

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

Thu 29 May 2025, 09:45 - 13:00

Lecture Room 8, Undergraduate Medical Building, Tunbridge Wells Hospital

Agenda

09:45 - 09:46
1 min

05-1
To receive apologies for absence
Annette Doherty

09:46 - 09:46
0 min


05-2
To declare interests relevant to agenda items
Annette Doherty

09:46 - 09:50
4 min


05-3
To note progress with previous actions
Annette Doherty
 Board actions log (Part 1).pdf (1 pages)

Reports from the Chair of the Trust Board and Chief Executive

09:50 - 09:55
5 min

05-4
Report from the Chair of the Trust Board
Annette Doherty
 Report from the Chair of the Trust Board - May 2025 - FINAL.pdf (2 pages)

09:55 - 10:00
5 min



05-5
Report from the Chief Executive
Miles Scott
 Chief Executive's report May 2025 - FINAL.pdf (4 pages)

Integrated Performance Report

10:00 - 10:00
0 min

05-6
Integrated Performance Report (IPR) for April 2025

Miles Scott and colleagues

-  Integrated Performance Report (IPR) for April 2025.pdf (47 pages)
-  Safe staffing report Planned v Actual - April 2025.pdf (1 pages)

Patient Experience

10:00 - 10:15
15 min

05-7 **Patient Experience story**

Charlotte Wadey



N.B. This item is scheduled for 10:00am.

-  Experience of Care Patient Story Paediatric May 2025.pdf (3 pages)

10:15 - 10:25
10 min

05-8 **NHS Children and Young People's Patient Experience Survey 2024: Management Report**

Joanna Haworth

-  Trust Board Cover page 2024 CYP survey results. updatedRG.pdf (2 pages)
-  2024 Children and Young People's Survey Trust Board RG.pdf (9 pages)

Patient Safety and Clinical Effectiveness

10:25 - 10:35
10 min

05-9 **Quality Committee, 21/05/25**

Maureen Choong

-  Summary of Quality C'ttee, 21.05.25.pdf (4 pages)

10:35 - 10:45
10 min

05-10 **Maternity Incentive Scheme Compliance (Minimum dataset from PQSM)**

Megan Fradgley and Jessica O'Reilly

N.B. This item is scheduled for 10.35am.

-  Maternity Report relating to the Perinatal Quality Surveillance Model.pdf (80 pages)

Patient Access

10:45 - 10:55
10 min

05-11 **Performance**

Sarah Davis

People

10:55 - 11:05
10 min

05-12

People and Organisational Development Committee, 23/05/25 (incl. approval of revised Terms of Reference)

Emma Pettitt-Mitchell

-  Summary of People and Organisational Development Cttee 23.05.25.pdf (3 pages)
-  Updated Terms of Reference.pdf (5 pages)

Sustainability

11:05 - 11:15
10 min

05-13

Finance and Performance Committee, 27/05/25

Neil Griffiths

-  Summary of Finance and Performance C'ttee 27.05.25.pdf (3 pages)


Systems and Partnerships

11:15 - 11:25
10 min

05-14

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

Rachel Jones

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

11:25 - 11:35
10 min

05-15

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

Sarah Davis

-  Board cover page template Maggies update May 2025.pdf (5 pages)

Governance and Assurance

11:35 - 11:45
10 min

05-16

Audit and Governance Committee, 15/05/25

David Morgan

-  Summary of Audit and Governance Cttee 15.05.25.pdf (3 pages)

11:45 - 11:55
10 min

05-17


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

Joanna Haworth

N.B. Please note that the red risk report is in the document section on admincontrol.

11:55 - 12:05 **05-18**
10 min **Emergency Planning Annual Report, 2024 and future emergency planning**
Sarah Davis
 Emergency Planning Annual Report, 2024 and future emergency planning.pdf (16 pages)

12:05 - 12:15 **05-19**
10 min **Annual Fire Safety Report**
Sarah Davis
 Annual Fire Safety Report.pdf (17 pages)

12:15 - 12:20 **05-20**
5 min **Assurance of compliance with the Fit and Proper Persons Test requirements**
Louise Thatcher
 Assurance of Compliance with Fit and Proper Persons Test-May 25.pdf (6 pages)

12:20 - 12:25 **05-21**
5 min **Board Assurance Framework (BAF)**
For Discussion
 Board Assurance Framework (BAF).pdf (14 pages)

Other matters

12:25 - 12:30 **05-22**
5 min **To consider any other business**
Annette Doherty

12:30 - 12:35 **05-23**
5 min **To respond to any questions from members of the public**
Annette Doherty

12:35 - 12:35 **05-24**
0 min **To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...**

Annette Doherty

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

Trust Board Meeting – May 2025

Log of outstanding actions from previous meetings

Chair of the Trust Board

Actions due and still 'open'

| Ref. | Action | Person responsible | Original timescale | Progress ¹ |
|-------|--|---------------------------------|-------------------------|-----------------------|
| 03-12 | Present the 'Close down' of the People Promise Exemplar to the Trust Board. | Helen Palmer | May Trust Board meeting | |
| 03-13 | Schedule a Deep Dive into recognition and management of the deteriorating patient at a future Quality Committee. | Maureen Choong and Sara Mumford | TBC | |

Actions due and 'closed'

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|------|--|--------------------|----------------|---|
| 03-5 | Link with the London region's maternity services to learn from their work undertaken with patients from the global majority. | Rachel Thomas | April 25 | Links have been made and learning is to be shared with the team |

Actions not yet due (and still 'open')

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

¹




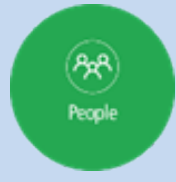


Not started

On track

Issue / delay

Decision required

| | | | | | |
|--|---|--------------------------|-------------------|--------------------------|-------------------------------------|
| Title of report | Report from the Chair of the Trust Board | | | | |
| Board / Committee | Trust Board 'Part 1' meeting t | | | | |
| Date of meeting | 29 th May 2025 | | | | |
| Agenda item no. | 05-4 | | | | |
| Executive lead | Annette Doherty, Chair | | | | |
| Presenter | Annette Doherty, Chair | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information |
| | | | | | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | Chair’s Report for the May Trust Board meeting. | |
| Any items for formal escalation / decision | N/A | |
| Appendices attached | There are no appendices to this report. | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| N/A | N/A | N/A |

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

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

I recently attended a South East Regional Leaders briefing which focussed mainly on financial and operational performance expectations. At this event, there was also a discussion about a new Board appraisal process being introduced which aligns to the NHS leadership competency framework for board members. Central to this will be the rollout of a digital 360-degree feedback tool, allowing for structured input from a range of stakeholders including peers, direct reports, and external partners. This tool is designed to provide a more holistic view of performance, leadership behaviours, and contribution to organisational culture. At the briefing, discussions have also taken place focussing on commissioning which is driven by population health outcomes. By embedding population health data into commissioning strategies, leaders aim to ensure that resources are targeted where they can deliver the most impact, supporting preventative care, reducing inequalities, and building collaboration across systems.

In support of further enhanced system partnership working, a Kent and Medway joint committee is in the process of being set up for later in the year. The role of this new committee is to establish governance for developing and managing work and savings across the healthcare system with the ambition of delivering better outcomes, efficiencies and greater value for money, while also focussing on providing improved patient and staff experiences.

Elsewhere, MTW is also working alongside system providers to develop a joint venture for the Kent and Medway Pathology Network. The project aims to build on the work already developed by the network and continue to consolidate services across the system, allowing for better resource allocation and expertise, helping to improve laboratory turnaround times for patient testing.

On 22 May I joined the Spring Forum Leadership Conference in the Academic Centre at Maidstone Hospital alongside a number of our senior leaders from across the Trust. The event, followed the success of the inaugural conference last year, and included a number of guest speakers with a focus on speaking up and the impact of communication as a leader, inclusion and personal growth. As part of the conference, I was also pleased to join our Chief People Officer, Helen Palmer and Non-Executive Director, Dr Wayne Wright, for a special Q&A panel on the importance of our Freedom to Speak Up (FTSU) service, which supports everyone working within the Trust to feel safe and confident to speak up on any issues they are concerned about. The FTSU service not only creates a safe space and transparent culture at MTW, but also helps our leaders to take the opportunity to learn and improve our processes and operations based on the lived experiences from those who speak up.




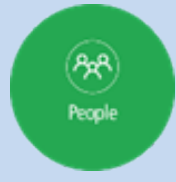


We have received a lot of interest in our two Non-Executive Director (NED) positions that have been advertised in recent weeks. Shortlisting has now taken place and interviews are scheduled in for next month.

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? |
|-------------|---|------------------------------|-------------------------------|------------|-------------------------------|--------------------------|
| 23/04/2025 | Consultant Physician - Interest in Geriatric Medicine & Acute Frailty | Jasmine Ellena Rebecca | Mann Bournat Jayasinghe | Geriatrics | 01/07/25 TBC TBC | New New New |
| 02/05/2025 | Consultant Neurologist | Laura | Midgley | Neurology | TBC | Replacement |

| | | | | | |
|--|--|--------------------------|-------------------|--------------------------|-------------------------------------|
| Title of report | Report from the Chief Executive | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | |
| Date of meeting | 29 th May 2025 | | | | |
| Agenda item no. | 05-5 | | | | |
| Executive lead | Miles Scott, Chief Executive | | | | |
| Presenter | Miles Scott, Chief Executive | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information |
| | | | | | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | Chief Executive Report for the May Trust Board meeting, summarising Trust developments and achievements over the last month. | |
| Any items for formal escalation / decision | N/A | |
| Appendices attached | There are no appendices to this report. | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| N/A | N/A | N/A |

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

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

- I am pleased to report that MTW has successfully achieved its financial plan for 2024/25, which means we have now delivered our financial plan for the last seven years. This accomplishment is a direct result of a great deal of hard work across the organisation by our teams who have continuously identified efficiencies, and has enabled us to invest in services, facilities and frontline patient care and respond to increased demands on our services.

As stated in my update last month, the NHS across the country is facing a significant financial challenge this year. This will see a steep increase in cost-saving requirements at MTW, in line with the Government's ask of provider trusts - to reduce both running costs and waiting lists. We will be required to think and work differently, and work in partnership across Kent and Medway, to ensure we are as efficient, effective and productive as possible while continuing to provide high quality care. The plan last year was partly achieved by reducing temporary staffing costs and this focus will continue. We are not alone in this as all trusts are being asked to reduce running costs and this will impact on staffing numbers. Together with senior clinical leaders we are finalising what this will mean for the Trust, and will ensure staff are informed and supported throughout the process.

- While this work progresses, we continue to develop our services and infrastructures. Following the handover of the newly completed Undergraduate Medical Building in March, the first students from the Kent and Medway Medical School (KMMS) recently moved in to the six-story building. The facility provides modern teaching facilities as well as accommodation for up to 144 medical students who are undertaking clinical placements with KMMS at our hospitals, and will help us achieve our shared vision with KMMS of training the next generation of doctors in the region. The development is also part of a national commitment to double the number of medical school places in England by 2031 and level up the training opportunities across the country.
- MTW continues to be recognised as a top performing trust and we regularly share our learning and experience with colleagues across the country.

Leaders from the Department of Health and Social Care, and from NHS trusts including North West Anglia, Hull, Buckinghamshire, Barnsley and West Hertfordshire, recently visited Maidstone Hospital to learn more about how our systems support us to manage patient flow and make the best use of our beds. They were given tours by the Trust's Emergency Department (ED), Virtual Ward and Care Co-ordination Centre (CCC) teams, which included a visit to MTW's Same Day Emergency Care units, where patients can receive appropriate treatment and avoid ED. The visitors also learned about the West Kent Single Point of Access Hub, which supports paramedics on scene with a patient and directs them to the most appropriate service.

On behalf of MTW, I also attended a roundtable discussion this month hosted by Pat McFadden MP, Chancellor of the Duchy of Lancaster, and Wes Streeting MP, Secretary of State for Health and Social Care, held at the Royal Berkshire Hospital. A small number of high performing trusts were invited to the event, with discussions focusing on how our innovative work practices and continued roll out of technologies such as electronic patient records are improving productivity and patient experience across the NHS.

- With the need for efficiencies and improvements across the NHS currently under the spotlight, our digital teams have been working on a pioneering fully automated observations process. Patients' vital signs were previously recorded on one device and then had to be manually uploaded to the Sunrise clinical system on another. This was both time consuming and open to human error. The teams have now developed fully automated vital signs, with staff using a single device to take observations which then uploads the data directly to Sunrise in real-time, with no manual input needed. Following a trial period, the innovative

system has now gone live across all adult inpatient areas at Maidstone and Tunbridge Wells hospitals, giving staff vital time back for patient care. Findings so far show that an average of three minutes per observation is being saved, which means the new system has made us safer, faster and more efficient. Other trusts are now approaching us for advice on how to replicate this success in their organisations.

- All letters issued on our patient portal have now become digital. Previously, letters on the portal that had not been read within 72 hours were automatically posted out. This function stopped earlier this month, and all letters are now remaining on the digital platform, and users are being reminded to read them via push notifications and emails. Patients can still print letters at home if needed, and they also have the option to add a carer to their account, or nominate someone they trust to support them in managing their letter.

So far, the portal has avoided more than 200,000 letters from being printed and posted, saving 600,000 sheets of paper. This change – brought in from 13 May -will enable the Trust to support sustainability by reducing waste even further and make savings that can be reinvested into NHS services. After going live just over a year ago, nearly 170,000 people have registered for the Trust's patient portal, and they can now view appointment details, appointment letters, clinical correspondence, discharge notifications and additional health information online. Users can also easily cancel or re-schedule an appointment, all of which saves them time and avoids a call to hospital administration teams.

- Sarah Flint has agreed to extended her term as Chief of Service for the Women's, Children's and Sexual Health Division by three months, and will now be stepping down from the role at the end of September. The succession planning for a new Chief of Service will run alongside Sarah's extension in order to ensure a smooth transition, with arrangements for this being confirmed before the end of Sarah's tenure. During her time in the role, alongside her colleagues across her division Sarah has delivered some incredible achievements to support patients and staff including:
 - Leading the divisional teams through the COVID pandemic, meeting the challenges and increased referrals with commitment to patient care and compassionate leadership
 - Helping our maternity team through complex service development while seeing positive results in recent patient satisfaction surveys
 - Being recognised as the Kent, Surrey, Sussex (KSS) Deanery's Obstetrics and Gynaecology (O&G) Trainer of the Year for 2023 for her contributions to the training of junior doctors and nurturing talent within the service
 - Leading the division to be in the top 10 nationally for gynaecology Referral to Treatment (RTT) performance. This proactive approach ensures patients receive timely access to care while supporting the clinical teams to manage capacity effectively and sustainably
 - Supporting the division with driving the financial plan and helping teams remain on track despite a challenging economic climate
 - Driving theatre utilisation improvements to optimise scheduling. These efforts not only improved productivity and patient flow but also contributed to better patient outcomes
 - Supporting the development of Fordcombe Hospital including contributing to the service planning and workforce modelling.







On behalf of the Board, I would like to thank Sarah for all her work. We look forward to continuing to work with her in the future.

- The Trust's Phoenix Midwifery team, which specialises in providing expert care to young parents aged 20 under, have recently celebrated its fourth anniversary. Though pregnancy rates for people aged under 18 has more than halved between 2011 and 2021, this age group can sometimes be challenged with additional complexities, including physical and mental health issues, and social difficulties. The Phoenix Midwifery team, which includes

specialist midwives, a maternity support worker and a consultant obstetrician and gynaecologist, was therefore set up to provide specialist support to these young parents. The team uses the continuity of carer model, an evidence-based method shown to build trust, improve outcomes, and reduce inequalities. Phoenix Midwifery puts this into practice by ensuring that every young parent has direct access to a named midwife, additional antenatal appointments, personalised antenatal education and labour care provided by a Phoenix midwife. Care continues post-birth with 28 days of at-home postnatal support and postnatal meet-up groups alongside the Kent Family Hubs. Through its work, the Phoenix Midwifery team has helped improve outcomes for babies - since the team's introduction in 2021, the rate of pre-term births has almost halved and the number of babies benefiting from an hour of skin to skin contact after birth has increased.

- MTW's third annual Nursing, Midwifery and Healthcare Support Worker Conference was held at Maidstone Hospital this month, with celebrations coinciding with International Day of the Midwife and International Nurses Day. The event included keynote sessions from external speakers including Joanne Bosanquet MBE, Chief Executive of the Foundation of Nursing Studies, who spoke to delegates about 'person centredness' and the professional identity of nursing and midwifery. Attendees also heard from three patients who have benefited from MTW's cancer support group, and presentations from a number of teams who showcased the innovative work taking place in their areas, including the virtual ward pathways. The conference also saw the announcement of winners of the Trust's annual Nursing and Midwifery Awards. On behalf of the Board, I would like to congratulate all the winners and nominees of these awards, and thank them for the continued dedication and outstanding care they show to our patients.
- MTW has officially launched our Armed Forces staff network, which already has more than 40 active members and is supported by Executive Sponsors, Dr Sara Mumford, Chief Medical Officer, and Helen Palmer, Chief People Officer. The network is non-exclusive and open to veterans, reservists, adult cadet force volunteers, spouses and children of someone currently serving, allies, and those with lived experience or a general interest in the Armed Forces. The network aims to become a community that connects colleagues with current and former service members who have transitioned into the NHS, providing a supportive and inclusive environment for all. The network forms part of the work the Trust is already undertaking to support the Armed Forces community, which led to our accreditation as Veteran Aware last year, and strengthens our aim to become a gold standard Forces-Friendly employer.
- Congratulations to the joint winners of the Trust's Employee of the Month award for April, Postnatal Nursery Nurse, Hannah Wain and Senior Sister in IU, Lucy Gosnell. Hannah was nominated for her work over the last year in fundraising for a specialist blanket that provides essential treatment for jaundice in newborn babies on the Postnatal ward. By securing funding through the League of Friends and taking part in a number of fundraising activities, Hannah has so far raised enough to secure five of these specialist blankets. Lucy was nominated for leading a project to improve standards of person-centred care by the multi-disciplinary critical care team. This led to the Intensive Care Unit at Tunbridge Wells Hospital becoming the first in the UK to receive the prestigious HU-CI and AENOR Certification of Good Practices in Humanisation of Intensive Care.

| | | | | | | |
|--|---|-------------------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | Integrated Performance Report (IPR) for April 2025 | | | | | |
| Board / Committee | Trust Board Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-6 | | | | | |
| Executive lead | Chief Executive / Executive Directors | | | | | |
| Presenter | Chief Executive / Executive Directors | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|--|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

| 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: <ul style="list-style-type: none"> 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 |

Integrated Performance Report

April 2025

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| • CMS: Overall Temporary Staff Spend as a % of Total Spend | Page 12 |
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Appendices

| | |
|--|---------------|
| • Forecast SPC Charts | Pages 30- 36 |
| • Business Rules for Assurance Icons | Pages 37 - 39 |
| • Consistently, Passing, Failing and Hit & Miss Examples | Page 40 |
| • Maternity Metric Definitions | Page 41 |

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.



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

| Name of Metric/KPI | Latest | | | Previous | | | Assurance | | | |
|--|--------------|----------------------|--------|--------------|----------------------|--------|-------------------|---|---|------------|
| | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Variance / Driver | Variation | Assurance | CM Action |
| A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm | 100 | 159 | Oct-21 | 100 | 159 | Sep-21 | Driver |  |  | Verbal CMS |

Further Reading / other resources

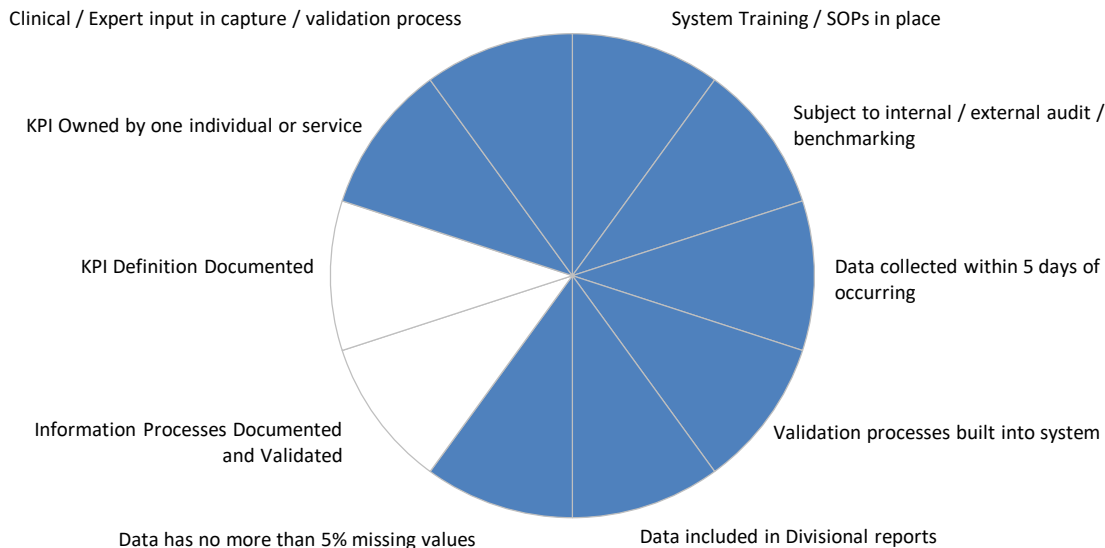
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - <https://improvement.nhs.uk/resources/making-data-count>

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. This has been reviewed for the new financial year and is currently being finalised. The new Objectives will be reflected in next month's report.

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 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 April 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. The rate of all outpatient appointments that are either a new appointment, or a follow up appointment with a procedure, is experiencing common cause variation and has passed the target for 6+ months. Both the Rates of E.Coli and C.Diff continue to experience common cause variation and variable achievement of the target. The rate of falls continues to experience common cause variation and passing the target for more than six months. VTE performance was above the 95% target in March (data runs one month behind) and continues to experience common cause variation and consistently passing the target.

Patient Access: The average non-elective length of stay indicator is currently experiencing common cause variation and consistently failing the target. The conversion rate from A&E to inpatient admission remains in common cause variation and variable achievement of the target. Ambulance Handovers <30mins continues to experience common cause variation but has failed the target for 6+ months. The Trust's performance for A&E 4hrs was below the new trajectory target for April at 81.5%. 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 the 62 day first definitive treatment standard. 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 was above the new trajectory target for April 25 of 88.4% at 89.5%. This indicator is experiencing common cause variation and variable achievement of the target and is therefore no longer escalated. This indicator was changed nationally in October 2024 to include endoscopy surveillance patients which has adversely affected the overall performance. In addition, the overall Diagnostics target has also now changed nationally from 99% to 95%. 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 above the new trajectory target for April 25 of 72.4% at 72.59% (Excluding SYS). Nationally we reported 72.51% (including SYS). This indicator is experiencing common cause variation and variable achievement of the target and is therefore no longer escalated. We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported one 52 week breaches at the end of April 25. The number of patients having waited more than 40 weeks (Excluding SYS) continues to experience common cause variation and variable achievement of the target.

Having been achieving the target for eight consecutive months, Outpatient utilisation dipped below the target in both February and March. April performance will improve as cashing up of clinics continues. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute continues to experience special cause variation of an improving nature but consistently failing the target. The percentage of patients on a PIFU Pathway is now experiencing special cause variation of an improving nature and variable achievement of the target. Performance for First Outpatients activity was below the new trajectory target for April 2025 (this is likely to improve as cashing up of clinics take place) and is now experiencing common cause variation and variable achievement of the target. Elective Activity (Inpatients and Day Case combined) were above the new plan and 19/20 levels for April 2025 and has passed the target for more than six consecutive months (21 months). Diagnostic Imaging activity levels were above plan and 19/20 levels in April and remains in common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints continues to experience common cause variation but has now failed the target for more than six months. Complaints related to communication issues remains in variable achievement of the target. Complaints responded to within the target date passed the target again in April, at 86%, and is now experiencing special cause variation of an improving nature and variable achievement of the target. The indicator for agency spend specifically related to B5 RMNs and Band 4 HSCWs continues to experience common cause variation and 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 April for all areas except A&E which has seen an increase. All touch points have failed the target for six consecutive months.

Systems: The 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 £5.6m in deficit in the month which was £0.7m adverse to plan. Delivery of the financial position remains in common cause variation. The reduction in non-pay spend is now experiencing common cause variation and variable achievement of the target. 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 its financial improvement programme.

Maternity: Both of the indicators for Women waiting for Induction of Labour (in less than 2 or 4 Hours) continue to experience 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 Access:

- 10% Reduction in Non-Elective LOS (P.19)
- Outpatient Calls answered <1 minute (P.20)
- Ambulance Handovers < 30 mins (P.20)

Systems:

- Depth of Coding - Average Number of Codes per Elective Episode (P.25)

Patient Safety & Clinical Effectiveness:

- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.15)
- % Capped Theatre utilisation (P.16)

Patient Experience:

- New Complaints Received (P.22)
- FT Response Rates: All areas (P.23)

Sustainability:

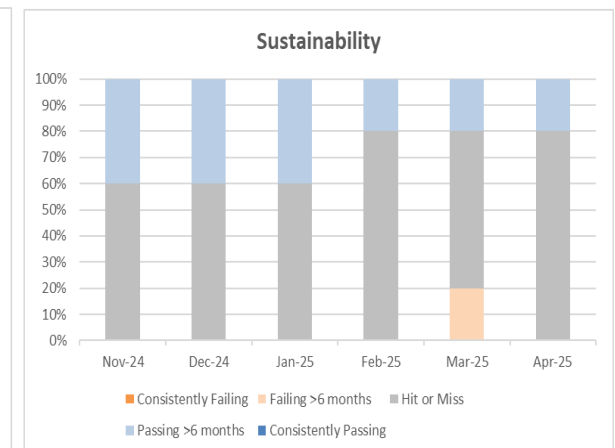
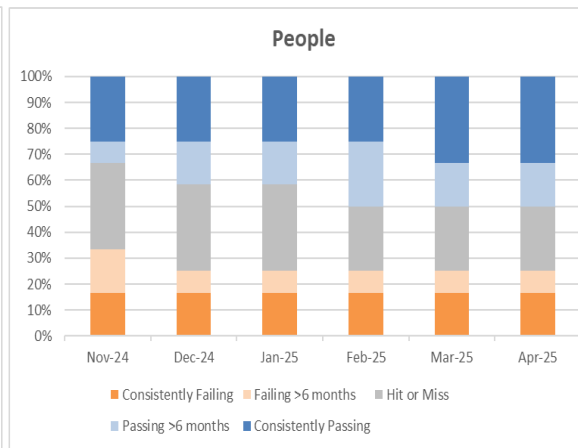
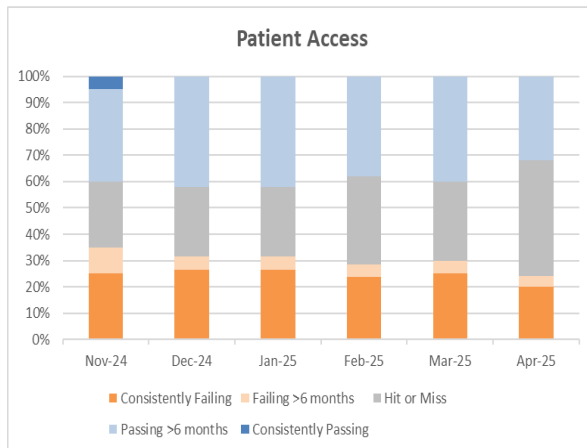
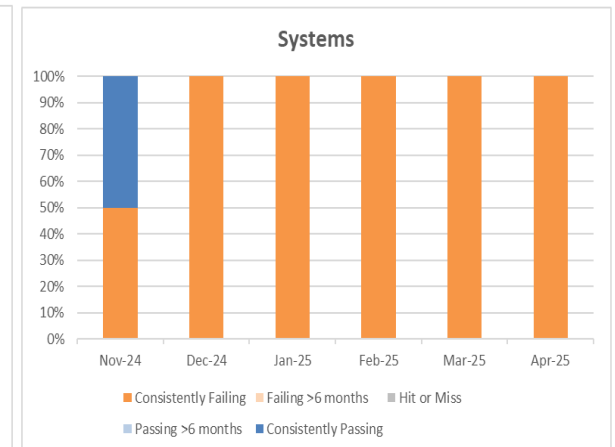
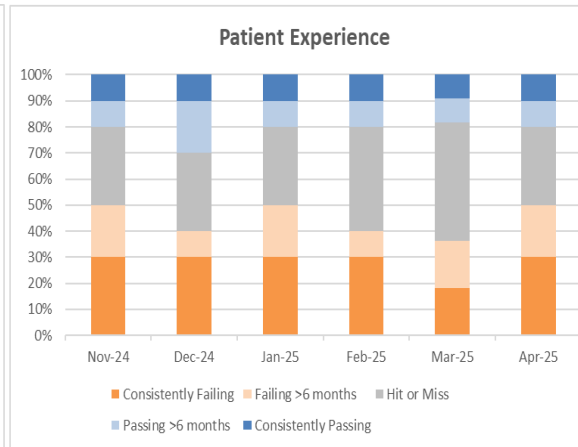
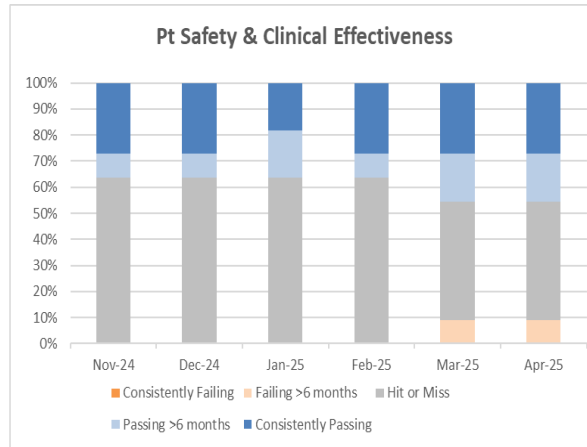
- None escalated

Maternity Metrics:

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

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

Assurance Stacked Bar Charts by Strategic Theme



Matrix Summary

April 2025

Assurance

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

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 | Three Month Forecast | Variation | Assurance |
| Vision | Well Led | Reduction in Total Pay Spend | | 43,243 | 44,261 | Apr-25 | 39,442 | 40,329 | Mar-25 | Driver | | | Full CMS | | | |
| Financial Breakthrough Objectives | Well Led | Overall Temporary Staff Spend as a % of Total Spend | | 8.5% | 10.1% | Apr-25 | 8.5% | 10.6% | Mar-25 | Driver | | | Full CMS | | | |
| | Well Led | Agency Spend as a % of spend – target of 3.2% | | 3.2% | 1.3% | Apr-25 | 3.2% | 1.8% | Mar-25 | Driver | | | Note Performance | | | |
| Constitutional Standards and Key Metrics | Well Led | Reduce the Trust wide vacancy rate to 8% | | 8.0% | 5.3% | Apr-25 | 8.0% | 5.6% | Mar-25 | Driver | | | Not Escalated | 4.7% | | |
| | Well Led | Reduce Turnover Rate to 12% | | 12.0% | 10.5% | Apr-25 | 12.0% | 10.3% | Mar-25 | Driver | | | Not Escalated | 10.2% | | |
| | Well Led | Sickness Absence | | 4.5% | 4.0% | Mar-25 | 4.5% | 4.1% | Feb-25 | Driver | | | Not Escalated | 4.2% | | |
| | Well Led | Statutory and Mandatory Training | | 85.0% | 89.9% | Apr-25 | 85.0% | 90.3% | Mar-25 | Driver | | | Not Escalated | 92.6% | | |
| | Well Led | Percentage of AfC 8c and above that are Female | | 66.0% | 74.0% | Apr-25 | 66.0% | 74.2% | Mar-25 | Driver | | | Not Escalated | 75.13% | | |
| | Well Led | Percentage of AfC 8c and above that have a Disability | | 4.0% | 8.0% | Apr-25 | 4.0% | 7.9% | Mar-25 | Driver | | | Not Escalated | 8.72% | | |
| | Well Led | Percentage of AfC 8c and above that are BAME | | 11.7% | 6.7% | Apr-25 | 11.3% | 6.0% | Mar-25 | Driver | | | Escalation | 6.32% | | |
| | Well Led | Staff Leavers within 12 months | | 15.3 | 16 | Apr-25 | 15.3 | 15 | Mar-25 | Driver | | | Not Escalated | 16 | | |
| | Well Led | Staff Leavers within 24 months | | 27.8 | 33 | Apr-25 | 27.8 | 38 | Mar-25 | Driver | | | Not Escalated | 33 | | |

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Reduction in Total Pay Spend

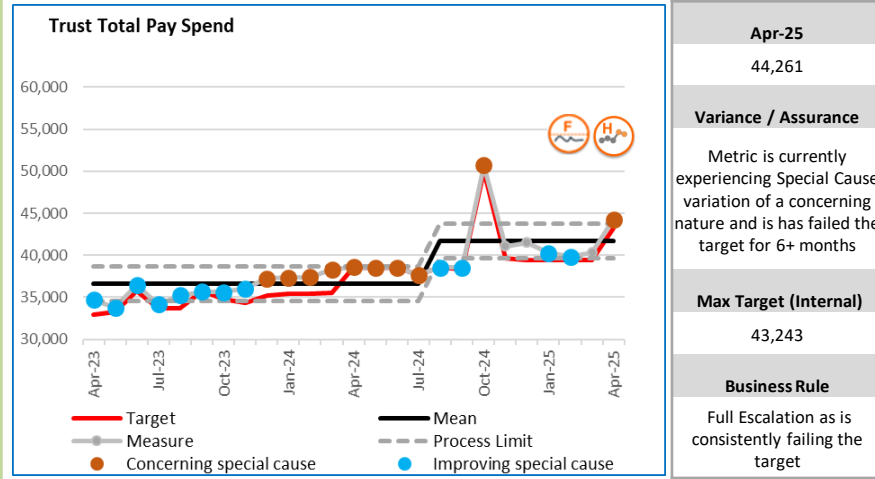
Owner: Chief People Officer

Workstream: Temporary Staffing

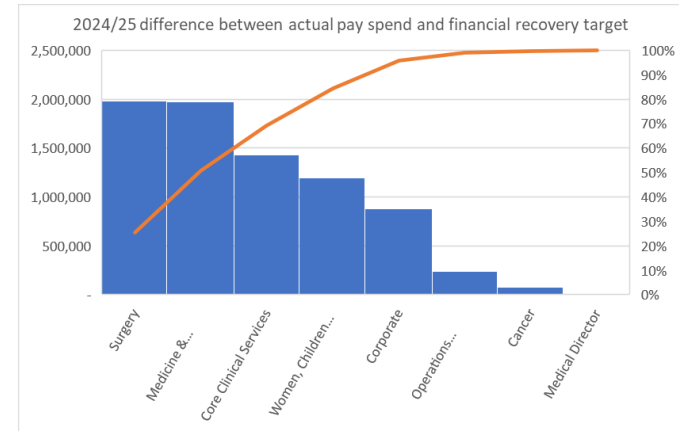
Metric: Overall Staff Spend compared to financial recovery forecast target

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



2. Stratified Data



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

3. Top Contributors & Risks

Top Contributors:

- In April 2025, total pay spend was adversely impacted by 2 factors. (1) A number of vacancies authorised in 24/25 had a disproportionate number of new starters delayed until April 2025. (2) In April 2025, we had a number of Medical staff who had previously at or near full time on the staff bank move over onto fixed term contracts, which while reduced temporary staffing spend and cheaper overall, did increase the substantive pay bill.

Risks:

- 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 Transformation | The Transformation team was set up in May, and will support the trust wide organisation change programme, which will have a direct impact on this objective. Next milestone is 29 May Board | Ongoing | 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 |
| Other Staffing Project | As part of the Financial Improvement Programme, the Other group is focusing on reducing the final few A&C corporate banks shifts down to zero, with a greater focus with operational colleagues on reducing A&C bank in the clinical divisions | ongoing | Deputy CPO with project leads |

Financial Breakthrough Objective: Counter Measure Summary

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

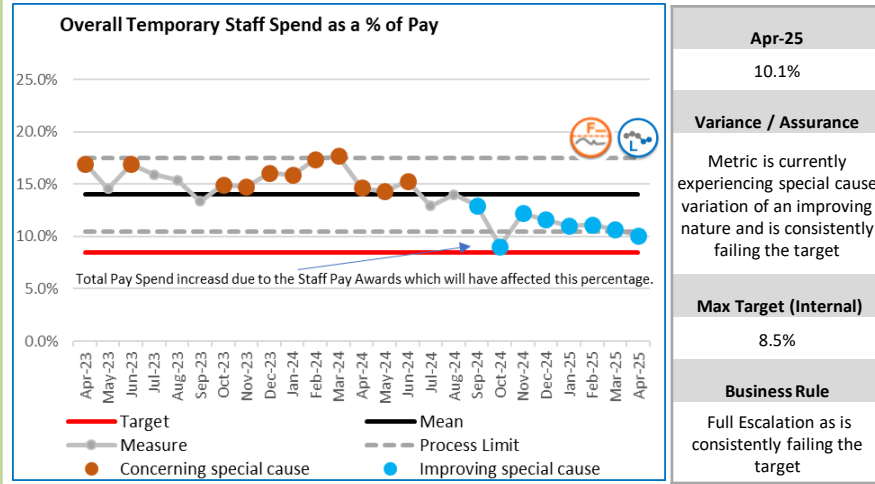
Owner: Chief People Officer

Workstream: Temporary Staffing

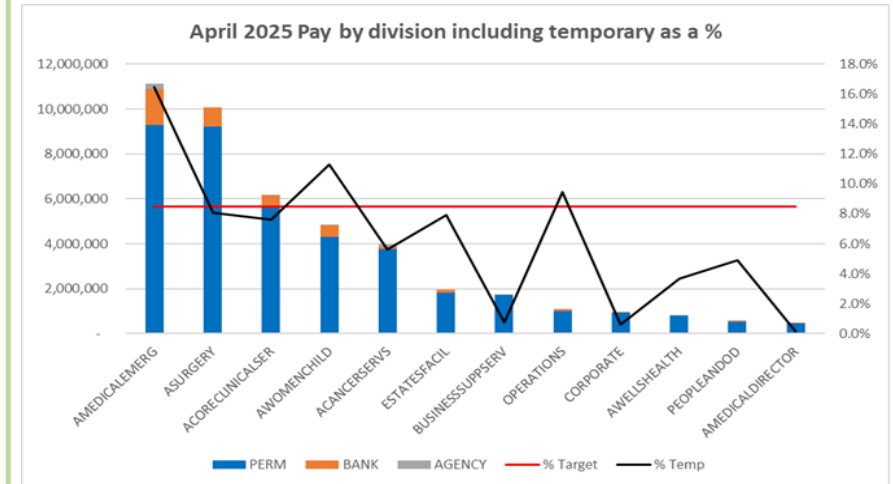
Metric: Overall Temporary Staff Spend as a % of Total Spend

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



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.

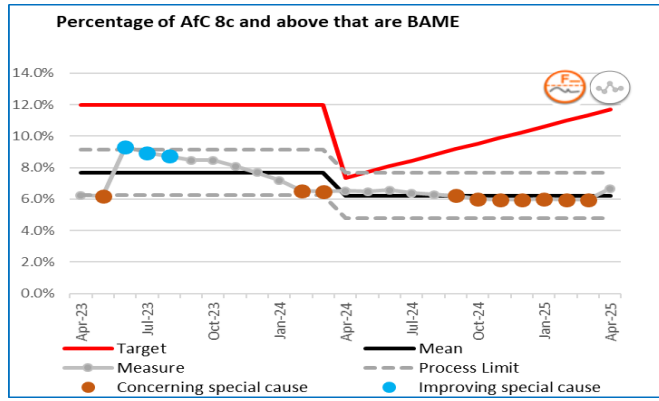
Risks:

- There is a risk that Divisions will not reduce their pay forecasts by the target level of 15% for Bank and 40% on agency as a minimum (Targets and trajectories are being worked up in line with 25/26 objectives)
- There is a risk that unexpected high demand on services will cause temporary staffing levels to be higher than planned

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



| |
|---|
| Apr-25 |
| 6.7% |
| 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: |
|---|---|---|
| <p>% of AfC 8c and above that are BAME: This metric is common cause variation and consistently failing the target.</p> | <p>% of AfC 8c and above that are BAME:</p> <p>Actions:</p> <p>Online Inclusive recruitment training is nearing completion and will be available from the end of May 2025</p> <p>Awaiting outcome of discussions between PODco Chair and Deputy CPO (OD) on EDI strategy and project review</p> <p>Executive Succession planning commencing June 2025</p> <p>Target will be reviewed in line with proposed draft NHS National Performance & Assessment Framework (NPAF)</p> | <p>% of AfC 8c and above that are BAME:</p> <p>Eliminating bias in the recruitment process is a key driver to achieve this target but senior recruiting manager attendance at the inclusive recruitment workshops has been poor. The workshops are being replicated with online learning that will be available through MTWLearning.</p> <p>The People Business Partners have been provided with suggested targets for recruiting managers</p> <ul style="list-style-type: none"> at least one person on every recruitment panel for 8C and above must have attended the workshop/undertaken online learning use positive action recruitment outcomes for all band 8B and above by the end of the financial year to have 80% of all recruiting managers skilled in inclusive recruitment <p>An EDI update went to PODco in April 2025 with suggestions of standing back up the EDI project and reviewing the EDI strategy</p> <p>Executive Succession planning including objective to increase diversity of successors and pipeline through to senior positions through a range of talent management and development activities</p> |

Strategic Theme: Patient Safety & Clinical Effectiveness

| | CQC Domain | Metric | DQ Kite Mark | Latest | | | Previous | | | Actions & Assurance | | | | Forecast | | |
|---|------------|---|--------------|--------------|----------------------|--------|--------------|----------------------|--------|---------------------|-----------|-----------|------------------|----------------------|-----------|-----------|
| | | | | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions | Three Month Forecast | Variation | Assurance |
| Vision | Safe | Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) | | 1.50 | 2.03 | Mar-25 | 1.50 | 1.69 | Feb-25 | Driver | | | Full CMS | 2.44 | | |
| Breakthrough Objective | Safe | Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) | | 2.1 | 1 | Mar-25 | 2.1 | 5 | Feb-25 | Driver | | | Verbal CMS | 3 | | |
| Financial Breakthrough Objectives | Safe | % Capped Theatre utilisation. | | 85.0% | 82.9% | Apr-25 | 85.0% | 81.7% | Mar-25 | Driver | | | Full CMS | | | |
| | Safe | Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) | | 49.0% | 51.0% | Apr-25 | 49.0% | 51.6% | Mar-25 | Driver | | | Note Performance | 53.1 | | |
| Constitutional Standards and Key Metrics | Safe | Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month | | TBC | 2 | Apr-25 | TBC | 4 | Mar-25 | Driver | | | Not Escalated | | | |
| | Safe | Number of new After Action Reviews (AARs), commissioned in month | | TBC | 2 | Apr-25 | TBC | 6 | Mar-25 | Driver | | | Not Escalated | | | |
| | Safe | Number of new SWARMS commissioned in month | | TBC | 0 | Apr-25 | TBC | 0 | Mar-25 | Driver | | | Not Escalated | | | |
| | Safe | Standardised Mortality HSMR | | 100.0 | 83.9 | Jan-25 | 100.0 | 82.3 | Dec-24 | Driver | | | Not Escalated | 82.0 | | |
| | Safe | Summary Hospital-level Mortality Indicator (SHMI) | | 100.0 | 88.0 | Jan-25 | 100.0 | 90.0 | Dec-24 | Driver | | | Not Escalated | 94.6 | | |
| | Safe | Never Events | | 0 | 0 | Apr-25 | 0 | 1 | Mar-25 | Driver | | | Not Escalated | 0 | | |
| | Safe | IC - Rate of Hospital E.Coli per 100,000 occupied beddays | | 32.6 | 27.4 | Apr-25 | 32.6 | 32.8 | Mar-25 | Driver | | | Not Escalated | 32.8 | | |
| | Safe | IC - Rate of Hospital C.Difficile per 100,000 occupied beddays | | 44.4 | 16.4 | Apr-25 | 44.4 | 53.3 | Mar-25 | Driver | | | Not Escalated | 56.2 | | |
| | Safe | IC - Number of Hospital acquired MRSA Bacteraemia | | 0 | 0 | Apr-25 | 0 | 0 | Mar-25 | Driver | | | Not Escalated | 0 | | |
| | Safe | Rate of patient falls per 1000 occupied bed days | | 6.4 | 5.2 | Apr-25 | 6.4 | 5.0 | Mar-25 | Driver | | | Not Escalated | 4.6 | | |
| | Caring | % VTE Risk Assessment (one month behind) | | 95.0% | 98.2% | Mar-25 | 95.0% | 98.2% | Feb-25 | Driver | | | Not Escalated | 98.8% | | |

Vision: Counter Measure Summary

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

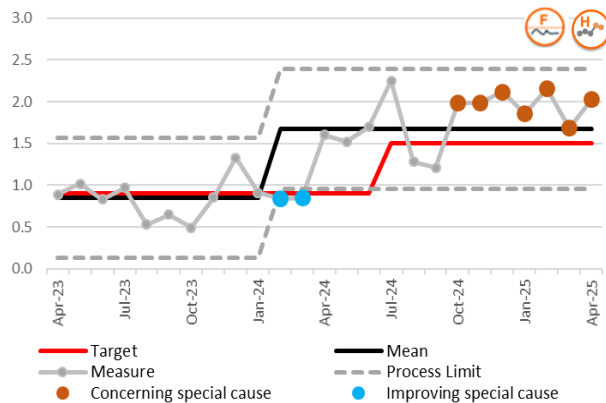
Owner: Medical Director

Metric: Incidents resulting in moderate+ harm per 1000 bed days

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

Rate of Incidents Resulting in Moderate+ Harm per 1000 Occupied Bed Days



Mar-25 (1 month arr)

2.03

Variance Type

Metric is currently experiencing common cause variation

Maximum Limit (Internal)

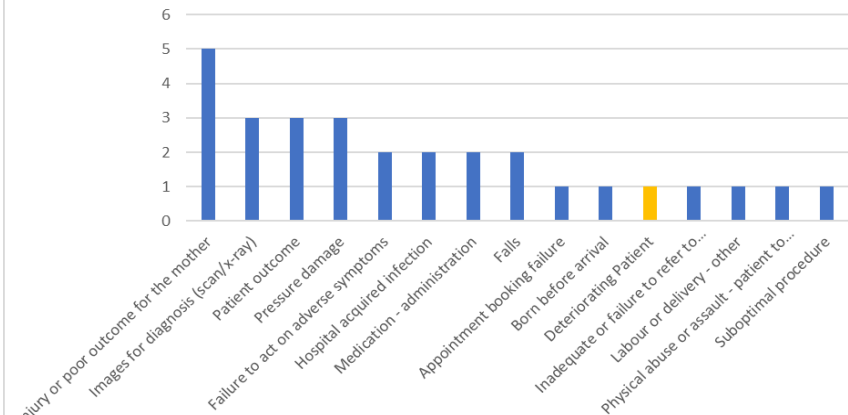
1.5

Target Achievement

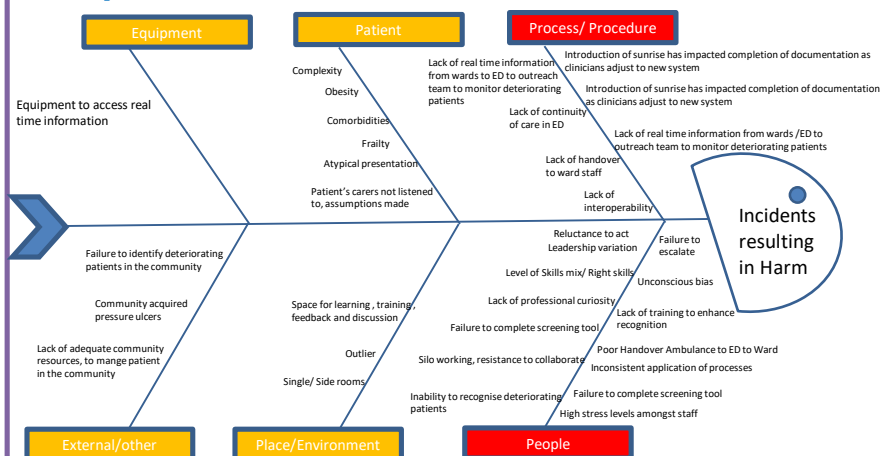
Metric has failed the target for 6+ months

2. Stratified Data

All Moderate and Above by Category - Mar-25



3. Top Contributors



4. Action Plan

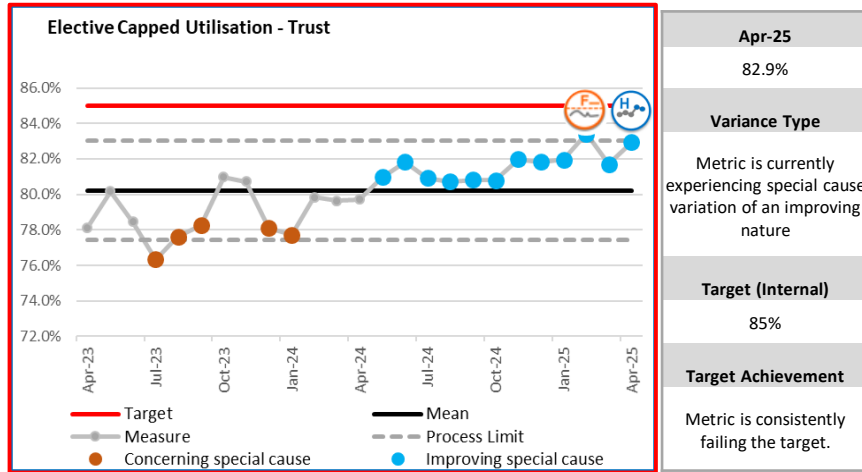
| Actions | Leads | Due by |
|--|--------------|---------|
| Deteriorating Patients | | |
| Review of all trust training for deteriorating patients: (online and F2F) | JB | Q1 |
| Explore roll out of Hospital at Night service | Project Team | Ongoing |
| Development of assessment of deteriorating patient document (SBAR) | JB/MH | Q1 |
| Alignment of RESPECT, TEP and DNACPR forms: Develop and roll out a combined TEP CPR status and pathway | HB | Aug-25 |
| Establish alerting system on Sunrise | JK | Ongoing |
| Collation of peri arrest data and update on InPhase | JB/PA | May-25 |
| Explore possibility of establishing a deteriorating patient champion on each ward | JB | Aug-25 |

Financial Breakthrough: Counter Measure Summary

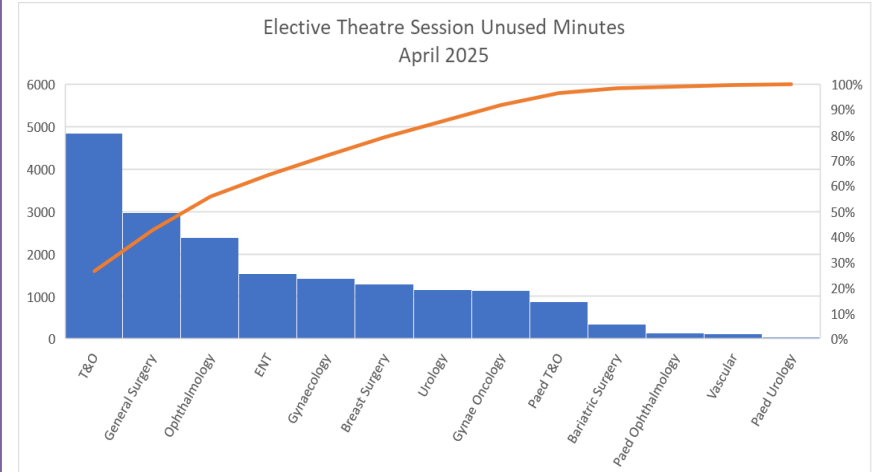
Project/Metric Name – % Capped Theatre utilisation.

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

1. Historic Trend Data



2. Stratified Data



3. Top Contributors

Theatre Utilisation:

- Elective paediatric beds
- Average procedure time per consultant to be reset
- Cancellations are high
- Scheduling – Specialties set action at TP to get 3 weeks ahead with booking.

Issues:

- MS Paed lists underutilised due to bed capacity
- Scheduling to the right capacity

Key Risks:

- OPEL 4 Escalation at TW
- Checking the instrumentation in is the right place at the right time.

4. Action Plan

| Action | Review | Status |
|--|------------------------|--------|
| Stake holders identified (Ophthalmology, Orthopaedics & Gynaecology) | Ongoing | Open |
| AKESO playback and discuss findings | 30 th April | Open |
| Cases per session (CPS) is the area of focus with cancellation avoidance T&F group | Ongoing | Open |
| Smarter scheduling (AKESO tool) meeting this week to discuss | Ongoing | Open |
| HIT list in GS scheduled for 29th May & 6th June | Ongoing | Open |



































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 | Three month Forecast | Variation | Assurance |
| Vision | Responsive | Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5) | | 5.9 | 6.7 | Apr-25 | 5.9 | 6.9 | Mar-25 | Driver | | | Full CMS | | | |
| Financial Breakthrough Objective | Responsive | Conversion rate from ED (Excluding Type 5 and including Direct Admissions) | | 16.0% | 15.3% | Apr-25 | 16.0% | 14.8% | Mar-25 | Driver | | | Verbal CMS | | | |
| Constitutional Standards and Key Metrics | Responsive | Achieve the Trust RTT Trajectory (Excluding SYS) | | 72.4% | 72.6% | Apr-25 | 81.2% | 74.2% | Mar-25 | Driver | | | Not Escalated | 73.5% | | |
| | Responsive | Achieve the Trust RTT Trajectory (Including SYS) - Reported Nationally | | 72.4% | 72.5% | Apr-25 | 81.2% | 74.1% | Mar-25 | Driver | | | Business Rules not applied (for info only) | | | |
| | Responsive | To achieve the planned levels of new outpatients activity (shown as a % 19/20) | | 130.6% | 122.7% | Apr-25 | 145.7% | 149.7% | Mar-25 | Driver | | | Not Escalated | 134.1% | | |
| | Responsive | RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) | | 691 | 785 | Apr-25 | 685 | 648 | Mar-25 | Driver | | | Not Escalated | 639 | | |
| | Responsive | RTT Patients waiting longer than 40 weeks for treatment (System Support only) | | N/A | 14 | Apr-25 | N/A | 19 | Mar-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 | 1 | Apr-25 | N/A | 0 | Mar-25 | Driver | | | Business Rules not applied (for info only) | | | |
| | Responsive | Access to Diagnostics (<6weeks standard) | | 88.4% | 89.5% | Apr-25 | 99.1% | 89.4% | Mar-25 | Driver | | | Not Escalated | 88.5% | | |
| | Responsive | A&E 4 hr Performance | | 84.8% | 81.5% | Apr-25 | 84.8% | 85.2% | Mar-25 | Driver | | | Not Escalated | 84.9% | | |
| | Responsive | Cancer - 31 Day First (New Combined Standard) - data runs one month behind | | 96.0% | 97.0% | Mar-25 | 96.0% | 97.6% | Feb-25 | Driver | | | Not Escalated | 96.0% | | |
| | Responsive | Cancer - 62 Day (New Combined Standard) data runs one month behind | | 85.0% | 86.1% | Mar-25 | 85.0% | 85.3% | Feb-25 | Driver | | | Not Escalated | 85.0% | | |
| | Responsive | Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) | | 75.0% | 77.9% | Mar-25 | 75.0% | 80.9% | Feb-25 | Driver | | | Not Escalated | 78.0% | | |
| | Responsive | Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) | | 90.0% | 90.2% | Mar-25 | 90.0% | 90.8% | Feb-25 | Driver | | | Not Escalated | 91.7% | | |

* 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)

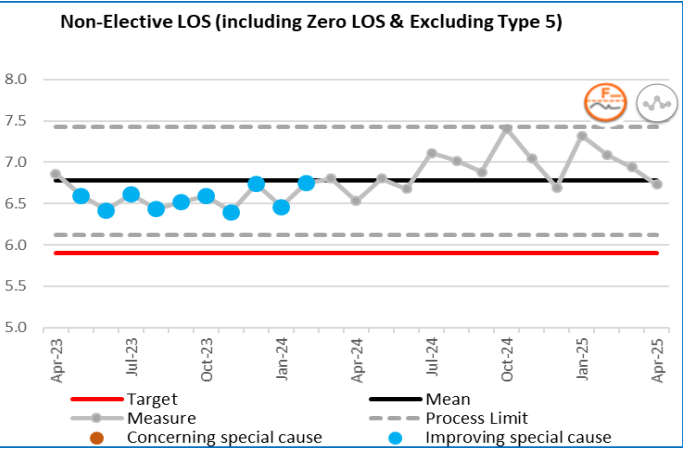
| | | | | Latest | | | Previous | | | Actions & Assurance | | | | Forecast | | |
|--|------------|--|--|--------------|----------------------|--------|--------------|----------------------|--------|---------------------|---|---|---------------|----------------------|---|---|
| | CQC Domain | Metric | DQ Kite Mark | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions | Three Month Forecast | Variation | Assurance |
| Constitutional Standards and Key Metrics | Effective | Transformation: % OP Clinics Utilised (slots) |  | 85.0% | 79.8% | Apr-25 | 85.0% | 81.9% | Mar-25 | Driver |  |  | Not Escalated | 85.6% |  |  |
| | Effective | Transformation: % of Patients Discharged to a PIFU Pathways |  | 5.8% | 6.6% | Apr-25 | 7.8% | 6.7% | Mar-25 | Driver |  |  | Not Escalated | 7.6% |  |  |
| | Effective | Transformation: CAU Calls answered <1 minute |  | 90.0% | 86.4% | Apr-25 | 90.0% | 84.1% | Mar-25 | Driver |  |  | Escalation | 88.1% |  |  |
| | Effective | Flow: Ambulance Handover Delays >30mins | TBC | 5.0% | 9.3% | Apr-25 | 5.0% | 7.2% | Mar-25 | Driver |  |  | Escalation | 9.3% |  |  |
| | Responsive | To achieve the planned levels of elective (DC and IP combined) activity (shown as a % 19/20) |  | 132.9% | 125.2% | Apr-25 | 152.7% | 173.1% | Mar-25 | Driver |  |  | Not Escalated | 140.2% |  |  |
| | Responsive | Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) |  | 49.0% | 51.0% | Apr-25 | 49.0% | 51.6% | Mar-25 | Driver |  |  | Not Escalated | 53.1 |  |  |
| | Responsive | To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) |  | 158.3% | 172.0% | Apr-25 | 173.7% | 187.7% | Mar-25 | Driver |  |  | Not Escalated | 154.9% |  |  |

Vision: Counter Measure Summary

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

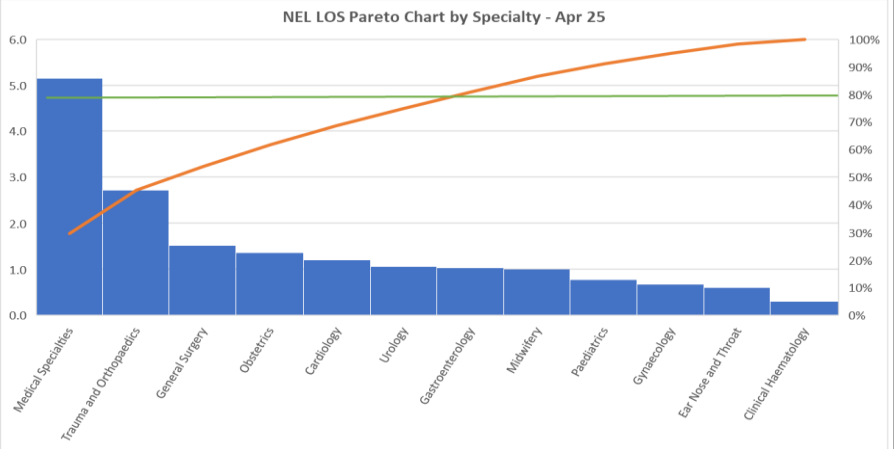
Owner: Chief Operating Officer
Workstream: Operational Flow
Metric: Non-Elective Length of Stay (LOS)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



| |
|---|
| Apr-25 |
| 6.7 |
| 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:

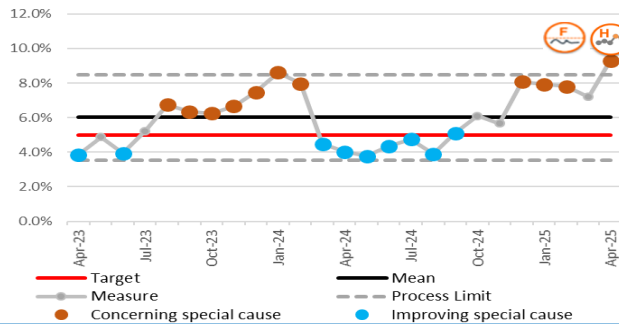
- Multiple operational challenges
- Out of hospital capacity
- Increased in NEL Demand due to Seasonal illnesses could impact on LOS

4. Action Plan

| Action | When |
|---|------------|
| Key focus areas for improvement: <ul style="list-style-type: none">• No criteria to reside• SDEC• Weekend discharges – CLD• Teletracking optimisation, innovation & expansion into Maternity | Ongoing |
| Data gathering and analysis | Apr/May 25 |
| Agree metrics for each focus area | May 25 |
| Analysis of financial impact | May 25 |
| PID/QIAs developed for CIP schemes | Jun 25 |
| Project/action plans completed for each area | May/Jun 25 |

Patient Access: CQC: Responsive

Ambulance Handover Delays > 30 mins



Apr-25

9.3%

Variance / Assurance

Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months

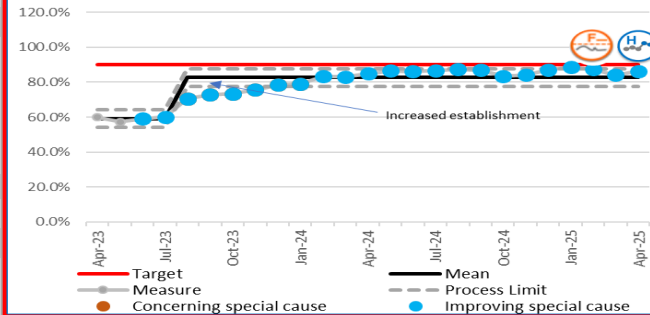
Max Limit (Internal)

5%

Business Rule

Full Escalation as has failed the target for 6+months

Calls Answered in under 1 min



Apr-25

86.4%

Variance / Assurance

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

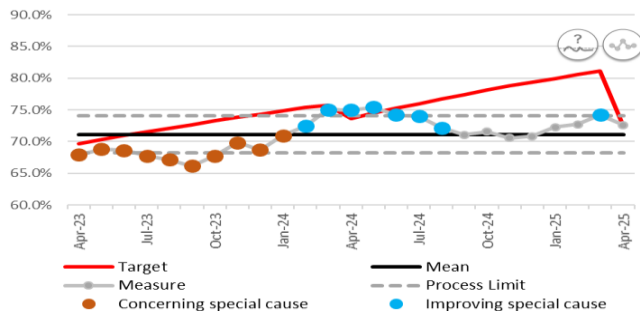
Target (Internal)

90%

Business Rule

Full Escalation as consistently failing the target

RTT Incomplete Pathway Performance (Excl SYS)



Apr-25

72.6%

Variance Type

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

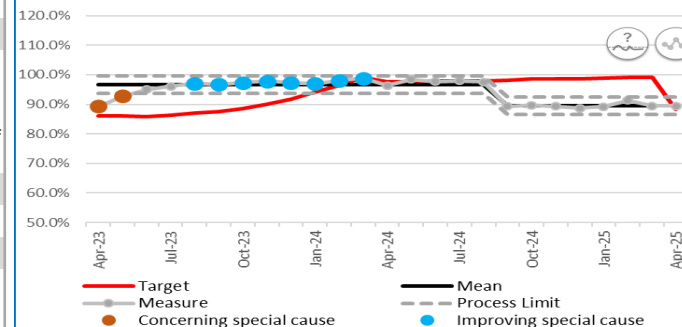
Target (Internal)

72.40%

Target Achievement

Shown for info as first month not escalated

Access to Diagnostics (<6wk)



Apr-25

89.5%

Variance / Assurance

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

Target (Internal)

88.4%

Business Rule

Shown for info as first month not escalated

Summary:

Ambulance Handover delays <30mins: is experiencing special cause variation of a concerning nature and has failed the target for 6+months

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

RTT: is experiencing common cause variation and variable achievement of the target and is no lower escalated.

% Diagnostics within 6 week: is experiencing common cause variation and variable achievement of the target and is no lower escalated.

Actions:

Ambulance Handover delays <30mins: The pressure has been due to flow out of the department as well as within the department.

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. Continued staffing issue within General Medicine, General Surgery and Surgical Specialities CAU. T&O implementing plan for increased performance throughout May.

RTT: Graph shown for information as has achieved the new trajectory target for April 25 and is no longer escalated.

MTW trajectory set for 2025/26 is to improve RTT by 5% to achieve a minimum of 75.4% within 18 weeks by March 26.

% Diagnostics within 6 week: Graph shown for information as has achieved the new trajectory target for April 25 and is no longer escalated.

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:

Ambulance Handover delays <30mins: The Division are reviewing internal flow against their own internal standards to highlight areas for improvement.

Calls Answered within 1 minute in the CAUs: Focus on underperforming specialities to reach 90% specifically T&O, Medicine & Endoscopy. Outpatient Contact Centre fully established and no new sickness.

RTT: The Trust has achieved the new trajectory target for the first month of the new financial year (April 25).

% Diagnostics within 6 weeks: The Trust has achieved the new trajectory target for the first month of the new financial year (April 25).

Strategic Theme: Patient Experience

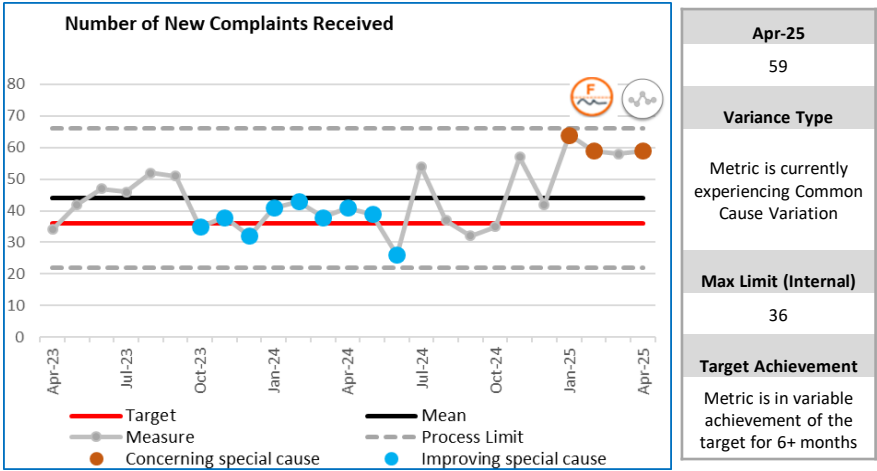
| | | | | Latest | | | Previous | | | Actions & Assurance | | | | Forecast | | |
|--|------------|--|--------------|--------------|----------------------|--------|--------------|----------------------|--------|---------------------|-----------|-----------|---------------|----------------------|-----------|-----------|
| | CQC Domain | Metric | DQ Kite Mark | Trust Target | Most recent position | Period | Trust Target | Most recent position | Period | Watch / Driver | Variation | Assurance | CMS Actions | Three Month Forecast | Variation | Assurance |
| Vision | Caring | To reduce the overall number of complaints or concerns each month | | 36 | 59 | Apr-25 | 36 | 58 | Mar-25 | Driver | | | Full CMS | 61 | | |
| Breakthrough Objective | Caring | To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. | | 24 | 25 | Apr-25 | 24 | 25 | Mar-25 | Driver | | | Verbal CMS | 25 | | |
| Financial Breakthrough Objective | Caring | Reduction in agency spend (specific to B5 RMNs and B3 HCSW) | | 190,000 | 194,975 | Apr-25 | 190,000 | 191,112 | Mar-25 | Driver | | | Verbal CMS | | | |
| Constitutional Standards and Key Metrics | Caring | Complaints Rate per 1,000 occupied beddays | | 3.9 | 3.2 | Apr-25 | 3.9 | 3.1 | Mar-24 | Driver | | | Not Escalated | 3.9 | | |
| | Caring | % complaints responded to within target | | 75.0% | 86.0% | Apr-25 | 75.0% | 82.0% | Mar-25 | Driver | | | Not Escalated | 75.0% | | |
| | Caring | Complaints Backlog – Older than 4 months | | 0 | 7 | Apr-25 | 0 | 6 | Mar-25 | Driver | | | Not Escalated | | | |
| | Caring | Complaints Closed in Month | | 38 | 62 | Apr-25 | 38 | 41 | Mar-25 | Driver | | | Not Escalated | | | |
| | Caring | Complaints - 3 Day acknowledgement | | 95.0% | 98.0% | Apr-25 | 95.0% | 100.0% | Mar-25 | Driver | | | Not Escalated | | | |
| | Caring | Friends and Family (FFT) % Response Rate: Inpatients | | 25.0% | 14.9% | Apr-25 | 25.0% | 18.5% | Mar-25 | Driver | | | Escalation | 17.24% | | |
| | Caring | Friends and Family (FFT) % Response Rate: A&E | | 15.0% | 12.17% | Apr-25 | 15.0% | 10.77% | Mar-25 | Driver | | | Escalation | 13.58% | | |
| | Caring | Friends and Family (FFT) % Response Rate: Maternity | | 25.0% | 10.4% | Apr-25 | 25.0% | 12.5% | Mar-25 | Driver | | | Escalation | 9.60% | | |
| | Caring | Friends and Family (FFT) % Response Rate: Outpatients | | 20.0% | 2.6% | Apr-25 | 20.0% | 11.2% | Mar-25 | Driver | | | Escalation | 11.70% | | |
| | Safe | Safe Staffing Levels (Nursing) | | 93.5% | 99.3% | Apr-25 | 93.5% | 100.6% | Mar-25 | Driver | | | Not Escalated | 103.5% | | |

Breakthrough: Counter Measure Summary

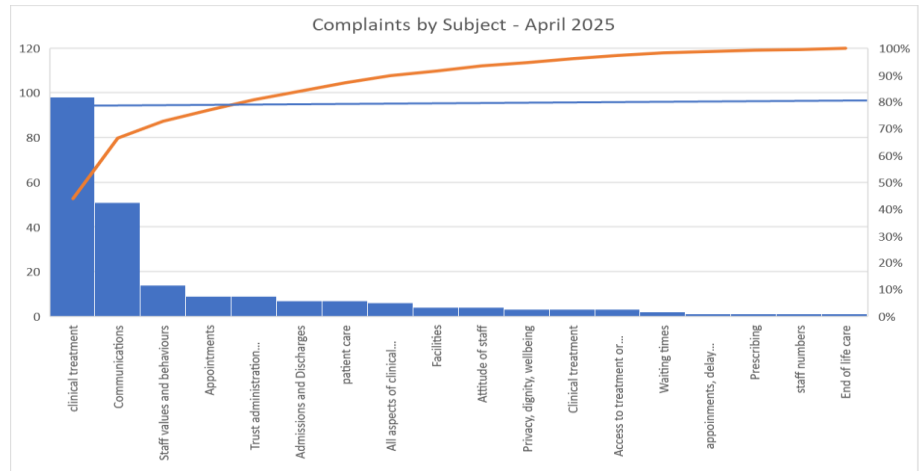
Metric Name – To reduce the overall number of complaints or concerns each month

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

1. Historic Trend Data



2. Stratified Data



3. Top Contributors and Key Risks

Using A3 Thinking, we have understood the themes of complaints received and poor communication was one of the main issues affecting patient experience.

Key Risks:

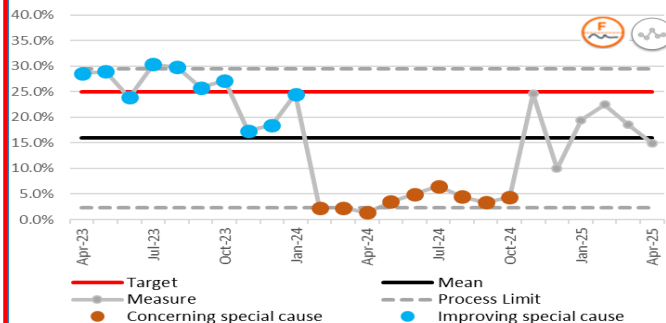
1. The key risk to delivery of the breakthrough objective actions is primarily staff capacity.
2. Standardisation of measures about Divisional actions for complaints
3. Competing workloads for Divisional teams to execute actions related to feedback received.

4. Action Plan of the Breakthrough Objective:

| Workstreams | Action | Who |
|------------------------|--|-------------------------|
| Trust-wide / core team | Review data to determine if the current trend may require an adjustment to the existing target | Patient Experience Team |
| Trust-wide / core team | Review data breakdown by theme to ascertain if there are any developing themes and trends | Patient Experience Team |
| | | |
| | | |
| | | |

Patient Experience: CQC: Caring

Inpatients Friends and Family (FFT) Response Rate



Apr-25

14.9%

Variance / Assurance

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

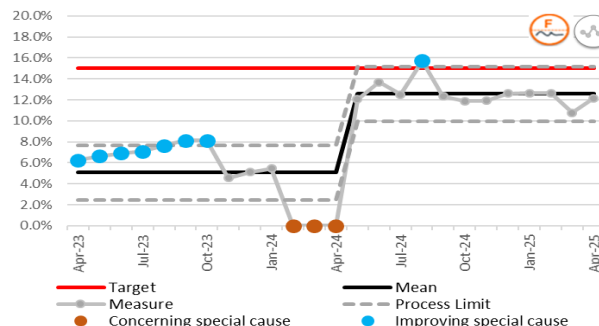
Target (National)

25%

Business Rule

Full Escalation as failing the target for 6+ months

A&E Friends and Family (FFT) Response Rate



Apr-25

12.2%

Variance / Assurance

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

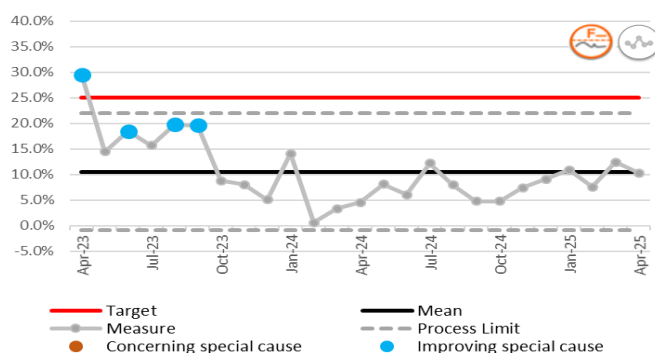
Target (Internal)

15%

Business Rule

Full Escalation as consistently failing the target

Maternity Friends and Family (FFT) Response Rate



Apr-25

10.4%

Variance / Assurance

Metric is currently experiencing common cause variation and consistently failing the target

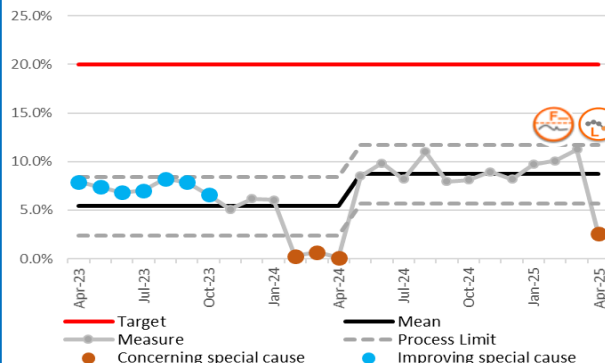
Target (Internal)

25%

Business Rule

Full Escalation as consistently failing the target

OP Friends and Family (FFT) Response Rate



Apr-25

2.6%

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:

Actions:

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%

Inpatients: Response rate has dipped very slightly this month, inpatient areas have favoured the utilisation of hard copy cards and this decrease is largely attributed to on-going issues with the courier collection of cards following a change of courier company by the FFT provider additionally hard copy cards are not always made available for collection in a timely manner by clinical areas. 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 staff attitude, environment and communication as negative themes. Negative comments commonly relate to lack of continuity of care, lack of 'joined up' care/communication, there are also several references to the quality of cleaning in some areas and waiting times for surgical procedures which in some cases were then ultimately cancelled.

A&E: The response rate has rallied slightly and increased slightly from last month and following an anticipated decrease due to the quality assurance work that took place in February/March. Positive themes: staff attitude – kindness and compassion with patients referencing the challenging, busy environment, a significant number of these were specifically for Riverbank. Areas for improvement: waiting times and lack of information in regards to these remains a consistent theme, lack of privacy and dignity was referenced on a number of occasions with patients mentioning discussions about symptoms and treatment being discussed in front of other patients, lack of comfort and space in waiting areas was also highlighted as well as several references to lack of cleanliness of the environment.

Maternity: The response rate continues to fluctuate, 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 and numerous staff being mentioned by name, to maintain staff engagement with FFT and in recognition of their efforts we will endeavour to share this feedback directly where possible. A high proportion of patients relayed their sense of being cared for and positive mood/feeling about the care received. Negative feedback centred on a lack of rapport and sense of discomfort with the midwife present during birth.

Outpatients: Response rate has plummeted this month, internal investigation and challenge to the provider highlighted that a significant proportion of SMS text requests for feedback had not been sent to patients as a result of an error in the files sent to the provider. The provider failed to alert us to this failure to send, requests were sent retrospectively but unfortunately and inevitably this has resulted in a lack of feedback. We await an update from the provider regarding how this situation arose.

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, environment and waiting times within department (clinics consistently starting late & running late, lack of accurate updates), poor communication about appointment cancellations/changes including inaccurate information contained in appointment letters.

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 48 hours despite significant sickness absence within the team.

The provider's failure to alert us to issues in the files sent resulting in a significant decrease in the number of SMS texts requests for feedback sent by them is extremely concerning, we now await the results of their investigation in to how this situation occurred and assurance regarding the control measures that will be instigated as a result. We are also now actively monitoring activity/quantity of data transferred versus the number of SMS text request sent by the provider on a weekly basis in addition to monitoring the feedback sent with missing hierarchy which has significantly improved following the recent QA exercise.

Strategic Theme: Systems

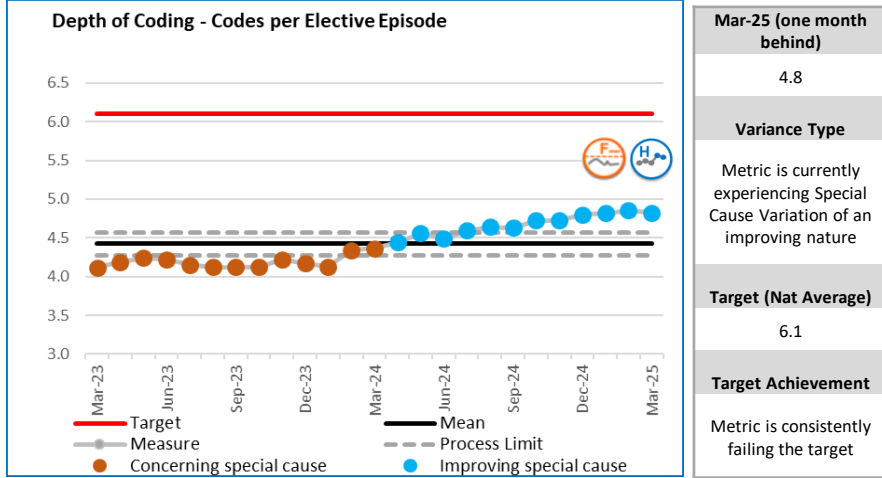
| | | | | Latest | | | Previous | | | Actions & Assurance | | | | Forecast | | |
|--|------------|---|---|--------------|----------------------|--------|--------------|----------------------|--------|---------------------|---|---|-------------|------------------|-----------|-----------|
| | CQC Domain | 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 | 4.8 | Mar-25 | 6.1 | 4.9 | Feb-25 | Driver |  |  | Full CMS | | | |
| Constitutional Standards and Key Metrics | Effective | Inpatient coding income (simple audit tool) |  | TBC | 284510 | Mar-25 | TBC | 99771 | Feb-25 | Driver |  |  | Escalation | | | |

Financial Breakthrough: Counter Measure Summary

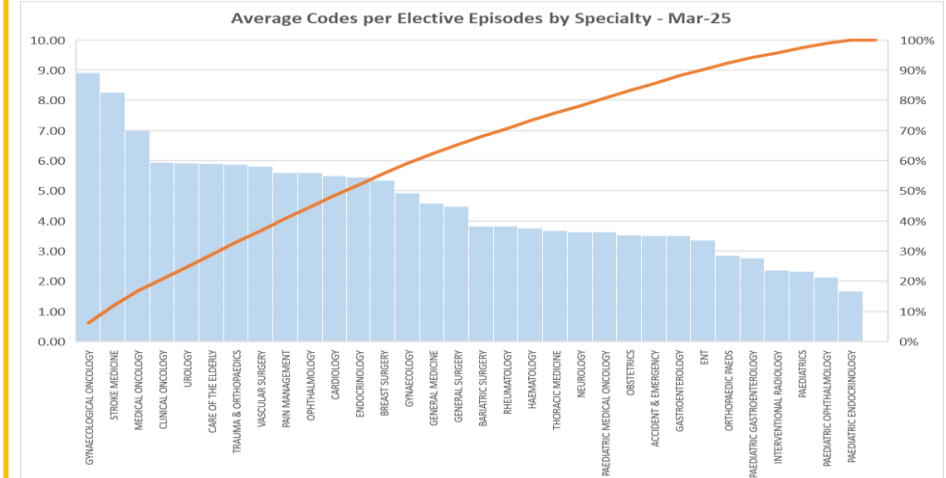
Project/Metric Name –To improve Coding – Depth of Coding – Codes per Elective Episode

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



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 | <ul style="list-style-type: none"> 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) | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Agree future state resourcing for Coding Team 2 new Trainee Clinical Coding Analysts starting in April | Clinical Coding Team |

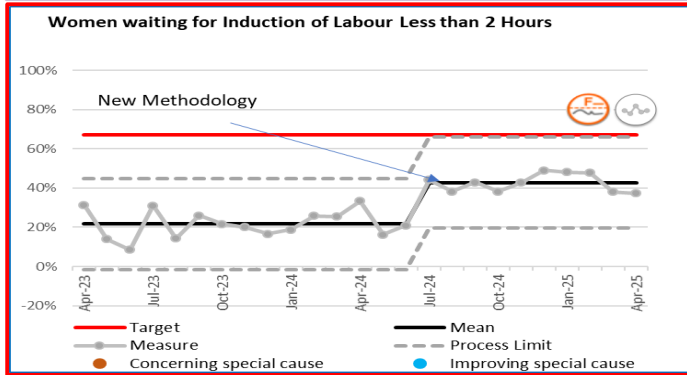
Strategic Theme: Sustainability

| | | | | 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 | Three Month Forecast | Variation | Assurance |
| Vision | Well Led | Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) |  | -5,626 | -6,284 | Apr-25 | 2,803 | 4,509 | Mar-25 | Driver |  |  | Verbal CMS | 1,834 |  |  |
| Financial Breakthrough Objectives | Well Led | Reduce non-pay spend |  | 23,073 | 22,402 | Apr-25 | 17,233 | 22,703 | Mar-25 | Driver |  |  | Verbal CMS | | | |
| Constitutional Standards and Key Metrics | Well Led | Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000 |  | 892 | 565 | Apr-25 | 752 | 767 | Mar-25 | Driver |  |  | Not Escalated | 565 |  |  |
| | Well Led | CIP |  | 1,355 | 832 | Apr-25 | 4,879 | 5,833 | Mar-25 | Driver |  |  | Not Escalated | | | |
| | Well Led | Cash Balance (£k) |  | 8,635 | 14,782 | Apr-25 | 4,000 | 13,116 | Mar-25 | Driver |  |  | Not Escalated | 14,782 |  |  |
| | Well Led | Capital Expenditure (£k) |  | 2,477 | 1,834 | Apr-25 | 4,467 | 33,663 | Mar-25 | Driver |  |  | Not Escalated | 1,834 |  |  |

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 | 463 | Apr-25 | 470 | 432 | Mar-25 | Driver | | No target | Not Escalated | 427 | | |
| | Maternity Metric | Antenatal bookings | | No target | 544 | Apr-25 | 545 | 538 | Mar-25 | Driver | | No target | Not Escalated | 530 | | |
| | Maternity Metric | Elective Caesarean Rate | | No target | 19.2% | Apr-25 | No target | 21.7% | Mar-25 | Driver | | No target | Not Escalated | 21.9% | | |
| | Maternity Metric | Emergency Caesarean Rate | | No target | 22.2% | Apr-25 | No target | 21.0% | Mar-25 | Driver | | No target | Not Escalated | 22.7% | | |
| | Maternity Metric | Induction of Labour Rate | | 36.0% | 26.0% | Apr-25 | 36.0% | 26.5% | Mar-25 | Driver | | | Not Escalated | 24.6% | | |
| | Maternity Metric | Women waiting for Induction of Labour less than 2 Hours | | 67.0% | 37.4% | Apr-25 | 67.0% | 38.0% | Mar-25 | Driver | | | Escalation | 47.9% | | |
| | Maternity Metric | Women waiting for Induction of Labour less than 4 Hours | | 100.0% | 46.5% | Apr-25 | 100.0% | 50.0% | Mar-25 | Driver | | | Escalation | 70.1% | | |
| | Maternity Metric | Preterm Birth (<37 weeks) Rate | | 6.0% | 8.0% | Apr-25 | 6.0% | 6.3% | Mar-25 | Driver | | | Not Escalated | 7.5% | | |
| | Maternity Metric | Unexpected term admissions to NNU (Data runs one month behind) | | 4.0% | 5.3% | Mar-25 | 4.0% | 6.9% | Feb-25 | Driver | | | Not Escalated | 6.0% | | |
| | Maternity Metric | Stillbirth rate | | 0.4% | 0.7% | Apr-25 | 0.4% | 0.2% | Mar-25 | Driver | | | Not Escalated | 0.4% | | |
| | Maternity Metric | PPH >=1500% Rate | | 3.0% | 3.3% | Apr-25 | 3.0% | 4.0% | Mar-25 | Driver | | | Not Escalated | 3.3% | | |
| | Maternity Metric | Major Tear (3rd/4th degree Rate) | | 2.5% | 3.4% | Apr-25 | 2.5% | 2.5% | Mar-25 | Driver | | | Not Escalated | 3.0% | | |
| | Maternity Metric | Breastfeeding Intention Rate at Birth | | 75.0% | 79.8% | Apr-25 | 75.0% | 80.5% | Mar-25 | Driver | | | Not Escalated | 79.5% | | |
| | Maternity Metric | Decision to delivery interval Category 1 caesarean section < 30 mins | | 95.0% | 70.0% | Apr-25 | 95.0% | 66.7% | Mar-25 | Driver | | | Escalation | 69.5% | | |
| | Maternity Metric | Decision to delivery interval Category 2 caesarean section < 75 mins | | 95.0% | 69.6% | Apr-25 | 95.0% | 79.2% | Mar-25 | Driver | | | Escalation | 78.1% | | |
| | Maternity Metric | One to one care in labour - % of women who are diagnosed in labour | | 100.0% | 100.0% | Apr-25 | 100.0% | 100.0% | Mar-25 | Driver | | | Not Escalated | 100.0% | | |
| | Maternity Metric | % of shifts for which Delivery Suite coordinator is supernumerary (MOPEL) | | 100.0% | 100.0% | Apr-25 | 100.0% | 100.0% | Mar-25 | Driver | | | Not Escalated | 100.0% | | |

Maternity Metrics

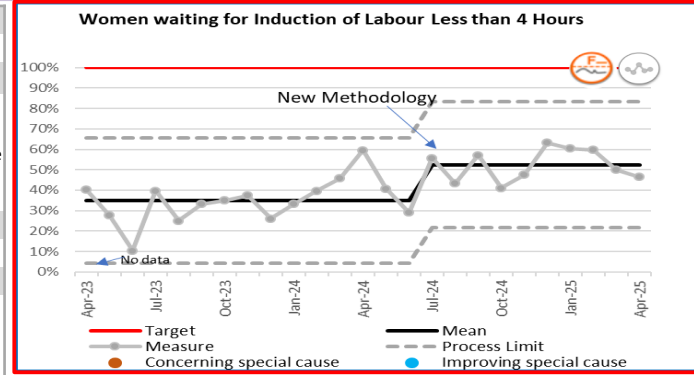


Apr-25
37.4%

Variance / Assurance
Metric is currently experiencing Common Cause Variation

Target (Internal)
67%

Business Rule
Full escalation as has failed the target for >6 months

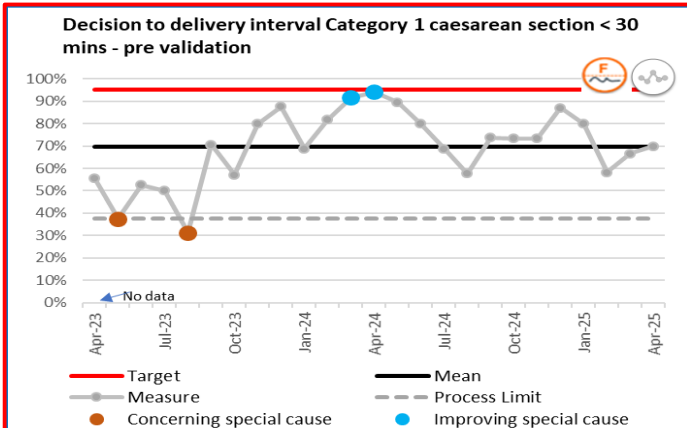


Apr-25
46.5%

Variance / Assurance
Metric is currently experiencing Common Cause Variation

Target (Internal)
100%

Business Rule
Full escalation as consistently failing the target

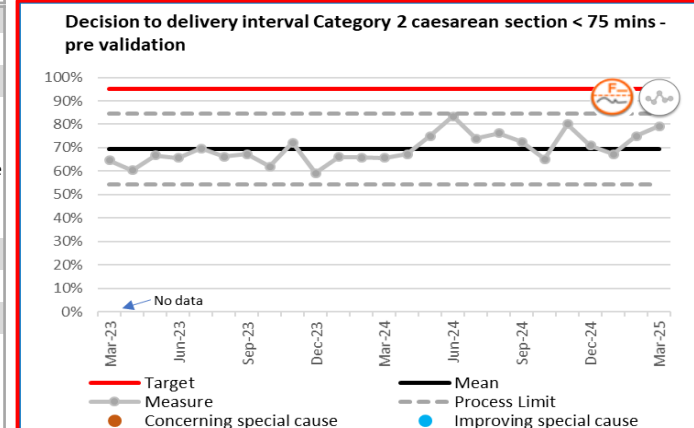


Apr-25
70.0%

Variance / Assurance
Metric is currently experiencing Common Cause Variation

Target (Internal)
95%

Business Rule
Full escalation as has failed the target for >6 months



Apr-25
69.6%

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 has been ratified by the policy ratification committee.
A3 implemented to address flow throughout the service which impacts transfer for ongoing induction of labour.

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 flow project and any actions required as a result.

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

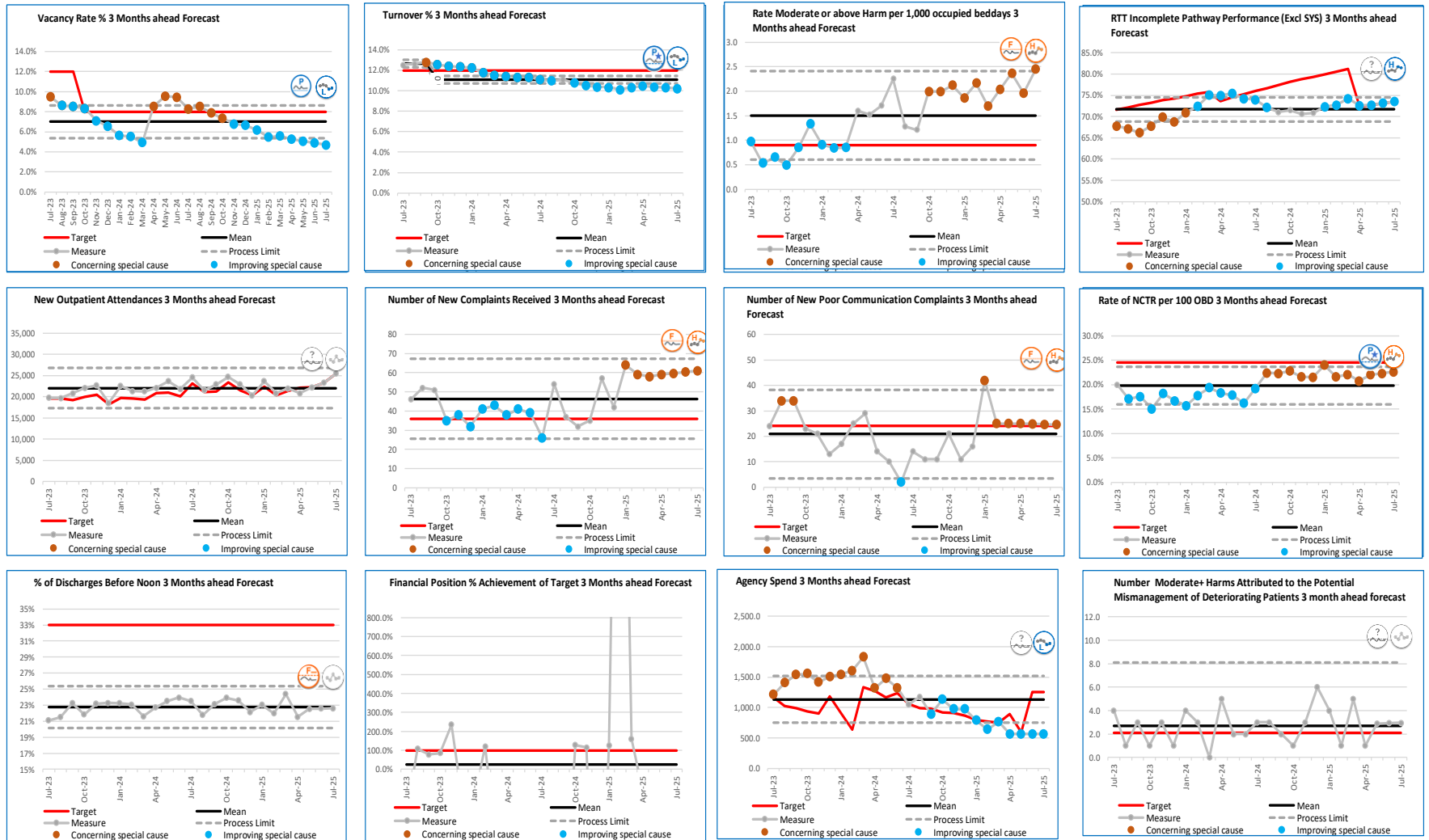
Improvements with compliance with Category 1 and 2 target times has been made. All cases which do not meet the target times are reviewed and avoidable / unavoidable causes identified and shared for learning.

Data validation continues to demonstrate 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.

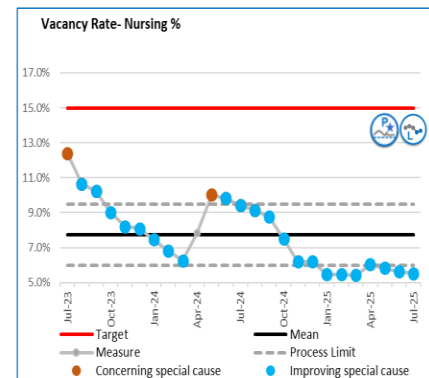
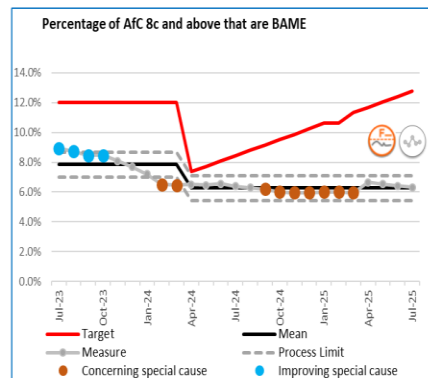
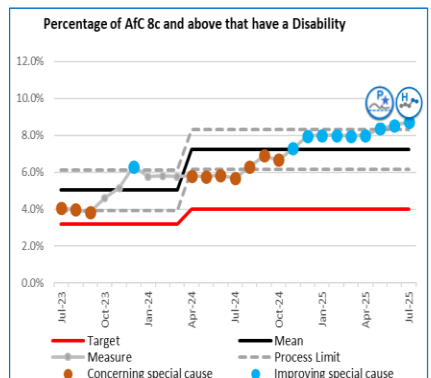
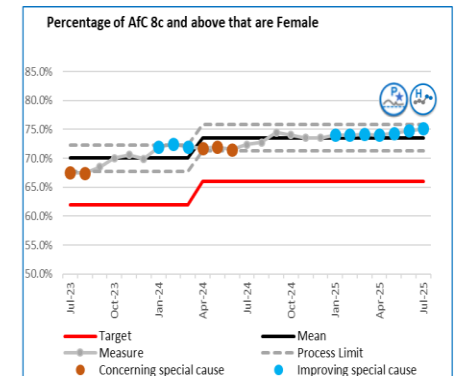
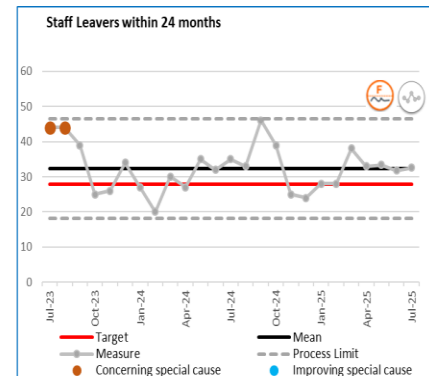
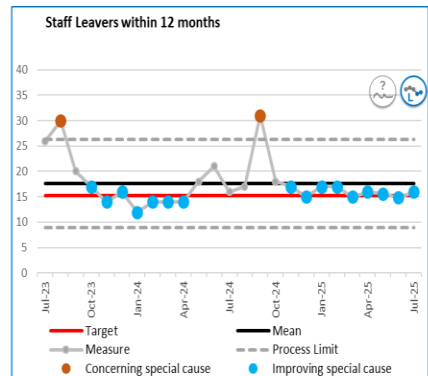
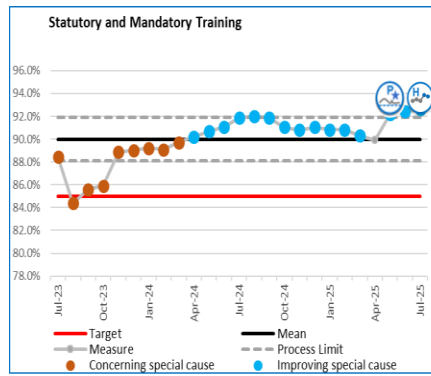
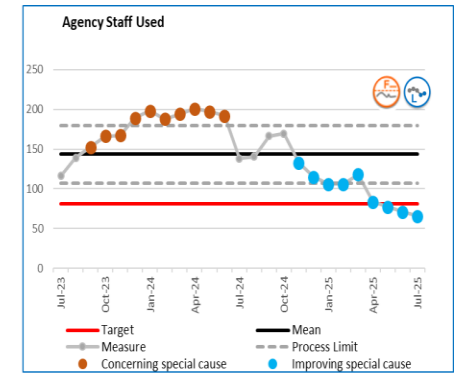
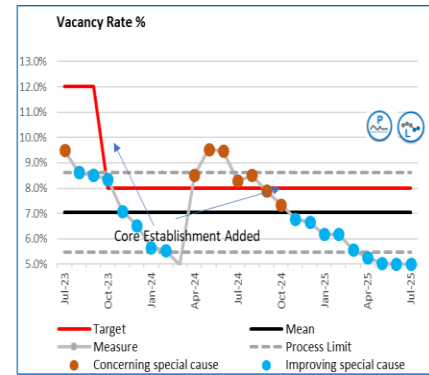
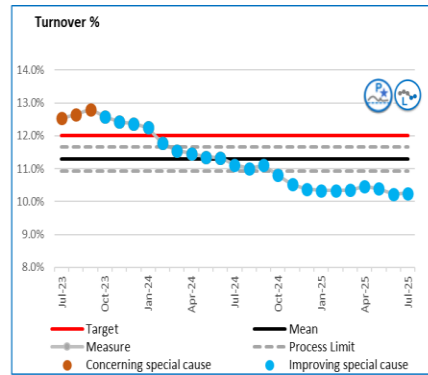
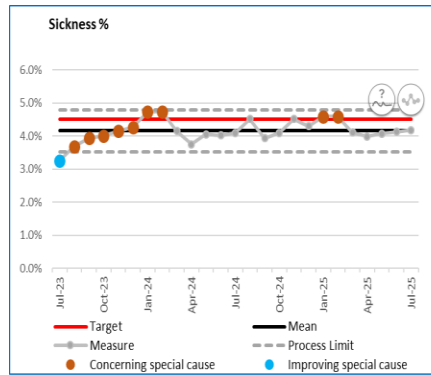
Following validation, 100% of category 1 target times were met, there were 5 wrongly categorised (Cat 2) and 1 data entry error. For the Category 2 cases in 44 of 47 cases (94%) target times were met, there was 1 data entry error and 14 cases wrongly categorised (Cat 3).

Appendices

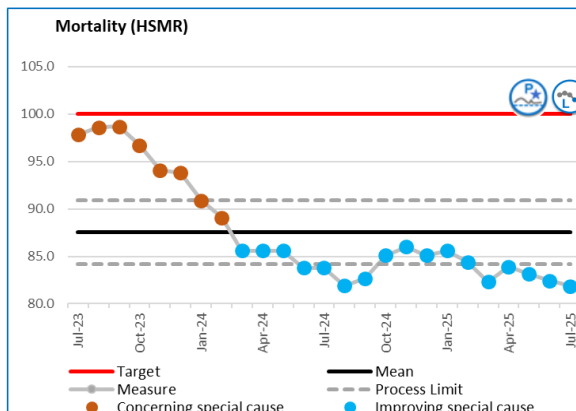
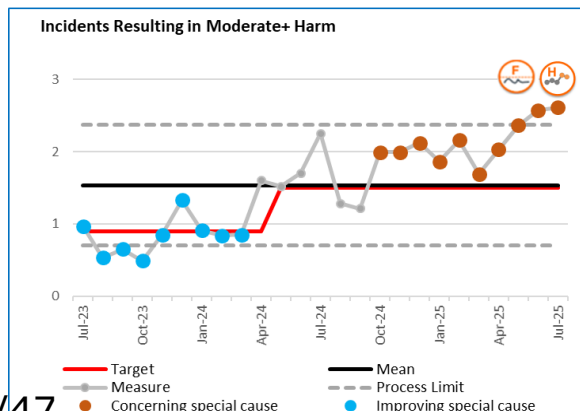
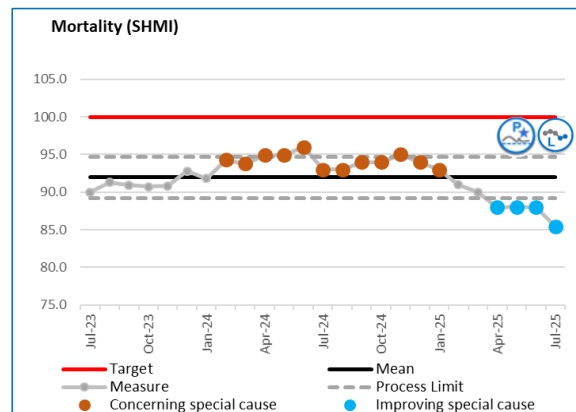
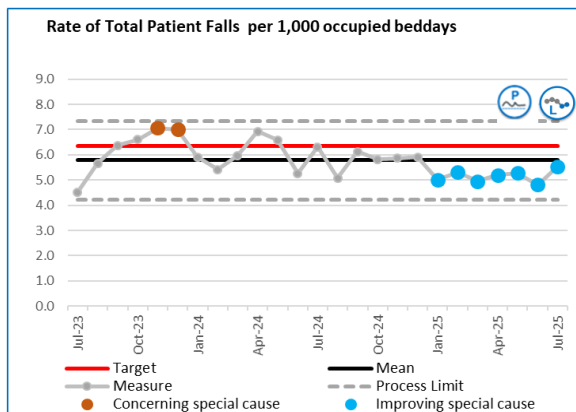
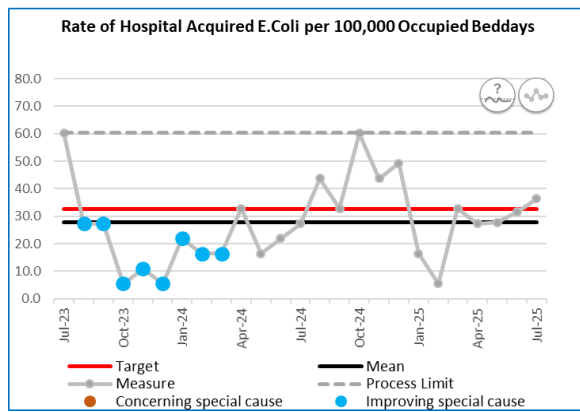
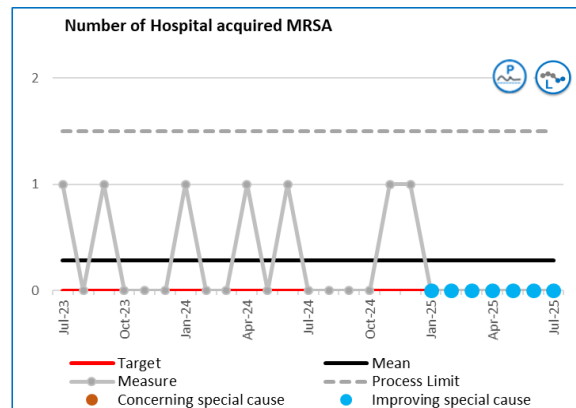
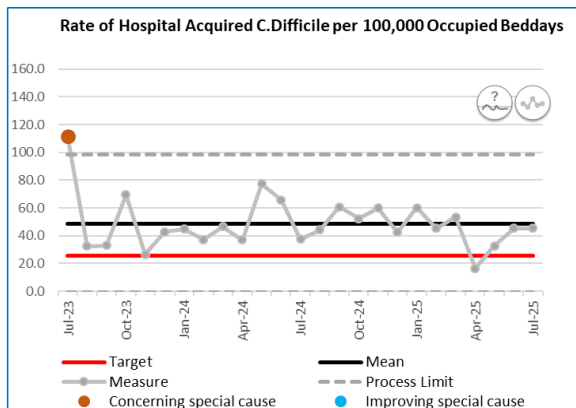
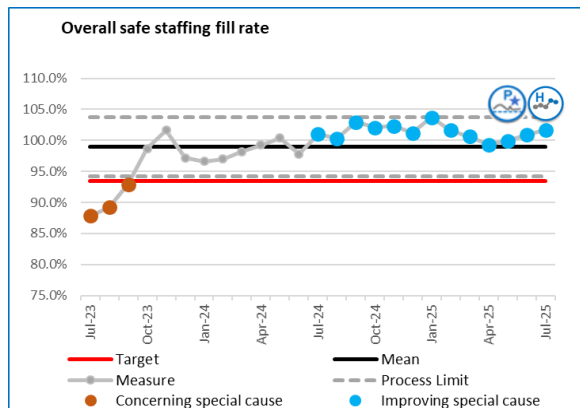
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives



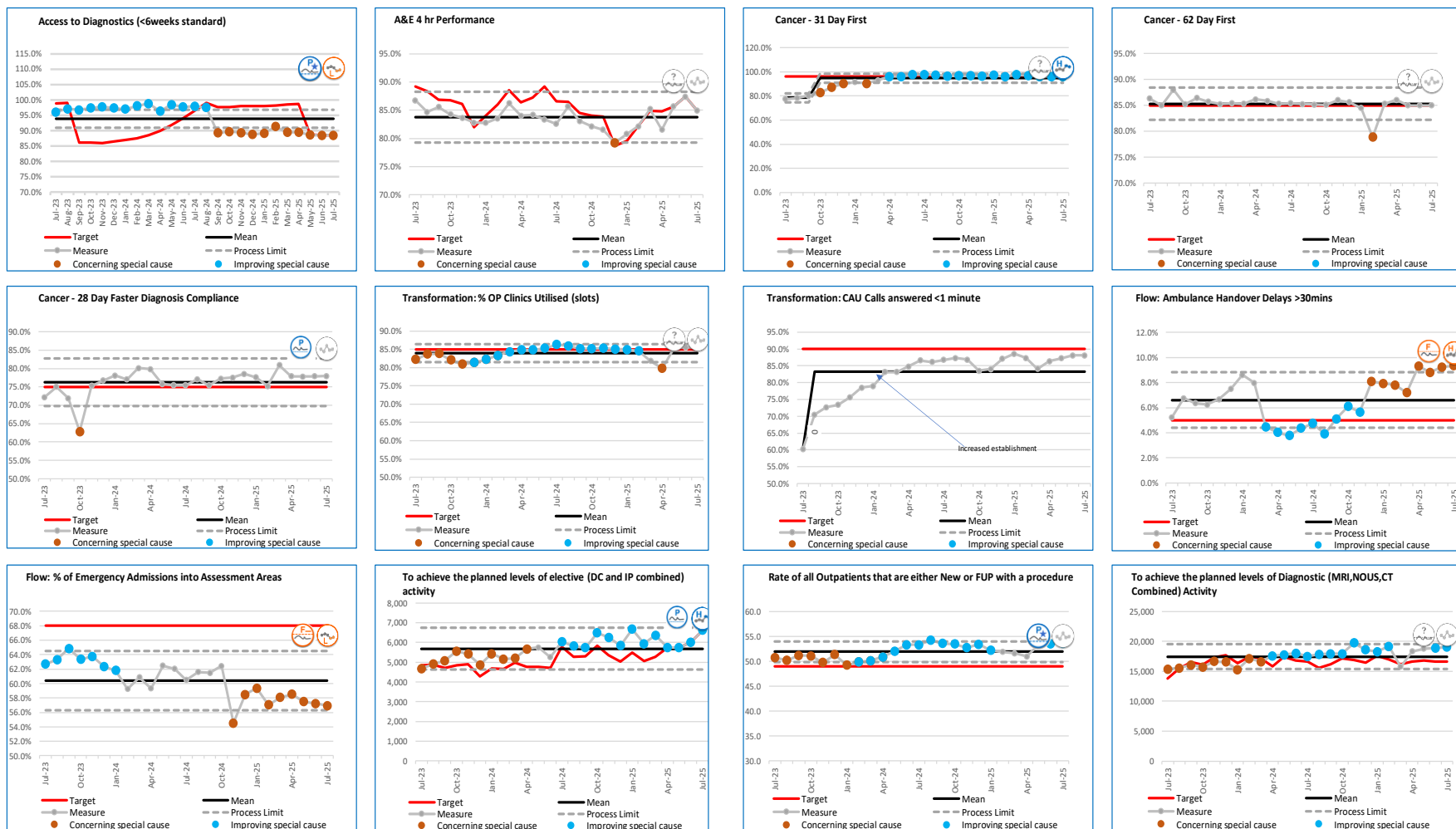
Forecast SPCs (3 month forward view) for People Indicators



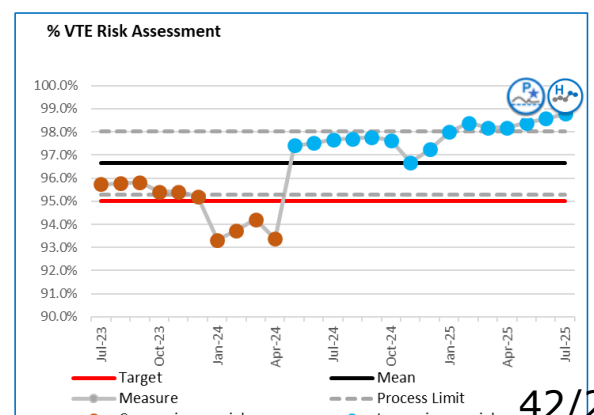
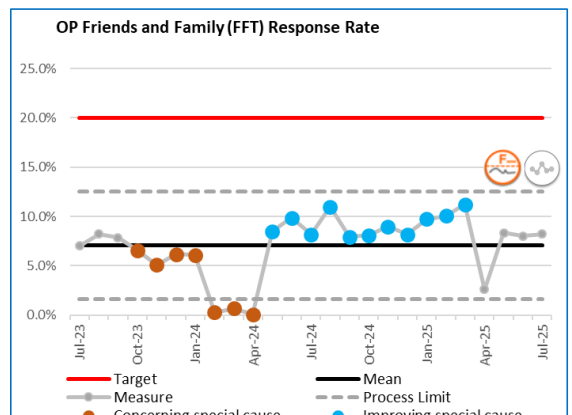
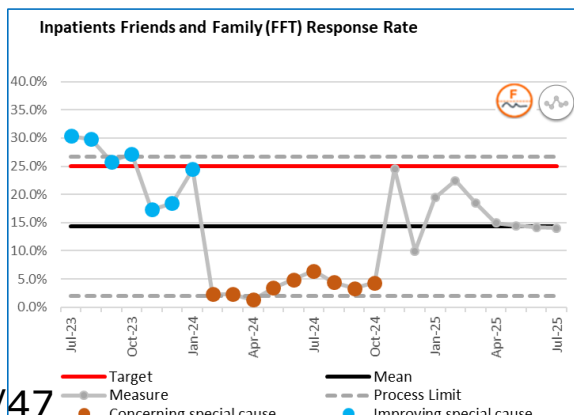
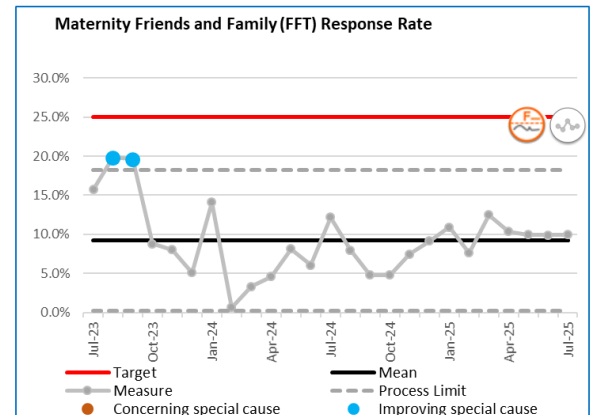
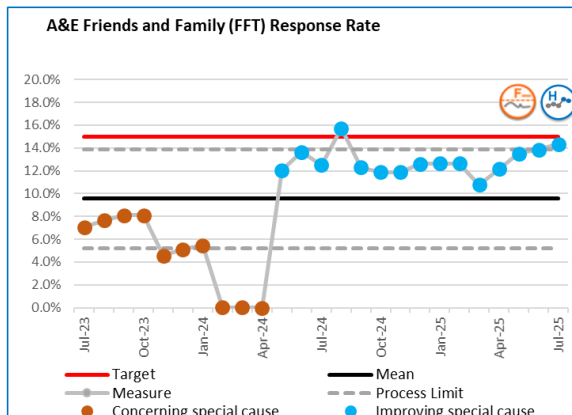
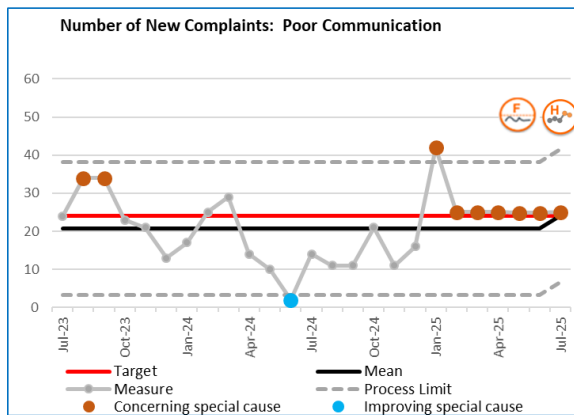
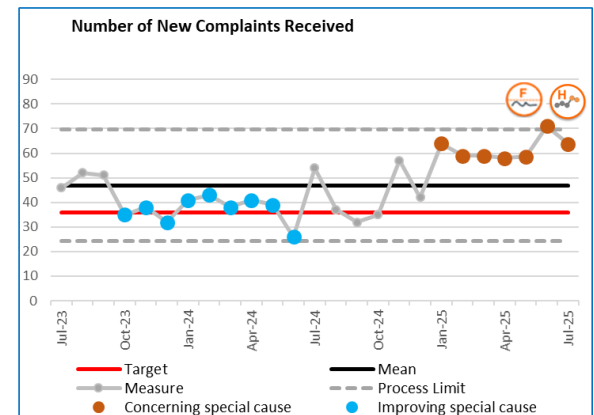
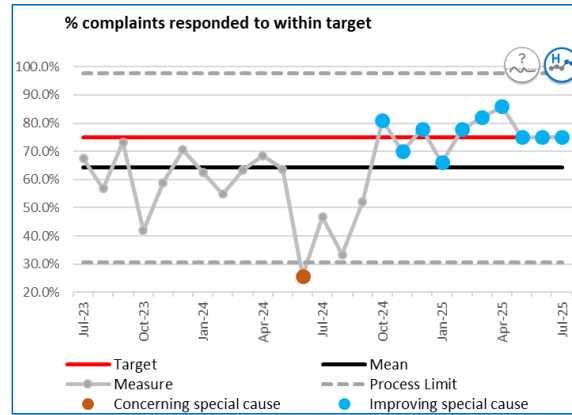
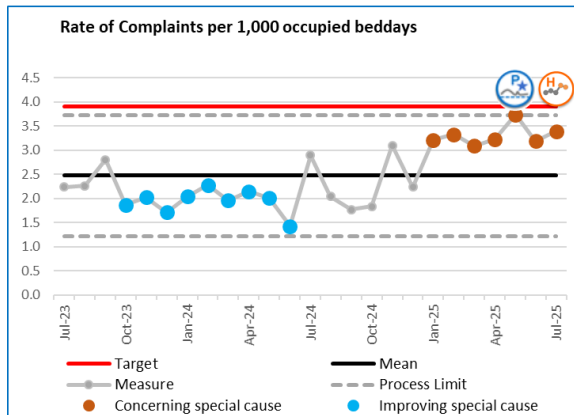
Forecast SPCs (3 month forward view) for Patient Safety Indicators



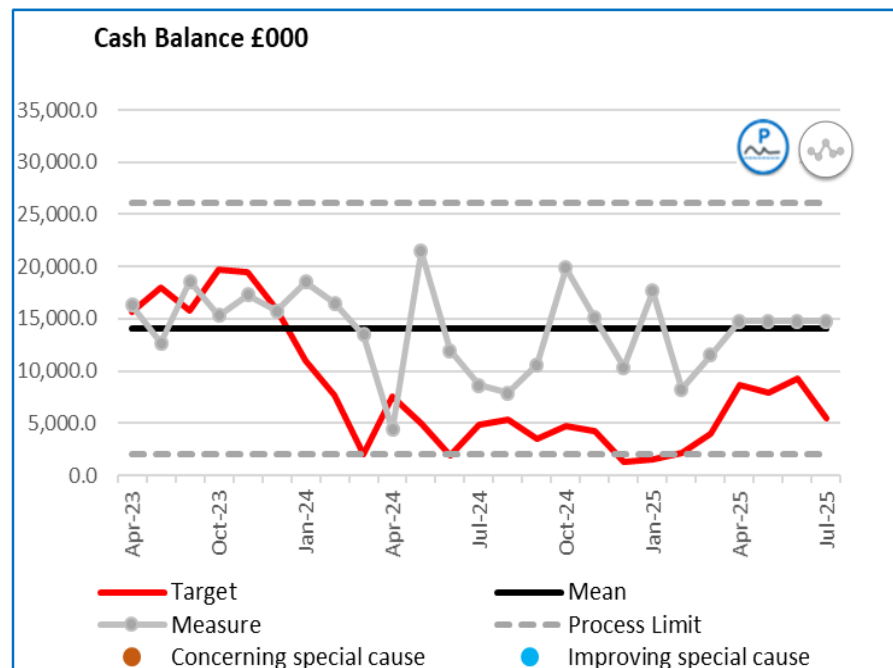
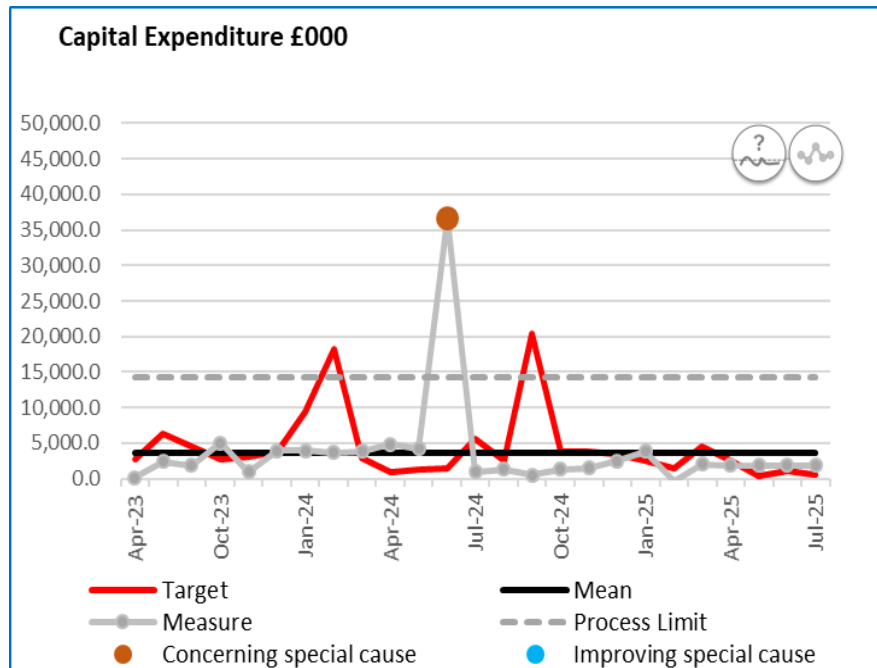
Forecast SPCs (3 month forward view) for Patient Access Indicators



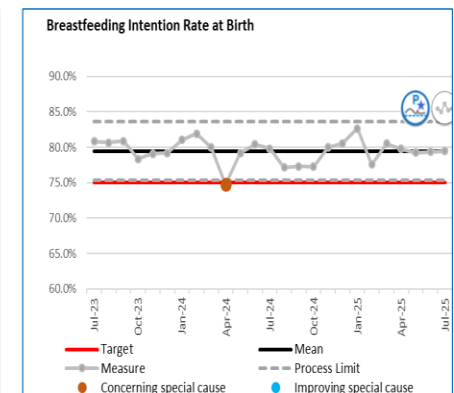
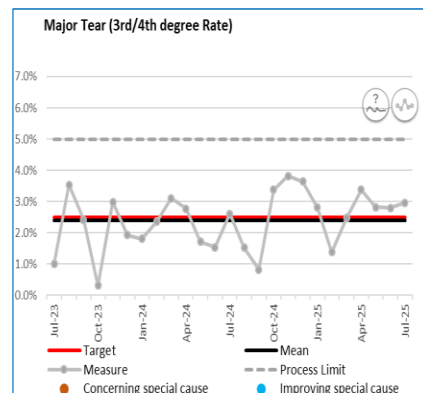
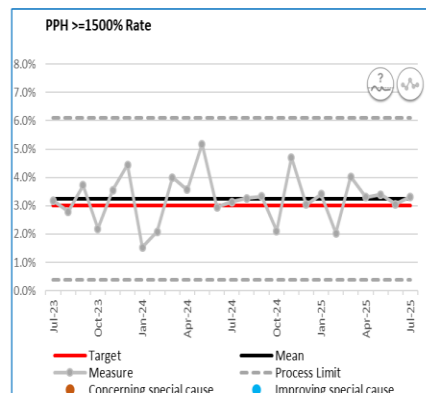
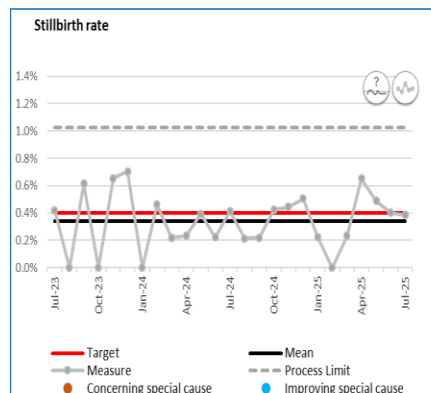
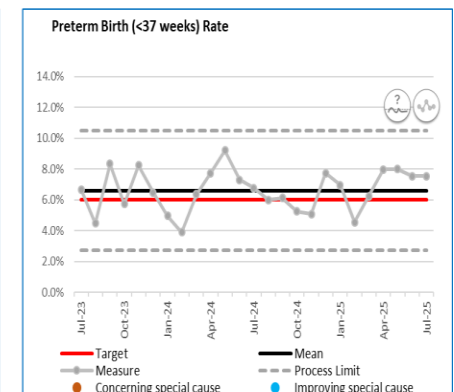
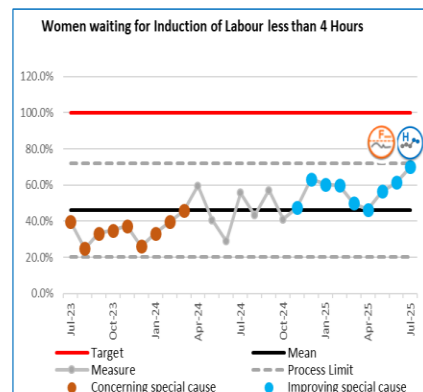
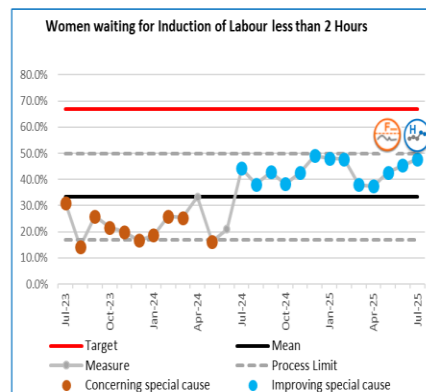
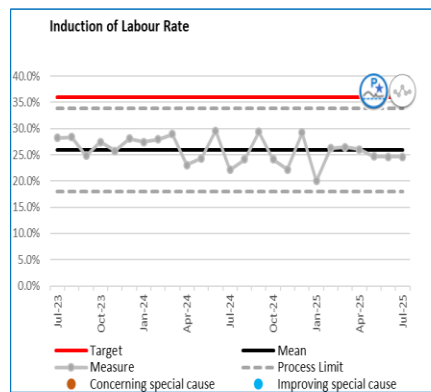
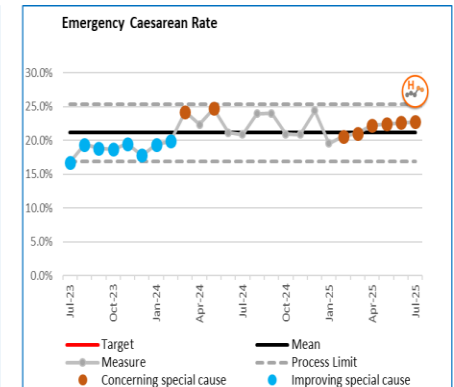
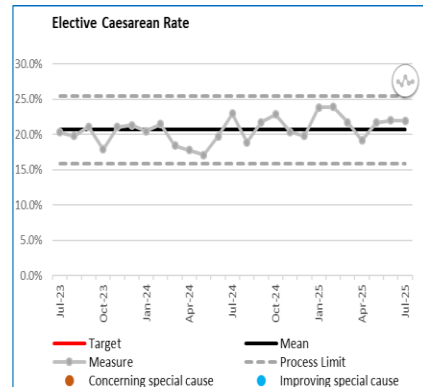
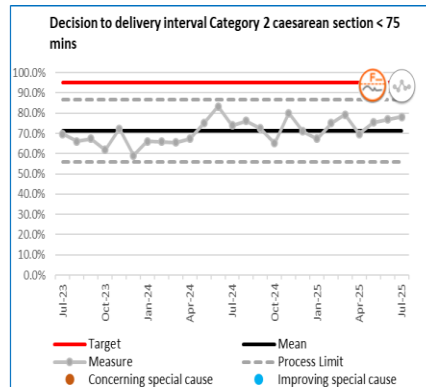
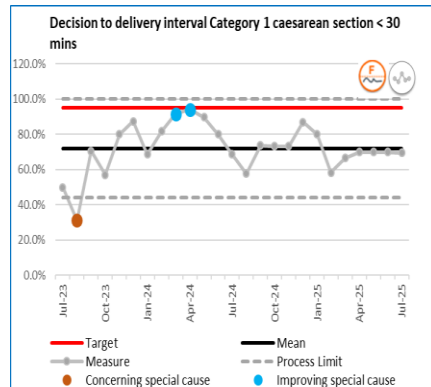
Forecast SPCs (3 month forward view) for Patient Experience Indicators



Forecast SPCs (3 month forward view) for Sustainability Indicators





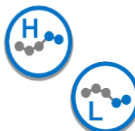



Forecast SPCs (3 month forward view) for Maternity Indicators



SDR Business Rules Driven by the SPC Icons

Assurance: Failing

| Variation | Assurance | Understanding the Icons | Business Rule – DRIVER | Business Rule - WATCH |
|---|--|---|---|--|
|  |  | <p>Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p> | <p>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</p> | <p>Metric is Failing the Target and is showing a Special Cause for Concern. Consider escalating to a driver metric.</p> |
|  |  | <p>Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.</p> | <p>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</p> | <p>Metric is Failing the Target and is in Common Cause variation. Consider next steps.</p> |
|  |  | <p>Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p> | <p>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</p> | <p>Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric</p> |





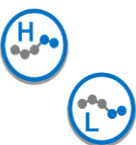
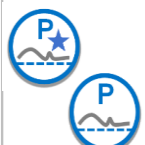
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss


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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

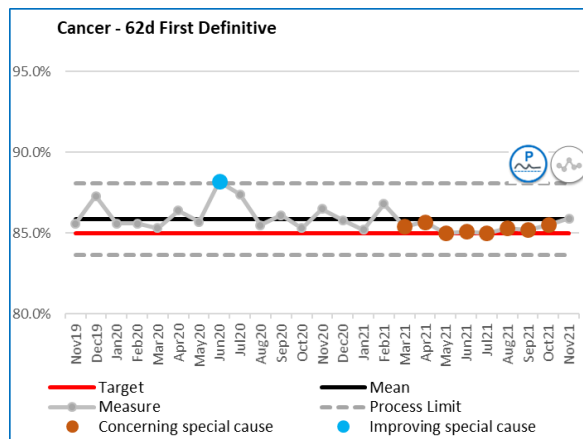
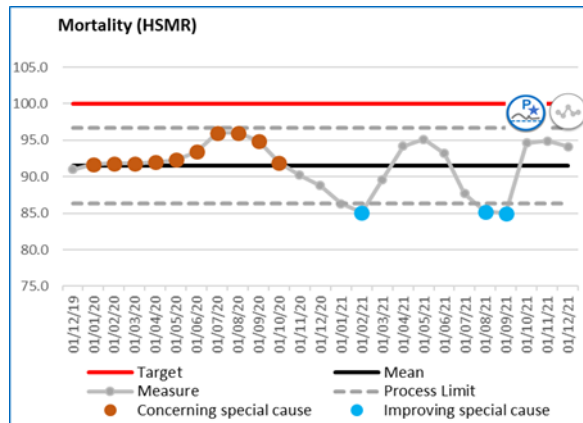
Passing, Failing and Hit & Miss Examples


Metrics that consistently **pass**  have:

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

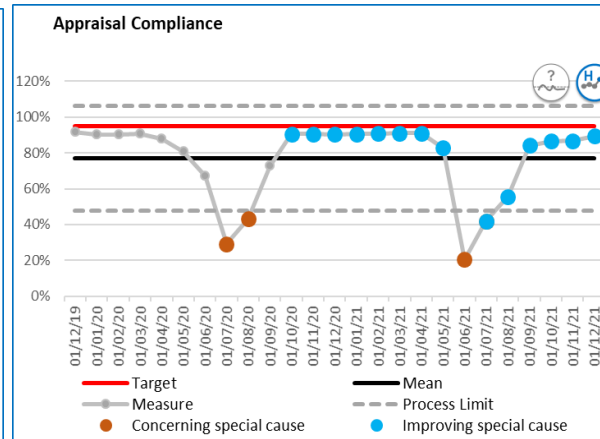
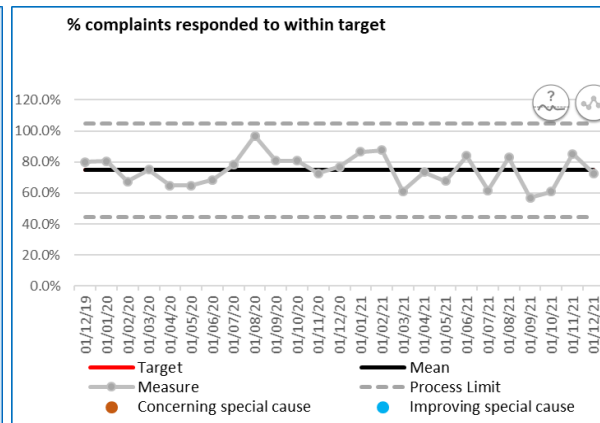
The **lower** control limit **above** the target line for metrics that need to be **above the target**


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

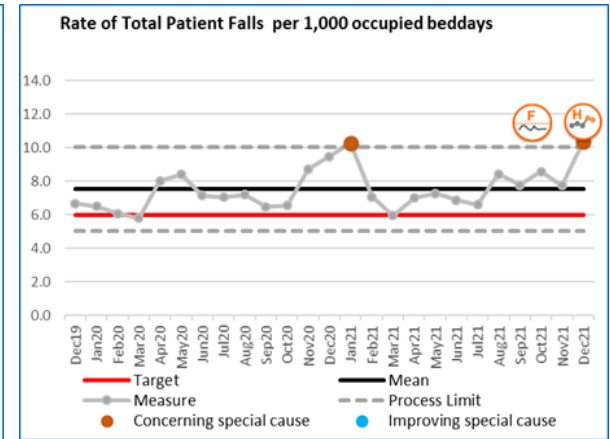
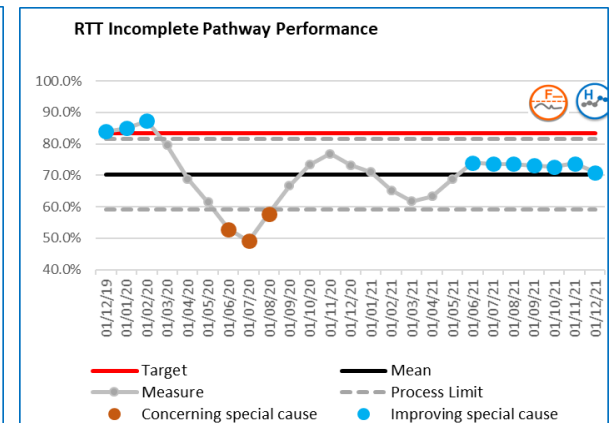


Metrics that consistently **fail**  have:

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 3 rd or 4 th degree perineal tear | Number of women with 3 rd and 4 th degree tear, by women having a vaginal birth | < 2.5% | National Maternity Dashboard average | - Potential long term impact - Morbidity & mortality - Length of stay |
| | Breastfeeding | Women who intend to breastfeed following birth | % of women | Women whose intention is to breastfeed their baby/ies at the time of birth. | Number of women with intention to breastfeed at time of birth | > 75% | National Maternity Dashboard average | - Infant health benefits - Maternal health benefits - Trends |
| | Premature births | Premature births <37 weeks gestation | % of births | Live babies born who are born less than or equal to 36+6 weeks | Number of preterm births at less than or equal to 36+6 weeks by the total births | < 6% | Saving Babies Lives Care Bundle national target | - Reducing premature births is a national target - Morbidity and mortality - Length of stay - Trends |
| | Neonatal morbidity & mortality | Stillbirth rate | per 1000 births | All babies stillborn after 24 weeks gestation | Number of stillbirths | < 4 | 2022 ONS data | - Reducing stillbirths is a national target - Mortality - Trends |
| | | Unanticipated admission to NNU >37 weeks | % of births | All babies born on or after 37 weeks who are admitted to the neonatal unit | Number of admissions to NNU by number of births after 37 weeks gestation | < 4% | National Standard (ATAIN) | - Reducing avoidable term admissions to NNU is a national target - Morbidity and mortality - Length of stay - Experience - Trends |
| | Timely Procedures | Induction of labour delayed < 2 hours | % of women | Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 2 hours of identification that the | The % of all women having induction of labour who transfer within 2 hours | 67.0% | Local target to aim for improvement | - Indicator of workload - Trends - Maternal & fetal risks |
| | | Induction of labour delayed < 4 hours | % of women | Women having induction of labour who are transferred to Delivery Suite for the next stage of the process within 4 hours of identification that the | The % of all women having induction of labour who transfer within 4 hours | 100.0% | Local target to aim for improvement | - Indicator of workload - Trends - Maternal & fetal risks |

Executive Summary

- The Trust was £6.3m in deficit which is £0.7m adverse to the plan.
- The key year to date pressures are: Pay overspend (£0.9m) and Fordcombe hospital slippage to plan (£0.4m). These pressures were offset by non pay underspends of £0.5m.
- The Trust has a £72.1m CIP savings target in 2025/26 which is split between Internal (£49m), System (£22.6m), national savings expectation (£1.3m) less £0.8m stretch. The Trust has currently identified £20.6m of schemes against the internal target and is working on developing transformation schemes to make a material progress towards the £49m target. Work is on going with system colleagues in developing detailed plans to meet these targets.

Current Month Financial Position

- The Trust was £6.3m in deficit which is £0.7m adverse to the plan.
- **Key Adverse variances in month are:**
 - Pay overspend excluding Fordcombe (£0.78m). In April the Trusts total worked WTE was 234 more than plan. The Trust was below plan on temporary staffing (83 wte) but was above plan on substantive staff by 317wte.
 - Fordcombe hospital slippage to plan (£0.36m)
- **Key Favourable variances in month are:**
 - The Trust underspent on non pay mainly due to activity being below plan generating an underspend of c£0.5m. The income from Kent and Medway ICB is deemed to be fixed therefore the underspend on non pay is not required to offset by any income pressures

Cost Improvement Plan

- The Trust has a £72.1m savings target in 2025/26. This is composed of £49m internal target, £22.6m system savings target, £1.3m national savings expectations less £0.8m stretch target.
- In April the Trust has saved £0.8m which was £0.5m adverse to plan.
- The Trust has implemented a Financial Improvement Programme Board (FIPB) which meets every two weeks to monitor progress against the overall CIP target of £72.1m. The Trust is aiming to have a fully developed plan by the end of June 2025.

Risk

- **Pathology Managed Service VAT reclaim** review (£5.3m) - 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 clarified.
- **Brookenhurst 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 was heard at the Supreme Court on 7th/8th April however no judgement has been released.
- **Contract agreement** - Discussions are ongoing with the ICB to finalise / agree the contract for 2025/26.
- **System savings** - The Trust has an assumption in the plan that £22.6m System savings will be achieved in 2025/26. Details / actions are still being developed with System colleagues with external support.

- **CIP delivery** - The Trust has identified £20.6m out of the £49m internal savings target. Work is ongoing to develop a fully identified plan by end of June. This is monitored through the Financial Improvement Programme Board (FIPB).
- **Reducing the Size of the challenge (Areas of Focus)** - The Trusts plan includes £23.5m of areas of focus opportunities to reduce the size of the challenge. Currently 49% (£11.5m) is risk assessed as either High or Medium High risk. Plans continue to be developed and reviewed at the FIPB.

Cashflow position:

- The closing cash balance at the end of April was £14.8m, this is higher than the plan value by £6.2m. The variance relates to overpayment of income received in March from two ICBs that will need to be paid within 2025/26. The brought forward cash position of £14.8m 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.
- 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 April the Trust's percentages were: Trade value 93% (m12 - 73.8%) and quantity 96% (m12 - 73.3%); NHS value 98.2% (m12 - 83.6%) quantity 99.3% (m12 69.9%).

Capital Position

- **Capital Plan**
 - The Trust's capital plan for 2025/26 is £18.282m. The Trust's planned share of the K&M ICS control total is £12.262m for 2025/26. This includes both purchased capital funding and IFRS 16 leased capital funding, as both are now managed at system level.
- **External Capital Funding**
 - National Funding has been agreed to purchase:
 - Diagnostic Equipment for £534k as part of the Constitutional Standards allocation for MTW
 - Linac Replacement at Kent and Canterbury Hospital £2.6m (equipment) and £300k (enabling works)
 - The Trust has also made bids for Critical Infrastructure funding (Estates backlog) and is awaiting final confirmation of any agreed funding.
- **Month 1 Actuals (excluding IFRS16)**
 - The YTD spend at M1 is £0.36m against a YTD budget of £0.33m.
- **Forecast**
 - At M1 the Trust is assuming that the FOT will be equal to the Plan.
- **Project Updates**
 - Estates - Enabling work on the TWH IR Suite is under way, other works are in the planning stages.

- Security - Schemes are currently being prioritised.
 - ICT - Backlog schemes are currently being prioritised.
 - Equipment - Backlog schemes are currently being prioritised. The TWH surgical robot operating table was delivered early April and is now up and running.
 - Linac replacement at K&C - Orders have been raised for the machine and the enabling work.
- **Leased/IFRS16 capital**
 - The M1 the actual spend relates to the start of the TWH Surgical Robot lease from 1.4.25. The variance in the YTD Plan and Spend relates to contracts that are currently under negotiation, and due to start in Q1.

Finance Report

**Month 1
2025/26**

| | Current Month | | | | | Year to Date | | | | |
|--|---------------|--------------|--------------|------------|--------------|--------------|--------------|--------------|--------------|--------------|
| | Actual | Plan | Variance | Pass- | Revised | Actual | Plan | Variance | Pass- | Revised |
| | | | | through | Variance | | | | through | Variance |
| | £m | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| Income | 65.4 | 65.7 | (0.2) | (0.0) | (0.2) | 65.4 | 65.7 | (0.2) | (0.0) | (0.2) |
| Expenditure | (66.7) | (66.3) | (0.3) | 0.0 | (0.4) | (66.7) | (66.3) | (0.3) | 0.0 | (0.4) |
| EBITDA (Income less Expenditure) | (1.2) | (0.6) | (0.6) | (0.0) | (0.6) | (1.2) | (0.6) | (0.6) | (0.0) | (0.6) |
| Financing Costs | (13.8) | (13.8) | (0.0) | 0.0 | (0.0) | (13.8) | (13.8) | (0.0) | 0.0 | (0.0) |
| Technical Adjustments | 8.8 | 8.8 | (0.0) | 0.0 | (0.0) | 8.8 | 8.8 | (0.0) | 0.0 | (0.0) |
| Net Surplus / Deficit | (6.3) | (5.6) | (0.7) | 0.0 | (0.7) | (6.3) | (5.6) | (0.7) | (0.0) | (0.7) |
| Cash Balance | 14.8 | 7.6 | 7.2 | | 7.2 | 14.8 | 7.6 | 7.2 | | 7.2 |
| Capital Expenditure (Incl Donated Assets and IFRS16) | 1.8 | 2.5 | 0.6 | | 0.6 | 1.8 | 2.5 | (0.6) | | (0.6) |
| Cost Improvement Plan | 0.8 | 1.4 | (0.5) | | (0.5) | 0.8 | 1.4 | (0.5) | | (0.5) |

Summary Current Month:

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Adverse Variances:

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CIP (Savings)

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Risks

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| Apr-25 | | | DAY | | | | NIGHT | | | | TEMPORARY STAFFING | | Bank / Agency Demand: RN/M (number of shifts) | WTE Temporary demand RN/M | Temporary Demand Unfilled - RM/N (number of shifts) | Occupied Beds | Planned CHPPD | Actual Care Hours per pt day | Nurse Sensitive Indicators | | | | | | Financial review | | |
|--------------------|-------------------------------------|---|--|----------------------------------|--|---|--|----------------------------------|--|---|--------------------|-------------------------------------|---|---------------------------|---|---------------|---------------|------------------------------|----------------------------|----------------------|-------|------------------|--|-----------|------------------|------------------------|--|
| Hospital Site name | Ward name | Health Roster Name | Average fill rate registered nurses/midwives (%) | Average fill rate care staff (%) | Average fill rate Nursing Associates (%) | Average fill rate Training Nursing Associates (%) | Average fill rate registered nurses/midwives (%) | Average fill rate care staff (%) | Average fill rate Nursing Associates (%) | Average fill rate Training Nursing Associates (%) | Bank/ Agency Usage | Agency as a % of Temporary Staffing | | | | | | | FFT Response Rate | FFT Score % Positive | Falls | PU ward acquired | Comments | Budget £ | Actual £ | Variance (£ overspend) | |
| Maldstone | Acute Assessment Unit (M) | Acute Medical Unit (M) - NG551 | 94.0% | 149.0% | - | - | 100.1% | 179.7% | - | - | 49.7% | 49.7% | 98 | 6.64 | 19 | 525 | 9.3 | 11.2 | - | - | 2 | 0 | 108 shifts filled for Mental Health enhanced care | £ 206,970 | £ 252,016 | (45,046) | |
| Maldstone | Stroke Unit | Stroke Unit (M) - NG551 | 107.6% | 94.7% | - | - | 100.0% | 108.7% | - | - | 27.7% | 4.5% | 90 | 6.36 | 10 | 937 | 8.1 | 8.4 | 50.0% | 100.0% | 6 | 2 | | £ 254,181 | £ 281,816 | (27,635) | |
| Maldstone | Hyperacute Stroke Unit | HA54 (34) - NG552 | 99.1% | 122.8% | - | - | 106.7% | 150.0% | - | - | 45.1% | 11.9% | 169 | 11.74 | 19 | 427 | 11.0 | 11.8 | 30.4% | 85.7% | 3 | 0 | Increased fill rate seen due to escalation | £ 160,185 | £ 178,443 | (18,256) | |
| Maldstone | Cornwallis | Cornwallis - NG551 | 97.9% | 100.1% | - | - | 106.7% | 100.0% | - | - | 13.1% | 2.4% | 36 | 2.49 | 3 | 499 | 7.6 | 7.6 | 81.7% | 94.8% | 0 | 0 | | £ 144,515 | £ 136,172 | 5,343 | |
| Maldstone | Culpepper and CCU | Culpepper Ward (M) - NG551 | 103.5% | 95.4% | - | - | 100.0% | 130.0% | - | - | 21.5% | 3.8% | 5 | 0.36 | 0 | 353 | 7.9 | 8.1 | 128.6% | 96.3% | 1 | 1 | | £ 131,341 | £ 147,641 | (16,300) | |
| Maldstone | Culpepper and CCU | CCU (M) - NG551 | 99.1% | - | - | - | 100.0% | - | - | - | 12.7% | 0.0% | 16 | 1.08 | 0 | 175 | 7.9 | 7.8 | 271.4% | 100.0% | 1 | 0 | | £ 131,341 | £ 147,641 | (16,300) | |
| Maldstone | Edith Cavell | Edith Cavell - NG459 | 125.5% | 89.1% | - | - | 100.0% | 101.1% | 187.2% | - | 40.3% | 28.8% | 38 | 2.67 | 5 | 659 | 5.8 | 6.8 | 55.9% | 100.0% | 4 | 1 | 60 shifts filled for mental health and dementia and delirium enhanced care | £ 134,272 | £ 146,878 | (12,606) | |
| Maldstone | John Day | John Day Respiratory Ward (M) - NTJ51 | 96.9% | 122.1% | - | - | 104.7% | 110.3% | - | - | 29.7% | 23.8% | 86 | 6.09 | 14 | 863 | 7.6 | 8.1 | 155.6% | 97.6% | 2 | 2 | 83 shifts filled for mental health and dementia and delirium enhanced care | £ 204,078 | £ 236,867 | (32,789) | |
| Maldstone | Intensive Care (M) | Intensive Care (M) - NA251 | 82.1% | 127.8% | - | - | 93.6% | 85.6% | - | - | 8.6% | 0.0% | 48 | 3.23 | 7 | 117 | 59.6 | 49.3 | 800.0% | 100.0% | 0 | 0 | | £ 266,031 | £ 239,688 | 26,343 | |
| Maldstone | Lord North | Lord North Ward (M) - NG651 | 100.2% | 66.6% | - | - | 100.0% | 98.9% | 100.0% | - | 30.4% | 0.6% | 19 | 1.41 | 1 | 454 | 8.4 | 7.8 | 28.6% | 100.0% | 1 | 0 | | £ 129,680 | £ 135,609 | (5,929) | |
| Maldstone | Mercer | Mercer Ward (M) - NJ251 | 97.6% | 123.3% | - | - | 100.0% | 100.0% | 189.0% | - | 42.4% | 32.7% | 47 | 3.34 | 4 | 771 | 5.9 | 6.8 | 19.0% | 100.0% | 5 | 0 | 77 shifts filled for Mental Health and dementia delirium enhanced care | £ 130,658 | £ 161,466 | (30,808) | |
| Maldstone | Peale | Peale Ward COVID - NG451 | 98.9% | 105.3% | - | - | 98.0% | 126.7% | - | - | 24.6% | 23.9% | 45 | 3.19 | 4 | 389 | 8.0 | 8.3 | 25.8% | 100.0% | 0 | 1 | | £ 111,677 | £ 103,452 | 8,225 | |
| Maldstone | Pye Oliver | Pye Oliver (Medical) - NK259 | 98.8% | 146.9% | - | - | 98.3% | 182.3% | - | - | 0.0% | No hours | No Demand | No Demand | No Demand | 821 | 6.3 | 8.1 | 180.8% | 89.4% | 2 | 2 | 130 shifts filled for Mental Health, learning Disability and dementia and delirium enhanced care | £ 169,682 | £ 88,394 | 81,288 | |
| Maldstone | Short Stay Surgery Unit (M) | Short Stay Surgical Unit (M) - NE751 | 84.9% | 87.2% | - | - | 79.4% | 99.5% | - | - | 4.1% | 0.0% | 11 | 0.62 | 1 | 40 | 60.8 | 49.8 | 0.0% | 98.2% | 0 | 0 | | £ 69,586 | £ 73,094 | (3,508) | |
| Maldstone | Whitman | Whitman Ward - NG959 | 94.3% | 109.2% | - | - | 100.0% | 194.2% | - | - | 34.7% | 11.5% | 62 | 4.23 | 4 | 635 | 8.4 | 9.4 | 45.5% | 100.0% | 3 | 2 | increased fill rate seen due to escalation and 45 enhanced care shifts | £ 163,416 | £ 204,383 | (40,967) | |
| Maldstone | Maldstone Birth Centre | Maldstone Birth Centre - NP751 | 96.1% | 89.2% | - | - | 102.5% | 100.3% | - | - | 13.0% | 0.0% | 17 | 0.91 | 0 | 34 | 65.2 | 63.5 | 0.0% | 100.0% | 0 | 0 | | £ 88,871 | £ 94,898 | (6,027) | |
| TWTH | Acute Medical Unit (TW) | Acute Medical Unit (TW) - NA901 | 93.3% | 102.4% | - | - | 100.0% | 96.7% | 135.7% | - | 42.9% | 18.2% | 133 | 9.45 | 23 | 807 | 8.6 | 8.8 | - | - | 3 | 0 | 41 shifts filled for mental health, dementia and delirium and risk of falls enhanced care | £ 280,208 | £ 290,556 | (10,348) | |
| TWTH | Coronary Care Unit (TW) | Coronary Care Unit (TW) - NP301 | 93.8% | 80.3% | - | - | 98.9% | - | - | - | 10.6% | 0.0% | 16 | 1.16 | 5 | 205 | 11.8 | 11.3 | - | - | 0 | 0 | | £ 84,330 | £ 75,760 | 8,570 | |
| TWTH | Hedgheg Ward | Hedgheg Ward (TW) - ND702 | 94.1% | 83.2% | - | - | 96.0% | 50.2% | - | - | 18.2% | 31.6% | 99 | 7.06 | 12 | 433 | 13.4 | 10.7 | 14.4% | 100.0% | 0 | 0 | | £ 228,880 | £ 195,223 | 33,657 | |
| TWTH | Intensive Care (TW) | Intensive Care (TW) - NA201 | 97.3% | 80.7% | - | - | 98.3% | 73.3% | - | - | 2.3% | 24.7% | 27 | 1.88 | 2 | 375 | 33.1 | 31.2 | - | - | 1 | 0 | | £ 422,928 | £ 443,854 | (20,926) | |
| TWTH | Wells Day Unit | Private Patient Unit (TW) - NR702 | 100.0% | 94.4% | - | - | 100.0% | 110.0% | - | - | 13.5% | 0.0% | 6 | 0.41 | 0 | 257 | 9.5 | 9.4 | 48.3% | 100.0% | 0 | 0 | | £ 81,610 | £ 87,683 | (6,073) | |
| TWTH | Ward 2 | Ward 2 (TW) - NG442 | 92.5% | 113.1% | - | - | 100.0% | 125.6% | 126.4% | - | 32.6% | 26.4% | 75 | 5.21 | 16 | 778 | 7.0 | 7.9 | 48.8% | 95.2% | 6 | 0 | increased fill rate seen due to escalation | £ 216,377 | £ 216,069 | 308 | |
| TWTH | Ward 11 | Ward 11 (TW) - NG131 | 92.3% | 103.8% | - | - | 97.3% | 92.9% | - | - | 16.5% | 4.7% | 63 | 4.36 | 7 | 886 | 7.1 | 6.6 | 20.2% | 100.0% | 6 | 0 | | £ 189,634 | £ 191,817 | (2,183) | |
| TWTH | Ward 12 | Ward 12 (TW) - NG132 | 109.8% | 104.5% | - | - | 100.0% | 113.2% | 106.6% | - | 44.0% | 29.2% | 149 | 9.88 | 16 | 884 | 6.7 | 7.3 | 15.4% | 83.3% | 3 | 0 | | £ 166,005 | £ 196,713 | (30,708) | |
| TWTH | Ward 20 | Ward 20 (TW) - NG130 | 96.9% | 110.3% | - | - | 100.0% | 105.9% | 105.1% | - | 27.9% | 18.5% | 87 | 5.77 | 16 | 886 | 6.7 | 6.9 | 40.4% | 68.4% | 10 | 0 | | £ 195,856 | £ 202,129 | (6,273) | |
| TWTH | Ward 21 | Ward 21 (TW) - NG231 | 101.2% | 93.3% | - | - | 100.0% | 97.3% | 105.6% | - | 14.0% | 4.9% | 30 | 2.07 | 8 | 863 | 7.3 | 7.2 | 24.0% | 83.3% | 3 | 1 | | £ 192,643 | £ 212,733 | (20,090) | |
| TWTH | Ward 22 | Ward 22 (TW) - NG332 | 99.0% | 145.3% | - | - | 98.3% | 146.5% | - | - | 35.1% | 40.2% | 32 | 2.20 | 7 | 949 | 6.2 | 7.5 | 102.7% | 86.8% | 5 | 1 | 107 shifts filled from dementia and delirium and risk of falls enhanced care | £ 185,644 | £ 213,897 | (28,253) | |
| TWTH | Ward 30 | Ward 30 (TW) - NG330 | 98.6% | 106.9% | - | - | 100.0% | 98.3% | 110.9% | - | 33.1% | 0.0% | 80 | 4.65 | 9 | 886 | 6.7 | 6.9 | 27.6% | 100.0% | 8 | 3 | | £ 168,653 | £ 208,649 | (39,997) | |
| TWTH | Ward 31 | Ward 31 (TW) - NG131 | 98.5% | 114.5% | - | - | 100.0% | 97.5% | 112.5% | - | 18.6% | 0.0% | 73 | 4.51 | 8 | 888 | 6.7 | 7.0 | 22.6% | 85.7% | 10 | 2 | | £ 161,548 | £ 205,128 | (43,580) | |
| TWTH | Ward 32 | Ward 32 (TW) - NG130 | 89.3% | 82.4% | - | - | 100.0% | 96.7% | 98.8% | - | 24.0% | 0.0% | 54 | 3.76 | 6 | 578 | 9.4 | 8.6 | 0.0% | 100.0% | 1 | 0 | | £ 167,783 | £ 161,030 | 6,753 | |
| TWTH | Gynae Ward | Ward 33 (Gynae) (TW) - ND302 | 98.5% | 95.4% | - | - | 98.3% | 100.0% | - | - | 20.2% | 0.0% | 20 | 1.24 | 2 | 280 | 7.8 | 7.6 | 20.8% | 86.4% | 0 | 0 | | £ 115,623 | £ 110,023 | 5,600 | |
| TWTH | SCBU | SCBU (TW) - NA102 | 84.7% | - | - | - | 94.9% | - | - | - | 13.9% | 10.9% | 75 | 4.34 | 4 | 497 | 10.4 | 10.2 | 9.1% | 100.0% | 0 | 0 | | £ 269,918 | £ 240,701 | 29,217 | |
| TWTH | Short Stay Surgical Unit (TW) | Short Stay Surgical Unit (TW) - NE901 | 85.4% | 114.1% | - | - | 100.0% | 111.7% | 96.4% | - | 12.7% | 8.8% | 30 | 1.95 | 1 | 255 | 15.3 | 13.2 | 18.6% | 95.2% | 0 | 0 | | £ 97,141 | £ 114,887 | (17,746) | |
| TWTH | Surgical Assessment Unit | Surgical Assessment Unit (TW) - NE701 | 105.6% | 72.4% | - | - | 100.0% | 100.0% | 93.3% | - | 5.0% | 0.0% | 6 | 0.41 | 0 | 157 | 15.5 | 15.1 | 4.5% | 93.8% | 0 | 0 | | £ 87,465 | £ 89,459 | (1,994) | |
| TWTH | Delivery Suite | Midwifery Services - Delivery Suite - NF102 | 89.9% | - | - | - | 89.5% | - | - | - | 25.0% | 23.7% | 250 | 15.68 | 71 | 1145 | 9.9 | 9.0 | - | - | - | - | | £ 446,484 | £ 400,011 | 46,473 | |
| TWTH | Delivery Suite | Midwifery Services - MSW (2022) - NF102 | - | 93.7% | - | - | - | 90.9% | - | - | 22.3% | 0.0% | No Demand | No Demand | No Demand | - | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Antenatal Ward | Midwifery Services - Antenatal Ward - NF122 | 91.1% | - | - | - | 91.2% | - | - | - | 25.3% | 11.0% | 59 | 3.60 | 15 | 348 | 6.0 | 5.4 | - | - | - | - | | £ 117,389 | £ 121,432 | (4,043) | |
| TWTH | Postnatal Ward | Midwifery Services - Postnatal Ward - NF132 | 132.8% | 96.3% | - | - | 119.5% | 100.0% | - | - | 38.5% | 8.2% | 199 | 11.35 | 23 | 654 | 6.6 | 7.9 | - | - | - | - | | £ 219,441 | £ 223,263 | (3,822) | |
| Crowborough | Crowborough Birth Centre | Crowborough Birth Centre (CBC) - NP775 | 93.3% | 100.0% | - | - | 96.7% | 99.9% | - | - | 13.9% | 0.0% | 29 | 1.62 | 0 | 38 | 58.5 | 56.4 | 22.7% | 100.0% | - | - | 77 shifted filled for mental health enhanced care | £ 80,627 | £ 87,620 | (6,993) | |
| Maldstone | A&E (M) | Accident & Emergency (M) - NA351 | 104.9% | 130.3% | - | - | 100.0% | 101.3% | 129.6% | - | 38.3% | 31.0% | 286 | 18.84 | 8 | 0 | - | - | 0.0% | 79.1% | - | - | | £ 413,324 | £ 477,071 | (63,747) | |
| TWTH | A&E (TW) | Accident & Emergency (TW) - NA301 | 104.3% | 87.1% | - | - | 100.0% | 105.5% | 91.2% | - | 25.6% | 20.5% | 238 | 16.52 | 11 | 0 | - | - | 12.9% | 78.9% | - | - | | £ 481,434 | £ 507,758 | (26,324) | |
| TWTH | Antenatal OP Clinic | Midwifery Services - Antenatal Clinic - NF142 | 84.4% | 93.7% | - | - | - | - | - | - | 7.6% | 0.0% | 8 | 0.39 | 0 | 0 | - | - | - | - | - | - | | £ 61,279 | £ 60,430 | 850 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - Team Leads - N160 | 75.2% | - | - | - | - | - | - | - | 0.0% | No hours | No Demand | No Demand | No Demand | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - TW/Ton/Pw/Hawthorn - N160 | 85.4% | 91.4% | - | - | - | - | - | - | 12.9% | 0.0% | 43 | 2.24 | 1 | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - Phoenix Team - N160 | 89.0% | 72.2% | - | - | - | - | - | - | 5.9% | 0.0% | 6 | 0.35 | 0 | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - Eden/Seven/Mallings - N160 | 92.9% | 47.0% | - | - | - | - | - | - | 9.3% | 0.0% | 24 | 1.19 | 3 | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - Maldstone/Leeds - N160 | 86.2% | 56.6% | - | - | - | - | - | - | 12.5% | 0.0% | 40 | 1.90 | 6 | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| TWTH | Community Midwifery Services (TW) | Community Midwifery Services - Crowborough - N160 | 91.4% | 63.3% | - | - | - | - | - | - | 0.0% | No hours | No Demand | No Demand | No Demand | 0 | - | - | - | - | - | - | | £ - | £ - | 0 | |
| | | Midwifery TW (four IP rosters) | 101.3% | 94.4% | - | - | 96.9% | 92.2% | - | - | 27.7% | 12.6% | 508 | 30.63 | 109 | | | | | | | | | £ - | £ - | 0 | |
| | | Midwifery TW Community (six comm. rosters) | 87.3% | 84.8% | - | - | - | - | - | - | 9.3% | 0.0% | 287 | 16.57 | 38 | | | | | | | | | £ 361,115 | £ 307,429 | 53,686 | |
| | | Midwifery TW (all fourteen rosters) | 86.2% | 88.7% | - | - | 97.2% | 92.2% | - | - | 15.7% | 10.7% | 573 | 35.41 | 46 | | | | | | | | | £ - | £ - | 0 | |
| Maldstone | MOU and K&M Orth Centre - inpatient | K&M Orth Centre - Inpatient Ward - TK153 | 87.4% | 50.9% | - | - | 100.0% | 62.0% | 61.3% | - | No Hours | 0.0% | No hours | No Demand | No Demand | 165 | 34 | 22.4 | 65 | | | | | | | | |

| | | | | | | |
|--|---|-------------------------------------|------------|-------------------------------------|-------------|-------------------------------------|
| Title of report | Experience of Care Patient Story | | | | | |
| Board / Committee | Trust Board ‘Part 1’ Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-7 | | | | | |
| Executive lead | Joanna Haworth, Chief Nurse | | | | | |
| Presenter | Charlotte Wadey Divisional Director of Nursing and Quality- Paediatrics Gynecology and Sexual Health | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|---|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The attached story represents the lived experience of a patient in the paediatrics services at MTW who was admitted to Hedgehog ward for 77 days. In particular, it focuses on the positive and negatives experiences and what improvements have been made for future patient’s experience. | |
| Any items for formal escalation / decision | No items for escalation but the Board is asked to note and discuss the NHS Child and Young people patient experience survey 2024 presented by the Chief Nurse. | |
| Appendices attached | | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| | | |

| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | 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 |
| Links to Trust Risk Register (TRR) | NA |
| Compliance / Regulatory Implications | NA |

Isabelle' s Story

Isabelle and her parents have given their consent for their story to be shared at Trust board and their real names to be used.

Isabelle was diagnosed with Anorexia in January 2021, aged 15 and is now 19. She was admitted onto Hedgehog ward in February 2021 and spent a total of 77 days in a cubicle on the ward before she was transferred to a specialist inpatient facility that could support her care needs in Hertfordshire as no local facilities had space available for her. Her Anorexia diagnosis followed the challenging year of 2020 with COVID, online schooling, not seeing friends and feeling isolated. These things added to her anxieties which culminated in limiting food, poor nutrition and counting calories. Following her stay on Hedgehog Isabelle spent nearly 2 years in inpatient mental health care. She continues to struggle with her mental health and has spent a prolonged period of time in mental health inpatient settings as well as on adult wards at MTW.

Isabelle has kindly provided the following positive and negative comments from her stay on Hedgehog Ward, her parents have also included their comments and the family are keen that the trust continues to improve its mental health support and facilities.

Positives

- *The play assistant went out of her way to help me and create works of art for the walls to track my progress*
- *The nurses tried their hardest to understand my situation*
- *The nurses and play assistant would play cards with me to help distract me*

Negatives

- *Nurses to have more training with NG feeding - on many occasions the speed they were feeding me made me feel sick*
- *When I was physically better I got little support for my mental health*
- *During my stay I was moved to multiple different rooms*
- *Mum and I felt on admission we were given little information as to what was happening (why did the room have no bathroom and no door handle)*
- *Lack of professional communication between ward staff and ED services*
- *Communication throughout the 77 days was limited*
- *Isabelle didn't see a psychiatrist until day 44. He challenged why we (parents) had been there 24 hours a day / 7 days a week for those first 44 days*
- *Isabelle felt isolated, due to being in a room at the end of the ward - it felt that as parents were there, the staff left her alone (other than the play assistant above).*
- *It's a physical hospital - Isabelle physical health issues were caused by her mental health but this was not really understood (e.g. "if you eat this meal, I'll show you a photo of my granddaughter") Crisis Team visits were pointless. Lack of reading notes and not aware of Issy's issues*

Despite her long stay on the unit and the challenges faced, Isabelle, her family and local community set out to fund raise to support an improvement in the facilities available on the ward – they have focused their fundraising on a break out room that young people with mental health related issues can use rather than remaining in one cubicle, with the resources to improve their mental wellbeing and provide opportunities for distraction and space to relax.

Isabelle family (Richard, Sarah, Olivia and William with Dexter the dog) each walked a total of 77 miles in the month of August 2021 to recognise the number of days Issy spent on

Hedgehog Ward. The family raised £15,000 and this room is now in place on the unit. The team on Hedgehog are awaiting Isabelle and her family to officially open this area and they would thank them for their patience whilst an opening date is confirmed.

Isabelle's story on her experience of care, clearly demonstrates that a joined-up young person-centred approach to support young people on the acute children's ward would be beneficial and in fact is essential to optimise recovery and understanding of health needs, medical, physical, emotional and social alongside any mental health needs.

The process to support children and young people on the paediatric ward has changed dramatically since Isabelle was on the ward. There are a number of improvements in place to support both the young person and the family through what is clearly a very difficult time for all of them, especially whilst the search for a specialist placement is undertaken.

Staff training has been undertaken to ensure that all staff have an awareness of mental health in children and young people with shared learning implemented across Paediatrics at MTW, other hospitals in Kent and Medway, the Integrated Care Board

A single point of contact is now fully implemented to ensure that families have one key person to update them with information and to act as an advocate for their child or young person.

The paediatric Mental Health Liaison role was developed and piloted, this was evaluated with our ICB colleagues and was implemented as a permanent post and similar roles have been implemented across the hospitals within Kent and Medway. This nurse is experienced in managing children and young people with mental health related conditions, they have completed formal training programmes and can also train our own staff to be able to manage all the facets of the conditions




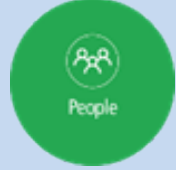


Weekly crisis teams meeting led by the ICB are fully embedded to escalate children and young people who need to be in a different placement than an acute paediatric ward to facilitate an earlier transfer whenever possible. A weekly meeting with the All Age Eating Disorder Team (Red Book Meetings) is fully embedded and the mental health liaison lead attends. This allows for a clear plan for treatment of eating disorders and involves the dietician team at MTW to support a programme of care tailored to the young person.

In addition, Paediatric Mental Health Support workers have been recruited, who receive specific training by Great Ormond Street Hospital (GOSH) in paediatric mental health conditions and can provide support and activities with the young people alongside the play specialist that can support their treatment plan

Multidisciplinary meetings are fully implemented led by the Single Point of Contact to optimise care delivery on the unit, parents can attend these meeting with all teams involved in the care of their child, as can the young person to discuss their concerns and issues. This ensures that a clear plan is put in place and additional support identified. The young person and parents now have a voice and are able to fully be involved in the processes in a transparent manner including where the delays are.

We thank Isabelle and her family for giving us their story and allowing mental health provision for children and young people to remain high on the paediatric and trust agenda. We continue to strive to improve the care we provide, working more closely with external agencies and the trust to support families whilst on this journey. The work is not over yet and there is more to do. The development to the break out room by Isabelle and her family is essential in allowing children and young people somewhere to feel safe and to relax.

| | | | | | | |
|--|--|-------------------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | 2024 Children and Young People's Patient Experience Survey update | | | | | |
| Board / Committee | Trust Board | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | To be completed by Committee / Board Administrator | | | | | |
| Executive lead | Jo Haworth, Chief Nurse | | | | | |
| Presenter | Jo Haworth, Chief Nurse | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|--|---|---|--|---|---|
|  |  |  |  |  |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| Executive Summary | | |
|--|---|---|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The Children and Young People’s Patient Experience Survey was undertaken by IQVIA on behalf of Maidstone and Tunbridge Wells NHS Trust (MTW) between October and December 2024. The sample period changed and was March to May 2024 rather than November to January 2025. Previous survey was completed in 2020. | |
| | As per the previous surveys, three different questionnaires were issued to patients depending on their age group: the 0-7 years questionnaire completed by the parent or carer; the 8-11 years questionnaire completed by both the child and parent or carer; the 12-15 years questionnaire completed by both the young person and parent or carer. | |
| | 199 completed questionnaires were returned from the sample of 921 patients. The final response rate for the Trust was 21.7%. | |
| Any items for formal escalation / decision | Board members are asked to note and discuss the report contained therein, the 2020 and the 2024 action plans based on the recommendations from the survey feedback. | |
| Appendices attached | • Slide presentation on the 2024 Children and Young People Survey | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| Experience of Care Oversight Group | 01 May 2025 | For further discussion at ETM and Quality Committee |
| Quality Committee Main | 21 May 2025 | For discussion at Trust Board |

| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | 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 |
| Links to Trust Risk Register | N/A |

| | |
|--|----|
| (TRR) | |
| Compliance / Regulatory Implications | NA |

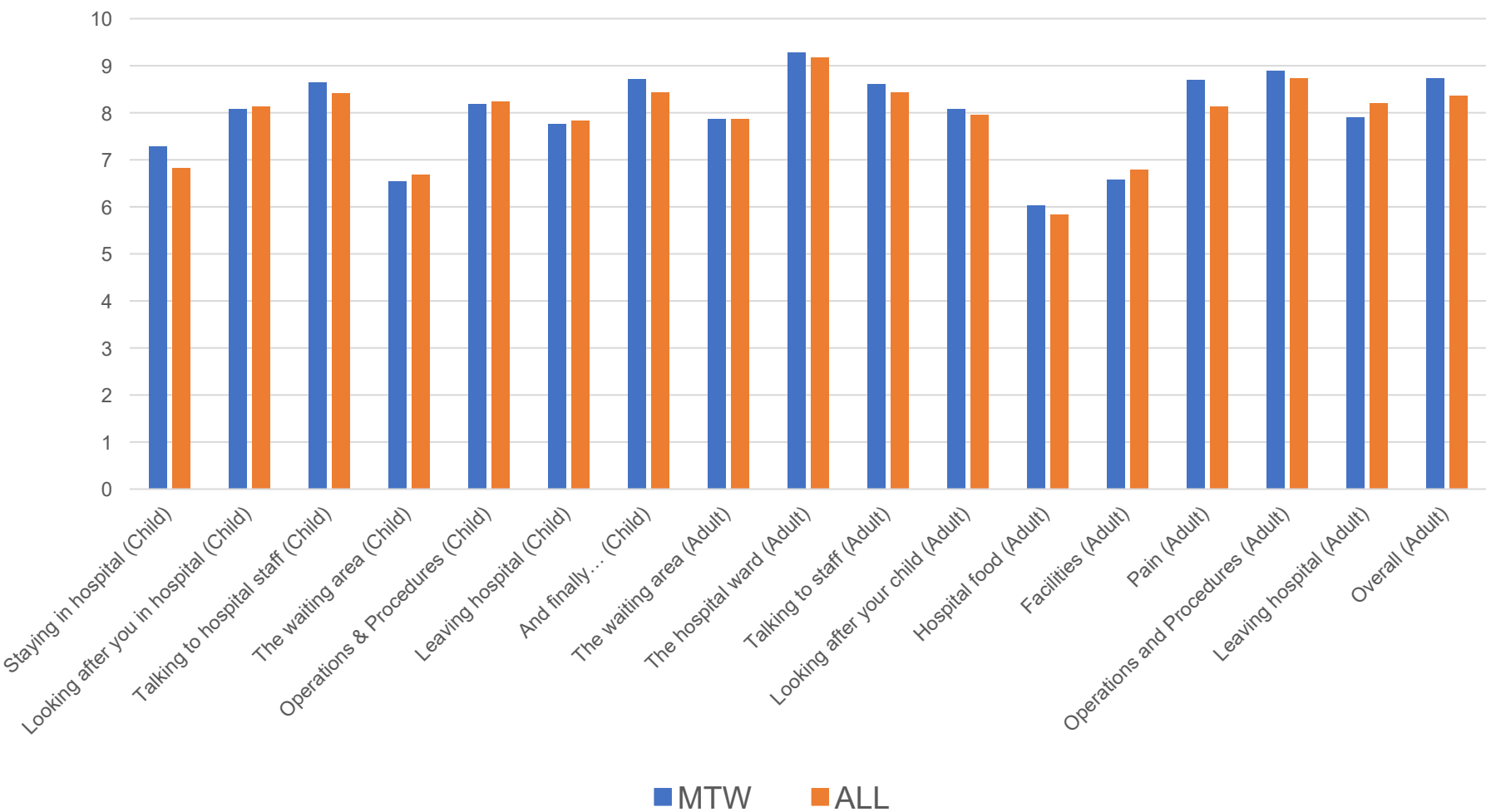
2024 Children and Young People's Patient Experience Survey update

Trust Board
29th May 2025

Executive Summary

- The Children and Young People's (CYP) Patient Experience Survey was undertaken by IQVIA on behalf of Maidstone and Tunbridge Wells NHS Trust (MTW) between October and December 2024. The last CYP Patient Experience Survey was completed in 2020 as per national schedule.
- For the first time since its inception, the Children and Young People's Patient Experience Survey was conducted using a mixed-mode approach: an online questionnaire followed by a reminder and a paper questionnaire being mailed to non-respondents (and those sample members who request a paper version specifically).
- Overall, the sampling procedure for CYP24 has remained largely similar to the 2020 Survey. However, the sample period has changed and is now March to May 2024 rather than November to January.
- As per the previous surveys, three different questionnaires were issued to patients depending on their age group: the 0-7 years questionnaire completed by the parent or carer; the 8-11 years questionnaire completed by both the child and parent or carer; the 12-15 years questionnaire completed by both the young person and parent or carer.
- 199 completed questionnaires were returned from the sample of 921 patients.
- The final response rate for the Trust was 21.7%. 65.7% of responses were for day case attendances with only 34.3% for inpatient stay with a further breakdown of 41.2% emergency admissions and 58.8% planned care
- At question level, when compared to other organisations surveyed by IQVIA, 24 scores are in the top 20% range. There are 48 scores that are in the intermediate 60% range and 7 in the bottom 20% range.

MTW Survey 2024 overall results compared to national average



Exceptional people,
outstanding care

This section of the report summarises MTW's highest and lowest score results for the 2024 survey results

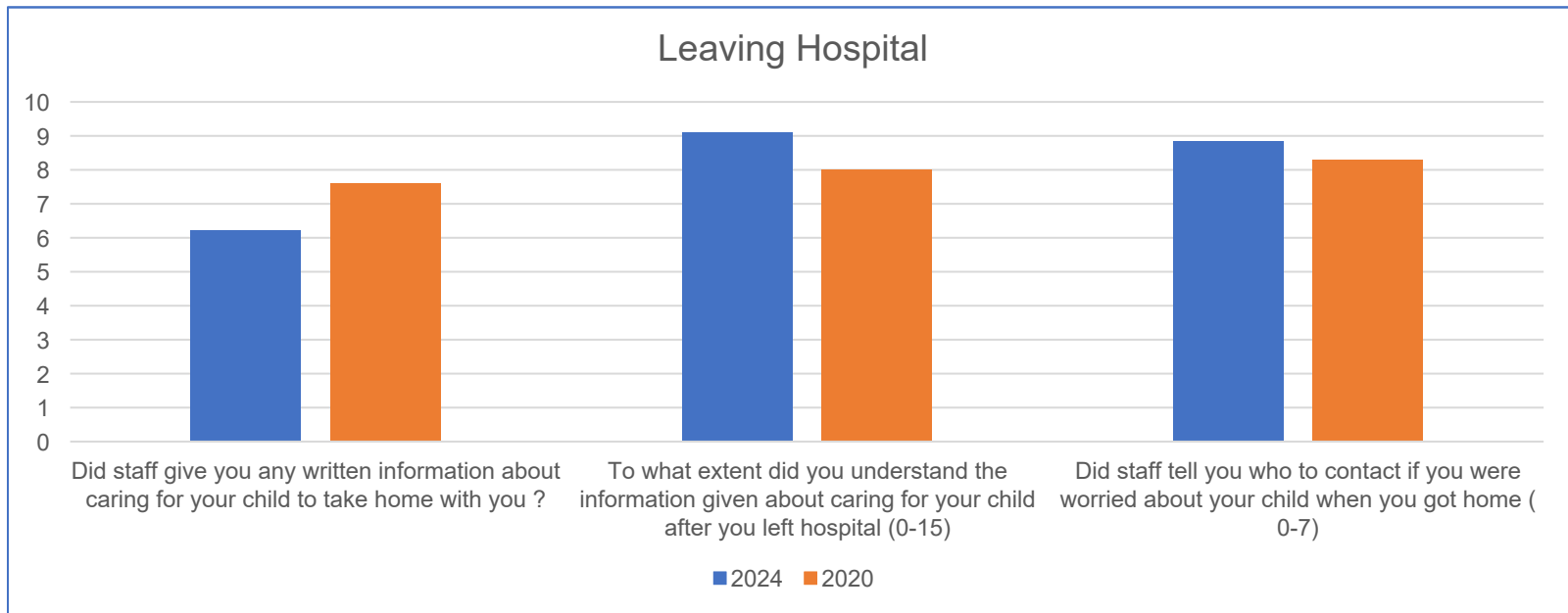
| Top 5 Questions | Score |
|--|-------|
| Q28 Did any of the following bother you when you were in the waiting area? Something else | 9.89 |
| Q43 For most of their stay in hospital, what type of ward did your child stay on? | 9.85 |
| Q46 Were you able to be with your child as much as you wanted to? | 9.66 |
| Q47 Did staff caring for and treating your child introduce themselves? | 9.55 |
| Q36 Did any of the following bother your child while you were in the waiting area? Noise from other patients | 9.50 |

| Bottom 5 Questions | Score |
|--|-------|
| Q29 Did any of the following bother you when you were in the waiting area? Nothing bothered me | 2.93 |
| Q24 Did any of the following bother you when you were in the waiting area? How long you had to wait | 4.32 |
| Q41 Did any of the following bother your child while you were in the waiting area? Nothing bothered my child | 4.53 |
| Q12 Did staff give you any activities to do while you were in hospital? | 4.84 |
| Q57 Did staff play with your child or do any activities with them while they were in hospital? | 5.69 |

Areas under review following 2024 survey results

1. Leaving Hospital

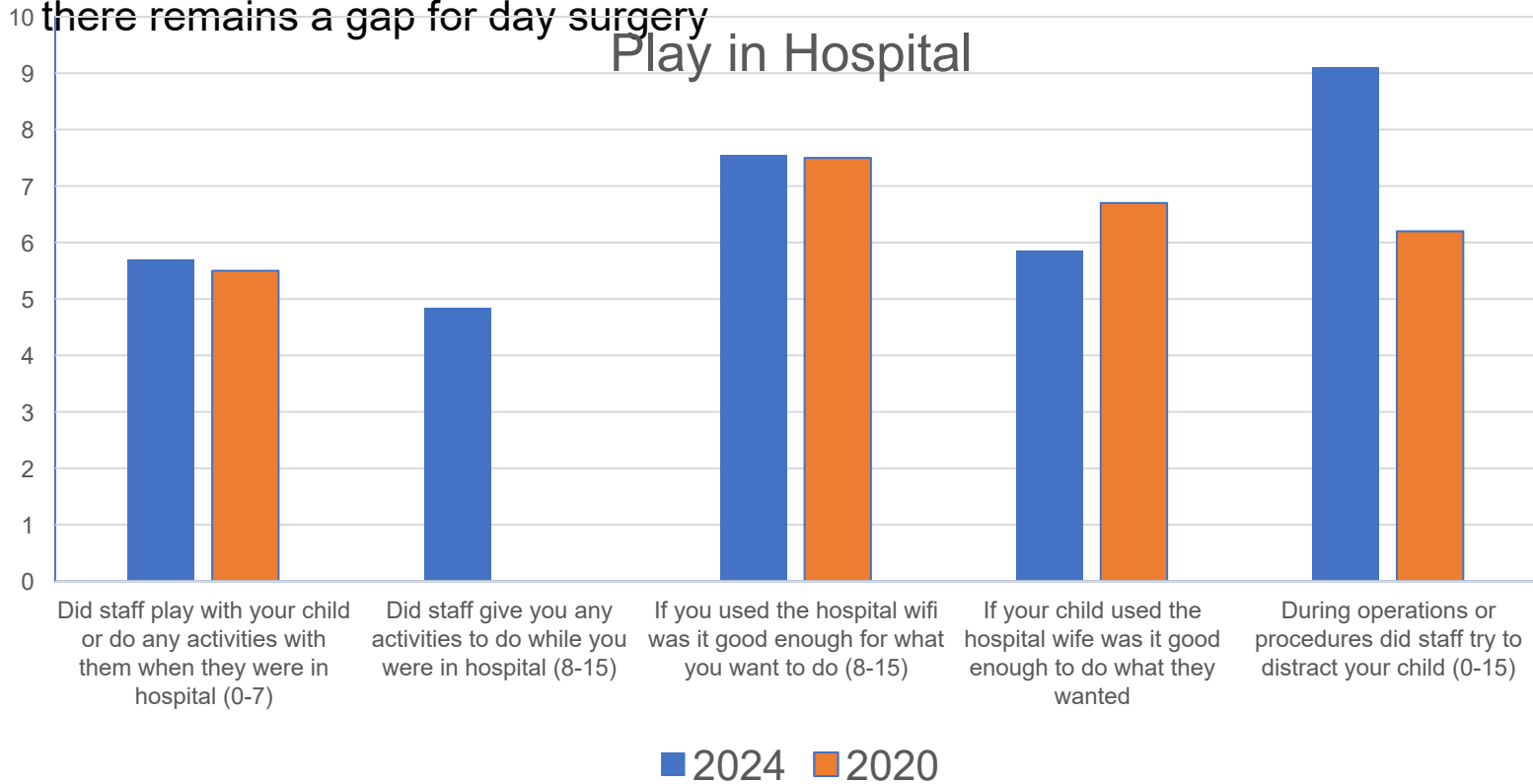
Sustained improvement in information sharing and safety netting from 2020 survey – however further work required on written information



Areas under review following 2024 survey results

2. Play in hospital

The play team has increased to support the inpatient, outpatient and ED areas however there remains a gap for day surgery



Previous results from the NHS Children and Young People Survey 2020



NHS Children and Young People's Patient Experience Survey

Results for Maidstone and Tunbridge Wells NHS Trust

Where patient experience **is best**

- ✓ **Hospital Wi-Fi:** parents/carers feeling that the hospital Wi-Fi was good enough for their child to entertain themselves
- ✓ **Hospital Wi-Fi:** patients feeling the hospital Wi-Fi was good enough to do what they wanted
- ✓ **Quiet hospital wards:** patients feeling it was quiet enough to sleep on the ward
- ✓ **Access to facilities:** parents or carers rating of the facilities for parents or carers staying overnight
- ✓ **Hospital food:** patients liked the hospital food

Where patient experience **could improve**

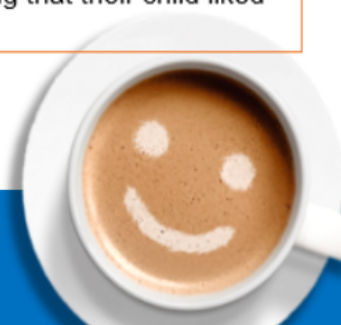
- **Play and activities:** parents or carers feeling that staff played with their child while they were in hospital
- **Enough things to do:** parents or carers feeling that there were enough things for their child to do in hospital
- **Admission dates:** patients were given a choice of admission dates
- **Operations & procedures:** parents/carers feeling staff played with child or distracted them during operations/procedures
- **Hospital food:** parents or carers feeling that their child liked the hospital food provided

These questions are calculated by comparing your trust's results to the national average. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average.

"Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of people who were discharged from an NHS acute hospital between 1st November 2020 and 31st January 2021. Between March and July 2021 a questionnaire was sent to 695 recent patients. Responses were received from 208 patients at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

86 Children and Young People's Patient Experience Survey | 2020 | | RWF | Maidstone and Tunbridge Wells NHS Trust



Exceptional people,
outstanding care




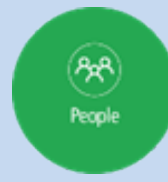


2020 - Children and Young People's Survey Action Plan

| Next steps : Recommendations | Actions | Completion | RAG |
|--|--|--|-----|
| Play and activities Review of current play service and development of roles and support for areas including inpatient, ambulatory and ED | <ul style="list-style-type: none"> Development of training pathway for play apprenticeship programme Deep dive into play services and optimisation of pathways Play guideline to be developed Roles and responsibilities for Health Play Specialists to be reviewed Funding for play specialist for surgery to be considered in future business cases - not managed by paediatrics. | <ul style="list-style-type: none"> Play apprenticeship training implemented successfully Play guideline approved and ratified Job plans reviewed and play support implemented for medical procedures to support distraction including phlebotomy / MRI Play specialist role implemented for Gastroenterology surgery as paediatric directorate specific Further investment required of play services within paediatric surgery. | |
| Improve the involvement of parents and carers in their child's care | <ul style="list-style-type: none"> Patient passport to be implemented for CYP with complex health conditions alongside learning disabilities Parental / young person involvement in professionals meetings to support advocacy Implementation of negotiated care with CYP and their families including attendance on ward rounds Implementation of Single Point of Contact for complex cases | <ul style="list-style-type: none"> Fully implemented NEW update - Patient passport under discussion currently with trust lead to link to trust processes including flagging on sunrise and to support transition | |
| Review of information provision for young people and their families on next steps post discharge and self care in the home for non- surgical related attendances . | <ul style="list-style-type: none"> Update ambulatory leaflets to include contact details and opening times Leaflet lead to be implemented to review all leaflets Process for leaflet review, publication and implementation to be developed To be added to agenda for Paediatric and Neonatal Policies and Guidelines Group | <p>Leaflets added to PGG and NGG groups for review</p> <p>All new leaflets now added to appropriate guideline to ensure updated when reviewed</p> | |
| Improve the provision of hospital food – although patients were happy, parents have raised as an area for improvement | <ul style="list-style-type: none"> Menu review to be undertaken including family and young peoples comments Consider changing cold menu and hot menu times around to support normal family processes Snack boxes to be available for all areas | <ul style="list-style-type: none"> Menu review completed and adapted Meal times changed to support family requests Facilities for parents to store or heat up meals from home placed within the ward for ease of access and microwaves and fridges updated Sandwiches and snacks in place throughout all areas | |

2024 - Children and Young People's Patient Experience Survey Action Plan

| Next steps : Recommendations | Actions – Assurance provided at the Experience of Care Oversight Group. | Responsible | Completion | RAG |
|--|---|---|--------------|-----|
| Leaving Hospital: Investigate why some parents / carers stated they were not given written information about caring for their child after discharge. Review the current materials and processes to ensure information is relevant and accessible to all parents and carers. | <ul style="list-style-type: none"> Ongoing work across the ICB and other trusts led by MTW for implementation of Healthier Together patient information website and app Delays in leaflets being authorised through PILG and updated by other areas ie surgery – pathway now in place to reviewed alongside guidelines and publish in appendix to ensure reviewed and updated regularly Trust websites being updated currently | Head Of Nursing for Paediatrics – Healthier Together and Medicine Matron for Planned Care - Surgery Patient Experience Lead | April 2026 | |
| Looking after you in hospital: Review provision of activities and toys available for children and young people. Where possible, seek to offer a variety of activities for patients to take part in during their stay. | <ul style="list-style-type: none"> Focus on Day surgery as currently no allocated play specialist in post Review of surgical pathways underway with Planned Care Matron to optimise play therapy support for planned care procedures To review at October 2025 Safer Staffing Reviews | Paediatric Matron for Planned Care | October 2025 | |
| The waiting area: Address the issues that are bothering children and young people whilst in the waiting areas. | <ul style="list-style-type: none"> ED working group in place to look at improving patient flow between departments on both sites especially to the inpatient ward Riverbank capacity and layout under review as no waiting area for surgical patients and on risk register Review of Treetops underway to optimise space configuration | Paediatric ED Matron Paediatric Acute Matron Paediatric Consultant ED and PAU | October 2025 | |
| Facilities: In light of lower overall scores for access to food whilst in hospital, appraise the choice of food and how it is made available. Adjust if needed in order to provide healthy options that meet a variety of dietary restrictions or requirements. | <ul style="list-style-type: none"> Parents concerned they have nowhere to access food out of hours when shops are closed on site and no restaurant access. To work alongside the Trust PLACE working group to review Access to hot drinks for parents on day surgery wards to be reviewed Inpatient Parent facilities recently reviewed and updated to include microwave, fridges and hot drink availability 24 hours a day and moved within the ward area | Quality & Technical Manager for Facilities (PLACE lead) Matron for Planned care | July 2025 | |
| Facilities: Review the coverage and strength of the Wi-Fi signal to ensure all patients have sufficient access for their needs. | <ul style="list-style-type: none"> Wi-Fi updated within the trust for all the areas involved in this survey – Information to be displayed in all areas for patients and parents to access trust Wi-Fi Patient information for families to be updated to include information on Trust Wi-Fi | Ward Managers | June 2025 | |

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|--|--|--------------------------|-------------------|--------------------------|--------------------|-------------------------------------|
| Title of report | Summary report from the Quality Committee, 21/05/25 | | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | | | | | | |
| Executive lead | Maureen Choong, Non-Executive Director | | | | | |
| Presenter | Maureen Choong, Non-Executive Director | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|--|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The Quality Committee met (virtually, via webconference) on 21 st May 2025 (a ‘main’ meeting). | |
| | The Committee considered the following topics: The Patient Safety Oversight Group Report, The Experience of Care Group Report, Maternity and Neonatal Care Oversight Group, Review of the draft Quality Accounts 2024/25; and NHS Children and Young People’s Patient Experience Survey 2024: Management Report. | |
| | The Committee noted that the reports presented, demonstrate that controls relating to Principal Risk 2,3, and 4 of the Board Assurance Framework are demonstrating levels of effectiveness. | |
| Any items for formal escalation / decision | N/A | |
| Appendices attached | There are no appendices to this report. | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| | | |

| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | <p>PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes</p> <p>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</p> <p>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</p> <p>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.</p> |

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| Links to Trust Risk Register (TRR) | <p>Please list any risks on the Trust Risk Register to which this report relates</p> <ul style="list-style-type: none"> • 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 21st May 2025 (a 'main' meeting).

The key matters considered at the meeting were as follows:







- The Committee reviewed the **actions from previous meetings**.
- The Committee had regard to the Board Assurance Framework (BAF) throughout the meeting.
- The Chief Medical Officer presented the **summary report from the Patient Safety Oversight Group**, wherein it was noted that there had been a Never Event in February regarding a wrong site biopsy in interventional radiology, and another in March relating to a wrong route administration of medication however, it was noted that no harm was caused and measures were in place to ensure these were not repeated. The group also heard that the Patient Safety Oversight Group received a presented from the VTE Patient Safety Lead which provided assurance that the same VTE risk assessment processes and systems were consistent between the Trust and Fordcombe Hospital; that they were updated on the positive improvement in Falls and Tissue Viability; that the Lead Practitioner for Deteriorating Patients confirmed that Martha's Rule had gone live at the Trust with two calls received to date with the system working smoothly; and that there were issues with the non-compliant water systems at the Trust, including both Maidstone and Tunbridge Wells Hospitals, wherein a discussion was held confirming that the water filters were only a temporary fix and were considering using some chemical dosing with chlorine dioxide in the water system at Tunbridge Wells to help improve this.
 - ❖ The Committee noted that this demonstrated a level of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4 and noted that there was ongoing work regarding the non-compliant water systems.
- The Chief Nurse then presented the **summary report from the Experience of Care Oversight Group**, which included that there had been an increase in the number of complaints which was constantly being monitored; that they undertook a comprehensive session with Healthwatch around the experiences of care homes, specifically the discharge process and the challenges regarding medication and poor communication, and that the Deputy Chief Nurse, Quality and Experience, was in discussion with Healthwatch to see how this could be improved moving forward; that an overview of the Experience of Care Strategy was received following a year of implementation, which provided a helpful insight of the work undertaken to deliver this; that the Patient First Team were going to attend the **IHA Quality and Patient Safety Forum** and provide a presentation for this event; and that the Patient Pledge was agreed. A discussion was also held amongst the Committee regarding the Trust's interpretation service and the ongoing work which was being undertaken to ensure that it meets the demands of the wider demographic.
 - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risk 4.
- The **summary report from the Maternity and Neonatal Care Oversight Group** was then presented, where the group heard that there had been an increase in the number of suspensions of service at Crowborough and Maidstone Birthing Centres and Homebirths; that there had been an increase in Total Parenteral Nutrition (TPN) incidents in neonates which was being monitored and that safety action 7, relating to the lack of Local Maternity and Neonatal System (LMNS) funding for Maternity and Neonatal Voices Partnership (MNVP) infrastructure, was currently rated amber and was a system-side risk; that that CNST were providing quarterly reports to provide assurance that their plan was being delivered; that the 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status remained 100%; and that swab compliance was 100% compliant for the past four months.
 - ❖ The Committee noted that this demonstrated a level the effectiveness of controls for the Board Assurance Framework, Principal Risk 2, which relate to patient outcomes.
- The Committee noted the **draft Quality Accounts 2024/25** and agreed to provide the Director of Quality Governance with any comments or feedback by 5pm Friday 23rd May.
- The Divisional Director of Nursing and Quality, Paediatrics, Gynaecology and Sexual Health presented the **NHS Children and Young People's Patient Experience Survey 2024: Management Report**, and highlighted that the 2024 overall results for the national average showed an improvement in all areas, apart from the waiting area and leaving hospital; that following further review and analysis, the team identified that the areas which could improve, including play and activities, related specifically to day surgery which could be a reflection of the increase in day surgery figures; and that the area to further improve relating to leaving hospital

was around written information, which was being investigated as part of the action plan. A conversation was held around the specific concerns raised, and it was noted that these included the speed and strength of the WIFI available throughout the hospitals, as it was unable to provide sufficient access to meet the demands of how the majority of children wish to use the internet; and the lack of out of hours facilities for parents to make food, as the current amount and positioning of kettles and microwaves needed re-evaluating.

- The **report from the Quality Committee 'deep dive' meeting, 09/04/25** was noted.
- The Committee considered the **assurance provided relating to the Quality BAF risk** and agreed that the current positions were accurate and on a health trajectory of becoming adequate.
- The Chair conducted an **evaluation of the meeting** wherein Committee members noted that referring to the BAF at the beginning and end of the meeting provided a helpful review of the position; that the exception reporting and the cover pages were very clear and insightful throughout; and that it would be beneficial for more members and attendees to be more involved within the discussions.

DRAFT

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|--|--|-------------------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | Maternity Report relating to the Perinatal Quality Surveillance Model | | | | | |
| Board / Committee | Trust Board | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-10 | | | | | |
| Executive lead | Jo Haworth, Chief Nurse | | | | | |
| Presenter | Megan Fradgley and Jessica O'Reilly | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|--|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| Executive Summary | |
|---|--|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | <p><u>PQSM Overview</u></p> <ol style="list-style-type: none"> 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 12 May 2025. These are summarised in the 3A report at pages 2-4. |
| Any items for formal escalation / decision | <ol style="list-style-type: none"> 1. The Board is invited to: <ol style="list-style-type: none"> a. review the attached May (March 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. |

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| Appendices attached | 1. Appendix 1 - May (March data) 2025 PQSM report | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| Maternity and Neonatal Care Oversight Group | 12 May 2025 | For review by the Trust Board |

| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation |
| Links to Trust Risk Register (TRR) | 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 | Fulfil the requirements of the Maternity Incentive Scheme |

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



Maidstone and
Tunbridge Wells
NHS Trust

| PQSM | | | |
|--|--|---|--|
| Report date: May 2025 March data | | PQSM Report lead: Jessica O'Reilly | Actions: |
| 1a | Alert (Include actions taken/mitigation s) | <p>Incident management :</p> <ul style="list-style-type: none"> 3 moderate harm incidents reported in month 2 escalated to PSIIs, 1 AAR, and 1 MDT roundtable approach. <p>Operational: There were a total of 17 suspension of service reported in month:</p> <ul style="list-style-type: none"> Crowborough Birth Centre suspensions- 1 x 24 suspension – 3 women affected - 1 woman had a home birth instead, 2 women delivered at TWH. Maidstone Birth Centre suspensions – 1x24 hour suspension (which was part of a 36 hour suspension commencing on 28/2) - 1 women affected, delivered at TWH. Home birth suspensions - A total of 13 suspension of service (6 day time suspensions and 7 overnight)– One due to midwives needed in the unit, the rest due to community staffing. 2 women impacted – one delivered in MBC, 1 delivered at TWH. <p>Complaints and FFT: 2 new complaints in month relating to clinical treatment and inconsistent communication.</p> <p>CNST: Safety Action 7 requires escalation to Trust Board. This safety action currently has an amber RAG rating due to lack of LMNS funding for MNVP infrastructure. If this is not resolved by Year 8 of the scheme, this will affect the Trust's ability to claim compliance.</p> <p>DOC Non compliance of 1st and 2nd DOC saw an increase in March, going forward process of oversight will be established to ensure no further breaches. Further training for new staff members initiated.</p> <p>Risk Register Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. (15)</p> <p>Training Neonatal consultant (71%) Specialist trainee and permanent NNU doctor (65%) training compliance due to new starters- plan in place</p> | <p>Incident management :</p> <ul style="list-style-type: none"> immediate learning from case review shared with staff <p>Complaints and FFT: Action plans being produced by complaints team.</p> <p>CNST : For addition to the risk register and creation of action plan in collaboration with the LMNS.</p> <p>Risk Register IOL risk as part of current working party. In the process of being updated.</p> |

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| 1b | Assurance | <p>CNST:</p> <ul style="list-style-type: none">• A quarterly report has been produced to ensure effective oversight of progress for Year 7 of the Scheme. All safety actions have been rag rated with action plans where required. <p>PMRT:</p> <ul style="list-style-type: none">• We remained 100% complaint with an external reviewer being present <p>Operational:</p> <ul style="list-style-type: none">• 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status remained 100% <p>Training:</p> <p>Compliance for Fetal monitoring and PROMPT compliance was met across all professionals, neonatal team have action plan in place for neonatal training.</p> <p>Complaints and FFT:</p> <ul style="list-style-type: none">• Increase in FFT responses in month• 0 breached complaints in month | |
|----|-----------|---|--|

| | | | |
|----|--------|--|--|
| 1c | Advise | <p>Risk Register:</p> <ul style="list-style-type: none">• 0 closed risks in month <p>Incident management:</p> <ul style="list-style-type: none">• No closed PSII reports in month• No AARs published• No MNSI reports published in month (two drafts received, awaiting final report) <p>PMRT:</p> <ul style="list-style-type: none">• No Reports published in month, two cases met PMRT criteria in March. <p>CNST:</p> <ul style="list-style-type: none">• A rag rating has been performed on all safety actions since the Year 7 guidance published, with action plans for all amber ratings. <p>Staffing</p> <ul style="list-style-type: none">• Birth to midwife ratio slight increase from 1:21 to 1:22• Slight reduction in sick leave from 4.04% to 4.01%• Annual leave rate remained above the trust target of 15% at 16.13%• Overall the unavailability of staff reduced from 37.61% to 29.822%• The use of bank and agency was stable at 31.7%, however the percentage of agency use reduced from 13% to 8.3%.• Consultant on call attendance at clinical scenarios 90.9% (one incident out of 11). <p>Complaints, FFT and service user feedback:</p> <ul style="list-style-type: none">• Themes from service user feedback relating to information sharing, pain relief options, lack of debrief service and discharge processes. | <p>PMRT:</p> <ul style="list-style-type: none">• PMRT processes followed. Quarterly report produced. <p>CNST:</p> <ul style="list-style-type: none">• MIS Lead meeting with all safety action leads to ensure progress against actions. <p>Staffing:</p> <ul style="list-style-type: none">• Incident regarding consultant on call reviewed by MDT and feedback given to staff involved. <p>Complaints and FFT:</p> <ul style="list-style-type: none">• Action plans created for all these themes to ensure responsiveness to service user concerns. |
|----|--------|--|--|

CQC Maternity Ratings

The Tunbridge Wells Hospital at Pembury

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

Maidstone Hospital

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

Crowborough Birthing Centre

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

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

Maternity Risk Register

(Extracted from risk register, rated 8 and above)

Closed

Nil in MARCH

New Risks

Nil in MARCH

Risks rated 8 and above

| Risk ID | Risk Identified | Inherent Risk Rating | Modified Risk Rating | Target | Risk Open Date | Target Completion Date |
|---------|---|----------------------|----------------------|--------|------------------------|------------------------|
| 1182 | Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. | 15 | 15 | 3 | 12.07.2025 | 31.02.2025 |
| 3269 | Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus | 15 | 15 | 6 | *Now closed in April * | |
| 3242 | Possible delays in accessing the second theatre in the Delivery Suite | 16 | 12 | 6 | 16.10.2024 | 16.12.2026 |
| 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 | 24.01.2025 | 31.12.2025 |
| 3358 | Risk to patient safety due the number of expired guidelines within the Directorate | 16 | 12 | 8 | 24.01.2025 | 02.06.2025 |
| 3310 | Cervical length screening not provided for all women with a previous caesarean section at full dilatation. | 12 | 12 | 2 | 04.12.2024 | 30.05.2025 |
| 3308 | Uterine artery dopplers not provided for all high risk women at anomaly scan | 12 | 12 | 3 | 04.12.2024 | 30.06.2025 |
| 3370 | Element 1 saving babies lives - non compliance with ultrasound pathway for all smokers | 12 | 12 | 2 | 04.12.2025 | 30.06.2025 |
| 1275 | Swab, needle and instrument count documentation is not being completed in line with Trust policy. | 16 | 12 | 4 | 01.03.2023 | 01.08.2025 |
| 3071 | Out of area booking process and procedure currently demonstrates a risk to mothers and babies | 12 | 9 | 8 | 21.02.2024 | 31.12.2025 |
| 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 | 07.10.2025 | 01.05.2025 |
| 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 | 09.02.2024 | 03.06.2025 |
| 1282 | Exposure to Entonox | 12 | 8 | 4 | 14.03.2025 | 30.09.2025 |
| 3072 | The current interpreting service provided by the Trust does not fulfil the needs of the maternity services at MTW. | 12 | 8 | 4 | 23.02.2024 | 31.05.2025 |

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

| Incidents Graded Moderate or above | | | 3 |
|------------------------------------|---|---|--------------------------------|
| ID | Incident Summary | Actions/Learning | Date Clinical Incident outcome |
| 38022 | Type 1 diabetic P1 D3 following SVD Seizure, hypoglycaemic no CBGs been recording for 2 days on her chart Tachycardia of 124 then 115 not followed up or escalated Insulin not prescribed | <ul style="list-style-type: none"> Ensure we are recording cbgs on her chart Escalating abnormal observations | AAR commissioned |
| 38264 | Mother was admitted to ITU following emergency LSCS (700mls) return to theatre where large retroperitoneal haematoma was identified. Total blood loss 2300mls. | No learning identified. | Awaiting PSRIG |
| 39207 | 25/40 BBA. | <ul style="list-style-type: none"> Ensuring neonatal team are at arrival with transport incubator | <i>MDT roundtable approach</i> |

Escalations to PSIRG in March

| Escalations to PSIRG | | | 6 |
|-----------------------|---|---|---|
| ID & Incident Summary | Summary | Actions/Learning | Outcome |
| 39274 | Oral morphine was administered via intravenous cannula. | <ul style="list-style-type: none"> Oral ENFIT purple syringes sourced and placed on all clinical areas Caps for the oral medication bottles were sourced from pharmacy and applied. Therefore only oral purple ENFIT syringes can be used for dispensing the medication. This practice has been updated within all clinical areas Liaised with stores to ensure that purple syringes are added to ward stock list for all clinical areas Posters put up instructing all liquid meds to be given via purple ENFIT enteral purple syringe Take 5 notification to all staff regarding medication management and practice Notification to university due to student involvement in incident Practice development involvement for student midwife and registered midwife relating to practice Ensured PMA support if offered IV drug labels sourced and communications shared to staff regarding their use in practice Patient Safety Incident Investigation (PSII) commissioned | <i>Commissioned Patient Safety Incident Investigation (PSII) – Meets national PSIRP for never event</i> |
| #39207 | 25/40 BBA. | <ul style="list-style-type: none"> Ensuring neonatal team are at arrival with transport incubator | <i>MDT roundtable approach</i> |
| 37028 | Late miscarriage at 16+6 | <p>Omissions; Missed early consultant review (should have been seen at 12 weeks) Missed referral at booking for cervical length scans due to previous LSCS at full dilatation (should have been completed at 18 weeks) Missed referral to safeguarding and ASF created at booking and again at 16 week community midwife appointment</p> <p>Safety Actions taken; 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</p> | <i>Commissioned AAR</i> |

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| 38567 | Category 1 Emergency Caesarean Section under GA for fetal bradycardia with neonatal unit admission for severe meconium aspiration. Baby transferred out for ECMO. 41+2 weeks gestation. | Reviewed with MDT on 11/3/2025 and the review group agreed no care and service delivery issues were identified. | No further investigation |
| 38264 | Mother was admitted to ITU following emergency LSCS (700mls) return to theatre where large retroperitoneal haematoma was identified. Total blood loss 2300mls. | Reviewed with MDT (including Obstetric Lead for Maternity Risk and Chief of Service) on 11/03/2025. The review group did not identify any care issues that impacted the outcome. The following positive learning points noted: Consultant present during EMCS, and took over following delivery of baby. Deterioration recognised quickly (MEWS) and acted upon Return to theatre timely and appropriate Appropriate discussion/counselling regarding PPH risk factors prior to delivery | <i>Commissioned Patient Safety Incident Investigation (PSII)</i> |
| 38554 | Mother delivered by category 2 Emergency Caesarean Section due to CTG concerns and labour progress. Blood loss following delivery 300ml. Day 4 deteriorated on postnatal ward and was returned to theatre where 1000ml was discovered in the abdomen. Evacuation of haematoma via CEPOD. Multiple ongoing delays and no escalation for deteriorating patient. | Care issues Lack of senior review on postnatal ward Tachycardia post EMCS and no bloods taken for 36 hours (when taken Hb 69) Delay in discussing with on call consultant Delay in accessing CEPOD Issues with interpretation and ?impact on care as non English speaker Multiple missed opportunities to escalate and multiple delays in appropriate care provision | |

Patient Safety Incident Review Framework



PSIRF

Ongoing Patient Safety Incident Investigations (PSIIs)

2** Patient Safety Incident Investigations (PSIIs) declared in March.

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 |
| December | #32159 | Mother experienced Psychosis, found to be hyponatraemic | White: British |
| March | #39274 | Mother had oral morphine administered through IV cannula in error | White: British |

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

Cases closed in March= 0

Patient Safety Incident Review Framework



PSIRF

Ongoing After Action Reviews (AARs)

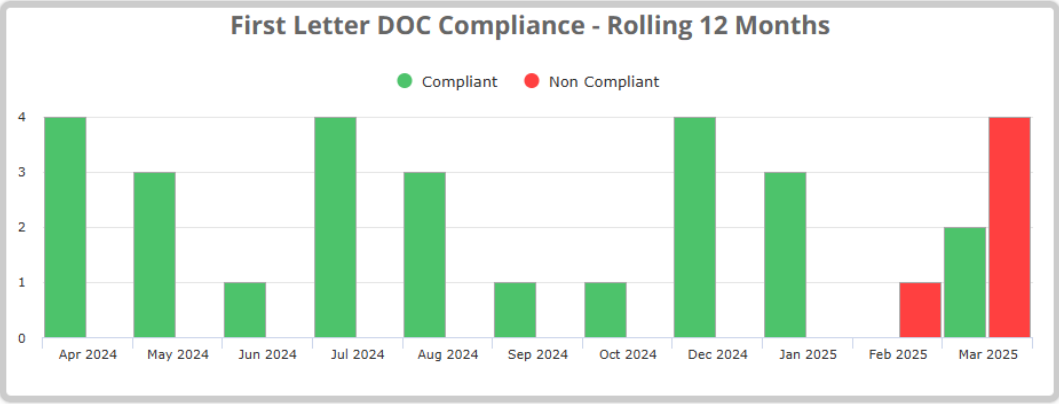
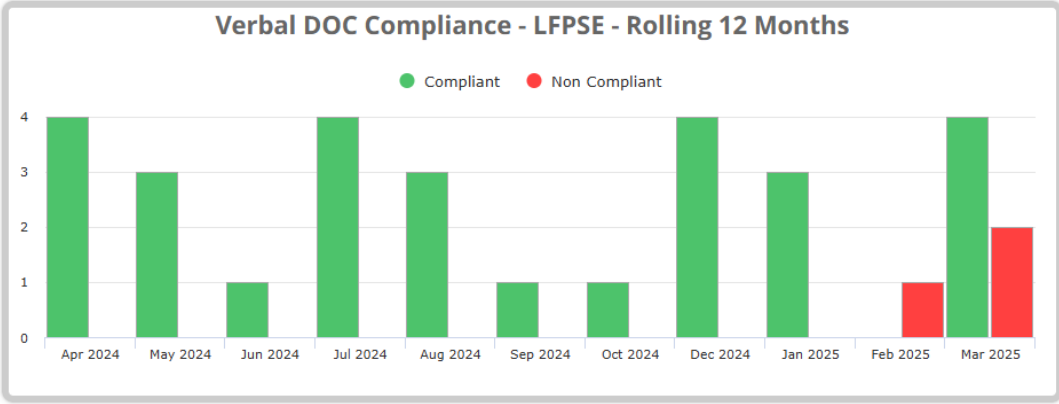
1 AAR's declared in March.

Current open incidents :

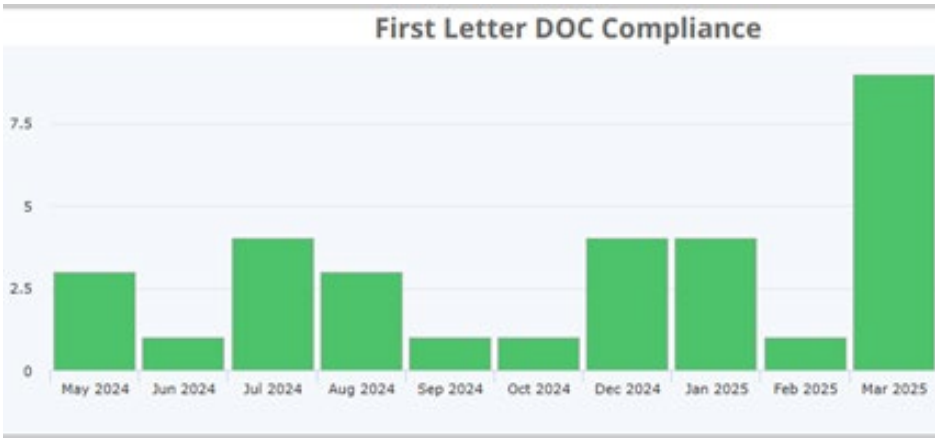
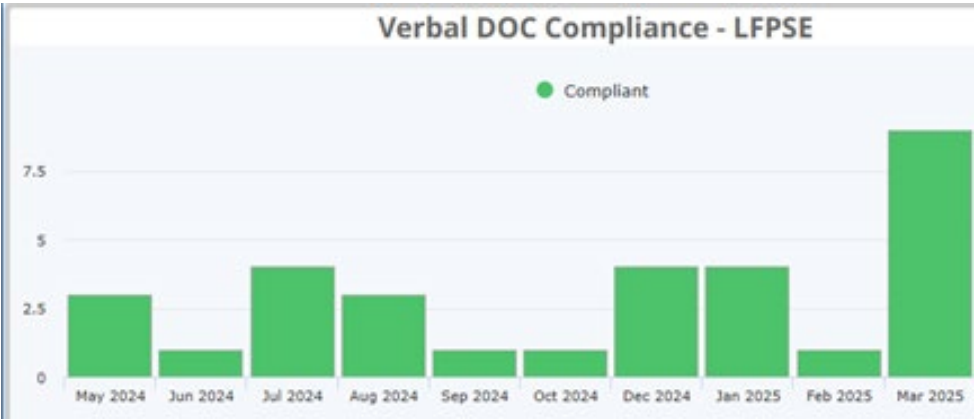
| Month | InPhase | Description | Maternal ethnicity |
|----------|---------|--|----------------------------|
| November | #30190 | Mother experienced 3b tear and 1700ml PPH | White British |
| January | #32197 | Mother experienced 3000ml PPH | White British |
| January | #34252 | Mother experienced 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 |
| January | #34331 | Baby found to have skull fracture and experienced seizures following emergency LSCS. | Any other mixed background |
| January | #34013 | Mother experienced 1600ml PPH | White British |
| February | #37542 | Mother found to be hyponatraemic after drinking 3300mls water. | White British |
| March | #38022 | Mother with Type 1 Diabetes experienced hypoglycaemia and seizure | White British |

Cases closed in March = 0

Duty of Candour



Non compliance of 1st and 2nd DOC saw an increase in March, going forward process of oversight will be established to ensure no further breaches. Further training for new staff members initiated.



Maternity & Newborn Safety Investigations (March 2025)



MNSI Reports published in March

No reports were published in March

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, we are now awaiting final reports

Patient Safety Incident Review Framework



Ongoing Patient Safety Incident Investigations (PSIIs)

| 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 |
| December | #32159 | Mother experienced Psychosis, found to be hyponatraemic | White: British |
| March | #39274 | Mother had oral morphine administered through IV cannula in error | White: British |

* We have received the draft report for #23178, #28793, #28570 and #30030

Patient Safety Incident Review Framework



Ongoing After Action Reviews (AARs)

| Month | InPhase | Description | Maternal ethnicity |
|----------|---------|--|----------------------------|
| November | #30190 | Mother experienced 3b tear and 1700ml PPH | White British |
| January | #32197 | Mother experienced 3000ml PPH | White British |
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| January | #34013 | Mother experienced 1600ml PPH | White British |
| February | #37542 | Mother found to be hyponatraemic after drinking 3300mls water. | White British |
| March | #38022 | Mother with Type 1 Diabetes experienced hypoglycaemia and seizure | White British |

Patient Safety Incident Review Framework (March 2025)



Cases meeting PMRT criteria in March within the Trust

| Month | InPhase | Description | Maternal ethnicity |
|-------|---------|--------------------------------------|--------------------|
| March | #38875 | Mother experienced IUD at 29+5 weeks | White: British |
| March | #40031 | Mother experienced IUD at 22 weeks | White: British |

PMRT reports published in March

| InPhase | Description | Grading | Learning |
|---------|-------------|---------|----------|
| / | / | / | / |

100% of perinatal mortality reviews include an external reviewer

**March 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 | 100% |
| 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 | 100% |
| 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 | 1 x 24 hour suspension, day to night. | <p>CBC closed day and night due to unit acuity- note both BC's closed at the same time but homebirths running.</p> <p>X 1 lady chose to have a homebirth instead.</p> <p>X2 births missed on night of the 1/3/25.</p> |
| Maidstone Birth Centre suspensions | 1x 24 hour suspension(this was part of a suspension from 28/2/25 for 36 hours | <p>MBC closed day and night for unit acuity</p> <p>Both BC's closed.</p> <p>No deliveries missed on the 1/3/25 but one missed on 28/2/25.</p> |
| Home birth suspensions | <p>6 day</p> <p>7night</p> | <p>All due to community staffing bar x1 night.</p> <p>X2 births missed - one for midwives needed in unit and she delivered at MBC.</p> <p>-one missed for no community staff available.</p> |

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 | 181 | 172 | 95% |
| Midwife community | 61 | 61 | 100% |
| Midwife Birth Centres | 27 | 27 | 100% |
| Obstetric Consultants | 20 | 20 | 100% |
| Obstetric Doctor | 21 | 21 | 100% |
| Total | 310 | 301 | 97% |

Data as at 31st March 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 | 183 | 178 | 97% |
| Midwife Community | 61 | 61 | 100% |
| Midwife Birth Centres | 27 | 27 | 100% |
| Obstetric Consultant | 20 | 20 | 100% |
| Obstetric Doctor | 51 | 51 | 100% |
| Anaesthetists | 36 | 33 | 92% |
| Anaesthetic Trainees | 3 | 3 | 100% |
| Maternity Support Worker & Nursery Nurse (excl. bank) | 73 | 69 | 95% |
| Total | 454 | 442 | 98% |

Data as at 31st March 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 | 271 (excluding bank) | 266 | 98% |
| Obstetric Consultant | 20 | 20 | 100% |
| Obstetric Doctor | 51 | 51 | 100% |
| Maternity Support Worker | 73 (excluding bank) | 69 | 95% |
| Total | 415 | 406 | 98% |

Data as at 31st March 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 | 71% (plan in place to improve compliance) | 100% |
| Specialist trainee and permanent NNU doctor | 65% (plan in place to improve compliance) | 70% (plan in place to improve compliance) |
| 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.

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 | 96 | - | 90.7 | - | 25.7 | 13.8 |
| Midwifery Services - MSW (2022) - NF102 | - | 90.3 | - | 95.2 | 27.4 | - |
| Midwifery Services - Antenatal Ward - NF122 | 90.5 | - | 90.1 | - | 44.3 | 14.6 |
| Midwifery Services - Postnatal Ward - NF132 | 129.2 | 92.7 | 118.6 | 100 | 39.8 | 4.7 |
| Midwifery TW (four IP rosters) | 104.1 | 91.2 | 97.2 | 96.4 | 31.7 | 8.3 |

| Unavailability (%) | | | |
|--------------------|----------------|-----------------|-----------|
| 29.822% | | | |
| Annual Leave (%) | Sick Leave (%) | Study Leave (%) | Other (%) |
| 16.13% | 4.01% | 3.88% | 5.81% |

| 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 | Mar 25 |
|--|------|--------|---------|--------|--------|--------|--------|--------|--------|
| Birth to midwife ratio | 1:24 | 1:26 | 1:25 | 1:27 | 1:25 | 1:24 | 1:25 | 1:21 | 1:22 |

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 |
| March | 90 | 90.9% | 0 | - | 0 | - | 0 | 0 | None |

Staff Engagement

Annual staff survey (From National NHS Staff Survey 2024 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) | 63% |
| Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to receive treatment (reported annually) | 69% |
| 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. Awaiting updated speciality trainee survey data.

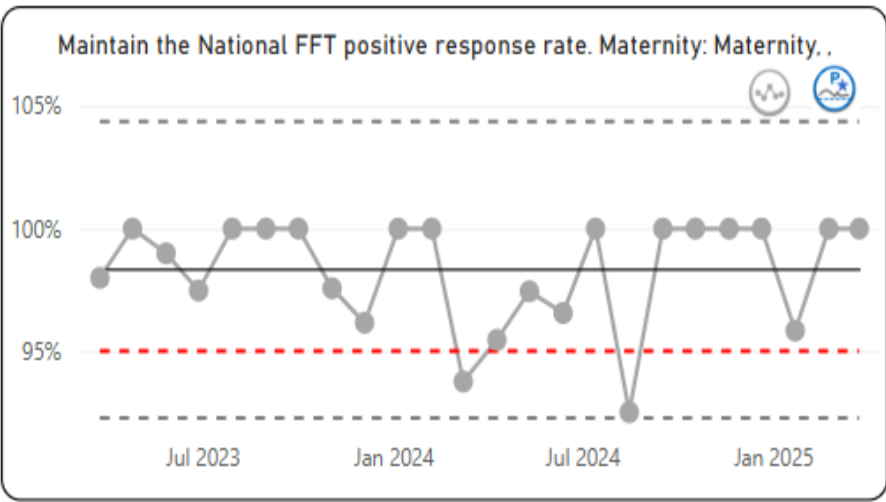
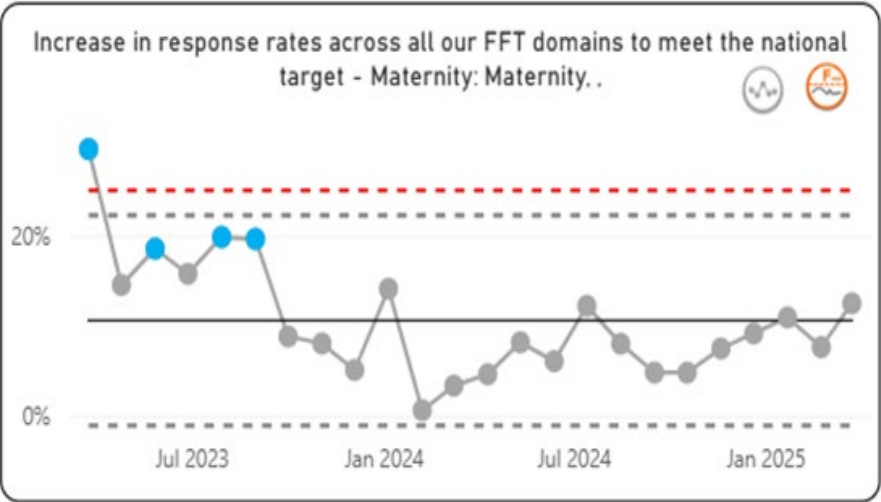
Hearing from women, birthing people, and their families

Service user feedback to include themes of feedback received by MNVP

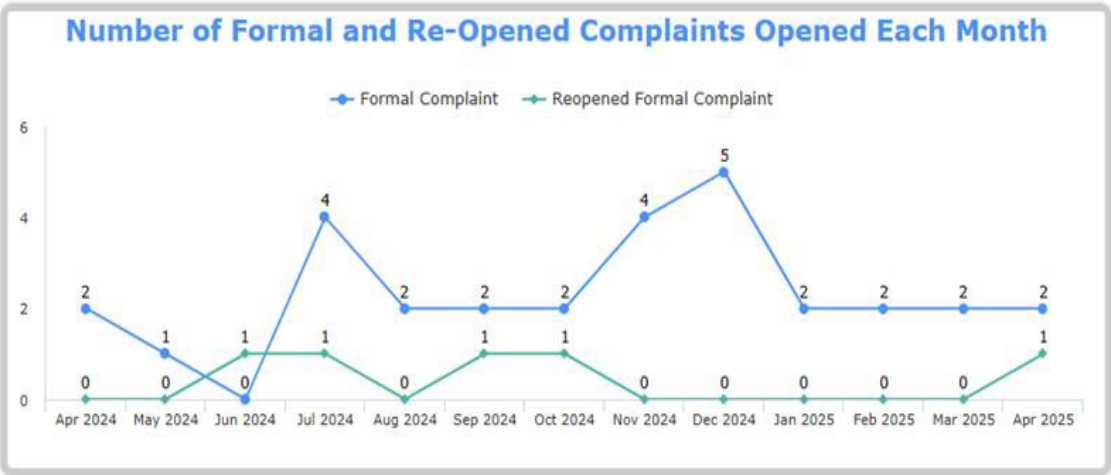
Qrly report not due

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

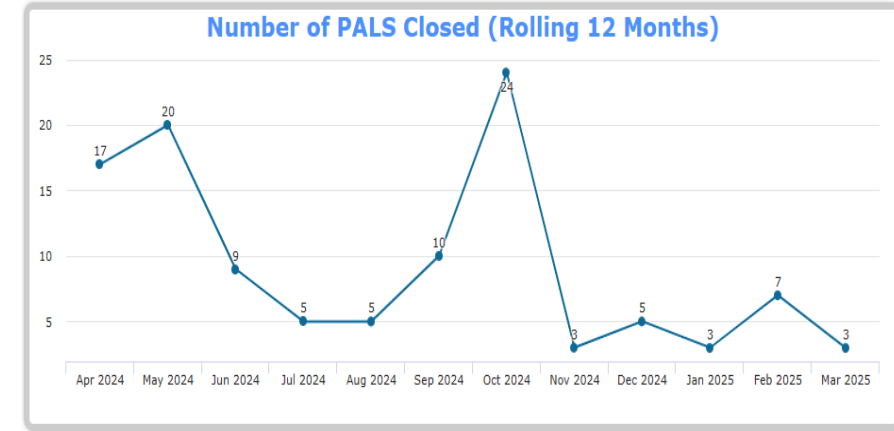
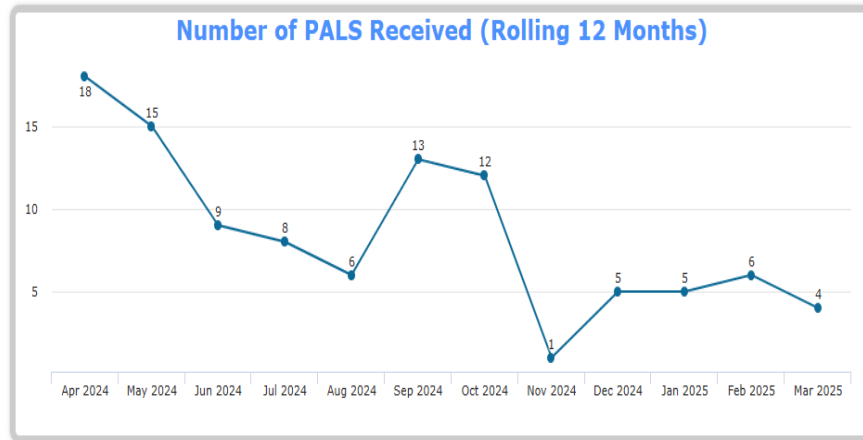
No open in service : 3

No of breached complaints: 0

| New Formal Complaints | | | | | |
|-----------------------|---------|------------|--|--|----------------------------|
| InPhase ID | MM/YYYY | Speciality | Description | Subject | Sub-Subject |
| 24013 | 17/3/25 | Midwifery | Lack of communication regarding induction options, inconsistencies in care and poor care. has concerns around tear on cervix she sustained giving birth. | Clinical treatment | Inconsistent communication |
| | 24/3/25 | Midwifery | Concerns regarding c-section, retained tissue caused substantial bleeding, sent home from A&E. No follow up. | Awaiting action by complaints team at time of writing report | |
| 24036 | | | | | |

PALS

No of PALS cases: 5



Themes/Learning

- Staff values, attitude and behaviours
- Poor communication

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 pain relief options on AN Ward | It has been recognised through service user feedback that a recurring theme exists where patients feel unheard during periods of pain, particularly during induction of labour (IOL) and in the latent phase of labour on the Antenatal (AN) Ward. | ‘Latent phase’ improvement task and finish MDT group which will look at improving pain relief on AN ward. MNVP asked to be involved. |

Progress in achievement of CNST 10 Safety Standards

Maternity Incentive Scheme Year 7 Progress Report – May 2025

Maternity incentive scheme
Maternity Incentive Scheme Progress April 2025
Key issues report

| Report date: 2025 | | Report Lead: MIS Lead – Megan Fradgley | Actions/Mitigations: |
|-------------------|--|--|--|
| 1a | Alert (Include actions taken and mitigation) | <p>Safety Action 7: RAG rating amber due to lack of LMNS funding for MNVP infrastructure.</p> <p>Safety Action 8: RAG rating amber due to enhanced oversight recommended for training compliance and continuing issues arranging anaesthetic training bookings.</p> | <p>Escalation in accordance with SA7, to include inclusion in PQSM, addition to the risk register, creation of action plan in collaboration with LMNS.</p> <p>Monthly education team faculty meetings to monitor compliance.</p> |
| 1b | Assurance | <p>Safety Action 9: Bi-monthly meetings between the perinatal leadership team and Board Safety Champions arranged for 2025 to enable progress against the culture improvement plan. Any support required by the Trust Board will be identified and escalated.</p> <p>Safety Action 9: Claims scorecard triangulation report discussed with Board Level Safety Champions via MNCOG in February.</p> | <p>To be discussed quarterly throughout Year 7.</p> |
| 1c | Advise | <p>Safety Action 4: If neonatal workforce remains below BAPM standards, then we must be able to demonstrate progress against the agreed action plan during Year 7.</p> <p>Safety Action 6: The latest version of Saving Babies Lives is due to be published imminently.</p> <p>Safety Action 10: All appropriate incidents reported to MNSI and NHSR. In these cases the families received information on the MNSI and EN schemes and duty of candour also carried out. DoC performed slower than usual due to staff sickness, but still within reasonable time.</p> | <p>Meeting arranged to discuss progress against action plan.</p> <p>Once published this safety action will require further review to assess for any potential challenges to achieving compliance in Year 7.</p> <p>Report with further detail to be prepared by Patient Safety Team.</p> |

Maternity Incentive Scheme – Year 7 Overview as at May 2025

Oversight for Year 7

- Monthly compliance will be reported via PQSM, with 3A report and rag rated summary to highlight areas of concern.
- Quarterly MIS reports to Trust Board (via maternity governance pathway) to ensure more detailed oversight of each safety action.
- Monthly meetings with key stakeholders to ensure progress made.

| Action No. | Maternity safety action | Overall Progress (RAG)* | Completed | On track | Delayed but in progress | Not started, issues with compliance identified | Total |
|------------|---|-------------------------|-----------|----------|-------------------------|--|-------|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | | | 7 | | | 7 |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | | | 2 | | | 2 |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? | | | 6 | | | 6 |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | | | 18 | 2 | | 20 |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | | | 5 | | | 5 |
| 6 | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | | | 4 | | | 4 |
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | | | 5 | 2 | | 5 |
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | | | 20 | 2 | | 22 |
| 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? | | | 9 | | | 9 |
| 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? | | | 8 | 1 | | 9 |

Maternity Improvement Programme Progress Report – assurance overview

| 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 | <ul style="list-style-type: none"> • Work continues on the amber actions: <ul style="list-style-type: none"> ➢ 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: <ul style="list-style-type: none"> • 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 | | | | | | | | | | | | | | | <ul style="list-style-type: none"> • 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 | |

Q3(7) SBLCB Compliance

| [SBL Team Q7/Q3] Key Issues Report April 2025 | | | |
|--|-----------|--|--|
| Report date: April 25 | | Report Author: [Alison Costello] | Actions taken: |
| 1a | Alert | <p>1. Interventions 4.2 & 4.4 - Hourly review & Fresh eyes for CTG and IIA remain significantly below compliance target of 80%</p> <p>Hourly review 51%, CTG 43% , IIA 67% Improving Trend but below 80% compliance</p> <p>Fresh eyes 22%, CTG 21%, IIA 23% Improving Trend but below 80% compliance</p> <p>1. Interventions 2.6 & 2.14 All pregnant women should have BP measurements performed on a digital device validated for use in pregnancy – Not able to fully meet standard on SBLCB</p> <p>1. Intervention 2.7 to provide Uterine artery dopplers for high risk women on growth assessment pathway – compliance not met with this</p> <p>1. Intervention 2.11 Staff training on Growth assessment – Audience errors on MTW learning platform hence data unreliable</p> <p>1. Intervention 5.14 Continuity of Carer – update no funding to extend existing Phoenix Team to all service users</p> | <p>Take five sent out regarding this and relevant guidelines to be updated</p> <p>Action group meetings commenced to develop improvement strategy – awaiting SBLCB vs 3.2</p> <p>Welch Alyn machines validated and most CTG machines in place for acute service. Purchase plan complete but awaiting funding approval-held devices to replace manual BP – Monies held till April 2025 Budget</p> <p>T&F group to evaluate pathway underway since Jan 25 – on risk register as no USS capacity to provide this at present</p> <p>Work on-going with workforce & MTW learning to correct issue – new staff positions and department cost coding created issue</p> <p>Point added for escalation purposes</p> |
| 1b | Assurance | <p>1. Below compliance for:</p> <ul style="list-style-type: none"> Intervention 1.4 smokers that have an opt out referral @ booking Intervention 1.6 % smokers referred that set quit date Intervention 1.9 Annual staff update “Very brief advice” Intervention 6.2d Specialist staff training for Team that provide CGM to patients | <p>Action Plan – QI project to improve rates Swap2Stop programme commenced Jan 2025</p> <p>Training compliance email to staff & line manager monthly specialist CGM annual update training agreed and compliance being recorded and chased monthly from Jan 2025</p> |
| 1c | Advise | <p>1. Update of Multiple pregnancy guideline will give compliance for intervention 2.17 risk assessment for growth assessment in multiple pregnancy & 5.6</p> | <p>Draft completed and in guideline approval process</p> |

Overview Provisional Position Statement for Q3(7) SBLCB Compliance

| Element Number | LMNS Validated Status Q1 | Self Assessment Status Q2 | Q2 LMNS Validated | Q3 Self Assessment | Actions / Exceptions / Escalations |
|-----------------------------|--------------------------|---------------------------|-------------------|--------------------|---|
| 1 - Smoking Reduction | 60% | 60% | 70% | 70% | 1.4, 1.6 & 1.9 Below Compliance / Action plan in place More accurate data now |
| 2 - Fetal Growth | 75% | 75% | 85% | 90% | 2.6 & 2.14 Purchase plan when funding available ? April 25- Training on digital BP commenced Mand Day 2** 2.7 Uterine Artery Dopplers not in current pathway in MTW Guidance - Project commenced for new pathway but may have financial implications- Hypertension guideline published Feb 25 2.11 81% - However Dec data not available as error with audience on MTW learning - Maternity Dept Update causing issues - Data unreliable** 2.17 Twin Guideline update required and re-audit after publication, draft completed NICE wraparound - Twins Midwife and Lead |
| 3 - Altered Fetal Movements | 50% | 100% | 100% | 100% | No issues noted Q3 |
| 4 - Fetal monitoring | 60% | 60% | 60% | 60% | 4.2 Hourly review 51%, CTG 43% , IIA 67% Improving Trend but below 80% compliance 4.4 Fresh eyes 22%, CTG 21%, IIA 23% Improving Trend but below 80% compliance |
| 5 - Preterm Optimisation | 85% | 93% | 93% | 96%? | 5.6 Guidance and audit update for multiple pregnancy required - Twin Specialist Midwife & Obs Lead Ms Nazir 5.14 Continuity of Carer Plan update completed - No financial support to extend Phoenix to all Core 20+5 - Escalation re-financial issue to Exec Team |
| 6 - Diabetes | 50% | 50% | 67% | 83% | Guideline Published 6.2d Training for staff below compliance but audience identified and collecting data since Dec 24 |
| Total | 73% | | 83% | | |

Perinatal Quality Surveillance Model report for Maternity & Neonatal Care Oversight Group

Neonatal Safety Report

May 2025 (March 2025 data)

Neonatal Safety Report

| Neonatal Safety Report Key Issues Report | | |
|--|---|---|
| Report Date: May 2025 (March 2025 data) | Report lead: Neonatal Matron/Senior Nurse Neonatal Quality & Risk | Actions: |
| 1a Alert (Include actions taken/mitigations) | | |
| 1b Assurance | <ul style="list-style-type: none"> The compliance for attendance at both annual and 4yearly Neonatal Life Support Training is above 90% target for nursing/ANNPs/Consultant teams | <ul style="list-style-type: none"> An action plan is in place to address the non-compliance with the resident doctors to support them to reach compliance |
| 1c Advise | <ul style="list-style-type: none"> There were 18 In Phase submissions this month, 4 were referred on to maternity. Continuing neonatal theme with marks from Sa02 monitor skin probes Three medication related incidents (TPN/infusions) Hypothermia remains a continuing theme with postnatal admissions | <ul style="list-style-type: none"> All In Phase submissions triaged by Matron/Senior Nurse for Quality & Risk Learning shared with neonatal team and need for adherence to guidance with documented skin assessment completed reinforced. Compliance with documentation being audited during quality rounds. Learning shared with the neonatal team and need for robust checking and handover procedures reinforced. Shared with neonatal ODN via tracking trends. To relaunch thermoregulation task and finish group |

Neonatal Risk Register March 2025

Neonatal risks reviewed monthly at Paediatric Directorate and Bi-monthly at Neonatal Risk Meeting

| Risk Identified | Date added to risk register | Initial risk rating | Current risk rating | Mitigation / Actions underway |
|---|-----------------------------|---------------------|---------------------|---|
| <p>There is a National shortage of neonatal trained nursing staff (QIS trained) to support escalation of the unit</p> <p>Partial compliance with BAPM standards</p> | 12/10/2023 | 12 | 9 | <ul style="list-style-type: none"> Escalation policy and pathway in place to support service and decision making T&F group with agency leads completed work with QIS staff now available on the framework agency, support provided by NHSE with this project Paediatric staff able to assist when available as long as QIS not required Training pathway in place for band 5-6 development Business case (BAPM) and recruitment underway to increase substantive staffing levels |
| <p>There is a lack of provision for psychological support on the neonatal unit which risks impacting on families and staff – failure to comply with BLISS Accreditation</p> | 3/1/2025 | 12 | 9 | <ul style="list-style-type: none"> Pilot project funded by KCC has now ceased Job description to support post on bank with HR for banding Request sent to trust psychology service to see if able to assist Parent support sister in post to support parents currently Included in BAPM business case |
| <p>Non-compliance with BAPM standards relating to access to therapies in the neonatal unit</p> <p>Moved from therapies to NICU risk register</p> | 28/6/2023 | 12 | 6 | <ul style="list-style-type: none"> Review underway with Core Therapies team regarding current staff job plans for current therapists x 2 business cases declined within therapy, currently being added to Neonatal business case for 2025 SALT member of staff (managed by KCHFT) in post 0.4 supporting inpatient service until end of April when contract being withdrawn when risk will increase – discussions underway within network to support this moving forward |
| <p>Non invasive ventilation equipment shortage – Vapotherm</p> <p>Two units condemned</p> | 14/3/2025 | 12 | 9 | <ul style="list-style-type: none"> Equipment shared between NICU and paediatrics - currently less requirement in paediatrics so can support NICU in short term only Emergency Capital bid submitted to replace equipment |

Neonatal Safety Metrics: In Phase LFPSE and Tracking Trends

Total incidents reported on In Phase this month: 18

Breakdown of the number of incidents under investigation:

Related to NNU: 13

Referred to Maternity: 4

Referred to another department outside of perinatal service: 1 shared between SECAMB/Maternity/Neonatal

Tracking Trends Submissions this month: 3

Related to medication infusion errors (TPN)

New referrals to PSIRG this month – 0

Themes for cases referred to maternity

- Blood incorrectly labelled
- Antenatal risk factors for sepsis not handed over resulting in a delay in screening/treatment
- Admission with hypothermia/hypoglycaemia
- Delay in escalation of baby with hypoglycaemia resulting in delayed admission to NNU

Themes & immediate learning from NNU investigations:

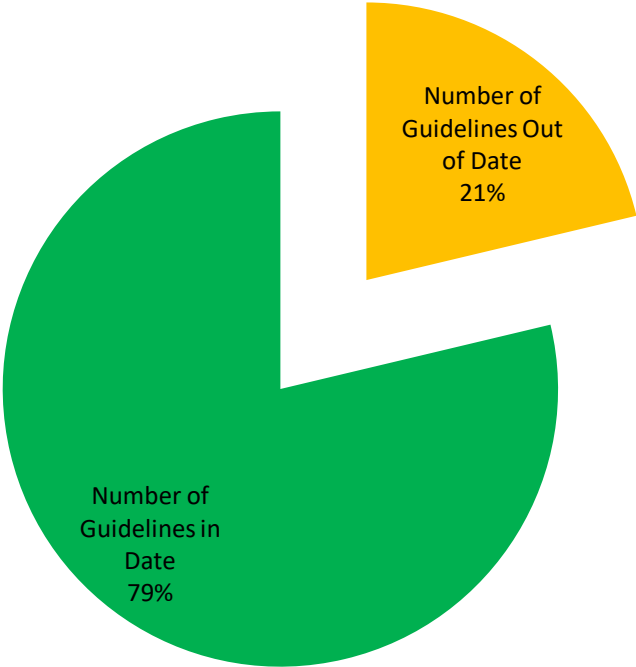
- Marks from SaO2 probes – need for probes to be changed regularly/in line with guidance and for skin integrity to be assessed and documented on every shift. Compliance with documentation of Sao2 probe changes being audited as part of quality rounds
- Need for all medical equipment to be checked and PAT tested by EME before use
- In the event of a baby coming in via emergency ambulance, NNU team to attend A&E to receive patient to allow earliest neonatal input with stabilisation
- 3x incidents related to administration of TPN – need for robust checking of TPN type/pump rates. All medications/infusions to be verified at handovers as a safety net.

Neonatal Deaths

There were no neonatal deaths on the neonatal unit during this time period

A baby born at term in February 2025 sadly passed away following an elective redirection of care in London (neurometabolic). A joint review will take place utilising the Perinatal Mortality Review Tool with Child Death Overview Panel oversight for expected death

Neonatal Guideline Compliance – March 2025



Robust process in place to review and update.




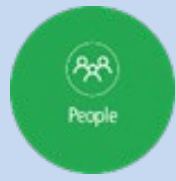


Guidelines circulated for two weeks to relevant teams and key stakeholders.

Then reviewed by neonatal guideline group with submitted comments, ratified where appropriate and submitted to the Paediatric Directorate / Clinical Director for final sign off. All guidelines that link to maternity are presented at MNIC.

Barriers to completion are time restrictions for meetings and completion of updated and ratified guidelines- governance role remains on risk register jointly with paed

| | |
|---|----|
| Total Guidelines | 94 |
| Out of date - circulated and for ratification at directorate and MNIC | 19 |
| Reviewed for publication | 1 |
| In Date being Reviewed | 2 |
| In date | 74 |

| | | | | | | |
|--|---|-------------------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | Quarterly Maternity Incentive Scheme Compliance Report | | | | | |
| Board / Committee | Trust Board | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-10 | | | | | |
| Executive lead | Jo Haworth, Chief Nurse | | | | | |
| Presenter | Jessica O'Reilly and Megan Fradgley | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|--|---|---|--|---|---|
|  |  |  |  |  |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| Executive Summary | |
|---|--|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | <u>Maternity Incentive Scheme Year 7 ("the Scheme") Progress Report</u> |
| | 1. To ensure effective Board oversight in Year 7 of the Scheme a quarterly report is submitted to Board (appendix 1). |
| | 2. The report provides an overview of progress against the Scheme, including any areas of concern or challenge. |
| | <u>PMRT Q1 Report</u> |
| | 3. In accordance with Safety Action 1 of the Scheme, the Trust Board is invited to review and note the quarterly PMRT Report (April 2025, Q1 data Jan-March 25) (appendix 2) which includes details of progress against requirements of the Scheme, details of all deaths from 1 December 2024, including reviews and consequent action plans. |
| | 4. The Board is reassured that, in accordance with the Scheme, this PMRT report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 12 May 2025. |
| | <u>Claims Scorecard Q4 Report</u> |
| | 5. In accordance with Safety Action 9 of the Scheme, the Trust Board is invited to review and note the Q4 Claims Scorecard Report (Jan-March 2025) (appendix 3), which triangulates the claims scorecard against incident and complaint data. |
| | 6. The Board is reassured that, in accordance with MIS, this Claims Scorecard report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 12 May 2025. |

| | | | |
|---|--|-------------|-------------------------------|
| | | | |
| Any items for formal escalation / decision | <u>Maternity Incentive Scheme Quarterly Report</u> | | |
| | The Board is invited to note the following points: | | |
| | 7. Safety Action 7: | | |
| | 7.1. Full implementation of Safety Action 7 is at risk due to lack of ICB funding for MNVP roles. | | |
| | 7.2. Escalation of this point to Trust Board will be sufficient to achieve Safety Action 7 compliance in Year 7 of the Scheme. However, the implementation of a functioning MNVP will be a requirement for Year 8 of the Scheme. | | |
| | 8. Safety Action 9: | | |
| | 8.1. In accordance with Safety Action 9, bi-monthly meetings between the Board Safety Champions and Perinatal Leadership Team have been arranged for Year 7 of the Scheme. | | |
| | 8.2. Culture improvement work will continue throughout Year 7 and at present no support of the Board has been identified. | | |
| Appendices attached | 1. Appendix 1 – MIS Quarterly Report May 2025 | | |
| | 2. Appendix 2 – PMRT Report Q1 (Jan – March 2025 data) | | |
| | 3. Appendix 3 – Claims Scorecard Report Q4 (Jan – March 2025 data) | | |
| | | | |
| Report previously presented to: | | | |
| Committee / Group | | Date | Outcome/Action |
| Maternity and Neonatal Care Oversight Group | | 12 May 2025 | For review by the Trust Board |

| Assurance and Regulatory Standards | |
|---|--|
| Links to Board Assurance Framework (BAF) | <p>PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer</p> <p>PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes</p> <p>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</p> |
| 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 | <p>Please list any compliance or regulatory matters raised or addressed by this report</p> <p>Fulfil requirements for Maternity Incentive Scheme</p> |

Maternity Incentive Scheme Year 7 Progress Report

Maternity incentive scheme
Maternity Incentive Scheme Progress May 2025
Key issues report

| Report date: April 2025 | | Report Lead: MIS Lead – Megan Fradgley | Actions/Mitigations: |
|-------------------------|--|--|--|
| 1a | Alert (Include actions taken and mitigation) | <p>Safety Action 7: RAG rating amber due to lack of LMNS funding for MNVP infrastructure.</p> <p>Safety Action 8: RAG rating amber due to enhanced oversight recommended for training compliance and continuing issues arranging anaesthetic training bookings.</p> | <p>Escalation in accordance with SA7, to include inclusion in PQSM, addition to the risk register, creation of action plan in collaboration with LMNS.</p> <p>Monthly education team faculty meetings to monitor compliance.</p> |
| 1b | Assurance | <p>Safety Action 9: Bi-monthly meetings between the perinatal leadership team and Board Safety Champions arranged for 2025 to enable progress against the culture improvement plan. Any support required by the Trust Board will be identified and escalated.</p> <p>Safety Action 9: Claims scorecard triangulation report discussed with Board Level Safety Champions via MNCOG in February.</p> | <p>To be discussed quarterly throughout Year 7.</p> |
| 1c | Advise | <p>Safety Action 4: If neonatal workforce remains below BAPM standards, then we must be able to demonstrate progress against the agreed action plan during Year 7.</p> <p>Safety Action 6: The latest version of Saving Babies Lives is due to be published imminently.</p> <p>Safety Action 10: All appropriate incidents reported to MNSI and NHSR. In these cases the families received information on the MNSI and EN schemes and duty of candour also carried out. DoC performed slower than usual due to staff sickness, but still within reasonable time.</p> | <p>Meeting arranged to discuss progress against action plan.</p> <p>Once published this safety action will require further review to assess for any potential challenges to achieving compliance in Year 7.</p> <p>Report with further detail to be prepared by Patient Safety Team.</p> |

Maternity Incentive Scheme – Year 7 Progress Report

Executive Summary

- MTW has not met compliance with CNST in both Year 5 and Year 6 of the Scheme. Action plans are in place with the aim of declaring compliance for Year 7.
- NHSR to formally publish Trust's non-compliance by the end of April, with confirmation of funding for non-compliant Trusts at the same time.
- Any funds received relating to MIS Year 6 must be ringfenced for use in the service to ensure compliance in Year 7.
- CNST Year 7 guidance was published on 2 April 2025 with the reporting period ending 30 November 2025, and submission 3 March 2026.
- This report includes the following:
 - Key changes for Year 7;
 - A rag rated overview of progress to date;
 - Areas of challenge identified with actions and mitigations;
 - Information which MIS Year 7 requires be brought to the Board's attention.

Maternity Incentive Scheme – Year 7

Key changes introduced in Year 7 of the Scheme

| | Summary of changes |
|------------------|--|
| Safety Action 1 | Increased requirement for PMRT reviews to be completed within 6 months, and minimum 50% reviews to include external member presence. |
| Safety Action 2 | Removal of some CQIM metrics, additional requirement for data relating to birthweight. |
| Safety Action 3 | Evidence of continued QI project work. |
| Safety Action 4 | Changes to audit of consultant on call attendances. Monitoring of neonatal staffing action plans including addition to risk register. |
| Safety Action 5 | No changes. |
| Safety Action 6 | No changes to MIS requirements, version 3.2 SBL expected April 2025. |
| Safety Action 7 | Requirement to escalate issues regarding infrastructure for MNVP involvement. |
| Safety Action 8 | Clarity provided regarding definitions of long term sickness/maternity leave relating to training compliance. Clarity provided relating to content of NLS training. Action plans for compliance for new starter medical staff on rotation to continue into Year 7. |
| Safety Action 9 | Requirement to send PQSM to Board for review reduced from monthly to quarterly (minimum). Increased collaboration between safety champions, LMNS and ODN. |
| Safety Action 10 | Information given to parents regarding NHSR/MNSI/Duty of Candour to be in accessible formats. |

Maternity Incentive Scheme – Year 7

Oversight for Year 7

- Monthly compliance will be reported via PQSM, with 3A report and rag rated summary to highlight areas of concern.
- Quarterly MIS reports to Trust Board (via maternity governance pathway) to ensure more detailed oversight of each safety action.
- Monthly meetings with key stakeholders to ensure progress made.

| Action No. | Maternity safety action | Overall Progress (RAG)* | Completed | On track | Delayed but in progress | Not started, issues with compliance identified | Total |
|------------|---|-------------------------|-----------|----------|-------------------------|--|-------|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | | | 7 | | | 7 |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | | | 2 | | | 2 |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? | | | 6 | | | 6 |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | | | 18 | 2 | | 20 |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | | | 5 | | | 5 |
| 6 | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | | | 4 | | | 4 |
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | | | 5 | 2 | | 5 |
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | | | 20 | 2 | | 22 |
| 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? | | | 9 | | | 9 |
| 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? | | | 8 | 1 | | 9 |

*Overall rag will be based on the lowest rag within the safety action to ensure any areas of concern are highlighted and actioned.

Maternity Incentive Scheme – Year 7

Reporting for Year 7

- Calendar created for oversight of reporting requirements by safety action, with report authors

| CALENDAR FOR REPORTING FOR CNST MIS | | | | | | | | | | | | | | |
|-------------------------------------|--------------------------|------------------|---|--|--------------------------------------|--|--|---|--|---|-------------------------------------|---|---|---|
| | | AUTHOR | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER |
| SA 1 | PMRT | Emily H/Jess | MNIC | MNCOG and Trust Board | | MNIC | MNCOG and Trust Board | | MNIC | MNCOG | Trust Board (no TB in Aug) | MNIC | MNCOG and Trust Board | |
| SA2 | MSDS | Emily B/Jodie | [Reported via PQSM] | | | | | | | | | | | |
| SA3 | ATAIN | ? | MNIC Q3 | MNCOG Q3 | | MNIC Q4 | MNCOG Q4 | | MNIC Q1 | MNCOG Q1 | | MNIC Q2 | MNCOG Q2 | |
| SA4 | CLINICAL WORKFORCE | Rachel | | | | | | [Update on medical and neonatal workforce action plans] | | | | | Trust Board Annual Clinical Workforce Report | |
| SA5 | MIDWIFERY WORKFORCE | Rachel | | | | | | Trust Board Bi-annual staffing report (include CoC update for SA6, 5.14) | | | | | Trust Board Bi-annual staffing report | |
| SA6 | SAVING BABIES LIVES | Jodie/Alie/Sarah | Final outcome for 2024 to Trust Board. Report to MNIC. | MNCOG Q2 full report Q3 provisional | | MNIC | MNCOG Q3 full report Q4 provisional | | MNIC | MNCOG Q4 full report Q1 provisional | | MNIC | MNCOG Q1 full report Q2 provisional | |
| SA7 | SERVICE USER INVOLVEMENT | Katy | [Monthly experience of care report to Operational/MRPS /MNIC and MNCOG] | | | Action plan re lack of MNVP funding to MNIC via PQSM. Also, Co-produced Action Plan re CQC survey results to MNIC. | Action plan re lack of MNVP funding to MNCOG and Trust Board via PQSM. Also, Co-produced Action Plan re CQC survey results to MNCOG. | | Update on action plan re lack of MNVP funding to MNIC via PQSM | Update on action plan re lack of MNVP funding to MNCOG and Trust Board via PQSM | | Update on action plan re lack of MNVP funding to MNIC via PQSM | Update on action plan re lack of MNVP funding to MNCOG and Trust Board via PQSM | |
| SA8 | TRAINING | Jennie | | | [Quarterly training report to MNIC]* | | | [Quarterly training report to MNIC] | | | [Quarterly training report to MNIC] | | | [Quarterly training report to MNIC] |
| SA9 | GOVERNANCE | Jess/Megan | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board | [No Trust Board] | PQSM to Trust Board (incl. August) | PQSM to Trust Board | PQSM to Trust Board | PQSM to Trust Board |
| | | Jess/Emily | | Claims scorecard triangulation report to MNCOG | | | Claims scorecard triangulation report to MNCOG | | | Claims scorecard triangulation report to MNCOG | | | Claims scorecard triangulation report to MNCOG | |
| | | Lisa/Andy/Shazia | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions. | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions | | Bi-monthly meeting between Perinatal Leadership Team and Safety Champions |
| | | Megan | Final MIS Position to MNCOG and Trust Board with Declaration | | | Quarterly MIS Update to MNIC. Include new MIS Guidance. | Quarterly MIS Update to MNCOG and Trust Board. Include new MIS Guidance. | | Quarterly MIS Update to MNIC. Include update on progress for new MIS guidance. | Quarterly MIS Update to MNCOG. Include update on progress for new MIS guidance. | Trust Board (no TB in Aug) | Quarterly MIS Update to MNIC. Include key risk areas for compliance. | Quarterly MIS Update to MNCOG and Trust Board. Include key risk areas for compliance. | |
| SA10 | LEGAL | Fiona | | Part 2 Trust Board Report | | | Part 2 Trust Board Report | | Part 2 Trust Board Report (No TB in August) | | | | Part 2 Trust Board Report | |

Maternity Incentive Scheme – Year 7

Further detail by safety action is detailed on the following pages with rag rating as follows:

| | |
|--|---|
| | Action completed and evidence available. |
| | Action ongoing throughout Year 7 but is running to time and has processes in place to ensure compliance. |
| | Action has been commenced but there are challenges/delays which may affect compliance. Mitigations identified. |
| | Action has not been commenced or there are challenges which will affect compliance, and no mitigation identified. |

Safety Action 1 Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Overall rag rating: Green

- Existing systems in place to ensure compliance;
- Increased requirements at 1.4 and 1.5 not expected to cause any issues as MTW consistently exceeds these figures;
- Quarterly reports prepared and discussed with Board Level Safety Champions via MNCOG, and then presented to Trust Board.

| | Requirement | Actions/progress | Next update due | Compliance status |
|-----|--|--|--------------------|-------------------|
| 1.1 | Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? | | Q1 Report May 2025 | |
| 1.2 | For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions? | | | |
| 1.3 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust. | | | |
| 1.4 | Were 75% of all reports completed and published within 6 months of death? | | | |
| 1.5 | For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? | Need to ensure external panel member is being recorded on PMRT, MTW consistently achieves 100% external panel member attendance. | | |
| 1.6 | Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans. | | | |
| 1.7 | Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions? | | | |

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Overall rag rating: Green

- *Data collection via E3.*
- *Digital midwife to ensure birthweight data available.*

| | Requirement | Lead | Actions/progress | Update due | Compliance status |
|-----|--|------|------------------|------------|-------------------|
| 2.1 | Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405) | | | | |
| 2.2 | Did July's 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) | | | | |

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Overall rag rating: Green

- *BAPM compliant TC pathways already embedded;*
- *3.3 and 3.4 not relevant as QI project commenced in Year 6;*
- *Will need to demonstrate progress against the QI project.*

| | Requirement | Actions/progress | Update due | Compliance status |
|-----|--|------------------|------------|-------------------|
| 3.1 | Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice? | | | |
| 3.2 | Or Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards. | | | |
| 3.3 | By 2 September 2025, register the QI project with local Trust quality/service improvement team. | | 02/09/25 | |
| 3.4 | By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress. | | 30/11/25 | |
| 3.5 | Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions. | | 01/10/25 | |
| 3.6 | By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period | | 30/11/25 | |

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

| | Requirement | Actions/progress | Update due | |
|-----|---|------------------|------------|--|
| 4.1 | Locum currently works in their unit on the tier 2 or 3 rota? | | | |
| 4.2 | OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)? | | | |
| 4.3 | OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums? | | | |
| 4.4 | Has the Trust Implemented the RCOG guidance on engagement of long-term locums in full? Trusts should demonstrate full compliance through audit of any 6-month period from February 2025 to 30 November 2025. | | | |
| 4.5 | Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. | | | |
| 4.6 | Is the Trust compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate full compliance through audit of any 3-month period from February 2025 to 30 November 2025. | | | |
| 4.7 | Do you have evidence that the Trust position with the above has been shared with Trust Board? | | | |
| 4.8 | Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions? | | | |
| 4.9 | Do you have evidence that the Trust position with the above has been shared with the LMNS? | | | |

| | Requirement | Actions/progress | Update due | |
|------|--|------------------|------------|--|
| 4.10 | Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence. | | | |
| 4.11 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? | | | |
| 4.12 | Is this formally recorded in Trust Board minutes? | | | |
| 4.13 | If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register. | | | |
| 4.14 | Was the above action plan shared with the LMNS? | | | |
| 4.15 | Was the above action plan shared with the Neonatal ODN? | | | |
| 4.16 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? | | | |
| 4.17 | Is this formally recorded in Trust Board minutes? | | | |
| 4.18 | If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register. | | | |
| 4.19 | Was the above action plan shared with the LMNS? | | | |
| 4.20 | Was the above action plan shared with the Neonatal ODN? | | | |

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Overall rag rating: Amber

- *Neonatal medical and nursing workforce not BAPM compliant.*
- *Actions plans were produced in previous MIS Years. Must demonstrate progress against action plans.*

| Actions/Next steps | Owner | Timescale |
|--|--|---------------------|
| Demonstrate progress against neonatal staffing action plans. | Charlotte Wadey, Jackie Tyler, Raj Gupta | By 30 November 2025 |

This safety action contains twenty requirements relating to:

Obstetric workforce

- Employment of locums
- Compensatory rest for consultants on call
- Audit of consultant on call attendance

Anaesthetic workforce

- Evidence that duty anaesthetist is available to the obstetric unit 24 hours a day

Neonatal medical workforce

- Whether BAPM staffing standards are met
- Where not met, that Trust Board has oversight of progress against action plans

Neonatal nursing workforce

- Whether BAPM staffing standards are met
- Where not met, that Trust Board has oversight of progress against action plans

- Current rag rating: 18 green and 2 amber.

Safety Action 5: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Overall rag rating: Green

- *Staffing report to be submitted to Trust Board in June 2025.*
- *Any deficits in staffing levels must include an action plan.*

| | Requirement | Actions/progress | Update due | Compliance status |
|-----|---|---------------------------|------------|-------------------|
| 5.1 | Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.) | | | |
| 5.2 | Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. | Next report due June 2025 | | |
| | We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated. | | | |
| 5.3 | Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? | | | |
| 5.4 | Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. | | | |
| 5.5 | Where deficits in staffing levels have been identified must be shared with the local commissioners. | | | |

5.2 detailed requirements:

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall.
- The midwife to birth ratio
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour
- Is a plan in place for mitigation/escalation to cover any shortfalls in the points above?

5.3 detailed requirements:

- Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives

NICE safe staffing red flags include:

- Redeployment of staff to other services/sites/wards based on acuity.
 - Delayed or cancelled time critical activity.
 - Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).
 - Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
 - Delay of more than 30 minutes in providing pain relief.
 - Delay of 30 minutes or more between presentation and triage.
 - Full clinical examination not carried out when presenting in labour.
 - Delay of two hours or more between admission for induction and beginning of process.
 - Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
 - Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Other midwifery red flags may be agreed locally.**

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Overall rag rating: Green

- 6.4 not required as implementation tool in use.
- Process in place with LMNS for monitoring of progress.
- Full implementation is not expected by the end of Year 7, so an improvement trajectory agreed with the LMNS will be required.
- This rating will require review once version 3.2 SBLCB published.

| | Requirement | Actions/progress | Update due | Compliance status |
|-----|--|------------------|------------|-------------------|
| 6.1 | Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. | | 30/11/25 | |
| 6.2 | Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: | | | |
| | <ul style="list-style-type: none"> Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. | | | |
| | <ul style="list-style-type: none"> Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. | | | |
| | <ul style="list-style-type: none"> Evidence of sustained improvement where high levels of reliability have already been achieved. | | | |
| | <ul style="list-style-type: none"> Regular review of local themes and trends with regard to potential harms in each of the six elements. | | | |
| | <ul style="list-style-type: none"> Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. | | | |
| 6.3 | Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory? | | 30/11/25 | |
| 6.4 | If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB. | | | |

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Overall rag rating: Amber

- LMNS unable to implement MNVP lead role in Year 6 of the scheme.
- The infrastructure detailed at 7.2 is in place, but challenges ensuring MNVP meeting attendance.
- If required compliance may still be obtained by the escalation pathways detailed at 7.3.
- Note that full implementation will be required by Year 8 of the Scheme.

| Actions/Next steps | Owner | Timescale |
|--|-------------------------------------|-----------|
| Ensure escalation via PQSM | Jessica O'Reilly, Megan Fradgley | May 25 |
| Lack of MNVP infrastructure onto risk register | Jessica O'Reilly, Megan Fradgley | May 25 |
| Liaise with LMNS regarding likely progress in Year 7 of the scheme, if required engage stakeholders to produce action plan for Year 8, including mitigation. | Rachel Thomas, Megan Fradgley | June 25 |

| | Requirement | Actions/progress | Update due | Compliance status |
|-----|---|------------------|------------|-------------------|
| 7.1 | Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data <u>which CQC have confirmed is available to all trusts free of charge</u> | | | |
| | <ul style="list-style-type: none"> • Has progress on the coproduced action above been shared with Safety Champions? • Has progress on the coproduced action above been shared with the LMNS? | | | |
| 7.2 | Evidence of MNVP infrastructure being in place from your LMNS/ICB, including all of the following: <ul style="list-style-type: none"> • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost | | | |
| 7.3 | <p>If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.</p> <p>If evidence for 7.2 cannot be provided, then the escalation route must be followed as stated above.</p> <p>Evidence requirements for 7.4 and 7.5 are only required if evidence has been provided for 7.2</p> <p>In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS for this safety action.</p> | | | |
| 7.4 | <p>Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), <u>including all of the following</u>:</p> <ul style="list-style-type: none"> • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee | | | |
| 7.5 | Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan. | | | |

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

| | Requirement | Actions/progress | Update due | Compliance status |
|------|---|--|------------|-------------------|
| | Fetal Monitoring training | | | |
| 8.1 | 90% of obstetric consultants | | | |
| 8.2 | 90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) | | | |
| 8.3 | For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust? | | | |
| 8.4 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres | | | |
| | Obstetric emergencies training | | | |
| 8.5 | 90% of obstetric consultants | | | |
| 8.6 | 90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota | | | |
| 8.7 | For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust? | | | |
| 8.8 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives | | | |
| 8.9 | 90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum). | | | |
| 8.10 | 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors | | | |
| 8.11 | 90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA. | Currently anaesthetic compliance figures above 90%. However, enhanced oversight recommended due to non-compliance in Year 6. | | |
| 8.12 | For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust? | | | |
| 8.13 | Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite. | | | |

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Overall rag rating: Amber

- *Increased oversight recommended due to non-compliance for anaesthetics in Year 6.*
- *Continued issues arising relating to booking anaesthetists onto training. PROMPT training not currently in job plans and anaesthetists report difficulty gaining study leave.*
- *Project also underway to establish effective compliance monitoring for neonatal staff.*

| Actions/Next steps | Owner | Timescale |
|--|---------------|------------|
| Arrange monthly faculty meetings to review compliance | Jennie Taylor | April 2025 |
| Establish system for neonatal compliance monitoring | Jackie Tyler | June 25 |
| Provide neonatal training compliance paperwork confirming BAPM compliant | Jackie Tyler | April 25 |

| | NLS training | | | |
|------|---|---|--|--|
| 8.15 | 90% of neonatal Consultants or Paediatric consultants covering neonatal units | | | |
| 8.16 | 90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births | Note there were issues obtaining this data in Year 6. Project underway to ensure effective compliance monitoring. | | |
| 8.17 | For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust? | | | |
| 8.18 | 90% of neonatal nurses (Band 5 and above who attend any births) | | | |
| 8.19 | 90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine. | | | |
| 8.20 | 90% of advanced Neonatal Nurse Practitioner (ANNP) | | | |
| 8.21 | 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) | | | |
| 8.22 | In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance. | Still awaiting training paperwork from neonatal team evidencing that training provided to BAPM standards. | | |

Safety Action 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?

Overall rag rating: Green

- Whilst we did not claim compliance with this safety action in Year 6, the current rag rating is green because a system of Board reporting has now been established and running since January 2025.

Evidence of progress against culture improvement plan:

- A key area of work for this safety action is in progressing the cultural leadership work by the perinatal leadership team. Steps taken to action this include:
 - Bi-Monthly meetings booked
 - ToR's and agenda produced
- This area will require continued progress throughout Year 7.

| | Requirement | Actions/progress | Update due | Compliance status |
|-----|--|------------------|------------|-------------------|
| 9.1 | Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025? (including the following) | | | |
| 9.2 | Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)? | | | |
| 9.3 | Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM <u>at least quarterly</u> , and presented by a member of the perinatal leadership team to provide supporting context. | | | |
| 9.4 | Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent? | | | |
| 9.5 | Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. | | | |
| 9.6 | Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025. | | 01/07/25 | |
| 9.7 | Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)? | | | |
| 9.8 | Evidence in the Trust Board minutes that Board Safety Champion(s) <u>and the MNVP lead (where infrastructure is in place as per SA7)</u> are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. | | | |
| 9.9 | Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented. | | | |

Safety Action 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 1 December 2024 to 30 November 2025?

Overall rag rating: Amber

- DoC performed slower than usual due to staff sickness in March 2025, now rectified and DoC completed within reasonable time. However, amber rating given due to potential for delay affecting compliance, action plan below.
- Note that regard must be had to ensuring documentation is in an accessible format, with action plans where this has not been possible.

| Actions/Next steps | Owner | Timescale |
|--|------------------|-----------|
| Ensure whole patient safety team DoC trained and understand time limits. | Jessica O'Reilly | Complete |
| Ensure systems in place to monitor DoC compliance. | Jessica O'Reilly | May 2025 |

| | Requirement | Actions/progress | Update due | Compliance status |
|------|--|------------------|------------|-------------------|
| 10.1 | Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025. | | | |
| 10.2 | Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025. | | | |
| 10.3 | Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them? | | | |
| 10.4 | For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future. | | | |
| 10.5 | Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. | | | |
| 10.6 | Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. | | | |
| 10.7 | Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this. | | | |
| 10.8 | Has Trust Board had sight of evidence of compliance with the statutory duty of candour? | | | |
| 10.9 | Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated. | | | |

| | |
|------------------------|--|
| Title of report | PMRT Report – Q4 (Jan – March 2025) |
| Date of meeting | 28 April 2025 |
| Agenda item no. | |
| Presenter | Jessica O'Reilly/Rachel Thomas |

| Report date: April 2025 | | Report Lead: Harriet Whyatt/Megan Fradgley | Actions: |
|----------------------------|--|--|---|
| 1a | Alert (Include actions taken and mitigation) | <p>The handover from the bereavement midwife to the patient safety team has not yet been fully actioned. As such two cases from this quarter have not yet been reviewed as quickly as they normally would have been, although they are still well within the expected time limits.</p> <p>One closed case this quarter graded care as “B” relating to management of recurrent UTI in pregnancy. However Trust guidelines were followed and outcome unlikely to have been affected.</p> | <p>Handover to take place shortly and reviews scheduled.</p> <p>Action made to review National guidance and seek microbiology input to assess if current guideline appropriate.</p> |
| 1b | Assurance | <p>The PMRT process will now be led by the governance team and no longer sit in the bereavement portfolio.</p> <p>CNST compliance has been met for Q4.</p> | |
| 1c | Advise | <p>3 cases reported to MBRRACE in this quarter – two stillbirths and one late miscarriage.</p> <p>1 case has been closed during the quarter. For this case no actions were identified by the panel.</p> | All 3 cases are currently being reviewed through the PMRT process. |

PMRT Q4

January to March 2025

Cases reported in this quarter:

3 cases reported to MBRRACE in this quarter:

There were two stillbirths and one late miscarriage.

| PMRT case ID | Type of loss | Cause of death | Gestation | Reported to MBRRACE within 7 working days? |
|--------------|-----------------------|-------------------------|-----------|--|
| 96620 | Antepartum stillbirth | Placental insufficiency | 24+3 | Yes |
| TBC | Antepartum stillbirth | Placental abruption | 29+5 | Yes |
| TBC | Late miscarriage | Unknown | 22+0 | Yes |

Summary of cases closed in this quarter:

There was one case closed in this quarter, the gradings were as follows:

Grading of care provided to the mother before the death of the baby

- Care was graded B

Grading of care provided to the mother after the death of the baby

- Care was graded A

Cases are graded using this grading template:

Grading of care

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ☐ A - The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
- ☐ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ☐ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ☐ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ☐ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ☐ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ☐ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ☐ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

| PMRT case ID | Summary of case | Cause of death | Grading of care | Issues | Actions | Person/team responsible and target completion date |
|--------------|-----------------|---------------------|-----------------|--|--|--|
| 95584 | 38+2 stillbirth | Placental abruption | B and A | This mother presented with repeated UTI's during the antenatal period. Antibiotics were prescribed on several occasions and then prophylactic antibiotics were also prescribed. The care was in line with Trust policy. However the panel graded the care a B because no microbiology input was sought to explore the reasons for the recurrent UTI's. It is unlikely that this would have made a difference to the outcome. | Although care given in line with Trust guidance, the Trust will review National guidance to consider whether microbiology input should have been sought. Lead to liaise with microbiology to discuss pathways for recurrent UTI's and whether further testing should be required in these circumstances. | Angela Clarke/Guidelines Team. July 2025. |

Summary of CNST standards for this quarter:

| MBRRACE-UK/PMRT standards for eligible babies following the PMRT process | Requirement % | MTW this quarter |
|---|----------------------|-------------------------|
| Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days | 100% | 100% |
| All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns. | 95% | 100% |
| A PMRT review must be commenced within two months following the death of a baby. | 95% | 100% |
| A PMRT must be completed within six months of the death of a baby's death. | 75% | 100% |
| External panel member present at review. | 50% | 100% |
| Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions | 100% | 100% |

Claims Score Card

Q4

| Report date: May 2025 | | Report Lead: Jessica O'Reilly | Actions: |
|-----------------------|--|---|--|
| 1a | Alert (Include actions taken and mitigation) | <p>Claims data</p> <ul style="list-style-type: none"> Two ENS cases were closed under the category of : Poor outcome of baby – case closed. No damages awarded. Three CNST cases were closed within Q4. One case was withdrawn and two were settled. <p>Triangulation themes</p> <ul style="list-style-type: none"> Theme relating to fetal monitoring, this is demonstrated through claim and incident data. Communication and ongoing theme through claim and complaint data. Documentation. | <p>Triangulation themes</p> <ul style="list-style-type: none"> Fetal monitoring training has been updated to reflect themes Mandatory training updated which included civility with staff Yearly documentation on audit plan for this year. As part of MDT risk reviews, the risk team feedback to clinicians issues that are raised with documentation and standards. |
| 1b | Assurance | There was a reduction of complaints and PSII declared within Q4 | |
| 1c | Advise | There were no inquests opened or closed during the Q4 | |

Triangulation of complaints, serious incidents and claims data

This report is a review of maternity complaints, serious incidents and claims data from 1 January 2025 –31st March 2025. The aim is to examine themes and trends identified, and any actions taken to reduce the risk of re-occurrence, improve patient safety and reduce the cost of litigation.

Claims Scorecard (10 Year data)

| | |
|---|--|
| Top injuries by volume: <ul style="list-style-type: none">• Stillborn (9)• Additional/Unnecessary Operations (6)• Brain injury (6)• Psychological Harm (6)• Unnecessary Pain (5) | Top injuries by value: <ul style="list-style-type: none">• Brain injury• Cerebral Palsy• Hypoglycaemia• Multiple Injuries• Unnecessary Pain |
| Top causes by volume: <ul style="list-style-type: none">• Fail/Delay Treatment (16)• Fail/Delay Diagnosis (7)• Fail to Recog. Complication of (5)• Not Specified (4)• Fail Antenatal Screening (3) | Top causes by value: <ul style="list-style-type: none">• Fail/Delay Treatment• Delay in Performing Operation• Fail/Delay Admitting to Hospital• Failure/Delay Diagnosis• Fail Antenatal Screening |

Claims themes Q4

| | |
|---|--|
| No new clinical negligence claims were opened during Quarter 4 relating to Maternity Services. | |
| Two ENS cases were closed. Category: Poor outcome of baby – case closed. No damages awarded | Subcategories: Failures/delays in diagnosis and treatment; psychiatric/psychological damage; |
| Three CNST cases were closed. One case was withdrawn and two were settled. Total damages awarded £165,000 | Profession- Obstetric/Midwifery |

Maternity Incentive Scheme - SA9

Quarterly review of Trust’s claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

| Themes | Linked themes |
|---------------------------------|--|
| 1. Documentation | Partograms – maternal pulse |
| 2. IAA | a. Interpretation b. Frequency c. Guidelines d. equipment |
| 3. Communication | a. Between staff – handovers – escalation b. Quality and consistency of advice to patients c. Informed consent regarding options of treatment/delivery/risks |
| 4. Delayed diagnosis/ treatment | a. Staffing issues b. Recognition of complications of treatment c. Continuity of care d. Equipment failures |
| 5. Poor clinical care | Education/training/skills |

Complaints Q4 (6 received)

| Subject | Sub Subject |
|--|---|
| Clinical treatment Communication Staff values and behaviours | Poor standard of obstetric care Breakdown in communication Staff attitude |
| Attitude of staff | Staff attitude (nursing) |
| Staff values and behaviours | Staff attitude (nursing) |
| Clinical treatment Staff values and behaviours | Poor standard of obstetric care Staff attitude (nursing) |
| Clinical treatment Communications | Poor standard of obstetric care Inconsistent information |
| Clinical treatment Staff values and behaviours | Poor standard of obstetric care Staff attitude (medical) |

Inquest themes Q2

No maternity inquests were heard during the quarter.

Actions arising from inquest themes

| | |
|------------|--|
| No Actions | |
|------------|--|

PSIRG declared Incidents – 1 Q4

| | |
|------------------------------|--|
| Maternity – Medication Error | |
|------------------------------|--|

PSII – No closures of cases in Q4

MNSI Report Themes – One closure in Q4




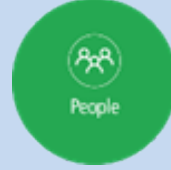


Safety recommendations:

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.

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.

| | | | | | | |
|--|---|-------------------------------------|------------|--------------------------|-------------|-------------------------------------|
| Title of report | Summary report from the People and Organisational Development Committee, 23/05/25 | | | | | |
| Board / Committee | Trust Board ‘Part 1’ Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-13 | | | | | |
| Executive lead | Emma Pettitt-Mitchell, Non-Executive Director | | | | | |
| Presenter | Emma Pettitt-Mitchell, Non-Executive Director | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|---|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| 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 23 rd May 2025 (a “deep dive’ meeting). | |
| | The Committee considered the following topics: 1) The People BAF risk 2) Monthly review of the “Strategic Theme: People” section of the Integrated Performance Report (IPR) 3) Review of the Trust’s People related risks 4) Review of the findings of the national NHS Staff Survey 2024 (incl. an update on the People Promise Exemplar) The Committee noted that the reports presented, demonstrate that controls relating to Principal Risk 1 and an element of Principal Risk 6 of the Board Assurance framework are demonstrating effectiveness. | |
| 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) | <p>PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer</p> <p>PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery</p> |
| 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 23rd April 2025 (a “deep dive” meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous ‘deep dive’ meetings** were reviewed.
- The updated **Terms of Reference** for the Committee were agreed, with the only change being the inclusion of the Chief Operating Officer as part of the Committee’s membership.
- The Committee noted the **People Board Assurance Framework (BAF) risk** and the Chief People Officer outlined that this had not been progressed due to the work aligned to workforce transformation being a priority however, the importance of the framework was noted and it was agreed that this would be updated prior to the next meeting.
- The Committee conducted a **monthly review of the “Strategic Theme: People” section of the Integrated Performance Report (IPR)**, wherein it was noted that both of the financial objectives were down by 0.5% although recognising the recent progress in this area; that the staff in post figure had increased year on year with a current number of staff at 7746 whole-time-equivalents, with a slightly increased turnover rate across the past few months and a decrease in the Trust vacancy rate; and that the overall sickness rate had decreased however attention was raised towards a number of staff groups within the organisation wherein the sickness rate had significantly increased, suggesting a potential area of concern. A discussion was held regarding the staff sickness rate and the importance of monitoring the long-term sickness figures alongside the increased service demands, and it was agreed that going forward, the Committee would be provided with more assurance that both the long-term and short-term sickness absence was being closely monitored to understand the trends and mitigating actions. It was also highlighted that a revised Enhanced Care Policy had been introduced with an overall objective to develop an internal Enhanced Care Team, in order to help respond to the changing patient cohorts.
 - ❖ The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- A **review of the Trust’s people related risks** was presented by the Head of People Performance and Improvement, which included that the number of open People related risks had reduced from 45 to 43, noting that out of the 7 red-rated risks, 4 were associated with the Clinical divisions and 3 were Trust-wide; and it was recognised that a new risk relating to the NHSE Financial Sustainability requirements for 2025/26 destabilising the workforce (no. 3432) was added to the register. A conversation was held around whether risk 3432 should be rated higher than moderate considering the current circumstances and it was agreed that the Head of Risk Management would review this. A discussion was also held around the length of time a number of risks have remained on the register and the number of target completion date extensions granted, highlighting that it could be beneficial for the team to liaise with the Business Partners for the specific divisions to gather further updates, and that a mechanism for maintaining progress on the risks with extended target completion dates could be considered. It was also recognised that further training sessions will commence in June 2025 providing an introduction to risk management, explanations of the risk registers and education around setting target completion dates.
- The Committee received the **Review of the findings of the national NHS Staff Survey 2024 (incl. an update on the People Promise Exemplar)**, wherein the group heard that the response rate from the survey was 46% compared to the 49% from the benchmarking group; that the Trust scored higher than all other acute Trusts across Kent and Medway for all themes and ranked in the top 10 nationally for the second year running; and that the highest scores for all divisions were within the ‘We are compassionate and inclusive’ group, followed closely by ‘Staff engagement’, whereas ‘Reward and recognition’, ‘Always learning’, and ‘Morale’ featured the lowest scores for all divisions. Attention was drawn to the scores provided by the Medical Director division as they continued to be the lowest rating, and the potential reasons behind this as well as the importance of addressing the issues were discussed. A conversation was also held around the People Promise Exemplar, highlighting that the work and dedication would need to be present throughout all levels of the organisation in order for progress to be made, and that it would be beneficial for a number of the priority actions from the extensive action plan should be extracted and pushed forward to provide clear objectives to help guide the Trust in the right direction. It was also noted







that an application for the Reverse Mentoring Programme, to be a case study on the NHS Futures Platform, has resulted in the Trust being offered a place on an online learning platform, in order to bring the case study to life and for other organisations to learn from how the Trust has delivered this.

❖ The Committee considered that this demonstrated assurance that the controls articulated in the Board Assurance Framework Principal Risk 1, are effective.

- The Committee noted the **forward programme**.
- The Chair conducted an **evaluation of the meeting** wherein Committee members noted that there was a good level of challenge within the questions asked from the group; that there was a sufficient amount of time allocated to the deep dive items, in order to allow for an in-depth review and discussion. It was noted that as a number of colleagues were unable to attend the meeting, other colleagues from the relevant departments should be invited to attend, to allow for further insight and helpful discussions.

DRAFT

| | | | | | |
|--|--|-------------------------------------|-------------------|-------------------------------------|---|
| Title of report | To agree revised Terms of Reference | | | | |
| Board / Committee | People and Organisational Development Committee | | | | |
| Date of meeting | 17 th April 2025 | | | | |
| Agenda item no. | 05-5 | | | | |
| Executive lead | Emma Pettit-Mitchell, Non-Executive Director | | | | |
| Presenter | Emma Pettit-Mitchell, Non-Executive Director | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information <input type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|---|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The Committee is asked to agree the Terms of Reference, to enable the revised Terms of Reference to be submitted to the Trust Board, for approval, at its meeting on 29 th May 2025. | |
| | The Chief Operating Officer has been added to the membership. | |
| Any items for formal escalation / decision | To agree the revised Terms of Reference (prior to the Terms of Reference being submitted to the Trust Board for approval) | |
| Appendices attached | | |
| 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) | |
| Compliance / Regulatory Implications | Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17, Good Governance NHSE Code of Governance for NHS Providers |

Terms of Reference

1. Purpose

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

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

2. Membership

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

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

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

3. Quorum

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

- The Chair or Vice Chair of the Committee and one other Non-Executive Director or Associate Non-Executive Director¹
- Two Executive Directors (i.e. Chief Nurse, Chief People Officer ~~or~~ Deputy Chief Executive/Chief Finance Officer or Chief Operating Officer). Deputies representing an Executive Director will count towards the quorum.

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

- The Chair or Vice Chair of the Committee and one other Non-Executive Director or Associate Non-Executive Director¹
- One Executive Director (i.e. Chief Nurse, Chief People Officer or Deputy Chief Executive/Chief Finance Officer). Deputies representing an Executive Director will count towards the quorum.

4. Attendance

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

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

5. Frequency of meetings

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

The Committee shall, generally, meet each month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' People and Organisational Development Committee.

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

6. Duties

To provide assurance to the Trust Board on:

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

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

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

7. Parent committees and reporting procedure

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

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

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

8. Sub-committee and reporting procedure

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

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

Finance and Performance Committee

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

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Committee Chair, after having consulted at least two Committee members who are Executive Directors. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

10. Administration

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

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

11. Review of Terms of Reference and monitoring compliance




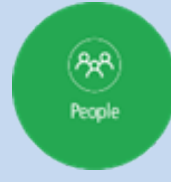


The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Review history

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

- Amended Terms of Reference approved by Trust Board, 30th March 2023
- Terms of Reference agreed by the People and Organisational Development Committee, 24th May 2024 (as part of the annual review)
- Amended Terms of Reference approved by Trust Board, 30th May 2024
- Terms of Reference agreed by the People and Organisational Development Committee, 23rd May 2025 (as part of the annual review) **pending**

| | | | | | |
|--|--|--------------------------|-------------------|--------------------------|--|
| Title of report | Summary report from the Finance and Performance Committee | | | | |
| Board / Committee | Trust Board Meeting | | | | |
| Date of meeting | 27 th May 2025 | | | | |
| Agenda item no. | 05- | | | | |
| Executive lead | Neil Griffiths, Non-Executive Director | | | | |
| Presenter | Neil Griffiths, Non-Executive Director | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|---|---|--|
|  Patient experience |  Patient access |  Sustainability |  People |  Systems and partnerships |  Patient safety and clinical effectiveness |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The Finance and Performance Committee met (in-person/face-to-face) on 27 th May 2025. | |
| | The Committee considered the following topics: <div><div>1) To consider the BAF risks</div><div>2) The patient access strategic theme metrics for April 2025</div><div>3) The financial performance for month 1, 2025/26</div><div>4) The Financial Improvement Plan</div><div>5) To confirm the approach to be taken for the compilation of the mandatory National Cost Collection (NCC); and to receive the latest information from the Costing Transformation Programme (CTP)</div><div>6) Cash Flow Forecast</div><div>7) Emergency Planning Annual Report, 2024 and future emergency planning</div></div> | |
| | The Committee also noted the Quarterly analysis of consultancy use. | |
| | 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 effectiveness in the information presented at the meeting. | |
| 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) | <ul style="list-style-type: none"> • 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 |

| | |
|---|---|
| | <ul style="list-style-type: none"> PR6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery |
| Links to Trust Risk Register (TRR) | <p>Please list any risks on the Trust Risk Register to which this report relates</p> <ul style="list-style-type: none"> 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 |







DRAFT

The Finance and Performance Committee met on 22nd April 2025, virtually, via webconference.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were noted.
- The group firstly considered and reviewed the Board Assurance Framework (BAF) risks relating to the Committee.
- The **Patient Access strategic theme** metrics for April were reviewed, and it was highlighted that the average non-elective length of stay indicator is currently experiencing common cause variation and consistently failing the target. The Committee heard that there are a number of workstreams underway to rectify this. It was noted that ambulance handovers, greater than 30mins continues to experience common cause variation and has failed the target for more than 6 months and the reasons for this were discussed and the work underway was noted. The Committee heard that the Trust continues to achieve the 28 Day faster diagnosis compliance and the combined 31 day first definitive treatment standards and the 62 day first definitive treatment standard. The Committee discussed Referral to Treatment times (RTT) and noted that the Trust continues to provide system support to other Trusts across Kent and Medway, which is therefore adversely affecting the Trust's performance that is reported nationally. RTT was above the new trajectory target for April 25 of 72.4% at 72.59%. It was noted that the Trust remains one of the best performing trusts in the country for longer waiters.
- The **financial performance month 1, 2025/26** was then presented by the Deputy Chief Executive / Chief Finance Officer, which included that at month 1, the Trust was £6.3m in deficit which is £0.7m adverse to the plan. The Committee noted the key pressure year to date and heard that the Trust is working on developing transformation schemes to make a material progress towards the target. The Committee heard of the work, which is ongoing with system colleagues in developing detailed plans to meet the targets.
- The Committee then received a presentation of **the Trust's Financial Improvement Plan**, wherein it was outlined that the Trust is working through its plan to reduce the size of the opening challenge, undertaking an Efficiency Programme of work, through 15 workstreams, driving to meet National savings expectations and working with collaboratives and Health Care partnerships to identify cost improvement opportunities.
- The Deputy Director of Finance – Performance then asked the Committee to **confirm the approach to be taken for the compilation of the mandatory National Cost Collection (NCC); and to receive the latest information from the Costing Transformation Programme (CTP)**. The Committee heard that the National Cost Collection is a mandatory return to NHS England and were provided with a summary of the approach to information collection. The Committee approved the approach.
- The **Cash Flow Forecast** was then presented by the Deputy Director of Finance – Performance, wherein the cash flow forecast for 2025-26 was set out, together with the key risks on liquidity for the Trust. The main drivers of cash pressure were discussed and included the Integrated Care System-wide position on debt recovery and cash management. The paper also covered the potential around the supplier stretch forecast and the process that the team follows.
- The Chief Operating Officer presented the **Emergency Planning Annual Report, 2024 and future emergency planning**, which included a summary of the work of the Emergency Preparedness, Resilience and Response (EPRR) team in: Multi Agency Partnership working; Exercises undertaken in pursuance of obligations under the Civil Contingencies Act 2004; Training undertaken; Maintenance of standards in relation to helipads and a summary of incidents.
- The Committee noted the **summary report from the April 2025 People and Organisational Development Committee**; the **Quarterly analysis of consultancy use**; 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.
- 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 | Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB) | | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-14 | | | | | |
| Executive lead | Rachel Jones. Director of Strategy, Planning and Partnerships | | | | | |
| Presenter | Rachel Jones. Director of Strategy, Planning and Partnerships | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input type="checkbox"/> | Information | <input type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|---|---|---|--|---|---|
|  |  |  |  |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | This is the monthly update on the activities and focus within the Integrated Care Board and West Kent Health Care Partnership and includes an update on NHSE changes. | |
| | The key risks have been updated to reflect the changing environment and the additional capacity funding proposal is included for information. | |
| Any items for formal escalation / decision | None | |
| Appendices attached | ICB/HCP slide pack | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| | | |

| Assurance and Regulatory Standards | |
|---|--|
| Links to Board Assurance Framework (BAF) | <p>Please list any BAF Principal Risks to which this report relates:</p> <ul style="list-style-type: none"> • |
| Links to Corporate Risk Register (CRR) | <p>Please list any risks on the Corporate Risk Register to which this report relates</p> <ul style="list-style-type: none"> • |
| Compliance / Regulatory Implications | <p>Please list any compliance or regulatory matters raised or addressed by this report</p> <ul style="list-style-type: none"> • |

ICB and West Kent HCP update

May 2025

ICB/ System news

- NHS Kent and Medway Integrated Care Board have awarded new community service contracts to KCHFT, as lead provider, in a new partnership with HCRG Care Group (HCRG) and Medway Community Healthcare (MCH). The contract will commence by 27 October 2025 and will run for at least five years.
- NHS Kent and Medway has recruited Bali Rodgers an independent people and communities champion to make sure the experiences and views of patients and local communities are always at the heart of decision making. She is the CEO and founder of the Safer Communities Alliance, a Dartford-based social enterprise.
- NHSE have published the proposed National Performance Assessment Framework (NPAF) for consultation with responses due by 30/5/25. They are also publishing a new pay framework for very senior managers
- NHSE have published the Model ICB Blueprint which is intended to help ICBs shape their 50% running cost reduction by end May.
- Local elections have seen the Reform Party take over 57 of the 81 seats in the leadership of Kent County Council in a landslide victory from the previous Conservative leadership. Linden Kemkaran is the new leader of KCC.







West Kent HCP

- MTW have developed a draft a business case to consider the transfer of the out of hours GP service to facilitate delivery of a 24/7 UTC which is the a request from the ICB.
- We are considering the implications of the Model ICB Blueprint on the transformation of the WK HCP team and working with HCP SROs across K&M.
- It is likely that the additional capacity funding will be significantly reduced beyond the version presented last month. We are awaiting details from the ICB however there could be an impact on services provided by MTW and system flow.
- KCHFT are leading the development of a business case to support the Better Use of Beds program which we hope will be ready by the end of the month.

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services. Of particular note are ongoing shortages of domiciliary care staff in social care, primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue along with community mental health trained staff.
- *Demand pressures* – specifically in Urgent care and relating to the potential transfer of the west Kent GP out of hours service and the pressures in the delivery of the KeaH service in the Tunbridge Wells area.
- *Running cost reduction* – is negatively impacting staff morale and will see a smaller, more focussed team from Q3.

| | | | | | |
|--|---|--------------------------|-------------------|--------------------------|-------------------------------------|
| Title of report | Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | |
| Date of meeting | 29 th May 2025 | | | | |
| Agenda item no. | 05-15 | | | | |
| Executive lead | Sarah Davis, Chief Operating Officer | | | | |
| Presenter | John Weeks, Director EPRR | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information |
| | | | | | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | Since the presentation by the Maggie’s team to the Board in November 2024, the team have engaged with key stakeholders as follows: | |
| | Cancer Divisional Board | November 2024 |
| | Oncology Consultants Meeting | November 2024 |
| | Maggie’s Project Board | 22 January 2025 |
| | Kent Ambassador’s Engagement Event | 15 April 2025 |
| | MTW staff Q&A sessions | April 2025 |
| | A planning application was submitted to the authorities in April 2025. An update will be provided as soon as a decision is received. | |
| Any items for formal escalation / decision | None | |
| Appendices attached | Appendix 1 - Maggie’s Presentation: Opening the doors on a new Maggie’s Centre for Kent | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| N/A | | |

| Assurance and Regulatory Standards | |
|---|-----|
| Links to Board Assurance Framework (BAF) | N/A |
| Links to Trust Risk Register (TRR) | N/A |
| Compliance / Regulatory Implications | N/A |

OPENING THE DOORS ON A NEW MAGGIE'S CENTRE FOR KENT



Maggie's works alongside the NHS to provide free expert practical, social and psychological support for people with cancer, their family and friends.

Our centres are built on the grounds of NHS cancer hospitals to provide uplifting and inspiring spaces, away from the clinical ward environment. With more people being diagnosed, Maggie's goal is to increase our reach and be at every NHS cancer centre in the UK.



A new Maggie's for Kent will be pivotal in our plans to expand the support we provide throughout the South of England.

"Maggie's provides expert help in an environment that is designed to be calm and welcoming. Having a purpose-built centre at Maidstone will make a huge difference – a place for the people we treat and their friends and family to find the emotional, practical and psychological support they need" Miles Scott, Chief Executive of Maidstone and Tunbridge Wells NHS Trust



Maidstone Hospital is host to the Kent Oncology Centre, providing specialist cancer services for 1.9 million people across Kent and East Sussex. Split across three sites, the Kent Oncology centre is the fourth largest oncology centre in the country. Our new Maggie's centre will be located to provide immediate support on the hospital grounds – just a short walk.

MAGGIE'S

Operational Maggie's

Centres in development

Future centres funded by Steve Morgan

Additional centres planned

- Telaviv
- Glasgow
- Dundee
- Cardiff
- Edinburgh
- Wales
- West London
- Chesham
- Nottingham
- Swansea
- Cambridge (intern)
- Exeter
- London
- Oxford
- Winn
- Lancashire
- Royal Free
- Manchester
- York Valley
- Ottawa
- B&B
- Canter
- The Royal Marsden (Oxford)
- Leeds
- Southampton
- Northampton
- Coventry
- Cardiff
- Irish
- Macdonald (Kant)
- North Wales
- Liverpool
- St. Paul & St. Thomas
- Stratford
- Leicester
- Wolverhampton
- Stoke-on-Trent

The first Maggie's centre opened in Edinburgh in 1996. There are now 24 Maggie's centres across the UK, all located alongside major cancer hospitals, as well as international centres in Barcelona, Tokyo, and Hong Kong.

"It brought a sort of calmness to me where, instead of panicking, suffocating, I just felt I could breathe a lot easier. I learned how to manage how I was feeling; I could start to find answers"

Maggie Keswick Jencks Cancer Caring Centres Trust (Maggie's), reg. charity no: SC024414

DESIGNING A NEW MAGGIE'S CENTRE



If you've ever been to a Maggie's centre, you'll know that they are special places, and many of them have won awards for their architecture and design. This is because we know that great design and architecture can help the people who come to us feel better – and help us to give the best possible support. Every Maggie's is a unique place that fits perfectly into its surroundings – a home from home that's designed to feel nothing like a hospital.

Every one of our centres is original and surprising, yet they all feel like they are part of the same family. They all:

- Are calm, friendly and welcoming places, full of light and warmth
- Have a kitchen table at their heart
- Offer glimpses and views of the nature that surrounds them
- Provide thoughtful spaces to find privacy as well as places to come together as a group

THE DESIGN FOR MAGGIE'S KENT

For Maggie's Kent we have chosen Assemble, a multi-disciplinary collective who work across the fields of art, design and architecture to create projects in partnership with the communities who use them. Assemble was the first architecture studio to win the Turner prize in 2015.



The site for Maggie's Kent presents a verdant backdrop in which to create a unique and beautiful centre nestled within a wooded landscape. Assemble wanted to create a building which is profoundly embedded in the culture, landscape, geology and heritage of Kent.






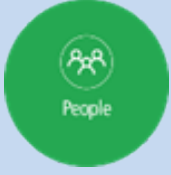


PROJECT UPDATE:

- We have signed an agreement with Maidstone and Tunbridge Wells NHS Trust to bring a new Maggie's centre to Kent and the land has been provided by the hospital on their site. Our new centre will be a short walk from the Kent Oncology Centre.
- We have now submitted our planning application and hope to have approval in early Summer. We have already completed a pre-planning consultation which was positive.
- All our Maggie's centres to date have been built thanks to exceptional philanthropic support for which we are immensely grateful. The lead gift to a Maggie's centre is awarded the opportunity to name our building.
- We are working on establishing a network of support within Kent to secure the £7 million we need to build our centre and grow a community who will help us to continue delivering impact for everyone affected by cancer.

We would be delighted to arrange visits to an existing Maggie's centre so that you can see first-hand what this new space will provide in Kent and how it would help us to support more people with cancer at the most challenging times.

FOR MORE INFORMATION ABOUT MAGGIE'S PLEASE CONTACT: Gemma Oakley, Head of Philanthropy (gemma.oakley@maggies.org Tel. 07557 972557)

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|--|---|--------------------------|-------------------|--------------------------|--|
| Title of report | Audit and Governance Committee, 15/05/25 | | | | |
| Board / Committee | Trust Board ('Part 1') Meeting | | | | |
| Date of meeting | 29 th May 2024 | | | | |
| Agenda item no. | 05-16 | | | | |
| Executive lead | David Morgan, Non-Executive Director | | | | |
| Presenter | David Morgan, Non-Executive Director | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input type="checkbox"/> | Information <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | <p>The Audit and Governance Committee met (virtually, via webconference) on 5th March 2025.</p> <p>The Committee considered the following topics in relation to the Board Assurance Framework; Review of the Trust's red rated risks, Internal Audit Annual Report for 2024/25 (incl. the draft Head of Internal Audit Opinion), Update on progress with the Internal Audit plan for 2025/26 (incl. progress with actions from previous Internal Audit reviews), Counter Fraud Annual Report for 2024/25, Informing the audit risk assessment for Maidstone & Tunbridge Wells NHS Trust 2024/25 – The Trust's response, Audit Progress Report and Sector Update from External Audit, Draft Annual Report for 2024/25 (incl. the Annual Governance Statement, Draft Annual Accounts for 2024/25 (incl. latest losses & compensations data), Approval of the Audit and Governance Committee Annual Report for 2024/25, The latest single tender/quote waivers data, Details of interests declared under the Conflict of Interests policy and procedure, Assurance of compliance with the Fit and Proper Persons Test requirements, Security Issues Annual Report, Update on Cyber Security and the Data Protection and Security Toolkit</p> <p>The Committee approved; Informing the audit risk assessment for Maidstone & Tunbridge Wells NHS Trust 2024/25 – The Trust's response, The Audit and Governance Committee Annual Report for 2024/25, the submission of the Assurance of compliance with the Fit and Proper Persons Test requirements to the Trust Board and the submission of the Data Protection and Security Toolkit to be presented to the June Trust Board meeting.</p> <p>An evaluation of the Committee was undertaken at the end of the meeting.</p> <p>The Committee considered the level of assurance that the controls of the Board Assurance Framework were effective for Principal risks 1-6 and noted where work was required to provide further assurance.</p> |

| | | |
|--|-----------------------------------|----------------|
| Any items for formal escalation / decision | n/a. | |
| Appendices attached | There are no appendices attached. | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| N/A | N/A | N/A |




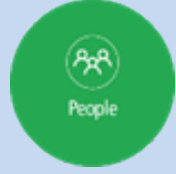


| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | <p>PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer</p> <p>PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes</p> <p>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</p> <p>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</p> <p>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</p> <p>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.</p> |
| Links to Trust Risk Register (TRR) | 802,3051,3378,1310,2945,2947,3096,3244,3243,3342,3288,3294,1270,3069,3364,3365,1286,1304,2980,3070,3109,3112,3113,3128,3328,1150,2981,3161,3355,3362,3209,2943,3253,1182,3269,3368,2998,3000,3300,3130,3157,3274,3043,3326 |
| Compliance / Regulatory Implications | <p>Code of governance for NHS provider trusts(2023)</p> <p>General Data Protection Regulations (GDPR)</p> |

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

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee considered the **Board Assurance Framework (BAF)** and considered any additional actions, that should be taken to give further assurance.
- The Head of Risk Management presented the **Review of the Trust's red-rated risks** and highlighted that the presented report has been amended to include committee assurance and demonstrate the link between risk management and the Strategic Deployment Review (SDR) process. The Committee heard that risk reports will be provided monthly to ETM, to ensure greater oversight of risk and the risk approval process has been updated. It was noted that report of the internal audit of risk management and BAF is due and should support assurance of the improvements made in the risk management process. DM noted that the report provided assurance that the risk management process is an effective one and recognised the journey that the organisation was on with an improving culture relating to risk management, which in turn will lead to further improvements in risk management.
- The Director of Audit, Tiaa Ltd presented the **Internal Audit Annual Report for 2024/25 (incl. the draft Head of Internal Audit Opinion)** and informed the Committee that, overall the Head of Internal Audit opinion is currently "Reasonable" for work undertaken through 2024-25.
- The Director of Audit, Tiaa Ltd also presented the **Update on progress with the Internal Audit plan for 2025/26 (incl. progress with actions from previous Internal Audit reviews)** and noted that three reports have been finalised since the last Committee.
- The Anti-Crime Specialist presented the **Counter Fraud Annual Report for 2024/25** and provided a summary of all the work that had been completed, which was detailed in the report. It was noted that, in accordance with the Government Functional Standard, 013 Counter Fraud, the Trust is required to complete a Counter Fraud Functional Standard Return (CFFSR). The Committee heard that this has been shared with the Chief Finance Officer and added that AI will also be included in the fraud risk assessment going forward.
- Deputy Director of Finance (Governance) presented the **Informing the audit risk assessment for Maidstone & Tunbridge Wells NHS Trust 2024/25 – The Trust's response**, for the Committee to consider and the Committee approved the report.
- The Director of Audit, Grant Thornton UK LLP provided a verbal update on the **Audit Progress and Sector Update from External Audit**.
- The **Draft Annual Report for 2024/25 (incl. the Annual Governance Statement) and the Draft Annual Accounts for 2024/25 (incl. latest losses & compensations data)** were presented to the Committee who were invited to provide comments and feedback on the content.
- The Chair of the Committee presented the **Audit and Governance Committee Annual Report for 2024/25** and the Committee approved the report.
- Deputy Director of Finance (Governance) presented **The latest single tender/quote waivers data, which** was noted to be the final quarter of the whole year, which was reviewed and discussed by the Committee.
- The Trust Secretary presented the **Assurance of compliance with the Fit and Proper Persons Test requirements** which has been submitted to the Trust Board under a separate agenda item.
- The Committee reviewed the **Security issues annual report** which has been submitted to the 'Part 2' Trust Board meeting, due to the confidential nature of the information contained therein.
- The Cyber security architect presented the **Update on Cyber Security**. The Committee noted the work being undertaken by the team to reduce the risk of cyber attacks and heard that working groups to oversee the use of Artificial Intelligence have been established.
- Head of Information Governance presented the **Data Protection and Security Toolkit** and noted that the Trust is required to complete and submit a Cyber Assessment Framework (CAF) baseline, as part of the Data Security and Protection Toolkit (DSPT), in line with NHS England and NIS Regulations 2018. The Committee approved the submission of the report to the Trust Board meeting in June.
- The Committee noted the **Details of interests declared under the Conflict of Interests policy and procedure, forward program** and conducted an **evaluation of the meeting**.

| | | | | | | |
|--|--|--------------------------|-------------------|-------------------------------------|--------------------|--------------------------|
| Title of report | Six-monthly review of the Trust's red-rated risks | | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-17 | | | | | |
| Executive lead | Jo Haworth, Chief Nurse | | | | | |
| Presenter | Jo Haworth, Chief Nurse | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | <p>This report provides the Board with an update on those risks rated 15+ as at 02 May 2025. Key changes since the last report in March are highlighted within the body of the report.</p> <p>Red-rated risks</p> <ul style="list-style-type: none"> 40 risks rated 15+ recorded on the Trust risk register 7 new risks added 2 risks increased in risk score to 15+ 16 risks rated 15+ open over 12 months 8 risks downgraded from 15+ to a moderate or low score 7 risks previously rated 15+ now closed <p>An approval process has been implemented for new risks whereby risks are signed off by the relevant governance team before being added to the Trust risk register. This is to ensure risk scores; target closure dates and risk wordings meet the expectations outlined in the Trust Risk Management Policy.</p> <p>Risk management key performance indicators are reported to the Risk and Regulation Oversight Group on a bi-monthly basis providing a breakdown by Division of</p> <ul style="list-style-type: none"> Percentage of red (15+) risks reviewed Percentage of risks below 15 reviewed Percentage of risks open over 12 months Percentage of risks with open action plans Percentage of open actions beyond target date |
| Any items for formal escalation / decision | There are no items for formal escalation. |
| Appendices attached | <ul style="list-style-type: none"> Red risk report May 2025 |
| Report previously presented to: | |
| Committee / Group | Date Outcome/Action |

| | | |
|--------------------------------|------------|---|
| Executive Team Meeting | 13.05.2025 | Additional narrative to be provided for risk appetite table |
| Audit and Governance Committee | 15.05.2025 | Risk movement tracker to include risks previously rated red Additional information to be provided in future reports of risk KPIs |

| Assurance and Regulatory Standards | |
|--|---|
| Links to Board Assurance Framework (BAF) | None |
| Links to Trust Risk Register (TRR) | This report provides an update on the red-rated risks on the Trust risk register. |
| Compliance / Regulatory Implications | None |

Red Risk Report

Board of Directors

May 2025

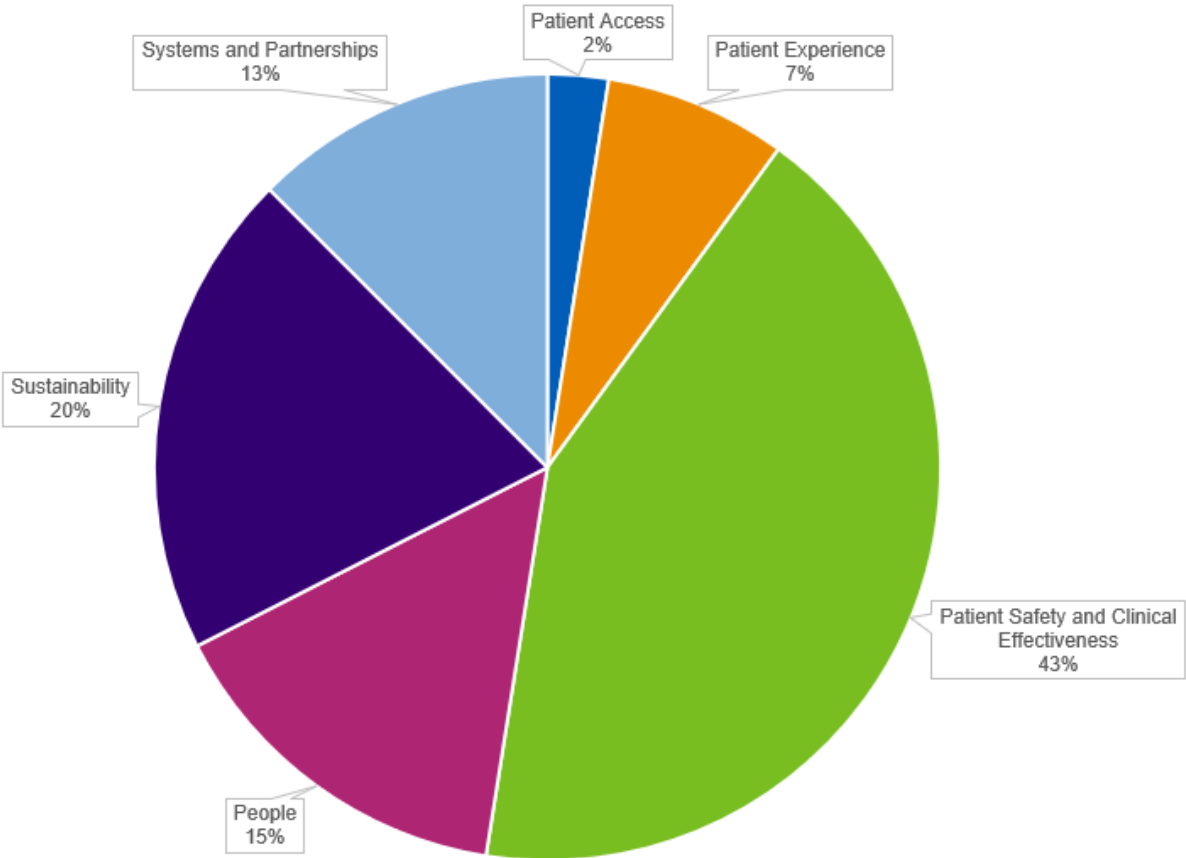
Author: Rhiannon Adey – Head of Risk Management



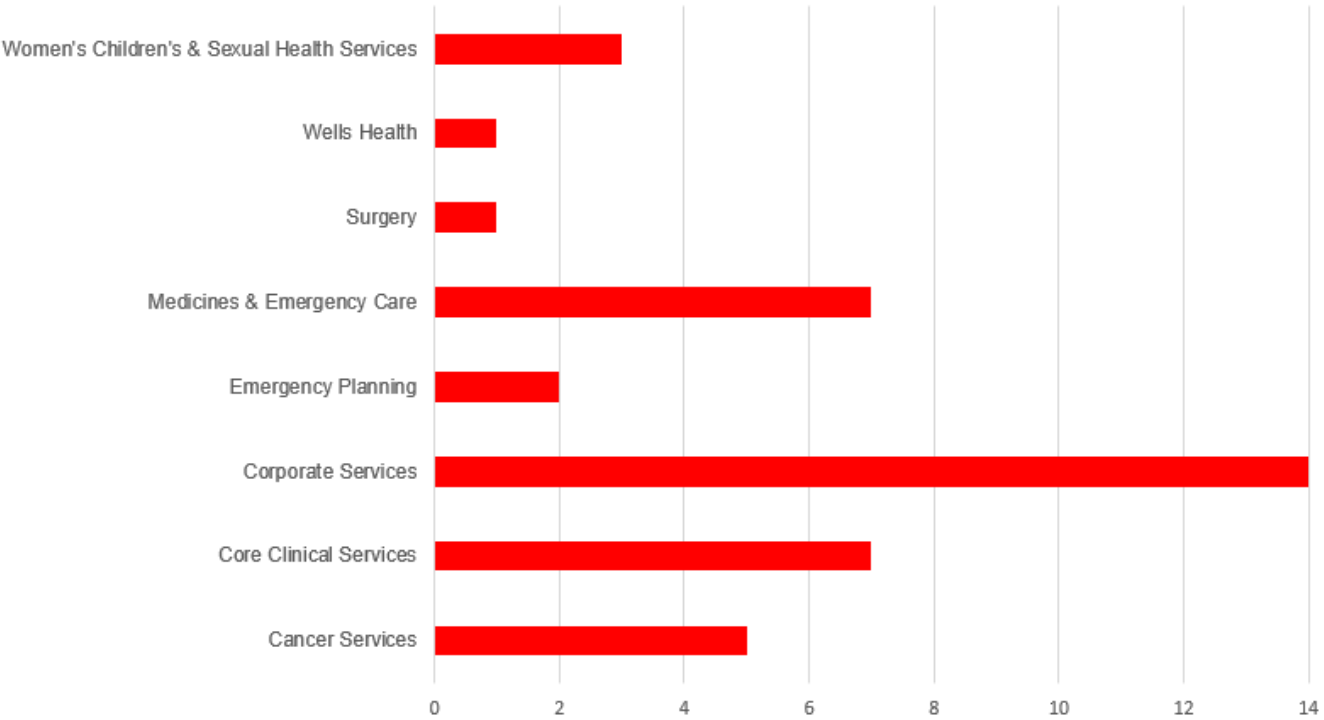
Trust Risk Profile

As of 02 May 2025 there were 246 open risks on the Trust risk register with 40 of these currently scoring 15+ (red), a reduction of 5 since the last report.

Risks scoring 15+ by Strategic Theme



Risks scoring 15+ by Division



Trust Risk Exposure and Risk Appetite

| Risk Type | Current risk exposure | Target risk exposure | Risk Appetite (as agreed by Board December 24) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------|--|----------------------|--|---|--|--|--|---|----|----|---|--|---|----|----|---|--|---|---|----|---|--|--|---|---|---|--|--|--|--|--|--|---|---|---|--|--|---|---|---|---|--|---|----|----|----|---|---|---|----|----|---|----------|
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| Regulatory | <table><tr><td></td><td>3</td><td></td><td></td><td></td></tr><tr><td></td><td>6</td><td>1</td><td>3</td><td></td></tr><tr><td></td><td>1</td><td>6</td><td>2</td><td>1</td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>1</td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr></table> | | 3 | | | | | 6 | 1 | 3 | | | 1 | 6 | 2 | 1 | | 1 | 2 | 3 | 1 | | | | | | <table><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>2</td><td>1</td><td></td><td></td></tr><tr><td></td><td>11</td><td>6</td><td>1</td><td>1</td></tr><tr><td>1</td><td></td><td>1</td><td>1</td><td>1</td></tr></table> | | | | | | | | | | | | 2 | 1 | | | | 11 | 6 | 1 | 1 | 1 | | 1 | 1 | 1 | Cautious |
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| | 6 | 1 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | 6 | 2 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | 2 | 3 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | 11 | 6 | 1 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | | 1 | 1 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quality | <table><tr><td></td><td>1</td><td>4</td><td></td><td></td></tr><tr><td></td><td>7</td><td>17</td><td>18</td><td>1</td></tr><tr><td></td><td>6</td><td>26</td><td>29</td><td>1</td></tr><tr><td></td><td>2</td><td>3</td><td>11</td><td>6</td></tr><tr><td></td><td></td><td></td><td>2</td><td>1</td></tr></table> | | 1 | 4 | | | | 7 | 17 | 18 | 1 | | 6 | 26 | 29 | 1 | | 2 | 3 | 11 | 6 | | | | 2 | 1 | <table><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td>1</td><td>1</td><td></td><td></td></tr><tr><td></td><td>9</td><td>2</td><td>4</td><td></td></tr><tr><td></td><td>21</td><td>23</td><td>15</td><td></td></tr><tr><td>1</td><td>4</td><td>12</td><td>32</td><td>8</td></tr></table> | | | | | | 2 | 1 | 1 | | | | 9 | 2 | 4 | | | 21 | 23 | 15 | | 1 | 4 | 12 | 32 | 8 | Cautious |
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| | 6 | 26 | 29 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | 3 | 11 | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2 | 1 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9 | 2 | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21 | 23 | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 4 | 12 | 32 | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reputational | <table><tr><td></td><td>1</td><td>2</td><td></td><td></td></tr><tr><td></td><td>1</td><td>6</td><td></td><td>1</td></tr><tr><td></td><td>1</td><td>8</td><td>3</td><td>1</td></tr><tr><td></td><td>1</td><td></td><td>1</td><td>1</td></tr><tr><td></td><td></td><td></td><td>1</td><td></td></tr></table> | | 1 | 2 | | | | 1 | 6 | | 1 | | 1 | 8 | 3 | 1 | | 1 | | 1 | 1 | | | | 1 | | <table><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>3</td><td>1</td><td></td><td></td></tr><tr><td></td><td>4</td><td>8</td><td>2</td><td></td></tr><tr><td>1</td><td>1</td><td>3</td><td>3</td><td>2</td></tr></table> | | | | | | | | | | | | 3 | 1 | | | | 4 | 8 | 2 | | 1 | 1 | 3 | 3 | 2 | Cautious |
| | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | 1 | 8 | 3 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | | 1 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | 3 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | 8 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 1 | 3 | 3 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| People | <table><tr><td></td><td>1</td><td></td><td></td><td></td></tr><tr><td></td><td>4</td><td>7</td><td>7</td><td></td></tr><tr><td></td><td>1</td><td>7</td><td>9</td><td></td></tr><tr><td></td><td></td><td>1</td><td>4</td><td>1</td></tr><tr><td></td><td></td><td>1</td><td></td><td></td></tr></table> | | 1 | | | | | 4 | 7 | 7 | | | 1 | 7 | 9 | | | | 1 | 4 | 1 | | | 1 | | | <table><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td></td></tr><tr><td>1</td><td>4</td><td>2</td><td>1</td><td></td></tr><tr><td></td><td>3</td><td>12</td><td>4</td><td></td></tr><tr><td>1</td><td>3</td><td>3</td><td>7</td><td>1</td></tr></table> | | | | | | 1 | | | | | 1 | 4 | 2 | 1 | | | 3 | 12 | 4 | | 1 | 3 | 3 | 7 | 1 | Open |
| | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | 7 | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | 7 | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 1 | 4 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 | 4 | 2 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | 12 | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 3 | 3 | 7 | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Risk movement tracker (15+) – last 12 months

| Risk No. | Risk Title | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | Target score | Target date |
|----------|---|-----------|---------|----------|---------|---------|---------|---------|---------|---------|---------|---------|---------|--------------|-------------|
| 802 | Significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment. | 10 = | 10 = | 10 = | 16 ↑ | 16 = | 16 = | 16 = | 16 = | 16 = | 20 ↑ | 20 = | 20 = | 4 | 30/08/25 |
| 3051 | Lack of resilience of TWH access control door system due to inappropriate back ups, single server and lack of suitable cyber security protections | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 20 = | 5 | 30/04/25 |
| 1150 | Impact of increase in number of inpatients with mental health needs / neurological deficit. | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 9 | 31/07/25 |
| 1270 | Lack of medical devices training in the Trust - training for medical devices for nursing and support staff is not mandatory, there is no corporate record of individual's device training. | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 30/06/25 |
| 1304 | There is a risk of avoidable VTEs for MTW patients linked to our E-Risk assessment and Anticoagulation prescription processes | 9 = | 9 = | 16 ↑ | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 14/08/25 |
| 2945 | Fluoroscopy room 27 at TWH exceeded end of life; failure would impact Fluoroscopy services for inpatient and elective pathways and complete suspension of proctogram service. | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 13/06/25 |
| 2947 | Mammography equipment at the TWH site exceeded end of life; degrading imaging quality and increased downtime, TWH unable to support national Breast screening programme | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 30/04/25 |
| 2980 | Risk of Healthcare associated C. difficile and breaching national limits of number of cases | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 12 | 08/05/25 |
| 2981 | Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 8 | 30/09/25 |
| 3069 | Chemotherapy e-prescribing | 12 = | 16 ↑ | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 8 | 30/06/25 |
| 3070 | Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 12 | 31/03/25 |
| 3096 | Risk of increased staff turnover/ sickness/ negative impact on wellbeing across Cellular Pathology- all roles. | 8 = | 8 = | 8 = | 16 ↑ | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 30/05/25 |
| 3112 | Lack of follow up of diagnostic reports | 16 New | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 01/04/26 |
| 3113 | There is a risk that the Trust will not have enough cash to meet its commitments resulting suppliers not being paid and the Trust not meet its BPPC (Better Payment Practice Code) target. | 16 New | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 8 | 31/03/25 |
| 3144 | There is a risk that the Trust may be subject to enforcement action from the Information Commissioner if we fail to comply with data protection legislation by breaching the disclosure timeframe for Subject Access Requests | | | 9 New | 9 = | 9 = | 9 = | 9 = | 9 = | 9 = | 16 ↑ | 16 = | 16 = | 6 | 31/07/25 |

Risk movement tracker (15+) – last 12 months

| Risk No. | Risk Title | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | Target score | Target date |
|----------|---|---------|---------|---------|---------|---------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|--------------|-------------|
| 3209 | The risk is personal injury through refusal to wear Safety goggles when using holmium laser. | | | | | | 4 New | 16 ↑ | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 30/05/25 |
| 3243 | General (plain film) x-ray service provision at MGH is compromised; largely due to an increase of unplanned equipment downtimes with subsequent impact on patient flow and turnaround times | | | | | | 16 New | 16 = | 16 = | 16 = | 16 = | 16 = | 16 = | 4 | 31/03/26 |
| 3245 | Interventional Radiology (IR) room at the TWH site exceeded end of life with detectors no longer available; will lead to reduced Trust overall capacity and no IR service at TWH for acute bleeds | | | | | | 8 New | 8 = | 12 ↑ | 12 = | 12 = | 16 ↑ | 16 = | 4 | 31/03/26 |
| 3288 | Low ligature risk room out of action due to damage caused by previous occupant | | | | | | | 16 New | 16 = | 16 = | 16 = | 16 = | 16 = | 6 | 28/02/25 |
| 3328 | Lack of Occupational Health capacity, as there are not enough OH nurses to meet the increasing demands placed on the service | | | | | | | | 16 New | 16 = | 16 = | 16 = | 16 = | 6 | 11/12/25 |
| 3344 | General (plain film) x-ray service provision at TWH is compromised; largely due to an increase of unplanned equipment downtimes with subsequent impact on patient flow and turnaround times | | | | | | | | | 16 New | 16 = | 16 = | 16 = | 4 | 02/01/26 |
| 3355 | Failing EBUS Image Processor MGH | | | | | | | | | 16 New | 16 = | 16 = | 16 = | 4 | 30/06/25 |
| 3362 | Medicine Follow Up Waiting Lists | | | | | | | | | 16 New | 16 = | 16 = | 16 = | 6 | 31/07/25 |
| 3365 | Lack of suitable equipment for radiation survey assessments to test Radiation Shielding as part of legal critical examination or to ascertain current shielding. | | | | | | | | | | 16 New | 16 = | 16 = | 4 | 31/08/25 |
| 3367 | Failure to meet RCPCH standards for Emergency Care at MGH | | | | | | | | | | 16 New | 16 = | 16 = | 12 | 30/09/25 |
| 3370 | Lack of Gamma Probes in Theatres | | | | | | | | | | 12 New | 12 = | 16 ↑ | 4 | 30/12/25 |
| 3404 | Due to increase in demand, risk of patients clinical deterioration/not getting timely treatment in Neurology | | | | | | | | | | | 16 New | 16 = | 12 | 30/06/25 |
| 3408 | The Trust lacks sufficient oversight of advanced clinical practitioners as there is no consistency of the governance framework being embedded for this professional group | | | | | | | | | | | | 16 New | 8 | 07/01/26 |
| 3418 | Microsoft Office is going out of support October 14th 2025. | | | | | | | | | | | | 16 New | 4 | 13/10/25 |
| 3422 | Planning application submitted by a charity to demolish the existing Occupational Health building at the Maidstone Hospital site will impact the provision of MTW Occupational Health services | | | | | | | | | | | | 16 New | 4 | 30/09/25 |
| 1182 | Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. | 15 ↑ | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 3 | 31/05/25 |

Risk movement tracker (15+) – last 12 months

| Risk No. | Risk Title | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | Target score | Target date |
|----------|---|---------|---------|---------|-----------|---------|-----------|-----------|---------|---------|-----------|---------|-----------|--------------|-------------|
| 2998 | Failure of the CT could result in significant disruption to the Radiotherapy service at Canterbury with the severity dependant on the length of time the CT is unavailable while repaired. | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 5 | 01/09/25 |
| 3000 | Failure of LA1C could result in significant disruption to the Radiotherapy service at Canterbury with the severity dependant on the length of time the linac is unavailable while repaired. | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 6 | 12/01/26 |
| 3043 | Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space. | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 12 | 30/09/25 |
| 3157 | There is a risk that due to the number of Virtual Servers being hosted at TWH on aging infrastructure, we will run out of available Compute | | | | 15 New | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 1 | 30/05/25 |
| 3253 | Lack of Resilience With Security Systems Contractor | | | | | | 15 New | 15 = | 15 = | 15 = | 15 = | 15 = | 15 = | 6 | 30/09/25 |
| 3274 | Patients across the Trust are not receiving timely Best Interest Assessments from the Local Authority resulting in Urgent Authorisations lapsing and unlawful deprivations of liberties. | | | | | | | 15 New | 15 = | 15 = | 15 = | 15 = | 15 = | 10 | 28/11/25 |
| 3368 | Lilie - Sexual Health patient admin system remains unsupported. There is a risk that should our system fail the supplier is unable or unwilling to fix the issue. | | | | | | | | | | 15 New | 15 = | 15 = | 6 | 30/04/25 |
| 3420 | Inaccurate and missed coding due to the high number of clinical systems and documents that need to be checked for coding and the incorrect completion of the clinical documentation. | | | | | | | | | | | | 15 New | 4 | 31/03/26 |
| 3426 | Trust will not be able to deliver it's financial efficiency programme | | | | | | | | | | | | 15 New | 10 | 31/03/26 |

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

| Risk No. | Risk Title | Opened | Initial score | Current score | Target score | Target date |
|----------|---|----------|---------------|---------------|--------------|-------------|
| 3367 | Failure to meet RCPCH standards for Emergency Care at MGH | 05.02.25 | 20 | 16 | 12 | 30.09.25 |
| 3404 | Due to increase in demand, risk of patients clinical deterioration/not getting timely treatment in Neurology | 26.03.25 | 16 | 16 | 12 | 30.06.25 |
| 3408 | There is a risk that the Trust lacks sufficient oversight of advanced clinical practitioners as there is no consistency of the governance framework being embedded for this professional group | 07.04.25 | 20 | 16 | 8 | 07.01.26 |
| 3418 | Microsoft Office is going out of support October 14th 2025. | 24.04.25 | 16 | 16 | 4 | 13.10.25 |
| 3426 | There is a risk that the Trust will not be able to deliver it's financial efficiency programme | 01.05.25 | 20 | 15 | 10 | 31.03.26 |
| 3422 | There is a risk that the planning application submitted by a charity on 17 April 2025 to demolish the existing Occupational Health building at the Maidstone Hospital site to build a centre that supports patients being treated for cancer as part of a partnership will impact the provision of MTW Occupational Health services, as there is insufficient alternative site provision being made on the Maidstone Hospital site for Occupational Health services to staff, resulting in an impact on staff and patient safety and increased clinical risk. | 25.04.25 | 16 | 16 | 4 | 30.09.25 |
| 3420 | There is a risk of inaccurate and missed coding due to the high number of clinical systems and documents that need to be checked for coding and the incorrect completion of the clinical documentation. Resulting in Loss of income, inability to accurately show the complexity of patients and care given. | 24.04.25 | 15 | 15 | 4 | 31.03.26 |
| 3370 | Lack of Gamma Probes in Theatres (escalated) | 07.02.25 | 16 | 16 | 4 | 30.12.25 |
| 3245 | Interventional Radiology (IR) room at the TWH site exceeded end of life with detectors no longer available; if fails, will lead to reduced Trust overall capacity and no IR service at TWH for acute bleeds (ED or theatres). (escalated) | 21.10.24 | 16 | 16 | 4 | 31.03.26 |

Risks rated 15+ open over 12 months

| Risk No. | Risk Title | Opened | Initial score | Current score | Target score | Target date |
|----------|--|----------|---------------|---------------|--------------|-------------|
| 802 | Significant delay in patient cancer results, due to the increased workload and complexity of cases which are above the capacity within the current Cellular Pathology department establishment. | 22/08/18 | 20 | 20 | 4 | 31/05/25 |
| 1150 | Impact of increase in number of inpatients with mental health needs / neurological deficit. | 21/04/22 | 20 | 16 | 9 | 01/04/25 |
| 1182 | Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. | 12/07/22 | 15 | 15 | 3 | 31/12/26 |
| 1270 | Lack of medical devices training in the Trust - training for medical devices for nursing and support staff is not mandatory, there is no corporate record of individual's device training. | 23/02/23 | 16 | 16 | 4 | 29/04/25 |
| 1304 | There is a risk of avoidable VTEs for MTW patients linked to our E-Risk assessment and Anticoagulation prescription processes | 01/03/23 | 16 | 16 | 4 | 14/08/25 |
| 2945 | Fluoroscopy room 27 at TWH exceeded end of life; failure would impact Fluoroscopy services for inpatient and elective pathways and complete suspension of proctogram service. | 03/04/23 | 16 | 16 | 4 | 13/06/25 |
| 2947 | Mammography equipment at the TWH site exceeded end of life; this has resulted in degrading imaging quality and increased downtime, TWH unable to support Breast screening programme | 03/04/23 | 16 | 16 | 4 | 31/03/25 |
| 2981 | Unsuitable environment for mental health and neurological deficit paediatric and adult patients in ED cross site | 03/08/23 | 12 | 16 | 8 | 01/03/25 |
| 2980 | Risk of Healthcare associated C. difficile and breaching national limits of number of cases | 03/08/23 | 20 | 16 | 12 | 31/03/25 |
| 3000 | Failure of LA1C could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the linac is unavailable while repaired. If repair is not possible the disruption would be extensive at both Canterbury and Maidstone sites and would be non-sustainable in the long term. | 04/09/23 | 9 | 15 | 6 | 28/03/25 |
| 2998 | Failure of the CT could result in significant disruption to the Radiotherapy service at Canterbury and cross-site with the severity dependant on the length of time the CT is unavailable while repaired. If repair is not possible the disruption would be extensive at both Canterbury and Maidstone sites and would be non-sustainable in the long term. | 01/09/23 | 15 | 15 | 5 | 01/09/25 |
| 3043 | Reduced service capacity of the Medical Infusion Suite and Endocrine testing due to increased demand and reduction of clinical space. | 02/01/24 | 15 | 15 | 12 | 31/03/25 |
| 3051 | Lack of resilience of TWH access control door system due to inappropriate back ups, single server and lack of suitable cyber security protections | 09/01/24 | 20 | 20 | 5 | 28/02/25 |
| 3070 | Mandatory Training Compliance for Basic Life Support is significantly below the Trust KPI | 21/02/24 | 20 | 16 | 12 | 31/03/25 |
| 3069 | Chemotherapy e-prescribing | 21/02/24 | 12 | 16 | 8 | 30/06/25 |
| 3096 | Risk of increased staff turnover/ sickness/ negative impact on wellbeing across Cellular Pathology- all roles. | 12/04/24 | 20 | 16 | 4 | 30/05/25 |

Downgraded Risks previously rated 15+

| Risk No. | Risk Title | Reason for downgrade | Initial score | Current score | Target score | Target date |
|----------|--|---|---------------|---------------|--------------|-------------|
| 3244 | The elective CT scanner (M7) which situated in Oncology MGH, which was manufactured in 2012 is currently 12 years old and end of life and likely to be end of service imminently. | Reduced grading, but pending work with Siemens and physics may require an > | 16 | 12 | 4 | 31/03/26 |
| 3294 | Lack of consultant cover in EGAU and Ward 33 as consultants are covering maternity, EGAU and ward 33 | New consultant hot day rota in place providing consultant emergency cover 8-5:30 Monday to Friday - update by KS risk scoring adjusted to 12 | 16 | 12 | 8 | 27/05/25 |
| 3394 | Failure to comply with National Hip Fracture Database audit requirements | Bank staff working to input data. Staff previously on unplanned absence will be returning to work imminently. With continued Bank staff support, backlog can be cleared in ~8-9weeks. | 20 | 12 | 4 | 30/08/25 |
| 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. | Aseptic unit support for clinical trials is improving. Two studies per month are being taken off the list of paused studies and opened. It is slow progress but an improving picture. | 20 | 12 | 6 | 05/05/25 |
| 3161 | Paper Based Systems and Tomcat not Compatible with other IT Systems | Due to effective mitigations in place, risk reduced to Amber 9, with a view to further review to ensure that no incidents are raised, and risk continues to be successfully managed and mitigated. | 16 | 9 | 6 | 21/05/25 |
| 2943 | Nuclear Medicine SPECT/CT at TWH exceeded end of life; failure would prevent services to operate at TWH site, reduction of Trust capacity, lack of specialised service for patients unable to be transferred to MGH and paediatrics and loss of service continuity for MGH site. | Feedback from risk manager- risk increased with FSN that closed TWH site; now resolved, risk returned to amber. | 12 | 12 | 3 | 31/03/26 |
| 3300 | There is a risk that as of 22 Nov 24, patients under the care of WK Melanoma Consultant (RP) may have delays to first Oncology OPA, FUP review, management of treatment due to unplanned absence of consultant for the foreseeable future [awaiting confirmation of timeframes]. | Risk reviewed and reduced with interim cover in place. Directorate will review and reassess in April | 20 | 9 | 4 | 28/02/25 |
| 3326 | There is a risk that should the blood issue fridge fail at Fordcombe hospital there is no back up which would result in failure of cold chain and therefore patient safety would be compromised if units were either not available due to them not being able to be used due to lack of cold chain or if accidentally used when cold chain is broken. If serologically compatible units were stored in the fridge which failed this would result in extra time for crossmatching of additional units from the Trust to arrive at Fordcombe for immediate issue to patient post receipt, which could increase morbidity and mortality for patients in need. | Awaiting mapping report which confirms that the back up blood fridge is fully operational and monitored. In interim staff are recording temperature manually and submitting to Pembury laboratory team. | 25 | 5 | 5 | 30/04/25 |




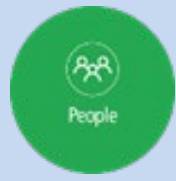


Closed Risks

| Risk No. | Risk Title | Reason for closure | Initial score | Current score | Target score |
|----------|--|--|---------------|---------------|--------------|
| 1310 | Acute general x-ray at TWH exceeded end of life; this is causing increase of downtimes and acute and inpatient flow and increase of patients requiring repeated imaging and additional exposure to radiation. | Closed, combined with Risk 3344 as the risk is for the same type of imaging equipment and all three are on the same site, each potentially effecting each other and part of the same mitigation plans. ES 17.04.2025: 1 room replaced; moderating score to amber 12- with the combined risk of replacing elective this meeting the target score- risk to be closed and new risk of X-Ray overall at TWH to be raised. | 20 | 12 | 12 |
| 3342 | Elective general x-ray at MGH exceeded end of life; this is causing increase of downtimes and subsequent impact on patient flow and turnaround times and increase of patients requiring repeated imaging and additional exposure to radiation. | Combined with Risk 3243, due to 3 rooms with the same type of imaging equipment all on the same site. Each room is the mitigation for each other to manage flow. 17.04.25- Room 4 replaced mitigating this risk from a red- amended target risk to 12 which would be accepted at point in time as contingency available for elective- risk closed overall and new X ray risk only raised for MGH site. | 16 | 12 | 12 |
| 3364 | Unavailability of suitable equipment to test Radiation Shielding as part of legal critical examination or to ascertain current shielding. | Duplicate of risk 3365 | 16 | 16 | 4 |
| 1286 | Statutory Compliance | A compliance review has been carried out relating to this risk and as a result this risk is closed. | 16 | 12 | 12 |
| 3269 | Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus | Budgets have now been reviewed and inline with Br+ all training is supported as a cost pressure. | 16 | 15 | 6 |
| 3130 | There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP) | CIP position delivered for 24/25 financial year | 16 | 16 | 8 |
| 3395 | D-Dimer cut off valve incorrectly assigned since July 2020. | This is no longer a risk as review of 3 months has been completed with no harm found. Further look back is ongoing but risk of harm to these patients is minimal. Risk is therefore to be closed. | 16 | 12 | 4 |

Recommendations

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

| | | | | | | |
|--|---------------------------------------|-------------------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | EPRR Annual Report 2024 - 2025 | | | | | |
| Board / Committee | Trust Board 'Part 1' meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-19 | | | | | |
| Executive lead | Chief Operating Officer | | | | | |
| Presenter | Chief operating Officer | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|--|---|---|--|---|---|
|  |  |  |  |  |  |
| ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| Executive Summary | | |
|--|---|----------------|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The EPRR Annual Report is required to be presented to public Trust Board each year. It summarises the work of the EPRR team in: <ul style="list-style-type: none">• Multi Agency Partnership working• Exercises undertaken in pursuance of obligations under the Civil Contingencies Act 2004• Training undertaken• Maintenance of standards in relation to helipads• Summary of incidents | |
| Any items for formal escalation / decision | Agreed at the ETM to come to the Trust Board for approval. | |
| Appendices attached | EPRR Report | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| | | |

| Assurance and Regulatory Standards | |
|---|---|
| Links to Board Assurance Framework (BAF) | PR1; PR2; PR3; PR4; PR5; PR6 |
| Links to Trust Risk Register (TRR) | |
| Compliance / Regulatory Implications | Civil Contingencies Act 2004 CAP guidance – Civil Aviation Authority – Helipads Standard National Contract Terrorism (Protection of Premises) Act 2025 Health & Safety At Work Act 1974 |

MTW EPRR Annual Report

2024 - 2025

Version 1.1



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1 Introduction

This EPRR annual report outlines the key activities of the EPRR team. A commitment to resilience, allows the organisation to safeguard patient care, support their loved ones, look after the health and well-being of staff and maintain the reputation of the organisation during times of emergency.

Over the past twelve months the EPRR team have focused on strengthening our trust resilience, improving staff readiness and fostering a culture of preparedness across all levels of the trust.

Our overall commitment is evidenced in this year's EPRR assurance results as the Trust remain fully compliant in all of the 64 core standards.

The Trust continues to meet the legislative requirement of the Civil Contingencies Act 2024. Additional legislation will require investment over the next few years after a careful and detailed assessment of the requirements.

2 Outbreak of Pandemic Disease

It is important to note that a pandemic remains one of the highest risks on the Trust risk register and the National Risk Register. The team will analyse any recommendations from the final Covid Public Inquiry Report relevant to Trust preparedness.

During the year new procedures for the management of High Consequence Infectious Diseases (HCID) have been implemented. The team continues to proactively engage with the Infection Prevention and Control team and specialist key divisions to enable the Trust to respond effectively, enhancing staff training to best practice and the latest guidance.

During the year planning and training has included the response to Mpox, Flu and Measles. There were two occasions when plans where plans were activated to suspected viral haemorrhagic fevers both proved not to be.

3 Training and Development

To increase knowledge around resilience the EPRR team have been participating in the MTW Connect days and local school recruitment days.



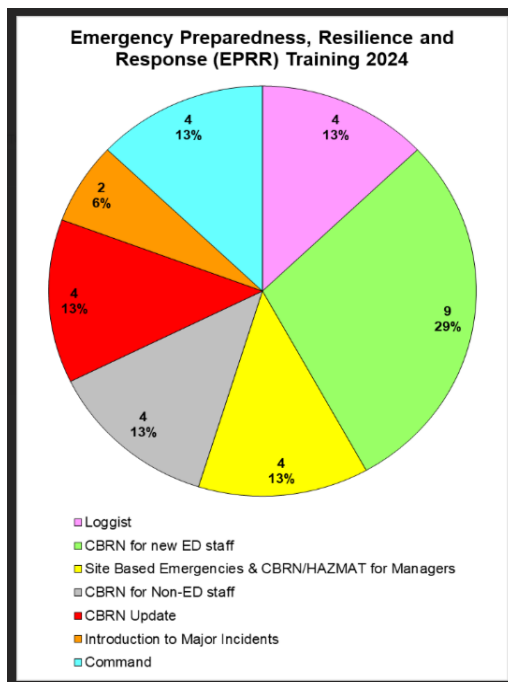
3.1 Training delivery

The team have continued to place a strong emphasis on staff training and development throughout the year.

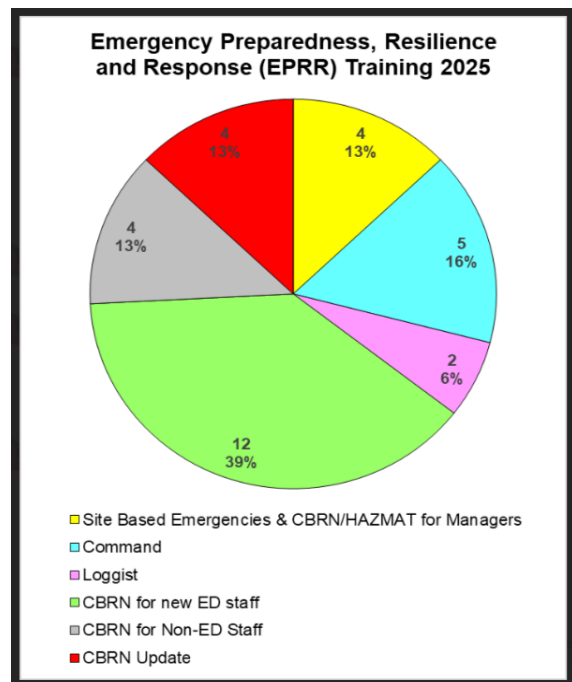
This includes bespoke training for teams usually when they have identified new or emerging risks and mandatory training including Chemical Biological Radiation and Nuclear Incident Training. Additional training included Commander and a new CPD training programme for on call managers and Directors.

The mandatory training covered for 2024 comprised of the following sessions:

2024:



2025:



4 Training themes - Emergency Services

Partnership working with other agencies is a critical part of the work of the EPRR team and reaps significant rewards when emergencies occur.

4.1 Kent Police

As a key part of the Mass Fatalities Plan for the county the EPRR Team worked with the Police to practice and reassess their response to Disaster Victim Identification. This also provided the opportunity for trust staff to get involved and practice their roles in this rare but important part of emergency response. The team wish to place on record our thanks to the Care After Death Directorate for their continuous support in this critical but often unseen area of emergency planning.



Kent Police working with NHS Staff as part of Disaster victim identification work at Tunbridge Wells Hospital.

4.2 Aircraft Providers

In June, the team were able to demonstrate the capabilities of a larger aircraft on a hospital helipad and the positive joint working relationships we have with the HM Coastguard Search and Rescue crews. The audience incorporated 25 Police cadets and Inspectors, crews from Kent Fire and Rescue Service and key response staff from the trust.

The helipads are regularly used by the Kent, Surrey and Sussex Air Ambulance to deliver time critical patient care. This year there has been an increase in the use of the helipads to deliver time critical transfers by air. This is important as it means staff are not out of the hospital meaning existing patients are better served especially during busy periods.

The Team has produced new Helicopter Operations Manuals and Risk assessments as required by NHS England and the Department for Transport in the wake of the learning into the tragic incident at a hospital in the South West of England.

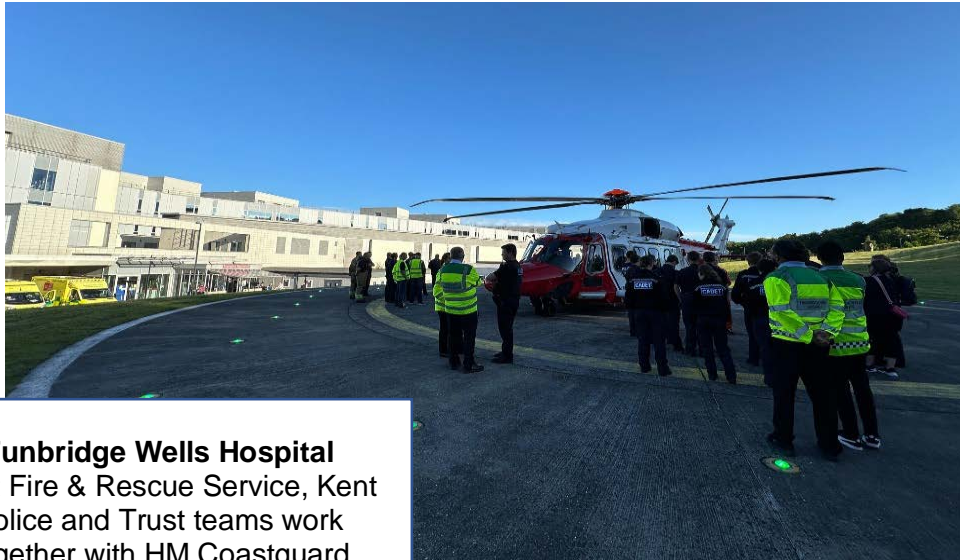
At Maidstone a generous donation by the HELP appeal has meant the helipad has been improved and is now open again to flights. The team will work with providers to further engage with local residents and staff who work in that area of the site.



Maidstone Hospital
Improved facility now open



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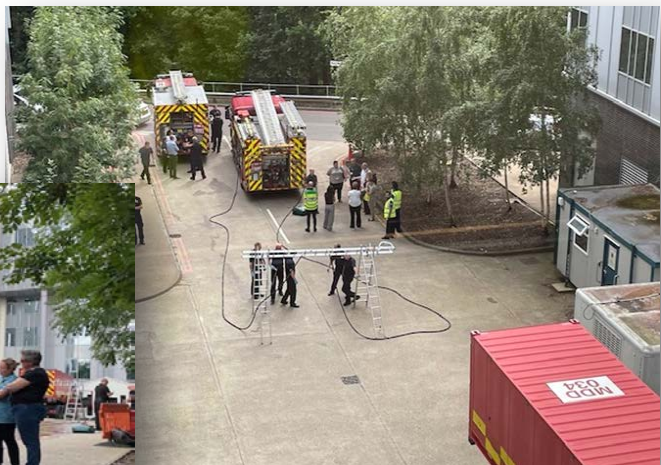


Tunbridge Wells Hospital
Kent Fire & Rescue Service, Kent
Police and Trust teams work
together with HM Coastguard

4.3 Kent Fire and Rescue Service

In the event of a large-scale incident involving contamination Kent Fire & Rescue have a key role in supporting the trust's decontamination capability. The team organised Kent Fire and Rescue Service to demonstrate the equipment and structure for this process. The invite was extended to other Acute NHS providers to see the kit in use. The kit when fully deployed requires an extensive footprint so pre-planning is essential.

Kent Fire & Rescue CBRN
Run through at TWH



5 Training Themes - Clinical Areas

5.1 Intensive Care Unit

Senior staff from ITU at TWH requested the EPRR team's expertise in guiding them to support organising a patient evacuation out of the unit including live testing and practicing the process. To gain professional input from subject matter experts we arranged and enlisted involvement from Kent Fire and Rescue Services amongst others.

OFFICIAL

This facilitated group discussions with positive outcomes allowing practical training and validation of plans. There was clear evidence of learning from previous incidents from around the UK.



Teams use mock patients to understand the complexity of evacuating critical care patients.

5.2 Emergency Department

The EPRR team work collaboratively with both Emergency Departments as its fundamental that the staff are skilled and equipped to deal with a time critical incident. Exercising is key to ensure they remain competent as the Trust's front door. Exercises in operational flow, resilience, triage and reception as well as HCID, decontamination and radiation monitoring have all occurred. The Board are asked to note the significant training burden required to keep the organisation safe on this already very busy area.



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5.3 Chemical Biological Radiation and Nuclear Incidents

The team in 2024 delivered CBRN training to 239 MTW staff and remains a mandatory training session for the Emergency Department staff.

We promote and encourage all staff to join and the course remains an ever-popular subject for trust staff outside the ED areas which is encouraged to ensure the trust has resilience.

As part of our annual assurance South East Coast Ambulance Service completed a peer review on our training scheme and materials with a very positive feedback. It was recommended that we should engage in demonstrating our materials to the wider acute sector as gold standard.



The team have provided external CBRN training to the community Urgent Treatment Centres and colleagues from NHS England attended MTW's Command Foundation Course.

5.4 Command Training

Providing Incident Commanders at all levels with the skills to manage an incident is important as they are different to the skills used in day to day management. This training is often overlooked by more senior managers due to the pace and complexity daily workload. In the event of an incident inquiry evidence of this training is often required so we are actively seeking attendance from senior managers and evidence should be requested at appraisals or set as an objective.

30-minute CPD events on-line have been introduced this year along with a dedicated MS Teams channel to share information and learning to help maintain skills and knowledge and so far, have been well attended.

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6 Exercising

In September, the team organised large live multi agency exercise involving all emergency services. The live exercise involved full scale activation of our new trust Evacuation Plan and required our staff and (fictitious) patients to act in real-time as if a genuine emergency was unfolding to validate the overall plan.

This allowed part of the trusts traffic management plan to be activated involving support from both the Police and the trust security team. The incident focussed on evacuating the new Kent Medway Orthopaedic Centre under realistic smoke logged conditions.



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6.1 Exercise Woodsmoke

As part of the risk assessment into the consequence of climate change the team identified higher risk at Tunbridge Wells which is surrounded by forest on three sides. The exercise in March involved key trust staff, PFI partners, Kent Fire & Rescue, Kent Police, South East Coast Ambulance Service, Highways and the K&M Integrated Care Board.

A number of recommendations were identified and are being worked through. Kent Fire & Rescue Service have also reviewed their plans and risk assessments for the site.



6.2 Exercise Medic

Following a successful training and familiarisation evening involving numerous fire crews from across West Kent a live evacuation of the new Kent & Medway Medical School building at Tunbridge Wells with Kent Fire & Rescue Service took place involving staff volunteers.

In the next year the team will be carrying out:

6.3 Exercise Bullfinch

The increase in discovery of unexploded ordnance has led to the creation of this table top exercise in conjunction with Kent & Medway NHS Partnership Trust to review plans for jointly responding to an incident at Maidstone where the two Trusts share boundaries.

6.4 Internal communication exercises

This will involve analysing the emergency cascade by the means of walking the process as an alternative to current practice of internal phone calls to busy clinical areas. This is in addition to the regular testing of the Everbridge Emergency Alerting System. The team are also working with Teletracking to test the use of banners on the screens to alert wards of incidents.

The Everbridge System allows a full audit of the responses of key people via an app, text message or e mail.

6.5 New Alerting from South East Coast Ambulance Service

A new system of alerting the Trust from Ambulance Control using the Everbridge System will be tested. This will include better use of the CCC to activate major incident plans.

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6.6 Exercise Beech

This is a regional virtual table top cyber exercise in July seeking to explore lessons identified from the recent London cyber-attacks. The team will continue to work with the new Chief Technology Officer on all aspects of IT resilience including switchboard and the bleep system.

6.7 Exercise Carbine

Working with Kent Police colleagues the team will train key staff and then test response plans to working with Police in a number of situations including firearms incidents, public order incidents, incidents involving VIPs and forensic capture.

7 Incidents

7.1 Major Incident

Tunbridge Wells Hospital was alerted in May to a Major Incident involving approximately 50 school children and a farm vehicle.

The Care Coordination Care was activated as the tactical command centre.

The Trust response was activated and executed extremely well especially in the creation of paediatric capacity which fortunately was not needed.

7.2 Site Based Emergency

An out of hours incident resulted in the EPRR team attending on site to provide tactical advice to the Tactical Commander in after a patient scaling the hospital roof working with all the emergency services to ensure a successful conclusion.

7.3 Chemical Incident

In December, an accidental spillage occurred within the vicinity of the microbiology labs, the EPRR team responded to establish the situation, seriousness of the incident and offered key advice

The result, a toxic chemical was dealt with under appropriate plans and staff and patients in the adjacent areas were safe. The team are working closely with the lab to review the current policy and procedures to maintain a safe approach in the unlikely event it happens again.

7.4 Industrial Action

The team continued the supportive role from the latter months of 2023 to 2024 with the protracted Doctors Industrial Actions from all grades. We provided the tactical advisor role and aided the organisation of information gathering for the Industrial Action Plan.

7.5 Business Continuity

During the course of the year, the trust was involved in utilities outages relating to water. Locally water collection points were established by the water company. The team worked with clinical teams to ensure careful discharge planning for our patients in affected areas and by providing bottled water. Further support was provided to ensure patients registered with the water company priority customer list. The team provided the trust with updates from South East Water demonstrating the good partnerships with South East Water.

During the course of the year both sites experienced intermittent complications with telephone and bleep systems. This has resulted in a review of plans and considering other alternative methods to safeguard patient care and maintain critical operations.



Testing of plans to deliver water direct to internal tanks in the event of water supply failure.

8 Internal & External Contract Partnership Working

8.1 Safety Advisory Groups (SAG)

The team is working seamlessly with local authority SAGs to review local event medical plans. The workload substantially increases in Summer months with a goal of protecting our sites by reducing attendances at ED. The team carry out site visits with partner agencies including local authorities and blue light services. This year medical cover has been the focus of a number of HM Coroner Inquests so its vital the team work collaboratively to ensure the public receive the best care by ensuring event medical providers understand the local NHS and what alternative pathways are available. The team work with ED to monitor attendance from events – this year one event spiked attendances and this was swiftly reported and collaborative work with others has led to action this year to prevent a reoccurrence.



8.2 Site developments

The hospital sites are constantly being developed. The teams work with Estates and contractors that undertake work in our hospitals to improve and replace essential equipment and machinery becomes important to protect our patients, service delivery and hospital.

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Key stakeholders within the trust have reached out to the EPRR Team for advice and planning to ensure all aspects are considered and covered with risk mitigation in place.

Examples include:

- Upgrades of UPS
- Upgrades of power switches
- Generators testing and urgent maintenance
- Removal and replacement of existing walk away TWH
- Water supplies



8.3 Fordcombe Hospital

The Team were involved in the transition of the Fordcombe site and facilitated a resilience workshop – in addition a new Fordcombe Site Emergency Plan is now available. Additional training has been delivered on site to cover a range of likely emergencies.

8.4 KMOC and CDC

Additional resilience work was undertaken this year to support the opening of KMOC, CDC and the medical school building.

9 Digital transformation

In the latter part of 2024, the EPRR team had been exploring the use of technology to enhance the efficiency, coordination and effectiveness of managing the documentation in use. This includes putting CPD training on line and the use of Teams has meant greater coverage of CPD training. Another example is utilising QR codes to aid the return of monthly checks – making the checklist freely available. Enhancing warning and informing was achieved in the CCC by streaming the high-level information required on to screens.

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10 EPRR Team and future plans

During the year the team have either received or carried out visits to Kings College Hospital as the Major Trauma Centre, National Highways Regional Control Centre at Godstone, Kent Highways, South East Water, Kent Fire & Rescue, Kent Police, South East Coast Ambulance Service, HM Coastguard, Maidstone Borough Council, Tunbridge Wells Borough Council, Sevenoaks District Council, NHS England, HM Prison Service, Allington Waste Management Facility, Environment Agency Flood Team and South Eastern Railway.

A debrief was facilitated via EPRR colleagues in to Operation Sandpiper

The team worked with a new Secure School alongside ED and Security to ensure patients from the facility could be admitted appropriately without disruption to services.

The team remain active members of the National Performance Advisory Group on Resilience (NPAG)

The team will continue to plan for climate change in particular flooding from extreme rainfall and disruption from Heatwaves.

A watching brief will be maintained in relation to the new European Entry System and any potential for disruption.

The team helped develop a new EPRR MSc module for the University of Kent which is currently being piloted.

Working with IT the team will support planning for Cyber incidents.

The Team were represented at the 30th anniversary of the Cowden Train Crash near Tunbridge Wells in October.

As a new year starts, planning is imperative to protect services the trust provides. The team will seek more efficient and cost-effective ways to maintain resilience.

Reflecting on the extensive work undertaken on the helipad at Maidstone, there will be a necessity to future proof the helipad at Tunbridge Wells Hospital to continue to expedite time critical care delivery, whilst conforming to the new national required standard.

Emerging threats and compliance with national standards mean there must be adequate and reliable chemical resistant PPE suits and a decontamination equipment to protect the safety and effectiveness of our staff working in hazardous incidents. Investment will be required in this financial year.

A number of inquiry reports, recommendations and new legislation will require focus this year and the Trust will need to take into consideration changes like the creation of Martyn's Law when the hospitals become enhanced tier premises. The Act called the Terrorism (Protection of Premises) Act 2025 was named after Martyn Hett who sadly died in the Manchester Arena Attack.

A key aim for this year will comprise of reenergising the Independent Sector partnership drawing up new agreements and different ways of working together.

The EPRR team will continue to showcase both of the sites and invite the Emergency services to undertake familiarisation and training opportunities recognising risks within the buildings.




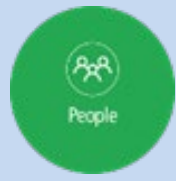


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11 Conclusion

The Trust remains well prepared for emergencies but this year the organisation should ensure that:

- It ensures that resilience remains an important consideration especially when difficult decisions are made or complex projects are undertaken.
- Staff including senior managers attend training and ensure their staff have the time to take part in training and exercising to maintain competence.
- Divisions ensure they review and keep up to date Business Continuity Plans during changes to departments, services and staffing. These require constant revision and adaptation.
- Capability in responding to CBRN incidents is maintained.
- The EPRR team will continue to monitor and horizon scan for emerging risks that require planning or action.
- The Resilience Committee will continue to require divisions to report on resilience work, incidents and application of lessons identified escalating where necessary.

| | | | | | | |
|--|--------------------------------------|--------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | Annual Fire Safety Report | | | | | |
| Board / Committee | Trust Board 'Part 1' Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-20 | | | | | |
| Executive lead | Sarah Davis, Chief Operating Officer | | | | | |
| Presenter | Sarah Davis, Chief Operating Officer | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> as appropriate) | | | | | |
|--|---|---|--|---|---|
|  |  |  |  |  |  |
| ✓ | <input type="checkbox"/> | <input type="checkbox"/> | ✓ | <input type="checkbox"/> | ✓ |

| Executive Summary | |
|---|--|
| Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals) | The Annual Fire Safety Report is enclosed. |
| Any items for formal escalation / decision | |
| 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) | 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) | N/A |
| Compliance / Regulatory Implications | N/A |

Annual Fire Safety Report 2024/25.



11 April 2025

Maidstone and Tunbridge Wells NHS Trust

Report Completed by: Mark Vince MIFSM CFRAR MIFPO

Senior Fire Officer



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Annual Fire Safety Report 2023/24.

1. Summary of Activity.

Summary
of Activity:

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

Key findings;

- Fires on site have decreased from 3 the previous year to 1 in this year.
- The fire incident occurred in the cold food preparation area on Level -2 at the Tunbridge Wells Hospital, where a Portable Hot Food Cabinet had caught fire. The fire almost immediately self-extinguished and there was no significant amount of smoke but enough for the fire alarm system to activate. A report was submitted via the InPhase reporting system. The report was investigated by the Senior Fire Officer however, no cause was identified as to why the ignition took place. The cabinet was sent for disposal, the remaining trolleys were checked for electrical safety and the incident closed. There was no attendance required by the Kent Fire and Rescue Service. There were no casualties as a result of this incident
- Unwanted fire signals have increased on last year by 5.
- The main factors causing unwanted fire signals were toasters, unintended activation of call points and aerosol use, (see pages 15/16 for a full breakdown).
- Risks identified during the fire safety inspection process generally fall into one of three categories and will be monitored as part of this year's ongoing inspection programme and addressed as part of planned works throughout the year. They are;
 - Fire doors condition;
 - Fire compartmentation;
 - Fire signage missing or faded.

Conclusions;

Evidence would suggest that the continued increase in unwanted fire signals is the use of unauthorised toasters. This type of incident has increased from 17 last year to 20 this year. Staff have been reminded through the Health and Safety Committee that the use of toasters must only be for the provision of toast to patients on wards. Any area that feel they need a toaster must submit a toaster application form to the Senior Fire Officer for approval. Toasters that were found to be the cause of fire alarm activation were removed by the Fire Response Team.

| | |
|--------|--|
| | <p>Fire alarms caused by patients/visitors activating fire alarm call points either deliberately or by accident believing them to be the door release button have remained high at 17, compared to 21 last year. As and when they occur going forward it is suggested that covers are fitted to the call points to prevent accidental activation.</p> <p>Over use of aerosols by patients caused 17 unwanted fire signals, the vast majority of which occurred at the Tunbridge Wells site where the en-suite rooms are located.</p> |
| Trust | Provide a safe working environment in line with the Trust objective of objective: exceptional people delivering outstanding care. |
| Legal: | Maidstone and Tunbridge Wells NHS Trust acknowledges its responsibilities under the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) and ensures that fire risk assessments are carried out on its premises to determine the general fire precautions and protective measures needed to comply with the articles imposed under this order. This is conducted in line with PAS 79-1. PAS 79-2 (Fire risk assessment – Guidance and a recommended methodology) is a Publicly Available Specification published by the British Standards Institution. |

2. Introduction.

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

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

2.1 Fire Safety Report 2024/25.

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

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

3. Performance.

The Fire Safety Department have visited every local fire station over the last twelve months to promote an open working relationship with our fire and rescue colleagues, all visits were well received and a standing open invite has been extended to Fire-Fighters to visit any of our sites for familiarisation visits.

To date the Fire Safety Department has hosted 10 such visits, including a visit by the Kent Fire & Rescue Service to the new Undergraduate Medical Building and a visit to the Sevenoaks Fire Station to discuss their concerns surrounding fire safety at the Sevenoaks Hospital, for which we are now partially responsible following the transfer of the UTC to the Trust. We will continue to promote our visits throughout the coming year.



Additionally, throughout the year the Fire Safety Department has been in constant communication with the Kent Fire and Rescue Service with regard to the inoperability of the local fire hydrants at the Maidstone site and the unavailability of firefighting lifts at Tunbridge Wells, either through routine maintenance or lift failure. The issue with regard to fire hydrants on the Maidstone site has now been resolved and our hydrants are now fully operational.

3.1 The Fire Safety Department.

Last year the Trust successfully completed recruitment to the role of Assistant Fire Safety Officer. The successful candidate, James Gibson, was recruited through the apprenticeship scheme. James has since successfully completed his NEBOSH fire certificate and is scheduled to complete his full apprenticeship by the end of May 2025.

This new post as well as providing the department with a succession plan, gives the Fire Safety Department the ability to increase fire safety inspections, fire drills and fire related training.

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

Below is a list of the live and simulation exercises that have taken place this year. Please see the Emergency Planning annual report for full details of these exercises, including outcomes and lessons learned.

| | | | |
|----------------------------------|------------|----------|-----------|
| Major Incident - RTC | 22/05/2024 | Incident | Live |
| KMOC - Ex PEARCE | 02/09/2024 | Exercise | Live Play |
| Bleep outage | 10/10/2024 | Incident | Live |
| Tele-tracking | 16/10/2024 | Incident | Live |
| EX Woodsmoke TWH | 24/03/2025 | Exercise | Table Top |
| Intermittent power failure - MGH | 18/03/2025 | Incident | Live |

In association with the Communications Department, the Fire Safety Department has developed a QR code poster for staff to report fire safety concerns. This is now being rolled out to areas when they receive a planned fire inspection.



3.2 Fires on Trust Premises.

- There was only one minor fire on Trust premises this year. The fire incident occurred in the cold food preparation area on Level -2 at the Tunbridge Wells Hospital, where a Portable Hot Food Cabinet had caught fire. The fire almost immediately self-extinguished and there was no significant amount of smoke but enough for the fire alarm system to activate. A report was submitted via the InPhase reporting system. The report was investigated by the Senior Fire Officer however, no cause was identified as to why the ignition took place. The cabinet was sent for disposal, the remaining trolleys were checked for electrical safety and the incident closed. There was no attendance required by the Kent Fire and Rescue Service. There were no casualties as a result of this incident

| Fires on MTW sites | 2023/24 | 2024/25 |
|--------------------|---------|---------|
| | 3 | 1 |

3.3 Unwanted Fire Signal (UFS).

A UFS is defined as follows;

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

| UFS's at MTW | 2023/24 | 2024/25 |
|--------------|---------|---------|
| | 92 | 97 |

See section 7 for a statistical breakdown of these figures.

Clarification as to current performance;

Unwanted fire signals are up on last year by 5 activations.

Evidence would suggest that the continued increase in unwanted fire signals is the use of unauthorised toasters. This type of incident has increased from 17 last year to 20 this year. Staff have been reminded through the Health and Safety Committee that the use of toasters must only be for the provision of toast to patients on wards. Any area that feel they need a toaster must submit a toaster application form to the Senior Fire Officer for approval. Toasters that were found to be the cause of fire alarm activation were removed by the Fire Response Team.

Fire alarms caused by patients/visitors activating fire alarm call points either deliberately or by accident believing them to be the door release button have remained high at 17, compared to 21 last year. As and when they occur going forward it is suggested that covers are fitted to the call points to prevent accidental activation.

Over use of aerosols by patients caused 17 unwanted fire signals, the vast majority of which occurred at the Tunbridge Wells site where the en-suite rooms are located.

3.4 Fire Safety Improvement Notices.

The Fire Safety Department have now implemented an internal fire safety improvement notice, these will be used to formally escalate persistent issues of breaches of fire safety legislation by a department but will also include help/advice as to what needs to be done to rectify the issue. Improvement notices issued will be included within the Fire Officer's report to the Health & Safety Committee.

3.5 Other Trust Sites;

Fordcombe; Now has a fully compliant PAS 79-1 fire risk assessment in place and a new fire evacuation plan is in situ. Fire response training has taken place throughout the year and will continue throughout this year. Fordcombe will now form part of the main monthly fire report, as with our other two main sites.

Hermitage Court; Roundall, Units A, D, F and the new Hounsfield Unit have all been inspected in the last twelve months. The only major issue identified was the lack of an auto-dialling system to alert main switchboard if a fire alarm is activated outside normal business hours in unit F and the Hounsfield Unit.

Oncology Kent and Canterbury Hospital; Local fire evacuation documentation is in place following last year's inspection. Training has been undertaken in the last twelve months with MTW staff covering fire evacuation and the role of the fire warden. There have been no fire safety concerns raised.

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

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

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

Park Wood; Final risk assessment conducted in 2023 prior to the closure of laundry services, no concerns identified. Planned inspections are still taking place and will continue until the building is handed back.

Sevenoaks UTC; Compliant risk assessments in situ following the transfer to MTW. Local fire evacuation documentation is in place following last year's inspection. Training has been undertaken in the last twelve months with staff covering fire evacuation and the role of the fire warden. There have been no fire safety concerns raised.

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

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

All outlying areas have planned inspections scheduled for the coming year. This will include the Undergraduate Medical Building, the Hounsfield Unit at Hermitage Court, as well as the newly acquired UTC at Sevenoaks.

3.6 Fire Risk Assessments.

One of the key factors of good fire safety management is an ongoing system of risk assessment and review. During 2024/25 considerable efforts have gone into ensuring all areas of the MTW site have current risk assessments in accordance with PAS 79-1 or PAS 79-2 requirements. In addition, all areas have a new local fire document issued in accordance with HTM 05-01 Section K. Contents include;

- Local fire risks;
- Fire exit maps;
- Roles and responsibilities in the event of fire;
- PEEP template;
- Fire inspection template;
- Special considerations (Departmental specific);
- Fire assembly point map.

ITU/HDU

EVACUATION IN THE EVENT OF FIRE OR SIMILAR EMERGENCY.




Progressive Horizontal Evacuation Routes are: **Theatres and Chronic Pain.**
**Should Chronic Pain be deemed not suitable or Theatres not available, MSSSU
Theatres & Recovery will be used.**

Document compiled by: Mark Vince MIFSM CFRAR MIFPO
Job Title: Senior Fire Officer
Area Name: ITU/HDU
Zone and Floor: Block E – First Floor
Document Number: FRAM 20

This document is to be used in conjunction with the overall PAS 79-1 Fire Risk Assessment for the hospital. This document is maintained by the Senior Fire Officer and is available on request by the Kent Fire & Rescue Service.

15/02/2025

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Senior Fire Officer
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Internal: 28985
E-mail: mark.vince@nhs.net
Mob: +44 (0)7712-333-093

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

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

4 Strategic Aims and Objectives.

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

This will be achieved through;

- Full multi-agency exercises at Fordcombe Hospital and the Undergraduate Medical Building aimed at refining fire evacuation procedures.
- Continuation of the replacement of non-compliant fire doors on the Maidstone Hospital site. Works on the main hospital street are in an advanced stage with only part of the ground floor remaining and will continue throughout this financial year. In addition, fire door inspection training has been undertaken within the Estates Maintenance Department to enable staff to correctly identify non-compliant fire doors. The Senior Fire Officer in conjunction with the Associate Director Estates have created a fire door inspection programme, this is based primarily on high risk areas where we have sleeping occupants as well as our accident and emergency department. This will all be monitored through the Fire Safety Committee.
- Continued promotion of the role of Fire Warden throughout the Trust, in particular in outlying services and improved access to training on e-Learning. Heightening intelligence to the Fire Safety Department in the prevention of fires as well as potential arson.
- Increase fire inspections. The Fire Safety Department completed 74 inspections in the last calendar year. This will be increased to a minimum of 100 in 2025. Monitored progress monthly through the electronic inspection system, (Safety Culture). This will create effective action plans based on risk to ensure the Trust remains compliant with current law and legislation and that future construction projects meet the recommendations by Dame Judith Hackitt following the Grenfell inquiry which has been incorporated into the new Building Safety Act.
- Developing and implementation of Fire Response Team training, aimed at delivering a consistent approach to our response to fire alarm activations. (Develop and present training to CSMs). This will be included in the subsequent annual fire safety board reports.
- Bespoke fire response training for all outlying areas, as well as bespoke fire response training for Fordcombe Hospital. (Develop training, deliver and record through the L&D platform. This will be included in the subsequent annual fire safety board reports.
- Visiting all local fire stations, Maidstone, Larkfield, Tunbridge Wells, Tonbridge, Crowborough and Sevenoaks to build on relationships already in place with our Fire & Rescue colleagues. Visits will be arranged and recorded as CPD for review at next appraisal.
- Facilitating familiarisation visits for all of our Fire & Rescue colleagues on request.
- Facilitating audits conducted by the Kent Fire & Rescue Service. Reports from visits will be presented through the Fire Safety Committee and to the Trust Health & Safety Committee.
- Internal audit of Maidstone Hospital against HTM 05-01 and HTM 05-02. Actions required will be tracked through the Fire Safety Committee and to the Trust Health & Safety Committee.
- Internal audit of Tunbridge Wells Hospital, (Mitie), against HTM 05-01 and HTM 05-02. Actions required will be tracked through the Fire Safety Committee and to the Trust Health & Safety Committee.
- Internal audit of Fordcombe Hospital against HTM 05-01 and HTM 05-02. Actions required will be tracked through the Fire Safety Committee and to the Trust Health & Safety Committee.

- Implement planned fire drills for all sites. Monitored progress monthly through the electronic inspection system, (Safety Culture).
- Conduct weekly fire alarm testing for all units occupied by MTW at Hermitage Court. Monitored progress monthly through the electronic inspection system, (Safety Culture).
- Update all PAS 79-1 and PAS 79-2 for all MTW locations, including staff accommodation. Progress reported through Fire Officer's report to the Health & Safety Committee.
- Update all local fire documents for all MTW locations, (approximately 90 in total). Progress reported through Fire Officer's report to the Health & Safety Committee.
- Provide expert fire safety and strategy advice for all areas including all capital projects.
- Develop resilience plan for fire alarm system failure. Once produced, this will be presented at the Trust Resilience Committee for approval by 31/07/2025.
- Develop further our electronic fire inspection system to include fire door inspections. We will then have the capability to provide bespoke reports for the Estates Maintenance team. Actions required will be tracked through the Fire Safety Committee.

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

This will be achieved through;

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

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

- Record and monitor any unresolved issues through the Fire Safety Committee, to ensure these unresolved issues are escalated and have robust plans, with associated achievable deadlines to resolve issue in an effective manner.

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

The Trust will achieve this through;

- Review of Fire Safety mandatory training. Current training addresses building and infrastructure fires, however, over the past year the Trust has had two fires which have involved patients. This is something that staff may have never encountered before and therefore it would seem prudent to include this subject as part of the mandatory training material.

- Develop a video that can be accessed by all staff on the Trust Intranet and by way of a QR code which clearly shows action to be taken in the event of a fire alarm activation and what action is required should a real fire be detected.

5. Maintaining a Safe Environment.

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

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

5.1 Lithium-ion Batteries and Car Park Fires.

A safety warning on the use of lithium batteries is being issued by Kent Fire and Rescue Service following several battery related fires this month. Lithium-ion batteries, or li-ion batteries (sometimes called LIBs) are commonly found in many items including mobile phones, laptops, e-bikes, vaping devices and scooters. KFRS has seen an overall increase in battery fires in the last two years, with over 20 believed to be caused by batteries in the last three months. The Fire Safety Department will continue to implement robust plans in the event of a lithium-ion battery fire, including electric vehicles, as well as looking at ways to reduce the risk of such fires across all MTW sites.

5.2 Fire Extinguishers

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

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

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

6. Future Projects

The forthcoming year will see a number of building refurbishment projects that require specific fire safety input with regard to fire inspection, risk assessment and emergency exercises. With two emergency exercises planned for the Undergraduate Medical Building and Fordcombe Hospital in which the Fire Safety Department will play a prominent role.

In addition to this the Fire Safety Department will be involved in all capital projects such as the new Cardiology Centre at Maidstone Hospital which will require a full fire safety inspection and review to ensure it meets fire legislative requirements.

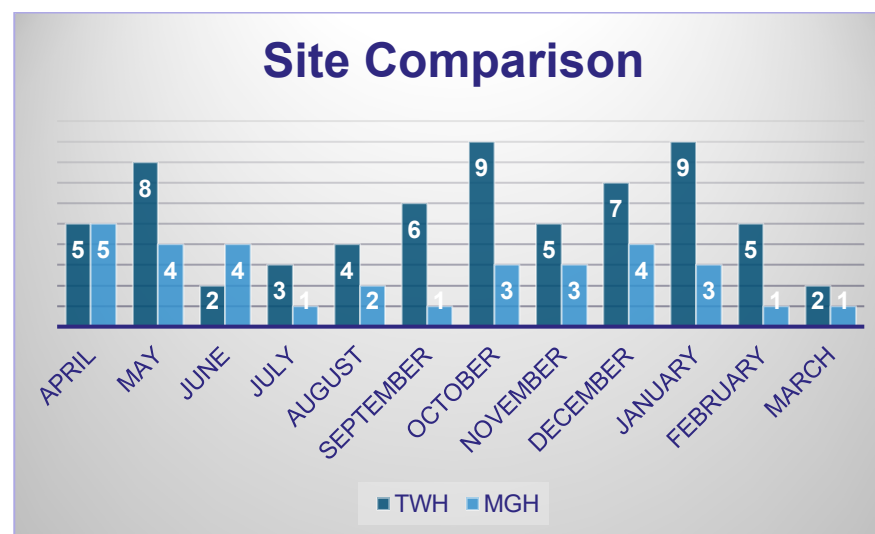
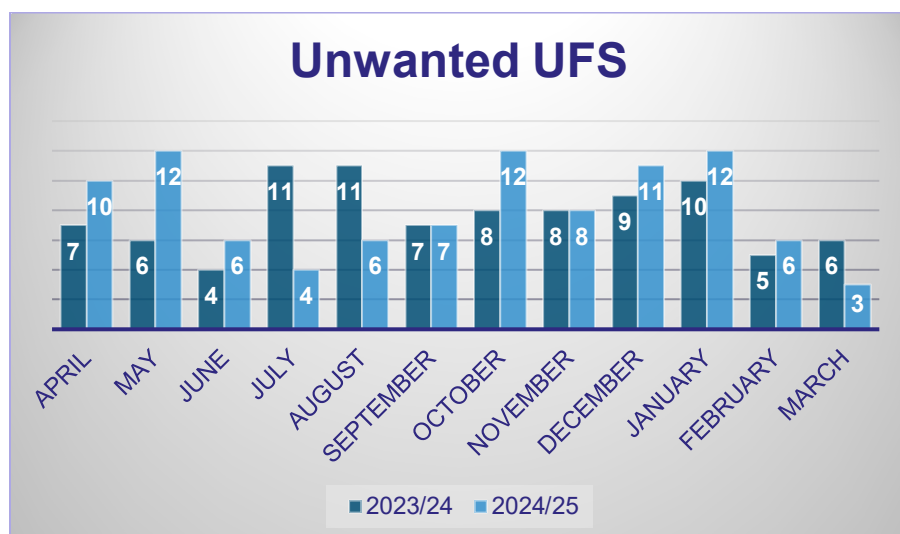
Ensuring that all fire safety requirements are dealt with at the earliest point in the project is essential so as to avoid problems post construction. The working relationship with the Estates Projects team and outside agencies has been positive and constructive but there is a continuous need for monitoring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

The Senior Fire Officer plays an active role in all space management projects to ensure fire safety is addressed as early as possible in a potential move or redevelopment of existing or newly acquired sites.

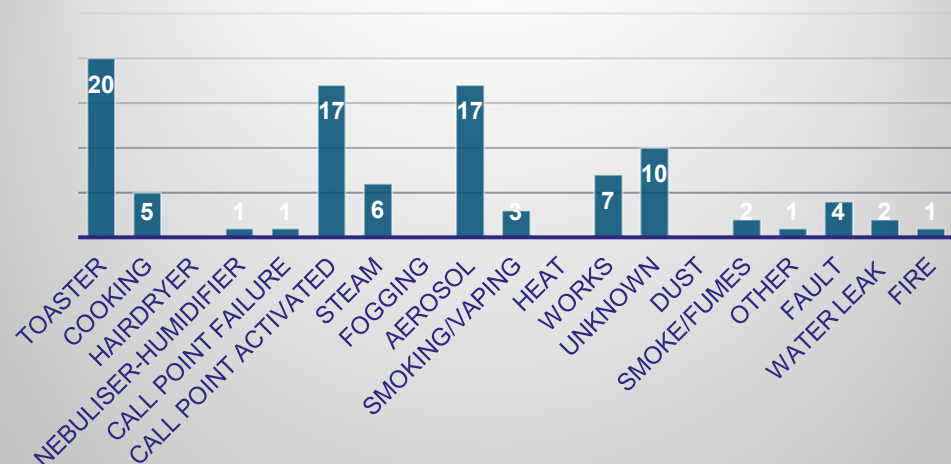
7. Statistics and Comparison.

| UFS | April | May | June | July | August | September | October | November | December | January | February | March | Total |
|---------|-------|-----|------|------|--------|-----------|---------|----------|----------|---------|----------|-------|-------|
| 2023/24 | 7 | 6 | 4 | 11 | 11 | 7 | 8 | 8 | 9 | 10 | 5 | 6 | 92 |
| 2024/25 | 10 | 12 | 6 | 4 | 6 | 7 | 12 | 8 | 11 | 12 | 6 | 3 | 97 |

| Site Comparison | April | May | June | July | August | September | October | November | December | January | February | March | Total |
|-----------------|-------|-----|------|------|--------|-----------|---------|----------|----------|---------|----------|-------|-------|
| TWH | 5 | 8 | 2 | 3 | 4 | 6 | 9 | 5 | 7 | 9 | 5 | 2 | 65 |
| MGH | 5 | 4 | 4 | 1 | 2 | 1 | 3 | 3 | 4 | 3 | 1 | 1 | 32 |




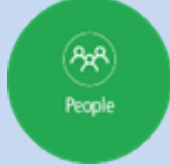




Causes



| Causes | |
|-----------------------------|-----------|
| Toaster | 20 |
| Cooking | 5 |
| Hairdryer | |
| Nebuliser-Humidifier | 1 |
| Call Point Failure | 1 |
| Call Point Activated | 17 |
| Steam | 6 |
| Fogging | |
| Aerosol | 17 |
| Smoking/Vaping | 3 |
| Heat | |
| Works | 7 |
| Unknown | 10 |
| Dust | |
| Smoke/Fumes | 2 |
| Other | 1 |
| Fault | 4 |
| Water Leak | 2 |
| Fire | 1 |
| Total | 97 |

| | | | | | | |
|--|--|-------------------------------------|------------|--------------------------|-------------|-------------------------------------|
| Title of report | Assurance of Compliance with Fit and Proper Persons Test | | | | | |
| Board / Committee | Trust Board ‘Part 1’ Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-21 | | | | | |
| Executive lead | Annette Doherty, Chair of the Trust Board | | | | | |
| Presenter | Louise Thatcher Trust Secretary | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input checked="" type="checkbox"/> | Discussion | <input type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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) | In line with the the Fit and Proper Persons Test requirements, the Trust has completed Fit and Proper Persons checks for all Trust Board members and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC as detailed in Appendix B. | |
| | This information will be shared with NHS England, via the NHS England South East Regional Director, no later than the 24 th June 2025 as requested. | |
| | The Trust Secretary has fully considered this with the Chair of the Trust Board, who has responsibility for this process for the period of this report. | |
| | The Trust Board Chair has signed off the Fit and Proper Person requirements as compliant. | |
| Any items for formal escalation / decision | For approval of the Board for submission of the report to NHSE. | |
| Appendices attached | Appendix 1- NHS FPPT submission reporting template | |
| Report previously presented to: | | |
| Committee / Group | Date | Outcome/Action |
| Audit and Governance Committee | 15 th May 20 | Approved submission to Trust Board |

| 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 | Fit and Proper Person Test ("FPPT") Framework, NHSE (2023) Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

Purpose of the Report

The Trust is required to comply with the Fit and Proper Persons Test requirements in line with NHS England's (NHSE) Fit and Proper Person Test ("FPPT") Framework for NHS board members and Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The "Procedures to comply with the "Fit and Proper Persons: Directors" Regulations (FPPR) and Fit and Proper Persons Test Framework (FPPT)" currently form part of the Trust's Standing Orders.

This report is intended to provide assurance of compliance with the Fit and Proper Persons Test requirements for 2024/25 to the Trust Board and requests the Board's approval for submission of the reporting template to NHSE by the 24th June deadline.

The report provides assurance that the Trust has met the Fit and Proper Person Test requirements in relation to Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Duties and Responsibilities

| Role | Responsibilities |
|--|---|
| Chair | <ul style="list-style-type: none">• Ultimate responsibility to discharge the FPPR placed on the Trust to ensure that all relevant post-holders (new and existing) meet the 'fitness' test and do not meet any of the 'unfit' criteria• Overall responsibility for compliance with the FPPR• Ensuring the fitness of all new and existing Directors has been assessed in line with the regulations on appointment and on an ongoing annual basis• Ensuring the necessary action is taken to ensure existing Directors who no longer meet the FPPR do not continue in their role |
| Senior Independent Director [SID] | <ul style="list-style-type: none">• Overseeing the outcome of FPPR for the Chair• Undertaking any investigations into any concerns raised about the Chair |
| Trust Secretary | <ul style="list-style-type: none">• Overseeing the implementation of the FPPR policy• Ensuring any FPPR tests undertaken comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair and/or Senior Independent Director [SID] (as appropriate)• Supporting the Chair and/or SID with any investigations• Ensuring the annual FPPR declarations are undertaken, recorded and evidenced on an individual's file• Maintaining the Directors register of interests including annual updates• Confirming compliance with the policy in the Trust's annual report• Providing advice and support to the Trust Board in respect of the administration of and compliance with the FPPR• Preparing annual reports for consideration by the appropriate committee as part of the appraisal process• Identifying any changes to the Regulations or guidance, recommending to the Trust Board the appropriate policy amendments |
| Recruitment Team | <ul style="list-style-type: none">• Undertaking all pre-employment checks (including the relevant component parts of the FPPR test) for Directors and providing evidence to demonstrate assurance• Ensuring the results (and evidence in the form of copies of certificates, etc) of the FPPR test undertaken on appointment are recorded within an individual's file• Ensuring any recruitment agencies/executive search companies involved in the recruitment process understand their responsibilities and comply with the requirements of this policy, i.e. that all necessary pre-employment checks (including FPPR) have been undertaken and |

| Role | Responsibilities |
|---|--|
| | evidence to demonstrate assurance is made available for inspection and retention by the Trust |
| Trust Board | <ul style="list-style-type: none"> • Ensuring ongoing compliance by receiving an annual report on the application of FPPR in relation to Executive Directors including the Chief Executive [CEO] • Ensuring ongoing compliance by receiving an annual report on the application of FPPR in relation to Non-Executive Directors [NEDs] including the Chair |
| Directors (individuals who fall within the policy) | <ul style="list-style-type: none"> • Providing consent to the required checks as described in this policy • Signing the declaration that they are a fit and proper person on appointment and on an annual basis • Providing evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position • Identifying any issues that may affect their ability to meet the statutory requirements on appointment and bringing any issues on an ongoing basis to the CEO (for Executive Directors) and the Chair (for NEDs). |
| Staff | <ul style="list-style-type: none"> • Raising any concerns via the appropriate Trust policies and procedures, e.g. through the Freedom to speak up: raising concerns policy [N.B. this forms part of the People Policies Manual] |
| CQC | <ul style="list-style-type: none"> • Powers to assess whether Directors are fit to carry out their role • Powers to assess whether providers have in place adequate and appropriate arrangements to ensure Directors are fit and proper persons both on recruitment and whilst in post • In undertaking inspections, will assess compliance as part of the well-led domain • Where appropriate will work alongside other regulators, e.g. professional bodies, to ensure that the correct processes are adhered to and information is shared when relevant and appropriate • Cannot prosecute for breach of the FPPR but can take regulatory action |

Appendix 1

NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

| NAME OF ORGANISATION | TYPE OF ORGANISATION <i>Select organisation</i> | | NAME OF CHAIR | FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST: |
|---|--|------------------|--------------------|--|
| Maidstone and Tunbridge Wells NHS Trust | ✓ | Trust | Dr Annette Doherty | May 2024-25 |
| | | Foundation Trust | | |
| | | ICB | | |

Part 1: FPPT outcome for board members including starters and leavers in period

| Role** | Total Number Count | Confirmed as fit and proper? | | | Leavers only | |
|-------------------------|--------------------|------------------------------|----|---|-------------------|--|
| | | Yes | No | How many Board Members in the 'Yes' column have mitigations in place relating to identified breaches? * | Number of leavers | Number of Board Member References completed and retained |
| Chair/NED board members | 10 | ✓ | | N/A | 1 | 1 |
| Executive board members | 7 | ✓ | | N/A | 2 | 2 |
| Partner members (ICBs) | 0 | | | | | |
| Total | 17 | | | | | |

* See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.

** Do not enter names of board members.

| | | |
|--|-----|----|
| Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members? | Yes | No |
|--|-----|----|


Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.




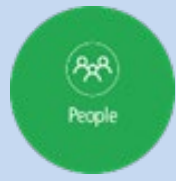


| Reviewer / inspector | Date | Outcome | Outline of key actions required | Date actions completed |
|----------------------|------------------------------|---------|---------------------------------|------------------------|
| CQC | None in the reporting period | N/A | | |
| Internal Audit | Planned May 2025 | N/A | | |
| | | | | |
| | | | | |

Add additional lines as needed

Part 3: Declarations

| DECLARATION FOR Maidstone and Tunbridge Wells NHS Trust- 2025 | | | | |
|---|--|---------------------------|----------|-----------------|
| For the SID/deputy chair to complete: | | | | |
| FPPT for the chair (as board member) | Completed by (role) | Name | Date | Fit and proper? |
| | Senior Independent Director | Maureen Choong | 08/05/25 | Yes |
| For the chair to complete: | | | | |
| Have all board members been tested and concluded as being fit and proper? | Yes/No | If 'no', provide detail: | | |
| | Yes | | | |
| Are any issues arising from the FPPT being managed for any board member who is considered fit and proper? | Yes/No | If 'yes', provide detail: | | |
| | No | | | |
| As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework. | | | | |
| Chair signature: |  | | | |
| Date signed: | 9 th May 2025 | | | |
| For the regional director to complete: | | | | |
| Name: | | | | |
| Signature: | | | | |
| Date: | | | | |

| | | | | | | |
|--|--------------------------------------|--------------------------|-------------------|-------------------------------------|--------------------|-------------------------------------|
| Title of report | Board Assurance Framework | | | | | |
| Board / Committee | Trust Board Meeting | | | | | |
| Date of meeting | 29 th May 2025 | | | | | |
| Agenda item no. | 05-22 | | | | | |
| Executive lead | Executive Members of the Trust Board | | | | | |
| Presenter | Executive Members of the Trust Board | | | | | |
| Report Purpose (Please <input checked="" type="checkbox"/> one) | Action/Approval | <input type="checkbox"/> | Discussion | <input checked="" type="checkbox"/> | Information | <input checked="" type="checkbox"/> |

| Links to Strategic Themes (Please <input checked="" type="checkbox"/> 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



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 | 2 | 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 | | | |  | | |  | | | | | 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 | | | |  | | | |  | | | | 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 |  |  | | | | | | | | | | 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 | | |  | |  | | | | | | | 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 | |  | | | | | |  | | | | Limited |
| PR6 | Failure to deliver the Trust financial plan resulting from the system being in financial recovery | Chief Finance Officer | Finance and Performance | | | |  | | | | |  | | | Limited |

-  Current
-  Tolerable
-  Target
-  Current to tolerable

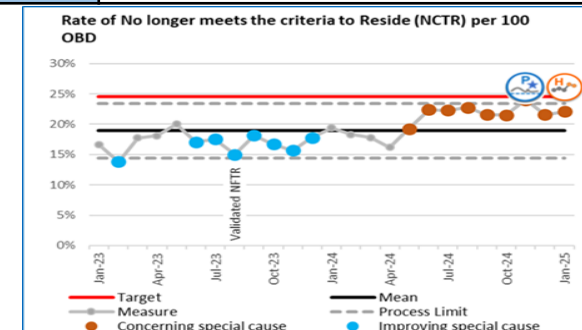
| | | | | | | | | | |
|---|---|------------------------------|---|--|------------|--|------------------------|--|------------------|
| Strategic theme | People: Creating an inclusive, compassionate and high performing culture where our people can thrive and be their best selves at work. | | | | | | | | |
| 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 | Insert TBC | |
| 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 Remuneration 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 |
| 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 | <u>Management</u> Patient Outcomes Oversight Group reports to CQC Clinical audit plan Audit reports to clinical audit committee <u>Risk and Compliance</u> Risk review meetings (Divisional) Risk and Regulation Oversight Group <u>Independent Assurance</u> 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 | <u>Management</u> Quality Governance reporting structure-directorate to board IPR- monitoring incident numbers Quality committee review of incidents and incident management <u>Risk and Compliance</u> Reports to Risk and Regulation Oversight Group Patient Safety Oversight Group <u>Independent Assurance</u> 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 severe 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 | <u>Management</u> PSOG ETM <u>Risk and Compliance</u> <u>Independent Assurance</u> 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 | Negligible-1 | Negligible-1 | Negligible-1 | Risk appetite | Cautious | | |
| Initial date of assessment | 20/05/2024 | Likelihood | Likely-5 | Possible-3 | Unlikely-2 | | | | |
| Last reviewed | 23/05/2025 | Risk rating | 5 | 3 | 2 | | | | |
| Last changed | 23/05/2025 | Links to Trust Risk Register | 791 – Failure to meet Referral to Treatment Targets (RTT) 3112 – Lost to follow up following a diagnostic test 3407 – Risk of significant physical and/or psychological harm to patients as a result of prolonged Histology turnaround times | | | | | | |
| 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 elective activity that results in poor patient experience and outcomes | Non-elective care - SPOA, SDECS, UEC pathways, Virtual wards and hospital at home. DM01 – Monitoring of demand and capacity. Flexing capacity as appropriate. Cancer - one stop pathways, straight to test, low diagnostic and treatment waiting times. Elective – Monitoring of demand and capacity. Activity, outpatient and theatre utilisation monitoring | | Unpredictable spikes in demand exceeding capacity. Aging diagnostic equipment requiring replacement | Senior clinical decision making and use of alternative pathways. Operational flow programme of work in progress. DM01 task and finish group implemented. Use of agreed WLIs to manage demand spikes for cancer. | | Management Daily site reports. Daily PTL management and oversight, Integrated performance reports, Strategy Deployment reviews. 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. | Adequate |
| Lost to follow up following a diagnostic test | Task and finish group implemented | | | Action plan in progress which supports the recommendations of the ENT lost to follow up to diagnostic test review reported at Quality Committee. | | 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 | Adequate |

| | | | | | | | |
|---|--|---|--|------------|--|-------------------------------|--|
| 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 |
| 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 |
| 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 | | <u>Management</u> 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 <u>Risk and Compliance</u> Risk reports <u>Independent assurance</u> 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 |
| 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 | | <u>Management</u> 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 <u>Risk and Compliance</u> <u>Independent assurance</u> Healthwatch feedback National Patient survey results | | PLACE action plan to be monitored by EOCOG |

| 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 | Finance and Performance | 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 Risk and Compliance <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 | Insert SPC | | |
| 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 | | | | | | | |
| 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. Financial Improvement Plan, along with a fortnightly management Financial Improvement Plan Board, is in place Additional support has been sourced to drive savings delivery, alongside a dedicated resource PMO support to Divisions to deliver CIP Strategy Deployment Reviews | | CIP programme only partially identified at the start of the year. CIP gap remaining System schemes are complex and have not delivered to this level previously Not all savings have been | Budgets have been set at divisional level with the required efficiency delivery removed. Additional pay controls, such as an Executive Led vacancy control panel are now in place Increased transparency of reporting to Executive Team Meeting, Finance and Performance Committee and Trust Board to drive necessary actions to drive required delivery | | <u>Management</u> Integrated Performance Report and Trust financial position monthly reports Financial Improvement Programme reporting fortnightly to the CEO and Exec Team. 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> Financial risks are identified and monitored on a monthly basis. A number of risks have been set out. Further transparency on these risks for the 25/26 financial year <u>Independent Assurance</u> A review across the K&M system looking at controls has taken place. Additional support has been brought in to drive savings delivery at Trust level and at System level | | | Savings not all yet identified – identification continues to increase. This is the subject of the Financial Improvement Programme Board meetings The month 1 financial position is off plan, CIPs have not been fully identified recurrently – some non-recurrent benefits identified in Month 1 | 16 |

| | | | | | | |
|--|--|---|---|--|---|----|
| | <p>monthly with all Divisions, and with Executives as part of the Executive Team Meeting</p> <p>System wide savings schemes have central governance in place, with additional external support</p> | delivered recurrently | | | | |
| <p>Failure to reduce the total pay spend (including reduction in corporate / back office pay spend) during 2025/26</p> | <p>Workforce Workstreams in place, focussing on the reduction of substantive, bank and agency spend.</p> <p>Workforce Transformation Team to co-ordinate and support pay spend reduction across the organisation in place.</p> <p>Monthly report to Executive Team, People and OD Committee, Finance and Performance Committee and Trust Board</p> <p>Targets have been set for reductions across the organisation. The financial consequences of these targets have been included within Divisional budgets</p> | <p>Substantive staffing has been on an upward trajectory for the last 5 years. The holding of posts at the end of the 24/25 year has created a larger step increase at the start of the 25/26 financial year</p> <p>Temporary staffing will need to reduce further to hit the 40% agency reduction and 15% bank reduction necessary</p> <p>Bank spend has reduced at a slower rate than agency spend.</p> | <p>All Divisions and directorates have a target reduction in pay spend and WTE.</p> <p>Executive Led Vacancy Control panel is in place, on top of Divisional panels.</p> <p>A number of actions / controls on restricting the use of temporary staff have been introduced and remain in place</p> | <p><u>Management</u> Integrated Performance Report, Trust financial position monthly reports. Fortnightly Financial Improvement Programme updates, including from workforce workstreams 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</p> <p><u>Risk and Compliance</u> A number of risks in relation to staffing have been included.</p> <p><u>Independent Assurance</u> A review across the K&M system looking at controls has taken place. Additional support has been brought in to drive savings delivery at Trust level and at System level</p> | <p>The Month 1 positions <u>shows</u> an overspend on total pay against budget – although some areas have underspent.</p> | 16 |

| | | | | | | |
|--|---|---|---|--|---|-----------|
| <p>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</p> | <p>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.</p> <p>The Trust runs a monthly capital steering group, which is a <u>sub-committee</u> of the Executive Team.</p> <p>Capital expenditure is reported monthly to the Executive Team, Finance and Performance Committee and Trust Board</p> <p>The Trust reviews IFRS16 capitalised leases and lease impacts alongside traditional capital</p> | <p>The capital allocated to the Trust does not equate to the full generated depreciation (capped by NHSE)</p> <p>The Trust has always fully utilised its capital, however it has more calls on the capital programme than it has been able to service.</p> <p>A number of areas have now reached end of life, and could potentially fail at short notice</p> <p>The capitalisation of leases under IFRS16 and the allocation provided for them, is likely to mean that traditional capital will need to be used to support these impacts going forward, minimising capital replacement and investment</p> | <p>The Trust is constructing a <u>multi year</u> view on its capital requirements which references risk, condition and age.</p> <p>Future annual capital programmes will need to have a higher weighting to replacement / renewal of infrastructure rather than new developments.</p> <p>The Trust will need to access ICS level capital for the replacement of certain assets or new developments (for example linear accelerators)</p> <p>The Trust is engaged in conversations regarding the potential use of private finance in the NHS as a way to secure additional investment into the sector in a way that will support the replacement and development of assets funded from traditional means</p> | <p><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</p> <p><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.</p> <p><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.</p> | <p>The Trust currently does not have the <u>multi year</u> plan in place – this is under construction</p> <p>While the capital programme maybe insufficient, any capital slippage is prioritised against our risk rated list.</p> | <p>12</p> |
|--|---|---|---|--|---|-----------|

| | | | | | | |
|---|--|--|--|---|--|----|
| <p>With the tightening of the cash regime for the NHS, that cash will be restricted impacting upon the provision of staff, goods and services to the organisation, with a potential consequential impact for local businesses and the local economy</p> | <p>The Trust includes cash flow information in its monthly reporting to Executive Team, Finance and Performance Committee and Trust Board.</p> <p>Cash is managed using a weekly cashflow model that is shared within the finance team, with actions being taken accordingly</p> <p>Delivery of the Trust's financial plan on a recurrent cost reduction basis should ensure that the cash position meets its plan over the course of the year</p> | <p>The Trust's planned financial position will place more stress on the cash position in the first 6 months of the financial year</p> <p>The Trust is adverse to plan in Month 1 creating more pressure on the cash position</p> | <p>Tactical working capital actions will support the cash position in the short term</p> <p>The Trust may need to source additional cash from NHSE and DHSC, although this is expected to be difficult and may well come with more stringent expectations on the management of the Trust's cost base</p> <p>Further, more detailed reporting to be presented to the Executive Team Meeting and the Trust Finance and Performance Committee meeting</p> | <p><u>Management</u> Integrated Performance Report Finance and Performance Committee meet monthly and provide assurance to the Board</p> <p><u>Risk and Compliance</u> The risk of our financial position on our cashflow is highlighted in the risk register</p> <p><u>Independent Assurance</u> Any request for additional cash will be reviewed by NHSE and DHSC</p> | <p>The financial position of the organisation and the cash management position of the organisation are intrinsically linked.</p> <p>Following discussion with Execs and F&P, any additional actions will be incorporated</p> | 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 | 2 | 3 | 4 | 5 |
|--|---------------------------------------|--|------------------------------------|---|---|
| | Rare | Unlikely | Possible | Likely | 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 |