MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 29TH MAY 2025, 09.45AM, LECTURE ROOM 8, LECTURE ROOM 8, UNDERGRADUATE MEDICAL BUILDING, TUNBRIDGE WELLS HOSPITAL

For Approval

Present:	Annette Doherty	Chair of the Trust Board (Chair)	(AD)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Davis	Chief Operating Officer	(SD)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Sara Mumford	Chief Medical Officer / Director of Infection Prevention and Control	(SM)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Tasha Gardner	Director of Communications and Corporate Affairs	(TG)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Alex Yew	Associate Non-Executive Director	(AY)
	John Hammond	Associate Non-Executive Director	(JHa)
	Becky Clewlow	Assistant Trust Secretary	(BC)
	Megan Fradgley	Maternity Incentive Scheme Lead (for item 05-10)	(MF)
	Jessica O'Reilly	Head of Maternity Governance (for item 05-10)	(JO'R)
	Louise Thatcher	Trust Secretary	(LT)
	Charlotte Wadey	Divisional Director of Nursing and Quality, Paediatrics, Gynaecology and Sexual Health (for item 05-7)	(CW)
	Natalie Adams	Head of Organisational Development	NA

05-1 To receive apologies for absence

Apologies for absence were received from Helen Palmer (HP), Chief People Officer and Jo Webber (JW), Associate Non-Executive Director.

05-2 To declare interests relevant to agenda items

No interests were declared.

05-3 To note progress with previous actions

The below actions were discussed:

- **03-12 ("Present the 'Close down' of the People Promise Exemplar to the Trust Board").** It was noted that this was presented to the People and Organisational Development Committee and future work on the program would need consideration from the Trust Board.
- **03-13 ("Schedule a Deep Dive into recognition and management of the deteriorating patient at a future Quality Committee").** It was noted that the item has been scheduled at the Quality Committee 'deep dive' meeting in August 2025.

Reports from the Chair of the Trust Board and Chief Executive

05-4 Report from the Chair of Trust Board

AD referred to the submitted report and highlighted the following:

- The Spring Leadership Conference took place on 22nd May and was well attended by Trust staff and colleagues from system provider organisations. The Kent and Medway Partnership Joint

Committee is being established and the Terms of Reference have been shared with Trust Board members for review. The Chair informed the Trust Board that interviews are planned for Non-Executive Director roles to replace the colleagues for whose terms will be ending this year.

05-5 Report from the Chief Executive

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

- The NHS is facing a greater financial challenge than in previous years and the Trust will be very focussed on that over the next year. It was noted that over 1500 members of staff dialled into calls on "Leading improvement through transformation" over recent days and the Trust Board heard that in the short-term, controls will be implemented, until the transformation plan has been worked through. MS referred to examples given in the Chair's and Chief Executive Officer's reports, where the appointment of Consultants has reduced the temporary staffing spend and the where the use of the patient portal has reduced administration costs. It was noted that stages of the transformation will be discussed in the private section of the Board meeting and will be shared with the organisation, when this has been finalised. Thanks, were offered to SF, who is extending her term as the Chief of Service for the Women's, Children's and Sexual Health Division by three months, to enable succession planning and thanked her for her contribution to improvements made in these services.

Integrated Performance Report (IPR)

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

The submitted report was noted and referred to throughout the meeting.

Patient experience

05-7 Patient experience story

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

- The patient's name is Isabelle and she requested that her story be shared with the Trust Board in order to recognise her positive experiences when in hospital, highlight the challenges experienced when being admitted to an acute hospital with mental health difficulties and that the improvements made following this, be shared, in order that others may benefit from this information. Isabelle was admitted to the Tunbridge Wells Hospital in February 2021 and spent 77 days in the hospital before she was transferred to a specialist inpatient facility. The positive aspects that Isabelle and her Mum experienced were; nursing staff striving to understand Isabelle's situation, nursing staff and play assistants working with Isabelle to create art works to track her progress and using ways to engage with her to distract her from the situation. Less positive experiences were reported to be: multiple room moves during her stay and being in rooms which made her feel isolated; limited communication throughout her stay, not seeing a psychiatrist until 44 days into her hospital stay and a lack of understanding that the physical health issues she experienced were as a result of her mental health issues. The Trust Board heard that, despite her long stay on the unit and the challenges faced, Isabelle, her family and local community have raised funds, to support the development of a break out room, that young people with mental health related issues can use, rather than remaining in one room. Isabelle's family each walked a total of 77 miles, to recognise the number of days Isabelle spent in the hospital and this room is now in place on Hedgehog Ward. The team on Hedgehog are awaiting Isabelle and her family to officially open this area and the team thanked them for their patience whilst an opening date is confirmed.
- Improvements made include: an increased awareness of mental health through training provided to staff; a single point of contact, to ensure that patients and their families have one key person to update them with information; a specialist paediatric mental health nurse and paediatric mental health support workers have been recruited and regular meetings with the single point of contact, the young person, their families and staff involved in their care are occurring to ensure regular and effective communication.
- AD noted the improvements made to the service and JH added that it is a good of example of where improvements have been made following the receipt of patient feedback. JHa queried how

the team will measure the success of the improvements and CW responded that this is monitored through the feedback received from patients and stakeholders. CW also reported that Isabelle is well and is very keen to work with the team on further improvements
- AD thanked Isabelle for sharing her story and CW and her team for the improvements made.

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

JH referred to the submitted report and highlighted the following points:
- The Children and Young People's Patient Experience Survey was undertaken between October and December 2024. 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. It was noted that 199 completed questionnaires were returned from the sample of 921 patients. The final response rate for the Trust was 21.7%.
- Areas for improvement were noted to be: the provision of information to young people and their families on discharge from hospital, coverage and strength of the Wi-Fi signal, choice and availability of food, the provision of activities and toys available and the layout of waiting areas. The Trust Board were presented with an action plan, to address the reported areas of improvement, which will be monitored by the Experience of Care Oversight Group.
- AY noted the response rate appeared to be low and JH responded that this is in line with the national picture and the Trust's response rate was better than the national average. AY queried the process of sharing feedback within the organisation and JH explained that each division collated information from feedback, which is presented to the Experience of Care Group and extended an invite to this meeting to Non-Executive Directors.
- DM noted an area of improvement relating to discharge from hospital has also been raised regarding other services in the hospital and queried if there was an issue throughout the organisation, with discharging patients. JH explained there are several issues which may lead to a poor experience on leaving hospital, which can include, the process happening quickly which may leave patients with a sense of feeling overwhelmed.
- JH drew attention to the elements for the Integrated Performance Report (IPR), relating to patient experience and noted there is an increase in the number of complaints, but noted there are no themes with regard to services within the Trust. The Trust Board heard that the team have exceeded the number of responses to complaints sent within the target time, the list of historical complaints is being maintained and the hard work of all the divisions and the complaints team was acknowledged. It was noted that the IPR contains information relating to how the organisation benchmarks nationally with Friends and Family Test scores, as the response rates are still lower than desired. WW noted that communication is the largest theme for complaints, which covers a wide variety of elements and queried if any work was being done to address this. JH responded that through the Strategic Deployment Review Process (SDR), divisions able to identify specific areas of improvement, which is monitored through the SDR process. NA added that some focussed work has been undertaken on communication between teams and how this is viewed by patients.
- DM noted the safe staffing figures in the IPR are variable and JH responded that staffing fluctuates in response to individuals requiring enhanced care.

Patient Safety and Clinical Effectiveness

SM referred to the IPR metrics and noted improvements in the recognition and management of deteriorating patients through the implementation of an action plan, a review of training provision by the deteriorating patient lead practitioner and the implementation of a process to facilitate referrals from nursing staff to medical staff. It was noted that theatre utilisation is now a standalone project and there is a focus on paediatric theatre lists and changes to scheduling surgery, to reduce cancellations.

05-9 Quality Committee, 21/05/25

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

- The Committee discussed the NHS Children and Young People's Patient Experience Survey, which resulted in a wider discussion about patient experience, and noted that the divisions are concentrating on their specific areas for improvement. The work of Healthwatch and the Maternity Neonatal Voice Partnership was referred to and how this contributes to service improvements. The Trust Board were informed that the draft Quality Accounts were presented to the Quality Committee and comments were being received. The Trust Board were invited to provide any additional comments to the Quality Accounts.

05-10 Maternity Report relating to the Perinatal Quality Surveillance Model (Including the Quarterly Maternity Incentive Scheme Compliance Report)

JO'R referred to the submitted report and highlighted the following points:

- That there were 17 suspensions of the maternity service in the reporting period, which affected six birthing persons. The service was compliant with foetal monitoring, 100% of birthing persons received one to one care in labour, with full compliance, in the delivery suite coordinator being supernumerary.
- The Trust Board also received the Maternity Incentive Scheme Compliance quarterly report and noted that the requirements for each safety action had been rated (Red, Amber, Green) to indicate that the service was compliant with all actions. The Board were informed that Safety Action 7, requires the service to have Maternity Neonatal Voice Partnership (MNVP) representation, but noted that service cannot access an MNVP currently, which was related to the recruitment of an MNVP in the Kent and Medway system. JH informed the Board that the Local Maternity Neonatal System have articulated that the MNVP resource is a system risk and is on the system's risk register as this is an Integrated Care Board (ICB) duty. JO'R added that a visit by the regional team was planned to be undertaken on the 11th June.

Patient Access

05-11 Performance

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

- It was highlighted that the average non-elective length of stay indicator is failing the target and that there are a number of workstreams underway to rectify this. It was noted that ambulance handovers, greater than 30mins has failed the target and the reasons for this were discussed and the work underway was noted.
- NG queried the performance of the Kent and Medway Orthopaedic Centre and SD reported an improving situation which was confirmed in a follow up visit from the Getting It Right First Time Team, who reported that the team were overachieving. It was noted that there is an increase in referrals, partly from the Trust's waiting list and also from system referrals. It was noted that the Fordcombe Hospital is progressing well, with improvement works to the infrastructure ongoing, an advertising campaign underway and continued engagement with insurance companies all contributing to improvements.
- WW noted that the Trust continues to achieve cancer targets: the 28 Day faster diagnosis compliance and the combined 31 day first definitive treatment standards and the 62 day first definitive treatment standards, which was noted to be a point to congratulate the team on.

People

NA referred to the IPR and highlighted that the total pay spend indicator will be monitored and managed through the Leading Transformational Change Programme and that bank and agency spend is reducing.

05-12 People and Organisational Development Committee, 23/05/25 (incl. approval of revised Terms of Reference)

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

- The Committee reviewed the NHS staff survey and offered congratulations to the Trust for being placed in the top 10 places to work nationally. The Committee also discussed the People Promise exemplar programme and future work on the program would need consideration from

the Trust Board. The Trust Board also heard that the Committee discussed the transformation programme and risks related to the People strategic theme.

- It was noted that the total pay spend was higher than planned and the Trust Board heard that this was as a result of delays in recruitment at the end of the financial year, which was not accounted for in the plan. The Trust Board were informed of the process for all decisions relating to vacancies being reviewed through vacancy review panels.
- The revised Terms of Reference for the People and Organisational Development Committee were approved by the Trust Board.

Sustainability

SO referred to the IPR metrics relating to sustainability and referred to the Financial plan for the year and that the team were in a contract commissioning stage with commissioners. The reduction in temporary staffing spend was highlighted and the Trust Board heard that cash management was presented to the Finance and Performance Committee, which included exploring the possibility of accessing cash support with NHSE regional and national teams. The Trust Board heard that capital allocations were still being announced regionally and that core capital may need to be spent internally if the Trust is unable to access those funds. MS also added clarity in that those trusts receiving deficit support funding in the system, is contingent on the system being on plan in aggregate.

05-13 Finance and Performance Committee, 27/05/25

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

- The Committee discussed the month 1 financial position and noted challenges in some parts of the Kent and Medway system. A focus of the meeting was on the financial improvement plan and Committee noted the detail and effort that been afforded to the plan, but that there was a tension between the plan being fully formed and meeting the year end position.

Systems and Partnerships

RJ informed the Trust Board that the project to improve coding through the organisation had moved to a “business as usual” status.

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

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

- That NHSE have published the Model ICB Blueprint, which is intended to help Integrated Care Boards (ICBs) shape their 50% running cost reduction. The Trust Board heard that the NHS Kent and Medway Integrated Care Board have awarded new community service contracts to KCHFT, as the 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. It was noted that the draft National Performance Assessment Framework has been published by NHSE for consultation.
- RJ referred to the results of the local elections, meaning there is new Kent County Council leader and noted that information regarding new council members has been shared with the Trust Board.
- The Trust Board also heard that the Trust is working with other system providers to develop a business case to support the “Better Use of Beds” programme.

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

RJ referred to the submitted report and highlighted that planning permission has been submitted for the development of Maggie’s Centre, which will be located close to the Kent Oncology Centre. Maggie’s Centres provide free practical, social and psychological for people living with cancer, their families and friends.

Governance and Assurance

05-16 Audit and Governance Committee, 15/05/25

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

- Risk has is being articulated throughout the Committee agenda and it was noted there are still improvements to be made.

05-17 Six-monthly review of the Trust's red-rated risks

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

- That the report is presented to the Executive Team Meeting and the Audit and Governance Committee and all Committees receive risk reports relating to their area. The total number of risks, those rated over 15, new risks, increasing or downgraded risks were presented. It was noted that there is a focus on risks which have been rated over 15 for more than 12 months, to consider if the mitigations are appropriate.
- It was noted that the report has been amended to include risk exposure and risk appetite and DM suggested that Statistical Process Control charts may also aid the monitoring of risk movement. The Trust Board heard that the culture of risk management is improving through the organisation and processes in risk management have been amended since the last meeting. Amendments include; the divisions governance teams reviewing risks and an additional review by the Head of Risk management, to ensure risks score are appropriate, consistently worded and have realistic target scores.
- AD noted that a number of risks are still showing target scores to be reduced, by dates which have passed and JH responded that improvements have been made, though there is more work to be done, in line with the risk management improvement plan. A number of comments relating to the presentation of the report were received by Trust Board members which included: ensuring the risk ratings accurately reflect the risk, realistic target dates and highlighting target scores that are due in month, which may be helpful to identify when risks are due for review.

05-18 Emergency Planning Annual Report, 2024 and future emergency planning

AD offered congratulations to the Director of Emergency Prevention, Planning and Resilience (EPPR) on all the work he does with EPPR, which was echoed by SD, who also expressed thanks to the team.

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

- That the most significant risk identified, is that of a pandemic and that the EEPR team have undertaken a number of exercises to prepare the organisation to respond to the risks of being in an organisation surrounded by a wooded area, "Operation Woodsmoke" and also to respond to the risk of a cyber-attack table, where the team invited a number of system providers to undertake a table-top exercise. It was also noted that the team are also considering undertaking a "live" event to prepare a response to a cyber-attack.
- DM added that the Director of Emergency Prevention, Planning and Resilience is actively engaging with other organisations and has worked with the Head of Risk Management to ensure the risks relating to EPPR are recorded appropriately.

05-19 Annual Fire Safety Report

The report was taken as read and no comments were received.

05-20 Assurance of compliance with the Fit and Proper Persons Test requirements

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

- That the Fit and Proper Persons Test has been completed for all Trust Board members and also for those staff who meet the regulatory requirement to meet the Fit and Proper Persons Test.
- The Trust Board approved the submission of the report of assurance to NHSE.

05-21 Board Assurance Framework (BAF)

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

- It has been recognised that the BAF is being well utilised in committee meetings. DM confirmed that there is recognition that assurance is being sought in committee meetings, adding that the assurance may change even if the risk does not. The Trust Board considered the risk appetite considering risks being reflected as they are and noted that it would be helpful to understand the Kent and Medway systems and its provider's risks.

Other matters

05-22 To consider any other business

There was no other business.

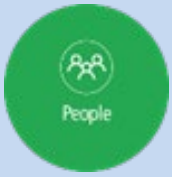
05-23 To respond to questions from members of the public

LT confirmed that no questions had been received ahead of or through the meeting.

05-24 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	26 June 2025					
Agenda item no.	To be completed by Committee / Board Administrator					
Executive lead	Miles Scott, Chief Executive					
Presenter	Miles Scott, Chief Executive					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chief Executive Report for the June 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:

- This year, like many in the NHS, we face a significant financial challenge. We have set a cost improvement target of £49 million, with £36.5 million of this needing to be achieved through workforce-related savings. In response, we are carefully reviewing our current staffing arrangements, including vacancies and temporary staffing, to help us meet this target in a safe and sustainable way.

  Our commitment to delivering high-quality care remains unchanged, and we are taking these difficult but necessary steps to protect that care for the future. We recognise the impact this may have on our staff, and we are committed to working closely with them and their representatives as we move through this process.

  So far, the controls we have put in place are having a positive effect, with a good financial position at Month 2. This early progress is encouraging, and we must keep up the momentum. Alongside our financial programme, we are making strong progress with our transformation workstreams, which focus on a number of key areas including: clinical services, automation and digital developments, outpatients optimisation, pharmacy, and corporate functions. These initiatives are already starting to improve how we work and the care we provide.

  We know change can be unsettling, and we will be open and honest in our communication. As our plans develop, we will keep our patients, staff, and communities informed and involved. Above all, our focus remains on delivering safe, effective care and supporting our workforce every step of the way.

- Following submission earlier this year, the planning application to bring a Maggie's Cancer Centre to MTW is still in process at the time of writing this report, and an update is expected in the coming days. Scheduled to open by 2028, the new centre based at the rear of Maidstone Hospital will provide free expert support to our cancer patients and their families, and the cost of the £7m project will be fully funded by Maggie's. Located close to the Kent Oncology Centre, the new building will be staffed by specialist professionals including psychologists, cancer support experts, and benefits advisors. By partnering with Maggie's, MTW is committed to enhancing holistic care beyond medical treatment - helping patients navigate the emotional, practical, and psychological challenges of a cancer diagnosis. With more than 11,000 people diagnosed with cancer annually in Kent, this centre is expected to support patients over 20,000 times each year. As the project moves forwards, next month we will be hosting two public Q&A events alongside Maggie's representatives, and there is further information on how to join these on our website.

- The Patient First Improvement System (PFIS) has now seen in excess of 1,365 tickets raised and completed since it was introduced in late 2022. Over 460 staff members covering 95 teams have received training on the system, which aims to ensure staff feel empowered and supported to make continuous improvements that will enhance the quality of their work, benefit our patients and improve staff wellbeing. PFIS began a pilot with the Patient Experience team and Volunteers service this month. Starting with the Trust's meet and greet volunteers, the system is supporting the teams to capture ideas from patients and to work on their own improvement suggestions within the volunteer and patient experience service.

  Recent PFIS improvement projects include:

  - Appointments for hearing assessments couldn't go ahead due to patients having wax blocking their ears. Patient appointment letters now include mandatory notes to get ears checked for wax before audiology appointments. This has helped avoid patient and clinical time being wasted in appointments and a need to schedule a follow-up.
  - The main Outpatient team at Tunbridge Wells Hospital has collaborated with the Mammogram team to ensure clear communication on the location of the mobile breast screening van, and to organise mammograms on patients' clinic days. This

has benefited patients by reducing the need to travel between sites, minimising time and appointment wastage, and ultimately providing a better experience of care.
    - At the Rubin Clinic at Maidstone Hospital, the consultant-led sexual health clinical day ran appointments according to sample collection times, which ended at 3pm. A new process has been agreed and a courier now collects samples out of hours when needed, allowing sessions to run later and improving the patient experience by having more clinic slots available.

  The success of the Trust's PFIS model was shared at the International Forum on Quality and Safety in Healthcare held in Utrecht last month, hosted by the Institute for Healthcare Improvement (IHI) and the British Medical Journal (BMJ) Group.

- Maidstone Hospital's Musculoskeletal Physiotherapy team recently held its first community appointment day to improve waiting times and provide patients with timely and personalised community-based care. Community appointment days involve inviting patients going to a local venue, away from the hospital setting, where they can speak to a range of specialists under one roof. The initiative helps to reduce waiting times and ensures patients receive care as quickly as possible. The team's first event took place at Hermitage Park Community Centre in Maidstone, and gave patients the opportunity to discuss their concerns with a physiotherapist, get advice on treatment, and set goals for their recovery. Representatives from other teams were also there, including Maidstone Citizens Advice Bureau, Mid Kent MIND and Diabetes UK, enabling patients to access a range of services all in one place.

- The Endoscopy team has passed its Joint Advisory Group (JAG) on Gastrointestinal Endoscopy review and been awarded national accreditation for its services. Run by the Royal College of Physicians, JAG accreditation is awarded to high-quality gastrointestinal endoscopy services and has four assessment areas: clinical quality, patient experience, workforce and training. Endoscopy services at MTW run seven days a week with a team of 111 staff, including clinical specialists, doctors and nurses who specialise in gastroenterology, surgery and nurse-led endoscopy, as well as administrative staff. Last year the service performed more than 15,000 procedures. The Trust has been JAG-accredited for the past 10 years, showing the commitment and professionalism of the team and the high standard care provided to patients. In the latest review, MTW's Endoscopy service was commended for the quality of its leadership, exceptional nurse training and development, and "continued efforts to support neighbouring sites and reduce their endoscopy waiting times".

- A 'super Saturday' clinic was recently held by our Audiology team, which saw 79 people fitted for hearing aids in just one day. Feedback received from the day was overwhelmingly positive, with many commenting on how thorough the team were with their explanations, and how helpful it was to meet others with hearing loss. The team will now be dedicating two days a month to these clinics, helping patients get the hearing care they need. The team has also been working hard to reduce their rates of 'did not attend' (DNA) by patients, which stood at 3% last year, identifying why they occurred and how this could be remedied. A significant number of DNAs were from patients in care homes, so processes have now been put in place to notify care home staff of appointments in advance, in addition to the seven-day reminder sent to patients, to ensure patients were ready and transport arranged. The team's work has led to a reduction in the DNA rates from 3% to 1.06% since the start of the year.

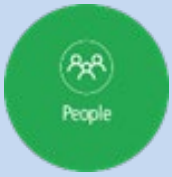
- Earlier this month, we welcomed colleagues from the regional NHS England (NHSE) team and the Kent and Medway Integrated Care Board (including the Local Maternity and Neonatal System, and Maternity and Neonatal Voices Partnership) to our maternity services at Tunbridge Wells Hospital. The visitors came to learn more about our progress against NHSE's three-year delivery plan and our own improvement work following the CQC inspection in August 2023. Our teams provided updates on the work the Trust has been doing to bring the voices of service users into sharper focus, how we're making better use of data to inform our strategy for improvement and how we have strengthened governance

processes to ensure safe, compassionate care. MTW's Maternity and Neonatal teams were recently recognised for their hard work and vital contributions in the Kent and Medway Local Maternity and Neonatal system recognition awards. The annual awards consisted of 21 categories in which colleagues were invited to nominate members of their teams who they feel have demonstrated exceptional effort and dedication in their roles. Nine of the 21 categories were awarded to MTW colleagues, including Midwife of the Year, Inspirational Leadership and Service User Choice. On behalf of the Board, I would like to congratulate the Maternity and Neonatal staff members who were recognised at the awards, and thank them for their continued dedication in delivering outstanding care to our patients.

- MTW's Ophthalmology department has become the first in the world to start using reusable hemp theatre hats, reducing waste and saving valuable NHS resources. On average, a full-time member of staff in theatres uses 464 disposable hats every year, with some needing seven or more in a day depending on the surgery being performed. Used hats are then incinerated, along with spare hats which are often discarded unused at the end of the day. This adds to costs and creates significant carbon emissions, highlighting the environmental impact of single-use hats and the need for greener alternatives. Reusable surgical hats can be washed and reused, reducing waste and environmental impact, while maintaining strict infection control standards. Unlike cotton, hemp needs minimal water and is carbon-negative, meaning it absorbs more carbon than it creates. By switching to reusable hemp surgical hats, the Ophthalmology teams are helping to reduce the Trust's carbon footprint and making progress towards a greener healthcare system.

- Congratulations to the winner of the Trust's Employee of the Month award for May, Senior Theatre Practitioner, Cheysel Bacani. Cheysel was nominated for her work in ensuring safe and effective surgical lists, and for taking initiative and always putting the patient first. EPR Configuration Analyst, Jessica Abraham, also received the Highly Commended Awarded for her unwavering commitment to supporting colleagues and her dedication to the overall success of MTW.

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board**					
Date of meeting	26th June 2025					
Agenda item no.	06-7					
Executive lead	Annette Doherty, Chair					
Presenter	Annette Doherty, Chair					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chair's Report for the June 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 attended the South East Regional Chairs meeting earlier this month, where we welcomed the Chair of NHS England, Penny Dash, who talked about the 10-year strategy and performance expectations.

At the Kent and Medway Joint NHS Committee meeting this month, hosted by the Kent and Medway Integrated Care Board, we discussed the future of health and care partnerships and the responsibilities of integrated neighbourhood teams. We also addressed the system's position following the Government's instructions to all trusts across the country to redesign service delivery and treat more patients with the same or fewer resources. During the meeting, we also welcomed the approvals of the Pathology Network proposal by all acute provider Boards, and discussed next steps.

After receiving a lot of interest in our two Non-Executive Director (NED) positions, interviews for the roles were held at the start of June. We were pleased to make some excellent selections which are currently going through the NHSE approval process.

I joined Chief Executive, Miles Scott in welcoming the Vice-Chancellor of Canterbury Christ Church University (CCCU), Professor Rama Thirunamachandran, and the University's Head of School of Nursing, Dr Paul Driscoll-Evans, to Tunbridge Wells Hospital on 13 June. The guests were given a tour of the new Undergraduate Medical Building, which is home to a number of students from the Kent and Medway Medical School (KMMS), a joint partnership between CCCU and the University of Kent. MTW provides clinical placements for KMMS students, enabling them to have hands-on experiences in a wide range of medical and surgical specialties, and the new accommodation building ensures the students can now live close to their work placement.

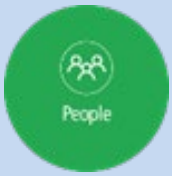
Consultant appointments

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?
N/A						

MTW Exceptional people, outstanding care

Title of report	**Experience of Care Patient Story**					
Board / Committee	**Trust Board**					
Date of meeting	26th June 2025					
Agenda item no.	06-6					
Executive lead	Joanna Haworth, Chief Nurse					
Presenter	Hannah White, Divisional Director of Nursing & Quality					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The attached story represents the Experience of Care of a patient in the Cancer division who is under the oncology team, cancer psychological service, community mental health and psychiatric liaison service.
Any items for formal escalation / decision	No items for escalation but the Board is asked to note and discuss the experience of care.
Appendices attached	• Appendix A – Experience of care patient story

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Mental Health Committee	May 2025	Actions being taken to look at the wider partnership working between different professionals and potential service improvement plan

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	1301 – Failure to meet national targets for complaints performance
Compliance / Regulatory Implications	N/A

NHS
Maidstone and Tunbridge Wells NHS Trust

Patient Story

Name: KR	
Date of care experienced: This story covers the months of December 2024 and January 2025	**Services/wards experienced:** Acute Oncology Service (CNSs) Breast Oncology Team (Consultant Oncologist, Registrar, CNSs) Breast Consultant Surgeon Cancer Psychological Service for Kent & Medway (CaPS-KM) Critical Care Psychology Service Community Mental Health Crisis Team Head of Nursing for Oncology & Cancer Performance

Outline of experience:

The patient, a woman in her early 30s, was undergoing treatment for cancer when she was referred to the Cancer Psychological Service for Kent & Medway by Clinical Nurse Specialists (CNSs) in both the breast oncology and acute oncology teams. She had been experiencing severe physical symptoms during treatment due to chemotherapy toxicity, including extreme pain, insomnia, fatigue and poor concentration and memory, all of which significantly impacted her psychological wellbeing. She reported persistent low mood, hopelessness and thoughts of suicide. She had been prescribed sleeping medication by her GP but did not notice any improvement in her sleep.

The patient attended a telephone triage appointment with the Cancer Psychological Service in mid-December 2024. At her first psychological assessment appointment in early January 2025 (via telephone), she disclosed serious suicidal ideation with intent. Her distress was rooted in the unbearable physical side effects of treatment, a sense of hopelessness about her ability to continue with treatment and a feeling of pressure from her partner and family to “keep going”. She was encouraged to attend A&E for an urgent review of her physical symptoms and to be assessed by the hospital’s Psychiatry Liaison Service. However, the patient declined because of the severity of her physical symptoms, concerns about a flu outbreak at A&E (she had been recently advised not to attend A&E) and a belief that no one or nothing could help her. Presenting to Same Day Emergency Care (SDEC) was considered, but the Psychiatry Liaison Service had concerns about seeing the patient there because SDEC is not a 24-hour service. Despite her partner’s offer to drive her to hospital, she felt unable to go.

In light of these concerns, a referral was made to the local NHS Mental Health Crisis Team by the Cancer Clinical Psychologist via NHS111 on the same day (Thursday). Following a telephone triage with the crisis team, a home visit was arranged by the local mental health team. She attended an oncology appointment on Monday of the following week. It was decided to discontinue chemotherapy as she was too unwell and was booked for a scan the following week.

Sadly, in the early hours of the following morning, the patient attempted suicide at home which resulted in an admission to critical care. The Critical Care Psychology Team supported the patient, her partner and family during this time. She was also reviewed regularly by the Psychiatry Liaison Service while an inpatient. A multidisciplinary team meeting was arranged to bring together all professionals involved in her care. The meeting was chaired by the Head of Nursing for Oncology & Cancer Performance with representation from cancer psychology,

an oncology doctor and CNSs (breast and acute oncology) and psychiatry liaison. An integrated plan was agreed and communicated clearly to the patient on the ward. This included a treatment update from oncology, a psychiatric review and risk management plan prior to discharge, and ongoing input from the Cancer Psychological Service and CNS team.

Since her discharge, the patient has engaged consistently with the cancer psychological therapy. Chemotherapy was stopped so the severe side effects resolved. She continued with immunotherapy and underwent surgery which was successful (a complete pathological response). It is planned for her to continue with immunotherapy until November 2025.

The patient reports notable improvements in her mood, coping and adjustment to her diagnosis. She continues to use therapy well to address ongoing psychological challenges and future sessions will focus on supporting her to better manage fear of recurrence and live in line with her values. Her partner was seen for a course of counselling within the Trust's Oncology Counselling Service.

Within therapy, the patient reflected that in the lead up to her suicide attempt her severe physical side effects, lack of sleep and difficulty with memory and concentration impacted her ability to understand what was happening to her and the plans for future treatment and to make decisions. She said that she now understands that she had one of the most severe chemotherapy toxicity reactions her team had seen, something she wasn't fully aware of at the time. She had attributed her difficulties to a lack of coping.

The patient's own reflections:

Before my cancer diagnosis, I was under considerable distress, having been dismissed by my GP when I asked to be referred after finding a lump, given my strong family history of cancer on the paternal and maternal side and an inherited mutated gene.
Upon diagnosis, this became more distressing, given that the grade 3 tumour had grown significantly and knowing that if I were referred sooner, my treatment plan and staging would have been quite different. My partner and I were also due to commence IVF days before diagnosis and I was then told that my chemotherapy may cause infertility and I'd be put into a surgical menopause to try and protect my ovaries, although this wasn't guaranteed. I had an immense number of phone calls, appointments and biopsies in the next couple of weeks and felt emotionally unsupported and very low.
I had an intense weekly chemotherapy and immunotherapy treatment regime ahead and started suffering from a plethora of side effects ranging from insomnia to confusion, extreme pain, weakness, sweats and exacerbation of existing autoimmune conditions. I had no single or clear point of contact for symptoms and would get varied and conflicting advice on how to treat them. My symptoms became more severe.

I have only vague memories from the events leading up to my admission to critical care and wasn't aware until much later due to perhaps a combination of confusion and medication I was on that my treatment had agreed to be paused. I remember the crisis team visiting our home and found this unhelpful, as I was told a story about how they had been through a tough time and got through it and then informed that no further care would be given, since my psychological issues were a result of my cancer diagnosis and treatment.

During my stay in ICU, staff were incredibly helpful, and my partner and family speak highly overall of the care I received. The Head of Nursing for Oncology helped greatly in explaining to me what was going on and the psychology team aided me to begin understanding what was happening and deal with the confusion I was experiencing. I was incredibly grateful that a plan was put together by all the teams involved in my care upon my discharge.

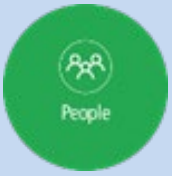
Since my discharge, I have continued treatment with immunotherapy and successful surgery, and I have been having regular psychological therapy sessions. These have been invaluable in helping me to start dealing with everything I have experienced and learning how to cope moving forwards. I have also found my psychologist having direct contact with my oncologist incredibly helpful. I have now also been assigned a single point of contact via a CNS that has made communication much clearer.

Positive points to highlight:	**Areas for improvement:**
• Specialist psychological intervention was crucial because of the intense psychological impact of the cancer treatment (in particular, the impact on decision-making and risk). Input from both the Cancer Psychological Service and Critical Care Psychology Team has helped the patient and her relatives. • Close communication and shared understanding between acute oncology, breast oncology (nurses and doctors), Cancer Psychological Service, Critical Care Psychology, surgical team, and Psychiatry Liaison service, particularly during the MDT meeting, was really helpful in generating a clear plan that was communicated well to the patient and which enabled the patient to be discharged from hospital feeling supported.	• An earlier referral to the Cancer Psychological Service may have been helpful • Further work is required to improve the feedback to acute services following patient reviews by community mental health teams. • A lack of alternative assessment area led to the patient not being seen in a timely manner. • An admission to hospital from clinic may have been helpful to manage risks and concerns, both physical and psychological.

Ongoing actions with case:

- Further work with outpatients and preventive care pathways with Community Mental Health Services.
- Further review to look at whether psychiatric assessment by psychiatry liaison may be possible in SDEC to avoid patients having to attend A&E.

Title of report	**Summary report from the Quality Committee, 18/06/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	26th June 2025					
Agenda item no.	06-9					
Executive lead	Maureen Choong, Non-Executive Director					
Presenter	Maureen Choong, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Quality Committee met in person on 18th April 2025 (a ‘‘deep dive’’ meeting). The Committee considered the following topics: The BAF risks overseen by the Quality Committee; A review of the Histopathology Recovery Plan; A review of the Vascular Access Service; and confirmed items for scrutiny at future Quality Committee ‘Deep Dive’ meetings. The Committee noted that the reports presented, demonstrate that controls relating to Principal Risks 2, 3, and 4 of the Board Assurance Framework demonstrate partial assurance.
Any items for formal escalation / decision	N/A
Appendices attached	There are no appendices to this report.

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

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation.
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 3417 - Risk of Significant physical and/or psychological harm to

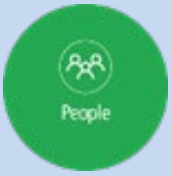
	patients as a result of prolonged Histology turnaround times • 3096 - Risk of increased staff turnover/ sickness/ negative impact on wellbeing across Cellular Pathology- all roles.
Compliance / Regulatory Implications	N/A

The Quality Committee met (virtually, via webconference) on 18th June 2025 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings**.
- The Committee considered the Board Assurance Framework (BAF) and highlighted the continuing areas of improvement throughout the 'Patient Access'; Patient Safety and Clinical Effectiveness' and 'Patient Experience' strategic themes. A number of encouraging updates were shared, including that severe fatal harm cases had reduced; that the Deteriorating Patient working group, and Martha's Rule were both up and running; and that the Trust had reached its target in terms of complaints responses for the fourth consecutive month.
- The Chief of Service, Core Clinical Services presented a **review of the Histopathology Recovery Plan,** where in the Committee heard that a number of contributing factors towards the deteriorating Histopathology turnaround times over the course of the last 18 months, which has been amplified over the past 12 months, included the increasing excessive demand in the last year; that expectations of what the service provides has changed due to the workload moving from East Kent to Medway, therefore the performance of the Urology service in East Kent has an effect on the pressures on the Urology and Histopathology services in West Kent; and an increase in the complexity of the workload and also the number of tests being performed. The recovery plan moving forward was discussed, and it was noted that they key areas to focus on, were the streamlining of laboratories and processes with future opportunities to automate, in order to help the issues around recruitment; reduction of excess workload; reduction in demand through the diagnostics team and mitigating risk averse behaviour; and a required small staffing increase to bridge the gap. There has been a significant reduction in backlog in the laboratory over the past 10 weeks and the turnarounds times have been gradually improving with the help of outsourcing through East Kent. The reporting system was also discussed, to ensure that the relevant progress was being reviewed, and it was outlined that Histopathology, as a Pathology based service, reports and issues concerns regarding the service operations to the United Kingdom Accreditation Service (UKAS) which is the NHSE appointed regulator for Pathology in the UK (equivalent to CQC for other hospital services); and it was noted that the Trust has an open dialogue with UKAS in regards to turnaround times with regular meetings in place between the Quality Manager and the assessment manager discussing position, impact, communications with users and recovery mechanisms.
    - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4.
- The Divisional Director of Nursing and Quality, Surgery, and the Deputy Chief of Service, Surgery then presented a **review of the Vascular Access Service,** wherein the Committee heard that the Vascular Access Service (VAS) has both elective and non-elective pathways across both the Maidstone and Tunbridge Wells sites; the service operates two main pathways: elective cancer-related line insertions and non-elective inpatient access, with emergency cases being managed via emergency theatre bookings; that there were concerns raised informally from the VAS regarding increased activity, reporting structure, workforce and patient experience; that the service was working to ensure that it is adequately job-planned, clinically efficient and clearly accountable; that the InPhase system was searched for phrases which could relate to the service, and showed 14 incidents from May 2024 to May 2025, including 9 no harm and 5 low harm incidents; and that incidents relating to cannulas in the same period was 473 however, it was difficult to determine whether these related to the VAS team. An in-depth discussion was held around the prioritisation of the next steps, and it was clear that obtaining and analysing the relevant data should be the first concern in order to understand the activity fully and benchmark the service, and that implementing a dedicated drop down on InPhase for VAS incidents could assist with this. It was outlined that alongside the governance and reporting, a more structured method of collecting patient feedback and quantifying the backlog in staff training would be beneficial in improving the flow of the service. It was agreed that the Divisional Director of Nursing and Quality, Surgery, and the Deputy Chief of Service, Surgery would identify any areas of support required, and feed this back to the Committee within the next four weeks.
    - ❖ The Committee noted that this demonstrated a level of effectiveness of controls for the Board Assurance Framework, Principal Risks 2, 3 and 4.
- The items for scrutiny at future Quality Committee 'deep dive' meetings were discussed, and the Chair then conducted an **evaluation of the meeting**.

Title of report	**Summary report from the People and Organisational Development Committee, 20/06/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	26th June 2025					
Agenda item no.	06-10					
Executive lead	Emma Pettitt-Mitchell, Non-Executive Director					
Presenter	Emma Pettitt-Mitchell, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
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Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The People and Organisational Development Committee met (face-to-face / in-person) on 20th June 2025 (a 'main' meeting). The Committee considered the following topics: 1) Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) 2) Review of the Equal Pay annual audit return for 2025/26 3) Update on violence and aggression against Trust staff The Committee noted that the reports presented, demonstrate that controls relating to Principal Risk 1 of the Board Assurance framework are demonstrating effectiveness, the principal risk will need to be reconsidered in light of the financial improvement mandated by NHSE		
Any items for formal escalation / decision	The Committee approved an amendment to the Terms of Reference		
Appendices attached	Appendix 1 – Terms of Reference		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

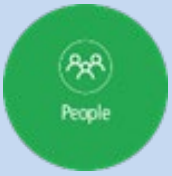
Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
Links to Trust Risk Register (TRR)	ID 994, ID 791,ID 1301, ID 3186, ID 3124, ID 3125, ID 3109, ID 3130, ID1211, ID 3432, ID 3454, ID 3372, ID 3116, ID 3252
Compliance / Regulatory Implications	N/A

The People and Organisational Development Committee met on 20th June 2025 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were noted.
- The Committee reviewed and discussed the People Board Assurance Framework (BAF) risk and considered that the updated risks reflect the maintenance of a compassionate and inclusive culture, balanced with the transformational change required. It was also noted that a component of BAF risk 6 relates to workforce and this has been reflected in the amended BAF Principal risk 1.
- The Committee conducted a **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**, wherein the Committee heard that there is a reduction overall head count and slight increase in vacancy rate. The Committee noted that temporary staff spend was 9.4% in May, which was a continued reduction from 14.3% at the same point last year. The progress made in reducing agency spend to 1.5%, from 3.7% last year, was also noted. A small percentage increase was reported in sickness absence rates and the Committee heard that this is being monitored for any themes or trends. The ratio of long term to short term sickness has changed from 41:59, 12 months ago to 52:48, at the time of reporting, indicating that further attention should be given to long term sickness absences. The top reasons for long term sickness absence were noted to be musculoskeletal problems and stress.
    - The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- The **review of the equal pay annual audit return 2024/25** was noted by the Committee, who heard that there is an under-representation of women in the highest paid positions. The Women's Health Network, which is available to staff within the Trust was referred to and the Committee considered that more detail on the work of the network would be welcome at a future meeting.
- The Head of Emergency preparedness, resilience and response (EPRR) attended to present the **Update on violence and aggression against Trust staff,** which outlined that a Violence and Aggression summit was held and a Violence and Aggression reduction strategy has been drafted, which will include a number of actions, including improving data quality to enable an accurate picture and improved reporting of incidents from clinical staff. The Committee heard that there is good compliance with Conflict Resolution training and that Managing Challenging Behaviour training is available to staff, to improve their confidence and ability to manage these situations, which was noted to have been well received by staff who have attended the training. It was noted that the rate of staff not attending some training, they had booked, was high and the Committee discussed reasons which may have caused this and actions which could be taken to improve. The Committee heard how the environment, communication and underlying long-term conditions can affect the incidence of violence and aggression and considered actions which could be taken to address these areas, which will be revisited at a later meeting.
- The approved an **amendment to the Terms of Reference.**
- The Committee noted the **forward programme.**
- The Chair conducted an **evaluation of the meeting**.

Title of report	**Summary report from the Finance and Performance Committee**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	26th June 2025					
Agenda item no.	06-11					
Executive lead	Neil Griffiths, Non-Executive Director					
Presenter	Neil Griffiths, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
					
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Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee met (virtually) on 24th June 2025. The Committee considered the following topics: 1) To consider the BAF risks 2) The patient access strategic theme metrics for May 2025 3) The financial performance for month 2, 2025/26 4) The Financial Improvement Plan 5) Update on the Kent and Medway Orthopaedic Centre (KMOC) 6) Update on Fordcombe Hospital 7) ID1061 - Replacement of LA1C Business Case 8) Recent findings from relevant Internal Audit reviews The Committee also noted the Annual review of the Trust's Green Plan; Update on the Estates and Facilities Directorate; Annual update on the PFI contract at Tunbridge Wells Hospital. 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)	• PR3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage • PR5: If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals • PR6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery

Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 791 – Failure to meet Referral to Treatment Targets (RTT) • 3109 – Failure to deliver Financial Plan including recurrent cost improvement programmes for 2024/25 • 3113 – There is a risk that the Trust will not have enough cash to meet its commitments resulting in suppliers not being paid and the Trust not meeting its BPPC (Better Payment Practice Code) • 3130 – There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)
Compliance / Regulatory Implications	N/A

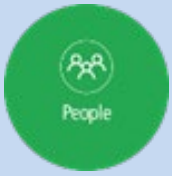
The Finance and Performance Committee met on 24th June 2025, virtually, via webconference.

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 May were reviewed, and it was highlighted that the Referral to Treatment Time (RTT) was above the new trajectory target for May 25 of 72.7% at 72. 66 % (Excluding patients referred from the system). It was noted the Trust remains one of the best performing trusts in the country for longer waiters. The Committee heard that work is ongoing to reduce the length of stay for patients on non-elective pathways and that there is variable achievement of the new Breakthrough Objective, "Reduction in weeks wait for first Outpatient Appointment" and the Committee heard this has a phased trajectory to achieve an average wait of 13 weeks for first outpatient appointment by March 26. The Committee noted the reduction in time for the target for ambulance handovers from 60 to 45 minutes and each patient that waits longer than 45 minutes is being reviewed.
- The **financial performance month 2, 2025/26** was then presented and the Committee heard that the Trust was £3.5m in deficit in the month which was £0.2m favourable to plan. Year to date the Trust is £9.8m in deficit which is £0.5m adverse to plan. The key year to date pressures were noted to be: Pay overspend (£0.6m), CIP slippage (£0.4m), Theatre consumables overspend (£0.4m), Fordcombe hospital slippage to plan (£0.3m) and CIP project support costs (£0.2m). These pressures were offset by non-pay underspends of £1.8m. The Trust identified £22.3m of schemes against the internal target and it was noted that it is working on developing transformation schemes to make a material progress towards the £49m target. The Committee heard that work is ongoing with system colleagues in developing detailed plans to meet these 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 14 workstreams, and five transformation schemes, which included the People transformation scheme to be discussed at the Trust Board meeting. Also, the trust was working toward meeting National savings expectations and working with collaboratives and Health Care partnerships to identify cost improvement opportunities. The Committee noted the work completed to date, which was considerable and detailed. There is however further activity needed to fully meet the target.
- The **Annual review of the Trust's Green Plan; Update on the Estates and Facilities Directorate; and Annual update on the PFI contract at Tunbridge Wells Hospital** were noted by the Committee.
- The Chief Operating Officer provided an **update on the Kent and Medway Orthopaedic Centre (KMOC),** which included that at the end of December 2024 the team submitted a KMOC recovery plan and by the end of March 2025 the team had delivered 104 more than the revised plan. The overall activity for adult orthopaedics had increased by 37% increase, compared to the previous year 2023/24, with an overall increase in activity of 147% from 2021/22 (which was the basis of the KMOC business case). The Committee heard that key areas of focus to realise this improvement were; theatre utilisation, reviewing patient pathways to reduce cancellations and reviewing waiting list initiatives. It was noted that an improvement has been achieved in all metrics, which is monitored monthly and that a benefits realisation analysis will be undertaken once KMOC has been operational for 12 months.
- The Committee received an update on **Fordcombe Hospital**, wherein, it was noted that the financial position at Month 2 reported a negative variance of £285k against a £1.3m target. The Committee heard that the division is experiencing challenges with regards to private referrals and noted that significant work has been undertaken in building consultant confidence, implementing a comprehensive marketing plan and working to establish a direct booking system for patients and GPs to be able to make referrals.
- The Director of Strategy, Planning and Partnerships presented the **Replacement of LA1C Business Case** to the Committee, which was approved by the Committee.
- The Trust Secretary provided the **recent findings from relevant Internal Audit reviews** which the Committee reviewed.
- The Committee noted the **summary report from the from the May 2025 People and Organisational Development Committee;** 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.

Title of report	**Integrated Performance Report (IPR) for May 2025**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	26th June 2025					
Agenda item no.	06-12					
Executive lead	Chief Executive / Executive Directors					
Presenter	Chief Executive / Executive Directors					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The IPR for May 2025 is enclosed.		
Any items for formal escalation / decision			
Appendices attached			
Report previously presented to:			
Committee / Group		Date	Outcome/Action
n/a			

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer • PR 5:If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals • BAF 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

May 2025

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

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

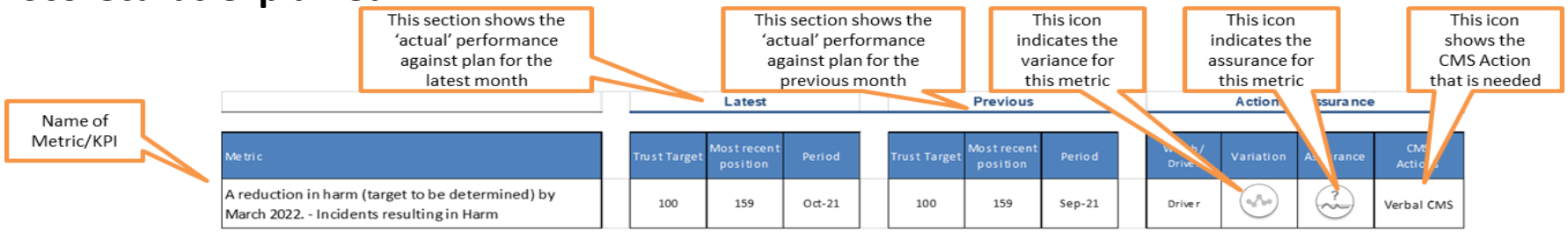
Escalation Pages:

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

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

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

Scorecards explained



Further Reading / other resources

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

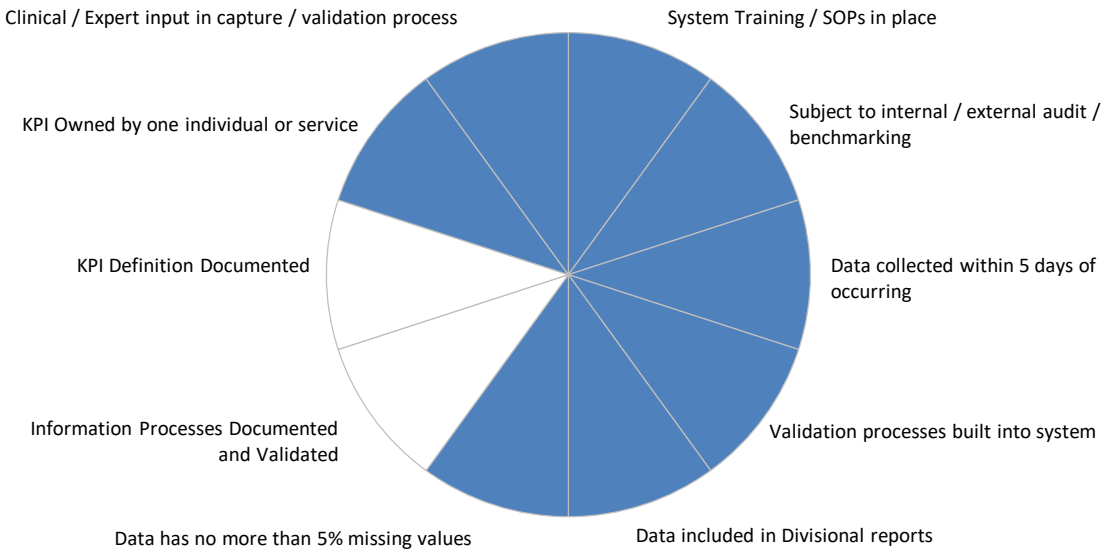
MTW exceptional people, outstanding care

Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Strategy Deployment Review (SDR) governance structure and Improvement process has been reviewed for the new financial year and the new Vision and Breakthrough Objectives for each of the six strategic themes have been agreed. The new objectives are therefore reflected in this report. These Key Performance Indicators are at an early stage and will continue to be developed as the improvement programme continues.

People: Delivery of the pay elements of the Financial Improvement Plan 25/26 indicator is experiencing common cause variation and variable achievement of the target. 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. The Breakthrough Objective is currently being reviewed. 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 May 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 be consistently passing the target. The Appraisal window opened again in April and will close at the end of June 2025. Early performance for May 2025 is currently 21.8% but this is expected to increase significantly closer to the end of June deadline. 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 remains in common cause variation but 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 is now experiencing special cause variation of a concerning nature and has failed the target for more than 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. 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 is now experiencing special cause variation of an improving nature and passing the target for more than six months. VTE performance was above the 95% target in April (data runs one month behind) and continues to experience common cause variation and consistently passing the target.

Patient Access: 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 May 25 of 72.7% at 72.66% (Excluding SYS). Nationally we reported 72.60% (including SYS). This indicator is experiencing common cause variation and variable achievement of the target. We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported four 52 week breaches at the end of May 25. The number of patients having waited more than 40 weeks (Excluding SYS) is now experiencing special cause variation of a concerning nature and variable achievement of the target. The new Breakthrough Objective "Reduction in weeks wait for first Outpatient Appointment" is currently experiencing common cause variation and variable achievement of the target. This has a phased trajectory to get to an average wait of 13 weeks for first outpatient appointment by March 26

Diagnostic Waiting Times was above the new trajectory target for May 25 of 88.6% at 89.1%. This indicator is experiencing common cause variation and variable achievement of the target. 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%.

Executive Summary (continued)

Patient Access (Continued): The Trust's performance for A&E 4hrs was below the new trajectory target for May at 81.4% but remains in common cause variation and variable achievement of the target. Performance remains one of the highest both Regionally and Nationally. The average non-elective length of stay indicator is currently experiencing common cause variation and consistently failing the target. Work continues to improve flow across the Trust. 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 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.

Outpatient utilisation is now experiencing special cause variation of a concerning nature and variable achievement of the target. May performance will improve as cashing up of clinics continues. Both the percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute and the percentage of patients on a PIFU Pathway continue to experience special cause variation of an improving nature. However, Calls answered within 1 minute remains consistently failing the target.. Performance for First Outpatients activity was slightly below the new trajectory target for May 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) was above the new plan for May 2025 and has passed the target for more than six consecutive months (22 months). 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 variable achievement of the target. Diagnostic Imaging activity levels were above plan in May and remains in common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints is now experiencing special cause variation of a concerning nature and has failed the target for more than six months. The rate of complaints per 1,000 occupied beddays is also experiencing special cause concern. The new Breakthrough Objective to increase the number of complaints that are closed through an initial conversation or local resolution is currently at ??%. The target for this is currently being worked up. Complaints responded to within the target date passed the target again in May, at 75%, and continues to experience special cause variation of an improving nature and variable achievement of the target. Friends and Family Response rates remain in common cause variation, except for outpatients which is now experiencing special cause variation of an improving nature. All touch points have failed the target for six consecutive months.

Systems: Both of the new Vision and Breakthrough Objectives are experiencing common cause variation and variable achievement of the target. New phased improvement trajectories for these are currently being finalised.

Sustainability: The Trust was £3.5m in deficit in the month which was £0.2m favourable to plan. Year to Date the Trust is £9.8 in deficit which is £0.5m 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.

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. Data validation for both of the indicators for Decision to delivery interval (Category 1 and Category 2) caesarean sections demonstrates frequent mis-classification and a level of delay due to clinically justifiable reasons. We are therefore now showing the data post-validation from April 24 onwards. Both indicators are therefore now experiencing common cause variation and variable achievement of the target and are no longer escalated.

Executive Summary (continued)

Escalations by Strategic Theme:

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

Patient Access:
- 10% Reduction in Non-Elective LOS (P.17)
- Outpatient Calls answered <1 minute (P17)
- Ambulance Handovers < 30 mins (P.17)
- % Capped Theatre Utilisation (P.17)

Systems:
- None Escalated

Sustainability:
- None escalated

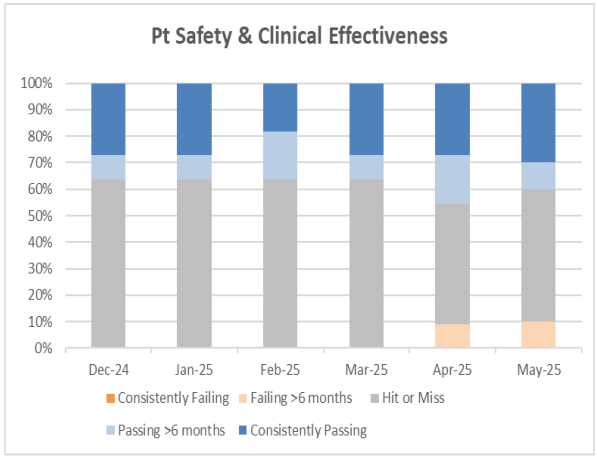
Patient Safety & Clinical Effectiveness:
- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.14)

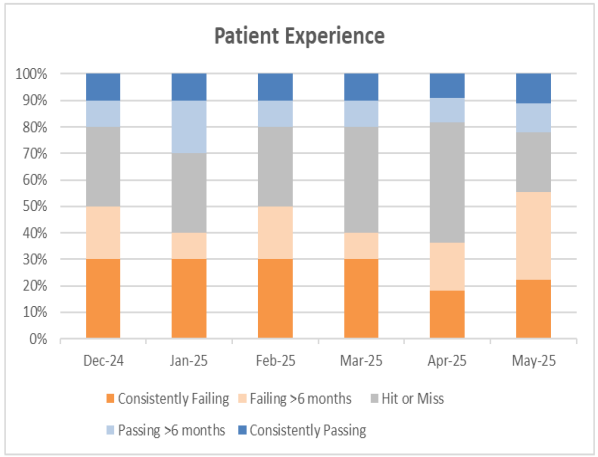
Patient Experience:
- New Complaints Received (P.19)
- FT Response Rates: All areas (P.20)

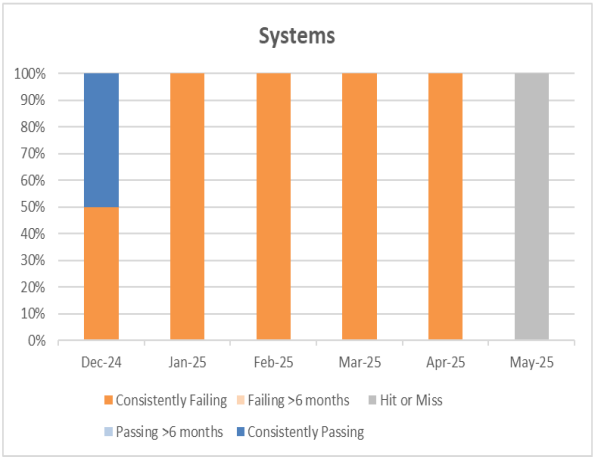
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.24)
- Women waiting for Induction of Labour <4 Hrs (P.24)

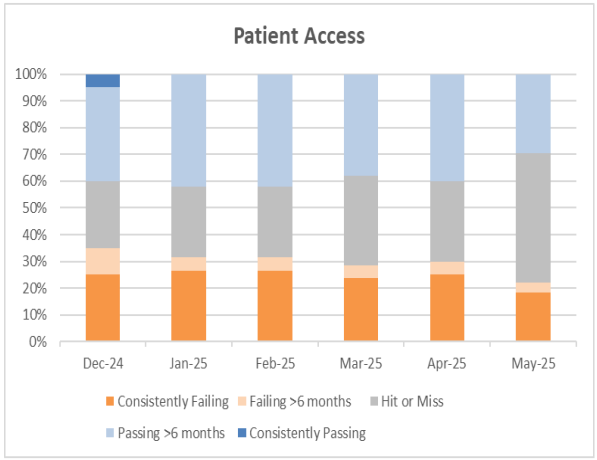
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

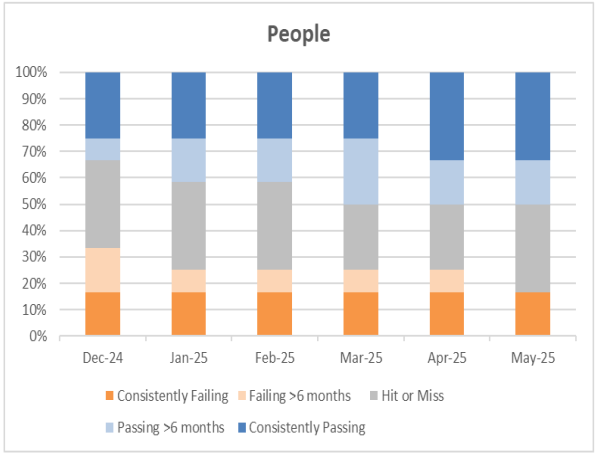
Assurance Stacked Bar Charts by Strategic Theme

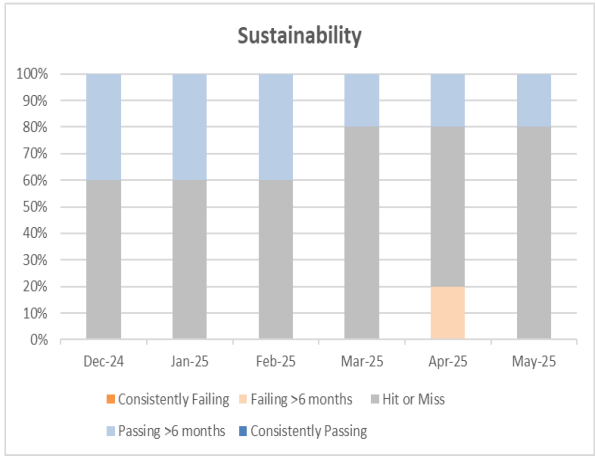












Matrix Summary

May 2025

Variance	Assurance: Pass ★	Pass	Hit and Miss	Fail	Fail -
Special Cause - Improvement	Reduce Turnover Rate to 12% Percentage of AfC 8c and above that are Female Percentage of AfC 8c and above that have a Disability Standardised Mortality HSMR Summary Hospital-level Mortality Indicator (SHMI) Rate of patient falls per 1000 occupied bed days Cancer - 31 Day First (New Combined Standard) - data runs one month behind Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) To achieve the planned levels of elective (DC and IP combined) activity	Agency Spend as a % of spend – target of 3.2% Reduce the Trust wide vacancy rate to 8% Rate of patient falls per 1000 occupied bed days Cancer - 31 Day First (New Combined Standard) - data runs one month behind Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways) Transformation: % of Patients Discharged to a PIFU Pathways		Overall Temporary Staff Spend as a % of Total Spend Transformation: CAU Calls answered <1 minute % Capped Theatre utilisation. Friends and Family (FFT) % Response Rate: Outpatients
Common Cause	Statutory and Mandatory Training % VTE Risk Assessment (one month behind)	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Safe Staffing Levels (Nursing) Cash Balance (£k)	Delivery of the pay elements of the Financial Improvement Plan 2025/26 Sickness Absence Staff Leavers within 12 months Staff Leavers within 24 months Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) Never Events IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Bacteraemia To achieve a 5%improvement in RTT (Excluding SYS) as per the Trust Trajectory To achieve a 5%improvement in RTT (Including SYS) - Reported Nationally Access to Diagnostics (<6weeks standard) A&E 4 hr Performance Cancer - 62 Day (New Combined Standard) data runs one month behind Conversion rate from ED (Excluding Type 5 and including Direct Admissions) To achieve the planned levels of new outpatients activity Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. To support the system financial recovery plan through the better use of beds programme - Daily Average In-Hospital Non-Elective Overnight Beddays (excluding Virtual Ward) Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays Delivery of the better use of beds programme for MTW - Average Non-Elective LOS for Fracture Neck of Femur (NOF) Delivery of financial plan, including operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) Reduce non-pay spend Capital Expenditure (£k)	Flow: Ambulance Handover Delays >30mins Friends and Family (FFT) % Response Rate: Inpatients Friends and Family (FFT) % Response Rate: A&E	Percentage of AfC 8c and above that are BAME Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5) Friends and Family (FFT) % Response Rate: Maternity
Special Cause - Concern	Complaints Rate per 1,000 occupied beddays		RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Transformation: % OP Clinics Utilised (slots)	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) To reduce the overall number of complaints or concerns each month	

Strategic Theme: People

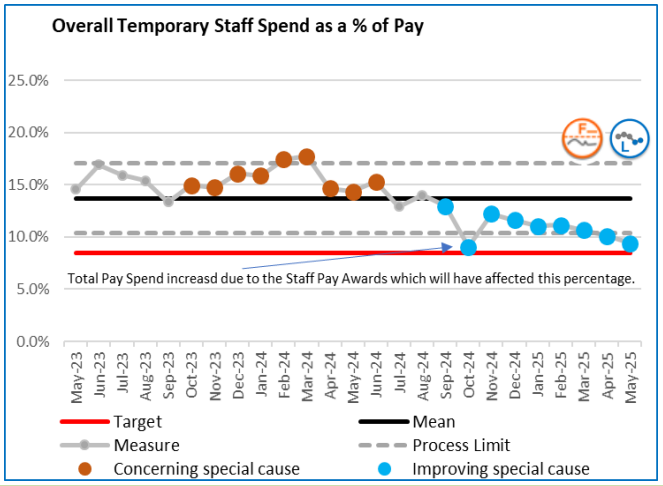
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Well Led	Delivery of the pay elements of the Financial Improvement Plan 2025/26		42,979	43,490	May-25	43,252	44,261	Apr-25	Driver			Verbal CMS			
Breakthrough Objective	Well Led	Overall Temporary Staff Spend as a % of Total Spend		8.5%	9.4%	May-25	8.5%	10.1%	Apr-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	1.5%	May-25	3.2%	1.3%	Apr-25	Driver			Not Escalated			
	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	5.5%	May-25	8.0%	5.3%	Apr-25	Driver			Not Escalated	5.4%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.6%	May-25	12.0%	10.5%	Apr-25	Driver			Not Escalated	10.5%		
	Well Led	Sickness Absence		4.5%	4.2%	Apr-25	4.5%	4.0%	Mar-25	Driver			Not Escalated	4.3%		
	Well Led	Appraisal Completeness		95.0%	21.8%	May-25	N/A	N/A	Apr-25	Driver	No SPC	No SPC	Not Escalated	95.0%	No SPC	No SPC
	Well Led	Statutory and Mandatory Training		85.0%	88.8%	May-25	85.0%	89.9%	Apr-25	Driver			Not Escalated	88.4%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	74.7%	May-25	66.0%	74.0%	Apr-25	Driver			Not Escalated	75.15%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	8.0%	May-25	4.0%	8.0%	Apr-25	Driver			Not Escalated	8.57%		
	Well Led	Percentage of AfC 8c and above that are BAME		12.1%	6.7%	May-25	11.7%	6.7%	Apr-25	Driver			Escalation	6.40%		
	Well Led	Staff Leavers within 12 months		15.3	20	May-25	15.3	18	Apr-25	Driver			Not Escalated	18		
	Well Led	Staff Leavers within 24 months		27.8	36	May-25	27.8	36	Apr-25	Driver			Not Escalated	33		

Financial Breakthrough Objective: Counter Measure Summary

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

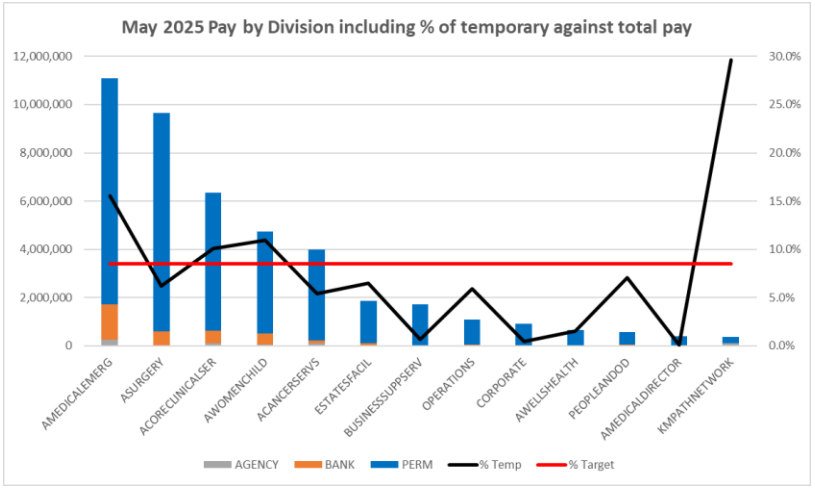
Owner: Chief People Officer
Workstream: Temporary Staffing
Metric: Overall Temporary Staff Spend as a % of Total Spend
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



May-25
9.4%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Max Target (Internal)
8.5%
Business Rule
Full Escalation as is consistently failing the target

2. Stratified Data



3. Top Contributors & Risks

Top Contributors:

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

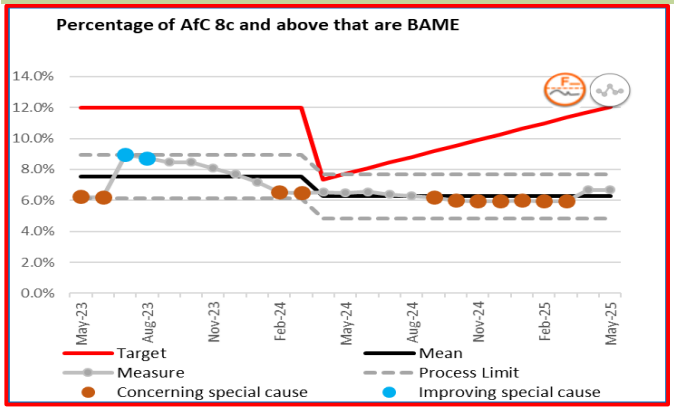
Risks:

- 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	Workforce Transformation Programme Phase 1 consultation commences	Jul 2025	Chief People Officer
	Workforce Transformation Programme Phase 2 reviewed at Trust Board	Jun 2025	Chief People Officer
Rostering Performance	Continue to develop and Temporary Staffing Dashboard to give operational teams visibility of key temporary staffing performance	Jul 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	complete	Deputy Medical Director
Medical Rostering (Patchwork)	Rollout of Patchwork in ED inc staff engagement and communications. Go live for Resident Doctors re-planned from 27 May to 23 June with Consultants to follow	Jun 2025	Patchwork Medical Rostering Programme Director

People – Workforce: CQC: Well-Led



May-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:
% of AfC 8c and above that are BAME: This metric is common cause variation and consistently failing the target.	**% of AfC 8c and above that are BAME:** **Actions:** Online Inclusive recruitment training is complete and will be available mid June 2025 Awaiting outcome of discussions between PODco Chair and Deputy CPO (OD) on EDI strategy and project review Executive Succession planning commencing June 2025 Target will be reviewed in line with proposed draft NHS National Performance & Assessment Framework (NPAF)	**% of AfC 8c and above that are BAME:** 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. The People Business Partners have been provided with suggested targets for recruiting managers • 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 An EDI update went to PODco in April 2025 with suggestions of standing back up the EDI project and reviewing the EDI strategy 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 .

Strategic Theme: Patient Safety & Clinical Effectiveness

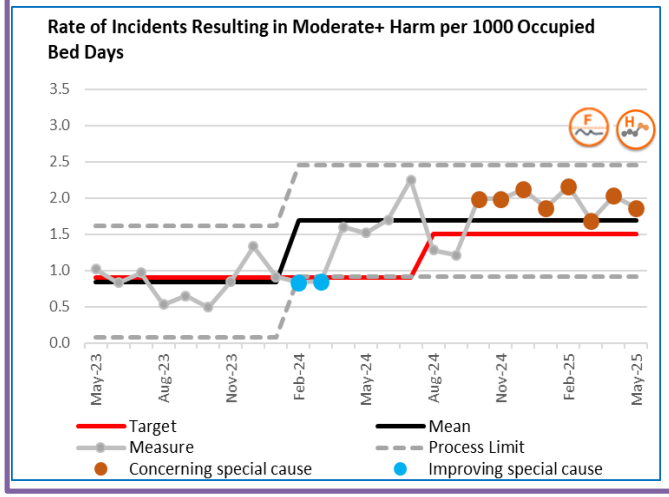
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	1.86	Apr-25	1.50	2.03	Mar-25	Driver			Full CMS	2.41		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	3	Apr-25	2.1	1	Mar-25	Driver			Verbal CMS	3		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	3	May-25	TBC	2	Apr-25	Driver			Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	2	May-25	TBC	2	Apr-25	Driver			Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	May-25	TBC	0	Apr-25	Driver			Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	83.9	Feb-25	100.0	83.9	Jan-25	Driver			Not Escalated	82.2		
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	88.0	Feb-25	100.0	88.0	Jan-25	Driver			Not Escalated	84.0		
	Safe	Never Events		0	0	May-25	0	0	Apr-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		23.1	26.4	May-25	23.1	26.4	Apr-25	Driver			Not Escalated	36.0		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.3	73.8	May-25	44.3	16.4	Apr-25	Driver			Not Escalated	52.8		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	May-25	0	0	Apr-25	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	3.6	May-25	6.4	5.2	Apr-25	Driver			Not Escalated	4.4		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	96.4%	Apr-25	95.0%	98.2%	Mar-25	Driver			Not Escalated	96.9%		

Vision: Counter Measure Summary

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

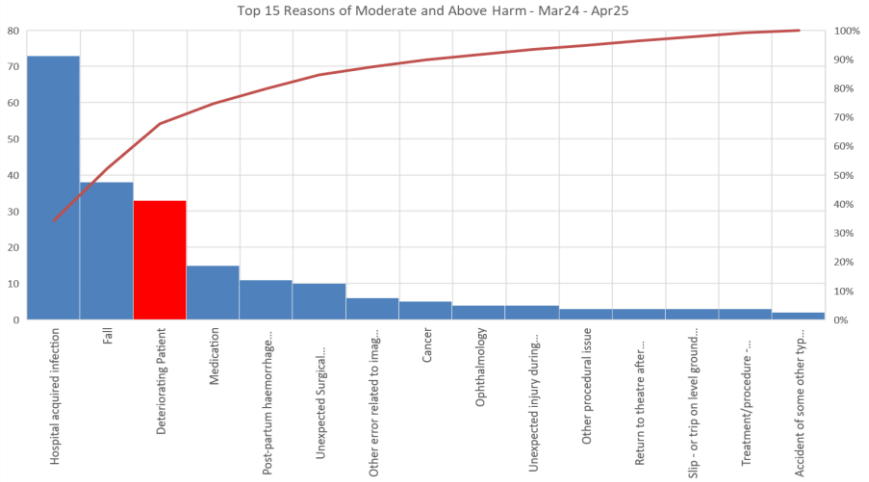
Owner: Medical Director
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

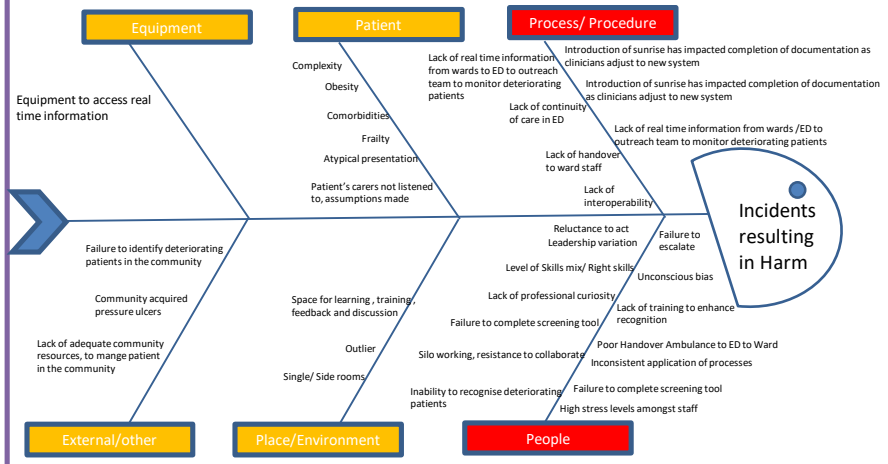


Apr-25 (1 month arr)
1.86
Variance Type
Metric is currently experiencing special cause variation of a deteriorating nature
Maximum Limit (Internal)
1.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



3. Top Contributors



4. Action Plan

Actions	Leads	Due by
Deteriorating Patients		
Review of all trust training for deteriorating patients: (online and F2F)	JB	Q1
Pilot 2am huddle meeting is an alternative to H@N	FL/KS	Jul-25
Piloting 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
Explore possibility of establishing a deteriorating patient champion on each ward	JB	Aug-25

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	To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory		72.7%	72.66%	May-25	72.4%	72.6%	Apr-25	Driver			Verbal CMS	73.8%		
Breakthrough Objective	Responsive	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways)	TBC	18.0	17.9	May-25	18.0	18.0	Apr-25	Driver			Note Performance	17.0		
Constitutional Standards and Key Metrics	Responsive	To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally		72.7%	72.60%	May-25	72.4%	72.5%	Apr-25	Driver			Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		703	949	May-25	691	785	Apr-25	Driver			Not Escalated	639		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	12	May-25	N/A	14	Apr-25	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally		N/A	4	May-25	N/A	1	Apr-25	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		88.6%	89.5%	May-25	88.4%	89.4%	Apr-25	Driver			Not Escalated	88.5%		
	Responsive	A&E 4 hr Performance		85.7%	81.4%	May-25	84.8%	81.5%	Apr-25	Driver			Not Escalated	83.0%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	98.0%	Apr-25	96.0%	97.0%	Mar-25	Driver			Not Escalated	96.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	85.6%	Apr-25	85.0%	85.2%	Mar-25	Driver			Not Escalated	85.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	77.0%	Apr-25	75.0%	77.9%	Mar-25	Driver			Not Escalated	77.3%		
	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	94.7%		

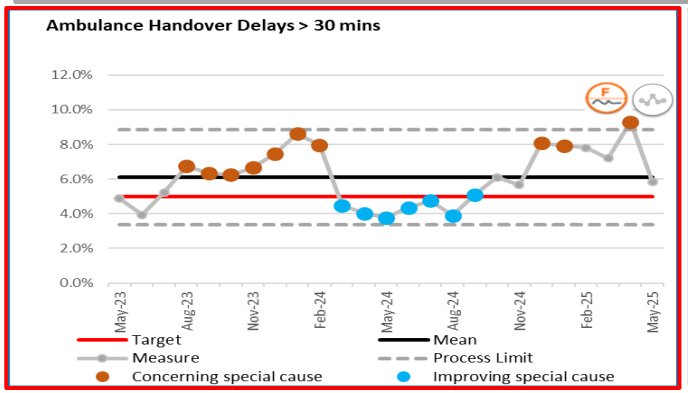
* The RTT Trajectory and Patients waiting more than 40 weeks excludes the patients that have been added to our waiting list as the Trust is now providing system support (SYS) to our neighbouring Trusts across Kent and Medway to help reduce long waiting patients to ensure these patients are treated as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

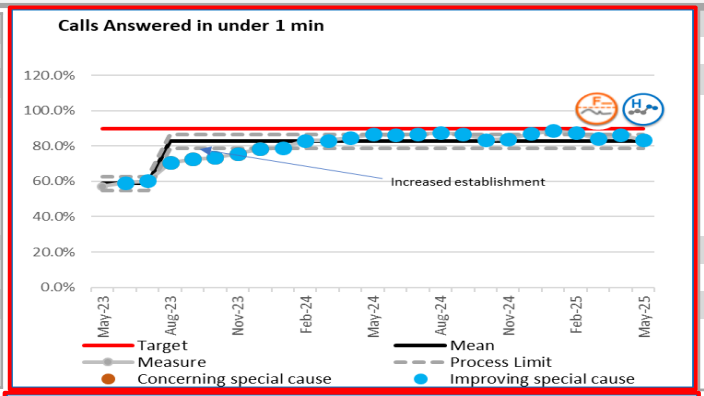
Strategic Theme: Patient Access (continued)

				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%	77.9%	May-25	85.0%	80.8%	Apr-25	Driver	L	?	Not Escalated	80.8%	L	F
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		5.9%	6.7%	May-25	5.8%	6.7%	Apr-25	Driver	H	?	Not Escalated	7.6%	H	?
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	83.4%	May-25	90.0%	86.2%	Apr-25	Driver	H	F	Escalation	84.7%	H	F
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	5.9%	May-25	5.0%	9.3%	Apr-25	Driver		F	Escalation	5.9%		F
	Effective	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5)		5.9	7.1	May-25	5.9	6.8	Apr-25	Driver		F	Escalation			
	Effective	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	14.7%	May-25	16.0%	15.4%	Apr-25	Driver		?	Not Escalated			
	Effective	To achieve the planned levels of new outpatients activity		22,187	21,913	May-25	22,120	21,051	Apr-25	Driver		?	Not Escalated	22,174		?
	Effective	To achieve the planned levels of elective (DC and IP combined) activity		5,737	6,175	May-25	5,266	5,783	Apr-25	Driver	H	P	Not Escalated	5,769	H	P
	Effective	% Capped Theatre utilisation.		85.0%	82.8%	May-25	85.0%	82.9%	Apr-25	Driver	H	F	Escalation			
	Effective	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	49.1%	May-25	49.0%	47.9%	Apr-25	Driver		?	Not Escalated	50.4		?
	Effective	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity		16,643	18,747	May-25	16,140	18,542	Mar-25	Driver		?	Not Escalated	19,125	H	P

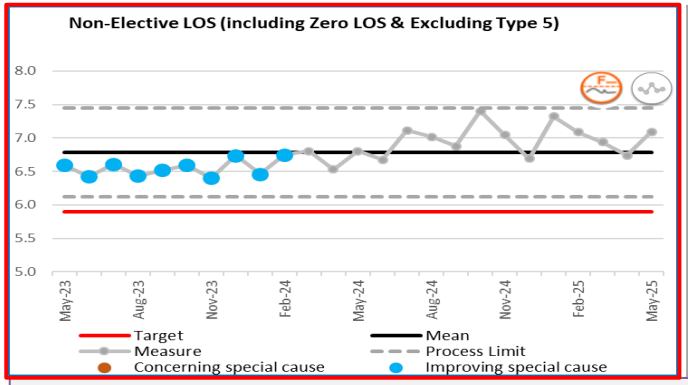
Patient Access: CQC: Responsive



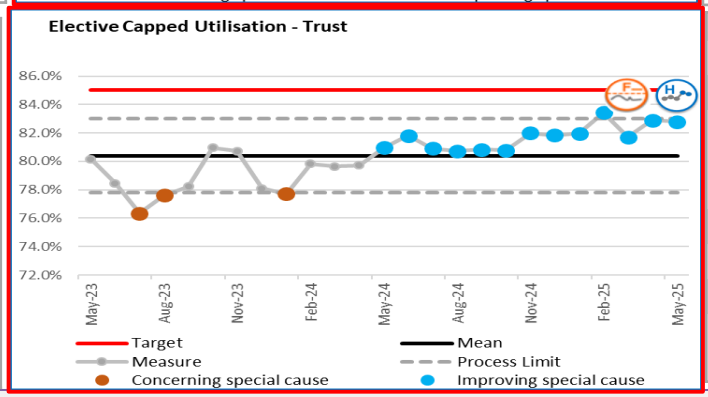
May-25
5.9%
Variance / ,Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
5%
Business Rule
Full Escalation as has failed the target for 6+months



May-25
83.4%
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 is consistently failing the target



May-25
7.1
Variance Type
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
5.9
Target Achievement
Full Escalation as is consistently failing the target



Mat-25
82.8%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target.

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.

Non-Elective LOS: is experiencing common cause variation and consistently failing the target.

Elective Capped Theatre Utilisation: is experiencing special cause variation of an improving nature and consistently failing the target.

Actions:

Ambulance Handover delays <30mins: The pressure has been due to flow out of the department as well as within the department. Majority of over 30 min handover delays are due to lack of capacity.

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.

Non-Elective LOS: Key focus areas for improvement:

- No criteria to reside
- SDEC
- Weekend discharges – CLD
- Teletracking optimisation, innovation & expansion into Maternity

Elective Capped Theatre Utilisation: Key actions include:

- Cancellation group set up – working on patient pathway
- HIT lists – successful in T&O/UGI/LGI/ENT
- Thick wraps for orthopaedic sets arriving in July
- Improve IPRO Pre-Op Assessment (POA) questionnaire completion – Posters/leaflets/update patient details/better coms
- Increase TUB to Bi-weekly

Assurance & Timescales for Improvement:

Ambulance Handover delays <30mins: Re review of current processes in line with new Ambulance target of no >45 min ambulance handovers. RCA completed and reported to the ICB.

Calls Answered within 1 minute in the CAUs: Continued focus on underperforming specialities to reach 90% specifically T&O, Medicine & Endoscopy. Outpatient Contact Centre have 1 new member of staff joining the team around w/c 7th July

Non-Elective LOS: This is the operation flow financial theme project and is reported on a fortnightly and monthly basis through the Financial Improvement Programme Board, up through F&P and to Trust board. Also aligned to the Better use of Beds system programme of work.

Elective Capped Theatre Utilisation: The Trust are working with AKESO looking at Smart scheduling in Ophthalmology, Trauma & Orthopaedics and Gynaecology and have had the initial meeting - confirming next steps

Strategic Theme: Patient Experience

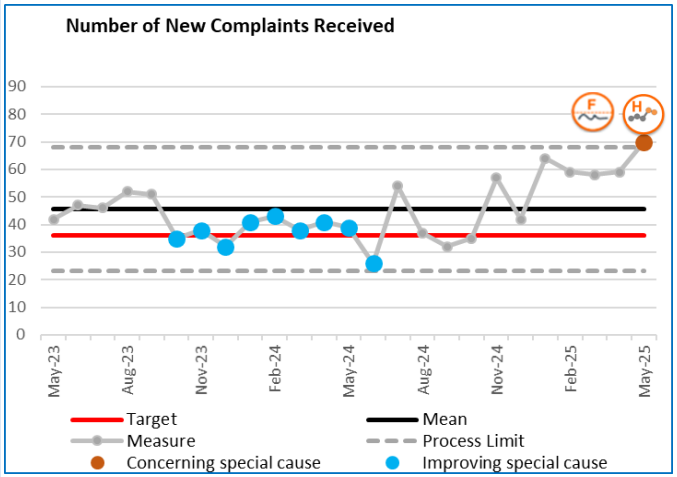
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		36	70	May-25	36	59	Apr-25	Driver	H	F	Full CMS	83	H	F
Breakthrough Objective	Caring	To increase the number of complaints that are closed through an initial conversation or local resolution - shown as a percentage of all complaints closed		TBC	11.6%	May-25	TBC	12.3%	Apr-25	Driver	No SPC	No SPC	Not Escalated			
Constitutional Standards and Key Metrics	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	17	May-25	24	25	Apr-25	Driver		?	Not Escalated	17		?
	Caring	Complaints Rate per 1,000 occupied beddays		3.9	3.7	May-25	3.9	3.2	Mar-24	Driver	H	P	Not Escalated	3.5	H	P
	Caring	% complaints responded to within target		75.0%	75.0%	May-25	75.0%	87.0%	Apr-25	Driver	H	?	Not Escalated	75.0%	H	?
	Caring	Complaints Backlog – Older than 4 months		0	10	May-25	0	7	Apr-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints Closed in Month		38	51	May-25	38	62	Apr-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	98.0%	May-25	95.0%	98.0%	Apr-25	Driver	No SPC	No SPC	Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	13.4%	May-25	25.0%	23.9%	Apr-25	Driver		F	Escalation	20.57%		F
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	12.71%	May-25	15.0%	12.17%	Apr-25	Driver		F	Escalation	14.10%	H	F
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	9.8%	May-25	25.0%	10.4%	Apr-25	Driver		F	Escalation	10.26%		F
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	15.3%	May-25	20.0%	2.5%	Apr-25	Driver	H	F	Escalation	15.20%	H	F
	Safe	Safe Staffing Levels (Nursing)		93.5%	97.7%	May-25	93.5%	99.3%	Apr-25	Driver		P	Not Escalated	101.4%		P

Breakthrough: Counter Measure Summary

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

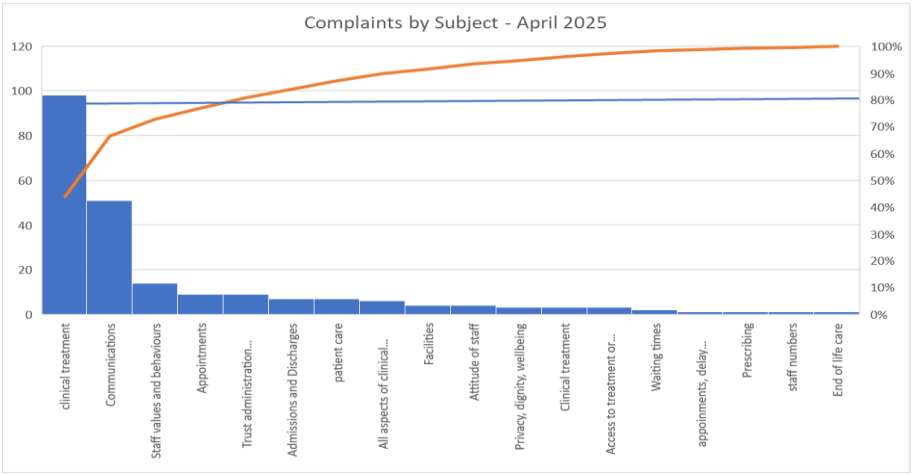
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



May-25
70
Variance Type
Metric is currently experiencing Special Cause Variation of a Deteriorating Nature
Max Limit (Internal)
36
Target Achievement
Metric is has failed the target for 6+ months

2. Stratified Data



3. Top Contributors and Key Risks

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

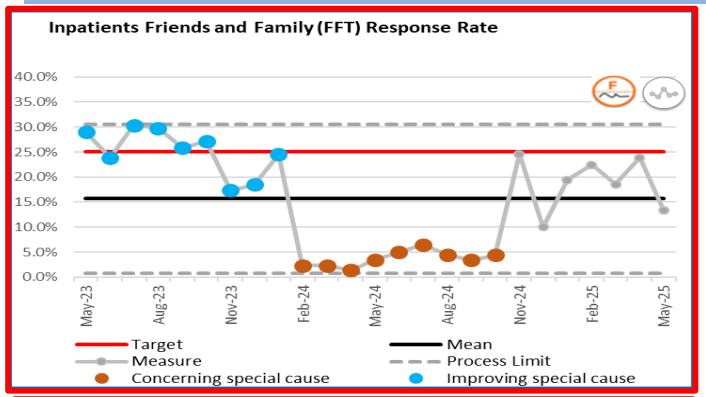
Key Risks:

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

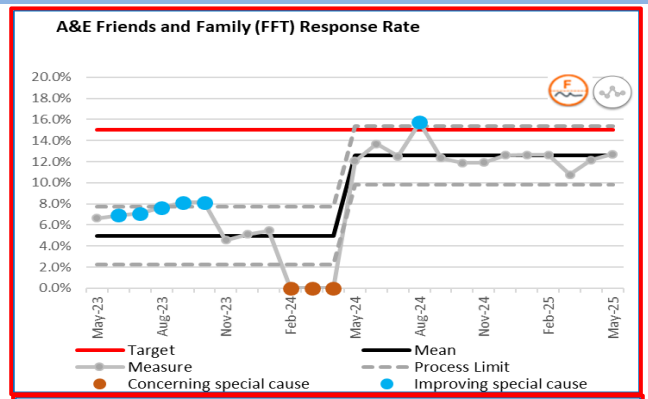
4. Action Plan of the Breakthrough Objective:

Workstreams	Action	Who
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

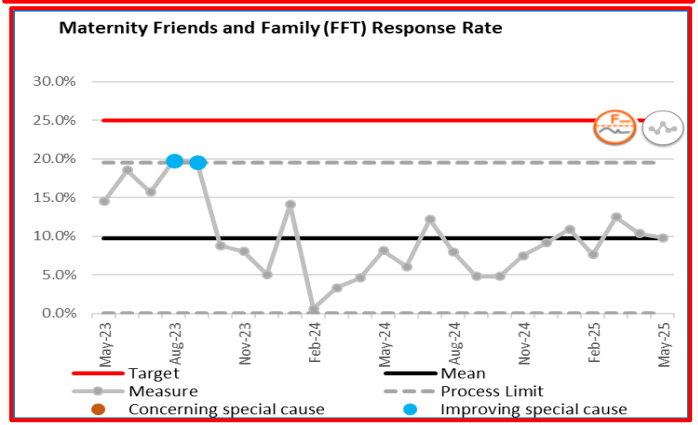
Patient Experience: CQC: Caring



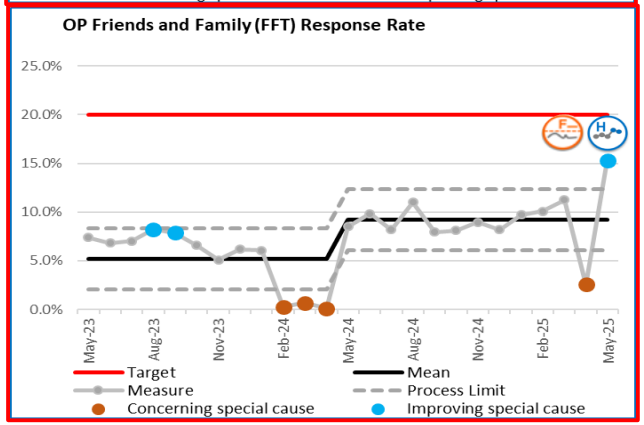
May-25
14.9%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (National)
25%
Business Rule
Full Escalation as failing the target for 6+ months



May-25
12.7%
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



May-25
9.8%
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



May-25
18.0%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

Friends and Family Response Rate - Inpatients: Is experiencing Common Cause variation has failed the target for 6+ months
National Response – 20.0%
Trust Recommended Rate is 92.2%

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 78.8%

Friends and Family Response Rate - Maternity: : Is experiencing common cause variation and consistently failing the target
National Response – 12.6%
Trust Recommended Rate is 95.2%

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 93.8%

Actions:

Inpatients: Response rate has decreased significantly this month. Inpatient areas have tended to favour the utilisation of hard copy cards, this decrease is associated with a failure in data entry/transcription of hard copy forms by the provider this month. This has obviously negatively impacted on the response rate this month and assuming the issue is resolved, will feasibly result in a higher response rate next month. Positive feedback significantly outweighs negative however, the 3 top themes are consistent and similar – 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, several comments about number of staff seemingly unoccupied by work and waiting times for surgical procedures with few updates which were often delayed or in some cases were then ultimately cancelled.

A&E: There has been a very slight increase in response rate from last month however, negative ratings have decreased slightly. Positive themes: staff attitude; implementation of care and environment – kindness and compassion with patients referencing the challenging, busy environment. Areas for improvement: waiting times from the point of triage in particular, lack of information in regards to these remains a consistent theme, limited privacy and dignity was highlighted with a number of comments referencing overhearing details of other's symptoms, diagnosis and treatment. Lack of availability of refreshments including limited supply/choice in vending machines was a repeated theme as was unpleasant/uncaring attitude of reception staff both of which were commented on a number of times.

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. A high proportion of patients relayed their feelings of calm, safety and reflected a supportive environment.

Outpatients: The outpatient response rate has increased this month following a technical issue last month resulting in a failure to send invitation text messages to eligible patients, it's anticipated that following QA measures put in place as a result of this issue and extensive work to associate clinic codes with the hierarchy that this trajectory should continue. Top themes remain consistent since last month with positive themes being caring attitude of staff, implementation of care and environment, numerous comments about the quality of explanation in relation to radiology procedures and positive feedback about the environment provided at the CDC. Areas for improvement: staff attitude – various comments about inconsistency of attitude across staff encountered and lack of joined up care; environment and waiting times with reference both to wait when attending appointment and lack of clarity of information when receiving appointments over the phone in particular.

FFT Response All: Response rates continue to fluctuate despite significant attempts to improve and enhance processes, unforeseen events including a process error with the provider resulting in a failure to send text invites last month and an inability to transcribe the hard copy cards received this month are being highlighted and discussed.

Assurance & Timescales for Improvement:

Friends and Family (FFT) Response Rates: Engagement across the organisation continues to increase with staff in a variety of areas attending drop in sessions to aid familiarisation with the platform and to gain the ability to create 'You Said, We Did' posters to ensure that feedback and resulting actions are available to staff and patients/public. Issues with specific processes at provider level are being taken forwards and challenged with necessary steps being taken to mitigate internally wherever possible however this isn't always feasible in a timely manner or at local level. It's possible that repeated issues will reduce engagement in FFT across the organisation.

Strategic Theme: Systems

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Effective	To support the system financial recovery plan through the better use of beds programme - Daily Average In-Hospital Non-Elective Overnight Beddays (excluding Virtual Ward)		600	604	May-25	600	589	Apr-25	Driver			Verbal CMS			
Breakthrough Objective	Effective	Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays		45	42	May-25	45	42	Apr-25	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Effective	Delivery of the better use of beds programme for MTW - Average Non-Elective LOS for Fracture Neck of Femur (NOF)		13.0	14.4	May-25	13.0	13.2	Apr-25	Driver			Not Escalated			

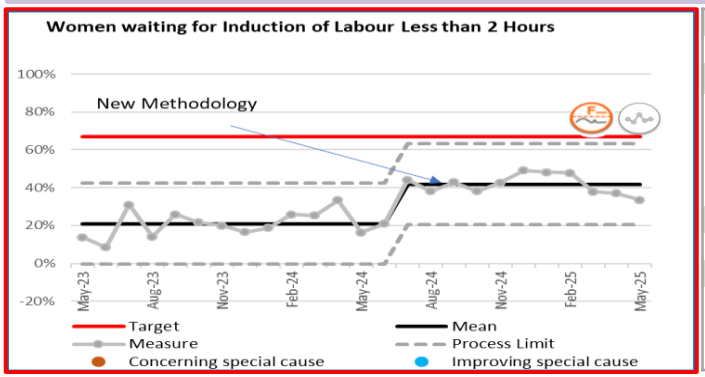
Strategic Theme: Sustainability

				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)		-3,736	-3,544	May-25	-5,625	-6,272	Apr-25	Driver			Verbal CMS			
Breakthrough Objectives	Well Led	Reduce non-pay spend		22,512	21,866	May-25	23,133	22,402	Apr-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		890	635	May-25	892	565	Apr-25	Driver			Not Escalated	675		
	Well Led	CIP		1,760	1,860	May-25	1,355	832	Apr-25	Driver			Not Escalated			
	Well Led	Cash Balance (£k)		7,864	10,676	May-25	8,635	14,782	Apr-25	Driver			Not Escalated	6,469		
	Well Led	Capital Expenditure (£k)		469	2,751	May-25	2,477	1,834	Apr-25	Driver			Not Escalated	390		

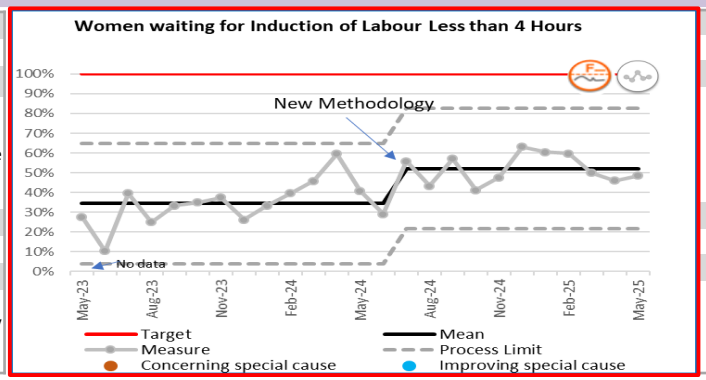
Maternity Metrics

				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	438	May-25	470	463	Apr-25	Driver		No target	Not Escalated	427		
	Maternity Metric	Antenatal bookings		No target	499	May-25	545	544	Apr-25	Driver		No target	Not Escalated	565		
	Maternity Metric	Elective Caesarean Rate		No target	21.9%	May-25	No target	19.2%	Apr-25	Driver		No target	Not Escalated	22.2%		
	Maternity Metric	Emergency Caesarean Rate		No target	21.9%	May-25	No target	22.2%	Apr-25	Driver		No target	Not Escalated	22.6%		
	Maternity Metric	Induction of Labour Rate		36.0%	26.1%	May-25	36.0%	26.0%	Apr-25	Driver			Not Escalated	24.9%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	33.7%	May-25	67.0%	37.0%	Apr-25	Driver			Escalation	51.6%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	48.5%	May-25	100.0%	46.0%	Apr-25	Driver			Escalation	51.0%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	7.5%	May-25	6.0%	8.0%	Apr-25	Driver			Not Escalated	6.9%		
	Maternity Metric	Unexpected term admissions to NNU (Data runs one month behind		4.0%	5.9%	Apr-25	4.0%	5.3%	Mar-25	Driver			Not Escalated	6.2%		
	Maternity Metric	Stillbirth rate		0.4%	0.7%	May-25	0.4%	0.7%	Apr-25	Driver			Not Escalated	0.5%		
	Maternity Metric	PPH >=1500% Rate		3.0%	1.9%	May-25	3.0%	3.3%	Apr-25	Driver			Not Escalated	3.0%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	2.9%	May-25	2.5%	3.4%	Apr-25	Driver			Not Escalated	3.1%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	76.8%	May-25	75.0%	79.2%	Apr-25	Driver			Not Escalated	78.8%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	100.0%	May-25	95.0%	100.0%	Apr-25	Driver			Not Escalated	102.6%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	92.0%	May-25	95.0%	93.6%	Apr-25	Driver			Not Escalated	95.1%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	May-25	100.0%	100.0%	Apr-25	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	May-25	100.0%	100.0%	Apr-25	Driver			Not Escalated	100.0%		

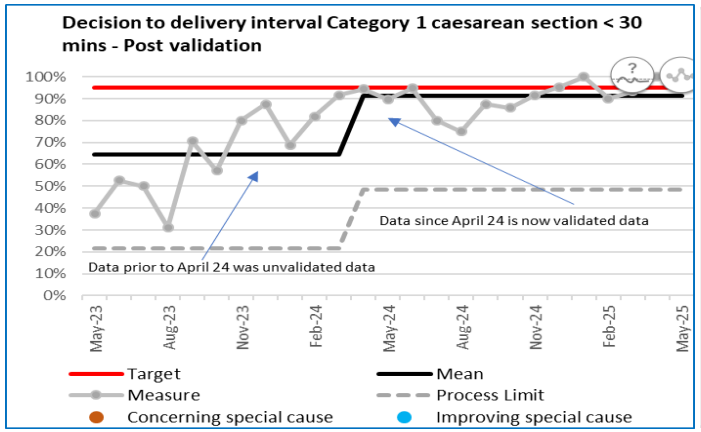
Maternity Metrics



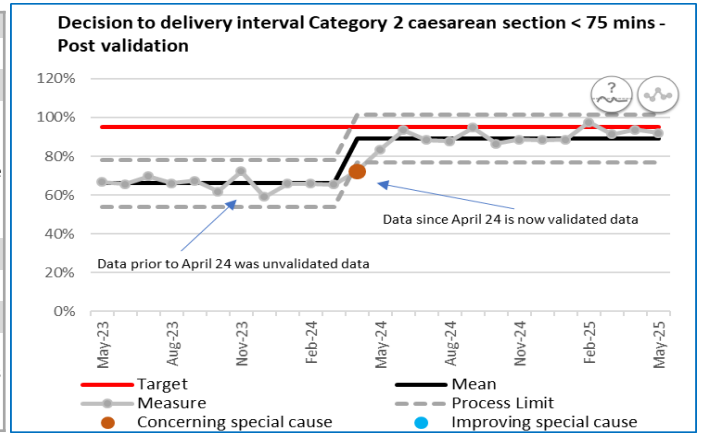
May-25
33.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as consistently failing the target



May-25
48.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



May-25
100%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Shown for info as the post-validation data now shows as variable achievement of target so **Not Escalated**



May-25
92.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
95%
Business Rule
Shown for info as the post-validation data now shows as variable achievement of target so **Not Escalated**

Summary:

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

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

Decision to delivery interval Category 1 and Category 2 caesarean sections (Post Validation): are experiencing common cause variation variable achievement of the target and are therefore no longer escalated but shown for information.

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.

Agreed escalation to Ward 33 to support with blockages.

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:

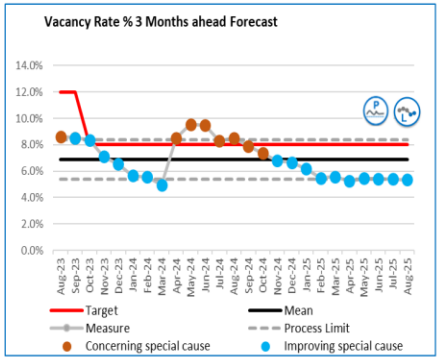
Data validation demonstrates frequent mis-classification and a level of delay due to clinically justifiable reasons. We are therefore now showing the data post-validation from April 24 onwards for ongoing oversight but will continue to work with staff to improve data entry.

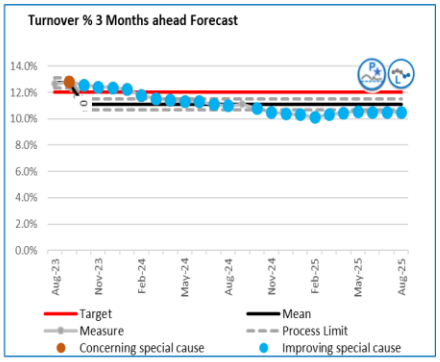
NHS
Maidstone and Tunbridge Wells NHS Trust

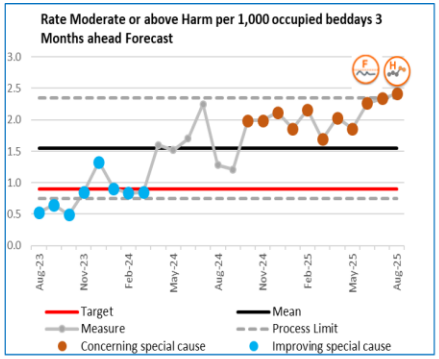
Appendices

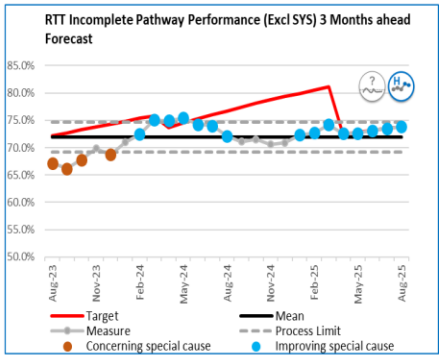
MTW
exceptional people, outstanding care

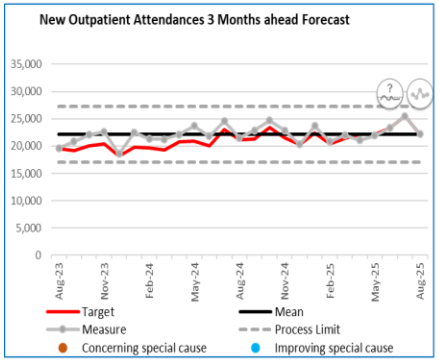
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

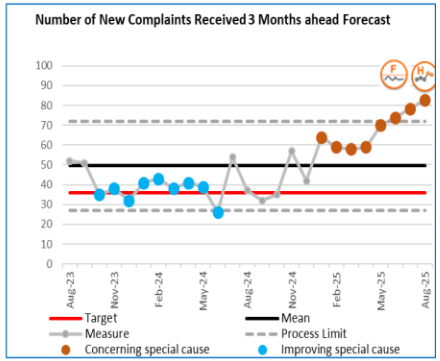


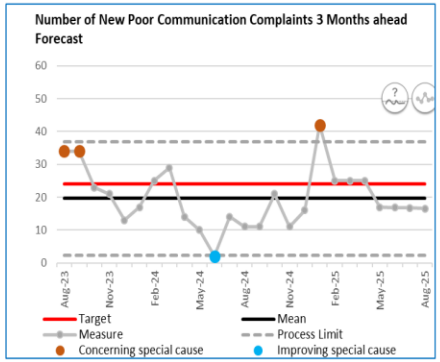


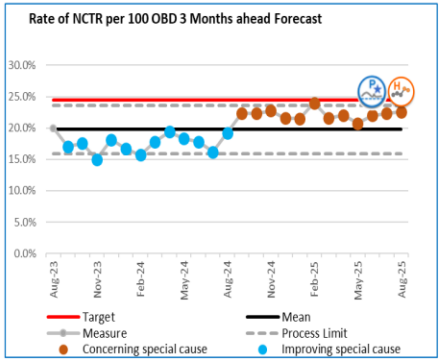


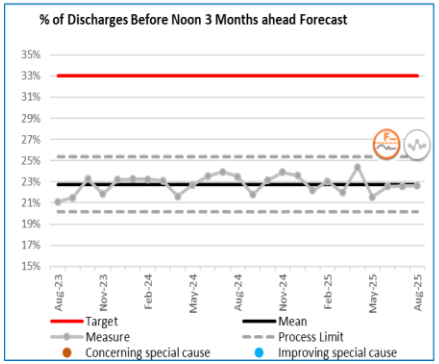


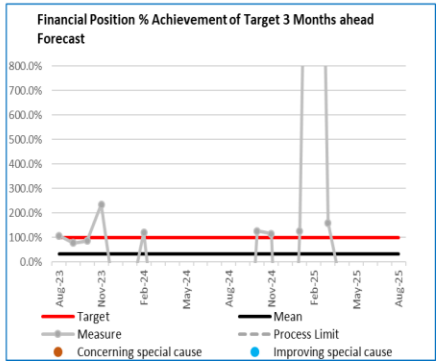


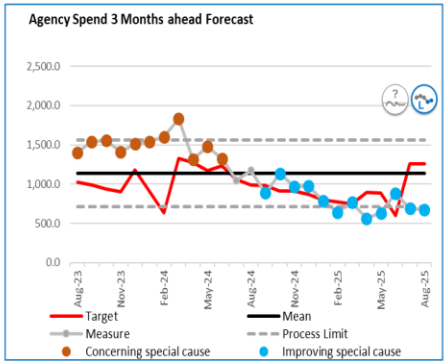


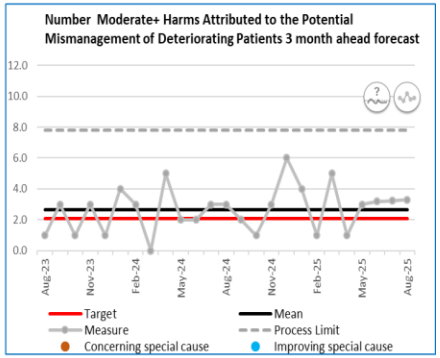




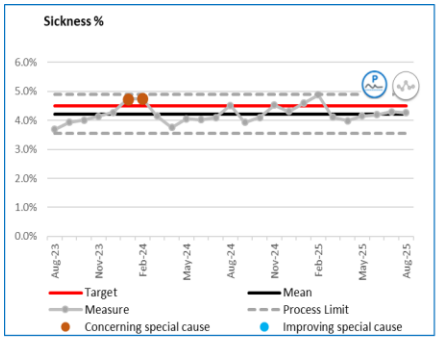


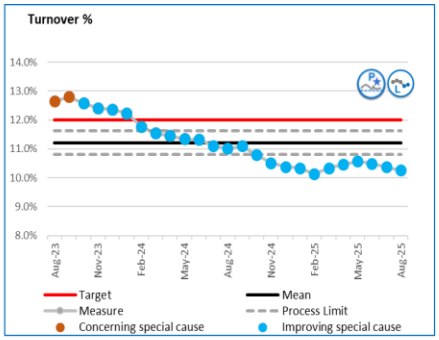


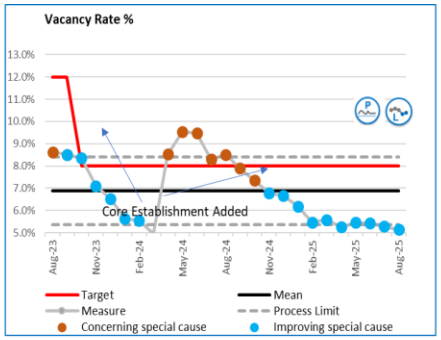


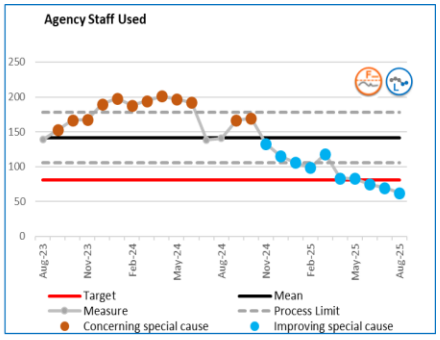


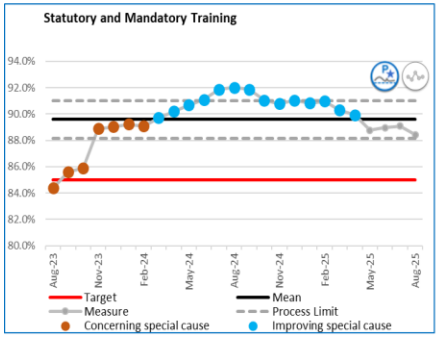
Forecast SPCs (3 month forward view) for People Indicators

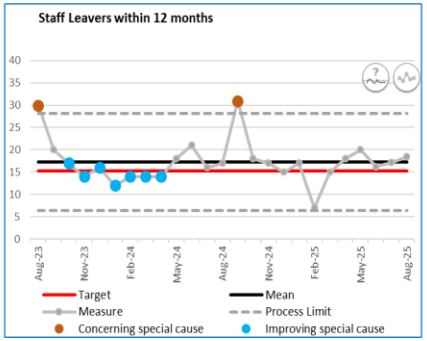


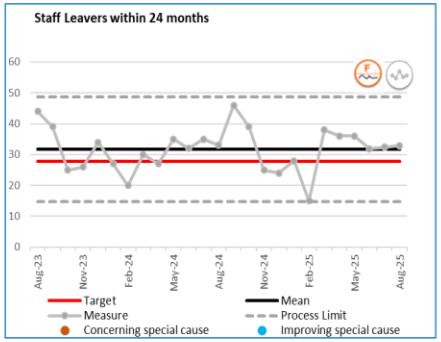


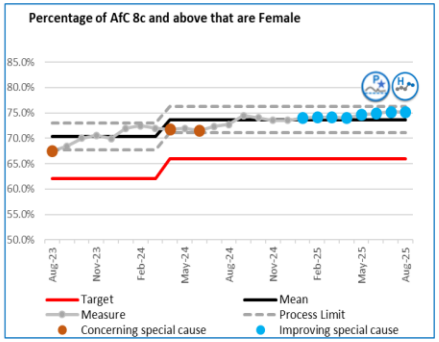


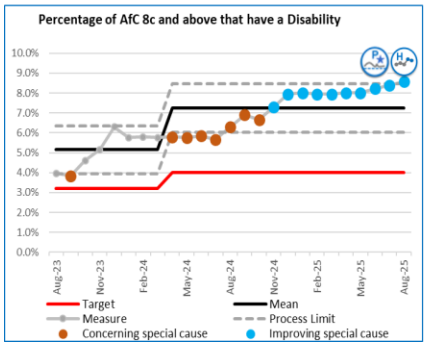


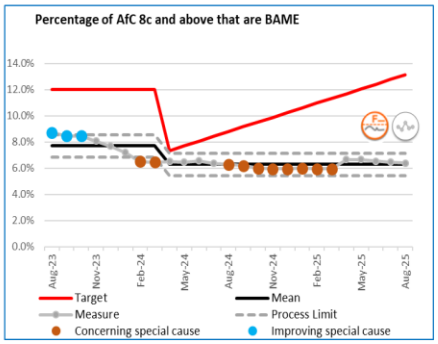


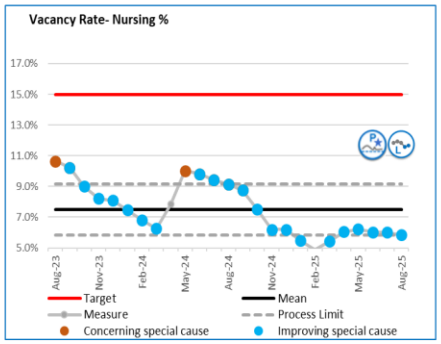




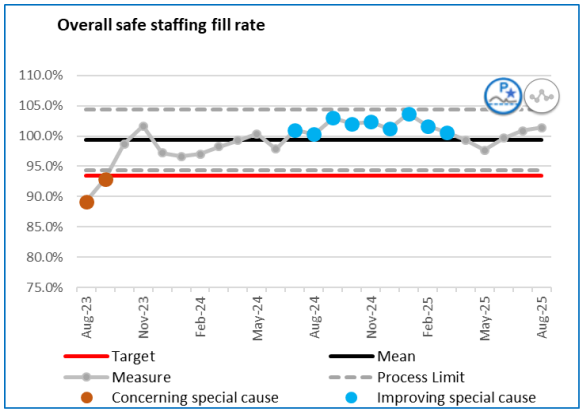


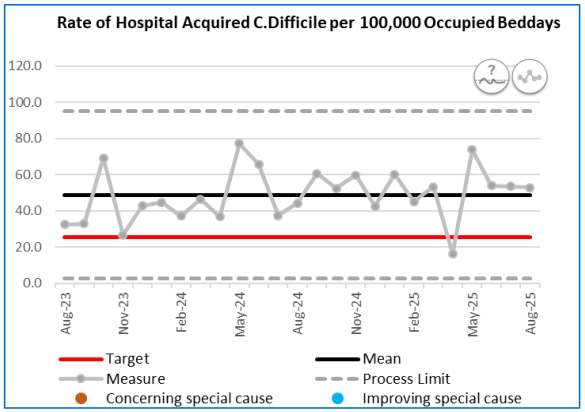


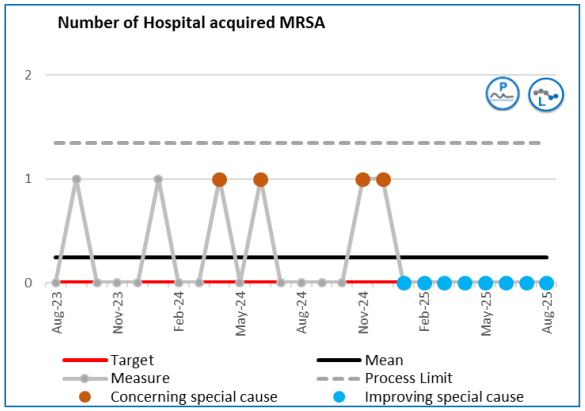


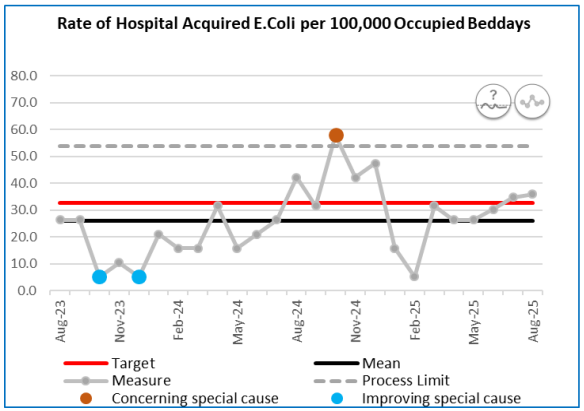


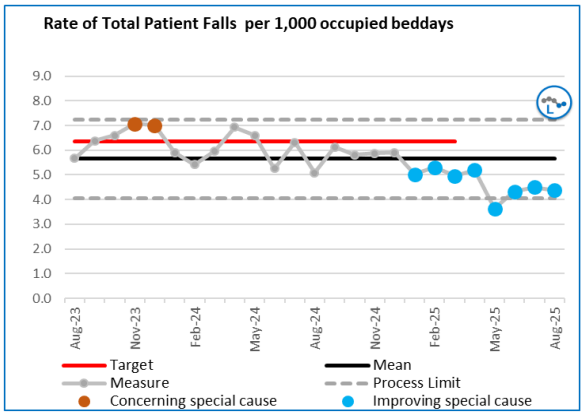
Forecast SPCs (3 month forward view) for Patient Safety Indicators

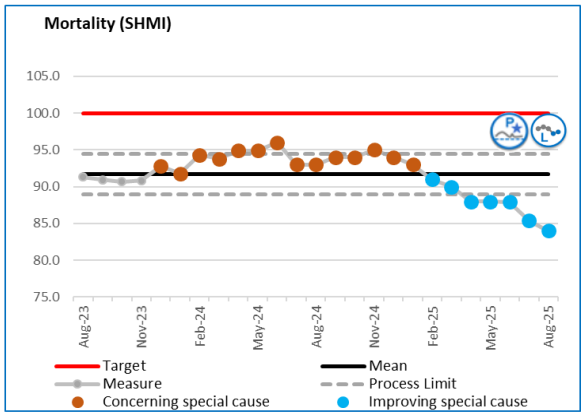


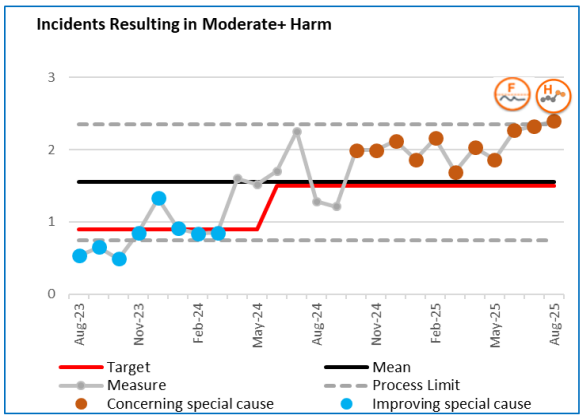


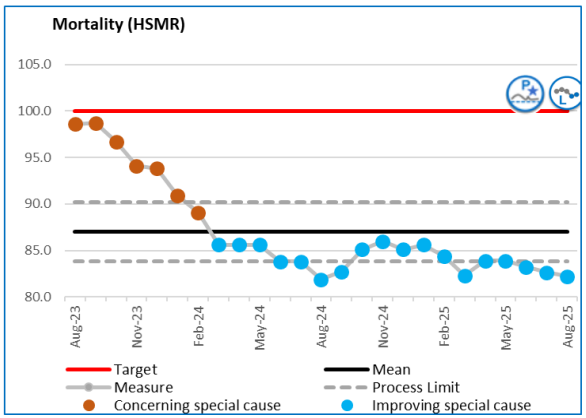




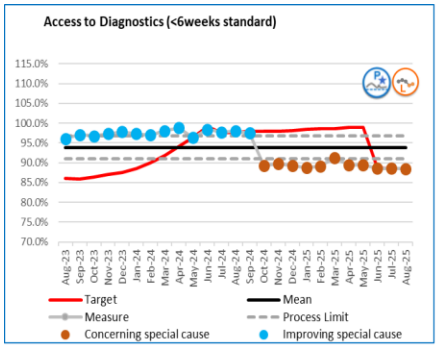


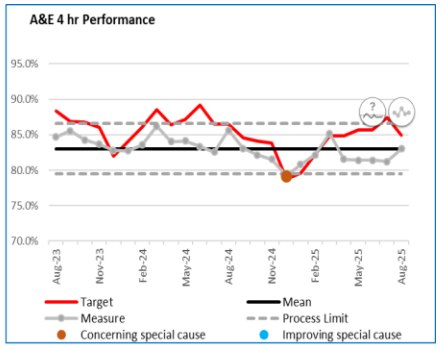


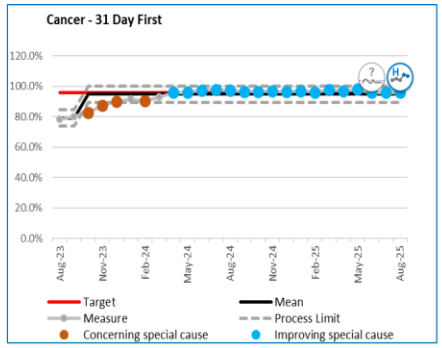


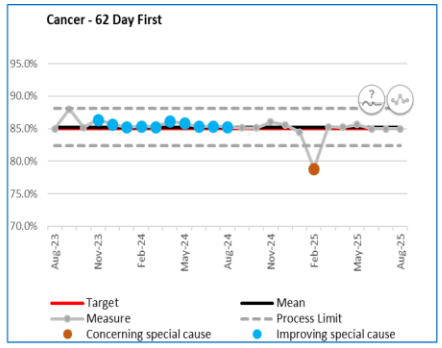


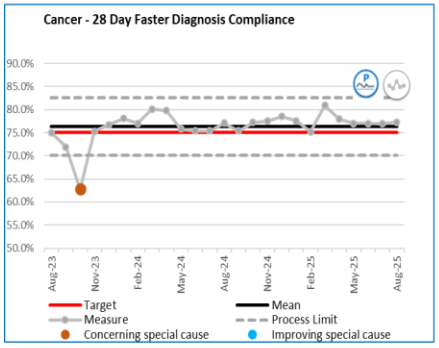
Forecast SPCs (3 month forward view) for Patient Access Indicators

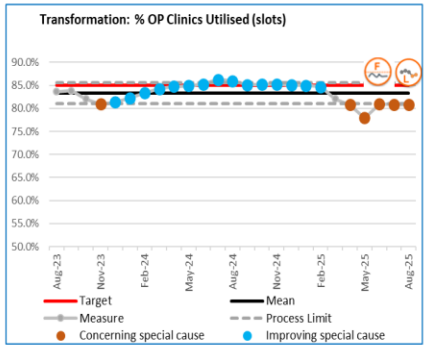


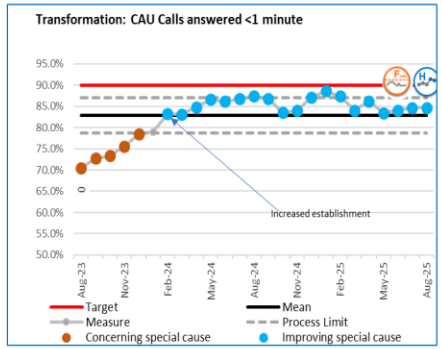


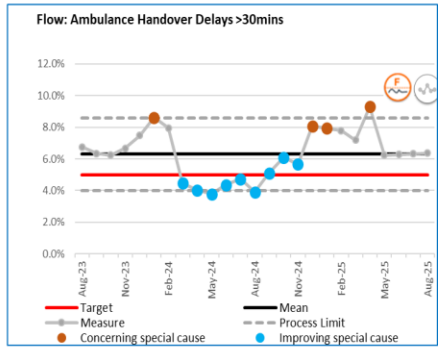


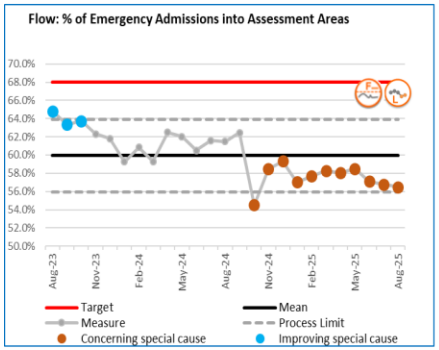


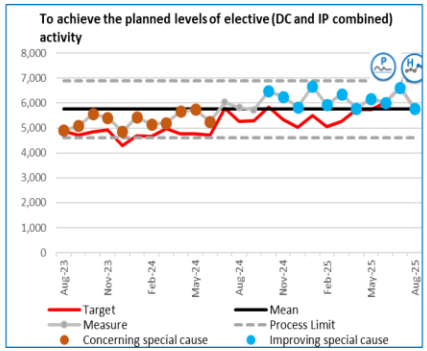


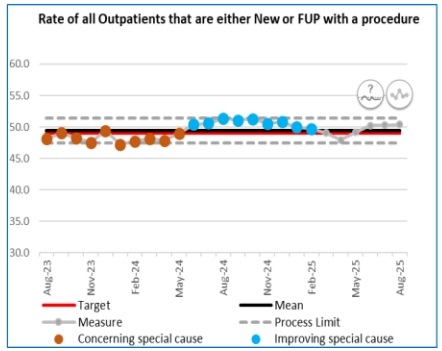


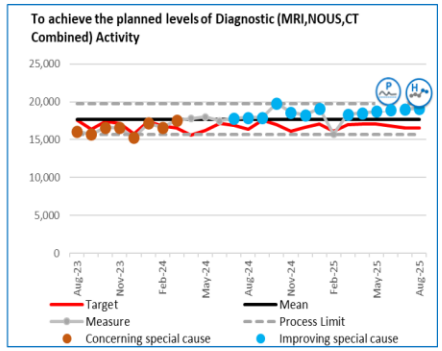




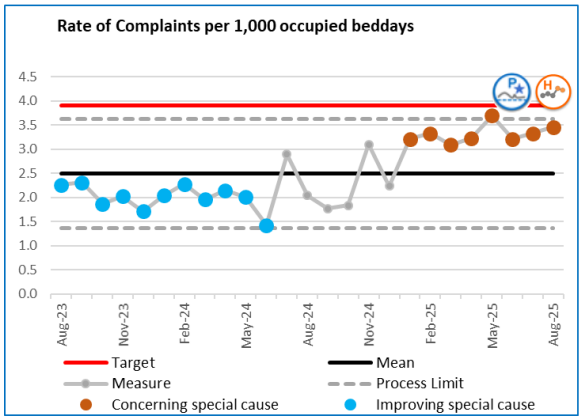


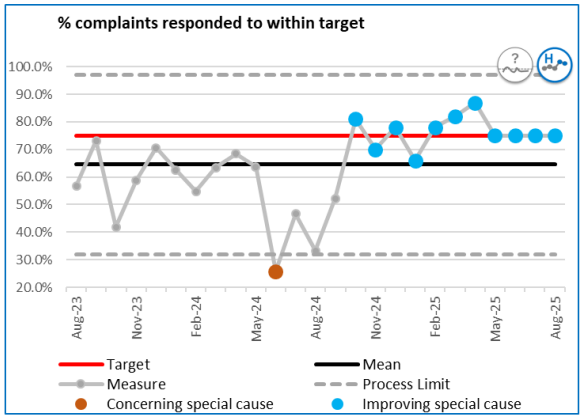


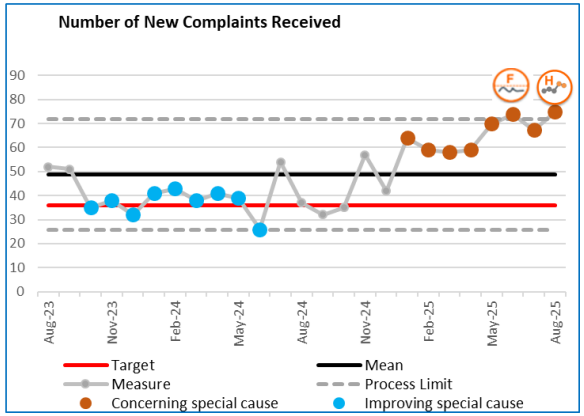


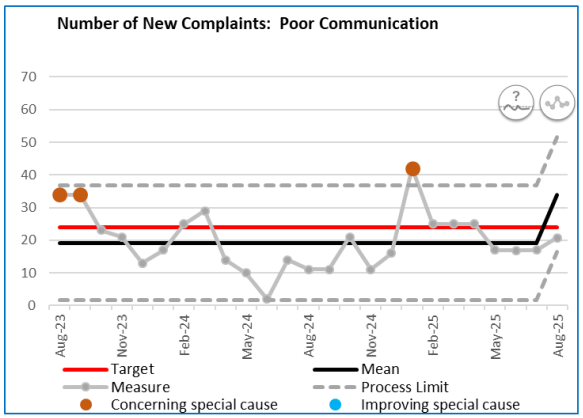


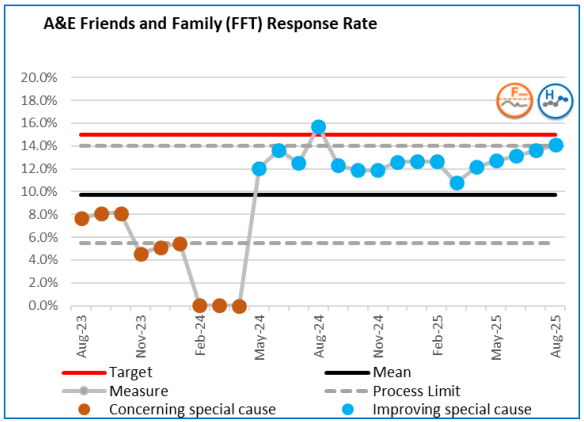
Forecast SPCs (3 month forward view) for Patient Experience Indicators

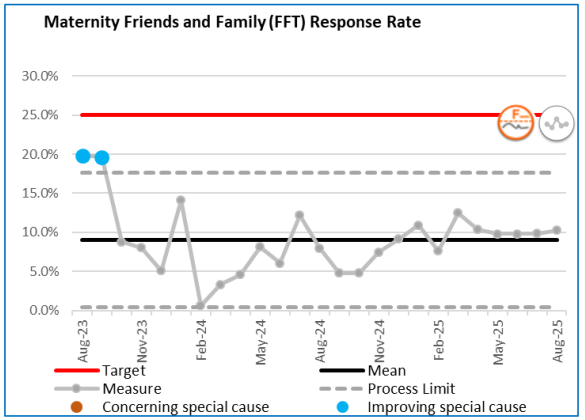


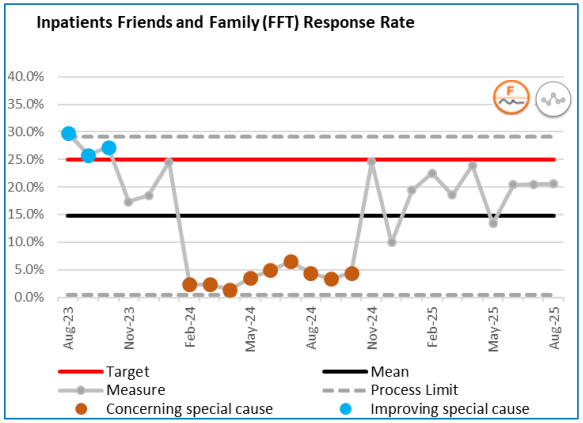


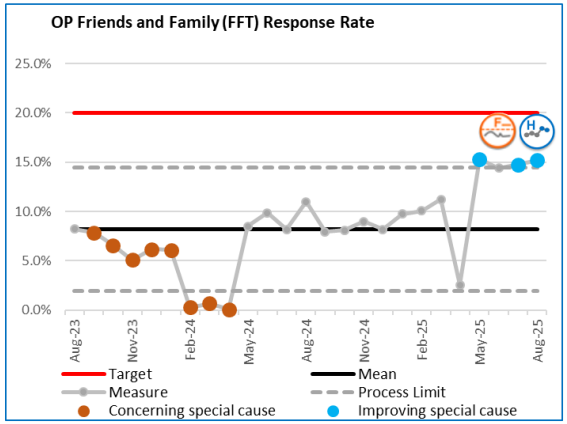


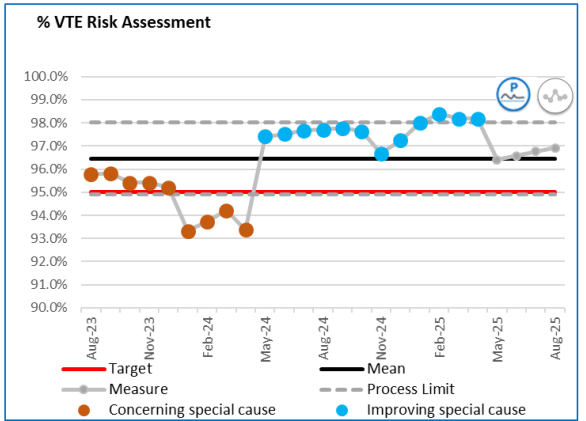




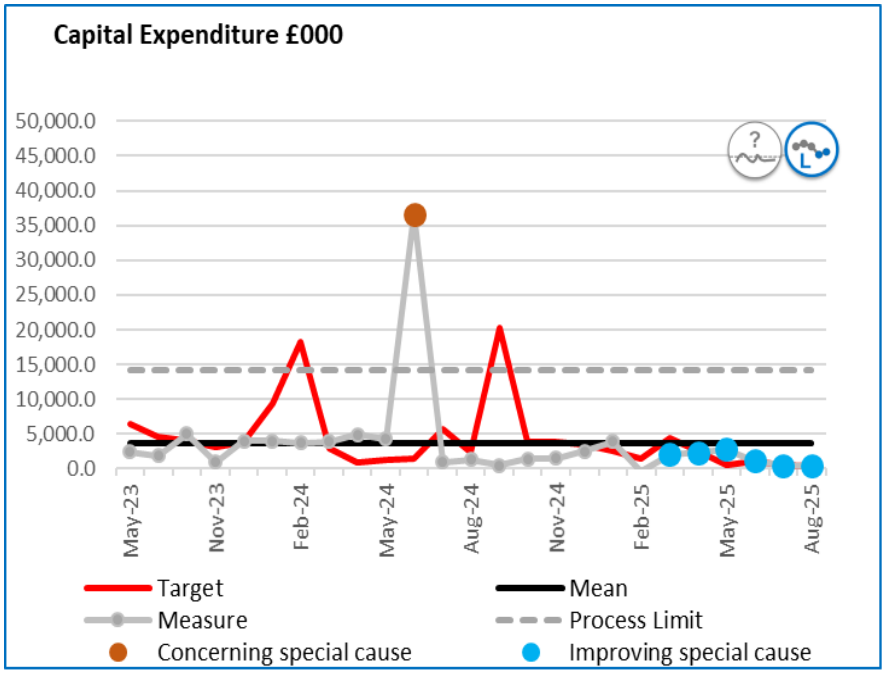


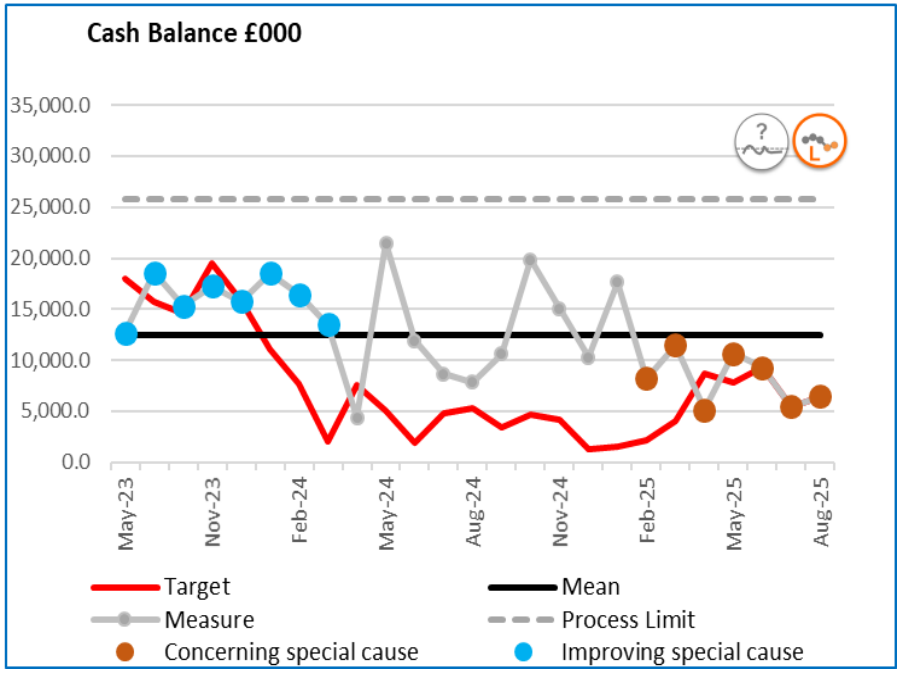






Forecast SPCs (3 month forward view) for Sustainability Indicators





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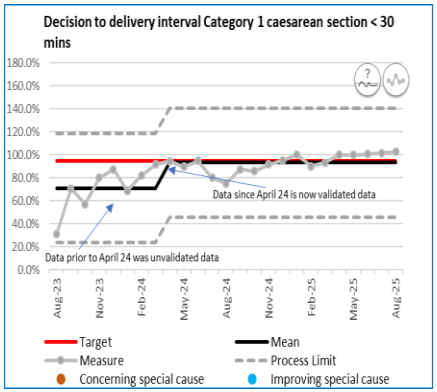
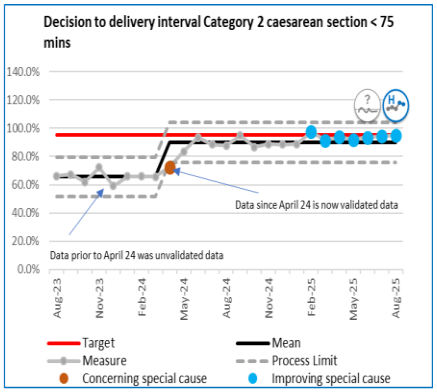
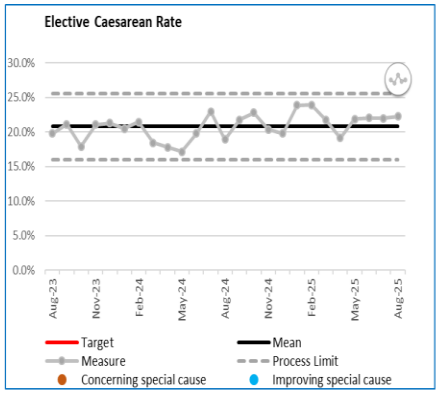
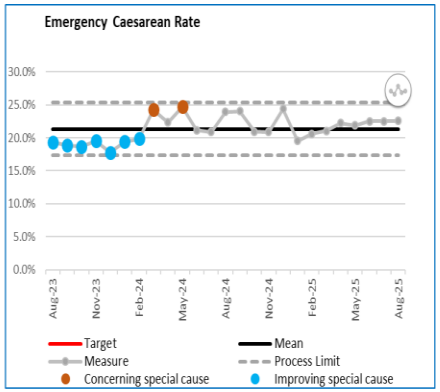
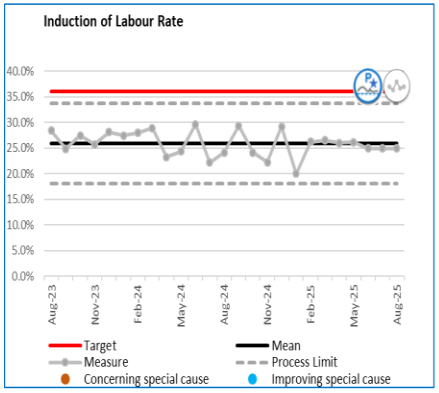
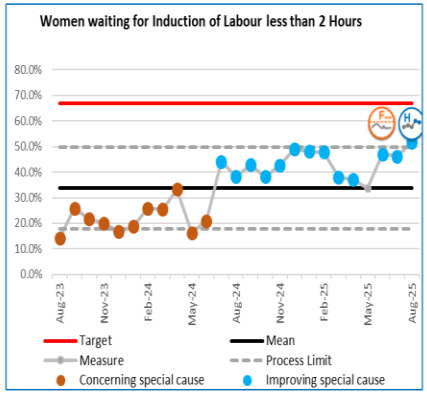


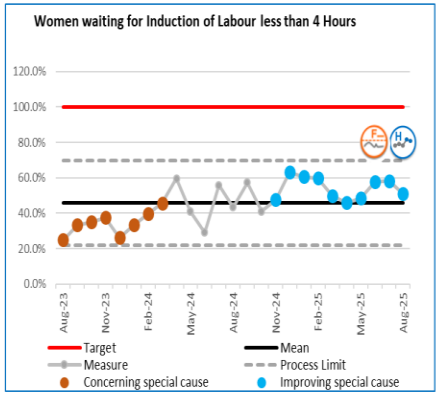


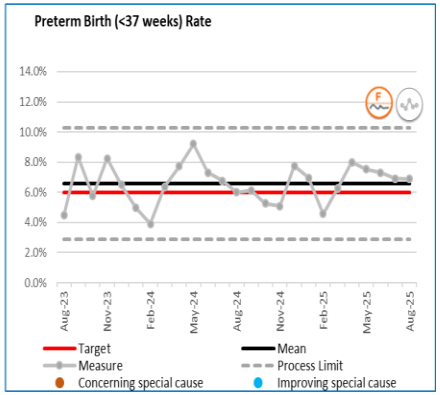


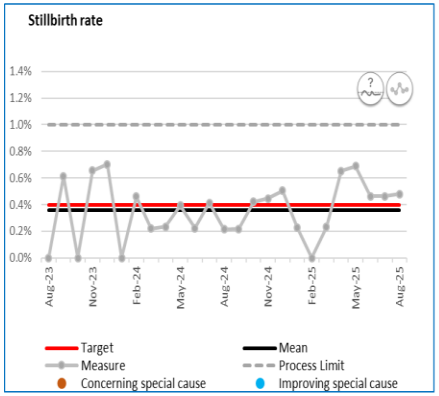


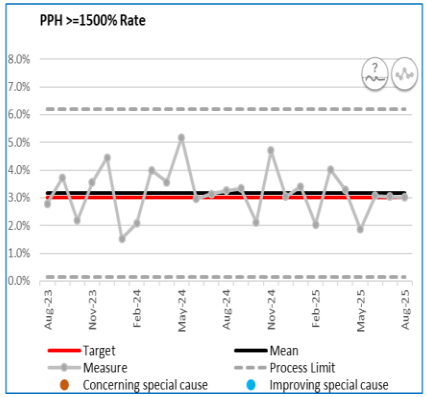


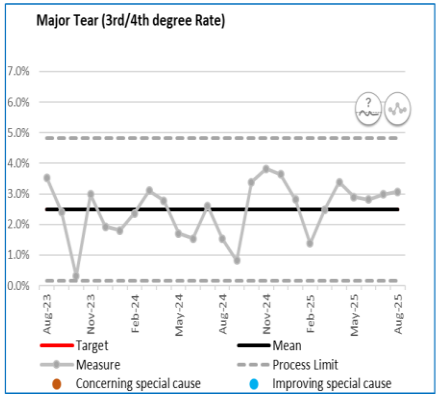


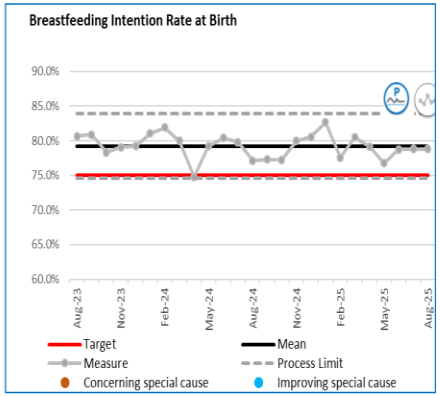






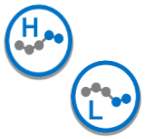






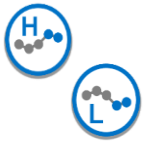
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

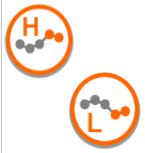
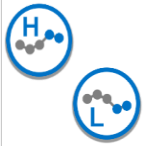
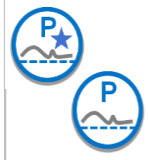
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

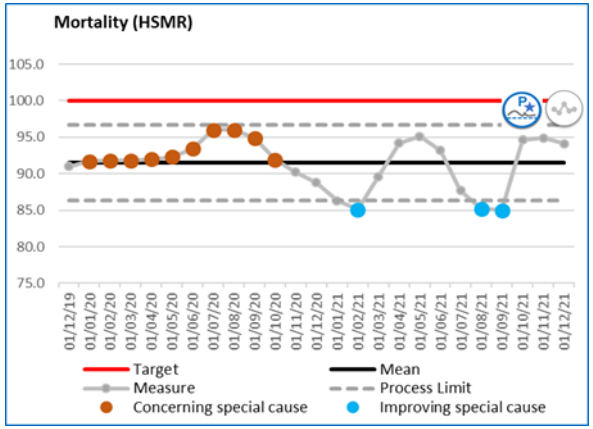
The **target** line **between** the **upper** and **lower** control limit for all metric types

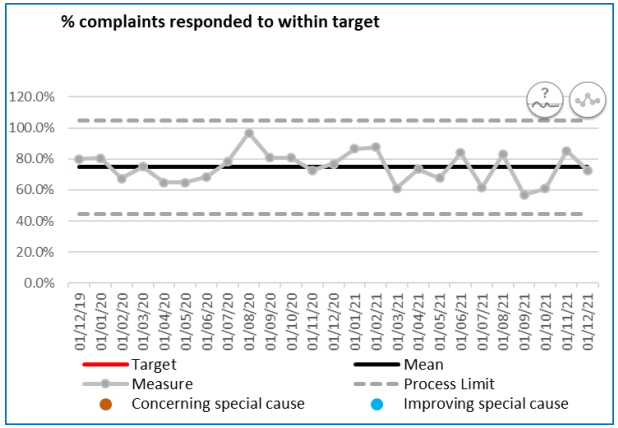
Metrics that consistently **fail** have:

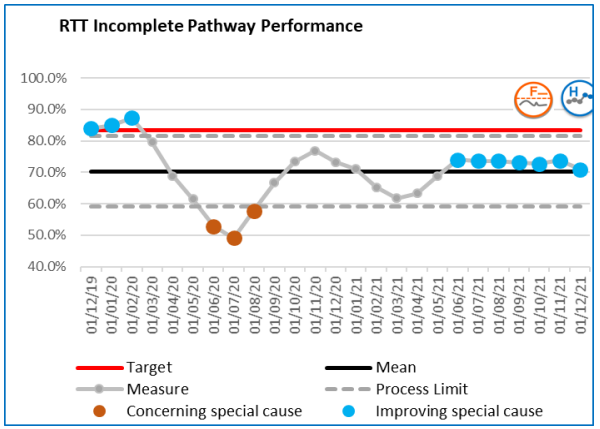
The **lower** control limit **above** the target line for metrics that need to be **below the target**

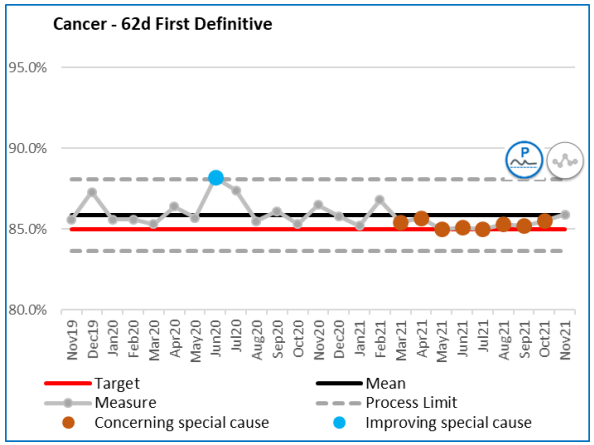
The **upper** control limit **below** the target line for metrics that need to be **above the target**

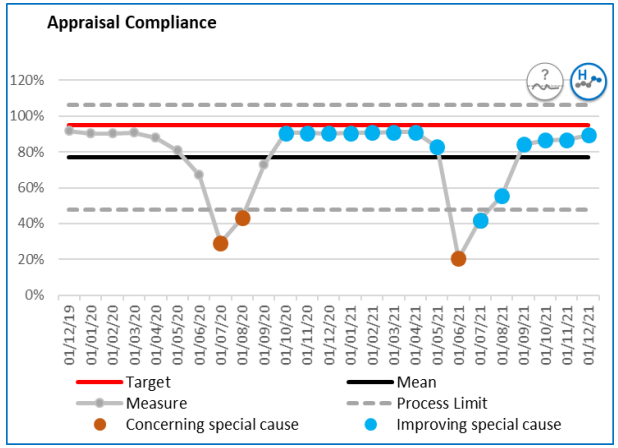
A metric not achieving the target for 6 months or more will be flagged as failing

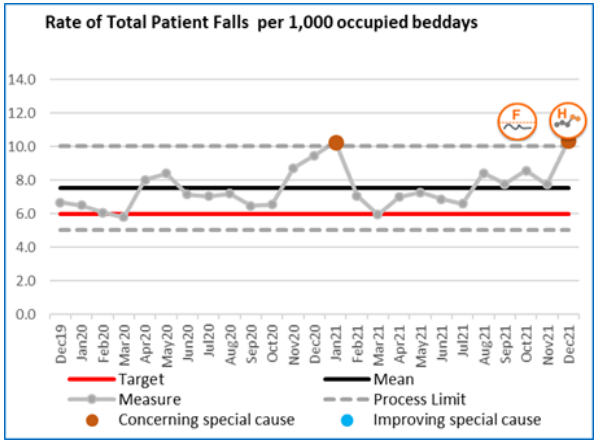












Maternity Metrics Definitions

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

Executive Summary

- The Trust was £3.5m in deficit in the month which was £0.2m favourable to plan. Year to date the Trust is £9.8m in deficit which is £0.5m adverse to plan.
- The key year to date pressures are: Pay overspend (£0.6m), CIP slippage (£0.4m), Theatre consumables overspend (£0.4m), Fordcombe hospital slippage to plan (£0.3m) and CIP project support costs (£0.2m). These pressures were offset by non pay underspends of £1.8m.
- 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 £22.3m 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 £3.5m in deficit which is £0.2m favourable to the plan.
- **Key Adverse variances in month are:**
    - Pay overspend excluding Fordcombe and CIP (£0.6m). In May the Trusts total worked WTE was 198 more than plan. The Trust was below plan on temporary staffing (133WTEwte) but was above plan on substantive staff by 331 WTE.
    - One off spend associated with theatre consumables consignment stock (£0.4m)
    - CIP project support costs (£0.2m)
    - Fordcombe hospital slippage to plan (£0.1m)
- **Key Favourable variances in month are:**
    - The Trust underspent on non pay mainly due to activity being below plan generating an underspend of c£0.8m. 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.
    - Drug underspend to budget (£0.5m)
    - CIP overperformance in month (£0.1m)

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.
- Year to date the Trust has saved £2.7m which is £0.4m adverse to plan
- The Trust has identified £31.5m of savings schemes towards the internal plan of £49m. This includes £9.9m of pay transformational schemes which are in the process of being validated.

Risk

- **Pathology Managed Service VAT reclaim** review (£5.4m) - 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.

- **Brockenhurst Car parking VAT claim (net £0.7m)** - The Trust has included back dated VAT claim of £1.4m (net £0.7m after input tax adjustment and fees). An appeal was heard at the Supreme Court on 7th/8th April however no judgement has been released.
- **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 £31.5m out of the £49m internal savings target. Work is ongoing to develop a fully identified plan, 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 46% (£10.8m) is risk assessed as either High or Medium High risk. Plans continue to be developed and reviewed at the FIPB.
- **2025/26 Pay award** – The 2025/26 final pay award is estimated to be c£4.8m more than the funding received
- **Redundancy Costs** – The Trust might incur c£15m of redundancy costs associated with the pay transformation plan

Cashflow position:

- The closing cash balance at the end of May was £10.7m, this is higher than the plan value by £2.9m. The variance primarily relates to the Trust receiving income from ICB associated with the pay award that will be paid to employees in August. The Trust needs to hold this funding to ensure this commitment can be paid. The brought forward cash position of £10.7m 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 e.g; salaries are higher than plan and the remaining months are amended to be in line with the current charges.
- The Trust is working closely with local NHS organisations and agreeing "like for like" arrangements when possible to reduce the debtor/creditor balances for both organisations. However, as cash positions with the local NHS organisations are all tight, there will be no cash gain from these agreements but it enables a reduction to both debtors/creditors balances.
- The 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 May the Trust's percentages were: Trade value 89.4% (m1 - 93%) and quantity 96.2% (m1 – 96%); NHS value 95.4% (m1 - 98.2%) quantity 92.4% (m1 99.3%).

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)
- Estates Safety schemes for £3.460m as part of the Critical Infrastructure Strategy allocation for MTW in M2. This award was made after the final plans had been set, so is additional to plan.

- The Trust has also been awarded £2m relating to the Urgent and Emergency Care (UEC) Performance Award in recognition in achieving A&E targets in 24/25. This will be shown in M3, and is again additional to plan.

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- **Month 2 Actuals (excluding IFRS16)**
  - The YTD spend at M2 is £2.6m against a YTD budget of £2.4m. Of this the majority at M2 is for IFRS 16 with spending of £2.146m against a YTD budget of £2.146m. The spend relates to the start of the TWH Surgical Robot lease from 1.4.25 and the MLS lease renewal in M2, together with various remeasurements

- **Forecast**
- At M2 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.
- Donated - some orders have been raised, others are in the planning/approval stage.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 2
2025/26

Maidstone and Tunbridge Wells NHS

Summary

May 2025/26

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	66.8	66.8	0.1	0.0	0.0	132.3	132.5	(0.3)	(0.1)	(0.2)
Expenditure	(65.4)	(65.5)	0.1	(0.0)	0.2	(132.0)	(131.9)	(0.1)	0.1	(0.2)
EBITDA (Income less Expenditure)	1.5	1.3	0.2	0.0	0.2	0.2	0.6	(0.4)	0.0	(0.4)
Financing Costs	(4.4)	(4.4)	0.0	0.0	0.0	(18.3)	(18.3)	(0.0)	0.0	(0.0)
Technical Adjustments	(0.6)	(0.6)	(0.0)	0.0	(0.0)	8.2	8.2	(0.0)	0.0	(0.0)
Net Surplus / Deficit	**(3.5)**	**(3.7)**	**0.2**	**0.0**	**0.2**	**(9.8)**	**(9.4)**	**(0.5)**	**0.0**	**(0.5)**
Cash Balance	10.7	5.0	5.7		5.7	10.7	5.0	5.7		5.7
Capital Expenditure (Incl Donated Assets and IFRS16)	2.8	0.5	(2.3)		(2.3)	4.6	2.9	1.6		1.6
Cost Improvement Plan	1.9	1.8	0.1		0.1	2.7	3.1	(0.4)		(0.4)

Summary Current Month:
- The Trust was £3.5m in deficit which is £0.2m favourable to the plan. The Trusts key variances to the plan are:

Adverse Variances:
- Pay overspend excluding Fordcombe and CIP (£0.6m). In May the Trusts total worked WTE was 198 more than plan. The Trust was below plan on temporary staffing (133 wte) but was above plan on substantive staff by 331wte.
- One off spend associated with theatre consumables consignment stock (£0.4m)
- CIP project support costs (£0.2m)
- Fordcombe hospital slippage to plan (£0.1m)

Favourable Variances
- The Trust underspent on non pay mainly due to activity being below plan generating an underspend of c£0.8m. 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.
- Drug underspend to budget (£0.5m)
- CIP overperformance in month (£0.1m)

Year to date overview:
- The Trust is £9.8m in deficit which is £0.5m adverse to the plan, the Trusts key variances to the plan are:

Adverse Variances:
- Pay overspend excluding Fordcombe and CIP (£1m). Year to date the Trusts total worked WTE was 432 more than plan. The Trust was below plan on temporary staffing (216 wte) but was above plan on substantive staff by 649wte.
- One off spend associated with theatre consumables consignment stock (£0.4m)
- CIP Slippage (£0.4m)
- Fordcombe hospital slippage to plan (£0.3m)
- CIP project support costs (£0.2m)

Favourable Variances
- The Trust underspent on non pay mainly due to activity being below plan generating an underspend of c£1.3m. 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.
- Drug underspend to budget (£0.4m)

CIP (Savings)
- 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 May the Trust has saved £1.9m which was £0.1m favourable to plan, year to date the Trust is £0.4m adverse to plan.

May-25			DAY												NIGHT												TEMPORARY STAFFING										Nurse Sensitive Indicators					Financial review		
Hospital Site name	Ward name	Health Roster Name	Planned Hours Registered (Day)	Actual Hours Registered (Day)	Average fill rate registered nurses/midwives (%)	Planned Hours UnRegistered (Day)	Actual Hours UnRegistered (Day)	Average fill rate care staff (%)	Planned Hours Nursing Assocate (Day)	Actual Hours Nursing Associate (Day)	Average fill rate Nursing Associates (%)	Planned Hours Training Nursing Assoicate (Day)	Actual Hours Training Nursing Assoicate (Day)	Average fill rate Training Nursing Associates (%)	Planned Hours Registered (Day)	Actual Hours Registered (Day)	Average fill rate registered nurses/midwives (%)	Planned Hours UnRegistered (Night)	Actual Hours UnRegistered (Night)	Average fill rate care staff (%)	Planned Hours Nursing Assocate (Night)	Actual Hours Nursing Assocate (Night)	Average fill rate Nursing Associates (%)	Planned Hours Training Nursing Assoicate (Night)	Actual Hours Training Nursing Associate (Night)	Average fill rate Training Nursing Associates (%)	Bank Hours	Agency Hours	Bank/ Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Occupied Beds	Planned CHPPD	Actual Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
Maidstone	Acute Assessment Unit (M)	Acute Medical Unit (M) - NG551	1,856.00	1,791.00	96.5%	1,166.00	1,521.50	130.5%	0.00	0.00	-	0.00	0.00	No Hours	1,353.00	1,342.00	99.2%	682.00	1,044.50	153.2%	0.00	0.00	-	0.00	0.00	No Hours	1,199.00	814.50	39.8%	40.5%	82	5.72	9	520	10	11.0	-	-						
Maidstone	Stroke Unit	Stroke Unit (M) - NK551	1,850.00	2,090.00	113.0%	1,887.00	1,735.50	92.0%	0.00	0.00	-	387.00	387.00	100.0%	2,046.00	2,266.00	110.8%	1,705.00	1,716.00	100.6%	0.00	0.00	-	0.00	0.00	No Hours	2,219.50	66.50	29.0%	2.9%	108	7.58	5	975	8	8.4	16.7%	66.7%						
Maidstone	Hyperacute Stroke Unit	HASU (34) - NK552	2,066.00	2,073.50	100.4%	372.00	388.50	104.4%	0.00	0.00	-	0.00	0.00	No Hours	2,046.00	2,090.00	102.2%	341.00	352.00	103.2%	0.00	0.00	-	0.00	0.00	No Hours	1,633.50	34.00	34.6%	2.0%	139	9.60	10	418	12	11.7	30.4%	85.7%						
LOOKUP TABLE SORT ERROR	LOOKUP TABLE SORT ERROR	Chaucer Ward (2022) - NS451	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	-	-						
Maidstone	Cornwallis	Cornwallis - NS251	1,120.00	1,078.67	96.3%	1,115.00	1,104.00	99.0%	0.00	0.00	-	0.00	0.00	No Hours	1,023.00	1,023.00	100.0%	682.00	693.00	101.6%	0.00	0.00	-	0.00	0.00	No Hours	431.50	0.00	11.0%	0.0%	26	1.76	3	535	7	7.3	21.2%	100.0%						
Maidstone	Culpepper and CCU	Culpepper Ward (M) - NS551	744.00	773.50	104.0%	1,116.00	1,009.50	90.5%	0.00	0.00	-	0.00	0.00	No Hours	682.00	682.00	100.0%	341.00	374.00	109.7%	0.00	0.00	-	0.00	0.00	No Hours	464.50	21.50	16.9%	4.4%	3	0.21	0	383	8	7.4	14.3%	100.0%						
Maidstone	Culpepper and CCU	CCU (M) - NS551	744.00	733.50	98.6%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	682.00	671.00	98.4%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	110.00	0.00	7.7%	0.0%	11	0.75	1	175	8	8.0	61.5%	87.5%						
Maidstone	Edith Cavell	Edith Cavell - NS459	1,114.50	1,415.00	127.0%	864.00	648.50	75.1%	0.00	0.00	-	253.50	253.50	100.0%	1,023.00	1,034.00	101.1%	682.00	816.25	119.7%	0.00	0.00	-	0.00	0.00	No Hours	1,177.25	162.00	34.0%	12.1%	39	2.70	5	636	6	6.6	25.0%	77.8%						
LOOKUP TABLE SORT ERROR	Foster Clarke	Foster Clark - NR359	1,488.00	1,433.00	96.3%	1,488.00	2,001.92	134.5%	0.00	0.00	-	0.00	0.00	No Hours	1,364.00	1,376.50	100.9%	1,023.00	1,581.18	154.6%	0.00	0.00	-	0.00	0.00	No Hours	1,560.50	1,038.10	48.5%	39.9%	76	5.28	3	846	6	7.6	9.3%	100.0%						
Maidstone	John Day	John Day Respiratory Ward (M) - NT151	2,245.00	2,195.00	97.8%	1,497.00	1,513.50	101.1%	0.00	0.00	-	0.00	0.00	No Hours	1,705.00	1,727.00	101.3%	1,364.00	1,122.00	82.3%	0.00	0.00	-	0.00	0.00	No Hours	1,015.50	128.00	16.8%	11.2%	56	3.66	6	880	8	7.5	11.9%	100.0%						
Maidstone	Intensive Care (M)	Intensive Care (M) - NA251	3,512.75	3,098.50	88.2%	713.00	529.00	74.2%	0.00	0.00	-	0.00	0.00	No Hours	2,909.50	2,771.70	95.3%	713.00	506.00	71.0%	0.00	0.00	-	0.00	0.00	No Hours	1,110.50	0.00	14.1%	0.0%	82	5.68	3	194	40	35.6	250.0%	40.0%						
Maidstone	Lord North	Lord North Ward (M) - NF651	1,570.50	1,567.25	99.8%	825.00	660.00	80.0%	0.00	0.00	-	0.00	0.00	No Hours	1,104.00	1,092.00	98.9%	372.00	432.00	116.1%	0.00	0.00	-	0.00	0.00	No Hours	186.00	84.00	7.0%	31.1%	11	0.75	2	506	8	7.4	31.8%	78.6%						
Maidstone	Mercer	Mercer Ward (M) - NJ251	1,488.00	1,518.42	102.0%	1,416.00	1,693.00	119.6%	0.00	0.00	-	72.00	72.00	100.0%	1,023.00	1,034.00	101.1%	660.00	1,120.50	169.8%	0.00	0.00	-	22.00	22.00	100.0%	1,120.50	695.50	38.8%	38.3%	42	2.86	1	784	6	7.0	16.7%	100.0%						
Maidstone	Peale	Peale Ward COVID - ND451	1,116.50	1,109.67	99.4%	732.00	768.00	104.9%	0.00	0.00	-	0.00	0.00	No Hours	1,023.00	1,001.00	97.8%	341.00	385.00	112.9%	0.00	0.00	-	0.00	0.00	No Hours	628.00	96.17	22.5%	13.3%	55	3.77	9	402	8	8.1	13.0%	66.7%						
Maidstone	Pye Oliver	Pye Oliver (Medical) - NK259	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	821	0	0.0	-	-						
Maidstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - NE751	984.50	977.00	99.2%	540.00	494.00	91.5%	0.00	0.00	-	0.00	0.00	No Hours	440.00	365.00	83.0%	132.00	114.50	86.7%	0.00	0.00	-	0.00	0.00	No Hours	42.50	0.00	2.0%	0.0%	6	0.26	0	45	47	43.3	0.0%	99.0%						
Maidstone	Whatman	Whatman Ward - NK959	2,160.00	2,044.00	94.6%	1,653.00	1,651.67	99.9%	0.00	0.00	-	0.00	0.00	No Hours	1,023.00	1,023.00	100.0%	682.00	1,166.00	171.0%	0.00	0.00	-	0.00	0.00	No Hours	1,470.50	58.00	27.7%	3.8%	68	4.64	6	634	9	9.3	17.9%	80.0%						
Maidstone	Maidstone Birth Centre	Maidstone Birth Centre - NP751	909.83	839.50	92.3%	371.58	326.50	87.9%	0.00	0.00	-	0.00	0.00	No Hours	691.50	676.00	97.8%	333.25	333.25	100.0%	0.00	0.00	-	0.00	0.00	No Hours	454.25	0.00	19.7%	0.0%	37	1.94	0	51	45	42.7	0.0%	#DIV/0!						
TWH	Acute Medical Unit (TW)	Acute Medical Unit (TW) - NA901	2,512.25	2,336.50	93.0%	1,380.00	1,483.25	107.5%	0.00	0.00	-	46.00	46.00	100.0%	2,130.50	2,120.00	99.5%	1,069.00	1,389.00	129.9%	0.00	0.00	-	0.00	0.00	No Hours	2,438.50	323.75	38.7%	11.7%	128	9.00	20	849	8	8.7	-	-						
TWH	Coronary Care Unit (TW)	Coronary Care Unit (TW) - NP301	1,116.00	1,089.50	97.6%	372.00	328.92	88.4%	0.00	0.00	-	0.00	0.00	No Hours	1,023.00	1,023.00	100.0%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	518.42	0.00	20.6%	0.0%	30	2.14	2	215	12	11.4	-	-						
TWH	Hedgehog Ward	Hedgehog Ward (TW) - ND702	2,484.00	2,084.75	83.9%	713.00	322.50	45.2%	0.00	0.00	-	0.00	0.00	No Hours	2,123.50	1,782.50	83.9%	713.00	114.50	16.1%	0.00	0.00	-	0.00	0.00	No Hours	599.00	66.75	11.0%	10.0%	65	4.55	11	431	14	10.0	-	-						
TWH	Intensive Care (TW)	Intensive Care (TW) - NA201	5,125.50	5,337.50	104.1%	813.75	733.40	90.1%	0.00	0.00	-	0.00	0.00	No Hours	4,841.50	4,864.50	100.5%	954.50	839.50	88.0%	0.00	0.00	-	0.00	0.00	No Hours	110.90	0.00	0.9%	0.0%	9	0.62	0	343	34	34.3	-	-						
TWH	Wells Day Unit	Private Patient Unit (TW) - NR702	744.50	747.00	100.3%	744.00	648.00	87.1%	0.00	0.00	-	0.00	0.00	No Hours	682.00	671.00	98.4%	341.00	396.00	116.1%	0.00	0.00	-	0.00	0.00	No Hours	300.00	0.00	11.9%	0.0%	8	0.57	2	284	9	8.7	33.3%	80.0%						
TWH	Ward 2	Ward 2 (TW) - NG442	1,657.50	1,525.50	92.0%	1,495.50	1,834.42	122.7%	0.00	0.00	-	168.00	168.00	100.0%	1,023.00	1,298.00	126.9%	1,265.00	1,858.00	146.9%	0.00	0.00	-	99.00	99.00	100.0%	1,674.25	849.67	44.2%	33.7%	83	5.73	16	813	7	8.3	3.7%	100.0%						
TWH	Ward 10	Ward 10 Winter escalation (TWH) - NG144	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	0.00	#DIV/0!	#DIV/0!	-	-						
TWH	Ward 11	Ward 11 (TW) - NG131	2,221.00	2,026.00	91.2%	1,452.00	1,650.00	113.6%	0.00	0.00	-	0.00	0.00	No Hours	1,320.00	1,309.00	99.2%	1,364.00	1,067.00	78.2%	0.00	0.00	-	0.00	0.00	No Hours	1,031.00	57.00	17.1%	5.2%	58	4.03	2	920	7	6.6	13.3%	70.0%						
TWH	Ward 12	Ward 12 (TW) - NG132	1,862.00	1,725.17	92.7%	1,491.50	1,642.00	110.1%	0.00	0.00	-	23.00	23.00	100.0%	1,364.00	1,375.00	100.8%	1,364.00	1,561.00	114.4%	0.00	0.00	-	0.00	0.00	No Hours	1,787.00	567.00	38.6%	24.1%	108	6.90	12	915	7	6.9	14.5%	88.9%						
TWH	Ward 20	Ward 20 (TW) - NG230	1,861.50	1,869.33	100.4%	1,421.00	1,481.00	104.2%	0.00	0.00	-	84.00	84.00	100.0%	1,364.00	1,440.33	105.6%	1,364.00	1,441.00	105.6%	0.00	0.00	-	0.00	0.00	No Hours	1,681.75	415.00	34.4%	19.8%	120	7.84	14	923	7	6.8	25.0%	71.4%						
TWH	Ward 21	Ward 21 (TW) - NG231	2,250.50	2,161.00	96.0%	1,393.50	1,446.50	103.8%	0.00	0.00	-	108.00	108.00	100.0%	1,705.00	1,683.00	98.7%	1,023.00	1,131.50	110.6%	0.00	0.00	-	0.00	0.00	No Hours	969.50	208.00	18.2%	17.7%	38	2.61	12	920	7	7.1	16.7%	85.7%						
TWH	Ward 22	Ward 22 (TW) - NG332	1,862.00	1,782.50	95.7%	1,488.00	2,276.33	153.0%	0.00	0.00	-	0.00	0.00	No Hours	1,364.00	1,364.00	100.0%	1,364.00	2,265.00	166.1%	0.00	0.00	-	0.00	0.00	No Hours	1,445.50	1,141.33	42.6%	44.1%	51	3.43	10	986	6	7.8	18.5%	60.0%						
TWH	Ward 30	Ward 30 (TW) - NG330	1,945.00	1,913.80	98.4%	1,392.00	1,498.50	107.7%	0.00	0.00	-	84.00	84.00	100.0%	1,364.00	1,301.80	95.4%	1,342.00	1,320.00	98.4%	0.00	0.00	-	22.00	22.00	100.0%	1,358.48	0.00	22.1%	0.0%	76	4.40	4	910	7	6.7	6.8%	75.0%						
TWH	Ward 31	Ward 31 (TW) - NG331	1,930.48	1,823.25	94.4%	1,392.00	1,580.00	113.5%	0.00	0.00	-	48.00	48.00	100.0%	1,364.00	1,354.00	99.3%	1,364.00	1,364.00	100.0%	0.00	0.00	-	0.00	0.00	No Hours	877.50	0.00	14.4%	0.0%	62	3.93	10	922	7	6.7	14.7%	80.0%						
TWH	Ward 32	Ward 32 (TW) - NG130	1,819.00	1,696.00	93.2%	1,150.50	1,038.00	90.2%	0.00	0.00	-	48.00	48.00	100.0%	1,353.00	1,342.00	99.2%	1,012.00	967.25	95.6%	0.00	0.00	-	0.00	0.00	No Hours	1,342.25	0.00	24.9%	0.0%	64	4.50	6	608	9	8.4	0.0%	100.0%						
TWH	Gynae Ward	Ward 33 (Gynae) (TW) - ND302	744.50	782.50	105.1%	409.50	499.75	122.0%	0.00	0.00	-	7.00	7.00	100.0%	676.00	720.00	106.5%	341.00	352.00	103.2%	0.00	0.00	-	0.00	0.00	No Hours	586.75	0.00	26.9%	0.0%	27	1.62	0	315	7	7.5	22.0%	94.4%						
TWH	SCBU	NICU (TW) - NA102	2,963.50	2,527.25	85.3%	0.00	303.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	2,345.00	2,191.50	93.5%	0.00	66.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	595.50	11.00	11.4%	1.8%	75	4.19	8	368	14	13.8	-	-						
TWH	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - NE901	**2,016.00**	**1,729.67**	85.8%	760.00	542.00	71.3%	0.00	0.00	-	116.00	116.00	100.0%	682.00	682.00	100.0%	341.00	352.00	103.2%	0.00	0.00	-	0.00	0.00	No Hours	192.00	0.00	4.9%	0.0%	7	0.47	1	270	15	**12.7**	5.8%	95.5%						
TWH	Surgical Assessment Unit	Surgical Assessment Unit (TW) - NE701	1,115.50	1,175.50	105.4%	312.00	240.00	76.9%	0.00	0.00	-	60.00	60.00	100.0%	682.00	660.00	96.8%	319.00	341.00	106.9%	0.00	0.00	-	22.00	22.00	100.0%	34.00	0.00	1.4%	0.0%	No Demand	No Demand	No Demand	141	18	17.7	3.8%	100.0%						
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	4,107.67	3,857.92	93.9%	490.00	433.00	88.4%	0.00	0.00	-	0.00	0.00	No Hours	3,330.50	3,026.75	90.9%	416.00	297.75	71.6%	0.00	0.00	-	0.00	0.00	No Hours	1,641.83	121.75	21.1%	6.9%	231	13.97	47	1123	11	8.5	#N/A	#N/A						
TWH	Delivery Suite	Midwifery Services - MSW (2022) - NF102	0.00	0.00	No hours	2,417.00	987.75	40.9%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	1,999.50	922.00	46.1%	0.00	0.00	-	0.00	0.00	No Hours	728.50	0.00	16.5%	0.0%	No Demand	No Demand	No Demand				#N/A	#N/A						
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	1,138.25	1,028.08	90.3%	254.00	156.00	61.4%	0.00	0.00	-	0.00	0.00	No Hours	990.50	939.00	94.8%	209.25	161.25	77.1%	0.00	0.00	-	0.00	0.00	No Hours	464.75	11.75	18.4%	2.5%	51	3.14	13	355	7	6.4	#N/A	#N/A						
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	1,953.50	2,506.08	128.3%	1,319.75	1,199.25	90.9%	0.00	0.00	-	0.00	0.00	No Hours	1,333.00	1,599.58	120.0%	763.25	602.00	78.9%	0.00	0.00	-	0.00	0.00	No Hours	1,316.42	11.75	24.7%	0.9%	164	9.04	15	665	8	8.9	#N/A	#N/A						
Crowborough	Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	869.00	810.00	93.2%	356.50	346.25	97.1%	0.00	0.00	-	0.00	0.00	No Hours	713.00	621.50	87.2%	356.50	333.50	93.5%	0.00	0.00	-	0.00	0.00	No Hours	246.50	0.00	10.7%	0.0%	30	1.86	7	16	143	132.0	-	#DIV/0!						
Maidstone	A&E (M)	Accident & Emergency (M) - NA351	5,351.00	5,376.62	100.5%	931.25	1,149.67	123.5%	0.00	0.00	-	120.50	120.50	100.0%	5,346.00	5,338.33	99.9%	1,055.50	1,410.20	133.6%	0.00	0.00	-	0.00	0.00	No Hours	3,745.22	1,100.07	37.8%	22.7%	282	18.97	7	0	#DIV/0!	#DIV/0!	0.0%	79.5%						
TWH	A&E (TW)	Accident & Emergency (TW) - NA301	5,372.00	5,542.75	103.2%	1,724.75	1,702.92	98.7%	0.00	0.00	-	45.75	45.75	100.0%	5,344.50	5,558.50	104.0%	1,695.50	1,713.15	101.0%	0.00	0.00	-	57.50	57.50	100.0%	3,014.50	649.32	25.7%	17.7%	234	16.14	9	0	#DIV/0!	#DIV/0!	13.2%	78.1%						
Maidstone	Chartwell Ambulatory Unit	Chartwell Ambulatory Unit (M) - NF451	767.50	793.75	103.4%	553.00	289.83	52.4%	0.00	0.00	-	140.50	140.50	100.0%	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Specialist Midwives	Midwifery Services - Specialist Midwives - NF152	1,490.25	1,766.42	118.5%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	363.25	352.58	97.1%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	208.42	0.00	11.2%	0.0%	29	1.28	1	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Womens Services Management	Midwifery Services - Management - AY451	1,479.00	936.00	63.3%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Antenatal OP Clinic	Midwifery Services - Antenatal Clinic - NF142	1,158.00	1,066.00	92.1%	1,005.00	942.50	93.8%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	256.75	0.00	11.9%	0.0%	10	0.48	0	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Midwifery Governance	Midwifery Governance - AE820	2,691.50	2,017.67	75.0%	240.00	231.00	96.3%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	606.00	421.25	69.5%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	munity Midwifery Services - TW/Ton/PW/Hawkhurst - N	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	874.00	757.50	86.7%	150.00	114.00	76.0%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	47.00	0.00	4.6%	0.0%	5	0.29	0	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	nmunity Midwifery Services - Eden/Seven/Mallings - N	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	ommunity Midwifery Services - Maidstone/Leeds - NJ1	2,052.50	1,888.92	92.0%	405.00	294.00	72.6%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	263.50	0.00	10.7%	0.0%	36	1.73	4	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	780.00	770.50	98.8%	202.50	142.00	70.1%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	41.25	0.00	4.2%	0.0%	6	0.25	0	0	#DIV/0!	#DIV/0!	#N/A	#N/A						
		Midwifery TW (four IP rosters)	7,199.42	7,392.08	102.7%	4,480.75	2,776.00	62.0%	0.00	0.00	-	0.00	0.00	No hours	5,654.00	5,565.33	98.4%	3,388.00	1,983.00	58.5%	0.00	0.00	No hours	0.00	0.00	No hours	4,151.50	145.25	20.7%	3.4%	446	26.15	75											
		Midwifery TW Community (six comm. rosters)	4,312.50	3,838.17	89.0%	757.50	550.00	72.6%	0.00	0.00	-	0.00	0.00	No hours	0.00	0.00	No hours	0.00	0.00	No hours	0.00	0.00	No hours	0.00	0.00	No hours	351.75	0.00	6.9%	0.0%	245	14.04	35											
		Midwifery TW (all fourteen rosters)	18,330.67	17,016.33	92.8%	6,483.25	4,499.50	69.4%	0.00	0.00	-	0.00	0.00	No hours	6,017.25	5,917.92	98.3%	3,388.00	1,983.00	58.5%	0.00	0.00	No hours	0.00	0.00	No hours	4,503.25	145.25	13.6%	3.1%	527	33.01	42											
Maidstone	MOU	Maidstone Orthopaedic Unit (M) - NP951	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	No hours	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	No Hours	No Hours	No Hours	No hours	No Demand	No Demand	No Demand	0	#DIV/0!	#DIV/0!	65.5%	86.7%						
Maidstone	K&M Orth Centre - Inpatient Ward	K&M Orth Centre - Inpatient Ward - TK153	1,488.00	1,416.00	95.2%	1,875.00	1,304.50	69.6%	0.00	0.00	-	336.00	336.00	100.0%	1,705.00	1,111.00	65.2%	341.00	264.00	77.4%	0.00	0.00	-	0.00	0.00	No Hours	0.00	0.00	0.0%	No hours	1	0.08	1	200	29	22.1575	#N/A	#N/A						
Fordcombe	Fordcombe Ward	Fordcombe Ward (AFC) - NU901	1,025.00	1,076.75	105.0%	240.00	300.00	125.0%	0.00	0.00	-	0.00	0.00	No Hours	667.00	678.50	101.7%	0.00	0.00	No Hours	0.00	0.00	-	0.00	0.00	No Hours	276.50	0.00	14.3%	0.0%	27	1.70	0	30	64	68.50833	#N/A	#N/A						

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

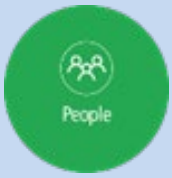
RAG Key

	↓	Reduction of greater than 5
	↑	Increase of greater than 5
↗→	↗→	Remains equal to Or less than a difference of 5

Reduction of greater than 5
Increase of greater than 5
Remains equal to Or less than a difference of 5

	Budget £	Actual £	Variance £
Total Established Wards			
Additional Capacity bed Cath Labs			
Whatman			
Other associated nursing costs			
Total			

Title of report	**Learning from Deaths Report**					
Board / Committee	**Trust Board**					
Date of meeting	Meeting date					
Agenda item no.	06-19					
Executive lead	Sara Mumford					
Presenter	Sara Mumford					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***		***Information***	✓

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

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

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

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

Quarterly Learning from Deaths Report June 2025

1 Learning from Deaths Group (LfDG)

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

1.1 Structured Judgement Reviews (SJR)

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

1.2 SJR Outcomes and Discussion

There were eight, nine and twelve cases referred for SJRs in March, April and May, respectively. SJRs can now be raised for community deaths within 30 days of hospital discharge; there were no community deaths referred for an SJR in March, April or May

Figure 1: SJR outcomes (January 2025 - May 2025)

Month	Very Poor care	Poor care	Adequate care	Good care	Excellent care	Total
Jan-25	1	0	3	4	3	11
Feb- 25	0	1	3	7	1	12
Mar-25	2	2	3	2	0	9
Apr-25	1	2	3	2	2	10
May-25	0	3	2	1	3	9
Total	**4**	**8**	**14**	**16**	**9**	**51**

1.3 Good Practice Identified

- Good management of sepsis and AKI on the wards, with daily consultant input and early ITU involvement
- Senior doctor involvement everyday of patient's admission
- In a case discussed at LfDG there was recognition of the patient's likely death and a seamless switch from active to palliative care with good discussions with family
- Excellent intensive care management to try to reverse and improve the patient's neurological condition.

- Senior clinician involvement throughout care with good MDT specialist involvement throughout admission.
- Excellent discussion prior to major surgery with patient and family regarding DNACPR wishes and patient able to make informed decision about their care.
- There was rapid assessment in ED with prompt investigations and involvement with other appropriate teams, this continued throughout the patient's admission with General Surgery and Orthopaedics.

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

There was one case referred to the Patient Safety team in March and another referred in April for further investigation.

In March, the Very Poor Care case discussed at the LfDG meeting was already awaiting a PSIRF panel review through the InPhase incidents process. The action was for it to be discussed at Clinical Governance to share learning. Another Poor Care case was discussed and upon review by the LfDG was revised to Very Poor Care. The action from this case was for the mortality lead to review the case with the team involved in the care.

- Two other Poor Care cases were discussed by the LfDG in March, the action was for Mortality leads to take the cases back to the teams involved for a case review.

At the April LfDG meeting, a Poor Care case was revised to Very Poor Care and referred to the Patients Safety team. It met the criteria for further investigation and has been declared a PSII. An action from another Poor Care case discussed was for it to be presented at the Oncology Clinical Governance to share learning

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

- Learning from poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates via discussion from Mortality leads
- Learning is also being shared via the Learning from Deaths Section in the Patient Safety Learning Hub on the intranet.
- Divisional mortality reports including mortality indicators and learning from SJRs are now provided to divisions to be presented at Clinical Governance meetings monthly.
- Feedback to directorates to aid learning from all SJRs occurs via mortality leads to teams, letters to clinical directors, and senior clinicians involved in the case. Cases are also discussed at Clinical Governance meetings.
- Excellent care is recognised with communication to individual and/or team involved

1.6 Areas of concern

In total there were 3 SJRs rated 'Very Poor Care' and 7 SJRs rated 'Poor Care' discussed at the LfDG meetings over the las 3 months. At the March LfDG meeting, 2 Poor Care and 2 Very Poor Care cases were discussed, whilst 1 'Very Poor Care' and 2 'Poor Care' cases were discussed at the April LfGD meeting. In May, 3 'Poor Care' cases were discussed at the LfDG meeting.

Themes Highlighted by SJRs

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

1.7 Planned Actions

1. The Project work to build and tailor the mortality module on InPhase to the current SJR process is in the user testing phase. SJR reviewers have tested the new system with required adjustments underway. The SJR form has been developed by the LfDG to support the thematic learning from the SJR process, including comorbidity data and tracking improvements.
2. An additional SJR reviewer has now been scheduled for training, the objective to recruit 3 additional reviewers has been met.

3. Data analysis of sepsis cases from November 2023 to November 24 has been completed. The analysis and outcome of the review is due to be presented to Deteriorating patient working group, Sepsis Committee and Patient Safety Oversight Group in June and July

4. Appoint Mortality Lead within Medicine and Emergency Care to attend LfDG and present cases at CG and Safety Rounds.

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

   Survey to resident doctors to assess the current situation and their preferred options has been completed. The response rate was low (only 28 replies) but with key preferences for learning: Grand Rounds, Safety events and a Safety newsletter.

   Next steps are to hold meeting with stake holders (Communication team, Safety team, Chief Registrars, Governance leads) to plan strategy of sharing Safety messages across Trust.

2 Medical Examiner Service (Hosted by MTW)

The number of deaths in the Trust is on the decline as we move away from the winter months were the highest numbers of deaths are recorded. In March, April and May 2025 there were 138, 137 and 119 deaths sadly occurring in the Trust.

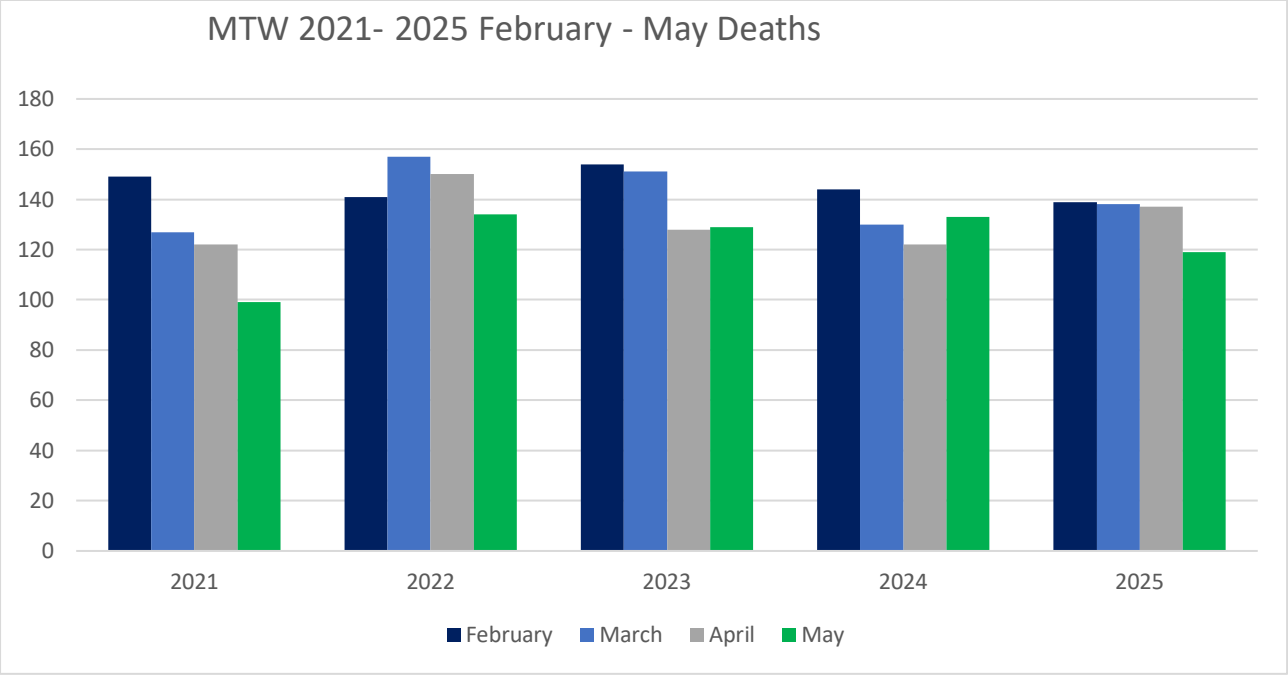


Figure 2: ME Scrutiny Vs Deaths and SJRs Raised

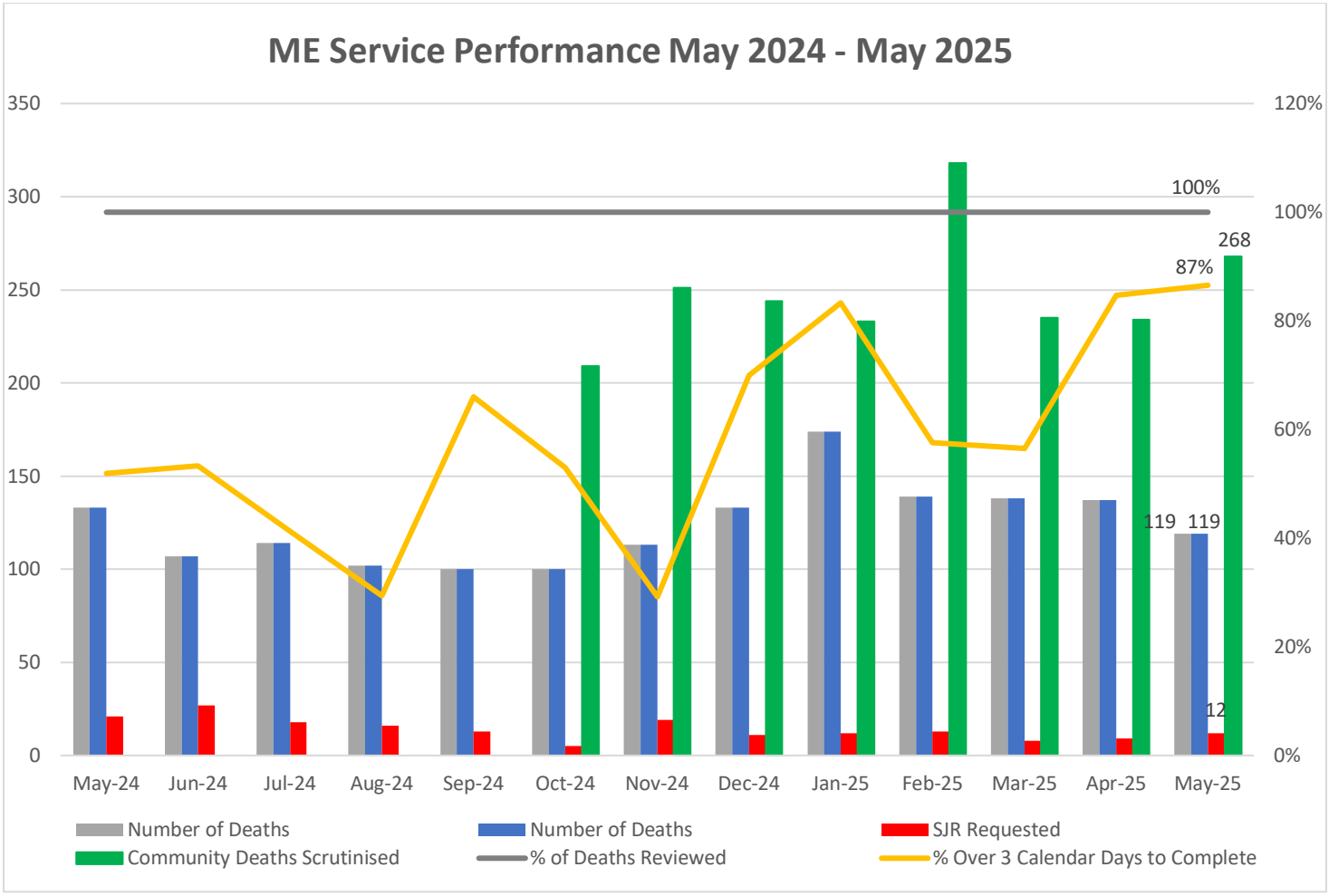


Figure 3: Deaths and ME data at MTW January 2025 - May 2025

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Jan-25	174	174	100%	145	83%
Feb-25	139	139	100%	80	58%
Mar-25	138	138	100%	78	57%
Apr-25	137	137	100%	116	85%
May-25	119	119	100%	103	87%

2.1 Medical Examiner (ME) Service Update

In March, April and May 2025, the percentage of cases which exceeded the three-workday performance target were 57%, 85% and 87% respectively. The increased workload from community deaths under review and staffing challenges continue to impact on ability of the Medical Examiner Service to complete reviews within 3 working days.

- Analysis of Medical Examiner data indicate majority of cases are completed within 4-6 calendar days.
- The Medical Examiners Service has initiated several initiatives to improve review times including changing staff working patterns, incidents raised via InPhase when deaths summaries are completed after 24 hours and improving communication to key stakeholders of the death certification process.
-

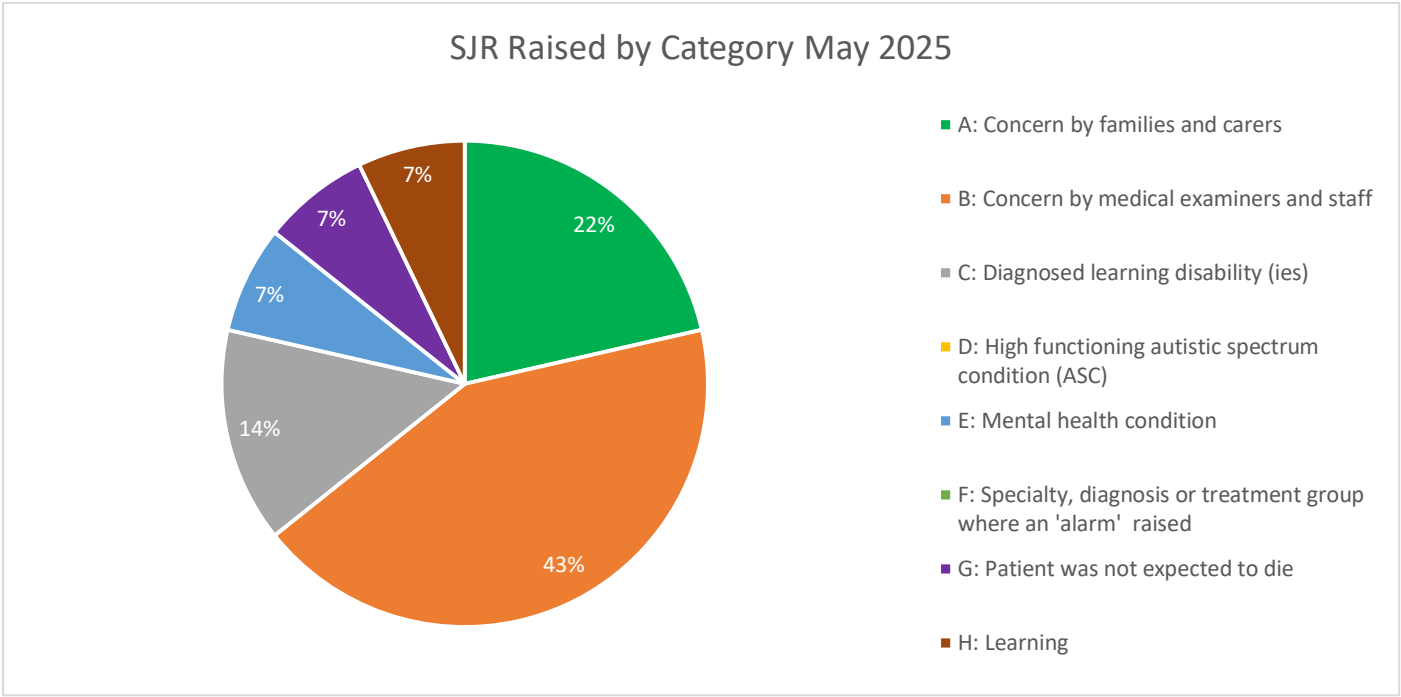
Figure 4: SJR Snapshot Position

LfDG SJR 25/26 Snapshot Position	Snapshot SJR Backlog Position	Cases <4 Weeks under Review	Unallocated Cases	Total Caseload within SJR Process	Number of Completed Cases in Financial Year
June -25	11	15	2	28	6

The current situation of completed and outstanding SJRs is shown in Figure 4. The table highlights all SJRs allocated and completed within the financial year 1 April 2025 – 16 June 2025 when this report was produced. Figure 5 tracks the number of SJRs within the SJR backlog (cases that have exceeded the 4-week target period for review), cases under review not within the backlog, and cases yet to be allocated to a reviewer. These three columns make up the total caseload within the SJR process. The number of completed cases is a snapshot of cases completed within the financial year at each given point in time.

The categories of SJR, as allocated by the ME Service in May 2025, are shown in Figure 5.

Figure 5: SJR Raised by Category



3 Mortality Data

The reporting period for this report covers hospital in-patient admissions from February 2024 to January 2025. It provides an overview and benchmarking of mortality using the Hospital Standardised Mortality Ratio plus (HSMR+) and the Standardised Mortality Ratio (SMR) provided in May 2025 by Telstra Health.

The Monthly Standardised Hospital Mortality Index (SHMI) data is updated monthly from NHS Digital's Indicator Portal. SHMI for the period January - 24 to December - 24 is 87.91 and "as expected". (see Appendix 1

Figure 6: Summary of Data for February 2025 – January 2025

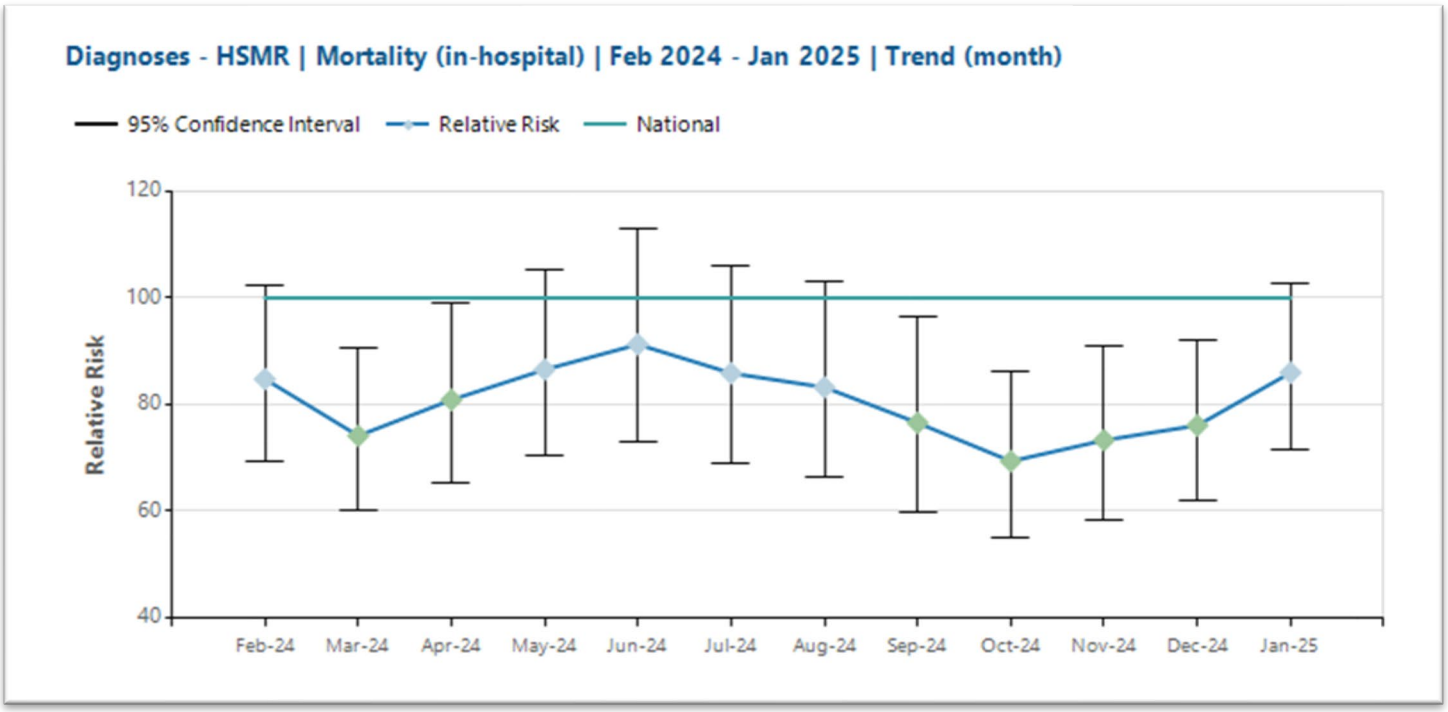
Metric	Result
HSMR	80.51 (lower-than-expected) (75.85 – 85.37)
HSMR position vs. peers	Regional (acute, non-specialist) peer group = 17 trusts: • 4 lower-than-expected • 12 within expected • 1 higher-than-expected Peer group = 96.5 (lower-than-expected) (95.2 – 97.7)
All Diagnosis SMR	77.8 (lower-than-expected)
Significant Diagnosis Groups	• Acquired foot deformities (208 superspells; 1 death)
CUSUM breaches	N/A
Emergency Weekend HSMR	90.6 (within expected)
Emergency Weekday HSMR	77.4 (lower-than-expected)
SHMI position	(Jan-24 to Dec-24) 87.91 (as expected)

Hospital Standardised Mortality Ratio + Summary

HSMR+ for Jan-25 is 86. and “within expected”, based on 3791 superspells and 121 deaths (crude rate 3.19%). The single-month HSMR+ value for the Trust whilst starting to rise given the winter period being reported is still within the expected levels for MTW.

HSMR+ for the period February 2024 to January 2025 is 80.51 and “lower-than-expected”, based on 42,645 superspells and 1116 deaths (crude rate 2.62%). The Trust continues to perform statistically significantly lower when compared to regional and national peers

Figure 7: HSMR Monthly Trend



3.1 Significant Diagnosis Groups

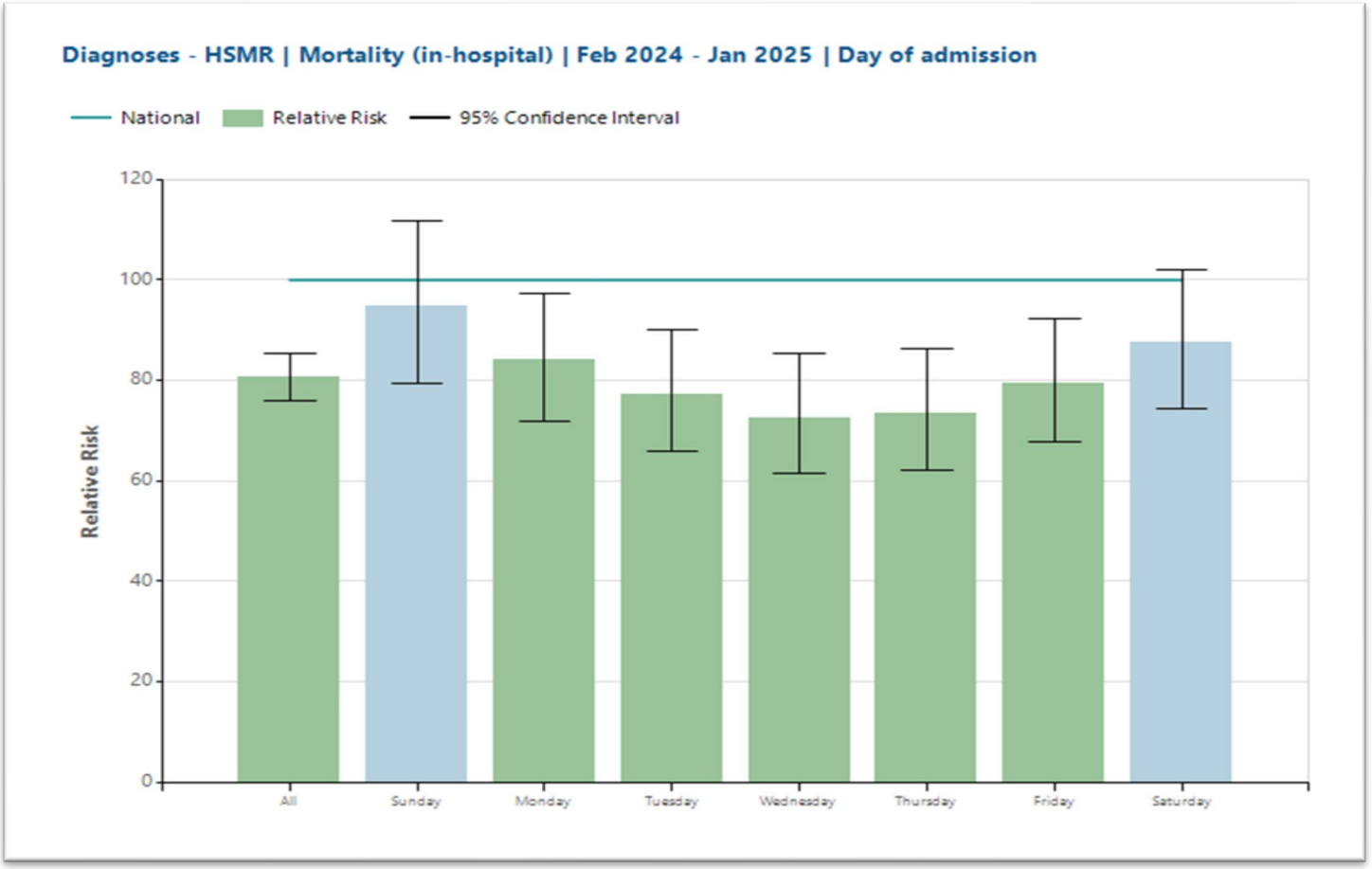
There are no new significant diagnosis group outliers this month, with the only remaining outlier for the previously investigated group ‘acquired foot deformities’. This was first reported to the Trust in January 2025 and occurred in September 2024. Acquired foot deformities will continue to be highlighted as an outlier in the significant diagnosis group for 12 months. In the last 12 months there have been 208 superspells and 1 death.

3.2 CUSUM Breaches

There are no CUSUM breaches this month.

Figure 8: HSMR Day of admission (Emergency only)

A bespoke deep dive analysis was conducted investigating the differences in Emergency Weekday HSMR+ and Emergency Weekend HSMR+ metrics. This includes analysis by specialty; as well as insights by day-of-discharge. The reason for this is because it is important to note that the Weekday/Weekend metrics are based on the day the patient admits, as opposed to the day the patient discharges (including where the discharge is death)



Summary of findings:

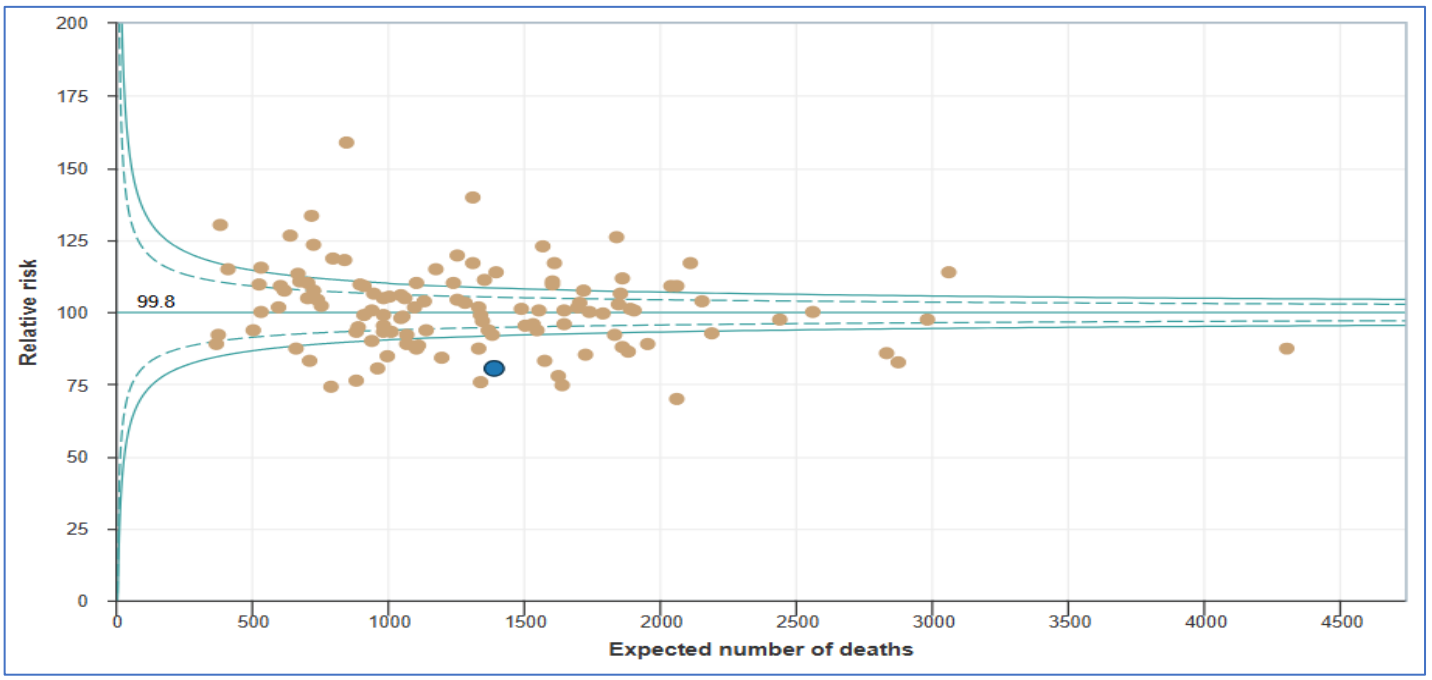
There are no statistical concerns with the difference between Emergency Weekend HSMR+ and Weekday outcomes; and Weekend has also shown signs of improvement recently.

No concerns are found at specialty level, although it is recommended the Trust supply a bespoke list of specialties mapped to divisions in order to perform more robust analysis.

Saturday & Sunday discharge HSMR+ are found to be “higher-than-expected” at the Trust, but so are all but two Trusts nationally. The Trust continues to perform statistically significantly lower when compared to national peers.

Figure 9: HSMR+ National Peer Comparison (Last 12 Months)

For the period February-24 to January -25 MTW performs statistically significantly better than national peers.
(MTW = blue; all other acute, non-specialist Trusts = brown)



4 Appendices

Appendix 1: MONTHLY SHMI

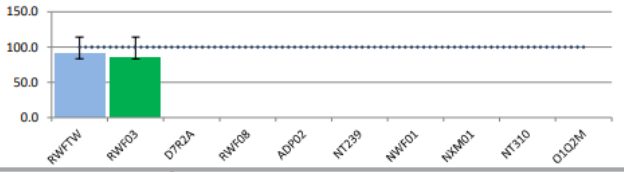
Key points: SHMI for the period January-24 to December-24 is 87.91 and “within expected”.

SHMI - Published (With Over Dispersion)

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

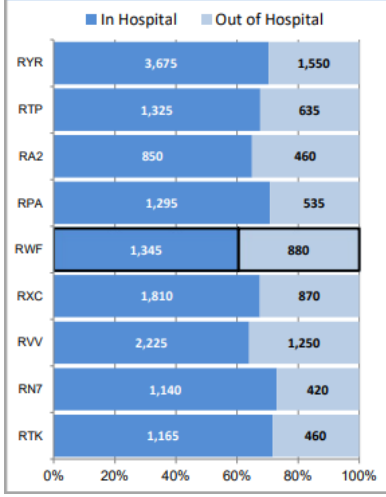
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTK	Ashford And St Peter'S Hospitals NHS Foundation Trust	59,505	1,625	1,675	-50	96.79	86.52	115.58
RN7	Dartford And Gravesham NHS Trust	59,195	1,560	1,475	85	105.69	86.43	115.70
RVV	East Kent Hospitals University NHS Foundation Trust	80,585	3,475	3,085	390	112.68	86.84	115.15
RXC	East Sussex Healthcare NHS Trust	61,230	2,680	2,600	80	103.04	86.77	115.25
RWF	Maidstone And Tunbridge Wells NHS Trust	99,095	2,230	2,535	-305	87.91	86.76	115.26
RPA	Medway NHS Foundation Trust	47,230	1,830	1,510	320	121.16	86.45	115.68
RA2	Royal Surrey County Hospital NHS Foundation Trust	61,230	1,315	1,655	-340	79.27	86.52	115.59
RTP	Surrey And Sussex Healthcare NHS Trust	62,165	1,960	2,065	-105	94.80	86.65	115.40
RYR	University Hospitals Sussex NHS Foundation Trust	154,230	5,225	5,020	205	104.11	86.99	114.96
Group		684,465	21,900	21,620	280	101.30		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
THE TUNBRIDGE WELLS HOSPITAL	62,225	1,210	1,340	90.19	85.75	116.61
THE MAIDSTONE HOSPITAL	35,115	1,020	1,195	85.44	85.66	116.75
KENT AND MEDWAY ORTHOPAEDIC	415	0	*			
CROWBOROUGH WAR MEMORIAL	330	0	*			
KIMS HOSPITAL (NEWNHAM COURT)	300	0	*			
NUFFIELD HEALTH, TUNBRIDGE	185	0	*			
BENENDEN HOSPITAL	185	0	*			
THE HORDER CENTRE - ST JOHNS	120	0	*			
SPIRE TUNBRIDGE WELLS HOSPITAL	105	0	*			
FORDCOMBE HOSPITAL	90	0	*			
SPIRE ALEXANDRA HOSPITAL	25	0	*			

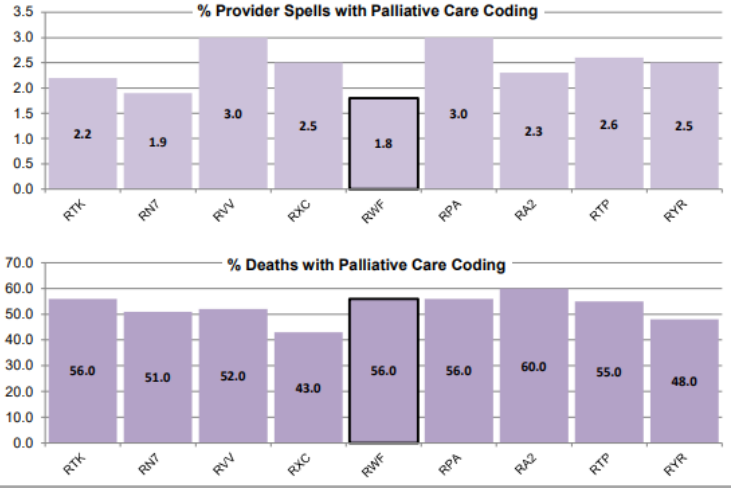


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	135	135.00	98.88	82.08 121.84
Cancer of bronchus, lung	20	20.00	85.77	65.19 153.39
Secondary malignancies	55	60.00	94.95	77.48 129.07
Fluid and electrolyte disorders	45	35.00	119.58	69.75 143.37
Acute myocardial infarction	30	25.00	111.30	68.12 146.81
Pneumonia	260	310.00	83.94	83.00 120.48
Acute bronchitis	15	30.00	58.95	65.23 153.30
Gastrointestinal haemorrhage	30	35.00	86.25	71.32 140.22
Urinary tract infections	45	50.00	91.28	68.09 146.86
Fracture of neck of femur (hip)	60	50.00	117.54	75.34 132.73

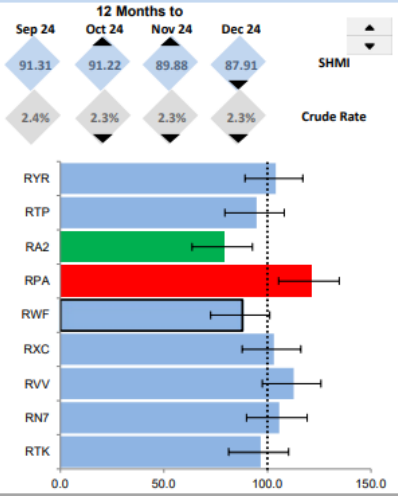
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



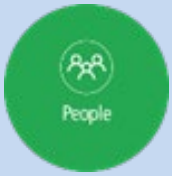
SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(38) Nutritional deficiencies, Disorders of lipid metabolism, Other nutritional, endocrine, and metabolic	25	15	166.67	107.83 246.04
(77) Aspiration pneumonitis, food/vomitus	85	75	113.33	90.52 140.14
(65) Congestive heart failure, nonhypertensive	100	95	105.26	85.64 128.03
(109) Infective arthritis and osteomyelitis (except that caused by tuberculosis or sexually transmitted	15	10	150.00	83.89 247.42
(99) Acute and unspecified renal failure	45	40	112.50	82.05 150.54
(75) Chronic obstructive pulmonary disease and bronchiectasis	55	55	100.00	75.33 130.17
(124) Intracranial injury	45	45	100.00	72.93 133.81
(66) Acute cerebrovascular disease	160	210	76.19	64.84 88.95

Appendix 2: Category of SJRs allocated by ME Service

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

Title of report	**Maternity Report relating to the Perinatal Quality Surveillance Model and Bi-Annual Workforce Report**					
Board / Committee	**Trust Board**					
Date of meeting	26 June 2025					
Agenda item no.	06-17					
Executive lead	Jo Haworth					
Presenter	Rachel Thomas					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	PQSM Overview 1. To ensure effective Board oversight in Year 7 of the Maternity Incentive Scheme, it is recommended that the monthly Perinatal Quality Surveillance Model (PQSM) report (Appendix 1) 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 18 June 2025. These are summarised in the 3A report at pages 2-4. Bi-annual workforce report 4. In accordance with Safety Actions 4 and 5 of the Maternity Incentive Scheme, a Bi-Annual workforce report (Appendix 2) is produced. 5. For Safety Action 5, this report ensures the Board have oversight of staffing/safety issues affecting the service on an ongoing basis and evidence of funded establishment being compliant with BirthRate+ calculations. 6. For Safety Action 4, this report provides the Board with oversight of obstetric medical staffing relating to RCOG compliance in the engagement of locums and consultant attendance at emergency

	scenarios, as well as anaesthetic provision to the service. For the neonatal workforce, the Board is provided an update relating to action plans to ensure BAPM workforce compliance.
Any items for formal escalation / decision	1. In relation to PQSM the Board is invited to: a. review the attached June (April 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. 2. In relation to the Workforce Report the Board is invited to: a. review and note the content of the report; b. confirm in the minutes of this meeting that funded establishment for midwifery staffing is compliant with BirthRate+ calculations; c. confirm in the minutes of this meeting that it has reviewed the updates on BAPM workforce compliance action plans for neonatal staff.
Appendices attached	1. Appendix 1 - June (April data) 2025 PQSM report 2. Appendix 2 – Biannual workforce report

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	18 June 2025	For referral to Trust Board

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: •
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 Fulfils requirements for Maternity Incentive Scheme

If you need any help with your coversheet, please feel free to contact the Committee secretary who will assist.

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

MTW

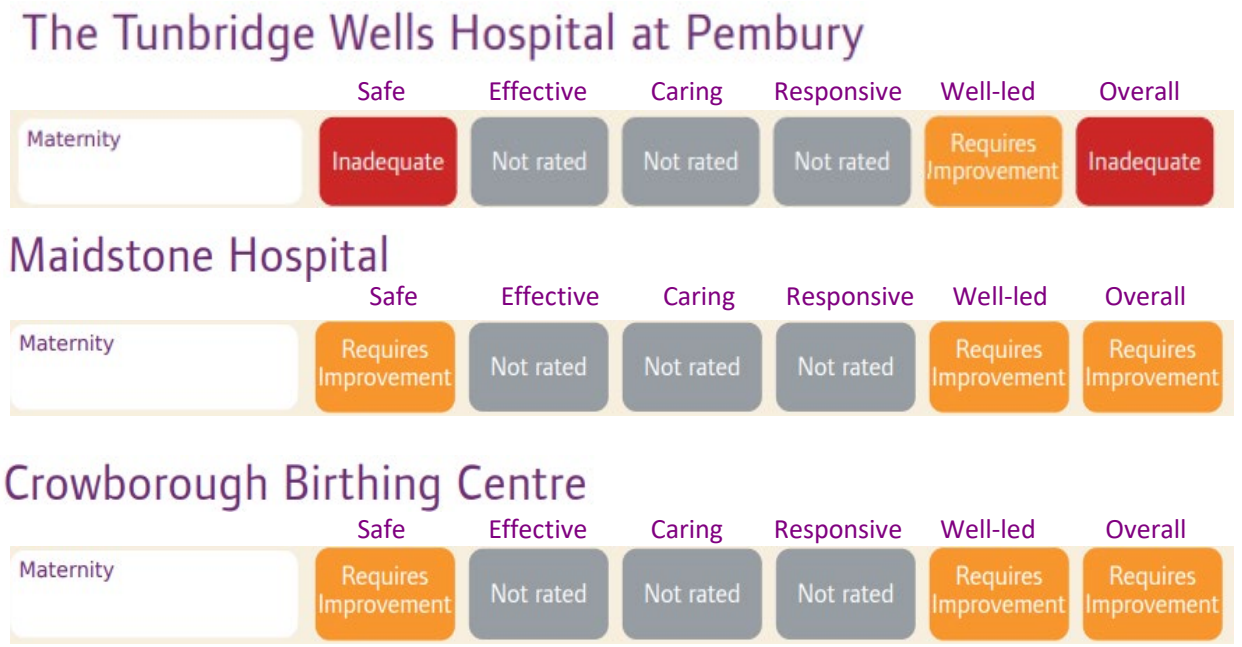
NHS
Maidstone and Tunbridge Wells NHS Trust

PQSM			
Report date: May 2025 March data		**PQSM** **Report lead:** Jessica O'Reilly	**Actions:**
1a	**Alert (Include actions taken/mitigations)**	**Incident management :** • 12 moderate harm incidents reported in month following MDT review and downgrades as appropriate 5 remained moderate harm • 1 PSIIs commissioned and 1 MNSI referral **Operational:** There were a total of 27 suspension of service reported in month: • Crowborough Birth Centre suspensions- (1 day time suspensions and 2 overnight) 1 woman affected by closure, who delivered at TWH • Maidstone Birth Centre suspensions – 0 • Home birth suspensions - A total of 24 suspension of service (12 day time suspensions and 10 overnight) – All due to community staffing bar x1 night which was due to the acuity in the acute service. **Complaints and FFT:** • 1 new complaints in month relating to communication and analgesia • 1 reopened complaint regarding outstanding questions relating to clinical treatment **CNST** • Safety Action 3: Inconsistencies in ATAIN data prevented report being sent to MNCOG last month. • Safety Action 7: At risk of non-compliance in Year 8 due to lack of LMNS funding for MNVP infrastructure. Compliance can be gained in Year 7 by escalation of lack of funding to Trust Board. • Safety Action 8: Awaiting neonatal team evidence that BAPM compliant NLS training being delivered, which is required to ensure SA8 compliance.. **Risk Register** One red risk on the register - Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience. (15) **Training** Neonatal consultant (58%) Specialist trainee and permanent NNU doctor (78%) training compliance due to new starters. If this is ongoing this is a risk relating to CNST compliance.	**Incident management :** Immediate learning disseminated with staff following MDT reviews. **CNST** • Stakeholder meeting arranged to address issues, report to be presented this month. • Escalation in accordance with SA7, including inclusion in PQSM, addition to the risk register, creation of action plan in collaboration with LMNS. • Neonatal team to send asap. **Training** Action plan in place for all staff to be trained by the end of June.

1b	Assurance	**Risk Register** 3269-Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus – was closed No new or amended risk in month **DOC** • Compliance now 100% **PMRT:** • We remained 100% complaint with an external reviewer being present **Operational:** • 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status remained 100% • 100% complaint for consultant attendance at clinical scenarios **Training:** Compliance for Fetal monitoring and PROMPT compliance was met across all professionals, neonatal team have action plan in place for neonatal training. **CNST:** • Safety Action 6: The latest LMNS assessment continues to show an improvement trajectory. • 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. • Safety Action 9: Claims scorecard triangulation report discussed with Board Level Safety Champions via MNCOG in May. • Quarterly report sent to Trust Board giving oversight of all safety actions. **Complaints and FFT:** • Increase in FFT responses in month from 166 to 409 • 0 breached complaints in month • MNVP Consistent visits and engagement maintained, with logs continuing.	**CNST:** SA9: To be discussed quarterly throughout Year 7.

1c	**Advise**	**Incident management:** • Two MNSI cases published in month, action plans being collated and tripartite meeting to be arranged **PMRT:** • 7 Reports published in month, 0 cases met PMRT criteria. **CNST:** • 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. **Staffing** • 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). **Complaints, FFT and service user feedback:** • Themes from service user feedback relating to information sharing, pain relief options, lack of debrief service and discharge processes. • Dates for future 15 steps and Walk the Patch visits proposed. • Promote personalized care and support plans to women and families using MNVP communication channels	**PMRT:** • PMRT processes followed. Quarterly report produced. **CNST:** Once published this safety action will require further review to assess for any potential challenges to achieving compliance in Year 7. **Staffing:** • Incident regarding consultant on call reviewed by MDT and feedback given to staff involved. **Complaints and FFT:** • Action plans created for all these themes to ensure responsiveness to service user concerns. • Once agreed, to share invite with key stakeholders. • LMNS project to be worked up.

CQC Maternity Ratings



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

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

Closed

3269-Devolved budgets to some clinical areas are not adequate to cover the midwifery establishment according to Birthrate Plus

New Risks

None

Amended risk scoring following review

None

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
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	8	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	07.102025	01.05.2025
3387	Lack of midwifery NIPIE lead for maternity services	12	8	4	27.02.2025	01.09.2025
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

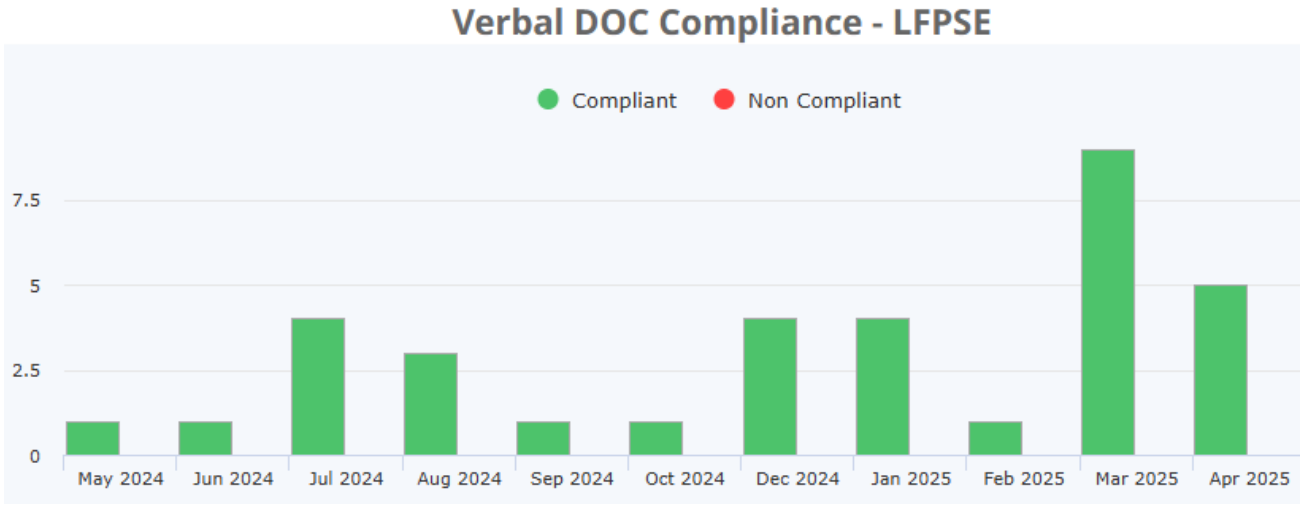
The number of incidents logged graded as moderate or above and what actions are being taken.

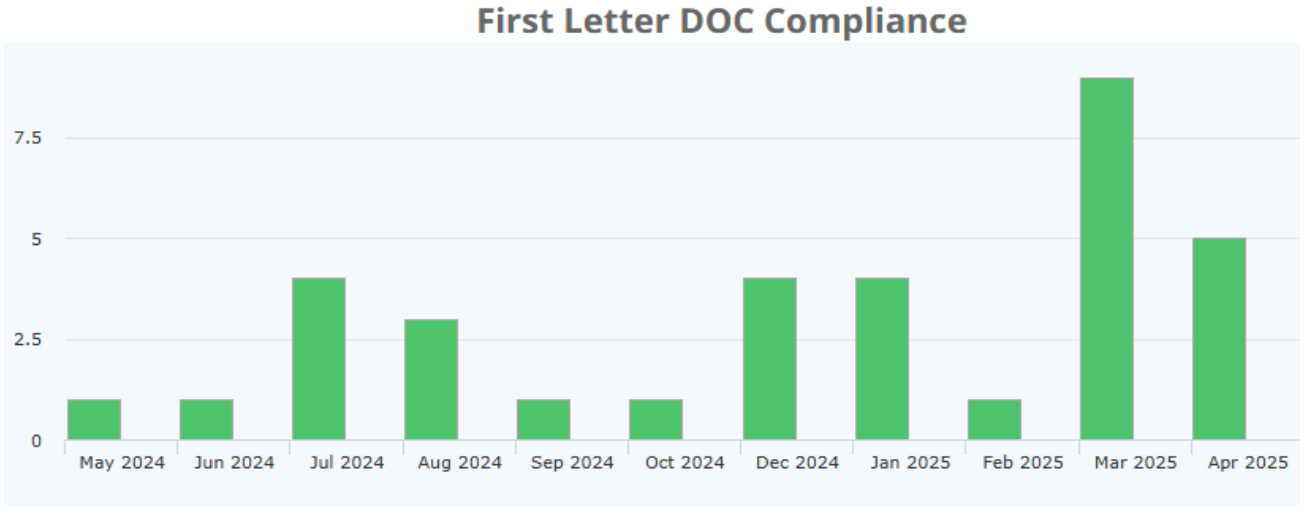
Incidents Graded Moderate or above			
ID	**Incident Summary**	**Actions/Learning**	**Date Clinical Incident outcome**
#40676 Incident 09/04/25 Reported 10/04/25	Maternal collapse perimortem EMCS 5000ml PPH ITU admission	- Case of excellence in team working downgraded from 'fatal' to low harm following MDT review - Case discussed at PSIRG 24/04/25	MDT rapid review 10/04/25
#41114 Incident 16/04/25 Reported 16/04/25	3rd degree tear 1600ml PPH	- Uterotonic optimisation - Documentation issues including use of MEOWS - More frequent MBL updates during PPH as large jump in MBL from arrival in theatre to procedure completion - Fluid management - Remains as moderate harm	MDT review 22/04/25
#41792 Incident 29/04/25 Reported 30/04/25	Unexpected admission to NNU	Initially graded as moderate but downgraded to low following ATAIN MDT review	ATAIN MDT review 01/05/25
#41614 Incident 26/04/25 Reported 27/04/25	2000ml PPH	Moderate due to volume No learning identified- Closed	MDT review 13/05/2025
#41588 Incident 25/04/25 Reported 26/04/25	IUD 20+2	Initially graded moderate psychological, low physical harm Reviewed and no learning identified. Confirmed no psychological harm and downgraded	MDT review 13/05/2025
#40755 Incident 10/04/25 Reported 11/04/25	17+1 Miscarriage	Low physical harm, moderate psychological harm but downgraded to low following MDT review.	MDT review 06/05/25

Escalations to PSIRG in April

ID	Summary	Actions/Learning	Outcome
#40169 Incident 01/04/25	-Baby transferred from MBC with seizures	Learning points noted: • SECAMB had no transwarmer available and this is the second incident where this has been the case in the last month. • Starting reluctant feeder observations earlier could of enabled earlier recognition and intervention • 2 missed fresh eyes on labour monitoring although this is an incidental finding • Some gaps in documentation were noted • Communication issues during deterioration on route, the unit were not updated by SECAMB so they were not anticipating such an unstable baby on arrival at TWH. If this had occurred a full retrieval team would have been available to meet the ambulance at the emergency entrance.	PSII commissioned
39285 Incident 19/03/25	Delay in preterm baby receiving IVABX with risk factors for Sepsis	Baby should have been screened and treated at birth – learning with NN team	No local learning - No further investigation needed
39322 Incident 20/03/25	Baby born via planned ELCS at 37+1 which is not Trust guideline – NNU admission	-Follow trust guidelines for ELCS delivery at appropriate gestation (39-40/40)	No local learning - No further investigation needed
39798 Incident 28/03/25	Avoidable term admission to NNU due to low temperature	-Follow new thermoregulation flowchart and guideline	No local learning - No further investigation needed
40676 & 40722 Incident 09/04/25	Maternal collapse perimortem EMCS 5000ml PPH ITU admission and baby transferred out for cooling	-Gaps identified in correct 2222 call categories – communication already circulated in this regard and ongoing work -Learning around accessing the blood fridge out of hours -Delay in commencing 40iu Syntocinon due to staff from other areas of the hospital not being familiar with obstetrics. -Incidental learning of missed obstetric review following USS findings of slowed growth and polyhydramnios	Positive feedback on incredible care given MNSI referral and investigation
41457 Incident 24/04/25	Shoulder Dystocia, fractured clavicle	No learning identified, well managed shoulder dystocia Escalated to PSIRG due to fracted clavicle for discussion	Expected complication of treatment. No investigation needed

Duty of Candour Compliance





Maternity & Newborn Safety Investigations (April 2025)

MNSI Reports published in April

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

MNSI were notified of the case below, however parents have not yet consented to MNSI investigation

April	#40676	Baby transferred for cooling following Category 1 LSCS (maternal cardiac arrest, suspected amniotic fluid embolism) at 39^{+0}	Any other Asian background

MI-038810 – Baby transferred for cooling following SVD at 38^{+4}

Safety Recommendations

1. It is recommended that the Trust undertakes a review of the pathways for mothers when they are accessing unscheduled clinical advice in pregnancy. There should be clear signposting to the correct pathway for the individual mother. The findings will be used to inform the development of robust pathways and guidance to support the access to and provision of unscheduled telephone advice.

Safety Prompts

The investigation found that the mother's care did not follow the antenatal care pathway for mothers with epilepsy which meant she did not receive information about pain relief options or a documented birth plan. She was given pethidine for pain relief which is not recommended for mothers with epilepsy.

- The investigation found that maternal observations were What measures are in place to ensure that mothers remain on the planned antenatal care pathway when maternal medicine appointments are missed or cancelled?
- What written information is available to support mothers with medical conditions to understand the implications of their condition for their care in labour?
- How are clinical staff supported to recognise where commonly used medications are not recommended?

The investigation found that maternal observations were not completed during the triage assessment and were not documented following her admission to the delivery suite. This meant the investigation could not be reassured that there was a complete assessment of maternal wellbeing in labour.

- How can staff be supported to complete all recommended observations in the face of competing demands?
- How can documentation systems or clinical tools support record-keeping in real time?

The investigation found that there was loss of contact on the CTG for 53 minutes before a fetal scalp electrode was used. The CTG was not formally categorised prior to the Baby's birth which meant that there was no escalation for a senior review.

- What barriers are in place when addressing loss of contact or poor quality CTG recording?
- How can staff be supported to undertake CTG reviews in the face of competing clinical demands?

MI-038677 – Mother experienced IUD at 38^{+2} following abruption

Safety Recommendations

1. It is recommended that the Trust reviews its risk assessment process at booking so that potential risk factors which may impact on care during pregnancy can be identified. This should involve provision of clear guidance for staff and facilitating access to all of the relevant medical records to allow a comprehensive assessment.
2. The Trust should review the local SOP for Use of Aspirin in Pregnancy guidance (Trust, 2023) to ensure that it is in line with the recommendations from the SBLCB V3 national guidance (NHS England, 2023). This should include 'previous SGA baby' and 'smoking' status as moderate risk factors which would lead staff to the consideration of aspirin in high-risk pregnancies.
3. It is recommended that the Trust ensure that there is adequate fetal monitoring equipment available to staff in all areas where fetal monitoring is carried out.
4. It is recommended that staff are supported to adequately perform fetal monitoring antenatally with the use of pinards and handheld Dopplers to differentiate between fetal and maternal heart rate in line with local and national guidance.
5. It is recommended that the Trust introduce guidance on Antenatal Care aligned with national guidance, with reference to the importance of urinalysis as a screening and diagnostic tool.

Safety Prompts

The investigation learned that The Mother did not feel heard throughout her pregnancy and considered this was due to her age.

- How do The Trust support staff to ensure that they work in partnership with, build relationships with and communicate clearly with women?
- How do staff enable and advocate for the views, preferences, and decisions of women, partners and families?
- Do staff have training in understanding and working to mitigate health and social inequalities?

The investigation learned that CTGs which had not met the Dawes Redman criteria were not reviewed by senior obstetricians due to acuity within the unit.

- Has the Trust conducted a recent review into the obstetric staffing within the triage department to ensure the timely and robust assessment of mothers who are admitted, where there are CTG concerns?

The investigation learned that during The Mother's admission at 30+2 many CTGs were carried out without the equipment to confirm acknowledgement of fetal movements using the handheld clicker.

- What are the barriers to adequate provision of equipment to assess fetal movements at the time of CTG recording?

The investigation learned that advice given during maternity triage calls is reliant on clinical judgement alone and that the IT systems do not always provide all of the medical records and information needed for gaining a holistic picture.

- Has the Trust considered ways to improve access to mothers' medical records which may be relevant during a mother's triage call?
- What are the barriers to accessing medical records during triage telephone calls?

Patient Safety Incident Review Framework

Ongoing Patient Safety Incident Investigations (PSIIs)
0 PSII's closed in April

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
March	#38554	Mother required returned to theatre following LSCS, found to have 1000mls in abdomen.	Asian or Asian British: Bangladeshi
April	#40169	Unexpected admission of baby to NNU at following SVD at Birth Centre	Any other White background

Patient Safety Incident Review Framework

Ongoing After Action Reviews (AARs)
0 AAR's closed in April

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 facture 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

Patient Safety Incident Review Framework (April 2025)

0 Cases meeting PMRT criteria in April

7 PMRT report published in April

InPhase	Description	Grading	Learning
#30652 21/11/24	Intrapartum IUD @ 38+1 Antenatal diagnosis of anencephaly at dating scan Cause of death: Anencephaly	B- The review group identified care issues which they considered would have made no difference to the outcome for the baby up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	From information identified earlier in the tool this mother met the national guideline criteria for screening for gestational diabetes but this does not appear to have been identified and she was not offered screening (Previous baby >4.5kg) **Action:** GLOW sent out
#30625 29/11/24	Antenatal IUD @ 27+6 of one twin Routine USS @ 27+6 showed IUD of one twin, pregnancy continued until labour @ 30+0 Cause of death: Twin to twin transfusion syndrome	B- The review group identified care issues which they considered would have made no difference to the outcome for the baby up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	This mother was not assessed but in retrospect she was high risk and should have been prescribed aspirin **Action:** Quality improvement project started with community, antenatal clinic, fetal wellbeing and patient safety to review process and improve care

Patient Safety Incident Review Framework (April 2025)

InPhase	Description	Grading	Learning
#38875 12/03/25	Antenatal IUD @ 29+5 Admitted via ambulance with abdominal pain and IUD confirmed on USS Cause of death: Placental Abruption	B- The review group identified care issues which they considered would have made no difference to the outcome for the baby up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	Patient did not have her first SFH measurement by 28+6 as her appointment was one day later than this. It made no difference to the outcome. **Action:** Fetal wellbeing team are auditing this monthly and reporting through SBL
#32213 26/12/24	Neonatal death @ 22+0 Attended triage at 21+6 with abdominal pain and budging membranes seen on speculum. The next day SROM and then sadly delivered that evening. Baby passed away shortly after Cause of death: Extreme prematurity	A- The review group identified no care issues up until the point of birth A- The review group identified no care issues up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	No learning identified

Patient Safety Incident Review Framework (April 2025)

InPhase	Description	Grading	Learning
#31597 16/12/24	Antenatal IUD @ 34+6 Attended triage with abdominal pain and IUD confirmed on USS Cause of death: Placental Abruption	B- The review group identified care issues which they considered would have made no difference to the outcome for the baby up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care and intrapartum care **Action:** Glow sent to all staff This mother had gestational diabetes but it was not managed appropriately **Action:** Diabetes team are reviewing processes for non English speaking women with GDM
#32725 05/01/25	Antenatal IUD @ 24+3 Anomaly USS showed HC <5th centile. Repeat USS in 4 weeks showed IUD Cause of death: Placental insufficiency	A- The review group identified no care issues up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	No learning identified
#32128 24/12/24	Antenatal IUD @ 38+4 RFM at 38+4 when IUD was diagnosed Cause of death: Undetermined	B- The review group identified care issues which they considered would have made no difference to the outcome for the baby up until the point the baby died A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	The review group identified that the woman was scanned by three different doctors in triage to confirm that the baby had passed away which was recognised to have potentially caused more distress to the family and a delay in confirmation. **Action:** Bereavement guideline being updated and will include clear guidance of scanning for confirmation

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	100%
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	100%
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 Day 2 Night	Closed due to the staffing and acuity in the acute service. MBC remained open, Homebirths suspended for 1 of the same nights 1 woman affected by closure, who delivered at TWH
Maidstone Birth Centre suspensions	nil	
Home birth suspensions	12 Day 10 Night	All due to community staffing bar x1 night which was due to the acuity in the acute service.

External Reviews/Actions Requested from

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

Report requested will add went sent through.

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	183	178	97%
Midwife community	55	55	100%
Midwife Birth Centres	29	29	100%
Obstetric Consultants	21	21	100%
Obstetric Doctor	22	22	100%
Total	309	304	98%

Data as at 30th April 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	185	179	97%
Midwife Community	55	55	100%
Midwife Birth Centres	29	29	100%
Obstetric Consultant	21	21	100%
Obstetric Doctor	32	32	100%
Anaesthetists	37	35	95%
Anaesthetic Trainees	3	3	100%
Maternity Support Worker & Nursery Nurse (excl. bank)	71	68	96%
Total	433	422	97%

Data as at 30th April 2025.

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

NLS - Maternity

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

Role	Total Staff	Compliant	Compliance %
Midwives	269 (excluding bank)	263	98%
Obstetric Consultant	21	21	100%
Obstetric Doctor	32	32	100%
Maternity Support Worker	71 (excluding bank)	68	96%
Total	393	384	98%

Data as at 30th April 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	58%	Piloting a new competency medical tool to be signed off
Specialist trainee and permanent NNU doctor	78%	
Foundation doctors and GP trainees	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: Plan in place for trust doctors and consultants to update Wednesday sessions moving forward
Aim for full compliance by end of June

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	89.9%	-	89.5%	-	25.0%	23.7%
Midwifery Services - MSW (2022) - NF102	-	93.7%	-	90.9%	22.3%	0.0%
Midwifery Services - Antenatal Ward - NF122	91.1%	-	91.2%	-	25.3%	11.0%
Midwifery Services - Postnatal Ward - NF132	130.8%	96.3%	119.5%	100.0%	38.5%	8.2%
Midwifery TW (four IP rosters)	101.3%	94.4%	96.9%	92.2%	27.7%	12.6%

Unavailability (%)			
31.24%			
Annual Leave (%)	**Sick Leave (%)**	**Study Leave (%)**	**Other (%)**
14.66%0	6.79%	4.01%	5.79%

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	April 2025
Birth to midwife ratio	1:24	1:26	1:25	1:27	1:25	1:24	1:25	1:21	1:22	1:24

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
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
April	90	100%	0	-	0	-	2	2	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

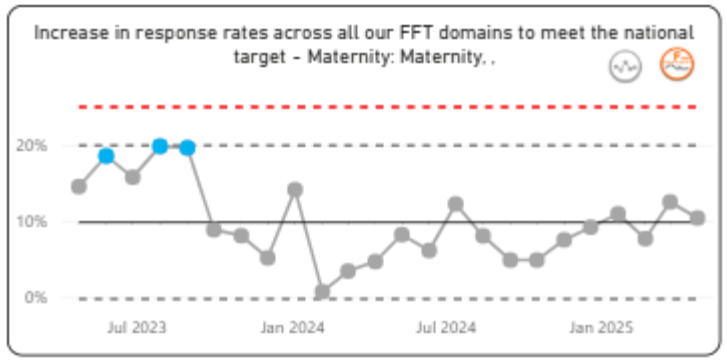
MNVP Key Issues Report Jodie Kennett			
Report date: May '25		**Report lead:**	**Actions:**
1a	**Alert** **(Include actions taken/mitigations)**	**Lack of funding for MNVP Lead**	The role of the MNVP (Maternity and Neonatal Voices Partnership) Lead is essential for ensuring the inclusion of service user feedback and co-producing meaningful improvement projects. Currently, funding from LMNS (Local Maternity and Neonatal System) covers only six days per month—three days dedicated to engagement work and three days for service collaboration. To maintain the momentum of this critical work, it has been acknowledged that there is a need for internal funding for the MNVP Lead role.
1b	**Assurance**	**Engagement Activities:** • Consistent visits and engagement maintained, with logs continuing • Maintains visible community presence through structured visits. **Achievements:** • Monthly status meetings are being held with MNVP Lead and PT EX Lead for Maternity. The aim of the meetings will be to review Feedback Log themes, agree actions and review overall MNVP business and progress. • Evidence of structured stakeholder collaboration and active feedback channels. • Implement 'You Said, We Did' activity via social media and on-site at MTW	Continue MNVP engagement work as per annual workplan 2025. Review and action plans Monitor and review KPIS and data to identify themes, which will enable workplan visits. MNVP to developed plan of venues, places, groups and clubs to visit. Publish to PEL and QA Lead. Develop clear communication outlets for birthing partners 'you said we did'.
1c	**Advise**	Dates for future 15 steps and Walk the Patch visits proposed. Promote personalized care and support plans to women and families using MNVP communication channels	Once agreed, to share invite with key stakeholders. LMNS project to be worked up.

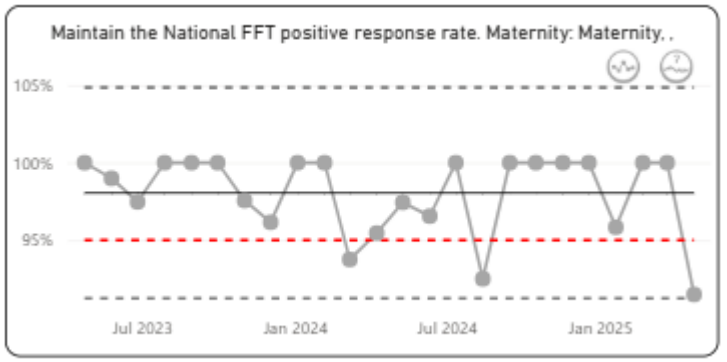
FFT Feedback

Total responses (Antenatal, Birth and Postnatal Surveys):

	May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25		Mar-25		Apr 25
Total responses	87		67		95		147		134		164		164		165		178		154		166		409

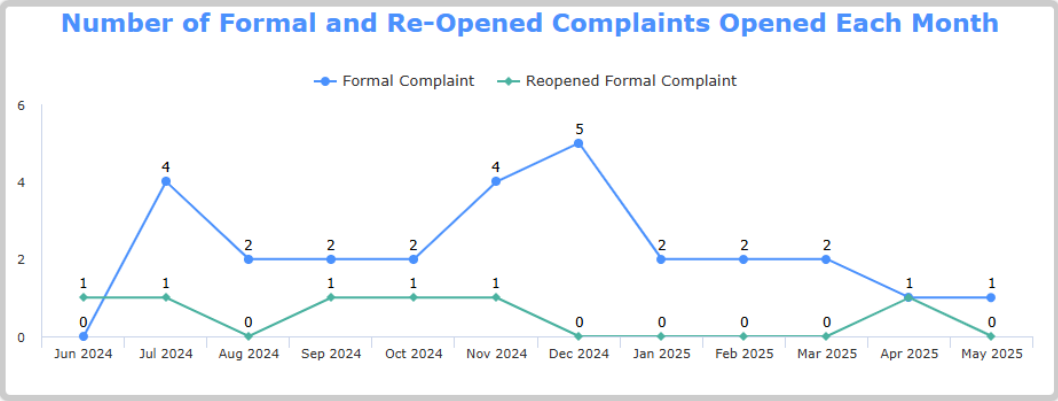
Response rate (in relation to total births) – **Birth only survey:**





The Trust's Patient Experience Team and Patient Experience Lead for Maternity have been working collaboratively to improve response rates. As part of this effort, we conducted a thorough review of the clinic codes linked to the automated Friends and Family Test (FFT) text message service. During this review, it was identified that some clinic codes were either missing or incorrectly assigned. These discrepancies have since been corrected to ensure accurate targeting and improved data collection.

Formal Complaints



No of formal complaints received in month : 1

No re-opened: 1

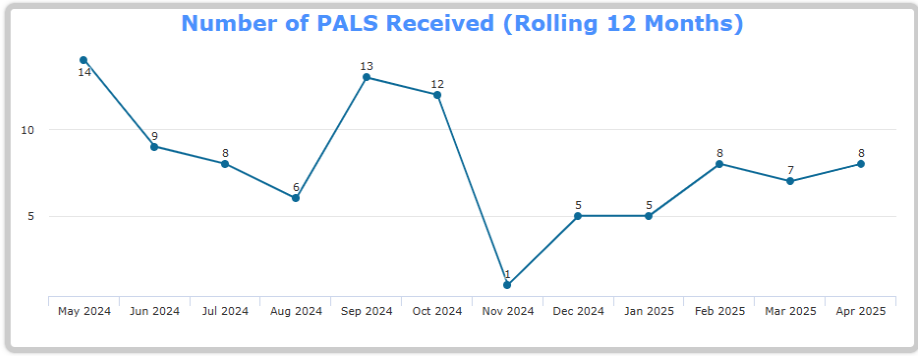
No of breached complaints: 2

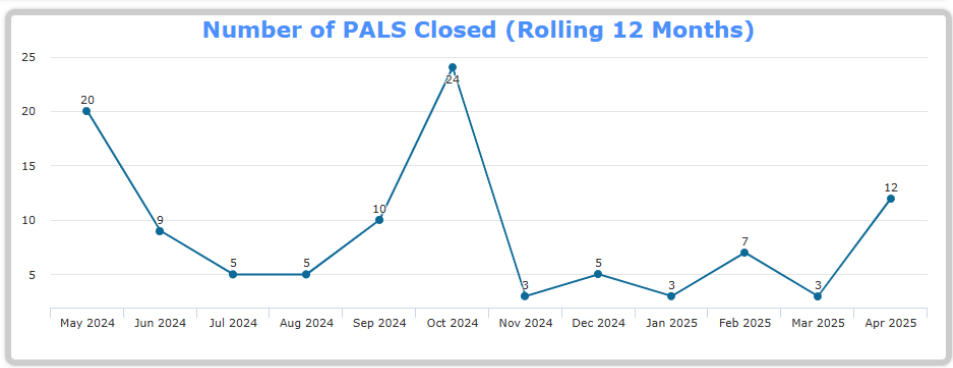
New Formal Complaints

InPhase ID	MM/YYYY	Speciality	Description	Subject	Sub-Subject
24079	08/04/25	Obstetrics	**Reopened complaint.** Some outstanding concerns regarding original complaint: The complaint addresses significant issues with obstetric care, including lack of access to important medical information, failure to properly address antibody risks, refusal to adjust the due date based on IVF accuracy, and inadequate communication and coordination across medical staff and trusts. The patient experienced delays in receiving critical results, inappropriate handling of appointments, and unhelpful attitudes from some staff members, leading to unnecessary stress and concerns about her and her baby's health.	Clinical treatment	Poorly co-ordinated care/lack of continuity
24036	09/04/25	Midwifery	Concerns regarding not being listened to during labour and denied examination to establish progress resulting in speedy delivery without adequate pain relief and without support of husband.	Communication - Patient/relative not listened to	Clinical treatment - Inadequate pain management

PALS

No of PALS cases: 8





Themes/Learning

- Staff values, attitude and behaviours
- Poor communication
- 2 compliments

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
Poor and inconsistent communication	Recognised recurring SU feedback theme highlights the need for improved communication	Staff training for Midwives (personalised care/communication commenced Jan 2025). Doctors training (personalised care and consent carried out in March '25) Communication tools for service users – development of BRAIN decision making tool poster
Poor discharge processes - Non-empathetic, rushed, delayed, insufficient information	Postnatal ward manager informed. Improvement project to improve flow underway.	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

Maternity incentive scheme Maternity Incentive Scheme Progress May 2025 Key issues report			
Report date: May 2025		**Report Lead: MIS Lead – Megan Fradgley**	**Actions/Mitigations:**
1a	**Alert** **(Include actions taken and mitigation)**	Safety Action 3: Inconsistencies in ATAIN data prevented report being sent to MNCOG last month. Safety Action 7: At risk of non-compliance in Year 8 due to lack of LMNS funding for MNVP infrastructure. Compliance can be gained in Year 7 by escalation of lack of funding to Trust Board. Safety Action 8: Awaiting neonatal team evidence that BAPM compliant NLS training being delivered, which is required to ensure SA8 compliance.	Stakeholder meeting arranged to address issues, report to be presented this month. Escalation in accordance with SA7, including inclusion in PQSM, addition to the risk register, creation of action plan in collaboration with LMNS. Neonatal team to send asap.
1b	**Assurance**	Safety Action 6: The latest LMNS assessment continues to show an improvement trajectory. 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. Safety Action 9: Claims scorecard triangulation report discussed with Board Level Safety Champions via MNCOG in May. Quarterly report sent to Trust Board giving oversight of all safety actions.	To be discussed quarterly throughout Year 7.
1c	**Advise**	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.	Once published this safety action will require further review to assess for any potential challenges to achieving compliance in Year 7.

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?			9	0		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/Ali/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.	Action plan re lack of MNVP funding to MNCOG and Trust Board via PQSM. ,Co-produced Action Plan re CQC survey results to MNIC.	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	

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	

SBL Team Q3 (Q7) Final report Key Issues Report May 2025			
Report date: May 2025		**Report Author:** Sarah Mander-McGregor	**Actions taken:**
1a	**Alert**	**SBL Risks** - true timing of identification of risks relating to SBL is not reflected in the current risk register. Risks 3308, 3310, 3370 were initially combined in risk 2989, opened on 20/07/23 in response to version 3 of the bundle. **Non-compliance** with bundle implementation is linked to the following: • Lack of service provision • Failure to follow current guidance • Low training compliance • Outstanding guideline amendment	• Clarity requested by SBL lead regarding approved process for amendment of risk register in 2024 • To discuss at May's Risk Register review meeting • MDT service provision meeting scheduled this month • Review of actions to date in order to identify new QI approaches • Engagement with LMNS and regional forums to support identification of best practice examples
1b	**Assurance**	**Q3 (Q7) Final report** – increased total implementation across bundle to 86% **MIS year 7** – Quarterly QI discussions with LMNS regarding implementation trajectory and compliance scheduled for 2025-26	• Report distributed to SBL MDT and discussed with individual element specialist midwife, as celebration of success and acknowledgment of existing barriers. • Attendance to NHS R MIS 7 national launch event • Ongoing engagement with LMNS to support yearly planning
1c	**Advise**	**SBLCB v3.2** – released 24/4/25 (link below), awaiting publication of updated implementation tool to confirm evidence and audit requirements, expected by June.	• SBL Team away day scheduled for June 2025 to review 2year progress since v3, changes in v3.2 and agree QI moving forward. • Away day format suggested to LMNS for element leads, to support standardisation and sharing.

Please provide any additional/relevant information below

NHS England » Saving babies' lives: version 3

MTW: Q7 Findings

NHS
Kent and Medway

Q7 Tool and Assessment

- Sustained implementation in elements 1,3, 4, and 5.
- Increase in implementation of elements 2 and 6.
- 1/6 elements now fully implemented.
- 3% rise in total implementation from previous Quarter.
- Self-assessment of interventions closely matched LMNS assessment.
- 9 interventions remain partially implemented; 1 intervention remains not implemented.

Trust: Maidstone and Tunbridge Wells NHS Trust

ICB: South East

% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9
Review Quarter	Q1 (Interim)	Q1 (Final)	Q2 (Interim)	Q2 (Final)	Q3 (Interim)	Q3 (Final)	Q4	Q5	Q6	Q7
Assurance Review Date	10/10/23	07/11/23	20/12/23	23/01/24	13/03/24	16/04/24	12/07/24	11/10/24	17/01/25	15/04/25
Element 1	30%	30%	30%	50%	70%	60%	70%	60%	70%	70%
Element 2	40%	40%	75%	75%	80%	80%	75%	75%	85%	90%
Element 3	50%	50%	50%	50%	50%	50%	50%	50%	100%	100%
Element 4	0%	20%	40%	60%	60%	60%	60%	60%	60%	60%
Element 5	30%	41%	48%	85%	52%	89%	89%	85%	93%	93%
Element 6	0%	50%	50%	50%	33%	50%	50%	50%	67%	83%
TOTAL	30%	39%	53%	71%	61%	76%	76%	73%	83%	86%

Together, we can

Exceptional people, outstanding care

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

Neonatal Safety Report

June 2025 (April 2025 data)

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Neonatal Safety Report

Neonatal Safety Report Key Issues Report			
Report Date: June 2025 (April 2025 data)		**Report lead:** Neonatal Matron/Senior Nurse Neonatal Quality & Risk	**Actions:**
1a	**Alert** (Include actions taken/mitigations)		
1b	**Assurance**	• The compliance for attendance at both annual and 4yearly Neonatal Life Support Training is above 90% target for nursing/ANNPs/Consultant teams • There were no events reaching the threshold for reporting to tracking trends • New risk added to the risk register as NNU have 21% of guidelines out of date and being reviewed.	• An action plan is in place to address the non-compliance with the resident doctors to support them to reach compliance • There is a plan to improve staggering of guideline expiry for the future • Team working hard to improve compliance
1c	**Advise**	• There were 16 InPhase submissions this month, 5 were referred on to maternity. • Continuing neonatal theme with marks from Sa02 monitor skin probes • Hypothermia/hypoglycaemia remains a continuing theme with postnatal admissions • There is significant leaning for the perinatal service in relation to jaundice AAR	• All InPhase 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 • Key learning themes contained within PQSM report

Neonatal Safety Metrics: InPhase LFPSE and Tracking Trends

Total incidents reported on InPhase this month: 16

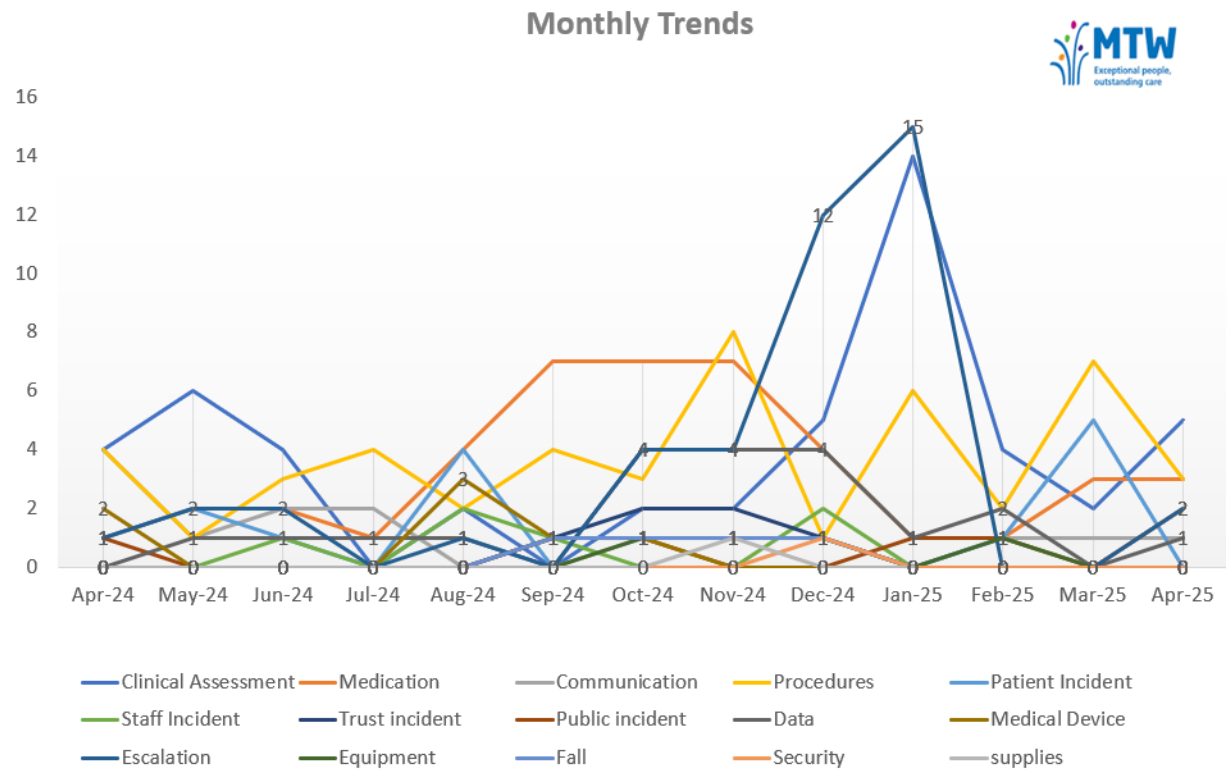
Breakdown of the number of incidents under investigation:
Related to NNU: 11
Referred to Maternity: 5
Referred to another department outside of perinatal service: 0

Tracking Trends Submissions this month: 0

However there were 2 near miss prescribing errors which were reported. Errors detected prior to administration and so no harm to patient (do not reach threshold for tracking trends reporting).

New referrals to PSIRG this month – 1

Baby sustained a significant skin burn from use of a vein finder, requiring referral to East Grinstead burns unit.
AAR currently in progress. Initial DoC completed.



Neonatal Safety Metrics: InPhase LFPSE/Tracking Trends – Themes and Immediate Learning

Themes for cases referred to maternity

- Inappropriate bleep cascade
- Hypothermia/Hypoglycaemia x 4 (recurring theme)
- Baby deterioration at birthing centre requiring transfer to MTW

Themes & immediate learning from NNU investigations:

- Marks from Sa02 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
- Need for careful prescribing – two errors picked up prior to administration
- Bloods not labelled in accordance with guidance – leading to need to repeat samples causing unnecessary discomfort to patient
- SBR result not plotted correctly – in line with new guidance all results must be checked and countersigned
- Data – multiple babies not admitted on badgernet for transitional care episodes – with impact on governance, communication with primary care and funding/resources

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

Neonatal Safety Metrics: InPhase LFPSE Themes and Immediate Learning from AAR

Summary of Case (InPhase ID 30592):
A baby was born at 37+1 weeks gestation. His mother was known to have anti c, d and jka antibodies. A plan was made pre delivery, for bloods to be sent (for DAT, FBC and SBR). These were taken, but unfortunately not chased, resulting in an avoidable 20hour delay. On admission to the neonatal unit, the baby's serum bilirubin level was significantly above the exchange transfusion line, putting him at risk of abnormal neurodevelopmental sequelae and hearing loss and causing him to need an extended stay on the neonatal unit.
The baby is currently progressing well, but following review, this case was graded as moderate physical harm

What went well?:
- Once the error was recognised, the baby was moved quickly to the neonatal unit to receive treatment
- The family were updated regarding the error quickly and an apology was given (verbal duty of candour)

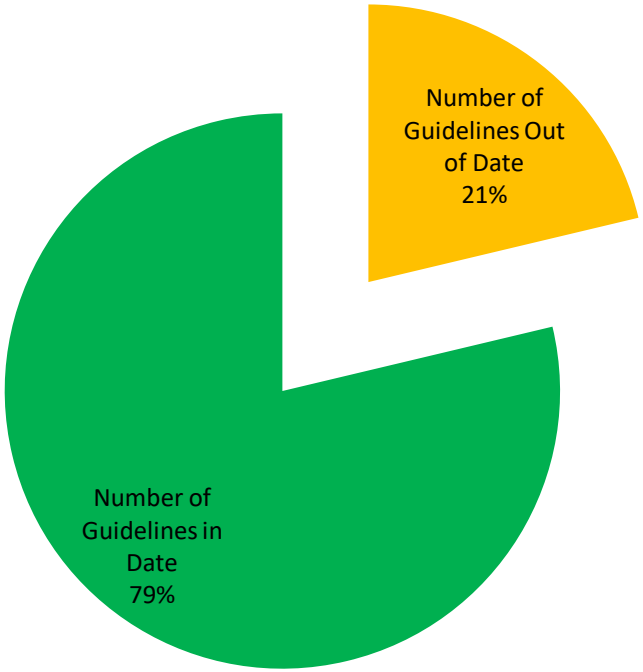
What have we learnt?
- There were inadequate processes in place to ensure the seamless handover of key information to safeguard the baby in this situation
- The IT systems that were being used did not provide any safety netting. If the Trust had been using a maternity/neonatal integrated system such as maternity badgernet + neonatal badgernet EPR, an alert banner would have been displayed and the blood results would have automatically plotted, flagging an issue.
- There were opportunities to improve family involvement in the incident review at an earlier stage.

Actions to prevent recurrence:
- Formulation of a SOP for jaundice, to support staff in detection, management and escalation
- Consideration for a 'traffic light' system to prioritise risks and guide work planning, in the handover system
- Review of current IT systems
- Continued investment in the neonatal governance team to improve availability of support to families involved in investigations

Role Specific Training - Neonatal Life Support Training

Role Specific Training (Newborn Life Support)	Compliance* (Minimum threshold 90%) (All registered practitioners) Annual GIC update	Valid resus council NLS (Minimum threshold 90%) for all attenders at resuscitation/stabilisation of newborn
Nursing Staff: band 5 and above (QIS nurses require Resus Council training)	100%	97%
ANNP's	100%	100%
Consultants	100%	100%
Specialist Trainees and Permanent NNU doctors	83% Formal Plan in place for annual basic life support update	100%
Foundation doctors and GP trainees	100%	100%

Neonatal Guideline Compliance – April 2025



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

Total Guidelines	**94**
Out of date circulated and for ratification	19
Reviewed for publication	1
In Date being Reviewed	2
In date	72

Neonatal Risk Register – April 2025

Risk	Grading March 2025	Current Grading	Actions/Comments
Lack of speech and language therapy provision for neonatal and paediatric areas	6	16	KCHFT withdrew support in April 2025. Discussion under way with EKHUFT for collaborative service. All issues to be logged on InPhase.
There is a shortage of QIS nurses (currently 59% vs 70% minimum recommended by BAPM)	9	9	Business case in progress. Bank and agency use continued to provide some mitigation
Policies and guidelines out of date/requiring review	9	12	Risk increased this month as the compliance has fallen for NICU. There is a very small team available to support with a large number of guidelines which have gone out of date at the same time. Plan to stagger expiry dates to reduce the burden on the team/improve availability of guidelines to support patient safety
Lack of psychology support for families/staff on NNU	9	9	Bank post approved at executive vacancy panel – currently out to advert
There is a shortage of non-invasive respiratory support equipment (vapotherm)	9	9	Equipment funded by emergency capital funding bid. Awaiting trial of new devices.

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

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

Neonatal Patient Experience Report

June 2025 (April 2025 data)

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Neonatal Patient Experience Report

Key Issues Report Neonatal Patient Experience			
Report Date: June 2025 (Apr 2025 data)		**Report lead:** Neonatal Matron / Senior Nurse – Neonatal Quality & Risk	**Actions:**
1a	**Alert** **(Include actions taken/mitigations)**	• MTW are currently one of only a few neonatal units with BLISS Platinum accreditation. Without substantive psychology funding, this accreditation is at risk of being removed which may affect the reputation of the service and parent experience	• Need to continue to seek substantive business case support for a psychotherapist • A bank post agreed at recent executive vacancy panel, to provide mitigation in meantime • Remains on risk register • Bank post now out to advert
1b	**Assurance**	• Positive verbal feedback received from families and no formal complaints received • Band 7s now in post with responsibility for improving family integrated care • Parent Support Sister working part time • Children's Safeguarding Sister working part time to provide additional social support for families • Parents support group now operational	• All posts (except data/audit now appointed to). - Family integrated care - Transitional Care - Discharge Planning - Risk and Governance
1c	**Advise**	• Maternity EDI lead recruitment in progress (offering support across perinatal service)	• Successful appointment – awaiting start date

Learning from patient experience and service user feedback

"After reading so many positive reviews online, we felt it was only right to share our own experience – and we can wholeheartedly agree with all the kind words others have said.

I can't thank the maternity unit enough for the incredible care and support we received throughout my pregnancy and birth. The delivery and postnatal teams were absolutely fantastic and made all the difference when it really mattered.

As a naturally nervous patient, I felt genuinely looked after – every member of staff was warm, kind, and patient. I had originally planned a c-section due to anxiety, but went into spontaneous labour five weeks early. The team responded with such calmness and sensitivity, helping me deliver naturally and making me feel safe and supported throughout the entire process.

Our baby needed extra care after birth, so we stayed in hospital for just under two weeks. We were on the transitional care ward, and I can't praise the staff there enough – they gave us that extra bit of love and support when we needed it most. The NICU team were also brilliant, stepping in with expert care and compassion whenever it was needed. The nurses, doctors, midwives, nursery nurses, and NICU staff all worked together seamlessly to make sure our baby received the very best care but also making sure we were okay physically and emotionally.

The facilities at the hospital were also amazing. Having a clean, private room gave us space to recover and bond in comfort, and receiving decent hospital meals three times a day honestly made such a difference during a very emotional and exhausting time.

By the time we went home, we felt well-informed, confident, and ready – thanks to the time and care they took to ensure we were prepared. The follow-up care has been just as excellent, with continued support from both the hospital, midwife team and our local health visitors, who have been checking in and providing reassurance as we've settled into life at home.

We're so grateful for everyone who helped us through what turned out to be a challenging and emotional time – your kindness, professionalism, and care meant the world to us. Thank you".

Maidstone and Tunbridge Wells NHS Trust

BI Annual MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

June 2025

1. Background

It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board 2016 (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) state that procedures are developed to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and birthing people and babies in all settings.

Previously midwifery staffing data has been included in the Nursing & Midwifery Workforce report, however, to provide further evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate summary is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics. Midwifery will however, continue to be included in the annual establishment review process and feature in the twice yearly N&M workforce report.

2. Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the Maternity Incentive Scheme Year 7.

3. Progress against Ockenden Actions

In previous years we have received additional funds from the ICB to support the Ockenden staffing recommendations for bereavement, workforce retention, improving clinical placement experience, obstetric leadership capacity and support for Maternity Support Workers. It is currently unclear whether this funding will be continued. These roles will require review once further details of funding are received.

A workforce lead has now been appointed and commenced in post in May 2025, she is supported in post by a workforce administrator who commenced in post in November 2024. The workforce lead is working in conjunction with our PMA lead to implement initiatives to improve retention.

Of the 4 outstanding Ockenden actions, 3 have been completed and progress has been made with the final action.

Recommendation	Action Required	Progress	RAG
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	- RECOMMENDATION 5 Trust to develop and conduct a regular audit to demonstrate there are Twice daily consultant led and	May 2025 Twice daily ward round are established in practice, 7 days a week. Compliance is monitored through the daily SITRep completed by care pathway co-ordinators.	

	present MDT ward rounds on labour ward as outlined within the Interim Ockenden Report (2020).Regional support offer		
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Agreed pathways and audit required	May 2025 Clear pathways established with shared KPI's and monthly reviews between Trust and Maternity Medicine Network.	
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Insights - RECOMMENDATION 6 Trust to formalise audit reporting and governance process for Personalised Care Support Plan within the Maternity Service	May 2025 – National audit tool being used to audit PCSPs.	
A review and solution to address the current perceived inequity in maternity on calls is required		March 2024 – Unit on call system restructured in response to review and staff feedback. May 2025 – Escalation policy ratified with clear processes in place for workforce redeployment at times of high acuity. May 2025 – Task and finish group relating to community on calls ongoing, proposal currently out for staff consultation until 27 May 2025. A plan will be formulated in response.	

4. Birthrate Plus Workforce Planning

In June 2023, the LMNS commissioned a Birthrate Report for all four providers including MTW. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. It should be mentioned that this methodology does not take in to account the increased responsibilities on maternity units from CNST, the Three Year Delivery Plan and national reports such as Ockenden and Kirkup.

This review did not recommend a birth to midwife ratio but calculated the ratio at MTW to be 24.2 births per 1 WTE midwife across the Trust.

4.1. Summary of Birthrate Plus results

Current Funded B3-9 as of June 2023	% Uplift	Birthrate Plus wte	Variance wte
261.02	21%	261.98	-0.96
261.02	23%	267.53	-6.51

As summarised in the above table, in June 2023 the budget included 261.02 WTE. In accordance with BR+ processes, this was the sum of all staff from bands 3 to 9. This included 241.10 RM's (with no RN's).

4.2. Action Plan to address findings from workforce review table-top exercise

In October 2023, there was a CQC assessment visit and the service was rated as inadequate. This prompted a review of the midwifery and obstetric workforce and a business case was submitted asking for further investment to support the service. New midwifery roles were brought in to support the governance portfolio and specialist roles to ensure concerns raised by the CQC could be addressed.

Therefore, establishment is now higher than the Birthrate+ calculations from 2023, with the current budget (at April 2025) including 256.1 RM's and RN's (15 WTE increase).

Further investment in additional clinical roles in triage, antenatal and postnatal ward, and community midwifery were also within the business case. The business case has been approved and recruitment is taking place in a phased approach through to 2027.

The increase in establishment reflects multiple changes that have taken place in maternity services over the last few years including:

- Increased requirements from the findings of National Reports and also in response to the CQC's S.29A warning notice issued in 2023.
- A 6.5% increase in high risk patients (increased inductions, as well as comorbidities such as GDM, mental health issues and high BMI) between 2020 and 2022.
- Additional funding for CNST posts, funded via Year 5 action plans.

4.3. The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

This information is shared with local commissioners via LMNS organised meetings. The information is also shared with Trust Board in accordance with MIS Year 7 requirements.

5. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas for March 2025

	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

Considerable work has been undertaken to ensure that the rosters reflect the staff needed for each shift to gain assurance that the planned vs actuals give the accurate picture

6. Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

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

7. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives.

There are currently 28.4 specialist midwives, out of 256.1 WTE RM's and RN's, representing 11.1% of the total.

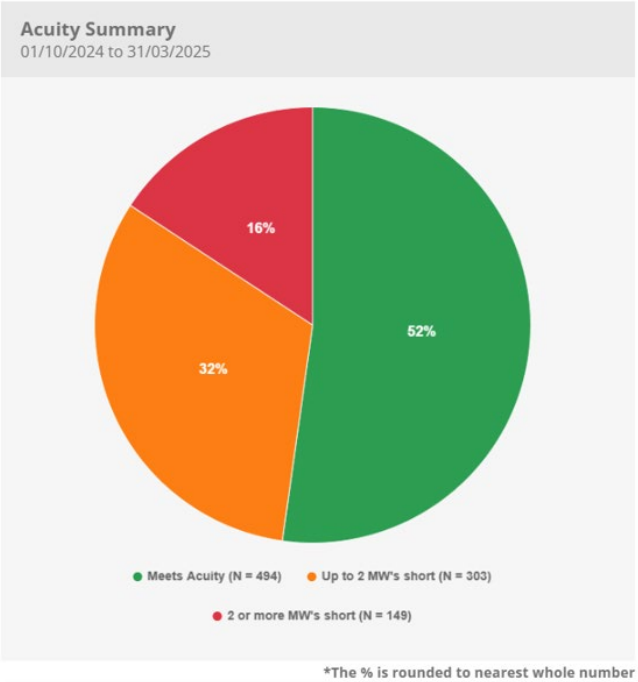
8. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool is implemented in the intrapartum areas and other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing toolkit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

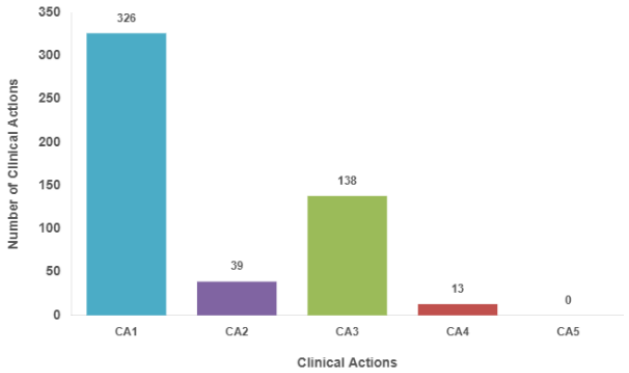
This chart below demonstrates the outcomes of the TWH Delivery Suite acuity tool records for October 2024 – March 2025, showing recommended staffing levels were achieved for 52% of entries, 32% of entries show up to 2 midwives' shortfall and 16% more than 2 midwives short, with an entry compliance rate of 86.63%.



The actions to be taken in periods of high acuity to support safe staffing are laid out in the Maternity Escalation policy published in May 2025.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

Number of Clinical Actions
01/10/2024 to 31/03/2025

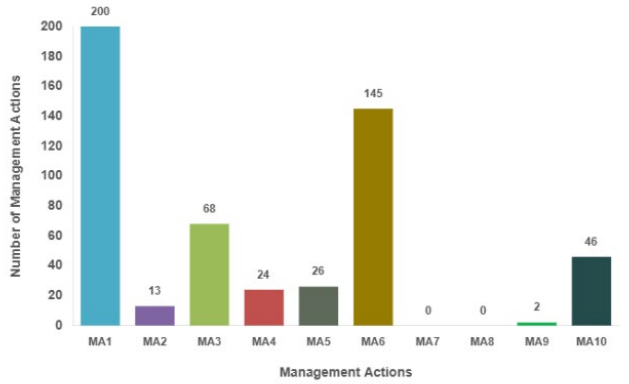


Number of Clinical Actions
01/10/2024 to 31/03/2025

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay of more than 4 hours for ARM/ Augmentation	326	63%
CA2	Delay in Commencing IOL	39	8%
CA3	Delay In Continuing IOL	138	27%
CA4	Delay In Elective LSCS	13	3%
CA5	Refusal of In-Utero Transfers Due To Acuity	0	0%
TOTAL		516	

*The % is rounded to nearest whole number

Number of Management Actions
01/10/2024 to 31/03/2025



Number of Management Actions
01/10/2024 to 31/03/2025

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeply Staff Internally	200	38%
MA2	Redeploy Staff Externally	13	2%
MA3	Staff Unable To Take Breaks	68	13%
MA4	Staff Stayed Beyond Rostered Hours	24	5%
MA5	Management/ Specialists Working Clinically	26	5%
MA6	Instigate Escalation Policy	145	28%
MA7	Cancel Study days	0	0%
MA8	Cancel Meetings	0	0%
MA9	Transfer To Neighbouring Sites	2	0%
MA10	On call Midwives Utilised	46	9%
TOTAL		524	

*The % is rounded to nearest whole number

This data demonstrates the challenge with our induction of labour pathway, which is subject to ongoing improvement work. This work includes implementation of NICE Guidance of 41 weeks for post-dates induction, streamlining of postnatal discharges, ongoing prospective audit for risk assessment and escalation for women experiencing delays in induction of labour. An improving trend in IOL delay times is noted during the period October 2024 to March 2025.

8. Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following table outlines the compliance by month. This data is extracted from daily MOPEL status report. Any occurrence of a breach of coordinator status will be recorded on InPhase.

	Compliance
October 2024	100%
November 2024	100%
December 2024	100%
January 2025	100%
February 2025	100%
March 2025	100%

9. One to One Care in Established Labour

Women and birthing people in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a ‘normal’ vaginal birth without interventions and will contribute to reducing

both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

	Compliance
October 2024	100%
November 2024	99.7%
December 2024	100%
January 2025	100%
February 2025	100%
March 2025	100%

Action plan approved for one incident of non-one to one care in labour in November 2024.

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). Red flags are collected through the live Birth Rate Plus acuity tool. Midwifery red flags are monitored and incident reports submitted where applicable in order to identify and minimise any associated risks. Red flags are dealt with dynamically in real time; once a red flag is identified, the coordinator will notify the Care pathway coordinator who will attempt to solve the issue. If this is not possible then the Operational Matron will review and apply further escalation measures. Out of hours this will be undertaken by the Manager on call. This process allows for quick identification of red flag issues and the opportunity for them to be resolved in a timely manner.

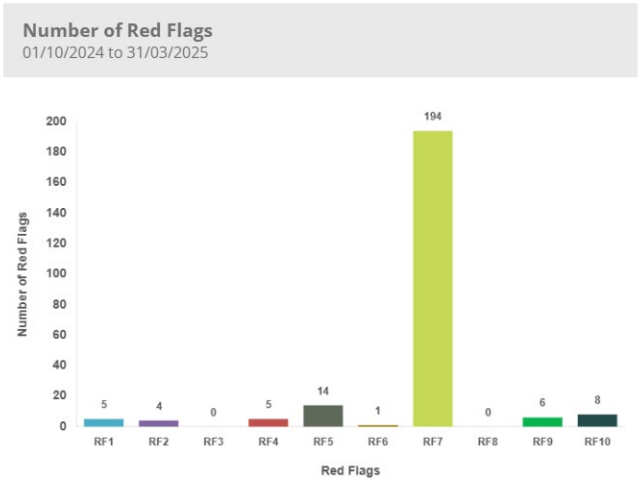
Number of Red Flags recorded
01/10/2024 to 31/03/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity-ie CAT 1 C/S time breached	5	2%
RF2	Missed or delayed care (for example delay over 60 min in suturing)	4	2%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	5	2%
RF5	Delay in being transferred to DS from Triage	14	6%
RF6	Full clinical examination not carried out when presenting in labour	1	0%
RF7	Induction waiting to come in from Antenatal ward/ home	194	82%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	6	3%
RF10	Missed routine observations on mother or baby	8	3%
TOTAL		237	

*The % is rounded to nearest whole number

Note that five incidents relating to non-one to one care in labour were reported on BR+ in October 2024. However, following review of cases it was noted these were recording errors and guidance was provided to staff on how to complete the tool appropriately.

One incident of non-one to one care in labour in November was reported and an action plan completed.



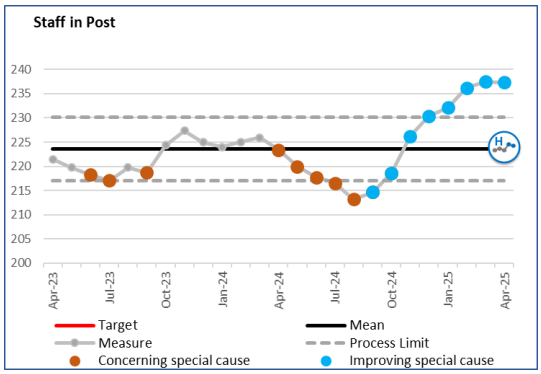
As above, this data demonstrates the challenge with our induction of labour pathway. An update on improvement work relating to this detailed above.

11. Midwifery Vacancy and Recruitment

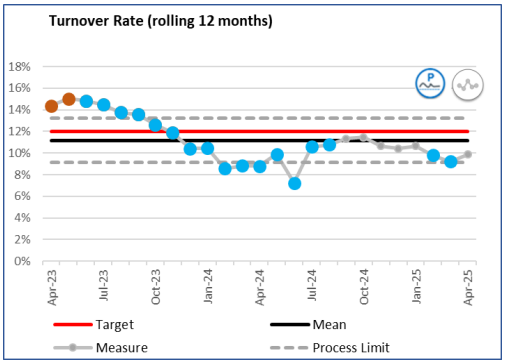
The table below present the current workforce position of Nursing and Midwifery registered staff group as at March 2025.

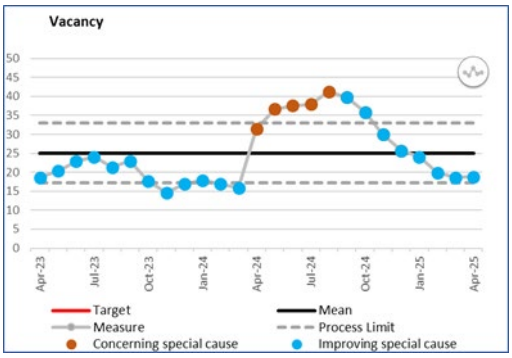
Staff Group	Budget WTE	Staff In Post	Vacancy	Vac. Rate	Turnover	Sick Rate
Nursing and Midwifery Registered	**256.1**	**237.4**	**18.8**	**7.3%**	**9.2%**	**3.7%**

The data shows a positive trend in the nursing and midwifery workforce, as we have been successful in increasing the number of registered staff and reducing the number of open positions through a targeted recruitment campaign.

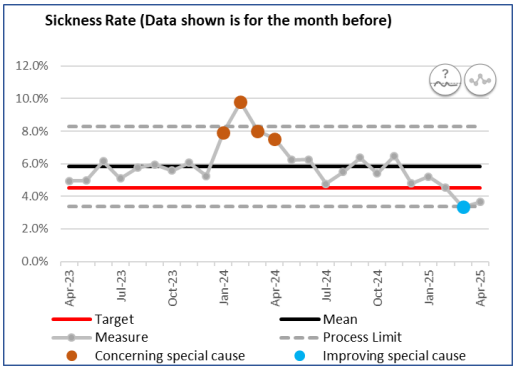


By successfully recruiting into substantive positions as well as retaining staff, we have also experienced a positive decrease in our turnover (from 11.3% to 9.2%) and vacancy rates (from 15.6% to 7.3%) in comparison to our previous submission.





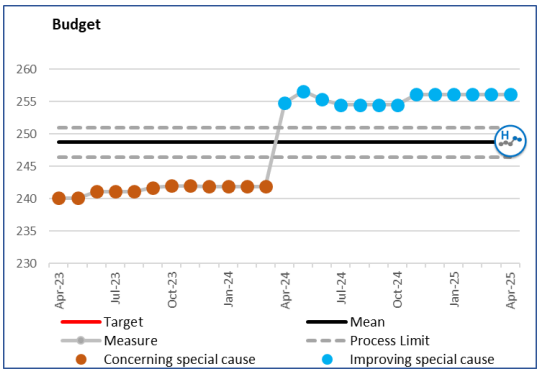
An increase in the substantive workforce has demonstrably reduced sickness absence rates. A decrease from 6.4% to 3.7% indicates a positive impact, suggesting more staff availability supports a healthier workplace.



The Maternity workforce model and ongoing improvement initiatives continue, aiming to ensure adequate staff and capacity within maternity services. The includes some new positions such as the Workforce Lead and EQI Lead for Maternity Services.

11.1 Current Recruitment Pipeline

Current recruitment projections show an improving trend with vacancy rates predicted to continue to fall during the next quarter.



12. Obstetric staffing

Consultants:

Funded posts WTE	SIP WTE	Mitigation	Next Steps
19	15	3 x Fixed Term	2 New Posts approved: 1 x Fetal Medicine 2 x General Gynae

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. At MTW consultant attendance is monitored monthly, and findings are shared with the Trust Board and the LMNS. Any incidents of non-attendance are reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. A formal three month audit will also be presented to Trust Board later in the Year in accordance with MIS Year 7 requirements.

2024-25	Consultant attendance at clinical scenarios (RCOG)
October	100%
November	100%
December	88.9%
January	100%

February	100%
March	90.9%

The Trust has implemented the RCOG guidance on engagement of long and short-term locums and use of locums is recorded locally to provide evidence and assurance of compliance. Data is reported monthly to the Women's Directorate meeting and then via PQSM to the Maternity and Neonatal Care Oversight Group (MNCOG). The Board Safety Champions and LMNS both attend MNCOG.

The RCOG guidance was used to develop the attached SOP which was implemented in January 2024. A tracker is used by the Directorate to collate the data and ensure evidence is collected.

SOP - Medical Agency and Internal

NEW Gynae locum tracker.xlsx

The RCOG guidance for non-resident consultants and senior Speciality and Specialist (SAS) doctors has been implemented. Compliance is monitored and data is reported monthly to the Women's Directorate Board and then via PQSM to the Maternity and Neonatal Care Oversight Group (MNCOG).

13. Anaesthetic staffing

For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. 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. (ACSA standard 1.7.2.1).

There is 24h anaesthetic cover for Obstetrics. The allocated anaesthetist does not have any additional duties other than cover in obstetrics/delivery suite (they do not cover elective obstetrics):

Month	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
% compliance	100%	100%	100%	100%	100%	100%

14. Neonatal medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements were not met in previous years, then action plans were developed to address any shortfall. In Year 7 of the Scheme, the Trust Board should receive updates on progress against any previously developed action plans. These should also be monitored via a risk register.

Junior Medical Staffing - compliant with BAPM standards and form part of the paediatric and neonatal formal rota

Neonatal Consultants – The paediatric and neonatal rota are now separated and currently permanent Neonatal consultants work to a 1:6 rota, with a 1:7 rota required to meet BAPM standards. As per the action plan presented in Year 6 of the Scheme, a business case is in progress to increase to a 1:7 rota to match updated BAPM standards from 2025.

15. Neonatal nursing staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

- The Neonatal unit does not currently meet BAPM standards for nurse staffing and this is demonstrated in the PQSM report and an action plan is in place to support the staffing gap. Recruitment of QIS trained staff remains a priority with improved cover for QIS currently being maintained above BAPM requirements utilising specialist agency and bank staff.

- Safe staffing reviews in place yearly for the neonatal unit with trust leads. Workforce dashboards reviewed and submitted. Funding approved following last year's safe staffing review for Band 7 Supernumerary Shift leaders with a phased approach. We have commenced interviews with substantial support from HR and Recruitment teams to optimise applications for these band 7 coordinator roles We have recruited into 4 of the 5 posts and have commenced the supernumerary nurses on day shifts, moving to all shifts as staff come into post. In April 2025 28.5% of shifts had a supernumerary team leader, this has increased from 17.7% in March 2025.

- There is a national shortage of QIS (Qualified in Speciality Nurses) and despite extensive recruitment efforts this remains challenging with an action plan place for substantive and bank/ agency recruitment. The agency recruitment has been successful and we now have QIS trained staff available to support a line of work for maternity leave and long-term sick leave from May 2025

- MTW run a formal programme for QIS trained staff with a minimum of two nurses on the course at any one time. ODN Funding now agreed to support supernumerary shifts to encourage competency sign off for those nurses on their QIS course to optimise development

- Nurse staffing (detailed in April 2025 Data) 57.9% of the total nursing workforce is Qualified in Speciality (QIS) against a national target of 70%. Utilising bank and agency as mitigation 76.2% compliance was achieved to support the unit. Further business case under development for band 6 staffing increase – short term we have increased the bank and agency availability for QIS staff with 9 additional QIS staff now available on agency lines and further work is ongoing on this.

April 2025	% of shifts QIS to toolkit	% of shifts with supernumerary shift leader	
MTW	**57.9% substantive** **76.2% with mitigation**	**28.5%**	**Mitigation to support unit in place utilising bank and agency staff with QIS qualification**
National Comparison (Level 2 units)	**74.06**	**61.32**	**70% BAPM recommended target**

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)

The neonatal safe staffing review occurs yearly and the action plan for staffing workforce tool is shared with the ODN on a quarterly basis

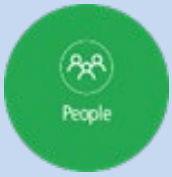
16. Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes that is has reviewed progress against action plans to ensure BAPM compliant staffing levels are met.

17. Action Plan for Maternity Incentive Scheme, Safety Action 4

Recommendation	Action	Owner	Timeframe	Update
Neonatal Medical Staffing				
Need to move from 1:7 to 1:6 rota	A business case is in progress to secure the funding for an extra WTE consultant post	AL	June 2025	Awaiting finalisation of budgets to confirm move to 1:7 rota.
Neonatal Nursing Staffing				
Does not meet BAPM standards	Recruit band 7 coordinator - roles are currently out to advert	LM/JT	September 2025	Funding approved following last year's safe staffing review for Band 7 Supernumerary Shift leaders with a phased approach. 4 out of 5 recruited so far.
	A business case is in progress to include funding for posts which have not been approved previously	LM/JT		Complete. Funding approved following last year's safe staffing review for Band 7 Supernumerary Shift leaders with a phased approach.
	There are currently two nurses waiting for QIS results and two further started the course this September	LM/JT		Complete. MTW run a formal programme for QIS trained staff with a minimum of two nurses on the course at any one time. ODN Funding now agreed to support supernumerary shifts to encourage competency sign off for those nurses on their QIS course to optimise development

Title of report	**SIRO report**					
Board / Committee	**Trust Board**					
Date of meeting	26th June 2025					
Agenda item no.	06-20					
Executive lead	Rachel Jones					
Presenter	Rachel Jones					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	x	***Information***	☐

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

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The purpose of this paper is to provide the Board with assurance that the Trust has robust Information Governance processes and frameworks in place that support the delivery of safe, high quality care enabling the Trust to act within the extent and limitations of its powers in relation to information and data and that identified risks are being properly managed.		
Any items for formal escalation / decision	None		
Appendices attached	SIRO report attached		
Report previously presented to:			
Committee / Group		Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	
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 • Information Governance

If you need any help with your coversheet, please feel free to contact the Committee secretary who

will assist.

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST MANAGEMENT EXECUTIVE – April 2025

SIRO ANNUAL REPORT **PRESENTER (RACHEL JONES)**

1. Background and Scope

There is a range of legal and professional obligations that limit, permit, prohibit, require or set out conditions in relation to the management, use and disclosure of information.

Information Governance covers all processing of data including the collection, retention, use, access to and decommissioning of information and data.

The purpose of this paper is to provide the Board with assurance that the Trust has robust Information Governance processes and frameworks in place that support the delivery of safe, high quality care enabling the Trust to act within the extent and limitations of its powers in relation to information and data and that identified risks are being properly managed.

2. Board Assurance

Assurance is provided by application of the following key points:

- An annual Data Security and Protection Toolkit Cyber Assessment Framework (DSPT-CAF) must be published for review by NHS England, commissioners and care partners, CQC and the Information Commissioner.
- A Senior Information Risk Owner (SIRO) must be appointed to take responsibility for managing the organisation's approach to information risks and to update the Board regularly on information risk issues. In MTW this role is fulfilled currently by the Director of Strategy, Planning and Partnership.
- A Caldicott Guardian, a senior clinician, must be appointed to advise the Board and the organisation on confidentiality and information sharing issues. In MTW this role is fulfilled currently by the Medical Director supported by a Deputy Caldicott Guardian, currently Consultant in Emergency Medicine.
- A Data Protection Officer (DPO), must be appointed who must be independent and report to the highest management level. The role of the DPO is to assist with the monitoring of internal compliance, advise on data protection obligations, provide advice regarding Data Protection Impact Assessments and act as a contact point for data subjects and the Information Commissioner's Office. In MTW this role is fulfilled currently by the Head of Information Governance and ICT Risk Management (Cyber Security).
- Appropriate annual IG training is mandatory for all staff who have access to personal data with additional training for all those in key roles. The Trust is required to maintain that 85% of staff have received training in the 12-month period. As at 01 April the Trust achieved 87.6% training compliance.
- Details of incidents involving cyber security, loss of personal data or breach of confidentiality must be published in annual reports and reported through the DSPT reporting tool
- All employees of the Trust have Information Governance responsibility detailed within their job description
- There is wide engagement with the Information Governance agenda throughout the Trust
- A wide range of Information Governance policies and procedures have been developed and are regularly reviewed and updated.
- Security issues related to confidentiality, integrity and availability of data are increasing. The Trust is registered with NHS England's TISP 'Respond to an NHS Cyber Alert' service and is a member of the FutureNHS Collaboration community, Cyber Associates Network (CAN)

3. Information Governance Committee

The Information Governance Committee (IGC) is chaired by the Senior Information Risk Owner and meets bi-monthly. The committee membership has wide representation from Divisions and Directorates across the Trust.

The IGC is a sub-committee of the Trust Executive Team Management and has the following sub-groups:

- Cyber Security Group
- Data Quality Steering Group
- Health Records Committee
- Core System Managers Forum (Information Asset Owners / Administration Group)

The key responsibilities of the IGC are:

- Aid the SIRO, Caldicott Guardian and DPO in the performance of their duties.
- To provide assurance that the Trust is compliant with the 19 policy statements detailed in the Information Governance Standards Framework – January 2023 ISB1512
- To ensure that the Trust is compliant with the requirements of the annual DSPT-CAF across the Data Security Standards.
- To agree the DSPT return prior to approval by the Trust Board, in line with the timetable issued each year.
- To seek external assurance on the quality and validity of the DSPT submission.
- To monitor progress in programmes to achieve compliance/certification with Cyber Essentials Plus.
- To establish an Information Governance improvement plan, secure the relevant resources and monitor implementation of the plan.
- To receive and consider reports into breaches of confidentiality and security and where appropriate undertake or recommend remedial action and when appropriate recommend declaration of a Serious Untoward Incident and participate in investigations.
- To review and develop the Trust's Freedom of Information publication scheme and review performance
- To ensure the Trust's compliance in relation to Data Subject Access Requests
- To ensure that the Trust undertakes or commissions annual assessments and audits of its Information Governance policies, procedures and arrangements.
- To liaise with other Trust groups/committees through work programmes in order to promote Information Governance and good practice.
- To promote a Trust wide culture that information governance is the responsibility of every member of staff and to promote learning that arises out of investigations into breaches in IG.
- To monitor the provision and uptake of training provided to support effective information governance to the Trust.
- To maintain the mandatory requirement of 90% of staff trained in Information Governance, reported annually via the DSPT.
- To ensure that staff are trained in Information Governance, comply with and understand the consequences of not adhering to Trust Information Governance and related policies.
- To keep abreast of national initiatives and development of policy and changes in legislation.
- To maintain IG risks and issues log and discuss as a regular standard agenda item.
- To assist the SIRO in producing appropriate information for Board level reports and in the preparation of an Annual Report.
- To ensure the Trust develops and maintains an appropriate framework for the management and protection of information which is appropriately supported by information asset owners and administrators.
- To ensure a register of all major Information Assets is established and maintained with responsibility or 'ownership' for each asset assigned to an Information Asset Owner. Lesser information assets should be managed through local policy and procedure.
- To receive reports of audits and monitoring of issues pertaining to Information Governance,

including Data Protection Impact Assessments and review progress against action plans as appropriate.
- To ensure that information sharing protocols are in place with organisation with whom to Trust routinely and regularly shares personal information.
- To ensure full and effective liaison with all external organisation such as the Information Commissioner's Office (ICO), Care Quality Commission, NHS England, NHS Digital and other local Trusts and relevant partner organisations.

Key Performance Indicators routinely monitored by the committee include:
- Data Security and Information Governance breaches
- Freedom of Information Requests
- Subject Access and 3rd Party Information Requests
- IG Training status
- Cyber Security Threat Analysis

4. **Horizon Scanning**

Digital transformation continues at pace under the NHS England Transformation Team. This work will see the adoption and development of AI technologies, of robotic processing and greater use software as a service, and Smart technologies to further transform health and care services enabling them to be delivered flexibly, remotely and with the provision of better information which will cross organisational boundaries and that will require robust governance arrangements and processes to be fully embedded.

The governance structures already in place as outlined in the Trust Digital and Data Strategy will enable the Trust to continue to meet its statutory and regulatory obligations.

5. Assurance

Data Security and Protection Toolkit – Cyber Assessment Framework
This aims to provide assurance in relation to the five objective areas set out by NHS England:

- Managing Risk
- Protecting against cyber-attack and data breaches
- Detecting Cyber security events
- Minimising the impact of incidents
- Using and sharing information appropriately

As part of our ongoing commitment to data security and governance, the Trust acknowledges the transition from the Data Security and Protection Toolkit (DSPT) to the Data Security Protection Toolkit - Cyber Assessment Framework (DSPT-CAF). This change aligns with evolving national standards and best practices to further enhance the security and resilience of our data and systems. All organisations that have access to NHS patient data and systems are required use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The new DSPT-CAF introduces a more structured and risk-based approach to assessing our cybersecurity measures, ensuring compliance with NHS and regulatory requirements. The Team are actively working to integrate these changes into our policies and procedures, reinforcing our commitment to safeguarding patient and organisational data.

We will continue to monitor developments and maintain transparency in reporting our progress, ensuring that data security remains a top priority within our quality improvement initiatives.

The deadline for the 2024/25 DSPT-CAF is 30th June 2025. The Trust continues with its preparations for the submission and has requested TIAA complete an independent audit of the evidence gathered by the Trust

to support its submission.

In order to provide further assurance that the organisation has in place effective data security and information governance controls and processes as directed by the DSPT - CAF, TIAA were requested to undertake an independent audit of the organisation's DSPT-CAF.

The TIAA review will adopt a one stage approach and follow the DSPT Independent Assessment Framework and Guidance published by NHS England. TIAA will review 8 mandatory assertions and 4 voluntary assertions. The overall conclusions from the TIAA report will be provided in due course ahead of submission.

Cyber Security

The financial year 2024/25 has seen a significant increase in cyber security related incidents affecting the NHS, including several high-profile attacks. These incidents have made it clear that one of the biggest cybersecurity risks to MTW is supply chain and third-party providers.

One of the more serious incidents involved Synnovis, a critical supplier of pathology services to several NHS trusts, including MTW. This highlighted the importance of thorough due diligence and ongoing monitoring of third-party suppliers as wells as robust business continuity arrangements to support any loss of service. As a result, MTW has procured a service from Core to Cloud, enabling regular and proactive cybersecurity monitoring and review of the Trusts top 25 clinical system providers.

There have also been several direct attacks on NHS trusts in recent months, necessitating the temporary offline status of their IT infrastructure. In each of these instances, the MTW Cyber Security team has analysed key details and lessons learned, reviewing them against our own configurations to ensure adherence to best practices and to prevent any potential future attacks on MTW infrastructure.

The Cyber Security team has been working collaboratively with other teams and departments to ensure our systems remain supported, regularly reviewed, and patched against known vulnerabilities. Additionally, we now assess all new systems before procurement and implementation. This combined effort has significantly reduced the overall cybersecurity risk to the Trust.

Data Quality

The Data Quality Steering Group was established as a sub group of the Information Governance Committee. The purpose of the Group is to ensure that the quality of all data held and used by the Trust meets any relevant national standards, local and contractual requirements and ensure that all clinical and corporate divisions and individual users are engaged and focused on improving Data Quality in accordance with the Trust's Data Quality Policy.

The group will oversee:

- The development of a new Data Quality Strategy and delivery of an implementation plan.
- A baseline assessment of data quality within the trust to identify areas of weakness.
- The collation of evidence for relevant DSPT - CAF requirements and the implementation of any action plans to improve compliance.
- Compliance with the Data Quality Improvement Plan within Schedule 6 of the contracts held by the Trust.
- Adherence to national, local and contractual data quality standards.
- Provision of assurance relating to the robustness of the data used corporately and clinically for decision making through the use of data quality 'kite marks'.
- The completion of any internal and / or external audit recommendations relevant to data quality.

Information Governance Incidents

Eight incidents occurred in the year 1st April 2024 – 31st March 2025, the detail of which triggered the use of the Data Security and Protection Incident Reporting Tool.

Reference	What happened
40128**	Unauthorised access to Trust Security Office and CCTV system.
40066**	Theft of a laptop and documentation from vehicle.
39135*	Anonymous report of patient data found in the street.
38477**	A data subject access request (DSAR) was disclosed to a patient containing pathology reports relating to 592 other patients.
37861**	Theft of a laptop, dictaphone and documentation from vehicle.
37186***	Reported purge of radiology data due to capacity limit being hit. All imaging identified as 'image exchange' from other care providers has been deleted. (approx. 1.4TB of data) this relates to 8042 images.
37009**	A member of staff has inappropriately accessed a patient record, who is also a member of staff.
36803**	An email from the Local Authority Social Care Team was printed and place in the patient's hand held maternity noted. The content of the email was not intended for sharing with the patient directly. The email contained highly sensitive planning information relating to ongoing plans for care.

Reporting Threshold
*Not reportable
**ICO Reportable
***DHSC, NHSE, ICO

Six of the above incidents met the threshold for notification to the ICO and the Trust was required to provide further detail of the incident and actions taken by the Trust. On reviewing the cases the ICO considered the actions that the Trust had taken, made recommendations for further action which have been implemented and the cases were closed. *

One of the above incidents met the threshold for reporting to the Department of Health and Social Care, NHS England and ICO. On review of the incident, all relevant authorities were satisfied with the actions taken by the Trust and the case closed with no further actions or recommendations made. **

Each of the incidents has been subject to the Trust internal incident investigation process whereby root causes are identified and remedial actions detailed and implemented.

The IG Committee receives a report at each meeting of all IG incidents reported on the InPhase reporting system for the relevant period. The committee discusses trends identified and possible actions that may be taken to prevent recurrence of incidents.

Information Risks
The Trust is migrating locally held risk registers to the central risk register within InPhase. All Information Governance and Cyber Security risks have been added, reviewed and updated accordingly.

All Directorates and Departments review their Business Continuity Plans annually to ensure they have been updated to reflect to Trust's ongoing journey to a paper-light environment.

A regional cyber security table top exercise is being hosted at Maidstone Hospital on Monday 12th May by the NHS England Regional Cyber Security Lead. This will bring together colleagues from across the Kent and Medway ICS to robustly test business continuity and resilience plans.

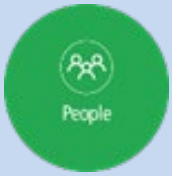
Which Committees have reviewed the information prior to ETM submission?

- Information Governance Committee (May 2025)

Reason for receipt at the ETM (decision, discussion, information, assurance etc.)

This report is provided to the ETM for assurance purposes.

Title of report	**Data Security and Protection Toolkit – Cyber Assessment Framework**					
Board / Committee	**Trust Board**					
Date of meeting	26th June 2025					
Agenda item no.	06-21					
Executive lead	Rachel Jones					
Presenter	Rachel Jones and Gemma Stephenson					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The 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. This includes mapping essential functions to the systems that support them and identifying cyber security gaps. The assessment informs our improvement plan and supports compliance, risk management, and operational resilience. The Trust Board is asked to note the requirement, support completion, and oversee ongoing cyber security governance.
Any items for formal escalation / decision	Note the requirement for Board approval prior to submission in June 2025.
Appendices attached	• Appendix A – DSPT – CAF Audit Committee Report • Appendix B – Draft TIAA 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: •
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 •

Maidstone and Tunbridge Wells NHS
NHS Trust

Audit Committee – 15th May 2025

PRESENTERS:

RACHEL JONES
EXECUTIVE DIRECTOR STRATEGY, PLANNING AND PARTNERSHIPS (SIRO)

GEMMA STEPHENSON
HEAD OF INFORMATION GOVERNANCE, TRUST DATA PROTECTION OFFICER (DPO)

The enclosed report provides an update and further detail in relation to the annual submission of the Data Security and Protection Toolkit – Cyber Assessment Framework.

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

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

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

1. **Purpose:**
   This report provides an update to the Audit Committee on the NHS Trust's obligations regarding the Data Security and Protection Toolkit (DSPT) submission, with particular focus on the newly added requirement to complete the Cyber Assessment Framework (CAF) in alignment with national guidance issued by NHS England.

2. **Background:**
   The Data Security and Protection Toolkit (DSPT) is the mandated annual self-assessment tool for all NHS organisations to demonstrate compliance with data protection and cyber security standards, including the 10 Data Security Standards defined by the National Data Guardian (NDG).

   As part of evolving cyber security governance arrangements and in response to the increasing threat landscape, NHS England now requires all Trusts classified as operators of essential services (OES) under the Network and Information Systems (NIS) Regulations 2018 to complete and submit a Cyber Assessment Framework (CAF).

   The Cyber Assessment Framework (CAF) is a structured methodology developed by the National Cyber Security Centre (NCSC) and adapted for the health and care sector. It supports NHS Trusts in evaluating the adequacy of their cyber security posture. Now aligned within the DSPT, the newly named DSPT-CAF measures organisations against five key objectives:

   - Managing Security Risk
   - Protecting Against Cyber Attack
   - Detecting Cyber Security Events
   - Minimising the Impact of Cyber Security Incidents
   - Using and Sharing Information Appropriately

   Each objective is supported by multiple contributing outcomes and indicators of good practice.

   Previously, the Trust submitted a 'Standard Met' status in 2023 – 2024 across the 10 data security standard areas. The newly aligned DSPT-CAF requires Trusts to assess their maturity across the five areas and determine their status against an Achieved, Partially Achieved, or Not Achieved status.

3. **Key Requirements:**

   DSPT-CAF Baseline Submission:
   Trusts must assess their current data security and cyber security maturity across the key objectives and submit a baseline assessment annually.

   The Trust baseline was submitted in December 2024 as 'Partially Achieved'.

   Essential Function Mapping:
   Trusts must identify and document essential clinical and operational functions, along with the digital systems and assets that support them.

The mapping of essential functions has enabled the Trust to identify any areas for improvement ahead of formal submission and will sit alongside an action plan for continued improvement to fully achieved status.

Action Plan:
Identified gaps must inform an action and improvement plan, governed through the IG Committee and overseen by the SIRO.

On completion of the independent audit conducted by TIAA, the action and improvement plan will become a standing agenda item at IG Committee for managing and oversight. This will include recommendations identified by the internal gap analysis as we as any recommendations made by TIAA in order to improve our compliance position.

Governance:
The DSPT-CAF must be reviewed and signed off by the SIRO and Trust Board prior to submission. NHS England may request evidence or conduct validation of this.

The submission report and independent audit report provided by TIAA will be will be returned to Audit Committee and the Finance and Performance Committee prior to presentation to Trust Board in June.

The deadline for the 2024/25 submission is the 30th June 2025.

4. Next Steps:

- Finalise the TIAA external audit and address any recommendations
- Report back to the Audit Committee with findings and planned actions and improvements
- Report to the Trust Board for approval to complete the submission

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting (Part 2) – 26th June 2025

PRESENTER:
RACHEL JONES
EXECUTIVE DIRECTOR STRATEGY, PLANNING AND PARTNERSHIPS (SIRO)
GEMMA STEPHENSON
TRUST DATA PROTECTION OFFICER

Purpose:
To inform the Board of the requirement to submit the annual Data Security and Protection Toolkit (DSPT) return for Maidstone and Tunbridge Wells NHS Trust, provide assurance on progress towards compliance, and seek support for submission at "Standards Met" status by the deadline of 30 June 2025.

Which Committees have reviewed the information prior to Board submission?
- Audit Committee
- Information Governance Committee

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

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

Background:
NHS Trusts are required to complete the DSPT annually to confirm compliance with:

- The UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018
- The National Data Guardian's 10 Data Security Standards
- The NHS Standard Contract
- Cyber resilience expectations set out by NHS England and the Cyber Assessment Framework (CAF)

The CAF, developed by the National Cyber Security Centre (NCSC), has been adopted by NHS England and is mandated for Trusts begin aligning their cyber security governance arrangements and assurance frameworks to the CAF, particularly across the key objective areas:

- Managing security risk
- Protecting against cyber attack
- Detecting cyber security events
- Minimising impact of cyber security incidents
- Using and Sharing Information appropriately

Action Taken:
A comprehensive review has been conducted by the Information Governance, Digital, and Cyber Security Teams. This has confirmed that the Trust can declare "Standards Met" status, based on the following assurances:

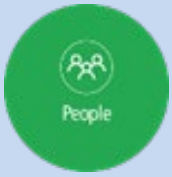
- All mandatory assertions have been assessed, and evidence has been collected to support compliance.
- The Trust has appropriate policies and procedures in place covering data protection, staff training, incident management, and business continuity.
- Cyber security controls have been reviewed and are being actively monitored through internal audit and IT governance frameworks.
- Completion of all mandatory DSPT evidence items
- Embedding of CAF-aligned controls in risk management, access controls, patching, incident response, and staff training
- No unresolved ICO-reportable incidents during the reporting period
- Independent validation of evidence through external auditing and oversight led by TIAA and the Trust Data Protection Officer

There remain 4 low-risk evidence items that are being finalised (see enclosed TIAA report), with action plans in place for the mandatory items to be completed prior to submission and remaining items due to be completed by the 31st July 2025.

Risk and Implications of Non-Submission:
Failure to submit the DSPT or to meet the "Standards Met" level may result in:
- Loss of access to essential national systems and services.
- Reputational damage.
- Increased regulatory scrutiny.
- Impact on the Trust's ability to bid for new services or participate in joint digital initiatives.

Recommendation:
The Board is asked to:
- Note the statutory requirement for DSPT submission by 30 June 2025.
- Acknowledge the internal assurance processes undertaken to evidence compliance.
- Support the submission of the DSPT return with a "Standards Met" status for 2024/25.
- Delegate authority to the SIRO to approve the final submission.

Title of report	**ICB & HCP update**					
Board / Committee	**Board**					
Date of meeting	26th June 2025					
Agenda item no.	06-16					
Executive lead	Rachel Jones. Director of Strategy, Planning and Partnerships					
Presenter	Rachel Jones. Director of Strategy, Planning and Partnerships					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	☐

Links to Strategic Themes (Please ☑ as appropriate)					
					
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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. Most activity is focused on the ICB Blueprint the design of the future HCP.		
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)	Please list any BAF Principal Risks to which this report relates: •
Links to Corporate Risk Register (CRR)	Please list any risks on the Corporate Risk Register to which this report relates •
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report •

NHS
Maidstone and Tunbridge Wells NHS Trust

University Hospitals Sussex NHS Foundation Trust

ICB and West Kent HCP update

June 2025

Exceptional people, outstanding care

ICB/ System news

- NHS Kent and Medway Integrated Care Board held a workshop on the K&M NHS Strategy Development on Monday 9th June which updated on the progress of the 4 agreed workstreams with a deep dive into Patient Experience, Access and Outcomes and Financial Sustainability.

- The ICB are focussed on Change 25 and developing their response to the ICB Blueprint.

- We await the revised National Performance Assessment Framework and the publication of the 10 year plan expected in the coming few weeks.

West Kent HCP

- The last West Kent Development Board took place on 15th May with the most recent executive meeting on 12th June.
- The focus remains on reviewing the ICB Blueprint and Neighbourhood Health guidance to design the future priorities and aligned workforce of the HCP.

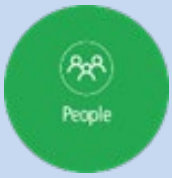
- The planned HCP quarterly Oversight Meeting has been stood down whilst we await the National Performance Assessment Framework

- Work continues on the HCP workplan with current focuses on:
  - Additional capacity Fund with the ICB
  - Better Use of Beds
  - Neighbourhood Health and Integrated Neighbourhood Team
  - GP out of hours

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	**Board Assurance Framework**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	26th June 2025					
Agenda item no.	06-24					
Executive lead	Annette Doherty, Chair of the Trust Board					
Presenter	Annette Doherty, Chair of the Trust Board					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The organisation's Board Assurance Framework (BAF) brings together in one place all the relevant information on risks to the Board's strategic objectives. The BAF reports on the most significant risks to the achievement of the organisation's six strategic objectives. Each BAF risk is owned by a member of the Executive Team and rated in accordance with the grading matrix set out at the end of this report. The Risk Owner ensures the controls, assurance, gaps and risk score reflect the management of the risk. A Trust Board Committee is also nominated to have oversight of each BAF risk will ensure that this is considered at each committee meeting.
Any items for formal escalation / decision	All Trust Board Committees have had regard to the BAF risks through the meetings.
Appendices attached	There are no appendices to this report

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

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: PR 1, PR 2, PR 3, PR 4, PR 5, PR 6
Links to Trust Risk Register (TRR)	ID 994, ID 791,ID 1301, ID 3186, ID 3124, ID 3125, ID 3109, ID 3130, ID 1211
Compliance / Regulatory Implications	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17, Good Governance

Board Assurance Framework

June 2025

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Board Assurance Framework (BAF)

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

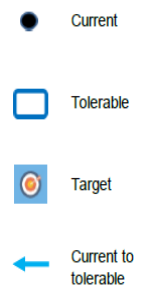
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify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

Likelihood score and descriptor

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

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

		Lead Director	Lead Committee	4	6	8	9	10	12	15	16	20	25	SRO Level of Assurance
PR1	Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer	Chief People Officer	People and OD			Target			Current					Limited ↔
PR2	If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes	Chief Medical Officer	Quality			Target				Current				Limited ↔
PR3	If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage	Chief Operating Officer	Finance and Performance	Target	Current									Adequate ↔
PR4	Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation.	Chief Nurse	Quality		Target		Current							Limited ↔
PR5	If we do not work effectively as a system, patients that are no longer fit to reside will remain within MTW for longer which may result in deterioration and poor clinical outcomes	Director of Strategy, Planning and Partnerships	tbc	Target						Current				Limited ↔
PR6	Failure to deliver the Trust financial plan resulting from the system being in financial recovery	Chief Finance Officer	Finance and Performance			Target					Current			Limited ↔



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	30/05/2025	**Risk rating**	12		8			
Last changed	30/05/2025	**Links to Trust Risk Register**	There are 43 risks on the Trust risk register in relation to the strategic theme of people. Trust-wide risks that link to and could specifically impact Principle Risk PR1 include: 3432 - NHSE Financial Sustainability requirements for 25/26 destabilising the workforce and impacting organisational performance. 3454 - Industrial Action concerning proposed pay awards for 25/26 that could adversely impact operations, performance, pressure on resources and staff workloads and morale, 3372 - Changes w.e.f 01/01/2025 to the UKBA eligibility criteria. 3116 – Flexible working implementation 3252 – Significant employee issues 994 - Our staff survey and WRES and WDES data demonstrate that our BAME and disabled communities have less opportunity at MTW (especially % representation of BAME (Global Majority) at band 8c+)					

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 and Ineffective workforce planning fails to deliver a diverse inclusive workforce with the capacity and capability to meet current and future Trust requirements	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 Executive led workstream in place to support Trust commitment to progressing the Equality, Diversity and Inclusion (EDI) agenda / achieving priority EDI objectives. Defined, organised and effective EDI governance structure and arrangements. Associate Director of EDI and resourced EDI Team supporting effective delivery of EDI Strategy Implementation Plans.	Evidenced in WRES data WDES data Succession planning goals and action plans shared with the Remuneration Committee Mechanisms in place to identify changes across external context / disproportionate impact (horizon scanning), to feed into strategic planning, e.g. through Staff Networks and ICB networks.	Board Succession Planning & Succession Committee Renumeration Committee Terms of Reference Executive Level / System Level leadership development	<u>Management</u> Board-approved EDI Strategy and 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 EDI training for Board of Directors and Governors – now completed. <u>Risk and Compliance</u> Risk reports WRES and WDES data National Staff Survey results and ongoing quarterly surveys	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 Workforce planning process aligned with annual business planning cycle, via Workforce Team reviewing Directorate Business Plans and identifying all known / planned workforce activity within them.	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	<u>Management</u> Monitoring of turnover Monitoring of Diversity being brought into the organisation Monitoring of numbers of staff promoted <u>Risk and Compliance</u> Risk reports WRES and WDES data Annual Workforce Plans submitted to ICB and NHSE– also used to inform training placements offered by Health Education England.	People and Organisation Development Strategy	
Insufficient staff resource, including Inability to retain staff due to market factors, compounded by national shortages across key areas of the workforce / impact of industrial action	NHS People Promise exemplar programme People and Organisation Development Strategy Strategic workforce plans Safe Staffing models, including: Safer Nursing care tool A&E Safer Nursing Care tool Midwifery interventions E-rostering systems in place and improvements eg Patchwork for Medical staff. Nursing and Midwifery eRoster Task and Finish Group in place with action plan to address governance issues identified in the internal audit report. Industrial Action Preparedness and Oversight Arrangements including implementation of Command Structure / Incident Control Centre.	Funding for the People promise programme is time limited People and OD Strategy expires in 2025 and needs a refresh, including re-alignment with NHS 10-year plan and 25/26 operational planning requirements from NHSE.	Staff leavers action plan including exit Interviews Retention planning including professional development Career development opportunities for those on internationally educated programs	<u>Management</u> 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 Safe Staffing models monitored by Chief Nurse. <u>Risk and Compliance</u> <u>Reporting of metrics to People and OD Committee.</u> <u>People Strategy Deep Dives at People and OD Committee</u> <u>Guardian of safe working hours annual report to People and OD Committee</u> <u>Use of existing staff and union consultative forums</u> <u>Independent assurance</u>: National Staff Survey results and ongoing quarterly surveys Well-led report CQC / Well-led Review	Embedding People Promise in the organisation Reporting to NHSE on progress Reinvigorated job planning, including Medical Job Planning Consistency Committee	

NHSE Financial Sustainability requirements for 25/26 will destabilise the workforce, resulting in poorer culture impacts such as staff anxiety, lower morale and a drop in organisational performance.	Trust Financial Improvement Programme Trust Transformation Programme that specifically considers people transformation Emphasising of Trust Health and Wellbeing Support and Partnership working with staff side and trade unions	Phasing approach being adopted to meet requirements by tight deadlines which do not consider future target operating model and strategic asks.	Trust approach focussing on corporate growth and admin and clerical roles initially, with further phases looking at clinical organisation design alongside target operating model Co-designing organisation design with managers and staff and consulting as appropriate Specific transformation workstreams considering employee experience and wellbeing as well as communications	Management Metrics monitored through the Integrated performance report reporting to the Board Monitoring of turnover 2025 Staff Survey results and ongoing quarterly surveys People risks and Occupational Health monitoring Risk and Compliance Reporting of metrics and feedback to Executive Team and People and OD Committee. Independent assurance: National Staff Survey results and ongoing quarterly surveys	Governance of Financial Improvement Programme and Transformation Programme	

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	Insert TBC
Lead director	Sara Mumford	**Consequence**	Moderate-3	Major-4	Major-4	**Risk appetite**	Cautious	
Initial date of assessment	11/01/2025	**Likelihood**	Almost certain-5	Possible-3	Unlikely-2			
Last reviewed	11/11/2024	**Risk rating**	15	12	8			
Last changed		**Links to Trust Risk Register**						

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

Strategic theme	**Patient Access**: Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome						
Principal risk	**PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage**					**SRO level of assurance**	Adequate ↔
Lead committee	Quality	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Access
Lead director	Sarah Davis	**Consequence**	Possible-1	Possible-3	Possible-3	**Risk appetite**	
Initial date of assessment	20/05/2024	**Likelihood**	Likely-5	Unlikely-2	Unlikely-2		
Last reviewed	24/04/25	**Risk rating**	5	6	6		
Last changed	24/02/25	**Links to Trust Risk Register**	791 – Failure to meet Referral to Treatment Targets (RTT)				

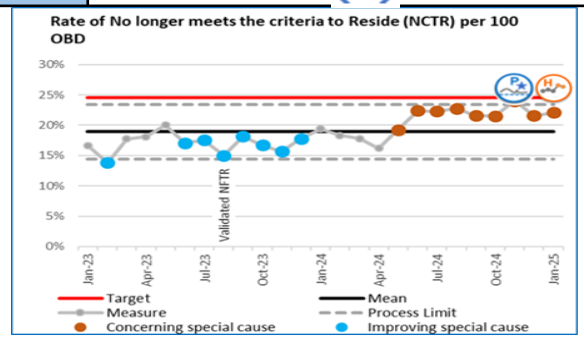
Strategic threat	**Primary risk controls**	**Gaps in control**	**Plans to improve control**	**Sources of assurance**	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Significant increases in demand for non-elective and cancer activity that results in poor patient experience and outcomes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

Insert TBC

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				Insert TBC

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

Strategic theme	**Systems and Partnerships**: Working with partners to provide the right care and support in the right place, at the right time						
Principal Risk	**PR 5:If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals.**					**SRO level of assurance**	Limited ↔
Lead committee	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 <u>Risk and Compliance</u> <u>Independent Assurance</u>	Community bed capacity is currently being reviewed by the ICB	

Strategic theme	**Sustainability**: Long term sustainable services providing high quality care through optimising the use of our resources						
Principal risk	**PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery**					**SRO level of assurance**	Limited
Lead committee	Finance and Performance	**Risk rating**	Current Exposure	Tolerable	Target	**Risk type**	Financial
Lead director	Chief Finance Officer	**Consequence**	Severe-4	Severe-4	Severe-4	**Risk appetite**	Open
Initial date of assessment	11/05/2025	**Likelihood**	Likely-4	Possible-3	Unlikely-2		
Last reviewed	11/11/2024	**Risk rating**	16	12	8		
Last changed		**Links to Trust Risk Register**	3109 – Failure to deliver Financial Plan including recurrent cost improvement programme for 24/25 3130 – Risk that the Trust will not be able to deliver its financial efficiency plan (CIP) 1211 – Trust wide capital equipment failure				Insert SPC

Strategic threat	Primary risk controls	Gaps in control	Plans to improve control	Sources of assurance	Gaps in assurance / actions to address gaps	Assurance rating
Failure to recurrently deliver our cost improvement programme will impact on the underlying financial position of the Trust	CIP programme in place and monitored on a regular basis CIP performance reported to Executive Team and Finance and Performance Committee in detail and Trust Board in summary on a monthly basis. 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 monthly with all Divisions, and with Executives as part of the Executive Team Meeting System wide savings schemes have central governance in place, with additional external support	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 delivered recurrently	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

	monthly with all Divisions, and with Executives as part of the Executive Team Meeting System wide savings schemes have central governance in place, with additional external support	delivered recurrently				
Failure to reduce the total pay spend (including reduction in corporate / back office pay spend) during 2025/26	Workforce Workstreams in place, focussing on the reduction of substantive, bank and agency spend. Workforce Transformation Team to co-ordinate and support pay spend reduction across the organisation in place. Monthly report to Executive Team, People and OD Committee, Finance and Performance Committee and Trust Board Targets have been set for reductions across the organisation. The financial consequences of these targets have been included within Divisional budgets	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 Temporary staffing will need to reduce further to hit the 40% agency reduction and 15% bank reduction necessary Bank spend has reduced at a slower rate than agency spend.	All Divisions and directorates have a target reduction in pay spend and WTE. Executive Led Vacancy Control panel is in place, on top of Divisional panels. A number of actions / controls on restricting the use of temporary staff have been introduced and remain in place	<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 <u>Risk and Compliance</u> A number of risks in relation to staffing have been included. <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	The Month 1 positions shows an overspend on total pay against budget – although some areas have underspent.	16

Risk that the need for investment in statutory and mandatory requirements, end of life equipment failures or regulatory interventions exceeds the capital available causing an impact on services	The Trust sets a capital programme at the start of the year to use the capital allocated it bearing in mind the prioritised risks and developments the Trust wants to invest in. The Trust runs a monthly capital steering group, which is a sub committee of the Executive Team. Capital expenditure is reported monthly to the Executive Team, Finance and Performance Committee and Trust Board The Trust reviews IFRS16 capitalised leases and lease impacts alongside traditional capital	The capital allocated to the Trust does not equate to the full generated depreciation (capped by NHSE) The Trust has always fully utilised its capital, however it has more calls on the capital programme than it has been able to service. A number of areas have now reached end of life, and could potentially fail at short notice The 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	The Trust is constructing a multi year view on its capital requirements which references risk, condition and age. Future annual capital programmes will need to have a higher weighting to replacement / renewal of infrastructure rather than new developments. The Trust will need to access ICS level capital for the replacement of certain assets or new developments (for example linear accelerators) 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	<u>Management</u> Integrated Performance Report, Trust capital position monthly reports, reports to the capital steering group Finance and Performance Committee meet monthly and provide assurance to the Board <u>Risk and Compliance</u> A number of risks in relation to capital replacement have been included. A number of deep dives at Quality Committee, Audit and Governance Committee and Finance and Performance Committee have highlighted these issues. <u>Independent Assurance</u> Capital is managed across the ICS by the K&M ICB. Capital plans and business cases are scrutinised by the K&M ICB Some issues are picked up and reviewed by Internal Audit regarding their efficacy.	The Trust currently does not have the multi year plan in place – this is under construction While the capital programme maybe insufficient, any capital slippage is prioritised against our risk rated list.	12

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	The Trust includes cash flow information in its monthly reporting to Executive Team, Finance and Performance Committee and Trust Board. Cash is managed using a weekly cashflow model that is shared within the finance team, with actions being taken accordingly 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	The Trust's planned financial position will place more stress on the cash position in the first 6 months of the financial year The Trust is adverse to plan in Month 1 creating more pressure on the cash position	Tactical working capital actions will support the cash position in the short term 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 Further, more detailed reporting to be presented to the Executive Team Meeting and the Trust Finance and Performance Committee meeting	<u>Management</u> Integrated Performance Report Finance and Performance Committee meet monthly and provide assurance to the Board <u>Risk and Compliance</u> The risk of our financial position on our cashflow is highlighted in the risk register <u>Independent Assurance</u> Any request for additional cash will be reviewed by NHSE and DHSC	The financial position of the organisation and the cash management position of the organisation are intrinsically linked. Following discussion with Execs and F&P, any additional actions will be incorporated	12

Risk Appetite

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

Key

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

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

5 x 5 Matrix

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

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

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