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

Thu 27 June 2024, 09:45 - 13:00

Virtually, via Webconference

Agenda

09:45 - 09:45

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

09:45 - 09:46

06-9
To receive apologies for absence

Annette Doherty

09:46 - 09:46

06-10
To declare interests relevant to agenda items

Annette Doherty

09:46 - 09:47

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

Annette Doherty

- Board minutes, 30.05.24 (Part 1).pdf (9 pages)
- Board minutes 25.06.24 (Part 1).pdf (2 pages)

09:47 - 09:50

06-12
To note progress with previous actions

Annette Doherty

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

Patient Experience story

09:50 - 10:20

06-13
Patient experience story

Representatives from the Surgery Division

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

- Patient Experience Story - Surgery - June 2024.pdf (4 pages)

Reports from the Chair of the Trust Board and Chief Executive

10:20 - 10:25

06-14
Report from the Chair of the Trust Board

Annette Doherty

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

10:25 - 10:35

06-15
Report from the Chief Executive (incl. a quarterly update on the Patient First Improvement System (PFIS))

Miles Scott

Report from the Chief Executive (incl. a quarterly update on the Patient First Improvement System (PFIS)) - June 2024.pdf (4 pages)

Reports from Trust Board sub-committees

10:35 - 10:40

06-16
Quality Committee, 12/06/24

Maureen Choong

Summary of Quality C'ttee, 12.06.24.pdf (2 pages)

10:40 - 10:45

06-17
Finance and Performance Committee, 25/06/24

Neil Griffiths

Summary of Finance and Performance C'ttee 25.06.24.pdf (2 pages)

10:45 - 10:50

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

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 21.06.24.pdf (2 pages)

Integrated Performance Report

10:50 - 11:35

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

Miles Scott and colleagues

Integrated Performance Report (IPR) for May 2024 V2.pdf (48 pages)

11:35 - 11:45 *10 minute intermission*

Quality Items

11:45 - 11:55

06-20
Quarterly mortality data

Sara Mumford

Quarterly mortality data.pdf (10 pages)

11:55 - 12:05

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

Joanna Haworth

To approve the Trust's Quality Accounts, 2023,24.pdf (42 pages)

People

12:05 - 12:20

06-22
Mid-year Nursing and Midwifery staffing review

Jo Haworth

Mid-year Nursing and Midwifery staffing review - June 2024.docx.pdf (37 pages)

Systems and Place

12:20 - 12:25

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

Rachel Jones

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (6 pages)

Planning and strategy

12:25 - 12:30

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

Rachel Jones

To approve the corporate objectives for 2024-25.pdf (8 pages)

Assurance and policy

12:30 - 12:40

06-25

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

Rachel Jones

Update from the SIRO (incl. approval of the Data Security and Protection Toolkit submission for 2023-24).pdf (24 pages)

Other matters

12:40 - 12:41

06-26

To consider any other business

Annette Doherty

12:41 - 12:42

06-27

To respond to any questions from members of the public

Annette Doherty

12:42 - 12:43

06-28

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 30TH MAY 2024, 09.45AM, VIRTUALLY VIA WEBCONFERENCE

FOR APPROVAL

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Sara Mumford	Medical Director / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director (until item 05-13)	(KC)
	Ainne Dolan	Deputy Chief People Officer, Organisational Development (representing the Chief People Officer)	(ADo)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Mel Norbury	Interim Trust Secretary	(MN)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Gemma Viner	Divisional Director of Nursing and Quality, Medicine and Emergency Care (for item 05-5)	(GV)
Observing:	The meeting was recorded live and uploaded to the Trust's YouTube Channel.		

05-1 To receive apologies for absence

Apologies were received from David Morgan (DM), Non-Executive Director; and Wayne Wright (WW), Non-Executive Director. It was also noted that Richard Finn (RF), Associate Non-Executive Director; and Sue Steen (SS), Chief People Officer would not be in attendance.

05-2 To declare interests relevant to agenda items

No interests were declared.

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

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

05-4 To note progress with previous actions

The content of the submitted report was noted.

Patient experience

05-5 Patient experience story

JH introduced the patient experience story and outlined the benefits associated with patient experience stories. GV referred to the submitted report and highlighted the following points:

- Thanks to the family of the patient involved for engaging with the Trust to enable the development of improvements within the Trust's Emergency Departments for neurodiverse patients.
- An overview of the presentation and management of Master A who attended the Trust following a head injury; the considerations which were afforded to where Master A was required to wait for care at the Trust; and the wound advice which had been provided.

- The mother contacted the Trust to express concerns related to treatment at the Trust which were related to waiting times for clinical review; lack of communication; and inconsistent advice in relation to appropriate wound closure.
- A meeting was held between the mother, paternal grandmother, Emergency Department Team, and the Trust's Learning Disability Liaison Nurse to discuss the concerns which had been raised regarding the care environment in the Paediatric Emergency Department; wherein, the need to improve the resources to care for neurodiverse patients was recognised.
- Several measures have been introduced to support the experience of neurodiverse patients in the Trust's EDs which included the creation of a sensory box, the provision of ear defenders, and the development of health passports; the latter of which was intended to be implemented in local schools.
- The next steps were to create a patient form which would provide assurance to the new Experience of Care Oversight Group; the development of information boards to celebrate individual differences; and discussions with the Kent and Medway Integrated Care Board to explore additional resources that could help support the management of neurodiverse patients at the Trust.

AD welcomed the summary of the case which had been provided and thanked GV for their involvement in the investigation and engagement with the patient's family. AD then thanked the family involved for their engagement with the Trust to support service improvements.

MS asked what, if any, measures had been implemented to ensure the lessons learned were disseminated to other service areas. GV provided assurance regarding the process for the dissemination of the lessons learned, which would be supported by the Trust's Heads of Nursing and emphasised the importance of engagement with families involved in incidents to ensure the appropriate learning was captured. GV added that representatives from both of the Trust's EDs would be involved in the patient forum which was under development.

EPM asked whether the Trust conducted listening events for those patients with additional needs and asked what proactive measures would be implemented to prevent such issues for occurring in the future. JH replied that the Trust's Experience of Care Strategy, which had been approved at the April 2024 'Part 1' Trust Board meeting had objectives which focused on communication and patient involvement, and noted the patient feedback model which had been adopted within the Cancer Services Division, which would be reviewed for wider use across the Trust. JH acknowledged the importance of ensuring that appropriate representatives were involved in the required service improvement programme.

EPM informed Trust Board members of the request from the Health and Wellbeing Committee for additional data regarding compliance with the Oliver McGowen training, and noted the benefits associated with such training. ADo confirmed that such data would be provided to the Health and Wellbeing Committee and noted the programme of work by the Trust's Disability Network to improve awareness across the Trust.

SM highlighted that the Patient Experience Story had been presented to the Chief of Service and Clinical Directors meeting, due to their responsibility in relation to patient care and acknowledged the importance of ensuring the patient experience was equitable for all service users.

MC noted the potential lived experience from Trust staff with neurodivergent qualities which could be utilised to support care at the Trust and queried how the progress against the actions and lessons learned would be monitored. GV replied that Medicine and Emergency Care Division's progress in relation to the lessons learned would be monitored by the Experience of Care Oversight Group.

JW asked what, if any, support and guidance had been received from local charities and other NHS Providers which supported neurodiverse patients. JH replied that the Learning Disability Liaison Nurse had a range of connections with partner organisations as well as experience as a community nurse; but noted that further work was required to ensure the lessons learned were captured and to support the required triangulation of information.

AD highlighted that poor communication was often the underlying reason for the concerns raised by service users and commended the transparency which had been provided in relation to the incident. AD then reiterated the thanks to the family for their engagement with the Trust.

Reports from the Chair of the Trust Board and Chief Executive

05-6 Report from the Chair of Trust Board

AD referred to the submitted report and highlighted the one consultant appointment which had been made in the reporting period. AD then thanked Trust staff for the welcome received upon joining as Trust chair on 20th May.

05-7 Report from the Chief Executive

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

- The Trust's Exceptional People, Outstanding Care Star Awards and Nursing and Midwifery Awards had been well received by Trust staff.
- Nine of the Trust's Healthcare Support Workers (HCSWs) had received awards from NHS England's (NHSEs) Chief Nursing Officer and Chief Midwifery Officer.
- The new Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) had been officially opened.
- A programme of work had been commissioned to install emergency defibrillators at the Trust, which were accessible to members of the public, and had been funded by the League of Friends of Maidstone Hospital, the first of which had been installed at the Maidstone Hospital Academic Centre and named 'Jez' in tribute to the Trust's Gardner.

Reports from Trust Board sub-committees

05-8 Quality Committee, 28/05/24

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

- The annual fire safety report 2023/24, which had been included in appendix 1, had been reviewed by the Committee.
- The initial reports from the Patient Safety Oversight Group and Maternity and Neonatal Assurance Group had been received; which reflected the significant programme of work in response to the findings of the Deloitte LLP external governance review; but, it was acknowledged that such reports were a work in progress and that they would continue to evolve as the remits of the Oversight Groups were defined.
- Under the evaluation of the meeting concerns had been raised regarding the potential of duplication within the revised quality committee structure, which would be monitored.

JH thanked MC for the feedback which had been received at the Quality Committee and noted that the new reporting template had enabled the points of escalation and key risks to be highlighted to the Quality Committee in a coherent, accessible, manner.

AD acknowledged the assurance provided by the Annual Fire Safety report for 2023/24 and asked whether there was sufficient confidence that the issues which led to an individual gaining access to the Oncology Department out of hours had been addressed. SB replied that such incidents were unusual and challenging to address; however, noted that a significant security review had been commissioned which included a review of the Trust's access control system arrangements which would address the issue. RJ added that a Business Case for the access control system at Maidstone Hospital had been scheduled for review at the Business Case Review Panel during the week commencing 3rd June 2024.

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

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

- The 'deep dive' had focused on the outpatient transformation programme, wherein assurance had been received regarding the use of digital innovations and the improvement in call handling times.

- Initial details had been received regarding the progress for the review and monitoring of the realisation of benefits outlined within Business Cases, an update on which would be provided to the Finance and Performance Committee on a quarterly basis.
- The Trust's Financial performance for Month 1 of 2024/25 was adverse to plan; therefore, the position would continue to be closely monitored.
- The Kent and Medway Integrated Care System (ICS) was in financial turnaround measures, therefore it was important that the Trust delivered the financial plan for 2024/25 and supported system-wide programme of work to deliver the control total as agreed by NHSE.

MS explained the Kent and Medway ICS financial position and the £120m deficit control total which had been agreed with NHSE; however, noted the inherent risks in the delivery of the financial plans for each of the NHS Providers in Kent and Medway; so, the Chief Finance Officers were working to identify the risks and interdependencies and determine how such risks could be mitigated appropriately. MS continued that NHSE had published further guidance on the 2024/25 financial regime and in-particular how there would be consequences for systems with deficits and incentives for those systems in financial balance.

SO then elaborated on the rationale for the allocation of the control total by NHSE and explained the consequences for those systems that were adverse to plan and the incentives for those systems which were either in financial balance or achieved a financial surplus. SO continued that the potential consequences for the Kent and Medway ICS were currently under review; however, noted that the key area of focus for the Trust was the delivery of the financial plan for 2024/25 which would significantly contribute to the delivery of the system-wide financial plan.

AD stated that the delivery of the financial plan for 2024/25 would require a number of challenging decisions and improved partnership working across the Kent and Medway ICS; therefore, it was important to identify those areas where the return on investment from partnership working could be maximised. AD then acknowledged the challenges contained within the Trust's Financial plan, the delivery of which would be a key area of focus for the Executive Directors. AD then queried to what degree Trust staff understood the financial pressures for 2024/25. MS replied that Trust staff had been informed through a number of formal mechanisms and noted the importance of ensuring line managers were engaged with staff in their service areas regarding the implications of the financial position.

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)

EPM referred to the submitted report and highlighted the following points:
- A discussion was held regarding the Trust's financial position in relation to the workforce plan for 2024/25; which would continue to be monitored, as required.
- Significant progress had been made in relation to the reduction of temporary staffing expenditure; however, the programme of work had plateaued; so, the Business Case was under development to support the programme of work, which would be reviewed by Committee members.
- Further assurance had been requested in regard to the Trust's Employee Value Proposition.

The revised Terms of Reference were approved as submitted.

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

MC referred to the submitted report and highlighted the following points:
- Assurance had been provided regarding the risk management improvement plan; although, it was acknowledged that further work was required.
- A 'Limited assurance' Internal Audit review had been received for outpatient utilisation due to insufficient utilisation of clinic capacity, particularly in relation to the short-notice cancellation of clinics.

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

MN referred to the submitted report and highlighted the key points therein.

The continuation of the Terms of Reference for the Remuneration and Appointments Committee was approved as part of the annual review process.

Integrated Performance Report (IPR)

05-13 <u>Review of the Integrated Performance Report (IPR) for April 2024</u>

MS introduced the IPR and reminded Trust Board members of the amendments which had been made to the IPR over the preceding months. ADo then referred to the "People" Strategic Theme and highlighted the following points:

- The turnover rate had been maintained at 11.5%, which was below the Trust's target of 12%; so, continued focus would be applied to 'hot spot' areas.
- The sickness absence rate reduced to 6.8%; but, there was an increase in long-term sickness absence, which would be duly reviewed.
- Discussions had been held regarding the Trust's ambition to increase diversity in Agenda for Change (AfC) Band 8c and above, with targeted interventions in place.

AD requested details of the key 'hot spot' areas in terms of staff turnover. ADo replied that the 'A3 Thinking' process had been utilised to focus on particular areas of concern which included administrative and clerical staff and those staff which left the Trust within their first 24 months of employment.

AY asked whether there were any new or innovative approaches to improve the percentage of Black, Asian and Minority Ethnic (BAME) staff in AfC pay band 8c and above. ADo replied that the Trust had been appointed as an NHSE People Promise Exemplar site which provided additional resources to focus on specific projects during 2024/25, the first of which was related to improving inclusivity in AfC pay band 8c and above.

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

- New metrics had been introduced following the introduction of the Patient Safety Incident Response Framework (PSIRF).
- The "Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days" and "Rate of Hospital C. Difficile per 100,000 occupied Bed days" metrics required escalation and Trust-wide outbreak meetings had been implemented in response to the latter; although, there were no indications of cross infection at the Trust.
- The Lead Nurse for the Deteriorating Patient role had been approved.

AD asked what, if any, lessons learned and best practice was available nationally to support the reduction in *Clostridium difficile* (C. Diff) cases. SM outlined the Kent and Medway ICS meetings which were held regarding the management of C. Diff and noted that the lessons learned were broadly aligned and related to the acuity of the presentations, the number of patients, the high bed occupancy rate and the issues in relation to anti-microbial stewardship. SM then explained the mattress audit and replacement programme which had been conducted, which had improved the Trust's *Escherichia coli* (E. Coli) rates; but, noted the importance of a robust deep clean programme to address the rates of C. Diff, which required de-escalation of ward areas.

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

- The "Cancer - 31 Day First (New Combined Standard) …" metric had been achieved for the first time.
- ED performance had reduced to 84%, so further work was required to improve performance.
- Access to Diagnostics (<6weeks standard) performance had decreased due to challenges in relation to echocardiograms.
- The Trust's system support activity had been incorporated, which had resulted in an increase in the number of patients waiting longer than 40 and 52 weeks for treatment; so, such patients had been incorporated under separate metrics, to support the Trust's monitoring arrangements.

JW queried whether the number of patients waiting longer than 40 weeks and 52 weeks were separate patients. SB explained that the Trust had 166 patients which had waited longer than 52 weeks, with a further 6 patients that had waited over 40 weeks; although, noted the figures has since increased as additional patients had been transferred to the Trust. MS emphasised that the Trust's support for system activity focused on those patients which had waited the longest for treatment; therefore, would impact the Trust's 52 week wait performance; but, noted that the intention was to ensure that patients originally referred to the Trust received treatment within the 40-week period. JW queried whether a triage process should be adopted to determine the urgency of the care required. MS clarified that the patients which had been waiting longer than 40 weeks required routine treatment, rather than urgent treatment; therefore, best practice was to treat the longest waiting patients in strict date order; although, noted that clinical judgement would be exercised on a case by case basis.

EPM stated it would be beneficial for some demand analysis to be conducted to understand the reasoning for the increase in referrals and whether such an increase had translated to an increase in the number of cases of cancer detected. MS requested that SB provide Trust Board members with details of the reasoning for the increase in referrals to cancer services and whether such an increase in referrals had resulted in an increase in the number of cases of cancer detected.

Action: Provide Trust Board members with details of the reasoning for the increase in referrals to cancer services and whether such an increase in referrals had resulted in an increase in the number of cases of cancer detected (Chief Operating Officer, May 2024 onwards)

NG queried how the Trust was maintaining staff morale in response to increases in demand and a recent slight deterioration of some of the Trust Key Performance Indicators (KPIs). SB noted the significant work which had been conducted to ensure any patients which had been waiting longer than 52 weeks received treatment; and explained that continued service development in response to achievement of KPIs had previously been a motivator for Trust staff, which was challenging under the current financial regime; so, staff morale would need to continue to be monitored.

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

- Performance against the "% complaints responded to within target" metric had improved and a review of alternative processes to streamline the Trust's complaints response process had been commissioned.
- A significant increase in Friends and Family Test (FFT) responses had been received following the transition to the new service provider, which provided additional granular detail to enable the Trust to accurately respond to patient feedback.
- The key feedback categories were "attitude", "care" and "waiting times"; the improvements in which would be aligned with the Experience of Care Strategy.

AY queried whether the significant reduction in the Trust's Friends and Family Test (FFT) performance was due to the change in service provider. JH confirmed the reduction in performance was associated with challenges during the transition period and noted the need to be pragmatic when review the performance forecast until the new provider was embedded. SO then provided an explanation of the methodology for the calculation of the forecast and noted that once the new provider was embedded the forecast would stabilise.

AD requested clarification between the difference in functionality between the new provider and the previous provider. JH duly elaborated on the improved functionality of the new FFT provider which included increased accessibility through a variety of modalities, refinement in contact points so that patients are not contacted upon each attendance at the Trust; and increased granularity regarding the data which is received to enable the Trust to understand where the patient experience could be improved.

[KC left the meeting at this point]

JH then referred to the "Maternity Metrics" and highlighted the following points:

- The "Decision to delivery interval Category 2 caesarean section < 75 mins" metric performance remained challenged; so, the Trust's improvement methodology would be utilised to investigate the key contributors, particularly in relation to the use of a second theatre.
- The Care Quality Commission (CQC) had agreed to amend the error within their inspection report for the Trust's Maternity Services, which had suggested that there had been three 'never events' when there had only been one 'never event' which the Trust Board was duly informed of.

AD requested an update on the programme of work to address the findings of the CQC Maternity Services inspection. JH replied that a comprehensive maternity improvement plan had been developed, which had resulted in improvements in a number of metrics such as the "decision to delivery interval Category 1 caesarean section < 30 mins" target. JH continued that the Trust had acknowledged that additional resources were required for the long-term support and improvement of the Maternity Services; and noted the impact of the scrutiny and improvement requirements on the staff within the Trust's Maternity Service. JH then outlined the initial feedback which had been received from NHSE.

AD asked whether a Business Case had been developed for the Maternity Service resources and skill mix required. JH confirmed that the Business Case was currently under development and included a range of roles, both clinical and quality governance roles.

RJ then referred to the "Systems" Strategic Theme and highlighted the following points:
- Performance had been maintained for the "Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR)…"; therefore, a stretch target was under consideration.
- The number of patients leaving by noon on the day of discharge remained a challenge; but, a comprehensive review of board rounds had been conducted to inform the individual changes which were required within specific ward areas; although, as part of the objective setting process, the breakthrough objective would be redefined to focus on patient flow.
- A detailed audit of Pathway 3 (i.e. the complex discharge pathway) had been commissioned, in conjunction with Kent County Council, to understand the totality of the patient pathway.

AD queried whether the lessons learned nationally in relation to improving the rate of discharges before noon had been considered as part of the programme of work. RJ provided assurance that national lessons learned were considered as part of the programme of work.

SO then referred to the "Sustainability" Strategic Theme and highlighted the following points:
- The Trust had reported a deficit position of £1.9m for Month 1 of 2024/25 which was £700k adverse to plan due to an underperformance in terms of both income delivery and achievement of the Cost Improvement Programmes (CIPs).
- The reduction in the Trust's agency expenditure had plateaued towards the end of the 2023/24 financial year; and noted that a targeted approach would be adopted for those areas with increased agency expenditure which included Consultants, Allied Health Professionals (AHPs), and the provision of care for mental health presentations. The programme of work was also focused on eRostering and the new Patchwork Healthcare Workforce Solution ('Patchwork') was currently under implementation.

NG asked what alternative approaches would be adopted for the delivery of the 2024/25 CIPs, particularly in relation to the utilisation of scenario planning. SO replied that the Trust was currently behind plan for the delivery of the 2024/25 CIP; therefore, the initial areas of focus were the realisation of benefits outlined within Business Cases; the utilisation of the model hospital system to deliver productivity improvements and the establishment of a Trust-wide Efficiency Group. SO then outlined the discussions which had been held with the Clinical Divisions and Corporate Directorates to identify additional CIPs. SO added that a number of actions were under development for implementation in the event that the Trust underperformed against the financial plan and emphasised the importance of Divisional ownership of the delivery of the financial plan within their service areas. EPM emphasised the importance of the accountability aspect in relation to the delivery of the financial plan and CIPs, and the provision of challenge for any deviation from the financial plan.

Systems and Place

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

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

- The Acute Provider Collaborative had accepted the recommendation to conduct a 'deep dive' into specific service areas.
- The NHS Kent and Medway five-year strategy would be submitted to a future Trust Board meeting, once available.
- The West Kent HCP was focused on sustainability and the development of integrated neighbourhood teams.

AD supported the acute service review which had been conducted and the proposed 'deep dive' into a specific patient pathway and noted the opportunities to improve productivity and efficiency through partnership working.

MC asked what, if any, measures had been considered to streamline the process for patient referrals to alleviate operational pressures for primary care providers. RJ confirmed that was part of the intended role of the Integrated Neighbourhood Teams, and elaborated on the progress to date in relation to the development of Integrated Neighbourhood Teams and the role of the Primary Care Networks (PCNs); however, acknowledged the challenges associated with operational pressures.

Planning and strategy

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

SB referred to the submitted report and highlighted that the provisional designs for the Maggie's Centre at Maidstone Hospital were expected to be received in June 2024. AD supported the development of the service at Maidstone Hospital.

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

AD acknowledged the importance of continuing to pursue technological advances and highlighted that a Full Business Case would be developed if the OBC for Robotic Assisted Surgery was approved. RJ then referred to the submitted report and highlighted that a significant clinical engagement programme had been conducted and a phased approach to the implementation of a surgical robot at Maidstone Hospital and Tunbridge Wells Hospital had been supported as the preferred option; which would support the attraction and retention of clinical staff that had received training in regards to Robotic Assisted Surgery.

AD requested details of the discussion which had been held at the Finance and Performance Committee. NG replied that the Committee had recommended approval of the OBC and that the discussion had focused on ensuring the Trust continued to provide leading surgical treatments supported by technological innovations; but, acknowledged the activity assumptions which had been included in the OBC.

EPM queried whether a specific return on investment had been identified, and what, if any, lessons had been learned from other NHS Providers that had Robotic Assisted Surgery provisions. RJ provided assurance that the return on investment would be detailed within the FBC, which would be informed by appropriate benchmarking, and noted that the Trust had secured a version of the FBC developed by Dartford and Gravesham NHS Trust for Robotic Assisted Surgery.

AD supported the importance of progressing with the Business Case to enable the Trust to deliver the efficiencies and return on investment associated with Robotic Assisted Surgery.

The OBC for Robotic Assisted Surgery was approved as submitted.

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

SB referred to the submitted report and highlighted the importance of expanding the Trust's Oncology Consultant workforce to respond to increase demand, which was currently addressed through the utilisation of temporary staff.

RJ outlined the rigor which had been applied to the development of the Business Case to ensure a self-funding option was realistic. AD acknowledged the importance of the Business Case to support the system-wide delivery of cancer care.

EPM queried whether an Equality, Diversity and Inclusion (EDI) 'lens' had been applied to the Business Case to consider any health inequalities. RJ confirmed that an equality impact assessment was conducted and as part of the implementation plan the actions to address any health inequalities were; however, noted that specific discussions regarding the EDI aspect would be held with EPM, external to the meeting.

The Business Case for Oncology Consultant Recruitment was approved as submitted.

Corporate Governance

05-18 <u>Assurance of compliance with the Fit and Proper Persons Test requirements</u>

MN referred to the submitted report and highlighted that a detail review had been conducted, which was informed by guidance from NHS England (NHSE), the findings of which had been signed off by David Highton as outgoing Chair of the Trust Board and would be submitted to NHSE to confirm the Trust's compliance with the Fit and Proper Persons Test requirements.

Other matters

05-19 <u>To consider any other business</u>

ADo informed Trust Board members that the interim Freedom to Speak Up Guardian had been appointed into the substantive position.

SM informed Trust Board members that the Trust had been selected as part of the Martha's Rule pilot and that the Trust would work collaboratively with NHSE as part of the implementation process throughout 2024/25. AD asked when the results of the Martha's Rule pilot were expected to be available. SM replied that the Martha's Rule pilot was expected to be fully implemented by March 2025, and explained the implementation approach which had been developed.

MS asked which, if any, of the Quality Committee sub-committees had been designated to receive information on the implementation of Martha's Rule. SM and JH agreed to consider, and advise the Trust Board, which of the Quality Committee sub-committees would monitor the Trust's implementation of the Martha's Rule pilot.

Action: Consider, and advise the Trust Board, which of the Quality Committee sub-committees would monitor the Trust's implementation of the Martha's Rule pilot (Chief Nurse and Medical Director; May 2024 onwards)

MS informed Trust Board members that the house of Parliament had been dissolved on the 29th May 2024 due to the upcoming general election and noted highlighted the requirements of the Trust during the pre-election period.

05-20 <u>To respond to questions from members of the public</u>

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

05-21 <u>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</u>

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

MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1') HELD ON MONDAY 25TH JUNE 2024, 11AM, VIRTUALLY, VIA WEBCONFERENCE

FOR APPROVAL

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Medical Director / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive (from item 06-3)	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Melanie Norbury	Interim Trust Secretary	(MN)
Observing:	The meeting was recorded live and published on the Trust's YouTube channel.		

06-1 To receive apologies for absence

No apologies for absence were received.

06-2 To declare interests relevant to agenda items

DM declared that his son worked for Grant Thornton UK LLP, although not within the Public Sector Audit Team.

Reports from the Trust Board sub-committees

06-3 Audit and Governance Committee, 25/06/24 (incl. the Committee's 2023/24 Annual Report)

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

- The External Auditors had confirmed the intention to issue an unmodified opinion, subject to the approval of the Annual Report and Accounts for 2023/24 by the Trust Board.
- The cooperation between the Trust and the external auditors had been commended, particularly in relation to the quality of the working papers which had been provided.
- The Value for Money (VFM) assessment had highlighted the increasing difficulties related to the Trust's financial position and the further work required in relation to risk management.

Annual Report and Accounts

06-4 To approve the Trust's Annual Report, 2023/24 (incl. Annual Governance Statement)

MN thanked those staff which had been involved in the development of the Annual Report for 2023/24 and it had been agreed by everyone that the Annual Report for 2023/24 should be dedicated to Kevin Rowan, Former Trust Secretary. MN then referred to the submitted report and highlighted that the Annual Report for 2023/24 was fully compliant with the Department of Health and Social Care Group Accounting Manual 2023/24 and the Code of governance for NHS provider trusts.

AD echoed the thanks provided to those staff involved in the production of the Annual Report for 2023/24 and noted the transparency which had been afforded in relation to the Trust's achievements and challenges.

The Annual Report for 2023/24 was approved as submitted.

06-5 To approve the Trust's Annual Accounts 2023/24

SO firstly thanked the members of the Finance Department which had been involved in the production of the Annual Accounts for 2023/24 and referred to the submitted report and highlighted the complexities associated with the Private Finance Initiative (PFI) remeasurement and the acquisition of the Spire Tunbridge Wells.

DM commended the quality of the Annual Accounts for 2023/24 and noted that the amendments to the original version had been primarily technical in nature and therefore had not impacted the statement of income and expenditure.

AD reported the positive feedback which had been received from the external auditors at the Audit and Governance Committee meeting earlier that day and the acknowledgement of the challenges associated with the acquisition of the Spire Tunbridge Wells at the end of the 2023/24 financial year.

The Annual Accounts for 2023/24 were approved in the form substantially submitted to the Trust Board, to enable any non-material changes to be enacted without additional approval.

06-6 To approve the Management Representation Letter, 2023/24

SO referred to the submitted report and highlighted that that representations XVII and XVIII were specific to the Trust and confirmed that the Trust's Senior Management were supportive of approval of the Management Representation Letter for 2023/24 by the Trust Board.

The Management Representation Letter for 2023/24 was approved as submitted.

Other matters

06-7 To consider any other business

There was no other business.

06-8 To respond to questions from members of the public

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

Trust Board Meeting – June 2024

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 is on the agenda for the June 2024 Finance and Performance Committee and an update will be provided to the Trust Board following the meeting.
05-13	Provide Trust Board members with details of the reasoning for the increase in referrals to cancer services and whether such an increase in referrals had resulted in an increase in the number of cases of cancer detected	Chief Operating Officer	May 2024 onwards	A verbal update will be provided at the meeing.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-19	Consider, and advise the Trust Board, which of the Quality Committee sub-committees would monitor the Trust's implementation of the Martha's Rule pilot	Chief Nurse; and Medical Director / Director of Infection Prevention and Control	June 2024	At the point of implementation, the Martha's Rule pilot will be considered in either the Patient Safety Committee or the Patient Outcomes Committee.

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).

[1]

Not started	On track	Issue / delay	Decision required

Patient Experience Story **Representatives from Surgery 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?
5. What does the story tell the board about availability of specialist spine services?

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

Maidstone and Tunbridge Wells NHS Trust

Patient Story

Name: Mrs B	
Date of care experienced: **April 2024- June 2024**	**Services/wards experienced:** **Trauma and Orthopaedics** **Inpatient Trauma Ward** **Oncology Nurse Specialist Team** **Palliative Care Team** **Hospice Team** **Care Coordination Centre**

Outline of experience:

Mrs B is a 64-Year-old lady who was admitted to a trauma ward having sustained a traumatic spinal injury that affected her spinal cord. She suffered reduced feeling and movement in her arms and legs from the level of her injury. Due to the effects of the injury, Mrs B required care for all aspects of her day- helping to be washed, dressed, repositioning in bed, using the toilet as well as needing assistance to eat and drink.

In the initial hours after her injury she became medically unwell and required an admission to the High Dependency Unit (HDU) for supportive care due to complications of her injury. Despite discussion with the regional spinal service, little could be offered that would improve her injury. After a week in HDU she was deemed stable enough to return to a trauma ward to begin her rehabilitation and is currently still awaiting transfer to a regional spinal rehabilitation unit.

During her admission she was supported by her husband and her daughter who both visited daily, building a close relationship with the clinical teams and communicating well throughout the admission. Sadly, during Mrs B admission, Mr B, who had been battling a lower Gasto Intestinal cancer, had reached the end of his chemotherapy treatment and was transferred to a palliative care pathway for further support.

Mr and Mrs B expressed a desire to spend as much time together as possible which sometimes included Mr B wishing to stay overnight. Whilst visiting his wife, Mr B was offered a visitor's bed (procured by the ward using charity funds) should he wish to stay overnight with Mrs B, and the wider family were able to visit at their leisure.

The Ward Manager noted how Mr B quickly became frailer, yet he persisted in visiting Mrs B each day. The Ward Manager approached her Head of Nursing to see what personalised care plan was possible for Mr B as during her time liaising with the family, she understood that Mr and Mrs B wanted to be together as much as possible and they would have wanted to be together when he passed away. She recognised that whilst he had no care needs at that time, he certainly would need care in the near future. She wished to explore an idea that, should the time come, he could be admitted to the same ward as Mrs B. Mrs B was unable to be cared for elsewhere due to needing specialist care, so options were discussed to enable Mr and Mrs B to be together at the end of his life if this is what they wished.

Following discussion with Mr and Mrs B and with the family, discussions were held with the Divisional Director of Nursing and Quality, Matron for General Surgery, Mr B's oncology nurse (with permission) and the Trusts Palliative Care and End of Life Lead Nurse to appraise all available options that could then be presented to Mr and Mrs B. The Ward Manager spoke with Mrs B and her daughter. They had a difficult discussion around what they would each prefer

individually at the end of his life and agreed they would speak with Mr B to ensure all wishes were considered.

Mr B had previously mentioned he wanted to be with Mrs B, and had initially declined an admission to the Hospice. The Ward Manager offered, once he needed palliative care, that Mr B could be admitted into the room next to Mrs B so they could be together as much as they wished including sharing one of the larger rooms if they wished (with a room adjacent for comfort, privacy and confidentiality if needed).

Due to Mr B's rapidly deteriorating state, the Neuro Rehabilitation Therapists started working on car transfers with Mrs B and the type of movements that she would need to undertake in order to visit Mr B at the end of his life if Mr B chose to be either at home or in another setting such as the Hospice.

In early June Mr B became acutely unwell and was subsequently not safe to be alone at home unsupported and was admitted under the care of the General Surgery Team to the hospital. The Trusts Site Managers and Care Coordination Centre (the team that manages admissions and flow within the hospitals) supported Mr B to be admitted to the room next to Mrs B on one of the Trauma and Orthopaedic wards. The usual ward for an admission for patients with a condition similar to Mr B would have been on a General Surgery Ward. The Surgical team looking after Mr B agreed to review Mr B on the Orthopaedic ward next to his wife.

Mr B improved following treatment and was deemed well enough to leave hospital. Having considered his options, Mr B was transferred to a hospice where he passed away peacefully with Mrs B and their family by his side. Mrs B was facilitated to visit daily which included preparing Mrs B for collection by her daughter and training her daughter to continue providing care outside of the hospital. The Ward Manager, Mrs B and Mrs B's daughter remain in constant contact whilst they await a long-term placement at the specialist rehabilitation centre.

Both Mrs B's Daughter and Son in Law have fed back the following regarding the care, "*We are so grateful for the ward facilitating every step of this journey. We are so thankful that the ward has considered all our wishes and given us time and support to agree what has been best for us all*."

The Ward Manager described her experience "*I feel I am able to achieve true holistic care for my patients. I am able to do this thanks to the support I receive from my Matron, Head of Nursing and the rest of the MDT."*

Positive points to highlight:	**Negative points to highlight:**
• Ongoing excellent relationship between the patient, her family and the Ward Manager • Outstanding leadership and role modelling from Ward Manager to the ward team • Due to the collaborative working Mr B's chosen place of death was facilitated • Overall intention "to do the right thing" • Personalised care plan written in collaboration with Mr B, his family and the team looking after Mrs B • Trauma and Orthopaedic Wards have extended visiting hours 10:00-20:00 with no restrictions on children unless unwell	• The time taken to obtain a specialist bed at a specialist referral centre despite daily escalations at system level

Ongoing actions with case:

- Review of patient and visitor rest area to provide a breakout space for all patients and visitors, not just those living with dementia
- Hot food availability is limited for those visiting long term patients
- Spinal cord injury patients currently have a long wait for specialist rehabilitation. There are currently no alternative pathways for those waiting

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?
10/06/2024	Consultant Physician - Interest in Geriatric Medicine & Acute Frailty	Jason	James	Acute Medicine	7/10/2024	Replacement

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

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

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

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

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

- Work on expanding our services to improve access to care for patients continues, with the ongoing development of a number of large-scale infrastructure projects:
  - **Fordcombe project**: We are now two months into the transition period following MTW's acquisition of the Spire Tunbridge Wells Hospital and work is progressing in a number of key areas. Clinical and operational colleagues are developing clinical pathways, and support services including IT, Pharmacy and Estates are regularly visiting the site to ensure operational readiness when the transition period ends in the autumn. The extra capacity the site enables us to provide across our hospitals will support the NHS across Kent and Medway and we have already agreed to take 2,500 of the longest waiting patients in the system. The first 400 patients are in Gastroenterology, Pain Management, and Ear, Nose and Throat. Trauma and Orthopaedics will follow. The Spire team are continuing to run the site until the end of this first phase and we are working closely with them to maximise NHS capacity during this period. MTW will take over the site at the end of the transition period and, in line with NHS naming principles, the hospital will be renamed Fordcombe Hospital.
  - **Kent and Medway Orthopaedic Centre (KMOC):** The revised timeline for handover of the Centre from the construction company is now early August, and KMOC will open to patients in mid-September. Staff are already running pre-operative assessment clinics with patients due to have surgery in the new Centre. Once completed, KMOC will provide three operating theatres and 24 dedicated surgical beds for patients across Kent and Medway undergoing planned orthopaedic surgery.
  - **Medical student accommodation:** Internal and external works on the medical student accommodation building at Tunbridge Wells Hospital are also progressing and we expect the building to be ready for handover in the autumn. The completed building will provide accommodation for up to 145 medical students and trainee doctors, as well as academic teaching spaces. The development of a student accommodation and teaching campus at Tunbridge Wells Hospital highlights the Trust's commitment to high quality medical education, giving students from Kent and Medway Medical School (KMMS), and other medical schools and health programmes, the facilities and accommodation they need to support their studies. Once fully established, KMMS - which opened in 2020 - will place 120 additional medical students at MTW for their clinical placements each year; a 315% increase on the number of students the Trust took before the new medical school opened.
  - **West Kent Community Diagnostic Centre (CDC):** Work on the final development phase of the West Kent CDC at Hermitage Court is progressing, and will see the completion of a dedicated unit to house the CT and MRI scanners, (currently operating out of temporary mobile facilities), along with outpatient rooms, phlebotomy and point of care testing. The groundworks for the modular are underway and installation of the steelworks have commenced. Delivery of the framework is due later this summer, and the building is currently scheduled to be handed over in early 2025.

- Fordcombe Hospital, KMOC, the medical student accommodation and the West Kent CDC will play important roles in both the development of services and the workforce across Kent and Medway, and collaborative working across the system. As part of this joined up approach, the following partnership work is ongoing:

  - The Trust is working with the Kent and Medway Integrated Care Board (ICB) on a strategy for NHS system partners. The strategy is designed to provide the direction of travel and priorities shared across all NHS partners in Kent and Medway, and is being jointly led with trust providers and colleagues in primary care.
  - The ICB acute provider collaborative work on reviewing services is also ongoing. Key service areas are being identified and priorities agreed for the next phase.
  - The work on the West Kent Health and Care Partnership continues with a focus on the development of multi organisational integrated teams in communities that meet the needs of the local population.

- Alongside our large-scale infrastructure projects, work is progressing on the delivery of the Trust's new Digital and Data Strategy, published in April. The strategy sets out MTW's vision to create exceptional digital and data services that enable our colleagues to provide outstanding care, as well as our strategic goal to provide digitally seamless and enhanced patient care. An example of the work involved in achieving this is the upcoming complete digitisation of the anaesthetic pathway. iPro, a new anaesthesia information management system, is due to go live this summer in the Surgical Division. iPro PreOp will gather all the patient pre-operative assessment information for anaesthetists to understand the health of the patient before surgery. iPro IntraOp will automate physiological data capture onto a digital anaesthetic chart, meaning anaesthetists will no longer need to write notes on paper during operations. Recovery teams will then be able to view the records from theatre within Sunrise before a patient is moved to a ward.

- Following the cyber ransomware attack on Synnovis earlier this month, the MTW Cyber Security team confirmed that our servers were secure. Synnovis run the pathology laboratories we refer patient samples to, and has sites at King's, Guy's and St Thomas' hospitals. Our Pathology teams rapidly developed plans to retrieve results for patients whose samples had already been referred to Synnovis, and alternative providers for those tests were investigated while the situation at Synnovis was resolved. The impact seen by our patients and clinical teams was minimal.

- On behalf of the Trust, I would like to congratulate Chief Operating Officer, Sean Briggs, and Chief People Officer, Sue Steen, who will both be moving on to new roles later this year. Sean will be joining the Royal Free Hospital Group as Chief Delivery Officer and Sue moves to Moorfields Eye Hospital to take up the role of their new Chief People Officer in September. They both join trusts with world-leading reputations for research and education, and we look forward to seeing them bring the same innovation and strategic thinking to their new roles as they have done at MTW. Their roles at the Trust are now being advertised, and I will bring news of new appointments at a future Board meeting.

- Sixty teams across all divisions of the Trust have now been trained on the Patient First Improvement System (PFIS), which was launched 21 months ago and aims to empower staff to make changes that will benefit our patients. Tickets raised by patients, staff and visitors are discussed by the trained teams during regular PFIS huddles. Recent PFIS improvement projects over the last three months include:

  - Incomplete referral forms in our Histopathology labs meant that one colleague was spending the equivalent of five days a month ensuring all information was included on the forms. An awareness project involving presentations, posters and face-to-face

meetings increased departments' understanding about what is needed on the referral forms and why, in order to save valuable time and resources.
  - An increase in palliative patients being treated by our Radiotherapy teams based at Kent and Canterbury Hospital was causing a shortage of PAT slides, resulting in treatment delays. Processes have now been reviewed and extra PAT slides received for three machines, reducing waiting times and improving the patient experience.
  - Midwives on our Antenatal ward were unable to give presentation scans, which check a baby's position, due to a limited number of midwifery staff with the relevant training. This meant the team were reliant on the availability of doctors. Scanning training sessions have now been held for all midwives on the unit, enabling them to carry out the scans.
  - The Short Stay Surgical Unit now has the ability to dispense a strong pain killer directly to patients who were prescribed it late in the day. This means patients no longer have to wait overnight for Pharmacy to dispense the drug.
  - The Finance team identified an inconsistent approach to accrual data which was leading to increased agency spend for clinical support workers. The approach was modified to match nurse accrual, supporting a consistent accrual approach which ensures clinical support worker agency spend is evened out and more accurate.

- The Trust has received a silver award for the Defence Employer Recognition Scheme. The award is given to employers who have:

  - pledged to support the Armed Forces;
  - signed the Armed Forces Covenant;
  - promoted being Armed-Forces friendly and;
  - are open to employing reservists, veterans, cadet instructors and their partners.

  The award recognises our ongoing work to support veterans and their families, which was reflected earlier this year when the Trust received the 'Veteran Aware' accreditation by the Veterans Covenant Healthcare Alliance (VCHA). Our commitment to this work will ensure no disadvantage to our Armed Forces community service users and proper recognition of the skills and different perspectives that serving personnel, reservists, and veterans can bring to our workforce. News of the award arrived ahead of the Trust celebrating Armed Forces Week this week, which began with a flag raising ceremony at Tunbridge Wells Hospital on Monday and will culminate in Armed Forces Day this Saturday, 29 June.

- A number of MTW staff represented the Trust at Pride Canterbury earlier this month. They were joined by colleagues from Kent and Medway NHS and Social Care Partnership Trust, Kent Community Health NHS Foundation Trust and East Kent Hospitals University NHS Foundation Trust. Among a number of events held throughout the month to celebrate Pride, the MTWProud Network welcomed their first guest speaker at their monthly meeting, Dr Michael Brady. As NHSE's National Advisor for LGBT Health, Dr Brady talked about his work in sexual health and LGBTQIA+ health inequalities.

- Due to strong winds and poor weather conditions, the abseiling challenge that was due to take place at Tunbridge Wells Hospital on Saturday 15 June in aid of the MTW Hospitals Charity was postponed. The event will now take place in the autumn, when over 100 staff, patients and members of the community will abseil down the 100ft building. The challenge has raised over £30,000 (including Gift Aid) for the MTW Hospitals Charity so far, significantly exceeding the initial target of £15,000. The Charity supports the Trust's services, enabling us to continue delivering outstanding care and making a real difference to the lives of our patients, visitors and staff. The money raised from the abseiling challenge will fund items such as digital windows in our ICU rooms to mimic landscapes and provide patients with a sense of natural light.

- As part of Volunteers Week earlier this month, we recognised the invaluable support that our volunteers provide to patients and staff. The Trust currently has 248 active volunteers and together, they give an incredible 744 hours of their time each week in over 25 different areas of the Trust, including Macmillan, chaplaincy, end of life care and the League of Friends. Our volunteers comfort and support patients and their families, providing directions and information as well as pastoral and emotional support. Volunteers also support staff by acting as an extra pair of hands and freeing them up to prioritise clinical care. On behalf of the Trust Board, I would like to express my heartfelt thanks to our volunteers at MTW who selflessly give their time to support our patients, their families, and our staff, and help us in our mission to deliver outstanding care.

- Congratulations to our joint winners of the Trust's Employee of the Month award for May, Kate Lawrence, Head of Financial Services, and Richard Sykes, Head of Financial Management. Both have worked tirelessly for the last few months to plan and prepare for the Year End and the Accounts, showing great determination, commitment and patience throughout. They are also a great example of how a team should operate. Robbie Smith, Senior IT Technician, also received the Highly Commended award for always providing an excellent first-class IT service. Robbie was described as being very approachable, friendly and a fantastic credit to the IT team.

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

Trust Board Meeting – June 2024

Quality Committee, 12/06/24 **Committee Chair (Non-Executive Director)**

The Quality Committee met (virtually, via webconference) on 12th June 2024 (a 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Committee reviewed the **actions from previous meetings** and the Chair of the Quality Committee provided an update on the action to "Discuss with the Chair of the People and Organisational Development Committee whether a 'deep dive' into violence and aggression against Trust staff should be scheduled at a future meeting" wherein the Committee were assured that a decision would be agreed by the next 'deep dive' meeting in August 2024.
   - The Lead Nurse for Palliative and End of Life Care presented a **Review of End of Life Care (EoLC)** which included recommendations of actions the Trust should undertake in relation to the CQC EoLC 'Requires Improvement' rating; and that the three main drivers for the mechanisms to improve EoLC were the restructuring of the EoLC Steering Committee; Monitoring EoLC Service data to review performance and effectiveness; and the InPhase EoLC dashboard. A discussion was held around the support required to achieve the outlined recommendations, and due to time constraints, it was agreed that Committee members should provide the Administration Assistant, Trust Secretary's Office, with any further questions or comments in relation to the 'Review of End of Life Care' report, to then be communicated to the Chief Nurse, Medical Director and Lead Nurse for Palliative and End of Life Care.
     - ❖ The Committee was **assured** that there were robust plans in place to address the CQC 'Requires Improvement' rating as that significant progress had been made.
   - The Clinical Director for Emergency Medicine presented a **Review of the appropriateness of the assessment models within the Trust's Emergency Departments** wherein details around triaging and initial assessment outcomes, with an overview of the 'hybrid models' for patient arrivals, were outlined. The review also covered the Emergency Department's current challenges which included that there was a large increase of in demand of up to 800 patients per day which was causing an overloaded triage system, and that make-shift areas were being utilised to accommodate the rapid increases and changes in process.
     - ❖ The Committee was **partially assured** as the next steps for the improvement of the running of the Emergency Department had been clearly outlined however, there were still areas around analysis and workload planning which required further investigation.
   - The Urgent Care Director provided the Committee with a **Brief update on the development of the oversight dashboard and reporting structure for the virtual ward programme** wherein a discussion was held around the developments that have been made and it was noted that the Urgent Care Director would commit to finalising the dashboard by the end of the week commencing 17/06/24. It was agreed that the Director of Quality Governance should liaise with the Urgent Care Director and the Clinical Audit & Regulatory Compliance Manager in regards to the development of a supplementary audit plan for the virtual ward programme.
     - ❖ The Committee was **partially assured** as significant improvements had been made in relation to the development of the oversight dashboard for the virtual ward programme however, further work was required for the completion of project.
   - The Divisional Director of Nursing and Quality for the Surgical Division presented the **Ophthalmology close down report** which the Committee was asked to note and to raise questions external to the meeting.
   - A discussion was held on the **items for scrutiny by the Quality Committee at future 'deep dive' meetings**; wherein the Committee considered a number of potential areas for scrutiny in 2024 which included:
     - o Review of the Trust's Medicine Management incidents
     - o Review of the management of mental health presentations

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

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

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

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

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

Trust Board Meeting – 27th June 2024

Summary report from the Finance and Performance Committee, 25/06/24	**Committee Chair (Non-Exec. Director)**

The Committee met on 28th May 2024, face-to-face / in-person, at Maidstone Hospital.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The Divisional Director of Operations, Medicine and Emergency Care; Chief of Service, Medicine and Emergency Care; and Divisional Director of Nursing and Quality, Medicine and Emergency Care presented a 'deep dive' into **the Model Hospital benchmarking opportunity within the Medicine & Emergency Care Division** which included a comprehensive overview of the financial opportunities illustrated within the Model Hospital benchmarking; the current position as confirmed by the Trust's Finance Department; and the intention for each Directorate within the Medicine & Emergency Care Division to focus on one key priority and a number of smaller priorities, to the continued delivery of efficiencies. The excellent work was noted as clearly a huge amount of work had been undertaken across a large number of schemes.
     - ❖ The Committee was **assured** regarding the progress which had been made to date and the opportunities which had been identified; although, it was noted that it may be beneficial for a further update to be provided at a future date to examine the progress in relation to the realisation of the opportunities.
   - The **Patient Access strategic theme metrics for May** were reviewed, and the Committee acknowledged the potential emerging challenges in relation to the increase in the Trust's Cancer Patient Tracking List (PTL) backlog.
     - ❖ The Committee was **assured** regarding the Trust's current performance; although, noted that continued monitoring of the Cancer PTL backlog was required.
   - The Chief Operating Officer provided the latest **monthly update on the provision of system support** which included an overview of the referrals which had been received to date; and a discussion was held regarding the importance of ensuring appropriate return on investment from the Fordcombe programme.
     - ❖ The Committee was **assured** on the system work and noted the prioritisation regarding patient safety and care.
   - The review of **financial performance for May** highlighted that the Trust was adverse to plan for Month 2 of 2024/25, although an improvement on Month 1. The under delivery against cost improvement targets has prompted further Financial Improvement Plan Meetings to focus on the measures which were required to support the delivery of the Trust financial position and explore the potential contingencies which could be enacted in the event of a deterioration of the Trust's financial position. It was agreed that the Assistant Trust Secretary should schedule a "Review of the Trust's Financial Improvement Plan" item at the Committee's meeting in July 2024. The Committee emphasised that this was a very important piece of work
     - ❖ The Committee was **assured** that appropriate measures had been enacted to supported the delivery of the Trust's financial plan for 2024/25; although, it was acknowledged that some challenging decisions may be required.
   - The Committee received the latest **quarterly update on productivity (incl. the Model Health System programme)** wherein a discussion was held regarding the future metrics which could be incorporated into the programme of work and the benefits associated with the adoption of a Statistical Process Control (SPC) process to illustrate the Trust's productivity over time, with additional granular detail to enable targeted interventions, where required. Overall the Trust does well across a number of measures, although further analysis at service level is needed for this to be a helpful and practical tool for improvement planning and to inform the current approach to financial management.
     - ❖ The Committee was **assured** regarding the progress to date; however, acknowledged that the measurement of productivity reflected an evolutionary approach and that further metrics would be developed in due course.
   - The Head of Costing and SLR attended to enable the Committee to **confirm the approach to be taken for the compilation of the mandatory National Cost Collection (NCC); and to receive the latest information from the Costing Transformation Programme (CTP).**

- ❖ The Committee **did not allocate an assurance rating** as the approach was nationally mandated.
- The Associate Director of Procurement attended for the latest **annual review of the Procurement Strategy** which included and overview of the potential opportunities related to a Kent and Medway system-wide approach to Procurement and the Committee acknowledged the intention to develop a new Procurement Strategy for the Trust.
  - ❖ The Committee was **assured** that that the Trust continued to operate robust procurement practices and acknowledged the potential benefits associated with the incorporation of social value into the supply chain.
- The Director of Estates and Capital Developments attended for the latest **annual review of the Trust's Green Plan** which included details of the programme of work to reduce the Trust's carbon footprint and the initial scoping exercise which had been conducting in relation to the generation of green energy at the Trust.
  - ❖ The Committee was **assured** regarding the Trust's current position and the informed decision-making which would be utilised for future green developments.
- The **Business Case for estates capital backlog work 2024/25** was reviewed, wherein the Committee acknowledged that the allocation of capital expenditure would be informed by a risk-based approach The Committee agreed to recommend that the Trust Board approve the Business Case, in July2024.
- The Director of IT; Associate Director of Business Intelligence; and the Deputy Medical Director, Workforce and Digital attended for the latest **quarterly update on the implementation of the Digital and Data Strategy** which included detail of the associated governance and prioritisation process as well as the range of clinical engagement mechanisms across the Trust.
  - ❖ The Committee was **assured** that the appropriate mechanisms were in place to deliver the programme of work; although, acknowledged the continued investment which was required.
- The **recent findings from relevant Internal Audit reviews** were noted.
- The **summary report from the from the May 2024 People and Organisational Development Committee** meeting; and the "**Workforce efficiency programme" report submitted to the People and Organisational Development Committee** (which relates to the "Reduce the amount of money the Trusts [sic] spends on premium workforce spend" Breakthrough Objective) was noted 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

Summary report from the People and Organisational Development Committee, 21/06/24	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (Face-to-face / in-person at Maidstone Hospital) on 21st June 2024 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Director of Medical Education presented a **review of the process for the non-clinical performance management of medical staff** wherein the Committee held an in-depth discussion regarding the importance of regular performance and behaviour conversations amongst departments in order to work on avoiding any misconduct, and steering from a reactive to a more proactive approach, and it was agreed that that Deputy Medical Director and the Director of Medical Education would liaise regarding the potential advantages and disadvantages of introducing more regular 360 discussions for medical staff. The Committee then held a discussion around the consistency of supervision and the operational capacity to support these, and it was agreed that the Deputy Medical Director would liaise with the Medical Director to identify which departments would need to prioritise resource in order to enable regular supervision slots and developmental support, in order to create greater consistency of performance management across the Trust's medical staff.
  - ❖ The Committee was **partially assured** as, although the consultancy rate for appraisals was high and that forums were in place for providing feedback and discussing operational matters, further work was required around adopting a more proactive approach 360 degree feedback and enable further training and support where required.
- An **update on the progress of the People Promise Exemplar Programme and staff engagement plan** was provided, wherein an overview of the key stakeholders; a roadmap of the project; and the next steps were outlined; however; Committee members noted anomalies within the governance structure of the project and it was agreed that the Deputy Chief Executive / Chief Finance Officer would ensure a discussion was held amongst the Executive Team relating to the Governance of the People Promise Exemplar Programme, prior to the project's next update to the Committee. The Committee then discussed the aspects of internal investments and the EVP lens, and it was agreed that these should be included in the next update to the Committee for assurance, and that a conversation would be held external to the meeting between the Vice Chair of the People and Organisation Development Committee and the Head of People Performance and Improvement in relation to the further work required on EVP.
  - ❖ The Committee was **partially assured** as, although the People Promise Exemplar Programme offered encouragement around staff retention, further work was required around the governance executive oversight to enable the progression of the Programme.
- The Deputy Chief Operating Officer provided an **update on the people-related aspects of the Kent and Medway Orthopaedic Centre,** which included that the programme was on track to becoming operational in mid-September 2024; and outline of the workforce risks and mitigations; and an overview of staff engagement including the regular updates provided via WhatsApp, team meetings, newsletters and Pulse.
  - ❖ 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.
- An **update on the People and Organisational Development capacity to support the Fordcombe Programme** was presented by the Deputy Chief Operating Officer, wherein a discussion was held around retention aspects of workforce in the hospital.
  - ❖ 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 and there is also a NED oversight meeting held bi-weekly.

- The **latest “Strategic Theme: People” section of the Integrated Performance Report (IPR)** and the **update from the Director of Medical Education (DME) (6-mothly report)** were noted by the Committee.

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

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

Trust Board meeting – 27th June 2024

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

The IPR for month 2, 2024/25, is enclosed, along with the monthly finance report, and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 25/06/24

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

Integrated Performance Report

May 2024

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    - Escalation Page: Workforce — Page 11
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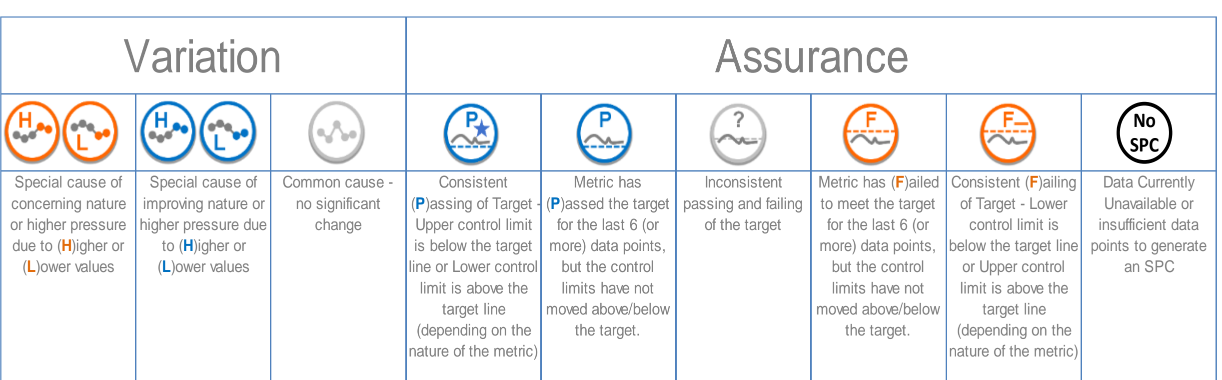
Appendices

- Forecast SPC Charts — Pages 29 - 35
- Business Rules for Assurance Icons — Pages 36 – 38
- Consistently, Passing, Failing and Hit & Miss Examples — Page 39
- Maternity Metric Definitions — Page 40

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



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)

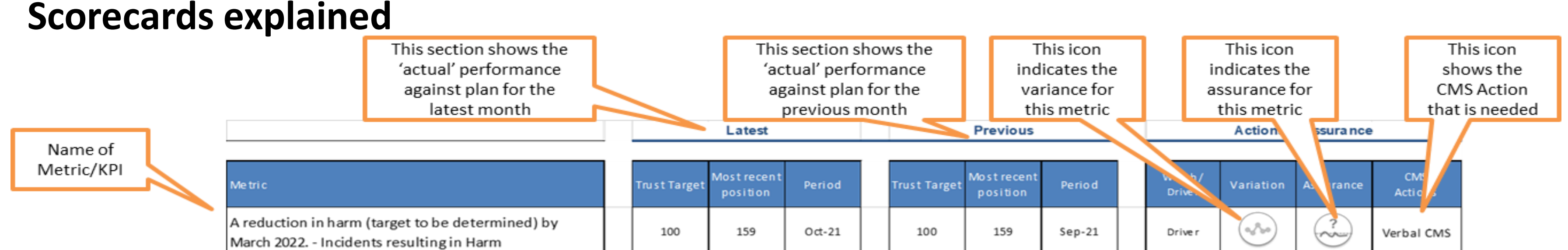
Escalation Pages:

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

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.

Scorecards explained



Further Reading / other resources

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

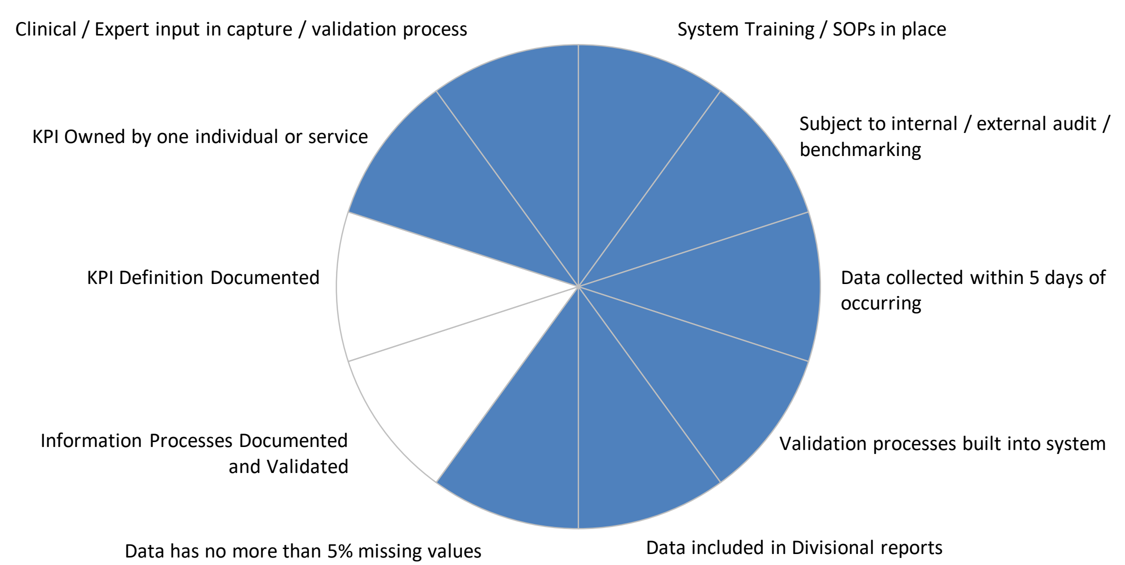
MTW exceptional people, outstanding care

Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

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

Vacancy Rate is above the 8% limit at 9.5% and continues to experience common cause variation and variable achievement of the target. Turnover Rate continues to experience special cause variation of an improving nature, achieving the maximum level target at 11.4%. Two new indicators for the number of staff that leave within 12 months and 24 months have been added, both of which are currently not escalated. The local targets are based on a 10% improvement of the April 22- March 23 short-term leavers average. Agency spend did not achieve the target for May 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 100.4% and continues to pass the target for more than six consecutive months. Sickness levels worsened in April 24, but continues to achieve below the maximum limit at 4.1%. This metric is therefore now experiencing common cause variation and variable achievement of the target. Statutory and Mandatory Training improved further in May, now experiencing special cause variation of an improving nature and consistently passing the target. 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 £2.5 in deficit in the month which was £0.1m adverse to plan. Year to Date the Trust is £4.5m in deficit which is £0.9m adverse to plan.

The rate of incidents causing patients moderate or higher harm remains in common cause variation but has failed the target for six months. The breakthrough indicator for this strategic theme is currently being reviewed and therefore no data is shown until this has been confirmed. The indicator of the number of SIs no longer exists as this metric has been replaced with the number of Number of new PSIIs, AARs and SWARMs commissioned in month. The rate of C.Difficile increased in May 24 but continues to experience common cause variation and failing the target for more than six months. The Rate of E.Coli has returned to common cause variation but continues to pass the target for more than six months. The Rate of Falls per 100,000 occupied beddays was slightly above the maximum limit in May but remains in common cause variation and variable achievement of the target. This indicator is now escalated as has been in variable achievement of the target for more than six months. Complaints data has not been updated due to staffing issues, though work on an automated solution is underway. 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 improved in May with the launch of the new provider. The launch was partly through the month of May, so we expect to see performance improve further in June.

Diagnostic Waiting Times was above the target for May 24 at 98.5% and 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 continues to provide system support (SYS) to other Trusts across Kent and Medway which is therefore adversely affecting the Trust's performance that is reported nationally. RTT achieved the trajectory target for May 24 of 74.5% at 74.9.0% (Excluding SYS). Nationally we reported 74.3% (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 May 24 (Excluding SYS). Nationally we have reported 323 52 week breaches at the end of May 24 (SYS). The Trust continues to achieve the internal target of less than 1.5% of total patients waiting having waited more than 40 weeks (Excluding SYS).

Executive Summary (continued)

Executive Summary (Continued):

Outpatient Utilisation continues to experience common cause variation and has failed the target for more than six months. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute has improved further and is experiencing special cause variation of an improving nature. Both of these two outpatient indicators are forecasted to achieve the target by August 24. Diagnostic Imaging activity levels were above plan and 1920 levels in May 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 May 2024. Both are continuing to experience common cause variation and passing the target for more than six consecutive months. The Trust is now monitoring performance against the new indicator for the rate of all outpatient appointments that are either a new appointment or a follow up appointment with a procedure (as per the national 2024/25 priorities and operational planning guidance). The national target is to have a rate of 49% or above. For May 24 the Trust achieved a rate of 49.2% (50% in April 24).

The number of patients leaving our hospitals before noon is now experiencing special cause variation of an improving nature and consistently failing the target. The top contributors have been identified and a number of actions continue to be implemented to improve the timely discharge of patients. The rate of patients no longer fit to reside remains in common cause variation. Ambulance Handovers <30mins improved further in May 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 May 24 at 84.2% 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, 28 Day faster diagnosis compliance standard and the new combined 31 day first definitive treatment standard. Work continues in order to now maintain compliance of all the Cancer Waiting Times (CWT) standards. CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh.

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

Escalations by Strategic Theme:

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

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

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

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

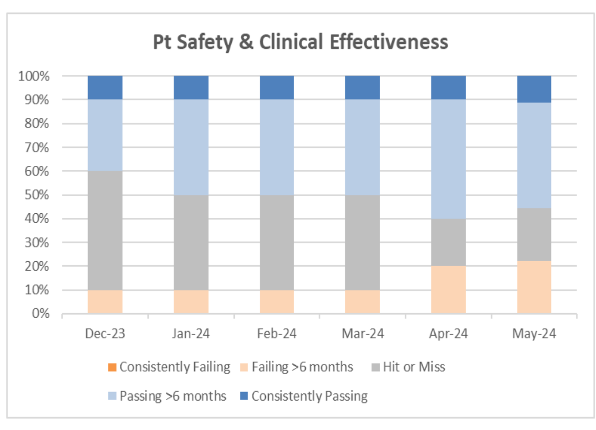
Systems:
- Discharges before Noon (P.23)

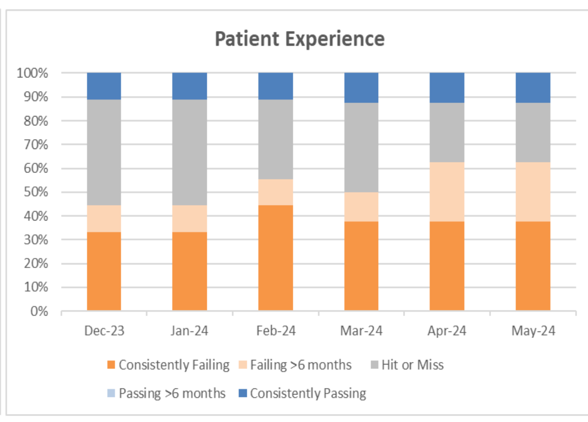
Sustainability:
- Agency Spend (P.25)

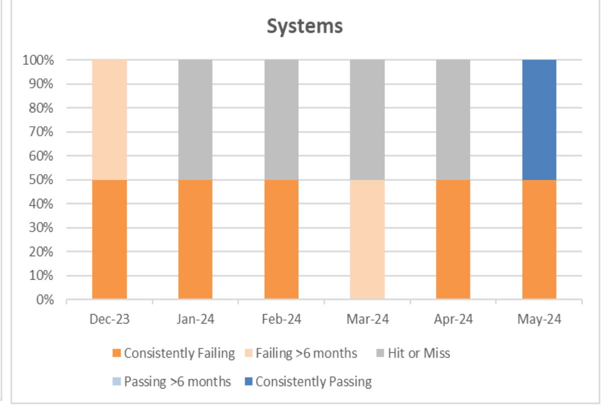
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.27)
- Women waiting for Induction of Labour <4 Hrs (P.27)
- Decision to delivery interval Category 1 caesarean (P.27)
- Decision to delivery interval Category 2 caesarean (P.27)

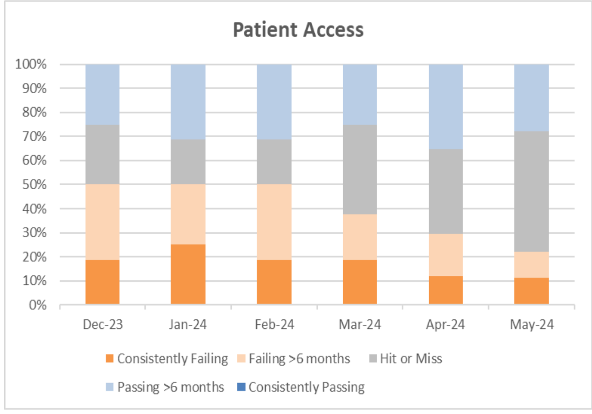
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

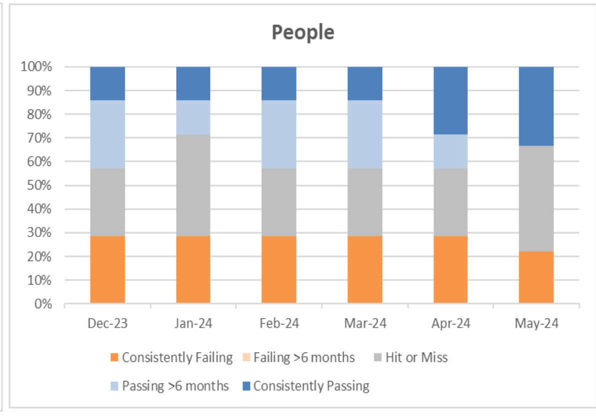
Assurance Stacked Bar Charts by Strategic Theme

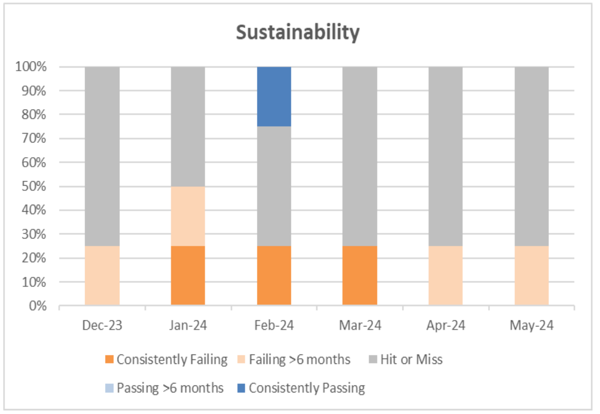












Matrix Summary

May 2024

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Statutory and Mandatory Training Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability	Standardised Mortality HSMR Never Events Safe Staffing Levels (Nursing) Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Access to Diagnostics (<6weeks standard) Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) To reduce the 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. Staff Leavers within 12 months		Reduce Turnover Rate to 12% Achieve the Trust RTT Trajectory (Excluding SYS) Transformation: CAU Calls answered <1 minute Friends and Family (FFT) % Response Rate: A&E To increase the number of patients leaving our hospitals by noon on the day of discharge
Common Cause	Summary Hospital-level Mortality Indicator (SHMI) Complaints Rate per 1,000 occupied beddays Decrease the number of occupied bed days for patients identified as no longer fit to reside (NFTR), (shown as rate per 100 occupied beddays)	IC - Rate of Hospital E.Coli per 100,000 occupied beddays To achieve the planned levels of new outpatients activity (shown as a % 19/20) To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	Reduce the Trust wide vacancy rate to 8% Sickness Absence IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days A&E 4 hr Performance Cancer - 2 Week Wait Cancer - 31 Day First (New Combined Standard) - data runs one month behind Transformation: % of Patients Discharged to a PIFU Pathways Flow: Ambulance Handover Delays >30mins Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Cash Balance (£k) Capital Expenditure (£k) Staff Leavers within 24 months	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) IC - Rate of Hospital C.Difficile per 100,000 occupied beddays Transformation: % OP Clinics Utilised (slots) Flow: % of Emergency Admissions into Assessment Areas % complaints responded to within target Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	Percentage of AfC 8c and above that are BAME Friends and Family (FFT) % Response Rate: Maternity Friends and Family (FFT) % Response Rate: Outpatients
Special Cause - Concern				Friends and Family (FFT) % Response Rate: Inpatients	

Strategic Theme: People

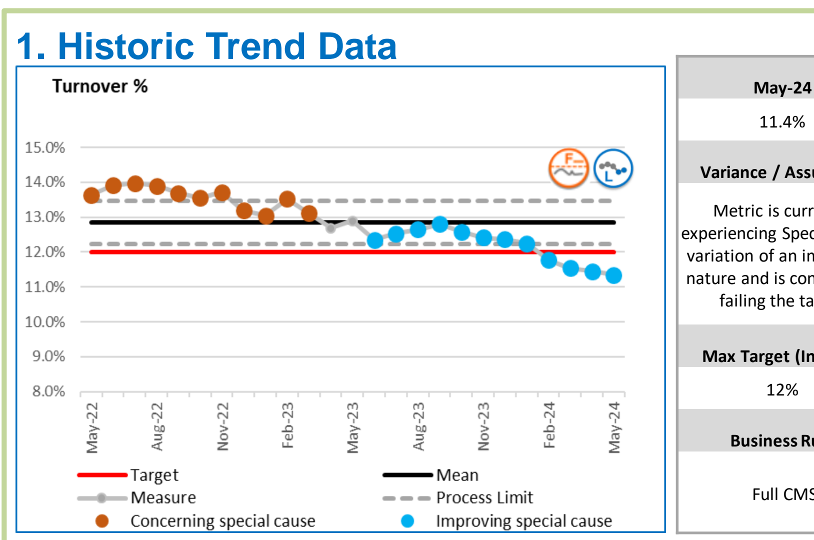
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 8%		8%	9.5%	May-24	8%	8.5%	Apr-24	Driver			Verbal CMS	8.6%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	11.4%	May-24	12%	11.5%	Apr-24	Driver			Full CMS	11.3%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	4.1%	Apr-24	4.5%	3.8%	Mar-24	Driver			Not Escalated	3.99%		
	Well Led	Statutory and Mandatory Training		85.0%	90.7%	May-24	85.0%	90.2%	Apr-24	Driver			Not Escalated	90.78%		
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	72.1%	May-24	62.0%	71.9%	Apr-24	Driver			Not Escalated	75.72%		
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	5.7%	May-24	3.2%	5.8%	Apr-24	Driver			Not Escalated	6.61%		
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	6.4%	May-24	12.0%	6.5%	Apr-24	Driver			Escalation	6.42%		
	Well Led	Staff Leavers within 12 months		15	17	May-24	15	14	Apr-24	Driver			Not Escalated	17		
	Well Led	Staff Leavers within 24 months		28	34	May-24	28	27	Apr-24	Driver			Not Escalated	29		

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

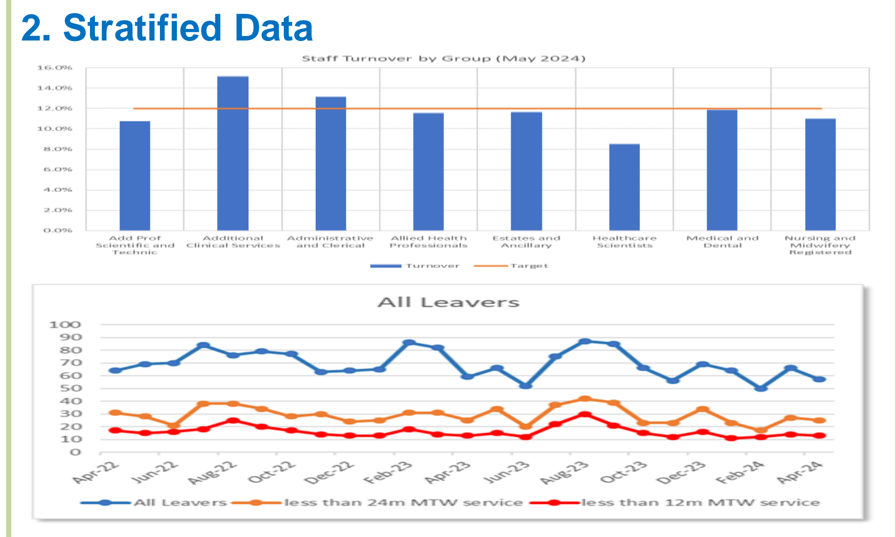
Owner: Chief People Officer
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



May-24
11.4%
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

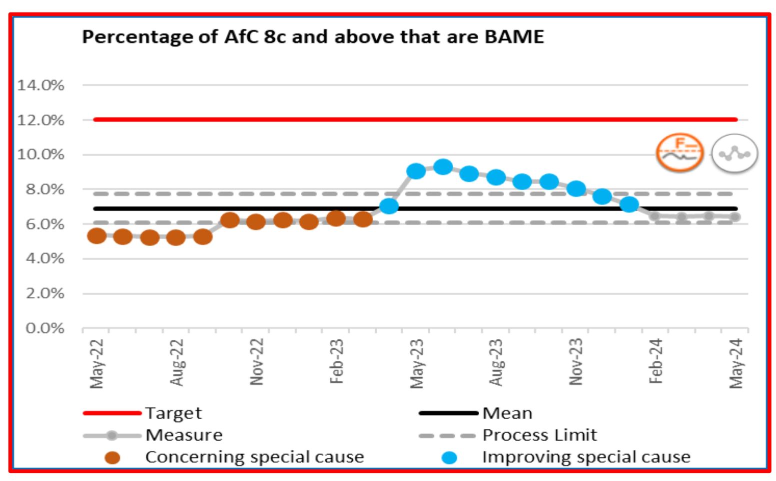
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership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

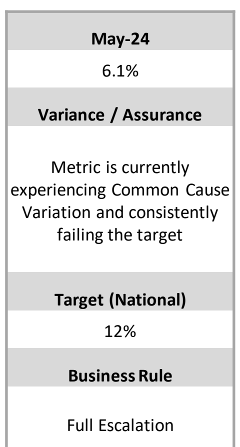
4. Action Plan

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
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





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

Recognising there is work to be done to improve the position for BME representation, a monthly trajectory to meet the 20% target is currently being developed. From next month, we will report progress on the target by identifying vacancies and appointments.

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.	• Launch of focussed work on inclusive recruitment in bands 8b and above with workshops scheduled from w/c 10/6/24 • Work ongoing between recruitment and EDI team to develop inclusive recruitment training for all recruiting managers due to complete July 2024 • Reverse mentoring cohort 2 celebration event took place early June with positive feedback from the programme. Cohort 3 scheduled for September expanding mentor group to including staff from the LGBTQIA+ community and mentee group to next level of senior leaders	% 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

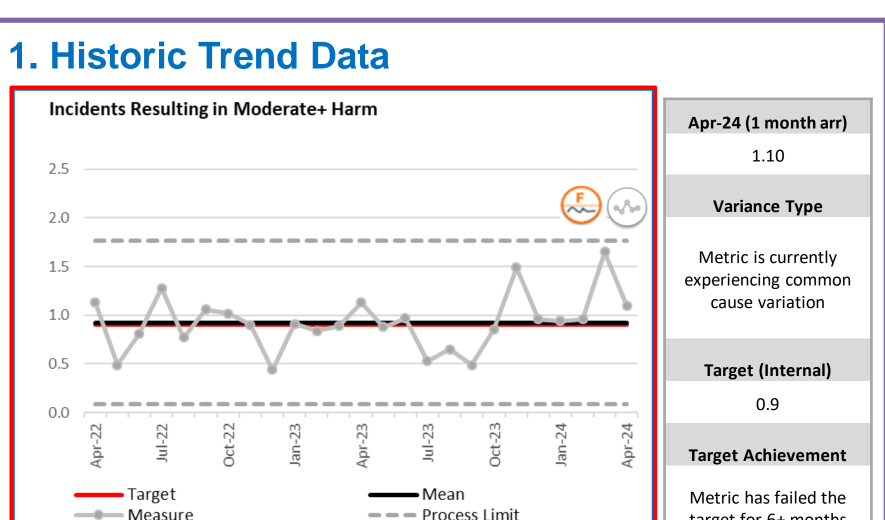
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	1.10	Apr-24	0.90	1.65	Mar-24	Driver			Full CMS	1.56 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		TBC	No SPC	No SPC
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month	TBC	TBC	1	May-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month	TBC	TBC	14	Apr-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month	TBC	TBC	1	Apr-24				Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	85.6	Feb-24	100.0	85.6	Jan-24	Driver			Not Escalated	86.4		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	94.9	Feb-24	100.0	94.9	Jan-24	Driver			Not Escalated	96.4		
	Safe	Never Events		0	0	May-24	0	0	Apr-24	Driver			Not Escalated	0		
	Safe	Safe Staffing Levels (Nursing)		93.5%	100.4%	May-24	93.5%	99.3%	Apr-24	Driver			Not Escalated	99.1%		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	15.5	May-24	32.6	31.5	Apr-24	Driver			Not Escalated	10.3		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		25.5	77.3	May-24	25.5	36.7	Apr-24	Driver			Escalation	50.4		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	May-24	0	1	Apr-24	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	6.6	May-24	6.4	6.9	Apr-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

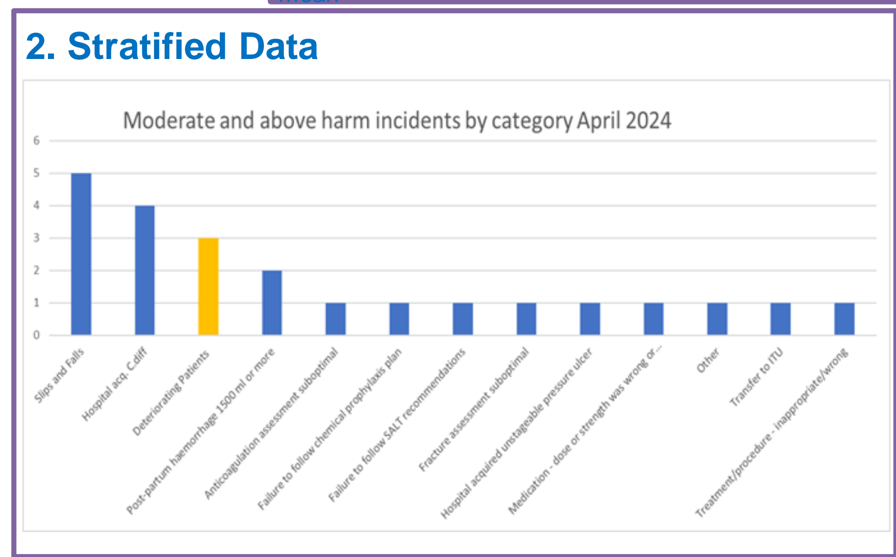
Owner: Medical Director
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

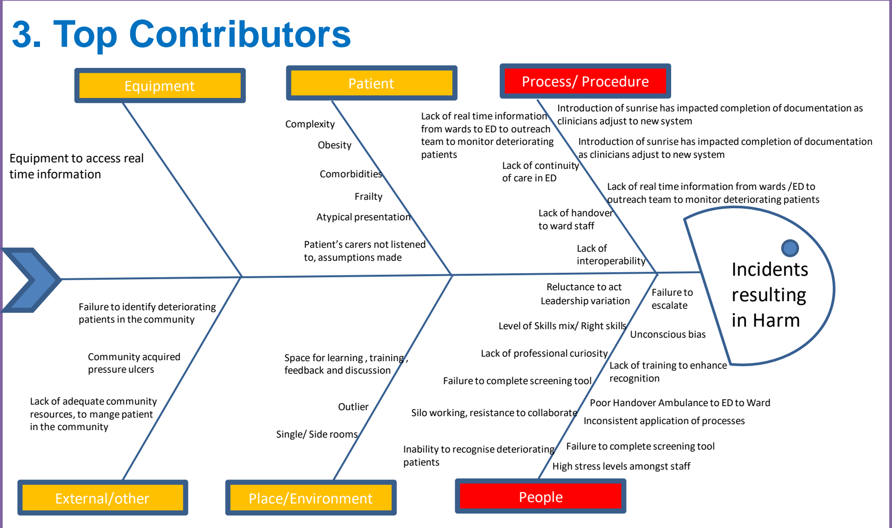


Apr-24 (1 month arr)
1.10
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
0.9
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



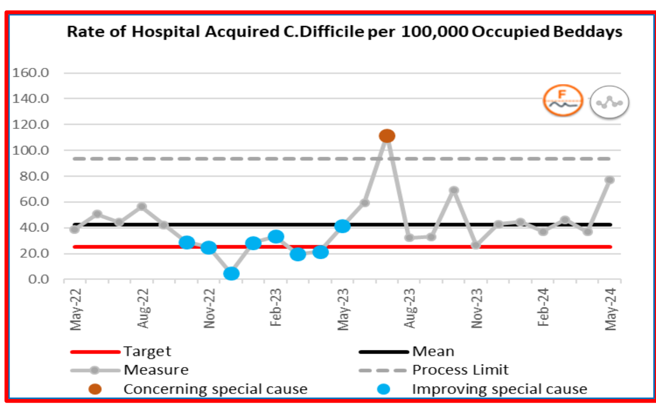
3. Top Contributors

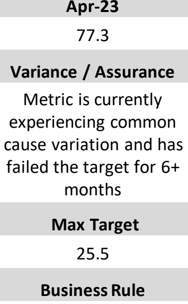


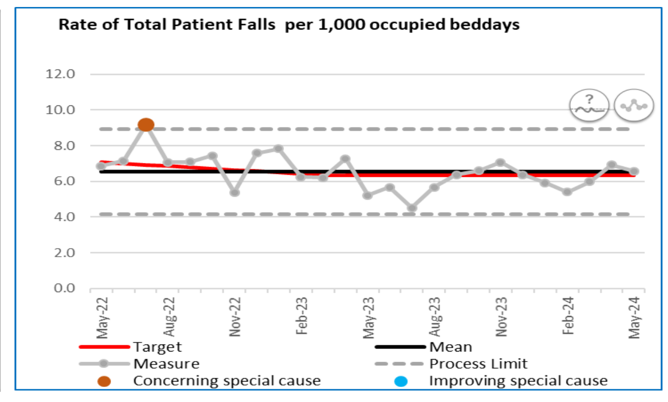
4. Action Plan

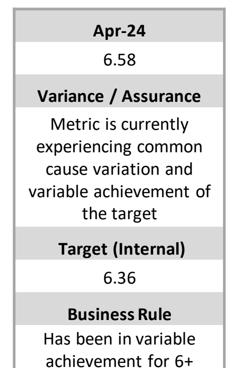
solution /countermeasure	Owner	Due By
Key Update:		
SOP for all unexpected ICU admissions shared with project team	HB	
JD for a lead nurse approved went to job matching panel	SM	
Treatment Escalation Plans on EPR: first wave of changes approved and being action by EPR Sunrise Team	HB	
Retrospective review of incidents reported for the last two years by the Patient Safety Team	Patient Safety Team	
Next Steps:		
SOP for all unexpected ICU admissions to be shared with the Clinical Directors	HB	
Send out advert for lead nurse for deteriorating patients	CM	
TEP changes to be presented on 29/5 at Clinical Directors' meeting.	HB	
Patient Safety Team reviewed 22/23 data. 23/24 data currently under review	Patient Safety Team	
Issue		
Lack of uptake and use of 2222 per-arrest form		
Staff not ticking the right boxes when searching the revised categories to report an incident on InPhase, thereby not always recording deteriorating patient related incidents correctly		

Patient Safety and Clinical Effectiveness: CQC: Safe









Summary:

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

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

Actions:

Infection Control: The C.diff rates during May remain higher than expected with 15 cases. The majority of cases are being seen at TWH and 4 avoidable cases in May due to inappropriate antibiotics. Actions being taken include.

- Further Trust wide incident meeting scheduled for July to help identify further actions to support a reduction in cases.
- Avoidable cases presented and discussed at PSIRG and escalated to Swarm huddle as needed. Learning from antimicrobial stewardship presented at Grand round.
- 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
- Ongoing review of bed turn around team to ensure that standards are being met and maintained

Inpatient Falls Rate:

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

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

Monthly audits for lying and standing blood pressure in progress- current compliance trust at 59% (Target is 85%)

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

Assurance & Timescales for Improvement:

Infection Control:

- No Evidence of transmission on C diff infection identified
- IPC team involvement in ICB CDI collaborative exploring local and regional interventions
- Rapid reviews of all cases provide timely feedback of learning from cases
- Learning from investigations are shared within the Directorate via the HCAI weekly status and IPC monthly newsletter.
- Directorate IPC reports presented to IPCC
- Plans in place to de-escalate ward at TW to provide a decant ward to facilitate a deep clean on AMU

Inpatient Falls Rate:

Training compliance for April was 81% (Target 85%)- This is an improving trajectory. All training sessions up to August are fully booked.

Reduction on the number of recurrent fallers

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

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

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

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

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)		74.5%	75.4%	May-24	73.6%	75.0%	Apr-24	Driver	H	F	Full CMS	77.1%	H	F
		Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		74.5%	74.7%	May-24	73.6%	74.7%	Apr-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)		119.0%	131.4%	May-24	123.4%	129.9%	Mar-24	Driver		P	Note Performance	133.9%		P
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		627	548	May-24	636	520	Apr-24	Driver	L	?	Not Escalated	580	L	P
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	423	May-24	N/A	172	Apr-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	391	May-24	N/A	166	Apr-24	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		97.6%	98.5%	May-24	97.6%	96.3%	Apr-24	Driver	H	?	Not Escalated	99.0%		?
	Responsive	A&E 4 hr Performance		87.2%	84.2%	May-24	86.4%	84.0%	Apr-24	Driver		?	Not Escalated	85.2%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	96.1%	Apr-24	96.0%	96.0%	Mar-24	Driver		?	Not Escalated	96.0%		?
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.8%	Apr-24	85.0%	86.2%	Mar-24	Driver	H	P	Not Escalated	86.5%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	75.8%	Apr-24	75.0%	79.8%	Mar-24	Driver	H	P	Not Escalated	78.1%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	91.0%	Apr-24	90.0%	90.2%	Mar-24	Driver	H	?	Not Escalated	95.0%	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)

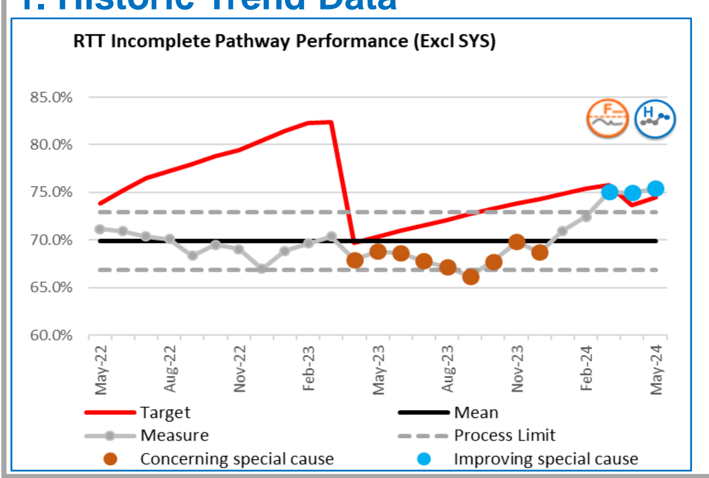
	CQC Domain	Metric	DQ Kite Mark	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions	Forecast: 3 Month Forecast	Forecast: Variation	Forecast: Assurance
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	83.1%	May-24	85.0%	84.1%	Apr-24	Driver		F	Escalation	86.9%	H	?
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.0%	5.9%	May-24	5.9%	6.5%	Apr-24	Driver		?	Not Escalated	6.6%	H	?
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	86.5%	May-24	90.0%	84.8%	Apr-24	Driver	H	F	Escalation	91.1%	H	F
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	3.8%	May-24	5.0%	4.0%	Apr-24	Driver		?	Not Escalated	3.9%		P
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	60.4%	May-24	65.0%	62.0%	Apr-24	Driver		F	Escalation	60.5%		F
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		98.6%	113.8%	May-24	110.1%	127.1%	Mar-24	Driver		P	Not Escalated	114.9%	H	P
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.6%	49.2%	May-24	50.3%	50.0%	Mar-24	Driver		?	Not Escalated	50.7		?
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		140.3%	155.1%	May-24	144.4%	164.0%	Apr-24	Driver	H	?	Not Escalated	160.9%	H	P

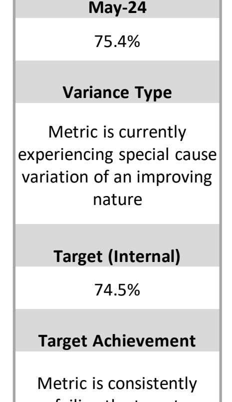
Vision: Counter Measure Summary

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

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

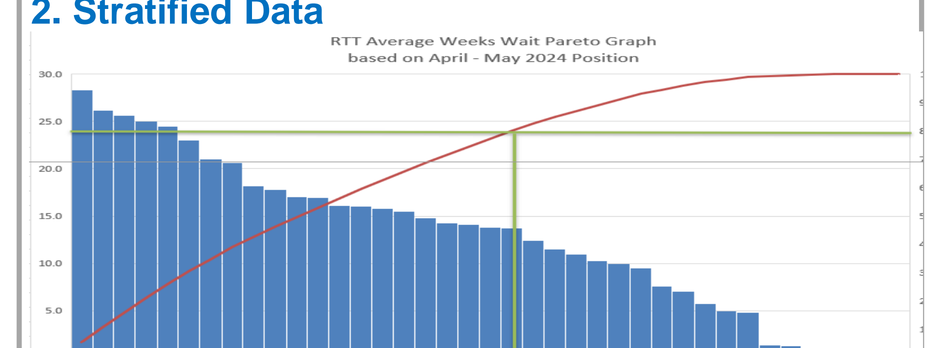
1. Historic Trend Data





May-24
75.4%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
74.5%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

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

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

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

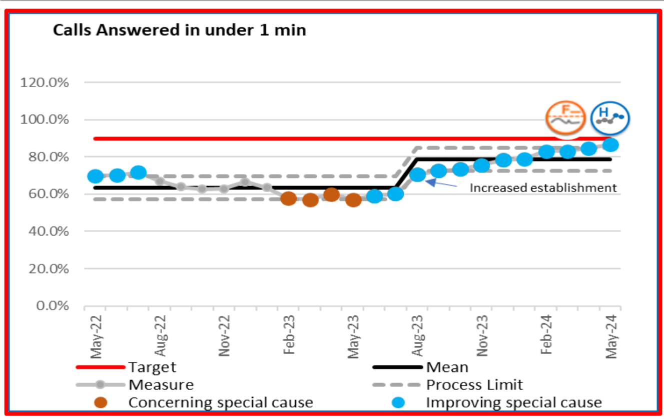
Key Risks:

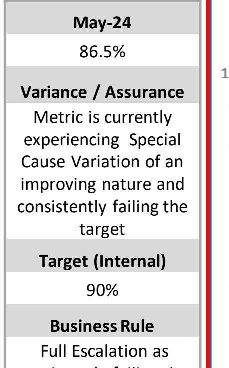
- Waiting list growth could be affected due to increase in referrals and systems pressure.
- Industrial Action could affect internal improvement plans

4. Action Plan

Countermeasures	Action	Who / By when	Complete
Review of Breakthrough Objective	Complete new A3 , review of data to understand biggest contributors to waits for first appointments	SD/SC/JT	April 24
Trajectory	Trajectory for achievement of reduction in waits for 1st appointment agreed and communicated wit specialty teams	SD/SC	June 24
Data Review	Review of data to identify specialties with longest waits. Specialty meetings to understand issues and develop improvement plans to achieve trajectory	SC/GM's	June 24
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots Reduction in FUPS and replacing with News in T&O following clinical validation	SC	On-going
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	Full roll out July 24
	Trust STT pathways pilot in Gen Surg/Gastro to reduce long waits for 1st Appointments	SC/GM's	On-going

Patient Access: CQC: Responsive





May-24

86.5%

Variance / Assurance

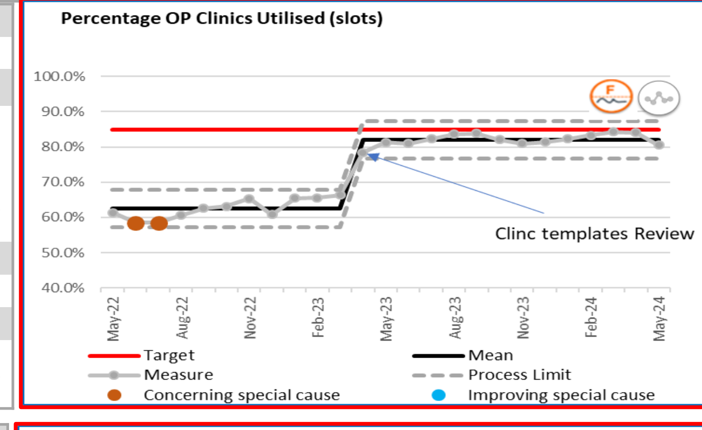
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

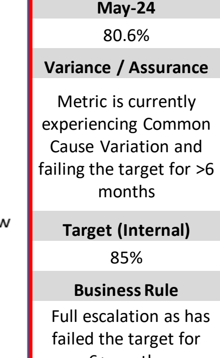
Target (Internal)

90%

Business Rule

Full Escalation as consistently failing the target





May-24

80.6%

Variance / Assurance

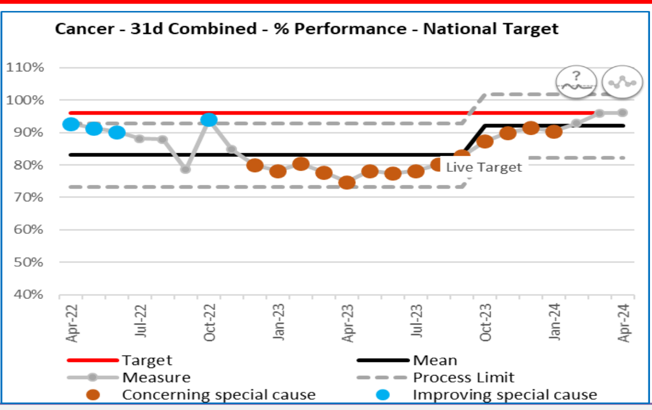
Metric is currently experiencing Common Cause Variation and failing the target for >6 months

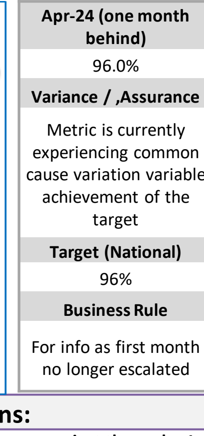
Target (Internal)

85%

Business Rule

Full escalation as has failed the target for 6+months





Apr-24 (one month behind)

96.0%

Variance / ,Assurance

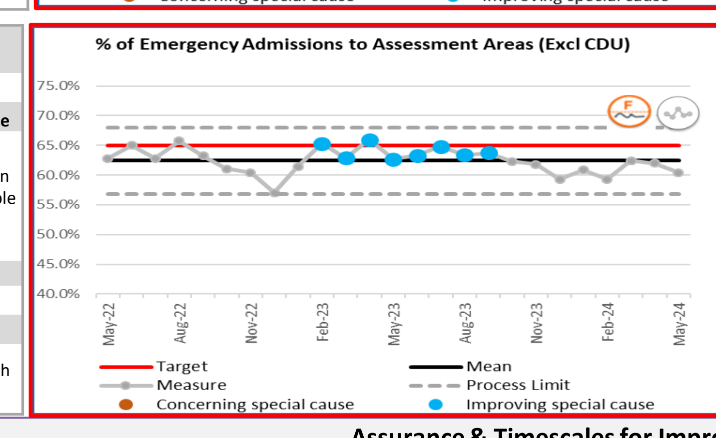
Metric is currently experiencing common cause variation variable achievement of the target

Target (National)

96%

Business Rule

For info as first month no longer escalated



May-24

60.4%

Variance / Assurance

Metric is currently experiencing common cause variation and failing the target for 6+ months

Target (Internal)

65%

Business Rule

Full Escalation as has failed the target for 6+months

Summary:

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

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

Cancer 31 day First Definitive (Combined): This National Standard has now changed and is a combination of the previous targets. This indicator is experiencing common cause variation variable achievement of the target (however new target only in place from October 2023). **The Trust achieved the 96% National Standard for March & April 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. Bi-weekly KPI meetings with specialities starting 12 June to put in place actions to improve performance metrics.

Outpatient Clinic Slot Utilisation: The OPD team continue to work with the CAUs on their clinic templates to sustain over 80% of clinics utilised across each division. OPD Team closely monitoring blocked slots and uncashed clinics. Consultant led is over 85% for the first time for two consecutive months. Bi-weekly KPI meetings with specialities starting 12 June to put in place actions to improve performance metrics.

Cancer 31 Day First Definitive (Combined): Focus continues on reducing waiting times for subsequent radiotherapy with a consistent increase in capacity. Ongoing clinically led review of urology and breast pathways.

% 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, May new record performance achieved (86.5%). 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. Note improvement in March (84.3%) and April (84.1%) Reporting timeframe for IPR means the true picture is not yet known for May but is expected to exceed 83%.

Cancer 31 Day First Definitive (Combined):
Focus on implementation of detailed recovery plan. Trajectory met consistently since set and now achieving the national target. 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	L	?	Note Performance	39		F
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	May-24	24	29	Apr-24	Driver	L	?	Note Performance	24		?
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	2.1	Apr-24	3.9	2	Mar-24	Driver		P	Not Escalated	2.2		P
	Caring	% complaints responded to within target		75.0%	68.4%	Apr-24	75.0%	63.3%	Mar-24	Driver		F	Escalation	67.21%		F
	Caring	% VTE Risk Assessment (one month behind)		95.0%	TBC	Apr-24	95.0%	TBC	Feb-24	Driver	No SPC	No SPC	Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	3.4%	May-24	25.0%	1.4%	Apr-24	Driver	L	F	Escalation	13.62%		F
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	12.06%	May-24	15.0%	0.00%	Apr-24	Driver	H	F	Escalation	4.09%		F
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	8.2%	May-24	25.0%	4.6%	Apr-24	Driver		F	Escalation	1.55%		F
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	9.2%	May-24	20.0%	0.1%	Apr-24	Driver		F	Escalation	1.79%		F

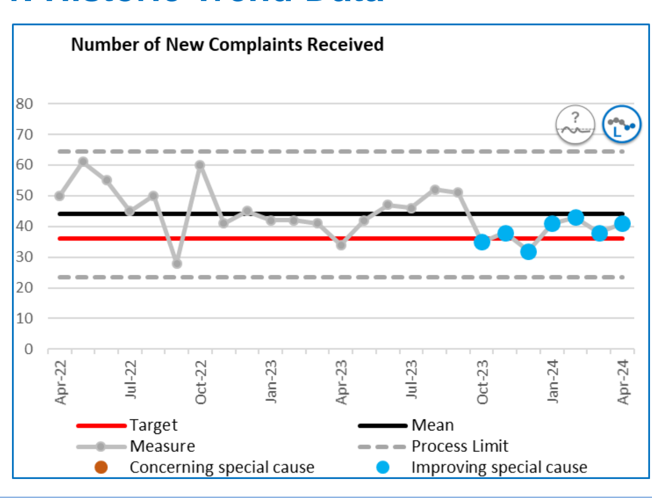
NB: There is no data available for VTE as there are some data quality issues that are been investigated.

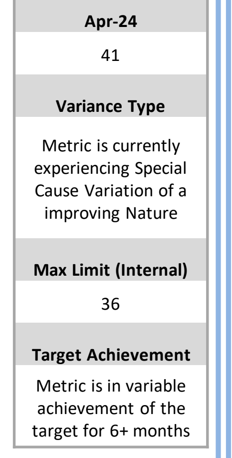
Vision: Counter Measure Summary

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

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

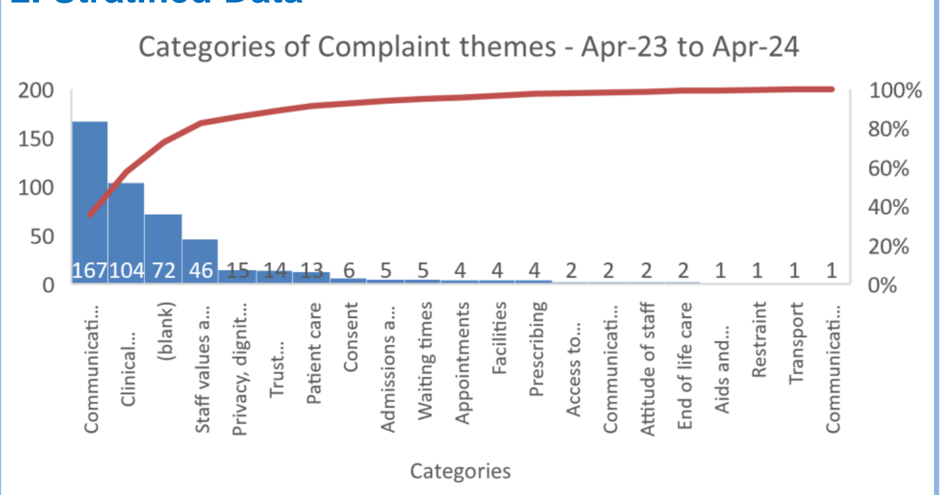
1. Historic Trend Data





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.

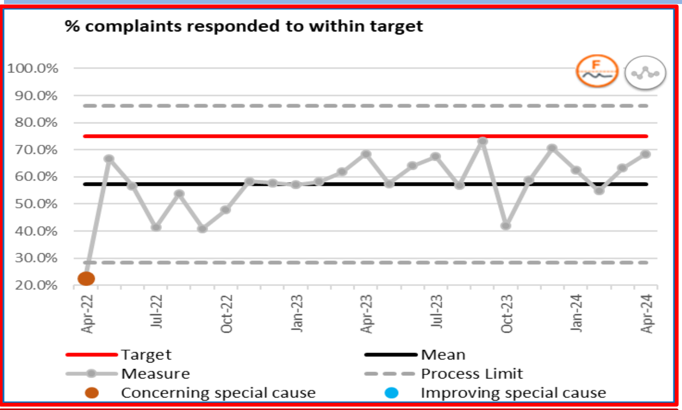
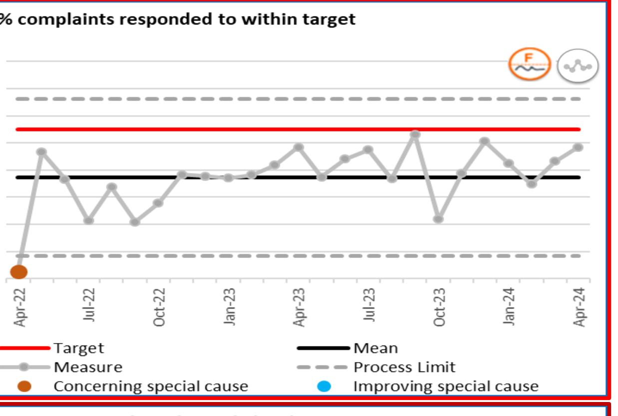
Key Risks:

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.

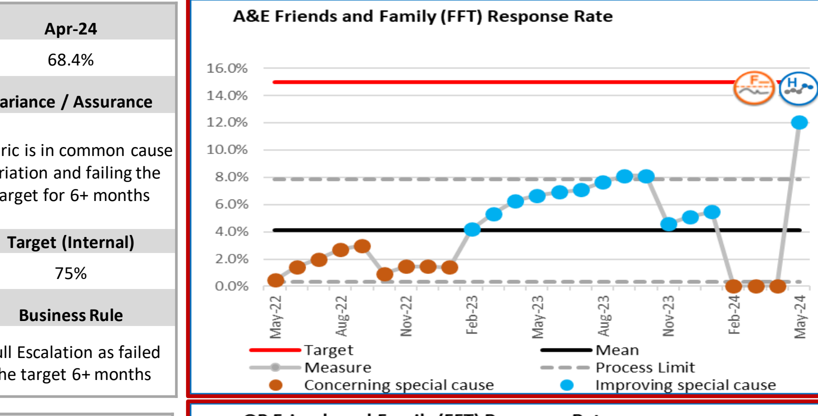
4. Action Plan of the Breakthrough Objective:

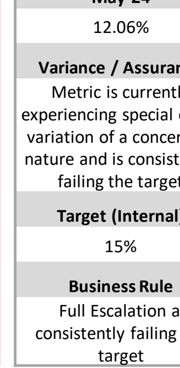
Workstreams	Action	Who
Written Communication - Patient Information Leaflets	• Working with the PILG group – to streamline processes and assurance for written information given to patients through Patient Leaflets	RG, GK
Education and Training	• Working with the Human Factors training team to create a 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

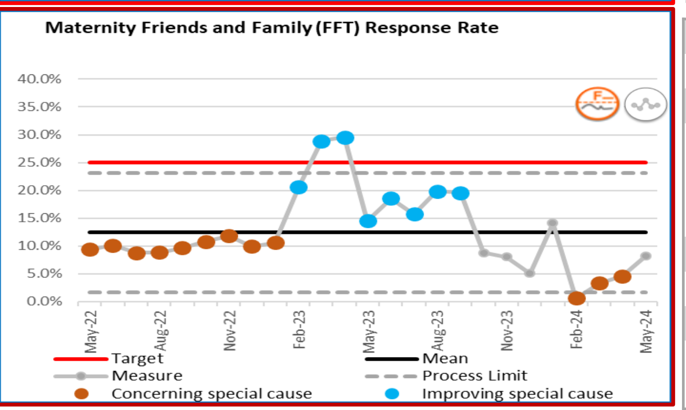



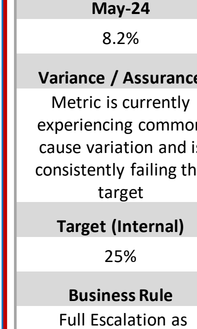
Apr-24
68.4%
Variance / Assurance
Metric is in common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



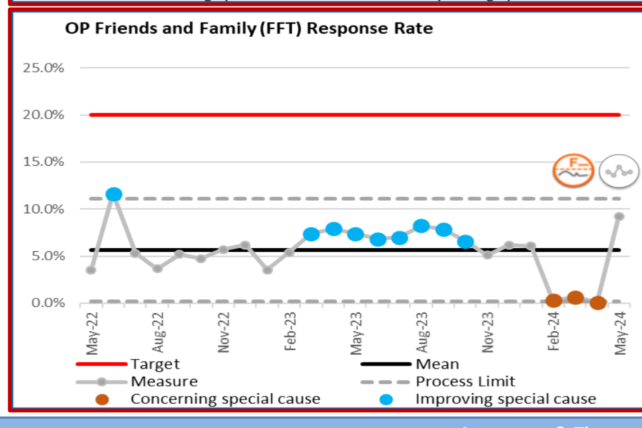


May-24
12.06%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target





May-24
8.2%
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



May-24
9.2%
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 – 11.2%

Recommended Rate is 100%

Friends and Family Response Rate - Maternity: Is experiencing Common Cause Variation, but is consistently failing the target. National Rate – 13.1%

Recommended Rate is 100%

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

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: Increased response rate of 12.06%, as compared to December (last complete IQVIA data). Top themes positive : *Staff attitude, Implementation of care, Environment and clinical treatment. Themes to improve: staff attitude, waiting time, and communication*.

Maternity: Response rate 8.2% as compared to 15%, however on onboarding is still ongoing with Maternity.

Sexual Health: Positivity rate is around 98%, with improvement suggested for *waiting times and pain experience.*

Outpatients: Response rate has increased for May24 to 9.2, with over 5000 responses. Top positive themes: *Staff attitude, Implementation of care and Environment* and top improvement theme were: *Staff attitude, waiting time and environment.*

Inpatients: Increased response rats in May24. Top positive themes: *Staff Attitude, Implementation of care, environment and patient mood.* Top themes for improvement: *Staff attitude, Environment and clinical treatment.*

FFT Response All: Since the new provider HCC came on board, our response rates have been improving. In May 2024, the Trust achieved a significant increase in response rate with Our overall positivity rate stands at 90.19%, while the negativity rate is 5.71%. The top five positive words were: *Staff, Good, time, service and friendly*. Top 5 negative words were: *Waiting, Hours, time, staff and appointment.* Top 5 positive themes *were Staff Attitude, Implementation of Care, Environment, Waiting Times and Clinical Treatment* and top themes for improvement: *Staff Attitude and Waiting Times, Implementation of care and Communication.*

Assurance & Timescales for Improvement:

Friends and Family (FFT) response Rates: SMS onboarding still ongoing with clinical areas. FFT cards are pending delivery to the Trust. Posters with QR codes ready for deployment with volunteers. Interactive voice messages (IVM) build completed, awaiting Quality assurance. Training and login details for HCC platform have been provided to all ward managers, matrons, heads of nursing.

Feedback from maternity being reviewed and volunteers being encouraged to collect FFT.

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

Strategic Theme: Systems

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the percentage of occupied bed days for patients identified as no longer fit to reside (NFTR)		24.5%	19.2%	May-24	24.5%	16.2%	Mar-24	Driver			Note Performance	17.8%		
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge		33.0%	24.5%	May-24	33.0%	23.8%	Apr-24	Driver			Full CMS	23%		

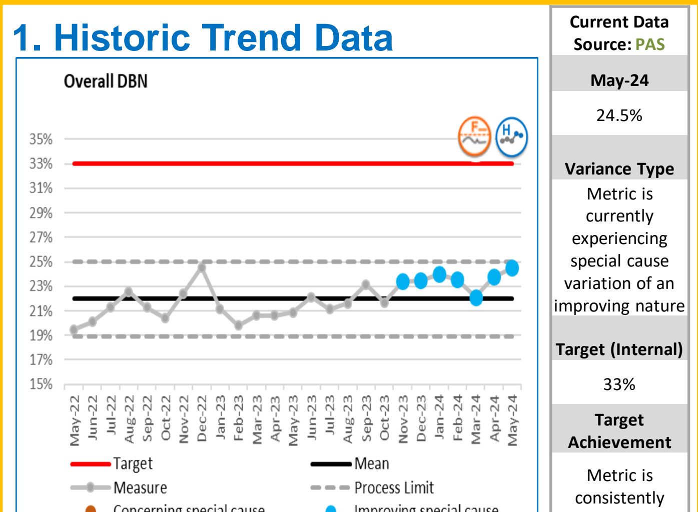
Please note – No longer Fit to Reside data has been reviewed after data quality challenges were identified and a revised methodology established displaying the metric as a percentage of bed days that are NFTR aligning with benchmark reporting (Model System). Target is currently set to the national average

Breakthrough: Counter Measure Summary

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

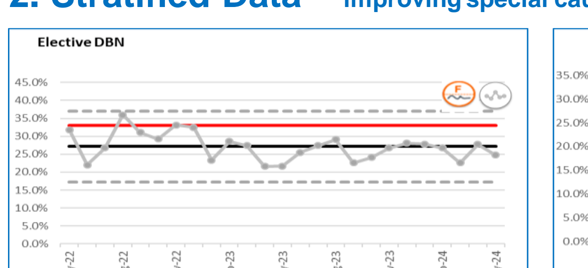
Owner: Director Strategy, Planning & Partnerships
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

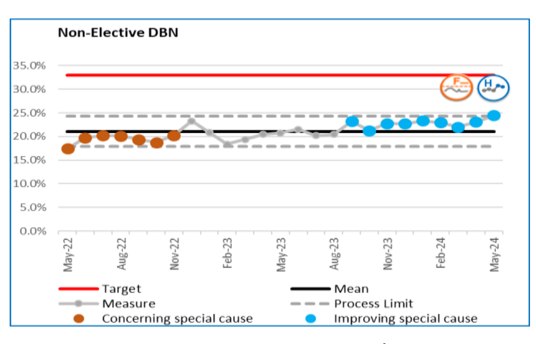
1. Historic Trend Data



Current Data Source: PAS
May-24
24.5%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
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:		May 2024	
	• Begin PFIS huddles on wards 30/31/32 relating to board round process & discharge planning	LS	June 2024	
	• Feedback back diagnostic/audit review of board round effectiveness to NIC team and then ward MDTs	BC		
	• Develop board round clinical simulation proposal	NP/BC/CI team		
	• Week of observation complete on Whatman/ Mercer/ Pye. Feedback to Matron's completed.	BC/FR	June 2024	
	• Wards visually tracking discharges & delays to create shared ownership		w/c 18/6	
	• Confirmation of next steps to be agreed with Matrons & Ward Managers • Timeline for PFIS training for MEC pilot wards identified • Identification of governance approach needed for MEC			
Criteria Led Discharge	• Explore opportunities for CLD development in: • KMOC • Gynae • ERAS related surgical pathways (Ward 32 and 11 patients) • Ward 21 • Haematology			In progress In progress

Strategic Theme: Sustainability

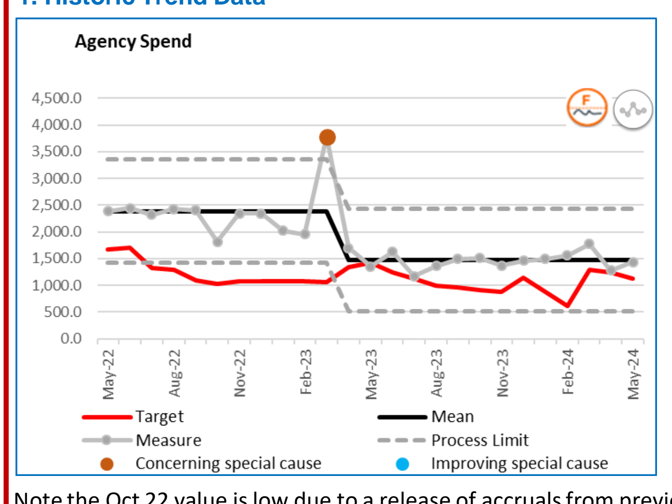
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-2,416	-2,545	May-24	-1,155	-1,903	Apr-24	Driver			Verbal CMS	-1159		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		1,134	1,433	May-24	1,292	1,278	Mar-24	Driver			Full CMS	926		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		1,770	1,286	May-24	1,899	983	Mar-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Cash Balance (£k)		4,994	7,865	May-24	2,000	8,634	Mar-24	Driver			Not Escalated	5299		
	Well Led	Capital Expenditure (£k)		1,329	1,329	May-24	2,944	933	Mar-24	Driver			Not Escalated	2464		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		TBC	24,979	May-24	TBC	11,004	Apr-24	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		TBC	5,401	May-24	TBC	2,658	Apr-24	Driver	No SPC	No SPC	Not Escalated			

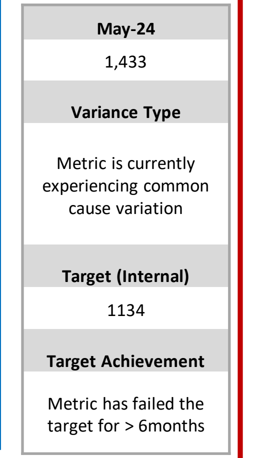
Breakthrough: Counter Measure Summary

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

Owner: Chief Finance Officer
Metric: Premium Workforce Spend
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data





May-24

1,433

Variance Type

Metric is currently experiencing common cause variation

Target (Internal)

1134

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

May Agency Spend - Breakdown by Division

Medical Actual, Diag Support Actual, Surgical Actual, Cancer Actual, W&C Actual

May Agency Spend - Breakdown by Staff Group

A&C/Sen Man Staff, Medical Staff, Nursing, Scientific Therap & Tech Staff, Support Staff, Support to Clinical Staff

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.

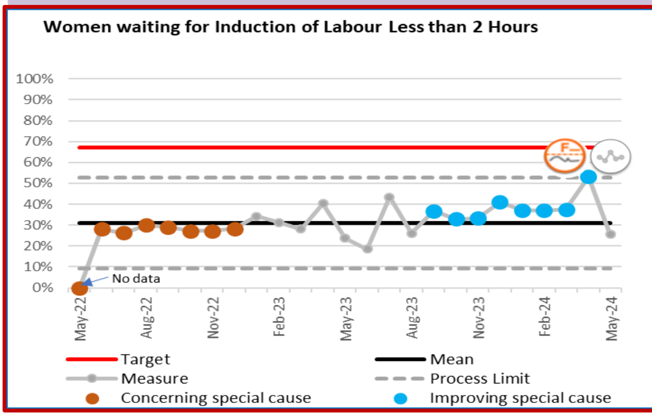
4. Action Plan

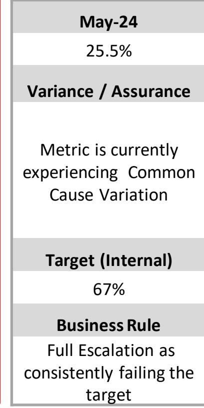
Action	Status	By when
Review of workstreams	Review is ongoing to identify key improvement activities outstanding under the Corporate Project that relate to AFC Rostering.	Q1 2024/25
	Plans to move implemented processes to BAU: • Roster Supervisor Training • Finance Training	
	Identify key trust wide activities to reduce premium workforce spend	
	Medical rostering (Patchwork) to be reported via Corporate Project report	

Maternity Metrics

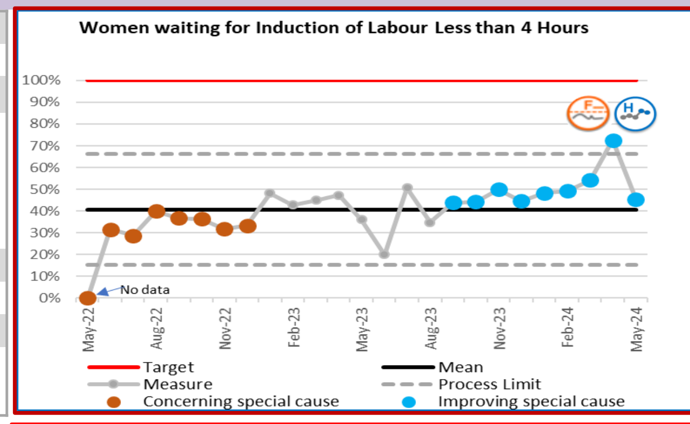
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics (not in SDR)	Maternity Metric	Registerable Births		No target	512	May-24	470	428	Apr-24	Driver		No target	Not Escalated	457		No SPC
	Maternity Metric	Antenatal bookings		No target	503	May-24	545	568	Apr-24	Driver		No target	Not Escalated	539		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	17.1%	May-24	No target	17.8%	Apr-24	Driver		No target	Not Escalated	19.5%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	24.9%	May-24	No target	22.3%	Apr-24	Driver		No target	Not Escalated	21.1%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.1%	May-24	36.0%	23.0%	Apr-24	Driver			Not Escalated	25.1%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	25.5%	May-24	67.0%	53.2%	Apr-24	Driver			Escalation	40.7%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	45.5%	May-24	100.0%	72.6%	Apr-24	Driver			Escalation	58.2%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	9.2%	May-24	6.0%	7.7%	Apr-24	Driver			Not Escalated	7.4%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	4.2%	Apr-24	4.0%	4.0%	Mar-24	Driver			Not Escalated	5.3%		
	Maternity Metric	Stillbirth rate		0.4%	0.4%	May-24	0.4%	0.2%	Apr-24	Driver			Not Escalated	0.3%		
	Maternity Metric	PPH >=1500% Rate		3.0%	5.2%	May-24	3.0%	3.6%	Apr-24	Driver			Not Escalated	3.8%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	1.7%	May-24	2.5%	2.8%	Apr-24	Driver			Not Escalated	2.9%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	79.2%	May-24	75.0%	74.8%	Apr-24	Driver			Not Escalated	82.1%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	89.7%	May-24	95.0%	94.1%	Apr-24	Driver			Escalation	97.1%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	75.0%	May-24	95.0%	67.3%	Apr-24	Driver			Escalation	69.0%		

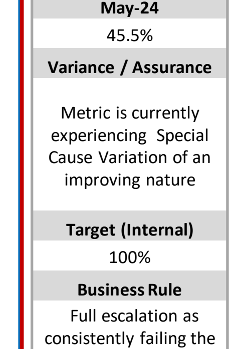
Maternity Metrics



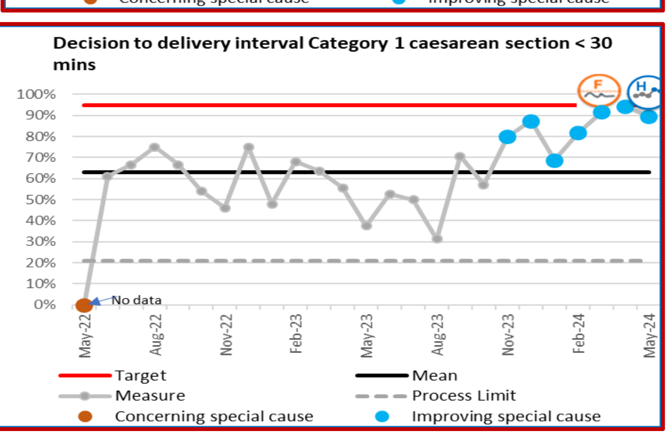


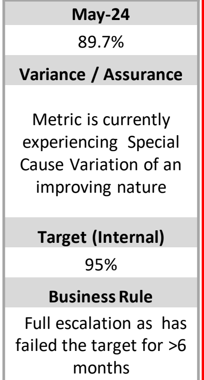
May-24
25.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full Escalation as consistently failing the target



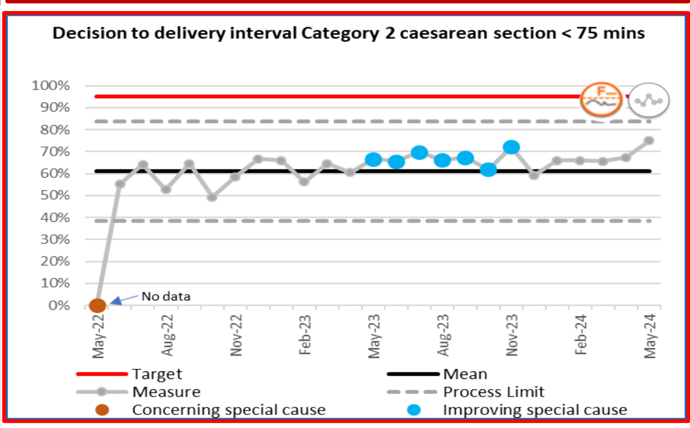


May-24
45.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target





May-24
89.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



May-24
75%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as consistently failing the target

Summary:

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

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

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

Decision to delivery interval Category 2 caesarean section: is experiencing common cause variation and consistently failing the target.

These are new metrics with data collection from June 22

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:

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

Assurance & Timescales for Improvement:

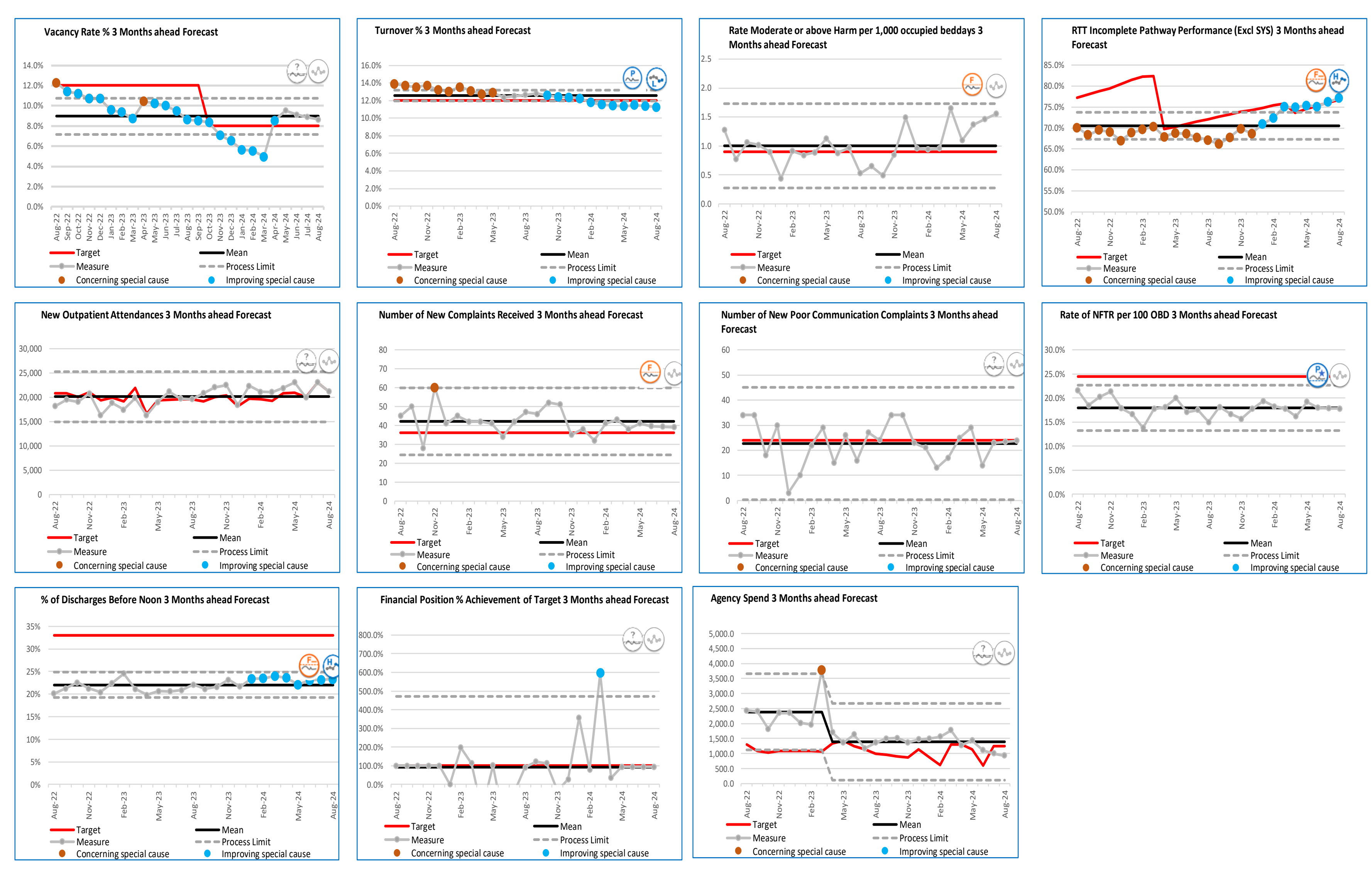
Women waiting for Induction of Labour less than 2 or 4 Hours: The process for robust risk assessment, daily obstetric reviews and prioritisation according to the latest clinical picture has been formalised and documented in an update to the Induction of Labour Guideline to ensure safety for those women 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:

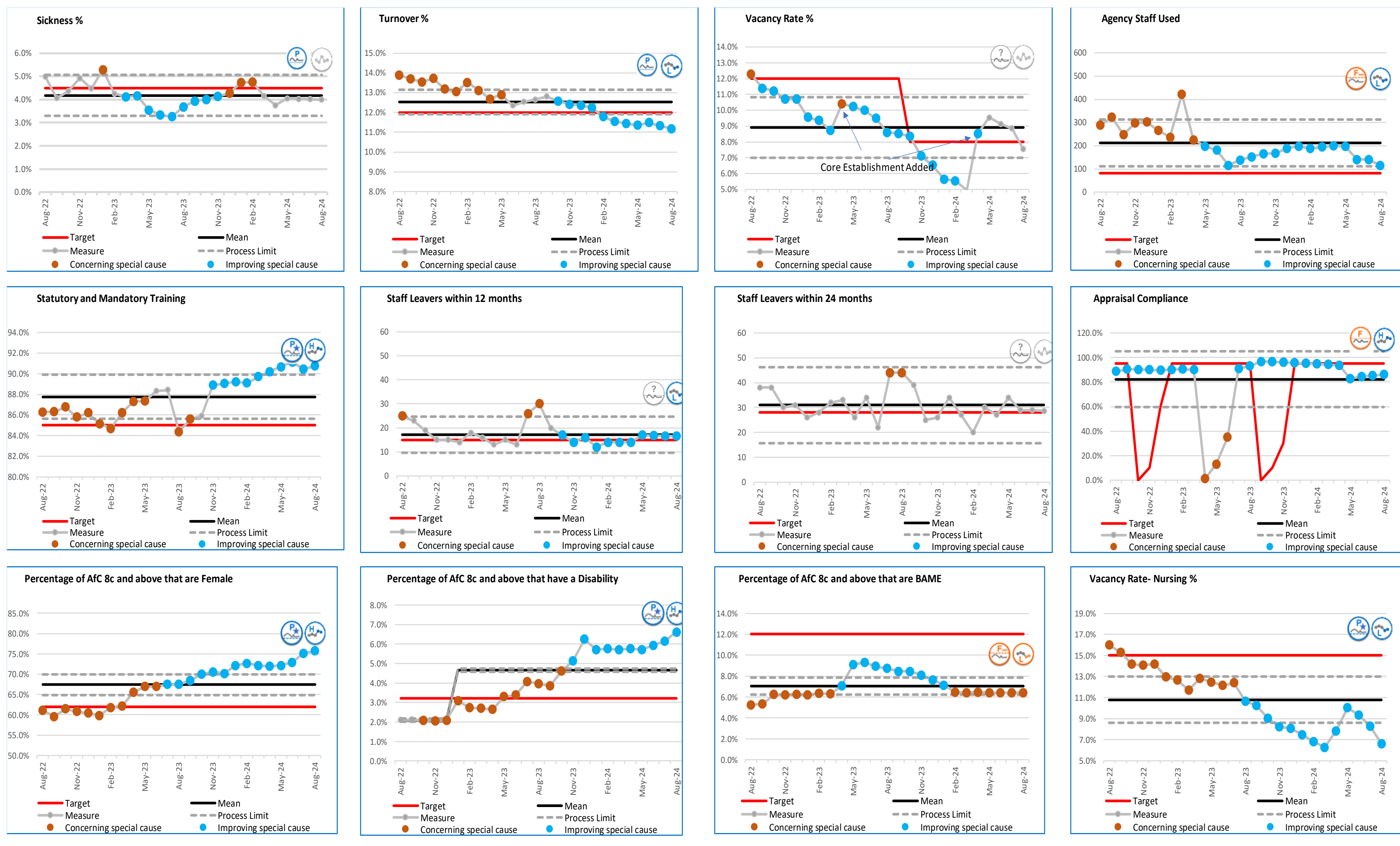
Progress is being made with improvement in compliance with Category 1 caesarean section but has been more challenging for Category 2 caesarean sections. All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified.

Appendices

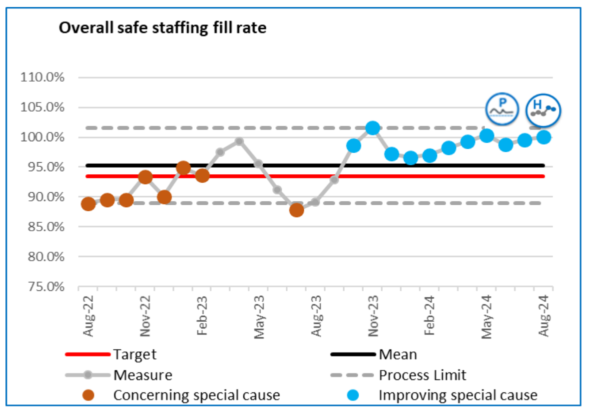
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

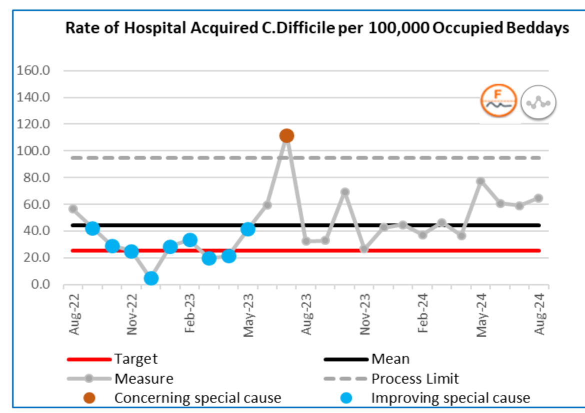


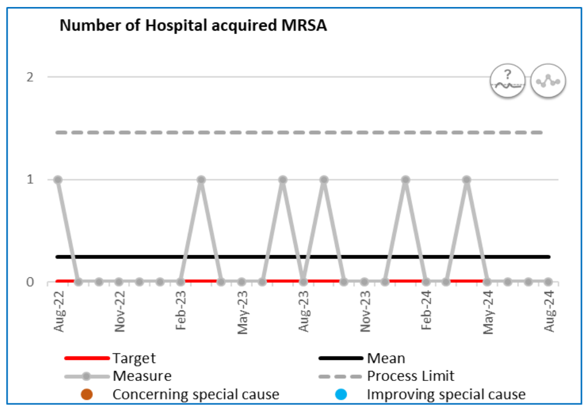
Forecast SPCs (3 month forward view) for People Indicators

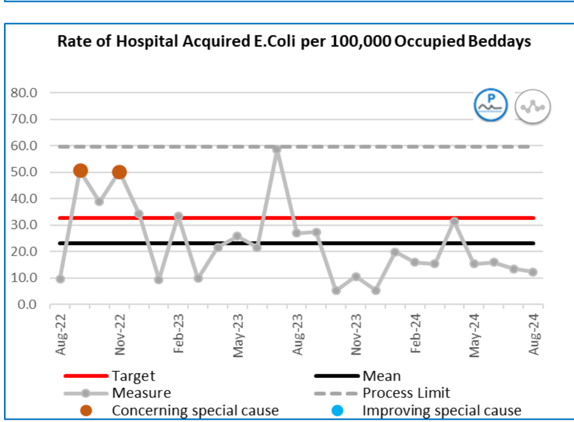


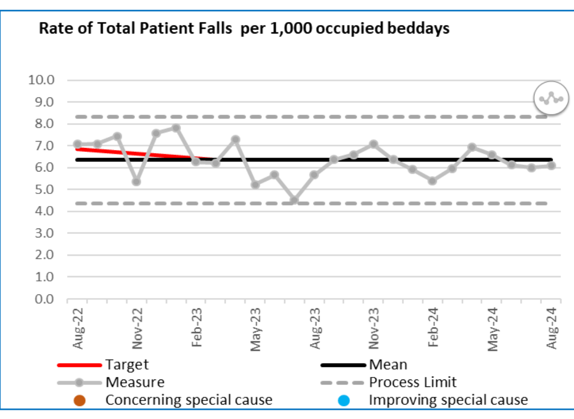
Forecast SPCs (3 month forward view) for Patient Safety Indicators

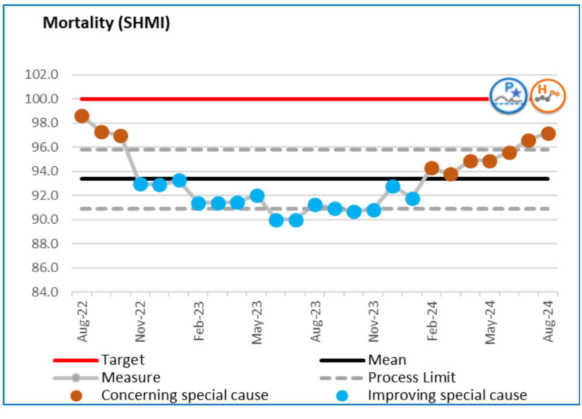


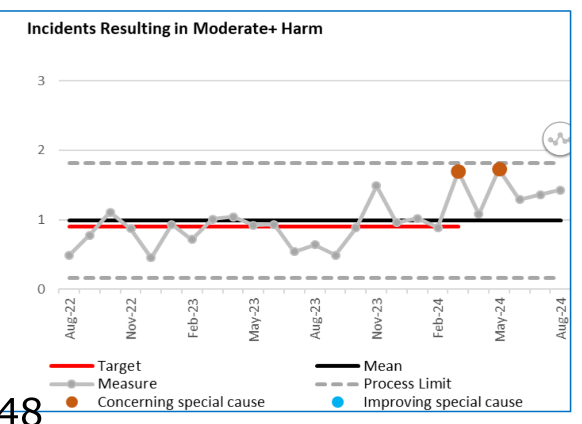


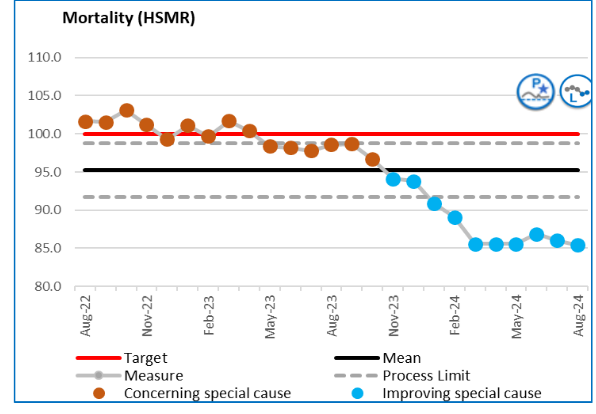




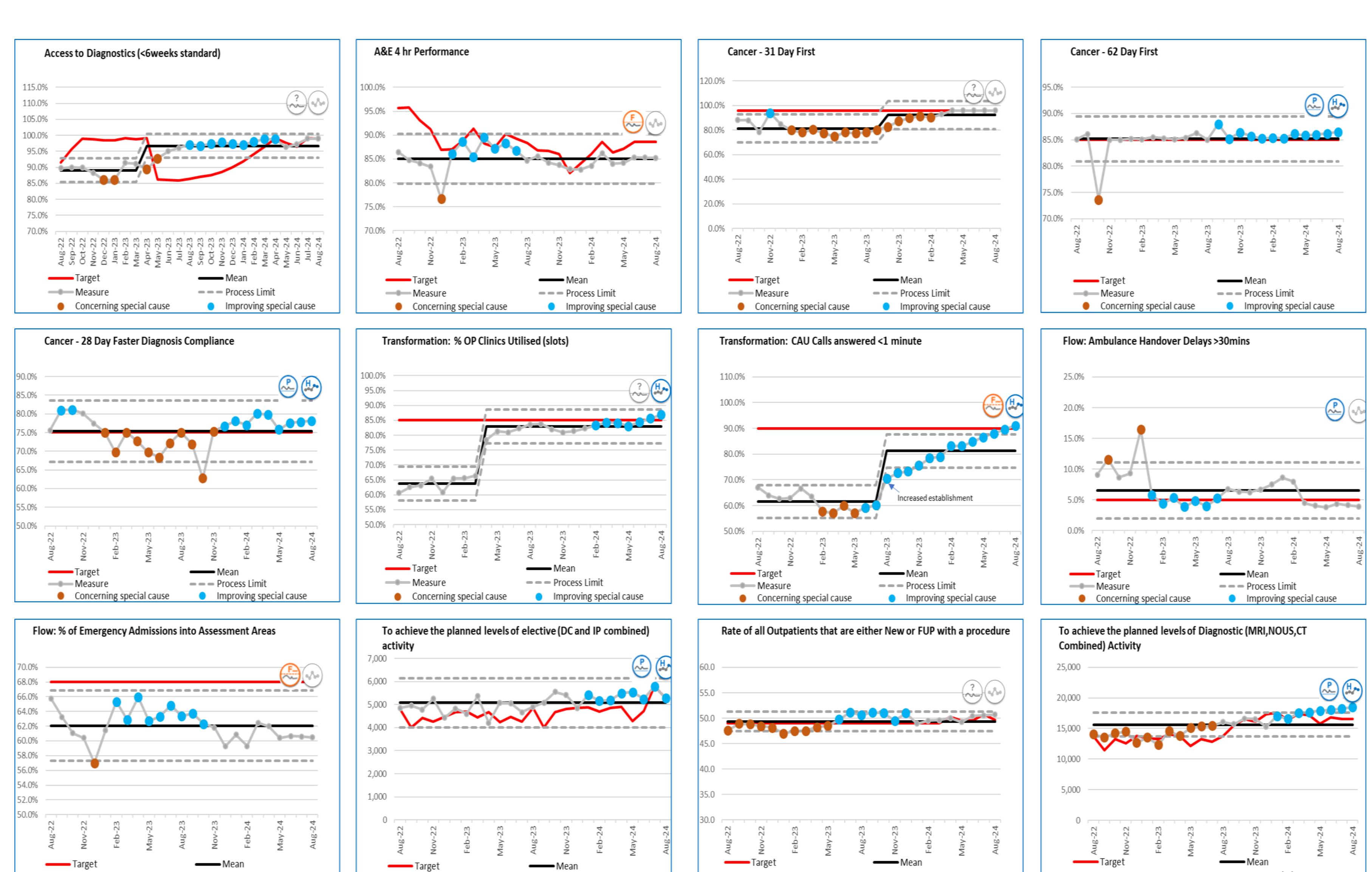




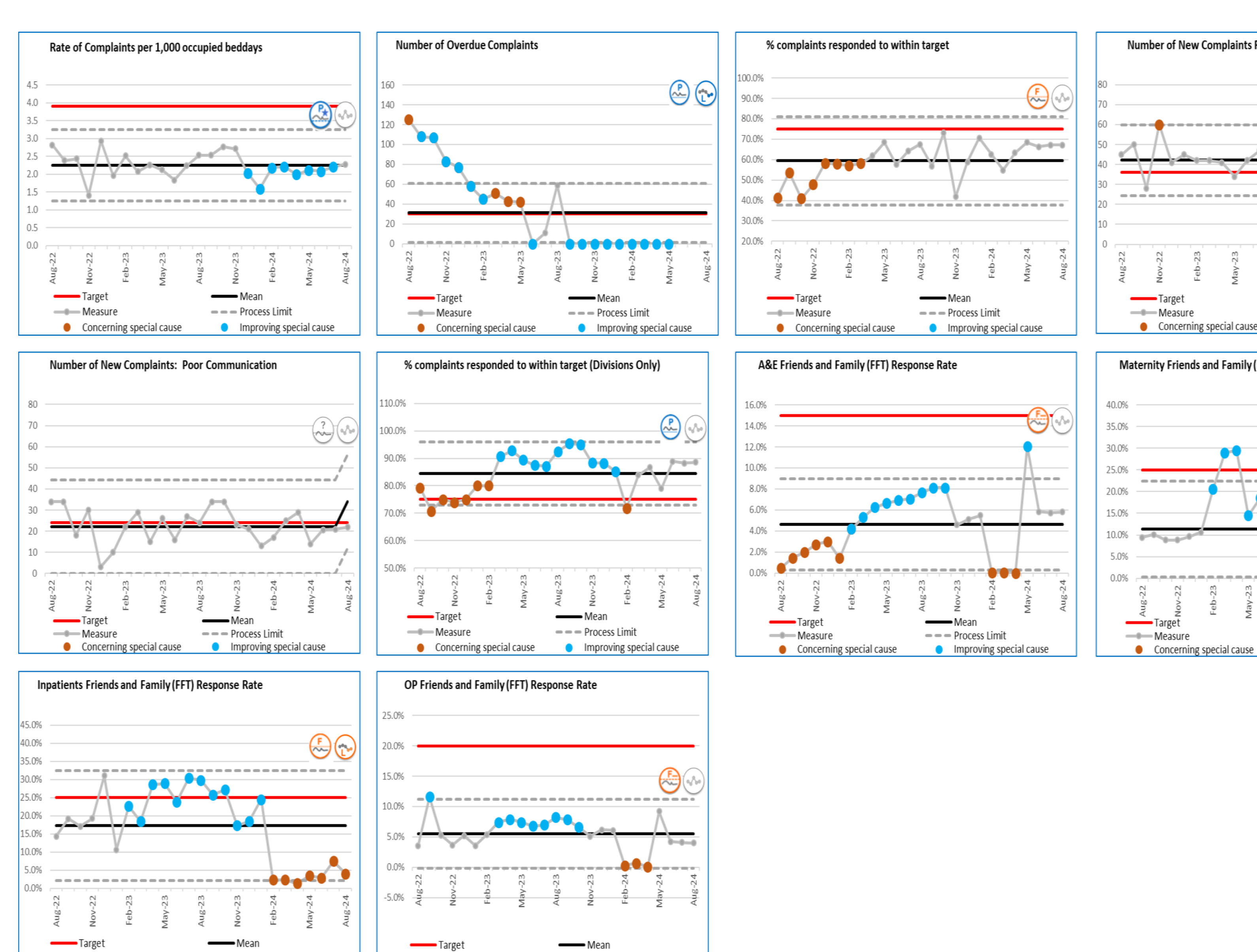




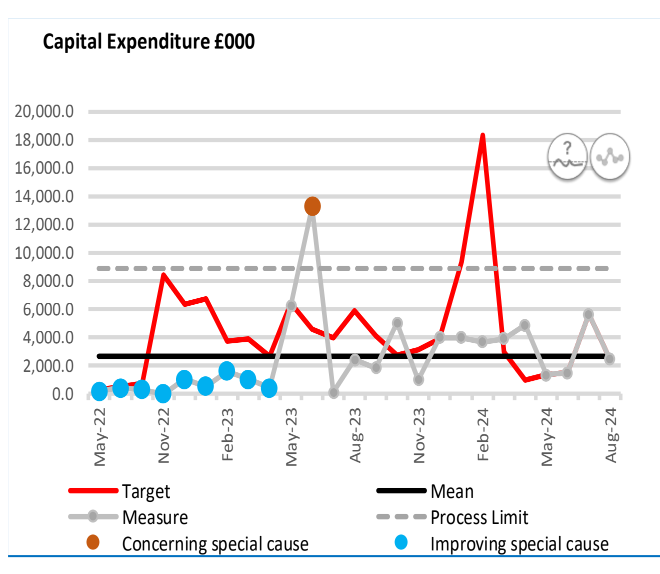
Forecast SPCs (3 month forward view) for Patient Access Indicators

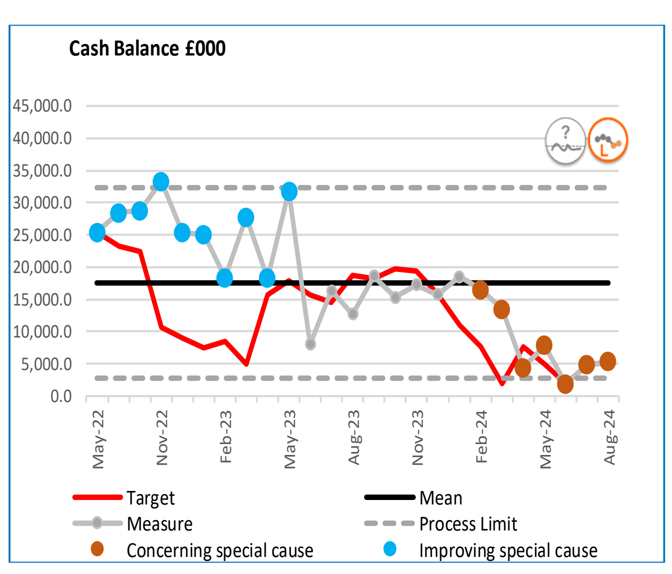


Forecast SPCs (3 month forward view) for Patient Experience Indicators

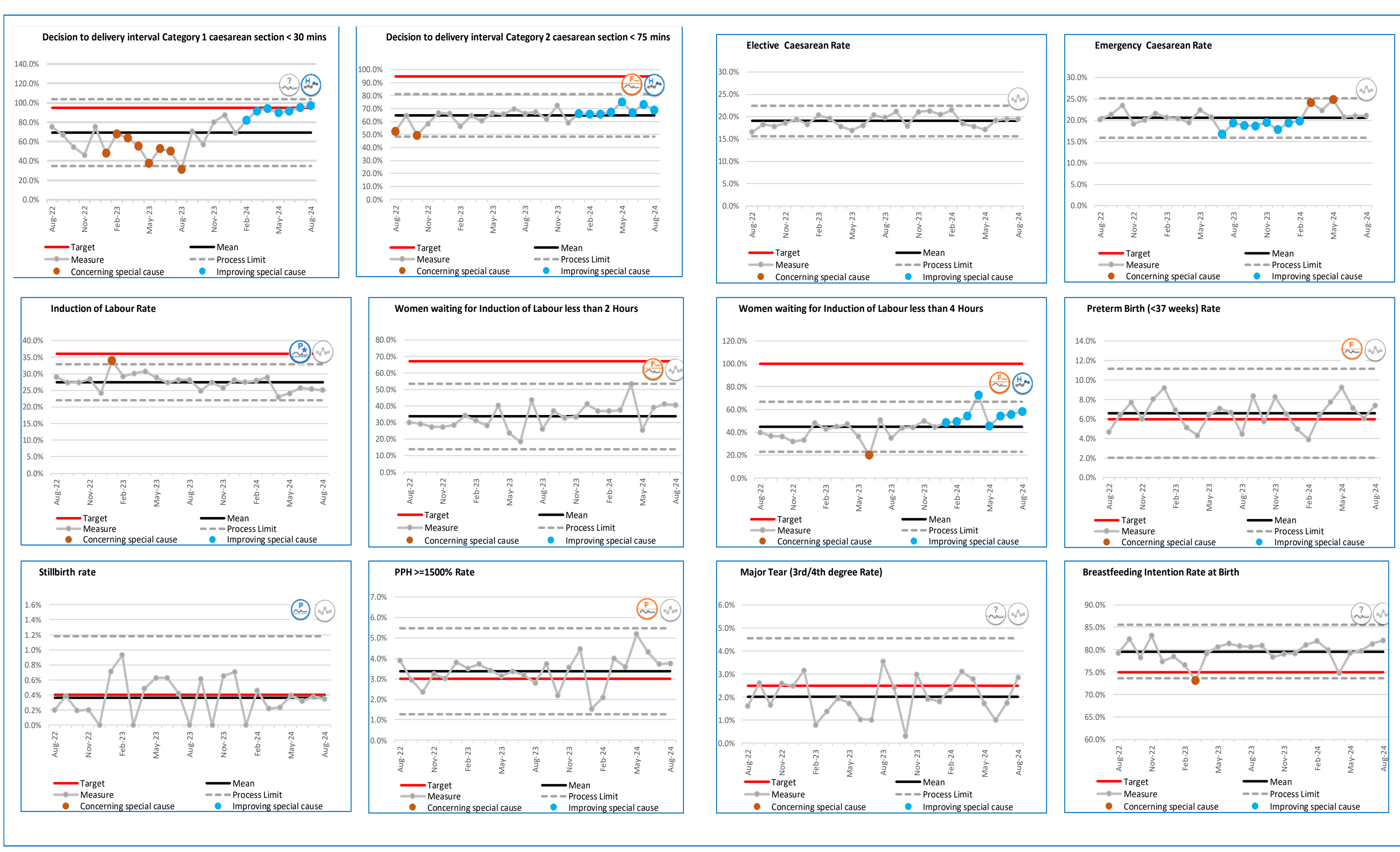


Forecast SPCs (3 month forward view) for Sustainability Indicators





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
H L	P P	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
	P P	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
H L	P P	Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

A metric achieving the target for 6 months or more will be flagged as passing

Metrics that are **hit and miss** have:

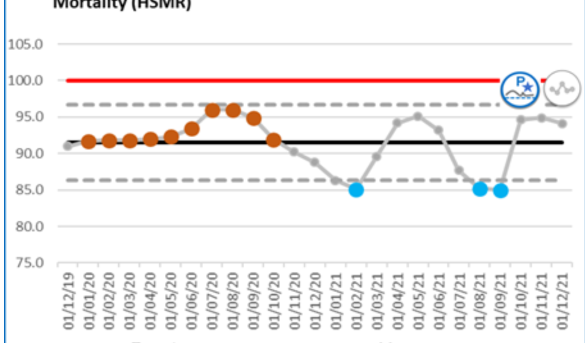
The **target** line **between** the **upper** and **lower** control limit for all metric types

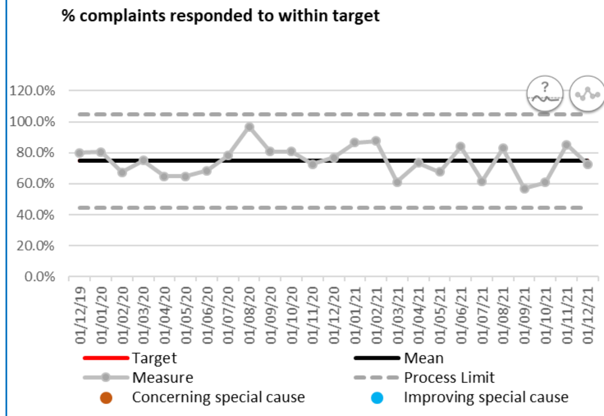
Metrics that consistently **fail** have:

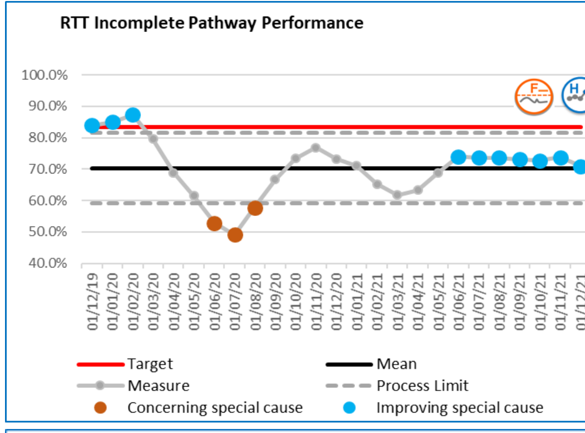
The **lower** control limit **above** the target line for metrics that need to be **below the target**

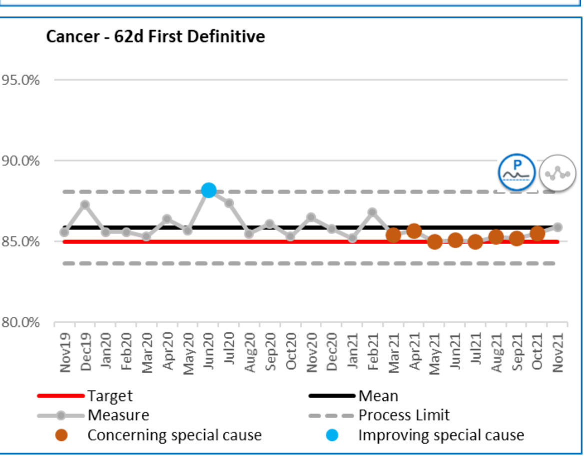
The **upper** control limit **below** the target line for metrics that need to be **above the target**

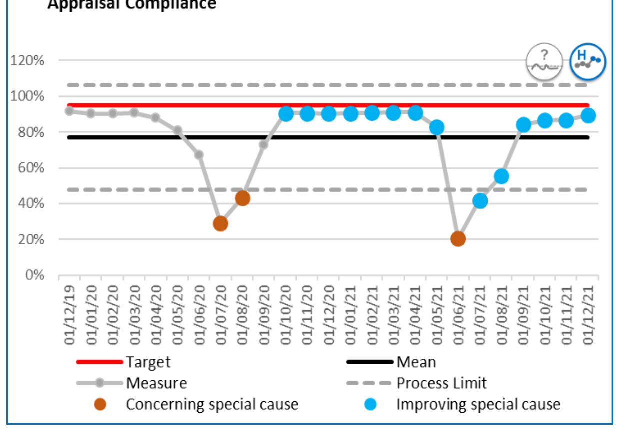
A metric not achieving the target for 6 months or more will be flagged as failing

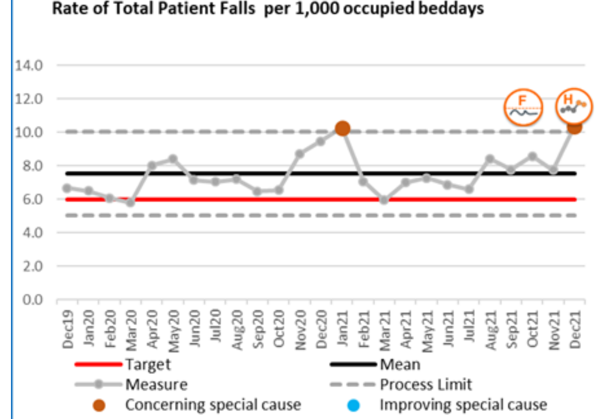












Maternity Metrics Definitions

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

Executive Summary

- The Trust was £2.5m in deficit in May which was £0.1m adverse to plan. Year to date the Trust is £4.4m in deficit which is £0.9m adverse to plan.
- The key year to date pressures are CIP slippage (£1.4m), unfunded escalation costs (£0.5m), net CDC slippage (£0.4m) and Fordcombe hospital adverse to plan by £0.2m. These pressures were partly offset by variable activity overperformance (£0.7m release of service development and contingency budgets (£0.7m) and underspend against depreciation (£0.2m)
- Cost Improvement Plans (CIP) was adverse to plan by £0.4m in May and year to date are £1.4m behind plan.

Current Month Financial Position

- The Trust was £2.5m in deficit in the month which was £0.1m adverse to plan
- **Key Adverse variances in month are:**
  - CIP slippage in May was £0.4m which related to unidentified CIP allocated in month 2
  - Net CDC slippage (£0.3m) and one-off costs in the month (£0.4m).
  - Unfunded Ward escalation costs (£0.2m)
- **Key Favourable variances in month are:**
  - The Trust benefitted by £0.5m of prior month relating clinical income
  - Overperformance on ERF/Variable related income by £0.3m
  - The Trust released £0.4m relating to Service development and contingency budgets offset income and expenditure pressures incurred

Year to Date Financial Position

- The Trust is £4.4m in deficit which was £0.9m adverse to plan
- **Key Adverse variances in month are:**
  - CIP Slippage (£1.4m)
  - Unfunded Ward escalation costs (£0.5m)
  - Net CDC slippage (£0.4m)
  - Fordcombe Hospital adverse to plan by £0.2m
- **Key Favourable variances in month are:**
  - Variable activity overperformance (£0.7m)
  - The Trust released £0.7m relating to Service development and contingency budgets offset income and expenditure pressures incurred
  - Underspend against the depreciation plan (£0.2m)

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In May the Trust saved £1.3m which was £0.4m adverse to plan, year to date the Trust is £1.4m adverse to plan.

Cashflow position:

- The closing cash balance at the end of May was £7.86m. The Trust receives its monthly block SLA income on the 15th of each month so the month end cash balance is required to cover the payment runs for the first two weeks of the following month and the weekly payroll including 247-time agency.
- The cash flow forecast is based on the Income and Expenditure plans as well as planned working capital movements. The year to date Income and Expenditure position is a £4.5m deficit which is £876k adverse to plan, the main element for the deficit is primarily due to the CIP programme being back ended. This deficit adversely impacts the cash position. The cashflow is updated daily and the forecast is regularly updated and reviewed if costs during the year increase e.g. salaries are higher than plan and the remaining months are amended to be in line with the current charges.
- The Trust is working closely with local NHS organisations and agreeing "like for like" arrangements when possible to reduce the debtor/'creditor balances for both organisations
- In June the Trust applied for Working Capital Support PDC of £9.98m to assist the Trust's cash position

Capital Position

Capital Plan

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

Other Funds

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

Month 2 Actuals (excluding IFRS16)

- The YTD spend at M2 is **£2.1m** against a YTD budget of **£2.1m**.
- 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 £25.456m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£22.092m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.364m). This is subject to approval and confirmation of this element of the financial regime in terms of final ICS allocations for 2024/25. The most significant element of the additions is the initial lease capitalisation of the Kent and Medway Medical School Accommodation building (£16.5m) on the TWH site that the Trust will recognise under IFRS 16 when it becomes available for use.

Risks

- Outstanding contract discussions with Commissioners - Contracts have been signed with Kent and Medway (K&M) however work is ongoing with commissioners to negotiate various contract adjustments in relation to: Elective Recovery Fund (ERF) variable target, Virtual Ward, Bariatrics, Repatriation, K&M Orthopaedic Centre (partially funded), Capital Charges Support, Tobacco Dependency, QFIT and Overseas Patient Debt Share.

- System contract total reduction (£2m) - The contract with K&M has been signed inclusive of a £2m reduction. The Trust plan (submitted June 24) assumed non recurrent income of £2m, a funding source has yet to be identified.
- Unidentified Efficiencies - Work is on-going to reduce the level of unidentified efficiencies, it is expected that the current gap is closed through a combination of additional schemes and Non-recurrent measures yet to be confirmed.
- Kent and Medway Orthopaedic Centre (KMOC) - The Trust plan included £21.6m for KMOC which was based on a expected opening of July 24. The recently announced extended delay to opening of KMOC to September creates a financial risk to the position from July onwards which will need to be managed by the Division and mitigated.

Finance Report

Month 2
2024/25

1a. Dashboard

May 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	64.2	61.3	2.9	0.6	2.3	124.7	122.6	2.1	0.8	1.3
Expenditure	(62.4)	(59.3)	(3.1)	(0.6)	(2.5)	(120.3)	(117.3)	(3.1)	(0.8)	(2.3)
EBITDA (Income less Expenditure)	1.8	2.0	(0.2)	0.0	(0.2)	4.4	5.3	(1.0)	0.0	(1.0)
Financing Costs	(3.8)	(3.9)	0.1	0.0	0.1	(20.2)	(20.3)	0.1	0.0	0.1
Technical Adjustments	(0.5)	(0.5)	0.0	0.0	0.0	11.4	11.4	0.0	0.0	0.0
Net Surplus / Deficit	**(2.5)**	**(2.4)**	**(0.1)**	**0.0**	**(0.1)**	**(4.4)**	**(3.6)**	**(0.9)**	**0.0**	**(0.9)**
Cash Balance	7.9	5.0	2.9		2.9	7.9	5.0	2.9		2.9
Capital Expenditure (Incl Donated Assets and IFRS16)	1.3	1.3	0.0		0.0	2.3	2.3	0.0		0.0
Cost Improvement Plan	1.3	1.8	(0.4)		(0.4)	2.3	3.7	(1.4)		(1.4)

Summary Current Month:
- The Trust was £2.5m in deficit in the month which was £0.1m adverse to plan.

Key adverse variances in month are:
- CIP slippage in May was £0.4m which related to unidentified CIP allocated in month 2
- Net CDC slippage (£0.3m) and one off costs in the month (£0.4m).
- Unfunded Ward escalation costs (£0.2m)

Key favourable variances in month are:
- The Trust benefitted by £0.5m of prior month relating clinical income and overperformance on ERF/Variable related income by £ 0.3m. The Trust released £0.4m relating to Service development and contingency budgets in May to help offset income and expenditure pressures incurred.

Year to date overview:
- The Trust is £4.4m in deficit which is £0.9m adverse to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£1.4m)
- Unfunded Ward escalation costs (£0.5m)
- Net CDC slippage (£0.4m)
- Fordcombe Hospital adverse to plan by £0.2m

Favourable Variances
- Variable activity overperformance (£0.7m)
- The Trust released £0.7m relating to Service development and contingency budgets offset income and expenditure pressures incu rred
- Underspend against the depreciation plan (£0.2m)

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.

Forecast
- The Trust is forecasting to deliver the planned breakeven position

May-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	120.5%	116.7%	-	-	130.3%	145.7%	-	-	42.2%	66.4%	98	6.69	10	11.5	-	-	2	0		190,137	267,882	(77,745)
MAIDSTONE	Stroke Unit (M) - NK551	94.6%	101.8%	-	100.0%	99.7%	110.9%	-	100.0%	19.6%	12.9%	100	6.94	11	8.9	21.1%	100.0%	9	1		226,803	330,016	(103,213)
MAIDSTONE	Cornwallis - NS251	207.6%	210.4%	-	-	102.5%	116.1%	-	-	11.9%	29.0%	36	2.14	6	16.2	-	-	2	0		123,347	125,477	(2,130)
MAIDSTONE	Culpepper Ward (M) - NS551	101.7%	82.5%	-	-	100.0%	119.4%	-	-	27.2%	0.0%	21	1.50	1	4.9	60.0%	85.7%	4	0		120,901	129,014	(8,113)
MAIDSTONE	Edith Cavell - NS459	121.0%	84.6%	-	100.0%	93.3%	132.0%	-	-	24.3%	49.4%	25	1.70	3	6.8	-	-	8	0		123,625	140,086	(16,461)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	84.1%	111.0%	-	-	102.2%	87.0%	-	-	32.3%	15.4%	94	6.49	16	7.6	8.3%	100.0%	5	2		187,980	202,213	(14,233)
MAIDSTONE	Intensive Care (M) - NA251	88.7%	90.6%	-	-	91.3%	92.1%	-	-	10.7%	0.0%	73	4.62	8	40.1	-	-	0	1		245,106	253,531	(8,425)
MAIDSTONE	Lord North Ward (M) - NF651	93.3%	106.2%	-	100.0%	100.0%	103.2%	-	-	25.0%	6.5%	62	4.60	7	7.4	33.3%	90.0%	2	1		119,377	127,433	(8,056)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	0.0%	0.0%	-	-	4.8%	-	-	-	1.5%	0.0%	3	0.20	0	0.0	24.7%	100.0%	1	0		0	16,642	(16,642)
MAIDSTONE	Mercer Ward (M) - NJ251	103.1%	107.7%	-	100.0%	105.5%	131.7%	-	100.0%	28.6%	26.7%	44	3.12	6	6.4	7.1%	100.0%	4	0		120,235	142,748	(22,513)
MAIDSTONE	Peale Ward COVID - ND451	97.4%	128.1%	-	-	103.2%	135.5%	-	-	31.3%	25.0%	78	5.34	15	9.1	20.0%	83.3%	2	0		109,875	111,968	(2,093)
MAIDSTONE	Pye Oliver (Medical) - NK259	133.2%	125.7%	-	-	159.6%	139.7%	-	-	67.8%	50.8%	162	11.49	9	8.4	11.4%	80.0%	3	0		138,845	215,209	(76,364)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	98.1%	83.6%	-	-	91.3%	-	-	-	7.7%	0.0%	8	0.56	0	31.7	11.3%	99.0%	0	0		71,233	66,782	4,452
MAIDSTONE	Whatman Ward - NK959	93.9%	114.5%	-	100.0%	100.0%	115.2%	-	100.0%	45.0%	24.0%	90	6.23	10	7.4	-	-	7	0		150,355	171,139	(20,784)
MAIDSTONE	Maidstone Birth Centre - NP751	105.7%	100.0%	-	-	99.9%	99.7%	-	-	12.0%	0.0%	28	1.41	0	45.5	8.3%	100.0%	0	0		79,200	95,215	(16,015)
TWH	Acute Medical Unit (TW) - NA901	104.2%	115.1%	-	100.0%	116.2%	132.7%	-	100.0%	44.4%	46.8%	184	13.15	28	9.9	-	-	10	0		272,538	293,104	(20,566)
TWH	Coronary Care Unit (TW) - NP301	95.6%	90.5%	-	-	99.8%	-	-	-	15.6%	6.1%	24	1.73	6	11.5	28.0%	100.0%	0	1		77,556	75,884	1,672
TWH	Hedgehog Ward (TW) - ND702	123.4%	121.5%	-	-	126.4%	128.9%	-	-	49.0%	66.3%	251	17.31	27	12.0	1.6%	50.0%	0	0		203,244	231,406	(28,162)
TWH	Intensive Care (TW) - NA201	100.6%	95.7%	-	-	97.9%	79.8%	-	-	2.9%	0.0%	34	2.35	3	32.5	50.0%	100.0%	2	0		389,675	396,721	(7,046)
TWH	Private Patient Unit (TW) - NR702	105.8%	86.7%	-	-	99.8%	102.1%	-	-	22.2%	0.0%	11	0.76	0	8.6	40.0%	87.5%	0	0		75,011	81,760	(6,749)
TWH	Ward 2 (TW) - NG442	95.0%	84.5%	-	100.0%	102.2%	118.0%	-	100.0%	32.8%	15.6%	65	4.55	15	7.1	6.7%	100.0%	7	0		199,272	187,940	11,332
TWH	Ward 10 (TW) - NG131	106.3%	106.3%	-	-	104.1%	90.6%	-	-	46.1%	7.1%	185	12.07	43	8.4	-	-	8	0		174,596	162,923	11,673
TWH	Ward 11 (TWH) Nov 2019 - NG144	82.3%	99.5%	-	100.0%	76.1%	89.4%	-	-	24.4%	2.2%	65	4.39	13	6.0	-	-	8	0		0	147,769	(147,769)
TWH	Ward 12 (TW) - NG132	122.8%	94.5%	-	100.0%	125.7%	102.5%	-	-	44.0%	47.1%	173	11.89	31	7.3	21.9%	92.9%	7	1		153,100	194,144	(41,044)
TWH	Ward 20 (TW) - NG230	118.9%	132.6%	-	100.0%	129.9%	123.6%	-	-	46.1%	56.5%	139	9.57	12	8.2	14.6%	100.0%	6	0		202,861	216,577	(13,716)
TWH	Ward 21 (TW) - NG231	86.0%	84.5%	-	100.0%	96.8%	90.3%	-	-	34.9%	11.0%	147	9.38	39	6.4	10.2%	66.7%	8	1		177,343	190,053	(12,710)
TWH	Ward 22 (TW) - NG332	91.1%	151.2%	-	-	96.1%	163.7%	-	-	46.7%	43.6%	88	5.88	20	7.9	12.2%	80.0%	15	1		170,934	179,586	(8,652)
TWH	Ward 30 (TW) - NG330	92.4%	93.7%	-	100.0%	96.1%	111.8%	-	100.0%	27.2%	0.0%	114	6.94	20	6.7	11.1%	100.0%	8	0		149,810	171,157	(21,347)
TWH	Ward 31 (TW) - NG331	107.2%	110.1%	-	100.0%	117.8%	108.9%	-	-	27.9%	28.9%	136	8.63	21	7.4	5.6%	100.0%	5	1		154,124	213,306	(59,182)
TWH	Ward 32 (TW) - NG130	91.4%	100.4%	-	100.0%	96.8%	94.7%	-	100.0%	14.1%	4.4%	47	3.11	13	8.8	26.7%	91.7%	3	1		154,471	169,408	(14,937)
TWH	Ward 33 (Gynae) (TW) - ND302	94.8%	96.9%	-	-	100.0%	87.1%	-	-	35.1%	3.2%	59	3.80	9	7.2	-	-	4	0		105,089	107,761	(2,672)
TWH	SCBU (TW) - NA102	101.5%	170.2%	-	-	115.9%	53.8%	-	-	17.3%	1.1%	85	4.89	2	12.5	-	-	0	0		245,886	208,487	37,399
TWH	Short Stay Surgical Unit (TW) - NE901	84.5%	74.9%	-	100.0%	103.2%	100.0%	-	-	6.7%	0.0%	13	0.88	0	13.4	5.8%	95.5%	0	0		89,352	98,074	(8,722)
TWH	Surgical Assessment Unit (TW) - NE701	101.1%	100.0%	-	-	100.0%	100.0%	-	-	4.5%	0.0%	5	0.34	0	16.2	3.8%	100.0%	0	0		80,409	85,420	(5,011)
TWH	Midwifery (multiple rosters)	79.8%	72.4%	-	-	88.1%	91.9%	-	-	17.5%	5.9%	751	43.26	131	**12.8**	32.0%	95.4%	**0**	**0**		1,390,447	1,399,283	(8,836)
Crowborough	Crowborough Birth Centre (CBC) - NP775	56.5%	68.4%	-	-	100.0%	100.0%	-	-	17.3%	0.0%	61	3.87	2	128.6	-	-	0	0		71,231	85,341	(14,110)
MAIDSTONE	Accident & Emergency (M) - NA351	106.8%	81.7%	-	100.0%	106.9%	89.6%	-	-	41.2%	36.7%	444	29.83	22	-	12.9%	82.4%	2	0		380,477	444,420	(63,943)
TWH	Accident & Emergency (TW) - NA301	103.4%	78.3%	-	100.0%	103.2%	79.0%	-	100.0%	38.1%	32.2%	425	29.42	25	-	11.2%	84.0%	4	0		422,802	508,152	(85,350)

	Budget £	Actual £	Variance £ (overspend)
Total Established Wards	**7,347,247**	**8,244,033**	**(896,786)**
Additional Capacity bec Cath Labs	59,124	54,051	5,073
Foster Clarke NS959	0	14,322	-14,322
Other associated nursing costs	6,081,365	5,465,183	616,182
Total	**13,487,736**	**13,777,589**	**(289,853)**

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%

Quarterly mortality data **Medical Director**

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Discussion and assurance

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

MORTALITY – SUMMARY REPORT

June 2024

The reporting period for this report is Jan 23 - Dec 23 with the most recent HSMR data refresh in April 2024. The lack of updated data is due to the data integrity issues with NHS England. A timeline for a resolution has been communicated by T Health and expected in the next few weeks.

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Healthcare Intelligence Portal tool, this report examines in-hospital mortality, for all inpatient admissions for the 12-month time period Jan 2023 - Dec 2023.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including October 2023(unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period Dec-22 – Nov-23 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

HEADLINES

Data Period: Nov 2022 - Oct 2023

Metric	Result
HSMR	85.77 (lower-than-expected) (81.1 – 90.6)
HSMR position vs. peers	Regional acute peer group = 18 trusts: • 14 lower-than-expected • 2 within expected • 2 higher-than-expected Peer group = 89.4 (lower-than-expected) (88.3 – 90.6)
All Diagnosis SMR	83.4 (lower-than-expected)
Significant Diagnosis Groups	• Septicemia (except in labour) (700 superspells; 163 deaths)
CUSUM breaches	• Septicemia (except in labour) (Feb-23) (Jun-23)
Emergency Weekend HSMR	87.3 (lower-than-expected)
Emergency Weekday HSMR	84.5 (lower-than-expected)
SHMI position	(Dec-22 to Nov-23) 93.92 (as expected)

HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW

HSMR for Dec-23 is 83.73 and “lower-than-expected”, based on 4311 superspells and 139 deaths (crude rate 3.22%).

HSMR for the period Jan-23 to Dec-23 is 85.77 and “lower-than-expected”, based on 49,975 superspells and 1261 deaths (crude rate 2.52%).

The Trust’s HSMR crude rate continues to fall sharply. The latest rolling-12-month crude rate for the period Jan-23 to Dec-23 is the lowest it has been in the last four years of data. Expected rate of mortality remains consistent. It should be noted that the current national HSMR value is decreasing and is currently performing “lower-than-expected”.

Figure 1 – HSMR 12 Month Rolling Trend

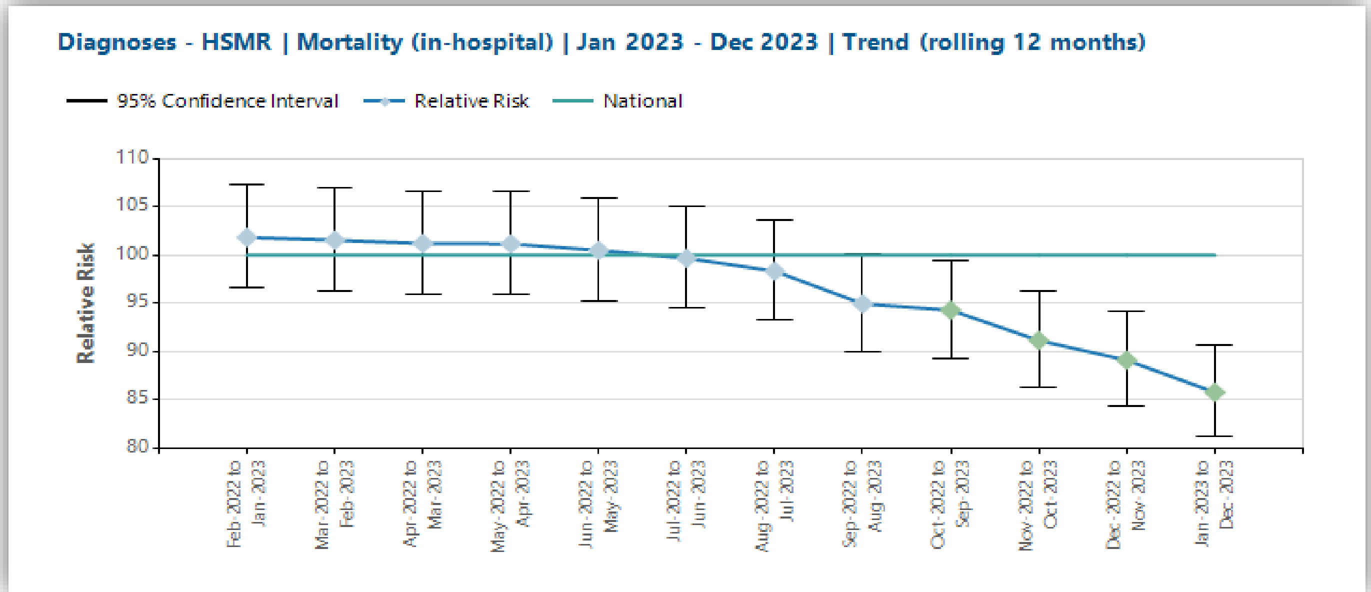


Figure 2 – HSMR 12 Month Peer Comparison

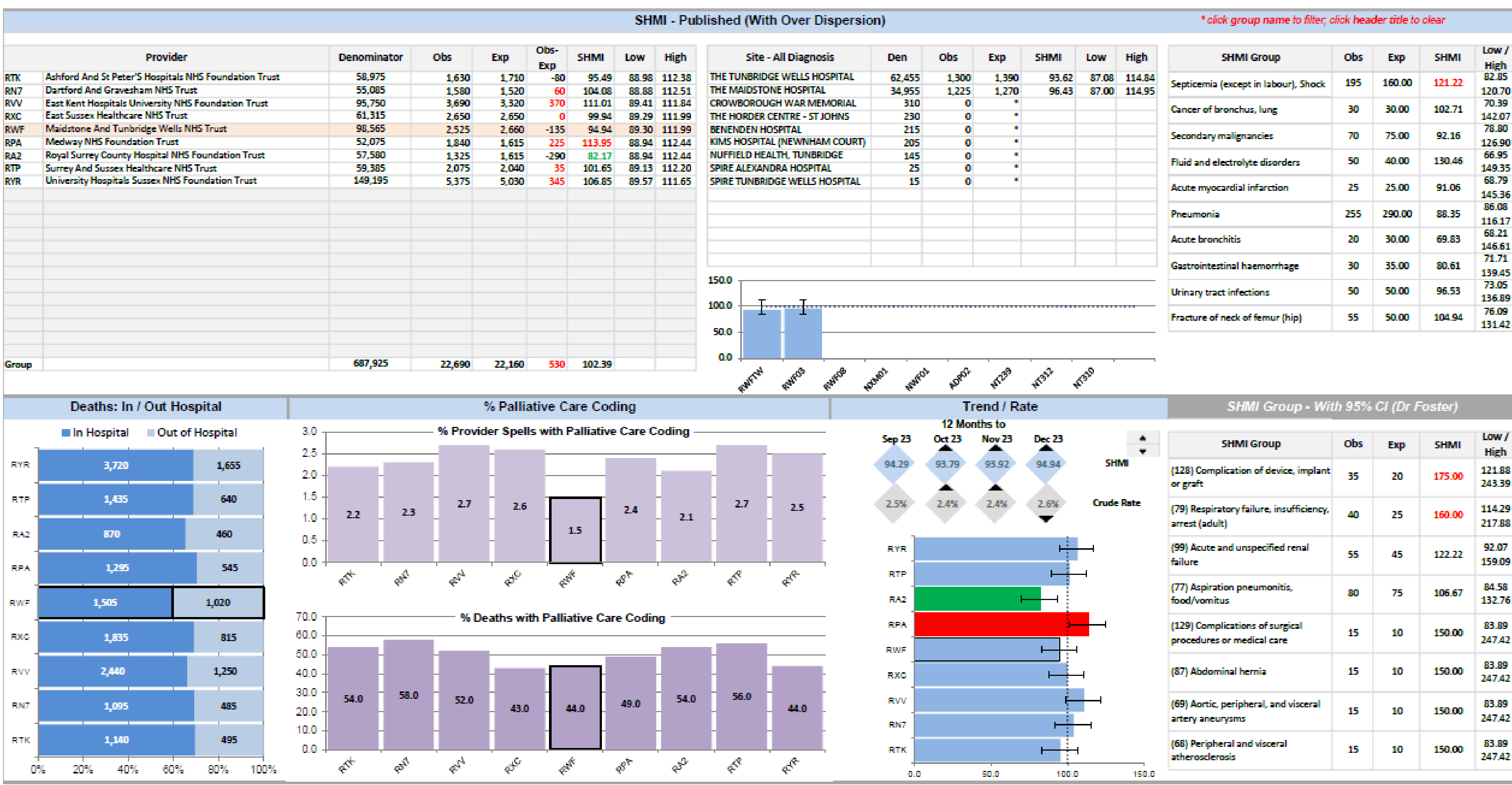
Diagnoses - HSMR | Mortality (in-hospital) | Jan 2023 - Dec 2023 | REGION (acute)

National
Relative Risk
95% Confidence Interval
Relative Risk
200
150
100
50
0
All
UNIVERSITY HOSPITALS SUSSEX NHSFT
OXFORD UNIVERSITY HOSPITALS NHSFT
EAST KENT HOSPITALS UNIVERSITY NHSFT
UNIVERSITY HOSPITAL SOUTHAMPTON NHSFT
PORTSMOUTH HOSPITALS UNIVERSITY NATIO...
MAIDSTONE AND TUNBRIDGE WELLS NHST
EAST SUSSEX HEALTHCARE NHST
HAMPSHIRE HOSPITALS NHSFT
BUCKINGHAMSHIRE HEALTHCARE NHST
FRIMLEY HEALTH NHSFT
DARTFORD AND GRAVESHAM NHST
ASHFORD AND ST PETER'S HOSPITALS NHSF...
ROYAL BERKSHIRE NHSFT
SURREY AND SUSSEX HEALTHCARE NHST
MEDWAY NHSFT
ROYAL SURREY COUNTY HOSPITAL NHSFT
ISLE OF WIGHT NHST
QUEEN VICTORIA HOSPITAL NHSFT

MONTHLY SHMI

Key points

SHMI value for Jan-23 to Dec-24 is 94.94 and ‘as expected’.



SHMI - Published (With Over Dispersion)

* click group name to filter; click header title to clear

	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTK	Ashford And St Peter'S Hospitals NHS Foundation Trust	58,975	1,630	1,710	-80	95.49	88.98	112.38
RN7	Dartford And Gravesham NHS Trust	55,085	1,580	1,520	60	104.08	88.88	112.51
RVV	East Kent Hospitals University NHS Foundation Trust	95,750	3,690	3,320	370	111.01	89.41	111.84
RXC	East Sussex Healthcare NHS Trust	61,315	2,650	2,650	0	99.94	89.29	111.99
RWF	Maidstone And Tunbridge Wells NHS Trust	98,565	2,525	2,660	-135	94.94	89.30	111.99
RPA	Medway NHS Foundation Trust	52,075	1,840	1,615	225	113.95	88.94	112.44
RA2	Royal Surrey County Hospital NHS Foundation Trust	57,580	1,325	1,615	-290	82.17	88.94	112.44
RTP	Surrey And Sussex Healthcare NHS Trust	59,385	2,075	2,040	35	101.65	89.13	112.20
RYR	University Hospitals Sussex NHS Foundation Trust	149,195	5,375	5,030	345	106.85	89.57	111.65
Group		687,925	22,690	22,160	530	102.39		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
THE TUNBRIDGE WELLS HOSPITAL	62,455	1,300	1,390	93.62	87.08	114.84
THE MAIDSTONE HOSPITAL	34,955	1,225	1,270	96.43	87.00	114.95
CROWBOROUGH WAR MEMORIAL	310	0	*			
THE HORDER CENTRE - ST JOHNS	230	0	*			
BENENDEN HOSPITAL	215	0	*			
KIMS HOSPITAL (NEWNHAM COURT)	205	0	*			
NUFFIELD HEALTH, TUNBRIDGE	145	0	*			
SPIRE ALEXANDRA HOSPITAL	25	0	*			
SPIRE TUNBRIDGE WELLS HOSPITAL	15	0	*			

SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	195	160.00	121.22	82.85 120.70
Cancer of bronchus, lung	30	30.00	102.71	70.39 142.07
Secondary malignancies	70	75.00	92.16	78.80 126.90
Fluid and electrolyte disorders	50	40.00	130.46	66.95 149.35
Acute myocardial infarction	25	25.00	91.06	68.79 145.36
Pneumonia	255	290.00	88.35	86.08 116.17
Acute bronchitis	20	30.00	69.83	68.21 146.61
Gastrointestinal haemorrhage	30	35.00	80.61	71.71 139.45
Urinary tract infections	50	50.00	96.53	73.05 136.89
Fracture of neck of femur (hip)	55	50.00	104.94	76.09 131.42

SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(128) Complication of device, implant or graft	35	20	175.00	121.88 243.39
(79) Respiratory failure, insufficiency, arrest (adult)	40	25	160.00	114.29 217.88
(99) Acute and unspecified renal failure	55	45	122.22	92.07 159.09
(77) Aspiration pneumonitis, food/vomitus	80	75	106.67	84.58 132.76
(129) Complications of surgical procedures or medical care	15	10	150.00	83.89 247.42
(87) Abdominal hernia	15	10	150.00	83.89 247.42
(69) Aortic, peripheral, and visceral artery aneurysms	15	10	150.00	83.89 247.42
(68) Peripheral and visceral atherosclerosis	15	10	150.00	83.89 247.42

Learning from Deaths Group (LfDG)

and

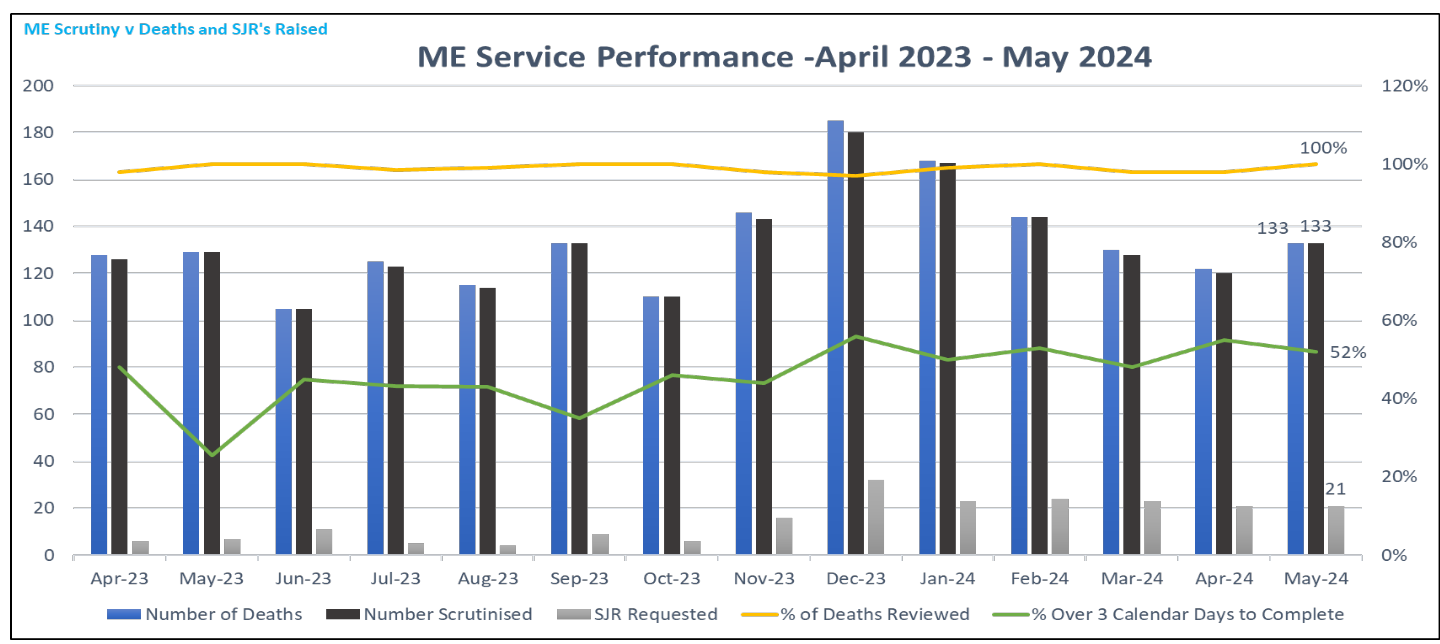
Medical Examiner Service Update

Medical Examiner Service

ME Service Update

- There has been a decrease in the number of deaths across the trust over the last 3 months. Deaths occurring in March 2024 were 130, reducing to 122 in April 2024 and increasing again to 133 deaths in May 2024.
- The Service continues to perform well, scrutinising a high percentage of cases within the month. 98-100% of all deaths were scrutinised by the Service in the last three months.
- The ME Service is due to become statutory on the 9th of September 2024. As a result, there is increased engagement with community care providers and cases being reviewed by the Service are steadily increasing in preparation for September 2024.
- The service is undergoing a full review to streamline processes and improve performance in readiness for the review of all community deaths from September 2024.
- The electronic system EDEN is now fully being used however reporting functions are still being tested

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Nov-23	146	143	98%	63	44%
Dec-23	185	180	97%	100	56%
Jan-24	168	167	99%	84	50%
Feb-24	144	144	100%	76	53%
Mar-24	130	128	98%	62	48%
Apr-24	122	120	98%	66	55%
May-24	133	133	100%	69	52%



The increase in SJRs raised by the ME Service in the last few months is due to the ME Service flagging all cases where Sepsis is mentioned. All of these cases may not require an SJR, however, they are being highlighted to support the work around Deteriorating Patients and Sepsis.

MTW exceptional people, outstanding care

Challenges faced by the ME Service

- Staffing due to the holiday season is challenging at a time when the caseload of the Service is on the rise in readiness for September 2024 when all community cases will be scrutinised by the Service.
- Timeliness of death summary completion by attending physicians impacts the ability of the Service to complete the scrutiny process within the stipulated 3 days.

Learning from Deaths Group (LfDG)

The Mortality Surveillance Group (MSG) has now been rebranded to the Learning from Deaths Group. This was approved at the March 2024 MSG meeting and the revised terms of reference are due to be ratified at the Patient Outcomes Oversight Group which reports to Quality Committee. The Learning from Deaths Group going forward is to be chaired by the Deputy Medical Director for Quality and Safety.

The role of the Learning from Deaths Group involves supporting the Trust to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary investigated. A further responsibility of the group is to ensure lessons learned from Mortality reviews are disseminated appropriately and actions implemented to improve outcomes for patients and the quality of services provided.

Learning from Mortality reviews identified the following needs:

- The quality of documentation is a theme emphasised by reviews. A case discussed at the LfDG group highlighted the need to clearly document discussions with patients especially where discussions enact treatment limitations and the reasons for such decisions. Other cases raised issues with the quality of notes both on paper and electronically with notes being written in retrospect or absent from the patient's records.
- Communication with family members/loved ones and between teams can be improved upon with high levels of variations in this area.
- Failure to recognise deterioration in the overall condition of a patient from their baseline during the initial assessment.

The following good practice was highlighted

- Evidence of input from all relevant specialities promptly and good communication between teams. Best interest discussion was used to decide on an escalation plan.
- Sensible decisions regarding appropriate ceiling of care. Good communication with relatives throughout, with their involvement in the decision making process.

- Several cases discussed at the LfDG involved the early detection and management of sepsis. In one case neutropenic sepsis was detected on admission early with initiation of the Sepsis six protocol within 30 minutes. In another case good Sepsis six protocol was started in an unwell patient with good recognition by ED and medical team
- The use of a care plan for the dying patient was utilised appropriately following several conversations with the patient and family leading to a comfortable death.

Structured Judgement Review (SJR)

An SJR is a standardised review of a patient's death undertaken by a trained clinician making safety and quality judgement of care phases. The SJR reviewer makes explicit comments about phases of care with scores attributed to each phase and the overall care received.

Key Themes Highlighted by SJRs

- Sepsis is a reoccurring theme discussed at LfDG, however in the last few months cases reviewed at the LfDG outline good sepsis management, which is positive. There is still a need for increased awareness to support early identification, treatment and escalation of sepsis
- Treatment delays is another key learning area from SJRs
- Improved communication with patients and families/carers
- Need for comprehensive and clear documentation
- Good multidisciplinary involvement in patient care has been highlighted
- Prompt recognition of patients who are at end of life is another good area of care

SJR Backlog Position

Year	Outstanding SJRs	<4 weeks	Completed SJRs
Apr 23 to Mar 24	5	0	97
Apr 24 to Mar 25	5	4	7
SJR Total backlog	10		

- The current SJR backlog position is 10, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4-week stipulated SJR turnaround time.
- There are 4 additional SJRs allocated to reviewers this year not within the backlog and 11 SJRs raised by the ME Service yet to be allocated to a reviewer
- This brings the total number of SJRs to be reviewed to 25.

Summary of 'Poor Care' and 'Very Poor Care' from SJR Reviews

LfDG Meeting	No of SJRs	Overall 'Poor care'	Overall 'Very poor Care'
Mar-24	16	1	1
Apr- 24	13	2	1
May-24	10	3	0

- In March, the Learning from Deaths Group reviewed 1 SJRs with an overall assessment of 'Poor care' and 1 Very poor care SJR
- In April, the Learning from Deaths Group reviewed 2 SJRs with an overall assessment of 'Poor care' and 1 Very poor care SJR.
- In May, the Learning from Deaths Group reviewed 3 SJRs with an overall assessment of 'Poor care' and no SJRs that were assessed as Very poor care.
- Learning from both very poor/poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates.
- Learning is also being shared via the Learning from Deaths Section in the Patient Safety Learning Hub on the intranet.
- Divisional mortality reports including mortality indicators and learning from SJRs are now provided to divisions to be presented at Clinical Governance meetings monthly.

Actions from 'Poor Care' and 'Very Poor Care' SJR Reviews

- Both poor and very poor care SJRs discussed in April and a poor care case discussed in May were referred through the Patient Safety team for review to determine if they meet the PSIRF threshold for further investigation. All three cases are still open pending a review outcome
- Feedback to directorates to aid learning from all SJRs occurs via mortality leads to teams, letter to clinical directors and senior clinicians involved in the case. Cases are also discussed at Clinical Governance meetings.

Next steps

- The annual mortality audit has been paused to review how best this process is managed going forward.
- 3 structured judgement reviewers have stepped down in the last 3 months reducing the number of reviewers in the trust to 9. This will have an impact on the SJR backlog, recruitment of additional reviewers is the next step to mitigate this risk.
- Rebranding the Mortality Surveillance Group to the Learning from Deaths Group is part of the strategy to focus on sharing the learning from SJRs and is a key objective in the coming months

To Approve the Trusts Quality Accounts 2023/24 **Chief Nurse**

The enclosed report provides information on the Trust's Quality Accounts for 2023/24 for review and approval.

The Trusts directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Services Regulations 2010).

In approving the Quality Accounts, directors are required to take steps to satisfy themselves of the following key criteria:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Accounts is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.
- The Quality Accounts have been prepared in accordance with Department of Health (DoH) guidance.
- The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Accounts.

The Quality Accounts in draft were submitted, reviewed and approved at the Trust's Quality Committee meeting in May 2024.

Following suggestions and amendments the Quality Accounts were circulated to the Trust's main external stakeholders at the beginning of June. Responses from the stakeholders and our patients are included in this final version. Noting the ICB's feedback remains outstanding at the point of submission

This year's accounts highlight the positive improvements achieved. A small number of the quality priorities set last year have not been delivered, these are highlighted alongside an explanatory narrative.

The deadline for the publication of the Quality Accounts on the NHS website is 30th June 2024

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

- Executive Team Meeting, 21/05/24
- Quality Main Committee, 26/05/24

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

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

Quality accounts

2023-2024

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Part one

Chief Executive's statement

2023/24 has been another very challenging, but successful year for Maidstone and Tunbridge Wells NHS Trust (MTW) as our teams work together to deliver the highest levels of care. The last 12 months have seen us focus on a number of key priorities including developing services to support patients in our local communities and across Kent and Medway, continuing to recover our pre-COVID performance levels, supporting the health and wellbeing of our staff – all while managing periods of industrial action.

Thanks to the hard work of colleagues across the organisation we are one of the best performing acute hospital trusts in the country against a backdrop of record-breaking attendances at our Emergency Departments (ED) and a large increase in cancer referrals. We are one of the few trusts in the country to have no long waiting patients (those waiting more than 52 weeks), reducing this from almost 1,000 to zero in less than a year. We are regularly in the top five trusts in the country for ED performance and have delivered the 62-day cancer standard each month for more than four-years running.

While ensuring our patients receive some of the quickest access to care in the country we have also delivered a number of major infrastructure projects, developed services and grown our workforce over the last year. This has included:

- The West Kent Community Diagnostic Centre (CDC) was formally opened in 2024 by the Secretary of State for Health and Social Care, Victoria Atkins. The CDC provides a broad range of elective diagnostics away from our main hospital sites.
- The Trust acquired the Spire Tunbridge Wells Hospital in March 2024, a purchase which enables us to develop clinical services in a number of areas and provide additional NHS capacity across Kent and Medway.
- In May 2024 the new Stroke Unit at Maidstone Hospital was formally opened. The unit, which contains a 14 bed Hyper Acute Stroke Unit and a 25 bed Acute Stroke Unit, enables the Trust to care for more than 1,000 patients a year, a 30% increase since 2019.
- Work on the Kent and Medway Orthopaedic Centre at Maidstone Hospital will complete in the summer, bringing three state of the art operating theatres and 24 dedicated surgical beds, and providing additional capacity for patients across Kent and Medway.
- Construction work is nearing competition on the new academic building for medical students at Tunbridge Wells Hospital. The six-storey building will provide teaching facilities and accommodation for 145 medical students a year, including trainee doctors from the Kent and Medway Medical School.
- The Trust has continued to develop our successful acute virtual ward service over the last year, caring for more than 750 patients and saving approximately 3,000 acute bed days. Virtual wards enable patients to receive hospital-level care at home safely, helping speed up their recovery and freeing up hospital beds for patients that need them most.
- During 2023/24 we were able to recruit almost 1,500 new colleagues and we achieved our target of reducing the Trust-wide vacancy rate.

We are proud of the progress we have made in performance and services, but we know there is still work to do. In 2023 the Trust was inspected by the Care Quality Commission (CQC) and we were delighted to receive a Good rating for Well-Led, however our End of Life Care service was rated "Requires Improvement"and our maternity service at Tunbridge Wells Hospital was rated "Inadequate". The CQC made a number of recommendations around governance, processes and documentation for both services. The Trust has taken steps to urgently address all of these recommendations, many of which have now been completed.

The Trust has also worked hard to respond to the Independent Inquiry into the issues raised by the David Fuller case. The Inquiry's Phase 1 report was published in November last year and contained 15 recommendations for MTW. In February 2024, following the introduction of a robust action plan, the Trust Board was assured all the recommendations had been fully implemented and the response and supporting evidence was signed off by the Kent and Medway Integrated Care Board and submitted to NHS England and the Department of Health and Social Care.

Looking ahead our attention is also on a number of projects which will strengthen our opportunities to work collaboratively with our partners and deliver real benefits to our patients. These include:

- Developing our collaboration with West Kent Health and Care Partnership, in particular the development of Integrated Neighbourhood Teams in primary and community care.
- Continuing to provide system support across Kent and Medway and developing, integrating and maximising services at the Spire facility.
- Completing the development of the CDC which will see a modular build to house static MRI, CT scanning, phlebotomy and outpatients. Once complete, it is predicted the CDC will provide an additional 105,000 scans and tests each year.
- Strengthening specialist inpatient cardiology service at Maidstone Hospital. This will enable us to provide increased capacity for inpatient care and an ambulatory area to support our Same Day Emergency Care services.
- Taking forward our programme of development in clinical operations in partnership with our nationally recognised electronic bed management system.
- Developing our patient portal which was launched in November last year. The system helps service users take control of the management of their outpatient appointments and in the first six months 100,000 patients registered for the portal electronic bed management system.
- Completing the integration of pathology services into a Kent and Medway-wide joint venture.

The Trust has taken a fresh approach this year when developing quality priorities by basing them on our corporate projects and linking them directly to the Trust's six Strategic Themes. A key quality priority is to reduce significant avoidable harm and as part of our work in this area we are pleased to have been registered as an early adopter for Martha's Rule. This will ensure patients, families, carers and staff have round-the-clock access to a rapid review from a separate care team if they are worried about a patient's condition. We look forward to participating in this pilot and the benefits this will bring to patient care. How we communicate with patients is also the focus of a quality priority. Work in this area will be supported by the ongoing development of the Trust's digital patient portal. This enables patients to view outpatient appointment details and letters and access online information and resources about their care from any device.

Achieving our vision of exceptional people providing outstanding care remains our motivation and our key priority and I am confident we will continue to build on the progress we've already made and take this into the years ahead.

Miles Scott
Chief Executive

Purpose of the Quality Account

Quality Accounts are reports to the public from providers of NHS healthcare service about the quality and standard of services they provide. Every acute NHS Trust is required by the Government to publish a Quality account annually. They are an important way for trusts to show improvements in the services they deliver to local communities. The quality of services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

Our year on a page

Delivered
59,228
radiotherapy treatments

Processed
713,251
pharmacy prescriptions

Performed
25,873
surgeries

Carried out
78,430
CT scans

Logged
62,603
IT service desk requests

Provided
454,883
outpatient appointments

Welcomed
5,566
babies into the world

Logged
292,056
portering jobs

Cared for
963
patients in our Intensive Care Units

Answered
586,000
calls via our switchboard

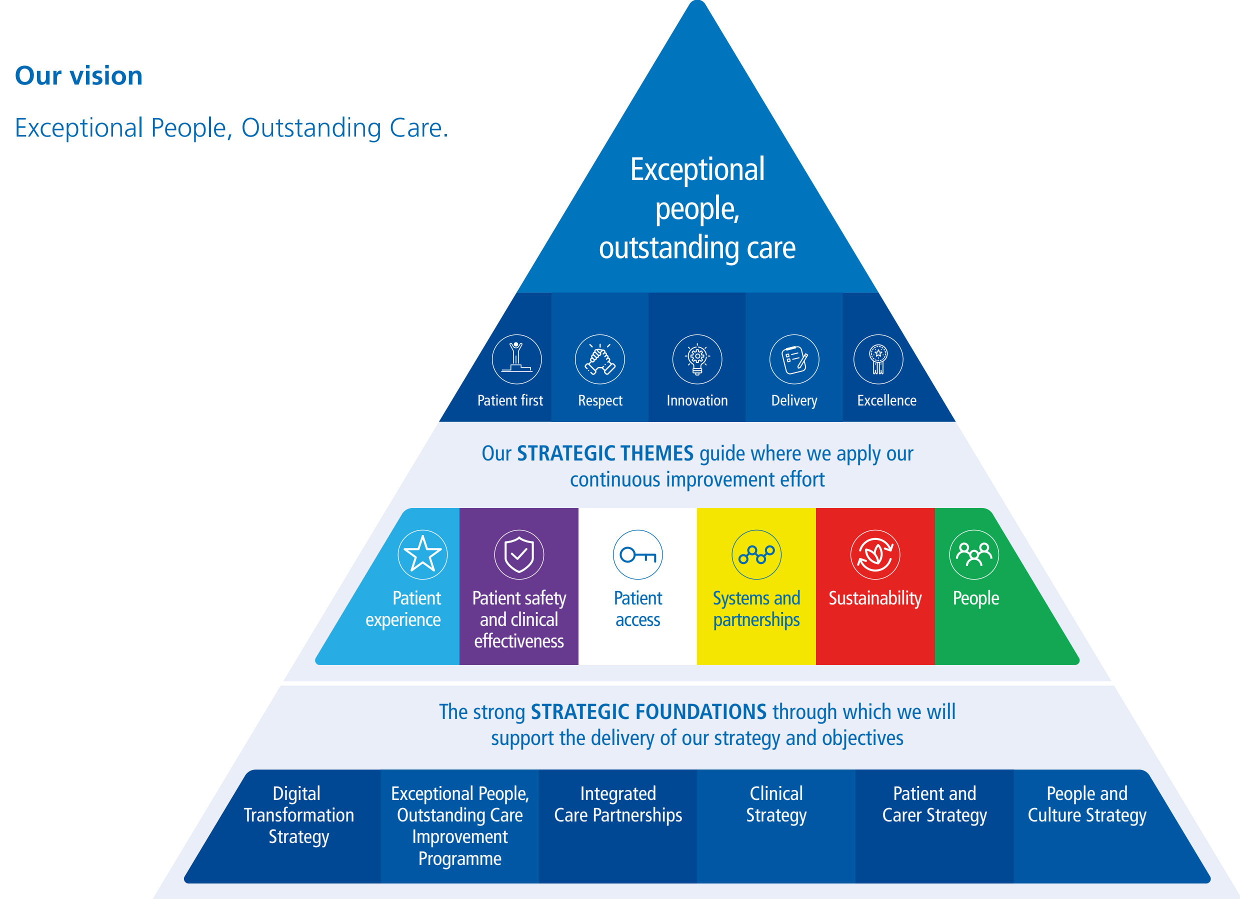
Recruited
1,487
new colleagues

Served
720,000
patient meals

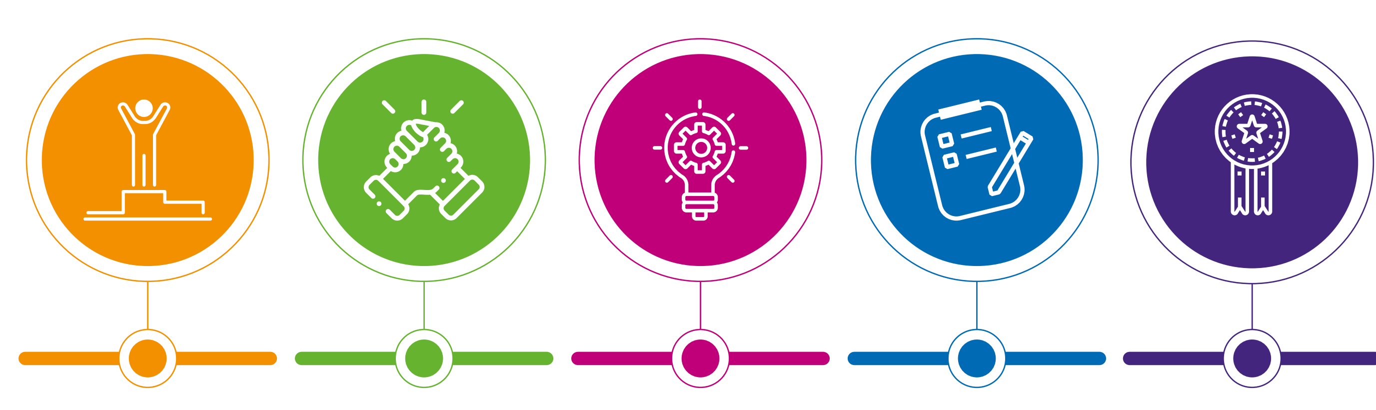
Our strategy, vision and values

Our vision

Exceptional People, Outstanding Care.



Our PRIDE values are at the heart of what we do.



Patient first
We always put the patient first.

Respect
We respect and value our patients, visitors and staff.

Innovation
We take every opportunity to improve services.

Delivery
We aim to deliver high standards of quality and efficiency in everything we do.

Excellence
We take every opportunity to enhance our reputation.

We have three objectives

- To be recognised as a caring organisation
- To provide sustainable services
- To be improvement driven across all areas

Part two

Quality priorities for improvement

Every year the Trust sets quality priorities which represent areas where we would like to see significant improvement over the course of the next year.

These priorities are aligned with the Trust's Six Strategic "Themes", which have been developed by the Executive Team and our clinical leaders to ensure we are delivering outstanding services.

This year, our quality priorities are based on the output of our learning from our internal clinical audit programme, our regular thematic reviews from adverse events and listening to and reviewing patient feedback. We will also include the Trust's top seven big corporate improvement projects as priorities.

We are confident that Maidstone and Tunbridge Wells NHS Trust's (MTW) commitment to quality improvement means our leaders have the right skills to lead on improvement. This has been achieved by the Trust's "Strategy Deployment for Leaders Programme", where leaders of our departments, directorates and divisions have been supported to lead change and improvement workstreams.

Strategic themes

Patient experience: To meet our ambition of always providing outstanding health care quality we need people to have a positive experience of care and support.

Patient safety and clinical effectiveness: Working together to put quality at the heart of all that we do. Achieving outstanding clinical outcomes with no avoidable harm.

Patient access: Ensuring all our patients have access to the care they need to ensure they have the best chance of getting a good outcome.

Systems and partnerships: Working with partners to provide the right care and support, in the right place, at the right time.

Sustainability: Long-term sustainable services providing high quality care through optimising the use of our resources.

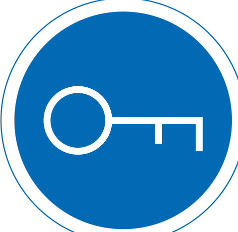
People: Creating an inclusive, compassionate and high-performing culture where our people can thrive and be their best self at work.

These are the key priorities that we need to focus on, that if we get them right, we will know we are delivering high quality care.

Quality improvement priorities for 2024/25:

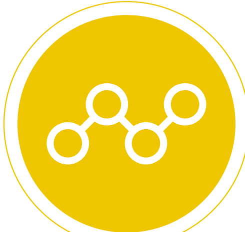
Patient Safety & Clinical Effectiveness

- Reduce significant avoidable harm
- Embedding and delivering the Patient Safety Incident Response Framework (PSIRF)
- Complete the implementation of the Electronic Prescribing and Medications Administration (EPMA) project
- Implement unified Maternity Improvement project



Patient Access

- Patient portal - improve how we communicate with our patients
- Achieve all constitutional patient access standards



Systems & Partnerships

- Reduce the number of delayed inpatient discharges

People

- Improve our staff retention rates
- Achieve a Trust-wide vacancy rate of 7% or less

Patient Experience

- Reduce the number of negative communication themed complaints
- Implement a new Quality Assurance Framework
- Improve upon our care of patients with mental health needs attending MTW

Sustainability

- Reduce our reliance on agency staff

Patient Safety & Clinical Effectiveness

Reduce significant avoidable harm

- We will reduce significant avoidable harm to 0.7 per 1000 bed days (for all severe and above harm).
- We will redesign and launch a revised suite of reporting categories to better identify deteriorating patient type incidents by the end of July 2024.

What will this mean for our patients?
Our patients who are starting to deteriorate will be identified sooner and receive treatments that ensure they have the best chance of recovering from their illness.

Patient Safety & Clinical Effectiveness

Embedding and delivering PSIRF

- We will roll out PSIRF.
- We will complete a deep dive review at year one of PSIRF and a refresh of the MTW Patient Safety Incident Response Plan (PSIRP) as required.

What will this mean for our patients?
Our patients, their families and carers will have the opportunity to be involved in incident investigations. They will be spoken to compassionately and will be supported to share their observations and concerns.

Patient Safety & Clinical Effectiveness

Complete the implementation of EPMA Project

The Electronic Prescribing and Medicines Administration (EPMA) Project will ensure that the Trust has a robust system that delivers safe, high quality and cost-effective ways to order prescriptions across MTW (excluding chemotherapy).

Patient Safety is improved whilst cost of delivering care is reduced.

With the implementation of EPMA by March 2025 the following will be managed electronically:

- 85% of all prescribing of drugs by doctors and/or non-medical prescribers.
- 95% stock management of drugs, on ward.
- 85% of dispensing of discharge medications.
- 100% of EDN (electronic discharge notifications) sent to GP.

What will this mean for our patients?
Our patients will be safer and their discharge from our Trust will be smoother and more efficient.

Patient Safety & Clinical Effectiveness

Implement unified Maternity Improvement Project

- We will implement a unified Maternity Improvement Project to improve upon how we both measure outcome data and our maternity outcomes within our maternity services.
- Our maternity services improvement work will be return the service to an improved Care Quality Commission (CQC) rating by June 2025.

What will this mean for our patients?
Our patients will receive safer care and treatment whilst attending our Trust.

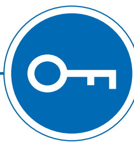
Patient Access

Patient portal - improve how we communicate with our patients

The Patient portal will allow us to improve patient-provider communication through secure messaging, and increased patient participation in healthcare decisions.

What will this mean for our patients?
Our patients will be better informed about their care and will be more actively involved in planning their care.

Patient Access

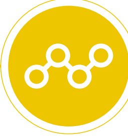


Access to care

- We will ensure that we achieve all constitutional patient access standards.
- We will work to achieve the planned levels of new outpatient activity shown as a percentage of 2019/20.
- We will achieve the Trust referral to treatment (RTT) trajectory by March 2025.

What will this mean for our patients?
Our patients will have shorter waiting times for their outpatient appointments.

Systems & Partnerships



Reduce the number of delayed discharges

- We will work to ensure that no patient resides in an acute hospital bed who needs care that can be provided in another setting.
- We will decrease the number of occupied bed days to 3.5 days (per 1000) for patients identified as no longer fit to reside.
- We will increase the number of patients leaving our hospitals by noon on the day of discharge.

What will this mean for our patients?
Our patients who are ready to be discharged will do so in a timely manner thereby reducing delays for patients waiting to transfer from the Emergency Department (ED) to our wards.

People

Improve our staff retention rates

Flexible working is a key driver of retention. We will agree, implement and cascade flexible working principles across MTW for clinical and non-clinical staff to better promote benefits of a range of flexible options available to all in line with new NHS England (NHSE) best practice.

We will educate line managers on the benefits, options and how to operationalise flexible and hybrid working in line with NHSE/Timewise best practice without impacting patient care (through job planning/rostering).

- We will increase the number of employees with flexible working patterns recorded on our electronic staff record (ESR).
- We will pilot fit for purpose hybrid working spaces in agreed non-clinical sites.

What will this mean for our patients?
Our patients will benefit from a more consistent approach to their care. With a confident, well-trained and content staff base, patients will see a reduction in patient safety incidents and an overall improvement to their experience as a patient at our Trust.

People

Achieve a Trust-wide vacancy rate of 7% or less

- We will improve upon the number of substantive employees working within the Trust.
- We will achieve a Trust-wide vacancy level of 7% by the end of the 2025/26 financial year. This would move MTW into one of the top performing NHS trusts in the South East.

What will this mean for our patients?
Our patients will benefit from a more consistent approach to their care. With fewer staffing shortfalls on a day to day basis, the Trust can ensure a reduction in patient safety incidents and an overall improvement to patients' experience at our Trust.

Patient Experience

We will reduce the number of negative communication themed complaints

- We will reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients' experience.
- We will reduce the overall number of complaints or concerns each month to a target of 24 by March 2024.
- We will work towards having a zero occurrence of negative communication themed complaints.

What will this mean for our patients?
Our patients will see an improvement in the way our staff share information with them. This will mean that information is shared consistently and accurately.

Patient Experience

Mental health in Acute Care

We will improve upon the support and standard of care offered to patients who have a mental health need within our acute care setting.

By May 2025, we will agree a new governance structure to oversee the quality of care offered to this patient group. We will also define a new set of data sets that will help us to better track the outcomes and this patient group's experience of care. And we will develop and launch a new improvement strategy for this patient group. We will invest in and recruit to a new specialist lead role for mental health.

- We will have fully implemented our new governance structure to oversee the quality of care offered to those in our care with mental health conditions
- We will have embedded our Improvement Project and have an established Mental Health Oversight Group
- We will develop and launch a new Mental Health strategy
- We will commit to investing long term to a lead for mental health role

What will this mean for our patients?
Our patients who attend our Trust with a mental health need will receive improved support and care**.** There will be an emphasis on ensuring these patients' experiences and outcomes are used to drive further improvements.

Patient Experience

Quality Assurance Framework

We will implement a new Quality Assurance Framework at Maidstone and Tunbridge Wells NHS Trust that:

- Is embedded in practice.
- Aligns to the new CQC inspection model.
- Measures MTW's performance against the quality statements.

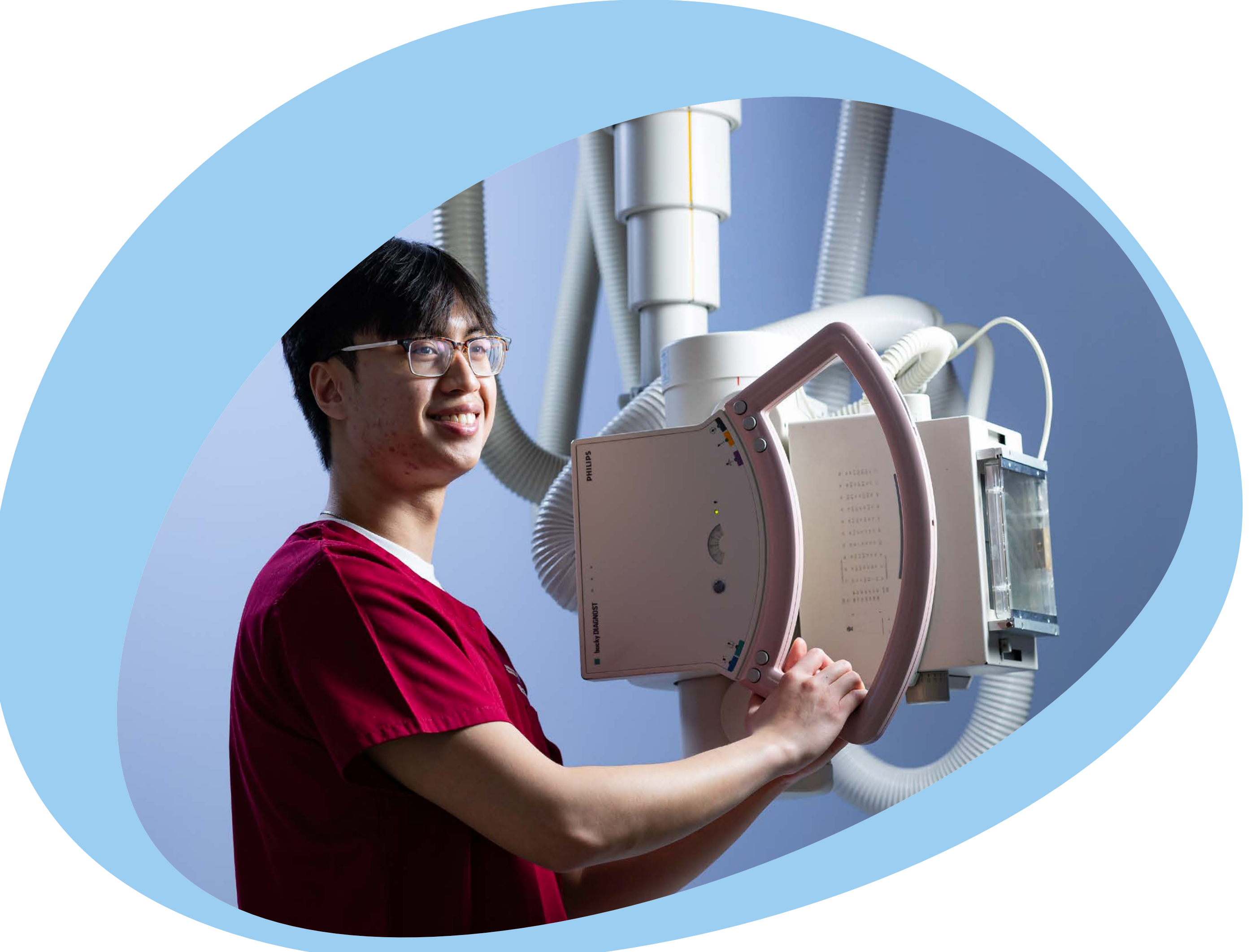
By July 2024 we will have:

- Relaunched a new peer review process at MTW.
- Introduced a new digital CQC self-assessment process across the Trust including implementing improvement plans where gaps are identified.
- Digitalised 20 local pre-existing quality checklists with live performance illustrated within each Division's dashboards.

By October 2024 we will have:

- Digitalised our oversight of guidelines within one MTW division.
- Signed off a MTW Quality Assurance Framework policy that aligns with the above activity.

What will this mean for our patients?
The quality and safety of our patients' care is paramount to the Trust. With an agreed quality assurance framework we will be able to better internally identify areas that require increased support and focus to improve. This will improve upon our patients' experience of care at MTW.



Sustainability

We will reduce our reliance on agency staff

- We will achieve the 2024/25 budget for agency and bank expenditure by March 2025.

What will this mean for our patients?
Our patients will benefit from a more consistent approach to their care. This will help to ensure a reduction in patient safety incidents and an overall improvement to their experience as a patient at our Trust.

Statements relating to the quality of NHS services provided as required within the regulations

In this section we report on statements relating to the quality of the NHS services provided as stipulated in the regulations.

The content is common to all providers so that the accounts can be comparable between organisations and provides assurance that the Maidstone and Tunbridge Wells NHS Trust Board has reviewed and engaged in national initiatives which link strongly to quality improvement.

The Trust is registered with the Care Quality Commission (CQC) to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites and our community diagnostic hub in Maidstone).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre).
- Surgical procedures (at both hospital sites).
- Termination of pregnancies (at Tunbridge Wells Hospital only).
- Treatment of disease, disorder or injury (at both hospital sites).

During 2023/24, Maidstone and Tunbridge Wells NHS Trust provided and/or sub-contracted acute and specialised services to NHS patients through our contracts with Integrated Care Boards, Kent County Council and NHS England. The Trust has subcontracted services to the Independent Sector Providers as part of the Prime Provider Model for elective care. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed for quality purposes in 2023/24 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing standards

To ensure that we are consistently providing services to the required standards, the Maidstone and Tunbridge Wells NHS Trust supported a number of reviews of its services undertaken by external organisations during 2023/24, including the following:

- Care Quality Commission (CQC) Well-led inspection: March - April 2023.
- CQC End of Life Care Inspection: March - April 2023.
- UKAS accreditation (ISO 15189:2012) SU1 Cellular Pathology: May 2023.
- General Medical Council – Trainee and Trainer Survey: March - May 2023.
- King's College London – Biannual Undergraduate Quality Visit: May 2023.
- UKAS accreditation (ISO 15189:2012) SU1 Blood Sciences: January 2024.
- Kent and Medway Medical School – Undergraduate Annual Quality Visit: May 2023.
- HTA – Microbiology (As part of Trauma and Orthopaedics research assessment): August 2023.
- CQC Maternity Inspection Tunbridge Wells Hospital: August 2023 - February 2024.
- Environment Agency – Waste management in Microbiology and Cellular Pathology: September 2023.
- CQC Inspection of compliance against IR(ME)R in Radiotherapy – Kent Oncology Centre: September 2023.
- UKAS accreditation (ISO 15189:2012) SU1 Microbiology: October 2023.
- Regional Quality Assurance of:
  - Aseptic Preparation Services assessment (October 2023).
  - Cellular Pathology (January 2024).
- UKAS transition visit against ISO 15189:2022 standards for Microbiology: October 2023.
- UNICEF Baby Friendly Inspection (BFI) Stage 3 Assessment: October 2023.
- CQC Routine Maternity Inspection: November 2023.
- UKAS accreditation (ISO 15189:2022 Transition assessment) Microbiology: November 2023.
- Independent inquiry into the issues raised by the David Fuller case Phase 1 Report: November 2023.
- UKAS accreditation (ISO 17043:2010) proficiency testing SE England General Histopathology EQA scheme: December 2023.
- UKAS reassessment visit against ISO 17043:2012 for EQA scheme: December 2023.
- UKAS accreditation (ISO 15189:2012) SU2 Cellular Pathology: January 2024.
- UKAS surveillance visit against the ISO 15189:2012 standards for:
  - Cellular Pathology: July 2023.
  - Microbiology: October 2023.
  - Blood Sciences: December 2023.
  - Cellular Pathology: January 2024.
- CASPE (Clinical Accountability, Service Planning and Evaluation) Healthcare Knowledge System (CHKS) (ISO 9001, CQC, Peer Review, TSR and Francis Rec.) Radiotherapy, Medical Physics (including E.M.E. Services), Chemotherapy, Clinical Trials, Oncology Outpatients, Clinical Haematology, admin and clerical site visit: February 2024.

External auditors

We work with TIAA (a company who specialise in undertaking internal audit programs) to audit key activities within the Trust in an effort to identify strategic, operational and financial risks.

TIAA undertook 12 reviews in total of which 11 were assurance reviews and the remaining one was an advisory review. Two assurance reviews provided substantial assurance, five provided reasonable assurance and four provided limited assurance.

There were no reviews that received no assurance. TIAA made 61 recommendations following the reviews of which nine were urgent, 23 were important and 29 were routine.

Internal reviews

Internally, we have the following reviews to assess the quality of service provision:

- Internal assurance inspections (based on the CQC methodology) with participation from our patient representatives and quality leads from the NHS Kent and Medway Integrated Care Board (ICB).
- Internal PLACE (Patient-Led Assessments of the Care Environment) reviews, Infection control reviews, including hand hygiene audits.
- Trust Board member "walkabouts".
- Matron's Quality Checks.

The outcomes of these assessments are included within our triangulation process to review clinical areas and identify any areas where additional support and actions are required to maintain standards. Action plans are developed locally and, alongside the associated reports, are scrutinised in the Quality Improvement Committee, within our governance structure and monitored accordingly.

Clinical Audit

Participation in national clinical audits, national confidential enquiries and local clinical audit is mandated and provides an opportunity to stimulate quality improvement at Maidstone and Tunbridge Wells NHS Trust. Identified aspects of care are evaluated against specific criteria to ascertain compliance and quality. Where indicated, changes are implemented and further monitoring is used to confirm improvement in healthcare delivery.

In 2023/24 MTW participated in eight (100%) of all relevant confidential enquiries and 91% (52/57) of all relevant national clinical audits. During the same period, MTW staff successfully completed 126 clinical audits of the 170 due to be completed (local and national) to action plan stage.

Actions plans were developed for the completed clinical audits that were not fully compliant and presented an opportunity to implement improvements. Examples of these improvements are listed in the tables below.

The remaining audits are at various stages of completeness and will be monitored through to completion. In 2023/24, 30 national clinical audits and confidential enquiries published full reports that covered the relevant health services provided by Maidstone and Tunbridge Wells NHS Trust. The Trust reviewed 24 of the national clinical audits and confidential enquiries that were published in 2023/24 and a further 30 national clinical audits and confidential enquiries that had been carried over from 2022/23. Work continues on the remaining reviews.

The list of Healthcare Quality Improvement Partnership (HQIP) national clinical audits and national confidential enquiries (NCEPOD National Confidential Enquiries into Patient Outcomes and Death) that Maidstone and Tunbridge Wells NHS Trust was eligible to participate in and participated in during 2023/24 can be found in Appendix A.

A full list of the clinical audits reviewed and the opportunities identified to implement changes for improvement is available from the Trust upon request by contacting Clinical Audit - mtw-tr.ClinicalAudit@nhs.net

Examples of the actions developed for the 54 national clinical audits that were reviewed by the Trust in 2023/24:

National Clinical Audit	Improvements to be implemented
HQIP National Diabetes Footcare Audit (NDFA)	To provide an increase in podiatry services with the aim to provide inpatient services to both sites of the trust.
	Use the audit findings to encourage commissioners and service managers to ensure NICE recommended diabetes foot care service is in place.
HQIP National Neonatal Audit Programme (NNAP)	Increase numbers of neonatal nurses and improve retention of this staff group. Recruit new nursing staff that are British Association of Perinatal Medicine (BAPM) compliant to include qualified Advanced Care Practitioners (ACP) and trainee ACPs.
HQIP ICNARC (Intensive Care National Audit and Research Centre)	Improve patient flow / delayed discharges - across Intensive Care and High Dependency Units at Tunbridge Wells Hospital by increasing Site Team and Command Control Centre (CCC) awareness of ward fit patients in Intensive Care.
HQIP National Prostate Cancer Audit	Consider establishing radiotherapy centre specialist gastrointestinal services to offer advice to people with bowel-related side effects of radiotherapy and develop firm links with a dedicated Gastroenterologist.
	Undertake internal audit and review of radiotherapy treatment delivery processes. Audit acute and late toxicity for three cohorts of patients reflecting changes made to the Prostate Radiotherapy Treatment Protocol since 2020.
NCEPOD Testicular Torsion study	Ask clinicians to add orchidectomies to the morbidity database for discussion at morbidity and mortality meetings.
National End of Life Audit 22.23 (Fourth Round)	Hospital Specialist Palliative Care Team to undergo workforce review to ensure sufficient staff to provide a seven-day service.

Examples of the actions developed for the 72 local clinical audits that were reviewed by the Trust in 2023/24:

Local Clinical Audit	Improvements to be implemented
Trust-wide Nasogastric (NG) Tube audit	Reduce pressure on staff for data collection of the clinical audit. Automate data collection from Sunrise document for future audits.
	Business case completed and actioned. Post to go out for recruitment. Urgent need for nutrition nurses to carry out the audits, provide training and ensure improvements in patient safety are achieved.
Re-audit Obstetric Cholestasis	Update flowchart to reflect new and updated guidelines. Print out the flow chart and place it in clinic rooms and triage.
Re-audit Maidstone and Tunbridge Wells NHS Trust Operating Theatres - Benchmarking of Perioperative Standards Audit	Trained Dementia Champion required for Maidstone Theatres. Already appointed a member of the staff as Dementia Champion at Tunbridge Wells and will take this link role for Maidstone Theatres.
Immediate Sequential Bilateral Cataract Surgery (ISBCS) audit	Agreed criteria for patient selection - patients who are at low risk of ocular complications during and after surgery, patients who need general anaesthetic (GA) for cataract surgery but for whom GA carries an added risk of complications or distress.
Re-audit Accuracy and completeness of Do not attempt cardiopulmonary resuscitation (DNACPR) orders	Liaise with electronic notes team regarding a compulsory prompt for senior review and endorsement and review of dates so that these are not overlooked on forms.
Mental Capacity Assessment (MCA) Audit	To develop a mental capacity competency framework for all registered practitioners using the MCA code of practice, when application of MCA is required in their day to day roles.

Research and Innovations

The past year has been very busy for the Research and Innovation Team and the last year has been one of the most research-productive at MTW yet. A number of new initiatives were introduced which are propelling research and innovation to new heights.

There has been a change in the culture of the delivery team over the last year in response to the Trust Research Strategy (2021-26) and the publication of 'Making Research Matter – Chief Nursing Officer for England's Strategic Plan for Research' (2021). Work has taken place to:

- Ensure that research opportunities are visible to clinicians and most importantly to patients.
- To increase patients' access to research and offer them more choice in their treatment options.

We believe that involving patients and the public in the design, development and delivery of research is paramount to ensuring that our efforts are aligned with their needs and priorities. We are strengthening our outreach work, facilitating open and inclusive dialogues, and ensuring that the voices of those we serve are heard, and incorporated into our research endeavours.

Our first research patient event was held for haematology patients and was very well received. A plan is in place to roll out similar engagement events for all research active areas of the Trust.

Expanding our MTW-led research and innovation portfolio is of prime importance. Our staff are brimming with innovative ideas so we are working on creating an MTW Seed Fund to pump-prime collaborative, grassroots projects for first-time researchers, enabling them to explore potentially life-changing discoveries and take the first step in their research journey.

A number of bids for research funding were submitted to the National Institute for Health and Care Research (NIHR) and other grant awarding bodies last year to support MTW research, totalling over one million pounds. Funding was sought to support research vaccination provision across Kent and Medway and to support research into gastric surgery.

In the autumn, MTW successfully secured the national Cancer Vaccine Launch Pad study. The project enables NHS patients with cancer to participate at the earliest possible opportunity in cancer vaccine trials and to accelerate the development of cancer vaccines. The Research and Innovation Team is working with surgical and Kent Cancer Centre staff to deliver this trial and offer this national study to eligible colorectal patients.

MTW is committed to driving continuous improvement and embracing innovation to enhance patient care and operational effectiveness. As such, we welcomed a new Innovation Manager in January, to cultivate an environment that fosters creative thinking, accelerates the creation, development, and adoption of new ideas, and streamlines the translation of research into tangible healthcare solutions.

During the first three months, the Innovation Manager has engaged in several key activities to lay the groundwork for the future growth of innovation at MTW:

Partnerships and Collaboration

- Working to strengthen strategic partnerships with local academic institutions, industry leaders, funding bodies, other NHS Trusts and public sector organisations to work together to find solutions to healthcare problems.
- Engaging with our Patient and Public Involvement and Engagement (PPIE) team to recruit a dedicated Patient Champion for innovation to ensure that our projects are aligned with real-world challenges and opportunities.

Promotion, Engagement and Fundraising

- Updating and promoting our innovation support offer to MTW staff and prospective external partners with the view of generating a pipeline of collaborative projects, from diagnostics and therapeutics to service delivery models – championing both clinical and corporate innovation.
- Establishing the Research and Innovation Charity fund. Contributions will be instrumental in furthering our work.

Innovation Projects

- We currently have nine registered innovation projects in various stages of development. These include a mix of commercial and investigator-led collaborations across various specialities, including Radiotherapy, Cardiology, Palliative Care, and Pathology. Looking ahead, the Innovation Manager will continue to build upon these foundational efforts and expand the scope of our work.

By fostering an environment that celebrates and enables innovation, R&I aims to position our Trust at the forefront of healthcare transformation, delivering tangible improvements in patient care and operational excellence.

A number of MTW staff were recognised for their involvement in research. The year ended with the Peggy Wood Breast Care Centre receiving an NIHR award in recognition of their support in delivering breast cancer studies.

Goals agreed with commissioners

This section describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The intention of the CQUIN framework when it was initially introduced was to support the cultural shift within the NHS to ensure that quality is the organising principle for all NHS services.

It provides a means by which payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals.

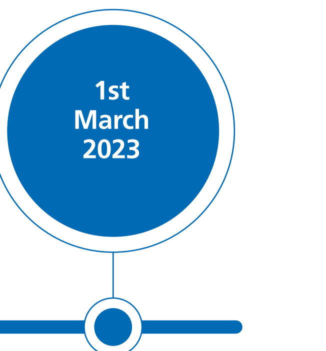
In 2023/24 our Integrated Care Board asked our Trust to focus on achieving the following key CQUINS:

- Prompt switching of intravenous to oral antimicrobial treatment: Achieving 40% (or fewer) patients still receiving intravenous (IV) antibiotics past the point at which they meet switching criteria.
- Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service: Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via a secure electronic message.
- National Early Warning Score (NEWS2): Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a National Early Warning Score (NEWS2) time of escalation (T0) and time of clinical response (T1) recorded.
- Reducing the numbers of pressure ulcers: Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
- Identification and response to frailty in emergency departments: Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
- Staff Flu Vaccinations: Ensuring a 90% uptake of flu vaccinations by frontline staff with patient contact.
- Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery: Ensure at least 75% of patients are aware of any material risks involved in the recommended treatment and are also aware of any reasonable alternative treatments via SDM conversations.
- Treatment of non-small-cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway: Achieve 85% of adults with non-small-cell lung cancer (NSCLC) stage I or II and good performance status having treatment with curative intent.

NHS England has paused the CQUIN programme for 2024/25.

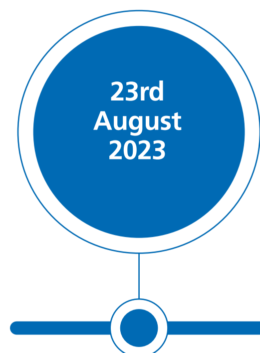
Statements from the CQC

Visits



Unannounced Inspection of End of Life Care Services

Routine Well-Led Inspection



Unannounced Maternity Safe and Well-Led Inspection

Proactive Radiotherapy IR(ME)R inspection

Routine Maternity Inspection

The CQC inspected the Trust on four occasions in 2023 with the last visit in November 2023 to our birthing centres in Crowborough and Maidstone.

In March 2023, the CQC carried out a Well-Led review of the Trust and reviewed one service, End of Life Care. MTW was once again rated as 'Good' for leadership and has been rated as "Requires Improvement" for End of Life Care.

As this was a focussed rather than a full inspection, the overall rating of Requires Improvement for the Trust remains unchanged and is based on the findings of the CQC's last comprehensive inspection in 2017.

As part of the CQC's National Maternity Programme in August 2023 our maternity service at TWH was inspected and the service was rated as "Inadequate", the CQC made a number of recommendations which focused on governance, processes and documentation in the Trust's maternity units. The Trust has taken steps to address all of these recommendations, many of which are now completed. These included:

- Undertaking a multidisciplinary workforce review within maternity services.
- The implementation of new guidelines on induction of labour.
- Additional training and new guidelines on the management of postpartum haemorrhage (PPH).
- Streamlining of the emergency theatre pathway.
- Improving the use of the data we capture and report on.

MTW NHS Trust are pleased that the CQC also highlighted examples of good practice and care at MTW. These included:

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

Following an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection in September 2023, the CQC issued an Improvement Notice regarding concerns linked to our quality assurance processes, specifically this related to our documentation and management of our radiation incidents. MTW NHS Trust submitted evidence regarding these concerns and was deemed to comply with the notice on 22 September 2023.

The Trust monitors compliance with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections and its quality governance framework.

Last rated
31 August 2023

Maidstone and Tunbridge Wells NHS Trust

Improving data quality

Maidstone and Tunbridge Wells NHS Trust is committed to providing services of the highest quality. Specifically, MTW needs to ensure its information is:

- Consistently captured;
- Recorded accurately;
- Securely shared within the boundaries of law.

NHS Number and General Medical Practice Code Validity

Data quality is also monitored for each submission the Trust is required to make throughout the year to NHS Digital, Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number was (as at Month 11):

- 99.8% (99.8% 22/23) for Admitted Patient Care
- 100% (100% 22/23) for Outpatient Care
- 99.4% (99.2% 22/23) for Accident and Emergency Care

The Trust has developed a data quality dashboard to assist service managers and clinicians.

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's (NDG) 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Organisations must make an annual submission supported by appropriate evidence to demonstrate that they are working towards or meeting the required standards.

The deadline for the 2023/24 DSPT is 30th June 2024. The Trust continues with its preparations for the submission and has requested TIAA complete an independent audit of the evidence gathered by the Trust to support its submission. The assertions audited are selected by NHS Digital, this will test the evidence for completeness and validity.

In June 2023 the Trust submitted the annual return for 2022/23 as 'Standards Not Met' due to NDG Standard 8, 'Unsupported systems' not being fully compliant with some limited assurance. NHS England were consulted and an action plan and timeline proposed. This was reviewed and approved by the Trust Board and NHS England with the status of the toolkit amended by NHSE to 'Approaching Standards' in August 2023.

It is anticipated that the Trust will again submit a 'Standards not met' assessment for 2023/24. The Trust remains in regular contact with NHS England to review the action plan at quarterly intervals. It is anticipated that the status of the DSPT will again be reassessed by NHS England to 'Approaching Standards' in July 2024.

In addition, the Senior Information Risk Owner, Data Protection Officer and Information Governance Lead regularly update the relevant committees and Trust Board, appraising of the progress of the project and any relevant governance updates affecting the organisation as required.

Clinical Coding

Code Type	Percentage Correct	Data Quality section of Data Security Standard 1 Level of Attainment	
		Standards met	Standards exceeded
Primary Diagnosis	96%	90% or above	95% or above
Secondary Diagnosis	93.10%	80% or above	90% or above
Primary Procedure	96%	90% or above	95% or above
Secondary Procedure	91%	80% or above	90% or above

The Clinical Coding Team at MTW have achieved "Standards Exceeded" in the Data Security and Protection audit for six consecutive years. Showing an increase in accuracy from 2022/23 for both secondary diagnosis and primary procedures.

Improvements:

We continue to work closely with our Coding Colleagues across Kent and Medway and at MTW we have delivered a comprehensive Clinical Coding Data Quality Improvement programme which has led to improvements in the quality of the clinically coded data.

Part three

Results and achievements against the 2023/24 quality priorities

The information below summarises the quality improvement priorities we set out to achieve during 2023/24.

Patient safety

Aim

Ensure robust processes are in place to measure and reduce avoidable harm.

Priorities

- Improve our sepsis pathway.
- Improve the management of our patients at risk of falling.
- Improve our Maternity services safety performance.
- Improve the systems in place to minimise risk to patients who have "Nasogastric Tube" care needs.
- Improve upon our intracranial haemorrhage clinical pathway.
- Develop processes to automate our data collection processes linked to clinical audit.

Patient experience

Aim

To ensure that patients have positive experiences in our care and are involved in developing and improving our services.

Priorities

- Redesign and launch a new patient experience improvement strategy with the help of our patient partners.
- Improve our responsiveness to our patients who have cause to complain.
- Improve our patient experience services and processes.
- Improve our end of life care support to our patients.

Clinical effectiveness

Aim

To improve the management of our patient journeys through the utilisation of evidence-based practice.

Priorities

- Improve our orthopaedic pathway by building the Kent and Medway Orthopaedic Centre.
- Improve our complex cardiology services.
- Finalise our plans to establish a Hyper Acute Stroke Unit and an Acute Stroke Unit.
- Improve patient flow across our hospitals.
- Improve waiting times for our patients.
- Improve reporting turnaround times for our patients who have had tests.

Patient safety

Aim: To sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.

Priority: Embedding a safety culture within the Trust through ongoing implementation of the National Patient Safety Strategy.

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
We will improve our Sepsis Pathway.	We will reduce adverse incidents resulting in harm linked to sepsis management by 90%. Target date of June 2024 set against 2020-2022 average performance.	There were no serious incidents (SIs) for sepsis reported for patients attending the Trust from April 2023 to February 2024.	Completed, achieved
We will improve upon our management of inpatient falls.	We will reduce our inpatient falls rate by 16% (aligned to strategic deployment review (SDR) Harm reduction metric for 2023/24).	The Trust has achieved a 14% reduction on the rate of falls per 1000 occupied bed days over the last ten months to 31st January 2024 (full year's data not yet available).	Ongoing, partially achieved
We will Improve our Maternity performance linked to our antenatal gap and grow measurement processes and improving how we monitor Mothers for signs of high blood pressure.	To continue to have no adverse events linked to antenatal "Gap & Grow" measurements and the monitoring of hypertension.	There was one adverse event linked to antenatal "Gap & Grow" measurements in 2023/24. The Trust training materials were reviewed and the new GAP 2.0 training programme will go live on the 1st April 2024. Blood pressure in pregnancy management: Hypertension guideline reviewed and updated after a cluster of incidents. Review revealed no overarching themes related to the incidents.	Ongoing, partially achieved
We will improve the safety of our Maternity services by delivering against all of the patient safety recommendations as outlined in the 2022 Ockendon report and the 10 key elements of the National Better Births Plan.	Evidence will be collated and uploaded to our Trust safety systems which will demonstrate assurance that each required action has been completed.	The recommendations from the three year delivery plan have been mapped to our new Overarching Improvement Plan. Each of the actions from the CQC report has also been mapped to the four themes of the three year delivery plan. This plan will be the focus for all the improvement workstreams in the Directorate and should be finalised by the end of June 2024.	Ongoing, partially achieved

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
We will improve upon the care of our patients who have nasogastric tube care needs.	60% of registered nurses in high use/acuity departments will have been trained and signed off as competent against the new framework.	Over the last year we have rolled out the NG eLearning training for eligible staff members across different professional groups (993). The compliance is now at 71%.	Completed, achieved
We will improve upon our patient outcomes for patients who have suffered an "Intercranial Haemorrhage / bleed" by improving our adherence to national best practice guidance.	Re-audit of the Management of Intercranial Haemorrhage against national best practice guidance results.	Re-audit currently in progress.	Ongoing, partially achieved
We will work with our health informatics team and clinical leaders to automate 10% of our "clinical audit" data collection processes This will release more of our frontline clinical staff's time.	10% of the current mandatory national clinical audits that are applicable to the Trust (50) will be automated by June 2024.	Limited progress has been made due to staff shortages in Clinical Audit and freezes on coding in the Sunrise Team.	Ongoing, not achieved

Improving patient experience

Aim: To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.

Priority: Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'.

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
With the help and input from our patient partners we will redesign and launch a new patient experience improvement strategy.	The strategy will be finalised and approved by our patient experience committee and Trust Board by December 2023.	We have been going through the process of re-writing our strategy for the next five years from 2024. We have been working with NHSE to complement the new Experience of Care framework and were delighted to be chosen as a pilot site for this.	Completed, achieved
We will increase our internal capacity to better respond to our patients when things have gone wrong by changing our Trust complaints handling target from 75% to 90% (the percentage of complaints responses being delivered within the timescale agreed with our patients).	By March 2024 we will have amended out Trust complaints handling target and this will be reflected in our Trust Board Integrated Performance Report.	Focus has been on stabilisation and recovery of the complaints performance. Our target has been changed to achieving 75% consistently by October 2024.	Ongoing, not achieved

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
We will amend our patient experience workforce model to ensure it meets the recommendations detailed in the new national complaints framework.	The new workforce model and processes aligned to the latest national complaints framework will be launched by March 2024.	Funding has been secured via a successful business case to ensure our workforce models are reconfigured to support this change. The new workforce model and processes align to the latest national complaints framework, which will be reflected in an updated complaints policy by July 2024.	Ongoing, partially achieved
We will improve upon our end of life care by implementing the recommendations from our latest national end of life care audit.	Assessing Trust compliance against 2022/23 National End of Life Care Audit (NACEL) report.	The End of Life Care Committee has been restructured to form six workstreams (Strategy and Delivery, Audit and Research, Governance and Risk, Education and Training, Digital and IT, and Security and Dignity of the Deceased Patient) to deliver on the MTW End of Life Care Action Plan. This action plan is informed by NACEL recommendations, national guidelines and CQC actions and is designed to equip the Trust to deliver high-quality, compassionate, and holistic End of Life Care.	Completed, achieved

Clinical effectiveness

Aim: To improve the management of our patient journeys through the utilisation of evidence-based practice.

Priority: Improving the flow of patients into and out of our wards and departments

Improving our clinical pathways

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
Improving our orthopaedic pathway by building Kent and Medway Orthopaedic Centre.	By June 2024, our new Theatres will have opened and evidence will have been collected to demonstrate improved patient experience and increased operating activity.	Delay in completion of building project, however building is on track to be completed by the end of May 2024 with preparations for the theatres to open taking place in June 2024.	Completed, achieved
Improving our complex cardiology (heart) services.	By June 2024 the new cardiac catheter laboratory will be in place.	Part of our cardiology improvement is in place. The reconfiguration of specialist cardiology services is progressing.	Ongoing, partially achieved
Finalising our plans to establish a Hyper Acute Stroke Unit and an Acute Stroke Unit.	By January 2024 the new stroke units will have launched.	1. The Hyper acute and acute stroke units (HASU/ASU) will be completed at the end of March 2024. The delay from 2022/23 was due to construction challenges unknown before building commenced. 2. The new unit will provide a HASU/ASU in line with national stroke standards and an assessment bay and clinic space to support patients on an ambulatory pathway. New pathways have been developed to streamline cases and provide the most effective care in the right setting for our patients. 3. Local patients from both MTW and Medway will have new and streamlined facilities which will enable staff to deliver care more efficiently and effectively.	Completed, achieved

Improving our operational clinical effectiveness

What we set out to achieve	How we planned to measure our success	Our performance	Did we succeed?
Improving patient flow across our hospitals.	By June 2024 90% of our patients will receive an initial assessment in our EDs within 15 minutes of their arrival.	65.1% of our patients receive an initial assessment within 15 minutes in our EDs as at 1st March 2024. A review has been completed of our current triage and documentation processes. A decision has been made to redesign our pathway based on the Manchester Triage System.	Ongoing, partially achieved
	All actions from the "Safer, Better, Sooner" improvement programme based upon the improved utilisation of our digital patient TeleTracking system will be delivered by June 2024.	Teletracking – Continued improvements being made to increase efficiencies.	Ongoing, partially achieved
Improving the waiting times for patients using our surgical and cancer services.	By June 2024 we will have implemented a 7-day a week acute oncology service (AOS) for our cancer patients.	We have a 7-day AOS service in place across both sites, Mon-Sun 9-5pm. This is also offered on bank holidays (only day not available on site is Christmas day but there is an on call service that day).	Completed, achieved
	By June 2024 we will have maintained our zero 52 week position.	Overall this has been achieved, however there were a few breaches for one or two specialties in 2023/24. Many specialties are now working towards to a zero 40 week wait for their patients.	Completed, achieved
Improving upon the time it takes for our services to review and provide reports for our patients who have had scans	We will be able to demonstrate improvements in the time taken to report patient scans and histopathology tests against 2021/22 activity levels	From both a pathology and radiology perspective, there has been significant work undertaken looking at the turnaround times and some positive steps in terms of how we manage, including ensuring appropriate KPIs and workload allocation. Unfortunately the demand on both services has grown significantly which has reduced the impact of any improvements made.	Ongoing, partially achieved

Further review of quality performance

The dedication and innovation of its staff has enabled MTW to become one of the top performing trusts in the country. It is one of the only trusts in England to have no long waiting patients (those waiting more than 52 weeks for planned surgery), is regularly in the top five in the country for emergency department performance and has delivered the national cancer standard consistently for over four years.

In this year's survey, staff experience scores across all seven NHS People Promise themes have improved, and even more staff say that they would recommend the Trust as a place to work compared with last year, placing MTW in the top ten acute trusts for improved scores in this important measure.

MTW Stroke Service

The latest Sentinel Stroke National Audit Programme (SSNAP) has awarded an overall A-rating to the Stroke Unit at Maidstone Hospital. The latest results mean the Unit is currently the highest-rated stroke service in the Kent and Medway region, placing Maidstone and Tunbridge Wells NHS Trust (MTW) in the top 5% of acute trusts in the country for stroke care.

The national healthcare quality improvement programme measures how well stroke care is being delivered in the NHS in England. The SSNAP provides information to clinicians, commissioners, patients and the public which can be used to improve the quality of care that is provided to patients.

The Trust's Stroke Unit treats around 1,000 stroke patients every year. A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. Urgent treatment is essential, as the sooner a person receives treatment for a stroke, the less damage is likely to happen.

Ten categories are individually scored as part of the SSNAP, ranging from scanning and specialist assessment to physio and discharge processes. The result for each category contributes to the overall score. As part of their overall A-rating, our Stroke Unit's performance was above the national average in a number of areas, including patient assessment times and the provision of therapy.

Emergency Department

Quality performance standard	Trust results	How did we do?
95% of patients should be seen, treated, admitted or discharged within 4 hours of arrival in Emergency Departments (ED).	85.4% of our patients were seen, treated, admitted or discharged within 4 hours of arrival in ED.	Ongoing, partially achieved
50.0% of patients arriving in the Emergency Departments to be treated within 60 minutes of arrival.	The Trust achieved this standard treating 65.2% of patients within 60 minutes of arrival.	Completed, achieved
95% of patients arriving in the Emergency Department should be assessed within 15 minutes of arrival.	The Trust did not achieve this standard with 64.2% of patients arriving in the ED being assessed within 15 minutes of arrival.	Ongoing, not achieved

Cancer waiting time targets

From October 2023 the Cancer waiting times (CWT) standards were updated and a number of the individual targets are no longer monitored as national CWT standards.

With the change in the CWT standards, there has been variable achievement of the combined standards from October 2023 and there is not yet a full year of reportable data available.

Quality performance standard	Trust results	How did we do?
28 day Faster Diagnosis - 75% of patients to be told that they either have a diagnosis of a cancer, or a non-cancer diagnosis within 28 days of referral.	For the six month period from October 2023 to March 2024, the Trust achieved 77.9%.	Completed, achieved
31 day Treatment - 96% of patients with a diagnosis of cancer to start their first definitive treatment (FDT), or any Subsequent Drugs, radiotherapy (RT), or surgery within 31 days of decision to treat (DTT).	Combining the subsequent treatments with the first definitive treatments has affected the achievement of this standard until March 2024, where the Trust successfully achieved 96.0%.	Completed, achieved
62 day Referral to Treatment - 85% of patients referred as an Urgent Suspected Cancer, OR as a Breast Symptom referral, OR through a Screening Service, OR with a Rare Cancer Diagnosis, OR as an Upgrade to start their first definitive treatment (FDT) within 62 days of referral.	The Trust continued to achieve the 62 day standard throughout 2023-24, and for the six month period from October 2023 the Trust achieved 85.67% against the new combined 62 day standard.	Completed, achieved

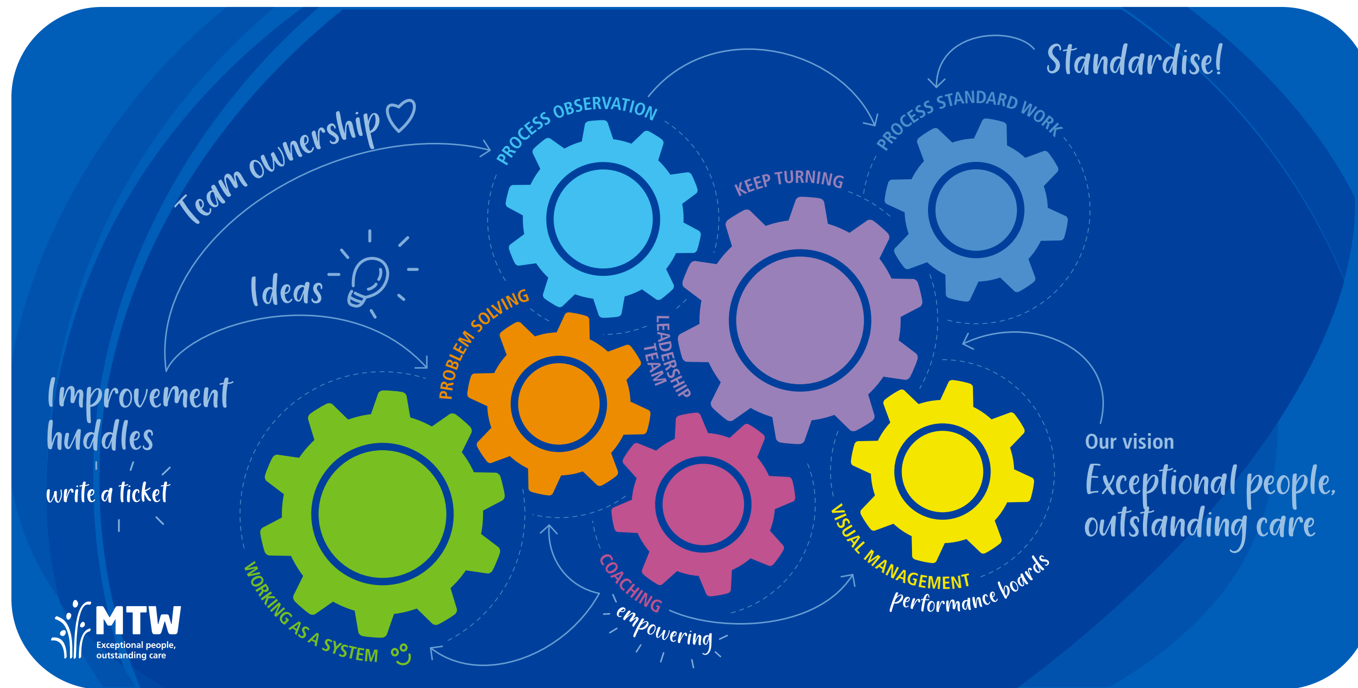
Other operational quality performance standards

Quality performance standard	Trust results	How did we do?
18-week standard: 92% of patients on an incomplete pathway should be treated within 18 weeks. Internal Trust target 75.8%	The Trust did not achieve the national standard of 92% of patients on an incomplete pathway being treated within 18 weeks (75.1%), however the Trust narrowly missed its internal target of 75.8%.	Ongoing, partially achieved
Cancelled operations standard: <0.8% of operations should be cancelled at the last minute.	The Trust achieved this target with 0.7% of operations cancelled at the last minute.	Completed, achieved
Venous thromboembolism (VTE) risk assessment standard: 95% of patients to be risk assessed for VTE on admission	The Trust ensured that 94.9% of patients had a VTE risk assessment completed on admission to hospital in 2023/24.	Completed, achieved
Reducing the number of patient falls	Trust average was 6.06 falls per 1000 occupied bed days (OBDs) in 2023/24. The Trust target is 5.96 falls per 1000 OBDs or less. This was achieved in 6 out of 12 months for 2023/24.	Ongoing, partially achieved
Improving care for patients who have had a stroke standard: 80% of stroke patients to spend 90% of their time on a dedicated stroke ward.	78.4% of stroke patients spent 90% of their time on a dedicated stroke ward.	Ongoing, partially achieved

Patient First Improvement System

Our vision at MTW is exceptional people, outstanding care and the Patient First approach supports us to achieve this ambition by empowering staff to make changes that will benefit our patients. In September 2022, we launched our Patient First Improvement System (PFIS) which trains teams to use new problem-solving skills to improve their processes and make continuous improvement part of their day to day duties.

18 months on and by mid-April 2024, a total of 46 clinical and non-clinical teams will have received training across all divisions of the Trust. By the end of 2024, approximately 500 staff members will be PFIS trained.



As part of PFIS, patients, staff and visitors can raise tickets with suggested improvements. The trained teams then hold regular huddles to discuss suggestions and decide how to implement them. Over 400 improvement tickets have been raised across the teams since January this year, resulting in the implementation of a number of projects to improve the experiences of patients and staff across the Trust. Recent improvement projects have included:

- The Short Stay Surgical Unit has implemented FP10 prescription forms to enable patients to obtain medication from a local pharmacy. This has been most impactful for patients on evening lists who were waiting overnight for Pharmacy to dispense medication before discharge, as it means they can now go home sooner.
- Finance have implemented better processes around finance coding, which have improved the accuracy of reporting and the manual resources needed to do this.
- Peale Ward has achieved a 100% compliance with lying/standing (L/S) blood pressure for two months in a row after raising an improvement ticket. Compliance with L/S blood pressure is important as it has an impact on the reduction of falls. When the Falls Team were auditing, Peale's scores were consistently low, suggesting the team were not completing them which may put patients at risk, however, the team were not ticking the correct section on Sunrise because they had not received the right training. By doing some focused work and applying structured problem solving they got to the root cause and implemented their solution.
- New dissection benches are being introduced in some of our laboratories to help turnaround times. More benches mean that the team are able to process more samples and still have people being trained. When training, there is much more time needed and so the benches are taken up for extended periods of time. A business case was written to address this as the labs are having more work each year, the complexity is higher and also there are a larger quantity of slides per sample. Recruiting reporting clinicians is challenging, so the best way is to grow our own, but that takes time and space.
- Teams on Ward 21 now complete bedside handovers so that they are able to monitor the weaning off of oxygen before doctors do their rounds. The issue was that the observations were being taken early in the morning, the handover was taking place from shift to shift and only at the doctor's rounds was it recognised if the oxygen needed to be reduced. Now by handing over by the bedside this can be checked and weaning started before the doctors see the patient. This will improve patient experience, clinical effectiveness and enable earlier discharges.

  They are now also using computers on wheels for handovers rather than paper. The benefit of this is the information is live and up to date rather than using a handover sheet that is printed at the start of the shift where there may be additional clinical need for the patient, it is also greener as less printing and less risk of information governance (IG).
- A ticket from our Women's, Children's and Sexual Health division was raised by two patients about the lack of a fridge for the patients to store their food, milk and supplies whilst on the ward (delivery suite/postnatal).

  Staff had two fridges for their own use and cleared and cleaned one out strictly for patient use only. This has improved patient experience for all of their new mums.

Green QIPs (quality improvement projects) carried out by MTW staff

Turning the treatment room green - recycling of sterile medical equipment packaging by Dr Natasha Varshney (SHO) and Dr Albert Joseph (SHO)

The aim of this QIP was to assess the recycling potential of sterile medical waste.

NHS trusts and Foundation trusts are currently producing about 377,000 tonnes of waste annually. To help achieve the NHS target of achieving net zero by 2045, reducing the amount of clinical waste going to landfill or being incinerated is key and recycling sterile medical equipment packaging is an important area for improvement.

The medical equipment stored in stock cupboards of treatment rooms in the Gastroenterology ward at Tunbridge Wells Hospital was investigated. The packaging of each piece of medical equipment was studied and data collected.

On the day of data collection, the treatment room had a total of 97 different pieces of equipment. 25 items (26%) had packaging that had recycling information. The results show that the amount of packaging which can be recycled is still low and that most of the medical equipment packaging lacks recycling information. This highlights the need to mandate the manufacturing companies to include recycling information on their packaging and ideally mandate that the packaging is recyclable if sterile.

One of the ways in which MTW staff can modify their behaviour to recycle sterile packaging is to prepare their medical equipment in the treatment room and dispose of the packaging via the appropriate waste stream rather than at the patient's bedside, where contamination can take place and the nature of the waste then changes from sterile to non- sterile and requires the clinical waste disposal route.

This study highlights the need for a central authority to oversee that recycling of sterile medical equipment packaging can take place. The recycling of sterile medical equipment packaging can be achieved by clear labelling, staff behaviour changes and having the means to recycle the packaging by the provision of recycling waste streams.

Increasing patient awareness of the carbon footprint associated with the use of salbutamol inhalers and encouraging 'greener' use of inhalers by Elsa Shijo, Trainee Pharmacist

NICE stated that in 2016/2017 more than 26 million prescriptions were written for metered dose inhalers in England. Salbutamol inhalers are a type of metered dose inhaler (MDI) which contain the propellant hydflurofoalkane-134a, a potent greenhouse gas used to propel the active ingredient from the device into the lungs to reach the target site, with 500g of CO_2 eq. emissions per dose. Comparatively, Salbutamol accuhalers which are a type of dry powder inhaler (DPI) do not contain propellants, producing only 20g of CO_2 equivalent per dose.

This project aims to understand patients' knowledge of the environmental impact of Salbutamol inhalers and to take steps to reduce the carbon footprint associated with the use of MDIs:

- To identify patients' awareness of the carbon footprint associated with the use of their inhaler, identifying current habits in terms of patients' use and disposal of their inhaler devices
- To review the inhaler techniques of patients who have not had an inhaler review in over six months and those who are not confident with their inhaler technique.
- To assess whether patients are suitable to be switched to the dry powder inhalers using an in-check device.

A survey was completed on all patients who have Salbutamol listed as a current or previous medication on their drug charts focusing on the respiratory ward and the acute admissions ward.

A number of interventions were implemented for those patients who were using their inhalers inappropriately e.g. over reliance, or were using incorrect inhaler technique or had brought in out of date or unusable inhalers.

Patient information leaflets were shared and patients were directed to resources to guide them on reducing their carbon emissions from their inhaler use.

A learning session on the results of the first cycle of the QIP was delivered to Pharmacy Staff on greener inhaler use.

In conclusion, patients included in this project had limited awareness of the environmental impact of Salbutamol inhalers and more should be done to enable patients to reduce the carbon impact of these devices.

Complaints

Some of the actions that MTW has taken in response to complaints received over the last year:

- A new policy has been implemented where patients are encouraged to let their friends and family know what their medical position is to ensure that they are disclosing their own information. Where this is not possible, a password system has been implemented where the person seeking the information can give a secure password provided by the patient, enabling staff to disclose the information with consent.

- The Haematology Service has introduced a new telephone system; incoming phone calls are initially directed to the identified individual, but should they not answer, the call opens to the remaining members of the team. This ensures that all calls are answered by a person negating the need for automated call answering services.

- All staff to undertake the new mandatory learning disability and autism training. In addition, bespoke training will take place on the wards to assist, guide and support staff when looking after patients with neurodiversity.

- The Urology Service are monitoring the length of clinic appointment wait times and increasing clinic capacity when required to ensure their patients do not have too long to wait for their appointments.

The number of complaints at MTW still remain within the expected parameters for an organisation of our size, however the Trust has seen a decrease in the number of complaints by 10.13% over the last year.

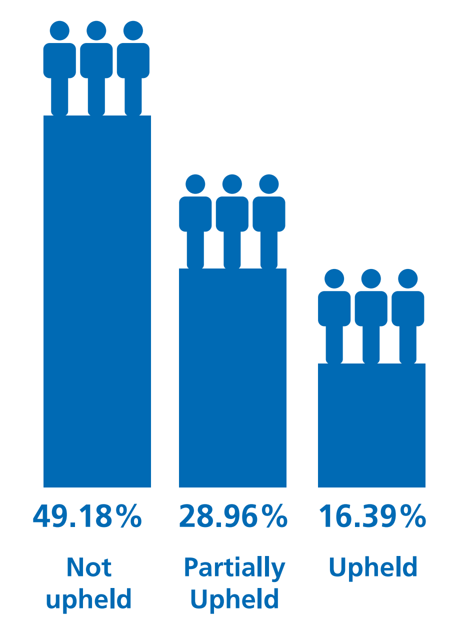
The Trust opened 470 formal complaint investigations in 2023/24, a decrease from 523 in 2022/23. This reflects efforts to resolve issues by both staff at ward and service level, and our Patient Advice and Liaison Service (PALS) as they each endeavour to address concerns and resolve issues as and when they arise. The majority of complaints were not upheld.

The Trust measures its performance in responding to complaints within either 25, 40 or 60 working days (depending on the severity and complexity of each case). In 2023/24, this was achieved in 64.27% of complaints; although an increase on 54.5% in 2022/23, the Trust recognises that there are huge improvements still to be made in this area. We have extended the number of our complaint handlers from two to five in order to make further improvements in our complaints service. Our Patient Advice and Liaison Service (PALS) dealt with 6,567 contacts in 2023/23, an increase from 4,832 contacts in 2022/2023. We have recruited an additional PALS Officer to support the service.

The main reasons for contacting PALS were:

- Concerns
- Information requests
- Liaison requests
- Messages
- Compliments

Complaints upheld or not upheld 2023/24



Patient experience surveys

The Trust employs a range of methods to gather feedback from patients including three different forms of patient surveys: National patient experience surveys, Local patient surveys and The Friends and Family Test (FFT).

National Patient Experience Surveys

The Trust participates in the national annual patient experience survey programme and undertakes all national surveys stipulated by the Care Quality Commission (CQC) each year. During 2023/24 the Trust participated in five national patient surveys: Maternity Survey, Inpatient Survey, Urgent and Emergency Care Survey, Cancer Patient Experience Survey and the Children and Young People's Patient Experience. The surveys were undertaken by IQVIA as contractors for our Trust. At the time of writing the Trust is still in the fieldwork process for the Inpatient Survey and the Maternity Survey. The results for the Urgent and Emergency Care Survey are due to be published nationally in June 2024.

Friends and Family Test

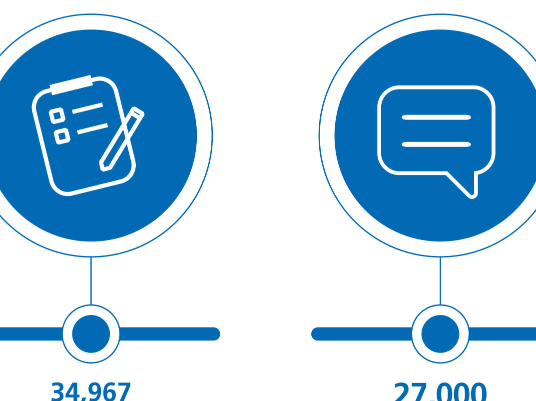
The Trust utilises a multi-modal approach to gathering the FFT data; paper surveys, online surveys, QR code capture and URLs to ensure accessibility and inclusivity for all patients. In the time period of 2023/24 there were 34,967 responses to the test. The number of responses was down on the previous year due to transitioning the surveys between two providers to enhance the data capture from our patients.

Of those, 94% of the respondents rated the care they received as very good and good.

102 responses were submitted by tablet, 20,490 online and 14,375 were paper cards.

33% of the respondents identified a disability, long term health or mental health condition.

FFT 2023/24



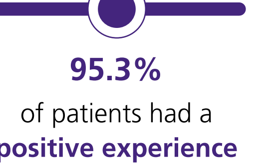
34,967
surveys received

27,000
free text comments
95% were positive

94%
of patients had a
positive experience

145
clinical areas contributed to
gathering feedback

FFT 2022/23



45,252
surveys received

35,490
free text comments
90% were positive

95.3%
of patients had a
positive experience

153
clinical areas contributed to
gathering feedback

Improving our workplace culture

MTW NHS Trust employs a team of over 6,000 full and part-time staff across our sites supported by a team of dedicated and committed volunteers. Every single one of our employees, whatever their role, contributes to the delivery of high quality care and experience for the communities we serve.

One of our key strategic ambitions is to "Create an inclusive, compassionate and high performing culture where our people can thrive and be their best self at work".

Improving Our "Staff Voice"

One of the key themes of the People Promise is that staff have a voice. It's really important that we encourage our staff to tell us what it's like for them working at MTW. We have therefore adapted our quarterly "staff experience survey" to ask key engagement questions from the "National NHS Staff Survey" to help us to benchmark against other NHS Acute Trusts and track the success of improvements.

Our strategic goal:

We will achieve continuous improvement to take MTW to the best place in the NHS Staff Survey amongst acute trusts.

Staff engagement and growth
We will listen to, enable and strengthen the staff voice and help people to develop and grow.

Supportive team behaviours
There will be a consistent experience of the Trust values in our teams and we will reward the right things.

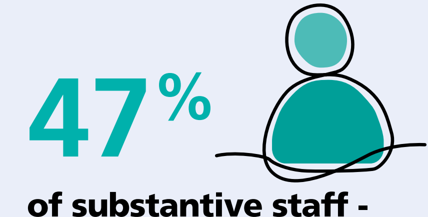
Recruitment and resourcing
Through workforce planning and clear career pathways we will create a sustainable productive workforce.

Collective and compassionate leadership
We value effective and compassionate leadership at all levels, learning from experience and seeking continuous improvement.

Equality, diversity and personalisation
We will continue to champion respect of difference, ensure equity of opportunity and enable people to bring their best selves to work.

Health and wellbeing
We will take a holistic and preventative approach to health and wellbeing in caring for our people.

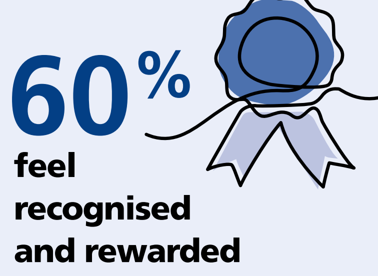
The results from the 2023 NHS Staff Survey



47% of substantive staff - Response rate

20% of bank staff - Response rate

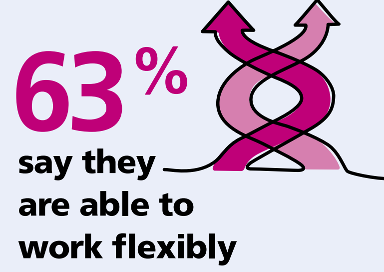
74% say we are compassionate and inclusive



60% feel recognised and rewarded

68% feel that we each have a voice that counts

61% say they are always learning



63% say they are able to work flexibly

68% feel part of a team

Highlights

- We have scored above the national average for acute trusts for all of the People Promise themes plus the additional staff engagement and morale themes measured by the survey
- Our staff ranked MTW as one of the top ten trusts in the country - and the second best trust in the south east - to work for.
- Our staff experience scores across all seven of NHS People Promise themes have also improved, and even more staff are telling us that they would recommend MTW as a place to work. This puts us in the top ten acute trusts for improved scores in this measure.

Going Forwards

- We will use technology and innovative working practices to enable our staff to work more flexibly and improve the care we provide to our patients
- We will continue to improve the value that our appraisals add to the career development of our staff
- We will continue building an inclusive working environment for all
- We will embed good team work and line management across the organisation

Equality, Diversity and Inclusion (EDI)

We want to create a working environment and culture where every individual can feel safe, have a sense of belonging and is empowered to achieve their full potential. By creating an environment in which everyone's voice is heard and considered, we can tap into a wealth of diverse perspectives, leading to increased collaboration, productivity and overall staff satisfaction. We are now in our second year of delivering our EDI Strategy and have created a Trust EDI project which is monitored through the SDR process. An EDI Steering Group has been established which monitors progress on the delivery of both the EDI strategy and the NHS EDI Improvement Plan.

The Trust supports a number of initiatives to ensure equal and inclusive access to learning and employment which include:

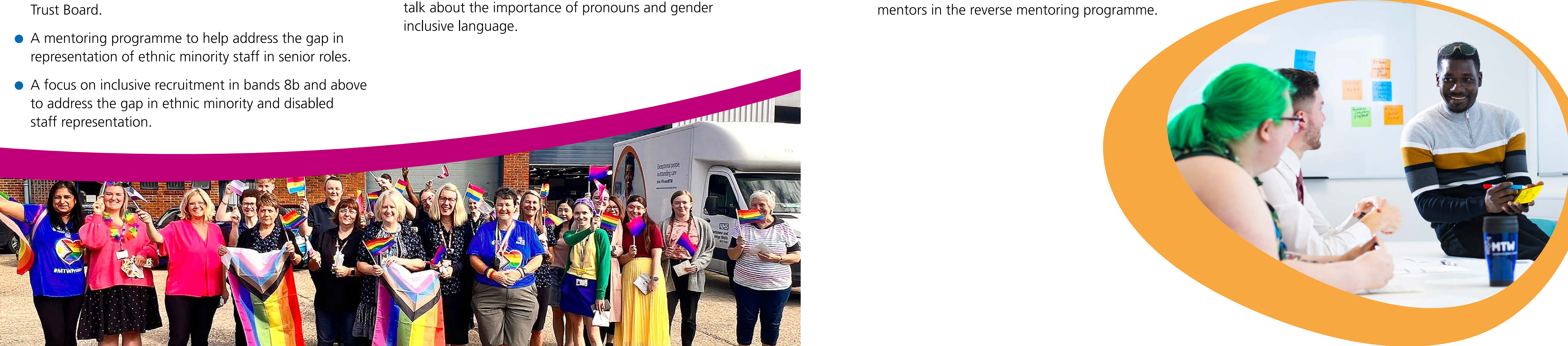
- Developing and empowering our vibrant staff networks - MTWProud, Cultural and Ethnic Minorities Network, DisAbility Network, Parental Responsibility Network, Chronic pain support group, neurodiversity support group, clinically extremely vulnerable support network, menopause support group and recently 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.

Our LGBTQIA+ community

We are committed to ensuring that staff who identify as LGBTQIA+ feel safe and valued at work. We want our staff to feel able to be authentic at work to reduce stress and ill health and increase morale and retention. We obtained a Bronze Award in the NHS Rainbow Badge Assessment demonstrating our commitment to inclusion in the recruitment and retention of staff from the LGBTQIA+ community, ensuring that they can develop and grow their careers at MTW.

Our LGBT+ network has re-launched this year with the appointment of a new Co-Chair, new Executive Sponsor and a more inclusive network name – MTWProud. The vibrant network is open to all LGBTQIA+ staff and allies, providing a safe space for all. They also provide advice and guidance to the Trust on EDI related initiatives. Over the last year they have:

- Celebrated LGBT History Month with a weekly feature on Health and Medicine – reliving some of the most historic times within the community and how history impacts their future.
- Hosted the second MTW Pride event, spreading their colourful wings to share information about the network to the majority of our sites.
- Joined other local NHS organisations in Canterbury Pride walking under the banner "Pride in our NHS".
- Regularly attend Department meetings and inclusion events for staff to sign the Rainbow Badge pledge and talk about the importance of pronouns and gender inclusive language.



Our staff with long term health conditions and disabilities

We are committed to supporting staff with long term health conditions, those with disabilities and anyone who acquires a disability during their employment with us. We are a Disability Confident Leader which demonstrates our commitment to the recruitment and retention of people with disabilities, how we ensure our policies, processes, training and culture enables disabled staff to flourish. We have had one cohort of Project SEARCH, a programme committed to transforming the lives of young people with learning disabilities and/or autism and we are currently working with Bemix to host supported internships from September 2024.

Our DisAbility Network has increased and a small committee has formed which has included the appointment of a Deputy Chair and a Secretary. The network provides advice and support to its members and act as a trusted advisor to the EDI Team in the implementation of initiatives such as increasing disability declaration rates on ESR. Over the last year they have:

- Hosted awareness stands during Disability History Month.
- Developed an accessible way to declare EDI data on ESR.
- Signposted staff and managers to access support . through Access to Work and Able Futures.
- Designed a commendation letter which is sent from the network and our Chief Executive to managers who have been recognised as providing excellent support to staff with health conditions.
- Provided advice to the Learning & Development team to ensure that staff accessing training could request reasonable adjustments and that training venue accessibility is assessed and communicated.
- Encouraged participation of network members as mentors in the reverse mentoring programme.

Our black and ethnic minority staff

We are proud to say that over 26% of MTW staff are from ethnic minority backgrounds and we are committed to supporting this staff group to have opportunities to learn, grow and develop their careers in the Trust. Our work on raising awareness of racism continues with anti racism workshops delivered to our senior leadership team and EDI recruitment representatives being present on panels of 8a and above. We have appointed a lead nurse for the pastoral care of our international recruits and have been awarded a national NHS pastoral care quality award in recognition of the support provided.

The Cultural and Ethnic Minorities Network (CEMN) continues to provide support to staff and is a trusted advisor to the EDI team in the implementation of initiatives such as the second cohort of the reverse mentoring programme. Over the last year they have:

- Led on the design and delivery of the Kent and Medway Integrated Care System Black History Month event.
- Created an event focussed on the experiences of our internationally educated staff.
- Hosted Black History Month event "Sheroes among us".
- Supported listening events with our Chief Nurse.
- Designed and delivered an event to recognise the contributions of our internationally educated staff past and present on Windrush Day.
- Encouraged participation of network members as mentors in the reverse mentoring programme.

Freedom To Speak Up (FTSU)

Collaborative working

The FTSU function works collaboratively with our teams to ensure key insights are shared to maximise our learning. In particular the FTSU team work closely with the following teams:

- Patient Safety.
- Organisational Development.
- Human Resources.
- Staff Networks.
- Retention Team.
- Health and Wellbeing.
- Occupational Health and Psychological Services.

This interdepartmental working has helped us to highlight areas for service improvement that, in isolation, one department might not have been able to identify.

Case Study

A recent FTSU case raised a potential area for improvement in communication between staff and managers out of hours. The incident highlighted the necessity for additional support during challenging times. Consequently, there is a renewed focus on rostering and on-call arrangements to ensure prompt assistance is available when urgently needed, thereby enhancing support for all staff members.

Our Strategic Foucs:

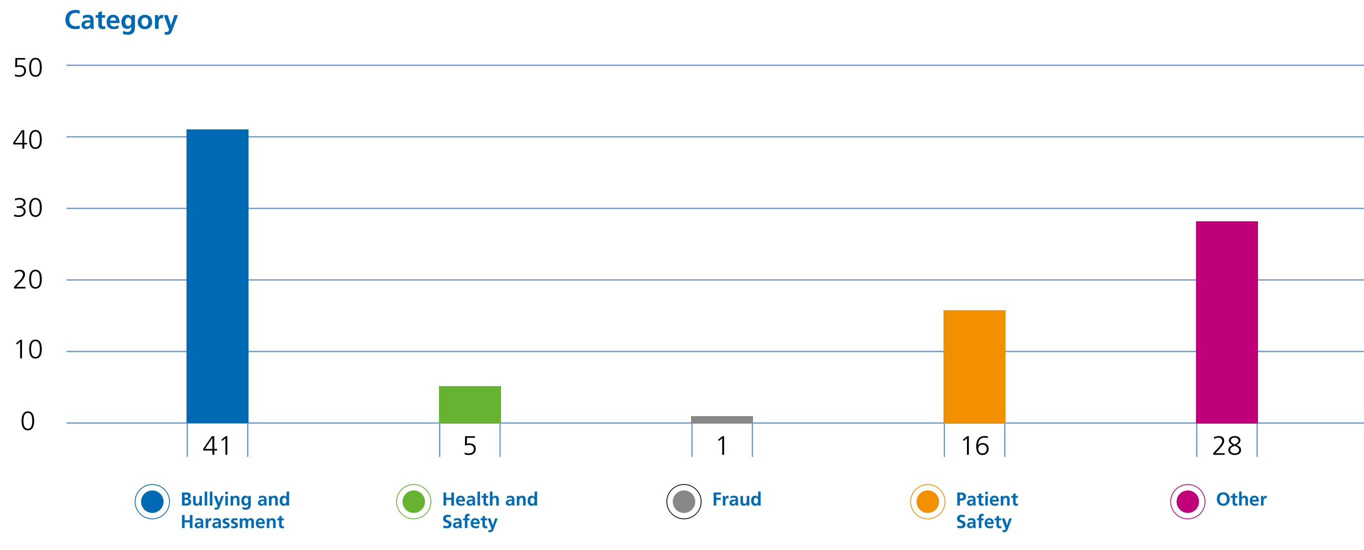
We are committed to actively engaging with staff across various departments and satellite sites to elevate the importance of speaking up. Our efforts are directed towards fostering a culture of constructive feedback, with a dual emphasis on enhancing services and promoting continuous learning. We aim to empower staff to voice their concerns, thereby nurturing a speaking up culture.

We are also aware of a discrepancy in speaking up habits across specific job roles. We are proactively reaching out to individuals experiencing digital poverty. Ensuring those who do not have access to a computer can still have their voices heard.

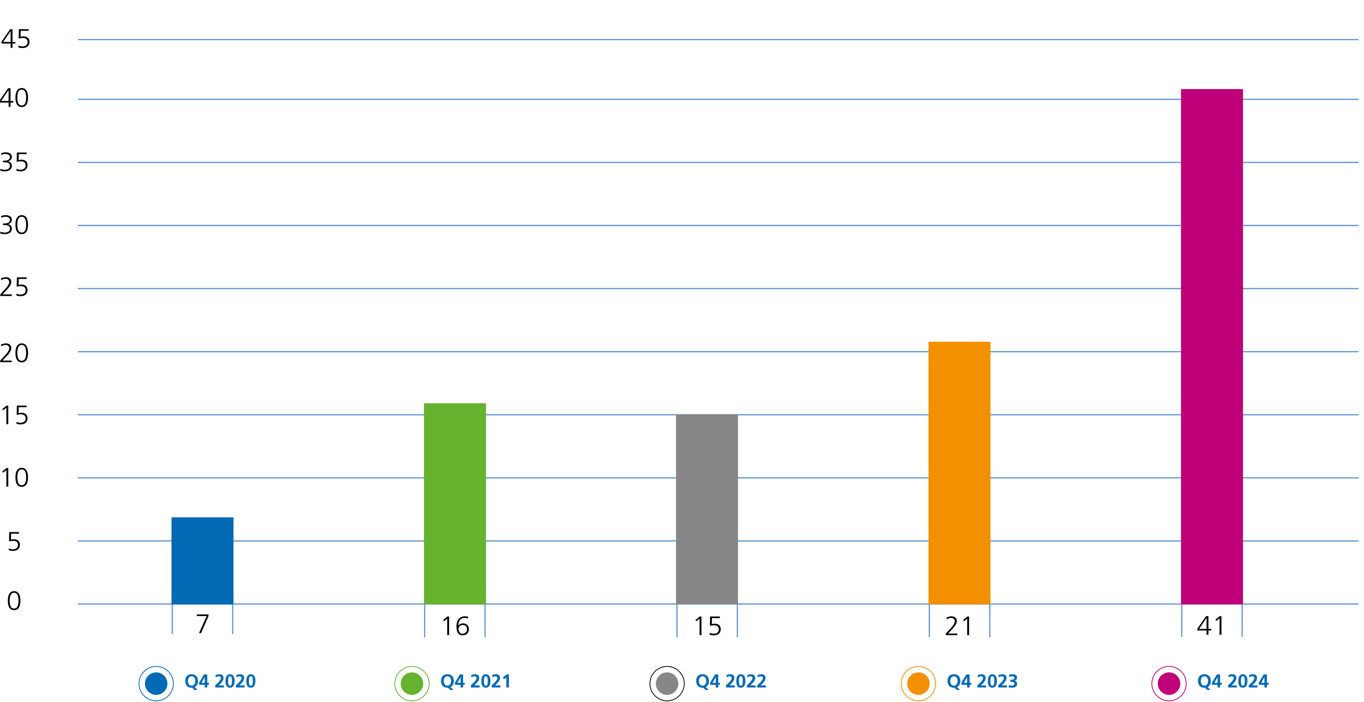
We are also spearheading multiple initiatives to improve reporting outcomes, and reporter satisfaction. We are using three main themes to do this:

- Awareness: Ensuring clarity on what issues can be raised and where they can be reported.
- Trust: Establishing confidence among staff that speaking up is integral to a culture of learning.
- Encouragement: Emphasising that every concern, regardless of its perceived significance, is valued and welcome.

2023/24 Freedom to Speak up Statistics



2023/24 Total concerns logged



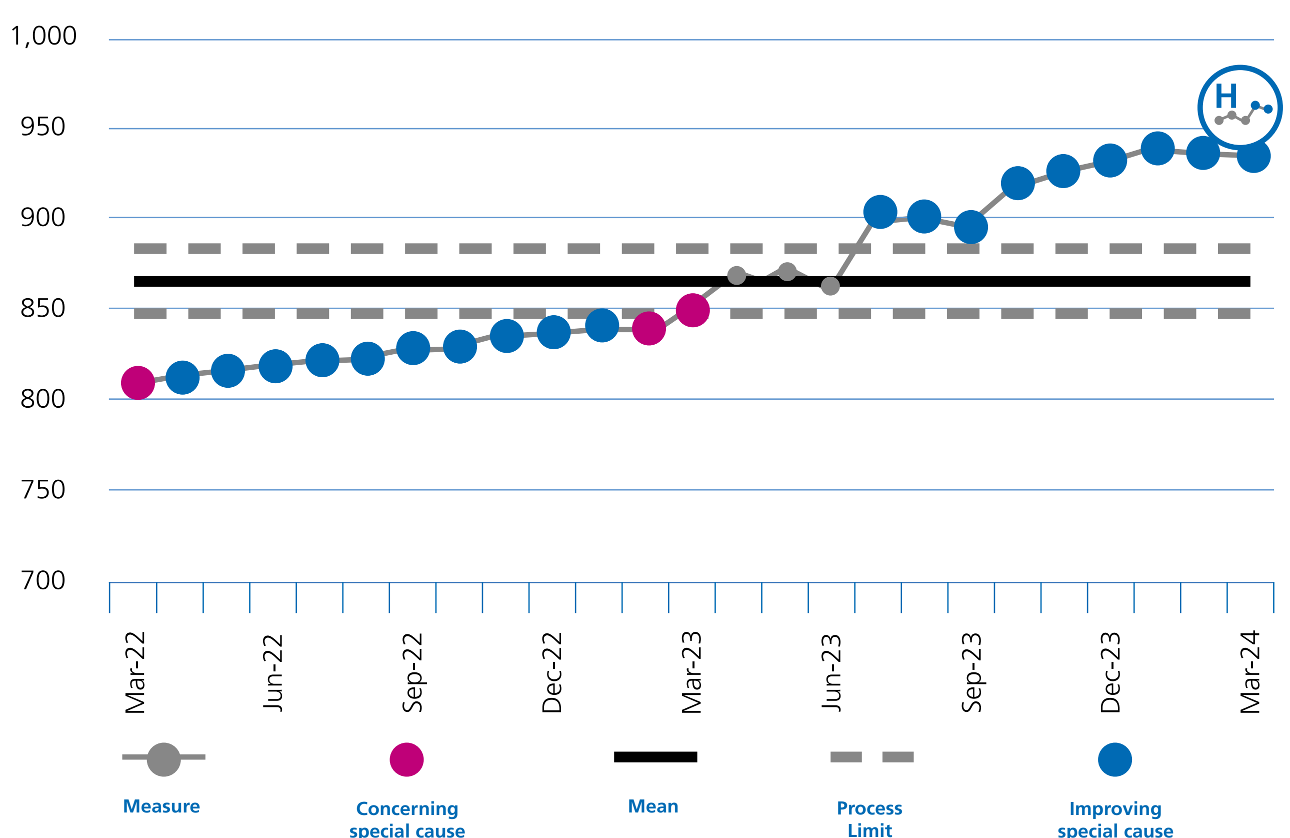
Medical rota gaps

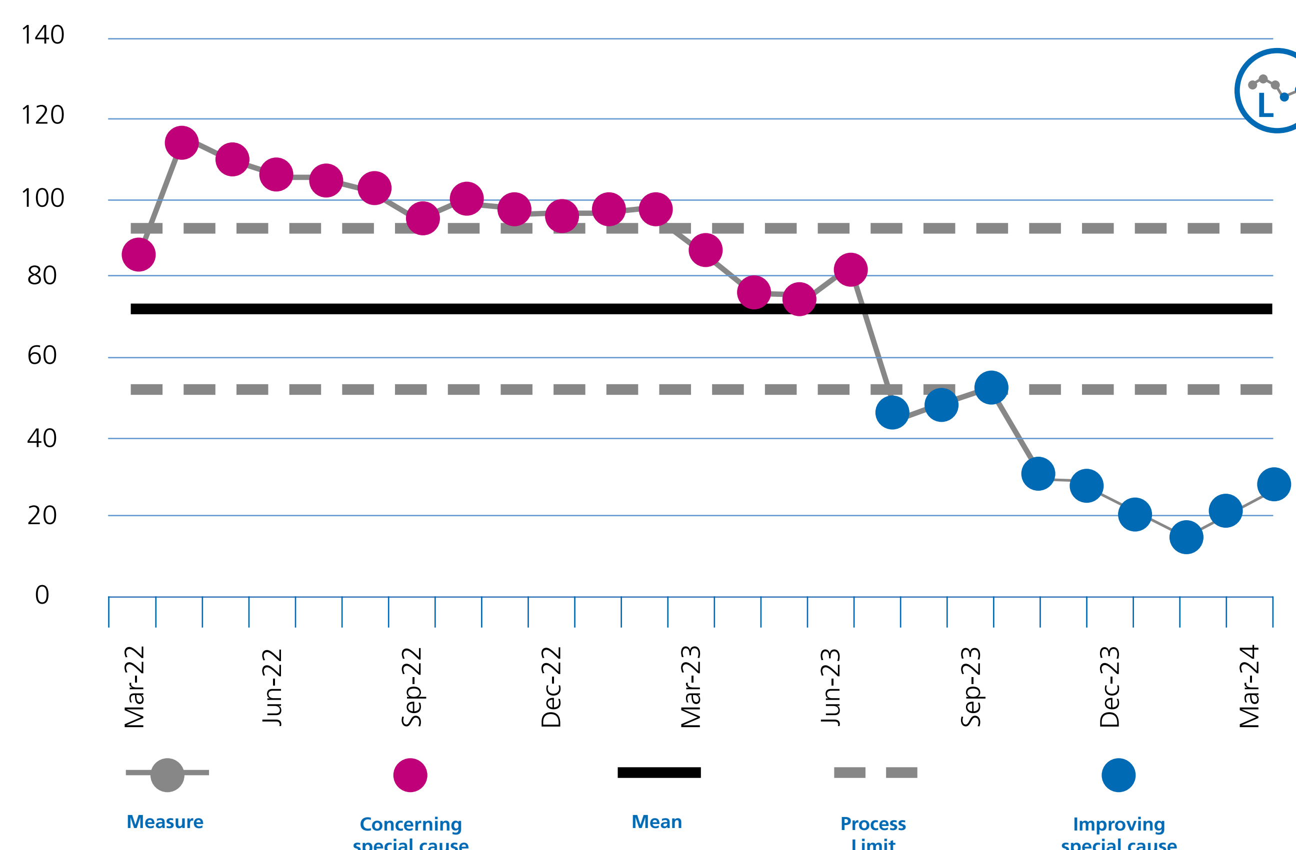
The overall fill rate of our training posts remains high. During the academic year 2023/24, through the expansion and redistribution of training posts, we were able to increase our posts at Higher, Core and Foundation training levels across our specialties.

We have a number of initiatives throughout our Departments which help support our rotas. These include programmes for Clinical Fellowships, Senior Clinical Fellow Certificate of Eligibility for Registration (CESR), Chief Medical Registrars and the Medical Training initiative for overseas doctors. Advanced Practitioner and Physician Associate roles continue to be recruited to and provide multi-professional support to our services and rotas.

The Guardian of Safe Working reports to the Board on any rota issues that may have been identified by Trainees through exception reporting which is a mechanism used by our Trainees to inform of variations to their scheduled work.

Maidstone and Tunbridge Wells NHS Trust have made a concerted effort over the last two years to increase the overall level of medical staffing and at the same time reduce the vacancy rate for doctors and allied health professionals. Our medical workforce has grown from around 800 in February 2022 to over 960 in February 2024.





Learning from deaths (mortality reviews)

Mortality rates within the Trust have seen a decline from January 2023 to December 2023, when compared to the same period in 2022. Deaths occurring in the Trust in the year ending 2023 was 1,656 compared to 1,747 deaths in the previous year.

Learning from deaths across the Trust has improved, especially in three areas;

1 Mortality Indicators:

Mortality indicators Hospital Standardised Mortality Ratio (HSMR), Standardised Mortality Ratio (SMR), and Summary Hospital level Mortality Indicator (SHMI) are produced by "T Health" (formally Dr Fosters). The most recent data for the period January 2023 to December 2023 showed the Trust HSMR and SMR at 85.77 and 83.4 respectively, both categorised as "lower-than-expected".

Nationally, the mortality indicator score for hospitals is set at 100, which indicates that the actual number of deaths is the same as the expected number. If the score is above 100, this means more deaths are occurring at the hospital than expected. A score under 100 means that a trust has fewer deaths than expected, therefore performing better.

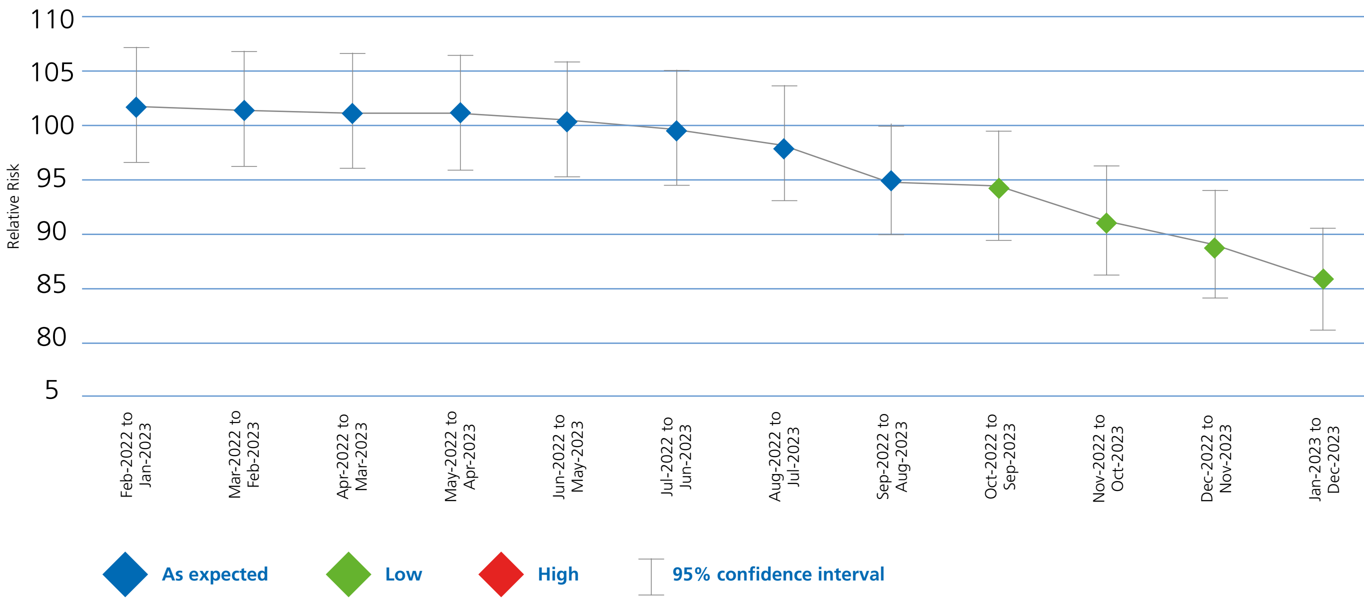
The Trust is currently performing at the 12th month of consecutive decline in the HSMR position, see below a graph of our performance on a 12-month rolling average.

There is a delay in the collation of data and this graph is based on the April 2024 T health data refresh.

The most recent Standardised Hospital Mortality Indicator (SHMI) data published by NHS England for the period December 2022 to November 2023 showed the Trust's SHMI as 93.92 which remains as expected. In the last year, the Trust mortality indicators have remained within the expected or lower-than-expected levels.
In Maidstone and Tunbridge Wells NHS Trust (MTW), mortality indicators continue to be closely monitored and reported to the Mortality Surveillance Group, Board, and Quality Committee regularly.

The improvement in MTW's mortality indicators is multifactorial with several developments around the learning from deaths process. There has been increased accuracy in the coding of care episodes, the coding team continues to work with clinicians to improve this which supports the accuracy of mortality indicators.

Figure 1 Diagnoses - HSMR trend rolling 12 months from Jan 23 - Dec 23



2 Mortality Reviews:

The Medical Examiner (ME) Service is now established, reviewing 97-100% of deaths within the hospital, and is an area that improves the learning from deaths process. The Service has streamlined the initial first-stage mortality review and supports clinicians with the death certification process. Contact with the loved ones, carers and relatives of deceased patients is a part of the ME review process. This highlights concerns about MTW's care provision which can initiate a Structured Judgement Review.

A Structured Judgement Review is an in-depth review carried out by a senior clinician reviewing and scoring different aspects of care received by patients in their last episode of care within the hospital. Structured Judgement Reviews (SJRs) are discussed at Mortality Surveillance Group (MSG) meetings by senior medical and nursing clinicians. Cases assessed as 'Poor' or 'Very Poor' may be referred through the Patient safety team for a review against the Patient Safety Incident Response Framework (PSIRF) threshold to determine if a Patient Safety Incident Investigation (PSII) is required. Referred cases are reviewed by an Executive panel and feedback on referral outcomes is made to MSG by the Patient Safety team.

There were over 50 cases in the SJR backlog up to three years in arrears. Improvements have included recruiting more SJR reviewers and effective management of the SJR process. There are currently no SJRs in the backlog.

A total of 128 SJRs were allocated and completed by specially trained reviewers in the period April 2023 - March 2024. Six (5%) of the SJRs completed had a score of 'Very Poor Care' and 16 (12%) were assessed as 'Poor Care'. Whilst this is slightly higher than last year's figures for cases within these categories there were 50% more cases reviewed this year (2023/24) 128, compared to 85 cases last year.

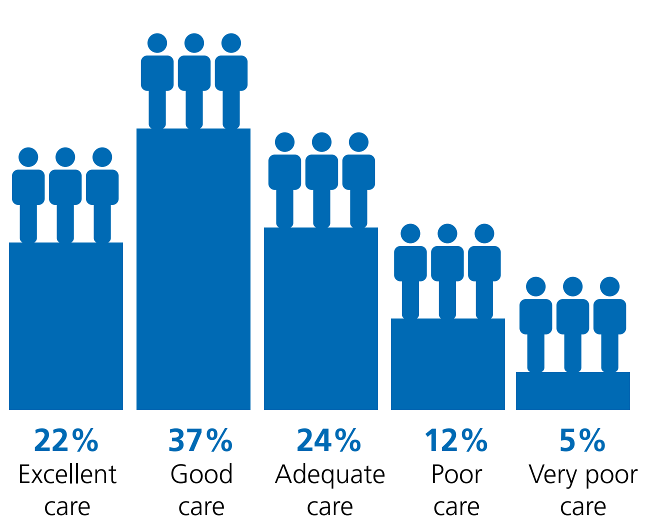
3 Sharing learning from deaths:

Another area of improvement is the sharing of learning from deaths. Mortality Surveillance Group writes to teams where a Structured Judgement Review demonstrates excellent care to commend exceptional care provision.
A divisional mortality report is now produced by the Medical Directorate team and is a standing agenda item at Clinical Governance to circulate both positive and negative learning from deaths reviewed. A mortality section has also been developed in the Patients Safety Learning Hub on the intranet where all the learning from SJRs are uploaded as well as divisional mortality reports. MSG may also write to teams and clinicians asking them to review their practice in line with cases discussed at MSG to encourage learning.

Learning from deaths identified in 2022/23 include:

- Sepsis is a recurring theme discussed at MSG, there is a need for increased awareness to support early identification, treatment, and escalation. A Deteriorating Patient Corporate Programme with Executive management oversight is being developed. Sepsis improvement will form part of this programme of work.
- Treatment delays are another key area of learning highlighted by SJRs.
- Improved communication with patients and families/carers.
- Need for comprehensive and clear documentation to support care.
- Good multidisciplinary involvement in patient care has been highlighted from reviews.
- Prompt recognition of patients who are nearing end of life and involvement of the palliative care team is another good area of care.

2023/2024 completed Structured Judgement Reviews



National indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on. Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:

- The Trust submitted a 'standards met' Data Security and Protection Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".
- In addition, three key indicators are selected and audited each year as part of the Trust's assurance processes.

The NHS Outcomes Framework has five domains:

1. Preventing people from dying prematurely.
2. Enhancing the quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring that people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Domains 1 and 2: Preventing people from dying prematurely and enhancing the quality of life for people with long-term conditions

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures. A ratio that is less than 1 indicates that less patients died at the Trust than expected. Trusts are categorised into one of three bands:

- Where Trust's SHMI is 'higher than expected' – Band 1.
- Where the Trust's SHMI is 'as expected' – Band 2.
- Where the Trust's SHMI is 'lower than expected' – Band 3.

In March 2024 the SHMI for Maidstone and Tunbridge Wells Trust was 0.94 (banded as level 2 'as expected').

Summary Hospital-level Mortality Indicator ("SHMI")	2023/24		2022/23	
	SHMI	Banding	SHMI	Banding
Maidstone and Tunbridge Wells NHS Trust	0.94	2	0.91	2
Best Performing Trust	0.72	3	0.72	3
Worst Performing Trust	1.26	1	1.22	1

Patients being treated by the palliative care team should have this recorded in their healthcare records and subsequently coded. Last year MTW saw a significant improvement in the recording of palliative care provided to our patients.

The percentage of patient deaths with palliative care coded	2023/24	2022/23
Maidstone and Tunbridge Wells NHS Trust	42%	32%
Lowest percentage Trust	16%	13%
Highest percentage Trust	66%	66%

Domain 3: Helping people to recover from episodes of ill health or following injury

Emergency readmissions to hospital shortly after being discharged are sometimes avoidable and may provide an indicator of the quality of care provided.

Prescribed data requirements	MTW NHS Trust	
	Aged 0-15	Aged 16 and over
Readmission rate to MTW within 28 days of being discharged from MTW	12.3%	21.31%

Domain 4: Ensuring that people have a positive experience of care.

Prescribed data requirements	2023/24	2022/23	National average
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	74%	70%	63%

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

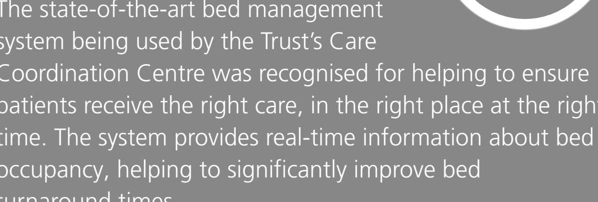
Prescribed data requirements	2023/24 local data	2022/23 local data
The percentage of patients who were admitted to hospital and who were at risk assessed for venous thromboembolism during the reporting period.	94.9%	96.2%
The rate per 100,000 bed days of cases of C. Difficile infection (healthcare associated) reported within the Trust amongst patients aged 2 or over during the reporting period.	47.2	24.34

The Trust limit for Clostridioides difficile infections (CDI) was exceeded with 107 Trust apportioned cases against a year end limit of 61. In response to these high rates, Trust-wide incident meetings were held and a CDI action plan developed which resulted in a downward trend in numbers. Key actions were implemented and good infection, prevention and control (IPC) practice and antimicrobial stewardship further promoted. All cases of CDI are reviewed to ascertain the likely cause and any areas for shared learning.

Awards

HSJ Digital Awards – April 2023

Shortlisted – 'Improving Urgent and Emergency Care Through Digital'



The state-of-the-art bed management system being used by the Trust's Care Coordination Centre was recognised for helping to ensure patients receive the right care, in the right place at the right time. The system provides real-time information about bed occupancy, helping to significantly improve bed turnaround times.

Platinum Bliss Awards - May 2023

Accreditation

The Neonatal unit at Tunbridge Wells Hospital became one of only four in the UK to receive platinum accreditation in the Bliss Baby Charter. Run by the charity Bliss, which supports premature or sick babies, the Baby Charter was established in 2005 and is now the UK standard for developing, measuring and improving family-centred care.

NIHR Clinical Research Network Kent, Surrey and Sussex Research Support Awards – February 2024

Highly Commended

Peggy Wood Breast Care Centre, for supporting the three trust-sponsored trials in the unit which led to the establishment of an embedded research clinic week.

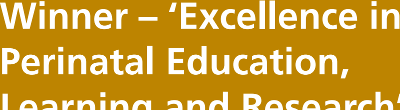
Shortlisted – Critical Care Outreach team, for their involvement with the AIRWAYS-3 project.

Shortlisted – Urology team, for supporting the TRANSLATE study, which looked into the use of two different biopsy methods.

South East Perinatal Learning and Sharing event – June 2023

Winner – 'Maternity Team of the Year'

Winner – 'Excellence in Perinatal Education, Learning and Research'



Our Maternity teams were awarded 'Maternity Team of the Year' for supporting a patient who received a terminal cancer diagnosis during her pregnancy and was given only four weeks to live. The Maternity Research team also won the 'Excellence in Perinatal Education, Learning and Research' award for supporting the research into group B Strep in pregnant women.

NHS England National Preceptorship Framework for Nursing - January 2024

Gold standard Quality Mark

MTW achieved the gold standard Quality Mark for the support we provide to newly-registered nurses. Our Preceptorship Programme aims to welcome and integrate newly-registered nurses into their teams at the Trust, providing them with a 12-month period of dedicated guidance and support. The Quality Mark is awarded to organisations who have created an environment where new team members can thrive, learn and grow.

HSJ Awards – November 2023

Finalist – 'Performance Recovery Award'

The Trust was recognised for introducing new ways of working which ensure patients in the area are receiving some of the fastest access to treatment in the country. These include the use of a real time bed management system, the growth in Same Day Emergency Care which provide quick access to diagnostic tests and specialist care, and investments in staff training and service developments.

Royal College of Anaesthetics (RCoA) – February 2024

Accreditation

The Anaesthetic department received accreditation under the prestigious RCoA Anaesthesia Clinical Services Accreditation (ACSA) scheme. The award recognised the department's commitment to a high standard of practice in providing safe, effective and compassionate care to patients.

HSJ Digital Awards – March 2024

Shortlisted – 'Improving Out of Hospital Care Through Digital'

The Acute Virtual Ward programme at MTW was shortlisted for its work in delivering acute hospital-level care directly to patients in their homes by a team of specialist nurses and doctors. The introduction of the programme has enabled MTW to increase its capacity for treating patients requiring acute-level care.

HSJ Partnership Awards – March 2024

Gold – 'HealthTech Partnership of the Year'

Silver – 'Best Acute Sector Partnership with the NHS'

The Trust's electronic bed and capacity management system won Gold and Silver awards in two categories of HSJ Partnership Awards. Used in our Care Coordination Centre, the technology provides real-time information about bed occupancy at both Maidstone and Tunbridge Wells hospitals, helping to maintain flow through our hospitals by reducing the amount of time a bed is empty.

Healthwatch Recognition Awards – March 2024

Winner – 'Excellence in Collaboration'

Winner – 'Excellence in inclusivity and equal access to services'

The Trust was recognised for its SWAN service, which was set up collaboratively with the Anne Robson Trust to provide companionship for patients in their final days and hours of life. The Trust also won an award for the Breast Radiology team's efforts to make breast screening services accessible and inclusive for all biopsy methods.

New developments

Patient portal:

In November 2023, we launched our patient portal – Patients Know Best – helping service users take control of the management of their outpatient appointments. By signing up to the portal, patients can view appointment letters, cancel and request to reschedule their appointments all with a few taps on their personal devices, meaning they do not need to call into our teams and also allowing others to be booked into cancelled or moved appointments. Nearly 100,000 patients registered in the first six months, helping to reduce calls into Clinical Admin Units, decrease Did Not Attends (DNAs) in our outpatient clinics and save on postage costs for patient letters.

Enhanced stroke services:

A new Hyper Acute Stroke Unit (HASU) at Maidstone Hospital opened to patients in December 2023 as part of a wider project to develop the Trust's stroke services. One of three specialist units in Kent and Medway, the HASU will help to consolidate existing stroke resources across the region in order to meet national best practice standards, ensuring all patients across Kent and Medway receive high-quality stroke care.

Kent and Medway Orthopaedic Centre:

2024 will see the official opening of the Kent and Medway Orthopaedic Centre at Maidstone Hospital, providing three state-of-the-art operating theatres and 24 dedicated surgical beds. It will expand the Trust's capacity for routine orthopaedic operations including more than 2000 extra knee and hip replacements each year, transforming care for Kent and Medway patients who need planned surgery on bones, joints and muscles. The theatre complex is located behind the main hospital building and will focus on orthopaedic care for patients, helping deliver many more operations for patients across Kent and Medway, and reducing the length of time patients stay in hospital.

West Kent Community Diagnostic Centre:

In January 2024, the West Kent Community Diagnostic Centre was officially opened by the Secretary of State for Health and Social Care, Victoria Atkins, enabling thousands more patients to get faster access to tests including x-rays, CT, MRI, DEXA and ultrasound scans. The centre at Hermitage Court, on Hermitage Lane, also provides additional clinic rooms and x-ray, respiratory and cardiology rooms and will provide tests, checks and scans to around 149,000 people in its first year.

Kent and Medway Medical School:

Following on from a wide range of infrastructure developments, 2024 will also see the opening of new medical student accommodation and an academic teaching building at Tunbridge Wells Hospital. The new state-of-the-art six storey building will provide teaching facilities and high-quality accommodation for 145 medical students and trainee doctors a year. Once fully established, it will place 120 additional medical students with MTW each year – a 315% increase in the total number of students the Trust currently takes.

Acquisition of the Spire Tunbridge Wells Hospital:

In March 2024, MTW bought Spire Tunbridge Wells Hospital, a private healthcare facility in Kent. The purchase will enable the Trust to develop clinical services in a number of areas and provide additional NHS capacity across Kent and Medway. The hospital at Fordcombe will provide MTW with additional facilities including: two theatres, 28 inpatient and day care beds, diagnostics including X-ray, MRI, CT and endoscopy, and a number of consultation and treatment rooms. This will increase NHS capacity and enable MTW to carry out more procedures for long waiting patients across Kent and Medway. Following the acquisition there will be a transition period, which is expected to be around six months, while MTW works on the development and integration of services.

Part four
Appendices

National Clinical Audit Participation 2023/24

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust was eligible to participate in during 2023/24 are shown in the table below. We are unable to provide percentages of cases submitted for every national clinical audit as work is still progressing on many of them.

National Clinical Audits 2023/24	Participation Y, N, N/A	% cases submitted	Comments
British Thoracic Society Adult Respiratory Support Audit	Y	100%	
The British Association of Urological Surgeons (BAUS) BAUS Nephrostomy Audit	Y	100%	
British Hernia Society British Hernia Society Registry	N/A		Due to start Spring 2024
NHS Digital Breast and Cosmetic Implant Registry	Y	100%	
Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Y	100%	
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Child Health Clinical Outcome Review Programme: Juvenile Idiopathic Arthritis	Y		Data submission in progress
NHS Digital Elective Surgery (National PROMs Programme)	Y	93%	
Royal College of Emergency Medicine Emergency Medicine QIPs: Care of Older People	Y		Data submission in progress
Royal College of Emergency Medicine Emergency Medicine QIPs: Mental Health (Self-Harm)	Y		Data submission in progress
Royal College of Paediatrics and Child Health Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	100%	
Royal College of Physicians Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Y	75%	Continual data submission
FFFAP: National Hip Fracture Database (NHFD)	Y	99%	Continual data submission
IBD Registry Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	N		Directorate decision. IQICC closed March 2024
IBD Registry Paediatrics Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit] NHS England Learning from lives and deaths	Y	100%	
NHS England Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Y	100%	
University of Oxford / MBRRACEUK collaborative Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	100%	

National Clinical Audits 2023/24	Participation Y, N, N/A	% cases submitted	Comments
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Medical and Surgical Clinical Outcome Review Programme: Endometriosis	Y	62.5% (5/8)	
NCEPOD: End of Life Care	Y		Data submission in progress
NCEPOD: Rehabilitation following critical illness	Y		Data submission in progress
NHS Digital National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Y	100%	
NDA:A21:C39 National Diabetes Inpatient Safety Audit (NDISA)	N		Staffing capacity issue
NDA: National Pregnancy in Diabetes Audit (NPID)	Y	100%	
NDA: National Diabetes Core Audit	Y	100%	
Royal College of Physicians National Asthma and COPD Audit Programme (NACAP): COPD Secondary Care	Y	47%	
NACAP: Pulmonary Rehabilitation	Y	38%	
NACAP: Adult Asthma Secondary Care	Y	36%	
NACAP: Children and Young People's Asthma Secondary Care	Y	100%	
University of York National Audit of Cardiac Rehabilitation	Y	100%	
NHS Benchmarking Network National Audit of Care at the End of Life (NACEL)	N/A		NACEL paused during 2023
Royal College of Psychiatrists National Audit of Dementia (NAD)	Y	100%	
NHS Digital National Audit of Pulmonary Hypertension	N/A		
Intensive Care National Audit & Research Centre (ICNARC) National Cardiac Arrest Audit (NCAA)	Y	100%	
National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	N/A		

National Clinical Audits 2023/24	Participation Y, N, N/A	% cases submitted	Comments
NCAP: National Congenital Heart Disease Audit (NCHDA)	N/A		
NCAP: National Heart Failure Audit (NHFA)	Y	100%	
NCAP: National Audit of Cardiac Rhythm Management (CRM)	N		Staffing capacity issue
NCAP: Myocardial Ischaemia National Audit Project (MINAP)	Y	100%	
NCAP: National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	100%	
University of Bristol National Child Mortality Database (NCMD)	N/A		
NHS Blood and Transplant National Comparative Audit of Blood Transfusion (NHSBT): 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Y	100%	
NHSBT: 2023 Bedside Transfusion Audit	Y		Data submission in progress
British Society for Rheumatology National Early Inflammatory Arthritis Audit (NEIAA)	Y	100%	
Royal College of Anaesthetists National Emergency Laparotomy Audit (NELA)	Y	100%	
Royal College of Surgeons of England (RCS) National Gastro-Intestinal Cancer Audit Programme (GICAP): NATCAN - National Bowel Cancer Audit (NBOCA)	Y	100%	All patients diagnosed with cancer are registered with National Cancer Registration Analysis Service for inclusion in the national clinical audit programme
NATCAN - National Oesophago-Gastric Cancer Audit (NOGCA)	Y	100%	
NATCAN- National Lung Cancer Audit (NLCA)	Y	100%	
NATCAN - National Prostate Cancer Audit	Y	100%	
Royal College of Surgeons of England (RCS) National Cancer Audit Collaborating Centre - National Breast Cancer Audit	Y	100%	
Healthcare Quality Improvement Partnership (HQIP) National Joint Registry (NJR)	Y	97%	Data submission in progress
British Obesity & Metabolic Surgery Society National Bariatric Surgery Registry (NBSR)	Y		Data submission in progress
Royal College of Obstetricians and Gynaecologists National Maternity and Perinatal Audit (NMPA)	Y	100%	
Royal College of Paediatrics and Child Health National Neonatal Audit Programme (NNAP)	Y	100%	

National Clinical Audits 2023/24	Participation Y, N, N/A	% cases submitted	Comments
NHS Digital National Obesity Audit (NOA)	Y	100%	
The Royal College of Ophthalmologists (RCOphth) - National Ophthalmology Database (NOD) Audit	N		Ongoing software issue
National Cataract Audit	N		Plan to register for 2024/25
Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit (NPDA)	Y	100%	
Royal College of Surgeons of England (RCS) National Vascular Registry (NVR)	N/A		
University of Warwick Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	N/A		
University of Leeds / University of Leicester Paediatric Intensive Care Audit Network (PICANet)	N/A		
University of Oxford / MBRRACE UK collaborative Perinatal Mortality Review Tool (PMRT)	Y	100%	
Royal College of Anaesthetists Perioperative Quality Improvement Programme	Y	100%	
King's College London Sentinel Stroke National Audit Programme (SSNAP)	Y	100%	
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme	Y	100%	
Society for Acute Medicine Society for Acute Medicine Benchmarking Audit	Y	100%	
The Trauma Audit & Research Network (TARN)	Y	100%	TARN closed June 2023
UK Kidney Association - UK Renal Registry National Acute Kidney Injury Audit	Y	100%	

MTW | Safer, Better, Sooner

NHS Maidstone and Tunbridge Wells NHS Trust

Patient Pledge

What you can expect from us:

- We commit to giving you the best possible care that we can
- We will treat you with respect, politeness and sensitivity
- Your spiritual and religious needs will be respected
- We will explain your care options and the risks involved to ensure you can give informed consent
- We are committed to involving you in the delivery of your health care
- Our aim is to not keep you in hospital for longer than necessary to reduce your risk of hospital acquired infection
- We will start planning for your discharge on admission, and keep you informed of your estimated discharge date
- We will listen, investigate and respond to all complaints and concerns

What we ask from you:

- Treat our staff with respect
- Participate in decision making
- Be proactive in planning for your discharge
- Work together to achieve realistic outcomes
- Be aware that hospital may not be the best place for you to be when recovering
- Take responsibility for your own health if you are able to
- Understand that for some patients, therapy is part of your recovery and it's important you participate if you are able
- Discuss your concerns with ward staff

What we ask of your nominated next of kin:

- Be involved in discussions and support you in making decisions
- Talk to us about what help and support you might need
- Support you in following agreed care plans
- Be respectful of decisions made by you
- Help us to get you home by supporting with the discharge plan and follow up services
- Provide us with up to date contact details

Glossary

ACP	Advanced Clinical Practitioner
AOS	Acute oncology service
ASU	Acute Stroke Unit (provides ongoing care after initial treatment in HASU)
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BLISS	Baby Life Support Systems
C. Difficile	Clostridium difficile
CASPE	Clinical Accountability, Service Planning and Evaluation
CCC	Command Control Centre
CDI	Clostridioides difficile infections
CEO	Chief Executive Officer
CESR	Certificate of Eligibility for Specialist Registration
CHKS	Caspe Healthcare Knowledge Systems
CO2	Carbon Dioxide
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSW	Care Support Worker
CT	Computer Tomography
CWT	Cancer waiting time
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DPI	Dry powder inhaler
DSPT	Data Security and Protection Toolkit
DTT	Decision to treat
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EME	Eletronic Medical Engineering
EDN	Electronic Dischange Notification
E-Learning	Learning conducted via electronic media e.g. the internet
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration system
ESR	Electronic staff record
FDT	First Definitive Treatment
FFFAP	Falls and Fragility Fracture Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
GA	General anaesthetic
GDPR	General Data Protection Regulation
GP	General Practitioner
HASU	Hyper-acute stroke unit
HASU	Hyper Acute Stroke Service (provides specialist care in the immediate first few days after a stroke)
HQIP	Healthcare Quality Improvement Partnership
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
HTA	Human Tissue Authority
ICB	Integrated Care Board
ICNARC	Intensive Care National Audit and Research Centre
ICS	Integrated Care System
IG	Information Governance
InPhase	Compliance management system for Quality Governance
IPC	Infection Prevention and Control
IR(ME)R	Ionising Radiation (Medical Exposure Regulations
ISBCS	Immediate Sequential Bilateral Cataract Surgery
IV	Intravenous
KPI	Key Performance Indicator
LGBT+	Lesbian, gay, bisexual and transgender people plus people with gender expressions outside of the norm
LGBTQIA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual
L/S	Lying/standing
MBRRACE: UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Assessment
MDI	Metered dose inhaler
ME	Medical Examiner
MGH	Maidstone General Hospital
MRI	Magnetic Resonance Imaging
MSG	Mortality Surveillance Group
MTW	Maidstone and Tunbridge Wells NHS Trust
NACAP	National Asthma and COPD Audit Programme
NACEL	National Audit of Care at the End of Life

Glossary

NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NDFA	National Diabetes Foot Audit
NDG	National Data Guardian
NEIAA	National Early Inflammatory Arthritis Audit
NEWS	National Early Warning Score
NG	Nasogastric Tube
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS Digital	Aims to improve health and care by providing national information, data and IT services
NHSE	National Health Service England
NHSE/Timewise	NHS England flexible working project for staff
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NSCLC	Non-small-cell-lung-cancer
OBDs	Occupied bed days
PALS	Patient Advice and Liaison
PFIS	Patient First Improvement System
PLACE	Patient Led Assessment of Care Environment
PMRT	Perinatal Mortality Review Tool
PPH	Postpartum hemorrhage
PROMS	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QIP	Quality Improvement Project
RCEM	Royal College of Emergency Medicine
RCoA	Royal College of Anaesthetics
R&I	Research and Innovation
SDEC	Same Day Emergency Care
SDM	Shared decision making
SDR	Strategy Deployment Review
SHMI	Summary Hospital Mortality Indicator
SHO	Senior House Officer
SHOT	Serious hazards of transfusion
SI	Serious Incident
SJR	Structured judgement review
SMR	Standard Mortality Indicator
SSNAP	Sentinel Stroke National Audit Programme
Sunrise	Trust electronic patient records system
T0	Time of escalation
T1	Time of clinical response
TeleTracking	System to provide real-time status of hospital beds
TIAA	Audit service used by MTW
TSR	Towards Safer Radiotherapy
TWH	Tunbridge Wells Hospital
UKAS	United Kingdom Accreditation Service
UNICEF	United Nations Children's Fund
VTE	Venous Thromboembolism

Part five

Feedback from our patients

"I found them fascinating, there is a huge amount of information there.

I like the year on a page early on in the report and the use of pictures with the numbers, easy to understand, although the vision triangle is quite hard to read when printed on A4.

The consistent use of symbols e.g. the star for patient experience is really helpful and allows links to be made.

I like the use of photos of real people too, not just diagrams throughout the report, this makes it feel person centred.

I thought it was important that the reviews of services were listed so that users could see external reviews are happening.(p.20) as well as the clinical audits and internal reviews etc.

Also good to see details of research and innovations. And awards.

Altogether I thought the information was presented in a very clear and informative manner, it's difficult to convey so much detail without having some pages with fairly dense text and you would lose something if that was simplified but where possible colour and diagrams/photos/ symbols and white space break it up so that it is still accessible.

Well done!"

"I have read through it, but with a great deal of difficulty, due to the very small fonts used - this may be down to my age (78) and the need to wear spectacles, but even on my 15" laptop screen, with the pages filling the screen, it was very difficult to read, so I had to use a magnifying glass to read many sections - I did print the Chief Executive's statement, but to have printed any more would have been very expensive in terms of paper, and, in particular, printer inks.

I can appreciate that, if you increased the font sizes to at least 10 to12 points, which the Royal National Institute for the Blind recommend for generally easy reading for people with visual impairments, the report would probably be very many pages longer, and some diagrams, etc, may be difficult to produce.

I did note that you offered, on page 41, the opportunity to request large print format, but I could only read that using the magnifying glass, so you may need to consider increasing the font size of that statement, to make it clearer for all to read.

Having said all that, which, I hope, will be taken as constructive criticism, I found the report extremely interesting, and full of admirable aims and objectives which, I believe, will vastly improve services to patients, and hopefully, help all NHS staff involved to carry out their duties more efficiently and with improved morale.

Well done to everyone involved, and I wish you all every success in achieving the proposed outcomes."

We have noted this patient's feedback and have increased the font-size on the back cover of the report.

"As a Health non-professional my observations regarding this document are from a layman's point of view. When I opened the document, I was somewhat dismayed by the length of it but of course, once I was into it I realised that this was an important "statement of intent" for a large and complex organisation, which MTW NHS Trust is.

My first impression was that this seemed very much like an election manifesto i.e. something of a "wish list". I then realised that if you don't aim high, you get nowhere and to aim for the very best is the only way to progress towards being the very best!

The layout is attractive – the photographs are integral to demonstrating the interest in the particular area being described. It took me a couple of sections to become accustomed to the methodology of the layout. Where, as a layman, I didn't understand some of the terminology, the paragraph regarding the effect on patients clarified the effect being sought. The Glossary became a very useful section for me!

There is a lot of text to read which sometimes became a bit tedious but is obviously necessary to convey what is relevant. I suspect readers will head for the sections they consider relevant to them. Item 3 of the suggested feedback is whether I might think there was anything missing – that is a question I am not qualified to answer. However, I personally felt the report was comprehensive and informative.

The graphs were well laid out and easy to understand and the use of different colour, especially for boxes containing information made the process of reading their content much easier (and less likely to be "skipped").

I found the whole document extremely interesting and discovered a much better understanding of the complex problems that running such a large organisation throws up! I guess that as a layman, actually reading it through could be considered as a positive.

I like the Patient Pledge. I have always been grateful for the care I have received from the NHS and appreciated the intense pressure that the staff are under. I am fortunate that my children as nominated next of kin (and attorneys of my LPA's) are closely involved in my life and hope they would adhere to what is requested by you and my wishes as imparted to them by me."

"On the whole the report is easy to understand. The charts and diagrams are mainly clear and easy to understand - however please see my comment below.

I don't think I can comment on whether anything is missing as I've not seen a QA report before but it seems very comprehensive and I don't think it would benefit from being any longer.

I hope you don't mind me pointing out there are one or two errors in the Chief Executive statement, there is no space between 'January 2024' and 'by' in the first bullet point and two commas after a word in the second bullet point. Also, although I really like the idea of the 'Year On A Page', that page seems quite 'busy' with a mixture of charts/graphics and quite a lot of different colours. It may be that as I was looking at it on a screen, the pyramid seems to have loads of information on it and the objectives look a bit small and crammed in on the end. I know you can't change it and there's probably loads of research why they are a good thing, but after 30yrs+ in the NHS, I find acronyms and pyramid charts a bit 'old hat'."

We have noted the typographical errors identified by this patient and have rectified them ahead of publication.

"I found the document easy to read and understand although it was longer than I expected. I liked the detail and diagrams as they helped the narrative. There was nothing I didn't like."

"I think that the report is clearly written on most parts, but p.54 and 55, graphs and text: could be clearer. I liked the use of colour coding and easy identifiable symbols, however p. 62 tells about exciting and positive new initiatives, such as Patients Know Best, but fails to acknowledge the challenges with the Patients Know Best and how these have been addressed and/or will be addressed in the future."

"Zero negative themed feedback in your industry is not possible (Patient Experience priority page 16). A restaurant can strive for that, as can a car manufacturer. However, in a hospital people are arriving in distress, or anxiety, as a result of bad things happening to them, or having treatment for life limiting illness, and you will have the full range of neurological disorders. Your patients are all going to have bad days, your staff can do their best, but patients' problems will cloud their initial judgement and expectations.

I would urge a diversity of feedback, and the great active listening you are doing. Same for accident reporting – if you target zero accidents, you achieve that quickly by encouraging non-reporting, which defeats the object.

Sustainability - the word means different things in all industries, but was expecting to see reference to waste targets and the 'reduce - re-use – recycle theme'.

Absolutely fantastic to see the plans and improvement initiatives. They just look undersold hidden away at the back of the report."

Feedback from the Kent and Medway Integrated Care Board

Kent and Medway Integrated Care Board - MTW Quality Account 2023/2024 Comments

We welcome the Quality Account for Maidstone and Tunbridge Wells NHS Trust. Kent and Medway Integrated Care Board (ICB) confirm that this Quality Account has been produced in line with the National requirements and includes all the required areas for reporting.

Your report clearly sets out your quality priorities for improvement for 2024/25, which are aligned to the Trust's Strategic themes and have been established following review of clinical audit results, and themes and trends from adverse events and patient feedback.

The Annual Account demonstrates an overview of quality of care in your focus areas, looking at improving the safety, and effectiveness of your services, as well as improving patient experience.

Throughout the report you have provided clear and measurable recommendations, and the report has a clear flow, that would be easy to follow for members of the public who may have an interest in reading this report.

We commend your achievement on reducing adverse incidents resulting in harm, linked to sepsis management, in addition to the work that has been undertaken to improve end of life care provided by the Trust. The implementation of a seven-day week to improve waiting times for patients using oncology and surgical services is also pleasing to see. The range of 'green' quality improvement projects that MTW staff have carried out this year is also acknowledged.

You have set clear priorities for the coming year, aligned to the aims of the organisation's strategy. We strongly support your priorities in relation to implementation of a unified Maternity Improvement Project and the digital improvement projects - Electronic Prescribing and Medications Administration project and developing a patient portal. We look forward to supporting you with reducing the number of delayed discharges from inpatient services. We invite you to highlight progress with your quality priorities in the Provider Quality Meetings.

It should be noted that five national audits have not been participated in. We understand the exceptional circumstances for these and look forward to working with you in ensuring compliance with all national audits in the future.

Thank you for your engagement at the Provider Quality Meetings and System Quality Group, continuing our collaborative partnership for the population of Kent and Medway. This report clearly sets out your vision for staff and service user support for the coming year and beyond.

Yours sincerely

Paul Lumsdon
Chief Nursing Officer
NHS Kent and Medway ICB

21 June 2024

Together, we can

Feedback from Healthwatch Kent

healthwatch Kent

Healthwatch Kent response to the Maidstone and Tunbridge Wells NHS Trust Quality Account 2023/24

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

We'd like to take this opportunity to support the Trust by setting out the areas we have worked together on in the past year:

- We are grateful to the patient experience team for working with Healthwatch Kent to gather feedback from patients in outpatient departments, as part of our Stakeholder Engagement Initiative.
- Maidstone and Tunbridge Wells were recognised at the Healthwatch Awards 2024, for their inclusivity and equal access to services for research looking at Gender Inequality in Breast Imaging Radiology.
- We regularly share what we hear from the public directly with the Patient Experience Team
- Trust representatives have been key in driving the work of the West Kent Health and Care Partnership.
- We worked with the trust to speak to people about their experience using physiotherapists and radiologists as part of our work with Canterbury Christ Church University.

We have read the Quality Account with interest. Generally, the report is clear and well presented. We particularly like how the account sets out what the priorities will mean for patients.

Healthwatch Kent June 2024

Feedback from Kent County Council

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Kent County Council's Health Overview and Scrutiny Committee has confirmed the receipt of the Maidstone and Tunbridge Wells NHS Trust's Quality Account on 24 May 2024. They thanked the Trust for the opportunity to comment on the Quality Account, but will not be submitting a statement for inclusion.

Statement of Directors' responsibilities in respect of the Quality Accounts

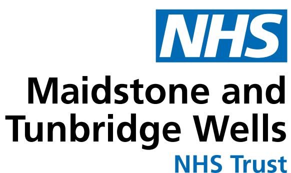
The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Accounts, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Accounts is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Accounts have been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Accounts.

Approved by order of the Trust Board (xxxx June 2024).



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Dacă doriți acest document cu caractere mari sau într-o altă limbă, vă rugăm să contactați un membru al departamentului de audit clinic la mtw-tr.ClinicalAudit@nhs.net

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Trust Board meeting – 27th June 2024

Mid-year Nursing and Midwifery staffing review **Chief Nurse**

Executive Summary:
In accordance with the Trusts Nursing and Midwifery establishment review policy and procedure, an establishment review is carried out in October each year. This policy was written and formalised in August 2022 and as part of the process the Nursing and Midwifery workforce is re-reviewed mid-year, in May, to monitor outputs and actions. This is in line with national recommendations as set out in the NHS Improvement Developing Workforce Safeguards Policy 2018 which outlines the requirements for all NHS Trusts to undertake a formal Nursing and Midwifery establishment reviews, bi-annually, using evidence-based tools, professional judgement, and clinical outcomes.

To fully comply with the national recommendations, there is a requirement for establishment reviews to be undertaken with finance and HR workforce in collaboration and signed off by the Chief Nursing Officer. This approach has been adopted with a shared understanding and vision for the N&M workforce amongst corporate and divisional teams. The full annual review informs decision making at annual budget setting as part of the business planning process.

The purpose of this report is to provide a mid-year overview of nursing and midwifery safe staffing including right staff, right skills, right place; update on establishment reviews actions, workforce planning, new and developing roles and recruitment and retention. This enables the nursing and midwifery staffing position to be shared with the Trust Board from both an assurance and risk perspective.

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

- Executive Team Meeting, 11/06/24

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

Information and Assurance

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

This report provides a mid-year update of the Nursing and Midwifery (N&M) workforce to provide assurance to the Board and public regarding N&M safe staffing levels.

1. Current Staffing position

Registered WTE

	ESR Establishment	SIP	Vacancy
Registered Nurses	1993.1 WTE	1841.2 WTE	151.8 WTE
Registered Midwives	241.4 WTE	218.2 WTE	23.2 WTE
IENs (awaiting PIN – move to B5 vacancy once obtained).			-40.6 WTE
Registered Nurse Associate	19.7 WTE	25.8 WTE	-6.1 WTE
Total	**2254.2 WTE**	**2,085.2 WTE**	**128.3 WTE**

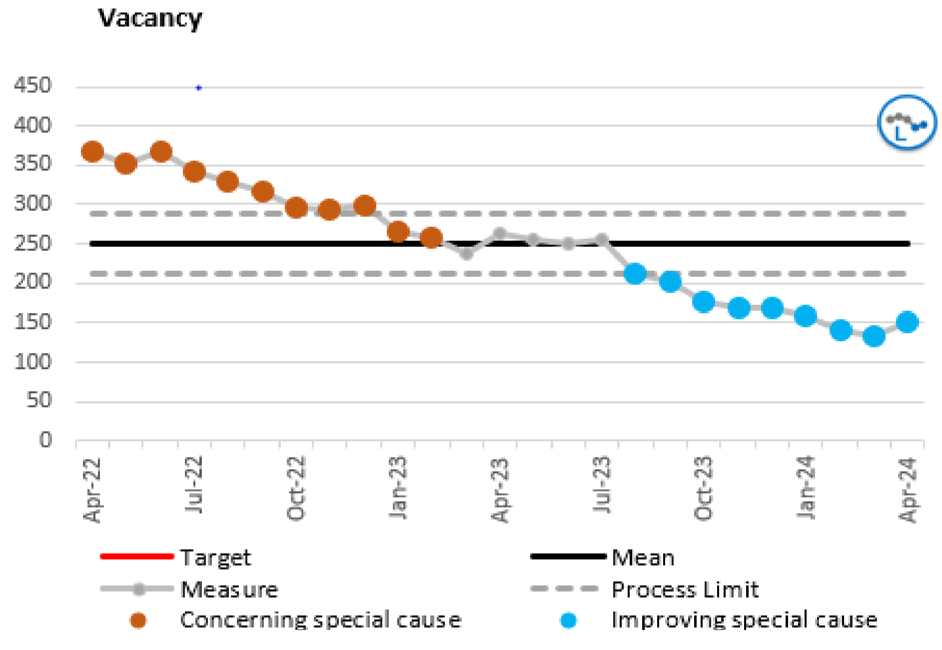
Unregistered WTE

	ESR Establishment	SIP	Vacancy
Healthcare Support Workers B2	458.8 WTE	407.9 WTE	51.0 WTE
Healthcare Support Workers B3	182.8 WTE	128.5 WTE	54.3 WTE
Maternity Support Workers	66.8 WTE	59.8 WTE	7 WTE
Paediatric Support Workers	21.2 WTE	15.5 WTE	5.7 WTE
Total	**729.6 WTE**	**611.7 WTE**	**118 WTE**

Registered Nursing

Significant progress has been made through robust recruitment efforts to reduce the vacancy rate with an improving trajectory over the last two years shown in figure 1. There is an establishment of 1993.1 wte with 1841.2 wte registered nurses in post. This leaves a vacancy rate of 7.6% equating to 151.8 wte vacancies. There are also currently 40.6 wte IENs in post that are awaiting NMC registration.

Figure 1: Registered Nursing Vacancies (wte)



The April 2024 position reflects the recent budget changes following the 2022 full establishment review which resulted in a business case to increase establishments resulting in a rise in vacancies.

Figure 2: Band 5 Vacancies - Top 15 areas

Band	Team	Department	Directorate	Division	Total
Nursing b5	HYPERACUTE STROKE UNIT	Stroke Services	Acute Medicine + Geriatrics	Medical + Emergency Care	20.8
	Accident & Emergency (TW)	Emergency Medicine	Emergency Medicine	Medical + Emergency Care	20.4
	Theatre Staff (TW)	Theatres	Theatres + Critical Care	Surgery	15.7
	Acute Medical Unit (TW)	Acute Medicine	Acute Medicine + Geriatrics	Medical + Emergency Care	12.9
	Theatre Staff (M)	Theatres	Theatres + Critical Care	Surgery	11.6
	K&M Orth Centre - Inpatient Ward	Trauma and Orthopaedic	Trauma and Orthopaedic	Surgery	11.2
	Accident & Emergency (M)	Emergency Medicine	Emergency Medicine	Medical + Emergency Care	9.3
	Ward 21 (TW)	Respiratory Medicine	Medical Specialities	Medical + Emergency Care	5.8
	Ward 2 (TW)	Care of the Elderly	Acute Medicine + Geriatrics	Medical + Emergency Care	5.8
	Catheter Laboratory (TW)	Cardiology	Medical Specialities	Medical + Emergency Care	5.3
	POST NATAL WARD	Midwifery	Womens Services	Women, Children and Sexual Health	5.1
	Midwifery Services (TW)	Midwifery	Womens Services	Women, Children and Sexual Health	5.1
	Ward 20 (TW)	Diabetic Medicine	Medical Specialities	Medical + Emergency Care	5.0
	Virtual Ward Hub	Deputy COO	Operations Management	Operations and Facilities Management	4.9
	SCBU (TW)	Children Services	Paediatrics	Women, Children and Sexual Health	3.6
	Riverbank / Woodlands (Paediatrics)	Children Services	Paediatrics	Women, Children and Sexual Health	3.1
	Stroke Unit (M)	Stroke Services	Acute Medicine + Geriatrics	Medical + Emergency Care	-16.5
b5 Total					95.2

Our 'hotspot' areas where focused effort is being given can be seen in figure 2. The recruitment team are working with international suppliers to recruit nurses with ED experience for the TWH ED. In addition, enhanced advertising is currently underway including creating a video to promote the TWH ED. There is a weekly meeting regarding vacancies in theatre, which are as a result of an increase in establishment due to activity, to ensure that we are mapping new starters closely to these vacancies.

Registered Midwifery

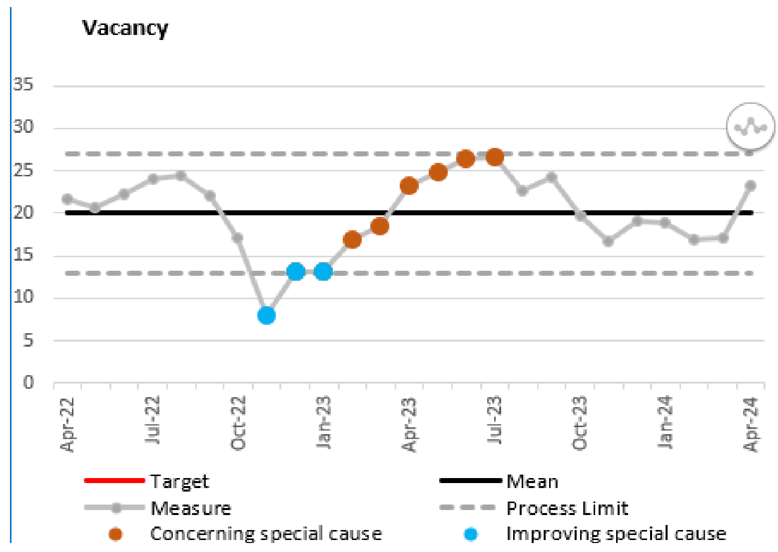
The funded establishment for registered midwives is 241.4 wte and there are 218.2 wte in post with a vacancy rate of 9.6% equating to 23.2 wte vacancies. The vacancy rate has steadily improved over the last year as shown in figure 3 however, the recruitment pipeline is challenging due to international recruitment of midwives not being as established as international nursing and a reduction in student midwives due to the discontinued programme at the local university (Canterbury and Christchurch University).

Community midwifery is an area of focus where there is the highest number of vacancies and is currently on the trusts risk register as a difficult to recruit to area with a high level of sickness. The Attraction Manager is currently working with the Matron for Recruitment and Retention to develop an advertising campaign in conjunction with the maternity team.

At the 2022 annual establishment review, an additional 10.28 wte registered nurses were approved and added to the substantive budget in April 2024. Whilst there have been temporary nurses on duty within midwifery services, this is a new model to employ RNs to care for women following a caesarean section releasing midwives to provide pre and postnatal midwifery care. Recruitment is currently underway for these RN positions. There was also an additional midwife 24/7 allocated to the Antenatal Ward.

The Women's Directorate are currently progressing further a business case to increase the staffing in other parts of the service, in particular in specialist roles. This is in response to the recommendations made by CQC in order to continue with the improvement work outlined in the Maternity Improvement Plan.

Figure 3: Registered Midwifery Vacancies (wte)



Birthrate Plus

In June 2023, a BirthRate Plus© establishment review was commissioned and published. The report concluded that based on 21% uplift there was a minimal deficit of 0.96 wte RMs comparing with the current funded establishment. The service recognises however, that the 21% uplift needs to be reviewed in light of the enhanced training requirements for maternity in order to comply with the Maternity Incentive Scheme Safety Actions.

Maternity Incentive Programme

The Maternity Incentive Programme outlines two compliance requirements which are; one to one care in labour and the supernumerary status of the delivery suite coordinator. These are monitored and reported on the maternity dashboard.

<u>One to one care in labour</u>

Between April 2023 and March 2024, one to one care in labour was reported on the dashboard as 99.5%. The 0.5% related to one case where further investigation revealed that there was rapid onset and progression of labour in Triage. The woman was transferred to delivery suite when labour was diagnosed and delivered quickly after arriving and was supported by a midwife.

<u>Supernumerary status of the Coordinator</u>

Between April 2023 and March 2024, the Supernumerary status of the Coordinator was 100%

Unregistered Nursing & Midwifery

There is an establishment of 729.6 wte for HCSWs bands 2 & 3 with 611.7 in post. The recruitment of Healthcare Support Workers (HCSWs) remains an area of focus and there has been steady improvement as shown in figure 4.

The New to Care programme has now been running for two years, encouraging those who haven't worked in the care industry previously and is part of the national agenda. This has been successful in terms of the reduction of vacancies however, is currently being reviewed to ensure the turnover rate improves for band 2 HCSW which is currently sitting at 15.7%.

Figure 4: Healthcare Clinical Support Workers vacancies (WTE)

2. Current Pipeline

There are currently 148.5 wte registered N&M and 81 wte HCSW who are being recruited to and due to commence in next three months. The Corporate Nursing Team works in conjunction with the Resourcing Team to ensure a joint approach to various recruitment campaigns, adverts, interviewing and open days with a weekly meeting between the two departments.

Domestic Recruitment

The recruitment events have recently been refreshed to run as combined RN/HCSW open days on Saturday's every 6 weeks. These events enable candidates to visit the site, meet members of the clinical team with the option of an interview and potential job offer on the day.

Student Nurses and Midwives are given the opportunity to join the Trust once they have qualified and are invited to complete an expression of interest form in their third year of training. Where possible students are allocated their preferred choice depending on vacancies.

Nurse to Midwife conversion

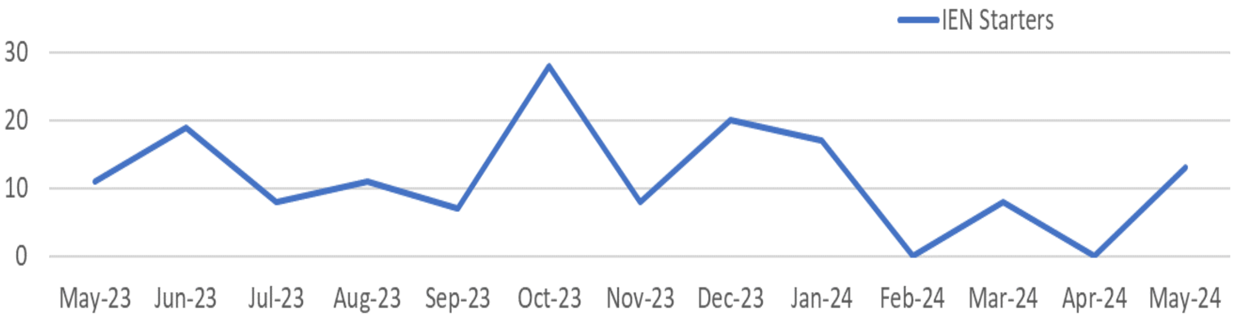
To assist with our maternity workforce a new programme is being offered to Registered Nurses to complete a two-year conversion course to become a Midwife. There are 6 funded spaces available to RNs who would embark on an academic programme with placements in the maternity department. There have been virtual information sessions held on Teams for RNs that may be interested and we have had at eight RNs show an interest with two of these go on to apply. This programme is currently running at Kingston University hence may not be as attractive as a pathway that would run at a local university.

International Recruitment

We are in the third and final year of the approved international recruitment business case which affords us to recruit a further 100 IENs this financial year. 41 of these IENs have been actively recruited to with 59 IENs to recruit for remainder of this financial year. To date 3 Internationally Educated Midwives (IEM) have been recruited to, currently our IEMs have to complete their OSCE

training at another location as we do not provide the training here at MTW due to the low number of candidates.

Figure 5: IEN Starters by month



Over the past three years we have been reliant on international recruitment to reduce the vacancy rate within nursing. Our IENs bring a wealth of experience and effort has been made through our Pastoral Care Lead Nurse and the wider team to ensure their onboarding and adjustment to the UK is seamless. The Chief Nurse regularly holds listening events with our IENMs, at the most recent event in May 2024 our IENs spoke positively about the onboarding process, pastoral support and OSCE training.

The corporate nursing team are currently reviewing the workforce modelling to understand the future demand for IENs and plan a potential business case for the next three years, recognising that the demand will be significantly less. Highlights of this will be shared in our next 6 monthly report.

3. Apprenticeships

We currently have apprenticeship programmes for Healthcare Support Worker (figure 6), Student Nursing Associate (SNA), Registered Nurse/Midwife Degree Apprentice (RNDA/RMDA) and Registered Nurse Degree Top Up (for those that have completed the SNA). The apprenticeship programmes are differing lengths.

-

- SNA – 2 years
- RNDA Top up – 2 years
- RNDA – 4 years
- RMDA – 3 years

Data below demonstrates numbers per cohort and there will therefore be an accumulation year on year (figures 7-11). These programmes allow us to ‘grow our own’ and we have demonstrated this through HCSW’s progressing to become an RNs. However, these programmes impose a financial burden to backfill the member of staff whilst they are in training.

Figure 6: Healthcare Support Workers on Apprenticeship Programmes

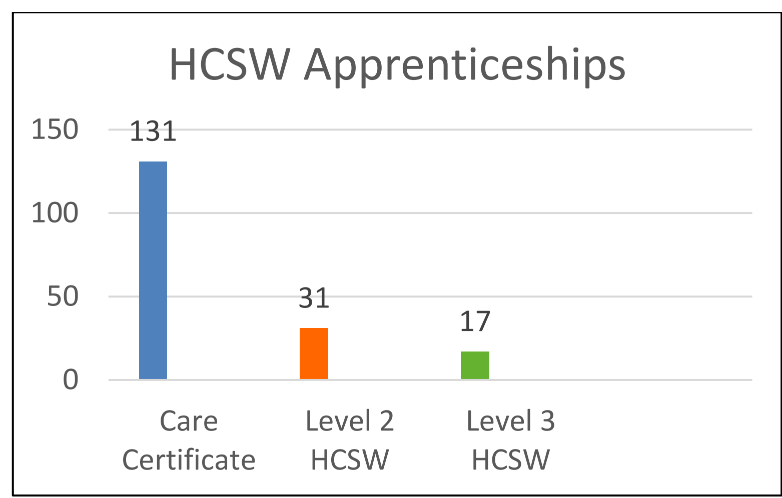
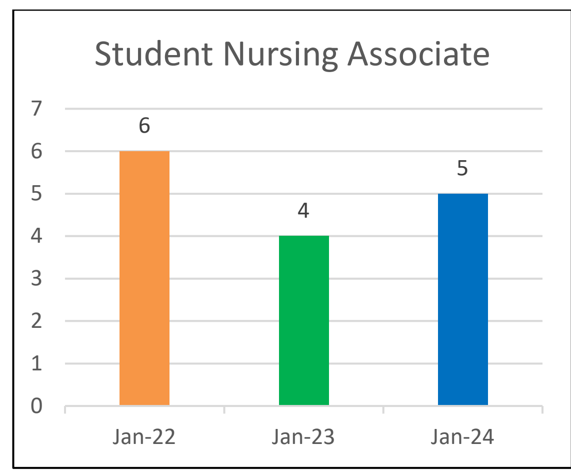
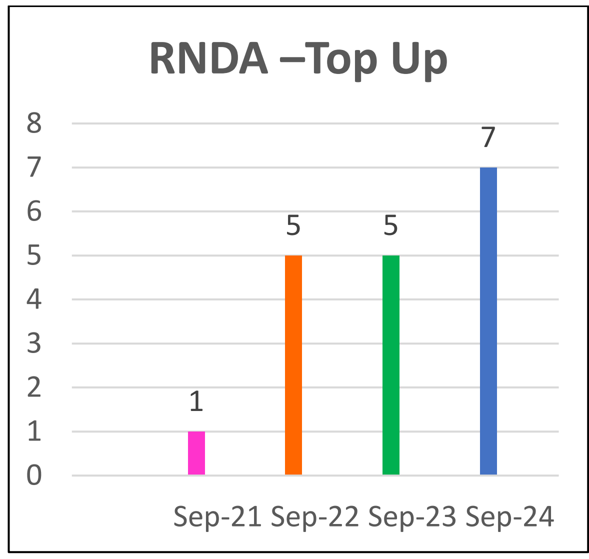


Figure 7: Student Nursing Associates on programme by Division



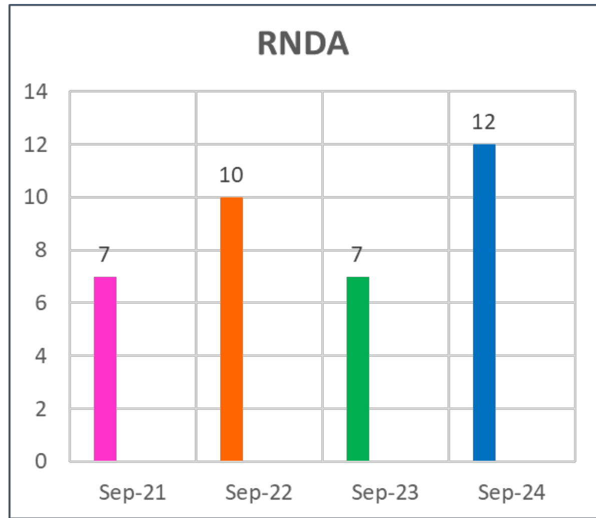
Division	Totals
MEC	9
Surgery	4
Cancer	1
WC&SH	1

Figure 8: Registered Nurse Degree Apprenticeship (Top up from SNA) by Division



Division	Totals
MEC	11
Surgery	6
Cancer	1
WC&SH	0

Figure 9: Registered Nurse Degree Apprenticeship by Division



Division	Totals
MEC	18
Surgery	8
Cancer	2
WC&SH	8

Figure 10: Registered Midwifery Degree Apprenticeship

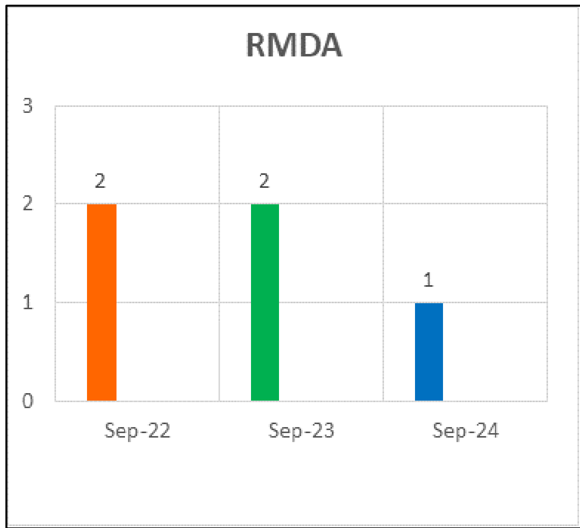
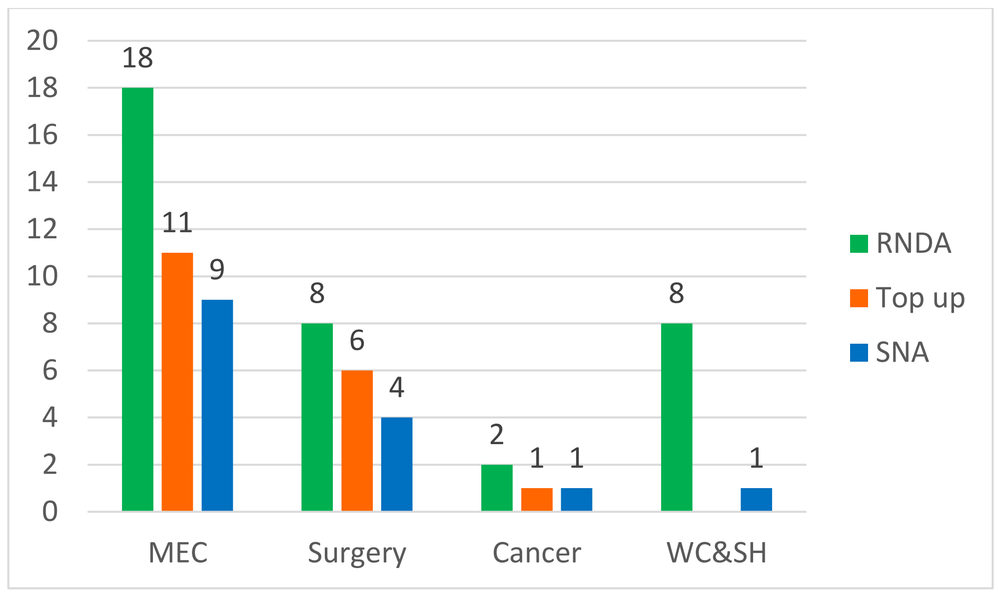


Figure 11: Total Nursing Apprenticeship Trainees by Division



Schools & College Engagement

We are currently working with MidKent College to support T Level Students on placement, the second cohort of 7 students for health are commencing placement in September. We are also working with the teams at MidKent regarding supporting other students into employment.

Careers events at local schools are being supported by the Nursing and Midwifery Education Team (NMET) to promote careers within nursing. A collaborative work experience programme has been developed with AHP's / Scientists to promote careers across the NHS, led by the NMET and Matron for Recruitment and Retention.

4. Turnover & Retention

The current turnover rate for Nursing and Midwifery is 10.1% meeting our target of 10.5%. With the reduction of vacancies our efforts are now focused on the retention of our nursing and midwifery staff. A number of initiatives have been rolled out to support the retention of nursing and midwifery staff;

- The Matron for Recruitment and Retention co-ordinates monthly retention rounds. In the last six months there has been an expansion of Stakeholder engagement on these rounds raising awareness of, flexible working, wellbeing, the CEMN network and Divisional Practice Development teams.
- The Professional Nurse Advocates role has seen an expansion in numbers. This National role supports restorative clinical supervision, career conversations and quality improvement projects within clinical areas. It provides a means for staff to express concerns and to access support easily from within teams.
- The Matron for Recruitment and Retention has been working with the Retention team, Divisions and BI to identify hotspots for turnover, and a deep dive into leaver data.
- Listening events have been facilitated by the Chief Nurse and Deputy Chief Nurses. This provides open access to the senior nursing team so issues can be addressed at pace.
- The Supporting Information for Employers (SIFE) programme to support internationally qualified RN's who are working as HCSW's to achieve their NMC registration is ongoing. This has supported the retention of these staff members, with RN employment being gained within their clinical areas.
- A Student Council has been created at MTW, facilitating added engagement and supporting the retention of students into employment post qualification.
- The Lead Nurse for IEN/M's and pastoral care, supports retention activities for the internationally educated Nursing and Midwives. Advising on career progression and signposting to training which will support their development.
- The Learning Needs Analysis process is now embedded within the Trust, supporting retention through increased parity and accessibility to CPD.

5. Safe Staffing

The focus for ensuring safe staffing within the clinical areas remains a priority and progress has been made with safe staffing governance and processes. Daily staffing levels continue to be closely monitored in real time at site meetings, daily staffing reports, Divisional daily staffing huddles and weekly recruitment activity meetings.

The Safe Staffing policy is live on Qpulse and is now fully operational. Critical staffing escalation cards were implemented in November 2023 and are embedded as part of the MTW Emergency Planning and Business Continuity process. The HoN for Safe Staffing is currently introducing 'Red Flag' reporting. NICE (2014) developed the 'Red flag events' guidance which warn when nurses in charge of shifts must take action to ensure they have enough staff to meet the needs of patients on that ward. Training is currently being provided on how to report red flags and progress will be shared in the next 6 monthly report.

The safe staffing paper is published monthly and incorporated in the executive team workforce update, it is also shared with divisional nursing and midwifery leads and at the monthly N&M Recruitment and Retention Programme steering group.

The Safer Nursing Care Tool (SNCT) audit process has completed four cycles, the fifth commenced on 3rd June 2024. BI SNCT reports are now used as part of the establishment review process, providing evidence of the acuity and dependency of inpatients to inform establishment setting. The June 2024 SNCT audit has been revised to utilise the updated Adult SNCT (2023), giving oversight of enhanced care patients requiring 1:1 or 2:1 supervision. The Emergency Departments are due to roll out the ED SNCT audit process in July 2024 as a pilot.

Safe Care®

Safe Care® is used across all adult and children inpatient areas to support the real time visibility of staffing levels across the Trust.

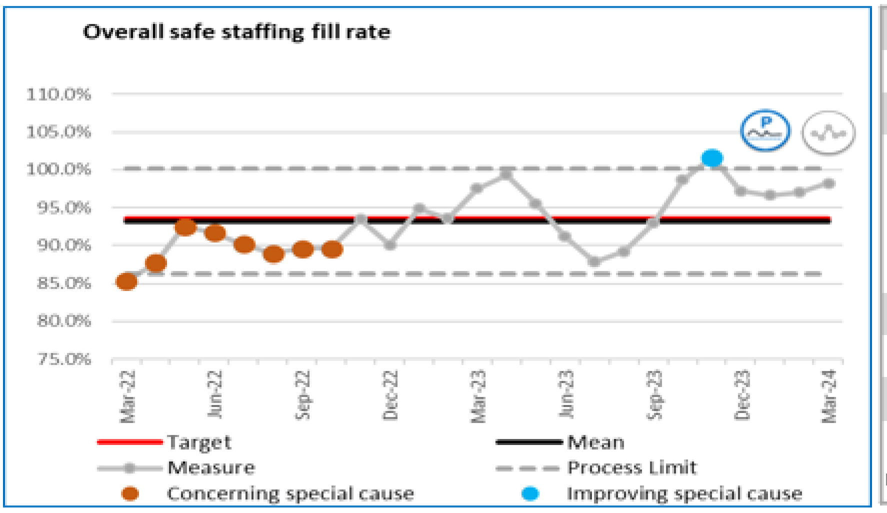
The final stage of the Safe Care project will conclude with the operationalisation of the system, which is scheduled for June 2024. This will see Safe Care® fully utilised in the CCC, with additional Safe Staffing training provided to Ops teams to support this development.

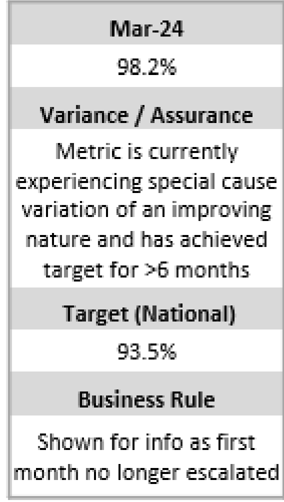
Staffing Fill Rates

Planned Vs actual staffing fill rates are monitored monthly and submitted to NHSIE. Safe Staffing fill rate has increased to 99.3% which is 5.8% above target as shown in figure 12. This reflects the increase of staff in post within clinical areas and a reduction of vacancy.

It should be noted that data is demonstrating overfill within the clinical areas, and this is especially prevalent on nights. This can be attributed to additional duties being added for enhanced care, and a governance structure in relation to additional duties is being developed as part of the Enhanced Care project and eRostering oversight.

Dynamic corrections are ongoing to Healthroster to ensure roster templates match the funded establishment. Further developments have seen changed to Healthroster profiles to support the reduction of temporary staffing spend and increase the management and accuracy of eRosters.
Figure 12: Safe Staffing fill rate





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

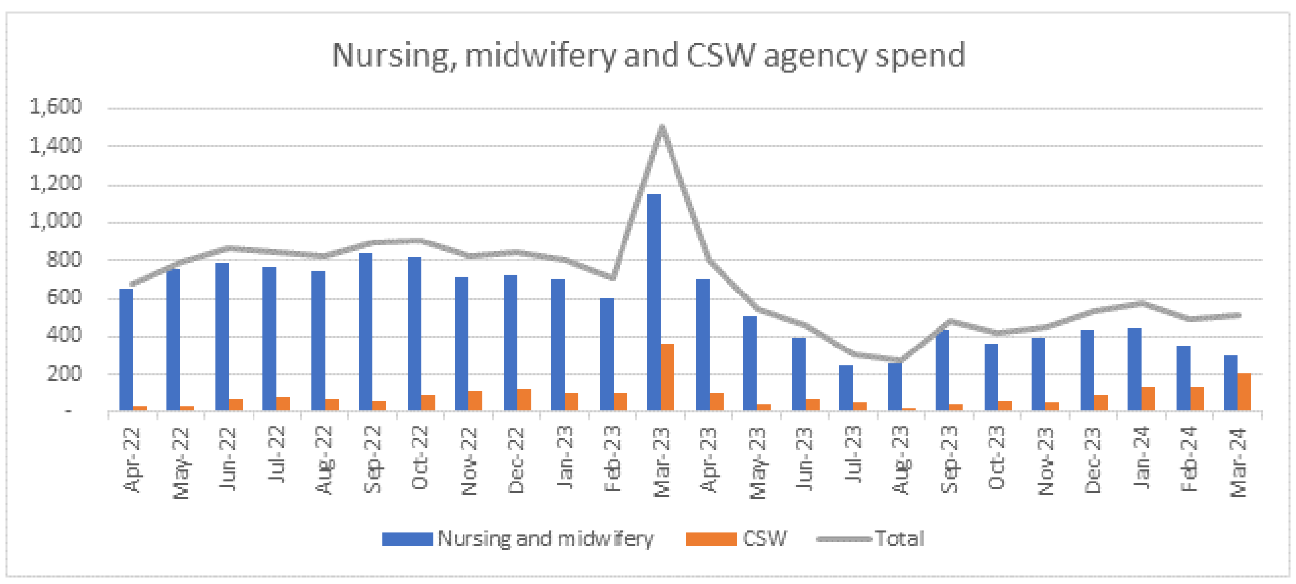
6. Rostering & Temporary Staffing

Confirm and support meetings with the divisions are now fully embedded led by the Head of Nursing (HoN) for Safe Staffing supported by the Corporate Rostering Team Leader. The purpose of these meeting is to ensure there is effective rostering reviewing KPIs for annual leave, net hours, roster approval times and use of additional duties/temporary staffing. KPI's are reviewed at

the meeting such as roster approval times, net hours (hours owed to or from staff member), annual leave allowance and temporary staffing use.

The HoN for Safe Staffing in collaboration with the temporary staffing team is now overseeing temporary staffing complaints. This provides a clinical perspective, with a process developed for clarity for the clinical and temporary staffing teams, and bank staff.

With the improved vacancy rate and new control measures in place there has been a significant reduction in agency use which is demonstrated in our finance reports as outlined in figure 13.
Figure 13: Trend in agency spend in Nursing & Midwifery



The Nursing and Midwifery workforce has delivered significant reduction in agency pay costs as demonstrated in figure 14.

Figure 14: Agency spend by staff group

	23/24	22/23	% reduction in spend compared to 22/23
Agency	**YTD Exp**	**YTD Exp**	
Admin and clerical	1,750,362	2,655,564	*-34%*
Medical Staff	7,482,279	10,937,534	*-32%*
Nursing and midwifery	4,836,970	9,312,423	*-48%*
AHP and healthcare scientists	2,301,606	2,741,916	*-16%*
CSWs / ward clerks	1,113,114	1,885,734	*-41%*
Total Agency	**17,484,332**	**27,533,172**	*-36%*

Whilst there has been an improvement in agency spend the bank spend has not made the same improvement, as seen in figures 15 & 16. This is currently an area of focus with control measures introduced to ensure that additional shifts added to the roster are reviewed prior to sending to bank. The reasons given for any additional duties are currently being analysed however, it is known that additional duties are regularly used to provide 1-1 care to patients such as those with dementia. In addition, our uplift, which currently sits at 21%, may not meet our needs in terms of mandatory training requirements and this is currently under review.

Figure 15: Bank spend in Registered Nursing & Midwifery

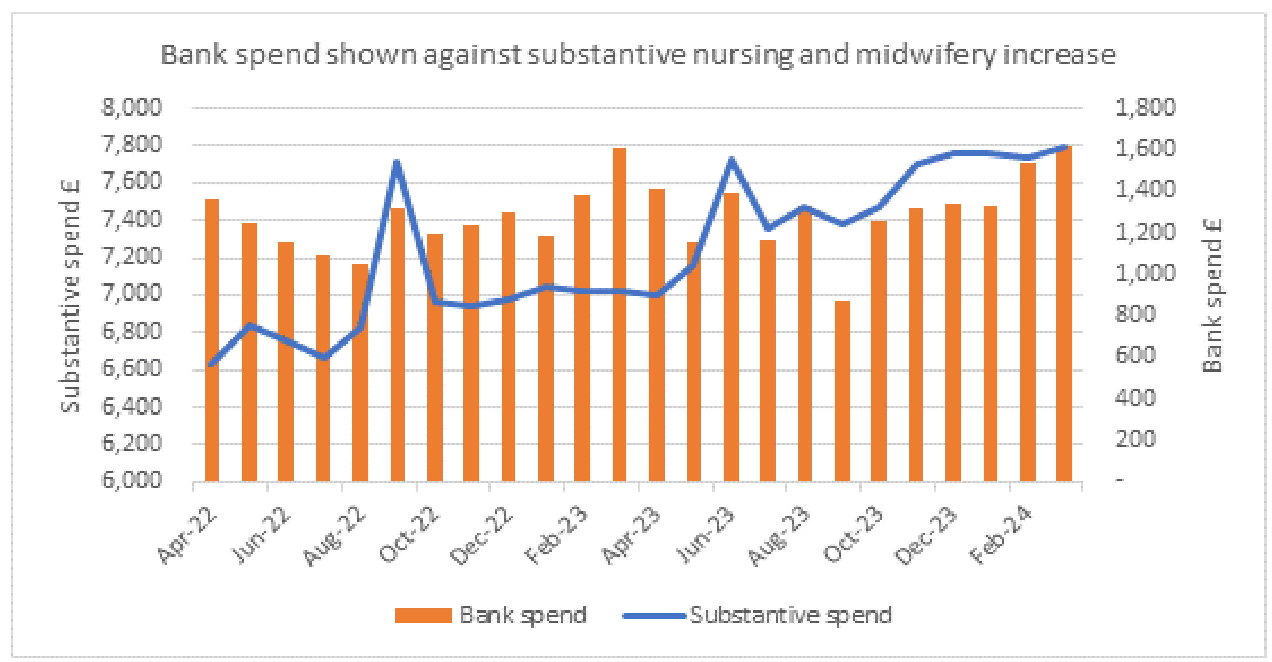
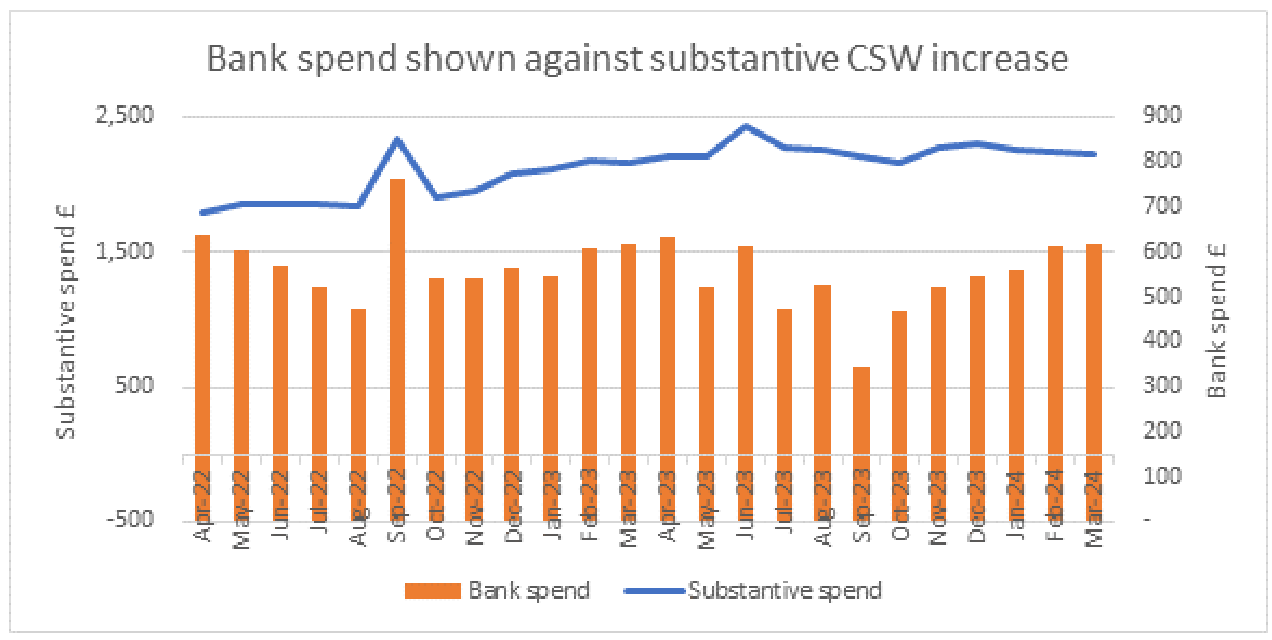


Figure 16: Bank spend in Healthcare Support Workers



7. Establishment Review Changes

The business case to increase establishments (from October 2022) was approved and went into budgets in April 2024. This saw an increase in establishments by 67.72 wte spilt between registered (31.35 wte) and non-registered (36.36 wte) positions.

The expected benefits of these changes, as outlined in the business case, have been identified are as follows:

1. Standardisation of nurse to patient ratios across all wards.
2. Reduction in temporary staffing spend in particular for RMNs and HCSW who provide enhanced care.
3. Improved patient and staff experience.
4. Improved patient flow with more time to focus on discharge planning.
5. Reduced redeployment of staff subsequently improving staff morale.
6. Improved retention rates.
7. Potential to increase placement capacity for Student Nurses.
8. Safer nursing and midwifery care delivery.

Progress against these will be monitored and shared in the October 2024 report. Other outstanding actions from previous establishment reviews can be seen in appendix 2 which are being considered as part of business planning in the divisions. Recommendations from the October 2023 annual establishment review identified the following safety critical recommendations (15.36 wte);

Surgical Division Recommendations

Area	Band	Recommend Change	Progress Update
Critical Care Outreach	7	Additional RN at night weekends (currently 1) 1.48wte	Not funded, using bank as required being considered as part of business planning.
		Total 1.48	

Medicine & Emergency Care Division Recommendations

Area	Band	Recommended Change	Progress Update
Ward 22 (TW)	2	Additional 1HCSW on Night extra two beds (2.48WTE)	Reviewing enhanced care costs to consider converting some of this spend to substantive
ED (TW)	5	To cover second 24hr Triage nurse (5.2wte)	Had been funded with winter pressures monies. Now unfunded and staff are reallocated where possible.
A&E Paediatric Services Riverbank - NC370	5	Increase by 1 RN day and night (5.2wte)	Day shift is in place as a cost pressure. Night shift not covered. MEC to discuss with Paediatrics to consider other options.
		Total wte: 12.88	

Cancer Division Recommendations

Area	Band	Recommended Change	Progress Update
Outpatients cross site	7	I WTE Practice Development Nurse (1.00wte)	Funded and in post
		Total wte: 1.00	

Given the significant financial investment from the previous year's establishment review, the remainder of the recommendations were redirected to the divisions to consider as part of business planning an update of which can be found in appendix 2.

8. Nursing and Midwifery Workforce Plan

The Nursing and Midwifery Workforce Plan has been developed and summarises the current N&M workforce position within the Trust outlining our recruitment and retention plan for the next 5 years

(see appendix 4). It describes the current establishment, strengths and challenges and our ambitions with the overarching objective to maintain a vacancy rate of 10% and maintain turnover below the 12% trust target.

Conclusion

This report provides an explanation of the current staffing position which demonstrates the improved vacancy and turnover rates, highlighting areas of focus for recruitment (hot spots) which are ED TWH, Theatres, Community Midwifery and HCSWs. The temporary staffing spend (agency) has improved but it is recognised there is still work to do in terms of reducing the bank spend. Uplift allowance for specialist areas and enhanced care continue to contribute to temporary spend and are currently being reviewed. The actions from last year's establishment review have not yet been delivered and continue to be considered within the divisions noting the current financial position and the significant investment N&M has already had this year. Going forward consideration needs to be given as to how we will fund any further international recruitment and apprenticeships programmes which come at a cost due to backfill.

Appendix 1: Nursing and Midwifery Workforce progress since previous report

The table below outlines key actions achievements since the last report in December 2023.

Theme	Action
Recruitment	• Combined 6 weekly recruitment events for RN & HCSW • Focused recruitment for hot spot areas – Theatres and ED. • On target with recruited the 100 IENs funded for this year. • Continuation of ambitious international recruitment campaigns. • Focused effort with student nurses/midwives in their third year of training and expression of interest the trust to join substantively. • Introduction of quarterly Saturday recruitment open days for Registered Nurses & Midwives. • Review of process underway for recruitment of temporary staffing.
Retention	• Increase pastoral support through establishment of Pastoral Care Lead Nurse • Listening events with the Chief Nurse • Review of internal transfer policy. • RN to RM conversion programme. • Themed programme of retention rounds implemented. • IEN/M Council established. • Student Council established. • Engagement calls for both IEN's and Domestic recruits • Staff recognition through reward programmed at local/ICB/National Level • Increased opportunities for external courses through LNA programme.
Safe Staffing	• SNCT Adult inpatient audit process now embedded, with March and June 2024 SNCT audit reset with Adult SNCT • Staffing Red Flags implemented in February 2024 • Full operationalisation of Safe Care system with go live in CCC June 2024. • Complaints process for temporary staffing devised and Temporary Staffing complaints now overseen by HoN for Safe Staffing. • Revised Healthroster Profiles implemented.
Training & Development	• Review of expectations in terms of hours required for each nurse/midwife/HCSW to complete mandatory training. • Continuation of apprenticeship programmes (RNDA, RMDA, TNA). • Continued efforts to complete annual learning needs analysis. • Introduction of Matron/HON Leadership Programme • Pilot of the Springboard Development Programme for Band 5's to 6 completed. • Multiprofessional Work Experience Programme commenced June 2024 • RN Induction programme reviewed and revised to launch in August 2024 to improve face to face content. • T-Level placements planned for second cohort September 2024 • Student Placement expansion project has enabled an increase in student placement capacity for pre-reg student nurses across both sites

Appendix 2: Establishment Review 2023 Recommendations

Divisions to consider as a priority, via business planning

Surgical Division

Area	Band	Recommend Change – Divisional Lead
SAU (TW)	5	Increase night by 1 RN
SAU (TW)	5	Increase day by 1 RN
ENT	4	Increase establishment by 1.2 WTE cross site
Vascular Access Service NT401	6	Additional 2 B6 WTE to support increased activity
ITU TWH	7	1 WTE Band 7 rehab and follow up

Medicine & Emergency Care Division

Area	Band	Recommended Change – Divisional Lead
Whatman Ward - NK959	2	Additional 1 HCSW on LD
Mercer Ward (M) - NJ251	2	Additional 1HCSW on Night
AMU/AEC (TW)	5	Addition B5 at weekend
Culpepper (M)	2	Additional 1 HCSW on Night
A&E Paediatric Services Riverbank - NC370	5	Increase by 1 NN to support 24 hour 7-day service
Paeds A&E TW	5	Increase by 1 RN day and N

Women Children & Sexual Health Division

Area	Band	Consider Recommendation – Divisional Lead
SCBU (TW) - NA102	7	Additional 0.5wte practice development Nurse
Paediatrics Out Patients - LC451 & LC402	7	BCG Clinic paediatrics & maternity
Hedgehog	6	To support National RCPCH Standards
Paediatrics Out patients – LC451 & LC402	2	Additional 2 HCSW (1 per site)
Ward 33	2	Additional 3 WTE HCSW

Cancer Division

Area	Band	Consider Change – Divisional Lead
HODU (TW)	6	Additional 1 WTE

Divisions to consider
Surgical Division

Area	Band	Division to consider with activity plans
Endoscopy (M)	7	Increase by 8 wte due to increase activity
Endoscopy (TW)	7	Increase by 2.2 wte due to increase in activity
Pain Team	7	Increase band 6-7 1 wte development role
ITU (TWH)	3	Increase rota coordinator to 2.4 wte

Medicine & Emergency Care Division

Area	Band	Division to consider with activity plans
CCU (TW)	5	Increase Ward clerk to 1 WTE
AMU/AEC (TW)	3	2 additional HCSW(posts removed for flow coordinator)
AAU	3	1 additional HCSW (posts removed for flow coordinator)
ED (M)	5	Additional 10.72 WTE band 5- phased approach

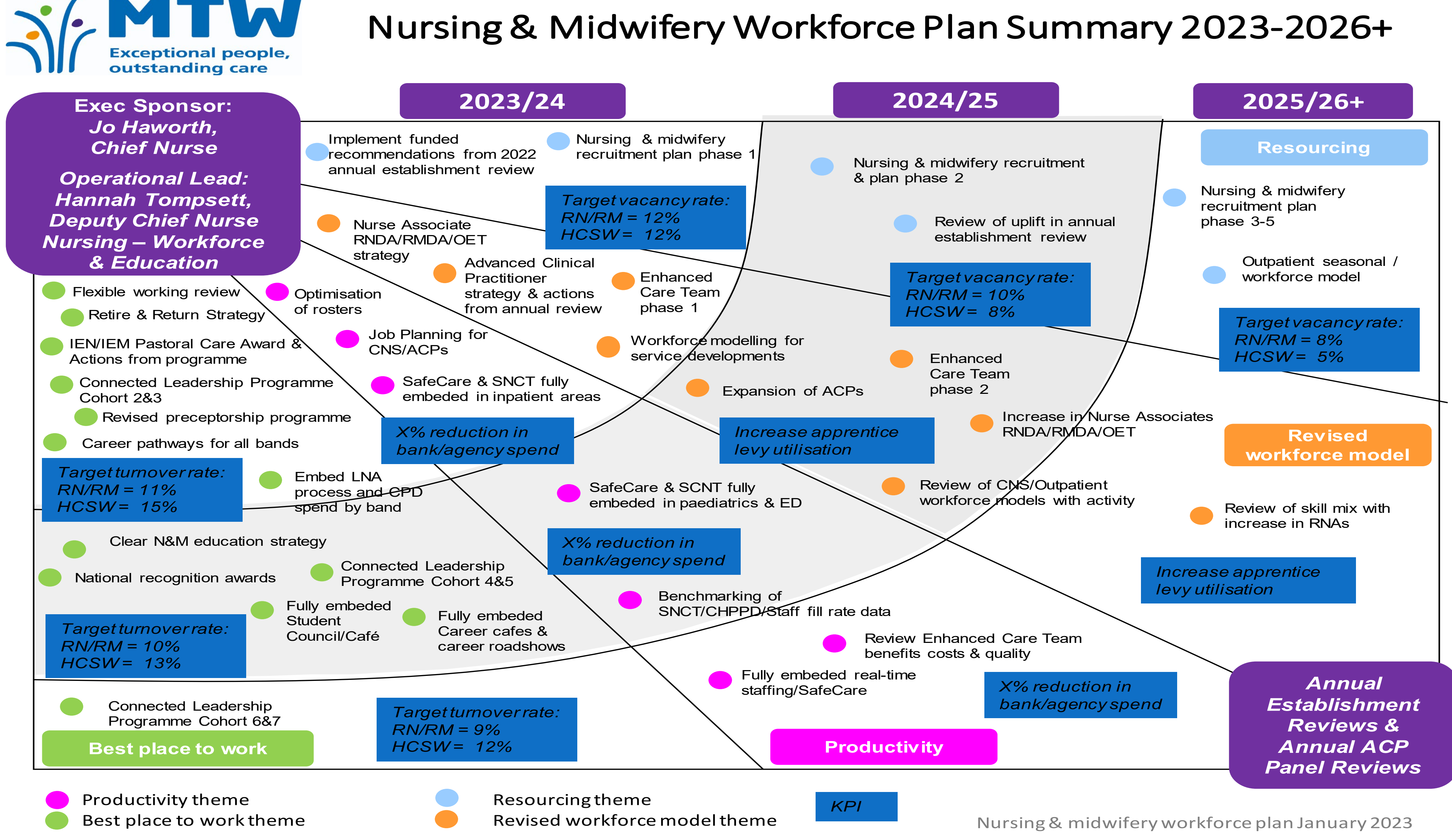
Women Children & Sexual Health Division

Area	Band	Division to consider with activity plans
Hedgehog (TW)	7	ACP role to be converted from band 6- 7
Neo-natal (TWH)	7	Parental support sister rebanded 6-7
Children’s OPD	2	1 additional HCSW on each site
Ward 33 (Gynae) (TW) - ND302	6	Triage Phone EGAU
Whitehead Ward (Gynae) (M) - NK359	6	Additional 0.8 WTE B6
Whitehead Ward (Gynae) (M) - NK359	3	Additional B3 A&C to make 1 WTE post, currently 0.64

Appendix 3: Outstanding Nursing & Midwifery Actions from previous establishment reviews

Actions from 2022	Owner	Status
Standardise skill mix % i.e number of Band 6 per ward	DCN	Ongoing
Review shift handover times in maternity	DCN/Head of Midwifery	Ongoing
Scope safeguarding demand paediatrics and maternity	DCN Quality & Patient Experience	Ongoing
Standardise Band 7 Supernumerary time	Chief Nurse/DCN	Ongoing
Standardise admin time for CNS with a clear job planning process	DDNQ	Ongoing
ACP role expansion to be included in business planning	DCN	Ongoing
Standardise use Workforce Rota Calculator	Matrons & Finance Managers	On going
Uplift not meeting national recommendations of 22% ward areas and 25% specialist areas	DCN/business planning	On going
Review activity in divisional business planning and impact on nursing workforce – ED, Clinical Nurse Specialists, Outpatients, Preop, Theatres.	DDNQ/DDO	On going
Increase in consultants Vs outpatient/CNS workforce mapping	DDNQ/DDO	On going
Standardise recruit to turnover by 2 WTE band 5's per ward	DCN/Head of Finance	Ongoing
Flexible working guidance for working predominately nights.	DCPO	Ongoing
Actions from 2023	**Owner**	**Status**
Review supernumerary time across all areas	DCN/DDNQ	Ongoing
Develop enhanced care team for HCSWs	DDNQ/Mental Health Lead	Ongoing
Reduce temporary staffing spend	DCN/DDNQ	Ongoing
Review uplift against number of mandatory training courses	DCN	Ongoing
Ensure new Consultant posts recruited to consider increased activity.	DDNQ	Ongoing

Appendix 4 - Nursing & Midwifery Workforce Plan Summary



BIRTHRATE PLUS® ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

June 2023

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Birthrate Plus®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community.

Factors affecting Maternity Services

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community

care. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there ae women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows. Should more local women choose to birth at the local hospital in the future adjustments will need to be made to workforce to provide the ante natal and intrapartum care.

The NICE guideline on Antenatal Care recommends that all women be ‘booked’ by 10 weeks’ gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal women.

Discussion of Results

1. This is a final report of the midwifery workforce requirement for maternity services in Maidstone and Tunbridge Wells (MTW) NHS Trust.

2. The decision was made to collect new casemix. The intrapartum casemix has the major impact on the midwifery establishment. A 3 months' sample from October to December 2022 was obtained from the Maternity System, with a manual review of records included and additional scrutiny by the Birthrate Plus consultant.

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
2022	1.6	12.4	18.5	30.4	37.1
	32.5%			*67.5%*	
2020	*39.0%*			*61.0%*	

Table 1: Casemix

3. Table 1 shows the current casemix and the increase to the higher categories from the 2020 data which reflects the rise in acuity of mothers and babies due to an increase in inductions, more co-morbidities such as gestational diabetes, perinatal mental health, high BMI. The same increase in acuity is happening in most maternity services.

4. Annual activity is for 2022/23. Total births of 5708 are allocated as below. This is similar to the birth numbers in the last report.

	Annual Total
Delivery Suite	5083
Maidstone Birth Centre	379
Crowbrough Birth Centre	162
Home Births	84
Total Births	**5708**

Table 2: Annual Activity

5. Table 3 shows the additional intrapartum activity in the delivery suite.

	Annual Total
Antenatal cases needing 1 to 1 care	1065
Postnatal readmissions	50
Escorted transfers OUT	16
Non-viable pregnancies	33

Table 3: Additional Intrapartum Activity

6. All delivery suites have antenatal cases where women require monitoring and often treatment for obstetric or medical problems such as antepartum haemorrhage, preterm labour, reduced fetal movements, etc. Often the women are transferred to the maternity ward or to another unit if need a higher level of neonatal services. Postnatal readmissions may require a theatre procedure or enhanced midwifery care for conditions such as sepsis.

7. Table 4 shows the annual inpatient activity on the maternity ward.

	Annual Total
Antenatal admissions *(exc. Elective cases)*	1371
Medical Inductions of Labour	1452
Postnatal women *(includes transfers from BCs)*	5118
P/N readmissions	98
Extra care babies	700
NIPEs and Frenotomies	*Weekly hours*

Table 4: Antenatal and Postnatal Ward Activity

8. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. The annual activity indicates 1371 admission episodes to the ward excluding inductions and elective sections. This is an increase from the previous assessment with 1080 reported.

9. Medical inductions of labour are mainly undertaken on the ward and the annual total of 1452 are actual insertions but may be less women as some may have more than one insertion.

10. The 'extra care babies' of 700 are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.

11. There is minimal readmission activity to the ward, namely 98 per annum.

12. Staffing is included for midwives to undertake the newborn examination (NIPE). The rest are undertaken in the community setting. NIPE for home and FMU births is routinely included.

13. The staffing for Triage covers a 24 hour period, 7 days per week, with 3 midwives during the day and 2 at night. In addition, there is a daily phone line staffed by a midwife. This is in line with the BSOTS model (Birmingham Symptom-specific Obstetric Triage System). This stipulates 2 midwives as a minimum throughout the

24 hours and 7 days a week with one carrying out the immediate triage assessment and one to undertake the detailed review.

14. The Day Assessment Unit (DAU) is staffed with a midwife 5 days a week for 10 hours each day and sees scheduled cases.

15. Outpatient Clinic services are based on the average hours of each session time and numbers of staff to cover these, rather than on the number of women attending and a dependency classification. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service.

16. Table 5 provides a summary of the community population receiving maternity care.

	Annual Total
Home Births	84
Community Exports (Out of Area births)	463
Imports – AN and PN care	619
Imports – AN care only	46
Imports – PN care only	350
Total Community Cases (AN &/or PN care)	6176
Attrition Cases *(pregnancy loss or move out of area)*	711
Significant Safeguarding cases	400

Table 5: Community Activity

17. The community annual total includes 619 women who birth in neighbouring units and receive ante and postnatal care from the Trust midwives (community imports). The antenatal and/or birth episodes are provided by neighbouring units. There are 46 women only having their antenatal care and 350 postnatal care.

18. The community exports of 463 are 'out of area' births (women who birth in MTW but live outside of the geographical area) and therefore and receive their community care in their local trust.

19. The 5711 attrition cases are women who may book and/or see a midwife in early pregnancy but either move out of area or have a pregnancy loss.

20. The Trust has 2 birth centres operating in Maidstone Hospital and Crowborough where women without complications are seen for delivery and immediate postnatal care. The ante and home based postnatal care is provided by the community teams. Table 6

shows the annual activity and staffing has been calculated based on 2 midwives throughout the 24 hours in Maidstone and 1 at all times in Crowborough.

	Maidstone	Crowborough
Births - transfer home	354	152
Births - transfer to obstetric unit	25	10
Transfers to delivery suite	74	193
Triage cases	500	48

Table 6: Birth Centres Activity

21. Approximately 400 women have safeguarding needs require significant input from the community midwives such as increased surveillance, support and signposting to other services. An additional 2.92wtte has been included for this additional care.

22. The total community cases of 6176 includes all imports and excludes home births and exports and attrition cases.

23. The annual community cases including FMU/home births and attrition is 6801which is more than the annual births by 1093 cases. Community cases are often different to the total birth numbers and this should be considered when deploying the wte required for each area.

24. The staffing figures (Table 6) include allowances of 21% uplift for annual, sick and study leave which is the current uplift plus the recommended wte for 23% uplift has also been included as requested by the Director of Midwifery. 12.5% travel allowance is included for community midwives.

25. The Birthrate Plus staffing is primarily based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

26. Day to day management by ward and department managers, community team leaders and coordination of intrapartum services are included in the clinical establishments.

27. The total clinical wte will contain the contribution from appropriately trained Band 3 MSWs in hospital and community postnatal services.

28. Most maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), possibly Band 4 Nursery Nurses and sometimes Band 5

RNs working in postnatal services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix, using professional judgement along with their local knowledge and expertise of the service.

Breakdown of Birthrate Plus® Staffing (21% and 23%)

	WTE 21%	**WTE 23%**
Delivery Suite • Births • Antenatal Cases • P/N Readmissions • In-utero transfers out • Non-viable cases	66.08wte RMs	67.17wte RMs
Triage	16.49wte RMs	16.76wte RMs
Antenatal care • Antenatal admissions • Inductions	10.84wte RMs	11.02wte RMs
Postnatal care • Postnatal women • Postnatal Re-admissions • Postnatal ward attenders • NIPE sessions • Extra Care Babies	53.87wte RMs and B3 MSWs	55.25wte RMs and B3 MSWs
Outpatient Services • Obstetric Clinics • Specialist Midwife Clinics • Midwife Clinics • Midwife sonography	6.34wte RMs	6.44wte RMs
Day Assessment Unit	1.61wte RMs	1.64wte RMs
Tunbridge Wells Hospital Total WTE	155.23wte	158.28wte
Community Services: • Home Births • Community Cases • Attrition Cases • Additional Safeguarding	64.53wte RMs and B3 MSWs	66.21wte RMs and B3 MSWs
Maidstone Birth Centre	10.84wte RMs	11.02wte RMs
Crowborough Birth Centre	5.42wte RMs	5.51wte RMs
Total Clinical WTE	**236.02 RMs and PN B3 MSWs**	**241.02 RMs and PN B3 MSWs**

Table 7: Birthrate Plus® Staffing – based on 21% and 23% uplift

29. Comparing the Birthrate Plus wte to current funded establishment will include the contribution from 5.42wte Band 3s working on the postnatal ward and 5.92wte MSWs in the community.

30. The remaining Band 3s and Band 2s are excluded as they provide additional support to women and babies.

Clinical Specialist Midwives

31. The clinical specialist midwives have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The remaining % is included in the non-clinical roles. Currently there are 31.76wte Specialist Midwives in substantive funded posts of which 214.95wte (47%) are allocated to the clinical total. The remaining 16.81wte (53%) are included in the additional wte.

Current Clinical Funded Bands 3 – 7

32. Comparisons are made with the current funded establishment as per table 8 below.

RMs Bands 5 – 7	Specialist Midwives contribution	MSWs bands 3/4	Current Total Clinical wte
206.92	14.95	11.34	233.21

Table 8: Current Funded Establishment

Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	% Uplift	Birthrate Plus establishment bands 3 – 7	Variance Bands 3 – 7
233.21	21%	236.02	-2.81
233.21	23%	241.02	-7.81

Table 9: Comparison of Clinical Staffing

33. Table 9 indicates a deficit of 2.81wte at 21% uplift and 7.81wte at 23%. Depending on the agreed skill mix, the shortfall will be midwives and or postnatal support staff as shown in Table 10.

% uplift	Skill mix %	RMs	MSWs	Variance
21%	Current 95/5	-2.67	-0.14	-2.81
	90/10	9.45	-12.26	-2.81
23%	Current 95/5	-7.43	-0.38	-7.81
	90/10	4.95	-12.76	-7.81

Table 10: Clinical Variance by skill mix

Non-Clinical Midwifery Roles

34. The total clinical establishment as produced from Birthrate Plus® is 236.02 or 241.02wte and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services, as summarised below.
    - Director of Midwifery, Head of Midwifery and Matrons (Ante and Postnatal Inpatients/ Delivery Suite, Triage and Theatres, Governance, Transformation, Recruitment and Retention, Safeguarding and Antenatal Clinics and Consultant Midwife
    - Specialist Midwives with responsibility for:
        - Bereavement
        - Screening
        - Diabetes
        - Smoking
        - Infant Feeding
        - Mental Health
        - Transitional Care
        - MECU

- Fetal Wellbeing
- Safeguarding
- PMA
- IT Support
- Risk and Governance
- Care Pathway Coordinator
- Practice Development
- Thrive Midwife
- Project Midwife
- Compliance Midwife

Applying 11% to the Birthrate Plus clinical wte provides additional staff of 25.96wte or 27.81wte wte for the above roles with it being a local decision as to which posts are required and appropriate hours allocated (Table 11).

Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles. The % can be set locally, although the RCM Staffing Guidance support 9-11% and Birthrate Plus is NICE endorsed hence being generally applied in maternity services.

Current funded wte	% Uplift	Birthrate Plus wte	Variance wte
27.81	21%	25.96	1.85
27.81	23%	26.51	1.30

Table 11: Comparison of additional specialist and management wte

35. Table 11 shows the current funded establishment is adequate to provide the additional roles.

Summary of Results

Current Funded Clinical, Specialist, Management wte	% Uplift	Birthrate Plus wte	Variance wte
261.02	21%	261.98	-0.96
261.02	23%	267.53	-6.51

Table 12: Total Clinical, Specialist and Management wte

36. The results indicate a minimal deficit of 0.96wte comparing with the current funded establishment inclusive of 21% uplift.

37. Applying a higher uplift of 23% increases the recommended staffing from 261.98wte to 267.53wte resulting in a deficit of 6.51wte.

38. In addition to the midwifery staffing, there is a need to have support staff usually at Bands 2 and 3 working on the birthing unit, maternity ward and in outpatient clinics. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

39. The current requirement of additional support staff is 54.27wte which will provide adequate staffing for delivery suite, supporting triage, ante/postnatal wards, in antenatal clinics and the birth centres.

Using ratios of births/cases to midwife wte for projecting establishments

40. To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will consider an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters. Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

41. In addition, a % is added (11%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

42. Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths. If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have all community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 95 cases to 1wte is the correct ratio to apply. To use the ratio of 24.2 births to 1wte will overestimate the staffing as this covers all ante, intra and postnatal care. As some women only have ante or postnatal care, the correct ratio can be used should this activity change.

43. A woman who births in hospital but is 'exported' to another community, then the ratio of 32.7 births to 1wte should be applied, as this will account for an increase in activity in all hospital services. The main factor in using ratios is to know if having total care from the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results

44. The ratios below are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, 21 % uplift for annual, sick and study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, staffing of birth centres and total number of women having community care irrespective of place of birth and primarily the configuration of maternity services. Decisions on staffing numbers per shift rather than on the activity alone affect ratios.

45. Note: the ratios are based on the staffing figures with 21%. There will be a change in the ratios using 23% uplift.

Hospital births, all hospital care	32.7 births :1 wte midwife
Home births *Note: The Birth Centres apply minimum staffing so not based on activity*	35.0 births:1wte midwife
Ante **and** postnatal community care (hospital births) *including attrition cases and safeguarding*	95.0 births:1wte midwife
Community ante OR postnatal care only (hospital births)	183 OR 232 cases to 1 wte
Overall ratio for all births	**24.2 births:1wte midwife**

Table 13: Ratios

46. The 1:24.2 ratio equates to the often-cited ratio of 28 births to 1 wte, but they are not directly comparable for the above local factors. The latter ratios were based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 4 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

Appendix 1

<u>Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery</u>

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

Trust Board meeting - 27th June 2024

Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	**Rachel Jones. 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?

The report has not yet been received by any other committees but will go the Executive Team meeting on 2nd July.

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

The reason for submission is for information and discussion.
It outlines the significant programmes of work being undertaken at system and place level.

[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

June 2024

Exceptional people, outstanding care

ICB/ System news

- The acute provider collaborative work on reviewing acute services is progressing with the first phase report now released. The two services agreed for the initial review are ENT and Endoscopy. It is recognised that work is currently underway in both areas and to provider collaborative will provide support and focus to those forums. The approach to this will be discussed at the Acute Provider Collaborative meeting on 20th June.

- The individual provider level data has been collated and the data packs shared with the relevant provider for local analysis and discussion. For MTW the initial focus will be general medicine and its sub specialities.

Exceptional people,
outstanding care

ICB/ System news

- 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 we are expecting it will come to Board in July alongside the Shared Delivery Plan which has also been refreshed.
- The system is preparing for the junior doctor industrial action planned for the 27th June to 2nd July and are encouraging people to access the most appropriate services for their needs with the support of **www.stopthinkchoose.co.uk**
- The ICB is leading work to shape its plans for improving community services and has several listening events planned which can be found at **www.kentandmedway.icb.nhs.uk/news-and-events/news/help-shape-future-community-healthcare**

Exceptional people, outstanding care

West Kent HCP

The Executive Group took place on Thursday 13th June and the meeting considered a number of items including joint working with the ICB to develop our approach to shared estate and estate utilisation. The group also had a presentation on an early draft of the approach to long term condition management in West Kent

The Development Board due to take place on Thursday 20th June was postponed due to the availability of agenda items and speakers.

The HCP is implementing the better use of beds programme in West Kent and had the first workshop on 7th June. The existing Discharge and Flow Programme Board will take responsibility for leading the work and the Terms of Reference are being reviewed to support that. This links directly to the community provider collaborative alongside the work in delivering Integrated Neighbourhood teams which remains the priority.

The process to TUPE the HCP facing staff currently employed by the ICB is being planned and expected to commence in July.

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.

Trust Board meeting – 27th June 2024

To approve the corporate objectives for 2024/25	Director of Strategy, Planning and Partnerships

The purpose of the report is to update the Board on the review of the corporate objectives, encompassing vision goal, vision target and break through objectives.

The areas under review are:
- The break through objective for patient access
- The internal break through objective for systems and partnerships and;
- The people break through objective

Which Committees have reviewed the information prior to Board submission?
This work is part of the executive Strategy Deployment Review (SDR) process reviewed at the Executive Team Meeting (ETM) once per month.

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

Corporate Objectives Review

Rachel Jones
Executive Director Strategy, Planning & Partnerships

June 2024

Patient Experience

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

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

- Staff attitude and behaviour
- Inconsistent communication
- Inaccurate communication

The vision goal, vision target and break through objective will remain as is.

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

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

Latest progress: Current Position is 1.10
Go live of revised incident reporting categories on InPhase on 2nd April which will support more accurate reporting in the future. The focus is currently on reducing unnecessary 222 calls for peri arrest.

The vision goal, vision target and break through objective have recently been updated and will remain as is.

Patient Access Vision Goal	All of our patients should be able to access the highest quality care and treatment when they need it, whether its as an emergency, waiting time for a cancer diagnosis or waiting for elective surgery.	Sean Briggs
Patient Access Vision Target	Achieve the Trust RTT Trajectory by March 2025	Sean Briggs
Patient Access Breakthrough objective	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Sarah Davis

Latest progress: Current position of 131.0% of new outpatient activity in May 2024, which has also improved our RTT18 week performance to 75.4%.
There have been a number of Trust wide improvements such as Patient portal and GIRFT Further Faster recommendations.

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

The vision goal and vision target will remain. The break through objective is being changed to Reduce the average waits for 1st Routine Outpatient appointment for elective patients from 19 weeks to 16 weeks in line with the Trust Trajectory by March 2025.

Systems and Partnerships

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

Latest progress: Current Position is 4.4 days per 1,000 and 24.5% of discharges before noon.
The key areas of focus are EDN completion, Effective Board rounds and Criteria Led Discharge
The work in now incorporated in the Safer Better Sooner programme which has given it some additional focus and governance alongside the divisional SDR monthly reviews.

The vision goal and system break through objective will remain as is. The vision target has been achieved and therefore a stretch target is being considered. The internal break through objective is being reviewed.

Sustainability

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

Latest progress: Current position - Premium workforce spend has increase in the for May 2024.

Improved rostering and vacancy controls have been put in place and the Patchwork bank product implemented Trust-wide. This is a real achievement and we know that we can go further in 24/25.
We will continue to focus on the role out of Patchwork Medical Rostering and focused improvement work to build on the success of last year and reduce Premium work force spend further.

The vision goal, vision target and break through objective will remain as is for 2024/25.

People

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

Latest progress: Current position is a vacancy rate at 9.5% and a turnover rate at 11.4% in February.
Work continues to streamline the recruitment processes through automation.
We continue to focus on hot spot areas with projects targeting admin and clerical, as well as short term leavers (within first 24 months).

The vision and breakthrough will remain however the Breakthrough objective is being reviewed with a likely focus on leavers within the first 2 years of employment.

Update from the SIRO (incl. approval of the Data Security and Protection Toolkit submission for 2023/24, and Trust Board annual refresher training on Information Governance)	**Director of Strategy, Planning and Partnerships**

The enclosed report provides an update and further detail in relation to the annual submission of the NHS England, Data Security and Protection Toolkit (DSPT) 2023 - 2024.

Which Committees have reviewed the information prior to Trust Board?

- Information Governance Committee, 07/06/2024.

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

For approval.

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

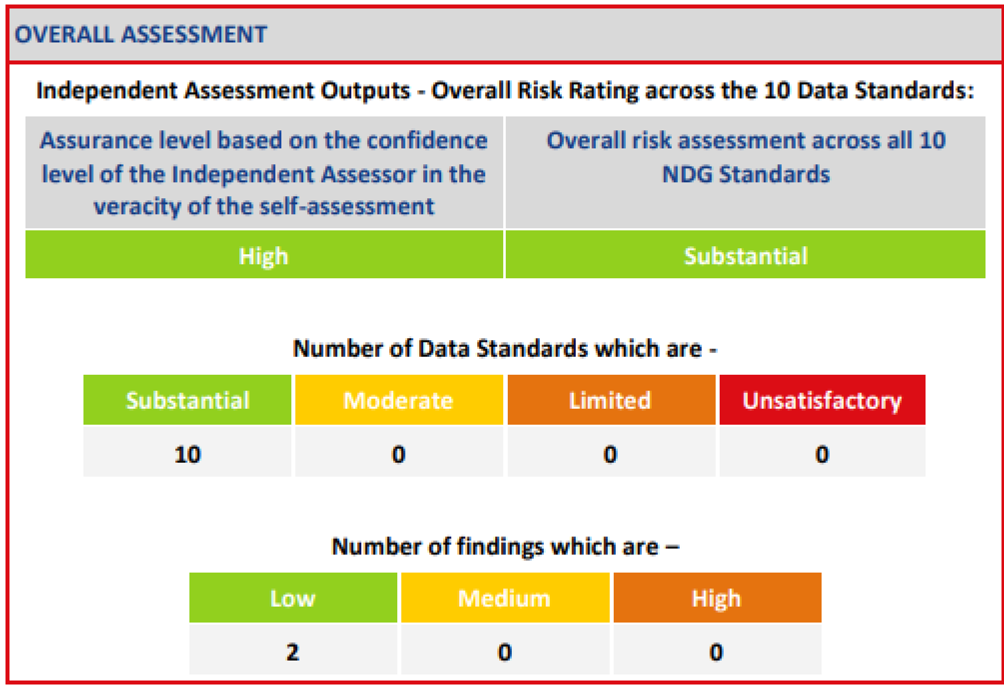
1. Background and Scope

The purpose of this paper is to provide the Trust Board an update of the Data Security Protection Toolkit (DSPT) and the status at the point of submission to NHS England on the 28th June 2024.

2022 – 2023 submission was made as 'Standards Not Met' recategorized to 'Approaching Standards' in August 2023 following the approval of an action plan by The Trust Board and NHS England.

2. Current Status

The DSPT submission has been independently verified by TIAA in June 2024, with the accompanying report provided for information.



OVERALL ASSESSMENT

Independent Assessment Outputs - Overall Risk Rating across the 10 Data Standards:

Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment	Overall risk assessment across all 10 NDG Standards
High	Substantial

Number of Data Standards which are -

Substantial	Moderate	Limited	Unsatisfactory
10	0	0	0

Number of findings which are –

Low	Medium	High
2	0	0

The two findings within the report for further review and action are:

2 – Staff Responsibilities	2.2.1	The employment contracts include confidentiality clauses but do not include requirements to follow the relevant IT security policies and procedures.	The employment contracts to include requirements to follow the relevant IT security policies and procedures.	Low	*Updates to employment contracts are in progress with recommendations made to the employee relations team. It is unlikely these will deliver before the end of June due to ratification processes, however, will be in place shortly after.*
7 – Continuity Planning	7.1.2	The Sunrise EPR Business Continuity Plan has a review date of December 2022. The Director of IT has confirmed that this is the current version and remains valid. However, the plan is now being reviewed as the Electronic Patient Record (EPR) Team now sits within the Digital and Data Team following a restructure.	The plan to be updated and approved.	Low	*The revised Digital and Data Strategy has now been published. With this comes a transition to a new divisional structure therefore the EPR BCP needs to be revised. This is in progress and being monitored by the IG Lead and IT Director.*

Staff Training:
Previous DSPT submissions have required NHS Trusts to achieve a minimum 95% compliance Data Security and Awareness Training. This assertion has now been amended to enable Trusts to set their own rate of compliance.

Maidstone and Tunbridge Wells NHS Trust has set this rate at 90%.

The compliance rate as at 31st May was 87%.

A significant push was made to improve this in readiness for the submission, however compliance remains lower in clinical areas.

Month	No Staff	IG Training Compliance	IG Training Target
April	9036	88.60%	95%
May	9018	88.70%	95%
June	9054	89.90%	95%
July	9196	90.20%	95%
August	9251	89.30%	95%
September	9333	89.40%	95%
October	9223	89.20%	95%
November	9178	88.60%	95%
December	9246	88.00%	95%
January	9329	88.10%	95%
February	9389	86.50%	95%
March	9449	85.80%	95%
April	9522	86.80%	90%
May	9448	87.00%	90%

Unsupported Systems:
8.4.2 All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted, regularly reviewed and signed off by the SIRO.

This assertion was not met by the Trust in the previous two submissions (2021 -2022 and 2022-2023), however following the significant progress of the IVE Server Programme and changes by NHS England to satisfy this assertion, the 2023 – 2024 submission will now be 'Standards Met' with SIRO approval provided.

A Quarterly Improvement Plan will remain in place to provide oversight of the IVE Server Programme until its completion.

3. Mitigation & Assurance

Training Compliance
An action plan to address training compliance has been drafted and presented to the Information Governance Committee. This action plan addresses the training needs and focuses on the improvement of training compliance across the Trust.

Unsupported Systems:
The following measures are currently used to provide mitigation where possible whilst the IVE Server Programme continues:

- **Patching**
  Where systems are unable to be patched due to vendor support no longer being available, the Trust strives to reduce the footprint of impacted systems and to isolate where possible while seeking a suitable, supported replacement.

- **Access Control**
  The Trust uses multi factor authentication where possible including Wifi and VPN remote access. Privileged accounts are kept to an absolute minimum and where used, they are for specific tasks only and not for day to day work.

- **Monitoring**
  The Trust is registered with the early warning service. High risk and critical alerts are actioned immediately. Internet facing infrastructure is patched as required.

- **Backups**
  Our data is backed up daily, weekly and monthly with files restored from back up daily.
  As part of the IVE Programme, data has been migrated from old to new infrastructure with backups being taken as part of this process.

- **Microsoft Defender**
  The Trust is enrolled in Microsoft Defender and shares its data with the NHS Cyber Security Team.

- **Antivirus**
  The Trust uses Sophos Antivirus.

- **Attack Surface**
  External PEN testing is undertaken yearly.

- **Secure Boundary**
  The Trust uses Palo Alto Firewalls to secure its internet boundaries.

4. Conclusion

Following consultation with the NHS England Regional Cyber Security Principal Consultant (South-East) The Trust's Data Security and Protection Toolkit 2023 – 2024 is proposed for submission as 'Standards met'.

5. Recommendation

The Trust Board are asked to support this report, associated TIAA Audit report and approve the submission of a 'Standards Met' Data Security and Protection Toolkit for 2023 – 2024.

END.

Internal Audit

FINAL

Maidstone and Tunbridge Wells NHS Trust

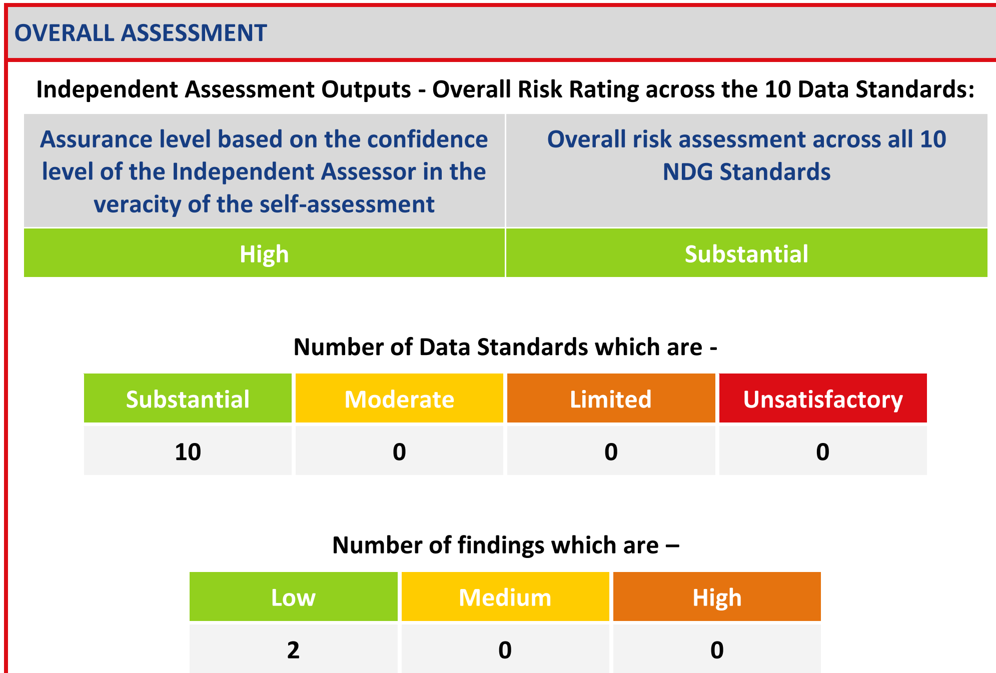
Data Security and Protection Toolkit (DSPT) v6

2023/24

June 2024

Executive Summary

OVERALL ASSESSMENT



Independent Assessment Outputs - Overall Risk Rating across the 10 Data Standards:

Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment	Overall risk assessment across all 10 NDG Standards
High	Substantial

Number of Data Standards which are -

Substantial	Moderate	Limited	Unsatisfactory
10	0	0	0

Number of findings which are –

Low	Medium	High
2	0	0

KEY STRATEGIC FINDINGS

106 out of 108 evidence items have been completed to date. The Auditor will update evidence item 9.4.5 on issue of the final report.

All policies reviewed are up to date.

The employment contracts do not include requirements to follow the relevant IT security policies and procedures.

GOOD PRACTICE IDENTIFIED

There is a Governance Framework in place. Information Governance Committee reports to the Trust Management Executive, which reports to the Board.

The most important logs for identifying malicious activity are retained for six months.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

NHS England have published their "Strengthening Assurance Audit Framework" for independent assessments of Data Security and Protection Toolkits.

SCOPE

The objective of this independent assessment from the organisation's perspective was to understand and help address data security and data protection risk and identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission.

TIAA undertook an independent audit of the 10 Data Security Standards. The audit coverage was aligned to the mandated areas in the Toolkit as selected by NHS England for 2023-2024.

There are 13 mandatory assertions – 1.1, 2.2, 3.1, 3.2, 4.4, 5.1, 6.2, 7.1, 8.4, 9.2, 9.5, 9.6 and 10.2.

The review is a single review in advance of the final submission in June 2024 resulting in a full report showing DSS risk scores and the audit opinion.

Introduction

Why data security and data protection issues require attention from Independent Assessors

Data and information are a critical business asset that is fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their data assets. Any personal data collected, stored and processed by public bodies are also subject to specific legal and regulatory requirements. Data security and data protection related incidents are increasing in frequency and severity; with hacking, ransomware, cyber-fraud and accidental data losses all having been observed across the Health and Social Care sector. For example, we need look no further than the WannaCry ransomware attack in May 2017 that impacted NHS bodies and many local authorities' IT services. Although Microsoft released patches to address the vulnerability, many organisations including several across the public sector didn't apply the patches, highlighting an inadequate ability to adapt to new and emerging threats.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks has been amplified by the introduction of the EU Directive on security of Network and Information Systems (NIS Directive) and the EU General Data Protection Regulation (GDPR). The NIS Directive focuses on Critical National Infrastructure and 'Operators of Essential Services'. The GDPR focuses on the processing of EU residents' personal data. As such, it is essential that Health and Social Care sector organisations take proactive measures to defend themselves from cyber-attacks and evidence their ability to do so in line with regulatory and legal requirements.

An additional complexity arises when a Health and Social Care organisation needs to share data. Organisations need to have mutual trust in each other's ability to keep data secure and also have a requirement to take assurance from each other's risk management and information assurance arrangements for this to happen successfully. Not getting this right means that either organisations fail to deliver the benefits of joining up services or put information at increased risk by sharing it insecurely across a wider network.

Achieving a realistic understanding of data security and data protection issues is therefore essential to protecting Health and Social Care organisations, personnel, patients and other stakeholders; particularly as the drive to making Health and Social Care services more 'digital' continues.

The DSP Toolkit is one of several mechanisms in place to support Health and Social Care organisations in their ongoing journey to manage data security and data protection risk. The DSP Toolkit allows organisations which access NHS patient data and systems to measure their performance against the National Data Guardian's ten data security standards, as well as supporting compliance with legal and regulatory requirements (e.g. the GDPR and NIS Directive) and Department of Health and Social Care policy through completion of an annual DSP Toolkit online self-assessment.

Completion of the DSP Toolkit therefore provides Health and Social Care organisations with valuable insight into the technical and operational data security and data protection control environment and relative strengths and weaknesses of those controls. However, the completion of the DSP Toolkit itself by the organisation is not the only mechanism in place to provide the level of comfort Health and Social Care organisation Boards need to achieve a reliable understanding of data security and data protection risk. Another mechanism is to independently assess/audit the data security and protection control environments of health and social care organisations.

Objectives

The independent assessment aimed to produce the following outputs:

- An assessment of the overall risk associated with the organisation's data security and data protection control environment. i.e. the level of risk associated with weak or failing controls and data security and protection objectives not being achieved.
- An assessment as to the veracity of the organisation's self-assessment / DSP Toolkit submission and the Independent Assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

The objective of this independent assessment from the organisation's perspective is to understand and help address data security and data protection risk and identify opportunities for improvement; whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission.

Limitations of Scope

The scope of this review will be limited to the 13 assertions defined during the scoping exercise. The assessment will consider the organisation meets the requirement of each evidence text, and also considers the broader maturity of the organisation's data security and protection control environment. Results will be based on interviews with key stakeholders as well as a review of key documents where necessary to attest controls/processes. As we are assessing the operational effectiveness of a sub-set of assertions, our assessment should not be expected to include all possible internal control weaknesses that an end-to-end comprehensive compliance assessment might identify. We are reliant on the accuracy of what we are told in interviews and what we review in documents. Efforts will be made to validate accuracy only on a subset of evidence texts and therefore there is a dependency on the organisation to provide accurate information. Furthermore, onsite verbal recommendations by the Independent Assessor staff do not constitute formal professional advice and should be considered in line with broader observations. Our report will contain recommendations for management consideration to address the weaknesses found.

Key Findings and Management Action Plan (MAP)

The following findings are summarised here as being amongst the most important issues to address in order to improve the data security and data protection control environment.

Assertion	Evidence Item	Finding	Implications	Recommendations	Risk Rating	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1 – Personal Confidential Data	1.1.3	The last review of privacy notices was completed by the Data Protection Officer (DPO) in January 2024. Arrangements are in place to review and present all notices to the Information Governance Committee in July 2024.	Evidence item is complete.	All privacy notices to be reviewed and presented to the Information Governance Committee in July 2024.	**Very low/insignificant**	*The privacy notices have been reviewed and are ready for presentation at the July Information Governance Committee.*	*31/07/2024*	*Head of IG/DPO*
2 – Staff Responsibilities	2.2.1	The employment contracts include confidentiality clauses but do not include requirements to follow the relevant IT security policies and procedures.	Evidence item may not be completed by the 30th June 2024 submission date.	The employment contracts to include requirements to follow the relevant IT security policies and procedures.	**Low**	*Updates to employment contracts are in progress with recommendations made to the employee relations team. It is unlikely these will deliver before the end of June due to ratification processes, however, will be in place shortly after.*	*1st September*	*Head of IG/DPO*
7 – Continuity Planning	7.1.2	The Sunrise EPR Business Continuity Plan has a review date of December 2022. The Director of IT has confirmed that this is the current version and remains valid. However, the plan is now being reviewed as the Electronic Patient Record (EPR) Team now sits within the Digital and Data Team following a restructure.	Evidence item may not be completed by the 30th June 2024 submission date.	The plan to be updated and approved.	**Low**	*The revised Digital and Data Strategy has now been published. With this comes a transition to a new divisional structure therefore the EPR BCP needs to be revised. This is in progress and being monitored by the IG Lead and IT Director.*	*1st October*	*Head of IG/DPO*

Overall risk rating and confidence level

The assurance is based on the confidence level of the Independent Assessor in the veracity of the self-assessment is 'Substantial'. This means that the organisation's self-assessment against the Toolkit agrees with what has been observed in the Independent Assessment.

Independent Assessment Outputs - Overall Risk Rating across the 10 Data Standards

Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment*	Overall risk assessment across all 10 NDG Standards**
High	Substantial

***Confidence Level**

Once the Independent Assessment Provider has completed the fieldwork and calculated the ratings for assertions, for each of the 10 NDG standards and the overall risk, the confidence-level in the veracity of the organisation's DSP Toolkit self-assessment submission should be determined by comparing the independent assessment findings against the latest DSP Toolkit submission. The following definitions should be used for aiding the decision of applying a confidence-level. It is noted that the evidence available to the Independent Assessor at the time of the assessment may differ or may have changed from the evidence in place at the time of the self-assessment. Furthermore, the self-assessment may not have much in the way of evidence. As such the Independent Assessor will need to take that into consideration when determining the confidence level and when writing the report and putting it into context. i.e. a like for like comparison may not be possible so the self-assessment and independent assessment may differ but not necessarily due to a lack of veracity or honesty in the self-assessment.

Key (as per NHS England Strengthening Assurance guidance):

Level of deviation from the DSP Toolkit submission and assessment findings	Confidence level
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" or "Standards Exceeded" but the independent assessment has found individual NDG standards as 'Unsatisfactory' and the overall rating is 'Unsatisfactory'.	Low
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a nontrivial deviation or discord between the two.	Medium
Low level of deviation- the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	High

**** Overall risk assessment across all 10 NDG Standards**

See Standard Level table below.

Standard Level

National Data Guardian (NDG) Standard	Number of DSP Toolkit Assertions Assessed by Independent Assessor	Assertion Level Risk Assessments				NDG Standard Level Risk Ratings		Overall DSP Toolkit level Ratings***
		Number of Assertions rated Critical and (Weighted Risk Score)	Number of Assertions rated High and (Weighted Risk Score)	Number of Assertions rated Medium and (Weighted Risk Score)	Number of Assertions rated Low And (Weighted Risk Score)	Risk Rating Scores (total points/ no. assertions assessed) *	Overall Risk Rating at the National Data Guardian Standard level**	Overall risk assessment across all 10 NDG Standards
1. Personal Confidential Data	1 assertion assessed in this standard				1	1	Substantial	Substantial
2. Staff Responsibilities	1 assertion assessed in this standard				1	1	Substantial	
3. Training	2 assertions assessed in this standard				2(1)	2/2 = 1	Substantial	
4. Managing Data Access	1 assertion assessed in this standard				1	1	Substantial	
5. Process Reviews	1 assertion assessed in this standard				1	1	Substantial	
6. Responding to Incidents	1 assertion assessed in this standard				1	1	Substantial	
7. Continuity Planning	1 assertion assessed in this standard				1	1	Substantial	
8. Unsupported Systems	1 assertion assessed in this standard				1	1	Substantial	
9. IT Protection	3 assertions assessed in this standard				3(1)	3/3 = 1	Substantial	
10. Accountable Suppliers	1 assertion assessed in this standard				1	1	Substantial	

Assertion Level Risk Assessments

***Points corresponding to Assertion Risk Ratings**

Key (as per NHSD Strengthening Assurance guidance):

Rating	Points for each Assertion
Critical	40
High	10
Medium	3
Low	1

****Calculation and assignment of the NDG Standard risk ratings**

Key (as per NHSD Strengthening Assurance guidance):

Rating	Rating Thresholds when only 1 assertion per NDG Standard is in scope	Rating Thresholds when 2 or more assertions are in scope for each NDG Standard. Mean score (Total points divided by the number of in-scope assertions)
Substantial	1 or less	1 or less
Moderate	Greater than 1, less than 10	Greater than 1, less than 4
Limited	Greater than/equal to 10, less than 40	Greater than/equal to 4, less than 5.9
Unsatisfactory	40 and above	5.9 and above

***** Overall risk assessment across all 10 NDG Standards**

Key (as per NHSD Strengthening Assurance guidance):

Overall risk rating across all in-scope standards	
Unsatisfactory	1 or more Standards is rated as 'Unsatisfactory'
Limited	No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'
Moderate	There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'.
Substantial	All of the standards are rated as 'Substantial'

Evidence Item - Independent assessment results and ratings

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
1.1.1	State your organisation's Information Commissioner's Office (ICO) registration number.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.3	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.4	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.5	List the names and job titles of your organisation's key staff with responsibility for data protection and data security.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.6	Your organisation has reviewed how it asks for and records consent to share personal data.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.7	Data quality metrics and reports are used to assess and improve data quality.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
2.2.1	All employment contracts contain data security requirements.	Not completed but on Action Plan	The evidence requires further expansion or improvement to fully achieve the claimed position	Moderate	Moderate	Low	Low
3.1.1	Training and awareness activities form part of organisational mandatory training requirements, with a training and awareness needs analysis (covering all staff roles) that is formally endorsed and resourced by senior leadership.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
3.1.2	Your organisation's defined training and awareness activities are implemented for and followed by all staff.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
3.1.3	Provide details of how you evaluate your training and awareness activities.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
3.2.1	Information governance and cyber security matters are prioritised by the board or equivalent senior leaders.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
3.2.2	Actions are taken openly and consistently in response to information governance and cyber security concerns.	Non-mandatory requirement for 2023/24					
3.2.3	Your information governance and cyber security programme is informed by wide and representative engagement with staff.	Non-mandatory requirement for 2023/24					

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
4.4.1	The organisation ensures that logs, including privileged account use, are kept securely and only accessible to appropriate personnel. They are stored in a read only format, tamper proof and managed according to the organisation information life cycle policy with disposal as appropriate.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
4.4.2	The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular email and web browsing.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
4.4.3	The organisation only allows privileged access to be initiated from devices owned and managed or assured by your organisation.	Non-mandatory requirement for 2023/24					
5.1.1	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security or protection incident, with findings acted upon.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
6.2.1	Antivirus/anti-malware software has been installed on all computers that are connected to or are capable of connecting to the Internet.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
6.2.3	Antivirus/anti-malware is kept continually up to date.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
6.2.6	Number of phishing emails reported by staff per month.	Non-mandatory requirement for 2023/24					

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
6.2.8	You have implemented on your email, Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisation's domains to make email spoofing difficult.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
6.2.9	You have implemented spam and malware filtering and enforce DMARC on inbound email.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
7.1.1	Your organisation understands the health and care services it provides.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
7.1.2	Your organisation has well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise.	Not completed but on Action Plan	The evidence requires further expansion or improvement to fully achieve the claimed position.	Moderate	Moderate	Low	
7.1.3	You understand the resources and information that will likely be needed to carry out any required response activities, and arrangements are in place to make these resources available.	Non-mandatory requirement for 2023/24					
7.1.4	You use your security awareness, e.g. threat intelligence sources, to make temporary security changes in response to new threats, e.g. a widespread outbreak of very damaging malware.	Non-mandatory requirement for 2023/24					
8.4.1	Your organisation's infrastructure is protected from common cyber-attacks through secure configuration and patching?	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
8.4.2	All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted, regularly reviewed and signed off by the SIRO.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
8.4.3	You maintain a current understanding of the exposure of your hardware and software to publicly known vulnerabilities.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.2.1	The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
9.2.3	The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.1	All devices in your organisation have technical controls that manage the installation of software on the device.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
9.5.2	Confirm all data are encrypted at rest on all mobile devices and removable media and you have the ability to remotely wipe and/or revoke access from an end user device.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
9.5.3	You closely and effectively manage changes in your environment, ensuring that network and system configurations are secure and documented.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.5	End user devices are built from a consistent and approved base image.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.6	End user device security settings are managed and deployed centrally.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.7	AutoRun is disabled.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.8	All remote access is authenticated.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.9	You have a plan for protecting devices that are natively unable to connect to the Internet, and the risk has been assessed, documented, accepted, reviewed regularly and signed off by the SIRO.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.5.10	Your organisation meets the secure email standard.	Non-mandatory requirement for 2023/24					
9.6.1	One or more firewalls (or similar network device) have been installed on all the boundaries of the organisation's internal network(s).	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
9.6.2	The administrative interface used to manage the boundary firewall has been configured such that; it is not accessible from the Internet; it requires second factor authentication or is access limited to a specific address.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.6.3	The organisation has checked and verified that firewall rules ensure that all unauthenticated inbound connections are blocked by default.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.6.4	All inbound firewall rules (other than default deny) are documented with business justification and approval by the change management process.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.6.5	Firewall rulesets are reviewed on a regular basis. Rulesets are removed/disabled when they are no longer required.	Completed	The evidence and/or statements given are valid to support the claimed position	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
9.6.6	All of your organisation's desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
10.2.1	Your organisation ensures that any supplier of IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low
10.2.3	Percentage of suppliers with data security contract clauses in place.	Non-mandatory requirement for 2023/24					

Evidence Item Ref	Evidence Item Text	Organisation's Evidence Item Status on the Toolkit	Independent Assessor's Comment	Likelihood Rating *	Impact Rating **	Evidence Item Risk Rating ***	Assertion Risk Rating ****
10.2.4	Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the supplier's responsibility.	Completed	The evidence and/or statements given are valid to support the claimed position.	Rare	Very Low/ Insignificant	Very Low/ Insignificant	
10.2.5	All suppliers that process or have access to health or care personal confidential information have completed a Data Security and Protection Toolkit, or equivalent.	Non-mandatory requirement for 2023/24					

* Likelihood Rating Table

Evidence texts are risk assessed on their likelihood and impact based on the assessment rationale in the tables below:

Likelihood rating	Assessment rationale
Almost Certain	Almost certain to happen in the next 12 months (80% or more)
Likely	Likely to happen in the next 12 months (60-80%)
Moderate	Moderately likely to happen in the next 12 months (40-60%)
Unlikely	Unlikely to happen in the next 12 months (20-40%)
Rare	Very low likelihood to happen in the next 12 months (less than 20%)

****Impact Rating Table**

Key (as per NHSD Strengthening Assurance guidance:

Impact rating	Assessment rationale
Catastrophic	• A Catastrophic Impact Finding could apply to Health and Social Care organisations that use extremely complex technologies to deliver multiple services or process large volumes of patient data, including processing for other organisations. Many of the services are at the highest level of risk, including those offered to other organisations. New and emerging technologies are utilised across multiple delivery channels. The organisation is responsible for/ maintains nearly all connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties. A catastrophic finding that could have a: • Catastrophic impact on operational performance or the ability to deliver services / care; or • Catastrophic monetary or financial statement impact; or • Catastrophic breach in laws and regulations that could result in material fines or consequences; or • Catastrophic impact on the reputation or brand of the organisation which could threaten its future viability.
Major	• A Major Impact Finding could apply to a Health and Social Care organisation that uses complex technology in terms of scope and sophistication. The organisation may offer high-risk products and services that may include emerging technologies. The organisation is responsible for/ maintains the largest proportion of connection types to transfer/store/process personal, patient identifiable or business-critical data with customers and third parties; other organisations and/or third-parties are responsible for/maintain a low proportion of connection types. A Significant finding that could have a: • Major impact on operational performance; or • Major monetary or financial statement impact; or • Major breach in laws and regulations resulting in large fines and consequences; or • Major impact on the reputation or brand of the organisation.
Moderate	• A Moderate Impact Finding could apply to a Health and Social Care organisation that uses technology which may be somewhat complex in terms of volume and sophistication. The organisation is responsible for/maintains some connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties; other organisations and/or third-parties are responsible f or/maintain a most of the organisation's connection types. A Moderate finding that could have a: • Moderate impact on the organisation's operational performance; or • Moderate monetary or financial statement impact; or • Moderate breach in laws and regulations with moderate consequences; or • Moderate impact on the reputation of the organisation.
Minor	A Minor Impact Finding could apply to a Health and Social Care organisation with limited complexity in terms of the technology it uses. It offers a limited variety of less risky products and services. The institution primarily uses established technologies. It is responsible for/maintains minimal numbers of connection types to transfer/store/process personal, patient identifiable or business-critical data to customers and third parties; other organisations and/or third-parties are largely responsible for/maintain connection types. A Minor finding that could have a: • Minor impact on the organisation's operational performance; or • Minor monetary or financial statement impact; or • Minor breach in laws and regulations with limited consequences; or • Minor impact on the reputation of the organisation

Impact rating	Assessment rationale
Very Low Insignificant	• A Low/Insignificant Impact Finding could apply to a Health and Social Care organisation that has very limited use of technology. The variety of products and services are limited and the organisation has a small geographic footprint with few employees. It is responsible for/maintains no connection types to transfer/store/process personal, patient identifiable or business-critical data too customers and third parties. A Low finding that could have a: • Very low/ insignificant impact on the organisation's operational performance; or • Very low/ insignificant monetary or financial statement impact; or • Very low/ insignificant breach in laws and regulations with little consequence; or • Very low/ insignificant impact on the reputation of the organisation.

*** Evidence Items Risk Ratings

Key (as per NHSD Strengthening Assurance guidance):

	Impact Rating				
Likelihood Rating	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost Certain	Low	Low	Medium	High	Extreme
Likely	Low	Low	Medium	Medium	High
Moderate	Low	Low	Low	Medium	Medium
Unlikely	Very Low/ Insignificant	Low	Low	Low	Low
Rare	Very Low/ Insignificant	Very Low/ Insignificant	Low	Low	Low

****Assertion Risk Rating

The DSP Toolkit Independent Assessment Provider must then exercise professional judgement to assign a risk rating at the assertion level. The Independent Assessor leverages knowledge and subject matter expertise alongside observations made during the assessment to assign each assertion a risk rating of 'Critical','High', 'Medium' or 'Low' based on the evidence text ratings and the Independent Assessor's knowledge of the relative importance of the controls in question and the mitigating or compensating controls in place.

Explanatory Information

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Acknowledgement

3. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

4. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	20th October 2023	20th October 2023
Draft Report:	11th June 2024	13th June 2024
Final Report:	13th June 2024	

AUDIT PLANNING MEMORANDUM

Client:	Maidstone and Tunbridge Wells NHS Trust		
Review:	Data Security and Protection (DSP) Toolkit v6		
Type of Review:	ICT Audit	**Audit Lead:**	Iqra Bakhtiyaar

Outline scope (per Annual Plan):	The objective of this independent assessment from the organisation's perspective is to understand and help address data security and data protection risk and identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission TIAA will undertake an independent audit of the 10 Data Security Standards (DSS). The audit coverage will be aligned to the mandated areas in the Toolkit as selected by NHS England for 2023-2024. Our review is a single in advance of the final submission in June 2024, resulting in a full report showing DSS risk scores and the audit opinion.
Detailed Scope:	The following mandatory evidence items will be reviewed: 1.1 The organisation has a framework in place to support Lawfulness, Fairness and Transparency. 2.2 Staff contracts set out responsibilities for data security. 3.1 Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness. 3.2 Your organisation engages proactively and widely to improve data security and has an open and just culture for data security incidents. 4.4 You closely manage privileged user access to networks and information systems supporting the essential service. 5.1 Process reviews are held at least once per year where data security is put at risk and following DS incidents. 6.2 All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway. 7.1 Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services. 8.4 You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service. 9.2 A penetration test has been scoped and undertaken. 9.5 You securely configure the network and information systems that support the delivery of essential services. 9.6 The organisation is protected by a well-managed firewall. 10.2 Basic due diligence has been undertaken against each supplier that handles personal information. Additional information: The audit will be conducted remotely. Please arrange access for the Auditor (Auditor role) to the Toolkit. Supporting evidence can be provided via NHSmail, SharePoint or Teams channel. The final report will be uploaded to the Toolkit in addition to completing evidence item 9.4.5 by the Auditor prior to the June submission date.
Exclusions from scope:	None

Planned Start Date:	13/05/2024	**Exit Meeting Date:**	03/06/2024	**Exit Meeting to be held with:**	Head of Information Governance and ICT Risk Management and Data Protection Officer

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N