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

Thu 27 March 2025, 09:45 - 13:00

Lecture Rooms 1 & 2, Education Centre, Tunbridge Wells Hospital

Agenda

09:45 - 09:46
1 min

03-1
To receive apologies for absence

Annette Doherty

09:46 - 09:46
0 min

03-2
To declare interests relevant to agenda items

Annette Doherty

09:46 - 09:50
4 min

03-3
To note progress with previous actions

Annette Doherty

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

Patient Experience story

09:50 - 10:15
25 min

03-4
Patient Experience story

Representatives from the Maternity Directorate

N.B. This item is scheduled for 09:50am.

Board cover page Experience of Care Maternity.pdf (1 pages)
Maternity Lived Experience for Trust Board (with audio) RG.pdf (3 pages)

Reports from the Chair of the Trust Board and Chief Executive

10:15 - 10:20
5 min

03-5
Report from the Chair of the Trust Board

Annette Doherty

Report from the Chair of the Trust Board - March 2025.pdf (2 pages)

10:20 - 10:25
5 min

03-6
Report from the Chief Executive (incl. a quarterly update on the Patient First

Improvement System (PFIS))

Miles Scott

Chief Executive's report March 2025.pdf (4 pages)

Reports from Trust Board sub-committees

10:25 - 10:28
3 min

03-7
Quality Committee, 19/03/25

Maureen Choong

Summary of Quality C'ttee, 19.03.25.pdf (4 pages)

10:28 - 10:31
3 min

03-8
Finance and Performance Committee, 25/03/25

Neil Griffiths

Summary of Finance and Performance C'ttee 25.03.25.pdf (4 pages)

10:31 - 10:34
3 min

03-9
People and Organisational Development Committee, 21/03/25

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee 21.03.25 v2.pdf (3 pages)

10:34 - 10:37
3 min

03-10
Audit and Governance Committee, 05/03/25 (incl. an update on bribery-related best practice)

David Morgan

Summary of Audit and Governance Cttee 05.03.25.pdf (4 pages)

10:37 - 10:40
3 min

03-11
Charitable Funds Committee, 12/03/25

David Morgan

Summary of Charitable Funds Committee, 12.03.25.pdf (3 pages)

Integrated Performance Report (IPR)

10:40 - 11:25
45 min

03-12
Integrated Performance Report (IPR) for February 2025

Miles Scott and colleagues

N.B. Please note that the safe staffing review can be found in the documents section on admincontrol.

Finalised Integrated Performance Report February 20250321.pdf (39 pages)

- IPR2 .pdf (4 pages)
- IPR 3.pdf (2 pages)

Quality items

11:25 - 11:35
10 min

03-13
Quarterly Learning from Deaths report

Sara Mumford

- LfD Board cover Template March 25.pdf (1 pages)
- March 2025 final LfD Summary Report for Board (002).pdf (12 pages)

11:35 - 11:45
10 min

03-14
Maternity Incentive Scheme Compliance (Minimum dataset from PQSM)

Sarah Flint and Rachel Thomas

N.B. This item is scheduled for 12.05pm.

- Cover page for PQSM March 2025 Trust Board.pdf (3 pages)
- Appendix 1 Maternity PQSM Report March 2025 (January data) .pdf (40 pages)

People

11:45 - 11:55
10 min

03-15
National Staff Survey Results, 2024

Helen Palmer

- Board cover page Staff Survey Results March 2025.pdf (2 pages)
- PODco_NSS_March 2025.pdf (18 pages)

Systems and Place

11:55 - 12:05
10 min

03-16
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

- HCP Cover page.pdf (1 pages)
- HCP update Mar 25.pdf (4 pages)

Planning and strategy

12:05 - 12:15
10 min

03-17
Update on the Trust’s planning submissions for 2025/26 (Verbal Update)

Rachel Jones and Steve Orpin

Assurance and policy

12:15 - 12:25
10 min

03-18
Six-monthly review of the Trust’s red-rated risks

Joanna Haworth

- Red risks frontsheet_.pdf (1 pages)
- Red Risk Report March 2025.pdf (12 pages)

Annual Report and Accounts

12:25 - 12:30
5 min

03-19
Confirmation of the outcome of the Trust’s ‘going concern’ assessment

Steve Orpin

- Annual Accounts 2024-25 update Trust Board 27.3.25.pdf (3 pages)

12:30 - 12:30
0 min

03-20
To consider any other business

Annette Doherty

12:30 - 12:30
0 min

03-21
To respond to any questions from members of the public

Annette Doherty

12:30 - 12:30
0 min

03-22
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.

NHS Maidstone and Tunbridge Wells NHS Trust

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
01-14	Maternity service team to bring the patient experience story to a future board meeting.	Trust Secretary	March 2025	The Maternity Patient Experience Story is scheduled for March 2025.

Actions not yet due (and still 'open')

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

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

MTW Exceptional people, outstanding care

Title of report	**Experience of Care Patient Story**					
Board / Committee	**Trust Board**					
Date of meeting	27th March 2025					
Agenda item no.	03-4					
Executive lead	Joanna Haworth, Chief Nurse					
Presenter	Rachel Thomas, Director of Maternity					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	☐	✓	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The attached slides and audio represent the lived experience of a patient in the maternity services at MTW. In particular, it focuses on the black women's reproductive health and well-being.
Any items for formal escalation / decision	No items for escalation but the Board is asked to note and discuss the experience and associated health inequalities, in general, for black women within maternity services.
Appendices attached	• Appendix A – Experience of care patient story and audio to played during the board meeting.

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	January 2025	Actions being taken to improve the lived experience of black mothers including quality improvement project

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	1182- Delays in Induction of Labour may result in poor clinical outcome and poor patient and staff experince
Compliance / Regulatory Implications	

Lived Experience

Black Women's Reproductive Health and Well-being

March 2025

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Black Women's Reproductive Health and Well-being

"Before the birth of my daughter, I found myself deeply afraid and fearful about the statistics surrounding maternal mortality for black mothers. Consequently, I reached out via email to the head of midwifery at MTW to find out how my family and I would be safeguarded against these statistics and against any racial issues which has statistically posed as threats for black mothers. She was very reassuring and helped to ensure I had a safe experience and was postnatally followed up with me to find out how my care went and signposted me to the mnvp.

I found that this communication positively impacted my care in the community and the midwives who looked after me where exceptional. However, my concern lingers for those who may not feel empowered to reach out in the same way. Reflecting on recent CQC results from the MTW maternity, I felt it was necessary to raise awareness so that women, including women of colour can receive the quality care.

When entering the birth centre and the hospital, I noticed a lack of representation in posters and information that reflected diversity. While most of staff were exceptional, representation truly matters and having posters and information packs which are diverse is important.

During my stay, I encountered challenges with medical procedures, such as multiple attempts to draw blood. While this has been an issue that I have experienced in the past, there was a remark from a young Dr, she said 'The reason why there may have been issue taking your blood is because we don't have many black women here'. This statement was quite upsetting and highlighted to me a pressing need for diversity training.

Another issue was during a vaginal exam I asked for pain relief, I was denied this at the time and was told that this was due to the baby monitoring concerns they had. Being denied pain relief was something which I had seen in the 'five times more' report so being denied this at the time was quite distressing during the examination.

Lastly regarding breastfeeding, I required some support after giving birth and was not offered any support with this on the labour ward. I think more support post delivery is necessary.

Despite these challenges, I want to give some positive feedback to individuals, such as Dr. Olly and Midwife Holly, the Malling team, and my postnatal midwife for their exceptional care and clear communication throughout."

Learning and actions:

- The service user is now an active member of the MNVP.
- Feedback has been shared with the EDI Champion and Patient Experience Champion team, with a strong focus on ensuring that ward-area information and posters are more diverse and inclusive.
- The Patient Experience Lead has connected with the CEO of Black Mama's Birth Village to explore opportunities for staff training. Funding has been successfully secured to support this initiative.
- Lived experience is being shared during Prompt sessions to foster reflective learning within the multidisciplinary team.
- The **Respectful Vaginal Examination (VE) Project relaunch** and the **Latent Phase Task and Finish Group** initiatives have been implemented to enhance the quality of care during intimate examinations and improve support during early labour. These initiatives focus on ensuring a more dignified and personalised approach, with an emphasis on clear communication, informed consent, and enhanced pain relief options
- The Patient Experience Lead and the service user remain in regular contact to provide ongoing updates and support.

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	27th March 2025					
Agenda item no.	03-5					
Executive lead	Annette Doherty, Chair					
Presenter	Annette Doherty, Chair					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chair's Report for the March Trust Board meeting		
Any items for formal escalation / decision	N/A		
Appendices attached	There are no appendices to this report.		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • N/A
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • N/A
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report • N/A

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

Last month's Board meeting included a seminar briefing and discussion on the 25/26 financial planning submission, which enabled us to gain insight and provide input into the shaping of the financial plan for the Trust and our partners in the system.

Financial planning was on the agenda at a number of other meetings I attended this month, including the South East Regional Chairs meeting in early March, which also focussed on productivity and innovation.

MTW's Chief Executive, Miles Scott and I joined the National NHS Leadership event for Chairs and CEOs on 13 March. Led by transition Chief Executive of NHS England, Sir Jim Mackey, discussions at the event centred around financial planning and the Government's 10-year plan for the NHS.

I was delighted to attend the NHS Kent and Medway Health System Chairs meeting earlier this month, where we welcomed the new Chair of the South East Cost Ambulance Service NHS Foundation Trust, Michael Whitehouse OBE.

I also recently attended a Freedom To Speak Up (FTSU) meeting with Non-Executive Director, Wayne Wright, Deputy Chief People Officer, Ainne Dolan and FTSU Guardian, Jack Richardson. We discussed the FTSU strategy, operational pressures and next steps. It is clear that the service is much appreciated by staff and is an important tool which enables us to continue fostering an open and transparent culture at the Trust. My thanks to Jack for his leadership, and to all the FTSU volunteers for their time and dedication in providing such a crucial service.

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
17/03/2025	Consultant Clinical Oncologist- Special interest in Gynae + TBC	Adenike	Williams	Oncology	May 2025	New

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	27 March 2025					
Agenda item no.	03-6					
Executive lead	Miles Scott, Chief Executive					
Presenter	Miles Scott, Chief Executive					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chief Executive Report for the March Trust Board meeting, summarising Trust developments and achievements over the last month.
Any items for formal escalation / decision	N/A
Appendices attached	There are no appendices to this report.

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • N/A
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • N/A
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report • N/A

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

- Following the Government's recent announcement on the abolition of NHS England and the reduction of Integrated Care Boards' running costs by 50%, NHS trusts are being asked to reduce the growth in running costs since the pandemic by 50%. This includes looking at delivering services more cost effectively. We are organising briefing sessions to update staff as further information is received, while continuing to provide support through our wellbeing resources. While the months ahead will be difficult, the Trust is working hard to develop improvement plans which will enable us to work more efficiently, provide safe high-quality care and live within our budget.

- Maidstone and Tunbridge Wells hospitals introduced Martha's Rule this month for adult inpatients, with paediatric pathways soon to follow. This national patient safety initiative gives patients and families access to an urgent review if they are worried that an inpatient's condition is getting worse. Maidstone and Tunbridge Wells hospitals were selected as two of the first 143 hospitals in England to implement the new patient service. Martha's Rule was introduced following the death of Martha Mills in 2021. The 13-year-old died after developing sepsis in hospital in London, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. The new service builds on the existing safeguards the Trust already has in place, and offers a clear and direct way for patients, family and friends to further escalate any concerns, empowering them to work closely with clinical teams and feel assured they will be listened to. Martha's Rule has three components:
  - All staff have access to an escalation route for concerns about deteriorating patients by contacting a Critical Care Outreach team who can provide rapid review 24/7.
  - This escalation route is also available to patients themselves, their carers and families.
  - Patients are asked on a daily basis about any worries or concerns about their condition. This information is then used in a structured way to escalate concerns.

- Staff feedback in the most recent NHS Staff Survey has ranked MTW as one of the top ten hospital trusts in the country – and the second best in the south east – to work for, for the second year in a row. The NHS Staff Survey takes place nationally each year, and gives insights into the experiences of staff, supporting local and national improvements. Last year, MTW was accepted on to the NHS England's national People Promise Exemplar programme allowing us to extend and improve best practice in project areas across three of the People Promise themes: flexible working, employee listening, and compassion and inclusion. The success of the Trust's work as part of the Exemplar programme is reflected in this year's NHS Staff Survey results, including a significant improvement in the 'we work flexibly' theme as a result of new flexible working initiatives. Feedback from our staff helps us improve their experience at work and highlights successes that we can all feel proud of. But we know there is always more we can do, so the coming year is an opportunity for us to continue to build on our vision of outstanding care provided by exceptional people, and the feedback given in this year's survey will help us continue to improve.

- A number of infrastructure developments have reached completion this month, including:
  - The final phase of the West Kent Community Diagnostic Centre (CDC) was completed with the opening of the new modular building, the Hounsfield Unit. The Unit houses CT, MRI scanners and phlebotomy services, and has been named after Godfrey Hounsfield, a British electrical engineer who was awarded a Nobel Prize for his part in developing the CT scan. Work on the CDC started with the arrival of mobile scanners in 2021, followed by the opening of the first building, Unit A, in 2023. Unit A, which was officially opened by then-Secretary of State, Victoria Atkins MP, offers ultrasound, X-ray, respiratory and cardiology tests, and has delivered 80,000 diagnostic tests so far. The newly opened Hounsfield Unit will significantly increase these numbers with a further 78,000 tests forecast to take place there each year. By significantly increasing testing capacity every year, the CDC will enable thousands more patients to quickly receive diagnostic tests while helping to reduce pressure on our hospitals.

- Lord North Ward at Maidstone Hospital re-opened earlier this month, following an extensive 12-week refurbishment programme. The ward, which cares for haematology and oncology patients, has benefitted from a new nurses' station as well as improvements to lighting, ventilation, flooring and decor. The refurbishment aims to improve the experience of patients on the ward and of the staff caring for them.
- The Undergraduate Medical Building at Tunbridge Wells Hospital is due to be handed over to the Trust this week. The six-storey building will provide accommodation for medical students and resident doctors, plus academic teaching space.

- Teams in the Kent and Medway Orthopaedic Centre at Maidstone Hospital recently performed an unprecedented 12 hip replacements in a day, led by just one consultant. Mr Syed S. Ahmed, Consultant Orthopaedic Surgeon, led teams who performed a dozen hip replacements across two parallel operating theatres. In a standard operating list, each patient is given their anaesthetic, has their operation and moves to recovery, before another patient is moved into theatre. This means there is time between each patient when the surgeon is not operating. With parallel lists, there is a staggered approach between patients. Two operating theatres and two surgical teams mean the surgeon can move from one patient to another without being delayed by the turnaround between cases. This allows many more operations to be done in a single day. The Kent and Medway Orthopaedic Centre opened in September 2024 and has already helped more than 1,300 patients have life-changing surgery on bones, joints and muscles.

- The Patient First Improvement System (PFIS) has now seen in excess of 1,200 tickets raised and completed since its introduction in late 2022, with hundreds more in progress. PFIS aims to empower staff to make continuous improvements that will enhance the quality of their work and the services we provide, with patients and their families also welcome to raise tickets and suggest areas of improvement. Over 420 staff have now received PFIS training, covering 87 teams. Work is also underway with the Trust's Volunteer Services, to enable them to participate and encourage patient involvement. Recent PFIS improvement projects include:
  - The Radiotherapy team have now gone paperless, making processes more efficient while also reducing costs.
  - Community maternity support workers are attending a tongue tie assessment course, which trains staff to diagnose the condition, ensuring a faster referral process and treatment for newborns.
  - The Outpatient team has introduced additional training for clinicians, enabling them to make more informed decisions about the type of appointment a patient may need or whether they can be discharged. This has contributed to a reduction in patient DNAs (did not attends).

- MTW has joined NHS England's sustainability scheme to recycle and reuse walking aids. Patients can now return crutches, metal walking sticks, walking frames and elbow crutches after use, with drop off points at the main receptions of Maidstone, Tunbridge Wells and Fordcombe hospitals. The returned items will be checked, cleaned, refurbished and reused for future patients. The new scheme will help ensure a ready supply of walking equipment while reducing our carbon footprint by minimising waste, and saving valuable NHS resources.

- BBC South East featured MTW international staff in a special news report on migration earlier this month. The BBC spoke to colleagues from overseas about their experiences of living and working in the UK. They also sat down with Helen Palmer, MTW's Chief People Officer, to discuss the important role that international staff play at the Trust, and across the wider NHS. Over 30% of staff at MTW are international, covering just under 100 nationalities. The incredible contribution that overseas staff make to the NHS, and the breadth of skills, experience and compassion they bring to patient care, was recently celebrated on Overseas NHS Workers Day, held on 7 March. On behalf of the Board, I would like to thank Dr Chirollos Romani-Naguib, Chief Registrar, Joanne Cabiguen, Theatre Practitioner and Ashmi Varghese, Domestic Supervisor, for taking part in the BBC South

East report.

- Congratulations to the winner of the Trust's Employee of the Month award for February, Theatre Support Worker, Roxanne Yarwood. Roxanne was described in her nomination as an “exceptionally proactive theatre support worker, who not only possesses a clear understanding of her role but also regularly exceeds expectations to enhance the patient experience.” She has played a key role in fostering a culture of continuous learning and development, and constantly seeks innovative ways to enhance the care the team provides. Her accomplishments include the development of a dedicated section in staff orientation packs on how to tailor care to effectively support patients with learning disabilities and autism.

Title of report	**Summary report from the Quality Committee, 19/03/25**					
Board / Committee	**Trust Board 'Part 1' Meeting**					
Date of meeting	27th March 2025					
Agenda item no.						
Executive lead	Maureen Choong, Non-Executive Director					
Presenter	Maureen Choong, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	☐	☐	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Quality Committee met (virtually, via webconference) on 19th March 2025 (a 'main' meeting). The Committee considered the following topics: The Patient Safety Oversight Group Report, The Experience of Care Group Report, The Patient Outcomes Oversight Group Report, Maternity and Neonatal Care Oversight Group, The Quality Improvement, Research and Innovation Oversight Group, Kent and Medway Pathology Network – Joint Venture Case for Change, Update on the Patient Safety Incident Response Plan (PSIRP), Review of the Trust's Quality related risks, Review of draft quality priorities for 2025/26 (for inclusion in the Quality Accounts 2024/25), and Recent findings from relevant Internal Audit reviews. The Committee noted that the reports presented, demonstrate that controls relating to Principle Risk 2,3, and 4 of the Board Assurance Framework are demonstrating levels of effectiveness.
Any items for formal escalation / decision	N/A
Appendices attached	There are no appendices to this report.

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation

	PR 5:If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals.
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 1310 – Replacement of equipment required for general and ED Plain film imaging rooms at Tunbridge Wells Hospital (TWH) • 3242 - Replacement of equipment required for general and ED Plain film imaging rooms at Maidstone Hospital • 2945 – Replacement of equipment required for Fluoroscopy imaging rooms at TWH • 3245 – Replacement of equipment required for interventional radiolog fluoroscopy imaging room at TWH • 2947 – Replacement of equipment required for mammography at TWH • 1301 – Failure to meet national targets for complaints performance • 1150 – Impact of increase in number of inpatients with mental health needs/neurological deficit • 2981 – Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site • 1182 – Delay in progress with induction of labour may result in a poor clinical outcome and poor patient and staff experience • 802 – There is a risk of significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment • 3128 – There is a risk that research patients (in particular oncology patients) will not receive treatment via clinical trials as there is a significantly reduced aseptic service resulting in patients not receiving clinical trial treatments as standard care • 3242 – Possible delays in accessing the second theatre in delivery suite • 3269 – Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus • 1182 – Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience
Compliance / Regulatory Implications	N/A

The Quality Committee met (virtually, via webconference) on 19th March 2025 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings**.
- The Committee had regard to the Board Assurance Framework (BAF) through the meeting.
- The Chief Nurse presented the **summary report from the Patient Safety Oversight Group,** wherein it was noted that the challenges remain with histopathology turnaround times, but there is a comprehensive recovery plan in place, overseen by a task and finish group. The Committee heard that the Trust was fully compliant with its statutory safeguarding obligations, but noted that training compliance for safeguarding adults, Level 3 at 70% was below the Trust target of 85% and that medical staff compliance with training was notably low. Assurance was given that divisions are focusing on improving compliance with this training. It was noted that the completion of estates work to Lord North Ward, to allow ventilation improvements and support good Infection, Prevention and Control practices had been well received by staff. The Committee heard that the sustained high *Clostridium difficile* rates were consistent with raised national rates since 2021 and discussed the work carried out to ensure cross contamination rates remained low. It was noted that the number of incidents relating to management of the deteriorating patients remained an area of focus, with communication of escalation identified as a key contributor to this. The Committee heard that improvements in prescribing critical medicines for patients with Parkinson's disease had reduced the number of incidents occurring in this patient group. The Committee were given an overview of key highlights from divisional reports and heard that there had been a reduction in all Hospital Acquired Pressure Ulcers for 2024, which was note to be the first reduction since 2017. It was also noted that the rate of falls in the Trust had reduced for the third consecutive month, however, in response to an increase in the number of falls in the Emergency Department the "Think Yellow" campaign had been revisited. The "Think Yellow" campaign is an initiative which uses visual cues (blankets and wristbands), to raise awareness of patients who are at a greater risk of falling.
  - ❖ The Committee noted that this demonstrated a level of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4 and noted that there was ongoing work regarding the management of the deteriorating patient.

  The Deputy Chief Nurse, Quality and Experience then presented the **summary report from the Experience of Care Oversight Group,** which included that Patient Stories continue to be a valuable source of learning from feedback given and is being shared across the organisation. The Committee heard that it was noted, there had been a significant reduction in the number of open legacy complaints from 2024, which is recorded on the Integrated Performance Report and the key themes from the complaints are clinical treatment followed by communication of treatment plans. The Committee were informed that data relating to the use of interpreting services was shared with the group and will aid service planning going forward. The Committee were informed about the "Relatives Clinic", which has been introduced and offers protected time for families and carers to speak with the team of clinicians involved in their loved one's care.
  - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risk 4.

  The **summary report from the Patient Outcomes Oversight Group** was then presented, where the group received a verbal update on the work being undertaken with regards to patients "lost to follow up". The Committee discussed the complexity of the work being undertaken and noted that a report will be presented, when the data has been validated and clarity regarding the issue has been established. The Trust's internal process of reviewing hospital associated deaths was presented to the group and included learning identified is shared across the organisation. It was noted that the Hospital Standardised Mortality Ratio plus (HSMR+) is reducing and is better than the expected rate. The Committee heard of the challenges with clinical audits being abandoned and noted that the clinical audit team, are prioritising audits to align those undertaken with the organisation's strategic priorities, which should reduce the number abandoned. An update on the work of the virtual ward was given and the Committee noted that since its implementation, the virtual ward has supported 1800 patients and pathways have been established with Medicine, Orthopaedics, Surgery and Haematology services. Challenges were noted from the Resuscitation Committee due to staffing capacity, struggling to meet the demand of the growing footprint of the organisation and aging equipment, but noted that business cases have been developed for both issues. The Committee discussed the theme

of replacing equipment which has reached its end of usability and the committee heard that work is being undertaken, to develop rolling equipment replacement programmes to rectify this.

- ❖ The Committee noted that this demonstrated a level the effectiveness of controls for the Board Assurance Framework, Principal Risk 2, which relate to patient outcomes.

The Director of Midwifery presented the **summary report from the Maternity and Neonatal Care Oversight Group,** wherein it was noted that the service is compliant with the following required standards: 100% Consultant attendance at clinical scenarios; Midwife to Birth ratio remained with the threshold of 1:25; 100% compliance with 1:1 care in labour and a supernumery Delivery Suite Co-Ordinator and it was noted that the agency staff use decreased from 10.3% compared to 26.6% last month. The Committee heard that three incidents occurred during one shift, which were undergoing full reviews, both individually and collectively. It was noted that one case met the threshold for a Perinatal Mortality Review in January and was being fully reviewed through that process. The Committee heard that new guidance regarding the Maternity Incentive Scheme is awaited and that the Trust had yet to receive the report from the CQC inspection of Maternity services undertaken in October 2024. It was noted that significant progress had been made with the Maternity Services improvement plan and that colleagues from the regional team would be reviewing the service in June to assess progress with the plan. The Committee heard that the team were engaging with stakeholders in the development of the Maternity Service vision and Strategy.

- The **summary report from the Quality Improvement, Research and Innovation Oversight Group** was noted by the Committee.
- The Managing Director, Kent and Medway Pathology Network (KMPN) attended to present the **KMPN Joint Venture Case for Change**, wherein it was noted that the proposal had been developed prior to the announcements made by NSHE last week regarding changes in funding to pathology networks. The Committee discussed the issues relating to quality assurance and heard that clinicians across the system have been working together to align reporting protocols and the responses to and management of incidents. The three phases of the proposal were described to the Committee and it was noted that they have been agreed in principle, by the Boards of all participating Trusts. The risks associated with not establishing the network were discussed as: increasing histology turnaround times, because of the growing demand being experienced by all organisations, which results in poor patient experience and a risk of patient safety incidents, in addition to the increasing costs with project delays. The Committee heard that the Phase 1 aspect of the proposal to develop single governance and oversight structure for pathology services to replace existing separate Trust oversight processes, is integral in moving the network forward. The Committee agreed that discussions between Non-Executive Directors across the system could support this further.
  - ❖ The Committee noted that the establishment of the network would support the controls for the Board Assurance Framework, Principal Risks 2,3, 4 and 5.
- An **update on the Patient Safety Incident Response Plan (PSIRP)** was given and the Committee heard that the plan is being amended in line with the commitment to undertake an annual review and will be presented to the Committee once all stakeholders have been engaged with and feedback has been received.
- The Head of Risk Management conducted a **review of the Trust's Quality related risks,** wherein the Committee noted that it was clear that the organisation's risk tracking and monitoring process was evident through the reports of the sub groups of the Committees and was being reflected in Board Committee and Trust Board discussions.
- The Clinical Audit Facilitator attended to present the **review of draft quality priorities for 2025/26 (for inclusion in the Quality Accounts 2025/26),** which included that through 2024/5 several of the metrics of the Quality priorities were stood down to enable greater focus on support for financial recovery. The Committee heard that 2 out of 13 of the 2024/25 priorities had been fully achieved. In total, 11 of the priorities have either significantly progressed or been fully achieved and the Committee confirmed their approval for these priorities to be continued into 2025/26 and included in the Trust's Quality Accounts.
- The Trust Secretary presented the **recent findings from relevant Internal Audit reviews,** wherein the audits which have been conducted or are in progress relating to the Quality Committee were shared.
- The **report from the Quality Committee 'deep dive' meeting, 13/02/25** was noted, and the Chair conducted an evaluation of the meeting.

Title of report	**Summary report from the Finance and Performance Committee**					
Board / Committee	**Trust Board 'Part 1' Meeting**					
Date of meeting	27th March 2025					
Agenda item no.	03-8					
Executive lead	Neil Griffiths, Non-Executive Director					
Presenter	Neil Griffiths, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	✓	✓	☐	✓	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee met (Face-to-face/in-person) on 25th March 2025. The Committee considered the following topics: 1) The patient access strategic theme metrics for February 2025 2) The financial performance for month 11, 2024/25 3) The Financial Improvement Plan 4) The quarterly productivity report 5) The final planning submission for 2025/26 6) Confirmation of the outcome of the Trust's 'going concern' assessment 7) Update on the Kent and Medway Pathology Network (KMPN) and the Case for Change 8) Update on the Estates Directorate to include the annual update on Facilities Management 9) Quarterly update on the implementation of the Digital and Data Strategy The Committee also the review of the Trust's finance, patient access and sustainability related risks. The Committee noted that the reports presented, demonstrate that controls relating to Principal Risks 3,5 and 6 of the Board Assurance Framework are demonstrating a level of effectiveness, but noted the additional improvements to be made.
Any items for formal escalation / decision	
Appendices attached	N/A

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards

Links to Board Assurance Framework (BAF)	• PR3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage • PR5: If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals • PR6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 791 – Failure to meet Referral to Treatment Targets (RTT) • 3109 – Failure to deliver Financial Plan including recurrent cost improvement programmes for 2024/25 • 3113 – There is a risk that the Trust will not have enough cash to meet its commitments resulting in suppliers not being paid and the Trust not meeting its BPPC (Better Payment Practice Code) • 3130 – There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)
Compliance / Regulatory Implications	N/A

The Finance and Performance Committee met on 25th March 2025, face-to-face / in-person.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The group firstly considered and reviewed the Board Assurance Framework (BAF) risks relating to the Committee.
   - The **Patient Access strategic theme metrics for February** were reviewed, and it was highlighted that the Trust continues to achieve the 28 Day faster diagnosis compliance and the combined 31 day first definitive treatment standards. The 62-day first definitive treatment performance was below the target at 78.9% in January and is now experiencing special cause variation of a deteriorating nature, which was considered to be related to the delays in histology result reporting times. The Committee heard that two workstreams for histology and cancer are working on action plans to address this issue. The Trust continues to provide system support to other Trusts across Kent and Medway which is adversely affecting the Trust's performance that is reported nationally and it was noted that the Trust remains one of the best performing trusts in the country for longer waiters.
     - ❖ The Committee considered that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risk 3 and noted the ongoing work to support further improvements in performance.
   - **The financial performance month 11, 2024/25** was then presented by the Deputy Chief Executive / Chief Finance Officer and included the **monthly update on the Trust's Financial Improvement Plan**, wherein the Committee were informed that the Trust was £4.8m in surplus in February which was £5m favourable to plan and was ahead of forecast. Year to date the Trust is £4.3m in deficit which is £1.5m adverse to plan. The Trust is forecasting to deliver the planned breakeven position however recovery actions of £6.3m are required to be delivered and it was noted that the divisions run rate had improved compared to the start of the financial year, which will be advantageous for the Trust at the start of the new financial year. Further actions to address the shortfall were discussed and the team were thanked for all the work done to reach this year end, but noted the challenge ahead for next year.
     - ❖ The Committee noted the controls for the Board Assurance Framework, Principal Risk 6 and that there was additional work to be done.
   - The **quarterly productivity report** was presented to the Committee, which included details of reports which built on the national reporting NHS England are providing via Model Health System. The reports contained a Trust-level scorecard which has been developed internally and highlighted Theatre Utilisation (Efficient use of surgical theatres); Numbers of surgical cases per session, the reduction in Non-Elective length of stay (the time a patient stays in hospital after an unplanned admission), the increase in patients leaving hospital before noon on the day of discharge, the Virtual Ward Utilisation and Overall Temporary Staff Spend as a percentage of Total Spend. It was noted that all these metrics are included in the Financial Recovery workstreams and subject to reporting and management via the Strategy Deployment Review process. The Committee heard that opportunities had been identified through the scorecard to improve productivity in areas of surgical services and they will be aligned to next year's operational plan.
   - The Deputy Chief Executive / Chief Finance Officer presented the **final planning submission for 2025/26,** wherein the Committee received an overview of the plan which had been developed following the publication of national planning guidance.
   - The Committee received **confirmation of the outcome of the Trust's 'going concern' assessment**, and it was noted that as part of the annual accounts, the Trust had to make a statement about the basis on which the accounts would be prepared. The Executive Team Meeting (ETM) had considered the issue and confirmed their support for the Trust's annual accounts for 2023/24 being prepared under the going concern principle. The Committee confirmed that they recommend to the trust Board that the Trust's annual accounts for 2024/25 should be prepared under the going concern principle.
   - The **Pathology Network Joint Venture Proposal – Case for Change** was presented to the Committee and heard that the three phases of the proposal had been agreed in principle, by the Boards of all participating Trusts. The risks associated with not establishing the network were discussed as: increasing histology turnaround times, a delay in organisations being able to access the cost savings, in addition to the increasing costs with project delays. The Committee heard that the Phase 1 aspect of the proposal to develop single governance and

oversight structure for pathology services to replace existing separate Trust oversight processes, is integral in moving the network forward. It was noted that the proposal had been developed prior to the announcements made by NHSE last week regarding changes in funding to pathology networks.

- The Committee confirmed their approval and support of the proposal.
- The Committee received an **update on the Estate Directorate to include the annual update on Facilities Management** and the **quarterly update on the implementation of the Digital and Data strategy**.
- The Committee noted the **review of the Trust's finance, patient access and sustainability related risks; the summary report from the from the February 2025 People and Organisational Development Committee meeting (incl. the "Temporary staffing programme" report);** and the **forward programme**.

Title of report	**Summary report from the People and Organisational Development Committee, 21/03/25**					
Board / Committee	**Trust Board 'Part 1' meeting**					
Date of meeting	27th March 2025					
Agenda item no.	03-9					
Executive lead	Emma Pettitt-Mitchell, Non-Executive Director					
Presenter	Emma Pettitt-Mitchell, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
☐	☐	☐	✓	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The People and Organisational Development Committee met (in-person/face-to-face) on 21st March 2025 (a 'deep dive' meeting). The Committee considered the following topics: 1) Staff Engagement Survey 2) Update on the workforce elements of the 25/26 financial improvement programme 3) Succession Planning and Talent Management The Committee noted the following paper: ○ Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) The Committee noted that the reports presented, demonstrate that controls relating to Principal Risk 1 of the Board Assurance framework are demonstrating effectiveness, the principal risk will need to be reconsidered in light of the financial improvement mandated by NHSE
Any items for formal escalation / decision	
Appendices attached	N/A

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer
Links to Trust Risk Register (TRR)	ID993 – Continued dependency on bank and agency staff following improvements in vacancy/recruitment levels
Compliance / Regulatory Implications	N/A

The People and Organisational Development Committee met (in-person/face-to-face) on 21st March 2025 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Committee reviewed and discussed the People Board Assurance Framework (BAF) risk and considered that a review of the principal risk will need to be undertaken in light of the financial improvement mandated by NHSE.
- The Head of Organisational Development presented the **Staff Engagement Survey,** wherein the Committee heard that the 2024 NHS national staff survey was open between September and November 2024, with results released on 13 March 2025. It was noted that high level data was presented, and the more in-depth information would be collated and shared with the divisions and a future Committee. It was noted that the Trust scored above the national average for acute Trusts in all People Promise themes, plus Staff Engagement and Morale. The Trust scored above the average in the Kent and Medway system in all themes except "We are a Team" (0.02 difference) and scored higher than all Acute Trusts in Kent and Medway in all themes. Similarly, the Trust scored above the South East average in all themes except "Reward and Recognition" (0.03 lower), "We Work Flexibly" (0.02 lower) and "We are a Team" (0.11 lower). The Committee held an in-depth discussion on the elements of the survey where the organisation had scored below the South East and National averages and considered the elements, which may have contributed to this. The effect of the temporary workforce actions was discussed at length.
  The Committee heard that 45.77% (3640) of Trust staff completed the survey and considered how more staff could be encouraged to complete the survey in the future. It was also noted that staff reported, that they felt the appraisal process was an effective one and that good quality appraisal conversations supported their personal development. The committee also noted that the divisional plans should reflect the staff survey results, and that the communication was important to be simple and clear to ensure all staff have access. The Committee noted that funding from the People Promise exemplar programme, will no longer be available
- An **update on the workforce elements of the 25/26 financial improvement programme** was presented by the Deputy Chief People Officer – People and Systems, which included that a number of high-level meetings had been taking place both at Trust and System level, regarding operational planning submissions, as metrics, targets and deadlines for submission have been moved on a number of occasions. The Committee heard that the overall temporary staffing spend remained static in Month 11, maintaining the target reduction for the second month in a row. It was noted that agency spend had reduced by £150k in month, bank spend had increased by £150k and overall, temporary staffing spend was 12.5% of all pay spend, down from a June 2024 which was at the highest level of 18.1%.
  The challenges to achieving the reduction required by the NHSE planning guidance was noted and discussed at length and the Committee were in agreement that a significant amount of change to the way the organisation provides its services and conducts its business, will need to be undertaken and it was noted that digital transformation will be a key enabler in this.The Committee heard that the Temporary Staffing programme will transition in March into the wider 2025/26 Financial Improvement Programme and will be actioned by four pay related workstreams: Nursing & Midwifery; Healthcare Professionals; Medical and Other staff. It was also noted that the reduction bank and agency spend currently approximately £4.5m a month and needs to reduce by a further £13m or £1.08m a month. This figure is representing a 40% reduction in agency spend and a 15% reduction in bank staff.
  - ❖ The Committee noted this element was not articulated in Principal Risk 1, but did reflect the controls within Principal Risk 6.
- The Head of Organisational Development updated the Committee on **Succession Planning and Talent Management,** wherein the group heard that it was recognised that an inconsistency in the Trust's approach to executive and senior leadership succession planning was recognised and the paper presented the process which has been developed to amend this. The Committee heard that the structured talent management and succession planning approach had been shared with the Renumeration and Appointments Committee and the Executive Team meeting and has received constructive and positive feedback from both groups. The Committee heard that the

approach would begin in April and will enable identification of staff who can be developed into more senior roles through the organisation. The People and Organisational Development team will bring the work completed to a future Committee for review and comment in October 2025.

- The committee also recognised that this process is being managed by the Head of Organisational Design, Head of Leadership Development and the People Business Partners alongside their current responsibilities and is not being managed by additional or released headcount.
    - ❖ The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 1.
- The Committee noted the **Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)** and the **forward programme.**
- The Chair conducted an **evaluation of the meeting** wherein Committee members noted that an 'in person' meeting was preferable to a meeting via web conference, reflected in the value of the conversations and noted the supportive contributions of Non-Executive colleagues who were cognisant of the challenges the organisation faces.

Title of report	**Audit and Governance Committee, 05/03/25 (incl. an update on bribery-related best practice)**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	27th March 2024					
Agenda item no.	03-10					
Executive lead	David Morgan, Non-Executive Director					
Presenter	David Morgan, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Audit and Governance Committee met (virtually, via webconference) on 5th March 2025. The Committee considered the following topics in relation to the Board Assurance Framework: Limited assurance internal audit review: Specialty and Associate Specialty Job Plans: Trust's red-rated risks; Update on the progress of the Internal Audit Plan for 2024/5; Approval of the Internal Audit plan for 2025/26; Counter Fraud update; Counter Fraud Annual Work Plan for 2025/26; Update on the Bribery Act (incl. details of any changes to bribery and corruption laws and regulations); External Audit Plan 2024/25; Update on the 2024/25 accounts process; Summary of the latest Financial Issues; the latest losses and compensations data; the latest losses and compensations data; Details of interests declared under the Conflict of Interests policy and procedure; Update on security issues; Update on Cyber Security; Review of the regulatory aspects of the Subject Access Requests (SAR) and considered the future approach to the review / survey of the Committee, External Audit Service, Internal Audit Service and Counter Fraud Service The Committee approved the Internal Audit Charter; the Counter Fraud Annual Work Plan for 2025/26; the External Audit Plan for 2024/25 and the accounting policies / approach to accounting estimates). The Committee considered the level of assurance that the controls of the Board Assurance Framework were effective for Principal risks 1-6 and noted where work was required to provide further assurance.
Any items for formal escalation / decision	n/a.
Appendices attached	There are no appendices attached.

Report previously presented to:		
Committee / Group	Date	Outcome/Action

N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation PR 5:If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals.
Links to Trust Risk Register (TRR)	802,3051,3378,1310,2945,2947,3096,3244,3243,3342,3288,3294,1270,3069,3364,3365,1286,1304,2980,3070,3109,3112,3113,3128,3328,1150,2981,3161,3355,3362,3209,2943,3253,1182,3269,3368,2998,3000,3300,3130,3157,3274,3043,3326
Compliance / Regulatory Implications	Code of governance for NHS provider trusts(2023) General Data Protection Regulations (GDPR)

The Audit and Governance Committee met (Virtually via webconference) on 5th March 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Deputy Medical Officer, Digital & Workforce presented the **limited assurance internal review: Specialist and Associate Specialty Job Plans,** wherein the action plan to address the significant issues raised by the audit relating to the Specialty and Associate Specialist (SAS) job planning was reviewed by the Committee; and it was noted that the follow-up review was likely to take place towards the end of the second quarter of the 2025/26 financial year, by which time a greater level of assurance is expected.
  - ❖ The Committee noted the work done, evidenced effectiveness of the controls for Principal Risk 1.
- The **Board Assurance Framework (BAF)** was reviewed by the Committee, and it was raised that the adoption of the audit level of assurance (i.e. substantial; reasonable; limited; or no assurance) should be used for the 'SRO level of assurance' section of the BAF, and it was agreed that the Trust Secretary would consider this.
- The Head of Risk Management presented a comprehensive **review of the Trust's red-rated risks** wherein an in-depth discussion was held regarding the potentially optimistic target scores across the Trust's risk register, noting that further guidance was required to provide a more accurate risk appetite. The method by which the Committee received assurance regarding the position of each risk and whether the correct accountability was considered, was discussed and it was agreed that the Head of Risk Management should include an introductory report highlighting the key matters for discussion for future 'Review of the Trust's red-risk" reports to the Committee.
- The Director of Audit, Tiaa Ltd provided an **update on progress with the Internal Audit plan for 2024/25** (incl. progress with actions from previous Internal Audit reviews) which included that three final reports had been submitted since the previous meeting, including one substantial and two reasonable assurances opinions given; that there were 36 recommendations due for the meeting, of which 28 had been closed; that there were 44 recommendations not due for the meeting, with 33 of those subject to follow up; and an overview of the plan for the remaining audits for the year was presented.
- The group approved the **Internal Audit Plan for 2025/26**, noting that ICT/Digital section of the Plan should be reviewed and defined, with the consideration of AI and a more robust business continuity plan regarding cyber security; and potentially reviewing the learnings from the Fordcombe Hospital takeover, as opposed to reviewing the current operating model.
- The Anti-Crime Specialist provided a **Counter Fraud update** and details of the **Counter Fraud Annual Work Plan for 2025/26,** which was approved by the Committee.
- It was noted by the group that details of **the Bribery Act** were updated in 2024 and was stated on the Trust's website.
- The Director of Audit, Grant Thornton UK LLP presented the **external audit plan for 2024/25,** wherein it was noted that the materiality was at 2% rather than the previous 1.5%. The plan was approved by the Committee.
- The Head of Financial Services provided an **update on the 2024/25 accounts process,** wherein an overview of the submission timetable; a full breakdown of in-year capital spend; and the intention to prepare the Trust's accounts on a 'going concern' basis was provided. The Committee recommended that the approach for the Trust to adopt the 'going concern' basis for the Annual Accounts 2024/25 should be approved by the Trust Board; and the Committee approved the draft accounting policies; key accounting assumptions; and estimation techniques.
- The **summary of the latest Financial issues** was presented by the Deputy Chief Executive/Chief Finance Officer, wherein the Committee noted the key areas of focus to improve the Trust's financial position.
  - ❖ The Committee noted there was more work to be done to provide assurance of the effectiveness of the controls for Principal Risk 6, which was underway.
- The **latest losses and compensations data** and the **latest single tender/quote waivers data** were reviewed by the Committee.
- The latest **details of interests declared under the Conflict of Interests policy and procedure** was noted by the Committee.

- The Head of Security Management attended for the latest an **update on security issues** wherein an in-depth discussion was held regarding the pilot for further security within the Emergency Department (ED) at Maidstone Hospital; the progress on the Business Case for bringing security guarding in-house; and the risks relating to the security in ED and the access control system at Tunbridge Wells Hospital. It was agreed that the Assistant Trust Secretary would liaise with the Head of Risk Management to identify what risks are recorded in respect of security issues, particularly in ED.
- The Trust's Cyber Security Architect provided an **update on Cyber Security** which included that the report had been issued relating to the Synnovis cyber incident in June 2024 which clarified that the total recovery costs equated to £32.7m; and that the number of cyber attacks, particularly relating to the NHS, had been increasing rapidly, highlighting that when the Medway Community Healthcare (MCH) incident occurred, the attackers also attempted to breach the Trust although were luckily unsuccessful. A discussion was held around how close the Trust came to being a victim of the cyber attack on MCH and the importance of keeping patching up-to-date and replacing legacy systems.
- A **review of the regulatory aspects of the Subject Access Requests (SAR)** was presented by the Director of Strategy Planning and Partnerships, which included an overview of the SAR process within the Trust and details of the Business Case for additional resource which was not supported back in 2024, due to the challenging financial position. A discussion was held around the issues relating to the service and it was noted that following the letter received by the Information Commissioner's Office (ICO), this was now recorded on the Trust's red-risk register, and that it was a priority to continue working closely with the ICO moving forward.
- The Committee discussed the **future approach to review / survey of the Committee, External Audit Service, Internal Audit Service and Counter Fraud Service,** and it was agreed that the Chair would discuss with the Trust Secretary an alternative method moving forward, which included a compilation of feedback from previous meetings.
- The Committee noted the **forward programme** and conducted an **evaluation of the meeting.**

Title of report	**Charitable Funds Committee, 12/03/25**					
Board / Committee	**Trust Board ('Part 1') Meeting**					
Date of meeting	27th March 2024					
Agenda item no.	03-11					
Executive lead	David Morgan, Non-Executive Director					
Presenter	David Morgan, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	☐	☐	✓	✓	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Charitable Funds Committee met (virtually, via webconference) on 12th March 2025. The Committee considered the following topics in relation to the Board Assurance Framework: Annual review and approval of the Charity Management Committee's Terms of Reference; Update on the risk register entries relevant to the Charitable Fund; To confirm the audit approach for the 2024/25 Maidstone and Tunbridge Wells NHS Trust charitable fund accounts; Financial overview at month 11, 2024/25; To review a proposal for the management and administration fee for 2025/26; Fundraising update (incl. details of progress with the Charitable Fund Fundraising Strategy); and an Update on the proposed partnership with Maggie's Centres. The Committee approved the revised Terms of Reference for the Charitable Management Committee. The Committee approved the recommendation that 2024/25 Charitable Funds Annual Report and Accounts are audited as an independent examination. The Committee approved the management and administration fee, subject to the business case for the Band 4 member of staff being approved. The Committee considered the level of assurance that the controls of the Board Assurance Framework were effective for Principal risks 1, 2, 4 & 5 and noted where work was required to provide further assurance.
Any items for formal escalation / decision	n/a.
Appendices attached	There are no appendices attached.

Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation PR 5:If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals.
Links to Trust Risk Register (TRR)	1038 , 3391, 3392
Compliance / Regulatory Implications	The Charities Act, 2022 The Fraud Act, 2006

The Charitable Funds Committee met (Virtually via webconference) on 12th March 2024.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee reviewed and approved the **Charity Management Committee's Terms of Reference.**
- The Trust Secretary provided the Committee with an **update on the risk register entries relevant to the Charitable Fund,** wherein the Committee heard that risks relating to the Charitable funds were being mitigated against and had actions in place.
- The Committee confirmed the **audit approach for the 2024/25 Maidstone and Tunbridge Wells Trust charitable fund accounts** as an independent examination.
- The Head of Financial Services the presented the **financial overview at month 11, 2024/25** which included details of Charitable Funds Income and Expenditure transactions from 1st April 2024 to 28th February 2025, including details of significant donations and expenditure purchases. It was noted that funds were being dispersed regularly, which was attributed to the effectiveness of the Charitable funds Management Committee.
- The group reviewed the **proposal for the management and administration fee for 2025/25**, and it was agreed that the management and administration fee is approved by the Committee, subject to the business case for the Band 4 member of staff being approved.
- The Head of Charity and Fundraising presented the **Fundraising update (incl. details of progress with the Charitable Fund Fundraising Strategy),** wherein the Committee heard about the work of MTW Hospitals Charity, with a particular focus on the progress that has been made over the last two years on the Fundraising Strategy, which was agreed and ratified by the Trust Board in January 2023 and the Committee noted the commitment of the Head of Charity and Fundraising in driving the Strategy forward and noted the achievements made.
- An **update on the proposed partnership with Maggie's Centres** was provided by the Chair of the Charity Management Committee, which included that Maggie's project board meetings were held in November 2024 and January 2025. The Committee heard that the Trust have been invited to a Kent Ambassadors meeting in April 2025 to inform them about the Maggie's project and encourage wider community engagement in the project.
- The Committee agreed that the **method of the Charitable Funds Committee's evaluation for 2025** would be by a survey shared to the group on an annual basis.
- The **forward programme** was noted by the group.

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

February 2025

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

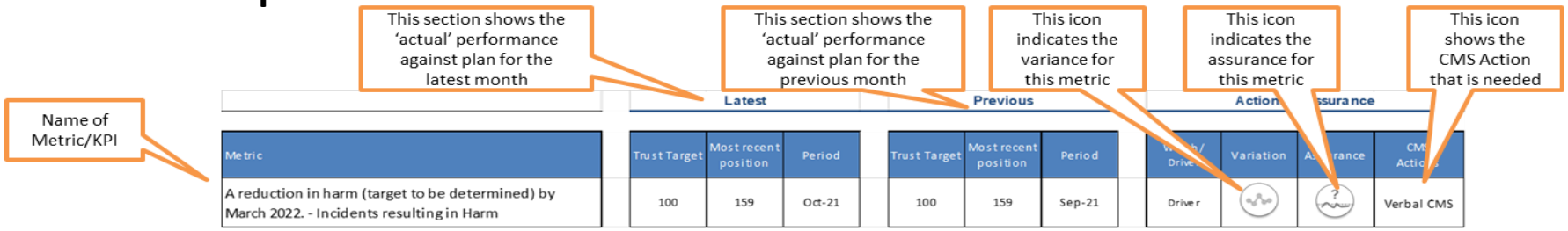
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

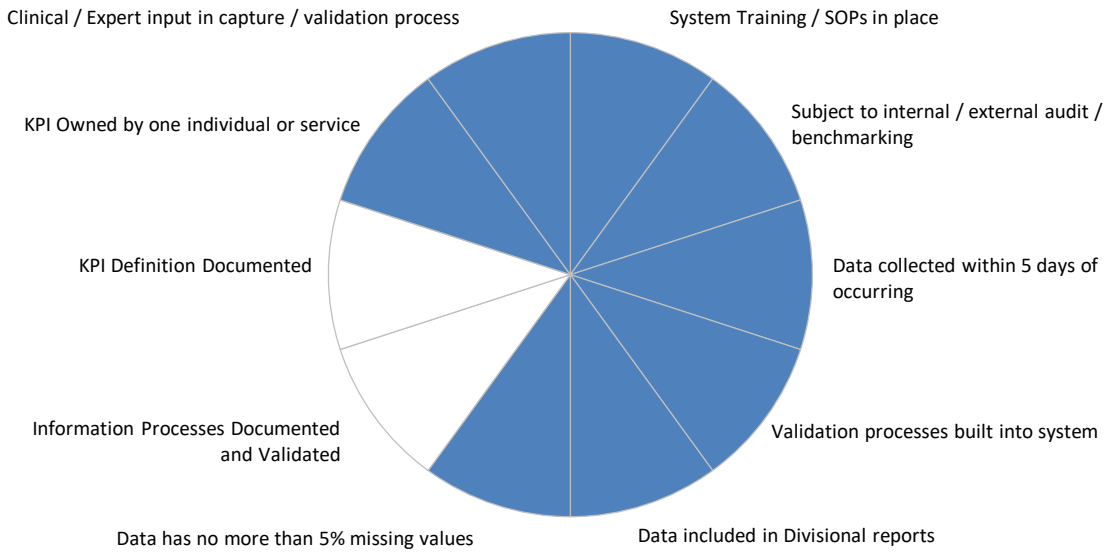
MTW exceptional people, outstanding care

Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Trust continues to refocus the Strategy Deployment Review (SDR) process to support the delivery of the Financial Improvement Programme across the organisation. We have therefore merged the six financial recovery workstreams into our existing SDR governance structure and have changed some of the Vision and Breakthrough Objectives as well as adding some new Financial Breakthrough Objectives.

People: An area of focus for the Trust is a reduction in the Total Pay Spend. The Trust implemented a target reduction and a number of actions to improve performance over the coming months. This indicator continues to fail the target for 6+ months. The overall temporary staffing spend as a percentage of the total pay spend continues to show special cause variation of an improving nature but is consistently failing the target. Agency staff spend as a proportion of the total pay spend continues to experience special cause variation of an improving nature and continues to pass the target for more than six consecutive months. Vacancy Rate continues to experience special cause variation of an improving nature and has now passed the target for over 6 months. Turnover Rate continues to experience special cause variation of an improving nature and achievement of the target for more than six consecutive months. The number of staff that leave within 12 and 24 both continue to be in variable achievement of the target. Agency spend was below the maximum limit in February and continues experiencing special cause variation of an improving nature. The Nursing Safe Staffing levels has achieved the target for more than six months. Sickness levels remain in common cause variation and Statutory and Mandatory Training continues to experience special cause variation of an improving nature and consistently passing the target. The Trust continues to consistently achieve the target for both the percentage of staff Afc 8c or above that are female or have a disability. Performance for the percentage of staff Afc 8c or above that are BAME has moved to common cause variation but is consistently failing the target. The Trust continues to implement a number of actions to improve performance.

Patient Safety & Clinical Effectiveness: The rate of incidents causing patients moderate or higher harm continues to experiencing common cause variation and variable achievement of the revised target. The number of incidents of moderate+ harms due to potential mismanagement of deteriorating patients is experiencing common cause variation and variable achievement of the target. Theatre Utilisation is experiencing special cause variation of an improving nature but is consistently failing the target. The rate of all outpatient appointments that are either a new appointment, or a follow up appointment with a procedure, is experiencing special cause variation of an improving nature and consistently passing the target. Both the Rates of E.Coli and C.Diff continue experiencing common cause variation and variable achievement of the target The rate of Falls has now passed the target for more than six months. VTE performance was below the 95% target in January and is now experiencing special cause variation of a deteriorating nature and variable achievement of the target.

Patient Access: A key area of focus is to reduce the average non-elective length of stay by 10%. This indicator is currently experiencing common cause variation and consistently failing the target. The conversion rate from A&E to inpatient admission remains in common cause variation. Ambulance Handovers <30mins continues to experience common cause variation but has failed the target for 6+ months. The Trust's performance for A&E 4hrs narrowly missed the trajectory target for February at 82.1%. Performance remains one of the highest both Regionally and Nationally. Work continues to improve flow across the Trust.

The Trust continues to achieve the 28 Day faster diagnosis compliance and the combined 31 day first definitive treatment standards. The 62 day first definitive treatment performance was below the target at 78.9% in January, now experiencing special cause variation of a deteriorating nature. 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. Diagnostic Waiting Times is now experiencing common cause variation but is now consistently failing the target. This indicator was changed nationally in October 2024 to include endoscopy surveillance patients which has adversely affected the overall performance. Focussed work and a number of actions are underway and will continue to ensure that these patients have their diagnostic test by their target date.

Executive Summary (continued)

Patient Access (Continued): With regards to RTT the Trust continues to provide system support (SYS) to other Trusts across Kent and Medway which is therefore adversely affecting the Trust's performance that is reported nationally. RTT was below the trajectory target for February of 80.6% at 72.7% (Excluding SYS). Nationally we reported 72.4% (including SYS). This indicator is experiencing common cause variation and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported zero 52 week breaches at the end of February 25. The number of patients having waited more than 40 weeks (Excluding SYS) is now experiencing common cause variation and variable achievement of the target.

Having been achieving the target for seven consecutive months, Outpatient utilisation dipped below the target at 83.5% in January. February performance will improve as cashing up of clinics continues. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute continues to experience special cause variation of an improving nature. The percentage of patients on a PIFU Pathway continues to experience special cause variation of an improving nature but consistently failing the target. Performance for both First Outpatients and Elective Activity (Inpatients and Day Case combined) were above plan and 19/20 levels for February. Both have passed the target for more than six consecutive months. Diagnostic Imaging activity levels were below plan and 19/20 levels in February and has returned to common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints remains in special cause variation of a concerning nature and variable achievement of the target. Complaints related to communication issues remains in variable achievement of the target. Complaints responded to within the target date passed the target last month, but remains in variable achievement of the target. The new indicator for agency spend specifically related to B5 RMNs and Band 4 HSCWs is experiencing common cause variation but has passed the target in February and so is in variable achievement of the target. A number of actions are being implemented to continue reduction in spend in this area. Friends and Family Response rates have increased across all touch points.

Systems: The new indicator to monitor the depth of coding continues to experience special cause variation of an improving nature but consistently failing the target based on the national average.

Sustainability: The Trust was £4.8m in surplus in the month which was £5m favourable to plan. Year to Date the Trust is £4.3 in deficit which is £1.5m adverse to plan. Delivery of the financial position, along with the reduction in non-pay spend and a reduction in agency spend continue to experience special cause variation of an improving nature and variable achievement of the target. The Trust continues with it's financial recovery plan.

Maternity: Both of the indicators for Women waiting for Induction of Labour (in less than 2 or 4 Hours) are experiencing common cause variation and failing the target. The project continues to review demand and capacity and to identify opportunities to improve flow throughout the department. Both of the indicators for Decision to delivery interval (Category 1 and Category 2) caesarean sections are experiencing common cause variation but are not at the required level and are consistently failing the target.

Executive Summary (continued)

Escalations by Strategic Theme:

People:
- Reduction in Total Pay Spend (P.11)
- Overall Temporary Staff Spend as a % of Total Spend (P.12)
- % of Afc 8c and above that are BAME (P.13)

Patient Safety & Clinical Effectiveness:
- % Capped Theatre utilisation (P.15)

Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.26)
- Women waiting for Induction of Labour <4 Hrs (P.26)
- Decision to delivery interval Category 1 caesarean (P.26)
- Decision to delivery interval Category 2 caesarean (P.26)

Patient Access:
- 10% Reduction in Non-Elective LOS (P.18)
- RTT Performance (P.19)
- Outpatient Calls answered <1 minute (P.19)
- Diagnostics waiting times <6weeks (DM01) (P.19)
- PIFU Performance (P.19)

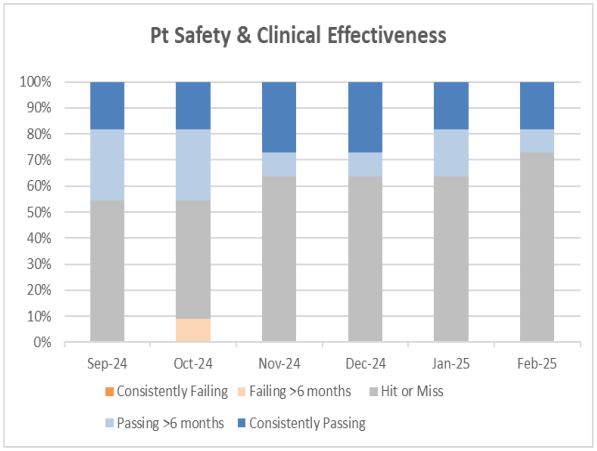
Patient Experience:
- FT Response Rates: All areas (P.21)

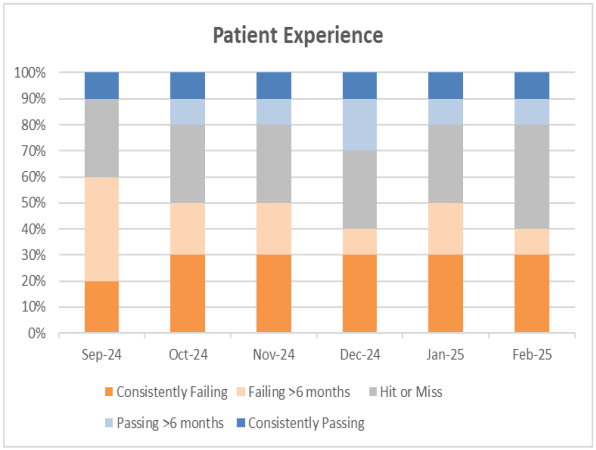
Systems:
- Depth of Coding - Average Number of Codes per Elective Episode (P.23)

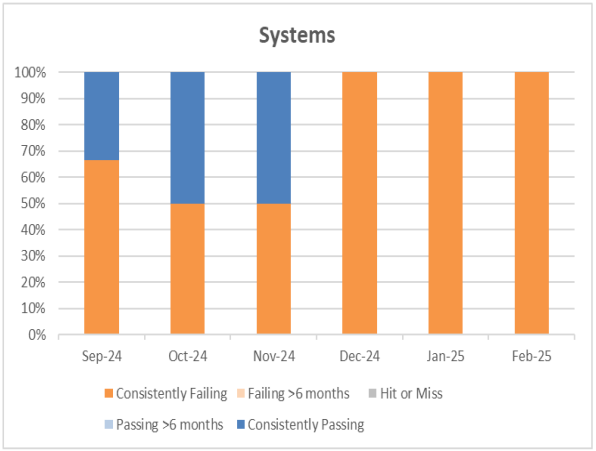
Sustainability:
- None escalated

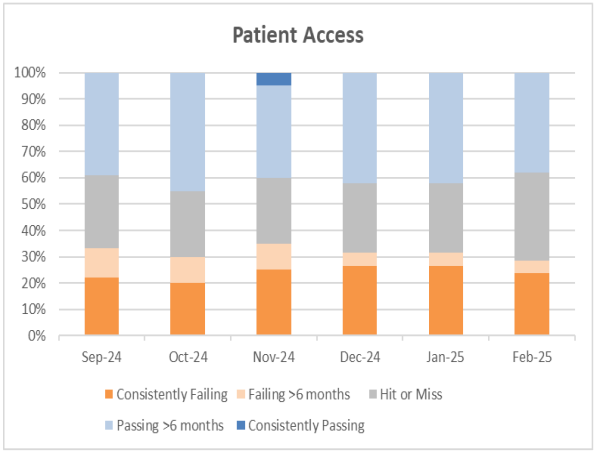
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

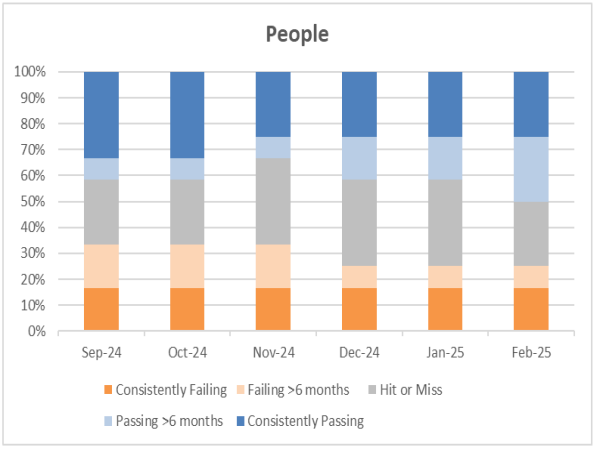
Assurance Stacked Bar Charts by Strategic Theme

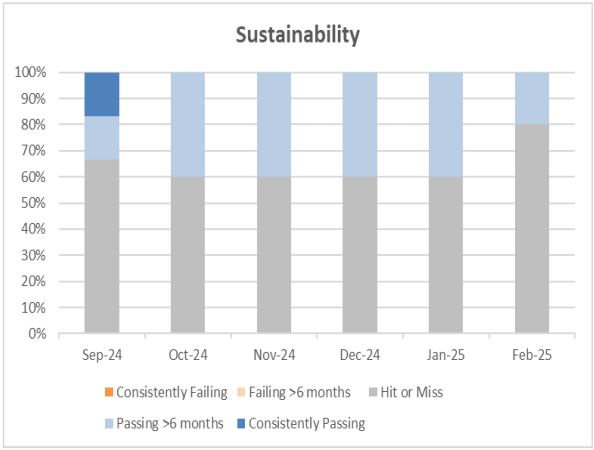












Matrix Summary

February 2025

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement (H / L)	Statutory and Mandatory Training Percentage of AfC 8c and above that have a Disability Standardised Mortality HSMR	Agency Spend as a % of spend – target of 3.2% Reduce the Trust wide vacancy rate to 8% Reduce Turnover Rate to 12% Cancer - 31 Day First (New Combined Standard) - data runs one month behind Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) To achieve the planned levels of elective (DC and IP combined) activity (shown as a % 19/20) Safe Staffing Levels (Nursing)	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Reduce non-pay spend Reduction in Postage Costs Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000 Capital Expenditure (£k)		Overall Temporary Staff Spend as a % of Total Spend Transformation: % of Patients Discharged to a PIFU Pathways Transformation: CAU Calls answered <1 minute Friends and Family (FFT) % Response Rate: A&E Friends and Family (FFT) % Response Rate: Outpatients Depth of Coding - Average Number of Codes per Elective Episode (Data runs one month behind)
Common Cause	Percentage of AfC 8c and above that are Female Summary Hospital-level Mortality Indicator (SHMI)	Rate of patient falls per 1000 occupied bed days To achieve the planned levels of new outpatients activity (shown as a % 19/20) Cash Balance (£k)	Staff Leavers within 12 months Staff Leavers within 24 months Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Bacteraemia Conversion rate from ED (Excluding Type 5 and including Direct Admissions) RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) A&E 4 hr Performance Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) To achieve the planned levels of Diagnostic (MR,NOUS,CT Combined) Activity (shown as a % 19/20) To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. Reduction in agency spend (specific to B5 RMNs and B3 HCSW) % complaints responded to within target	Flow: Ambulance Handover Delays >30mins Friends and Family (FFT) % Response Rate: Inpatients	Percentage of AfC 8c and above that are BAME Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5) Achieve the Trust RTT Trajectory (Excluding SYS) Access to Diagnostics (<6weeks standard)
Special Cause - Concern (H / L)	Complaints Rate per 1,000 occupied beddays		Sickness Absence Never Events Cancer - 62 Day (New Combined Standard) data runs one month behind Transformation: % OP Clinics Utilised (slots) To reduce the overall number of complaints or concerns each month	Reduction in Total Pay Spend	Friends and Family (FFT) % Response Rate: Maternity

Strategic Theme: People

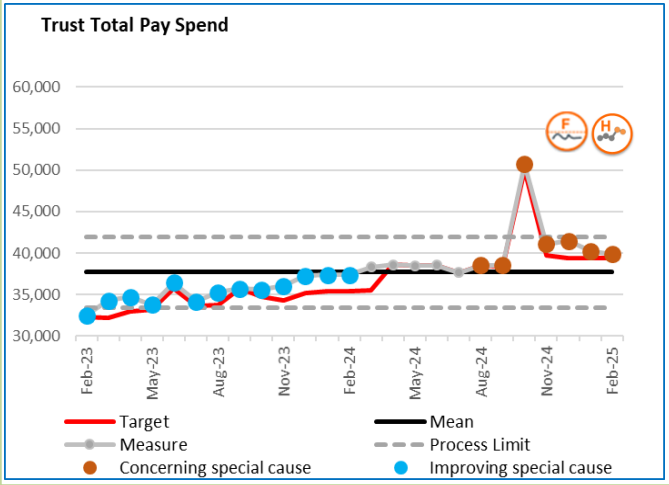
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Well Led	Reduction in Total Pay Spend		39,394	39,850	Feb-25	39,442	40,261	Jan-25	Driver			Full CMS			
Financial Breakthrough Objectives	Well Led	Overall Temporary Staff Spend as a % of Total Spend		8.5%	11.1%	Feb-25	8.5%	11.0%	Jan-25	Driver			Full CMS			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	1.5%	Feb-25	3.2%	1.9%	Jan-25	Driver			Note Performance			
Constitutional Standards and Key Metrics	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	5.5%	Feb-25	8.0%	6.2%	Jan-25	Driver			Not Escalated	5.5%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.1%	Feb-25	12.0%	10.3%	Jan-25	Driver			Not Escalated	9.7%		
	Well Led	Sickness Absence		4.5%	4.9%	Jan-25	4.5%	4.6%	Dec-24	Driver			Not Escalated	4.98%		
	Well Led	Statutory and Mandatory Training		85.0%	91.0%	Feb-25	85.0%	90.8%	Jan-25	Driver			Not Escalated	92.99%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	74.2%	Feb-25	66.0%	74.0%	Jan-25	Driver			Not Escalated	75.23%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	7.9%	Feb-25	4.0%	8.0%	Jan-25	Driver			Not Escalated	8.52%		
	Well Led	Percentage of AfC 8c and above that are BAME		11.0%	6.0%	Feb-25	10.6%	6.0%	Jan-25	Driver			Escalation	5.84%		
	Well Led	Staff Leavers within 12 months		15.3	7	Feb-25	15.3	17	Jan-25	Driver			Not Escalated	11		
	Well Led	Staff Leavers within 24 months		27.8	15	Feb-25	27.8	28	Jan-25	Driver			Not Escalated	23		

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Reduction in Total Pay Spend

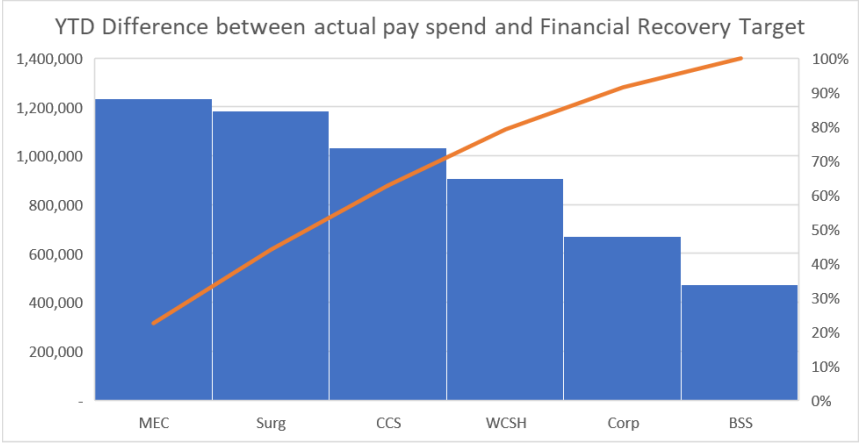
Owner: Chief People Officer
Workstream: Temporary Staffing
Metric: Overall Staff Spend compared to financial recovery forecast target
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Feb-25
39,.850
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and is has failed the target for 6+ months
Max Target (Internal)
39,438
Business Rule
Full Escalation as is consistently failing the target

2. Stratified Data



3. Top Contributors & Risks

Top Contributors:

- Whilst overall pay spend, year to date, is under the original 2024/25 budget, financial recovery targets were set, to reduce H2 temporary staffing spend by £9m from the M5 forecast figures, in order to reduce overall pay spend.
- Temporary Staffing costs have exceeded the internal targets set at M5 however have continued to reduce month on month whilst substantive pay has remained stable.

Risks:

- There is a risk that winter pressures and unexpected high demand on services will cause temporary staffing levels to be higher than planned.
- There is a risk that Divisions will not reduce their pay forecasts to the targets set in M5.
- There is a risk that staff sickness will cause additional need for temporary staffing.

4. Action Plan of the Breakthrough Objective

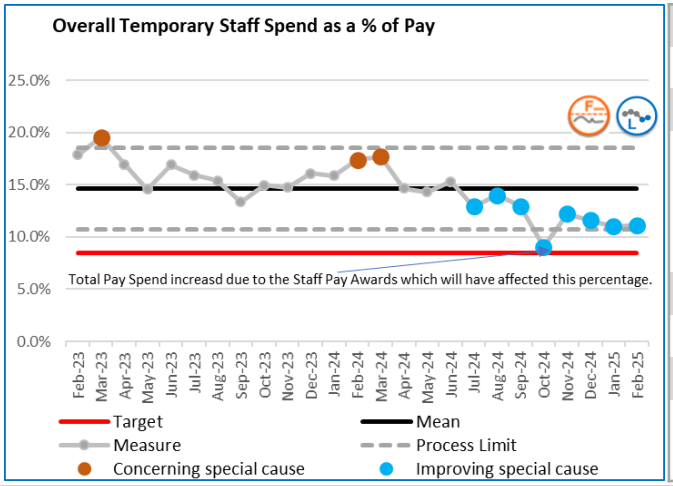
Workstreams	Actions	When	Who
2025/26 planning	2025/26 Financial Improvement will split pay initiatives into four workstreams aligned to staff groups. All current actions to be included in the scoping of the new workstreams	Mar 2025	Chief Nurse, Chief Medical Officer & Chief People Officer
Trust Total Pay Spend	Review of data to triangulate substantive WTE, vacancy, sickness and activity against temp staff spend to ensure that we understand what is driving this metric	Mar 2025	Workstream SRO's and Leads
Temporary Staffing Project	Division / directorate forecast meetings – including focus on areas over £50k variance to budget	ongoing	Deputy CPO / Head of Financial Management

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Overall Temporary Staff Spend as a % of Total Spend

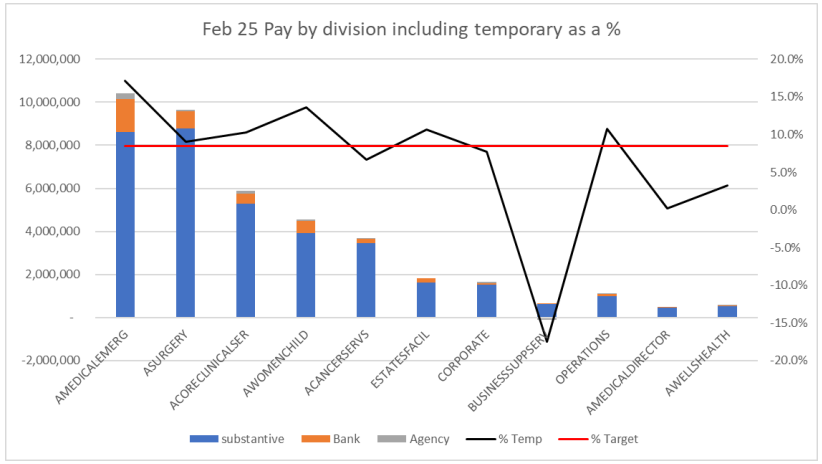
Owner: Chief People Officer
Workstream: Temporary Staffing
Metric: Overall Temporary Staff Spend as a % of Total Spend
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Feb-25
11.1%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Max Target (Internal)
8.5%
Business Rule
Full Escalation as is consistently failing the target

2. Stratified Data



3. Top Contributors & Risks

Top Contributors:

- Inconsistent controls to assess requests for temporary staffing.
- High levels of retrospective rostering creating inaccurate bank demand.
- Medical rosters not recorded consistently.

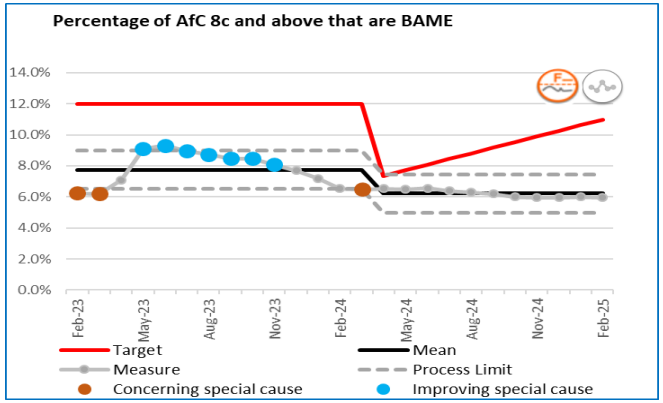
Risks:

- There is a risk that Divisions will not reduce their pay forecasts by the target level of 1.9% (£9m)
- There is a risk that unexpected high demand on services will cause temporary staffing levels to be higher than planned
- There is a risk that the temporary staffing team do not have sufficient resource capacity to deliver project deliverables

4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Programme Delivery	Develop an A3 to identify strategic divisional actions to take forward	Q4 2024/25	Senior Continuous Improvement Manager
	Temporary Staffing Business Case review at ETM	Complete	CPO / Deputy CPO
	2025/26 Financial Improvement will split pay initiatives into four workstreams aligned to staff groups. All current actions to be included in the scoping of the new workstreams	March 2025	Workstream SRO's and Leads
Rostering Performance	Embed use of Temporary Staffing Dashboard to give operational teams visibility of key temporary staffing performance	Apr 2025	Deputy CPO / Head of Temporary Staffing
	Division / directorate forecast meetings – including focus on areas over £50k variance to budget	Ongoing	Deputy CPO / Head of Financial Management
Vacancy and Pay Controls	Review & respond to ICB pay controls	Ongoing	Deputy CPO
	Review of Corporate Consultancy usage and baseline	Mar 2025	
Medical Rate Framework	New Framework implementation	Mar 2025	Deputy Medical Director
Medical Rostering (Patchwork)	Rollout of Patchwork in ED inc staff engagement and communications.	To be agreed with MEC	Patchwork Medical Rostering Programme Director

People – Workforce: CQC: Well-Led



Feb-25
6.0%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
8.4%
Business Rule
Full Escalation

Summary:	Actions:	Assurance & Timescales for Improvement:

% of AfC 8c and above that are BAME: This metric is common cause variation and consistently failing the target.	**% of AfC 8c and above that are BAME:**
	Actions:
	• Launch of focussed work on inclusive recruitment for bands 8b+
	• Inclusive recruitment workshops extended to all recruiting managers.
	• There was a Q3 24/25 focus on inclusive recruitment. Reverse mentoring cohort 3 planned.
	• Increased visibility of staff networks through corporate briefing
	• Whilst the EDI project is closing down, focus on EDI strategy and NHSE deliverables will continue.
	• We will review the full year recruitment data for 24/25 when it is available to see if there are any further insights and to inform any revised approach for improving this metric in 25/26 given performance.
		% of AfC 8c and above that are BAME:
		• % of AfC 8c and above that are BAME:
		• In January, 3 inclusive recruitment workshops were scheduled as follows:
		  • Workshop one - 5 attended
		  • Workshop two - cancelled due to only 2 people being booked
		  • Workshop three – 7 booked
		• Work has started developing on demand training for inclusive recruitment which should be ready to pilot towards the end of February 2025, meanwhile workshops have been postponed
		• An update to ETM with WRES and WDES regional updates and support required from senior leaders is planned. This was scheduled for January (date TBC).
		• The EDI team met with People BPs in January to go through EDI data dashboard to inform People and OD plans for Divisions
		• Executive Succession planning commencing April 2025. Including objective to increase diversity of successors and pipeline through to senior positions through a range of talent management and development activities.

Strategic Theme: Patient Safety & Clinical Effectiveness

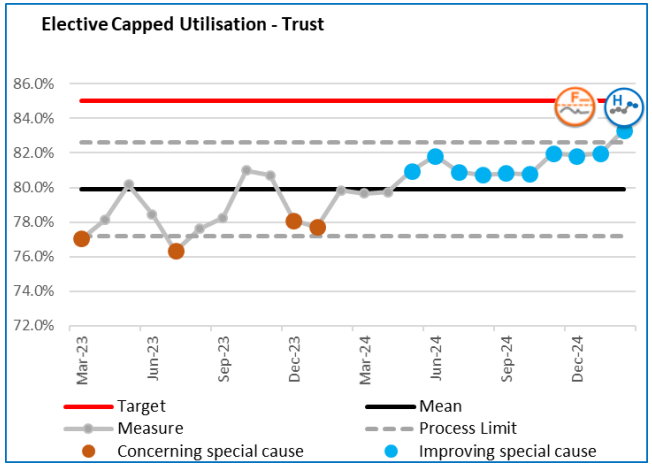
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	2.16	Jan-25	1.50	1.86	Dec-24	Driver			Verbal CMS	2.15		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	1	Jan-25	2.1	4	Dec-24	Driver			Verbal CMS	3		
Financial Breakthrough Objectives	Safe	% Capped Theatre utilisation.		85.0%	83.3%	Feb-25	85.0%	82.0%	Jan-25	Driver			Full CMS			
	Safe	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	47.8%	Feb-25	49.0%	47.4%	Jan-25	Driver			Verbal CMS	53.5		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	4	Feb-25	TBC	5	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	13	Feb-25	TBC	19	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	1	Feb-25	TBC	2	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	84.4	Nov-24	100.0	85.6	Oct-24	Driver			Not Escalated	83.1		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	91.0	Nov-24	100.0	93.0	Oct-24	Driver			Not Escalated	95.5		
	Safe	Never Events		0	1	Feb-25	0	0	Jan-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	0.0	Feb-25	32.6	16.9	Jan-25	Driver			Not Escalated	35.5		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.4	50.8	Feb-25	44.4	60.2	Jan-25	Driver			Not Escalated	55.3		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Feb-25	0	0	Jan-25	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.3	Feb-25	6.4	5.0	Jan-25	Driver			Not Escalated	4.9		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	92.2%	Jan-25	95.0%	96.3%	Dec-24	Driver			Not Escalated	96.21%		

Financial Breakthrough: Counter Measure Summary

Project/Metric Name – % Capped Theatre utilisation.

Owner: Medical Director
Workstream: Productivity
Metric: % Capped Theatre utilisation.
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Feb-25

83.3%

Variance Type

Metric is currently experiencing special cause variation of an improving nature

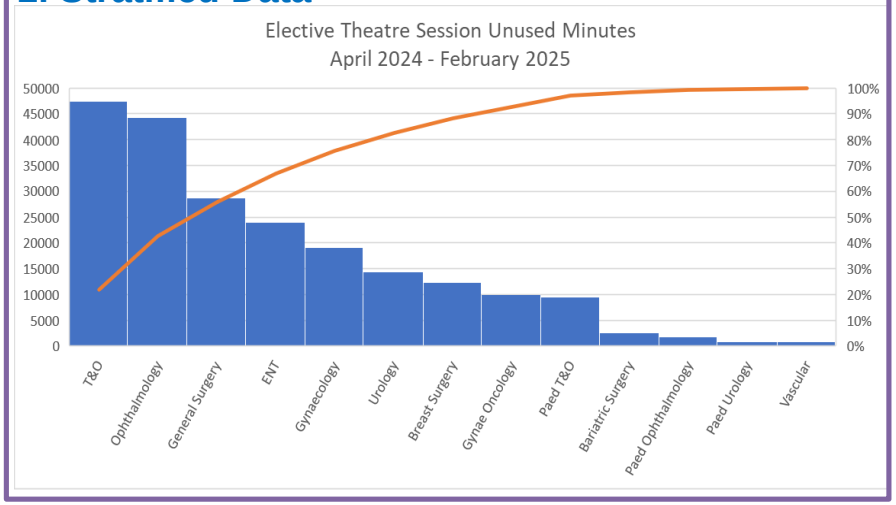
Target (Internal)

85%

Target Achievement

Metric is consistently failing the target.

2. Stratified Data



3. Top Contributors

Theatre Utilisation:

- Elective paediatric beds
- Incorrect procedure times
- Cancellations (POA capacity increased 12 F2F per speciality & x 24 slots for T&O p/w, 10 F2F p/w at Fordcombe gen surgery & ENT, Additional Saturday clinics
- Scheduling – Specialties set action at TP to get 3 weeks ahead with booking. Good progress made across the board
- Backfilling of sessions in orthopaedics

Issues:

- Humidity in KMOC while we worked through concerns raised from the clinical team impact was over 2 days
- Patients with flu unfit resulting in short notice cancellations

Key Risks:

- POA capacity - SB SOP completed, shared, embedding across specialties
- Paediatric ward opening times- being picked by David and Kym at business planning (ACTION)
- TAT-high volume lists with 2 cohorts of patients resulting in mid list down time - recommendation to Sarah Davis awaiting confirmation (ACTION in progress)

4. Action Plan

Action	Review	Status
Review of paediatric bed options (Populate later part of list with adults, start list earlier, adjust job plans)	Ongoing	Open
Paed ward opening times – Business Planning Action	Ongoing	Commenced
Complete an A3 in Ophthalmology to understand root causes for underutilisation and cancellations	Ongoing	Commenced
Review all operating lists at scheduling-check NCR and with consultants if queries. Specialties to review actual Vs planned report – Improve Procedure times	Ongoing	Commenced
Fellows to backfill (flip lists), FTLC to work flexibly to backfill, HIT/HVLC lists are identified at 6-4-2. to utilise cancelled slots	Ongoing	Commenced
If a session cannot be backfilled then the resources of the cancelled session will be moved to support the running list to maximise efficiencies – tied in with above action	Ongoing	Commenced

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	Year End Forecast	Variation	Assurance
Vision	Responsive	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5)		5.9	6.9	Feb-25	5.9	7.2	Jan-25	Driver			Full CMS			
Financial Breakthrough Objective	Responsive	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	16.6%	Feb-25	16.0%	15.4%	Dec-24	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Responsive	Achieve the Trust RTT Trajectory (Excluding SYS)		80.6%	72.7%	Feb-25	79.9%	72.3%	Jan-25	Driver			Escalation	73.0%		
	Responsive	Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		80.6%	72.4%	Feb-25	79.9%	72.0%	Jan-25	Driver			Business Rules not applied (for info only)			
	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		122.0%	123.0%	Feb-25	126.0%	132.0%	Jan-25	Driver			Not Escalated	122.0%		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		659	811	Feb-25	658	908	Jan-25	Driver			Not Escalated	813		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	22	Feb-25	N/A	26	Jan-25	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	0	Feb-25	N/A	0	Jan-25	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		99.0%	91.3%	Feb-25	98.9%	89.2%	Jan-25	Driver			Escalation	91.3%		
	Responsive	A&E 4 hr Performance		82.2%	82.1%	Feb-25	79.6%	80.8%	Jan-25	Driver			Not Escalated	81.4%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	96.1%	Jan-25	96.0%	97.1%	Dec-24	Driver			Not Escalated	96.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	78.9%	Jan-25	85.0%	84.5%	Dec-24	Driver			Not Escalated	85.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	75.2%	Jan-25	75.0%	77.6%	Dec-24	Driver			Not Escalated	77.6%		
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	90.6%	Jan-25	90.0%	93.5%	Dec-24	Driver			Not Escalated	91.2%		

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

- CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh and the position is expected to improve.

Strategic Theme: Patient Access (continued)

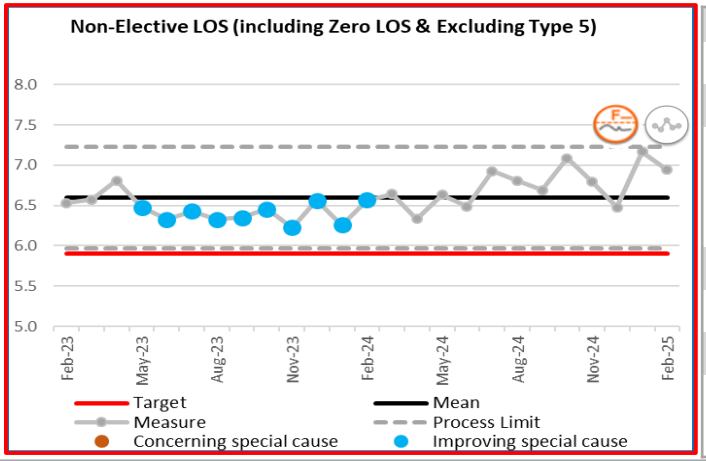
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	80.8%	Feb-25	85.0%	83.5%	Jan-25	Driver			Not Escalated	85.0%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		8.0%	7.0%	Feb-25	7.1%	7.3%	Jan-25	Driver			Escalation	7.4%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	87.5%	Feb-25	90.0%	88.6%	Jan-25	Driver			Escalation	90.2%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	7.8%	Feb-25	5.0%	7.9%	Jan-25	Driver			Escalation	7.9%		
	Responsive	To achieve the planned levels of elective (DC and IP combined) activity (shown as a % 19/20)		109.4%	117.9%	Feb-25	113.8%	131.6%	Jan-25	Driver			Not Escalated	112.7%		
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	47.7%	Feb-25	49.0%	47.3%	Jan-25	Driver			Not Escalated	51.0		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		145.5%	142.3%	Feb-25	141.4%	158.3%	Dec-24	Driver			Not Escalated	162.2%		

Vision: Counter Measure Summary

Project/Metric Name – Achieve 10% Reduction in Non-Elective LOS

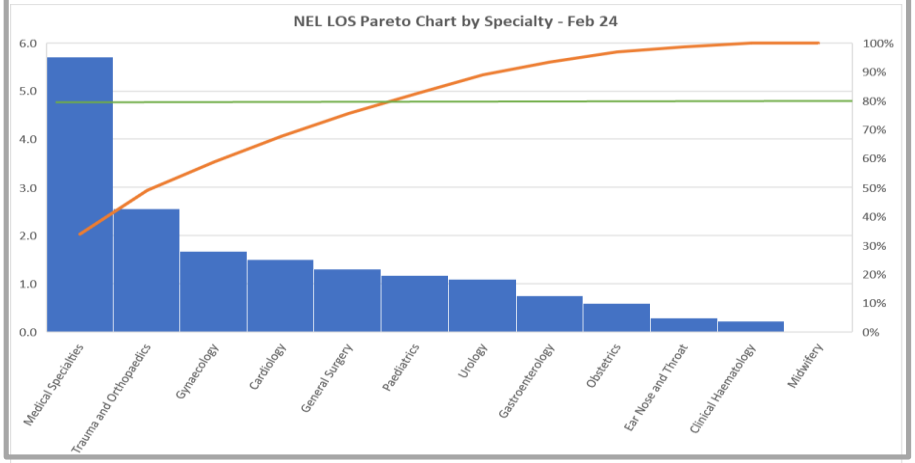
Owner: Chief Operating Officer
Workstream: Front to Back Doors
Metric: Non-Elective Length of Stay (LOS)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Feb-25
6.9
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
5.9
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

- High number of DTA's overnight post weekend impacting on flow
- Review of SDEC pathways/utilisation
- Patients with extended stays (NCTR)
- Low weekend discharges

Quick win

- Pathway 0 management

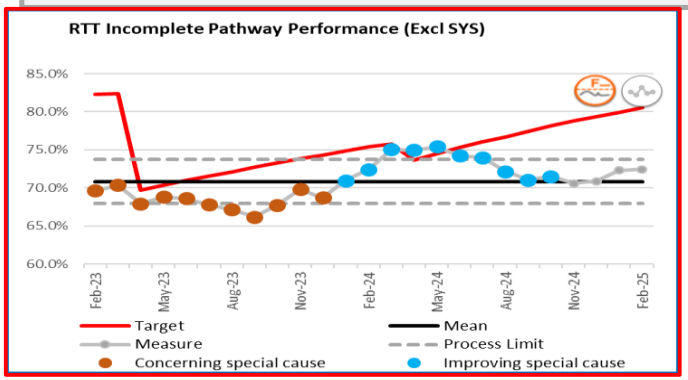
Key Risks:

- Multiple operational challenges
- Out of hospital capacity
- Increased in NEL Demand due to Seasonal illnesses could impact on LOS

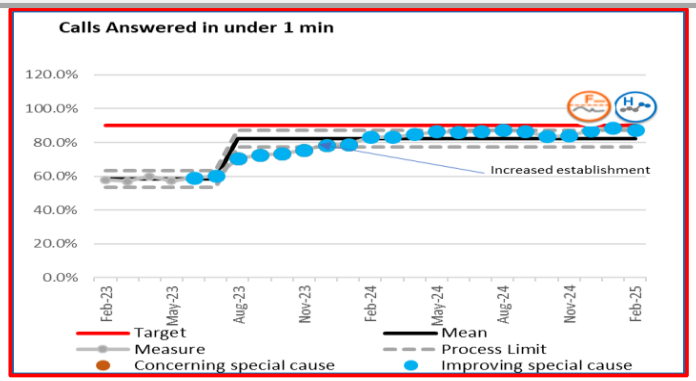
4. Action Plan

Action	When
Project being transitioned to Operational Flow as part of 2025/26 financial improvement programme	Mar 25
Key focus areas for improvement – plans being refined • No criteria to reside • SDEC • Weekend discharges • Teletracking optimisation & innovation	ongoing
Data gathering and analysis	Apr 25
Agree metrics for each focus area	Apr 25
Analysis of financial impact	Apr 25

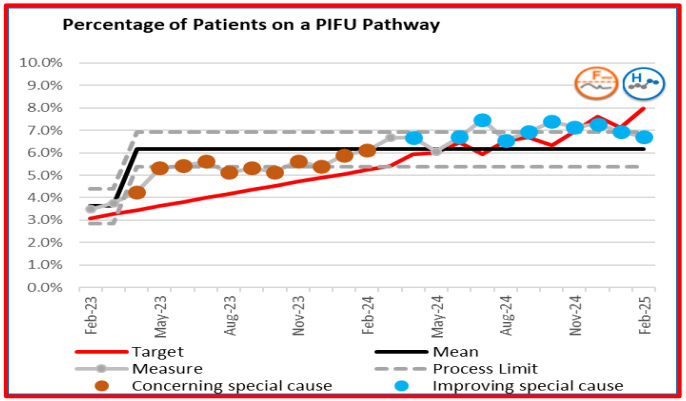
Patient Access: CQC: Responsive



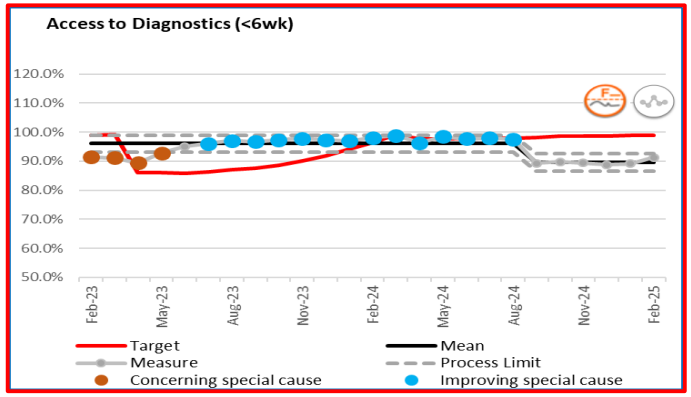
Feb-25
72.7%
Variance Type
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
80.6%
Target Achievement
Metric is consistently failing the target



Feb-25
87.5%
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



Feb-25
7.0%
Variance / ,Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target (Internal)
7.97%
Business Rule
Full Escalation as consistently failing the target



Feb-25
91.3%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
99%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

RTT: is experiencing common cause variation and is consistently failing the target.

Calls Answered <1 min: is experiencing special cause variation of an improving nature and remains consistently failing the target.

% of Patients on a PIFU Pathway: is experiencing special cause variation of an improving nature and consistently failing the target.

% Diagnostics within 6 week: is experiencing common cause variation and consistently failing the target.

Actions:

RTT: Data reviewed to identify specialties with longest waits. Identify 2 areas for focussed improvement- Gynaecology and ENT with further data to drill down on improvement areas, Process Mapping sessions completed, areas of improvement and action plan to be identified.
Performance against the under 1 minute KPI: Daily report by hour and by speciality are circulated to the General Managers and team leaders to highlight peaks and troughs of performance. Bi-weekly KPI meetings with specialities to put in place actions to improve performance metrics. Under-performing specialities escalations to GM level.
% of Patients on a PIFU Pathway: Review of specialty level data to understand specialties that are under GIFT peers to identify areas of recovery.

% Diagnostics within 6 week: This was changed nationally in October 2024 to include endoscopy surveillance patients which has adversely affected the overall performance. Focussed work and a number of actions are underway and will continue to ensure that these patients have their diagnostic test by their target date.

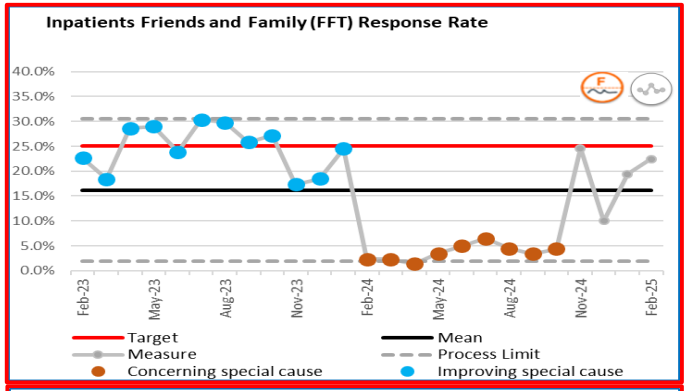
Assurance & Timescales for Improvement:

RTT: We've established and communicated a clear trajectory for reducing wait times for first appointments with the specialty teams. Teams are implementing super clinics, and we're continuing to enhance the straight-to-test pathways. Notably, there have been improvements in gynaecology regarding their wait times for first appointments. Although, some progress has been affected by the resources allocated to system support, particularly for Gastro and ENT services , the specialties have now reduced their long waiting patients below 52 weeks and are now focussing on the clearance of patients over 40 weeks.. Internal Recovery plans for the divisions and specialties have been completed and are monitored monthly I Trust Performance. Triage to test pathway roll out starting in Cardiology by end Jan with fast roll out of other specialties from April.
Calls Answered within 1 minute in the CAUs: Remain on upward trajectory. Focus on underperforming specialities to reach 90% specifically T&O. Outpatient Contact Centre fully established and no new sickness. Known staffing issue within General Surgery and Surgical Specialities CAU.
% of Patients on a PIFU Pathway: : Remote monitoring of PIFU for long term conditions. Specialty plans for benchmarking against GIRFT/Model Hospital % to be reviewed in GIRFT monthly meetings.
% Diagnostics within 6 weeks: The Trust is currently in the process of securing endoscopy activity at our new Fordcombe site to help improve performance in this area. Underperforming specialties are developing recovery plans and DDPA to commence DM01 PTL meetings starting w/c 24.2.25

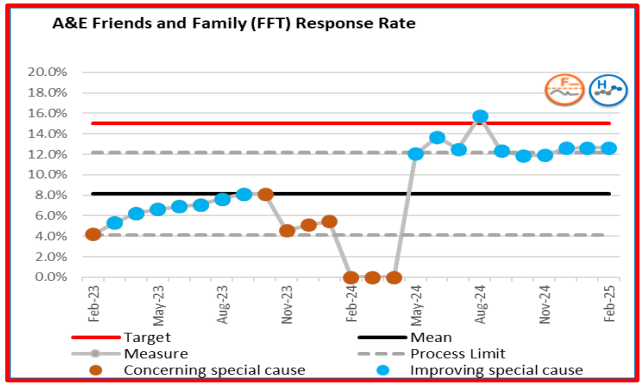
Strategic Theme: Patient Experience

				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	Caring	To reduce the overall number of complaints or concerns each month		36	66	Feb-25	36	66	Jan-25	Driver			Verbal CMS	61		
Breakthrough Objective	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	25	Feb-25	24	42	Jan-25	Driver			Verbal CMS	15		
Financial Breakthrough Objective	Caring	Reduction in agency spend (specific to B5 RMNs and B3 HCSW)		190,000	135,676	Feb-25	190,000	239,500	Jan-25	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Caring	Complaints Rate per 1,000 occupied beddays		3.9	3.7	Feb-25	3.9	3.3	Mar-24	Driver			Not Escalated	2.5		
	Caring	% complaints responded to within target		75.0%	78.0%	Feb-25	75.0%	66.0%	Jan-25	Driver			Not Escalated	75.0%		
	Caring	Complaints Backlog – Older than 4 months		0	4	Feb-25	0	6	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints Closed in Month		38	51	Feb-25	38	39	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	100.0%	Feb-25	95.0%	100.0%	Jan-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	22.5%	Feb-25	25.0%	19.4%	Jan-25	Driver			Escalation	16.78%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	12.65%	Feb-25	15.0%	12.65%	Jan-25	Driver			Escalation	13.93%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	7.6%	Feb-25	25.0%	10.9%	Jan-25	Driver			Escalation	6.71%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	10.3%	Feb-25	20.0%	9.8%	Jan-25	Driver			Escalation	10.25%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	101.6%	Feb-25	93.5%	103.7%	Jan-25	Driver			Not Escalated	99.4%		

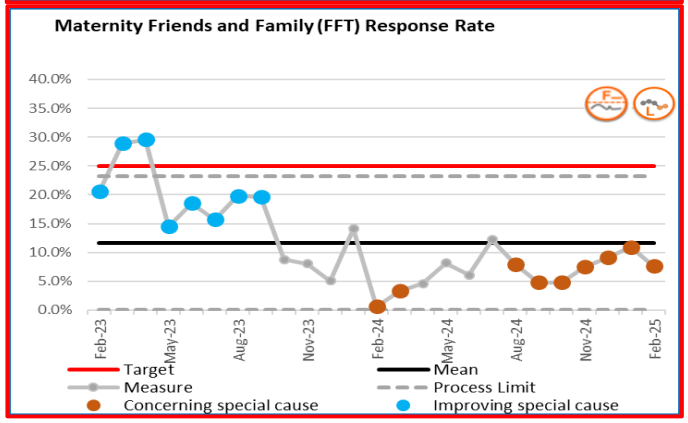
Patient Experience: CQC: Caring



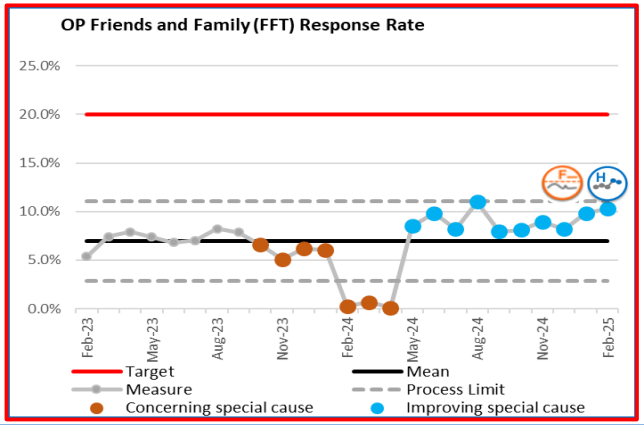
Feb-25
22.5%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (National)
25%
Business Rule
Full Escalation as failing the target for 6+ months



Feb-25
12.7%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Feb-25
7.6%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Feb-25
10.3%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

Friends and Family Response Rate - Inpatients: Is experiencing Common Cause variation has failed the target for 6+ months
National Response – 21.5%
Trust Recommended Rate is 92.2%

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.
National Response – 10.0%
Trust Recommended Rate is 82.2%

Friends and Family Response Rate - Maternity: : Is experiencing Special Cause variation of a concerning nature and is consistently failing the target
National Response – 11.7%
Trust Recommended Rate is 95.8%

Friends and Family Response Rate - Outpatients: Is experiencing Special Cause Variation of an improving nature variation but is consistently failing the target.
National Response – 16.1%
Trust Recommended Rate is 94.1%

Actions:

Inpatients: Response rate has continued to rise although it continues to fail the Trust target. This is attributed to an increase in reliability/accuracy in data return from the provider but more importantly, greater engagement from staff following a concentrated effort to enhance internal comms about FFT. Inpatients continue to be the greatest source of feedback via FFT cards with one third of feedback received via this route this month. Positive feedback significantly outweighs negative however, the 3 top themes are the same – staff attitude, implementation of care and environment across both areas and this is also consistent with those identified last month.. Negative comments commonly relate to lack of continuity of care, lack of 'joined up' care/communication between teams/MDT, several particularly negative comments in relation to patient discharges and inter-unit transfers.

A&E: Response rate is stable although continues to fall below target, the vast majority of responses continue to be received digitally. Positive themes: staff attitude – kindness and compassion with patients referencing the challenging, busy environment. Areas for improvement: waiting times and lack of information in regards to these; staff attitude including a lack of kindness and compassion – several references to personal conversations taking place amongst staff, the need to repeatedly explain symptoms as notes seemingly not updated/available.

Maternity: FFT cards & posters containing QR codes on display, link is also shared by post-natal team as part of information resources sent. Feedback is also being shared via other means e.g. social media this may impact on response rates for FFT. Positivity rate of feedback received is high with standard of care provided by staff, being a recurrent theme, negative feedback largely in relation to fragmented care and quality of communication as well as administration of medications.

Outpatients: Response rate has increased marginally. Top positive themes: caring attitude of staff, implementation of care and environment. Areas for improvement: staff attitude & communication including lack of continuity of care, waiting times within department (clinics consistently starting late & running late, lack of accurate updates), poor communication about appointment cancellations/changes.

FFT Response All: Response rates are slowly improving in the majority of areas, recent efforts to increase staff engagement via internal comms, drop-in staff training as well as rapid responses to queries received to the generic email address including requests for FFT cards appear to be having a positive impact. Low response rates in maternity are partially attributed to incorrect assignment of location via the hierarchy highlighted in a recent QA exercise, this will be rectified on 1st April.

Assurance & Timescales for Improvement:

Friends and Family (FFT) Response Rates:
The communications plan continues to be delivered across the organisation. The drop in training sessions for the platform have been well received and appreciated by attendees with numerous staff gaining confidence and exploring the potential to create 'you said, we did' posters for their areas. Stocks of new forms have been supplied to multiple locations as a result of staff engagement with efforts being made to ensure that these are available within 48hrs of a request being received to the generic email address.
A significant internal QA exercise has incorrect assignments of feedback notably for maternity, and highlighted substantial gaps in the clinic codes being used to support data collection via SMS text, steps are being taken to rectify this with changes likely to be implemented from the beginning of April. Whilst it is expected that an increase in the number of texts being sent will results in increased costs we would also expect to see an increase in response rates as a result of these changes. Efforts to further embed FFT and increase staff and public awareness of the tools will continue.

Strategic Theme: Systems

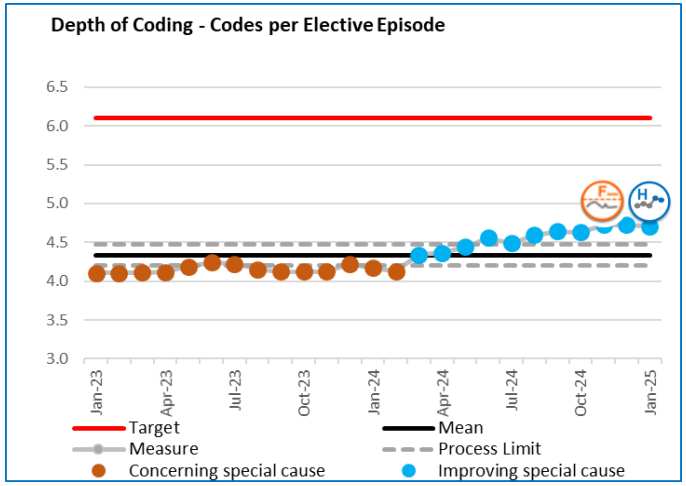
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Financial Breakthrough Objectives	Effective	Depth of Coding - Average Number of Codes per Elective Episode (Data runs one month behind)		6.1	4.7	Jan-25	6.1	4.7	Dec-24	Driver			Full CMS			
Constitutional Standards and Key Metrics	Effective	Inpatient coding income (simple audit tool)		TBC	51163	Dec-24	TBC	50665	Nov-24	Driver			Escalation			

Financial Breakthrough: Counter Measure Summary

Project/Metric Name –To improve Coding – Depth of Coding – Codes per Elective Episode

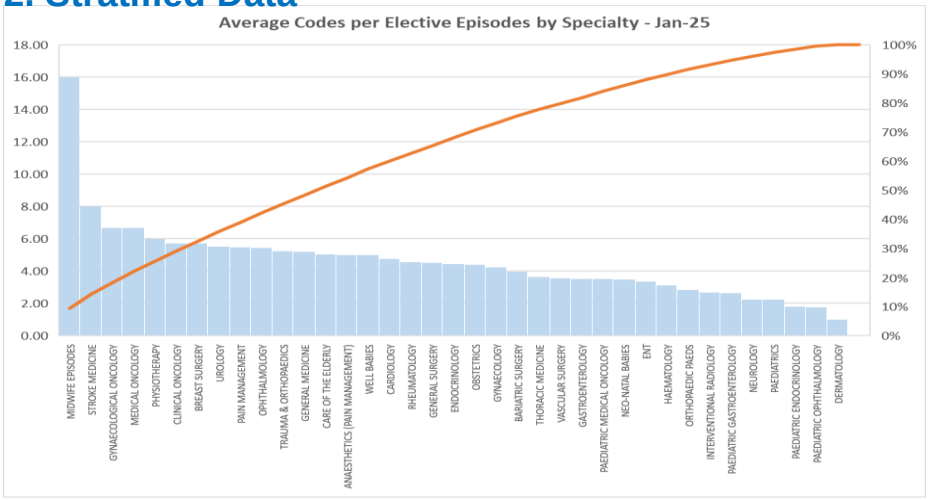
Owner: Director Strategy, Planning & Partnerships
Workstream: Capturing Income
Metric: Codes per Elective Episode
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Jan-25 (one month behind)
4.7
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Nat Average)
6.1
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors and Key Risks

Top Contributors

- Quality of clinical information recorded at depth appropriate to patient complexity

Key Risks

- Resourcing the Coding Team to manage activity demands and administrate Simple Coding audits.
- Inclusion of new coding for Frailty index highlights recording issues of co-morbidities
- Poor quality of information within the clinical systems and documentation
- Engagement from clinicians to understand and adopt effective coding practices.

4. Action Plan

Workstreams	Action	Who
Inpatient Activity Coding	• Review and validate health record data quality - Live Audit tool • Resource the activity • Create SOPs and processes for use of the tool	Clinical Coding Team
Education and Awareness (inpatient)	• Identify opportunities for additional training support. • Delivery of training to Improve organisational awareness of coding and existing processes for use of electronic documentation.	Clinical Coding Team / Sunrise Team
Governance	• Amend governance structure to reflect new Coding Opportunities Group responsibilities • Validate, approve and expedite coding income opportunities • Process to assure income and progress of coding opportunities	Counting & Coding Opportunities Governance Group
Resource	• Agree future state resourcing for Coding Team • 2 new Trainee Clinical Coding Analysts starting in April	Clinical Coding Team

Strategic Theme: Sustainability

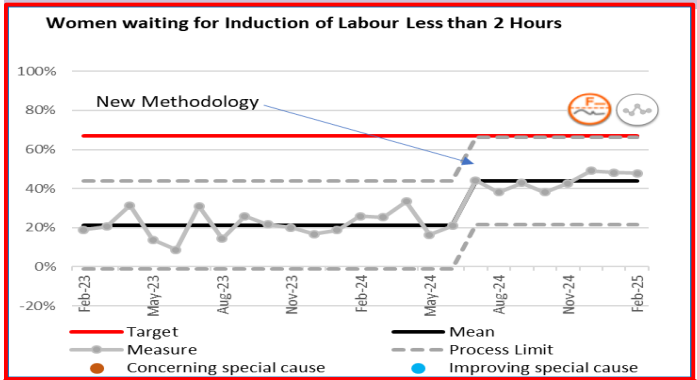
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		-134	4,838	Feb-25	1,422	1,790	Jan-25	Driver			Note Performance	4,577		
Financial Breakthrough Objectives	Well Led	Reduce non-pay spend		19,351	19,423	Feb-25	19,461	22,600	Jan-25	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		748	622	Feb-25	776	767	Jan-25	Driver			Not Escalated	841		
	Well Led	CIP		3,618	3,611	Feb-25	3,626	3,223	Dec-24	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		2,133	13,968	Feb-25	1,592	5,142	Jan-25	Driver			Not Escalated	#N/A		
	Well Led	Capital Expenditure (£k)		1,497	2,192	Feb-25	2,592	2,356	Jan-25	Driver			Not Escalated	#N/A		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		159,699	151,916	Feb-25	145,238	137,868	Jan-25	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		23,148	22,974	Feb-25	21,086	20,249	Jan-25	Driver			Not Escalated			

Note – Forecast is for year end

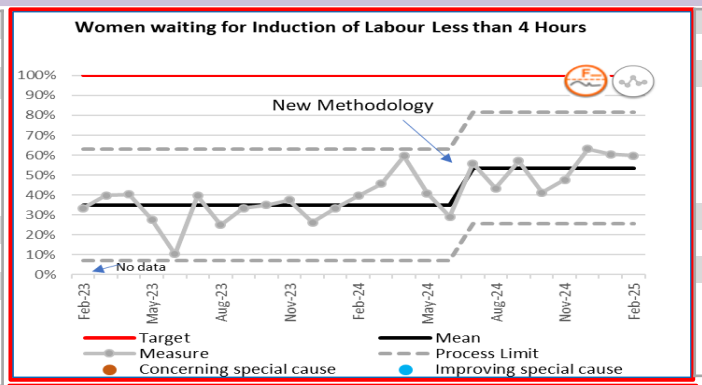
Maternity Metrics

	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	Maternity Metric	Registerable Births		No target	394	Feb-25	470	444	Jan-25	Driver		No target	Not Escalated	424		No SPC
	Maternity Metric	Antenatal bookings		No target	160	Feb-25	545	613	Jan-25	Driver		No target	Not Escalated	144		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	23.9%	Feb-25	No target	23.9%	Jan-25	Driver		No target	Not Escalated	22.4%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	20.6%	Feb-25	No target	19.4%	Jan-25	Driver		No target	Not Escalated	20.0%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	26.2%	Feb-25	36.0%	20.0%	Jan-25	Driver			Not Escalated	24.1%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	47.8%	Feb-25	67.0%	48.1%	Jan-25	Driver			Escalation	60.7%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	59.8%	Feb-25	100.0%	60.5%	Jan-25	Driver			Escalation	64.0%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	4.6%	Feb-25	6.0%	7.0%	Jan-25	Driver			Not Escalated	5.2%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	6.1%	Jan-25	4.0%	4.3%	Dec-24	Driver			Not Escalated	5.7%		
	Maternity Metric	Stillbirth rate		0.4%	0.0%	Feb-25	0.4%	0.2%	Jan-25	Driver			Not Escalated	0.2%		
	Maternity Metric	PPH >=1500% Rate		3.0%	2.0%	Feb-25	3.0%	3.4%	Jan-25	Driver			Not Escalated	3.2%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	1.4%	Feb-25	2.5%	2.8%	Jan-25	Driver			Not Escalated	2.7%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	77.6%	Feb-25	75.0%	82.6%	Jan-25	Driver			Not Escalated	80.6%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	58.3%	Feb-25	95.0%	80.0%	Jan-25	Driver			Escalation	63.6%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	75.0%	Feb-25	95.0%	67.3%	Jan-25	Driver			Escalation	75.8%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Feb-25	100.0%	100.0%	Jan-25	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Feb-25	100.0%	100.0%	Jan-25	Driver			Not Escalated	100.0%		

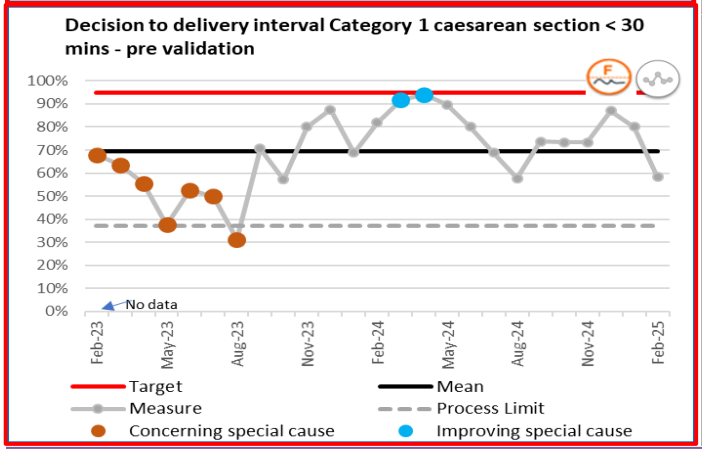
Maternity Metrics



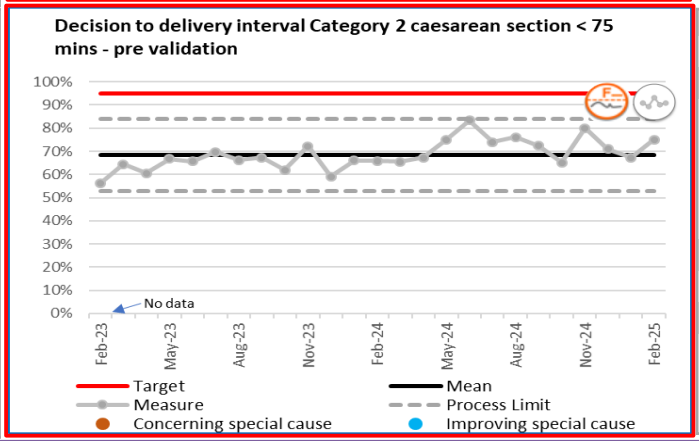
Feb-25
47.8%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as has failed the target for >6 months



Feb-25
59.8%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Feb-25
58.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



Feb-25
75.0%
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 has failed the target for more than six months

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

Decision to delivery interval Category 1 caesarean section: is experiencing common cause variation and has failed the target for more than six months

Decision to delivery interval Category 2 caesarean section :is experiencing common cause variation and has failed the target for more than six months

Actions:

Escalation policy under review.
A3 implemented to address flow throughout the service which impacts transfer for ongoing induction of labour.
Reconfiguration of Level 3 W&C proposed to increase postnatal capacity

MDT staff engagement has seen improved team working to meet target times for Category 2
Plan to work with BI to use validated data for reporting.
Local reporting of both raw and validated data is being shared to prompt improved data recording and recognition of NICE definitions

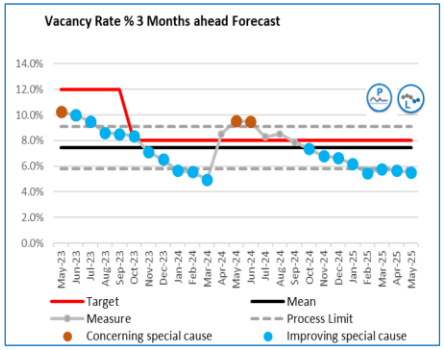
Assurance & Timescales for Improvement:

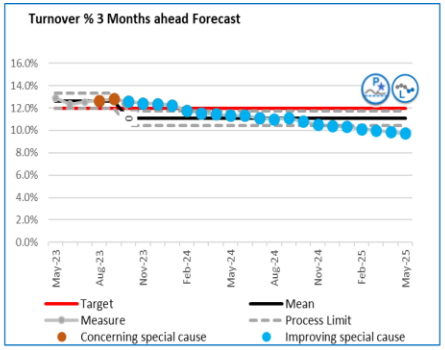
Women waiting for Induction of Labour less than 2 or 4 Hours:
This metric is impacted by periods of high activity which are largely unpredictable, as well as staffing availability.
Ongoing risk assessment and prioritisation is in place to maintain the safety of women whose care is delayed. Timescales for improvement will be dependent on the outcome of the demand and capacity project and any actions required as a result.

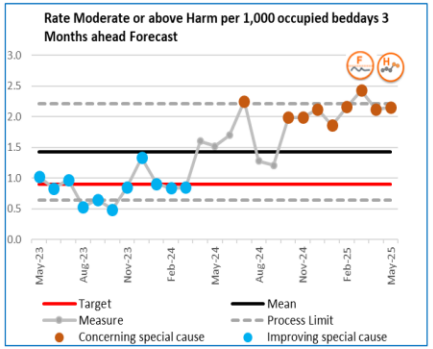
Decision to delivery interval Category 1 and Category 2 caesarean section:
Improvements with compliance with Category 1 and 2 target times has been made. All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified and shared for learning.
Data validation demonstrates frequent mis-classification and a level of delay due to clinically justifiable reasons. The department would like to use validated data for ongoing oversight and will work with staff to improve data entry.
Following validation, 9 cases in 10 (90%) of category 1 target times were met and 38 cases of 39 (97%) of category 2 target times were met.

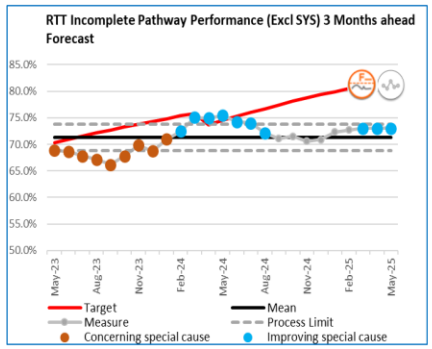
Appendices

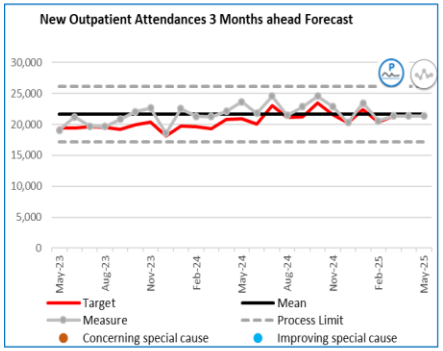
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

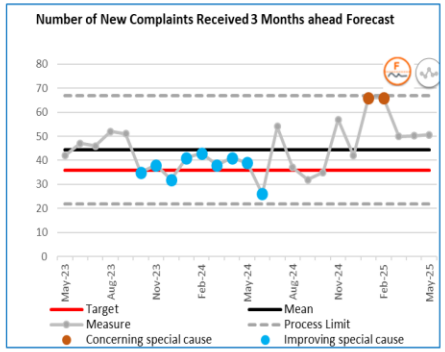


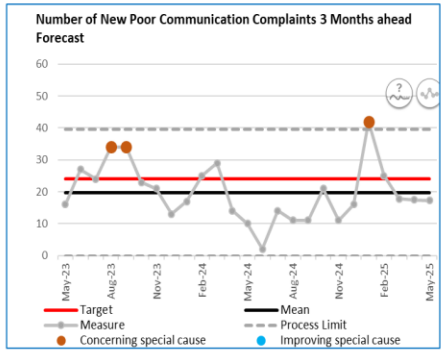


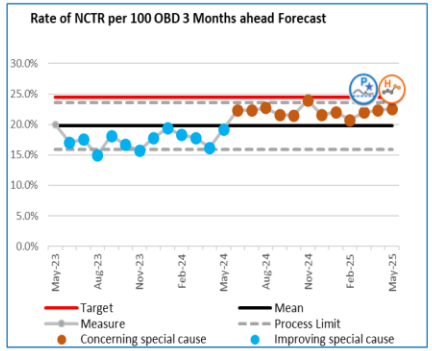


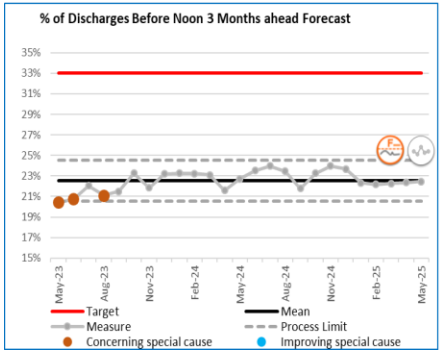


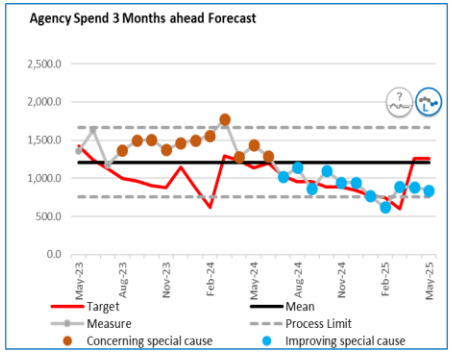


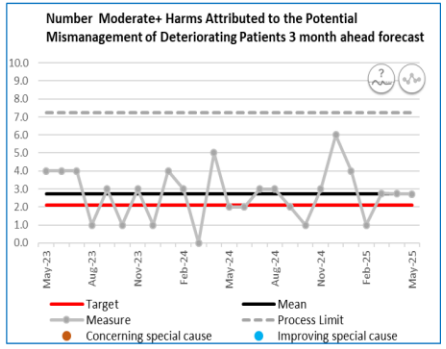




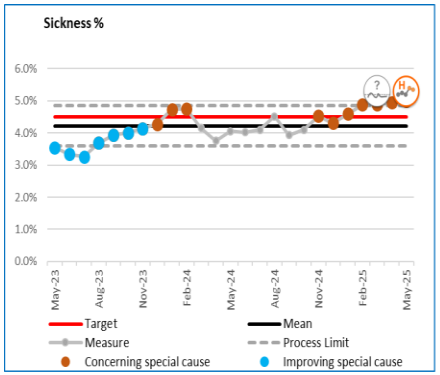


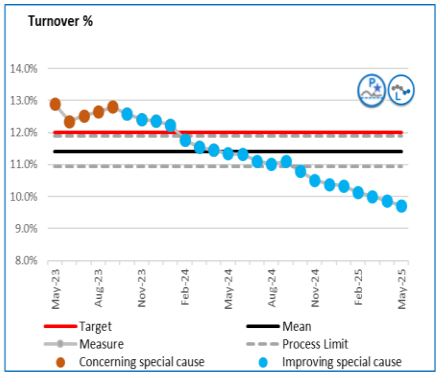


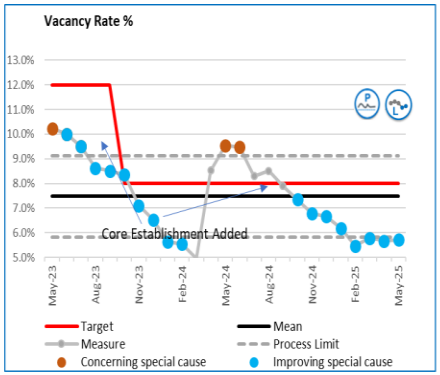


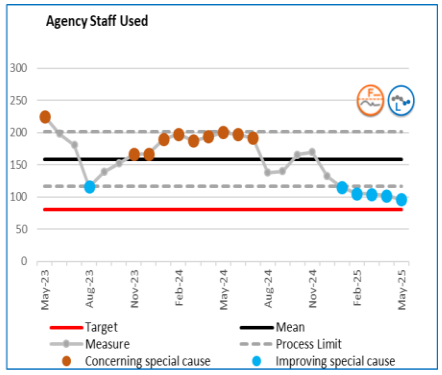


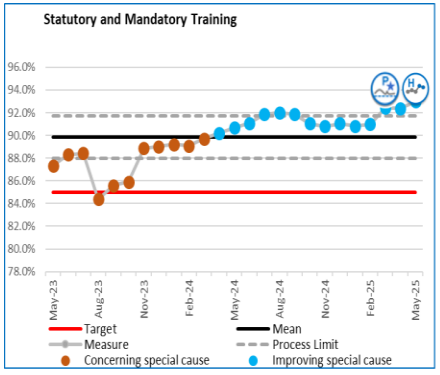
Forecast SPCs (3 month forward view) for People Indicators

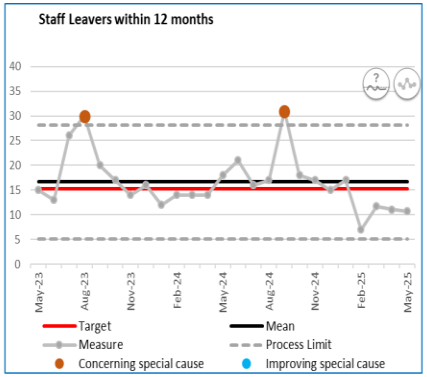


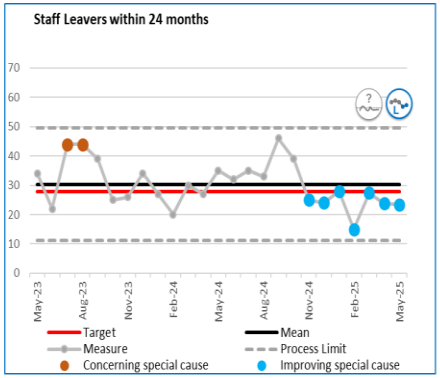


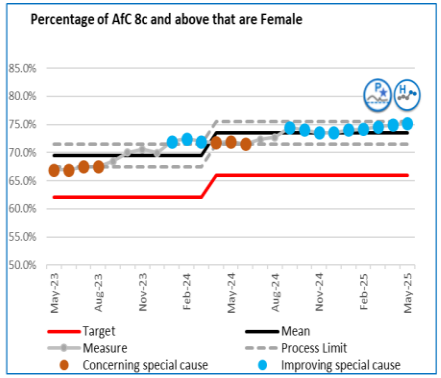


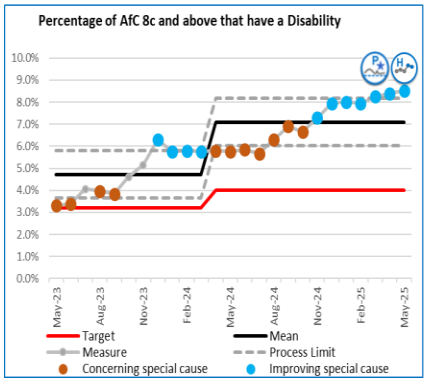


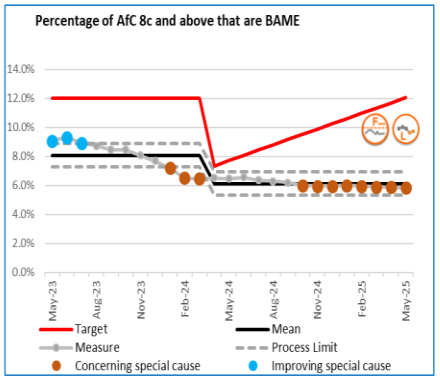


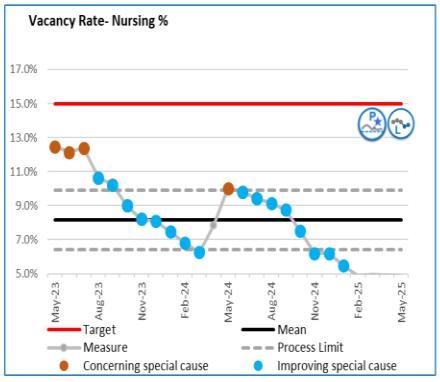




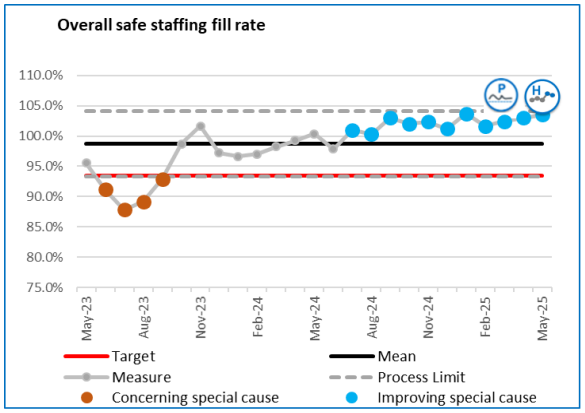


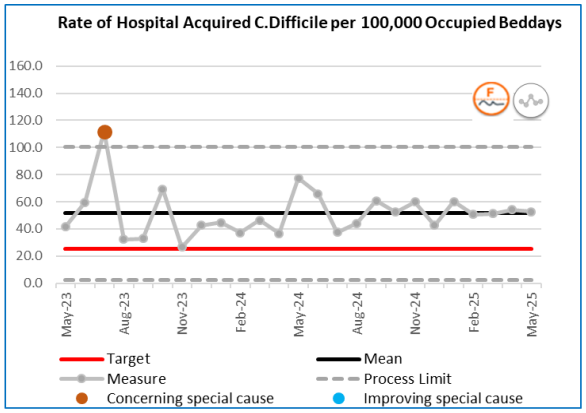


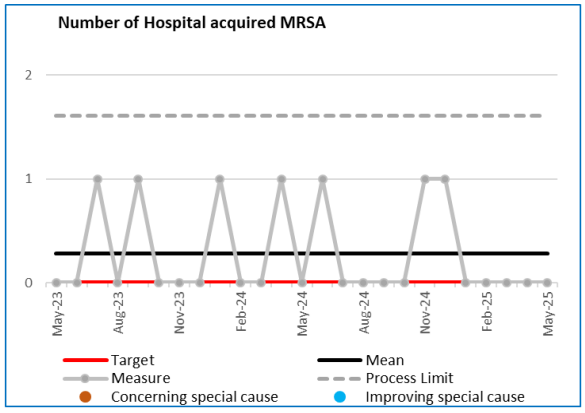


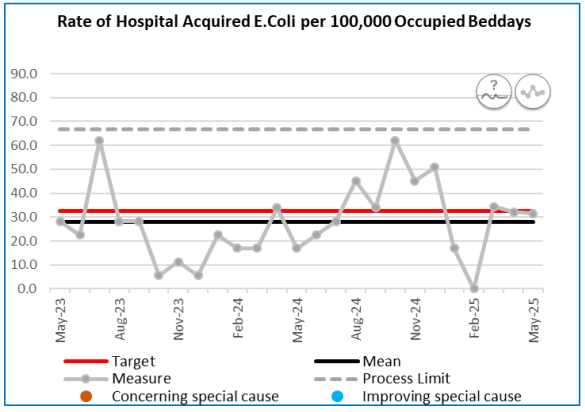


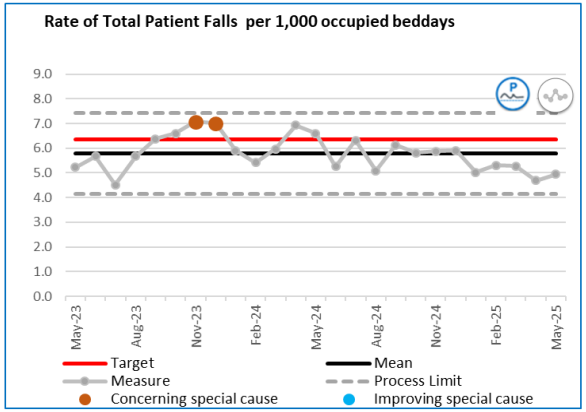
Forecast SPCs (3 month forward view) for Patient Safety Indicators

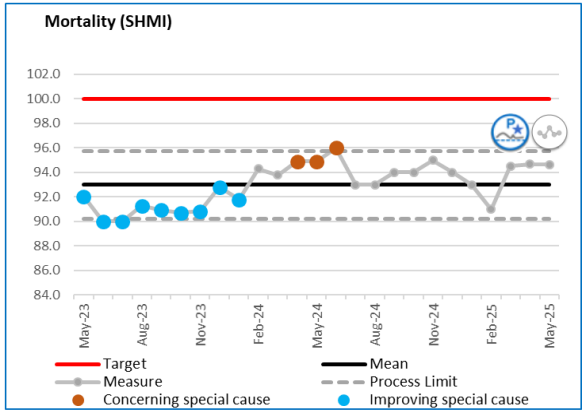


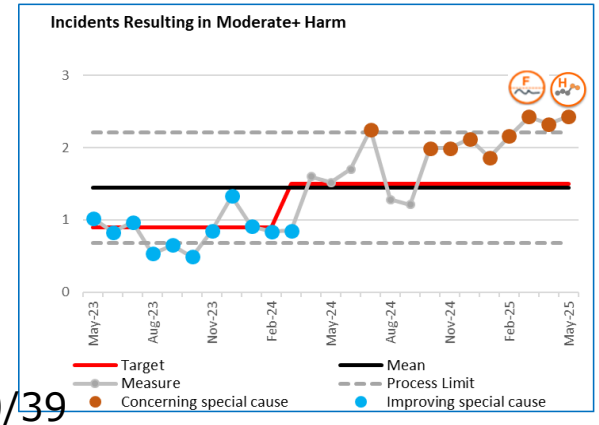


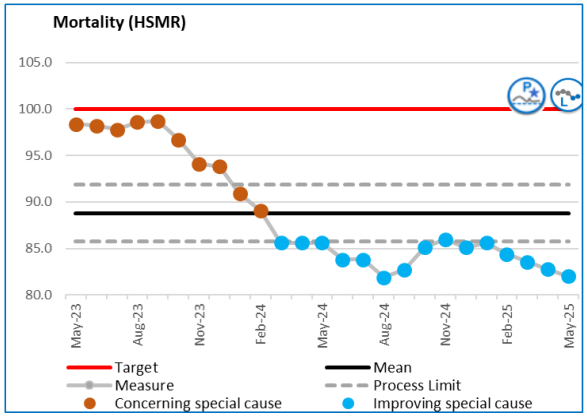




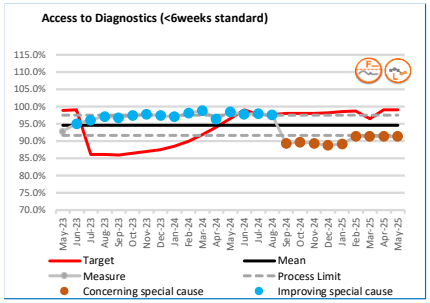


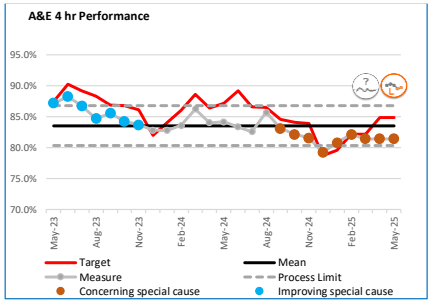


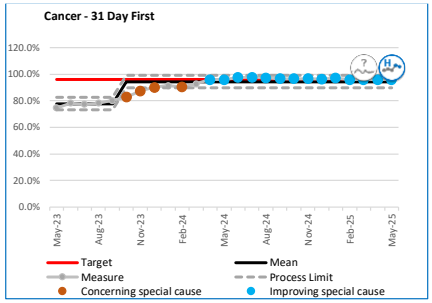


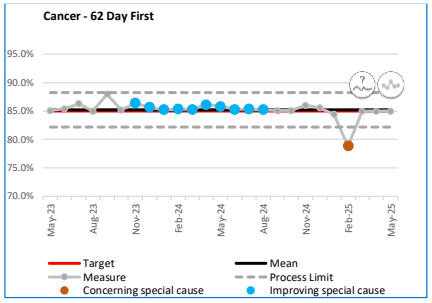


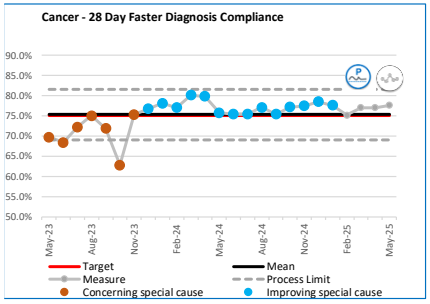
Forecast SPCs (3 month forward view) for Patient Access Indicators

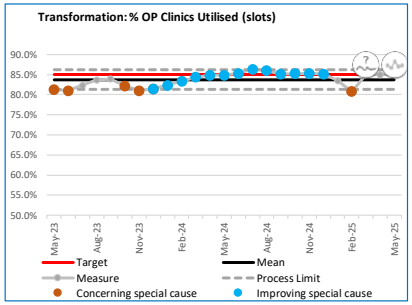


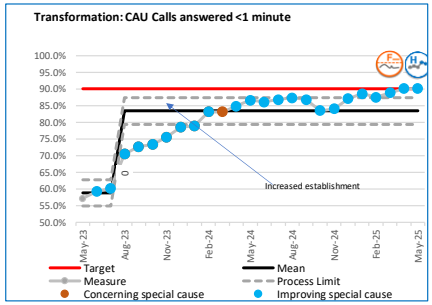


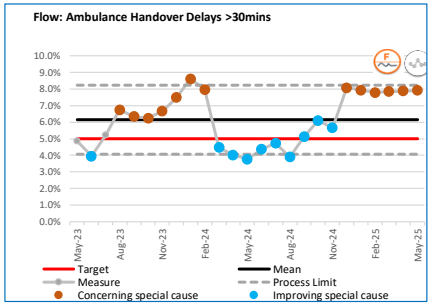


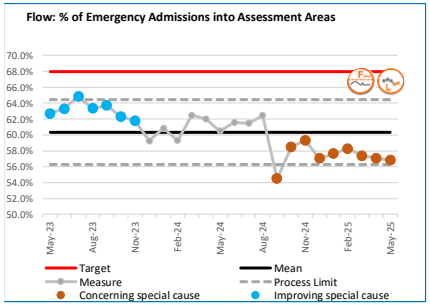


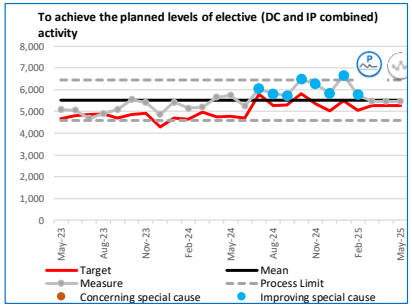


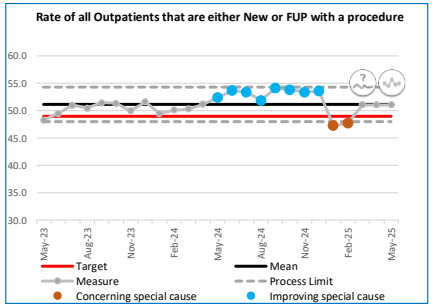


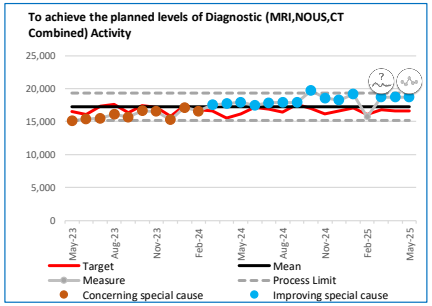




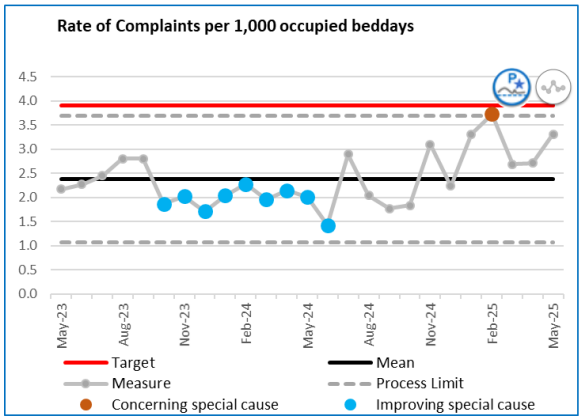


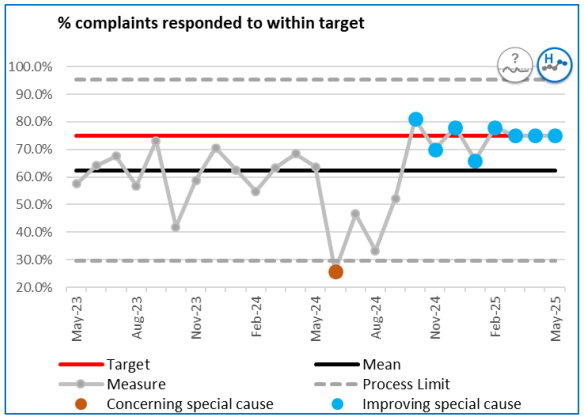


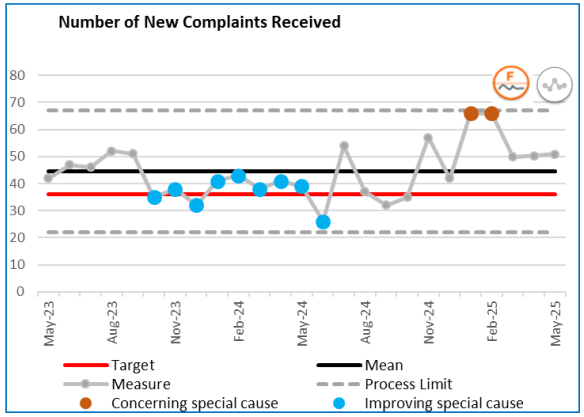


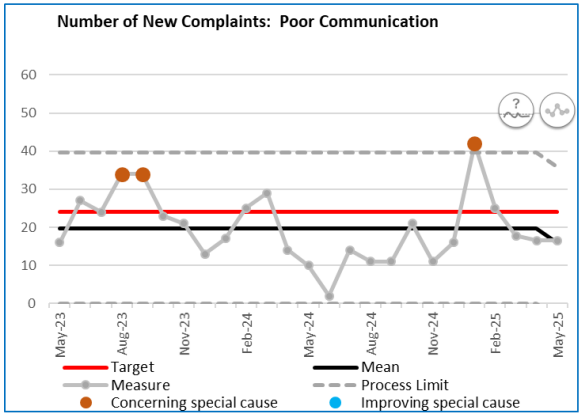


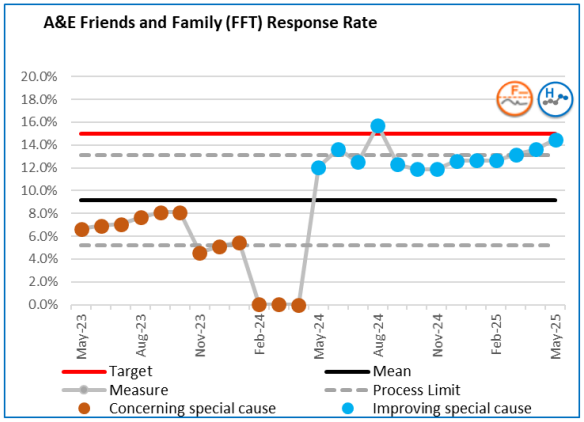
Forecast SPCs (3 month forward view) for Patient Experience Indicators

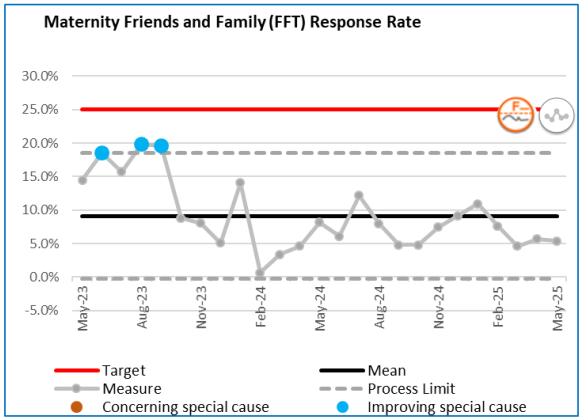


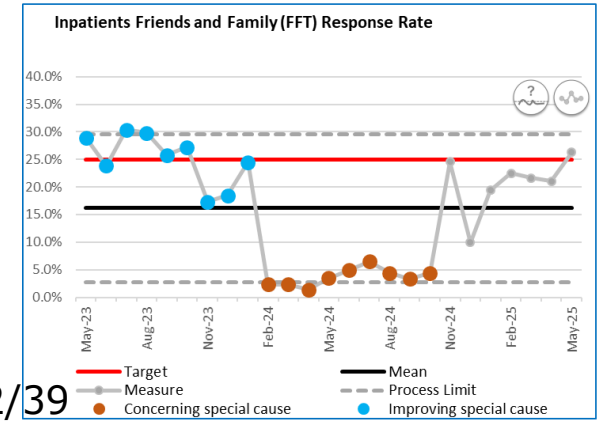


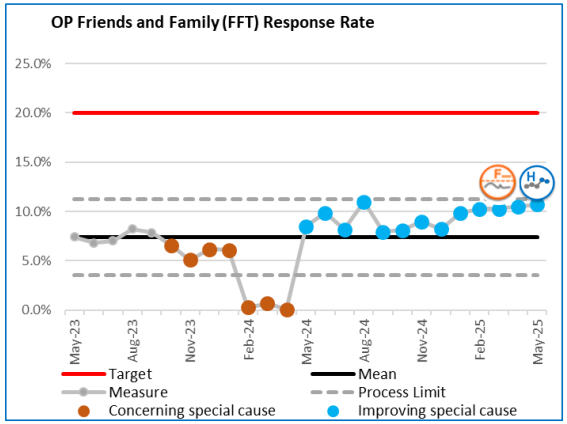


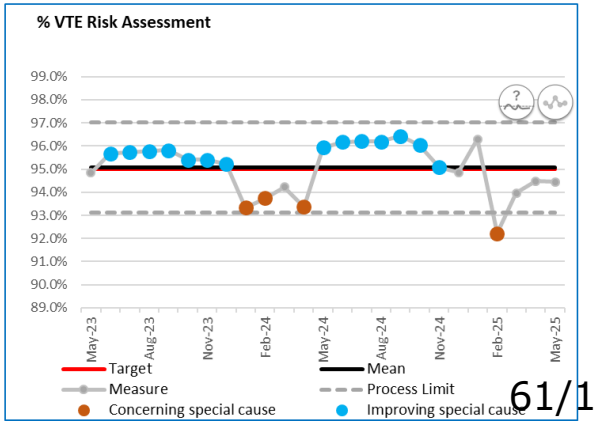




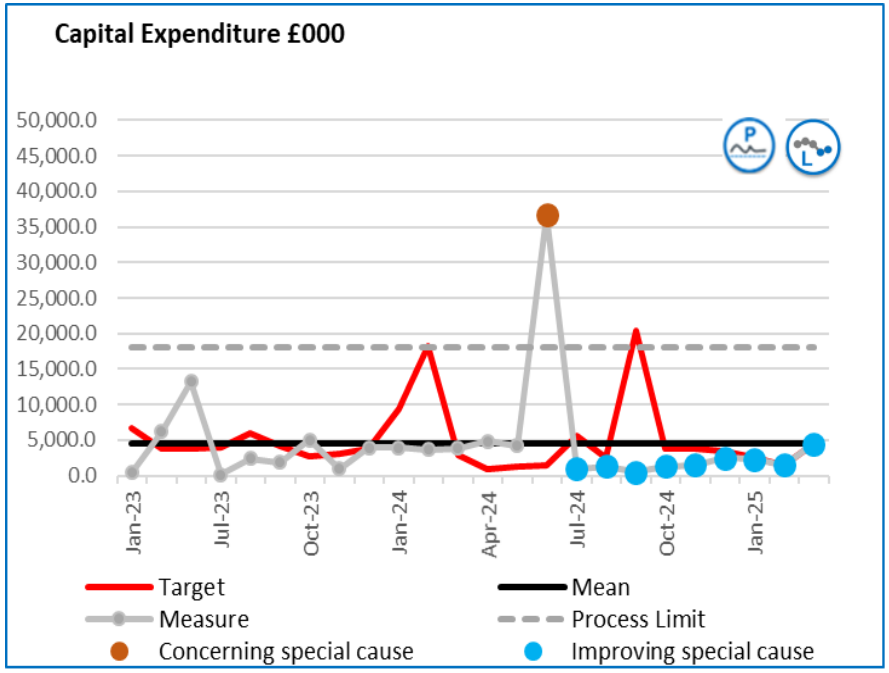


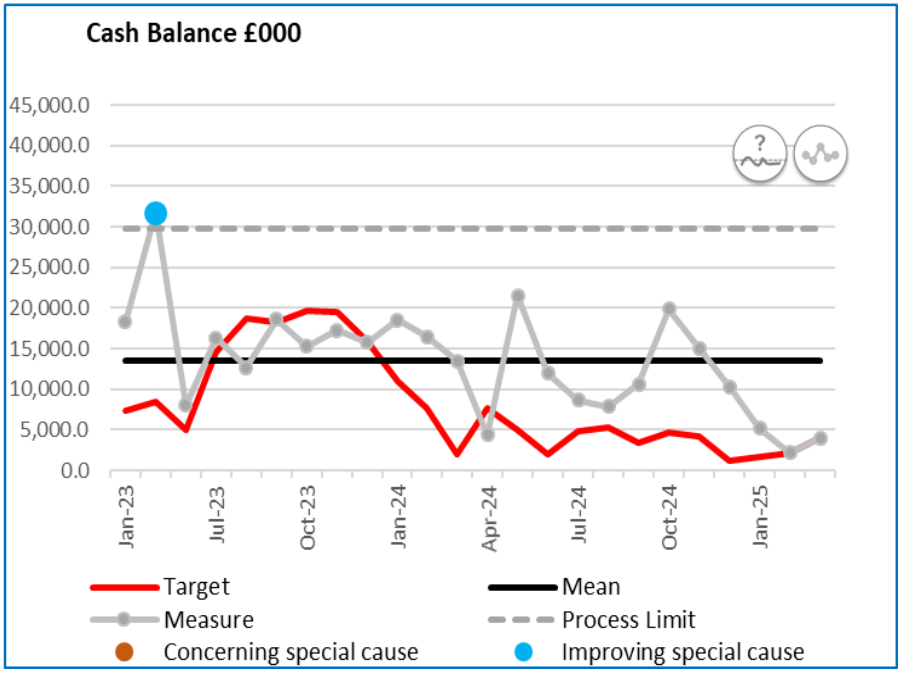




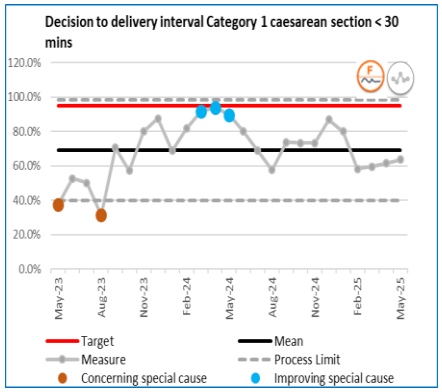


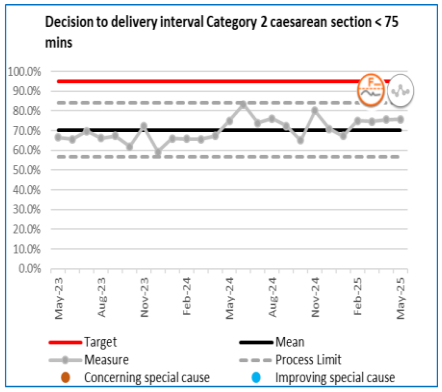
Forecast SPCs (3 month forward view) for Sustainability Indicators

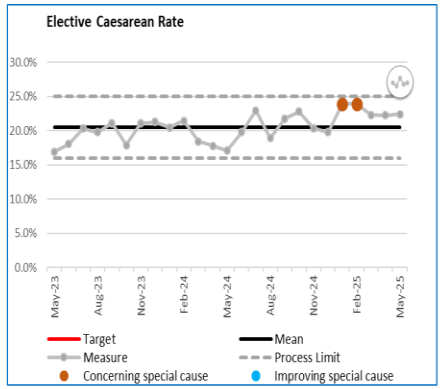


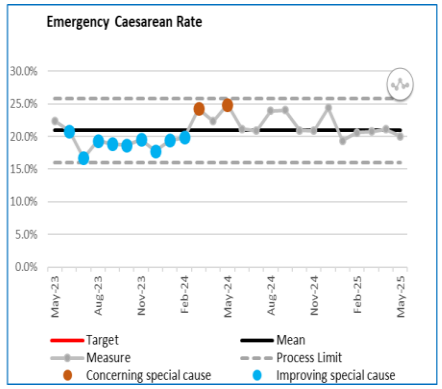


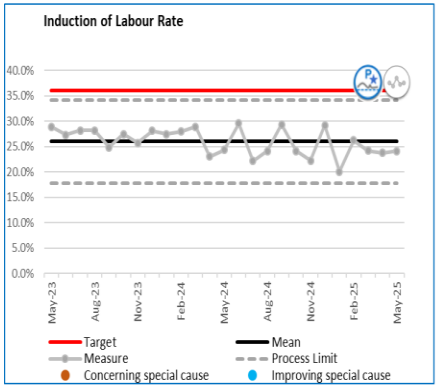
Forecast SPCs (3 month forward view) for Maternity Indicators

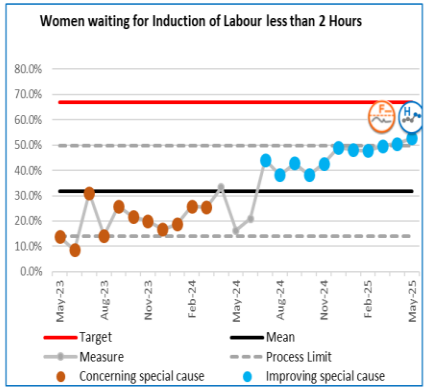


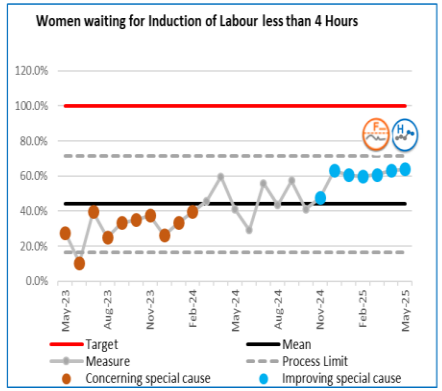


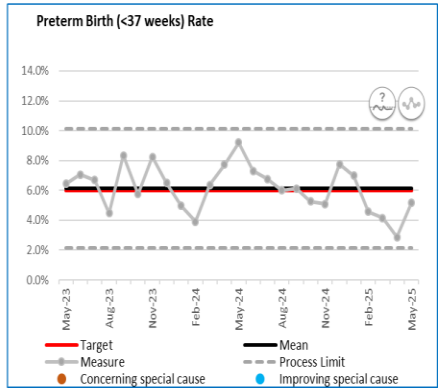


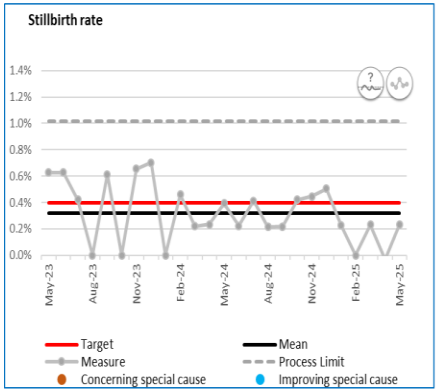


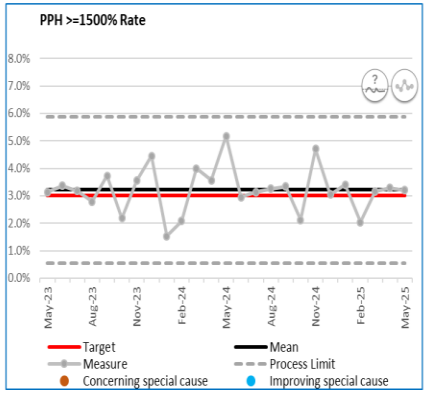


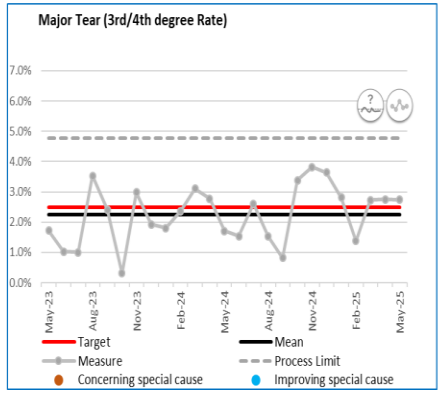


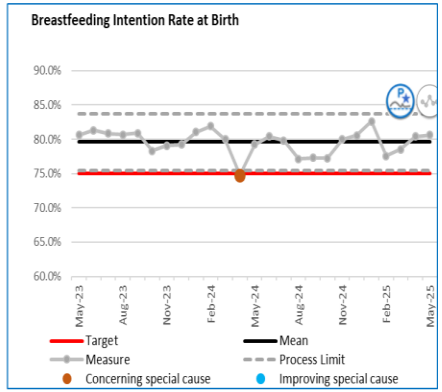






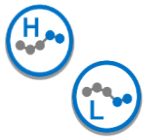






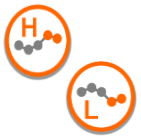
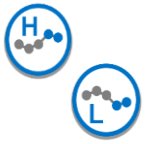
SDR Business Rules Driven by the SPC Icons

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

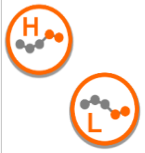
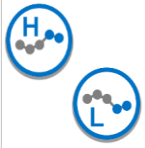
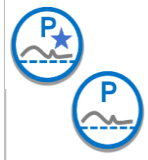
SDR Business Rules Driven by the SPC Icons

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
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target, but is showing a Special Cause for Concern. A verbal CMS is required to support continued delivery of the target	Metric is Passing the Target, but is showing a Special Cause for Concern. Note performance, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is in Common Cause variation. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is in Common Cause variation. Note performance
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance, consider revising the target / downgrading the metric to a 'Watch' metric	Metric is Passing the Target and is showing a Special Cause of Improvement. Note performance

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

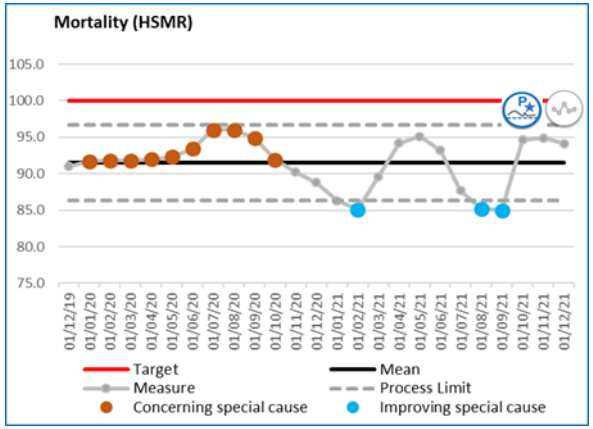
The **target** line **between** the **upper** and **lower** control limit for all metric types

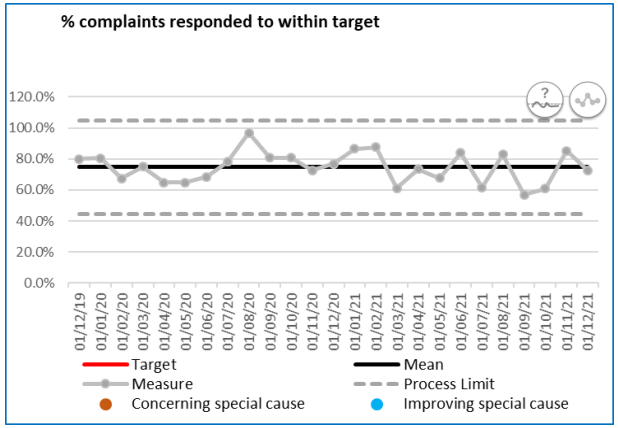
Metrics that consistently **fail** have:

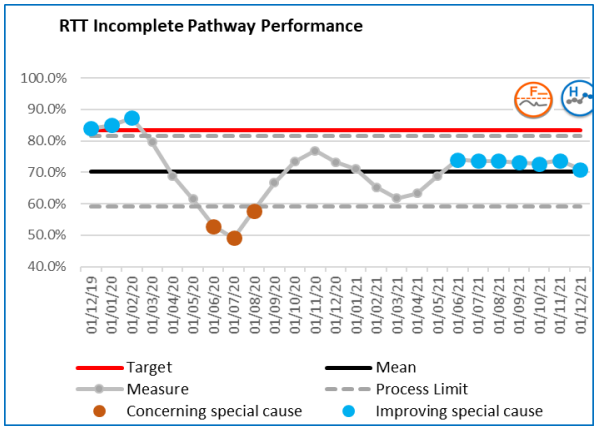
The **lower** control limit **above** the target line for metrics that need to be **below the target**

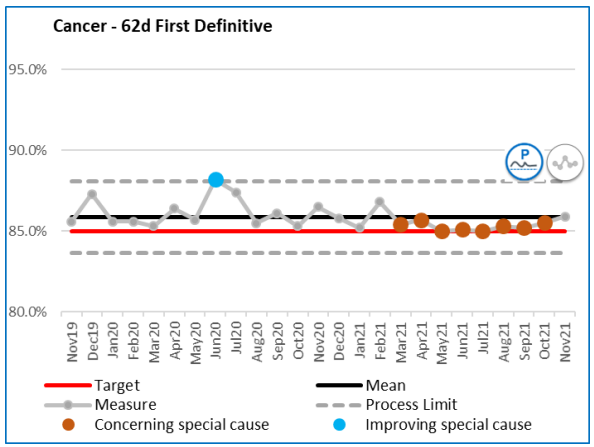
The **upper** control limit **below** the target line for metrics that need to be **above the target**

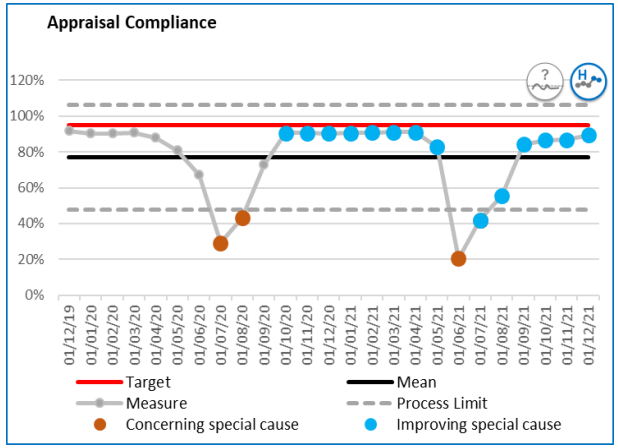
A metric not achieving the target for 6 months or more will be flagged as failing

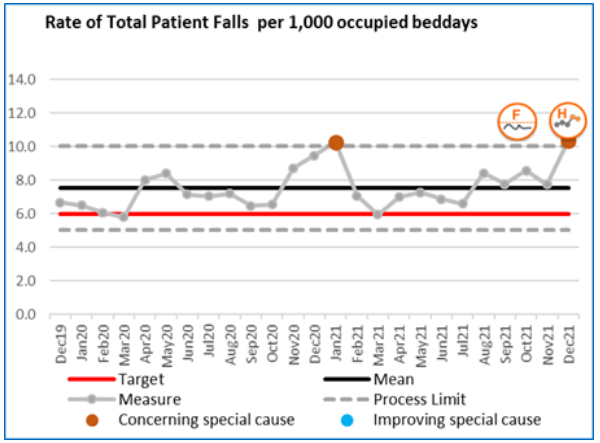












Maternity Metrics Definitions

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

NHS Maidstone and Tunbridge Wells NHS Trust

REVIEW OF LATEST FINANCIAL PERFORMANCE **CHIEF FINANCE OFFICER**

Summary / Key points

Executive Summary

- The Trust was £4.8m in surplus in February which was £5m favourable to plan. Year to date the Trust is £4.3m in deficit which is £1.5m adverse to plan.
- The key year to date pressures are: CIP slippage (£5.1m), Kent and Medway Orthopaedic Centre (KMOC) slippage to plan (estimated £8.5m net adverse impact), contract challenges with Kent and Medway ICB (£1.8m), Fordcombe hospital adverse to plan by £3.7m, overspends within non passthrough related drugs/devices (£1.9m) and Cancer alliance income shortfall (£0.9m). These pressures were partly offset by clinical income overperformance (£9.5m), non-recurrent benefits (£6m) and release of service development and contingency budgets (£5m)
- The Trust is forecasting to deliver the planned breakeven position however this includes £6.3m of recovery actions.

Current Month Financial Position

- The Trust was £4.8m in surplus in the month which was £5m favourable to plan
- **Key Adverse variances in month are:**
  - Kent and Medway Orthopaedic Centre (KMOC) slippage (£1.7m)
  - Fordcombe hospital slippage to plan (£0.6m)
- **Key Favourable variances in month are:**
  - One off non recurrent benefits helped to improve the position by £4.1m. The majority related to income opportunities back dated to April which were part of the financial recovery forecast as well as CoS VAT rebate (£0.5m) relating to a review of April to October invoices.
  - Clinical Income (excluding Fordcombe, KMOC and back dated income opportunities identified within the forecast recovery plan) was £2.3m favourable in the month. The main benefits in the month relate to overperformance within ERF (excluding KMOC (T&O)).
  - The Trust released £0.5m relating to Service development and contingency budgets in February to partly offset income and expenditure pressures incurred.

Year to Date Financial Position

- The Trust is £4.3m in deficit which was £1.5m adverse to plan
- **Key Adverse variances year to date are:**
  - CIP Slippage (£5.31)
  - KMOC delay and slippage (£8.5m - net)
  - Contract challenges with Kent and Medway ICB which includes £1.5m associated with System stretch target

- Fordcombe hospital slippage to plan (£3.7m)
- Non-passthrough related drugs/devices (£1.9m)
- Cancer alliance income shortfall (£0.9m)

- **Key Favourable variances year to date are:**
  - Clinical Income overperformance (£9.5m) which excludes Fordcombe, KMOC and pass through high cost drugs and devices. Within this income overperformance there is a risk of c£1.1m which relates to uncoded activity, there is a risk when this has been coded it might fall outside of the ERF/Variance related income rules.
  - Non recurrent benefits (£6m)
  - The Trust released £5m relating to Service development and contingency budgets offset income and expenditure pressures incurred

Cost Improvement Plan

- The Trust has a savings target for 2024/25 of £37.3m. In February the Trust saved £3.6m which was equal to the plan, year to date the Trust is £5.1m adverse to plan and is forecasted to be £5.9m adverse to plan.

Cashflow position:

- The closing cash balance at the end of February was £13.9m, this is higher than the plan value by £11.9m. The main reason for a higher cash position is that the Trust needs to ensure sufficient funds are held at the end of each month to cover the first two weeks of the following month's commitments. This is due to the Trust receiving its monthly block SLA income on the 15th of each month – these commitments include weekly supplier payment runs and weekly payroll including 247-time agency.
- The cashflow is updated daily and the forecast is regularly updated and reviewed if costs during the year increase eg; salaries are higher than plan and the remaining months are amended to be in line with the current charges
- The Trust is working closely with local NHS organisations and agreeing "like for like" arrangements when possible to reduce the debtor/creditor balances for both organisations. However, as cash positions with the local NHS organisations are all tight, there will be no cash gain from these agreements but it enables a reduction to both debtors/creditors balances.
- The Trust has applied for £10m cash backed PDC for additional capital including UEC and system based funds. NHSE agreed the application and submitted to DHSC in January and we are waiting the outcome in February to allow time to draw this funding down before the end of the financial year. In addition the Trust has agreed to support the ICS group capital slippage by utilising £2m of capital schemes, we are not expecting this to be cash backed.
- The Better Payment Practice Code (BPPC) which is a target that all NHS Organisations are measured to ensure suppliers are paid within 30 day payment terms; the target all NHS organisations are measured against is 95%. For February the Trust's percentages were: Trade value 76.4% (M10 78.4%) and quantity 77.8% (M10 80.7%); NHS value 88.20% (M10 89.7%) quantity 76.0% (M10 76.9%).

Capital Position

Capital Plan

- The Trust's capital plan, excluding IFRS16 leases, for 2024/25, is £26.531m. The Trust's planned 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).

- The Trust's application for System Capital Support of £9.278m of PDC Cash was approved in July and the cash has now been drawn down. This provided cash to support the internally resourced schemes, where the cash had been used at the end of 2023/24 to purchase the Fordcombe Hospital. A further application for PDC cash has been made in November to support the system funded items and UEC allocations, that did not come with cash backing (£10.3m).

External Capital Funding

- In addition to the Plan, National Funding has been agreed to purchase 2 Mammography Systems for £739k as part of the Diagnostic Screening Programme. Also, the Trust was successful in a System bid for part of the remaining System allocation, £183k has been agreed for equipment and security projects. There has also been System slippage approved for MTW to fund AdviseInc (£389k), C-arms and Patient Monitoring (£468k brokerage), E-chemo (£360k) and ICT & Estates staffing costs (£816k). This has increased the Trust's share of the overall control total.

Month 11 Actuals (excluding IFRS16)

- The YTD spend at M11 is £16m against a YTD budget of £25.6m.
- YTD underspend variance relates in part to the CDC, which was completed in Feb 25, waiting for final invoices. Diagnostic enabling works being completed, invoices are pending. Estates backlog works are in process of being completed, there is some delay compared to plan. ICT Clinical applications delayed in YTD due to the necessary focus on Fordcombe arrangements. Projects allocated with capital from the UEC Winter Incentive are underway but agreed later than planned. Frontline Digitisation funding has now been approved by NHSE, but the expenditure will fall into the final quarter of the financial year.

Forecast

- The Trust is forecasting full use of its main capital resource. There remain risks of both over and under spending at this point in the financial year on specific schemes. Risks remain in terms of confirming final spend on the CDC scheme. The risks on underspending relate mainly to confirming the re-allocation of resource where there has been a significant delay or slippage e.g. with the cardiology scheme; and on the nationally funded Frontline Digitisation scheme, where the confirmation of funding has only recently been received. The Trust has a strong track record of utilising its capital, and working in an agile way to ensure that maximum value is obtained, even with the pressures of last quarter allocation and procurement.

Project Updates

- **CDC** – This was completed in Feb 2025. Final invoices are pending.
- **UEC Funding** – All the schemes are well underway and due to be completed by the end of March.
- **Cardiology** – The costs in 24/25 are related to design fees only, so there is planned slippage on the scheme in 2024/25. Funds have been re-allocated towards other priorities and bringing forward 2025/26 key schemes.
- **Estates** – Diagnostic enabling works being finalised, invoices are pending. Estates Backlog works are in process of being completed, there is some delay compared to plan.
- **ICT** – Work is ongoing to install IT infrastructure and network systems and work is progressing to upgrade Compucare for the private patient system. The main focus is now on Frontline Digitisation and DMZ, for delivery by the end of March.
- **Equipment** – All schemes are planned to be delivered by end of March.
- **Security** – All schemes are planned to be delivered by end of March.
- **Donated** – The majority spend relates to £170k for helipad resurfacing at MGH. Some schemes have been deferred to 25/26

Leased/IFRS16 capital

- The Trust included £25.46m of in-year IFRS 16 lease capital resource in its planning submission to cover planned additions (£22.08m) and remeasurements arising from rent reviews or the application of contractual rent uplifts (£3.38m).
- The most significant element of the additions is the Kent and Medway Medical School Accommodation (£17.4m) on the TWH site that the Trust will recognise under IFRS 16 when it becomes available for use, which has now slipped to the end of March.
- The £4.2m underspend on FOT relates to schemes planned but not committed before the point at which NHSE reduced/confirmed ICS allocations.

Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position however recovery actions of c£6.3m are required to be delivered.

Reason for circulation to Trust Board
To discuss the February financial position and note the risks to delivery of the financial plan.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 11
2024/25

Maidstone and Tunbridge Wells NHS

Summary

February 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	69.4	67.2	2.2	0.2	2.0	728.3	729.4	(1.1)	2.9	(4.0)
Expenditure	(59.9)	(62.5)	2.6	(0.2)	2.8	(683.3)	(681.1)	(2.2)	(2.9)	0.7
EBITDA (Income less Expenditure)	9.5	4.7	4.8	(0.0)	4.8	45.0	48.3	(3.3)	0.0	(3.3)
Financing Costs	(3.9)	(4.3)	0.4	0.0	0.4	(56.0)	(57.7)	1.7	0.0	1.7
Technical Adjustments	(0.7)	(0.5)	(0.2)	0.0	(0.2)	6.6	6.5	0.1	0.0	0.1
Net Surplus / Deficit	**4.8**	**(0.1)**	**5.0**	**(0.0)**	**5.0**	**(4.3)**	**(2.8)**	**(1.5)**	**0.0**	**(1.5)**
Cash Balance	14.0	2.1	11.8		11.8	14.0	2.1	11.8		11.8
Capital Expenditure (Incl Donated Assets and IFRS16)	4.2	1.5	(2.7)		(2.7)	18.3	47.5	(29.2)		(29.2)
Cost Improvement Plan	3.6	3.6	(0.0)		(0.0)	27.3	32.4	(5.1)		(5.1)

Summary Current Month:
- The Trust was £4.8m in surplus in the month which was £5m favourable to plan.

Key adverse variances in month are:
- Kent and Medway Orthopaedic Centre (KMOC) slippage (£1.7m)
- Fordcombe hospital slippage to plan (£0.6m)

Key favourable variances in month are:
- One off non recurrent benefits helped to improve the position by £4.1m. The majority related to income opportunities back dated to April which were part of the financial recovery forecast as well as CoS VAT rebate (£0.5m) relating to a review of April to October invoices.
- Clinical Income (excluding Fordcombe, KMOC and back dated income opportunities identified within the forecast recovery plan) was £2.3m favourable in the month. The main benefits in the month relate to overperformance within ERF (excluding KMOC (T&O)).
- Non-passthrough related drugs/devices (£0.5m)
- The Trust released £0.5m relating to Service development and contingency budgets in February to partly offset income and expenditure pressures incurred.

Year to date overview:
- The Trust is £4.3m in deficit which is £1.5 adverse to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£5.1m)
- KMOC delay and slippage (£8.5m - net)
- Fordcombe hospital slippage to plan (£3.7m)
- Contract challenges with Kent and Medway ICB which includes £1.8m associated with System stretch target
- Non-passthrough related drugs/devices (£1.9m)
- Cancer alliance income shortfall (£0.9m)

Favourable Variances
- Clinical Income overperformance (£9.5m) which excludes Fordcombe, KMOC and pass through high cost drugs and devices. Within this income overperformance there is a risk of c£1.1m which relates to uncoded activity, there is a risk when this has been coded it might fall outside of the ERF/Variance related income rules.
- Non recurrent benefits (£6m)
- The Trust released £5m relating to Service development and contingency budgets offset income and expenditure pressures incurred

CIP (Savings)
- The Trust has a savings target for 2024/25 of £37.3m, year to date the Trust has saved £27.3m which is £5.1m below plan

Forecast
- The Trust is forecasting to deliver the planned breakeven position which requires £6.3m of financial accounting opportunities to be delivered.

Title of report	**Learning from Deaths Report**					
Board / Committee	**Trust Board 'Part 1' Meeting**					
Date of meeting	27th March 2025					
Agenda item no.	03-13					
Executive lead	Sara Mumford, Chief Medical Officer					
Presenter	Sara Mumford, Chief Medical Officer					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***		***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	☐	☐	☐	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This paper focuses on national benchmarking mortality data at the Trust, statutory scrutiny by Medical Examiner service and the work of the Learning from Deaths Group.
Any items for formal escalation / decision	No new concerns identified from National benchmarking data
Appendices attached	Appendix 1: SHMR data Appendix 2: ME SJR referral categories

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	1304: VTE risk assessment and anticoagulation prescribing 1150: Impact of increase in needs of inpatients with mental health needs 2981: Unsuitable environment for mental health patients in ED
Compliance / Regulatory Implications	Nil

Quarterly Learning from Deaths Report March 2025

1 Learning from Deaths Group (LfDG)

The Learning from Deaths Group meets monthly to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary referred to Patient Safety team for further investigation. A further responsibility of the group is to ensure learning from Mortality reviews are disseminated appropriately.

1.1 Structured Judgement Reviews (SJR)

When a concern is raised by the ME service regarding a death (according to one of nine categories, see Appendix 2), a trained clinician will undertake an SJR. The SJR reviewer makes explicit comments about phases of care with scores (excellent, good, adequate, poor, very poor) attributed to each phase and the overall care received. The overall score is agreed by the LfDG. SJRs are not shared with families.

There were twelve and thirteen cases referred for an SJR in January and February, respectively. SJRs can now be raised for community deaths within 30 days of hospital discharge; there were no community deaths referred for an SJR in January and February.

1.2 SJR Outcomes and Discussion

The outcome of the SJRs discussed since October 2024 is shown in Figure 1. Eleven cases were reviewed in January and twelve in February at the monthly LfDG meeting.

Figure 1: SJR outcomes (October 2024 - February 2025)

Month	Very Poor care	Poor care	Adequate care	Good care	Excellent care	Total
Oct-24	0	3	2	5	2	12
Nov-24	0	3	3	2	2	10
Dec-24	0	1	1	7	3	12
Jan-25	1	0	3	4	3	11
Feb- 25	0	1	3	7	1	12
Total	**1**	**8**	**12**	**25**	**11**	**57**

1.3 Good Practice Identified

- Senior clinician involvement throughout care with good MDT specialist involvement throughout admission.
- A DNACPR order was determined to be pre-existing from the community early in the admission. The discussion with the family regarding end-of-life care decisions was appropriate, palliative care was notified, and the patient was transferred to a hospice according to the wishes of the patient and their family

- Good documentation of the diagnosis, investigation results, and management plan with evidence of good communication with family throughout. Appropriate anticipation of the patient's decline and family updated throughout the admission.
- Good early involvement from the specialist teams, with prompt transfer to TWH and appropriate escalation to ITU.

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

- There were no cases referred to the Patient Safety team in January and February for further investigation.
    - The action from the January LfDG meeting regarding the Very Poor Care case was for the Medicine and Radiology departments to carry out a joint audit specifically focused on out-of-hours CT requests.
    - An After-Action Review was conducted before the Poor Case was discussed at the February LfGD meeting. As part of that process, the case was upgraded to a PSII as per the PSIRF plan, the concluding investigation is due to go to the Board in April 2025. There was no further action from LfDG as the case had already been referred to the Patient Safety team.
    - The case referred from the December LfDG has been reviewed and met the PSIRF criteria

1.5 How are we currently sharing the Learning and measuring improvement?

- Learning from poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates via discussion from Mortality leads
- 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.
- Feedback to directorates to aid learning from all SJRs occurs via mortality leads to teams, letters to clinical directors, and senior clinicians involved in the case. Cases are also discussed at Clinical Governance meetings.
- Excellent care is recognised with communication to individual and/or team involved

1.6 Areas of concern

There was one SJR rated ‘Very Poor Care’ discussed at the January meeting, and one SJR rated ‘Poor Care’ discussed at the February meeting.

Themes Highlighted by SJRs

- Sepsis is a recurring theme
    - Including failure to recognise sepsis by residents together with low levels of senior input over the weekend
- Senior input on ward rounds
- Early planning of care post discharge
- Communication with patient and families
- Delayed reporting of outpatient scans caused delayed management decisions
- Prompt assessment of our patients’ pressure areas on admission and the delivery of timely treatment if indicated.
- The need for prompt venous thromboembolism (VTE) assessment and timely preventative measures if these are indicated.
- Need for thorough assessment of patients prior to discharge from the Emergency Department.
- Delay in recognition and communication of End of Life
    - Inappropriate investigations
    - Lack of clear communication with patients and their families.
- Moving of patients between sites and lack of speciality review on alternate site

1.7 Planned Actions

1. Project work is ongoing to build and tailor the mortality module on InPhase to the current SJR process. The form has been developed by the LfDG to support the thematic learning from the SJR process, including comorbidity data and tracking improvements.
2. Two more SJR reviewers have been scheduled for training; an additional clinician is being sought to meet the initial objective to train 3 additional reviewers.
3. Data analysis of sepsis cases from November 2023 to November 24 is ongoing to support the Deteriorating Patient programme of work. The analysis and outcome of the review to be presented to Deteriorating patient working group, Sepsis Committee and Patient Safety Oversight Group
4. Focus efforts to share learning and make meaningful change when care has not been optimal within Medicine and Emergency Care as the division with most deaths.

5. A significant piece of work has begun to establish a 'toolkit' by which to share Safety messages including mortality, incidents and also learning from excellent care across all staff recognising that there are different styles of learning.

   The first step is to survey our resident doctors to assess the current situation and their preferred options. This is due for discussion at the next LAB meeting on 19th March 2025.

2 Medical Examiner Service (Hosted by MTW)

In January, MTW recorded the highest number of deaths in the last 12 months, 174. However, there was a significant reduction in February deaths to 139. Historically, the highest numbers of deaths are reported in December or January, with a decline expected from February. Comparing winter deaths over the last five years indicates a similar trend, but overall, as highlighted by the mortality indicators, there is a downward trend in the number of patient deaths at the Trust.

Figure 2: ME Scrutiny Vs Deaths and SJRs Raised

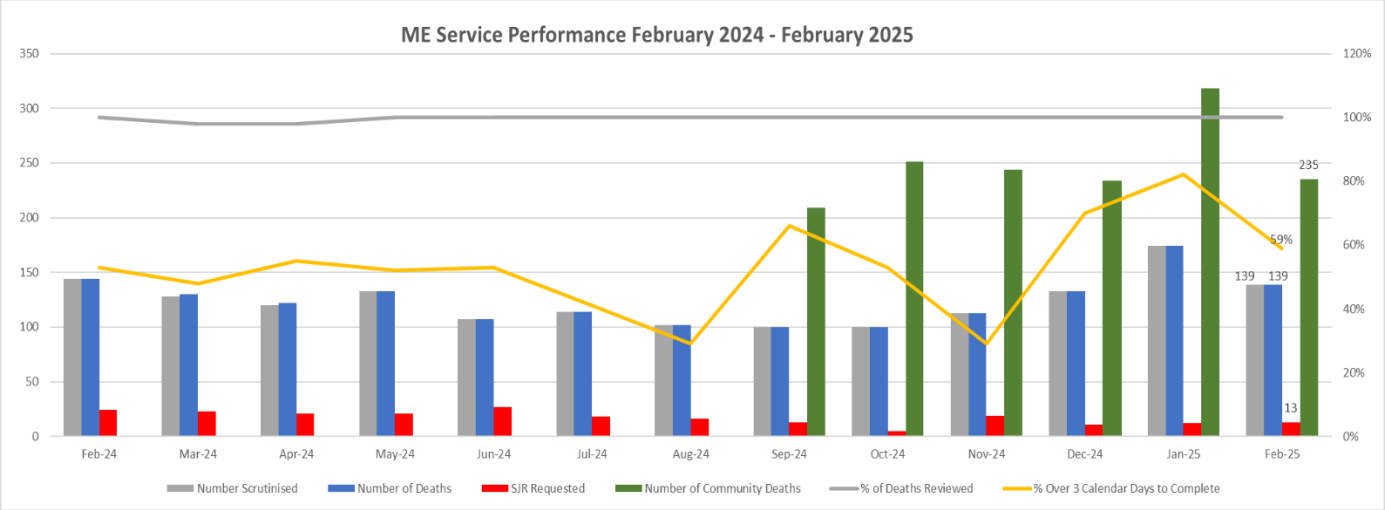


Figure 3: Deaths and ME data at MTW November 2024 - February 2025

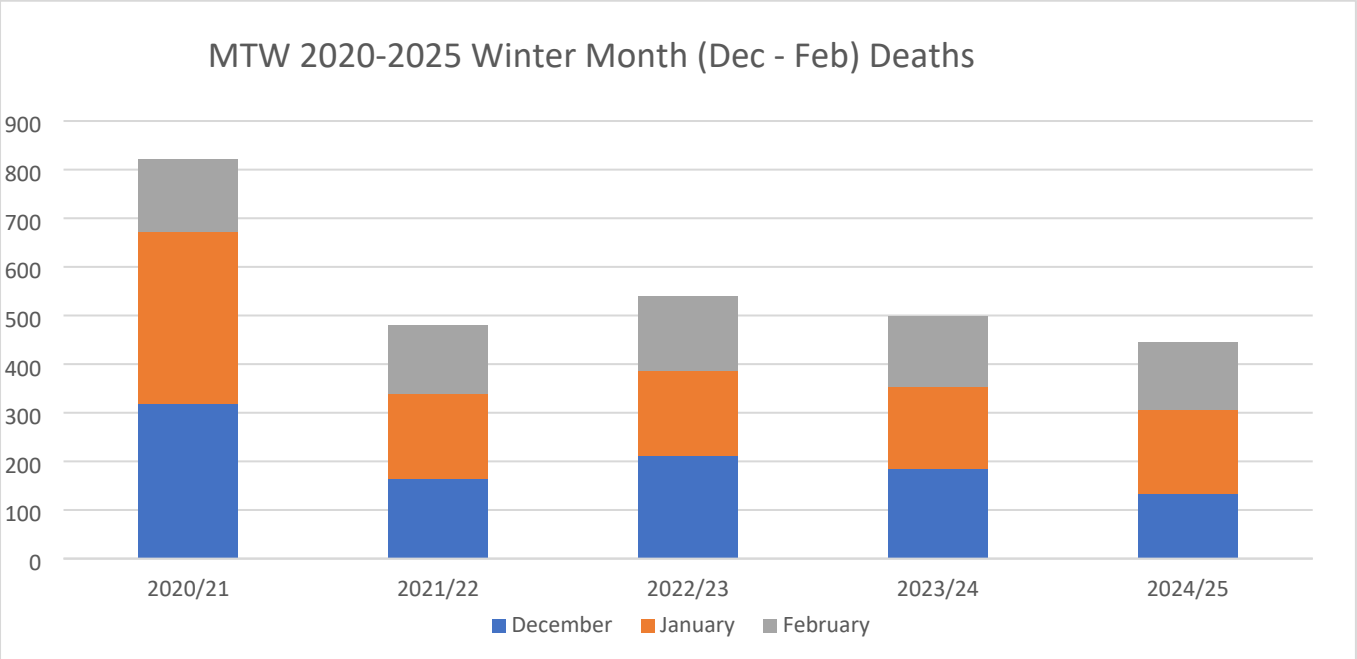
Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Nov-24	113	113	100%	33	34%
Dec-24	133	133	100%	93	70%
Jan-25	174	174	100%	143	82%
Feb-25	139	139	100%	82	59%

2.1 Excess Winter Deaths

A winter mortality measure is used to compare the number of deaths that occurred in the winter period (December to March) with the average of the non-winter periods (August to November and

April to July). This was previously reported by the Office of National Statistics but is no longer being reported centrally. Business Intelligence will be producing this data for MTW for our April Learning from Deaths Group.

Figure 4: MTW Winter Months (December-February) Deaths by Year



2.2 Medical Examiner (ME) Service Update

In January, 82% of cases reviewed and 59% of cases in February exceeded the three-workday performance target. The increased workload from community deaths under review and staffing challenges contributed to this decline in performance. However, the ME Service has implemented several initiatives aimed at improving performance:

- The ME Service adjusted Friday working hours to 10 a.m. to 6 p.m. to improve turnaround times.
- In-Phase incidents were raised when death summaries took longer than 24 hours, contributing to performance improvement.
- A communication email outlining expectations and time limits was sent to doctors, facilitating open discussions on making improvements.
- ME Service processes were streamlined and standardised to minimise time delays in line with GIRFT.

Figure 5: SJR Snapshot Position

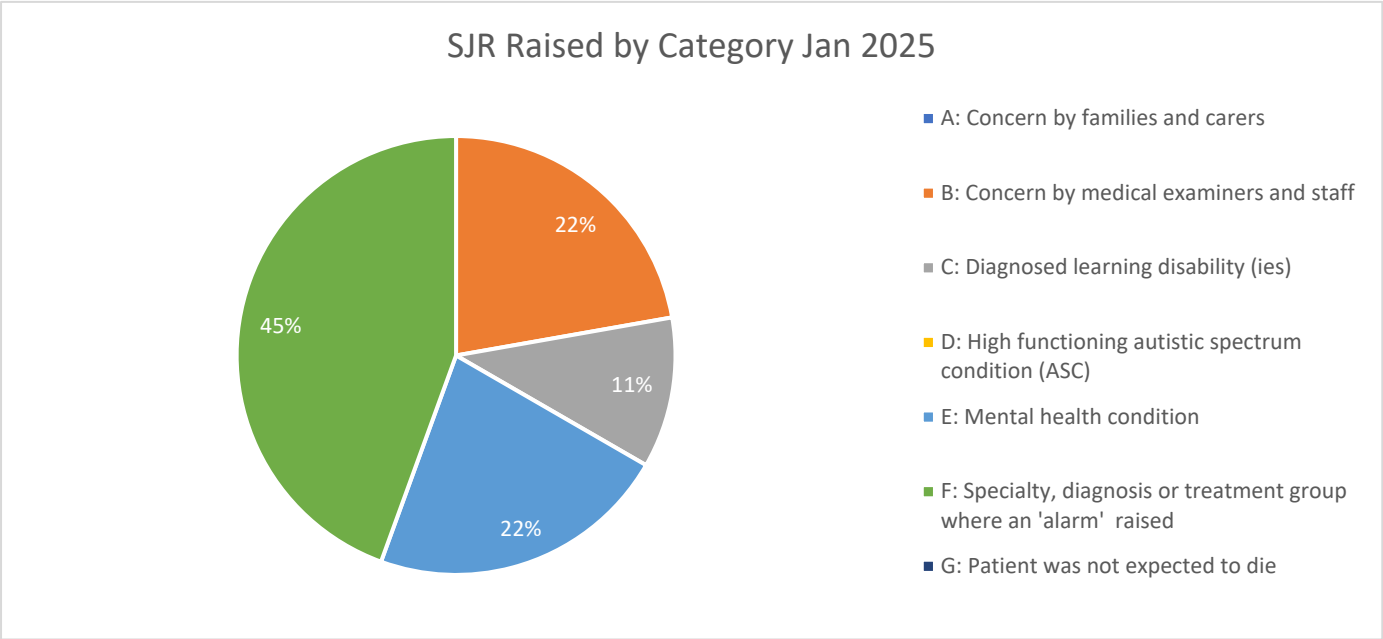
LfDG SJR 24/25 Snapshot Position	Snapshot SJR Backlog Position	Cases <4 Weeks under Review	Unallocated Cases	Total Caseload within SJR Process	Number of Completed Cases in Year

Mar-25	16	10	0	26	96
Jan-25	8	12	6	26	87
Sep-24	13	12	18	43	43
Jun-24	12	7	12	31	19

The current situation of completed and outstanding SJRs is shown in Figure 5. The table highlights all SJRs allocated and completed within the financial year 1 April 2024 – 17 March 2025 when the report was produced. Figure 5 tracks the number of SJRs within the SJR backlog (cases that have exceeded the 4-week target period for review), cases under review not within the backlog, and cases yet to be allocated to a reviewer. These three columns make up the total caseload within the SJR process. The number of completed cases is a snapshot of cases completed within the financial year at each given point in time.

The categories of SJR, as allocated by the ME Service in January 2025, are shown in Figure 6.

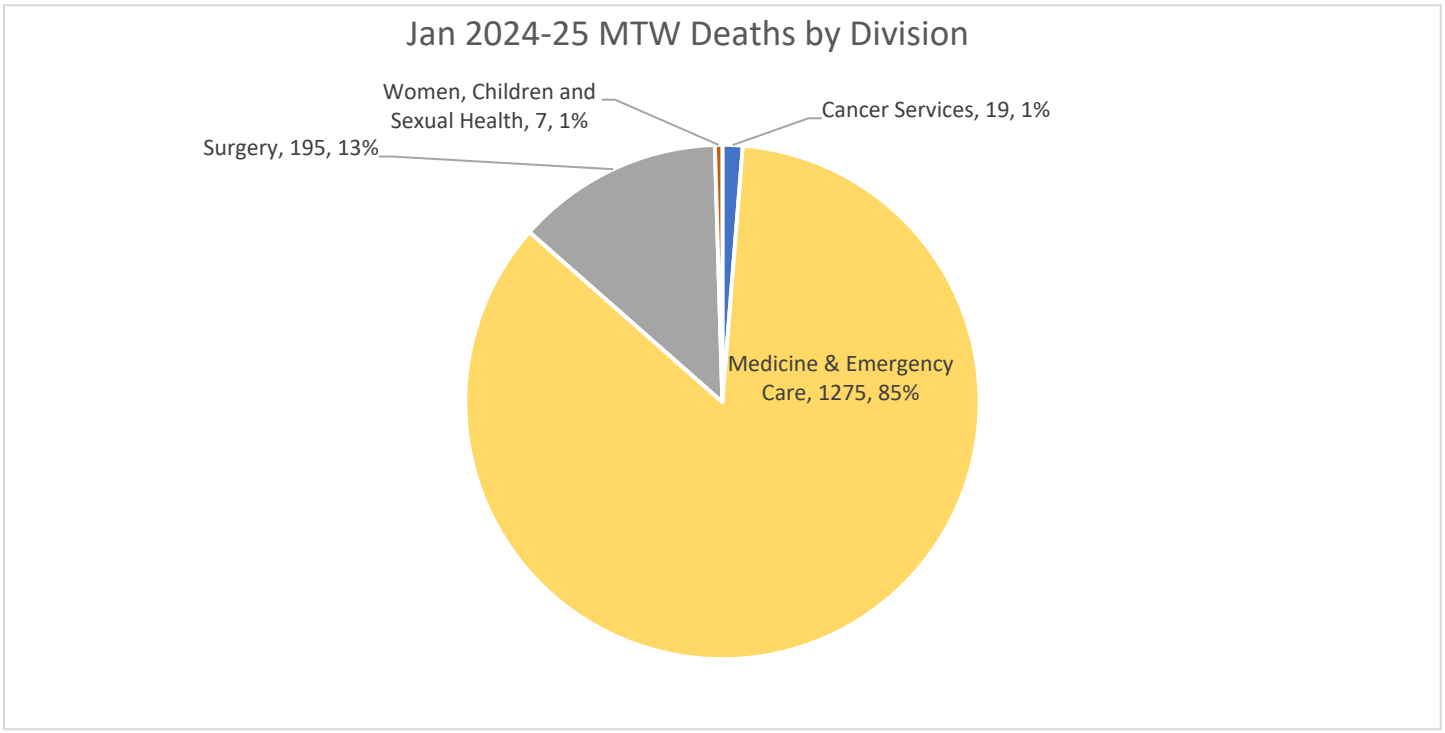
Figure 6: SJR Raised by Category



2.3 Summary of Deaths at MTW by Division

Between January 2024 and January 2025 1640 patients sadly died whilst in our care. The majority of deaths were in patients cared for in Medicine and Emergency Care Division which would be expected due to the admission profile.

Figure 7: MTW Deaths by Division



3 Mortality Data

The reporting period for this report covers hospital in-patient admissions from November 2023 to October 2024. It provides an overview and benchmarking of mortality using the

Hospital Standardised Mortality Ratio plus (HSMR+) and the Standardised Mortality Ratio (SMR) provided in February 2025 by Telstra Health.

The Monthly Standardised Hospital Mortality Index (SHMI) data is updated monthly from NHS Digital's Indicator Portal. SHMI for the period Oct-23 to Sep-24 is 91.31 and "as expected". (see Appendix 1)

Figure 8: Summary of Data for November 2023 – October 2024

Metric	Result
HSMR	82.15 (lower-than-expected) (77.52 – 86.99)
HSMR position vs. peers	Regional (acute, non-specialist) peer group = 17 trusts: • 5 lower-than-expected • 10 within expected • 2 higher-than-expected Peer group = 95.8 (lower-than-expected) (94.6 – 97.0)
All Diagnosis SMR	79.5 (lower-than-expected)
Significant Diagnosis Groups	• Acquired foot deformities (201 superspells; 1 death)
CUSUM breaches	• Cancer of bone and connective tissue (Jul-24)
Emergency Weekend HSMR	96.7 (within expected)
Emergency Weekday HSMR	77.7 (lower-than-expected)
SHMI position	(Oct-23 to Sep-24) 91.31 (as expected)

There is one new CUSUM alert this month for the diagnosis group 'cancer of bone and connective tissue'. The diagnosis group flagged as an outlier recently, and a review of the 2 deaths reported was presented. This CUSUM alert is also based on the same 2 deaths, and is likely only flagging now due to very minor changes in activity over the last 12 months of data. As the group is low volume, it is going to be more sensitive to alerting or flagging when very minor changes occur in the data.

Hospital Standardised Mortality Ratio + Summary

HSMR+ for Oct-24 is 64.33 and “lower-than-expected”, based on 3796 superspells and 78 deaths (crude rate 2.05%). The single-month HSMR+ value for the Trust is the lowest single-month HSMR+ value the Trust has reported over the last 5 years. This follows September 2024 which had previously been one of the all-time low values over the last five years.

HSMR+ for the period November 2023 to October 2024 is 82.15 and “lower-than-expected”, based on 42,323 superspells and 1174 deaths (crude rate 2.77%). As with single-month values, the rolling-12-month HSMR+ value is one of the all-time lower values for the Trust, and this is mostly driven by observed deaths falling to new all-time low values.

Figure 9: HSMR Monthly Trend

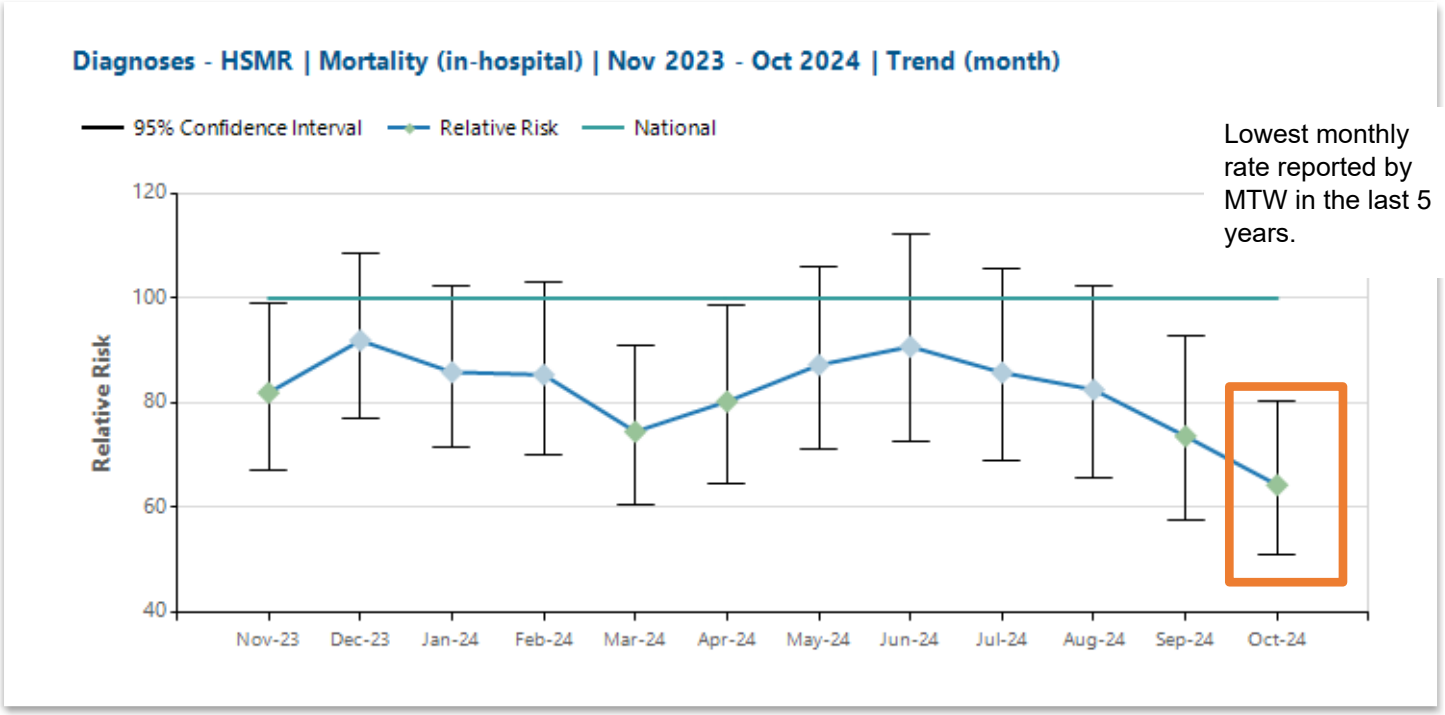


Figure 10: HSMR Day of admission (Emergency only)

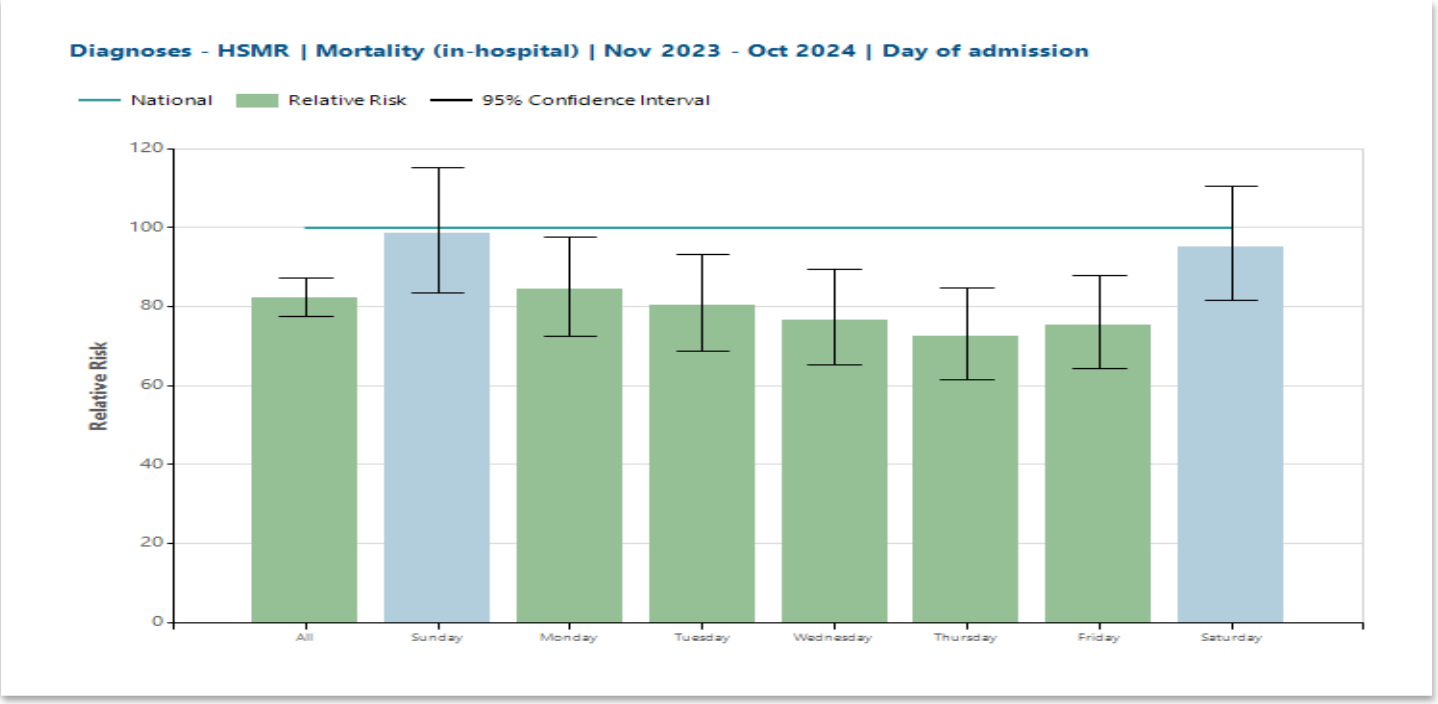
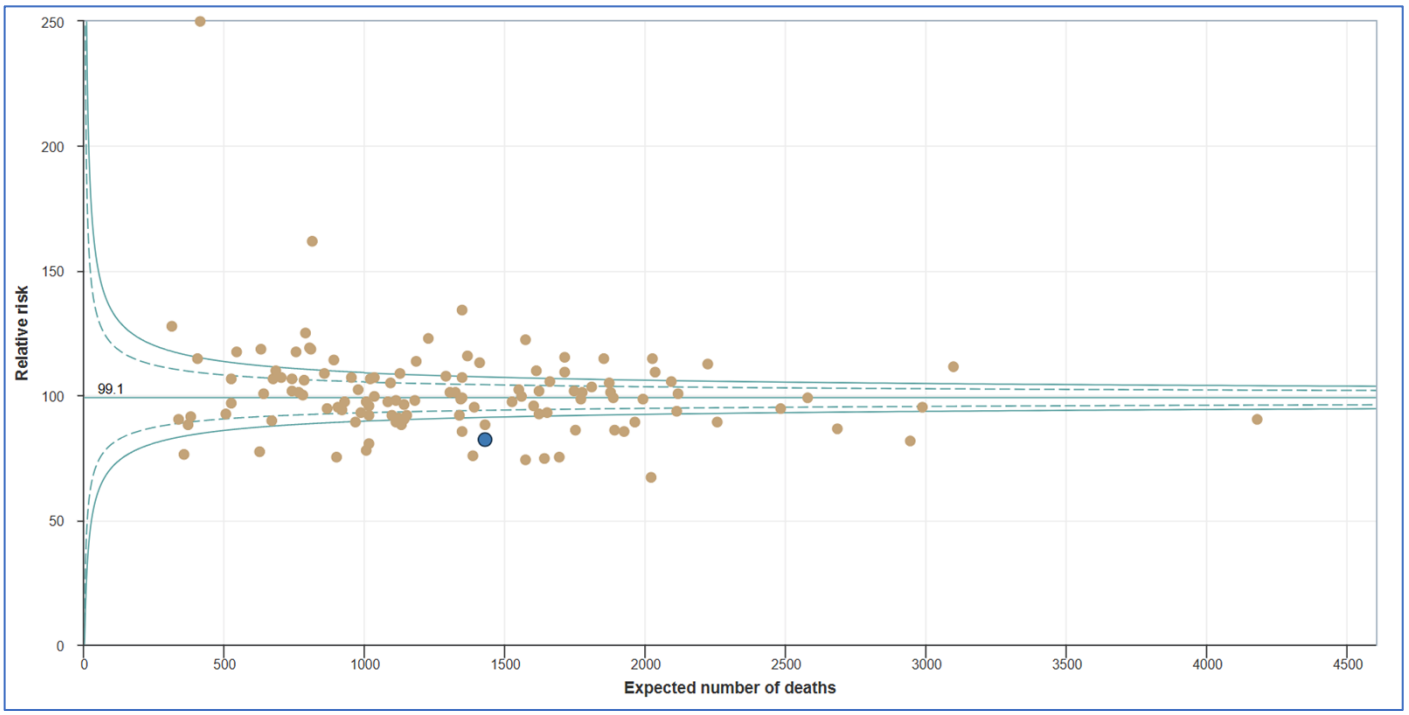


Figure 11: HSMR+ National Peer Comparison (Last 12 Months)

For the period Nov-23 to Oct-24 MTW performs statistically significantly better than national peers.



4 Appendices

Appendix 1: MONTHLY SHMI

Key points

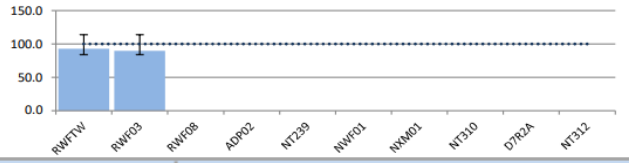
SHMI for the period Oct-23 to Sep-24 is 91.31 and “within expected”. There is a slight downward trend (improvement) in the SHMI at current, tallying with performance in HSMR+ model too. There are no outlying diagnosis groups.

SHMI - Published (With Over Dispersion)

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

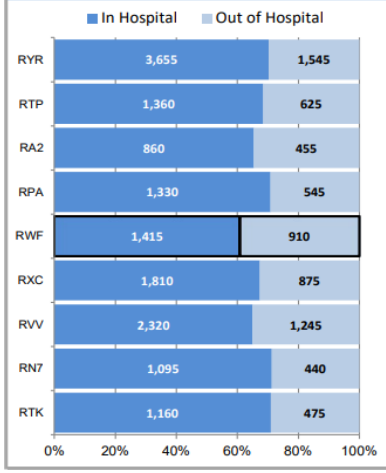
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTK	Ashford And St Peter'S Hospitals NHS Foundation Trust	58,920	1,630	1,660	-30	98.36	87.51	114.28
RN7	Dartford And Gravesham NHS Trust	58,440	1,535	1,470	65	104.47	87.41	114.40
RVV	East Kent Hospitals University NHS Foundation Trust	85,275	3,565	3,130	435	114.00	87.87	113.81
RXC	East Sussex Healthcare NHS Trust	62,350	2,685	2,620	65	102.46	87.79	113.91
RWF	Maidstone And Tunbridge Wells NHS Trust	98,315	2,325	2,545	-220	91.31	87.77	113.93
RPA	Medway NHS Foundation Trust	50,325	1,880	1,565	315	119.88	87.46	114.34
RA2	Royal Surrey County Hospital NHS Foundation Trust	61,380	1,315	1,640	-325	80.12	87.50	114.29
RTP	Surrey And Sussex Healthcare NHS Trust	61,460	1,985	2,030	-45	97.85	87.65	114.10
RYR	University Hospitals Sussex NHS Foundation Trust	151,840	5,200	5,015	185	103.68	88.03	113.60
Group		688,305	22,120	21,675	445	102.05		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
THE TUNBRIDGE WELLS HOSPITAL	61,570	1,235	1,335	92.79	86.23	115.97
THE MAIDSTONE HOSPITAL	35,455	1,085	1,210	89.74	86.14	116.09
CROWBOROUGH WAR MEMORIAL	295	0	*			
KIMS HOSPITAL (NEWNHAM COURT)	280	0	*			
NUFFIELD HEALTH, TUNBRIDGE	190	0	*			
BENENDEN HOSPITAL	190	0	*			
THE HORDER CENTRE - ST JOHNS	150	0	*			
SPIRE TUNBRIDGE WELLS HOSPITAL	110	0	*			
KENT AND MEDWAY ORTHOPAEDIC	45	0	*			
SPIRE ALEXANDRA HOSPITAL	25	0	*			

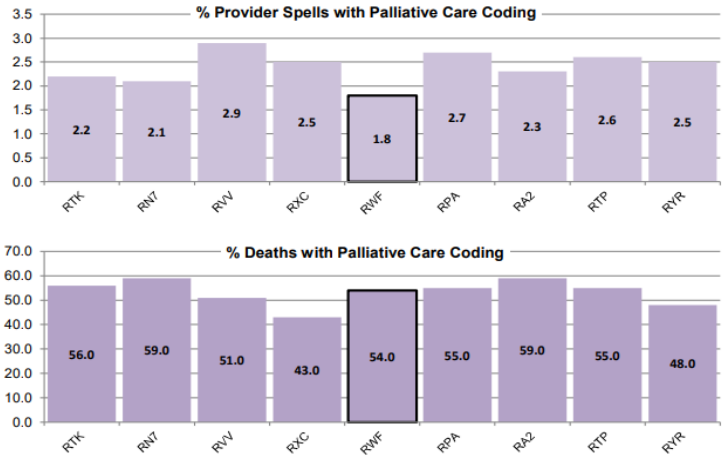


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	145	135.00	108.31	82.40 121.36
Cancer of bronchus, lung	20	20.00	89.47	65.60 152.45
Secondary malignancies	60	65.00	91.53	77.63 128.82
Fluid and electrolyte disorders	50	35.00	131.90	70.15 142.55
Acute myocardial infarction	30	25.00	116.15	67.09 149.06
Pneumonia	280	305.00	91.83	84.10 118.90
Acute bronchitis	15	30.00	58.55	67.66 147.80
Gastrointestinal haemorrhage	30	35.00	93.94	71.48 139.91
Urinary tract infections	45	50.00	95.39	68.67 145.63
Fracture of neck of femur (hip)	60	50.00	114.93	75.89 131.77

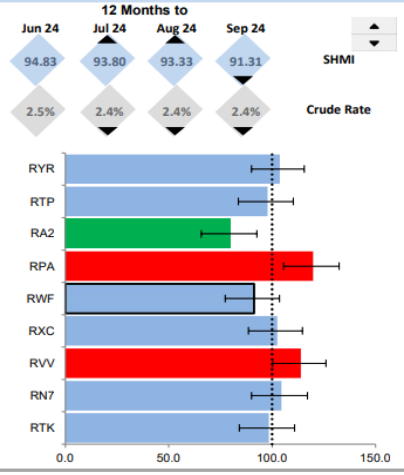
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(77) Aspiration pneumonitis, food/vomitus	95	80	118.75	96.07 145.17
(75) Chronic obstructive pulmonary disease and bronchiectasis	65	55	118.18	91.21 150.64
(109) Infective arthritis and osteomyelitis (except that caused by tuberculosis or sexually transmitted	15	10	150.00	83.89 247.42
(99) Acute and unspecified renal failure	45	40	112.50	82.05 150.54
(68) Peripheral and visceral atherosclerosis	20	15	133.33	81.41 205.93
(38) Nutritional deficiencies, Disorders of lipid metabolism, Other nutritional, endocrine, and metabolic	20	15	133.33	81.41 205.93
(65) Congestive heart failure, nonhypertensive	100	100	100.00	81.36 121.63
(124) Intracranial injury	45	45	100.00	72.93 133.81

Appendix 2: Category of SJRs allocated by ME Service

A	Deaths where a significant concern about the quality of care provided is raised by families and carers
B	Deaths where a significant concern about the quality of care provided is raised medical examiners and staff
C	Deaths where the patient had a diagnosed learning disability (ies)
D	Deaths where the patient had a diagnosis of a high functioning autistic spectrum condition (ASC) (formerly known as Asperger's)
E	Deaths where the patient has a recognised mental health condition/was known to mental health services
F	Deaths in a specialty, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns, InPhase raised
G	Deaths where the patient was not expected to die - for example, in elective procedures
H	Deaths where learning will inform the provider's quality improvement work (e.g. sepsis)
I	Maternal or neonatal deaths

Title of report	**Maternity Incentive Scheme Compliance (Minimum dataset from PQSM)**					
Board / Committee	**Trust Board**					
Date of meeting	27th March 2025					
Agenda item no.	03-14					
Executive lead	Jo Haworth					
Presenter	Rachel Thomas					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
✓	☐	✓	✓	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	PQSM Overview 1. To ensure effective Board oversight in Year 7 of the Scheme, it is recommended that the monthly Perinatal Quality Surveillance Model (PQSM) report is available at every Trust Board, which includes the minimum dataset required by Safety Action 9. A member of the perinatal leadership team will be available to provide supporting context (as specifically required by Safety Action 9). 2. Trust safety champions (including the Non-Executive Director) already see this data monthly, which enables early action to be taken and support to be provided should the data identify an area of concern or need. The Board's review of this data provides assurance of effective ward to Board reporting, and reassures the Board of the check and challenge applied by the safety champions. 3. The following summary of items to be escalated were identified via the Maternity and Neonatal Care Oversight Group Meeting on 12 March 2025: 4. Areas of concern 4.1. Three escalations to PSIRG in month – AAR's commissioned. (Poor management of PPH, Hospital acquired VTE & Joint escalation for poor management of PPH and both 3rd degree tears in one shift) 1.1. One case met the threshold for PMRT review in January. Care review underway through PMRT. 1.2. Ongoing issues on ensuring internal obstetric consultants are able to attend PMRT to ensure quoracy. 1.3. Operational Performance: a total of 10 suspensions of service occurred in January (5 day shifts & 5 night shifts) relating to the home birth service, this affected one woman who delivered at TWH.

	1.1. Ten open complaints within the division relating to maternity and obstetric services. Service User Feedback this month highlighted a new theme of Poor and inconsistent communication (unprofessional conversations being heard in ward areas). 2. Positive assurance 2.1. Risk Register: One risk was closed in month - Increase of staff required to support the Governance Team and ongoing Maternity Improvement Plan (#3095). 2.2. 0 Patient Safety Incident (PSIs) declared in January 2.3. 0 MNSI referrals in month. 2.4. Training compliance for NLS, Fetal Monitoring and PROMPT was met across all professions. 2.5. Continued increase in FFT response seen with maintained positive repose of 100% seen. 2.6. Consultant attendance at clinical scenarios (defined by RCOG): 100%. 2.7. Midwife to Birth ratio remained with the threshold of 1:25. 2.8. Agency usage decrease to 10.3% in comparison from last month's usage of 26.6%. 2.9. One to one care in labour and delivery suite coordinator supernumerary status at 100% compliance. 3. Decisions 3.1. Risk Register: Two new risks added in month - Risk to patient safety due to the number of expired guidelines within the directorate (Risk ID 3358 – 12) / Risk to patient safety due to using a combination of a number of different digital systems and paper maternity records which may lead to oversight of clinical information (Risk ID 3359-12). 3.2. One moderate harm incident that had been reported in month was downgraded following MDT review. 3.3. 8 AARs closed in month, actions from learning underway.
Any items for formal escalation / decision	1. The Board is invited to: a. review the attached March (January data) 2025 PQSM report and the summary of items for escalation set out above for information and assurance; b. confirm in the minutes of this meeting that it has reviewed and discussed the PQSM report to undertake a review of maternity and neonatal quality and safety; c. decide if any further information, action and/or assurance is required.
Appendices attached	1. Appendix 1 - PQSM report March (January data) 2025

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	12 March 2025	For referral to Trust Board

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	1182,3269,3242,3308,3310,3293,3358,3359,1294,1275,33073390,3296,3290,3397,3345,3071,3016, 3309,3179,3065,1282,3387,3088,3062,2951,1248,1101
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report Fulfils requirements for Maternity Incentive Scheme

Perinatal Quality Surveillance Model report for Maternity & Neonatal Care Oversight Group March 2025 (January data)

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

PQSM (January 2025 data)			
Report date: March 2025 January data		**PQSM** **Report lead:** Jessica O'Reilly	**Actions:**

1a	**Alert (Include actions taken/mitigations)**	**Incident Reporting:**
		• 3 escalations to PSIRG in month – AAR's commissioned. (Poor management of PPH, Hospital acquired VTE & Joint escalation for poor management of PPH and both 3 degree tears in one shift)
		• 1 case met the threshold for PMRT review in January. (24+3 spontaneous labour and delivery with signs of life, then NND). Care review underway through PMRT.
		
		PMRT: Ongoing issues on ensuring internal obstetric consultants are able to attend to ensure quoracy
		
		Operational Performance: a total of 10 suspensions of service occurred in January (5 day shifts & 5 night shifts) relating to the home birth service, this affected one woman who delivered at TWH
		
		Complaints:
		• 10 open complaints within the division relating to maternity and obstetric services,
		  • 2 received in month
		  • 1 breach in month
		• 3 PALS cases
		Service User Feedback this month highlighted a new theme of Poor and inconsistent communication (unprofessional conversations being heard in ward areas)
			PMRT: plan moving forward to look at day/time of meeting around job planning
			
			Operational Performance: the one woman who was affected as part of the home birth suspension has had professional DOC carried out
			
			Complaint: Working with clinical teams review barriers of the complaint process to ensure compline timeframes for responses are met.
			
			FFT & Service user feedback: Feedback comments from the FFT have been shared with ward managers and staff, and ongoing actions are aligned with the MNVP/Patient Experience Lead workplan. The Patient Experience Midwife is actively collaborating with the Trust Patient Experience Team and remains an active member of the Patient Experience Breakthrough Objective Steering Group, which is dedicated to reducing complaints related to communication.

1b	Assurance	**Risk Register :** One risks was closed in month - Increase of staff required to support the Governance Team and ongoing Maternity Improvement Plan (#3095) **Incident reporting:** • **0** Patient Safety Incident (PSIs) declared in January • **0** MNSI referrals in month **Training:** Compliance for NLS, Fetal monitoring and PROMPT compliance was met across all professionals. **FFT:** Continued increase in FFT response seen with maintained positive repose of 100% seen. **Consultant attendance at clinical scenarios (RCOG):** 100% **Midwife to Birth ratio:** remined with the threshold of 1:25 **Workforce:** The agency usage saw a decrease to 10.3% in comparison from last month's usage of 26.6%	
1c	Advise	**Risk Register:** Two new risks added in month - Risk to patient safety due to the number of expired guidelines within the directorate (Risk ID 3358 – 12) / Risk to patient safety due to using a combination of a number of different digital systems and paper maternity records which may lead to oversight of clinical information (Risk ID 3359-12) **Incident Reporting:** • 1 moderate harm incident reported in month relating a return to theatre, following MDT review downgraded. • 8 AARs closed in month, actions from learning underway • **Safety:** 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status achieved 100% compliance	**Risk Register:** Regular risk register meeting with the MDT now in place from march to ensure oversight

CQC Maternity Ratings

The Tunbridge Wells Hospital at Pembury

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Inadequate	Not rated	Not rated	Not rated	Requires Improvement	Inadequate

Maidstone Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement	Not rated	Not rated	Not rated	Requires Improvement	Requires Improvement

Crowborough Birthing Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement	Not rated	Not rated	Not rated	Requires Improvement	Requires Improvement

Date of last inspection:	**October 2024 (report pending)**
Maternity Safety Support Programme:	No
Improvement advisor (if applicable):	N/A

Maternity Risk Register
(Extracted from risk register, rated 8 and above)

Closed

- Increase of staff required to support the Governance Team and ongoing Maternity Improvement Plan (#3095)

New Risks

- Risk to patient safety due to the number of expired guidelines within the directorate (3358)
- Risk to patient safety due to using a combination of a number of different digital systems and paper maternity records which may lead to oversight of clinical information (3359)

Risks rated 8 and above

Risk ID	Risk Identified	Inherent Risk Rating	Modified Risk Rating	Target
1182	Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience.	15	15	3
3269	Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus	15	15	6
3242	Possible delays in accessing the second theatre in the Delivery Suite	16	12	6
3310	Cervical length screening not provided for all women with a previous caesarean section at full dilatation.	12	12	2
3308	Uterine artery dopplers not provided for all high risk women at anomaly scan	12	12	3
3370	Element 1 saving babies lives - non compliance with ultrasound pathway for all smokers	12	12	2
3358	Risk to patient safety due the number of expired guidelines within the Directorate	16	12	8
3359	Risk to patient safety due to using a combination of a number of different digital systems and paper maternity records which may lead to oversight of clinical information	16	12	8
1275	Swab, needle and instrument count documentation is not being completed in line with Trust policy.	16	12	4
3071	Out of area booking process and procedure currently demonstrates a risk to mothers and babies	12	9	8
3179	Not all current cardiotocograph machines equitable in performance and reliability. This is increasing the number of machines not available due to servicing requirements.	12	8	4
3065	There is a risk of suboptimal outcomes within Maternity - this risk was identified via a review of patient safety incidents where staff have not followed IIA (Intelligent Intermittent Auscultation) guidance	15	8	4
1282	Exposure to Entonox	12	8	4
3072	The current interpreting service provided by the Trust does not fulfil the needs of the maternity services at MTW.	12	8	4

The number of incidents logged graded as moderate or above, PSIRG escalations and what actions are being taken.

Incidents Graded Moderate or above		
ID & Incident Summary	**Actions/Learning**	**Date Clinical Incident Review (CIR) Completed**
#34325 Return to theatre post ELCS	No learning identified, good care therefore downgraded as not caused moderate harm	MDT review 04/02/2025
Escalations to PSIRG		
ID & Incident Summary	Actions/Learning	Date Clinical Incident Review (CIR) Completed
#32197 Poor management of PPH	• Delay in placing CODE RED 2222. The PPH Guideline advises: *'Activate CODE RED protocol if MBL exceeds 1500ml or where there is uncontrolled bleeding which is likely to require urgent transfusion of blood components. NOTE, therefore, that CODE RED protocol may be activated even where the patient would seem to be haemodynamically stable.'* • Limited awareness of ongoing measured blood loss • No evidence of escalation to the On-call Consultant **IMMEDIATE ACTIONS** Directorate GLOW (Getting Learning Out Weekly) drafted to remind all staff re CODE RED protocol, to be circulated w/c 20/01/2025. PPH workstream lead to discuss at Consultant Meeting. Learning also shared with Lead Anaesthetist for Obstetrics to share with Anaesthetic team.	MDT review 14/01/2025
#33959 Hospital acquired VTE	• Missed VTE assessments on multiple antenatal admissions • LMHW prescribed on one admission but never given • Incorrectly assessed postnatally and LMHW not prescribed **Immediate actions** • Take 5 for all areas • GLOW with immediate learning sent out	MDT review 28/01/2025
#34224 and #34252 Joint escalations for poor management of PPH and both 3 degree tears in one shift	• Poor documentation from midwife on case 34224 • No PPH bloods taken at time of PPH on both cases • No ongoing measurement of blood loss on case 34224 • Obstetric consultant not informed and therefore did not attend on both cases **IMMEDIATE ACTIONS** • GLOW sent out same week for previous case escalated	MDT review 28/01/2025

Ongoing Patient Safety Incident Investigations (PSIIs)

0 Patient Safety Incident Investigations (PSIIs) declared in January

Current open incidents :

Month	InPhase	Description	Maternal ethnicity
August	#23178	Unexpected admission of baby to NNU at 39^{+2} following emergency LSCS	Any other Asian background
November	#28570	Unexpected admission of baby to NNU at 40^{+4} following emergency LSCS	White: British
November	#28793	Mother experienced late miscarriage at 21^{+0}, missed referral for cervical length screening.	Black or Black British: African
November	#30030	Mother admitted for IOL for GDM and cellulitis, developed AKI 1 and had 2200mls PPH following LSCS. Unexpected admission of baby to NNU at 38^{+2}	Any other White background

Cases closed in January**: 0**

Ongoing After Action Reviews (AARs)

4 AAR's declared in January

Current open incidents :

Month	InPhase	Description	Maternal ethnicity
November	#30190	Mother experienced 3b tear and 1700ml PPH	White British
November	#30216	Mother missed antenatal care after 16 week appointment	White British
December	#30904	Mother transferred to ITU with hypotension following LSCS for severe PET	White British
January	#32197	Mother experienced 3000ml PPH	White British
January	#34252	Mother experienced 3b tear and 2000ml PPH	Any other Asian background
January	#34224	Mother experienced 3b tear and 2000ml PPH	White British
January	#33959	Mother developed PE and DVT postnatally, - incorrect assessment on VTE form – no Fragmin recommended.	Any other Asian background

8 cases closed in January

AAR cases closed in January

InPhase	Description	Issues identified	Learning actions
#24167	Poor management of a PPH >1500mls • ELCS transferred to PN ward, MBL 300mls Overnight patient asked for maternity pads to be checked, pads not measured. • Day staff try to mobalise patient ++ lochia on pad • Obstetric review and plan for bloods, 2 hourly observations and review in afternoon • SHO bleeped to review patient and bloods taken. VBG 83g?L • Transferred to DS. USS showing clots inside • Return to theatre. 4 units transfused	• There are no appropriate scales on postnatal ward to weigh maternity pads or incontinence pads • Documentation was unclear and limited around blood loss. Terms such as 'a bit significant lochia ++' is vague and non-specific. Clear language must be used- such as Lochia minimal, moderate or heavy with a clear plan of care noted. • Listen to the patient's concerns even if they do not align with your own, consider escalating to a junior doctor for review and reassurance.	• Scales purchased, delivered and place on Postnatal ward for use of measuring postnatal blood loss • Individual learning for Agency Midwife • GLOW
#24800	Near miss swab management incident / retained instrument Red tag from swab pack lost in post suture count. Patient's room was explored for red tag including all bins and bed stripped etc. Speculum examination conducted with consent to ensure not left in patient's vagina and reason for examination explained. Red tag not found	• To make use of the Swab Safe containers for swab and instrument counts to ensure swabs, red tags and instruments are contained and visible. • Consider changing procured packs to those without red tags • To consider if a follow-up appointment is required with Consultant in near miss incidents	• GLOW • Procurement contacted to determine if new packs can be ordered without red tags- Full exploration by procurement who report back no provider found for swab packs without a red tag. • Considered – No capacity for near miss appointments, verbal duty of candours at the time.

AAR cases closed in January

InPhase	Description	Issues identified	Learning actions
#25406	Unexpected Maternal admission to ICU following delivery • Admitted with PPROM and PET at 32+2 • Became symptomatic of PE • Transferred to DS due to fetal bradycardia on CTG • Rapid deterioration and transferred to MECU • Cat 1 EMCS then to ITU	• The use of ROM+ (diagnostic tool for SROM) would be beneficial to making care plans and assist towards additional diagnosis's and treatment. • **Improved communication with the patient and family. The staff were conscious that this could have been improved when the patient deteriorated.**	• To look at ROM+ for directorate • Share case via PS presentation at clinical governance • Patient experience lead and MNVP to look at standard process to nominate a designated member of staff responsible for providing regular updates to families and relatives during acute obstetric emergencies
#26743	Poor Management of a 3rd degree tear Delay in repair as other emergencies, unable to open a second theatre – CEPOD unable to provide a team and Anaethetist. 17:20 Perineum examined, 3rd degree tear confirmed. 20:43 Into theatre 21:27 Suturing complete	• CEPOD cannot provide a team or open a second theatre unless the patient is of category 1 priority otherwise they must stay in main theatres to cover all other aspects of emergency surgery. Patients are prioritised based on clinical need.	• No learning identified

AAR cases closed in January

InPhase	Description	Issues identified	Learning actions
#27220	Medication (Anticoagulation wrong dose administered) • Patient readmitted to PN ward with wound infection • The patient was intermediate risk VTE (Venous Thromboembolism) and was prescribed 5000iu of Fragmin • Fragmin put in patients locker for self administration • On the 3rd day of the patient's admission, it was found that the patient had been given 7500iu over the last 3 days instead of 5000iu.	• Medication must be checked by two midwives • Fragmin stored in patient lockers should be checked daily during drug rounds to ensure the correct dose has been provided. • Human factors contributed to this incident, staff to ensure they have completed human factors training. • Patient lockers can be full and hard to see, can patient's SAMS be displayed clearly in the room so staff can view them during drug rounds or ensure they are checked • Staff must clearly write the code '10' within the patient's drug chart if the drug is being self-administered. • Staff must check the drug chart if administering normally self-administered Fragmin.	• Two members of staff to sign out all TTO medications • Take 5's sent out with learning points • Staff involved offered human factors training
#27477	Anticoagulation wrong dose administered • Instrumental delivery and deemed to be intermediate risk • The patient was correctly prescribed 5000iu of anticoagulants on the drug chart, however; on the nights of both the 14th and 15th October, the patient had the higher dose of 7500iu administered. On the 16th October the higher dose of anticoagulation TTO was noted in the patient's room and discarded.	• Fragmin boxes of different dosages need to be separated/ easily identifiable and staff have become reliant on colour of the box rather than checking the dosage on the box • All medication should be countersigned as a TTO before providing to the patient. • All Self-administration medication is to be countersigned by two members of staff • Members of staff should also remember to undertake the 5 R's of medication administration • Importance of patients being aware of the medication and dosages that they have ben prescribed • Human factors contributed to this incident happening. Staff are looking after many different maternity patients and their baby's. Usually very task heavy. Staff from ward could do with being sent on human factors training	• Two members of staff to sign out all TTO medications • Take 5's sent out with learning points • Staff involved offered human factors training • Extra signage on cupboard on PN ward • Compliance check audit performed • 5 'R's poster to be put on drug trolleys

AAR cases closed in January

PSIRF

InPhase	Description	Issues identified	Learning actions
#29493	Medication (Anticoagulation wrong dose administered) • ELCS of 3rd baby • The patient was prescribed 5000iu of Fragmin anticoagulation to prevent Venous Thromboembolism. • The patient was given the first dose of Fragmin as prescribed of 5000iu. The patient's booking weight was 93kgs. Patients 91kg and over should be prescribed 7500iu and therefore the wrong dose was prescribed and administered.	• For Elective patients, a huddle in the morning can be completed and the latest weight to be discussed and noted on drug chart during this huddle • Weight to be recorded on drug chart in the designated section which will allow the patient's weight to be more accessible. • Patients to be weighed when seen in triage or on admission-this will be discussed with triage management by the postnatal ward manager. • Compliance of correct Fragmin prescription and administration needs to be monitored.	• Discussion with theatre lead • Take 5 sent out • Audit of drug chart compliance • Discussion on ordering scales for triage • Audit of notes to look at compliance with fragmin
#27339	Failure in the Gap & Grow Measurement processes impacting plan of care • G+G chart not generated at dating scan, 16/40 or 34/40 CMW appointment • Delay in referral for growth scans • The patient was seen on 08/10/2024 in community, where her fundal height was not plotted on the growth chart. If it had been plotted, it would have been identified as below the 10th centile and an urgent scan (within 72 hours) would have been organised and performed.	• Individual learning to staff member	• Individual learning to staff member

MNSI: Referrals and findings of review of cases

0 referrals undertaken in January

Current open referrals :

Month	MNSI Reference	InPhase	Description	Maternal ethnicity	Update
August	MI-038041	#23924	Baby transferred for cooling at 42^{+0} following breech vaginal delivery*	White British	Draft report received in December and returned for factual accuracy Awaiting final report
October	MI-038677	#27170	Mother experienced IUD at 38^{+2} following abruption	White British	
October	MI-038810	#28006	Baby transferred for cooling following SVD at 38^{+4}	White British	

Themes from reviews of perinatal deaths

Cases that met the threshold for reporting in January:

Month	InPhase	Description	Maternal ethnicity
January	#32725	24+3 spontaneous labour and delivery with signs of life, then NND	Any other white background

0 PMRT reports published in January

100% of perinatal mortality reviews include an external reviewer

January meeting held with external and internal reviewers

Escalation in month:

Ongoing issues on ensuring internal obstetric consultants are able to attend, plan moving forward to look at day/time of meeting around job planning

1:1 Care in Labour

1:1 Care in Labour (target 100%)	
Month	Achieved (%)
January	100%
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	

From March 2024, babies born to women not diagnosed in established labour on Delivery Suite have not been included in the calculations for one to one care in labour.
(as per NHSR definition)

Delivery Suite Co-Ordinator Supernumerary Status

Supernumerary Maintained (target 100%)	
Month	Achieved (%)
January	100%
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	

There were no occasions when a supernumerary Delivery Suite coordinator was not available at the start of a shift in January.

NB - The process for capturing data on supernumerary status of the coordinator moved from identifying that no incident report was raised during the month until June 2024, to a daily record using the MOPEL tool from July.

Operational Performance

Impact of operational change

	Occurrence	Impact of Operational Change
Diverts out of Trust	0	N/A
Crowborough Birth Centre suspensions	0	N/A
Maidstone Birth Centre suspensions	0	N/A
Home birth suspensions	5 day shifts 5 night shifts	This impacted one woman who had a planned homebirth who went to deliver at TWH.

External Reviews/Actions Requested from

- CQC, Coroner 28 reg.
- NHSR, MNSI, HEE
- RCOG

No Report this month.

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

Fetal Monitoring

*Exc LTS & Mat leave

*Exc Bank only

Role	Total Staff	Compliant	Compliance %
Midwife acute	182	169	93%
Midwife community	59	58	98%
Midwife Birth Centres	28	28	100%
Obstetric Consultants	20	19	95%
Obstetric Doctor	22	21	95%
Total	310	294	95%

Escalation: This data cannot be accurately taken from MTW Learning and is reliant on the accuracy of the PDM team's manual database.

PROMPT

*Exc LTS & Mat leave

*Exc Bank only

Role	Total Staff	Compliant	Compliance %
Midwife acute	182	170	93%
Midwife Community	59	58	98%
Midwife Birth Centres	28	27	96%
Obstetric Consultant	20	20	100%
Obstetric Doctor	50	50	100%
Anaesthetic Consultant	36	34	94%
Anaesthetic Doctor	3	3	100%
Maternity Support Worker & Nursery Nurse	75	72	96%
Total	445	434	96%

Escalation: This data cannot be accurately taken from MTW Learning and is reliant on the accuracy of the PDM team's manual database.

NLS

Role	Total Staff	Compliant	Compliance %
Midwives	269 (excluding bank)	255	95%
Obstetric Consultant	20	20	100%
Obstetric Doctor	50	50	100%
Maternity Support Worker	75 (excluding bank)	72	96%
Neonatal Nurse	58	55	95%
Neonatal Doctor	34	31	91%
Neonatal Consultant	7	7	100%
Total	513	504	97%

Escalation: Nil

*Exc LTS & Mat leave

Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively

Midwifery Staffing

*Minimum data set for PQSM requires safe staffing levels with planned cover vs actual

	Day		Night		TEMPORARY STAFFING	
	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing
Midwifery Services - Delivery Suite - NF102	87.6%	-	100.0%	100.0%	30.3%	21.7%
Midwifery Services - MSW (2022) - NF102	-	92.8%	94.3%	-	28.9%	0.0%
Midwifery Services - Antenatal Ward - NF122	90.0%	-	-	88.4%	48.5%	7.6%
Midwifery Services - Postnatal Ward - NF132	118.1%	84.3%	86.1%	-	31.0%	3.3%
Midwifery TW (four IP rosters)	96.9%	91.0%	94.6%	89.6%	32.2%	10.3%

Unavailability (%)			
27.25%			
Annual Leave (%)	**Sick Leave (%)**	**Study Leave (%)**	**Other (%)**
12.89%	5.24%	3.71%	5.41%

The birth to midwife ratio is calculated monthly using Birth Rate Plus and the actual months delivery rate	Aim	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 24
Birth to midwife ratio	1:24	1:26	1:25	1:27	1:25	1:24	1:25

Obstetric staffing

2024	Consultant presence on site - hours per week	Consultant attendance at clinical scenarios (RCOG)	Short term locums employed who do not work on the unit	"Certificate of Eligibility for Locums" completed and verified (RCOG)	Long term locums employed	RCOG guidance followed on the engagement of long-term locums	Requests for compensatory rest	Compensatory rest accommodated	Impact on service
Target	90	100%	-	100%	-	Yes	-	Yes	None / minimal
April	90	98%	3	3	0	-	1	1	None
May	90	94%	2	2	0	-	1	1	None
June	90	95%	2	2	0	-	1	1	None
July	90	94%	1	1	0	-	1	1	None
August	90	96%	1	1	0	-	1	1	None
September	90	100%	0	-	0	-	1	1	None
October	90	100%	0	-	0	-	0	-	-
November	90	100%	0	-	0	-	0	-	-
December	90	88.9%	0	-	0	-	2	2	None
January	90	100%	0	-	0	-	0	0	None

Staff Engagement

Annual staff survey (From National NHS Staff Survey 2023 and GMC medical trainee survey 2023)

Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work (reported annually)	62%
Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to receive treatment (reported annually)	68%
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	38%

Oversight of this data and action plan is being monitored by the divisional peoples committee through the monthly meeting.

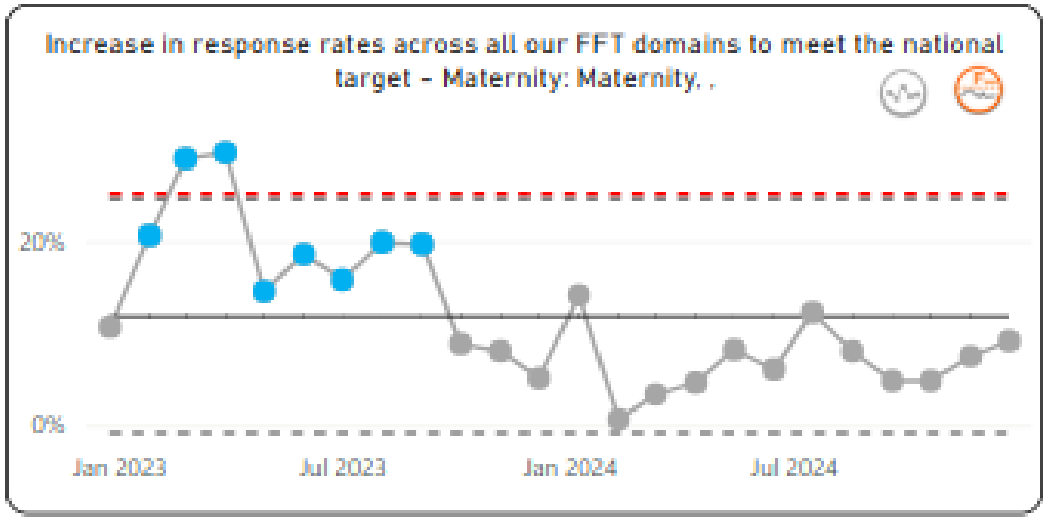
Hearing from women, birthing people, and their families

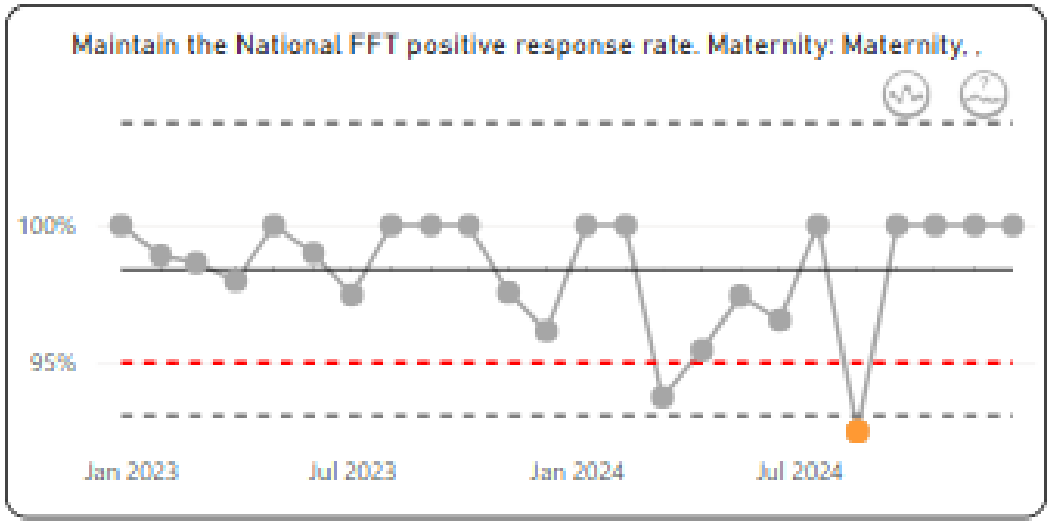
Service user feedback to include themes of feedback received by MNVP

Qrly report not due

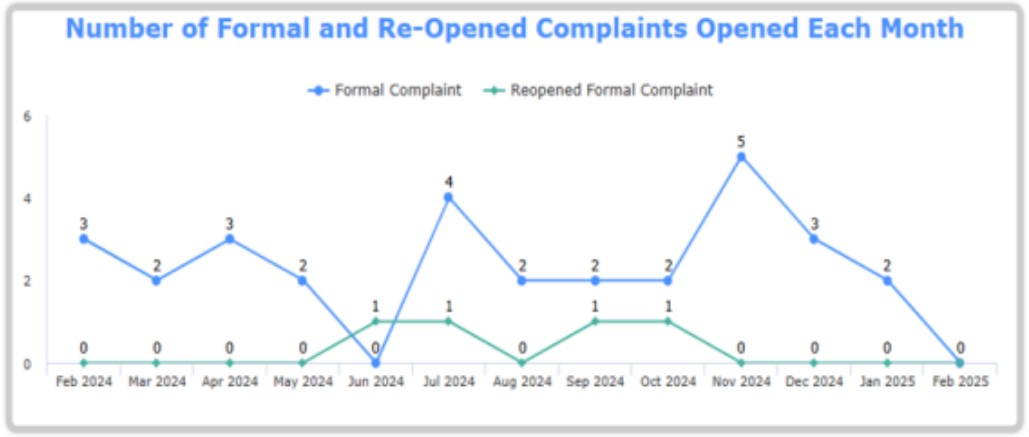
FFT Feedback

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Total responses	87	67	95	147	134	164	164	165	178





Formal Complaints



No of formal complaints received in month : 2

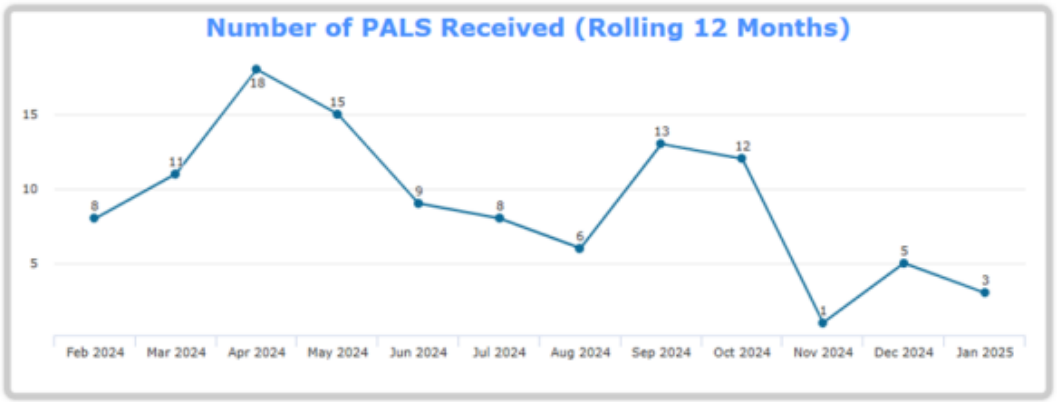
No open in service : 10

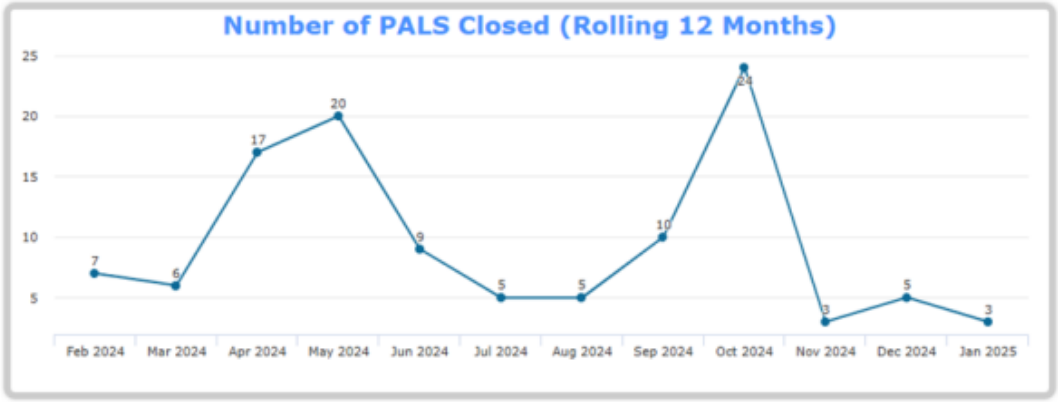
No of breached complaints: 1

Themes	Actions/Learning
Communication	The Patient Experience Midwife is actively collaborating with the Trust Patient Experience Team and remains an active member of the Patient Experience Breakthrough Objective Steering Group, which is dedicated to reducing complaints related to communication.
Lack of information	Monthly MNVP status meetings in place with MNVP Lead and PT EX Lead for Maternity. The aim of the meetings is to review Feedback Log themes, agree actions and review overall MNVP business and progress
Delay in treatment	Monthly MNVP status meetings in place with MNVP Lead and PT EX Lead for Maternity. The aim of the meetings is to review Feedback Log themes, agree actions and review overall MNVP business and progress
Attitude of staff	Staff training for Midwives (personalised care/communication commenced Jan 2025). Doctors training to commence March ’25.

PALS

No of PALS cases: 3





Listening to women engagement activities and evidence of co-production

Service User Feedback	Themes	Actions/Learning
January's service user feedback themes were collected from the following sources: • FFT comments • Social media feedback • Complaints/PALS • MNVP	Negative: • Poor and inconsistent communication (unprofessional conversations being heard in ward areas) • Lack of pain relief options on AN Ward • Poor discharge process/information Positive: • Helpful, caring, Professional, knowledgeable staff • Good BF support • Birth centres highly valued	• Feedback comments from the FFT have been shared with ward managers and staff, and ongoing actions are aligned with the MNVP/Patient Experience Lead workplan. • The Patient Experience Midwife is actively collaborating with the Trust Patient Experience Team and remains an active member of the Patient Experience Breakthrough Objective Steering Group, which is dedicated to reducing complaints related to communication. • Monthly Maternity Experience Committee meetings are held, and Patient Experience Champions are actively fulfilling their roles. The 'You Said, We Did' initiative, based on FFT comments, has addressed several concerns. Issues were raised regarding unprofessional conversations in ward areas, and a reminder of professionalism expectations will be sent to staff. Feedback from a MNVP highlighted concerns about staff discussing workloads in front of patients and poor communication between midwives and GPs, which will be escalated. • Monthly MNVP status meetings are being held with MNVP Lead and PT EX Lead for Maternity. The aim of the meetings will be to review Feedback Log themes, agree actions and review overall MNVP business and progress (no meeting in Jan '25 due to unforeseen circumstances) • Staff training for Midwives (personalised care/communication commenced Jan 2025). Doctors training to commence March '25.

Progress in achievement of CNST 10 Safety Standards

Maternity Incentive Scheme Progress Report

Final position for Year 6 of the Scheme

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	0	0	3	1	4
4	0	0	20	0	20
5	0	0	6	0	6
6	0	0	6	0	6
7	0	0	7	0	7
8	1	0	20	0	21
9	1	0	8	0	9
10	0	0	8	0	8
Total	2	0	86	1	89

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Maternity Incentive Scheme Progress Report

Final position for Year 6 of the Scheme

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	No	18	1
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	No	8	1
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0

Maternity Improvement Programme Progress Report – assurance overview 6th January 2025

Maternity CQC action plan	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Comments
29A Warning Notice and CQC Report "Must" and "Should" Activities – progress															
Complete	2	15	17	35	54	82	96	100	108	126	132	144	151	**168**	• Work continues on the amber actions: ➢ Escalation policy update – in draft ➢ Workforce planning and reporting • Good progress with development and initiation of new meeting and governance structures now that the senior governance team posts have been appointed and are in post • Progress is being made with recruitment to a number of additional roles. However, some are yet to be in post and the business case for funding has yet to be agreed. Recruitment to date is currently a cost pressure to the service
On track and on time	23	11	3	153	113	99	89	33	22	37	34	27	30	**15**	
Breached but progressing	1	0	6	0	23	9	5	57	60	24	26	21	15	**13**	
Breached at risk	0	0	0	0	0	0	0	0	0	6	0	0	0	**0**	
Milestone Actions completed for the Delivery Areas: • Reduction in harm associated with PPH • C-section undertaken within appropriate time frame • Safe systems for Triage • Robust Medicines Management • Birth Centre Booking Processes • Birth Centre Risk Assessment • Safe Clinical Environments															• Ongoing monitoring and oversight has been established for these delivery areas and the workstream activity has transitioned to business as usual

Outstanding CQC Recommendations

Actions which MUST be taken:	Action taken	Progress	RAG
The service must ensure there are effective governance systems and processes to identify and manage incidents, risks, issues, and performance and to monitor progress through completion of audits, action plans and oversight of improvements and reduce the recurrence of incidents and harm	Reporting and meeting structures reviewed Audit processes and programme reviewed	New meeting structure and processes developed and in use. PDSA cycle will review ToR, as required Women's Services Risk and Safety Strategy to be updated to reflect changes	
The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies	Establishment reviews Workforce reporting in development Ongoing recruitment	Workforce reporting under development for regular reporting through the local meeting structure	
The service must ensure all policies and procedures are up to date and in line with best practice.	Guideline taskforce project in progress	A number of key documents have been updated. Work continues to address those yet to be reviewed	
Actions which SHOULD be taken:	**Action taken**	**Ongoing monitoring**	**RAG**
The service should ensure the vision and values relate to the current model of maternity care and all staff understand and apply them to their work	Project to develop and publish a Maternity Strategy	Project progressing. Draft in review	
The service should review incidents related to health inequalities	EDI data added to InPhase reports Development of local dashboard of clinical outcomes using EDI metrics	EDI considered at incident reviews Dashboard EDI development continues – BI analyst recruited to support	

Q2 (LMNS Q6) Implementation

Trust: Maidstone and Tunbridge Wells NHS Trust

ICB: South East

% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8
Review Quarter	Q1 (Interim)	Q1 (Final)	Q2 (Interim)	Q2 (Final)	Q3 (Interim)	Q3 (Final)	Q4	Q5	Q6
Assurance Review Date	10/10/23	07/11/23	20/12/23	23/01/24	13/03/24	16/04/24	12/07/24	11/10/24	17/01/25
Element 1	30%	30%	30%	50%	70%	60%	70%	60%	70%
Element 2	40%	40%	75%	75%	80%	80%	75%	75%	85%
Element 3	50%	50%	50%	50%	50%	50%	50%	50%	100%
Element 4	0%	20%	40%	60%	60%	60%	60%	60%	60%
Element 5	30%	41%	48%	85%	52%	89%	89%	85%	93%
Element 6	0%	50%	50%	50%	33%	50%	50%	50%	67%
TOTAL	30%	39%	53%	71%	61%	76%	76%	73%	83%

Increase in implementation of elements 1, 2, 3, 5, 6; sustained implementation of element 4

Increase in total implementation – now at 83%

10 interventions remain as partially implemented (1.3, 1.6, 1.9, 2.11, 2.17, 4.3, 4.4, 5.6, 5.14, 6.2)

2 interventions remain not implemented (2.7, 6.1)

***** Year 6 – CNST Compliance delivered for SBL.*****

Title of report	**2024 National Staff Survey Results**					
Board / Committee	**Trust Board Meeting (Part 1)**					
Date of meeting	25th March 2025					
Agenda item no.	03-15					
Executive lead	Helen Palmer, Chief People Officer					
Presenter	Helen Palmer, Chief People Officer					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	☐	☐	✓	☐	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The 2024 NHS national staff survey was open between September and November 2024 with results released at 9.30am on 13 March 2025. At the point of report preparation, high level data only is available with more in-depth data expected once the embargo is lifted. This information will be presented to ETM and this committee in due course. 45.77% (3640) of MTW staff completed the survey. Since 2021, the annual survey has been aligned to the NHS People Promise. These are themes that healthcare staff have identified as making the biggest difference to their workplace experience. These seven areas are key to staff retention and are depicted by the icons below. Staff Engagement and Morale are also measured. The 2024 results are now available through the Survey Coordination Centre website, which includes an interactive dashboard. Comparative Bank Survey scores will be received next month. For the first time, free text comments are available by Division. This report includes a timeline depicting analysis, distribution, action planning and review through to the launch of the 2025 survey. MTW scored above the national average for acute trusts in all People Promise themes, plus Staff Engagement and Morale. The Trust scored above the average in the Kent and Medway ICS in all themes except "We are a Team" (0.02 difference) and scored higher than all Acute Trusts in Kent and Medway in all themes. Similarly, MTW scored above the South East average in all themes except "Reward and Recognition" (0.03 lower), "We Work Flexibly" (0.02 lower) and "We are a Team" (0.11 lower). National ranking of Acute Trusts is not yet available.
Any items for formal escalation / decision	
Appendices attached	

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer • PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes • PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates •
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report •

2024 National Staff Survey Results
March 2025

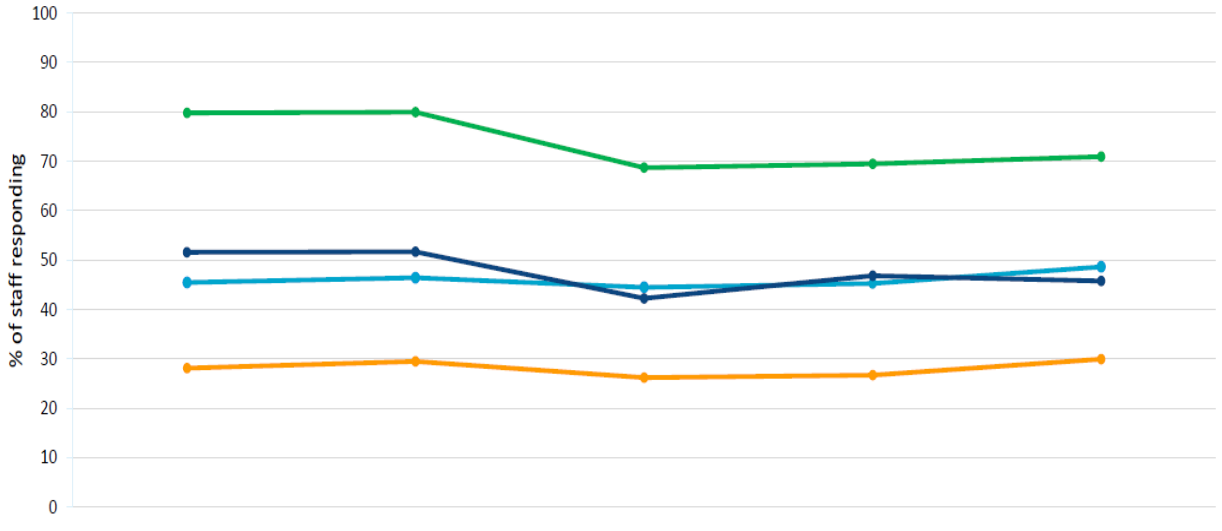
MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Summary of the report

- The 2024 NHS national staff survey was open between September and November 2024 with results released at 9.30am on 13 March 2025. At the point of report preparation, high level data only is available with more in-depth data expected once the embargo is lifted. This information will be presented to ETM and this committee in due course. 45.77% (3640) of MTW staff completed the survey.
- Since 2021, the annual survey has been aligned to the NHS People Promise. These are themes that healthcare staff have identified as making the biggest difference to their workplace experience. These seven areas are key to staff retention and are depicted by the icons below. Staff Engagement and Morale are also measured. The 2024 results are now available through the Survey Coordination Centre website, which includes an interactive dashboard. Comparative Bank Survey scores will be received next month. For the first time, free text comments are available by Division.
- This report includes a timeline depicting analysis, distribution, action planning and review through to the launch of the 2025 survey.
- MTW scored above the national average for acute trusts in all People Promise themes, plus Staff Engagement and Morale. The Trust scored above the average in the Kent and Medway ICS in all themes except "We are a Team" (0.02 difference) and scored higher than all Acute Trusts in Kent and Medway in all themes. Similarly, MTW scored above the South East average in all themes except "Reward and Recognition" (0.03 lower), "We Work Flexibly" (0.02 lower) and "We are a Team" (0.11 lower).
- National ranking of Acute Trusts is not yet available.

Response Rates



	2020	2021	2022	2023	2024
Your org	51.56%	51.66%	42.22%	46.81%	45.77%
Highest	79.77%	79.95%	68.69%	69.45%	70.92%
Average	45.43%	46.38%	44.46%	45.23%	48.61%
Lowest	28.09%	29.47%	26.17%	26.65%	29.91%
Responses	3199	3385	2907	3469	3640

Key Points to Note

- All staff in post on 1st September 2024 were eligible to complete the 2024 NSS – 7953 substantive staff and 1005 Bank staff were sent the survey
- While the Substantive staff completion rate dropped, the Bank completion rose and is significantly higher than the average Bank completion rate for Acute and Acute Community Trusts.
- Not all of our staff fill in the survey. Some staff groups, pay bands, roles are over or under represented. We must continue to work on this as we engage with staff in our Divisions.

Within MTW: Key Disparities

Divisions and Directorates:

- Detailed divisional data is not yet available

Staff Groups:

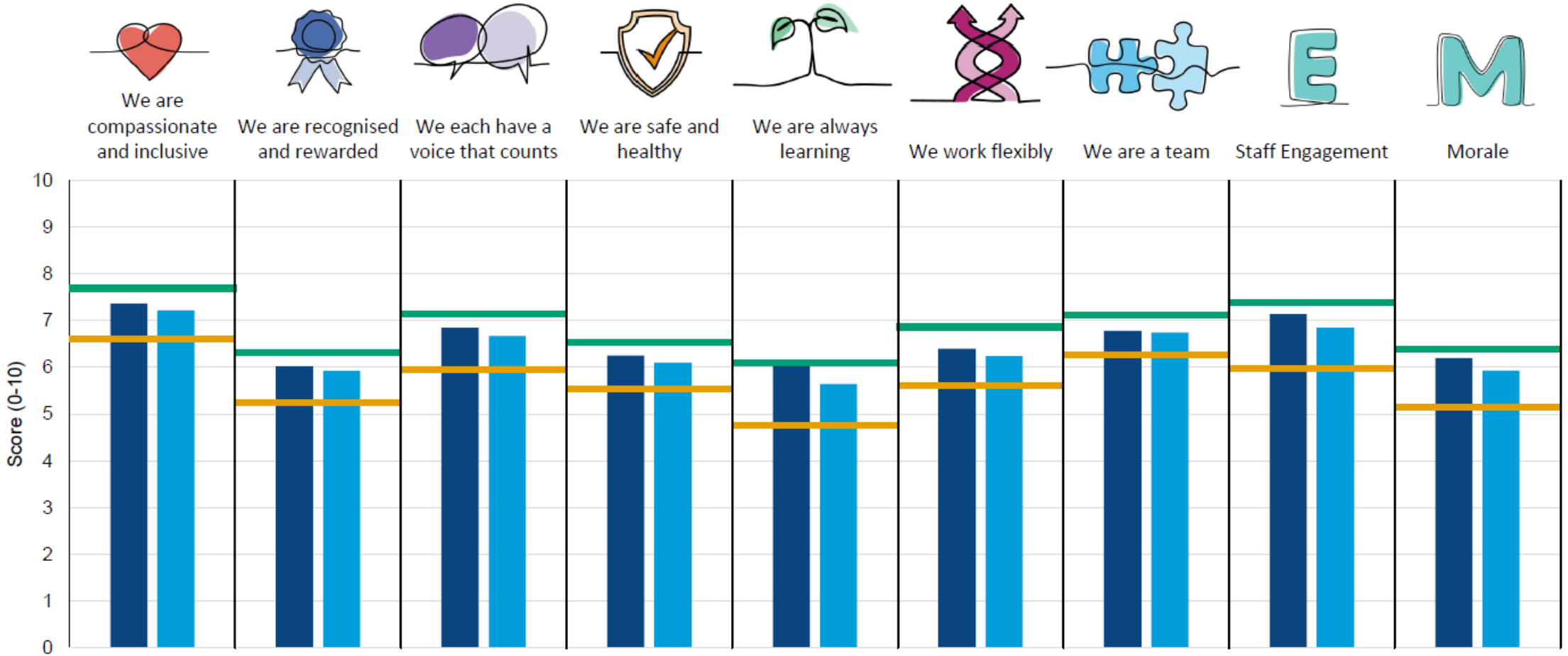
- The response rate percentage is not yet known for staff groups.

Identity:

- Ethnicity: While representation across White, Black and Asian groups increased, the sharpest increase in response rates were among Asian groups.
- Sex, Age, Long-Term Health Condition status and Sexuality: This data is not currently available.

People Promise Overview

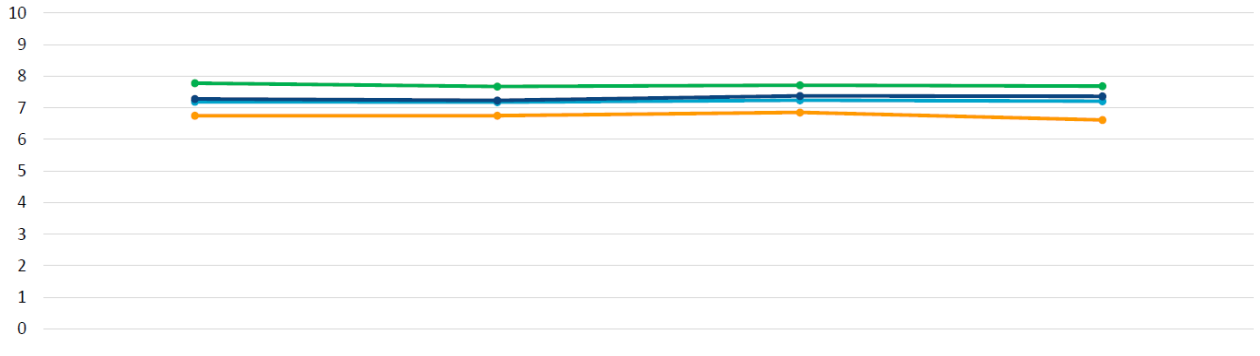
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.36	6.01	6.84	6.24	6.06	6.39	6.78	7.13	6.19
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3613	3615	3550	3575	3483	3584	3603	3616	3619

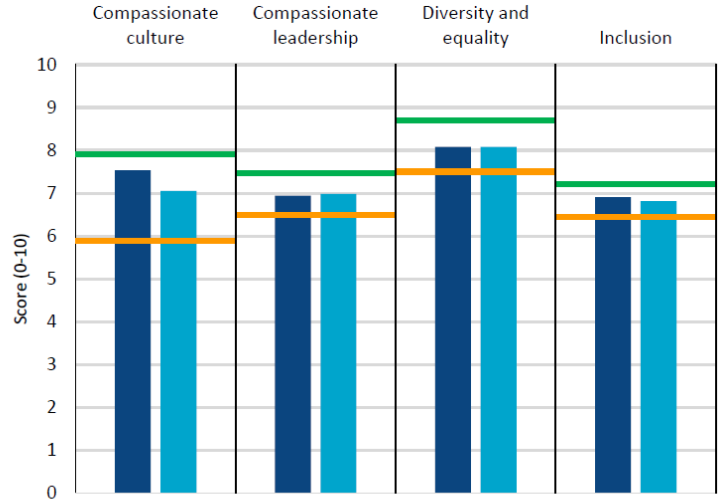
We are compassionate and inclusive

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	7.28	7.23	7.38	7.36
Best result	7.78	7.67	7.72	7.69
Average result	7.19	7.18	7.24	7.21
Worst result	6.75	6.75	6.85	6.61
Responses	3371	2893	3451	3613

THEME BREAKDOWN



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.53	6.94	8.08	6.91
Best result	7.91	7.47	8.69	7.20
Average result	7.05	6.98	8.08	6.81
Worst result	5.89	6.50	7.50	6.44
Responses	3591	3609	3602	3599

Within MTW: Key Disparities

Bank vs Substantive:

- There is no statistically significant change from 2023 results for substantive staff, with a reduction of 0.02.
- Bank staff scores for this theme are have improved 0.05 and are slightly lower than substantive staff scores- all scores are out of 10.

Divisions and Directorates:

This information will be made available to us when the embargo lifts

Staff Groups:

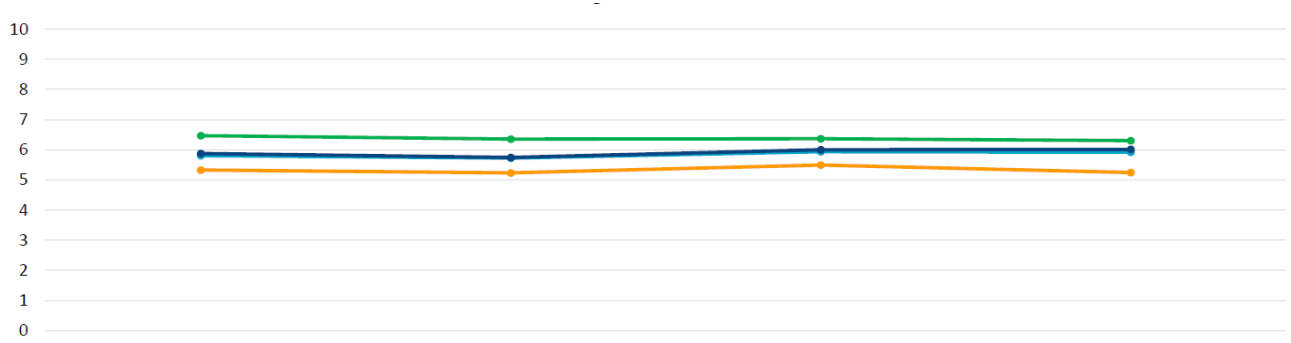
This information will be made available to us when the embargo lifts

Key Theme Questions

- 'My organisation acts on concerns raised by patients/service users' improved by 2.35%
- 'I would recommend my organisation as a place to work' increased by 1.2%

We are Recognised and Rewarded

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	5.88	5.75	6.00	6.01
Best result	6.47	6.36	6.37	6.30
Average result	5.81	5.72	5.94	5.92
Worst result	5.33	5.24	5.49	5.24
Responses	3359	2891	3460	3615

Within MTW: Key Disparities

Bank vs Substantive:

- Standing at 6.07, Bank staff scored 0.04 points higher than substantive staff for this theme, although this is lower than the 2023 score.
- Substantive staff have had an increase of 3.2 for satisfaction in level and an increase of 0.4 for being recognised for doing good work.

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

- This information will be made available to us once the embargo lifts

THEME BREAKDOWN

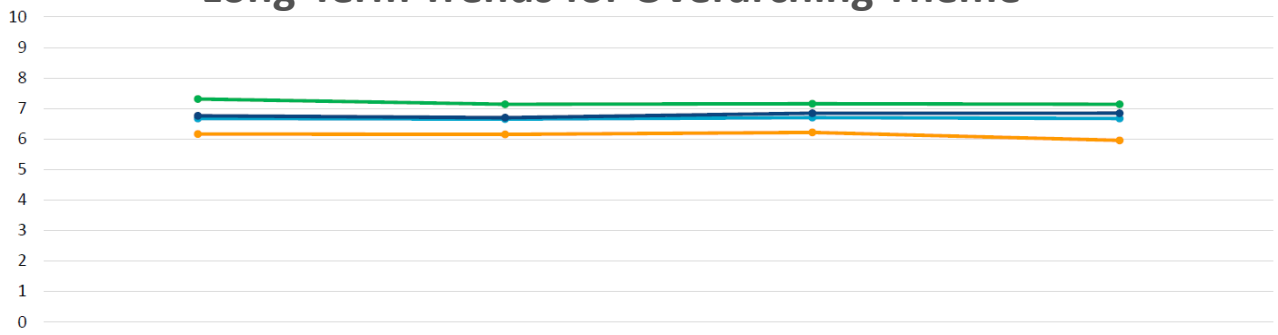
There is no theme breakdown available for ‘We are Rewarded and Recognised’

Key Points to Note

- This People Promise element continues to be our lowest score and includes questions relating to being valued and appreciated, and pay.
- We have improved slightly on the 2023 score, and we are above the national average within our sector.
- Concerning our need to improve retention, previous NSS results indicate that staff who feel that their organization values their work more are more likely to stay. This will need to be a key area of concern within the ‘Recognised and rewarded’ theme. (NHS England, 2024)

We each have a voice that counts

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	6.76	6.70	6.84	6.84
Best result	7.31	7.14	7.16	7.14
Average result	6.67	6.65	6.70	6.67
Worst result	6.16	6.15	6.21	5.95
Responses	3334	2858	3405	3550

Within MTW: Key Disparities

Bank vs Substantive:

- Bank staff scores for this theme statistically significantly lower than substantive scores, highlighting improving their voices as a key area for improvement.

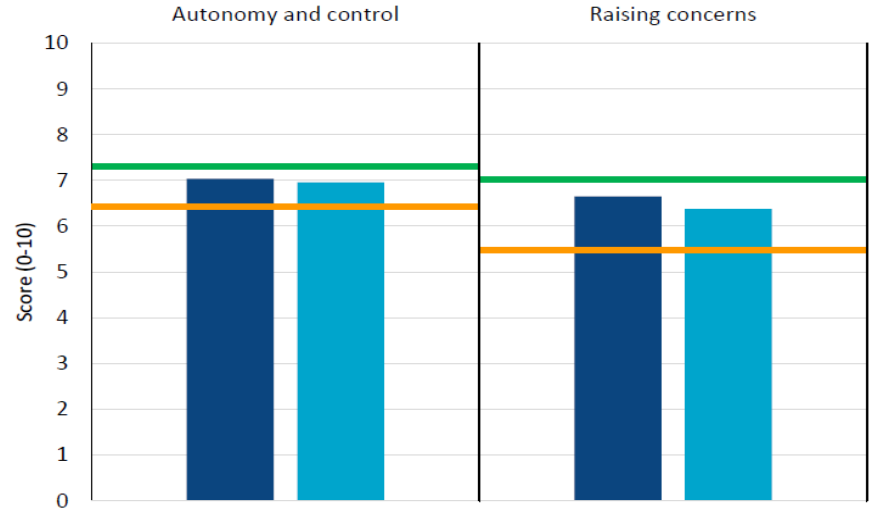
Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

- This information will be made available to us once the embargo lifts

THEME BREAKDOWN



	Autonomy and control	Raising concerns
Your org	7.04	6.65
Best result	7.31	7.02
Average result	6.96	6.38
Worst result	6.43	5.48
Responses	3613	3562

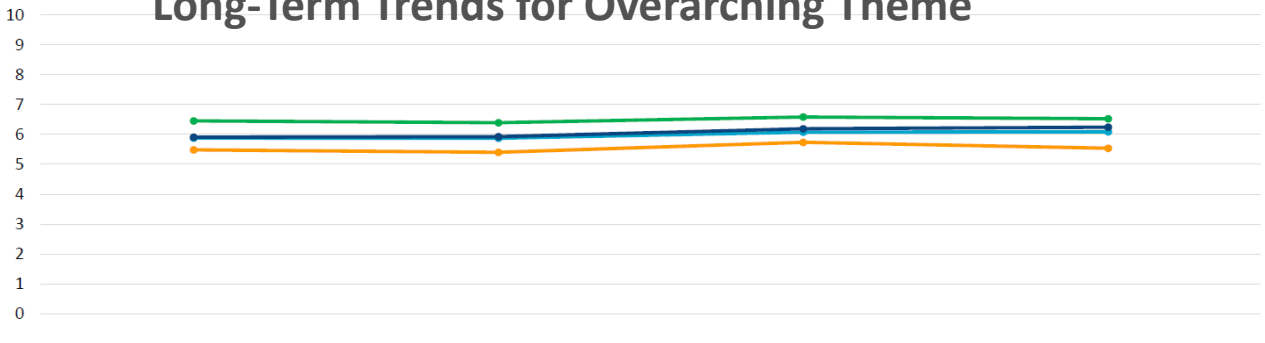
Key Points to Note

- 'I am trusted to do my job' scores have significantly declined, and this is the largest drop in scores for the 2024 survey overall highlighting that work is needed to empower our staff.

- Our Quarterly Staff Experience Survey (QSES) trends, captured every January, April and July, remain important for maintaining staff involvement, predicting NSS trends and increasing retention by understanding from staff voice whether our interventions are working. Prioritising these surveys remains an integral part of continuing to improve staff engagement.

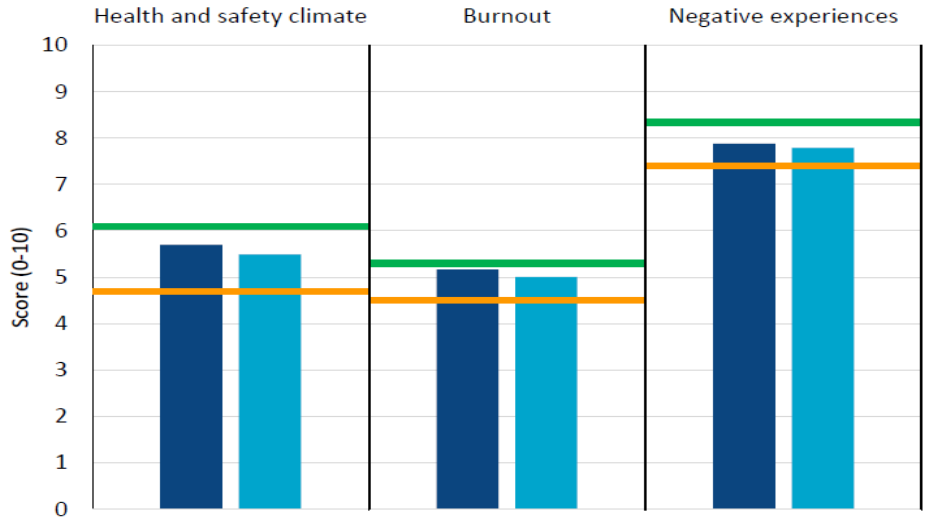
We are safe and healthy

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	5.91	5.93	6.19	6.24
Best result	6.46	6.40	6.59	6.53
Average result	5.88	5.88	6.08	6.09
Worst result	5.49	5.41	5.74	5.54
Responses	3357	2886	3408	3575

THEME BREAKDOWN



	Health and safety climate	Burnout	Negative experiences
Your org	5.70	5.16	7.88
Best result	6.09	5.30	8.34
Average result	5.49	5.01	7.79
Worst result	4.70	4.50	7.39
Responses	3615	3612	3600

Within MTW: Key Disparities

Bank vs Substantive:

- Bank staff have scored significantly better than substantive staff in this section, with a 0.61 difference in scores

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

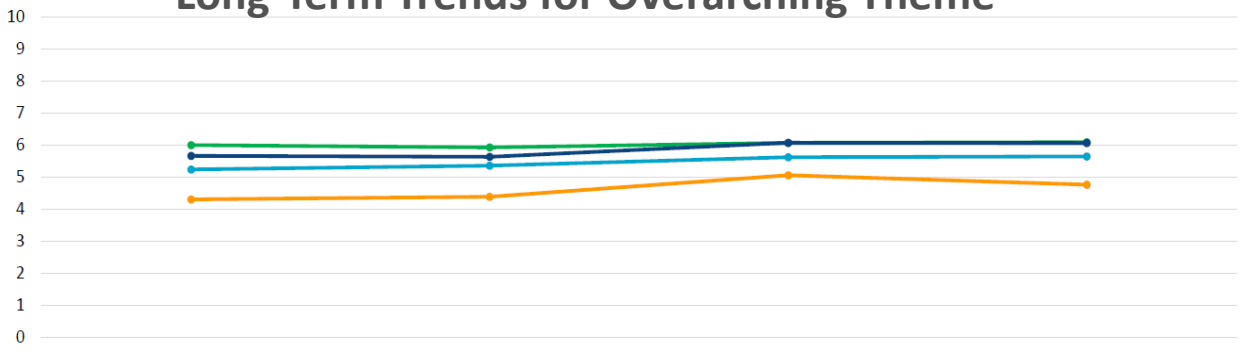
- This information will be made available to us once the embargo lifts

Key Points to Note

- Overall in this section our score has improved since the 2023 survey
- For trusts in our sector that use the same survey supplier as MTW, we are significantly lower on the score for , for question 10b 'on average how many additional PAID hours do you work, over and above your contracted hours?' with a 5.5% difference. Once the embargo lifts we will be able to see where we are compared to local and all national comparable trusts
- Across MTW, staff experiencing unwanted sexual behaviours from patients/service users/patient relatives, reduced from 7.96% in 2023 to 6.95% . From staff/colleagues this reduced from 4.14% in 2023 to 3.38% in 2024
- With regards to improving retention, previous NSS results indicate that staff who feel less frustrated in work are more likely to stay. We must therefore continue to work on reducing burnout. (NHS England, 2024)

We are always learning

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	5.66	5.63	6.07	6.06
Best result	6.00	5.92	6.07	6.09
Average result	5.24	5.35	5.62	5.64
Worst result	4.30	4.39	5.06	4.76
Responses	3251	2800	3319	3483

THEME BREAKDOWN

	Development	Appraisals
Your org	6.69	5.42
Best result	6.80	5.50
Average result	6.40	4.86
Worst result	5.69	3.83
Responses	3606	3492

Within MTW: Key Disparities

Bank vs Substantive:

- Bank staff scores were have decreased by 0.22, where as substantive have dropped by 0.01 points

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

- This information will be made available to us once the embargo lifts

Key Points to Note

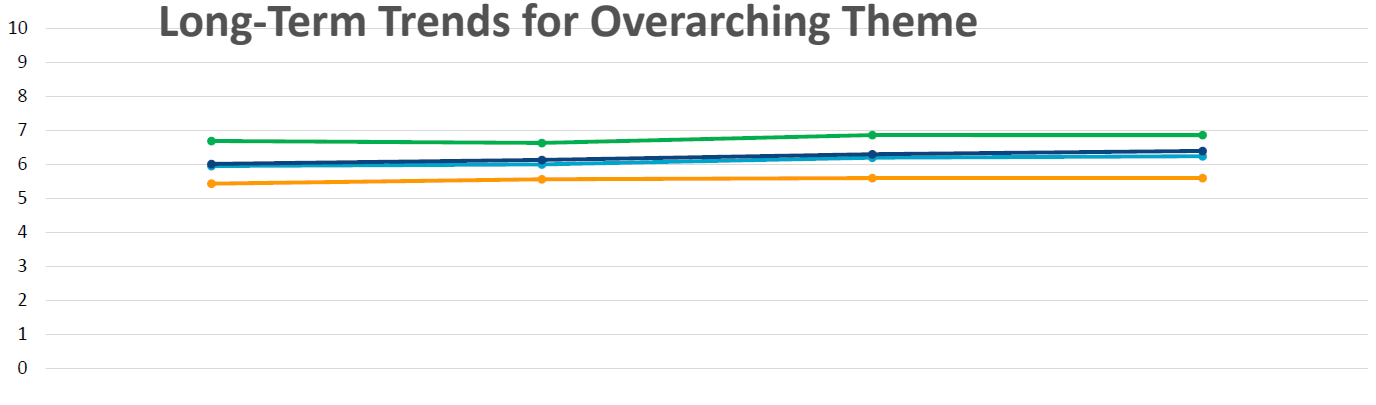
- The 2 sub questions in this section with the most significant change are;

'There are opportunities for me to develop my career in this organisation' reducing by 2.1% , and ' I have opportunities to improve my knowledge and skills' reducing by 1.58%

- With regards to improving retention, previous NSS results indicate that staff who feel more supported to develop their potential are more likely to stay with their current organisation/role.

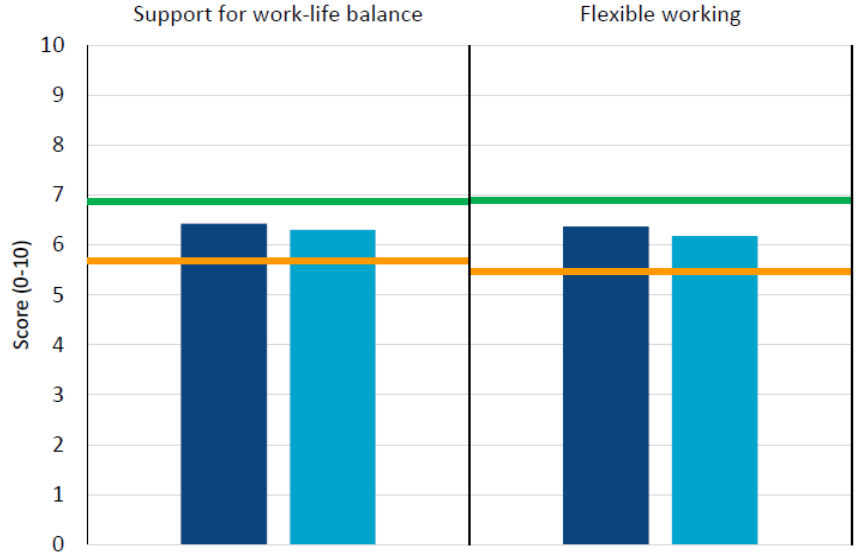
We work flexibly

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	6.01	6.13	6.30	6.39
Best result	6.69	6.63	6.86	6.86
Average result	5.95	6.00	6.20	6.24
Worst result	5.43	5.56	5.60	5.60
Responses	3334	2872	3428	3584

THEME BREAKDOWN



	Support for work-life balance	Flexible working
Your org	6.43	6.36
Best result	6.87	6.88
Average result	6.30	6.17
Worst result	5.67	5.47
Responses	3615	3592

Within MTW: Key Disparities

Bank vs Substantive:

- There is no significant difference between bank and substantive staff for this theme

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

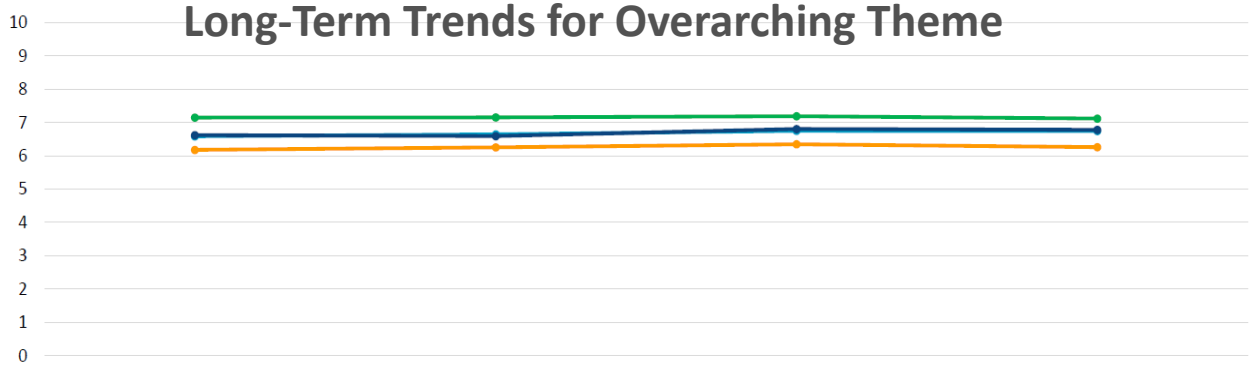
- This information will be made available to us once the embargo lifts

Key Points to Note

- Our scores for supporting work life balance have improved, notably 'My organisation is committed to helping me balance my work and home life' which has improved by 1.7%
- Staff who feel that their organisation is more committed to helping them balance work and home life are more likely to stay. This indicates that we must continue to focus on supporting us to all work flexibly. (NHS England, 2024)

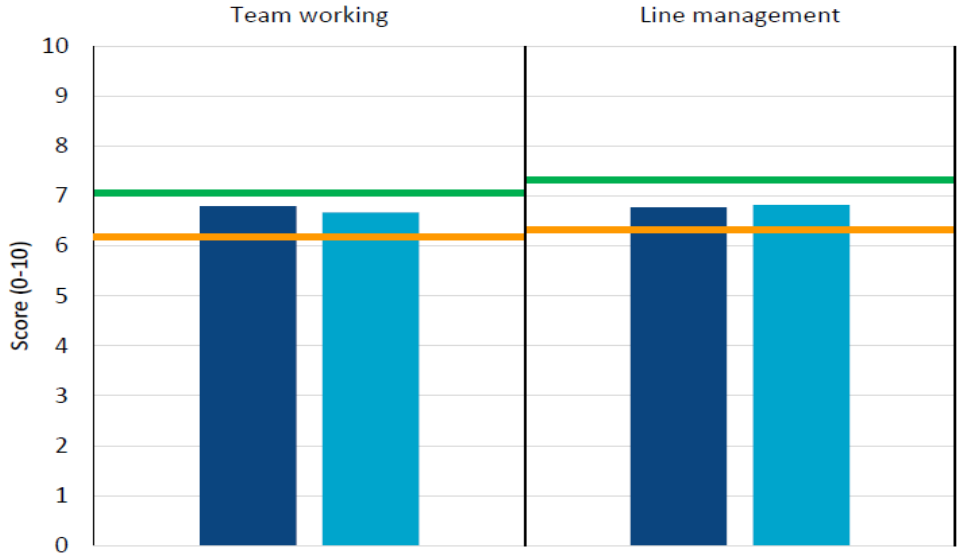
We are a team

Long-Term Trends for Overarching Theme



	2021	2022	2023	2024
Your org	6.62	6.59	6.80	6.78
Best result	7.15	7.15	7.19	7.12
Average result	6.58	6.64	6.75	6.74
Worst result	6.18	6.25	6.34	6.26
Responses	3363	2887	3440	3603

THEME BREAKDOWN



	Team working	Line management
Your org	6.79	6.77
Best result	7.06	7.31
Average result	6.67	6.82
Worst result	6.18	6.33
Responses	3611	3613

Within MTW: Key Disparities

Bank vs Substantive:

- Where last year the results indicate that substantive staff feel more part of a team than bank staff (who scored 1.1 points lower), this year bank staff scored 0.02 higher than substantive

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

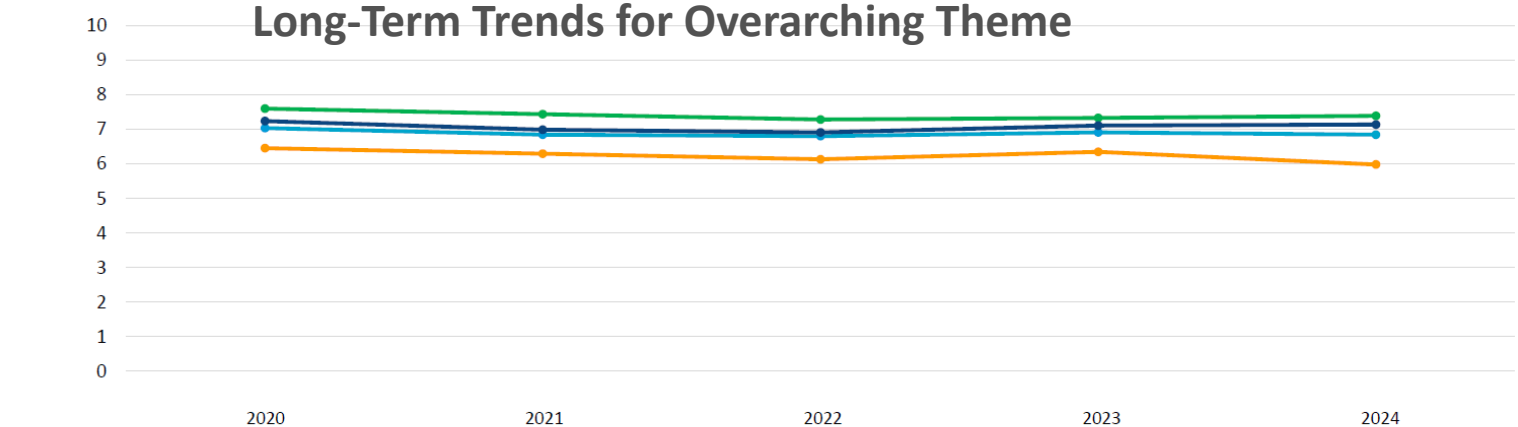
Staff Groups:

- This information will be made available to us once the embargo lifts

Key Points to Note

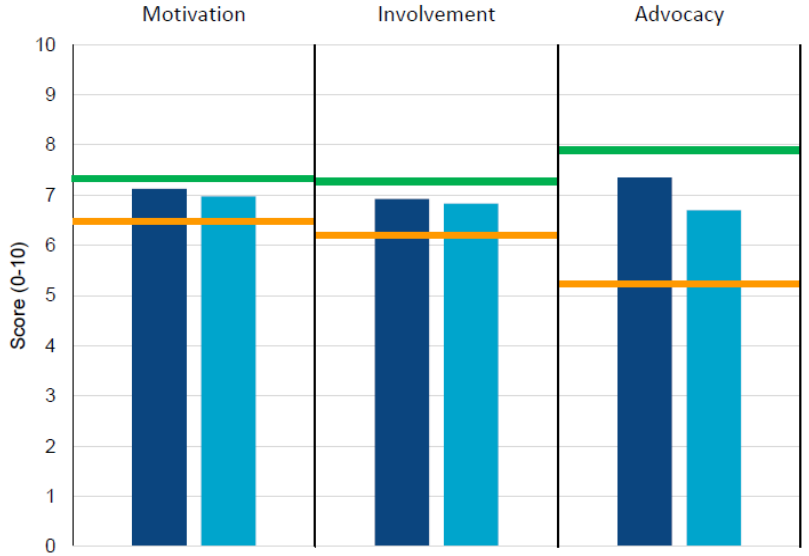
- Survey questions for the 'Team working' sub-theme relate to understanding each other's roles, working to shared objectives, treating each other with respect and working with teams across the Trust.
- Questions for the 'Line Management' theme relate to managers taking a positive interest in health and wellbeing, supporting staff voice and providing feedback and encouragement.
- Team support continues to be the key driver of employee engagement (NHS England, 2024)

Staff Engagement



	2020	2021	2022	2023	2024
Your org	7.23	6.98	6.91	7.11	7.13
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	3190	3374	2896	3455	3616

THEME BREAKDOWN



	Motivation	Involvement	Advocacy
Your org	7.13	6.93	7.35
Best result	7.33	7.27	7.90
Average result	6.98	6.83	6.70
Worst result	6.49	6.20	5.24
Responses	3546	3613	3591

Within MTW: Key Disparities

Bank vs Substantive:

- Bank staff scores (69.9%) were lower than our substantive scores (71.3%).

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

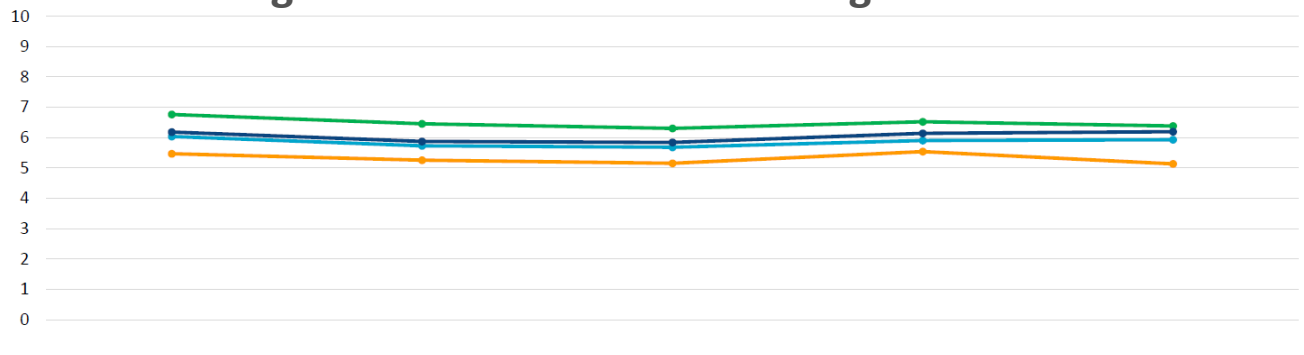
- This information will be made available to us once the embargo lifts

Key Points to Note

- Staff engagement has risen slightly within MTW, however communication barriers continue to impact staff involvement and advocacy. Comparison to local trusts will be available once the embargo lifts.
- With regards to improving retention, previous NSS results indicate that staff who feel more inclined to recommend their organization as a place to work and staff who feel more enthusiastic about going to work are more likely to stay (NHS England, 2024). We must therefore work to increase advocacy and motivation at MTW.

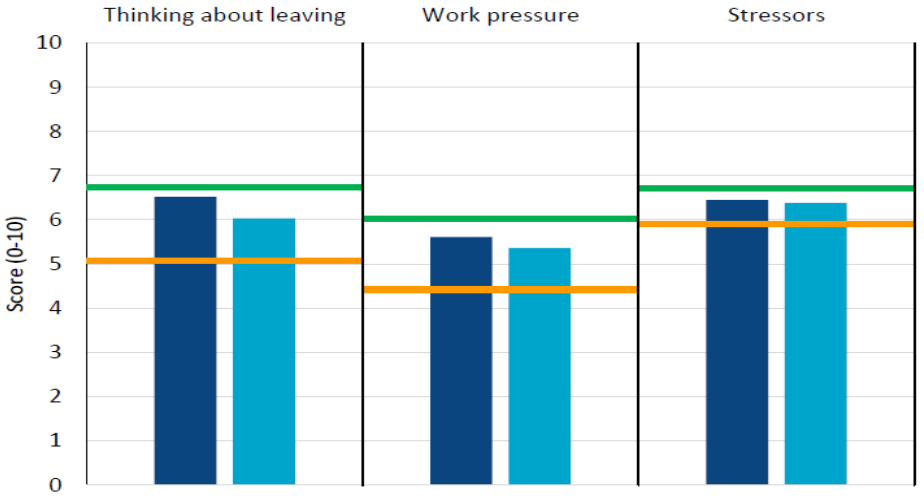
Morale

Long-Term Trends for Overarching Theme



	2020	2021	2022	2023	2024
Your org	6.18	5.87	5.84	6.14	6.19
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	3187	3377	2897	3461	3619

THEME BREAKDOWN



	Thinking about leaving	Work pressure	Stressors
Your org	6.52	5.62	6.45
Best result	6.73	6.03	6.70
Average result	6.04	5.36	6.38
Worst result	5.07	4.42	5.91
Responses	3604	3613	3611

Within MTW: Key Disparities

Bank vs Substantive:

- Bank staff positive scores (59.9%) were lower than our substantive scores (62.1%).

Divisions and Directorates:

- This information will be made available to us once the embargo lifts

Staff Groups:

- This information will be made available to us once the embargo lifts

Key Points to Note

- The 'Thinking about leaving' theme provides a good indication of whether staff would like to leave MTW or the sector, but requires additional data triangulation from other data we hold, including from our 'Leavers' Survey, to help us to identify the factors influencing turnover.
- Burnout from work pressure and stressors remain key factors generally impacting retention (NHS England, 2024).

Summary

- MTW scored above the national average for acute trusts in all People Promise themes, plus Staff Engagement and Morale. The Trust scored above the average for the Kent and Medway ICS in all themes except “We are a Team” (0.02 difference) and scored higher than all Acute Trusts in Kent and Medway in all themes. Similarly, MTW scored above the South East average in all themes except “Reward and Recognition” (0.03 lower), “We Work Flexibly” (0.02 lower) and “We are a Team” (0.11 lower).

- Our scores reflect that whilst the NHS and MTW a have been significantly impacted by financial constraints and operational pressures over the past year, the dedicated work that we have done to improve the experience of our staff is having a positive impact. Projects on Flexible Working, supported by the People Promise Exemplar, and work to improve morale through reward and recognition such as the reintroduction of Long Service Awards are starting to show positive effect in the scores

- The focus on people promise work has seen a reduction in staff turnover to below the breakthrough objective target, and continued focus on this work is key to ensure that this target continues to be met, supporting our service delivery and business development goals, and maintaining a skilled workforce. The areas that matter most to our staff - including EDI, flexible working, feeling recognised and rewarded, and experiencing consistent communications within our Trust - all present themselves as key areas for continued improvement. We must also continue to focus on improving other critical areas of concern including reducing instances of unwanted sexual behaviour, continuing to improve the value that our appraisals add to career development, and embedding good team work and line management across the Trust.

- Staff feeling trusted to do their work remains a key area of improvement - We need to look at how we can empower our staff across the trust, working with line managers and supervisors to ensure they are fostering a culture of autonomy and trust. The continued implementation of PFIS and Exceptional Leaders across the trust will give staff the opportunity to make suggestions to positively affect patient care and staff experience, and increased leadership attendance at the huddles would help staff feel more confident in raising issues without the need to be anonymous.

- We need to review the amount of paid overtime being worked by staff members and understand the underlying reasons for this.

- Bank staff satisfaction levels have dropped on all questions apart from ‘We work flexibly’ - listening events with this workforce would help understand the underlying issues for bank staff as we do not want to lose this valuable staff group. Quarterly Staff Experience Survey results have indicated that failure to increase bank pay rates has impacted negatively on bank staff.

Next Steps

- Staff survey results will be shared with each division through the People Business partners, supporting them to understand the data and celebrate successes, and also to help us to understand communication and engagement needs necessary for creating People and OD Plans that improve priority areas.
- The Staff Impact Council, comprising a diverse range of staff from across the organisation, will play a key role in helping to interpret the data and develop ideas and actions across the people promise themes.
- P&OD plans will be co-designed within teams supported by their People Business Partners and taking into account other people related data (but not in total isolation from directorate or divisional priorities), using the different engagement approaches identified as being necessary for different divisions, roles and identities.
- The support of the Executive Leadership Team will be crucial to increasing the uptake of critical staff support interventions developed, deployed and scaled over the coming year. It is therefore important that we assess how we, in our respective capacities, can actively support the programme of work.
- We anticipate that the coming year will continue to be as, if not more challenging, MTW leaders will need to proactively engage with initiatives that will ameliorate potential damage to MTW's staff experience. We will bring a paper back to ETM to discuss this further.
- More in-depth data analysis is underway following embargo lifting which will include Divisional level data and analysis of experience by staff group.
- WRES and WDES information will feature within the EDI update scheduled for this committee in April 2025.

Survey Dissemination Timeline

Timescale	Action	Owner
12/3/25	People Promise overview for whole Trust including review of progress since 2023 to ETM	Author: Harriet Barkeley (HB) Presenter: Helen Palmer
13/3/25	Embargo lifts and Trust wide communication created (including electronic noticeboards in staff restaurants, the Pulse, CEO update, Team Brief plus external communications through MTW social media channels and used within Attraction campaigns	HB & Comms Team
13/3/25	Analysis of Trust wide and Divisional data begins Theming of free text comments begins	HB & BI Team
20/3/25	Divisional data provided to People Business Partners & Divisional Triumvirates Free text comments provided to PBPs	HB HB
21/3/25	People Promise overview for whole Trust including review of progress since 2023 presented to People and OD Committee	Author: HB Presenter: Natalie Adams
End March	Infographic depicting Trust position created (see next slide)	HB & Comms Team
Mid-End April	People & OD Plans created in response to NSS data triangulated with other workforce data using Plan on a Page structure (see next slide) Local infographics created (dependent on comms availability)	PBPs & Triumvirates PBPs, Triumvirates & Comms Team
End April	Deep dive of data prepared for ETM & made available to People and OD Committee (including Divisional action plans)	HB, PBPs & HP

Survey Dissemination Timeline

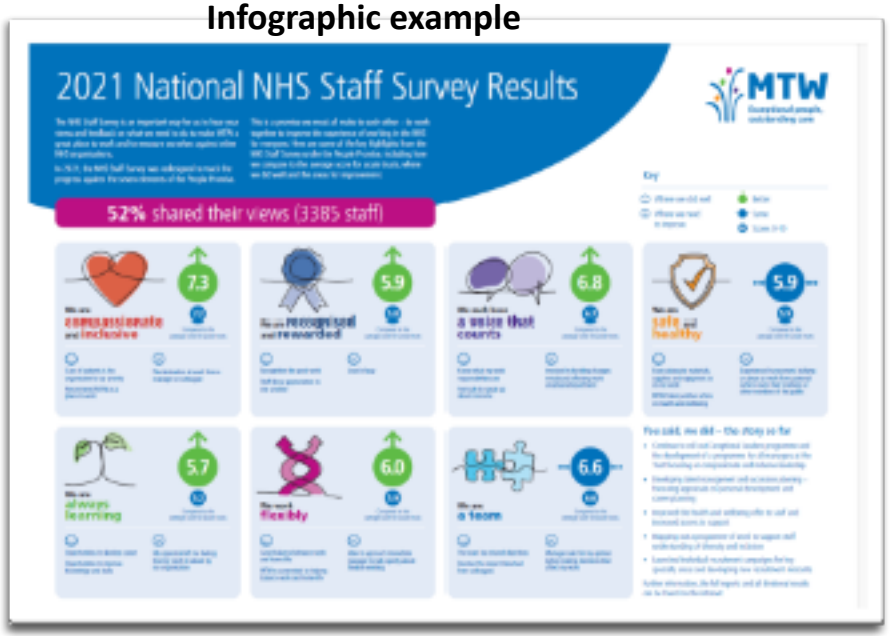
Timescale	Action	Owner
End April	Trust wide and Divisional data overview and action plans available for Trust Board	HB & HP
July/August	ETM review progress of Divisional action plans in preparation for launch of 2025 survey	PBPs & HP
August/Sept	Prepare for 2025 survey	HB, PBPs & BI Team
End Sept/early Oct	2025 survey launch	HB & PBPs

Plan on a Page template

Ongoing Communication

To ensure the staff survey - and the importance of staff voice - stays at the forefront of the minds of all staff, regular communications will be scheduled throughout the year. This will include showcasing the changes Divisions have made following staff feedback.

Infographic example



Key Questions for the Committee

1. Does the Committee have any thoughts on the overarching results and our ranking within the South East Region?
2. Is the Committee assured that we are taking appropriate steps to disseminate the data appropriately, utilising a range of communication styles to reach our diverse workforce?
3. What may leadership need to mindful of in order to give future assurance of maintaining current levels of staff experience across MTW?

Title of report	**Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)**					
Board / Committee	**Trust Board Meeting (Part 1)**					
Date of meeting	18th March 2025					
Agenda item no.	03-16					
Executive lead	Rachel Jones. Director of Strategy, Planning and Partnerships					
Presenter	Rachel Jones. Director of Strategy, Planning and Partnerships					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
☐		☐	☐	✓	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This is the monthly update on the activities and focus within the Integrated Care Board and West Kent Health Care Partnership.
Any items for formal escalation / decision	None
Appendices attached	ICB/HCP slide pack

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR 5: If we do not work effectively as a system, patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals.
Links to Corporate Risk Register (CRR)	N/A
Compliance / Regulatory Implications	N/A

NHS
Maidstone and Tunbridge Wells NHS Trust

ICB and West Kent HCP update

March 2025

Exceptional people, outstanding care

ICB/ System news

- The ICB has bought forward the provider Operational Plan submissions, due on 20th March, to the 13th March in order to give more opportunity to finalise the system submission.
- NHSE have called a CEO and Chair meeting on 13th March review the current outputs of the headline planning submissions which are unaffordable and do not deliver the expected improvements. This is likely to impact the current assumptions being used in 25/26 planning and we await the outcome.
- There has been, and will likely continue to be, significant change within NHSE. The CEO, CFO, COO and CDO all stepping down by April. Sir Jim Mackey and Dr Penny Dash will commence as the interim CEO and chair respectively.
- Wes Streeting has announced plans to reduce the NHSE & DHSC workforce by 50%.
- It has been confirmed that Kent and Medway councils will not be progressing with devolution in 2025 to become strategic authorities however will need to progress to a Unitary Authority. Elections will continue as planned in May 2025

West Kent HCP

- The Executive group meeting took place on 13th March 2025 and will focus on our local updated health inequalities needs analysis and the work programme for 25/26.

- The better use of beds programme in West Kent has re-mobilised and is focussed on current performance in each domain and an action plan for 25/26.

- The HCP is working closely with the ICB on the establishment of 24/7 Urgent Treatment Centres involving the GP out of hours service. The current planned start is April 2025.

- The HCP is undertaking a governance and structure review, including meetings, membership, responsibilities in line with the priorities for 25/26.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services. 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 along with community mental health trained staff.
- *Demand pressures* - Pressures across WK system arising from range of sources including: planned care backlog, demand for urgent care services, reduced out of hospital capacity in pathway 1 and pressure in primary care services.
- *Finance pressures* – the system pressures and focus on financial balance is likely to have an impact on the development activities of the HCP for 25/26, specifically in delivery of integrated neighbourhood teams.

Title of report	**Six monthly review of the red risks**					
Board / Committee	**Trust Board Meeting (Part1)**					
Date of meeting	27th March 2025					
Agenda item no.	03-18					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Jo Haworth, Chief Nurse					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	✓	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
					
✓	✓	✓	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration	This report provides the group with an update on those risks rated 15+ as at 19 March 2025. Key changes since the last report in July are highlighted within the body of the report.
Any items for formal escalation / decision	There has been an increase in the number of risks rated 15+. • 25 new risks added • 4 risk increased in risk score to 15+ • 18 risks rated 15+ open over 12 months • 9 risks downgraded from 15+ to a moderate or low score • 10 risks previously rated 15+ now closed
Appendices attached	• Red Risk Report March 2025 • Appendix 1 – Red risk register 19.03.2025

Report previously presented to:		
Committee / Group	Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	All of the Board Assurance Framework Risks
Links to Trust Risk Register (TRR)	This report provides an update on the Trust risk register.
Compliance / Regulatory Implications	Specified within the detail of the risks

Red Risk Report

Board of Directors
March 2025

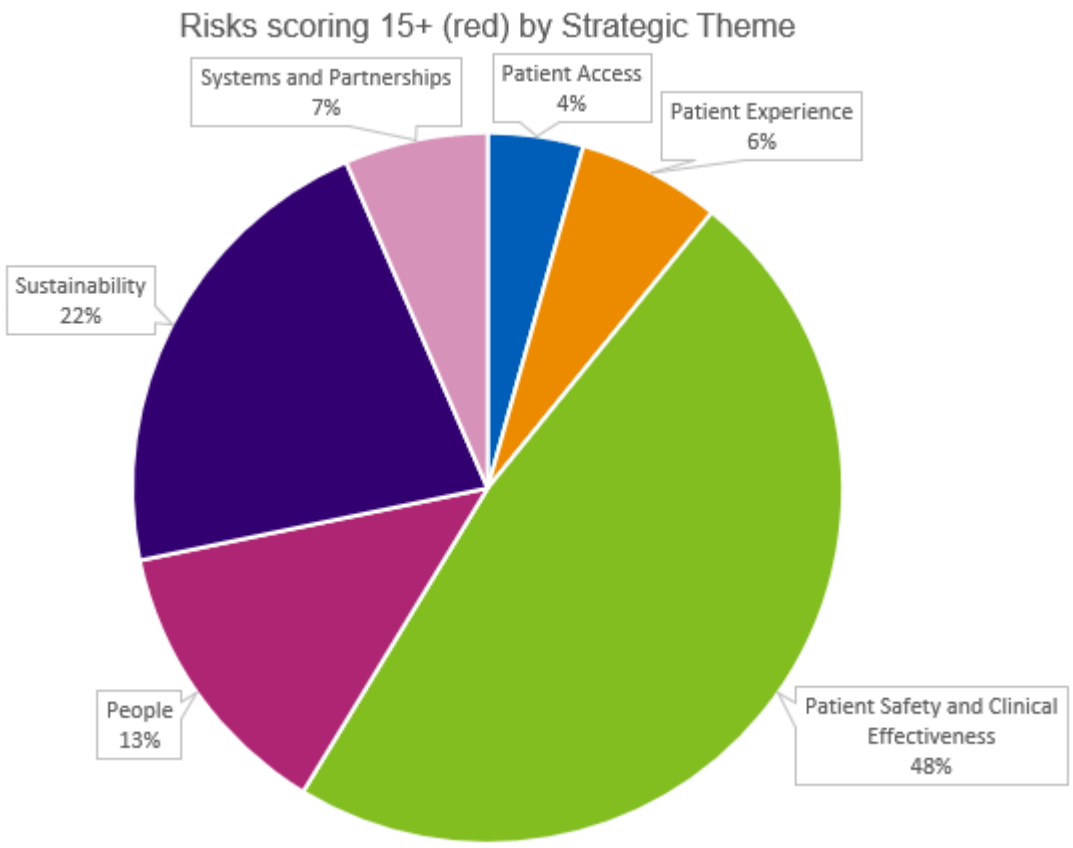
Author: Rhiannon Adey – Head of Risk Management

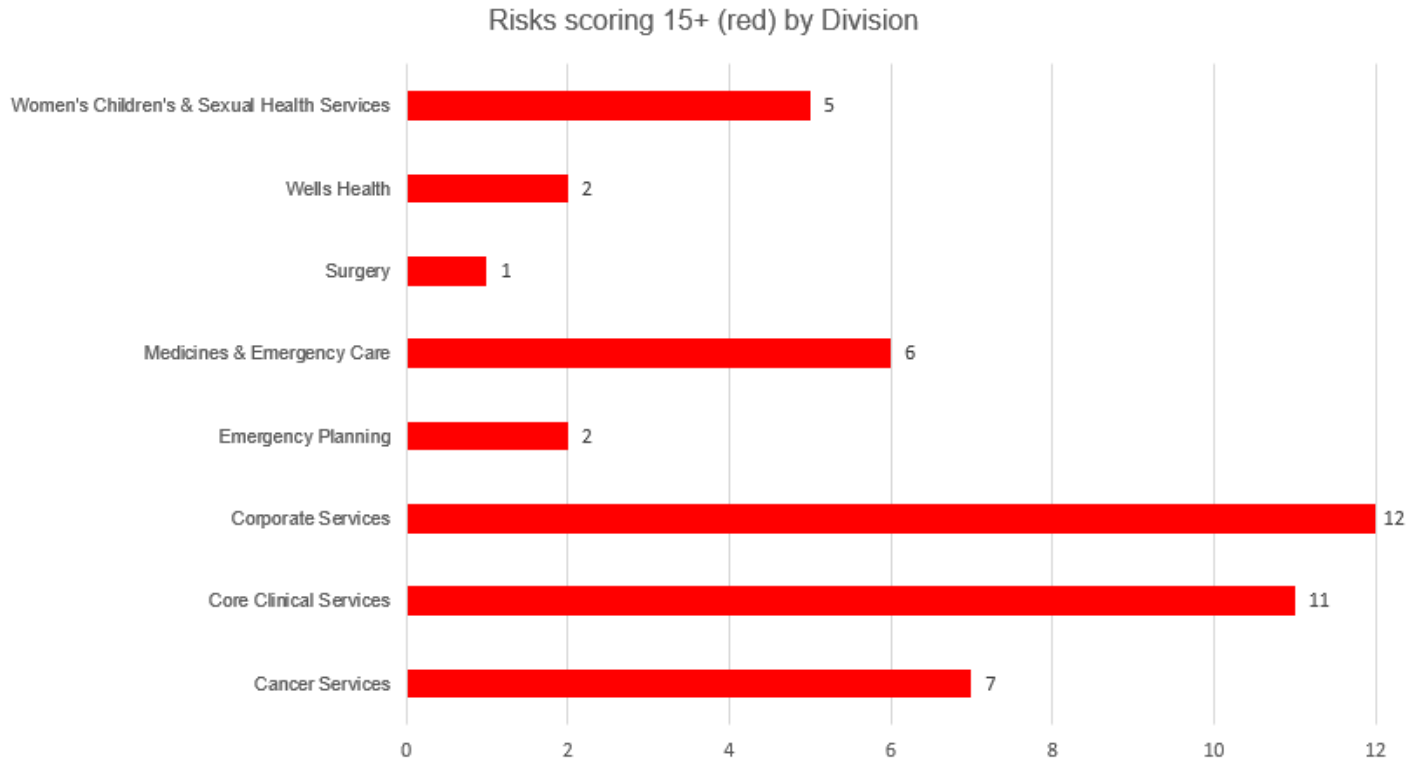
MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Trust Risk Profile

As of 19 March 2025 there were 256 open risks on the Trust risk register with 46 of these currently scoring 15+ (red).





Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Target score	Target date
802	Significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment.	10 =	10 =	10 =	10 =	16 ↑	16 =	16 =	16 =	16 =	16 =	20 ↑	20 =	4	30/08/25
3051	Lack of resilience of TWH access control door system due to inappropriate back ups, single server and lack of suitable cyber security protections	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	5	28/02/25
3394	Failure to comply with National Hip Fracture Database audit requirements												20 New	8	30/06/25
1310	Acute general x-ray at TWH exceeded end of life; causing increase of downtimes; acute and inpatient flow; increase of patients requiring repeated imaging; additional exposure to radiation	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	30/04/25
2945	Fluoroscopy room 27 at TWH exceeded end of life; failure would impact Fluoroscopy services for inpatient and elective pathways and complete suspension of proctogram service.	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	13/06/25
2947	Mammography equipment at the TWH site exceeded end of life; this has resulted in degrading imaging quality and increased downtime, TWH unable to support Breast screening programme	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	30/04/25
3096	Risk of increased staff turnover/ sickness/ negative impact on wellbeing across Cellular Pathology- all roles.	8 New	8 =	8 =	8 =	16 ↑	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	30/05/25
3244	Elective CT scanner exceeded end of life; failure would impact Virtual Colonoscopy and CT guided biopsies							8 New	8 =	16 ↑	16 =	16 =	16 =	4	31/03/26
3243	Acute general x-ray at MGH exceeded end of life; causing increase of downtimes; acute and inpatient flow; increase of patients requiring repeated imaging; additional exposure to radiation								16 New	16 =	16 =	16 =	16 =	4	31/03/26
3344	Elective general x-ray at TWH exceeded end of life; causing increase of downtimes; impact on patient flow; turnaround times; increase of patients requiring repeated imaging; additional exposure to radiation.										16 New	16 =	16 =	4	02/01/26
3342	Elective general x-ray at MGH exceeded end of life; causing increase of downtimes; impact on patient flow; turnaround times; increase of patients requiring repeated imaging; additional exposure to radiation.										16 New	16 =	16 =	4	02/01/26
3288	Low ligature risk room out of action due to damage caused by previous occupant								16 New	16 =	16 =	16 =	16 =	6	28/02/25
3294	Lack of consultant cover in EGAU and Ward 33 as consultants are covering maternity, EGAU and ward 33								16 New	16 =	16 =	16 =	16 =	8	27/05/25
1270	Lack of medical devices training in the Trust - training for medical devices for nursing and support staff is not mandatory, there is no corporate record of individual's device training.	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	29/04/25
3069	Chemotherapy e-prescribing	12 =	12 =	16 ↑	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	30/06/25

Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Target score	Target date
3395	D-Dimer cut off valve incorrectly assigned since July 2020. Utilised for low-risk patients with Wells score to be discharged with no need for further investigation. False negatives have been authorised with potential for patients to have been discharged from A&E with a VTE.												16 New	8	30/05/25
3365	Lack of suitable equipment for radiation survey assessments.											16 New	16 =	4	30/04/25
1286	Statutory Compliance	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	12	31/10/25
1304	There is a risk of avoidable VTEs for MTW patients linked to our E-Risk assessment and Anticoagulation prescription processes	9 =	9 =	9 =	16 ↑	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	14/08/25
2980	Risk of Healthcare associated C. difficile and breaching national limits of number of cases	16 ↓	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	12	31/03/25
3070	Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	12	31/03/25
3245	Interventional Radiology room at the TWH site exceeded end of life with detectors no longer available; will lead to reduced Trust overall capacity and no IR service at TWH for acute bleeds.							8 New	8 =	12 ↑	12 =	12 =	16 ↑	4	31/03/26
3112	Lack of follow up of diagnostic reports		16 New	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	4	01/04/26
3113	There is a risk that the Trust will not have enough cash to meet its commitments resulting suppliers not being paid and the Trust not meet its BPPC (Better Payment Practice Code) target.		16 New	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	31/03/25
3144	Trust may be subject to enforcement action from the ICO if we fail to comply with data protection legislation by breaching the disclosure timeframe for Subject Access Requests				9 New	9 =	9 =	9 =	9 =	9 =	16 ↑	16 =	16 =	6	31/07/25
3328	Lack of Occupational Health (OH) capacity, as there are not enough OH nurses to meet the increasing demands placed on the service									20 New	20 =	16 ↓	16 =	6	11/12/25
1150	Impact of increase in number of inpatients with mental health needs / neurological deficit.	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	9	31/07/25
2981	Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	30/09/25
3161	Paper Based Systems and Tomcat not Compatible with other IT Systems						16 New	16 =	16 =	16 =	16 =	16 =	16 =	6	25/01/25
3355	Failing EBUS Image Processor MGH										16 New	16 =	16 =	4	31/03/25
3362	Medicine Follow Up Waiting Lists										16 New	16 =	16 =	6	31/03/25

Risk movement tracker (15+) – last 12 months

Risk No.	Risk Title	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Target score	Target date
3209	The risk is personal injury through refusal to wear Safety goggles when using holmium laser. (2 surgeons reasons for not wearing)							16 New	16 =	16 =	16 =	16 =	16 =	4	30/05/25
3130	There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)			15 New	15 =	15 =	15 =	15 =	16 ↑	16 =	16 =	16 =	16 =	8	07/04/25
3253	Lack of Resilience With Security Systems Contractor							15 New	15 =	15 =	15 =	15 =	15 =	6	30/09/25
1182	Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience	12 =	15 ↑	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	3	31/12/26
3269	Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus								15 New	15 =	15 =	15 =	15 =	6	28/02/24
3368	Lilie - Sexual Health patient admin system remains unsupported. There is a risk that should our system fail the supplier is unable or unwilling to fix the issue.											15 New	15 =	6	31/03/25
2998	Failure of the CT could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the CT is unavailable.	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	01/09/25
3000	Failure of LA1C could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the linac is unavailable.	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	6	28/03/25
3300	Patients under the care of WK Melanoma Consultant may have delays to first Oncology OPA, FUP review, management of treatment due to unplanned absence of consultant.								15 New	15 =	15 =	15 =	15 =	4	28/02/25
3157	Due to the number of Virtual Servers being hosted at TWH on aging infrastructure, we will run out of available Compute and will be unable to build any new virtual servers which will limit the services we can provide to the Trust.					15 New	15 =	15 =	15 =	15 =	15 =	15 =	15 =	1	11/04/25
3274	Patients across the Trust are not receiving timely Best Interest Assessments from the Local Authority resulting in Urgent Authorisations lapsing and unlawful deprivations of liberties.								15 New	15 =	15 =	15 =	15 =	10	28/11/25
3043	Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space.	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	12	31/03/25
3326	Should the blood issue fridge fail at Fordcombe hospital there is no back up which would result in failure of cold chain and therefore patient safety would be compromised									15 New	15 =	15 =	15 =	5	30/04/25
2943	Nuclear Medicine SPECT/CT at TWH exceeded end of life; failure would prevent services at TWH site, reduction of Trust capacity, lack of specialised service for patients unable to be transferred to MGH and paediatrics and loss of service continuity for MGH site.	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	15 ↑	15 =	15 =	15 =	3	31/03/26
3389	Lengthy waits for IG approval for research and innovation projects is significantly impacting on the ability of staff to open trials and progress innovation projects.												15 New	4	04/04/25

New Risks rated 15+ (Please see risk register in Documents for full details including controls and actions)

Risk No.	Risk Title	Opened	Initial score	Current score	Target score	Target date
3144	There is a risk that the Trust may be subject to enforcement action from the Information Commissioner if we fail to comply with data protection legislation by breaching the disclosure timeframe for Subject Access Requests	23/07/24	12	16	6	31/07/25
3157	Due to the number of Virtual Servers being hosted at TWH on aging infrastructure, we will run out of available Compute and will be unable to build any new virtual servers which will limit the services we can provide to the Trust.	21/08/24	15	15	1	11/04/25
3161	Paper Based Systems and Tomcat not Compatible with other IT Systems	02/09/24	16	16	6	25/01/25
3209	The risk is personal injury through refusal to wear Safety goggles when using holmium laser	01/10/24	16	16	4	30/05/25
3243	Acute general x-ray at MGH exceeded end of life; this is causing increase of downtimes and acute and inpatient flow and increase of patients requiring repeated imaging and additional exposure to radiation	21/10/24	20	16	4	31/03/26
3244	Elective CT scanner (Oncology Maidstone) exceeded end of life; failure would impact Virtual Colonoscopy; CT guided biopsies (and cancer pathways); lose on site contingency for MGH ED CT scanner which supports ED and Stroke pathways	21/10/24	16	16	4	31/03/26
3245	Interventional Radiology (IR) room at the TWH site exceeded end of life with detectors no longer available; if fails, will lead to reduced Trust overall capacity and no IR service at TWH for acute bleeds (ED or theatres).	21/10/24	16	16	4	31/03/26
3253	Lack of Resilience With Security Systems Contractor	24/10/24	15	15	6	30/09/25
3269	Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus	04/11/24	16	15	6	28/02/24
3274	Patients across the Trust are not receiving timely Best Interest Assessments from the Local Authority resulting in Urgent Authorisations lapsing and unlawful deprivations of liberties	06/11/24	20	15	10	28/11/25
3288	Low ligature risk room out of action due to damage caused by previous occupant	11/11/24	12	16	6	30/04/25
3294	Lack of consultant cover in EGAU and Ward 33 as consultants are covering maternity, EGAU and Ward 33	19/11/24	16	16	8	27/05/25
3300	Patients under the care of WK Melanoma Consultant may have delays to first Oncology OPA, FUP review, management of treatment due to unplanned absence of consultant.	25/11/24	20	15	4	28/02/25
3326	Should the blood issue fridge fail at Fordcombe hospital there is no back up which would result in failure of cold chain and therefore patient safety would be compromised	09/12/24	25	15	5	30/04/25
3328	Lack of Occupational Health (OH) capacity, as there are not enough OH nurses to meet the increasing demands placed on the service	11/12/24	20	16	6	11/12/25
3342	Elective general x-ray at MGH exceeded end of life; this is causing increase of downtimes and acute and inpatient flow and increase of patients requiring repeated imaging and additional exposure to radiation	02/01/25	16	16	4	02/01/26
3344	Elective general x-ray at TWH exceeded end of life; this is causing increase of downtimes and subsequent impact on patient flow and turnaround times and increase of patients requiring repeated imaging and additional exposure to radiation.	02/01/25	16	16	4	02/01/26
3355	Failing EBUS Image Processor MGH	16/01/25	16	16	4	31/03/25
3362	Medicine Follow Up Waiting Lists	29/01/25	16	16	6	31/03/25
3365	Lack of suitable equipment for radiation survey assessments to test Radiation Shielding as part of legal critical examination or to ascertain current shielding.	04/02/25	16	16	4	30/04/25

New Risks rated 15+ (Please see risk register in Documents for full details including controls and actions)

Risk No.	Risk Title	Opened	Initial score	Current score	Target score	Target date
3368	Lilie - Sexual Health patient admin system remains unsupported. There is a risk that should our system fail the supplier is unable or unwilling to fix the issue.	06/02/25	15	15	6	31/03/25
3389	Lengthy waits for IG approval for research and innovation projects is significantly impacting on the ability of staff to open trials and progress innovation projects.	04/03/25	15	15	4	04/04/25
3394	Failure to comply with National Hip Fracture Database audit requirements	11/03/25	20	20	8	30/06/25
3395	D-Dimer cut off valve incorrectly assigned since July 2020. Utilised for low-risk patients with Wells score to be discharged with no need for further investigation. False negatives have been authorised with potential for patients to have been discharged from A&E with a venous thromboembolism.	06/03/25	20	16	8	30/05/25

Escalated Risks (Please see risk register in Documents for full details including controls and actions)

Risk No.	Risk Title	Reason for escalation	Opened	Initial score	Current score	Target score	Target date
802	There is a risk of significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment. Resulting in significant delays in patient cancer diagnosis and treatment and can have outcome implications.	Continual significant delays occurred to patient pathways with 3 Trusts having rescheduled appointments and multiple complaints received. Discussed by CCS triumvirate and divisional largest project and focus of discussions across Trusts- risk rating increased as quantity of specimens broken through 8000 in Q3 25/26 and turnaround times decreased to lowest levels.	22/08/18	20	20	4	31/05/25
3096	Risk of increased staff turnover/ sickness/ negative impact on wellbeing across Cellular Pathology- all roles.	6 weeks behind on reporting cases in some disciplines. Multiple complaints received.	12/04/24	20	16	4	30/05/25
1304	There is a risk of avoidable VTEs for MTW patients linked to our E-Risk assessment and Anticoagulation prescription processes	Risk increased due to number of incidents and the inability to mandate prescribing of prophylaxis on ePMA.	01/03/23	16	16	4	14/08/25
2943	Nuclear Medicine SPECT/CT at TWH exceeded end of life; failure would prevent services to operate at TWH site, reduction of Trust capacity, lack of specialised service for patients unable to be transferred to MGH and paediatrics and loss of service continuity for MGH site.	Urgent Medical Device Correction notice received from GE Healthcare relating to the gamma camera at TWH. There is a safety issue with the risk of life-threatening injury. The detector support mechanism needs to be inspected by GE to determine if our system is affected by the fault. Once inspected they will either be issued with a certificate stating they are able to use the gamma camera, or they will need to return to fix the issue. They have given no time frame on this and will call back to book a slot for the engineer to visit. Escalated to division and triumvirate by NM. Fortunately, the camera at MGH, being a different newer model, is unaffected.	03/09/22	12	15	3	31/03/25

Risks rated 15+ open over 12 months

Risk No.	Risk Title	Opened	Initial score	Current score	Target score	Target date
802	Significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment.	22/08/18	20	20	4	31/05/25
1150	Impact of increase in number of inpatients with mental health needs / neurological deficit.	21/04/22	20	16	9	01/04/25
1182	Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience.	12/07/22	15	15	3	31/12/26
2943	Nuclear Medicine SPECT/CT at TWH exceeded end of life; failure would prevent services to operate at TWH site, reduction of Trust capacity, lack of specialised service for patients unable to be transferred to MGH and paediatrics and loss of service continuity for MGH site.	03/09/22	12	15	3	31/03/25
1270	Lack of medical devices training in the Trust - training for medical devices for nursing and support staff is not mandatory, there is no corporate record of individual's device training.	23/02/23	16	16	4	29/04/25
1304	There is a risk of avoidable VTEs for MTW patients linked to our E-Risk assessment and Anticoagulation prescription processes	01/03/23	16	16	4	14/08/25
1286	Statutory Compliance	21/03/23	16	16	12	31/10/25
1310	Acute general x-ray at TWH exceeded end of life; causing increase of downtimes; acute and inpatient flow; increase of patients requiring repeated imaging; additional exposure to radiation	03/04/23	20	16	4	30/04/25
2945	Fluoroscopy room 27 at TWH exceeded end of life; failure would impact Fluoroscopy services for inpatient and elective pathways and complete suspension of proctogram service.	03/04/23	16	16	4	13/06/25
2947	Mammography equipment at the TWH site exceeded end of life; this has resulted in degrading imaging quality and increased downtime, TWH unable to support Breast screening programme	03/04/23	16	16	4	31/03/25
2981	Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site	03/08/23	12	16	8	01/03/25
2980	Risk of Healthcare associated C. difficile and breaching national limits of number of cases	03/08/23	20	16	12	31/03/25
3000	Failure of LA1C could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the linac is unavailable while repaired. If repair is not possible the disruption would be extensive at both Canterbury and Maidstone sites and would be non-sustainable in the long term.	04/09/23	9	15	6	28/03/25
2998	Failure of the CT could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the CT is unavailable while repaired. If repair is not possible the disruption would be extensive at both Canterbury and Maidstone sites and would be non-sustainable in the long term.	01/09/23	15	15	5	01/09/25
3043	Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space.	02/01/24	15	15	12	31/03/25
3051	Lack of resilience of TWH access control door system due to inappropriate back ups, single server and lack of suitable cyber security protections	09/01/24	20	20	5	28/02/25
3070	Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI	21/02/24	20	16	12	31/03/25
3069	Chemotherapy e-prescribing	21/02/24	12	16	8	30/06/25

Downgraded Risks previously rated 15+

Risk No.	Risk Title	Reason for downgrade	Initial score	Current score	Target score	Target date
3128	Risk that research patients will not receive treatment via clinical trials as there is a significantly reduced aseptic service resulting in patients not receiving clinical trial treatments as standard care	Aseptic unit support for clinical trials is improving. Two studies per month are being taken off the list of paused studies and opened. It is slow progress but an improving picture.	20	12	6	05/05/25
3062	Patient information is vulnerable as maternity diaries are held on NHS Mail which isn't intended for confidential patient information. No back up of data and may be subject to cyber-attack	NHSmail is approved for the exchange of clinical/sensitive data in clearly defined scenarios, under the NHSmail Acceptable Use Policy. Users are able to restore their own deleted data for a duration of up to 180 days after deletion as per the NHSmail data retention policies. After this time, it may be possible to recover a whole mailbox by logging a support ticket but individual item level recovery may not be possible.	16	6	3	27/05/25
3023	Haematology patients are at risk of being lost to follow up due to current booking processes and pathway management.	Waiting list validation exercise has now been completed, a full time post as been appointed to to review and implement new processes in CAU to reduce risk of lost to follow up. Ongoing work with sub speciality teams to support additional ad hoc capacity, and locum consultant still in place to aid clinical reviews and long waiters.	16	12	8	02/05/25
3042	Issues at East Kent Foundation Trust hospital relating to time form referral to reporting of scans and histologist	Radiology meeting with EKHUFT, improvement in reporting. 3-4 radiologists recruited and significant improvement of reporting times. More staff to be recruited. Biopsies remain issue but improving due to recruitment. Escalation pathways improved.	16	6	3	06/06/25
1233	Equipment failure risk due to age of Endoscopy Wassenburg decontamination	PlasmaTYPHOON washers have been installed. Wassenberg washers on the Trust Capital replacement list.	20	12	6	31/07/25
1289	Risk of patient harm linked to the backlog of patients awaiting review in the Virtual Stroke Clinic	Directorate at maintenance level for hot list, and is expected to be at maintenance level for cold list within the next 7 days. There are some actions that need to be taken so that the clinical overview of this list is distributed between the consultant team.	12	6	6	21/05/25
2995	Shortage of Defibrillators	3 x defibs have been ordered; awaiting delivery. Full business case for AED replacements is being worked on.	20	10	5	30/06/25
3065	Suboptimal outcomes within Maternity - review of patient safety incidents where staff have not followed Intelligent Intermittent Auscultation guidance	Trust guideline updated and comprehensive training programme rolled out	15	8	4	03/02/25
3086	Our SACT advice line is not provided appropriate clinical advice or being managed by SACT trained professionals which could put patients at serious of harm	All chemo SACT nurses have been retrained and signed off. ICI Task and finish group closed with outstanding Audit actions moved to SACT local working group meeting. Monitoring of InPhases over the last 6 months, no moderate harm or above incidents relating to SACT triage phone.	15	10	5	30/05/25

Closed Risks

Risk No.	Risk Title	Reason for closure	Initial score	Current score	Target score
3063	There is a risk to the delivery of the community midwifery service due to vacancy and long term absence	Rewritten following midwifery workforce reviews. Community midwifery staffing still inadequate, so replaced with risk 3269 following discussions at Maternity and Neonatal Improvement Committee.	16	16	8
3127	Lack of appropriate placement for child or young person requiring enhanced care observation and no discharge profile available when medically fit for discharge	Patient discharged - no current MH patients requiring additional enhanced care on the unit. To reopen if other patients attend	20	9	9
2948	Risk that MTW IT systems will be slowed / have functionality issues secondary to Server Processing Capacity	System fully replaced and risk mitigated.	25	5	5
3009	Due to a planned reduction in community clinic space within the primary care setting, women and pregnant people will not be able to access care. This will result in reduced opportunities to assess the wellbeing of mother and baby.	Thornhill clinic is remaining. Staff at the Ark have been relocated successfully to Abbey Court. Currently no risk to care provision.	20	10	10
3052	TWH access control door system is not resilient	Information transferred to risk 3051	20	20	5
3053	TWH access control door system lacks suitable cyber security protections	Information transferred to risk 3051	20	20	5
3123	There is a risk that patients will remain in hospital whilst no longer fit to reside as the non-recurrent funding providing out of hospital capacity for Hilton will end in September	Hilton contract has now ceased - new risk articulated relating to KEAR service 3186	16	6	6
2952	There is a facilities risk (affecting ICT infrastructure) that due to inadequate air conditioning capability within the Main ICT server room the server system could overheat causing a loss of ICT across the Trust	Risk resolved in totality	20	10	10
1202	Industrial Action	All pay awards for Medical and Dental AfC and VFM staff have now been paid implementing the 23/24 and 24/25 pay awards, with the arrears for AfC staff at band 8 and 9 who achieved the new 2 year incremental pay point backdated to 1/4/24 now run in ESR and payroll and will be paid in November. All unions have now indicated that no further industrial action is planned given awards in respect of 23/24 and 24/25. 25/26 processes have yet to be confirmed, but should industrial risk materialise this will be set up as a new risk as agreed. Having reassessed the risk as unlikely (2) and and any impact as moderate (3) given this with a score of 6 and now below the target of 12, this risk is now being closed.	20	6	6
3122	There is a financial risk to the Trust as Trust/private ambulances are being funded as a cost pressure to support patient discharges	Reduced ambulance service and have sent booking guidance. Met with G4S and ICB are challenging management of the contract which has reduced the number of issues.	16	3	3

Recommendations

- Consider whether the risks included within this report are the most significant risks to the Trust
- Ensure that progress is recorded against each of the risks rated 15+ (red)
- Review Appendix 1 to ensure that each risk rated 15+ has adequate actions recorded and consider whether the controls in place have reduced the current risk score.

Title of report	**Going Concern basis for Annual Accounts 2024/25**					
Board / Committee	**Trust Board 'Part 1' Meeting**					
Date of meeting	27th March 2025					
Agenda item no.	03-20					
Executive lead	Steve Orpin, Deputy Chief Executive/Chief Finance Officer					
Presenter	Steve Orpin, Deputy Chief Executive/Chief Finance Officer					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
☐	☐	✓	☐	☐	☐

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Trust proposes to prepare its 2024/25 Accounts using the Going Concern basis as set out in the DHSC Group Accounting Manual. The assessment is set out in the paper below.
Any items for formal escalation / decision	The Trust Board is asked to review and confirm the Trust's plan to prepare the Trust's 2024/25 accounts on a going concern basis, as defined by the public sector interpretation of the requirements of the accounting standard.
Appendices attached	

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Audit and Governance Committee	5th March 2025	Recommendation to adopt the Going Concern basis for reporting 2024/25
Executive Team Meeting	18th March 2025	Recommendation to Trust Board to adopt the Going Concern basis for reporting 2024/25
Finance and Performance Committee	25th March 2025	Pending at time of paper publication

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates
Compliance /	Completion of the audited Annual Reports and Accounts (ARA) is a

Regulatory Implications	statutory requirements for NHS Trusts.

Going Concern

The DHSC Group Accounting Manual requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts. From para 4.19 it states:

‘‘For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern”.

In 4.24 “DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity”.

Trust Management will be assessing the Trust’s ability to continue for the foreseeable future in the light of the GAM guidance. The Trust is planning to compile the 2024/25 accounts on a “going concern” basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the Trust’s hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.
- National NHS Provider/Commissioner Planning guidance has been issued to Integrated Care Systems by NHSE that outlines the process and framework for funding arrangements within which NHS Commissioners and Providers will operate during 2025/26. Systems are working to agree planning positions in order to submit the final set of planning returns towards the end of March 2025.
- The Trust will be submitting a draft 5-year capital plan to the ICB which manages the overall resource level within the patch, now including IFRS 16 resource, with plans to be submitted in March 2025.
- The Trust is an active participant and fully engaged in financial planning within the ICS as well as locally within the West Kent Health and Care Partnership (HCP) locality and the Provider Collaborative.
- The Trust expects to have signed contracts in place for the provision of healthcare services in 2025/26. The Trust contracts will be held with the local commissioning bodies for patient care in Kent & Medway, Sussex, Surrey Heartlands and South East London. In line with changes in national guidance where specialised services are being delegated to local ICBs to commission, all regional contracts for Specialised Commissioning, Public Health and Health and Justice will now be varied into Host ICB contracts effective from April 2025. A small number of services will be retained as NHSE specialised services and will continue to be commissioned and contracted directly with NHS England. The planned financial regime provides certainty for income and cash flows for the full financial year 2025/26.
- The Trust does not consider that there are any material uncertainties to the going concern basis.

For these reasons, the Trust will prepare its Accounts using the going concern basis in line with the GAM guidance.

Recommendation

The Trust Board is asked to consider and approve the basis for preparing the accounts in 2024/25 using the going concern judgement.