 23/24 Submitted Plan	**111%**

Total Elective (IP, DC and All First OP)	Total
24/25 Plan as % of 1920	126%
24/25 Plan as % of 23/24 Actuals	**105%**
24/25 Plan as % of 2324 Submitted Plan	**111%**

Total OP New Activity	1920	23/24 FOT	24/25 Activity Plan	Variance Activity Plan vs 23/24 FOT	Activity Plan as a % of 23/24 FOT	Activity Plan as a % of 1920
Surgery Division	106755	119956	128907	8951	107.5%	120.8%
Medicine Division	26557	29468	32410	2943	110.0%	122.0%
Oncology Division	8032	11109	11464	355	103.2%	142.7%
Women's & Children's Division	50258	47276	49553	2276	104.8%	98.6%
Core Clinical Division	7739	7950	9314	1365	117.2%	120.4%
Tomcat	0	27729	28998	1269	104.6%	

Total Elective Inpatient/Day Case Activity	1920	23/24 FOT	24/25 Activity Plan	Variance Activity Plan vs 23/24	Activity Plan as a % of 23/24	Activity Plan as a % of 1920
Surgery Division (inc all Endo)	37849	35964	38393	2429	106.8%	101.4%
Medcine Division (exc Endo)	8518	9414	9414	0	100.0%	110.5%
Oncology Division (Exc Endo)	1679	3862	4165	303	107.8%	248.1%
Women's & Children's Division	3413	5760	5620	-140	97.6%	164.7%
Core Clinical Division						
Tomcat						

- Electives: Activity includes Inpatient overnight, day case and Endoscopy. Includes KMOC Activity (July 24 to March 25).
- OP New Attendances include Tomcat activity (excluding insourcing), KMOC Activity (April 24 to March 25 and CDC Activity (Tomcat).

	RTT including WLIs	Mar-24	Mar-25	Variance
TRUST	Total Waiting List	43068	35170	-7898
	IP Waiting List	7346	6314	-1032
	OP Waiting List	35722	28856	-6866
	IP Backlog	3743	2907	-836
	OP Backlog	8084	3716	-4368
	Total %	**72.54%**	**81.17%**	**8.63%**

RTT Trajectory includes KMOC and is based on the core activity levels plus both funded and **unfunded** activity. It does not take into account any validation which can improve the position by approximately 3% to 4%.

24/25 Performance Trajectories – Elective/Cancer Waiting Times

RTT Possible Trajectory **with proposed** Unfunded/WLI activity

	RTT including WLIs	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Variance
TRUST	Total Waiting List	43068	42417	41770	41144	40431	39775	39124	38422	37770	37148	36476	35823	35170	-7898
	IP Waiting List	7346	7261	7176	7094	7001	6916	6832	6741	6656	6575	6488	6398	6314	-1032
	OP Waiting List	35722	35156	34593	34050	33430	32859	32293	31681	31114	30573	29988	29424	28856	-6866
	IP Backlog	3743	3658	3573	3491	3398	3313	3229	3154	3106	3060	3010	2955	2907	-836
	OP Backlog	8084	7523	7071	6681	6304	5959	5613	5244	4901	4618	4313	4012	3716	-4368
	Total %	**72.54%**	**73.6%**	**74.5%**	**75.3%**	**76.0%**	**76.7%**	**77.4%**	**78.1%**	**78.8%**	**79.3%**	**79.9%**	**80.6%**	**81.17%**	**8.63%**

Cancer Waiting Times (CWT) Standards

New Combined		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Cancer 31 combined standard (96%)	Total Patients Seen	811	698	841	848	826	771	818	798	892	784	856	817	778	**9,727**	2,387	2,415	2,474	2,451
	>31 day wait	32	28	34	34	33	31	33	32	36	31	34	33	31	**389**	95	97	99	98
	Peformance %	96.05%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	**96.00%**	96.00%	96.00%	96.00%	96.00%

New Combined		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Cancer 62 days (85%)	Total Patients Seen	120.5	142.5	201.0	213.0	166.0	201.5	202.5	179.0	230.0	234.0	208.0	198.5	189.0	**2,365.0**	557	570	643	596
	>62 day wait	17.5	20.5	29.0	31.0	24.0	29.0	29.5	26.0	33.5	34.0	30.0	29.0	27.5	**343.0**	81	83	94	87
	Peformance %	85.51%	85.61%	85.57%	85.45%	85.54%	85.61%	85.43%	85.47%	85.43%	85.47%	85.58%	85.39%	85.45%	**85.50%**	85.53%	85.53%	85.46%	85.47%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Cancer Faster Diagnosis 28 Days	Total Patients	1,748.7	1,818.2	1,938.1	1,991.2	2,089.4	2,111.0	1,894.8	2,174.1	2,122.8	1,920.0	2,124.7	2,028.1	1,931.5	**24,143.9**	5,747	6,095	6,217	6,084
	>28 days or no date	437.0	454.0	484.0	497.0	522.0	527.0	473.0	536.0	517.0	460.0	503.0	472.0	444.0	**5,889.0**	1,435	1,522	1,513	1,419
	Peformance %	75.01%	75.03%	75.03%	75.04%	75.02%	75.04%	75.04%	75.35%	75.64%	76.04%	76.33%	76.73%	77.01%	**75.61%**	75.03%	75.03%	75.66%	76.68%

24/25 Performance Trajectories: Diagnostic Waiting Times

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust Overall Diagnostics	Total Patients Waiting	8,290	8,210	8,196	7,990	8,079	8,100	8,025	8,089	8,041	7,846	7,736	7,597	7,561
	in target	7,968	8,016	7,999	7,824	7,917	7,934	7,879	7,970	7,933	7,739	7,654	7,523	7,495
	Patients waiting >6wks	220	194	197	167	162	166	146	119	107	107	82	74	66
	Performance %	97.3%	97.6%	97.6%	97.9%	98.0%	98.0%	98.2%	98.5%	98.7%	98.6%	98.9%	99.0%	99.1%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
MRI	Total Patients Waiting	2,438	2,388	2,338	2,288	2,238	2,188	2,138	2,088	2,038	1,988	1,938	1,888	1,838
	in target	2,348	2,307	2,266	2,224	2,182	2,140	2,097	2,055	2,012	1,968	1,919	1,869	1,820
	Patients waiting >6wks	90	81	72	64	56	48	41	33	26	20	19	19	18
	Performance %	96.3%	96.6%	96.9%	97.2%	97.5%	97.8%	98.1%	98.4%	98.7%	99.0%	99.0%	99.0%	99.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
CT	Total Patients Waiting	1,575	1,575	1,600	1,575	1,600	1,625	1,600	1,575	1,550	1,600	1,575	1,550	1,550
	in target	1,570	1,569	1,586	1,570	1,595	1,612	1,595	1,570	1,545	1,594	1,570	1,545	1,545
	Patients waiting >6wks	5	6	14	5	5	13	5	5	5	6	5	5	5
	Performance %	99.7%	99.6%	99.1%	99.7%	99.7%	99.2%	99.7%	99.7%	99.7%	99.6%	99.7%	99.7%	99.7%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
NOUS	Total Patients Waiting	2,229	2,210	2,280	2,260	2,230	2,300	2,280	2,250	2,210	2,270	2,250	2,230	2,230
	in target	2,165	2,154	2,218	2,207	2,181	2,249	2,238	2,216	2,182	2,238	2,224	2,211	2,217
	Patients waiting >6wks	64	56	62	53	49	51	42	34	28	32	26	19	13
	Performance %	97.1%	97.4%	97.3%	97.7%	97.8%	97.8%	98.2%	98.5%	98.7%	98.6%	98.9%	99.1%	99.4%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
DEXA	Total Patients Waiting	200	210	230	220	210	230	220	210	210	230	220	210	220
	in target	198	208	228	218	208	228	218	208	208	228	218	208	218
	Patients waiting >6wks	2	2	2	2	2	2	2	2	2	2	2	2	2
	Performance %	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Barium Enema	Total Patients Waiting	158	148	138	128	118	130	125	120	120	130	115	120	120
	in target	131	124	116	108	100	111	108	104	106	116	104	109	110
	Patients waiting >6wks	27	24	22	20	18	19	18	16	14	14	12	11	10
	Performance %	83.0%	83.5%	84.0%	84.5%	85.0%	85.5%	86.0%	87.0%	88.0%	89.0%	90.0%	91.0%	92.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Cardiology	Total Patients Waiting	372	372	372	354	407	372	372	407	372	354	390	354	372
	in target	266	368	368	350	403	368	368	403	368	350	386	350	368
	Patients waiting >6wks	4	4	4	4	4	4	4	4	4	4	4	4	4
	Performance %	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

24/25 Performance Trajectories: Diagnostic Waiting Times

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Colonoscopy	Total Patients Waiting	261	258	260	214	242	248	284	265	297	250	249	248	247
	in target	259	256	258	213	241	246	279	261	294	248	248	247	246
	Patients waiting >6wks	2	2	2	1	1	2	5	4	3	2	1	1	1
	Performance %	99.2%	99.2%	99.2%	99.5%	99.6%	99.2%	98.2%	98.5%	99.0%	99.2%	99.6%	99.6%	99.6%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Flexi Sigmoidoscopy	Total Patients Waiting	106	97	67	65	64	104	102	134	139	73	70	67	64
	in target	105	96	66	64	63	103	100	132	137	72	69	66	63
	Patients waiting >6wks	1	1	1	1	1	1	2	2	2	1	1	1	1
	Performance %	99.1%	99.0%	98.5%	98.5%	98.4%	99.0%	98.0%	98.5%	98.6%	98.6%	98.6%	98.5%	98.4%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Gastroscopy	Total Patients Waiting	291	281	238	160	200	184	171	250	313	253	249	246	242
	in target	283	276	233	158	189	173	160	239	302	239	242	241	239
	Patients waiting >6wks	8	5	5	2	11	11	11	11	11	14	7	5	3
	Performance %	97.3%	98.2%	97.9%	98.7%	94.5%	94.0%	93.5%	95.6%	96.5%	94.5%	97.2%	98.0%	98.8%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Cystoscopy	Total Patients Waiting	49	53	58	78	78	54	67	33	42	39	29	41	43
	in target	31	41	46	64	62	39	50	26	31	28	23	33	34
	Patients waiting >6wks	18	12	12	14	16	15	17	7	11	11	6	8	9
	Performance %	63.3%	77.2%	79.2%	81.9%	79.2%	71.7%	74.3%	78.0%	73.2%	71.2%	79.5%	80.3%	79.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Audiology	Total Patients Waiting	608	616	613	646	690	663	663	754	747	656	648	640	632
	in target	608	616	613	645	690	663	663	754	746	656	648	640	632
	Patients waiting >6wks	-	-	-	1	-	-	-	-	1	-	- 0	- 0	-
	Performance %	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Urodynamics	Total Patients Waiting	3	3	3	3	3	3	3	3	3	3	3	3	3
	in target	3	3	3	3	3	3	3	3	3	3	3	3	3
	Patients waiting >6wks	-	-	-	-	-	-	-	-	-	-	-	-	-
	Performance %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

24/25 Elective Activity plan vs Actual 23/24 and Actual 1920 (inc. Possible WLIs/Unfunded)

All Cons and Non-Cons Follow Up OP Total	Total
24/25 Plan as % of 1920	114%
24/25 Plan as % of 23/24 Actuals	104%
24/25 Plan as % of 2324 Submitted Plan	110%

Total Consultant Follow Up without a Procedure	Total
24/25 Plan as % of 1920	110%
24/25 Plan as % of 23/24 Actuals	106%
Actual 23/24 as % of 1920	104%

Total OP FUP Activity	1920	23/24 FOT	24/25 Activity Plan	Variance Activity Plan vs 23/24	Activity Plan as a % of 23/24	Activity Plan as a % of 1920	23/24 Plan	Activity Plan as a % of 23/24
Surgery Division	151856	149906	154612	4706	103.1%	101.8%	147868	104.6%
Medicine Division	53831	54376	53435	-940	98.3%	99.3%	58464	91.4%
Oncology Division	54193	87208	90135	2927	103.4%	166.3%	72131	125.0%
Women's & Children's Division	32487	35098	34259	-839	97.6%	105.5%	33754	101.5%
Core Clinical Division	26516	24664	31991	7327	129.7%	120.6%	22984	139.2%
Tomcat	0	3039	3039	0	100.0%		3339	91.0%

Total OP FUP Activity without a Procedure	1920	23/24 FOT	24/25 Activity Plan	Variance Activity Plan vs 23/24	Activity Plan as a % of 23/24	Activity Plan as a % of 1920
Surgery Division	116124	103792	110019	6227	106.0%	94.7%
Medcine Division	50619	50877	50033	-844	98.3%	98.8%
Oncology Division	52323	77864	84606	6741	108.7%	161.7%
Women's & Children's Division	19982	18569	17289	-1280	93.1%	86.5%
Core Clinical Division	25669	24319	31647	7327	130.1%	123.3%
Tomcat	0	0	0	0	0	0

We will be compliant with the new OP targets based on total Follow Ups (with and without a procedure) does not include Radiotherapy as per local agreement.

Total Follow Ups (with and without a procedure) now includes the additional Oncology Follow Ups with a procedure as per the counting and coding changes.

24/25 Non- Elective Activity plan vs Actual 23/24 and Actual 1920 (Core Capacity plus Funded Activity)

Total Non-Elective (including New SDEC)	Total
24/25 Plan as % of 1920	143%
24/25 Plan as % of 23/24 Actuals	104%
24/25 Plan as % of 2324 Submitted Plan	110%

Non Elective	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
0 day length of stay (New SDEC)	992	921	997	946	976	925	942	1,081	1,045	1,060	1,050	943
+1 length of stay (Not Inc CDU Overnights)	2,356	2,499	2,391	2,548	2,477	2,418	2,721	2,541	2,549	2,679	2,473	2,577
Total Non elective admissions	**3,505**	**3,461**	**3,397**	**3,494**	**3,453**	**3,343**	**3,662**	**3,622**	**3,594**	**3,739**	**3,523**	**3,520**

Some Non- Elective Zero day LOS now moved to SDEC row below as by July 24 this activity will be recorded as SDEC Type 5 A&E Attendances as per national change/guidance.

	Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Same Day Emergency Care (SDEC)		3,178	3,431	3,401	3,624	3,597	3,426	3,508	3,301	3,298	3,510	3,283	3,446

24/25 Plan for A&E Attendances

Total A&E	Total
24/25 Plan as % of 1920	129%
24/25 Plan as % of 23/24 Actuals	103%
24/25 Plan as % of 2324 Submitted Plan	104%

A&E Type 1	Total
24/25 Plan as % of 1920	134%
24/25 Plan as % of 23/24 Actuals	102%
24/25 Plan as % of 2324 Submitted Plan	105%

A&E Type 3&4	Total
24/25 Plan as % of 1920	96%
24/25 Plan as % of 23/24 Actuals	98%
24/25 Plan as % of 2324 Submitted Plan	95%

A&E	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Type 1 A&E attendances	17,842	19,134	18,761	19,245	18,302	18,667	19,032	18,296	18,569	18,205	16,883	18,214	**221,148**
Type 2, 3&4 A&E attendances	2,216	2,412	2,372	2,445	2,255	2,318	2,164	2,072	2,088	2,052	1,985	2,034	**26,413**
Total A&E Attendances	**20,058**	**21,547**	**21,133**	**21,690**	**20,557**	**20,985**	**21,195**	**20,367**	**20,656**	**20,256**	**18,868**	**20,248**	**247,562**

24/25 Performance Trajectories - Flow

	A&E >4hrs from Decision to Admit	Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
A&E Type 1 & Type 3	Total Patients Seen	18,235	20,058	21,547	21,133	21,690	20,557	20,985	21,195	20,367	20,656	20,256	18,868	20,248	**247,562**	62,738	63,232	62,219	59,373
	>4hr Wait	2,546	2,730	2,763	2,284	2,918	2,780	3,245	3,379	3,293	4,395	4,137	3,360	3,069	**38,353**	7,777	8,944	11,067	10,565
	Peformance %	86.04%	86.39%	87.18%	89.19%	86.55%	86.48%	84.54%	84.06%	83.83%	78.72%	79.58%	82.19%	84.84%	**84.51%**	87.60%	85.86%	82.21%	82.21%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
A&E Type 1 Only	Total Patients Seen		17,842	19,134	18,761	19,245	18,302	18,667	19,032	18,296	18,569	18,205	16,883	18,214	221,148	55,737	56,213	55,896	53,302
	>4hr Wait		2,706	2,739	2,260	2,894	2,756	3,221	3,355	3,269	4,371	4,113	3,336	3,045	38,065	7,705	8,872	10,995	10,493
	Peformance %		84.8%	85.7%	88.0%	85.0%	84.9%	82.7%	82.4%	82.1%	76.5%	77.4%	80.2%	83.3%	82.79%	86.18%	84.22%	80.33%	80.31%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Patients in A&E Department for 12 hours or more	Total Patients Seen		20,058	21,547	21,133	21,690	20,557	20,985	21,195	20,367	20,656	20,256	18,868	20,248	**247,562**	62,738	63,232	62,219	59,373
	Out of Target		866	786	650	840	803	935	1,121	1,182	1,357	1,039	861	762	**11,202**	2,302	2,577	3,660	2,662
	Peformance %		95.7%	96.4%	96.9%	96.1%	96.1%	95.5%	94.7%	94.2%	93.4%	94.9%	95.4%	96.2%	**95.5%**	96.3%	95.9%	94.1%	95.5%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Ambulance Handover delays	Number of arrivals	3,357	3,377	3,590	3,368	3,501	3,454	3,408	3,573	3,554	3,630	3,656	3,266	3,266	**41,644**	10,335	10,363	10,757	10,188
	Delays 15-30mins	1,508	1,489	1,555	1,494	1,555	1,516	1,471	1,523	1,525	1,626	1,587	1,449	1,458	**18,248**	4,538	4,541	4,674	4,495
	Delays 30-60 mins	189	210	218	189	205	203	216	230	227	275	236	197	173	**2,579**	618	624	732	606
	Delays >60mins	5	7	4	3	5	5	5	4	4	5	3	1	1	**48**	15	15	14	4
	% Delays >30 mins		6.4%	6.2%	5.7%	6.0%	6.0%	6.5%	6.6%	6.5%	7.7%	6.5%	6.1%	5.3%	6.3%	6.1%	6.2%	6.9%	6.0%

	Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Not meeting the criteria to Reside	106	105	105	105	105	115	110	105	110	115	120	110	105

Average Daily Number of Long Stay patients >21	Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Days	107	106	107	107	116	96	111	105	111	103	104	109	106

Bed Occupancy	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Average number of G&A Beds occupied per day	658	652	621	626	610	606	634	639	635	667	672	625	637
Average number of G&A Core Beds available per day	711	711	711	711	711	711	711	711	711	711	711	711	711
Average number of G&A Escalation Beds available per day	23	23	23	23	23	23	23	23	23	23	23	23	23
Bed Occupancy	**89.7%**	**88.8%**	**84.7%**	**85.2%**	**83.1%**	**82.6%**	**86.3%**	**87.0%**	**86.5%**	**90.9%**	**91.5%**	**85.1%**	**86.8%**

Core Beds now include all bed-headed areas such as Short Stay Surgery even though not always occupied overnight as per national guidance change which makes the Bed Occupancy look lower. All reporting now shown in this way.

Workforce Plan

Workforce Phasing

Through close working between divisions, People Business Partners, Finance Managers and some Executive Director led challenge sessions, initial forecasts have been re-worked with the latest cut of the forecast (8th April) set out below. The forecast includes ICB agreed increases to the establishment budget (such as Kent & Medway Orthopaedic Centre, CDC funding).

23/24 recruitment and turnover data have been used to inform the forecast, with the current Trust vacancy rate (5.5%) applied. Compared to March 24 position, the forecast shows an increase of 237 WTE (substantive), with a reduction in bank and agency of 269 WTE and 63 WTE respectively in March 25.

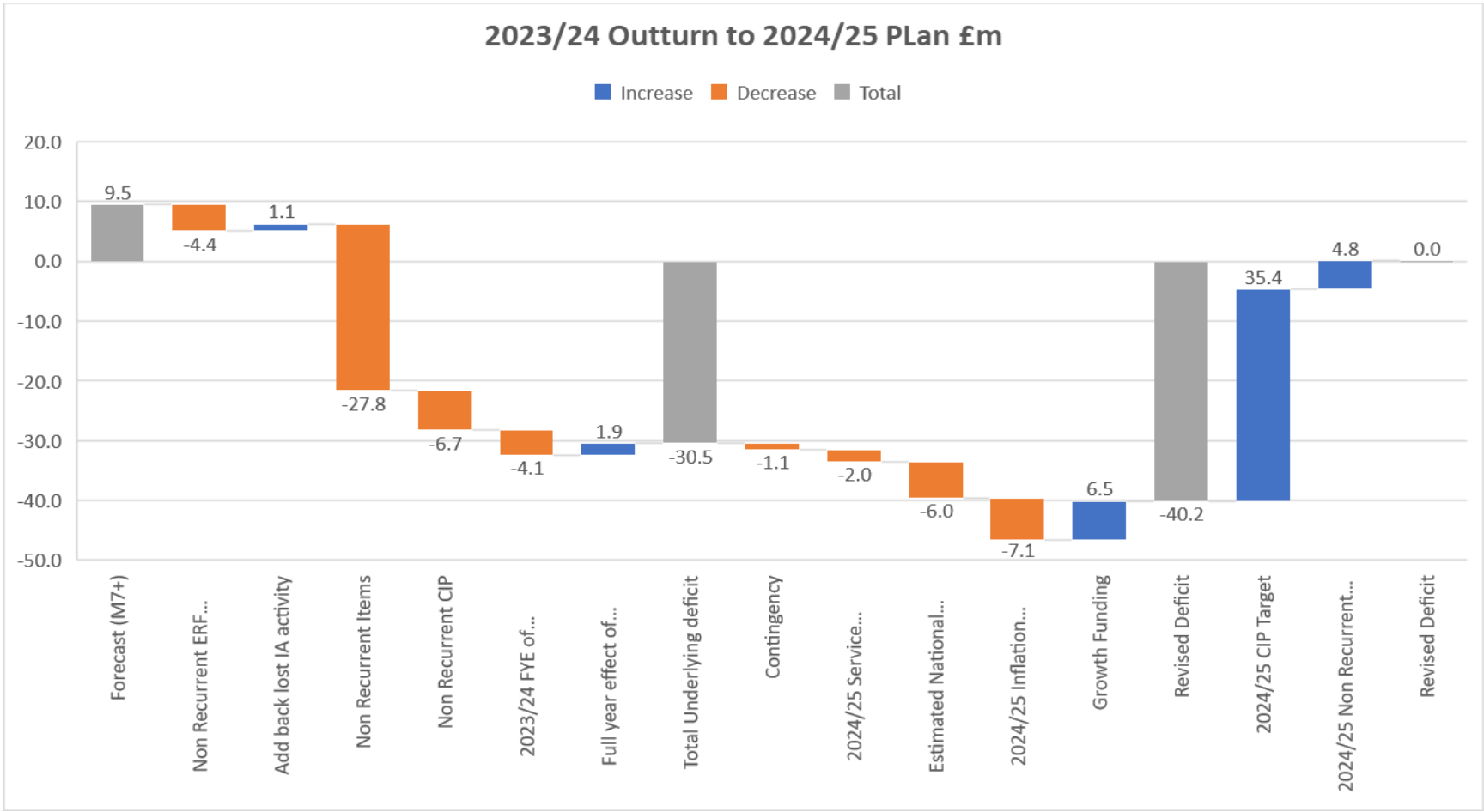
	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	Staff in post outturn	Establishment	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Establishment
Total	8003	7560	7989	7921	7884	7859	7854	7851	7851	7862	7890	7901	7911	7908	7859
Substantive (breakdown below)	7193	7560	7213	7232	7252	7272	7292	7311	7331	7351	7371	7390	7410	7430	7859
Bank	646		615	540	489	458	441	418	404	394	407	403	397	377	
Agency	164		162	149	143	129	122	121	116	117	113	108	104	101	
Registered Nursing, Midwifery and Health visiting staff	2053	2171	2063	2074	2085	2096	2106	2117	2128	2138	2149	2160	2171	2181	2238
Registered/ Qualified Scientific, Therapeutic and Technical Staff	897	1007	901	904	907	910	913	916	919	922	925	928	931	934	1029
Support to Clinical staff	1288	1343	1290	1291	1292	1294	1295	1296	1297	1299	1300	1301	1302	1304	1456
NHS Infrastructure Support	1996	2072	1999	2002	2005	2008	2011	2014	2018	2021	2024	2027	2030	2033	2124
Medical & Dental	946	960	948	949	951	953	955	956	958	960	961	963	965	967	1003
Any Other Staff	12	8	12	12	12	12	12	12	12	12	12	11	11	11	8

Agency forecast spend is below the NHSE target of 3.2% of pay budget.

Staff in post forecast exceeds core establishment. Cost pressure review meetings are scheduled to confirm divisional budgets which may increase core establishment, and further work on reducing B&A forecast will be undertaken.

Financial Plan

Bridge – 2023/24 Outturn to 2024/25 Plan



The Trust is forecasting to deliver a breakeven plan in 2024/25 however this will require a total of £37.3m CIP (including FYE fomr 23/24) and £4.8m on non recurrent benefits.

2024/25 Plan

Grouping	Subjective Group	£m
Op Inc from Pat Care Activity	Clinical SLA Income	697.7
	Other Pat Care Income	10.8
Op Inc from Pat Care Activity Total		**708.5**
Other Operating Income	Other Operating Income	49.6
Other Operating Income Total		**49.6**
Pay	A&C/Sen Man Staff	-42.0
	Medical Staff	-130.5
	Nursing	-124.3
	Pay Reserves	-1.7
	Qualified Ambulance + Paramed	-0.7
	Scientific Therap & Tech Staff	-57.2
	Support Staff	-18.7
	Support to Clinical Staff	-76.7
Pay Total		**-451.9**
Non Pay	Clinical Negligence	-23.6
	Drugs & Medical Gases	-74.0
	Other Non Pay	-81.0
	Purch healthcare from non NHS	-23.0
	Supplies & Services	-47.6
Non Pay Total		**-249.1**
Other	Depreciation	-30.2
	Other Finance Costs	-20.2
	Public Dividends Payable	-8.0
Other Total		**-58.4**
Total Deficit		**-1.2**
Technical Adjustments		1.2
Revised Deficit		**0.0**

Income
Contract values have not yet been confirmed with commissioners.
The plan has been uplifted for the latest inflation and efficiency values. There was an additional uplift for CNST which is now included in the plan.
The Trust is still working through a revised activity plan to confirm the income value. The plan assumes July opening of KMOC with outpatient appointments continuing in Q1.

Pay The 2024/25 plan reflects the workforce model with CIP assumptions applied. However there is still internal work to do with Divisions to confirm any changes to core establishment.

Non Pay The 2024/25 plan includes national inflation assumptions which match the increase in funding through tariff/baseline funding. However there are specific increases relating to CNST (£2.7m), PFI (£1.5m) and depreciation (£1.8m) which are above the national tariff increase which have been included in the plan as a pressure. Discussions are ongoing with commissioners about funding support for these pressures

2024/25 Financial Plan – Key position & issues

Risks

- PDC has been based on the forecast outturn for 2023/24, further work is required to be done to forecast these costs for 2024/25 based on capital and asset valuation updates
- PFI – The 2024/25 forecast is based on the current method of accounting for the PFI. The 2024/25 plan will however need to reflect a change to this accounting treatment which will need to be reflected in the plan.

Further investments

Project Dalmatian – The finance plan does not include any revenue assumptions for project Dalmatian. The assets transferred in 23/24 are included in the balance sheet plan. Any revenue impact of the assets is assumed to be funded from the final operating model.

.

Service Developments: The plan includes £2m for new 2024/25 service developments. The Trust has a number of significant clinical priorities that are still to be agreed and therefore these aren't in the financial plan:

Maternity CQC review, National CSW Band 2 to Band 3 uplift, New Urology Investigation Unit, Robotic Surgery, Estates Statutory Compliance, Temporary Staffing team investment, Cardiology reconfiguration and 7 day service.

The above will have to be funded from either this contingency or through additional income and or cost reduction benefits over and above the CIP target.

2024/25 CIPs

The Trust has a CIP target of £37.3m which is 5% of turnover. The Trust has identified £20.4m of the CIP target which leaves another £16.9m to be identified. Nearly 50% of identified savings relates to additional income and the rest is reduction in expenditure.

£1.9m is FYE of 23/24 CIP

Next steps include reviewing if non-recurrent CIPs in 23/24 can be made recurrent and ensuring the benefits of business cases approved in 23/24 are included in the CIP tracker.

Classification	£m
Pay	5.3
Non-Pay	6.0
Non-Clinical Income	0.5
Private patient income	0.3
Clinical Income	5.4
Coding	3.0
Unidentified	16.9
Total	**37.3**

Risk Status	£m	%
Low Risk	6.5	0.17
Medium risk	3.8	0.10
High Risk	10.1	0.27
Unidentified	16.9	0.45
Total	**37.3**	

	£m
Recurrent	16.0
Non-recurrent	4.4
Unidentified	16.9
Total	**37.3**

	£m
New	35.4
Rollover	1.9
Total	**37.3**

2024/25 Financial Plan – Next Steps

Next Steps

Review with Divisions and Corporate Directorates of unfunded cost pressures and temporary staffing usage.

Service Developments to be prioritised

Activity Plan to be costed

CIPs
Review of Non recurrent CIPs in 23/24
Review of business cases approved to ensure CIP captured.

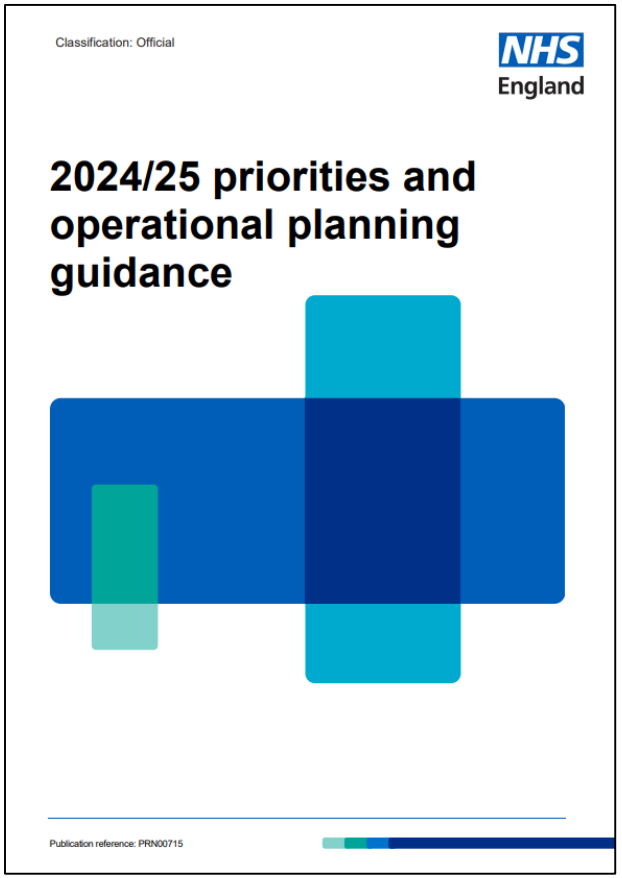
Business Plan for project Dalmatian to be developed

Appendix

Summary of the 24/25 Operational planning guidance

Key points

- Flat real funding 24/25 with a balanced system position expected
- Elective Recovery Fund access criteria broadly same as 23/24
- Carryover priorities linked to recovering core services and productivity with emphasis on elective recovery.
  - Incoming benchmarking metrics for all acute providers to be published.
- Further prioritisation of quality and safety, with an additional focus on workforce
- Push for the digital technology and physical infrastructure to be fit for the future.
- Incentive scheme for consistent 80% ED Type 1 performance



Key headlines with objectives

These will form the basis for assessment alongside local priorities agreed by ICS

	Headline priority	Key associated objectives
1.	Maintain focus on quality and safety of services, particularly maternity and neonatal, and reduce inequalities	Implement Patient Safety framework (PSIRF) Establish women's health hubs by Dec24 Increase % patients treated with hypertension to 80% (↑ 77% 23/34) Increase % patients on lipid lowering therapies to 65% (↑ 60% 23/34)
2.	Improve ambulance response and A&E waiting times	Target 78% of patient to be seen within 4 hours in ED (↑ 76% 23/34)
3.	Reduce elective long waits and improve performance against the core cancer and diagnostic standards	Deliver (or exceed) the system specific activity targets Increase % OP appointments classified as First or Fup+procedure to 46% Improve patients' experience of choice at point of referral Improve Cancer performance to 70% against the headline 62-day standard Increase performance on 28 day standard to 77% (↑ 75% 23/34)
4.	Make it easier to access community and primary care services, particularly dentistry	Focus on reducing long waits for primary care Recover and reform NHS dentistry
5.	Improve access to mental health services	Target 60% of patients with SMI receiving full annual physical health check Increase number of adults completing treatment for anxiety and depression
6.	Improve staff experience, retention and attendance	Systemic implementation of People Promise interventions Improve conditions for doctors in training (induction, rotas, payroll errors) Maximise clinical placement and apprenticeship pathways
7.	Balanced system financial position with new performance reporting	Temporary staffing spend at 3.2% total pay bill

Priorities for 2024/25

- **Recovery of core services** – Better Care Funding remains, focus on increasing diagnostic capacity, shifting OP activity toward News and Fups+procedure, improving the productivity of cancer pathways. NHS Impact to focus on interventions to improve patient flow. New oversight framework clarifying the interplay between ICB and providers with a focus on commissioning.

- **Supporting the workforce** - new emphasis on improving the staff experience and safety at work, implementing the new pregnancy and baby loss framework, support for menopause, improving working lives specifically for junior doctors, and embedding the NHS EDI improvement plan.

- **Improving productivity** - ongoing commitment to reducing temporary staffing spend, reduction of discharge delays, improving use of best value frameworks and contracts. Ensure flexible practices in place to reflect recent workforce growth. NHS England will report on productivity and supporting metrics at a national, ICB and trust level starting from the second half of 2024-25.

Headline Priority 1 - Focus on quality and safety of services

Requirement to apply the Patient Safety Incident Response Framework (PSIRF) which we have underway with our ratified response plan. Specific mention of maternity and neonatal services, with a request to implement the three-year Maternity plan and develop women's health hubs.

Additionally, trusts and systems are required to:

- Complete the NHS Impact self-assessment
- Ensure a robust governance framework in place drawing on the forthcoming Insightful Board guidance
- Embed quality and equality impact assessment (QEIA) process in financial and operational decision making.
- Improve the engagement of patients and families in incident responses.
- Use the Learn from Patient Safety Events (LFPSE) service to support learning.
- Support the uptake of training under the NHS Patient Safety Syllabus
- Appoint at least two patient safety partners to safety-related governance committees.

The guidance says NHSE will begin implementing Martha's Rule over 2024/25. NHSE have invited expressions of interest by **10th April** to take part in the first phase of the programme.

Headline Priority 2 - Improve A&E waiting times

Already meeting and will continue to exceed the minimum 78% patients seen within 4 hours in ED.

	A&E >4hrs from Decision to Admit	Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
A&E Type 1 & Type 3	Total Patients Seen	18,235	20,058	21,547	21,133	21,690	20,557	20,985	21,195	20,367	20,656	20,256	18,868	20,248	**247,562**	62,738	63,232	62,219	59,373
	>4hr Wait	2,546	2,730	2,763	2,284	2,918	2,780	3,245	3,379	3,293	4,395	4,137	3,360	3,069	**38,353**	7,777	8,944	11,067	10,565
	Peformance %	86.04%	86.39%	87.18%	89.19%	86.55%	86.48%	84.54%	84.06%	83.83%	78.72%	79.58%	82.19%	84.84%	**84.51%**	87.60%	85.86%	82.21%	82.21%

Opportunity

Financial incentive if able deliver 80% against the four-hour target by the end of 2024/25.
In aggregate terms we are planning to achieve this, however there is a higher degree of risk in Dec & Jan 24.

Headline Priority 3 - Reduce elective long waits and improve performance against core standards (1/2)

Consistent strong performance with no 65 weeks waits. Expectation to reduce size of waiting lists. Proposed plan including WLIs reduces RTT lists by 7620.

Plan to achieve the stretch target for new or follow-up outpatient attendances with a procedure at 49.5%.

	RTT including WLIs	Mar-24	Mar-25	Variance
TRUST	Total Waiting List	43068	35170	-7898
	IP Waiting List	7346	6314	-1032
	OP Waiting List	35722	28856	-6866
	IP Backlog	3743	2907	-836
	OP Backlog	8084	3716	-4368
	Total %	72.54%	81.17%	8.63%

Asked to improve patient's experience of choice at point of referral, optimised with PKB portal.

62 day standard for Cancer has been revised down to 70% as expected, and we continue to exceed throughout the year.

New Combined		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Cancer 31 combined standard (96%)	Total Patients Seen	811	698	841	848	826	771	818	798	892	784	856	817	778	9,727	2,387	2,415	2,474	2,451
	>31 day wait	32	28	34	34	33	31	33	32	36	31	34	33	31	389	95	97	99	98
	Peformance %	96.05%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%

Improving performance against the 28 day faster diagnosis standard to meet target 77% by year end.

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	Q1	Q2	Q3	Q4
Cancer Faster Diagnosis 28 Days	Total Patients	1,748.7	1,818.2	1,938.1	1,991.2	2,089.4	2,111.0	1,894.8	2,174.1	2,122.8	1,920.0	2,124.7	2,028.1	1,931.5	24,143.9	5,747	6,095	6,217	6,084
	>28 days or no date	437.0	454.0	484.0	497.0	522.0	527.0	473.0	536.0	517.0	460.0	503.0	472.0	444.0	5,889.0	1,435	1,522	1,513	1,419
	Peformance %	75.01%	75.03%	75.03%	75.04%	75.02%	75.04%	75.04%	75.35%	75.64%	76.04%	76.33%	76.73%	77.01%	75.61%	75.03%	75.03%	75.66%	76.68%

Headline Priority 3 - Reduce elective long waits and improve performance against core standards (2/2)

Target to increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Compliant with the target percentage of 95% patients receiving a diagnostic test within 6 weeks by year end. However, two challenged service lines: Barium enema and Cystoscopy currently proposing to be non-compliant, cystoscopy for the second year running.

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust Overall Diagnostics	Total Patients Waiting	8,290	8,212	8,198	7,992	8,081	8,102	8,027	8,091	8,043	7,848	7,750	7,601	7,565
	Patients waiting >6wks	220	194	198	165	156	160	144	116	105	105	87	79	71
	Peformance %	97.3%	97.6%	97.6%	97.9%	98.1%	98.0%	98.2%	98.6%	98.7%	98.7%	98.9%	99.0%	99.1%

Risk

Recovery plans required for Ba enema and Cystoscopy services to achieve 95% compliance by March 25

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Barium Enema	Total Patients Waiting	158	148	138	128	118	130	125	120	120	130	115	120	120
	in target	131	124	116	108	100	111	108	104	106	116	104	109	110
	Patients waiting >6wks	27	24	22	20	18	19	18	16	14	14	12	11	10
	Performance %	83.0%	83.5%	84.0%	84.5%	85.0%	85.5%	86.0%	87.0%	88.0%	89.0%	90.0%	91.0%	92.0%

		Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Cystoscopy	Total Patients Waiting	49	55	60	80	80	56	69	35	44	41	43	45	47
	in target	31	43	48	68	70	47	54	30	35	32	32	32	33
	Patients waiting >6wks	18	12	12	12	10	9	15	5	9	9	11	13	14
	Performance %	63.3%	78.0%	79.9%	84.9%	87.4%	83.8%	78.3%	85.8%	79.6%	78.1%	75.0%	72.1%	69.5%

Headline Priorities 4 & 5 - Access to community and primary care services; and Mental Health services

Trusts asked to appoint designated leads for primary-secondary care interface. Regular interface meetings already underway led by Ritchie Chalmers. Further plans underway with PCN colleagues to pilot a Primary Care Liaison service to act as a single point of contact and a fast-response helpdesk for concerns, issues and complaints raised by PCNs.

Further expected to meet the Mental Health Investment Standard. Additional funding allocated to grow the workforce and expand services. An additional £70m of service development funding will be used to support children and young people's (CYP) services. Programme of work underway to establish MH committee and write Trust MH strategy with incoming new MH lead for the Trust.

Asked to weight resources to areas with higher avoidable mortality with recurrent funding for health inequalities. Systems are asked to demonstrate how they are using this funding with publication of updated Joint Forward Plans by June 24.

Opportunities

- Pilot of the PCLS in 24/25.
- Additional funding for CYP services.
- Adjusted recurrent funding of £200m to tackle health inequalities through JFPs.

Headline Priority 6 - Improve staff experience, retention and attendance

Systems are asked to improve retention and staff attendance by ensuring that plans embed a focus across all elements of the NHS People Promise. We are a People Promise exemplar site.

Also required to embed the six high impact actions in the NHS equality, diversity and inclusion improvement plan, and actions from the sexual safety charter.

Systems are also asked to develop action plans to improve workforce productivity, identifying the rationale for increases in staffing since 2019/20, based on outcomes, safety, quality, or new service models.

Guidance on improving rosters and removing duplication for junior doctors to be published.

Opportunity

A ‘One workforce’ strategy to be developed at ICB level.

Headline Priority 7 - Balanced system position and benchmarking

The guidance confirms that the 2024/25 payment system will continue with the activity-based payment model for planned elective activity. ERF remains broadly similar. Low value activity has been removed and outpatient activity is inclusive of Follow-ups plus procedure. All Trusts are expected to meet the minimum 2.2% efficiency target and eliminate off-framework agency by July 24. Our temporary staff spend sits at 2.9% total pay below the 3.2% target threshold.

The K&M ICB submission was a -£180m deficit plan.

	24/25 Plan £ 000
DARTFORD AND GRAVESHAM NHS TRUST	-27,633
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	-85,772
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	0
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	0
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	0
MEDWAY NHS FOUNDATION TRUST	-28,958
KENT AND MEDWAY ICB	-37,292
SYSTEM TOTAL (DEFICIT)	**-179,655**

NHSE to publish core productivity and efficiency metrics for acute providers, later expanding to all other sectors. The initial set of draft metrics will be tested and further developed with systems and acute trusts.

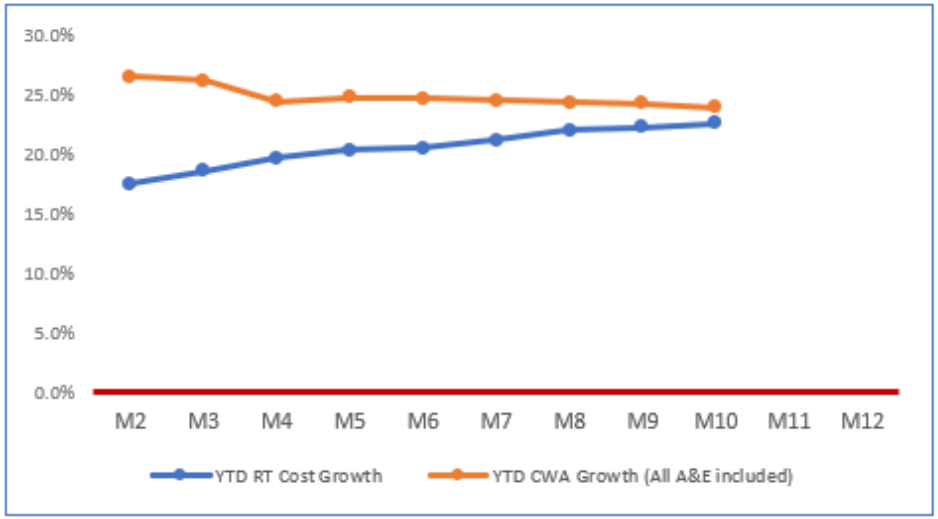
Headline Priority 7- Productivity benchmarking

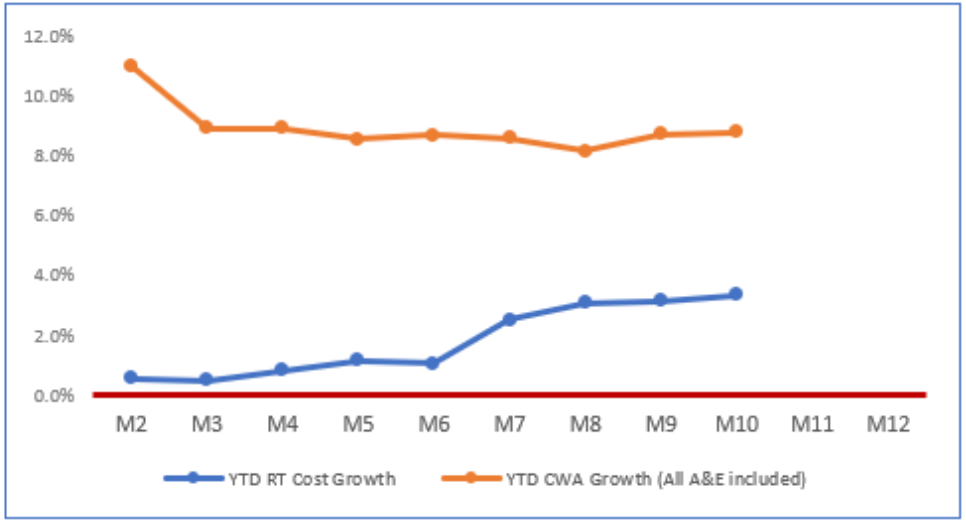
Although the framework for productivity assessment has yet to be published MTW are the only Trust in the south-east to have improved productivity vs spend and cost waited activity, and one of only ten Trusts nationally.

23/24 YTD Acute Productivity vs 19/20 - activity vs cost growth

23/24 YTD Acute Productivity vs 22/23 - activity vs cost growth

If CWA growth line is above real terms cost growth line, this indicates a positive productivity growth, otherwise, it indicates a productivity gap





NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the corporate objectives for 2024/25	Director of Strategy, Planning and Partnerships

The enclosed report provides information on the current position and next steps for the corporate objectives.

Which Committees have reviewed the information prior to Board submission?

The Executive Team meeting considers performance against these objectives once per month, last undertaken on 23rd April 2024.

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

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

Corporate Objectives Review

Rachel Jones
Executive Director Strategy, Planning & Partnerships

April 2024

Patient Experience

Strategic Theme	Vision Goals	Strategic Theme Lead
Patient Experience Vision Goal	To provide outstanding care and experience where patients are at the centre of all that we do. Communicating in an effective and timely way. Keeping patients, families and their carers' fully informed and updated throughout each step of their journey	Joanna Haworth
Patient Experience Vision Target	To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month	Joanna Haworth
Patient Experience Breakthrough objective	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience to 24 per month	Richard Gatune

Latest progress: Current Position 25 per month.
A dedicated programme board has been set up to oversee the Trust wide action plan, focusing on the top contributors identified:

- Staff attitude and behaviour
- Inconsistent communication
- Inaccurate communication

Patient Safety and Clinical Effectiveness

Patient Safety and Clinical Effectiveness Vision Goal	An organisation which has a blame free reporting and real time learning culture, delivering harm free hospital care.	Sara Mumford
Patient Safety and Clinical Effectiveness Vision Target	Reduce moderate and severe harm rate from a12 month average of 1.0 per 1000 occupied bed days to 0.9 per 1000 occupied bed days by April 2024 and 0.85 per 1000 bed days by December 2024	Sara Mumford
Patient Safety and Clinical Effectiveness Breakthrough objective	Reducing Deteriorating patients and sepsis by 50%.	Sara Mumford

The vison metric has been refined to focus on moderate and severe harm and therefore the break through objective has been revised. The previous work on reducing falls is now incorporated into business as usual.

Latest progress: Current Position is 1.09
Go live of revised incident reporting categories on InPhase on 2nd April which will support more accurate reporting in the future. The focus is currently on reducing unnecessary 222 calls for peri arrest.

Patient Access

Patient Access Vision Goal	All of our patients should be able to access the highest quality care and treatment when they need it, whether its as an emergency, waiting time for a cancer diagnosis or waiting for elective surgery.	Sean Briggs
Patient Access Vision Target	Achieve the Trust RTT Trajectory by March 2023	Sean Briggs
Patient Access Breakthrough objective	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Sarah Davis

Latest progress: Current position of 121.9% of new outpatient activity in February, which has also improved our RTT18 week performance to 72%.
There have been a number of Trust wide improvements such as Patient portal and GIRFT Further Faster recommendations.

Our focus remains on sustained improvements, including initiatives to reduce the weeks wait for first outpatient appointments.

Systems and Partnerships

Systems and Partnerships Vision Goal	People receive timely care from the right care provider in the most appropriate setting and avoid unnecessary transfer of care delays	Rachel Jones
Systems and Partnerships Vision Target	Decrease the number of occupied bed days to 3.5 days per 1.000 for patients identified as medically fit for discharge.	Rachel Jones
Systems and Partnerships Breakthrough objective	To increase the number of patients leaving our hospitals by noon on the day of discharge	Bob Cook
Systems and Partnerships Breakthrough objective	No patient resides in an acute hospital bed who needs care that can be provided in another setting	Doug McClaren

Latest progress: Current Position is 3.3 days per 1,000 and 23.7% of discharges before noon.
The key areas of focus are EDN completion, Effective Board rounds and Criteria Led Discharge
The work in now incorporated in the Safer Better Sooner programme which has given it some additional focus and governance alongside the divisional SDR monthly reviews.

Sustainability

Sustainability Vision Goal	Continued delivery of our financial plan, allowing us to invest sustainably in high quality services and infrastructure, improving patient experience and outcomes, and providing staff the tools they need to do their job	Steve Orpin
Sustainability Vision Target	Delivery of financial plan, including operational delivery of capital investment plan	Steve Orpin
Sustainability Breakthrough Objective	To reduce the amount of money the Trusts spends on premium workforce spend	Katie Goodwin

Latest progress: Current position - There has been a reduction in premium workforce spend by £11m to £17mper month over the last 12 months.
Improved rostering and vacancy controls have been put in place and the Patchwork bank product implemented Trust-wide. This is a real achievement and we know that we can go further in 24/25.
We will continue to focus on training and rostering as well as targeting remaining areas where there is high premium workforce spend.

People

People Vision Goal	Delivery of a robust workforce plan and pipeline supply that meets our operational plan so that our people are well supported and are able to provide high quality patient care. People leaders will support and coach people by setting clear objectives, encourage and support learning, communicate effectively and with compassion line with our leadership framework	Sue Steen
People Vision Target	Reduce the Trust wide vacancy rate to 8% by the end Jan 2024	Sue Steen
People Breakthrough objective	Reduce turnover to 12% by March 24.	Rob Henderson

Latest progress: Current position is a vacancy rate at 5.5% and a turnover rate at 11.78% in February.
Work continues to streamline the recruitment processes through automation.
We continue to focus on hot spot areas with projects targeting admin and clerical, as well as short term leavers (within first 24 months).
The vacancy rate vision target will now be reviewed.

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Outline Business Case (OBC) for the East Kent Oncology build	Director of Strategy, Planning and Partnerships

The enclosed report provides information on the outline business case detailing a recommended preferred option supporting the development of fit for purpose oncology (radiotherapy) services delivered in East Kent.
The case requests support to develop a full business case to support access to any funding that may become available. The case will also consider possible funding routes and opportunities.
The business case objectives are:

- The provision of high quality, safe, compliant and reliable Oncology Service facilities for East Kent.
- A design and co-location of the Oncology Service estate that leads to best practice and improved patient flow and service productivity.
- Suitable, sufficient and flexible Oncology Service estate capacity to run the required services for the next 25 years.
- Accessible Oncology Services for the population of East Kent.

The cost of the case ranges from £33.24m to £53m depending on the on the 4 options presented.
The case recommends the development of a Full Business Case for option A:

- 2 storey new build incorporating 2 new bunkers, clinical preparation space, OP accommodation and ground level plant.

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

- Business Case Review Panel
- Executive Team Meeting, 19/03/24
- Finance and Performance Committee, 26/03/24

Reason for submission to the Trust Board (decision, discussion, information, assurance etc.) [1]
The case has been submitted to the Trust Board for discussion and decision in respect of supporting the development of a Full Business Case for the preferred option.

[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

Provision of Oncology Services in east Kent

Outline Business Case

January 2024

BUSINESS CASE

Title	East Kent Oncology services provision

Issue date	January 2024
Department	Oncology
Directorate	Cancer, Haematology
Author	Grainne Barron, Head of Performance and Delivery Cancer Services, MTW Amy Seymour, Senior Strategic Projects Manager, EKH Rachel Jones. Director Strategy, Partnerships and Planning MTW
Clinical lead	Miss Phillipa Moth, Chief of Staff Dr Kannon Nathan, Chair of Clinical Reference Group.
Executive sponsor	Miles Scott/ Tracy Fletcher
Senior Responsible Officer	Rachel Jones/ Nicky Bentley
ID reference	

Approved by	Name	Signature	Date
Director of Operations			
Finance manager			
Clinical Director			
Executive sponsor			
Supported by		**Signature**	**Date**
Director Estates & Facilities			
Director of Informatics			
HR Business Partner			
Approved by	**Name**	**Minute**	**Date**
Divisional Board			
Finance & Performance Committee			
Trust Board			

Outline Business Case

Provision of Oncology Services in East Kent

January 2024

Version History

Version	Issue date	Brief summary of change	Owner's name
Draft 5	22-10-2019	All sections reviewed, activity and pay tables added.	Angela Gallagher
Draft 6	23-10-2019	Section 5 – The Financial Case	AG
Draft 7	29-10-2019	Risk section updated and other corrections following SOC group meeting	AG
Draft 8	5-11-2019	Activity data updated following further work by ops and finance team.	AG
Draft 9	6-11-2019	Finance information included (SD & GP) & case for change 2.8.4 (accessible services) updated (AG)	AG
Draft 10	17-11-2019	Section 3.3 replaced with updated version with more comprehensive assessment of assessing a preferred way forward. (NB)	AG
Draft 11	19-11-2019	National Context updated Map replaced Risks (2.10) updated and now include the risk register (?? If this is appropriate) Updated section on "summary description of developing options"	
Draft 12	23-11-2019	• The Commercial Case now included (Section 3) • The Financial Case up-dated (section 4) • Appendices updated and numbers changed • General tidy up of all sections • Index & page numbers added	
Draft 13	06-12-2019	• Front sheet updated • Section 5 updated to in-clude additional options	

		so now includes 4A,4B,4C. • Narrative in	
Draft 13	15-1-2020	• Option 4b deleted	
Draft 14	16-01-2020	• Changes above agreed & draft 14 issued to exec.	
Draft 15	21-01-2020	• Update in section 5.1 regarding Private Patient Income and workforce productivity.	
Draft 16	February 2021	• Update case for change using CRG document • Update to all LINAC narrative to reflect the replacement work on LAC3 • Inclusion of EKH Chemotherapy activity • Update to Initial Assessment of the Options to reflect workshop held at the end of January • Update to risks in terms of source of funding • Update to management case to reflect current and proposed joint organisational working • Update to financial case due to time lapse • Additional section on recommendations included • Update to Exec summary to reflect all of the above	Grainne Barron / Amy Seymour
Draft 17	June 2023	Business case updated with: • Capital Investment Appraisal • Benefit realisation • Options appraisal • Current financial information • Recommended option • Updated exec summary	Rachel Jones/Amy Seymour

Draft 18	November 2023	Updated economic model Updated do nothing option	Rachel Jones
Draft 19	January 2024	Tidied up the case to flow	Rachel Jones
Draft 20	February 2024	Amended finance tables, minor amends and remove appendix 3 and 4 as out of date	Rachel Jones

Contents

1.0 Executive Summary

1.1 The purpose of this document:

The purpose of this business case is to explore the options for delivering a sustainable solution for the provision of oncology services in east Kent provided by Maidstone & Tunbridge Wells NHS Trust (MTW) and East Kent Hospitals University Foundation Trust (EKHUFT).

This Business Case has been developed in accordance with the 5 Case Model recommended by HM Treasury and includes:

- **Strategic Case** which sets out the strategic context and the case for change.
- **Economic Case** which works through an options appraisal.
- **Commercial Case** which outlines the procurement and contractual approach
- **Financial Case** which outlines the affordability of the development and
- **Management Case** which outlines the project management, monitoring and governance to give assurance regarding delivery of the project objectives and improved service.

1.2 The Strategic case

This case directly supports the core strategic objectives of both Trusts, in particular the aspirations for:

- Ensuring the safe and effective clinical care to our patients
- Delivering services that are clinically viable and financially sustainable.

In October 2019 work joint work between EKHFUT and MTW commenced to review the sustainable delivery of oncology services delivered from the Kent & Canterbury Hospital. By January 2021 an outline business case was developed supported by an underpinning clinically engaged governance structure. Work was then paused due to the Covid pandemic and resumed again in early-2022. This case has been developed during a time of significant change in the NHS with a number of programmes and plans underway including: The East Kent Hospital's Acute Reconfiguration Strategy and implementation of the Integrated Care Board /Integrated Care System in K&M during the Covid 19 pandemic.

MTW & EKHUFT share the aim of working openly to progress the programme and in doing so ensure the delivery of safe, high quality oncology services to patients. Collaboration will be achieved by:

- Working closely to achieve our common objectives and with other stakeholders to achieve system priorities
- To regard each other's decisions
- To obtain views of service users and act in their best interests
- To proactively pool and share intelligence to identify emerging issues early and respond to concerns

Cancer is one of the most prevalent diseases and causes of mortality in the UK. Local access to cancer treatment is a vital component of improved outcomes for patients and their families. Radiotherapy and chemotherapy are both used in the standard treatment of a wide range of cancers.

MTW currently provide radiotherapy services from the K&M Cancer Centre in Maidstone Hospital and from the Kent and Canterbury Hospital (K&C) in Canterbury via 3 linear accelerators. The Oncology Unit is based in the 1937 building at the Kent and Canterbury Hospital. The unit contains a CT scanner for radiotherapy planning, three treatment units for radiotherapy, a collection of clinical/administrative offices and eight outpatient clinic rooms. The 20-chair chemotherapy unit is adjacent to the Oncology Unit and joined by a short corridor with a level 2b inpatient haematology ward for inpatient chemotherapy delivery in a separate part of the building. Of the three treatment units (Linear Accelerators), LA3C was decommissioned on 31 May 2020 and replaced in 2021, LA1C exceeded its 10-year life span in 2021 and LA2C will do so in 2024.

Failure to act risks a catastrophic breakdown in equipment that would result in significantly reduced capacity to offer local treatment to east Kent residents and increased waiting times for cancer treatment. In addition, two of the three bunkers which house the linear accelerators are too small to support direct replacement of the equipment. One of these bunkers houses the equipment that has exceeded its useful life. In 2020 NHS England decommissioned one of the LINACs due to its age which resulted in some activity transferring to Maidstone for a period of time. This would not be a possibility in the current climate.

The case for change is built on the three main aspects:

1. The radiotherapy bunkers are small and not able to house modern linear accelerators. This was evidenced during the eventual replacement of LA3C in 2021. Modern equipment is larger and heavier than when the unit was built and is not able to be accommodated without severe impact on staff – for example they cannot currently access both sides of a machine without going under a work surface.

2. The radiotherapy department building has not been able to be maintained to a reasonable standard resulting in inadequate facilities with multiple leaks, mould and damp. There are only 3 toilets in the K&C Radiotherapy suite with no disabled toilets or baby changing facilities in the department.

3. The clinical service is fragmented with staff groups working in various office space throughout the 1937 building, including a temporary wooden hut building for administration staff.

The objectives of this case are:

1 The provision of high quality, safe, compliant and reliable Oncology Service facilities for East Kent.

2 A design and co-location of the Oncology Service estate that leads to best practice and improved patient flow and service productivity.

3 Suitable, sufficient and flexible Oncology Service estate capacity to run the required services for the next 25 years.

4 Accessible Oncology Services for the population of East Kent.

Unfortunately, MTWs and EKHFUTs annual capital allocation is insufficient to support the development of new bunkers and the replacement of the equipment.

1.3 The Economic Case

The Economic Case outlines the options for equipment and estate replacement and highlights the preferred option based on the most robust service delivery and best value for money. The investment objectives for the case are:

1 **Quality Care -** The provision of high quality, safe, compliant and reliable Oncology facilities for the east Kent catchment area for cancer patients.
2 **Design & Adjacency -** A design and co-location of Oncology Services that provides a high-quality service, improved patient flow and service productivity.
3 **Sustainability -** Suitable, sufficient and flexible Oncology Service estate capacity to run the required services for the next 25 years.
4 **Accessibility -** Accessible Oncology Services for the population of east Kent.

The transformation programme is envisaged to be conducted in 2 phases. Firstly, the re-provision of Radiotherapy estate and equipment delivered by MTW and secondly the re-provision of chemotherapy services delivered by EKHUFT. The timeline is subject to the consideration and approval of the business cases from each organisation, support to the case from the ICB, agreement of funding and design and construction timelines.

The combined objectives and critical success factors were used to refine a long list of options to a short list which forms the preferred way forward at this stage of case development.

The following short list of options was developed and then further assessed using clinical, non-financial assessment criteria at a clinically led workshop. This initial assessment of the options recommended that all options with the exception of Options 1 and 2 are carried forward.

1 **Do minimum** – retain the current accommodation with minimal refurbishment

2 **Refurbishment** - Refurbishment & updating of the current accommodation

3 **A new build** - A new building to accommodate the radiotherapy services that are currently provided in the 1937 building

4 **A new build plus** – A new building to accommodate a co-located oncology service to include, radiotherapy, chemotherapy, outpatients, related clinical support & administration services and enhanced patient amenities.

5 **A new build plus (located off site)** - A new building to accommodate a co-located oncology service to include, radiotherapy, chemotherapy, outpatients, related clinical support & administration services and enhanced patient amenities.

6 **Two new builds** – As option 4 but with a new build at Margate to accommodate 1 of the 3 east Kent LINACs

7 **Refurb and expansion** – A refurbishment of the existing building at Canterbury but to include an expansion into adjacent parts of the building to accommodate some growth in demand.

The clinically led evaluation scorecard is shown below that led to the recommendation to carry all options forward into the OBC with the exception of Options 1 and 2 as they do not meet the essential

needs of the case.

Criteria	Option 1 - Do Min	Option 2 - Refurb	Option 3 - New Build	Option 4 - New Build Plus	Option 5 - New Build Plus Off site	Option 6 - New Build plus Margate	Option 7 - Refurb and Extension
Adjacency with other Clinical / Admin Support Services	0	1	1	2	1	1	1
Compliance of Service against National Specification	-1	0	1	2	1	1	2
Amenities Available on site	-1	-1	1	2	1	1	1
Ability to Cover Service Provision	0	0	0	0	0	0	0
Training and Supervision	-1	-1	2	2	2	1	1
Recruitment and Retention	-1	-1	1	2	2	-1	1
Infection Prevention and Control	0	0	2	2	1	2	0
Fit with EKHUFT Acute Services Reconfiguration	2	2	2	2	-1	2	2
Sustainability Score on Number of Years	-1	-1	1	2	1	1	1
Future Proofing Including space required for LINACs	-1	0	2	2	2	2	1
Service Resilience	-1	-1	1	2	2	1	1
Patient Pathway	0	0	1	2	1	-1	1
Continuity of Care	-1	-1	1	2	1	1	1
MDT Co-location	0	0	0	0	0	0	0
Patient Access	0	0	0	0	0	1	0
Ability to Quality Assure Service Provision	0	0	1	2	1	1	0
Implementation Timeline	-1	-1	-1	-1	0	-1	-1
Current Total	-7	-4	16	25	15	12	12
Original Total (from workshop)	-8	-5	17	26	19	15	13
	Referred to Exec Group for decision						
	Not required						

The SOC (Strategic Outline Case) assessed the financial viability of each of the options and determined that none were affordable. In response a "Do Minimum" option was developed which considered affordability.

Prior to commencement of the OBC and after a further programme pause the shortlisted options were further reviewed according to the green book processes. The options carried forward into this case are as follows:

- **Option A – Do Minimum** - Total programme is a mix of new build and refurbishment
    - 2 storey new build incorporating 2 new bunkers, clinical preparation space, Out Patient accommodation and ground level plant. (this includes £ for maternity moves that EKH need to make).
- **Option B – Radiotherapy and Outpatients Only New Build**
    - A 3-storey new build including 3 new bunkers, new CT suite, clinical prep areas, OP accommodation and MTW admin located at the Nackington Road entrance.
- **Option C – New Build**
    - A 3-storey new build including 3 new bunkers, new CT suite, clinical prep areas, OP accommodationand MTW admin and including chemotherapy located at the Nackington Road entrance.
- **Option D – New Build on car park plot** – as above but that the front of K&C on the current sexual health clinic is located

In recognition of the need to describe a 'do nothing' for service and financial comparison, this has also been included in the OBC.

1.4 The Commercial Case

The Commercial Case sets out procurement and contractual issues which will need to be addressed in the Full Business Case. It is imperative that the procurement associated with this scheme, regardless of the option to be taken forward, ensures the best value for money and, in addition is completed in a timely manner and due consideration is given to Health and Safety to provide a facility, built with zero defects and that suits the end user requirements in full.

Consideration also needs to be given to the route that will allow the provision of clinical services to be maintained throughout the works will little or no impact on the service provision.

1.5 The Financial Case

Due to the scale of required investment, the source of funding has not currently been identified for this project. This will require further discussion at the Finance and Performance committees of both organisations. The programme has been included in the ICS estates strategy and the case would require ICB approval. The recommended option in this business case would require NHSE approval as the total value exceeds £25m.

The financial case sets out in detail the assumptions that underpin the financial appraisal.

Option Description	Initial capital costs
BAU	£27,475,489
Option A	£33,242,115
Option B	£46,475,731
Option C	£50,563,363
Option D	£53,013,846

1.6 The Management Case

The re-provision of oncology services in east Kent is an organisational priority for both MTW and EKHUFT and, as such, the project governance, resources and infrastructure are already in place.

1.7 Conclusion

This business case confirms the need for a plan for the re-provision of high cost specialist capital equipment and estate space for oncology services in east Kent. The case acknowledges the medium to long term unsustainable nature of business as usual and the risk of catastrophic equipment failure with limited alternative options. The case recommends the option that is best value for money recognising that it remains a substantial investment.

Provision of reliable, well-maintained equipment is a critical part of the strategy to maintain and develop local access for east Kent residents to outcome critical oncology services.

The certainty of new up to date equipment and estate brings service and financial efficiencies but also supports delivery of the Trust mission to be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community and the vision of providing outstanding hospital services delivered by exceptional people.

This business case delivers substantial benefits to local people in the development of oncology services by:

- Having capacity available and assured to support delivery of activity to lower waiting times.
- Using Trust resources efficiently and effectively including staff clinical time
- Enabling the development of the service as one of the steps in delivering the Trust clinical strategy
- Improving patient and relatives experience
- Increases in capacity which improve patient flow.

2. Introduction

The purpose of this business case is to explore the options for delivering a sustainable solution for the provision of estate and clinical equipment for oncology (radiotherapy and chemotherapy) services provided at the Kent & Canterbury Hospital.
The aim is to recommend a preferred option for development into a Full Business Case which delivers a sustainable high-quality service model and offers the most efficient value for money.

2.1 Purpose of this business case

The purpose of this business case is to describe the options to deliver a fit for purpose estate to ensure a sustainable oncology service to the residents of east Kent.

The business case has considered options for delivering:

- LINAC, outpatient and administration estate solutions at the Kent & Canterbury Hospital
- the sustainable provision of chemotherapy services at the Kent & Canterbury Hospital
- effective and efficient oncology service delivery

Each option will be assessed against detailed criteria relating to value for money and operational efficiency.

2.2 MTW & EKHUFT

Maidstone & Tunbridge Wells NHS Trust (MTW) and East Kent Hospital University Foundation Trusts (EKHUFT) are both mid to large acute hospital Trusts in the south east of England who provide a wide range of general hospital services. Both organisations provide some specialist services to wider populations.

MTW provides specialist cancer services to around 1.9 million people in Kent, Medway and East Sussex via the Kent Oncology Centre at Maidstone Hospitals, and at Kent and Canterbury Hospital in Canterbury. The Trust also provides outpatient clinics across a wide range of locations in Kent and East Sussex. EKHFUT provides chemotherapy services to the east Kent population from a number of locations with a main base at Kent and Canterbury Hospital (K&C) adjacent to the oncology department.

2.3 Oncology at MTW &EKHUFT

2.3.1 Overview

Oncology is a branch of medicine that specialises in the diagnosis and treatment of cancer. It includes medical oncology (the use of chemotherapy, hormone therapy, and other drugs to treat cancer), radiation oncology (the use of radiation therapy to treat cancer), and surgical oncology (the use of surgery and other procedures to treat cancer).

2.3.2 Radiotherapy Machines

There are 6 linear accelerator (LINACs) at Maidstone hospital and 3 at K&C hospital. At K&C, one was re-placed in 2021 following a decommission in 2020, one reached the end of its useful life in 2022 with the other due in 2024.

2.3.3 Outpatient services

Outpatient services, are provided at Maidstone, Tunbridge Wells, The Conquest, Darent Valley, Kent & Canterbury, Medway Maritime, QEQM and William Harvey Hospitals.

2.4 Scope of the Business Case

The service scope of this business case is:

- Provision of radiotherapy services at the Kent & Canterbury Hospital
- Provision of chemotherapy services at the Kent & Canterbury Hospital
- Provision of oncology outpatients and treatment planning
- Provision of oncology administration

NB provision of any inpatient oncology service is out of scope for this business case

2.5 Structure of the OBC

The case has been prepared using the agreed standards and format for Business Cases from NHSE. The document has been written in accordance with the 5 Case Model recommended by HM Treasury and includes:

- The **strategic case** which sets out the strategic context and the case for change together with the supporting investment objectives for the scheme.
- The **economic case** to demonstrate that the Trust has selected the option which best meets the existing and future demands of the service and optimises value for money.
- The **commercial case** outlines the procurement and contractual issues associated with the development.
- The **financial case** confirms the affordability of the development.
- The **management case** which demonstrates that the scheme is achievable and can be delivered successfully to time, cost and quality.

2.6 Approvals

This business case is submitted to the following for approvals:

- MTW Business case review panel.
- EKHUFT Capital Investment Group
- MTW Executive Team Meeting
- MTW and EKHUFT Finance and Performance Committees.
- MTW and EKHFT Trust Boards
- Kent and Medway Integrated Care Board (ICB)

3.0 The Strategic Case

Cancer is a key cause of ill health and death world-wide. Around one in two people will be diagnosed with cancer at some point in their lifetime.
Treatments for cancer include radiotherapy and chemotherapy and both Trusts have developed this case to ensure long term sustainable delivery of these treatments from the Kent & Canterbury Hospital which is not currently fit for purpose.

3.1 Introduction

This Outline Case (OBC) sets out the preferred way forward and a shortlist of options, to address the objectives set out within the case for change, for Oncology (radiotherapy and chemotherapy) sand supporting services in east Kent.

3.2 National Context

Oncology is a branch of medicine that deals with the study, diagnosis, treatment and prevention of tumours. Cancer begins when cells in a part of the body start to grow out of control. One in two people will be diagnosed with cancer in their lifetime and millions of people are living with or have had cancer. Clinical oncology relates to any type of cancer treatment that is not surgery, including radiotherapy and chemotherapy.

Radiotherapy uses the radiation energy from machine-generated particles and radioactive materials to precisely target and kill tumours. Radiotherapy typically refers to 'external beam' radiotherapy, where patients are treated with X-rays beamed into the body, most often created by a machine called a linear accelerator (LINAC). A newer type of external beam radiotherapy called proton beam therapy, which uses proton particles instead of X-rays, has also started being used in the UK for patients with very specific cancers.

Systemic therapies include chemotherapy, which stops cancer cells multiplying; hormone therapy, which limits hormones that can encourage cancer to grow; and immunotherapy, which primes the body's immune system to fight cancer.

There are several documents that consider radiotherapy provision listed below:

National	Key themes and context for case
Radiotherapy Services in England (Department of Health and The National Radiotherapy Advisory Group, 2012	Recommendations for: The increase of radiotherapy capacity across England to meet rising demand in order to deliver minimum of 55,206 radiotherapy attendances per million of population by 2016; and 60,057 by 2020. The implementation of new forms of radiotherapy, including Intensity Modulated Radiotherapy (IMRT), and four-dimensional Image Guided Radiotherapy (3D/4D IGRT) to a higher proportion of patients. Additional radiotherapy capacity is achieved through locally-based linked units closely aligned to an existing cancer centre. This is to promote local access to services, but also ensure consistency of integrated cancer treatment pathways.

National	Key themes and context for case
	To improve outcomes from radiotherapy, there must be equitable access to high quality, safe and timely radiotherapy care.
Recommendations for achieving a world-class radiotherapy services in the UK (The Tavistock Institute, 2014)	At least 52% of cancer patients should receive radiotherapy as part of their treatment. There is significant variation in access to radiotherapy across England due to inequitable location of radiotherapy facilities.
Vision for Radiotherapy, 2014-2024. NHS England in partnership with Cancer Research UK.	NHS England's broader ambitions around equitable access to the most clinically and cost-effective radiotherapy treatments The report emphasises the importance of local access to radiotherapy and acknowledges that radiotherapy is critical to improving patient outcomes. Radiotherapy service developments should take account of technological advances and innovations to deliver standardised radiotherapy pathways in order to deliver the same standard of treatment to patients regardless of where they live. The report places further emphasis on the need to deliver local treatments through a network of linked radiotherapy units.
NHS Outcomes Framework (Department of Health, 2015/16)	As stated in the NHS Radiotherapy Service Specification (see below): The appropriate delivery of radiotherapy treatments to patients with cancer will ensure that the outcomes from treatment will meet the requirements of the 5 domains of the NHS Outcomes Framework. Domain 1 Preventing people from dying prematurely, Domain 2 Enhancing quality of life for people with long-term conditions, Domain 3 Helping people to recover from episodes of ill health or following injury, Domain 4 Ensuring that people have a positive experience of care, and, Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.
Achieving World-Class Cancer Outcomes – a strategy for England 2015 - 2020 (Independent Cancer Taskforce 2015)	Improve initiatives to improve public health. Achieve an earlier diagnosis of cancer – by 2020, 95% of patients referred for testing are given a definitive cancer /not cancer diagnosis within four weeks. Patient experience should be on a par with clinical effectiveness and safety. Investment is required in the equipment necessary to deliver modern high-quality radiotherapy services, including a rolling plan to upgrade LINACs at 5-6 years and replace them once they reach 10 years. Invest in imaging equipment to improve radiotherapy treatment planning (MR and PET-CT for example).
NHS Long Term Plan for Cancer (January 2019)	Improve the proportion of cancers diagnosed at stages 1 and 2 to 75% by 2028. From 2025, 55,000 more people each year will survive their cancer for

National	Key themes and context for case
	at least 5 years after diagnosis. Safer and more precise advanced radiotherapy techniques will continue to support improvements in survival rates. Reforms to the specialised commissioning payments for radiotherapy hypofractionation will be introduced to support further equipment upgrades. Faster, smarter and effective radiotherapy, supported by greater networking of specialised expertise, will mean more patients are offered curative treatment, with fewer side effects and shorter treatment times.
Adult External Beam Radiotherapy Services Delivered as Part of a Radiotherapy Network Specification (2019) Operational Delivery Networks for Adult External Beam Radiotherapy Services Specification (2019)	Describes aims, objectives and required specifications for adult radiotherapy services delivered as part of a radiotherapy network (the Kent Oncology Centre (KOC) does not provide paediatric services), including: • improved access to modern, advanced and innovative radiotherapy that allows service users to benefit from cutting-edge technology and treatment, • increased participation in clinical trials, • reduced variation in equipment utilisation with an average 15% increase in equipment utilisation across England as a whole over the next 3 years, • ensure LINACs are replaced once they reach 10 years and that treatment planning systems and software are updated regularly.

Guidance on cancer treatments and, within that, radiotherapy treatments, are being constantly reviewed and updated. An example of this is changes to radiotherapy treatment protocols for breast cancer.

3.3 Local Context

MTW provides radiotherapy services consisting of 3 radiotherapy machines and outpatient rooms within east Kent at K&C hospital. EKHUFT provide a chemotherapy service from an adjacent unit and the two services work closely together.

3.4 Organisational overview

MTW is responsible for the recruitment of the medical workforce and a number of those staff are allocated to provide services under an SLA for radiotherapy that includes both outreach outpatient clinics at William Harvey and QEQM Hospitals and also has oncologists who are based in east Kent at K&C Hospital.

External beam radiotherapy services are currently provided by MTW from three LINACs in K&C Hospital. The Oncology Unit is housed in the 1937 building which is the oldest section of the hospital and for a number of reasons it has not been possible to maintain or refurbish to a level that would be expected of a modern healthcare facility. The Oncology Unit suffers from roof leaks due to a flat roof construction.

Of the LINACs at Kent and Canterbury Hospital, LA3C was decommissioned on 31 May 2020 and was replaced in 2021, LA1C reached its 10-year life span in 2021 and LA2C will in 2024.

In the current financial set-up MTW receives the income for the radiotherapy activity directly from NHS England as a specialised service and in turn rents the space at Kent and Canterbury Hospital from East Kent under a service level agreement.

East Kent provides outpatient chemotherapy units at William Harvey Hospital in Ashford, (10 chairs), Queen Elizabeth the Queen Mother Hospital in Margate (12 chairs) and K&C Hospital (20 chairs). A mobile chemotherapy unit is also operated and provides chemotherapy treatment in Ashford, Dover and Herne Bay. In addition, there is a level 2b inpatient haematology ward for inpatient chemotherapy delivery at K&C Hospital.

East Kent Hospitals employs nursing and administrative teams in order to deliver the chemotherapy activity at the three acute hospital sties. There is a local management structure for the chemotherapy service. Pharmacy services include on site aseptic services at Kent and Canterbury Hospital for the production of a proportion of the chemotherapy drugs and the remainder is bought in.

Activity already included under contract with commissioners will remain the sole interest of each Trust. Neither organisation will extend the scope of their work in such a way that will impact on the financial position of the other with regard to oncology services.

3.4.1 Unit location map

The following map shows the location of radiotherapy units currently operating and planned radio therapy units in the surrounding region.

3.4.2 The population served by the Kent Oncology Centre

District	Population covered
Ashford	124
Canterbury	156
Dartford	97
Dover	109
Gravesham	104
Maidstone	162
Sevenoaks	118
Shepway	103
Swale	144
Thanet	137
Tonbridge & Malling	127
Tunbridge Wells	114
Eastbourne	13
Hastings	73
Lewes	0
Rother	72
Wealden	40
Medway	195
Total	1889k

3.5 Summary of current services

The Oncology Unit is based in the 1937 building at the Kent and Canterbury Hospital. The unit contains a CT scanner for radiotherapy planning, three treatment units for radiotherapy, a collection of clinical/administrative offices and eight outpatient clinic rooms. The chemotherapy unit is adjacent to the Oncology Unit and joined by a short corridor.

There are also chemotherapy units at the WHH in Ashford and the QEQM Hospital in Margate. A smaller number of outpatient clinic appointments are undertaken at the WHH and QEQM Hospitals than at the K&C Hospital.

Radiotherapy Physics staff including the Treatment Planning Team plus an engineering team to support the LINACs are based in Canterbury.

3.6 Radiotherapy and Radiotherapy Outpatient Activity at Kent & Canterbury Hospital.

Due to the global Covid-19 Pandemic, the Trust, like many of its neighbouring organisations experienced a drop-in activity during 2020. The historical activity was reviewed and it was agreed that the baseline for future growth projections would be set from total final activity for the financial year 2019-2020 (April 2019 to March 2020)

Across all activity, growth has been calculated based on the demographic growth for defined age brackets within Districts, related to patient Post Codes.

- **Radiotherapy Activity – actuals from April 2016 to March 2020, and forecasts to 2024-25**

Following the detailed work this table shows total growth % demonstrated over final activity numbers per year

Radiotherapy

	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
Total per year	**21622**	**19036**	**20226**	**20042**	**20474**	**20946**	**21353**	**21718**	**22059**
Activity difference from previous year					**432**	**472**	**407**	**366**	**340**
Growth % over previous year					**2.2%**	**2.3%**	**1.9%**	**1.7%**	**1.6%**

In addition to current activity, further work was done to project a possible repatriation of some services and further activity planned for new treatments.

	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
Plus, Brain (All + growth)						790	805	819	832
Plus, Skin (All + growth)					491	502	512	521	529
Lung Primary (current Maidstone only)						89	91	92	94
SABR Mets Phase 1 (New treatments)						46	47	48	48
SABR Mets Phase 2 (New treatments)						9	9	9	9
				20042	**20965**	**22382**	**22817**	**23207**	**23571**
					4.6%	**6.8%**	**1.9%**	**1.7%**	**1.6%**

- **Radiotherapy Outpatient Attendances (New and Follow up) – Consultant Led - actuals from April 2016 to March 2020 and forecasts to 2024-25**

New Patient Activity

	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
NEW	**2706**	**2733**	**2654**	**2780**	**2840**	**2905**	**2962**	**3013**	**3060**
Activity difference from previous year					60	65	56	51	47
Overall % growth					2.2%	2.3%	1.9%	1.7%	1.6%

Follow Up Patient Activity

	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
Follow Up	13549	13391	12869	**14674**	**14990**	**15336**	**15634**	**15901**	**16151**
Activity difference from previous year					316	345	298	268	249
Overall % growth					2.2%	2.3%	1.9%	1.7%	1.6%

- **Radiographer-led Clinic Activity totals – actuals from April 2016 to March 2020 and forecasts to 2024-25**

Total Activity

	FY16-17	FY17-18	FY18-19	FY19-20	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
Curr Total	**4589**	**4802**	**5648**	**5566**	**5686**	**5817**	**5930**	**6032**	**6126**
Activity difference from previous year					120	131	113	102	95
Overall % growth					2.2%	2.3%	1.9%	1.7%	1.6%

East Kent Chemotherapy Activity

Diagnosis Activity

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Total as per KCC growth data	2,909	2,595	2,507	2,167	*2,220*	*2,269*	*2,321*	*2,383*	*2,433*	*2,491*	*2,542*
					2.4%	2.2%	2.3%	2.7%	2.1%	2.4%	2.1%

Chemotherapy Treatment Activity

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Total as per KCC growth data	11,625	8,582	9,068	10,055	*10,208*	*10,333*	*10,483*	*10,641*	*10,795*	*10,933*	*11,038*
					1.5%	1.2%	1.5%	1.5%	1.5%	1.3%	1.0%

This information includes all of the chemotherapy activity undertaken at the K&C site.

Both organisations have been using a similar methodology to understand the predicted growth in both radiotherapy and chemotherapy and has now been finalised. As part of the next steps both organisations will look at the interplay of the different activity types to understand the relationship between growth in outpatient specialities and follow on treatment.

3.7 Investment objectives

The proposed investment has four key objectives

1 The provision of high quality, safe, compliant and reliable Oncology Service facilities for East Kent.

2 A design and co-location of the Oncology Service estate that leads to best practice and improved patient flow and service productivity.

3 Suitable, sufficient and flexible Oncology Service estate capacity to run the required services for the next 25 years.

4 Accessible Oncology Services for the population of East Kent.

3.8 Case for change

The case for change has been aligned to each objective.

3.8.1 The case for change in relation to the provision of high quality, safe, compliant and reliable Oncology Service facilities for east Kent cancer patients

The current facility that houses the radiotherapy, and the oncology outpatients at the K&C Hospital is not fit for purpose for modern healthcare. The clinical service is fragmented with staff groups working in various office space throughout the 1937 building, including a temporary wooden hut building for administration staff.

The building is no longer able to accommodate the most up-to-date radiotherapy treatment (LINAC) machines. The replacement of a LINAC in Canterbury in 2011 encountered a number of issues including height of the room to accommodate the modern machine, additional floor strengthening required to support the weight of the new treatment unit as well as asbestos and vermin removal. Since the initial draft of this case a further LINAC, due for replacement in 2014, was decommissioned in May 2020 and replaced in 2021, again with a significant number of estate challenges. The two older machines have been and are due for replacement in 2021 and 2024.

The facility does not adequately facilitate multi-disciplinary working for the Oncology service i.e. centralised cohesive working of the full clinical team i.e. Consultants, trainees, CNS', research nurses, MDT co-ordinators, admin & secretarial support and other allied health professionals.

In addition:

- Many of the rooms (clinical and administrative) are under flat roofs that leak during moderate rainfall.
- The above has led to numerous issues with mould and damp.
- Modern radiotherapy equipment is larger and heavier than previous treatment units and therefore require additional installation works at increased cost.
- Patient experience is poorer than at Maidstone due to outdated facility. An example of poor patient experience is the space to manoeuvre within clinic rooms where a patient is on a trolley. In addition, the space around chemotherapy chairs for patients and their carers also does not currently meet patient expectation. There are only 3 toilets in the K&C oncology department,

there are no disabled toilets or baby changing facilities in the department. This is a major unmet need and a vital requirement for patients either on pre-treatment or treatment pathways. Parking at the K&C site, space for ambulances and the ability to access complimentary therapies are all recognised by both patients and staff as contributing to poor patient experience.

- Staff surveys suggest that staff experience could be positively impacted by an improved facility. Being able to resolve some of the issues currently facing staff across the departments related to both the facilities available and patient flow as well enhancing patient experience would enable staff to feel they are offering optimum service provision.

3.8.2 The case for change in relation to a design and co-location of the Oncology Service estate that leads to best practice and improved patient flow and service productivity

The current facility offers a fragmented service with the oncology & its support services spread across a number of areas and separate areas for two key components of cancer treatment i.e., chemotherapy and radiotherapy. It is widely accepted that the current infrastructure problems adversely affect service delivery and the ability to provide the best patient experience. Most agree that a co-location of the key components of an oncology service, outpatients, chemotherapy, radiotherapy, planning and administration works most effectively for patients when these are co-located with other support and wellness services. This also enables a more critical analysis of current workflows and patient pathways to deliver the most clinically effective and productive service models.

Models of care within cancer services often require patients to see a range of professionals during clinic attendances and currently this is delivered across different rooms and floors of the K&C building. This fragmented service delivery is replicated within oncology pre-treatment and treatment areas. Patients attend a different department for insertion of an IV. The number of rooms available within the pre-treatment area is restricting for patients who require pre-treatment planning, moulding and other types of preparation. Radiotherapy and chemotherapy services are not located closely enough to benefit those patients who require shared and overlapping treatments. There is also no ability to provide an inpatient service within oncology for those who require it during treatment or a trolley bay for those patients arriving in an emergency requiring radiotherapy.

Though there are some pharmacy clinics running within the oncology department, the dispensary is located on a separate floor within the 1937 building. Patients feedback has indicated that the ability to access this within the department would be a significant improvement in the service.

There are currently four desks available for consultants working at the Kent and Canterbury co-located with administrative support for Oncology in a separate building on the site. This space is currently shared between seven consultants but this will need to be expanded to account for trainees in future. It is the expectation of the GMC that trainees are provided with adequate office space and IT access. The Trust is not alone is not being able to provide this currently but would expect to be able to as part of any future plans, to support both the efficient delivery of pathways as well the improved ability to recruit and retain medical staff.

Weekly Multi-disciplinary team (MDT) meetings are key decision-making meetings to decide upon a patient's treatment following diagnosis. Currently these meetings are held across sites via video link but also across multiple rooms at the Kent and Canterbury site. The number of contributors dialling in from multiple locations as well as some IT issues are hindering increased productivity from these meetings. In a similar vein administrative staff supporting MDTs are not co-located with the services prohibiting further collaboration and cross -cover in the event of staff absences.

Administration staff including those operating the cancer care line, chemotherapy schedulers and storage of patient notes are currently separated from the oncology services located in a separate

wooden hut building and this can sometimes hinder efficient communication for staff. In turn this can impact on patient flow and treatments times.

East Kent Hospitals are planning new and exciting research facilities and the importance of clinical trials in cancer patients cannot be emphasised enough. This will continue to be in a separate building under any future plans but it would be ideal if there was easy access in close proximity to the services.

3.8.3 The case for change in relation to suitable, sustainable and flexible Oncology Service estate capacity to run the required services for the next 25 years

The current estate at the K&C Hospital is not fit for purpose to house modern linear accelerators and specifically the need for adjacency and co-location of key services for oncology patients.

A new purpose-built facility will offer the opportunity to commission the most recent and modern LINACs which will in turn facilitate the implementation of modern and more productive workflows and increase the overall capacity and daily through-put of patients receiving radiotherapy. There are small groups of cancer patients who require specialised radiotherapy within east Kent geography that currently have to travel to MTW or Guys and St Thomas's. We know that some east Kent residents, especially those from our most deprived communities, do not access radiotherapy if it cannot be provided from a local facility due to travel time and cost.

Outpatient services within the 1937 building suffer from a severe lack of clinic space which has limited the services ability to provide new models of care for patients as they are intended and a truly seamless service. Staff within the oncology department still manage to implement new care models but with enormous logistical challenge and not to the high degree of quality desired for patients. The number of patients requiring treatment is expected to increase over time and therefore the lack of space now will become more of a problem in the coming years.

The lack of flexibility in terms of both the space and size of rooms to adapt to future service requirements as well as service developments remains of great concerns to clinicians leading these services.

Key to offering a sustainable service is the on-going recruitment and retention of staff. The ability to deliver education, training and supervision for medical students is a fundamental part of the Trust and service being an attractive place to work. Linked to the development of the medical school in Kent, by 2023/2034 there will need to be space to accommodate 40 students across the two sites in Kent. In addition, Health Education England (HEE) has recently approved a substantial increase in National Training posts for Clinical Oncology and Medical Oncology outside of London. HEE intends to allocate these training posts according to the local need for Consultant Oncologists - targeting areas of England which have struggled to recruit Consultant Oncologists in the past. If these additional posts are maintained, this will boost the workforce in the future. The local Training Programme Director is aware and is in the process of approaching MTW to secure the required 50% funding for each additional Oncology Trainee post. Any changes to the facilities will need to accommodate this additional workforce.

The IM&T facilities to support this development will need to be improved and focus on the safe treatment of patients. This will require secure network solutions between the treatment machines and treatment planning facilities within both Trusts as well as to cater for the national requirement for peer review of radiotherapy volumes.

3.8.4 The case for change in relation to accessible Oncology Services for the population of east Kent

Access to radiotherapy treatment by the whole of the east Kent cancer population has been debated widely. The analysis below has been undertaken to support the selection of future provision, specifically in relation to the Thanet population.

The English Index of Multiple Deprivation 2015 (IMD2015) which was released in September 2015, shows Thanet as the most deprived local authority in Kent and evidence from Cancer Research UK shows a much higher incidence of cancer among the population of the most deprived areas.

The NHS England radiotherapy service specification 2013/14 states that in 2016, there should be 54,000 fractions of radiotherapy delivered per million populations. The service specification also suggests that the average number of fractions per patient will be 18. This equates to 3,000 patients per million populations being treated with radiotherapy or 0.3%.

The activity figures and predictions have been checked using the Malthus simulation which is a model that uses information on treatment schedules obtained from published evidence and by consensus amongst Clinical Oncologists. This information is combined with cancer incidence statistics at the local commissioner level from the National Cancer Intelligence Network. This provides a more nuanced prediction of expected patients that would be treated with radiotherapy per million populations.

The two tables below demonstrate that the proportion of the population treated with radiotherapy was almost identical for the whole of Kent and Thanet in both 2016 and 2017. This would suggest that there doesn't appear to be an issue with reduced access to radiotherapy in Thanet with the current configuration and location of LINACs when compared to the rest of the county. However, given the published information regarding the connection between high deprivation and greater incidence of cancer, both Trusts support the proposal to explore the provision of radiotherapy (1 LINAC) at the Queen Elizabeth Queen Mother Hospital at Margate. There is an opportunity to explore that possibility in detail as part of this transformation programme and will include a full assessment of travel times and evidence of treatment outcomes across the EKH and MTW catchment areas.

2.8.4.1 Number of patients expected to be treated with radiotherapy per population versus actual number of patients treated for Thanet

	2016	2017
Expected number of patients to be treated	422	424
Expected percentage	0.30%	0.30%
Actual number of patients treated	383	402
Actual percentage	0.27%	0.28%
Variance (patients)	-39	-22

Number of patients expected to be treated with radiotherapy per population versus actual number of patients treated for Kent

	2016	2017
Expected number of patients to be treated	4626	4664
Expected percentage	0.30%	0.30%
Actual number of patients treated	4383	4237
Actual percentage	0.28%	0.27%
Variance (patients)	-243	-427

3.9 Benefits Criteria

The following main benefits are expected from the investment:

- Up-to-date and suitable clinical environment for providing high quality patient care.
- Sustainable building appropriately built to accommodate the latest LINAC design which allows for future-proofing.
- Improved staff facilities and environment to support training and development and facilitate recruitment and retention.
- An ability to co-locate all the elements of a non-surgical oncology service and optimise the benefits of MDT working and collaboration in relation to patient care.

3.10 Risks

The main project risks and mitigation factors have been identified at a high level and are noted below. A Project Risk Register has been developed which details and quantifies project risk. This will be reviewed and updated through progression to Full Business Case

The key risks identified so far are:

- The availability of capital funds particularly post the national pandemic.
- Impact of having to replace one or both of the oldest LINACs at K&C before a solution is delivered
- The costs of the project in light of volatile construction costs and extended lead in times

At the commencement of this case the replacement of the oldest LINAC in the current unit was included as a risk due to the significant cost that would be required to remove the current treatment unit, refurbish and strengthen the bunker and then install the new treatment unit. This risk fully materialised in 2020, however concurrently the programme has also been delayed due to the pandemic.

3.11 Constraints

There are a number of key constraints/ dependencies associated with the delivery of this project:

- Maintain current service provision whilst carrying out development work. The project group considered this a very important constraint given the lack of any spare radiotherapy capacity in the trusts.
- Workforce availability
- Constrained availability of land on site to build new accommodation.
- The capital has not yet been identified.

- External capital finance is required as the size of the proposal is beyond the combined Trust's internally generated capital availability.

3.12 Dependencies

Key dependencies for the project include:

- Single agreed business case between EKHUFT and MTW
- Affordability
- Collaboration and co-operation between both Trust's to deliver the preferred option.

4.0 The Economic Case

The purpose of the economic appraisal is to appraise and rank the shortlisted options in terms of their relative value to society. The base year for the evaluation is 2023/24 and the evaluation period has been set at 64 years based on a four-year project period from 2023/24 to opening and a standard 60-year life for new buildings.
The economic assessment confirms that Option A represents the best value for money, so should be considered the Recommended Option.

4.1 Identifying a long list of options

A key component of developing a business case is the option appraisal exercise. It is only by comparing the alternatives that the real merits of any particular course of action are exposed.
In accordance with NHSI's 's guidance and the requirements of HM Treasury's Green Book (A Guide to Appraisal in the Public Sector), this section of the OBC documents the process and provides evidence for the preferred way forward

The Economic Case sets out:

- Critical Success Factors;
- Long Listed Options;
- Preferred Way Forward
- Short Listed Options;

This exercise of generating the long list was undertaken by the Project Team in September 2018 and is summarised below in section 3.3

4.2 Critical Success Factors

The following critical success factors that each option is accessed against have been agreed by the project group. The CSFs are used in conjunction with the investment objectives to evaluate the Long List of possible options:

Strategic fit and business need fit. Must meet MTW's wider investment objectives, business needs and service requirements and allow the delivery of all relevant national and local strategies. Must result in provision of facilities for patients, relatives and staff that are functionally suitable, safe, clinically effective and fit for the future.

Flexible and sustainable solution. Must optimise the level of future proofing to continue to meet changing business and service needs in an efficient and cost-effective way.

Potential affordability. Must match MTW's and EKHUFTs ability to fund the required level of capital or secure capital from other sources such as the ICB and DHSC.

Promotes optimum patient flow, through design and appropriate adjacency between all aspects of oncology services including support and survivorship services.

Potential value for money. Must deliver improved and integrated services that provide value for money in terms of clinical efficiency in support of the strategy.

Potential achievability. MTW must have the ability to support the service model and maintain service continuity at all times. MTW board must have the ability to manage associated risks and establish a Project Team with the necessary level of skills (capacity and capability) to deliver the project

4.3 The long list options

4.3.1 Exploring the preferred way forward

The work on the options commenced in 2019 and has considered all possible options including other NHS and non-NHS site locations for the provision of oncology services in east Kent. The dates and comments below represent the work undertaken 2019 to 2020. The long list of options was generated by the project group using an options framework around key dimensions of; scope, service solution, service delivery, implementation and funding.
Project objectives and critical success factors were used to refine the long list to a short list for further work described in this OBC.

Scope

Project dimension	**Do nothing**	**Radiotherapy only**	**Clinical Oncology services**
1	**1.0**	**1.1**	**1.2**
Service scope	Business as Usual	Radiotherapy services currently provided in the 1937 building	East Kent Radiotherapy, Oncology outpatients and Chemotherapy
	Carried forward	Carried forward	Carried Forward

Service location solution

Project dimension	**Do nothing**	**Do minimum**	**Do minimum +**	**New Build Canterbury**	**New Build multiple sites**
2	**2.0**	**2.1**	**2.2**	**2.3**	**2.4**
Service location solution	Remain in 1937 building	Refurbishment of the existing building	Refurbishment of the existing building with a small new build	New build whole service on K&CH or another site in Canterbury	Two builds one LINAC at Margate or Ashford, 2 LINACs in K&C
	Carried forward	Carried forward	Carried Forward	Carried forward	Carried forward

Service delivery

Project dimension			
3	**3.0**	**3.1**	**3.2**
Service delivery	Managed by MTW NHS Trust via KOC through facilities managed by MTW	Managed by MTW NHS Trust via KOC through facilities managed by MTW – Although Chemotherapy delivered across east Kent, partly in facilities managed by East Kent Hospitals	Managed by MTW NHS Trust via KOC through facilities managed by East Kent Hospitals
	Carried forward	Carried forward	Carried forward

Implementation/ timescale

Project dimension			
4		**4.1**	**4.2**
Implementation/ timescale		Phased to coincide with next LINAC replacement at K&C	Construction starts on site as soon as possible (2021)
	N/A	Carried forward	Carried forward

Funding

Project dimension	**Business as usual**			
5		**5.1**	**5.2**	**5.3**
Funding		Internally generated capital	System capital	Joint venture/partnership arrangement
	N/A	Carried forward	Carried forward	Carried forward

Summarising the long list into a short list excluding discarded options

	Business as usual	Do minimum	Do minimum plus	New Build K&CH	New Build Canterbury	New Build combined sites
Service scope	1.0	1.1	1.1	1.2	1.1	1.2
Service location	2.0	2.1	2.1	2.3	2.2	2.4
Service delivery	3.0	3.0	3.0	3.0	3.1	3.0
Implementation/ timescale	N/A	4.1	4.1	4.1	4.1	4.2
Funding	N/A	5.1/5.2/5.3	5.1/5.2/5.3	5.1/5.2/5.3	5.1/5.2/5.3	5.1/5.2/5.3

4.3.2 Summary description of developing options

Business as usual – do nothing. This assumes the service will continue until such time the equipment fails.

Do minimum – Refurbishment of existing facilities. This option is a refurbishment of the existing estate only and does not include any new build element.

New build - East Kent Radiotherapy and outpatients only.

New Build Canterbury- East Kent Radiotherapy, Oncology outpatients and Chemotherapy, on a new build at the Kent & Canterbury Hospital Site, or on another site in Canterbury.

New Build other sites - East Kent Radiotherapy, Oncology outpatients and Chemotherapy, on a new build at site, in any combination of Margate, Ashford and Canterbury.

4.3.3 Summary of early Initial Assessment of the Options

Description of option	**Do nothing**	**Do minimum** Refurbishment	**New Build radiotherapy only**	**New build plus** New build K&CH site or Canterbury	**Two New Build** Two builds one LINAC at Margate or Ashford, 2 LINACs in K&CH
Spending objectives					
Quality Care	×	?	?	✓	✓
Design & Adjacency	?	?	?	✓	✓
Sustainability	×	?	?	✓	✓
Accessibility	?	?	?	?	✓
Critical success factors					
Strategic fit	×	?	?	?	✓
Flexible & sustainable solution	×	?	?	✓	✓
Potential affordability	✓	✓	✓	✓	?
Promotes optimum patient flow	×	?	?	?	✓
Potential value for money	×	✓	✓	✓	?
Potential achievability	✓	✓	✓	?	✓
Summary	Discounted	Carried forward	Carried forward	Carried forward	Carried forward

Having carried out this initial assessment against the objectives and critical success factors a further assessment using clinical, non-financial assessment criteria was carried out at a clinically led workshop.

4.4 Initial Assessment of the Options

A workshop took place on Friday 28th June 2019 for the clinical body to undertake a clinical appraisal of the short list of options that were generated from the discussions at the steering group, and agree the preferred options to take forward to financial appraisal and outline business case development. The outcome would then be the mandate for the next phase of the EKH Oncology Programme steering group's work plan and provide the information to produce the scope for the programme.

It was explained that a very long list of sub-options was developed in the steering group using a number of varied iterations of the identified shortlist. An initial short list of 5 options were presented to the group and following discussion around the do nothing and do minimum refurb options (1 & 2) it was suggested that a 6th option should be considered to include "a refurb plus expansion" option, as the clinical team felt that more could be achieved in the current accommodation if some expansion was possible. It was therefore agreed to add a 6th option for consideration against the same assessment criteria.

Since the initial assessment of the 6 options, due to the COVID -19 pandemic there was been a pause in the programme. It was been decided that there would be a further assessment of the options due to:

- Time elapsing due to the pandemic and the need to initiate the programme of work once more
- To ensure the presence of a wider range of clinicians from both organisations at the assessment of the options
- One of the LINAC machines has now been replaced (as described above)

The initial assessment of the options considered the following options:

1. Do nothing– retain the current accommodation as

2. Do minimum - Refurbishment & updating of the current accommodation

3. A new build - A new building to accommodate the radiotherapy services that are currently provided in the 1937 building

4. A new build plus – A new building to accommodate a co-located oncology service to include, radio-therapy, chemotherapy, outpatients, related clinical support & administration services and enhanced patient amenities.

5. A new build plus (located off site) - A new building to accommodate a co-located oncology service to include, radiotherapy, chemotherapy, outpatients, related clinical support & administration services and enhanced patient amenities.

6. Two new builds – As option 4 but with a new build at Margate to accommodate 1 of the 3 east Kent LINACs

7. Refurb and expansion – A refurbishment of the existing building at Canterbury but to include an expansion into adjacent parts of the building to accommodate some growth in demand.

4.4.1 Process and Format

Each of the options were appraised using clinical & operational criteria based on whether the application of a particular option would have an impact on the current service as:

a greatly improve (score of 2)

b greatly worsen (score -2),

c would make no change (score zero),

d would somewhat improve (score 1),

e would somewhat worsen (score -1)

4.4.2 Criteria used

The criteria were focused across the identified CSFs of the programme. In line with green book guidance no weighting has been used at this stage in the process in the absence of Multi-criteria decision analysis being undertaken.

The criteria were determined following clinical and managerial discussion and additional criteria added for this second assessment of the options. The criteria used were not exhaustive but relevant for this stage in the process. A presentation was shared with all attendees of the group in advance and for each criterion specific questions were asked. For each question and criteria, information was provided for

clinicians which formed the basis of debate and tried to ensure no overlap between criteria as well as appropriately focussing conversation.

The criteria were as follows:

Strategic fit and business need fit:
Adjacency with other Clinical / Admin Support Services
Compliance of Service against National Specification
Amenities Available on site
Ability to Cover Service Provision
Training and Supervision
Recruitment and Retention
Infection Prevention and Control
Fit with EKH Acute Services Reconfiguration

Flexible and sustainable solution:
Sustainability Score on Number of Years
Future Proofing Including space required for LINACs
Service Resilience

Promotes optimum patient flow:
Patient Pathway
Continuity of Care
MDT Co-location
Patient Access

Potential achievability:
Ability to Quality Assure Service Provision
Implementation Timeline

The other CSFs will be addressed in the financial part of this case.

4.4.3 Discussion and Debate

Each criterion was discussed at length between the clinical teams and the final scores and full minutes of the assessment workshop can be found in Appendix 1. As a number of the criteria were referred to the executive steering group for final decision, this was undertaken post the initial workshop.

For strategic fit and business need it was felt that most options would see an improvement in terms of adjacency to other clinical and admin services with the exception of the Do Minimum. All options also represented an improvement in the ability to meet the national service specification, though to varying degrees. On the ability to cover service provision, it was felt that this had cross over with several other criteria and so was referred to the exec group for decision and after further review was removed from the criteria.

For training and supervision, this focussed on the need to comply with training expectations and having enough physical space for trainees which is why negative scores were recorded under options 1 and 2. For the recruitment and retention criteria it was pointed out that recruitment and retention is influenced by many factors not impacted by the proposals for example organisational culture. However, the environment within which staff work is a factor in both recruiting and retaining staff and this formed the focus of the conversation. The limitations of Options 1 and 2 resulted in the negative score whilst Option 6 presented concerns for clinicians due to fragmentation of the service across sites and therefore staff.

How far each option went toward improving infection prevention and control caused some debate in relation to Option 5 due to facilities services not being available immediately on site.

Finally, the fit with the EKHUFT acute reconfiguration criteria was referred to the executive steering group for decision. Clinicians from MTW in particular felt there was not enough information to reach a consensus score. At the executive group it was agreed that all of the options had strategic fit with both of the acute reconfiguration options being considered with the exception of Option 5. In both reconfiguration options the main oncology services remain at the Kent and Canterbury site. All options scored a 2 with a minus 1 for the off-site option.

For building a flexible and sustainable solution, as the sustainability score was closely linked to the acute reconfiguration this was also referred to the executive steering group. Scores had been suggested at the workshop and so these were maintained with the exception of a change to Option 5 which was reduced in score. In terms of future proofing for LINACs Option 7 scored the lowest after Options 1 and 2 because the work that can be done to improve the bunkers is more constrained than in the other options where they can be newly built.

For promoting optimum patient flow, Option 4 offered the best solution to the current issues due to being able to re-design the space to be fit for purpose. For continuity of care it was agreed that all options represented an improvement with the exception of Options 1 and 2 where space is so constrained, the opportunity for improvement is not available. Pre-pandemic, more emphasis was put on the need for a number of large MDT meeting spaces but following learnings from the pandemic it was decided this criterion should be removed. Patient access considered both travel times for patients to their treatment as well as parking and drop off facilities. It was agreed that the Option 6 could bring some benefits to the Thanet population but this would only be for certain treatments so this was scored as offering some improvement compared with all the other options.

The two criteria considered under achievability were quality assurance and implementation timelines. Major improvement from a CQC perspective was not expected under Options 1, 2 and 7. Implementation timelines were unknown for Options 1 and 2 but broadly the same for the other options though with different delays potentially presenting as part of each. For example, planning delays may be expected under Option 4 as opposed to logistical complexity under option 7. The off-site option was scored as a 0 due to the lack of disruption to any other services for this option and the remainder at -1 due to the disruption to either oncology or other EKH services.

The Criteria and scores are presented below:

4.4.4 Initial appraisal of short list Scores

Note: In line with HM Treasury Guidance, the full appraisal of short list happens at Outline Business Case (OBC) stage, not at Strategic Outline Case (SOC) Stage

Criteria	Option 1 - Do Min	Option 2 - Refurb	Option 3 - New Build	Option 4 - New Build Plus	Option 5 - New Build Plus Off site	Option 6 - New Build plus Margate	Option 7 - Refurb and Extension
Adjacency with other Clinical / Admin Support Services	0	1	1	2	1	1	1
Compliance of Service against National Specification	-1	0	1	2	1	1	2
Amenities Available on site	-1	-1	1	2	1	1	1
Ability to Cover Service Provision	0	0	0	0	0	0	0
Training and Supervision	-1	-1	2	2	2	1	1
Recruitment and Retention	-1	-1	1	2	2	-1	1
Infection Prevention and Control	0	0	2	2	1	2	0
Fit with EKHUFT Acute Services Reconfiguration	2	2	2	2	-1	2	2
Sustainability Score on Number of Years	-1	-1	1	2	1	1	1
Future Proofing Including space required for LINACs	-1	0	2	2	2	2	1
Service Resilience	-1	-1	1	2	2	1	1
Patient Pathway	0	0	1	2	1	-1	1
Continuity of Care	-1	-1	1	2	1	1	1
MDT Co-location	0	0	0	0	0	0	0
Patient Access	0	0	0	0	0	1	0
Ability to Quality Assure Service Provision	0	0	1	2	1	1	0
Implementation Timeline	-1	-1	-1	-1	0	-1	-1
Current Total	-7	-4	16	25	15	12	12
Original Total (from workshop)	-8	-5	17	26	19	15	13
	Referred to Exec Group for decision						
	Not required						

4.5 Outcome of the Initial Assessment of the Options

Following the assessment of the options it was decided that all options with the exception of Options 1 and 2 should be considered for financial evaluation. The highest scoring option is the New Build plus, Option 4 which supports the preferred way forward identified in the initial shortlisting process. At the present time all other options remained on the table.

It is important to note that further to the initial assessment of the options the team gave more consideration to how well Option 1 and 2 (above) were able to meet the essential aims of the case and were credible for use as a Do Minimum. It was agreed further development work was required on a Do Minimum. Both Options 1 and 2 scored negatively and will be unsuccessful in achieving the aims the case sets out.

4.5.1 Rejection of the do-nothing option

Do Nothing was originally considered as Business as Usual Scenario with no planned investment required to maintain both the building and the LINACs. The time elapse since this work means that the Do Nothing / Business as Usual will also require investment given the age and condition of the building and the equipment.

Whilst equipment is often used past the end of its useful life there is an increasing risk that the oldest LINAC, due for replacement last year, will fail with a 2nd machine due for replacement in 2024. This scenario will represent the 'do nothing' baseline for the case. It is recognised that we would continue to run all 3 LINACS until such time equipment fails.

Should a LINAC fail then approximately 30% of the current activity would be impacted and waiting times would immediately increase, likely outside of the national standards. Some additional activity would be delivered through extended working days and weekend working on the remaining 2 machines recognising a further machine is also due to replacement in 2024 and therefore coming to the end of its life. Currently additional activity from the Maidstone service through extended days/weekend working would be very limited due to staffing constraints. The service already has significant access challenges and an improvement programme to meet demand within acceptable timescales.

Given cancer treatment is very time dependent alternative provision would need to be sourced and there are a number of options all of which would incur a revenue cost and be a cost pressure to MTW. These solutions include:

- Purchasing capacity outside of K&M – this will result in reduced access for east Kent patients related to time and travel costs
- A mobile LINAC solution – the specification of mobile machines is constrained and therefore types of treatments are likely to be limited

The do nothing would also need to consider making short term improvements to the current environment due to regular water leaks and vermin infestations. Whilst this is part of EKHUFTs ongoing maintenance responsibilities there are well-documented and very substantial backlog maintenance delays due to the age and condition of many of their buildings.

4.5.2 Rejection of the do-minimum option.

This do-minimum refers to no additional estate provision, rather a straight forward internal refurbishment of the current estate. As outlined in the case for change the current estate is fundamentally not fit for purpose, specifically the 2 oldest radiotherapy bunkers are now too small to house the new and most modern LINACs. If the bunkers are not re-provided then there will be significant restrictions on the type of treatments that are possible for next 10 years. This will cause a negative impact on the population and a widening inequality with the rest of K&M. This option would have a negative impact on recruitment and retention as it would deliver a long-term solution that was inadequate and unattractive. It would also represent very poor value for money.

A New Do Minimum option was requested by the EKH Board which considered affordability and the resolved the issues with the current bunkers. Clinicians from both Radiotherapy and Chemotherapy services prioritised issues for resolution and from this a phased Do Minimum was developed. Phase 1 and 2 of the Do Minimum will see a new building erected behind the existing centre with 2 new bunkers and associated preparation areas as well as an Outpatient suite. As part of these phases remaining shielding upgrades required to the 3rd bunker will occur thereby increasing the types of treatment that can be undertaken. Phases 3 and 4 of the Do Minimum are not costed within this OBC and would need to be considered at a later stage but include major refurbishment of the existing radiotherapy areas and chemotherapy suite.

4.6 Reviewing the Options

The recommended approach is set out below:

> *"Revisit and refine the efficacy of the preferred way forward and other options in the short-list, because more detailed information of the associated inputs, outputs and activities will be required for preparing the economic appraisals.*
>
> *Review and test the recommended short-list against the following 'long-list to short-list' criteria:*
>
> > *Do any of the options fail to deliver the spending objectives and CSFs for the project?*
> >
> > *Do any of the options appear unlikely to deliver sufficient benefits, bearing in mind that the intention is to deliver a positive Net Present Social Value (NPSV)?*
> >
> > *Are any options clearly impractical or unfeasible – for example, the technology or land are unavailable?*
> >
> > *Is any option clearly inferior to another, because it has greater costs and lower benefits?*
> >
> > *Do any of the options violate any of the constraints – for example, are any clearly unaffordable?*
> >
> > *Are any of the options sufficiently similar to allow a single representative option to be selected for detailed analysis?*
> >
> > *Are any of the options clearly too risky?" (Project Business Case, HM Treasury, 2018)*

The above process is applied to the options that remain at the end of the SOC. These are:

- Revised Do Minimum – A refurbishment of the existing building at Canterbury including a small extension

- Option 3 – Radiotherapy Only New Build - A new building to accommodate the radiotherapy and outpatient services that are currently provided in the 1937 building
- Option 4 – New Build Plus - A new building to accommodate a co-located oncology service to include, radiotherapy, chemotherapy, outpatients, related clinical support & administration services and enhanced patient amenities
- Option 5 – New Build Plus but Off-site
- Option 6 – Two New Builds - As option 4 but with a new build at Margate to accommodate 1 of the 3 east Kent LINACs
- Option 7 – A refurbishment of the existing building at Canterbury but to include an expansion to accommodate some growth in demand.

The SOC also recommends the development of an alternative Do Minimum option that is less costly due to the programme currently having no source of funding.

4.7 Application of the Long to Short List Criteria

1. *Do any of the options fail to deliver the spending objectives and CSFs for the project?*

All of the options currently meet the spending objectives of the case and the non-financial critical success factors to varying degrees, as concluded in the initial assessment of the options.

None of the options meet the potential affordability CSF, based on an initial assessment of the options. Currently all options are unaffordable for both MTW and EKH across a five-year period. The finances for the case are being reviewed but there are unlikely to be any further material changes without amendment to the options at this stage. Full assessment of value for money can only be tested at the OBC stage when the investment will be looked at across a 60-year period.

It is therefore recommended that no options are removed from the process when assessed against this criterion.

2. *Do any of the options appear unlikely to deliver sufficient benefits, bearing in mind that the intention is to deliver a positive Net Present Social Value (NPSV)?*

All of the options are likely to deliver sufficient benefits, again to varying degrees. This will be fully tested at OBC stage. It is therefore recommended that no options are removed from the process when assessed against this criterion.

3. *Are any options clearly impractical or unfeasible – for example, the technology or land are unavailable?*

Further work has been undertaken on Option 6 and concluded that this option is not feasible. Firstly, the total staffing would need to increase to be able to provide radiotherapy care across two sites. This would not be achievable for some staff groups for example medical physics therefore support would need to be delivered remotely. Due to available staffing the LINAC could only be used for a limited number of tumours sites therefore reducing the throughput of activity, resulting in inefficient use of the machine.

Therefore, it is recommended that Option 6 is removed when assessed against this criterion as it is not feasible.

Option 5 cannot be deemed feasible or unfeasible at this time as land has not been secured and would only be secured once a decision has been reached. Further work would need to be done to identify a site and this used as a proxy before this option can be fully economically assessed.

Further to completing the SOC, a detailed assessment of the issues with the existing bunkers has been undertaken. This assessment identified that LA1C and LA2C are both below recommended HBN size and would be unable to provide the flexibility to respond to new technologies and medical advance in treatment. Work to investigate the possibilities of expanding these bunkers within the existing spatial constraints has failed to identify any practical solutions to the issues faced. Therefore, it is recommended that the Revised Do Minimum is removed when assessed against this criterion.

4. *Is any option clearly inferior to another, because it has greater costs and lower benefits?*

The main difference between Options 4 and 5 is that Option 4 is a new building on site at the Kent and Canterbury and Option 5 is off-site. The movement of this option off-site has a cost of land associated with it, currently estimated to be in the region of £4m. In the initial assessment of the options, compared to Option 4 this option scored lower for adjacency to other clinical services, patient pathway and continuity of care.

Therefore, it is recommended that Option 5 is removed when assessed against this criterion as it has greater costs and lower benefits than a very similar option.

Option 7 has been costed at over £54m. To create a new Do Minimum this option was scaled back to £38m. This was achieved through reducing some of the waiting areas, facilities, removing the café as well as clinic and admin space, therefore reducing the need for extension and some of the upper floor refurbishment. The new Do Minimum does not deliver substantially less than Option 7 yet can be achieved at a reduced cost.

Therefore, it is recommended that Option 7 is removed when assessed against this criterion.

5. *Do any of the options violate any of the constraints – for example, are any clearly unaffordable?*

All of the options are unaffordable over the short to medium term. The finances for the case are being reviewed but there are unlikely to be any further material changes without amendment to the options at this stage.

It is therefore recommended that no options are removed from the process when assessed against this criterion.

6. *Are any of the options sufficiently similar to allow a single representative option to be selected for detailed analysis?*

None of the options are sufficiently similar to allow a single representative option to be selected for detailed analysis.

7. *Are any of the options clearly too risky?"*

Option 5, is politically too risky due to the need for public consultation to enable the services to be moved off-site.

Therefore, it is recommended that Option 5 is removed when assessed against this criterion.

4.8 Summary

The outcome of the analysis above is to remove the following options from full work up in the OBC:

- Option 6 – Two New Builds - As option 4 but with a new build at Margate to accommodate 1 of the 3 east Kent LINACs
- Revised Do Minimum – A refurbishment of the existing building at Canterbury including an extension
- Option 5 – New Build Plus but Off-site

It is recognised that all options make a loss across the first 5 years, therefore further work will need to be undertaken to improve the affordability position of the all of the options presented.

4.9 Recommendations

It was recommended that the following options will be fully worked up as part of the OBC:

- Do Minimum
- Option 3 – Radiotherapy Only New Build
- Option 4 – New Build Plus
- New Build Plus on car park plot.

For clarity, and due to the number of options the project has considered over time, it is also recommended that these options are referred to as per the suggestions below going forward:

- **Option A – Do Minimum** - Total programme is a mix of new build and refurbishment
    - 2 storey new build incorporating 2 new bunkers, clinical preparation space, OP accommodation and ground level plant. (this includes £ for maternity moves that EKH need to make).
- **Option B – Radiotherapy and Outpatients Only New Build**
    - A 3-storey new build including 3 new bunkers, new CT suite, clinical prep areas, OP accommodation and MTW admin located at the Nackington Road entrance.
- **Option C – New Build**
    - A 3-storey new build including 3 new bunkers, new CT suite, clinical prep areas, OP accommodation and MTW admin and including chemotherapy located at the Nackington Road entrance.
- **Option D – New Build on car park plot** – as above but that the front of K&C on the current sexual health clinic is located

In recognition of the need to describe a 'do nothing' for service and financial comparison, this has also been included in the OBC.

4.10 Economic appraisal

4.1.1 Introduction to the economic appraisal

The purpose of the economic appraisal is to appraise and rank the shortlisted options in terms of their

relative value to society. This is done by carrying out a cost benefit analysis using a balanced judgement of two measures, the net present social value (NPSV) and the benefits to cost ratio (BCR), to identify the shortlisted option that is most likely to offer best social value. The evaluation has been carried out in accordance with HM Treasury's "Central Guidance on Appraisal and Evaluation" ("The Green Book") and HM Treasury's "Guide to Developing Project Business Cases" with the results produced using the Treasury's comprehensive investment appraisal (CIA) model (see Appendix xxx).

The base year for the evaluation is 2023/24 and the evaluation period has been set at 64 years based on a four-year project period from 2023/24 to opening and a standard 60-year life for new buildings.

4.1.2 Scope of the economic modelling

The economic appraisal differs from the financial appraisal in that it considers the project impact from the perspective of "UK PLC" and not just the two trusts and wherever possible, it assigns a monetary value to costs, benefits and risks. The table below helps to explain this difference by summarising which categories of cost, risk and benefit have been included in the economic modelling for this project.

Table 5: Scope of the economic modelling

Category of cost	Inclusion within the modelling	Notes
Opportunity costs	Excluded	Opportunity costs normally consider foregone land sale. In this case, it would not be practicable to sell the land from which the service is provided.
Land	Excluded	No land transactions in this business case
Initial capital cost	Included	Based on QS costings VAT, contingency and inflation beyond 2023/24, excluded as per Green Book
Lifecycle capital cost	Included	Based on QS costings
Optimism bias	Included	As per QS
Revenue costs	Included	Modelling limited to in-scope services i.e. costs that will alter as a result of the scheme
Avoided costs	Included	Shown within capital and revenue costs for BAU
Transitional costs	Included	Within revenue costs
Externality (displacement) costs	Excluded	None assessed as applying
Net contributions	Excluded	None apply
Costed risks	Included	Project and operational risks
Cash releasing benefits	Excluded	None apply
Non-cash releasing benefits	Included	
Monetisable societal benefits	Included	

4.1.3 Initial capital costs

The initial capital costs of the shortlisted options are shown in the table below. It should be noted that the two appraisals (the economic and financial cases) use different capital figures:

- The economic appraisal excludes sunk costs, VAT, contingency or inflation (beyond 2023/24). The contingency figure is however, used to inform the value of costed risks.

- The capital figures used in the financial case include all capital costs incurred since the start of the project, inflation (to the mid-point of construction), VAT and contingency.

The initial capital costs are summarised below:

Table 6: Initial capital costs by option

Initial capital costs	BAU	Option A	Option B	Option C	Option D
Building works	£12,086,440	£12,131,485	£22,490,621	£24,773,627	£26,130,852
Fees	£2,137,228	£2,161,167	£4,048,312	£4,459,253	£4,703,553
Non-works costs	£110,000	£4,295,404	£287,458	£287,458	£287,458
Equipment	£4,856,074	£4,856,074	£4,856,074	£4,856,074	£4,856,074
Contingency	£1,412,072	£1,418,265	£2,664,893	£2,934,288	£3,094,441
Optimism bias	£2,329,919	£2,839,367	£4,382,417	£4,825,436	£5,105,827
Sub total	£22,931,732	£27,701,763	£38,729,775	£42,136,136	£44,178,205
VAT	£4,543,757	£5,540,353	£7,745,955	£8,427,227	£8,835,641
Total capex	£27,475,489	£33,242,115	£46,475,731	£50,563,363	£53,013,846

Less contingency	-£1,412,072	-£1,418,265	-£2,664,893	-£2,934,288	-£3,094,441
Less inflation beyond 2023	-£1,157,703	-£1,413,986	-£1,940,199	-£2,108,960	-£2,210,203
Less VAT	-£4,543,757	-£5,540,353	-£7,745,955	-£8,427,227	-£8,835,641
Relevant initial capital costs for economic appraisal	**£20,361,957**	**£24,869,512**	**£34,124,683**	**£37,092,888**	**£38,873,562**

Split in economic model	BAU	Option A	Option B	Option C	Option D
Initial capital	£18,032,039	£22,030,145	£29,742,266	£32,267,452	£33,767,735
Optimism bias	£2,329,919	£2,839,367	£4,382,417	£4,825,436	£5,105,827
Relevant initial capital costs for economic appraisal	**£20,361,957**	**£24,869,512**	**£34,124,683**	**£37,092,888**	**£38,873,562**

Discounted cost in economic appraisal	***£18,441,302***	***£22,523,678***	***£30,905,848***	***£33,594,076***	***£35,206,786***

The initial capital investment required under the four "do something" options has been worked up by the Trust's cost advisers, Helden Consultants Limited and also include the cost of a new Linac. The BAU capital cost covers a modular building to house a third Linac as well as the cost of a new Linac. Further details of the costs for all four do something options can be found in Appendix 1.

4.1.4 Lifecycle capital costs

In addition to the initial capital investment, the following lifecycle capital investment would be needed over the next 60 years.

Table 7: Lifecycle capital costs

Lifecycle costs	BAU	Option A	Option B	Option C	Option D
Whole project (4+60 years)	£44,484,697	£58,160,253	£79,804,549	£86,746,043	£90,910,357
Annual average	£695,073	£908,754	£1,246,946	£1,355,407	£1,420,474
Excl VAT (for economic appraisal)	£37,070,581	£48,466,878	£66,503,791	£72,288,369	£75,758,630
Discounted costs	*£12,081,831*	*£18,168,811*	*£24,930,320*	*£27,098,789*	*£28,399,689*

Lifecycle costs for Option A were worked up by Helden's and these have been used as the basis of calculations to estimate the costs of the new build options (options B, C and D). The lifecycle costs of the BAU assume the modular building has a 20-year useful economic life, so is replaced twice during the 60-year period modelled. Taking initial capital costs, optimism bias and lifecycle costs together gives the following combined actual and discounted capital costs within the economic model.

Table 8: Total lifetime capital cost

Lifetime capital costs	BAU	Option A	Option B	Option C	Option D
Initial capital	£18,032,039	£22,030,145	£29,742,266	£32,267,452	£33,767,735
Optimism bias	£2,329,919	£2,839,367	£4,382,417	£4,825,436	£5,105,827
Sub-total initial capital	£20,361,957	£24,869,512	£34,124,683	£37,092,888	£38,873,562
Lifecycle capital	£37,070,581	£48,466,878	£66,503,791	£72,288,369	£75,758,630
Total	£57,432,539	£73,336,390	£100,628,473	£109,381,257	£114,632,193
Discounted costs	*£30,523,133*	*£40,692,489*	*£55,836,169*	*£60,692,865*	*£63,606,475*

Revenue costs

The revenue costs included in the CIA are the direct costs of in-scope services and the related estate (facilities costs) excluding capital charges. Costs in-scope relate to both the radiotherapy and chemotherapy services. Staff pay costs remain unchanged once the new facility is opened. In Year 1 of opening there is a non-recurrent non-pay cost of relocating Linac's. In the years post-opening non-pay and overheads costs also increase significantly reflecting the increase in facilities costs, particularly for the new build options.

The discounted revenue costs included in the economic evaluation are summarised by option, below.

Table 11: Net revenue costs (discounted)

Net revenue costs (discounted)	Option 0 (BAU)	Option A	Option B	Option C	Option D
Radiotherapy & chemotherapy	£329,907,392	£344,962,505	£364,603,200	£356,918,210	£356,918,045
Total	**£329,907,392**	**£344,962,505**	**£364,603,200**	**£356,918,210**	**£356,918,045**

4.1.6 Costed risks

The following costed risks are included in the appraisal.

Table 12: Costed risks (discounted)

Costed risks (discounted)	Option 0 (BAU)	Option A	Option B	Option C	Option D
Project risks	£1,278,877	£1,284,486	£2,413,525	£2,657,509	£2,802,555
Operational risks	£15,228	£45,683	£45,683	£45,683	£45,683
Total costed risks	**£1,294,105**	**£1,330,170**	**£2,459,209**	**£2,703,193**	**£2,848,239**

The project-related costed risks are based on the contingency within the capital cost estimated by the trusts' cost consultants shown in OB forms (see Appendix 2). Operational risks relate to the risk of disruption during the project and commissioning phases (BAU has lower operational risk costs because only one Linac is commissioned).

4.1.7 Monetised benefits

Two categories of monetised benefit are included in the economic evaluation:

- **Non-cash releasing benefits (Non-CRB) for the NHS.** These benefits are those where an option may improve overall productivity, but this will not result in direct savings, instead being realised through enhanced quality of care or ability to support activity growth more cost effectively. For example, options will increase the amount of patient facing time staff are able to deliver as a result of improving the physical layout of the departments. The Trust does not expect to reduce staff numbers as a result; the gain is staff being able to provide better quality care and absorb growth in activity without increasing costs. Non-CRBs also include the benefit of freeing-up space within the existing building and a forecast reduction in unplanned Linac downtime caused by estate problems.

- **Societal benefits (SB).** These are benefits that do not affect NHS finances or efficiency in any way, but still have a positive impact on society. A good example is where an option may increase the likelihood of good patient outcomes. Where possible the appraisal has identified a financial figure to represent the social "value" of these benefits. As an example, this category has been used to reflect the benefit of being able to repatriate some work from Maidstone.

The whole life discounted value of non-CRBs is summarised by option, below.

Table 16: Non-cash releasing benefits

Non-cash releasing benefits (discounted)	Description	Option 0 (BAU)	Option A	Option B	Option C	Option D
NCRB1	Evidence based design	£584,668	£1,754,003	£1,754,003	£3,157,205	£3,157,205
NCRB2	Improved layouts (more value adding patient time)	£1,278,951	£1,937,805	£3,875,609	£9,293,725	£6,970,294
NCRB3	Improved service resilience	£305,751	£917,252	£917,252	£917,252	£917,252
NCRB4	Staff recruitment & retention	£0	£93,696	£96,150	£154,936	£154,936
NCRB5	Improved integration of chemo & radiotherapy services	£0	£0	£0	£0	£0
NCRB6	Freed-up space	£0	£19,678,494	£19,678,494	£19,678,494	£19,678,494
NCRB7	Improved maternity environment	£0	£2,859,931	£0	£0	£0
Total		**£2,169,369**	**£27,241,180**	**£26,321,507**	**£33,201,611**	**£30,878,179**

The most material benefit is the space freed-up in the 1937 building which would then become available for other new or expanded services. This space has been given a value based on the potential financial contribution per metre squared of usable space.

Other important non-CRBs are benefits accruing from a fit for purpose estate with layouts, environment etc reflecting modern evidence-based design and associated standards as set out in health building notes. This creates three non-CRBs:

- Value to both chemotherapy and radiotherapy measured as a reduction in the number of errors linked to environmental factors such as poor lighting and acoustics, which would be resolved through the proposed investment.
- An increase in patient facing time achieved through better departmental layouts that support operational flow. As with the previous benefit, there is a wealth of literature setting out efficiency and quality benefits linked to better buildings. This benefit is more material for the 100% new build options because of some compromises that will be inevitable under Option A. A benefit has been ascribed to the BAU in relation to the modular building.
- The same type of benefit applied to the maternity department which would be re-provided under Option A.

The investment will also replace old, often failing estate with a physical environment which would not be expected to fail. This is recognised in the economic assessment as an assumption that unplanned Linac downtime caused by problems with the physical environment, is halved.

Both trusts also expect an improved physical environment will assist with staff recruitment and retention.

The final group of benefits that have been monetised are societal benefits. These benefits are to patients, their families and society as a whole. The Trust's approach has been to recognise benefits such as better-quality services for people who use services and their wider families in the consideration of benefits, but not to attempt to quantify most of these benefits because of the risk of double counting. At a high-level the societal benefits expected can be summarised as per the table below.

Table 17: Wider societal benefits

Benefit to	Benefit
'UK PLC' – the economy	'Gross Value Add' – the economic impact of the construction and wider project Social value add through the project Tax revenues Employment
Local people	Social value including local employment Improved environment Carbon reduction
People who use our services and their families	Positive health impacts Reduced length of stay Improved outcomes and wellbeing

The societal benefits that have been monetised are as follows.

Table 18: Societal benefits

Societal benefits (discounted)	Description	Option 0 (BAU)	Option A	Option B	Option C	Option D
SB1	Evidence based design	£0	£818,804	£818,804	£867,833	£1,473,847
SB2	Improved patient outcomes e.g. from local access & new equipment -	£0	£0	£0	£0	£0
SB3	Avoids reduction in Health Inqualities (DISbenefit of BAU)	£0	£0	£0	£0	£0
SB4	Repatriation of EK work from Maidstone to Canterbury - benefit to patients: less travel time & cost	£12,544,798	£25,089,597	£25,089,597	£25,089,597	£25,089,597
SB5	Repatriation of EK work from Maidstone to Canterbury - benefit to patients: more patients access Rx	£40,623,401	£81,246,802	£81,246,802	£81,246,802	£81,246,802
SB6	Research benefit	£0	£0	£0	£0	£0
SB7	Improved maternity environment	£0	£1,290,140	£0	£0	£0
Total		**£53,168,199**	**£108,445,342**	**£107,155,203**	**£107,204,232**	**£107,810,246**

This category of benefit is the most material. The evidence-base design benefits discussed above benefit patients as well as the trusts, resulting in the evidence-based design benefit also featuring as a societal benefit.

The most material societal benefit is an increase in activity at Canterbury under all options due to some breast and urological cancer treatments being repatriated from Maidstone. Currently two of the three Linac's at Canterbury are limited in terms of patient suitability resulting in activity being moved to Maidstone; under options A – D there will be no restrictions, whilst under the BAU the Linac in the modular building will also have no restrictions but one of the two other Linac's will continue to be restricted. The assumption is that some people currently not willing to travel the longer distance to Maidstone will start accessing treatment if provided in Canterbury – this particularly impacts on people living in the Thanet and surrounding areas furthest from Maidstone. This repatriation of work has a QALY-based benefit regarding patient outcomes and a separate time and cost benefit to those patients who currently do travel to Maidstone but who will now have shorter journeys. The benefit has the same value under options A, B, C and D because we assume the same number of patients would benefit under each option. A 50% adjustment has been applied to the BAU to reflect one Linac still having a restricted use.

Net present societal value

Bringing capital and revenue costs, costed risks, non-cash releasing benefits and monetised societal benefits together, gives the following incremental net present societal values (NPSV) and benefit to cost ratios (BCR) for the whole life of the project.

Table 19: Incremental NPSV and cost benefit ratio

Discounted costs & benefits - incremental from BAU	Option 0 (BAU)	Option A	Option B	Option C	Option D
Incremental costs:					
Capital	£0	-£9,707,961	-£23,454,141	-£27,909,606	-£30,569,273
Optimism bias	£0	-£461,394	-£1,858,895	-£2,260,126	-£2,514,069
Revenue	£0	-£15,055,113	-£34,695,808	-£27,010,818	-£27,010,653
Net contribution	£0	£0	£0	£0	£0
Costed risks	£0	-£36,065	-£1,165,104	-£1,409,088	-£1,554,134
Total incremental costs	**£0**	**-£25,260,533**	**-£61,173,948**	**-£58,589,637**	**-£61,648,129**
Incremental benefits:					
Cash releasing benefits	£0	£0	£0	£0	£0
Non-cash releasing benefits	£0	£25,071,811	£24,152,138	£31,032,242	£28,708,810
Societal benefits	£0	£55,277,143	£53,987,003	£54,036,033	£54,642,046
Total incremental benefits	**£0**	**£80,348,954**	**£78,139,141**	**£85,068,274**	**£83,350,857**
Net societal value	**£0**	**£55,088,420**	**£16,965,194**	**£26,478,637**	**£21,702,728**
NPSV rank	5	1	4	2	3
Benefit to cost ratio	**0.00**	**3.18**	**1.28**	**1.45**	**1.35**
BCR rank	5	1	4	2	3

In comparison with the BAU, all four 'do something' options have a positive NPSV. Option A delivers the highest NPSV and the highest BCR (which is close to the HM Treasury 'rule of thumb' target of 4.0).

Selection of preferred option

The choice of preference (the "Preferred Option" at OBC) should be made "in the round" by considering both

the value for money results (with the BCR being the primary metric) and the non-financial assessment. Option A was the preference on a non-financial basis and is ranked highest for BCR and NPSV so is confirmed as the preference subject to switching and sensitivity analysis.

Switching points and downside sensitivity analysis

Switching analysis was carried out to understand the point at which the preference based on BCR would switch from Option A to the second ranked option, Option C. The results were:

- A 75% increase in the lifetime capital costs of Option A would be needed to switch preference to Option C. This level of increase is not considered credible.
- An 9% increase in the annual revenue costs of Option A would switch the preference to Option C. Although this level of increase could be possible, any increase to option A's revenue costs would probably also apply to all other options so it would be unlikely that any increase would actually switch the preference to option C.
- A further test was carried out to estimate the impact of reducing monetised societal benefits linked to Option A. The result was that Option A's benefits would need to reduce to 59% of the estimated value for the switch to occur. Again, it is unlikely that a reduction in Option A's benefits would not also impact Option C given the overlap in benefits listed.

Sensitivity analysis was carried out to ascertain the impact on the BCR of cost increases/ reductions in benefits. The results were:

- A 10% increase in lifetime capital costs would reduce the BCR of Option A from 3.18 to 1.34.
- A 10% increase in annual revenue costs would reduce the BCR of Option A to 2.74.
- A 10% reduction in the value of societal benefits would reduce the BCR to 2.75.

The conclusion of the switching and sensitivity analysis is that there are no credible scenarios under which the preference would switch to Option B.

4.11 Conclusion to the economic case

The economic assessment confirms that Option A represents the best value for money, so should be considered the recommended option.

5 The Commercial Case

The delivery of the agreed scheme, regardless of which option is chosen, will require a full procurement process to be followed as parts of all of the options require the provision of a level of new estate. The specification will be developed for the full business case and the procurement process and timeline confirmed for the preferred option.

5.1 General Considerations:

It is imperative that any procurement associated with this scheme, regardless of the option to be taken forward, ensures the best value for money and, in addition is completed in a timely manner and due consideration is given to Health and Safety to provide a facility, built with zero defects and that suits the end user requirements in full.

Consideration also needs to be given to the route that will allow the provision of clinical services to be maintained throughout the works will little or no impact on that service provision.

5.2 Options

The procurement routes available for this scheme will be very much dependant on which option is taken forward.

- Option A - Do Minimum

The extent of the refurbishment could, potentially further guide the procurement route to be considered.

A refurbishment could be taken forward using a traditional specification and drawing tendering process based on one of JCT forms of contract.

- Options B/C/D – A new build

There are numerous construction frameworks which can be used for the procurement of the new build schemes these include

a ProCure22 (P22) is a Construction Procurement Framework administrated by the Department of Health & Social Care for the development and delivery of NHS and Social Care capital schemes in England. It is consistent with the requirements of Government Policy including the Productivity and Efficiency agenda; the Government Construction Strategy; the Public Contracts Regulations 2015; the National Audit Office guidance on use of centralised frameworks; and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector. It includes six contractors, each of which would be invited to submit an expression of interest at the outset of the scheme

b SCAPE Framework, which includes three contractors over three price bands, with a single contractor being in place for each band. The framework is based on a direct appointment dependant on the price band and allow for an early engagement with a single contractor.

c Pagabo Framework, which is a “further competition” or “direct award” framework which includes 13 contractors across three project bands. This framework would have the option, which for direct award for early engagement with contractor (as above) but has the added benefit of mini competition.

5.3 Wholly owned subsidiary (WOS)

EKH operate a WOS company and consideration should be given to carrying out the developments, regardless of option, to be taken forward by procurement through this company.

If procurement through the WOS is followed there will still be a requirement to consider the procurement options as identified above.

6.0 The Financial Case

Growth levels have been assumed as 1-2% per annum based on demographic growth, cancer incidence rates and national guidance. No assumptions have been included regarding private patient income at this stage but this will be reviewed as part of the Full Business Case.
The recommended do minimum option (A) has a capital cost of £33.24m compared to the other options representing new builds range in cost from £46 to 53m. Whilst all of the options have additional cost to business as usual, option, A, delivers the least additional cost and delivers a much-improved quality and sustainable service.

This section models the financials for all the options included in this case. Information provided includes the estimated capital cost, the impact on income from activity growth and the high-level estimate of changes in infrastructure costs related to the new build based on the currently available information. A summary of the options is included followed by narrative on each option.

Due to the scale of required investment, the source of funding has not currently been identified for this project. This will require further discussion at the Finance and Performance committees of both organisations. The programme has been included in the ICS estates strategy and the case would require ICB approval. The recommended option in this business case would not need NHSE approval as the total value remains under £25m however it is noted that other options would require NHSE approval due to their total value exceeding £25m.

6.1 General Financial Assumptions for all Options

Activity assumptions

Growth levels have been assumed as 1-2% per annum based on demographic growth, cancer incidence rates and national guidance. The following sources were referenced in relation to this:

- Specialised Commissioning Team
- Cancer Research
- Kent County Council
- Other centres (Nationally)

No assumptions have been included regarding private patient income at this stage but this will be reviewed as part of the Full Business Case.

Hard and Soft FM costs are assumed to be the same as they are currently charged in the SLA between organisations. Therefore, the increase in square meterage causes a significant increase in these costs. It is possible that these could be reduced in a new build scenario and will be further considered at FBC stage.

For all of the options, as there is now, there will be a need for re-charge between the organisations for rental costs, either ground and/or building rental. The calculations made include these so that the impact on contribution for each organisation of each option is understood.
There will be a full analysis and recommendations regarding the workforce productivity gains that will be achieved as part of the more streamlined and modern workflows that will emerge with the transfer to a purpose-designed oncology unit. This will focus mainly on the radiotherapy pathway.

The capital costs have been estimated by a quantity surveyor following development of each option with external architects, attached at Appendix 3. An optimism bias to cover planning and costing uncertainties has been added to the baseline capital costs.

The case assumes replacement of the next 2 LINACs in line with the national guidance assumption of 10 years useful life. Similarly, the CT Simulator was due for replacement in 2023/24 and therefore it is recommended this is included in the full business case.

The current land charge is assumed to be included in the Trust to Trust SLA as a revenue rental and this has been used to model the cost of the larger facility. However, under the change of accounting that took place in April 2020 for IFRS 16 (Leases) it is anticipated that the lease element for the land will require to be capitalised on the balance sheet, and treated as a "right to use asset" under a finance lease. This is unlikely to materially change the impact on revenue costs but would require the capital resource to account for the lease impact in year. As assumption that the current rate of land rental, has been increased in line with the increase in size of the build.

A detailed list of assumptions, capital proformas and full costing schedules for the Do Minimum option are included in Appendix 4.

6.2 Summary of the Options

Capital Purchase / Build Costs
Table 20

	Business as Usual	Option A: Do Mini-mum	Option B: RT and OP New Build	Option C: Canterbury New Build	Option D: Canterbury New Build (Car Park)
Modular Build (RT)	21,435,250				
Refurbishment Costs		22,128,341			
Decant Costs		4,923,535			
Bunker Upgrade		150,000			
Radiotherapy New Build			40,435,492		
3 Storey New Build				44,523,125	
3 Storey New Build Car Park					46,973,607
Truebeam Linac (3 truebeam)	5,827,289	5,827,289	5,827,289	5,827,289	5,827,289
One off (not per Linac)	212,950	212,950	212,950	212,950	212,950
Total	**27,475,489**	**33,242,115**	**46,475,731**	**50,563,363**	**53,013,846**

6.3 Financial Baseline Information

The current service makes a significant positive financial contribution to the both organisations income and expenditure, in part related to the age and condition of the existing site infrastructure.

Baseline - Income and Expenditure

MTW Radiotherapy

Pay	WTE	Annual Gross £
Therapeutic Radiography	29.62	1,393,920
Radiotherapy Physics	16.63	925,336
Medical Physics Engineering (Cant)	3.00	176,622
Management Costs	1.29	132,560
Total Pay	**50.54**	**2,628,438**
Non Pay		
Therapeutic Radiography		11,000
Radiotherapy Physics		36,600
Medical Physics Engineering (Cant)		188,600
East Kent RT SLA		297,948
Total Non Pay		**534,148**
Depreciation and Capital Charges		
Linac Depreciation (x3)		644,364
CCU and Delta 4		23,547
Total Depr and Capital Charges		**667,911**
Overheads		
Est overheads @ 11.68% of Yr1 Expenditure		**369,390**
Income		
Radiotherapy Income		-4,440,978
Radiotherapy Service Annual Contribution		**-241,091**

Income

- MTW income is generated from the planning and delivery of radiotherapy fractions from the three current linear accelerator machines.
- EKHUFT income is generated from the planning and delivery of Outpatient clinics and chemotherapy services.
- This income is received from NHSE/I Specialist Commissioners. The additional activity and income assumptions will need to be agreed with the commissioning body, currently the NHSE/I Specialist Commissioners.
- The income is priced using national tariffs for the relevant component HRGs and the local MFF (1.100953 for 2019/20). Income is based on the current planning and treatment HRG national tariffs plus MFF. It is recognised that this may not be the case in future years but is yet to be confirmed.
- the income in the baseline and all options includes a growth assumption

Table 21- year 1 only income

Income

	Business as Usual	Option A: Do Minimum	Option B: RT and OP New Build	Option C: Canterbury New Build	Option D: Canterbury New Build (Car Park)
Radiotherapy	-4,440,978	-4,440,978	-4,440,978	-4,440,978	-4,440,978
Outpatients, Chemotherapy and RT SLA	-7,115,854	-7,422,936	-7,739,713	-7,469,416	-7,469,416
Total	**-11,556,832**	**-11,863,914**	**-12,180,691**	**-11,910,394**	**-11,910,394**

Costs

- The majority of pay costs relate to the staff directly responsible for the provision of the clinical services. These include Radiotherapy, Radiotherapy Physics, Medical Physics Engineering Chemotherapy, outpatient and administration staff.
- Direct non-pay costs for MTW comprise of;
  - Maintenance consumables to maintain the linear accelerators
  - Maintenance contracts for the machines
- Direct non-pay costs for both organisations include:
  - Trust to Trust SLA charge from EKHFT for accommodation costs of the Radiotherapy service
  - General department consumables.
- Indirect Non-Pay costs for EKH relate to support services such as Pathology, Pharmacy and Radiological services.
  - Overheads are estimated at 11.68% for MTW and 14% for EKH (covering non-directly charged Trust costs including, estates, corporate costs and CNST) derived from the Trust's costing model/SLR.
  - Rechargeable High Cost Drugs are excluded from income and expenditure.

Table 22 – year 1 only expenditure

Total Expenditure

	Business as Usual	Option A: Do Minimum	Option B: RT and OP New Build	Option C: Canterbury New Build	Option D: Canterbury New Build (Car Park)
Radiotherapy	6,369,391	5,882,757	7,237,830	6,700,723	6,797,270
Outpatients and Chemotherapy	8,407,877	9,737,320	9,984,830	10,384,475	10,438,105
Total	**14,777,268**	**15,620,076**	**17,222,660**	**17,085,198**	**17,235,376**

The linear accelerator machines and associated equipment is owned by MTW but the bunkers and accommodation are provided by EKH under a Service Level Agreement and therefore the assets are on EKH asset register.

5.4 Business as usual

Whilst equipment is often used past the end of its useful life there is an increasing risk that the oldest LINAC, due for replacement 2 years ago, will fail. This scenario represents the 'do nothing' baseline for the case. It is recognised that we would continue to run all 3 LINACS until such time equipment fails.

Should a LINAC fail then approximately 30% of the current activity would be impacted and waiting times would immediately increase, likely outside of the national standards. Some additional activity would be delivered through extended working days and weekend working on the remaining 2 machines recognising the one of the machines is also due to replacement in 2024 and therefore coming to the end of its life.

Currently additional activity from the Maidstone service through extended days/weekend working would be very limited due to staffing constraints. The service already has significant access challenges and an improvement programme to meet demand within acceptable timescales.

Given cancer treatment is very time dependent alternative provision would need to be sourced and there are a number of options all of which would incur a revenue cost and be a cost pressure to MTW. These solutions include:

- Purchasing capacity outside of K&M – this will result in reduced access for east Kent patients related to time and travel costs
- A mobile LINAC solution – the specification of mobile machines is constrained and therefore types of treatments are likely to be limited

The do nothing would also need to consider making short term improvements to the current environment due to regular water leaks and vermin infestations. Whilst this is part of EKHUFTs ongoing maintenance responsibilities there are well-documented and very substantial backlog maintenance delays due to the age and condition of many of their buildings.

The following table demonstrates the financial impact of the options over 10 years and the comparison to the predicated business as usual costs:

10 Year - Income and Expenditure Comparison

10 Year Income and Expenditure Comparison

		Business as Usual	Option A: Do Minimum	Option B: RT and OP New Build	Option C: Canterbury New Build	Option D: Canterbury New Build (Car Park)
Pay	Radiotherapy	28,838,856	28,838,856	28,838,856	28,838,856	28,838,856
	Outpatients and Chemotherapy	36,745,659	36,745,659	36,745,659	36,745,659	36,745,659
Total Pay		**65,584,515**	**65,584,515**	**65,584,515**	**65,584,515**	**65,584,515**
Non Pay	Radiotherapy	6,759,399	8,829,899	12,206,473	9,503,495	9,503,495
	Outpatients and Chemotherapy	32,147,360	37,308,017	42,940,895	42,169,232	42,169,232
Total Non Pay		**38,906,759**	**46,137,916**	**55,147,368**	**51,672,728**	**51,672,728**
Depreciation	Radiotherapy	15,363,963	7,114,391	9,771,311	8,905,751	9,140,183
	Outpatients and Chemotherapy	0	3,756,771	1,614,275	3,161,107	3,335,089
Total Capital		**15,363,963**	**10,871,162**	**11,385,586**	**12,066,858**	**12,475,272**
Capital Charges	Radiotherapy	6,509,358	5,946,978	11,166,549	9,500,346	9,951,626
	Outpatients and Chemotherapy	0	3,785,309	3,107,479	6,085,131	6,420,047
Total Capital Charges		**6,509,358**	**9,732,287**	**14,274,028**	**15,585,477**	**16,371,674**
Overheads	Radiotherapy	4,157,876	3,992,263	3,992,263	3,992,263	3,992,263
	Outpatients and Chemotherapy	15,185,749	15,185,749	15,185,749	15,185,749	15,185,749
Total Overheads		**19,343,625**	**19,178,012**	**19,178,012**	**19,178,012**	**19,178,012**
Total Expenditure	**Radiotherapy**	**61,629,452**	**54,722,388**	**65,975,453**	**60,740,711**	**61,426,423**
	Outpatients and Chemotherapy	**84,078,767**	**96,781,504**	**99,594,056**	**103,346,878**	**103,855,777**
	Total	**145,708,219**	**151,503,892**	**165,569,509**	**164,087,590**	**165,282,200**
Total Income	Radiotherapy	-48,628,188	-48,628,188	-48,628,188	-48,628,188	-48,628,188
	Outpatients, Chemotherapy and RT SLA	-77,931,484	-79,584,384	-82,752,158	-80,049,180	-80,049,180
	Total	**-126,559,672**	**-128,212,572**	**-131,380,346**	**-128,677,368**	**-128,677,368**
Surplus / (Loss)	**Radiotherapy**	**-13,001,264**	**-6,094,200**	**-17,347,264**	**-12,112,523**	**-12,798,235**
	Outpatients and Chemotherapy	**-6,147,284**	**-17,197,120**	**-16,841,899**	**-23,297,698**	**-23,806,597**
	Total	**-19,148,547**	**-23,291,320**	**-34,189,163**	**-35,410,222**	**-36,604,832**
	Overall Change from Business as Usual	*0*	*-4,142,772*	*-15,040,616*	*-16,261,674*	*-17,456,285*

Whilst all of the options have additional cost to business as usual, the preferred option, A, delivers the least additional cost and delivers a much-improved quality and sustainable service.

7.0 The Management Case

A project team of clinicians, executive directors, senior service management and operational staff has been in place for many years. This team has overseen the development of the business case and will continue to so as the Full Business Case is developed. Programme Governance will also remain in place.

7.1 Stakeholder support

The development of the east Kent oncology service is supported by the boards of each Trust. The cancer leads at Specialised Commissioning, and NHS Kent and Medway are aware of the programme and have engaged in including it in the K&M estates plan. A programme director from the Cancer Alliance is a member of the EKH Oncology steering group.

7.2 Project management arrangements

Programme Governance

Executive Programme Board (joint co-chairs) – Rachel Jones of Strategy, Planning & Partnerships & Nicky Bentley Director of Strategic Development & Capital Planning
Remit: Approval & Authority; Allocation of Resources

Project Steering Committee (chair – Gráinne Barron, head of performance & delivery for cancer services MTW)
Remit: Delivery of key work-packages; Identify & manage key risks & issues; Make recommendations i.e. resources, work-plan; Service model & build design.

Clinical Reference Group (CRG) chair – Dr Kannon Nathan Consultant Clinical Oncologist MTW
Remit:

Develop & recommend clinical & service model;
Create appropriate specialty level subgroups;
Advise the design & build;
Agree patient pathways across all aspects of oncology care;
Develop a workforce plan;
Ensure appropriate IM&T infrastructure;
Develop an equipment & products plan.

Operations, Finance Working Groups (key leads- Stuart Doyle, Stephen Duck, Amanda Williams, Sarah Collins, Amy Seymour):
Remit:

Confirm activity levels & associated costs;
Confirm current baseline costs, I&E;
Financial appraisal of preferred options;
Evaluation of capital costs;
Agree procurement options;
Business case development;
Operational policy development.

Design & Build Team (key leads Estates MTW & Estates EKH):
Remit:

Agree suitability of allocated location;
Provide design options based on service model & outputs from CRG;
Confirm level of enabling works;
Confirm plan for decant & evacuation of preferred location;
Car parking;
Access & egress.

The programme steering group oversees the delivery of the workstreams and are responsible for reporting progress, reviewing actions and risks. The steering group meets monthly and membership is cast widely among the clinical, admin and support services across both Trusts.

The technical leadership and project management is provided by both Trusts.

The programme governance arrangements have been developed and approved through the EKH Programme Steering Group with both Trusts providing leadership and accountability at executive and divisional management levels.

The programme structure ensures appropriate representation of the interests of all key stakeholders. MTW will be responsible for the appointment of the design team and contractor and the arrangements will reflect and recognise EKH's primacy in respect of knowledge, experience and responsibility on the hospital site.

7.2.1 Milestones and indicative timetable

Phase	Title	Stages	Duration	Ownership
1	**Measure & Understand** Analysis, Development and Approval	Activity analysis & financial modelling, Demand and Capacity Service model, specification, patient pathways, equipment needs and costs. Design and architecture of the new facility Business Case Development & stakeholder engagement to facilitate consideration and approval. Approval of the Business Case Development of inter-provider agreements and contracts	I – 1.5 years	Steering Group Steering Group Steering Group Executive Programme Board / Trust Boards
2	**Design & Build** Construction & Service Configuration	Construction of the facility, selection of procurement of equipment.	2.5 – 3-year implementation time	Steering Group

3	Implementation, Sustain & Close Service Monitoring & evaluation of benefits.	Implementation of new service, monitoring delivery and performance as well as benefits post completion. Ongoing service monitoring and review of long-term benefits.	On-going	Steering Group Trust Boards

Milestone	Indicative Timescale
Strategic Outline Case completion	April 2021
Outline business Case completion	March 2024
Approval of OBC	April/May 2024
FBC completion	January 2025
Approval of FBC	TBC
Purchase Order placed for Construction	2 weeks
Contractor Mobilisation	2 weeks
Construction start on site	2 months
Construction Handover	TBC
Trust Commissioning	I month
Clinical Handover	TBC

7.3 Business assurance and benefits realisation arrangements.

The Cancer Division, at MTW, as the accountable owners of the programme, will oversee a rigorous process of assessment and analysis to ensure that the benefits and outcomes from this investment will be monitored and delivered. Monitoring will occur through the use of KPIs and adherence to agreed criteria. The management team will be required as part of the OBC development to assign a confidence level for the delivery of each documented benefit. The confidence level will be monitored and updated over time, to provide assurance that benefit realisation is on track to deliver. Appendix 5 details an early Quality Impact Assessment that has been completed.

7.4 Risk Management and Contingency plans

The project uses a standard MTW 'risk categorisation matrix' scoring to develop a project risk register. During the Outline Business Case process a project risk register will be maintained and developed further with the Project Team.

Risk	Suggested Baseline Risk Score	Mitigation	Suggested Risk Mitigated Score
The sources of capital funding for a new build have not been identified and remains unclear. In addition external funds will be required for the replacement LINACs. Though this in line with how other LINACs have been replaced it will add additional pressure to the existing capital funding pressures.	25	Further clarity required about the amount of funding that could be available in future years and further work as to how productivity and efficiency can support the future financing.	20
The uncertainty regarding the timeline could affect the LINAC replacement programme & trigger the need to replace existing LINACs & CT Simulator at K&CH in advance of the new build being available.	20	Confirming funding available to replace LINACs in line with replacement programme and assumption built into the case to account for cost of moving existing LINACs.	16
Although a location is identified there are no detailed plans in place to decant the current services and people from the buildings.	16	The steering group has directed a working group to meet and develop a realistic plan to decant, vacate and hand over the existing facility.	12
On-going interruption of the programme due to the COVID -19 pandemic potential 3rd wave / reset & recovery.	16	Take flexible and varied approach to packages of work.	12
Disruption to site and service delivery during a new build / refurbishment and/or extension.	12	Detailed decant plans to be prepared as part of the OBC.	9
Potential objections to planning permission if a new build option proceeds, from local residents.	12	Ensure appropriate engagement with the local community is undertaken and information is readily available.	9
Region wide reconfiguration of services, may impact unexpectedly on demand - not aware of reconfiguration in relation to cancer services.	9	Strategic case to be shared with senior strategic leads across health community.	6
Complex governance shared between East Kent and MTW could impair planning.	12	Governance to be made clear in management case before case progresses to OBC stage. Representatives from East Kent, MTW and commissioning colleagues represented on programme steering group. Clear communication in place regarding strategic development and service reconfiguration plans in both Trusts.	6

7.5 Arrangements for post project evaluation

Post Project Evaluation (PPE) will be undertaken to improve future project briefing, project management, and implementation for future projects.

PPE will include:
1. Process issues - in 5 case model called the Post evaluation review (PER)

This review appraises how well the project was managed. The project evaluation, should be undertaken as soon as possible after the implementation of the service to capture lessons learnt

2. Outcome issues - in 5 case model called the Post implementation review (PIR)
This review ascertains whether the anticipated benefits have been delivered. This will be timetabled to occur 12 months from the commencement of live running. It will be used to measure the performance of the completed facility against the benefits identified within this Business Case.

8.0 Recommendations

The recommendation is for EKHUFT and MTW to support the development of a Full Business Case is to support option A which is new building erected behind the existing centre with 2 new bunkers and associated preparation areas as well as an Outpatient suite. As part of these phases remaining shielding upgrades required to the 3rd bunker will occur thereby increasing the types of treatment that can be undertaken.

8.1 Further Work

The Full Business case must consider the different funding options to support the recommended option including Trust capital, ICB capital, central capital and an investor model which may include lease options.

8.2 Decision

The project team ask for recommendation from the approving bodies (Divisional board, TME /Trust Board) to either:

1. Move ahead with the project and develop the case to FBC stage, including agreement or adjustment to the proposed short list of options, considering the additional work recommended above.

2. Abandon the project, because it is considered unaffordable, too ambitious, or too high risk in relation to the expected return.

3. Modify or delay the project.

9.0 Appendices

Appendix 1 – Full Minutes from Initial Assessment of the Options Workshop

SECOND DRAFT 15 February 2021

Maidstone & Tunbridge Wells NHS Trust

Minutes of the
MTW/EKH East Kent New Oncology Build Option Appraisal

Held on 20th January 2021

Location: via Microsoft Teams

Present:

Grainne Barron	GB	MTW	Head of Performance and Delivery for Cancer Services
Katie Goodwin	KG	MTW	Divisional Director of Operations for Cancer Services
Dr Henry Taylor	HT	MTW	Chief of Cancer Services
Nicky Bentley	NB	EKH	Director of Strategy and Business Development
Dr Kannon Nathan	KN	MTW	Consultant Clinical Oncologist
Mark Nicholls	MN	EKH	Transformation Lead, Cancer Clinical Haematology and Haemophilia Care Group
Sarah Collins	SC	EKH	Operational Director & Head of Nursing for Cancer, Clinical Haematology and Haemophilia Care Group
Amanda Williams	AW	MTW	Head of Radiotherapy Services
Stephen Duck	SD	MTW	Director of Medical Physics
Dr Moya Young	MY	EKH	Consultant Haematologist and Clinical Lead
Dr Albert Edwards	AE	MTW	Consultant Clinical Oncologist
Dr Andrew Nordin	AN	EKH	Clinical Director of Cancer Care Group
Charlotte Wadey	CW	MTW	Director of Nursing and Quality Cancer Services/Lead Cancer Nurse
Martine Henniker	MH	EKH	Clinical Matron for Cancer, Clinical Haematology and Haemophilia Care Group
Kathryn Stephens	KS	EKH	Clinical Matron for Cancer, Clinical Haematology and Haemophilia Care Group
Amy Seymour	AS	EKH	Senior Strategic Projects Manager - Strategic Development and Capital Planning
Robert Cook	RC	MTW	Head of Strategic & System Integration
Sarah Lightfoot	SL	EKH	Pharmacy Aseptics and Cancer Services Lead Pharmacist
Miguel Capo-Mir	MC	EKH	Haematology pharmacist
Lee Foster	LF	EKH	Management Trainee (observer)

Apologies: None received.

Minutes

KG advised that it would be beneficial to go around round the room with introductions and confirm if we have equal levels of scoring.

HT present – expecting HT entry to score

KN – present – expecting KN to score

AN – present – expecting AN to score

SC – present – expecting SC to score

KG – present – expecting KG to score

SD – present – expecting SD to score

AW – present – expecting Aw to score

Kathryn Stephens – Not expecting to score

Martine Henniker – Not expecting to score.

Mark Nicholls – present – expecting MN to score

SM - Not expecting to score.

MY – Happy to score.

AS advised that, with regards to the scoring, the idea is really about having the people we want to contribute to the debate to come up with a consensus score. AS followed on to say that today is not necessarily about individual scoring, it is really about the list of people that we are really keen to be a part of the very important debates/discussions that we need to have today.

AN advised that he agrees with AS's statement and highlighted that the reason we were keen for MY and SM to be involved is because they represent important stakeholder segments of EK organisation. The haematology service is going to be directly impacted on the vision of chemotherapy services in East Kent and the large surgical oncology component of EK will also be impacted; so that was the reason for their representation. AN went on to say that he would have thought as we are going to be presenting and discussing each of the options, whether the people outlined in the attendees have been involved in previous meetings or not shouldn't bear much relevance.

GB ran through the objectives of today's meeting, which is to build a state-of-the-art oncology centre in EK for oncology patients.

RC queried an earlier point made, around the scoring reaching consensus. He advised that, rather than individual scores, which is a sensible suggestion maybe we could just touch base on that once we get to start the scoring and agree how we are going to facilitate that. If we can't reach a consensus, need to look at how we are going to manage that moving forward.

AS introduced herself to the group and advised that she thought it would be useful before we get into the actual criteria and scoring for today to just give the group an overview of where we are.

AS advised that this is about completing the strategic outline case, which we call the SOC, and today is about an initial assessment of the options. She recognised that it is a repeat for some of the group members, but reiterated that today is really important, because crucially we have a broader range of stakeholders here to support the important debate that we need to have.

She advised that the assessment of the options takes place in two parts, and we are doing the first part of that today so this is about the clinical view of the options. Naturally we will also be looking at the financials of the options as

well and the idea of that is to essentially go forward into the next part of these business cases with a reduced number of options.

AS highlighted that we have a lot of options on the table and at the Outline Business Case stage there is a significant amount of work to be done, particularly around economic appraisals. People do not normally go forward with seven options, it is usually around four, but advised that it would be really good if we could move things forward today.

AS advised that there are some good reasons why we are re-doing this today, and that is because some of the options evolved and developed and there has been a bit of time-lapse between when this project started and where we are now. She also drew attention to the recent the pandemic and to bring together the huge amount of work that has been done so far.

AS went on to say that after this session, we hope to have been able to finalise the Strategic Outline Case and to recommend those options to take through into an Outline Business Case. It will need to go through the governance of both of organisations again; as has not yet been through EK governance and then we will be able to socialise more formally the fact that we will be looking for investment for this case. AS advised that, for those of the group that have been involved, will understand that there is a sizable investment involved in this case and wanted to give an outline of a little bit of the process that we will need to go through.

AS explained that the availability of capital is challenging at this point in time. When a case is above 35-50 million, then NHSEI become more involved. AS reiterated the importance of bringing this process together and ensuring that we have very robust governance on how and why we have made the decisions that we have made.

Criteria to be used

AS advised that there were some criteria that was used previously for this section back in 2019. We have kept those criteria and fitted them underneath the critical success factors that were originally put together by Angela Gallagher. We have also added to them. AS advised that these are sensible addition in her view, but will pause and let everyone have an input in the discussion.

East Kent Reconfiguration Case: AS outlined that we need to consider how this case fits in with the East Kent reconfiguration. The EK reconfiguration case is big and has received a huge amount of national attention. We need to make ensure that this case has strategic fit with those proposals.

Infection Prevention and Control: AS highlighted that we need to pay closer attention to this area, particularly given the recent pandemic. NHSEI took particular interest infection control with the EK reconfiguration case.

IT/Clinical systems: AS highlighted that there was previously a criterion that was primarily focused on ensuring compatibility with the IT and the MTW IT systems, and feels that we need to expand that to adjacency to other clinical support, radiology, pathology etc.

Implementation Timeline: AS advised that a lot of conversation have been had about decants and we do need to be realistic about those.

Critical success factors for the case

AS relayed that a question was posed to her yesterday, that these are quite MTW focused – therefore this is something that GB and herself will have a further look at.

AS suggested that a change be adopted with the scoring methodology. The treasury green book guidance, suggests that we should not be weighting the scoring because you would need a number of independent facilitators and a number of independent experts. In essence, today is an initial assessment of the options and determining the best way forward but this is not a detailed options appraisal. This is just an easy way for the group to measure what they think we should be moving forward with. The actual scoring in terms of no change, improve or worsen – exactly the same as before.

KG highlighted that her understanding is that this was the options appraisal for that OBC and not to revisit the one for the SOC.

AS advised that this was not her understanding of today's meeting. She explained that the process for the OBC is that a significant amount of economic work needs to be done and financial analysis. There is also something called an investment appraisal model that needs to be done and we would then need to go through the risks and benefits of each of the options we take forward in quite a lot more detail and we would then do a full options appraisal with various colleagues from different functions across the organisation.

KG advised that she was of the understanding that at the executive meeting at the beginning of December this was about feeding that OBC that is in draft format and that we wanted out at the end of January on a qualitive basis for us then to put the financial and economic case together. KG reiterated that her understanding was that these seven are the shortlisted options.

AS clarified that, at the end of the SOC you should assess the shortlist in terms of which options you would like to take forward into the OBC. She advised that, it is her understanding that previously a discussion had been had, but didn't involve of the clinical and operation team at East Kent.

She went on to day that, what was agreed with Amanjit is that we will try then to get the SOC agreed in January to move us forward into OBC. The OBC is a big undertaking and the SOC has been socialised with NHSEI and ITP. We need to approval from our organisation before we outlay any investment.

KG reiterated that was not her understanding for meeting this afternoon.

There was some discussion around the fit with the EK reconfiguration comment. HT commented that there needs to be a very clear definition as to what the EK reconfiguration plan is. HT gave a reflection of the first scoring and advised with the absence of weighting, a lot of the clinicians came away feeling that we ended up with the wrong decision.

AN responded to HT query with respect to the EK reconfiguration and advised that, as a clinician who has worked in East Kent for 20 years, elements of past building legacies have left parts of the service fragmented.

Strategic fit and Business Need

Adjacency with Other Clinical / Administrative Support Services

GB gave a brief outline of the options for this slide. KG higlighted that Options 3 – 7 seem to be identical with respect to IT capability and Options 1 and 2 will have an impact, because at the moment, it is a 1937 building without 2021 IT function. KG asked the group whether they agree that with respect to the question of whether it would offer IT compatibility with the current MTW IT service for all Options it would be a potential 'yes'.

AS advised that IT capability was one of the subjects raised in the previous Options Appraisal and in her view, in any option we should look to improve IT facilities. AS highlighted that emphasis needs to be focused on the second question, 'does the option have other clinical support facilities available?' and look at what issues we may experience in terms of clinical support services.

HT raised a point around adjacencies and advised that it is likely that a lot of the cancer diagnostic work will go via the community diagnostic hubs; so, in terms of adjacencies, HT not convinced that there is a need for centralisation with East Kent acute hub. He pointed out that meetings on MS Teams, is looking to be more the norm and IT links are likely to improve over time. As long as there is strong IT support a lot of the issues can be overcome.

AN raised the point that having specialists together and having services together in an integrated way, facilitates the patient pathway. Although the majority of oncology work is outpatient focused, there are some inpatients beds and in the gynaecology oncology service, which is small component of the East Kent Oncology Service, most days there will be 6 or more patients in hospital. Therefore, having a facility where everything is in one place is a definite advantage.

AE raised that the major problems IT issues, in his experience are hardware and software; such as passwords needing to be re-entered multiple times. He added that having an IT department adjacent is not going to improve how patients are treated.

All in agreement that it would be beneficial, for the sake of time and efficiency, for AS and GB to take the group through the slides and highlight the areas we need to discuss further before scoring.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: 0 – as not going to change anything.
Option 2: +1 - slight improvement.
Option 3: +1
Option 4: +2
Option 5: +1
Option 6: +1
Option 7: +1

Compliance of service against national specification

GB gave a brief overview and advised that the earlier SOC did not include reference to the Francis Report 2013.

GB advised that Options 3-5 meet the national specification context, as does Option 7. Options 1 and 2 partly meet the national specification and the Margate Options meets a more local need.

SC questioned whether it truly meets the needs of the local population because what was proposed was a limited service.

HT followed-up that he was of the understanding that the local discussion with the patient population group in Margate had felt that it might not be a local service need.

GB advised that two surveys have been undertaken to gauge population need.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: 0
Option 3: +1
Option 4: +2
Option 5: +1
Option 6: +1 - meeting the service need for the population for some degree – but not greatly.
Option 7: +2

KN advised that patients were polled regarding a satellite facility at Margate and only 10% from the Margate area wanted it. The remaining 90% wanted to come to the main centre for various other support. This was a poll of over 50 patients – covering all tumour sites.

Amenities available on site

Does the option include all amenities that should be available to patients?

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: +1
Option 4: +2
Option 5: +1
Option 6: +1
Option 7: +1

There was some discussion around amenities and MY queried with Option 7 whether the expansion will be moving out other services, such a Brabourne Ward.

KN clarified that with Option 7, Brabourne Ward was going to be part of the multi-storey of the refurb hybrid expansion and therefore shifted upwards vertically and will not be factored into this.

Ability to cover service provision

Does the option ensure that the clinical standards are met and how far does each option improve on the current level of compliance?

GB advised that initial thoughts on Options 1 – 5 were yes. Options 6 has clarified that with, respect to the limitations on the service we would be providing at Margate, Options 7 is the same as the rest (1 – 5).

SC advised that, in terms of transparency, it would appear upon reading this that our only concern is around targets and suggested that wording be altered to reflect that targets are not the only factor.

CW agreed with SC and advised that it would be better to look at this from an infection control and patient mobility perspective. The old build can pose issues with infection control and space whereas if you had a new purpose built centre the correct facilities can be put in place - basins, ramps in etc. In essence, with the existing building you have to make do with current infrastructure.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: 0 – no change
Option 2: 0 – no change
Option 3: +1
Option 4: +2 – patient focused
Option 5: +2 – patient focused
Option 6: +1
Option 7: +1

AN raised that a new build off-site could compromise provision. Aspects of a large hospital site not available to the clinician. He advised that he would therefore mark this as a +1.

NB raised that, as a group, need to be clear when we are talking about service provision and patient flow, needs to be clear whether they are they the same thing or two different things.

AN advised that by physically fragmenting the service you add obstacles. Lots of scenarios that will only become apparent when moved - therefore you eliminate the obstacles by having the centre on-site.

This criterion was referred to Executive Team for guidance, as there was a difference of opinion with respect to Option 5. The scoring has not been included in the overall total at present.

Training and Supervision

Does the option meet the curriculum specifications for education and training for medical students, nurses, doctors, physicists and allied health professionals? E.g, (Promoting Excellence: standards for medical education and training 2016).

GB outlined that Options 3-6 – meets the standards. Options 1, 2 and 7 – partly meets the standard.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: 2
Option 4: 2
Option 5: 2
Option 6: 1
Option 7: 1

Recruitment and retention

Could the option result in improved recruitment and retention?

It should be noted that recruitment and retention is based on a number of factors. This slide will highlight how each option can support the wider EKH organisational recruitment and improvement plan.

KG highlighted that this comes back to AW point on rotas and the ability to attract people (away from London for example). She asked the group whether they feel that Options 1 and 2 are in negative territory in terms of scoring.

AS gave some advice to the group. She advised that when the team looked at the East Kent reconfiguration case, they found that recruitment and retention is far more about the buildings and although it is important to think at how an improved environment will attract people it is more than just that.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues

requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: +1
Option 4: 2
Option 5: 2
Option 6: -1 – If radiotherapy service is fragmented there will not be the staff available to look after the satellite LINAC.
Option 7: +1

NB advised that all we can do is talk about the experience with the big transformation programme, where EKUHFT looked at Options where potentially critical care would fall over. NHS England encouraged them to articulate what their mitigating actions would be if they do not get the money and they cannot do anything because they will still have to provide services.

Infection Prevention and Control

Does the option enable new IP&C requirements to be met?

It should be noted that all learnings from the pandemic will need to be taken forward and implemented in any of the Options. This analysis focusses on ease of implementation and the degree to which IP&C guidance can be met and is based on the paper written in the summer of 2020

CW highlighted that, at the moment you have to do infection control, therefore does not feel it will make it worse. Existing Options of 1 and 2: 0. Options 3,4,5,6,7: 1.

SC advised that from an off-site option, you have to build in the fact that you would not be able to clean as effectively as you would normally do, in terms of support services.

KG posed to the group that, counter to SC comment, would the off-site option help stop super green patients from mixing with Covid patients?

SC clarified that there still needs to be emergency clean, which is a separate team. Which would cost more money.

KN agreed with SC, that having seen the deep clean, following the outbreak in radiotherapy, pre-Christmas. It is important they are on-site – so off-site option difficult.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: 0
Option 2: 0
Option 3: 2
Option 4: 2
Option 5: 2
Option 6: 2
Option 7: 0

There was some discussion around the off-site option being easier to maintain as a green zone. HT queried why the cleaning aspect could not be overcome, if not looking at cost at present.

It was ultimately agreed that this should be covered under service provision and resilience.

Fit with EKH Acute Service Reconfiguration

Does the option have strategic fit with the proposed EKH acute reconfiguration?

In Option 1 – the Kent and Canterbury site will become a planned care centre.
In Option 2 – the area adjacent to the current oncology service will be dedicated Women's and Children's services.

NB gave the group a brief overview of the option. Both Options currently have a proposal within it, that fits around the fact that we will have an oncology centre on the Kent and Canterbury site - so within the reconfiguration:

Option 1:
Major emergency centre at WHH, which would have a 24/7 A&E, women's health, critical care, hyperacute stroke unit. There will be a 24/7 A&E at QEQM and acute medical services. Canterbury would be an integrated care hospital (24/7 urgent treatment centre) not a full A&E.

Option 2: Major emergency centre, critical care co-located at Canterbury. Includes acute medical services, high risk surgery. Both QEQM and WHH would become integrated care hospital where you have 24/7 urgent treatment centre, rather than A&E, a range of elective low risk services.

NB advised that, in terms of process and timeline, EK are in the process of bidding for the capital acute reconfiguration. A decision has not yet been made but the overall timeline for the build is around 7 years for both Options.

AN advised that the clinical community have had long discussion about these Options. Options 2 would be the preferable direction for services in East Kent and if that objective is met then building the oncology development on the Canterbury site would be fantastic for the long-term future. If Option 1 is selected, then there should be a discussion about whether that would be the right configuration given that 42% of EK gynaecology oncology cases are through emergency admission.

After some discussion, it was ultimately agreed that this would be taken back to the executive meeting, to be discussed further with Amanjit Jhund and Liz Shutler, and a proposed solution will be given to the group.

Sustainability Score on Number of Years

Does the option deliver the required sustainability of 1) the physical building i.e. lifespan of 25 years +, and 2) service provision i.e. optimum patient flow, co-adjacencies, efficiencies etc.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: 1
Option 4: 2
Option 5: 2
Option 6: 1
Option 7: 1

After some discussion, it was ultimately agreed that this would be deferred to the executive meeting, for further discussion with Amanjit Jhund and Liz Shutler, and a proposed solution will be given to the group. The scoring has not been included in the overall total.

Future Proofing including space required for LINACs

Does the option allow for adjustments to the physical spaces in the future and the new LINACs / advances in other equipment?

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1 – current bunkers cannot be expanded.
Option 2: 0
Option 3: 2
Option 4: 2
Option 5: 2
Option 6: 2
Option 7: 1

Service Resilience

Does the option offer an ability to prepare and respond to a range of emergencies/challenges e.g., surge in activity, failure of key equipment? Does the option allow greater flexibility / adaptability in the delivery of services to patients i.e. potential increase in demand as a result of COVID, ability to socially distance?

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: 1
Option 4: 2
Option 5: 2

Option 7: 1

MY advised that, she agrees with KN scoring from a chemotherapy point-of-view. She added that if you have a new build specifically for the oncology side of things then that might open up an opportunity for the team to develop a specific haematology chemotherapy unit beside Braebourne Ward – which will help the haematology

team develop their services.

Patient Pathway

Does the option improve the pathway for patients and physical flow of service delivery?

AN and CW highlighted that it is hard to disassociate this slide from the clinical strategy slide.

Initial scoring indicates the following:
Option 1: 0
Option 2: 0
Option 3: 1
Option 4: 2
Option 5: 1
Option 6: 1
Option 7: 0

All agreed that this would be marked amber and a final decision would be made once the team have the strategic view, the scoring has not been included in the overall total at present.

Continuity of care

How will the option improve continuity of care for patients e.g., can it accommodate service expansion / additional clinics/treatments for both radiotherapy and chemotherapy?

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: -1
Option 2: -1
Option 3: 1
Option 4: 2
Option 5: 1
Option 6: 1
Option 7: 1

NB highlighted two points. She advised that around the expansion piece, we need to reflect somewhere in the process around the impact of Covid, because that has changed the way we deliver outpatients and clinics virtually. In time some of the other outpatient areas will become available that could be used for space expansion. NB also highlighted that, we need to be mindful that the group are giving Option 5 a score of 2 for various things, but we don't have an Option 5 at present, so could go either way.

AN highlighted that, for continuity of care, in terms of the geographical location of K&C it is improbable that it is going to be readily accessible to the hospital. Oncology patients need the facilities from other departments within the hospital and we are creating a barrier. Transport links around Canterbury not great therefore hard to score Option 5 as 2.

MDT co-location

Is space available to hold physical MDTs and planning of treatment?

KG queried that, with the launch of virtual MDM's as the result of Covid, is this still a subject that needs considering?

AE highlighted that KOC is spread across two sites and being forced to go remote, has facilitated things such as radiotherapy planning peer review. He advised that it is a bit of a contradiction saying we need to have these big MDM rooms. Historically MDM's are not used in many parts of the world and need to accept that the current MDM structure might not be going forward like that in the future for cancer services.

HT raised the concern that, although the potential need for MDM room might not be there, it would be a good idea to plan for a seminar room, in order to carry out training sessions etc.

AN highlighted that, the reality in Kent is that it is not possible for everyone to go to MDT – but if working in a big London hospital for instance – would all be able to go, as all in same place. We still need a nucleus, where fast majority of people are collected. MDT wouldn't work with 14/15 people dialling in.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: 0
Option 2: 0
Option 3: 2
Option 4: 2
Option 5: 2
Option 6: 2
Option 7: 2

It was decided that this criterion would be removed from the scoring, therefore it has not been incorporated in to the overall score.

Patient Access

How do patient journey times change as a result of the proposed option?	Does the option allow for improved ease of access for patients/relatives and ambulances?

GB: 1 and 2 – no change. Option 3 – no change to journey times and we think we could improve access for patients. Option 4 – no change to journey times and accessible parking bays.

KG: Option 1 and 2 remain the same.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues

requesting their input, the scores were then agreed as follows:

Option 1: 0
Option 2: 0
Option 3: 0
Option 4: 0
Option 5: 0
Option 6: +1
Option 7: 0

Ability to Quality Assure Service Provision

CQC – 5 standards: safe, effective, caring, responsive to people's needs, well led. NHS Health Check Annual medical revalidation

CW clarified that, from a CQC point of view, you have to deliver those five in all areas. She advised that she feels that a new build option with purpose-built facilities will enable us to deliver this in a more effective way. MN agreed with this point and added that it is important to be responsive to the needs of the patient and service.

KN was asked his opinion on the scoring, he outlined his scores, and opened discussion with his colleagues requesting their input, the scores were then agreed as follows:

Option 1: 0 - not massively improving what you have.
Option 2: 0 - not massively improving what you have.
Option 3: 1
Option 4: 2 – a self-purpose service from the ground up.
Option 5: 1
Option 6: 1
Option 7: 0 – not massively improving what you have.

Implementation Timeline

Is the build time for each of the Options reasonable and what impact will it have on the current service?

GB and AS advised that they have both touched base with the estates leads at both MTW and EKH.

There was some discussion around the timeline and it was ultimately agreed that it would be beneficial to ask the Estates Team's their expert opinion on build time.

Overall Scores:
AS read out the overall initial scores for this Options appraisal:
Option 1: Do nothing / minimum **-7**
Option 2: Refurbishment **-4**
Option 3: New build radiotherapy only **13+**
Option 4: A new build plus (RT & Chemo back of 1937 building) **20+**
Option 5: A new build plus Off- Site **16+**
Option 6: Two new builds (new build plus, and Margate Satellite) **11+**

Option 7: Refurb & Expansion (Hybrid) **9+**

Issues deferred for strategic direction to Project Executive Board

1. Fit with EKH Acute Service Reconfiguration – Remove this criteria?

Does the option have strategic fit with the proposed EKH acute reconfiguration?
In Option 1 – the Kent and Canterbury site will become a planned care centre.
In Option 2 – the area adjacent to the current oncology service will be dedicated Women's and Children's services.

2. Sustainability Score on Number of Years

Does the option deliver the required sustainability of 1) the physical building i.e. lifespan of 25 years +, and 2) service provision i.e. optimum patient flow, co-adjacencies, efficiencies etc?

3. Patient Pathway

Does the option improve the pathway for patients and physical flow of service delivery?
AN and CW highlighted that it is hard to disassociate this slide from the clinical strategy slide.
All agreed that this would be marked amber and a final decision would be made once the team have the strategic view.

4. Ability to cover service provision

Group could not reach consensus on option 5 – off site build.

Criteria removed

1. MDT co-location.

Issue deferred to MTW & EKH Estates Departments

Implementation Timeline

1. Is the build time for each of the Options reasonable and what impact will it have on the current service?

Appendix 2 – Quality Impact Assessment

Quality Impact Assessment	The Management Case
Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who. Clinical Director, other oncology Consultants, Head of Radiotherapy Director of Medical Physics Full discussion at the Cancer Clinical board attended by all consultants in Oncology	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes, the national predicted demand data for radiotherapy activity level (known as MALTIS modelling) National benchmarking with other satellite radiotherapy units National trends in growth in oncology patient from a variety of sources including Macmillan and the Royal Colleges	
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
• Department KPIS including efficient of treatment, number of fractions of radiotherapy per patient, incidence of side effects • Audits of radiotherapy practice undertaken regularly • Complication rates audited regularly • Mortality and morbidity meetings • Both Radiotherapy and Physics are ISO 9001:2008 certified and CHKS accredited	
Are there any risks to clinical effectiveness? If yes, list. • There are minimal risks to clinical effectiveness by the preferred option: • The patient experience may be affected if the satellite unit does not offer the exact same treatments as the main oncology centre. • This would be mitigated by moving any patient who requires a treatment to the main site. • The satellite unit will have a standard operating procedure for each treatment protocol. • This will ensure that there is no risk to clinical effectiveness. • Staff will rotate through the KOC sites (where appropriate) and therefore all staff will remain competent minimising risk.	
Have the risks been mitigated? Yes – the unit will be subject to the same clinical protocols that already exist in the department. • These are all mitigated by standard operating procedures and risk assessments are already in place where required.	
Have the risks been added to the departmental risk register and a review date set? Not to date. This will be actioned shortly	
Are there any benefits to clinical effectiveness? If yes, list • Patients will continue to be treated closer to home • Better patient flow by collocating services on one site	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y

Quality Account priorities?	Y
CQUINS?	Y
Are there any risks to patient safety? If yes, list There are no known risks to patient safety at the time of writing as the radiotherapy service is highly governed and there are a number of inherent patient safety checks that are performed prior to administration of radiotherapy.	
Have the risks been mitigated? Yes	
Have the risks been added to the departmental risk register and a review date set? Not applicable	
Are there any benefits to patient safety? If yes, list.	
Patients using the unit will have a quality service delivered in an appropriate time scale in a geographically convenient location.	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
Yes, the impact of the redesign has been assessed. There should be no impact on the patients/ carers or members of the public apart from the radiotherapy patients being offered a superior service to the one that is currently available within the existing resources.	
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? – Yes, no impact • Tackling health inequalities? - Yes, no impact	
Does the redesign lead to improvements in the care pathway? If yes, identify	
Yes, patients will be seen in a location closer to home and meet unmet patient need for treatment.	
Are there any risks to the patient experience? If yes, list	
No	
Have the risks been mitigated?	
NA	
Have the risks been added to the departmental risk register and a review date set?	
NA	
Are there any benefits to the patient experience? If yes, list	
• Modern environment for patient care • Possibility of co-location of chemo, radiotherapy and Out-Patients • The benefit of co-locating all chemo services to one site is expected to improve patient outcomes and quality of service and also to improve staff recruitment and retention •	
Equality & Diversity	
Has the impact of redesign been subject to an Equality Impact Assessment?	
Yes	
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)	
No	
Has any negative impact been added to the departmental risk register and a review date set?	

NA					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	X	Maintains quality		Reduces quality	
Clinical lead comments:					
Case is fully supported by all the CD in Oncology as well as the Clinical Leads. It has been fully discussed at the Cancer Board. It also has full support from the Estates and Facilities Department.					

NHS Maidstone and Tunbridge Wells NHS Trust

To review the Trust's NHS IMPACT self-assessment	Deputy Chief Executive / Chief Finance Officer

Background

NHS IMPACT requested that all NHS Trusts carry out the Impact self-assessment and, through honest self-reflection, determine the extent to which they have a culture of continuous improvement established. The assessment is categorised by 5 key principles that underpin a systematic approach to continuous improvement

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding inter-management systems and processes

During the same period (2023), the Trust also requested a maturity assessment to be carried out by Eden Health and Social Care to review the organisations 'Exceptional People, Outstanding Care' programme maturity and provide an independent view

Analysis / conclusions

Following completion of the Impact assessment in October last year and the completed Eden Health Maturity assessment. It is evident that the recommendations of both are strongly linked and determine five key areas of action to consider.

Recommendation/s

To identify the key actions of both reviews that will support our Exceptional People Outstanding Care Strategy and define our priorities going forwards

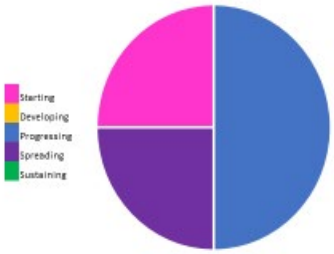
Which Committees have reviewed the information prior to Board submission?
N/A

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

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

NHS Impact: How are we doing?

1. Building a shared Purpose and vision



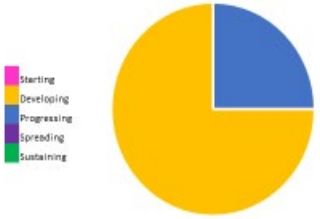
Key Successes

- Shared purpose and vision in place
- translated through the Strategy Deployment Process.
- Improvement work aligned to the Strategy
- Monthly Share and Learn forum in place for Patient First
- Celebrations shared from floor to Executive SDR
- Some patient engagement with improvement huddles but very localised

Next steps:

- Refresh communication strategy and update the MTW story and ensure consistent and active communication and visibility about EPOC with key successes aligned to the strategy
- Align celebrations and learning events with medical education and the quality improvement programme
- More accountability for Inch wide mile deep focus
- Standardise our approach to patient engagement for improvements and service redesign

2. Investing in people and Culture



Key Successes

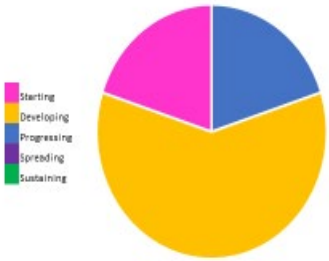
- 8 Cohorts of Patient First from Feb 24 rolled out
- Improvement huddles happening in 34 areas (2 corporate)
- Three quality Strategic themes have used data from patients and staff to inform the improvement work
- Additional leadership training being rolled out by OD including AFFINA team journey.
- Coaching approach being embedded in Patient First, Strategy Deployment and Exceptional Leaders

Next steps:

- LEAN training and coaching development at senior leader and board level
- Leader standard work to be developed and rolled out
- More consistent and structured approach to 'go and see'
- Leaders to be more visible at improvement huddles to continue to develop their coaching style and empower staff.

NHS Impact: How are we doing?

3. Developing leadership behaviours



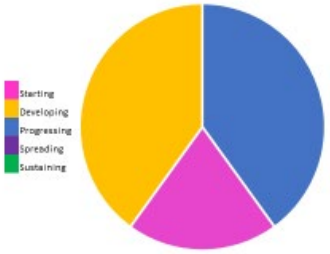
Key Successes

- Exceptional Leaders Programme now rolled out at all levels of the Trust
- MTW Leadership behaviours developed & agreed
- Leadership understands the importance of 'Go & See' but this is not consistent approach
- Improvement is discussed every Board- with the IPR
- Coordinated improvement through the SDR process

Next steps:

- Focussed training on Leader Standard Work to free up time to support improvement/improve visibility at huddles
- Lean Practitioner training to be rolled out to replace A3 thinking
- Develop a consistent and structured approach to 'go and see'
- Leaders to be more visible at improvement huddles to continue to develop their coaching style and empower staff.

4. Building improvement capability and capacity



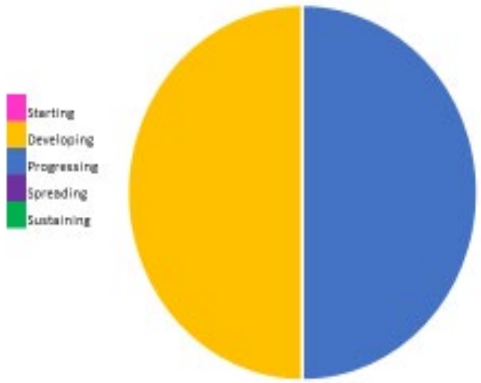
Key Successes

- In-house training for frontline staff (Patient first/SDR/A3 thinking/Exceptional Leaders)
- Lean Improvement methodology and Trust-wide approach agreed
- Improvement is monitored from Board to divisional level
- Consistent use of SPC and business rules across the organisation
- Staff attendance at Improvement huddles

Next steps:

- Embed a maturity framework across the EPOC programme
- Roll-out of 'Platinum Directorate'
- Ensure that lived –experience and service users are able to participate in local activity
- Consider a standard approach for service user inclusion in wider improvements
- Continued up-skilling of the organisation in the improvement methodology

5. Embedding into management systems and processes



Key Successes

- Aligned goals set and agreed at Trust Board
- Management system in place to support improvement (Strategy Deployment)
- Project filter and catchball process embedded
- Widespread use of SPC charts
- Use of SPC charts and data embedded into training.

Next Steps

- Roll-out of SDR in Corporate Areas
- Development of Directorate level scorecards on Power BI
- Increase the visibility of improvements across the organisation and stick to agreed approach for selecting and prioritising improvement work

Our overall self-assessment rating following the Impact assessment evidences that we are predominantly 'Developing' and 'Progressing' which is a very positive position

NHS Impact: Next steps identified to move us to sustaining overall

- LEAN training and coaching development at senior leader and board level- to include Divisional Leadership/triumvirates
- Leader standard work to be developed and rolled out across all EPOC training programmes (SDR & PFIS for Leaders)
- Link Strategy Deployment and Patient First by introducing Directorate and divisional Driver meetings (Platinum Directorate)
- Development of Directorate level scorecards on Power BI
- Roll-out of SDR in Corporate Areas and develop the scorecards- HR/Business Support/E&F
- Embed Gemba into training at all levels
- Reinforce link between Exceptional Leaders and Lean leadership behaviours with joint working across organisational development
- Review and relaunch communication strategy and update the MTW Story that reinforces the CI trajectory for the Trust
- Embed a maturity framework across the EPOC programme (PFIS/ SDR/LSW/Gemba)
- Collaborate with Medical education to develop knowledge & training in the Trusts improvement approach
- Standardise approach to patient engagement on improvements and service redesign

Eden Health Maturity Assessment

NHS
Maidstone and Tunbridge Wells NHS Trust

"This is our assessment of MTW maturity against the foundations needed for successful deployment of a Continuous Improvement system.

There are good foundations in place with strong domains and evidence of progress. People and culture are strongest with all domains showing progress.

This result is better than the findings from other healthcare organisations we have assessed.

This provides a strong foundation to build on and we did not identify anything which is a blocker or threat to the ability to progress."

Health Variation: The Improvement Journey	Our Assessment
Leadership & Governance Visible & focused leadership Effective governance & management processes	Leadership engaged and developing An effective QI management system has been developed.
Infrastructure & Resources A management system & infrastructure capable of providing teams with the data, equipment & resources to plan and deliver sustainable improvement	Effective introduction, development and roll out of QI system. Partnering model and access to capable and supportive resources
Skills & Workforce A programme to build the skills and capability of staff throughout the organisation	Exceptional leaders programme and QI training plan are both developing capability and capacity
Culture & Environment The presence of a supportive, collaborative and inclusive workplace culture that allows reflective thinking with new ideas and approaches.	Talented and capable people with a desire to improve. Focus on delivery for patients. Environmental challenges being effectively managed.

Eden Health: Recommendations

NHS
Maidstone and Tunbridge Wells NHS Trust

Executive Team:

- Arrange Green Belt Training for Executive Team to improve knowledge and confidence
- Some of the Executive Team need coaching for Improvement support
- ‘Go See’, explore other systems externally to learn, inspire and motivate
- Executive Leader Standard work not in place and needs to be developed

To Increase CI Capability:

- A plan needs to be developed for all Divisions to roll out SDR to directorates and specialties and align to PFIS plan
- To increase Leader Standard work engagement and development across the middle management tier

Developing Sustainability:

- Review the future needs of the CI Team and then recruit Leader and develop accordingly

Where do NHS Impact & our Maturity Assessment align?

NHS Impact Assessment	EPOC Maturity Assessment
• LEAN training and coaching development at senior leader and board level- to include Divisional Leadership/triumvirates • Leader standard work to be developed and rolled out across all EPOC training programmes (SDR & PFIS for Leaders)	• Arrange Green Belt Training for Executive Team to improve knowledge and confidence • Some Executives needs coaching for improvement support • Executive Leader Standard Work not in place and needs to be developed. • To increase Leader Standard work engagement and development across the middle management tier
• Link Strategy Deployment and Patient First by introducing Directorate and divisional Driver meetings (Platinum Directorate) • Development of Directorate level scorecards on Power BI • Roll-out of SDR in Corporate Areas and develop the scorecards	• A plan needs to be developed for all Divisions to roll out SDR to directorate and specialty and align to PFIS plan
• Embed Gemba into training at all levels • Reinforce link between Exceptional Leaders and Lean leadership behaviours with joint working across organisational development	• 'Go See', explore other system externally to learn, inspire and motivate.
• Review and relaunch communication strategy and update the MTW Story that reinforces the CI trajectory for the Trust	• To develop a more CI focused communication plan for the whole organisation

Recommendation/s for the ETM

- Agree to undertake & demonstrate Leader Standard Work as part of leadership behaviours role-modelling for EPOC
- Agree to Lean belt training and to adopt and embed the coaching approach
- Agree to undertake regular Gemba or 'Go and See' and encourage divisional leadership to do the same in order to support the embedding and success of the EPOC Programme and other Quality frameworks such as 'Outstanding Care'
- Agree to a relaunch of our MTW Story and drive forward a new improvement communications strategy
- Support the roll-out of 'Platinum Directorate,' and SDR/Patient First link-up with structured oversight from leaders at Divisional SDR

Appendix

1) NHS Impact self Assessment document

2) Eden Health and Social Care Maturity Assessment

Classification: Official
Publication reference: PRN00718

NHS England

NHS IMPACT self-assessment

NHS IMPACT
Improving Patient Care Together

All NHS organisations and systems are being supported to embed an approach to improvement aligned with NHS IMPACT (Improving Patient Care Together).

The NHS IMPACT self-assessment is designed to support you to understand where you are in your improvement journey. It will support you to identify strengths and opportunities for development when applying an organisation-wide approach to improvement. It should provide you with a framework to build your development strategy.

This is a generalised self-assessment tool. It may need to be interpreted for your own area however it is designed to stimulate a discussion and debate about how your organisation could embed the five components of NHS IMPACT. For example, the tool may reference Board leadership which may not be applicable in your area, however you may choose to think about your senior leaders when considering your response to this theme.

A full list of the questions and a glossary of terms is available on the NHS IMPACT website along with top tips on how to complete the self-assessment.

When completing the self-assessment, please select the option that best reflects your current situation.

For support, contact england.improvementdelivery@nhs.net

NHS IMPACT
Improving Patient Care Together

Building a shared purpose and vision

What this looks like in practice:

- Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team.
- Find ways to involve diverse communities, people with lived experience and staff as partners in the design of the vision and shared purpose.
- Find ways to make the shared purpose and vision practical, so that they are lived everyday by its people and are underpinned by core values.
- Ensure all improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation's context, including the pressures it is facing.
- Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process.
- Understand the world in which your staff are working, their challenges, their successes, and the improvement they'd like to see to guide this shared purpose and vision through methods of co-design and collaboration.
- Take account of the current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework, value-based healthcare) and where there are areas for improvement.
- The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user's perspective. Celebrate and share good practice where possible.

1. Board and executives setting the shared purpose and vision:

☐ **Starting:** We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our Board. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.

☐ **Developing:** Our Board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.

☒ **Progressing:** Our Board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it

meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (for example, operations, quality, financial and people/workforce).

☐ **Spreading:** Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated with and understand our shared vision in a way that means something to them.

☐ **Improving and sustaining:** Our vision and shared purpose is well embedded and often referred to by the board and all leaders, who can bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.

2. Improvement work aligned to organisational priorities:

☐ **Starting:** Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all our teams.

☐ **Developing:** Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.

☒ **Progressing:** Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.

☐ **Spreading:** Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.

☐ **Improving and Sustaining:** Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.

3. Co-design and collaborate - celebrate and share successes:

☐ **Starting:** We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused at Board level.

☐ **Developing:** The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.

☐ **Progressing:** Our improvement goals are developed and refined through a collaborative engagement process, which at least involves senior leaders and most managers and a two-way feedback process.

☒ **Spreading:** We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.

☐ **Improving and sustaining:** Our senior leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.

4. Lived experience driving this work (patients, staff, communities):

☒ **Starting:** There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.

☐ **Developing:** People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision and may have a role in setting improvement priorities.

☐ **Progressing:** Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.

☐ **Spreading:** Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.

☐ **Improving and sustaining:** Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at Board level, including setting the strategic direction of the organisation and any working with the wider system.

Investing in people and culture

What this looks like in practice:

- Set the expectation (for example, through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work.
- Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them.
- Facilitate opportunities for people to visit other organisations to understand different ways of operating and different organisational cultures.
- Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work.
- Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to.
- Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (Plan, Do, Study, Act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn.
- Have a locally agreed method to measure and assess organisational improvement culture, including drawing on current quality indicators (for example, staff survey scores, Care Quality Commission well-led framework) to support organisational development and learning.

5. Pay attention to the culture of improvement:

☐ **Starting:** There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.

☐ **Developing:** Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (for example, using a cultural survey or the NHS staff survey) and readiness for improvement.

☒ **Progressing:** Our improvement approach considers culture as an integral aspect involving all functions of the organisation, recognising the value they bring to enabling organisational improvement. Most improvement activity starts with ways to actively engage staff and teams from all areas in supporting improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.

☐ **Spreading:** Senior leaders and managers at all levels understand their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to senior leaders and managers when they are 'walking the floor'.

☐ **Improving and sustaining:** We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (for example, NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.

6. What matters to staff, people using services and carers:

☐ **Starting:** Our ways of understanding what matters most to staff, people using services and carers tend to be reliant on formal mechanisms (for example, surveys) and the link to improvement is not strong or systematic.

☒ **Developing:** We understand well as an organisation what matters most to staff, people using services and carers and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.

☐ **Progressing:** Most of our services and functions have a good understanding of what matters most to staff, people using services and carers, and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (for example, through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patients and carers into improvement priorities or goals.

☐ **Spreading:** Most of our teams have a good understanding of what matters most to staff, people using services and carers, and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have available to participate in improvement activity which matters to them.

☐ **Improving and sustaining:** Most of our staff can describe what matters most to them, people using services and carers, and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.

7. Enabling staff through a coaching style of leadership:

☐ **Starting:** There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.

☒ **Developing:** There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (for example, through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.

☐ **Progressing:** A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities to help unblock issues. Senior leaders participate in improvement celebration and learning events on a regular basis. Staff generally feel supported and empowered.

☐ **Spreading:** Senior leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers/clinicians/staff participate in improvement celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.

☐ **Improving and sustaining:** A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our senior leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.

8. Enabling staff to make improvements:

☐ **Starting:** Improvement activity is limited and may be centralised (for example, led by a discrete 'improvement team' operating independently). Staff do not generally feel able to make improvements in their own area of work.

☒ **Developing:** Some staff and teams feel able to make improvements (for example, if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.

☐ **Progressing:** Most staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.

☐ **Spreading:** Most teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative) and can solve problems effectively.

☐ **Improving and sustaining:** Staff and teams are systematically engaged in improvement activity as part of their day-to-day work and are proactive in sharing the learning, and in looking for ways to collaborate with people with lived experience and other teams and organisations in improvement programmes.

Developing leadership behaviours

What this looks like in practice:

- Have a clear leadership and management development strategy in place, outlining capability requirements and access to training.
- Understand current leadership styles and approaches through Board and executive development sessions identifying strengths and gaps for each individual and as a team.
- Create Board and executive leadership stability and continuity of approach.
- Support senior leaders and managers to live and breathe the values and behaviours of the organisation focussing on enabling all staff to improve their daily work. Regularly visit staff in their place of work.
- Hold senior leaders and managers to account for behaviours, not just improvement outcomes through a clear framework and agreed expectations.
- Clearly agree and outline the support which is in place for people to improve their own services.
- Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement.
- Encourage Board development to better understand how current senior leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps.
- Engage with peer support networks to understand different approaches to the issues, as well as leadership and management behaviours.
- Empower teams delivering on the ground to carry out and test improvement projects.

9. Leadership and management development strategy:

☐ **Starting:** Our Board, executive and senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.

☐ **Developing:** Our executive and senior leadership team have started to develop their improvement knowledge and are gaining an understanding of how it can impact their role.

☒ **Progressing:** Our executive and senior leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.

☐ **Spreading:** Our executive and senior leadership and management teams actively enable staff to own improvement as part of their everyday work, and all teams and staff have had training in improvement.

NHS IMPACT
Improving Patient Care Together

☐ **Improving and sustaining:** Our Board focus on constancy of purpose through a multi-year journey and executive hiring and development, including succession planning. Our Board is visibly linked to future planning at a system level.

10. Board, executive and senior leadership and management values and behaviours:

☐ **Starting:** Our executive and senior leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach. Existing behaviours could do more to promote the health and wellbeing/psychological safety of staff.

☒ **Developing:** Executive and senior leadership values and behaviours (that acknowledge the health and wellbeing/psychological safety of staff) are agreed across our organisation.

☐ **Progressing:** Executive and senior leadership values and behaviours (that acknowledge the health and wellbeing/psychological safety of staff) are agreed, and role modelled by leaders and managers across the organisation.

☐ **Spreading:** Executive and senior leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to. Existing behaviours actively promote the health and wellbeing/psychological safety of staff.

☐ **Improving and sustaining:** A clear framework and expectations for executive and senior leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.

11. Senior leadership and management acting in partnership:

☐ **Starting:** The goals our executive and senior leadership are working to could benefit from greater clarity and alignment.

☒ **Developing:** Most of our executive and senior leaders work in partnership with their fellow leaders and managers.

☐ **Progressing:** Our executive and senior leadership team have shared goals with the organisations they work with in their wider systems.

☐ **Spreading:** Our executive and senior leadership team has shared longer-term goals with network partners and/or commissioners, as well as collaborative involvement over the wider health economy.

☐ **Improving and sustaining:** Our Board and wider system focus on constancy of purpose through multi-year journey with improvement at its core.

12. Board development to empower collective improvement leadership:

☐ **Starting:** Our Board discusses improvement at Board meetings, but it is not a regular occurrence.

☒ **Developing:** Our Board has received some improvement training and visits parts of the organisation at least monthly. Improvement is discussed at every board meeting.

☐ **Progressing:** Our executive and senior leadership works with managers and teams across the organisation to enable and co-ordinate improvement.

☐ **Spreading:** Our executive and senior leadership and management teams actively enable staff to own improvement as part of their everyday work.

☐ **Improving & Sustaining:** Our leaders – chief executive officer and chair through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care/operational work is delivered.

13.'Go and see' visits:

☒ **Starting:** Some senior leaders spend time engaging directly with staff from time to time, but it is not routine or widely practised. This can be in person during ‘go and see visits’ or virtually.

☐ **Developing:** Our executive and senior leaders understand the importance of engaging directly with staff, but we have variation in leader participation; some leaders and managers use our improvement tools.

☐ **Progressing:** Our executives regularly engage directly with staff; they incorporate the tools and methods into their meetings, strategic planning and daily management.

☐ **Spreading:** All levels of leadership and management engage directly with staff as a matter of routine and the insights they gain inform decision making and problem solving to support improvement.

☐ **Improving and sustaining:** All levels of leaders and managers undertake regular learning or ‘go and see’ visits at external bodies to visit their site and to observe different ways of working.

Building improvement capability and capacity

What this looks like in practice:

- Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement.
- Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work.
- Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.
- Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work.
- Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.
- Create and embed a training strategy to increase improvement capability.
- Senior leaders and managers attend team huddle boards and work to unblock issues which teams are facing.

14. Improvement capacity and capability building strategy:

☐ **Starting:** We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (for example, academic health science networks and Institute for Healthcare Improvement Open School).

☐ **Developing:** Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.

☒ **Progressing:** Training is a balance of technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing improvement capability.

☐ **Spreading:** Sustainability is addressed via ‘in-house’ training and development approaches including train the trainer models. Improvement capability building for ‘lived experience’ service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.

☐ **Improving and sustaining:** There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with more than 80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation shares capability, building learning with other sites, regionally and nationally.

15. Clear improvement methodology training and support:

☐ **Starting:** No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.

☐ **Developing:** There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development and training needs for NHS IMPACT components, alongside a dosing formula and training strategy to support capability building ambitions.

☒ **Progressing:** Clarity exists on which improvement methodology and approach is being consistently applied. There is a longer-term commitment to training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.

☐ **Spreading:** Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.

☐ **Improving and sustaining:** Learning from improvement activity is driving continuous improvement. There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.

16. Improvements measured with data and feedback:

☐ **Starting:** Our organisational approach to reviewing and tracking progress against goals has yet to be defined. At present improvement doesn't feature in whole organisational measures.

☐ **Developing:** We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad hoc and stakeholders do not feel it supports them to deliver.

☐ **Progressing:** We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.

☒ **Spreading:** Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet

the clearly defined goals if required. Data analysts and business intelligence teams are integral to tracking improvement.

☐ **Improving and sustaining:** Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer-term sustainability are reviewed regularly at organisational level.

17. Co-production:

☐ **Starting:** We have small discrete teams with relevant skills operating independently from one another. They are working in silos reporting to various senior leaders with no lived experience partners co-producing improvement.

☒ **Developing:** People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvement, but this is rarely shared across departments.

☐ **Progressing:** People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, people with lived experience and other stakeholders have access to improvement capability development.

☐ **Spreading:** Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together.

☐ **Improving and sustaining:** Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process.

18. Staff attend huddles:

☐ **Starting:** Any huddles are only traditional legacy mechanisms (for example, shift change clinical handovers).

☒ **Developing:** There is a plan in place for team huddles to focus on continuous improvements in some areas with clinical and operational staff in attendance.

☐ **Progressing:** The majority of areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all clinical/operational/support areas.

☐ **Spreading:** All clinical/operational/support areas have continuous improvement team huddles established.

☐ **Improving and sustaining:** There is a cascade of huddles for all teams from executive to frontline teams (clinical/operational/support) which hold regular continuous improvement huddles using a standardised format and process.

Embedding into management systems and processes

What this looks like in practice:

- Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at Board level, throughout and across all services and functions.
- Put systems in place to identify and monitor early warning signs for all organisational process and quality risks. Ensuring clear standard processes of how to respond to these.
- Set up the management system as a standard way of operating that enables ongoing continuous improvement of access, delivery, quality, experience, value and outcomes whilst ensuring financial sustainability.
- Build a management system with a consistent and coherent set of systems and processes that enables the organisation to respond to system and national priorities more easily and with greater agility.
- A committed Board and senior leadership team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.

19. Aligned goals:

☐ **Starting:** Where improvement plans exist they are very locally determined and driven. Our strategic planning is an activity conducted at Board and senior leadership level but executives' and functions goals are often not well aligned with each other.

☐ **Developing:** We do not share improvement planning across our organisation with departments and directorates feeling siloed. Our business planning is an activity conducted at executive leadership level to produce goals that are cascaded top-down to the rest of the organisation.

☒ **Progressing:** Our organisational goals are established to support our overall vision; our department/team goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.

☐ **Spreading:** Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.

☐ **Improving and sustaining:** Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.

20. Planning and understanding status:

☐ **Starting:** Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.

☒ **Developing:** Our business planning and performance management processes give the executive leadership team reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.

☐ **Progressing:** Our business planning and performance management processes give the executive and senior leadership team and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff from enabling services (for example, human resources, finance, communications, information) understand our improvement priorities and embed them within and across their work across the organisation.

☐ **Spreading:** Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff from enabling services understand our improvement priorities and embed them within and across their work across the organisation.

☐ **Improving and sustaining:** Our business planning and performance management processes give good visibility of status and progress against our goals across all teams and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.

21. Responding to local, system, and national priorities:

☐ **Starting:** We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead, it is perceived as reactive or firefighting.

☐ **Developing:** Across the organisation, we believe having a management method (for example, lean) is important to our success. Some of our leaders are using management methods, which is recognised to be helping.

☒ **Progressing:** Most senior leaders and managers in the organisation use our management methods to manage and run their areas, including responding to problems that may arise or to take account of changing priorities.

☐ **Spreading:** Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG (red, amber, green - a risk management rating system) or tables. Our business decisions are aligned with our management system goals.

☐ **Improving and sustaining:** All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (for example, SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.

22. Integrating improvement into everything we do:

☐ **Starting:** Improvement is seen as separate to the day-to-day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply and may be sending conflicting signals within the organisation.

☒ **Developing:** Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some areas.

☐ **Progressing:** Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many areas across the organisation.

☐ **Spreading:** As part of our management system, all parts of the organisation are using improvement methods, and learning occurs between areas (for example, to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.

☐ **Improving and sustaining:** The way we understand, manage and improve performance across the organisation, including how we use and report data, is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

QI Maturity Assessment

November 2023

Dame Marianne Griffiths
David Townsend
Denise Farmer

Eden Health and Social Care Ltd

CONTENT

1 PURPOSE OF REVIEW

1. **Provide independent view of maturity of Quality Improvement system**
   - High performing organisation take time to reflect, review and plan
   - Independent assessment brings an objective view and external comparison
2. **Highlight and celebrate the progress and delivery to date**
   - We do not always recognise our success as it becomes business as usual
   - We do not always take time to reflect and celebrate the great progress we have made
3. **Identify opportunities to progress**
   - Having a full view of maturity shows the breadth of potential opportunities
   - This will help to determine the priorities for your roadmap ahead
4. **Provide maturity model to allow organisation to use and review progress in the future**
   - You can see how you have progressed against the plan you put in place from this review
   - You can map your improvement journey over time and continually identify opportunities
5. **Provide maturity model which can be developed for benchmarking with other organisations**
   - There is the potential to network and share maturity outputs with others for mutual support and understanding

2 METHODOLOGY

Documents

- a review of current reports, CI material and material on Trust operation and performance

Interviews

– 121 meetings with Executive team, CI team, Divisional leadership and Corporate leadership

- collection of views on CI system and how it is operating currently

Process Observation

– review of SDR meetings and SDR reports

Maturity model

-

- assessment of maturity against domains
- review of maturity against CI principles
- collection of strengths and opportunities against the maturity domains
- recommendations based on assessment

3 MATURITY MODEL

The maturity model has 3 areas of assessment.

A : Foundations is the readiness assessment model used at start of an organisations CI journey. It provides relevant criteria for success and is used to assess the status of 4 domains needed to progress.

B : QI Pillars matrix looks in more depth at the application of the QI system across six pillars

C : Environmental Factors captures the external and the organisational situation across nine domains, as we know these can impact on the ability to progress maturity of the QI system

All 3 areas are scored using 5 levels of maturity to provide consistency of assessment across all areas.

CI Maturity Matrix Foundations

CI Maturity Matrix Foundation & Pillar Levels

0 No Evidence
1 Early Progress
2 Good Progress
3 Maturity
4 Exemplar

CI Maturity Matrix Environment Levels

0 Disruptive
1 Challenging
2 Neutral
3 Supportive
4 Enables

	QI Maturity Matrix Pillars
1	**Stategy Development**
1	True North
2	Vision & Values
3	Strategic Priorities
4	Breakthrough objectives
5	Strategic Initiatives
6	Corporate Projects
7	QI Governance arrangements
8	QI assurance report
9	Visual Mananagement
10	Capability development plan
2	**Strategy Deployment**
11	Engagement & communication
12	Business rules
13	Project filter
14	Roadmap
15	PFIS roll out plan
16	Clear criteria to measure programme effectiveness
17	Driver & watch metrics
18	Dashboards
19	Catchball
20	
3	**PFIS**
21	Team readiness assessment
22	Status Exchanges
23	Improvement huddles
24	A3s & PDSA approach
25	Standard work
26	Countermeasure summaries
27	Process improvement and waste reduction
28	Engagement and support
29	Maturity model
30	Performance improvement
4	**Kaizen Team**
31	Clarity of role and remit of Team
32	Team capability
33	Team performance
34	Team development
35	Visibility
36	Level of contribution - strategic/operational
37	Recognition of contribution
38	Team and individual goals & objectives
39	Contribution to development of improvement system
40	Evidence of innovation and continuous improvement
5	**Projects**
41	Green belt projects
42	Yellow belt projects
43	A3s
44	Use of data, root cause and evidence
45	Ownership and progress tracking
46	Prioritisation and resources
47	Process for project selection and leadership
48	Alignment of projects to strategy and priorities
49	
50	
6	**Leadership Behaviours**
51	Personal A3
52	Behaviours self assessment & improvement
53	Coaching & teaching others
54	Being coached
55	Leader standard work
56	Visibility
57	Gemba visits
58	
59	
60	

	QI Maturity Matrix : Environmental Factors
1	**System**
	Maturity of regional structure
	Relationships with local partners
	Reputation in local system
	Size of agenda and level of demand on the Trust
2	**Quality**
	CQC Rating and action plans
	Governance arrangements
	Performance
	Limited focus on person centered care
3	**Workforce**
	Turnover
	Vacancies
	Engagement
	Staff shortages and high use of agency staff
	Not allowing dedicated staff time for training and development
4	**Corporate Services**
	Sufficient resources
	Strength & depth of resources
	Alignment of priorities
	Size of agenda
	Ability to support front line services
	Communication effectiveness
5	**Infrastructure**
	Quality of Estate
	Effectiveness of IT systems
	Lack of management time or organisational capability
	Systems not set up to support integration into existing processes
6	**Finances and Funding**
	Financial performance
	Level of CIP
	Capital allocation
	System financial situation
	Budget management and control
7	**Information & Data**
	Availability of data
	Access to accurate and timley information
	Lack of information sharing within organisations and teams
	Insufficient use of data available
	Insufficient information and analysis systems
	Lack of, or inflexible, feedback structures in place
8	**Culture**
	Lack of culture of improvement
	Perceived culture of blame
	Insufficient engagement of professionals and patients
	Lack of priority placed on improvement
	Risk averse culture and prioritisation of defensive practices
	Behaviours and 'rituals' that undermine improvement
9	**Leadership**
	Lack of strong leadership and a shared vision for improvement, including at board level
	Hierarchical leadership culture rather than transformational or engaging leadership
	Not ensuring leadership and autonomy for improvement at multiple organisational
	Lack of accountability for improvement
	Wanting to see 'quick wins' rather than allowing improvement time to embed

3A MATURITY MATRIX – FOUNDATIONS

Domain	Description	Level 0 - No	Level 1 - Early progress	Level 2 - Good progress	Level 3 – Maturity	Level 4 - Exemplar
Good People	The extent to which the workforce is engaged with improvement	Evidence of staff disengagement with improvement. No locally led service improvement.	Some signs of some staff engaging with improvement. A few examples of locally led service improvement but limited to a small range of staff groupings.	Good evidence of staff engaging with improvement across a broad range of staff groupings. Locally led service improvements across a range of staff groupings.	Strong evidence of staff engaging with improvement across most staff groupings. Locally led service improvements across most staff groupings.	Comprehensive evidence of staff engaging improvement across all staff groupings. Locally led service improvement across all staff groupings.
Leadership consistency	The extent to which there is a strong and stable board that is able to lead the continuous improvement journey and how it integrates within the organisation	High recent turnover at Board level and interims in key leadership positions. No shared vision for continuous improvement. Multiple priorities.	Stable Board and most leadership positions are substantively filled. Board can articulate its vision for continuous improvement but limited evidence of it being shared by staff. Defined range of priorities and clear improvement focus.	Board vision for continuous improvement is shared by all senior leaders and by key stakeholders. Board has defined its risk appetite.	Board vision for continuous improvement is shared by all staff. Board has identified trade- offs to enable their vision for continuous improvement. Explicit support from external stakeholders including regulators.	External stakeholders acting as ambassadors for the trust brand and supporting other trusts in their continuous improvement journeys.
Culture	The extent to which the organisation culture will enable continuous improvement.	Lack of recognition of the value of improvement.	There is broad recognition of the value of improvement and its contribution to improving quality across the organisation.	There is an open and learning culture that supports innovation and managed risk taking. The workforce is empowered to solve their own problems.	There are service and clinical champions sharing best practice across the organisation.	There are service and clinical champions sharing best practice with other organisations.
Method	The extent to which an improvement management system and methodologies are used in the organisation.	Lack of understanding of lean improvement methodologies.	There is broad understanding of a lean improvement system and the tools that may be used.	There is evidence of lean improvement tools being used to deliver improvement across a number of services.	There is evidence of lean improvement tools being used to deliver improvement across a number of services. A lean improvement system is deployed in specific areas and is understood by staff in those areas.	There is a fully embedded lean improvement system that is understood by staff and is delivering improvement.

3B MATURITY MATRIX – QI PILLARS

	QI Maturity Matrix Pillars					
1	**Stategy Development**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
1	True North	Vision & values not recognised in Trust. Multiple strategic priorities and competing demands. No clear process to determine priorities. QI is seen as project.	Strategic priorities are limited and focussed on True North. Process in place to communicate priorities and align reporting. QI development plan and reporting in place.	Strategic, breakthrough and corporate priotoes are aligned. Cascade process in place. Development of service engagement of prioritisation and visibility of contribution to improvement.	There is an effective process to regularily review priorities up and down the organisation. There is one performance management system operating at all levels of the organisation. Performance is visual.	Clarity, visibility & alignment of Trust priorities across whole organisation. Clear & regular process for priority review.
2	Vision & Values					
3	Strategic Priorities					
4	Breakthrough objectives					
5	Strategic Initiatives					
6	Corporate Projects					
7	QI Governance arrangements					
8	QI assurance report					
9	Visual Mananagement					
10	Capability development plan					
2	**Strategy Deployment**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
11	Communication plan	Performance management focussed on current challenges. Large number of metrics all with equal value. No alignment or consistency of performance monitoring.	Roadmap developed. Performance management system focussed on key priorities. Development plan in place for new QI management system.	SDR operating at Divisional level. Performance meetings using business rules. Some fromt line teams working on Driver metrics	Countermeasure summaries being used consistently to report progress. Annual strategic planning & QI system fully aligned.	Alignment and clarity of QI system evident at all levels of the organisation. Standard processes and standard work in place to maintain and improve the QI system. Value and performance of QI system is clear to everyone.
12	Business rules					
13	Project filter					
14	Roadmap					
15	PFIS roll out plan					
16	Clear criteria to measure programme effectiveness					
17	Driver & watch metrics					
18	Dashboards					
19	Catchball					
20	Countermeasure summaries					
3	**PFIS**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
21	Team readiness assessment	Training of front line teams has not started. Teams not using QI tools and processes.	Some teams trained. Variable maturity. No maturity matrix in place. Not all tools and processes in place in teams that have been trained. Team selection plan in place.	Roll out underway. Some Divisions are complete. Demand created to attend training. Driver metrics improving. Clarity of maturity of teams. Training effectiveness measured and improving	Over 50% of teams trained. Majority of teams operating QI management wystem. Join up from team to board in place. Corporate teams have had their version of PFIS.	Majority of teams trained. Maturity matrix shows majority at high level. Leaders spending time coaching & improving management system. Breakthrough results being delivered.
22	Status Exchanges					
23	Improvement huddles					
24	A3s & PDSA approach					
25	Standard work					
26	Leadership support					
27	Process improvement and waste reduction					
28	Engagement					
29	Maturity model					
30	Performance improvement					

3B MATURITY MATRIX – QI PILLARS

	QI Maturity Matrix Pillars					
4	**Kaizen Team**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
31	Clarity of role and remit of Team	No QI Team is in place. Team going through transformation and not yet operational. Performance & behaviour issues currently.	Limited capability. Focus is on operational delivery. Clear role and remit for team. Developing role and contribution.	Team is contibuting to training and projects. Capability is evident and developing. Performance is clear and contribution recognised by others. Team leadership strong.	Team has established standard work. Leading by example. Team capability in demand from orgnaisation. Have an active coaching role. Active and valued Contribution to development of system and QI model	Team members are supporting externally and showcasing QI to others. Contibuting at strategic & operational levels. Evidence of innovation. Evidence of continuous improvement.
32	Team capability					
33	Team performance					
34	Team development					
35	Visibility					
36	Level of contribution - strategic/operational					
37	Recognition of contribution					
38	Team and individual goals & objectives					
39	Contribution to development of improvement system					
40	Evidence of innovation and continuous improvement					
5	**Projects**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
41	Green belt projects	No visibility of number, size & resources working on projects. Random project initiation. No tracking or measurement of outcomes/success.	Project tracking at some levels. Project mapping is underway to understand whole picture.	Common project methodology in place & in use. Project resources working in an aligned way with QI team. Some QI project resource have been trained. A number of projects are using QI methodology.	Project prioritisation process in operation. Resource requirements & impact part of project selection process. Project methodology uses QI tools. Alignment of projects at Exec, divisional and service level.	Projects align and support strategic priorities. Trained and skilled project resources available to every Division & service. Priorities & alignment of projects reviewed regularity as part of standard work.
42	Yellow belt projects					
43	A3s					
44	Use of data, root cause and evidence					
45	Ownership and progress tracking					
46	Prioritisation and resources					
47	Process for project selection and leadership					
48	Alignment of projects to strategy and priorities					
49						
50						
6	**Leadership Behaviours**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
51	Personal A3	Traditional leadership model remains in place. No leadership training completed. Priority remains on quick wins, immediate results and fire fighting. Improvement system development not being supported	Some leadership training completed. Some tools being used. Team has advocates and people with desire to learn and improve. Some parts of management system are being used by leaders.	Leaders understand their behaviours and are actively working on personal improvement. BAU and management processes are being improved. Leaders are visible and seen to be supportive of QI.	Leaders are being coached. QI leadership and behaviours training are embedded in standard processes. There is a process to develop new starters and new leaders	Leaders are coaching and teaching. There is standard work for key processes and activities. Leaders are continuously improving and reflecting. Others see Leaders leading by example. Leaders are influencial with external CI development
52	Behaviours self assessment & improvement					
53	Coaching & teaching others					
54	Being coached					
55	Leader standard work					
56	Visibility					
57	Gemba visits					
58						
59						
60						

3B MATURITY MATRIX – QI PILLARS

	Pillar Evidence
1	Strategic priorities are clear and well communicated
2	Corporat teams and their agendas are aligned to front line services
3	Priorities, performance and goals are visible across the organisation
5	QI development plan is in place for the next 1 to 3 years
6	QI roll out, development and performance is being reviewed monthly
7	There is a process to determine priorities and continually manage competing demands
8	Majority of resources are focussed on organisational priorities
9	A3 thinking and A3 problem solving is embedded across organisation
10	Performance is improving
11	Waste is being eliminated
12	There is greater value added processes and activities
13	Standard methods are being consistently used
14	There is clarity of progress and maturity of QI in the organisation
15	Engagement and support for QI is high across the organisation
16	There is dedicated QI expertise with the capacity and capability to support
17	The quantity of improvements is increasing every month
18	Leaders are demonstrating the right behaviours and continusly improving themselves
19	The voice of the patient is actively and widely used to deliver improvements
20	The capacity and capability of improvement resources is increasing

	Pillar Evidence
21	Learning is captured at end of project/countermeasure work
22	Improvement work creates value for the **patient**
23	Creating Value add to the organisation
24	Creating constancy of purpose
25	Systematic scientific approach
26	Focus on key results
27	Focus on key behaviours
28	Alignment of Key priorities
29	Common QI tools and one system
30	Enablement - move from doing to enabling
31	Assure quality at source
32	Inch wide mile deep
33	Delivery of 3Ms improvements (Waste; Process variation; Overburden)
34	Use of data analysis and information
35	Visual Management
36	Alignment of improvement, performance, regulation and governance
37	Capability building - increasing CI resource & expertise
38	Balance of corporate, divisional and service priorities
39	Leaders support improvement at all levels
40	Countermeasure reports used to update on progress

3C MATURITY MATRIX - ENVIRONMENTAL FACTORS

QI Maturity Matrix : Environmental Factors	0 Disruptive	1 Challenging	2 Neutral	3 Supportive	4 Enables
1 System					
Maturity of regional structure	Multiple meetings with no value. Continual data & information requests. Competition with others. Under spotlight for performance. Poor behaviours from partners.	Size of agenda. Multiple organisations in difficulties. Competing priorities.	Agenda is not having major impact on Trust priorities. Demands and support manageable.	Others understand and supportive of challenges and aspirations. Good relationships with partners. Some alignment of priorities.	Active support from others to our priorities. Leadership role in system improvement. Influential on wider agenda
Relationships with local partners					
Reputation in local system					
Size of agenda and level of demand on the Trust					
2 Quality					
CQC Rating and action plans	Significant plans in place to meet external quality concerns. Poor internal processes to deliver, understand and manage quality of delivery. Significant adverse performance on key quality metrics.	Difficulties delivering safe services. Performance information poor. Reactive approach predominates. Multiple action plans.	Good governance arrangements in place. No significant quality issues. Clarity of performance. Services understand and deliver on key regulartory and national standards.	Governance is aligned to QI system. Primary focus is on improvement activity rather than retrospective reporting.	High performing against peers. Recognised externally for quality of services and delivery.
Governance arrangements					
Performance					
Limited focus on person centered care					
3 Workforce					
Turnover	Large gaps in workforce. Difficulty recruiting. Reliance on agency and temporary workforce. Poor staff survey results. Relationships between staff and leaders strained. Services and disciplines self serving	No time for staff development. No clear recruitment and retention strategy. High level of staff dissatisfaction.	Some service areas with gaps but majority stable. Sufficient resources with some reliance on agency support. Plans and progress on recruitment and retention strategy.	Staff survey results strong. Workforce engaged and support improvement activity. Trunover and vacancy levels stable or improving. Resources sufficient to meet demands on service delivery.	Workforce have time and motivation to learn and contribute to improvement. Services have expertise to deliver and develop. There is good stability and succession planning in place for key roles.
Vacancies					
Engagement					
Staff shortages and high use of agency staff					
Not allowing dedicated staff time for training and development					

3C MATURITY MATRIX - ENVIRONMENTAL FACTORS

QI Maturity Matrix : Environmental Factors	0 Disruptive	1 Challenging	2 Neutral	3 Supportive	4 Enables
4 Corporate Services					
Sufficient resources	Silo working. Lack of expertise. Competing demands. Critical gaps in capacity of key resources. Major works or projects which will significantly impact service delivery.	Poor communication challenges between corporate teams and clinical services. Not enough resources to deliver agenda.	Responsive to business needs. Managing demands with minimal disruption.	Support to clinical services recognised and valued. Processes improving to reduce waste and increase Value Add.	Corporate teams trained & using QI tools to improve delivery. Corporate agenda aligned to clinical services and making a positive contribution to patient service delivery. Corporate services actively engaged with clinical teams on improvement projects.
Strength & depth of resources					
Alignment of priorities					
Size of agenda					
Ability to support front line services					
Communication effectiveness					
5 Infrastructure					
Quality of Estate	Insufficient space to deliver services. Quality of space not fit for purpose. Reactive response to issues. Problems take too long to be resolved. Patient delivery disrupted.	Poor quality space for patients and staff. Major development or changes to estate or systems which will consume staff time and impact on continuity of delivery	No major challenges or deficits to infrastructure. Majority of services have sufficient space. Systems are supporting clinical delivery	High quality estate. Systems integrated and information is accurate, up to date and useful to corporate and front line services. Stong and capable management support.	Patients have good access to quality environment. Staff have the resources needed to support them deliver services. There is development and investment plan to maintain and improve infrastructure.
Effectiveness of IT systems					
Lack of management time or organisational capability					
Systems not set up to support integration into existing processes					
6 Finances and Funding					
Financial performance	Large CIP with no plan. Capital constained and not able to invest in critical infrastructure. Poor visibility of financial performance. Lack of budgetary management and control	Size of CIP is challenging and no clear delivery plan. Lack of engagement to targets.	Sufficient capital to meet current priorities. Good budget management processes with clear plans and reporting of performance.	System is in financial balance. Capital allocation is supporting investment plan. Good financial performance.	Generating surplus which can be reinvested. Clear and positive financial plan for net 3 years. QI improvements delivering productivity gains.
Level of CIP					
Capital allocation					
System financial situation					
Budget management and control					

3C MATURITY MATRIX - ENVIRONMENTAL FACTORS

QI Maturity Matrix : Environmental Factors	0 Disruptive	1 Challenging	2 Neutral	3 Supportive	4 Enables
7 Information & Data					
Availability of data	IT systems not fit for purpose. Data is out of date and inaccurate. Insufficinet resources. High burden of data collection with minimal benefit to teams. Focus on IT system needs rather than IT support to clinical services.	Multiple systems and no alignment or integration adding to data entry and reporting burden. Data breaches and immature IT governance	Visibility of performance at organisation level. Front line teams have sufficient information to deliver services. Data capture is manageable and capability to develop and deliver information reports	Information reporting consistent and comprehensive. Useful information avaialble at all levels of the organisation. Information accurate and used to support delivery and improvement.	Management information easily available, accurate, up to date. Data used to inform decisions and analysis. Teams have access to support and information
Access to accurate and timley information					
Lack of information sharing within organisations and teams					
Insufficient use of data available					
Insufficient information and analysis systems					
Lack of, or inflexible, feedback structures in place					
8 Culture					
Lack of culture of improvement	Fire fighting is the norm. Poor behaviours accepted. We know best approach. Services compete internally for resources. Historic ways of working which are embedded and not delivering best outcomes.	Teams over burdened and unrealistic demands & expectations. Patient feedback is not used to inform service development. Silo working and inconsistent delivery.	Teams work well with each other. People open to new ideas. Effective communication channels.	Evidence of innovation and promotion of new ideas from across organisation. People positive about Trust and motivated to improve. Good clinical engagement and clinical leadership.	Teams supportive of change and patient focussed. Good inter team working. Compassionate people. Staff feel valued and passionate about the organisation
Perceived culture of blame					
Insufficient engagement of professionals and patients					
Lack of priority placed on improvement					
Risk averse culture and prioritisation of defensive practices					
Behaviours and 'rituals' that undermine improvement					
9 Leadership					
Strong leadership and a shared vision for improvement, including at board level	Command and control approach. Lack of trust and poor teamwork. High instability and lack of experience in leadership team. Disagreement on priorities and approach. Agenda dominated by 1 or few people. Cliques operating.	Gaps and deficits in leadership structure. Multiple styles and approaches causing confusion and inconsistency. Conflict and politics impacting on progress.	Positive leadership developing. Leaders do not negatively impact service delivery. Good leadership evident and supported.	Leaders take time to develop self and others. Alignment and consistency of approach across leadership team. Compassionate and supportive leadership approach.	Alignment of leadership team and desire for continuous improvement. Proactive in support of QI management system. Strong development and succession planning. Leaders behaviours support delivery and development of QI.
Hierarchical leadership culture rather than transformational or engaging leadership					
Leadership and autonomy for improvement at multiple organisational levels					
Lack of accountability for improvement					
Wanting to see 'quick wins' rather than allowing improvement time to embed					

4A MATURITY ASSESSMENT – FOUNDATIONS

This is our assessment of MTW maturity against the foundations needed for successful deployment of a Continuous Improvement system.

There are good foundations in place with strong domains and evidence of progress. People and culture are strongest with all domains showing progress.

This result is better than the findings from other healthcare organisations we have assessed.

This provides a strong foundation to build on and we did not identify anything which is a blocker or threat to the ability to progress.

Domain	Description	Level 0 - No	Level 1 - Early progress	Level 2 - Good progress	Level 3 – Maturity	Level 4 - Exemplar
Good People	The extent to which the workforce is engaged with improvement	Evidence of staff disengagement with improvement. No locally led service improvement.	Some signs of some staff engaging with improvement. A few examples of locally led service improvement but limited to a small range of staff groupings.	Good evidence of staff engaging with improvement across a broad range of staff groupings. Locally led service improvements across range of staff groupings.	Strong evidence of staff engaging with improvement across most staff groupings. Locally led service improvements across most staff groupings.	Comprehensive evidence of staff engaging improvement across all staff groupings. Locally led service improvement across all staff groupings.
Leadership consistency	The extent to which there is a strong and stable board that is able to lead the continuous improvement journey and how it integrates within the organisation	High recent turnover at Board level and interims in key leadership positions. No shared vision for continuous improvement. Multiple priorities.	Stable Board and most leadership positions are substantively filled. Board can articulate its vision for continuous improvement but limited evidence of it being shared by staff. Defined range of priorities and clear improvement focus.	Board vision for continuous improvement is shared by all senior leaders and by key stakeholders. Board has defined its risk appetite.	Board vision for continuous improvement is shared by all staff. Board has identified trade- offs to enable their vision for continuous improvement. Explicit support from external stakeholders including regulators.	External stakeholders acting as ambassadors for the trust brand and supporting other trusts in their continuous improvement journeys.
Culture	The extent to which the organisation culture will enable continuous improvement.	Lack of recognition of the value of improvement.	There is broad recognition of the value of improvement and its contribution to improving quality across the organisation.	There is an open and learning culture that supports innovation and managed risk taking. The workforce is empowered to solve their own problems.	There are service and clinical champions sharing best practice across the organisation.	There are service and clinical champions sharing best practice with other organisations.
Method	The extent to which an improvement management system and methodologies are used in the organisation.	Lack of understanding of lean improvement methodologies.	There is broad understanding of a lean improvement system and the tools that may be used.	There is evidence of lean improvement tools being used to deliver improvement across a number of services.	There is evidence of lean improvement tools being used to deliver improvement across a number of services. An improvement system is developed in specific areas and is understood by staff in those areas.	There is a fully embedded lean improvement system that is understood by staff and is delivering improvement.

Health Variation: The Improvement Journey	Our Assessment
Leadership & Governance Visible & focused leadership Effective governance & management processes	Leadership engaged and developing An effective QI management system has been developed.
Infrastructure & Resources A management system & infrastructure capable of providing teams with the data, equipment & resources to plan and deliver sustainable improvement	Effective introduction, development and roll out of QI system. Partnering model and access to capable and supportive resources
Skills & Workforce A programme to build the skills and capability of staff throughout the organisation	Exceptional leaders programme and QI training plan are both developing capability and capacity
Culture & Environment The presence of a supportive, collaborative and inclusive workplace culture that allows reflective thinking with new ideas and approaches.	Talented and capable people with a desire to improve. Focus on delivery for patients. Environmental challenges being effectively managed.

We also reviewed literature and a range of documents produced to support organisations looking at improvement system introduction.

This is our assessment of MTW using the Health Foundation Learning report

The Improvement Journey – why organisational improvement matters and how to get started.
Bryan Jones, Tim Horton and Will Warburton: May 2019

We have taken the information and evidence gathered and applied it to the enablers identified in the report.

Again, this shows positive factors across all 4 domains with Infrastructure & Resources along with culture & environment as the strongest.

4B MATURITY ASSESSMENT PILLARS – STRATEGY

	QI Maturity Matrix Pillars							
1	**Stategy Development**	**0**	**1**	**2**	**3**	**4**	**Positive Evidence**	**Gaps Identified**
1	True North				■		All Divisions view priorities as agreed and jointly owned. "development of performance forecasting reporting" "involved in catchball (Corporate team)" "GIRFT, model hospital and True North all brought together to avoid duplication" "corporate teams supportive of/to clinical teams"	Is EPOC linked to Continous Improvement system and how are benefits being measured? *Use of process observation chart. Extent of visual management. "Hard to see our contribution to Corporate goals" "not sure transformational work is following lean processes" "CI development plan for Division not clear" "Inspections and regulation not picked up in SDR" "Not the understanding at Exec of size of (regulation/scrutiny) agenda" "Visual management is limited" "are priorities based on data and biggest win?" "Quality improvement committee & seperate governanace structure(s) - duplication" "Consistency/maturity sporadic - people do not have total understanding of system and support not in place to coach and develop"*
2	Business rules				■			
3	Strategic Priorities				■			
4	Breakthrough objectives				■			
5	Strategic Initiatives				■			
6	Corporate Projects			■				
7	QI Governance arrangements			■				
8	QI assurance report			■				
9	Visual Mananagement			■				
10	Capability development plan			■				
2	**Strategy Deployment**	**0**	**1**	**2**	**3**	**4**		
11	Communication plan			■			*"Divisional leads own CI" "More people are presenting at SDR" SDR well supported in Division" "Continuous improvement mindset, even when performance is high" "roadmap refreshed in August" SDR provides structure" "Weekly SDR meetings (in Division)" "SDR has delivered results and focus" "allows Division to showcase priorities progress to Exec" "can see value of SDR for Division" "business partner model with Divisions"*	Role of all Executives and collective approach. Some concerns & emerging issues are picked up outside of CI processes and system. Still operating duplicate and alternative meeting/processes. *"CI development plan for Division is not clear - what & who" "some pockets not engaging and some consultants not engaged" "Time after SDR to reflect and deliver" "ownership of roadmap?" "SDR seen as additional thing" "Finance partners swamped" "BI limited capacity" "no visibility of other Divisions priorities" "feedback to Divisions on next streps (for CI)" "Dashboard imposed and difficult as 60% is non applicable" "SDR not always representative of important things for Division and does not give frich picture and feeling of accountability (finance & risk)" "lots of BAU stuff sits outside SDR process and some seperate dashboards"*
12	Business rules			■				
13	Project filter			■				
14	Roadmap			■				
15	PFIS roll out plan				■			
16	Clear criteria to measure programme effectiveness			■				
17	Driver & watch metrics				■			
18	Dashboards				■			
19	Catchball				■			
20	Countermeasure summaries			■				

4B MATURITY ASSESSMENT PILLARS – PFIS & KAIZEN TEAM

	QI Maturity Matrix Pillars							
3	**PFIS**	0	1	2	3	4		
21	Team readiness assessment			■			*"Teams enthusiastically embracing CI" "most leaders (8B and above have been through training" "57% of Division has been trained and 15 different huddle board operating" "PFIS for leaders is 80%" "PFIS training reviewed after each cohort and improvements delivered" "looking at 2 day yellow belt training" "looking at lean training fro junior doctors" "Refresh training at induction and for new starters" "maturity assessment being developed and trialled" "good feedback from CI training" "corporate PFIS in development" "workbook produced and updated after each cohort"*	*How is effectiveness of training evaluated and is it providing teams with ability to self sustain? Corporate PFIS in development. Training not yet complete for Divisions. "consistency & maturity sporadic - people do not have total understanding of system and support not in place to coach and develop" "some teams feel unsupported doing CI work" "some huddles used to moan about problems rather than deliver value to patients" "not enough opportunity for teams to work on their improvements" "A3 needs more embedding & training" "clinicians not engaged or attenting training" "teams are receiving huddles rather than engaging in them"*
22	Status Exchanges		■					
23	Improvement huddles		■					
24	A3s & PDSA approach			■				
25	Standard work		■					
26	Leadership support			■				
27	Process improvement and waste reduction		■					
28	Engagement				■			
29	Maturity model		■					
30	Performance improvement			■				
4	**Kaizen Team**	0	1	2	3	4		
31	Clarity of role and remit of Team			■			"PMO Team going through PFIS training in new year" "positive feedback on support provided after training" "Division is well supported"	*"Not a consistent standard in QI team" "Clarity of QI team role and responsibilities" "Not getting resource to support projects but getting admin" "Resource constrained" "mixed level of capability in team" "Lack of QI team leadership" "concern about current black and green belt training being undertaken - too technical and unsure of benefit" "have not pulled away support from any PFIS teams so concern about sustainability" Access to space/desk" "limited engagement with other QI trusts" "some silo working"*
32	Team capability			■				
33	Team performance			■				
34	Team development			■				
35	Visibility				■			
36	Level of contribution - strategic/operational				■			
37	Recognition of contribution				■			
38	Team and individual goals & objectives			■				
39	Contribution to development of improvement system		■					
40	Evidence of innovation and continuous improvement			■				

4B MATURITY ASSESSMENT PILLARS – PROJECTS AND LEADERSHIP BEHAVIOURS

	QI Maturity Matrix Pillars							
5	**Projects**	0	1	2	3	4		
41	Green belt projects	■					*"patient experience manager for Division and keen to have patient representatives" "have some of the best business partners" "focus is on the patient even non patient facing teams" "some improvement tickets raised by patients"*	*"danger of copy and paste (project reports)" Lots of other projects/work (outside of CI projects) - where does work come from and how is it prioritised" "some things stay on for 12 months - could be quicker" "More being added, less coming off" "middle managers have different priorities and multiple projects" "not sure transforamtion work is following lean processes" "projects focussed on performance rather than pathways" "people not able to lead and manage own A3s" "Divisions need to refocus - doing too much and things being done under the radar"*
42	Yellow belt projects	■						
43	A3s				■			
44	Use of data, root cause and evidence				■			
45	Ownership and progress tracking				■			
46	Prioritisation and resources				■			
47	Process for project selection and leadership			■				
48	Alignment of projects to strategy and priorities		■					
49								
50								
6	**Leadership Behaviours**	0	1	2	3	4		
51	Personal A3	■					Examples of coaching style, listening and supportive behaviours. *Exceptional Leaders programme. "Exec leadership really supportive and visible" "CEO is going to floor to do healthcare work" "Steve is a good advocate and has a coaching style" "Exec engaged and can tell Steve believes in methodology and helps with coaching style" "good role models and lots of 121 time with Exec" "Clinically led (Divisions)" "Collaborative leadership" "leadership supportive with grip and trusted" "Exec all very approachable and open to listen" "Execs commited to CI - people now realise it is here to stay"*	Role and confidence of all Executive team. Role and engagement of clinicians and managers below senior Divisional Leads. CI leadership behaviours under developed. Exec Gemba visits with purpose? *"Leadership behaviours imature" "middle managers have different priorities and multiple projects" "Delegation from senior team could be better" "middle managers are not releasing staff to do A3s" "Easy to get consumed by firefighting" "Doctors not as engaged - protected from management speak" "not sure all Execs are on board with methodology" "not much challenge from Exec, only Steve and Rachel" "Delegation from senior team could be better" "greater coaching from leaders/middle managers and less micro managing meeded" "gaps in knowledge of lean in Exec" "Operational managers not attending huddles except to support escalations rather than as Gemba" "managers not adopting CI leadership behaviours"*
52	Behaviours self assessment & improvement		■					
53	Coaching & teaching others		■					
54	Being coached		■					
55	Leader standard work		■					
56	Visibility			■				
57	Gemba visits		■					
58								
59								
60								

4B MATURITY ASSESSMENT – CI PRINCIPLES

	Pillar Evidence	0	1	2	3	4	Comments
1	Strategic priorities are clear and well communicated				■		Divisions clear of priorities and good SDR process to focus on delivery
2	Corporat teams and their agendas are aligned to front line services			■			Business partner model and positive feedback on contribution to services
3	Priorities, performance and goals are visible across the organisation		■				Not fully rolled out in Divisions and to all front line services yet
5	QI development plan is in place for the next 1 to 3 years			■			Roadmap in place and Divisions have development plans
6	QI roll out, development and performance is being reviewed monthly				■		Monthly reports at SDR
7	There is a process to determine priorities and continually manage competing demands		■				Process for priorities in place at corporate level but not yet extended and signs of overburden
8	Majority of resources are focussed on organisational priorities		■				PFIS still being rolled out and embedded in services. Leadership CI underdeveloped.
9	A3 thinking and A3 problem solving is embedded across organisation			■			Good use of A3 tool.
10	Performance is improving				■		Good performance and opportunity for more from CI approach
11	Waste is being eliminated		■				Less evidence of removing duplication and improving processes
12	There is greater value added processes and activities		■				Limited involvement of patient voice in improvement work
13	Standard methods are being consistently used		■				Standard work developing but not yet extensively used
14	There is clarity of progress and maturity of QI in the organisation			■			Good insight into progress and opportunities for development of CI system
15	Engagement and support for QI is high across the organisation				■		High level of enthusiasm and interest in developing QI. Still being rolled out and some pockets of cynicism
16	There is dedicated QI expertise with the capacity and capability to support			■			Good capacity and capability with potential to develop exemplar team
17	The quantity of improvements is increasing every month		■				Gradual increase as teams embed learning and more teams are trained
18	Leaders are demonstrating the right behaviours and continusly improving themselves		■				Good levels of leadership training but underdeveloped personal CI development
19	The voice of the patient is actively and widely used to deliver improvements	■					Desire to involve patient voice and few examples of steps to engage
20	The capacity and capability of improvement resources is increasing		■				Organisation is still reliant on a small number of people to develop and maintain CI systen delivery
21	Learning is captured at end of project/countermeasure work			■			CI team have process to review and improve
22	Improvement work creates value for the **patient**		■				Most people described value to process and service rather than patient. Less evidence of patient voice in improvement delivery
23	Creating Value add to the organisation				■		Lots of examples of improvement delivery to Trust processes and service delivery.
24	Creating constancy of purpose			■			Very effective where CI has been implemented. Opportunity to increase standard work and depth of application into services.
25	Systematic scientific approach				■		Good and consistent use of CI tools. Opportunity to increase knowledge and use of methodology to deliver improvements.
26	Focus on key results					■	Strong focus and alignment of performance delivery at Executive and divisional level. High level of performance delivery.
27	Focus on key behaviours			■			Leadership team engaged, supportive and contributing to CI development. Consistency and engagement of leaders across Trust
28	Alignment of Key priorities				■		Strong alignment at Exec and Divisional levels. Division to Service and corporate teams in development
29	Common QI tools and one system			■			Roll out of PF Training still in progress.
30	Enablement - move from doing to enabling			■			Very supportive leadership team embracing CI practises. Opportunity to increase improvement capacity and capability.
31	Assure quality at source		■				SDR not yet fully embedded in teams so performance cascade and assurance not fully mature.
32	Inch wide mile deep			■			Strong focus on performance and project priorities. Some overburdening and duplication still impacting
33	Delivery of 3Ms improvements (Waste; Process variation; Overburden)		■				Less evidence of focus and delivery of these
34	Use of data analysis and information			■			High quality performance data. Plan for development of performance forecasting and information at service level.
35	Visual Management		■				Good visibility in places with opportunity to increase to engage and inform wider audience
36	Alignment of improvement, performance, regulation and governance		■				Management system not fully rolled out and evidence of some duplication and separate reporting systems
37	Capability building - increasing CI resource & expertise			■			Roll out training plan in place. Opportunity to increase leadership QI capability and expertise within services
38	Balance of corporate, divisional and service priorities			■			Performance metric analysis shows good balance of priorities. Good processes to determine priorities in place
39	Leaders support improvement at all levels		■				Middle managers not yet fully trained and engaged in CI system development and delivery
40	Countermeasure reports used to update on progress				■		Good and consistent use of countermeasures

4B MATURITY ASSESSMENT QI PILLARS - METRICS

Metrics Analysis by Division and Type

Driver Metrics	Surgery	Medical	Women & Children	Core clinical	Cancer	Comments
People	0	1	1	1	0	
Patient Safety & Clinical Effectiveness	1	0	0	2	2	5 to 7 Driver metrics in place for all Divisions
Patient Access	4	3	1	1	3	Access features in every Division
Patient Experience	1	0	1	0	0	Sustainability also features in all except 1 Division
Systems	1	0	0	0	0	Systems only has 1 metric in 1 Division
Sustainability	0	2	2	2	1	Different profile for each Division evidencing catchball in place
Strategic Theme Total	**7**	**6**	**5**	**6**	**6**	
Vision Goals/Targets	0	1	0	0	0	Balance of organisation and Divisional priorities
Breakthrough objectives	3	2	2	2	2	Other key metrics may be escalated or service critical metrics
Divisional Priority Metric	2	3	3	4	3	
Other key metrics	2	0	0	0	1	
Type of Metric Total	**7**	**6**	**5**	**6**	**6**	
Alerting Watch Metrics						
People	1	0	0	0	0	3 Divisions using Alerting Watch metrics
Patient Safety & Clinical Effectiveness	0	0	0	0	0	Patient Access represents all except 1 metric
Patient Access	1	1	3	0	0	
Patient Experience	0	0	0	0	0	
Systems	0	0	0	0	0	
Sustainability	0	0	0	0	0	
Strategic Theme Total	**2**	**1**	**3**	**0**	**0**	
Vision Goals/Targets	0	0	0	0	0	All except 1 metric is a key metric, so relevent to Division
Breakthrough objectives	1	0	0	0	0	
Divisional Priority Metric	0	0	0	0	0	
Other key metrics	1	1	3	0	0	
Type of Metric Total	**2**	**1**	**3**	**0**	**0**	
Non Alerting Watch Metrics						
People	5	5	5	4	6	Similar total number of metrics across Divisions
Patient Safety & Clinical Effectiveness	5	6	8	4	7	Patient Access is largest in 4 of 5 Divisions
Patient Access	10	11	7	13	15	Balance of metrics across all Strategic themes
Patient Experience	6	6	7	4	6	
Systems	1	6	2	2	2	
Sustainability	5	3	5	4	0	
Strategic Theme Total	**32**	**37**	**34**	**31**	**36**	
Vision Goals/Targets	6	6	6	6	5	As expected majority of watch metrics are other key metric type
Breakthrough objectives	1	4	3	4	4	
Divisional Priority Metric	2	0	1	1	0	
Other key metrics	23	27	24	20	27	
Type of Metric Total	**32**	**37**	**34**	**31**	**36**	

4B MATURITY ASSESSMENT – QI PILLARS

	QI Maturity Matrix Pillars					
1	**Stategy Development**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
1	True North	Vision & values not recognised in Trust. Multiple strategic priorities and competing demands. No clear process to determine priorities. QI is seen as project.	Strategic priorities are limited and focussed on True North. Process in place to communicate priorities and align reporting. QI development plan and reporting in place.	Strategic, breakthrough and corporate priotoes are aligned. Cascade process in place. Development of service engagement of priorities and visibility of contribution to improvement.	Priorities are aligned at all levels of the organisation. There is an effective process to regularly review priorities up and down the organisation. There is one performance management system. Performance is visual.	Clarity, visibility & alignment of Trust priorities across whole organisation. Clear & regular process for priority review.
2	Vision & Values					
3	Strategic Priorities					
4	Breakthrough objectives					
5	Strategic initiatives					
6	Corporate Projects					
7	QI Governance arrangements					
8	QI assurance report					
9	Visual Mananagement					
10	Capability development plan					
2	**Strategy Deployment**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
11	Engagement & communication	Performance management focussed on current challenges. Large number of metrics all with equal value. No alignment or consistency of performance monitoring.	Roadmap developed. Performance management system focussed on key priorities. Development plan in place for new QI management system.	SDR operating at Divisional level. Performance meetings using business rules. Some fromt line teams working on Driver metrics	Countermeasure summaries being used consistently to report progress. Annual strategic planning & QI system fully aligned.	Alignment and clarity of QI system evident at all levels of the organisation. Standard processes and standard work in place to maintain and improve the QI system. Value and performance of QI system is clear to
12	Business rules					
13	Project filter					
14	Roadmap					
15	PFIS roll out plan					
16	Clear criteria to measure programme effectiveness					
17	Driver & watch metrics					
18	Dashboards					
19	Catchball					
20						
3	**PFIS**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
21	Team readiness assessment	Training of front line teams has not started. Teams not using QI tools and processes.	Some teams trained. Variable maturity. No maturity matrix in place. Not all tools and processes in place in teams that have been trained. Team selection plan in place.	Roll out underway. Some Divisions are complete. Demand created to attend training. Driver metrics improving. Clarity of maturity of teams. Training effectiveness measured and improving	Over 50% of teams trained. Majority of teams operating QI management wystem. Join up from team to board in place. Corporate teams have had their version of PFIS.	Majority of teams trained. Maturity matrix shows majority at high level. Leaders spending time coaching & improving management system. Breakthrough results being delivered.
22	Status Exchanges					
23	Improvement huddles					
24	A3s & PDSA approach					
25	Standard work					
26	Countermeasure summaries					
27	Process Improvement and waste reduction					
28	Engagement and support					
29	Maturity model					
30	Performance Improvement					
4	**Kaizen Team**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
31	Clarity of role and remit of Team	No QI Team is in place. Team going through transformation and not yet operational. Performance & behaviour issues currently.	Limited capability. Focus is on operational delivery. Clear role and remit for team. Developing role and contribution.	Team is contibuting to training and projects. Capability is evident and developing. Performance is clear and contribution recognised by others. Team leadership strong.	Team has established standard work. Leading by example. Team capability in demand from orgnaisation. Have an active coaching role. Active and valued Contribution to development of system and QI model	Team members are supporting externally and showcasing QI to others. Contibuting at strategic & operational levels. Evidence of innovation. Evidence of continuous improvement.
32	Team capability					
33	Team performance					
34	Team development					
35	Visibility					
36	Level of contribution - strategic/operational					
37	Recognition of contribution					
38	Team and individual goals & objectives					
39	Contribution to development of improvement system					
40	Evidence of innovation and continuous improvement					
5	**Projects**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
41	Green belt projects	No visibility of number, size & resources working on projects. Random project initiation. No tracking or measurement of outcomes/success.	Project tracking at some levels. Project mapping is underway to understand whole picture.	Common project methodology in place & in use. Project resources working in an aligned way with team. Some QI project resource have been trained. A number of projects are using QI methodology.	Project prioritisation process in operation. Resource requirements & impact part of project selection process. Project methodology uses QI tools. Alignment of projects at Exec, divisional and service level.	Projects align and support strategic priorities. Trained and skilled project resources available to every Division & service. Priorities & alignment of projects reviewed regularity as part of standard work.
42	Yellow belt projects					
43	A3s					
44	Use of data, root cause and evidence					
45	Ownership and progress tracking					
46	Prioritisation and resources					
47	Process for project selection and leadership					
48	Alignment of projects to strategy and priorities					
49						
50						
6	**Leadership Behaviours**	**0 No Evidence**	**1 Early Progress**	**2 Good Progress**	**3 Maturity**	**4 Exemplar**
51	Personal A3	Traditional leadership model remains in place. No leadership training completed. Priority remains on quick wins, immediate results and fire fighting. Improvement system development not being supported	Some leadership training completed. Some tools being used. Team has advocates and people with desire to learn and improve. Some parts of management system are being used by leaders.	Leaders understand their behaviours and are actively working on personal improvement. Team and management processes are being improved. Leaders are visible and seen to be supportive of QI.	Leaders are being coached. QI leadership and behaviours training are embedded in standard processes. There is a process to develop new starters and new leaders	Leaders are coaching and teaching. There is standard work for key processes and activities. Leaders are continuously improving and reflecting. Others see Leaders leading by example. There is external influence on
52	Behaviours self assessment & improvement					
53	Coaching & teaching others					
54	Being coached					
55	Leader standard work					
56	Visibility					
57	Gemba visits					
58						
59						
60						

This is our assessment of MTW maturity on the QI pillars.

Strategy development is progressing well and there is a lot of good evidence of ownership and maturity.

Strategy Deployment is progressing well with Divisions but is currently not being consistently applied below that level.

It is also well developed at Executive levels with an engaged senior executive team.

PFIS training is developing well and clear roll out plans are in place. There are some challenges with consistency of teams trained, clinical engagement and leadership support.

The CI Team has good capacity and is developing its capability. There is the opportunity to increase team integration, improve clarity of role and extend the contribution to the development of the CI system. There is also a need for clear and effective leadership of the team which is acknowledged.

Project selection and reporting is well developed. These can both be extended by developing yellow and green belt resources which will increase improvement capability and consistency of delivery and reduce overburdening.

Leadership capability and performance is very good. However, CI leadership behaviours are less developed and middle management has not yet had sufficient training and support.

Clinical leadership and engagement is patchy and there are opportunities to increase involvement and contribution.

There are many examples across all pillars of high levels of maturity, but at this stage in the development of the CI system, there is also areas of underdevelopment and inconsistency.

This result places MTW as a leading CI healthcare organisation with excellent progress to date on developing the CI system. Reaching maturity takes time and the Trust is well placed to develop into an exemplar organisation over the next few years.

4C MATURITY ASSESSMENT – ENVIRONMENT

	QI Maturity Matrix : Environmental Factors	0	1	2	3	4	0 Disruptive	1 Challenging	2 Neutral	3 Supportive	4 Enables
1	**System**										
	Maturity of regional structure						Multiple meetings with no value. Continual data & information requests. Competition with others. Under spotlight for performance. Poor behaviours from partners.	Size of agenda. Multiple organisations in difficulties. Competing priorities.	Agenda is not having major impact on Trust priorities. Demands and support manageable.	Others understand and supportive of challenges and aspirations. Good relationships with partners. Some alignment of priorities.	Active support from others to our priorities. Leadership role in system improvement. Influential on wider agenda
	Relationships with local partners										
	Reputation in local system										
	Size of agenda and level of demand on the Trust										
2	**Quality**										
	CQC Rating and action plans						Significant plans in place to meet external quality concerns. Poor internal processes to deliver, understand and manage quality of delivery. Significant adverse performance on key quality metrics.	Difficulties delivering safe services. Performance information poor. Reactive approach predominates. Multiple action plans.		Governance is aligned to QI system. Primary focus is on improvement activity rather than retrospective reporting.	High performing against peers. Recognised externally for quality of services and delivery.
	Governance arrangements										
	Performance										
	Limited focus on person centered care										
3	**Workforce**										
	Turnover						Large gaps in workforce. Difficulty recruiting. Reliance on agency and temporary workforce. Poor staff survey results. Relationships between staff and leaders strained. Services and disciplines self serving	No time for staff development. No clear recruitment and retention strategy. High level of staff dissatisfaction.	Some service areas with gaps but majority stable. Sufficient resources with some reliance on agency support. Plans and progress on recruitment and retention strategy.		Workforce have time and motivation to learn and contribute to improvement. Services have expertise to deliver and develop. There is good stability and succession planning in place for key roles.
	Vacancies										
	Engagement										
	Staff shortages and high use of agency staff										
	Not allowing dedicated staff time for training and development										
4	**Corporate Services**										
	Sufficient resources						Silo working. Lack of expertise. Competing demands. Critical gaps in capacity of key resources. Major works or projects which will significantly impact service delivery.	Poor communication challenges between corporate teams and clinical services. Not enough resources to deliver agenda.	Responsive to business needs. Managing demands with minimal disruption.	Support to clinical services recognised and valued. Processes improving to reduce waste and increase Value Add.	Corporate teams trained & using QI tools to improve delivery. Corporate agenda aligned to clinical services and making a positive contribution to patient service delivery. Corporate services actively engaged with clinical teams on improvement projects.
	Strength & depth of resources										
	Alignment of priorities										
	Size of agenda										
	Ability to support front line services										
	Communication effectiveness										
5	**Infrastructure**										
	Quality of Estate						insufficient space to deliver services. Quality of space not fit for purpose. Reactive response to issues. Problems take too long to be resolved. Patient delivery disrupted.	Poor quality space for aptients and staff			Patients have good access to quality environment for treatment. Staff have the resources needed to support them deliver services. There is development and investment plan to maintain and improve infrastructure.
	Effectiveness of IT systems										
	Lack of management time or organisational capability										
	Systems not set up to support integration into existing processes										
6	**Finances and Funding**										
	Financial performance						Large CIP with no plan. Capital constained and not able to invest in critical infrastructure. Poor visibility of financial performance. Lack of budgetary management and control	Size of CIP is challenging and no clear delivery plan. Lack of engagement to targets.		System is in financial balance. Capital allocation is supporting investment plan. Good financial performance	Generating surplus which can be reinvested. Clear and positive financial plan for net 3 years. QI improvements delivering productivity gains.
	Level of CIP										
	Capital allocation										
	System financial situation										
	Budget management and control										
7	**Information & Data**										
	Availability of data						IT systems not fit for purpose. Data is out of date and inaccurate. Insufficinet resources. High burden of data collection with minimal benefit to teams. Focus on IT system needs rather than IT support to clinical services.	Multiple systems and no alignment or integration adding to data entry and reporting burden. Data breaches and immature IT governance			Management information easily available, accurate, up to date. Data used to inform decisions and analysis. Teams have access to support and information
	Access to accurate and timley information										
	Lack of information sharing within organisations and teams										
	Insufficient use of data available										
	Insufficient information and analysis systems										
	Lack of, or inflexible, feedback structures in place										
8	**Culture**										
	Lack of culture of improvement						Fire fighting is the norm. Poor behaviours accepted. We know best approach. Services compete internally for resources. Historic ways of working which are embedded and not delivering best outcomes.	Teams over burdened and unrealistic demands & expectations.		Evidence of innovation and promotion of new ideas from across organisation.	Teams supportive of change and patient focussed. Good inter team working. Compassionate people. Staff feel valued and passionate about the organisation
	Perceived culture of blame										
	Insufficient engagement of professionals and patients										
	Lack of priority placed on improvement										
	Risk averse culture and prioritisation of defensive practices										
	Behaviours and 'rituals' that undermine improvement										
9	**Leadership**										
	Lack of strong leadership and a shared vision for improvement, including at board level						Command and control approach. Lack of trust and poor teamwork. High instability and lack of experience in leadership team. Disagreement on priorities and approach. Agenda dominated by 1 or few people. Cliques operating.	Gaps and deficits in leadership structure. Multiple styles and approaches causing confusion and inconsistency. Conflict and politics impacting on progress.	Positive leadership developing. Leaders do not negatively impact service delivery. Good leadership evident and supported.	Leaders take time to develop self and others. Alignment and consistency of approach across leadership team. Compassionate and supportive leadership approach	Alignment of leadership team and desire for continuous improvement. Proactive in support of QI management system. Strong development and succession planning. Leaders behaviours support delivery and development of QI.
	Hierarchical leadership culture rather than transformational or engaging leadership										
	Not ensuring leadership and autonomy for improvement at multiple organisational										
	Lack of accountability for improvement										
	Wanting to see 'quick wins' rather than allowing improvement time to embed										

FINDINGS

The Trust is dealing with the difficult challenges of the environment vey well.

There remains a high level of scrutiny and regulation which could significantly impact on the Trusts ability to develop its CI system. Currently our view is that the impact is broadly neutral.

Corporate services are strong and well placed to support the development of CI. Information and data are good and improving. There is a very positive culture which is supporting continuous improvement.

IMPACTS

Industrial action
ED pressures
Wait list pressures
Winter pressures
Financial balance
Deloitte risk review
CQC criticism of risk governance
High level of external scrutiny/inspection/regulation for some services
Significant impact if regulation/inspection fails
NHS model for improvement assessment

5 Maturity Assessment – Summary of Strengths

1. **Leadership Consistency**
   - ***Senior leadership visibility, trust and support***
   - ***Quality of senior leaders***
   - ***SRO passion for process***
   - ***Priorities jointly owned***
   - ***Performance and delivery despite challenging environment***
   - ***Coaching and enabling style***
   - ***Bonding humour!***
2. **Culture**
   - ***Positive culture – people willing to engage and help***
   - ***Patient centered mindset***
   - ***Real sense of togetherness***
   - ***High level of insight to CI development opportunities***
3. **People**
   - *Real investment in training and development to enable an improvement mindset*
   - *Pockets of magnificence!*
   - *Front line enthusiastic and engaged*

5 MATURITY ASSESSMENT – SUMMARY OF STRENGTHS

4. Method

- *SDR process*
- *SDR information and reporting*
- *Business partner model*
- *High level of insight to CI development opportunities*
- *Teams embracing Continuous Improvement system*
- *Celebrations really exceptional!*

6 MATURITY ASSESSMENT – SUMMARY OF OPPORTUNITIES

1. **Leadership**

   - *Consistency, confidence and ownership of Executive Team (very reliant on SO and RJ)*
   - *Leadership behaviours and knowledge (See recommendation for Green Belt Training)*
   - *Consistency and adoption of Standard Work*
   - *Exec team investment in lean and coaching support*
   - *Level of Clinical Engagement variable*

2. **Culture**
   - *Depth and capabilities of CI for middle managers*
   - *Connections need to be made more explicit*
   - *Divisional and below not fully connected to CI agenda*
   - *Needs more effective Communications*
   - *Patient voice - engagement and development of patient participation*

3. **People**
   - *Medical workforce and clinical engagement*
   - *Capacity and training expertise*
   - *Middle management engagement and training*

4. **Method**
   - *Projects effectiveness due to capacity, over burden and visibility of Divisional/Service*
   - *CI team clarity of role, skills development, silo working and leadership*
   - *Silo's - join up management system*
   - *Visual Management more generally*

7 MATURITY ASSESSMENT – RECOMMENDATIONS

1. **Executive Team**
    1. *Arrange Green Belt Training for Executive Team to improve knowledge and confidence*
    2. *Some of the Executive Team need coaching for Improvement support*
    3. *'Go See', explore other systems externally to learn, inspire and motivate*
    4. *Executive Leader Standard work not in place and needs to be developed*

2. **To Increase CI Capability**
    1. *A plan needs to be developed for all Divisions to roll out SDR to directorates and specialties and align to PFIS plan*
    2. *To increase Leader Standard work engagement and development across the middle management tier*
    3. *A plan is also needed to maximise Corporate Services contribution*
    4. *For PFIS, develop a baseline measure pre and post training inputs to measure engagement*
    5. *A training plan needs to be developed to support Divisions*
    6. *Deliver platinum Service to define and showcase mature system*
    7. *Develop and deliver CI specific yellow and green belt training to increase project resource capacity*
    8. *To develop an engagement plan and development programme for Clinical leaders*

3. **Developing Sustainability**
    1. *Review governance arrangements and determine next phase of development for CI management system*
    2. *Review projects, BAU and regulatory requirements to reduce burden and support priorities*
    3. *Review the future needs of the CI Team and then recruit Leader and develop accordingly*
    4. *To develop a more CI focused communication plan for the whole organisation*

APPENDICIES

8 MATURITY ASSESSMENT – SUPPORTING INFORMATION

1. 8.1 Interview list and Observation list
2. 8.2 Document list
3. 8.3 Interview topics
4. 8.4 Observation sheet
5. 8.5 Foundations needed for Patient First
6. 8.6 Patient First Principles
7. 8.7 What Patient First Delivers

8.1 INTERVIEW & OBSERVATION LIST

Steve Orpin – Executive Director
James Jarvis – Director Business Intelligence
Jo Haworth – Chief Nursing Officer
Sue Steen – Chief People Officer
Sean Briggs – Chief Operating Officer
Sara Mumford - CMO
Tracey Jardine
Sarah Cadlock
Angela Collison
Sue Forsey
Katherine Goodwin
Augusta Kennett
Ellie Morrison
Gemma Paling
Tammy Pike
Richard Snowdon
Amanda Timms
Gavin Ward
Susan Young
Rob Henderson
James Saunders

Steph Pearson
Lisa Bonifacio
James Ripley
Oksana Vynohradska
Lee Smith
Linda Parambath
Martina Tidball
Emma Bray
Stephen Pearson
Ruby Dey
Stephen Bundock
Faith Ezugwu
Toyin Falana
Lesley Johnson
Sriaswini Mnjunathan
Wendy Martin
Linda Parambath

Cancer Division SDR
Medicine Division SDR
Women & Childrens Division SDR
Core Clinical Division SDR
Surgery Division SDR

David Robinson – Surgery division
Richie Chalmers – Core Clinical division
Jelena Pochin - Core Clinical division
Alice Farrell – Cancer division
Hannah White – Cancer division
Philippa Moth – Cancer division

8.2 LIST OF DOCUMENTS

Cancer Division SDR Papers
Medicine Division SDR Papers
Women & Childrens Division SDR Papers
Core Clinical Division SDR Papers
Surgery Division SDR Papers
CQC Reports
Staff Survey
Leadership Programmes
SLT SDR Papers

8.3 INTERVIEW TOPICS

	Pillar Evidence
1	Strategic priorities are clear and well communicated
2	Corporat teams and their agendas are aligned to front line services
3	Priorities, performance and goals are visible across the organisation
5	QI development plan is in place for the next 1 to 3 years
6	QI roll out, development and performance is being reviewed monthly
7	There is a process to determine priorities and continually manage competing demands
8	Majority of resources are focussed on organisational priorities
9	A3 thinking and A3 problem solving is embedded across organisation
10	Performance is improving
11	Waste is being eliminated
12	There is greater value added processes and activities
13	Standard methods are being consistently used
14	There is clarity of progress and maturity of QI in the organisation
15	Engagement and support for QI is high across the organisation
16	There is dedicated QI expertise with the capacity and capability to support
17	The quantity of improvements is increasing every month
18	Leaders are demonstrating the right behaviours and continusly improving themselves
19	The voice of the patient is actively and widely used to deliver improvements
20	The capacity and capability of improvement resources is increasing
21	Learning is captured at end of project/countermeasure work
22	Improvement work creates value for the **patient**
23	Creating Value add to the organisation
24	Creating constancy of purpose
25	Systematic scientific approach
26	Focus on key results
27	Focus on key behaviours
28	Alignment of Key priorities
29	Common QI tools and one system
30	Enablement - move from doing to enabling
31	Assure quality at source
32	Inch wide mile deep
33	Delivery of 3Ms improvements (Waste; Process variation; Overburden)
34	Use of data analysis and information
35	Visual Management
36	Alignment of improvement, performance, regulation and governance
37	Capability building - increasing CI resource & expertise
38	Balance of corporate, divisional and service priorities
39	Leaders support improvement at all levels
40	Countermeasure reports used to update on progress

	QI Maturity Matrix : Interview sheet	Person Interviewed	Date
	Key Topics	Feedback and Reflections	
1	Division Progress and Maturity		
2	Priorities - how determined		
3	Engagement and involvement		
4	Consistency		
5	Support		
6	Leadership behaviours		
7	Culture		
8	External pressures and environment		
9	Next steps		
10	Roadmap		
11	PFIS training		
12	QI team resources/training/support		
13	Leadership training		
14	Corporate teams involvement/engagement		
15	Site differences		
16	Division differences		
17	Views on benefits and impact		
18	Corporate and Clinical interface		
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

8.4 OBSERVATION SHEET

	QI Maturity Matrix : Observation sheet	Event/process				Date					
	Key Questions	Observations and Reflections									
1	Is there standard work? Is it being available to all? Is it being used?										
2	Is there a clear lead? Are roles allocated?										
3	Everyone engaged?										
4	Updates on progress provided?										
5	Sufficient time to discuss new opportunities?										
6	Success celebrated?										
7	Sufficient probing?										
8	Is there a clear plan and actions?										
9	Actions have a clear owner and timeline allocated?										
10	Open ended questions used and asked in a respectful and enquiring way?										
11	Current data and information is available?										
12	Sufficient balance to review and discussions?										
13	Problems and priorities identified?										
14	Assumptions and jumping to solutions were avoided										
15	Patient voice and value add driving decisions?										
16	Waste is being identified and eliminated										
17	It is clear to everyone how we are progressing.										
18	It is aligned to True North										
19	There is an appropriate balance of time on domains										
20	Right balance of challenge and coaching										
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
		0 No Evidence	1 Early Progress	2 Good Progress	3 Maturity	4 Exemplar	0	1	2	3	4

8.5 FOUNDATIONS NEEDED FOR PATIENT FIRST

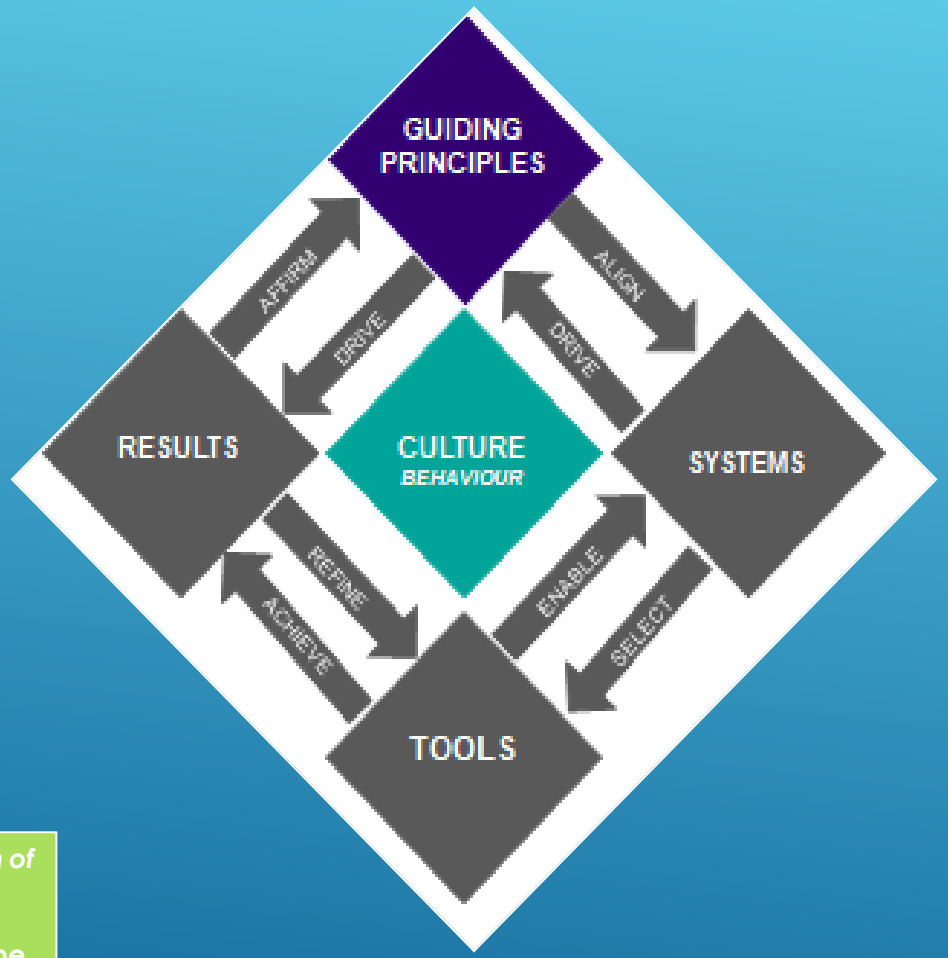
"Most of what we call 'management' consists of making it difficult for people to get their work done." Peter Drucker

"Business and human endeavors are systems… we tend to focus on snapshots of isolated parts of the system and wonder why our deepest problems never get solved."
Peter Senge

*"We cannot solve our problems with the same level of **thinking** that created them."* Albert Einstein

"If today is going to be any different from yesterday we must blaze new trails every day." Shigeo Shingo

"Improvement means the elimination of waste, and the most essential precondition for improvement is the proper pursuit of goals. We must not be mistaken, first of all, about what improvement means. The four goals of improvement must be to make things easier, better, faster, cheaper." Dr Shigeo Shingo



The SHINGO Model

"All work in organisations is the outcome of a system.

Systems must be designed to produce a specific end goal, otherwise they evolve on their own.

Systems drive the behaviour of people or rather they create the conditions that cause people to behave in a certain way.

Variation in behaviour leads to variation in results

Operational excellence requires ideal behaviours that translate into consistent and ideal results"

Dr Shigeo Shingo

Insights of Operational Excellence

Ideal results require ideal behaviours

To achieve the very best results, leaders must do the hard work of creating a culture where ideal behaviours are expected and evident in every staff member.

Purpose and systems drive behaviour

Managers must realign management and work systems which drive the ideal behaviours required to achieve the ideal results.

Principles inform ideal behaviour

The more deeply someone understands the ideal principles, the more they will come to understand the ideal behaviours.

[redacted]

8.6 PATIENT FIRST PRINCIPLES

Customers (patients) are an organisations first concern
What does the customer want?
How can I deliver it with least time and waste?

Value Add
the customer must see value in the process step
it must transform the product/service some way
it must be done correctly first time

Inch wide Mile deep
Focus everyone on delivery of priority improvements

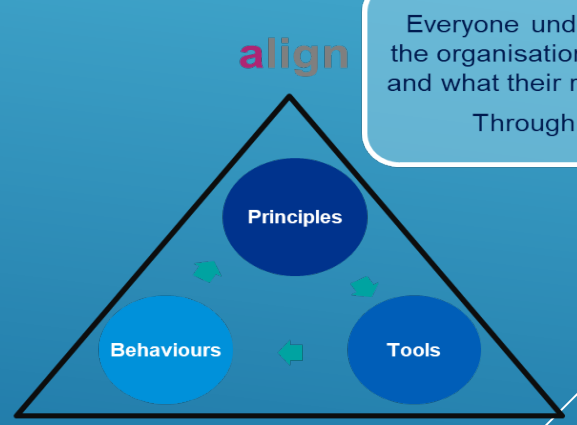
Standard work and processes
Establishes the current best way to deliver the work

Increase Value Add to patients, Optimise VA to organisation and eliminate Waste

Improve how leaders spend their time and increase the improvement capacity and impact

The majority of leadership time is spent firefighting	Dedicated time for Proactive Planning & time for People Development
Day to day things that get in our way may not dealt with or sustained	A system for team led Daily Continuous Improvement and ensuring sustainability
Improvements are not initiated by the frontline team actually providing the service	Team driven changes that align together to create larger scale impact for the Trust (True North)
Poor standardisation of frequently repeated processes and chaotic Leader diaries	Using the current best known standards across the team to improve practices and sustain improvements

Align, Enable and Improve



align

Everyone understands what the direction of the organisation is, what the key priorities are, and what their role is achieving these priorities

Through **Strategy Deployment**

enable

Leaders and managers shift from doing to enabling frontline staff through adopting a coaching style

Through **PFIS** and **improvement leadership behaviours**

improve

QI is common way of working across the organisation – using the relevant tools and methods to solve problems and improve performance

Through **PFIS**, our **QI office** and **improvement projects**

8.7 WHAT PATIENT FIRST DELIVERS

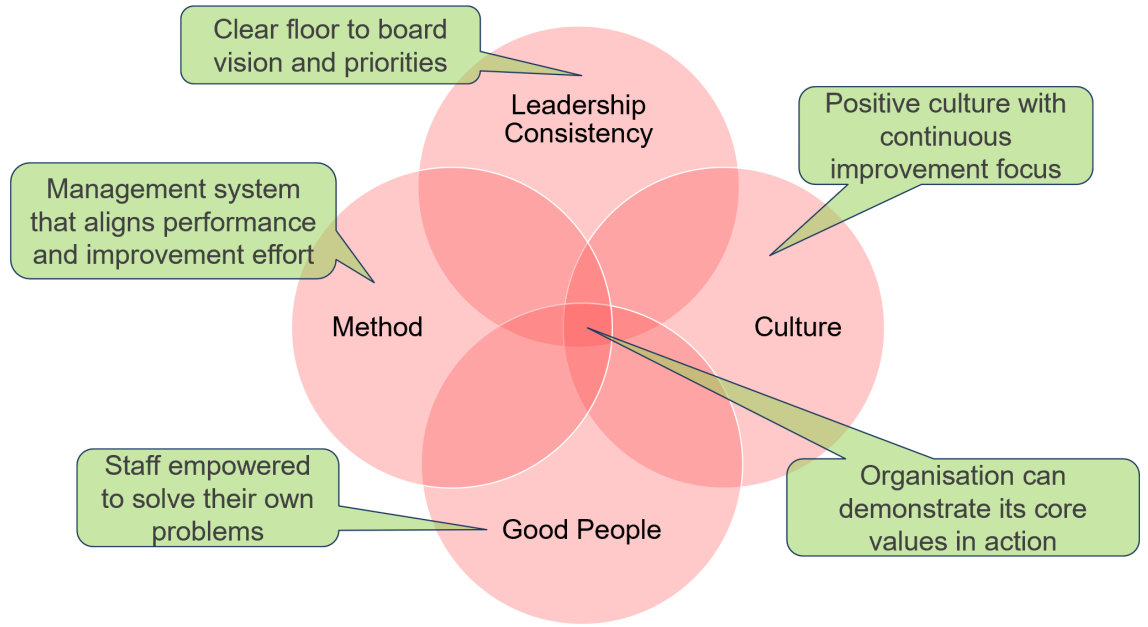
1. **Enable leaders to understand and run the Trust** using a management method based in QI tools.
2. To **create a culture that supports and enables** continuous quality improvement and innovation.
3. **Develop internal experts** to lead QI, to teach and coach others.
4. **Develop leaders** who will personally champion and apply QI methods and tools.
5. **Deliver a mature, sustainable and visible** quality improvement organisation
6. The application of QI tools and disciplines by teams will **improve their day-to-day operations.**
7. **Delivery of increased patient quality, patient experience, support for staff and lower costs.**
8. **Culture of continuous improvement**
9. **Transformation** of services and processes to increase value to patients

A Quality Management Improvement System
To develop our people to solve problems and improve performance

What would you need to see each month to know if we're winning or losing?

Mind set : listening, continuous improvement, prioritisation, leadership consistency
Tool set : problem solving (A3), communication processes, performance visibility, improvement
Skill set : coaching, teaching, listening, standard work, process improvement
Reliability : standard & consistent management system delivering continual improvement

If we do this, and do it well, this is what your organisation will feel like…



…..all delivered by putting patients first

Trust Board meeting – April 2024

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian	**Freedom to Speak Up Guardian (FTSUG)**

The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.

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

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

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q4 (January 2024 – March 2024)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the fourth quarter report for the period January 2024 to March 2024 presented to the board by the Freedom To Speak Up Guardian (FTSUG). The purpose of this report is to identify trends, issues; and provide a progress report on the Freedom to Speak Up function.

The Freedom to Speak Up Guardian received **forty-one** concerns raised in the last quarter, which equates to 45% of the annual Freedom to Speak Up requests for this financial year. In Q4, as in previous quarters, the majority of concerns raised relate to cases where staff feel unfairly treated or harassed at work, with **fifteen** cases logged in the respect and dignity category.

Concerns were received through various routes including: direct contact with the FTSUG, anonymous portal logs, safe space champions, exit interviews and staff side conversations.

Author: Jack Richardson, Freedom To Speak Up (FTSU) Guardian

Date: April 2024

Freedom To Speak Up Non-Executive Director	Wayne Wright
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian	Jack Richardson

The FTSU Agenda is to:

- Protect patient safety and quality are
- Improve experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as an opportunity for learning and development

---

Introduction

During the last quarter, the FTSU Guardian has identified three sections that act as a barrier and prevent an individual speaking up. These three categories are:

1. People do not speak up as they don't know how or who to speak up to.
2. People do not speak up as they feel their issues are not great enough to warrant discussing.
3. People do not speak up as they are afraid of repercussion.

The FTSU Guardian has put in place action plans for each of these categories to ensure that these barriers are actively being worked against.

To tackle people not knowing who to speak up to, the FTSU Guardian has carried out outreach with specific departments, joining huddles to introduce themselves, and ensuring that every targeted newsletter included an introduction, along with instructions on how to access FTSU. They have updated our intranet page to be more informative and easier to navigate. They have also carried out night shifts and satellite site visits to ensure every staff member has equal opportunity to access the FTSU service. FTSU also continue to present at induction on a fortnightly basis.

To combat people not feeling their issues are great enough to warrant discussing, the FTSU guardian has been pushing specific messaging during outreach. This messaging is that 'In healthcare, if we wait for a concern to be confirmed, it is too late.' The FTSU guardian has also been working on reducing stigma around the speaking up service, and encouraging people to have informal conversations to bring up any issue they feel is too small. This has been achieved at all levels of the organisation, from coffee conversations, to regular meetings with divisional triumvirates, where overviews of ongoing cases can be discussed in a productive, learning focused manner.

Finally to manage people's fear of repercussions, the FTSU Guardian has ensured information on Whistleblower rights is made easily accessible on the intranet, following the BBC's report on the importance of whistleblowing. Most of all, the service seems to be accessing more people through word of mouth, which is the best way to combat this fear. People are sharing their experiences with colleagues, and as such, trust is being built within the service. This translates into a more open and honest culture, and is a step in the right direction.

2023/24 year data collection

Quarter	Month/Year	MGH	TWH	Unknown/ Satelite	No. of Contacts
Q1	April-June 2023	6	5	6	17
Q2	July – September 2023	7	3	5	15
Q3	October – December 2023	4	6	9	19
Q4	January – March 2024	20	10	11	41

With the majority of cases being around dignity and respect, workplace relationships and behaviours continues to be the main area of concern for staff. With satellite site visits taking place and planned, it is hoped greater interaction between these sites and the FTSU Guardian will take place. There are also plans to create satellite site representatives amongst the Safe Space Champions to help build trust and rapport. Whilst FTSU will always be accessible by all, this provides another route for these individuals to raise concerns.

Anonymised reporting:

The number of "unknown" factors in reporting is a frustration to analysis. However, it's existence is an indicator of how many of the reports are being made are anonymised. 43% of issues raised in the last quarter have been anonymous. This can be broken down even further:

Division	Number of Reports	Number of Anon Reports	Percentage of Anon Reports
Cancer	1	1	**100%**

WCSH	9	1	**11%**
Medicine and Emergency	2	1	**50%**
Core Clinical	5	2	**40%**
Surgery	7	2	**29%**
Estates and Facilities	4	4	**100%**
Business Support	8	4	**50%**

What we can gleam from the above is that there are areas that are more comfortable than others at speaking openly. This also gives us direction within areas of a high anonymous rate, allowing us to focus more efforts on decreasing fear of repercussions of speaking up, and that if that fear is derived from a specific source, we can understand where that is.

Themes/Issues

Theme	Number
Patient Safety	**10**
Bullying/ Harassment	**15**
Fraud	**1**
Health & Safety	**0**
*Other	**15**
Total	**41**

*Breakdown of 'Other' category	Number
General advice	6
Ongoing coaching/support	1
Unfair recruitment/banding	4
Antisocial behaviour/smoking	3
EV charging	1
Total	**15**

Concerns falling under the "other" category are escalated and raised with relevant Managers as appropriate. In many cases the concern being "closed" upon passing the concern on. In some cases it may remain open until a response has been received from the Manager.

The quarter 4 data (Appendix B) has had a large increase in the past year with both Maidstone and Tunbridge Wells Hospital seeing an increase this last quarter. We believe this increase is due to the high amount of outreach we have been carrying out, as well as a backfill of issues from a reduced service in Q3.

Annual Review

The 2023/24 statistics (Appendix C) evidence bullying and harassment as being the main reason people speak up through the FTSU route with patient safety in second place. This would suggest there is still more work organisationally around growing a culture of compassion, dignity and respect. The FTSU Guardian works closely with teams in the People Directorate to continue building and embedding initiatives to support this such as mediation, respectful resolution, organisational development and compassionate leadership. The FTSU Guardian has also been working with the HR BPs to introduce Workplace Environment Reviews as a way of investigating a culture in a less direct way. This is being used in areas where individuals do not feel comfortable sharing their concerns, but there is need for specific intervention.

TWH has seen an increase in speaking up and this is partly attributable to how active Safe Space Champions are on that site. The role of the Safe Space Champions is clearly crucial in enabling staff to speak up and as such we will continue to grow this team of volunteers.

Within the last quarter we have also worked across Kent and Medway with neighbouring trusts to collaboratively work on new innovations. These will continue development into the next quarter.

Appendix A: Staff Group who have raised concerns

Staff Group	Number
Nursing & Midwifery	21
Medical	0
Unknown	3
AHP's	0
Corporate Services	12
Administration, Clerical & Maintenance/Ancillary	5
Total	**41**

Appendix B: Comparison of concerns logged and staff group

Year	Concerns
2018/19	9
2019/20	39
2020/21	49
2021/22	107
2022/23	117
2023/24	92

Notes; FTSU Guardian started in October 2018 1 day per week alongside working another full time role.

Deputy FTSU Guardian started in October 2020 4 days per week.

We did not have a fulltime FTSU Guardian between the months of August – December 2023

Total concerns logged	Q4 2020	Q4 2021	Q4 2022	Q4 2023	Q4 2024
Maidstone	6	7	7	6	20
Tunbridge Wells	1	4	5	9	10
Unknown	0	5	3	6	11
Total	**7**	**16**	**15**	**21**	**41**

Appendix C: 2023/24 Statistics

The category “unknown” features highly. This aspect will be targeted over the coming year to improve data capture.