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

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

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

09:45 - 09:45

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

09:45 - 09:46 **07-1**

To receive apologies for absence

Neil Griffiths

09:46 - 09:46 **07-2**

To declare interests relevant to agenda items

Neil Griffiths

09:46 - 09:47 **07-3**

To approve the minutes of the 'Part 1' Trust Board meeting of 27th June 2024

Neil Griffiths

Board minutes 27.06.24 (Part 1).pdf (11 pages)

09:47 - 09:50 **07-4**

To note progress with previous actions

Neil Griffiths

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

Patient Experience story

09:50 - 10:15 **07-5**

Patient experience story

Representatives from the Core Clinical Services Division

N.B. This item has been scheduled for 09:50am

Patient Experience Story - Core Clinical Services Division.pdf (4 pages)

Reports from the Chair of the Trust Board and Chief Executive

10:15 - 10:20

07-6
Report from the Chair of the Trust Board

Neil Griffiths

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

10:20 - 10:25

07-7
Report from the Chief Executive

Miles Scott

Chief Executive's report July 2024.pdf (3 pages)

Reports from Trust Board sub-committees

10:25 - 10:30

07-8
Quality Committee, 10/07/24

Maureen Choong

Summary of Quality C'ttee, 10.07.24.pdf (2 pages)

10:30 - 10:35

07-9
Finance and Performance Committee, 23/07/24

Neil Griffiths

Summary of Finance and Performance C'ttee 23.07.24.pdf (2 pages)

10:35 - 10:40

07-10
People and Organisational Development Committee, 19/07/24 (incl. quarterly report from the Guardian of Safe Working Hours)

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 19.07.24 (incl. quarterly update from Guardian of Safe Working Hours).pdf (5 pages)

10:40 - 10:45

07-11
Audit and Governance Committee, 15/07/24 (incl. the External Auditor’s Annual Report for 2023/24)

David Morgan

Summary of Audit and Governance Committee, 15.07.24 (incl. External Audit Annual Report).pdf (29 pages)

10:45 - 10:50

07-12
Charitable Funds Committee, 17/07/24

David Morgan

Summary of Charitable Funds Cttee, 17.07.24.pdf (1 pages)

Integrated Performance Report

10:50 - 11:35

07-13
Integrated Performance Report (IPR) for June 2024

Miles Scott and colleagues

Integrated Performance Report (IPR) for June 2024.pdf (48 pages)

People

11:35 - 11:45

07-14
Six-monthly update on the implementation of the sexual safety in healthcare charter

Sue Steen

Six-monthly update on the implementation of the sexual safety in healthcare.pdf (3 pages)

Planning and strategy

11:45 - 11:50

07-15
Annual approval of the Trust's Green Plan

Miles Scott

Annual approval of the Trust's Green Plan - July 2024.pdf (14 pages)

11:50 - 11:55

07-16
To approve the Business Case for Estates Capital backlog work 2024/25

Steve Orpin

To approve the Business Case for Estates Capital backlog work 2024-25.pdf (17 pages)

11:55 - 12:05

07-17
To approve the Full Business Case for Robotic Assisted Surgery

Steve Orpin

To approve the Full Business Case for Robotic Assisted Surgery.pdf (36 pages)

Assurance and policy

12:05 - 12:10

07-18
Quarterly report from the Freedom to Speak Up Guardian

Jack Richardson

N.B. This item has been scheduled for 12.05pm

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

12:10 - 12:15

07-19
Six-monthly review of the Trust's red-rated risks

Joanna Haworth

Six-monthly review of the Trust's red-rated risks.pdf (42 pages)

Other matters

12:15 - 12:25

07-20
Six monthly update on mortuary issues

Dominic Chambers, Lydia Judge-Kronis and Joanna Haworth

N.B. This item ha been scheduled for 12.15pm

Six monthly update on mortuary issues - July 2024.pdf (3 pages)

12:25 - 12:26

07-21
To consider any other business

Neil Griffiths

12:26 - 12:27

07-22
To respond to any questions from members of the public

Neil Griffiths

12:27 - 12:28

07-23
To approve the motion (to enable the Board to convene its 'Part 2' meeting) that...

Neil Griffiths

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 27TH JUNE 2024, 09.45AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Medical Director / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Mel Norbury	Interim Trust Secretary	(MN)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Sharon Page	Divisional Director of Nursing and Quality, Surgical Division (for item 06-13)	(SP)
Observing:	The meeting was recorded live and uploaded to the Trust's YouTube Channel.		

06-9 To receive apologies for absence

No apologies were received.

AD acknowledged and commended the contribution of Karen Cox, Associate Non-Executive Director during their tenure at the Trust. AD then thanked those staff involved in the Trust's planning and response to the Junior Doctors industrial action and the focus on maintaining patient safety.

06-10 To declare interests relevant to agenda items

No interests were declared.

06-11 To approve the minutes of the 'Part 1' Trust Board meeting of 30th May 2024 and 25th June 2024

The minutes were approved as a true and accurate records of the meetings.

06-12 To note progress with previous actions

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

- **05-13 ("Provide Trust Board members with details of the reasoning for the increase in referrals to cancer services and whether such an increase in referrals had resulted in an increase in the number of cases of cancer detected").** SB reported that the increase in referrals had resulted in an increase in the number of cases of cancer detected by approximately 8% and noted that an investigation into the associated reasoning had been commissioned. AD queried when the data analysis was expected to be available. SB confirmed the data analysis would be available for the July 2024 Trust Board meeting.

Patient experience

06-13 Patient experience story

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

- Mrs B had presented with a traumatic spinal injury which had resulted in reduced sensation within the arms and legs, requiring support for all aspects of care. Mrs B subsequently became medically unwell and required admission to the High Dependency Unit (HDU) for supportive care and, once the condition improved, was transferred to the Trauma ward whilst awaiting transfer to a regional spinal rehabilitation unit.
- During Mrs B's admission, the Mr B reached the end of chemotherapy treatment and was transferred to a palliative care pathway; so, discussions were held with Mr and Mrs B regarding their wishes, and it was agreed to collocate Mr and Mrs B on one of the Trust's Trauma and Orthopaedic Wards, so that they were able to spend as much time together as possible.
- Positive feedback had been received from all individuals involved and a holistic approach to care had been achieved for Mr and Mrs B.
- The positive highlights from the patient story included the development of a personalised care plan produced in collaboration with Mr B, the family and the team providing care for Mrs B; the outstanding leadership and role modelling from the Ward Manager to the ward team; and the facilitation of the chosen place of death for Mr B through collaborative working.

MS asked how SP and JH utilised such patient experience stories to inspire other staff across the Trust to ensure patients received the best experience and care possible and to demonstrate to Trust staff what was possible in terms of patient care. SP replied that the patient experience story had been shared at both the Nursing, Midwifery and Allied Health Professional Group (AMAHPG) and the Trust's Clinical Divisional Governance Meetings. replied that share at the nursing AHP Board, and divisional governance meetings. JH confirmed that was the case; although, noted that the process was in its infancy and, therefore would continue to evolve and improve.

MS acknowledged the challenges with access to specialist rehabilitation services across Kent and Medway due to capacity limitations; and noted that consideration was required as to whether additional, local, capacity should be created. JW added that there were a number of specialist services with capacity issues in the South East such as Tier 4 Child and Adolescent Mental Health Services and noted that it would be beneficial to understand which services were accessible for the Trust; although, highlighted that in the case of Mr and Mrs B access to spinal rehabilitation would have adversely impacted their ability to be collocated during Mr B's end of life care. MS committed that himself and RJ would discuss with the Kent and Medway Integrated Care Board (ICB) the need to consider the requirements for access to sustainable specialist rehabilitation services, which are limited at present, as part of the Kent and Medway NHS Strategy programme of work.

Action: Discuss with the Kent and Medway Integrated Care Board the need to consider the requirements for access to sustainable specialist rehabilitation services, which are limited at present, as part of the Kent and Medway NHS Strategy programme of work (Chief Executive and Director of Strategy, Planning and Partnerships, June 2024 onwards)

WW commended the intention to ensure the patient received the best experience possible through a compassion of culture and commended SS on the exceptional Leaders course which supported the delivery of compassionate leadership.

AD thanked SP for the patient experience story which had been provided. AD then welcomed the focus on demonstrating to Trust staff the importance of a kind and compassionate approach to patient care, and the provision of respect and dignity during end-of-life care.

Reports from the Chair of the Trust Board and Chief Executive

06-14 Report from the Chair of Trust Board

AD referred to the submitted report and highlighted the one consultant appointment which had been made in the reporting period. AD then reported the following:

- A flag raising ceremony had been conducted on the 24th June 2024 as part of armed forces week and the Trust had received the silver award as part of the Veteran Aware accreditation scheme.

- As part of the induction process visits had been organised to a range of developments and service areas such as the Kent and Medway Medical School Accommodation; which would provide a host of benefits; and the Frailty and Geriatric Ward, Kent Oncology Centre and the Hyper Acute Stroke Unit / Acute Stroke Unit (HASU / ASU).
- An unmodified audit opinion had been issued for the Annual Report and Accounts 2024/25 and the work of those staff involved had been recognised by the Trust.
- The Executive Team continued to focus on the delivery of efficiency savings and the delivery of the Trust's financial plan for 2024/25.
- The programme of work with East Kent Hospitals University NHS Foundation Trust was a testament to partnership working and collaboration in Kent and Medway; so those staff involved in rebooking long waiting patients should be commended.

06-15 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:

- A number of significant infrastructure projects were nearing completion at the Trust, which would contribute to the core purpose of the Trust and, once fully operational, would contribute to patient care, access and experience and enable the Trust to further support the Kent and Medway system-wide position; however, such infrastructure project coincidence with the most challenging financial plan in the Trust's recent history, so it was important to ensure the infrastructure projects were delivered and any associated risks were identified and controlled.
- Charities and volunteers continued to perform an important role in the development of, and service delivery at, the Trust, with a recent celebration held for the chair of the League of Friends of Tunbridge Wells Hospital (TWH) who had held the post for 25 years.

AY queried, due to the significant increase in the number of infrastructure projects, whether a corresponding increase in the associated management resource was required. MS confirmed that additional project management resources had been deployed and that external support had been commissioned, as required. MS then informed Trust Board members to conduct a holistic post-project review of the major infrastructure projects and detailed the associated rationale.

WW queried when the Trust Board would receive a further update on the actions in response to the phase one report of the independent inquiry into the issues raised by the David Fuller case. MS replied that the Trust Board had signed off the progress against the associated action plan and an assurance statement which highlighted that all recommendations and lessons learned had been embedded. MS continued that it had been agreed that the Trust Board would receive a six-month update on mortuary issues to provide continued assurance.

AD queried, due to the increase in cyber security attacks across the NHS, whether the Trust was confident that there were sufficient risk mitigation and response plans in place. MS replied that the Director of IT and Head of Information Governance had conducted a proactive lesson learned review of the recent cyber-attack on Synnovis and a review had been commissioned to determine what, if any, impact had been experienced by patients at the Trust. MS continued that there was a wider question to consider as to what incidents could potentially overwhelm the Trust's business continuity plans and noted that the Trust was committed to engage with the official findings of the lessons learned review of the Synnovis cyber-attack. SO provided assurance that the Trust had a dedicated cyber-security team, which had direct links with the National Cyber Security Team, to ensure all lessons learned were implemented at the Trust. SO continued that one of the initial lessons learned was the importance of Multifactor Authentication (MFA), which was embedded across the totality of NHSmail accounts at the Trust. SO agreed to provide assurance to a future Trust Board meeting regarding the Trust's scenario planning for potentially catastrophic cyber security incidents.

Action: Provide assurance to a future Trust Board meeting regarding the Trust's scenario planning for potentially catastrophic cyber security incidents (Deputy Chief Executive / Chief Finance Officer, June 2024 onwards)

Reports from Trust Board sub-committees

06-16 Quality Committee, 12/06/24

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

- Discussions were ongoing regarding the appropriate forum to conduct a 'deep dive' into violence and aggression against Trust Staff.
- A comprehensive presentation was provided by the End-of-Life Care Team which included assurance regarding the plans in place to address the Care Quality Commission (CQC) 'Requires Improvement' rating and the progress which had been made to date.
- A review the assessment models within the Trust's Emergency Departments highlighted the further work required in relation to demand and activity planning; but, provided assurance that there was a robust commitment to the continued improvement of patient experience and safety.
- A brief update had been provided by the Virtual Ward Team regarding the new performance dashboard.

AD noted the rapid progression of the virtual ward programme and supported the improved ability to articulate the improvements from a data analytics point. AD noted the importance of the continued expansion of the virtual ward programme to support patient flow at the Trust.

06-17 <u>Finance and Performance Committee, 25/06/24</u>

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

- The Medicine and Emergency Care Divisional Triumvirate had provided an update on the utilisation of the Model Hospital benchmarking opportunity which had illustrated the enhanced focus within each Directorate on the simultaneous delivery of one key priority and a number of smaller priorities, the progress against which would be reported to the Committee later in 2024.
- There had been an improvement in the Trust's financial performance for month 2 of 2024/25; however, further work was required in relation to the delivery of Cost Improvement Programmes (CIPs) and it had been agreed that an update on the Trust's Financial Improvement Plan would be considered in July 2024.
- The latest quarterly update on productivity had highlighted the Trust's current position and it had been agreed that additional granular detail was required to support the Trust's Divisions and Directorates in improvement planning, with additional metrics to be incorporated into the Integrated Performance Report in due course.
- The Committee had conducted the annual review of the Trust's Green Plan and a Business Case for Estates Capital for 2024/25, both of which had been recommended for approval at the July 2024 Trust Board meeting.

EPM asked how the experience of the Medicine and Emergency Care Division was shared with other Divisions and whether there was a consistent methodology across the Trust. SO provided assurance that there was a dedicated central team to support CIPs and efficiency programmes, with dedicated programme management skills and support from the Continuous Improvement Team. SO continued that there were monthly meetings to share lessons learned and prevent duplication of programmes of work; although further work was over the next month to confirm which transformational change programmes should be pursued for 2024/25.

AD highlighted that developing accountability within the Divisional Leadership structure was critical for the delivery of the 2024/25 financial plan and noted that it was important to focus on a small number of large-scale Trust-wide efficiency programmes, which could be supported by a range of smaller efficiency opportunities. AD added that it was important to share Trust and system performance metrics to highlight the focus on both to support the Kent and Medway Integrated care system (ICS) position.

06-18 <u>People and Organisational Development Committee, 21/06/24</u>

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

- Additional consideration was required, as part of the process for non-clinical performance management of medical staff, regarding a more proactive approach to utilisation of 360-degree feedback; and it had been agreed that the Director of Medical Education and Deputy Medical Director, Workforce and Digital would consider a more proactive approach to the utilisation of 360-degree feedback.

- National funding had been provided for the first 12-months of the People Promise Exemplar programme; but further work was required to develop the internal governance arrangements for the programme of work.

Integrated Performance Report (IPR)

06-19 Review of the Integrated Performance Report (IPR) for May 2024

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

- The turnover rate had reduced to 11.4% and had exceeded the performance target of 12% for a five-month period, therefore was likely to no longer be escalated as per the Trust's Statistical Process Control (SPC) approach; however, would remain an area of focus.
- The Percentage of AfC 8c and above that are Black, Asian and Minority Ethnic (BAME) metrics reflected the national target set by NHSE, which was expected to increase to 20%; however, the achievement of the target would require a long-term focus; so, a performance trajectory would be developed with achievable targets to maintain momentum and motivation of those staff involved in the process.
- For all Agenda for Change (AfC) Band 8a and above the recruitment campaigns would be managed on a campaign-by-campaign basis with a review of the end-to-end recruitment process to ensure an inclusive recruitment and shortlisting approach; a report on which would be generated after each recruitment process to highlight any further areas of improvement. A workshop had been developed for all managers recruiting to AfC band 8a and above to address any conscious and unconscious bias to ensure an equitable approach for all individuals. The recruitment of BAME individuals and those from other protected demographics would be monitored in-depth by the People and Organisational Development Committee.

AY asked whether there was an understanding of what measures other Trusts were implementing to increase the recruitment of BAME staff and queried whether it would be beneficial to adopt a system-wide approach. SS replied that in terms of learning from other Trusts there was a range of case studies and good practice guidance available and noted that the Trust's reserve mentoring programme had been nominated for a national aware. SS continued that across Kent and Medway there was a focus on the delivery of anti-bias recruitment training anti-racism training and that the current focus was on debiasing recruitment through the way in which roles were advertised. SS informed Trust Board members that the system lead for equality and diversity role was currently vacant, which had been raised at the last Equality, Diversity and Inclusion (EDI) Board.

EPM supported the "Percentage of AfC 8c and above that are BAME" target and the associated talent and succession planning; however, emphasised the importance of understanding the lived experience of staff from BAME backgrounds. WW echoed the importance of robust talent management as there was a range of talent across the Trust which could be utilised and highlighted the further work that was required.

WW acknowledged the significant progress in terms of the vacancy rate; however, queried how additional assurance would be provided regarding the turnover of staff within the first two-years of employment at the Trust. SS provided assurance that as part of the Strategy Deployment Review (SDR) process additional metrics regarding the turnover of staff within the first two-years of employment at the Trust would be incorporated into the IPR.

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

- There had been two further incidents of moderate and above harm related to deteriorating patients; so, the focus continued to be on the introduction of robust foundations to reduce the rate of such incidents. The Lead Nurse for the Deteriorating Patient role had been approved which would support education of Trust staff at a ward level.
- Further work was required with Junior Doctors to ensure the completion of 2222 peri-arrest forms.
- There had been a significant increase in *Clostridium difficile (C. diff)* rates, partially due to poor antimicrobial stewardship although there was no indication of cross-infection through ribotyping; so, Trust-wide incident meetings continued to be held to monitor and address the issue.

Escalation capacity at Tunbridge Wells Hospital had been closed, which would enable a deep clean of the Acute Medical Unit to be conducted.

JW asked what, if any, system-wide approach had been adopted in relation to antimicrobial resistance. SM replied that there were no explicit issues with antimicrobial resistance in Kent and Medway and noted that the Trust was represented on both the Kent and Medway Antimicrobial Stewardship Group and the Infection Prevention and Control Leadership Forum. SM continued that there the three-year strategy for antimicrobial resistance and antimicrobial stewardship was currently being refreshed. JW queried whether the increase in C. Diff cases was a national problem. SM confirmed that was the case; however, Kent and Medway represented a 'hot spot' area, so further work was required to address the issue.

AD asked whether SM was comfortable with the current level of compliance with the sepsis bundle. SM replied that there were concerns associated with the suboptimal management of patients; also, data was only available for patients which had the undergone the sepsis protocol. SM then outlined the challenges with the audit process and the further work required to automate the process on the 'Sunrise' Electronic Patient Record (EPR).

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

- Access to Diagnostics (<6weeks standard) performance had improved to 98.5% against a target of 99%.
- Emergency Department performance remained consistent; but, further work was required to improve the Trust's performance, which would focus on the Trust's ED admission process and patient flow through the discharge programme of work which was led by RJ.
- There was a focus on providing clarification to partner organisations across Kent and Medway the Trust's current Referral To Treatment (RTT) and long waiting patients performance, as the Trust's internal RTT performance had improved to 75.4%; however, the overall RTT performance including system support was 74.7% and the number of patients waiting over 52 weeks had increased to 391, all of which represented patients which had been transferred to the Trust from East Kent Hospitals University NHS Foundation Trust (EKHUFT) as part of the collaborative working approach to support the treatment of patients across Kent and Medway. This will have a positive impact in reducing the long waiting times for patients.

MS emphasised the importance of ensuring an appropriate narrative for the provision of system support, as once such patients had been transferred to the Trust they became Trust patients with the same categorisation process; although, noted the need to demonstrate the Trust's role in the provision of system support.

WW referred to the "A&E 4 hr Performance" metric and queried the impact in terms of the number of patients seen at the Trust. SB replied that approximately 650 to 800 patients were seen per day at the Trust. A brief discussion was then held wherein the importance of providing additional context to the Trust's performance was outlined, due to the fluctuation in the number of attendances per month and the increase in Emergency Department (ED) activity over the last five-year period and associated response by the Trust was described in detail. AD requested that SB consider the inclusion of details of the number of Emergency Department attendances in the associated month to provide additional context to the "A&E 4 hr performance" within the IPR.

Action: Consider the inclusion of details of the number of Emergency Department attendances in the associated month to provide additional context to the "A&E 4 hr performance" within the Integrated Performance Report (Chief Operating Officer, June 2024 onwards)

NG supported the importance of the provision of system support; however, emphasised the need to avoid adverse consequences for any deterioration in the Trust's performance as a result of the provision of such support. NG then requested assurance that the Trust would not be adversely impacted financially for the provision of administrative support to system partners. SB detailed the outsourcing arrangements for administrative support and noted that although further discussions would be helpful regarding reimbursement it was emphasised that no current concerns had been identified to date.

DM queried the severity of the conditions that patients were awaiting treatment for and noted that typically the majority of patients on waiting lists were awaiting diagnostic tests. SB replied that the Trust utilised a clinical urgency coding mechanism to determine the priority of care required, and elaborated on the process by which clinical urgency was determined and the associated impact on treatment times. SB continued that all long waiting patients underwent a regular harm review process and noted that the focus on the "Access to Diagnostics (<6weeks standard)" metric reduced the time patients spent waiting for diagnostic tests. SB highlighted that although the Trust's RTT was in the best position since the COVID-19 pandemic, there remained significant further work to achieve the national standard of 93%; but, provided assurance that the clinical and operational teams continued to focus on the timely delivery of patient care.

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

- Communication remained a key theme of the Trust's complaints; however, progress was being made with the Trust's action plan and bespoke human factors training had been developed.
- The Complaints performance data was unavailable for May 2024 due to a system error, which was under investigation and was expected to be reported at the July 2024 Trust Board meeting along with the June 2024 performance data.
- The new Friends and Family Test (FFT) provider enabled the Trust to access additional granular detail and identify any key themes.
- Although "Decision to delivery interval Category 1 caesarean section < 30 mins" performance had improved, further work was required to improve the "Decision to delivery interval Category 2 caesarean section < 75 mins" performance; so, the Trust's A3 Thinking methodology had been applied to identify the key challenges. Any patients which exceeded the timeframe for caesarean sections were reviewed on an individual basis to ensure that there were no concerns with the quality of patient care or their outcomes, and no issues have been identified to date.

AD supported the importance of focusing on human factors and welcomed the positive impact of the new FFT provider on the Trusts performance.

RF acknowledged the improvement in the FFT provider; however, noted the further work that was required to achieve the Trust's target and asked whether the new FFT provider had made any commitments to support the Trust in the achievement of the target. JH replied that only the first month of data from the new FFT provider was available and there was further functionality which had not yet been implemented; but, provided assurance that the ambition was to improve the Trust's FFT performance.

JW highlighted the Trust's performance against the Trust's performance against the "Women waiting for Induction of Labour less than 2 Hours" and "Women waiting for Induction of Labour less than 4 Hours" metrics and asked how the targets had been determined. JH replied that there were no national targets relating to waiting times for induction of labour; so, it was intended to conduct a review of other organisations to determine whether the Trust's target was realistic and emphasised the importance of appropriate care for women and birthing people. JW highlighted the need to ensure the target was related to patient safety. JH acknowledged the point and noted the programme of work with the Business Intelligence Team to review the targets.

MS commented that it was important for the Maternity and Neonatal Assurance Group to consider the implications of not achieving the targets for those patients involved and to demonstrate the rationale for not achieving such targets. MC provided assurance that a multidisciplinary team from within the Maternity Services presented the Trust's performance to the Regional Neonatal and Patient Safety Team and informed Trust Board members that a detailed review was conducted of each clinical case, which was discussed at the Maternity and Neonatal Assurance Group, with a robust follow-up produce for each parent and baby. MC noted that delays were primarily related to clinical safety, such as failed epidurals.

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

- Additional granular detail had been obtained for the number of patients discharged before noon, which had identified significant variation in the reasons for delays at a ward level; and that the

key areas of focus were board rounds, the provision of an estimated date of discharge. The programme of work had identified the need for a broader approach to deliver the intended benefit.
- The "Decrease the percentage of occupied bed days for patients identified as no longer fit to reside (NFTR)" metric had been aligned to the Model Health System.

AD asked whether medication dispensing times impacted discharge times and queried whether there were alternative discharge mechanisms which could be considered. RJ confirmed that delays in the medication dispensing times had been identified as one of the underlying reasons for delays in patient discharges and noted that a holistic approach had been adopted to improve patient discharge times. RJ continued that an initiative had been developed to provide medications to patients at home, where safe to do so, to expedite patient discharges.

RF asked what, if any, actions had been implemented to ensure there was sufficient external capacity to support patient discharges. RJ outlined the recent challenges in terms of external capacity and agreed to submit a "Review of the system-aspects of patient discharges" report to a future Trust Board meeting.

Action: Submit a "Review of the system-aspects of patient discharges" report to a future Trust Board meeting (Director of Strategy, Planning and Partnerships, June 2024 onwards)

SO then referred to the "Sustainability" Strategic Theme and highlighted the following points:
- The Trust was £900k adverse to plan for year-to-date at the end of Month 2 of 2024/25.
- A significant change in temporary staffing expenditure had been delivered since the start of 2023/24; however, the Trust commenced the 2024/25 financial year with open escalation capacity, which had recently closed, so further positive impacts on temporary staffing expenditure were expected for June and July 2024. There were a number of drivers for the Trust's temporary staffing expenditure which included high-cost medical agency staff and the additional support required for complex mental health presentations.
- The cash position and associated cash management would remain an area of focus as the Trust was currently adverse to its financial plan which was causing pressure on its cash position; however, a number of actions were being taken to manage the situation and any deterioration would be escalated, as required.

EPM requested an update on the Business Case for the development of the Temporary Staffing Team. SS replied that the Business Case was nearing completion; however, the scale had been reduced due to the Trust's financial position; so, capacity across the People and Organisational Development Department had been explored.

EPM asked whether the delay to the Kent and Medway Orthopaedic Centre (KMOC) was expected to adversely impact the Trust's income position. SO replied that the Trust's financial plan had assumed an opening date at the end of Quarter 1 of 2024/25, which had been delayed into Quarter 2 of 2024/25 and therefore was expected to result in an estimated circa £1.5m financial impact; however, the Trust's Operational Teams were exploring what proportion of the intended activity could be delivered prior to the opening of KMOC to mitigate the impact as the additional activity would be funded via the Elective Recovery Fund (ERF). SO continued that there were ongoing discussions with NHSE regarding the reinstatement of cash which had been utilised by the Trust to support the acquisition of the Spire Tunbridge Wells Hospital.

EPM asked whether there would be any financial concerns related to a further delay to KMOC. SO replied that if further delays were identified then scenario planning would be conducted to determine the impact of such delays; and noted that the cash challenges were reflective of the financial position within the Kent and Medway ICS. SO added that a delay of one month could be managed; however, a long delay may cause concerns.

WW queried the anticipated impact of the Junior Doctors industrial action on the Trust's financial position for 2024/25 and asked what additional measures could be implemented to support the delivery of the Trust's CIPs. SO replied that further clarification nationally was required in relation to funding approach for the Junior Doctors industrial action; however, outlined the approach which had been previous adopted in terms of the provision of funding in response to industrial action. SO continued that, in terms of CIP delivery, it had been agreed that a review of the Trust's Financial

Improvement Plan would be considered at the July 2024 Finance and Performance Committee meeting, which was intended to highlight the mechanisms which would be implemented to support identified CIPs a well as what additional measures would be implemented, with a particular focus on large scale transformational changes. SO then outlined the discussions which had been held to date with Divisional / Directorate staff to reinvigorate the process. AD acknowledged the focus of the Executive Directors on the delivery of the financial plan for 2024/25 and provided assurance that there would be transparency regarding the mechanisms to support delivery of the financial plan and engagement with Trust staff.

Quality Items

06-20 Quarterly mortality data

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

- The Mortality Surveillance Group had been renamed to the Learning from Deaths Group to reflect the wider focus on lessons learned.
- The Medical Examiners Service scrutinised all inpatient deaths and referred any concerns for a Structured Judgement Review (SJR). It had also been agreed in December 2023 that all deaths which involved sepsis as a contributory factor would undergo further investigation to determine any lessons to be learned.

AY queried the timeframes associated with the dissemination and implementation of the lessons learned. SM duly explained the process for review of the findings from SJRs and noted the dissemination of information via clinical governance meetings with a cross-Division / Directorate approach to ensure all Clinical Divisions were aware of any pertinent points.

06-21 To approve the Trust's Quality Accounts, 2023/24

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

- The Quality Accounts had been prepared in accordance with the Department of Health and Social Care Guidance and had been reviewed by a range of internal and external stakeholders.
- It had been agreed to reduce the number of Quality Priorities for 2024/25 and that such priorities should be aligned to the Trust's Strategic Themes, with the exception of the maternity improvement project, to enable increased focus and improved delivery.

MC provided assurance that the Quality Accounts for 2023/24 had been reviewed, and supported, by the Quality Committee and that the Quality Committee had supported the reduction in the number of quality priorities to ensure a focused improvement approach.

SM outlined the concerns which had been raised in relation to the "…Physician Associate roles continue to be recruited to and provide multi-professional support to our services and rotas" statement and provided assurance that Physician Associates were not utilised to cover medical rota gaps and that Physician Associates operated within their scope of practice. A discussion was then held, and it was agreed that SM and JH should agree a revised form of words for the Quality Accounts in relation to the deployment of physician associates.

Action: Agree a revised form of words for the Quality Accounts in relation to the deployment of physician associates (Chief Nurse and Medical Director / Director of Infection Prevention and Control, June 2024)

JH then thanked the Trust's Clinical Audit and Regulatory Compliance Manager who had been instrumental in the development of the Quality Accounts for 2023/24.

The Quality Accounts for 2023/24 were approved in the form substantially submitted to the Trust Board, to enable any changes to be enacted to the "Physicians Associate" statement without additional approval.

People

06-22 Mid-year Nursing and Midwifery staffing review

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

- The nursing vacancy rate had reduced to 7.6%; however, there remained 'hot spot' areas such as the Community Midwifery Team.
- The nursing and midwifery recruitment pipeline remained an area of focus with a shift in focus to national and local recruitment with the utilisation of a number of initiatives including apprenticeships and engagement with local schools.
- The turnover rate was circa 10%, with the key areas of focus being those staff which had been employed by the Trust for less than two-years and Health Care Support Workers (HCSWs).
- A significant reduction in agency expenditure had been achieved; so, further focus would be applied to the reduction of bank expenditure and improved roster management.
- The recommendations from October 2023 Nursing and Midwifery establishment review continued to be progressed by the Trust's Clinical Divisions as part of the business planning processes.

AD and EPM commended the progress which had been made to date and the focus the delivery of safe care.

Systems and Place

06-23 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

RJ referred to the submitted report and highlighted the following points:
- The Acute Provider Collaborative had agreed, following the first phase report of the review of acute services, to focus on Ear Nose and Throat (ENT) and Endoscopy. Each NHS Provider within Kent and Medway had also been provided with an individual data pack, to enable an informed view to be developed as to which services should be key areas of focus, with General Medicine having been identified as an area of focus for the Trust.
- A range of engagement events had been commissioned to support the improvement of community services, with a focus on the prioritisation of Integrated Neighbourhood Teams.
- An initial planning process for the Transfer of Undertakings (Protection of Employment) ('TUPE Transfer') of HCP facing staff employed by the Kent and Medway ICB had commenced.

AD stated that system-working would continue to be a growing area of focus at future Trust Board meetings. MS acknowledged the point and supported the approach which had been adopted by the Acute Provider Collaborative to initially focus on ENT and Endoscopy which, once completed, would enable further focus on additional opportunities. AD added that the Kent and Medway Chairs Meeting had emphasised the importance of focusing on one or two key priorities which is in line with the proposed approach by the Acute Provider Collaborative.

EPM queried whether the Trust was required to resource the TUPE transfer. RJ confirmed that was the case as the Trust was the host organisation for the West Kent HCP. EPM then asked whether there were any synergies between the TUPE of staff from the West Kent HCP and the Spire Tunbridge Wells Hospital. RJ confirmed that was the case; however, noted that the West Kent HCP staff were on NHS contracts, which reduced the associated complexities. SS supported the assurance which had been provided and added that there were no concerns to raise regarding the availability of resources within the People and Organisational Development Department.

RF expressed concerns over the resourcing arrangements of the Executive Team in response to increased system-working requirements and emphasised the importance of ensuring that there were no negative impacts on the leadership and management of the Trust. The point was acknowledged and assurance regarding the delivery of system-wide and Trust priorities would continue to be considered by MS and the Executive Team.

Planning and strategy

06-24 To approve the corporate objectives for 2024/25

RJ referred to the submitted report and highlighted the corporate objectives formed the fundamental basis of the IPR, which was reviewed on a monthly basis, so the report provided a high-level summary of the proposed changes.

The proposed changes to the Corporate Objectives for 2024/25 were approved as submitted.

Assurance and policy

06-25 Update from the SIRO (incl. approval of the Data Security and Protection Toolkit submission for 2023/24, and Trust Board annual refresher training on Information Governance)

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

- The Data Security and Protection Toolkit submission had been independently verified by Tiaa Ltd with only two low priority recommendations identified.
- A decision had been made to amend the Information Governance training compliance target to 90%.
- Due to a change in the process by which NHSE assessed compliance for unsupported systems and the infrastructure improvements through the IVE Server Programme the Trust had achieved a 'Standards Met' position in relation to unsupported systems.
- The Cyber assessment framework due to be implemented for 2024/25, an update on which would be provided to a future Trust Board meeting.

AD queried whether the Data Security and Protection Toolkit submission had been considered by the Audit and Governance Committee prior to submission to the Trust Board. A brief discussion was then held wherein RJ clarified that the report had been considered by the Information Governance Committee, DM confirmed support for approval of the Data Security and Protection Toolkit submission for 2023/24 and WW outlined the future focus, through the new standards, which would be required in relation to Artificial Intelligence due to the emerging risks. It was agreed that RJ should ensure that future Data Security and Protection Toolkit submissions were considered by the Audit and Governance Committee, prior to submission to the Trust Board.

Action: Ensure that future Data Security and Protection Toolkit submissions were considered by the Audit and Governance Committee, prior to submission to the Trust Board (Director of Strategy, Planning and Partnerships, June 2024 onwards)

The Trust Board approved the Data Security and Protection Toolkit submission for 2023/24.

Other matters

06-26 To consider any other business

There was no other business.

06-27 To respond to questions from members of the public

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

06-28 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
04-11	Ensure that future Integrated Performance Reports highlight those metrics which directly contributed to the Trust's value weighted activity as part of the productivity calculation	Deputy Chief Executive / Chief Finance Officer	April 2024 onwards	A verbal update will be given at the meeting.
06-15	Provide assurance to a future Trust Board meeting regarding the Trust's scenario planning for potentially catastrophic cyber security incidents	Deputy Chief Executive / Chief Finance Officer	June 2024 onwards	A verbal update will be given at the meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	Details of the consideration of the generation of renewable green energy will be reported verbally as part of the "Annual approval of the Trust's Green Plan" report
05-13	Provide Trust Board members with details of the reasoning for the increase in referrals to cancer services and whether such an increase in referrals had resulted in an increase in the number of cases of cancer detected	Chief Operating Officer	July 2024	The increase in referrals had resulted in an increase in the number of cases of cancer detected by approximately 8% and noted that an investigation into the associated reasoning has been commissioned.
06-13	Discuss with the Kent and Medway Integrated Care Board the need to consider the requirements for access to sustainable specialist rehabilitation services, which are limited at present, as part of the Kent and Medway NHS Strategy programme of work	Chief Executive and Director of Strategy, Planning and Partnerships	July 2024	The requirement for investment in specialist rehabilitation services was raised with the Kent and Medway Integrated Care Board as part of the Kent and Medway NHS Strategy programme of work
06-19a	Consider the inclusion of details of the number of Emergency Department	Chief Operating Officer	July 2024	Details of the number of Emergency Department attendances in the

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	attendances in the associated month to provide additional context to the "A&E 4 hr performance" within the Integrated Performance Report			associated month to provide additional context to the "A&E 4 hr performance" will be included within future Integrated Performance Report
06-19b	Submit a "Review of the system-aspects of patient discharges" report to a future Trust Board meeting	Director of Strategy, Planning and Partnerships	July 2024	A discussion was held with Director of Strategy, Planning and Partnerships and the "Review of the system-aspects of patient discharges" item has been scheduled for the September 2024 'Part 1' Trust Board meeting.
06-21	Agree a revised form of words for the Quality Accounts in relation to the deployment of physician associates	Chief Nurse and Medical Director / Director of Infection Prevention and Control	June 2024	A revised form of words was duly agreed prior to submission to NHS England.
06-25	Ensure that future Data Security and Protection Toolkit submissions were considered by the Audit and Governance Committee, prior to submission to the Trust Board	Director of Strategy, Planning and Partnerships	June 2024	The forward programme for the Audit and Governance Committee has been duly updated to ensure that Data Security and Protection Toolkit submissions were considered by the Audit and Governance Committee, prior to submission to the Trust Board

Actions not yet due (and still 'open')

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

NHS Maidstone and Tunbridge Wells NHS Trust

Patient Experience Story **Representatives from Core Clinical Services**

Patient stories are undeniably powerful in gaining an understanding of their experience of care on what actually happened in the course of receiving care or treatment at the Trust.

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, the Trust can improve and develop what we provide.

The patient story that follows describes the experience of care of Mrs X, who is a patient at Maidstone and Tunbridge Wells NHS Trust (MTW) together with her family as part of the cancer pathway.

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

1. What does this story reveal about Trust staff?
2. How does the story relate to the information contained in the Trust's quality or performance reports?
3. What does the story tell the board about how staff communicate with patients?

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: Mrs X	Services/wards experienced at Maidstone and Tunbridge Wells NHS (MTW):
Date of care experienced: **May 2024- June 2024**	**Faster Diagnosis Standard (FDS) Pathway** **Pharmacy** **Pathology** **Radiology** **Peggy Wood** **Oncology**

Outline of experience:

Mrs X is a patient with a history of stage 3 breast cancer from 2016 which was treated with chemotherapy, radiotherapy alongside reconstruction surgery and continuation of medications until 2021. In addition, Mrs X's medical history amongst others, included kidney stones.

In May 2024, Mrs X felt a slight ache in lower back and sought advice from their GP in case this was due to her kidney stones. The GP arranged a CT scan to be done at MTW and thereafter contacted Mrs X to requesting her to come in to the surgery on the 17th May for a review. At this appointment, Mrs X was informed that the imaging showed possible secondary cancer in the liver and the GP was referring her to MTW for further investigation and follow up.

On Monday 20th May, Mrs X was phoned by a nurse from the FDS pathway to review her history. The following day, Mrs X received another phone call from a doctor who also took het history and requested a CT of the abdomen, chest and pelvis plus an ultrasound. Mrs X was informed that this CT was unlikely to be reported before the next available appointment on the 29th May as there was a bank holiday the proceeding week and the next available date to be reviewed was 5th June.

The family of Mrs X were concerned on the suggested turnaround time of reporting of the scan and sought clarification with the Radiology department. The scan was undertaken and reported in normal turnaround time on the 24th May and Mrs X was contacted on the 28th May asking her to come for a review the following day.

At the appointment, the doctor asked Mrs X if she knew why she was here, Mrs X confirmed she was aware and observed that this was the same doctor and nurse that she had spoken to on the phone the week before as part of the FDS pathway review. The doctor informed the patient that her liver looked 'somber and sobering' and asked if Mrs X wanted to see the images to which she said yes and was told that good tissue is pale and dark tissue is bad- the image that was displayed was mottled.

The doctor proceeded to outline the pathway that would be followed including identifying the primary site of cancer and would refer Mrs X to the upper gastrointestinal (GI) multidisciplinary meeting (MDM) for further review and discussion. At this point the family of Mrs X queried why this would not go to the breast team as she had a known history of breast cancer and referred to the previous discussions that had taken place the previous week and also highlighted that the same information about her cancer history had been written on the CT report.

The doctor reiterated that referral to the Upper GI MDM was the best course of action with expected discussion of Mrs X's case to take place in 4 weeks' time (anticipated 26th June). Mrs X's family, who are well versed in cancer care, asked if the team would do a liver biopsy before the 26th June to give a full picture for the MDM to which the doctor replied that this would be

ordered by the upper GI MDM. The family's view was that the biopsy be able to support molecular testing of the original breast tissue against the liver to see if this was the area that was the primary cause. The family queried again why their case was not going to be referred to the breast MDM considering her history of breast cancer. Additionally, Mrs X's family challenged the doctor about the lack of an examination on Mrs X's back considering the original complaint was lower back ache, a physical examination did not occur and the doctor ordered an MRI scan.

At the end of the appointment the doctor moved to discharge the patient from the FDS pathway to which the nurse challenged the decision to discharge as felt there would be a risk the patient would be lost to follow up and preferred this did not occur until the case had been reviewed at MDM.

The family of Mrs X approached a different consultant pathologist at MTW for a second opinion, they chose this method as they did not feel they had been listened to following the previous review. The consultant pathologist reviewed the case with a breast surgeon and both agreed that Mrs X's case would benefit from being discussed at the breast MDM that was to take place the following week.

At the breast MDM, a liver biopsy was requested and the patient was given an appointment to go to Peggy Wood for the 6th June.

On the 7th June Mrs X was phoned at home by the original FDS doctor to discuss the MRI results of her back; it is important to note that Mrs X was on her own when receiving this communication and without her family's support in understanding medical terminology and requested a more simplified discussion. The doctor questioned if Mrs X understood what malignant meant, and following this phone call, Mrs X became quite distressed.

Further mammograms and the liver biopsy occurred via interventional radiology with the biopsy reported for the next breast MDM where Mrs X's case was discussed on the 18th June and planned oncology appointment set for the 26th as there was a confirmed diagnosis of metastatic breast cancer.

On the 26th June; Mrs X went home with chemotherapy, happy that this was resolved but very concerned that this was not as a result of our pathways but because of her family challenging the decisions made and thanked the efforts of many individuals across a collection of services.

Mrs X's final feedback was that it might not work out for the next patient who may not have someone with them able to understand and challenge decisions when it doesn't feel safe and from Mrs X wanted learning to occur from her story.

Feedback was then received from Mrs X's family member and both her and Mrs X agreed that this story should be shared at Trust board for wider learning.

Positive points to highlight:	Negative points to highlight:
• Mrs X and her family wanted to highlight the staff who were wonderful providing care: the reception and nursing team in the FDS pathway, the breast surgeon, Peggy Wood staff, interventional radiology and the oncology staff. The feedback received included: *'Peggy Wood was amazing and kind'* *'Interventional radiology is the bee's knees; a sweet and kind radiologist and lovely nurses'* *'The CDC is lovely'* *There is a really nice doctor, consultant and individual at pharmacy hatch with the one stop clinic nurse lovely- feels safe and right'* • The nurse at the FDS appointment recognised risk of loss to follow up and challenged clinical decision to discharge Mrs X. • Pathology team were proactive in discussions with the patient's family and supported their challenge. • The breast surgeon went above and beyond in reviewing the case and ensuring that it was discussed in a timely manner.	• Mrs X and her family's concerns and points raised at appointment with a doctor were disregarded. • Mrs X felt that the doctor had not read the historical clinical notes and therefore did not feel safe. • Incorrect information about turnaround times for Radiology were provided to Mrs X. • The language used at first appointment and on phone consultation following MRI was very distressing to Mrs X. • There was no consideration of the impact of delivery of the results of the MRI to Mrs X and they were not asked if there was anyone with them for support when this was relayed.

Actions to take from this:

- Feedback to be given to all respective areas from the patient's perspective for personal reflections.
- Story to be discussed at clinical governance forum for Consultant Pathologist to encourage their role in as part of an MDM and discuss how they can provide another route/ set of professionals who patient or the families can liaise with for a second opinion.
- Feedback to be given at Nursing, Midwifery and Allied Health Professionals and Pharmacy Board to illustrate importance of challenge and benefits of speaking up.
- Feedback to be given through experience of care strategy of need to listen to patient and family.
- Radiology turnaround times for reporting images to be made available on the intranet pages so that clinical teams to refer to when planning next appointments.
- Involvement of Radiology team in the new patient information working group.

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?
24th June 2024	Consultant Breast Radiologist	Nicky Ellen	Dineen	Radiology	TBC	New
9th July 2024	Consultant Obstetrician & Gynaecologist- Interest high-risk obstetrics	Nnaemeka Nwakonobi	Onwudiwe	Obstetrics &Gynaecology	TBC	New
9th July 2024	Consultant Obstetrician & Gynaecologist- Adv Laparoscopic Surg & Endo	Rahul Ambadas	Gore	Obstetrics &Gynaecology	TBC	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:

- Following the Care Quality Commission's inspection of maternity services at MTW last year as part of a wider national maternity inspection programme, our teams have continued to work on their service improvement actions, focussing on the report's recommendations for Tunbridge Wells Hospital and our birth centres at Maidstone and Crowborough hospitals. As part of this work, NHS England and the Kent and Medway Integrated Care Board (ICB) recently carried out an assurance visit to review the improvement plan and outcomes to date. Following the visit, the ICB highlighted the positive changes made since the last visit in February, including the work to implement governance structures and processes, as well as the improved choice of care for our parents and their babies. They also recognised the teams' work on bringing in digital solutions to better understand our population, capturing equality, diversity and inclusion (EDI) metrics and assessing services against EDI standards. The ICB commended teams on their improvement projects which have formed the basis of system wide developments, recognising MTW's role as a positive influencer in the local maternity system.

- Following MTW's acquisition of the Spire Tunbridge Wells Hospital, work on the integration programme is progressing in a number of key areas ahead of the transition period ending in the autumn. The Trust has been able to support the NHS across Kent and Medway by taking on a significant number of the longest waiting patients in the system – to date, 999 patients have been transferred to MTW for treatment, with an agreement to ensure 2,500 patients are transferred by the end of the financial year. The development of IT systems is progressing well and these will be in place by the end of the transition period. MTW staff are regularly present on the Fordcombe site to meet with Spire staff at all levels, giving them the opportunity to speak to our teams and ask any questions they may have regarding the transfer, including details of how the Trust will consolidate MTW and Spire services while building on existing services at the site. The Trust has also been engaging with Spire staff on their terms and conditions of employment, working closely with them to meet all the TUPE requirements (Transfer of Undertakings Protection of Employment) in full and ensuring a positive transfer experience. Nursing and quality standards are being consolidated and we have also made good progress on finalising the clinical and operational model for the Fordcombe site, while working in collaboration with the Fordcombe teams to align patient pathways and integrate theatre timetables.

- Emergency departments (ED) on each site have both seen a rapid increase in patients in recent years. In 2023, our ED teams treated more than 220,000 patients and the rise in attendances shows no sign of slowing down. Last month we saw a 12% rise in attendances compared to June 2023 and treated more than 20,000 patients. Despite this, we continue to demonstrate strong emergency care performance, with more than 83% of patients being treated within four hours, putting MTW first in the south east and third in the country against this important standard. To highlight the work of our ED staff, the ED teams at Tunbridge Wells Hospital will once again feature in a new series of Channel 5's 'A&E After Dark'. The teams previously appeared in series 5 of the programme, which was watched by over 250,000 people each week. Filming is currently underway, and the new series will air later this year.

- We are treating more patients than ever before while also successfully recruiting more staff, and the increase in both has put pressure on our car parks. As our workforce and services grow, we know parking continues to be an ongoing challenge at our busy

hospital sites and this can often be frustrating for patients, visitors and our staff. To support this, the Trust has invested in a number of measures in recent years which have included:

- Additional parking and new multi-storey car parks at both Maidstone and Tunbridge Wells hospitals.
- Funding free public transport options for staff from the town centres and between hospital sites.
- Free off-site parking for staff located next to Tunbridge Wells Hospital.
- Partnership working with Kent County Council on improving cycle routes around Maidstone Hospital and encouraging staff to cycle to work.

The Trust is currently looking into a number of solutions to increase parking capacity at our hospitals. At present we cannot build new parking due to capital and planning issues, however we continue to look at options to further improve capacity on site, for example, by the introduction of a Park and Ride scheme. A consultation was held for all staff this month to gather their views on proposed solutions, and their feedback will be taken into consideration in our final plans.

- In my update last month, I confirmed that the Trust's Chief Operating Officer, Sean Briggs, and Chief People Officer, Sue Steen, will be moving on to new roles later this year and progressing their careers in trusts with world-leading reputations in research and education. We are pleased to have attracted a number of strong candidates for both their roles, and interviews and stakeholder panels will take place next week. Following the sudden and very sad death of Kevin Rowan in February, we have now appointed a new Trust Secretary who will take up the role in the autumn.

- I am delighted to report that our nursing staff have recently been shortlisted for the Nursing Times Awards. The awards provide an opportunity to recognise the excellent dedication, inspiration and hard work nursing colleagues provide every day on a national stage:

    - Vicky Williams, Stroke Clinical Lead and Lead Stroke Specialist Nurse in the Stroke Unit, has been shortlisted as Nurse Leader of the Year. Vicky's nomination praised her approach to pioneering innovative solutions to improve the Trust's Stroke Service, which includes the development of the Stroke Assessment Bay, one of the first of its kind in the UK.
    - Learning Disability Liaison Nurse, Becky Hankin, and Mental Capacity Act Clinical Nurse Specialist, Philippa Routs, have been shortlisted in the Learning Disabilities Nursing category. Their nominations recognised their work in developing pathways to support patients with learning disabilities and making sure their experience is as positive as possible.
    - The Infection Prevention and Control team have also been shortlisted in the Infection Prevention and Control category. Their nomination highlighted the team's quality improvement project to prevent bloodstream infections by improving the care and management of peripheral cannulas.

    The winners will be announced at an awards ceremony in October.

    The Leadership Development team has also been shortlisted for two national awards. Their 'Exceptional Leaders for All Programme' has been shortlisted for the CIPD People Management Awards in the Best Learning and Development Initiative – Public/Third Sector' category, and also the British Training Awards. The programme supports our colleagues to develop new leadership skills and forms a crucial step in delivering our vision of *Exceptional people, outstanding care*.

- Our second cohort of the Reverse Mentoring Programme, a scheme designed to build relationships between staff and leaders, has now completed after running over six months from December 2023. The programme focuses on creating a powerful alliance

between senior leaders and colleagues from ethnic minority groups as well as staff living with long-term health conditions. The initiative encourages participants to have honest, open, two-way conversations to explore and challenge attitudes and behaviours. Overall, the latest cohort consisted of 12 pairings, including clinical and non-clinical staff. I was delighted to take part in the programmes as a mentee, alongside other executives, non-executives and senior leaders. A celebration event was recently held which allowed participants to reflect on their experiences, feedback what they learnt from the programme and share how it will shape the way they work in future.

- Dr Michael Coutts, Consultant Gynaecological Pathologist, has been involved in a multidisciplinary project to develop a cervical screening service in Moldova. With a population of 2.8 million, Moldova's cervical cancer survival rate was approximately 50% in 2016, with the country seeing some 500 cases a year and 250 deaths. By comparison, the UK sees 3,300 cases of cervical cancer per year with 850 deaths, despite a population 24 times larger, and this is largely due to an effective screening programme. A team of pathology professionals from the UK have been working on a cervical screening programme since 2016, supporting all areas of the new process from planning its development to welcoming its first patients. Dr Coutts provided his expertise in histology, which involves the tissue diagnosis of cancer and identifying precancerous states from biopsies. As part of the project, the Trust welcomed pathologists from Moldova to shadow Dr Coutts. Working in Maidstone Hospital, the visitors gained valuable insight into histological and pathological practice which they could feed back to their colleagues in Moldova. Thanks to the project, the country now has a cervical screening programme up and running, similar to that of the UK, which should enable earlier diagnosis of cervical cancer and higher survival rates.

- After recently celebrating reaching all three cancer waiting time standards, including the 31-day national standard for the first time, colleagues from the Kent Oncology Centre have been representing the Trust across the UK by attending conferences to showcase their work and share best practice. Members of the Lung Cancer team joined the annual conference for the British Thoracic Oncology Group (BTOG) held in Belfast, which brings together health care professionals involved with thoracic malignancies throughout the UK. Colleagues also attended and presented at the UK and Ireland Prostate Brachytherapy Conference in Portsmouth. The annual meeting brings together medical, scientific, practitioner and industry experts from across the country to update and progress the field of prostate brachytherapy, drawing in speakers from around the world, including Melbourne and Texas.

- Congratulations to the winner of the Trust's Employee of the Month award for June, Hide Yamamoto, Urology Consultant. Hide frequently receives very positive feedback from patients and is passionate about improving the service to deliver the best care. He inspires colleagues working beside him and displays great leadership skills. Staff Nurse Matilda Ojo and Operating Department Practitioner Devika Rai also received the Highly Commended award for their quick thinking and actions when responding to an incident in the Ophthalmology Clinic and providing life-saving support to a patient.

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, 10/07/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (virtually, via web conference) on 10th July 2024 (a 'main' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Committee reviewed the **actions from previous meetings** wherein the Committee acknowledged the agreed approach for the provision of an easy-read or alternative language version of the Trust's Quality Accounts, if required.
   - The Chief Nurse provided an **update on the Patient Outcomes Oversight Group and Quality Improvement, Research and Innovation Oversight Group (QIRIOG)** which included details of the progress which had been made to date and the further work which had been conducted to ensure alignment of the QIRIOG with the Trust's quality improvement and continuous improvement methodologies, which had concluded that the Chair of the QIRIOG should be allocated to the Director of Strategy, Planning and Partnerships, with the Deputy Chair allocated to the Deputy Chief Executive / Chief Finance Officer.
   - The Chief Nurse then presented the **summary report from the Patient Safety Oversight Group** which included the proposed changes to the After-Action Review (ARR) process and details of the programme of work to reduce the prevalence of *Clostridium difficile (C. diff)* with a specific focus on anti-microbial prescribing. It was agreed that the Chief Nurse should ensure that future escalation reports from the Quality Committee's sub-committees were amended to incorporate the feedback received at the Committee meeting on 10/07/24 (i.e. provide assurance regarding the timeline and measures to address any matters of concern / key risks to escalate; and enhance the visibility of the name of the reporting forum). It was also agreed that the Chief of Service, Cancer Services should conduct a further review of risk ID3023 "Haematology patients are at risk of being lost to follow up due to operational pressures" to determine whether the "Rating (Current)" was accurate, or, if required, should be amended to reflect the mitigations in place.
   - The **summary report from the Experience of Care Oversight Group (EOCOG)** was then presented by the Chief Nurse, which included the challenges in relation to the Trust's complaints performance and the mitigations which had been implemented; the challenges in relation to the patient transport service; and details of the patient experience which had been considered. It was agreed that the Head of Quality, NHS Kent and Medway should escalate the current challenges in terms of the patient transport service to the Kent and Medway Integrated Care Board, due to the central management of the patient transport service contract. The Chief Nurse agreed to notify the Trust's Executive Directors of the agreed escalation.
   - The Chief Nurse presented the **summary report from the Maternity and Neonatal Assurance Group** wherein the Committee acknowledged the further work which had been commissioned to ensure that there was comprehensive Equality, Diversity and Inclusion (EDI) data for women and birthing people to ensure any specific areas of concern could be appropriately addressed.
   - The **minutes of the Quality Committee 'deep dive' meeting, 10/04/24**, were noted.
   - The Committee reviewed the **Trust's Quality related risks** which included an overview of the risks within the "Patient Experience" and "Patient Safety and Clinical Effectiveness" Strategic Themes; and the programme of work which had been commissioned to review of risks which had been on the risk register for longer than one year. The Committee highlighted the importance of ensuring that overarching risks were recorded on the risk register, to prevent duplication of risks. It was agreed that the Head of Risk Management should ensure that future "Review of the Trust's Quality related risks" reports grouped risks by the forum which was accountable for the review and monitoring of the risk.
     - ❖ The Committee was **assured** that there was an appropriate plan and programme of work in place to review the Trust's Quality related risks and ensure any specific areas of concern were escalated through the Trust's governance structure.
   - The Committee conducted the latest **annual review of Quality Impact Assessments (QIAs)**, wherein the outputs of the QIAs for the significant service transformation programmes and

Cost Improvement Programmes (CIPs) were acknowledged; but, the Committee highlighted the importance of considering those programmes of work which had been rejected, to understand the associated rationale and the need to ensure that the time commitment for the delivery of a project reflected the associated benefits. It was agreed that the Chief Nurse should discuss the feedback received from the Committee in regard to the "Annual review of Quality Impact Assessments (QIAs)" report with the Improvement and Delivery Team to consider which aspects should be incorporated into future iterations of the report.
    - ❖ The Committee was **assured** that the appropriate QIAs had been conducted; but, recommended some areas of enhancement for incorporation into the annual review process.
- The **final Quality Accounts for 2023/24** were noted.
- The Committee conducted an **evaluation of the meeting** wherein Committee members provided their observations and reflections on the meeting which included the benefits associated with a concise agenda which provided sufficient capacity for challenge; the additional focus afforded by the escalation matrix; and that further utilisation of the process was required to ensure that the required assurances were received on an ongoing basis.
    - ❖ The Committee confirmed **partial assurance** in regards to the revised Quality Committee structure, as although significant progress had been made and the initial outputs had been well supported further meetings were required to ensure the approach operated effectively in practice and provided the required continuing oversight.

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

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

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

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

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

Summary report from the Finance and Performance Committee, 23/07/24	Committee Chair (Non-Exec. Director)

The Committee met on 23rd July 2024, virtually, via web conference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Financial Improvement Director and Deputy Chief Executive / Chief Finance Officer presented a 'deep dive' into **the Trust's Financial Improvement Plan** wherein an in-depth discussion was held regarding the Trust's forecast financial position, the downside assumptions which had been included and the cross-cutting projects which had been identified at the Senior Leaders Forum. It was agreed that the Deputy Director of Finance, Performance should liaise with the Deputy Chief Executive / Chief Finance Officer to ensure alignment between the "Quarterly update on productivity…" report to the Committee and the productivity improvements related to the Trust's Financial Improvement plans. It was also agreed that the Chief Executive should ensure that Quality Impact Assessments (QIAs) and Equality Impact Assessments (EQIAs) are conducted for each of the three domains within the Trust's Financial Improvement Plan with an update to be provided to the next meeting of the Committee.
     - ❖ The Committee was **assured** regarding the three key areas of focus and associated supporting activities; however, acknowledged that a number of next steps were required to support the delivery of the cross-cutting projects which had been identified.
   - The review of **financial performance for June** highlighted that the Trust was £0.3m adverse to plan for month 3 of 2024/25 which represented a slight deterioration on the Trust's month 2 performance. The Committee noted the further work which was required in relation to Cost Improvement Programmes (CIPs) and it was agreed that the Deputy Director of Finance, Performance should provide Committee members with an update on the delivery of the 22 CIPs which had not yet had a value identified and progress with the completion of the remaining Project Initiation Documents (PIDs).
   - The Committee noted the latest **quarterly analysis of consultancy use.**
   - The **Patient Access strategic theme metrics for June** were reviewed, and the Committee was informed of the range of measures which had been developed to support patient flow, and to respond to the change in operating models.
     - ❖ The Committee was **assured** regarding the continued focus on maintaining and, where feasible, improving, the Trust's performance.
   - The Deputy Chief Operating Officer provided the latest **update on the options being pursued to manage the risk relating to the age of the imaging equipment in Radiology** which included an overview of the various options which were under consider and the enabling works which were required to support the instalment of new equipment. It was agreed that the Deputy Trust Secretary should schedule a "Review of the replacement programme for the Trust's high-value clinical equipment, including Linear Accelerators" item at the Committee's meeting in January 2024.
     - ❖ The Committee was **assured** that there was sufficient focus on the mitigation of the issues; although, acknowledged the importance of continued monitoring of imaging equipment.
   - The Chief Executive provided an **update on the Kent and Medway Medical School Accommodation** wherein the Committee acknowledged the post-project evaluation was intended to be conducted of all major infrastructure developments in quarter 3 of 2024/25.
     - ❖ The Committee was **assured** that the risks associated with the completion of the development had been appropriately addressed.
   - The **Full Business Case for Robotic Assisted Surgery** was reviewed, wherein the Committee acknowledged the risks associated with a lack of a robotic assisted surgery provision. The Committee agreed to recommend that the Trust Board approve the alternative option for the Business Case (i.e. a lease agreement in accordance with International Financial Reporting Standard (IFRS) 16), which has been submitted to the Trust Board under a separate agenda item.
   - The **summary report from the from the June 2024 People and Organisational Development Committee** meeting was noted.

- Under the Committee's **forward programme** it was agreed that the Deputy Trust Secretary should schedule an "update on the Trust's Financial Improvement Plan" item at the Extraordinary Finance and Performance Committee meeting in August 2024

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, 19/07/24 (incl. quarterly report from the Guardian of Safe Working Hours)

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (Face-to-face / in-person at Maidstone Hospital and virtually via web conference) on 19th July 2024 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Deputy Chief People Officer, People and Systems provided an update on the **Workforce Efficiency Programme** wherein an in-depth discussion was held regarding the Temporary Staffing financial improvement programme during the Committee highlighted the importance of considering any cultural impacts of the programme of work and understanding the timeframes associated with the achievement of the achievement of the cost savings. The Committee emphasised the importance of expediting the development of the Business Case for the expansion of the Temporary Staffing Team to support the delivery of the programme of work. It was agreed that the Chief People Officer and Deputy Chief Executive / Chief Finance Officer should consider, and advise the Committee, on the governance arrangements in relation to the Trust's financial improvement projects. It was also agreed that a "Review people aspects of the temporary staffing financial improvement programme" item, which included the key interdependences, should be scheduled at the Committee's meeting in September 2024 with representation from the Senior Operational Team present at the meeting.
  - ❖ The Committee was **assured** that the appropriate planning and discussions had been implemented to progress the programme of work; although, acknowledged that further work was required to support the delivery of the programme of work.
- An **update on the Trust's response to the limited assurance review of use of Temporary staffing** was provided, wherein the Committee acknowledged the progress which had been made against of the Internal Audit recommendations and noted the additional measures which had been developed to provide additional assurance beyond Internal Audit recommendations. The importance of adherence to the appropriate processes and intended enhancements to ensure compliance were noted.
  - ❖ The Committee was **assured** the recommendations as outlined within the Internal Audit review had been addressed and additional mitigations developed.
- The Deputy Chief Nurse, Workforce and Education provided an **update on Internationally Educated Professionals (incl. Nurses and Doctors),** which included the enhancements in pastoral support which had been delivered; details of the key themes which had emerged for the 'listening events' and Internationally Educated Nurse / Midwife (IEN/M) Council; and the intended transition of the programme of work to focus on cultural intelligence. The Committee acknowledged the importance of the next steps in relation to the development of Cultural Intelligence, the progress against which would be reported to the Committee in due course. It was agreed that the Deputy Chief People Officer, People and Systems should discuss with the Deputy Medical Director, Workforce and Digital how the positive progress which had been made in relation to the experience of IEN/Ms could be replicated for International Medical Graduates. It was also confirmed that the Committee should receive a further update on the programme of work in February 2025.
  - ❖ The Committee was **assured** regarding the improvements which had been made; although, noted the continued strive to deliver the best experience for internationally educated professionals.
- The Deputy Chief People Officer, Organisational Development provided an **update from the Trust's various staff feedback mechanisms,** which included the intended 'deep dive' process into 'hot spot' areas and the benefits associated with the Trust's Health and Wellbeing programme.

- ❖ The Committee was **assured** that there was a full and in-depth process to capture feedback from staff across the Trust; but, noted the further targeted work to improve net engagement score.

- An **update on Learning and Development at the Trust** was presented by the Head of Learning and Development, wherein the improvements in statutory and mandatory training compliance and next steps to further enhance compliance were noted and a discussion was held around regarding the Trust's appraisal process for 2024, with a focus on pursuing 100% appraisal compliance and ensuring all staff received a high-quality appraisal. The Committee was informed of the progress in relation to the development of the Multidisciplinary Learning and Development Strategy, which was scheduled for consideration in September 2024. It was agreed that the Head of Learning and Development should investigate what, if any, measures could be implemented to prevent the duplication of statutory and mandatory training requirements for those staff which provided services for the Trust, but were primarily based at other NHS Providers.
  - ❖ The Committee was **assured** regarding the enhancements which had been made to learning and development at Trust; and positively supported the process which had been commissioned for the development of the Multidisciplinary Learning and Development Strategy.
- The **Guardian for Safe Working Hours** attended for their latest **quarterly update (covering April to June 2024)**, which has been enclosed under appendix 1, for information and assurance. The report highlighted the significant reduction in the number of exception reports compared to the previous year to date.
- The **latest "Strategic Theme: People" section of the Integrated Performance Report (IPR)** was noted.

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

The issues from the meeting that need to be drawn to the Board 's attention as follows: the quarterly update from the Guardian of Safe Working Hours (April to June 2024) is enclosed in appendix 1, for information and assurance.

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

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

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – JULY 2024

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (APRIL - JUNE 2024) **GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period January -March 2024

- During this period there were a **total of 54** exception reports
- **52** exception reports were made due to **work schedules**.
- 1 exception reports were made due to **patient safety**
- 1 exception reports were related to missed educational opportunities

Reason for circulation to People and Organisational Development Committee
Assurance

Reporting Period: April - June 2024

Exception Reports-Patient Safety related

Specialty	Grade	No. Exceptions raised
Haematology	ST7	1
Total		1

Exception Reports-Work Schedule related (hours)

Specialty	Grade	No. Exceptions raised
Anaesthetics	CT3	2
Cardiology	FY1	1
Clinical oncology	CT1	1
Clinical oncology	ST3	7
General Medicine	CT1	2
General Medicine	FY1	9
General Medicine	ST4	1
Haematology	CT2	8
Oncology	ST5	3
Obstetrics & Gynaecology	ST2	3
Obstetrics & Gynaecology	ST3	3
Obstetrics & Gynaecology	ST7	7
Paediatrics	FY2	4
Urology	FY1	1
Total		**52**

Exception Reports-Educational Opportunities missed

Specialty	Grade	No. Exceptions raised
General Medicine	CT2	1
Total		1

Comparison to last quarterly report (January - March 2024)

There is a decrease in ERs of 38%,

From 85 ERs January -March 2024 to 52 ERs April-June 2024

Comparison to the same quarter last year (April - June 2023)

There is a decrease in ERs of 46%,

From 98 ERs April – June 2023 to 52 ERs April-June 2024

Work Schedule Reviews

NA

Fines

NA

Report commentary

There has been a pleasing reduction in the number of exception reports. This is largely due to the reduction of reports from FY1 in General Medicine which have decreased from 36 last quarter to 9 this quarter.

I can confirm non-training grades are now able to exception report, numbers will be reported in the next quarterly report.

Dr Tim Bell
Guardian of safe working

Audit and Governance Committee, 15/07/24 (incl. the External Audit Annual Report for 2023/24)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met, virtually via web conference, on 15th July 2024.

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

- The **actions from previous meetings** were reviewed.
- The Director of IT, Cyber Security Architect, Head of Information Governance, Digital Committee received and Regional Cyber Security Principle Consultant (SE), NHS England attended to provide **education on the key areas for consideration in regards to Artificial Intelligence (AI)** wherein an in-depth discussion was held regarding the supply chain and procurement considerations related to AI and the potential opportunities afforded by AI. It was agreed that the Director of IT and Deputy Chief Executive / Chief Finance Officer should consider, and advise the Committee, on the next steps in regards to the Trust's strategy in terms of AI; the process for the day-to-day management of AI; and the measures which should be implemented in regards to the risk management of AI.
- The Cyber Security Architect attended for the latest **update on cyber security** wherein the Committee emphasised the importance of a culture of cyber security awareness.
- The Divisional Director of Operations, Cancer Services and General Manager, Outpatients and Oncology attended for the **limited assurance internal audit review of Outpatients utilisation** which included details of the actions which had been subsequently implemented, the monitoring arrangements for the programme of work, and the progress against the Internal Audit recommendations. It was agreed that the General Manager, Outpatients and Oncology should Provide Committee members with details of the timelines associated with the internal review of the Trust's Outpatients data and expected date by which the data cleansing would be sufficiently completed.
  - ❖ The Committee was **assured** that there was significant focus on addressing the challenges in terms of clinic utilisation and clinic cancellations; although, acknowledged that a further assurance rating would be provided as part of the follow-up Internal Audit review.
- The Chief Nurse and Head of Risk Management attended for the **limited assurance internal audit review of Risk Management and Board Assurance** wherein the Committee acknowledged that the Internal Audit review had been commissioned to identify any additional areas for consideration as part of the risk management improvement plan.
  - ❖ The Committee was **assured** that the recommendations had been incorporated into the risk management improvement plan.
- The Head of Risk Management and Chief Nurse attend for the latest **review of the Trust's red-rated risks** wherein the Committee highlighted the additional focus which was required on recovery in the event that a risk occurred and acknowledged the further training which was scheduled for Trust staff in relation to risk management to ensure a consistent approach.
  - ❖ The Committee was **assured** in relation to the progress that had been made; but, noted the further work which was scheduled to improve risk management at the Trust.
- The Head of Security Management attended for the latest **update on security issues** wherein the Committee acknowledged the progress which had been made in relation to Conflict Resolution Training (CRT) and noted the ongoing work to address the challenges associated with capturing Equality, Diversity and Inclusion (EDI) data on the InPhase Patient Safety and Risk Management System.
- The Committee received the latest **update on progress with the Internal Audit plan for 2024/25** (which included progress with actions from previous Internal Audit Reviews) and commended the achievement of B Corporation (B Corp) certification by Tiaa Ltd. The list of recent Internal Audit reviews is shown below (in section 2).
- The findings from the **review/survey of the Internal Audit Service and Counter Fraud Service** were noted.
- The Anti-Crime Manager provided the latest **Counter Fraud update** wherein a discussion was held regarding the potential fraud risks associated with AI.

- The Committee reviewed the **findings of the review/survey of the External Audit Service** and it was agreed that the Chair of the Audit and Governance Committee should liaise with the Director of Audit, Grant Thornton UK LLP, to discuss the findings of the evaluation of the External Audit Service and consider what, if any, enhancements should be enacted.
- The Deputy Chief Executive / Chief Finance Officer provided a verbal **summary of the latest financial issues** which included an overview of the Trust's financial position as of month 2 2024/25 and the risks associated with the Trust's financial plan.
- The **latest single tender / quote waivers data**; **latest losses & compensation data**; and **detail of interests declared under the Conflict of Interest policy and procedure** were noted.
- The **forward programme** was noted and it was agreed that the Interim Trust Secretary should discuss with the Chair of the Trust Board and the Chief Executive whether the Trust Board should conduct a review of the effectiveness of the implementation of the recommendations raised by the Deloitte LLP external governance review and, if so, the associated timeframes.
- The Committee undertook an **evaluation of the meeting**.

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

- "Data Security and Protection Toolkit Part 2" (which received a "Substantial Assurance" conclusion)
- "Data Quality of Key Performance Indicators - Percentage of Patients Discharged Before Noon, Rate of No Longer Fit to Reside per 100 Occupied Bed Days and 18 Weeks Referral to Treatment" (which received a "Reasonable Assurance" conclusion)
- "Risk Management and Board Assurance" (which received a "Limited Assurance" conclusion due to the further work required to ensure active management of risks and enhance compliance with the Trust's Risk Management Policy and Procedure)
- "Security and Access to Controlled Drugs" (which was an "Advisory review" and therefore not allocated an assurance conclusion)

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

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

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

- The External Audit Annual Report for 2023/24, which was considered at the Committee's meeting in June 2024, is enclosed under appendix 1 for assurance.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, and assurance.

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

Grant Thornton

Maidstone and Tunbridge Wells NHS Trust

Auditor's Annual Report for the year ended 31 March 2024

June 2024

Contents

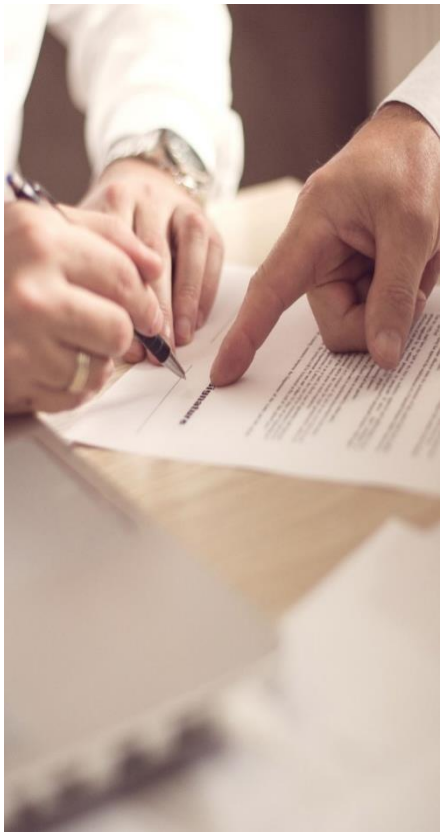
We are required under Section 21(2A)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the National Audit Office (NAO) requires us to report to you our commentary relating to proper arrangements.

We report if significant matters have come to our attention. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Introduction

Purpose of the Auditor's Annual Report

This report brings together a summary of all the work we have undertaken for Maidstone and Tunbridge Wells NHS Trust during 2023/24 as the appointed external auditor. The core element of the report is the commentary on the value for money (VfM) arrangements. Here we draw the reader's attention to relevant issues, recommendations arising from our work and how the Trust has responded to recommendations made in previous years. The responsibilities of the NHS Trust are set out in Appendix A.



Responsibilities of the appointed auditor

Opinion on the financial statements

Auditors provide an opinion on the financial statements which confirms whether they:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023/24, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006

We also consider the Annual Governance Statement, the relevant disclosures within the Annual Report including the remuneration report and undertake work relating to the Whole of Government consolidation exercise.

Value for money

We report our judgements on whether the Trust has proper arrangements in place regarding arrangements under the three specified criteria:

- financial sustainability
- governance
- Improving economy, efficiency and effectiveness

Other powers

Under Section 30 of the Local Audit and Accountability Act 2014, the auditor of an NHS body has a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the Secretary of State. They may also issue:

- Statutory written recommendations to the Trust Board which they must consider publicly
- A Public Interest Report (PIR)

The Value for Money Auditor responsibilities are set out in Appendix B.

Executive summary

Executive summary

Under the Local Audit and Accountability Act 2014, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money). The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas as set out below.

Financial sustainability

The Trust achieved a surplus of £5.258 million in 2023/24 and plans to breakeven in 2024/25. However, 70% of the Trust's planned efficiencies for 2024/25 are high risk and there are more non-recurring than recurring efficiencies planned for.

The Trust is overseeing three high profile projects which will change the way that services are delivered in the local area (a new orthopaedic centre; a new hospital; and digital investment). In time, these may change the balance of recurring and non-recurring benefit.

Financial risk is included on the corporate risk register but the register does not provide granular analysis of the type of financial risk the Trust faces. We raise a key recommendation around efficiencies and an improvement recommendation around recording financial risk.

Governance

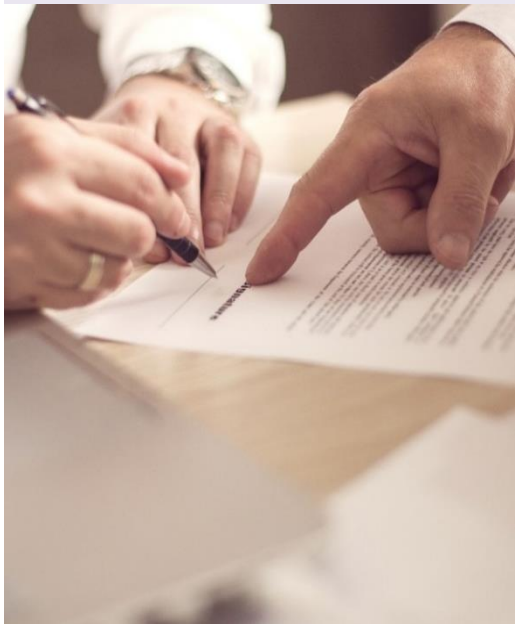
The Trust had effective arrangements in place during 2023/24 for reporting operational risk to the Trust Board via Audit and Governance Committee summaries; full Red RAG rated risk reports twice per annum (May and January); and Integrated Performance Reports. The Trust is now planning to re-introduce a Board Assurance Framework arrangement for reporting on risk during 2024/25. The Trust has effective arrangements for budget setting, budget monitoring, decision-making and legal and regulatory compliance. However, external professional consultants made recommendations around strengthening risk management and wider governance arrangements and we raise an improvement recommendation in this area as well.

We note that all recommendations from Phase 1 of the David Fuller enquiry were implemented by the Trust during the year.

Improving economy, efficiency and effectiveness

The Trust utilises performance information from across the business to identify areas for improvement. The Trust engages with stakeholders and partners when developing strategic priorities; and has effective arrangements for procurement and contract management. We note that three separate Care Quality Commission (CQC) inspections during 2023/24 resulted in action plans for improvement needing to be developed and, in one case, a Section 29A warning notice being issued. Separate updates have been made to the Trust Board on progress with the action plans and there is no single overarching action plan to draw on and monitor all findings from CQC together. We raise a third improvement recommendation in this area.

We have completed our audit of your financial statements and intend to issue an unqualified audit opinion on following the Audit Committee meeting and Board meetings in June 2024. Our findings are set out in further detail on page 9 and 10.



Executive summary (continued)

Overall summary of our Value for Money assessment of the Trust's arrangements

Criteria	2023/24 Risk assessment	2023/24 Auditor judgement on arrangements		2022/23 Auditor judgement on arrangements	
Financial sustainability	No risks of significant weakness identified	R	A significant weakness in arrangements for efficiencies was identified and a key recommendation is made relating to efficiency planning. We also raise an improvement recommendation around managing financial risk. Our recommendations have been agreed by management. Details are set out on Pages 14 and 15 of this report. On Page 26 we show that work is ongoing around our improvement recommendations from 2022/23.	A	Our work did not identify any areas where we considered that key recommendations were required. We made two improvement recommendations around medium term financial planning and the timing of cost improvement plans. On Page 26 of this report, we show that work is ongoing around these recommendations.
Governance	No risks of significant weakness identified	A	No significant weaknesses in arrangements was identified, but one improvement recommendations was raised. This surrounds risk management arrangements. Our recommendation has been agreed by management. Details are set out on Page 17 of this report.	G	Our work did not identify any areas where we considered that key or improvement recommendations were required.
Improving economy, efficiency and effectiveness	No risks of significant weakness identified	A	A section 29A warning notice is in place and there are two other CQC action plans being monitored. We raised an improvement recommendation around strengthening arrangements in this area. Our recommendation has been agreed by management. Details are set out on Page 19 of this report.	G	Our work did not identify any areas where we considered that key or improvement recommendations were required.

G	No significant weaknesses in arrangements identified or improvement recommendation made.
A	No significant weaknesses in arrangements identified, but improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendations made.

Executive summary (continued)

Significant weakness identified in Financial Sustainability

We reviewed the Trust's arrangements to deliver financial sustainability and have concluded that there is a significant weakness in arrangements.

High risk and unidentified efficiencies

The Trust planned to deliver efficiencies of £33.296 million in 2023/24 but went on to deliver just £18.847 million (57%). For 2024/25, the Trust plans to deliver efficiencies of £37.315 million but assessed in May 2024 that £26.524 million of that amount (70%) was high risk. Unidentified efficiencies for 2024/25 were valued at £16.7 million in May 2024 - making them nearly as high in value as undelivered efficiencies were during 2023/24 (£14 million).

The Trust has little in the way of a ready pipeline of future and potential efficiencies that it can bring "on tap" if current efficiency schemes experience slippage during 2024/25.

Furthermore, the Trust's planned efficiencies for 2024/25 have a higher element of planned non-recurring than recurring schemes within them (£21.18 million compared with £16.13 million) . During 2023/24, slippage was higher amongst recurring than non-recurring schemes, although we do note that planned schemes around a new orthopaedic centre, digital investment, and a new hospital may change this balance in time.

Key recommendation 1

Where there are still unidentified elements in the budgeted efficiencies for 2024/25, granular plans should be developed at pace. Assigned ownership and monitoring arrangements will then also be needed.

The Trust should consider its approach towards identifying efficiencies captured from the orthopaedic centre, digital investment, and new hospital schemes.

The Trust also should build-up its pipeline of other future and potential savings schemes.

Opinion on the financial statements and use of auditor's powers

Opinion on the financial statements

Audit opinion on the financial statements

We intend to issue an unqualified opinion on the Trust's financial statements by the 28 June 2024 deadline.

The full opinion will be included in the Trust's Annual Report for 2023/24, which can be obtained from the Trust's website.

Grant Thornton provides an independent opinion on whether the Trust's financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006

We conducted our audit in accordance with:

- International Standards on Auditing (UK)
- the Code of Audit Practice (2020) published by the National Audit Office, and
- applicable law

We are independent of the Trust in accordance with applicable ethical requirements, including the Financial Reporting Council's Ethical Standard.

Findings from the audit of the financial statements

The Trust provided draft accounts in line with the national deadline.

Draft financial statements were of a good standard and supported by detailed working papers.

On 31 March 2024, the Trust acquired the unincorporated business of the Fordcombe Hospital (Spire TW). The transaction has been assessed as meeting the definition of a business combination, as opposed to the purchase of a subsidiary or collection of assets, and therefore accounted for under IFRS3. Several disclosures have been made in the accounts in relation to the acquisition as it impacts accounting policies, PPE fixed assets balances, intangible assets (due to the need to account for goodwill) and the cashflow statement. A specific note to the accounts, Note 15, has been included to describe the acquisition in detail, as well as details in the annual report.

Audit Findings Report

We report the detailed findings from our audit in our Audit Findings Report. A final version of our report was presented to the Trust's Audit Committee on 25 June 2024. Requests for this Audit Findings Report should be directed to the Trust.

Other reporting requirements and use of auditor's powers

Remuneration and Staff Report

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to audit specified parts of the Remuneration and Staff Report included in the Trust's Annual Report for 2023/24. These specified parts of the Remuneration and Staff Report have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023/24.

Annual Governance Statement

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to consider whether the Annual Governance Statement included in the Trust's Annual Report for 2023/24 does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit. We have nothing to report in this regard.

Annual Report

Under the Code of Audit Practice (2020) published by the National Audit Office, we are required to consider whether, based on the work undertaken in the course of the audit of the Trust's financial statements for 2023/24, the other information published together with the financial statements in the Trust's Annual Report for 2023/24 is consistent with the financial statements. We have nothing to report in this regard.

Whole of Government Accounts

To support the audit of Consolidated NHS Provider Accounts, the Department of Health and Social Care group accounts, and the Whole of Government Accounts, we are required to examine and report on the consistency of the Trust's consolidation schedules with their audited financial statements. This work includes performing specified procedures under group audit instructions issued by the National Audit Office. Our work did not identify any significant issues.

We bring the following matters to your attention:

Referrals to the Secretary of State

We issued a section 30 referral to the Secretary of State for Health and Social Care because the Trust had a cumulative deficit of £20.8 million as at 31 March 2024 which gave rise to a duty on us to report under section 30(b) of the Local Audit and Accountability Act 2014 in respect of the three year period ending 31 March 2024. We issued this report on 10 May 2024.

Statutory recommendations

Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors can make written recommendations to the audited body.

We did not issue any statutory recommendations to the Trust in 2023/24.

Public Interest Report

Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.

We did not issue a report in the Public Interest.

Value for Money
Commentary on arrangements

The current NHS landscape

National context

In 2023/24, the NHS has continued to show commitment to patient care and service delivery. Advancements in digital health technologies including virtual wards have the potential to support service redesign, reduce waiting times, and improve patient outcomes. Data published by NHS England in April 2024 indicates that performance against key metrics for elective waiting times, diagnostic tests access, and A&E 4 hour waits all improved year on year, though performance is still some way from target. These achievements demonstrate the resilience and adaptability of NHS staff amidst ongoing pressures.

Integrated Care Systems, established on 1st July 2022, remain at varying stages of maturity. Some systems have developed changes to patient pathways designed to improve outcomes, create efficiencies, tailor services to the needs of their local population and address local health inequalities. Most systems continue to face significant challenges, including workforce shortages, rising demand for healthcare services, and efficient resource management, all resulting in financial sustainability uncertainties.

Pay and productivity remain key challenges nationally. Staffing numbers have increased significantly since 2019/20 with staff costs now exceeding the funding available in many systems, exacerbated by industrial action costs. At the same time, activity growth has not kept pace, leaving a "productivity gap" that is not yet fully understood. This is further hampered by staff absences and pressures in social care staffing. NHS England has requested that all systems formally review the workforce increases seen over recent years. Many NHS bodies are already recognising an urgent need to manage down their temporary and agency staff costs, and recruit and retain the substantive staff they need to deliver services. There also needs to be a continued focus on quality and ensuring system governance is sound. Learning from public inquiry reports and maintaining high standards of behaviour is key to improving patient safety and building public trust.

These challenges are likely to make 2024/25 another challenging year for all local health services. However, the NHS is focusing on the recovery of core services through continuous improvement in access, quality, and productivity whilst transforming the way care is delivered and creating stronger foundations for the future.

Local context

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south-east of England. The Trust provides a full range of general hospital services, and some areas of specialist complex care to around 760,000 people living in the south of west Kent and the north of East Sussex. The Trust employs a team of 8,000 staff. Its core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and during 2023/24, it operated from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The latter is a Private Finance Initiative (PFI) hospital.

The Trust is a member of the Kent and Medway integrated care system, which is led by the Kent and Medway Integrated Care Board, Kent County Council, and Medway Council. The Trust is one of six Trusts within the integrated care system. Together they are responsible for improving outcomes in population health and health care; tackling inequalities in outcomes, experience, and access; enhancing productivity and value for money; and helping to support broader social and economic development in the Kent and Medway area. It is within this context that we set out our commentary on the Trust's value for money arrangements in 2023/24 and make recommendations where any significant weaknesses or improvement opportunities in arrangements have been identified to support management in 2024/25.

Financial sustainability

We considered how the Trust:	Commentary on arrangements	Assessment
identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The Finance team works with divisions to identify financial pressure that needs to be managed. They factor in central assumptions, for example around pay awards. The Trust factored into its financial plans for 2023/24 that growth money and pay award funding may be received late. Strong financial control exercised through the year meant that the Trust was on track to break even anyway by year end. When the growth money and pay award money was received towards the end of the year, the Trust was able overall to achieve a surplus of £5.258 million. For 2024/25, the Trust plans to breakeven but has prudently highlighted in its budget that this will depend on efficiencies of £37.315 million being achieved. The Trust started work in 2023/24 to develop a medium-term financial plan. It is also developing a new forecasting and planning model that it hopes will come into use part way through 2024/25.	G
plans to bridge its funding gaps and identify achievable savings	For 2023/24, the Trust planned efficiencies of £33.296 million but only delivered efficiencies of £18.847 million. For 2024/25, the Trust plans efficiencies of £37.315 million but some £26.524 million of that amount (70%) was considered by the Trust to be high risk in May 2024. The Trust works hard to "de-risk" efficiency plans; to co-operate with divisions in finding efficiencies; and to monitor progress. Nevertheless, with 70% of the plan "high risk" in May 2024, delivery in 2024/25 is likely to be as challenged as it was in 2023/24. There is also little in the way of a pipeline of future and potential efficiencies to draw on if slippage occurs (for whatever reason) in live efficiency programmes once they are in progress during 2024/25. The approach towards efficiency has tended to be focused on short term achievement since the Covid-19 pandemic. For 2024/25, there are more non-recurring than recurring efficiencies planned and in 2023/24, the rate of slippage was higher in recurring than non-recurring schemes. We note however that planned projects around a new orthopaedic centre, digital investment, and new hospital may change this balance in time.	R
plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	Financial planning is consistent with strategic objectives, workforce planning and activity planning. As an example, we note pay costs planning for 2024/25 were triangulated with the workforce plan. The Trust has a good understanding of its cost base and how that links to performance. The Trust uses Model Hospital and Getting It Right First-Time data to identify and challenge areas for efficiency.	G
ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning which may include working with other local public bodies as part of a wider system	Financial planning assumptions are aligned with other strategic planning assumptions. The Trust has three high profile projects ongoing which will change the way services are delivered in 2024/25. They surround a new orthopaedic centre; a new hospital; and new community diagnostics centre. Delays on the orthopaedic centre project have been reflected in the 2024/25 budget, as have the new workforce and activity streams which will come into effect in the second half of the year with the new hospital. For the Community Diagnostics Centre, plans to replace temporary scanners with fixed scanners once the centre is fully opened are also reflected in the budget.	G
identifies and manages risk to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions in underlying plans	The Trust monitors risk to the financial plan through the monthly financial reporting process. Monthly reports are shared with the Finance and Performance Committee which in turn updates the Trust Board. Financial risk appears on the corporate risk register, although not with any granular analysis of the type of financial risk the Trust faces. At the time of writing this report, options around developing a contingency plan were under discussion.	A

Financial sustainability (continued)

Significant weakness identified

Before the Covid-19 pandemic, the Trust had a good track record of delivering efficiencies. However, there was significant under-delivery of efficiencies in both 2022/23 and 2023/24. This now looks set to continue.

Internally, the Trust planned to deliver efficiencies of £30 million in 2022/23. It went on to deliver efficiencies of just £14.9 million (c50%). The Trust planned to deliver efficiencies of £33.296 million in 2023/24 but went on to deliver just £18.847 million (c57%), although we note that recurring income did increase. For 2024/25, the Trust plans to deliver efficiencies of £37.315 million but assessed in May 2024 that some £26.524 million of that amount (70%) was high risk. Unidentified efficiencies for 2024/25 were valued at £16.7 million in May 2024 - making them nearly as high in value as undelivered efficiencies were during 2023/24 (£14 million). We note that by the end of Month 2 on 2024/25, the delivery of planned efficiencies was falling behind schedule.

The Trust has little in the way of a pipeline of future and potential efficiencies that it can bring "on tap" if current efficiency schemes experience slippage in the short term, although the projects around a new orthopaedic centre, digital investment, and new hospital are expected to yield medium- and long-term gains.

Our Auditor's Annual Report for 2022/23 noted that a pipeline of future and potential schemes had been maintained before the Covid-19 pandemic, but that it had fallen into dis-use during the pandemic. There are tentative signs of the pipeline being re-developed, but at the start of 2024/25, there were still only insignificant sums of potential areas for saving listed on it (£54,000).

We also note that the Trust's planned efficiencies for 2024/25 have a higher element of planned non-recurring than recurring schemes within them (£21.18 million compared to £16.13 million) . During 2023/24, slippage was higher amongst recurring than non-recurring schemes. We do note though that the benefits from the planned projects around the new orthopaedic centre, digital investment, and new hospital are expected to be recurring.

Key Recommendation

Where there are still unidentified elements in the budgeted efficiencies for 2024/25, granular plans should be developed at pace. Assigned ownership and monitoring arrangements will then also be needed.

The Trust should consider its approach towards identifying efficiencies captured from the orthopaedic centre, digital investment, and new hospital schemes.

The Trust also should build-up its pipeline of other future and potential savings schemes.

Financial sustainability (continued)

Areas for improvement

In March 2024, the Trust Board recommended that a financial contingency plan be developed, to be enacted in December 2024 if progress with outturn and cost improvements was falling short of target. Developing a contingency plan ("what can we pause/stop") was taken as an action from the meeting. It will be important as the year progresses that the Trust Board has assurance over how comprehensive the contingency plan is and whether there is active monitoring in place as the year progresses to determine whether contingency will be needed.

The Trust's corporate risk register includes a risk around financial risk but only refers to delivering "the financial plan with recurrent cost improvements". The Trust faces other financial risks, for example around the containing the growing workforce; controlling capital costs for three high profile service redesign projects it is running; and securing financial benefit from those projects. Options for including more granular information on the corporate risk register should be considered.

Improvement Opportunity 1

Arrangements for providing the Trust Board with assurance around contingency planning should be introduced. The Trust should also explore options for disclosing the nature of financial risk more granularly on the corporate risk register.

Governance

We considered how the Trust:	Commentary on arrangements	Assessment
monitors and assesses risk and how the Trust gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust had effective arrangements in place during 2023/24 for reporting operational risk to the Trust Board via Audit and Governance Committee summaries; full Red RAG rated risk reports twice per annum (May and January); and Integrated Performance Reports. The Trust is planning to re-introduce a Board Assurance Framework arrangement for reporting on risk during 2024/25. The Trust adopted a Risk Improvement Plan during 2023/24 and engaged external professional consultants to make recommendations around strengthening risk management (including in divisions) and wider governance arrangements. There are action plans in place for responding to consultant findings, but these are not directly linked to the Risk Improvement Plan, although Internal Audit provided Reasonable Assurance over the Trust's arrangements for internal control in 2023/24. All recommendations from Phase 1 of the David Fuller enquiry were implemented by the Trust during the year. Overall responsibility for monitoring the actions for Phase 2 has been allocated to the Trust's Director of Communications	A
approaches and carries out its annual budget setting process	The Trust has an effective budget setting arrangement in place. Finance managers work with budget holders to identify cost pressures and triangulate activity and workforce data within the budget. The Executive Team meet with Chiefs of Service as part of this process and there is input from clinicians. The Trust's financial performance in 2023/24 (budgeted for breakeven and achieved surplus) indicates a prudent approach towards budget setting.	G
ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information; supports its statutory financial reporting; and ensures corrective action is taken where needed, including in relation to significant partnerships	Monthly financial performance reports are shared with the Trust's Finance and Performance Committee. The reports provide clear information on current month and year to date outturn against budget. Explanations for variances highlight relevant workforce and activity trends. The reports also include progress with efficiencies; and cash balances and capital expenditure. The Finance and Performance Committee provides the Trust Board with summaries. There has been a reasonable level of stability within the financial accounting team. With the exception of delays in obtaining valuations data for a newly acquired private hospital (known about at the start of the audit) and workings for a Private Finance Initiative model after a change of accounting standard, there were no significant issues with the financial accounting process for 2023/24.	G
ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency, including from audit committee	The Trust has an effective decision-making process, with comprehensive information provided in board papers and active engagement and challenge by the Board. In December 2023, external professional consultants made a series of recommendations around overall Board effectiveness and leadership; committee structure and effectiveness; and governance connectivity. The recommendations are being tracked by the Trust in an Action Plan, which has named owners and defined target dates for implementation. In May 2024, a new structure for committees and sub-committees was agreed and is now due for implementation in response to consultant findings.	G
monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of staff and board member behaviour	The Trust does take legal and regulatory duties seriously. There are arrangements for reporting issues to the Trust Board; taking corrective action where necessary (for example around cyber incidents); and ongoing internal audit and counter fraud vigilance (for example around conflicts of interest and gifts and hospitality). The procurement team ran a comprehensive campaign of training and awareness around procurement regulations for budget holders during 2023/24. The number of single tender waivers more than halved between 2022/23 and 2023/24 as a result.	G

Governance (continued)

Areas for improvement

Our Auditor's Annual Report for 2021/22 recommended that strategic risks be shown clearly in the Integrated Performance Reports shared with the Trust Board and that the RED RAG rated risk reports shared with the Trust Board show clear links to corporate objectives. By the end of 2023/24, these recommendations had not yet been implemented. However, the Trust had instead adopted a Risk Improvement Plan, which showed an intention to launch a new Board Assurance Framework in June 2024. This means that arrangements will change anyway and our recommendations from 2021/22 will no longer apply.

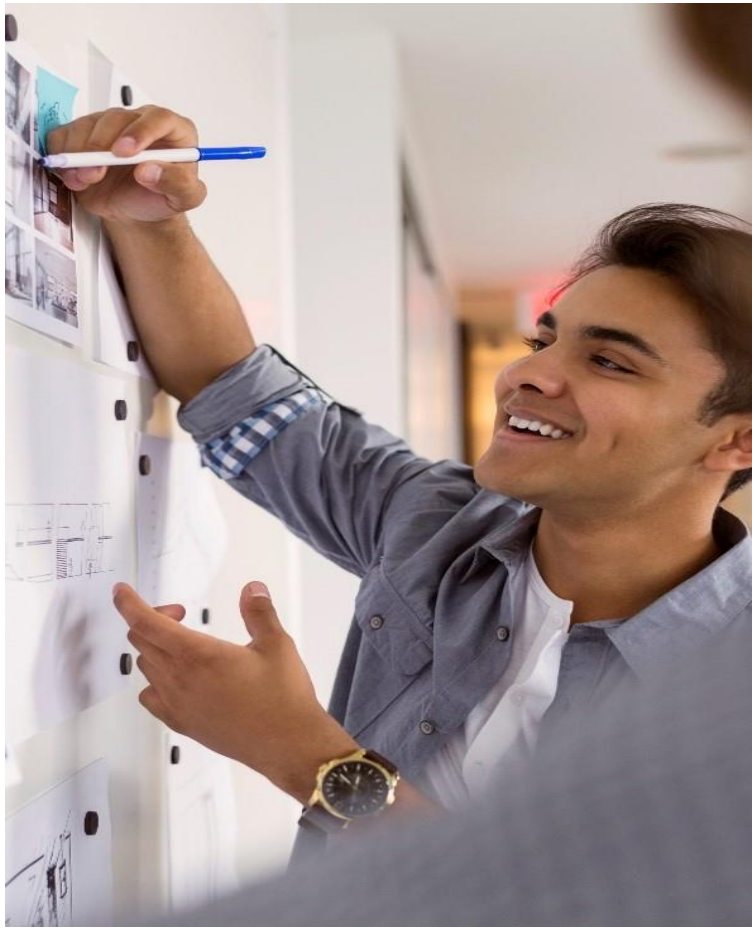
In December 2023, external professional consultants engaged by the Trust to undertake a Governance Review set out a series of recommendations around strengthening strategic risk management and the risk management process. In all, the consultants made seven risk related recommendations, broadly around planning for risk identification; using an executive risk management group; stronger mechanisms for reviewing risk; and increasing capacity for managing risk. When the Governance Review was published, the Trust was already monitoring progress with the Risk Improvement Plan. It was therefore already addressing themes in this area. It will be important that the Risk Improvement Plan does capture everything the Trust wants to action around risk management – those points it was already monitoring, and any new aspects raised by the consultants.

We note that an Internal Audit review of the Trust's risk management processes had concluded in November 2023 that Reasonable Assurance could be provided over the Trust's approach. This was nearly eight months after the CQC raised concerns about divisional risk management arrangements and one month before external professional consultants produced a series of recommendations for improvement.

Improvement Opportunity 2

The Trust should ensure the Risk Improvement Plan captures everything the Trust wants to action around risk management – those points it was already monitoring in the original risk improvement plan, and any new aspects raised by external professional consultants in December 2023.

Going forward, the Trust should adopt a strategic approach towards the assurances it seeks on risk management once the new processes are embedded.



Improving economy, efficiency and effectiveness

We considered how the Trust:	Commentary on arrangements	Assessment
uses financial and performance information to assess performance to identify areas for improvement	The Trust effectively utilises performance information from across the business to identify areas for improvement. Performance information is shared monthly with the Trust Board and areas for action and improvement are discussed. The Trust has a kite marking system for providing assurance on the quality of performance data and uses data from other sources such as Getting It Right First Time and Model Hospital for identifying areas for improvement. We note that in March 2024 the Trust reported that there were no metrics experiencing special cause variation of a concerning nature.	G
evaluates the services it provides to assess performance and identify areas for improvement	The Trust is graded as a 1 in the NHS Oversight Framework segmentation. However, three separate CQC inspections during 2023/24 resulted in Action Plans for improvement needing to be developed and, in one case (maternity and midwifery services), a Section 29A warning notice being issued. Updates to the Trust Board on progress with the action plans are not co-ordinated and are not set out consistently. Furthermore, there is no single overarching action plan to draw on and monitor all three sets of findings from CQC together. The Trust has now set up a new governance structure. An overarching plan would support the new governance structure.	A
ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives	The Trust does engage with stakeholders and partners when developing strategic priorities, and there is evidence that these priorities are reviewed on a regular basis to ensure delivery is on track and that they contribute sufficient value to the organisation. The Trust does actively engage in partnership working within the integrated care system to tackle common challenges. There is evidence that feedback is reported to the Trust on a regular basis.	G
commissions or procures services, assessing whether it is realising the expected benefits	The Trust has effective arrangements in place for identifying, managing, and realising the benefits from key contracts. Performance on contracts is generally monitored through monthly or quarterly meetings between budget holders and their counterparts. For high profile outsource contracts, the meetings and monitoring are facilitated by the Trust's central procurement team. The Trust has a three-year Procurement Strategy which is reviewed annually. The Trust works well with Heads of Procurement from across the Kent and Medway system.	G

Improving economy, efficiency and effectiveness (continued)

Areas for improvement

A Section 29A warning notice is currently in place for the Trust, having been issued by CQC after a midwifery and maternity services inspection. The warning notice was published in October 2023. We note that two other CQC inspections which took place during 2023/24 also resulted in action plans for improvement being drawn up by the Trust (for End-of-Life Care and for Ionising Radiation (Medical Exposure) Regulations).

The Board was notified of the outcomes and of the immediate actions taken to address the outcomes after each of the three CQC visits. However, there was variation in the arrangements for monitoring, reporting and gaining assurance over the progress achieved in addressing actions after that.

The action plan related to midwifery and maternity was assessed as a higher risk and assurance concern because of the inadequate rating and section 29A notice. Therefore, a more rigorous governance process was applied. As actions are completed for midwifery and maternity, they are reviewed by the maternity leadership team and then reviewed at the weekly maternity improvement group which is chaired by the Chief Nurse. Final sign off is by Chief Nurse and Director of Quality Governance.

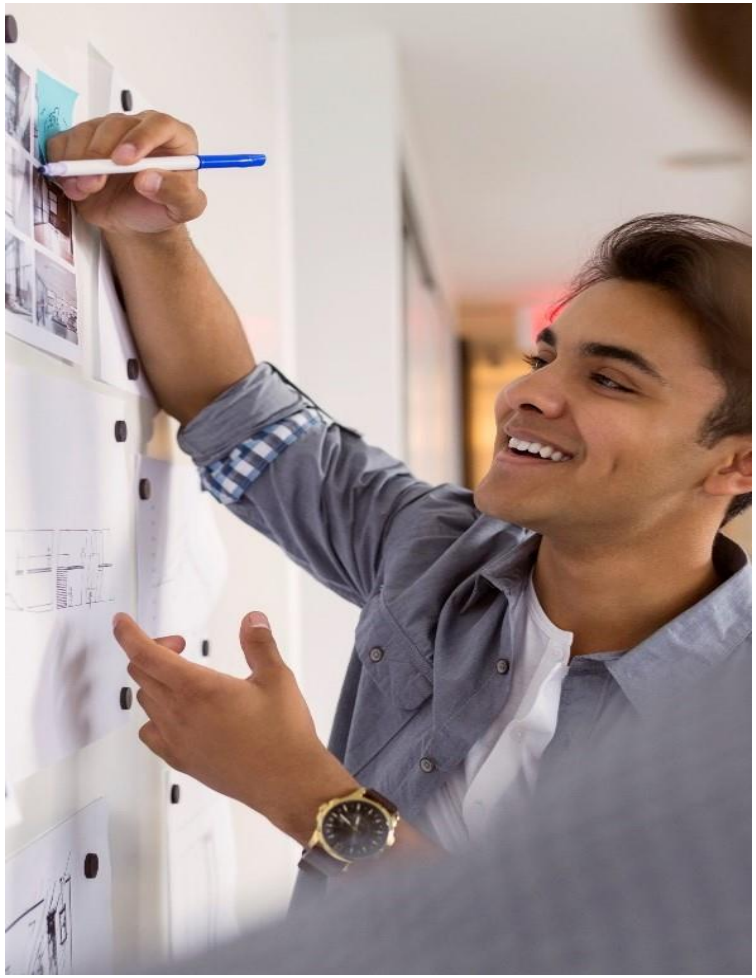
The End-of-Life (EOL) action plan is monitored by the EOL Care Committee and Quality Committee, which reports to the Trust Board. The Ionising Radiation action plan had an action plan that was deliverable within one month and therefore monitored over a shorter timescale.

The Trust is in the process of enhancing its Committees and Sub-Committees governance structure – for example, creating a Risk and Regulation Oversight Committee. The intention is that all actions from all plans will be channelled through the Risk and Regulation Oversight Committee to the Trust Board. The Trust's In-phase reporting software has functionality to make this easier which the Trust can explore.

Improvement Opportunity 3

The Trust should develop an overarching action plan that incorporates all the open regulatory requirements raised in CQC reports and standardises arrangements for monitoring, reporting and gaining assurance over progress in addressing actions.

Regular slots for sharing the overarching action plan with the Risk and Regulation Oversight Committee and, after that, the Trust Board should be considered.



Value for Money Recommendations raised in 2023/24

Recommendations raised in 2023/24

Recommendation	Type of recommendation *	Criteria impacted	Evidence	Impact or possible future impact	Actions agreed by Management
Where there are still unidentified elements in the budgeted efficiencies for 2024/25, granular plans should be developed at pace. Assigned ownership and monitoring arrangements will then also be needed. The Trust should consider its approach towards identifying efficiencies captured from the orthopaedic centre, digital investment, and new hospital schemes. The Trust also should build-up its pipeline of other future and potential savings schemes.	Key Recommendation	Financial sustainability	Financial Planning Returns to NHSE and supporting data on efficiencies	Longer term approach towards efficiency planning.	Actions: (1). Financial Improvement Plan being implemented July 2024 with targeted focus on CIP identification and delivery. (2) Themes across the Trust to identify new opportunities. (3). In the short term, other meetings stood down to focus time with Divisions and develop new schemes. Responsible Officer: Hannah Ferris, Deputy Director of Finance – Performance; and Ruby Dey – Head of PMO. Executive Lead: Deputy CEO and CFO Due Date: September 2024.
Arrangements for providing the Trust Board with assurance around contingency planning should be introduced. The Trust should also explore options for disclosing the nature of financial risk more granularly on the corporate risk register.	Improvement Opportunity 1	Financial sustainability	Financial Planning Returns to NHSE and supporting data on efficiencies	More robust approach towards efficiency planning.	Actions: The Trust will develop a list of mitigations to be applied if the initial plan is not being achieved or is forecast to not achieve. This will be agreed with the ETM and the Finance and Performance Committee. Responsible Officer: Hannah Ferris, Deputy Director of Finance – Performance. Executive Lead: Stephen Orpin, Deputy CEO and CFO Due Date: July 2024

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Recommendations raised in 2023/24

Recommendation	Type of recommendation *	Criteria impacted	Evidence	Impact or possible future impact	Actions agreed by Management
The Trust should ensure the Risk Improvement Plan captures everything the Trust wants to action around risk management – those points it was already monitoring in the original risk improvement plan, and any new aspects raised by external professional consultants in December 2023. Going forward, the Trust should adopt a strategic approach towards the assurances it seeks on risk management once the new processes are embedded.	Improvement Opportunity 2	Governance	Risk Improvement Plan Internal Audit reports Governance Review conducted by external professional consultants	Stronger Board oversight over strategic risks	**Actions:** (1) We will review the Trust's risk improvement plan regularly at our risk and regulation meeting ensuring it is capturing everything that the Trust would like to improve in relation to risk. (2) A strategy relating to risk management will be developed once the improvement plan is embedded. **Responsible Officer:** Helen Callaghan, Director of Quality Governance. **Executive Lead:** Rachel Jones, Executive Director, Strategy, Planning and Partnerships. **Due Date:** TBC
The Trust should develop an overarching action plan that incorporates all the open regulatory requirements raised in CQC reports and standardises arrangements for monitoring, reporting and gaining assurance over progress in addressing actions. Regular slots for sharing the overarching action plan with the Risk and Regulation Oversight Committee and, after that, the Trust Board should be considered.	Improvement Opportunity 3	Improving economy, efficiency and effectiveness	CQC reports CQC Action Plans Minutes and papers from Trust Board and Quality Committee meetings	Stronger Board oversight over progress with recommendations	**Actions:** (1) An overarching plan that highlights the progress of all live regulatory improvement actions will be developed. (2) We will amend the TOR for the risk and regulation meeting to include regular updates on the overarching progress of regulatory improvement action. **Responsible Officer:** Helen Callaghan, Director of Quality Governance **Executive Lead:** Jo Haworth, Chief Nurse **Due Date:** TBC

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

Appendices

Appendix A:
Responsibilities of the NHS Trust

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The directors of the Trust are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Appendix B:
Value for Money Auditor responsibilities

Value for Money arrangements work

All NHS Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. The Trust's responsibilities are set out in Appendix A.

NHS Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under the Local Audit and Accountability Act 2014, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

Financial Sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the Trust makes decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

2023/24 is the fourth year that we have reported our findings in this way. We undertake and report the work in three phases as set out in the Code.

Phase 1 – Planning and initial risk assessment

As part of our planning, we assess our knowledge of the Trust's arrangements and whether we consider there are any indications of risks of significant weakness. This is done against each of the reporting criteria and continues throughout the reporting period.

Information which informs our risk assessment	
Cumulative knowledge of arrangements from the prior year	Key performance and risk management information reported to the Board
Interviews and discussions with key officers	NHS Oversight Framework (NOF) rating
Progress with implementing recommendations	Care Quality Commission (CQC) reporting
Findings from our opinion audit	Annual Governance Statement including the Head of Internal Audit annual opinion

Phase 2 – Additional risk-based procedures and evaluation

Where we identify risks of significant weakness in arrangements we will undertake further work to understand whether there are significant weaknesses. We use auditor's professional judgement in assessing whether there is a significant weakness in arrangements and ensure that we consider any further guidance issued by the NAO.

Phase 3 – Reporting our commentary and recommendations

The Code requires us to provide a commentary on your arrangements which is detailed within this report. Where we identify weaknesses in arrangements we raise recommendations. A range of different recommendations can be raised by the Trust's auditors as follows:

- **Key recommendations** – the actions which should be taken by the Trust where significant weaknesses are identified within arrangements.
- **Improvement recommendations** – actions which should improve arrangements in place but are not a result of identifying significant weaknesses in the Trust's arrangements.
- **Statutory recommendations** – written recommendations to the Trust under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014.

Appendix C:
Follow-up of previous recommendations

	Recommendation	Type of recommendation *	Date raised	Progress to date	Addressed?	Additional further action required?
1	The Trust should prioritise medium term financial planning. Medium term financial planning should be supported by sensitivity analysis or scenario planning. Year on year decreases in cash balances highlight the importance of supporting planning with sensitivity analysis.	Improvement	June 2023	The Trust started work in 2023/24 to develop a medium-term financial plan. The Trust is also developing a new forecasting and planning model that it hopes will come into use part way through 2024/25. Cash balances remain above the Trust's recommended prudent minimum.	In progress	No Work to respond to the recommendation is already underway.
2	The Trust should prioritise swift catch-up of the time phasing for recurrent 2023/24 cost improvement schemes, so that benefits can be enjoyed for the whole of 2023/24, not just the later months.	Improvement	June 2023	For the first six months of 2023/24, the value of non-recurrent efficiencies delivered was higher than the value of recurrent efficiencies delivered. Although this did change in the second half of 2023/24, there are more non-recurrent efficiencies planned for 2024/25 than recurrent efficiencies. 2023/24 is the second year running that we have raised concerns around efficiencies. We raise a new key recommendation this year.	No	Yes New key recommendation raised on Page 14 of this report.

* Explanations of the different types of recommendations which can be made are summarised in Appendix B.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Charitable Funds Committee, 17/07/24	Committee Chair (Non-Executive Director)

The Charitable Funds Committee (CFC) met on 17th July 2024, virtually, via webconference.

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

- The Interim Trust Secretary provided an **update on the risk register entries relevant to the Charitable Fund** wherein it was confirmed that no specific concerns had been identified; but the Interim Trust Secretary and Head of Charity and Fundraising committed to conduct a review of the risk framework for the Trust's Charitable Funds, in accordance with the Charity Commission Guidelines and best practice across the NHS.
- The Committee undertook a **review of the draft Charitable Fund Annual Report and Accounts for 2023/24** wherein the timelines associated with independent examination were acknowledged. The Committee noted that the total income for 2023/24 was £536k, total expenditure was £480k, resulting in a year-end balance of £930k and it was agreed that the Head of Financial Services should ensure that the version of the draft Charitable Fund Annual Report and Accounts for 2023/24 which was circulated to Committee members at the end of July 2024 highlighted any specific areas for feedback.
- The **financial overview at Month 3, 2023/24** was considered wherein the Committee noted the intention for the Cancer Services Division to develop a strategy for the disbursement of funds raised within the Cancer Services Charitable Fund account.
- The Committee received the latest **fundraising update** (which included details of progress with the Charitable Fund Fundraising Strategy) which included the programme of work to increase the visibility of the Trust's Charitable Fund and the reinvigoration of the Charity Management Committee.
- The Chair of the Charity Management Committee provided latest **update on the proposed partnership with Maggie's Centres.**
- The **findings from the Committee's evaluation for 2024** were reviewed and the Interim Trust Secretary and Head of Charity and Fundraising advised that a full and detailed Committee effectiveness review of the Trust's Charitable Funds Committee would be conducted in the Autumn of 2024.

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

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

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information 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 June 2024	Chief Executive / Executive Directors

The IPR for month 3, 2024/25, is enclosed, along with the monthly finance report, and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 23/07/24

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

June 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

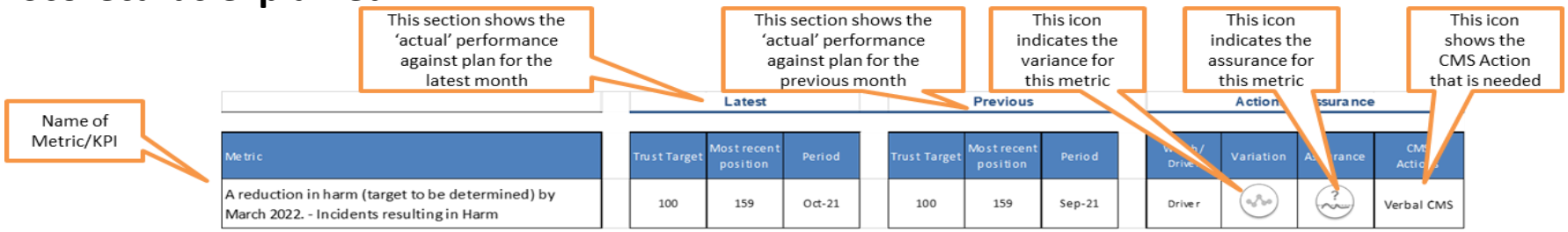
Escalation Rules:

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

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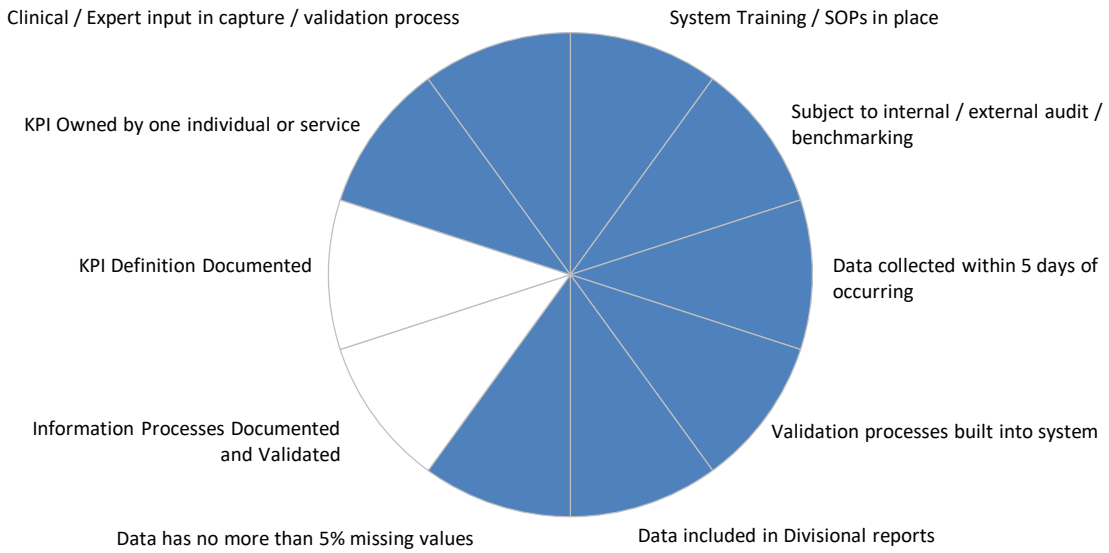
Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Trust continues to not have any metrics experiencing special cause variation of a concerning nature (except FTT Response Times for inpatients due to the limited data issues) and a significant number of the indicators are now experiencing special cause variation of an improving nature and passing the target for more than six consecutive months.

Vacancy Rate is above the 8% limit at 9.5% and continues to experience common cause variation and variable achievement of the target. Turnover Rate continues to experience special cause variation of an improving nature, achieving the maximum level target at 11.3%. Two new indicators for the number of staff that leave within 12 months and 24 months, as a percentage of all leavers, have been added, both of which are currently not escalated. Agency spend did not achieve the target for June 24 experiencing common cause variation. The Trust has narrowed down the contributing factors to premium workforce spend and continues to implement a number of actions to improve performance. The Nursing Safe Staffing Levels were at 97.8% in June and continue to pass the target for more than six consecutive months. Sickness levels continues to achieve below the maximum limit at 4.0%. This metric is therefore now experiencing common cause variation and variable achievement of the target. Statutory and Mandatory Training improved further in June, now experiencing special cause variation of an improving nature and consistently passing the target. The national EDI metrics targets for representation at 8c and above has increased for 2024/25 to 66% Female, 4% Disability and 20% BAME. The Trust is consistently achieving the target for both the percentage that are female or have a disability. The percentage of staff Afc 8c or above that are BAME continues to experience common cause variation and consistently failing the target. Recognising there is work to be done to improve the position for BAME representation, a monthly improvement trajectory has been developed and the Trust continues to implement a number of actions to improve performance is this area. The Trust was £4m in deficit in the month which was £0.3m adverse to plan. Year to Date the Trust is £8.5m in deficit which is £1.1m adverse to plan.

The rate of incidents causing patients moderate or higher harm remains in common cause variation but has failed the target for six months. The breakthrough indicator for this strategic theme is currently being reviewed and therefore no data is shown until this has been confirmed. The indicator of the number of SIs no longer exists as this metric has been replaced with the number of Number of new PSIIs, AARs and SWARMs commissioned in month. The rate of C.Difficile decreased in June 24 but continues to experience common cause variation and failing the target for more than six months. The Rate of E.Coli continues to experience common cause variation and passing the target for more than six months. The Rate of Falls per 100,000 occupied beddays improved in June but remains in common cause variation and variable achievement of the target. This indicator is now escalated as has been in variable achievement of the target for more than six months. Complaints data is only partially updated due to staffing issues. The number of complaints related to communication issues continues to experience special cause variation of an improving nature and variable achievement of the target. Friends and Family Response rates continue to improve in June with the launch of the new provider.

Diagnostic Waiting Times was slightly below the target for June 24 at 97.7% (-0.2%) and is now experiencing common cause variation and variable achievement of the target. Focus work continues for the two modalities mostly affecting the overall under-performance. With regards to RTT the Trust continues to provide system support (SYS) to other Trusts across Kent and Medway which is therefore adversely affecting the Trust's performance that is reported nationally. RTT was slightly the trajectory target for June 24 of 75.3% at 74.2% (Excluding SYS). Nationally we reported 72.8% (including SYS). 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 June 24 (Excluding SYS). Nationally we have reported 530 52 week breaches at the end of June 24 (SYS). The Trust continues to achieve the internal target of less than 1.5% of total patients waiting having waited more than 40 weeks (Excluding SYS).

Executive Summary (continued)

Executive Summary (Continued):

Outpatient Utilisation continues to experience common cause variation and has failed the target for more than six months. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute continues to experience special cause variation of an improving nature. The percentage of patients on a PIFU Pathway is now experiencing common cause variation and consistently failing the target. Diagnostic Imaging activity levels were above plan and 1920 levels in June 24 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 June 2024. Both are continuing to experience common cause variation and passing the target for more than six consecutive months. The Trust is now monitoring performance against the new indicator for the rate of all outpatient appointments that are either a new appointment or a follow up appointment with a procedure (as per the national 2024/25 priorities and operational planning guidance). The national target is to have a rate of 49% or above. For June 24 the Trust achieved a rate of 51.7%. This indicator is experiencing special cause variation of an improving nature and passing the target for more than six consecutive months.

The number of patients leaving our hospitals before noon is experiencing common cause variation and consistently failing the target. The top contributors have been identified and a number of actions continue to be implemented to improve the timely discharge of patients. The rate of patients no longer fit to reside remains in common cause variation. Ambulance Handovers <30mins continues to experience common cause variation and variable achievement of the target. The Trust's performance for A&E 4hrs was below the trajectory target for June 24 at 83.4% and has now failed the target for six consecutive months. Performance remains one of the highest both Regionally and Nationally. Work continues to improve flow across the Trust. The Trust continues to achieve the new combined 62 day First Definitive Treatment Standard, 28 Day faster diagnosis compliance standard and the new combined 31 day first definitive treatment standard. Work continues in order to now maintain compliance of all the Cancer Waiting Times (CWT) standards. 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.

Both of the indicators for Women waiting for Induction of Labour (in less than 2 or 4 Hours) are consistently failing the target. The project continues to review demand and capacity and to identify opportunities to improve flow throughout the department. Both of the indicators for Decision to delivery interval (Category 1 and Category 2) caesarean sections are experiencing special cause variation of an improving nature but are not at the required level. Category 1 <30mins has failed the target for more than six months and Category 2 <75 mins is consistently failing the target. Improvement activity and the A3 project continues to identify the root cause of delays and potential mitigation and solutions.

Escalations by Strategic Theme:

People:
- Turnover Rate (P.10)
- % of Afc 8c and above that are BAME (P.11)

Patient Safety & Clinical Effectiveness:
- Incidents resulting in Moderate + Harm (P.13)*
- Infection Control – Rate of C.Diff (P.14)
- Rate of Falls per 1,000 occupied beddays (P.14)*

Patient Access:
- RTT Performance (P.17)
- Outpatient Calls answered <1 minute (P.18)
- Outpatient Clinic Utilisation (P.18)
- A&E 4hr Performance (P.18)
- Emergency Admissions in Assessment Areas (P.18)
- Percentage of patients on a PIFU Pathway (P.19)

Patient Experience:
- New Complaints Received (P.21)*
- Complaints responded within target (P.22)
- FFT Response Rates: All areas (P.22)

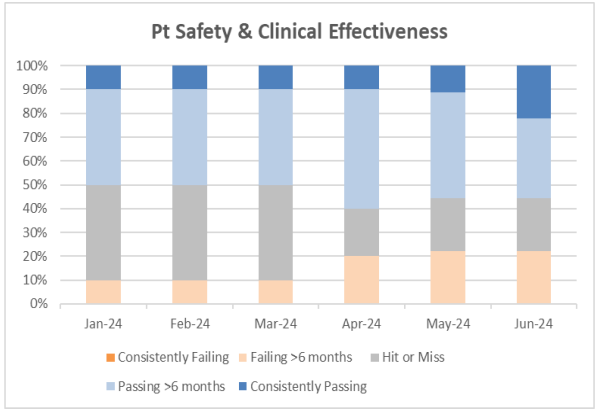
Systems:
- Discharges before Noon (P.24)

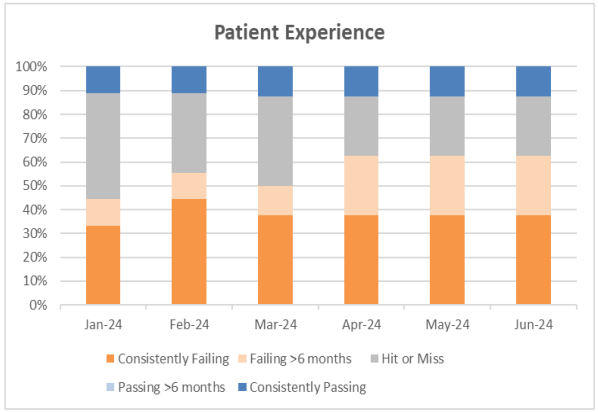
Sustainability:
- Agency Spend (P.26)

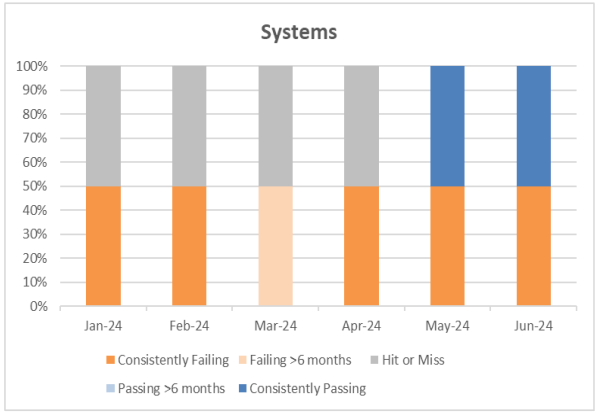
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.28)
- Women waiting for Induction of Labour <4 Hrs (P.28)
- Decision to delivery interval Category 1 caesarean (P.28)
- Decision to delivery interval Category 2 caesarean (P.28)

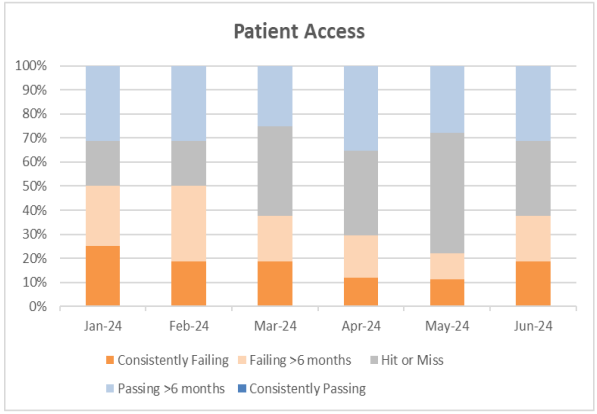
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

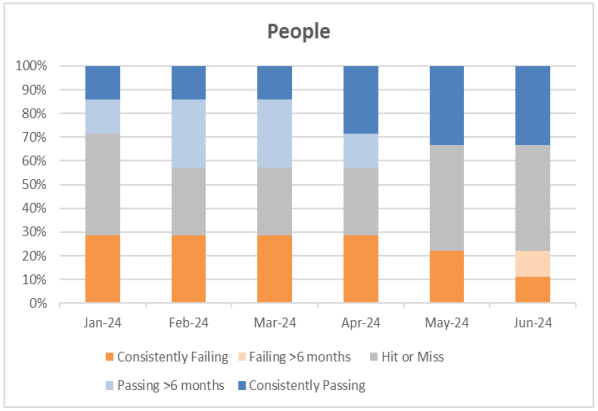
Assurance Stacked Bar Charts by Strategic Theme

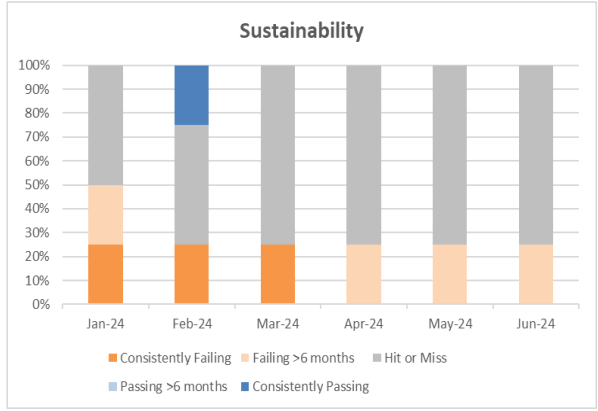












Matrix Summary

June 2024

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Statutory and Mandatory Training Standardised Mortality HSMR	Never Events Safe Staffing Levels (Nursing) RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)	Reduce Turnover Rate to 12% Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.		Achieve the Trust RTT Trajectory (Excluding SYS) Friends and Family (FFT) % Response Rate: A&E
Common Cause	Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability Complaints Rate per 1,000 occupied beddays Decrease the percentage of occupied bed days for patients identified as no longer fit to reside (NFTR)	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)	Reduce the Trust wide vacancy rate to 8% Sickness Absence Staff Leavers within 12 months IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days Access to Diagnostics (<6weeks standard) Cancer - 31 Day First (New Combined Standard) - data runs one month behind Flow: Ambulance Handover Delays >30mins To reduce the overall number of complaints or concerns each month Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Cash Balance (£k) Capital Expenditure (£k)	Staff Leavers within 24 months Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) IC - Rate of Hospital C.Difficile per 100,000 occupied beddays A&E 4 hr Performance Transformation: % OP Clinics Utilised (slots) Flow: % of Emergency Admissions into Assessment Areas % complaints responded to within target - Data not currently avaiable for May and June 24 Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	Percentage of AfC 8c and above that are BAME Transformation: % of Patients Discharged to a PIFU Pathways Friends and Family (FFT) % Response Rate: Maternity Friends and Family (FFT) % Response Rate: Outpatients To increase the number of patients leaving our hospitals by noon on the day of discharge
Special Cause - Concern	Summary Hospital-level Mortality Indicator (SHMI)			Friends and Family (FFT) % Response Rate: Inpatients	

Strategic Theme: People

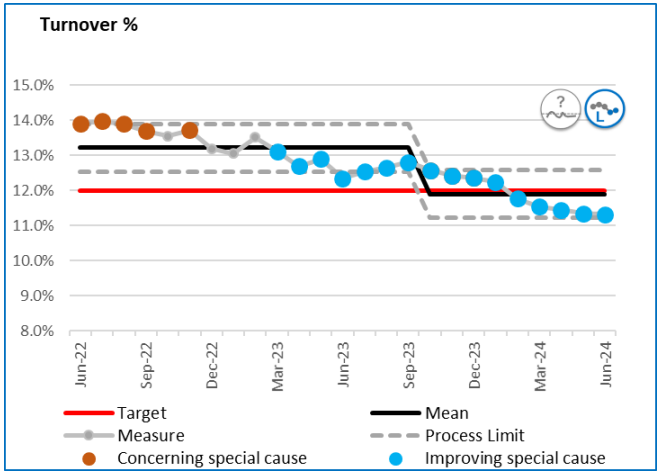
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 8%		8%	9.5%	Jun-24	8%	9.5%	May-24	Driver			Verbal CMS	8.9%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	11.3%	Jun-24	12%	11.4%	May-24	Driver			Full CMS	11.1%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.0%	May-24	4.5%	4.1%	Apr-24	Driver			Not Escalated	3.98%		
	Well Led	Statutory and Mandatory Training		85.0%	91.1%	Jun-24	85.0%	90.7%	May-24	Driver			Not Escalated	91.08%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	71.5%	Jun-24	66.0%	71.9%	May-24	Driver			Not Escalated	73.24%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	5.8%	Jun-24	4.0%	5.8%	May-24	Driver			Not Escalated	6.94%		
	Well Led	Percentage of AfC 8c and above that are BAME		8.1%	6.6%	Jun-24	7.7%	6.5%	May-24	Driver			Escalation	6.61%		
	Well Led	Staff Leavers within 12 months (as a % of all leavers)		18.4%	29.2%	Jun-24	18.4%	28.2%	May-24	Driver			Not Escalated	25.6%		
	Well Led	Staff Leavers within 24 months (as a % of all leavers)		35.3%	46.7%	Jun-24	35.3%	56.4%	May-24	Driver			Not Escalated	46.4%		

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

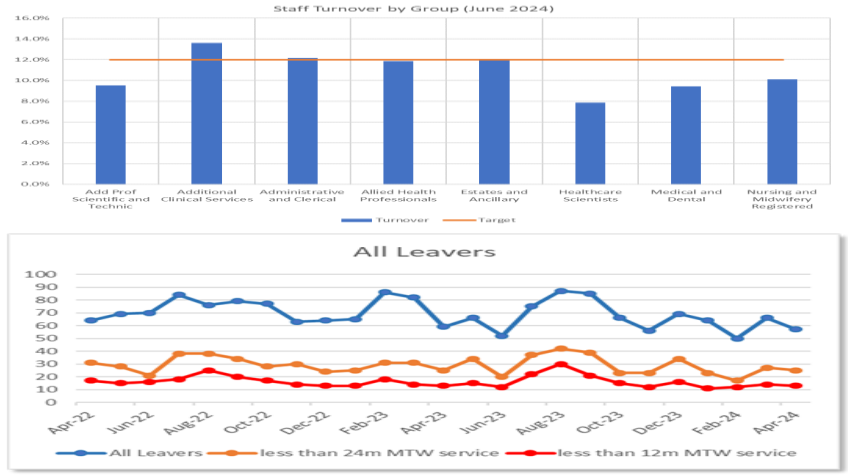
Owner: Chief People Officer
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Jun-24
11.3%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and has been in variable achievement of the target for 6+ months
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

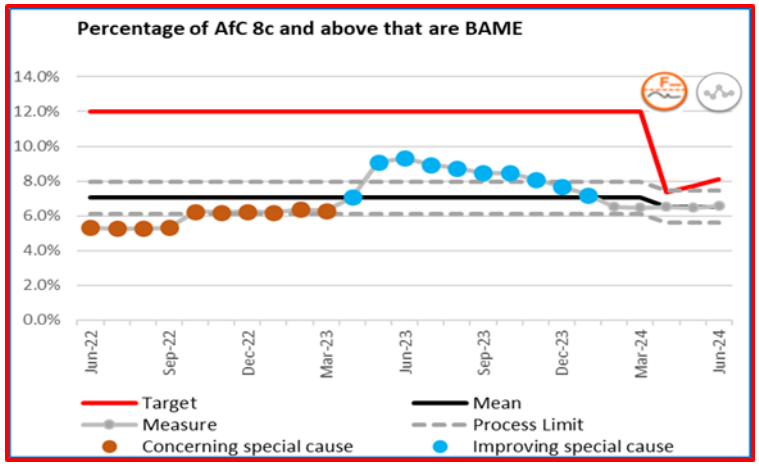
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership 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
Continue to develop A3 to target reducing the number of leavers who have been with the Trust for 24 months or less	Aug-24
Offer expanded work experience placements programme for nursing to commence in June to August.	Aug-24
Continue to develop A3 to target reducing number of admin & clerical leavers	Aug-24
Review of workstreams going forward as part of the new People Promise Delivery Group (includes a review of existing Terms of Reference, and review of corporate A3 exercises and the progression of countermeasures)	Aug-24

People – Workforce: CQC: Well-Led



Jun-24
6.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
8.1%
Business Rule
Full Escalation

The national metrics targets for representation at 8c and above has increased for 2024/25 to:
BME background 20%
Women 66%
Staff with a declared disability 4%

Recognising there is work to be done to improve the position for BAME representation, the Trust has developed a monthly phased improvement trajectory to be able to meet the 20% target over the next three years (by Mar 27). The Graph is therefore now showing our internal target each month.

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:** **Actions:** • Launch of focussed work on inclusive recruitment for bands 8b and above • EDI supporting recruitment team to develop inclusive recruitment training for all recruiting managers • Reverse mentoring cohort 3 planned • Increased visibility of staff networks through corporate briefing	**% of AfC 8c and above that are BAME:** From the beginning of June, all band 8B and above roles have People BPs working closely with recruiting managers to support the process. This includes reviewing JDs, working with the Attraction Team to create appealing adverts and guiding managers through the shortlisting, interview and selection processes. Between June and the end of September, Inclusive Recruitment workshops are available for all recruiting managers of band 8a and above to book which focusses on how to remove bias from recruitment The Recruitment Team are developing recruitment training modules which are being reviewed by the EDI team – due to complete end of July then to e-Learning development and pilot The second cohort of Reverse Mentoring closed in June with positive feedback from mentors and mentees. Cohort 3 will launch in the early Autumn expanding to encompass mentors from the LGBTQIA+ community and mentees from a wider pool of leadership. Case study currently being created for submission to the NHS Futures Platform - EDI national repository From July, staff network Chairs present, on a rotational basis, an update of activity and future plans at Corporate Team Brief

Strategic Theme: Patient Safety & Clinical Effectiveness

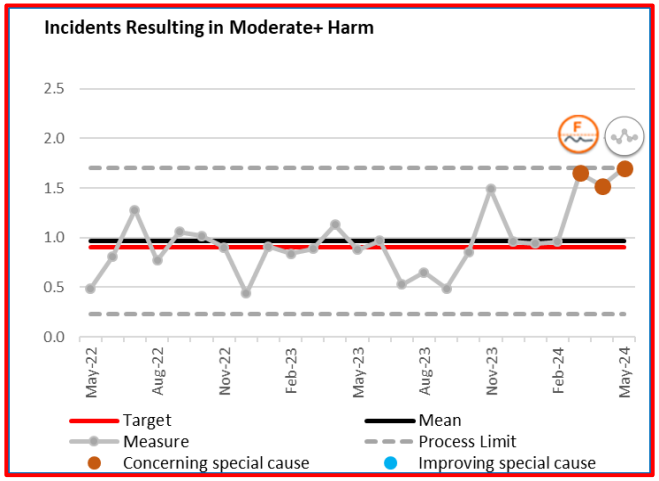
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.70	May-24	0.90	1.52	Apr-24	Driver			Full CMS	1.32 May 24		
Breakthrough Objectives	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		TBC	5	Apr-24	TBC	5	Apr-24	Driver				TBC	No SPC	No SPC
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month	TBC	TBC	3	Jun-24	TBC	3	May-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month	TBC	TBC	16	Jun-24	TBC	15	May-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month	TBC	TBC	3	Jun-24	TBC	0	May-24	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	83.8	Mar-24	100.0	85.6	Feb-24	Driver			Not Escalated	80.0		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	96.0	Mar-24	100.0	94.9	Feb-24	Driver			Not Escalated	98.0		
	Safe	Never Events		0	0	Jun-24	0	0	May-24	Driver			Not Escalated	0		
	Safe	Safe Staffing Levels (Nursing)		93.5%	97.8%	Jun-24	93.5%	100.4%	May-24	Driver			Not Escalated	100.0%		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	21.9	Jun-24	32.6	15.5	May-24	Driver			Not Escalated	13.9		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	65.8	Jun-24	25.5	77.3	May-24	Driver			Escalation	65.3		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Jun-24	0	0	May-24	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.3	Jun-24	6.4	6.6	May-24	Driver			Verbal CMS	5.8		

Vision: Counter Measure Summary

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

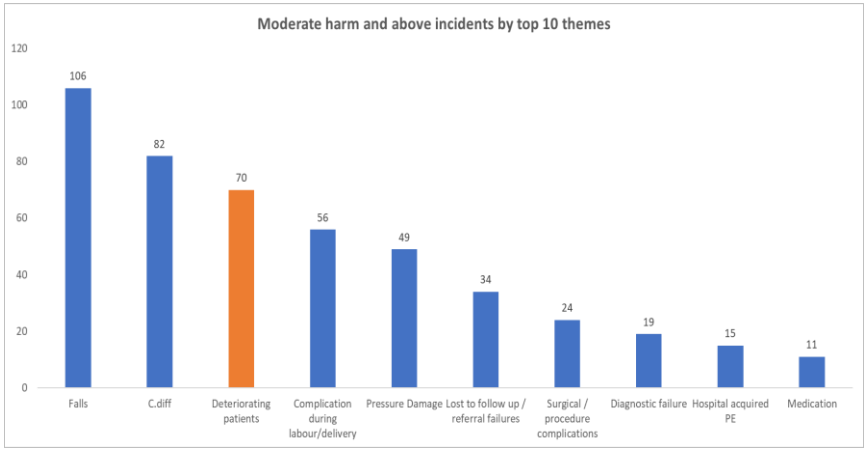
Owner: Medical Director
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



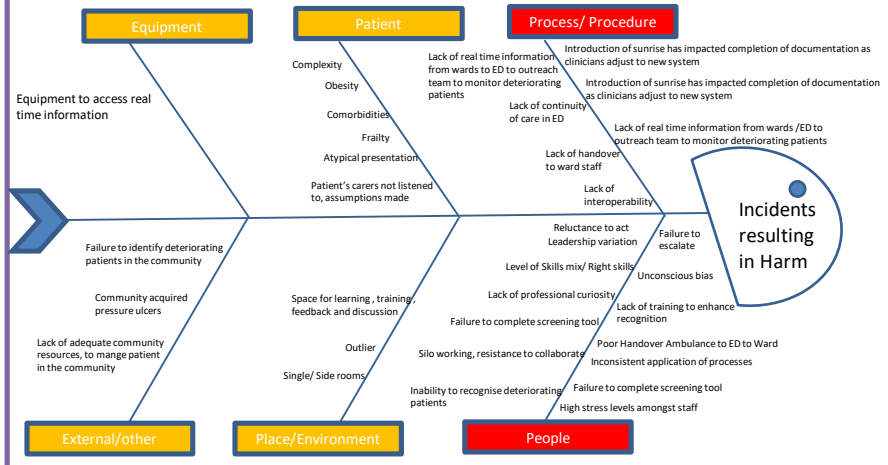
May-24 (1 month arr)
1.7
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



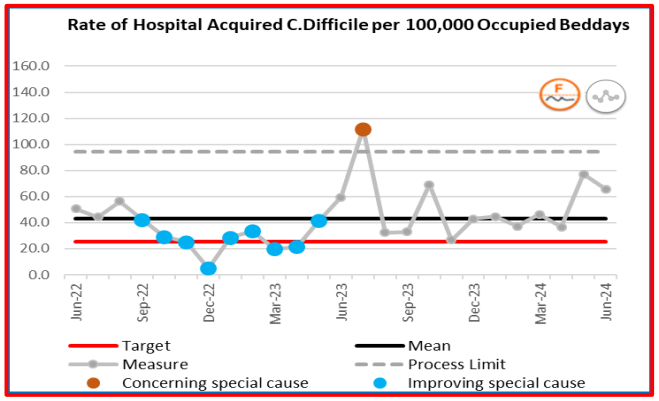
This chart is a two year view of incidents following an audit by the Patient Safety Team.

3. Top Contributors

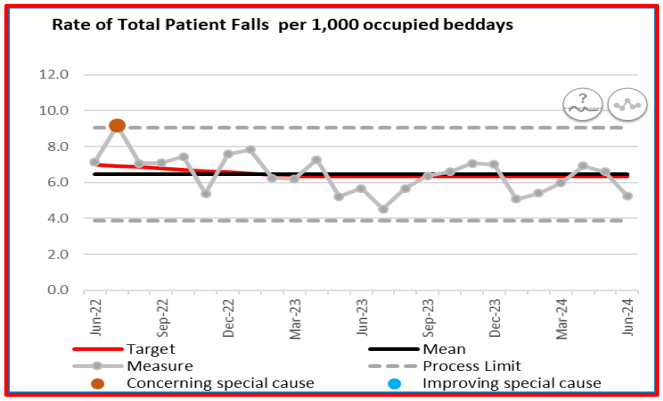


solution /countermeasure	Owner	Due By
Key Update:		
• Advert for deteriorating patients lead nurse closed and being shortlisted. Interviews booked for 1st Aug	VI	
• Treatment Escalation Plans on EPR: TEP proposals presented to CDs who agreed the plan but requested minor amendments	HB	
• Data collection underway against proposed KPIs in order to set baseline	JR & VI	
• Risks and issues being developed and graded in collaboration with leads	JR	
Next Steps:		
• Demo of the new SBAR/sepsis tool expected at the next deteriorating patients meeting. Training to be developed to support roll out.	JK	Jul-24
• Obtain baseline data against KPIs	JR & VI	Aug-24
• Appointment of lead nurse	VI/SM	Aug-24
Issue		
• Lack of uptake and use of 2222 per-arrest form		
• Staff not ticking the right boxes when searching the revised categories to report an incident on InPhase, thereby not always recording deteriorating patient related incidents correctly		

Patient Safety and Clinical Effectiveness: CQC: Safe



Jun-23
65.8
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



Jun-24
5.26
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (Internal)
6.36
Business Rule
Has been in variable achievement for 6+ months

Summary:

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

Inpatient Falls Rate - is experiencing common cause variation and has been in variable achievement of the target for 6+ months

Actions:

Infection Control:

- The C.diff rates during June remain higher than expected with 12 cases. The majority of cases (8) were seen at TWH. Actions being taken include.
- Further Trust wide incident meeting scheduled for July to help identify further actions to support a reduction in cases.
- Avoidable cases presented and discussed at PSIRG and escalated to Swarm huddle as needed.
- Deep cleaning planned for TW AMU as soon as cleaning contactor in agreed
- 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
- Ongoing review of bed turn around team to ensure that standards are being met and maintained
- IPC team to undertake further CDI focused interventions to address learning from incidents

Inpatient Falls Rate:

Monthly slip, trips and falls meeting taking place with the ward leaders (falls champions), matrons and Heads of Nursing. This also involves medical lead for falls prevention and education. AHP's have now been invited and are attending.

Monthly falls champions meetings to follow up actions and learning from AAR and local incident reviews.

Monthly audits for lying and standing blood pressure in progress- current trust's compliance at 69% for June 2024 (Target is 85%) This shows an improving trajectory from previous month (May) showing 58%

Weekly reviews of high risk falls patient now in place and supported by falls prevention practitioner.

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 IPC reports presented to IPCC

Inpatient Falls Rate:

Training compliance for May was 82% (Target 85%)- This is an improving trajectory. All training sessions up to August are fully booked.

Reduction on the number of recurrent fallers

Recruitment of the falls lead practitioner has taken place- awaiting start date confirmation.

Thematic reviews from AAR's now in place and identifying any trends- May review showed increase of falls in patients with dementia and delirium, fall from beds and incomplete falls assessments.

Monthly reports provided to the directorates identifying falls incidents and trajectories.

Falls action plan for 24/25 with KPI's currently under review.

Live falls dashboard now available and all falls champions (Ward Managers), Heads of Nursing and Matrons can now access live data, themes, trends and share learning.

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 (Excluding SYS)		75.3%	74.2%	Jun-24	74.5%	75.4%	May-24	Driver	H	F	Full CMS	75.3%	H	F
		Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		75.3%	72.8%	Jun-24	74.5%	74.7%	May-24	Driver	H	F	Business Rules not applied (for info only)			
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		122.1%	129.7%	Jun-24	119.0%	134.3%	May-24	Driver		P	Note Performance	122.8%	H	P
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		617	558	Jun-24	627	548	May-24	Driver	L	P	Not Escalated	540	L	P
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	744	Jun-24	N/A	423	May-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment (System Support only) - Reported Nationally		N/A	530	Jun-24	N/A	391	May-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		97.9%	97.7%	Jun-24	97.6%	98.5%	May-24	Driver		?	Not Escalated	99.4%		?
	Responsive	A&E 4 hr Performance		89.2%	83.4%	Jun-24	87.2%	84.2%	May-24	Driver		F	Escalation	84.1%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.5%	May-24	96.0%	96.1%	Apr-24	Driver		?	Not Escalated	96.0%	H	?
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.3%	May-24	85.0%	85.8%	Apr-24	Driver	H	P	Not Escalated	86.5%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	75.4%	May-24	75.0%	75.8%	Apr-24	Driver	H	P	Not Escalated	78.8%		P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	93.4%	May-24	90.0%	91.0%	Apr-24	Driver	H	?	Not Escalated	95.7%	H	P

* The RTT Trajectory and Patients waiting more than 40 weeks excludes the patients that have been added to our waiting list as the Trust is now providing system support (SYS) to our neighbouring Trusts across Kent and Medway to help reduce long waiting patients to ensure these patients are treated as quickly as possible.

- 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)

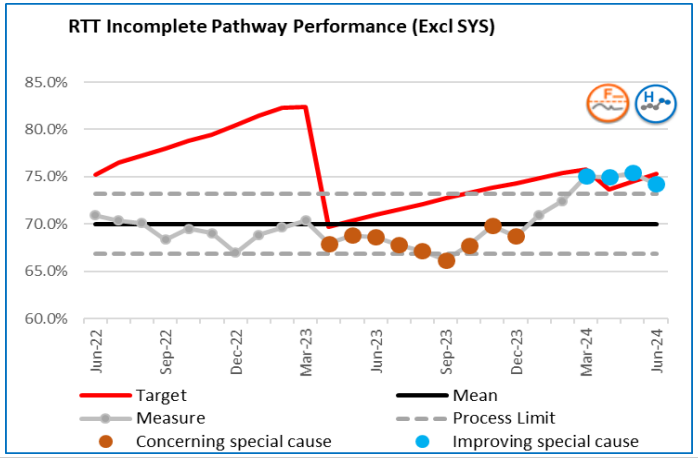
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	84.0%	Jun-24	85.0%	84.7%	May-24	Driver		F	Escalation	84.6%	H	F
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.5%	5.0%	Jun-24	6.0%	4.6%	May-24	Driver		F	Escalation	5.5%		F
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	86.1%	Jun-24	90.0%	86.6%	May-24	Driver	H	F	Escalation	89.8%	H	F
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	4.4%	Jun-24	5.0%	3.8%	May-24	Driver		?	Not Escalated	3.5%	L	P
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	61.5%	Jun-24	65.0%	60.5%	May-24	Driver		F	Escalation	62.0%		F
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		110.2%	116.4%	Jun-24	98.6%	116.2%	May-24	Driver		P	Not Escalated	105.0%		P
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.6%	51.7%	Jun-24	49.6%	51.3%	May-24	Driver	H	P	Not Escalated	49.8	H	P
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		149.7%	151.9%	Jun-24	140.3%	155.1%	May-24	Driver	H	?	Not Escalated	164.2%	H	P

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT (Excluding System Support)

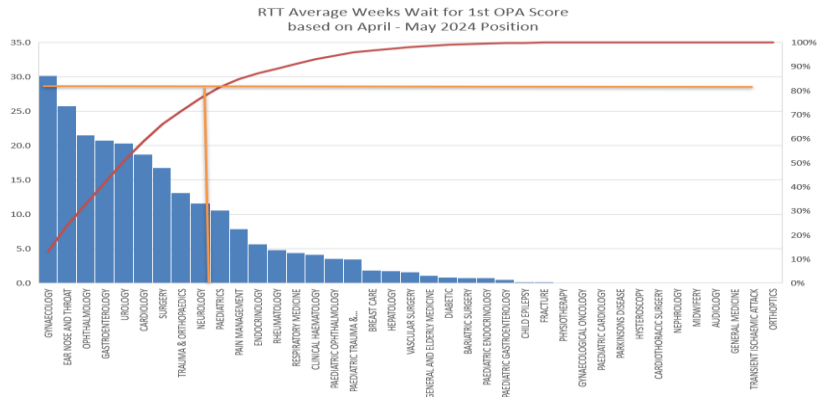
Owner: Chief Operations Officer
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Jun-24
74.2%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
75.28%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

Despite being above plan for our new outpatients, some of the key specialties with long waits are still under plan.
To further improve the trust RTT position the focus will look at reduction in waits for 1st routine elective appointment.
This was identified as the trust top contributors affecting achievement of the RTT national standard of 92%.

- Long waits for 1st Outpatient appointment – average wait @19 weeks.

BAU actions continue and focussed clinical engagement with Further Faster GIRFT Programme. Including implementation of STT, Clinical Validation, expansion of advice and guidance and delivering on Activity plans.

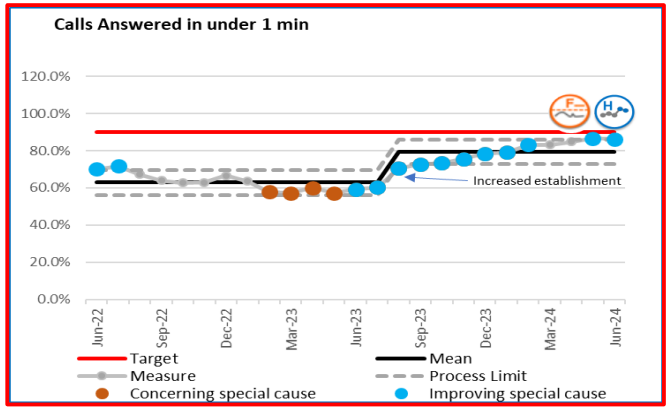
Key Risks:

- Waiting list growth could be affected due to increase in referrals and systems pressure.
- Industrial Action could affect internal improvement plans

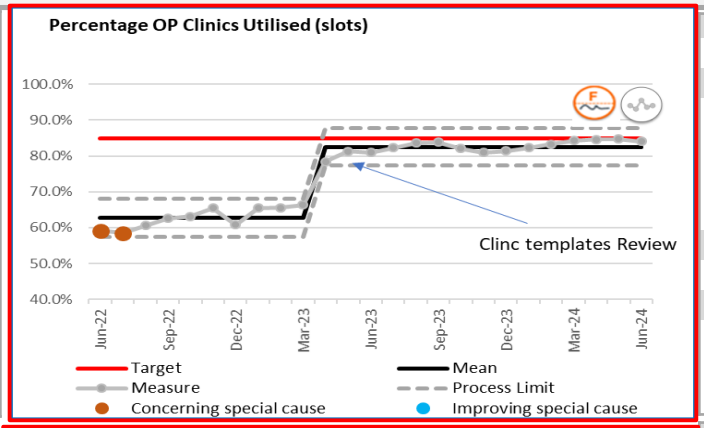
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Review of Breakthrough Objective	Complete new A3 , review of data to understand biggest contributors to waits for first appointments	SD/SC/JT	April 24✓
Trajectory	Trajectory for achievement of reduction in waits for 1st appointment agreed and communicated with specialty teams	SD/SC	June 24✓
Data Review	Review of data to identify specialties with longest waits.	SC/GM's	June 24✓
	Complete initial fishbone diagram with Root causes of waits for 1st appointments	SC/Tleads	July 24✓
	Identify 2 areas for focussed improvement- Gynaecology and ENT with further data to drill down on improvement areas	SC/GM	Aug 24 ✓
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	On-going
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	Full roll out July 24

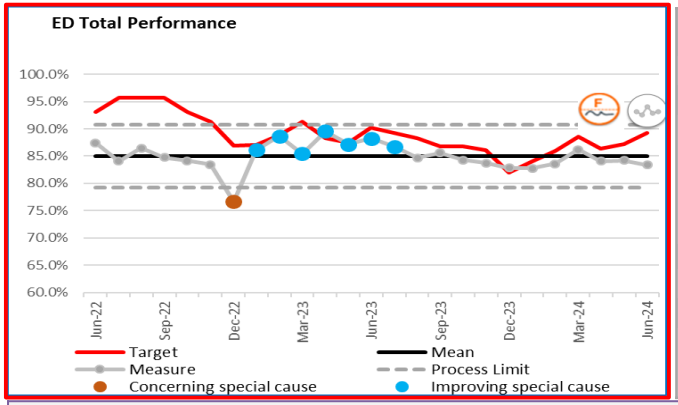
Patient Access: CQC: Responsive



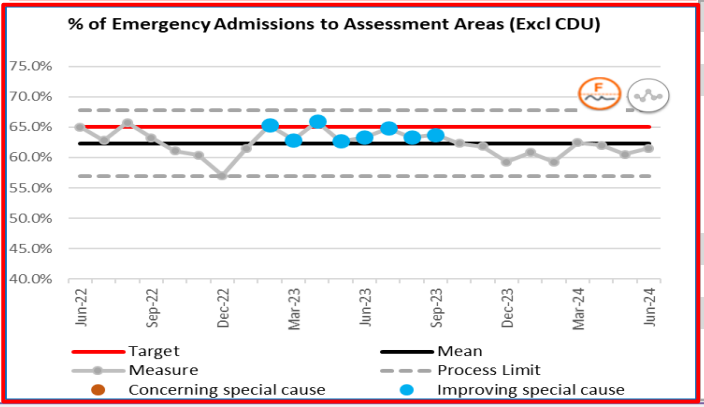
Jun-24
86.1%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target



Jun-24
84%
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



Jun-24
83.36%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for >6 months
Target (Internal)
89.19%
Business Rule
Full escalation as has failed the target for 6+months



Jun-24
61.5%
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.

ED Performance <4hrs: is experiencing common cause variation and has failed the target for more than six months

% 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. Bi-weekly KPI meetings with specialities to put in place actions to improve performance metrics.

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. Consultant led is over 85% for three consecutive months. Bi-weekly KPI meetings with specialities in place actions to improve performance metrics and a focus on nurse-led clinics to increase to over 85%.

ED Performance<4hrs: The ED team are constantly reviewing ways to improve our performance and ensure consistency as we are seeing thousands more patients each month. We are reviewing each step of the pathways both within ED and with our specialty colleagues to improve performance.

% 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%-49% 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:

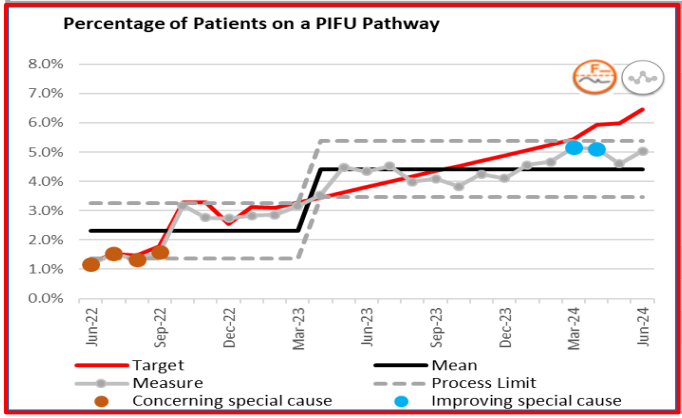
Calls Answered within 1 minute in the CAUs: Remain on upward trajectory. Focus on underperforming specialities to reach 90%. OCC has one vacancy being recruited to currently.

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. Note improvement in April (84.7%) and May (84.7%). Reporting timeframe for IPR means the true picture is not yet known for June but is expected to exceed 84%. Consultant-led utilisation has been above 85% since March.

ED Performance<4hrs: We continue to strive for our patients to be seen and either discharged or admitted within 4 hours. We have been working at our front door to stream what we can from initial assessment to the best areas which could be SDEC areas or our Urgent Treatment Centre. We are reviewing volume of patients that could be streamed to our UTC if we were to have additional slot capacity.

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

Patient Access: CQC: Responsive



Jun-24
5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
6.5%
Business Rule
Full Escalation as consistently failing the target

Summary:	Actions:	Assurance & Timescales for Improvement:
Percentage of Patients on a PIFU Pathway: is experiencing common cause variation and consistently failing the target. PIFU trajectory is set to increase over 24/25 inline with business planning. Some specialties are underperforming against previous months.	**Percentage of Patients on a PIFU Pathway:** Review of specialties underperforming against model hospital data Review of specialties performance and gain understanding as to why there may have been a drop in performance Establish documented pathways to support discharge to PIFU PIFU for long term conditions- work with specialties to implement a digital solution to enable PIFU for long term conditions	**Percentage of Patients on a PIFU Pathway:** Benchmarking included within GIRFT dashboard and reviewed within panel and review meetings Review of SPC charts per specialty to understand trends Review of documented pathways with specialties and identify any underlying issues Working group established and pilot pathways being agreed with specialties

Strategic Theme: Patient Experience

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month		36	25	Jun-24	36	40	May-24	Driver			Verbal CMS	39		
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.		24	2	Jun-24	24	10	May-24	Driver			Note Performance	14		
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	1.3	Jun-24	3.9	2	Mar-24	Driver			Not Escalated	12.9		
	Caring	% complaints responded to within target - Data not currently avaiable for May and June 24		75.0%	68.4%	Apr-24	75.0%	63.3%	Mar-24	Driver			Escalation	67.21%		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	TBC	May-24	95.0%	TBC	Apr-24	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	4.9%	Jun-24	25.0%	3.4%	May-24	Driver			Escalation	1.33%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	13.66%	Jun-24	15.0%	12.06%	May-24	Driver			Escalation	8.29%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	6.1%	Jun-24	25.0%	8.2%	May-24	Driver			Escalation	4.36%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	10.2%	Jun-24	20.0%	8.6%	May-24	Driver			Escalation	10.13%		

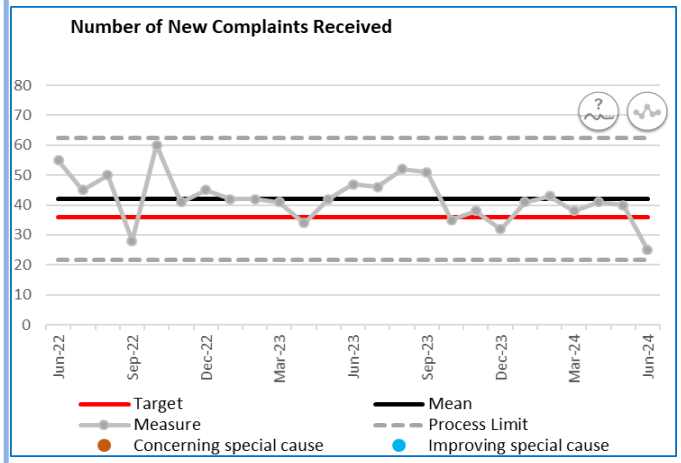
NB: There is no data available for VTE as there are some data quality issues that are been investigated. Reporting will recommence next month.

Vision: Counter Measure Summary

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

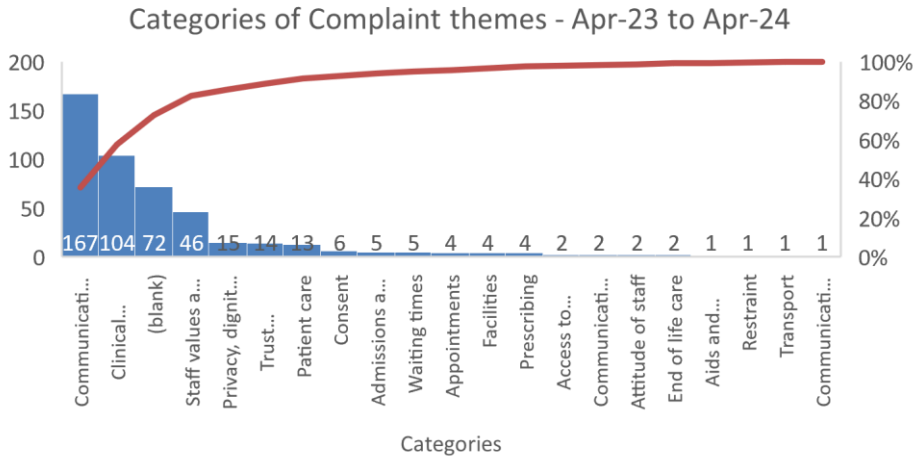
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



June-24
25
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.

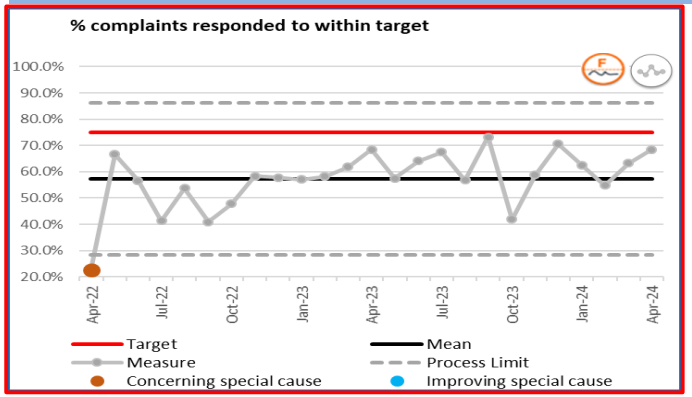
Key Risks:

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.

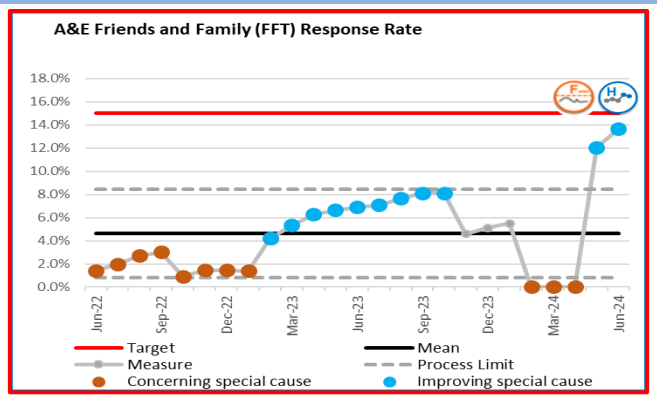
4. Action Plan of the Breakthrough Objective:

Workstreams	Action	Who
Written Communication - Patient Information Leaflets	• Working with the PILG group – to streamline processes and assurance for written information given to patients through Patient Leaflets	RG, GK
Education and Training	• Working with the Human Factors training team to create a bespoke training for Communication training	RG, SM, Sim team
Divisional Assurance	• Surgery and Medicine have **completed** their action plans – PDSA cycles are being followed. W&C are gearing up for their action plan	RG,S,M Divisional leads
Review of Communication theme from FFT	• Data from FFT being used to drive improvement action plans.	RG, RS, SM, SJ
Outpatient Communication themes	• To discuss with OPD GMs – specific themes relating to Outpatients departments	RG, GD, SM

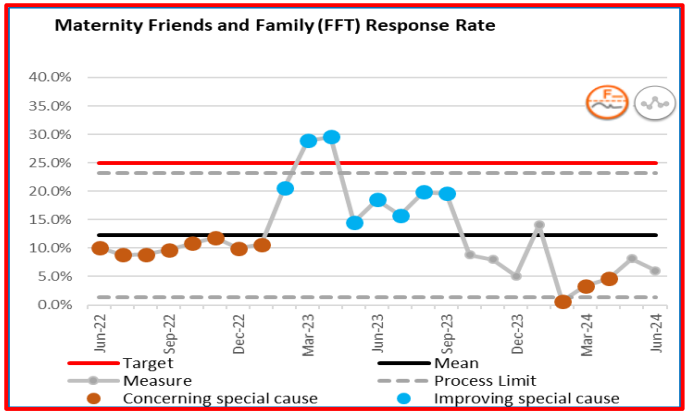
Patient Experience: CQC: Caring



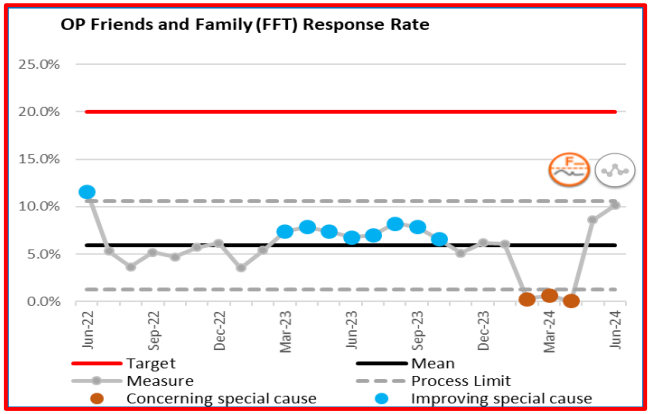
Apr-24
68.4%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Jun-24
13.66%
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



Jun-24
6.1%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Jun-24
10.2%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

% Complaints responded to within target: this indicator is experiencing common cause variation and has failed the target for >6months, noting the target has not been met since November 2021

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target. National Rate – 11.2%

Recommended Rate is 82.1%

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

National Rate – 13.1%

Recommended Rate is 96.6%

Friends and Family Response Rate - Outpatients: Is experiencing common cause variation and is consistently failing the target. National Rate – 1.6%

Recommended Rate is 93.8%

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: Increased response rate from 12.06% in May to 13.6% in June following implementation of text reminder service, the vast majority contains a score and no comments. Top themes positive : *compassion and care, implementation of care, environment and clinical treatment. Themes to improve: staff attitude, waiting time, communication to patients, friends and family in addition to communication across the Multi-Disciplinary Team (MDT), basic needs including access to refreshments (lack of vegetarian hot meal, vending machine broken, visitor to canteen).*

Maternity: Response rate has continued to decrease despite 4 touch points for text reminders as recommended by NHSE, Patient Experience team has just circulated FFT cards and posters containing QR codes to provide further options for response.

Sexual Health: Positive responses for recommendation of service 95% (211 responses), treatment plan explanation received a 95% positive response rate, 98% of patients felt that they were treated with respect and dignity during their appointment. *185 (81%) were booked appointments as compared 19% (43) walk in and wait.*

Outpatients: Response rate has increased for June to 10.2% from 9.2% in May. Top positive themes: *Staff attitude, confidence in clinical decision making, implementation of care and environment* and top improvement theme were: *Staff attitude & communication (brusque, inaccurate information or instructions), waiting times within department (clinics consistently running late).*

Inpatients: Response rate has increased, 2730 texts sent at discharge, responses received from 558 individuals (19.74%). Top positive themes: *Staff attitude (compassion and care, commitment), implementation of care, environment and patient mood (confidence in staff).* Top themes for improvement: *Staff attitude, environment and clinical treatment.*

FFT Response All: Since the new provider HCC came on board, our response rates have been improving. In June 2024 the Trust achieved a positivity rate of 90.4% up from 90.19% in May 24. The top five positive words were: *Staff, good, time, service and friendly*. Top 5 negative words were: *Waiting, hours, time, staff and wait.* Top 5 positive themes *were staff attitude, implementation of care, environment, waiting times and patient mood.* Top themes for improvement: *Staff attitude and waiting times, environment, communication and clinical treatment.*

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: SMS onboarding still ongoing with clinical areas. FFT cards have been circulated along with posters with QR codes. Interactive voice messages (IVM) build completed and facility now live. Training and login details for HCC platform have been provided to all ward managers, matrons, heads of nursing with more drop in session planned and the re-instigation of the FFT monthly meetings. Final data quality checks on-gong with HCC. Feedback from maternity being reviewed and work being undertaken with the newly appointed Patient Experience Lead for maternity services.

Sexual Health Services: Due to patient confidentiality, these services use a different FFT system and will continue to do so.

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 percentage of occupied bed days for patients identified as no longer fit to reside (NFTR)		24.5%	22.4%	Jun-24	24.5%	19.2%	Mar-24	Driver			Note Performance	22.0%		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	25.1%	Jun-24	33.0%	24.3%	May-24	Driver			Full CMS	23%		

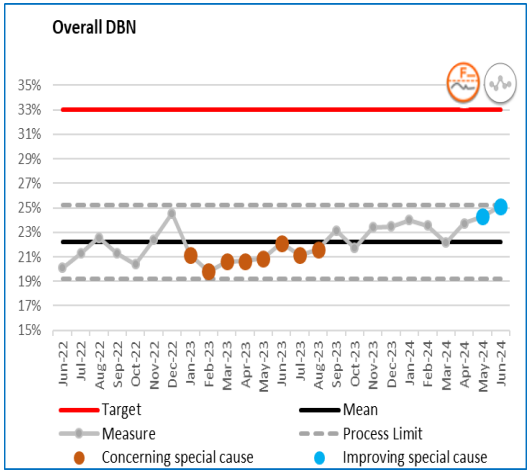
Please note – No longer Fit to Reside data has been reviewed after data quality challenges were identified and a revised methodology established displaying the metric as a percentage of bed days that are NFTR aligning with benchmark reporting (Model System). Target is currently set to the national average

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%

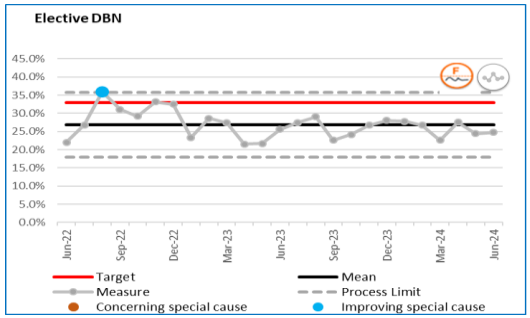
Owner: Director Strategy, Planning & Partnerships
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

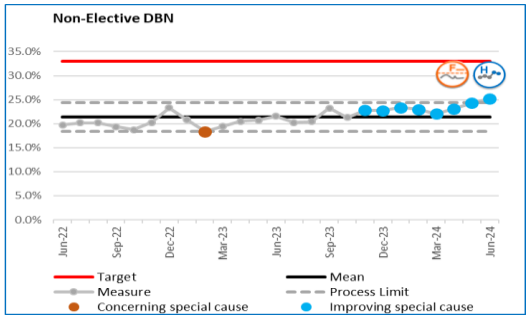
1. Historic Trend Data



Current Data Source: PAS
Jun-24
25.1%
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. Alignment of resource to support wide ranging improvement process

4. Action Plan

Counter Measure	Action	Who	When	Complete
Board Round Pilots	• Pilot reviewing board rounds and discharge processes on surgical wards completed, • PFIS huddles engaged on wards 30/31/32 with new set of board round process & discharge planning • Engagement in PFIS huddles, new process • Next steps to include Cornwallis ward • Week of observation complete on Whatman/ Mercer/ Pye. Feedback to Matron's completed. • Prompt engagement on Whatman, Mercer and Pye needed from above • Wards visually tracking discharges & delays to create shared ownership • Confirmation of next steps to be agreed with Matrons & Ward Managers • MEC booked on PFIS training	 LS BC NP/BC/Cl team BC/FR	 May 2024 June 2024 June 2024 w/c 18/6	
Criteria Led Discharge	• Gynae competency pack approved for 3 conditions , timeline agreed for completion with nursing staff • Meeting with Resp CD and agreed 2 weeks for pathways for specific conditions • Meeting with Haem and agreed 2 weeks for pathways for specific conditions			In progress In progress
TTOs and Pharmacy	• Process mapping underway between Whatman ward team and Pharmacy to identify delays and formulate an action plan to improve process efficiencies			
	• Data reconciliation between systems – PAS and Teletracking. We should also add that work is being done in assuring data accuracy in recording the discharge times for patients			

Strategic Theme: Sustainability

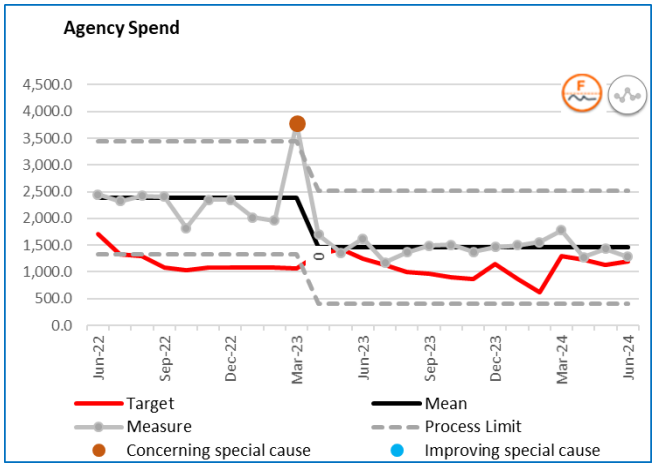
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-3,750	-4,007	Jun-24	-2,416	-2,547	May-24	Driver			Verbal CMS	-2,527		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		1,199	1,285	Jun-24	1,134	1,433	May-24	Driver		F	Full CMS	-3,874		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		2,307	1,459	Jun-24	1,770	1,477	May-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Cash Balance (£k)		1,897	10,609	Jun-24	4,994	7,865	May-24	Driver			Not Escalated	3,444		
	Well Led	Capital Expenditure (£k)		1,490	483	Jun-24	1,329	1,329	May-24	Driver			Not Escalated	28,469	H	P
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		TBC	36,069	Jun-24	TBC	24,979	May-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		TBC	7,769	Jun-24	TBC	5,251	May-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: Chief Finance Officer
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

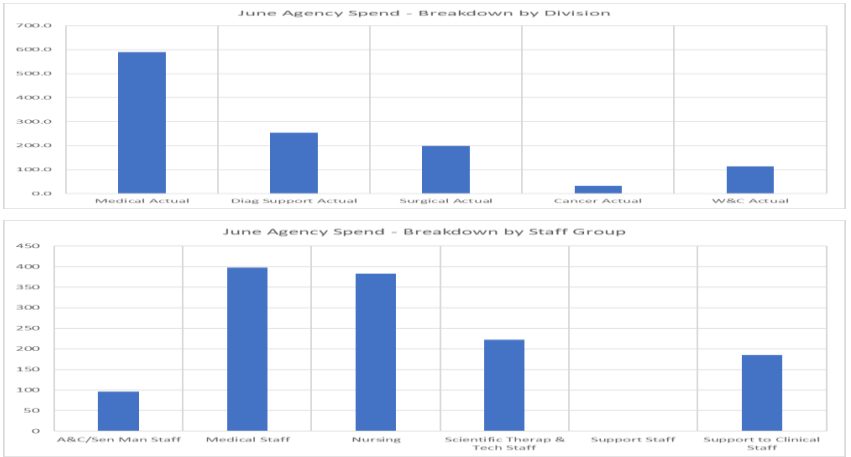
1. Historic Trend Data



Jun-24
1,285
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
1199
Target Achievement
Metric has failed the target for > 6months

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

Issues

- Increased demand to our ED adversely impact premium workforce spend
- Industrial action for junior doctors will require backfill with premium workforce

Risk

- Annual leave planning and sickness management could impact need for temporary staff

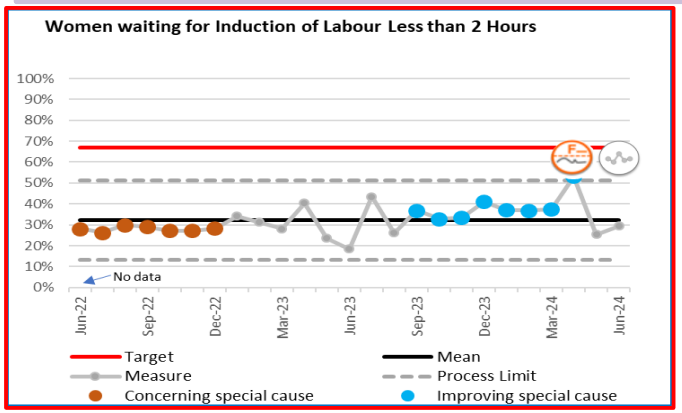
4. Action Plan

Actions	By when
Review to identify key improvement activities outstanding under the Corporate Project that relate to AFC Rostering nearing completion	Complete
Agree new priorities with SRO	August 2024
Plans to move implemented processes to BAU: • Roster Supervisor Training • Finance Training Training dates already published until September – BAU process for following cohorts	September
Next steps: AFC Rostering: to review the latest data to understand biggest contributor to poor rostering, by better understanding the link between rostering and premium agency spend.	July 2024

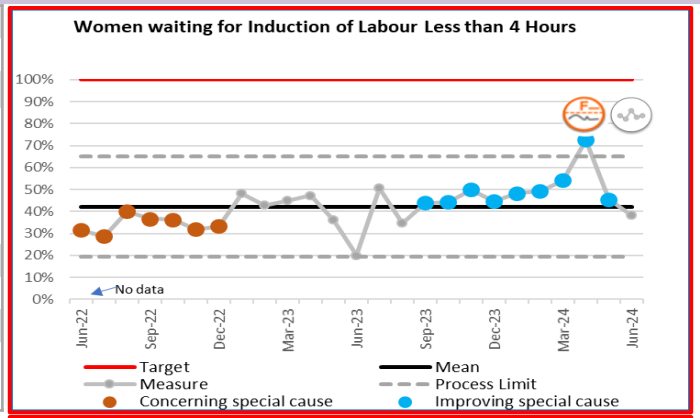
Maternity Metrics

				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)	Maternity Metric	Registerable Births		No target	452	Jun-24	470	511	May-24	Driver		No target	Not Escalated	457		No SPC
	Maternity Metric	Antenatal bookings		No target	456	Jun-24	545	503	May-24	Driver		No target	Not Escalated	517		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	19.8%	Jun-24	No target	17.1%	May-24	Driver		No target	Not Escalated	19.6%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	21.1%	Jun-24	No target	24.7%	May-24	Driver		No target	Not Escalated	21.3%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	29.5%	Jun-24	36.0%	24.1%	May-24	Driver			Not Escalated	25.8%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	29.4%	Jun-24	67.0%	25.5%	May-24	Driver			Escalation	37.8%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	38.2%	Jun-24	100.0%	45.5%	May-24	Driver			Escalation	54.5%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	7.3%	Jun-24	6.0%	9.2%	May-24	Driver			Not Escalated	8.6%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	3.7%	May-24	4.0%	4.2%	Apr-24	Driver			Not Escalated	5.1%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Jun-24	0.4%	0.4%	May-24	Driver			Not Escalated	0.3%		
	Maternity Metric	PPH >=1500% Rate		3.0%	3.0%	Jun-24	3.0%	5.2%	May-24	Driver			Not Escalated	3.4%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	1.5%	Jun-24	2.5%	1.7%	May-24	Driver			Not Escalated	2.7%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	80.4%	Jun-24	75.0%	79.2%	May-24	Driver			Not Escalated	82.4%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	80.0%	Jun-24	95.0%	89.7%	May-24	Driver			Escalation	91.3%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	81.7%	Jun-24	95.0%	75.0%	May-24	Driver			Escalation	73.7%		

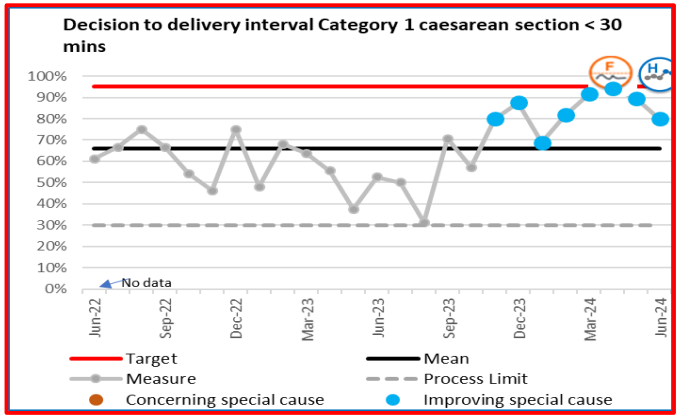
Maternity Metrics



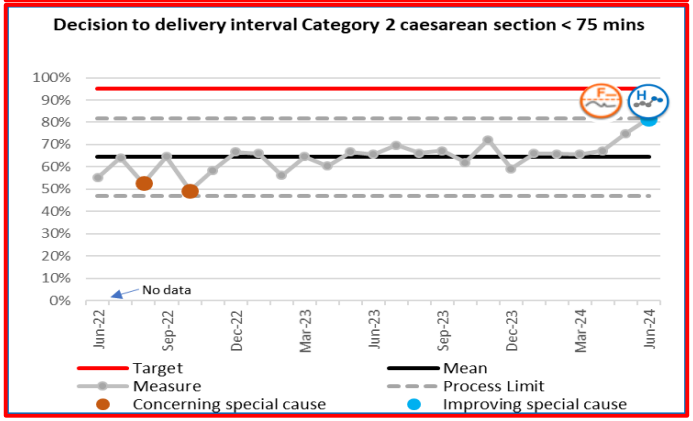
Jun-24
29.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



Jun-24
38.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Jun-24
80%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



Jun-24
81.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
95%
Business Rule
Full escalation as consistently failing the target

Summary:

Women waiting for Induction of Labour less than 2: is experiencing common cause variation and consistently failing the target.

Women waiting for Induction of Labour less than 4 Hours: is experiencing common cause variation and consistently failing the target.

Decision to delivery interval Category 1 caesarean section: is experiencing special cause variation of an improving nature and has failed the target for more than six months

Decision to delivery interval Category 2 caesarean section :is experiencing special cause variation of an improving nature and has failed the target for more than six months

Actions:

Women waiting for Induction of Labour less than 2 or 4 Hours: Work continues 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.

Decision to delivery interval Category 1 and Category 2 caesarean section:

A3 projects continue to identify and mitigate challenges with meeting Cat 2 CS target times and with accessing second theatre.

MDT staff engagement has seen improved team working to meet target times for Category 2

Assurance & Timescales for Improvement:

Women waiting for Induction of Labour less than 2 or 4 Hours:

This metric is impacted by periods of high activity which are largely unpredictable.

Timescales for improvement will be dependent on the outcome of the demand and capacity project and any actions required as a result

Decision to delivery interval Category 1 and Category 2 caesarean section:

Improvements with compliance with Category 2 target time has been made in the last 2 months.

Small total numbers for Category 1 cases results in more variance in compliance rates.

All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified.

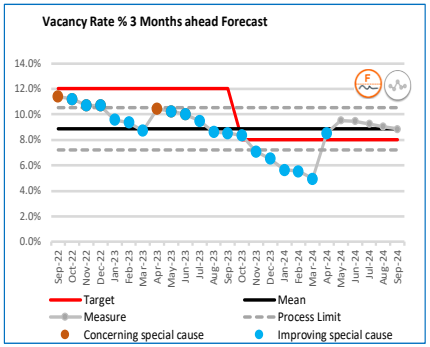
These are new metrics with data collection from June 22

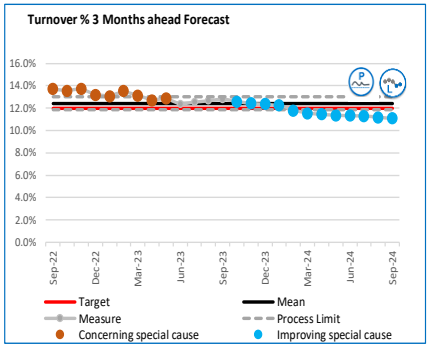
NHS
Maidstone and Tunbridge Wells NHS Trust

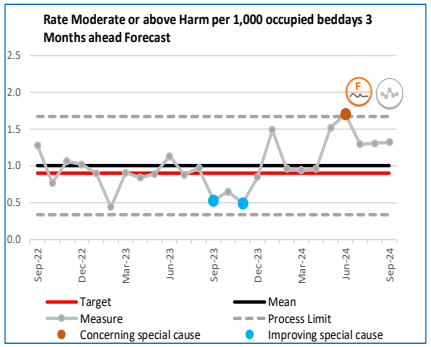
Appendices

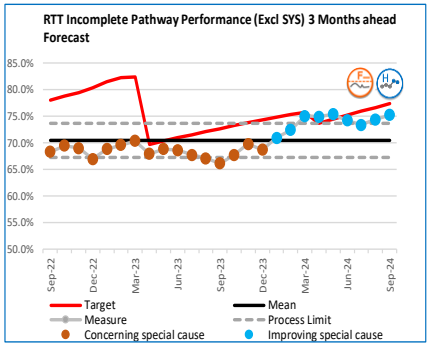
MTW
exceptional people, outstanding care

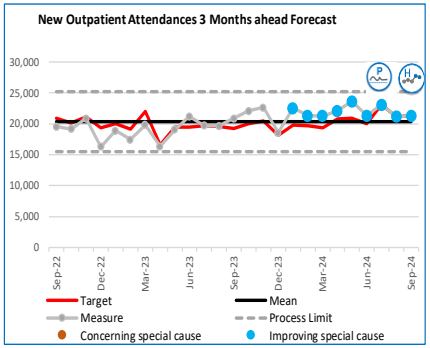
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

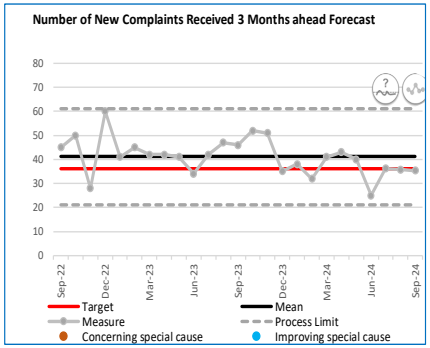


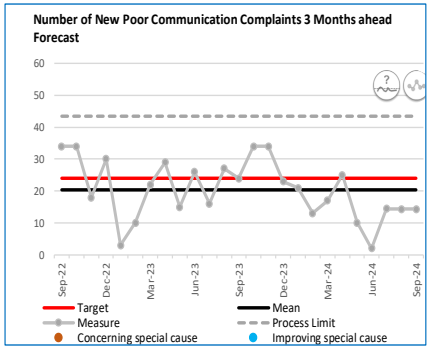


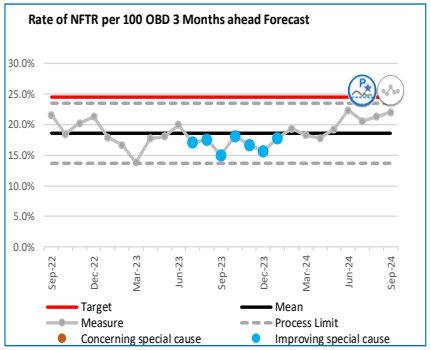


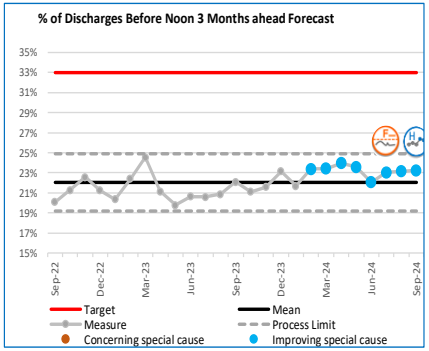


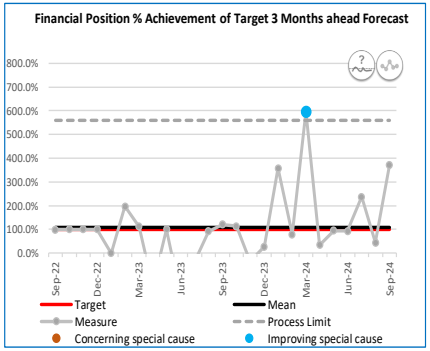


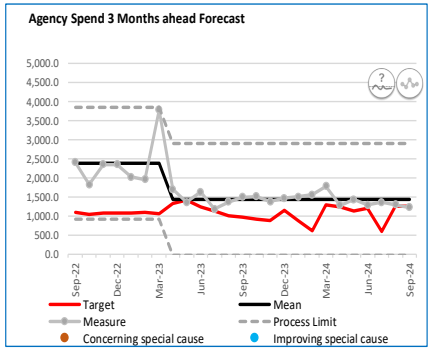


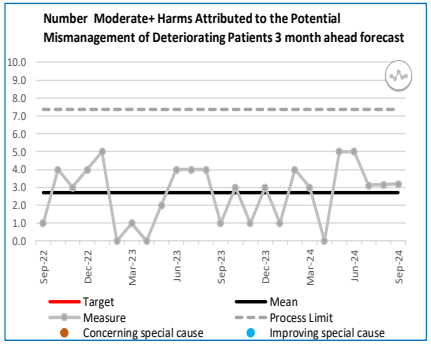




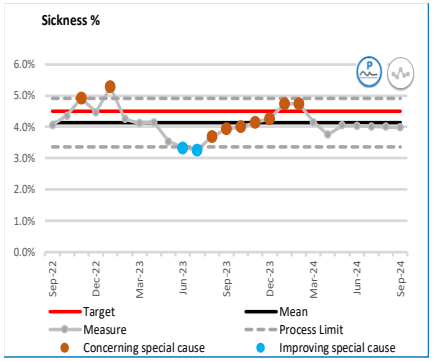


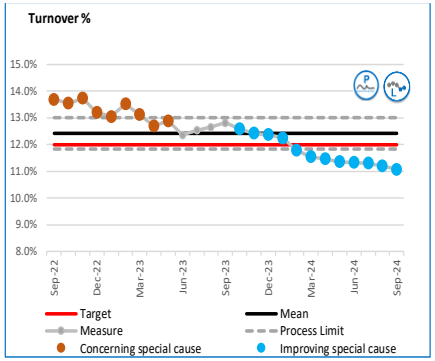


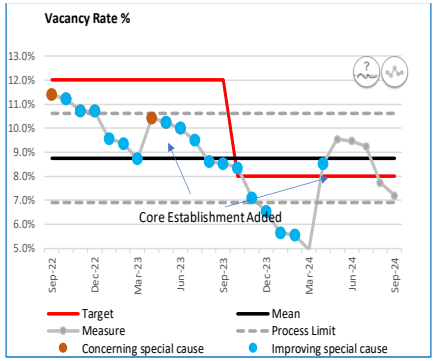


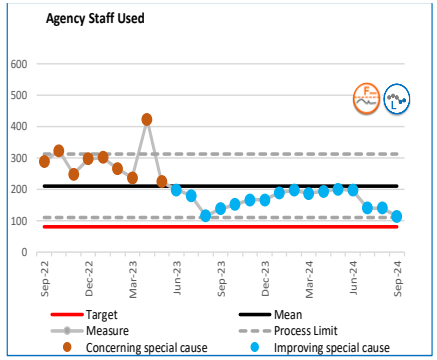


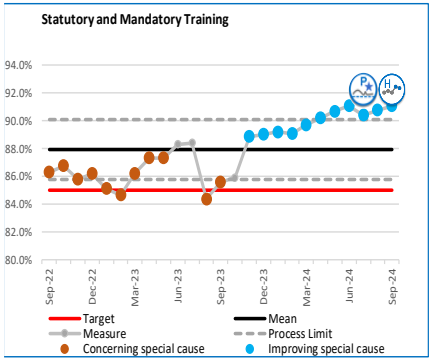
Forecast SPCs (3 month forward view) for People Indicators

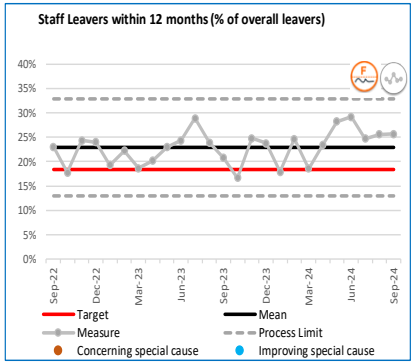


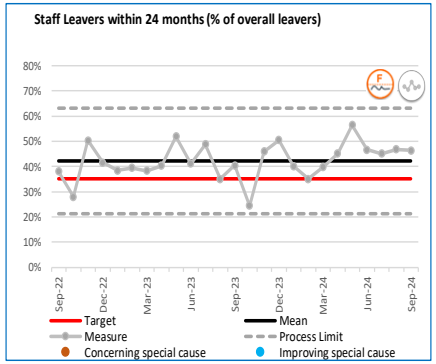


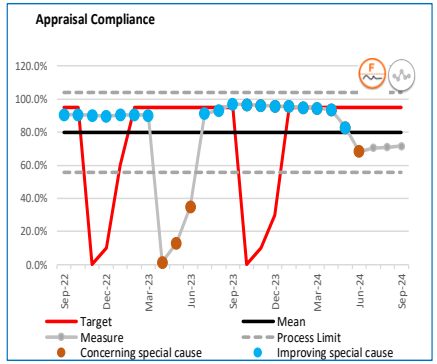


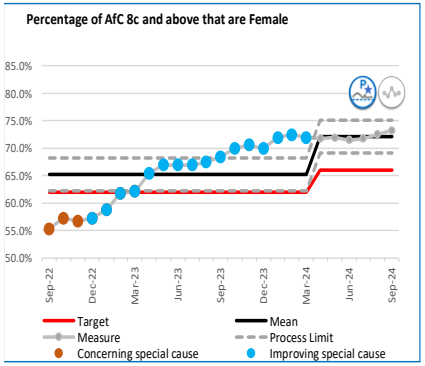


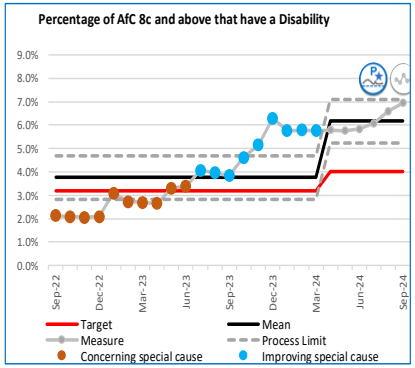


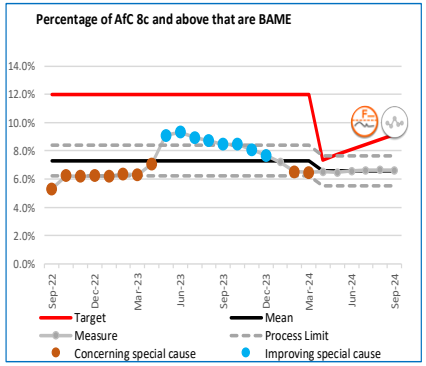


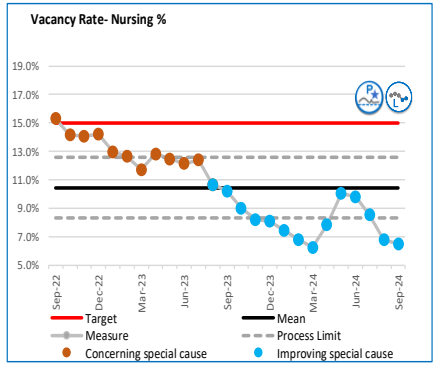




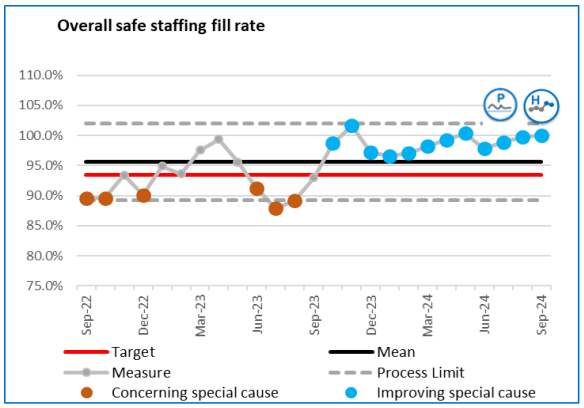


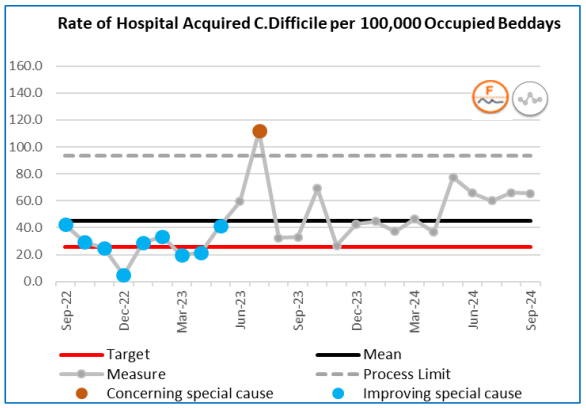


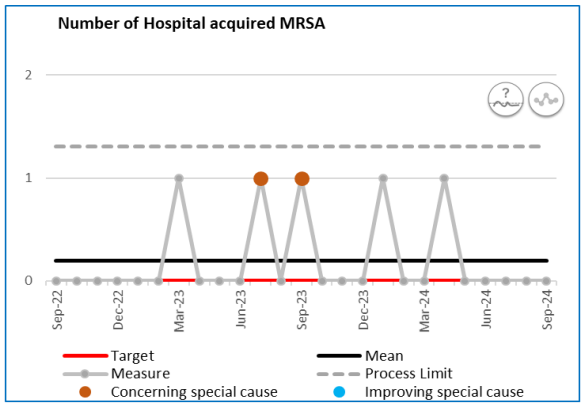


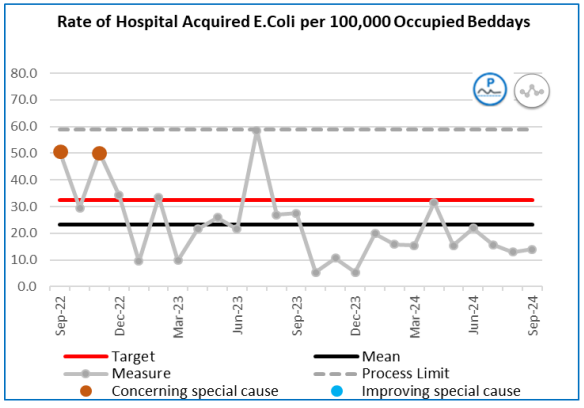


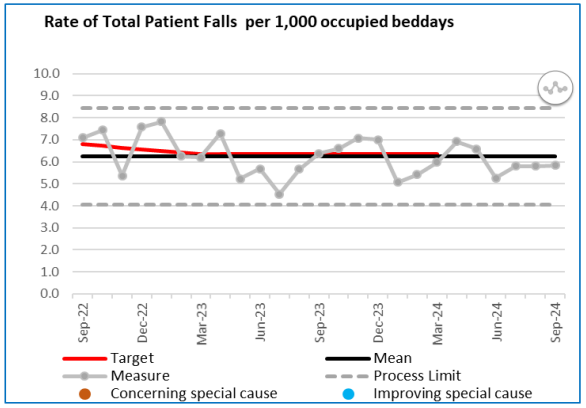
Forecast SPCs (3 month forward view) for Patient Safety Indicators

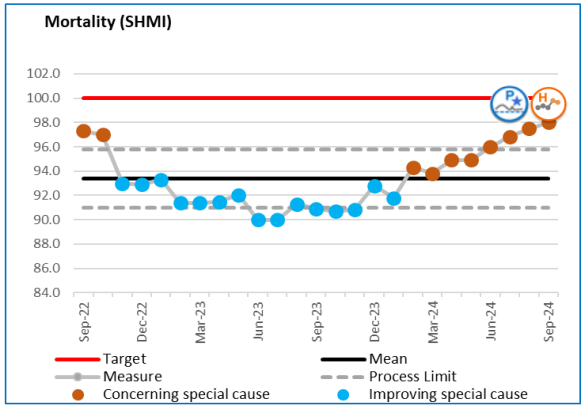


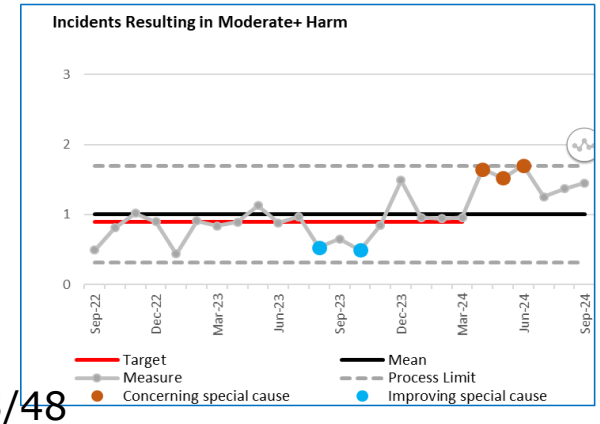


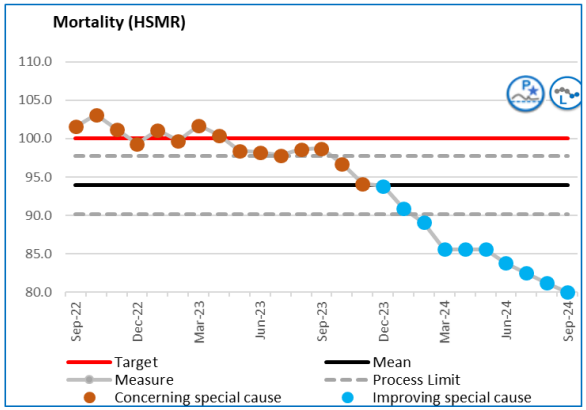




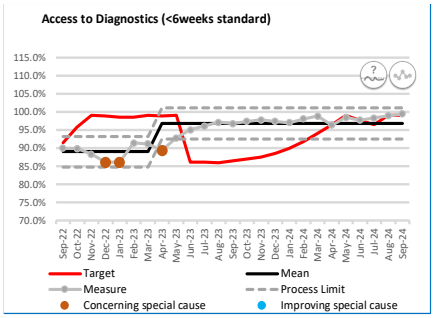


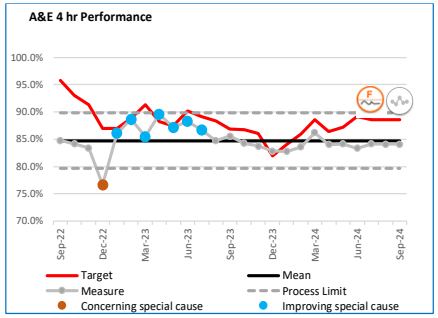


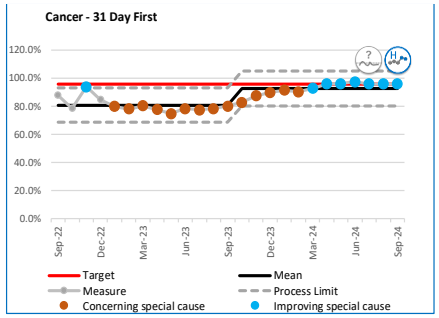


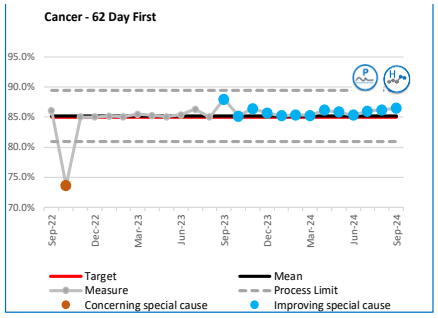


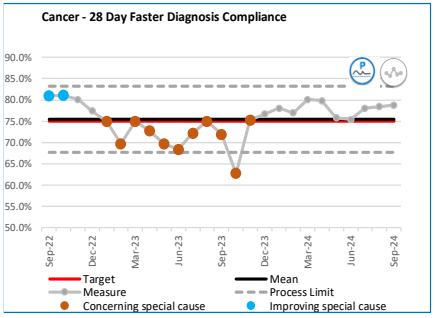
Forecast SPCs (3 month forward view) for Patient Access Indicators

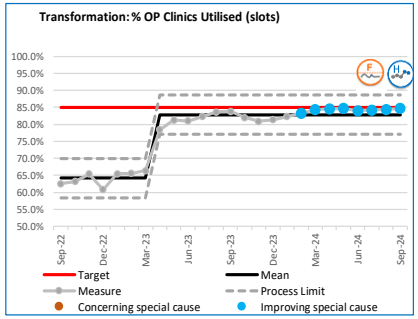


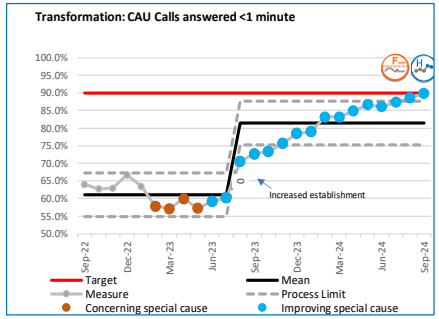


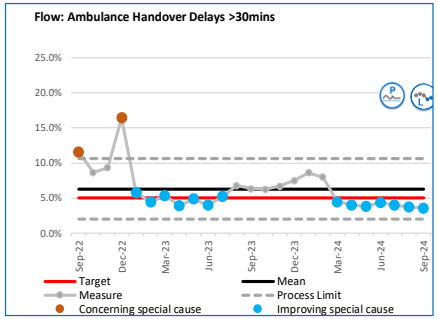


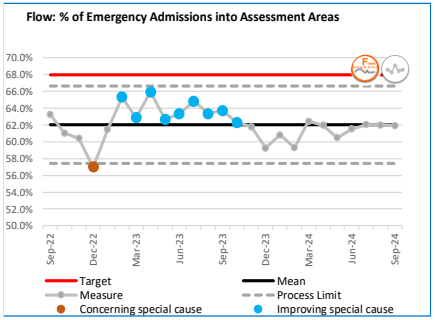


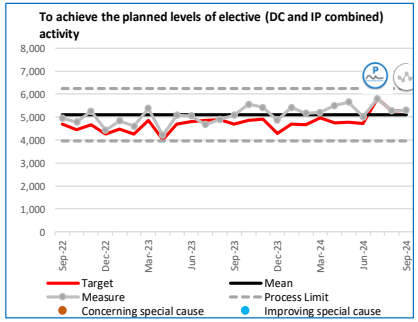


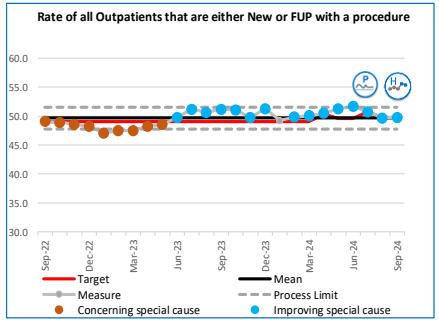


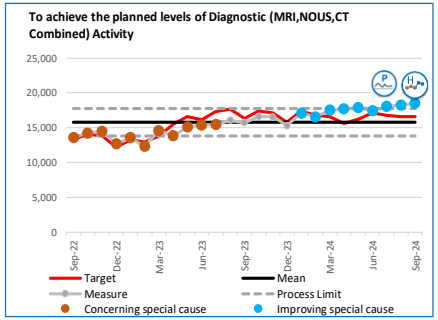




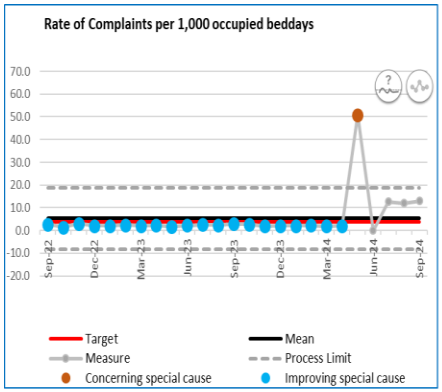


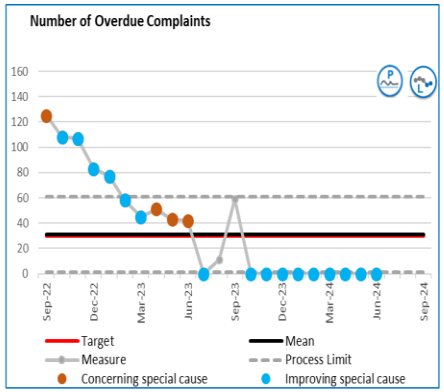


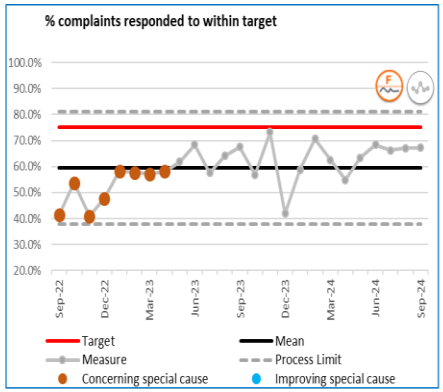


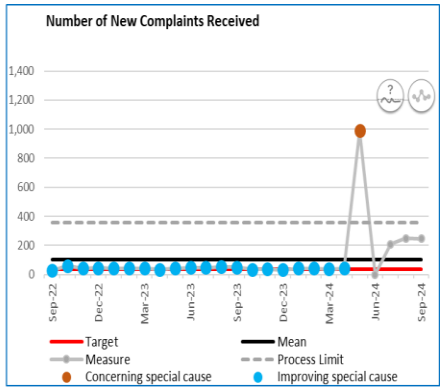


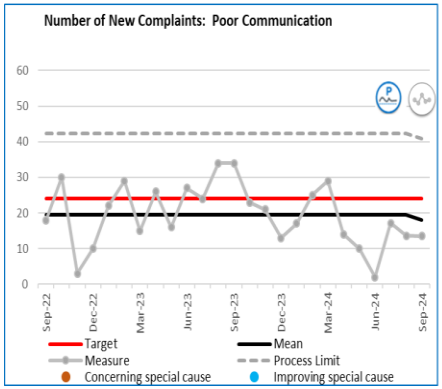
Forecast SPCs (3 month forward view) for Patient Experience Indicators

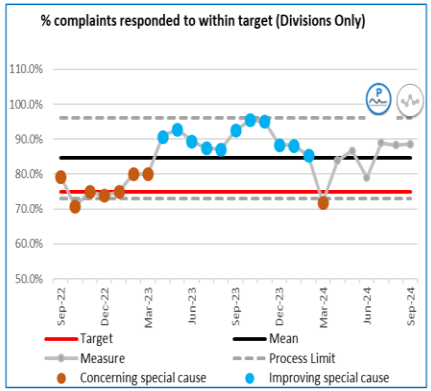


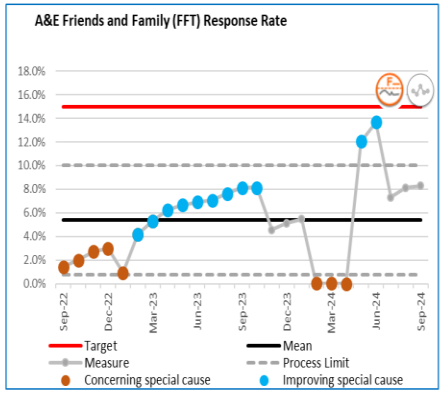


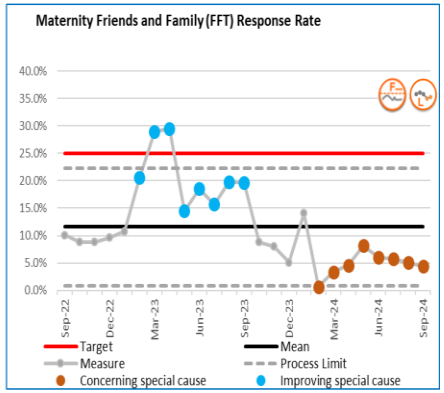


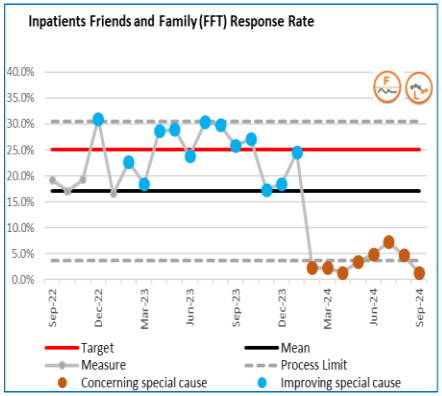


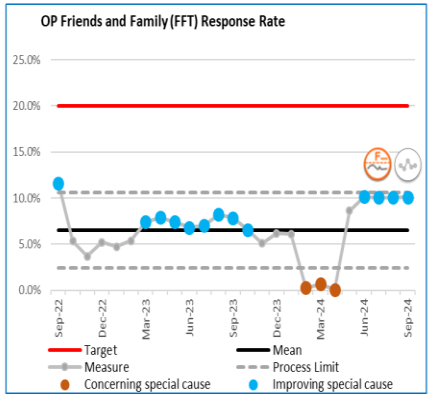




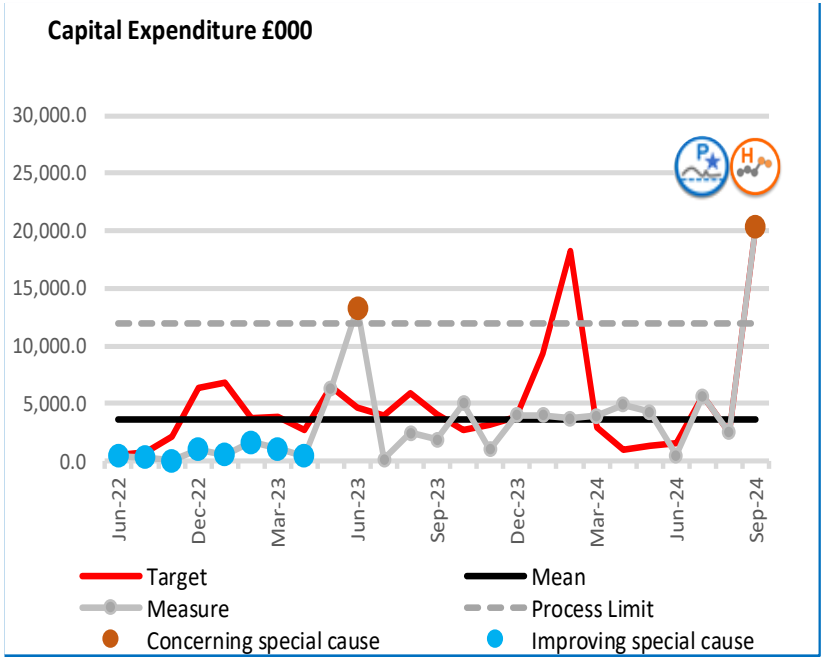


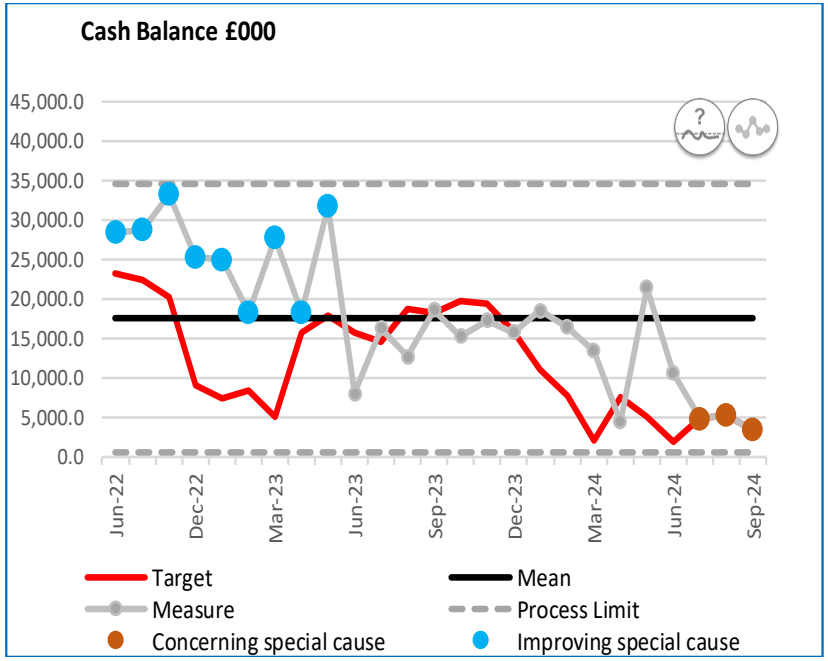




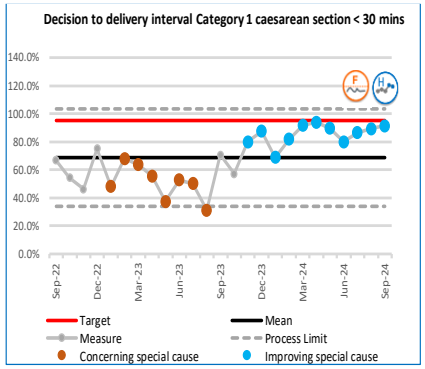


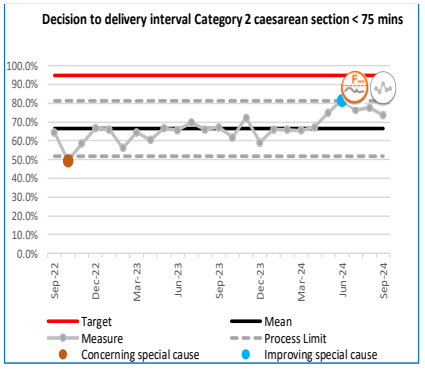
Forecast SPCs (3 month forward view) for Sustainability Indicators

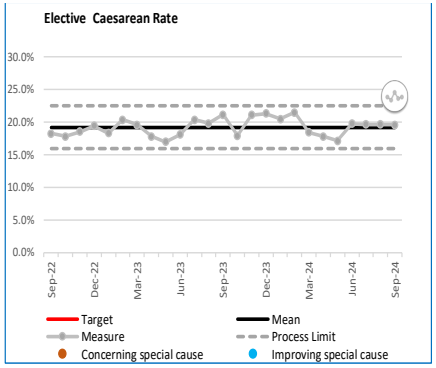


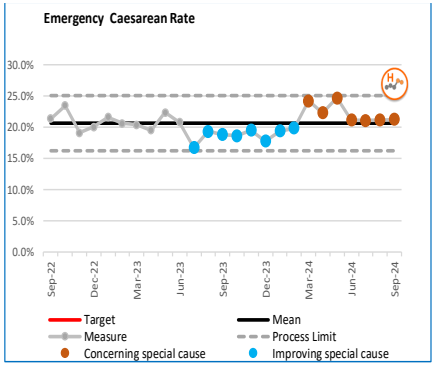


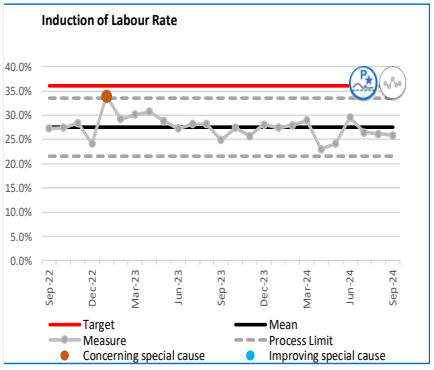
Forecast SPCs (3 month forward view) for Maternity Indicators

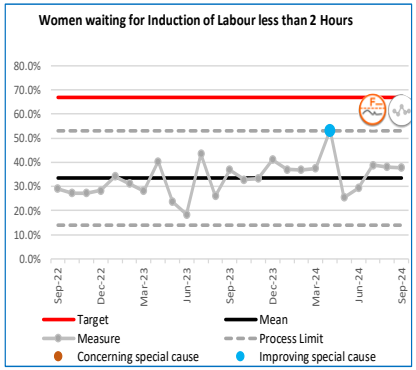


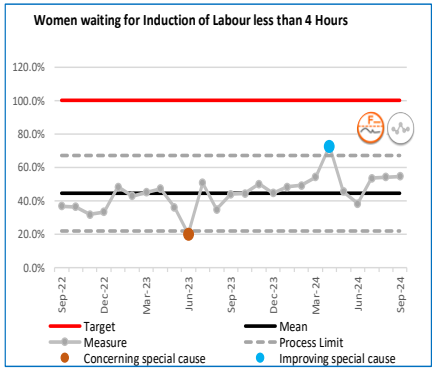


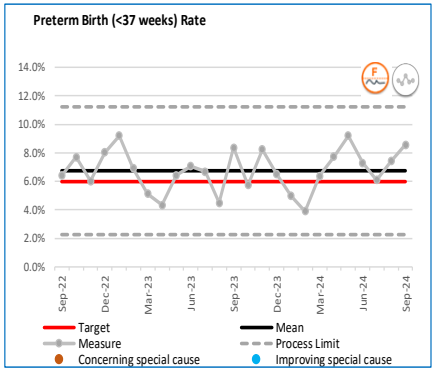


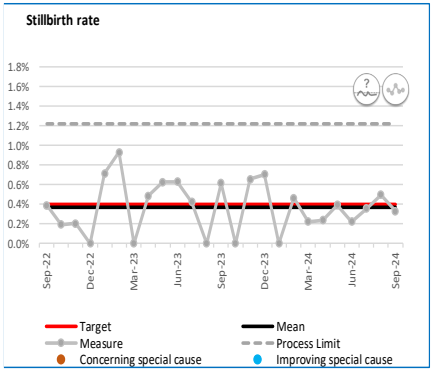


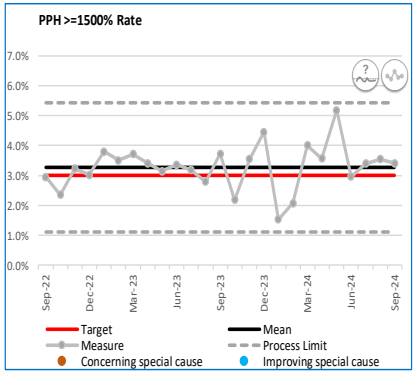


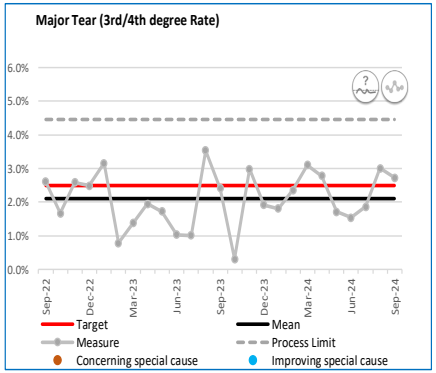


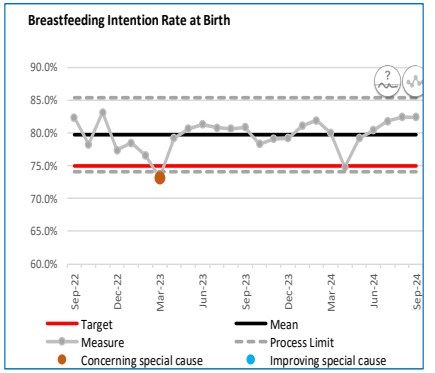






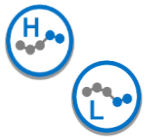






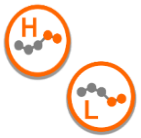
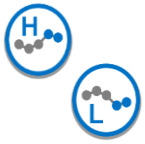
SDR Business Rules Driven by the SPC Icons

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

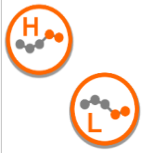
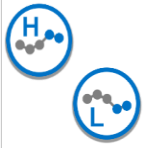
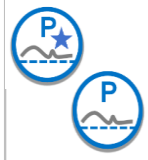
SDR Business Rules Driven by the SPC Icons

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:

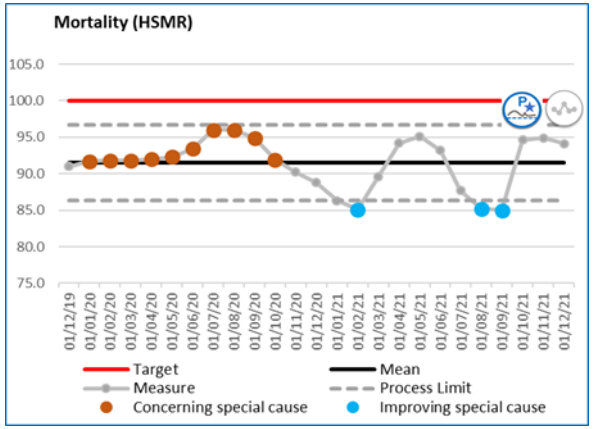
The **target** line **between** the **upper** and **lower** control limit for all metric types

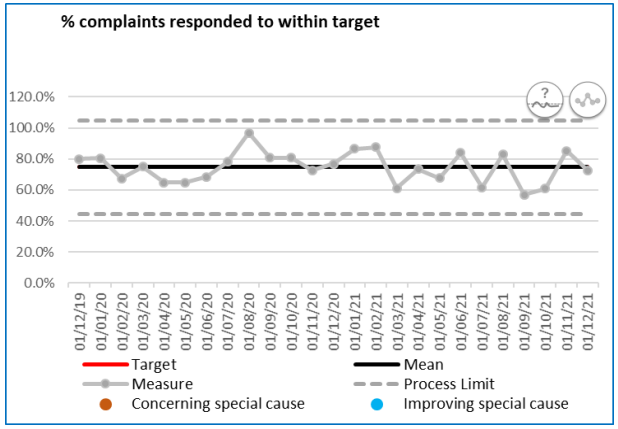
Metrics that consistently **fail** have:

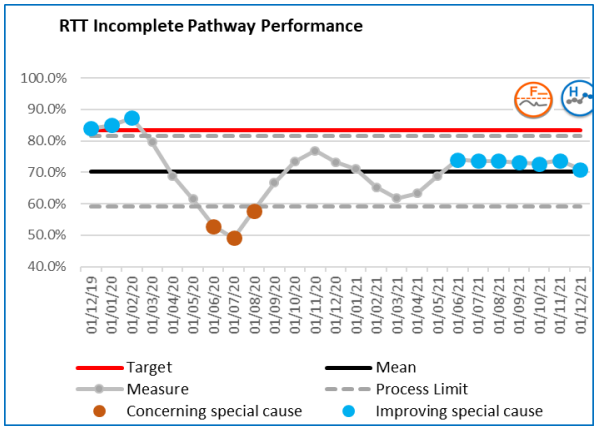
The **lower** control limit **above** the target line for metrics that need to be **below the target**

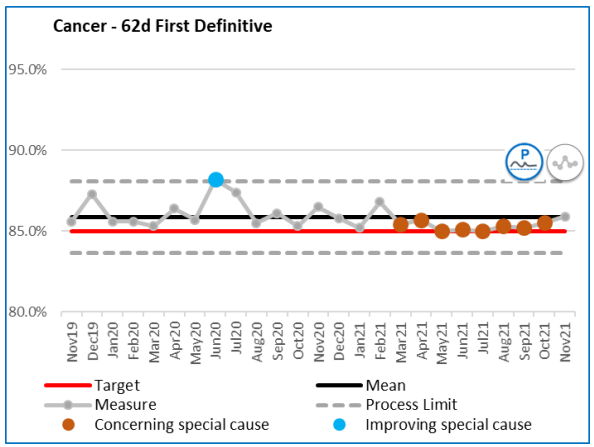
The **upper** control limit **below** the target line for metrics that need to be **above the target**

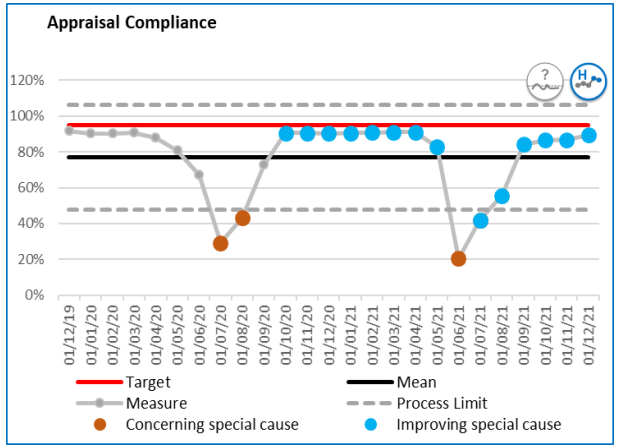
A metric not achieving the target for 6 months or more will be flagged as failing

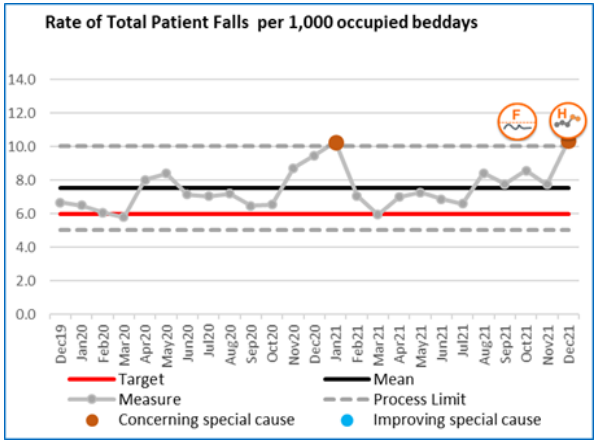












Maternity Metrics Definitions

Type	Section	Metric Name	Measure	Definition	Calculation - extracted from E3	Target	Target source	Rationale for inclusion
Activity	Women Birthed	Number of births	Women birthed	Women who gave birth (includes all registerable live births and stillbirths).	Number of women birthed	> 470	Average births per month at MTW last 5 years	- For use as denominator - Indicator of workload - Trends
	Caesarean birth	Elective caesarean birth rate	Elective	Women who gave birth that had elective caesarean section as the method of birth (Category 4 CS only).	Number of women birthed by an elective caesarean section	NA	National recommendation not to set targets for type of birth	- Provide insight into contributing factors for total c/s rate - Maternal risks - Impact on baby care and feeding - Length of stay
		Emergency caesarean birth rate	Emergency	Women who gave birth that had an emergency caesarean section as the method of birth (Categories 1-3 CS only).	Number of women birthed by an emergency caesarean section	NA	National recommendation not to set targets for type of birth	- Provide insight into contributing factors for total c/s rate - Maternal risks - Impact on baby care and feeding - Length of stay
	Induction of labour	Induction of labour rate	% of women	Women who commenced induction of labour with prostaglandins, artificial rupture of membranes or a syntocinon drip when not in labour	Number of women with onset of labour is induced	< 36%	Average National Rate (March 2024)	- Indicator of workload - Trends
Bookings	Number of new Bookings	Bookings	No of women	Women who have the first booking visit with the midwife, including transfers in where a previous booking visit has taken place out of area.	Number of women booked	> 545	Average bookings per month at MTW last 5 years	- For use as denominator - Indicator of workload - Trends
Clinical Indicators	Timely EMCS	Category 1 caesarean birth - decision to birth ≤ 30 mins	% of women	Women having Category 1 caesarean section within 30 minutes of decision for procedure	The % of all women having Cat 1 C-section with decision to birth interval less than or equal to 30 minutes	100%	RCOG best practice	- Indicator of workload - Trends - Maternal & fetal risks
		Category 2 caesarean birth - decision to birth ≤ 75 mins	% of women	Women having Category 2 caesarean section within 75 minutes of decision for procedure	The % of all women having Cat 2 C-section with decision to birth interval less than or equal to 75 minutes	100%	RCOG best practice	- Indicator of workload - Trends - Maternal & fetal risks
	Maternal Morbidity	Post partum haemorrhage ≥ 1500ml	% of women	Women who gave birth who had a measured blood loss of 1500ml or over	Number of women who have birthed with PPH ≥ 1500ml	< 3%	National Maternity Dashboard average	- Morbidity & mortality - Length of stay
		3rd/4th degree tear	% of women	Women with a vaginal birth (spontaneous or assisted) who sustained a 3rd or 4th degree perineal tear	Number of women with 3rd and 4th degree tear, by women having a vaginal birth	< 2.5%	National Maternity Dashboard average	- Potential long term impact - Morbidity & mortality - Length of stay
	Breastfeeding	Women who intend to breastfeed following birth	% of women	Women whose intention is to breastfeed their baby/ies at the time of birth.	Number of women with intention to breastfeed at time of birth	> 75%	National Maternity Dashboard average	- Infant health benefits - Maternal health benefits - Trends
	Premature births	Premature births <37 weeks gestation	% of births	Live babies born who are born less than or equal to 36+6 weeks	Number of preterm births at less than or equal to 36+6 weeks by the total births	< 6%	Saving Babies Lives Care Bundle national target	- Reducing premature births is a national target - Morbidity and mortality - Length of stay - Trends
	Neonatal morbidity & mortality	Stillbirth rate	per 1000 births	All babies stillborn after 24 weeks gestation	Number of stillbirths	< 4	2022 ONS data	- Reducing stillbirths is a national target - Mortality - Trends
		Unanticipated admission to NNU >37 weeks	% of births	All babies born on or after 37 weeks who are admitted to the neonatal unit	Number of admissions to NNU by number of births after 37 weeks gestation	< 4%	National Standard (ATAIN)	- Reducing avoidable term admissions to NNU is a national target - Morbidity and mortality - Length of stay - Experience - Trends
	Timely Procedures	Induction of labour delayed < 2 hours	% of women	Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 2 hours of identification that the	The % of all women having induction of labour who transfer within 2 hours	67.0%	Local target to aim for improvement	- Indicator of workload - Trends - Maternal & fetal risks
		Induction of labour delayed < 4 hours	% of women	Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 4 hours of identification that the	The % of all women having induction of labour who transfer within 4 hours	100.0%	Local target to aim for improvement	- Indicator of workload - Trends - Maternal & fetal risks

Executive Summary

- The Trust was £4m in deficit in June which was £0.3m adverse to plan. Year to date the Trust is £8.5m in deficit which is £1.1m adverse to plan.
- The key year to date pressures are CIP slippage (£1.9m), unfunded escalation costs (£0.7m), net CDC slippage (£0.8m), unfunded impact of industrial action (£0.3m) and Fordcombe hospital adverse to plan by £0.2m. These pressures were partly offset by variable activity overperformance (£1.5m release of service development and contingency budgets (£1.1m) and underspend against depreciation (£0.1m)
- Cost Improvement Plans (CIP) was adverse to plan by £0.8m in June and year to date are £1.9m behind plan.
- The Trust is forecasting to deliver the planned breakeven position however there are challenges relating to unidentified CIP and the need to recover the year to date deficit.

Current Month Financial Position

- The Trust was £4m in deficit in the month which was £0.3m adverse to plan
- **Key Adverse variances in month are:**
    - CIP slippage in May was £0.8m which included £0.4m of unidentified phased CIP plan as well as slippage within the Medicine and Emergency division on pay related CIPs
    - Estimate impact of Junior Doctor Strike in June was £0.3m
    - Net CDC slippage (£0.2m)
    - Unfunded Ward escalation costs (£0.2m)
- **Key Favourable variances in month are:**
    - Overperformance on ERF/Variable related income by £0.8m
    - The Trust released £0.4m relating to Service development and contingency budgets offset income and expenditure pressures incurred

Year to Date Financial Position

- The Trust is £8.5m in deficit which was £1.1m adverse to plan
- **Key Adverse variances in month are:**
    - CIP Slippage (£1.9m)
    - Unfunded Ward escalation costs (£0.7m)
    - Net CDC slippage (£0.8m)
    - Estimate impact of Junior Doctor Strike in June was £0.3m
    - Fordcombe Hospital adverse to plan by £0.2m
- **Key Favourable variances in month are:**
    - ERF/Variable activity overperformance (£1.5m)
    - The Trust released £1.1m relating to Service development and contingency budgets offset income and expenditure pressures incurred
    - Underspend against the depreciation plan (£0.1m)

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In June the Trust saved £1.5m which was £0.8m adverse to plan, year to date the Trust is £1.9m adverse to plan.

Cashflow position:

- The closing cash balance at the end of June was £10.6m. The Trust receives its monthly block SLA income on the 15th of each month so the month-end cash balance is required to cover commitments for the first two weeks of the following month – this includes weekly supplier payment runs and weekly payroll including 247-time agency.
- The cash flow forecast is based on the Income and Expenditure plans as well as planned working capital movements. The year to date Income and Expenditure position is a £8.5m deficit which is £1.1m adverse to plan, this deficit adversely impacts the cash position. The cashflow is updated daily and the forecast is regularly updated and reviewed if costs during the year increase eg; salaries are higher than plan and the remaining months are amended to be in line with the current charges.
- The Trust is working closely with local NHS organisations and agreeing "like for like" arrangements when possible to reduce the debtor/creditor balances for both organisations. However, as cash positions with the local NHS organisations are all tight, there will be no cash gain from these agreements but it enables a reduction to both debtors/creditors balances.
- In June the Trust applied for Working Capital Support PDC of £9.98m to assist the Trust's cash position. In July the Trust received confirmation from NHSE that it was successful with its application and has been awarded £9.2m capital PDC which is expected to be given towards the end of July.

Capital Position

Capital Plan

- The Trust's capital plan, excluding IFRS16 leases, for 2024/25, is **£26.531m**. The Trust's share of the K&M ICS control total is **£19.412m** for 2024/25, including £10.134m from system funds (CDC £2.134m, Cardiology £3m and Urgent and Emergency Care (UEC) Winter Incentive £5m). The Trust also plans to receive National funding of **£5.343m** (CDC £1.9m, Frontline Digitisation £2.790m and Digital Pathology £653k)

Other Funds

- PFI lifecycle spend per the Project company model of **£1.5m** - actual spend will be notified periodically by the Project Company. Donated Assets of **£200k** relating to forecast donations in year.

Month 3 Actuals (excluding IFRS16)

- The YTD spend at M3 is **£2.584m** against a YTD budget of **£3.31m**.

The KMOC project completion has been delayed - there may be risk relating to the financial budget which needs to be worked through. Initial quotes relating to diagnostic equipment enabling works indicate elements which are significantly more expensive that previously planned. Review of the design and quotes is currently being undertaken by the Core Clinical Division and Estates.

Leased/IFRS16 capital

- The Trust included £25.456m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£22.092m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.364m). This is subject to approval and confirmation of this element of the financial regime in terms of final ICS allocations for 2024/25. The most significant element of the additions is the initial lease capitalisation of the Kent and Medway Medical School Accommodation building

(£16.5m) on the TWH site that the Trust will recognise under IFRS 16 when it becomes available for use.

Risks

- **Outstanding contract discussions with Commissioners** - Contracts have been signed with Kent and Medway (K&M) however work is ongoing with commissioners to negotiate various contract adjustments in relation to: Elective Recovery Fund (ERF) variable target, Virtual Ward, Bariatrics, Repatriation, K&M Orthopaedic Centre (partially funded), Capital Charges Support, Tobacco Dependency, QFIT and Overseas Patient Debt Share.
- **System contract total reduction (£2m)** - The contract with K&M has been signed inclusive of a £2m reduction. The Trust plan (submitted June 24) assumed non recurrent income of £2m, a funding source has yet to be identified.
- **Unidentified Efficiencies -** Work is on-going to reduce the level of unidentified efficiencies, it is expected that the current gap is closed through a combination of additional schemes and Non-recurrent measures yet to be confirmed.
- **Kent and Medway Orthopaedic Centre (KMOC)** - The Trust plan included £21.6m for KMOC which was based on a expected opening of July 24. The recently announced extended delay to opening of KMOC to September creates a financial risk to the position from July onwards which will need to be managed by the Division and mitigated.

Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position however there are challenges relating to unidentified CIP and the need to recover the year to date deficit.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 3
2024/25

Maidstone and Tunbridge Wells NHS

Summary

June 2024/25

	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	61.5	64.0	(2.5)	0.1	(2.6)	186.2	186.6	(0.4)	0.9	(1.3)
Expenditure	(60.9)	(63.2)	2.3	(0.1)	2.4	(181.3)	(180.5)	(0.8)	(0.9)	0.1
EBITDA (Income less Expenditure)	0.6	0.7	(0.2)	(0.0)	(0.2)	4.9	6.1	(1.1)	(0.0)	(1.1)
Financing Costs	(4.0)	(4.0)	(0.1)	0.0	(0.1)	(24.2)	(24.2)	0.0	0.0	0.0
Technical Adjustments	(0.5)	(0.5)	(0.0)	0.0	(0.0)	10.8	10.8	(0.0)	0.0	(0.0)
Net Surplus / Deficit	**(4.0)**	**(3.7)**	**(0.3)**	**(0.0)**	**(0.3)**	**(8.5)**	**(7.3)**	**(1.1)**	**(0.0)**	**(1.1)**
Cash Balance	10.6	1.9	8.7		8.7	10.6	1.9	8.7		8.7
Capital Expenditure (Incl Donated Assets and IFRS16)	0.7	1.5	0.7		0.7	3.0	3.8	(0.7)		(0.7)
Cost Improvement Plan	1.5	2.3	(0.8)		(0.8)	4.1	6.0	(1.9)		(1.9)

Summary Current Month:
- The Trust was £4m in deficit in the month which was £0.3m adverse to plan.

Key adverse variances in month are:
- CIP slippage in June was £0.8m which included £0.4m of unidentified phased CIP plan as well as slippage within the Medicine and Emergency division on pay related CIPs.
- Estimate impact of Junior Doctor Strike in June was £0.3m
- Net CDC slippage (£0.2m) , Unfunded Ward escalation costs (£0.2m)

Key favourable variances in month are:
- The Trust benefitted by overperformance on ERF/Variable related income by £0.8m in the month. The Trust released £0.4m relati ng to Service development and contingency budgets in June to help offset income and expenditure pressures incurred.

Year to date overview:
- The Trust is £7.5m in deficit which is £1.1m adverse to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£1.9m)
- Unfunded Ward escalation costs (£0.7m)
- Net CDC slippage (£0.8m)
- Estimate impact of Junior Doctor Strike in June was £0.3m and Fordcombe Hospital adverse to plan by £0.2m

Favourable Variances
- ERF/Variable activity overperformance (£1.5m)
- The Trust released £1.1m relating to Service development and contingency budgets offset income and expenditure pressures incu rred
- Underspend against the depreciation plan (£0.1m)

CIP (Savings)
- The Trust has a savings target for 2024/25 of £37.3m. In June the Trust saved £1.5m which was £0.8m adverse to plan.

Forecast
- The Trust is forecasting to deliver the planned breakeven position however there are challenges relating to unidentified CIP and the need to recover the year to date deficit.

Jun-24		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	112.6%	120.7%	-	-	117.7%	150.4%	-	-	44.0%	58.2%	100	7.04	21	9.8	-	-	5	-		190,137	240,666	(50,529)
MAIDSTONE	Stroke Unit (M) - NK551	96.4%	100.7%	-	100.0%	98.4%	101.3%	-	100.0%	31.2%	7.2%	122	8.45	8	8.2	10.5%	100.0%	1	-		226,803	243,836	(17,033)
MAIDSTONE	HASU (34) - NK552	99.4%	96.6%	-	-	104.4%	100.0%	-	-	33.6%	14.0%	121	8.61	14	11.5	#N/A	#N/A	4	1		147,542	157,459	(9,917)
MAIDSTONE	Cornwallis - NS251	109.5%	95.1%	-	-	111.1%	111.6%	-	-	14.6%	46.4%	82	5.60	6	15.9	15.5%	100.0%	3	-		123,347	141,901	(18,554)
MAIDSTONE	Culpepper Ward (M) - NS551	100.2%	87.6%	-	-	100.0%	127.9%	-	-	26.3%	14.8%	12	0.84	0	4.9	40.0%	100.0%	0	-		120,901	130,929	(10,028)
MAIDSTONE	Edith Cavell - NS459	124.3%	100.9%	-	100.0%	105.1%	155.8%	-	-	34.8%	56.7%	35	2.35	4	11.5	-	-	6	3		123,625	143,233	(19,608)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	90.2%	94.5%	-	-	100.2%	82.5%	-	-	23.9%	3.6%	81	5.88	18	7.1	11.1%	100.0%	2	-		187,980	189,729	(1,749)
MAIDSTONE	Intensive Care (M) - NA251	88.4%	76.9%	-	-	96.6%	90.0%	-	-	7.1%	0.0%	41	2.89	7	46.5	200.0%	100.0%	0	-		245,106	233,150	11,956
MAIDSTONE	Lord North Ward (M) - NF651	98.7%	102.4%	-	100.0%	95.5%	100.0%	-	-	17.2%	0.0%	41	2.90	6	7.1	16.7%	80.0%	1	-		119,377	120,780	(1,403)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	3.2%	0.0%	-	-	0.0%	-	-	-	1.1%	0.0%	3	0.15	0		0.0%	88.5%	1	-		0	-34,096	34,096
MAIDSTONE	Mercer Ward (M) - NJ251	104.3%	103.5%	-	100.0%	101.1%	141.2%	-	-	38.2%	24.5%	57	3.92	0	6.5	10.7%	100.0%	2	-		120,235	167,344	(47,109)
MAIDSTONE	Peale Ward COVID - ND451	101.0%	121.2%	-	-	98.9%	159.7%	-	-	27.9%	9.4%	47	3.31	1	9.1	3.3%	100.0%	1	2		109,875	101,734	8,141
MAIDSTONE	Pye Oliver (Medical) - NK259	125.7%	145.2%	-	-	127.5%	171.7%	-	-	76.8%	54.8%	161	11.41	10	9.1	20.5%	77.8%	7	2		182,314	221,225	(38,911)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	95.2%	82.2%	-	-	84.3%	-	-	-	10.4%	0.0%	11	0.69	0	42.7	0.0%	100.0%	0	-		71,233	66,576	4,657
MAIDSTONE	Whatman Ward - NK959	91.1%	95.1%	-	-	100.0%	124.6%	-	100.0%	40.2%	6.9%	82	5.69	15	6.7	4.0%	100.0%	1	2		150,355	175,273	(24,918)
MAIDSTONE	Maidstone Birth Centre - NP751	103.2%	101.3%	-	-	102.1%	96.7%	-	-	14.4%	0.0%	34	1.65	0	40.4	0.0%	100.0%	0	-		87,006	93,899	(6,893)
TWH	Acute Medical Unit (TW) - NA901	99.7%	119.4%	-	100.0%	107.5%	136.5%	-	-	44.1%	43.2%	159	11.33	29	9.8	-	-	7	-		229,069	299,525	(70,456)
TWH	Coronary Care Unit (TW) - NP301	90.0%	69.6%	-	-	100.0%	-	-	-	15.2%	0.0%	19	1.45	9	11.2	-	-	2	-		77,556	75,438	2,118
TWH	Hedgehog Ward (TW) - ND702	127.9%	109.9%	-	-	131.1%	110.2%	-	-	53.8%	63.1%	245	16.59	13	11.4	1.6%	100.0%	2	-		203,244	225,693	(22,449)
TWH	Intensive Care (TW) - NA201	103.5%	80.9%	-	-	98.8%	81.6%	-	-	6.0%	0.0%	69	4.66	2	31.7	-	-	1	1		389,675	413,501	(23,826)
TWH	Private Patient Unit (TW) - NR702	100.9%	96.0%	-	-	100.0%	96.5%	-	-	21.3%	0.0%	12	0.79	0	8.8	35.0%	85.7%	0	-		75,011	82,234	(7,223)
TWH	Ward 2 (TW) - NG442	86.8%	96.4%	-	100.0%	100.0%	124.3%	-	100.0%	35.7%	19.7%	92	6.02	26	7.0	-	-	10	-		199,272	204,529	(5,257)
TWH	Ward 10 (TW) - NG131	27.3%	37.1%	-	100.0%	32.0%	33.3%	-	-	15.4%	3.5%	62	4.23	16	10.8	2.1%	-	0	-	This data is low as ward 10 was deescalated during June 2024	174,596	170,189	4,407
TWH	Ward 11 (TWH) Nov 2019 - NG144	102.2%	96.6%	-	-	95.6%	100.0%	-	-	27.2%	1.2%	70.00	4.75	13.00	7.3	12.3%	88.9%	3	1		0	118,536	(118,536)
TWH	Ward 12 (TW) - NG132	106.9%	96.2%	-	100.0%	120.8%	96.6%	-	100.0%	41.3%	30.9%	158	10.69	28.00	7.1	3.1%	-	8	2		153,100	179,496	(26,396)
TWH	Ward 20 (TW) - NG230	119.2%	137.8%	-	100.0%	137.2%	124.2%	-	-	52.4%	60.7%	172	11.90	25	8.5	14.6%	83.3%	13	-		202,861	224,745	(21,884)
TWH	Ward 21 (TW) - NG231	97.6%	80.4%	-	100.0%	95.3%	101.1%	-	-	27.9%	4.8%	86	5.42	20	6.7	8.5%	100.0%	1	1		177,343	188,891	(11,548)
TWH	Ward 22 (TW) - NG332	96.3%	113.1%	-	100.0%	99.9%	135.8%	-	-	39.5%	20.8%	74	5.03	8	7.1	2.4%	100.0%	11	-		170,934	196,218	(25,284)
TWH	Ward 30 (TW) - NG330	99.1%	82.4%	-	100.0%	100.8%	115.3%	-	100.0%	25.1%	0.0%	80	4.73	6	6.9	22.2%	75.0%	7	2		149,810	183,893	(34,083)
TWH	Ward 31 (TW) - NG331	101.2%	99.0%	-	100.0%	99.2%	105.0%	-	-	10.3%	0.0%	39	2.22	7	6.8	13.9%	60.0%	9	1		154,124	191,488	(37,364)
TWH	Ward 32 (TW) - NG130	93.0%	101.5%	-	100.0%	95.8%	121.7%	-	100.0%	18.5%	0.0%	63	4.21	15	9.6	0.0%	87.5%	4	-		154,471	165,437	(10,966)
TWH	Ward 33 (Gynae) (TW) - ND302	97.4%	92.7%	-	-	101.5%	87.4%	-	-	44.5%	1.3%	65	4.22	7	7.1	-	-	0	-		105,089	105,760	(671)
TWH	SCBU (TW) - NA102	108.1%	150.6%	-	-	122.8%	64.3%	-	-	27.8%	13.9%	122	7.61	4	11.9	-	-	0	-		217,172	231,307	(14,135)
TWH	Short Stay Surgical Unit (TW) - NE901	80.5%	73.9%	-	100.0%	101.7%	100.0%	-	-	4.7%	0.0%	10	0.68	0	12.0	14.9%	100.0%	1	-		89,352	91,981	(2,629)
TWH	Surgical Assessment Unit (TW) - NE701	100.2%	100.0%	-	-	100.0%	100.0%	-	-	5.3%	0.0%	4	0.29	0	19.3	5.8%	100.0%	0	-		80,409	78,549	1,860
TWH	Midwifery (multiple rosters)	80.7%	73.2%	-	-	83.7%	94.6%	-	-	0.0%	No hours	797	44.90	158	**14.7**	47.1%	92.0%	**0**	-		1,373,379	1,335,003	38,376
Crowborough	Crowborough Birth Centre (CBC) - NP775	72.1%	77.6%	-	-	100.0%	100.0%	-	-	26.0%	0.0%	51	3.37	3	151.9	61.5%	87.5%	0	-		71,231	75,496	(4,265)
MAIDSTONE	Accident & Emergency (M) - NA351	103.2%	112.3%	-	100.0%	103.3%	115.0%	-	100.0%	44.1%	34.2%	398	26.47	12	-	0.0%	82.2%	5	-		380,477	474,296	(93,819)
TWH	Accident & Emergency (TW) - NA301	100.9%	80.1%	-	100.0%	101.7%	81.7%	-	100.0%	40.6%	22.3%	411	28.43	15	-	12.4%	81.9%	7	-		422,802	499,763	(76,961)

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%

Total Established Wards	**7,456,813**	**8,205,608**	**(748,795)**
Additional Capacity bed Cath Labs	59,124	51,820	7,304
Foster Clarke	0	-4,561	4,561
Ward 11 (TW) Winter E	0	0	0
KMOC	297,101	226,222	70,879
Other associated nursing costs	5620010.00	5344996.04	275013.96
Total	13,433,048	13,824,084	(391,036)

NHS Maidstone and Tunbridge Wells NHS Trust

Six-monthly update on the implementation of the sexual safety in healthcare charter — **Chief People Officer**

Summary / Key points

The Trust Board approved the signature to the sexual safety in healthcare in January 2024 and made a commitment to the pledges and implementation of further support and policy to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.

Since this commitment there has been ongoing work to develop a project to introduce a restorative and just culture within the Trust that will support the approach that is taken in response to employee relations cases.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To approve the signature of the sexual safety in healthcare charter on behalf of the Trust

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

Update and Overview of Next Steps and Progress to date (progress in blue)

The following update is provided for the Trust Board as an interim position on the Restorative and Just Practice Project and the focus on supporting and eradicating inappropriate behaviours of sexual harassment and abuse in the workplace.

1. We will actively work to eradicate sexual harassment and abuse in the workplace.

   The Trust Policy has been updated and strengthened to reinforce the expectation of zero tolerance in the workplace. Any complaints or concerns received through any route will result in an MDT serious case review and will identify the most effective course of action. This could be a mediated conversation, an OD or engagement intervention, through to a potential suspension and an immediate investigation put into place.

   The Policy also strengthens early intervention particularly in actions which cause issues of safety to be undermined in the workplace or could lead to individuals or groups feeling intimidated or abused.

2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.

   The Policy and training that will support the changes will also encourage a culture of speaking up and include active bystander training (ABT) which will be promoted to address sexual harassment, alongside other forms of poor behaviour, discrimination, and harassment.

   We will also review an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.

3. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.

   We have a number of active support mechanisms available which includes our Freedom to Speak up Guardian; our wellbeing team; access to the EAP Employee Assistance Programme; in-house psychologists; People and OD team; staff side/union support and safe space champions and network chairs.

4. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.

   As part of the launch of the revised policy and training we will also include a significant focus on restorative practice and just culture – this will cover the principle focus of ensuring that where appropriate we can maintain and develop ongoing positive relationships as well as ensuring that accountability is recognised and responded to.

   A number of colleagues in the People and OD team have undertaken formal Restorative Practice Training with Mersey Care NHS Foundation Trust and Northumbria University which is a four-day course on the principle and practises of Restorative Just Culture, which is also part of the learning encouraged in the NHS plan; We are the NHS: People Plan 2020/21 – action for us all.

5. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.

   This is covered in the updates above.

6. We will ensure appropriate, specific, and clear training is in place.

   This is covered in the update and plan above.

7. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.

The Trust has a number of ways which staff can report unwanted inappropriate sexual behaviour:

- Through the Freedom to Speak up Guardian and FTSU champions
- Through our safe space champions
- On the In-Phase reporting system
- To a member of the People and OD Team
- To a trusted colleague or line manager
- To a Trade union/staff side representative
- To the FTSU Trust Board champion directly.

8. We will take all reports seriously and appropriate and timely action will be taken in all cases.

   The strengthening of the Trust Policy and the introduction of serious case reviews for any concern that is raised which includes inappropriate behaviour of sexual conduct ensures that a full consideration of the context and background of the complaint as well as potentially wider team dynamics or psychological safety in the workplace.

9. We will capture and share data on prevalence and staff experience transparently.

   All cases including inappropriate sexual behaviour is recorded in our case management system and is also reported to the Trust Board in confidence on a monthly basis, anonymised for the protection of the person/persons concerned.

These commitments will apply to everyone in our organisation equally.

In addition to the updates above the Trust is also an active member of the NHSE National Lead Group which is producing and developing significant resources to support Trusts with training, learning, policy and support documents to further enhance the approach to zero tolerance in the workplace.

Next Steps:

	Compassionate leaders who are visible, listen, and take action based on feedback.	Pause & Reflect introduced- Super clear process of escalation, timings, and unbiased feedback.	Common clear language and shared understanding.	Regular team check-ins for support and learning Campaign focused on civility and respect	Sexual Safety
In order to achieve	**Leadership & Accountability**	**Equitable processes & new approach to informal resolution**	**A common language understood by all**	**Restorative practice in teams, reduction in bullying and harassment**	**Meeting our commitments from sexual safety charter**
Actions	intentional work/actions involving senior leaders (board to mid management) Sept-Further adoption into ElfA and Managers fundamentals	July -Introduce a Pause and Reflect process and policy for resolution of all appropriate concerns before a formal stage. Capture baseline data on grievances, time to resolve Ensure all ER/PBP and key colleagues trained and informed Sept-Scope training for managers as part of HR manager training	July 24: Engagement with trust-wide colleagues around how 'restorative just culture' translates to them Sept 24: Culture change plan group to review colleague feedback and agree common language	July-Civility and Respect (review and rolling out of toolkit regarding bullying, harassment and sexual safety, review of Kindness into Action) People Promise Project From Sept 24: Pilot work in - Cancer Division for restorative practice, KIA and pause and reflect FTSU/Safe Space plans PSIRF & PFIS (this doesn't need to be duplication but just highlighting there is a shared vision and any key actions)	Now-External Training for ER and PBPs Sept-Review of policy following training Nov-Training for Leaders and Managers Incorporation of specific sexual safety data, review and actions into Civility and Respect Action plan
Leads	Ainne, Natalie and Sarah	Sally/Rob Lucy/Liam	Jennie	OD Consultants In partnership with FTSU/SSC and Staff-side Tia	Sally/Lucy/Liam Tia
Stakeholders	Board, SL Forum	Staff Side, networks, people managers	POD, Staff networks, staff side	Pilot team, Comms, PPE project team	Staff side, PPE project team

NHS Maidstone and Tunbridge Wells NHS Trust

Annual approval of the Trust's Green Plan **Chief Executive**

Overview

- The Green Plan was approved in July 23 and therefore has been in place for the last year.
- The Green Committee and Champion Networks have met every quarter and some real progress has been made.
- There are now 60 Green Champions across the Trust.
- Driving ahead with the Green Plan objectives.
- Making progress on reducing the Trust's carbon footprint.
- Great support from the Communications Team who have delivered a communications plan and provide regular digital updates.
- Recruited a Sustainability Manager.
- Many projects in progress – both clinical and non-clinical.
- Received some external funding for a decarbonisation plan for MTW and completion of LED lighting at Tunbridge Wells Hospital.

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

- Executive Team Meeting, 18/06/24
- Finance and Performance Committee, 25/06/24

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

Objectives due for delivery 23/24 FY

Green Pillar	Description	Agreed target	23/24 progress			Update/Comments
			Starting out	Working towards	Achieved	
Workforce & system leadership	The Green Strategy will be revised	Jun-23				Approved by Board July 23
	Launch our Green Champion Network	Sep-23				In place with 1/4ly meetings at both acute sites
	Ensuring sustainability & decarbonisation are considered as part of all decision making	Dec-23				Now in procurement T&Cs, considering for all new builds and replacement
	Expand Green Champions Network	Mar-25				Recruiting new members gradually as comms gets to wider Trust
Sustainable clinical care models	Environment & social sustainability assessments are included as standard within business cases and service redesign plans	Dec-23				Part of business case process. Aiming to embed across all service re-designs
	Agree with commissioners opthamology services that could be transferred into community settings	Dec-23				Progressed with transferring stable glaucoma patients to the community provision. This is being done by MTW at the moment with the issue still ongoing with the ICB. The main discussion with them is to ensure parity of community provision.
	Virtual ward implemented caring for 157 patients (3,658 bed days)	Mar-24				VW has cared for nearer 700 patients now, saving over 3000 bed days. Now rolled out across 12 pathways.
Digital transformation	Develop a digital Trust strategy	Dec-23				The Digital Strategy has been written and approved
	Implement the patient portal	Mar-24				Phase 1 of the programme has been deployed.
Estates	Launch an energy efficiency campaign	Sep-23				Energy saving information and literature produced for dissemination
	Establish agreed consumption expectations/measures for MH	Mar-24				We have predicted energy consumptions as a feature of the budgeting process
Climate Adaption	Establish climate change adaptation working group	Dec-23				Part of the Trust Resilience Committee who already discuss climate change and risk – flooding , heatwave etc. The TORs will be amended to reflect the addition/change.
	Establish a clear and achievable trajectory for carbon reduction to monitor progress towards net zero	Dec-23				A Heat Decarbonisation plan is written for Maidstone and funding applied for at TWH. These will inform the trajectory.

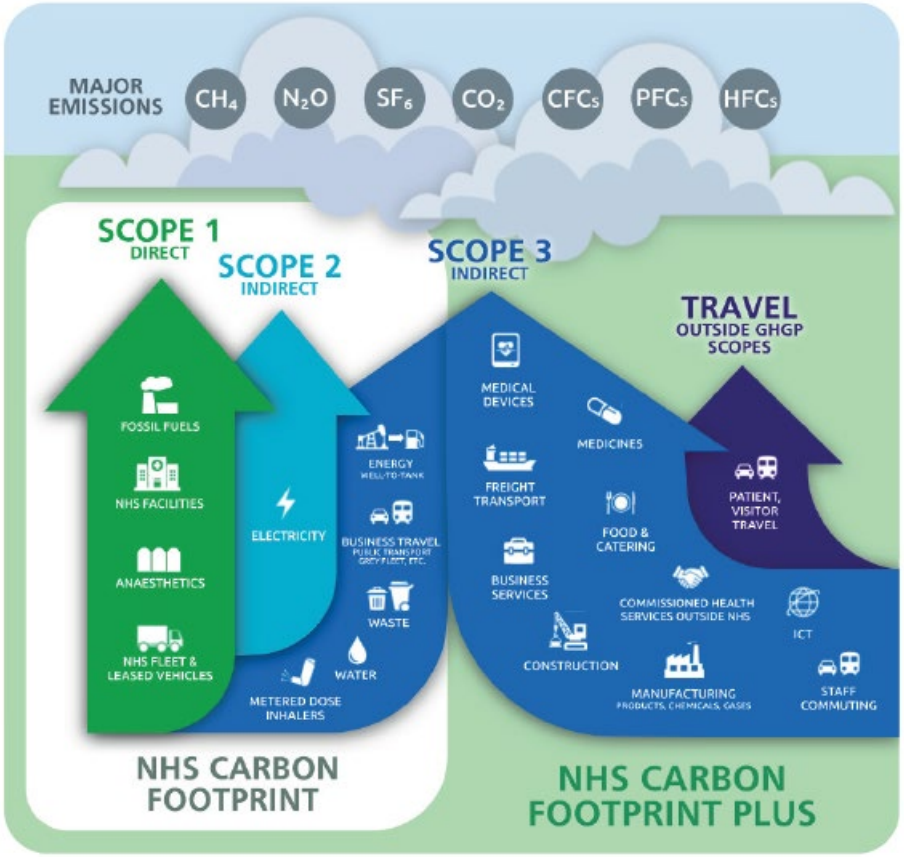
Objectives due for delivery 23/24 FY (cont)

Green Pillar	Description	Agreed target	23/24 progress			Update/Comments
			Starting out	Working towards	Achieved	
Facilities	Relaunch our waste strategy across the Trust	Dec-23				Relaunched as part of waste contract changes
	Deliver a campaign to change behaviour of staff and visitors	Mar-24				Ongoing continuous education. Sharpsmart now attending SWG. Education through variable media sources i.e. posters, pulse, trust intranet, L&D.
	Set up a clinically led taskforce to create a focus on single-use plastics	Mar-24				Partnership working with procurement & Sharpsmart established. Both attending monthly SWG- workstream ongoing.
Travel & transport	Undertake a staff travel survey to track staff travel patterns	Dec-23				The annual travel survey was sent out in January 2024. 455 responses were received and the results have now been integrated within the Trust's Travel plans to support sustainable transport objectives.
	Develop a business case to introduce a park and ride scheme within the Trust	Dec-23				Business case has been presented to Exec for consideration
	Develop an in-house bid for the patient transport service when the G4S contract is tendered	Mar-24				At present no plans to develop
	Encourage sustainable travel through communications eg walking maps, incentives	Mar-24				Business cases are awaiting approval for park and ride schemes, additional EV chargers, and improved cycling facilities. Once approved these, and associated incentives, will be communicated to Trust staff.
Food & Nutrition	Undertake a benchmarking exercise that establishes the Trust's adherence to the national standards for Healthcare Food & Drink	Dec-23				An initial assessment grid has been completed and we are currently reviewing all Trust policies
	Replace all sauce sachets in the staff restaurants with re-usable bottles	Dec-23				Complete
	Reduce single use food packaging by 75%	Dec-23				Some already replaced but an ongoing project is underway
	Explore a full range of options and produce a business case for delivery of a paperless menu	Mar-24				Various demonstrations of systems have been undertaken. Digital menu discussed at Nutrition and Hydration Group as nursing input will be required in system selection and review. Being progressed.
Medicines	Purchase 2 trollies for nitrous oxide cylinders on the Maidstone site to enable decommissioning	Jun-23				Complete
	Decomission the nitrous oxide manifold at MH	Dec-23				Both MH and TWH sites decommissioned (TWH 1 year early)
	Build in consideration of moving propellants wherever possible as part of the procurement process	Dec-23				Complete
Supply chain & procurement	Reduce the contribution from medical devices by using from NHSE's 'opportunity dashboard' for remanufacturered devices	Dec-23				Procurement is already using the Product Opportunity Dashboard. JC uploads the opportunities as projects to Procurement's workplan.

3 year Priorities (July 23 to April 26)

	Progress			
3 YEAR PRIORITIES	Starting out	Working towards	Achieving	Update/Comments
Launch and develop the green champions network to drive change at grass roots level				In place and constantly reviewing to keep interest and drive change
Support and develop staff to have the competencies and skills to deliver sustainable healthcare within their areas of work				This is planned to be taken forward in Q2 2024/25 by the Workforce and System Leadership SWG.
Meet the national ambition of 25% of outpatients appointments being offered in virtual clinics				We have a strategy to offer virtual OP appts and this happens in a number of specialties. The average number of virtual OP appts for 22/23 was 27%, with every month consistently meeting or exceeding the 25% target.
Develop a digital and data strategy that will support delivery of the green plan				Strategy written and approved
Relaunch the waste strategy, supported by a comrehensive campaign to change the behaviour of staff and visitors				Relaunched as part of waste contract changes but requires further review to improve waste segregation
Secure funding to ensure that heating and hot water is provided without the use of fossil fuels as the primary heat source				Initial funding to carry our a decarb plan secured and plan written.
Complete a business case for installing on-site, self sufficient energy generation				Initial meetings held with various sources of funding to achieve this.
Launch an energy efficient campaign of empower staff to switch off any lighting and equipment not in use				We have produced some energy saving information and literature for dissemination
Cut business mileage by 20% supported by staff travel survey that will track and monitor staff travel patterns				Ongoing. Reviewing buses, cycle to work scheme etc to give staff alternative options to driving
Undertake a benchmark exercise to establish the Trust's adherence to the National Standards for Healthcare Food & Drink				Sachin Rai is leading on this – an initial assessment grid has been completed and we are currently reviewing all Trust policies.
Decommission the nitrous oxide manifold at MH and plan to decommission the manifold at TWH				Both completed, with TWH a year ahead of schedule.
Establish a baseline for stock that exceeds its expiry date and has to be placed in the waste and reduce it by 20%				As part of the theatre waste project, stock waste is recorded on a monthly basis to ensure consistency in the procurements dashboard. We are on track to achieve a reduction in waste.

Measures of Carbon Reduction

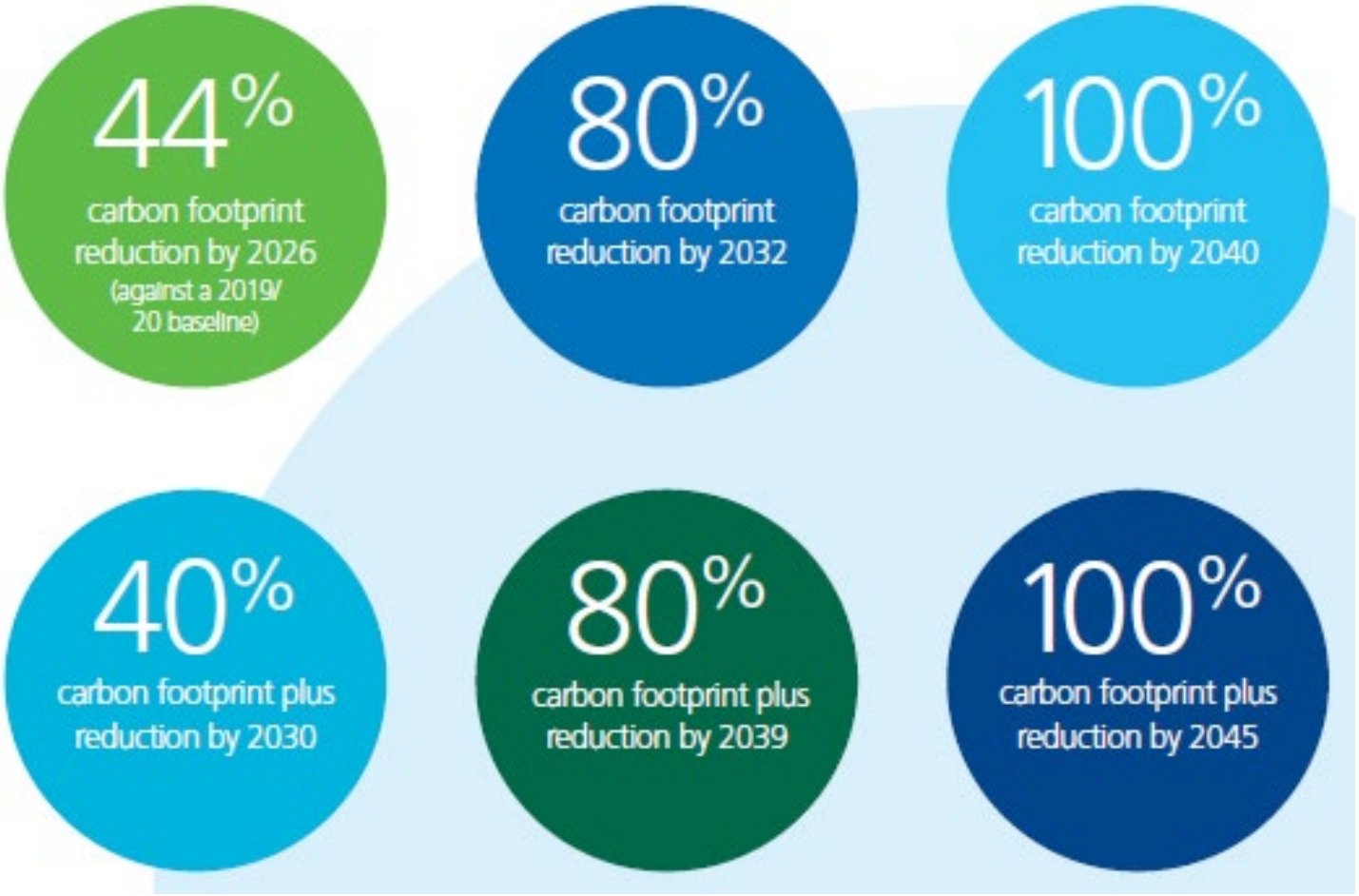


Our Green Plan details how the NHS has categorised it's carbon footprint.

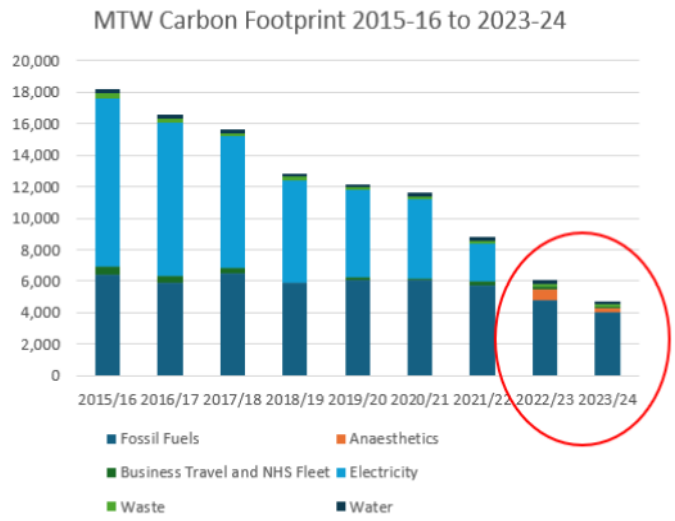
The NHS Carbon Footprint covers scope 1 (direct), scope 2 (indirect) and part scope 3 (indirect). This is easier for us to measure.

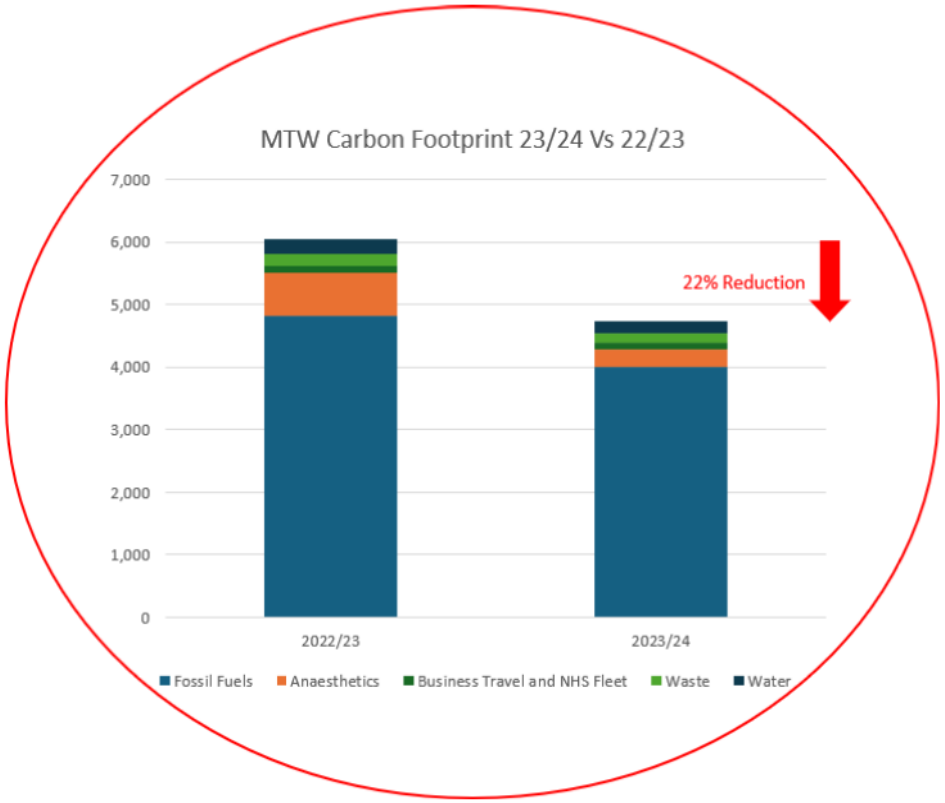
The NHS Carbon Footprint Plus is most of scope 3 (indirect) and is much harder to measure as this is dependent on the supply chain - how they manufacture, transport and deliver services and goods.

NHS Targets


44%
carbon footprint reduction by 2026
(against a 2019/20 baseline)
80%
carbon footprint reduction by 2032
100%
carbon footprint reduction by 2040
40%
carbon footprint plus reduction by 2030
80%
carbon footprint plus reduction by 2039
100%
carbon footprint plus reduction by 2045

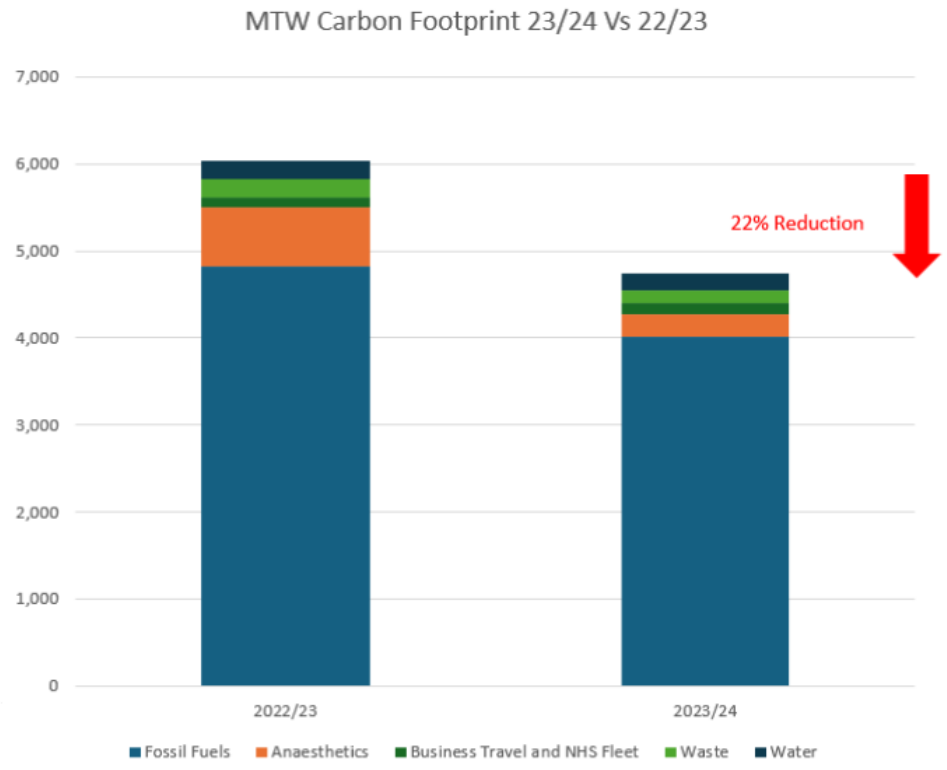
The Trust's Carbon Footprint – Progress this year





2023/24 has seen a reduction in the Trust Carbon Footprint of 22% against 2022/23.

The Trust's Carbon Footprint – Progress this year



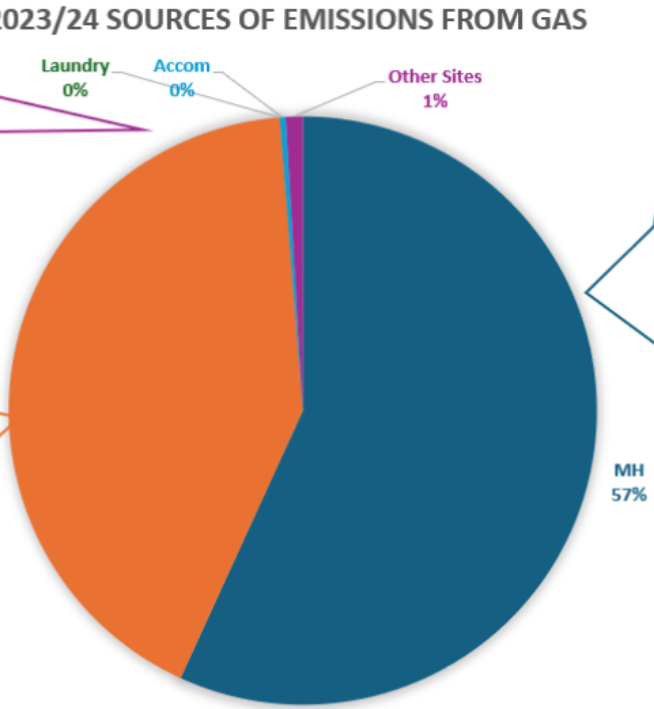
	2022/23	2023/24
Source	**tCO2e**	**tCO2e**
Fossil Fuels	4823.0	4013.0
Anaesthetics	682.4	266.9
Business Travel and NHS Fleet	111.0	120.6
Waste	203.0	147.9
Water	222.8	187.1
Total	**6042.2**	**4735.5**

Fossil Fuel reduction is due to a reduction in gas consumption – this is principally due to the closure of the laundry site. To reduce this further requires the decommissioning of gas boilers across the estate.

Anaesthetics reduction is due both a reduction in Entonox use as well as the decommissioning of the nitrous oxide manifolds across both sites.

Options for Decarbonisation – Reducing Gas Consumption

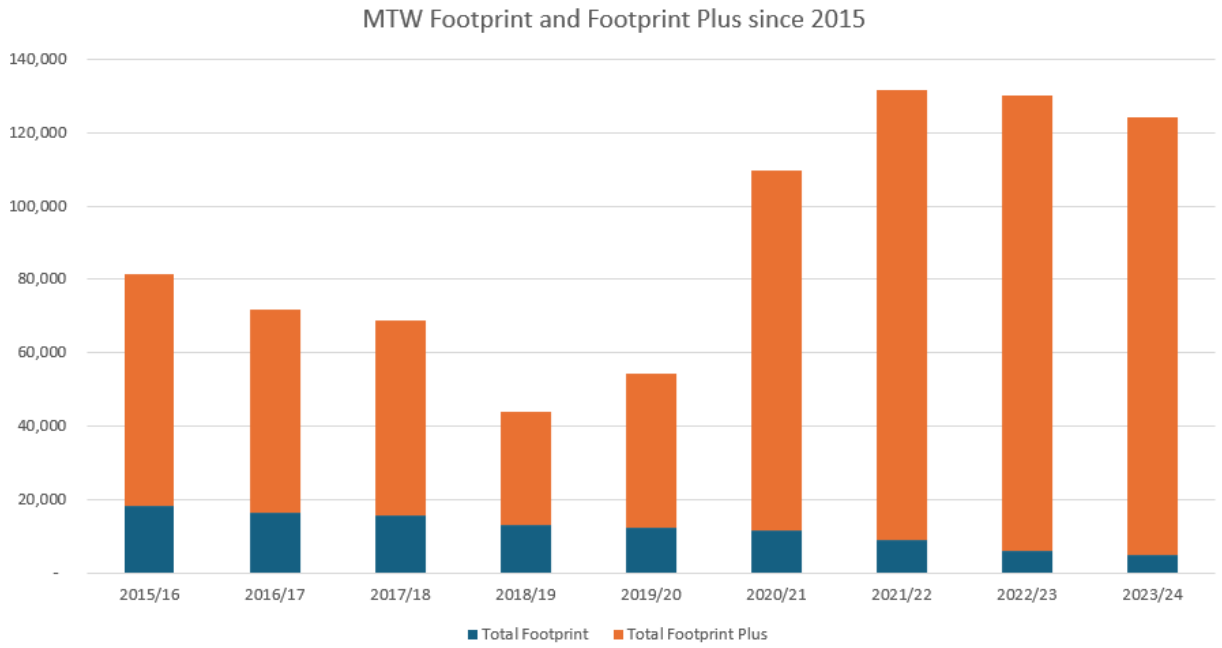
Approximately 1% of the Trust's gas consumption occurs in "other sites", including Medical Records, Hermitage Court and Staff Accommodation. These are lease properties.



57% of the gas use in the Trust occurs at Maidstone Hospital, and of this 93% is in the main boiler house.
The replacement of the steam installation with a Low Temperature Hot Water (LTHW) system will reduce the gas consumption at the site by around 33%, and the replacement of the boilers with electrical heat pumps will reduce the gas consumption at the site by 80% - 90% depending upon the final system design.
This project has been costed at circa £15m through the development of a Heat Decarbonisation Plan funded by the Public Sector Low Carbon Skills Fund

42% of the Trust's gas consumption occurs at Tunbridge Wells Hospital.
The hospital already has a Low Temperature Hot Water (LTHW) system in place so the only possible reductions to gas consumption are through the complete or partial replacement of boilers with heat pumps.
An application has been submitted to the Public Sector Low Carbon Skills Fund to allow Mitie to develop this project as a part of a wider Heat Decarbonisation Plan

The Trust's Carbon Footprint Plus – Progress this year



This graph is a calculation of the emissions associated with our supply chain using analytical methods.

The emissions have reduced slightly in recent years. This is partially due to new data being available for analysis and a reduction in the intensity metrics being provided by HM Govt.

Emissions from the Footprint are based on consumptions and actual data, whereas emissions from the Footprint Plus are based on financial reporting and the application of generic intensity metrics, hence the accuracy is lower.

The Trust's Carbon Footprint Plus – Progress this year

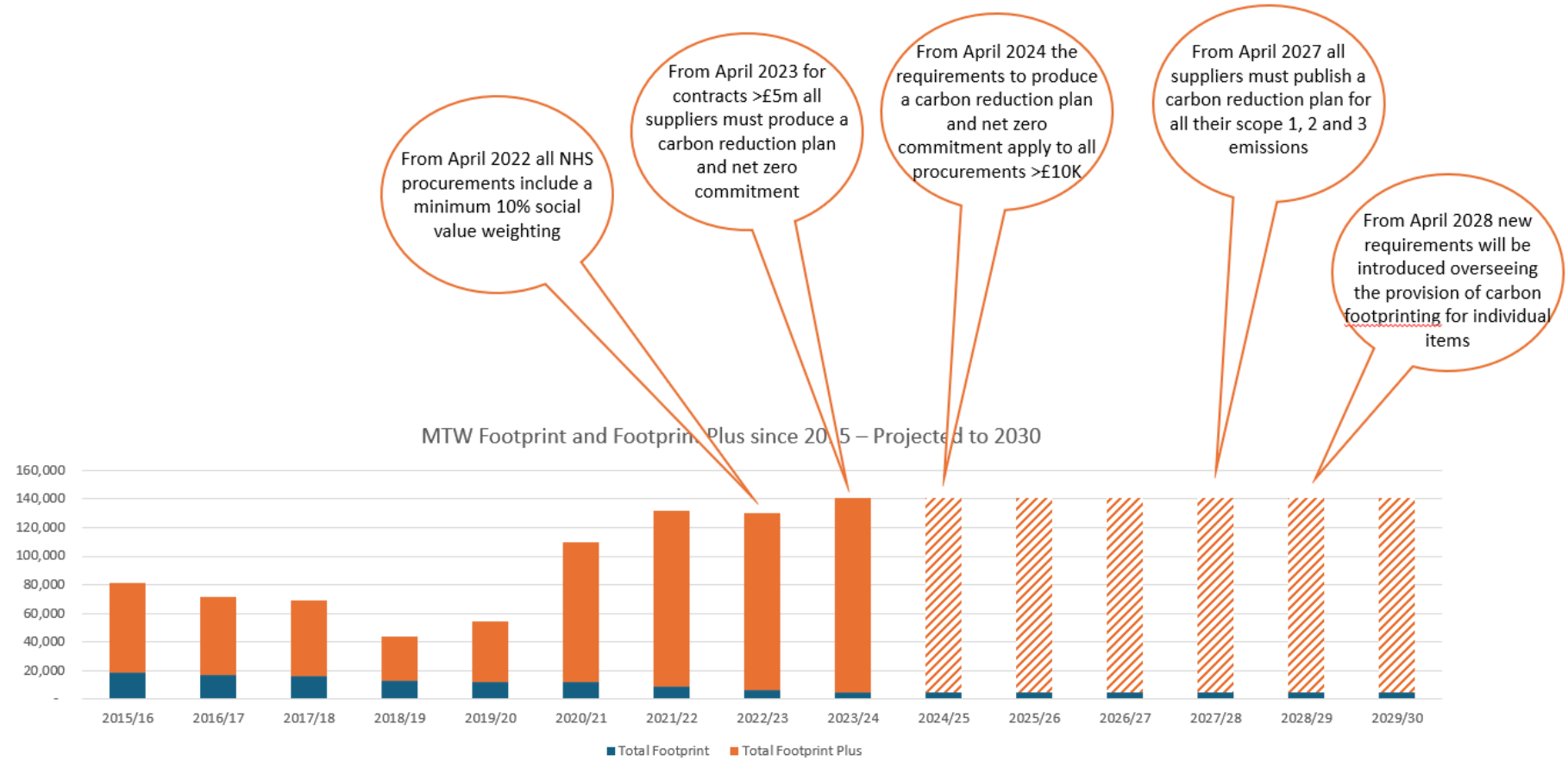
Category	2022/23 Emissions tCO2e	2023/24 Emissions tCO2e	Change %	Change in tCO2e
Business Services	13,590	19,892	46%	6,302
Commissioned Healthcare	3,873	4,758	23%	885
Construction	4,012	10,924	172%	6,912
Food and Catering	1,902	416	-78%	-1,486
Freight Transport	3,306	4,887	48%	1,581
ICT	7,719	2,366	-69%	-5,353
Manufacturing	2,999	4,664	56%	1,665
Medical Devices	57,888	35,813	-38%	-22,075
Medicines	19,199	26,896	40%	7,697
Other	2,644	1,559	-41%	-1,085
Patient Visitor Travel	6,640	5,397	-19%	-1,243
Staff Commuting	483	1,899	293%	1,416
Total	**124,255**	**119,471**	**-4%**	**4,784.37**

The differences between the 22/23 and the 23/24 emissions factors are largely driven by 2 factors:

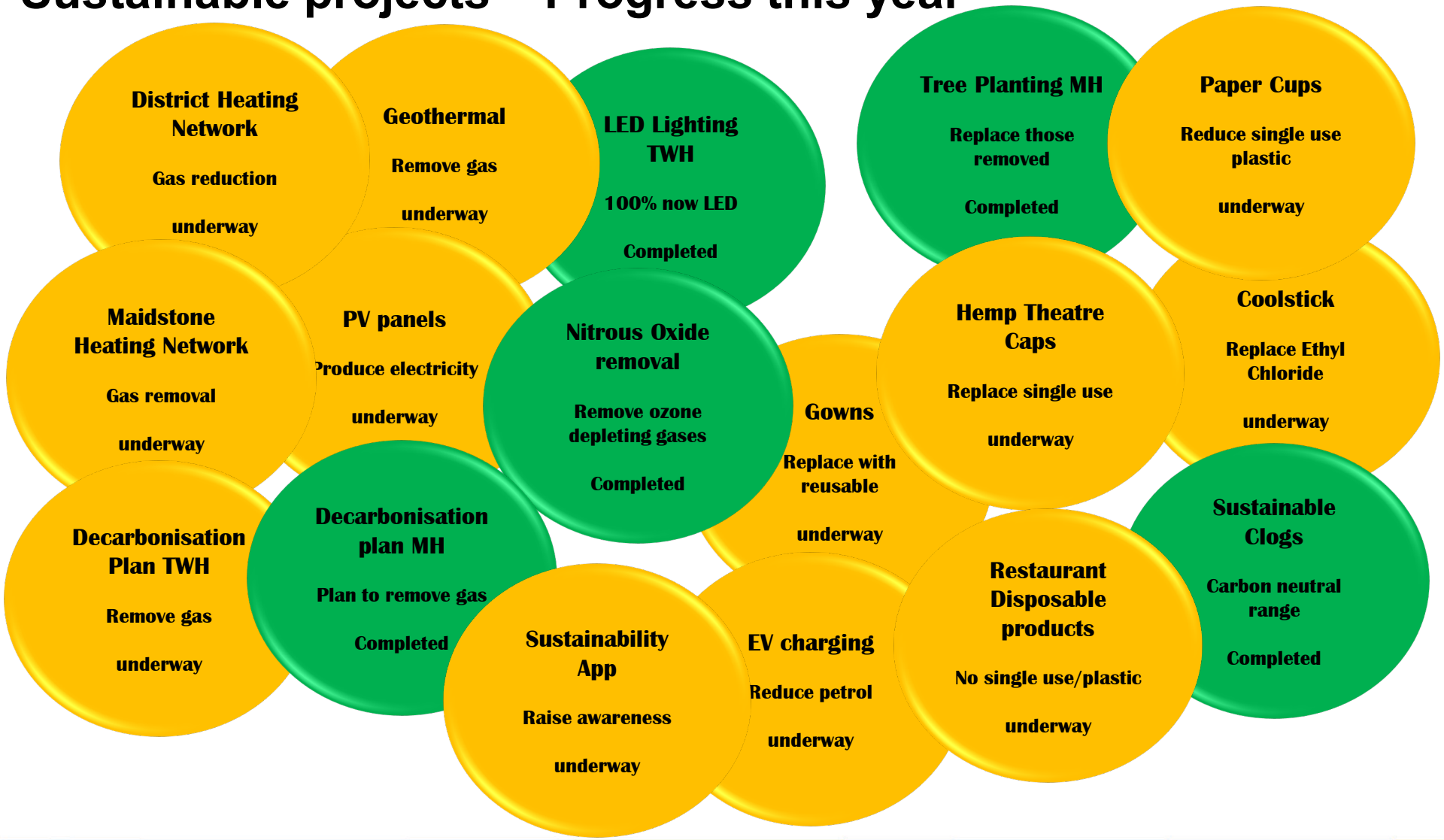
- A different spend profile within the category, ie a reduction in spend will have a lower emissions profile and;
- A change in the modelled carbon intensity of each category in KgCO2e/£ ie the spend has stayed the same but the emissions have fallen

The methodology for calculating the emissions associated with the supply chain is both crude and meant to provide indicative data only, with an estimated accuracy of +/- 20%.

Potential future emissions trajectory



Sustainable projects – Progress this year



Next Steps…..

Sustainability Manager joins 15th July

Revamp the Green Champions Network & expand within Trust

Improve awareness throughout Trust via App & Team meetings

Develop carbon reduction strategy for Estates

Start to change culture by including in Inductions & JDs

Improve waste segregation & recycle effectively

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Business Case for Estates Capital backlog work 2024/25	Deputy Chief Executive / Chief Finance Officer

The Trust Board is requested to review, and if appropriate approve, the Business Case for Estates Capital backlog work for 2024/25, which was recommended for approval by the June 2024 Finance and Performance Committee meeting

Background

- The backlog maintenance programme comprises of outstanding works that need to be resolved to help prevent future asset failure, mitigate safety issues and prevent unplanned operational downtime.
- The schemes selected are the highest risks as shown on the Estates Priority Register, many of which are part of rolling programmes in line with funding availability year on year. These also sit within the categories submitted to the ICB earlier this year and risk assessed against the ICB capital rationale.
- The need for completing these works and for the this to continue in following years is to ensure mandatory and statutory compliances are being worked towards, improving resilience of the engineering services and built environment to minimise impact to operational services in the event of failure and improve safety for those using the building.

Business Case objectives

- Reduce Estates backlog maintenance
- Improve site safety for all that use Maidstone and Tunbridge Wells sites.
- Reduce statutory non-compliance of the Trust's built environment.
- The funding has been allocated within Trust's Capital Programme for 2024 / 2025

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

- Business Case Review Panel
- Executive Team Meeting, 18/06/24
- Finance and Performance Committee, 25/06/24

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

The Business case has been submitted to the Trust Board, 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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Title	Backlog Maintenance Proposed Spend 2024/2025

Stage of plan *Please delete those not applicable to show the stage of case*	• Single stage "Justification"			
ID reference *Available from mtw-tr.bcrp@nhs.net*	TBD			
Division	Estates			
Department/Site/ Directorate	Capital Development			
Author	David Pym			
Clinical lead/Project Manager	David Pym			
Prioritisation has been agreed at *(Highlight as applicable and please provided detail in strategic background section)*	**Capital prioritisation group – in capital plan**	**Service development priority in divisional annual plan**		

Approved by *(When submitting case, please provide evidence of sign off from each key stakeholder as applicable)*	**Name**	**Date approved**
General Manager/Service Lead		
Finance manager	Stuart Doyle	
Clinical Director or their clinical deputy		
Executive sponsor	Debbie Morris	
Division Leadership Team		
Supported by – *as applicable*	**Name**	**Date supported**
Estates and Facilities Management (EFM)	Debbie Morris	
ICT		
Deputy Chief Operating Officer		
Diagnostics and Clinical Support Services		
Emergency Planning		
Human Resources (HR) Business Partner		
Procurement	Bob Murray	
EME Services Manager		
Outpatients		

Executive Summary

Recommendation: This business case seeks approval to invest £ 1,333,000 in 2024/2025

The investment will be funded by the Estates Capital Plan 2024 / 2025

Strategic background context and need

The backlog maintenance programme comprises of outstanding works that need to be resolved to help prevent future asset failure, mitigate safety issues and prevent unplanned operational downtime.
The need for completing these works and for the this to continue in following years is to ensure mandatory and statutory compliances are being worked towards, improving resilience of the engineering services and built environment to minimise impact to operational services in the event of failure and improve safety for those using the building.

Objectives -

The key objectives in delivering a backlog maintenance programme are:
1. Reduce risks associated with outstanding backlog maintenance
2. Improve patient safety across the MTW sites
3. Improve resilience by replacing plant and equipment which has passed its operational lifecycle.

The preferred option. *List exactly what is required in terms of staff (WTE and band)/ equipment/estate*

The preferred option is Option 2.

Delivery the Estates Capital Programme against a risk-assessed method working on the high risk prioritised within the budget allowance allocated for the financial year.

There are no staffing changes and the delivery will be managed through the Estates Capital Development Team.

Planned key benefits to come from the investment.

The key benefits from delivering a backlog maintenance programme are:
1. Reduce the backlog risk to the Trust
2. Improve site safety
3. Reduce non-compliance across the site.

Measurable benefit Key Performance Indicator (KPI)	Baseline Position	Future Outcome
Reduce backlog risk	Risk on ERR	Identified risk reduced to an acceptable level
Improve site safety	Risk on ERR	Safety improvements implemented across site

Main risks associated with the investment

Risk of not doing it: All backlog risks identified will remain.

Delivery risk: Specific items may have a duration of works outside of this financial year. This will be escalated to the Capital Steering Group for a decision to allow to continue or defer and replace with a scheme that is deliverable.

Residual Risk: Risks on the Estates Risk Register that are not included within this financial year due to affordability will remain.

Financial impact of the preferred option Full year effect – include VAT unless recoverable			
Summary of financial impacts			
CAPITAL COSTS	**1,333,000**	**FUNDING SOURCE**	**£**
Estates	**1,333,000**	Identified in the Trust capital plan	**1,333,000**
IT		Identified in directorate revenue budget	
Equipment		Other *(specify)*	
Total Capital Cost	**1,333,000**	**Additional Financial Information**	
REVENUE COSTS			
Pay			
Non- Pay			
Capital Charges			
Total Revenue Cost per annum			
INCOME			
SLA			
Other			
Surplus/Loss			
	0		

Timetable	
Milestone	**Date**
Approval of Business Case	**June 2024**
Engage with Design Teams	**June 2024**
Design	**August 2024**
Procurement of Works	**October 2024**
Engage with Contractors	**October 2024**
Commence Works on Site	**November 2024**
Completion	**January 2025**

Strategic Case

The backlog maintenance programme comprises of outstanding works that need to be resolved to help prevent future asset failure, mitigate safety issues and prevent unplanned operational downtime.

The need for completing these works and for the this to continue in following years is to ensure mandatory and statutory compliances are being worked towards, improving resilience of the engineering services and built environment to minimise impact to operational services in the event of failure and improve safety for those using the building.

The extent of the programme is based around the allocation of capital funding available within the Estates Capital Plan for 2024 / 2025 and has been prioritised using a risk-based methodology has been established to select those tasks with the highest risk scores and are prioritised and where no mitigations remedial actions are in place to prevent the risk being realised.

Further selection criteria have also been applied that prioritise risks associated with fire safety and water management above others.

The highest priority tasks are identified in the Estates Risk Register are shown in the appendices.

The case for change

1. Reduce risks associated with outstanding backlog maintenance

2. Improve patient safety across the MTW sites

3. Improve resilience by replacing plant and equipment which has passed its operational lifecycle.

Case for change re objective 1

There are a number of Estates risks identified within the Estate Risk Register that impact site safety, compliance and resilience. Reducing the most significant of these which are focussed on fire and water management for the 2024 / 2025 programme improves the built environment and safety within the Trust.

Case for change re objective 2

There are a number of Estates risks identified within the Estate Risk Register that impact site safety. The backlog maintenance budget is used to address estates risk for the built environment and site infrastructure, improving building safety with the budget for this year focussed on fire safety and water management.

Case for change re objective 3

There are a number of Estates risks identified within the Estate Risk Register that impact site resilience. The backlog maintenance budget is used to address estates risk for the built environment and site infrastructure, improving building safety with the budget for this year focussed on fire safety, ensuring there is adequate integrity to the fire compartment through the main hospital building at Maidstone.

Constraints and dependencies

The key constraints and dependencies are through the design and procurement processes to award a contract and commence with works onsite. These are identified within the programme for this has been identified in the financial and management cases.

The approach taken for other dependencies that have operational impact have been outlined within the clinical impact assessment.

Economic Case - The available options

Option 1 – Do nothing / do minimum

Description
Do not use the Estates Capital Programme allocation for backlog maintenance this financial year.

Key activity and financial assumptions:
Allow the risks that could be reduced within this financial to be retained and do not spend the allocated capital budget.

Strengths / Opportunities
The funds could be allocated to other capital priorities across the Trust.

Weaknesses / Threats
The risks being reduced may be realised and consequences incurred.

This option is Preferred / Rejected because:
This option is rejected
This option does not work to reduce the backlog works and retaining these risks leaves the Estates with those issues identified as being addressed within this financial year as well as those still be addressed during future years. This is compounded with the ageing estate the backlog activities will increase as future issues arise.
All of which could impact operational services should a risk materialise.

Option 2 – Risk Assessed Programme of Works

Description
Delivery the Estates Capital Programme against a risk-assessed method working on the high risk prioritised within the budget allowance allocated for the financial year.

Key activity and financial assumptions:
Use the budget allocated for backlog within the capital budget to address Estates risks that have been assessed using the risk matrix as published with the NHS document ‘A risk-based methodology for stabling and managing backlog’ and have the greatest potential of failure or to cause harm.

The Estates Risk Register is included within the appendices of this document.

Strengths / Opportunities
To base this years backlog programme on the highest estates risk, improving safety across site and helping to provide a greater resilience to the Trust through the built environment.

Weaknesses / Threats
With the emphasis of these works being non-patient facing systems or improvements. This will have minimal impact on the aesthetics within the hospitals.

This option is Preferred / Rejected because:
This is the preferred option.
This option will work towards reducing the highest risks identified within the infrastructure and the built environment for the Trust.

Option 3 – Operational Led Programme of Works

Description
Delivery the Estates Capital Programme against an operational service led priority list within the budget allowance allocated for the financial year.

Key activity and financial assumptions:
Use the budget allocated for backlog within the capital budget to address improvements that have been identified through Clinical Operational Estates.

Strengths / Opportunities
These schemes will improve the day to day activities within the clinical operational departments.

Weaknesses / Threats
These schemes will not prioritise the highest risks to operational services from the sites infrastructure and built environment posed by the aging estate.

This option is Preferred / Rejected because:
This option is rejected.
This option does not work towards reducing the highest risks identified within the infrastructure and the built environment for the Trust.

Option 4 – Patient Led Programme of Works

Description
Delivery the Estates Capital Programme against a patient led priority list within the budget allowance allocated for the financial year.

Key activity and financial assumptions:
Use the budget allocated for backlog within the capital budget to address improvements that have been identified through patient led activities.

Strengths /Opportunities
These schemes will improve make improvements to the hospital as seen from a patient perspective.

Weaknesses/ Threats
These schemes will not prioritise the highest risks to operational services from the sites infrastructure and built environment posed by the aging estate.

This option is Preferred / Rejected because:
This option is rejected.
This option does not work towards reducing the highest risks identified within the infrastructure and the built environment for the Trust.

The preferred option

Summarise how the preferred option optimises value for money

Option 2, the preferred option optimises value for money as the works identified are competitively tendered and these are also schemes that reduce the risk the Trust from those presented from the built environment.

Commercial Case

Services, assets and space required

None, this business case is to overcome the outstanding backlog maintenance achievable within the budget allocated for this financial year.

Staffing plans

None – the staffing for the delivery of the backlog programme will be through the Estates Capital Development Team, the costs of the team against these projects will be recorded and charged back to the capital scheme.

Notes on workforce plan

None

Impacts on and interfaces with other services.

Impacts on and interface with other services will be minimised through the design of the works and carried out during times that have least impact.

When this cannot be avoided close communication and liaison with the effected services will take place. Where practicable temporary services will be provided, or close management of the works during these periods to ensure works are completed within the shortest duration achievable.

Activity, contractual and service level agreement implications. Commissioner involvement and input.

None

Procurement route

The procurement route for the works will use NHS approved frameworks for engaging the professional design teams for the construction and engineering bias works.

The works once designed will be competitive tendered through the Trust's procurement portal following the Trust's SFI's

Works above £50k will be delivered through the appropriate form of contract such as JCT and administered by an external consultant on behalf of the Trust.

In the event works are only available by a Trust incumbent or an OEM supplier then dispensation will be requested through a waiver in line the Trust's SFI's.

Financial Case – Funding and affordability

Please include at a minimum:

- the capital and revenue costs of the proposed investment
- how the investment will be funded
- any affordability gap (if applicable).

For the preferred option. Full year effect – include VAT unless recoverable

Breakdown of financial impacts	Y 0 23/24	Y1	Y2	Y 3	Y 4	Y 5
CAPITAL COSTS Estates	1,110,833					
IT						
Equipment						
VAT	222,167					
Total Capital Costs	1,333,000					
REVENUE COSTS Pay						
Non-pay						
Other						
Other (non- operating) expenditure						
Capital charges						
Total Revenue Costs						
INCOME SLA						
Other (e.g. cash releasing benefits) Please specify and describe below)						
Surplus/Loss						

Summarise the activity, income assumptions relating to the preferred option.

None

How the investment will be funded

Funding source/ body	£ & % of total	Secured? If not secured indicate status of negotiation
Identified in the Trust capital programme	1,333,000	Estates Capital Plan 2024 / 2025
Identified in directorate revenue budget		
Other *(specify)*		

Management Case - Arrangements for successful implementation

Please indicate arrangements to deliver the investment successfully:

Governance arrangements

The reporting of the backlog budget will be through the monthly Capital Steering Group Meeting. At this meeting the detailed programme will be presented along with the forecast outturn and committed spend for all schemes. Any risks and issues raised will also be identified as part of a financial report submitted by the Associate Director of Capital Development.

Internally within the Estates Directorate through the Senior Management Team (SMT) meeting will review the estates capital plan to ensure these schemes are on target and to make decisions within the envelope of the approved budget to address issues within these schemes or to consider prioritisation of additional schemes should high risk matters arise during the financial year. The SMT meetings will be chaired by the Director of Estates and Capital Development.

Should additional funding become available within the financial year, the allocation of this will be agreed through the Capital Steering Group and the Estates capital allocation will be adjusted accordingly and delivered as set out within this business case.

The selection of additional schemes will follow the rationale identified within this business case using the Estates Priority Register as the source document to identify the works to be completed. With funding coming available later within the financial year, the deliverability due to lead times may now also be a consideration for scheme selection and lower risk items addressed when those with higher priority numbers are undeliverable within the set timescale.

Project team

The project team will be resourced through the Estates Capital Development with the key personnel as below:

Debbie Morris – Director of Estates – SRO
David Pym – Associate Director of Capital Development – Project Lead
Tim Fletcher – Project Officer
Mark Tucker – Project Officer

Due to the complexity of these projects there will be a requirement to buy in the design and other professional building services, these team will be managed by the Project Officers and include the disciplines below as appropriate:

- Architect
- Building Services Engineer
- Structural Engineer
- Quantity Surveyor / Contract Administrator
- Principal Designer

Delivering the key measurable benefits

Include key measurable benefits with quantification of change in value, measure, timing and responsibility. Summarise this on p2

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
Reduce backlog risk			Risks removed from risk register	March 25	
Improve site safety			Risks removed from risk register	March 25	

Timetable

Milestone	Date
Approval of Business Case	June 2024
Engage with Design Teams	June 2024
Design	August 2024
Procurement of Works	October 2024
Engage with Contractors	October 2024
Commence Works on Site	November 2024
Completion	January 2025

Managing any key risks associated with delivering the project

Risk	Baseline risk score (l x i)	Summary mitigation/ contingency	Mitigated risk score (L x i)	Lead
Unable to delivery within the financial year	3x3	The schemes identified have indicative programmes that include design periods and conclude before the end of the financial year.	2x2	David Pym
Cost of schemes is higher than the budget available	3x3	The highest priority schemes will be selected to the extent of the budget allocation with all other schemes then for consideration in the next financial year.	1x2	David Pym

Clinical Quality Impact Assessment **(preferred option)**

Clinical Effectiveness

Have clinicians been involved in the service redesign? If yes, identify lead	N/A
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	N/A
Are relevant Clinical Outcome Measures already being monitored?	N/A
Are there any risks to clinical effectiveness? If yes, list	No
Have the risks been mitigated?	N/A
Have the risks been added to the departmental risk register and a review date set?	No
Are there any benefits to clinical effectiveness? If yes, list	No

Patient Safety. Has the impact of the change been considered in relation to: *(highlight as appropriate)*	
Infection Prevention and Control?	Yes
Safeguarding vulnerable adults/ children?	Yes
Current quality indicators?	N/A
Quality Account priorities?	N/A
CQUINS?	N/A
Are there any risks to patient safety? If yes, list	Yes, there may be limited engineering service disruptions to allow for works to commence. These will be managed, designed and carried out at times of least disruption with site and clinical services be kept in close communication at all times.
Have the risks been mitigated?	Yes, once the risks are defined during the design process, mitigations will be developed, then managed and communicated within those areas affected by the disruption.
Have the risks been added to the departmental risk register and a review date set?	No
Are there any benefits to patient safety? If yes, list	Yes, these schemes improve the safety of the built environment of the hospital.

Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed?	N/A
Does the redesign lead to improvements in the care pathway? If yes, identify	N/A
Are there any risks to the patient experience? If yes, list	Yes, there may be limited engineering service disruptions to allow for works to commence. These will be managed, designed and carried out at times of least disruption with site and clinical services be kept in close communication at all times.
Have the risks been mitigated and / or added to the departmental risk register and a review date set?	Yes, once the risks are defined during the design process, mitigations will be developed, then managed and communicated within those areas affected by the disruption.

Are there any benefits to the patient experience? If yes, list					
Health inequalities					
What planned or potential positive or negative impacts will the development have on health inequalities? Consider who may have their service or access to service improved or compromised? Describe these impacts					
None					
Service					
What is the overall impact on service quality? – please highlight one box					
Improves quality		Maintains quality	X	Reduces quality	
Clinical lead comments					

Appendices

Appendix 1 Links to latest NHS guidance.

ERIC collects information relating to the costs of providing and maintaining the NHS Estate including such things as building, maintaining and equipping hospitals, the provision of services such as cleaning, laundry, food and portering and the consumption and associated costs of utilities.

Estates Returns Information Collection, Summary page and dataset for ERIC 2021/22 - GOV.UK (www.gov.uk)

NHS England » A risk-based methodology for establishing and managing backlog

Appendix 2 – Option benefits scoring (example)

Choose up to 5 key potential benefits. Use the same benefits for each option. Weight each benefit between 5 and 1 (5 = very important 1 = minimal importance) and score each option between 5 and 1 (5 = high score 1 = low score) on the same set of benefits. Add the weighted benefits together for each option. This allows you to show how each option compares against the others on the (non- financial) benefit associated with it.

Option benefits comparison table

	Benefit Weight (A)	Option 1		Option 2		Option 3		Option 4	
Benefit description		Score (B)	A x B	Score (B)	A x B	Score (B)	A x B	Score (B)	A x B
1 Estates risks reduced	**4**	1	4	4	16	2	8	2	8
2 Improved mandatory compliance	**4**	1	4	4	16	2	8	2	8
3 Improved site safety	**4**	1	4	4	16	3	12	3	12
4 Improved site resilience	**4**	1	4	4	16	2	8	2	8
5									
		Option 1 Total	16	Option 2 Total	64	Option 3 Total	36	Option 4 Total	36

Appendix 3 – Option risk scoring (example)

Risk 1: Estates risks not reduced

Risk 2: Site safety not improved

Risk 3: Site resilience not improved

Option risks comparison table

	Risk 1			Risk 2			Risk 3			Sum of option risk scores
Option	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	Likelihood of risk occurring (L)	Impact if risk occurs (i)	Risk score (L * i)	
Option 1	4	4	**16**	4	4	**16**	4	4	**16**	**48**
Option 2	2	4	**8**	2	4	**8**	2	4	**8**	**24**
Option 3	3	4	**12**	3	4	**12**	3	4	**12**	**36**
Option 4	3	4	**12**	3	4	**12**	3	4	**12**	**36**

Appendix 4 – Estates Priority Register (Highest Risks)

Estates (Hard FM) Backlog Priorities

	Priority and RAG Rating	Fire	Legionella	H&S	Asbestos	Location	Block No.	Description	Item	HTM and Statue Applicable and Current Compliance	Additional Description	Scoring: Consequence	Scoring: Likelihood	Scoring: Score
1	25	X				*MGH Oncology First Floor*	*Block T*	Oncology Fire Compartmentation & Fire / Smoke Damper Installation Works	Fire Protection & Containment	Inadequate fire compartmentation which fails the fire HTM, fire exits routes not protected, no fire damper control on vent system, all this in a general public area.	General lack of fire breaks above ceiling, very little fire damper control so if fire does occur the vent system would feed air to the fire.	5	5	25
1	25	X				*Site Wide*	*Site Wide*	Fire Dampers	Fire Protection & Containment	Inadequate fire compartmentation which fails the fire HTM, fire exits routes not protected, no fire damper control on vent system, all this in a general public area.	General lack of fire breaks above ceiling, very little fire damper control so if fire does occur the vent system would feed air to the fire.	5	5	25
2	25	X				*Site Wide*	*Site wide*	Fire Hydrant not operational	Fire Hydrant Shut Down	No Fire Hydrant ring main around site due to leak, meaning also in the event of fire restricted water supply for fire brigade. Non Compliant with Fire HTM.	Restricted fire hydrant water main for fire brigade, could cause delays in the event of fire.	5	5	25
3	25	X				*Site Wide*	*Various*	Damaged Fire Doors	Fire Doors	Current fire doors were replaced approx. 2017/18 but many now are non compliant due to being hit and damaged by beds, trolleys and other devices. These doors are in staff and public areas.	Not all the doors are fully automated due to the costs.	5	5	25
4	25	X				*Site Wide*	*Various*	Breached Fire Compartmentation	Fire Protection & Containment	Due to no fire compartment walls above ceilings this fails HTM. Review of compartments to take place to bring up to modern day standards and make compliant.	As projects allow to bring up to modern day standard and formalise proper fire compartments. Could be a devastating effect in the event of fire.	5	5	25
6	25	X				*TWH Ground Floor*	*Zone 2*	SAU Tunbridge Wells Hospital Post project remedial works (Fire Related)	Fire	Building not compliant for fire with missing fire stopping in fire compartment walls missing, fire doors of the wrong rating fitted with not correct closers or sign off. Standard doors fitted instead of where fire doors should be.	Further investigation required to understand how amount of fire proofing required with building control. No fire extinguisher brackets fitted to wall, extinguishers standing on floor.	5	5	25
7	25	X				*TWH Ground Floor*	*Zone 2*	Paeds ED Tunbridge Wells Hospital Post project remedial works (Fire Related)	Fire	Building not compliant for fire with inadequate or no fire stopping in fire compartment walls missing, fire doors of the incorrect rating fitted with not correct closers or sign off.	Patients and Staff at risk in the event of fire. Remedials required to bring up to acceptable and compliant standard. Standard doors fitted instead of where fire doors should be. No fire extinguisher brackets fitted to wall, extinguishers standing on floor.	5	5	25
8	25	X				*TWH*	*Outside of Zone 1*	Tunbridge Wells Hospital New Car Park Post project remedial works (Fire Related)	Fire	Fire officer is not aware of this one, but there is a Health & Safety Issue by the Women's & Children drop off which requires protection as deep drop beyond wall.	Risk to vulnerable people who would want to jump off.	5	5	25
9	25	X				*MGH*	*T1*	Oncology Outpatients Department Post project remedial works (Fire Related)	Fire	Fire doors excessive gaps not meeting correctly. This is a fire HTM issue.	Fire exit doors & standard doors not closing into catches properly, fire exits discharge out onto steps , with no ramp on 1 fire exit. Most double fire doors when close have a large gap in the middle when they meet. The stair well has stored items underneath it which has the potential to prevent a safe exit in the event of fire. It would appear 1 set of fire doors fitted wrong way around. Fire exit signage is in correct in places , needs to be relooked at. landscaping out side to give safe egress, overall non compliant.	5	5	25
10	25		X			*MGH Main Boilers*	*Block L*	Main Hospital Hot Water Calorifier Replacement & HWS Return System to Whole Hospital	Water Hygiene Works	Non HTM Compliant, end of life. Poor temperatures causing water test failures. Periodic leaks in pipework causing fabric issues.	Poor circulation in certain areas, causing poor temperatures which could lead to other water management issues.	5	5	25
11	25		X			*MGH*	*Block L*	Hot Water System - Upgrade Block L HWS Plantroom Refurbishment / Pipework Reconfiguration tendered via Design in submission end of March 2022	Water Hygiene	End of life, Non Compliant. Not to current standards, leading to poor water hygiene, bring up to current standard and comply with current HTM regulations.	Loss of this service would cause adverse effect to patients and staff across whole site.	5	5	25
12	25		X			*MGH*	*Block L*	Main Large Tanks 1 & 2 2 New lids, 2 new valves, new air vents, new valves to be housed inside raised chambers with side entry hatches, 2 man access hatches, removal and install of all parts was approved around.	Water Hygiene	End of life, non compliant, isolation valves that do not hold, non suitable drain offs, concrete tanks, with metal plate covers. These tanks feed most of the hospital via other tanks. Bring up to modern day standards and HTM Complaint.	If these tanks were to fail, it would effect staff and patients and services across the hospital, with the potential to cause adverse publicity.	5	5	25
13	25		X			*MGH*	*Block N*	Softened Tank 3 Unable to isolate the tank therefore this tank cannot be cleaned. This work will require at total shut down of the hot water system, replacement valve. Then we can clean the tank	Water Hygiene	End of life, poor isolation means tank not cleaned that could lead to water management issues. Non HTM compliant.	Poor isolation, total hws shutdown required.	5	5	25
14	25		X			*MGH*	*Site wide*	Poor HWS circulation throughout the Maidstone Site - Most areas on the HWS suffer from poor circulation due to additional building old Plant, Pumps	Water Hygiene	End of life, obsolete pumps, poor design in places, with poor circulation causing water management issues in certain places as correct temperatures cannot be reached.	Poor temperatures leading to waste water in trying to maintain acceptable temperature. Adverse effect on site to staff and patients. Potential for higher costs with more water failures.	5	5	25
16	25		X			*MGH Ground Floor*	*Block L*	Steam Boiler Water feed supply	Boilers	During the winter months our boiler feed water pumps struggle to keep up when there is high steam demand which causes major steam distribution issues across the site to our heating & hot water systems as the boilers lock out on low water alarm as the existing feed pumps cannot supply enough feed water to boilers fast enough so the consequences of	To carry out and investigate through a feasibility study the cause of the lack of water and then design a scheme to eradicate the problem. Without the work it has the potential to cause damaging effects to the operation of the hospital for various services and function of wards , depts. est cost of feasibility £6K with remedial works of 30K	5	5	25
17	25			X		*MGH First Floor*	*Oncology Block S*	Plant Room S	Heating pressurisation unit	Pressurisation system old and obsolete parts. Requires total replacement. Requires replacement in the summer months when the heating is off.	There is an issue with the heating pressurisation system which covers Block T , CC, & DD, this needs replacing ASAP due to obsolete parts and the unavailability of pumps and sensors. And the system age , quotes available, this is a critical piece of equipment and needs replacing NOW, through the summer months while the heating is switched off, if this is not replaced the heating system would fail and the above blocks could be effected for 3 to 6 weeks min whilst new equipment purchased and installed.	5	5	25
18	25	X				*Maidstone First Floor*	*Block EE*	IT Hub Room	Fire Improvement works	Non Compliant fails fire HTM. In that the data hub room failed its fire integrity test, the room has many penetrations from cable basket, trunking entry's also there is 2 entry hatches in the ceiling which are not sealed but cannot be opened up into the area above as there is services and other metal work impeding the way.	The issues around fire integrity of the room needs to be rectified and brought up to the current standard. The means of access to do this needs to be fully investigated and the complications fully understood. It may mean gaining access from the outside by a scaffold and making as entry via the roof , and a purpose fire rated hatch.	5	5	25

Appendix 5 – Estates Capital Plan 2024 / 2025

Estates allocation for 2024 / 2025 is highlighted in yellow below.

MTW Spend Plan 2024/25	Category	NHSE Plan 02/05/24	Additional/ Updated funds	Updated position	Notes
		£'000	£'000	£'000	
Bfwd Commitments					
CDC	System	2,463	-329	2,134	CDC System funding - now adjusted following national funds award
CDC	Internal	1,631	-1,071	560	Brokerage element b/f; additional national funds agreed
Returned Internal funding re CDC	Internal		1,071	1,071	ICB notification - funds to be allocated by ETM
Imaging equipment enabling works	Internal	1,240		1,240	MRI/CT/IR/X-ray Room - prior to X ray room ventiliation plant costs
KMOC (Barn) potential slippage	Internal	2,250		2,250	Updated assessment Mar23 but prior to latest completion date
Cardiology	System	3,000		3,000	First of two tranches - £3m in 2025/26
UEC incentive capital	System		5,000	5,000	ICB notification - awaiting NHSE confirmation. To be allocated by ETM
Sub total		**10,584**	**4,671**	**15,255**	
Uncommitted budgets					
Estates	Internal	1,333		1,333	
Facilities/Security	Internal	150		150	
Equipment	Internal	1,341		1,341	
ICT	Internal	1,333		1,333	
Sub total		**4,157**		**4,157**	
				0	
Draft System Control Total		**14,741**	**4,671**	**19,412**	
				0	
National Funding - Approved				0	
Digital Pathology		653		653	Approved MOU
CDC		500	1,400	1,900	Approved MOU + LOA for additional funds
Sub total		**1,153**	**1,400**	**2,553**	
				0	
Anticipated/bid National Funding				0	
Frontline Digitisation		**2,790**	**0**	**2,790**	FBC submitted - not approved yet for 24/25
				0	
PlanTotal Capital Resource (CRL)		**18,684**	**6,071**	**24,755**	

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Full Business Case for Robotic Assisted Surgery	Deputy Chief Executive / Chief Finance Officer

The enclosed report provides information on the full business case to procure 2 surgical robots for 7 year terms between autumn 2024 and May 2025 for the Maidstone and then Tunbridge Wells sites. In order to:

- Improve the quality of care; improve operative safety, improved outcome and improved experience for patients requiring complex surgery.
- Develop our staff and ensure that MTW remains a dynamic, high quality environment in which to work and learn, attracts and retains the best medical and other clinical staff (trainees, registrars, and consultant surgeons)
- Secure a position as a leading surgical centre in the region. All of the other three acute general hospital trusts in K&M and around our SE region already have Robot Assisted Surgery (RAS)

Expected benefits

- Improved health and clinical outcomes for patients.
- Reduced operative and post-operative complications, pain and infections leading to readmission.
- Reduced length of stay in a hospital bed.
- Development opportunities for current clinical staff while recruiting and retaining the surgeons of the future.

The business case can be funded via multiple routes which have all been considered and discussed at F&P. Overall the case is self-funding after the first year of operation and will require a modest amount of Trust capital to facilitate the installation enabling works. For 2024/25 £237k of capital is required and for 2025/26 £140k is required.

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

- Executive Team Meeting, 16th July 2024 with the following clarifications:
  - Number of theatre sessions utilised – update in the case
  - Phasing of the robot implementation – updated in the case
  - Preferred financing model – to be agreed in F&P
  - To link with the ICB and Medway again about the planned urology (kidney) activity – request the case is supported subject to that as ICB approval will be required anyway via the double lock process
- Finance and Performance Committee, 23rd July 2024

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE	Robotic assisted surgery at MTW

Stage of Plan	**Stage 3 - Full Business Case (FBC)** ✓
ID reference *Contact: mtw-tr.bcrp@nhs.net*	**ID935**
Division	Surgery, and Women's and Children's
Site / Department / Directorate	Cross site – Surgery/ Urology /Gynaecology/ Gynae-oncology
Project Lead	David Robinson
Prioritisation has been agreed at *(Tick as applicable and please provide detail in strategic background section)*	Service development priority in surgical divisional annual plan ✓
	Charitable funds group/s ☐
	Other (Specify) ☐ Through Trust strategic development review process

Approvals *(mandatory to complete)*	**Name**	**Date approved**
Has the case been approved at a Divisional Board? YES		
If not, who from Divisional Leadership Team has approved the case on behalf of the Division?	N/A	N/A
Executive Sponsor / SRO approval	Rachel Jones	June 2024
Other approval? ☐ *Please specify*	Chief of Service for Surgery	June 2024

Checklist *(please complete in conjunction with your Finance Business Partner)*
Is the case financially breakeven/cost neutral or better? ☐ Funding: Recurrent ✓ or Non-Recurrent ☐
Is there a Capital Funding requirement? ✓ Is that requirement in the Trust's prioritised Capital Programme? ☐
Have the funding assumptions been clearly documented in the Financial Case, including whether funding is fully secured? ✓
ICB approval is required for all revenue investments with a full year effect of more than £10k for non-pay and £50k for pay. Is it more than £10k non-pay ✓ or £50k pay ☐
Have benefits and risks been identified and quantified ✓
Does the proposal impact on other Divisions/Directorates? Yes (Women's and Children's – Gynae and Corporate)
Have they been involved in the planning? YES

Stakeholders			
Role	**Name**	**Role**	**Name**
Finance Manager	Doug Wood /M Nye	EME Services Mgr.	Michel Chalklin
Estates	David Pym	Outpatients lead/s	N/A
Facilities Management	Michelle Lowings	Charitable funds mgr.	Claire Ashby
ICT/Clinical Systems & EPR	Malcolm Catchpole/Louise Wilkinson	HR Business Partner	N/A
Core Clinical Services lead/s	N/A	Procurement team	Bob Murray/Richard Cardy
Emergency Planning team	N/A	Other (specify)	
Finance Dep Director	Stuart Doyle	Other (specify)	

Executive Summary

Recommendation:
This FBC seeks approval to enter into a 7-year contract to set up a surgical robotic service at each of MGH and TWH hospital sites.

In May 2024, the Trust Board approved an outline business case for a Robotic Assisted Surgery (RAS) programme at MTW. This Full Business Case sets out the costs and contract and the financial case associated with that programme from the chosen supplier.

The preferred supplier chosen through procurement evaluation exercise is: Intuitive Surgery (Da Vinci xi robot)
Key terms are summarised in the Commercial case section below. A copy of the intended contract is attached at Appendix 7

The financial implications of this two-robot procurement are below, the wider financial context is within the financial section of the case.

	Da Vinchi Xi - Financing options			
Difference per year from 23/24 actual	**Capital purchase**	**Pay-per-procedure**	**IFRS16 Lease**	**Notes**
8-year total	**£000**	**£000**	**£000**	
Income				
NHS Activity	18,378	18,378	18,378	Includes additional Gen Surg. Short stay activity arising from reduced recovery times
Private Activity	4,464	4,464	4,464	
	22,842	**22,842**	**22,842**	
Pay Costs	-	-	-	Private activity to be done within existing sessions - no additional staffing.
Non Pay Costs				
General Non-Pay & Consumables	10,915	10,915	10,915	
Da Vinci maintenance	2,102	-	2,411	
Da Vinci pay per px contract	-	7,434	-	
Depreciation & PDC	4,786	427	427	
IFRS16 depreciation & PDC	-	2,954	2,954	For the pay-per-procedure option, this is related to the subsquent valuation of the IFRS16 right of use asset.
Interest	-	-	521	
	17,803	**21,730**	**17,227**	
I&E Total surplus / (deficit)	**5,039**	**1,112**	**5,615**	
Capital expenditure	4,230	377	377	Capital expenditure for the pay-per procedure and IFRS16 lease options relates to MTW direct installation and set-up costs.
IFRS16 Capital	-	2,954	2,954	IFRS16 capital is within the allowance included in the plan for this project - plan not yet approved. Pay-per procedure will not impact CDEL.

The majority of the NHS operations to be performed using robotic assisted approach, would have been carried out at MTW using a laparoscopic or open approach. Therefore, most of the activity does not attract additional income but, as reflected in the financial model, there are significant clinical efficiency savings from using RAS approach and a significant risk is mitigated of consultants and other clinical staff not wishing to join the Trust due to the lack of a robot at the Trust.

Strategic background context and need

Over the last 40 years, the surgical model of care has been transformed with the adoption of minimally-invasive laparoscopic surgery, also known as 'key hole' surgery.

Now, robotic-assisted surgery (RAS) is emerging as a preferred approach as it enables surgeons to perform complex procedures in hard to reach areas with more precision, flexibility and control. Our senior surgeons consider that developing RAS has changed from being a 'nice to have' to being an essential tool for any modern surgery centre that wishes to attract new surgeons to work in the centre.

At present units in Kent with a robot are referring patients to the gynae oncology service at Maidstone for non-robotic surgery because Maidstone is the referral centre. It is the senior clinical view that this situation is untenable and that services will be taken away soon, if this situation continues

For our patients, there is evidence that the RAS approach:

- Reduces complication rate
- Enables a minimal access approach in cases which where it might not have been possible without robot assistance. which then leads to the established clinical and operational and patient benefits of:
    - Less operative trauma
    - Shorter hospital stays
    - Less pain and quicker recovery

The 'early' OBC, in June 2023, outlined the proposal to develop RAS within the Surgery Division, initially around Urology and Gynae-oncology with possible progression to General surgery and Gynaecology surgery. In the six months since that stage of planning General surgery and Gynaecology have become fully engaged in developing the RAS plans and this is reflected in the option evaluation within the case.

The OBC was approved in May 2024 with the outcome to fully develop this FBC.

Objectives

The objectives of developing RAS at MTW are:

1. Improve the quality of care; improve operative safety, improved outcome and improved experience for patients requiring complex surgery

2. Develop our staff and ensure that MTW remains a dynamic, high quality environment in which to work and learn, attracts and retains the best medical and other clinical staff (trainees, registrars, and consultant surgeons).

3. Secure a position as a leading surgical centre in the region. The other three acute general hospital trusts in our region already have RAS, with Dartford commencing from June 2024.

The preferred option.

Begin a RAS development programme at MTW, with two robots, initially one at MGH in autumn 2024/25 then one at TWH in April 2025. The initial robot for the trust will be located at MGH and will therefore support gynae-oncology procedures, current urological activity and some benign gynaecology. The second robot will be based at TWH and will support general surgery, including colorectal and bariatrics.

This preferred option was informed through evaluation of patient activity/ clinical / operational/ value of each system using a multicriteria decision analysis across the range of clinical specialties. The multi-criteria decision analysis matrix can be found in appendix 4.

The final choice of robot supplier was based on the system that the project group considered provides the best clinical outcome and value for money chosen through a robust procurement evaluation exercise.

Alternative financial models were reviewed e.g. capital purchase, capitalised lease (IFRS 16) and potential revenue solutions. The preferred financial model is a pay per case revenue model as this is fully within the Trust's control and does not depend upon capital resourcing (whether IFRS 16 leased or purchased). However, the Trust has included a request for IFRS 16 capital resource in its 2024/25 plans, and this approach, if fundable, does provide a significantly better I&E financial outcome.

Contract information and costs of procurement are included the financial and commercial case below.

Note: There are there are no assumptions in this case around the Fordcombe and Wells Suite activity, thus ensuring no double counting of activity.

Key benefits to come from the investment.

For patients and for hospital efficiency:

Improved health and clinical outcomes for patients *(trials have shown a "striking" four-fold (77 per cent) reduction in prevalence of blood clots (deep vein thrombus & pulmonary emboli) - a significant cause of health decline and morbidity[1]) See appendix three on clinical quality improvements and associated cost avoidance*

Reduced operative and post-operative complications, pain and infections leading to re admission. Reduced readmission (*trials have shown a 21% 90-day readmission rate for the robot-assisted group vs 32% for open surgery*

Reduced length of stay in a hospital bed leading from a quicker recovery time and return to normal activities *(trials show 20% less time in hospital[2])*

For staff and for hospital efficiency

There is clear consensus that with a programme of RAS in place MTW will have a boost to surgical centre status and ongoing improvement in the ability to recruit to senior surgical roles

To offer robotically trained staff the opportunity to use their key skills within MTW

Development opportunities for current clinical staff while recruiting and retaining the surgeons of the future

Reduction in risk of occupational injury/repetitive strain injury

The potential to lever RAS to develop private income for the trust

Placing MTW strategically in a position to expand urology cancer surgery as regional opportunities arise

KPI Measurable benefits

Note: The will be further joint development, in partnership with Intuitive Surgical, of a range of KPIs to support most effective delivery of the RAS programme. This collaborative development of KPIs will be a key part of the implementation phase of the project

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
Reduced average LOS for key procedures	Existing px ALOS open c.8 days lap 2.5 days	1 day	LoS Data. Sign post procedure malignant hysterectomy 2022-23	12 months	Surgery and gynaecology GM with BI support

[1] https://doi.org/10.1186/s13063-022-06421-7

[2] https://jamanetwork.com/journals/jama/fullarticle/2792543

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
			compared to 12 months from go live		
Reduce readmission rate for key procedures	Existing px 30-day readmission open 8% days lap 5%	2%	Readmissions rate 30 days (%) within days for all malignant hysterectomy		
Reduce time to fill consultant vacancy	X	x-30%	Medical staffing data for gynaecology – oncology consultant vacancy and appointment	12 months	surgery and gynaecology GM with BI support
Increase RAS surgery performed at MTW	0	725 / yr	Activity data	ongoing	surgery and gynaecology GM with BI support

Main risks associated with the investment

Risk if not doing it:

The most significant risk of not offering robotic surgery opportunities is the impact of recruitment and retention of surgeons. Many, in fact most new trainees, are now trained on this technology and are looking for jobs which support their career.

At present units in Kent with a robot are referring patients to the gynae oncology service at Maidstone for non-robotic surgery because Maidstone is the referral centre. It is the senior clinical view that this situation is untenable and that services will be taken away soon, if this situation continues

Delivery risks:

- Learning Curve: Surgeons require extensive training to master the system, potentially affecting initial productivity and requiring a significant investment in training resources and their own time.
  - The risk is mitigated by ensuring a robust training programme is included in the contract so that there is ample time for the clinical teams to be trained. Consultants have expressed interest in additional sessions/time to support learning.

- Operational Challenges: The system's size can present logistical challenges in operating rooms, and setup and operative times may be longer than traditional surgeries.
  - The risk is mitigated by ensuring comprehensive planning and designing of the system. A full structural and electric survey of both hospital sites has been undertaken.

TIMETABLE -	
Milestone	**Date**
Feasibility and clinical engagement study complete	Feb 2024
OBC to BCRP	March 2024
ETM	April 2024
OBC approved at Finance and Performance Committee	May 2024
Tender and tender evaluation	June 2024
FBC to Board	August 2024
ICB double lock	September 2024
Enter into contract and collaborative KPI development	September 2024
Training	September- October 2024
First robot operational	October 2024
Check point – pre-purchase of second robot	December 2024
2nd robot operational TWH	April 2025

Appendices

1. Activity plan
2. Financial model
3. Cost reduction and cost savings
4. Robot clinical option evaluation matrix
5. Robot Theatre Schedule Plan
6. Benefits tracker
7. Draft Pay Per Case contract

Strategic Case

This Full Business Case (FBC) is for the provision of two surgical robots for MTW.

Background

Robotic Assisted Surgery (RAS) allows clinicians to perform complex procedures with more precision, flexibility and control than is possible with conventional techniques.

Over the last 25 years minimally invasive laparoscopic surgery has increasingly replaced open surgery across many specialties, resulting in significant patient benefits as well as much reduced lengths of stay with consequent positive impact on hospital bed capacity.

RAS was first introduced in 1999 and was a way of carrying out minimally invasive surgery (MIS) with the robot performing the surgery, whilst being controlled by the surgeon at a 'console'. It gives the surgeon the advantage of a three-dimensional (3-D), high-definition view, the control of the camera and a number of robotic arms. The instruments are all articulated with a robotic wrist, which precisely mimics the surgeon's movements.

Whilst RAS was first developed for cardiac procedures, it has been used mostly in urological procedures, particularly radical prostatectomy. Now it is increasingly being used in gynaecological procedures, general surgery and bariatric surgery.

All of the 3 other acute general hospital trusts in our region already have surgical robots in place.

The Royal College have established an England Robotics Group and a robotics and digital surgery initiative (RADAR) to inform the development of the future of surgery. There is no doubt that robotic technologies are a key part of the future of surgery

The case for change

As described above, RAS is a surgical technique being performed worldwide and is increasing year on year. Currently, MTW does not have a surgical robot on either of its sites. Some of our urologists provide robot assisted surgery at Medway Foundation Trust and in Eastbourne Hospital in East Sussex. Long term, this is considered an unsatisfactory arrangement. The provision of a robot is important to the future of surgery developments and many surgeons in training have robotic skills that they wish to use and develop in consultant career. A continued lack of access to robotic assisted surgery at MTW will have a direct impact on recruitment and retention of surgeons for the future.

At present units in Kent with a robot are referring patients to the gynae oncology service at Maidstone for non-robotic surgery because Maidstone is the referral centre. It is the senior clinical view that this situation is untenable and that services will be taken away soon, if this situation continues.

Objectives

The development of a robotic surgery programme at MTW has the following objectives:

1. Improve the quality of care; including safety, outcome and experience for patients requiring complex surgery
2. Develop our staff and ensure that MTW remains a dynamic, high quality environment in which to work and learn and that the trust attracts and retains the best medical and other clinical staff (including trainees, registrars, and consultant surgeons).
3. Secure a position as a leading surgical centre in the region. The other 3 acute general hospital trusts in our region already have RAS.

Case for change re objective 1

Improve the quality of care; improved safety, improved outcome and improved experience provided for patients

The benefits of minimal access surgery are well understood, quicker return to normal activities, reduction in complications, pain and infection, less blood loss, length of stay and readmission rate are all improved with a laparoscopic over open approach. RAS will increase the volume of patients, particularly patients who require the more complex surgery, suitable for laparoscopic rather than open surgical approach.

Minimally Invasive surgery has proven better outcomes in many procedures, including:

- Less operative trauma
- Shorter hospital stays
- Less pain and quicker recovery

There is evidence that the RAS approach can further:

- reduce complication rate
- enable a minimal access approach which might not be possible without robot assistance, which then leads to the clinical benefits of:
  - Less operative trauma
  - Shorter hospital stays
  - Less pain
  - Quicker recovery

These benefits have published quantifiable data that is referenced and applied to planned activity later in this case. For some major cancer oncology cases the data shows cost reduction of over £2600 and £800 per robotic assisted case against open and laparoscopic approaches respectively. (see appendix 3 – cost savings)

Case for change re objective 2

Develop our staff and ensure that MTW attracts and retains the best medical staff (trainees, registrars, and consultant surgeons).

For surgeons there are several reported benefits of a robotic assistance approach:

- Better vision - Augmented reality allows the surgeon to see things that are not clearly visible to the human.
- Precision – scaling of movements, filter of tremor, 4 instruments leading to better retraction, greater degrees of freedom of movement. Leading to lower blood loss.
- Ergonomic – With manual laparoscopic instruments, a surgeon has to carry out every movement through a tiny incision, pivoting their hand to the right to move their instrument left and so on. Surgeons are often forced to lean or stoop with arms stretched at awkward angles, meaning that repetitive strain injury (RSI), back, knee and neck injuries are common. The physical challenge for surgeons is particularly severe when operating on patients with high BMI. A robot considerably reduces fatigue and work-related injuries, enabling surgeons to remain in work when they might otherwise retire earlier.

There are over 44,000 surgeons trained in RAS worldwide. As new consultants look for where to choose to work in their new hospital roles, the availability of robot and ongoing training and experience is a factor in their decision making. Many surgeons are accessing robotics as part of their training and would expect to have access to the technology as they develop their consultant careers. MTW have a number of robotically trained surgeons, some of whom are accessing robot time in other organisations to maintain their skills. This is not a sustainable solution and has already presented challenges.

Case for change re objective 3

Secure a position as a leading surgical centre in the region

The Trust provides specialist cancer services to around 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre at MGH and at Kent and Canterbury Hospital in Canterbury. MTW is the regional cancer centre in Kent and Medway and therefore developing a recognised surgical centre of excellence is a key deliverable and will support improved patient outcomes and staff satisfaction.

All three of the other Acute NHS Trusts in Kent and Medway already have RAS in place

At present units in Kent with a robot are referring patients to the gynae oncology service at Maidstone for non-robotic surgery because Maidstone is the referral centre. It is the senior clinical view that this situation is untenable and that services will be taken away soon, if this situation continues

- A robot will Improve recruitment and retention - without a robot it will become increasing difficult to recruit and retain surgeons and theatre staff because access to RAS is increasingly 'the norm' in key specialties and a significant factor in accepting and remaining in a job. This could in turn compromise the ability of the trust to offer viable services and threaten its designation as a cancer centre and training hub.
- MTW surgeons are highly skilled at laparoscopic surgery with excellent outcomes. It takes a long time to become accomplished in laparoscopic surgery. A number of MTW surgeons are nearing retirement age and succession planning is needed. Attracting trainees is increasingly difficult as trainees expect to train on a robot. Training times for RAS are considerably shorter than for laparoscopic surgery.
- Robotic Surgery would complement the specialist surgery required within the Kent Oncology Centre and the training undertaken within the International Minimal Access Centre for Surgery (IMACS). Not offering a robotic service to our patients carries a significant risk that MTW surgery will miss out on development opportunities and complex surgical services will be developed elsewhere in the region.

Constraints and dependencies

Constrained by need for high quality theatre environment.

In collaboration with the preferred supplier the Trust has had appropriate surveys completed

Estates – Structural and Electrical surveys to have taken place and the costs of required works are in the financial model

IT **–** To be confirmed on completion of procurement stage. Initial costs estimate, agreed with Digital colleagues included within the business case financial model

Economic Case - The short list options reviewed in detail at Outline Business case stage

Options

1. Do nothing
2. Develop a RAS programme beginning with one surgical robot at Maidstone Hospital
3. Develop a RAS programme beginning with one surgical robot at Tunbridge Wells Hospital
4. Develop a phased RAS programme with two surgical robots, one at each site. Initially one at MGH followed by one at TWH

There are a range of possible financial payment mechanisms for each option. In summary these include:

1. Capital purchase – conventional approach
2. Capitalised Lease – i.e. an arrangement to lease the asset over a term with annual rentals. These are now capitalised under IFRS 16
3. Revenue solution – examples of these may include a fully variable cost per case approach, or a shared/pooled asset approach where there is no specifically identified asset that the Trust uses.

These financial options were tested as part of the procurement and the result is that a pay per case revenue is proposed as not requiring capital funding. See Commercial section of the case.

Option 1 – Do nothing

Description: The do-nothing option would see no development of RAS at MTW c within its footprint either directly or in-directly with a partner. Some of our robotically trained surgeons would continue to access robots in other Trusts.

Potential benefits and risks: The benefits of this option are that it maintains the status quo and requires no change. There is no additional cost associated with this option and it does not require any additional training of staff. The risks are that the potential best patient outcomes are not achieved, current surgeons may choose to leave the Trust to access reliable robotic capacity and that we fail to recruit new surgeons, ultimately resulting in the potential loss of MTW as a cancer centre.

Key activity and financial assumptions:
There are no activity assumptions associated with this option. The most likely financial risk is the use of expensive agency and locum surgeons to cover future vacancies if we fail to recruit or lose existing surgeons due to a lack of access to robotic surgery. There will be no avoided costs relating to clinical or workforce saving

Strengths /Opportunities
None

Weaknesses/ Threats
It does not deliver RAS for the patients and staff. Local patients who require RAS will have to travel to other more distant regional centres. RAS surgeons employed by MTW need to spend part of their time travelling to other trusts and the patient pathway is split across hospitals

This option is rejected because it does not deliver RAS for the patients and staff at MTW and does not meet any of the business case objectives.

Option 2 – Develop a RAS programme at MTW with one surgical robot at Maidstone Hospital

Description
Develop RAS initially on the Maidstone site at MTW. **Initially with one surgical robot used for the gynae oncology, gynaecology and potentially urology services to the required specification**. We will

look to enter a contract that, subject to appropriate review, allows for the expansion of robotic assisted surgery across sites at MTW over the programme

Potential benefits and risks: The benefits of this option are that MTW will initially have a robot at MGH with a boost to surgical centre status and recruitment/ retention of clinical staff. West Kent patients will have increased access to robotic surgery with improved outcomes and experience.

Option 2 Key activity assumptions:

Activity plan for MGH						
Spec	**Procedure**	**Yr 0 (6 months)**	**Yr 1**	**Yr2**	**Yr3**	**Yr 4**
GynOnc	Total abdominal hysteroctomy	30	77	130	150	150
GynaeOnc	Simple hysterectomy (increase trainig ramp)	20	40	0	0	0
Gynae	Hysterectomy	20	60	80	120	120
	Pyeloplasty	10	20	20	20	20
	Adrenacdectomy	10	10	10	10	10
	Bring Kidneys back (MFT - how many)	20	40	40	40	40
	simple kidney work (already do internally)	5	10	10	10	10
Gen Surg	T202 - Primary repair of inguinal hernia	40*	0	0	0	0
	* activity for training /weekend					
Total	**MGH NHS**		**160**	**250**	**310**	**350**
Private	weekend or flexi 6-4-2	10	20	25	25	25

Strengths /Opportunities
This will secure MGH as a surgical centre of choice for new consultants and support the existing robotically trained consultants. It will offer more West Kent patients the opportunity to access robotic surgery with improved outcomes and experience. It will also support the development of wider theatre and surgical ward nursing teams in learning new skills and techniques as well as an improved opportunity to undertake research.

Risks
Any phased return of complex urology surgery from Eastbourne and Medway (not in the model) requires regional co-operation and careful management of specialised surgery centre requirements.

Option 3 – Develop a RAS programme at MTW with one surgical robot at the Tunbridge Wells Hospital

Description
Develop RAS initially on the Tunbridge wells site at MTW. Initially with one surgical robot used for the general surgery colorectal / upper GI and gynaecology services to the required specification. We will look to enter a contract that, subject to appropriate review, allows for the expansion of robotic assisted surgery across sites at MTW over the programme

Potential benefits and risks: The benefits of this option are that MTW will initially have a robot at TWH with a boost to surgical centre status and recruitment/ retention of clinical staff. West Kent patients will have increased access to robotic surgery with improved outcomes and experience.

Key activity and financial assumptions:
Please refer to key clinical activity assumptions below
Each site option has an available ‘pool’ of procedures that could be done using robotic assistance.
The number of the procedures actually forecast to be carried out from the pool is a function of the operational timing. Phasing as the new techniques becomes embedded and capacity constraints

Activity plan for TWH		in learning curve				
Spec	Procedure	Yr 0 (6 months)	Yr 1	Yr2	Yr3	Yr 4
General Surgery	Bariatrics/UGI	0	125	175	175	175
General Surgery	Colorectal/LGI	0	150	200	200	200
TWH NHS Total		**0**	**275**	**375**	**375**	**375**
Private	weekend or flexi 6-4-2		25	50	50	50

Strengths /Opportunities
This TWH option will secure TWH as a surgical centre of choice for new consultants and support the existing robotically trained consultants. It will offer more West Kent patients the opportunity to access robotic surgery with improved outcomes and experience. It will also support the development of wider theatre and surgical ward nursing teams in learning new skills and techniques as well as an improved opportunity to undertake research.

Bariatric surgery is a relatively new robotic procedure, this development could support research/further development opportunities with a potential robot manufacturer. There may be potential for proctorships for our bariatric consultant surgeons.

Option 4 – Develop a RAS programme starting with two surgical robots, one at each hospital site

Description: It provides robot assisted surgery for MTW patients via a robot located on both Maidstone and Tunbridge Wells.

Potential benefits and risks: The benefits are that MTW clinicians and patients at both sites have access to a dedicated robot.

Key activity and financial assumptions:

Activity plan for MGH						
Spec	Procedure	Yr 0 (6 months)	Yr 1	Yr2	Yr3	Yr 4
GynOnc	Total abdominal hysteroctomy	30	77	130	150	150
GynaeOnc	Simple hysterectomy (increase trainig ramp)	20	40	0	0	0
Gynae	Hysterectomy	20	60	80	120	120
	Pyeloplasty	10	20	20	20	20
	Adrenacdectomy	10	10	10	10	10
	Bring Kidneys back (MFT - how many)	20	40	40	40	40
	simple kidney work (already do internally)	5	10	10	10	10
Gen Surg	T202 - Primary repair of inguinal hernia	40*	0	0	0	0
	* activity for training /weekend					
Total	**MGH NHS**		**160**	**250**	**310**	**350**
Private	weekend or flexi 6-4-2	10	20	25	25	25

Activity plan for TWH		in learning curve				
Spec	Procedure	Yr 0 (6 months)	Yr 1	Yr2	Yr3	Yr 4
General Surgery	Bariatrics/UGI	0	125	175	175	175
General Surgery	Colorectal/LGI	0	150	200	200	200
TWH NHS Total		**0**	**275**	**375**	**375**	**375**
Private	weekend or flexi 6-4-2		25	50	50	50

Strengths /Opportunities
It offers our clinicians access to a robot at both sites quickly and West Kent patients increased access to robotic surgery. It has the potential to develop for the region additional complex urology surgical capacity.

Commentary on the choice of preferred option

The surgical and operational leads conducted a rigorous assessment of available RAS suppliers.

Visits to each supplier included familiarisation with each system a look at the manufacturing, the robot's strengths and weaknesses and a good assessment of what is available and what capabilities are available in the market currently.

To assist our surgical teams with developing a specification and choosing a best value for money option a Multi criteria decision (MCD) analysis was carried out. The MCD format can be found in appendix 4.

The preferred option was option 4. Provide robot assisted surgery for MTW patients via two robots, with phased introduction of one robot located on both Maidstone and Tunbridge Wells sites. The first robot will be located at Maidstone in the autumn of 24/25 with the robot at TW being implemented in April 2025.

Once fully operational, after 6 months, it is envisaged both robots will deliver 5 days per week operating capacity. During the implementation and training the utilisation will be phased and this has been built into the planning.

Benefits summary

The main benefits that accrue from implementation relate to clinical quality and patient experience - reduced operating times and improved accuracy allow a quicker recovery with less pain, an ability to get back to normal activity faster and lower complication and re- operation rates with better long-term functional outcomes.

In the OBC we developed the forecast clinical efficiency savings based on calculations from Di Vinci evidence/research and alternative efficiency metrics based on Nuffield Trust clinical data over a number of years, comparing results (*on ALOS /complications/ conversions and readmissions*) between laparoscopic / open surgical approaches to robotic approaches applied to the MTW projected robotic case mix.

For the FBC these assumptions have been further reviewed. The financial model now includes additional income relating to an estimate of future growth in short stay surgical activity arising from increased throughput of elective sort stay surgery across a range of procedures. The capacity for this additional activity, as well as additional private patient activity, has come from a reduction in bed ALOS compared to MTW current averages and theatre capacity arising from productivity and efficiency in theatres.

Commercial Case

Procurement route

Procurement advised on the Robot procurement. They identified two compliant frameworks that allowed a mini-competition

Reasons for choice of Intuitive DaVinci as preferred provider was summarised in a clinical matrix and included the following:

Training – Training is provided both off and on site with Intuitive, this is free of charge

Evidence – Most published high-level evidence is from users of the DaVinci robots

Components – The DaVinci has integrated wristed stapling device, integrated ICG, integrated wristed energy device, integrated table motion. All of these elements make the robot ideal for robotic surgery which allows the procedure to be carried out totally robotically rather than hybrid (half robotic, half standard laparoscopic)

NHSSC advised that the Trust can direct award under the Framework as a compliant route to market. The chosen supplier is Intuitive Surgical

Agreed charging mechanisms

Pay per use programme is an elevated relationship between Intuitive and MTW that aligns on providing more access to deliver more minimally invasive care.

The relationship does include:

- System & Service pricing at a procedure level
- Flexibility in fleet management, ability to upgrade to new technology without penalty through the life of the partnership
- Access to new technology at launch
- Elevated da Vinci Eco-system resource management

Agreed contract length

This is 7 years

Key contractual clauses

- Agree on total procedures during the 7-year contract
- Fee per procedure calculation = system price + service + Interest / total procedure for 7-year term
- Quarterly billing
- No penalty or adjustment of pay per procedure cost for over or underperforming i.e. the Trust only pays for what it uses, with no fixed minimum payment or volume requirement
- Intuitive can end contract at any time

Staffing plans

Provision of a surgical robot does not require any additional staff and will support the recruitment into some surgical vacancies i.e. consultant posts.

Some of the current surgeons are robotically trained and have either current experience of undertaking robotic procedures or are robotically trained.

There are a number of others who will require training which can be provided by the surgical robot supplier and supported by the Trust. The costs will be fully tested during procurement.

Training Plans

Implementing a comprehensive training program for surgeons and staff is crucial for the successful integration of robotic surgeries into a healthcare facility. Outlined below are the key components of the training program needed for surgeons and staff involved in operating and assisting in robotic surgeries

- Basic Robotic Surgical Training
- Console Training for Surgeons
- Advanced Console Skills
- Procedural Training
- Team Training
- Instrumentation and Sterilisation Training
- Staff Cross-Training
- Continuous Education and Simulation
- Certification and Credentialing
- Integration of Robotic Training into Residency Programs
- Mentoring and Peer-to-Peer Learning
- Evaluation and Feedback Mechanisms
- Training on System Maintenance and Troubleshooting
- Ethical and Legal Considerations
- Continuous Professional Development

A comprehensive training program is planned to encompass these elements and will ensure the safe and effective use of robotic surgical systems but will also contribute to the ongoing professional development and success of the surgical team. Regular updates and adaptations to the training programs based on technological advancements and feedback from participants are essential for continuous improvement.

Training is supported by the company and is included in price of purchase.

The core training is provided on site with a tutor paid by the company and will speed up learning curve without affecting the patient care. Each consultant surgeon will be expected to undertake the following training program before having access to use the robot in live operations:

- 30 Hours Simulation Training to be carried out within Hospital after system delivery on the da Vinci platform – Supported by Intuitive Surgical Clinical Team
- 3 days (staggered) In-Service Sessions covering:
  - Theatre lay-out
  - Troubleshooting
  - Port placement
  - Patient positioning
  - Rolls and task allocation
  - System set-up
  - Docking

All the above are supported by Intuitive Surgical Clinical Team

As part of implementation planning, there will be a training plan for all RAS staff, this will ensure that the phased approach will not see too many surgeons being away for training at one time, therefore not impacting on the delivery of current activity. The surgeons will commit to carrying out training during their SPA's not to impact on current activity. Consultant surgeons are keen to do additional sessions to support learning curve.

Impacts on and interfaces with other services.

The provision of a surgical robot will have a minimal impact on other clinical service such as diagnostics and outpatients.

Critical Care – evidence shows that a reduction in open/conversion to open surgery will reduce the demand on ICU/HDU beds.

Decontamination / Sterilisation:

The current sterilisation service provided for MTW is offered through IHSS with a service that runs 24/7. Normal decontamination turnaround time is 24 hours. Some robotic equipment requires a low temperature sterilisation process. IHSS provide this service but there is some uplift in cost £109.84 vs current (£30-£60) reflected in the financial model. In the implementation phase more accurate costings will be developed and these can be monitored in year as low temperature processes are separately recorded.
There is one location currently in K&M where this sterilisation method can be performed. If that site fails the business continuity process is a provider in London which would entail a loner turnaround time. However, breakdown is rare and costs of breakdown are covered in current contract terms

Theatres - Training of theatre staff is part of the training package to be included in the tender evaluation. Surgeons who commit to developing their skills on MTW surgical robots will undertake an initial application procedure including some agreed commitment to flexible working, in order to make best use of theatre / robot time while training and ramping up of robotic procedure volumes. Some of the available capacity is on Saturdays and within existing budget.

Robot Theatre Schedule Plan

Included at appendix 5

Estates – Structural and Electrical surveys have taken place
The electrical systems at MGH have been surveyed and do require some work to bring them up to standard
The initial estimate is in the financial case and comprises prioritised elements of the following elements of work with a budget recommendation in the financial model of c £90k. This will require capital funding.

8kVA IPS with IPS and TNS circuits. Dual 10kVA modular UPS supply and install.
Isolate circuitry and modify wiring to provide IPS and TNS circuits to new vertical medical trunking.
Removal of camera stack pendant, double screen pendant, single screen pendant and endoscopy pendant.
Make good plasterboard ceiling etc.
Supply and install vertical medical trunking
Reinstate electrical blinds
Replacement of luminaires.
Decommission C02.
Re supply 2 number data ports to vertical medical trunking
Test and commissioning.
Preliminaries
BWIC.
OHP at 10%.

IT –Estimated costs, agreed with Digital colleagues of c.£25k covering both sites for server and licence costs, included within the business case financial model and requiring capital funding.

Financial Case – Funding and affordability

Our preferred payment method is “Pay Per Case” revenue approach, although a simple capitalised lease option has also been explored, and is included here for comparison. The main reason for the choice of a revenue approach is that no capital funding is required, so the case is not constrained by availability of capital. The Trust has included a request for lease capital in its 2024/25 plans submitted to NHSE, and if that capital is made available, an IFRS 16 solution would afford a better Income and Expenditure position.

The summarised financial impacts of the pay per Case funding option are:

Da Vinchi Xi	Pay per Procedure								
	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Total (8 Yrs)
Difference to 23/24 actual	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income									
Gynae	-	-	-	-	-	-	-	-	-
Gynae Onc	-	-	-	-	-	-	-	-	-
Urology	184	407	407	407	407	407	407	407	3,033
Gen Surg	-	-	-	-	-	-	-	-	-
Bariatric	-	260	678	678	678	678	678	678	4,326
Private	-	394	678	678	678	678	678	678	4,464
Additional SS - Gen Surg	24	1,106	1,499	1,678	1,678	1,678	1,678	1,678	11,019
	208	**2,167**	**3,262**	**3,441**	**3,441**	**3,441**	**3,441**	**3,441**	**22,842**
Pay Costs									
Private activity - additional sessions									-
	-	-	-	-	-	-	-	-	-
Non Pay Costs									
General Non-pay (NHS)	79	956	1,365	1,498	1,498	1,498	1,498	1,498	9,891
General Non-pay (Private)	-	87	156	156	156	156	156	156	1,023
Da Vinchi Maintenance									-
Da Vinci pay per px contract	249	928	1,190	1,286	1,286	1,286	780	428	7,434
Depreciation & PDC	25	66	64	62	60	58	56	38	427
Capital charges - IFRS16	105	422	422	422	422	422	422	316	2,954
Interest	-	-	-	-	-	-	-	-	-
	459	**2,458**	**3,197**	**3,424**	**3,422**	**3,420**	**2,912**	**2,436**	**21,730**
I&E Total surplus / (deficit)	**(251)**	**(291)**	**66**	**17**	**18**	**20**	**529**	**1,005**	**1,112**
Capital expenditure	**237**	**140**							**377**
IFRS16 capital	**1,477**	**1,477**							**2,954**
Initial stock order - cashflow only	**90**	**90**							**180**

Notes:

Assumes that private activity will be delivered within existing sessions - no additional staff costs have been included.

The summarised financial impacts of the Lease funding option are:

Da Vinchi Xi	IFRS16 Lease								
	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Total (8 Yrs)
Difference to 23/24 actual	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income									
Gynae	-	-	-	-	-	-	-	-	-
Gynae Onc	-	-	-	-	-	-	-	-	-
Urology	184	407	407	407	407	407	407	407	3,033
Gen Surg	-	-	-	-	-	-	-	-	-
Bariatric	-	260	678	678	678	678	678	678	4,326
Private	-	394	678	678	678	678	678	678	4,464
Additional SS - Gen Surg	24	1,106	1,499	1,678	1,678	1,678	1,678	1,678	11,019
	208	**2,167**	**3,262**	**3,441**	**3,441**	**3,441**	**3,441**	**3,441**	**22,842**
Pay Costs									
Private activity - additional sessions									-
	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Non Pay Costs									
General Non-pay (NHS)	79	956	1,365	1,498	1,498	1,498	1,498	1,498	9,891
General Non-pay (Private)	-	87	156	156	156	156	156	156	1,023
Da Vinchi Maintenance	86	344	344	344	344	344	344	258	2,411
Da Vinci pay per px contract									-
Depreciation & PDC	25	66	64	62	60	58	56	38	427
Capital charges - IFRS16	105	422	422	422	422	422	422	316	2,954
Interest	34	127	109	91	71	51	29	8	521
	330	**2,002**	**2,461**	**2,573**	**2,552**	**2,529**	**2,506**	**2,274**	**17,227**
I&E Total surplus / (deficit)	**(122)**	**165**	**802**	**868**	**889**	**912**	**935**	**1,166**	**5,615**
Capital expenditure	**237**	**140**							**377**
IFRS16 capital	**1,477**	**1,477**							**2,954**
Initial stock order - cashflow only	**90**	**90**							**180**
Notes:									
Assumes that private activity will be delivered within existing sessions - no additional staff costs have been included.									

Project lifetime of 84 months per unit. All costs include VAT.

Additional Financial Information & Assumptions

The pay per use approach is within the IFRS 16 lease accounting standard as the Trust obtains substantially all the economic benefits of use of the robots, and the robots are specifically identified with the Trust and under its control. However, as the payment mechanism is fully variable with use, there is no guaranteed payment stream to be assessed as constituting a lease payment. Therefore, there is no initial capital impact of this approach, and the implicit “right of use asset” value is zero.

As the arrangement does fall within IFRS 16, there is then a requirement to consider if this carrying value is appropriate. It has been assumed in this case that the robots would then be revalued, using IFRS 16

principles, and the resultant asset value would be depreciated over the term of the contract. This is charge included in “capital charge IFRS 16” in the pay per procedure financial model above.

This does introduce an element of “double count” into the financials, and this anomaly has been raised with NHSE/DHSC accounting leads for consideration and review (in relation to a different business case) but the accounting as currently understood is represented in this case.

The alternative, direct IFRS 16 approach in the second table requires capital funding as the initial transaction is capitalised as a lease. However, this funding approach avoids the “double-count” issue and is therefore preferable from an Income and Expenditure position. If the capital lease funding is made available following the plan submission, this route would be preferred, at least for the first robot in 2024/25.

The current financial modelling includes both the estimated impact of IFRS16 for both the pay per case and full lease options, but this will need to be reviewed once the contract is finalised.

For all options, there is a requirement for capital funding required in the case relating to installation works, peripheral equipment and the provision of an additional IT server. The requirements total £377k across 2 financial years as shown above. There is also an up-front purchase of stock required for the equipment and consumables used with the Robot. This will be a cashflow only impact, as the costs will be charged to the I&E as used, and are included in the general non-pay costs in the financial modelling.

The majority of targeted procedures would have been carried out at MTW using a laparoscopic or open approach, and therefore there is minimal income growth from these procedures. However, the use of RAS will result in improved recovery times, resulting in lower bed day use for the targeted patients, and the business case includes an assumption of increase in general surgical short-stay activity, which will utilise this additional capacity

The private patient income has been estimated using an uplift of 20% from tariff (based on the MTW 23/24 average for private billings), although this will vary depending on who is paying, and which specific procedures are performed. This has resulting in an average margin close to the £4k per procedure used in the OBC. No staffing costs have been included for the private patient work as it is anticipated that these procedures will be done within existing surgical sessions, rather than having specific additional sessions for private work.

The Surgical Service plan for this is in the activity plan in appendix 1.

Avoided costs of locum surgeon cover, estimated at £550k in total over the seven years of the programme, were included in the OBC. However, these have not been included in the FBC financial modelling above as they would be an avoidance of future overspends against budget, rather than a reduction in budget required. It is considered reasonable to assume that a modern surgical department with latest up to date tools will be more attractive to new surgeons and that without offering these tools recruitment will be increasingly difficult. Therefore, in comparison with doing nothing, there will be avoided costs of locum surgeon consultant cover, with that cost avoidance building over the 7 years of the programme.

Further details on the workings behind the financial model are attached at Appendix 2.

Management Case: Arrangements for successful implementation

Governance arrangements
The scheme is an integral part of surgery development programme

Project team
The surgical divisional leadership team will hold responsibility for developing the RAS programme supported by corporate services.

Delivering the key measurable benefits
See appendix 6

Description / Measurable Benefit	Baseline value	Actions / Notes	Named Lead
A short description of the expected benefit's	What is the current position	Actions that may be required to ensure that this benefit will be realised	The person accountable for this benefit
Reduced average LOS for key procedures (malignant hysterectomy)	Existing px ALOS open 6 days lap 2.5 days	LoS Data. Sign post procedure malignant hysterectomy 2022-23 compared to 12 months from go live	Surgery and gynaecology GM with BI support
Reduce readmission rate for key procedures (malignant hysterectomy)	Existing px 30 day readmission open 8% days lap 5%	Readmissions rate 30 days (%) within days for all malignant hysterectomy	Surgery and gynaecology GM with BI support
Reduce time to fill surgical consultant vacancy by 30%	X		surgery and gynaecology GM with BI support
Increase RAS surgery performed at MTW	725		surgery and gynaecology GM with BI support

Timetable/ project plan

TIMETABLE -	
Milestone	**Date**
Feasibility and clinical engagement study complete	Feb 2024
OBC to BCRP	March 2024
ETM	April 2024
Finance and Performance Committee	May 2024
Trust Board – OBC requesting decision to go to procurement process	June 2024
Tender and tender evaluation	July 2024
FBC to Board	August 2024
ICB double lock	September 2024
Enter into contract and collaborative KPI development	September 2024

Training	September- October 2024
First robot operational	October 2024
Check point – pre-purchase of second robot	December 2024
2nd robot operational TWH	April 2025

Managing any key risks associated with delivering the project

Risk	Baseline risk score (l x i)	Summary mitigation/ contingency	Mitigated risk score (L x i)	Lead
Condition of theatres	10	Estates on working group	0	Director of Surgery
Private activity	12	Requires a trust private facility at the Wells suite and at MGH	10	Exec for Strategy Planning, System and Partnerships with Director of surgery
Steep learning curve Surgeons require extensive training to master the system, potentially affecting initial outcomes and requiring a significant investment in training resources	10	Comprehensive training programme.	6	Clinical directors of surgery
Operational Challenges - The system's size can present logistical challenges in operating rooms, and setup and operative times may be longer than traditional surgeries.	10	Review with estates and operating theatre teams	6	Operating theatre management team

Data Protection Impact Assessment (DPIA)

The process designed to identify risks arising out of the processing of personal data and to minimise these risks as far and as early as possible

Not required ☐ Completed ☐ Required but not completed yet ✓

The DPIA process is well underway, the DPIA is in working draft. The MTW cyber security team are engaged with the project, aware that international data transfer and data processing agreements are required. Entering into contract will only happen once the DPIA has been approved. There is agreement with Intuitive Surgery to collaborate on this with the Trust.

Clinical Quality Impact Assessment (preferred option)

Clinical Effectiveness			
Have clinicians been involved in the service redesign?	Yes ✓	No ☐	N/A ☐
Has evidence been used in the redesign? (e.g. NICE guidance)	Yes ✓	No ☐	N/A ☐
Are relevant Clinical Outcome Measures already being monitored?	Yes ✓	No ☐	N/A ☐
Are there any risks to clinical effectiveness?	Yes ☐	No ✓	N/A ☐

Have the risks been mitigated?	Yes ☐	No ☐	N/A ✓
Have risks been added to departmental risk register review date set?	Yes ☐	No ✓	N/A ☐
Are there any benefits to clinical effectiveness?	Yes ✓	No ☐	N/A ☐

Notes on clinical effectiveness:
Improved health and clinical outcomes for patients

- Reduced operative and post-operative complications, pain and infections
- Reduction in occupational injury/repetitive strain injury
- Reduced length of stay
- Reduced recovery time, quicker return to normal activities
- Development opportunities for current clinical staff while recruiting and retaining the surgeons of the future

Patient Safety. Has the impact of the change been considered in relation to: *(highlight as appropriate)*			
Infection Prevention and Control?	Yes ✓	No ☐	N/A ☐
Safeguarding vulnerable adults/ children?	Yes ☐	No ☐	N/A ✓
Current quality indicators?	Yes ✓	No ☐	N/A ☐
Quality Account priorities?	Yes ✓	No ☐	N/A ☐
CQUINS?	Yes ✓	No ☐	N/A ☐
Are there any risks to patient safety?	Yes ✓	No ✓	N/A ☐
Have the risks been mitigated?	Yes ☐	No ☐	N/A ✓
Have the risks been added to department risk register & review date set?	Yes ☐	No ☐	N/A ✓
Are there any benefits to patient safety?	Yes ✓	No ✓	N/A ☐
Notes on patient safety:			

Patient experience			
Has the impact of the redesign on patients/ carers/ members of the public been assessed?	Yes ✓	No ☐	N/A ☐
Does the redesign lead to improvements in the care pathway?	Yes ☐	No ✓	N/A ☐
Are there any risks to the patient experience?	Yes ☐	No ✓	N/A ☐
Have the risks been mitigated and / or added to the departmental risk register and a review date set?	Yes ☐	No ☐	N/A ✓
Are there any benefits to the patient experience?	Yes ✓	No ☐	N/A ☐
Notes on patient experience:			

Health inequalities

What planned or potential positive or negative impacts will the development have on health inequalities? Consider who may have their service or access to service improved or compromised? Describe these impacts

RAS offers considerable patient benefits compared to open surgery for some procedures, including smaller incisions, less post-operative pain, fewer surgical site infections, shorter hospital stays, fewer complications, faster recovery and return to normal activities, more retention of physical functions / less nerve damage, and fewer readmissions.

The increasing numbers of patients with cancer is leading to a larger cohort of patients requiring complex surgeries, some of which are not possible with traditional surgery. RAS minimises surgical trauma and making RAS available to some of these patients that could not otherwise have had surgery has improved their clinical outcomes. This is of particular note when patients enter the surgical phase compromised from prior chemo-radiotherapy treatments. Therefore, RAS is of benefit to both patients and clinicians.

Compared to open surgery RAS offers reduced operating times and improved accuracy allow a quicker recovery with less pain, an ability to get back to normal activity faster and lower complication and re operation rates with better long-term outcomes. This is due to:

- Reduced wound size – and associated complications from larger wounds.
- Anaesthetic/operative time reduction.
- Improved recovery postoperative from reduced physical debilitation from large wound etc.
- Reduced blood loss (bloodless field).

RAS is particularly advantageous for patients with high BMI. It enables the surgeon to have a good operating view, and reduces postoperative complications and improves wound healing by avoiding the problems associated with large abdominal incisions in obese patients.

Obesity is becoming more prevalent. Health Survey for England 2019 published by NHS Digital[3] found that 28.0% of adults in England were obese and a further 36.2% were overweight. Among adults 16 and over, 68% of men and 60% of women were overweight or obese.

RAS makes it possible to provide a nerve sparing approach to complex endometrial surgery cases to help reduce autonomic urinary, bowel and sexual complications that can occur if pelvic autonomic nerves are damaged during excision.

RAS offers the potential to reduce the incidence of repetitive strain injury, back and neck injuries and fatigue associated with laparoscopic surgery because surgeons are comfortably seated at the console.

The physically demanding nature of laparoscopic surgery, particularly for the increasing proportion of high BMI patients, is contributing to occupational health issues, a reduction in the number of cases that surgeons are able to undertake in a day.

Overall impact on quality					
What is the overall impact on service quality? – *please tick one box*					
Improves quality	✓	Maintains quality	☐	Reduces quality	☐

Clinical lead's comments:

[3] Health Survey for England (HSE) 2019, NHS Digital. Health Survey for England 2019 [NS] - NHS Digital.
HSE 2019 Overweight and obesity in adult and child (digital.nhs.uk)

Appendix 1 Activity plan

Activity plan for MGH						
Spec	**Procedure**	**Yr 0 (6 months)**	**Yr 1**	**Yr2**	**Yr3**	**Yr 4**
GynOnc	Total abdominal hysteroctomy	30	77	130	150	150
GynaeOnc	Simple hysterectomy (increase trainig ramp)	20	40	0	0	0
Gynae	Hysterectomy	20	60	80	120	120
	Pyeloplasty	10	20	20	20	20
	Adrenacdectomy	10	10	10	10	10
	Bring Kidneys back (MFT - how many)	20	40	40	40	40
	simple kidney work (already do internally)	5	10	10	10	10
Gen Surg	T202 - Primary repair of inguinal hernia	40*	0	0	0	0
	* activity for training /weekend					
Total	**MGH NHS**		**160**	**250**	**310**	**350**
Private	weekend or flexi 6-4-2	10	20	25	25	25

Activity plan for TWH		in learning curve				
Spec	**Procedure**	**Yr 0 (6 months)**	**Yr 1**	**Yr2**	**Yr3**	**Yr 4**
General Surgery	Bariatrics/UGI	0	125	175	175	175
General Surgery	Colorectal/LGI	0	150	200	200	200
TWH NHS Total		**0**	**275**	**375**	**375**	**375**
Private	weekend or flexi 6-4-2		25	50	50	50

Appendix 2 Financial model

Summary

Appendix 2 - Financial Summary.p

Activity and financial modelling detail

Appendix 2 - activity & finance m

Capital impact detail

Appendix 2 - MTW Capex.pdf

Appendix 3 Cost reduction and cost savings

There is published evidence of achieved clinical cost savings through application of robotic surgery.

These relate to indicators on:

- Reduction in LOS
- Conversions. (Reduced number of minimal access approaches converting to open procedures)
- Complications – reduced recorded complications from the same surgical procedures
- 30- day readmission – recorded reduction in patient readmission within 30 days of discharge from hospital for the same surgical procedure

Calculating these savings of robotic surgical approaches versus open and laparoscopic approaches at procedure type level, then applying average saving to MTW projected case mix, gives the following forecast savings by each specialty planning to adopt RAS in this case.

A selection of these savings will be tracked through benefits realisation review by the Surgical Division working with the RAS supplier and the detail of this tracking is something the preferred supplier will work together with the trust to define as part of the implementation phase of this project

The next four pages show detail on MTW current metrics by indicator, by surgical route, for the representative selection of surgical procedures that will convert to RAS and the target metrics once conversion to RAS completed.

MTW current metrics by indicator by procedure type set against the target metrics

The current metrics are sourced from NHS HES data (22/22)

The target metrics are

Average Length of Stay

Speciality procedure type	Existing route at MTW	Avg. MTW Surgical Bed Length of Stay (from HES)	Target average surgical bed Length of Stay	Evidence source for target
Colon	Existing Open Cases	10.8	4.7	Benlice
Colon	Existing Lap Cases	8.1	4.7	Benlice
Rectal	Existing Open Cases	10.6	6	Hyde
Rectal	Existing Lap Cases	10.3	6	Hyde
Benign Hysterectomy	Existing Open Cases	2.3	1	Chalooub (QTI)
Benign Hysterectomy	Existing Lap Cases	1.5	1	Chalooub (QTI)
Endometriosis	Existing Open Cases	2	0.8	Raza (QTI)
Endometriosis	Existing Lap Cases	1.3	0.8	Raza (QTI)
Salpingo-Oophorectomy	Existing Open Cases	3.1	1.3	National HES data 22_23
Incisional Hernia	Existing Open Cases	6	1.4	Le Blanc
Benign Hysterectomy (Maid)	Existing Open Cases	4.6	1	Chalooub (QTI)
Benign Hysterectomy (Maid)	Existing Lap Cases	2.5	1	Chalooub (QTI)
Hysterectomy Malignant (Maid)	Existing Open Cases	6	1	Lippiatt (QTI)
Hysterectomy Malignant (Maid)	Existing Lap Cases	2.5	1	Lippiatt (QTI)
Salpingo-Oophrectomy (Maid)	Existing Open Cases	4.1	1.3	National HES data 22_23
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	1.8	1.3	National HES data 22_23
Fundoplication	Existing Lap Cases	3.1	2.1	National HES data 22_23
Hiatial Hernia	Existing Lap Cases	4.7	2.1	National HES data 22_23
Ventral Hernia	Existing Open Cases	2.2	1.7	National HES data 22_23

% conversions

Speciality procedure type	Existing route at MTW	Avg. MTW Surgical conversions (from HES)	Target average conversions	Evidence source for target
Colon	Existing Open Cases	0%	3.0%	Benlice
Colon	Existing Lap Cases	33%	3.0%	Benlice
Rectal	Existing Open Cases	0%	7.0%	Hyde
Rectal	Existing Lap Cases	8%	7.0%	Hyde
Benign Hysterectomy	Existing Open Cases	0%	0.0%	Chalooub (QTI)
Benign Hysterectomy	Existing Lap Cases	2%	0.0%	Chalooub (QTI)
Endometriosis	Existing Open Cases	0%	0.0%	Raza (QTI)
Endometriosis	Existing Lap Cases	0%	0.0%	Raza (QTI)
Salpingo-Oophorectomy	Existing Open Cases	0%	0.0%	National HES data 22_23
Incisional Hernia	Existing Open Cases	0%	0.6%	Le Blanc
Benign Hysterectomy (Maid)	Existing Open Cases	0%	0.0%	Chalooub (QTI)
Benign Hysterectomy (Maid)	Existing Lap Cases	10%	0.0%	Chalooub (QTI)
Hysterectomy Malignant (Maid)	Existing Open Cases	0%	0.0%	Lippiatt (QTI)
Hysterectomy Malignant (Maid)	Existing Lap Cases	5%	0.0%	Lippiatt (QTI)
Salpingo-Oophrectomy (Maid)	Existing Open Cases	0%	0.0%	National HES data 22_23
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	6%	0.0%	National HES data 22_23
Fundoplication	Existing Lap Cases	0%	0.0%	National HES data 22_23
Hiatial Hernia	Existing Lap Cases	0%	0.0%	National HES data 22_23
Ventral Hernia	Existing Open Cases	0%	0.0%	National HES data 22_23

% complications

Speciality procedure type	Existing route at MTW	Avg. MTW % complications	Target average % complications	Evidence source for target
Colon	Existing Open Cases	30%	15.0%	Benlice
Colon	Existing Lap Cases	17%	15.0%	Benlice
Rectal	Existing Open Cases	33%	0.0%	Hyde
Rectal	Existing Lap Cases	20%	0.0%	Hyde
Benign Hysterectomy	Existing Open Cases	4%	0.6%	Chalooub (QTI)
Benign Hysterectomy	Existing Lap Cases	3%	0.6%	Chalooub (QTI)
Endometriosis	Existing Open Cases	0%	0.0%	Raza (QTI)
Endometriosis	Existing Lap Cases	7%	0.0%	Raza (QTI)
Salpingo-Oophorectomy	Existing Open Cases	10%	5.0%	National HES data 22_23
Incisional Hernia	Existing Open Cases	23%	24.0%	Le Blanc
Benign Hysterectomy (Maid)	Existing Open Cases	10%	0.6%	Chalooub (QTI)
Benign Hysterectomy (Maid)	Existing Lap Cases	10%	0.6%	Chalooub (QTI)
Hysterectomy Malignant (Maid)	Existing Open Cases	20%	5.0%	Lippiatt (QTI)
Hysterectomy Malignant (Maid)	Existing Lap Cases	5%	5.0%	Lippiatt (QTI)
Salpingo-Oophrectomy (Maid)	Existing Open Cases	8%	5.0%	National HES data 22_23
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	6%	5.0%	National HES data 22_23
Fundoplication	Existing Lap Cases	13%	5.0%	National HES data 22_23
Hiatial Hernia	Existing Lap Cases	10%	6.0%	National HES data 22_23
Ventral Hernia	Existing Open Cases	8%	5.0%	National HES data 22_23

% 30 - day readmission

Speciality procedure type	Existing route at MTW	MTW current % 30-day readmission	Target % 30-day readmission	Evidence source for target
Colon	Existing Open Cases	27%	8.0%	Benlice
Colon	Existing Lap Cases	11%	8.0%	Benlice
Rectal	Existing Open Cases	22%	7.5%	Hyde
Rectal	Existing Lap Cases	8%	7.5%	Hyde
Benign Hysterectomy	Existing Open Cases	2%	0.0%	Chalooub (QTI)
Benign Hysterectomy	Existing Lap Cases	9%	0.0%	Chalooub (QTI)
Endometriosis	Existing Open Cases	0%	0.0%	Raza (QTI)
Endometriosis	Existing Lap Cases	7%	0.0%	Raza (QTI)
Salpingo-Oophorectomy	Existing Open Cases	10%	11.0%	National HES data 22_23
Incisional Hernia	Existing Open Cases	23%	1.9%	Le Blanc
Benign Hysterectomy (Maid)	Existing Open Cases	0%	0.0%	Chalooub (QTI)
Benign Hysterectomy (Maid)	Existing Lap Cases	0%	0.0%	Chalooub (QTI)
Hysterectomy Malignant (Maid)	Existing Open Cases	8%	2.0%	Lippiatt (QTI)
Hysterectomy Malignant (Maid)	Existing Lap Cases	5%	2.0%	Lippiatt (QTI)
Salpingo-Oophrectomy (Maid)	Existing Open Cases	8%	11.0%	National HES data 22_23
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	0%	11.0%	National HES data 22_23
Fundoplication	Existing Lap Cases	13%	10.0%	National HES data 22_23
Hiatial Hernia	Existing Lap Cases	10%	10.0%	National HES data 22_23
Ventral Hernia	Existing Open Cases	8%	5.0%	National HES data 22_23

Supplier derived Cost savings Metrics

Based on adoption rate - Capacity Impact if approx 66% of current open and lap cases moved t

*Cost of 1 general bed day £407

Speciality	Patient Source	Est. Annual Open/Lap Cases	Est. Annual Open/Lap Cases Converted to dV	Length of Stay (Open/Lap)	Length of Stay (dV)	Length of Stay Difference (dV vs. Open/Lap)	Annual Bed Days Avoided	Annual Length of Stay Cost Avoided*	Potential Incremental Cases	Capacity Increase (Annual)
TOTALS		**989**	**650**	**5.2**	**2.4**	**2.9**	**1,864**	**£ 758,788**	**1,004**	**155%**
Colon	Existing Open Cases	107	**75**	10.8	4.7	**6.1**	**457**	**£ 185,954**	**97**	130%
Colon	Existing Lap Cases	92	**60**	8.1	4.7	**3.4**	**206**	**£ 83,661**	**44**	72%
Rectal	Existing Open Cases	45	**32**	10.6	6	**4.6**	**145**	**£ 58,974**	**24**	77%
Rectal	Existing Lap Cases	50	**33**	10.3	6	**4.3**	**141**	**£ 57,503**	**24**	72%
Benign Hysterectomy	Existing Open Cases	95	**52**	2.3	1	**1.3**	**67**	**£ 27,286**	**67**	130%
Benign Hysterectomy	Existing Lap Cases	115	**54**	1.5	1	**0.5**	**27**	**£ 11,033**	**27**	50%
Endometriosis	Existing Open Cases	30	**18**	2	0.8	**1.2**	**22**	**£ 8,791**	**27**	150%
Endometriosis	Existing Lap Cases	60	**25**	1.3	0.8	**0.5**	**12**	**£ 5,058**	**16**	63%
Salpingo-Oophorectomy	Existing Open Cases	40	**29**	3.1	1.3	**1.8**	**52**	**£ 21,350**	**40**	138%
Incisional Hernia	Existing Open Cases	65	**47**	6	1.4	**4.6**	**218**	**£ 88,662**	**156**	329%
Benign Hysterectomy (Maid)	Existing Open Cases	20	**16**	4.6	1	**3.6**	**59**	**£ 23,862**	**59**	360%
Benign Hysterectomy (Maid)	Existing Lap Cases	20	**16**	2.5	1	**1.5**	**24**	**£ 9,942**	**24**	150%
Hysterectomy Malignant (Maid)	Existing Open Cases	55	**45**	6	1	**5**	**224**	**£ 91,139**	**224**	500%
Hysterectomy Malignant (Maid)	Existing Lap Cases	85	**69**	2.5	1	**1.5**	**104**	**£ 42,255**	**104**	150%
Salpingo-Oophrectomy (Maid)	Existing Open Cases	25	**20**	4.1	1.3	**2.8**	**57**	**£ 23,199**	**44**	215%
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	35	**29**	1.8	1.3	**0.5**	**14**	**£ 5,800**	**11**	38%
Fundoplication	Existing Lap Cases	15	**11**	3.1	2.1	**1**	**11**	**£ 4,361**	**5**	48%
Hiatial Hernia	Existing Lap Cases	10	**7**	4.7	2.1	**2.6**	**19**	**£ 7,559**	**9**	124%
Ventral Hernia	Existing Open Cases	25	**12**	2.2	1.7	**0.5**	**6**	**£ 2,398**	**3**	29%

Cost saving references

Clinical metric	Resource(s)	Calculation method	Published value	Value adjustment
Length of stay (General Ward)	NHS National Schedule of Reference Costs 2017-18.	Median value of all national unit costs for general ward	N/A	£407
	Estimated cost savings for General Ward Length of stay were calculated by Intuitive, taking the median of all national average unit cost, provided by the NHS during the 2017 to 2018 collection period. The NHS data includes elective inpatient excess bed days.			
Conversions	NHS Harvey Walsh (open and MIS data, included averages for prostatectomy, partial nephrectomy, hysterectomy, lobectomy, colon resection, and rectal resection), Rouanet et. al publication, (cited below, formula), Internal analysis (calculation of formula and average days) "Rouanet, P., Mermoud, A., Jarlier, M., Bouazza, N., Laine, A. and Mathieu Daudé, H. (2020), Combined robotic approach and enhanced recovery after surgery pathway for optimization of costs in patients undergoing proctectomy. BJS Open, 4: 516-523. doi:10.1002/bjs5.50281"	Formula is ((LOS (open) – LOS (MIS)) x cost per general ward day) + additional cost of open surgery (7.8 open day average - 4.9 MIS day average)=2.9 days, 3 days used as rounded value Three days of additional length of stay costs (see Ref a, above) at £407 equals £1221, add £1000 for usage of open surgery equipment in addition to MIS equipment.	N/A	£2,221

Clinical metric	Resource(s)	Calculation method	Published value	Value adjustment
Complications	Straatman, et al. Hospital cost analysis of complications after major abdominal surgery. Digestive Surgery Journal, 2015.	Patients with **minor** complication costs (€15,412.96) - Patients without complication costs (€8,584.81) = cost of minor complication (€6,828) €6,828 converted to British pounds (9/9/2020) = £6,204	Patient without complication costs: €8,584.81 Patient with minor complication costs: €15,412.96	£6,204
	Estimated cost savings for complications was calculated by Intuitive based only on the hospital cost estimates reported for open and laparoscopic major abdominal surgery (including upper GI, colorectal HPB procedures) in Straatman, et al. The difference in the cost between cases with minor complication and no complication was used to represent the cost savings for complications. Major complications were published at €29,198.23 and were not used for the purpose of this calculation.			
Readmissions	NICE National costing statement: Implementing the NICE guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2015)	£2.4B / 1M patients= £2,400	£2.4B readmission cost, over 1M patients	£2,400
	Estimated cost savings per readmission is calculated by Intuitive based on the cost estimates reported in 2015 NICE National Costing statement. Average cost per readmission is based on the annual cost to the economy (2.4B) divided by the total number of annual readmissions (1M). Readmissions were defined as all emergency readmissions within 30 days of discharge from an all-cause stay inpatient hospital setting			

Appendix 4 Robot clinical option evaluation matrix

Robot. Clinical evaluation summary scoring matrix

Please fill in all light green boxes with a number from 0 to 10 according to your assessment of how each platform scores on each critieria

Following discussion re core and aspirational procedures it is intended the robot/s are used for, this matrix is then intended to help structure conversations around; what we are looking for in a platform? The relative merits of each platform and potential ways forward to develop the RAS programme

Directorate (please enter here)

Your preferred platform/why? (please enter here)

Now please complete the sections below

ID	Criteria	Weight (Available % for this criteria)	CMR - Versius Criteria score (Out of 10 With 10 being excellent , 0 very poor)	Intuitive Davinci x Criteria score (Out of 10 With 10 being excellent , 0 very poor)	Intuitive Davinci xi Criteria score (Out of 10 With 10 being excellent , 0 very poor)	Medtronic Hugo Criteria score (Out of 10 With 10 being excellent , 0 very poor)
4	**Range of procedures** this robot can assist with now. The perceived level of clinical risk in expanding to potential caseload . *(lower risk indicating a higher % score here)* Include consideration of level of clinical risk if indication of use is expanded , consider track record of delivery. Consider if the available range of accessories meets clincial needs now.	25%	0	0	0	0
5	**Effectiveness** of the robotic assistance in practice. Include consideration of availabiity of multicentre results across a range of procedures on this platform.	20%	0	0	0	0
6	**Ease and practicality of use.** Include consideration of ease of use for a) console surgeon b) RAS first assistant c) RAS scrub nurse	10%	0	0	0	0
8	**Existing skilled operators and development of skills training** - Considering staff already trained on platform , staff with existng fellowship training and experience on this platform. Quality and comprehensiveness of training schedule	10%	0	0	0	0
	Digital 'ecosystem' Consider the set of technologies the platform brings together to provide high quality, more usable surgical information	5%	0	0	0	0
9	**Future proof** in terms of update and expansion from this base system	5%	0	0	0	0
10	**Flexibility** in terms of ability to move robot between operating theatres	5%	0	0	0	0
11	**Cleaning and sterilisation**	2%	0	0	0	0
12	**Environmental friendliness**	3%	0	0	0	0
13	**Support** - effectiveness of after purchase **maintenance** and service support	5%	0	0	0	0
14	**Deliverability.** Overall assessment of short and long term deliverability	5%	0	0	0	0
15	**Contract** flexibilty	5%	0	0	0	0
	Sum of weighted score	100%	0.0	0.0	0.0	0.0
16	**Total Cost** (NPV) £	£				
	Cost / value Ratio	#VALUE!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Appendix 5

Robot Theatre Schedule Plan

	Maidstone Theatre					Current Ave (Apr-March 24)
		Week 1	Week 2	Week 3	Week 4	
M	AM	Montalto	Montalto	Montalto	Montalto	79 cases, 6.5 p/m
	PM	Montalto	Montalto	Montalto	Montalto	
T	AM	Henderson/ Godfrey	Henderson/ Godfrey	Henderson/ Godfrey	Henderson/ Godfrey	Henderson 183 cases 15 p/m, Godfrey 69 cases 5.75p/m
	PM	Henderson/ Godfrey	Henderson/ Godfrey	Henderson/ Godfrey	Henderson/ Godfrey	
W	AM	Hide/Andreas	Hide/Andreas	Hide/Andreas	Hide/Andreas	Hide 252 cases, 21 p/m Andreas 82 cases, 6.8 p/m
	PM	Hide/Andreas	Hide/Andreas	Hide/Andreas	Hide/Andreas	
T	AM	Devaja/Cynk	Devaja	Devaja/Cynk	Devaja	Devaja 75 cases, 6.25 p/m Cynk 120 cases, 10 p/m
	PM	Devaja/Cynk	Devaja	Devaja/Cynk	Devaja	
	3rd	Cynk		Cynk		
F	AM	Gynae	Gynae	Gynae	Gynae	All activity 158 cases, 13 p/m
	PM	Gynae	Gynae	Gynae	Gynae	

Friday assume El-Gohori TWH 118 (9.8) MGH 40 (3.3)

	TW Theatre					Current Ave (Apr-March 24)
		Week 1	Week 2	Week 3	Week 4	
M	AM	Wright	Wright	Wright	Wright	Wright 85 cases, 7 p/m
	PM	Wright	Wright	Wright	Wright	
T	AM	Lordon	Yasser	Lordon	Yasser	Lordon 56 cases, 4.6 p/m Yasser 97, 8 cases p/m
	PM	Lordon	Yasser	Lordon	Yasser	
W	AM	Raza	Raza	Raza	Raza	86 cases, 7 p/m
	PM	Raza	Raza	Raza	Raza	
T	AM	General Surgery	Haythem	Will Lynn	Haythem	Lynn 74 cases, 6 p/m Haythem 96 cases, 8 p/m
	PM	General Surgery	Haythem	Will Lynn	Haythem	
F	AM	Lawes	Lawes	Lawes	Lawes	83 cases, 7 p/m
	PM	Lawes	Lawes	Lawes	Lawes	

Appendix 6

Benefits tracker

Note: The will be further joint development, in partnership with Intuitive Surgical, of a range of KPIs to support most effective delivery of the RAS programme. This collaborative development of KPIs will be a key part of the implementation phase of the project

Business Case Benefits Tracker										
Business Case Title	Robotic Assisted Surgery				**Business Case ID**	ID935				
Division	Surgery				**PMO BP**					
Delivery Lead	David Robinson									
Benefit number	**Benefit Title**	**Description / Measurable Benefit**	**Baseline value**	**Actions / Notes**	**Named Lead**	**Action Completion Date**	**Benefit Code / Category**	**Measure**	**Dependencies**	**Risks**
Unique ID Number Suffix= Business Case ID Number		A short description of the expected benefit's	What is the current position	Actions that may be required to ensure that this benefit will be realised	The person accountable for this benefit	Date the action will be complete and Benefits realisation will start	List - see below	How and when to measure the benefit	Related projects /other dependencies	Assumptions /Risks to delivery of benefit
935-B001	LOS indicator	Reduced average LOS for key procedures	Existing px ALOS open 6 days lap 2.5 days		Surgery and gynaecology GM with BI support	Apr-26	Quantitative	Standard recording	N/A	None identified
935-B002	Readmission indicator	Reduce readmission rate for key procedures	Existing px 30 day readmission open 8% days lap 5%		Surgery and gynaecology GM with BI support	Apr-26	Quantitative	Standard recording	N/A	None identified
935-B003	Vacancy	Reduce time to fill surgical consultant vacancy by 30%	X		surgery and gynaecology GM with BI support	Apr-26	Qualitative	Review with medical recrutiment	N/A	None identified
935-B004	RAS number	Increase RAS surgery performed at MTW	725		surgery and gynaecology GM with BI support	Apr-26	Quantitative	Standard recording	N/A	None identified

Trust Board meeting – July 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 Q1 (April 2024 – June 2024)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the first quarter report for the period of April 2024 to June 2024 presented to the board by the Freedom to Speak Up Guardian. 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-seven concerns raised in the last quarter. For another quarter, the most reported category is Bullying and Harassment, with a close second of 'Other' which includes concerns around not being heard at an organisational level.

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: June 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

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Introduction

At the last board report, the Freedom to Speak Up (FTSU) Guardian identified three key barriers that prevent individuals from speaking up. These were:

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 significant enough to warrant discussing.
3. People do not speak up as they are afraid of repercussions.

The FTSU Guardian has implemented action plans for each of these categories to actively address these barriers. Below is an update on the progress for each barrier.

To address the issue of people not knowing who to speak up to, the FTSU service has continued specific outreach with departments known to have issues. I have worked closely with the Engagement Lead to ensure any areas that have low staff survey results are contacted. This is an ongoing piece of work to ensure we have a presence in these critical areas. There has also been an increased presence in satellite sites such as Medway, Magnitude House, and Crowborough Birthing Centre. The FTSU Guardian has also been actively involved in network events across the Trust, ensuring a visible presence. Business cards have been distributed to teams to raise awareness, and FTSU presentations are made at fortnightly inductions.

To tackle the perception that issues are not significant enough to discuss, the FTSU Guardian has been promoting the Safe Space Champions. We have been actively recruiting through events like MTW Connect and Exceptional Leaders. We have been in communication with the Nursing and Midwifery panel about securing release time for clinical staff who wish to be a Safe Space Champion. We have also continued to push the message: “In healthcare, if we wait for a concern to be confirmed, it is too late.” This effort has led to an increase in reports to the Safe Space Champions, with seven this quarter being escalated to FTSU.

To manage people’s fear of repercussions, the FTSU Guardian continues to provide a confidential service. Overcoming this barrier will take time, as trust must be built organically through good practice. However, the service is reaching more people through word of mouth, indicating a reduction in fear. As people share their positive experiences with colleagues, trust in the service is growing. This development fosters a more open and honest culture. An example of this feedback is: “Thank you so much for all the support. Since raising the issue, I’ve had conversations with my manager that have allowed me to open up and resolve my issue in a way I never thought possible.”

Q1 2024 quantitative data collection and comparison

Quarter	Month/Year	MGH	TWH	Unknown/ Satelite	No. of Contacts
Q1	April-June 2023	6	5	6	17
Q1	April-June 2024	19	18	10	47

Looking at annual trends, it is evident that Q1 is an average quarter in reporting numbers, whereas Q2 is often quieter, and Q3 incredibly busy. Despite these annual trends, we have seen an increase of 176% in reporting. This has provided the service with assurance that we are moving in a positive direction with our outreach.

The majority of these cases are categorised as bullying and harassment. Most of these cases revolve around dignity and respect, workplace relationships, and behaviours, continuing to be the main area of concern for staff. It also infers that the FTSU service is being used predominantly for bullying cases. Covered more extensively within the ‘Qualitative’ section of this report, we can see a trend that often the cases of bullying and harassment are due to a breakdown in communication or a result of Trust policy being misused by management.

A close second in reporting numbers is the ‘other’ category. This quarter has been turbulent and an outlier within the data we usually present. There has been a high amount of change within the workplace, with projects such as KMOC and The Spire resulting in an increased level of uncertainty. We believe this has had an effect on reporting in both the ‘Other’ category and the Surgery division (specifically theatres).

The other category can be broken down as follows:

Other breakdown	Number of reports	Comment
Advice on HR or ER processes	5	These include appealing grievances, these are usually picked up by SSC
Service suggestions	1	
Parking related reports	7	This is the highest reported issue within the Other category, and seems to only be increasing. FTSU is not the correct channel for these reports but I believe them to be indicative of a further issue.
Unfair recruitment	2	These include worries around the legitimacy of a recruitment process

Division	Number of issues
Core Clinical Services	6
Medicine and Emergency Care	4
Womens Children and Sexual health	1
Cancer	5
Surgery	10
People and OD	1
Medical Education	3
Facilities	9
Business Support Services	1
Unknown	7

*Facilities issues include parking concerns, which equates to 7 reports.

The number of “unknown” factors in reporting is a frustration to analysis. However, its existence is an indicator of how many of the reports are being made anonymously. 32% (15) of issues raised in the last quarter have been anonymous. Almost half of the anonymous reports (7) have been to do with parking and EV charging. The second highest area of anonymous reporting is Surgery.

Whilst in past reports we have focused on the cultural impact of departments as a direct cause of anonymous reports, this quarter we have seen an increase in highly complex cases that come through anonymous means. This suggests that anonymous reports are being used for those cases people believe are ‘trivial’ or if the issue is very complex. I would consider those raising the extreme cases anonymously to be those afraid of repercussions.

Q1 Qualitative data and themes

Within the reports of bullying and harassment, several recurring themes have been identified across the Trust. A significant issue is the misuse or unfair application of policies by managers. This includes failing to escalate issues,

not progressing employee relations cases to the ER team, and poor communication styles from management. This raises concerns about our expectations for managers, how those expectations are monitored, and the adequacy of training provided when they assume their roles. Discussions with managers reveal misconceptions about policies and processes, gaps in their knowledge or soft skills, and a perceived lack of support from their own managers and support services. These gaps in knowledge negatively impact both the managers, who feel overwhelmed and as though they are failing, and the staff members when these policies are incorrectly applied during critical times. This leads to a general feeling of unfairness and harm. Reports frequently mention conflicting advice and unclear processes. This issue has been raised at a triumvirate level for high-reporting areas and a plan to create training sessions aimed at managers to detail the process has started, but it is also a piece of work that should be addressed to some extent through the Just and Restorative work being undertaken by the People and OD function.

Another key theme in bullying and harassment is discriminatory incidents, particularly those based on race and disability. These cases often involve behaviours such as othering, intimidation, inappropriate language, and efforts to undermine individuals.

Additional themes identified throughout the review of FTSU cases are:

1. **Discriminatory Incidents**: Particularly those based on race and disability. These cases often involve behaviours such as othering, intimidation, inappropriate language, and efforts to undermine individuals. There is usually an undertone of cultural misunderstanding in these cases.
2. **Inadequate Training and Professional Development**: There are members of staff in training roles who are not able to access their training due to resourcing, staffing, or constant training delays. This has led to frustration and stagnation among staff and trainees.
3. **Car Park and EV Chargers:** Persistent issues with workplace facilities involving parking. People are reporting the feeling of being dismissed or not heard regarding these issues. It is pertinent to note that this has not been reported since the recent parking consultation that has been opened up for staff.

Joint up working

As part of our ongoing commitment to fostering a culture of inclusivity and open communication, this quarter FTSU has focused on enhancing system operations, maintaining services, and updating outdated processes in reporting and recording data. Our outreach efforts have expanded, including speaking at Exceptional Leaders and bringing FTSU initiatives to the forefront through the Nursing and Midwifery panel to increase clinical engagement.

In our efforts to cultivate a new culture, we are emphasising collaboration and support within a speaking-up environment. The Patient Safety team has implemented the Patient Safety Incident Response Framework (PSIRF), resulting in fewer patient safety cases being reported to FTSU. However, this does not mean I am not actively collaborating with Patient Safety to maintain broader awareness of Trust issues. The same applies to our work with the Employee Relations (ER) team. While the number of complex cases for FTSU has decreased this quarter, we remain informed of these issues through ongoing dialogue and joint efforts.

FTSU has been working closely with the Triumvirates and the HR Business Partners to ensure they are aware of the issues within their areas and are able to overcome any hurdles blocking progress. We have also initiated meetings with Business Support Services, the Deputy Chief Nurse for workforce matters, and the Head of Healthcare Professionals for any AHP-related concerns.

We have been actively working with the Engagement Lead to share data on key outreach areas, and in the coming months, I have invited them to join our triumvirate catch-up meeting. This will allow the Triumvirate, the Engagement Lead, and myself to discuss where we would like to target our outreach in the next quarter.

Our service has partnered with the OD consultants to develop and deliver tailored training sessions on having difficult conversations. These sessions are specifically designed for areas with high reporting or communication issues.

Additionally, over the last quarter, we have collaborated with neighbouring Trusts across Kent and Medway, providing support to the ICB's newer Guardian through our FTSU service. Some of the practices from MTW FTSU are now being adopted system-wide. This collaboration has also allowed us to gain insights into how other Trusts operate, enhancing our skills through this system-wide approach.

Appendix A: Comparison of concerns logged

Total concerns logged	Q1 2020	Q1 2021	Q1 2022	Q1 2023	Q1 2024
Maidstone	3	9	7	6	19
Tunbridge Wells	9	4	9	5	17
Unknown	3	4	7	6	11
Total	**15**	**17**	**23**	**17**	**47**

NHS Maidstone and Tunbridge Wells NHS Trust

Six-monthly review of the Trust's red-rated risks **Chief Nurse**

The enclosed report provides information on

- The current red rated risks open on the Trust risk register
- A risk tracker has been provided within the report to provide oversight of the risks rated over 15 and enables the Board to view the length of time risks have been open, any movement of risk scoring in the last year, target score and target completion date
- The revised report format focuses on movement of the risks since the last report namely
    - New risks rated 15+ that have opened since the last report
    - Any risks that have increased and been escalated from Divisional risk registers now scoring 15+
    - Downgraded risks that were previously included within the report, no longer scoring 15+
    - Risks that have been closed since the last report
- Appendix 1 provides detail of all red rated risks including controls in place, actions and progress.

The Board of Directors are asked to consider whether it is assured that the red-rated risks are being appropriately mitigated.

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

- Quality Committee, 10/07/24
- Audit and Governance Committee, 15/07/24

Reason for submission to the Trust 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

Red Risk Report

Board of Directors

July 2024

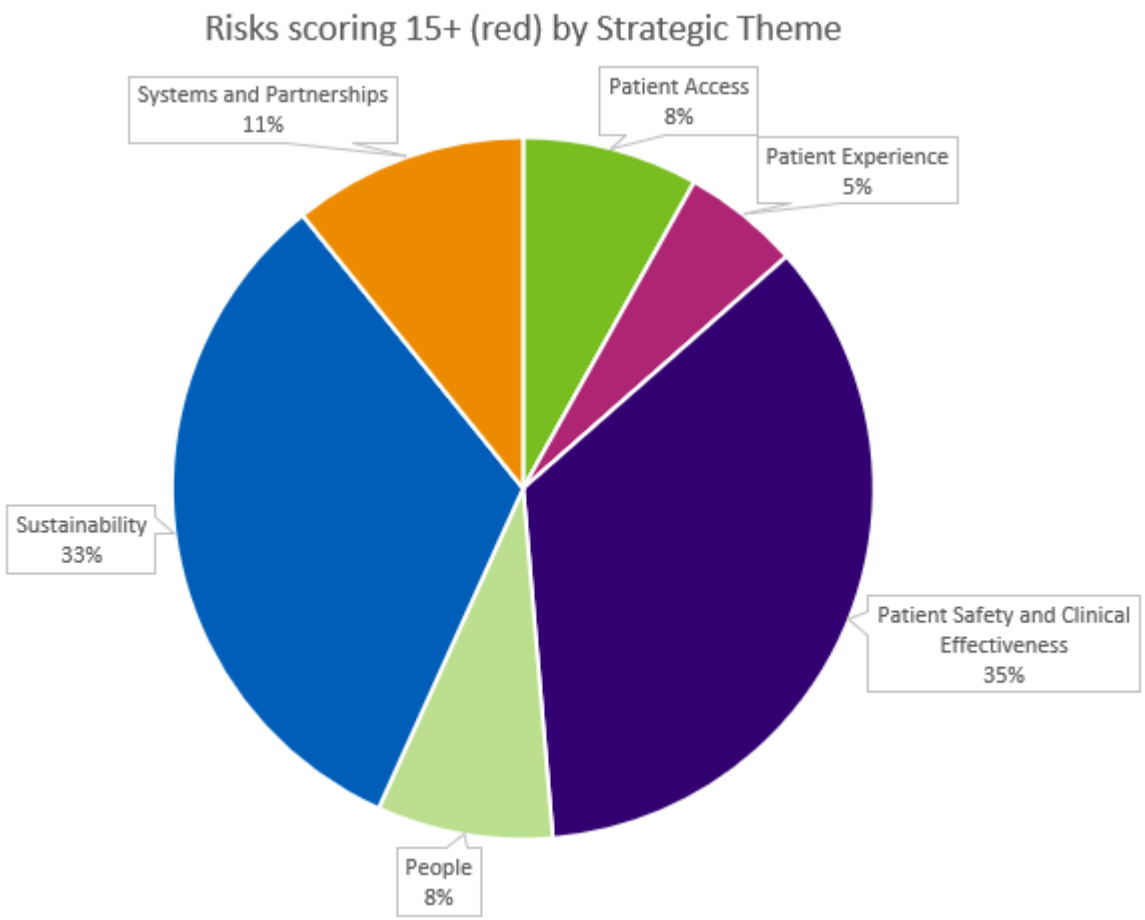
Author: Rhiannon Adey – Head of Risk Management

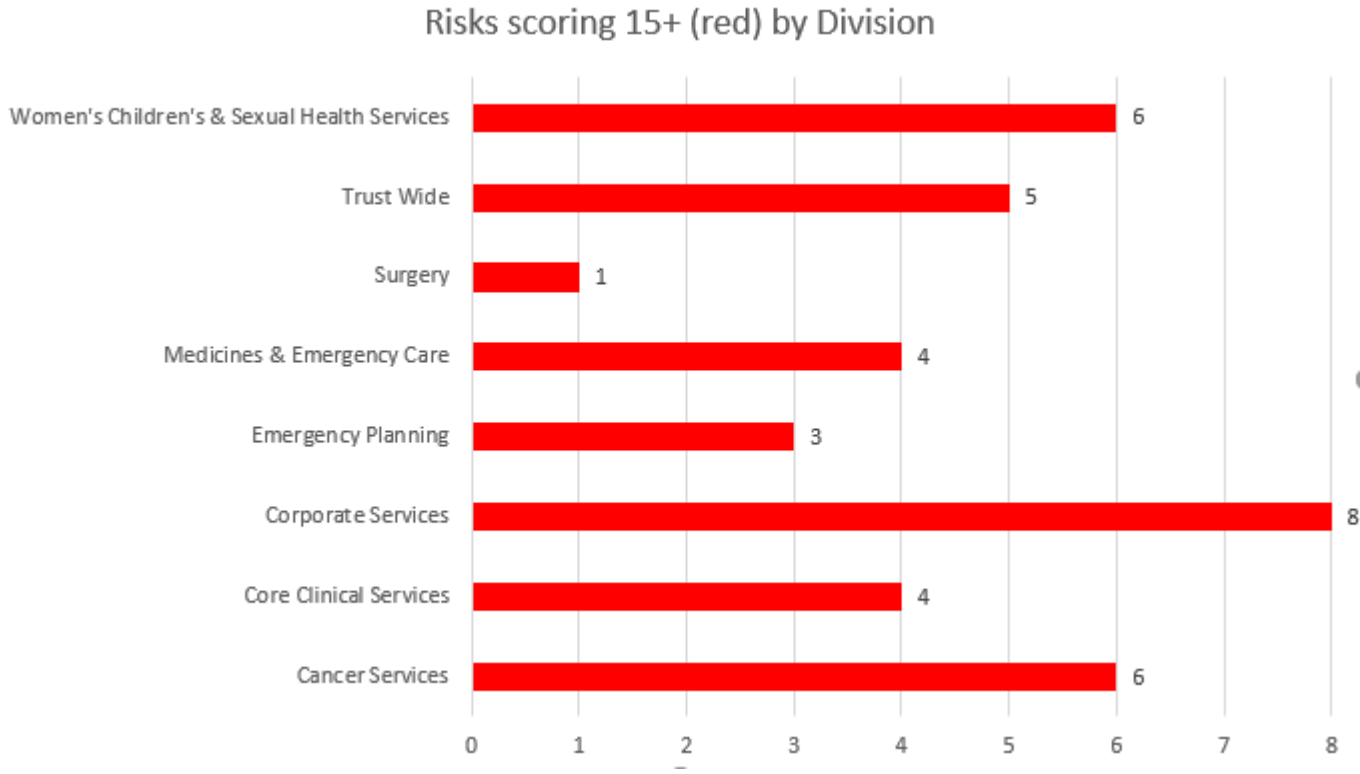
MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Trust Risk Profile

As of 08 July 2024 there were 195 open risks on the Trust risk register with 37 of these currently scoring 15+ (red).





Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Target score	Target date
1202	Industrial Action	20 =	20 =	20 =	20 =	20 =	15 ↓	15 =	15 =	15 =	15 =	20 ↑	20 =	12	20/09/24
3128	There is a risk that research patients (in particular oncology patients) will not receive treatment via clinical trials as there is a significantly reduced aseptic service.											20 New	20 =	6	31/07/24
3051	Insufficient backups of TWH access control door system						20 New	20 =	20 =	20 =	20 =	20 =	20 =	5	31/08/24
3052	TWH access control door system is not resilient						20 New	20 =	20 =	20 =	20 =	20 =	20 =	5	31/08/24
3053	TWH access control door system lacks suitable cyber security protections						20 New	20 =	20 =	20 =	20 =	20 =	20 =	5	31/08/24
3023	Haematology patients are at risk of being lost to follow up due to operational pressures			16 New	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	12	26/07/24
3042	Issues at East Kent Foundation Trust hospital relating to time form referral to reporting of scans and histologist					16 New	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	30/08/24
1310	Equipment - Replacement of equipment required for General and ED Plain Film Imaging Rooms across the MGH and TWH sites.	20 =	20 =	20 =	20 =	20 =	20 =	16 ↓	16 =	16 =	16 =	16 =	16 =	8	31/07/24
2945	Equipment - Replacement of equipment required for Fluoroscopy imaging rooms at the TWH site	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	31/07/24
2947	Equipment - Replacement of equipment required for Mammography at the TWH site.	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	30/06/24
3112	Lack of follow up of diagnostic reports										16 New	16 =	16 =	4	01/04/26
1286	Statutory Compliance	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	12	31/10/25
3113	Trust will not have enough cash resulting in suppliers not being paid and the Trust not meet its BPPC target										16 New	16 =	16 =	8	31/03/25
3122	Financial risk to the Trust as Trust/private ambulances are being funded as a cost pressure to support patient discharges											16 New	16 =	3	31/03/25
3123	Patients will remain in hospital whilst no longer fit to reside as the non- recurrent funding for Hilton will end in September											16 New	16 =	6	01/09/24
1150	Impact of increase in number of inpatients with mental health needs / neurological deficit.	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	9	29/03/24

Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Target score	Target date
2981	Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site	16 New	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	03/12/23
1233	Equipment failure risks due to age of Endoscopy Wassenburg decontamination plant	12 =	12 =	12 =	12 =	12 =	12 =	16 ↑	16 =	16 =	16 =	16 =	16 =	6	31/12/23
1270	Lack of medical devices training in the Trust	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	29/03/24
2980	Risk of Healthcare associated C. difficile and breaching national limits of number of cases	20 New	20 =	20 =	20 =	20 =	20 =	20 =	20 =	16 ↓	16 =	16 =	16 =	12	31/03/25
3070	Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI							16 New	16 =	16 =	16 =	16 =	16 =	12	31/12/24
3062	Maternity Diaries are supported by NHSmail. NHS mail are not aware that we are utilising this system to manage all community midwifery diaries							16 New	16 =	16 =	16 =	16 =	16 =	8	08/08/24
3063	Community midwifery sickness affecting the workload within the community setting							16 New	16 =	16 =	16 =	16 =	16 =	8	01/04/24
3069	Chemotherapy e-prescribing							12 New	12 =	12 =	12 =	16 ↑	16 =	8	31/10/24
1289	There is a risk of patient harm linked to the backlog of patients awaiting review in the Virtual Stroke Clinic	9 =	9 =	9 =	9 =	9 =	9 =	9 =	9 =	9 =	9 =	9 =	16 ↑	12	29/01/25
3127	Lack of appropriate placement for child or young person requiring enhanced care observation and no discharge profile available when medically fit for discharge											15 New	15 =	9	25/07/24
2998	Radiotherapy CT Canterbury Provision		15 New	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	01/07/24
3000	Linac LA1C - Canterbury		20 New	20 =	20 =	20 =	20 =	20 =	20 =	15 ↓	15 =	15 =	15 =	6	31/03/24
3086	SACT advice line is not provided appropriate clinical advice or being managed by SACT trained professionals which could put patients at serious of harm								15 New	15 =	15 =	15 =	15 =	10	01/09/24
2948	MTW IT systems will be slowed / have functionality issues secondary to Server Processing Capacity	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	31/07/23
2952	Due to inadequate air conditioning capability within the Main ICT server room the server system could overheat causing a loss of ICT across the Trust	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	10	30/09/23
3043	Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space						15 New	15 =	15 =	15 =	15 =	15 =	15 =	12	01/07/24

Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Target score	Target date
2995	Shortage of Defibrillators				15 New	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	10	16/12/24
3130	There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)											15 New	15 =	10	03/01/25
3009	Planned reduction in community clinic space within the primary care setting, women and pregnant people will not be able to access care		20 New	20 =	20 =	20 =	20 =	20 =	20 =	15 ↓	15 =	15 =	15 =	10	31/03/24
3065	Suboptimal outcomes within Maternity – this risk was identified via a review of patient safety incidents where staff have not followed IIA (Intelligent Intermittent Auscultation guidance)							15 New	15 =	15 =	15 =	15 =	15 =	5	09/06/24
1182	Delay in progress with induction of labour (IOLs) may result in a poor clinical outcome and poor patient and staff experience	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	15 ↑	3	31/12/26

New Risks rated 15+

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3112 23/05/24	Core Clinical Services Pathology	Lack of follow up of diagnostic reports	There are no standardised processes for tracking diagnostic requests and results within specialties and MDT's.	16	- Red spot system utilised within Radiology for majority of specialities. - Manual process in place from Soliton to send unexpected findings to MDM teams. - Publicity of risk and responsibilities of requestor occurring through various meetings (QIC, CLIPARM, SI previously group, NMHAPP etc). - Spreadsheet issued by Histology of confirmed cancers agreed in SNOMED codes issues to various areas in Trust, DGT and MFT.	16	Cleanse options available for selection with varieties of Dr unknown – 31 Aug 24 Prepare Trust draft P&P for management of results – 31 Oct 24 Stop issue of printing out Histology reports to MTW requestors – 30 Nov 24 Build order comm sets for Histopathology orders – 31 Dec 25	5

New Risks rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3113 24/05/24	Corporate Finance	There is a risk that the Trust will not have enough cash to meet its commitments resulting suppliers not being paid and the Trust not meet its BPPC (Better Payment Practice Code) target.	The impact of suppliers not being paid is that they could with hold further deliveries such as drugs, food and clinical supplies which could impact patient care. The Trust will also lose discounts for prompt payment and incur late payment charges. The suppliers may increase prices in future to cover future late payments.	16	Cashflow is updated daily and compared with the I&E plan or forecast. The Head of Financial Services reviews the cashflow to ensure payments due are affordable for the next month. If there is a risk of going overdrawn then payment to suppliers is reduced. Active Debt is chased by the receivables team. A weekly cash report is circulated to the Heads of Finance and CFO. A bi-monthly working capital group meets to review the cash position. The Finance and Performance Committee receive a monthly update and cashflow report in the finance report. A more detailed cash analysis is provided on a quarterly basis. If actions are not delivered then the Trust will seek a revenue support loan from DHSC which will attract interest and be repaid.	16	Trust CIP must be delivered to ensure enough cash. – 28 May 24 Invoices to be raised promptly so that cash can be paid to Trust – 28 May 24 Seek National cash support for the purchase of Fordcombe Hospital which was CDEL funded but not cash backed. – 28 May 24 The Trust has received additional Capital CDEL for UEC of £5m but it wasn't cash backed. Ask for cash support from National team – 28 May 24 Confirm monthly cash payments from ICB and NHSE are aligned to plan and if not negotiate additional cash whilst contract negotiations are completed. – 28 Jun 24	5

New Risks rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3122 13/06/24	Corporate Services Operational Flow	There is a financial risk to the Trust as Trust/private ambulances are being funded as a cost pressure to support patient discharges	Currently 5 ambulances Monday - Friday and two at weekends are provided to support discharges home and for appointments unfunded. This is causing an overspend to ensure patient flow and patient safety in ED.	16	Escalation to Kent and Medway ICB for G4S contract and East Sussex ICB for SCAS contract	16	Continue to meet with K&M ICB and East Sussex ICB regarding transport contracts – 29 Nov 24	3
3123 13/06/24	Corporate Services Operational Flow	Patients will remain in hospital whilst no longer fit to reside as the non-recurrent funding providing out of hospital capacity for Hilton will end in September	Hilton service currently supports patients discharge (50 per week) . This service ends in September with no current new contract in place.	16	Pre-planning for patients whilst in hospital Discussions taking place with alternative providers and the ICB	16	Continue to meet with ICB around alternative providers – 30 Aug 24	6

New Risks rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3127 24/06/24	Women's Children's & Sexual Health Services	Lack of appropriate placement for child or young person requiring enhanced care observation and no discharge profile available when medically fit for discharge	Patients with complex learning behaviours or mental health related conditions are required to be admitted to Hedgehog Ward as there are no other suitable placements available. The patients do not have a medical need for admission and are not under a section. Risk of self harm and absconding. Risk of injury to staff, visitors and other patients on the unit. Risk of damage to infrastructure and facilities. Risk of adverse publicity to the trust. No legal framework in place to support restrictions required	20	Room 16a low ligature room is preferred choice for placement Patient to use toilet nearest to 16a as door opens both ways safely Safety corridor to be implemented dependent on risks identified to act as a buffer for noise from self harming / distress to others and to reduce access to other patients and exits Enhanced care observations to be implemented RMNs to be employed if requiring any periods of restraint or sectioned and security to be in place if additional risks identified up to 4:1 Restraint documentation, rapid tranquillisation policy and daily review by Mental Health Liaison nurse to review and update on any behavioural plans in place	15	None recorded on InPhase	3

New Risks rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3130 28/06/24	Trust wide	There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)	Challenge to find projects or schemes that are going to deliver a CIP to the level required (£37.5 million)	20	CIP meetings with the COO and Deputy COO monthly with each Division Meetings with Divisional Triumvirates and senior teams Divisional CIP meeting with PMO Business Partners and Finance Managers Monthly EPOC financial efficiency steering board chaired by CFO Exceptional meetings for 3 months focusing on cross-cutting schemes CIP plan Frequent review of pipeline schemes	15	None recorded on InPhase	10

New Risks rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3128 27/06/24	Trust wide	There is a risk that research patients (in particular oncology patients) will not receive treatment via clinical trials as there is a significantly reduced aseptic service resulting in patients not receiving clinical trial treatments as standard care.	1. Patients are not receiving trial medications as part of standard care (in patients where standard treatment options have failed or are not available) 2. New studies are not being set up to address the needs to new patients requiring trial treatments 3. MTW has reneged on a number of commercial contracts of profitable, high-profile studies. 4. There is a reputational risk to MTW through not opening commercial clinical trials despite having eligible patients	20	1. Clinical trials are reviewed by pharmacy staff on a case by case basis to see if they can be accommodated	20	None recorded on InPhase	6

Escalated Red Risks

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1202 09/08/22	Corporate Services People and Organisational Development	Industrial Action Junior Doctors have announced a 5 day period industrial action and this will take place from 07.00 Thur 27 June - 06.59 Tues 02 July 2024. 24/25 awards remain unresolved as pay body recommendations not published and any awards will be deferred until after the general election and this is also an issue. As such, likelihood remains 5 and consequence uprated to 4 (ie 20) as the outlook has declined, with a view to reassessing next month.	With the backdrop of increasing and significant levels of inflation and the cost of living it is highly likely that the pay offer for public sector workers and therefore the NHS will fall short of trade union expectations. This may lead to a positive ballot for industrial action and disruption to service delivery. There is mounting pressure more generally with other sectors taking industrial action such as the rail disruption currently ongoing.	20	National NHSE led guidance Industrial Action Protocol Relationship with staff side and recognised Trade Unions. Communication channels available to update staff Minimum service levels established New legislative framework	20	None recorded on InPhase	12

Escalated Red Risks

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3069 21/02/24	Cancer Services Oncology	Chemotherapy e-prescribing The ICB are not funding the ARIA project this year. Discussed at Oncology directorate – discussed and raised to a 16 red risk.	The inability of our version of Aria now being able to accept FDB updates. We are currently on version 11 of ARIA, and although Varian will still support us with this product it may be over time things become problematic and they may not be able to provide fixes within our current version. Varian's latest version is now v17. This will be the last version of ARIA. If we were to upgrade to this, Varian states they would support us with this product for at least 5 years. Some validation for this upgrade will be required before it comes into the live environment.	12	Monitoring to ensure no clinical incidents arise due to the risks described There is currently an OBC for discussion with partners across the K&M as the current software is used by the 4 acute trusts	16	None recorded on InPhase	8

Escalated Red Risks

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1289 04/04/23	Medicines and Emergency Care Acute Medical and Geriatrics	There is a risk of patient harm linked to the backlog of patients awaiting review in the Virtual Stroke Clinic	An excess of 570 patients have been allowed to build on the list with what appears to be outstanding medical review or review of investigation, due to lack of oversight and lack of medical capacity. Current there are no criteria for this list or parameters for timely review.	9	1. Stroke Consultants responsible for timetabling frequent weekly Junior doctor time to address the virtual clinic list 2. Doctor Assistant monitoring and populating virtual list spread sheet with investigation results 3. Review of the medical staffing to ensure capacity 4. Doctor ax to monitor activity 5. Doctor assistant escalating delayed results to Lead Stroke nurse and Stroke Consultant, refereeing into vascular services where appropriate. 6. Development of separate vascular virtual list 7. Dr Assistant populating spreadsheet and highlighting delayed results to Stroke consultants	16	1289 - backlog of pts for r/v virtual Stroke Clinic *New Sunrise referral to be developed	12

Escalated Red Risks

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1182 12/07/22	Women's Children's & Sexual Health Services Women's Services	Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. Review of grading and current situation with SN and RA. May 2024 73% delays	Increased activity across the region with inductions being started and delayed at point of ARM or transfer to delivery suite. There is increase anxiety from the staff that there are typically 5 people waiting for an ARM on any given shift with at least the same amount coming into the service to commence IOL. Patient expectation is hard to manage because women and birthing people have been told that they need a IOL for a clinical reason and when this is process is stalled, naturally they become anxious.	15	Care Pathway Coordinators to manage the day to day flow and report twice daily to the senior team on how many IOLs are waiting for ARM/Delivery Suite (as part of the daily sheet) Risk assessment to be done by A/N ward manager or senior midwife in charge and consultant leading to twice daily prioritisation of the IOLs with up to date information Rapid risk assessment if delay >2 hrs and thereafter 4hrly risk assessment Ongoing communication with CPC, Consultant and Senior Midwife and patient during ongoing risk assessment when delay Appropriate use of escalation policy which includes mutual aid Monitoring of delays using metrics monthly and reporting to Trust Board	15	Publication of patient leaflet and amended guideline	3

Downgraded risks previously rated 15+

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3098 15/04/24	Cancer Services Oncology	Melanoma team - reduced staffing	We have one substantive band 7 in the team, we have a ACP working 2.5 days a week in the melanoma service, b7 interviews week 20th May.	16	Weekly meeting with Melanoma speciality at directorate level Bank use for CNS cover although difficult to obtain due to skill requirement review of clinics and number of reviews for patient AOS supporting where appropriate	12	Audit number of patients who are referred and currently being seen by melanoma, Audit of clinics overbooked in Melanoma – 03 May 24 Review of skill mix and establishment of melanoma team – 03 May 24 Weekly meeting with directorate and melanoma speciality with action plan to mange patient safety in melanoma – 19 Jul 24	6
3039 11/12/23	Corporate Services Corporate	There is a digital informatics risk that a misconfiguration in the Maternity EPR (E3) can cause backfilling of new clinical information into a historical patient record creating an erroneous medical record	MTW has worked very closely with Magentus to resolve the key issues identified and work is now completed to assess the needs and to make local configuration safe.	16	Directorate aware and they are managing via local mitigations (see linked risk) Trust head of IG and CNIO and CCIO are currently reviewing to consider potential emergency tendering process	8	Pop-up information and warnings are being added to provide an additional layer of assurance. Icons will also be added to identify if any changes have been made to the workflows, including demographics.	4

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1275 01/03/23	Women's Children's & Sexual Health Services Women's Services	Swab, needle and instrument count documentation is not being completed in line with Trust policy.	Reason for downgrade not documented	16	Documentation of count pre and post suturing within hand held notes requiring 2 signatures Electronic documentation on E3 of swab check Guideline update following 2021 Never Event Swab Safe containers introduced White boards in delivery rooms for contemporaneous documentation with pens being readily available Requirement of all staff to read swab count policy during induction period Update of documentation process to reduce duplication A3 to determine contributory factors B7 coordinators to check documentation in real time	12	Complete audit of 60 notes from September and accompanying action plan – 23 Nov 23 Complete audit of compliance with single safety checklist and staff feedback – 23 Nov 23 Process needed on how/who will gather the data on a monthly basis needed for metric for SDR – 20 Nov 23 Re audit of 40 notes in October • Video to be recorded w/c 14/8/23 to update staff with ongoing work – 24 Aug 23 Repeat non-compliance measures to be communicated to staff – 20 May 24 Edit current video to introduce amended count proforma – 05 Jul 24	4

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3095 12/04/24	Women's Children's & Sexual Health Services Women's Services	Increase of staff required to support the maternity improvement plan	Key safety issues have been prioritised	16	Existing staff are supporting with additional hours, where possible, and key safety issues are being prioritised	9	Develop a business case for additional resources – 31 May 24 Recruit to additional posts subject to finances being approved – 02 Sep 24	6
1277 01/03/23	Women's Children's & Sexual Health Services Women's Services	Lack of assurance that there is timely assessment of people presenting to Triage	Reason for downgrade not documented	16	Increased midwifery staffing on triage. Primary triage midwife in place when acuity allows Aim for senior Medical Consultant/Registrar cover 9-5pm weekdays Agreed uplift of band 6 core triage midwives from 5 WTE to 8 Escalation pathway developed for obstetric referral Consultant allocated as lead to undertake service improvement project	9	Pilot new pathway – 24 Aug 23 Complete ward meeting with staff to inform of relaunch – 24 Apr 24 Relaunch BSOTS – 02 May 24 Care Pathway to collect data on daily staffing – 31 May 24	4

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1267 17/02/23	Corporate Services Clinical Governance	Clinical Audit performance	New member of staff joined. The NDA and NPDA data has been submitted with regards to the funding section of each audit. Further submissions due in May 2024.	16	Local clinical audits are currently under a three strikes and you are out policy when they hit target dates. Team working on site more often to facilitate easier completion of assessment of compliances. Overdue action amnesty put in place in November 2023 for actions greater than 18 months overdue after Clinical Audit Overview Committee meeting.	12	Review of Directorate Clinical Audit Lead JDs underway with Trust Clinical Audit Support reviewing performance of current DCALs with plans to put these posts out for recruitment where appropriate. Long-term automation of data collection for appropriate national clinical audits project in early stages of development.	6
2999 02/09/23	Trust Wide Trust Wide	Radiation Incidents not being automatically notified via InPhase or categorised so that reports can be made as required under IR(ME)R, IRR, or EPR	Radiation Physics provided new category codes to patient safety for adding to Inphase picklists, plus associated staff members who should receive notifications.	16	Manual notification by patient safety to radiation physics.	12	Patient safety to meet with key leads to add required fields to reporting form	4

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
1259 08/02/23	Trust Wide Trust Wide	Statutory & Mandatory Training Compliance	May data now received. This shows that stat and mand training was at 90.7% and no division was below the 85% target.	16	Monthly reporting to all key stakeholders to high areas for improvement. Additional data interrogation to support identification of outliers by department. Multiple system issued reminders to the individual and line manager to warn of upcoming programme expiry and non-compliance Use of National e:learning for Health programmes where possible	12	Review data in a month to ensure consistent achievement of compliance	12
2955 30/06/23	Corporate Services Nursing	Insufficient workforce within the 3 safeguarding teams to meet the current demand	Staff members in midwifery safeguarding have been moved to corporate team. Support is now agreed and combined from the children's and adult team to support current activity	16	One band 7 safeguarding practitioner Community midwifery team supporting midwifery safeguarding team	9	JD for all age safeguarding practitioner undergoing review by HR and ER team PMO team have been invited to review current activity and demand to realign the service requirements against divisional responsibilities	6

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
3035 06/12/23	Surgery Ophthalmology	Recurrent failure of IT systems and equipment vital for the clinical imaging of patients for clinical review with the potential for delays in service delivery.	IT Working Group continue to meet monthly. Server update June 2024.	20	regular review and servicing strong links with EME and careful tracking of patient who have attended appointments on individual sites re-attending at a later stage when the equipment is functional or attending another site	9	divisional IT impact assessment and working group Identify new ways of working with the current system to make the patient pathway more effective an active equipment log additional equipment	8

Downgraded risks previously rated 15+ (continued)

ID / Opened	Division / Directorate	Title	Reason for downgrade	Initial risk rating	Controls	Current risk rating	Actions	Target risk rating
634 04/05/16	Women's Children's & Sexual Health Services Women's Services	There is a risk that it may not be possible to access an additional obstetric theatre on delivery suite resulting in delay in delivery of care to pregnant people and babies	Risk title, description and grading amended with Risk Management Lead and Clinical Director to reflect current risk appropriately	15	Incident reporting to monitor incidence of delays in care. Escalation plan in place to request mutual aid. Interrupt routine theatre work to free up obstetric and theatre team on delivery suite. Dedicated anaesthetist now working on delivery suite during daytime weekdays. Additional ODP dedicated to maternity overnight; to cover emergency recovery also. Focus on reducing number of perineal tears in line with national campaign, to reduce the need for theatre. Increased awareness amongst staff of delays in care. Escalation tool to guide staff on process of efficiently requesting access to an additional operating theatre has been created. Monitoring delays in timeframes for Cat 1 and Cat 2 LSCS as part of Improvement Programme	12	Recruitment of 1 recovery nurse and 1 scrub nurse for 2nd obstetric theatre team Engagement with the site team regarding out of hours theatre escalations Timeframe for cat 2 delays data required Review of current risk, grading and mitigation Deployment of obstetric theatre team to be based on delivery suite SOP for escalation when 2nd theatre team required	6

Closed risks

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Reason for closure	Target risk rating
1205	Corporate Services Corporate	Patients are at risk of legionella infections from unsafe, non-complaint hot and cold-water systems at Tunbridge Wells Hospital	Hot and cold-water systems are unsafe and non-compliant due to poor water circulation and low temperature control increasing the risk of bacterium legionella pneumophila becoming established within the water system and other water pathogens.	20	Trust employed flushing team setup to flush augmented care areas every day and all other areas twice weekly. Remedial works carried out, additional daily flushing, disinfection and descaling of TNV or TMT and POU filter installed to protect users. Hospital wide works on the water system to rebalance and replace valves. POU filters in place across the Trust in clinical areas to minimise risk of patients coming into contact with contaminated water.	15	Risk closed as a duplicate of risk 942	10
3012	Emergency Planning Emergency Planning	There is a risk that the poor radio reception at TWH will affect the security teams effectiveness	Poor reception in some areas of the hospital. Made worse by extreme weather conditions, particularly heat and rain. Orientated more towards the ED side of the hospital, increasing criticality.	16	12 brand new radios and batteries on hire.. Although this has not solved all the issues. 2 quotes from external suppliers have been received offering a permanent solution, these are currently under consideration.	4	Remedial works completed by way of additional antenna and repeater works. Additional 12 new radio handsets also purchased. Works successful.	4

Closed risks (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Reason for closure	Target risk rating
3054 11/01/24	Corporate Services Information Technology	UPS in PPP Server Room is aged and in need of replacement	There was a spike of power in the grid, the UPS didn't perform as it should and we lost power to the server room. With the UPS in its current state, should there be any powercut to the hospital, there is a risk that we may lose the server room and any systems / file shares that reside there.	20	Black Start generator testing has been amended so that the area that houses the PPP server room is not tested.	10	The UPS in PPP has now been replaced.	10
1260 09/02/23	Women's Children's and Sexual Health Services Women's Services	Potential for poor patient experience regarding consent	Patients are not receiving sufficient verbal and written information to enable informed decisions to be made regarding their care. There has been an increase in complaints and consent is the subject of an ongoing serious incident	16	Trust Policy and procedure for consent to examination or treatment Consent for vaginal examination is a required field to be answered within the procedure documentation	4	Agreement at MRRG that risk target has been met following deep dive report, attached. For ongoing monitoring by Patient Experience Lead once in role	4

Closed risks (continued)

ID / Opened	Division / Directorate	Title	Description	Initial risk rating	Controls	Current risk rating	Reason for closure	Target risk rating
1154 26/04/22	Trust-wide	Challenges in maintaining staff moving and handling skills resulting in related incidents with potential for harm to patients and staff	There has been an increase in incident reports, as well as reports from assessments in conjunction with occupational health and the health and safety team. There have been concerns raised from staff regarding compliance of training and competencies in carry out moving and handling tasks safely, especially with staff new to the Trust and those potentially less experienced with moving and handling tasks. Equipment is not being used appropriately increasing risks to patients and staff.	16	E-learning packages to meet training needs Safe systems of work and risk assessments Moving and handling strategy group Audits Collaboration work with Occupation health and health and safety	6	Board summary report from December 2023 to April 2024 indicate that training has had a consistent compliance towards Trust target of 85%. Current, May 2024 clinical training compliance is 86.7% and non-clinical compliance is 91%.	6

Recommendations

- Consider whether the risks included within this report are the most significant risks to the Trust
- Ensure that progress is recorded against each of the risks rated 15+ (red)
- Review Appendix 1 to ensure that each risk rated 15+ has adequate actions recorded and consider whether the controls in place have reduced the current risk score.

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
1202	09-Aug-22	People	Corporate Services	People and Organisational Development	19-Jul-24	Industrial Action	With the backdrop of increasing and significant levels of inflation and the cost of living it is highly likely that the pay offer for public sector workers and therefore the NHS will fall short of trade union expectations. This may lead to a positive ballot for industrial action and disruption to service delivery. There is mounting pressure more generally with other sectors taking industrial action such as the rail disruption currently ongoing. As of 5 April 2024, there now remains one outstanding registered trade dispute between the British Medical Association (BMA) and HSCA medical unions in respect of Junior Doctors (Doctors in Training) grades and separately for Specialty and Specialist (SAS) grade doctors. In addition, the Government has not confirmed pay awards for the 2024/2025 financial year and this may lead to further ballots. The closing date of the action has therefore been extended from 29 March 2024 to 20 September 2024.	20	National NHSE led guidance and advice on Industrial action impact Industrial Action Protocol developed Working Group set up to develop contingency plans and scenario options Working relationship with staff side and recognised Trade Unions. Communication channels available to update staff Liaison at system level to ensure consistency and mutual aid Critical incident room ready to be stood up in the event of industrial action Emergency plans being written in collaboration between emergency planning team and divisions Working group moved to meeting weekly Emergency planning event planned Additional JMCC arranged with staff side / BMA rep alongside routine JMCC sessions In addition for 2024/25, we will maintaining staff welfare interventions, eg trolley rounds and signposting to our wider wellbeing offer during any industrial action. We are also working closely with senior operational managers to prepare for and mitigate impacts on staff and patients. It was announced that the consultants dispute for 2023/24 was resolved with an acceptance of a revised pay offer on 5 April 2024. This does	20	None recorded on InPhase	19.06.2024 - As at 19 June 2024, the BMA and HCSA announced on 18 June that SAS grade doctors have accepted the pay offer for 23/24 and that dispute is settled. However, the Junior Doctor pay dispute w.r.t 23/24 pay awards remains unresolved and talks via mediation broke down as no offer made and no further talks during the general election rune. Junior Doctors have announced a 5 day period industrial action in response and this will take place from 07.00 Thur 27 June - 06.59 Tues 02 July 2024. This will be the 11th period of such action and we are putting our contingency plans into action and we have established minimum service levels through joint collaborative working which will help to mitigate impacts. 24/25 awards remain unresolved as pay body recommendations not published and any awards will be deferred until after the general election and this is also an issue. As such, likelihood remains 5 and consequence uprated to 4 (ie 20) as the outlook has declined, with a view to reassessing next month.	12	20-Sep-24
3128	27-Jun-24	Patient Safety and Clinical Effectiveness	Trust Wide	Trust Wide	27-Jun-24	There is a risk that research patients (in particular oncology patients) will not receive treatment via clinical trials as there is a significantly reduced aseptic service resulting in patients not receiving clinical trial treatments as standard care.	The aseptic unit on the Tunbridge Wells site has been running at reduced capacity for a number of months due to staffing issues. Pharmacy support of clinical trial set up, especially oncology trials, has been severely impacted. Reducing clinical trial activity is a control measure for the aseptic unit risk. This impact is having a severe impact on trial set up and delivery which impacts on MTW in a number of ways 1. Patients are not receiving trial medications as part of standard care (in patients where standard treatment options have failed or are not available) 2. New studies are not being set up to address the needs to new patients requiring trial treatments 3. MTW has reneged on a number of commercial contracts of profitable, high-profile studies. 4. There is a reputational risk to MTW through not opening commercial clinical trials despite having eligible patients	20	1. Clinical trials are reviewed by pharmacy staff on a case by case basis to see if they can be accommodated	20	None recorded on InPhase	None recorded on InPhase	6	31-Jul-24
3051	09-Jan-24	Systems and Partnerships	Emergency Planning	Emergency Planning	30-Jul-24	Insufficient backups of TWH access control door system	The door security system is not backed up appropriately including no offsite or offline storage of the backups.	20	There are no appropriate controls in place at present to mitigate this risk	20	Start negotiations with Mitie / Trust I.T. to obtain agreement to transfer system on to Trust Servers Obtain costs to transfer access control system to Trust servers.	13.06.2024 - No progress to date. ProjectCo have asked for another meeting as they have concerns (as yet unknown). Hope to have meeting at end of June. Trust I.T. are ready to carry out site visit which is now delayed by ProjectCo.	5	31-Aug-24

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
3052	09-Jan-24	Systems and Partnerships	Emergency Planning	Emergency Planning	31-Jul-24	TWH access control door system is not resilient	The door security system is on a single server with no resilience and ability to failover to an alternative source.	20	There are no appropriate controls in place at present to mitigate this risk	20	Start negotiations with Mitie / Trust I.T. to obtain agreement to transfer system on to Trust Servers Obtain costs to transfer access control system to Trust servers.	13.06.2024 - No progress to date. ProjectCo have asked for another meeting as they have concerns (as yet unknown). Hope to have meeting at end of June. Trust I.T. are ready to carry out site visit which is now delayed by ProjectCo.	5	31-Aug-24
3053	09-Jan-24	Systems and Partnerships	Emergency Planning	Emergency Planning	31-Jul-24	TWH access control door system lacks suitable cyber security protections	The door security system is not patched regularly, has no anti virus and the support provider maintenance contract has no provision for restoring service due to a cyber incident.	20	The system has no internet access slightly mitigating the risk but this does not protect from internal or local attacks originating from connected devices such as PCs or USB devices.	20	Start negotiations with Mitie / Trust I.T. to obtain agreement to transfer system on to Trust Servers Obtain costs to transfer access control system to Trust servers.	13.06.2024 - No progress to date. ProjectCo have asked for another meeting as they have concerns (as yet unknown). Hope to have meeting at end of June. Trust I.T. are ready to carry out site visit which is now delayed by ProjectCo.	5	31-Aug-24
3023	24-Oct-23	Patient Safety and Clinical Effectiveness	Cancer Services	Clinical Haematology	28-Jun-24	Haematology patients are at risk of being lost to follow up due to operational pressures	There is a risk of haematology patients being lost to follow up due to operational pressures and processes which could lead to significant harm to patients and or delay to patient's treatment.	16	1. Currently project being undertaking on lost to follow up patients 2. From 9th of October 2023 a new follow up process has been implemented which is currently being measured & evaluated 3. Follow up waiting list for haematology have been validated twice and going forward the list will be validated weekly by service manager and general manager 4. Saturday follow up clinics have been introduced 5. Locum consultant been brought in to support	16	None recorded on InPhase	31.05.2024 - Focused work project being carried out by Service Manager to reduce long waiters and develop ongoing SOP for admin to follow regarding follow up patients	12	26-Jul-24
3042	21-Dec-23	Systems and Partnerships	Cancer Services	Oncology	28-Jun-24	Issues at East Kent Foundation Trust hospital relating to time form referral to reporting of scans and histologist	There is a risk at East Kent Hospital of delays of time from referral to reports of PET, CT and histologist reports for cancer patients. This will effect MTW patient and their pathways	16	Cancer Alliance are supporting pathway work with all of the TSSGs which will result in a data dashboard (separated by trust) of the time to each step of the pathway and the numbers involved - this will help to flag up these issues at a trust level. Cancer Alliance picked up the IR issue at EKHUFT as a result of the lung TSSG where it was discussed. Some of the issue is around number of IR consultants at EKHUFT. MTW has recently recruited three IR consultants so we now have a good team. Discussions around mutual aid with East Kent and MTW.	16	board to board discussion to be undertaken	31.05.2024 - No current updates from East Kent	8	30-Aug-24
2945	03-Apr-23	Sustainability	Core Clinical Services	Imaging	27-Jun-24	Equipment - Replacement of equipment required for Fluoroscopy imaging rooms at the TWH site	Replacement required for 1 fluoroscopy imaging equipment, its primary use being interventional radiology, as it was installed 2011 and is past the acceptable life of the equipment. Replacement required for 1 fluoroscopy imaging equipment, primary use at present being non-sterile imaging. Known as rooms 27 (dirty fluoro) and 119 (clean fluoro).	16	Local QA Physics QA PPM Fault/error escalation Cross site support Move list to another room where possible	16	2945 - RA for Interventional room replacement (119) 2945 TWH Fluoro2 Equipment Install Mitie to complete the turnkey works	13.06.2024 - Equipment remains is storage. Discussions around understanding any impact of new Building Regs. Ready to place order for works. SH chasing daily.	4	31-Jul-24

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
2947	03-Apr-23	Sustainability	Core Clinical Services	Imaging	12-Jul-24	Equipment - Replacement of equipment required for Mammography at the TWH site.	This mammography machine is over ten years old. Functionally it is increasingly slow to expose, and mechanical failures are commonplace. The images produced are of diagnostic value, however, due to the increased exposure time, incidents of blurred images are more likely. The presence of blur on an image would require a repeat image or referral to a newer machine at Maidstone, this would qualify as a radiation incident. We are unable to use this machine to support the Breast Screening Programme clients as the mammograms take too long and the quality isn't high enough. The clients we would usually screen here are now booked elsewhere which is reducing choice to the client and overbooking other clinics. It breaks down on average every 2-3 months, and requires rebooting at least weekly.	**16**	- Local QA and calibration. - Physics QA - use another machine if a list isn't booked (rarely)	**16**	2947 - Create business case	12.06.2024 - SH is escalating further concerns with the mammography machine at TW to medical physics. Image quality is poor and acquisition times too long.	**4**	30-Jun-24
3112	23-May-24	Patient Safety and Clinical Effectiveness	Core Clinical Services	Pathology	18-Jul-24	Lack of follow up of diagnostic reports	There have been 21 serious incidents at the Trust from January 2023 - March 2024 due to abnormal diagnostic results not being actioned, making this now the top theme for serious incidents and a clinical safety risk. This has been experienced through multiple specialties and diagnostic tests for routine referrals with unexpected or subsequent findings, which are not currently on a cancer fast track pathway or the primary reason for the diagnostic referral. There are no standardized processes for tracking diagnostic requests and results within specialties and MDT's. The current responsibility of tracking patients' diagnostic results is not clear and this contributes to the problem of abnormal results not being identified and managed in a timely fashion. IT systems used within the Trust do not currently flag diagnostic results ready for review to requesters or support tracking of when Radiology requests are made. Histology remains a paper based request with requesting and results not available as part of the EPR; this adds to the complication of managing results and prevents mandatory fields on requests. The lack of clinical ownership on diagnostics requests (particularly paper forms) has also added to the issue of who to send or escalate results to for further escalation and management. The impact of this issue to patients includes poor experience or care and harm as a result of delayed treatment and management of condition with potential of poorer outcomes and possibly death. This could also lead to a poor reputation for the Trust and potential for litigation, which could have financial implications.	**16**	- Red spot system utilised within Radiology for majority of specialities. - Manual process in place from Soliton to send unexpected findings to MDM teams. - Publicity of risk and responsibilities of requestor occurring through various meetings (QIC, CLIPARM, SI previously group, NMHAPP etc). - Spreadsheet issued by Histology of confirmed cancers agreed in SNOMED codes issues to various areas in Trust, DGT and MFT.	**16**	Build order comm sets for Histopathology orders Cleanse options available for selection with varieties of Dr Unknown Prepare Trust draft P&P for management of results Stop issue of printing out Histology reports to MTW requestors	13.06.2024 - Clarified in meeting this week between Histopathology Consultants, Pathology IT and Sunrise team results are available to access via EPR. Teams requested to undertake verification so information displayed in same format as if printed and encompasses all including molecular; if this is the case; corresponding risk can be closed. How this has been done has been requested to share with EKHUFT. Have share information with HON and matron for ENT, AGM for GS, secretary for UGI consultant to see if they are able to access information.	**4**	01-Apr-26

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
1310	03-Apr-23	Sustainability	Core Clinical Services	Imaging	12-Jul-24	Equipment - Replacement of equipment required for General and ED Plain Film Imaging Rooms across the MGH and TWH sites.	TWH The 2 AE X-ray rooms at TWH hospital are 12 years old, with an expected working life of 7-10 years. Over the past 3 years they have had repeated faults and downtimes for various issues. Many of these faults have been repaired under the service contract, however there have also been chargeable repairs. These repairs have led to downtime on the main A&E / Inpatient x-ray rooms. Both systems are at End of Life in Dec 2023 and full support from the manufacturer will not be available as parts cannot be guaranteed to be available These rooms are crucial in providing our inpatient and AE service at TWH and failure to replace will impact on our turnaround times especially the Trust's AE waiting time. MGH The 2 GE Digital X-ray rooms at Maidstone hospital are 10 years old, with an expected working life of 7-10 years. Over the past 3 years they have had repeated faults and downtimes for various issues. Most of these faults have been repaired under the service contract, however there have also been chargeable repairs. This has led to downtime on the main A&E / Inpatient x-ray rooms. Equipment also develops faults which, while still operational, reduce the capabilities of the room until it is repaired. This means certain examinations are unable to be carried out. Further narrative is on the RA.	16	1. Rooms serviced regularly 2. Take rooms out of action completely 3. Engineers called when fault occurs 4. Transfer patients to an alternative imaging room, or across site 5. Outsource activity to other Trusts in the network 6. Local QA, at regular intervals 7. Physics QA, at regular intervals	16	1310 - BC MGH R4 equipment replacement 1310 - Install equipment Rm4 MGH 1310 - RA MGH Sept review	13.06.2024 - TW Room169 detector failed. Its been replaced x2 over a 12 month period. Discussions held at directorate and divisional levels, where its agreed this room will be replaced as a priority. SoC agreed. Probably to go to procurement, TBC. TW Adora room BC agreed. MGH Air handling discussions ongoing. TW building regs understanding of impact discussions being held.	8	31-Jul-24
3123	13-Jun-24	Patient Access	Corporate Services	Operational Flow	13-Jul-24	There is a risk that patients will remain in hospital whilst no longer fit to reside as the non- recurrent funding providing out of hospital capacity for Hilton will end in September	Hilton service currently supports patients discharge (50 per week) . This service ends in September with no current new contract in place.	16	Pre-planning for patients whilst in hospital Discussions taking place with alternative providers and the ICB	16	Continue to meet with ICB around alternative providers		6	01-Sep-24
3122	13-Jun-24	Patient Experience	Corporate Services	Operational Flow	30-Sep-24	There is a financial risk to the Trust as Trust/private ambulances are being funded as a cost pressure to support patient discharges	Currently 5 ambulances Monday - Friday and two at weekends are provided to support discharges home and for appointments unfunded. This is causing an overspend to ensure patient flow and patient safety in ED.	16	Escalation to Kent and Medway ICB for G4S contract and East Sussex ICB for SCAS contract	16	Continue to meet with K&M ICB and East Sussex ICB regarding transport contracts		3	31-Mar-25
1286	21-Mar-23	Sustainability	Corporate Services	Estates	28-Jun-24	Statutory Compliance	The Estates maintenance department has identified that processes are not in place to ensure the department meets its duty with regard to maintenance statutory requirements.	16	Estates department have commissioned a full independent audit to identify gaps in processes and will then formulate an action plan accordingly to address the areas identified deficiencies.	16	None recorded on InPhase	15.04.2024 - As previously reported. In addition awaiting update from Exec regarding report and presentation.	12	31-Oct-25
3113	24-May-24	Sustainability	Corporate Services	Finance	28-Jun-24	There is a risk that the Trust will not have enough cash to meet its commitments resulting suppliers not being paid and the Trust not meet its BPPC (Better Payment Practice Code) target. The impact of suppliers not being paid is that they could with hold further deliveries such as drugs, food and clinical supplies which could impact patient care.	There is a risk that the Trust will not have enough cash to meet its commitments resulting suppliers not being paid and the Trust not meet its BPPC (Better Payment Practice Code) target. The impact of suppliers not being paid is that they could with hold further deliveries such as drugs, food and clinical supplies which could impact patient care. The Trust will also lose discounts for prompt payment and incur late payment charges. The suppliers may increase prices in future to cover future late payments.	16	Cashflow is updated daily and compared with the I&E plan or forecast. The Head of Financial Services reviews the cashflow to ensure payments due are affordable for the next month. If there is a risk of going overdrawn then payment to suppliers is reduced. Active Debt is chased by the receivables team. A weekly cash report is circulated to the Heads of Finance and CFO. A bi-monthly working capital group meets to review the cash position. The Finance and Performance Committee receive a monthly update and cashflow report in the finance report. A more detailed cash analysis is provided on a quarterly basis. If actions are not delivered then the Trust will seek a revenue support loan from DHSC which will attract interest and be repaid.	16	Increase monthly cash payments from ICB and NHSE are aligned to plan CIP Delivery Invoices raised promptly Additional Cash support for Fordcombe Additional Cash support for UEC Capital		8	31-Mar-25

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
1150	21-Apr-22	Patient Safety and Clinical Effectiveness	Medicines & Emergency Care	Acute Medical and Geriatrics	16-Jul-24	Impact of increase in number of inpatients with mental health needs / neurological deficit.	There has been an increase in the number of patients with mental health and / or neurological impairment on the inpatient wards across Directorates 2 and 3 (AMG & MedSpec). These patients can present a risk to themselves and / or other patients and / or staff. The risk could be verbal and / or physical abuse, self-harm, damage to Trust property. The Directorates continue to request staff via staff bank/agency to fulfil the staffing shortages, but this is not always effective due to staff unavailability. This can lead to patients not receiving the appropriate supervision to keep them safe.	20	1. Use of Enhanced Care policy, and continued request for extra staff via staff bank/Agency. 2. locating the patient in a bed / room close to the nurse station and removing all items the patient could use for self-harm. 3. Reminding staff of the use of non-confrontational language / tone of voice and use of distraction techniques. 4. Development c/o the corporate team or RMN and Mental Health working teams employed by MTW to provide support onto the wards. 5. Staff compliance with conflict and resolution training, and the management of challenging behaviour 6. Ensure staff are aware of the de-escalation techniques by attending study days and co ordinating Mark Dunnett and G to attend Divisional wards	16	None recorded on InPhase	30.06.2024 - 21/05/2024 - As part of the Mental Health Committee work, there is now a SOP for Mental Health for ED and Inpatients. The Mental Health Committee meetings is in its early stages, and is attended by HON Kinsella, HON Hallewell and Divisional DDNQ. MHC meeting in April 24 Amy Daniels the new head of Mental Health for the Trust confirmed that the initial focus for adult inpatients was ensuring all areas had competed their ligature risk assessments. Enhanced care work is to continue, whilst looking at decreasing bank and agency spend and ensuring that patients are receiving the correct level of oversight by the right person. Minutes of this meeting are attached. There remains a significant risk to patients and staff as the number of Mental Health patients coming through ED and the wards remain significant. The SMART tool, committee meetings and enhanced care groups that may be coming forward are supporting with mitigation, but as a Division we are not in a position to reduce the risk to Amber.	9	29-Mar-24

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2981	03-Aug-23	Patient Safety and Clinical Effectiveness	Medicines & Emergency Care	Emergency Medicine	16-Jul-24	Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site	This risk replaces risk 1255 titled delays in psychiatric pathways. Due to the busy environment the psychiatric assessment rooms are not considered conducive for this type of patient. There is a risk that the unsuitability of the assessments rooms will contribute to patients leaving the department before being seen by the psychiatric team. The busy environment is at risk of triggering patients to self-harm.	12	1.Ensuring every patient in the department with an acute mental health presentation, has a Safeguarding and Managing Risk Tool (SMART) completed at the point of initial triage. This is to assess level of risk to themselves or others. The SMART tool has also been adapted to include a physical description of patient to allow security to be able to search the hospital grounds for an absconded patient. The SMART tool is now live on Sunrise. 2. Inform Psychiatric Liaison triage if based in ED of the patient so that an assessment can be undertaken immediately. If Psychiatric Liaison not available, contact in accordance with Trust policy and Psychiatric Liaison pathway. Patient escalated to the Nurse-In Charge. 3.Ensure that a patient deemed high risk of suicide, suicidal idealisation or thoughts/active self-harm in a high visibility cubicle within the Majors area. 4. Escalation to Matron in hours and Site manager out of hours if a patient has triggered as red or high risk on the SMART tool. 5. If patient is placed in a cubicle, then they must not be alone and be visible to staff at all times. 6. The NIC should request a mental health CSW and/ or RNM from the MH staff pool and if one is not available, inform security in order to mitigate the risk. 7. Security should be contacted in order to monitor the patient for signs of unusual behaviour or aggression. Security should also search the patient with a staff member present to identify weapons that could cause harm to the patient or others. 8. Staff should contact security in the event of absconders from the department and those deemed at risk / lacking capacity. Staff to follow the AWOL policy. 9. Staff are performing robust safety handovers	16	None recorded on InPhase	03.05.2024 - 03/05/2024 - The mental health/neuro diversity working group has now been established under the mental health committee. Works underway for improvements including (but not limited to): TWH: Psychiatric assessment room having floor to ceiling boards (white rock) installed with mural on the wall. Lightening to be changed to a softer, less-clinical brightness. Awaiting CCTV to be installed and a strip alarm for safety. MGH: Awaiting door to be changed to add a viewing window (with slatted shutter) to be added to the door on the waiting room side. Work to be completed as part of the Mental Health working group, alongside the newly recruited Head of Mental Health to look at therapeutic work for all patients with additional needs.	8	03-Dec-23
1233	30-Nov-22	Sustainability	Surgery	General Surgery	30-Jun-24	Equipment failure risk due to age of Endoscopy Wassenburg decontamination plant	Multiple washer chambers have faults resulting in only 3 out of 8 chambers functional. There is an ongoing risk of failure due to the age of the equipment. One drying cabinet out of three is non functional resulting in reduced storage of scopes ready for procedure. The risk is at both sites.	20	EME currently working to restore function with regular updates to department.	16	Business case declined. Options of leasing explored but still expensive so business plan will be re presented	21.05.2024 - Plasma washers are with EME and being checked. These Plasma washers are part of business continuity plan.	6	31-Dec-23

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1270	23-Feb-23	People	Trust Wide	Trust Wide	23-Mar-23	Lack of medical devices training in the Trust	Training for medical devices for nursing and support staff is not mandatory. This could result in a serious incident as a result of a lack of training. There is the aim is to include training on non-high risk medical devices on induction. Competency assessments will be carried out in the working environment to significantly reduce the risk to patients. However, issues remain: 1. No plan put in place for ward manager to identify who has had training on what device. 2. Staff come from other Trusts trained on other equipment from different companies which is unsafe. 3. Training and competency documents are: - kept with staff - stored in managers office - scanned on computer drive in different departments/wards - sent to E.M.E. Services Learning and development are not able to take all training documents 4. Staff using equipment with no training at all 5. Practice Development Team - role doesn't involve training medical devices 6. If the training isn't mandatory then staff are not aware that there is such training to complete. If mandatory, then Learning and Development can flag up to staff to complete and update their training. 7. E.M.E. Services can be inundated with calls from ward staff on faulty equipment when it is user error due to no training. Data is recorded monthly by Head of Clinical Engineering. 8. Staff are able to use infusion pumps without any training as training on this is not mandatory.	16	The Medical Device Training provides two Medical Devices training days a month. These cover training on 9 pieces of equipment - beds, mattresses, vital signs monitor, checking oxygen and suction, feeding tube device, cardiac monitor, bladder scanner, suction on the resus trolley, ECG, and falls monitor. Both training days are fully booked up months in advance. A training day is only able to have 12 attendees and so more resources need to be provided for all clinical staff to receive this training. High risk equipment is taught individually. Two e-learning packages set up and the 3rd to be completed in the next month.	16	None recorded on InPhase	None recorded on InPhase	4	29-Mar-24

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2980	03-Aug-23	Patient Safety and Clinical Effectiveness	Trust Wide	Trust Wide	17-Jul-24	Risk of Healthcare associated C. difficile and breaching national limits of number of cases	During 23/24 we exceeded out rates of CDI with 107 cases against a year end limit of 61. 2 episodes of transmission of infection has occurred between one patient to one other in July and Dec 23 and unprecedent high rates (21) were seen in July 23. This increase has also been seen across the K&M ICB and nationally The cause of C. difficile outbreaks is known to be multi-factorial and includes high bed occupancy, contaminated environment, poor antimicrobial stewardship, low staff numbers and high community carriage levels.	**20**	- Hierarchy of controls: Elimination - risk can be reduced by effective cleaning. - Deep clean programme (including HPV fogging) was undertake on 5 wards at TW during 2023. Plan to recommence once decant ward is available again (anticipated to start June/ July 24) - At MH, no decant ward available, additional ad hoc deep cleaning of bays to be facilitated where cases arise in bays. - Cleaning audits to continue with IPC team joining some audits - Bed turnaround team process under review to ensure highest standards of cleaning is achieved and maintained - Mattress integrity guidelines shared with domestic and nursing staff including bed turnaround teams - All damaged mattresses to be removed from use and replaced - Additional mattresses to be sourced to maintain contingency supply - Patient rooms and equipment must be cleaned at least daily and after every use using DiffX - HPV cleaning for all side rooms used for C. difficile patients - Equipment such as computers on wheels must be cleaned between wards and should not be taken into rooms of C. difficile patients Substitution - no substitute available Engineering of controls - isolation of patients with C. difficile carriage or infection - All patients with C. difficile infection or C. difficile carriage to be isolated in single rooms - all samples sent to the reference laboratory for ribotyping to assist in surveillance and identification of transmission of infection -Trust wide incident meeting to be held in April 24 further meeting planned for July Administration - management of patients	**16**	None recorded on InPhase	None recorded on InPhase	**12**	31-Mar-25

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3070	21-Feb-24	Patient Safety and Clinical Effectiveness	Trust Wide	Trust Wide	21-Mar-24	Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI	Trustwide compliance with Basic Life Support Training (BLS) has been below the KPI of 85% for a significant period of time, however, as of January 2024 the compliance level dropped a further 4.1% to just 69.9%, 15.1% below the KPI, and 20.1% below the stretch target KPI of 90.0%. In total, 30.1% of the staff required to attend this training are non-compliant with the risk being to patient safety. In order to achieve compliance of 85%, 864 clinical staff need to successfully complete this training. There is a significant risk to the Trust in the event of a serious incident.	20	Monthly reporting is provided to divisional leads, which provides an overview of the compliance in their areas by team, and the names of those who are non-complaint. Monthly reporting is also shared with Board and ETM via IPR Scorecards. The MTW Learning system sends regular email reminders to all staff and their line managers 3 months before their annual expiration, then monthly thereafter to advise of non-compliance. The course was reduced in length during covid to make it more accessible, and consists of a short e:learning theory programme and a face to face competency assessment run by our in house resus team. The e:learning is available 24/7 to all staff and there are currently in excess of 500 places available to book for the competency assessments across both sites. The course takes approx. 1.5 hours in total to complete. DNA rates for courses are high, if a staff member books and does not attend a course both they and their line manager receive an email notification from the system advising them of the DNA and asking them to re-book. The Resus team supported by Learning and Development also offer bespoke sessions in wards or clinical areas to support with the release of staff, however find that release is a challenge and often these sessions will have less than 5 attendees. Weekend courses and out of hours sessions were offered for a period in 2023 but uptake was low and costs high.	16	None recorded on InPhase	None recorded on InPhase	12	31-Dec-24
3063	07-Feb-24	People	Women's Children's & Sexual Health Services	Women's Services	28-Jun-24	Community midwifery sickness affecting the work load within the community setting.	Community midwifery sickness affecting the work load within the community setting. 20% vacancy rate 25% sickness rate, many long-term health issues. Routine clinics are having to be cancelled due to no cover. Homebirth service is unreliable and requiring review on a daily basis. Effect on the service user: The above lack of staffing is removing pregnant people's choice and disrupting continuity of care which has risks. Effect on staff: Exhaustion, lack of job satisfaction, burn out. This leads to further sickness so a vicious circle.	16	•Booking bank staff •Hourly workforce planning from matron and team leads to cover workload •Changing routine work to contingency planning causing disruption to patient care •Moved staff back from specialist secondment roles •Team leads working clinically leading to no cover within management roles	16	Recruitment campaign to be launched	11.06.2024 - Email from Community Matrons attached as • Total 13.44 WTE across the service which should have 57 WTE = 24% vacancy We am escalating as community matron that the service is no longer safe, and the challenge is going to become insurmountable over the summer period, where annual leave increases.	8	01-Apr-24

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3062	06-Feb-24	Sustainability	Women's Children's & Sexual Health Services	Women's Services	23-Jul-24	Maternity Diaries are supported by NHS mail. NHS mail are not aware that we are utilising this system to manage all community midwifery diaries. This includes booking of GTT, IOL, LSCS, MBC and CBC clinics.	Maternity Diaries are supported by NHS mail. NHS mail are not aware that we are utilising this system to manage all community midwifery diaries. This includes booking of GTT, IOL, LSCS, MBC and CBC clinics. As NHS mail does not recommend storing information using their system, they offer no protection around security of patient information or threat of the system losing the information due to an interruption in service. The rest of the Trust use Allscripts for appointment bookings and Sunrise for electronic notes. Maternity use Allscripts for booking appointments and E3 for electronic notes. Discussed with maternity LMNS, local trusts are not using this facility. They are using paper-based diaries, this is not something that we should be moving to, would be a backwards step for MTW	**16**	Currently there is no mitigation for this issue – raised with the senior team. Accessed the business intelligence teams to begin the process of changing this to a safer option	**16**	Scope use of RIO Admin staff to manage PAS	24.06.2024 - Meeting planned for alternative software supplier.	**8**	08-Aug-24
3069	21-Feb-24	Patient Safety and Clinical Effectiveness	Cancer Services	Oncology	25-Jul-24	Chemotherapy e-prescribing	The risks are as follow: •the inability of our version of Aria now being able to accept FDB updates. •we are currently on version 11 of ARIA, and although Varian will still support us with this product it may be over time things become problematic and they may not be able to provide fixes within our current version. •Varian's latest version is now v17. This will be the last version of ARIA. If we were to upgrade to this, Varian states they would support us with this product for at least 5 years. Some validation for this upgrade will be required before it comes into the live environment. •The current requirement for more licenses for ARIA due to the repeated incidences of users not being able to access the system due to the number of people using the programme. This is with the IT team. There is a reputation and financial implication that the version of ARIA that we currently have does not support our SACT returns to NHS E and MTW & K&M will be a national outlier	**12**	Monitoring to ensure no clinical incidents arise due to the risks described There is currently an OBC for discussion with partners across the K&M as the current software is used by the 4 acute trusts	**16**	None recorded on InPhase	02.07.2024 - The ICB are not funding the ARIA project this year. Discussed at oncology directorate - discussed & raised at a 16 red risk	**8**	31-Oct-24
1289	04-Apr-23	Patient Access	Medicines & Emergency Care	Acute Medical and Geriatrics	16-Jul-24	Their is a risk of patient harm linked to the backlog of patients awaiting review in the Virtual Stroke Clinic	The Virtual Stroke clinic is an initiative to reduce length of stay or avoid admission. It is available for clinicians to apply the patient details suitable be discharged from the ward or alternatively seen in the Stroke assessment bay and not admitted at all, discharged with outstanding review and or investigations. It is expected that the virtual Stroke clinic will be monitored regularly by the junior medical team on the Stroke ward with Stroke Consultant oversight. Risk: An excess of 570 patients have been allowed to build on the list with what appears to be outstanding medical review or review of investigation, due to lack of oversight and lack of medical capacity. Current there are no criteria for this list or parameters for timely review.	**9**	1. Stroke Consultants responsible for timetabling frequent weekly Junior doctor time to address the virtual clinic list 2. Doctor Assistant monitoring and populating virtual list spread sheet with investigation results 3. Review of the medical staffing to ensure capacity 4. Doctor ax to monitor activity 5. Doctor assistant escalating delayed results to Lead Stroke nurse and Stroke Consultant, refereeing into vascular services where appropriate. 6. Development of separate vascular virtual list 7. Dr Assistant populating spreadsheet and highlighting delayed results to Stroke consultants 8. Stroke Consultant Dr Busch to formulate a clinical criterion for a 'hot' and 'cold' clinic list to identify a window in which each should be reviewed 9. Virtual List / Clinic to have nominated daily or weekly consultant 10. Monthly Stroke team meetings to review progress 11. GM team have agreed to fund locum Dr to support with the clinic	**16**	1289 - backlog of pts for r/v virtual Stroke Clinic *New Sunrise referral to be developed	08/07/2024 - update from Stroke CNS - Although the historical list has been fully cleared, the current list for 2023/24 has 752 patients who have had their outpatient investigations and are ready for a remote clinical review. The expectation is that this list would be cleared daily as new investigations become available for review and therefore this number should be 0. The virtual clinic list is split into 2 lists; hot (investigation expected to be complete <2 weeks) and cold (>2 weeks). The Stroke CNS has suggested that the risk meets the threshold for red 16, with a removal risk of Amber 12.	**12**	29-Jan-25

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3086	20-Mar-24	Patient Safety and Clinical Effectiveness	Cancer Services	Oncology	28-Jun-24	There is a risk at that our SACT advice line is not provided appropriate clinical advice or being managed by SACT trained professionals which could put patients at serious of harm	There is a risk at that our SACT advice line is not provided appropriate clinical advice or being managed by SACT trained professionals which could put patients at serious of harm of having a SACT toxicity and not being managed in a timely manner	15	all patients calling out of hours who are on immunotherapy to speak to on call registrar to discuss, within hours current arrangements. Matron, unit managers aware as part of our SOP that only trained SACT professionals should be providing advice as part of their scope of practice. if a SACT professional is not available to manage the advice line, calls to be diverted to on call reg.	15	None recorded on InPhase	16.05.2024 - May updated task and finish group action log attached.	**10**	01-Sep-24
2998	01-Sep-23	Sustainability	Cancer Services	Oncology	26-Jun-24	Radiotherapy CT Canterbury Provision	The Radiotherapy CT at Canterbury is end of life as of June 2023 and is exhibiting ongoing issues, related to hardware failures. This has resulted in approximately eight manufacturer maintenance attendances with significant downtime and has not resolved the issue. The manufacturer has already had to supply reconditioned parts. No new parts are being manufactured, repairs are on a best effort basis. Replacement parts will be taken from existing stock held nationally and worldwide. Part may therefore be available but with delays while they are located and shipped or may not be available at all resulting in a loss of the CT. Failure of the CT could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the CT is unavailable while repaired. If repair is not possible the disruption would be extensive at both Canterbury and Maidstone sites and would be non-sustainable. See attached risk assessment form for full details.	15	A Platinum Maintenance contract in place with Canon. However, end of life therefore availability of parts limited to those held in stock in UK and worldwide. Short term loss of CT capacity at Canterbury can be supported by extending hours of operation at Canterbury when the CT is returned to use and by patients being scanned at Maidstone as necessary. Business continuity plans for medium or long term loss of CT at Canterbury are for all patients to be CT'd at Maidstone. This will require extended hours of operation at Maidstone into evenings and weekends, Canterbury Planning CT staff to work at Maidstone and use of Radiology CT scanner capacity. See attached risk assessment form for full details.	15	None recorded on InPhase	10.06.2024 - Business case proposal discussed at Executive meeting 04/06/24. Progressing through Trust process. No other changes. Reviewed in Directorate Risk Review Meeting 21/05/24. No change. Next risk review meeting 26/06/24.	**5**	01-Jul-24
3000	04-Sep-23	Sustainability	Cancer Services	Oncology	23-Jun-24	Linac LA1C - Canterbury	LA1C is 14 years old. Recommended useful life for a linear accelerator is 10 years. LA1C is a Varian iX and we have received notification that this machine will reach end of support 31st July 2024. Beyond this limited support will be provided by Varian including limited maintenance support, part availability, software upgrades, compatibility with oncology information and treatment planning software developments. LA1C already does not support all the treatment techniques available on the more modern machines in the department. Some restrictions on treatment techniques are in place due to poorer performance compared to the more modern TrueBeam machines. See attached Risk Assessment Form for full details. Risk score 9 - Amber until 31st July 2024 then will be 20 - Red.	**9**	The service has fully trained on-site engineers with access to parts and support from Varian. Many spare parts held locally. Controls will be less effective once Varian end support on 31st July 2024. Business continuity through extended use of other two machines at Canterbury, including weekend work or at Maidstone. Bookings made appropriately to maximise use of LA1C while taking into account limitations/restrictions. See attached Risk Assessment Form for full details.	15	None recorded on InPhase	03.06.2024 - A paper for replacement of the linac has been submitted to the Executive Board. Awaiting outcome. Preparatory work ongoing with regard to options for replacement. No change to current mitigations, risk reviewed at Core Cancer Services monthly risk review meeting, 21/05/24, risk score unchanged.	**6**	31-Mar-24
2948	21-Jun-23	Sustainability	Corporate Services	Information Technology	24-Aug-23	There is a risk that MTW IT systems will be slowed / have functionality issues secondary to Server Processing Capacity	The number of connections from staff has increased over a period of time, which has led to detrimental performance of the servers. At times capacity is 95% and above creating an impact on performance for staff logging on to PC's and laptops utilising non clinical and non clinical systems.	**25**	Emergency BC submitted and approved to purchase new equipment Servers delivered 28th June Replication of data paused during the day to alleviate impact Staff encouraged to use Microsoft Teams for sharing files Purchase of a cloud environment A number of technical changes have also been actioned (ICT have a record of this) Folder visibility change being implemented as an interim solution	15	None recorded on InPhase	None recorded on InPhase	**5**	31-Jul-23

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2952	29-Jun-23	Sustainability	Corporate Services	Information Technology	01-Jul-24	There is a facilities risk (affecting ICT infrastructure) that due to inadequate air conditioning capability within the Main ICT server room the server system could overheat causing a loss of ICT across the Trust	The ICT servers within the PPP room (Triple P) room at Maidstone hospital are at risk of overheating as the air conditioning for the room is not fit for purpose. This is linked to the fire suppressant installation and the current permanently installed wall mounted air condition units are no longer fit for purpose. One unit is broken and they are struggling to repair it secondary to its age. Additional temporary sir conditioning that has been added to the room however even with this in place the temperature is spiking to unacceptably high levels. A GSTT report which outline the impact on their Trust when a similar issue caused their servers to fail is attached to this risk	20	Temporary additional air conditioner units	15	2952 - Replacement permanent a/c units	20.06.2024 - Work on the AC is due to commence tomorrow (21/06) and completed by 28/06.	10	30-Sep-23
1182	12-Jul-22	Patient Experience	Women's Children's & Sexual Health Services	Women's Services	31-Jul-24	Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience.	Delay in progress with induction of labour (IOL) may result in a poor clinical outcome and poor patient experience. Increased activity across the region with inductions being started and delayed at point of ARM or transfer to delivery suite. There is increase anxiety from the staff that there are typically 5 people waiting for an ARM on any given shift with at least the same amount coming into the service to commence IOL. Patient expectation is hard to manage because women and birthing people have been told that they need a IOL for a clinical reason and when this is process is stalled, naturally they become anxious.	15	Care Pathway Coordinators to manage the day to day flow and report twice daily to the senior team on how many IOLs are waiting for ARM/Delivery Suite (as part of the daily sheet) Risk assessment to be done by A/N ward manager or senior midwife in charge and consultant leading to twice daily prioritisation of the IOLs with up to date information Rapid risk assessment if delay >2 hrs and thereafter 4hrly risk assessment Ongoing communication with CPC, Consultant and Senior Midwife and patient during ongoing risk assessment when delay Appropriate use of escalation policy which includes mutual aid Monitoring of delays using metrics monthly and reporting to Trust Board	15	Publication of patient leaflet and amended guideline	03.07.2024 - Review of grading and current situation with SN and RA. May 2024 73% delays.	3	31-Dec-26

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
3043	02-Jan-24	Patient Safety and Clinical Effectiveness	Medicines & Emergency Care	Medical Specialities	16-Jul-24	Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space.	There is currently a reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space. There has been no permanent space for MIS since 2019. Over the last 13 months, space is currently being facilitated within the Chronic Pain Unit and Charles Dickens Unit, however there is current plans for Surgical Pre-assessment to move into Chronic Pain Unit, which is causing additional demand on space and resources. Effects of lack of a permanent location include •Reduced chair capacity •Limited trolley facilities •Area challenges – corridor, low level lighting, no oxygen etc •Multiple storeroom locations •Limited office space in separate location •Appointment cancellations •Increased backlog and waiting times •Increased errors •Miscommunications •Lack of confidentiality for both patients and staff •Lack of teamwork •Disjointed working •Negative effects on staff wellbeing •No staff room •Staff lockers in separate location •Negative effect on staff retention •Negative patient experience •Increased complaints/feedback •Treatment delays •Delays in diagnosis •Reduced hospital avoidance due to insufficient service and treatment received in timely manner. •Patient safety In addition, the department has had 14 relocations in three years. This has resulted in thousands of pounds worth of equipment misplaced during multiple moves and an increase in low staff morale, and feelings of being unsupported.	15	1. Delayed diagnosis of endocrine conditions Consultants triage referrals as urgent/routine, based on clinical suspicion and judgement. Urgent tests are aimed to be performed in two weeks. If investigation is unable to be performed in two weeks, then medication/treatment is commenced as precaution while awaiting test. Insulin tolerance test – used to diagnose hypopituitarism with multiple hormone deficiencies, and Saline Suppression test for Conns Syndrome require trolley access which is restricted to once a week. This causes longer waiting times and greater delays in diagnosis – currently we update requesting Consultants and tertiary centres with realistic expectations of waiting time. 2. Delayed treatment Endocrine: Updates given at senior meetings, Clinical Governance breakout sessions and MDT. Current waiting times for routine endocrine tests approximately 16 weeks. Waiting lists are audited. MIS: Earliest (long) appointment date for urgent infusions given -currently a 4 week wait. No control measures currently in place due to equality across services – patients are currently booked in dependant on referral time and not condition. 3. Disjointed working due to multiple unit locations – errors, miscommunication, lack of team working Endocrine: desk space is used on a rotational basis – desk rota in place. Teams chat is used on daily basis to communicate regarding patients and tasks completed. Files saved on S-Drive are available to ESN team to update on bookings and tasks such as telephone log, audit sheets etc. Monthly team service meetings to discuss improvements, raise concerns and resolve	15	None recorded on InPhase	20.05.2024 - 20/05/2024 - space committee continue to look for permanent location. No suitable areas have currently been identified. DDO continues to support.	**12**	01-Jul-24

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
3127	24-Jun-24	Patient Safety and Clinical Effectiveness	Women's Children's & Sexual Health Services	Children's Services	25-Jul-24	Lack of appropriate placement for child or young person requiring enhanced care observation and no discharge profile available when medically fit for discharge	Patients with complex learning behaviours or mental health related conditions are required to be admitted to Hedgehog Ward as there are no other suitable placements available. The patients do not have a medical need for admission and are not under a section - lack of legal framework to hold them on the unit and enhanced care observation including additional RMNS and security guards are required to maintain safety of self and others . Risk of self harm and absconding Risk of injury to staff, visitors and other patients on the unit Risk of damage to infrastructure and facilities Risk of adverse publicity to the trust No legal framework in place to support restrictions required if not sectioned under mental health act or under social care jurisdiction Resubmitted as previously raised as patient specific risk - now generic	**20**	Room 16a low ligature room is preferred choice for placement Patient to use toilet nearest to 16a as door opens both ways safely however will still require enhanced care observations dependent on risk assessment Safety corridor to be implemented dependent on risks identified to act as a buffer for noise from self harming / distress to others and to reduce access to other patients and exits Enhanced care observations to be implemented dependent level on daily risk assessments regarding level of care needed RMNs to be employed if requiring any periods of restraint or sectioned and security to be in place if additional risks identified up to 4:1 Restraint documentation, rapid tranquillisation policy and daily review by Mental Health Liaison nurse to review and update on any behavioural plans in place and ensure that RMNs and security are aware of roles and responsibilities Strat Meetings to be implemented with appropriate department leads with safeguarding and matron involvement - escalation to executive team if any delays identified in discharge once medically fit If not under section consider discussion with MTW legal team to apply for a DOLS under High Court as under 16 with level of restraint and seclusion approved. Involve family with all decision making and ensure that an advocate is in place for the child / young person if court is required - this included their own solicitor Daily review by paediatric consultant. Weekly review by Psychiatrist if under CAMHS team Identification of community services that can attend MTW to be implemented where possible following local discussions	15	None recorded on InPhase	None recorded on InPhase	**9**	30-Sep-24
2995	03-Nov-23	Patient Safety and Clinical Effectiveness	Trust Wide	Trust Wide	15-Jul-24	Shortage of Defibrillators	A Business Case was approved to replace all of the defibrillators in the Trust over a couple of years. Some new ones were initially purchased and old ones replaced, however there is now no more money available to continue this replacement. Some of the old ones are now failing and it is not possible to repair them, they have to be condemned as it is no longer possible to get parts and there are no batteries available in this country. This could potentially lead to a shortage of Defibrillators in some areas of the Trust.	**20**	Where old ones have been replaced, EME have kept the old ones to swap out for any that fail. This is a short term solution as we now only have 2 spares available in the Trust.	15	monitoring of Devices left to swap for failed ones.	17.06.2024 - 41 new Defibrillators have now been deployed and EME have 7 more to send out which includes 2 for KMOC. We have 83 still to replace. We have 6 of the old defibrillators that have been swapped out that we can use to replace any that can no longer be fixed. However there are some components in them that when they fail the whole machine has to be condemned, so we have a dwindling supply of replacements. No funding has yet been identified to replace all of the others.	**10**	16-Dec-24
3130	28-Jun-24	Sustainability	Trust Wide	Trust Wide	30-Aug-24	There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)	Challenge to find projects or schemes that are going to deliver a CIP to the level required (£37.5 million)	**20**	CIP meetings with the COO and Deputy COO monthly with each Division Meetings with Divisional Triumvirates and senior teams Divisional CIP meeting with PMO Business Partners and Finance Managers Monthly EPOC financial efficiency steering board chaired by CFO Exceptional meetings for 3 months focusing on cross-cutting schemes CIP plan Frequent review of pipeline schemes	15	None recorded on InPhase	None recorded on InPhase	**10**	03-Jan-25

Risk Id	Opened	Strategic Sub-Theme	Division	Directorate (OD)	Next review date	Title	Description	Risk level (Initial)	Controls in place	Rating (current)	Action required	Progress	Rating (target)	Target Completion Date
3065	09-Feb-24	Patient Safety and Clinical Effectiveness	Women's Children's & Sexual Health Services	Women's Services	17-Jul-24	There is a risk of suboptimal outcomes within Maternity - this risk was identified via a review of patient safety incidents where staff have not followed IIA (Intelligent Intermittent Auscultation) guidance	Poor outcomes identified through patient safety incidents when staff have not followed IIA guidance	15	Individual staff refection when errors noted through review	15	LMNS guidance for ratification at MRRG on 16/4/24 Workshops for staff training completed	17.06.2024 - 4th June 2024 First IIA working group meeting held and minutes taken. Next meeting planned for beginning of July. 11th June 2024 Kent and Medway new guideline launched including update with IIA	5	09-Jun-24
3009	29-Sep-23	Patient Access	Women's Children's & Sexual Health Services	Women's Services	31-Jul-24	Due to a planned reduction in community clinic space within the primary care setting, women and pregnant people will not be able to access care. This will result in reduced opportunities to assess the wellbeing of mother and baby.	Midwives are being given minimal/no notice of removal of their clinic space within the community setting/GP surgery. Children's centres are closing on 31/3/24 across MTW geographical area. There is a real risk that at short notice pregnant people will not be able to be reviewed by a midwife during their pregnancy and postnatal period. This review includes a physical and emotional wellbeing check including national screening KPI's. Some surgeries have contracts, many do not, this may result in a lack of commitment from the primary care sector to our maternity patients. There is concern within the community midwifery management team that instigating conversations with clinics regarding contracts could lead to the primary sector protecting their own space at the expense of the maternity team needs. Antenatal care is projected, disruption to antenatal care may lead to failure to follow up patients who are have high risk social, medical and obstetric requirements.	20	Contacted the commissioner to discuss the issue No other areas to relocate too, clinic space in all areas at a premium	15	Prepare ICB report on current community space requirements General Manager to enquire on replacement venue Project group required to address the problem Scope alternative sites for Kings Hill and Abbey Court Space management to scope for alternative clinic space	24.06.2024 - Kings hill is improving but contracted space not yet in place but getting there. The Arc has not moved the midwives using space in the diabetes centre but there are issues with being accepted in the space.	10	31-Mar-24

Six monthly update on mortuary issues	**Clinical Director of Pathology and Care after Death Directorates; Head of Service, Care After Death Directorate; and Chief Nurse**

The enclosed report provides information and assurance regarding the Trusts mortuary services. This includes:
1 – Directorate clarification
2 - Security control, authorised access and CCTV
3 - Mortuary staff and DBS
4 - Quality and Governance
5 – Mortuary Service contracts
6 – Continued oversight and review of safeguarding

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]
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

Following the publication and recommendations of the Fuller report, the Board was provided with assurance regarding implementation of all 17 recommendations. This report provides an update on the ongoing activity within the mortuary related to these recommendations.

1- The Care After Death (CAD) directorate has been established 18th December 2023. The management structure has been formed of specialists from all aspects of the professions which routinely manage after death processes. There is a Clinical director (Pathologist and HTA Designated Individual), Head of Service (APT) and appropriate hierarchy and organisational chart. The mortuary sits within this directorate, together with bereavement services and the medical examiner service. (Recommendation 4, 5)

2- Mortuary security remains robust with monthly audits which include the Snowdrop room in maternity. The audits include a review of signed visitors logs, CCTV reviews, access system record and reviews on all access points. This includes not only the locking mechanisms but also that the combination codes are changed at regular intervals. The audits are carried out by the Head of Service (HoS), nominated security operations manager and/or names security supervisor.
The retention period for CCTV footage has been extended from 31 days to 38 days.
There is regular communication between the mortuary and security teams.
New equipment is in the mortuary with a protected area within the post mortem room which is blanked from being recorded.
It is not possible to remove any patient from the fridge units without this being captured on both sides of the units.
To maintain compliance with HTA license training and competency records for those with authorised access are retained by the mortuary manager. This includes porters and security officers who attend in pairs.
CAD HoS is an active member of the security committee
The relocation of the Maidstone site concealment trolley has not yet been resolved, currently sitting with Facilities (Recommendation 1,6,7,8,9)

3- The mortuary is now fully staffed with 3 trainee and two qualified APTs supported by the HoS as an APT. Basic DBS checks current for the team as per National DBS protocol.
The mortuary manager achieved the status of registered scientist with the Science Council in March 2024. CPD is being embedded into the Team and reviewed at one to ones to ensure current practice and processes are introduced and followed.
Training is being encouraged for the further development of identified roles (such as EDI lead, First-aid, H&S lead etc.). Appraisals are in process and will be completed by 31/7/24 in line with Trust guidance.
(Recommendation 2, 3, 4)

4- Quality and governance compliance is maintained using the Q-Pulse and InPhase systems. HoS meets with the Divisional Quality and Governance lead monthly and the directorate have representation at the monthly divisional quality meeting. Audits carried out within the last 5 months are:

- Vertical Patient Pathway (post mortem examination and non-post mortem examination)
- Governance and Quality
- Consent
- Traceability
- Record keeping
- Security

No outlying trends have been identified. Compliance can be assured.
There are currently 3 Inphase records which are mortuary related and the team have reported 12 during the time period of this report which involved other services.
There has been 1 HTARI during this period which has been investigated and closed, by the HTA who were satisfied with the investigation and Trust response. The incident was

reported to the quality lead and was included in the End of Life Care (EoLC) workstream report. This was also presented in the Divisional and Directorate meetings. (Recommendation 4,6,10,11)

5- The contracts with local county councils to provide mortuary services for East Sussex County Council (ESCC) have been completed and for Kent County Council (KCC)are in progress. More explicit information is to be included around reporting and communication. Fortnightly meetings are held with the mortuary manager and KCC to discuss the service. Meetings are planned for ESCC and KCC managers to meet with the HoS. (Recommendation 12)

6- The EoLC,Security and Dignity of the Deceased workstream reports into the EoLC Committee and all incidents and learning is shared as part of this meeting. The working group is made up from cross discipline staff groups to promote and highlight care of the deceased and the importance of maintaining dignity and respect at all times. The Chief Nurse has regular meetings with the HoS and regular visits to both mortuaries
The HTA stakeholders group met on May 20th 2024. This meeting is an opportunity for the Designated Individual and Persons Designated to discuss related issues and discuss updates. No concerns were raised. There has not been any further communication from the HTA regarding any planned inspection to date. The Chief Nurse has regular 1-2-1s with the HoS and regular visits to both mortuaries (Recommendation 14, 15, 16, 17)