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

Thu 30 May 2024, 09:45 - 13:00

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live via Microsoft Teams 'town hall', the joining instructions are available on the Trust's website (https://www.mtw.nhs.uk/about-us/trust-board/board-meetings-and-papers/)

05-1
To receive apologies for absence

Annette Doherty

05-2
To declare interests relevant to agenda items

Annette Doherty

05-3
To approve the minutes of the 'Part 1' Trust Board meeting of 25th April 2024

Annette Doherty

Board minutes, 25.04.24 (Part 1).pdf (11 pages)

05-4
To note progress with previous actions

Annette Doherty

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

Patient Experience Story

05-5
Patient Experience Story

Representatives from the Medicine and Emergency Care Division

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

Patient Experience Story - Medicine and Emergency Care Division.pdf (4 pages)

Reports from the Chair of the Trust Board and Chief Executive

05-6
Report from the Chair of the Trust Board

Annette Doherty

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

05-7
Report from the Chief Executive

Miles Scott

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

Reports from Trust Board sub-committees

05-8
Quality Committee, 28/05/24

Maureen Choong

Summary of Quality C'ttee, 28.05.24.pdf (17 pages)

05-9
Finance and Performance Committee, 28/05/24

Neil Griffiths

Summary of Finance and Performance C'ttee 28.05.24.pdf (2 pages)

05-10
People and Organisational Development Committee, 24/05/24 (Incl. the Quarterly update from the Guardian of Safe Working Hours, Jan. to March 2024; and approval of revised Terms of Reference)

Emma Pettitt-Mitchell

Summary of the PODco C'ttee 24.05.24 (Incl. the Quarterly update from the Guardian of Safe Working Hours, Jan. to March 2024; and approval of revised Terms of Reference).pdf (10 pages)

05-11
Audit and Governance Committee, 14/05/24

Maureen Choong

Summary of Audit and Governance Committee, 14.05.23.pdf (2 pages)

05-12
To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)

Mel Norbury

To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review).pdf (3 pages)

Integrated Performance Report

05-13
Integrated Performance Report (IPR) for April 2024

Miles Scott and colleagues

Integrated Performance Report (IPR) for April 2024.pdf (46 pages)

Systems and Place

05-14
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) - May 24.pdf (5 pages)

Planning and strategy

05-15
Six-monthly update on the project to develop a Maggie’s Centre at Maidstone Hospital

Sean Briggs

Six-monthly update on the project to develop a Maggie’s Centre at Maidstone Hospital - May 2024.pdf (1 pages)

05-16
To approve an Outline Business Case (OBC) for Robotic Assisted Surgery

Sean Briggs and Rachel Jones

To approve the Outline Business Case for Robotic Assisted Surgery - May 2024.pdf (31 pages)

05-17
To approve the Business Case for Oncology Consultant Recruitment

Sean Briggs

To approve the Business Case for Oncology Consultant Recruitment - May 2024.pdf (18 pages)

Corporate Governance

05-18
Assurance of compliance with the Fit and Proper Persons Test requirements

Mel Norbury

Assurance of compliance with the Fit and Proper Persons Test requirements.pdf (30 pages)

Other matters

05-19
To consider any other business

Annette Doherty

05-20
To respond to any questions from members of the public

Annette Doherty

05-21
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

Annette Doherty

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(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	(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:	Karen Cox	Associate Non-Executive Director (from item 04-12)	(KC)
	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)
	Alice Farrell	Divisional Director of Operations, Cancer Services (for item 04-5)	(AF)
	Tasha Gardner	Director of Communications	(TG)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Jack Richardson	Freedom to Speak Up Guardian (for item 04-19)	(JR)
	Hannah White	Divisional Director of Nursing for Cancer Services and Outpatients (Interim) (for item 04-5)	(HW)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

04-1 To receive apologies for absence

No apologies were received.

04-2 To declare interests relevant to agenda items

No interests were declared.

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

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

04-4 To note progress with previous actions

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

Patient experience

04-5 Patient experience story

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

- It was important to hear the voice of Mr A as the lived experience of care and feedback from patients supported quality, safety and experience improvements.

- A local resolution meeting had been conducted with the family of Mr A in March 2024 which included clinicians and operational staff and provided a first-hand overview of the families concerns on behalf of the patient and the experience of treatment at the Trust.
- Learning opportunities had been identified as part of the case; however, it was important to understand how such the lessons learned could be evidenced and embedded to provide feedback to the family and noted that multiple discussions had been held with the family of Mr A following the local resolution meeting to ensure they were informed of the progress which had been made.

AF added that an After-Action Review (AAR) had been conducted and a task and finish group had been established which had made progress on key actions such as amending the triage form which had been utilised and increasing the visibility of alerts, which would be incorporated into the 'Sunrise' Electronic Patient Record. AF continued that it was intended to commence 'hot clinics' for Acute Oncology, which would be further expanded by the Business Case which was under development.

DH requested that members of the Trust Board be provided with an overview of the AAR process which was part of the new Patient Safety Incident Response Framework (PSIRF). JH explained the background for the introduction of the PSIRF in April 2024; the categorisation of incidents and the associated response which was required; and the process by which an AAR operated.

MS firstly asked how the Division intended to spread the practice improvements in terms of the management of complaints to other Divisions. MS then asked how the lessons learned would be disseminated to wider staff groups, as a range of staff were involved in patient care. HW replied that a programme of work had been commenced with the Complaints Team to conduct a pilot for the management of complaints wherein when a complaint is received the complainant received a phone call to acknowledge the complaint and explore whether the issue can be de-escalated. HW continued that for formal complaints the written response process had been replaced with local resolution meetings, and noted that the lessons learned would be discussed at various forums including the Oncology Governance Meeting. HW added that a meeting had been held with the Kent and Medway Cancer Alliance regarding immunotherapy and checkpoint inhibitors to discuss any areas of concern and provided assurance that a system-wide approach would be adopted to share the lessons learned. SM highlighted the guidelines were under development for the Trust's Emergency Departments to ensure that staff were aware of the potential compliances associated with checkpoint inhibitors and immunotherapy.

MC emphasised the importance of understanding how the Cancer Services Division would confirm that the feedback loop had been closed to provide assurance that the required changes had been embedded. MC continued that an additional focus was required in relation to the Primary Care aspect of the incident, to improve communication and support the delivery of improved outcomes as immunotherapy became more prominent.

AY asked whether there was a structured approach to the provision of updates to the families involve and whether there was an optimal timeframe in which a local resolution meeting should be conducted. HW outlined the process by which the families of those involved were provided updates, which included approximate completion dates for any actions, and noted that an AAR should be conducted within a maximum of 45 days; however, there had been delays associated with sickness absence as a Multi-disciplinary Team approach was required and noted that the consultant responsible for Mr A's care attended the AAR.

WW queried whether any amendments were required to the Trust's triage process to prevent a similar incident from occurring. HW confirmed that a review had been conducted of the documentation on the Kent Oncology Management System (KOMS) which was identified as not being user friendly; so, a revised from had been developed with a comparison to the baseline data to investigate what, if any, further improvements were required and noted that the triage process was likely to be included on the AAR action plan.

WW asked how the wellbeing of staff that were involved in the outcome was supported. HW acknowledged the importance of staff health and wellbeing and provided assurance that one to one debriefs had been conducted with the staff involved wherein they were informed of the various support mechanisms which were available from the Trust.

Reports from the Chair of the Trust Board and Chief Executive

04-6 Report from the Chair of Trust Board

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

- One new consultant appointment had been made during the reporting period
- Thanks to all staff at the Trust at the staff and Trust Board members, for the Trust's achievements in the 2023/24 financial year.

04-7 Report from the Chief Executive

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

- Commendation of the contribution made by DH to the Trust during their tenure as Chair of the Trust Board.
- Dr Annette Doherty had been appointed by NHS England as the new Chair of the Trust Board and would commence in post on the 20th May 2024.
- The Trust performance in 2023/24 had demonstrated the benefit of the alignment of the Trust's strategic objectives to the Strategy Deployment Review (SDR) process.
- The Trust had completed the acquisition of the Spire Tunbridge Wells Hospital and significant work had commenced in regard to the associated programme management and governance arrangements
- Two new Chief Clinical Information Officers had been appointed
- The Stroke Service had maintained a Sentinel Stroke National Audit Programme (SSNAP) A rating for over twelve months; and commended those staff involved in the development of the new Acute Stroke Unit (ASU) and Hyper Acute Stroke Unit (HASU) at Maidstone Hospital.

Reports from Trust Board sub-committees

04-8 Quality Committee, 10/04/24

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

- It had been agreed that the Committee would conduct a 'deep dive' into instances of violence and aggression against Trust staff, with the lessons learned to be reported to the People and Organisational Development Committee.
- Partial assurance had been received regarding the virtual ward programme as further work was required to develop the governance framework; however, assurance had been received in relation to the data collection mechanisms, which would be developed in a Patient Safety Dashboard.
- As part of the review of the Trust's Diabetes Service it had been agreed to investigate alternative staffing models to support the service.

DH queried whether there was potential to increase the capacity of the virtual ward programme. SB confirmed that was the case, and noted the discussions with various service areas to agree an operating model.

DM suggested that it would be beneficial to involve the Trust's Head of Security Management, as there was an active programme of work to address incidents of violence and aggression and noted the potential under reporting by specific demographics. MC acknowledged the under reporting of such incidents and noted the support which had been provided to Trust staff by the Head of Security Management.

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

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

- The delivery of productivity improvements had been a key theme of the Committee's discussions.
- The 'deep dive' into the Ophthalmology Service had provided assurance regarding a continued focus on improving the services productivity.
- The Business Case for Oncology Consultant Recruitment and Outline Business Case for Robotic Assisted Surgery had been recommended for approval at the 'Part 1' Trust Board meeting in May 2024.

WW asked what mechanisms that Committee had adopted to review whether Business Cases had delivered the anticipated benefits. NG outlined the previous approach which had been adopted and noted the intention to increase the frequency of the Business Case review and benefits realisation process. RJ then outlined the role of the Business Case Review Panel (BCRP) in the process and noted the report which was scheduled for the May 2024 Finance and Performance Committee meeting.

EPM emphasised the importance of ensuring an Equality, Diversity and Inclusion impact assessment was conducted for Business Cases. RJ provided assurance that the BCRP would be accountable for ensuring such assessments were conducted. RF then provided details of the discussion which had been held regarding the consideration of 'soft benefits' as part of the Business Case process. The point was acknowledged.

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

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

- A discussion had been held regarding retention and the importance of ensuring a tailored approach to the retention of different staff groups.
- The Committee was monitoring the performance and delivery of organisational development programmes to 'frontline' staff.

Integrated Performance Report (IPR)

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

MS introduced the IPR and noted that additional explanation of the method which had been included on pages 4 and 5. DM queried which metrics were utilised to determine the Trust's national productivity ranking. MS noted that the calculations were based on cost based against value weighted activity and highlighted the timeframe which had been utilised. SO elaborated on the methodology and suggested that those metrics which directly contributed to the Trust's value weighted activity as part of the productivity calculation could be highlighted in future Integrated Performance Report. DM supported the proposed approach.

Action: 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)

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

- The Trust's turnover rate had reduced from 11.8% to 11.5% and further reductions were expected over the coming months; so, the focus had been shifted to those members of staff that left the Trust within the first 12 to 24 months as a driver for the reduction of the Trust's overall turnover rate.
- The "Percentage of AfC 8c and above that are BAME" metric performance was currently at 6.5% against a national target of 12%, so provided assurance that a range of interventions had been developed to improve the Trust's performance which included the Cultural and Ethnic Minorities Network, the reverse mentoring programme and the development of a bespoke programme of work to support the recruitment of Agenda for Change (AfC) Band 8b and above to create a talent pipeline, supported by a well-established interview processes.
- Responses had been received from all Trust Board members regarding their individual Equality, Diversity and Inclusion (EDI) objectives which would be incorporated into the appraisal process.

WW highlighted the importance of sufficient focus on talent management, particularly for BAME staff, to provide mentoring and support to increase the number of BAME staff in Agenda for Change Band 8c and above. SS provided assurance that there was a significant focus on talent management and succession planning and part of the People and Culture Strategy and noted the intended development of a recruitment pipeline for AfC Band 8c staff.

AY queried whether the 12% AfC Band 8c above target for BAME staff, which had been set by NHS England, was reflective of local demographics. SS replied that from a compliance perspective the Trust was required to achieve the target; although, noted that AfC Band 8c and above represented a small cohort of staff. DH highlighted that the national target likely reflected national demographics

rather than local demographics; although, noted the impact of international recruitment on staffing demographics at the Trust.

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

- Further work was required to develop the supporting data, so the incident reporting categories had been revised to help improve the stratified data; but, acknowledged there had been an increase in incidents of moderate and above harm, with no trends identified.
- There had been a reduction in the prevalence of *Clostridium difficile (C. diff)* infections; however, the Trust had not achieved the proposed trajectory for 2023/24, so the Trust-wide outbreak meetings had been increased in frequency to consider what, if any, alternative approaches were required which would be supported by the Safe Care Project.

JW queried whether the programme of deep cleaning would continue into the summer once further de-escalation had been achieved. SM confirmed that was the case; and noted that escalation capacity was currently required for an increased prevalence of norovirus. JW then asked whether any trends had emerged in relation to the *C. Diff* cases. SM replied that there had been one episode of cross infection in 2023; however, there was no trends in terms of ribotypes.

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

- The Trust had achieved the year-end performance target of 75% for Referral to Treatment (RTT), supported by the work of the Deputy Chief Operating Officer
- The Emergency Departments had achieved the required performance for the NHSE urgent and emergency care winter incentive, which provided additional capital funding to the Trust.
- A performance of 98.8% had been achieved for the Diagnostics Waiting Times and Activity (DM01) standard against a target of 99%.

DH noted that the Trust's four-hour Emergency Department performance contained a significant proportion of type 1 activity (i.e. Emergency Department attendances) compared to other high-performing Trusts which included a higher proportion of type 3 activity (i.e. urgent treatment centre attendances), which should be considered when interpreting the Trust's performance.

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

- There was a continued focus on the reduction of the number of complaints related to communication with areas of best practice and lessons learned from Clinical Divisions cascaded across the Trust.
- Delivery of the Trust's complaints performance target remained challenging; although, the work illustrated by the Cancer Services Division would be considered for Trust-wide implementation.
- Friends and Family Test (FFT) response rates remained low due to the ongoing transition to the new FFT provider; however, the new provider was expected to 'go live' by the end of April 2024, so an improvement was expected in the data for May 2024.

RF queried whether the Trust could transition to assessing the level of satisfaction obtained by patients and service users in relation to the complaints responses received; which included the timeliness and quality of such responses. JH outlined the challenges associated with measuring satisfaction; although, noted that the number of reopened complaints was monitored and the letters to patients included an invitation to provide feedback on the quality control aspect. RF suggested that the After-Action Review (AAR) process afforded the opportunity to obtain feedback on the quality of responses. JH provided clarification regarding the utilisation of AARs and local resolution meetings.

JW emphasised the importance of actively receiving confirmation from patients that they are satisfied with the resolution of complaints rather than relying on those patients which were inclined to voice further concerns. MS provided assurance that the approach outlined under the patient experience story would support the Trust in obtaining such feedback.

MC commented that the local resolution meetings provided a grounded sense of the experience of patients and their careers and emphasised the importance of encouraging staff to conduct local resolution meetings and circulate the lessons learned. MC noted the importance of ensuring patients

felt they had been listened to. DM suggested that a random sample of satisfaction data could be collected, rather than monitoring overall satisfaction. JH acknowledged the point and noted that some Trusts had a 'lay person' that helped review complaints; which would be investigated for implementation at the Trust. JH then noted the depth of experience possessed by HW in terms of conducting local resolution meetings.

JH then referred to the "Maternity Metrics" and highlighted the following points:
- The Trust's improvement methodology would be utilised to investigate the root causes for delays to the induction of labour

RJ then referred to the "Systems" Strategic Theme and highlighted the following points:
- A reduction in the number of patients no longer fit to reside for inpatient care had been achieved and the discharges before noon performance had been maintained; with initial feedback being received from clinical staff regarding the new Electronic Discharge Notification (EDN)
- Standard work for board rounds had been agreed and would be piloted on six wards, as inconsistent board rounds had been identified as a key contributor to delays in discharge.

SO then referred to the "Sustainability" Strategic Theme and highlighted the following points:
- A signification reduction had been achieved in premium temporary staffing expenditure of £10.5m; but, further work was required to achieve a further reduction, so it was proposed that the reduction of temporary staffing expenditure remained a priority for 2024/25.
- There had been an increase in capital expenditure for month 12 of 2023/24 due to the provision of additional external capital funding.

Systems and Place

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

RJ referred to the submitted report and highlighted the following points:
- The Acute Provider Collaborative had received the first phase report on the review of acute services and the outputs of the initial discussions would be reported to the May 2024 Trust Board meeting.
- Trust Board members were encouraged to review the Kent and Medway Integrated Care Strategy and the six outcomes therein.
- The Integrated Care Board was leading on the development of the Kent and Medway NHS Strategy, which focused on the development of the NHS to response to future challenges, and would be submitted to the Trust Boards of NHS providers in Kent and Medway in June 2024.
- The West Kent HCP 'away day' received a presentation from Kent County Council on Family Hubs and discussed the next steps in relation to Integrated Neighbourhood Teams and the positive impact of the health inequalities programme.

NG noted the update on system support which had been submitted to the Finance and Performance Committee and queried how the support provided by the Trust would be reported to other NHS providers in Kent and Medway. RJ agreed to consider how the Trust's provision of system support could be incorporated into the Trust's quarterly oversight framework submission to the Kent and Medway Integrated Care Board.

Action: Consider how the Trust's provision of system support could be incorporated into the Trust's quarterly oversight framework submission to the Kent and Medway Integrated Care Board (Director of Strategy, Planning and Partnership, April 2024 onwards)

RF asked whether there was an overview of the time commitments of Executive Directors in terms of involvement in system conversations. A discussion was then held wherein the Trust's role in system working was acknowledged; it was noted that it was important to ensure the Executive Directors were involved in productive discussions regarding system working; and the key areas of focus, which included productivity and financial improvement were highlighted.

DM outlined the discussions which had been held at the recent Kent and Medway Integrated Care System (ICS) Audit Committee Chair's meeting regarding the potential creation of cost pressures for other organisations through increased productivity. MS elaborated on the funding approach for the

Elective Recovery Fund (ERF) for 2024/25 and noted that such funds were additional funds for the Kent and Medway ICS. SO then highlighted the financial challenges within the Kent and Medway ICS and emphasised the considerations which were afforded to any productivity improvements. MS added that any decisions consider the impact on both the Trusts budget and productivity; however, noted further work was required to advance productivity improvements and responsible budgetary improvements.

Planning and strategy

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

SO referred to the submitted report and highlighted the key points therein which included that the Digital and Data Strategy had been considered at a number of Trust Board sub-committees and that Digital and Data were fundamental enablers for the Trust's future plans.

WW detailed the previous discussions which had been held regarding the important of the governance of Artificial Intelligence (AI). SO referred to page 19 of 25 and highlighted the commitment to robust governance processes particularly in relation to A and associated next steps. A discussion was then held regarding whether the strategy should be amended to significantly increase the focus therein on AI, including the integration with procurement and cyber security, wherein the importance of ensuring the Trust was in a position to obtain the benefits from AI but also mitigate the risks; the utilisation of the "what good looks like" framework to develop the strategy; and the further understanding and exploration which was required in relation to AI before formalisation of the Trusts approach. MS then suggested that a future Trust Board 'away day' session could focus on AI and Robotic Process Automation (RPA) and the likely effects on the Trust to enable the development of the Trusts strategy and approach. WW supported the suggestion and noted the importance of ensuring that the strategy was a dynamic document due to the pace of change in relation

EPM asked what, if any, assurance was available the roles of individuals at the Trust were aligned to the strategy. SO provided assurance that the workforce implications had been considered as part of the development process, noting that the Trust was the only Trust with a dedicated cyber-security team. SO added that consideration was also required to data literacy and the technology and training which was required by Trust staff. EPM highlighted the potential for changes and innovations to emerge over the duration of the strategy.

JW stated that there were a proportion of patients which were not digitally enabled and requested assurance that such patients would be appropriately supported. SO replied that the Trust's patient portal currently had 98000 users registered; however, provided assurance that there continued to be support for those patients which were not digitally enabled and noted that any transition would be conducted over a period of time.

DH highlighted that the implementation of an Electronic Patient Record (EPR) at the Trust had been delayed due to a lack of funding and noted the optimisation which had been required with clinical staff; therefore, a key aspect was ensuring that the Trust embedded the basics.

SS supported the importance of horizon scanning and noted the increased utilisation of Robotic Process Automation (RPA) and AI in the People and Organisational Development Function. SS continued that there were a variety of opportunities and emerging risks related to AI, the management of which required further consideration.

MC recommended the utilisation of an equality impact assessment as part of the digital and data strategy to identify any areas of digital deprivation and the associated next steps.

The Digital and Data Strategy was approved as submitted; although, it was acknowledged that amendments would be required over the duration of the strategy to reflect technological and governance developments.

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

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

- The Experience of Care Strategy aligned the Trust's strategy with the wider NHS England terminology.
- Four key objectives had been identified, based on patient feedback, which were categorised as "communication"; "involvement"; "partnership" and "culture".
- 'Roadmaps' and comprehensive delivery plans had been identified for each of the objectives and the Patient Experience Committee had been renamed to the Experience of Care Committee.

MC queried whether Trust Board members would be provided with the detailed workplan which underpinned the strategy. JH confirmed that the intention was for the workplan to be submitted to the Experience of Care Committee and subsequently the Quality Committee.

DH referred to page 15 of 21 and asked whether the colours of the strategic objectives and the "Start With People" section indicated an alignment. JH confirmed that was the intention; although, noted that further work was required to improve the alignment. NG noted the importance of the NHSApp in enabling the programme of work.

KC asked how the strategy would be embedded at the Trust to ensure appropriate visibility and traction. JH replied that once the strategy had been approved a comprehensive communication plan would support the roll out and noted the intention for the strategy to be considered at a range of forums across the Trust as well as being a standing agenda item at the Experience of Care Committee.

EPM queried whether there were any financial implications associated with the strategy. JH replied that the next step was to review the Patient Experience Team, the efficiencies therein, and how the Trust operated in conjunction with existing communities.

WW asked how the Trust supported nursing staff during periods of high demand. JH provided assurance that Trust staff had been involved in the development of the strategy and noted the alignment with the work of SS. JH then further elaborated on the intended support for Trust staff and the mechanisms which were in place. WW queried whether the strategy aided staff in understanding the support which was available. JH clarified that the strategy was targeted at services users rather than Trust staff, but outlined the integration with the Trust's People strategies. SS then detailed the direct correlation with the improvement in the Trust staff survey results and the increased appraisal compliance which included wellbeing conversations.

The Patient Experience Strategy was approved as submitted.

04-15 <u>The final planning submissions for 2024/25</u>

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

- There had been no changes to the planning assumptions; but further work was required in terms of the Trust's workforce plan and then intended utilisation of a 'one-in, one-out' approach to reduction of bank and agency staff.
- A budget setting process had been commissioned to ensure that all Divisions and Directorates had an achievable target for 2024/25; although, noted that there was a small amount of funding available for unfunded service developments.
- The final planning submission to NHSE was scheduled for 02/05/2024, subject to any requests for further iterations.

SO stated that the key risk to the delivery of the 2024/25 financial plan was the identification and subsequent delivery of Cost Improvement Programmes (CIPs).

JW queried whether the operational plan for 2024/25 supported the achievement for barium enema and cystoscopy. RJ replied that the operational plan had been developed based on realistic activity forecasts and noted the challenges in terms of training and recruiting staff for the provision of cystoscopies; although, noted that work would continue throughout 2024/25 to improve the Trusts position.

JW queried whether the Spire Tunbridge Wells Hospital had been included within the Trust's planning submissions. RJ confirmed that the Spire Tunbridge Wells Hospital had been omitted due

to the availability of data; however, provided assurance that an update would be provided to the Trust Board in due course.

JW asked what measures would be implemented to improve CIP delivery for 2024/25. SO replied that targets had been agreed with the Divisions and Directorates as well as the Chiefs of Service. SO continued that key areas of focus included improving the benefit realisation from previously approved Business Cases and maximising the delivery of recurrent CIPs and improved productivity. DH noted that additional elective activity income had been included within the financial plan for 2024/25; therefore, could not be utilised to mitigate any shortfall in CIPs. SO acknowledged the point; although, noted that the Trust would continue to pursue additional elective activity above plan.

KC noted that a significant proportion of CIPs were either high-risk or unidentified and queried when such CIPs would be of concern and what, if any, levers were available to improve delivery. SO replied that unidentified CIPs amounted to a deficit position; so the Trusts should function accordingly and noted the intention to commence development of alternative strategies which could be implemented to achieve the Trust's financial position, which would be submitted to a future Trust Board meeting.

MN noted that several references had been made to Project Dalmatian and requested clarification for members of the public. MS replied Project Dalmatian was the name originally allocated to the acquisition of the Spire Tunbridge Wells Hospital. DH added additional context regarding the allocation of the project name.

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

RJ referred to the submitted report and highlighted the key points therein; which included details of the progress against each of the corporate objectives; the key challenges in relation to the "Patient Experience" and "Patient safety and clinical effectiveness" strategic themes; and the intended submission of revised corporate objectives and breakthrough objectives to a future Trust Board meeting.

DM noted the accessibility of the format of the report and suggested that it could be utilised to inform the development of the Trust's Board Assurance Framework.

JW queried how long a corporate objective should be pursued for before a new objective should be allocated to ensure that such objectives reflected the Trust's current issues. RJ provided assurance that there was a robust monthly 'check and challenge' process at the Executive Team Meeting (ETM) which considered the progress which had been made, and whether any fundamental changes were required. RJ then provided details of the discussions which had been held regarding the "Systems and Partnerships" strategic theme due to the plateau in progress and noted that the corporate objectives required a longer-term focus to deliver the required improvements.

DH suggested there would be additional challenges associated with the reduction of expenditure on bank staff to below 5.5% due to the impact of the cost of living crisis and queried whether maintaining a slightly elevated vacancy rate would support flexibility. DH noted the challenges associated with improving eRostering arrangements to a point whereby bank shifts were no longer required. SO replied that there had been an increase in expenditure on bank staff against a reduction in the Trust's vacancy rate; and noted the programme of work to improve the control environment. SS added that the initial focus had been on reducing agency expenditure, which included a transfer for staff to the Trust's staff bank and noted that the next step was to transfer those staff into substantive positions. JH concluded that further cultural and educational work was required in relation to eRostering.

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

The Business Case was approved as submitted.

Assurance and policy

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

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

- The NHS Impact self-assessment represented the implementation of a semi-standardised improvement framework by NHS England
- An Eden Health maturity assessment was conducted as part of the examine the progress of the Exceptional People, Outstanding Care programme, which reached a broadly similar conclusion to the NHS Impact self-assessment.
- Slide 9 of 60 ("Recommendation/s for the ETM") outlined the recommendations which had been agreed at the ETM earlier in 2024; such as the roll-out of a 'Platinum Directorate'.

NG queried whether the NHS Impact self-assessment would replace, or improve, the Trust's improvement methodology. SO replied that the NHS Impact self-assessment was intended to inform the Trust's existing improvement methodology and highlight elements which were not currently in place at the Trust.

WW commended the implementation of LEAN training and queried whether the Trust had a Business Analyst to explore the data which was available., SO confirmed that was the case; although, noted the intention to increase the utilisation of qualitative and narrative date in the future, which would enable the identification of key contributors to productivity.

EPM referred to the "Interview & observation list" and queried whether the individuals selected represented a diverse population. SO replied that the individuals were selected by Eden Health and Social Care Ltd, rather than the Trust.

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

JR referred to the submitted report and highlighted the following points:
- Wayne Wright, Non-Executive Director had been appointed as the Trust's new Freedom to Speak Up (FTSU) Non-Executive Director
- Although there was a reduction in the number of FTSU reports within the 2023/24 financial year there had been a high turnover within the FTSU service and 45% of the total FTSU reports had been received within the last quarter of 2023/24 which had been delivered through a focus on addressing the three main barriers to reporting
- Monthly night shifts had been introduced with the Patient Safety Team to provide open door sessions to increase the visibility of the FTSU service.
- The role of the Safe Space Champions had been relaunched to provide a safe space for staff to speak up and regularly monthly meetings had been established with each Divisional Triumvirate to address the backlog of FTSU cases.

MC emphasised the importance of understanding the experience of those that utilised the service and whether resolution had been achieved. JR replied that a feedback form had been developed and a programme of work had been implemented with East Kent Hospitals University NHS Foundation Trust (EKHUFT) and South East Coast Ambulance Service (SECAmb) to develop a signed response form for the manager of the case to ensure an appropriate resolution was achieved.

SO referred to the "Anonymised reporting" section and noted that 50% of the reports received from Business Support were anonymous and queried whether, as Executive Director for the service area, there should be an awareness of the issues. JR clarified that Business Supported lacked robust categorisation and therefore encapsulated the majority of non-clinical service areas.

SS thanked JR for their professional and renewed approach to the FTSUG role, the increase in the reporting achieved in quarter 4 of 2023/24; and the increased engagement with those staff working night shifts and at the Trust's satellite site's.

Other matters

04-20 To consider any other business

There was no other business.

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

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

04-22 **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 quarterly update on productivity has been scheduled for the June 2024 Finance and Performance Committee; once the metrics within are agreed we will have a standard series of metrics which will be included in the IPR. The cost weighted methodology does not use any of the metrics currently in the IPR as it uses a separate calculation.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-16 (2023)	Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions.	Trust Secretary	May 2024	A review of the Trust's compliance with the new NHS Provider Licence conditions was conducted and the outputs were considered at the Audit and Governance Committee meeting on the 14th May 2024.
04-12	Consider how the Trust's provision of system support could be incorporated into the Trust's quarterly oversight framework submission to the Kent and Medway Integrated Care Board	Director of Strategy, Planning and Partnerships	May 2024	The Trust's provision of system support was discussed at the recent quarterly oversight meeting with the Kent and Medway Integrated Care Board
03-24a	Ensure that the "Maternity Metrics" section of the April 2024 Integrated Performance Report included additional narrative regarding the methodology for the calculation of the metrics, how the target was developed and details of "what good looks	Deputy Chief Executive / Chief Finance Officer	March 2024 onwards	The "Maternity Metrics" section of the May 2024 Integrated Performance Report includes additional narrative regarding the methodology for the calculation of the metrics, how the target was developed and details of

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	like"			"what good looks like"

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
11-12a	Ensure that the next "Annual approval of the Trust's Green Plan" report to the Trust Board included details of what the Trust could do to generate renewable green energy.	Chief Executive	July 2024	The Director of Estates and Capital Development has been asked to ensure the content is included in the report submitted to the Trust Board meeting in July 2024 (which will be submitted to the Executive Team Meeting and Finance and Performance Committee beforehand).

NHS Maidstone and Tunbridge Wells NHS Trust

Patient Experience Story **Representatives from Medicine and Emergency Division**

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

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

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

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

1. What does this story reveal about Trust staff?
2. What does the story reveal about the context in which clinicians work?
3. How does the story relate to the information contained in the Trust's quality or performance reports?
4. What does this story tell the board about the environment that patients are cared in and the associated patient experience?

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: Master A	
Date of care experienced: 09/01/24	**Services/wards experienced:** **Paediatric Emergency Department**

Outline of experience:

Master A is a 5-year-old boy with a diagnosis of high functioning Autism who also presents as non-verbal. Master A attended Tunbridge Wells Paediatric Emergency Department ED) on 09/01/24 following a head injury at school. He arrived by ambulance and was accompanied by his mother.

Master A was triaged on arrival at 14.26 during which a history of autistic spectrum disorder and global development delay was documented. Master A and his mother were directed to wait in the paediatric mental health assessment room. This is a multipurpose room, although it can be used for patients with complex needs including young people who present in mental health crisis. The room is ligature free, has weighted furniture and is painted in neutral colours which provides a non-stimulating environment by reducing sensory overload. It is a designated safe room in the department. This was determined to be a conducive environment for Master A and his mother whilst they waited to see the Doctor but would also allow the nursing staff to attend to him. The majority of the Paediatric ED is an open area with trollies that can become very busy and potentially over stimulating.

Master A was seen at 16.13 following him becoming increasingly unsettled. History was taken noting Master A's additional care needs, his wound was assessed and his neuro observations were completed. There was further discussion around suitable wound closure methods.
Master A was discharged home at 18.02 following closure of his wound on his head with written advice relating to care following a head injury and wound care. An Electronic Discharge Notification was sent to his GP.

On the 15/01/2024, an email was sent to the Trust's Chief Executive Office and Head of Nursing (HoN) for paediatrics from Master A s Mum describing the disappointing experience for both herself and her son and including the following areas of concerns:

- Length of time in the room before being seen.
- Lack of communication around pain medication and waiting time.
- Initial inconsistent advice regarding appropriate wound closure.
- Environment in Paeds ED

The email was acknowledged and responded to via email by the Divisional Director of Nursing and Quality (DDNQ) within 24hrs and a face to face meeting organised by the HoN for ED via a telephone call within 48hrs, the meeting was to be held 9 days later with attendance from the department, Division and supported by the Learning Disability Liaison Nurse.

The meeting was primarily around the environmental concerns raised by the family following their attendance.

Positive points to highlight:	Negative points to highlight:
Concerns raised and rapidly escalated to DDNQ and HoN who contacted the patient's mother, initially via email within 24 hrs then followed up with a telephone conversation. Face to face local resolution meeting (LRM) held with mother, paternal grandmother, HoN, Divisional Governance HoN and Learning Disability Liaison Nurse in paediatric ED. Family really engaged and contributing to ongoing improvement work in Paediatric ED which aims to improve the experience of neuro diverse patients and their families. This includes creation of a sensory box, ear defenders, and health passports. This work is ongoing. Following the local resolution meeting a flagging system has been added on the Emergency Department patient tracking board on Sunrise EPR that highlights presence of a hospital passport and allows staff direct access to passport at triage. Importance of offering local resolution meetings as this gives staff the opportunity to discuss patients concerns openly as opposed to a written response via complaints route. There has been further written communication with Master A's Mum to update her on the progress. Learning Disability Nurse and paternal grandmother liaising to promote health passport approach in schools. Liaison between LD Nurse, department staff and Master A's family to continue to drive improvements for other neuro diverse children attending the Emergency Department	Highlighted environmental constraints in Emergency Departments as listed earlier. Poor communication with mother during Masters A's attendance to ED on 09/01/24 Highlighted need to improve resources in Emergency Department that cater for the needs of neuro diverse patients. Further improvements required in increasing awareness for staff. i.e. continued focus on the Oliver McGowan training. This will enable staff to "ask, listen and do "as a major part in the care of patients who are neurodiverse.

Ongoing actions with case:

Creation of patient experience group in Emergency Departments with patient/relative involvement. This will provide updates at the Experience of Care Committee.

Environmental review in Paeds ED ongoing with support from Ms V and maternal grandmother.

Rollout of Health passport for other children with neurodiverse conditions in preparation for a hospital visit.

EDI champion in ED developing information board for waiting room to raise awareness and celebrate differences with support from Trust EDI lead.

Deputy Chief Nurse for Quality and Patient Experience in discussion with the ICB (Learning disability and autism clinical lead) to improve the experience of patients and staff across MTW

Further work to scope introduction of another Learning Disabilities Nurse with a special interest in Autism to support the work that is ongoing and to offer support to the existing LD liaison nurse. This is being led by the Deputy Chief Nurse for Quality and Patient Experience.

NHS Maidstone and Tunbridge Wells NHS Trust

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

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
22nd April 24	Dr	James	Milton	Stroke	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:

- On behalf of the Board, I am delighted to welcome Dr Annette Doherty as the new Chair of the Trust, taking over from David Highton who completed his term of office at the end of April after seven years as Chair. Dr Doherty has 35 years of international experience working in the pharmaceutical sector and has been directly involved in the research, development and launch of new medicines in respiratory, infectious diseases, cancer and inflammatory conditions. She is also President Elect of the Royal Society of Chemistry. Dr Doherty's experience in the pharmaceutical sector and in leadership roles both within the NHS and across a range of sectors, will provide a fresh insight and focus for MTW as we continue to develop services and improve care for our local communities.

- The incredible work of staff and volunteers at MTW was celebrated at the Trust's Exceptional People, Outstanding Care Star Awards celebration on Friday 24 May. Pharmacists, nurses, doctors and volunteers were among those honoured as awards were presented in 10 categories, with more than 250 staff attending the event in Maidstone. You can read about all our winners on the Trust's website.

- The Stroke Unit at Maidstone Hospital is providing some of the best facilities in the region, following the development of a new Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU). The new stroke facilities were officially opened by Dame Tracey Crouch DBE, MP for Chatham and Aylesford, earlier this month. Dame Tracey was joined by Professor Sir Stephen Powis, NHS England National Medical Director, and the event was attended by Trust staff and past Stroke patients, who were all given a tour of the new facilities. The new HASU is the first of three specialist units to open in Kent and Medway, and is home to a dedicated Stroke Assessment Bay, where 90% of suspected stroke admissions are directly brought in on arrival at the hospital. The Stroke Assessment Bay is the first of its kind in the Kent and Medway region, and means patients do not need to go through the Emergency Department first. Together with the newly developed ASU, the Trust's Stroke Unit now has capacity to care for over 1,000 patients a year.

- In recent weeks we have also seen improvements in care in other areas of the Trust. In the Kent Oncology Centre, we have consistently reached the 62-day standard – ensuring treatment begins within 62 days after cancer is suspected and diagnosis confirmed – for more than four and a half years. The teams have also now delivered the 31- day standard across March, the first time we have achieved this since the cancer treatment standards were changed in October last year. This means 96% of patients start treatment within 31 days of agreeing a treatment plan with their doctor. This development is the result of a large amount of hard work in Cancer services and across the Trust but the recent progress in Radiotherapy services has played a major role in bringing treatment times forwards, despite a 60% increase in radiotherapy treatments since April 2022. The improvement in performance and reduction in treatment times has been supported by the upskilling of teams, providing additional training and qualification to enable more colleagues to deliver specialist areas of care. We have also expanded radiotherapy clinic hours during the week, introduced weekend working and invested in new technology.

- Mildred Johnson, Chief Pharmacist at the Trust, has been appointed to the UK Pharmacy Professional Leadership Advisory Board. One of nine independent expert members, Mildred will play a pivotal role in shaping and supporting the work of the Board, which was established by the Department of Health and Social Care. The Board enables greater collaboration across the UK pharmacy professional leadership bodies and specialist professional groups. Its objectives

include the development of independent prescribing as part of the initial training for pharmacists, and expanding on the role of pharmacy technicians.

- Nine of MTW's healthcare support workers (HCSWs) have recently received awards from NHS England's Chief Nursing Officer and Chief Midwifery Officer. Annette Farrell and Debbie Knight from NHS England (South East) visited Maidstone Hospital to present the awards, which are highly coveted in the nursing profession. The awards are presented every year to a small number of healthcare support workers in recognition of their compassion, dedication and demonstration of NHS values. HCSWs support clinicians to deliver high quality care for patients, from helping with personal care and ensuring patients' comfort to recording observations. Working at the heart of clinical settings, HCSWs make a real difference to patient experience and play an integral role in their care. On behalf of the Board, I would like to congratulate our nine HCSWs on winning these awards.

- This month we also celebrated International Day of the Midwife and International Nurses Day, recognising the enormous contribution our nursing and midwifery professionals make across our hospitals and in our communities. Our teams at MTW include over 1,700 nurses and over 200 midwives, with more than 150 international nurses and midwives joining the Trust in 2023/2024, bringing with them a wealth of knowledge and skills. The celebrations culminated in our Nursing and Midwifery Awards, where our Chief Nurse presented awards to colleagues who had been nominated by their MTW peers in a number of categories, including Nurse Innovator of the Year and Student Midwife of the Year. On behalf of the Board, I would like to congratulate the winners of our Nursing and Midwifery Awards, and thank all our nursing and midwifery colleagues for their outstanding work in ensuring our patients receive the best possible care.

- A new emergency defibrillator was recently unveiled at Maidstone Hospital. The new defibrillator has been named 'Jez' in memory of Trust gardener Jez Clark, who sadly passed away in the hospital's staff car park two years ago following a cardiac arrest. The emergency defibrillator is the first of four to be installed on the hospital grounds, all of which have been generously funded by the Maidstone Hospital League of Friends (LoF). Four further cabinets will be fitted at Tunbridge Wells Hospital, thanks to the support of the Tunbridge Wells Hospital LoF. Located at the entrance of Maidstone Hospital's Academic Centre, the emergency defibrillator includes an assistance phone that can be used to request urgent medical assistance. The equipment is linked to the ambulance control room, meaning anyone who rings 999 can be given the code to access the defibrillator. It is also linked to the Trust's security control room, in the event of a security incident. The other three emergency defibrillators at Maidstone Hospital are located in the Oncology Unit top car park, at the Renal Unit, and at the Pathology block near the Birthing Centre.

- The Crowborough Breastfeeding Café is celebrating its first full year of providing much-needed local infant feeding support for parents and caregivers. Over 800 people and their babies from Sussex, Kent and Surrey have attended, with many returning regularly for skilled and compassionate feeding support, and the opportunity to spend time with other parents. Run by MTW staff who manage the birthing centre, and funded by the Friends of Crowborough Hospital, the café has become a valued source of support for the local community. Parents have shared how the café has helped them to make improvements to their feeding technique and routine, and how people can support their partners with feeding. One mum said her breastfeeding may not have continued without the café.

- Congratulations to the winner of the Trust's Employee of the Month award for April, Guilherme Junior (known as 'Junior'), a Healthcare Support Worker in the Acute Assessment Unit at Maidstone Hospital. Junior helped to keep a patient safe during a serious incident, sustaining injuries to his left hand while preventing the situation from escalating.

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, 28/05/24 (incl. the Annual Fire Safety Report, 2023/24)	Committee Chair (Non-Executive Director)

The Quality Committee met (virtually, via web conference) on 28th May 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 Medical Director confirmed that the Terms of Reference for the Trust's Clinical Ethics Committee would be submitted to the Committee's meeting in July 2024.
- The Chief Nurse provided an **update on the revised Committee structure** which included details of the initial proposed meeting dates for the revised Committee structure; and the holistic overview which was provided via the revised meeting structure due to increased triangulation. The Committee acknowledged that development of the revised structure was an evolutionary process and that further refinements were likely to be required.
  - ❖ The Committee was **assured** that initial progress had been made to embed the revised Committee Structure; although, it was noted that further refinements were expected.
- The Committee reviewed and approved the **Terms of Reference for the Patient Safety Committee** subject to the amendment of the Committee's name from the "Patient Safety Committee" to the "Patient Safety Oversight Group" to reflect the further guidance which had been received from Deloitte LLP
  - ❖ The Committee did not allocate an assurance rating.
- The Chief Nurse presented the first **summary report from the Patient Safety Committee** wherein the Committee acknowledged that the report would continue to evolve as the Patient Safety Committee and associated reporting arrangements were embedded; and a discussion was held to enable Committee members to provide their feedback on the first Patient Safety Committee and to identify any potential areas of improvement in terms of the function of the meeting and the format of the escalation report. The Committee was informed of the scoping exercise which had been commissioned to investigate issues related to patients being lost to follow-up and develop robust mechanisms to address such issues in the future. It was agreed that the Chief Nurse should ensure that the summary report from the Patient Safety Oversight Group to the Committee's meeting in July 2024 included an update on the review of patients lost to follow up.
  - ❖ The Committee was **assured** regarding the direction of travel; although, noted that the approach would be subject to continual improvement
- The Chief Nurse presented the **summary report from the Maternity and Neonatal Assurance Group** which included details of the challenges associated with the vacancy rate within the Community Midwifery Team. It was agreed that the Assistant Trust Secretary should ensure that the Head of Risk Management was invited to future 'Main' Quality Committee meetings.
  - ❖ The Committee was **assured** that the areas of escalation would continue to receive the appropriate focus.
- The **minutes of the Quality Committee 'deep dive' meeting, 10/04/24**, were noted.
- The **annual fire safety report 2023/24**, (which has been enclosed under appendix 1, for information), was supported as submitted
  - ❖ The Committee was **assured** that the relevant areas of fire safety had been appropriately considered.
- The Committee reviewed the **final draft Quality Accounts for 2023/24** which included the **quality priorities for 2024/25**, wherein the alignment with the Trust's Strategic Themes and Corporate Objectives was acknowledged and it was agreed that the Director of Quality Governance should liaise with the Learning Disabilities Team to explore whether it would beneficial to develop an easy-read version of the Quality Accounts for 2023/24.
  - ❖ The Committee was **assured** as that the Quality Accounts for 2023/24 appropriately reflect the key areas of focus.

- The Committee conducted an **evaluation of the meeting** wherein the importance of preventing duplication between forums was acknowledged and the need to ensure safe, open, discussions, to promote a culture of learning, was supported.

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

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

- The Annual Fire Safety Report, 2023/24 is enclosed in appendix 1, for information.

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

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Annual Fire Safety Report 2023/24.

12 April 2024

Maidstone and Tunbridge Wells NHS Trust
Report Completed by: Mark Vince MIFSM CFRAR
Fire Safety Officer

The Institute of Fire Safety Managers IFSM Member

The Institute of Fire Safety Managers IFSM Tier 2 Competent Fire Risk Assessor (CFRAR) 2024

Contents.

Annual Fire Safety Report 2023/24.

1. Summary of Activity.

Summary of Activity:

- Monitoring of fires and Unwanted Fire Signals;
- Risk management via the Risk Assessment Programme;
- Training of staff and response to emergency incidents;
- Fire safety for existing and future projects;
- Strategic Aims.

Key findings;

- Fires on site have increased to 3 compared with the 1 in the previous year.

- The first incident occurred on John Day ward, where a patient on oxygen therapy believed they had a cigarette in their mouth and attempted to light the imaginary cigarette which cause a fire. The fire was immediately extinguished by staff and there was no significant amount of smoke therefore the fire alarm system did not activate. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There was a single casualty who received burns to their person, this was investigated through the Serious Incident process.

- The second incident was a deliberate act of arson within the Oncology Department in a public toilet on the Maidstone site, where an individual gained access to the department outside of normal business hours and locked themselves in a public toilet and set fire to toilet paper and hand towels in the sink. A single firefighting appliance attended but the fire was extinguished by a member of staff before their arrival. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There were no casualties.

- The third fire occurred when a patient on AAU on the Maidstone site locked themselves in a patient toilet and stuffed toilet paper up the legs of their pyjamas and set the paper alight. The Kent Fire and Rescue Service were not called as a member of staff extinguished the fire and the fire alarm was not activated. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There were two casualties who received burns to their person, these were not major enough to be considered as RIDDOR reportable.

- Unwanted fire signals are up on last year by 24.

	• Risks identified during the fire safety inspection process generally fall into one of two categories and will be monitored as part of this year's ongoing inspection programme and addressed as part of planned works throughout the year. They are;
	  • Fire doors condition;
	  • Fire compartmentation.
	
	Conclusions;
	
	Evidence would suggest that the increase in unwanted fire signals is the use of unauthorised toasters in non-pantry areas. This type of incident has increased form 2 last year to 17 this year. Staff have been reminded through the Health and Safety Committee that the use of toasters must only be for the provision of toast to patients on wards. Any area that feel they need a toaster must submit a toaster application form to the Fire Safety Officer for approval. Toasters that were found to be the cause of fire alarm activation were removed by the Fire Response Team.
	
	Fire alarms caused by patients/visitors activating fire alarm call points either deliberately or by accident believing them to be the door release button have remained high at 21, compared to 22 last year. As and when they occur going forward it is suggested that covers are fitted to the call points to prevent accidental activation.

Trust objective:	Provide a safe working environment in line with the Trust objective of exceptional people delivering outstanding care.
Legal:	Maidstone and Tunbridge Wells NHS Trust acknowledges its responsibilities under the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) and ensures that fire risk assessments are carried out on its premises to determine the general fire precautions and protective measures needed to comply with the articles imposed under this order. This is conducted in line with PAS 79-1. PAS 79-2 (Fire risk assessment – Guidance and a recommended methodology) is a Publicly Available Specification published by the British Standards Institution.

2. Introduction.

Maidstone and Tunbridge Wells NHS Trust, (MTW), has a statutory duty to ensure that all of the premises owned or operated by it comply with current fire safety legislation. The Trust has to ensure that suitable and sufficient arrangements are in place for the management of fire safety and the implementation of any necessary fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005.

Current fire safety law requires an employer to take a risk-based approach to fire management. This will ensure significant risks are identified and adequate controls are put in place. The effectiveness of these controls will become evident by the number of fire service interventions on site, the number of unwanted fire signals, the effects of these calls on service delivery and the reactions of staff to a fire emergency.

2.1 Fire Safety Report 2023/24.

The purpose of this report is to give a clear indication as to the Trust's performance in fire safety management and legal compliance.

The first section covers matters of performance over the reporting period whilst the second section looks at the aims for the coming year and performance monitoring. The second section contains specific risks and addresses these with specific strategic objectives. The third comments on matters of day to day fire management and maintaining a safe environment. The final section covers statistics and year on year statistical comparison.

3. Performance.

On 15th November 2023 the Kent Fire & Rescue Service conducted a regulatory fire audit at the Tunbridge Wells site. The audit focused on the Women's & Children areas and specifically Neo Natal, Ante Natal and Delivery Suite, the report into their findings was positive and recommended only two items for consideration, the report is as follows with mitigating actions/responses in red;

The Regulatory Reform (Fire Safety) Order 2005, as amended.
Re: Mother and Child Wards (Green Zone L2), Tunbridge Wells Hospital, Pembury, Tunbridge Wells, Kent TN2 4QJ.

Following the fire safety regulatory inspection of the above premises on 15 November 2023, I am of the opinion that the premises currently demonstrate broadly compliant measures to satisfy the requirements of the above legislation.

The following recommendations will assist you to sustain a good standard of fire safety:

Fire Safety Management

1. Hospital streets, corridors and stairways that form part of escape routes should be always kept clear and hazard free. Items that may be a source of fuel or pose an ignition risk should not normally be located on any hospital street, corridor or in a protected stairway. Relocate Vending machines out of Hospital Streets/Service Corridors.

   The Fire Safety Officer has checked HTM 05-02, (2.14 and 2.15), as well as consulting with the Authorising Engineer Fire and both agree that a suitable and sufficient fire risk assessment by a competent person is enough to allow the vending machine to remain in place due to the location affording multi-directional evacuation.

2. It is essential that escape routes, and the means provided to ensure they are used safely, are managed, and maintained to ensure that they remain usable and available always when the premises are occupied. Routine checks of final exit doors and security fastenings should be carried out.

   Final Fire Exits are checked daily by the Mitie fabric team and is a PPM within the CAFM system.

3. The responsible person must establish relevant safety procedures in case of serious and imminent danger to safeguard the safety of relevant people and ensure they are practiced through drills.

   Specifically, Emergency evacuation procedure must include:(but not limited to)

   - Understanding the requirement and demonstrating use of nearest subT compartment/compartment (PHE).
   - Person in charge to contact relevant support departments where required (Delivery Suit – available oxygen ports) etc.
   - The procedures to be followed by staff to evacuate the Ward, considering prioritizing high risk vulnerable patients.
   - Managing staffing levels so suitable amounts of staff will be available in event of full sub-compartment/compartment evacuation.
   - Simulations to use/factor all medical equipment that may be required in a full evacuation of the compartment.

     Fire drills/Simulations should be carried out to include “worst case scenarios” to confirm staff understanding and identify any weaknesses in the strategy

   Staff already have local fire documentation which covers their roles and responsibilities. In addition, the Clinical Site Manager will always attend a fire alarm activation and they fully understand the principles of PHE. However, it was clear at the audit this question was not

answered to the satisfaction of the Fire Service when they asked it. The Fire Safety Officer has therefore re-written the local fire documentation to make it easier to understand. In addition, the Trust is working on producing a video that we can disseminate to all staff to aid understanding of the process.

Additionally, throughout the year the Trust has been in constant communication with the Kent Fire and Rescue Service with regard to the inoperability of the local fire hydrants at the Maidstone site and the unavailability of firefighting lifts at Tunbridge Wells, either through routine maintenance or lift failure. This issue with regard to fire hydrants on the Maidstone site is recorded and tracked on the Trust Risk Register, works are now underway to address this issue, which will be resolved following the construction of two additional hydrants for the Kent and Medway Orthopaedic Centre.

3.1 Changes to the Fire Safety Department.

Over the last six months the Trust has successfully completed recruitment to the role of Assistant Fire Safety Officer. The successful candidate, James Gibson, was recruited through the apprenticeship scheme. The new post as well as providing the department with a succession plan, gives us the ability to increase fire safety inspections, fire drills and fire related training.

The department has also moved into the Emergency Planning Directorate, this greatly improves day to day working with other operational departments, such as, Emergency Planning and Security, increasing our intelligence network and encouraging greater inter-departmental working in areas such as new construction projects, multi-agency exercises and dovetailing emergency plans.

3.2 Fires on Trust Premises.

There were three fires on Trust premises this year, two of which involved patients. The first incident occurred on John Day ward, where a patient on oxygen therapy believed they had a cigarette in their mouth and attempted to light the imaginary cigarette which cause a fire. The fire was immediately extinguished by staff and there was no significant amount of smoke therefore the fire alarm system did not activate. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There was a single casualty who received burns to their person, this was investigated through the Serious Incident process.

The second incident was a deliberate act of arson within the Oncology Department in a public toilet on the Maidstone site, where an individual gained access to the department outside of normal business hours and locked themselves in a public toilet and set fire to toilet paper and hand towels in the sink. A single firefighting appliance attended but the fire was extinguished by a member of staff before their arrival. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There were no casualties.

The third fire occurred when a patient on AAU on the Maidstone site locked themselves in a patient toilet and stuffed toilet paper up the legs of their pyjamas and set the paper alight. The Kent Fire and Rescue Service were not called as a member of staff extinguished the fire and the fire alarm was not activated. A report was submitted following investigation by the Fire Safety Officer. There was no follow up investigation required by the Kent Fire and Rescue Service. There were two casualties who received burns to their person, these were not major enough to be considered as RIDDOR reportable.

A copy of all reports can be obtained on request from the Fire Safety Officer.

Fires on MTW sites	2022/23	2023/24
	1	3

3.3 Unwanted Fire Signal (UFS).

A UFS is defined as follows;
"An incident to which the Fire Service may have been called and that on investigation no fire is found."
It should be noted that although many calls to the Trust can be unwanted by the Fire and Rescue Service they would be as a result of staff following Trust policy. For example, a smell of burning may well prompt a member of staff to raise the alarm in accordance with the policy. However, if no fire is found the Trust will record this as an UFS.

UFS's at MTW	2022/23	2023/24
	68	92

See section 8 for a statistical breakdown of these figures.

Clarification as to current performance;

Unwanted fire signals are up on last year by 24.

Evidence would suggest that the increase in unwanted fire signals is the use of unauthorised toasters in non-pantry areas. This type of incident has increased form 2 last year to 17 this year. Staff have been reminded through the Health and Safety Committee that the use of toasters must only be for the provision of toast to patients on wards. Any area that feel they need a toaster must submit a toaster application form to the Fire Safety Officer for approval. Toasters that were found to be the cause of fire alarm activation were removed by the Fire Response Team.

Fire alarms caused by patients/visitors activating fire alarm call points either deliberately or by accident believing them to be the door release button have remained high at 21, compared to 22 last year. As and when they occur going forward it is suggested that covers are fitted to the call points to prevent accidental activation.

3.4 Other Trust Sites;

Hermitage Court; Roundall, Units A, D and F have all been inspected in the last twelve months. The only major issue identified was the lack of an auto-dialling system to alert main switchboard if a fire alarm is activated outside normal business hours in units A, D and F. Works commence this month to address this issue in units A and D. This will leave only unit F without auto-dialling capability.

Oncology Kent and Canterbury Hospital; Local fire evacuation documentation is now in place following last year's inspection. Training has been undertaken in the last twelve months with MTW staff covering fire evacuation and the role of the fire warden.

Crowborough; Inspected within the last twelve months, no concerns identified. Current risk assessments and evacuation documentation in situ for both the Birth Centre and Outpatients.

Sexual Health Clinics, (Dartford, Gravesham and Tunbridge Wells); All inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

Health Records Paddock Wood; Compliant risk assessments in situ, no concerns identified.

Park Wood; Final risk assessment conducted in 2023 prior to the closure of laundry services, no concerns identified. Further inspection will be scheduled if the site is to be used for other services going forward.

Magnitude House; Compliant risk assessments in situ, no concerns identified.

Abbey Court; Inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

Priory Gate; Inspected in the last twelve months, compliant risk assessments in situ, no concerns identified.

All outlying areas have planned inspections scheduled for the coming year. This will include the Kent and Medway Orthopaedic Centre, The Kent Medical School, CDC at Hermitage Court, as well as the newly acquired Spires Tunbridge Wells Hospital.

3.5 Fire Risk Assessments.

One of the key factors of good fire safety management is an ongoing system of risk assessment and review. During 2023/24 considerable efforts have gone into ensuring all areas of the MTW site have current risk assessments in accordance with PAS 79-1 or PAS 79-2 requirements.

On completion of fire risk assessments any significant findings that are identified during this process that cannot be immediately addressed will be placed on the In Phase system.

The Fire Safety Officer has an electronic inspection system and inspection programme that will ensure all areas under the control of the Maidstone and Tunbridge Wells NHS Trust receive at least one inspection for fire safety throughout the course of the following year.

4 Strategic Aims and Objectives.

4.1 To reduce the number of potential fire incidents and their consequences.

This will be achieved through;

- Full multi-agency exercises at the Kent and Medway Orthopaedic Centre and the new student medical accommodation aimed at refining fire evacuation procedures.
- Continuation of the replacement of non-compliant fire doors on the Maidstone Hospital site. Works on the main hospital street are in an advanced stage and will continue throughout this financial year. In addition, fire door inspection training will be undertaken within the Estates Maintenance Department to enable staff to correctly identify non-compliant fire doors. The new Head of Engineering is also undertaking a full survey of current fire doors through a nominated competent contractor. Non-compliant fire doors identified will be repaired based upon the risk they pose in conjunction with the Fire Safety Officer. This will all be monitored through the Fire Safety Committee.
- Bespoke training to be created for the Fire Response team to ensure they fully understand their duties and to increase their overall knowledge of fire safety and fire incident response duties. This was scheduled for last year but due to lack of resources in the Fire Safety Department was unable to be addressed. The Fire Safety Department now has an Assistant Fire Safety Officer in situ and therefore this training can now take place.
- Continued promotion of the role of Fire Warden throughout the Trust, in particular in outlying services and improved access to training on e-Learning. Heightening intelligence to the Fire Safety Department in the prevention of fires as well as potential arson.
- Focus on advice for departments to avoid combustible material build up in hospital streets and adjacent to fire exits, something which appeared to be on the increase over the past 12 months. Department managers to be encouraged to report junk and not allowing it to build up in corridors
- Department managers encouraged to walk staff through evacuation routes as part of induction and local fire procedures as part of departmental training
- Reminders to managers of the dangers of vaping inside hospital premises. There have be two recorded incidents of this taking place in ward areas by staff.
- Managers to remind staff of the correct use of toasters to avoid unwanted fire signals.
- Adopt a risk based approach to the replacement of existing firefighting equipment with new multi-purpose extinguishers and more fire blankets in ward and office areas.
- Increase perimeter fire inspections to cover the specific risk of arson. This is outlined in section 5 of this document.

4.2 Aim to reduce the number of Unwanted Fire Signals (UFS) and the disruption to service delivery.

This will be achieved through;

- Review of all UFS incidents, where appropriate enforce action to reduce issues identified.
- Continuation of monitoring misuse of the fire alarm call points which was the main cause of unwanted fire signals this year. Should the situation not improve the Fire Safety Officer will consider solutions to reduce their numbers.
- Fire Safety and Security teams will have an increased focus on reduction of potential of arson attack which continues to be highlighted as an increased threat nationwide. A new training programme aimed at Security Officers identifying potential arson risks has now been developed and is currently being rolled out to all Security staff.

4.3 To manage fire safety in line with current laws and regulations using a risk-based approach with effective action plans. This will be achieved through;

- Monthly inspection regime, which will create effective action plans based on risk to ensure the Trust remains compliant with current law and legislation and that future construction projects meet the recommendations by Dame Judith Hackitt following the Grenfell inquiry which has been incorporated into the new Building Safety Act.
- Record and monitor any unresolved issues through the Fire Safety Committee, to ensure these unresolved issues are escalated and have robust plans, with associated achievable deadlines to resolve issue in an effective manner.

4.4 To ensure the workforce have a sound understanding of fire safety provisions and emergency procedures.

The Trust will achieve this through;

- Review of Fire Safety mandatory training. Current training addresses building and infrastructure fires, however, over the past year the Trust has had two fires which have involved patients. This is something that staff may have never encountered before and therefore it would seem prudent to include this subject as part of the mandatory training material.
- There will be an increase in fire drills across all of our sites to ensure staff respond correctly to a potential fire incident. Any issues identified during these drills will be addressed with staff on the day.
- Develop a video that can be accessed by all staff on the Trust Intranet and by way of a QR code which clearly shows action to be taken in the event of a fire alarm activation and what action is required should a real fire be detected.
- The Fire Safety Officer, in conjunction with the Emergency Planning and Response team will carry out exercises across both hospital sites involving multi-disciplinary response to ensure staff are familiar with their responsibilities in relation to fire incident management. This will include the two new major construction projects, namely the Kent and Medway

Orthopaedic Centre at Maidstone and the Student Medical accommodation at the Tunbridge Wells site.

5. Maintaining a Safe Environment.

Satisfying legal requirements and the pursuit of performance indicators can, at times, become so much the point of focus that day to day management of fire safety gets overlooked.

It is with this in mind that the following comments are made as part of this report in order to highlight how changing situations can impact upon fire safety management.

5.1 Lithium-ion Batteries and Car Park Fires.

A safety warning on the use of lithium batteries is being issued by Kent Fire and Rescue Service following several battery related fires this month. Lithium-ion batteries, or li-ion batteries (sometimes called LIBs) are commonly found in many items including mobile phones, laptops, e-bikes, vaping devices and scooters. KFRS has seen an overall increase in battery fires in the last two years, with over 20 believed to be caused by batteries in the last three months.

With this now at the forefront of fire safety, the Fire Safety Officer will be undertaking a full review of Lithium-ion battery use, storage and disposal within the Trust. In addition, a full review of fire incident response to an electric vehicle fire in Trust car parks will be undertaken. The Trust has an electrical vehicle fire response plan but this will be tested in the coming year with particular attention being paid to the underground car park at the Tunbridge Wells site.

5.2 Fire Extinguishers

Over the past year the Trust has had 3 fires, 2 involving patients and 1 act of deliberate arson and I see no way that this will not become an increasing trend. Although staff went above and beyond to extinguish these fires, which is to be commended, on two occasions the wrong fire extinguisher was used and in the third case staff were unsure of which piece of firefighting equipment to use.

Therefore, the Fire Safety Officer will conduct a review of firefighting equipment used across the Trust. It will concentrate on swapping out foam and CO2 extinguishers with new P50 extinguishers. These are multi-purpose extinguishers which mean staff can never accidentally grab the wrong extinguisher in an emergency situation. In addition, they only require servicing once every 10 years rather than annually which we see a reduction in maintenance costs.

The Fire Safety Officer will look at reducing the number of extinguishers on both hospital sites, concentrating in placing them in key strategic locations that will benefit the Kent Fire and Rescue Service. On wards and in office areas fire extinguishers will be replaced by fire blankets which will be more effective in dealing with patient fires and electrical equipment fires.

The plan for role out will be developed with the Estates Maintenance Department and Mitie to ensure it is done in the most cost effective and least labour intensive way possible.

5.3 Loading Bay and Perimeter Inspections.

Healthcare premises are vulnerable to arson by any number of persons, (for example patients with disturbed patterns of behaviour, employees and others who may enter sites, including contractors and even casual passers-by).

HTM 05-03: Operational provisions – Part F: Arson prevention in NHS concludes that premises with pharmaceuticals, may be targets for theft and consequently fires to conceal the theft. Where the area has a history of criminal activity, consultation with the police and Head of Security Services should take place. This consultation should be reflected and recorded in the hospital risk assessment together with appropriate measures to mitigate the risk.

With this in mind, as well as the planned internal fire safety inspections, the Fire Safety Department will increase the number of loading bay and hospital perimeter inspections it undertakes. The inspections will pay specific attention to arson prevention. Open areas are naturally more vulnerable to arson attack and therefore warrant a more specific form of fire safety inspection.

These inspections will be recorded on the new electronic inspection system and outcomes shared with all departments that may need to undertake improvements to fire safety.

6. Future Projects

The forthcoming year will see a number of building projects completed that require specific fire safety input with regard to fire inspection, risk assessment and emergency exercises. With two emergency exercises planned for the Kent and Medway Orthopaedic Centre and the Kent Medical School in which the Fire Safety Department will play a prominent role.

In addition to this the Fire Safety Department will be involved in projects such as the new Clinical Diagnostic Centre at Hermitage Court and the new acquisition of the Spires Tunbridge Wells Hospital which will require a full fire safety inspection and review to ensure it meets fire legislative requirements.

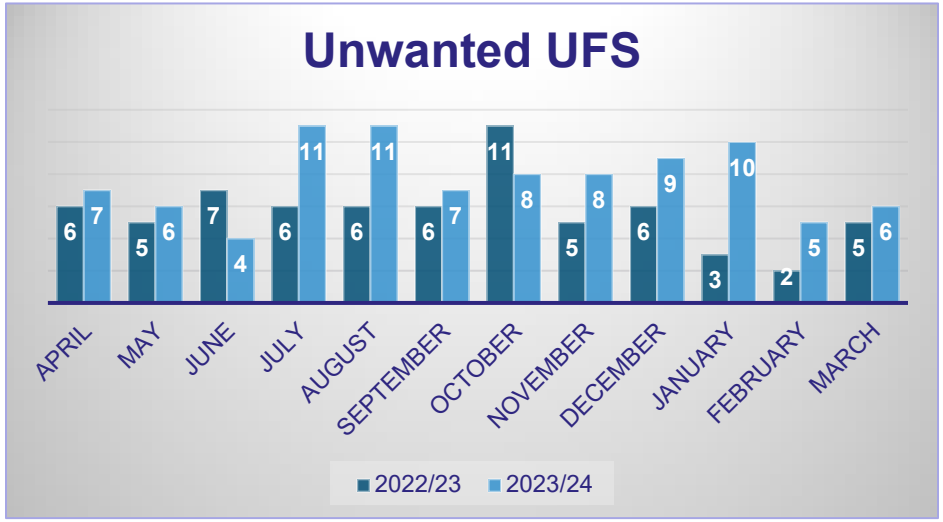
Ensuring that all fire safety requirements are dealt with at the earliest point in the project is essential so as to avoid problems post construction. The working relationship with the Estates Projects team and outside agencies has been positive and constructive but there is a continuous need for monitoring throughout the project. This is to ensure building works do not compromise the safety of the hospital and that of staff and patients.

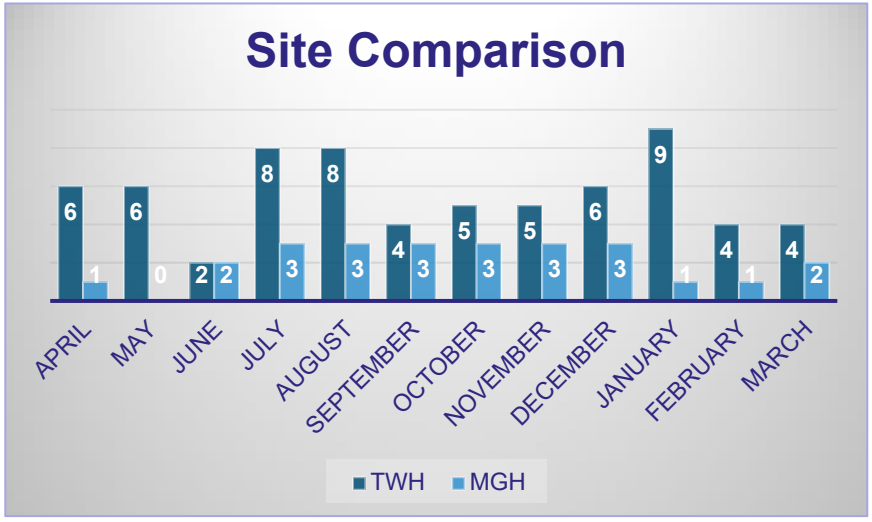
The Fire Safety Officer is also now included in all space management projects to ensure fire safety is addressed as early as possible in a potential move or redevelopment of existing or newly acquired sites.

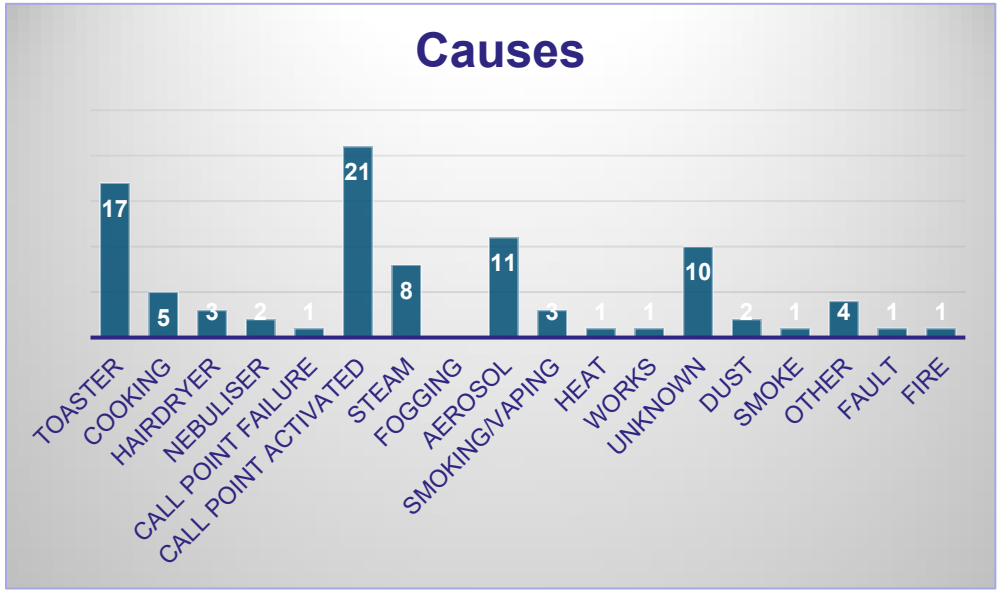
7. Statistics and Comparison.

UFS	April	May	June	July	August	September	October	November	December	January	February	March	Total
2022/23	6	5	7	6	6	6	11	5	6	3	2	5	68
2023/24	7	6	4	11	11	7	8	8	9	10	5	6	92

Site Comparison	April	May	June	July	August	September	October	November	December	January	February	March	Total
TWH	6	6	2	8	8	4	5	5	6	9	4	4	67
MGH	1	0	2	3	3	3	3	3	3	1	1	2	25







Causes	
Toaster	**17**
Cooking	5
Hairdryer	3
Nebuliser	2
Call Point Failure	1
Call Point Activated	**21**
Steam	8
Fogging	
Aerosol	11
Smoking/Vaping	3
Heat	1
Works	1
Unknown	10
Dust	2
Smoke	1
Other	4
Fault	1
Fire	1
Total	92

Summary report from the Finance and Performance Committee, 28/05/24	Committee Chair (Non-Exec. Director)

The Committee met on 28th May 2024, virtually, via web conference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Divisional Director of Operations, Cancer Services presented a 'deep dive' into **the outpatients transformation programme** which included before and after reporting against the three key identified KPIs for the pathway transformation workstream; the significant improvement which had been delivered in relation to call handling times; and the programme of work to improve clinical utilisation and the intended development of a Business Case for a Clinician Room Management System. It was agreed that the Deputy Chief Executive / Chief Finance Officer should liaise with the Divisional Director of Operations, Cancer Services, to further consider the governance arrangements for the outpatients transformation programme, and what, if any, alignment was required with the Trust's Strategy Deployment Review (SDR) processes. It was also agreed that the Assistant Trust Secretary should schedule an "Update on the outpatients transformation programme" as the topic for the 'deep dive' at the Committee's meeting in October 2024.
     - ❖ The Committee was **assured** as significant improvements had been delivered, although it was noted there was further work required to improve clinic utilisation and reduce the number of short notice cancellations.
   - The **Patient Access strategic theme metrics for April** were reviewed, and the impact of the Transfer of long-waiting patients onto the Trust's Patient Tracking List (PTL) was acknowledged.
     - ❖ The Committee was **assured** regarding the continued focus on service delivery and patient care.
   - The Chief Operating Officer provided the latest **monthly update on the provision of system support** which included details of the additional system support which had been provided via the Spire Tunbridge Wells Hospital.
     - ❖ The Committee was **assured** that the Trust continued to support other NHS Providers within Kent and Medway.
   - The Deputy Chief Executive / Chief Finance Officer provided an **update on the 2023/24 year-end financial position** which included the adjustments which had been required since the year-end position was considered at the Committee's meeting in April 2024.
     - ❖ The Committee was **assured** that the adjustments were appropriate.
   - The review of **financial performance for April** highlighted that the Trust was adverse to plan for Month 1 of 2024/25; however, there was robust understanding of the root cause and mitigating actions were under development to support the achievement of the Trust's financial plan for 2024/25. A discussion was then held regarding the Kent and Medway Integrated Care System (ICS) financial position; wherein, Committee confirmed the Trust's support and commitment to work with partners to deliver the Kent and Medway ICS financial recovery plan and the associated actions.
     - ❖ The Committee was **assured** that there was sufficient focus on the development of additional mitigating actions and controls to support the delivery of the Trust's financial position.
   - The Chief Operating Officer provided a brief verbal **update on the options being pursued to manage the risk relating to the age of the imaging equipment in Radiology.**
     - ❖ The Committee did not allocate an assurance rating on this occasion.
   - The Committee received an **annual update on the PFI contract at Tunbridge Wells Hospital** which included that there was expected to be an increase in life cycle expenditure as the Trust entered the latter half of the Private Finance Initiative (PFI) arrangement.
     - ❖ The Committee was **assured** that the Trust continued to review the PFI arrangements to ensure contractual requirements were fulfilled.
   - The Director of Estates and Capital Developments attended for the latest **update on the Estates Directorate** which included that the details of the Trust's statutory compliance and the development of an asset register to support the prioritisation of backlog maintenance.

- ❖ The Committee was **assured** regarding the improvements which had been delivered.
- The Director of Strategy, Planning and Partnerships attended for a **review of the approach to business case and benefits evaluation** wherein the Committee acknowledged the challenges associated with the development of the process and supported the proposed approach. It was agreed that the Assistant Trust Secretary should schedule a "Quarterly update on the Business Case benefits realisation" item at the Committee's meeting in September 2024 and quarterly thereafter.
  - ❖ The Committee was **assured** that the appropriate areas of focus had been considered as part of the development of the initial approach, although, it was acknowledged that further work was required.
- The **Business Case (OBC) for Rapid Respiratory Testing and 7-day Service** was reviewed and the Committee acknowledged that Business Case would be considered as part of the Business Case prioritisation process for unfunded service developments.
- The **Business Case (OBC) for for 7-day service – Phase 3** was approved as submitted and the Committee acknowledged that a phase approach would be adopted to the associated recruitment, to prevent increased temporary staffing expenditure.
- The **summary report from the from the April 2024 People and Organisational Development Committee** meeting was noted and the Committee received **notification of the use of the Trust Seal**.

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, 24/05/24 (Incl. the Quarterly update from the Guardian of Safe Working Hours, Jan. to March 2024; and approval of revised Terms of Reference)

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually) on 24th May 2024 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed. The revised Terms of Reference, are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Committee reviewed the **workforce plan for 2024/25,** wherein a discussion was held around potential nursing apprenticeship schemes and the reduction of international recruitment, and it was agreed that the Interim Deputy Chief People Officer – People and Services and the Deputy Chief Nurse – Workforce & Education would liaise regarding the funding around this and provide an update to the Committee.
  - ❖ The Committee did not allocate an assurance rating as the report was intended to provide an update on the current position and the associated next steps.
- The Programme Director of Premium Staffing Spend presented that latest update on the **workforce efficiency programme** which included an update on the year to date agency spend position and project progress with key next steps, alongside an update on compliance. The Programme Director, Premium Staffing Spend outlined the Business Case for staffing and the rostering team and it was agreed that Deputy Chief Executive / Chief Finance Officer and the Deputy Chief Nurse – Workforce & Education would liaise to determine the position of the Business Case and whether this should be distributed to Committee members external to the meeting.
  - ❖ The Committee was assured however, was awaiting further information regarding the costs relating to the Spire Tunbridge Wells Hospital in the next update, and a progress update on the Business Case.
- The Head of People Performance and Improvement provided an **update on the work in relation to the Trust's Employee Value Proposition (EVP)** wherein the Committee reviewed the focus on the recruitment and attraction team for the development of the trust's EVP and associated challenges, and the recommendation for the focus of EVP on specific personas for hotspot areas in the Talent Acquisition space. It was also noted that retention of staff had not received enough attention alongside recruitment.
  - ❖ The Committee was not assured as there was a number of challenges and subsequent work still required.
- The Committee reviewed **the equal pay annual audit return 2023/24** wherein the Deputy Chief People Officer, Organisational Development provided a 2023 results overview and comparison, which highlighted the work around equitable recruitment practices, and that the equal pay gap had reduced.
  - ❖ The Committee was **partially assured** however, it was agreed that a mid-term update on the activities and actions that have contributed to the shift in equal pay, prior to the annual audit report, would be scheduled at a future meeting to provide further assurance.
- The Head of People Performance and Improvement presented the latest monthly review of the "**Strategic Theme: People" section of the Integrated Performance Report (IPR)** which included that although the overall sickness absence rate had decreased, there was an increase in the long-term rate; that April 2024 was the third month of turnover below the target of 12% with additional A3 activity continued; and that there was continued focused work on consultant recruitment, the reduction of agency spend, and recruitment and retention.
  - ❖ The Committee was assured that there was the appropriate focus on continued improvements.

- The latest **quarterly update from the Guardian of Safe Working Hours** (January to March 2024) and **update from the Health and Wellbeing Committee** were noted; the latter is enclosed in Appendix 2, for information and assurance.
- The Committee conducted **an evaluation of the meeting** wherein it was noted that there was a good range of robust challenges outlined within the reports, and it was recommended that there should be further representation from medical and operational personnel at future meetings, and deputies when they are unable to attend.

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

1. The Deputy Chief Executive / Chief Finance Officer and Interim Deputy Chief People Officer – People and Services should consider, and confirm to the Committee, the proposed frequency of the 'workforce plan for 2024/25' item at future Committee meetings.

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

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval
- The quarterly update from the Guardian of Safe Working Hours (January to March 2024) is enclosed in Appendix 2, for information and assurance

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

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

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

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – MAY 2024

NHS Maidstone and Tunbridge Wells NHS Trust

TO AGREE UPDATED TERMS OF REFERENCE (ANNUAL REVIEW) COMMITTEE CHAIR

The People and Organisational Development Committee's Terms of Reference are due their annual review.

The enclosed revised Terms of Reference are therefore submitted to the Committee for review and agreement, prior to being submitted to the Trust Board, for approval (in May 2024).

The proposed changes are shown as 'tracked'. The majority of the proposed changes are minor/'housekeeping' changes, with the one significant change reflecting the current reporting arrangements between the Committee and the Finance and Performance Committee.

The Committee is however welcome to agree any further changes it wishes to see.

Reason for submission to the People and Organisational Development Committee
Review and agreement (to enable the Terms of Reference to be submitted to the Trust Board, for approval)

People and Organisational Development Committee

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of people development, planning, performance and employee engagement.

The Committee will work to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success.

2. Membership

- Non-Executive Director (Chair)*
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)*
- One other Non-Executive Director or Associate Non-Executive Director*
- Chief Nurse*
- Chief People Officer*
- Deputy Chief Executive / Chief Finance Officer*
- Deputy Medical Director, Workforce and Digital ~~(with responsibility for workforce issues)~~
- Director of Medical Education (DME)
- Health and Wellbeing Guardian

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members can send an appropriate deputy if they are unable to be present at a Committee meeting.

3. Quorum

The 'main' meeting of the Committee will be quorate when the following members are present:

- The Chair or Vice Chair of the Committee and one other Non-Executive Director or Associate Non-Executive Director[1]
- Two Executive Directors (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). Deputies representing an Executive Director will count towards the quorum.

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Committee and one other Non-Executive Director or Associate Non-Executive Director[1]
- One Executive Director (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). Deputies representing an Executive Director will count towards the quorum.

4. Attendance

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and Executive Directors (i.e. apart from those listed in the "Membership") are welcome to attend any meeting of the Committee.

Other staff, including members of the People and Organisational Development Function, may be invited to attend, as required, to meet the Committee's purpose and duties.

5. Frequency of meetings

The Committee shall, generally, meet each month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable

[1] For the purposes of quorum, the Chair of the Trust Board will be regarded as a Non-Executive Director

detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' People and Organisational Development Committee.

The Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings).

6. Duties

To provide assurance to the Trust Board on:

- People planning and development, including alignment with business planning and development;
- Equality, Diversity and Inclusion (EDI) in the workforce;
- Employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- Occupational health and wellbeing in the workforce;
- External developments, best practice and industry trends in employment practice;
- Staff recruitment, retention and satisfaction;
- Employee engagement;
- Internal communications;
- Terms and conditions of employment, including reward;
- Organisational development, organisational change management and leadership development in the Trust;
- Training and development activity;
- Reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training);
- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements; and
- The Trust's wellbeing arrangements

To convene task & finish groups to undertake specific work identified by the Committee or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7. Parent committees and reporting procedure

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

A written summary report of each Committee meeting will be submitted to the Trust Board. The Committee Chair will present the Committee report to the next available Trust Board meeting.

Any relevant feedback and/or information from the Trust Board will be reported to the Committee by the Committee Chair, as they deem necessary.

8. Sub-committee and reporting procedure

The following Committee reports to the People and Organisational Development Committee through its chair or representatives following each meeting:

- Local Academic Board (LAB) (reporting to occur via the report from the DME).

Finance and Performance Committee

A summary report of the Committee will be submitted to the Finance and Performance Committee, as means of alignment as pay-roll by way of example represents a significant aspect of the expenditure for the Trust, for information / assurance (the summary report submitted from the Committee to the Trust Board will be used for the purpose).

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Committee Chair, after

having consulted at least two Committee members who are Executive Directors. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

10. Administration

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

- The Committee's forward programme, setting out the dates of key meetings & agenda items;
- The Committee's pre-meeting discussion;
- The meeting agenda; and
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Review history

- Terms of Reference agreed by Workforce Committee: 29th September 2016
- Terms of Reference approved by Trust Board: 19th October 2016
- Terms of Reference agreed by Workforce Committee: 30th October 2017
- Terms of Reference approved by Trust Board: 29th November 2017
- Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
- Amended Terms of Reference approved by Trust Board: 1st March 2018
- Terms of Reference agreed by Workforce Committee: 28th March 2019
- Amended Terms of Reference approved by Trust Board: 25th April 2019
- Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)
- Terms of Reference agreed by Workforce Committee: 26th March 2020 (as part of the annual review, and to include the Inclusion Committee as a sub-committee, to add the Deputy Medical Director as a member, and to reflect the agreement that members can send deputies if they are unable to be present)
- Terms of Reference approved by Trust Board: 30th April 2020 (as part of the annual review)
- Amended Terms of Reference agreed by Workforce Committee: 15th May 2020 (to withdrawn the membership of the Chief Operating Officer and to add the Chief Finance Officer as a member)
- Amended Terms of Reference approved by Trust Board: 21st May 2020
- Change approved by the Trust Board, 25th June 2020, to increase the frequency of meetings to monthly
- Change of the Committee's name and removal of the Inclusion Committee as a sub-committee, agreed by the Workforce Committee, 15th October 2020
- Change approved by the Trust Board, 22nd October 2020, to change the Committee's name (from the Workforce Committee to the People and Organisational Development Committee) and removal of the Inclusion Committee as a sub-committee.
- Terms of Reference agreed by the People and Organisational Development Committee: 23rd April 2021 (as part of the annual review, to remove the Health and Safety Committee as a sub-committee, to reflect the change of job title from Director of Workforce to Chief People Officer, to include the differentiation between the 'main' and 'deep dive' meeting and to more explicitly indicate the quorum requirements)
- Amended Terms of Reference approved by Trust Board: 29th April 2021
- Terms of Reference agreed by the People and Organisational Development Committee, 25th March 2022 (as part of the annual review)
- Amended Terms of Reference approved by Trust Board, 31st March 2022
- Terms of Reference agreed by the People and Organisational Development Committee, 23rd September 2022 (to include the Wellbeing Guardian within the Committee's membership)
- Amended Terms of Reference approved by Trust Board, 29th September 2022
- Terms of Reference agreed by the People and Organisational Development Committee, 24th March 2023 (as part of the annual review)
- Amended Terms of Reference approved by Trust Board, 30th March 2023

- Terms of Reference agreed by the People and Organisational Development Committee, 24th May 2024 (as part of the annual review)
- Amended Terms of Reference approved by Trust Board, 30th May 2024

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – MAY 2024

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (JANUARY TO MARCH 2024)	**GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period January -March 2024

- During this period there were a **total of 85** exception reports
- 85 exception reports were made due to **work schedules**.
- 2 exception reports were made due to **patient safety** – all related to inadequate staffing levels (*so counted within work schedule ER numbers*)
- 0 exception reports were related to missed educational opportunities

Reason for circulation to People and Organisational Development Committee
Assurance

Reporting Period: January to March 2024

Exception Reports-Patient Safety related

Specialty	Grade	No. Exceptions raised
General Medicine	CT3	1
Haematology	ST7	1
Total		2

Exception Reports-Work Schedule related

Specialty	Grade	No. Exceptions raised
Acute medicine	FY1	1
Anaesthetics	FY1	1
Anaesthetics	CT3	1
Cardiology	FY1	1
Clinical oncology	ST£	2
General Medicine	CT1	2
General Medicine	CT2	3
General Medicine	CT3	2
General Medicine	FY1	36
General Medicine	FY2	9
General Surgery	FY1	3
Haematology	ST3	8
Haematology	ST7	3
O&G	ST1	1
O&G	ST2	2
O&G	ST3	1
O&G	ST6	1
T&O	FY1	5
T&O	FY2	2
Urology	FY1	1
Total		85

Exception Reports-Educational Opportunities missed

NA

Comparison to last quarterly report (Oct to Dec 2023)

There was a decrease in ERs of 38%,

From 137 ERs Oct-Dec 2023 to 85 ERs Jan-Mar 2024

Comparison to the same quarter last year (Jan to Mar 2023)

There was a decrease in ERs of 7%,

From 91 ERs Jan – Mar 2023 to 85 ERs Jan – Mar 2024

Work Schedule Reviews

NA

Fines

NA

Report commentary

During the period January to March 2024 there were a total of 85 exception reports
85 were Work Schedule related/extra hours worked
2 were due to patient safety. These were double counted with the work schedule related exception reports.
Pleasingly there were none due to missed educational opportunities

I attend several junior forums and they are all I believe aware of the need to exception report where necessary therefore I see the reduction in numbers hopefully as a reflection of improving adherence to the trainee's contract.

The largest number of reports is still in medicine
This is particularly at the FY1 level (36).The majority of these where reports for overtime. Mostly for an hour. The majority of reasons given were finishing documentation/administrative tasks. In a few cases they were for dealing with a sick patient or talking to relatives.

I will continue to engage with the medical directorate in particular in order to see if these figures can be improved still further.

I am pleased to update that the process for exception reporting for non-training grades has progressed, the medical staffing team have now emailed all LEDs to explain the move to including exception reporting for them. Medical Staffing are now in the process of adding user details to the system to allow access to exception reporting. Further detail to follow.

Dr Tim Bell
Guardian of safe working

Audit and Governance Committee, 14/05/24 **Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met, virtually via web conference, on 14th May 2024.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed.
   - The Director of Quality Governance and Head of Risk Management attended for the latest **review of the Trust's red-rated risks** wherein an initial review was conducted of the Terms of Reference for the Risk and Regulation Committee, with feedback provided by Committee members; and a discussion was held regarding the risk management improvement plan. It was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should provide the Head of Risk Management with examples of accompanying guidance which was utilised by other Tiaa Ltd clients for 5 x 5 risk scoring matrix.
     - ❖ The Committee was **assured** that although further work was required; an initial roadmap to improve the Trust's risk management processes had been developed.
   - The Committee received the **Internal Audit Annual Report for 2023/24** (incl. the draft Head of Internal Audit Opinion) and an **Update on progress with the Internal Audit plan for 2024/25** (incl. progress with actions from previous Internal Audit reviews) and a discussion was held under the latter regarding the Limited Assurance review of Outpatients Utilisation and the two key recommendations related to improving clinic utilisation and ensuring that a minimum of six-weeks' notice was provided for clinic cancellation. It was agreed that the Assistant Trust Secretary should ensure that the recommendations from the Limited Assurance review of outpatient utilisation were considered as part of the "Update on the outpatients transformation…" item at the May 2024 Finance and Performance Committee and the outputs of the discussion were reported to the Audit and Governance Committee.
   - The Committee reviewed the Counter Fraud Annual Report for 2023/24.
   - The **Informing the audit risk assessment for Maidstone & Tunbridge Wells NHS Trust 2023/24 – The Trust's response** and **the Chair's Response** were reviewed and it was agreed under the former that the Director, Audit, Grant Thornton UK LLP should provide the Trust Secretary's Office with details of the outstanding climate change related external audit inquiry, to enable the response to be reported to the June 2024 Audit and Governance Committee meeting.
   - The Director, Audit, Grant Thornton UK LLP provided a verbal **Audit Progress Report and Sector Update from External Audit** which provided assurance regarding the engagement from the Trust as part of the External Audit process.
   - The Interim Trust Secretary presented that **draft Annual Report for 2023/24** which included the **Annual Governance Statement** and it was agreed that the Interim Trust Secretary should liaise with the Chief Executive to consider inclusion of a statement related to the Fuller Inquiry within the "A message from the Chair of the Trust Board and Chief Executive" section of the Annual report for 2023/24.
   - The Head of Financial Services presented the **draft Annual Accounts for 2023/24** (incl. latest losses & compensations data) wherein further details were provided regarding the approach to the Private Finance Initiative (PFI) remeasurement under International Financial Reporting Standard (IFRS) 16
   - The Committee approved the **"Audit and Governance Committee Annual Report for 2022/23",** subject to the amendments requested by the Director of Audit, Tiaa Ltd (Head of Internal Audit), which will be submitted to the Extraordinary 'Part 1' Trust Board meeting in June 2024 as part of the assurances required, by the Trust Board, for approval of the Trust's Annual Report and Accounts for 2023/24.
   - The Committee reviewed and was assured regarding the **Trust's compliance with the NHS Providers Licence.**
   - The Committee received **assurance of compliance with the Fit and Proper Persons Test Requirements**; which has been submitted to the Trust Board under a separate agenda item.
   - The **latest single tender / quote waivers data** were noted.

- The Committee reviewed the **Security issues annual report** which has been submitted to 'Part 2' Trust Board meeting, as a supplementary report, for information, due to the confidential nature of the information contained therein.
- The Director of IT, Cyber-Security Architect and Head of Information Governance attended for the latest **update on Cyber Security**.
  - ❖ The Committee was **assured** that the Trust continues to response to any cyber security developments

2. **The Committee received details of the following completed Internal Audit reviews:**
   - "Outpatient utilisation" (which received a "Limited Assurance" conclusion due the cancellation notice period that was provided for some clinics and the further work to ensure any cancelled appointments were utilised)
   - "Follow Up of Bed and Trolley Management" (which received a "Substantial Assurance" conclusion)
   - "Payroll" (which received a "Reasonable 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):** The Director of Audit, Tiaa Ltd (Head of Internal Audit) should ensure that the "Education on the key areas for consideration in regards to Artificial Intelligence (AI)" item included the considerations required in relation to the Trust's procurement approach.

5. **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

To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review) — **Interim Trust Secretary**

The annual review of the Remuneration and Appointments Committee's Terms of Reference is overdue, as the Trust Board last approved the Terms of Reference in April 2023. The review has been awaiting the scheduling of the Remuneration and Appointments Committee's next meeting, but as no future meetings are currently scheduled, it has been agreed that the Terms of Reference should be submitted directly to the Trust Board, for approval.

The Interim Trust Secretary has reviewed the Terms of Reference and confirmed that they remain fit for purpose. The Trust Board is asked to approve the continuation of the current Terms of Reference.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval of the continuation of the Terms of Reference to the Remuneration and Appointments Committee

[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

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- The Chair of the Trust Board (Chair of the Committee)
- All Non-Executive Directors

The Vice Chair of the Committee will be the Vice Chair of the Trust Board.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chair and two Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Chief Executive
- Chief People Officer
- Associate Non-Executive Directors

Other staff may be invited to attend, to meet the Committee's purpose and duties.

5. Frequency of Meetings

Meetings will be scheduled according to need, but there will be a minimum of one meeting per year.

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 To review, on behalf of the Trust Board as required, the remuneration, allowances and terms of service of the Executive Directors[3], to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

6.3 To review, with the Chief Executive, the performance of the Executive Directors.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of the Trust's Standing Financial Instructions and national guidance, as appropriate. Any non-contractual payment to an Executive Director must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant changes to remuneration e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[4].

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[2] Department of Health, 1994 (and subsequent revisions)

[3] The Executive Director roles are defined within the Trust's Standing Orders

[4] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff

7. Parent Committee and reporting procedure

The Remuneration and Appointments Committee is a sub-committee of the Trust Board.

The Chair of the Remuneration and Appointments Committee will determine the extent (and format) to which the activities of the Committee are reported to the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference

9. Administration

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

The Committee will be serviced by administrative support from the Trust Secretary.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration and Appointments Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted the Committee's Vice Chair or the Chair of the Audit and Governance Committee. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

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

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 25/01/17
- Revised Terms of Reference approved by the Trust Board, 22/02/17
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 23/01/18
- Revised Terms of Reference approved by the Trust Board, 01/03/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 29/03/18 (to list Chief Executive among those invited to attend each meeting, and note the change in secretariat function)
- Revised Terms of Reference approved by the Trust Board, 26/04/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/12/19
- Revised Terms of Reference approved by the Trust Board, 30/01/20
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/11/20
- Revised Terms of Reference approved by the Trust Board, 26/11/20
- Revised Terms of Reference approved by the Trust Board, 24/02/22
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 30/03/23 (annual review)
- Revised Terms of Reference approved by the Trust Board, 27/04/23 (annual review)
- Revised Terms of Reference approved by the Trust Board, 30/05/24 (annual review)

NHS Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 1, 2024/25, is enclosed, along with the 'A3' for staff turnover, the monthly finance report, and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 28/05/24

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

April 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

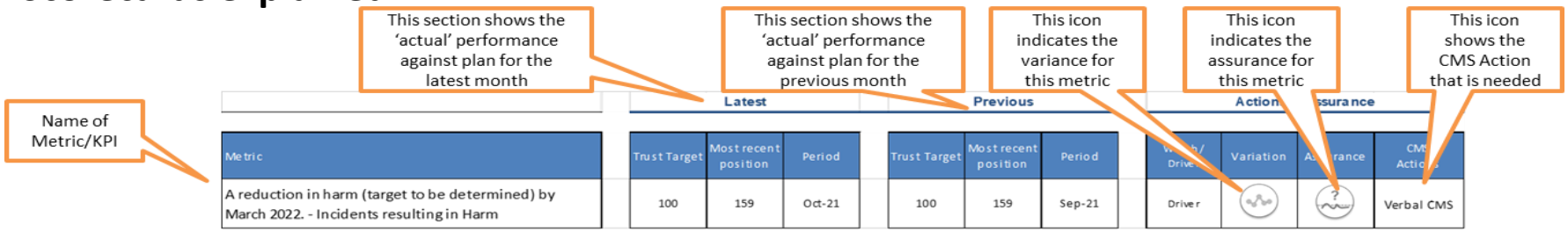
Escalation Rules:

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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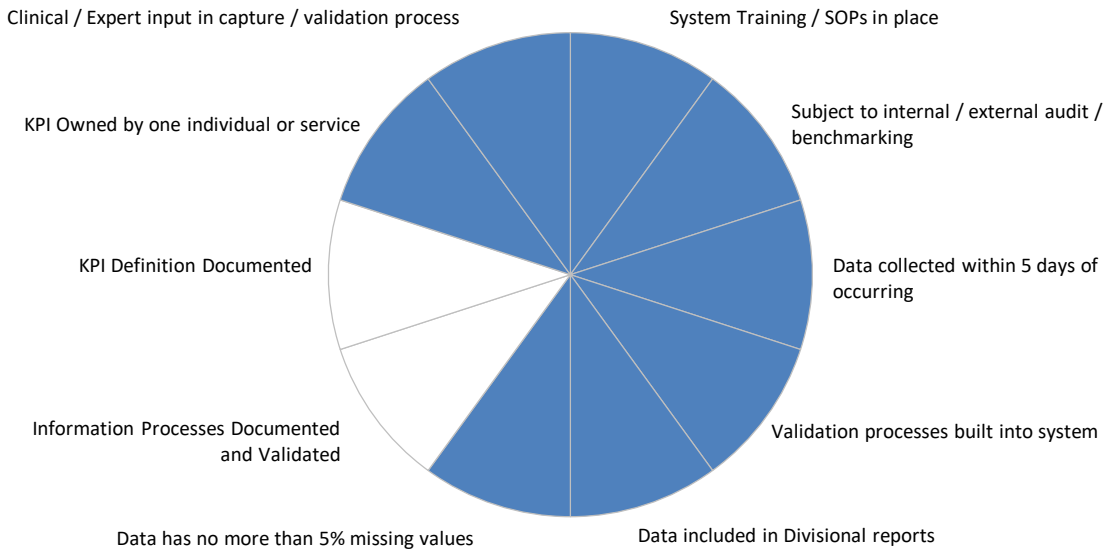
Forecasts

	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 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 slightly above the 8% plan at 8.5%. This is mainly due to the establishment added for the new financial year. Turnover Rate continues to experience special cause variation of an improving nature, achieving the maximum level target at 11.5%. Agency spend did not achieve the target for April 24 but continues to experience special cause variation of an improving nature. 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 improved further to 99.3% and has now passed the target for more than six consecutive months. Sickness levels improved in March 24, achieving below the maximum limit at 3.8%. This metric is therefore now experiencing common cause variation and variable achievement of the target. Statutory and Mandatory Training improved further in April, now experiencing special cause variation of an improving nature and passing the target for more than six months. The percentage of staff Afc 8c or above that are BAME continues to experience common cause variation and consistently failing the target. The Trust continues to implement a number of actions to improve performance is this area. The Trust was £1.9m in deficit in the month which was £0.7m adverse to plan

The rate of incidents causing patients moderate or higher harm remains in common cause variation and variable achievement of the target. The breakthrough indicator for this strategic theme is currently being reviewed and therefore no data is shown 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 improved in April 24 but continues to experience common cause variation and failing the target for more than six months. The Rate of E.Coli is now experiencing special cause variation of an improving nature and has passed the target for more than six months. The Rate of Falls per 100,000 occupied beddays was slightly above the maximum limit in April but remains in common cause variation and variable achievement of the target. Both the total number of complaints and the number of complaints related to communication issues are now experiencing special cause variation of an improving nature and variable achievement of the target. Complaints response times improved a little in April but continues to experience common cause variation and failing the target for more than 6 months. Friends and Family Response rates have been adversely affected by the change in service provider for the collection of responses and there is limited data available as a consequence. The new service provider is now in place (end of May 24) and therefore performance is expected to improve from June 24.

Diagnostic Waiting Times was below the target for April 24 at 96.3% but continues to experience special cause variation of an improving nature. Focus work continues for the two modalities mostly affecting the overall under-performance. With regards to RTT the Trust is now providing system support (SYS) to other Trusts across Kent and Medway which means that some of their longer waiting patients have been added to our waiting list for us to treat in order to ensure that these patients are treated as quickly as possible. This will therefore adversely affect the Trust's performance that is reported nationally. We are therefore now showing the Trust's performance both with and without these patients included in this report but are only applying the Business Rules to the performance excluding these patients. RTT achieved the trajectory target for April 24 of 73.6% at 75.0% (Excluding SYS). Nationally we reported 74.66% (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 April 24 (Excluding SYS). Nationally we have reported 166 52 week breaches at the end of April 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). In April 24 an additional 172 > 40 weeks breaches were added (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, however this indicator is forecasted to achieve the target by July 2024. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute has improved further to 84.8% in April 24 and is experiencing special cause variation of an improving nature. Diagnostic Imaging activity levels were above plan and 1920 levels in April 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 April 2024. Both are continuing to experience common cause variation and passing the target for more than six consecutive months.

The number of patients leaving our hospitals before noon continues to experience common cause variation and consistently failing the target. The 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 improved further in April 24 and continues to experience special cause variation of an improving nature. Ambulance Handovers <30mins improved further in April 24 and 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 April 24 at 84% but 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 as well as the 28 Day faster diagnosis compliance standard. The 31 day first definitive treatment is now a combined standard for which the Trust has now achieved the National target of 96% for this standard in March 24. 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 experiencing special cause variation of an improving nature and consistently failing the target. A project is underway 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 common cause variation. Category 1 <30mins has failed the target for more than six months and Category 2 <75 mins is consistently failing the target. Improvement activity was implemented following the CQC inspection and an A3 project has been started 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)

Patient Access:
- RTT Performance (P.17)
- Outpatient Calls answered <1 minute (P.18)
- Outpatient Clinic Utilisation (P.18)
- Emergency Admissions in Assessment Areas (P.18)
- Cancer 31 Day Standard (Combined) (P.18)

Patient Experience:
- New Complaints Received (P.20)*
- Complaints responded within target (P.21)
- FFT Response Rates: All areas (P.21)

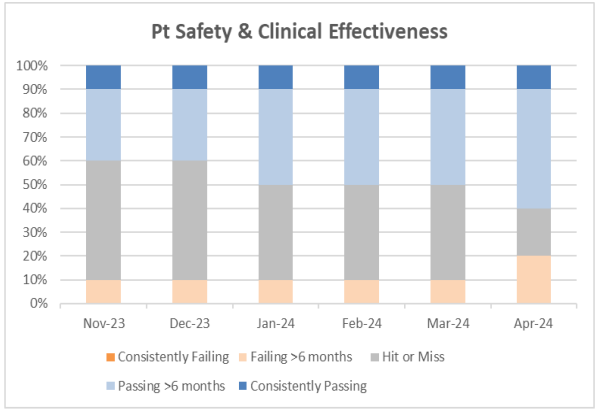
Systems:
- Discharges before Noon (P.23)

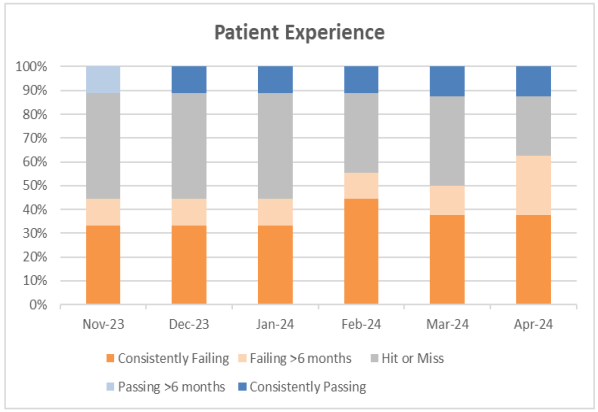
Sustainability:
- Agency Spend (P.25)

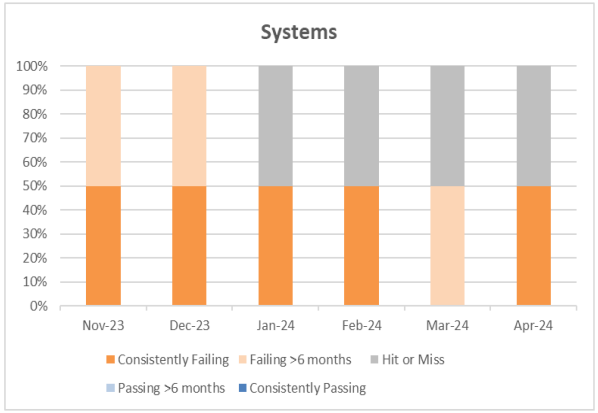
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.27)
- Women waiting for Induction of Labour <4 Hrs (P.27)
- Decision to delivery interval Category 1 caesarean (P.27)
- Decision to delivery interval Category 2 caesarean (P.27)
- Registerable Births (P.27)

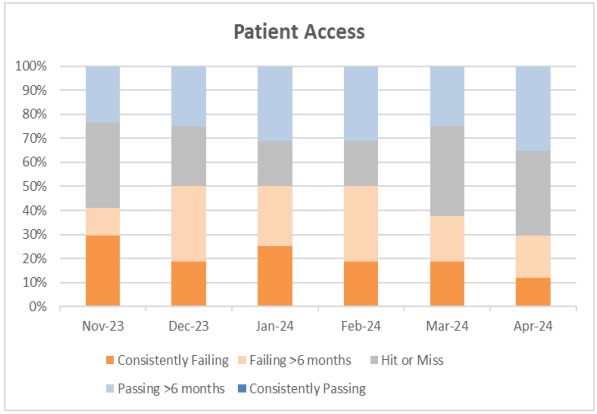
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

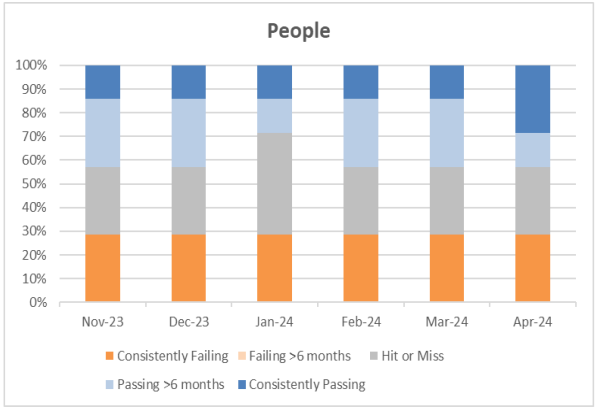
Assurance Stacked Bar Charts by Strategic Theme

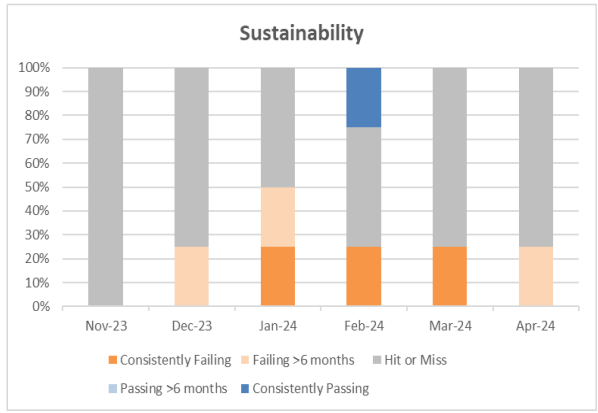












Matrix Summary

April 2024

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability	Statutory and Mandatory Training Standardised Mortality HSMR Never Events Safe Staffing Levels (Nursing) IC - Rate of Hospital E.Coli per 100,000 occupied beddays Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) Transformation: % of Patients Discharged to a PIFU Pathways	Reduce the Trust wide vacancy rate to 8% Access to Diagnostics (<6weeks standard) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) To reduce the overall number of complaints or concerns each month To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	Reduce Turnover Rate to 12% Achieve the Trust RTT Trajectory (Excluding SYS) Transformation: CAU Calls answered <1 minute
Common Cause	Summary Hospital-level Mortality Indicator (SHMI) Complaints Rate per 1,000 occupied beddays	To achieve the planned levels of new outpatients activity (shown as a % 19/20) Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	Sickness Absence IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days RTT Patients waiting longer than 40 weeks for treatment (Excluding SYS) A&E 4 hr Performance Flow: Ambulance Handover Delays >30mins To achieve the planned levels of outpatients follow up activity (shown as a % 19/20) Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Cash Balance (£k) Capital Expenditure (£k)	Percentage of AfC 8c and above that are BAME IC - Rate of Hospital C.Difficile per 100,000 occupied beddays Cancer - 31 Day First (New Combined Standard) - data runs one month behind Flow: % of Emergency Admissions into Assessment Areas % complaints responded to within target	Percentage of AfC 8c and above that are BAME Friends and Family (FFT) % Response Rate: Maternity To increase the number of patients leaving our hospitals by noon on the day of discharge
Special Cause - Concern				Friends and Family (FFT) % Response Rate: Inpatients	Friends and Family (FFT) % Response Rate: A&E Friends and Family (FFT) % Response Rate: Outpatients

Strategic Theme: People

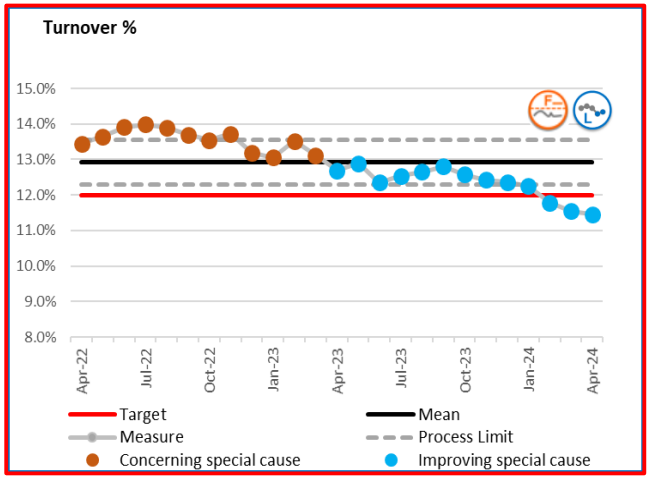
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 8%		8%	8.5%	Apr-24	8%	5.0%	Mar-24	Driver			Note Performance	5.1%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	11.5%	Apr-24	12%	11.5%	Mar-24	Driver			Full CMS	11.4%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	3.8%	Mar-24	4.5%	4.2%	Feb-24	Driver			Not Escalated	3.93%		
	Well Led	Statutory and Mandatory Training		85.0%	90.2%	Apr-24	85.0%	89.7%	Mar-24	Driver			Not Escalated	90.67%		
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	71.9%	Apr-24	62.0%	72.1%	Mar-24	Driver			Not Escalated	75.58%		
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	5.8%	Apr-24	3.2%	5.7%	Mar-24	Driver			Not Escalated	6.45%		
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	6.5%	Apr-24	12.0%	6.4%	Mar-24	Driver			Escalation	6.67%		

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

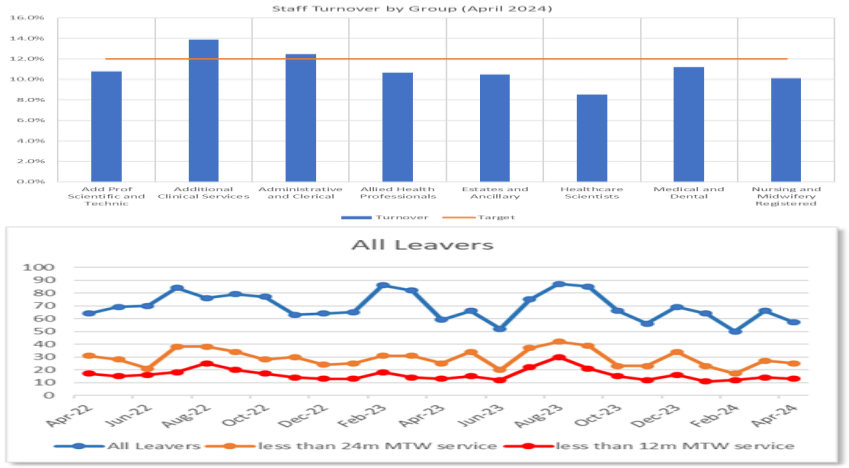
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Apr-24
11.46%
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and is consistently failing the target
Max Target (Internal)
12%
Business Rule
Full CMS

2. Stratified Data



3. Top Contributors & Risks

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

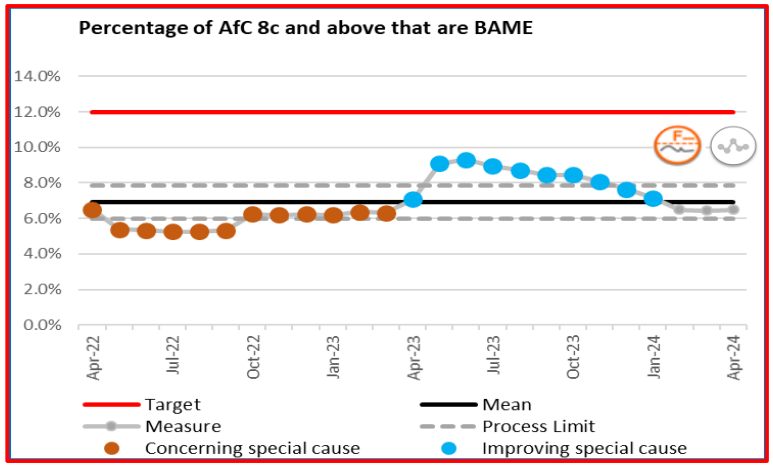
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership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

4. Action Plan

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

Countermeasures	Target Completion Date
Continuation of end to end Recruitment Transformation, to reduce time to hire metrics	Sep-24
Combined new starter, recruitment and induction surveys to create the onboarding survey, and data is now available on a monthly basis	May-24
Continue to develop A3 to target reducing the number of leavers who have been with the Trust for 24 months or less	Jun-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	Jun-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)	Jun-24

People – Workforce: CQC: Well-Led



Apr-24
6.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (National)
12%
Business Rule
Full Escalation

Summary:	Actions:	Assurance & Timescales for Improvement:
% of AfC 8c and above that are BAME: This metric is experiencing common cause variation and consistently failing the target.	% of AfC 8c and above that are BAME: (NB: These are not rapidly changing indicators). As at April 24 the current number of staff (WTEs) that are AfC 8c and above is 139 (Mar 24: 140, Nov 23: 136). Of these 7 ((Mar 24:7, Nov 23: 7) have a disability , 9 (Mar 24: 9, Nov 23: 11) are BAME and 100 (Mar 24: 100, Nov 23: 96) are female. **Actions:** Training for People Business Partners took place on 16/05/2024 then they will start working with the recruiting managers for 8b and above from w/c 20/05/2024. They will be better able to challenge and support recruiting managers in all stages of the recruitment process to ensure an appropriate pipeline of candidates at all stages. This should give more focus to inclusive recruitment practices. Various actions have been undertaken during 23/24. This included developing and delivering, initially targeting managers in Divisions with high turnover. A more comprehensive end of year update on actions is provided in the next column, with relevant actions continuing in 24/25 to sustain performance and improvement:	% of AfC 8c and above that are BAME: The following was an end of year update, with relevant actions continuing in 24/25 to sustain performance and improvement. (These measures will also help with % of AfC staff below 8c that are BAME: • Developing and empowering our vibrant staff networks - MTWProud, Cultural and Ethnic Minorities Network, DisAbility Network, Parental Responsibility Network, Chronic pain support group, neurodiversity support group, clinically extremely vulnerable support network, menopause support group and recently re-launched Senior Women Leaders. • Representation from our staff networks on the EDI Steering Group, Health and Wellbeing Committee and various stakeholder interview panels ensuring the voices of our minority staff are heard. • Developing interactive workshops on inclusive recruitment and allyship. • Delivering interactive sessions on bias, micro aggressions and advancing cultural competence. • Increasing the number of EDI recruitment representatives to help raise awareness of and offer peer to peer support for inclusive recruitment. • Ensuring equality objectives are in place for the Trust Board. • A mentoring programme to help address the gap in representation of ethnic minority staff in senior roles • A focus on inclusive recruitment in bands 8b and above to address the gap in ethnic minority and disabled staff representation. • Participating in Step into Health programme which helps those leaving the Armed Forces to access employment opportunities in the NHS. • A second cohort of reverse mentoring which enables staff from ethnic minority backgrounds and those with long term health conditions share their experiences with senior colleagues including our Trust Board and Divisional Leaders

Strategic Theme: Patient Safety & Clinical Effectiveness

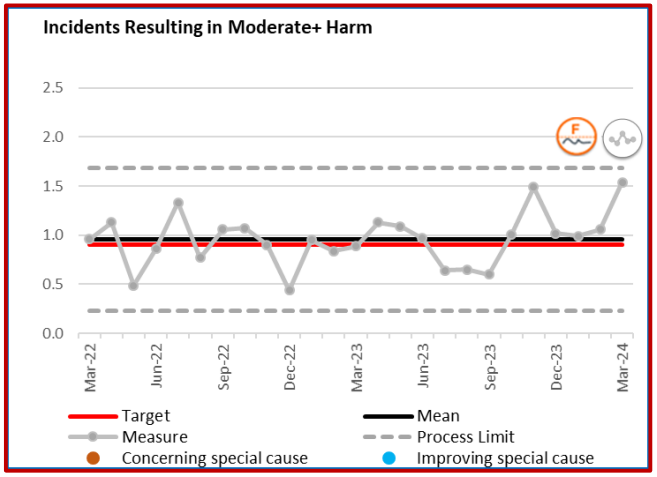
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.54	Mar-24	0.90	1.06	Feb-24	Driver			Full CMS	1.15 May 24		
Breakthrough Objectives	Safe	Number of Deteriorating Patients with Moderate+ Harm (data runs one month behind)		TBC	TBC	TBC	TBC	TBC	TBC	Driver	No SPC	No SPC	Verbal CMS	TBC	No SPC	No SPC
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	1	Apr-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	14	Apr-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	1	Apr-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	85.6	Jan-24	100.0	85.6	Dec-23	Driver			Not Escalated	86.4		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	94.9	Jan-24	100.0	93.8	Dec-23	Driver			Not Escalated	96.4		
	Safe	Never Events		0	0	Apr-24	0	0	Mar-24	Driver			Not Escalated	0		
	Safe	Safe Staffing Levels (Nursing)		93.5%	99.3%	Apr-24	93.5%	98.2%	Mar-24	Driver			Not Escalated	99.1%		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	26.2	Apr-24	32.6	15.4	Mar-24	Driver			Not Escalated	10.3		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	36.7	Apr-24	25.5	46.3	Mar-24	Driver			Escalation	50.4		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	1	Apr-24	0	0	Mar-24	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	6.9	Apr-24	6.4	6.0	Mar-24	Driver			Verbal CMS	5.9		

Vision: Counter Measure Summary

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

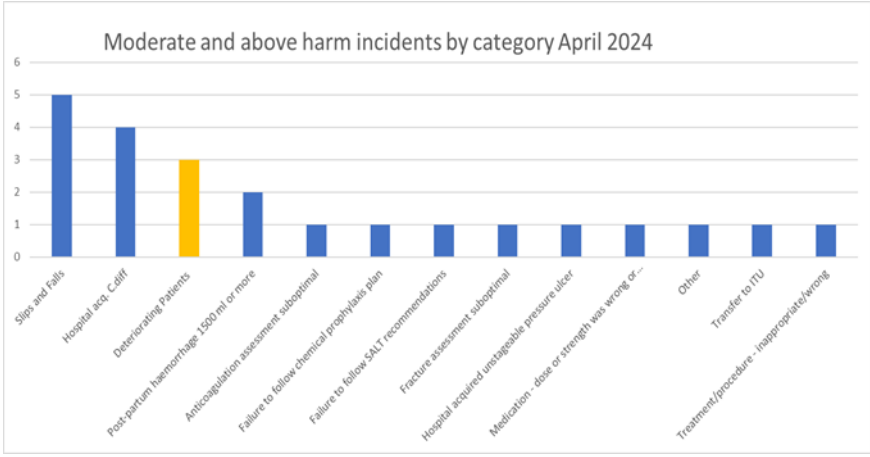
Owner: Sara Mumford
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

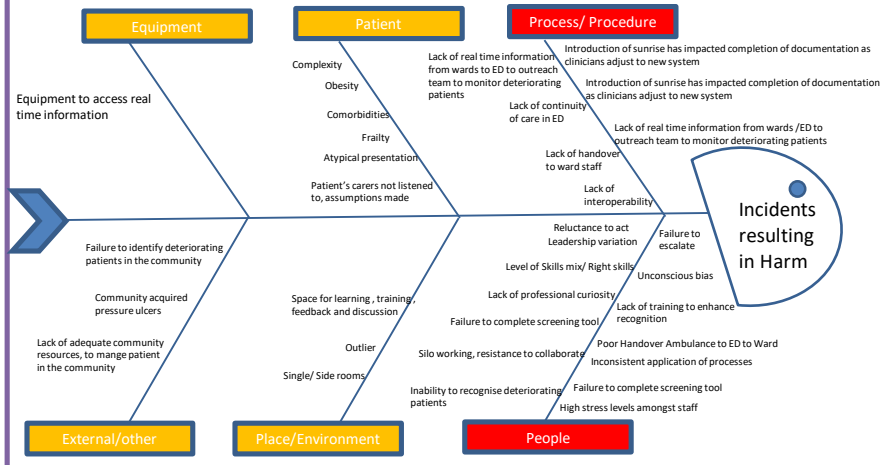


Mar-24 (1 month arr)
1.54
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



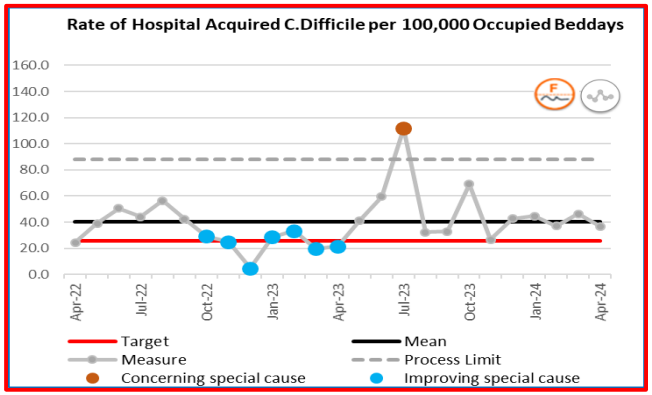
3. Top Contributors



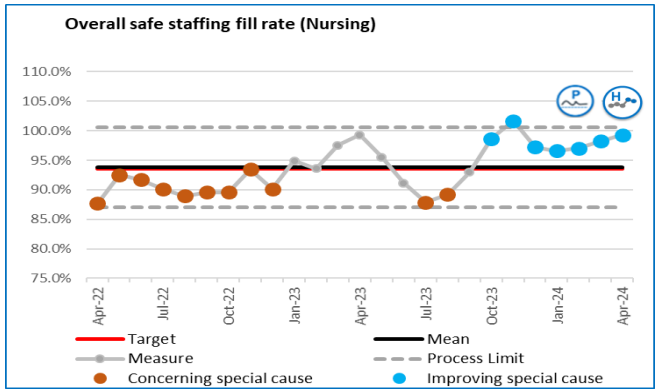
4. Action Plan

solution /countermeasure	Owner	Due By
Key Update:		
ITU Referral Form: now live on EPR and working well.	Henry Boyle	
HASU/ASU peri-arrest call reduction: there is now a monthly MDT simulation and education programme being delivered, to increase confidence in managing a deteriorating patient	Paul Abdey	
Business Case for Deteriorating Patients Nurse Lead – approved at BCRP		
Updated TEP live on Sunrise	Henry Boyle	
Next Steps:		May
JD for Deteriorating patient nurse lead awaiting banding panel	Sara Mumford	May
Data collection for deteriorating patients (sepsis, NEWS triggers/escalations)	Anna Spyrka	
Update ED sepsis report template to provide richer data	Jo Kelly/Jo Wade	May
Raising awareness and training on use of 2222 form	Chief Registrars	
Comms strategy for deteriorating patient project being developed		
Issue		
Lack of uptake and use of 2222 per-arrest form	Paul Abdey	
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 Team	

Patient Safety and Clinical Effectiveness: CQC: Safe



Apr-23
36.7
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Target
25.5
Business Rule
Escalated as failed target for 6+ months



Apr-24
99.3%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and has achieved target for >6 months
Target (National)
93.5%
Business Rule
Shown for info

Summary:

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

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

Actions:

Infection Control: The C.diff rates during April remain higher than expected with 8 cases. The majority of cases are being seen at TWH and 4 avoidable cases in April due to inappropriate antibiotics. Actions being taken include.

- A Trust wide incident meeting scheduled for the 3rd May to help identify further actions to support a reduction in cases.
- Avoidable cases presented and discussed at PSIRG
- Deep cleaning planned as soon as escalation capacity becomes available
- 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
- Review of bed turn around team to ensure that standards are being met and maintained

Safe staffing Fill Rate:

- The senior corporate nursing team have met with Divisions as finance for the 2022/23 Establishment review business case has now been released. Budgets have been aligned and posts are now being recruited into.
- Progress has been made on SafeCare being implemented in the CCC. Hardware is being scored and training is ongoing. This will provide Trust wide oversight of N&M staffing and patient acuity and dependency within the clinical areas.

Assurance & Timescales for Improvement:

Infection Control:

- Antimicrobial stewardship lessons learnt to be shared at Grand round and clinical teams
- 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

Safe Staffing Fill Rate:

- Oceans Blue system ward guardians reporting is currently being piloted for 11 inpatient areas. These are being reviewed in Rostering Confirm and Support meetings, giving oversight to compliance with Rostering KPI's.
- SafeCare training for the Clinical site teams has now commenced. This will support the live system can be utilised on a daily basis.
- An annual report of Rostering utilisation is currently being compiled. This will focus on annual leave usage, bank usage, roster finalisation, partial and full approval compliance and additional duties.

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)		73.6%	75.0%	Apr-24	75.8%	75.1%	Mar-24	Driver	H	F	Full CMS	76.2%	H	F
		Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		73.6%	74.7%	Apr-24	75.8%	75.1%	Mar-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)		123.4%	128.6%	Apr-24	131.9%	143.6%	Mar-24	Driver		P	Note Performance	121.0%	H	P
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		636	520	Apr-24	605	477	Mar-24	Driver		?	Not Escalated	580	L	P
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	172	Apr-24	N/A	0	Mar-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	166	Apr-24	N/A	0	Mar-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		97.6%	96.3%	Apr-24	99.1%	98.8%	Mar-24	Driver	H	?	Not Escalated	98.1%	H	F
	Responsive	A&E 4 hr Performance		86.4%	84.0%	Apr-24	88.6%	86.2%	Mar-24	Driver		?	Not Escalated	84.1%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	96.0%	Mar-24	96.0%	92.9%	Feb-24	Driver		F	Escalation	96.0%		F
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	86.2%	Mar-24	85.0%	85.3%	Feb-24	Driver	H	P	Not Escalated	85.5%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	79.8%	Mar-24	75.0%	80.1%	Feb-24	Driver		P	Not Escalated	80.3%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		80.0%	90.2%	Mar-24	80.0%	90.4%	Jan-24	Driver	H	P	Not Escalated	91.7%	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)

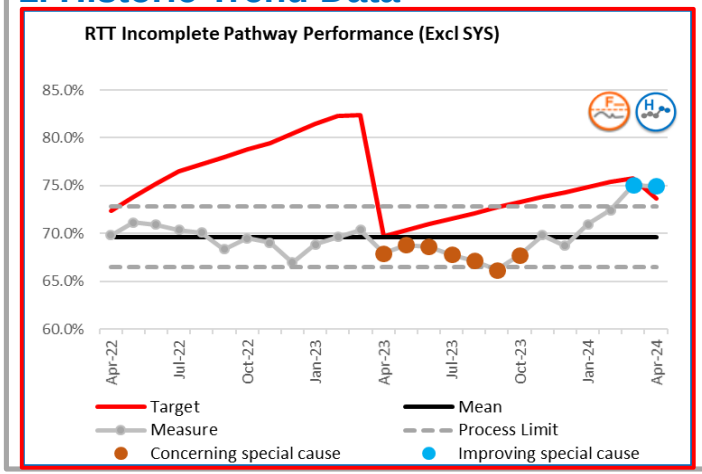
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	82.2%	Apr-24	85.0%	84.2%	Mar-24	Driver			Escalation	86.2%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		5.9%	6.5%	Apr-24	5.4%	6.7%	Mar-24	Driver			Not Escalated	7.2%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	84.8%	Apr-24	90.0%	83.1%	Mar-24	Driver			Escalation	90.1%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	4.0%	Apr-24	5.0%	4.5%	Mar-24	Driver			Not Escalated	5.0%		
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	62.0%	Apr-24	65.0%	62.4%	Mar-24	Driver			Escalation	61.3%		
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		110.1%	124.3%	Apr-24	144.2%	142.7%	Feb-24	Driver			Not Escalated	119.3%		
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)		109.9%	122.8%	Apr-24	113.1%	118.6%	Feb-24	Driver			Not Escalated	113.8%		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		144.4%	163.9%	Apr-24	169.7%	179.2%	Mar-24	Driver			Not Escalated	149.7%		

Vision: Counter Measure Summary

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

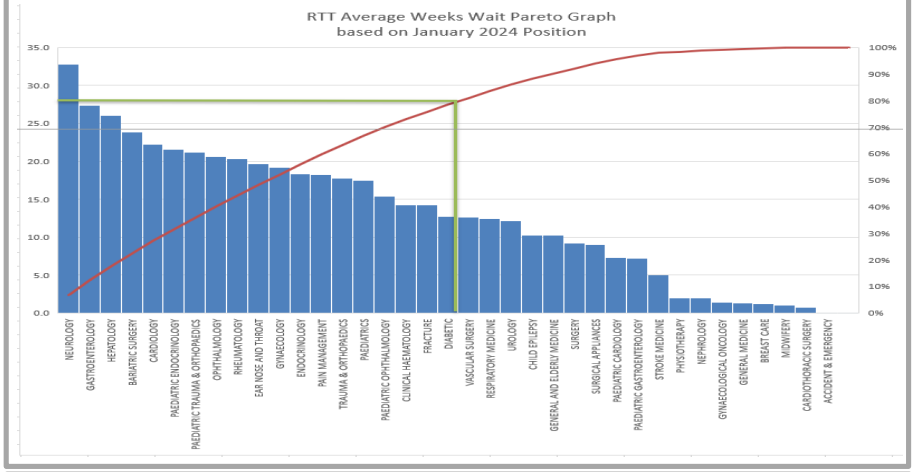
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Apr-24
75.0%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
73.6%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

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

- Long waits for 1st Outpatient appointment – average wait @19 weeks. Trust trajectory to reduce waits for first appointment being developed
- Achievement of activity targets for new outpatients and electives
- Follow ups without procedure above plan

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

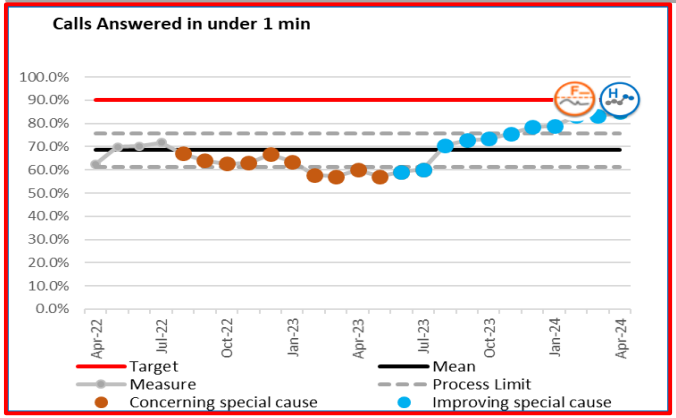
Key Risks:

- Waiting list growth could be affected due to increase in referrals and systems pressure.
- Trajectory assumes that Additional activity continues until end financial year, this could be impacted by financial position

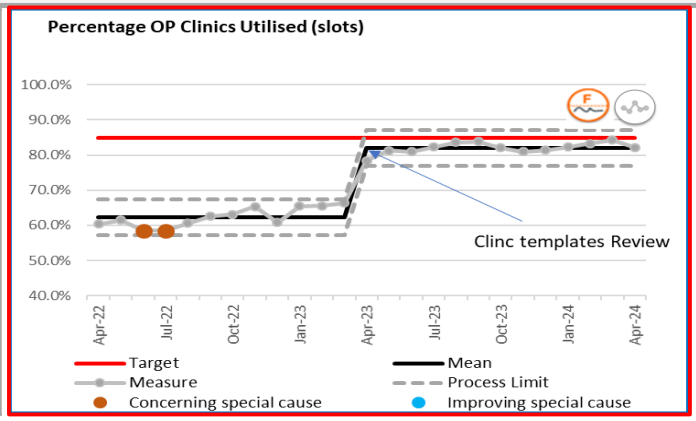
4. Action Plan

Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots Reduction in FUPS and replacing with News in T&O following clinical validation	SC	Mar24
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	Full roll out May 24
	Trust STT pathways pilot in Gen Surg/Gastro to reduce long waits for 1st Appointments	SC/GM's	March 24
DNA Reduction	Two Way Text roll out for adults/paeds. Reduction of DNA 1% = 432 less missed appts	SC	Sept 23✓
	Failed text reminder report developed to improve DQ	SC	March 24✔
Monitoring of over 40 weeks	Tuesday PTL and Trust Access Performance meeting. Additional PTLs for Gastro, Neuro & Gen Surg	Data Assurance Lead	Weekly and in progress✔
Recovery Plan	Full RTT recovery plan by end March- Reduction of 40wks, RTT trajectory, Training plan	SC	March 24
Review of Breakthrough Objective	Complete new A3 , review of data to understand biggest contributors to waits for first appointments	SD/SC/JT	April 24

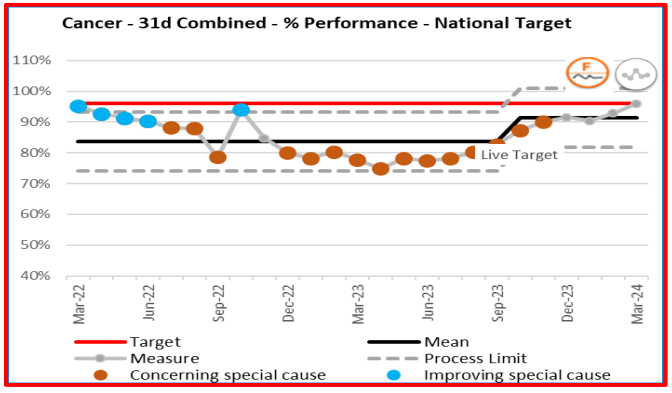
Patient Access: CQC: Responsive



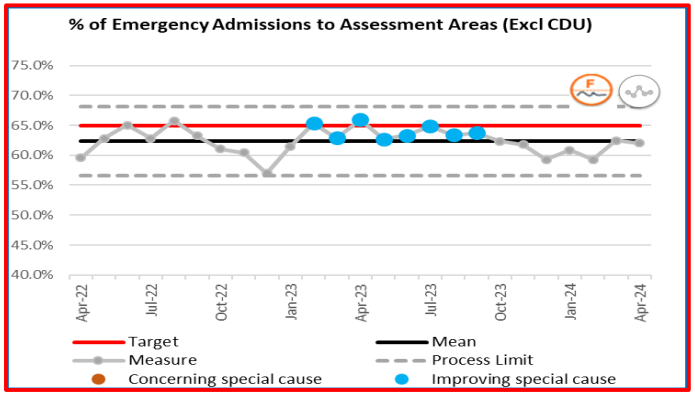
Apr-24
84.8%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target



Apr-24
82.2%
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



Mar-24 (one month behind)
96.0%
Variance / ,Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (National)
96%
Business Rule
Full escalation as has failed the target for 6+months



Apr-24
62%
Variance / Assurance
Metric is currently experiencing common cause variation and failing the target for 6+ months
Target (Internal)
65%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

Calls Answered <1 min: is experiencing special cause variation of an improving nature and remains consistently failing the target. The areas with the lowest rate is 2WW, Women & Children, Surgical Specialties, and T&O.

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

Cancer 31 day First Definitive (Combined): This National Standard has now changed and is a combination of the previous targets. This indicator is experiencing common cause variation and has failed the target for 6+months (however new target only in place from October 2023). **The Trust achieved the 96% National Standard for March 24**

% 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.

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.

Cancer 31 Day First Definitive (Combined): Detailed recovery plan in place to reduce waiting times for subsequent radiotherapy, as this is the area resulting in the most 31 day breaches. Additional staff now in place to allow consistent increase in capacity. Ongoing clinically led review of urology and breast pathways to create efficiencies.

% of Emergency Admissions to Assessment Areas (Excl CDU): Medical SDEC performance continues to be at above national standard of 33% of medical take with AFU and AEC taking over 48% of medical NE attenders. A trust wide working group for flow will have a focus on improvements in surgical SDEC including SAU pulling over night and OAU taking more patients from ED.

Assurance & Timescales for Improvement:

Calls Answered within 1 minute in the CAUs: Remain on upward trajectory, April new record performance achieved (84.8%). Focus on underperforming specialities to reach 90%.

Outpatient Slot Utilisation The aim is to ensure that no planned elective / consultant led clinic is under 85% utilised. Delay in cashing up impacting performance but closely monitored and flagged to specialities. DNA working group and speciality based GIRFT . A3 work to support improvement.

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

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

Strategic Theme: Patient Experience

				Latest			Previous			Actions & Assurance				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	41	Apr-24	36	38	Mar-24	Driver			Note Performance	37		
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	14	Apr-24	24	29	Mar-24	Driver			Note Performance	22		
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	2.2	Apr-24	3.9	2	Mar-24	Driver			Not Escalated	2.2		
	Caring	% complaints responded to within target		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	Mar-24	95.0%	TBC	Feb-24	Driver	No SPC	No SPC	Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	1.4%	Apr-24	25.0%	2.3%	Mar-24	Driver			Escalation	13.62%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	0.00%	Apr-24	15.0%	0.01%	Mar-24	Driver			Escalation	4.09%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	4.6%	Apr-24	25.0%	3.3%	Mar-24	Driver			Escalation	1.55%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	0.1%	Apr-24	20.0%	0.7%	Mar-24	Driver			Escalation	1.79%		

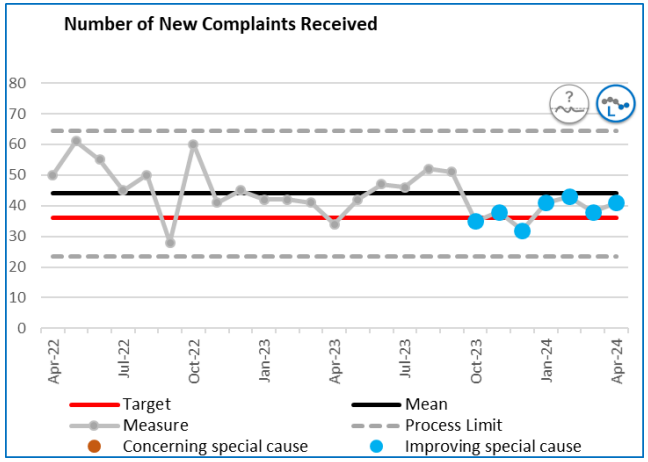
NB: There is no data available for VTE as there are some data quality issues that are been investigated. This metric will be reported again from next month once the issues have been resolved

Vision: Counter Measure Summary

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

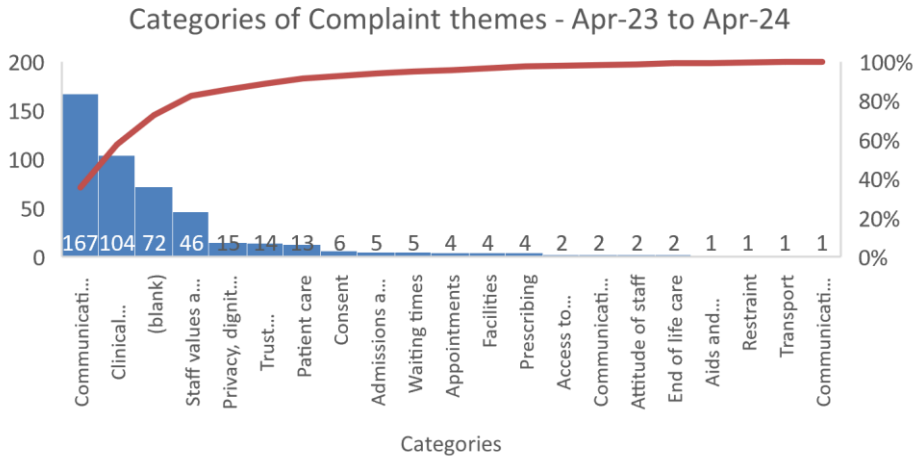
Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Apr-24
41
Variance Type
Metric is currently experiencing Special Cause Variation of a improving Nature
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.

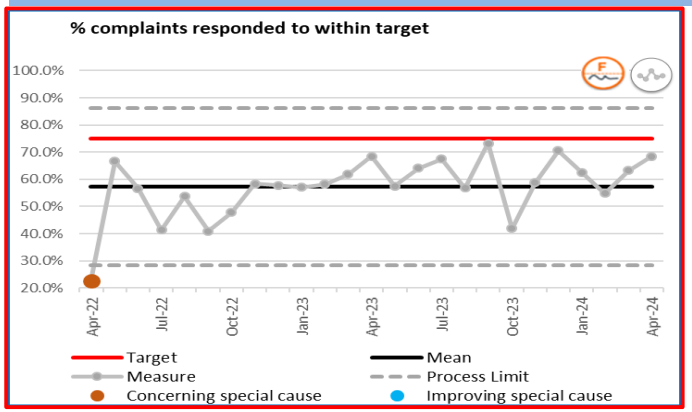
Key Risks:

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.

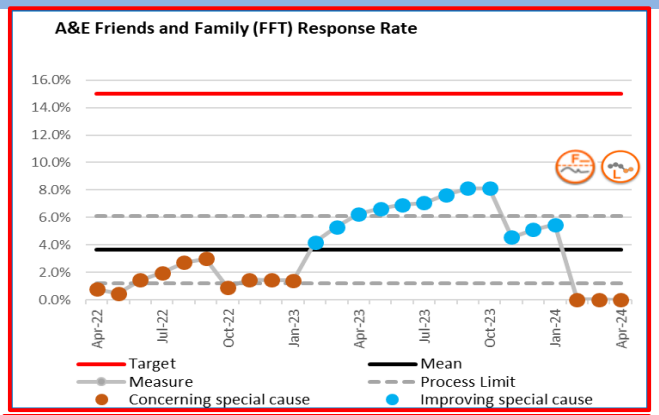
4. Action Plan of the Breakthrough Objective:

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	• Medicine and Surgery Action plan in the Implementation stage	RG,SM Divisional leads
Review of Communication theme from FFT	• Triangulate the data available from FFT, Complaints and PALS for continuing themes	RG, RS, SM, SJ
Outpatient Communication themes	• To discuss with OPD GMs – specific themes relating to Outpatients departments	RG, GD, SM

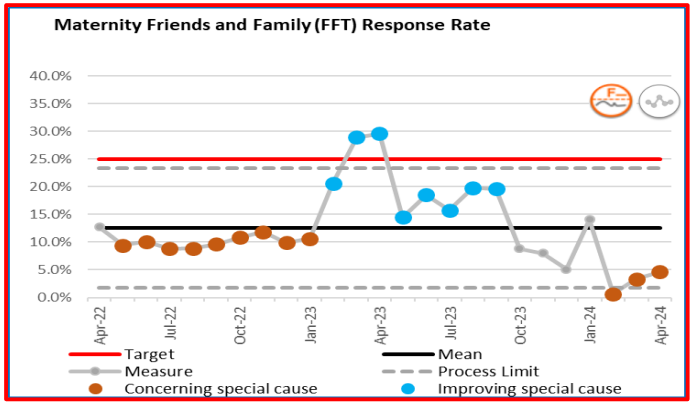
Patient Experience: CQC: Caring



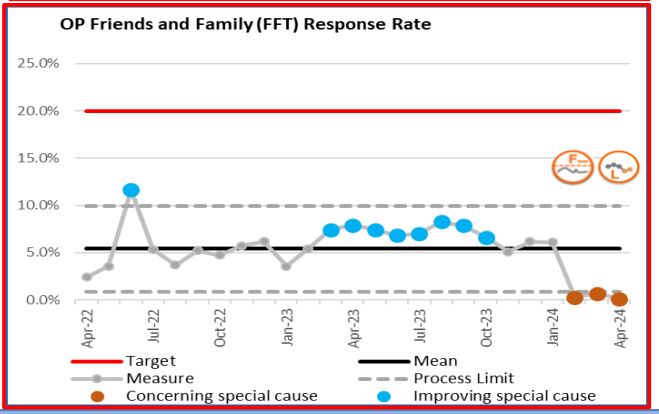
Apr-24
68.4%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Apr-24
0.01%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Apr-24
4.6%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Mar-24
0.0%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

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

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target. National Rate – 11.5%

Recommended Rate is 100%

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

National Rate – 12.2%

Recommended Rate is 100%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of a concerning nature and is consistently failing the target. National Rate – 2.4%

Recommended Rate is 97.5%

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

Actions:

Complaints Response Rate: Complaints performance recovery and stabilisation actions include:
Oversight meetings between complaints manager and DQG
Weekly meetings between complaints leads and the directorates
Business Case for revised complaints model/team provisionally approved
Recruitment ongoing to bolster the capacity of the Complaints team

A&E: Minimal FFT data available as trust was in the transition process and onboarding the new HCC provider. Survey monkey links were still available for patients to complete for April and deactivated the 10th of May 2024.

Maternity: Minimal FFT data available as trust was in the transition process and onboarding the new HCC provider. Survey monkey links were still available for patients to complete for April and deactivated the 10th of May 2024.

Outpatients: Minimal FFT data available as trust was in the transition process and onboarding the new HCC provider. Survey monkey links were still available for patients to complete for April and deactivated the 10th of May 2024.

Inpatients: Minimal FFT data available as trust was in the transition process and onboarding the new HCC provider. Survey monkey links were still available for patients to complete for April and deactivated the 10th of May 2024.

FFT Response All: For the month of April 156 responses were received through Survey monkey. 89.1% very good, 9% Good, 0.6% Poor or very poor (3 responses). Top3 positive themes were : Staff attitude, Implementation of care and Environment and Top 3 negative themes were : Staff attitude, environment and waiting times.

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: SMS Text messaging through HCC has been activated from 1st May 2024. Online surveys are also now available from the 10th of May. Awaiting FFT cards to be delivered to the Trust. Posters with QR codes to be deployed from the w/c 20th May. Interactive voice messages (IVM) build completed, awaiting Quality assurance.

The risk of embedding the new FFT provider has been mitigated and currently received 14.9% response rate since 1st of May 24. Positivity rate– 89%.

Strategic Theme: Systems

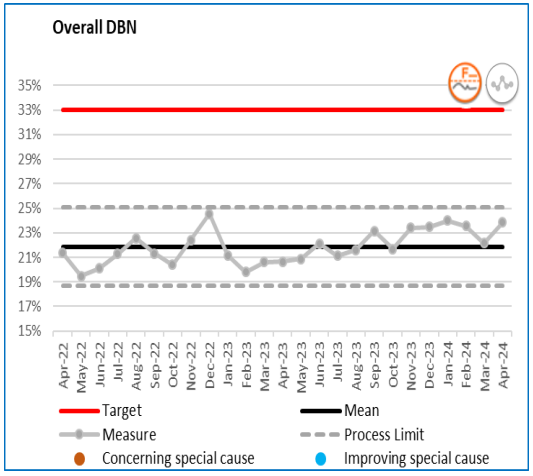
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)		3.5	1.9	Apr-24	3.5	2.0	Mar-24	Driver			Note Performance	2.2		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	23.9%	Apr-24	33.0%	22.1%	Mar-24	Driver			Full CMS	23%		

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

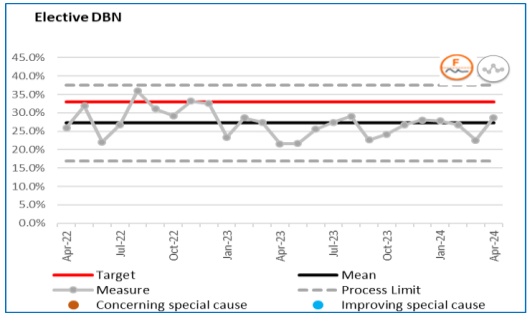
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

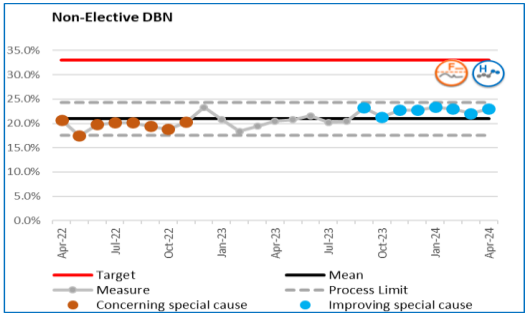
1. Historic Trend Data



Current Data Source: PAS
Apr-24
23.9%
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	• 3 weeks of pilot reviewing board rounds and discharge processes on surgical wards completed, following engagement piece. Move to improvement phase, next steps:
	  • Begin PFIS huddles on wards 30/31/32 relating to board round process & discharge planning
	  • Feedback back diagnostic/audit review of board round effectiveness to NIC team and then ward MDTs
	  • Begin pilot on MEC wards, Pye Oliver, Mercer & Whatman
	  • Develop board round clinical simulation proposal
		LS
		BC
		NP/BC/CI team
		BC/FR
			21/4 (and ongoing)
			22/24
			21/4
			Ongoing	

Criteria Led Discharge	• Explore opportunities for CLD development in: • KMOC • Gynae • ERAS related surgical pathways (Ward 32 and 11 patients)			In progress In progress
P3	• Project team and key stakeholders agreed with governance framework • Development of data pack/ Staff questionnaire returned and data analysed • Present state mapping of P3 finalised and agreed by all stakeholders • IDT / Therapy leads engaged with operational teams for agreement • 4 T&F groups identified with op leads incl. Transfer of Care Hub, Data process, Discharge Sit Rep, structure and SOP's • Teletracking report finalised for circulation • All T&F groups to develop goals, KPI's, action plans with project support	SF Teletracking/ FR SF AG/ JD SF FR	Feb 24 Mar 24 Apr 24 Apr 24 May 24 21/5/24	COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE In progress

Strategic Theme: Sustainability

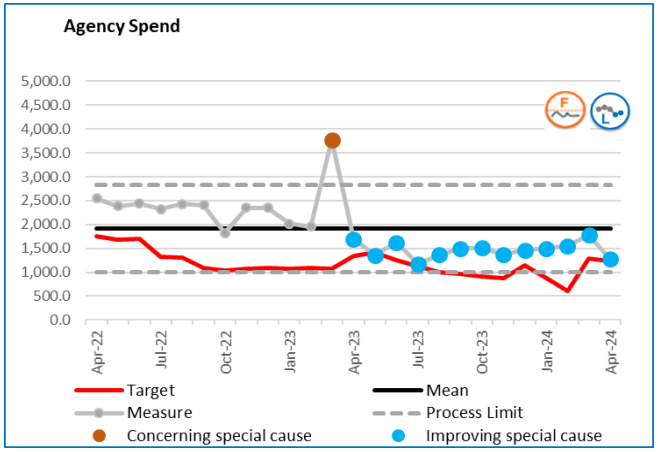
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-1,155	-1,903	Apr-24	864	-3,429	Mar-24	Driver			Verbal CMS	1189		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		1,235	1,278	Apr-24	1,292	1,777	Mar-24	Driver			Full CMS	997		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		1,899	970	Apr-24	3,694	1,446	Mar-24	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		7,608	8,634	Apr-24	2,000	11,947	Mar-24	Driver			Not Escalated	4822		
	Well Led	Capital Expenditure (£k)		1,029	771	Apr-24	2,944	36,679	Mar-24	Driver			Not Escalated	1450		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		TBC	11,004	Apr-24	123,606	133,787	Mar-24	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		TBC	2,658	Apr-24	30,153	29,057	Mar-24	Driver			Not Escalated			

Breakthrough: Counter Measure Summary

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

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

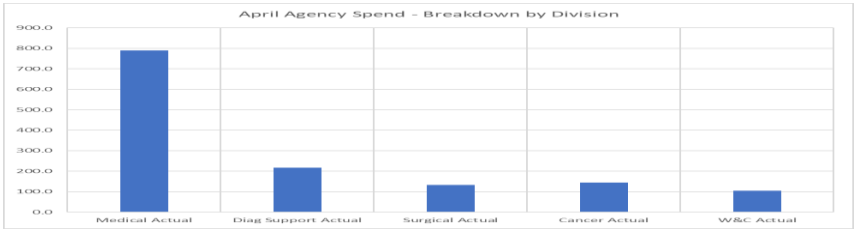
1. Historic Trend Data

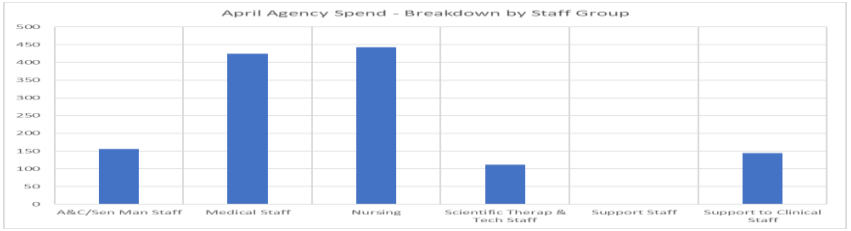


Apr-24
1,278
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
1235
Target Achievement
Metric has failed the target for > 6months

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

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

4. Action Plan

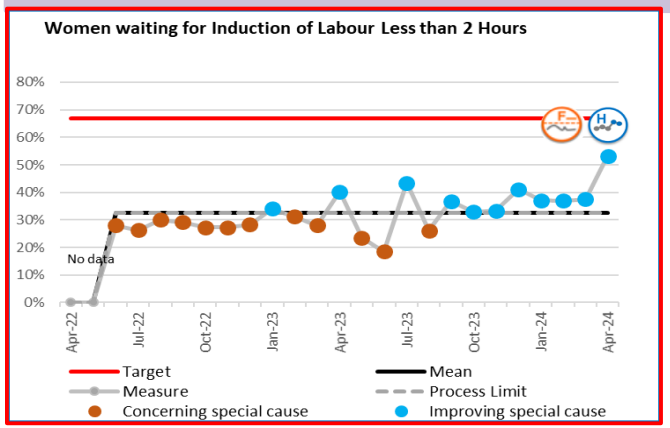
Action	Status	By when
Medical rostering	The Business Case for Patchwork (medical rostering) was signed off by BCRP and the first Steering Group is being held 21/5 with operational and clinical teams, now a project manager is in post. Ophthalmology rosters went live 13/5.	Q1 2024/25
Review of workstreams	A review is underway, focussing on the workstreams complete and outstanding under the Corporate Project; what additional support might be required in aiding any workstreams moving to BAU; and what opportunities might be taken forward as Continuous Improvement workstreams. The project team will determine the priorities to be taken forward.	Q1 2024/25

Maternity Metrics

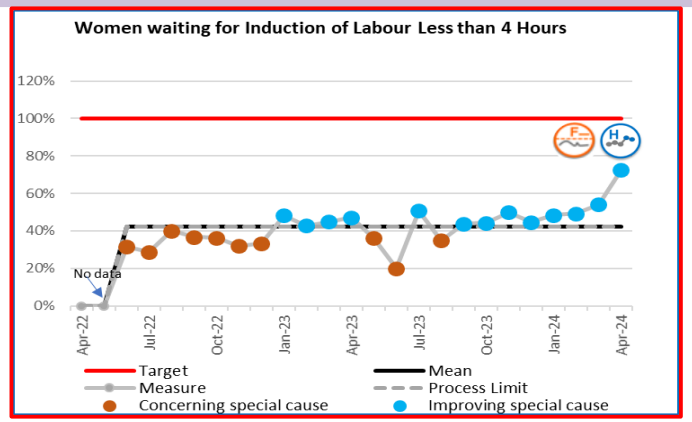
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Maternity Metric	Registerable Births		No target	429	Apr-24	470	455	Mar-24	Driver		No target	Not Escalated	437		No SPC
	Maternity Metric	Antenatal bookings		No target	571	Apr-24	545	508	Mar-24	Driver		No target	Not Escalated	547		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	17.8%	Apr-24	No target	18.4%	Mar-24	Driver		No target	Not Escalated	20.2%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	22.3%	Apr-24	No target	24.2%	Mar-24	Driver		No target	Not Escalated	20.2%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	23.0%	Apr-24	36.0%	28.9%	Mar-24	Driver			Not Escalated	26.1%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	53.2%	Apr-24	67.0%	37.5%	Mar-24	Driver			Escalation	43.4%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	72.6%	Apr-24	100.0%	54.2%	Mar-24	Driver			Escalation	57.3%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	7.7%	Apr-24	6.0%	6.4%	Mar-24	Driver			Not Escalated	5.4%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	4.2%	Mar-24	4.0%	4.0%	Feb-24	Driver			Not Escalated	5.3%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Apr-24	0.4%	0.2%	Mar-24	Driver			Not Escalated	0.4%		
	Maternity Metric	PPH >=1500% Rate		3.0%	3.9%	Apr-24	3.0%	4.0%	Mar-24	Driver			Not Escalated	3.4%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	2.8%	Apr-24	2.5%	3.1%	Mar-24	Driver			Not Escalated	2.1%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	74.6%	Apr-24	75.0%	80.0%	Mar-24	Driver			Not Escalated	81.3%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	94.1%	Apr-24	95.0%	87.5%	Mar-24	Driver			Escalation	85.9%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	70.9%	Apr-24	95.0%	65.6%	Mar-24	Driver			Escalation	73.0%		

* Registerable Births: The UK has seen a decline in the birth rate since 2008, although MTW has generally not reflected this over the same period, the rate has fallen since an unusually high rate in 2021.

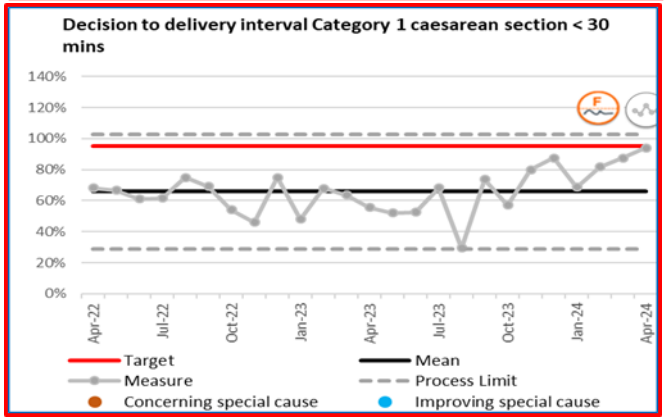
Maternity Metrics



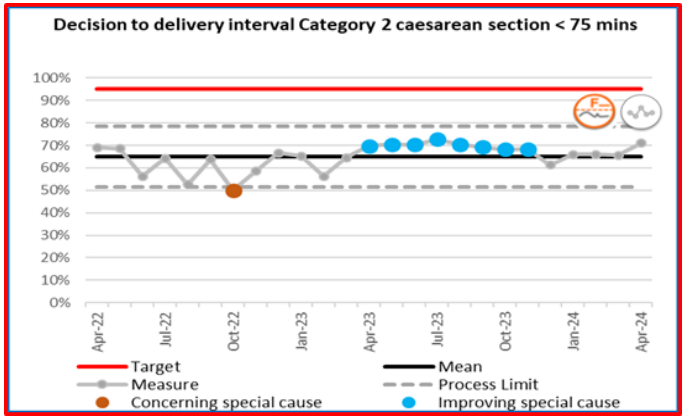
Apr-24
53.2%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



Apr-24
72.6%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Apr-24
94.1%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full Escalation as failed the target for >6 months



APr-24
70.9%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target

Summary:

Women waiting for Induction of Labour less than 2 or 4 Hours: These indicators are experiencing special cause variation of an improving nature and consistently failing the target. **These are new metrics with data collection from June 22**

Decision to delivery interval Category 1 and Category 2 caesarean: section: These indicators are experiencing common cause variation. Category 1 <30mins has failed the target for >6months and Category 2 <75 mins is consistently failing the target.

Actions:

Women waiting for Induction of Labour less than 2 or 4 Hours: The Maternity Service is working with the Business Intelligence Team and other stakeholders to review demand and capacity and to identify opportunities to improve flow throughout the department and reduce the occurrence of lack of bed or midwife capacity on Delivery Suite to enable timely transfer of women for ongoing induction of labour.

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

Improvement activity was implemented following the CQC inspection with amended request form to clearly identify and document decision time and target time and staff engagement to raise awareness of target times

Assurance & Timescales for Improvement:

Women waiting for Induction of Labour less than 2 or 4 Hours: The process for robust risk assessment, daily obstetric reviews and prioritisation according to the latest clinical picture has been formalised and documented in an update to the Induction of Labour Guideline to ensure safety for those women who are delayed. Timescales for improvement will be dependent on the outcome of the demand and capacity project and any actions required as a result

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

Progress is being made with improvement in compliance with Category 1 caesarean section but has been more challenging for Category 2 caesarean sections. For Category 1 April's failure of 5.9% was due to 1 case not meeting the target time. For Category 2 an A3 project has been started to identify root cause of delays and potential mitigation and solutions

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

NHS
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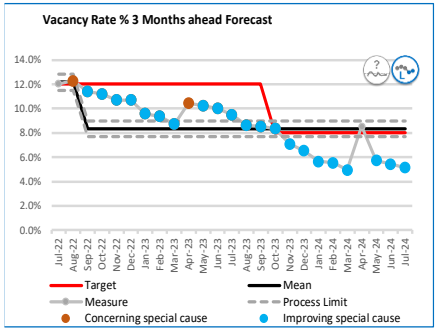
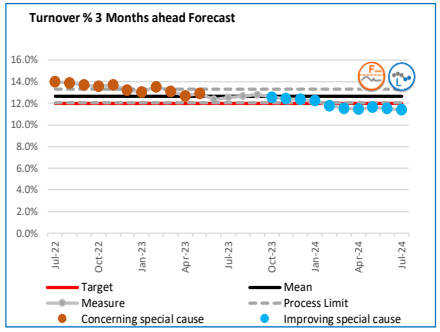
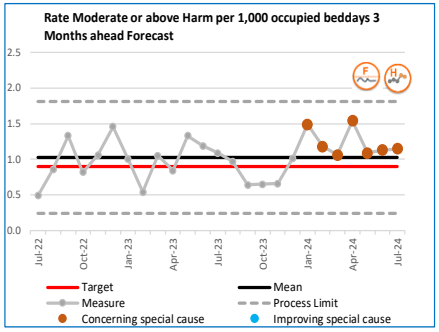
Appendices

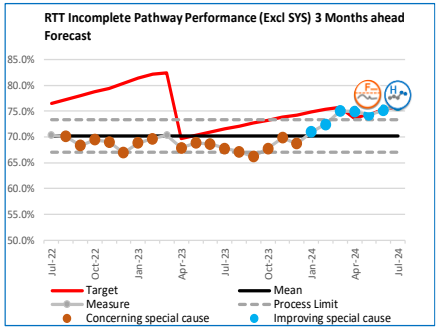
MTW
exceptional people, outstanding care

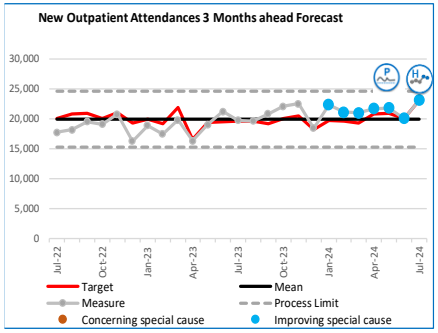
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

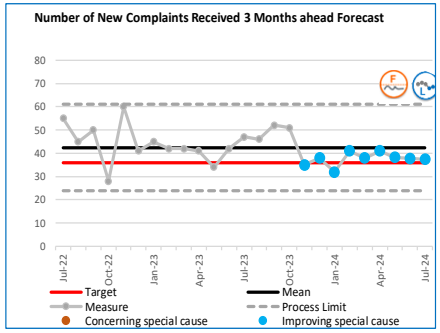


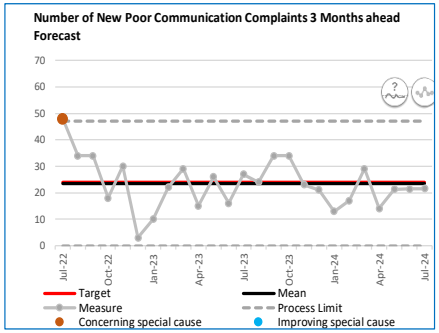


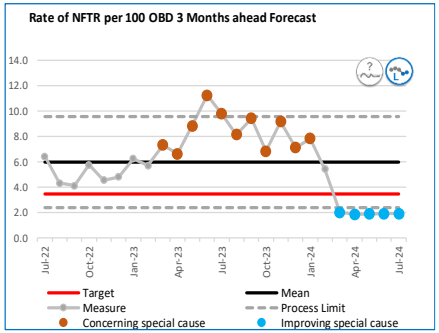


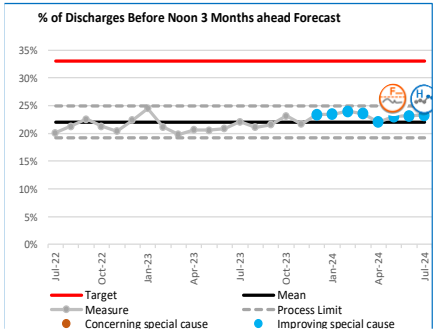


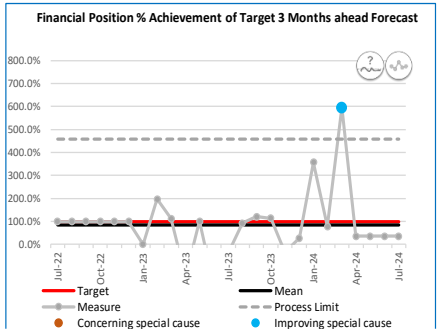


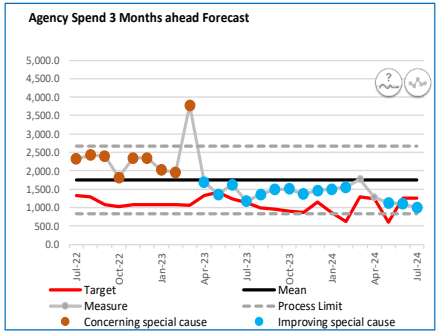




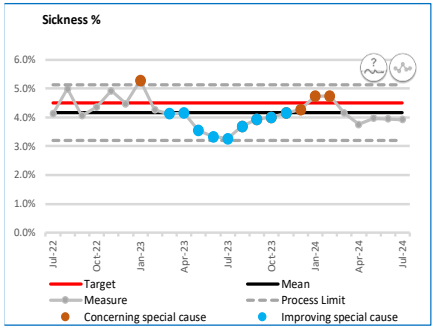


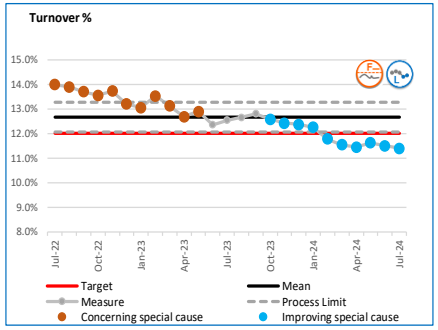


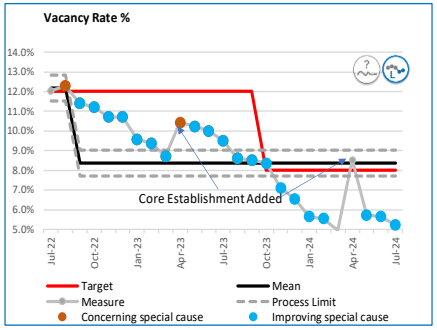


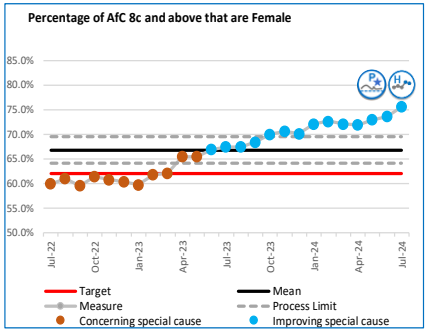


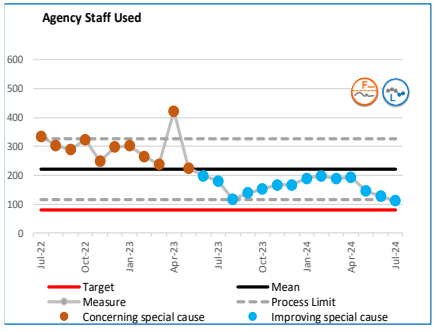
Forecast SPCs (3 month forward view) for People Indicators

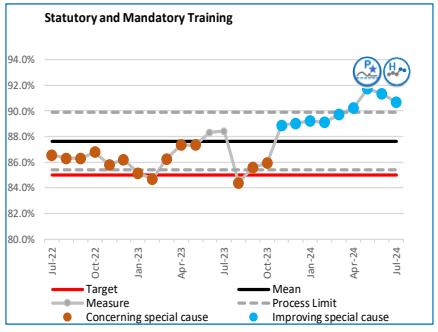


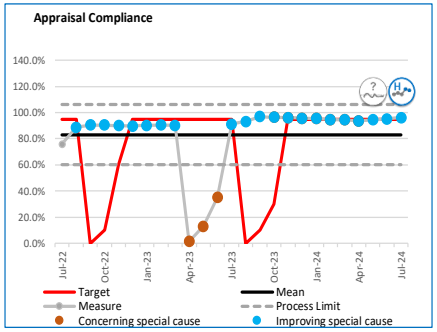


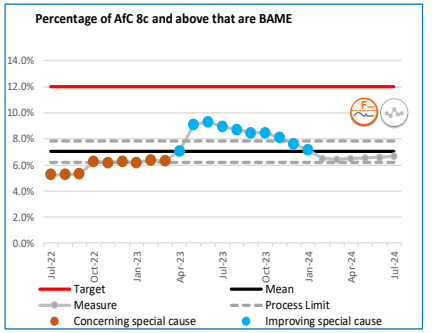


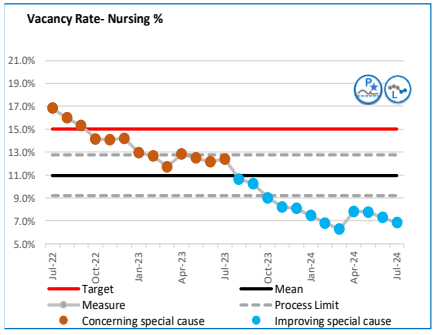


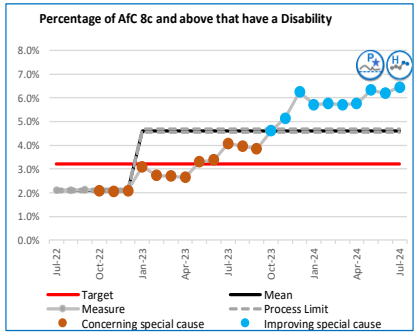




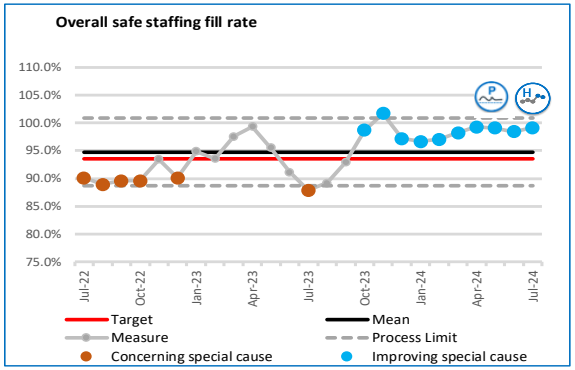


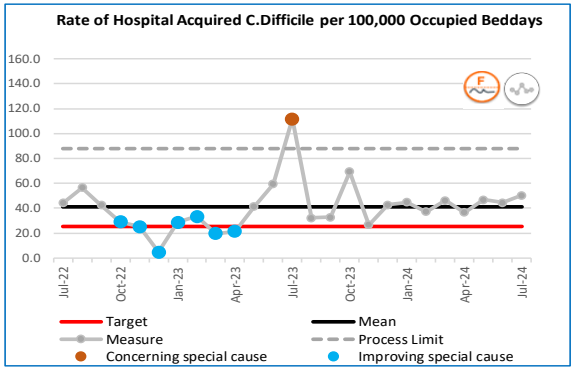


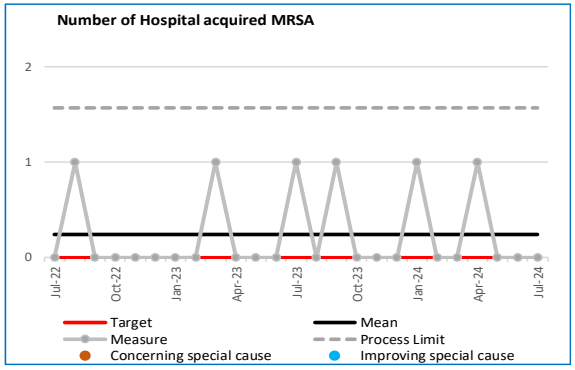


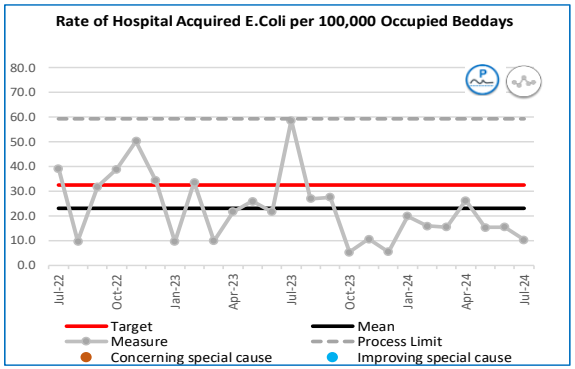


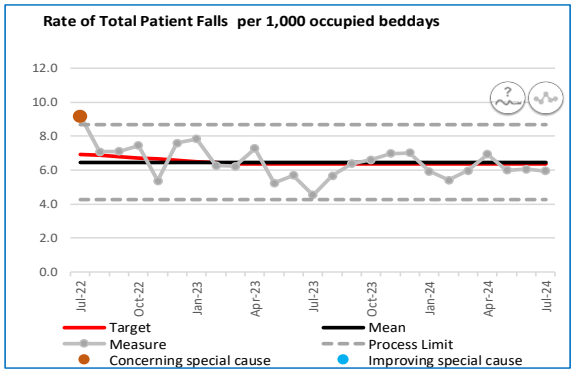
Forecast SPCs (3 month forward view) for Patient Safety Indicators

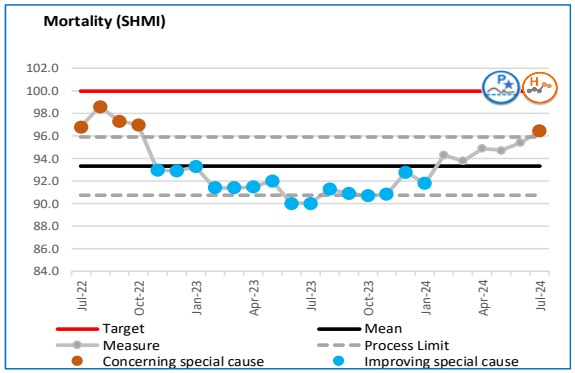


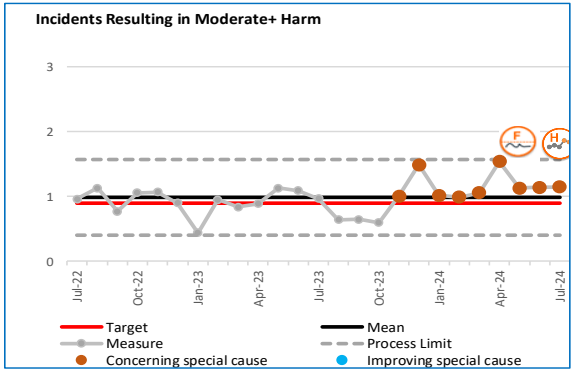


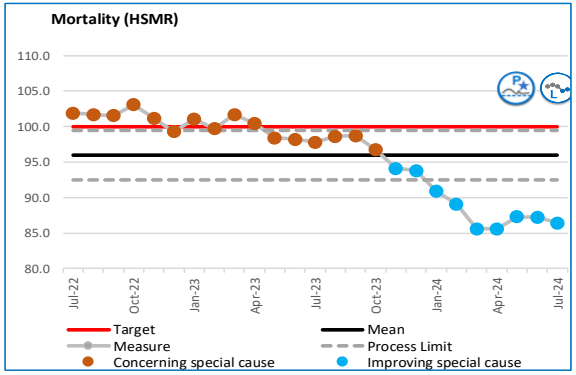




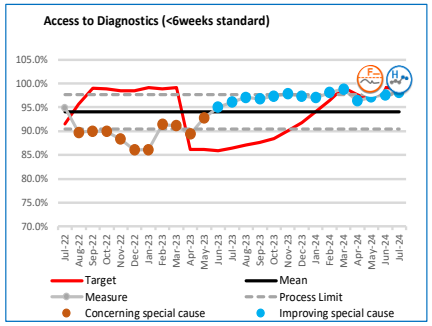


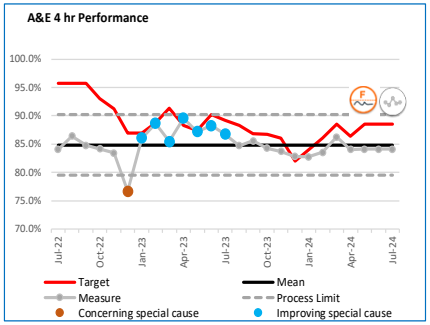


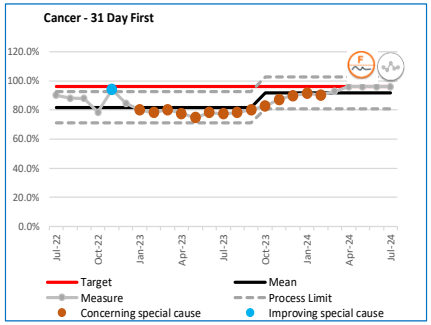


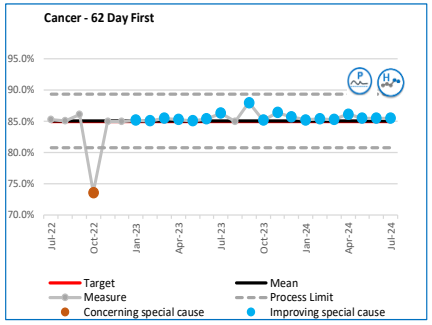


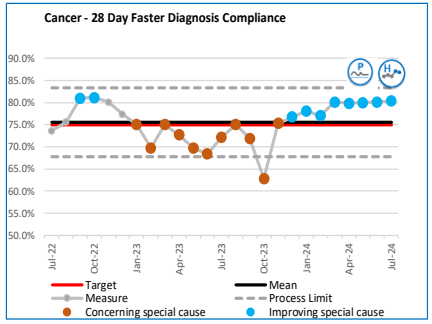
Forecast SPCs (3 month forward view) for Patient Access Indicators

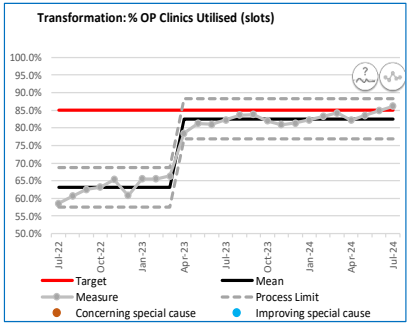


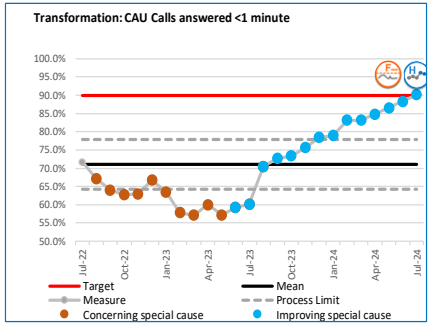


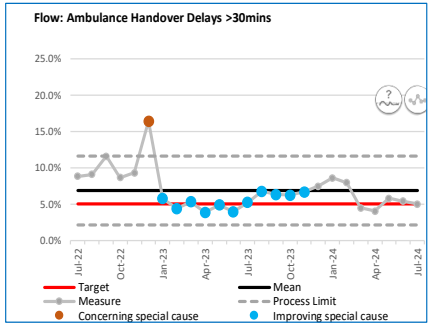


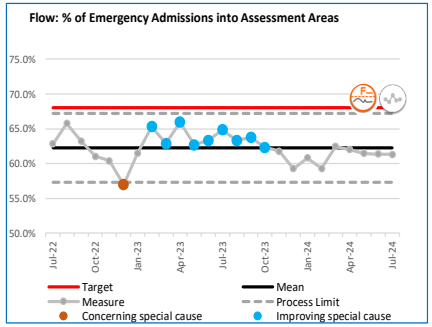


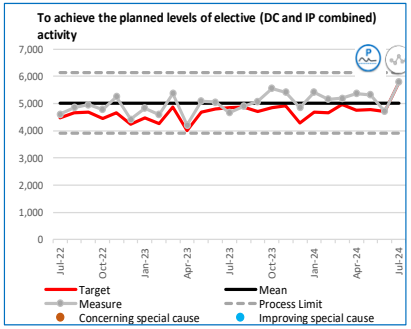


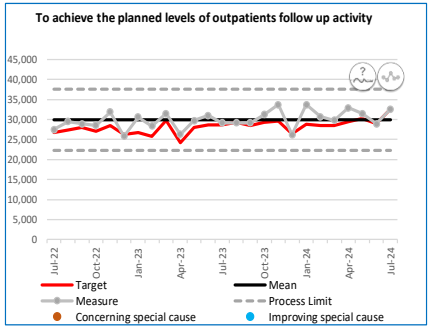


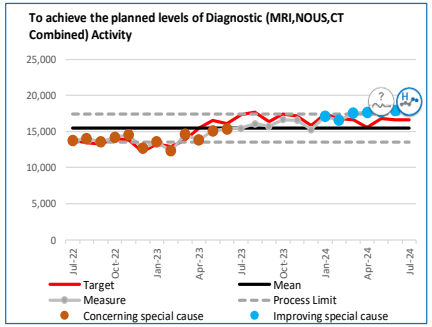




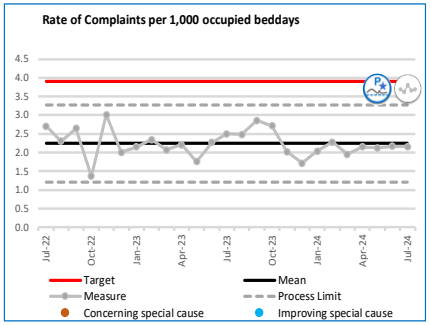


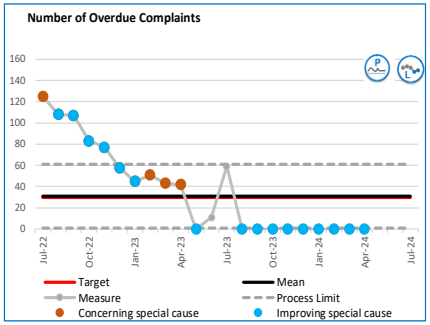


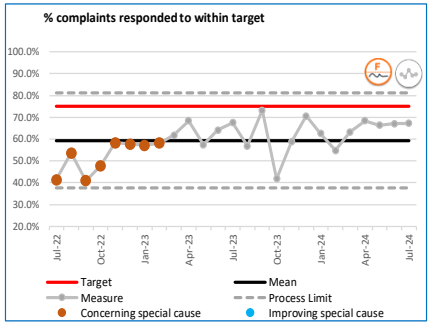


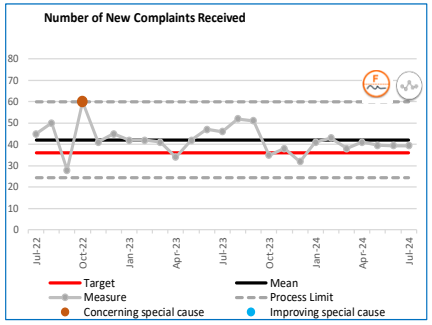


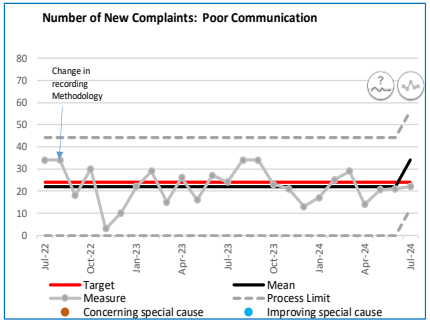
Forecast SPCs (3 month forward view) for Patient Experience Indicators

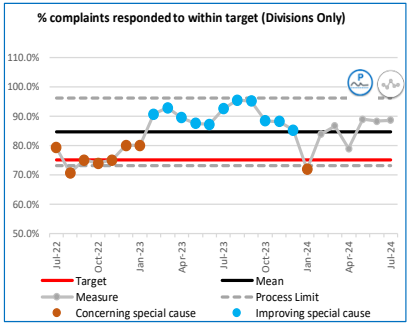


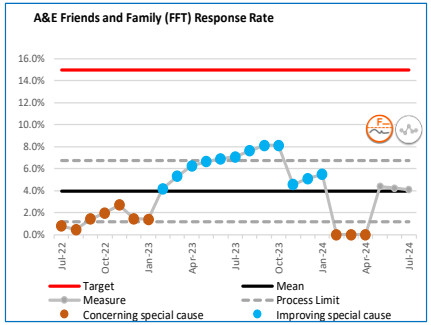


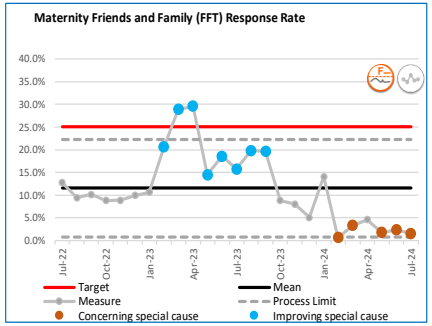


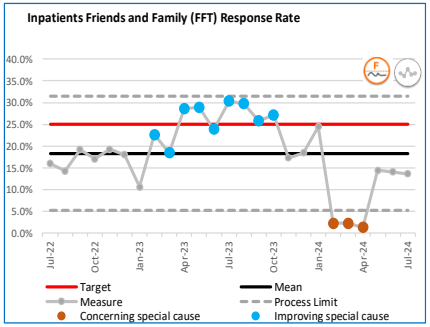


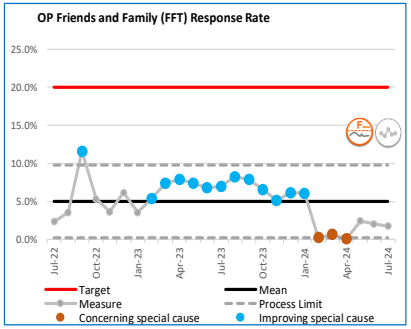


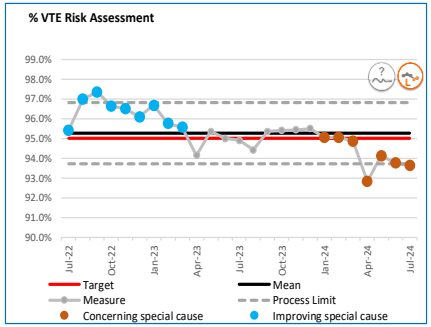




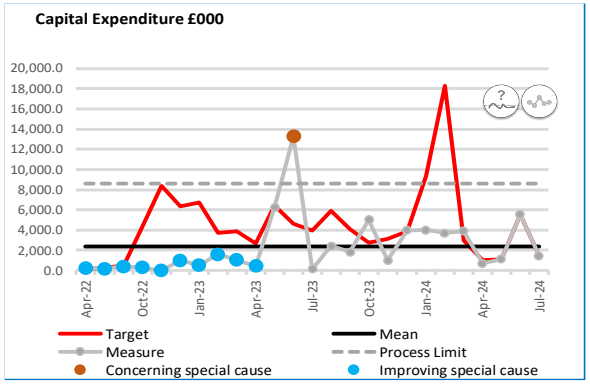


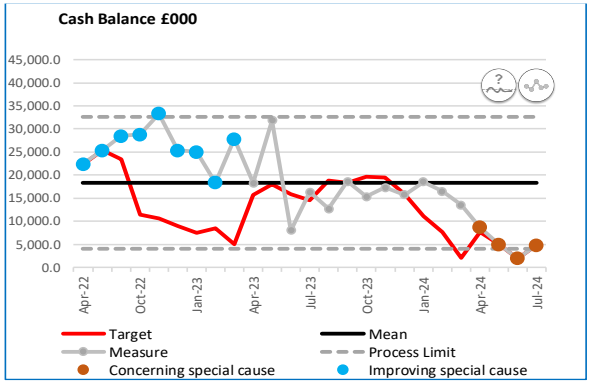




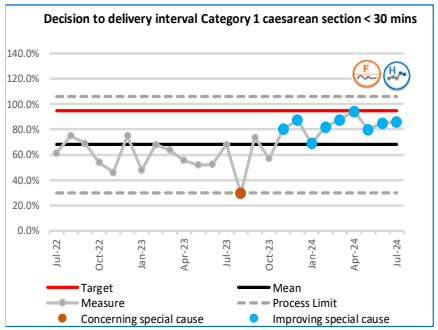


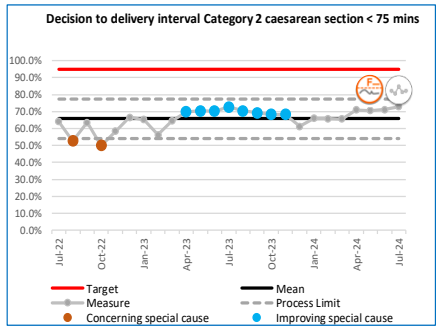
Forecast SPCs (3 month forward view) for Sustainability Indicators

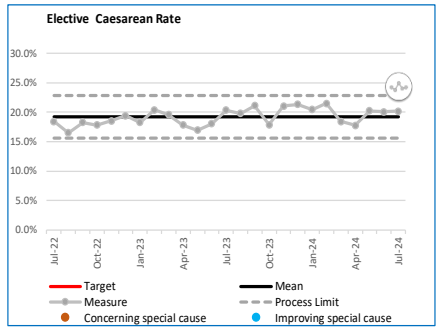


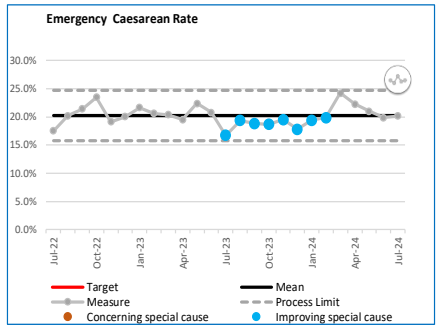


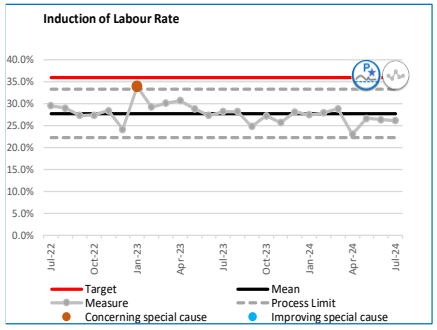
Forecast SPCs (3 month forward view) for Maternity Indicators

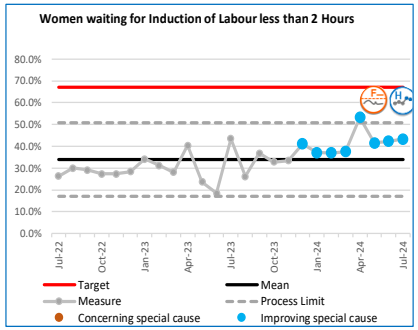


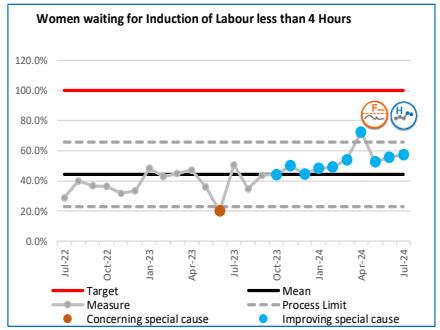


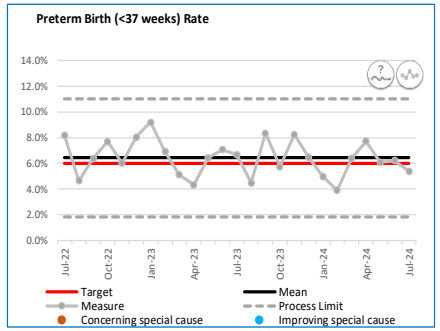


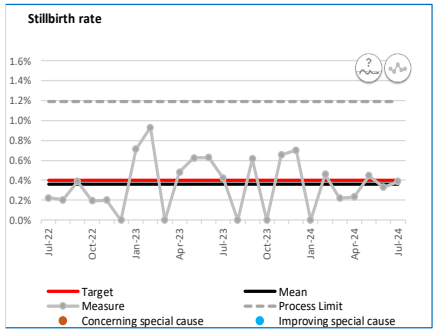


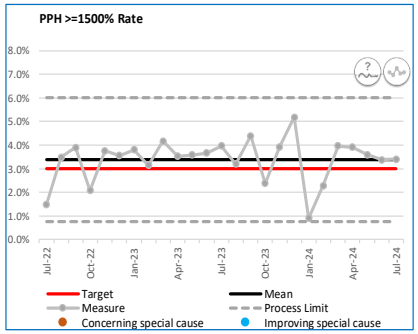


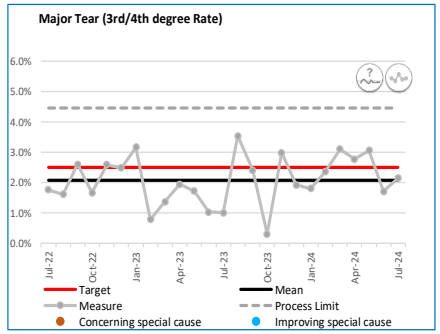


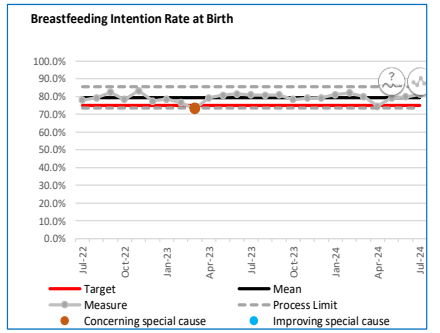






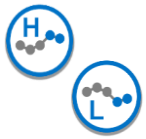






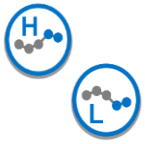
SDR Business Rules Driven by the SPC Icons

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

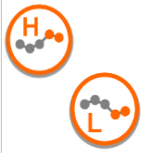
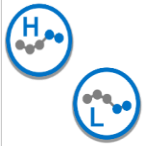
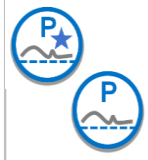
SDR Business Rules Driven by the SPC Icons

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:

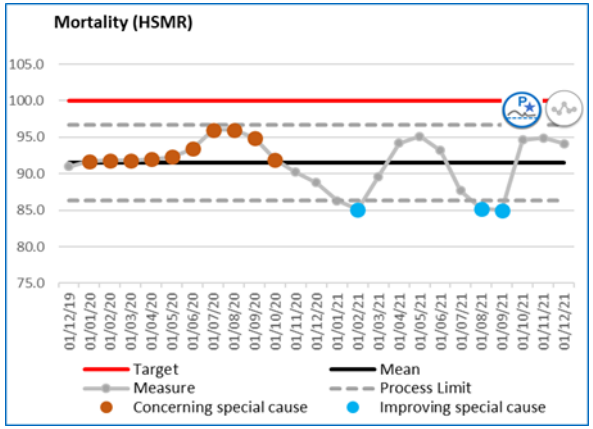
The **target** line **between** the **upper** and **lower** control limit for all metric types

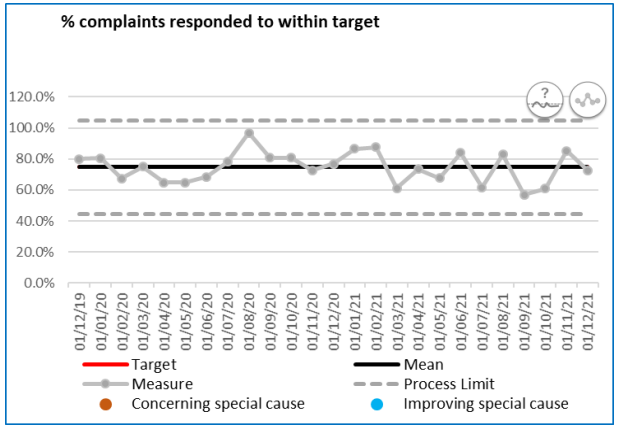
Metrics that consistently **fail** have:

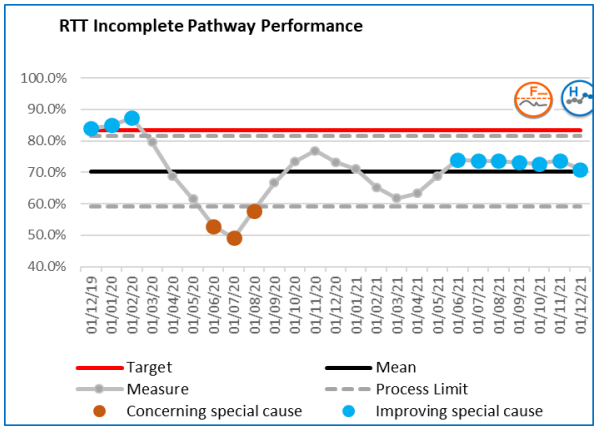
The **lower** control limit **above** the target line for metrics that need to be **below the target**

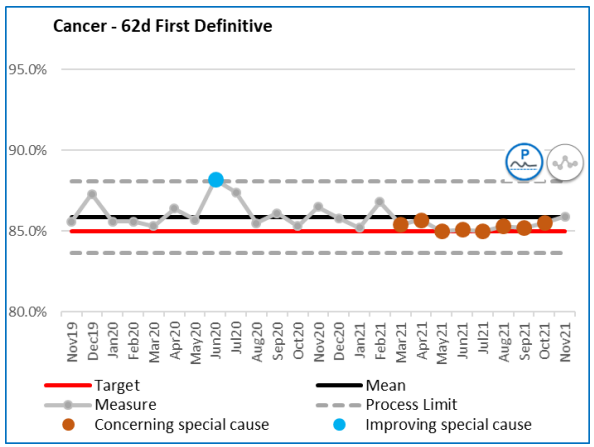
The **upper** control limit **below** the target line for metrics that need to be **above the target**

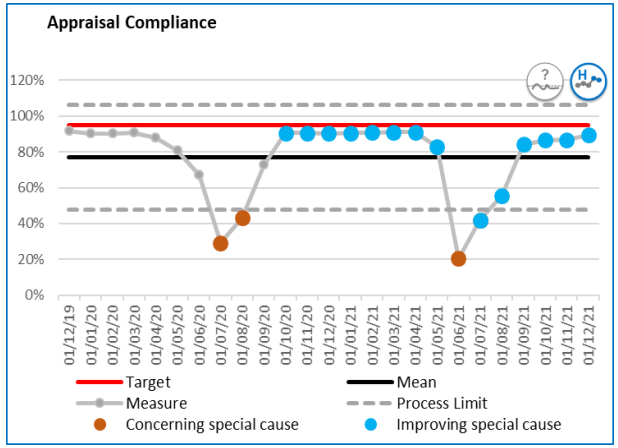
A metric not achieving the target for 6 months or more will be flagged as failing

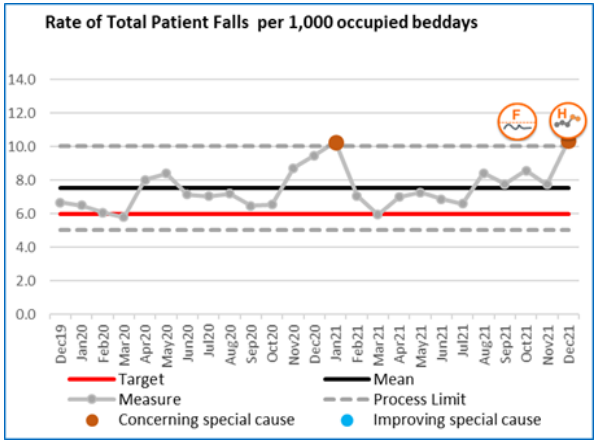












Executive Summary

- The Trust was £1.9m in deficit in the month which was £0.7m adverse to plan
- The main pressure in April related to income underperformance (£1m) and CIP slippage (£0.9m). These pressures were partly offset by non-recurrent benefits (£0.85m) and the release of April service development and contingency budgets (£0.4m).
- Cost Improvement Plans (CIP) was adverse to plan by £0.9m in April

Current Month Financial Position

- The Trust was £1.9m in deficit in the month which was £0.7m adverse to plan
- **Key Adverse variances in month are:**
    - Clinical Income net of passthrough related costs underperformed in the month by £1m. The key pressures in the month related to ERF underperformance (£0.7m) which included a CIP target of £0.4m in April and CDC underperformance to plan (£0.2m).
    - Total CIP slippage in April was £0.9m of which unidentified CIP allocated in month 1 was £0.6m therefore slippage against identified schemes was £0.3m.
- **Key Favourable variances in month are:**
    - The Trust benefitted by non-recurrent benefits in April of £0.85m and also released £0.4m relating to Service development and contingency budget relating to April to help offset income and expenditure pressures incurred.

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In April the Trust saved £1m which was £0.9m adverse to plan.

Cashflow position:

- The closing cash balance for April was £8.6m which is higher than the plan value of £7.6m. The main reason for the small variance of £1m is primarily due to capital creditors; at the year end the Trust had capital creditors of £6m but only £4.7m have been paid in April 2024. The remaining invoices will be paid once they have been received and authorised.
- The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance Sheet. If the in-year I&E position moves adversely then this has a negative impact on the Trusts cash flow and the Trust would need to implement various strategies to ensure the Trust cash remains in balance whilst meeting its commitments.
- The cashflow is updated daily ensuring that the most up to date information is recorded. From May the Trust has commenced stretching the payment terms of supplier payments in order to ensure that it has a positive cash balance until it receives its monthly block income on the 15th of each month. This causes pressures in the week leading up to this date which results in liquidity strategies being applied. The Trust is continuing to forecast payment runs twice a week within the cash flow.
- The Trust is working with Suppliers, the Procurement Department and budget holders/authorised signatories to ensure invoices are receipted, approved and paid as promptly as possible, this is to assist with the Trust adhering to the Better Payment Practice Code (BPPC) target of 95%. For April the percentages were for Trade suppliers by value 98.1%, and by volume 94.7%; for NHS suppliers by value 95.6% and by volume 91.5%.

Capital Position

Capital Plan

- The Trust's draft capital plan, excluding IFRS16 leases, for 2024/25 is **£20.46m**. The Trust's share of the K&M ICS control total is **£14.741m** for 2024/25, including **£5.463m** from system funds (CDC £2.463m and Cardiology £3m). The Trust also plans to receive

National funding of **£3.943m** (CDC £500k, Frontline Digitisation £2.790m and Digital Pathology £653k)

Potential Additional Resources

- A Letter of Approval has been issued to the Trust to notify us of an additional £1.4m of national CDC funding to be provided to the Trust. The System funding will be reduced by £329k to £2,134k, but this will enable the Trust to release back £1.07m of the internal funding previously set aside in the plan, for other Trust uses.
- The ICB has written to the Trust to state that NHSE has confirmed to them that the Trust has been successful in earning the maximum incentive capital of £5m under the Urgent and Emergency Care (UEC) scheme, that was dependent upon achieving 4 hour wait targets. This will be reported in M2.

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 1 Actuals (excluding IFRS16)

- The YTD spend at M1 is **£0.59m** against a YTD budget of **£0.85m**. The KMOC scheme is expected to complete in the first quarter of the financial year - there were no invoices applicable to April, so that is behind plan. Conversely work undertaken on enabling MRI and CT installations at TWH is ahead of plan. Some equipment replacements were released early, but are still awaited in terms of delivery.
- 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 Division and Estates.

Leased/IFRS16 capital

- The Trust included £30.16m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£26.8m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.36m). 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** - Work is ongoing with commissioners to resolve various contract adjustments which remain outstanding in relation to: Virtual Ward, Bariatrics, Repatriation, K&M Orthopaedic Centre, Capital Charges Support, Tobacco Dependency, Stroke HASU, QFIT and Overseas Patient Debt Share.
- **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.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 1
2024/25

Maidstone and Tunbridge Wells NHS

1a. Dashboard

April 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	60.5	61.4	(0.9)	(0.0)	(0.9)	60.5	61.4	(0.9)	(0.0)	(0.9)
Expenditure	(58.0)	(58.1)	0.2	0.0	0.1	(58.0)	(58.1)	0.2	0.0	0.1
EBITDA (Income less Expenditure)	2.6	3.3	(0.8)	(0.0)	(0.7)	2.6	3.3	(0.8)	(0.0)	(0.7)
Financing Costs	(16.4)	(16.4)	0.0	0.0	0.0	(16.4)	(16.4)	0.0	0.0	0.0
Technical Adjustments	11.9	11.9	0.0	0.0	0.0	11.9	11.9	0.0	0.0	0.0
Net Surplus / Deficit	**(1.9)**	**(1.2)**	**(0.7)**	**(0.0)**	**(0.7)**	**(1.9)**	**(1.2)**	**(0.7)**	**(0.0)**	**(0.7)**
Cash Balance	8.6	7.6	1.0		1.0	8.6	7.6	1.0		1.0
Capital Expenditure (Incl Donated Assets and IFRS16)	0.8	1.0	0.3		0.3	0.8	1.0	(0.3)		(0.3)
Cost Improvement Plan	1.0	1.9	(0.9)		(0.9)	1.0	1.9	(0.9)		(0.9)

Summary Current Month:
- The Trust was £1.9m in deficit in the month which was £0.7m adverse to plan.

Key adverse variances in month are:
- Clinical Income net of passthrough related costs underperformed in the month by £1m. The key pressures in the month related to ERF underperformance (£0.7m) which included a CIP target of £0.4m in April and CDC underperformance to plan (£0.2m).
- Total CIP slippage in April was £0.9m of which unidentified CIP allocated in month 1 was £0.6m therefore slippage against identified schemes was £0.3m.
-

Key favourable variances in month are:
- The Trust benefitted by non recurrent benefits in April of £0.85m and also released £0.4m relating to Service development and contingency budget relating to April to help offset income and expenditure pressures incurred.

CIP (Savings)
- The Trust has a savings target for 2024/25 of £37.3m. In April the Trust saved £1m which was £0.9m adverse to plan.

Risks
- **Outstanding contract discussions with Commissioners** - Work is ongoing with commissioners to resolve various contract adjustments which remain outstanding in relation to: Virtual Ward, Bariatrics, Repatriation, K&M Orthopaedic Centre, Capital Charges Support, Tobacco Dependency, Stroke HASU, QFIT and Overseas Patient Debt Share.
- **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.

Apr-24		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	113.6%	113.9%	-	-	121.7%	144.2%	-	-	46.2%	49.6%	112	7.83	13	11.2			2	1		190,137	253,063	(62,926)
MAIDSTONE	Stroke Unit (M) - NK551	93.0%	97.5%	-	100.0%	96.7%	108.7%	-	100.0%	27.7%	16.3%	132	9.26	19	8.9	47.1%	75.0%	10	3		226,803	300,542	(73,739)
MAIDSTONE	Cornwallis - NS251	207.0%	187.0%	-	-	98.9%	101.7%	-	-	10.6%	7.0%	82	5.02	6	15.4	5.6%	100.0%	3	1		123,347	127,369	(4,022)
MAIDSTONE	Culpepper Ward (M) - NS551	100.1%	86.3%	-	-	100.0%	103.3%	-	-	22.2%	9.2%	15	1.06	2	4.8	0.0%		0	0		120,901	126,963	(6,062)
MAIDSTONE	Edith Cavell - NS459	132.8%	114.9%	-	100.0%	108.0%	201.7%	-	-	50.8%	65.2%	52	3.57	11	7.8			4	1		123,625	160,451	(36,826)
MAIDSTONE	Foster Clarke Winter Escalation - NS959	57.0%	57.8%	-	-	85.2%	65.5%	-	-	29.0%	5.4%	54	3.91	21	7.4			1	0		0	106,577	(106,577)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	98.4%	99.8%	-	-	102.6%	72.8%	-	-	27.9%	19.4%	76	5.38	11	6.9			4	3		187,980	196,070	(8,090)
MAIDSTONE	Intensive Care (M) - NA251	91.2%	95.8%	-	-	95.9%	93.8%	-	-	13.0%	6.4%	86	5.44	14	51.7	100.0%	100.0%	0	1		245,106	259,096	(13,990)
MAIDSTONE	Lord North Ward (M) - NF651	88.8%	107.9%	-	100.0%	100.0%	100.0%	-	-	18.3%	0.0%	47	3.33	12	7.5	11.1%	100.0%	2	0		119,377	121,670	(2,293)
MAIDSTONE	Mercer Ward (M) - NJ251	95.6%	110.7%	-	100.0%	98.8%	127.0%	-	100.0%	35.9%	19.7%	57	3.90	9	6.3			6	1		120,235	144,548	(24,313)
MAIDSTONE	Peale Ward COVID - ND451	102.4%	87.9%	-	100.0%	102.2%	130.0%	-	-	30.5%	30.1%	55	3.86	2	8.4			2	0		109,875	107,538	2,337
MAIDSTONE	Pye Oliver (Medical) - NK259	126.4%	131.2%	-	-	162.1%	145.0%	-	-	67.6%	50.0%	131	9.19	6	8.2	2.2%		8	1		138,845	200,057	(61,212)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	101.5%	87.7%	-	-	90.1%	-	-	-	11.0%	0.0%	13	0.79	0	41.1	0.0%	98.2%	0	0		71,233	67,866	3,367
MAIDSTONE	Whatman Ward - NK959	97.3%	147.4%	-	100.0%	101.1%	184.1%	-	-	62.1%	46.3%	73	5.26	8	7.8			5	1		115,191	187,252	(72,061)
MAIDSTONE	Maidstone Birth Centre - NP751	107.0%	96.8%	-	-	102.1%	96.7%	-	-	11.5%	0.0%	26	1.41	0	38.2			0	0		79,200	94,027	(14,827)
TWH	Acute Medical Unit (TW) - NA901	108.3%	113.6%	-	100.0%	113.9%	131.5%	-	100.0%	39.7%	48.2%	160	11.38	30	10.0			10	0		272,538	305,689	(33,151)
TWH	Coronary Care Unit (TW) - NP301	96.9%	98.6%	-	-	98.9%	-	-	-	14.8%	0.0%	30	2.04	4	12.0			0	0		77,556	79,712	(2,156)
TWH	Hedgehog Ward (TW) - ND702	112.3%	132.0%	-	-	116.5%	130.0%	-	-	39.9%	58.8%	188	12.81	24	11.0			2	0		174,741	207,794	(33,053)
TWH	Intensive Care (TW) - NA201	98.9%	83.3%	-	-	95.5%	84.4%	-	-	4.5%	2.0%	55	3.85	5	32.2			0	1		389,675	417,290	(27,615)
TWH	Private Patient Unit (TW) - NR702	102.0%	105.5%	-	-	100.2%	133.3%	-	-	31.2%	0.0%	31	2.11	0	9.3			1	1		75,011	89,403	(14,392)
TWH	Ward 2 (TW) - NG442	88.6%	101.4%	-	100.0%	99.3%	148.1%	-	100.0%	30.3%	9.5%	63	4.51	19	7.4			12	0		199,272	194,404	4,868
TWH	Ward 10 (TW) - NG131	97.2%	99.4%	-	-	102.5%	104.7%	-	-	54.9%	7.9%	208	13.51	51	7.5			2	0		174,596	155,068	19,528
TWH	Ward 11 (TWH) Nov 2019 - NG144	82.0%	88.9%	-	-	97.5%	91.7%	-	-	19.9%	1.8%	66.00	4.40	17.00	6.1	21.7%	100.0%	4	0		0	143,987	(143,987)
TWH	Ward 12 (TW) - NG132	117.8%	90.1%	-	100.0%	119.1%	93.1%	-	-	33.6%	34.4%	137	9.39	23.00	7.1			12	0		153,100	188,298	(35,198)
TWH	Ward 20 (TW) - NG230	113.7%	128.6%	-	100.0%	124.3%	125.0%	-	-	44.4%	62.0%	155	10.76	25	8.1	2.7%	100.0%	10	2		180,399	226,040	(45,641)
TWH	Ward 21 (TW) - NG231	89.1%	101.0%	-	100.0%	90.7%	114.5%	-	-	29.1%	11.1%	135	8.60	38	5.9			8	1		177,343	186,019	(8,676)
TWH	Ward 22 (TW) - NG332	89.7%	115.4%	-	-	98.2%	114.2%	-	-	20.8%	11.4%	57	4.02	10	6.4			16	1		162,378	170,763	(8,385)
TWH	Ward 30 (TW) - NG330	95.1%	97.1%	-	100.0%	99.1%	139.5%	-	100.0%	22.6%	0.0%	86	5.11	11	6.1	12.5%	100.0%	9	1		139,732	178,428	(38,696)
TWH	Ward 31 (TW) - NG331	100.1%	116.2%	-	100.0%	99.2%	130.8%	-	-	24.9%	0.8%	86	5.33	12	7.0	11.4%	60.0%	4	4		154,124	210,308	(56,184)
TWH	Ward 32 (TW) - NG130	91.9%	86.9%	-	100.0%	95.8%	95.8%	-	100.0%	17.5%	0.0%	55	3.39	16	8.6	0.0%		0	0		154,471	163,520	(9,049)
TWH	Ward 33 (Gynae) (TW) - ND302	97.9%	100.6%	-	-	101.7%	99.6%	-	-	32.1%	1.7%	37	2.45	2	7.4			0	0		105,089	105,241	(152)
TWH	SCBU (TW) - NA102	95.7%	185.4%	-	-	110.1%	137.5%	-	-	18.2%	0.0%	75	4.37	0	11.0			0	0		245,886	214,815	31,071
TWH	Short Stay Surgical Unit (TW) - NE901	72.3%	77.2%	-	100.0%	105.2%	100.0%	-	100.0%	10.2%	0.0%	16	1.04	0	12.2	18.6%	95.2%	2	0		89,352	97,497	(8,145)
TWH	Surgical Assessment Unit (TW) - NE701	98.9%	96.7%	-	-	100.0%	96.7%	-	-	11.9%	0.0%	11	0.77	0	18.1	4.5%	93.8%	0	0		80,409	83,087	(2,678)
TWH	Midwifery (multiple rosters)	84.4%	66.8%	-	-	102.0%	92.0%	-	-	15.6%	8.5%	719	40.88	124	15.6	8.8%	97.6%	0	**0**		1,381,186	1,374,750	6,436
Crowborough	Crowborough Birth Centre (CBC) - NP775	77.8%	93.9%	-	-	101.7%	93.3%	-	-	19.0%	0.0%	71	4.47	8	134.3	61.5%	100.0%	0	0		71,230	84,046	(12,816)
MAIDSTONE	Accident & Emergency (M) - NA351	104.6%	97.8%	-	100.0%	103.4%	97.7%	-	-	38.7%	35.4%	397	27.22	23	-	0.0%		2	0		380,477	483,794	(103,317)
TWH	Accident & Emergency (TW) - NA301	99.2%	73.3%	-	100.0%	100.8%	67.8%	-	100.0%	38.0%	34.0%	402	27.92	22	-			6	0		422,802	503,271	(80,469)

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%

	Budget £	Actual £	Variance £ (overspend)
Total Established Wards	**7,233,222**	**8,316,314**	**(1,083,092)**
Additional Capacity bed Cath Labs	59,124	50,248	8,876
MOU	0	19,090	-19,090
Other associated nursing costs	5,795,132	5,418,612	376,520
Total	13,087,478	13,804,264	-716,786

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The purpose of the report is to update the Board on the programmes of work being undertaken in the ICB and West Kent HCP.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting (ETM), 21/05/24

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

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

ICB and West Kent HCP update

May 2024

ICB/ System news

- The acute provider collaborative work on reviewing acute services is progressing with the first phase report now ready. The outputs of the data analysis have been reviewed with providers. Five top services have been identified as well as some additional quick wins focussed on variation. The next steps are being discussed at the APC meeting on 16th May with a CEO workshop on 23rd May.

- Work on the strategy for the NHS partners in Kent and Medway continues. This strategy is designed to provide the direction of travel and priorities shared across all NHS partners in Kent and Medway. It will be owned by the NHS system, including but not limited to the ICB, and to this end, it is being jointly led with NHS trust providers and colleagues in primary care. A series of workshops have been held to develop it and I look forward to bringing this to the Board.

West Kent HCP

The Executive Group took place on Thursday 9th May and the meeting focussed the role of the HCP in supporting NHS K&M sustainability and the Development Board away day outputs.

The Development Board took place on Thursday 16th May focussed on Integrated Neighbourhood teams referencing the K&M ICB Integrated Neighbourhood Team framework being developed and the outputs from the recent away day.
There were 10 actions agreed in three areas:

- ICB support around data sharing, OD
- West Kent PCN team clarification/data sharing
- Leadership and enablers

The other main items were the system financial recovery and, particularly, how the HCP support that and the outcome of the NHS Kent & Medway Governance and Partnership review. The presentation covered a series of actions related to HCPs around key areas such as delegation, accountability and relationship with the ICB.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.
- *Demand pressures* - Pressures across WK system arising from range of sources including: planned care backlog; Covid/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.
- *Finance pressures* – the system pressures and focus on financial balance is likely to have an impact on the development activities of the HCP for 23/24 and 24/25.

NHS Maidstone and Tunbridge Wells NHS Trust

Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital	Chief Operating Officer

Introduction

Since the last update the Trust have continued to engage with the Maggie's team on a regular basis via the bi-monthly project board meetings to provide information as requested.

In October 2023 the Maggie's team, including architects and landscape designers, spent two days based in the Kent Oncology Centre engaging with staff, patients, directors, consultants and nurses sharing ideas and gaining information. This was very successful and the Maggie's team were then invited to join the oncology consultant meeting to brief on the project. Following on from this there has been engagement between Maggie's and individual consultants.

Introductions have been made between Maggie's and the following teams:

- Cancer Performance team - who have provided information on the Kent Oncology Centre catchment area and other details needed to provide an effective service.
- Trust solicitor - as the Trust continue to look at legal advice to adapt the Heads of Terms if necessary and work towards a Development Plan.
- Trust communications team - who are working with Maggie's to populate the comms plan which will inform external and internal comms.
- Charity team - the Trust Head of Charity and the Charity Manager both visited Maggie's West London where they spent time with staff talking about how they work operationally and fundraising.

Next steps

The Maggie's design team have been working hard on a building design and hope to be in a position to share this from June 2024. Maggie's are aiming to submit a planning application in quarter four of this year.

The next Maggie's project board meeting is 25th June 2024.

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

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

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

To approve an Outline Business Case (OBC) for Robotic Assisted Surgery	**Director of Strategy, Planning and Partnerships; and Chief Operating Officer**

The enclosed report provides information on the outline business case detailing a recommended preferred option for the development of Robotic Assisted Surgery at the Trust.

The business case objectives are:

- 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)

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 Trust Board is requested to review, and if appropriate approve, the development of a Full Business Case for the preferred option of a phased approach to the procurement of two surgical robots, one located at Maidstone Hospital in 2024/25 and one located in Tunbridge Wells Hospital, from 2025/26.

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

- Business Case Review Panel
- Executive Team Meeting, 09/04/24
- Finance and Performance Committee, 23/0/24

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 of the development of Full Business Case for the preferred option.

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE	Robotic assisted surgery at MTW

Stage of Plan	Single stage "Justification" (J) ☐ Stage 2 – Outline Business Case (OBC) ✓ 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	Feb 2024
Other approval? ☐ *Please specify*	Chief of Service for Surgery	Feb 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 *(please identify other individuals, not already listed, who have been involved in preparing this case. Include external stakeholders where appropriate)*

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

Executive Summary

Recommendation: This business case seeks approval to go out to formal procurement tender evaluation to procure, using a phased approach, two surgical robots for the trust to develop Robot Assisted Surgery (RAS) at MTW.

In June 2023, in line with an 'early' outline business case, the ETM recommended further planning for a RAS programme at MTW. This 'full' Outline Business Case (OBC) sets out a preferred option to start that programme along with the evaluation of options that led us to that recommendation. It sets out the base financial case. Subject to approval of this OBC and a tender evaluation exercise, the Full Business Case (FBC) with financial case and contractual detail will be completed

The preferred option is: Procure two robots. One for MGH in 2024/25 and one for TWH in 25/26 with the following indicative overall cost.

Outright capex purchase £4,722,199

Total revenue cost over the 84 months of the programme £7,429,170

Avoided costs / cost savings over the 84m of the programme of £8,032,088

Total surplus from investment over the 84m of the programme £602,919.

There is an additional income opportunity from private income (MTW margin) over the 7 years of the programme estimated (outside of the core financial model) of £1,200,000

A robot sited at MGH provides a regional strategic opportunity to repatriate some complex urology surgery from Eastbourne and Medway with an income potential (outside the core financial model) over the lifetime of the project of £8,883,750

The majority of the 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

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.

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.

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. Two of the 3 other acute general hospital trusts in our region already have RAS and the third (Dartford) is embarking on the investment of a robot.

The preferred option.

Begin a RAS development programme at MTW, with two robots, initially one at MGH in 2024/25 then one at TWH in 2025/26. The initial robot for the trust will be located at MGH and will therefore support gynae-oncology procedures and potential complex urology repatriation. The second will be based at TWH and will support general surgery, including colorectal and bariatrics and benign gynaecology.

This preferred option will be used in future tender evaluation and was informed by comparison of summarised 'base case' capital costs for each supplier against the 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 at FBC based on the system that provides the best clinical outcome and value for money will be chosen through a robust procurement evaluation exercise. The financial case will review alternative financial models e.g. capital purchase, capitalised lease (IFRS 16) and potential revenue solutions. Our preferred payment method is likely be an option that minimises capital expenditure or a revenue solution (e.g. a cost per case mechanism).

Preparatory contract information and costs of procurement are included the financial and commercial case below. These are based on estimates from initial pre-market engagement with prospective suppliers and will be used as a benchmark in procurement evaluation.
Financial and contractual details will be finalised at Full Business Case through tender evaluation and contract negotiation.

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

Measurable benefit Key Performance Indicator (KPI)	**Baseline Position**	**Future Outcome**
Reduced average LOS for key major robotic procedures	See appendix 3	x-20%
Reduce 30-day readmission rate for key open procedures	See appendix 3	x- (>10%)
Increase RAS surgery performed at MTW	0	885 robotic cases/yr. by 2027/28 *(including urology repatriation)*

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.

Delivery risks:

- The time taken to train the clinical teams
- The risk is mitigated by a ensuring a robust training programme is included in the contract
- Lack of capital, mitigated by alternative funding solutions
- Commissioner sign off and approval

Residual Risk:
The private activity assumptions in the case (not in the financial model) are at risk and would be dependent on appropriate private supporting facility at MGH, which would be subject to its own business case plan, and availability of the private bed base at TWH.

[1] https://doi.org/10.1186/s13063-022-06421-7
[2] https://jamanetwork.com/journals/jama/fullarticle/2792543

Summarised financial impact of the preferred option Project lifetime of 84 months – includes VAT			
Summary of financial impacts			
CAPITAL COSTS		**FUNDING SOURCE**	**£**
Estates		Identified in the Trust capital plan	
IT		Identified in directorate revenue budget	
Equipment	4,142,280	Other *(specify)*	
Total Capital Cost	**4,142,280**	**Financial note on costs** The expected scale of expenditure is based on estimates from initial pre-market engagement with prospective suppliers. It is not guaranteed and will be fully defined in Full Business Case. Additional income potential (outside model) • Private income £1,200,000 • Urology repatriation £8,883,750	
REVENUE COSTS			
Instruments and consumables	£86,970		
Initial set up	£336,000		
MTW IT	£100,000		
Service and maintenance	£2,184,000		
Capital Charges (Depreciation and PDC)	£4,722,199		
Total Revenue Cost over the 7 years	**£7,429,170**		
INCOME Savings/efficiencies from the switch to the robot, and the freed capacity			
Clinical efficiency savings	-£7,482,088		
Avoided locum savings	-£550,000		
Total income and savings	**-£8,032,088**		
Surplus	**£602,919**		

Additional Financial Information

The forecast clinical efficiency savings are calculated from clinical data by comparing results (*on ALOS /complications/ conversions and readmissions*) between laparoscopic / open surgical approaches to robotic approaches applied to the 5148 MTW projected robotic case mix.
The metrics sources and detail can be found at Appendix 3

The most significant proportion of the clinical efficiency savings comes from a reduction in ALOS of 2.9 days for these major procedures with each day given a cost saving of £407. The alternative to shutting the bed to realise the saving would be to bring additional activity through the vacated bed capacity. The Nuffield Trust[3] calculate for 1-6 LOS patients the income would be over £718 per bed day. For prudent planning the £407 figure has been used.

Avoided costs of locum surgeon cover are estimated at £550k in total over the seven years of the programme. (0.2WTE temporary staff spend avoided in Y1 rising to 0.8WTE temporary staff spend saving in y4 onwards) 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

[3] The Nuffield Trust- Understanding patient flow in hospitals https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf

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.

Forecast income Robotic surgery has the potential to provide the trust with additional private income of c £1.2M in total over the seven years of the programme. The project group estimate this could develop to up to 50 cases per annum by year 3 with a margin of c £4000 per case. 300 cases in total over 7 years. That income is at risk and subject to the development of private facilities at MGH outside of the scope of this investment

A robot at MGH would provide the region with strategic potential to develop Urology RAS at MTW. Additional income could flow from that regional development. (Each radical prostatectomy is associated with a tariff income of approximately £7,200. With a projection of 1150 procedures the potential scale of income over the 84 months of the programme could be in the region of £8.8M) However, this income would be offset by comparable costs, requires regional collaboration and is not included in financial summary here

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	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

Strategic Case

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.

Two of the 3 other acute general hospital trusts in our region already have robots and the third (Dartford) is embarking on the investment

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.

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. Two of the 3 other acute general hospital trusts in our region already have RAS and the third (Dartford) is embarking on the investment

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.

Each of the other acute Trusts in Kent and Medway either already have RAS in place (EKUHFT and MFT) or are actively developing their plan to invest in RAS (DGT)

- 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

Urology repatriation would be dependent on collaboration with the cancer specialist surgical centres at Medway and Eastbourne. Currently, the specialist urological cancer surgery services covering our population are located at Medway and Eastbourne. Discussions have commenced to ensure services are not destabilised and to ensure collaborative work to best support activity levels. Specialist commissioning policies currently constrain the procedures that will be commissioned and the commissioners need to be included in contract negotiation.

Constrained by need for high quality theatre environment. As part of the feasibility study in 2023 and in February 2024 both Cambridge Robotics (CMR) and DaVinci have undertaken surveys of the theatres at MGH and TWH and both have approved the theatres in terms of size. All delivery bays, corridors, doors and lifts are more than adequate. Theatre 4 at MGH does require improvement work but is currently being used for complex surgery. The constraint will be subject to maintenance plan / business case outside the scope of this robotic case but is noted here as size and manoeuvrability of robot will be a factor in tender evaluation. Clinical Engineering, IT and Estates have been involved in the project to ensure RAS fits into our current infrastructure.

Private activity in this case is dependent on the Trust developing a private surgery offer at Maidstone in the next 3-4 years. That private facility offer is not planned here but the central assumption in the activity modelling is that it will be possible to offer private robotic activity at Maidstone from 2025/26.

Economic Case - The available options

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 will need to be tested as part of the tender requirements in seeking the range of solutions from the potential partners. Discussions with the potential suppliers has indicated that each of them are developing a range of solutions to meet NHS Trust needs in response to a constrained capital environment.

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:

		Maidstone Hospital								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
34	open gynae-onc	7	19	23	34	34	34	34	17	202
106	lap gynae-onc	22	58	72	106	106	106	106	53	629
	gynae-onc total	**29**	**77**	**95**	**140**	**140**	**140**	**140**	**70**	**831**
	open/lap benign									
220	**hysterorectomy**	**14**	**39**	**48**	**70**	**70**	**70**	**70**	**35**	**415**
190	**Upper GI/Bariatrics**	**8**	**22**	**27**	**40**	**40**	**40**	**40**	**20**	**237**
885	**overall totals**	**51**	**138**	**170**	**250**	**250**	**250**	**250**	**125**	**1,484**

Option 2 Key financial information

Financial summary of activity, costs and savings 2024-25 to 2031-32

	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
Pay	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
non-Pay	£190,768	£112,735	£209,675	£217,899	£217,899	£210,099	£202,299	£101,150	£0	**£1,462,524**
Depreciation	£73,969	£295,877	£295,877	£295,877	£295,877	£295,877	£295,877	£221,908	£0	**£2,071,140**
PDC	£71,195	£64,723	£54,367	£44,012	£33,656	£23,300	£12,945	£3,883	£0	**£308,082**
total incremental extra costs	**£335,933**	**£473,335**	**£559,920**	**£557,788**	**£547,432**	**£529,277**	**£511,121**	**£326,941**	**£0**	**£3,841,746**
cost and efficiency savings	£69,962	£212,704	£269,570	£378,780	£391,280	£391,280	£391,280	£195,640	£0	**£2,300,497**
incremental income generated	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
total incremental benefits	**£69,962**	**£212,704**	**£269,570**	**£378,780**	**£391,280**	**£391,280**	**£391,280**	**£195,640**	**£0**	**£2,300,497**
total surplus/(loss) of investment	**-£265,971**	**-£260,631**	**-£290,350**	**-£179,008**	**-£156,152**	**-£137,997**	**-£119,841**	**-£131,301**	**£0**	**-£1,541,249**

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

Robotic surgery activity forecasts for TWH

		Tunbridge Wells Hospital								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
220	hysterorectomy	0	102	150	150	150	150	150	150	1,002
165	Colorectal/general	0	112	165	165	165	165	165	165	1,102
190	Upper GI/Bariatrics	0	102	150	150	150	150	150	150	1,002
885	overall totals	0	316	465	465	465	465	465	465	3,106

Financial summary of activity, costs and savings 2024-25 to 2032-33										
	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
Pay	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
non-Pay	£0	£181,327	£182,387	£182,387	£182,387	£182,387	£166,787	£166,787	£0	**£1,244,446**
Depreciation	£0	£221,908	£295,877	£295,877	£295,877	£295,877	£295,877	£295,877	£73,969	**£2,071,140**
PDC	£0	£68,607	£59,545	£49,190	£38,834	£28,478	£18,122	£7,767	£1,294	**£271,837**
total incremental extra costs	**£0**	**£471,841**	**£537,809**	**£527,453**	**£517,098**	**£506,742**	**£480,786**	**£470,430**	**£75,264**	**£3,587,423**
cost and efficiency savings	£0	£580,461	£854,355	£854,355	£866,855	£866,855	£866,855	£841,855	£0	**£5,731,591**
incremental income generated	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
total incremental benefits	**£0**	**£580,461**	**£854,355**	**£854,355**	**£866,855**	**£866,855**	**£866,855**	**£841,855**	**£0**	**£5,731,591**
total surplus/(loss) of investment	**£0**	**£108,620**	**£316,546**	**£326,902**	**£349,757**	**£360,113**	**£386,069**	**£371,425**	**-£75,264**	**£2,144,168**

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:

		Maidstone & Tunbridge Wells Hospitals combined								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
34	open gynae-onc	7	19	23	34	34	34	34	17	202
106	lap gynae-onc	22	58	72	106	106	106	106	53	629
	gynae-onc total	**29**	**77**	**95**	**140**	**140**	**140**	**140**	**70**	**831**
	open/lap benign									
220	**hysterorectomy**	**14**	**141**	**198**	**220**	**220**	**220**	**220**	**185**	**1,417**
165	**Colorectal/general**	**0**	**112**	**165**	**165**	**165**	**165**	**165**	**165**	**1102**
190	**Upper GI/Bariatrics**	**8**	**124**	**177**	**190**	**190**	**190**	**190**	**170**	**1,239**
885	**overall totals**	**51**	**454**	**635**	**715**	**715**	**715**	**715**	**590**	**4,590**

Please note the potential urology repatriations are not in the financial model – see urology activity potential in appendix 1

Capex purchase of Robot and related equipment (both MGH and TWH)
Financial summary of activity, costs and savings 2024-25 to 2032-33

	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
Pay	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
non-Pay	£190,768	£294,061	£392,062	£400,286	£400,286	£392,486	£369,086	£267,936	£0	**£2,706,970**
Depreciation	£73,969	£517,785	£591,754	£591,754	£591,754	£591,754	£591,754	£517,785	£73,969	**£4,142,280**
PDC	£71,195	£133,330	£113,913	£93,201	£72,490	£51,779	£31,067	£11,650	£1,294	**£579,919**
total incremental extra costs	**£335,933**	**£945,176**	**£1,097,729**	**£1,085,241**	**£1,064,530**	**£1,036,018**	**£991,907**	**£797,371**	**£75,264**	**£7,429,170**
cost and efficiency savings	£69,962	£793,165	£1,123,925	£1,233,135	£1,258,135	£1,258,135	£1,258,135	£1,037,495	£0	**£8,032,088**
incremental income generated	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
total incremental benefits	**£69,962**	**£793,165**	**£1,123,925**	**£1,233,135**	**£1,258,135**	**£1,258,135**	**£1,258,135**	**£1,037,495**	**£0**	**£8,032,088**
total surplus/(loss) of investment	**-£265,971**	**-£152,011**	**£26,196**	**£147,894**	**£193,605**	**£222,117**	**£266,228**	**£240,124**	**-£75,264**	**£602,919**

The clinical efficiency savings are calculated from clinical data comparing results (on ALOS /complications/ conversions and readmissions) between laparoscopic / open surgical approaches to robotic approaches applied to the 5148 MTW projected robotic case mix. The metrics sources and detail can be found at Appendix 3

The most significant proportion of the clinical efficiency savings comes from a reduction in ALOS of 2.9 days for these major procedures with each day given a cost saving of £407.
The alternative to shutting the bed to realise the saving would be to bring additional activity through the vacated bed capacity. The Nuffield Trust calculate for 1-6 LOS patients the income would be over £718 per bed day. For prudent planning the £407 figure has been used

In addition, avoided costs of locum surgeon cover are estimated at £550k in total over the seven years of the programme. (0.2WTE temporary staff spend avoided in Y1 rising to 0.8WTE temporary staff spend saving in y4 onwards) 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.

Robotic surgery has the potential to provide the trust with additional private income of c £1.2M in total over the seven years of the programme. The project group estimate this could develop to up to 50 cases per annum by year 3 with a margin of c £4000 per case. 300 cases in total over 7 years. That income is not in the core model and is at risk and subject to the development of private facilities at MGH outside of the scope of this investment

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 is: 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. Starting with MGH

From this point on the sections should be completed for the preferred option only

The preferred option – detail

Develop on-site RAS at MTW with activity and financial profile as per option 4. A robot at MGH in October 2024 and a robot in TWH from April 2025. Go out to tender to procure the best value for money robot from the supplier that scores most highly in the procurement exercise. Initial pre-market engagement with prospective suppliers has produced indicative top-end costing. It is anticipated that this cost will come down following a competitive tendering exercise

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.

The forecast clinical efficiency savings are calculated from clinical data by comparing results (*on ALOS /complications/ conversions and readmissions*) between laparoscopic / open surgical approaches to robotic approaches applied to the 4,590 MTW projected robotic case mix. (Excludes urology activity)

The metrics sources and detail can be found at Appendix 3 and are reflected in the financial model.

The most significant proportion of the clinical efficiency savings comes from a reduction in ALOS of 2.9 days for these major procedures with each day given a cost saving of £407. The alternative to shutting the bed to realise the saving would be to bring additional activity through the vacated bed capacity. The Nuffield Trust[4] calculate for 1-6 LOS patients the income would be over £718 per bed day. For prudent planning the £407 figure has been used.

[4] The Nuffield Trust- Understanding patient flow in hospitals https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf

Commercial Case

Procurement route

Procurement have been involved from the early stages and have advised on the Robot procurement. They have identified two compliant frameworks that will allow a mini-competition, SBS and CCS.

The suppliers of RAS technology include:

- Intuitive Surgical - Da Vinci (American original)
  - Market leader - operational since 1998 with 70% of the market
  - Focussed on Urological Cancers
  - Preferred at MGH and East Kent and currently the type of robot our surgeons use most often

- CMR - Versius (designed in Cambridge)
  - Does not have any units operational nationally
  - CE branded – indicating conformity with Health, Safety and Environmental Protection standards within the EEA.
  - Available under an NHS framework agreement.
  - CMR have indicated they are prepared to enter into an agreement which shares the risk of benefits realisation
  - At the time of writing the CMR robot has limited functionality for renal surgery

- Medtronic
  - One of the world's largest medical technology company
    - Hugo surgical robot

Developing a robot supplier decision matrix

The tender procurement decision matrix will be finalised after OBC approval/

Staffing plans

Provision of a surgical robot will not require any additional staff and is expected to 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.

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. This primarily through the potential repatriation of some procedures currently being undertaken at Eastbourne and Medway Foundation Trust. It is expected this work will be subject to system regional discussion, its own business case and plan for investment of any associated income.

Theatres - training of theatre staff is part of the training package to be included in the tender evaluation

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

Financial Case – Funding and affordability

Financial- payment mechanisms

A surgical robot can be funded through a number of routes:

Both revenue and capital options are available however capital, both purchased and leased options, remains constrained at a Trust and system level.

1. **Capital purchase** – this option purchases the robot from Trust capital funds and is fully owned by the Trust. The capital cost is depreciated over the expected useful life, and both the depreciation and the cost of capital (3.5% on the net average asset value) are charged to annual expenditure budgets.

2. **Capitalised Lease (IFRS 16**) -this includes any arrangement in which the Trust pays an annual charge to a supplier in order to obtain the use of an asset over a contract term. The present value of the rentals, or lease charge, over the whole of the contract term, is capitalised at the start of the arrangement (excluding VAT, which is charged directly to revenue). The capitalised right of use asset is charged to Trust capital funds – at present this stream of capital funding is additional to mainline capital, and from 2024/25 will need to be agreed at ICB system level per Trust. The right of use asset is depreciated, like a purchased capital asset, and a financing interest charge is made to revenue budgets, based on the financing rate inherent in the agreement, or the DHSC default financing rate.

   IFRS 16 leases can take a variety of forms:

   - An explicit lease or rental agreement providing use of the asset for a defined contract term. There may be other services or consumables provided as part of the arrangement which are charged directly to revenue. The contract may include options to purchase the asset at the end of the contract, or renew the arrangement, or break clauses. These all need to be considered as part of determining the initial lease financial impacts.
   - An implicit lease agreement e.g. where the cost of the asset is charged to the Trust by means of a consumable or other charges rather than an explicit rental; or where there is a fixed minimum payment or guaranteed volume of use that the Trust agrees to as part of the contract

3. **Revenue models** – arrangements may be established that do not fall to be treated as a capitalised lease under IFRS 16 but are instead service arrangements, and charged directly as revenue costs on an annual basis. These can include:
   - Arrangements where the equipment is managed and used by the supplier to provide the service, and not under the control or direction of the Trust e.g. outsourced services
   - Arrangements where the Trust is charged on a fully variable basis for the outputs of the service provided, with no minimum payment or volume guarantees, or other termination clawback provisions. Here the Supplier takes the risk that the Trust only pays for what it uses. The accounting for this approach is currently being reviewed by DHSC/NHSE accounting leads, as it may fall technically within IFRS 16 in some circumstances, and although there would be no initial capital impact, there could be a need to revalue the asset incurring additional revenue costs.
   - Arrangements where the Trust does not have an identified asset as part of the arrangement or where the asset used to provide the service is shared with other organisations. This can include a range of options e.g. the supplier has the right to substitute the assets throughout the contract for its own economic benefit; or the supplier uses the same assets to provide services to other organisations. Such arrangements may constitute a service not a lease.

The project team recognise the likely limited availability of capital funds for 2024/25 within MTW and the K&M system. With that in mind, the project team have been encouraging potential partners to develop revenue solutions.

The expected scale of expenditure on the preferred option

Summarised financial impact of the preferred option Project lifetime of 84 months – includes VAT			
Summary of financial impacts			
CAPITAL COSTS		**FUNDING SOURCE**	**£**
Estates		Identified in the Trust capital plan	
IT		Identified in directorate revenue budget	
Equipment	4,142,280	Other *(specify)*	
Total Capital Cost	**4,142,280**	**Financial note on costs** The expected scale of expenditure is based on estimates from initial pre-market engagement with prospective suppliers. It is not guaranteed and will be fully defined in Full Business Case. Additional income potential (outside model) • Private income £1,200,000 • Urology repatriation £8,883,750	
REVENUE COSTS			
Instruments and consumables	£86,970		
Initial set up	£336,000		
MTW IT	£100,000		
Service and maintenance	£2,184,000		
Capital Charges (Depreciation and PDC)	£4,722,199		
Total Revenue Cost over the 7 years	**£7,429,170**		
INCOME Savings/efficiencies from the switch to the robot, and the freed capacity			
Clinical efficiency savings	-£7,482,088		
Avoided locum savings	-£550,000		
Total income and savings	**-£8,032,088**		
Surplus	**£602,919**		

Additional Financial Information

The forecast clinical efficiency savings are calculated from clinical data by comparing results (*on ALOS /complications/ conversions and readmissions*) between laparoscopic / open surgical approaches to robotic approaches applied to the 5148 MTW projected robotic case mix.
The metrics sources and detail can be found at Appendix 3

The most significant proportion of the clinical efficiency savings comes from a reduction in ALOS of 2.9 days for these major procedures with each day given a cost saving of £407. The alternative to shutting the bed to realise the saving would be to bring additional activity through the vacated bed capacity. The Nuffield Trust[5] calculate for 1-6 LOS patients the income would be over £718 per bed day. For prudent planning the £407 figure has been used.

Avoided costs of locum surgeon cover are estimated at £550k in total over the seven years of the programme. (0.2WTE temporary staff spend avoided in Y1 rising to 0.8WTE temporary staff spend saving in y4 onwards) 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

[5] The Nuffield Trust- Understanding patient flow in hospitals https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf

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.

Forecast additional income outside financial model Robotic surgery has the potential to provide the trust with additional private income of c £1.2M in total over the seven years of the programme. The project group estimate this could develop to up to 50 cases per annum by year 3 with a margin of c £4000 per case. 300 cases in total over 7 years. That income is at risk and subject to the development of private facilities at MGH outside of the scope of this investment

A robot at MGH would provide the region with strategic potential to develop Urology RAS at MTW. Additional income could flow from that regional development. (Each radical prostatectomy is associated with a tariff income of approximately £7,200. With a projection of 1150 procedures the potential scale of income over the 84 months of the programme could be in the region of £8.8M) However, this income would be offset by comparable costs, requires regional collaboration and is not included in financial summary here

Management Case: Arrangements for successful implementation

Governance arrangements

The surgical division will be supported by the strategy team, finance and estates team to develop the Full Business Case.

Project team

The surgical divisional leadership team will hold responsibility for developing the Full Business Case supported by corporate services. Appropriate clinical teams will input into the equipment specification to ensure a robust financial model is developed that will meet clinical need.

Delivering the key measurable benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
Reduced average LOS for key procedures	x	x-20%	LoS Data. Sign post procedure malignant hysterectomy 2022-23 compared to 12 months from go live	12 months	Surgery and gynaecology GM with BI support
Reduce readmission rate for key procedures	x	x-20%	Readmissions rate (%) within 90 days for all malignant hysterectomy		
Reduce time to fill consultant vacancy	X	x-50%	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	See forecast / yr	Activity data	ongoing	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	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
Finance	20	Deputy Director of Finance on working group	16	Dep Dir Finance
Condition of theatres	10	Estates on working group	6	Director of Surgery
Commissioning Risk/Wider System Providers	12	Exec/Clinical Lead to discuss with ICB and system providers	6	Director of Strategy
Private activity	10	Requires a trust private facility at MGH	10	TBC

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

(Please tick box as appropriate)

Not required ✓ Completed ☐ Required but not completed yet ☐

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[6] 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:

[6] 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 forecast

		Maidstone & Tunbridge Wells Hospitals combined								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
34	open gynae-onc	7	19	23	34	34	34	34	17	202
106	lap gynae-onc	22	58	72	106	106	106	106	53	629
	gynae-onc total	**29**	**77**	**95**	**140**	**140**	**140**	**140**	**70**	**831**
	open/lap benign									
220	**hysterorectomy**	**14**	**141**	**198**	**220**	**220**	**220**	**220**	**185**	**1,417**
165	**Colorectal/general**	**0**	**112**	**165**	**165**	**165**	**165**	**165**	**165**	**1102**
190	**Upper GI/Bariatrics**	**8**	**124**	**177**	**190**	**190**	**190**	**190**	**170**	**1,239**
885	**overall totals**	**51**	**454**	**635**	**715**	**715**	**715**	**715**	**590**	**4,590**

		Maidstone Hospital								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
34	open gynae-onc	7	19	23	34	34	34	34	17	202
106	lap gynae-onc	22	58	72	106	106	106	106	53	629
	gynae-onc total	**29**	**77**	**95**	**140**	**140**	**140**	**140**	**70**	**831**
	open/lap benign									
220	**hysterorectomy**	**14**	**39**	**48**	**70**	**70**	**70**	**70**	**35**	**415**
190	**Upper GI/Bariatrics**	**8**	**22**	**27**	**40**	**40**	**40**	**40**	**20**	**237**
885	**overall totals**	**51**	**138**	**170**	**250**	**250**	**250**	**250**	**125**	**1,484**

		Tunbridge Wells Hospital								
annual cases		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
at full 100%	ramp up phasing	41%	55%	68%	100%	100%	100%	100%	100%	
220	**hysterorectomy**	**0**	**102**	**150**	**150**	**150**	**150**	**150**	**150**	**1,002**
165	**Colorectal/general**	**0**	**112**	**165**	**165**	**165**	**165**	**165**	**165**	**1,102**
190	**Upper GI/Bariatrics**	**0**	**102**	**150**	**150**	**150**	**150**	**150**	**150**	**1,002**
885	**overall totals**	**0**	**316**	**465**	**465**	**465**	**465**	**465**	**465**	**3,106**

Urology potential activity (outside of financial model)

	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
1) Income										
no. of Prostatectomy procedures	45	170	170	170	170	170	170	85		**1,150**
Tariff per procedure	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725		
total Tariff income gained	**£347,625**	**£1,313,250**	**£1,313,250**	**£1,313,250**	**£1,313,250**	**£1,313,250**	**£1,313,250**	**£656,625**		**£8,883,750**

Over the 84 month life of the Robot for MGH there would be 1,150 procedures realising £8.9m in additional income.

But without any 'net of' incremental costs for bed capacity required at MGH, nursing requirements etc.

Appendix 2 Financial model

Capex purchase of Robot and related equipment (both MGH and TWH)
Financial summary of activity, costs and savings 2024-25 to 2032-33

	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
1) Income										
no. of Prostatectomy procedures	0	0	0	0	0	0	0	0		**0**
Tariff per procedure	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725	£7,725		
total Tariff income gained	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**		**£0**
2) Pay										
nothing new identified	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
3) non-Pay										
(i) Supplier related										
Instruments & accessories	£5,268	£7,461	£7,662	£15,886	£15,886	£15,886	£15,886	£3,036		**£86,970**
initial set-up costs/stocking order	£168,000	£168,000	£0	£0	£0	£0	£0	£0		**£336,000**
sterilisation of equipment										**£0**
Servicing & maintenance	£0	£93,600	£374,400	£374,400	£374,400	£366,600	£343,200	£257,400		**£2,184,000**
ii) Other non-Pay										
IT (MTW)	£17,500	£25,000	£10,000	£10,000	£10,000	£10,000	£10,000	£7,500		**£100,000**
Depreciation	£73,969	£517,785	£591,754	£591,754	£591,754	£591,754	£591,754	£517,785	£73,969	**£4,142,280**
PDC	£71,195	£133,330	£113,913	£93,201	£72,490	£51,779	£31,067	£11,650	£1,294	**£579,919**
total incremental costs	**£335,933**	**£945,176**	**£1,097,729**	**£1,085,241**	**£1,064,530**	**£1,036,018**	**£991,907**	**£797,371**	**£75,264**	**£7,429,170**
4) Cost and efficiency savings										
clinical efficiency savings	-£69,962	-£743,165	-£1,048,925	-£1,158,135	-£1,158,135	-£1,158,135	-£1,158,135	-£987,495		**-£7,482,088**
avoided locum consultant costs	£0	-£50,000	-£75,000	-£75,000	-£100,000	-£100,000	-£100,000	-£50,000		**-£550,000**
total cost and efficiency savings	**-£69,962**	**-£793,165**	**-£1,123,925**	**-£1,233,135**	**-£1,258,135**	**-£1,258,135**	**-£1,258,135**	**-£1,037,495**		**-£8,032,088**
total net cost of investment	**£265,971**	**£152,011**	**-£26,196**	**-£147,894**	**-£193,605**	**-£222,117**	**-£266,228**	**-£240,124**	**£75,264**	**-£602,919**
total new income generated	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**		**£0**
total surplus/(loss) of investment	**-£265,971**	**-£152,011**	**£26,196**	**£147,894**	**£193,605**	**£222,117**	**£266,228**	**£240,124**	**-£75,264**	**£602,919**

Capex purchase of Robot and related equipment (both MGH and TWH)
Financial summary of activity, costs and savings 2024-25 to 2032-33

	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32	FY 2032-33	lifetime totals
Pay	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
non-Pay	£190,768	£294,061	£392,062	£400,286	£400,286	£392,486	£369,086	£267,936	£0	**£2,706,970**
Depreciation	£73,969	£517,785	£591,754	£591,754	£591,754	£591,754	£591,754	£517,785	£73,969	**£4,142,280**
PDC	£71,195	£133,330	£113,913	£93,201	£72,490	£51,779	£31,067	£11,650	£1,294	**£579,919**
total incremental extra costs	**£335,933**	**£945,176**	**£1,097,729**	**£1,085,241**	**£1,064,530**	**£1,036,018**	**£991,907**	**£797,371**	**£75,264**	**£7,429,170**
cost and efficiency savings	£69,962	£793,165	£1,123,925	£1,233,135	£1,258,135	£1,258,135	£1,258,135	£1,037,495	£0	**£8,032,088**
incremental income generated	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
total incremental benefits	**£69,962**	**£793,165**	**£1,123,925**	**£1,233,135**	**£1,258,135**	**£1,258,135**	**£1,258,135**	**£1,037,495**	**£0**	**£8,032,088**
total surplus/(loss) of investment	**-£265,971**	**-£152,011**	**£26,196**	**£147,894**	**£193,605**	**£222,117**	**£266,228**	**£240,124**	**-£75,264**	**£602,919**

Appendix 3 Cost savings

Research has shown clinical cost savings for certain clinical events. Applied these savings to MTW case mix shows the following indicative savings using RAS. A selection of these savings will be tracked through benefits realisation review by the Surgical Division working with the RAS supplier

		clinical efficiency savings per year								
Specialty split		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
	saving/case									
Gynae Onc	£1,703	£48,876	£131,131	£162,126	£238,420	£238,420	£238,420	£238,420	£119,210	**£1,415,023**
Benign	£842	£12,083	£118,301	£166,379	£185,240	£185,240	£185,240	£185,240	£155,770	**£1,193,493**
Colorectal/General	£3,187	£0	£357,581	£525,855	£525,855	£525,855	£525,855	£525,855	£525,855	**£3,512,711**
Upper GI / Bariatrics	£1,098	£9,004	£136,152	£194,566	£208,620	£208,620	£208,620	£208,620	£186,660	**£1,360,861**
total clinical efficiency savings		**£69,962**	**£743,165**	**£1,048,925**	**£1,158,135**	**£1,158,135**	**£1,158,135**	**£1,158,135**	**£987,495**	**£7,482,088**

		savings (-) / additional costs (+) on equipment and accessories costs per year								
cost difference /case		2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
Gynae Onc	**£132**	£3,789	£10,166	£12,569	£18,484	£18,484	£18,484	£18,484	£9,242	**£109,704**
Benign	**£132**	£1,895	£18,550	£26,089	£29,047	£29,047	£29,047	£29,047	£24,426	**£187,146**
Colorectal/General	**-£133**	£0	-£14,971	-£22,016	-£22,016	-£22,016	-£22,016	-£22,016	-£22,016	**-£147,067**
Upper GI / Bariatrics	**-£51**	-£416	-£6,284	-£8,980	-£9,629	-£9,629	-£9,629	-£9,629	-£8,616	**-£62,813**
		£5,268	**£7,461**	**£7,662**	**£15,886**	**£15,886**	**£15,886**	**£15,886**	**£3,036**	**£86,970**

locum consultant cost savings per year (for two robots)								
2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	totals
£0	**£50,000**	**£75,000**	**£75,000**	**£100,000**	**£100,000**	**£100,000**	**£50,000**	**£550,000**

Cost savings Metrics

Metrics for Surgical Bed Capacity Analysis		Metrics for Existing Open/Lap Cases*				Metrics for RAS Cases				Publication/ QTI	
Speciality	Patient Clinical Opportunity	Avg. Surgical Bed Length of Stay	% Conversions	% Complications	% 30 Day Readmission	Avg. Surgical Bed Length of Stay	% Conversions	% Complications	% 30 Day Readmission	Source/ Author	Date
Colon	Existing Open Cases	10.8	0%	30%	27%	4.7	3.0%	15.0%	8.0%	Benlice	2016
Colon	Existing Lap Cases	8.1	33%	17%	11%	4.7	3.0%	15.0%	8.0%	Benlice	2016
Rectal	Existing Open Cases	10.6	0%	33%	22%	6	7.0%	0.0%	7.5%	Hyde	2020
Rectal	Existing Lap Cases	10.3	8%	20%	8%	6	7.0%	0.0%	7.5%	Hyde	2020
Benign Hysterectomy	Existing Open Cases	2.3	0%	4%	2%	1	0.0%	0.6%	0.0%	Chalooub (QTI)	2022
Benign Hysterectomy	Existing Lap Cases	1.5	2%	3%	9%	1	0.0%	0.6%	0.0%	Chalooub (QTI)	2022
Endometriosis	Existing Open Cases	2	0%	0%	0%	0.8	0.0%	0.0%	0.0%	Raza (QTI)	2022
Endometriosis	Existing Lap Cases	1.3	0%	7%	7%	0.8	0.0%	0.0%	0.0%	Raza (QTI)	2022
Salpingo-Oophorectomy	Existing Open Cases	3.1	0%	10%	10%	1.3	0.0%	5.0%	11.0%	National HES data 22_23	2022
Incisional Hernia	Existing Open Cases	6	0%	23%	23%	1.4	0.6%	24.0%	1.9%	Le Blanc	2021
Benign Hysterectomy (Maid)	Existing Open Cases	4.6	0%	10%	0%	1	0.0%	0.6%	0.0%	Chalooub (QTI)	2022
Benign Hysterectomy (Maid)	Existing Lap Cases	2.5	10%	10%	0%	1	0.0%	0.6%	0.0%	Chalooub (QTI)	2022
Hysterectomy Malignant (Maid)	Existing Open Cases	6	0%	20%	8%	1	0.0%	5.0%	2.0%	Lippiatt (QTI)	2022
Hysterectomy Malignant (Maid)	Existing Lap Cases	2.5	5%	5%	5%	1	0.0%	5.0%	2.0%	Lippiatt (QTI)	2022
Salpingo-Oophrectomy (Maid)	Existing Open Cases	4.1	0%	8%	8%	1.3	0.0%	5.0%	11.0%	National HES data 22_23	2022
Salpingo-Oophrectomy (Maid)	Existing Lap Cases	1.8	6%	6%	0%	1.3	0.0%	5.0%	11.0%	National HES data 22_23	2022
Fundoplication	Existing Lap Cases	3.1	0%	13%	13%	2.1	0.0%	5.0%	10.0%	National HES data 22_23	2022
Hiatial Hernia	Existing Lap Cases	4.7	0%	10%	10%	2.1	0.0%	6.0%	10.0%	National HES data 22_23	2022
Ventral Hernia	Existing Open Cases	2.2	0%	8%	8%	1.7	0.0%	5.0%	5.0%	National HES data 22_23	2022

Cost savings Metrics

Based on adoption rate - Capacity Impact if approx 66% of current open and lap cases moved †
*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 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 procedure**s 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 i**n 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!

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Business Case for Oncology Consultant Recruitment — **Chief Operating Officer**

The Trust Board is requested to review, and if appropriate approve, the Business Case for Oncology Consultant Recruitment, which was recommended for approval by the April 2024 Finance and Performance Committee meeting

The business case objectives are:

- Provide equitable access to timely oncology review and treatment across Kent and Medway
- Increase service capacity to allow for the provision of new and labour-intensive drugs across Kent and Medway
- Reduce reliance on premium agency staff and improve continuity of care for long-term cancer patients

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

- Business Case Review Panel
- Executive Team Meeting, 26/03/24
- Finance and Performance Committee, 23/04/24

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	Oncology Consultant Recruitment

Stage of Plan	Single stage "Justification" (J) ☐ Stage 2 – Outline Business Case (OBC) ☐ Stage 3 - Full Business Case (FBC) ✓
ID reference *Contact: mtw-tr.bcrp@nhs.net*	**ID 998**
Division	Cancer Services
Site / Department / Directorate	Oncology Directorate
Project Lead	Naomi Butcher
Prioritisation has been agreed at *(Tick as applicable and please provide detail in strategic background section)*	Service development priority in divisional annual plan ✓
	Charitable funds group/s ☐
	Other (Specify) ☐

Approvals *(mandatory to complete)*	**Name**	**Date approved**
Has the case been approved at a Divisional Board?		
If not, who from Divisional Leadership Team has approved the case on behalf of the Division?	Alice Farrell / Philippa Moth	05.02.2024
Executive Sponsor / SRO approval	Sean Briggs	14.03.2024
Other approval? ☐ *Please specify*	Hannah Ferris	

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? Yes – laptops only
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
Have they been involved in the planning? YES

Stakeholders *(please identify other individuals, not already listed, who have been involved in preparing this case. Include external stakeholders where appropriate)*

Role	**Name**	**Role**	**Name**
Finance Manager	Gemma Paling	EME Services Mgr.	Michal Chalklin
Estates	Debbie Morris	Outpatients lead/s	N/A (outpatients managed in oncology)
Facilities Management	Maria Fabian	Charitable funds mgr.	Claire Ashby
ICT/Clinical Systems & EPR	Mark Price	HR Business Partner	Angie Collison

Core Clinical Services lead/s	Jelena Pochin	Procurement team	N/A
Emergency Planning team	John Weeks	Clinical Director	Kannon Nathan / Tim Sevitt
General Manager	Naomi Butcher	Pharmacy	Dhalvir Midda

Executive Summary

Recommendation: This business case seeks approval to invest £1,735,415 in revenue to support the appointment of 5.5 WTE oncology consultants (above baseline budget) plus supportive staff. It also seeks to fund administrative staff for the appointment of 2.00 WTE consultants who are funded through upcoming PA reduction and retirements.

The investment will be funded through an increase in PBR income (£1.475m). This is £1.2m of PBR outpatient and chemotherapy income, and 275k Acute Oncology Same Day Emergency Care activity. This will also allow the removal of agency spend for two long term consultants, which will generate a run rate saving of £534k.

Strategic background context and need

Kent Oncology Centre (KOC) provides specialist oncology services for 1.9 million people across Kent and Medway.

The demand for oncology services continues to grow rapidly on the basis patients are living longer with access to new treatment opportunities and improved treatment efficacy. In 23/24, KOC predicted a 5% growth on IV chemotherapy and year-to-date (YTD) have met this plan with similar growth expected next year. Further, new patient (NP) activity was forecast to grow by 6% in 23/24 and YTD the service has seen an additional average growth of 6% over plan.

In January 2021, Oncology services were given the go-ahead to appoint 7.5 WTE consultants above the 4.5 WTE vacant posts within baseline budget at that time. To date, these vacancies have been filled, yet unsurprisingly – given the data shown above - there is still further requirement to ensure a substantive baseline workforce and to replace ongoing reliance on premium agency staff.

This business case outlines a request to increase baseline workforce by a further 5.5 WTE consultants across Kent and Medway, and includes supporting administrative, chemotherapy and core clinical resource to manage this increased activity. This additional resource is applied to the appointment of 2.00 WTE consultants funded through PA reduction and upcoming retirements.

Objectives

- Provide equitable access to timely oncology review and treatment across Kent and Medway.
- Increase service capacity to allow for the provision of new and labour-intensive drugs across Kent and Medway.
- Reduce reliance on premium agency staff and improve continuity of care for long-term cancer patients.

The preferred option

Fund the appointment of 5.50 WTE oncology consultants and supporting staff. Fund the appointment of supporting staff for 2.00 WTE consultants budgeted through PA reduction and upcoming retirements.

This will help to maintain a safe service for patients, and allow KOC to continue to be recognised as a centre of excellence for oncological treatment comparable to partners in Manchester or London.

As demonstrated with the above activity data, the service is expanding rapidly in line with national campaigns on early cancer detection, improved research into treatment innovation, and a growing and ageing population.

This recruitment will also help to support the set-up, and future development, of an acute oncology same day emergency care unit through a commitment to include acute oncology within consultant job plans, or releasing consultant time within current workforce.

Planned key benefits to come from the investment

- Help to support a growing oncological service and ensure patients are seen and treated sooner; improving patient outcomes and prognosis.
- Support new innovative treatments to improve patient outcomes and prognosis.
- Reduce inequity in service accessibility across Kent and Medway.
- Improve job satisfaction; reducing turnover, keeping staff for longer, attracting staff across SE to support future service development.
- Reduce agency spend, which not only supports the trust financial baseline, but improves continuity of care for patients who have substantive staff and not temporary agency staff.
- Support the set-up, and future development, of an acute oncology same day emergency care unit.

Measurable benefit Key Performance Indicator (KPI)	**Baseline Position**	**Future Outcome**
Improve 24-day first definitive treatment (FDT) target	<70%	75%-80%
Increase the proportion of 'on-active-treatment' patients seen in the specified timeframe	<55%	>70%
Ability to accommodate new innovative treatments	Not achieved in recommended timeframe or equitably across the county	Equitable roll out of new treatment regimens; managed through the non-surgical oncology group (NOG)
Number of patients seen in SDEC space and prevention of A+E space	N/A – not currently recorded	To work alongside medicine division once pilot is live

Main risks associated with the investment

Risk of not doing it:
Current workforce do not have the capacity to manage the growth in oncological demand.
Continued reliance on premium workforce to manage this.
Reduced timely access to review and treatment, and inability to implement new innovative treatments equitably across the county.

Delivery risk:
Recruitment into consultant positions quickly.
Treatment capacity to manage ongoing demand. Linked to Radiotherapy business case and additional chemotherapy staffing capacity within.

Residual Risk:
Expected continued growth in oncological demand.

Financial impact of the preferred option

Full year effect – include VAT unless recoverable

Summary of financial impacts			
CAPITAL COSTS	**£000**		
Estates	0		
IT	19		
Equipment	0		
Total Capital Cost	**19**	**Additional Financial Information** Pay costs have been calculated using an average substantive consultant cost for a 10PA Consultant.	
REVENUE COSTS			
Pay	1,735		

		Please see attached Finance workings for detailed costings. Clinical income has been calculated using the average income per Consultant. Laptops have been assumed for 7.5 Consultants and 6 additional admin staff. The case includes an additional £275k income associated to the SDEC pilot, for which these roles are imperative. It will also enable the Directorate to reduce a forecast run rate pressure of £534k per annum based on the current locums in place. Funding shortfall: For ease of financial summaries, not all 'new income' has been included for posts which we have seen this financial year. Job plans have been created across sites (and therefore split income) to improve retention and attract candidates to the area. This equates to approximately 2 x 0.5 clinical oncology job plans at Maidstone. The average income for a clinical oncologist is £252,000 (see finance spreadsheet) and offsets the funding shortfall detailed to the left. Cost for these posts has been included in the business case, so note of the income must be made for reference despite not being additional.
Non- Pay	50	
Depreciation and PDC (Y1)	5	
Total Revenue Cost per annum	**1,790**	
INCOME/BUDGET		
ICB elective income	1,205	
AO SDEC income	275	
Identified in directorate revenue budget	310	
Funding Shortfall	**(0)**	

Timetable	
Milestone	**Date**
Recruitment of consultants	Ongoing. Recruitment for consultant oncologists has been a challenging and therefore a specific timeline will be difficult. Weekly recruitment meetings within oncology can update on progress against this milestone.

Strategic Case

Kent Oncology Centre (KOC) provides specialist oncology services to 1.9 m patients across Kent and Medway, often treating up to 600 patients every day. Consultant Oncologists are employed by Maidstone and Tunbridge Wells NHS Trust and provide outpatient clinics at both of the Trust's hospitals, as well as across the county in East Kent, Medway and Darenth Valley. Due to this, historically there have been significant challenges in recruiting staff into different areas, and instead this has lent on a core consultant group to deliver a majority of the increasing workload.

In January 2021, the oncology directorate received agreement to appoint 7.5 WTE consultant over the 4.5 WTE vacancies within the budget at the time. In total, this gave baseline budget for 42 WTE consultant without any additional service delivery roles appointed to support this expansion.

In December 2023, all of these vacancies had been appointed to, which significantly helped support colleague motivation, manage extended periods of sickness without issue, improve retirement planning and reduce job plans/workloads where significantly high. Unfortunately, the service still relies on a small number of premium workforce to manage the demand across parts of the service – for example, urology cancer – and difficult to recruit areas.

Looking at today's activity, oncology services continues to grow rapidly on the basis patients are living longer with access to new treatment opportunities and improved treatment efficacy.

	19/20 Actuals	FOT 22/23 (as at Dec 22)	22/23 Actuals	Planned growth from 22/23 FOT to 23/24 plan	23/24 Plan	23/24 Actuals (YTD M1 - M10)	23/24 FOT (pre-booked)	Growth from 23/24 plan to 23/24 FOT (%)	Growth from 19/20 Actuals to 23/24 FOT (%)
New consultant activity	3696	4364	4462	6%	4626	3955	4906	6.05%	32.74%
New non-consultant led activity	2909	3554	4236	6%	3767	3723	4546	20.68%	56.27%
F/up consultant activity	17913	21974	22775	4%	22853	21890	26298	15.07%	46.81%
F/up non-consultant led activity	25250	31725	32823	4%	32994	30942	37074	12.37%	46.83%
IV chemotherapy	13809	15337	15613	6%	16192	13714	16486	1.82%	19.39%
Oral chemotherapy	3563	5992	5981	16%	6923	5501	6682	-3.48%	87.54%

Since 19/20, we have seen a 32% growth in consultant led new patient (NP) appointments and 56% growth in non-consultant led NP appointments. Growth is forecast to be above plan for this year, despite adding significant growth predictions across both consultant led and non-consultant led activity.

Further, IV Chemotherapy has shown nearly a 19% increase in activity since 19/20 financial year; a significant proportion of which we have seen this recent financial year (8% growth in line with plan and above). This demonstrates the growth in treatment delivery as a proportion of additional new patients into the service, and also through the introduction of new treatments for a wider cohort of eligible patients.

The case for change

- Provide equitable access to timely oncology review and treatment across Kent and Medway. This translates into improving performance against the 24-day referral to treatment standard, and improving the number of 'on-active treatment' patients who are able to be seen within their expected timeframe.
- Allow bandwidth for the provision of new and labour-intensive drugs across Kent and Medway – e.g. drugs with increased toxicity requiring frequent follow up and review between cycles, and allowing provision equitably in all parts of the county.
- Reduce reliance on premium agency staff and improve continuity of care for long-term cancer patients.

Case for change re objective 1

24-day treatment standard

The Cancer Waiting Times (CWT) standards commit to the drive for patients on a suspected cancer pathway to be diagnosed by day 28 (Faster Diagnosis Standard) and treated by day 62. For referrals into tertiary treatment services, such as oncology, patients are measured against a 24-day treatment standard meaning patients need to be both seen and treated within this timeframe.

The national target for the 24-day standard is 85% and below summarises KOC's average performance over the last 4 years.

	2019-20	2020-21	2021-22	2022-23	Apr-Nov 2023-24 YTD
Avg. % Performance per year Overall	58.28%	69.61%	66.86%	62.46%	69.41%

This table evidences a consistent underperformance (below 70%) of the 24-day treatment standard. Increasing baseline capacity, as a result of this business case, will help to improve time to first appointment and ability to treat cancer patients within the nationally agreed clinical standards.

On-active-treatment follow-up timeframe

Recently, the service has reviewed new data tracking what proportion of patients on-active-treatment – and therefore requiring close follow-up – are seen within the requested timeframe. Using an average of the snapshots taken so far, it has shown only 52% of patients are rebooked within 2 days of the requested timeframe.

This is due to the increasing volume of new patients adding burden to consultant clinics, and longer-term follow up created from new and improved treatment efficacy. Access to timely oncology treatment is the biggest indicator of successful clinical outcomes and remains an important indicator for improved patient experience.

Case for change re objective 2

Due to major developments in the complexity of treatment, and the versatility of treatment in managing patient symptoms for longer, the workload is expanding significantly.

One case study example of this is the introduction of adjuvant Abemaciclib chemotherapy in breast cancer patients who have a high recurrence risk and are hormone receptor positive, HER2 negative and node-positive. The specificity of this patient cohort demonstrates the complexity of increasing oncological treatments in widening patient eligibility and ultimately increasing demand on service provision.

With initial modelling, this specific drug showed approximately 180 patients per year, across West Kent alone, would be eligible. And the delivery of this drug required 'medical' review after each cycle, which forecast an increased demand for follow up slots (at maximum patient numbers) of 18 per week. This equates to 0.5 WTE consultant outpatient capacity for a single additional oncological treatment.

It is important to consider the use of different roles in the future running of oncology services, for example, nurse consultants and prescribing pharmacists, however these staff still require specialist input into the management of complex side effects and toxicities of these drugs.

Remaining disadvantages of recruitment to date include the ability to deliver new treatments equitably across Kent and Medway due to a disparity in staff capacity. The above treatment is not easily accessible in different parts of Kent as a result of this.

Case for change re objective 3

The below table demonstrates the overall agency spend across the 23/24 financial year. At the beginning of the year, we relied heavily on locum services to fill key gaps in the workforce. However, this has started to change due to the appointment of additional consultant bodies into the team.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Spend	86,010	69,927	259,373	99,304	124,258	123,828	136,082	148,718	63,050	61,084	68,820	68,820	1,309,274
											Forecast Spend		

This business case costs the YTD spend for two WTE consultant positions we aim to replace with substantive roles. Recruiting substantive roles helps to improve service security and most importantly the continuity of patient experience throughout their care pathway. Utilising short-term agency roles has a negative impact on patient outcomes and patient satisfaction, as well as having a significant impact on the financial position.

Constraints and dependencies

- Limited chemotherapy capacity to expand delivery. The business case importantly includes chemotherapy nursing costs to maximise delivery capacity. The growth of the chemotherapy unit at Maidstone is feasible due to available clinical space, however this will displace other activity which needs to be reviewed in the longer-term space plan.
- Challenged radiotherapy services to manage increased demand. Currently there is a business case going through to increase baseline staffing for current demand. Additional workforce needed to manage demand will need to be reviewed.
- Outpatient space for delivering clinics. Internally, oncology have separate outpatient space to develop flexible working, but delivering oncology services to peripheral sites is more challenged due to space availability at these sites.

Economic Case - The available options

Option 1 – Do nothing.

Stop oncology consultant recruitment at 43.0 WTE in 23/24, and appoint only within current budget when there are changes to job plans and/or leavers.

Strengths /Opportunities

- Reduced financial risk associated to income assumptions.

Weaknesses/ Threats

- Continued spend on agency staff putting financial pressure on baseline budget; £534k full year effect on premium staffing.
- Oncology services will not be able to cope with the capacity to support a growing population.
- Patients will wait longer for appointments and treatment, impacting on their prognosis and outcomes.
- Inability to support new treatments due to the increase in patient numbers or monitoring requirements.
- Inequity in service provision across Kent and Medway, leading to a postcode lottery for accessing new and innovative treatments.
- Increased job dissatisfaction due to volume of workload. Negative feedback cycle with reduced retention, early retirement and lack of credibility as a centre to attract new staff.
-

This option is not feasible should we wish to maintain a safe service for patients, and to continue being a recognised centre of excellence for oncological treatment comparable to partners in Manchester or London.

Option 2 – Recruit the identified posts.

Recruit identified posts within the business case to help bring us into a fully staffed position for current demand.

Strengths /Opportunities

- Help to support a growing oncological service and ensure patients are seen and treated sooner; improving patient outcomes and prognosis.
- Support new innovative treatments to improve patient outcomes and prognosis.
- Reduce inequity in service accessibility across all of Kent and Medway.
- Improve job satisfaction; reducing turnover, keeping staff for longer, attracting staff across SE to support further service development.
- Reduced agency spend which helps support financial management of the budgets.
- Support the set-up, and future development, of an acute oncology same day emergency care unit

Weaknesses

- Limited space and risk of treatment capacity minimising ability to accommodate staff and maximise income opportunities.

This is the preferred option should we wish to maintain a safe service for patients, and to continue being a recognised centre of excellence for oncological treatment comparable to partners in Manchester or London.

The preferred option

Summarise how the preferred option optimises value for money:

- Increase income from ERF to support additional revenue requirements
- Reduce spend on agency staff covering current demand across the service

The attached finance spreadsheet helps to break down the expected income aligned to chemotherapy and new patient activity for a clinical oncologist and medical oncologist, and helps to justify the income assumptions against the below activity assumptions.

New patient activity

Between 22/23 and 23/24 financial year, a 6% growth was expected on new patient activity in oncology. We have met plan and gone above this in the delivery of consultant led (+6.00%) and non-consultant led (+20.68%) activity.

Making efficiencies in service delivery has meant we have supported 20% of this additional growth within baseline budget (funded growth), however the remaining overperformance (895 NP appointments) is associated to a budget overspend in additional resource to manage this demand (approximately 3.50 WTE consultant time, as broken down in the finance spreadsheet, tab 3, detailing clinical and medical oncology average outpatient activity values).

22/23 FOT (as at Dec 22)	23/24 Plan (as at Dec 22)	23/24 FOT	Submitted funded 24/25 plan	Submitted unfunded 24/25 activity	24/25 plan with projected growth from additional recruitment
7918	8393	9452	8600	895	9720

This is based on an average of 228 new patient appointments per consultant per year (see tab 3 finance spreadsheet).

The appointment of an additional 2.00 WTE oncology consultants on top of these 3.50 WTE, will help to sustainably manage the growth we have seen this year and support the future trajectory of oncology new patient demand throughout the next financial year. The activity delivered by the new appointments will likely be phased throughout the new year (based on recruitment) and therefore only 6 months have been assumed in the activity table above.

Follow up activity

Whilst this activity hasn't been used to quantify income generation, the expected growth in follow up activity has been included to show predicted growth.

23/24 Plan	23/24 FOT (as at Jan 24)*	Submitted funded 24/25 plan*	Submitted unfunded 24/25 activity	24/25 plan with projected growth from additional recruitment
62519	68139	74730	5198	83,288

*including outpatient procedure activity

Growth has been worked out on the basis of 30 follow up appointments a week over a 42-week year. Additional outpatient procedure follow up activity has been included at an average of 35 appointments a month over 12 months.

Chemotherapy activity

As above, a 6% growth on 22/23 actuals was forecast on the delivery of oncology IV chemotherapy. To date, we have met plan and gone above this (+1.82%).

It has been challenging to support this additional growth within baseline budget. An overspend in pay to deliver this has been matched with an overperformance in associated chemotherapy income

22/23 FOT (as at Dec 22)	23/24 Plan (as at Dec 22)	23/24 FOT (as at Dec 23)	24/25 projected growth from additional recruitment
15337	16192	16486	17386

This is based on an average of 900 chemotherapy attendances per consultant per year (see tab 3 finance spreadsheet).

With the new appointments and phased increase in activity detailed above, we would be able to achieve the suggested growth in chemotherapy activity throughout next financial year.

Commercial Case

Services, assets and space required

This case will require additional staffing for the following Directorates:

Capital

- Laptop equipment for x 7.5 consultants
- Computer equipment for x 6 admin staff

Oncology admin

- 6 x admin staff (3 x Band 4 / 3 x Band 3)

Chemotherapy

- 2 chemotherapy nurses (2 x Band 6)

Core Clinical

- Agreed proportion of funding for core clinical recruitment to manage increased demand
- 2 Pharmacy roles (1 x Band 8a Pharmacy Prescriber / 1 x Band 6 Pharmacy Technician)

Staffing plans

All staff needed as soon as recruitment permits.

Please note the below table is for staff above current establishment only. The financial plan includes the understanding we have the budget currently for 2 consultants (within agreed job plan changes).

	WTE
Consultants	5.50
Admin	6.00
Chemotherapy Nurses	2.00
Diagnostics	TBC*
Pharmacy	2.00
Total Expenditure / WTE	**15.50**

**proportion of total funding agreement given to core clinical for expenditure accordingly.*

Impacts on and interfaces with other services

The two main impacts are on radiology and pathology. These are specialist resources which are not in control of the Cancer Division.

The Division has consulted with DDO for Core Clinical and GM for Pathology and Radiology individually. They have advised on suggested costs for core clinical services.

Activity, contractual and service level agreement implications. Commissioner involvement and input – n/a

Procurement route – n/a

Financial Case – Funding and affordability

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

		Total Revenue		Budget in Division		Investment Required	
Summary		**WTE**	**£**	**WTE**	**£**	**WTE**	**£**
Pay	Consultant	7.50	1,162,500	2.00	310,000	5.50	852,500
	Admin	6.00	192,165	0.00	0	6.00	192,165
	Chemotherapy	2.00	106,744	0.00	0	2.00	106,744
	Diagnostics		163,333	0.00	0	0.00	163,333
	Pharmacy	2.00	110,673	0.00	0	2.00	110,673
	Total Pay	**17.50**	**1,735,415**	**2.00**	**310,000**	**15.50**	**1,425,415**
Non-Pay	Outpatients		10,022		0		10,022
	Chemotherapy		39,917		0		39,917
	Total Non-Pay		**49,938**		**0**		**49,938**
Income	Clinical SLA income		**-1,204,953**		**0**		**-1,204,953**
	AO SDEC income		**-275**				
Capital Charges (Yr1)			**4,512**		**0**		**4,512**
Total		**17.50**	**310,000**	**2.00**	**310,000**	**15.50**	**0**

Summarise the activity, income assumptions relating to the preferred option.
Income assumptions drawn from an average per consultant of identified clinical income within the financial spreadsheets in 23/24. This covers income from NP / Day case activity / Chemotherapy (but not Radiotherapy due to block contract funding agreement). Workings are detailed in the finance spreadsheet attached and in breakdown within preferred option.

Capital costs agreed with I.T team.

For ease of financial summaries, not all 'new income' has been included for posts which we have seen this financial year. Job plans have been created across sites (and therefore split income) to improve retention and attract candidates to the area. This equates to approximately 2 x 0.5 clinical oncology job plans at Maidstone.

The average income for a clinical oncologist is £252,000 (see finance spreadsheet) and offsets the funding shortfall detailed above. Cost for these posts has been included in the business case, so note of the income must be made for reference despite not being additional.

AO SDEC activity and income assumption workings

Predictions are:

6 x patients x 4 days a week x 52 weeks of the year at £300 per attendance = £374,400k

This has been taken at an outpatient rate not day case. This is because we do not have any comparative examples to benchmark and therefore have taken a reserved estimation. We expect this to be higher due to most activity being a pre-planned admission and therefore coded as a regular day attender, in line with other models of SDEC delivery at MTW.

£100k of staffing cost has been removed from the income total, and will form a separate recruitment drive once the pilot has started.

Management Case

Arrangements for successful implementation

Governance arrangements

Postholders will be integrated into the Oncology consultant team.

Project team

Implementation and integration of doctors will be supported by oncology management team (Service Manager / Deputy General Manager).

Delivering the key measurable benefits

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
Improve 24-day FDT treatment target	<70%	75%-80%	% of patients seen and treated for their first definitive treatment in oncology within 24 days of referral	*Difficult to allocate timeframe on until appointed – challenging staffing groups to appoint*	General Manager for Oncology / Clinical Director for Oncology
Increase the proportion of 'on-active-treatment' patients seen in the specified timeframe	<55%	>70%	% of patients 'on-active-treatment' who receive their follow up appointment in the specified timeframe from previous review		General Manager for Oncology / Clinical Director for Oncology
Ability to accommodate new	Not achieved in recommended	Equitable roll out of new	Equitable roll out of new treatment regimens;		General Manager for Oncology /

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility & notes
innovative treatments	timeframe or equitably across the county	treatment regimens	managed through Oncology CG and NOG		Clinical Director for Oncology
Number of patients seen in SDEC space and prevention of A+E space	N/A – not currently recorded	Discuss with medicine division once pilot is live	Number of patients attending SDEC who would otherwise attend A+E		General Manager for Oncology / Clinical Director for Oncology

Timetable

Milestone	Date
Recruitment of consultants	Ongoing. Recruitment for consultant oncologists has been a challenging and therefore a specific timeline will be difficult. Weekly recruitment meetings within oncology can update on progress against this milestone.

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
Chemotherapy capacity to deliver increased demand	Likelihood = 3 Consequence = 4 Score = 12	Additional overtime to support the service. Space to expand at weekends and evenings. Resource built into B/C to support capacity.	Likelihood = 2 Consequence = 4 Score = 8	Tracey Spencer Brown Lisa Godsiff Naomi Butcher
Radiotherapy capacity to deliver increased demand Impact on additional metrics such as capacity to deliver simple (77.5% against target of 94%) and complex (36.9% against target of 94%) palliative RT treatments.	Likelihood = 4 Consequence = 4 Score = 16	Additional overtime to support the service. Concurrent B/C to review staffing across RT.	Likelihood = 4 Consequence = 4 Score = 16	Grainne Barron Amanda Williams Naomi Butcher
Difficulty in recruitment	Likelihood = 2 Consequence = 4 Score = 8	All posts will be advertised in line with trust policy. Local recruitment plan in place	Likelihood = 3 Consequence = 3 Score = 9	Naomi Butcher Tim Sevitt Kannon Nathan

Clinical Quality Impact Assessment (preferred option)

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, identify lead	Yes, Tim Sevitt (Clinical Director Oncology)
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	N/A
Are relevant Clinical Outcome Measures already being monitored?	Some are for example, 24-day treatment standard.
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?	N/A
Are there any benefits to clinical effectiveness? If yes, list	Yes – refer to planned benefits in outline table. Improved prognosis and quicker review/treatment for patients
Patient Safety. Has the impact of the change been considered in relation to: *(highlight as appropriate)*	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality Account priorities?	Y
CQUINS?	Y
Are there any risks to patient safety? If yes, list	No
Have the risks been mitigated?	N/A
Have the risks been added to the departmental risk register and a review date set?	N/A
Are there any benefits to patient safety? If yes, list	N/A
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	Yes, improve equity of access to treatments across Kent and Medway
Are there any risks to the patient experience? If yes, list	N/A
Have the risks been mitigated and / or added to the departmental risk register and a review date set?	N/A
Are there any benefits to the patient experience? If yes, list - Improved access to timely oncology review and treatment	
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 - Improved capacity to equitably provide oncology treatments across all of Kent and Medway.	
Service	
What is the overall impact on service quality? – please highlight one box	

Improves quality	x	Maintains quality		Reduces quality	
Clinical lead comments				Necessary to support the growing demand on oncological services. Current workforce don't have the capacity to manage patient demand and treatment innovation.	

Maidstone and Tunbridge Wells NHS Trust

Finance Workings for Oncology Consultant Business Case

Pay - Substantive Consultant Costing

Total WTE Required	7.50
Average Cost per Substantive Consultant	155,000
Total Estimated 10PA Consultant Cost	**1,162,500**

Pay - Additional Admin Cost

	Medical Secretary	Clinic Co-ordinator	Total
Total WTE Required	3.00	3.00	**6.00**
Average Cost per WTE	34,117	29,938	**64,055**
Total Estimated Consultant Cost	**102,350**	**89,814**	**192,165**

Pay - Additional Chemotherapy Costing 32027.42

Total WTE Required	2.00
Average Cost per Chemo Nurse	53,372
Total Estimated Chemotherapy Cost	**106,744**

Pay - Additional Diagnostics Costs

Assumption of 0.50wte Path Consultant every 1.50wte Oncologist appointed

Average Cost per Substantive Pathology Consultant	140,000
0.50wte addit Pathologist for every 1.50wte new Consultants	46,667
Total Additional MTW Oncology Consultant WTE	3.50
Estimated Total Diagnostic Cost	**163,333**

Non Pay - Additional Outpatients Non Pay

Total Maidstone Oncology Outpatients Nonpay	71,584	<<<< based on M1-10 23/24 actuals
Total MTW substantive Consultants	25.00	
Outpatient non pay cost per Consultant	2,863	
Total New MTW Consultants	3.50	
Estimated Total Outpatient Non Pay Cost	**10,022**	

Non Pay - Additional Chemotherapy Non Pay

Total Charles Dickens Nonpay	285,118	<<<< based on M1-10 23/24 actuals
Total MTW substantive Consultants	25.00	
Chemo non pay cost per Consultant	11,405	
Total New MTW Consultants	3.50	
Estimated Total Chemotherapy Non Pay Cost	**39,917**	

Agency Expenditure Run Rate Saving

	Locum (MBY)	Locum (BN)	Total
Locum Hourly Rate	132.5	134.32	
Average Weekly Hours	40	40	
Hours Cover	50	50	
Total Annual Locum Costs	**265,000**	**268,640**	**533,640**

Clinical Income Estimate

Med Onc:	M1 - 7 Income	Est M8 - 12 Income	Total Estimated Annual Income	Per 1.00wte	
CHW - 0.8 WTE consultant - Maidstone	213,460	152,471	365,931	457,414	<<< Use for Average
CM - 0.9 WTE consultant - Maidstone	234,509	167,506	402,015	446,684	<<< Use for Average
RP - 0.5 Maidstone WTE consultant	145,563	103,974	249,537	499,073	<<< Use for Average
MH - 1.3 WTE consultant (13 PAs) - Maidstone	557,124	397,946	955,070	734,669	<<< Do not use for Average - outlier
Average Income Med Onc				**467,724**	
Additional Med Onc MTW Consultants			1.50	**701,586**	

Clin Onc:					
AZ - 1.0 WTE consultant - Maidstone	92,993	66,424	159,417	159,417	<<< Use for Average
KL - 0.8 WTE consultant - Maidstone	103,918	74,227	178,145	222,681	<<< Use for Average
RJ - 1.0 WTE consultant - Maidstone	228,389	163,135	391,524	391,524	<<< Use for Average
JS - 0.7 WTE consultant - Maidstone	95,188	67,991	163,179	233,113	<<< Use for Average
Average Income Clin Onc				**251,684**	
Additional Clin Onc MTW Consultants			2.00	**503,368**	

Total Estimated Additional Clinical Income	**1,204,953**

Acute Oncology SDEC income has been calculated at £285k per annum, therefore the income has been assumed to reduce the cost of the case to breakeven.

Pay - Additional Pharmacy Costs

	Prescribing Pharm	Pharmacy Tech	Total
Total WTE Required	1.00	1.00	**2.00**
Annual Cost	64,054	46,619	**110,673**
Total Annual Cost	**64,054**	**46,619**	**110,673**

Summary		Total Revenue WTE	Total Revenue £	Budget in Division WTE	Budget in Division £	Investment Required WTE	Investment Required £
Pay	Consultant	7.50	1,162,500	2.00	310,000	5.50	852,500
	Admin	6.00	192,165	0.00	0	6.00	192,165
	Chemotherapy	2.00	106,744	0.00	0	2.00	106,744
	Diagnostics		163,333	0.00	0	0.00	163,333
	Pharmacy	2.00	110,673	0.00	0	2.00	110,673
	Total Pay	**17.50**	**1,735,415**	**2.00**	**310,000**	**15.50**	**1,425,415**
Non Pay	Oupatients		10,022		0		10,022
	Chemotherapy		39,917		0		39,917
	Total Non Pay		**49,938**		**0**		**49,938**
Income	Clinical SLA income		**-1,204,953**		**0**		**-1,204,953**
	Additional AO SDEC Income		**-274,911**		0		**-274,911**
Capital Charges (Yr1)			**4,512**		**0**		**4,512**
Total		**17.50**	**310,000**	**2.00**	**310,000**	**15.50**	**0**

Capital Workings

	Medical	Admin	
Req Laptop and accessories	7.50	6.00	
Cost per new Laptop and accessories	1392	1392	
Total Capital Cost	10,440	8,352	18,792
IT Useful life in years	5	5	
Annual Depreciation	2,088	1,670	3,758

Maidstone and Tunbridge Wells NHS Trust
Oncology Consultant Business Case

Position	WTE requirement	Med / Clin Onc	Location - Tumour site	Impact/ Comments	Activity location	Activity plan	Additional resource (pathology / radiology)	Budget already in Establishment	Consultant Cost	Med Sec / Clinc Co-ordinators	Additional Diagnostics Required	Chemotherapy Nursing	Assumed Additional income (SLA / MTW Variable)	Net Investment Required	Additional Consultant WTE	Additional Chemotherapy WTE	Additional Admin WTE	Agency Run Rate Saving	
1	0.5	Clin	Urology WK	Locum covering role (MBY)	Activity already included accounted for in 23/24 financial year	As is current activity	Resource already accounted for	0	77,500	0	0	0	No additional income or activity in 23/24 as already being delivered at a pressure, therefore funding the core establishment is required.	77,500	0.50	0.00	0.00	-132,500	
2	0.5	Med	UGI WK	Locum covering role (BN)	Activity already included accounted for in 23/24 financial year	As is current activity	Resource already accounted for	0	77,500	0	0	0		77,500	0.50	0.00	0.00	-134,320	
3	0.5	Med	Breast WK	Locum covering role (BN)	Activity already included accounted for in 23/24 financial year	As is current activity	Resource already accounted for	0	77,500	0	0	0		77,500	0.50	0.00	0.00	-134,320	
4	0.5	Clin/Med	LGI WK	Locum covering role (MBY)	Activity already included accounted for in 23/24 financial year	As is current activity	Resource already accounted for	0	77,500	0	0	0		77,500	0.50	0.00	0.00	-132,500	
5	1	Clin	MTW Growth	Demand driven	Additional Maidstone activity	New forecast actviity		0	155,000	48,041	46,667	30,498	-251,684	28,522	1.00	0.57	1.50	0	Lower variable income because RT under block
6	0.5	Med	MTW Growth	Demand driven	Additional Maidstone activity	New forecast actviity		0	77,500	16,014	23,333	15,249	-233,862	-101,766	0.50	0.29	0.50	0	
7	1	Clin	MTW Growth	Demand driven	Additional Maidstone activity	New forecast actviity		0	155,000	48,041	46,667	30,498	-251,684	28,522	1.00	0.57	1.50		
8	1	Med	MTW Growth	Demand driven	Additional Maidstone activity	New forecast actviity		0	155,000	48,041	46,667	30,498	-467,724	-187,518	1.00	0.57	1.50	0	
9	0.3 0.7	Clin Clin	WK – Gynae / Breast WK – Gynae / Breast	Job Plan reduction request – April 2024 Full retirement – April 2026	Activity already included in SLA agreements and local plan	As is current activity	Resource already accounted for	155,000	155,000	0	0	0	0	0	0.00	0.00	0.00	0	
10	0.3	Clin	WHH – Breast	Job Plan reduction request - asap	Activity already included in SLA agreements and local plan	As is current activity	Resource already accounted for	46,500	46,500	21,352	0	0	0	21,352	0.00	0.00	0.67	0	
11	0.4	Clin	EK – H+N	Job Plan reduction request – asap	Activity already included in SLA agreements and local plan	As is current activity	Resource already accounted for	62,000	62,000	21,352	0	0	0	21,352	0.00	0.00	0.67	0	
12	0.3	Clin	DVH – Lung	Job Plan reduction request - asap	Activity already included in SLA agreements and local plan	As is current activity	Resource already accounted for	46,500	46,500	21,352	0	0	0	21,352	0.00	0.00	0.67	0	
	7.5							310,000	1,162,500	224,192	163,333	106,744	-1,204,953	141,816	5.50	2.00	7.00	-533,640	

NHS Maidstone and Tunbridge Wells NHS Trust

Assurance of compliance with the Fit and Proper Persons Test requirements	**Interim Trust Secretary**

In line with the changes to the Fit and Proper Persons Test requirements, which were required to be implemented by the 31st March 2024, the Trust has conducted a full review of its Fit and Proper Persons requirements, and made changes where appropriate to ensure the Trust's compliance going forward.

The Trust has achieved full compliance as evidenced within the report.

This information will be shared with NHS England, via the NHS England South East Regional Director, no later than the June 2024 as requested.

The Interim Trust Secretary has fully considered this with the outgoing Chair of the Trust Board, David Highton, who has responsibility for this process for the period of this report.

The outgoing Chair has signed off the Fit and Proper Person requirements as compliant.

The following appendices have been enclosed:

- Appendix 1 – Duties and responsibilities
- Appendix 2 – Procedures to comply with the "Fit and Proper Persons: Directors" Regulations (FPPR) and Fit and Proper Persons Test Framework (FPPT), approved by the Trust Board in March 2024
- Appendix 3 – The role of the CQC
- Appendix 4 – Annual 'Fit and proper person' self-attestation for Trust Board Members
- Appendix 5 – Compliance with regulations
- Appendix 6 – Checks conducted for each Trust Board member

Which Committees have reviewed the information prior to Board submission?
Audit and Governance Committee, 14.05.24

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To provide assurance of the Trust's compliance with the Fit and Proper Persons Test Requirements and associated next steps

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

Objective of the report

The Trust is required to comply with the Fit and Proper Persons Test requirements that changed on 2nd August 2023, when NHS England (NHSE) published the new Fit and Proper Person Test ("FPPT") Framework for NHS board members, which was the culmination of NHSE's work to respond to the recommendations in Tom Kark's 2019 Review of the FPPT.

The "Procedures to comply with the "Fit and Proper Persons: Directors" Regulations (FPPR) and Fit and Proper Persons Test Framework (FPPT)" (Appendix 2) and "Annual 'Fit and proper person' self-attestation for Trust Board Members" (Appendix 4) which form part of the Trust's Standing Orders were reviewed, and updated, to ensure compliance with the new FPPT Framework and alignment with the NHS leadership competency framework for board members, which was published on the 28th February 2024. The amendments were ratified at the Trust Board meeting on the 28th March 2024.

The duties and responsibilities in relation to ensuring compliance with the Fit and Proper Persons Test requirements have been enclosed under (Appendix 1).

This report is intended to provide assurance of compliance with the Fit and Proper Persons Test requirements for 2023/24 to the Audit and Governance Committee, Trust Board and NHS England.

The table at (Appendix 5) provides assurance that the Trust has met the Fit and Proper Person Test requirements in relation to Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and identifies how the Trust assures itself about the suitability of the relevant individuals.

Compliance with Fit and Proper Person Test (FPPT) requirements

Self-attestation (section 3.3. of the FPPT Framework)

- The Trust has complied with the requirement for this annual self-attestation of all Trust Board members by each individual completing the form in (Appendix 4), and their nominated deputies, as evidenced in the compliance table (Appendix 6). These returns have been fully considered and the self-attestations have formed part of the overall FPPT for the Trust.

The Trust has complied with this requirement	Complied

New appointments (section 3.4 of the FPPT Framework)

- Only one new appointment was made to the Trust Board within 2023/24 – the Medical Director. The Trust has implemented the requirement of the Inter Authority Transfer (IAT) requirements into ESR for all future appointments.
- The full FPPT assessment for the Trust includes an assessment against each of the core elements for any new appointments:
  - Good character.
  - Possessing the qualifications, competence, skills required and experience.
  - Financial soundness.
- Recruitment for the Board now involves the completion of a self-attestation by the applicant. These checks are in addition to the ones listed in (Appendix 6) which have been carried out for current Trust Board members, which will also be undertaken for any future applicant.
- Board roles for the Trust are all subject to approval by NHS England.

  * Note: A new Chair of the Trust Board was appointed in April 2024, that does not form part of the considerations contained within this report. This appointment was managed and approved by NHS England.

The Trust has complied with this requirement	Complied

Additional considerations (section 3.5 of the FPPT Framework)

- The Trust has noted the requirements for a joint appointment across different NHS organisations in the event of:
  - two or more NHS organisations want to create a combined role;
  - two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

  The Trust would work jointly with any other NHS organisation as appropriate to ensure that FPPT requirements were achieved.

  * Note: Alex Yew, Associate Non-Executive Director is also an Associate Non-Executive Director on the Performance and Investment Committee of the Kent and Medway Integrated Care Board (ICB), the Trust engaged with the Kent and Medway Integrated Care Board, they have also carried out separate checks in line with the FPPT requirements.

The Trust has complied with this requirement	Complied

Role of the chair in overseeing FPPT (section 3.6 of the FPPT Framework)

- The Chair of the Trust Board is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. The Chair of the Trust Board of Maidstone and Tunbridge Wells Hospital ('MTW') has achieved this with support from the Interim Trust Secretary where appropriate. This has included the evidence contained within this report, the individual self-attestations, appraisals (this will be shared with NHS England) which included the identification of training and development needs for individuals by way of example.
- Pre-employment checks have been enhanced in the event of a new Trust Board member in line with Appendix 2. The Trust Board member reference template has been updated using the recommended standard template .

The Trust has complied with this requirement	Complied

FPPT assessment – core elements – good character (section 3.7.1 of the FPPT Framework)

- The Trust is required to assess whether a person is of good character, ensuring that there is a robust process to make sure that all appropriate checks are conducted, such as the review of any professional registrations held by the individual, a search of any convictions for any offences, and a review of the Companies House register to ensure that no Trust Board member is a disqualified director. This has been achieved by conducting checks for each Trust Board members, and their nominated deputies. The evidence of which is contained in (Appendix 6). This has also been signed off as compliant by the outgoing Trust Chair of the Trust Board for the FPPT requirements.
- The annual self-attestation requires Trust Board members to confirm their adherence to the Nolan Principles of Standards in Public Life and the NHS Leadership Competency Framework six competency domains.
- The Trust Board member reference template has been updated, to strengthen the assurances provided in relation to any upheld / ongoing or discontinued disciplinary findings, grievance findings or whistleblowing findings.

The Trust has complied with this requirement	Complied

FPPT assessment – core elements – Serious mismanagement or misconduct (section 3.7.1.1 of the FPPT Framework)

- The Trust is required, as part of the consideration of good character, to consider whether a Trust Board member has been responsible for, contributed to or facilitated any serious misconduct or mismanagement in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere, such as fraud, discrimination as per the Equality Act 2010, or Disregard for appropriate standards of governance. The Trust has conducted checks for each Trust Board member, and their nominated deputies, and the outgoing Trust Chair has signed to confirm compliance with the FPPT requirements. The evidence of which is contained in (Appendix 6).

The Trust has complied with this requirement	Complied

FPPT assessment – core elements – Qualifications, competence, skills required and experience (section 3.7.2 of the FPPT Framework)

- The Trust is required to ensure Trust Board members have the required qualifications, competence, skills required and experience. The Trust achieves this through the development of tailored job descriptions for the roles of Executive Directors, and the utilisation of a competitive interview process. A full review has also been conducted of the continuing professional registration of Trust Board members and their nominated deputies, where relevant, as evidenced in (Appendix 6) to ensure compliance with the FPPT requirements. This has been confirmed as compliant by the outgoing Chair of the Trust Board. This will continue to be an ongoing consideration as part of the Trust's appraisal process.
- The Trust, along with NHS England, considers the balance, completeness and appropriateness of the Trust Board, which includes the skillset and experience at the time of recruitment of Non-Executive Directors. This would be considered by the Remuneration and Appointments Committee for an Executive appointment.

The Trust has complied with this requirement	Complied

FPPT assessment – core elements – Financial soundness (section 3.7.3 of the FPPT Framework)

- The Trust has complied with the requirement to achieve assurance that Trust Board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations; which included search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt as evidenced in line with Appendix 6.

The Trust has complied with this requirement	Complied

Breaches to core elements of the FPPT (section 3.8 of the FPPT Framework)

- No breaches of the core elements of the FPPT were identified in 2023/24. In the circumstances where a Trust Board member were to breach the FPPT requirements a documented explanation as to why the Trust board member is unfit and the mitigations taken would be submitted to the NHS England South East Regional Director, for review.

The Trust has complied with this requirement	Complied

Board member references and appraisals (section 3.9 of the FPPT Framework)

- A standardised board member reference has been introduced to ensure greater transparency, robustness and consistency of approach. The Trust has adopted the recommended Trust Board member reference template to comply with the FPPT framework.
- The annual declarations for Non-Executive Directors were completed in line with their appraisal in April 2024. Executive Directors have completed their annual declarations in May 2024 in line with the financial year-end and their forthcoming appraisal.
- The Trust has adopted the new chair appraisal process in 2024 in communication with NHS England. Stakeholders provided the required feedback.
- The NHS Leadership Competency Framework references six competency domains, which should be incorporated into senior leader job descriptions, appraisals and senior leader recruitment processes. An assessment of competencies has taken place for the Non-Executive Directors and Chair appraisals in line with the six competency domains. The NHS leadership competency framework for board members is currently being adopted by the Trust and was used for the recent Chair appraisals by way of example.
- Appraisals are to be shared with NHS England in line with the requirements.

The Trust has complied with this requirement	Complied

Electronic Staff Record (ESR) (section 3.10 of the FPPT Framework)

- The Trust has complied with the requirement to ensure that ESR remains current and is updated for relevant changes in a timely manner. The FPPT section of the ESR profile for each Trust Board member, and their nominated deputies, was updated following completion of the due diligence checks.
- The Trust has ensured compliance with the requirement for Disclosure and Barring Checks to be conducted on a three-year cycle, as per the FPPT requirements and the Trust's Disclosure and Barring Service (DBS) checks policy. DBS update service subscriptions are maintained for all Trust Board members.

The Trust has complied with this requirement	Complied

Record retention (section 3.11 of the FPPT Framework)

- The Trust has ensured compliance with the GDPR requirements as set out within the NHS Records Management Code of Practice. Individual records will be held for a period of six years. In relation to ESR, the information and accompanying references will be kept career long, which at a minimum will be until the 75th birthday of the board member.

The Trust has complied with this requirement	Complied

Dispute resolution (section 3.12 of the FPPT Framework)

- No disputes were raised during by Trust Board members in relation to the findings of the FPPT regulations in 2023/24. In the event of a dispute Trust Board members are entitled to request a review which will be conducted in line with Appendix 2 in the first instance.

The Trust has complied with this requirement	Complied

External Quality assurance and governance (section 4 of the FPPT Framework)

- The Care Quality Commission are required to ensure that NHS organisations have robust processes in place to ensure compliance with the Fit and Proper Persons Test requirements as part of any Well Led reviews.

- NHS England will provide oversight of the Trust's FPPT arrangements through the requirement for Trust's to make an annual submission to the relevant NHS England regional director.

- Every three years, the Trust is required to undergo an Internal Audit review of compliance with the FPPT requirements. An Internal Audit review of the Trust's Fit and Proper Persons arrangements has been scheduled within the 2025/26 Internal Audit plan.

- To ensure good governance the Trust is required to provide an update to a meeting of the Trust Board in public, to confirm that the requirements for FPPT assessment have been satisfied at least annually. This report complies with this requirement.

Outcome:

The Trust has achieved full compliance as evidenced within the report

Recommendation:

This report has been considered by the Audit and Governance Committee in May 2024 and has been signed by the outgoing Chair, David Highton as compliant for the period 2023/24. The Trust Board is asked to note assurance that the Trust is compliant with the Fit and Proper Person requirements. This information will be shared with NHS England in June 2024 as per the requirements.

David Highton, Chair of the Trust Board

Appendix 1 - Duties and Responsibilities

Role	Responsibilities
Chair	• Ultimate responsibility to discharge the FPPR placed on the Trust to ensure that all relevant post-holders (new and existing) meet the 'fitness' test and do not meet any of the 'unfit' criteria • Overall responsibility for compliance with the FPPR • Ensuring the fitness of all new and existing Directors has been assessed in line with the regulations on appointment and on an ongoing annual basis • Ensuring the necessary action is taken to ensure existing Directors who no longer meet the FPPR do not continue in their role
Senior Independent Director [SID]	• Overseeing the outcome of FPPR for the Chair • Undertaking any investigations into any concerns raised about the Chair
Trust Secretary	• Overseeing the implementation of the FPPR policy • Ensuring any FPPR tests undertaken comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair and/or Senior Independent Director [SID] (as appropriate) • Supporting the Chair and/or SID with any investigations • Ensuring the annual FPPR declarations are undertaken, recorded and evidenced on an individual's file • Maintaining the Directors register of interests including annual updates • Confirming compliance with the policy in the Trust's annual report • Providing advice and support to the Trust Board in respect of the administration of and compliance with the FPPR • Preparing annual reports for consideration by the appropriate committee as part of the appraisal process • Identifying any changes to the Regulations or guidance, recommending to the Trust Board the appropriate policy amendments
Recruitment Team	• Undertaking all pre-employment checks (including the relevant component parts of the FPPR test) for Directors and providing evidence to demonstrate assurance • Ensuring the results (and evidence in the form of copies of certificates, etc) of the FPPR test undertaken on appointment are recorded within an individual's file • Ensuring any recruitment agencies/executive search companies involved in the recruitment process understand their responsibilities and comply with the requirements of this policy, i.e. that all necessary pre-employment checks (including FPPR) have been undertaken and evidence to demonstrate assurance is made available for inspection and retention by the Trust
Trust Board	• Ensuring ongoing compliance by receiving an annual report on the application of FPPR in relation to Executive Directors including the Chief Executive [CEO] • Ensuring ongoing compliance by receiving an annual report on the application of FPPR in relation to Non-Executive Directors [NEDs] including the Chair
Directors (individuals who fall within the policy)	• Providing consent to the required checks as described in this policy • Signing the declaration that they are a fit and proper person on appointment and on an annual basis • Providing evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position • Identifying any issues that may affect their ability to meet the statutory requirements on appointment and bringing any issues on an ongoing basis to the CEO (for Executive Directors) and the Chair (for NEDs).

Role	Responsibilities
Staff	• Raising any concerns via the appropriate Trust policies and procedures, e.g. through the Freedom to speak up: raising concerns policy [N.B. this forms part of the People Policies Manual]
CQC (see appendix 3)	• Powers to assess whether Directors are fit to carry out their role • Powers to assess whether providers have in place adequate and appropriate arrangements to ensure Directors are fit and proper persons both on recruitment and whilst in post • In undertaking inspections, will assess compliance as part of the well-led domain • Where appropriate will work alongside other regulators, e.g. professional bodies, to ensure that the correct processes are adhered to and information is shared when relevant and appropriate • Cannot prosecute for breach of the FPPR but can take regulatory action

APPENDIX 2 - Procedures to comply with the "Fit and Proper Persons: Directors" Regulations (FPPR) and Fit and Proper Persons Test Framework (FPPT), approved by the Trust Board in March 2024

Procedures to comply with the "Fit and Proper Persons: Directors" Regulations (FPPR) and Fit and Proper Persons Test Framework (FPPT)

1. This procedure will apply to all Trust Board Members (as defined in the Standing Orders). The Chair of the Trust Board is responsible for ensuring that all Trust Board Members meet the fitness test and do not meet any of the 'unfit' criteria. A failure or refusal by a candidate for appointment to comply with any of the procedures set out below will immediately disqualify that person from the proposed appointment.

Process for new appointments

2. The Trust has in place robust processes for the recruitment of Trust Board Members. These processes include pre-employment checks in accordance with NHS Employers Employment Check Standards. All appointments to the Trust Board, whether permanent or temporary (including secondments), where greater than six weeks, require the following:[2]
   a. Identity checks
   b. Professional registration and qualification checks - Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator and the NHS Leadership Competency Framework (LCF) six competence categories. Consideration will be afforded to any training and development the Trust Board member has undergone or is undergoing in line with the duties they are required to perform.
   c. Right to work checks
   d. Disclosure and Barring Service (DBS) checks as appropriate to the role. To safeguard service users by identifying unsuitable candidates, any appointment will be dependent upon the satisfactory completion of a "Standard" disclosure through the DBS[3]. The level of check undertaken for Executive Directors will be determined by the type of activities required by their role and the level of unsupervised access this will allow them to patients. The Trust will apply the "DBS update" process to all Trust Board Members, for which Trust Board members will be required to provide written consent on a form held by the Trust Secretary's Office. The Update Service is an online subscription that, subject to the employee's consent, lets employers carry out a free, instant online check to view the status of an existing standard or enhanced DBS certificate. If the DBS update service lists the status of the DBS check as "This DBS certificate is no longer current" a further DBS check will be required to get the most up-to-date information, so the Trust Secretary's office will liaise with the relevant Trust Board member to understand the reason(s) why there has been a change. If the DBS check identifies any convictions that have not been declared, the Chair of the Trust Board will discuss the findings of the check with the individual (and the Chief Executive, for Executive Directors), and instigate appropriate action. The reasons for any decisions made under this process will be recorded and shared with those who need to be made aware.
   e. At least two references, including references where the individual resigned or retired from a previous role, one being from the most recent employer, which should be provided on the NHS England Trust Board member reference template.[2] In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought.

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[2] For the initial appointment of the Chair of the Trust Board and Non-Executive Directors (excluding Associate Non-Executive Directors), NHS England will obtain Trust Board member references and carry out the initial social media checks.

[3] The role expected to be undertaken by most Trust Board Members does not justify "Enhanced" or "Enhanced with Barred list(s)" DBS checks being undertaken, based on the eligibility criteria for DBS checks (as described in the DBS' guides to adult and child workforce roles for registered bodies and employers)

f. Work health assessment check - consideration will be given to the physical and mental health of Trust Board members in accordance with the demands of the role and good occupational health practice. If the individual has declared a disability or long-term health condition (physical or mental health related), an Occupational Health Assessment will be conducted. Occupational Health will, as part of the pre-appointment process, work with the individual to identify reasonable adjustments that will need to be made to support them to perform the tasks that are intrinsic to the office or position for which they are appointed. In the event that health conditions deteriorate over time requiring adjustments that are not felt to be reasonable, this may result in termination of the Trust Board member's employment.
g. Interview processes including panel interviews

N.B. All of the checks listed above will be recorded and evidenced by the Trust Secretary's Office, in liaison with the Trust's People and Organisational Development Department.

h. Accounting within contracts of employment for all officer (i.e. employee) Trust Board Members for the fact that an individual cannot continue within the role should they meet any of the criteria for being "unfit"
i. Completion of a self-attestation (Appendix 5 of the Standing Orders: RWF-COR-COR-FOR-1), which includes, among other aspects, confirmation that none of the unfit criteria apply. If an individual is unable to sign the self-attestation, the reasons should be discussed with the Chair of the Trust Board (the Trust Secretary will also be available for an initial discussion). For Executive Directors, the discussion should involve the Chief Executive. If, on discussion, the individual is deemed suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations, the self-attestation may be amended to reflect the specific circumstances of that individual and to enable them to sign it (providing this does not conflict with the Regulations). For example, the individual may have been convicted[4] in the UK of a minor offence, which would prevent them from the signing the self-attestation, but which, in the judgement of the Chair, would not mean that they were not of "good character". A record will be kept (by the Trust Secretary's Office) of the reasons for the decision and why the self-attestation form was amended. Information about the decision will be shared with those that need to be aware.

3. Additionally, the Trust Secretary's Office will ensure that 'due diligence' checks are undertaken for each Trust Board Member (via searching the relevant registers and other on-line information), to determine whether the individual:
   a. is an undischarged bankrupt;
   b. has had sequestration awarded (which has not been discharged) in respect of their estate;
   c. is the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland;
   d. is a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b));
   e. has made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it);
   f. is not prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities;
   g. has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals;
   h. has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity; including, but not limited to:
      - fraud or theft
      - sexual harassment of staff
      - bullying or harassment
      - discrimination as per the Equality Act 2010

[4] In the UK "conviction" means an admission of guilt or a finding of guilt in a criminal court whether by judge, jury, magistrate or certain tribunal Chairman conducting criminal cases. Therefore, fixed penalty notices and speeding fines are not convictions.

- dishonest conduct including deliberately transmitting information to a public authority or to any other person, which is known to be false; or providing false information or references as part of the recruitment process
- disregard for appropriate standards of governance
- failure to make full and timely reports to the Trust Board of significant issues or incidents

i. has been disqualified from being a charity trustee or is listed on the Charity Commission's Register of Removed Trustees;
j. has been subject to an adverse finding on the Register of Judgments[5] (including any company of which they are the Director or Secretary);[6]
k. has been subject to a negative decision from an employment tribunal[6]
l. has posted anything on social media that could potentially bring the Trust into disrepute or conflict with the Trust's values.[6,2]

N.B. The social media checks for newly appointed Trust Board members will be conducted by an external analytics company, to ensure sufficient examination of all aspects of their entire online presence.[7]

4. Such 'due diligence' checking will also incorporate any specific qualification requirements for Executive roles (e.g. that the Chief People Officer be a member of the Chartered Institute of Personnel and Development), and will include (but not be limited to) publicly available registers, such as:
   a. the Individual Insolvency Register (IIR)
   b. the Companies House database of disqualified directors (under the Company Directors Disqualification Act 1986)
   c. the Insolvency Service's register of Directors they got disqualified
   d. Register of Removed Charity Trustees
   e. the List of Registered Medical Practitioners held by the General Medical Council (GMC)
   f. Nursing and Midwifery Council (NMC) register
   g. Other professional registers
   h. Publicly available investigation reports of failings within health and social care provision

5. For those Trust Board members who have lived for periods abroad (non-UK) before joining the Trust the initial 'due diligence' checks, conducted by the Trust Secretary's Office, will incorporate the equivalent registers, if available, from the country of origin; however, the annual 'due diligence' checks thereafter will only include the relevant UK registers

6. Following completion of the 'due diligence' checks the Trust Secretary's Office, in conjunction with the Chair of the Trust Board, will complete the "Fit and Proper Persons Test" section on the Trust's Electronic Staff Record (ESR) to confirm that the required 'due diligence' checks were undertaken. Such information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the Trust Board member.

Trust Board member references

7. The Trust Board member reference should provide evidence of broad competence across each of the six NHS Leadership Competency Framework domains and ensure there are no areas of significant lack of competence which may not be remedied through a development plan. The Annual 'Fit and proper person' self-attestation for Trust Board Members and the annual appraisal process will inform the evidence required for the Trust Board member reference; with the latter enabling the provision of a development plan to remedy any areas of concern.
8. The Trust Board member reference will be based on the outputs of the 'due diligence' checks and include information regarding any discontinued, outstanding, or upheld complaint(s)

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[5] This includes County Court Judgments, High Court Judgments, Tribunal Awards, Administration Orders, Fine Defaults and Child Support Agency Liability Orders

[6] This check is related to the FPPR requirements relating to "good character"

[7] Upon ratification of this procedure, in March 2024, the social media checks for all Trust Board members will be conducted by an external analytics company

tantamount to gross misconduct or serious misconduct or mismanagement; confirmation of any discontinued, outstanding or upheld disciplinary actions under the Trust's disciplinary procedures; and any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a Trust Board member. Investigations declared will be limited to those which are applicable and potentially relevant to the FPPT; with the reason any investigation was discontinued to be clearly stated including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that the individual is not fit and proper)

9. The Trust will maintain complete and accurate Trust Board member references at the point where the Trust Board member departs, including in circumstances of retirement, irrespective of whether there has been a request from another NHS organisation (see paragraph 6).
10. Trust Board member references are required in the following instances:
    i. A new appointment that has been promoted within the Trust
    ii. An existing Trust Board member at another NHS organisation who transferred to the Trust to in the role of a Trust Board member
    iii. An individual who has joined the Trust in the role of a Trust Board member for the first time from an organisation that is outside of the NHS
    iv. An individual who has been a Trust Board member in an NHS organisation and joins the Trust in a role other than that of a Trust Board member, that is, they take a non-Board level role

Revising references

11. If the Trust has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:
    - become aware of matters or circumstances that would require them to draft the reference differently
    - determined that there are matters arising relating to serious misconduct or mismanagement
    - determined that there are matters arising which would require them to take disciplinary action
    - concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations

    The Trust should make reasonable attempt to identify if the individual's current employer is an NHS organisation, and, if so, provide an updated reference / additional detail within a reasonable timeframe. Such updates should be reflected within the Trust Board member reference held by the Trust.

Assessment of on-going fitness

12. The annual appraisal process for all Trust Board members will incorporate a formal review and confirmation that the individual:
    a. continues to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
    b. continues to be able by reason of their health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which they are employed
13. These aspects will be part of the formal documentation for such appraisals. This step is not intended to prevent any changes in an individual's circumstances being reviewed and responded to at the time such changes occur (i.e. relevant action should not be deferred until an individual's annual appraisal).
14. The Chief Executive will be responsible for appraising the Executive Directors, whilst the Chair of the Trust Board will be responsible for appraising the Non-Executive Directors and Associate Non-Executive Directors. The Chief Executive will be appraised by the Chair of the Trust Board. The appraisal of the Chair of the Trust Board will be undertaken in accordance with the framework for conducting annual appraisals of NHS Provider Chairs.
15. There will be an annual requirement for post holders to complete the annual self-attestation form described in point 2i. This will usually be scheduled to be undertaken towards the end of each financial year (i.e. 31st March).

16. The Trust Secretary's Office will also repeat the 'due diligence' checks outlined in paragraph 3 on an annual basis. The Trust will pay the costs for the fee charged for undertaking the checks of the Register of Judgments (www.trustonline.org.uk). The Trust Secretary's Office will also update the "Fit and Proper Persons Test" section on the Trust's ESR, as outlined in paragraph 6, to reflect the outcome of the annual 'due diligence' checks.
17. The Trust Secretary's Office will check the DBS update service every six months to ascertain the status of Trust Board members' DBS certificates.

Joint appointments across different NHS organisations

18. In the event of a joint appointment, if the Trust is the designated host/employing NHS organisation the full 'due diligence' checks need to be completed and in concluding the assessment input will be required from the Chair of the other contracting NHS organisation to ensure that the Trust Board member is eligible to perform both roles. Where the joint appointment results in a new Trust Board member (for the NHS organisation in question), it will constitute a new appointment and as such, the Trust should provide a 'letter of confirmation' to the other NHS organisation(s). The template for the 'letter of confirmation' is available from NHS England and held by the Trust Secretary's Office.
19. Where there is a joint appointment, if the Trust was responsible for the 'due diligence' checks then the Trust should also lead on conducting the joint appraisal ensuring adequate input from the other contracting NHS organisation.
20. Where two or more NHS organisations employ or appoint an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the 'due diligence' checks. If the Trust identifies any areas of concern within the 'due diligence' checks the other contracting NHS organisation should be informed and the rationale explained.

Shared roles within the same NHS organisation

21. Where two individuals share responsibility for the same Trust Board member role (e.g. a job share) at the Trust, both individuals will be required to undergo the 'due diligence' checks.

Temporary absence

22. A temporary absence is considered as leave for a period of six consecutive weeks or less and where the Trust is leaving the Trust Board position open for the Trust Board member to return. As such there is no requirement to approve another permanent appointment for the open Trust Board position.
23. Where there is a temporary absence, the Trust Secretary or Chief People Officer will liaise with the Chair of the Trust Board and/or Chief Executive to ensure temporary cover is provided; and to ensure that the Trust's ESR is adequately updated to record the start and projected end date of the temporary absence.
24. Where an individual is appointed on an interim basis, and has not undergone the associated 'due diligence' checks, the Trust should ensure appropriate support and mitigations are in place, as decided between the Chair of the Trust Board, Chief Executive and Trust Secretary (or an appropriate Deputy).
25. If the temporary appointment is for longer than six weeks then the full 'due diligence' checks should be conducted, as outlined within the "Process for new appointments" section.

Concerns regarding an individual's continued FPPR compliance

26. Where matters are raised, identified or declared that cause concerns relating to an individual being fit and proper to carry out their role, the Chair of the Trust Board will oversee an investigation which will be appropriate, timely and proportionate to the matter raised. Any investigation will have due regard to the relevant Trust Policies and Procedures along with guidance issued by the Care Quality Commission (CQC) and the NHS England FPPT Framework. The Chair of the Trust Board may consult with the Trust's Chief People Officer and / or Senior Independent Director on this. If the matters raised relate to or involve the Chair of the Trust Board, responsibility for oversight of the investigation will fall to the Vice-Chair of the Trust Board supported by the Chief People Officer. If concerns are substantiated by evidence, proportionate, timely action will be taken to investigate this through either the FPPR or the Trust's "Disciplinary Policy and Procedure" or "Performance Management (Capability) Policy

and Procedure", whichever is judged to be the most appropriate to the circumstances. As part of the investigation the individual may be requested to attend an interview to clarify any ambiguities, or provide further information, in relation to any potential concerns which are identified. Where an individual's fitness to carry out their role is being investigated appropriate interim measures will be considered to minimise any risk to patients or the Trust.

27. The final decision on whether the individual is fit and proper following an investigation under the FPPR lies with the Chair of the Trust Board. If the Chair determines that the individual does not or no longer meets the requirements of a fit and proper person, that person shall not be appointed, or their appointment will be terminated. Should the Chair determine that the individual is or remains a fit and proper person the reasons for this decision will be recorded and shared with those who need to be aware. If the matters raised relate to or involve the Chair of the Trust Board the final decision will rest with the Vice-Chair of the Trust Board

Sharing concerns with other bodies

28. Where appropriate, the Trust will also inform other organisations about concerns or findings relating to an individual's fitness, for example, professional regulators, the CQC and other relevant bodies and, if required, notify the outcome to NHS England for validation. The Trust will also support any related enquiries or investigations carried out by others.

Overseeing the role of the chair of the Trust Board

29. Annually, the Senior Independent Director (SID) or Vice-chair of the Trust Board, in conjunction with the Trust Secretary, will review and ensure that the Chair of the Trust Board continues to meet the requirements of the FPPR. If the SID and Vice-chair of the Trust Board are the same individual, another Non-Executive Director should be nominated to review the compliance of the Chair of the Trust Board with the FPPR on a rotational basis.

Annual reporting to NHS England

30. The Trust will submit, on an annual basis, details of the findings of the 'due diligence' checks, for both starters and leavers during the period, to the South East Regional Director of NHS England, using the "Annual NHS FPPT submission reporting template" which is available from NHS England and held by the Trust Secretary's Office.

Assurance to the Trust Board

31. The Trust Board will receive an annual report to confirm implementation of the FPPR for existing post holders. The Chair of the Trust Board is the responsible officer for ensuring compliance with the FPPT.

Inclusion in the Trust's Annual Report

32. The Trust will include a high-level overview of the outcome of the FPPT assessments within the annual report for the associated financial year, which, once approved, will be accessible to members of the public on the Trust's website

Requirements for Trust Board members leaving the Trust

33. At the end of the tenure of a Trust Board member a reference, informed by the annual appraisals of the previous three years, and aligned to the NHS England Leadership Competency Framework, should be completed, and retained by the Trust for provision, within 14-days of a request being received, to any future employer. The Trust Board member reference will be completed, by the Trust Secretary's Office in conjunction with representatives from the People Function, using the "Board member reference template", which is available from NHS England and held by the Trust Secretary's Office.

Internal audit/external review

34. At a minimum of every three years, the Trust will commission an internal audit review to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit will include sample testing of FPPT assessments and associated documentation.

35. The Trust will consider, where appropriate, inclusion of FPPT process and testing in the specification for any commissioned external Well-Led/Board effectiveness reviews.

Processing of personal data

36. The basis for which the FPPT data contained with the ESR Is set out in Article 6(1)(e) of the UK General Data Protection Regulation (GDPR) (i.e. the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller).

APPENDIX 3

The role of the CQC

In the national guidance, CQC makes it clear that it has no remit to investigate the fitness of individuals. It is for the Trust to consider whether the Director in question remains fit and proper. CQC's role is to assess that Trusts have followed appropriate, effective and robust processes, and to take action against a Trust if they are failing to meet these requirements.

CQC cannot prosecute for breach of the FPPR or any of its part but as the regulator of health and social care services it can take regulatory action to address an individual's breach of a regulation, condition of registration or other relevant requirement.

CQC assesses compliance with the FPPR at three different stages:

- At the time of applications for registration
- During the inspection process, under the 'well-led' key question and key lines of enquiry as well as through the annual well-led inspection
- When concerns are raised about individuals.

The role of the CQC in determining whether a Trust's processes and investigations are satisfactory should be confined to forming a view on the quality of the evidence and whether it has been taken into account, rather than attempting to interrogate the decision of the Board. If CQC has its own concerns about a Director it will instigate enforcement action against the Trust.

Where appropriate, CQC will work alongside other regulators (such as the General Medical Council, Nursing and Midwifery Council, General Pharmaceutical Council and other relevant professional regulators), to ensure that the correct processes are adhered to and information is shared when relevant and appropriate.

APPENDIX 4

Annual 'Fit and proper person' self-attestation for Trust Board Members

In accordance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires that Directors (or equivalent) of health service bodies be "fit and proper persons", and the NHS England fit and proper person test framework for board members, I hereby declare that…

(a) I am of "good character". In this regard…
- … I have not been convicted[8] in the UK of any offence, or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence
- … I have not been erased from, removed from, or struck-off, a register of professionals maintained by a regulator of health care or social work professionals.
- … I am not subject to an upheld or ongoing disciplinary finding; grievance finding, whistleblowing finding or finding pursuant to any of the Trust's policies or procedures concerning board member behaviour

(b) I have the qualifications, competence, skills and experience which are necessary for the work for which I am employed / relevant office or position for which I am appointed; including the requisite experience and skills to fulfil the minimum standards against the NHS Leadership Competency Framework six competency domains i.e.:
- i. Setting strategy and delivering long term transformation.
- ii. Leading for equality.
- iii. Driving high quality, sustainable outcomes.
- iv. Providing robust governance and assurance.
- v. Creating a compassionate and inclusive culture.
- vi. Building trusted relationships with partners and communities.

(c) I have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity[9] or providing a service elsewhere which, if provided in England, would be a regulated activity

(d) I am able by reason of my health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which I am employed / office or position for which I am appointed

(e) I am not "unfit". In this regard…
- … I am not an undischarged bankrupt
- … I have not had sequestration awarded (which has not been discharged) in respect of my estate
- … I am not the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
- … I am not a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b)).
- … I have not made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
- … I am not included in the children's barred list or the adults' barred list, maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- … I am not prohibited, by or under any enactment, from holding my office or position, or from carrying on any regulated activities[9]

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[8] In the UK "conviction" means an admission of guilt or a finding of guilt in a criminal court whether by judge, jury, magistrate or certain tribunal Chairman conducting criminal cases. Therefore, fixed penalty notices and speeding fines are not convictions.

[9] Regulated activities are listed in Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are: 'Personal care'; 'Accommodation for persons who require nursing or personal care'; 'Accommodation for persons who require treatment for substance misuse'; 'Treatment of disease, disorder or injury'; 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Management of supply of blood and blood-derived products etc.'; 'Transport services, triage and medical advice provided remotely'; 'Maternity and midwifery services'; 'Termination of pregnancies'; 'Services in slimming clinics'; 'Nursing care'; and 'Family planning services'. Any provider carrying on any of these activities in England must register with the Care Quality Commission.

(f) I am not disqualified from being a charity trustee, or listed on the Charity Commission's Register of Removed Trustees.
(g) I (or any company of which I am the Director or Secretary) have not been issued with a County Court Judgement (CCJ)
(h) I will abide by the Professional Standards Authority's "Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England" at all times when at the service of the Trust.
(i) I will adhere to the Nolan Principles of Standards in Public Life.
(j) I have not posted anything on social media that could potentially bring the Trust into disrepute or conflict with the Trust's values (see section 2).

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Full name	
Job title / role	
Professional registrations held (ref no.) (if relevant):	
Date of last appraisal, and by whom:	
Signature:	
Date of signature	
For completion by the Chair of the Trust Board	
Signature of the chair to confirm receipt:	
Date of signature of chair:	

Please direct any queries towards the Trust Secretary

Section 2: Confirmation of any existing social media presence

Social media is defined within the Trust's 'Social media policy and procedure' [RWF-OPPCS-NC-TM38] as the term commonly used for websites that allow people to interact with each other in virtual communities, by sharing information, videos, images, opinions, knowledge and interests. As the name implies, social media involves the building of online communities or networks, encouraging participation and engagement. Social networking websites (such as Facebook and Twitter) are perhaps the most well-known examples of social media, but the term covers other web-based services. Examples include:

- blogs (a contraction of the term web log - a regularly updated website or web page, typically run by an individual or small group, that is written in an informal or conversational style) and vlogs (a contraction of the term video log – a blog in which the postings are primarily in video form);
- closed groups or pages on Facebook;
- audio and video podcasts;
- 'wikis' (such as Wikipedia);
- message boards (forums);
- social bookmarking websites (such as del.icio.us);
- photo, document and video content sharing websites (such as Instagram, Flickr, TikTok and YouTube);
- micro-blogging services (such as X (formerly known as Twitter), Google+, LinkedIn, Facebook, Telegram, Threads); and
- Mobile messaging services[10] (such as video messaging application Snapchat) (N.B. WhatsApp has been deemed outside the scope the confirmation[11])

Based on the definition above do you now, or have you ever, had a social media account?

Yes / No Please delete as applicable

If yes, please confirm whether the social media account remains accessible (i.e. has not been archived): *Yes / No* Please delete as applicable

If one or more social media accounts remain accessible please complete the table below:

Social media platform (e.g. Facebook; Instagram; etc.)	**Profile / display name**	**Visibility** **(delete as appropriate)**
		Private / Public
		Private / Public
		Private / Public
		Private / Public
		Private / Public
		Private / Public
		Private / Public

In relation to statement (i) if you have ever posted anything on social media that could potentially bring the Trust into disrepute[12] please provide further details:

……
……
……

[10] This only applies to those mobile messaging services which could be accessed by members of the public

[11] WhatsApp has been deemed outside of the scope of the confirmation as a status can only be seen by someone if there is a reciprocal presence within both parties' address book.

[12] Consideration should be given to any messages / information which could be made available to the public by third parties. Guidance on the acceptable use of social media can be found within the 'Social media policy and procedure' [RWF-OPPCS-NC-TM38]

APPENDIX 5 - Compliance with regulations

In the table below, unless the contrary is stated or the context otherwise requires, “ED” means Executive Directors and Director-equivalent and “NED” means Non-Executive Director.

Standard	Assurance	Evidence
Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4 Part 2 of the Regulations. *Schedule 4 Part 2: Whether the person has been convicted in the UK of any offence or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.*	Employment checks are undertaken in accordance with NHS pre-employment checks standards and include: • Two references, one of which must be most recent employer • Qualification and professional registration checks • Right to work checks • Identity checks • Occupational health clearance • DBS checks In addition, we also carry out: • Declarations of ‘fitness’ by candidates • Search of insolvency and bankruptcy register • Search of disqualified directors register • ‘Good character’ checks • Employment tribunal checks	• References • Photo ID • Other pre-employment checks • DBS checks • Signed annual ‘Fit and proper person’ self-attestation signed declaration forms • Register(s) search results • List of referees
If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter	• Disciplinary policy provides for such investigations • Contracts allow for termination in the event of non-compliance with regulations and other requirements	• ED contracts of employment • NEDs terms and conditions of service agreements • Disciplinary policy • Standards of Business Conduct for NHS Staff • Standards of conduct at work policy
Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4 Part 2 of these Regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware	• This would be subject of debate at the Remuneration and Appointments Committee (for Executive Directors and Director-equivalents) and NHS England (for NEDs). The minutes would record such decisions • Chair would take advice from internal and external advisers as appropriate	Minutes of meetings

Standard	Assurance	Evidence
Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator	• This requirement is included within the job/role description for relevant posts and is checked as part of the pre-employment checks • Proof of qualifications checked as part of the pre-employment checks	• Job/role description/person specification • Recruitment and selection policy and procedure
The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required (which may include appropriate communication and leadership skills and a caring and compassionate nature) to undertake the role; these should be followed in all cases and relevant records kept	• Employment checks include a candidate's qualifications and employment references • The recruitment process also includes values-based questions • Decisions and reasons for decisions recorded within the People and Organisational Development Function **Actions identified to strengthen/maintain compliance:** • Utilise the NHSE Trust Board member reference template for all new Trust Board level appointments and associated deputies	• Recruitment and selection policy and procedure • Competency based questions • Values-based questions
The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe	• Any such decision would be discussed by the Remuneration and Appointments Committee and would be minuted • Actions would be subject to follow-up as part of ongoing review and appraisal	• ED appraisal framework • NED appraisal framework • Remuneration and Appointments Committee minutes
When appointing relevant individuals the provider has processes for considering a person's physical and mental health in line with the requirements of the role	• All post-holders are subject to clearance by Occupational Health as part of the pre-employment process • If a health issues is raised, should consider if it falls within definition of disability and if it does consider whether reasonable adjustments in compliance with the Equality Act 2010 can be made	Occupational Health clearance

Standard	Assurance	Evidence
Wherever possible, reasonable adjustments are made in order than an individual can carry out the role	• This is a current requirement in the Trust's Recruitment policy; Sickness Management policy; Stress Management Policy and Change Management Policy (Equality Act 2010) • NHS employment check standards	• Trust's Recruitment policy; Sickness Management policy; Stress Management Policy and Change Management Policy (Equality Act 2010)
9 The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity, this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. *"Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.* *"Privy to" means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.* *"Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.*	• Checks as set out in 1 **Actions identified to strengthen/maintain compliance:** • Utilise the NHSE Trust Board member reference template for all new Trust Board level appointments and associated deputies	• ED/NED recruitment information pack includes FPPR information • FPPR pre-employment declaration • Reference requests
The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity, this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	• Checks as set out in 1 • People policies • Check publicly available information **Actions identified to strengthen/maintain compliance:** • Utilise the NHSE Trust Board member reference template for all new Trust Board level appointments and associated deputies	• ED/NED recruitment information pack • Reference requests • People policies

Standard	Assurance	Evidence
Only individuals who will be acting in a role that falls within the definition of "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). *CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.*	• Standard DBS checks based on the eligibility criteria for DBS checks (as described in the DBS' guides to adult and child workforce roles for registered bodies and employers). • The requirement for Enhanced DBS checks will be determined by the type of activities required by their role and the level of unsupervised access this will allow them to patients	• Disclosure and Barring Service (DBS) checks policy • Annual review of DBS status via the DBS subscription service for Trust Board members
As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list.	Eligibility for DBS/barring list checks will be assessed for each vacancy arising	• Disclosure and Barring Service (DBS) checks policy
The fitness of Directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in, the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	• Post holders undertake annual 'Fit and proper person' self-attestation • Annual checks of insolvency and bankruptcy register and register of disqualified directors undertaken • Annual DBS checks • Regular checks of relevant professional regulator's register • Annual report to the Trust Board and Audit and Governance Committee	• Annual declaration • Trust Board and Audit and Governance Committee minutes • Register checks • Continued assessment as part of appraisal process • Annual report
The provider has arrangements in place to respond to concerns about a person's fitness after they are appointed to a role, identified by itself or others, and these are adhered to.	• Arrangements included in the People policies manual including Disciplinary policy and Standards of conduct at work policy • Contracts (for Executive Directors) and agreements (for NEDs) include maintenance of fitness as a contractual requirement	• People policies • Standards of conduct at work policy • Standards of Business Conduct for NHS Staff • ED contracts of employment • NEDs agreements
The provider investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties and where concerns are substantiated, proportionate and timely action is taken, the provider must demonstrate due diligence in all actions	• This will be undertaken if concerns are identified; action taken and recorded as required • Contracts provide for termination if individuals fail to meet necessary standards	• ED contracts of employment • NEDs agreements • People policies • Standards of conduct at work policy • Standards of Business Conduct for NHS Staff • Disciplinary policy

Standard	Assurance	Evidence
Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users	• This would be reviewed when concerns are identified • People Policies Manual	• Standards of conduct at work policy • Disciplinary policy • Managerial action taken to backfill posts as necessary
The provider informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others	• This would be reviewed when concerns are identified • People Policies Manual	Referrals made to other agencies if necessary

APPENDIX 6 – Checks conducted for each Trust Board member

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Maureen Choong, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Morgan, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma Pettitt-Mitchell, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
Wayne Wright, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Karen Cox, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Finn, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Jo Webber, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alex Yew, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Sean Briggs, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Jo Haworth, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rachel Jones, Director of Strategy, Planning and Partnerships	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Sara Mumford, Medical Director and Director of Infection Prevention and Control	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
Sue Steen, Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hannah Ferris, Deputy Director of Finance, Performance	Updated DBS requested*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ainne Dolan, Deputy Chief People Officer, Organisational Development	Updated DBS requested*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sally Quinn, Interim Deputy Chief People Officer, People and Systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
Clare Wykes, Deputy Medical Director, Quality and Safety	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laurence Nunn, Deputy Medical Director, Service Development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bob Cook, Deputy Director of Strategy, Planning and Partnerships	Updated DBS requested*	✓	✓	✓	✓	✓	✓	✓	N/A	✓
Richard Gatune, Deputy Chief Nurse, Quality and Experience	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hannah Tompsett, Deputy Chief Nurse, Workforce and Education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Checks conducted									
Name:	DBS Status	Disqualified Directors register	Disqualification from being a Charity Trustee	Employment tribunal judgement	'Good character' check, including: ○ Mismanagement and misconduct checks ○ Register of Judgements check	Insolvency review	Social Media checks	Self-attestation form completed	Professional register check (if applicable)	Conflicts of Interest declared
Sarah Davis, Deputy Chief Operating Officer	Updated DBS requested*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tasha Gardner, Director of Communications	Updated DBS requested*	✓	✓	✓	✓	✓	✓	✓	N/A	✓

N.B. These checks were conducted in April and May 2024, in line with the year-end reporting. This also coincided with the appraisal process for Non-Executive Directors.

* New DBS Certificates have been requested in accordance with the Trust's Disclosure and Barring Service (DBS) checks policy for Trust Board members, which is annually and not every three years. A three-year time limit is in line with the Fit and Proper Persons Test guidance last updated by NHS England on 21st March 2024.