MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 27TH MARCH 2025, 09.45AM, LECTURE ROOMS 1&2, EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Davis	Chief Operating Officer	(SD)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Chief Medical Officer / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Helen Palmer	Chief People Officer	(HP)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Becky Clewlow	Assistant Trust Secretary	(BC)
	Louise Thatcher	Trust Secretary	(LT)
	Rachel Thomas	Director of Maternity (for item 03-4 and item 03-14)	(RT)

03-1 To receive apologies for absence

Apologies for absence were received from Emma Pettitt-Mitchell (EPM), Non-Executive Director. It was also noted that Tasha Gardner (TG), Director of Communications and Corporate Affairs would not be in attendance.

03-2 To declare interests relevant to agenda items

No interests were declared.

03-3 To note progress with previous actions

There were no open actions.

Patient experience

03-4 Patient experience story

JH welcomed colleagues from the maternity services to the meeting, gave an overview of the reason for this story being presented and invited colleagues to listen to the patient's experience, which was shared through an audio presentation given by the service user. The Trust Board listened carefully to the presentation and expressed their gratitude for the service user for taking their time to make a record of their experience.

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

- That the service was extremely grateful to service user for sharing their story and noted that she has presented this to the Motherhood group, which is supporting Black maternal experiences. It was noted that the service user has also been generous in giving their time to coproduce information for mothers residing on the post-natal ward. RT noted that improving equity is a key component of the maternity improvement plan, and the story has been shared at the Maternity and Neonatal Care Oversight Group (MNCOG), the Nursing, Midwifery, Health Professionals and Pharmacy Board and is now being used as part of PROMPT Practical Obstetric Multi-Professional training. PROMPT training provides training for maternity units; helping midwives, obstetricians,

anaesthetists and other maternity team members be safe and more effective. The Trust Board heard that every member of maternity staff will also hear the recording and engage on a reflective session at the time of the training. It was noted that the service user had referred to denied pain relief, which is a theme noted in national reports regarding maternal care. It was noted that the maternity service has started a "Respectful Vaginal Examination" project, which educates staff about vaginal examinations, seeking patient's consent and developing equitable pain management plans. The maternity service has also commissioned specific training with inclusion and diversity experts from "Black Mamas Birth Village". Black Mamas Birth Village is a free community for Black pregnant women and new mothers to provide information and support through a birth person's journey from pregnancy to motherhood. The Trust Board heard that in response to the points raised within the recording, the maternity services team have developed an action plan which has been shared with the patient for their review and feedback.

- JO reiterated the gratitude to the service user who has demonstrated bravery in coming forward and noted that there may be other service users who may not feel able to do so. It was noted that it is important for the Board to acknowledge that similar experiences may be occuring in other areas within the organisation and it was noted that the story is being share widely across the Trust for teams to share and consider the way in which they engage with patients.
- A number of questions were raised by the service user and put to the Trust Board. The first question was: What are the KPIs (Key Performance Indicators) for measuring disparities in maternal health for ethnic minority women at MTW and how are the Trust taking steps to reduce those disparities? RT responded that there are no national KPIs, but the Trust now has a digital system, to be able to identify data which can be used to formulate KPIs and the importance of engaging with service users on understanding the performance they feel would be of benefit. SO noted that although the Trust has the ability to analyse data, he queried how it is being used to investigate further. RT noted that the data and metrics included within the Perinatal Quality Surveillance Model (PQSM) is reviewed, analysed and action plans are developed from this, using it as an oversight tool. It was also noted that the Local Maternity and Neonatal System (LMNS) were developing a dashboard to review KPIs, which included a detailed review of service users from the global majority and will be used to identify themes.
- The second question was: Would the Trust consider partnering with advisory boards made up of service users from ethnic minority backgrounds to ensure policies and interventions are genuinely inclusive? RT reiterated the some of the co-production work that has been undertaken with the service user, but also noted that the team are working with the Maternity Voices Partnership, but recognised the team can do more to engage with service users and noted there is ongoing work to encourage more people to engage with service, which was welcomed by Trust Board members.
- JH welcomed co-production, but noted that the burden of those responsibilities falls to service users who are unpaid and considered if there could be any recompense for people involved.
- The third question posed was: With the rise of digital technologies how is the trust ensuring that advancements in maternity care do not widen the gap for Black and ethnic minority women, particularly those from low-income families or those who don't speak English? RT noted that there is an element of the Maternity Service Three-Year Delivery Plan, which is dedicated to the improved use of technology. RJ referred to work being undertaken in the region on social prescribing, which supports service users with low incomes, who experience digital poverty and do not have access to technology and ensure they are not disadvantaged as a result of this.
- The final question put to the Trust Board was: I wanted to add that one of my suggestions was around the black motherhood conference which occurred last week. However, it was mentioned there was no budget given to attend this. I understand there are budget constraints, but black women are experiencing near misses and dying at a higher rate than their counterparts. If attending a conference to improve service standards and patient safety for ethnic minority women can't be facilitated then I wonder to what extend we are prioritising this issue. RT noted that this had been added to the training needs analysis and staff will be supported to attend the conference in the future and AD reiterated that the patient's story highlights areas of training, which needs to be invested in.
- WW reiterated thanks to the service user for their feedback and noted that best practice models of working with service users from the global majority are in place in London hospital's Maternity services and queried if there is an opportunity to link with them and learn from them. RT referred

to the work being undertaken in London Hospitals and noted she would make it an action point to link in with them.

- JH commented that training needs are often applied using a deficit model, in that training needs are recognised, when it has been identified that something has not been done as it should have and considered a more proactive approach to training needs analysis be undertaken. Also, that language used can identify service users as 'different' or 'other' and asked those attending to consider this.
- MC noted that the feedback received from the service user was regarding Doctors and sought confirmation that the action plan was relating to all staff. RT confirmed that the PROMPT training is for all staff and the services user's story, is also being shared with resident Doctors, as part of their training.
- AD invited the service user, who attended the meeting to comment on the discussion and the service user offered thanks. AD thanked the service user for taking the time to provide her feedback, join the meeting and for sharing her questions. AD also noted the work she was undertaking with the team and other organisations to support other services users.

Action: RT to link in with the London region's maternity services to learn from their work undertaken with patients from the global majority.

Reports from the Chair of the Trust Board and Chief Executive

03-5 Report from the Chair of Trust Board

AD referred to the submitted report and highlighted the following:

- Financial planning has been on the agenda for the Trust Board, developing its own plan, but also contributing to that of the system and the Trust's system partners. Financial planning has also been discussed at the South East Regional Chair's meeting and the National NHS leadership event for Chair's and Chief Executive Officers.
- AD then thanked the Trust Board team for their support in being appointed as Chair of East Kent University Hospitals NHS Foundation Trust (EKUFT).
- The Trust Board heard that AD remains fully committed to her role as the Chair of the Trust Board at this Trust and noted she will be giving up other commitments as a Non-Executive Director of Cambridge NHS Foundation Trust and as a trustee of St John's Ambulance Service, to facilitate this. AD informed the Trust Board that she will be as present and visible as she has been to date. It was noted that colleagues in this Trust and at EKUFT have commented on the opportunity for the two Trusts to work together.
- MS congratulated AD on her appointment and offered the Trust Board's support and understanding that this is a good opportunity to enhance system working.

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

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

- The Executive team remain committed to meet the significant financial challenges the organisation faces and noted 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. It was noted that this starts with staff experience at work and referred to the positive staff survey results, which contributes to the Trust's vision of providing exceptional care by outstanding people. MS referred to the patient first improvement system, in supporting our staff to improve their own work environments, by providing safe care and doing the right thing environmentally which is evidenced in the Trust's achievements in Getting it Right First time (GIRFT) and implementing "Martha's rule". The GIRFT programme is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. "Martha's Rule," is a patient safety initiative in England, which allows patients, families, and staff to request an urgent review from a critical care outreach team if they have concerns about a patient's deteriorating condition that they feel are not being adequately addressed.

Reports from Trust Board sub-committees

03-7 Quality Committee, 19/03/25

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

- The Committee heard from the clinical and managerial leaders from the Kent and Medway Pathology Network (KMPN) and the work being undertaken to progress the case for change. It was noted that there is a commitment from the clinical teams to achieve this project, with a huge amount of intentional and discretionary effort to promote patient safety. It was noted that some frustration was articulated by the team in the system's ability to achieve the outcome of the establishment of a single governance system in the first instance and they requested that Non-Executive Directors in the system support this work in order to achieve its completion. The Trust Board heard that the Committee were supportive of the project.
- The Trust Board also heard that there had been a reduction in patient harm, through the reduced number of hospital-acquired pressure ulcers and falls. The Committee were informed about the "Relatives clinic", which offers protected time for families and carers to speak with the team of clinicians involved in their loved one's care. MC noted that those of us who have had experience of a family member or loved one in hospital would welcome being able to speak with all clinicians involved in their care at one time. The initiative has been positively received by carers and family members to date, but has not formally captured with patient experience surveys.
- JH felt there may be an opportunity to develop a research project regarding to the Relative's clinic which could lead to the publication of a paper and JH agreed to discuss this further.

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

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

- The Trust has achieved a breakeven year end position and thanks were extended to SO and the Executive team in navigating a fluctuating environment, to achieve what they have. Thanks, were also offered to SD and the team for ensuring that patients continue to be treated in a timely manner through this period.
- The Trust Board heard that the Committee received a presentation on productivity by the Surgical services team and noted the volume of work achieved by the team and the importance of a continued focus on productivity through next year's operational plan. DM confirmed that the productivity report will help the organisation going forward and that the use of data should progress from monitoring to informing next steps or changes required.
- It was noted that the Committee also received a presentation by the KMPN network team and the Committee offered the proposal their support.
- It was noted that a large part of the Committee focussed on discussions regarding the operational planning submission. The Committee commended the Executive team on their work on the plan, and it was noted that externally, the changes to planning requirements have been continuous. It was noted that the work done, was presented clearly and the Committee was mindful that the organisation will have to work differently next year.
- AD offered congratulations to the Executive team to get the organisation to a break even position seven years in a row. It was noted that the surgical deep dive was a practical example of innovation, and the desire for the team to innovate and improve productivity was clear. AD noted that the planning submission is challenging, but recognised that, as the organisation is so innovative, it will find ways to drive productivity.

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

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

- The meeting was a deep dive focussing on: The results of the NHS staff survey; an update on workforce planning; and the process regarding succession planning and talent management. The Trust Board heard that the Board Assurance Framework was reviewed at the start of the meeting.
- It was noted that the Staff survey results were positive and Trust staff were thanked for being open and candid in their feedback. The Trust Board heard that the organisation is in the top 10 in the country for its survey results, the second in the South East region and number one in Kent. The Committee discussed how we can use exemplar areas to enhance other areas and improve results further. It was noted that funding for the People Promise exemplar programme will come

to an end and it was considered that work going forward will need to be innovative to emulate the practice that process has provided the organisation with.

- The Trust Board heard that the Committee discussed Workforce planning and the impact that any further reduction on spend may have on culture and using innovation to find new ways of working. In addition, it was noted that the proposed succession planning process was described to the Committee as starting at the Executive level and will work through the organisation. RF noted that the succession planning process is best practise and of high quality and is looking forward to seeing the results, which will be presented back to the Committee at a future meeting.

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

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

- A number of items were discussed at the meeting, which included the approval of annual plans for internal and external audit. It was noted that the Board Assurance Tool is well received and there is focus now on how to use it to the best effect and its full benefit.
- The Trust Board heard that the Committee received an update on Cyber security and it was noted that a breach of a neighbouring Trust's IT system involved the perpetrators attempting to access the Trust's system, but were not successful, as the IT team had followed guidance in a timely manner. The importance of acting on notifications was reiterated to prevent cyber-attacks from being successful.
- The Committee received a report on issues with response times to Subject Access Requests, secondary to a large increase in numbers of requests, which had prompted a communication from the Information Commissioner's Office. The Committee heard that the risk profile has been raised because of this and mitigations had been implemented. It was noted that the Committee will receive an update on their effectiveness at a later date. A Subject Access Request (SAR), is a legal right under data protection laws, allowing individuals to request access to their personal data held by an organisation.

03-11 Charitable Funds Committee 12/03/25

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

- That the Committee were encouraged by the work done by the Head of Charity and Fundraising and the team, in increasing the profile of the Charity, which is evidenced in the number and value of donations being received. It was noted that the Charitable Funds Committee is a governance committee and the Charitable Management Committee (CMC) has responsibility for the work of fundraising and dispersal of the funds.
- The Trust Board heard that there was a discussion on how clinicians could be involved in the CMC and RJ noted that there are individuals who have a particular interest in the Charity's work and would be approached to consider joining the group.

Integrated Performance Report (IPR)

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

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

- Total pay spend continues to exceed the target because the number of staff has increased and there has been difficulty in reducing the number of bank shifts. The Trust Board heard that the total pay spend is reducing but the spend on temporary staffing has remained static, although has reduced from June 2024. It was noted that the spend on agency staff has continued to reduce and that vacancy and staff turnover rates were improving. The Trust Board heard that four dedicated workstreams are focussing on controls to manage the use of agency and bank staff: Nursing and Midwifery; Medical; Health Professionals and Other staff.
- The Trust Board heard that there has been little movement on the target to increase staff in Agenda for Pay Bands 8c and above from the global majority, but the staff survey results indicate that staff from the global majority have the same access to learning, but that career opportunities or opportunities to develop are less available. It was noted that the third cohort of the reverse mentoring scheme and staff network groups are being engaged to promote opportunities for this staff group.

- JW noted that the numbers of staff leaving has reduced and this may be staff secondary to recent NHS news, which indicates a reduction in workforce is required nationally, but HP responded that it is not possible to identify this from the data. AD queried if an update would be provided, following the cessation of the People Promise exemplar programme and HP informed the Board, that a piece of work will be undertaken to close the programme which will detail, what elements from the programme will be moved into business as usual.

Action: HP to present the 'Close down' of the People Promise Exemplar to the Trust Board.

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

- Training is being targeted in specific areas as a result of moderate or higher harm incidents, Martha's rule is live through the organisation, except for paediatric services, which will be implemented shortly. The Trust Board heard that the effective use of theatres is improving and moving toward the target and the work to improve this further will continue in a dedicated project through the new financial year. The rates of Clostridium Difficile and Escherichia coli were noted to be high and the Board were informed that all Infection Prevention and Control measures were in place to reduce this. The Trust Board heard that the rate of falls has decreased and is at its lowest level in eight years and it was noted that Venous thromboembolism performance has dropped below the target for the first time.

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

- The Trust had failed to meet the 62-day cancer standard target in January in Urology and Breast cancer pathways. The Trust Board heard that this is secondary to the increasing length of time for reports on biopsy test results to be produced, length of time this takes is fluctuating and there is an improvement plan in place to rectify this. It was noted that no further decline in performance was anticipated.
- The Trust Board heard that the performance in the Emergency Department has been consistent and will achieve at least one of the four metrics of NHSE's Capital Incentive Scheme and will result in a funding award.
- WW queried the drivers which have affected ambulance handover times and SD reported that the front to back door project will improve this and also that the team were considering "Immediate handovers" from ambulance crews, which has been shown to reduce handover times in a local acute Trust.

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

- There had been a consistent increase in the number of complaints each month, but it was noted that the team have maintained performance, and are reducing the number of legacy complaints. It was noted that in light of the increase in complaints, the metrics in the report, may need to be reconsidered. There was an acknowledgement of the hard work of staff in the complaints teams and divisional staff in responding to complaints in a timelier manner.
- The Trust Board heard that there was a continued reduction in the agency spend for Band 3 and 5 staff and it was noted that in February the agency spend had reduced to half of that at the starting point and staff were recognised for this achievement.
- It was noted that the number of women waiting for the induction of labour has remained the same and the failure to meet this target is as a result of periods of high activity. The Trust Board heard the time between the decision to have a Category 1 caesarean section and delivery of the baby has failed to meet the target for the preceding six months and that each case is reviewed by the multidisciplinary team, the causes of not meeting the target are identified and shared with the team.
- A query was raised regarding the CQC report following the inspection undertaken in October 2024 and the Trust Board heard that the report has been delayed because of formatting issues and anticipate that this will be received soon, but it was noted that there are no enforcement notices associate with the inspection.

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

- The work undertaken on clinical coding has become 'business as usual' with the support of clinical champions and it was noted that the audit tool business case has realised a return on the investment made.

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

- The Trust had reported a surplus of £4.8m favourable to plan and there was a year-to-date deficit of £4.3m. The Trust Board heard that more Cost Improvement Plans and been identified through the year, but a large percentage of those were non-recurrent. It was noted that there was an increase in capital spend and a high cash balance, which was noted to be in line with all other organisations.

Quality Items

03-13 Quarterly Learning from Deaths Report

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

- The Learning from Deaths Group provides assurance that all hospital associated deaths are monitored, reviewed, reported and ensure learning from Mortality reviews are shared. A Structured Judgement Review is undertaken by the Medical Examiner service when the family or the Medical Examiner have identified the need for a review of a death. It was noted that the majority of reviews demonstrated good care and when opportunities to learn are identified, this is shared in a variety of ways. The group are working with the Local Academic Board to ensure learning is shared to reach Resident Doctors more effectively.
- The Trust Board heard that themes highlighted by reviews include, failure to recognise sepsis by Resident Doctors and their training provision is being reviewed as a result of this. A number of Medical Examiners have been recruited to the Trust to review Community Deaths as well as those in hospital, a requirement which was mandated in September 2024.
- The Hospital Standardised Mortality Ratio plus (HSMR+) 82.15% and is lower than the expected rate and the Trust's peer group. The HSMR+ shows the overall rate of deaths within an NHS Trust. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI at 91.3% which is within the expected range.
- JW raised the issue of failure to recognise sepsis and queried improvements being made to address this. SM reported that the deteriorating patient group has conducted a review of all training, and noted that training was being delivered on wards in how to identify the deteriorating patient. Also, that Martha's rule should aid early identification of those patients, in addition to wellness questions being asked daily, as learning from other organisation identified that an increase in an unwellness score may indicate an underlying pathology. WW asked if SM felt that there was enough urgency around this issue and is the support there to give the attention it deserves. SM reported that staff engagement is good with training and the improvements required, but that there was a lot of work to be undertaken and it may take time to see the changes required. MS noted that the it would be helpful to have objectives identified to support understanding if this work has been effective. SM noted that peri arrest data is being recorded, which should aid the demonstration that improvements have been made. MC confirmed that the reasons for deteriorating patients are multifactorial and there are a number of catch points to record along their journey. AD suggested that a deep dive at a Quality committee, may help a further understanding of the work being done.

Action: Schedule a Deep Dive into recognition and management of the deteriorating patient at a future Quality Committee.

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

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

- It was noted that some changes had been made to the format of the report and escalations were noted to be: three incidents which 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 Trust Board received positive assurance that; the maternity services governance team has been fully recruited to; there were no referrals to the Maternity and Newborn Safety Investigations program, training compliance was good; there was an increase in responses to the Friends and Family Test; 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; 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.
- AD noted the team are maintaining their mandatory training and referred to low staff engagement in staff survey completion, in particular with specialty trainees. RT noted there is a deanery action plan and the service has implemented an mobile phone application, which staff can use to report the way they are feeling. HP added medical have a number of different surveys to complete and that may be a reason why the response rate to the mentioned survey is low. RT also added that a Professional midwifery advocate is employed by the organization to support staff following incidents to enable staff to feel valued and listened to. JH noted that the walkabouts enable Executive and Non-Executive Directors to assess the culture in the team and MC noted that during walkabouts, staff are notably more positive and gave specific examples of staff reporting a positive change in the culture of the service.

People

03-15 National Staff Survey Results, 2024

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

- The 2024 NHS national staff survey was open between September and November 2024 with results released at 9.30am on 13 March 2025. It was noted that staff who had joined the organisation before September 2024 were included in the survey, which meant that staff at Fordcombe Hospital were not included in the survey on this occasion. It was also noted that the survey took place during through the challenging Financial Improvement programme and winter period.
- It was noted that at the point of report preparation, only high-level data was available and the more in-depth data will be reviewed by the team, shared with the Trust's divisions and the People and Organisational Development Committee in due course.
- The Trust Board heard that the Trust scored higher than the national average on all people promise themes, was placed 2nd in the South East region and 9th nationally.
- It was noted that the results should be celebrated and the Trust Board heard that staff reported that the quality of appraisals was high and they had good personal development opportunities. Staff who completed the survey reported they "Have a voice that counts" and work in a "Compassionate an inclusive organisation". It was noted that staff are not afraid to speak up and the Freedom to Speak UP Guarding and Patient First initiative contributes to this. The importance of staff being aware their voice counts was noted and that there are plans to develop this further in the new year. AY referred to the low response rate and queried whether it is possible to know who did and did not complete the survey. HP commented that it is not easy to identify those who are engaged or disengaged, but highlighted the importance of demonstrating what the Trust is doing in response to the survey. WW reiterated that engagement with the survey was discussed at the People and Organisational Development Committee and in particular who is responding to the survey, and assurance was given that work will be done to improve engagement with the survey further.
- Congratulations were offered to the Executive team on the staff survey results and it was noted that staff engagement is critical to everything the organisation does, especially when work pressures and demand is so high and it was recognised that the Trust has a strong foundation with its staff.

Systems and Place

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

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

- 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.
- Following announcements by NHSE regarding the reduction of workforce in Integrated Care Systems, the Kent and Medway Integrated Care Board (ICB) have deferred the transfer of its staff to East Kent University Hospital Foundation Trust and Medway NHS Foundation Trust and it was noted that the Trust employs staff transferred from the ICB and a single approach to managing to this issue will be established.

Planning and strategy

03-17 Update on the Trust's planning submissions for 2025/26

RJ raised the following points:

- Even with the changes that have happened with NHSE, the planning submissions have continued in the same way in which it was started. It was noted that the goal is to achieve a balanced plan position within the system. It was noted that the Trust's submission would be made today and will mean a significant increase in savings and efficiencies in terms of the system, as individual providers and it was noted that the Trust will be a smaller organisation in regard to numbers of staff.
- AD acknowledged the work done in a short period of time, to develop a plan that is ready for submission.

Assurance and policy

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

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

- The paper was presented to the Audit and Governance Committee, 25 new risks have been added, and two risks have been escalated. It was noted that there has been progress in terms of reviewing risks, but it was noted that there were 18 risks, which scored over 15, open over 12 months, which were being reviewed regularly. The Trust Board heard that the most common risks across the organisation are patient safety and clinical risks.
- AD referred to the target dates and queried whether they are realistic. JH noted that the risk management process is still on a journey and there is an element of education required but this has to be completed one division at a time to ensure all areas are covered.
- The Head of Risk Management was thanked for all the work done to date. It was noted that the Risk and Regulation Oversight Group will be a focal point for reviewing and managing risks and educating staff and it was noted that other organisations are more developed in this area, which could be looked to for additional advice or support. JW noted that the financial challenges of the next year and that the risk register can be used as a proactive tool to plan to mitigate risks in advance of issues arising.

Annual Report and Accounts

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

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

- 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. This has been discussed at and supported by the Executive Team Meeting, the Audit and Governance Committee and the Finance and Performance Committee.
- The Trust Board confirmed that the Trust's annual accounts for 2024/25 should be prepared under the going concern principle.

03-20 To consider any other business

There was no other business.

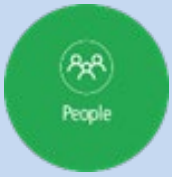
03-21 To respond to questions from members of the public

LT confirmed that no questions other than those posed in response to the patient experience story, had been received ahead of the meeting.

03-22 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-6					
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 April 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)	Principal Risk 1,2,3,4,5 and 6
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

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

I have begun the transition to become Chair of East Kent Hospitals University NHS Foundation Trust (EKHUFT) on 1 May, a role I will undertake while continuing as Chair of MTW, and have been spending time with EKHUFT colleagues, shadowing their Board, interviewing for new non-executive director positions and visiting hospital sites.

I joined our Trust Chief Executive, Miles Scott, at a Kent and Medway Integrated Care Board meeting earlier this month, which looked at ways to reshape the NHS in Kent and Medway. The event gave us the opportunity to share our perspectives on the challenges faced by NHS organisations across the system, consider ideas to accelerate progress and evaluate what activities should be further developed or halted in light of the recent Government announcements. The meeting also enabled NHS trusts in Kent and Medway to align in our actions and consider next steps across the system to reduce waiting lists and running costs.

I also recently attended the NHS Kent and Medway Provider Collaborative Board meeting, where we discussed opportunities for driving our system work forward more rapidly. Topics covered included the endoscopy strategy in the acute sector, better use of beds in the community and the proposal to create an MHLDA (mental health, learning disabilities and autism), Community and Primary Care Collaborative.

At the Trust Board Away Day last week, we were given a tour of the new Undergraduate Medical Building at Tunbridge Wells Hospital, which will provide new teaching space as well as accommodation for medical students and resident doctors. In light of recent Government announcements, we also discussed how the Trust will develop over the next three years and reviewed how the Board will support it to meet the financial challenges faced by the NHS this year.

My clinical shadowing sessions continued this month, and I visited our Ophthalmology teams at Tunbridge Wells Hospital. I was impressed with the breadth of clinical care provided to patients with a range of conditions, and offer my congratulations to the teams for continuing to deliver high quality care while focusing on productivity and efficiency, and delivering against the financial plan.

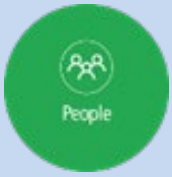
I also met with physiotherapists from our Therapies directorate earlier this month. The teams are focussing on pathways to accelerate patients receiving care from hospital to community when appropriate, supporting ongoing rehabilitation outside of the acute setting. This approach plays a pivotal role in improving capacity in our hospitals, enabling us to reduce waiting times and care for more patients.

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?
17/04/25	Consultant Radiologist	Kate	Holmes	Radiology	05/05/25	New
17/04/25	Consultant Radiologist	Ishaan	Bhide	Radiology	08/09/25	New
17/04/25	Consultant Radiologist	Jonathan	Adlam	Radiology	05/05/25	New
17/04/25	Consultant Radiologist	Aparajita	Singh	Radiology	05/05/25	New
17/04/25	Consultant Radiologist	Amy	Agahi	Radiology	07/05/25	New

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-7					
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 April 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)	Principal Risks 1,2,3,4,5 and 6
Links to Trust Risk Register (TRR)	N/A
Compliance / Regulatory Implications	N/A

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

- With the recent announcements that NHS England (NHSE) and the Department for Health and Social Care will merge, and that NHSE will be abolished by October 2026, the Government's plan is to reverse the 2012 top down reorganisation of the NHS, remove bureaucracy and improve efficiency. A new interim NHSE Transformation Management team has been created, with Sir Jim Mackey as CEO and Dr Penny Dash as Chair, and a new Executive Transformation team has also been appointed. In addition, guidance has been issued on the expected running cost reductions for Integrated Care Boards (ICBs) and NHS trusts during 2025/26, with ICBs needing to reduce running costs by 50% and trusts to reduce the growth in running costs since 2018/19 by 50%.

  The Government's 10-Year Health Plan is expected later this spring in response to the Darzi report, and will focus on five reform objectives; to cut waiting times, to improve primary care access, to improve urgent and emergency care, to change the operating model and to drive efficiency and productivity. There are currently several working groups supporting the development of the plan. We believe the plan is in the final stages of preparation and expect it to be published in May or June.

- The new financial year began this month, and sees significantly increased cost-saving requirements across the Trust, in line with the latest Government changes to the NHS to reduce both running costs and waiting lists. Two thirds of our Trust costs are workforce, and over the next 12 months we will continue our recent success in reducing expensive temporary staffing while also focussing on reviewing substantive staffing and not recruiting to a number of vacant posts. Where we have seen an increase in running costs over the last five years, we will question and challenge our services to reduce these. While the financial year ahead will be challenging, we are working hard to develop improvement plans which will enable us to work more efficiently while providing safe high-quality care to patients, supporting staff wellbeing and continuing to play a role in system wide projects.

- MTW's Chair, Dr Annette Doherty, has been appointed as Chair of East Kent Hospitals University NHS Foundation Trust (EKHUFT). Annette will continue in her role as Chair of MTW and her new position offers an exciting opportunity for greater partnership working between the trusts, as we work to improve and develop NHS services. As part of the Kent and Medway health system, MTW and EKHUFT have already developed close working relationships and a culture of support and collaboration. While remaining separate organisations, we will work with colleagues in east Kent to maximise the opportunities for joined up healthcare which benefit our staff and patients. Dr Doherty will take up the role on 1 May.

- The Trust is currently in the process of building an Artificial Intelligence (AI) Strategy, which will sit alongside our Digital and Data Strategy. This will help to refine the way we work, making our processes more efficient and streamlined, and supports one of the three main shifts of the Government's 10-Year Health Plan to move from analogue to digital. Use of AI has already begun across the Trust, enabling faster patient outcomes, saving clinical time and helping to reduce costs. AI projects have included:
  - MTW has been selected to take part in the Kent and Medway ICB pilot of the AI assistant, TORTUS. The AI-powered voice recognition technology is being used to generate comprehensive clinic notes and summary letters, enabling clinicians to devote more focussed time to patients in clinic. TORTUS has so far been piloted in Oncology and Haematology, with other specialist areas now being considered.
  - An AI pilot for another automated voice system, Dora, is also running in Ophthalmology, with the system being used to enhance care for cataract patients before and after their surgery. Dora is able to call patients to ask questions, understand their answers and accurately identify responses indicating the need for clinical review. It has been used to look at efficiencies in pre-assessment, calling eligible patients to check important details, and is now beginning to be used for pre-surgery reminder calls, ensuring delays are

minimised and theatre lists can be used effectively.

- The first robot-assisted surgery at Tunbridge Wells Hospital took place at the start of this month. Patients began benefiting from the new robot just days after it was delivered, and it is currently being used to support general surgery, including colorectal and bariatric (weight management) surgery. In the coming months, this will also include gynaecology procedures. Robot-assisted surgery has many benefits for patients – it is less invasive, leads to less pain after the operation, and can mean a faster recovery time. The Trust took delivery of its first robot at Maidstone Hospital in September, and thanks to the hard work of staff across the organisation, the surgical team progressed to full theatre schedules using the robot faster than any other hospital in the UK and Ireland has done over the past five years, and has already treated over 150 patients.

- An innovative service involving a nurse-led triage system has reduced the time from referral to treatment for rhinosinusitis patients by almost 50%. A nurse triages referrals during a weekly telephone assessment clinic, speaking with patients to determine next steps for their care. The new service provides patients with a phone consultation early in the process, allowing diagnostic tests to be arranged promptly. Receiving clinical assessments and initial investigations at the earliest opportunity means results are quickly available for clinicians to make informed decisions, giving patients tailored treatment plans and avoiding unnecessary delays.

- To help improve what we can offer on site to our cancer patients, the Trust has been working with partners at Maggie's – a charity who for three decades have provided free expert care and support for people living with cancer through their 24 centres across the UK. In partnership with Maggie's, we are moving forward with plans for a centre at Maidstone Hospital, and the planning application was submitted earlier this month. The centre will be fully funded by Maggie's and construction is not due to begin until 2027 at the earliest. As this project moves forwards, representatives from MTW joined the Kent Ambassadors event on 15 April which brought together a network of experienced stakeholders to support all aspects of life in Kent, with guests including former MP, Dame Tracey Crouch. This was an opportunity to talk more about the Maggie's centre for Kent to local people and highlight the benefits it will bring to those in the region living with cancer, and their families.

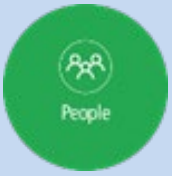
- MTW's Urology teams have contributed to an international research study which has become the first in the world to show how a specific biopsy method provides more effective diagnoses for prostate cancer patients. The TRANSLATE study is funded by the National Institute for Health and Care Research (NIHR) and led by Oxford University. As part of the study, MTW's Consultant Urological Surgeon, Mr Hide Yamamoto, alongside the Trust's Urology team have been researching the 'transperineal' biopsy and its benefits compared to the more traditional surgical process which is delivered through the bowel. The research by TRANSLATE confirmed previous findings that this new process provides very low rates of infection and also helps improve the rate of cancer detection meaning patients are diagnosed and provided with quicker access to ongoing care. The study saw hundreds of suspected prostate cancer patients randomly allocated to the new method of treatment, with Mr Yamamoto pioneering the ground-breaking treatment after becoming one of the first in the country to offer it to patients in 2017. Since then, Mr Yamamoto has taught the technique to doctors and nurses in hospitals across the country while also running regular courses at Maidstone Hospital, so even more patients are able to have access to the improved outcomes.

- MTW midwife, Hannah Sydee, has been awarded the Cavell Star Award for her work contributing to patient safety in maternity at the Trust. The Cavell Star Awards are run by the Cavell charity, an organisation dedicated to supporting nurses, midwives, nursing associates and maternity support workers. The awards aim to highlight and celebrate staff who have gone above and beyond in their roles, showing exceptional care towards their colleagues, patients and patient's families. Hannah is part of MTW's Maternity Governance team, who

are responsible for monitoring our systems and processes to ensure that we are continuously improving the quality of our maternity service and safeguarding high standards of care. On behalf of the Board, I would like to congratulate Hannah on achieving this well-deserved recognition.

- Congratulations to the winner of the Trust's Employee of the Month award for March, Mechanical and Electrical Assistant, Stephen Cox. Stephen was nominated for the key part he played in the successful delivery of the Lord North Ward improvement project. His commitment, care and positive attitude in liaising with the teams involved ensured all works adhered to the project programme. Assistant General Manager for Surgery, Rob Osborne, also received the Highly Commended Award for his work in supporting the division with flow over the winter period while always putting the patient first.

Title of report	**Summary report from the Quality Committee, 09/04/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-9					
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 in person on 9th April 2025 (a ‘‘deep dive’’ meeting). The Committee considered the following topics: The BAF risks overseen by the Quality Committee; A review of the Patient Safety Incident Response Plan; A review of the Trust’s Melanoma service and confirmed items for scrutiny at future Quality Committee ‘Deep Dive’ meetings The Committee noted that the reports presented, demonstrate that controls relating to Principal Risks 2, 3, and 4 of the Board Assurance Framework demonstrate limited assurance.
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.
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

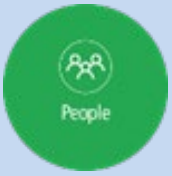
	Plain film imaging rooms at Tunbridge Wells Hospital (TWH) • 3242 - Replacement of equipment required for general and ED Plain film imaging rooms at Maidstone Hospital • 2945 – Replacement of equipment required for Fluoroscopy imaging rooms at TWH • 3245 – Replacement of equipment required for interventional 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 9th April 2025 (a 'deep dive' 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) throughout the meeting and considered that the risk profile of each strategic theme could be reviewed to ensure.
- The Director of Governance presented the **updated Patient Safety Incident Response plan,** where in the Committee heard that in April 2024 the Trust moved to the national Patient Safety Incident Response Framework (PSIRF) for managing patient safety incidents. The PSIRF framework requires acute providers to follow national mandated requirements, regarding the investigation of a defined number of incidents and develop locally agreed approaches to investigating other types of patient safety incidents, which should be based on the key patient safety issues facing each provider. The approaches to investigating incidents are set out in the Patient Safety Incident Response Plan (PSIRP). The Committee heard that each element of the Trust's original plan had been reviewed to amend the learning response to a number of incident categories, to ensure learning points were identified in a timelier way.
  The Committee heard that the learning responses adopted use the SEIPS (Systems Engineering Initiative for Patient Safety) framework to understand and improve outcomes within complex systems and include: A Patient Safety Incident Investigation; After Action Reviews; Thematic Reviews; Multidisciplinary Team reviews; Process mapping and Swarm events. Swarm is a form of safety incident huddle that takes place as close as possible in time and place to the incident, allows blame-free investigation and leads to prompt action. The Committee noted the work undertaken would enable staff to identify learning points, improve patient engagement and staff engagement, through a 'Just Culture', which supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.
  - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4 in supporting the management of reviewing and learning from incidents and engaging with patients to improve their experience.
- The then presented a **Review of the Trust's Melanoma service,** wherein the Committee heard of a number of changes and improvements made to the way the service functions to ensure patients are receiving high quality care in a timely manner. The presentation included: an overview of melanoma, which is a type of skin cancer that can spread to other areas of the body; the main causes of melanoma being ultraviolet light, which comes from the sun and sunbeds; and the main treatment of melanoma being surgery, but can also include the use of Immune Checkpoint Inhibitors (ICI). The Committee heard that the Melanoma Service is within the Oncology Directorate and manages Oncology Consultants (Doctors specialising in cancer) across West Kent and East Kent. The presentation focussed on the West Kent Service, which had seen a 23% growth numbers of patients from 2022/23 to 2023/24 and an increase in new patients over the time-period. Through 2024, a number of areas for improvement were identified and the team developed an action plan to ensure clear pathways and processes were in place regarding: patient referral criteria, policies and process being aligned to the most up to date national guidance; the use of a system wide patient record system and staff being able to network with other specialist staff within and external to the Kent and Medway system. The Committee noted the improvements made, that the team were considering how to change the service further in response to increasing demand and also heard that patients who had been attending the service for a number of years had remarked on the improvements in the way the service was delivered.
  - ❖ The Committee noted that this demonstrated a level of effectiveness of controls for the Board Assurance Framework, Principal Risks 2, 3 and 4.
- The Chair then conducted an evaluation of the meeting.

Title of report	**Summary report from the People and Organisational Development Committee, 17/04/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-10					
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 (virtually, via webconference) on 17th April 2025 (a 'main' meeting). The Committee considered the following topics: 1) Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) 2) Update on the temporary staffing programme 3) Update on EDI 4) Review of internal and external communications 5) Update on Learning and Development at the Trust 6) Update on Internationally Educated Professionals (incl. Nurses and Doctors) 7) Quarterly update from the Guardian of Safe Working Hours 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	

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 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
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 (virtually) on 17th April 2025 (a 'main' meeting).

The key matters considered at the meeting were as follows:

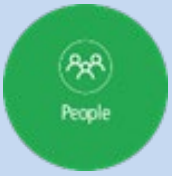
- The **actions from previous 'deep dive' meetings** were noted.
- The updated Terms of Reference for the Committee were agreed.
- The Committee reviewed and discussed the People Board Assurance Framework (BAF) risk and considered that a review of the Principal Risk 1 should be undertaken to reflect the planned changes to the ways of working through the year and noted that the Principal Risk 6 should include the risks that are associated with financial targets and that there should be alignment of Principal Risks 1 and 6. Also, that both risks should be included for the Committee to review going forward and that triangulation of information from other Committees would help to ensure the different impacts affecting different Committees is reviewed and triangulated.
- The Committee conducted a **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**, wherein it was noted that significant progress has been made in the vision objective; to reduce total pay spend by £39,442 by achieving the most recent position of £40,329. The Committee heard that the Trust has achieved an overall temporary staff spend of 10.6% against a target of 8.5% and noted the additional work to be undertaken. The improvement in agency spend of 1.8%, was noted to be better than the target of 3.2% and the Trust's turnover rate was 10.3%, which was better than the target of 12.0%. The Committee heard that the rate of sickness absence had reduced to 4.1% (against a target of 4.5%) and that there was no change in the targets regarding staff that are Agenda for Changed 8c and above for females, those with a disability of those from the global majority. The Committee were informed of the work being undertaken in Executive vacancy review panels in reviewing all vacancies submitted for approval.
    - The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- An **update on the temporary staffing programme** was provided, which included the achievements of programme for 2024/25. The Committee heard that the highest month of spend was June 2024 (£10m) and had reduced to £4.47, which was a continuous reduction from the previous two months. The Committee heard that progress was still being made and consideration was given on the further work to be done. The work of the People and Organisational Development team was noted in achieving the continued reduction in temporary workforce spend and that there are a number of workstreams in place to continue to drive this work further. It was also noted that staffing is reviewed daily to ensure that patient safety is maintained at all times.
    - The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- The Head of EDI, Engagement and Retention attended to present the **update on Equality, Diversity and Inclusion (EDI),** wherein the group noted that The South East Region WRES and WDES reports were released in November 2024, which made comparisons to other Acute Trusts in the South East and nationally. Areas where the Trust requires improvement in the WRES report were: a gap in representation from Agenda for Change band 8c to Very Senior Manager non-clinical roles, the likelihood of appointment from shortlisting; reports of bullying or harassment and representation of global majority staff at the Trust Board. Areas where the Trust should consider continued focus in the WDES report were: non-declaration rate of disability on the electronic staff record (ESR); staff experience of bullying and harassment and feeling pressure from managers to work despite not feeling well.
  It was noted that the National staff survey data was more current and indicated small improvements in: staff experience from the global majority regarding bullying and harassment, from patients and staff; staff experiencing discrimination at work from a manager/ team leader or other colleagues and a reduction in staff feeling that MTW provides equal opportunities for career progression or promotion. It was noted that more staff are declaring disabilities on ESR which aids a better understanding of the situation.

The Committee heard that the majority of the EDI improvement strategy has been delivered, but that it had not yet realised the intended improvements and reasons for this were discussed, which included ensuring that the focus on Equality, Diversity and Inclusion should be managed as 'business as usual', driven by strong leadership and by holding each other to account. The Committee considered that as the current EDI strategy was nearing its end, there was an opportunity to review the strategy, consider a way in which the EDI project could be reopened and ensure the Trust Board understood their responsibilities regarding EDI.

- An update on **Six-monthly review of internal and external communications** was received and included an overview of the work of the Communications team, which focussed on digital developments, divisional support, campaigns and areas of focus for next six months. The Committee noted the volume and quality of work undertaken by the team and how it supports the work of the organisation.
- An **update on Learning and Development at the Trust** was provided by the Head of Learning and Development, which highlighted that current compliance with statutory and mandatory training was 90.2% against a Key Performance Indicator of 85%, but that training in Basic Life support was at 69.6%, due to challenges in delivering training and staff not attending booked training. The Committee heard that there is work in place to rectify the situation. An overview of the NHSE Optimise, Rationalise & Redesign project, which focusses on alignment to the Core Skills Training Framework (CSTF) to support the NHS Workforce Plan and people passporting was presented and the Committee heard that the appraisal window was launched on 31st March 2025. The Committee heard about the range of career development activities undertaken in 2024/25 and received an update on Equality, Diversity and Inclusion in the Learning and Development team, which included access to development through reasonable adjustments being made so all staff can access training.

  The Committee received a progress update ahead of launch of Multidisciplinary Learning Development & Education Strategy, which included an update on the Library & Knowledge Services Quality Impact and Outcomes Framework (QIOF) assessment and developing strategy. The Committee heard that the key challenges for Learning & Development in 2025/26 were; team capacity and decreased availability of apprenticeships and apprenticeship levy changes and the availability of space and rooms to deliver training.
- The Committee received an **update on Internationally Educated Professionals (incl. Nurses and Doctors)** which included that pastoral and practical support is provided to all internationally educated professionals from the time of appointment (before arrival), on arrival and continued once staff were in post through buddying programmes and regular meetings. The Committee heard that although the business case for recruiting international nursing staff was at an end, the team were looking to support staff to gain registration in this country, where they had the relevant experience, and had implemented the 'Stay and Thrive' programme to encourage staff to remain working at the Trust.
- The **quarterly update from the Guardian of Safe Working Hours (covering Jan. to Mar. 2025)** was received by the Committee.
- The group reviewed the **findings from the Committee's evaluation for 2024/25.**
- The Committee noted the **forward programme.**
- The Chair conducted an **evaluation of the meeting** wherein Committee members noted that the level of discussion was stretching and robust, but not critical and resulted in a collegiate and supportive meeting.

Title of report	**Summary report from the Finance and Performance Committee**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-11					
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 (virtually, via webconference) on 22nd April 2025. The Committee considered the following topics: 1) An update on the Outpatients transformation programme 2) The patient access strategic theme metrics for March 2025 3) The financial performance for month 12, 2024/25 4) The Financial Improvement Plan 5) The Budget Plan for 2025/26 6) The quarterly update on the Business Case benefits realisation The Committee also noted the notification of the use of the Trust Seal. 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 22nd April 2025, virtually, via webconference.

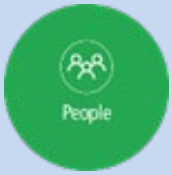
1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were noted.
   - The group firstly considered and reviewed the Board Assurance Framework (BAF) risks relating to the Committee.

- The Chief of Service and Director of Nursing and Quality for the Cancer Division attended to present an **update on the outpatients transformation programme,** wherein the Committee heard that that the £4m savings target has been achieved through optimising Outpatient pathways through: expanding the use of Triage to Test (where patients undertaken investigations before their appointment), Advice and Guidance (where referrers can call a clinician before they refer a patient) and increasing the use of patient-initiated follow up (PIFU) appointments. The Committee heard that Outpatient clinic availability and use, has been enhanced through close monitoring of booked appointments compared to actual clinic use, reviewing outpatient costs to reduce waste and achieve savings and through ongoing work to reduce missed appointments. In addition, the Committee heard that the use of Patient Portal, which gives patients the opportunity to be able to view appointment letters as well as re-schedule and cancel appointments, which has enabled remote patient monitoring and reduced communication costs. Regarding performance, the Committee heard that the team have sustained 80% of calls being answered within one minute for over a year, abandoned calls, have reduced from 4.4% in 2023 to 2.4% in 2025 and the team are looking into reasons for calls being abandoned. It was noted that 85% of clinic slots have been utilised since June 2024, and noted that there is more work to be undertaken in nurse led clinics, regarding the process around booking appointments. The Committee also heard that there has been a reduction in Did Not Attend (DNA) rates to 4.5% (from 8.7% in May 2022) and has remained under 6% since March 2024. Work which has helped this includes: two-way text reminders, patient portal, notifications and messaging through the NHS App, of which the Trust is the second in the country to implement. The Committee commended the work of the team in improving patient experience and reducing costs in Outpatient services.
- The **Patient Access strategic theme** metrics for March were reviewed, and it was highlighted that the performance in Referral to Treatment times achieved 74.2% in the month, which was a notable achievement in light of the work undertaken to support the system. The Committee heard that no patients were waiting more than 52 weeks and the Trust's performance for the Accident and Emergency 4-hour target was above the trajectory for March at 85.2%, achieving the target overall for Quarter 4. It was noted that the Trust continues to be one of the highest performers in the regionally and nationally in relation to the Accident and Emergency targets. The Committee heard that work to improve flow is ongoing in order to improve the reduction in non-elective stay and in reducing diagnostic waiting times, especially for those patients who require an endoscopy and it was noted that the recovery plan relating to this is being revisited.
- The **financial performance month 12, 2024/25** was then presented by the Deputy Chief Executive / Chief Finance Officer, which included that the Trust had reported a surplus of £4.5m (£1.7m favourable to plan) in March. This resulted overall in a £0.2m surplus for the end of the year, which was favourable to plan. The Committee heard that this position has been submitted to NHS England and draft accounts will be submitted next week and follow the audit process which will be submitted to the Trust Board for approval in June. The Committee congratulated the team for their achievements throughout the year.
- The Committee then received a presentation of **the Trust's Financial Improvement Plan**, for 2025/26, wherein it was outlined that the plan focussed on four elements: Reducing the size of the opening challenge (£23.5m); Efficiency Programme, which involves 15 workstreams, each with an executive sponsor and supported by corporate and clinical team members (£49m); National savings expectations (£1.3m) and System-led Cost Improvement Plan opportunities (£22.6m). The model of operation for achieving the plan was presented, which included the structure and membership of meetings and the method of reporting and escalating, where necessary. The Committee discussed the plan at length, which included risks to the achievement of the plan and commended the clarity of presentation. It was noted that there is confidence in the direction of travel and that a greater level of detail would be presented, when it was available.
- The Deputy Chief Executive / Chief Finance Officer then presented the **Budget Plan for 2025/26**, which included an overview of the budget following the operational planning

submission, which was a breakeven plan and would align to the budget plans throughout the organisation. The Committee noted the budget plan.

- The Director of Strategy, Planning and Partnerships provided the **quarterly update on the Business Case benefits realisation,** and highlighted that a review of business cases dating back three years had been undertaken to identify if the benefits articulated in the original plans had been realised. The Committee noted the difficulty in quantifying non-financial benefits and that the process was a good opportunity to identifying learning, which would enable those submitting business cases to consider how all benefits could be measured and to consider how to reassess a business cases in light of changing costs, especially for those cases, which may take some time to realise the benefit.
- The Committee noted the **summary report from the from the March 2025 People and Organisational Development Committee;** the **notification of the use of the Trust Seal;** and the **forward programme**.
- The Committee **considered the assurance provided at the meeting relating to the Board Assurance Framework** and noted that the information presented, demonstrated that controls relating to Principal Risks 3,5 and 6 of the Board Assurance Framework are demonstrating effectiveness, but noted additional improvements to be made and that the risks would be amended in line with the change in focus of the Trust for the coming year.
- The Chair then conducted an evaluation of the meeting and comments were noted to be collated and would be included as part of the Committee's annual effectiveness review.

Title of report	**Integrated Performance Report (IPR) for January 2025**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-12					
Executive lead	Chief Executive / Executive Directors					
Presenter	Chief Executive / Executive Directors					
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 IPR for April 2025 is enclosed.		
Any items for formal escalation / decision			
Appendices attached			
Report previously presented to:			
Committee / Group		Date	Outcome/Action
n/a			

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 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 • BAF 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 / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

March 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

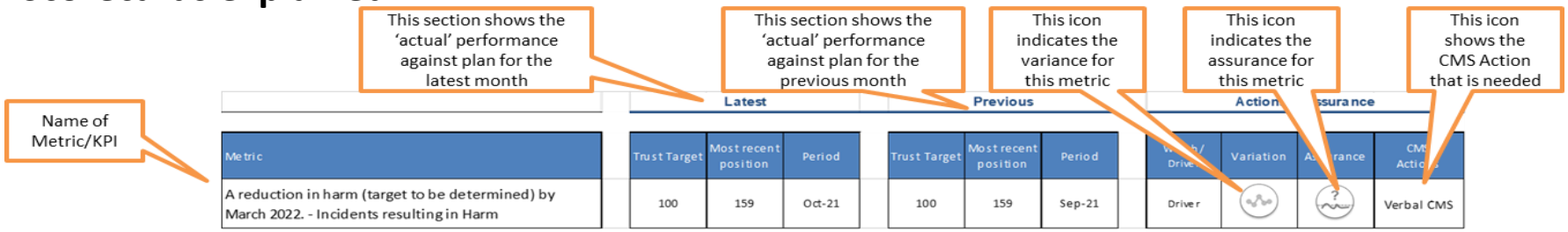
Escalation Rules:

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

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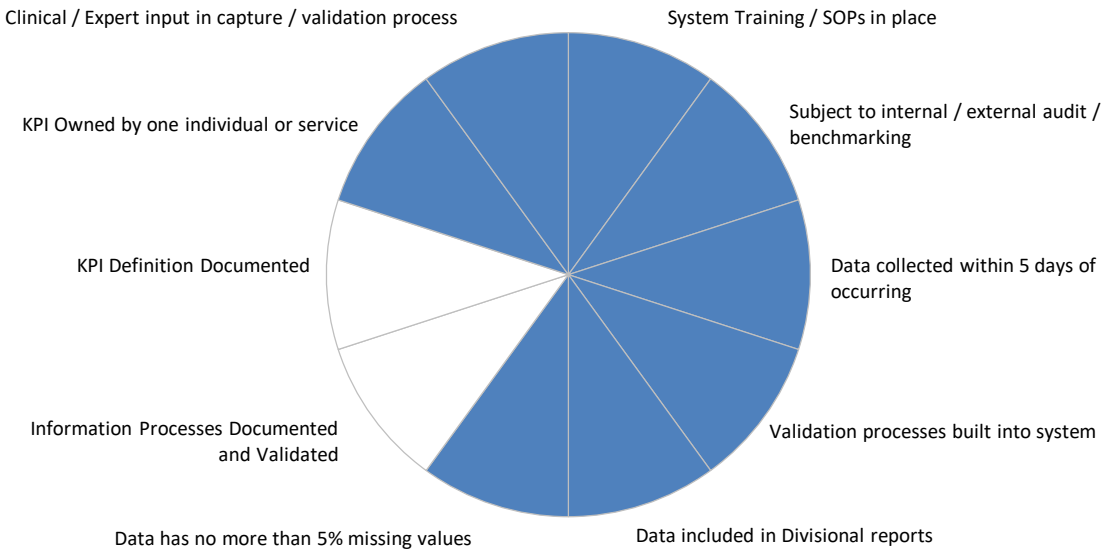
Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Trust continues to 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: The reduction in Total Pay Spend 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 is now consistently passing the target. 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 March 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 but has now failed the target for six consecutive months. 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 with a monthly average of 81% for the year. 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 has passed the target for 6+ months and overall for the year. Both the Rates of E.Coli and C.Diff continue experiencing common cause variation and variable achievement of the target and at year end Trust C.Diff cases are above the threshold of 102 at 120. The rate of Falls has now passed the target for more than six months and overall for the year with a rate of 5.8 against a target of 6.4 per 1000 occupied bed days. VTE performance was above the 95% target in February and has achieved the target every month for the year with an average of 96.1%.

Patient Access: The average non-elective length of stay indicator is currently experiencing common cause variation and consistently failing the target with the average length of stay for the year at 6.7 days. The conversion rate from A&E to inpatient admission remains in common cause variation at 15.9% for the year. Ambulance Handovers <30mins continues to experience common cause variation but has failed the target for 6+ months. Performance was 93.7% <30mins for the year. The Trust's performance for A&E 4hrs was above the trajectory target for March at 85.2% and also achieved the target overall for Quarter 4. The Trust achieved 82.81% for the year of against the Trust target of 84.51%. 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 and has achieved the target overall for the year to date (11 months). The 62 day first definitive treatment performance has once again achieved the national target in February, and has achieved 10 of the 11 months reported to date (following validation). 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 March of 81.2% at 74.2% (Excluding SYS). Nationally we reported 74.09% (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 March 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 in both January and February. The average performance for the year (excluding March as this performance will improve as cashing up of clinics continues) achieved the target at 85.1%. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute continues to experience special cause variation of an improving nature but consistently failing the target with an average of 86.1% of calls answered within 1 minute for the year. The percentage of patients on a PIFU Pathway also 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 March. Both have passed the target for more than six consecutive months and have also achieved the plan for the year of 2024/25. Diagnostic Imaging activity levels were above plan and 19/20 levels in March and remains in common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints is experiencing common cause variation 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 again in March, 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 March 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 decreased in March for Inpatients and A&E but have increased for Maternity and Outpatients. All touch points have failed the target for six consecutive months.

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 £4.5m in surplus in the month which was £1.7m favourable to plan. Year to Date the Trust is £0.2m in surplus which is £0.2m favourable to plan. Delivery of the financial position remains in common cause variation. The reduction in non-pay spend is now experiencing common cause variation but has failed the target for 6+months. The 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)

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)

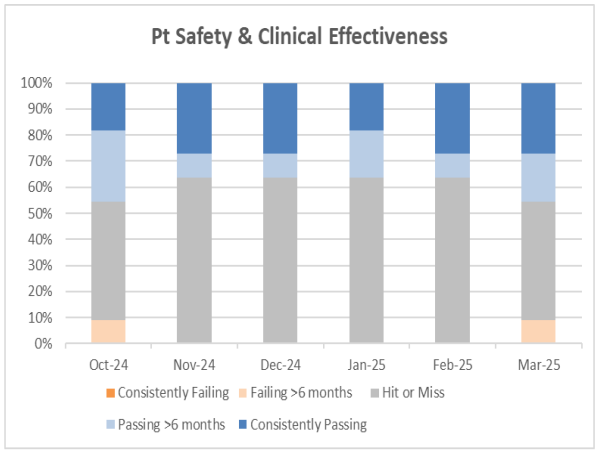
Systems:
- Depth of Coding - Average Number of Codes per Elective Episode (P.23)

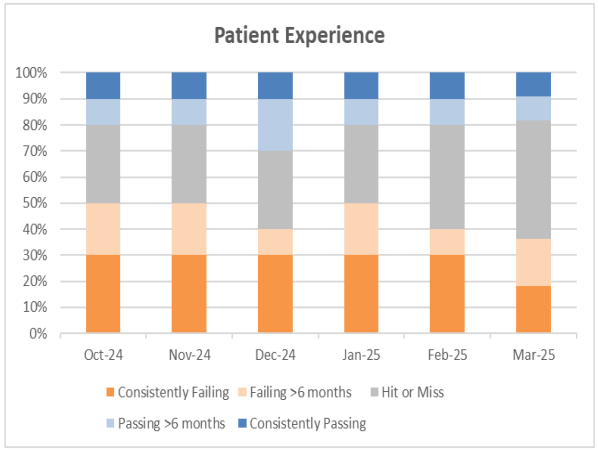
Sustainability:
- None escalated

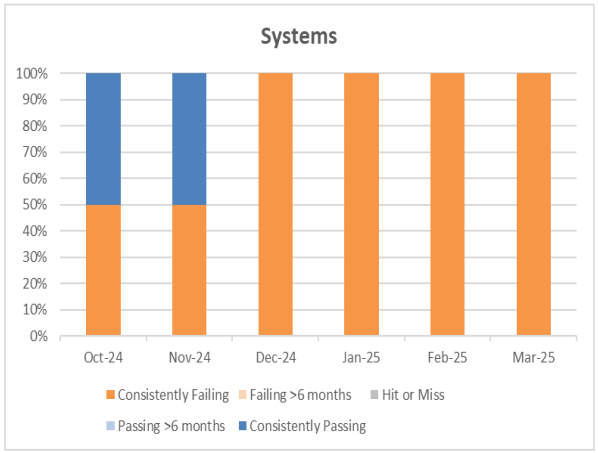
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.26)
- Women waiting for Induction of Labour <4 Hrs (P.26)
- Decision to delivery interval Category 1 caesarean (P.26)
- Decision to delivery interval Category 2 caesarean (P.26)

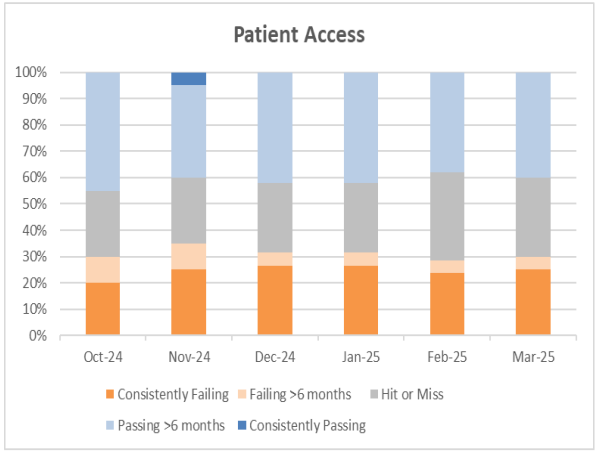
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

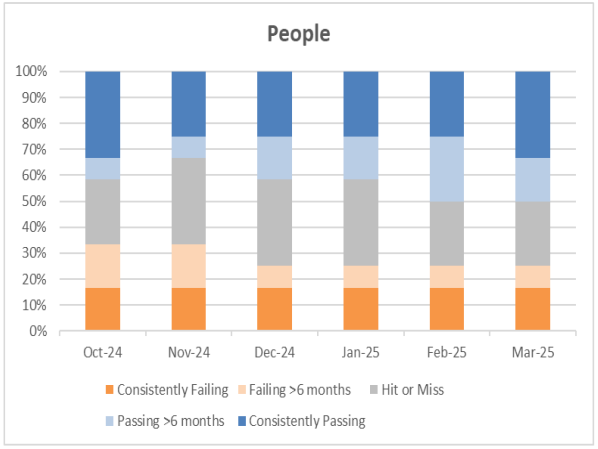
Assurance Stacked Bar Charts by Strategic Theme

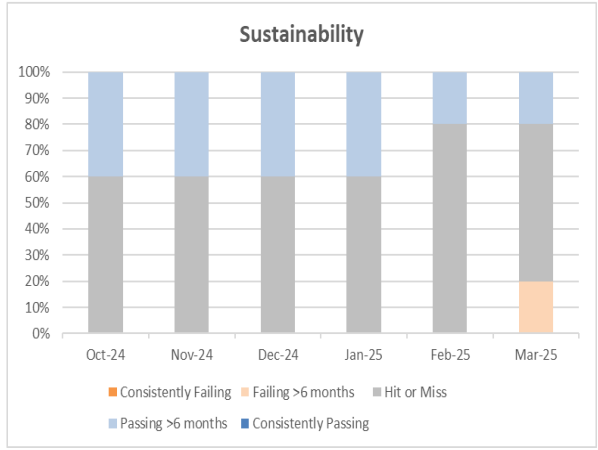












Matrix Summary

March 2025

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

Strategic Theme: People

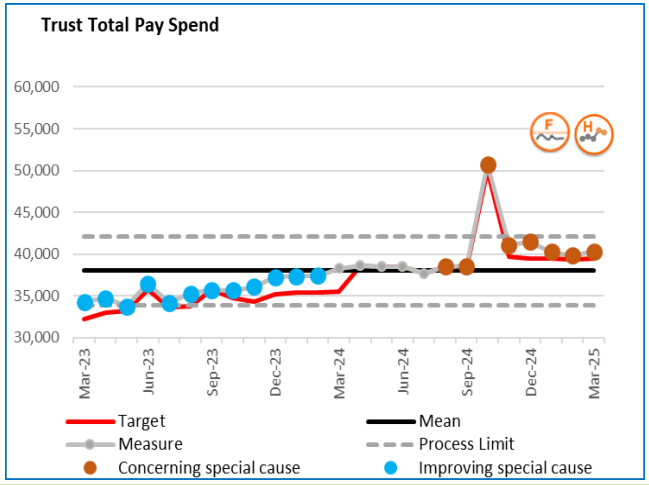
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Well Led	Reduction in Total Pay Spend		39,442	40,329	Mar-25	39,394	39,850	Feb-25	Driver			Full CMS			
Financial Breakthrough Objectives	Well Led	Overall Temporary Staff Spend as a % of Total Spend		8.5%	10.6%	Mar-25	8.5%	11.1%	Feb-25	Driver			Full CMS			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	1.8%	Mar-25	3.2%	1.5%	Feb-25	Driver			Note Performance			
Constitutional Standards and Key Metrics	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	5.6%	Mar-25	8.0%	5.5%	Feb-25	Driver			Not Escalated	5.3%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.3%	Mar-25	12.0%	10.1%	Feb-25	Driver			Not Escalated	10.0%		
	Well Led	Sickness Absence		4.5%	4.1%	Feb-25	4.5%	4.9%	Jan-25	Driver			Not Escalated	4.32%		
	Well Led	Statutory and Mandatory Training		85.0%	90.3%	Mar-25	85.0%	91.0%	Feb-25	Driver			Not Escalated	92.96%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	74.2%	Mar-25	66.0%	74.2%	Feb-25	Driver			Not Escalated	75.16%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	7.9%	Mar-25	4.0%	7.9%	Feb-25	Driver			Not Escalated	8.63%		
	Well Led	Percentage of AfC 8c and above that are BAME		11.3%	6.0%	Mar-25	11.0%	6.0%	Feb-25	Driver			Escalation	5.93%		
	Well Led	Staff Leavers within 12 months		15.3	15	Mar-25	15.3	7	Feb-25	Driver			Not Escalated	13		
	Well Led	Staff Leavers within 24 months		27.8	36	Mar-25	27.8	15	Feb-25	Driver			Not Escalated	28		

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Reduction in Total Pay Spend

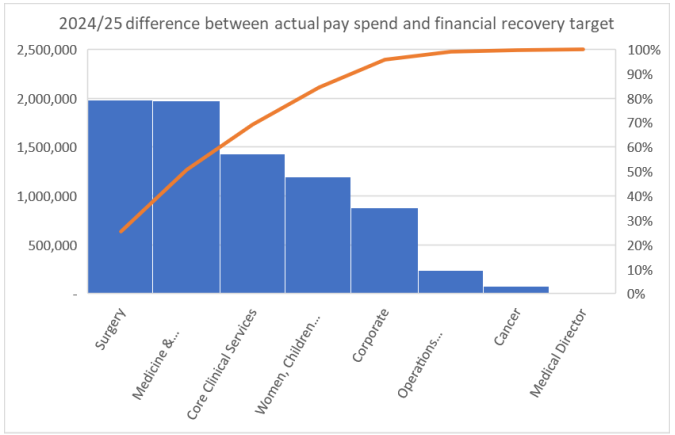
Owner: Chief People Officer
Workstream: Temporary Staffing
Metric: Overall Staff Spend compared to financial recovery forecast target
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-25
40,329
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)
39,442
Business Rule
Full Escalation as is consistently failing the target

2. Stratified Data



Wells Health, Estates & facilities and Business Support Services met target

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 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.
- There is a risk that increased demand for services and enhanced care will cause the need for additional temporary staffing.

4. Action Plan of the Breakthrough Objective

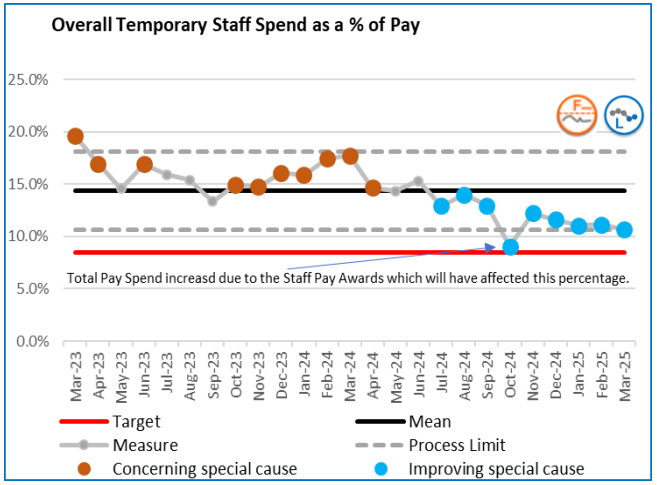
Workstreams	Actions	When	Who
2025/26 planning	2025/26 Financial Improvement will split pay initiatives into four workstreams aligned to staff groups. All current actions to be included in the scoping of the new workstreams	complete	Chief Nurse, Chief Medical Officer & Chief People Officer
Trust Total Pay Spend	Pay budgets to be set for 2025/26 taking 2024/25 spend into consideration	Apr 2025	Finance & Divisions
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



Mar-25
11.0%
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.

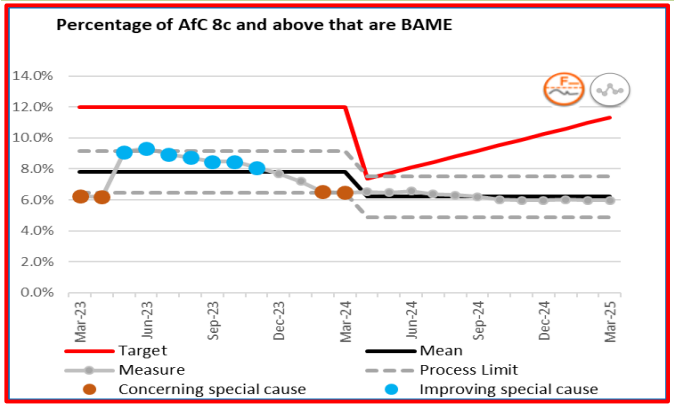
Risks:

- 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	Countermeasures identified via an A3 fed into 2025/26 Financial Improvement pay workstreams	complete	Senior Continuous Improvement Manager
	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	complete	Workstream SRO's and Leads
Rostering Performance	Continue to develop Temporary Staffing Dashboard to give operational teams visibility of key temporary staffing performance	Jun 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
Medical Rate Framework	New Framework implementation being delivered via the Medical Staffing Workstream of 2025/26 Financial Improvement Programme	Jun 2025	Deputy Medical Director
Medical Rostering (Patchwork)	Rollout of Patchwork in ED inc staff engagement and communications. Go live for Resident Doctors planned for 27 May with Consultants to follow	May 2025	Patchwork Medical Rostering Programme Director

People – Workforce: CQC: Well-Led



Mar-25
6.0%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
11.3%
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:
	Between June 2024 and the end of January 2025, 18 inclusive recruitment workshops were delivered with a capacity of 180. 91 recruiting managers attended with fewer than 20 senior recruiting managers.
	
	Work continues on the development of online learning to provide ease of access for recruiting managers
	
	An EDI update paper is scheduled to go to PODco on 17th April with recommendations around the imposition of mandatory inclusive recruitment training and the scrutiny of senior appointments.
	
	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.
		% 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

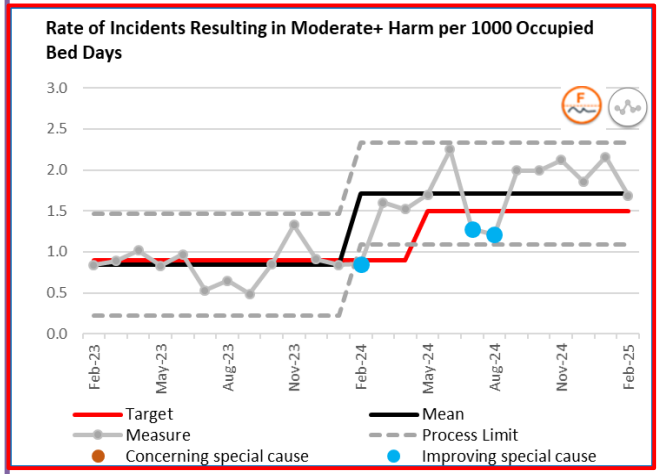
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	1.69	Feb-25	1.50	2.16	Jan-25	Driver			Full CMS	1.80		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	5	Feb-25	2.1	1	Jan-25	Driver			Verbal CMS	3		
Financial Breakthrough Objectives	Safe	% Capped Theatre utilisation.		85.0%	81.7%	Mar-25	85.0%	83.4%	Feb-25	Driver			Full CMS			
	Safe	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	51.6%	Mar-25	49.0%	51.9%	Feb-25	Driver			Note Performance	53.0		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	4	Mar-25	TBC	4	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	6	Mar-25	TBC	13	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	Mar-25	TBC	1	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	82.3	Dec-24	100.0	84.4	Nov-24	Driver			Not Escalated	82.3		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	90.0	Dec-24	100.0	91.0	Nov-24	Driver			Not Escalated	90.0		
	Safe	Never Events		0	1	Mar-25	0	1	Feb-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	32.0	Mar-25	32.6	5.3	Feb-25	Driver			Not Escalated	31.2		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.4	53.3	Mar-25	44.4	45.1	Feb-25	Driver			Not Escalated	53.1		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Mar-25	0	0	Feb-25	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	5.0	Mar-25	6.4	5.3	Feb-25	Driver			Not Escalated	5.8		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	98.1%	Feb-25	95.0%	98.4%	Jan-25	Driver			Not Escalated	96.1%		

Vision: Counter Measure Summary

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

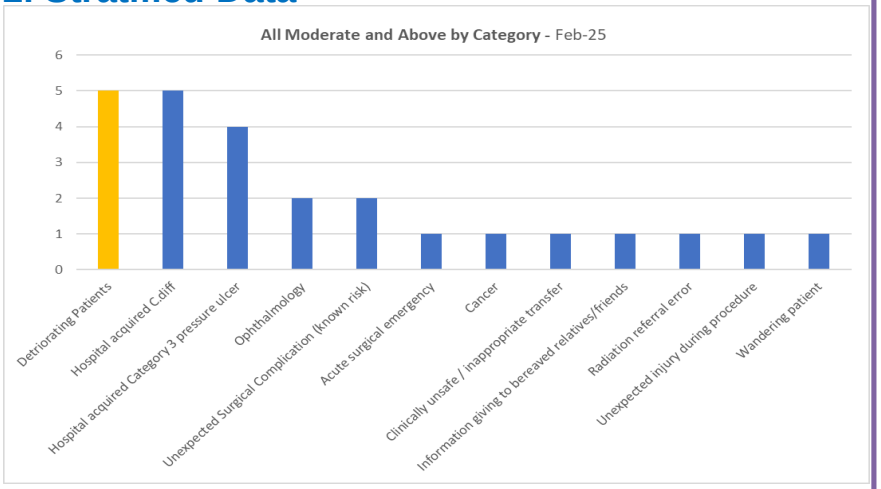
Owner: Medical Director
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

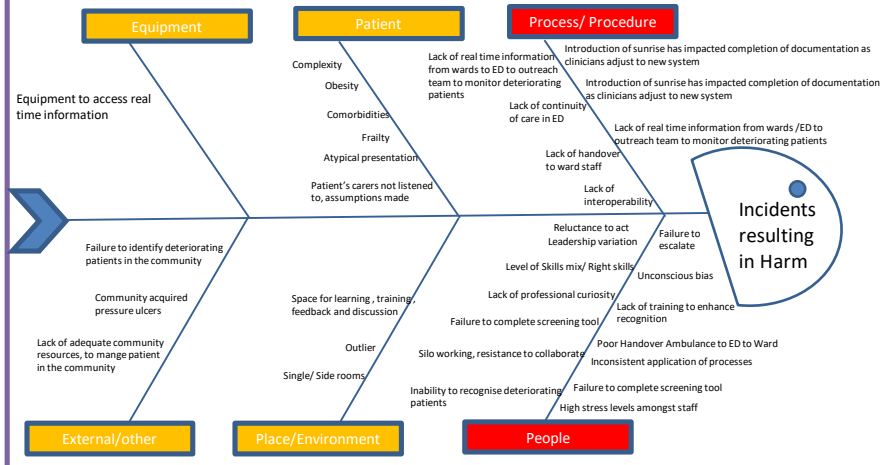


Feb-25 (1 month arr)
1.69
Variance Type
Metric is currently experiencing common cause variation
Maximum Limit (Internal)
1.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



3. Top Contributors



4. Action Plan

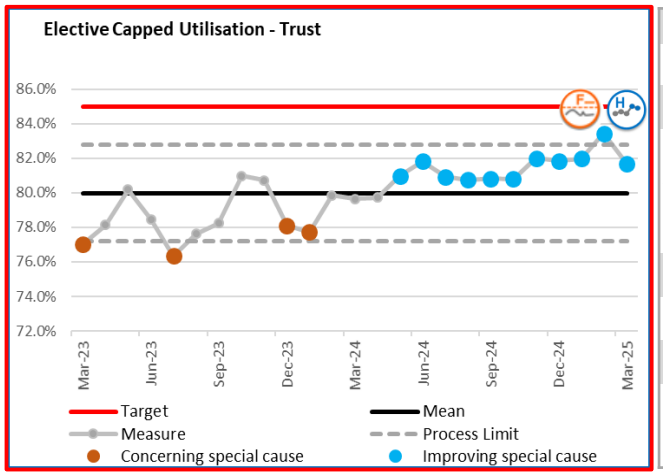
Actions	Leads	Due by
Hospital acquired pressure ulcers		
Surgery division undertaking A3 to identify improvement in pressure ulcers	TV Team	TBC
Continue to focus on pressure ulcer prevention and pressure ulcer classification at our teaching sessions	TV Team	Ongoing
Review and analyse the data from the pressure ulcer prevalence audit undertaken on 21/11/2024	TV Team	Ongoing
Hospital acquired C difficile		
Implement Trust-wide pressure ulcer action plan	IPC Team	Ongoing
Deteriorating Patients		
Review educational offering to develop new education package	JB	Q1
Explore roll out of Hospital at Night service	Project Team	Ongoing

Financial Breakthrough: Counter Measure Summary

Project/Metric Name – % Capped Theatre utilisation.

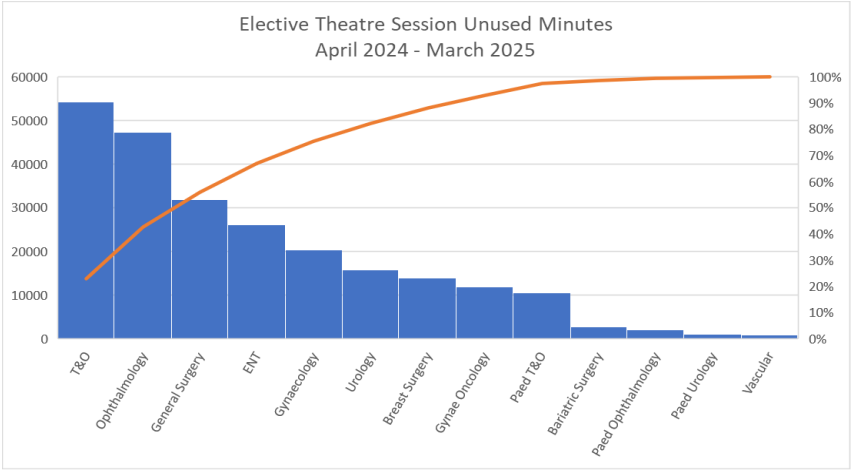
Owner: Medical Director
Workstream: Productivity
Metric: % Capped Theatre utilisation.
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Mar-25
81.7%
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 for some consultants
- Cancellations are high
- Scheduling – Specialties set action at TP to get 3 weeks ahead with booking.
- Backfilling of sessions in orthopaedics

Issues:

- MS Paed lists underutilised
- Scheduling not far enough ahead
- Theatre capacity at TW
- Better awareness of service users – how are we doing boards

Key Risks:

- OPEL 4 Escalation at TW
- Instrumentation sometimes experience holes in set wraps

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
AKESO playback and discuss findings		
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	7.0	Mar-25	5.9	6.9	Feb-25	Driver			Full CMS			
Financial Breakthrough Objective	Responsive	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	15.1%	Mar-25	16.0%	15.7%	Feb-25	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Responsive	Achieve the Trust RTT Trajectory (Excluding SYS)		81.2%	74.2%	Mar-25	80.6%	72.7%	Feb-25	Driver			Escalation	74.2%		
	Responsive	Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally		81.2%	74.1%	Mar-25	80.6%	72.4%	Feb-25	Driver			Business Rules not applied (for info only)			
	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		145.1%	147.9%	Mar-25	122.4%	124.9%	Dec-24	Driver			Not Escalated	130.9%		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		685	648	Mar-25	659	811	Feb-25	Driver			Not Escalated	648		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	19	Mar-25	N/A	22	Feb-25	Driver			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	Mar-25	N/A	0	Feb-25	Driver			Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		99.1%	89.4%	Mar-25	99.0%	91.3%	Feb-25	Driver			Escalation	89.4%		
	Responsive	A&E 4 hr Performance		84.8%	85.2%	Mar-25	82.2%	82.1%	Feb-25	Driver			Not Escalated	85.2%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.6%	Feb-25	96.0%	96.1%	Jan-25	Driver			Not Escalated	96.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.3%	Feb-25	85.0%	78.9%	Jan-25	Driver			Not Escalated	85.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	80.9%	Feb-25	75.0%	75.2%	Jan-25	Driver			Not Escalated	81.3%		
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	90.8%	Feb-25	90.0%	90.6%	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)

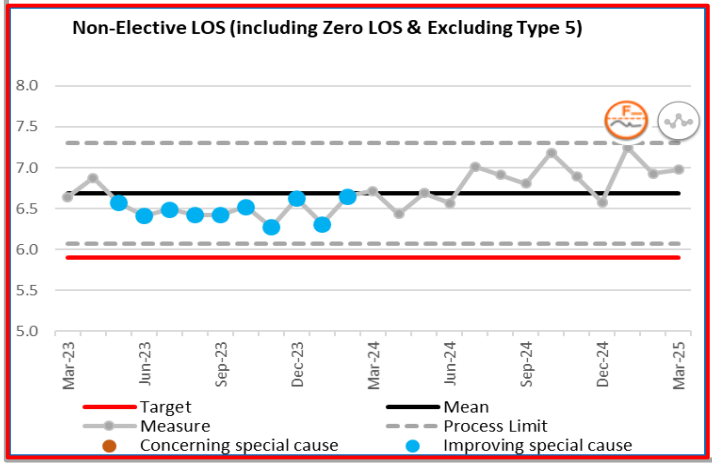
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	79.3%	Mar-25	85.0%	83.5%	Feb-25	Driver			Not Escalated	85.1%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		7.8%	6.9%	Mar-25	8.0%	6.7%	Feb-25	Driver			Escalation	6.9%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	84.0%	Mar-25	90.0%	87.3%	Feb-25	Driver			Escalation	86.2%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	7.2%	Mar-25	5.0%	7.8%	Feb-25	Driver			Escalation	7.3%		
	Responsive	To achieve the planned levels of elective (DC and IP combined) activity (shown as a % 19/20)		152.7%	171.6%	Mar-25	109.4%	122.5%	Feb-25	Driver			Not Escalated	127.8%		
	Responsive	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	51.6%	Mar-25	49.0%	51.9%	Feb-25	Driver			Not Escalated	53.0		
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		173.7%	187.6%	Mar-25	145.5%	142.3%	Feb-25	Driver			Not Escalated	163.8%		

Vision: Counter Measure Summary

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

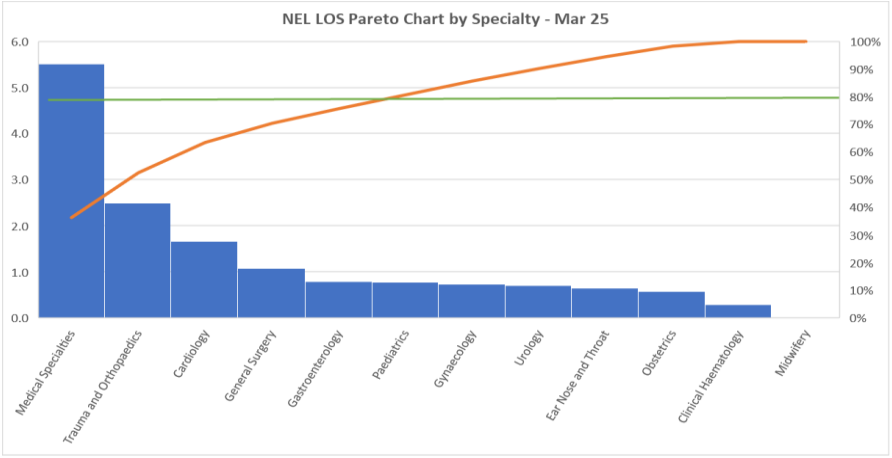
Owner: Chief Operating Officer
Workstream: Operational Flow
Metric: Non-Elective Length of Stay (LOS)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-25
7.0
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

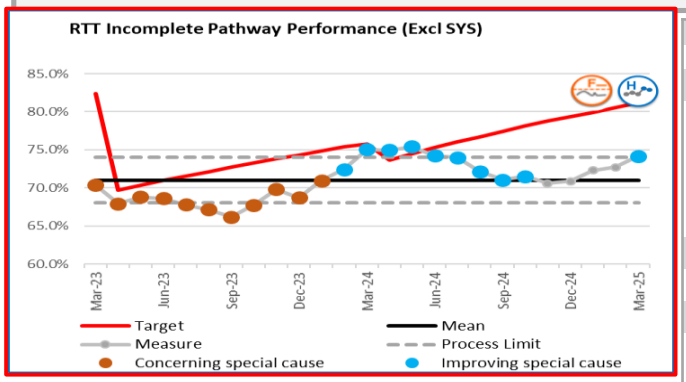
Key Risks:

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

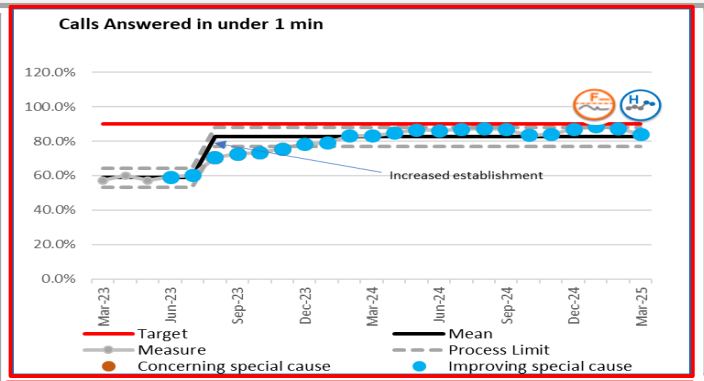
4. Action Plan

Action	When
Key focus areas for improvement: • No criteria to reside • SDEC • Weekend discharges • Teletracking optimisation, innovation & expansion into Maternity	Ongoing
Data gathering and analysis	Apr 25
Agree metrics for each focus area	Apr 25
Analysis of financial impact	Apr 25
Project plans developed	May 25

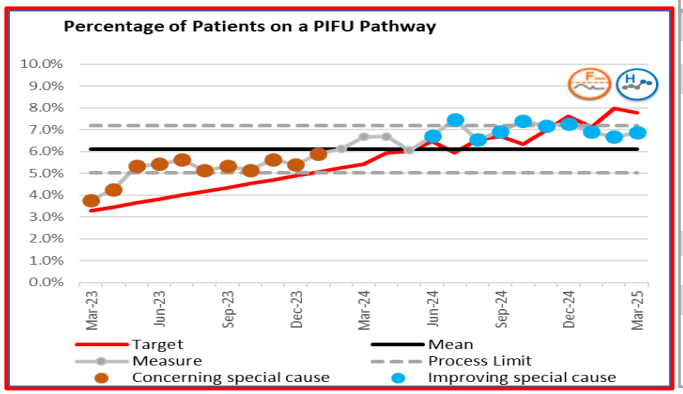
Patient Access: CQC: Responsive



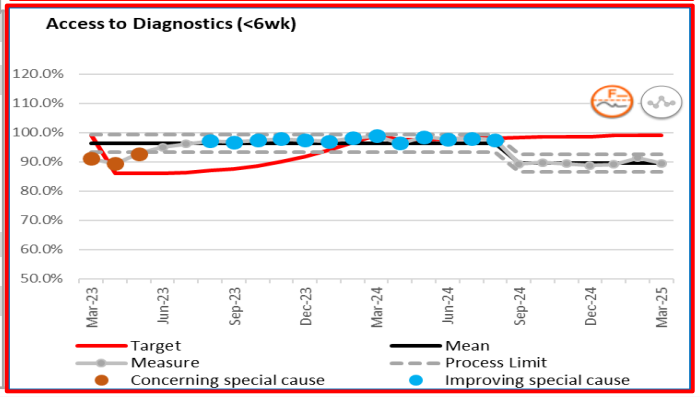
Mar-25
74.2%
Variance Type
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target (Internal)
81.2%
Target Achievement
Metric is consistently failing the target



Mar-25
84%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as consistently failing the target



Mar-25
6.9%
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



Mar-25
89.4%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
99.1%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

RTT: is experiencing special cause variation of an improving nature 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. Known staffing issue within General Medicine, General Surgery and Surgical Specialities CAU.

% 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.
Overall Diagnostics target has also now changed nationally from 99% to 95% and MTW trajectory set for 2025/26 is to achieve a minimum of 95% within 6 weeks by March 26.

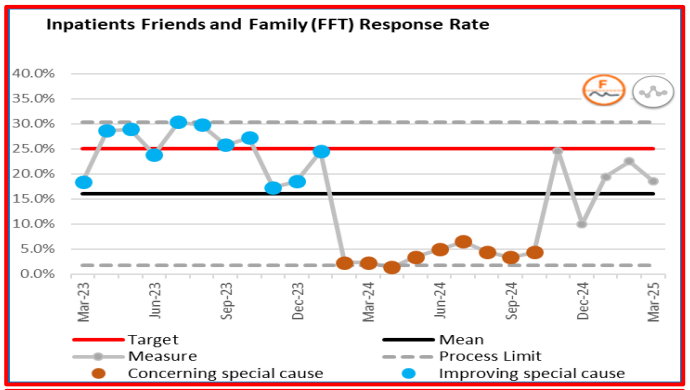
Assurance & Timescales for Improvement:

RTT: Clear trajectory for reducing wait times for first appointments with the specialty teams established and communicated. Super clinics implemented. Straight-to-test pathways for Gastro and ENT in the implementation phase. Internal Recovery plans for the divisions and specialties have been completed and are monitored monthly. Task and Finish Group implemented to move specialties back to a directly bookable service for first appointments, Respiratory sleep studies have gone live with further pathways due to be implemented. T&O services for Hand & Wrist, Shoulder and foot and ankle going live in May.
Calls Answered within 1 minute in the CAUs: Remain on upward trajectory. Focus on underperforming specialities to reach 90% specifically T&O & Endoscopy. Outpatient Contact Centre fully established and no new sickness.
% of Patients on a PIFU Pathway: Specialty plans for benchmarking against GIRFT/Model Hospital being reviewed monthly. Remote monitoring of Long Term Conditions via our digital platforms have gone live for Neurology, further specialties being identified, GIRFT tool Kits to support faster implementation.
% Diagnostics within 6 weeks: Endoscopy capacity secured at Fordcombe to help improve performance. Underperforming specialties are developing recovery plans.

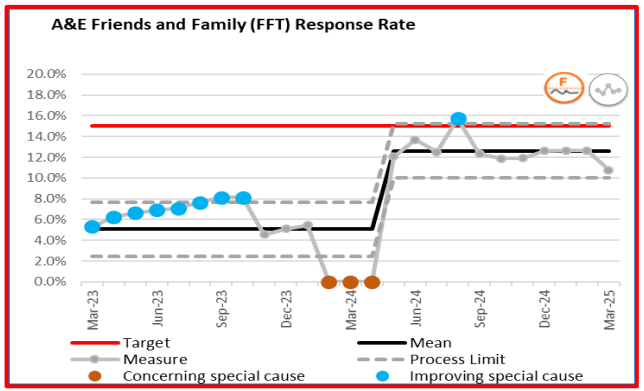
Strategic Theme: Patient Experience

				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	Year End Forecast	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		36	58	Mar-25	36	59	Feb-25	Driver			Verbal CMS	58		
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	Mar-25	24	25	Feb-25	Driver			Verbal CMS	25		
Financial Breakthrough Objective	Caring	Reduction in agency spend (specific to B5 RMNs and B3 HCSW)		190,000	191,112	Mar-25	190,000	164,380	Feb-25	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Caring	Complaints Rate per 1,000 occupied beddays		3.9	3.1	Mar-25	3.9	3.3	Mar-24	Driver			Not Escalated	3.1		
	Caring	% complaints responded to within target		75.0%	80.0%	Mar-25	75.0%	78.0%	Feb-25	Driver			Not Escalated	80.0%		
	Caring	Complaints Backlog – Older than 4 months		0	6	Mar-25	0	4	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints Closed in Month		38	41	Mar-25	38	51	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	100.0%	Mar-25	95.0%	100.0%	Feb-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	18.5%	Mar-25	25.0%	22.5%	Feb-25	Driver			Escalation	26.26%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	10.77%	Mar-25	15.0%	12.65%	Feb-25	Driver			Escalation	14.49%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	12.5%	Mar-25	25.0%	7.6%	Feb-25	Driver			Escalation	5.38%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	11.2%	Mar-25	20.0%	10.1%	Feb-25	Driver			Escalation	10.72%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	100.6%	Mar-25	93.5%	101.6%	Feb-25	Driver			Not Escalated	100.6%		

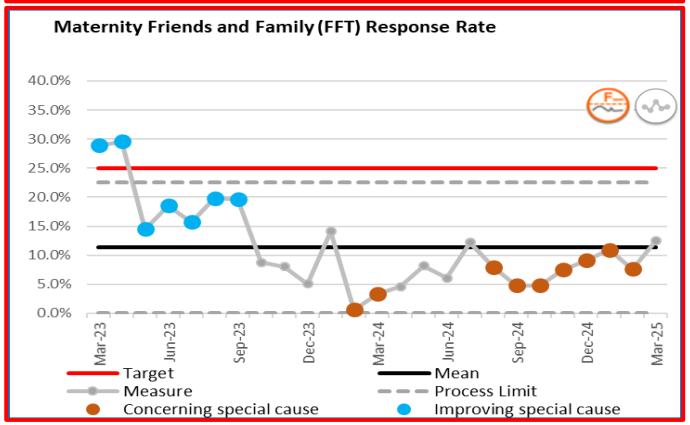
Patient Experience: CQC: Caring



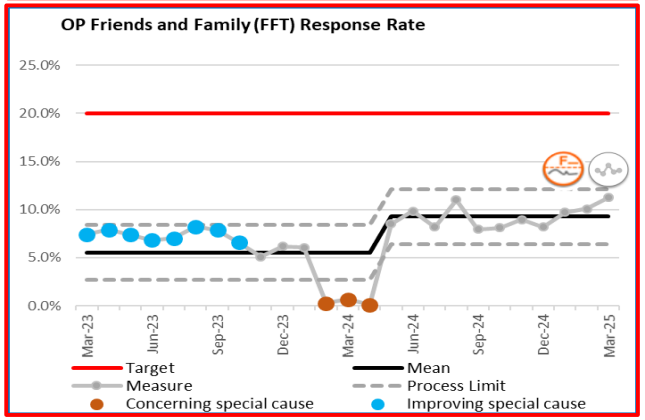
Mar-25
18.5%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (National)
25%
Business Rule
Full Escalation as failing the target for 6+ months



Mar-25
10.0%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Mar-25
12.4%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Mar-25
14.3%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

Friends and Family Response Rate - Inpatients: Is experiencing Common Cause variation has failed the target for 6+ months
National Response – 20.0%
Trust Recommended Rate is 94.5%
Friends and Family Response Rate - A&E: Is experiencing common cause variation and has failed the target for 6+ months
National Response – 9.9%
Trust Recommended Rate is 80.6%
Friends and Family Response Rate - Maternity: : Is experiencing common cause variation and consistently failing the target
National Response – 12.6%
Trust Recommended Rate is 100.0%
Friends and Family Response Rate - Outpatients: Is experiencing common cause variation and is consistently failing the target
National Response – 16.9%
Trust Recommended Rate is 93.7%

Actions:

Inpatients: Response rate appears to have decreased this month however, a failure in planned courier collections of hard copy responses is likely to be a cause of this as inpatient responses normally comprise a significant proportion of the FFT cards submitted. Positive feedback significantly outweighs negative however, the 3 top themes are very similar and consistent – staff attitude, implementation of care and environment were identified as positive themes and environment, staff attitude and communication as negative themes. Negative comments commonly relate to lack of continuity of care, lack of 'joined up' care/communication, specific comments related to updates/information provided to relatives/supporters and inability to be accompanied on the day of the procedure at SSU.

A&E: Response rate has dipped slightly this month, this is attributed to recent quality assurance work undertaken on the hierarchy structure which demonstrated that a proportion of feedback has been incorrectly attributed to ED, these responses should mostly have been attributed to outpatients and may therefore be part of the reason for an increase in the response rate there this month. 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 – several patients getting 'lost' in the system resulting in extended waiting times; staff attitude including a lack of kindness and compassion; the need to repeatedly explain symptoms as notes seemingly not updated/available and lack of communication between staff groups/areas.

Maternity: The response rate has increased significantly from last month, the teams continue to collaborate and maintain engagement with the clinical teams to promote the survey. Positivity rate of feedback received is extremely high with standard of care provided by staff, being a recurrent theme, unfortunately of the 4 respondents providing the lowest feedback scores 2 failed to provide any detail of the issues encountered, the remaining negative feedback was associated with waiting times.

Outpatients: Response rate has continued to increase, as above this is partially attributed to changes to the hierarchy and feedback being correctly directed when received. The top themes remain consistent since last month with positive themes being 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 continue to fluctuate, significant steps have been made as a result of internal quality assurance undertaken in recent months, it's anticipated that the results of these efforts will be seen in the coming months. Low response rates in maternity are partially attributed to incorrect assignment of location via the hierarchy highlighted in a recent QA exercise with several amendments having already been implemented and others likely.

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, further dates are planned. Stocks of new forms continue to be provided to requesting areas rapidly with an aspired TAT of 48hours despite significant sickness absence within the team.
A significant internal QA exercise has demonstrated incorrect assignments of feedback and highlighted substantial gaps in the clinic codes being used to support data collection via SMS text. Measures to rectify this have now been implemented and it is anticipated that the impact of this work will begin to be seen in the April data following implementation of the changes on 1st April 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 test will continue.
A further QA exercise over the coming months will involve liaison with each Division and Directorate to ensure that clinic codes are being correctly mapped to the hierarchy, this work has already commenced with maternity.

Strategic Theme: Systems

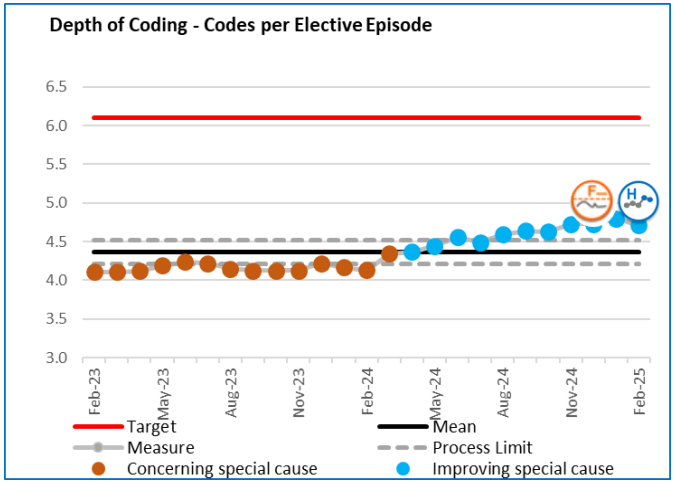
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Financial Breakthrough Objectives	Effective	Depth of Coding - Average Number of Codes per Elective Episode (Data runs one month behind)		6.1	4.7	Feb-25	6.1	4.8	Jan-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Effective	Inpatient coding income (simple audit tool)		TBC	99771	Feb-25	TBC	72585	Jan-25	Driver			Escalation			

Financial Breakthrough: Counter Measure Summary

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

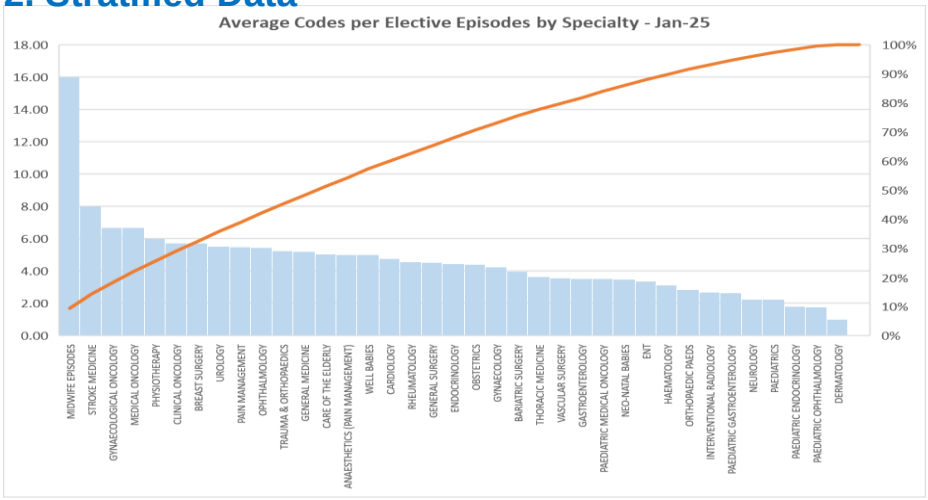
Owner: Director Strategy, Planning & Partnerships
Workstream: Capturing Income
Metric: Codes per Elective Episode
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Feb-25 (one month behind)
4.8
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	Year End Forecast	Variation	Assurance
Vision	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000)		2,803	4,509	Mar-25	-134	4,838	Feb-25	Driver			Verbal CMS	161		
Financial Breakthrough Objectives	Well Led	Reduce non-pay spend		17,233	22,701	Mar-25	19,351	19,423	Feb-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		730	745	Mar-25	748	622	Feb-25	Driver			Not Escalated	745		
	Well Led	CIP		4,879	5,833	Mar-25	3,618	4,136	Feb-25	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		4,000	13,116	Mar-25	2,133	13,968	Feb-25	Driver			Not Escalated	13,116		
	Well Led	Capital Expenditure (£k)		4,467	33,663	Mar-25	1,497	2,192	Feb-25	Driver			Not Escalated	33,663		
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		174,805	167,087	Mar-25	159,699	151,916	Feb-25	Driver			Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		25,332	25,104	Mar-25	23,148	22,974	Feb-25	Driver			Not Escalated			

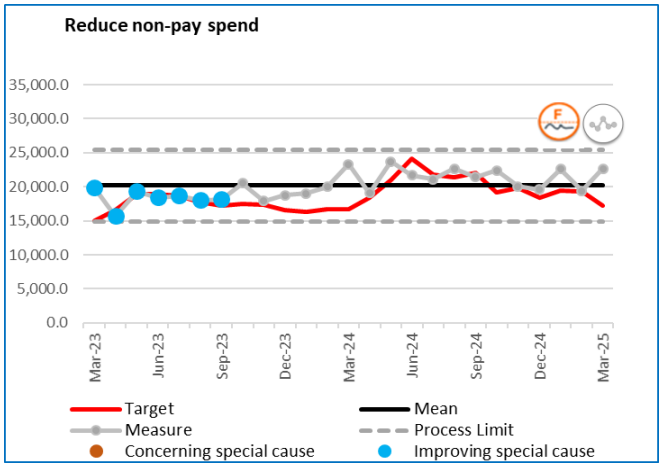
Note – Forecast is for year end

Financial Breakthrough: Counter Measure Summary

Project/Metric Name – Reduce non-pay spend - £000

Owner: Chief Finance Officer
Metric: Non-Pay Spend
Desired Trend: 7 consecutive data points below the mean

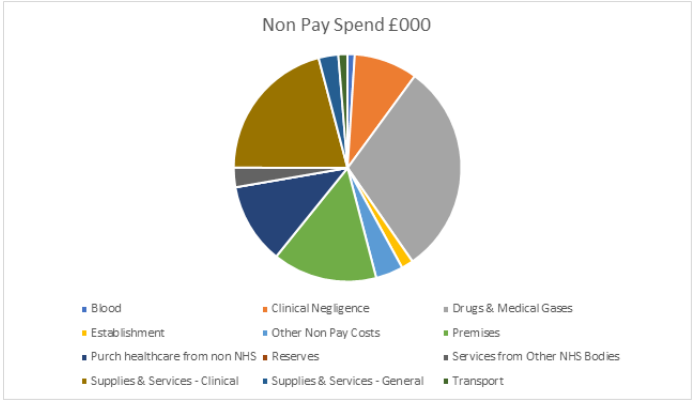
1. Historic Trend Data



Mar-25
22,701
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
17,233
Target Achievement
Metric has failed the target for 6+ months

Note the Oct 22 value is low due to a release of accruals from previous months

2. Stratified Data



The plan included 1.5m of non-recurrent benefits in March however these were identified though out the financial year resulting in an adverse variance in month

3. Top Contributors/Risks

- 1st class postage costs
- Taxi & Courier spend
- External venue costs
- Bespoke stationary
- Patient transport – private ambulance costs
- Implementation of clinic letters via the patient portal

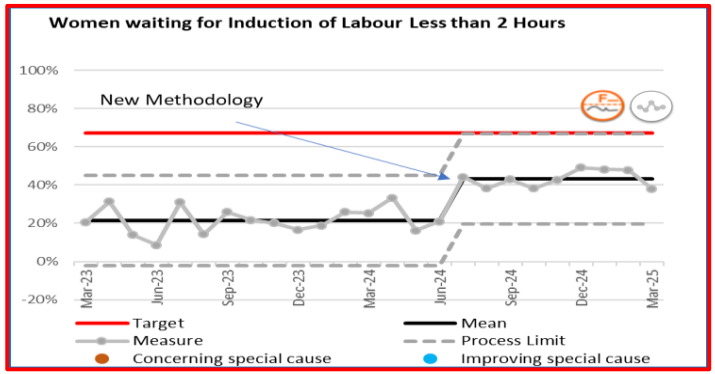
4. Action Plan

Actions	By when
Additional specialities clinic letters to be sent through the patient portal	Q4 2025
Private ambulance process implementation	Q2 2025
Monitoring the 1st class postage savings	Q2 2025

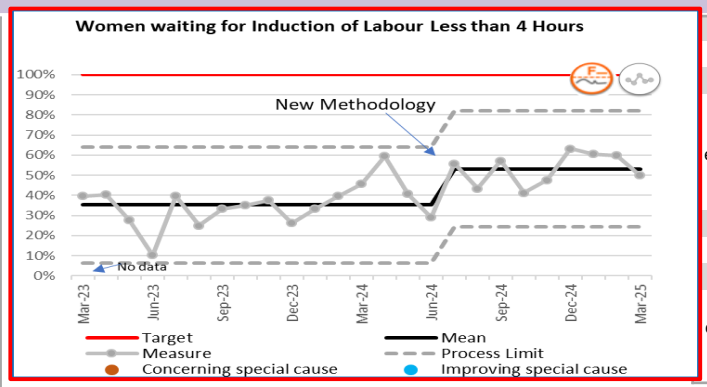
Maternity Metrics

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Maternity Metric	Registerable Births		No target	432	Mar-25	470	394	Feb-25	Driver		No target	Not Escalated	423		
	Maternity Metric	Antenatal bookings		No target	538	Mar-25	545	562	Feb-25	Driver		No target	Not Escalated	542		
	Maternity Metric	Elective Caesarean Rate		No target	21.7%	Mar-25	No target	23.9%	Feb-25	Driver		No target	Not Escalated	22.8%		
	Maternity Metric	Emergency Caesarean Rate		No target	21.0%	Mar-25	No target	20.6%	Feb-25	Driver		No target	Not Escalated	21.9%		
	Maternity Metric	Induction of Labour Rate		36.0%	26.5%	Mar-25	36.0%	26.2%	Feb-25	Driver			Not Escalated	24.3%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	38.0%	Mar-25	67.0%	47.8%	Feb-25	Driver			Escalation	51.3%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	50.0%	Mar-25	100.0%	59.8%	Feb-25	Driver			Escalation	62.7%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	6.3%	Mar-25	6.0%	4.6%	Feb-25	Driver			Not Escalated	6.2%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	6.1%	Feb-25	4.0%	4.3%	Jan-25	Driver			Not Escalated	5.7%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Mar-25	0.4%	0.0%	Feb-25	Driver			Not Escalated	0.2%		
	Maternity Metric	PPH >=1500% Rate		3.0%	4.0%	Mar-25	3.0%	2.0%	Feb-25	Driver			Not Escalated	3.4%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	2.5%	Mar-25	2.5%	1.4%	Feb-25	Driver			Not Escalated	3.7%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	80.5%	Mar-25	75.0%	77.6%	Feb-25	Driver			Not Escalated	80.0%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	66.7%	Mar-25	95.0%	58.3%	Feb-25	Driver			Escalation	68.2%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	79.2%	Mar-25	95.0%	75.0%	Feb-25	Driver			Escalation	78.7%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Mar-25	100.0%	100.0%	Feb-25	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Mar-25	100.0%	100.0%	Feb-25	Driver			Not Escalated	100.0%		

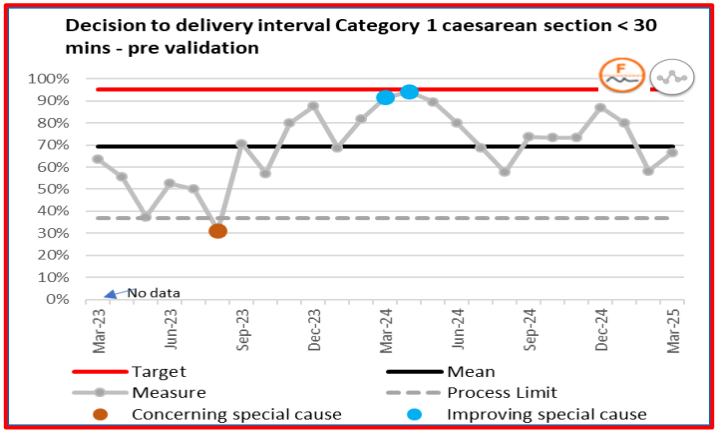
Maternity Metrics



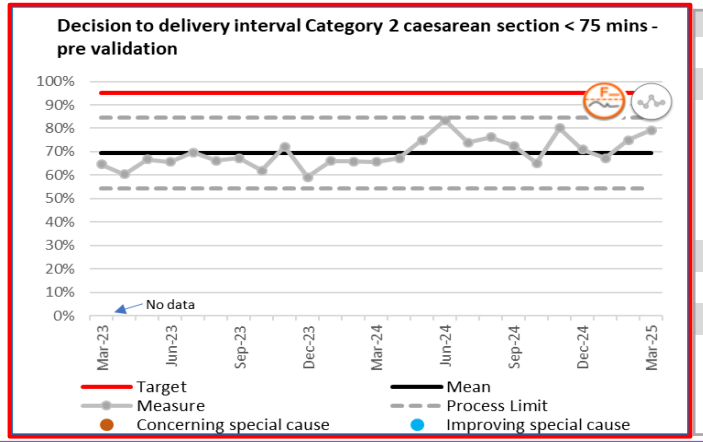
Mar-25
38%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as has failed the target for >6 months



Mar-25
50%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Mar-25
66.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Full escalation as has failed the target for >6 months



Mar-25
79.2%
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.

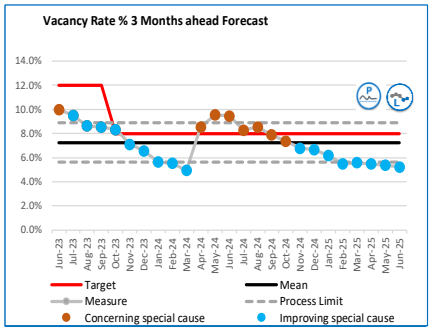
Decision to delivery interval Category 1 and Category 2 caesarean section:
Improvements with compliance with Category 1 and 2 target times has been made. All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified and shared for learning.
Data validation demonstrates 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, 14 cases in 15 (93%) of category 1 target times were met and 36 cases of 41 (89%) of category 2 target times were met.

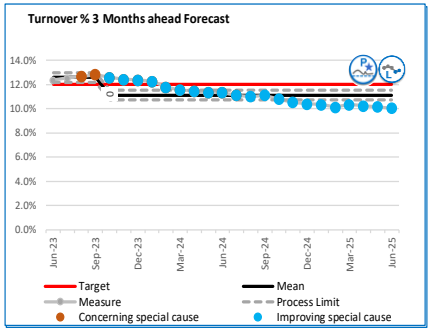
NHS
Maidstone and Tunbridge Wells NHS Trust

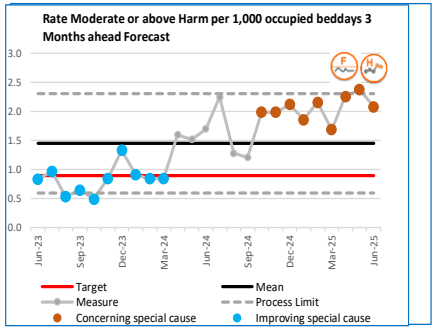
Appendices

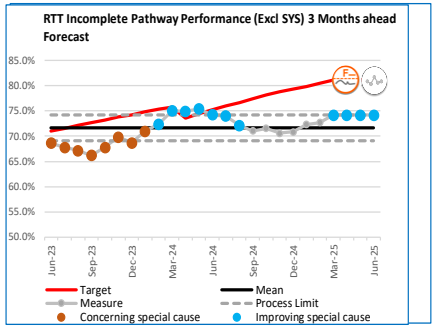
MTW
exceptional people, outstanding care

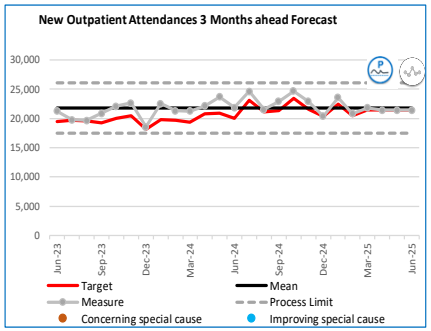
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

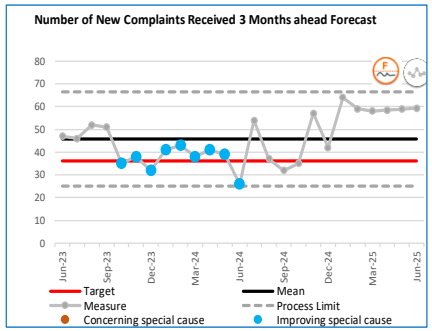


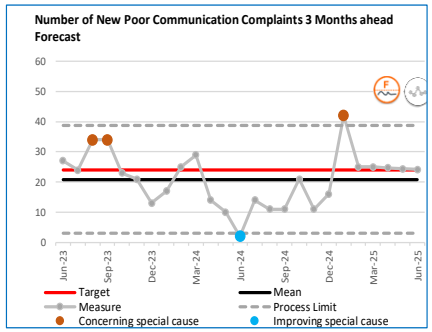


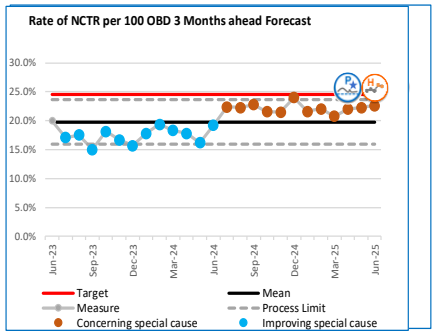


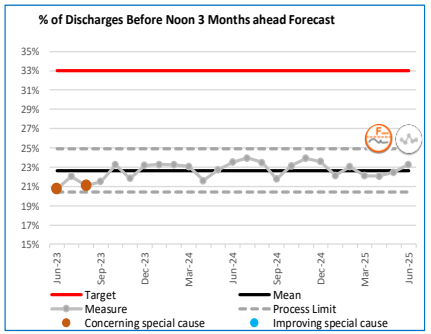


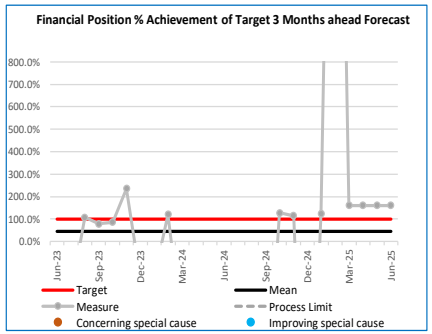


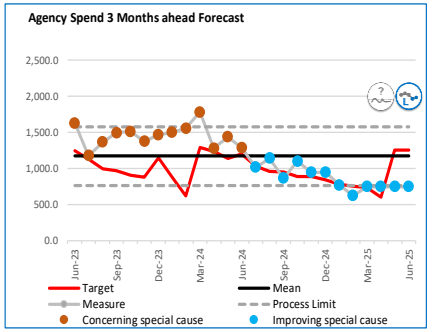


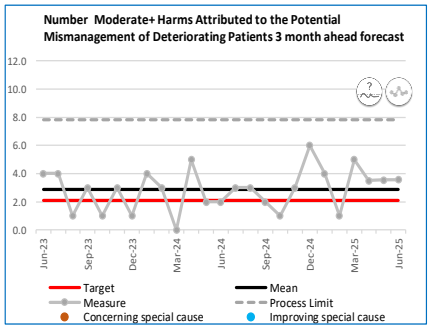




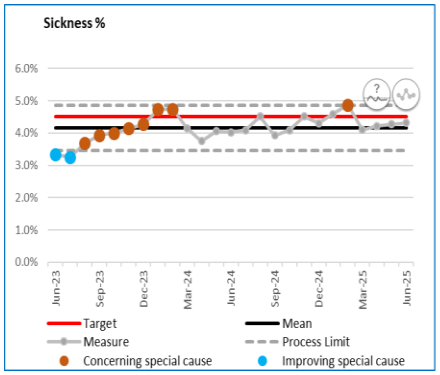


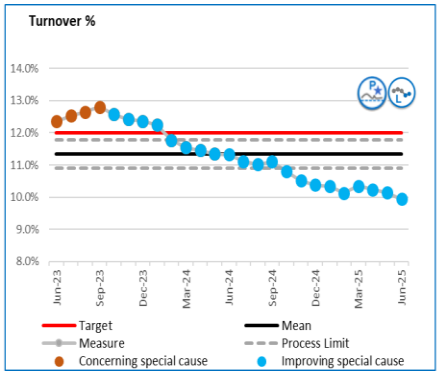


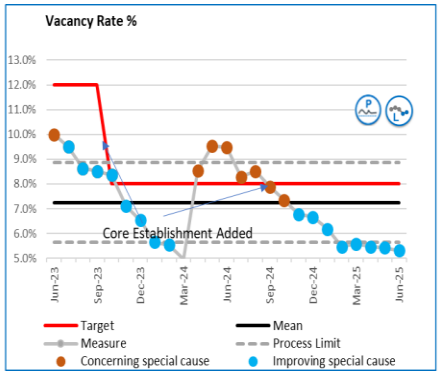


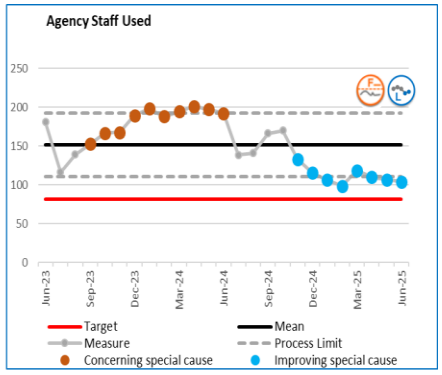


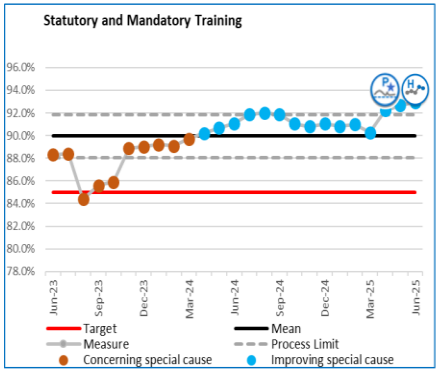
Forecast SPCs (3 month forward view) for People Indicators

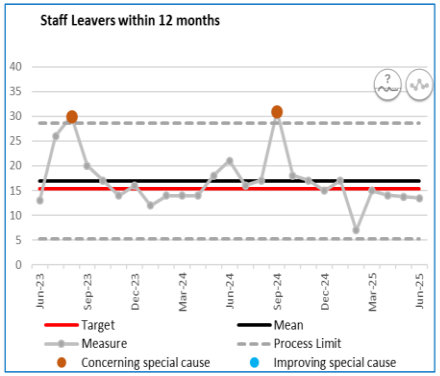


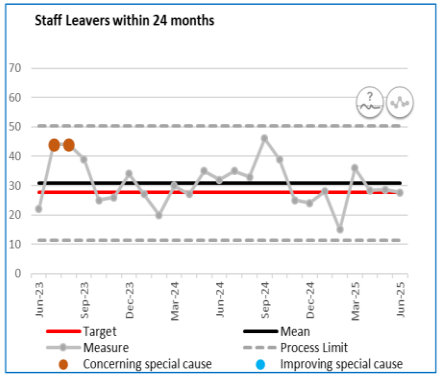


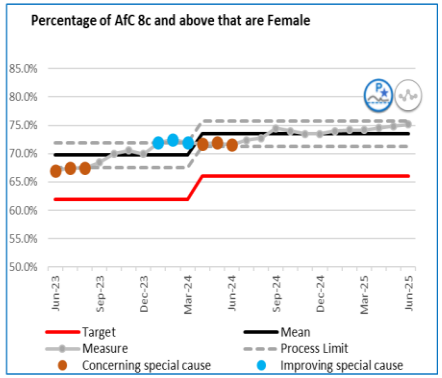


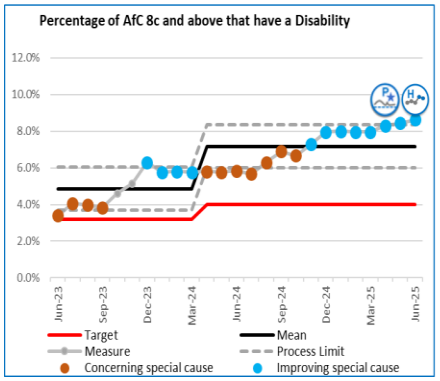


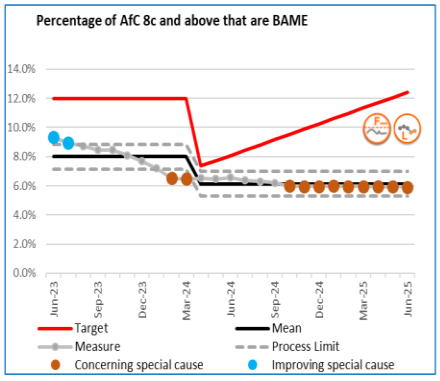


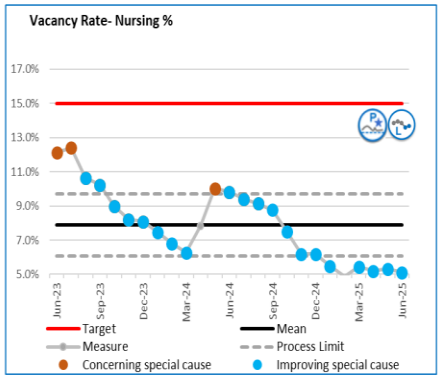




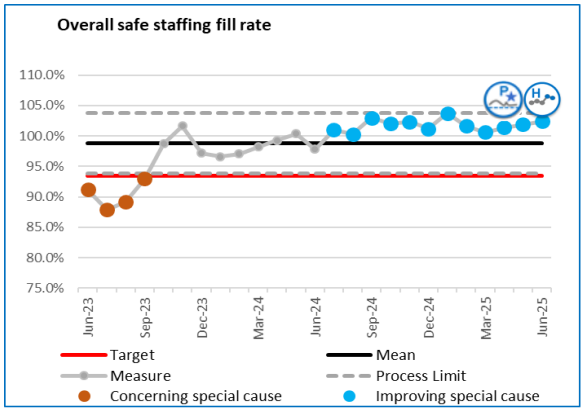


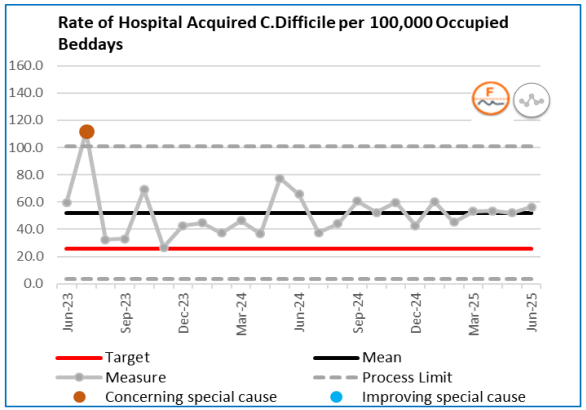


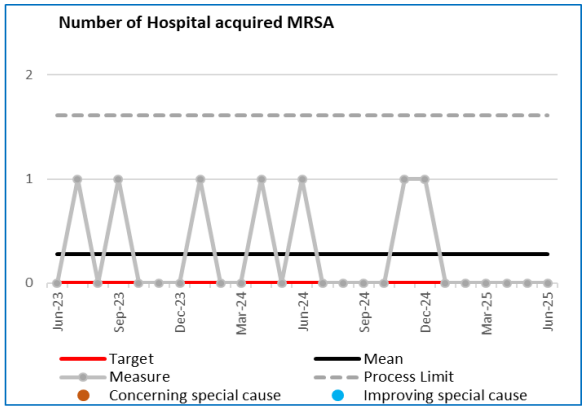


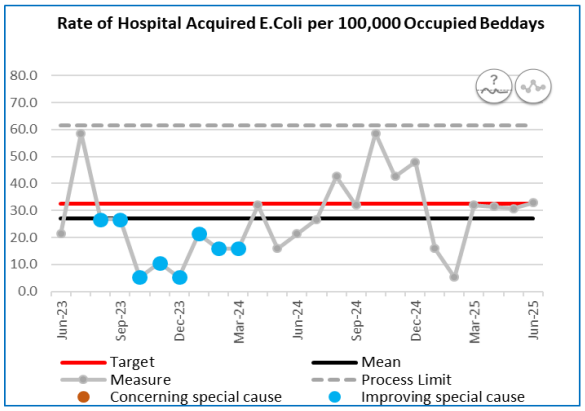


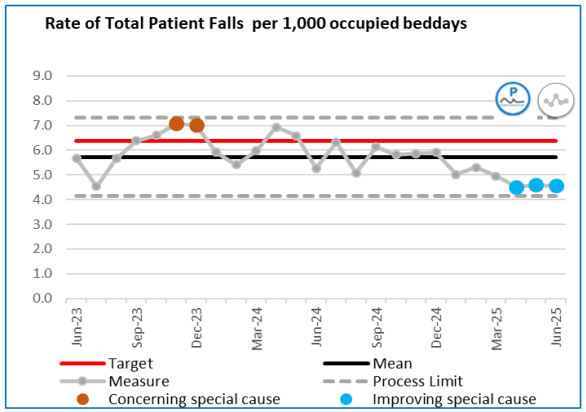
Forecast SPCs (3 month forward view) for Patient Safety Indicators

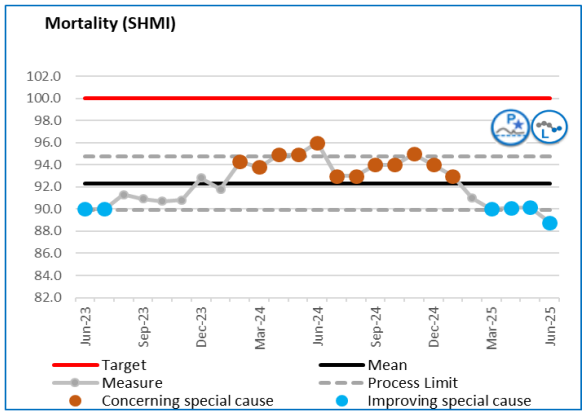


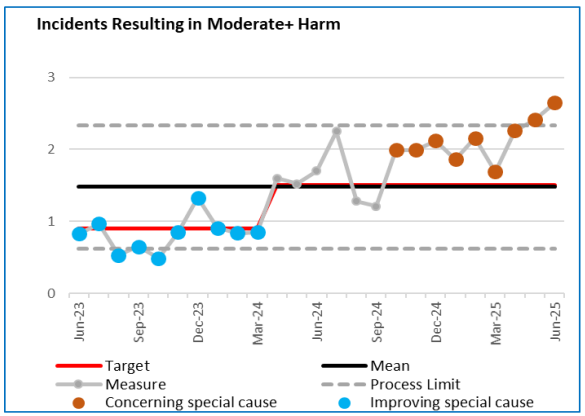


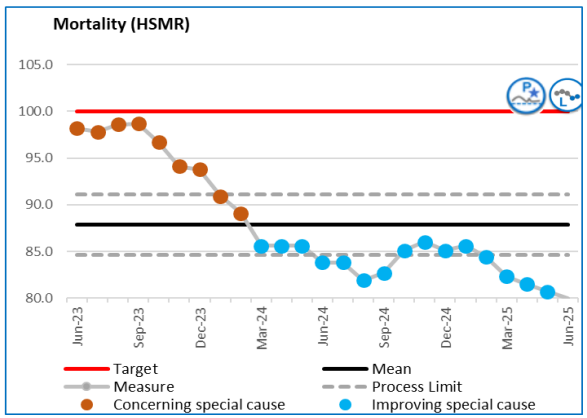




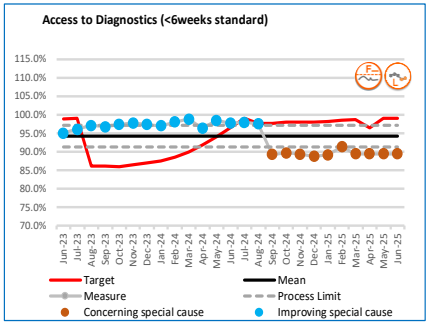


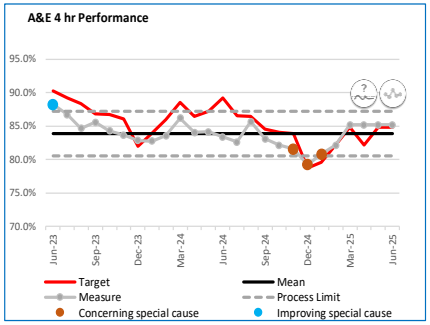


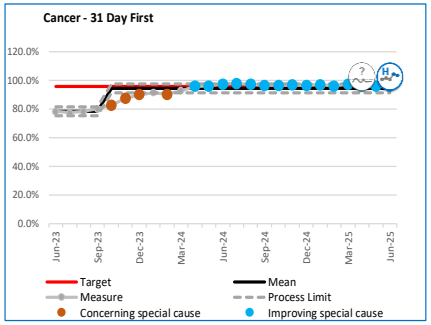


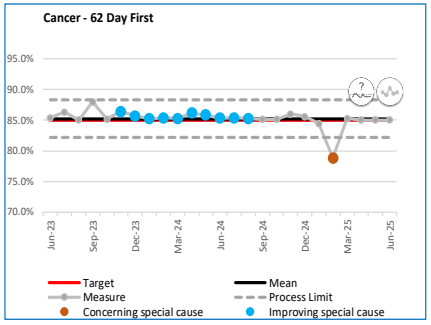


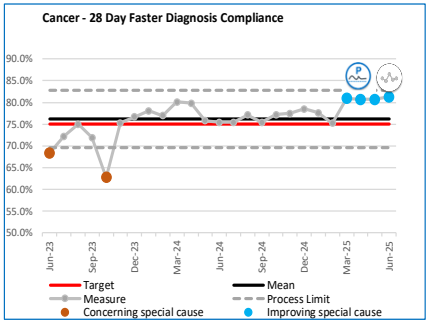
Forecast SPCs (3 month forward view) for Patient Access Indicators

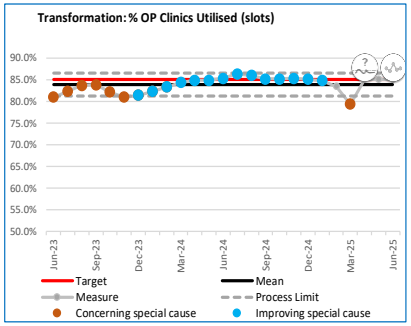


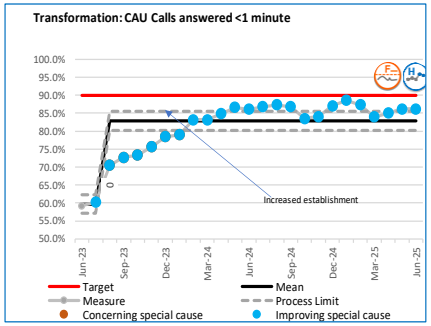


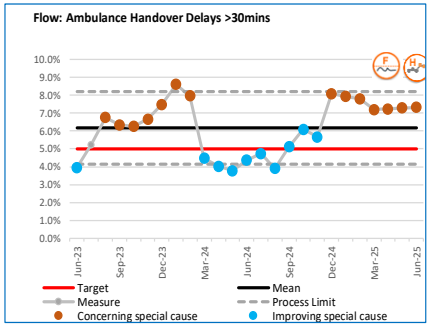


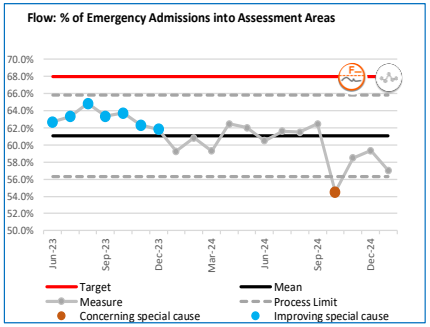


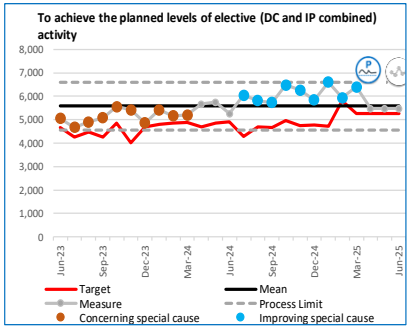


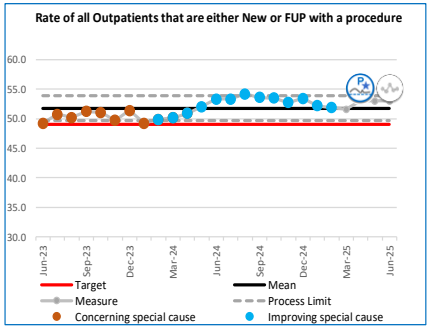


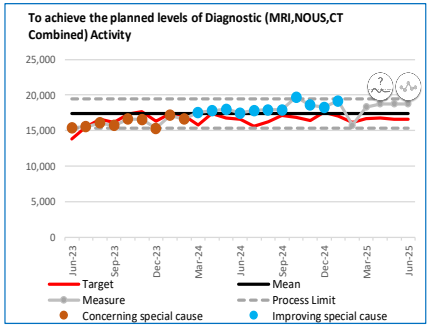




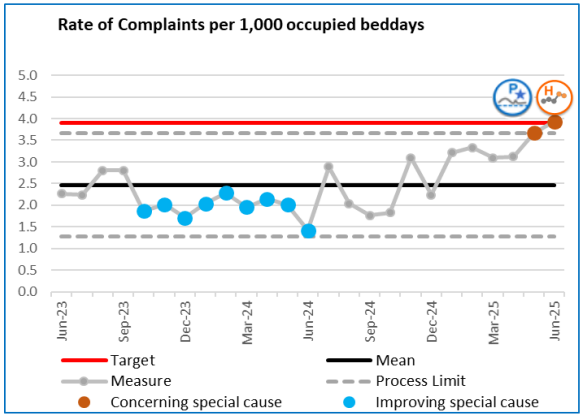


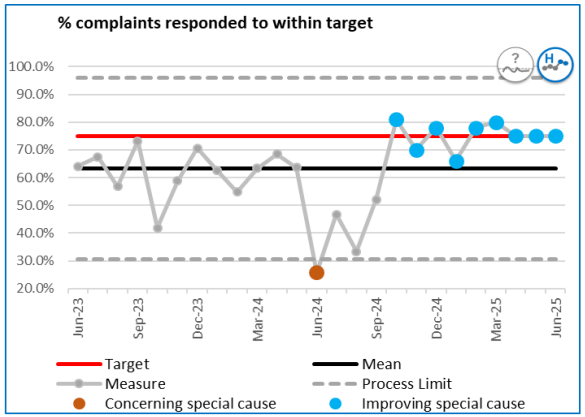


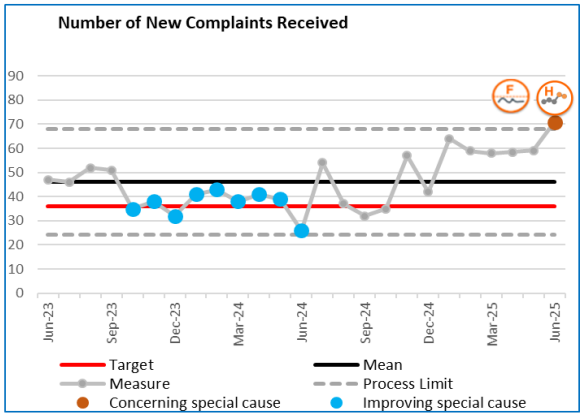


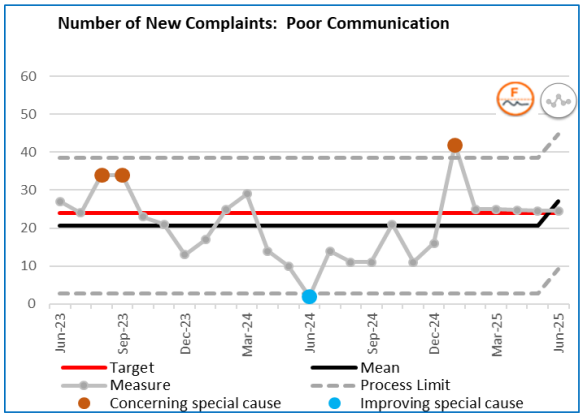


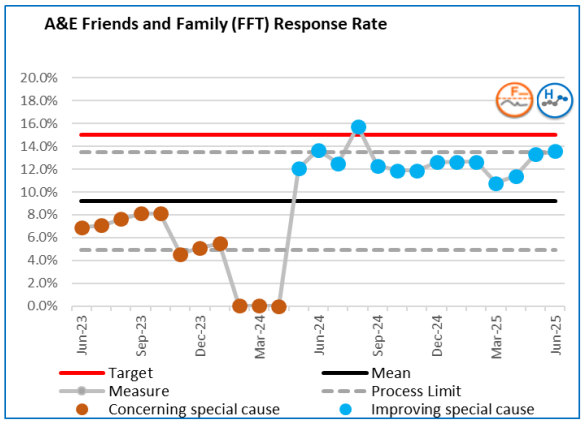
Forecast SPCs (3 month forward view) for Patient Experience Indicators

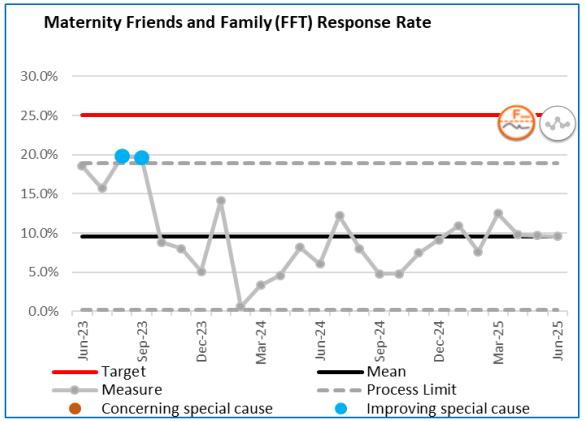


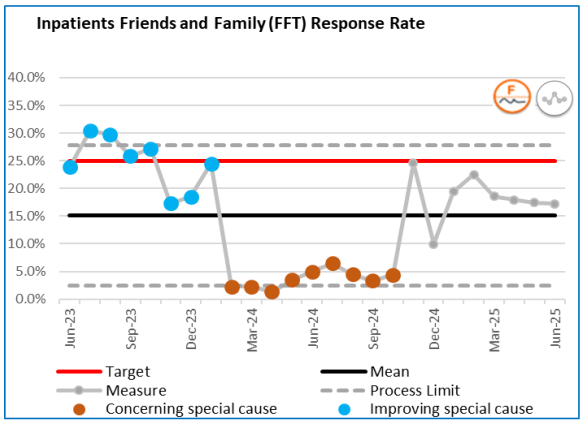


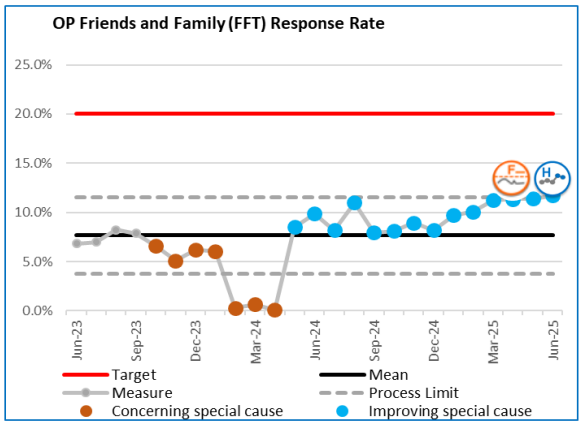


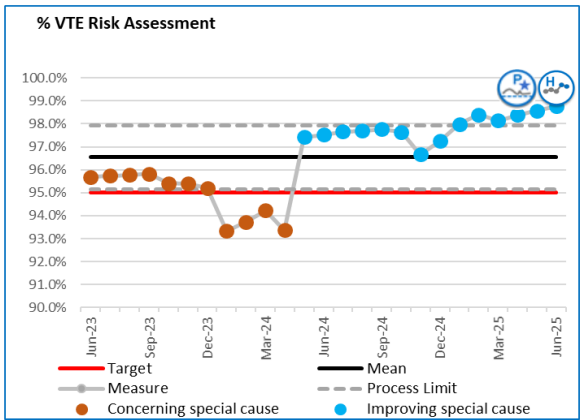




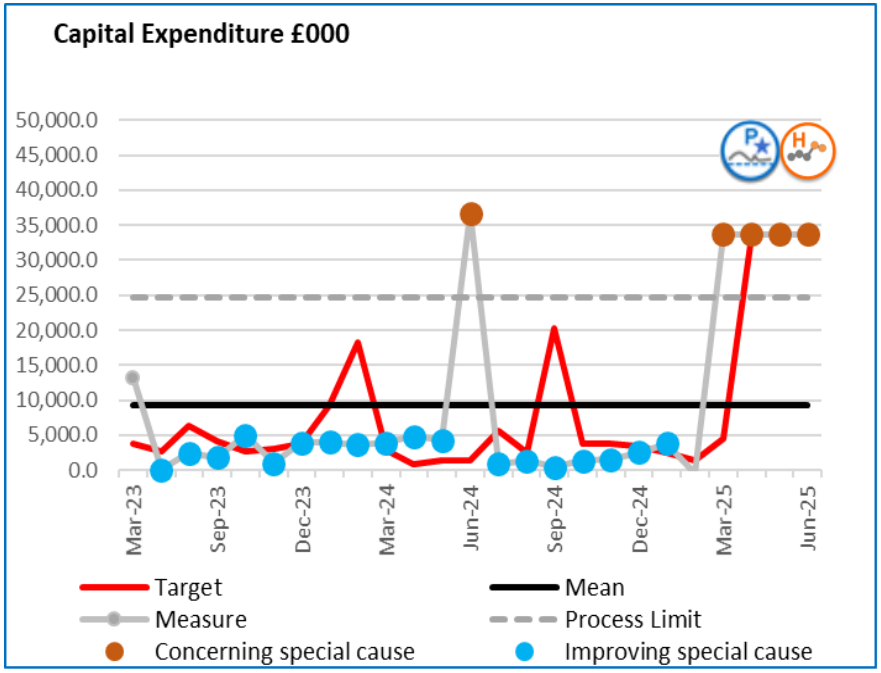


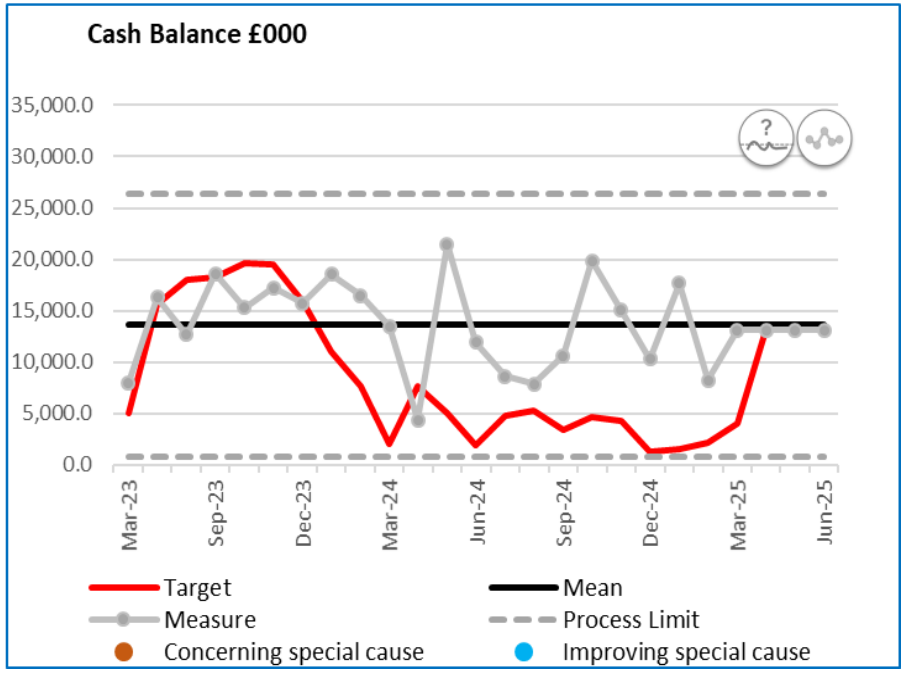




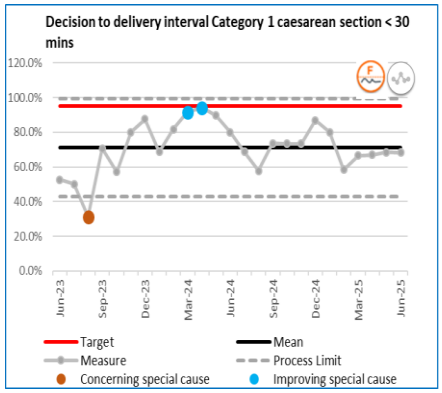


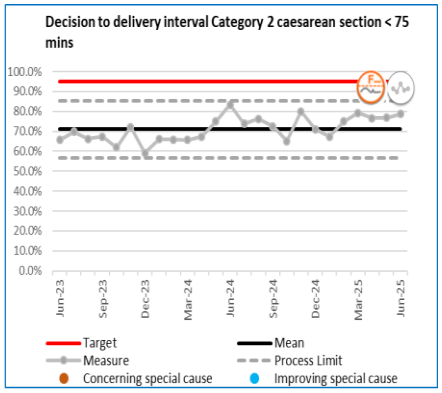
Forecast SPCs (3 month forward view) for Sustainability Indicators

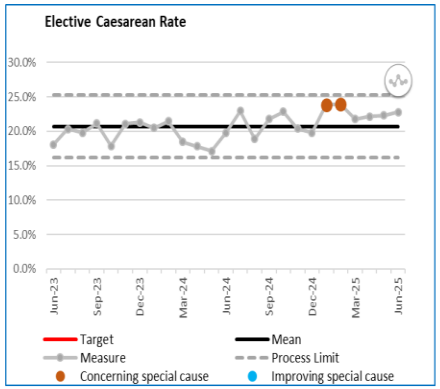


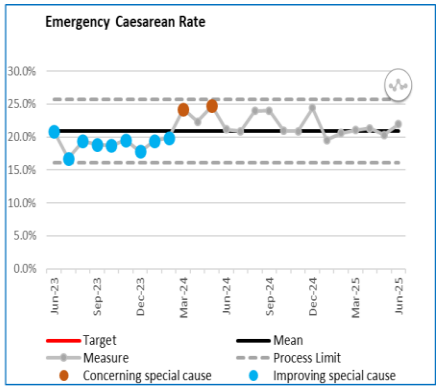


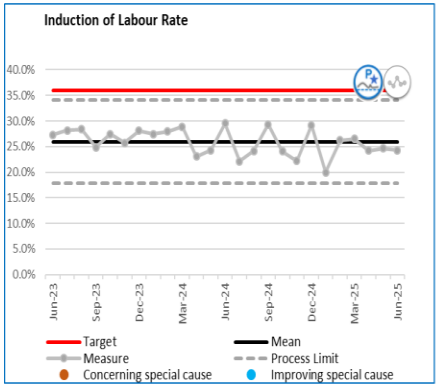
Forecast SPCs (3 month forward view) for Maternity Indicators

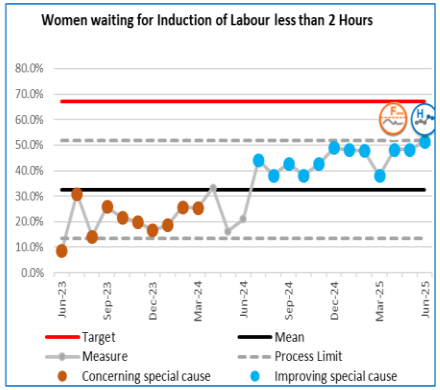


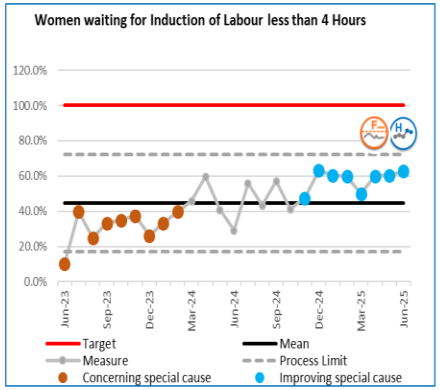


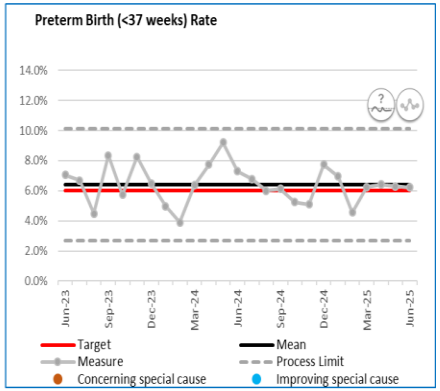


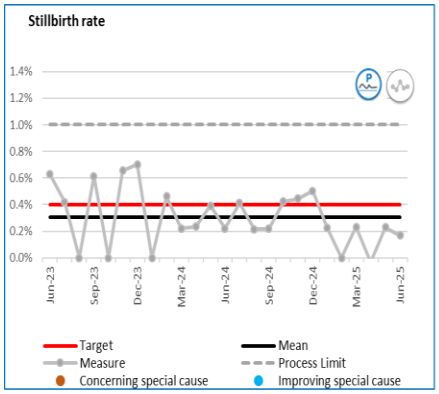


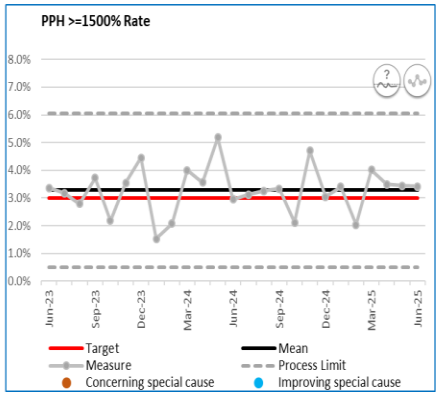


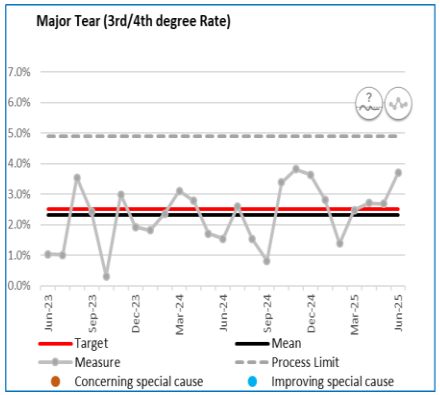


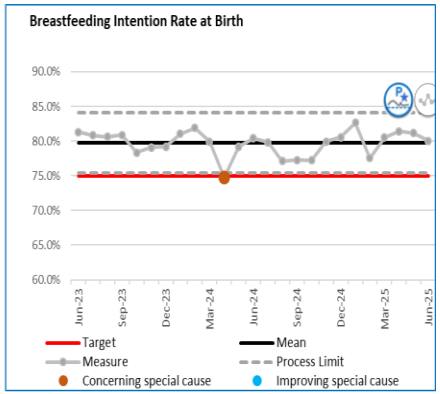






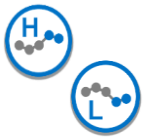






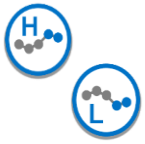
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is showing a Special Cause for Concern. Consider escalating to a driver metric.
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target and is in Common Cause variation. Consider next steps.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is Failing the Target (which is likely if it is a Driver Metric). A full CMS is required to support actions and delivery of a performance improvement	Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric

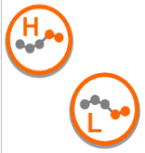
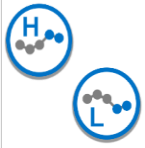
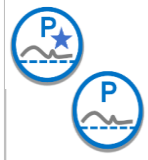
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is in Common Cause, but is showing a Special Cause for Concern. **Note performance**, but do not consider escalating to a driver metric
		Common Cause - no significant change. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is in Common Cause variation. A **verbal CMS** is required to support ongoing actions and delivery of a continued / permanent performance improvement	Metric is Hitting & Missing the Target and is in Common Cause variation. **Note performance**, but do not consider escalating to a driver metric
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. **Note performance**
Any		Assurance indicates inconsistently hitting or missing the target.	A Driver Metric that remains in Hit & Miss for 6 months or more will need to complete a **full CMS**	N/A

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

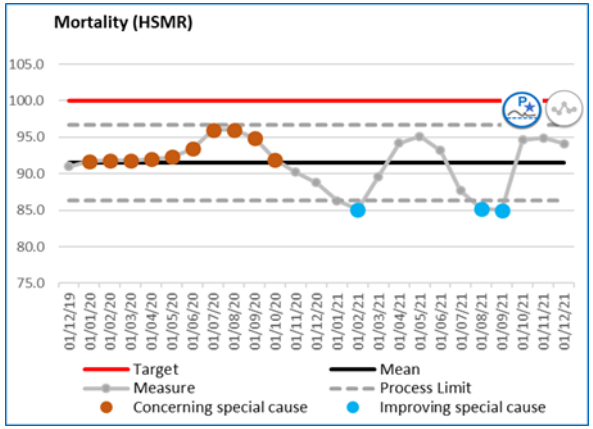
The **target** line **between** the **upper** and **lower** control limit for all metric types

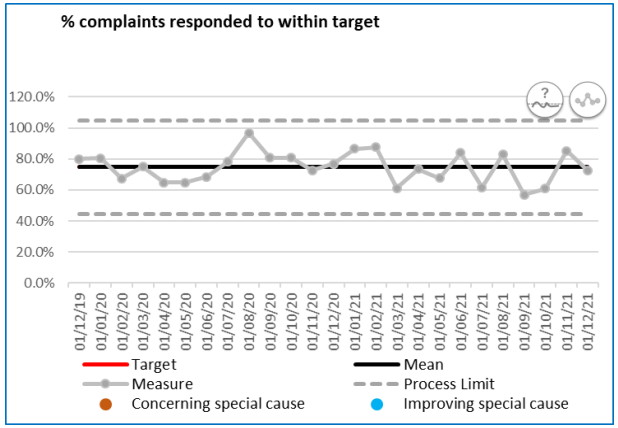
Metrics that consistently **fail** have:

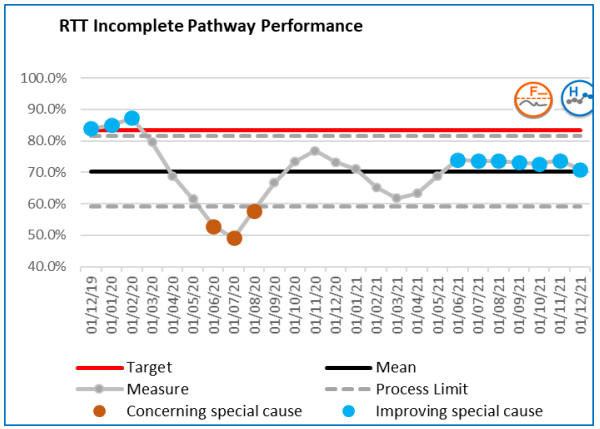
The **lower** control limit **above** the target line for metrics that need to be **below the target**

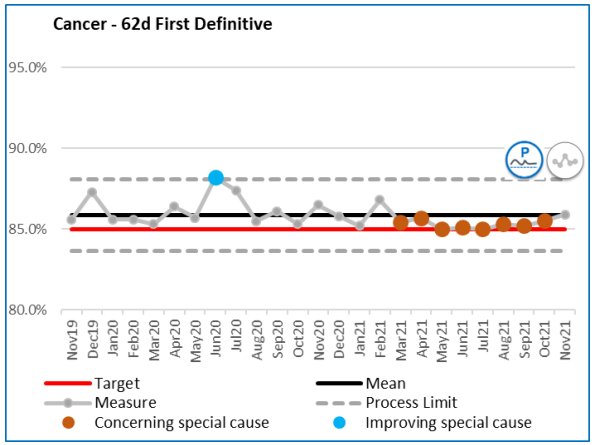
The **upper** control limit **below** the target line for metrics that need to be **above the target**

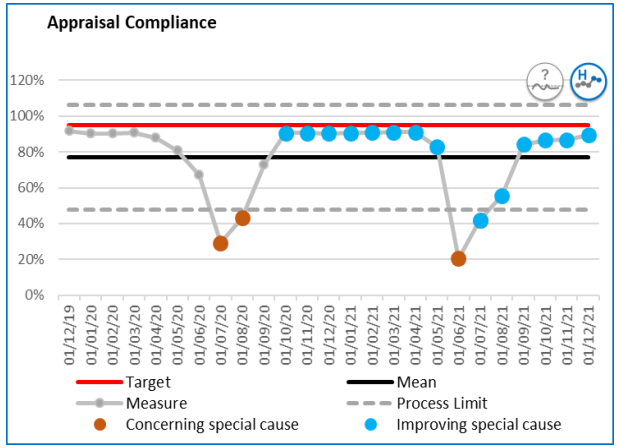
A metric not achieving the target for 6 months or more will be flagged as failing

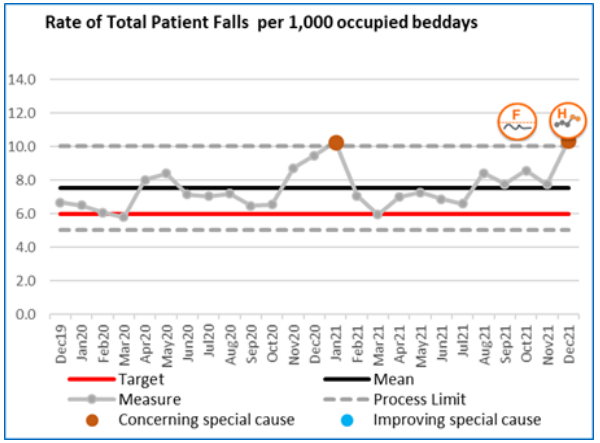












Maternity Metrics Definitions

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

TRUST BOARD – APRIL 2025

NHS Maidstone and Tunbridge Wells NHS Trust

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

Summary / Key points

Executive Summary

- The Trust was £4.5m in surplus in March which was £1.7m favourable to plan. Year to date the Trust is £0.2m in surplus which is £0.2m favourable to plan.
- The key year to date pressures are: Kent and Medway Orthopaedic Centre (KMOC) slippage to plan (estimated £9.5m net adverse impact), Fordcombe hospital adverse to plan by £4.3m, CIP slippage (£2.7m), overspends within non passthrough related drugs/devices (£1.4m), Cancer alliance income shortfall (£1m), provision for potential arrears of pay for band 2 to band 3 CSWs(£1m) and overspends within security (£0.5m) and research (£0.4m). These pressures were partly offset by clinical income overperformance (£11.2m), non-recurrent benefits (£4.6m) and release of service development and contingency budgets (£5.5m)

Current Month Financial Position

- The Trust was £4.5m in surplus in the month which was £1.7m favourable to plan
- **Key Adverse variances in month are:**
    - Kent and Medway Orthopaedic Centre (KMOC) slippage (£1m)
    - Provision for CSWs band 2 to band 3 potential arrears of pay (£1m)
    - Fordcombe hospital slippage to plan (£0.6m)
    - Overspend within clinical supplies (£0.3m), increase in doubtful debt (£0.2m), overspend within outsourcing / insourcing (£0.2m) and backdated charges from Kings for neurology tests (£0.1m)
    - Cancer alliance shortfall (£0.1m)
- **Key Favourable variances in month are:**
    - Clinical Income (excluding Fordcombe, KMOC and back dated income opportunities identified within the forecast recovery plan) was £3.9m favourable in the month which mainly related to non-recurrent income support.
    - Public Dividend Capital (PDC) was £0.7m favourable to plan
    - The Trust released £0.5m relating to Service development and contingency budgets in March to partly offset income and expenditure pressures incurred.

Year to Date Financial Position

- The Trust is £0.2m in surplus which was £0.2m favourable to plan
- **Key Adverse variances year to date are:**
    - KMOC delay and slippage (£9.5m - net)
    - Fordcombe hospital slippage to plan (£4.3m)
    - CIP Slippage (£2.7m)
    - Non-passthrough related drugs/devices (£1.4m)

- Cancer alliance income shortfall (£1m)
- Provision for CSWs band 2 to band 3 potential arrears of pay (£1m)
- Overspend within security (£0.5m) and Research (£0.4m)

- **Key Favourable variances year to date are:**
  - Clinical Income overperformance (£11.2m) which excludes Fordcombe, KMOC and pass through high cost drugs and devices
  - Non recurrent benefits (£4.6m)
  - The Trust released £5.5m relating to Service development and contingency budgets offset income and expenditure pressures incurred

Cost Improvement Plan

- The Trust has saved £34.1m in 2024/25 which is £3.2m below the annual savings target (£37.3m).

Cashflow position:

- The closing cash balance at the end of March was £13.1m, this is higher than the plan value by £9.1m. The difference relates to capital creditors cfwd to 2025/26 of £3.6m with the remaining balance relating to income received from other NHS organisations primarily in respect of debtors and accrued income. The brought forward cash position of £13.1m supports 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 received in full the capital National PDC of £16.4m which were linked to specific capital projects with invoices being paid during February and March
- 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 March the Trust's percentages were: Trade value 73.8% (m11 76.1%) and quantity 73.3% (m11 77.8%); NHS value 83.6% (m11 88.1%) quantity 69.9% (m11 76.0%).

Capital Position

Capital Plan

- The Trust's capital plan, excluding IFRS16 leases, for 2024/25 was **£26.531m**.
- The Trust's share of the K&M ICS control total was **£19.412m** for 2024/25. The Trust received additional PDC cash following an application to support the System funded items of **£10.134m,** for the following.
  - CDC - £2.134m,
  - Cardiology - £3m
  - Urgent and Emergency Care (UEC) Winter Incentive - £5m.

- The Trust also received National funding of **£5.343m** for the following.

- CDC - £1.9m
- Frontline Digitisation - £2.79m
- Digital Pathology - £653k

- The Trust received **additional funding** during the year from both National and System sources, which is set out below.

  - **National Funding in addition to Plan - Total £739k**
    - Mammography Systems x 2 = £739k, as part of the Diagnostic Screening Programme.

  - **System Funding in addition to Plan (without additional cash support) - Total £2.169m**
    - Equipment and Security projects - £183k
    - AdviseInc Licence - £389k
    - C-arms and Patient Monitoring - £419k (brokerage)
    - E-chemo - £360k
    - ICT & Estates staffing costs - £818k

Year-end outturn (excluding IFRS16)

- The Trust reported **£29.4m** spend at year-end, M12 alone saw a significant spend value of over £13.5m. Some equipment is being held on the Trust's behalf offsite, under the Trust's control, with the enabling and installation work taking place in 2025/26.

Other Capital Funding

- The PFI Lifecycle (IFRIC 12) final spend of **£1.3m** was slightly lower than the Plan figure.
- The donated schemes totalled **£280k** for the year.

Leased/IFRS16 capital

- The Trust IFRS 16 lease capital resource for the 2024/25 plan was in total £25.46m. During the final quarter of the financial year the Trust revised the FOT value by c.£4.2m by either financing projects differently or delaying them to future years this was to assist with ICS allocations.
- Actual additions during 2024/25 were £19.9m and rent reviews £1.4m in total £21.3m
- The most significant element of the additions was the Kent and Medway Medical School Accommodation (£17.4m) on the TWH site, other additions were the Surgical robot at Maidstone £1.5m and some additional leases taken out at the Fordcombe Hospital of £0.7m

Reason for circulation to Trust Board
To discuss the March financial position.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 12
2024/25

Maidstone and Tunbridge Wells NHS

Summary

March 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	102.8	67.6	35.1	29.6	5.5	831.0	797.0	34.0	32.4	1.6
Expenditure	(94.1)	(59.5)	(34.6)	(29.6)	(5.0)	(777.4)	(740.6)	(36.8)	(32.4)	(4.5)
EBITDA (Income less Expenditure)	8.6	8.1	0.5	0.0	0.5	53.6	56.5	(2.8)	0.0	(2.8)
Financing Costs	(11.3)	(5.4)	(5.9)	0.0	(5.9)	(67.2)	(63.1)	(4.2)	0.0	(4.2)
Technical Adjustments	7.1	0.1	7.1	0.0	7.1	13.8	6.6	7.2	0.0	7.2
Net Surplus / Deficit	**4.5**	**2.8**	**1.7**	**0.0**	**1.7**	**0.2**	**(0.0)**	**0.2**	**0.0**	**0.2**
Cash Balance	13.1	4.0	9.1		9.1	13.1	4.0	9.1		9.1
Capital Expenditure (Incl Donated Assets and IFRS16)	32.4	4.5	(27.9)		(27.9)	50.7	52.0	(1.3)		(1.3)
Cost Improvement Plan	6.0	4.9	1.1		1.1	34.6	37.3	(2.7)		(2.7)

Summary Current Month:

- The Trust is £4.5m in surplus which is £1.7m favourable to the plan. There was an impairment of £8m in the month which is reported within Financing costs, this impaimrent is also treated as a Technical adjustment therefore does not impact the finanical position. the Trusts key variances to the plan are:

Adverse Variances:

- CSW Band 2 to Band 3 provision for potential arrears (£1m)
- KMOC delay and slippage (£1m - net)
- Fordcombe hospital slippage to plan (£0.6m)
- Cancer alliance income shortfall (£0.1m)
- Overspend within clinical supplies (£0.3m), increase in doubtful debt (£0.2m), overspend within outsourcing / insourcing (£0. 2m) and backdated charges from Kings for neurology tests (£0.1m)

Favourable Variances

- Clinical Income overperformance (£3.9m) mainly due to non recurrent income support.
- Public Dividend Capital (PDC) was £0.7m favourable to plan
- The Trust released £0.5m relating to Service development and contingency budgets offset income and expenditure pressures incu rred

Year to date overview:

- The Trust is £0.2m in surplus which is £0.2m favourable to the plan, the Trusts key variances to the plan are:

Adverse Variances:

- KMOC delay and slippage (£9.5m - net)
- Fordcombe hospital slippage to plan (£4.3m)
- CIP Slippage (£2.7m)
- Non-passthrough related drugs/devices (£1.4m)
- Cancer alliance income shortfall (£1m)
- Provision for potential band 2-3 CSW arrears (£1m)
- Overspend within security (£0.5m) and Research (£0.4m)

Favourable Variances

- Clinical Income overperformance (£11.2m) which excludes Fordcombe, KMOC and pass through high cost drugs and devices.
- Non recurrent benefits (£4.6m)
- The Trust released £5.5m 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, the Trust has saved £34.1m which is £3.2m below plan

Risks

- Pathology Managed Service VAT reclaim review (£5.2m) - The review is not complete by HMRC. Further questions were asked in November requiring a response by 31st December which have been submitted. Mitigation actions are using our VAT advisers to dispute the process undertaken and to counter challenge the basis of the HMRC position when it is clarifi ed. This is the forecast year end value of the risk. These mitigations would negate the risk in 2024/25
- Brockenhurst Car parking VAT claim (net £0.7m) - The Trust has included back dated VAT claim of £1.4m (net £0.7m after input tax adjustment and fees), an appeal for the test case is being heard in the high court during April.

Title of report	**Freedom To Speak Up Guardian Report Q4 (January 2025 – March2025)**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-17					
Executive lead	Helen Palmer, Chief People Officer					
Presenter	Jack Richardson - Lead Freedom To Speak Up Guardian					
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 quarterly report for the period January 2025 to March 2025, presented to the board by the Freedom To Speak Up Guardian (FTSU). The purpose of this report is to identify trends, address issues, and provide a progress update on the Freedom to Speak Up function. During this quarter, 45 concerns were raised. The most reported location was Maidstone, followed by Tunbridge Wells. Divisional breakdown highlights CCS and MEC as the divisions with the highest number of cases. Concerns were received through various routes, including direct contact with the FTSUG, anonymous portal logs, safe space champions, and staff side conversations. This report provides a detailed analysis of these concerns and associated trends.
Any items for formal escalation / decision	1. Relationships in Line Management Chains 2. Strategic leaders being left out of decisions. 3. Case for additional FTSU resource
Appendices attached	• There are no appendices in this report

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

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)	993 – Continued dependency on bank and agency staff following improvements in vacancy/recruitment levels 3252 – Significant Employment Issues 994 – Our staff survey and WRES and WDES data demonstrate that our BAME and disabled communities have less opportunity at MTW (especially % representation of BAME (Global Majority) at band 8C+)

Introduction

In the previous Board report, the Freedom to Speak Up (FTSU) Guardian identified three key barriers that prevent individuals from speaking up:

- People do not speak up because they do not know how to.
- People do not speak up because they feel their issue is not significant enough.
- People do not speak up because they fear repercussions.

These ongoing challenges continue to inform the strategic direction of the FTSU service. A three-year plan has been developed, which includes an evolving Guardian role designed to create capacity for more proactive, preventative work.

This quarter has seen the continued application of a proactive model, with a focus on trend analysis and learning across systems. Owing to a manageable caseload, more time has been dedicated to strategic development—including exploration of how our internal processes may unintentionally cause harm. This builds on previous communication efforts, such as the internal video on Disability Leave, which appears to have contributed to a reduction in related concerns and demonstrates the benefit of targeted, educational content.

However, the increasing complexity of concerns raised—particularly those relating to management capability, disability, and organisational pressure—makes a strong case for expanding service capacity, outlined later in this report through a formal business case.

Q4 2024 Data Collection

Q1 2025 Data Collection

Total Concerns Logged: 45

Theme	Number

Bullying and Harassment	15
Health and Safety	10
Other	13
Patient Safety	7
Fraud	0
Total	**45**

Breakdown by Theme

Bullying and Harassment (15 cases)

This category remains the most reported theme. It includes:

- **Disability discrimination**: Notably in return-to-work situations and where **Occupational Health recommendations were not followed**. This is being actively explored in partnership with the **DisAbility Network**, and outreach is being shaped around reinforcing clarity of the line manager's role. In particular, it is not for a line manager to decide whether an employee's condition does or does not constitute a disability.
- **Race discrimination**: Two cases this quarter, both appropriately escalated.
- **Relationship breakdowns** between staff and line managers.
- Concerns around **the application of policies**, where inconsistent or inappropriate application has been perceived as bullying.
- **Micromanagement** was referenced in several bullying and harassment cases. This appears to be linked to organisational pressures—including resource constraints and Cost Improvement Programme (CIP) targets—which may be prompting managers to adopt more controlling behaviours.

In many of these cases, line managers are applying formal processes correctly, but the **perceived experience of harm** remains significant. This reinforces our focus on reducing **unintentional harm**, and we are actively working with the People and OD teams to explore how policies can be applied with more compassion and clarity.

Health and Safety (10 cases)

Health and Safety concerns have risen notably this quarter and are dominated by:

- **Rising stress levels** due to increasing workplace pressures, whilst this is to be expected with cost pressures, it is integral we find ways to mitigate this stress to retain our staff.
- Several individuals reported feeling close to **burnout** or have since taken **sickness absence**.
- Concerns around a **toxic work culture**, particularly where mental health is not taken seriously or is affected by team dynamics.

These cases demonstrate the direct link between organisational pressure and staff well-being, particularly in under-resourced areas or where team cohesion is low.

Patient Safety (7 cases)

Themes under patient safety this quarter included:

- **Insufficient training**, particularly where complex care or systems are involved.
- **Inexperienced management** leading teams with limited understanding of risks or protocols.
- **Escalating pressures**, often beyond staff control, increasing the chance of error.

These issues represent both training and systemic challenges, particularly where patient safety may be affected by **indirect strain**—a growing area of concern.

Other (13 cases)

A wide variety of concerns were raised under this category, including:

- **Smoking on site**: Complaints from staff concerned about breaches of policy and environmental health.
- **Advice on HR processes**: Enquiries around informal resolution, long-term sickness and flexible working.
- **Issues with Trust policy**: One case included dissatisfaction over the installation of **CCTV**. This was appropriately addressed, with an explanation provided regarding its necessity for maintaining a safe working environment.

- **Perceived hierarchy within the Trust**: Several comments referenced a growing divide between staff in Bands 1–7 and Bands 8a and above. One individual stated, *"The Trust feels like two different businesses."* This is particularly concerning and raises questions about inclusivity, transparency, and the visibility of senior leadership.

- **Relationships at work**: Cases involving personal relationships (e.g. parent-child or romantic partners) impacting fairness or decision-making, raising **conflicts of interest**.

Outreach and Proactive Work

Planned outreach has been paused temporarily due to capacity constraints. However, strategic work has continued, including:

- **Process Harm Review**: Ongoing evaluation of how Trust processes (e.g. performance management, sickness absence) may unintentionally create psychological harm, especially for disabled staff.

- **Managerial Clarity**: Collaborations with the People and OD teams to clarify expectations of line managers and reduce misinterpretation of HR policies.

Further concerns

In addition to the concerns identified through last quarter's trend analysis, there are two broader trends that I believe require the board's attention.

1. Relationships in Line Management Chains

A recurring concern involves personal relationships—whether pre-existing or developed while working together—that impact workplace dynamics. These relationships have, in some cases, led to issues being dismissed or the perception of fairness being undermined. For instance, there was a reported case of bullying where no action was taken because the alleged perpetrator had a personal relationship with the manager handling the complaint.

While we have a Conflict of Interest policy in place and we are in the process of updating this. Although it is not appropriate for us as an employer to dictate personal relationships, I strongly believe that having such relationships within direct line management chains is inappropriate and warrants a policy review.

2. Strategic leaders being left out of decisions.

There is a recurring issue of strategic leaders being excluded from decision-making processes that directly impact their teams, resulting in significant downstream challenges. Clinical Directorates, such as Core Clinical Services, are under severe strain due to increased demand from other directorates. This strain is evident in all directorates but most acutely in pathology—particularly cellular pathology—radiology, and pharmacy, where rising workloads are compounded by reduced staffing levels. Upon review, it seems this strain stems from initial planning meetings that failed to include representatives from these critical teams. Consequently, these divisions enter new developments at a disadvantage, and the constraints imposed by the Cost Improvement Programme (CIP) leave them unable to address these challenges effectively. This dynamic has contributed to higher staff turnover, decreased job satisfaction in these areas and decreased ps.

Business Case: Expanding the FTSU Service

The complexity and frequency of cases being raised continue to grow. Currently, a single full-time Guardian supports the entire Trust. To future-proof the service and ensure sustainability, we are proposing the appointment of a second (Deputy) Guardian.

Why Now?

- The service has matured rapidly under the proactive model.
- Caseloads are increasing, with higher emotional and logistical complexity.
- Outreach work—integral to prevention—cannot currently be delivered consistently.

Proposed Benefits

- **Service Resilience**: Ensures continuity during absences and mitigates risk of burnout.
- **Succession Planning**: Supports long-term planning and development of internal expertise.
- **Improved Responsiveness**: Enables faster turnaround for cases and quicker interventions.
- **Peer Support**: Reduces emotional burden on individuals, fostering wellbeing and sustainability.

Comparative Learning from Other Trusts

South Tees Hospitals NHS Foundation Trust

Introduced four part-time Guardians (2.0 WTE in total) supported by 17 FTSU Champions, improving accessibility and approachability. Embedded FTSU within cultural transformation, diversity work, and mandatory training—resulting in significantly improved speaking up culture and staff confidence.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Adopted a specialisation model, with Guardians aligned to themes (e.g. mental health, HR). Combined with strong EDI partnerships, this approach enabled more tailored support and proactive training on compassionate leadership.

Financial Implications

Investing in the FTSU service offers clear returns, including:

- **Staff Retention**: Preventing a single resignation of a skilled nurse can save the Trust approximately **£12,000**.
- **Reduced Formal Cases**: Informal resolution avoids the **£1,141** average cost of formal disciplinary action.
- **Legal Risk Mitigation**: One avoided legal case can save upwards of **£145,600**.
- **Sickness Absence**: Reducing stress-related leave can save around **£1,812** per affected staff member annually.

Conclusion

This quarter reinforces the growing importance of a responsive, well-resourced FTSU service. Concerns are becoming more nuanced and emotionally charged, often reflecting systemic strain on individuals and teams. Supporting the Guardian role with additional resource will safeguard the service, promote a compassionate and inclusive workplace culture, and reduce financial and reputational risk.

As the speaking up culture at MTW matures, we have a real opportunity to lead by example—by embedding FTSU not just as a safety net, but as a proactive, values-driven service that empowers our people and strengthens our Trust.

Title of report	**Revised MTW Patient Safety Incident Response Plan**					
Board / Committee	**Trust Board meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-15					
Executive lead	Sara Mumford, Chief Medical Officer and Jo Haworth, Chief Nurse					
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)	In April 2024 the Trust moved to the new national patient safety incident response framework (PSIRF) in respect of the operational model for managing patient safety incidents. The PSIRF framework requires acute providers to develop locally agreed approaches to investigating various types of patient safety adverse incidents. This should be based on the key patient safety issues facing each provider Following our launch we have now amended our incident response plan (see attached) and this has been approved at ETM and Quality Committee Deep Dive in April 2024. Key information for the Board to note • MTW will continue to follow nationally mandated investigation processes e.g. incidents resulting in the death of a MTW patient will require the most comprehensive of investigations approaches to be commissioned (page 14 of the attached document). • Our locally developed plan is (unlike most providers) split into a bespoke maternity plan (page 22) and “other” services plan (page 18) *this is secondary to the enhanced level of assurance currently required of MTW’s maternity services. • Our local plan is less risk averse than 2024/25, where, secondary to the need to provide absolute clarity for all stakeholders, our plan was more prescriptive than some partners in our system. • We will schedule a revised plan for April 2026 The Board are asked to approved the attached plan for 2025/26
Any items for formal escalation / decision	None
Appendices attached	New PSIRP 2025/26 PSIRP 2024/25

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Quality Committee Deep Dive	09 April 2025	Approved
ETM	08 April	Approved

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR2: Patient Safety and clinical effectiveness: Achieving outstanding clinical outcomes with no avoidable harm • Risk of not undertaking timely and cohesive learning from incidents, patient feedback, experience and claims
Links to Trust Risk Register (TRR)	00001275 – Swab Count Risk 00001299 – Absconding Patients Risk 00002963 – IPC Risk 00003020 – PEWS Risk 00003021 – Triage in ED Risk 0003023 – Lost to Follow Up Risk 00003163 – Timely Review of Diagnostics Outpatients Risk 00001235 – Ligature Assurance Risk 00001235 – Nursing Documentation Standards Risk 00003155 - ED Paediatric Risk 0003164 – ED Radiology Reporting Risk 00003241 – Trust Wide Falls Risk
Compliance / Regulatory Implications	PSIRF compliance

Patient Safety Incident Response Plan (PSIRP)

	NAME	TITLE	DATE AUTHORISED
Author	**Carrie Parmenter**	**Trust Patient Safety Specialist**	**09/04/2025**
Reviewer	**Helen Callaghan**	**Director of Quality Governance**	**09/04/2025**
Authoriser	**Joanna Haworth**	**Chief Nurse**	**09/04/2025**
Authoriser	**Dr Sara Mumford**	**Chief Medical Officer**	**09/04/2025**
Authoriser	**Quality Committee**		**09/04/2025**

Contents

Introduction

This patient safety incident response plan sets out how Maidstone and Tunbridge Wells NHS Trust intends to respond to patient safety incidents over the next 12 to 18 months. The plan is flexible and can be changed in response to new and emerging patient safety issues. Therefore, we will remain vigilant and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This plan is underpinned by our Trust policies on incident reporting and investigation which are available to all staff via our organisation's intranet page. Each policy has been updated to reflect the new 2023 patient safety incident response framework (PSIRF). NHS England published the new Patient Safety Incident Response Framework (PSIRF) in August 2023, outlining how NHS organisations should respond to patient safety incidents for the purpose of learning and improvement.

At MTW the PSIRF replaced the Serious Incident Response Framework from 1st April 2024. PSIRF represents a significant shift in the way the NHS responds to patient safety incidents, centering on delivering a compassionate service that offers higher levels of collaboration and support to those families and patients affected by adverse incidents related to their care. Key changes also involves moving away from the traditionally commissioned root cause analysis investigations to a more visual "system" based approach to investigations drawing out earlier learning and improvements with considered and proportionate responses based on the organisation's key patient safety issues.

PSIRF is intended to be a major step towards improving safety management across the healthcare system in England and it is envisaged it will greatly support the NHS to embed the key principles of a healthy patient safety culture. It will ensure the NHS and MTW focuses on understanding how incidents happen, rather than apportioning blame on individuals; allowing for more effective learning and improvement, and ultimately making NHS care safer for patients.

PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated, allowing for other incidents to be investigated and for learning response resource to focus on areas with the greatest potential for patient safety improvement.

An ongoing thematic analysis plan is in place to determine areas of patient safety priorities for the Trust, produced 6-12 monthly. The local incident response plan detailed within this report was reproduced based on the output of the thematic analysis approach, allowing us to focus our resources on these priority areas.

Alongside the framework, a 'Guide to engaging and involving patients, families and staff following a patient safety incident' has also been published, setting out expectations for how those affected by a patient safety incident should be treated with compassion and involved in any investigation process. .

We hope that following the implementation of PSIRF, we will see a reduction in recurring serious harm and death in our patient safety priority areas over a 2 year period. This will be measured using an average of the last 5 years Serious Incident data (taking into consideration years of extra-ordinary incidents such as Hospital Acquired COVID-19). As part of the transition to PSIRF, we will monitor themes and trends on a live dashboard to feed into future areas of focus for our incident response plan.

Our services

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust provides a wide range of general hospital services across Maidstone and Tunbridge Wells and their surrounding boroughs. The Trust hosts the Kent Oncology Centre, providing specialist Cancer services to circa 1.9 million people across Kent and East Sussex, the fourth largest oncology service in the country.

The Trust employs over 6,900 full and part-time staff, and operates from three main sites Fordcombe Hospital, Maidstone Hospital and Tunbridge Wells Hospital at Pembury and outpatient services at several other community locations.

Further information about our organisation can be found on the Trust website

https://www.mtw.nhs.uk/

Defining our patient safety incident profile

The patient safety incident profile was created through engagement with the following stakeholders:

- Our staff – through reviewing and theming our incidents reported on the Trust incident management system and taking feedback from our internal safety culture survey
- Senior leaders within the organisation
- Our patients – through reviewing themes and trends from patient concerns and complaints
- Commissioners/ICB partner organisations – through partnership working with the ICS patient safety and quality leads
- Various governance forums and the Trusts PSIRF implementation working group
- Patient Experience Committee and Healthwatch partners
- Our Patient Safety Partner

The Trust-wide patient safety risks were identified through the following data sources:

- Thematic analysis of three years of Serious Incident data 2019-2022
- Analysis of themes and trends from PSIRF reviews conducted between April 2024-December 2024
- Key themes from complaints/PALS/claims/inquests/incidents
- Key themes identified from specialist safety & quality committees (e.g. Sepsis, falls, pressure ulcers)

Defining our patient safety improvement profile

The Trusts' patient safety improvement profile is set out within the Quality Accounts and the Trust's Strategic aims and objectives. They detail the planned improvement and service transformation work that will impact patient safety across the organisation. Our patient safety aim is to sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.

Snapshot of the Patient Safety Aims from the 2023/24 Quality Accounts

Aim	How will we make the improvement	How we will measure our success	Progress
 We will improve our Sepsis Pathway	Reviewing and improving our neutropenic sepsis pathway Improving our sepsis safety netting processes in our Emergency Departments by improving our digital sepsis screening processes Redesigning and relaunching our Trust wide sepsis education programme	We will reduce adverse incidents resulting in harm linked to Sepsis management by 90%, this will be monitored via the Deteriorating patient group and workstream	There were no serious incidents (SIs) for sepsis reported for patients attending the Trust from April 2023 to February 2024. The deteriorating patient improvement workstream is working towards the development of a Trust-wide improvement plan to improve and sustain earlier recognition, management and screening compliance.

 We will improve upon our management of inpatient falls	Trust Wide Strategic Quality Improvement Workstream One "Improving our patients' environment and our specialist falls reduction equipment" Trust Wide Strategic Quality Improvement Workstream Two "Improving our processes and Improving our workforce" Trust Wide Strategic Quality Improvement Workstream Three "Improving our workforce and understanding our patients evolving needs"	We will reduce our inpatient falls rate by 20% We will monitor compliance with preventative measures via the monthly falls audits	The Trust has achieved a 14% reduction on the rate of falls per 1000 occupied bed days over the last ten months to 31st January 2024 (full year's data not yet available) A number of After-Action Reviews were conducted in the first 10 months of PSIRF, and the 2025 plans include moving to a post-fall toolkit approach with themes and trends feeding into the monthly slips, trips and falls group and improvement plan review.
 We will Improve our Maternity performance linked to our antenatal gap and grow measurement processes and improving how we monitor Mothers for signs of high blood pressure	Via dedicated quality improvement projects clinical leaders in maternity will be supported to identify opportunities to improve these specific pathways and explore digitisation of gap and grow	Having no adverse events linked to antenatal "Gap & Grow" measurements & the monitoring of hypertension	There was one adverse event linked to antenatal "Gap & Grow" measurements in 2023/24. The Trust training materials were reviewed and the new GAP 2.0 training the programme will go live on the 1st April 2024.

 We will improve the safety of our Maternity services by delivering against all of the patient safety recommendations as outlined in the 2022 Ockendon report & the 10 key elements of the National Better Births Plan	We will utilise existing "ward to board" governance and oversight structures to support the leaders in maternity services to track progress, unblock barriers to progress and demonstrate assurance against the key recommendations in the report	Evidence will be collated and uploaded to our Trust Safety Systems which will demonstrate assurance that each required action has been completed	The recommendations from the three year delivery plan have been mapped to our new Overarching Improvement Plan. Each of the actions from the CQC report has also been mapped to the four themes of the three year delivery plan. This plan will be the focus for all the improvement workstreams in the Directorate and should be finalised by the end of June 2024.
 We will ensure MTW implements all of the recommendations as outlined in the new National Patient Safety Strategy (PSIRF)	Our PSIRF implementation group will continue to deliver on implementing the numerous changes to our systems and processes to ensure we are compliant with the new framework	We will have produced a PSIRF-compliant plan (Patient Safety Incident Response Plan) signed off by our Trust Executive Board and our ICS by March 2024	V1.0 of the PSIRP launched on 1st April 2024 and this new plan V2.0 supersedes previous versions.

Aim	How will we make the improvement	How we will measure success	Progress
 We will implement a new annual Trust-wide safety culture measurement system and improve upon our patient safety training	We will launch the 2 new digital systems as part of our existing MTW E-learning (electronic staff learning) system We will work collaboratively with our Organisational Development team and Freedom to Speak Up Guardians to support culture improvement work and measurement	90% of MTWs 6000 staff will have undertaken the basic patient safety module by June 2024 We will relaunch a safety culture measurement diagnostic We will roll out a Just Culture improvement project in collaboration with Organisational Development	The safety culture survey is now embedded into everyday practice through a new link set up on the homepage of the InPhase incident reporting module. The Just Culture improvement project launched in summer 2024 and is ongoing.
 We will improve upon the care of our patients who have nasogastric tube care needs	We will redesign and relaunch our trust wide Nasogastric Tube education plan and competency framework for our staff	We will have launched the new plan and competency framework by August 2022 and by June 2023 60% of registered nurses in high use/acuity departments will have been trained and signed off as competent against the new framework	Over the last year we have rolled out the NG eLearning training for eligible staff members across different professional groups (993). The compliance is now at 71%.

 We will improve upon our patient outcomes for patients who have suffered an “Intercranial Haemorrhage / bleed” by improving our adherence to national best practice guidance	The clinical teams will be supported to develop an improvement plan which benchmarks this clinical pathway against best practice	Re-audit of the Management of Intracranial Haemorrhage against national best practice guidance results.	There is a Re-audit currently in progress which will be reviewed when results are available.
 We will work with our health informatics team and clinical leaders to automate 10% of our “clinical audit” data collection processes This will release more of our frontline clinical staff’s time	We will work with our informatics leads to review the data available from our new electronic patient record “Sunrise”, to automate 10% of our current mandated national clinical audits We will revamp our existing category set on InPhase and launch a new coding set that will enable greater oversight of themes and trends for our incident data	10% of the current mandatory national clinical audits that are applicable to the Trust (61) will be automated by June 2023 Launch of new category set in April 2024 and ongoing monitoring of the data and themes and trends	Limited progress has been made due to staff shortages in Clinical Audit and freezes on coding in the Sunrise Team.

 We will improve our medicines management safety by launching a new trust wide digital ePMA (electronic prescribing and medicines administration system)	The sunrise / informatics implementation project team will lead on this funded Trust wide transformational change which was launched in December 2022	Transcription Drug Prescribing Errors" will be reduced by 90%	With the implementation of EPMA by March 2025 the following will be managed electronically: 85% of all prescribing of drugs by doctors and/or non-medical prescribers. 95% stock management of drugs, on ward. 85% of dispensing of discharge medications. 100% of EDN (electronic discharge notifications) sent to GP A medication incident deep dive was completed and presented in 2024 along with the creation of a medication incident live dashboard.

Our patient safety incident response plan: national mandated requirements

The following patient safety incident types must be responded to according to national requirements. (see Appendix A: National event response requirements in the Guide to responding proportionately to patient safety incidents).

Patient safety incident type	Required investigative response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable (incidents meeting the learning from deaths criteria for PSII investigations)	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process

Child deaths	To refer to the Child Death Overview Panel review. PSII (or other response) may be required alongside the Panel review, recommendations from the Child Death Overview Panel will be taken to PSIRG.	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). PSII may be required if commissioned by the LeDeR process.	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Safeguarding incidents	Following local safeguarding review processes. Refer to local authority safeguarding lead, they may commission or refer a case on for but not limited to: Domestic Abuse Related Death Review (DARD, independent inquiries, joint targeted area inspections, Local Child Safeguarding Practice Reviews LCSPR, any safeguarding reviews (and enquiries mandated by Section 47 Children Act 1989 or Section 42 Care Act 2014) as required by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process

Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. MTW will fully support these investigations where required to do so.	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process

Our patient safety incident response plan: nationally mandated maternity requirements

The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

Patient safety incident type	Required investigative response	Anticipated improvement route
All term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes*: • Intrapartum stillbirth • Early neonatal death • Potential severe brain injury	To refer to MNSI for external patient safety incident investigation	If appropriate respond to safety recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.	To refer to MNSI for external patient safety incident investigation	If appropriate respond to safety recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process

**N.B. MNSI do not investigate cases where health issues or congenital conditions (something that is present before or at birth) have led to the outcome for the baby. MNSI do not investigate maternal death due to suicide but may expand their investigation criteria for some maternal deaths which do not fit within the table above*

For further information and exclusion criteria please visit: What we investigate (mnsi.org.uk)

Our patient safety incident response plan: Locally agreed approach based on current key safety themes

Patient safety incident type or issue	Required investigative response	Anticipated improvement route
Delay in recognition / management of a deteriorating patient (Inc. sepsis) *Missed opportunities to identify, treat in a timely manner, or escalate a deteriorating patient that results in harm and or Trust wide learning opportunities which would encapsulate near misses* Examples include • Inadequate escalation of a deteriorating patient's clinical observations, blood results or point of care testing such as ABG/VBG that required time critical treatment and response • Inadequate response when a deteriorating patient is escalated for review leading to a delay in time critical treatment • Mismanagement or delay in the diagnosis and treatment of amber or red flag Sepsis *(Includes significant near misses)*	PSII	If appropriate create local organisational actions and feed the learning into the Deteriorating patient improvement workstream

Diagnostic errors • Specifically – Errors in interpreting diagnostic imaging results resulting in a significant delay in treatment	Completion of reflective practice proforma and application of Just Culture guide	If appropriate create local organisational actions and feed these into the relevant Clinical Governance forums and REALM meeting
IRMER reportable incidents Deemed IRMER reportable by radiation protection advisor	Local review by clinical leads – sharing of themes and trends and any new learning into existing improvement work	If appropriate create local organisational actions and feed these into the relevant Clinical Governance forums
Patients lost to follow up ***for a period of time that would impact on their treatment/management plans** • Ophthalmology patients lost to follow up resulting in deterioration in vision • Patients lost to follow-up on the cancer pathway	Local review – sharing of themes and trends and any new learning into existing improvement work	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Inpatient falls resulting in fractured neck of femur or intracranial injury *(*Deaths of patients following inpatient falls will be assessed on a case by case basis in line with the learning from deaths criteria to establish if they require a PSII)*	Post-fall toolkit to be completed by the Ward Manager with peer review by the Falls team	Themes and trends shared at the monthly slips, trips and falls group. If appropriate consider additions to ongoing Trust-wide improvement plan for falls prevention
Emerging theme of safety incidents occurring in theatres	AARs / deep dive *case reviews may be commissioned if single error identified	If appropriate create local organisational actions and consider additions to ongoing

		Trust-wide improvement actions
Unexpected new and significant concerning safety event or emerging theme which has potential for future or significant harm	Local case review – if significant learning identified commissioned full PSII **consider adding / amending PSIRP for future PSIIs*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Hospital acquired 3 &4 pressure ulcer* *(*Deaths directly relating to a hospital acquired pressure ulcer that meet the learning from deaths criteria will require a PSII)*	Rapid review to be completed by the Ward Manager with peer review by the Tissue Viability Team.	Introduction of monthly pressure ulcer prevention group to share themes and trends. If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions for pressure ulcer prevention
Hospital acquired MRSA* *(*Deaths directly relating to a hospital acquired infection that meet the learning from deaths criteria will require a PSII)*	IPC Rapid review *If red flags from IPC Rapid review commission MDT review with patient safety attendance*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Hospital acquired C.diff* *(*Deaths directly relating to a hospital acquired infection that meet the learning from deaths criteria will require a PSII)*	IPC Rapid review *If red flags from IPC Rapid review commission MDT review with patient safety attendance*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Hospital acquired venothromboembolism* *(*Deaths directly relating to a hospital acquired VTE that meet the learning from deaths criteria will require a PSII)*	Rapid review by VTE Lead *If red flags from Rapid review commission MDT review with patient safety attendance*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
New or evolving trend concerning medication incidents or administration of blood products	Deep dive thematic review to be presented at Trust Patient Safety Oversight Group / feed into Medicine Management Committee	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Significant emerging risks identified as a result of the use of our digital systems	Multidisciplinary team (MDT) review with key informatics and clinical leads	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Safety II - Learning from excellence – events demonstrating significant potential for organisational learning	After Action Review (AAR) or MDT Review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Our patient safety incident response plan: Locally agreed approach based on current key maternity safety themes

Patient safety incident type or issue	Planned response	Anticipated improvement route
Stillbirth not meeting the MNSI criteria *excludes expected or unavoidable death in utero	MDT review , if red flags identified to escalate an internally led PSII	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Failure to rescue a deteriorating Mother or New-born infant **Near miss presenting a significant risk of future harm / incident causing significant harm*	PSII	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Near miss swab management / retained instrument incident that demonstrates a significant risk to the safety check procedures	Process Map Incident +/- commissioned After Action Review (AAR) (*Incidents meeting the Never Event criteria will require a full PSII)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Poor management of 3rd or 4th degree vaginal tears	Rolling local thematic review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Poor management of Postpartum Haemorrhage >1500mls (failure to recognise the risk, or manage appropriately)	Rolling local thematic review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Failure in the Gap & Grow Measurement processes impacting plan of care **(Failure to monitor foetal growth correctly)**	SWARM	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Dropped New-born *clinical staff or family	AAR for dropped new-born by staff Post incident debrief and identification of any safeguarding concerns	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Inappropriate discharge from Maternity Services that should have triggered an admission	Local rapid MDT review – learning and improvement actions documented on InPhase	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Shoulder Dystocia **(failure to recognise the risk, or manage appropriately)**	Local rapid MDT review – learning and improvement actions documented on InPhase	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Skull fractures and/or intracranial injury related to instrumental deliveries	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Unexpected Maternal admission to ICU following delivery	MDT review using PSIRF tool , if red flags identified to escalate an internally led PSII under deteriorating mother PSIRP criteria	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Unexpected admission to the neonatal unit (full term babies)	Follow ATTAIN process and MDT Review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

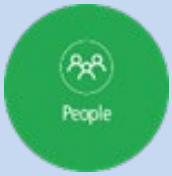
Appendices

Appendix 1 – PSIRF Learning Response Toolkit	NHS England » Patient safety learning response toolkit

Version control

1.0	First version
1.1	Amendment to falls criteria and clarification of wording regarding criteria for deteriorating patients, diagnostic incidents and lost to follow-up. Terminology updated regarding reporting committees. Removal of 'digital investigation tool' proposal due to project ceasing at this time.
2.0	Full review

Title of report	**Maternity Report relating to the Perinatal Quality Surveillance Model**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-13					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Rachel Thomas, Director of Midwifery					
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)	PQSM Overview 1. To ensure effective Board oversight in Year 7 of the Maternity Incentive 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. Items to be escalated were identified via the Maternity and Neonatal Care Oversight Group Meeting on 15 April 2025. These are summarised in the 3A report at pages 2-4. 4. It is of note that the Year 7 MIS Guidance has reduced the requirement to report to Trust Board from monthly to quarterly. The report must still contain the full PQSM dataset to enable the Trust Board to review maternity and neonatal quality and safety. However, the current system of monthly reporting was established in response to the Trust's not meeting MIS compliance for both Year's 5 and 6 of the Scheme, and is designed to ensure regular and effective oversight. As such it is proposed that monthly reporting should continue at this time, despite the amendments to the Year 7 MIS guidance. This will be in line with the reporting processes of other Trusts within the LMNS.

Any items for formal escalation / decision	1. The Board is invited to: a. review the attached April (February 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 April (February data) 2025

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	15 April 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	Fulfils requirements for Maternity Incentive Scheme

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

MTW

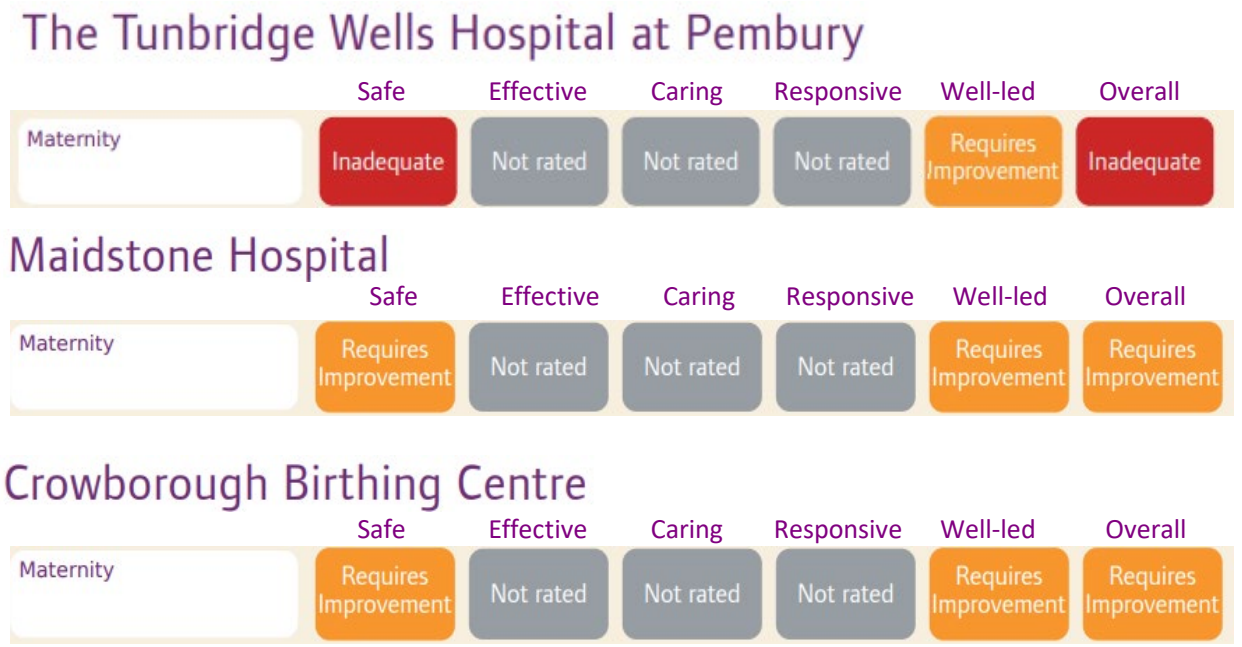
NHS
Maidstone and Tunbridge Wells NHS Trust

PQSM			
Report date: April 2025 February data		**PQSM** **Report lead:** Jessica O'Reilly	**Actions:**
1a	**Alert (Include actions taken/mitigations)**	**Incident management :** • 4 moderate harm incidents reported in month • 4 estuations to PSRIG, 1 PSII commissioned (management of Psychosis), 2 AAR's~(Skull fracture and management of a PPH) and one for local learning (Management of safeguarding) **Operational:** There were a total of 21 suspension of service reported in month • Crowborough Birth Centre suspensions- 2 day time suspensions – 0 women affected • Maidstone Birth Centre suspensions - 2 day time suspensions - 0 women affected • Home birth suspensions -A total of 17 suspension of service (9 day time suspensions and 8 overnight) - All due to community staffing. 3 women impacted – one delivered in MBC, 2 delivered at TWH **Complaints and FFT:** • 2 new complaints in month relating to pain relief and staff attitude • A recurring theme in service user feedback highlights concerns about the limited pain relief options available on the Antenatal Ward, particularly during early labour and IOL. **CNST**: MTW has not claimed compliance relating to Safety Actions 8 and 9 for Year 6 of the Scheme.	**CNST :** • Action plans submitted to NHSR. **Incident management :** • immediate learning from case review shared with staff **Complaints and FFT:** • The Antenatal Ward manager has been informed of the related feedback. 'Latent phase' improvement task and finish MDT group which will look at pain relief on AN ward. MNVP asked to be involved.

1b	Assurance	**CNST:** • A structured programme of Board reporting has been created to improve governance processes and ensure compliance with Year 7 of the scheme. Further details of Year 7 guidance will be shared in April. **PMRT:** • We remained 100% complaint with an external reviewer being present **Operational:** • 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status remained 100% **Training:** Compliance for NLS, Fetal monitoring and PROMPT compliance was met across all professionals. **Staffing:** 100% compliance of obstetric staffing for consultant attendance in clinical scenarios **Complaints and FFT:** • Increase in FFT responses in month • 0 breached complaints in month	

1c	**Advise**	**Risk Register:** • closed risks in month **Incident management:** • No closed PSII reports in month • 2 AARs published • 1 MNSI report published in month **PMRT:** • 1 Report published in month, The review group identified care issues which they considered would have made no difference to the outcome for the baby and they also concluded that there were no issues with care identified for the mother following confirmation of the death of her baby **CNST:** • The Year 6 Submission was submitted to NHSR on 28 February 2025. NHSR's formal response is expected towards the end of March. Provisional information has been received from NHSR regarding Year 7, with a summary of changes from Year 6. Additional guidance relating to Year 7 is expected on 2 April 2025, with NHSR holding an information morning on 28 April. **Staffing** • Birth to midwife ratio improved from 1:25 to 1:21 • There was a decrease in sick leave from 5.24% to 4.04% • Annual leave rate increased from 12.89% to 16.49% above the trust target of 15% • Overall the unavailability of staff increased from 27.26% to 37.61% • There was a decrease in bank and agency expenditure from 32.2% to 31.6%, however the percentage of agency use increased in month from 10.3% to 13%. **Complaints and FFT:** • Recurring Service user feedback theme highlights the need for improved communication from the team.	**Incident management:** • Learning from AARs and MNSI to be shared with the team via staff communication platform • MNSI report AP collated and tripartite meeting arranged for April **PMRT:** • PMRT action plan collated and report shared with family **CNST:** • MIS Lead to meet with all Safety Action Leads to discuss Year 7 requirements, once published. **Complaints and FFT:** • The Patient Experience Lead is collaborating with an Obstetric Doctor to develop a training session focused on enhancing communication techniques, informed consent and personalised care and this is also part of the midwifery mandatory training day

CQC Maternity Ratings



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 – Nil

New Risks – NIPIE lead for Women's Health

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 and what actions are being taken.

Incidents Graded Moderate or above		4
ID & Incident Summary	**Actions/Learning**	**Date Clinical Incident Review (CIR) Completed**
#36558 Anomaly scan NAD. Evelina scan at 26 weeks noted cardiac defect Diabetic type 1- Evelina referral delayed until 23+6 ?reason	**Reported as moderate psychological harm** • Awaiting response from lead sonographer to review images from anomaly • Lead sonographer to discuss scan with sonographer and advise on refresher training • Lead sonographer to contact Tiny Tickers training charity and arrange training and have some general peer discussion around recent cases	
#36754 Low CBG on TC baby not escalated	**Reported as moderate physical harm** • MDT review escalated to PSIRG – outcome for local learning	
#37531 Baby admitted to NNU from delivery suite with unrecordable temperature	**Reported as moderate physical harm**. Reviewed and closed by ward manager • If parents declining artificial warming a closer observations of temp recommended • Take 5 to remind staff of pre term temp drops	
#37944 USS at 39 weeks showed HC of 30cm. No alert raised. Baby check head 29cm below 0.4 centile- no senior opinion. Seen 6 months later with poor vision and development delay	**Reported as moderate physical harm** • Awaiting response from lead sonographer to review images • No concerns on baby check or on NIPE • No guideline for midwives to refer for small HC	

Escalations to PSIRG in Febuary

Escalations to PSIRG		
ID & Incident Summary	Actions/Learning	Date Clinical Incident Review (CIR) Completed
#34331 Baby found to have skull facture and experienced seizures following emergency LSCS.	• No learning identified at present	Reviewed as MDT on 04/06/2025 PSIRG 06/02/2024 – For AAR
#32159 Mother experienced confusion and disorientation in labour ?psychosis ?hyponatremia. EMCS under GA	• To await findings from PSII	Reviewed as MDT on 14/01/2025 Reviewed by safeguarding on 15/01/2025 PSIRG 13/02/24- For PSII
#37028 Late miscarriage at 16+6. Missed safeguarding referrals and cervical screening	•Communication community midwives to go out regarding women at risk of early loss and appropriate referrals to make. For targeted learning now as previously GLOWs have been sent out as well as posters/emails. •To discuss case with antenatal clinic matron and manager for how referrals can be more safety managed and triaged •Ensure this patient has correct follow up, advice and care for future pregnancies	Reviewed as MDT on 25/02/2025 PSIRG 27/02/25- For local learning
#34013 PPH at CBC then transferred to TWH. Total MBL 1300mls	PPH happened over handover and another patient in labour at birth centre Blood loss not initially weighed therefore delay in recognition of PPH Delay in perineum inspection (2 hours 45 minutes post-delivery) and trauma then identified and suturing commenced Delay in cannulation and catheter insertion	Reviewed as MDT 25/02/2025 PSIRG 27/02/2025- For AAR

Patient Safety Incident Review Framework

Ongoing Patient Safety Incident Investigations (PSIIs)

1 Patient Safety Incident Investigations (PSIIs) declared in February.

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
February	#32159	Mother experienced confusion and disorientation in labour ?psychosis ?hyponatremia. EMCS under GA	White: British

* We have received the draft report for #23178 and #28793

Cases closed in February = 0

Patient Safety Incident Review Framework

Ongoing After Action Reviews (AARs)

2 AAR's declared in February.
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
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
February	#34331	Baby found to have skull facture and experienced seizures following emergency LSCS.	Any other mixed background
February	#34013	Mother experienced 1600ml PPH	White British

Cases closed in February = 0

Maternity & Newborn Safety Investigations (February 2025)

MNSI Reports published in February (see next page)

Month	MNSI Reference	InPhase	Description	Maternal ethnicity
August	MI-038041	#23924	Baby transferred for cooling at 42^{+0} following breech vaginal delivery*	White British

Ongoing MNSI reviews

Month	MNSI Reference	InPhase	Description	Maternal ethnicity
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

* We have received the draft reports for both MI-038677 and MI-038810 in March, draft reports have been circulated for factual accuracy comments.

Maternity & Newborn Safety Investigations (February 2025)

1 MNSI Report published in February- Action plan being created

MI-038041- Vaginal breach delivery following IOL with delay in delivery of head

Safety recommendations;

1. It is recommended the Trust review the information that is shared with mothers when induction of labour is offered. This should include the timing of and risks and benefits of induction of labour. This will ensure mothers are supported to make informed decisions.

2. It is recommended that the Trust include CTG categorisation as part of risk assessments in line with local guidance until the birth of the baby. This will support oversight, recognition and consideration of fetal wellbeing when counselling mothers on mode of birth.

See next page for safety prompts

Maternity & Newborn Safety Investigations (February 2025)

MI-038041- Vaginal breach delivery following IOL with delay in delivery of head

Safety Prompts;

1. The Baby's breech presentation was not identified until the Mother was in the second stage of labour.
    - Has the Trust considered performing presentation ultrasound scans prior to commencing an induction of labour to ensure the baby is in a cephalic presentation?
2. When the Mother and Father attended triage with an episode of reduced fetal movements, there was no obstetric review.
    - What barriers are in place, when triage has long waits, to ensure mothers have a full understanding of their risks to inform their decision making and care planning.
3. When a mother attends triage, usual practice is that staff print out the findings of the assessment and place it in the mother's notes.
    - What barriers prevent staff from ensuring all documentation is included in a mother's handheld notes?
4. When the Mother attended for her induction of labour, the investigation heard staff reviewed her hand held notes, and this did not contain a printout of her attendance with reduced fetal movements the previous day. This meant staff were unaware of
5. The Mother's attendance and it was not factored into the risk assessment prior to her being discharged home.
    - What barriers are in place when staff need to review a mother's electronic records and hand held notes to ensure all previous attendances are included in ongoing risk assessments and care planning.

Patient Safety Incident Review Framework (February 2025)

0 Cases meeting PMRT criteria in February

1 PMRT report published in February

InPhase	Description	Grading	Learning
#27170 and #27159	IUD at 38+2 Transferred from home via ambulance due to heavy bleeding, IUD confirmed on arrival and EMCS. Cause of death: Placental abruption	The review group identified care issues which they considered would have made no difference to the outcome for the baby The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	No actions or learning

100% of perinatal mortality reviews include an external reviewer

Febuary meeting held with external and internal reviewers

1:1 Care in Labour

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

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	nil	
Crowborough Birth Centre suspensions	2 day time suspensions	CBC staffing on one occasion, both incidences overnight 1 due to acute unit staffing (same night for both centres) No women affected
Maidstone Birth Centre suspensions	2 day time suspensions	Closed both times for acute unit staffing
Home birth suspensions	A total of 17 suspension of service (9 day time suspensions and 8 overnight)	All due to community staffing 3 women impacted – one delivered in MBC, 2 delivered at TWH (one of these was seen at home earlier in the day but wasn't in labour, because they had already been out there weren't enough staff to then support her)

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 new starter medical staff

*Exc Bank only midwives

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	21	21	100%
Total	310	295	95%

Data as at 28 February 2025.

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 new starter medical staff

*Exc Bank only midwives

Role	Total Staff	Compliant	Compliance %
Midwife acute	182	173	95%
Midwife Community	59	58	98%
Midwife Birth Centres	28	27	96%
Obstetric Consultant	20	20	100%
Obstetric Doctor	51	51	100%
Anaesthetic Consultant	30	30	100%
Anaesthetic Doctor	10	9	90%
Maternity Support Worker & Nursery Nurse (excl. bank)	71	68	96%
Total	451	436	97%

Data as at 28 February 2025.

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

NLS - Maternity

*Exc LTS & Mat leave
*Exc new starter medical staff
*Exc Bank only midwives

Role	Total Staff	Compliant	Compliance %
Midwives	269 (excluding bank)	258	95%
Obstetric Consultant	20	20	100%
Obstetric Doctor	50	50	100%
Maternity Support Worker	71 (excluding bank)	68	96%
Total	410	396	97%

Data as at 28 February 2025.

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

NLS - Neonatal

Role	Compliance: Basic NLS Annual Update *	Compliance: BAPM Airway Management NLS update**
Neonatal nurse (band 5 and above)	100%	97%
ANNP	100%	100%
Neonatal consultant	100%	100%
Specialist trainee and permanent NNU doctor	83% (plan in place to improve compliance)	100%
Foundation doctors and GP trainees	100%	100%

*Annual NLS refresher delivered by GIC Instructor
**Advanced training for all staff who attend resuscitations as primary resuscitator. Training compliant with BAPM airway management basic level training, either Resus Council NLS Course or in house course, minimum 4 yearly.

Data as at 28 February 2025.
Escalation: Project underway to ensure MTW Learning accurately captures this data, currently data collated manually via spreadsheet.

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	94.5%	-	90.3%	-	27.1%	28.0%
Midwifery Services - MSW (2022) - NF102	-	89.2%	-	83.9%	24.4%	0.0%
Midwifery Services - Antenatal Ward - NF122	85.7%	-	84.5%	-	41.8%	8.9%
Midwifery Services - Postnatal Ward - NF132	124.4%	91.3%	120.7%	100.3%	41.2%	6.0%
Midwifery TW (four IP rosters)	101.2%	89.8%	96.4%	86.2%	31.6%	13.0%

Unavailability (%)			
37.61%			
Annual Leave (%)	**Sick Leave (%)**	**Study Leave (%)**	**Other (%)**
16.49%	4.04%	4.70%	6.39%

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 25	Feb 25
Birth to midwife ratio	1:24	1:26	1:25	1:27	1:25	1:24	1:25	1:21

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
February	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.

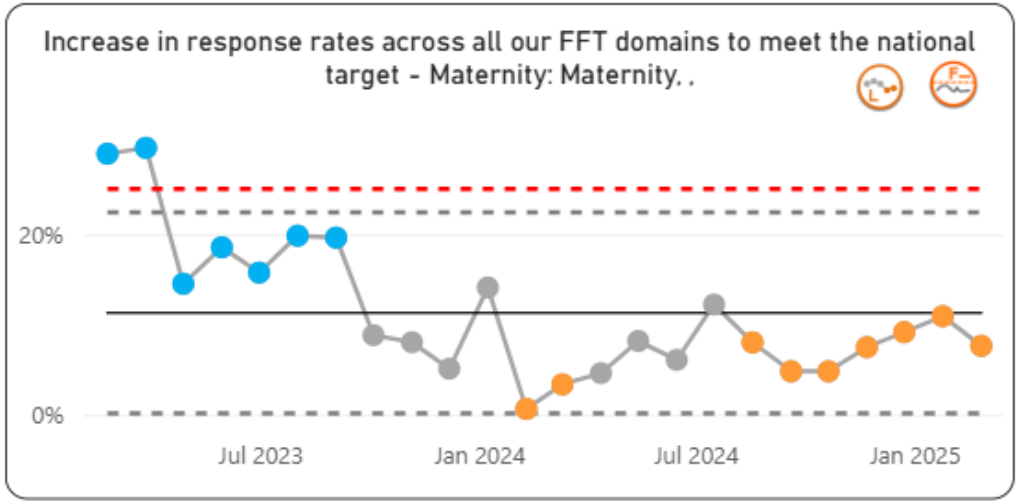
Hearing from women, birthing people, and their families

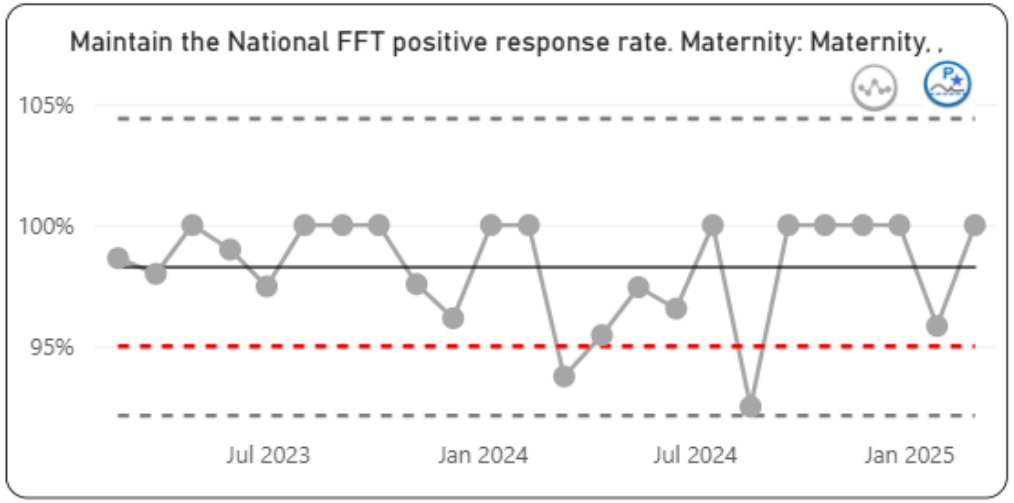
Service user feedback to include themes of feedback received by MNVP

Qrly report not due

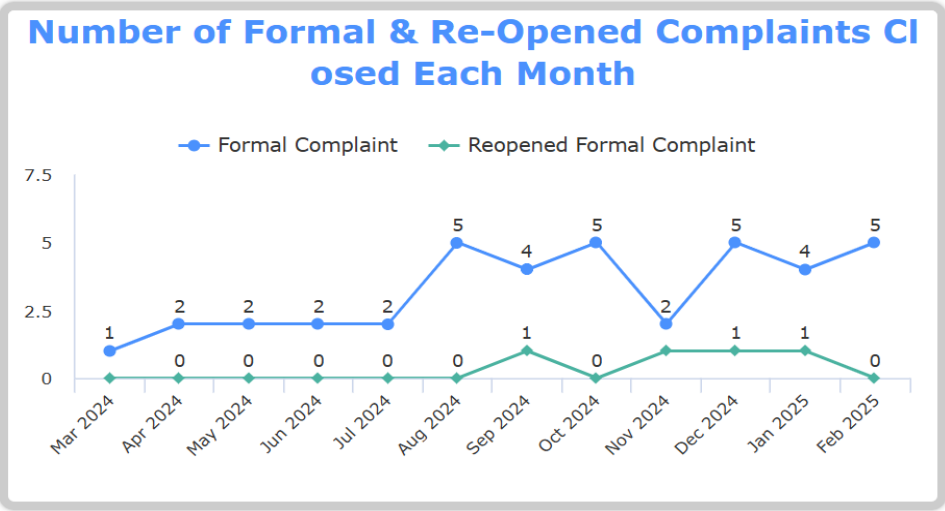
FFT Feedback

	May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25
Total responses	87		67		95		147		134		164		164		165		178		154		166





Formal Complaints



No of formal complaints received in month : 2

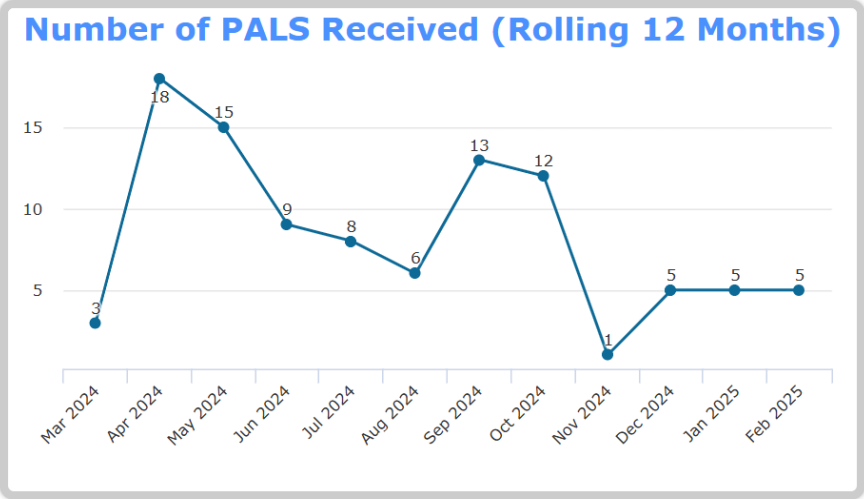
No open in service : 5

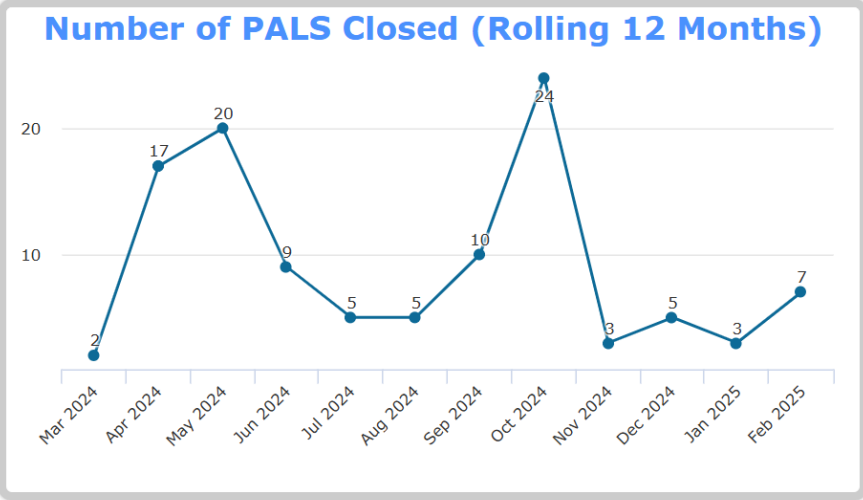
No of breached complaints: 0

New Formal Complaints		
Description	**Subject**	**Sub-Subject**
Concerns around attitude and behaviour of midwife and lack of management for blood loss and lack of support for breast feeding.	Staff attitude and behaviours	
Concerns around pain relief offered and care from a midwife not reflecting Trust values.	Staff attitude and behaviours	Lack of pain relief (on AN ward)

PALS

No of PALS cases: 5





Themes/Learning

- Staff values, attitude and behaviours
- Poor communication

- 1 compliment:

  "I've had many encounters with Pembury over the years but I received absolutely exceptional care from Jorgen Ho (C&G Teaching Fellow) and an obstetrics consultant called Philippa today.

  Jorgen truly made me feel cared for and I trusted him. He did a very thorough job during our consultation and it really did feel like he was doing everything he possibly could to help. It was, without a doubt, the best experience I've ever had with doctors at Pembury. He made me feel so at ease and it was a really pleasant encounter."

Listening to women engagement activities and evidence of co-production

What our service users are telling us	What we have done	What are we going to do about it
Lack of information regarding recovery from caesarean section birth	Recognised that there is no specific information – currently only Antenatal information provided rather than recovery.	Infographic developed which will has been co-produced with MNVP.
Poor discharge processes - Non-empathetic, rushed, delayed, insufficient information	Postnatal ward manager informed – to share with ward staff	Improve discharge process – project to be co-produced with MNVP early 2025
Lack of de-brief/birth reflection service	Ensured sufficient signposting to other appropriate services are available	A3 project underway to re-instate service in collaboration with MNVP, mental health midwife and Thrive midwife. Aims to also clarify Obstetric de-brief processes.
Lack of Basic Amenities for Birth Partners	Discussed issues at Maternity Patient Experience Committee – recognised that there is a need to better manage partner expectations.	Create an infographic for birth partners. To co-produce with MNVP.

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.*****

Neonatal PQSM Report

Key Issues Report

Report Date: April 2025 (February 2025 data)		**Report lead:** Neonatal Matron/Senior Nurse Neonatal Quality & Risk	**Actions:**
1a	**Alert** (Include actions taken/mitigations)	• There was one case reviewed at PSIRG relating to a significant delay (20hrs) in recognition and treatment of jaundice in a baby with known antenatal risk factors • MTW are currently one of only a few neonatal units with BLISS Platinum accreditation. Without substantive psychology funding, this accreditation is at risk of being removed which may affect the reputation of the service and parent experience	• Verbal duty of candour completed at time of the incident and family contacted and supported during ongoing review • Immediate learning from MDT shared and changes to process underway • Commissioned AAR as meets local PSIRP for diagnostic incident - now underway with maternity • Need to continue to seek business case support for psychotherapist • Added to risk register • Job descriptions sent to HR to review so that we can have a psychologist on staff bank to support whilst service is reviewed
1b	**Assurance**	• The compliance for attendance at both annual and 4yearly Neonatal Life Support Training is above 90% target for nursing/ANNPs/Consultant teams • Positive verbal feedback received from families and no formal complaints received • Band 7s now in post with responsibility for improving family integrated care • Parent Support Sister working part time • Safeguarding champion working part time to provide additional social support for families • Parents signposted to support network • Neonatal parent group in place	• Meeting arranged with MTW learning to enable recording of both nursing and medical NLS on trust systems for data accuracy • Training programme under development for Trust doctors and Consultants to support yearly compliance
1c	**Advise**	• Kent and Medway ICB will not be continuing with Maternity and Neonatal Independent Senior Advocate Pilot. Last day of MNISA in post 24/03/2025	• To work in collaboration with MNISA to support wind down of service to prevent compounding harm to families • Continuing signposting of families to appropriate support

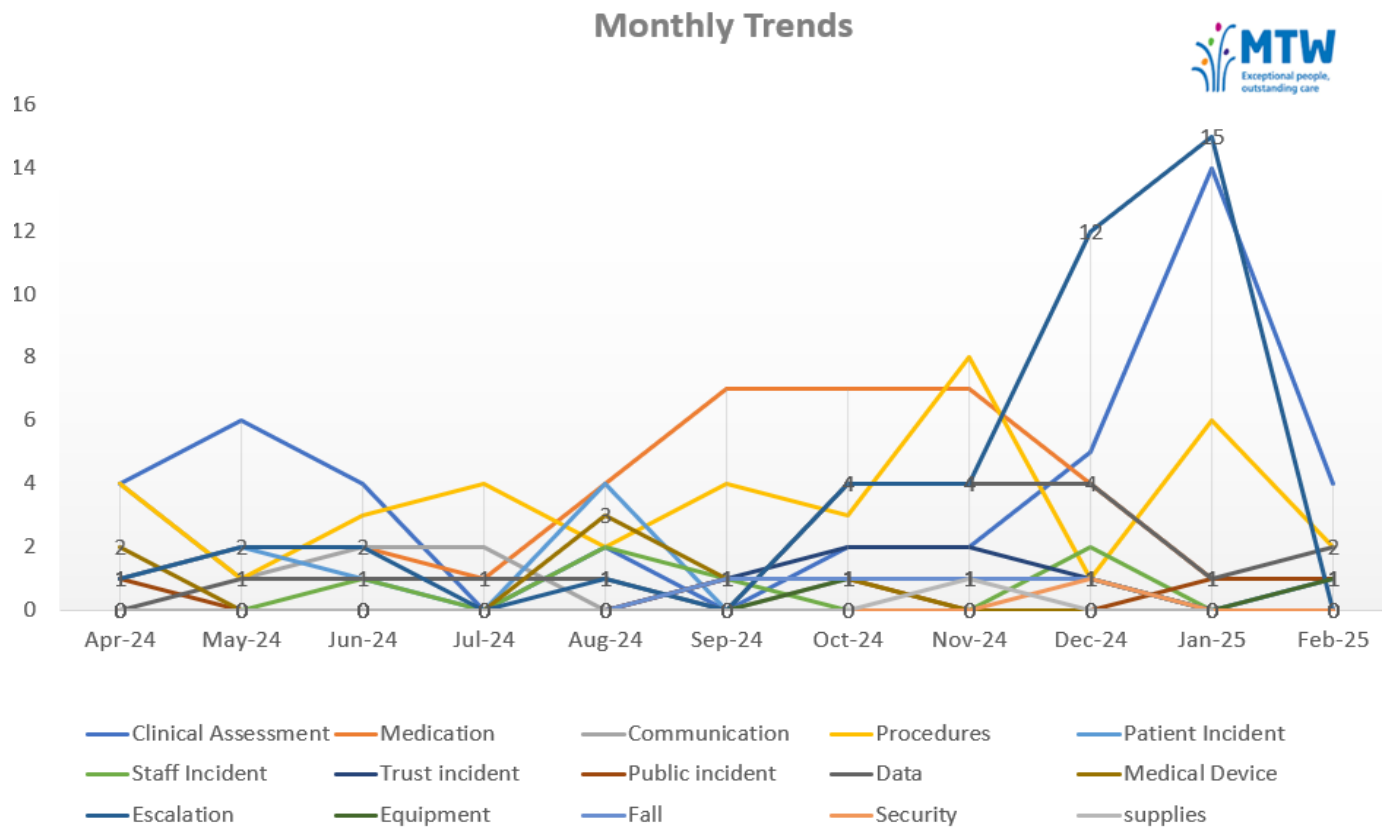
Neonatal Safety Metrics: In Phase LFPSE and Tracking Trends

Incidents reported on InPhase this month: 13

Theme: Two babies admitted from maternity with low temperature (three last month)

Action: Referred to maternity for further investigation/action plan

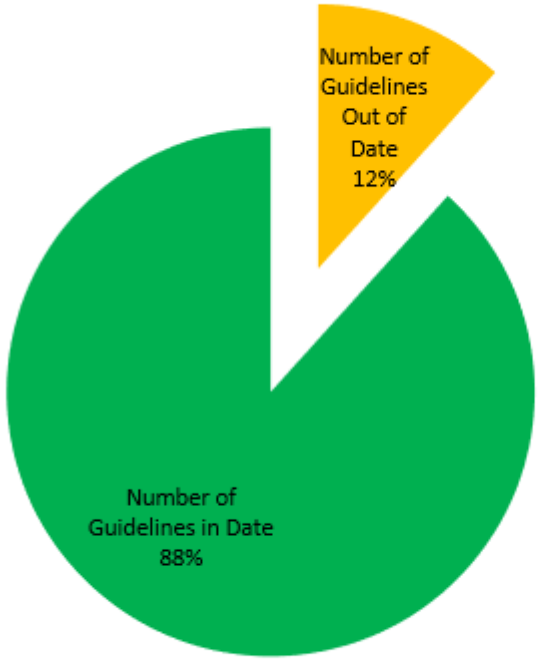
Tracking Trends Submissions this month: 0



Role Specific Training - Neonatal Life Support Training

Role Specific Training (Newborn Life Support)	Compliance* (Target 90%) (All registered practitioners) Annual GIC update	UK Resus Council NLS attendance compliance (All staff attending neonatal resuscitation call)
Nursing Staff: band 5 and above (QIS nurses require Resus Council training)	100%	97%
ANNP's	100%	100%
Consultants	100%	100%
Specialist Trainees and Permanent NNU doctors	83% Formal Plan in place for annual basic life support update	100% compliant for NILS
Foundation doctors and GP trainees	100%	100%

Neonatal Guideline Compliance – February 2025



Robust process in place to review and update.
Guidelines circulated for two weeks to relevant teams and key stakeholders. Then reviewed by neonatal guideline group with submitted comments, ratified where appropriate and submitted to the Paediatric Directorate / Clinical Director for final sign off.
Barriers to completion are time restrictions for meetings.

Total Guidelines	**94**
Out of date being reviewed	11
Reviewed for publication	8
In Date being Reviewed	9
In date	66

Neonatal Risk Register – February 2025

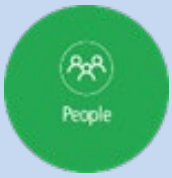
Risk ID	Risk identified	Inherent risk rating	Modified Risk Rating	Target
3016	There is a shortage of neonatal trained nursing staff available to support escalation of the unit	12	9	6
3345	There is a lack of provision for psychological support on the neonatal unit which risks impacting families and staff	12	9	4
2951	Risk to neonatal babies due to non-compliance with guidance related to therapies impacting both hospital stay and ongoing referrals	12	6	4
Maternity Risks (Neonatal)				
1101	Risk of baby abduction due to poor security on maternity	12	6	4

Neonatal Business Cases in progress: Consultant Staffing, Nurse/Admin and AHP Staffing

Neonatal risks reviewed

- Bi-monthly at Neonatal Risk Meeting
- Monthly at Paediatric Directorate Meeting

Title of report	**Board Assurance Framework**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	24th April 2025					
Agenda item no.	04-8					
Executive lead	Annette Doherty, Chair of the Trust Board					
Presenter	Annette Doherty, Chair of the Trust Board					
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 organisation's Board Assurance Framework (BAF) brings together in one place all the relevant information on risks to the Board's strategic objectives. The BAF reports on the most significant risks to the achievement of the organisation's six strategic objectives. Each BAF risk is owned by a member of the Executive Team and rated in accordance with the grading matrix set out at the end of this report. The Risk Owner ensures the controls, assurance, gaps and risk score reflect the management of the risk. A Trust Board Committee is also nominated to have oversight of each BAF risk will ensure that this is considered at each committee meeting.
Any items for formal escalation / decision	All Trust Board Committees have had regard to the BAF risks through the meetings.
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)	Please list any BAF Principal Risks to which this report relates: PR 1, PR 2, PR 3, PR 4, PR 5, PR 6
Links to Trust Risk Register (TRR)	ID 994, ID 791,ID 1301, ID 3186, ID 3124, ID 3125, ID 3109, ID 3130, ID 1211
Compliance / Regulatory Implications	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17, Good Governance

Board Assurance Framework

March 2025

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Board Assurance Framework (BAF)

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, which forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – current (residual), tolerable and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low-risk options; **Cautious** = preference for low-risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Executive team with agreed timescales

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target
OR
- gaps in control and assurance are being addressed

Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

Likelihood score and descriptor

	Rare1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not necessarily a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

		Lead Director	Lead Committee	4	6	8	9	10	12	15	16	20	25	SRO Level of Assurance
PR1	Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer	Chief People Officer	People and OD			Target			Current					Limited
PR2	If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes	Chief Medical Officer	Quality			Target				Current				Limited
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	Chief Operating Officer	Finance and Performance	Target	Current									Adequate
PR4	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.	Chief Nurse	Quality		Target		Current							Limited
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 deterioration and poor clinical outcomes	Director of Strategy, Planning and Partnerships	tbc	Target						Current				Limited
PR6	Failure to deliver the Trust financial plan resulting from the system being in financial recovery	Chief Finance Officer	Finance and Performance			Target					Current			Limited

Current
Tolerable
Target
Current to tolerable

Strategic theme	**People**: Creating an inclusive, compassionate and high performing culture where our people can thrive and be their best selves at work.						
Principal risk	**PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer**					**SRO level of assurance**	Limited
Lead committee	People and Organisational Development Committee	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	People
Lead director	Chief People Officer	**Consequence**	Major-4		Major-4	**Risk appetite**	Open
Initial date of assessment	11/11/2024	**Likelihood**	Possible-3		Unlikely-2		
Last reviewed	12/02/2025	**Risk rating**	12		8		
Last changed		**Links to Trust Risk Register**	994 – Our staff survey and WRES and DES data demonstrate that our BAME and disabled communities have less opportunity at MTW				

Strategic threat	**Primary risk controls**	**Gaps in control**	**Plans to improve control**	**Sources of assurance**	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Our Board is not reflective of our local communities and staff population	The terms of reference for the Remuneration & Appointment Committee (RemCom - subcommittee of the Board) approved Board Succession Planning (Executive and Non-Executive) process approved by RemCom VSM and Non Exec Director recruitment and assessment process approved by RemCom EDI strategy aligned to the People and Organisational Development Strategy Reverse mentoring programme	Evidenced in WRES data WDES data Succession planning goals and action plans shared with the Remuneration Committee	Board Succession Planning & Succession Committee Renumeration Committee Terms of Reference Executive Level / System Level leadership development	Management EDI Strategy monitored through People and Organisational Development Committee Board Succession Planning Committee monitored through the Remuneration Committee Metrics monitored through the Integrated performance report reporting to the Board EDI and Well-being steering committee Risk and Compliance Risk reports WRES and WDES data	EDI Strategy and succession planning activity	
Lack of effective talent management and succession planning at all levels of the organisation	People and Organisation Development Strategy Appraisal Process Inclusive recruitment workshops Reverse Mentoring - MTW and ICB programs	EDI Strategy - engagement with Employee Networks Inconsistent application of appraisals and career development conversations Lack of forecasting turnover	People and Organisation Development Strategy Enhanced EDI strategy Implementation of succession planning Implementation of divisional People and OD plans Access to learning and development opportunities	Management Monitoring of turnover Monitoring of Diversity being brought into the organisation Monitoring of numbers of staff promoted Risk and Compliance Risk reports WRES and WDES data	People and Organisation Development Strategy	
Inability to retain staff due to market factors	NHS People Promise exemplar programme	Funding for the People promise programme is time limited	Staff leavers action plan including exit Interviews Retention planning including professional development Career development opportunities for those on internationally educated programs	Management Metrics monitored through the Integrated performance report reporting to the Board Monitoring of turnover Monitoring of Diversity being brought into the organisation Monitoring of promotion rates Independent assurance: National Staff Survey Well-led report CQC Well-led Review	Embedding People Promise in the organisation Reporting to NHSE on progress	

Strategic theme	**Patient Safety and clinical effectiveness**: Achieving outstanding clinical outcomes with no avoidable harm						
Principal risk	**PR**:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes					**SRO level of Assurance**	Limited
Lead committee	Quality	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Safety
Lead director	Sara Mumford	**Consequence**	Moderate-3	Major-4	Major-4	**Risk appetite**	Cautious
Initial date of assessment	11/11/2024	**Likelihood**	Almost certain-5	Possible-3	Unlikely-2		
Last reviewed	11/11/2024	**Risk rating**	15	12	8		
Last changed		**Links to Trust Risk Register**					

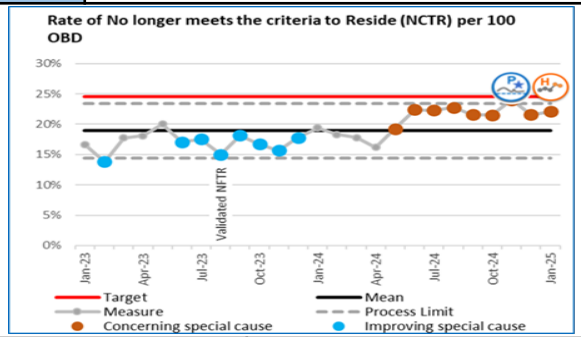
Strategic threat	Primary risk controls	Gaps in control	Plans to improve control	Sources of assurance	Gaps in assurance / actions to address gaps	Assurance rating
Risk that patients do not receive care and treatment in line with best practice	Patient Safety Oversight Group	Lack of educational programme of deteriorating patient Policies out of date for review Inconsistent divisional risk review meetings	Deteriorating patient working Group Implementation of Martha's rule Review management of policy ratification process Review of NICE guidance Full implementation of divisional risk review meetings	Management Patient Outcomes Oversight Group reports to CQC Clinical audit plan Audit reports to clinical audit committee Risk and Compliance Risk review meetings (Divisional) Risk and Regulation Oversight Group Independent Assurance ICB Provider Quality meetings	Deloitte review action plan Post external review improvement plans	
Risk of not undertaking timely and cohesive learning from incidents, patient feedback, experience and claims	PSIRF implementation established to review systems and processes Monthly Patient Safety Oversight Group Quality directorate and divisional governance meetings	Directorate/divisional groups enable silo working	Trust wide development of dissemination of learning	Management Quality Governance reporting structure-directorate to board IPR- monitoring incident numbers Quality committee review of incidents and incident management Risk and Compliance Reports to Risk and Regulation Oversight Group Patient Safety Oversight Group Independent Assurance CQC Review, external accreditation/ regulation: HTA, UKAS, JAG,MHRA, ICB provide quality meetings	Trust wide learning process not fully embedded	
Risk of reputational damage to Trust, due to patients suffering sevee harm	Complaints management PSIRF-collaborative investigations of PSII Board oversight of PSII Patient stories at Board	Complaints backlog and performance Patient safety champions not in post	Complaints improvement action plan Appoint Patient Safety Champion	Management PSOG ETM Risk and Compliance Independent Assurance ICB Provider Quality meetings	Policies updated and signed off NICE guidance reviewed within 3 months of publication Divisional risk meeting s to be fully implemented Deteriorating patient educational programme Implement Martha's rule-report to PSOG	

Strategic theme	**Patient Access**: Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome								
Principal risk	**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**						**SRO level of assurance**	Adequate	
Lead committee	Quality	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Access	Insert TBC	
Lead director	Sarah Davis	**Consequence**	Possible-1	Possible-3	Possible-3	**Risk appetite**			
Initial date of assessment	20/05/2024	**Likelihood**	Likely-5	Unlikely-2	Unlikely-2				
Last reviewed	24/02/25	**Risk rating**	5	6	6				
Last changed	24/02/25	**Links to Trust Risk Register**	791 – Failure to meet Referral to Treatment Targets (RTT)						

Strategic threat	**Primary risk controls**	**Gaps in control**	**Plans to improve control**	**Sources of assurance**	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Significant increases in demand for non-elective and cancer activity that results in poor patient experience and outcomes	For non-elective care - UEC pathways, SPOA, SDECS, Virtual wards and hospital at home. For cancer - one stop pathways, straight to test, low diagnostic and treatment waiting times	Unpredictable spikes in demand exceeding capacity.	Senior clinical decision making and use of alternative pathways for non-elective demand Use of agreed WLIs to manage demand spikes for cancer. Longer term business cases to increase capacity. Increased	Management Daily site reports. Integrated performance report. SDR Achievement of all Cancer Waiting Times standards Risk and compliance Independent Assurance	Appropriate estate to manage demand - mitigated by teletracking on a daily basis and future health planning The impact of workforce availability on capacity - mitigated by targeted recruitment and retention activities.	5
Lost to follow up	Task and finish group to validate waiting list data Task and Finish group to review processes and		Action plan supporting recommendations of Quality Committee recommendations	Management Monthly meetings with the operational teams to work through validation of FUP waiting lists Risk and compliance Risk stratification of data Independent Assurance Independent review of FUP data to risk stratify patient cohorts and provide guidance on validation strategy	Workforce availability to validate patient cohorts at pace	5
ED Total Performance	Front to back door workstream SDEC Operational flow working group		Operational flow action plan	Metrics monitored through the Integrated performance report reporting to the Board Risk and compliance Independent Assurance		5

Strategic theme	**Patient Experience**: To meet our ambition of always providing outstanding healthcare quality we need people to have a positive experience of care and support							
Principal risk	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						**SRO level of assurance**	Adequate
Lead committee	Quality	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Patient experience and quality	Insert TBC
Lead director	Jo Haworth	**Consequence**	Moderate-3	Moderate-3	Moderate-3	**Risk appetite**	Cautious	
Initial date of assessment	11/11/2024	**Likelihood**	Possible-3	Possible-3	Unlikely-2			
Last reviewed	17/04/2025	**Risk rating**	9	9	6			
Last changed	17/04/2025	**Links to Trust Risk Register**	1301 – Failure to meet national targets for complaints performance					

Strategic threat	**Primary risk controls**	**Gaps in control**	**Plans to improve control**	**Sources of assurance**	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Risk that regulatory action is taken against the trust if areas of non-compliance are found with service delivery	Maternity Improvement Plan Oversight of actions being undertaken to address CQC Must and Should-do at RROG	Gaps in quality assurance process	Self-assessment against quality standards TIAA internal audit of Fuller recommendations	Management Monitoring of regulatory reviews and improvement plans through Risk and Regulation Oversight Group Maternity and Neonatal Care Oversight Group (MNCOG) End of Life Care Steering Group Risk and Compliance Risk reports Independent assurance CQC reviews and reports Regular oversight meetings and visits from NHS England/LMNS Engagement with MNVP	Quality Assurance framework under development Maternity rated inadequate by the CQC	Adequate
Risk that adequate feedback mechanisms are not in place to improve patient experience	SDR model and breakthrough objective re: complaints Complaints Improvement Plan developed Friends and Family Test data	Complaints data evidences communication as a key theme Inconsistent FFT data	Develop bespoke training for Communication FFT data being used to drive improvement action plans Feedback loop to be strengthened Contract review of FFT provider	Management Metrics monitored through the Integrated performance report reporting to the Board Complaints Improvement Plan monitored through Experience of Care Oversight Group (EOCOG) Oversight of divisional patient experience and engagement activity at EOCOG PLACE assessment undertaken annually Risk and Compliance Independent assurance Healthwatch feedback National Patient survey results	PLACE action plan to be monitored by EOCOG	Adequate

Strategic theme	**Systems and Partnerships**: Working with partners to provide the right care and support in the right place, at the right time								
Principal Risk	**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.**							**SRO level of assurance**	Limited
Lead committee	TBC	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Systems working		
Lead director	Rachel Jones	**Consequence**	Moderate-3	Moderate-3	Minor-2	**Risk appetite**	TBC		
Initial date of assessment	20/05/2024	**Likelihood**	Likely-5	Possible-3	Unlikely-2				
Last reviewed	19/02/25	**Risk rating**	15	9	4				
Last changed	16/12/24	**Links to Trust Risk Register**	3186 – Long delays for patients awaiting discharge to KEaH 3124 – Reduction in community beds at Sevenoaks Community Hospital 3125 – Risks for patients no longer fit to reside residing over 28 days in inpatient beds						

Strategic threat	Primary risk controls	Gaps in control	Plans to improve control	Sources of assurance	Gaps in assurance / actions to address gaps	Assurance rating
Inability to discharge patients due to timely internal processes and access to community/external capacity	Virtual Ward Hospital at Home Integrated Discharge Team Better use of beds program	No routine use of Estimated Date of Discharge internally Timely EDN completion linking to TTO and transport planning Access to pathway 1 capacity Lack of access to WK system	Front to back door action plan for internal processes Implementation of Better use of beds Application for funds to support additional pathway 1 capacity	<u>Management</u> Metrics monitored through the Integrated performance report reporting to the Board Flow improvement Board (front to back door work) HCP discharge and flow board UEC Board <u>Risk and Compliance</u> <u>Independent Assurance</u>	Community bed capacity is currently being reviewed by the ICB	

Strategic theme	**Sustainability**: Long term sustainable services providing high quality care through optimising the use of our resources						
Principal risk	**PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery**					**SRO level of assurance**	Limited
Lead committee	Finance and Performance	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Financial
Lead director	Chief Finance Officer	**Consequence**	Severe-4	Severe-4	Severe-4	**Risk appetite**	Open
Initial date of assessment	11/11/2024	**Likelihood**	Likely-4	Possible-3	Unlikely-2		
Last reviewed	11/11/2024	**Risk rating**	16	12	8		
Last changed		**Links to Trust Risk Register**	3109 – Failure to deliver Financial Plan including recurrent cost improvement programme for 24/25 3130 – Risk that the Trust will not be able to deliver its financial efficiency plan (CIP) 1211 – Trust wide capital equipment failure				Insert SPC

Strategic threat	Primary risk controls	Gaps in control	Plans to improve control	Sources of assurance	Gaps in assurance / actions to address gaps	Assurance rating
Failure to recurrently deliver our cost improvement programme will impact on the underlying financial position of the Trust	CIP programme in place and monitored on a regular basis CIP performance reported to Executive Team and Finance and Performance Committee in detail and Trust Board in summary on a monthly basis. PMO support to Divisions to deliver CIP Strategy Deployment Reviews monthly	CIP programme only partially identified at the start of the year. CIP gap remaining Not all savings have been delivered recurrently	A financial improvement programme was initiated. Additional controls have been enacted, these need to be reviewed to ascertain the ability for them to be made recurrent. To focus on elective activity income and delivering this benefit on a recurrent basis Through these actions increase the CIP delivered in year and recurrently	Management Integrated Performance Report, Trust financial position monthly reports, Financial improvement reporting on a monthly basis CIP Programme reporting monthly to the CFO and Exec Team. Finance and Performance Committee meet monthly and provide assurance to the Board Strategic Deployment Review meetings held with Divisions monthly Risk and Compliance Financial risks are identified and monitored on a monthly basis. A number of risks have been set out. Independent Assurance A review across the K&M system is underway looking at controls in place. We also submit a return to K&M ICB on the status of our controls.	CIPs not all yet identified - the financial recovery plan is in place. The month 8 YTD financial position remains off plan, with a gap in CIP delivery remaining. CIPs have not been fully identified recurrently	16
Failure to reduce the use of temporary staffing spend will impact on the delivery of the Trusts financial position for the 24/25 financial year	Temporary Staffing Workstream in place, focussing on the reduction of bank and agency spend. Monthly report to Executive Team, People and OD Committee, Finance and Performance Committee and Trust Board Targets have been set for reductions across the organisation	Temporary staffing is not at the national level of 8.5% of Total Pay Bank spend has reduced at a slower rate than agency spend	All Divisions and directorates have a target reduction in temporary staffing For AFC staff, a temporary staffing dashboard is in place that has real time data on a ward / department basis. A number of actions / controls on restricting the use of temporary staff have been introduced. Further control of rates, particularly in medical staffing, is planned to be introduced	Management Integrated Performance Report, Trust financial position monthly reports, Financial improvement reporting on a monthly basis Temporary Staffing reduction reporting monthly to the CFO and Exec Team. People and OD Committee and Finance and Performance Committee meet monthly and provide assurance to the Board Strategic Deployment Review meetings held with Divisions monthly Risk and Compliance A number of risks in relation to temporary staffing have been included. Independent Assurance A review across the K&M system is underway looking at controls in place. We also submit a return to K&M ICB on the status of our controls.	The Month 8 position with regard to temporary staffing spend remains above the national target and above expected reductions	12

Failure to reduce the use of temporary staffing spend will impact on the delivery of the Trusts financial position for the 24/25 financial year	Temporary Staffing Workstream in place, focussing on the reduction of bank and agency spend. Monthly report to Executive Team, People and OD Committee, Finance and Performance Committee and Trust Board Targets have been set for reductions across the organisation	Temporary staffing is not at the national level of 8.5% of Total Pay Bank spend has reduced at a slower rate than agency spend	All Divisions and directorates have a target reduction in temporary staffing For AFC staff, a temporary staffing dashboard is in place that has real time data on a ward / department basis. A number of actions / controls on restricting the use of temporary staff have been introduced. Further control of rates, particularly in medical staffing, is planned to be introduced	<u>Management</u> Integrated Performance Report, Trust financial position monthly reports, Financial improvement reporting on a monthly basis Temporary Staffing reduction reporting monthly to the CFO and Exec Team. People and OD Committee and Finance and Performance Committee meet monthly and provide assurance to the Board Strategic Deployment Review meetings held with Divisions monthly <u>Risk and Compliance</u> A number of risks in relation to temporary staffing have been included. <u>Independent Assurance</u> A review across the K&M system is underway looking at controls in place. We also submit a return to K&M ICB on the status of our controls.	The Month 8 position with regard to temporary staffing spend remains above the national target and above expected reductions	12
Risk that the need for investment in statutory and mandatory requirements, end of life equipment failures or regulatory interventions exceeds the capital available causing an impact on services	The Trust sets a capital programme at the start of the year to use the capital allocated it bearing in mind the prioritised risks and developments the Trust wants to invest in. The Trust runs a monthly capital steering group, which is a sub committee of the Executive Team. Capital expenditure is reported monthly to the Executive Team, Finance and Performance Committee and Trust Board	The capital allocated to the Trust does not equate to the full generated depreciation (capped by NHSE) The Trust has always fully utilised its capital, however it has more calls on the capital programme than it has been able to service. A number of areas have now reached end of life, and could potentially fail at short notice	The Trust is constructing a multi year view on its capital requirements which references risk, condition and age. Future annual capital programmes will need to have a higher weighting to replacement / renewal of infrastructure rather than new developments. The Trust will need to access ICS level capital for the replacement of certain assets or new developments (for example linear accelerators)	<u>Management</u> Integrated Performance Report, Trust capital position monthly reports, reports to the capital steering group Finance and Performance Committee meet monthly and provide assurance to the Board <u>Risk and Compliance</u> A number of risks in relation to capital replacement have been included. A number of deep dives at Quality Committee, Audit and Governance Committee and Finance and Performance Committee have highlighted these issues. <u>Independent Assurance</u> Capital is managed across the ICS by the K&M ICB. Capital plans and business cases are scrutinised by the K&M ICB Some issues are picked up and reviewed by Internal Audit regarding their efficacy.	The Trust currently does not have the multi year plan in place – this is under construction While the capital programme maybe insufficient, any capital slippage is prioritised against our risk rated list.	12

Risk that investments approved by the Trust do not fully deliver the benefits ascribed to them from the business case	The Trust reviews its business case benefits realisation on a regular basis via Executive Team and Finance and Performance Committee The Trust reviews its productivity on a quarterly basis via the Executive Team and Finance and Performance Committee The Integrated Performance Report, including key metrics, is presented to Executive Team, Finance and Performance Committee and Trust Board on a monthly basis	It has proven difficult to obtain a clear statement of benefits realised from business cases previously approved The Trusts productivity, as measured nationally, has reduced since the start of 2023/24	A review on the approach on benefits realisation has been scheduled for the January 2025 Finance and Performance Committee. A fuller exposition of the national productivity metric is scheduled for the February 2025 Finance and Performance Committee.	<u>Management</u> Integrated Performance Report Finance and Performance Committee meet monthly and provide assurance to the Board – business case benefit realisation is a standing item <u>Risk and Compliance</u> Some of these business cases have been funded by external funding – either for the capital or revenue consequences. We need to have a clear view on benefits delivery <u>Independent Assurance</u> Some developments are picked up and reviewed by Internal Audit regarding their implementation and benefits delivery	There is a belief that the benefits realisation process could be improved – this is under review.	9
Risk that the productivity position of the Trust will deteriorate impacting on both the financial position and service delivery to patients	The Trust reviews its productivity on a quarterly basis via the Executive Team and Finance and Performance Committee The Integrated Performance Report, including key metrics, is presented to Executive Team, Finance and Performance Committee and Trust Board on a monthly basis	The Trusts productivity, as measured nationally, has reduced since the start of 2023/24	A fuller exposition of the national productivity metric is scheduled for the February 2025 Finance and Performance Committee. The Productivity Report has a Trust overview section but also has a deep dive into a Division of the organisation on a rotational basis.	<u>Management</u> Integrated Performance Report Finance and Performance Committee meet monthly and provide assurance to the Board – productivity is a standing item	The Trust does have a productivity opportunity that could improve the financial position and the services being delivered. This is a relatively new area and as such, is under development.	9

Risk that the commercial income will not meet required targets impacting on both the financial position and service delivery to patients	The Trust reviews its commercial income, particularly the acquisition of Fordcombe, currently on a monthly basis via the Executive Team and Finance and Performance Committee The Integrated Performance Report, including key metrics, is presented to Executive Team, Finance and Performance Committee and Trust Board on a monthly basis	The current delivery of Fordcombe / Wells Health is behind plan and is causing a financial issue. The Trust is not delivering the opportunity to deliver greater levels of commercial income which could underpin the provision of NHS services to our population	Additional support from operational, financial, programme management teams has been targeted to support the short term improvement in the position. There is currently no fully signed off and agreed strategy for the development of this opportunity in the medium / long term	<u>Management</u> Individual bespoke reviews of the current situation at Fordcombe being presented to the Executive Team and the Finance and Performance Committee Integrated Performance Report Finance and Performance Committee meet monthly and provide assurance to the Board <u>Risk and Compliance</u> The business case for the purchase of Fordcombe has been funded by NHSE and the K&M ICB – either for the capital or revenue consequences. We need to have a clear view on benefits delivery	The current performance still remains adverse – a recovery plan is being worked on.	12
Risk that the new Government will introduce a new financial regime that will impact on the Trusts recurrent financial position	Currently the first planning guidance under the new Government is awaited. Once reviewed this will help us to understand the situation. Delivering our financial plan for the year, recurrently and improving our recurrent financial position will put us in a good position to weather changes in the financial regime.	Planning guidance awaited Forecasting to deliver our in year financial position, but with a larger amount of non-recurrent benefits than originally planned.	Financial Improvement Plan in place for delivery of the current year financial position	<u>Management</u> Integrated Performance Report, Trust financial position monthly reports, Financial improvement reporting on a monthly basis Finance and Performance Committee meet monthly and provide assurance to the Board <u>Risk and Compliance</u> Financial risks are identified and monitored on a monthly basis. A number of risks have been set out. The Trust will need to comply with national planning guidance when published <u>Independent Assurance</u> A review across the K&M system is underway looking at controls in place.	Continued focus on the recurrent financial position Quick analysis of the planning guidance when published.	12

Risk Appetite

Risk Type		Risk Appetite
Financial	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. We will invest for the best possible return where we are able to put appropriate controls in place to realise the best possible return.	Open
Regulatory	We are prepared to accept the possibility of limited regulatory challenge. We would be open to challenge by regulators where we believe there is evidence of improved outcomes.	Cautious
Quality	Our preference is for risk avoidance. However, if necessary we will take decision on quality where is a low degree of inherent risk and the possibility of innovation for improved outcomes, and appropriate controls are in place.	Cautious
Reputational	We want to be valued as a highly performing organisation, however, we are prepared to make decisions that may bring scrutiny with the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	Cautious
People	We are prepared to accept the possibility of some workforce risk if there is the potential for improved skills, capabilities and wellbeing of our staff. We recognise that innovation is likely to be disruptive in the short term with the possibility of long-term gains, we will deliver this by ensuring we take our staff with us.	Open

Key

The likelihood score is based on the probability of the consequence occurring. Select a descriptor from the left-hand column, then work along the columns in the same row to assess the likelihood of the risk on the scale of 1 to 5 to determine the likelihood score, which is the number given at the top of the column.

Likelihood descriptor	**1** **Rare**	**2** **Unlikely**	**3** **Possible**	**4** **Likely**	**5** **Almost certain**
Frequency Time-based	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue/ circumstance	Will undoubtedly happen/recur possible frequently
Probability Will it happen or not?	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

5 x 5 Matrix

	Consequence				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Likelihood					
5 Almost certain	**5**	**10**	**15**	**20**	**25**
4 Likely	**4**	**8**	**12**	**16**	**20**
3 Possible	**3**	**6**	**9**	**12**	**15**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
1 Rare	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 6	Low risk
8 – 12	Moderate risk
15 – 25	High risk