

Title of report	Report from the Chair of the Trust Board				
Board / Committee	Trust Board				
Date of meeting	Thursday 25 th September				
Agenda item no.	09-7				
Executive lead	Annette Doherty, Chair				
Presenter	Annette Doherty, Chair				
Report Purpose (Please ☒ one)	Action/Approval	☐	Discussion	☐	Information ☒

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

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chair’s Report for the September 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:

Following the Trust's recognition as one of the top performing acute trusts in the country in the new NHS England National Oversight Framework (NOF), I would like to congratulate and thank all Trust staff for their hard work in achieving this outcome. The NOF enables our patients and partners to understand how we are performing in key services, including urgent and emergency care and elective services, and our recent ranking demonstrates the outstanding care that our teams are delivering to local communities.

Over recent weeks I have continued to meet staff in wards and departments across the Trust, shadowing colleagues in their roles and learning more about their services. This has included visits to wards 21, 22 and the Acute Medical Unit at Tunbridge Wells Hospital and the Emergency Department and Acute Frailty Unit at Maidstone Hospital, where I've experienced first-hand the high-quality care our teams provide. I was also delighted to shadow Mr Oliver Wildman, Consultant Obstetrician and Gynaecologist, as he led an antenatal clinic. Mr Wildman became the new Clinical Director in the Women's Services, part of the Women's Children's and Sexual Health Division, last month.

Last week I was invited by Mr Haythem Ali, Consultant Surgeon and Clinical Director for Surgery, to observe robot-assisted surgery at Tunbridge Wells Hospital. It was a fantastic opportunity to witness how innovation is improving care. The Trust's use of surgical robots was recently featured in an ITV Meridian news special, which broadcast interviews with our surgery teams and footage of the technology being used to undertake gynaecology procedures.

I also attended the inaugural graduation ceremony of the first cohort of Kent and Medway Medical School (KMMS) students last week, who began their five-year course in 2020. The medical students undertook their third-year placements at MTW, participating in hands-on learning across our hospitals in a range of medical and surgical specialties. A collaboration between the University of Kent and Canterbury Christ Church University, KMMS aims to attract talented students from all backgrounds to Kent and Medway and offer opportunities to help transform the future of healthcare in the area.

Finally, the Trust Board Away Day was held yesterday, which covered topics including the NHS Provider Oversight Framework, the Strategic Deployment Review Process and further development of the Trust Strategy in light of the Government's 10-year health plan. We also officially welcomed our new Non-Executive Director, Lisa Thompson, who joined the Trust Board this month.

Lisa is a registered Speech and Language Therapist, and has a Master's degree in Healthcare Management. She has previously served as Director of Children and Young People's Services at Oxleas NHS Foundation Trust, where she provided strategic leadership for service delivery across three London boroughs. Lisa has led initiatives resulting in improved health and social care outcomes across the NHS, local authorities and voluntary organisations, and her vast experience in these areas will make her a valuable addition to our Board.

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
20 th August	Dr	Sahaj	Sethi	Emergency Medicine	2 nd November-TBC	New
20 th August	Dr	Pedro	Mondim	Emergency Medicine	1 st October-Confirmed	New

20 th August	Dr	Anna	Biscoe	Emergency Medicine	1 st October- TBC	New

Title of report	Report from the Chief Executive				
Board / Committee	Trust Board				
Date of meeting	25 th September 2025				
Agenda item no.	09-8				
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)					
 Patient experience	 Patient access	 Sustainability	 People	 Systems and partnerships	 Patient safety and clinical effectiveness
✓	✓	✓	✓	✓	✓

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

- MTW has been recognised as one of the top performing acute trusts in the country and placed in segment 1 of the new NHS Oversight Framework (NOF). The NOF is a tool which measures the performance of all trusts against a number of key metrics. These include waiting times for operations, cancer treatment, time spent in A&E, patient experience, patient safety and finance. These metrics are combined to give each organisation a rating of between 1 at the top, down to level 4. MTW has been assessed against these metrics for acute trusts and placed in the highest segment and ranked 12th out of all acute trusts in the country. This is a significant achievement which reflects the hard work, dedication, and skill shown across our organisation, and recognises our strength in performance, patient safety, leadership and governance. It is also good news for the communities we serve, as top performing trusts will benefit from greater freedom and investment to enhance and develop the services they provide. We look forward to working more closely with our partners across Kent and Medway, transforming services and supporting our staff to ensure patients receive the highest quality care.
- As you know trusts across the country are navigating a challenging financial landscape while continuing to prioritise patient care and staff wellbeing. Work continues on delivering the Trust's cost improvement programme for 2025/26. This totals £49 million, with £36.5m of this needing to be achieved through workforce-related savings. In line with a national focus on treating more patients, improving efficiencies and ensuring long term sustainability we are reviewing all services across the Trust to ensure we can deliver and continue to develop services in the coming years. We are engaging with colleagues and unions throughout this process and our priority remains the delivery of high-quality care to the communities we serve and supporting our staff.
- Following an inspection by the Care Quality Commission in October 2024, our Maternity service has been rated 'good' by the Care Quality Commission (CQC), meaning the Trust has improved by two rating levels since our previous inspection in August 2023. This significant upgrade has been made possible by the dedication of colleagues who have developed an extensive programme to address areas like management of post-partum haemorrhage, maternity triage processes and category 1 and 2 c-section waiting times. The CQC's new report recognised a range of improvements, including strengthened oversight and management of governance as well as a positive safety culture where incidents were investigated and learning was embedded to promote good practice and outcomes. The report also highlighted the routine monitoring of care and treatment to continuously improve outcomes for mothers and babies, with staff making sure people's care and treatment meet individual needs and preferences, harnessing a culture of kindness and compassion.
- Due to ongoing staffing shortages we have taken the difficult decision to temporarily pause births at Crowborough Birthing Centre from 2 October until May next year. Antenatal and postnatal services, including parent education classes and the Infant Feeding Café, will continue at the centre as normal. Each month between 10 and 20 babies are born at Crowborough Birthing Centre, around 30 are born at the Maidstone Birth Centre and more than 400 at Tunbridge Wells Hospital. While we know this will be disappointing news for the people who are affected, our priority is to provide safe, high-quality and reliable maternity care for families and we are working with partners across Kent and Sussex to look at how we deliver a long-term, sustainable service. We remain committed to ensuring women and birthing people have choice and our services at Tunbridge Wells Hospital and Maidstone Birth Centre, both of which offer high-quality midwifery-led care with access to birthing pools, reflect our dedication to personalised care which supports each person's preferences. Neighbouring facilities at other trusts are also available, including the Princess Royal Hospital at Haywards Heath and the Eastbourne Midwifery Unit at Eastbourne District General Hospital.
- The Kent and Medway Orthopaedic Centre (KMOC) at Maidstone Hospital has been accredited as an elective surgical hub by NHS England's Getting it Right First Time (GIRFT) programme. Run in collaboration with the Royal College of Surgeons of England, the accreditation scheme recognises and rewards excellence in operational management,

clinical standards and patient experience. The accreditation, which KMOC has gained less than a year since opening, confirms the centre is delivering safe and high-quality care to patients from across the region. Surgical hubs are an important part of the Government's plans to increase surgical capacity. To date, KMOC has already helped nearly 3,000 patients with life-changing surgery on bones, muscles and joints.

- The West Kent Community Diagnostic Centre (CDC) near Maidstone Hospital has been officially opened by Professor Sir Mike Richards, Chair of the Care Quality Commission. The CDC delivers a wide range of tests from two units; the Franklin Unit and the Hounsfield Unit. Named after Dr Rosalind Franklin, a key figure in the discovery of DNA's structure, the Franklin Unit (previously known as Unit A) opened in January 2024 and houses X-ray, DEXA, ultrasound, respiratory and cardiology testing. The Hounsfield Unit, which opened in March this year, houses CT, MRI and phlebotomy services, and was named after Godfrey Hounsfield, whose ground-breaking work led to the invention of the CT scanner.

The CDC serves around 149,000 patients annually, and has ranked among the top ten in England for test volume and third in the south east. By operating outside busy hospital settings, the CDC reduces waiting times, speeds up diagnoses and enables quicker treatment starts, while supporting the Government's 10-year-plan for the NHS which prioritises moving care into the community. Almost 98% of patients have rated the service at the CDC as 'excellent' or 'very good', with many mentioning speed of service, helpful staff and modern facilities in their feedback.

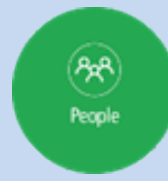
- We welcomed NHS England's Director for Elective Care, Cancer and Diagnostics, Mark Cubbon, to Maidstone Hospital last month, to see developments at the Trust including KMOC and the West Kent CDC. Mr Cubbon spoke with colleagues about the new technologies and innovations we are using to consistently achieve national cancer standards, which include upgraded equipment such as Halcyon radiotherapy machines that halve treatment times and the use of technology including capsule endoscopy. Mr Cubbon was also given a tour of KMOC to see the facilities that enable us to deliver approximately 2,000 extra planned orthopaedic procedures a year. His visit concluded with a tour of the West Kent CDC, where he spoke with staff about the range of elective diagnostics that the centre provides away from a hospital setting, enabling quicker access to tests and greater convenience to patients.
- The Trust's surgical team recently performed their first robot-assisted hysterectomy, making MTW one of the first NHS trusts in the region to deliver this pioneering surgery. The procedure is set to help hundreds of women living with severe endometriosis and other gynaecological conditions. The Trust took delivery of its first surgical robot at Maidstone Hospital in September 2024 and a second at Tunbridge Wells Hospital in April this year. Over 340 of our patients have already benefited from robot-assisted surgery for colorectal, bariatric (weight management), gynae-oncology and urology procedures. Robot-assisted surgery has many benefits for patients – it is less invasive, leads to less pain after the operation, and can mean a faster recovery time.
- Winter planning is underway, and we will be working with partners to help increase external capacity in the community and support the patient discharge process. The Trust's Winter Plan will review all areas of activity across the organisation during the winter, to identify gaps and risks, developing mitigations to ensure safe and timely care and working within financial parameters. This includes beginning of our staff winter vaccine campaign, with a focus on achieving 55% of all staff vaccinated. Staff will be offered flu vaccines - they will not be provided with the COVID-19 vaccine, in line with this year's national vaccination programme for healthcare workers. Staff who are immunocompromised will be entitled to a COVID-19 vaccine via their GP.
- The Patient First Improvement System (PFIS) has seen in excess of 1,635 improvement tickets raised and completed since it was introduced in late 2022. Over 560 staff members across 116 teams have now received training on the system, learning how to use problem-

solving skills to improve their processes and embed a continuous improvement approach into their day to day work.

Recent PFIS improvement projects include:

- The Radiotherapy team at Canterbury have developed a process to capture and upload clear screenshots of surface and skin rendering to their system, to assist with treatment delivery. This enhancement helps staff see vital reference information more easily and clearly, making patient positioning for treatments faster and simpler, and reducing the chance of errors. For patients, this means the team can deliver treatments safely and accurately. The clearer references help ensure the correct areas are targeted during radiotherapy, resulting in safer and more effective care.
 - Prescriptions for patients in our Woodlands paediatric unit to take home after surgery are now being issued in order of discharge, meaning they have been authorised and prepared by the time the patient is ready to go home. This has improved the patient experience, while also freeing up beds and contributing to better flow.
 - A high number of patients on the Virtual Ward were being issued with iPads as part of their at home monitoring equipment, even though they already owned smart devices. This was limiting the availability of devices for those who needed them, reducing efficiency. Set criteria has now been introduced to assess whether a patient requires specific equipment, enabling better resource allocation and management.
- We are recognising the Trust's Employee of the Month for both July and August in this report:
 - Congratulations to our winner of the Trust's Employee of the Month award for July, Ana Teixeira, Lead Theatre Practitioner. Ana is described as a respected and compassionate leader who creates an environment where colleagues feel supported and heard. Her hard work and dedication ensure theatres operations run smoothly and that patient-centred care is maintained at all times. Buster Hubbard, Inventory Specialist, also received the Highly Commended Award for the significant and positive difference he has made to ICU operations. This has included sourcing cost-saving products and managing supply disruptions by finding alternatives.
 - Congratulations also to the winner of the Employee of the Month award for August, Danielle Brogden, Consultant General and Colorectal Surgeon. Danielle was nominated by a patient, who praised her for her exceptional care and dedication during their stay at Tunbridge Wells Hospital. The patient described Danielle's clear communication and consistent, compassionate care as being key in improving their physical health and mental wellbeing. Chris Hetherington, a Cleaner in the Estates and Facilities Management team, also received the Highly Commended Award for her helpful and proactive approach in handling her duties, and her willingness to take on additional tasks.

Title of report	Summary report from the Quality Committee, 13/08/25 & 10/09/25					
Board / Committee	Trust Board Meeting					
Date of meeting	25 th September 2025					
Agenda item no.	09-9					
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)					
 Patient experience	 Patient access	 Sustainability	 People	 Systems and partnerships	 Patient safety and clinical effectiveness
☒	☒	☐	☐	☒	☒

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Quality Committee met in person on 13 th August 2025 (a “deep dive” meeting) and virtually on 10 th September 2025 (a “main” meeting)	
	The Committee considered the following topics:	
	The BAF risks overseen by the Quality Committee; An update on the Trust’s Medical Equipment; Management of the Deteriorating Patient; A brief update on the work undertaken to review waiting list management development and confirmed items for scrutiny at future Quality Committee ‘Deep Dive’ meetings.	
	The Patient Safety Oversight Group Report; Maternity and Neonatal Care Oversight Group; The Experience of Care Group Report; Patient Outcomes Oversight Group; Joint Safeguarding Annual Report 2024/25; Annual review of Quality Impact Assessments (QIAs); Complaints Annual Report 2024/25. The Recent findings from relevant Internal Audit reviews was also noted by the Committee.	
	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. • 3128 • 1304 • 1301 – Failure to meet national targets for complaints performance • 3424 – There is a risk that the PALS service will not meet local KPIs • 3427 – There is a risk that we are using temporary escalation spaces to manage patient flow through the Trust • 3292 – There is a CQC requirement to report our mixed sex breaches as we do not have the capability through our electronic bed management system
Compliance / Regulatory Implications	N/A

The Quality Committee met (in-person / face-to-face) on 13th August 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.
- The Director of Core Cancer Services presented **an update on the Trust's Medical Equipment**, which included details of staff competency compliance; the barriers identified to completing training and the actions implemented, to help improve compliance, which included an agreement to undertake a six-month training and assessment pilot for Registered Nurses. The Committee also received an overview of preventative equipment maintenance, including the audit and benchmark processes in Clinical Engineering. A discussion was held regarding the Medical Devices Committee and the requirement for this to be strengthened, in terms of providing oversight and assurance through reporting into the Risk and Regulation Oversight Group, and supporting the divisions to enable a representative from each to regularly attend the meetings. The importance of developing the service into a more proactive service, as opposed to a reactive one, was also highlighted. It was noted that this would be achieved, by ensuring the data was accurately analysed, enabling strong oversight of each category, in order to set clear indicators for relevant divisions.
 - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4.
- The Chief Medical Officer / Director of Infection Prevention and Control, and the Lead Practitioner for Deteriorating Patients, then presented the **management of the Deteriorating Patient**, wherein the Committee heard about the main reasons for incidents, resulting in moderate harm and that the main three key performance indicators (KPIs) provide a clear picture of the current situation, which included: Sepsis Protocol documentation; a rolling 12-month Deteriorating Patient total, and total number of Peri Arrest calls made per 1000 occupied bed days. The Committee heard that the patient demographics relating to Deteriorating Patient incidents, including the locations, ages and genders of cases were being reviewed. In addition, a comprehensive review of training has been undertaken and it was outlined that the face-to-face training was to a good standard however, improvements were required for the online training package and to improve staff training attendance. Immediate changes had been implemented, which included: piloting micro environment training, in high incident areas to improve the ability for staff to attend training; developing documentation on the patient record system, to enable staff to escalate concerns more quickly and the roll out of Martha's Rule. The Committee heard that next steps were: the development of assessment tools, to aid staff; the development of a new and accessible Deteriorating Patient training package, to be made mandatory for clinical staff and training videos to reach a wider audience; collecting more data to draw out themes from incidents and propose solutions, and the appointment of Deteriorating Patient Champions. It was also noted that the Deteriorating Patient Committee would replace the Sepsis Committee to create a more streamline reporting route. Discussions were held amongst the group relating to the significance of recognising unwell patients with different skin tones, the importance of training compliance and how this could be monitored in detail moving forward. The Committee also discussed, that although patients with sepsis were being treated well, the tools provided to staff were not able to be used efficiently and it was noted that the team were working with Business Intelligence, to create a dashboard, which would support management of the deteriorating patient further.
 - ❖ The Committee noted that this demonstrated a level of effectiveness of controls for the Board Assurance Framework, Principal Risks 2, 3 and 4.
- The Chief Operating Officer then provided **a brief update on the work undertaken to review waiting list management**, which included the establishment of a multidisciplinary Task and Finish Group and a review of pathway management, including a commitment to implement the Referral to Treatment (RTT) module of the national Federated Data Platform, with a planned go live date of November 2025. The next steps included: workflow standardisation; user training enhancement; data correction and quality improvement; patient engagement strategies and on-going monitoring and reporting. It was agreed that a more detailed overview would be presented at the next 'deep dive' meeting in October 2025.

- ❖ 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**.

The Quality Committee met (virtually, via webconference) on 10th September 2025 (a 'main' meeting).

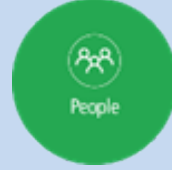
The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings**.
- The Committee had regard to the Board Assurance Framework (BAF) throughout the meeting.
- The **summary report from the Patient Safety Oversight Group** was noted by the Committee, and it was highlighted that there was a sustained increase in Clostridium difficile (C. diff) numbers, and that a Task and Finish Group had been established to investigate this further and to explore new cleaning programmes. The group discussed the cluster of errors around anti-coagulation and prescribing errors, and it was noted that the anti-coagulation errors were identified as process issues and was not related to any change in anti-embolic processes. The team were praised for their positive work in relation to pressure ulcers.
 - ❖ The Committee noted that this demonstrated a level of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4.
- The Deputy Chief Nurse, Quality and Experience presented the **summary report from the Experience of Care Oversight Group**, which included that there was a stable number of complaints received through the Patient Advice and Liaison Service (PALS) and the performance against the target had been maintained; that there were a number of Patient-led assessment of clinical environments (PLACE) assessments were ongoing with action plans in place, led by the Estate and Facilities Team with clinical involvement; and that there was a significant reduction of the recommendation rate of 52%, in relation to the Friends and Family Test (FFT), therefore the team were undergoing a deep dive to identify the cause of this.
 - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risk 4.
- The Director of Quality Governance then presented the **summary report from the Patient Outcomes Oversight Group**, which included that the group now received direct reporting from a large number of Committees and groups throughout the Trust in order to gain strong oversight; that the performance against NICE guidelines was at 88.5%, achieving higher than the Integrated Care Board (ICB) target of 85%; and that the Task and Finish Group undertaking the review of Patients Lost to Follow Up were continuing to work through the improvement work and validating the data. The group discussed the Virtual Ward and Getting It Right First Time (GIRFT), and the importance of progressing these forward.
 - ❖ The Committee noted that this demonstrated the effectiveness of controls for the Board Assurance Framework, Principal Risk 4.
- The Director of Maternity provided the **summary report from the Maternity and Neonatal Care Oversight Group**, which included that more work was required around the Key Performance Indicators (KPIs) around induction of labour, wherein a new Obstetric Lead had been appointed in order to identify further improvement measures. The Committee also heard that the increase in agency spend in maternity had now reduced; that the escalations in Neonates was now on the Trust's risk register; and that further discussions were required to identify a solution to be agreed regarding the Maternity and Neonatal Voices Partnership (MNVP) required funding.
 - ❖ The Committee noted that this demonstrated a level the effectiveness of controls for the Board Assurance Framework, Principal Risk 2.
- The Deputy Chief Nurse, Quality and Experience presented the **Joint Safeguarding Annual Report, 2024/25**, wherein assurance was provided that the Trust continued to meet its statutory obligations although, due to the realignment of the roles and competences for healthcare staff, the training compliance had reduced to roughly 69% by the end of August 2025. The group discussed the importance of increasing this compliance figure, and how this could be achieved through completing the level 3 section of the training. The risks outlined within the report related to the absence of an independent hospital Domestic Violence Advisor however, this role has now been recruited into; and the management of patients under the provision of Deprivation of Liberty Safeguards (DOLS). It was noted that the DOLS backlog was also recognised throughout Kent and in various places nationally however, the Committee were assured that the Trust's mitigation of weekly meetings has resulted in a number of applications no longer being required and also provides assurance that patients were not being deprived of their liberties.
- The **annual review of the Quality Impact Assessments (QIAs)** was conducted, wherein the group heard that the process had been strengthen through becoming more robust and streamlined, with transparent oversight through weekly meetings to sign off the QIAs. There

was now also structured clinics, direct sign off and clear escalation routes. It was noted that all quality indicators were all aligned to strategic themes, and were therefore being worked through by all levels of the organisations and through the Strategy Deployment Review (SDR) processes. Feedback was provided on the new process including that it was supportive with appropriate challenge and was working well.

- The **Complaints Annual Report 2024/25** was presented to the Committee, which included that there was an uptake of the number of complaints to the Trust at the end of the fourth quarter of the 2024/25 financial year; and that out of the 502 complaints closed across the year, 65 were fully upheld. It was highlighted that team has committed to a complete refresh of the Complaints policy which would be shared with the Experience of Care Oversight Group in October 2025. The key risks which were noted by the Committee related to the operational management of the service, and clinical treatment overtaking communication as a complain driver. Early resolution meetings were regularly held, and the importance of supporting staff in feeling safe to be open with patients and colleagues, was recognised.
- The **recent findings from relevant Internal Audit reviews** was noted by the group.
- The **report from the Quality Committee 'deep dive' meeting, 13/08/25** was noted.
- The Chair conducted an **evaluation of the meeting**.

Title of report	Summary report from the People and Organisational Development Committee, 19/09/25					
Board / Committee	Trust Board Meeting					
Date of meeting	25 th September 2025					
Agenda item no.	09-10					
Executive lead	Helen Palmer, Chief People Officer					
Presenter	Richard Finn, Associate Non-Executive Director					
Report Purpose (Please ☒ one)	Action/Approval	☐	Discussion	☒	Information	☒

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

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The People and Organisational Development Committee met (virtually, via webconference) on 19 th September 2025 (a ‘main’ meeting).	
	The Committee considered the following topics:	
	1) The People BAF risk 2) Monthly review of the “Strategic Theme: People” section of the Integrated Performance Report (IPR) 3) Responsible Officer’s Annual Report 2024/25 4) Update on the Workforce Transformation Programme (incl. an update on temporary staffing) 5) Update on Equality, Diversity and Inclusion (EDI) 6) Update on the Trust’s various staff feedback mechanisms 7) Update on Learning and Development at the Trust 8) Quarterly update from the Guardian of Safe Working Hours 9) Recent findings from relevant Internal Audit reviews 10) 10 Point Plan to improve resident doctors’ working lives	
	The Committee noted that the reports presented, demonstrate that controls relating to Principal Risk 1 and an element of Principal Risk 6 of the Board Assurance framework are demonstrating effectiveness.	
Any items for formal escalation / decision		
Appendices attached		
Report previously presented to:		
Committee / Group	Date	Outcome/Action
N/A	N/A	N/A

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer PR 6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery

Links to Trust Risk Register (TRR)	ID993 – Continued dependency on bank and agency staff following improvements in vacancy/recruitment levels
Compliance / Regulatory Implications	N/A

The People and Organisational Development Committee met (virtually) on 19th September 2025 (a 'main' meeting).

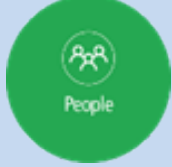
The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed.
- The Committee considered the **People Board Assurance Framework (BAF) risk** and had regard to this throughout the meeting.
- The Committee conducted a **monthly review of the “Strategic Theme: People” section of the Integrated Performance Report (IPR)**, wherein it was noted that the Trust had not achieved the staff leavers within 24 months key metric target for six months, and it was suggested that this should be considered as a future 'deep dive' item to the Committee in order to investigate further into the data. Another key metric highlighted as an area of improvement was the percentage of staff agenda for change (AfC) 8c and above from a Global Majority background. It was noted that the figure for staff in post had reduced to 7707, alongside a decrease in the gap year on year. The Committee discussed the data around long-term sickness and it was agreed that a report identifying the causes and progression of this should be scheduled for the next meeting.
 - ❖ The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 1.
- The Chief Medical Officer presented the **Responsible Officer's Annual Report 2024/25**, which outlined that the Trust was a designated body under the General Medical Council (GMC) and was therefore recognised as an organisation which could recommend doctors for revalidation, to ensure that five appraisals were conducted during the five-year cycle and that multi-source feedback had been completed. It was noted that during the past year, 189 revalidation recommendations were made; 652 appraisals were supported; and there was only 1 doctor who failed to complete their appraisal without a prior extension agreed. It was acknowledged by the group that locum and agency doctors would have their appraisals completed by the agency Responsible Officers.
- An **update on Workforce Transformation (incl. an update on temporary staffing)** was provided by the Chief People Officer, wherein the Committee heard that the 45-day consultation period for Phase 1 of the transformation had concluded and all staff had been written to informing them of the organisational changes, noting that all eight of the process recommendations made were accepted either in-part or in-full. An additional two weeks were taken in order to review the feedback and alternative proposals in detail, as well as producing a lessons learned after action review, which would be presented at a future Committee meeting. The selection process commenced on 08/09/25 and will close on 28/09/25. The Chief People Officer also informed the group that the Elective Representative process and subsequent manager training would both be redesigned as a result of the feedback received from Phase 1. The Committee discussed the redeployment pool and recruitment concept and were informed that further details on this would be available following the closure of the selection process however, it was noted that the current 58 vacancies would aim to be appointed to an internal redeployed member of staff and if this was unsuccessful, would then be considered by the Integrated Care Board (ICB) redeployment hub. The Committee then received an update on temporary staffing wherein it was recognised that the overall trend continued to move in the right direction with an overall percentage reduction, noting the slight impact caused as a result of the industrial action.
 - ❖ The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- The Head of EDI, Engagement & Retention presented an **update on Equality, Diversity and Inclusion (EDI)**, which highlighted that the data showed how white staff were progressing to higher banded roles within the organisation in both clinical and non-clinical areas, which was not replicated by staff from the Global Majority, and was reflective of systemic barriers in career development, access and progression. Bullying and harassment from managers against staff with

long-term health conditions was at its lowest over the course of five years however, was still an area in need of improvement. It was outlined that the action plan over the past two years had been delivered however, the change needed had not been achieved. The Committee discussed the importance of the issues raised and it was highlighted that it could be beneficial for the EDI team to have more of an active involvement in the recruitment practices in order to provide a better understanding what inclusive recruitment looks like. The importance of ensuring all staff groups were equally supported, once recruited into the organisation, was also emphasised.

- An **update on the Trust's various staff feedback mechanisms** was presented by the Chief People Officer, which included that a key focus for the organisation around the listening strategy was to provide opportunities for staff to be heard through multiple routes including the People Promise Exemplar Programme; Freedom To Speak Up; and through a number of different networks. The response rate for the National Staff Survey (as of 18/09/25) was 5.6% which was much higher than any other year at this current stage, and the results of the National Staff Survey would not be available until March 2026. It was noted by the Committee that the areas of low engagement included Cancer; Estates; and Medicine and Emergency Care, and it was acknowledged that the Employee Experience Partners identifying the reasons behind this.
- The Committee received an **update on Learning and Development at the Trust**, wherein the Committee heard that statutory and mandatory training was currently sitting at 91% against the key performance indicator (KPI) of 85% and stretch performance target of 90%; that the team were working on the reporting project to ensure that reports on did not attend (DNA) rates and temporary staffing were included; and that the fortnightly induction process had now been revised into one single multi-disciplinary induction conducted once a month. The Committee discussed the appraisal rate of 91.2% against the KPI of 95%, acknowledging that this was the first time the KPI had not been achieved since 2020, and heard that the Business Partners would be liaising with senior leaders to identify the reasons behind this reduction.
- The **quarterly update from the Guardian of Safe Working Hours (covering April to June 2025)** was presented, and it was noted that there had been a significant decrease in the number of exception reports since the previous quarter which was likely in relation to winter pressures; and that out of the 103 exception reports from resident doctors, 102 related to work schedules, 3 related to patient safety and inadequate staffing levels, and 1 related to missed educational opportunities.
- The group noted the **recent findings from relevant Internal Audit reviews**, and it was highlighted that focused work was ongoing around DBS compliance with a report due to be scheduled at a future Committee meeting providing an update on the position; and work was also ongoing to provide regular reporting around sickness and bank rates in order to provide assurance to the Committee.
- The Deputy Medical Director provided the Committee with the **10 Point Plan to improve resident doctors' working lives**, which included that out of the ten conditions to be made, the Trust required further work around on-call parking spaces for the resident doctors; provision of self-directed leaning time; the inclusion of a resident representative to Board; and statutory and mandatory training issues. The Committee were assured that the Trust was on-track to ensuring all points were resolved within the 12-week window.
- The Committee noted the **forward programme** and 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	25 th September 2025				
Agenda item no.	09-11				
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)					
 Patient experience	 Patient access	 Sustainability	 People	 Systems and partnerships	 Patient safety and clinical effectiveness
☐	☒	☒	☐	☒	☐

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee met (in-person/face-to-face) on 23 rd September 2025.	
	The Committee considered the following topics: 1) To consider the BAF risks 2) The patient access strategic theme metrics for August 2025 3) The financial performance for month 5, 2025/26, including an update on the Financial Improvement Plan 4) Quarterly productivity report 5) An update on Fordcombe Hospital 6) Provider Assessment Framework 7) Review of the forthcoming winter period 8) The Medium Term Plan 9) Head of Mental Health & Enhanced Therapeutic Observations and Care Team (Etoc) Business Case 10) Histology Workforce Full Business Case 11) Managed equipment service extension	
	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 23rd September 2025, in-person / face-to-face.

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 August were reviewed, and it was highlighted that Referral to treatment times were below the target of 73.8% in July at 69%. Contributors to this were noted to be a growth in waiting lists and an action plan had been developed and shared with NHS England. The Committee heard that the Trust failed to meet the National Performance Assessment standard for the 28 day faster diagnosis standard in July and discussed ways in which transformation work will have an impact on performance data in the future.
- The **financial performance month 5, 2025/26** was then presented by the Deputy Director of Finance, which included that the Trust was £1.6m in deficit in the month which was breakeven to the plan. Year to date the Trust was £12.6m in deficit which is £0.1m adverse to plan. The adverse and favourable variances in-month were discussed, the progress against the cost improvement plan was presented and the risks both internally and within the system were shared with the Committee. The Committee also considered an application for Four-day Operating Spend Revenue Cash Support. The Committee questioned the impact of the year to date deficit on the Trust cash position and was assured that actions were in place to mitigate cash pressures but additional cash was required to continue to make payments to suppliers. It was noted that the Trust Financial Plan had included the requirement for cash support. Therefore the committee recommended that an agreement to support an application be sought from the Trust Board.
- The Chief of Service and Divisional Director of Operations for Cancer then provided the **quarterly productivity report**, and highlighted the work being undertaken within the outpatient's element of the cancer division. Areas of focus were noted to be the number of follow up outpatient appointments and the variety of ways in which outpatient appointments could be undertaken. The Committee also heard of improvements within radiotherapy services, which had a positive impact on patient experience.
- The Associate Director of Business Intelligence provided an overview of the **Provider Assessment Framework**, where the Committee heard how NHS Oversight Framework 2025/26 follows a structured, rules-based process to determine how NHS providers are segmented for oversight and support.
- An **update on Fordcombe Hospital** was provided, wherein the Committee heard of the number of achievements made by the team, which included: the completion of remedial works to the estate, ahead of the planned schedule; the growth in activity within the Wells Health division; development of the Wells Health Brand in line with the marketing campaign and positive feedback received from patients and clinicians. The Committee requested an updated report next month presenting the plan to address the current end of year forecast.
- The Committee received a **review of the upcoming winter period**, which included a comprehensive overview of the modelling and demand predictions for winter 25/26 and the mitigations to ensure patient safety throughout the period. The winter plan summarised the national assurance winter framework and best practice emergency care framework, to provide assurance to Executive Management Team and to this Committee of the state of readiness for winter 2025/26. The Committee were assured of the state of readiness for winter 2025/26.
- The Director of Strategy, Planning & Partnerships attended to present the **Medium-Term Plan**, which included details of the framework published by NHSE on 8th September 2025 and the purpose of the framework, to provide clarity on roles and responsibilities within the new operating model, set out in the 10-year plan. The Committee heard that providers will be required to submit integrated 5-year plans and demonstrate financial sustainability over the medium term. The Committee heard that the framework indicated a planning return in December 2025, which will include financial, workforce and operational plans for the first year, that providers and ICBs will be held to account for delivering. It was noted that it is expected that these plans will have been formally assured by the trust board.
- The **Head of Mental Health & Enhanced Therapeutic Observations and Care Team (Etoc) Business Case** was reviewed by the Committee, and was recommended for approval.

- The Committee were then presented with the **Histology Workforce Full Business Case**, and the case was approved subject to costs remaining the same as the current position - which needed to be confirmed. The **managed equipment service extension** was presented to the Committee, who approved the extension.
- The Committee noted the **summary report from the from the July 2025 People and Organisational Development Committee; notification of the use of the Trust Seal; and the forward programme**.
- The Committee **considered the assurance provided at the meeting relating to the Board Assurance Framework** and noted that the information presented, demonstrated that controls relating to Principal Risks 3,5 and 6 of the Board Assurance Framework are demonstrating effectiveness.

Title of report	Integrated Performance Report (IPR) for August 2025					
Board / Committee	Trust Board Meeting					
Date of meeting	25 th September 2025					
Agenda item no.	09-12					
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)					
 Patient experience	 Patient access	 Sustainability	 People	 Systems and partnerships	 Patient safety and clinical effectiveness
☐	☐	☒	☒	☒	☐

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The IPR for August 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

Integrated Performance Report

August 2025

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

Key to KPI Variation and Assurance Icons

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

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

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

Escalation Rules:

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

Escalation Pages:

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

Scorecards explained

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

Further Reading / other resources

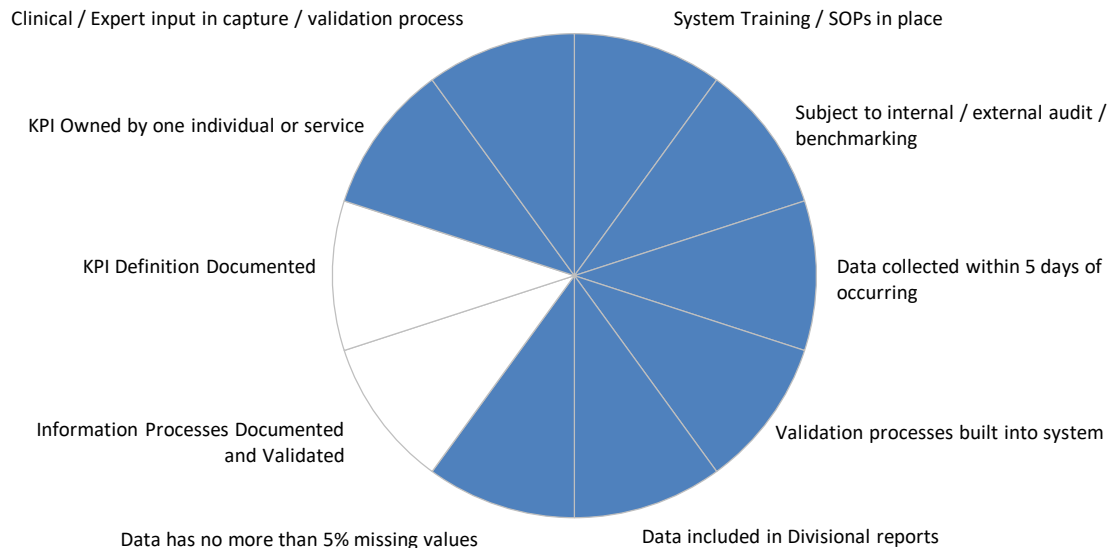
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - <https://improvement.nhs.uk/resources/making-data-count>

Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The 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. Any indicators that are part of the National Performance Assessment Framework (NPAF) have been highlighted or added if they were not already included in the report.

People: Delivery of the pay elements of the Financial Improvement Plan 25/26 indicator is experiencing common cause variation but has now failed the target for 6+ months. The breakthrough objective of achievement of the workforce plan in WTEs is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months with both the substantive staff element and Agency staff elements of this also currently escalated. However, the agency staff element is improving and has achieved the plan for last five consecutive months. Agency staff spend as a proportion of the total pay spend continues to experience special cause variation of an improving nature and continues to pass the target for more than six consecutive months. Vacancy Rate continues to experience special cause variation of an improving nature and has passed the target for over 6 months. Turnover Rate continues to experience special cause variation of an improving nature and is consistently passing the target. The number of staff that leave within 12 months continues to be in variable achievement of the target, however those within 24 months has now failed the target for 6+months. 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 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 continues to experience common cause variation 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. There were no After Action Reviews for Swarms commissioned this month. Both the Rates of E.Coli and C.Diff continue to experience common cause variation and variable achievement of the target. However, the new NPAF Indicators which monitor a 12 month rolling count of cases as a proportion of the Trust Threshold for both E.Coli and C.Difficile are currently escalated, along with the rolling 12 month count of MRSA cases. 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 July (data runs one month behind) and is experiencing common cause variation and is consistently passing the target.

Patient Access: The Trust continues to provide system support (SYS) to other Trusts across Kent and Medway which is therefore adversely affecting the Trust's RTT performance that is reported nationally. RTT was below the trajectory target for July 25 of 73.8% at 69.05% (Excluding SYS). Nationally we reported 69.0% (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 zero 52 week breaches at the end of August 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 "Reduction in weeks wait for first Outpatient Appointment" indicator is currently experiencing special cause variation of an improving nature but consistently failing 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 performance was slightly above the new trajectory target for August 25 of 88.5%. 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 August at 80.2% but remains in common cause variation and variable achievement of the target. The new NPAF Indicator for A&E 4hrs (a rolling 3 months position) is currently escalated. Performance remains one of the highest both Regionally and Nationally. Both the average in-hospital non-elective length of stay and Ambulance Handovers <30mins indicators are currently experiencing common cause variation but have failed the target for 6+ months. Work continues to improve flow across the Trust. The conversion rate from A&E to inpatient admission remains in common cause variation and has now achieved the target for 6+months. The Trust continues to achieve the 28 Day faster diagnosis compliance, the combined 31 day first definitive treatment standard and the 62 day first definitive treatment standard (both the monthly snapshot and new NPAF aggregated quarter positions). 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. The new NPAF indicator for the 28 Day Faster Diagnosis standard which is an aggregate quarterly position is currently escalated due to the target for NPAF being 80% rather than the current national target of 75%.

Outpatient utilisation continues to experience special cause variation of a concerning nature and variable achievement of the target. August performance will improve as cashing up of clinics continues. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute continues to experience special cause variation of an improving nature but remains consistently failing the target. Performance for First Outpatients activity was below the new trajectory target for August 2025 (this is likely to improve further as cashing up of clinics take place). This indicator is experiencing common cause variation and variable achievement of the target. Elective Activity (Inpatients and Day Case combined) was above the new plan for August 2025 and is now experiencing special cause variation of an improving nature and variable achievement of the plan. Theatre Utilisation is experiencing special cause variation of an improving nature but is consistently failing the target. The rate of all outpatient appointments that are either a new appointment, or a follow up appointment with a procedure, is experiencing common cause variation and has achieved the target for 6+ months. Diagnostic Imaging activity levels were above plan in August and remains in common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints continues to experience special cause variation of a concerning nature and has failed the target for more than six months. The Breakthrough Objective to increase the number of complaints that are closed through an initial conversation or local resolution is currently at 9%. The target for this is currently being worked up. Complaints responded to within the target date passed the target again in August, at 83%, and continues to experience special cause variation of an improving nature. This indicator has now passed the target for 6+ months. Friends and Family Response rates remain in common cause variation and have failed the target for six consecutive months or are consistently failing.

Systems: Both the daily average in-hospital non-elective beddays (Excluding Virtual Ward) and the daily average virtual ward beddays are experiencing common cause variation but have failed the target for more than six months. The target for the Virtual Ward beddays has been increased to 95% of the 60 beds. The Average Non-Elective LOS for Fracture Neck of Femur (NOF) is now experiencing common cause variation and variable achievement of the target.

Sustainability: The Trust was £1.6m in deficit in the month which was breakeven to plan in the month. Year to Date the Trust is £12.6m in deficit which is £0.1m adverse to plan. Delivery of the financial position and the reduction in non-pay spend are both experiencing common cause variation and variable achievement of the target.

Maternity: Both of the indicators for Women waiting for Induction of Labour continue to experience common cause variation and failing the target. The Trust is now showing data post-validation (April-24 onwards) for both of the indicators for Decision to delivery interval (Category 1 & Category 2) caesarean sections. 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:

- Delivery of the pay elements of the Financial Improvement Plan 2025/26 (P.11)
- Achievement of Workforce Plan (WTEs) (P.12)
- Achievement of Substantive Element of Workforce Plan (WTEs) (P.13)
- Achievement of the Agency Element of Workforce Plan (WTEs) (P.13)
- % of Afc 8c and above that are BAME (P.13)
- Staff Leavers within 24 months (P.13)

Patient Access:

- RTT - Reduction in weeks wait to first out patient appointment (Average) (P.19)
- 10% Reduction in Non-Elective LOS (P.20)
- Outpatient Calls answered <1 minute (P.20)
- Ambulance Handovers < 30 mins (P.20)
- % Capped Theatre Utilisation (P.20)
- Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - rolling 3 months *NPAF Metric* (P.21)
- Cancer - 28 Day Faster Diagnosis Compliance - Quarter Position Aggregated *NPAF Metric* (P.21)

Systems:

- Daily Average In-Hospital Non-Elective Overnight Beddays (excl Virtual Ward) (P.26)
- Daily Average Virtual Ward Beddays (P.27)

Sustainability:

- None escalated

Patient Safety & Clinical Effectiveness:

- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.15)
- 12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* (P.16)
- 12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric* (P.16)
- 12 month rolling count of MRSA cases *NPAF Metric* (P.16)

Patient Experience:

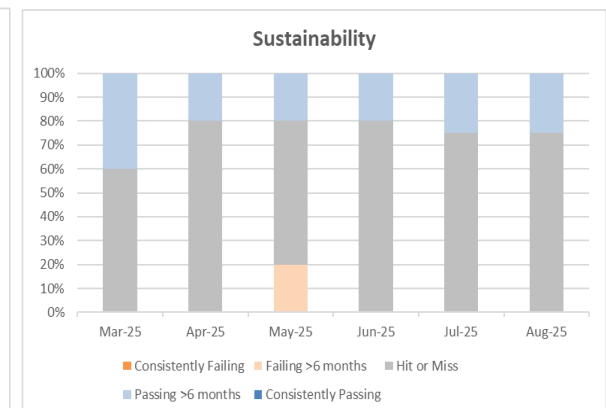
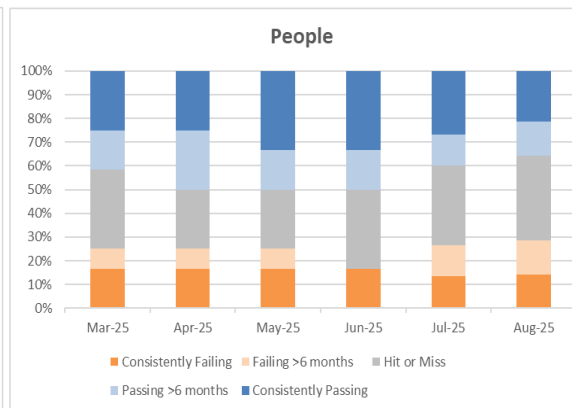
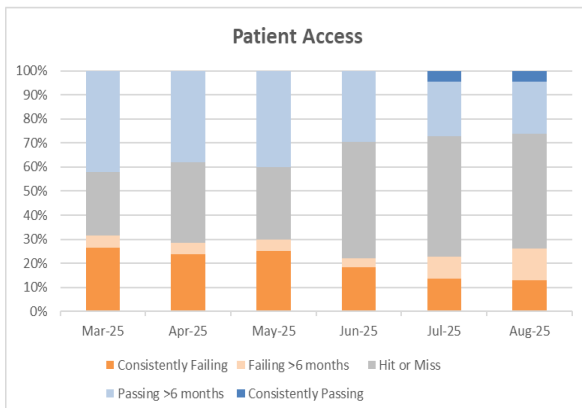
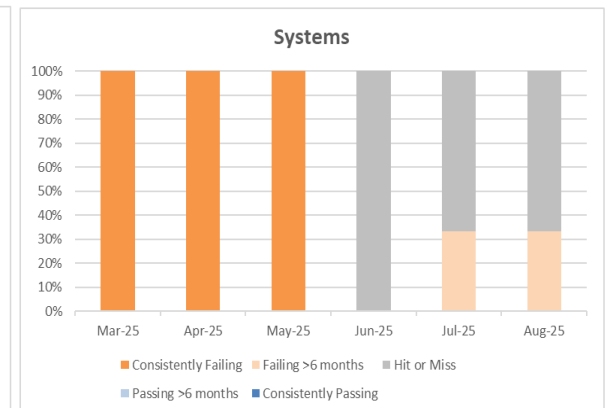
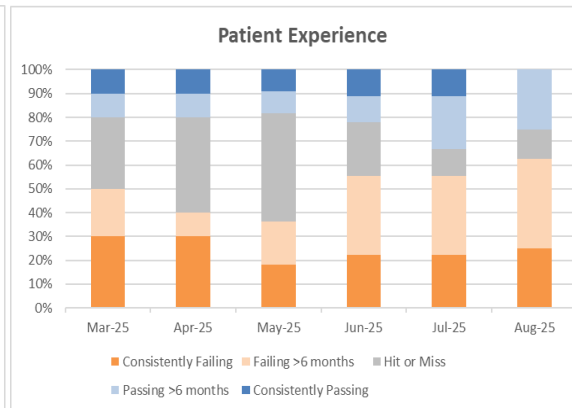
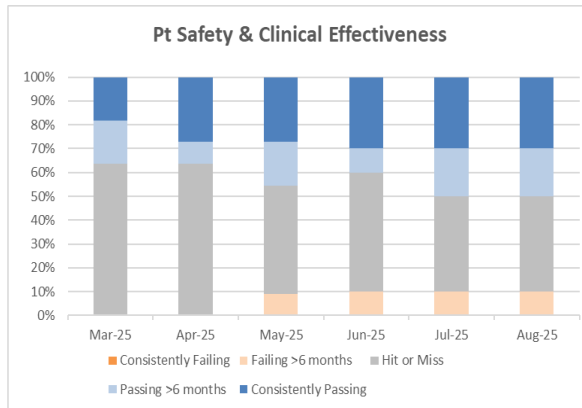
- New Complaints Received (P.23)
- FT Response Rates: All areas (P.24)

Maternity Metrics:

- Women waiting for Induction of Labour <2 Hrs (P.30)
- Women waiting for Induction of Labour <4 Hrs (P.30)

**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

August 2025

August 2025		Assurance				
		Pass★ 	Pass 	Hit and Miss 	Fail 	Fail - 
Variance	Special Cause - Improvement 	Reduce Turnover Rate to 12% Statutory and Mandatory Training Percentage of A/C 8c and above that have a Disability Standardised Mortality HSMR Summary Hospital-level Mortality Indicator (SHMI) *NPAF Metric*	Agency Spend as a % of spend – target of 3.2% Reduce the Trust wide vacancy rate to 8% IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days Cancer - 31 Day First (New Combined Standard) - data runs one month behind % complaints responded to within target	To achieve the planned levels of elective (DC and IP combined) activity		Achievement of Agency Element of Workforce Plan (WTEs) 12 month rolling count of MRSA cases *NPAF Metric* RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways) Transformation: CAU Calls answered <1 minute
	Common Cause 	Percentage of A/C 8c and above that are Female % VTE Risk Assessment (one month behind) *Cancer - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric*	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Conversion rate from ED (Excluding Type 5 and including Direct Admissions) Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) Safe Staffing Levels (Nursing) Cash Balance (€k)	Achievement of Bank Element of Workforce Plan (WTEs) Sickness Absence *NPAF Metric* Staff Leavers within 12 months Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays To achieve a 50improvement in RTT (Excluding SVS) as per the Trust Trajectory *NPAF Metric* To achieve a 50improvement in RTT (including SVS) - Reported Nationally Access to Diagnostics (<6weeks standard) A&E 4 hr Performance Percentage of emergency department attendances spending over 12 hours in the department - monthly snapshot *NPAF Metric* Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) Transformation: %of Patients Discharged to a PFIU Pathways To achieve the planned levels of new outpatients activity To achieve the planned levels of Diagnostic (MR/INOUS/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. Delivery of the better use of beds programme for MTW - Average Non-Elective LOS for Fracture Neck of Femur (NFOR) - Data runs one month behind Delivery of financial plan, inc. operational delivery of capital investment plan (net surplus/(-)net deficit (+) £000) *NPAF Metric* Reduce non-pay spend Capital Expenditure (€k)	Delivery of the pay elements of the Financial Improvement Plan 2025/26 Staff Leavers within 24 months Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) *Cancer - 28 Day Faster Diagnosis Compliance (one month behind) - Quarter Position Aggregated *NPAF Metric* Flow: Ambulance Handover Delays >30mins Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward) Conversion rate from ED (Excluding Type 5 and including Direct Admissions) Friends and Family (FFT) % Response Rate: Inpatients Friends and Family (FFT) % Response Rate: A&E 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 - Target is 95% of 60 beds	Percentage of A/C 8c and above that are BAME Friends and Family (FFT) % Response Rate: Maternity Friends and Family (FFT) % Response Rate: Outpatients
	Special Cause - Concern 			Never Events RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Transformation: % OP Clinics Utilised (slots) Complaints Rate per 1,000 occupied beddays	12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* 12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric* To reduce the overall number of complaints or concerns each month	**Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - rolling 3 months *NPAF Metric*

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		41,280	42,772	Aug-25	43,216	43,889	Jul-25	Driver			Full CMS			
Breakthrough Objective	Well Led	Achievement of Workforce Plan (WTEs)		7983	8332	Aug-25	8002	8368	Jul-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Well Led	Achievement of Substantive Element of Workforce Plan (WTEs)		7313	7707	Aug-25	7329	7753	Jul-25	Driver			Escalation			
	Well Led	Achievement of Bank Element of Workforce Plan (WTEs)		581	578	Aug-25	583	549	Jul-25	Driver			Not Escalated			
	Well Led	Achievement of Agency Element of Workforce Plan (WTEs)		90	48	Aug-25	90	48	Jul-25	Driver			Escalation			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	1.1%	Jul-25	3.2%	1.1%	Jun-25	Driver			Not Escalated			
	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	5.7%	Aug-25	8.0%	5.2%	Jul-25	Driver			Not Escalated	5.8%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.4%	Aug-25	12.0%	10.5%	Jul-25	Driver			Not Escalated	9.7%		
	Well Led	Sickness Absence *NPAF Metric*		4.5%	3.8%	Jul-25	4.5%	4.1%	Jun-25	Driver			Not Escalated	4.0%		
	Well Led	Statutory and Mandatory Training		85.0%	91.8%	Aug-25	85.0%	91.1%	Jul-25	Driver			Not Escalated	91.9%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	73.3%	Aug-25	66.0%	74.0%	Jul-25	Driver			Not Escalated	74.54%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	9.3%	Aug-25	4.0%	9.7%	Jul-25	Driver			Not Escalated	10.20%		
	Well Led	Percentage of AfC 8c and above that are BAME		13.1%	6.7%	Aug-25	12.8%	6.5%	Jul-25	Driver			Escalation	6.75%		
	Well Led	Staff Leavers within 12 months		15.3	20	Aug-25	15.3	18	Jul-25	Driver			Not Escalated	18		
	Well Led	Staff Leavers within 24 months		28	34	Aug-25	27.8	36	Jul-25	Driver			Escalation	34		

Vision: Counter Measure Summary

Metric Name – Delivery of the pay elements of the Financial Improvement Plan 2025/26

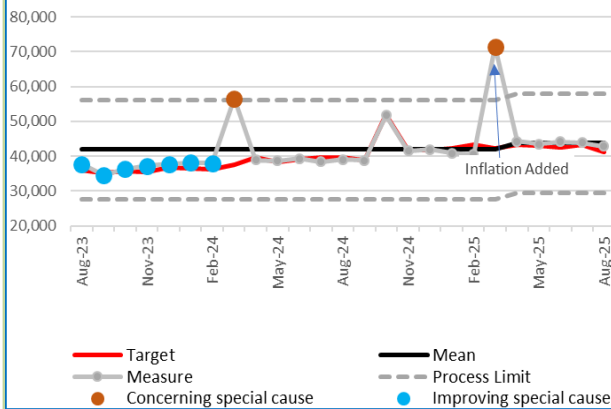
Owner: Chief People Officer

Metric: Delivery of the pay elements of the Financial Improvement Plan 2025/26

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

Delivery of the pay elements of the Financial Improvement Plan 2025/26



Aug-25

42,772

Variance / Assurance

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

Max Limit (Internal)

41,280

Business Rule

Full Escalation as has failed the target for 6+ months

2. Stratified Data

	Current Month ' £000			Current Month WTE		
	Submitted			Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	38,595	37,039	-1,556	7,707	7,313	-394
Bank	3,668	3,466	-202	578	581	3
Agency	357	675	318	48	90	42
Other	151	159	8	0	0	0
Total Pay	42,772	41,339	-1,433	8,332	7,983	-349

	Year to Date £000			Year to Date WTE		
	Submitted			Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	197,247	189,673	-7,574	38,661	36,805	-1,856
Bank	17,878	18,680	802	2,803	3,068	264
Agency	2,517	4,030	1,513	341	528	187
Other	863	780	-83	0	0	0
Total Pay	218,505	213,163	-5,342	41,805	40,401	-1,404

3. Top Contributors & Risks

Top Contributors:

- Historic substantive recruitment above plan
- High levels of retrospective rostering creating inaccurate bank demand.
- Medical rosters not recorded consistently on electronic systems.
- High levels of demand and acuity including enhanced care.
- Turnover remains low.

Risks:

- There is a risk that Divisions will continue to rely on temporary staffing above plan
- There is a risk that unexpected high demand on services will cause temporary staffing levels to be higher than planned
- There is a risk that WTE may increase due to planned industrial action

4. Action Plan

Workstreams	Actions	When	Who
Programme Delivery	Workforce Transformation Programme Phase 1 consultation closes	Aug 2025	Chief People Officer
	Workforce Transformation Programme Phase 2 consultation proposal submission	Sept 2025	Chief People Officer
Rostering Performance	Ongoing programme to establish e-rostering for all HCP teams.	Ongoing	Head of Temporary Staffing
	Regular review of nursing rostering KPIs with Divisions	Ongoing	Deputy Chief Nurse
Vacancy and Pay Controls	Review of responsibility allowances	Oct 2025	Chief People Officer
	Exec Vacancy Control Panel – challenging recruitment requests and holding roles for redeployment opportunities	Ongoing	Chief People Officer
Bank pay	Implementation of pay to shift for AFC	Sept 2025	Deputy Chief Nurse
Data analysis	Project team reviewing data to identify root causes of variance of WTE to plan	Sept 2025	Project team
Medical Staffing	System-wide harmonisation of pay rates Roll-out of Patchwork/rostering and revised job planning approaches.	Ongoing	Chief Medical Officer/ Chief People Officer

Financial Breakthrough Objective: Counter Measure Summary

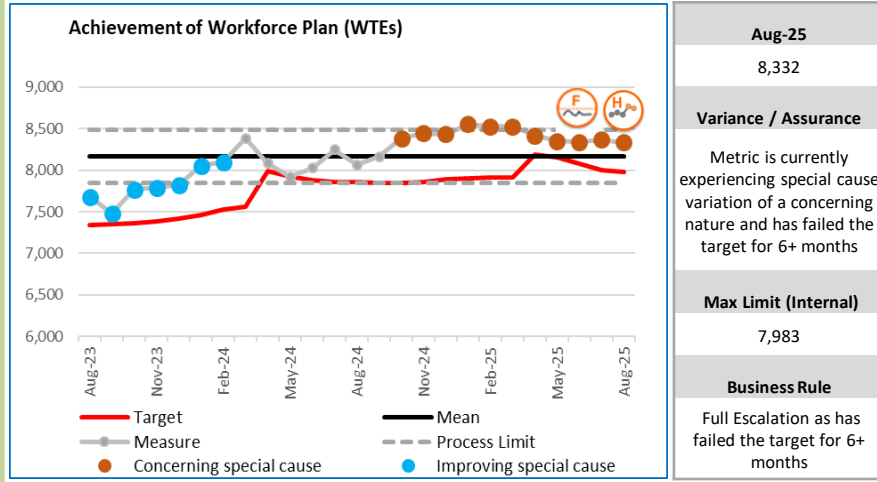
Metric Name – Achievement of Workforce Plan (WTEs)

Owner: Chief People Officer

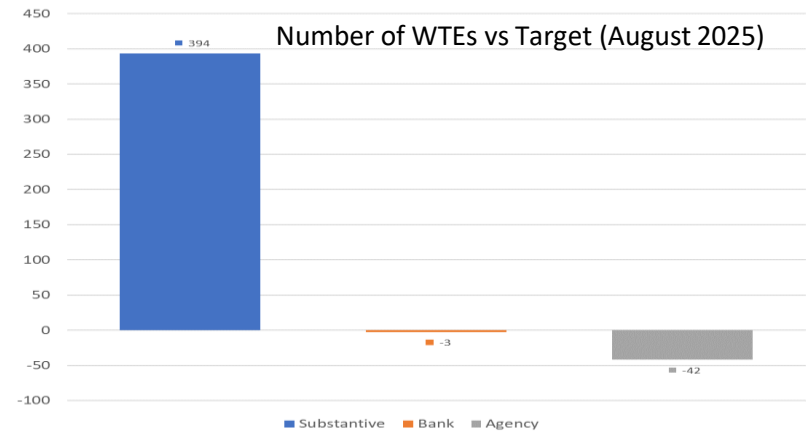
Metric: Achievement of Workforce Plan (WTEs)

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



2. Stratified Data



3. Top Contributors & Risks

Top Contributors:

- Historic substantive recruitment above plan
- Lack of clarity in some areas around the alignment of the Workforce Plan/budgets and Employee Staff Record (ESR)

Risks:

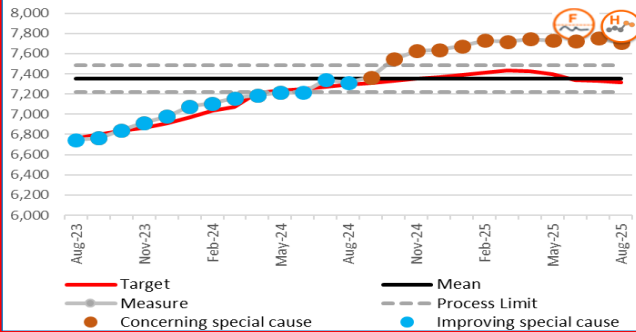
- There is a risk that recruitment continues at a rate higher than planned
- There is a risk that the vacancy control panels are not as effective in controlling establishment, given the Trust's and System's financial sustainability position.

4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Project Charter	Project Charter Developed	Sept 25	Project Team
	Project Charter awaiting sign off	Sept 25	Project Team/Chief People Officer
Data analysis	Project team reviewing data to identify root causes of variance of WTE to plan (ETM SDR Request)	Sept 2025	Project team
Workforce Pay Controls	Re-visit workforce pay controls including vacancy control panels to see if terms of reference etc need tightening for H2 25/26	Oct 2025	Chief People Officer/Chief Finance Officer

People – Workforce: CQC: Well-Led

Achievement of Substantive Element of Workforce Plan (WTEs)



Aug-25

7,707

Variance / Assurance

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

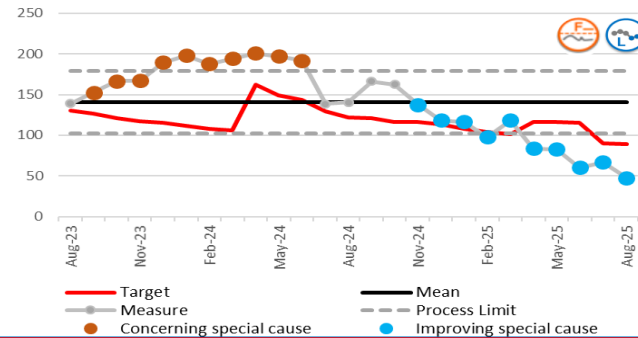
Max Limit (Internal)

7,313

Business Rule

Full Escalation

Achievement of Agency Element of Workforce Plan (WTEs)



Aug-25

48

Variance / Assurance

Metric is currently experiencing special cause variation of an improving nature and consistently failing the target

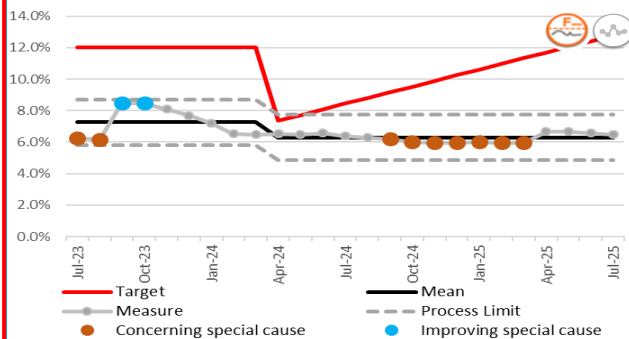
Target (Internal)

90

Business Rule

Full Escalation

Percentage of AfC 8c and above that are BAME



Jul-25

6.5%

Variance / Assurance

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

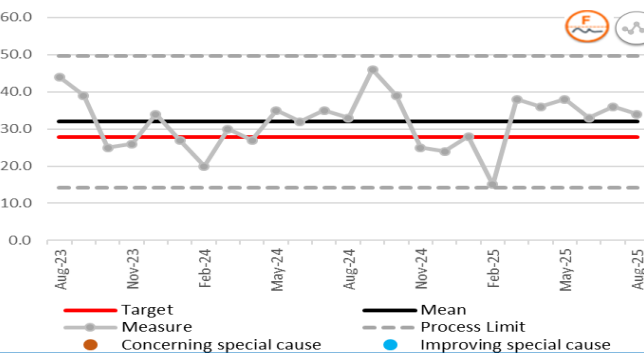
Target (Internal)

12.8%

Business Rule

Full Escalation

Staff Leavers within 24 months



Jul-25

7,754

Variance / Assurance

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

Target (Internal)

7,329

Business Rule

Full Escalation

Summary:

Achievement of Substantive Element of the Workforce Plan: is experiencing special cause variation of a concerning nature and has failed the target for 6+ months

Achievement of Agency Element of the Workforce Plan: is experiencing special cause variation of an improving nature but is consistently failing the target

% of AfC 8c and above that are BAME: This metric is common cause variation and consistently failing the target.

Staff Leavers within 24 months: is experiencing common cause variation and has failed the target for 6+ months

Actions:

Achievement of Substantive Element of the Workforce Plan: The freeze on external recruitment for all but the most critical (timing and to patient care) is in place and monitored by executive colleagues. We will see a much steeper drop at the end of Q3 as the outcome of Phase 1 impacts. We are unlikely to see an impact of Phase 2 until the end of Q4 onwards.

Substantive identified as top contributor to breakthrough objective. Deep dive underway to understand reasons for variance. (reported in CMS)

Achievement of Agency Element of the Workforce Plan: Review the inclusion of a step change regarding the system and Trust went into Level 4 NHSE Intervention and Investigation (I & I) May/June 24

% of AfC 8c and above that are BAME: Online Inclusive recruitment on demand training went live on 14th July 2025 and is being communicated.

Awaiting outcome of discussions between PODco Chair and Deputy CPO (OD) on EDI strategy and project review
Executive Succession planning commenced June 2025
Target will be reviewed in line with proposed draft NHS National Performance & Assessment Framework (NPAF)

Staff Leavers within 24 months: We will undertake a review in Q3 25/26 especially amongst lower banded staff that appear to be a key driver.

Assurance & Timescales for Improvement:

Achievement of Substantive Element of the Workforce Plan: Continued use of the divisional and executive panels to halt all but the most needed external recruitment (in place and ongoing)

Impact of Phase 1 (from October through to December 2025). Impact of Phase 2 (expected January to March 2026 onwards)

A3 being developed – problem statement and current condition complete, stratified data review in progress (Quarter 3 2025/2026)

Achievement of Agency Element of the Workforce Plan: Trust continues the good work in this area to over-achieve this indicator for the last five consecutive months.

% 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

Staff Leavers within 24 months: Employee Experience Team to undertake deep dive in Q3 25/26

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	2.00	Jul-25	1.50	1.99	Jun-25	Driver			Full CMS	2.14		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	3	Jul-25	2.1	2	Jun-25	Driver			Verbal CMS	3		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	3	Aug-25	TBC	7	Jul-25	Driver			Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	0	Aug-25	TBC	0	Jul-25	Driver			Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	Aug-25	TBC	0	Jul-25	Driver			Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	83.1	May-25	100.0	83.1	Apr-25	Driver			Not Escalated	82.3		
	Safe	Summary Hospital-level Mortality Indicator (SHMI) *NPAF Metric*		100.0	88.0	May-25	100.0	88.0	Apr-25	Driver			Not Escalated	87.0		
	Safe	Never Events		0	1	Aug-25	0	0	Jul-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	16.4	Aug-25	32.6	43.7	Jul-25	Driver			Not Escalated	29.3		
	Safe	12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric*		1.0%	1.46%	Aug-25	1.0%	1.50%	Jul-25	Driver			Escalation			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.3	43.7	Aug-25	44.3	75.8	Jul-25	Driver			Not Escalated	64.8		
	Safe	12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric*		1.0%	1.22%	Aug-25	1.0%	1.15%	Jul-25	Driver			Escalation			
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Aug-25	0	0	Jul-25	Driver			Not Escalated	0		
	Safe	12 month rolling count of MRSA cases *NPAF Metric*		0	2	Aug-25	0	0	Jul-25	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	4.0	Aug-25	6.4	4.1	Jul-25	Driver			Not Escalated	3.7		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	96.2%	Jul-25	95.0%	98.0%	Jun-25	Driver			Not Escalated	99.0%		

Vision: Counter Measure Summary

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

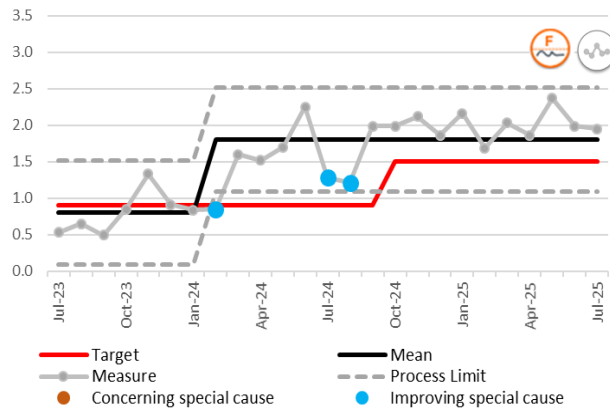
Owner: Chief Medical Officer

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

Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

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



Jul-25 (1 month arr)

1.95

Variance Type

Metric is currently experiencing common cause variation

Maximum Limit (Internal)

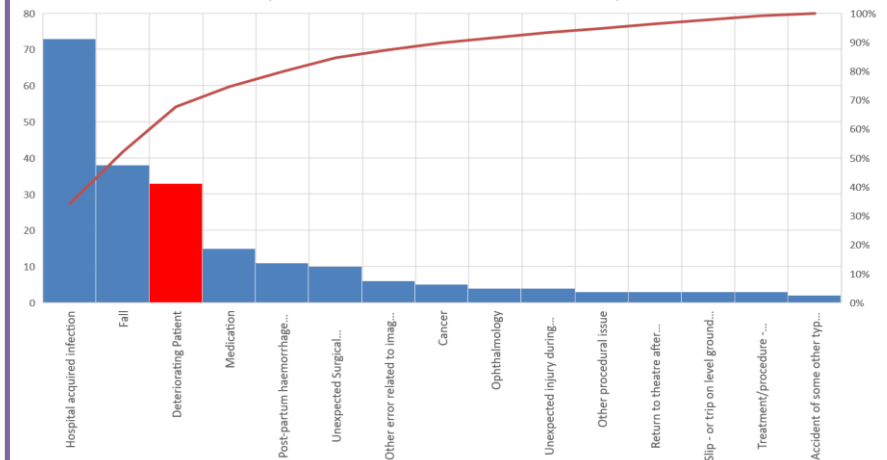
1.5

Target Achievement

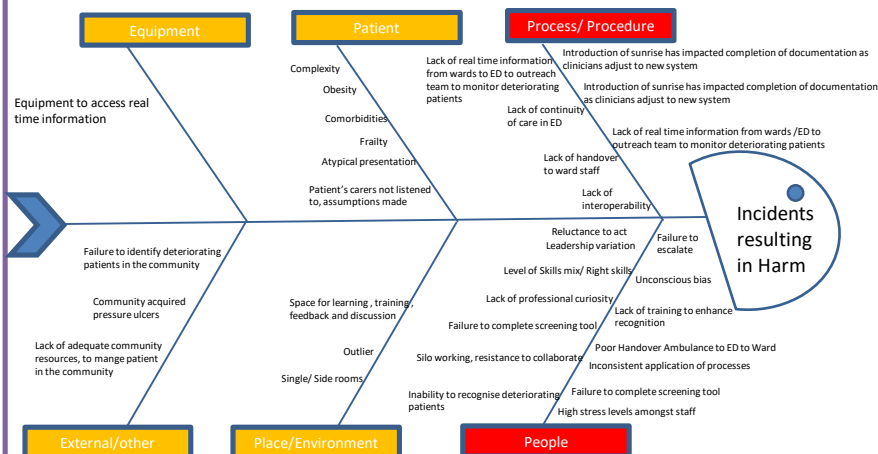
Metric has failed the target for 6+ months

2. Stratified Data

Top 15 Reasons of Moderate and Above Harm - Mar24 - Apr25



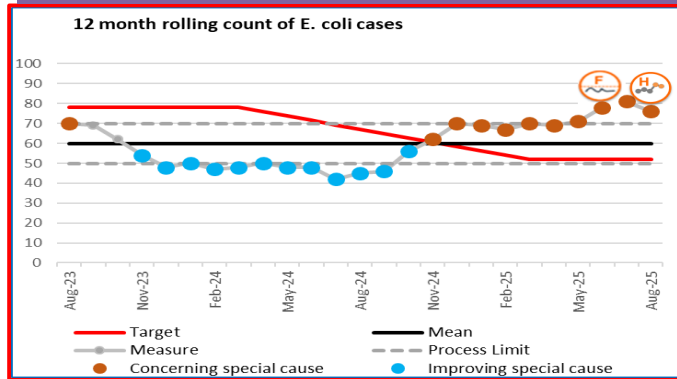
3. Top Contributors



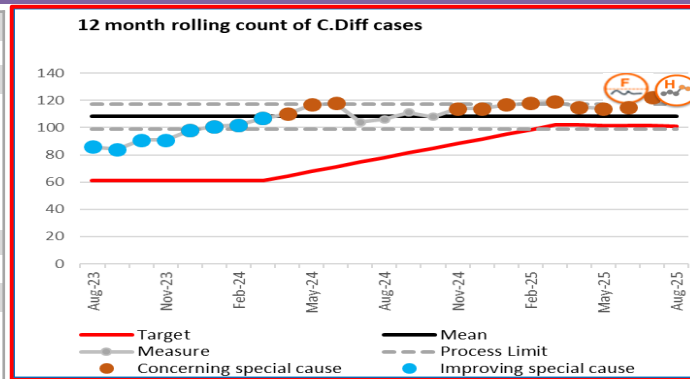
4. Action Plan

Actions	Leads	Due by
Deteriorating Patients		
10 @ 10 Training roll out	JB	Aug-26
Launch local inductions (to include deteriorating patients)	JB	Sep-25
Pilot 2am huddle meeting as an alternative to H@N	FL	Sep-25
Piloting of deteriorating patient document (SBAR)	JB/MH	Sep-25
Review of Board Round standard work to see if option for question to be added around TEP/DNR	JB/HB	Ongoing
Establish alerting system on Sunrise	JK	Ongoing
Develop Deteriorating patients training package	JB	Mar-26

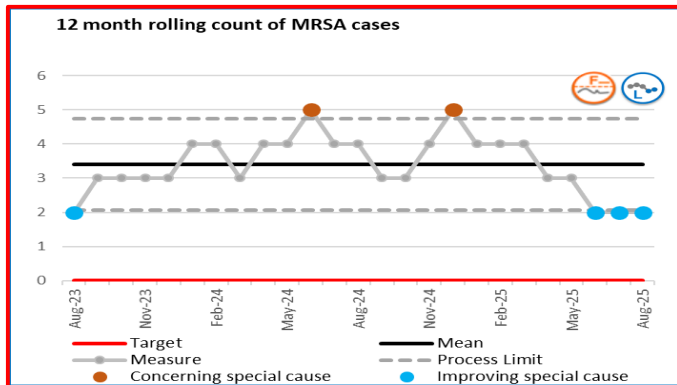
Patient Safety & Clinical Effectiveness: CQC: Safe



Aug-25
76
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months
Target (Threshold)
60
Business Rule
Full Escalation as has failed the target for 6+months



Aug-25
122
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months
Target (Threshold)
90%
Business Rule
Full Escalation as has failed the target for 6+months



Aug-25
2
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature but is consistently failing the target
Target (Threshold)
0
Target Achievement
Full Escalation as consistently failing the target

Summary:

12 Month rolling count of E. Coli cases: The NPAF Metric uses a 12 month rolling data period and measures the number of cases as a proportion of the Trust Threshold. The Graphs above show the number of cases reported in a 12 month period as at the end of each month. This metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months

12 Month rolling count if C.Diff cases: The NPAF Metric uses a 12 month rolling data period and measures the number of cases as a proportion of the Trust Threshold. The Graphs above show the number of cases reported in a 12 month period as at the end of each month. . This metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months

12 Month rolling count of MRSA cases: The NPAF Metric uses a 12 month rolling data period and measures the number of cases reported.. The Graphs above show the number of cases reported in a 12 month period as at the end of each month. . Metric is currently experiencing Special Cause Variation of an improving nature but is consistently failing the target

Actions:

E. coli:- Focus of the week, IPT newsletters, ad hoc department training sessions, annual audits are carried out on:

- Catheter care/ daily documentation of catheter care
- Hydration initiatives
- IV care and documentation
- Hand hygiene

A review of disinfectants is in progress and a trial planned 1st October Staff to clean mattresses at the time of linen changes

C.Diff:- Actions include:

- Rapid review of all healthcare attributable cases (HOHA, COHA) with the clinical teams and microbiologist
- Sharing of learning with divisions at governance forums
- Change to first line treatment for C. diff infection for 6-month pilot
- Change in cleaning agent for environment and equipment
- Enhanced bed and mattress cleaning
- Deep cleaning programme for high-risk areas due to start

MRSA - The Trusts continues to review all cases of MRSA bacteraemia and share learning where appropriate. The ICB is notified as per schedule 4 of any cases for their investigation and actions.

Assurance & Timescales for Improvement:

E. coli:- A rapid review is undertaken by the IPT to identify any themes and trends, any areas for learning is fed back to clinical teams.

C.Diff:- The Trust has a working action plan which is regularly updated and taken to the IPCC for overview.

MRSA: We have a screening programme in place for MRSA on acute admissions meeting a risk criteria, and for those undergoing certain elective procedures.

We actively treat and take appropriate precautions for patients who have been identified as being colonised with MRSA.

Overall: The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising, RCA scrutiny will continue for alert organisms including E.Coli and C.Difficile, with the aim of seeing a month-on-month reduction in cases.

Strategic Theme: Patient Access

	CQC Domain	Metric	DQ Kite Mark	Latest			Previous			Actions & Assurance				Forecast		
				Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three month Forecast	Variation	Assurance
Vision	Responsive	To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric*		73.8%	69.05%	Aug-25	73.5%	70.5%	Jul-25	Driver			Verbal CMS	70.9%		
Breakthrough Objective	Responsive	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways)		16.5	18.0	Aug-25	17.0	17.7	Jul-25	Driver			Full CMS	17.4		
Constitutional Standards and Key Metrics	Responsive	To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally		73.8%	69.00%	Aug-25	73.5%	70.4%	Jul-25	Driver			Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		732	1020	Aug-25	723	822	Jul-25	Driver			Not Escalated	709		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	5	Aug-25	N/A	11	Jul-25	Driver			Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally *NPAF Metric*		N/A	0	Aug-25	N/A	3	Jul-25	Driver			Not Escalated			
	Responsive	Access to Diagnostics (<6weeks standard)		88.5%	91.3%	Aug-25	88.5%	89.2%	Jul-25	Driver			Not Escalated	89.8%		
	Responsive	A&E 4 hr Performance		85.1%	80.2%	Aug-25	84.9%	83.1%	Jul-25	Driver			Not Escalated	80.8%		
	Responsive	**Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - rolling 3 months *NPAF Metric*		85.1%	82.5%	Aug-25	84.9%	82.4%	Jul-25	Driver			Escalation			
	Responsive	Percentage of emergency department attendances spending over 12 hours in the department - monthly snapshot *NPAF Metric*		4.8%	7.1%	Aug-25	5.1%	5.6%	Jul-25	Driver			Not Escalated			
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.1%	Jul-25	96.0%	96.9%	Jun-25	Driver			Not Escalated	98.0%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	82.2%	Jul-25	85.0%	85.7%	Jun-25	Driver			Not Escalated	85.0%		
		*Cancer - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric*		85.0%	85.4%	Jun-25	85.0%	82.9%	Mar-25	Driver			Not Escalated			
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	75.1%	Jul-25	75.0%	77.3%	Jun-25	Driver			Not Escalated	75.3%		
		*Cancer - 28 Day Faster Diagnosis Compliance (one month behind) - Quarter Position Aggregated *NPAF Metric*		80.0%	76.5%	Jun-25	80.0%	78.0%	Mar-25	Driver			Escalation			
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	88.7%	Jul-25	90.0%	92.7%	Jun-25	Driver			Not Escalated	89.0%		

* 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%	81.2%	Aug-25	85.0%	81.6%	Jul-25	Driver			Not Escalated	80.3%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.0%	5.8%	Aug-25	5.2%	6.4%	Jul-25	Driver			Not Escalated	6.6%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	86.9%	Aug-25	90.0%	86.5%	Jul-25	Driver			Escalation	87.5%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.0%	Aug-25	5.0%	5.7%	Jul-25	Driver			Escalation	6.2%		
	Effective	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward)		5.9	6.7	Aug-25	5.9	6.1	Jul-25	Driver			Escalation			
	Effective	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	13.2%	Aug-25	16.0%	15.7%	Jul-25	Driver			Not Escalated			
	Effective	To achieve the planned levels of new outpatients activity		22,174	19,434	Aug-25	25,468	24,324	Jul-25	Driver			Not Escalated	22,186		
	Effective	To achieve the planned levels of elective (DC and IP combined) activity		5,769	5,877	Aug-25	6,617	6,434	Jul-25	Driver			Not Escalated	5,780		
	Effective	% Capped Theatre utilisation.		85.0%	81.8%	Jul-25	85.0%	82.2%	Jun-25	Driver			Escalation			
	Effective	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	49.8%	Aug-25	49.0%	50.7%	Jul-25	Driver			Not Escalated	50.0		
	Effective	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity		19,622	18,921	Aug-25	17,916	17,996	Jul-25	Driver			Not Escalated	19,063		

Breakthrough Objective: Counter Measure Summary

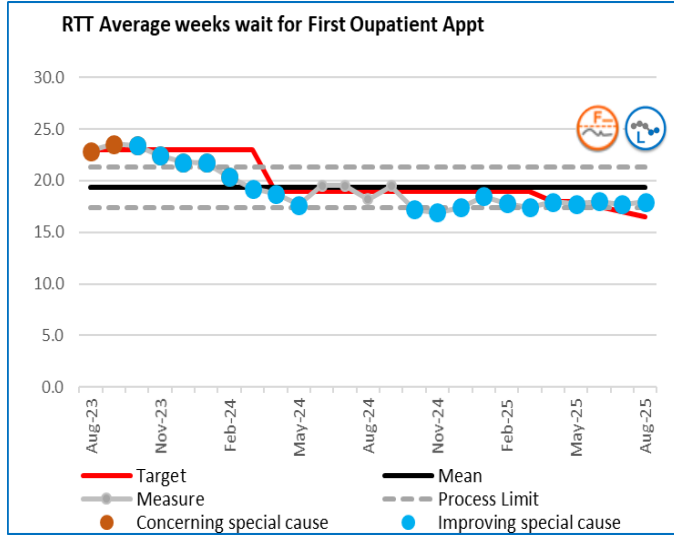
Project/Metric Name – RTT - Reduction in weeks wait to first outpatient appointment (Average weeks wait excluding cancer pathways)

Owner: Chief Operating Officer

Metric: RTT – Reduction in weeks wait to first outpatient appointment (Average)

Desired Trend: 7 consecutive data points below the mean

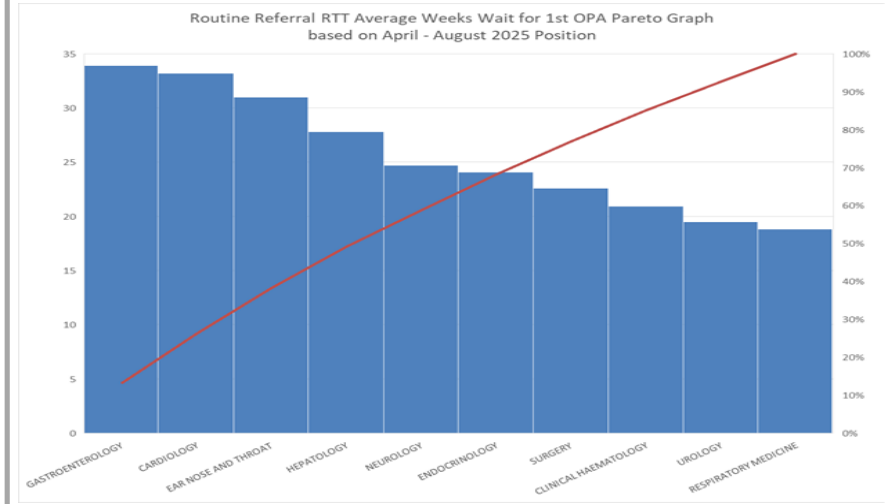
1. Historic Trend Data



Aug-25
18.0
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Limit (Internal)
16.5
Target Achievement
Metric is consistently failing the target

2. Stratified Data

Pareto- Top 10specialities and Number of patients waiting over 18 weeks for 1st OPA



3. Top Contributors

- Cardiology
- Gastroenterology
- ENT- Increase in Urgent Referrals
Capacity – below expected activity plans
Follow up activity -12.5% over activity plan (377 from Apr-Aug)
- Project plan in development regarding digital triage of referrals with ENT the first speciality to go live – date TBC.

Key Risks:

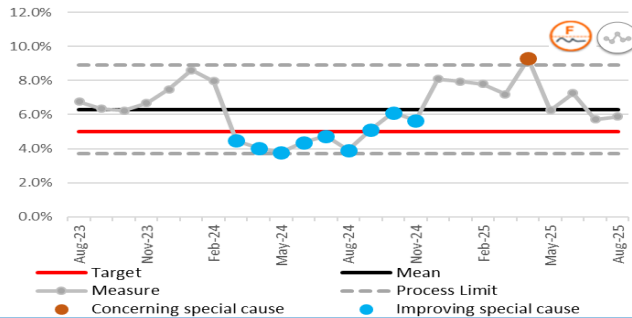
- System capacity challenges
- Cancelled activity due to industrial action may impact performance
- Financial constraints could impact ability to deliver activity levels
- Clinical engagement to transform pathways

4. Action Plan

Action	When
Top contributors identified by speciality	July 25 ✓
High level pathway mapped	July 25 ✓
Data triangulation in progress	Aug 25 ✓
Root cause analysis for each pathway to be undertaken	Sept 25 - Ongoing
Review data and develop multiple cancellation report	Oct 25
Analysis and root cause of 52 week breaches over the last 18 months (excluding system data)	Sept 25 ✓
Analysis and root cause of a sample of 40 week breaches (excluding system data) for top 3 contributors	Oct 25
Triangulate all data against top specialty contributors	Sept 25-Ongoing
Analyse referral trends to see if there are any increases compared to last year	Sept 25✓

Patient Access: CQC: Responsive

Ambulance Handover Delays > 30 mins



Aug-25

5.9%

Variance / Assurance

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

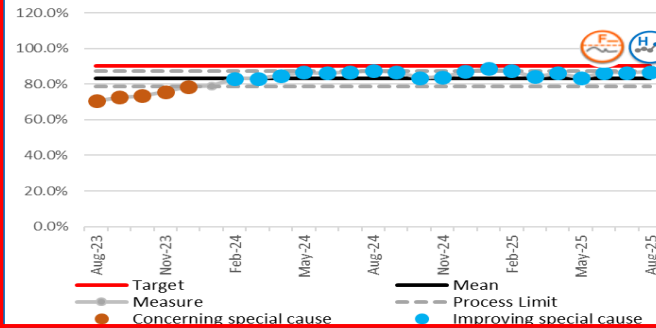
Max Limit (Internal)

5%

Business Rule

Full Escalation as has failed the target for 6+months

Calls Answered in under 1 min



Aug-25

86.3%

Variance / Assurance

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

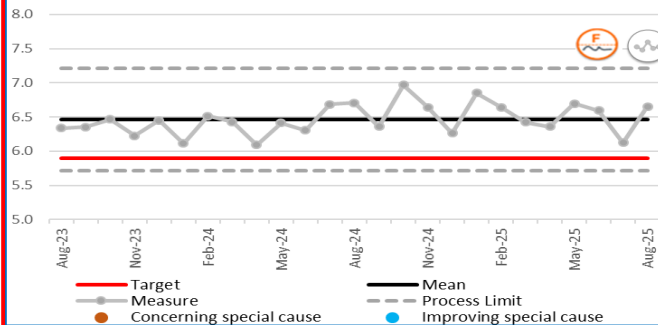
Target (Internal)

90%

Business Rule

Full Escalation as is consistently failing the target

Non-Elective LOS (including Zero LOS & Excluding Type 5 & Virtual Ward)



Aug-25

6.7

Variance Type

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

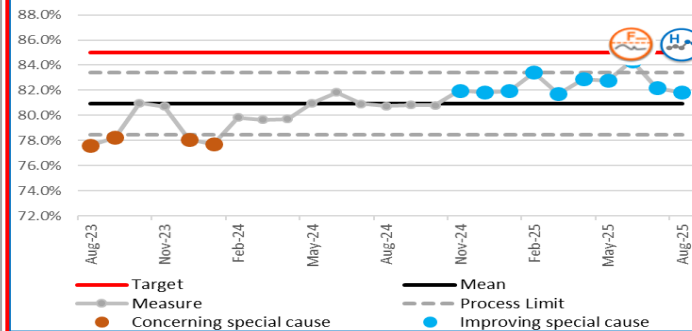
Target (Internal)

5.9

Target Achievement

Full Escalation as has failed the target for 6+months

Elective Capped Utilisation - Trust



Aug-25

81.8%

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 common cause variation 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 (Excluding VW): This indicator how now been changed to exclude the Virtual Ward (VW) LOS. It is now experiencing common cause variation and has failed the target for 6+ months.

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

Actions:

Ambulance Handover delays <30mins: Due to current pressures on capacity and flow the over 30 min ambulance delays can fluctuate across both sites.

Performance against the under 1 minute KPI: Discussion with under-performing CAU teams to discuss plans to improve. Working on how to decrease the calls by maximising PKB Portal and auditing the incoming call data for reasons on why patients are calling in

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:

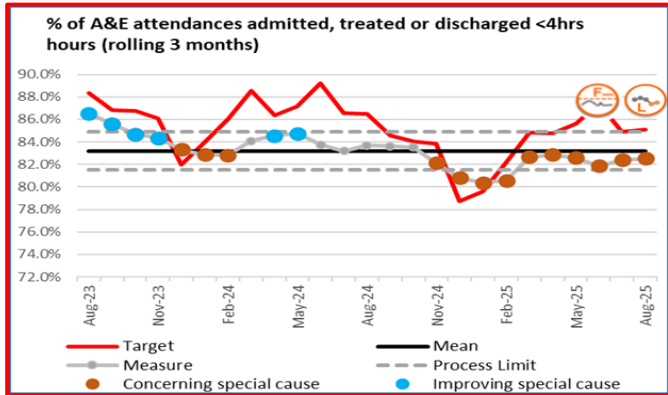
Ambulance Handover delays <30mins: Daily review and validation of ambulance delays. Finding trends and themes for improvement works. New trial from the 9th September 2025 at TWH to create a new flow through a super rap. Review of impact in 4 weeks.

Calls Answered within 1 minute in the CAUs: Calls reduced from the previous month by 4713 and performance did improve from the month before.

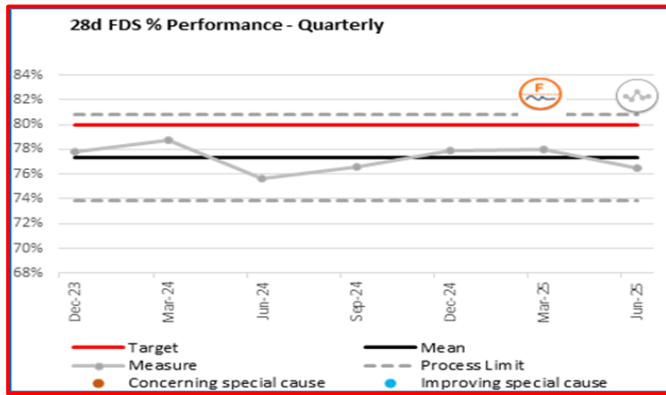
Non-Elective LOS: This is the operation flow financial theme project and is reported on a fortnightly and monthly basis through the Financial Improvement Programme Board, up through F&P and to Trust board. Also aligned to the Better use of Beds system programme of work.

Elective Capped Theatre Utilisation: Smart scheduling in Ophthalmology, Trauma & Orthopaedics and Gynaecology has been implemented.

Patient Access: CQC: Responsive



Aug-25
82.5%
Variance / Assurance
Metric is currently experiencing special case variation of a concerning nature
Target (Bus. Plan)
85.1%
Business Rule
Full Escalation as is consistently failing the target



Jun-25
77.4%
Variance / Assurance
Metric is currently experiencing common case variation
Target (NPAF)
80%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:	Actions:	Assurance & Timescales for Improvement:
A&E 4 hrs (NPAF): The NPAF metric for the 4-hour ED standard uses a three-month rolling data period and ranks trusts in order of their performance. The Q1 NAF score for this metrics was 1.00 as our performance relative to our local and national peers remains strong. Our internal NPAF report also uses a three-month rolling period to the actual performance as well as to the plan that has been submitted as part of our business plan (as we are unable to replicate the national rankings). When our internal business rules are applied to this, the metric is escalated. 28 Day Faster Diagnosis: Performance for the 28-day Faster Diagnosis against the 80% NPAF target is below the target and so this will continue to show as a failing metric – although the variation remains common cause because performance does not vary significantly around the calculated mean. The mean is currently 77.3% so that is above the national Cancer Waiting Times standard of 75%, which has been successfully achieved for all 7 quarters since Q3 23-24, with the lowest performance being 75.63% in Q1 24-25).	A&E 4 hrs (NPAF): ED improvement Action Plan formulate and submitted. Key actions : • Consultant front door streaming at TWH • Super RAP implementation • CDU optimisation workstream • SOP for Minors Surge • UTC utilization focus work SDEC transformational work to create space for improved patient flow 28 Day Faster Diagnosis: 28-day FDS action plan formulated and managed within the organisation Sample key actions: • Improve timeframe for Breast O/S pathway – including opportunity for low-risk pain pathway • Implementation and improvement of current STT pathways in Gynaecology and Head & Neck. • Cross tumour site review of ‘benign’ communication to patients Plan formulated on triangulation of data completeness, diagnosis (Yes/No) and overall compliance.	A&E 4 hrs (NPAF): Improve to 84% in September and realign with submitted trajectory thereafter 28 Day Faster Diagnosis: Performance is benchmarked against the national target as per the 25/26 Operating Plan (80% for 28 days), rather than achieving 80% at yearend as per previous guidance. When this was questioned, NHSE explained that there had been considerable discussion about whether performance should be assessed against individual organisational plans rather than against the agreed year-end standards. However, they felt that using plans as the denominator could create perverse incentives, discouraging ambition in target-setting. For this reason, their Board agreed that where a 25/26 target level has been defined, this should form the basis for measurement. Therefore, they felt the approach recognised achievement at the agreed benchmark level, while applying a fair and proportionate scoring system for those who fall short, based on the degree of variance from the target.

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	81	Aug-25	36	55	Jul-25	Driver			Full CMS	86		
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	9.0%	Aug-25	TBC	18.1%	Jul-25	Driver			Note Performance			
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	18	Aug-25	24	18	Jul-25	Driver			Not Escalated	21		
	Caring	Complaints Rate per 1,000 occupied beddays		3.9	4.4	Aug-25	3.9	3.0	Mar-24	Driver			Not Escalated	4.1		
	Caring	% complaints responded to within target		75.0%	83.0%	Aug-25	75.0%	89.0%	Jul-25	Driver			Not Escalated	75.0%		
	Caring	Complaints Backlog – Older than 4 months		0	1	Aug-25	0	5	Jul-25	Driver			Not Escalated			
	Caring	Complaints Closed in Month		38	54	Aug-25	38	55	Jul-25	Driver			Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	94.0%	Aug-25	95.0%	93.0%	Jul-25	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	16.1%	Aug-25	25.0%	20.1%	Jul-25	Driver			Escalation	20.79%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	12.8%	Aug-25	15.0%	14.0%	Jul-25	Driver			Escalation	14.41%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	9.2%	Aug-25	25.0%	10.0%	Jul-25	Driver			Escalation	10.84%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	13.6%	Aug-25	20.0%	13.7%	Jul-25	Driver			Escalation	15.29%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	98.3%	Aug-25	93.5%	98.5%	Jul-25	Driver			Not Escalated	99.3%		

Breakthrough: Counter Measure Summary

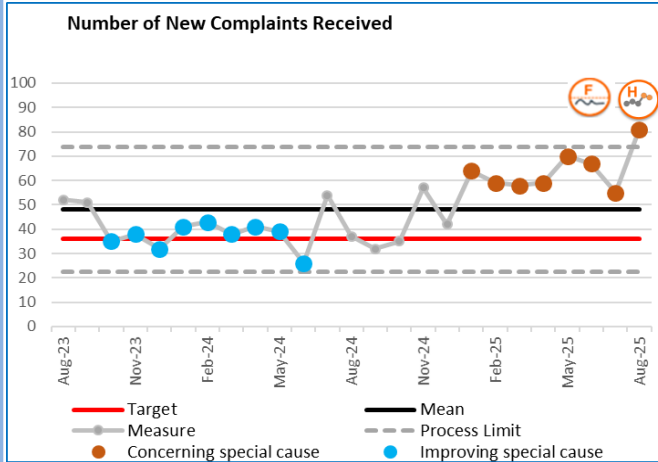
Metric Name – To reduce the overall number of complaints or concerns each month

Owner: Chief Nurse

Metric: Number of Complaints Received Monthly

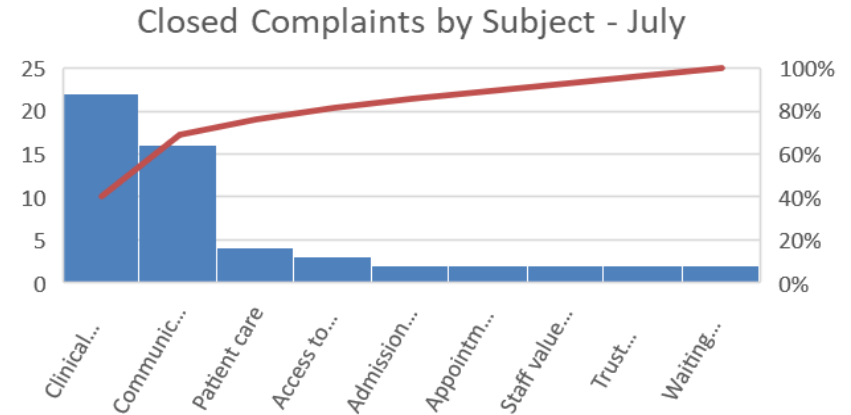
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Aug-25
81
Variance Type
Metric is currently experiencing Special Cause Variation of a Concerning 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.

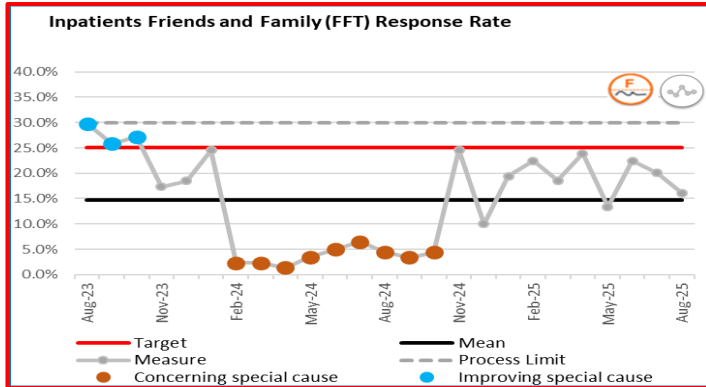
Key Risks:

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 of data underway to determine if the current trend may require an adjustment to the existing target	Patient Concerns Lead
Trust-wide / core team	Review data breakdown by theme underway to ascertain if there are any developing themes and trends	Patient Concerns Lead
Breakthrough Objective Actions		
Trust-wide / core team	Undertake stakeholder engagement event for new A3 in Sep-25	Patient Experience Team
Trust-wide / core team	Re-established Patient Experience Breakthrough Objective Steering Group for new A3 programme, in Aug-25	Patient Experience Team

Patient Experience: CQC: Caring

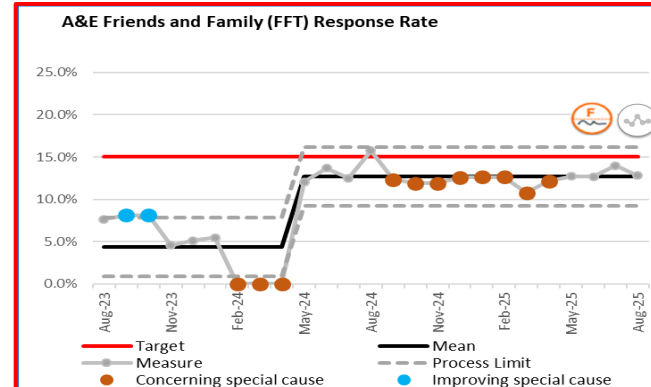


Aug-25
16.1%

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

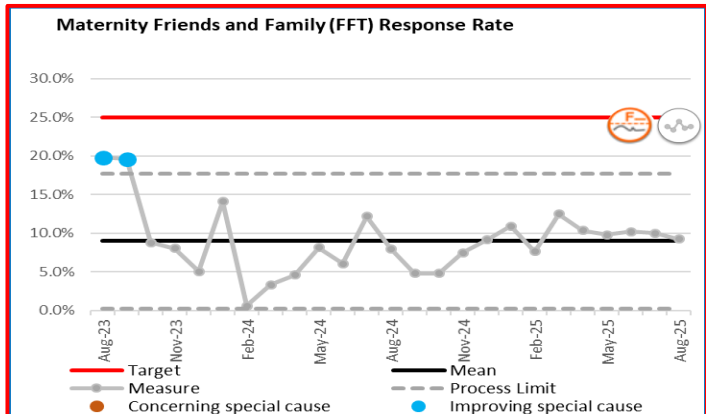


Aug-25
12.8%

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

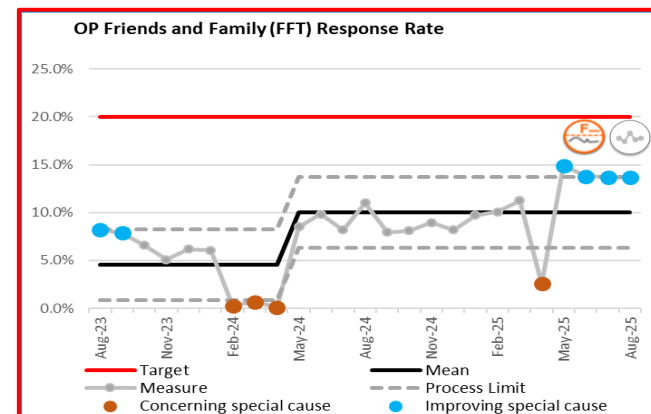


Aug-25
9.2%

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



Aug-25
13.6%

Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target

Target (Internal)
20%

Business Rule
Full escalation as is consistently failing the target

Summary:

Actions:

Assurance & Timescales for Improvement:

Friends and Family Response Rate - Inpatients:

Is experiencing Common Cause variation has failed the target for 6+ months

Trust Recommended Rate is 94.9%

Friends and Family Response Rate - A&E: Is experiencing common cause variation and has failed the target for 6+ months

National Response – 9.9%

Trust Recommended Rate is 80.3%

Friends and Family Response Rate - Maternity: :

Is experiencing common cause variation and consistently failing the target

National Response – 12.6%

Trust Recommended Rate is 97.9%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of an improving nature and is consistently failing the target

National Response – 16.9%

Trust Recommended Rate is 93.4%

Inpatients: The response rate for August has decreased as compared to previous months. Feedback is received via paper cards 39% (361/935) the majority of feedback is in response to SMS text requests. 95% of respondents rated the care received as very good or good. The 3 top themes for positive feedback are consistent and similar – staff attitude, implementation of care and environment. Negative comments are limited but areas for focus include staff attitude, clinical treatment and environment. This is the first time in recent months that clinical treatment has appeared within the top 3 themes.

A&E: In contrast to inpatients, the vast majority of feedback for ED continues to be as a result of SMS text requests with 98% (2658/2702). Positive themes remain consistent on staff attitude; implementation of care and environment – limited/shorter than anticipated waiting time correlates closely with overall patient satisfaction. Kindness, courtesy and professionalism were terms used frequently within the feedback, a variety of staff were named individually within feedback. Themes identified for improvement include staff attitude, waiting time and environment. Negative comments relating to staff attitude tend to focus on medical staff and receptionists; time taken for triage to take place and a lack of/incorrect information about waiting times were consistent points of feedback.

Maternity: The response rate remains reasonably consistent with previous months. Whilst the quantity of feedback remains low, the positivity ratings remain high with the care and kindness of midwives commonly referred to. Conversely, where negative comments were received they end to encompass all of the top 3 negative themes: waiting time, staff attitude and patient mood/feeling.

Outpatients: The outpatient response rate remains reasonably stable. Similar to ED, the most significant proportion of responses are as a result of SMS text invitations. 84% (6706/7972) are via this means despite the likely impact of the survey fatigue filter applied for SMS text requests. Top themes have remained consistent over the last few months with positive themes being attitude of staff, implementation of care and environment, many comments refer to kindness and helpfulness of staff. Areas for improvement continue to be: staff attitude, environment and waiting time – various comments about lack of joined up care – frustration repeatedly expressed about clinical information not being shared between specialities or with primary care; lack of clarity of information when receiving appointments particularly over the phone.

FFT Response All: August has seen a slight reduction in patient feedback in all areas. The patient experience team continues to facilitate the receipt of feedback from patients, carers, relatives and clinical teams in order to obtain feedback and put improvement actions in place through 'You Said, We Did'. There is an opportunity to triangulate the 2024 CQC survey results with current themes within FFT feedback.

Wells Health are submitting the required data to the Private Healthcare Information Network (PHIN) for private patient activity; NHS activity undertaken at Wells Health is included within the above response rates. The transcription of hard copy responses by the provider company – Health Care Communications (HCC) will cease at the end of September 2025 at which time it will be taken in-house, this is likely to demonstrate a small cost saving with the removal of transcription and courier costs however the sustainability of this model will need to be monitored.

Formal notice of the cessation of provision of patient experience services by HCC at the end of August 2026 has now been received.

Friends and Family (FFT) Response Rates:

An alternate provider for FFT is now being sought. In order to facilitate a seamless transition of service discussions are currently ongoing with procurement teams and other providers within the region to understand the different systems in use and potential options.

Strategic Theme: Systems

	CQC Domain	Metric	DQ Kite Mark	Latest			Previous			Actions & Assurance				Forecast		
				Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	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) *		524	549	Aug-25	524	587	Jul-25	Driver			Full CMS			
Breakthrough Objective	Effective	Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays - Target is 95% of 60 beds		57	45	Aug-25	57	50	Jul-25	Driver			Full 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) - Data runs one month behind		12.0	11.4	Jul-25	12.0	10.9	Jun-25	Driver			Not Escalated			

*This strategic theme is focussing on contributors to the overall non-elective length of stay that are part of the Better Use of Beds programme.

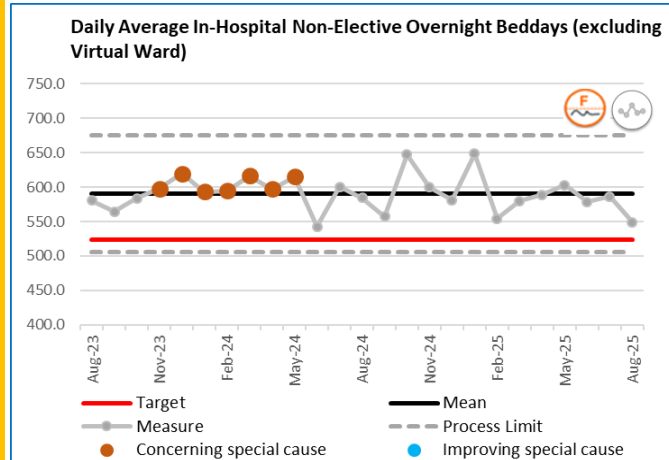
Please note that the target for the Vision metric is a 10% reduction which represents the Trust's internal stretch target.

Vision: Counter Measure Summary

Project/Metric Name –Delivery of the Better Use of Beds programme for MTW - Daily Average In-Hospital Non-Elective Overnight Beddays (Excluding Virtual Ward)

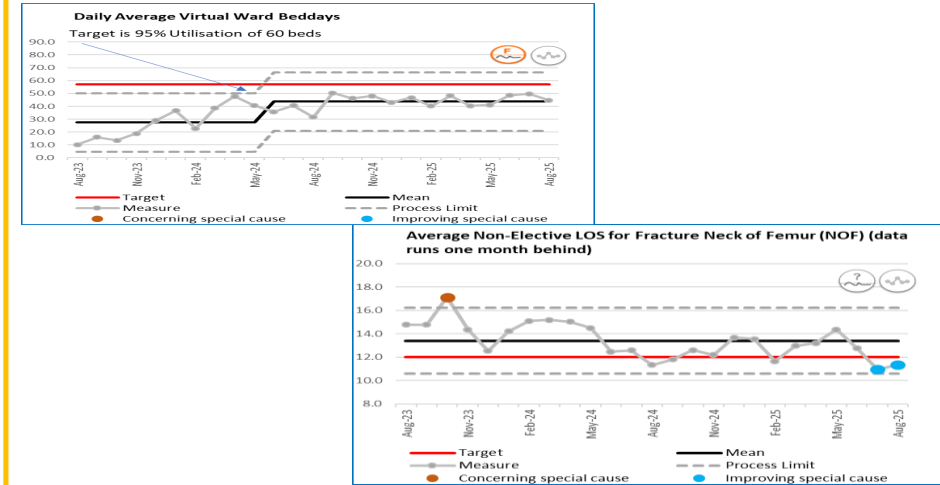
Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average In-hospital non-elective Beddays
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Aug-25
549
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
524 (10% reduction)
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



3. Top Contributors and Key Risks

Top Contributors:

Virtual ward is the top contributor from the Better Use of Beds programme.

Other aspects of flow impacting bed utilisation are being reviewed as part of the operational flow project.

Key Risks/Issues:

Virtual ward funding for 26/27

Lack of pathway 1 performance data

4. Action Plan

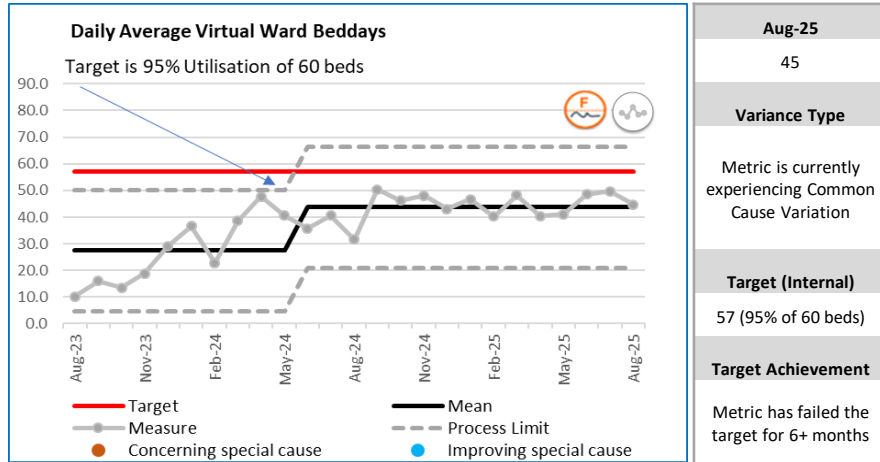
Workstreams	Actions	When	Who
Strategic Theme – Vision Metric	Review target for Vision Metric	Complete	Project Team
	SRO to discuss interdependency of vision metric with LOS Metric with COO.	complete	SRO
VW Beddays	Project Charter being developed and scope being defined and timeline for A3 development scoped	complete	Project Team
	Agree Stakeholders	complete	Project Team
	Set up Project Meetings	Complete	Project Team
	Review Data sets to identify top contributors and stratified data.	Complete	Project Team
	Agree effective utilization rate	Complete	Project Team
Pathway 0 discharges	To develop a measurable record of pathway 0 discharges	Dec 25	BI/project team

Breakthrough Objective: Counter Measure Summary

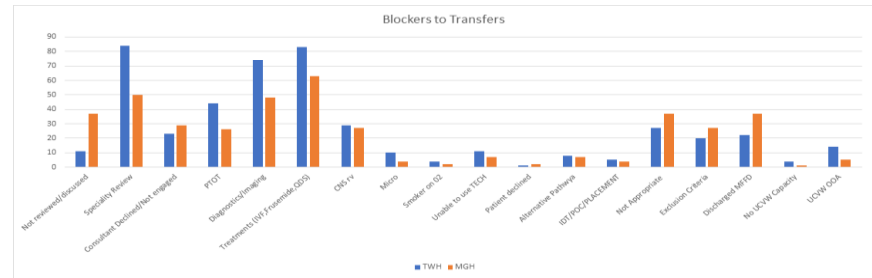
Project/Metric Name – Daily Average Virtual Ward Beddays - Target is 95% of 60 beds

Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average Virtual Ward Beddays - Target is 95% of 60 beds
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



2. Stratified Data



The top 3 reasons that patients are not discharged to VW are:

- Clinical team engagement/specialty review
- The need for more diagnostic tests
- The need for treatments in the home – e.g IV & Frusemide.

3. Top Contributors and Key Risks

Top Contributors:

Areas where pathway utilisation could be improved are:

- Gastroenterology (TPN, stoma)
- Respiratory (weekend)
- Orthopaedics
- Diabetes
- Women's

Key Risks/Issues:

Virtual ward funding for 26/27.

4. Action Plan

Workstreams	Actions	When	Who
Virtual ward utilisation	Agree an effective utilisation rate	Complete	SRO and ETM
	Review virtual ward utilisation data	Commenced	SRO with FJ
	Identify top 3 areas to improve utilisation	End September	SRO with FJ
	Review blockers to utilisation	Complete	SRO with FJ
	Work with divisions to support improved utilisation	End November	FJ and VW team
	Develop programme of work to push suitable patients to the VW	End December	SRO and FJ

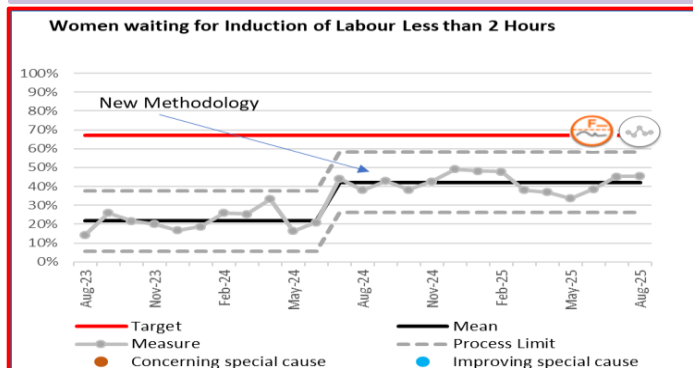
Strategic Theme: Sustainability

				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, inc. operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) *NPAF Metric*		-1,614	-1,603	Aug-25	297	164	Jul-25	Driver			Verbal CMS	-3,271		
Breakthrough Objectives	Well Led	Reduce non-pay spend		22,055	21,514	Aug-25	22,243	21,853	Jul-25	Driver			Verbal CMS	21,741		
Constitutional Standards and Key Metrics	Well Led	CIP		5,173	3,659	Aug-25	4,297	7,469	Jul-25	Driver			Not Escalated	7,781		
	Well Led	Cash Balance (£k)		6,469	24,969	Aug-25	5,472	20,604	Jul-25	Driver			Not Escalated	7,986		
	Well Led	Capital Expenditure (£k)		390	2,975	Aug-25	522	372	Jul-25	Driver			Not Escalated	309		

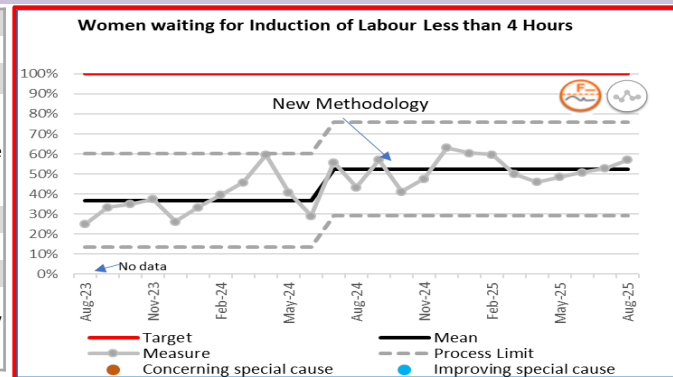
Maternity Metrics

				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	461	Aug-25	470	450	Jul-25	Driver		No target	Not Escalated	449		
	Maternity Metric	Antenatal bookings		No target	484	Aug-25	545	563	Jul-25	Driver		No target	Not Escalated	514		
	Maternity Metric	Elective Caesarean Rate		No target	20.6%	Aug-25	No target	23.0%	Jul-25	Driver		No target	Not Escalated	22.2%		
	Maternity Metric	Emergency Caesarean Rate		No target	29.2%	Aug-25	No target	22.5%	Jul-25	Driver		No target	Not Escalated	24.3%		
	Maternity Metric	Induction of Labour Rate		36.0%	28.1%	Aug-25	36.0%	27.0%	Jul-25	Driver			Not Escalated	27.2%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	45.5%	Aug-25	67.0%	45.3%	Jul-25	Driver			Escalation	50.2%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	57.0%	Aug-25	100.0%	52.8%	Jul-25	Driver			Escalation	58.4%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	6.5%	Aug-25	6.0%	5.3%	Jul-25	Driver			Not Escalated	6.9%		
	Maternity Metric	Unexpected term admissions to NNU (data runs one month behind)		4.0%	4.2%	Aug-25	4.0%	4.0%	Jul-25	Driver			Not Escalated	5.1%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Aug-25	0.4%	0.2%	Jul-25	Driver			Not Escalated	0.2%		
	Maternity Metric	PPH >=1500% Rate		3.0%	4.2%	Aug-25	3.0%	1.8%	Jul-25	Driver			Not Escalated	2.8%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	2.2%	Aug-25	2.5%	2.1%	Jul-25	Driver			Not Escalated	2.7%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	78.9%	Aug-25	75.0%	78.6%	Jul-25	Driver			Not Escalated	79.4%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	100.0%	Aug-25	95.0%	91.7%	Jul-25	Driver			Not Escalated	33.4%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	86.5%	Aug-25	95.0%	96.0%	Jul-25	Driver			Not Escalated	38.4%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Aug-25	100.0%	100.0%	Jul-25	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suite coordinator is supernumerary (MOPEL)		100.0%	100.0%	Aug-25	100.0%	100.0%	Jul-25	Driver			Not Escalated	100.0%		

Maternity Metrics



Aug-25
45.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as consistently failing the target



Aug-25
57.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target

Summary:

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

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

Actions:

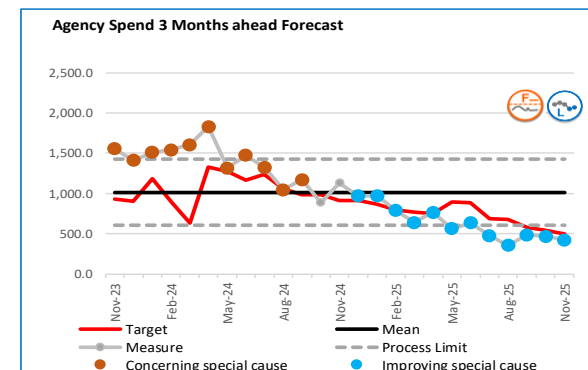
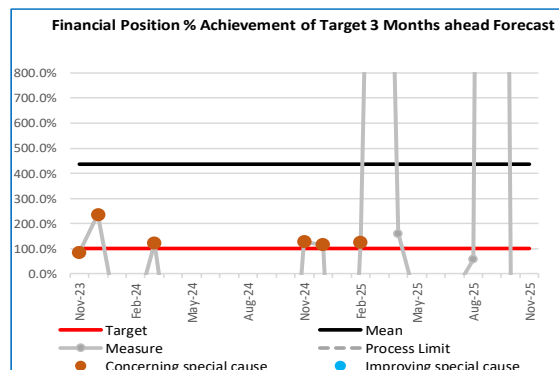
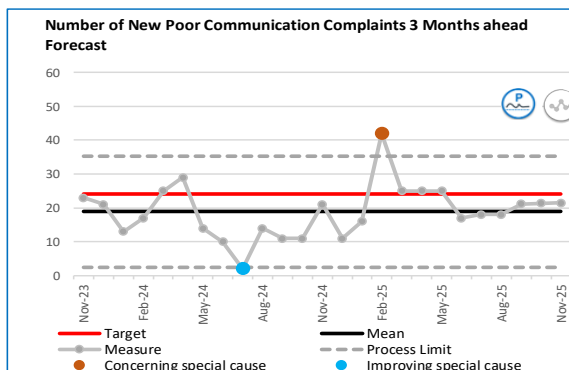
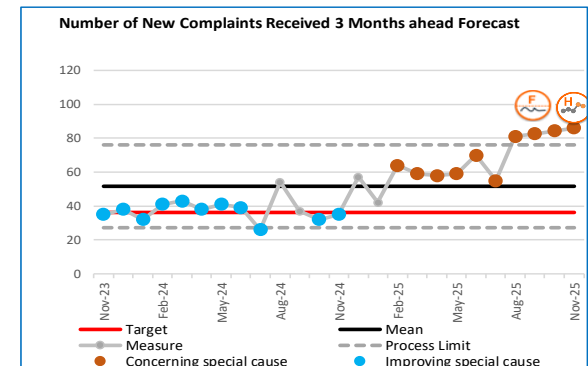
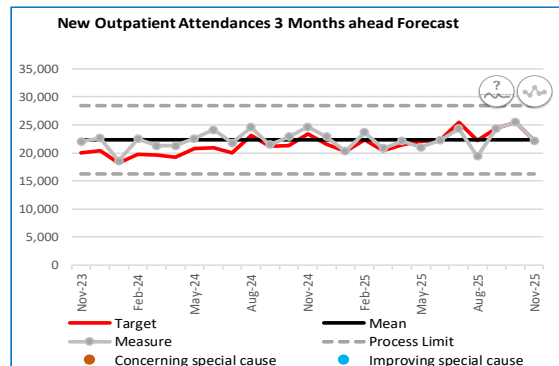
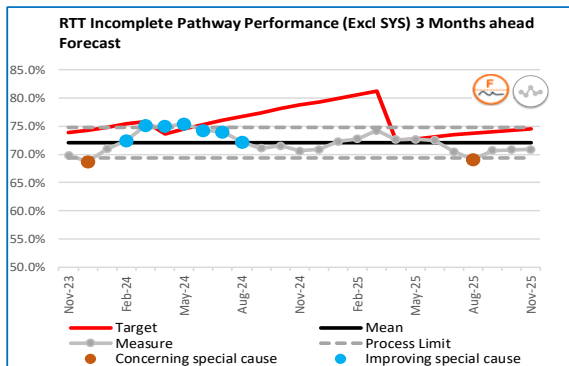
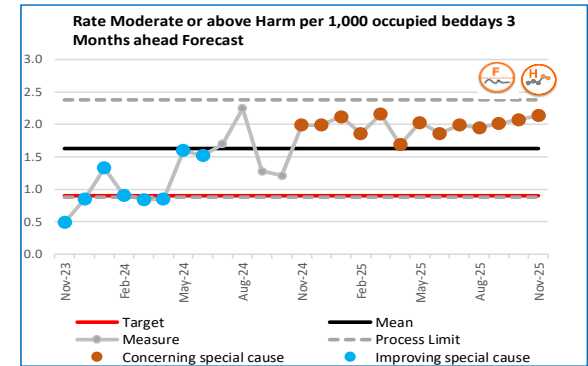
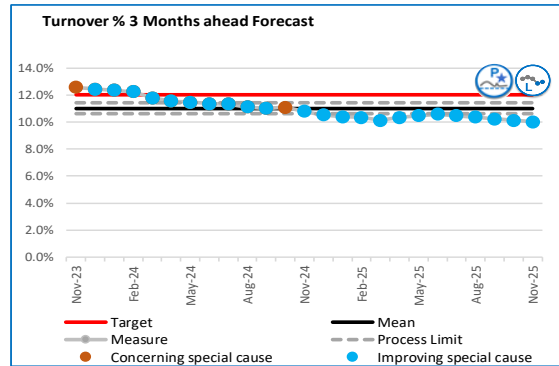
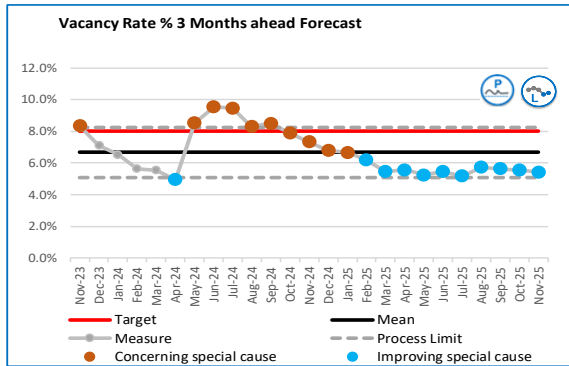
Escalation policy has been ratified by the policy ratification committee.
A3 implemented to address flow throughout the service which impacts transfer for ongoing induction of labour.
Agreed escalation to Ward 33 to support with blockages.
IOL project group is proposing the allocation of an IOL midwife on Triage and delivery suite to support flow through pathway.

Assurance & Timescales for Improvement:

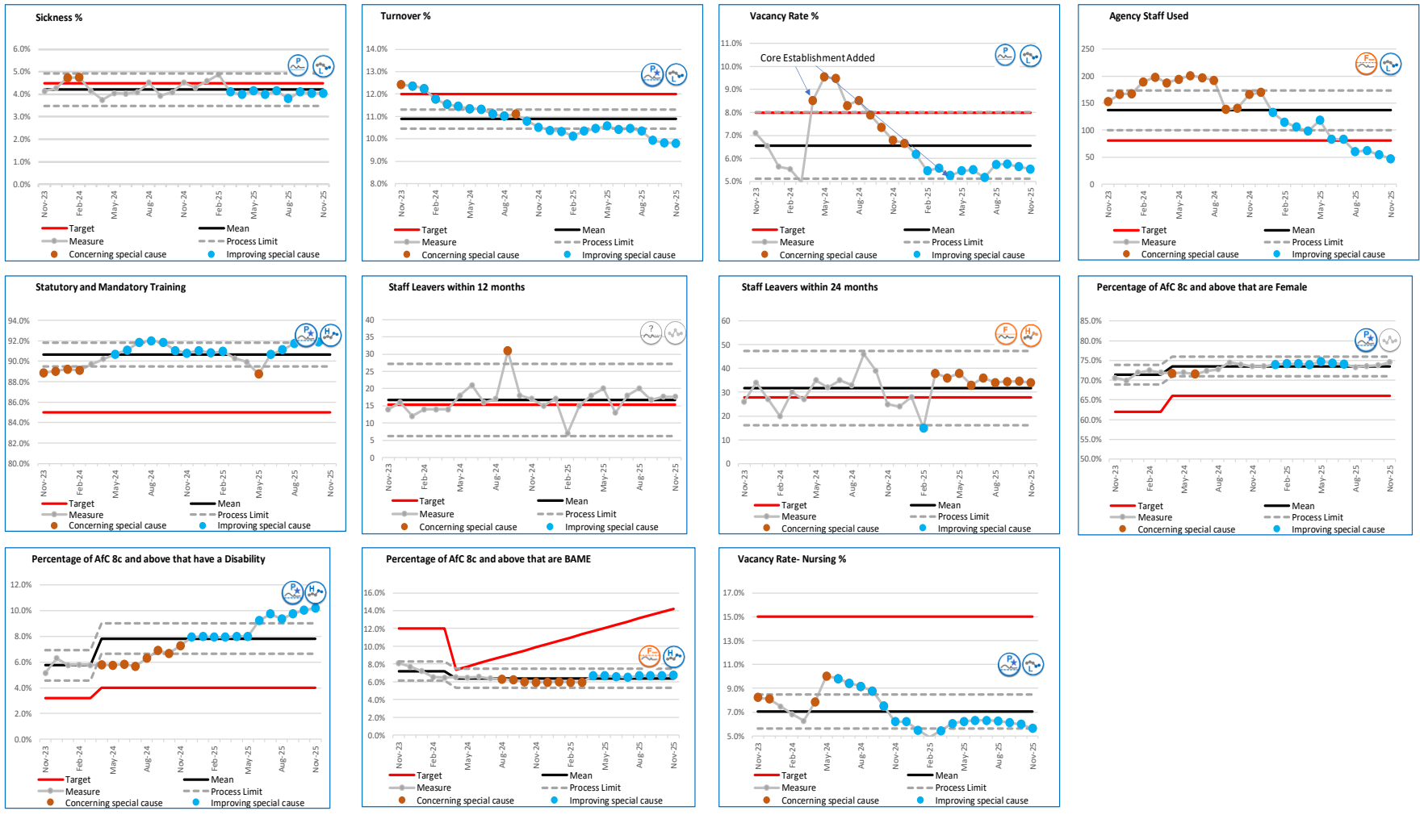
Women waiting for Induction of Labour less than 2 or 4 Hours:
This metric is impacted by periods of high activity which are largely unpredictable, as well as staffing availability. Ongoing risk assessment and prioritisation is in place to maintain the safety of women whose care is delayed. Initial consensus is there has been no significant impact from the change in IOL for post dates, however it is recognised that more data is required. Initially, challenges around staffing and bed space on postnatal was thought to be the main bottle neck however, delivery suite staffing and practises have a significant impact. Timescales for improvement will be dependent on the outcome of the flow project and any actions required as a result.

Appendices

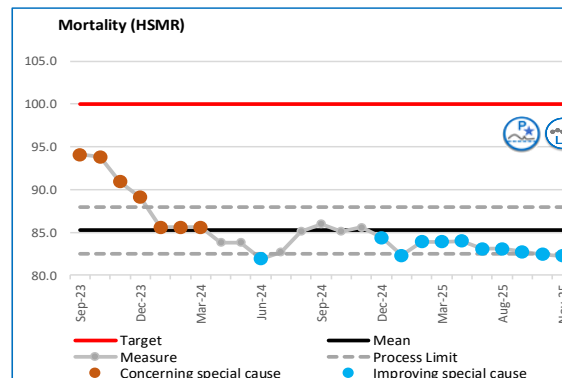
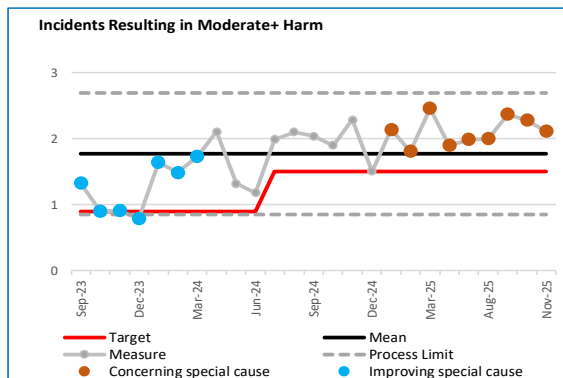
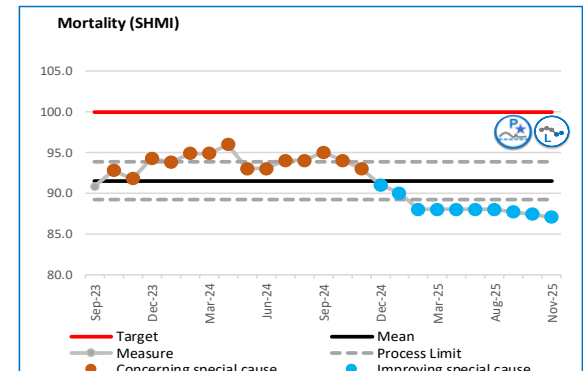
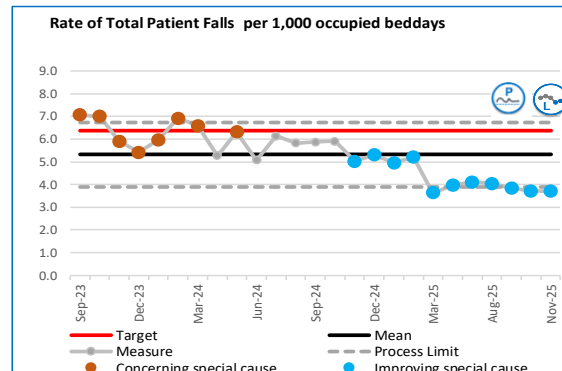
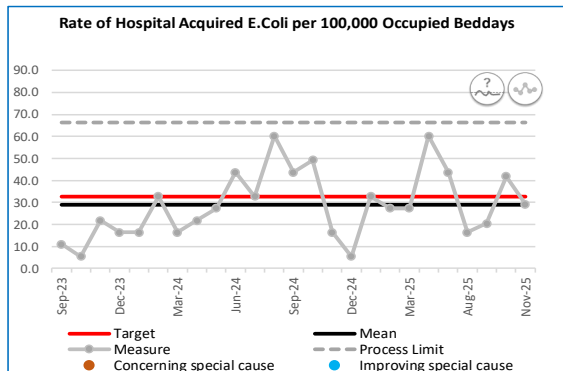
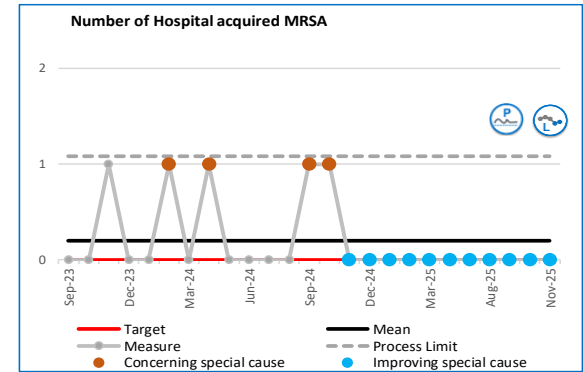
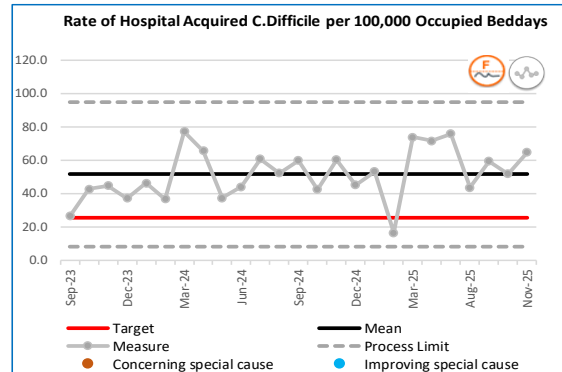
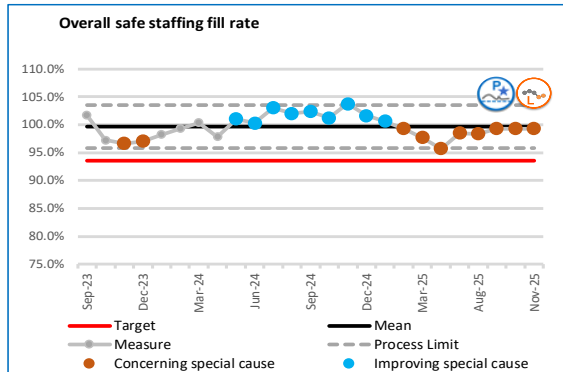
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives



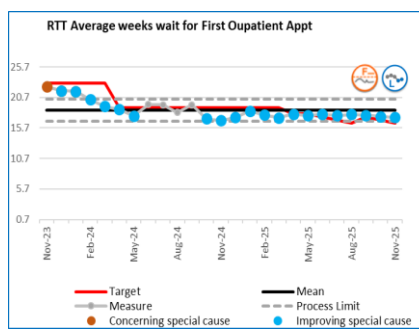
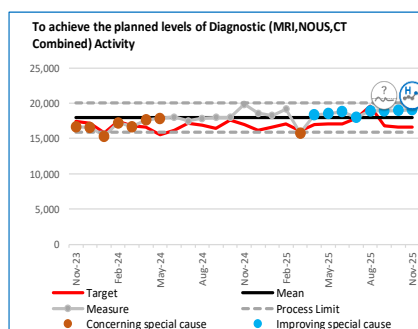
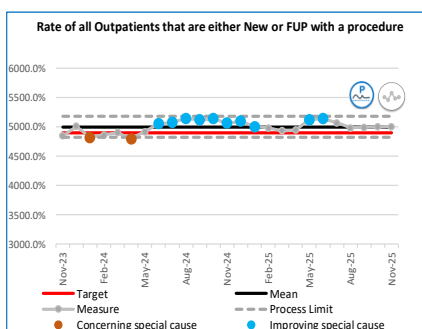
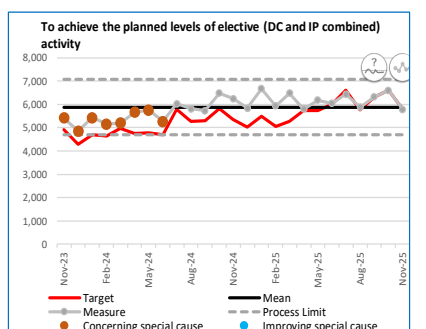
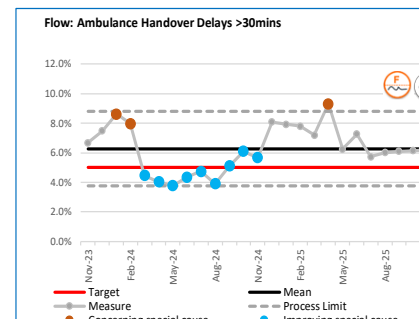
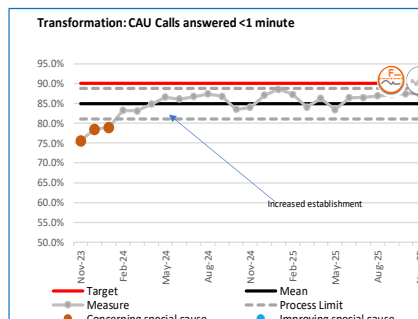
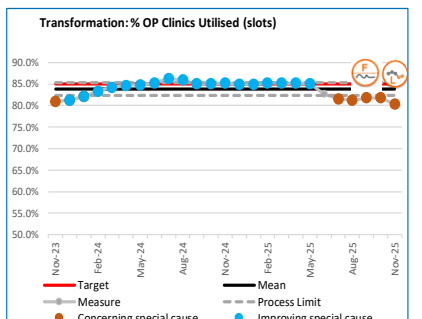
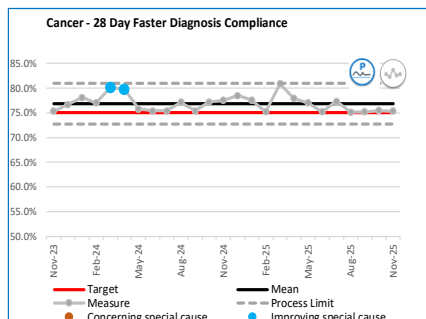
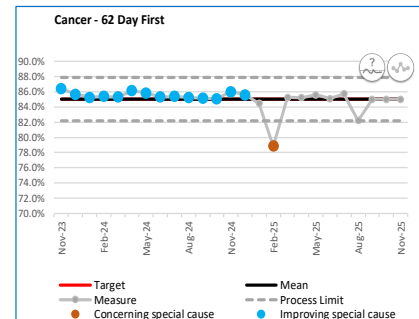
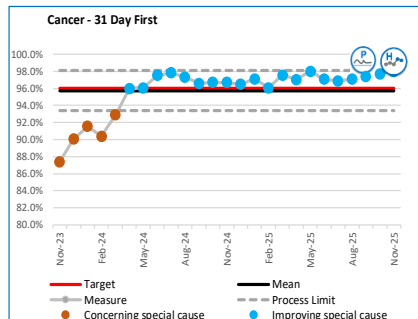
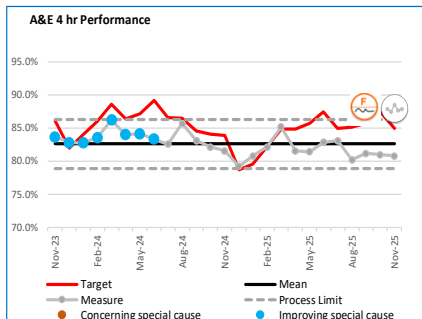
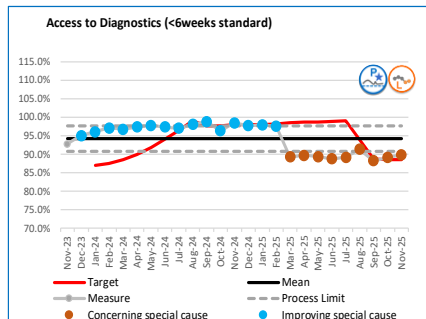
Forecast SPCs (3 month forward view) for People Indicators



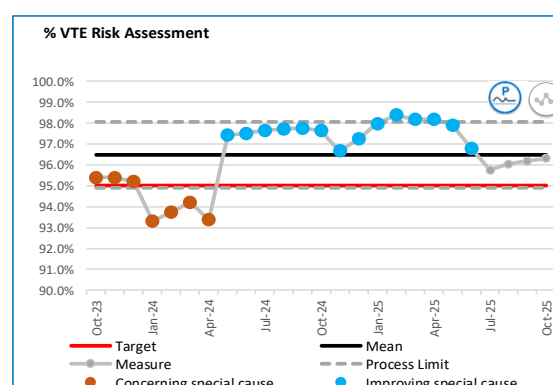
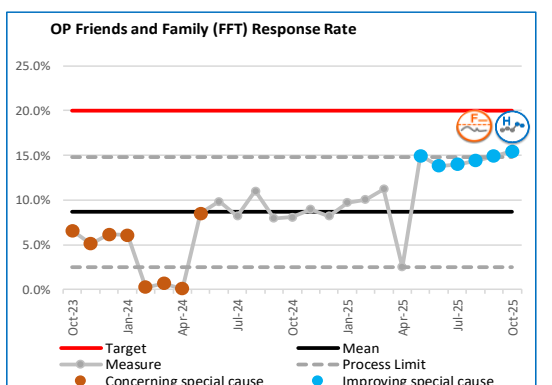
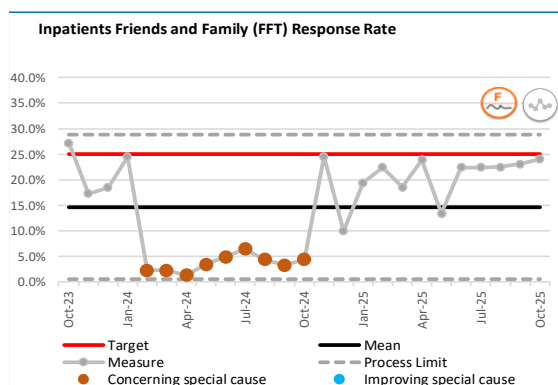
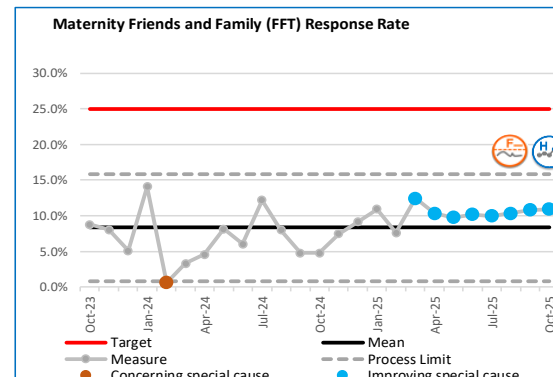
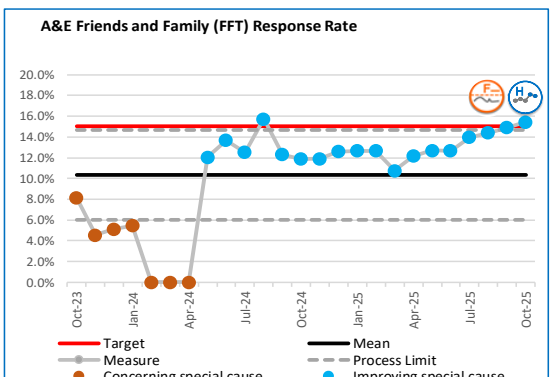
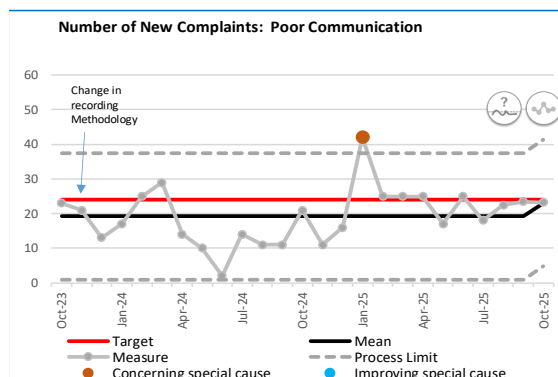
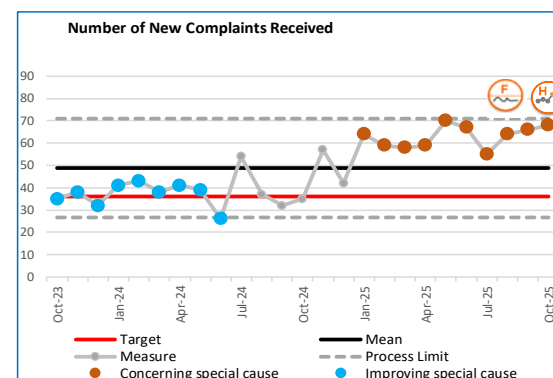
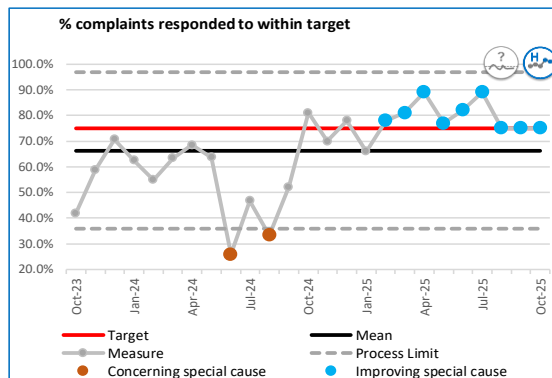
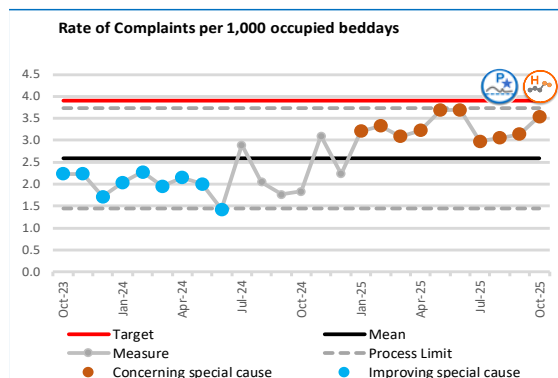
Forecast SPCs (3 month forward view) for Patient Safety Indicators



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

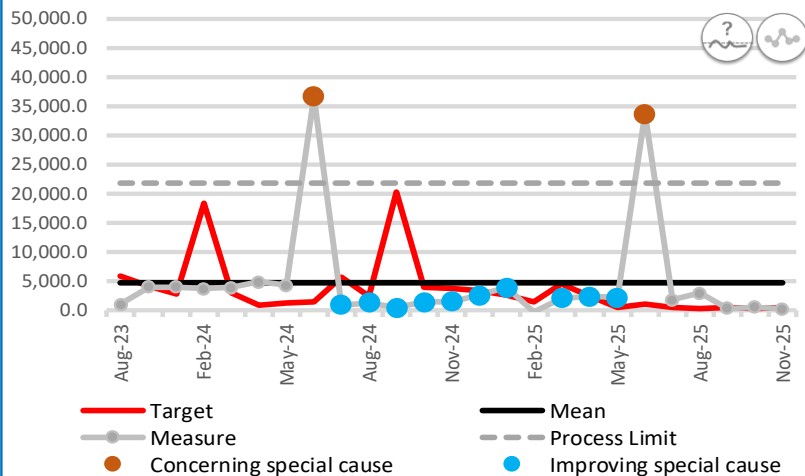


Forecast SPCs (3 month forward view) for Patient Experience Indicators

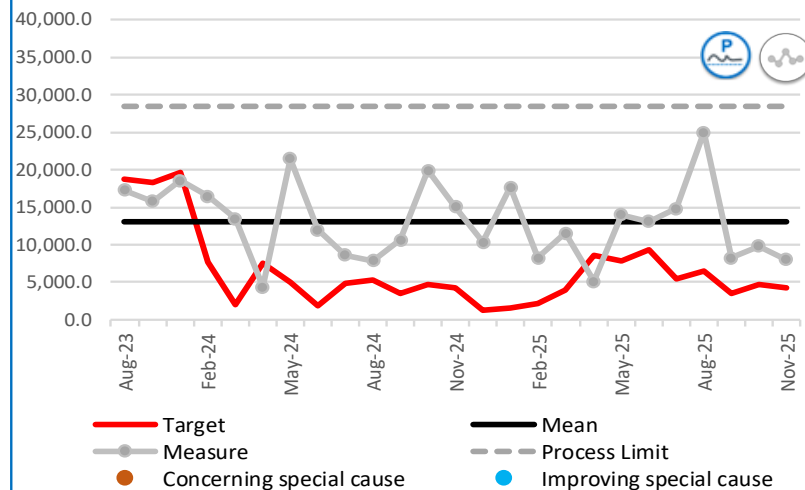


Forecast SPCs (3 month forward view) for Sustainability Indicators

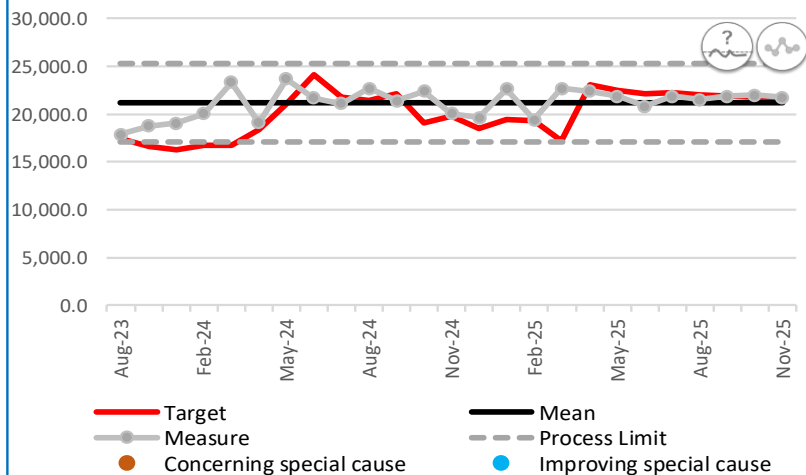
Capital Expenditure £000



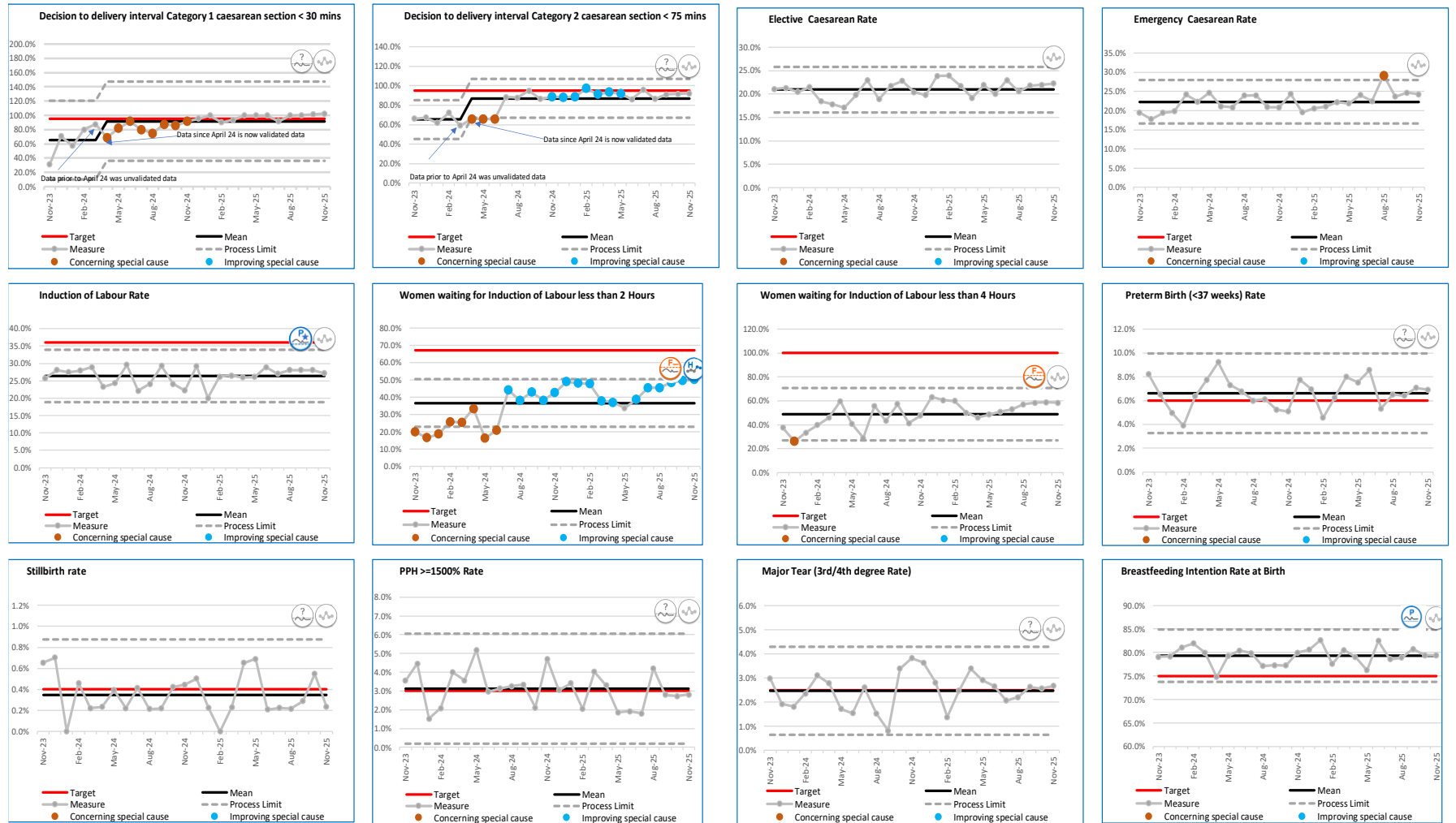
Cash Balance £000



Non-Pay Spend

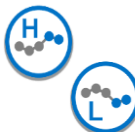


Forecast SPCs (3 month forward view) for Maternity Indicators



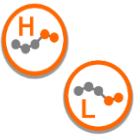
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

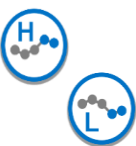
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates inconsistently hitting or missing the target.	Metric is Hitting & Missing the Target and is showing a Special Cause for Concern. A <u>verbal CMS</u> 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. <u>Note performance</u>, 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 <u>verbal CMS</u> 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. <u>Note performance</u>, 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. <u>Note performance</u>	Metric is Hitting and Missing the Target, but is showing a Special Cause of Improvement. <u>Note performance</u>
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 <u>full CMS</u>	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

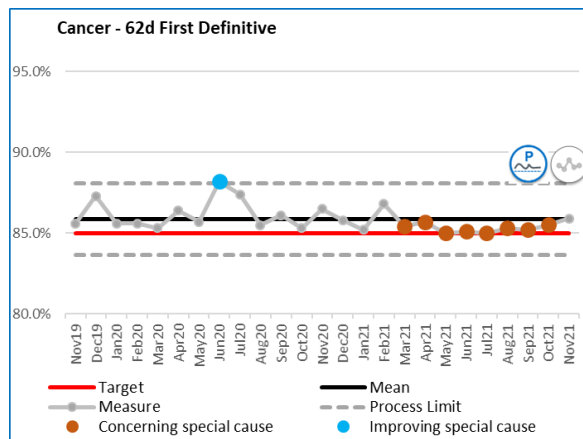
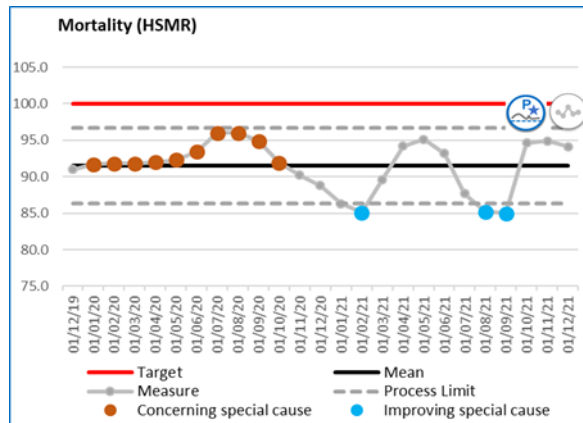
Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass**  have:

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

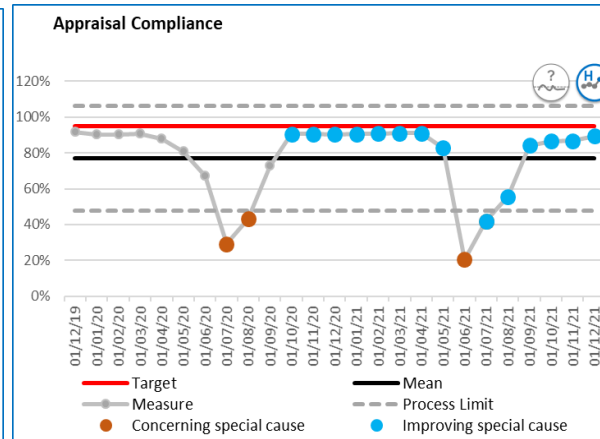
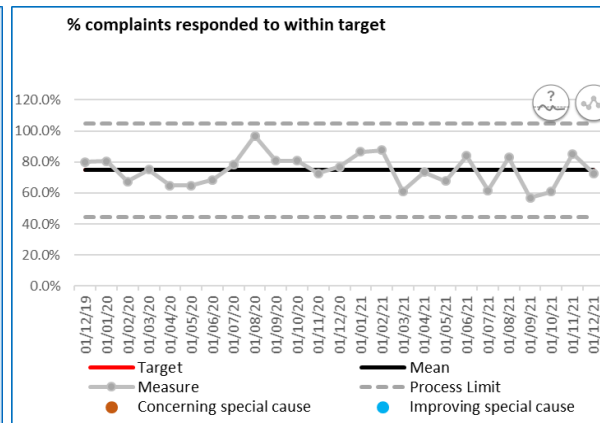
The **lower** control limit **above** the target line for metrics that need to be **above the target**

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

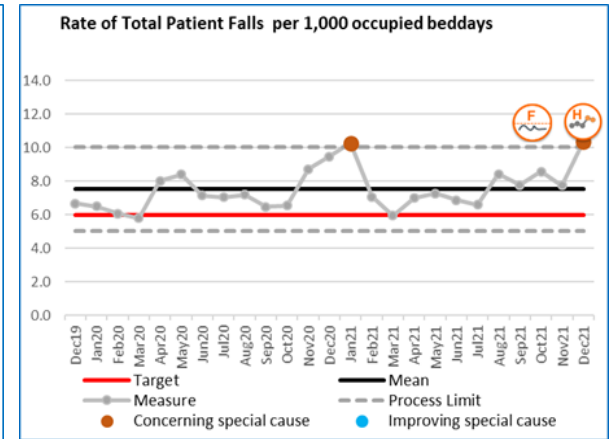
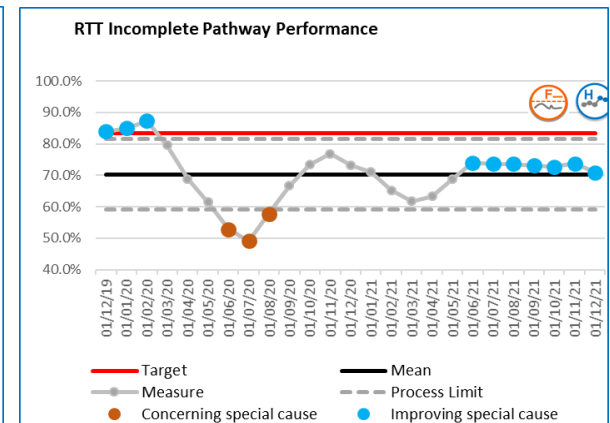


Metrics that consistently **fail**  have:

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

Executive Summary

- The Trust was £1.6m in deficit in the month which was breakeven to the plan. Year to date the Trust is £12.6m in deficit which is £0.1m adverse to plan.
- The key year to date pressures are: Pay pressure (£0.9m), Fordcombe slippage to plan (£0.8m) and CIP project support costs (£0.6m). These pressures were offset non recurrent benefits (£0.8m), CNST rebate (£0.6m), Pathology income overperformance net of additional cost (£0.5m) and additional radiotherapy income (£0.3m)
- 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 is forecasting to deliver £47.4m which is £24.7m adverse to plan. The main slippage relates to system savings which is £21.8m adverse to plan
- The Trust is forecasting to deliver the year-end financial plan (breakeven) however recovery actions / CIP delivery of £36m are required to be delivered.

Current Month Financial Position

- The Trust was £1.6m in deficit which was breakeven to the plan.
- **Key Adverse variances in month are:**
 - CIP (£1.5m). The Trust was £1.5m adverse to plan in the month which was mainly due to slippage against system related savings (£1.8m)
 - Drugs (£0.1m). The Trust overspent within drugs by £0.1m (excluding pass through related costs), the main area of pressure in the month related to homecare drugs.
- **Key Favourable variances in month are:**
 - Clinical income benefits in the month (£1.2m) which included: Year to date income adjustment (£0.5m) to fund costs associated with the COVID Medicine Decision Unit (CMDU), contract discussions are ongoing with commissioners to secure this income. Due to ongoing discussions with Kent and Medway ICB to finalise 2024/25 income values the Trust has removed £0.6m of income risk in month 5. The income position also includes £0.1m additional radiotherapy income (£0.3m YTD) to reflect the positive ongoing discussion with Specialist commissioning.
 - Non Recurrent expenditure benefits (£0.3m).
 - Brockenhurst Car Parking VAT rebate for 25/26 (£0.1m). The Trust has included £0.1m net benefit of a VAT rebate linked to Car parking.

Year to Date Financial Position

- The Trust was £12.6m in deficit which is £0.1m adverse to the plan.
- **Key Adverse variances are:**
 - Pay pressure (£0.9m). Year to date the Trust has incurred £0.9m additional pay costs compared to the 2024/25 adjusted baseline used for the plan (month 9 year end forecast adjusted for inflation and planning assumptions) which includes £0.1m associated with industrial action in July.
 - Fordcombe hospital slippage to plan (£0.8m)
 - CIP project support costs (£0.6m)
- **Key Favourable variances are:**
 - Non recurrent benefits (£0.8m)

- Pathology income overperformance net of additional costs (£0.5m) mainly associated with a change in charging approach.
- CNST (£0.6m) - The Trust has received a reduction of £0.6m relating to maternity CNST
- Radiotherapy income (£0.3m) above plan from specialist commissioning

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 August the Trust has saved £3.6m which was £1.5m adverse to plan mainly due to a slippage associated with the system wide savings target (£1.8m)
- Year to date the Trust has saved £17m which is £1.7m favourable plan.
- The Trust has implemented a Financial Improvement Programme Board (FIPB) which meets every two weeks to monitor progress against the overall CIP target of £72.1m.
- The Trust is currently forecasting to deliver £47.4m of savings in 2025/26 which is £24.7m adverse to plan. The main slippage relates to the system wide savings target (£21.8m adverse)
- The Trust is forecasting to deliver £55.1m in a full year,

Risk

- **Pathology Managed Service VAT reclaim** review (£6.4m) - 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.
- **Brookenhurst Car parking VAT claim (net £0.9m)** - The Trust has included back dated VAT claim of £0.7m (net 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 is forecasting to deliver £47.4m which is £24.7m adverse to plan. The main slippage relates to system savings which is £21.8m adverse to plan
- **Redundancy Costs** – The Trust might incur c£4.7m of redundancy costs associated with the pay transformation plan although its estimated c£1.3m could be mitigated due to through the redeployment of staff
- **2024/25 Outstanding contract issues** - The Trust has £7.2m of outstanding contract issues with Kent and Medway ICB.

Cashflow position:

- The closing cash balance at the end of August was £24.97m, this is higher than the plan value by £18.57m. The reasons behind this increase is 1) the Trust needs to pay Tax, NI and Pension for the back dated payrise element that employees received in August across in September; 2) the Trust is currently holding £4m carried forward cash from year end which the Trust is in discussion with K&M ICB on when they will reclaim this; 3) within September under "other revenue payments" is £5m relating to mths 1-5 for the Roche managed service contract extension agreement, the Trust is expecting invoices relating to these periods within this month.
- The month end cash balance also needs to cover the first two weeks of the following month's commitments; this is due to the Trust receiving its monthly block SLA income on the 15th of each month – these commitments include weekly supplier payment runs and weekly payroll including 247-time agency.

- The cashflow is updated daily and the forecast is regularly updated and reviewed if costs during the year increase eg; salaries are higher than plan and the remaining months are amended to be in line with the current charges. The Trust has implemented various cash strategies to ensure future commitments are met.
- The Trust is working closely with local NHS organisations and agreeing reciprocal 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 is not much cash gain from these agreements but it enables a reduction to both debtors/creditors balances. The ICS have set up a weekly cash meeting which the Trust actively participates in. The ICB are encouraging organisations to pay other NHS organisations and not withhold payments as in previous years. The Trust is engaging well with EK, KMPT and KCHFT other organisations are not replying in a prompt manner so this has been escalated to Deputy Director of Finance level for assistance.
- 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 August the Trust's percentages were: Trade value 75.3% (m4 – 81%) and quantity 75.9% (m4 – 84%); NHS value 88.9% (m4 – 92.3%) quantity 72.1% (m4 84.6%).

Capital Position

- **Capital Plan**

- The Trust's capital plan for 2025/26 is £18.3m. The Trust's planned share of the K&M ICS control total is £12.3m 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 £0.5m as part of the Constitutional Standards allocation for MTW
 - Linac Replacement at Kent and Canterbury Hospital £2.6m (equipment) and £0.3m (enabling works)
 - Estates Safety schemes for £3.46m as part of the Critical Infrastructure Strategy allocation for MTW which is additional to the plan.
 - System Capital Support - The Trust has also been awarded £2m relating to the Urgent and Emergency Care (UEC) Incentive Award in recognition of achieving A&E targets in 24/25. This is additional to Plan. Schemes are currently being prioritised

- **Month 5 Actuals (excluding IFRS16)**

The YTD spend at month 5 is £6.31m against a YTD budget of £4.97m. The main YTD variance relates to the delivery of the Linac at K&C, which is earlier than planned, however, other schemes for estates diagnostic enabling are behind plan.

- **Forecast**

- At Month 5 the Trust is assuming that the FOT will be equal to the Plan, plus additional System/National awards

- **Project Updates**

- Estates - Enabling work on the TWH IR Suite and CT Sim has been delayed, they are still expected to be completed in year. Other works are in the planning stages.
- Security - Schemes are currently being prioritised.
- ICT - Backlog schemes are currently being prioritised.

- Equipment - Most of the backlog schemes have been ordered, some have been delivered. Constitutional Standard schemes; all business cases have now been approved and have been sent to NHSE for final approval.
- Linac replacement at K&C - The machine was delivered to site at the end of July and is currently being commissioned over the next few months, before going into clinical use.
- Donated - some orders have been raised, others are in the planning/approval stage.
- IFRS16 Leases - The YTD spend relates to the start of the TWH Surgical Robot lease, MLS lease renewal together with various remeasurements.

Year end Forecast

The Trust is forecasting to deliver the planned breakeven position however recovery actions of £36m are required to be delivered.

Finance Report

**Month 5
2025/26**

Summary

August 2025/26

	Current Month					Year to Date				
	Actual	Plan	Variance	Pass-	Revised	Actual	Plan	Variance	Pass-	Revised
				through	Variance				through	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	67.6	66.7	0.9	0.0	0.8	339.4	337.7	1.7	0.2	1.4
Expenditure	(64.3)	(63.3)	(1.0)	(0.0)	(0.9)	(327.0)	(325.2)	(1.7)	(0.2)	(1.5)
EBITDA (Income less Expenditure)	3.3	3.4	(0.1)	0.0	(0.1)	12.4	12.5	(0.1)	0.0	(0.1)
Financing Costs	(4.2)	(4.4)	0.2	0.0	0.2	(31.3)	(31.5)	0.2	0.0	0.2
Technical Adjustments	(0.7)	(0.6)	(0.1)	0.0	(0.1)	6.3	6.5	(0.2)	0.0	(0.2)
Net Surplus / Deficit	(1.6)	(1.6)	0.0	0.0	0.0	(12.6)	(12.5)	(0.1)	0.0	(0.1)
Cash Balance	25.0	5.3	19.7		19.7	25.0	5.3	19.7		19.7
Capital Expenditure (Incl Donated Assets and IFRS16)	3.0	0.4	(2.6)		(2.6)	6.3	5.0	1.3		1.3
Cost Improvement Plan	3.7	5.2	(1.5)		(1.5)	17.0	15.3	1.7		1.7

Summary Current Month:

- The Trust was £1.6m in deficit in the month which was breakeven to plan. The Trusts key variances to the plan are:

Adverse Variances:

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Favourable Variances

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Year to date overview:

- The Trust is £12.6m in deficit which is £0.1 adverse to plan. The Trusts key variances to the plan are:

Adverse Variances:

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- CIP project support costs (£0.6m)

Favourable Variances

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CIP (Savings)

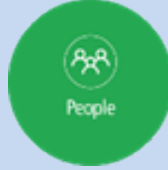
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Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position however recovery actions of c£36m are required to be delivered.

Aug-25			DAY				NIGHT				Temporary Staffing				Occupied Beds	Planned CHPPD	Actual Care Hours per pt day	Nurse Sensitive Indicators				Financial review				
Thought Site name	Ward name	Health Roster Name	Average fill rate registered nurses/individuals (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/individuals (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Use	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/N (number of shifts)	WTE Temporary demand RN/N				FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (over/under)	
Madisonstone	Acute Assessment Unit (M)	Acute Medical Unit (M) - N6551	91.7%	127.1%	-	-	99.2%	105.9%	-	-	39.3%	34.7%	102	7.19	17	513	10	10.9	-	-	1	0	Over fill in care staff both day and night shifts due to 55-Enhanced care additional shifts were required to cover	210,834	204,072	6,762
Madisonstone	Stroke Unit	Stroke Unit (M) - N6551	98.9%	85.5%	-	100.0%	92.5%	87.7%	-	100.0%	21.5%	6.1%	74	5.16	14	978	9	8.9	-	-	5	0	Underfill for day shifts due to vacancy (RN 1.6 WTE and HCWS 5.7 WTE), sickness and parenting leave.	254,667	256,234	(1,567)
Madisonstone	Hyperacute Stroke Unit	HASU (M) - N6552	98.7%	126.2%	-	-	100.2%	144.7%	-	-	48.2%	12.2%	186	13.10	28	433	11	11.5	-	-	2	0	17-Enhanced care additional shifts were required to cover	219,719	187,065	32,654
Madisonstone	Centralis	Centralis - N6553	98.6%	102.2%	-	-	98.6%	99.9%	-	-	20.7%	2.7%	48	3.28	2	524	8	7.5	-	-	0	0	Underfill in HCWS day shifts due to vacancy (RN 1.1 WTE and HCWS 2.5 WTE) and sickness rate. Underfill in night shifts due to reduced activity through the unit at night.	136,186	144,188	(8,002)
Madisonstone	Culpeper and CCU	Culpeper Ward (M) - N6554	101.2%	99.2%	-	-	100.0%	100.0%	-	-	21.5%	0.0%	5	0.35	1	400	7	7.2	-	-	2	0	Underfill in care staff both day and night shifts due to 181-Enhanced care additional shifts were required to cover	142,780	149,967	(7,187)
Madisonstone	Culpeper and CCU	CCU (M) - N6555	100.0%	-	-	-	100.0%	-	-	-	14.9%	0.0%	19	1.31	0	179	8	8.0	-	-	0	0	Underfill in care staff both day and night shifts due to 181-Enhanced care additional shifts were required to cover	0	0	0
Madisonstone	Edith Cavell	Edith Cavell - N6459	108.4%	136.1%	-	100.0%	100.0%	213.0%	-	-	64.7%	45.2%	22	1.53	1	673	6	7.9	-	-	6	0	Over fill in care staff both day and night shifts due to 85-Enhanced care additional shifts were required to cover	114,943	137,573	(22,630)
Madisonstone	Foster Clark	Foster Clark - N6559	95.6%	121.1%	-	-	95.2%	103.5%	-	-	48.2%	18.5%	79	5.12	12	838	6	7.2	-	-	3	2	Over fill in care staff both day and night shifts due to 85-Enhanced care additional shifts were required to cover	296,830	206,441	(9,614)
Madisonstone	John Day	John Day Respiratory Ward (M) - N7151	92.0%	117.0%	-	-	99.4%	108.9%	-	-	27.3%	25.0%	69	4.84	15	848	8	8.3	-	-	4	0	Over fill in care staff both day and night shifts due to 70-Enhanced care additional shifts were required to cover	208,580	226,699	(17,918)
Madisonstone	Intensive Care (M)	Intensive Care (M) - N6251	102.2%	110.7%	-	-	99.9%	100.0%	-	-	3.2%	0.0%	18	1.13	0	110	52	52.7	-	-	0	0	Underfill in HCWS day shifts due to vacancy (1.0 WTE) and long term sickness	260,715	225,770	34,945
Madisonstone	Lord North	Lord North Ward (M) - N6551	93.3%	71.6%	-	-	100.0%	100.0%	-	-	8.5%	0.0%	25	1.80	5	513	7	6.7	-	-	3	0	Over fill in care staff both day and night shifts due to 67-Enhanced care additional shifts were required to cover	120,030	122,096	(2,066)
Madisonstone	Mercer	Mercer Ward (M) - N6251	99.0%	111.8%	-	100.0%	100.8%	140.1%	-	100.0%	43.7%	22.3%	53	3.63	3	798	6	7.0	-	-	6	0	Over fill in care staff both day and night shifts due to 12-Enhanced care additional shifts were required to cover	110,857	201,131	(90,274)
Madisonstone	Peake	Peake Ward COVID - N6451	95.1%	106.4%	-	-	95.8%	129.0%	-	-	36.1%	1.9%	79	5.43	8	430	8	8.0	-	-	1	0	Underfill in day shifts due to vacancy (RN 1.1 WTE and HCWS 2.5 WTE) and sickness rate. Underfill in night shifts due to reduced activity through the unit at night.	141,918	106,768	35,150
Madisonstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - N6751	87.2%	84.1%	-	-	75.7%	42.9%	-	-	1.9%	0.0%	3	0.22	1	42	56	45.4	-	-	0	0	6-Enhanced care additional shifts for MND/Dementia/Delirium	76,122	67,867	8,255
Madisonstone	Whitman	Whitman Ward - N6559	93.9%	104.4%	-	-	99.1%	115.0%	-	-	33.2%	12.3%	85	5.74	9	633	9	9.2	-	-	2	2	Underfill in day shifts due to vacancy (RN 1.1 WTE and HCWS 2.5 WTE) and sickness rate. Underfill in night shifts due to reduced activity through the unit at night.	184,425	187,237	(2,812)
Madisonstone	Madisonstone Birth Centre	Madisonstone Birth Centre - N6751	78.8%	79.8%	-	-	94.1%	99.5%	-	-	17.3%	0.0%	30	1.94	0	23	99	85.6	-	-	0	0	Underfill of RM and MSW on day shifts due to increased sickness rate	87,006	94,338	(7,332)
TWYN	Acute Medical Unit (TW)	Acute Medical Unit (TW) - N6951	91.6%	98.2%	-	100.0%	97.8%	100.0%	-	-	32.3%	4.4%	142	10.18	29	839	9	8.2	-	-	4	0	Underfill in HCWS shifts seen on day shifts due to vacancy (1.8 WTE)	307,978	297,830	10,148
TWYN	Coronary Care Unit (TW)	Coronary Care Unit (TW) - N6951	93.1%	89.8%	-	-	97.3%	-	-	-	28.1%	1.2%	53	3.75	9	214	12	11.1	-	-	0	0	Underfill in HCWS shifts seen on day shifts due to vacancy (1.8 WTE)	100,125	84,888	15,237
TWYN	Hedgehog Ward	Hedgehog Ward (TW) - N6702	87.5%	94.1%	-	-	88.7%	52.7%	-	-	21.1%	27.5%	99	7.08	23	392	15	12.2	-	-	0	0	Underfill in day shifts due to vacancy (RN 1.7 WTE and HCWS 1.5 WTE) and sickness rate. Underfill in night shifts due to reduced activity through the unit at night.	221,803	186,609	35,194
TWYN	Intensive Care (TW)	Intensive Care (TW) - N6201	104.3%	110.1%	-	-	100.0%	110.1%	-	-	0.4%	28.6%	5	0.25	0	344	31	31.9	-	-	0	1	Underfill for both day and night due to staff redeployment and reduced activity, beds ringfenced for private patients.	418,653	422,579	(3,926)
TWYN	Wells Day Unit	Private Patient Unit (TW) - N6702	86.4%	108.6%	-	-	54.8%	42.2%	-	-	0.0%	-	-	-	-	40	62	39.6	-	-	0	0	Underfill for both day and night due to staff redeployment and reduced activity, beds ringfenced for private patients.	83,071	84,091	(1,020)
TWYN	Ward 2	Ward 2 (TW) - N6442	87.4%	114.1%	-	-	75.9%	131.5%	-	-	33.8%	11.3%	94	6.58	22	795	8	7.7	-	-	5	1	Over fill in HCWS due to 84-Enhanced care additional shifts for MND/Dementia/Delirium. Underfill in RN day shifts due to vacancy (4.8 WTE) and sickness rate.	251,580	221,382	29,998
TWYN	Ward 11	Ward 11 (TW) - N6331	96.0%	101.0%	-	-	96.8%	25.6%	-	-	23.1%	0.0%	84	5.87	7	874	7	6.9	-	-	1	0	Underfill of HCWS night shifts due to sickness and annual leave allocation.	191,157	194,040	(2,883)
TWYN	Ward 12	Ward 12 (TW) - N6332	90.0%	127.1%	-	-	96.0%	124.2%	-	-	43.5%	27.5%	102	6.64	22	922	7	7.2	-	-	2	0	78-Enhanced care additional shifts to cover	209,735	188,759	20,976
TWYN	Ward 20	Ward 20 (TW) - N6330	88.8%	126.2%	-	100.0%	97.5%	126.7%	-	-	40.1%	35.5%	110	6.97	23	917	7	7.2	-	-	2	0	78-Enhanced care additional shifts to cover	210,827	204,136	6,691
TWYN	Ward 21	Ward 21 (TW) - N6331	96.4%	121.3%	-	-	97.4%	154.8%	-	-	35.7%	25.8%	58	3.80	13	913	7	7.9	-	-	5	2	Over fill in HCWS day and night shifts due to 88-Enhanced care additional shifts to cover MND/Dementia/Delirium	179,877	211,913	(32,036)
TWYN	Ward 22	Ward 22 (TW) - N6332	96.0%	130.9%	-	-	98.1%	128.8%	-	-	36.7%	22.3%	81	5.44	7	969	6	7.1	-	-	6	0	Over fill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	180,030	186,993	(6,963)
TWYN	Ward 30	Ward 30 (TW) - N6330	100.7%	107.0%	-	100.0%	97.6%	100.0%	-	100.0%	21.2%	0.0%	104	6.16	8	910	7	6.9	-	-	4	2	Underfill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	183,145	171,655	11,490
TWYN	Ward 31	Ward 31 (TW) - N6331	97.3%	111.8%	-	100.0%	99.2%	103.2%	-	100.0%	18.8%	0.0%	58	3.44	10	906	7	6.9	-	-	0	0	Underfill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	185,515	183,766	1,749
TWYN	Ward 32	Ward 32 (TW) - N6330	96.7%	101.0%	-	100.0%	101.0%	97.3%	-	100.0%	11.2%	18.3%	20	1.39	4	551	8	8.9	-	-	1	0	Underfill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	166,509	134,125	32,384
TWYN	Ward 33 (Gynaecology)	Ward 33 (Gynaecology) - N6302	99.4%	108.2%	-	-	99.9%	100.0%	-	-	22.5%	0.0%	12	0.64	1	276	8	8.1	-	-	0	0	Underfill seen due to vacancy (7.5 WTE) and sickness. Agency usage to cover QIS trained requirement for unit.	114,995	114,776	(219)
TWYN	SCBU	SCBU (TW) - N6302	84.4%	-	-	-	81.2%	-	-	-	22.0%	20.8%	132	8.16	10	389	15	13.8	-	-	0	0	Underfill in RN day shift due to parenting and sickness. Underfill in HCWS day shifts due to vacancy (2 WTE).	265,192	244,609	20,583
TWYN	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - N6301	87.0%	86.7%	-	100.0%	103.5%	103.5%	-	-	11.0%	0.0%	10	0.67	0	263	15	13.6	-	-	0	0	Underfill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	113,556	106,777	6,779
TWYN	Surgical Assessment Unit	Surgical Assessment Unit (TW) - N6701	100.0%	100.0%	-	-	100.0%	99.7%	-	-	7.6%	0.0%	10	0.68	0	126	20	19.6	-	-	0	0	Underfill in HCWS shifts due to 73-Enhanced care additional shifts to cover MND/Dementia/Delirium	82,025	90,886	(8,861)
Madisonstone	ABE (M)	Accident & Emergency (M) - N6551	96.0%	118.9%	-	100.0%	99.0%	131.7%	-	-	43.7%	22.4%	361	24.56	35	0	-	-	-	-	0	0	Over fill in HCWS shifts 88-Enhanced care additional shifts to cover MND/Dementia/Delirium	413,120	514,664	(101,544)
TWYN	ABE (TW)	Accident & Emergency (TW) - N6301	99.0%	95.8%	-	100.0%	101.8%	98.1%	-	100.0%	32.2%	12.3%	285	19.70	22	0	-	-	-	-	0	0	10-Enhanced care additional shifts for MND/Dementia/Delirium	443,891	500,430	(56,539)
Madisonstone	K&M Orth Centre - Inpatient Ward	K&M Orth Centre - Inpatient Ward - T6333	85.8%	71.0%	-	100.0%	52.9%	48.0%	-	100.0%	0.0%	-	-	-	-	170	34	21.5	-	-	1	0	Underfill in HCWS day shifts due to redeployed due to reduced activity	167,730	139,937.38	27,792.62
Fordhouse	Fordhouse Ward	Fordhouse Ward (A&C) - N6301	121.1%	111.8%	-	-	100.0%	-	-	-	14.3%	0.0%	28	1.64	0	90	22	24.5	-	-	0	0	Underfill of shifts and increase in temporary staffing usage due to increased sickness levels and redeployment	8,907	77,007.48	(889.52)
TWYN	Delivery Suite	Midwifery Services - Delivery Suite - N6302	93.2%	82.5%	-	-	93.0%	51.7%	-	-	21.2%	10.4%	191	11.94	40	1123	8	7.0	-	-	0	0	Underfill of shifts and increase in temporary staffing usage due to increased sickness levels and redeployment	348,317	373,088	(24,771)
TWYN	Antenatal Ward	Midwifery Services - Antenatal Ward - N6322	94.8%	81.8%	-	-	96.9%	58.3%	-	-	21.9%	5.4%	68	3.99	11	388	7	6.6	-	-	0	0	Underfill of shifts and increase in temporary staffing usage due to increased sickness levels and redeployment. Overfill due to increase staffing levels following CDC recommendations	103,140	116,341	(13,201)
TWYN	Postnatal Ward	Midwifery Services - Postnatal Ward - N6322	113.0%	79.5%	-	-	114.1%	85.5%	-	-	19.3%	1.9%	96	5.18	13	686	9	9.2	-	-	0	0	Underfill of shifts and increase in temporary staffing usage due to increased sickness levels and redeployment. Overfill due to increase staffing levels following CDC recommendations	245,263	218,810	26,453
Crownborough	Crownborough Birth Centre	Midwifery Services - Crownborough Birth Centre - N6721	40.4%	60.1%	-	-	52.0%	51.5%	-	-	6.8%	0.0%	16	1.14	6	25	92	57.1	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	67,403	62,339	5,064
TWYN	Specialist Midwives	Midwifery Services - Specialist Midwives - N6342	47.2%	-	-	-	101.0%	-	-	-	6.4%	0.0%	28	1.92	0	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	88,913	123,788	(34,875)
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - N6350	63.3%	-	-	-	-	-	-	-	0.0%	-	-	-	0	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	0	0	0
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - TW Educator (TW) - N6350	78.9%	98.2%	-	-	-	-	-	-	8.1%	0.0%	32	1.60	3	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	0	0	0
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - N6350	86.0%	6.0%	-	-	-	-	-	-	0.0%	-	-	-	0	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	0	0	0
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - Seven/Mornings - N6350	85.8%	-	-	-	-	-	-	-	0.0%	-	-	-	0	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	0	0	0
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - Madstone/Leeds - N6350	79.8%	57.3%	-	-	-	-	-	-	10.8%	0.0%	40	1.74	4	0	-	-	-	-	0	0	Underfill of shifts due to sickness, resulting in unit closure.	0	0	0
TWYN	Community Midwifery Services (TW)	Community Midwifery Services - Crownborough - N6160	80.3%	57.9%	-	-	-	-	-	-	14.7%	0.0%	16	0.87	0	0	-	-	-	-	0	0	Underfill of shifts			

Title of report	Safeguarding Annual Report 2024-2025					
Board / Committee	Trust Board					
Date of meeting	September 2025					
Agenda item no.	09-13					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Jo Haworth, Chief Nurse					
Report Purpose (Please ☒ one)	Action/Approval	☒	Discussion	☒	Information	☒

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

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	It is a requirement for the Trust to receive an annual safeguarding report outlining how the Trust’s safeguarding statutory and contractual obligations/ functions have been discharged.	
	The enclosed report provides the annual safeguarding report on the following areas: - How the Trust is meeting its statutory duties to safeguard adults and children by preventing and responding to concerns or risks of abuse, harm or neglect of patients, visitors and staff from April 2024- March 2025. - Data relating to safeguarding activities. - Red rated risks associated with Safeguarding. - Education and training compliance in all areas associated with safeguarding. - Key national, regional or local updates relevant to safeguarding.	
Any items for formal escalation / decision	Compliance in safeguarding adults training level 3 is 67%, below the Trust target of 85%.	
Appendices attached	Annual report attached	
Report previously presented to:		
Committee / Group	Date	Outcome/Action
Joint Safeguarding Committee	29 th August 2025	ETM Review (09 th September 2025) and Submission to Quality Main 10 th September /2025

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR2: If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes. PR4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients their familiesand carers and may affect the reputation of the organisation
Links to Trust Risk Register (TRR)	1301- Failure to meet national targets for complaints performance. 3274-Risk that patients not receiving timely best interest assessments from the local authority following DoLS application. 3357- Absence of HIDVA 1259- Compliance in Statutory and Mandatory training
Compliance / Regulatory Implications	The Care Act 2014 The Children's Act 1989 and 2004 Working together to Safeguard Children 2023 The Domestic Abuse Act 2021 Modern Slavery Act 2015 PREVENT Act 2015 Mental Capacity Act (Amendment) 2019 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 NHS Standard Contarct 2024/2025 Schedule 4- Safeguarding Metrics.

**JOINT SAFEGUARDING ANNUAL REPORT,
2024-2025**

CHIEF NURSE

Executive Summary.

The safeguarding Annual Report, 2024-2025, including what the Trust board needs to know is enclosed.

The Safeguarding Annual Report provides the Trust Board with an overview of all safeguarding adults and children activities within Maidstone and Tunbridge Wells NHS Trust (The Trust).

The purpose is to Inform and provide assurance to the Trust Board, through the Joint Safeguarding Committee, on the following areas:

- How the Trust is meeting its statutory duties to safeguard adults and children (including those unborn) by preventing and responding to concerns or risks of abuse, harm or neglect of patients, visitors and staff from April 2024- March 2025.
- Activity and demand related to safeguarding activities.
- Red rated risks associated with Safeguarding
- Education and training compliance in all areas associated with safeguarding

The Annual report is in four sections:

• Summary and introduction	page 1-7
• Section 1 report on Children’s safeguarding	page 8 - 23
• Section 2 report on Adult Safeguarding	page 24- 33
• Section 3 report on Midwifery Safeguarding	page 34- 45
• Appendices	Page 46- 49

Key areas to note are:

National

The NHS Safeguarding Accountability and assurance Framework was updated in June 2024 and provides guidance and minimum standards for safeguarding in line with underlying legal duties.

The Adult Safeguarding: Roles and Competencies for Health Care Staff was updated and published in July 2024. The document sets out the minimum training requirements for health care staff along with education and training principles.

The Victims and Prisoners Act 2024 legislated a name change from Domestic Homicide Reviews (DHRs) to Domestic Abuse Related Death Reviews (DARDRs) and introduced changes to the review criteria.

Regional

The Trust is an active participant within the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and the Kent and Medway Safeguarding Adults Board (KMSAB) and their constituted sub-groups.

The Trust has access to multi-agency training via both the KMSAB and KSCMP on-line training provided by the e-Learning for Health platform.

The Trust contributed to 19 Safeguarding Adult Review (SAR's) requests across 2024-2025, including some backlog work from the previous year.

The Kent and Medway ICB designated safeguarding leads have continued to attend the MTW safeguarding learning and improvements panels held at MTW.

In October 2024, NHS Kent and Medway published its Modern Slavery and Human Trafficking Statement in accordance with Section 54, Part 6 of the Modern Slavery Act.

Designated Nurses/Professionals continued to attend the Joint Safeguarding Committee with bespoke levels of support provided based on the NHS Oversight Framework (NOF) segmentation. The Designates have utilised Provider Quality Meetings for escalations.

Local

The Trust's safeguarding activities comply with the current Working Together Guidelines (2023) the Intercollegiate Documents (2024 and 2019) and the NHS Accountability and Assurance Framework (2024).

Key policies and training remain updated to reflect the Fuller Inquiry on the safeguards and care of the deceased.

During the reporting period, the Trust continued to achieve both organisational contractual safeguarding obligations (Schedule 4) and remained compliant with constituent legislative safeguarding responsibilities such as Section 11 of the Children Act 2004.

Effective May 2024, the Named Midwife for Safeguarding stopped having a dual Named Midwife/ specialist maternity matron role. The Safeguarding Midwifery service was transferred to the corporate nursing directorate and aligned with adults and children's safeguarding teams, as part of the All Age Safeguarding Service.

A new All Age Safeguarding Practitioner was employed by the Trust and will provide specialist support between children and adults safeguarding caseload.

The majority of the total safeguarding adults' referrals were related to self-neglect. This is similar to the national data available.

The Trust submitted 984 urgent deprivation of liberty safeguards (DoLS) but only one standard DoLS was granted by the local authority, as the supervising body.

The total safeguarding adults' referrals for 2024-2025 reached 540 compared to 436 referrals in 2023-2024. This increase reflects improved staff recognition and confidence in reporting safeguarding concerns, supported by ongoing training and awareness initiatives.

There has been a noted increase in activity relating to safeguarding referrals and patient admitted to the Trust with complex medical and mental health needs.

Hospital related safeguarding concerns reduced slightly from 98 in 2023/24 to 94 in 2024/25, with 10 upheld following robust review through internal and external safeguarding panels

The Trust continues to meets its statutory requirements in relation to Disclosure and Barring (DBS) checks.

3 red rated risks are associated with safeguarding and are being addressed. The risks are:

- 3274-Risk that patients not receiving timely best interest assessments from the local authority following DoLS application.
- 3357- Absence of HIDVA
- 1259- Compliance in Statutory and Mandatory training

A review of the core skills framework in safeguarding training has been completed. Further review of staff groups is still ongoing and this has affected the level 3 safeguarding adults training compliance. At the end of the reporting year, compliance with Safeguarding Adults Level 3 training was recorded at 75% of the Trust's target staff group, which is below the Trust target of 85%. The reduced compliance is included in risk number 1259- Compliance in statutory and mandatory training.

The Trust made 14 LeDeR referrals for further review compared to 6 in the previous reporting period.

For the reporting period, there were 18 children taken through the Non Accidental Injury (NAI) pathway. 13 Children did not require any further action but 5 children were proven to have suffered Non Accidental Injuries.

Most common reason for referral to midwifery safeguarding service is maternal mental health.

The safeguarding teams have undertaken several audits to provide assurance that safeguarding systems and processes are being achieved. These also include multi-agency audits with partner agencies

The PREVENT data was submitted in line with national reporting requirements.

Safeguarding Annual Report 2024-2025

INTRODUCTION AND OVERVIEW.

The Trust holds a statutory responsibility to safeguard children and adults under the Care Act (2014) and accompanying guidance Care and Support Statutory Guidance (DoH 2016), Children Act 2004, Working Together to Safeguard Children 2023, Safeguarding Vulnerable People in the NHS and the Children and Social care Act 2017. The NHS Accountability and Assurance Framework (2024) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Trust Board assurance processes in respect to its statutory duties and responsibility around safeguarding. All individuals working for the Trust, or engaged by the Trust, have a fundamental responsibility to safeguard children, young people, and adults at risk of abuse or neglect, regardless of their role or employment type.

The Trust also complies with the Care Act (2014) and NHS Guidance by having in place named professionals for safeguarding adults, safeguarding children and a named midwife to ensure the it fulfils its legal duty towards adults or children at risk of harm or abuse.

GOVERNANCE AND OVERSIGHT

The Trust Executive Lead for Safeguarding is the Chief Nurse, who delegates responsibilities to the Deputy Chief Nurse (DCN)- Quality and Patient Experience in relation to both adults, children and midwifery. The Trust is accountable to the NHS Kent and Medway Integrated Care Board (ICB) and reports directly to the Trust Quality Committee via the Joint Safeguarding Committee. Additionally, quality and monitoring for East Sussex is captured on the Safeguarding Metrics and submitted to NHS Sussex.

The Kent and Medway ICB Designated Nurses for Safeguarding are members of the Trust's Joint Safeguarding Committee.

The NHS safeguarding accountability and assurance framework (SAAF, 2024)

The safeguarding of children, young people and adults who are at risk is a fundamental obligation for everyone who works in the NHS and its partner agencies. Safeguarding children and adults at risk of abuse or neglect must be kept constantly under review. While there are some similarities, the safeguarding of children and adults are distinct and separate entities which need different approaches. Each person requires a unique safeguarding approach by a professional based on their circumstances and needs.

This SAAF (2024) aims to provide guidance and minimum standards for safeguarding, but should not be seen as constraining the development of effective local safeguarding practice and arrangements, in line with the underlying legal duties.

The responsibilities for safeguarding forms part of the statutory functions for each organisation, and its executive board must therefore ensure effective discharge within agreed baseline funding.

Fundamentally, every NHS organisation and every individual healthcare professional working in the NHS, must ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied: the needs of these at-risk citizens and communities must be at the heart of everything the NHS does.

JOINT SAFEGUARDING COMMITTEE

The Joint Safeguarding Committee draws its work plan and objectives from both local and national Safeguarding objectives. It is a forum for the review of practice and learning from incidents. Work streams are identified from themes and action plans arising from serious (Safeguarding) incidents, Safeguarding Adults Reviews, Domestic Homicide Reviews and Child Safeguarding Practice Reviews. The committee provides a forum to support and facilitate feedback and discussion between clinicians, divisions and directorates, and the designates.

NAMED PROFESSIONALS

Although the Named Nurses (adults and children) and Midwife for safeguarding work in close partnership to provide a seamless and robust Safeguarding service, they have individual work streams that are pertinent to their areas and expertise.

They have joint responsibility for:

- Design and delivery of training for Safeguarding Adults, Safeguarding Midwifery, and Safeguarding Children, with an emphasis on the 'Think Family' agenda; also includes training on the principles of the Care Act (2014), the role of the lead agency, application of the Mental Capacity Act (2005), Domestic Abuse, PREVENT (under the Counter-Terrorism and Security Act 2015), Exploitation and Female Genital Mutilation (FGM)

- PREVENT –the Named Nurses for Safeguarding are Home Office approved trainers for the PREVENT agenda
- Domestic Abuse – includes training, policy updating and support of staff & patients who are victims of Domestic Abuse; also includes developing the links with ED and local Domestic Abuse services.

LEGISLATION AND REGULATORY COMPLIANCE.

The Trust can demonstrate that there are appropriate safeguarding governance systems in place for discharging its statutory safeguarding responsibilities and functions in line with the following key legislation and regulatory compliance:

- The Care Act 2014
- The Children's Act 1989 and 2004
- Working together to Safeguard Children 2023
- The Domestic Abuse Act 2021
- Modern Slavery Act 2015
- PREVENT Act 2015
- Mental Capacity Act (Amendment) 2019
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13.
- NHS Standard Contract 2024/2025 Schedule 4- Safeguarding Metrics.

POLICIES

The following policies relating to safeguarding are in use across the Trust:

- Safeguarding Children Policy was updated May 2024 and incorporates recent legislative and statutory guidance changes.
- The Safeguarding Children Supervision policy and procedure remains in date and due for full review in 2027.
- Safeguarding Adults at risk policy and procedure was updated in March 2025 and incorporates recent legislative and statutory guidance changes.
- Safeguarding Adults Supervision policy and procedure was also reviewed and ratified in January 2025.
- Deprivation of Liberty Safeguards (DoLS) policy and procedure is undergoing review following learning relating to cases in ED.
- Domestic abuse policy and procedure was updated in June 2024.

- Policy and procedure for the identification and management of female genital mutilation (FGM) is due for review in November 2025

Section 1

Safeguarding Children Annual Report 2024-2025

1.0 INTRODUCTION

This annual report is to inform the board on how the Trust is meeting its statutory duties to safeguard children by identifying, preventing and responding to concerns of abuse, harm or neglect of patients, visitors and staff from April 2024 to March 2025.

The NHS Accountability and Assurance Framework (2024) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Maidstone and Tunbridge Wells NHS Trust Boards assurance processes in respect to its statutory duties and responsibility around safeguarding

An updated Section 11 audit (for Safeguarding Children services) was submitted in September 2024. The Trust was able to evidence that it meets all its statutory responsibilities.

The Safeguarding Children team have continued to incorporate recommendation 17 of the Fuller Report (2023) into all their training provided. This ensures that all staff are aware of their responsibility to treat the deceased with the same due regard to dignity and safeguarding as it does its other patients

2.0 INTERAGENCY PARTNERSHIP WORKING

The Safeguarding Children's team is proactive in working with a wide range of external partners in delivering the Safeguarding agenda across Kent and Medway. The Trust has close ties with our partners in other provider and commissioner organisations, and the Local Authority.

Safeguarding needs to be joined up between partners with clear information sharing and an understanding of the role of partners. No longer can individual teams work within narrow confines; we all need to have a view on the bigger picture and how we can contribute to that world view. Kent has a clear vision of what partnership working looks like

and clear procedures for challenging any deviation from this normal. The Kent Safeguarding Children Multi-Agency Partnership (KSCMP – the Partnership) has been in existence since 2020 and has a clear vision on its priorities for the coming 24 months. These include the Mental Health of Children and Young People, the Impact of Parent Mental Health, Effective Multi-Agency Working, and On-line Safety. The Trust aligns its own priorities to match these.

The Local Authority (Kent County Council - KCC) is the lead agency for investigations into Safeguarding concerns. KCC (and East Sussex County Council - ESCC) assume responsibility for triaging all referrals and ensuring learning outcomes are shared as needed.

Health providers and commissioners in Kent and Medway attend the Health Safeguarding group (HSG) to enable debate and information sharing between organisations. This forum is attended by the Chief Nurses from across Kent and Medway.

The Kent and Medway Health Reference Group feeds into the HSG. These forums are for Named Nurse Professionals to meet and share information, develop guidelines and raise concerns to the HSG. The HRG (Children) is chaired by the ICB

3.0 SAFEGUARDING CHILDREN

The Safeguarding Children team has a close relationship with our Local Authority partners in both Kent and Medway, and East Sussex. The Safeguarding Children team (including Safeguarding Midwives) attend Child Protection Conference's and Strategy Meetings across the Local Authority areas and are a key partner in developing Child Protection Plans for our most vulnerable children and the unborn child.

The Safeguarding Children's team have a close working relationship with their counterparts in Kent Community Health NHS Foundation Trust (KCHFT), East Kent Hospitals University NHS Foundation Trust (EKUHFT), Medway Foundation NHS Trust (MFT), and Dartford, Gravesham and Swanley (DGS) regularly meet to share information and learning. Further support to the team is also provided by the ICB Designated Nurses.

The Safeguarding Children's team supports Trust staff to challenge decisions made by the Local Authority if there is professional disagreement. The Kent and Medway escalation process is clearly laid out and staff are encouraged to use this framework if they feel an

inappropriate decision has been reached. It is important that staff feel able to challenge decisions as this empowers staff in their decision making and serves to highlight the important role that the Trust services have in Safeguarding.

4.0 OVERSIGHT AND SCRUTINY

a. Disclosure and Barring (DBS) checks.

The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with adults at risk and children undergo an enhanced level of assessment. All staff are currently having their DBS checks renewed as per national policy. Internal assurance is provided through the People and Organisational Development Oversight group that reports to the Trust Board.

b. Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The S.11 report for Maidstone and Tunbridge Wells NHS Trust was submitted in September 2024; the KSCMP have previously noted that as an organisation, the Trust met its statutory requirements to safeguard all Children and Young People. There are no outstanding actions from the 2024 audit.

c. Was Not Brought

The Trust has a process in place for following up children who are not brought to outpatient appointments within any speciality, to ensure their care and health is not affected in any way. The Named Nurse Safeguarding Children, and the wider team, follow up on children not brought to appointments and liaises with Health Visitor teams, GP's and the Local Authority (if needed). The Trust has a ratified an all age 'Was Not Brought' policy for all ages.

d. Flagging Systems in Place:

- Children who are subject to a child protection plan. The Trust has the national Child Protection Information Sharing System (CP-IS)
- National FGM-IS.
- Children who are designated as a Child in Care

- Adults and Children subject to MARAC procedures

e. Child Protection Information System (CPIS)

The CPIS is a national initiative in England designed to facilitate secure information sharing between health and Local Authorities regarding children who are subject to Child Protection Plans, or are Looked After by a Local Authority. This enables healthcare professionals to identify children known to a Local Authority when they present to any unplanned care setting.

CPIS has been live at the Trust for more than 5 years. Every child/young person who attends ED at either of our sites (including Sevenoaks UTC) has a CPIS check when booking into ED. Current evidence suggests that 98% of children/young people attending unplanned care settings have a CPIS check.

The Trust will be rolling out CPIS to Maternity and Paediatric Services (including planned care areas) in 2025 with the aim of improving information sharing and identifying vulnerable Children and Young People

f. Training Design and Delivery

All eligible staffs are required to undertake relevant Safeguarding training; this is regularly reviewed to ensure it is up to date and fit for purpose. The Trust has a training strategy in place with regard to delivering safeguarding training. All Safeguarding Children training is in line with the current Intercollegiate Document (2019) and highlights emerging themes as highlighted by NHSE.

There will be an updated Intercollegiate Document published in 2025 with regard to Safeguarding Children training and competencies. Currently, this document is at the proposal stage with the consultation having ended in April 2025.

5.0 SAFEGUARDING CHILDREN TRAINING

Safeguarding Children training is now delivered across a hybrid model of virtual and face to face options. Staff have access to external training from a wide variety of providers and are actively encouraged to do so. Face to face training is covered in one day and encompasses a wide variety of subject matter, including, Recognising and Responding to Abuse, Non-Accidental Injuries, Domestic Abuse, Exploitation, FGM, and Mental Health. All training was reviewed at the beginning of 2025 to ensure that it is fit for purpose and meets the new Core Skills Training Framework. This is an on-going piece of work.

Compliance for level 3 Safeguarding Children training has consistently been rising all areas and is just below the Trust standard of 85%. As of June, 2025, Trust compliance was 84.8% (Risk register ID 1259). This has risen from a low of 79% in 2020. The Safeguarding Children team target areas where compliance is below 85% and support and bespoke training

Compliance for both levels 1 and 2 is above Trust standard and sits at 90% and above. The Named Nurse Safeguarding Children is compliant with Level 4 Safeguarding Children training as required by the current Intercollegiate Document.

The Safeguarding Children team have provided bespoke training to newly acquired services at the Trust – Fordcombe and the UTC at Sevenoaks Hospital. The team have worked closely with the new staff to align their competencies with those of the Trust. See appendix 1 for further details on the ethos of safeguarding children.

6.0 MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY (DOL)

The current legislation (Mental Capacity Act 2005) is applicable to 16- and 17-year olds who fall within the definition of a child. The Safeguarding Children's team provides expert advice on a range of consent issues for Children and Young People, and the application of legal frameworks around consent (especially the Fraser Guidelines and Gillick competence). The named professionals work together to provide consistent advice to areas where the Mental Capacity Act may be applicable.

Due to the legal complexity of some admissions to Hedgehog Ward, and the delay in discharges, the Trust has sought legal advice on several occasions to ensure that the Trust is not depriving children of their liberty, and that staff are using the least restrictive options when discharges are delayed. The Trust Legal Services team has supported the Safeguarding Children's team and ward staff through these legal proceedings. During the reporting period, the Trust was involved in 2 applications for DoL orders. One was initiated by the Trust and the other by the East Sussex local authority with support from the Trust.

It is also acknowledged that there is a national shortage of appropriate placements that are able to meet the needs of these young people; this is particularly acute in the South-East with the reduction in beds for young people with Mental Health needs, and limited providers of appropriate registered placements. It is illegal to place a young person in an

unregistered setting and the Local Authority need to put forward a clear rationale for using an unregistered placement. These inevitable delays to discharge lead to an increased length of stay with financial implications for the Trust in getting suitably trained staff to help in the care of these young people.

For assurance, the Safeguarding Children's team and the senior nursing team in paediatrics continuously monitor these cohort of young people and the following is in place in the Trust:

- The Trust has developed a clear escalation pathway for Children and Young People who are at risk of delayed discharge due to their multiple complexities.
- Published risk assessments, for use in ED and ward areas, for identifying concerns with clear pathways to help staff with planning care for young people
- Professional network meetings are held within 24 hours of admission – led by the Trust. The aim is to identify how to overcome the barriers to discharge, and to work with a variety of external agencies to develop a workable plan to keep the young person safe and transferred to an appropriate setting that meets their needs.
- The Safeguarding Children's team and senior staff in paediatrics review all extended/delayed discharges to understand the sequence of events, and take learning for these incidences; support is also requested from the Trust Head of Mental Health.
- The Safeguarding Children's team have also continued to work with external agencies to develop and share community safety plans for Children and Young People.
- There is a further movement towards developing 'Admission Avoidance Plans'; these enable Young People and their families to understand what to do if the young person is in crisis and who to contact; it is hoped that these plans may result in fewer ED presentations and inappropriate admissions
- Where individuals are approaching sixteen, transition to adult services should form part of the considerations.
- A common approach to sharing and recording case details should be made a priority.

The Trust has a formal transition policy for all children under the Specialist Nursing Teams; the nationally recognised Ready Steady Go model is used

(<https://www.readysteadygo.net/>).

7.0 SAFEGUARDING CHILDREN AUDITS

In November 2024 an audit was carried out in the ED’s at the Trust to understand how many Safeguarding assessments were completed on Children and Young People attending ED.

The audit found a compliance rate of 81% against an expected 100% compliance.

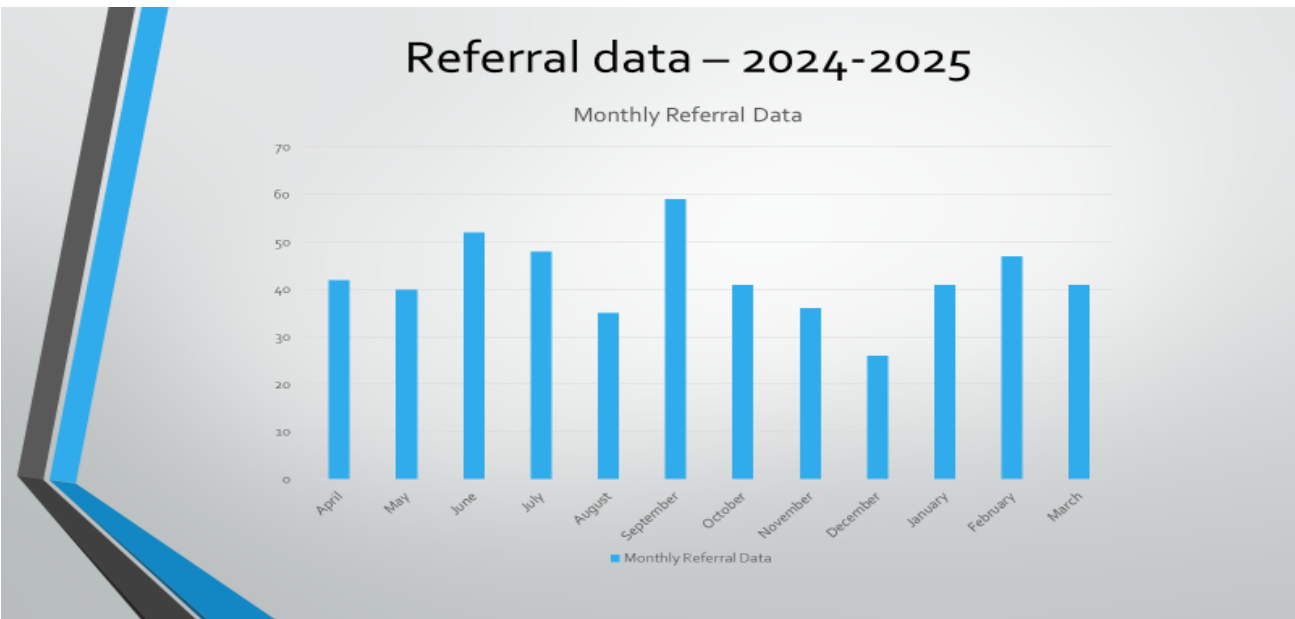
Bespoke training and staff support has been added for ED staff in order to achieve full compliance of safeguarding children assessments in ED. A review audit is planned to take place in September 2025.

8.0 SAFEGUARDING REFERRALS AND INVESTIGATIONS - CHILDREN

Safeguarding Children activity has been maintained in the 2024-2025 reporting period.

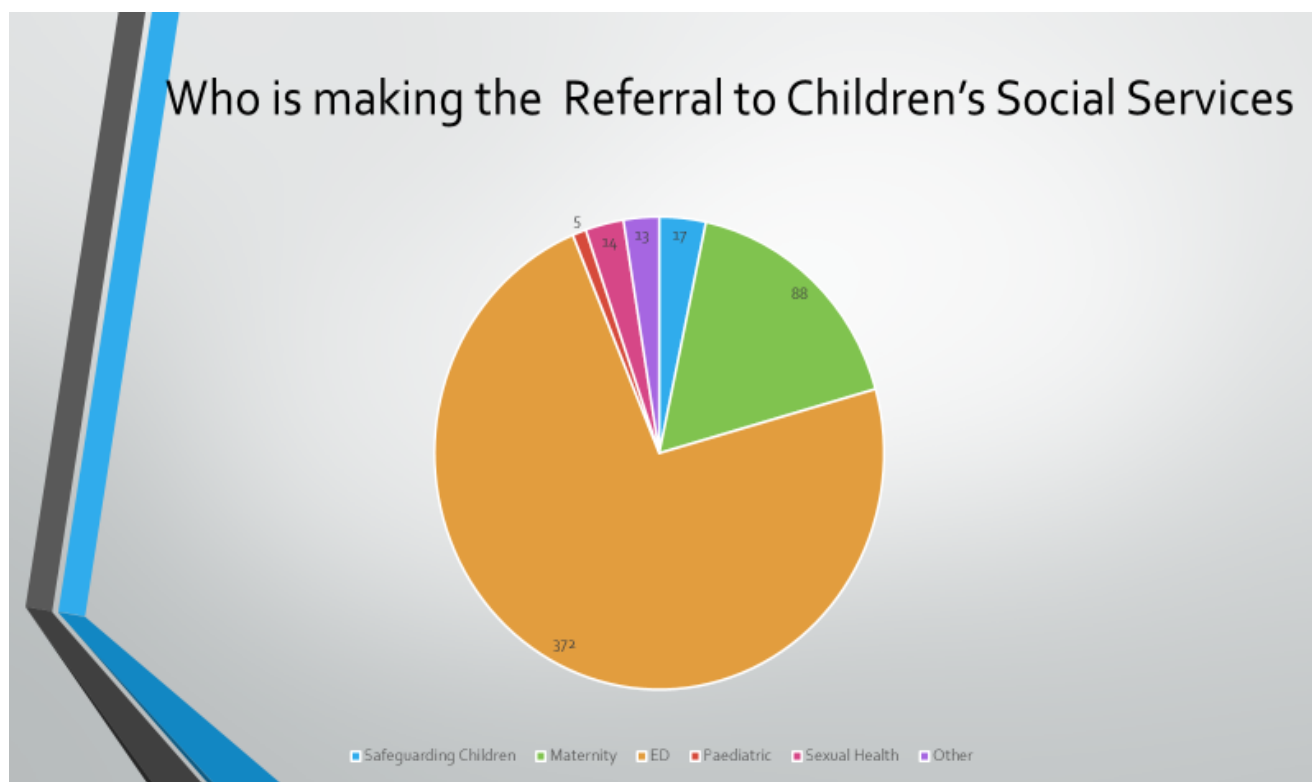
The Trust made a total of 508 referrals to Children's Services in the reporting period. This compares with 524 in the previous 12 months; a drop of 3.05%. It is noted that December 2024 saw a large drop in the referral rate – there would appear to be no obvious reason why, but possibly due to the Christmas break.

Staff are confident in using the Local Authority referral systems, and identifying ‘at risk’ children. This is seen as a result of increasing training compliance within ED, and the bespoke training also provided to ED staff. The Safeguarding Children team is very visible within ED and has excellent relationships with the department; the team operates an ‘open door’ policy which provides reassurance and support to staff. The busiest periods are June and September – these coincide with school holidays and the subsequent return to school.



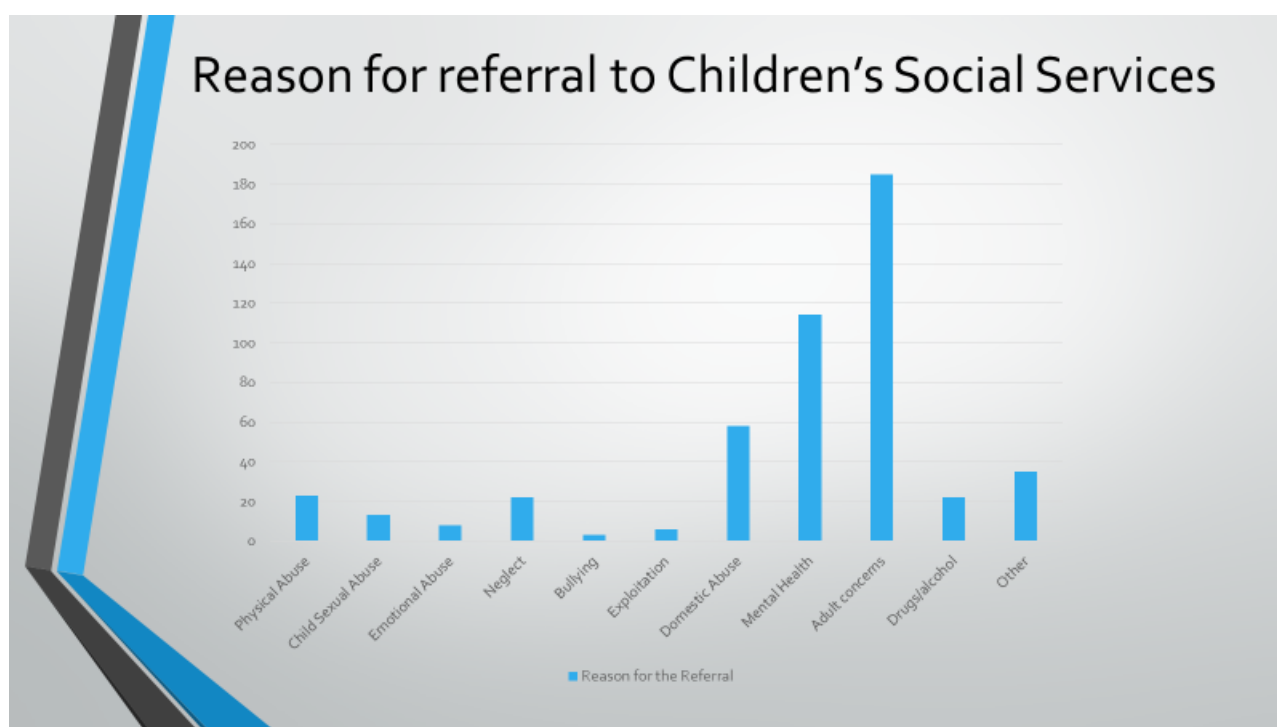
8.1 Who is making the referrals?

Consistently, the majority of referrals are submitted by ED or Maternity services. Although the Trust has no permanent Safeguarding presence in either of the ED's the Safeguarding team are highly visible and visit the departments regularly. Staff know how to contact the team and are proactive in doing so.



8.2 Reason for the referral

An analysis of why referrals are being made shows that the majority are related to both Adult/parent concerns, and the Mental Health concerns of both adults and children. As a team the quality of the referrals are reviewed. Training is provided on 'how to make a quality referral', and staff are encouraged to get referrals reviewed by safeguarding practitioners prior to submission.



9.0 Local Child Safeguarding Practice Reviews

In the current reporting period the Trust has been notified of 8 Rapid Reviews and we have contributed to 3 of these reviews. The Local Safeguarding Children Partnership has updated its process in relation to Rapid Reviews and Child Safeguarding Practice Reviews; as a consequence, the number of requests has decreased by 50%. All actions following the reviews have been reviewed and completed. Some of the recommendations that directly affect the Trust include:

- Jasper Red case review ([Kent-LCSPR-Jasper-Red-publication-version.pdf](#))
- The Trust with other agencies are to ensure that there is optimum learning on cumulative harm across all staff groups. The learning has been incorporated into safeguarding training.
- The Trust with other agencies are consider how they can improve practice in respect of appropriate access to information and information sharing about mental health, including access by health services/practitioners to the Kent and Medway Care Record. This is currently work in progress between all agencies.
- In the Child U case review ([Child-U-Executive-Summary.pdf](#))
- All agencies, including the Trust, need to have training available to staff around recognising and responding to domestic abuse, including understanding its dynamics and immediate safety planning measures.

- Agencies, including the Trust, must recognise children are victims of domestic abuse and may intervene in incidents. Domestic Abuse Act (2021) now recognises children as victims, not witnesses- This is incorporated in the safeguarding training.
- Consideration should be given to the cultural needs of individuals and using gender appropriate workers and interpreters. The Trusts translation and interpretation service is currently being reviewed with the aim of incorporating cultural needs of patients, carers and relatives.
- Every person and family's needs should be considered and assessed in the context of their identity and experiences.
- Agencies, including the Trust, should use a trauma informed/healing centred approach to assessment to gain an understanding of an individual or family's circumstances and experience.
- Professionals should use chronologies to effectively map cumulative harm and other concerns, and any positive change. This can support onward referral, decision making, and effective escalation where appropriate. This practice is now well established across the Trust.
- Even if an injury is considered to be accidental, professionals should be curious to understand whether the child is living in a safe and protective environment and if that environment has contributed in any way to the harm. There is a well established Non Accidental Injury pathway in the Trust.
- The Trust to continue engaging in the new MARAC process.

10.0 CHILD DEATHS

The Child Death Review Guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in the Working Together Guidelines (2023), and clarifies how individual professionals and organisations, across all sectors involved in the child death review, should contribute to reviews. The guidelines place a responsibility on all organisations to improve the experience of bereaved families, and professionals involved in caring for children. They also ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths.

The Trust is fortunate in that there are very few child deaths. The Named Nurse Safeguarding Children is notified of all Child Deaths in Kent – of which there are 101 in total in the current reporting period. Of these, sadly 22 children, known to the Trust's

services, passed away in the reporting period. The majority were due to complex health needs or life limiting conditions.

10.1 Child Death team at MTW

The Named Nurse Safeguarding Children and Paediatric Head of Service lead on Child Death for the Trust. The Trust has a Named Paediatrician for Child Death who works closely with the Leads.

Please see appendix 2 for the child death infographic process in place at the Trust.

10.2 Kennedy Sampling

In 2016 Baroness Helena Kennedy reviewed the Child Death procedures, and recommended that, in the event of a sudden or unexpected death, various samples are taken immediately after death to aid the investigation into the child's death. These samples may include blood, urine, CSF and Nasopharyngeal Aspirate; physicians can also recommend that the child undergoes a CT scan and Skeletal Survey. This process is colloquially known as 'Kennedy Sampling'. All samples must be taken on Human Tissue Authority (HTA) -licensed premises and are nationally recognised guidelines.

Following an East Sussex Serious Case Review in 2019 it was recommended that the Trust start the process of becoming licensed. Following a scoping exercise across the Kent and Medway health economy it became clear that no acute Trust in Kent has a HTA licence; Medway Foundation Trust has a limited agreement with the Medway Coronial Service to take some samples from children who are under 12 months old. No Trust offers a CT scan or Skeletal Survey, following death.

The Trust has led on the project to agree the new licensing process across Kent and Medway. The region is awaiting finalisation of the agreements but MTW does now have a licence. It is important to note that we will not be offering CT Scans or Skeletal Surveys when a child is declared life extinct at the Trust. The final agreement with the police and coroners about the process of requesting Kennedy Samples is due for ratification in Autumn 2025.

11.0 DOMESTIC ABUSE

In April 2021 The Domestic Abuse Act became law. There is a revised definition of Domestic Abuse –

‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members regarding of gender or sexuality’.

The Trust ratified a new Domestic Abuse policy in 2021 which considers the new legislation. This policy was reviewed and updated in June 2024.

12.1 Hospital Based Independent Domestic Abuse Advisor (HIDVA)

In 2023 the Trust secured funding for a HIDVA service; The post has been vacant since August 2024 (Risk register ID 3357). The Trust has a new HIDVA who started in July 2025 and she will be joined by a second in September 2025. Both work part time and will be covering all sites.

The role of the HIDVA is -

- To provide immediate support and advice to victims of domestic violence within the hospital setting; this service is for patients, staff and visitors and is a cross-site service
- To link individuals and families to longer-term community-based support
- To provide hospital staff with expert training so that they have the confidence to ask about domestic abuse

12.0 CHILDREN WITH MENTAL HEALTH NEEDS

Within this Trust it is apparent that an increasing number of children are being admitted with acute Mental Health needs; these include anxiety, Deliberate Self-Harm (DSH) and overdoses. There are huge challenges in supporting admission to a tier 4 Mental Health bed; often this can take up to 4 weeks (and longer). This leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff.

The Paediatric team on Hedgehog Ward now has a team of practitioners who lead on Children and Young Peoples Mental Health. Children and Young People have access to a Mental Health Liaison Nurse and Mental Health CSW's. This team works closely with the external Mental Health provider to develop safety plans, community plans and discharge plans. This model has been rolled out across other acute Trusts in Kent and Medway with high success rate.

Admissions to Hedgehog Ward:

Children with multiple co-morbidities (ASC/ LD /Mental Health) are the most challenging in terms of coordinating care pathways and safe discharges.

The Trust has a robust care pathway and risk assessments for these children. Staffs are supported by both the Paediatric Head of Service, Paediatric Matrons and the Named Nurse Safeguarding Children. All work closely with the ICB, CAMHS, NHSE (as the 'bed manager' for tier 4 beds) and the Local Authority to ensure appropriate care for these children is given.

All children admitted in a Mental Health crisis receive a daily CAMHS assessment. A weekly meeting is held with CAMHS to ensure that there are robust care plans in place and a Discharge Planning Meeting is held for the majority of children. Trust senior managers are updated on admissions and acuity on a regular basis by Paediatric Head of Service and/or Named Nurse Safeguarding Children. The DCN would be part of a coordinated response to extended admissions due to lack of a forward placement

A new volunteer service to support children in ED with Mental Health is in place and is provided by a charity called EMERGE. They have vast experience of supporting children in an ED environment and aim to prevent admission. They work with the CAMHS crisis team to build a plan of support for the child and will follow up in the community for up to 3 months after presentation.

13.0 NON-ACCIDENTAL INJURIES (NAI)

The Trust has a NAI/ suspected Physical Abuse pathway that is in use. Over the 12-month period ending in March 2025, 18 children were seen and assessed through the Trust's NAI pathway (see below); 5 children were deemed to have proven non-accidental injuries.

Once a NAI is suspected this will trigger a process which involves admission to Hedgehog Ward, referral to the Local Authority and police involvement. The child undergoes a series of investigations which include a Skeletal Survey, CT scan (dependant on age), ophthalmic review and a full set of bloods are taken. Advice is sought from external Radiologists to confirm any injury reported by MTW Radiologists.

The Safeguarding Children's team together with clinical staff will liaise with external statutory partners (Police and Local Authority) to agree a safety plan for the child/ren. For those children where an injury is proven and unexplained the usual course is for a child to be placed in Local Authority foster care.

A parental guidance leaflet has been published which explains what the Trust's process is and what parents can do.

14.0 PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities. The revised PREVENT Duty was published in July 2022.

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

The Trust has met the PREVENT training standard for Basic Awareness and achieved 93.5%. The Trust made no referrals to the Prevent process in the reporting year but has been involved in several Prevent information sharing enquiries.

15.0 KENT SAFEGUARDING CHILDREN MULTI-AGENCY PARTNERSHIP (KSCMP)

The KSCMP brings together the Statutory Partners (Local Authority, ICB Police) in a local area to ensure that there are arrangements in place to promote the welfare of all children in a local area. Each partner has an equal and joint duty to act as indicated.

The Partnership sets out its priorities on a bi-annual basis. Each priority is reviewed and progress checked against a locally agreed dashboard. As would be expected MTW will feed into these priorities and monitor our progress against the agreed standards.

Please see appendix 3 for the KSCMP Priorities for 2024/26:

More information can be found via the following link:

<https://www.kscmp.org.uk/about-kscmp/partnership-priorities-and-strategic-plan>

16.0 PATIENT SAFETY INCIDENT (PSI) INVESTIGATIONS

There have been no PSII's in the current reporting period that focus on Safeguarding Children

17.0 THE LADO AND EDUCATION SAFEGUARDING ADVISORY SERVICES (LESAS)

The Kent Local Authority Designated Officer (LADO) service and Education Safeguarding Service merged in September 2024 to form LESAS.

The role of LESAS is to build upon the statutory function of the LADO to support the children's workforce, in Kent, to ensure that they meet their Safeguarding responsibilities, and respond to Safeguarding concerns. LESAS will manage the process where an

allegation is made against a member of the children's workforce, which includes healthcare professionals.

In the reporting period the Trust has been actively involved in 9 referrals to LESAS. The Safeguarding service has supported staff through this process, and has been instrumental in developing risk assessments to allow staff to return to their roles (or a similar role).

18.0 ANY OTHER INFORMATION

18.1 RECENTLY PUBLISHED GUIDANCE:

- The Kent Safeguarding Children Multi-Agency Partnership has published up to date guidance on a range of subjects. Details can be found via the following link –
[Guidance - Kent Safeguarding Children Multi-Agency Partnership.](#)
- Child Safeguarding Practice Reviews (CSPR):

Recently published reviews for Kent Children and Young People can be found via the following link - [Recently published reviews - Kent Safeguarding Children Multi-Agency Partnership](#)

- The NSPCC is the national repository for all CSPR's. it also provides a series of resources on learning from case reviews - NSPCC | The UK children's charity | NSPCC

19.0 PRIORITIES FOR 2025- 2026

The safeguarding children's team recognise that there will be new and differing priorities for the coming 12 months.

Some of the key priorities will be focused on the following –

- Education and Training – increasing compliance on mandatory training by offering creativity in delivering training; increased use of on-line platforms and incorporate learning following child safeguarding practice reviews.
- Complex Needs –building on the process for escalation of children who may have complex needs to include mental health needs and empower other Trust staff in the discussions with other agencies.
- NAI in the under 2's – highlighting in training the complexity of AHT, NAI's and care pathways

- Develop a schedule of audits that will continue to assess safeguarding children assessments in clinical areas that children are reviewed.
- Compliance with the revised schedule 4 metrics for 2025-2026, based on NHSE protocols.

Section 2

Safeguarding Adults Annual Report 2024-2025

1.0 INTRODUCTION

The Adult Safeguarding Service (ASG) is aligned with the Children's Safeguarding Service and together the services promote the 'Think Family' approach. The Trust is committed to working in partnership with key stakeholders to ensure that adults at risk who come into contact with the Trust's services are identified early and protected from harm.

Safeguarding adults is the process of supporting adults with care and support needs who appear to be at risk of abuse or neglect and who are not able to protect themselves due to their needs for care and support (Definition of an Adult at Risk). The Local Authority is the lead agency and NHS Trusts have a statutory duty to work alongside them, in the multi-agency setting, to support those adults identified as being an adult at risk and are subject to any form of abuse.

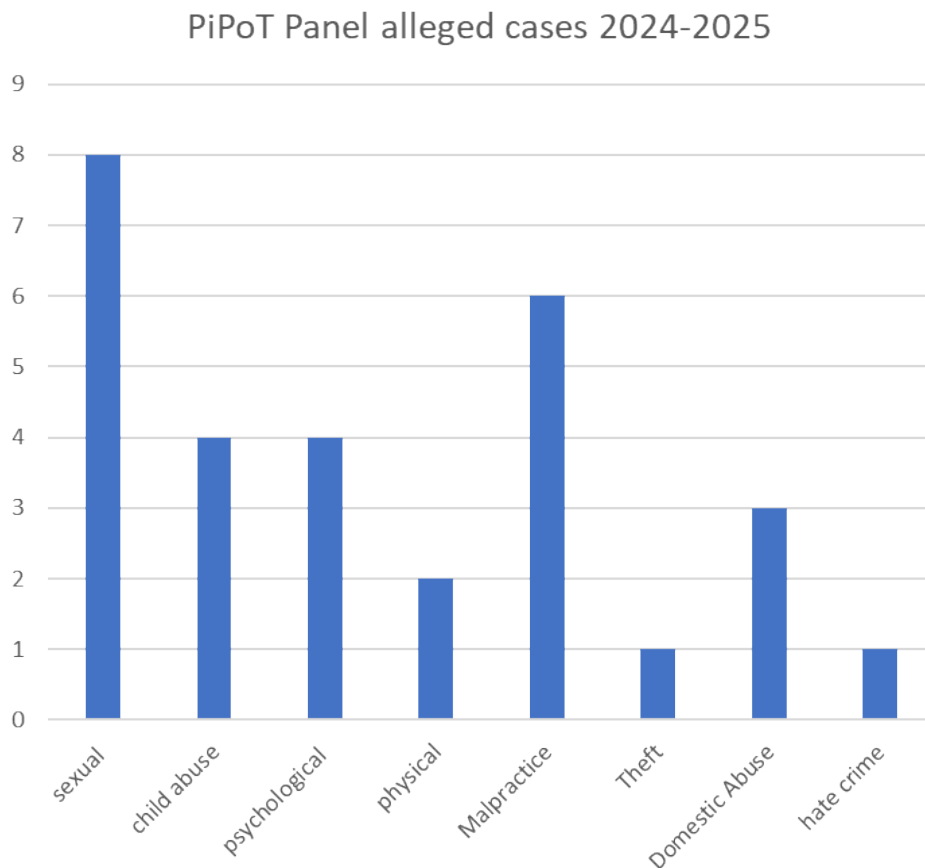
This annual report provides assurance to the Trust Board on how the Trust is meeting its statutory duties to safeguard adults at risk by identifying, preventing, and responding to concerns of abuse, harm, or neglect relating to patients, visitors, and staff during the period April 2024 to March 2025. Where relevant, information outside of these timeframes has been included to provide context and highlight key developments.

During 2024/25, the Trust has continued to strengthen its safeguarding arrangements in line with the NHS Safeguarding Accountability and Assurance Framework (SAAF) 2024. Policies and procedures have been reviewed and updated, including the clear definition of the Person in a Position of Trust role, the safeguarding adults supervision policy and the safeguarding adults policy and procedure, ensuring that safeguarding practice remains robust and legally compliant. Through strong governance, collaborative working, and ongoing review, the Trust continues to evidence compliance with its statutory responsibilities and remains committed to ensuring that adults at risk are identified early, protected from harm, and supported with dignity and respect.

2.0 SAFEGUARDING ADULTS ACTIVITY.

2.1 Person in Position of Trust (PiPoT)

During 2024/25, a total of 29 PiPoT cases were referred to and considered by the Trust's PiPoT Panel. Each case was reviewed in line with both internal processes and KMSAB guidance, ensuring that concerns involving staff or individuals in a position of trust were managed robustly, transparently, and in accordance with best practice. All cases were heard at the panel with representation from the appropriate personnel, including Human Resources partners, Directorate Leads, Service Managers, and the Safeguarding Named Nurses. This multi-disciplinary approach ensured that decisions were balanced, proportionate, and informed by both operational and safeguarding perspectives. The PiPoT risk assessment tool provided a clear framework for the panel, enabling consistent and objective decision-making. Although the panel was formally established in 2023, it became fully operational in 2024, providing a structured and reliable process for managing these sensitive cases. This development has strengthened the Trust's ability to provide assurance that concerns relating to individuals in positions of trust are addressed appropriately, with necessary actions taken to safeguard patients, colleagues, and the wider public. All PiPoT cases were reported to the relevant external agencies, including the Police where appropriate. Allegations of sexual assault were investigated by the Police, but in all instances no evidence was found to support further action. This demonstrates that due process was followed, that independent oversight was sought, and that the Trust acted in line with its statutory safeguarding responsibilities. In addition to case management, the PiPoT Panel has begun to identify themes and trends across the referrals received. This intelligence is being used to inform governance discussions, strengthen preventative measures, and support improvements in staff training and awareness, further enhancing the Trust's safeguarding culture.



2.2 Learning Disability and Autism

In 2024 the learning Disability service was nominated for the Nursing Times award for their contribution to the complex admission pathway for patients with learning disability Nursing Times Awards 2024. Additionally, the Trust successfully submitted the NHS improvement standards for Learning disability year 7 data. The Trust responses were identified as very good examples of good practice in the care of patients with learning disability. Examples of these practices include:

- The Trust has strengthened its support for patients with Learning Disabilities (LD) and Autism, with clear improvements in identification, patient experience, and staff confidence. Hospital flags, admission plans, and the new LD attribute on the Tele-Tracking system ensures patients are promptly identified, supports the delivery of reasonable adjustments, and allows the Trust to track admissions, re-admissions, and “Was Not Brought” data more effectively.
- Reasonable adjustments are embedded from first contact and tailored to individual need, supported by bespoke training from the Learning Disability Liaison Nurse (LDLN), which has improved staff knowledge and confidence.

- Collaboration with community teams and external agencies supports coordinated care and safe discharge planning.
- Staff resources are expanding, including easy-read materials, an image library, and consideration of sensory resources and quiet spaces.
- The Trust continues to value the important role of carers during hospital admissions. Agreements with Kent County Council and Continuing Healthcare (CHC) have ensured that funded carers remain actively involved in providing social and emotional support, safeguarding patient wellbeing throughout their hospital stay.
- Specialist admission pathways, including the Young Person and Adult LD Oral Sedation Pathway for Minor Interventions and the Complex Admission Pathway for Interventions under General Anaesthetic, have enabled access to essential health care for patients who may otherwise experience significant barriers to treatment.

2.3 Mental Capacity Act

The statutory principles of the Mental Capacity Act (2005) came into full force in October 2007 and apply to all persons aged 16 and over in England and Wales. The Act is a key safeguarding measure designed to protect individuals who lack capacity to make decisions for themselves. All practitioners have a statutory duty to apply the Act in their practice where required, and the Trust Board is assured that the MCA framework is embedded within clinical practice.

The 2024/25 MCA and DoLS audit provided evidence of strong compliance with Principle 1 of the MCA: the presumption of capacity. Staff demonstrated that patients with cognitive impairments were not automatically assumed to lack capacity, but were presumed to have it unless there was clear reason to doubt. This reflects the positive impact of training and represents a marked improvement on historical practice, where assumptions of incapacity were more common.

All assessments reviewed during the audit were completed using the revised documentation template, introduced in July 2024. This has improved both the quality and specificity of decision-making records. Where best interest decisions were required, documentation was consistently satisfactory or above, with the Trust now close to achieving full compliance.

Examples of outstanding practice were found in Edith Cavell Ward and Ward 20, both of which achieved 100% compliance across all standards. In each case where capacity was in doubt, high-quality assessments were undertaken, DoLS were appropriately authorised, and the statutory framework was applied rigorously. These examples demonstrate that excellent practice is not only achievable but already embedded in some areas of the Trust. Where local improvements in the application of the MCA were identified, bespoke sessions were offered to the clinical teams. Further audits on the application of the MCA are planned to take place in 2025-2026.

During 2024/25, the Trust submitted 984 urgent DoLS applications, yet only one standard authorisation was granted by the Local Authority as Supervisory Body. Although the Trust continues to apply robust internal safeguards, this lack of authorisation represents a significant legal and safeguarding risk that has been formally raised with the Local Authority (Risk register ID 3274). In response, the Trust's Mental Capacity Specialist Nurse is leading targeted improvement work with clinical teams. Key actions include:

- Ensuring that capacity assessments are consistently undertaken and documented to a high standard.
- Reinforcing awareness of DoLS statutory requirements, including the "Acid Test," across all clinical areas.
- Engaging medical and therapy staff to strengthen their involvement in MCA decision-making.
- Maintaining active dialogue with the Local Authority regarding the urgent need for standard authorisations, while applying local safeguards to protect patients in the interim.

3.0 SAFEGUARDING ADULTS TRAINING

During 2024/25, the Safeguarding Adults team delivered a comprehensive programme of training across the Trust, including Safeguarding Adults Levels 2 and 3 and MCA Levels 2 and 3, offered through both face to face and online sessions to maximise accessibility for all staff groups.

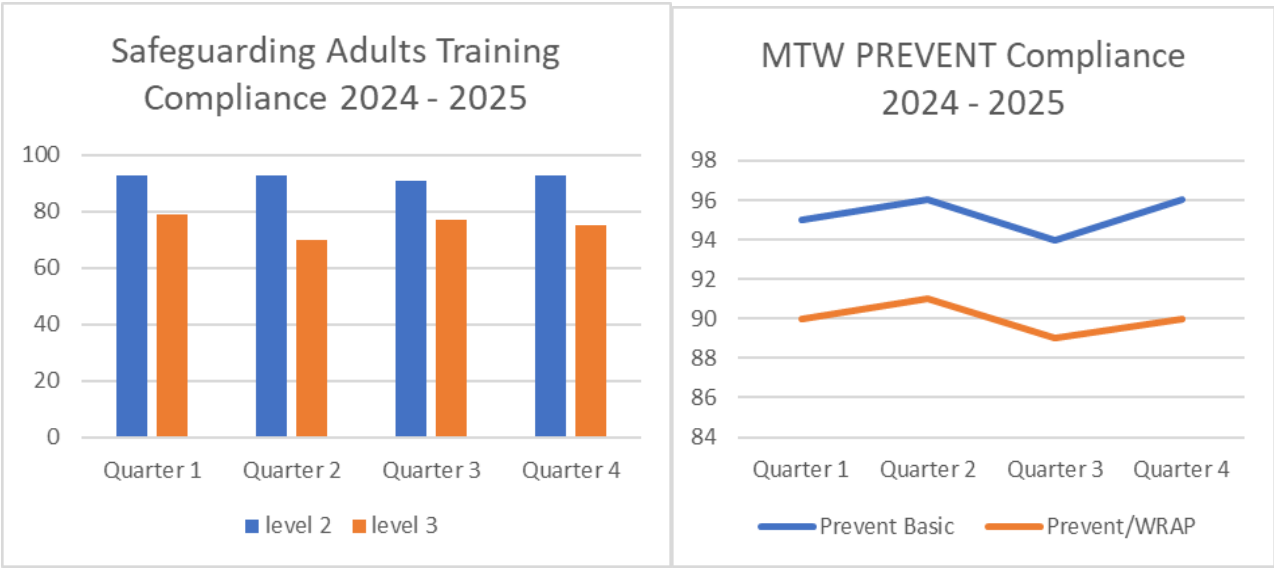
Training delivery was realigned in line with the Royal College of Nursing (RCN) Roles and Competencies guidance, ensuring that staff receive the level of training appropriate to their role and responsibilities. While this realignment temporarily impacted compliance figures for Safeguarding Adults Level 3 and MCA training, actions were implemented to mitigate this.

These actions included direct engagement with the hard to reach staff, such as the night staff, bespoke training sessions for specific departments, escalation of compliance issues to senior leaders, and close collaboration with the Learning and Development Manager to strengthen compliance monitoring and follow-up.

A significant development in 2024 was the introduction of senior leadership MCA workshops, which were widely welcomed across the organisation. Feedback was overwhelmingly positive, with senior leaders formally requesting that these sessions become a recurring element of leadership development, further embedding MCA principles at a strategic level and ensuring oversight of best practice across services.

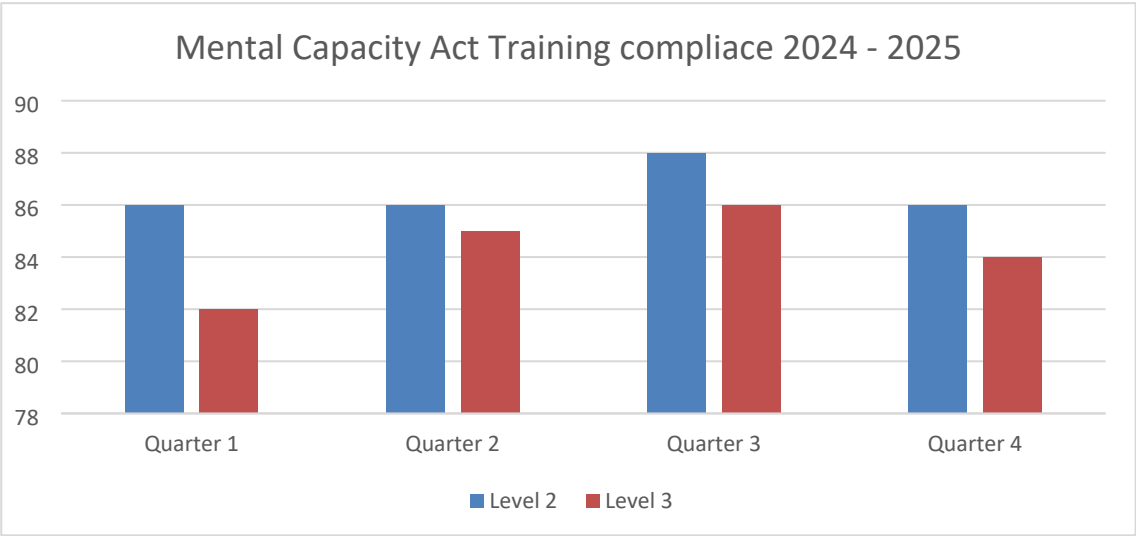
The safeguarding adults team also strengthened academic partnership working through the Care of the Elderly Masters-level module for MTW staff, developed in collaboration with Canterbury Christ Church University. This programme provides advanced education in safeguarding, mental capacity, and domestic abuse, and has been highly valued by participants as an important component of professional development.

Prevent training, delivered under the Home Office framework, continues to be well attended across the Trust. Compliance submissions have consistently met national requirements on the NHS Data Dashboard, providing assurance that statutory duties are being met in this area.



Although compliance figures for Safeguarding Adults Level 3 have shown a reduction, this is due to the movement of several staff cohorts from Level 3 to Level 2, in line with the RCN

guidance, and does not represent a reduction in the Trust’s safeguarding capability (Risk register ID 1259).

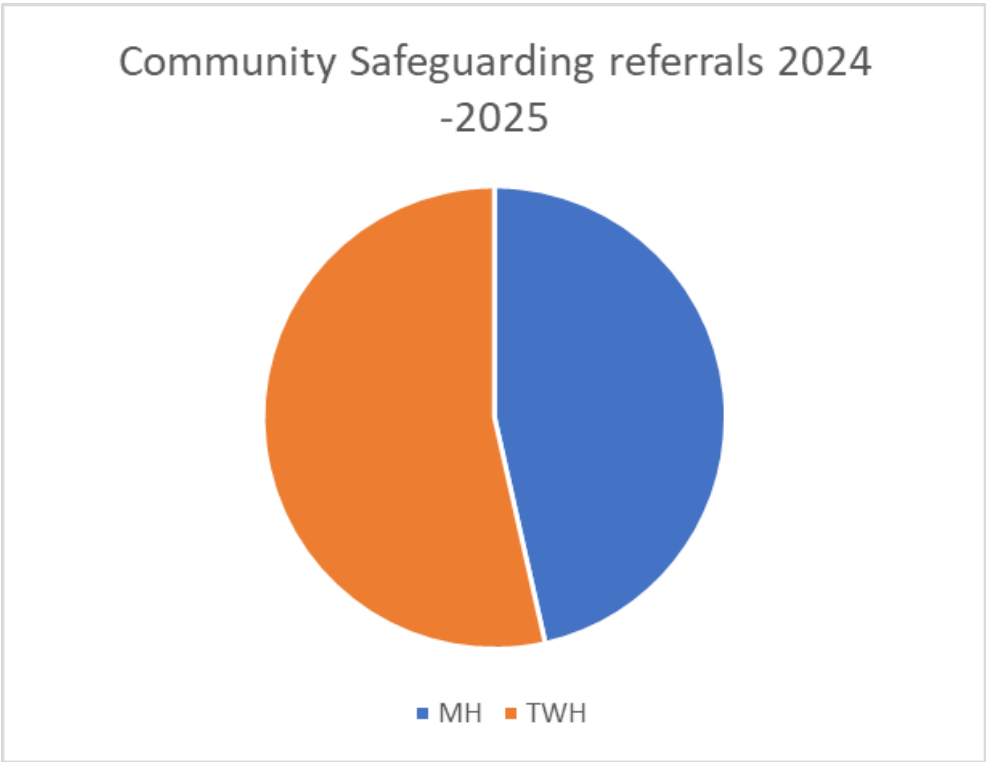


4.0 SAFEGUARDING ADULTS REVIEWS (SARS)

During 2024 - 2025, the Safeguarding Adults Named Nurse contributed to a number of the 19 Safeguarding Adults Reviews (SARs) published by the Kent and Medway Safeguarding Adults Board (KMSAB), as well as up to four Domestic Abuse-Related Death Reviews (DADRs) coordinated through the Kent Community Safety Partnership. These reviews provide critical system learning where serious harm or death has occurred, ensuring that all agencies, including the Trust, can reflect, adapt, and strengthen safeguarding practice. Learning and associated action plans arising from both SARs and DADRs are systematically presented to the Trust Joint Safeguarding Committee, where they are scrutinised and monitored. This process provides assurance to the Board that lessons are not only identified but embedded into operational practice, with progress against actions closely tracked.

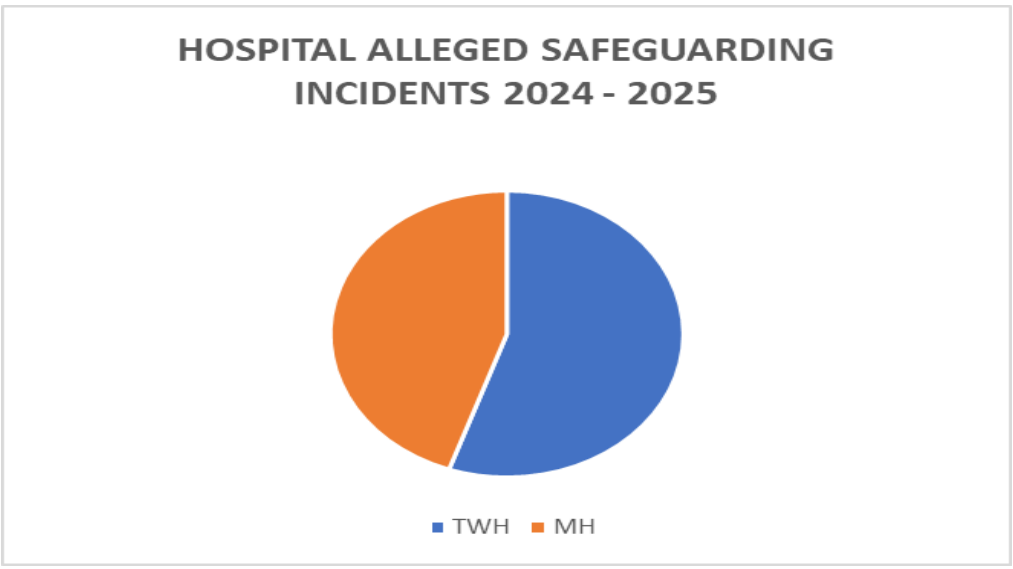
The impact of this engagement is already visible within the Trust. Findings from SARs and DADRs have directly informed enhancements to safeguarding training, particularly in relation to professional curiosity, domestic abuse, self-neglect, and the interface between mental and physical health care (this was the highlight during the Safeguarding Adults Awareness Week) where there was a collaboration of events between the Trust and local mental health hospital. Escalation pathways have also been strengthened to ensure safeguarding concerns are raised promptly and acted upon effectively.

5.0 SAFEGUARDING REFERRALS AND INVESTIGATIONS – ADULTS



MH- Maidstone Hospital

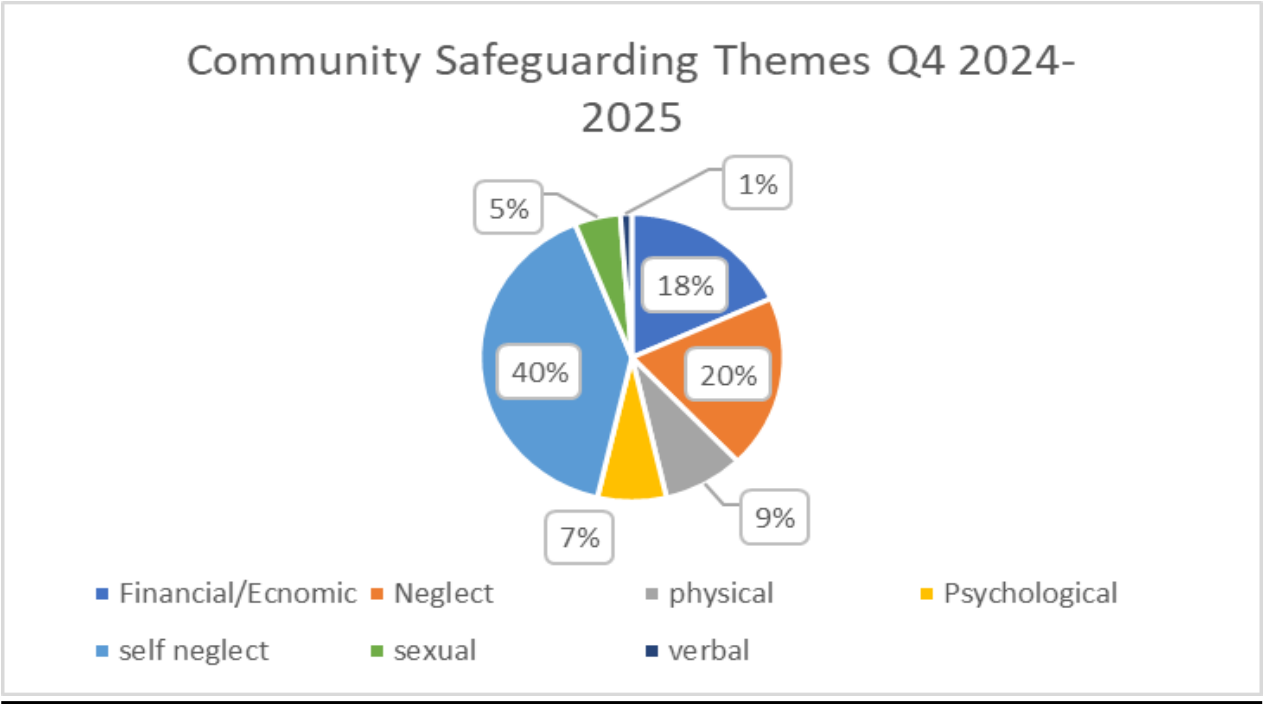
TWH- Tunbridge Wells Hospital



Analysis of referrals highlights several recurring themes. Self-neglect remains the most prominent issue within community safeguarding incidents, alongside sexual abuse and assault, neglect, and domestic abuse. The prominence of self-neglect aligns with findings from Safeguarding Adults Reviews (SARs) published by the Kent and Medway Safeguarding Adults Board (KMSAB), demonstrating consistency between Trust-level concerns and wider

system learning. The majority of community safeguarding concerns are identified in the Emergency Department (ED), ensuring early recognition and timely intervention before patients are transferred to ward areas.

In addition to community concerns, 94 hospital safeguarding concerns relating to hospital practice were raised during 2024/25, a 4% decrease from the 98 concerns reported in 2023/24. Of these, only 10 were upheld following review by both the Safeguarding Adults Learning and Improvement Panel and the Local Authority. Learning from upheld concerns is systematically embedded into practice through divisional governance structures, ensuring scrutiny, assurance, and improvements to patient safety and safeguarding culture.



The recognition and reporting of safeguarding concerns by Trust staff continues to grow, reflecting strengthened awareness, training, and confidence across the organisation. During 2024/25, a total of 540 Safeguarding Adults referrals were made, compared to 338 in 2023/24, representing a 60% increase year-on-year. This substantial rise demonstrates that safeguarding is increasingly embedded in everyday clinical practice.

6.0 SAFEGUARDING ADULTS AUDIT

A thematic audit of safe discharge processes was undertaken during Quarter 1 of 2024/25, reviewing a sample of thirty patient records. The review found that patients were routinely provided with clear discharge information, and communication with General Practitioners was consistently maintained, supporting safe transitions and continuity of care. Patient views

were incorporated into discharge planning in almost all cases, and safeguarding considerations were well embedded, reflecting the Trust's commitment to a 'Think Family' approach.

The audit shows that safe discharge practice within MTW is largely robust, particularly in relation to patient involvement, safeguarding and communication with GPs. However, further work is needed to strengthen multi-agency collaboration and ensure MCA assessments are consistently applied where decision-making capacity is uncertain. Addressing these areas will improve both patient safety and the overall quality of discharge planning.

7.0 PRIORITIES FOR 2025-2026

The safeguarding adults team recognise that there will be new and differing priorities for the coming 12 months and see Safeguarding as being central to business continuity for the Trust.

The team's priorities will be focused on the following –

- Education and Training – increasing compliance on mandatory training by offering creativity in delivering training; increased use of on-line platforms to all staff groups incorporating learning from PIPOT cases, safeguarding adult reviews
- Strengthening the joint working between the named professionals and other external partners
- Embedding key areas of learning following SAR reviews.
- Audit to assess whether MCA training and its application continues to be embedded by all staff.

It is recognised that there have been challenges in the previous 12 months, which will inevitably impact on health services in the next 12 months. The Safeguarding team has recognised and risen to the challenge to support all staff and will continue to build on the positive work started in the previous 12 months.

Section 3

Safeguarding Midwifery Annual Report 2024-2025

1.0 INTRODUCTION

The midwifery safeguarding team work in partnership with the Named Nurses for Safeguarding Children & Adults (and their respective teams) to deliver the All Age Safeguarding agenda. Promoting the early identification and management of safeguarding concerns through professional leadership, expert practice, research and education to ensure that the Trust effectively discharges its statutory Safeguarding duties.

The Deputy Chief Nurse provides direct line Management to the Named Midwife for Safeguarding. Professional midwifery guidance is provided by the head of midwifery or director of Maternity. Additionally, the midwifery safeguarding team provide support and expert opinion on the Maternity and Neonatal Assurance Board, Nursing and Midwifery Board and Maternity Oversight Meetings. They also provide additional support to the maternity Risk team as required for After Action Reviews (AAR), Rapid Review and relevant incident investigations.

Outside of the Joint Safeguarding Committee's Quarterly and Yearly Reporting structure, there is High Level oversight from the Maternity Service in respect of Safeguarding service development, service provision & any safeguarding risks which may affect Maternity Services. This is communicated via the Perinatal Quality Surveillance Model (PQSM) report, Midwifery team briefings at the Maternity and Neonatal Assurance Board, Clinical Governance meeting and during the weekly Oversight Meeting chaired by the Head of Midwifery.

The Named Midwife and Deputy Named Midwife work closely with their direct counterparts in Kent, Medway and East Sussex to safeguard families across the County and neighbouring borders.

There is a well-established Regional Network of safeguarding specialist Midwives who meet regularly across the South East and further afield as part of the National Maternity Safeguarding Network. Both forums are chaired by NHS England providing peer support, National Updates and project work as well as an opportunity to benchmark Safeguarding Service Provision Nationally.

Outside of the Joint Safeguarding Committee's Quarterly and Yearly Reporting structure, there is High Level oversight from the Maternity Service in respect of Safeguarding service development, service provision & any safeguarding risks which may affect Maternity Services. This is communicated via presentations at Divisional & Directorate board, Clinical Governance and monthly meetings with the Maternity Triumvirate. The Maternity Workforce also now receive a monthly staff All Age Safeguarding team newsletter with service updates, summary service statistics, points of interest and links to Safeguarding training opportunities.

The midwifery safeguarding team works closely with the Head of Quality and Neonatal Services {Kent & Medway LMNS- (Local Maternity and Neonatal System)} and the service receives external oversight from the ICB Kent & Medway Designate Safeguarding Lead.

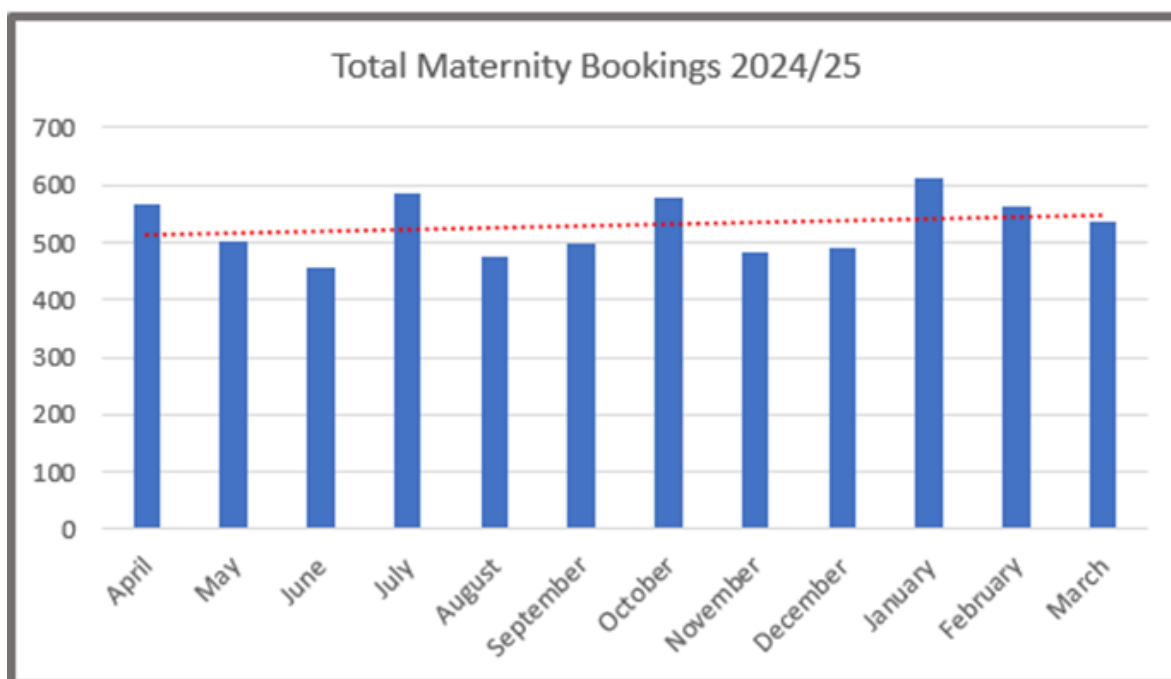
The Safeguarding Maternity service aims to support clinical teams to fulfil a number of strategic, operational and cultural ambitions:

- 1) Protecting mothers, babies and children through early identification and intervention:
Early identification is the cornerstone of effective safeguarding. Midwives are often the first professionals to engage with pregnant women, making them uniquely positioned to detect early signs of risk. This includes but is not limited to:
 - Routine enquiry for domestic abuse
 - Screening for mental health & substance misuse concerns and support needs
 - Recognising non-verbal cues or inconsistencies in a woman's account where concerns have been raised.Services must invest in robust screening tools, clear referral pathways, and interdisciplinary collaboration to act swiftly on concerns.
- 2) Embedding Trauma-Informed compassionate care in every contact: Trauma informed care acknowledges that many women have experienced past abuse, neglect or violence. This approach prioritises emotional safety and empowerment whilst avoiding triggering trauma through insensitive language or procedures. A Trauma informed approach to safeguarding encourages open, honest communication, shared decision making and respect for autonomy.
- 3) Listening to women: Women are more likely to disclose safeguarding concerns when they feel heard and believed. Midwives must ensure that time and space is provided to have private, uninterrupted consultations, where women are heard and receive non-judgemental care.

- 4) Every Contact Counts: Safeguarding should be woven into every interaction, not treated as a separate task. This means asking safeguarding questions routinely and sensitively. Observing non-verbal cues and family dynamics and using every appointment or contact to assess wellbeing.
- 5) Clear integrated pathways across Maternity and Community services: Safeguarding is rarely the responsibility of a single professional. Effective protection requires clear communication channels between Midwives, social workers, GP's, mental health teams and community support services. Collaboration is strengthened by shared care plans, multi-agency meetings joint training and shared accountability structures where each professional plays a role that forms a whole.
- 6) Workforce preparedness: Training every Midwife in Safeguarding excellence.
Safeguarding is a dynamic field with evolving risk. The Midwifery workforce are supported by mandatory regular training and updates which are tailored to local risk and National agendas and receive regular supervision and debriefing to manage the emotional impact of complex safeguarding caseloads which may lead to practitioner distress and burnout.
- 7) Safeguarding Leadership: Accountability and Governance at every level. Safeguarding is not only a front-line responsibility- it must be embedded throughout the entire organisation at every level. This ensures that Safeguarding is prioritised, monitored and continuously improved through clear leadership and robust governance.
Maidstone and Tunbridge Wells Trust has executive level commitment to the integration of safeguarding strategic objectives. Oversight is provided by risk registers, quality improvement plans, and regular board reports on safeguarding performance, risks and learning from incidents.

2.0 SAFEGUARDING MIDWIFERY SERVICE STATISTICS.

During the reporting period, the number of maternity bookings increased from 5,406 to 6,273, which is a rise of approximately 16%. During the same period, referrals to Children's Social Care (CSC) increased from 126 to 194, representing a much steeper rise of 54%. This means that while more women were entering maternity services, the proportion of those being referred to CSC grew at a significantly faster rate (2.33% in 2023 to 3.09% in 2024).



3.0 REFERRALS TO SAFEGUARDING MIDWIFERY

The most common reason for referral to the Safeguarding Midwifery service is maternal mental health, which accounted for over 200 cases. This includes a wide spectrum of conditions, from anxiety and depression to more severe psychiatric disorders, and often coexists with other vulnerabilities such as substance misuse or domestic abuse.

Domestic abuse remains a significant driver of referrals, with both current and historic abuse frequently reported. Non recent abuse, in particular, appears to have a lasting impact on maternal wellbeing and parenting confidence, and its prevalence in the data suggests that trauma-informed care is essential in maternity safeguarding. Families with a known history of social care involvement also feature prominently in referrals. These cases often involve intergenerational safeguarding concerns, where previous child protection issues continue to influence current pregnancies.

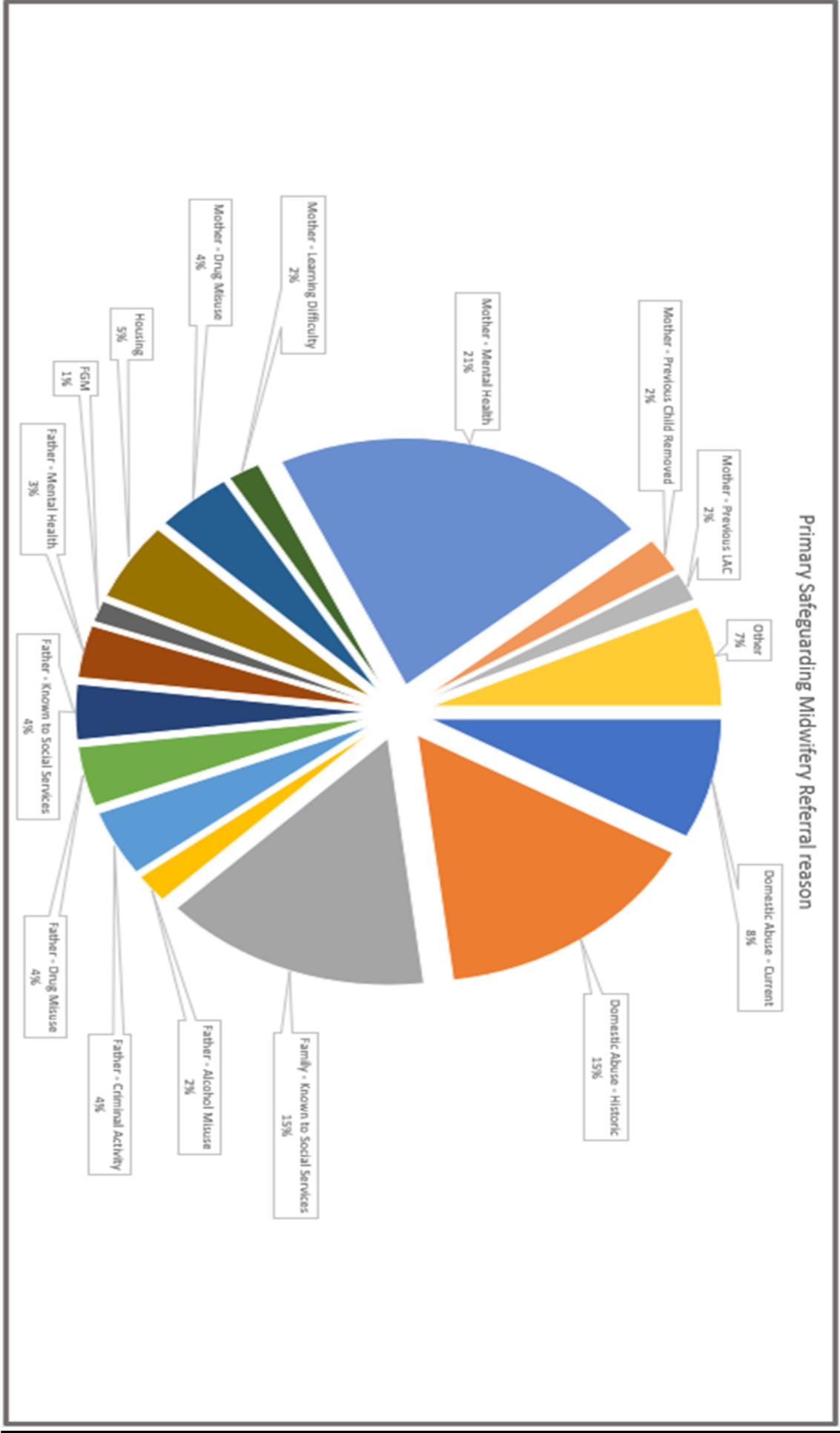
Socioeconomic factors such as housing instability and financial hardship are also common. These issues, while sometimes seen as secondary, often exacerbate other risks and can significantly affect a family's ability to engage with services

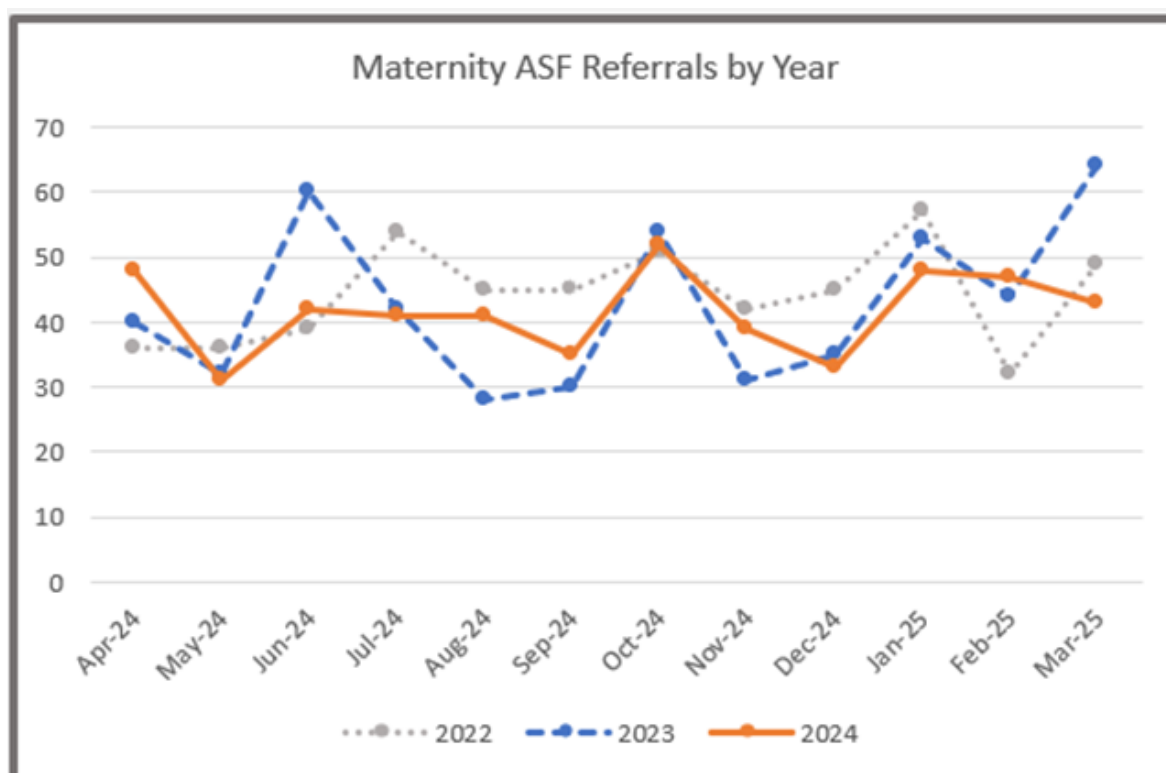
Less frequent but still important concerns include cultural and contextual risks such as female genital mutilation (FGM), honour-based violence, and immigration-related

vulnerabilities. These cases require specialist knowledge and culturally sensitive approaches.

For families, being referred to the maternity safeguarding team can be both a protective and distressing experience. On one hand, it can open the door to vital support services, helping to address risks early and improve outcomes for both mother and baby. On the other hand, referrals can trigger anxiety, particularly for those with previous involvement in child protection processes. Some families may fear that engagement with safeguarding services will lead to child removal, which can result in mistrust, disengagement, or even concealment of risk.

Frontline maternity staff, particularly midwives, play a critical role in identifying and escalating safeguarding concerns. This responsibility carries a significant emotional burden. Staff often find themselves navigating difficult conversations with families, balancing the need to build trust with the duty to protect. In cases involving domestic abuse or child protection history, midwives may experience moral distress, especially when the outcomes of referrals are uncertain or when services are unable to respond quickly.

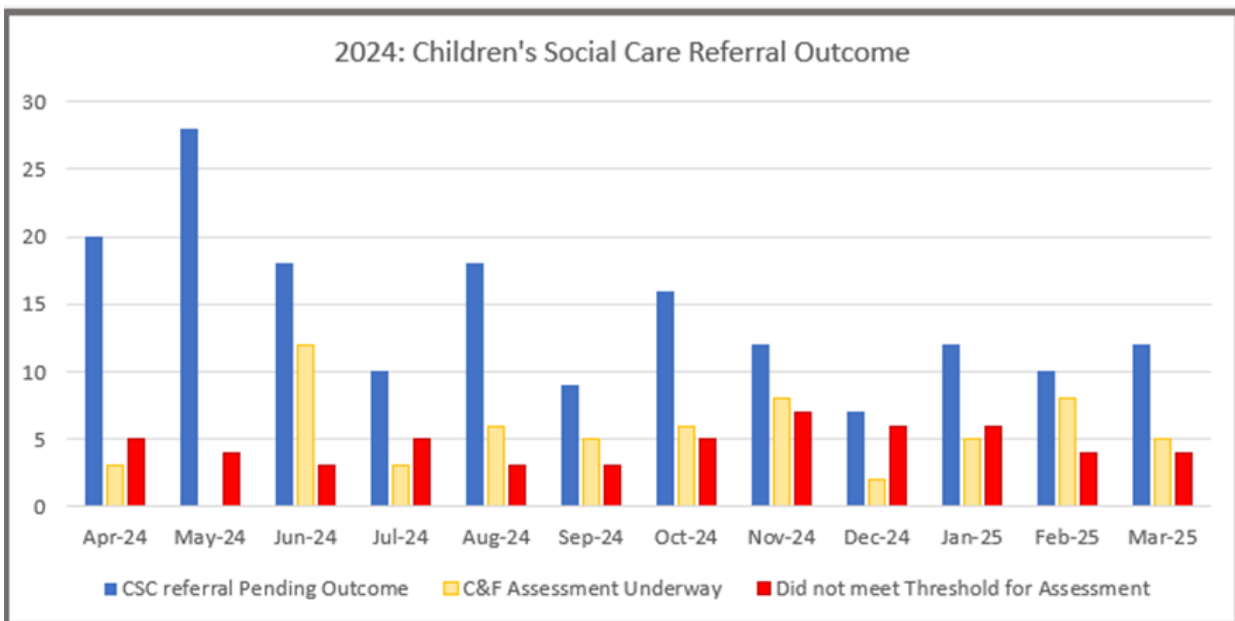
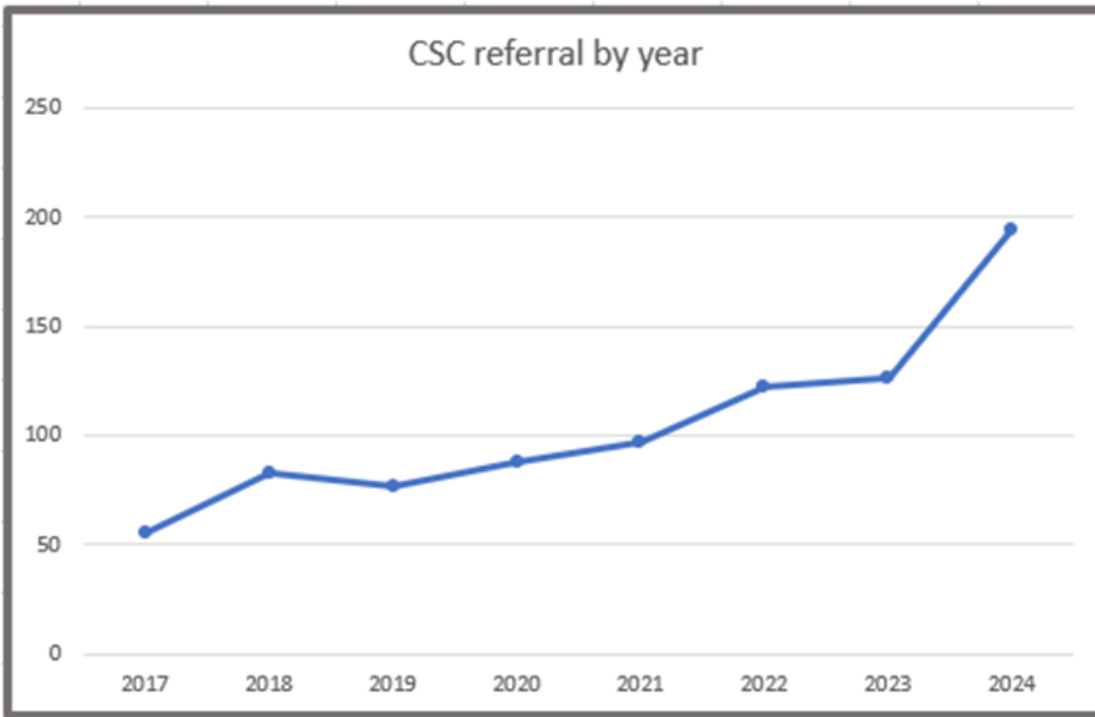




ASF- (Additional support forms)- This is a joint Safeguarding and Perinatal Mental Health Midwifery referral (Although only ASF's with a Safeguarding element are included here). This provides access to Safeguarding Advice, Midwifery Hub and Enhanced Health Visiting if required

4.0 CHILDREN'S SOCIAL CARE REFERRALS (CSC).

Formally known as 'Social Services', CSC support children, young people and families who need additional help to protect children and young people from Harm. Focusing on the last three years—2022, 2023, and 2024—the data reveals an increasing pattern in maternity referrals to Children's Social Care Services (CSC). In 2022, there were 122 referrals, which increased modestly to 126 in 2023, representing a 3.3% rise. However, in 2024, referrals increased to 194, marking a 54% increase from the previous year.



5.0 MATERNITY HUBS

The Maternity Hub Process was first initiated around 2016 at MTW. Its original intent was a multidisciplinary safeguarding information sharing forum to discuss complex cases. Chaired by the deputy named midwife and a senior social worker it brings together teams from Safeguarding Children, Midwifery, Health Visiting, Family Partnership Practice (FPP), Perinatal Mental Health Services, Early Help, and Clarion Housing to discuss complex safeguarding Maternity cases and provide peer support and advice. As the numbers of

complex Safeguarding Midwifery cases have evolved, the Maternity Hub has evolved with it seeing an ever-increasing volume of cases being discussed.

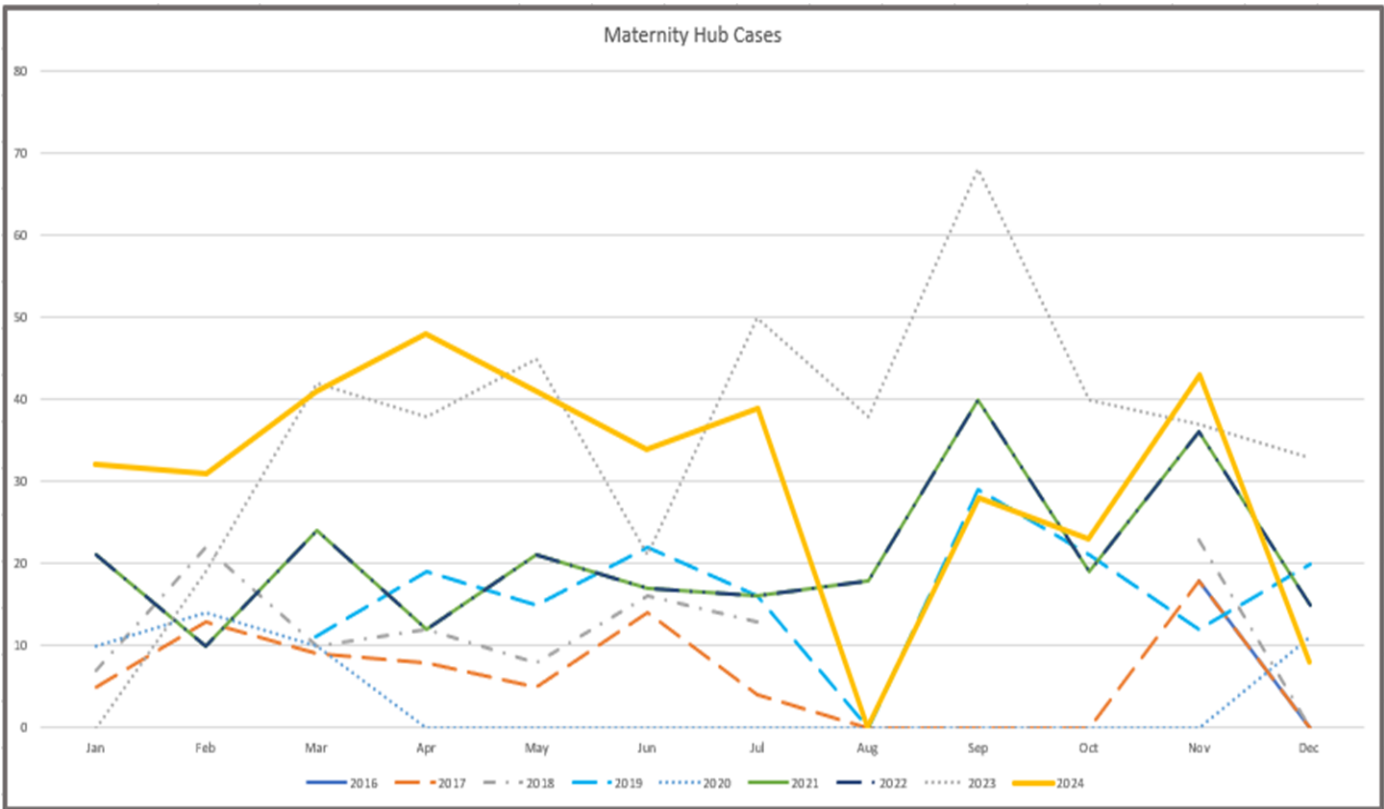
The Hub process, Intent and format is currently under review, with respective TORs and SOP to be updated in due course.

Due to staff absence within the midwifery safeguarding team, the children safeguarding practitioners have continued to support and chair the hub meetings (as needed) as they also form the quoracy of the hub meetings.

There are 4 hubs around the MTW catchment area and these are:

- Maidstone
- Sevenoaks South, and Tunbridge Wells SSTW).
- Tonbridge and Malling
- Wealden (Crowborough)

Hub activity by cases per calendar year



6.0 ACTUAL SAFEGUARDING DISCHARGE OUTCOMES

The 2024 maternity safeguarding outcome data provides a comprehensive view of the various pathways taken to ensure the safety and wellbeing of mothers and their babies. Each outcome represents a decision made at the conclusion of a pregnancy, whether

through birth, miscarriage, or termination, and reflects the complex interplay of health, social, and legal factors involved in safeguarding.

The most frequently recorded outcome was miscarriage or termination of pregnancy, with 23 cases, accounting for approximately 29.1% of the total. This high proportion suggests that a significant number of pregnancies ended prematurely, either due to natural causes or medical decisions. It also highlights the importance of providing emotional and psychological support to women experiencing pregnancy loss, particularly where safeguarding concerns may have contributed to the decision to terminate.

The second most common outcome was the transfer of care to another NHS Trust, with 17 cases, representing 21.5% of the total. This outcome reflects the need for robust handover between Safeguarding teams as a number of women transfer Trust due to Housing and Social reasons or in an attempt to evade child protective service input. It underscores the importance of effective communication and coordination between healthcare providers to ensure continuity of care and appropriate safeguarding oversight.

Nine cases, or 11.4%, resulted in the removal of the baby from the mother's care. This is a significant and often distressing outcome, typically involving legal proceedings and multi-agency assessments. It indicates that in these instances, the risks to the child were deemed too great to allow them to remain with their birth parent. Closely related to this, six cases involved the baby being removed directly from the maternity unit, suggesting immediate postnatal concerns that required urgent intervention. In these cases, the Safeguarding Midwifery team support clinical staff directly to ensure smooth discharge and transfer of baby, emotional support of the mother and extended family and clinical support and supervision for staff during this period of heightened emotion.

Eight cases, or just over 10%, involved mother and baby being placed together in a foster care setting. This outcome reflects situations where the mother was considered capable of parenting with support, but not in her own home environment. Such placements aim to preserve the mother-child bond while ensuring safety and stability. Similarly, five cases involved the baby being placed in foster care without the mother, indicating that the mother was either unavailable or deemed unable to provide safe care.

Mental health-related outcomes were also present in the data. Three cases involved psychiatric care for the mother only, while another three required emergency psychiatric intervention during pregnancy. These figures highlight the ongoing need for robust perinatal mental health services and early identification of mental health issues. Two cases involved admission to a psychiatric mother and baby unit, where both mother and child could remain together during treatment. This outcome is particularly important for maintaining attachment

and supporting recovery in cases of severe perinatal mental illness. However, the low number of such admissions may reflect limited availability of these specialist units or stringent admission criteria.

Three cases resulted in adoption, a permanent legal outcome that typically follows extensive safeguarding assessments and court proceedings. Adoption is often considered when no safe or suitable family placement can be identified, and long-term care outside the birth family is deemed necessary.

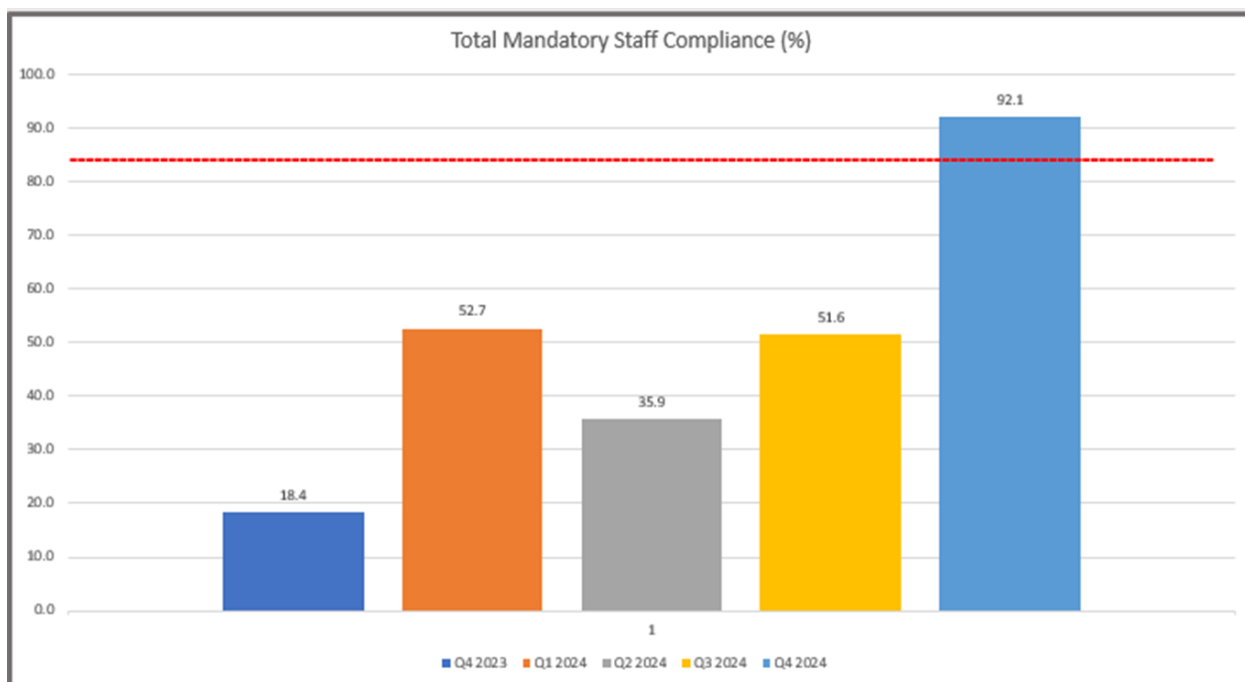
There were three recorded cases of surrogacy which required significant support and oversight, including one where the surrogacy agreement had broken down.

In summary, the data reveals a diverse range of safeguarding outcomes, with a strong emphasis on mental health, care transitions, and protective interventions. The high number of pregnancy losses and transfers of care points to the complexity of safeguarding in maternity services. Meanwhile, the presence of foster placements and removals underscores the critical role of social care in protecting vulnerable infants. This analysis highlights the need for integrated, trauma-informed approaches that support both mothers and babies through challenging circumstances.

7.0 Midwifery safeguarding supervision.

During the reporting period, it was recognised that compliance in midwifery staff supervision had improved. Restorative supervision also strengthens professional resilience and promotes psychological safety within teams. By encouraging open dialogue and mutual support, it fosters a culture where staff feel valued, heard, and empowered to raise concerns or seek guidance. This is particularly important in safeguarding, where multidisciplinary collaboration and trust are vital.

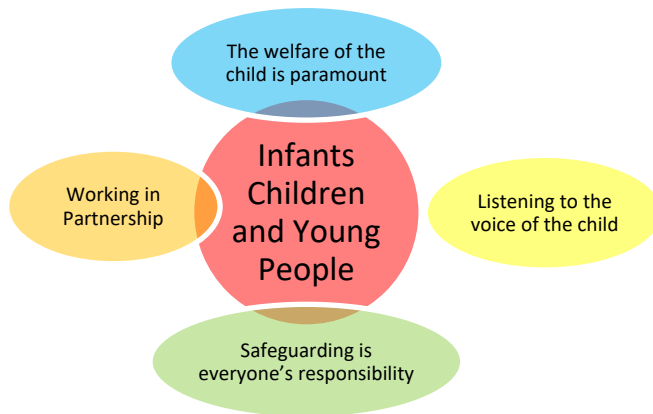
The Named Midwife and Deputy Named Midwife provide Group Safeguarding Supervision for all Community, Antenatal Clinic and Birth Centre Staff Midwives in line with the Intercollegiate Document (2019). The Team Managers and Matrons receive quarterly bespoke supervision so they are better able to provide confident first line support to their teams. Supervision compliance, staff exemptions, staff documents, new starters, and Spotlight Themes are now tracked via a supervision database with live dashboard.



Appendices:

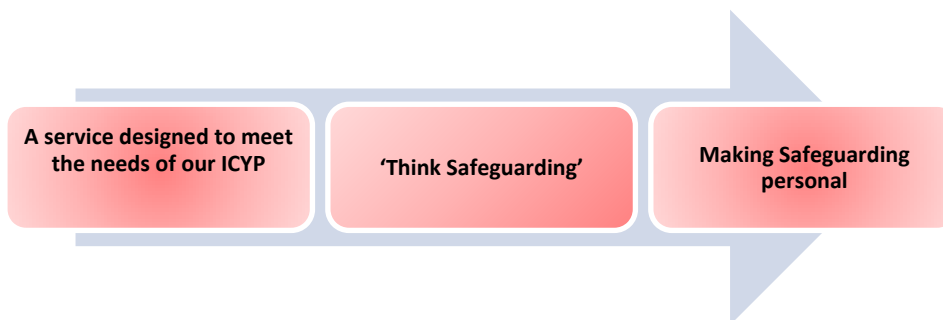
Appendix 1 Ethos for safeguarding children.

SAFEGUARDING CHILDREN – Trust ethos puts children and young people at the centre of all activities

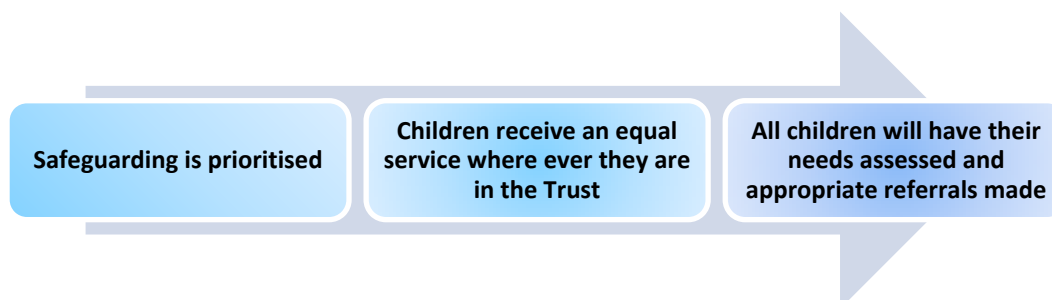


The Safeguarding Children team has taken the 5 CQC domains and uses these as our framework

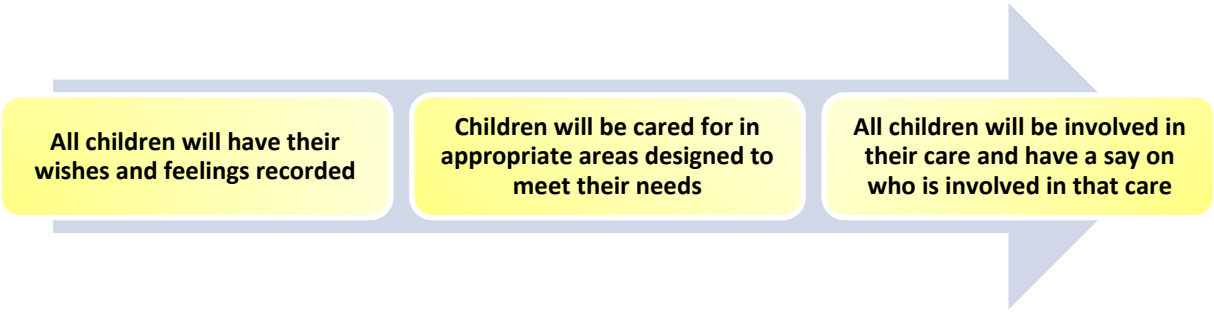
A. CARING - PUTTING CYP AT THE CENTRE OF OUR WORK



B. SAFE – THE WELFARE OF THE CHILD IS PARAMOUNT



C. RESPONSIVE – LISTENING TO THE VOICE OF THE CHILD



D. WELL-LED – SAFEGUARDING IS EVERYONE’S RESPONSIBILITY



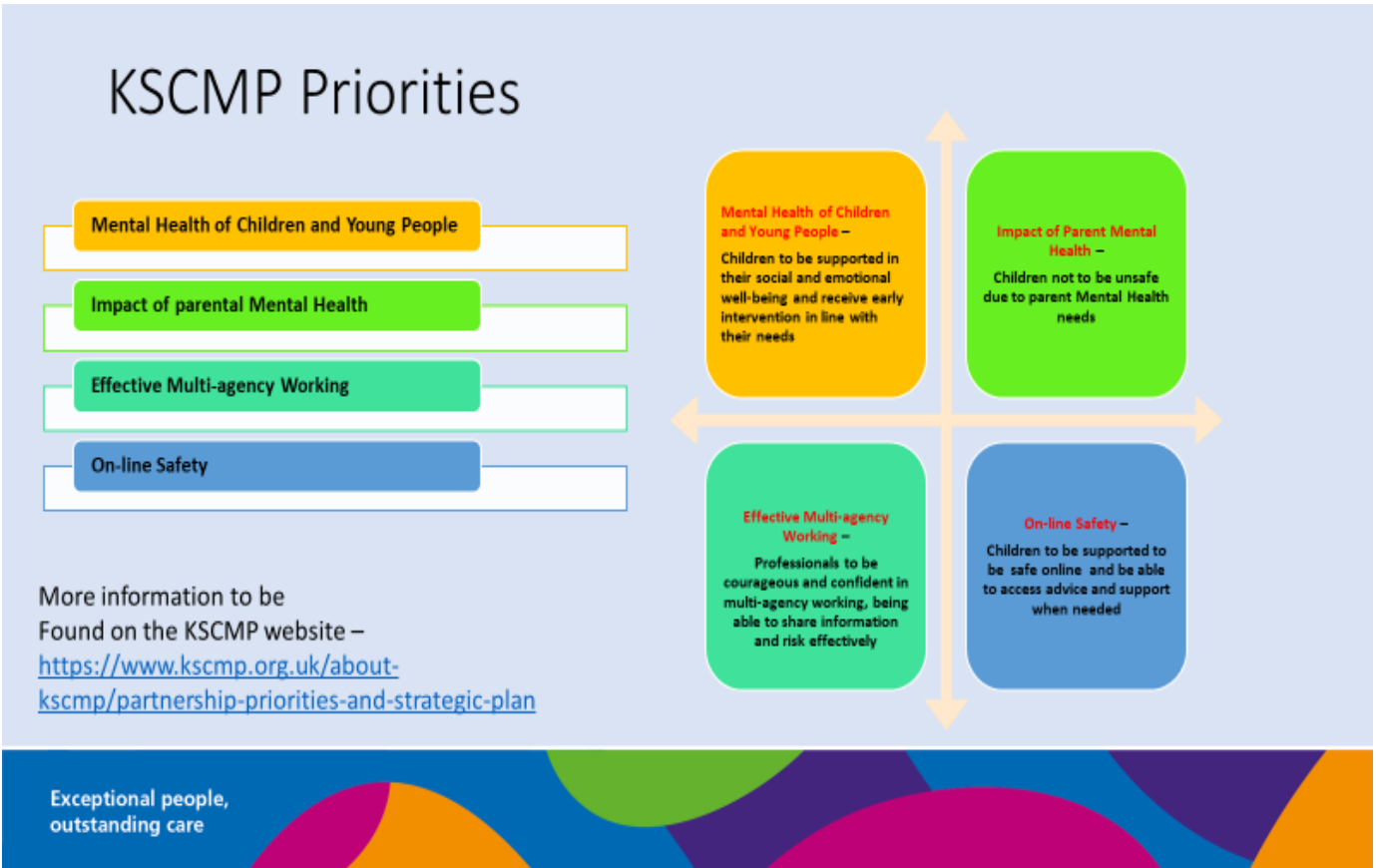
E. EFFECTIVE PARTNERSHIP WORKING



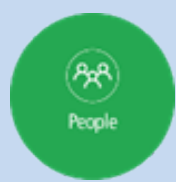
Appendix 2- Child death infographic process in place at the Trust



Appendix 3 -KSCMP Priorities for 2024/26



Title of report	Maternity compliance status report related to the Section 29a Warning Notice relating to maternity and midwifery services issued by the Care Quality Commission on 31 October 2023					
Board / Committee	Trust Board					
Date of meeting	25 th September 2025					
Agenda item no.	09-15					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Rachel Thomas, Director of Maternity					
Report Purpose (Please ☒ one)	Action/Approval	☒	Discussion	☒	Information	☒

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	<u>Overview</u> This report is presented to the Trust Board to provide an update of the compliance status for meeting the requirements of the Section 29a warning notice issued to the maternity service in October 2023
	<u>Background</u> Following an inspection as part of a national programme, on the 31 October 2023, the Care Quality Commission (CQC) issued a Section 29a warning notice to our Trust, under the provisions of the Health and Social Care Act 2008. The concerns listed were as follows: 1.The service does not have effective governance processes or accurate data collection to monitor, gain assurance, and work to reduce the incidence and severity of post-partum haemorrhage (PPH). 2. The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for women, birthing people, and babies. 3.The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored. 4.The service does not reduce the risks to women, birthing people waiting for induction of labour putting them at risk of harm. 5. The service does not always provide timely emergency caesarean sections putting women, birthing people, and babies at risk of harm.

	<u>Compliance status</u> 1.The service does not have effective governance processes or accurate data collection to monitor, gain assurance, and work to reduce the incidence and severity of post-partum haemorrhage (PPH). Actions complete 2. The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for women, birthing people, and babies. Actions complete (although some minor aspects are outstanding) Outstanding actions: - Review and rewrite Women's Services Risk Management Strategy to reflect agreed changes in structures and pathways – anticipated by end 2025 3.The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored. Actions complete 4.The service does not reduce the risks to women, birthing people waiting for induction of labour putting them at risk of harm. Partially complete (further steps required) Outstanding actions: - An ongoing quality improvement project (3A) has been maintained to ensure that focus remains on the management and oversight of induction of labour and the service continues to strive to reduce delays 5. The service does not always provide timely emergency caesarean sections putting women, birthing people, and babies at risk of harm. Actions complete It should be noted that the 29a Warning Notice was lifted following a further CQC inspection of maternity services in October 2024.	
	Any items for formal escalation / decision The Trust Board is asked to: - Review and approve the Compliance status report - Acknowledge and agree that oversight of the completion of the minor outstanding actions will be maintained by the Maternity and Neonatal Care Oversight Group	
	Appendices attached Appendix 1 Maternity Improvement Progress Update	
	Report previously presented to:	
	Committee / Group	Outcome/Action
	Maternity and Neonatal Care Oversight Group	17.09.25 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	Please list any risks on the Trust Risk Register to which this report relates

Risk Register (TRR)	•
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report Relates to Section 29a warning notice under the provisions of the Health and Social Care Act 2008

The requirements of the Section 29a Warning Notice relating to maternity and midwifery services, issued by the Care Quality Commission on 31 October 2023 – compliance status

Introduction & Summary

Following an inspection as part of a national programme, on the 31 October 2023, the Care Quality Commission (CQC) issued a Section 29a warning notice to our Trust, under the provisions of the Health and Social Care Act 2008. The concerns listed were as follows:

1. The service does not have effective governance processes or accurate data collection to monitor, gain assurance, and work to reduce the incidence and severity of post-partum haemorrhage (PPH).
2. The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for women, birthing people, and babies.
3. The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored.
4. The service does not reduce the risks to women, birthing people waiting for induction of labour putting them at risk of harm.
5. The service does not always provide timely emergency caesarean sections putting women, birthing people, and babies at risk of harm.

Following receipt of the 29a warning notice, an improvement programme was established, supported by a maternity improvement advisor. This report provides a summary and assurance on delivery of measures to address the five points raised.

The content of the report has been developed via the following means:

- *Oversight Meetings, initially weekly with transition to monthly, between the Maternity Leadership Team, the Chief Nurse and the Director of Quality Governance.*
- *Document review by the Maternity Services Improvement Programme Manager*

It should also be noted that this document provides a written summary of the overarching compliance against the improvement work within Maternity services, which is tracked formally via the following embedded slide set (Appendix One). The slide set was initially updated weekly, when many immediate actions were taken, with oversight at Service Level Improvement Group which have continued to provide a regular touchpoint for the workstreams and maternity leaders. The slide set continues to be updated on a monthly basis and, additionally, oversight and challenge is gained via the Trust's monthly Maternity Oversight Group (a sub-committee of our Quality Main Committee) which is chaired by the Chief Nurse.

Current position

The Section 29a Warning Notice was lifted following the Care Quality Commission inspection of maternity services in October 2024.

Requirement 1	The service does not have effective governance processes or accurate data collection to monitor, gain assurance, and work to reduce the incidence and severity of post-partum haemorrhage (PPH)

Current status:	Complete

Comments and/or evidence:

Having recognised and reported a rising trend, the maternity team had already developed an action plan and began to put actions in place in early August 2023.

Following the CQC visit the existing PPH improvement plan was strengthened to address the CQC findings.

The following improvement actions have been completed:

- Review of all incidents of PPH >1000ml with quarterly thematic analysis
- The PPH guideline and associated proformas linked to PPH management have been updated and published in November 2023, with roll out to embed consistent practice of measured blood loss
- The equipment in the Maternity delivery suite rooms was reviewed and modified to facilitate access to the necessary equipment to manage PPH
- Training programmes have been modified from January 2024 to reflect new guidance and embed best practice to prevent or manage PPH
- A proforma was developed in January 2024, piloted and revised in June 2024 to support consistent review of all cases of PPH reported via InPhase against expected standards. This approach was approved by the maternity governance and leadership teams for use by the maternity patient safety team.
- Additional sets of scales were purchased to facilitate contemporaneous measurement of blood loss
- The Maternity digital incident reporting trigger list was updated to include PPH $\geq 1000\text{ml}$ – in line with the CQC's recommendations
- PPH rates now have directorate, divisional and trust oversight within the maternity clinical outcomes dashboard, SDR scorecard and IPR metrics reporting

These changes have resulted in the following current practice:

- Maternity staff carry out a PPH risk assessment, prevention and management as per the directorate's guideline
- Maternity staff undertake multi-disciplinary emergency drill training to embed and maintain skills
- All incidents of PPH $\geq 1000\text{ml}$ have a structured review using a standardised template and learning from themes and trends is shared with staff and incorporated into training programmes where applicable
- There is a failsafe process for capturing any missed incident reports via the maternity information system
- Thematic reviews are undertaken to identify trends in challenges to comply with best practice and actions are implemented to support staff to improve compliance
- Additional equipment has been made available in clinical areas to support measured blood loss and appropriate management of ongoing bleeding
- The PPH rate is monitored with monthly reporting at service, divisional and trust level

Comments and/or evidence:

- The service aims to improve support for women who have experienced PPH. Acknowledging that significant PPH can be a traumatic event for women and their families, staff are encouraged to provide the opportunity for birth discussions and, where appropriate, to offer a follow up appointment for debrief.

Further work required, if relevant:

Requirement 2	The service and trust board does not have effective governance processes to monitor and improve clinical outcomes for women, birthing people, and babies

Current status:	Complete (though some minor aspects are outstanding)

Comments and/or evidence:

The following improvement actions have been implemented:

- Implementation of digital clinical and incident maternity dashboards with agreed metrics and tools to robustly identify trends, patterns and anomalies from April 2024
- Timely high-quality reviews and investigations are carried out by a skilled, experienced and capable multi-disciplinary team, with reviews of adverse incidents within 72 hours in preparation for weekly Trust safety meetings
- A 'learning to improve' framework has been in place since April 2024 to enable learning from incidents of harm and to drive improvements in clinical outcomes
- Restructuring and expansion of our governance team and local governance meetings concluded in January 2025. The structure and processes now include a monthly clinically-led review of the digital dashboard and clinical outcomes, with agreement and monitoring of action plans / quality improvement initiatives
- Strengthened 'Ward to Board' reporting utilising a refreshed Perinatal Quality and Safety Model report. This launched in April 2024
- Appointment of a Maternity Lead for Equality, Diversity and Inclusion and recruitment of an additional Perinatal Mental Health Specialist Midwife to provide oversight of data to identify themes and trends for improvement, supporting personalised care and responding to individual health inequalities.

These changes have resulted in the following current practice:

- Clinical dashboard data is presented with trends and benchmarking to enable effective analysis and identification of alerts or trends of concern for escalation
- Development of the clinical and incident dashboards to include outcomes for women with health inequalities
- Patient Safety Incident Response Framework (PSIRF) has been implemented in partnership with the trust Patient Safety Team with a clear pathway to PSIRG meetings to determine and agree the executive led commissioning of appropriate learning responses.
- The recently expanded maternity governance team review all incidents using structured proformas, where applicable, for the systematic and thorough investigation of incidents. The team also provides support for ward and department managers to review incidents in their areas
- Thematic reviews are conducted where trends and themes in incidents are identified to enable learning to be shared and action plans to be formulated
- A variety of media, training opportunities and meetings are employed, in collaboration with the multi-disciplinary practice development teams, to share and embed learning from incidents and clinical outcomes
- A working group has reviewed and restructured the meeting programme, agendas and terms of reference across the maternity service to support effective flow of

Comments and/or evidence:

information from and to ward to board with alignment to the trust governance structure. The new structure came into operation in September 2024

- Recruitment into vacant and additional roles within the governance team in recognition of the need for additional resources to ensure best practice completed in January 2025
- Plans are under development to increase the involvement of service users and their families in incident reviews and improvement work initiatives to drive better outcomes for everyone. This is supported by the Maternity Patient Experience Lead in collaboration with the Maternity and Neonatal Voices Partnership (MNVP) Lead who coordinate attendance of service users at Patient Safety forums such as the Perinatal Mortality Review Group.
- The Patient Experience and MNVP Leads' work plans include plans to specifically seek feedback from "less heard" service users.
- The new maternity meeting structure and terms of reference have been reviewed and revised through a PDSA cycle to identify any improvements

Further work required, if relevant:

- Review and rewrite Women's Services Risk Management Strategy to reflect agreed changes in structures and pathways

Requirement 3	The service does not have an effective program of regular audit to ensure the quality and safety of services is monitored

Current status:	Complete

Comments and/or evidence:

The following improvement actions have been implemented:

- Audit leads were identified to provide clinical leadership and to develop a structured audit programme with appropriate prioritisation
- Job planning has facilitated clinical leads to be available for key meetings to support audit and other governance meetings
- Collaboration with the Local Maternity and Neonatal System (LMNS) audit midwives has led to a new monthly peer support forum to discuss and share audit programmes
- National Institute for Clinical Excellence (NICE) Benchmarking - Baseline assessment tools have been used to measure gaps in compliance with national guidance
- A review of the forward audit programme has created a five-year overview plan, with NICE quality standards and national audits prioritised. The 2025/26 programme was approved in January 2025
- The governance process for audit has been clarified and documented to describe the process to be followed prior to and during the Audit life cycle
- A new monthly multi-disciplinary Audit and Guideline Compliance Committee was implemented from May 2024, in the new meeting structure, to provide governance and oversight for Audit outcomes and compliance with National Guidance
- From August 2024 maternity quality audits were developed using InPhase digital proformas

These changes have resulted in the following current practice:

- Results and recommendations from Audits are shared in clinical areas on Patient First Improvement System (PFIS) boards and through a variety of media and forums
- The process for conducting clinical audit and use of InPhase is more widely understood among clinical teams
- Improved guidance and support for those undertaking audit leads to better quality audits with more meaningful results and actions
- MEWS audit action plan has led to an accelerated adoption of the national tool in October 2024
- NEWS audit captured through quality assurance programme led to implementation of the national tool – NEWTT-2 in June 2025
- Real time audit of Birmingham Symptom-specific Obstetric Triage System (BSOTS) was implemented from September 2023
- Quality assurance audits designed and recorded in InPhase "Quality Checklist" module providing oversight of actions resulting from audit
- Following benchmarking against NICE guidance, the service has agreed to move from locally developed guidelines to NICE guidance where possible

Comments and/or evidence:

- Audit and quality assurance reports are included in agendas for the new meeting structure to provide ward to board assurance and/or alerts
- Temporary additional resource was employed to support updating of guidelines
- Final agreement and sign off for the revised maternity meeting structure and terms of reference, aligned to trust governance structure, in September 2024.
- PDSA review of the meeting structure and terms of reference in place
- A new Audit and Guideline Compliance Committee was implemented to maintain oversight of audit recommendations and actions and drive continuous improvement
- The service continues to work on the development of Quality Assurance templates in InPhase Quality Checklist module
- Increased use of InPhase Oversight Dashboards to monitor progress with Clinical Audits and Quality Improvement Projects
- Improved process for allocation of upcoming audits - to ensure the right people are doing the right audits at the right time

Further work required, if relevant:

Requirement 4	The service does not reduce the risks to women, birthing people waiting for induction of labour (IOL) putting them at risk of harm

Current status:	Partially complete (further steps required)

Comments and/or evidence:

Following the visit, the maternity team developed an improvement plan to address the CQC findings. The improvements aimed to ensure safety by regular risk assessment during delays and by prioritisation of transfer according to clinical need. The service also aims to reduce the risk associated with delay in the induction process by taking steps to reduce the incidence of delays.

The following improvement actions have been completed:

- The Induction of Labour guideline and associated proformas have been updated and published in October 2023, June 2024, January 2025 and March 2025 as processes have been updated, to include the continuous risk assessment process and escalation of delays to the operational management team
- The Induction of Labour Guideline was subsequently updated to bring local guidance in line with NICE recommendations to offer induction of labour at 41 weeks of pregnancy in July 2025
- A demand and capacity working group was established in January 2024 to identify any improvements that can be made to reduce delays in patient flow throughout the maternity inpatient wards. The group established that access to a second theatre was not a significant contributory factor.
- Delay in transferring women and babies to the postnatal ward was identified as a factor in delaying transfer of women to delivery suite for ongoing induction of labour
- Consideration was given to reconfiguration of the directorate bed base to increase postnatal bed capacity. Local initiatives have also been implemented to reduce length of stay, including changes to management of neonates and use of the virtual ward for some postnatal women
- The Maternity Patient Experience and MNVP Leads have actively sought feedback from service users about their experience of induction of labour

These changes have resulted in the following current practice:

- Antenatal ward staff have engaged with the development and implementation of the guideline and the new risk assessment tool to support a robust roll out of the new process
- Compliance with the process is monitored via continuous audit of the risk assessment forms, which is reported to the improvement programme group. Compliance is monitored locally by the maternity service as a key performance indicator within the antenatal ward manager's monthly report to the Maternity Operational Forum, identifying actions to address any challenges with compliance and escalation, if required, through the maternity governance structure

Comments and/or evidence:

- The percentage of delays of two, four and six hours during the induction of labour process is monitored with monthly reporting at service, divisional and Trust level
- The escalation process, described within the revised Induction of Labour Guideline, has been incorporated into an update to the Maternity Services Escalation Policy, ratified in May 2025
- Red Flags for maternity staffing, including delays in ongoing induction of labour, are monitored and reported within the maternity workforce report with oversight at department and trust level
- Teletracking (a digital bed management system) has been implemented in the Maternity unit to improve oversight of challenges to efficient patient flow which may impact delays in transfer for women waiting for IOL
- Medical and midwifery staffing models have been reviewed to reduce the risk of delays to medical and midwifery reviews for women waiting for IOL

Further work required, if relevant:

- An ongoing quality improvement project (3A) has been maintained to ensure that focus remains on the management and oversight of induction of labour and the service continues to strive to reduce delays

Requirement 5	The service does not always provide timely emergency caesarean sections putting women, birthing people, and babies at risk of harm

Current status:	Complete

Comments and/or evidence:

Following the visit, the maternity team developed an improvement plan to address the CQC findings. The improvements aimed to ensure safety by reviewing all cases of delay, identifying the barriers to meeting the target decision to birth interval, raising staff awareness of the targets and, subsequently, reducing the incidence of delayed emergency caesarean section

The following improvement actions have been completed:

- The "Request for emergency C-section form" was revised to document the target delivery time at the point of decision in January 2024
- The revised form improved the data collection for an ongoing prospective audit of decision to birth interval which began in January 2024 and will continue to be monitored on a monthly basis
- Workstream leads engaged with the multi-disciplinary team to improve compliance with target times
- An improvement project was initiated to identify challenges and barriers to meeting the targets, including challenges when accessing and staffing a second obstetric theatre. The project concluded in June 2024 having identified issues with classification of caesarean sections and subsequent impact on the data and the inevitable challenge associated with prioritisation according to clinical circumstances

These changes have resulted in the following current practice:

- There was a 12% improvement in the rate of category 1 caesarean section performed within the 30-minute target from an average of 67% for 2023-24 to 89% in 2024-25 and a similar picture in meeting the 75-minute target for category 2 cases from an average of 66% in 2023-24 to 88% in 2024-25
- All cases which do not meet the target time are reviewed to identify avoidable / unavoidable delays, barriers to meeting the target time, learning to be shared and neonatal outcomes
- Incidence of emergency caesarean section delays have been added to the maternity clinical dashboard which are now reported at service level and also at the monthly Executive chaired maternity oversight group
- Reporting, monitoring and oversight of compliance with target decision to birth interval has been implemented at service, divisional and Trust level
- Work continues across the multi-disciplinary teams to identify and minimise the challenges to timely procedures with monthly reporting to the Maternity Operational Forum and Obstetric Theatre Meetings
- Staff report incidents of delays InPhase. The delivery suite and maternity patient safety teams review all cases to identify and share learning

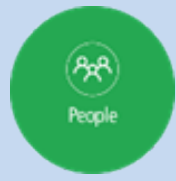
Further work required, if relevant:

Appendix One – Maternity Improvement Progress Update



Maternity
Improvement Progre

Title of report	Maternity Report relating to the Maternity Incentive Scheme					
Board / Committee	Trust Board					
Date of meeting	25 th September 2025					
Agenda item no.	09-16					
Executive lead	Jo Haworth					
Presenter	Rachel Thomas and Sarah Flint					
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)	Maternity Incentive Scheme Year 7 ("the Scheme") Progress Report - To ensure effective Board oversight in Year 7 of the Scheme a quarterly report is produced. - The report provides an overview of progress against the Scheme, including any areas of concern or challenge. - The last quarterly report was produced in July 2025 and presented to the Board Safety Champions at MNCOG on 19 August, but not presented to Trust Board as there was no August Board. - As such, to ensure up to date information is provided to the Board, a summary progress report dated August 2025 is included at Appendix 1.
	PMRT Q1 Report - In accordance with Safety Action 1 of the Scheme, the Trust Board is invited to review and note the quarterly PMRT Report (July 2025, Q1 data April-June 25) (Appendix 2) which includes details that the PMRT has been used to review eligible perinatal deaths, that required standards have been met and consequent action plans. - The Board is reassured that, in accordance with the Scheme, this PMRT report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 19 August 2025.
	Claims Scorecard Q1 Report In accordance with Safety Action 9 of the Scheme, the Trust Board is invited to review and note the Q1 Claims Scorecard Report (April - June 2025) (Appendix 3), which triangulates the claims scorecard against incident and complaint data.

	8. The Board is reassured that, in accordance with the Scheme, this Claims Scorecard report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 19 August 2025.
Any items for formal escalation / decision	<u>Maternity Incentive Scheme Quarterly Report</u> The Board is invited to note in the minutes the following points: 9. Safety Action 6: 9.1. An improvement trajectory for the implementation of the Saving Babies Lives Care Bundle, as agreed with the ICB, must be demonstrated across the year to gain compliance for Year 7 of the Scheme. Improvements have been seen in the first two quarters of the year. Challenges with ultrasound provision may affect full implementation. 10. Safety Action 7: 10.1. As previously reported, full implementation of Safety Action 7 is at risk due to lack of ICB funding for MNVP roles. 10.2. Escalation of this point to Trust Board will be sufficient to achieve Safety Action 7 compliance in Year 7 of the Scheme. However, the implementation of a functioning MNVP will be a requirement for Year 8 of the Scheme. 10.3. The LMNS continue to escalate within the ICB, however mitigations proposed were not agreed. 10.4. Action plan in place and agreed with LMNS. 11. Safety Action 8: 11.1. Safety Action 8 requires 90% compliance with obstetric emergencies, neonatal life support training. 11.2. In the event that medical staff who are new starters to the Trust (commencing after 1 July 2025) have not yet completed their training, this will not affect MIS compliance as long as an action plan is in place to ensure compliance within 6 months. 11.3. Whilst this is likely to affect minimal members of staff the Board is asked to confirm in the minutes that, should any new starters not be compliant as at 30 November 2025, there is a commitment in place to ensure compliance within 6 months of their start date. To achieve this the following actions will be taken: 11.3.1. Booking staff onto the next available training date; 11.3.2. Ensuring their rota enables attendance. 12. Safety Action 9: 12.1. In accordance with Safety Action 9.1, the non-executive director has been working with the Board Safety Champion, ensuring clear oversight on maternity and neonatal safety and quality issues. 12.2. In accordance with Safety Action 9.8, bi-monthly meetings between the Board Safety Champions and Perinatal Leadership Team are taking place. The last meeting took place on 22 August 2025 and no support of the Board has been identified. 12.3. In accordance with Safety Action 9.9, culture improvement work is continuing and monitored throughout Year 7 and at present no support of the Board has been identified.
Appendices	1. Appendix 1 – MIS Quarterly Report July 2025

attached	2. Appendix 2 – PMRT Report Q2 (April - May 2025 data)	
	3. Appendix 3 – Claims Scorecard Report Q1 (April – June 2025 data)	
Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	19 August 2025 and 17 September 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 Fulfil requirements for Maternity Incentive Scheme

Maternity Incentive Scheme Year 7 Progress Report

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

Report date: August 2025		Report Lead: MIS Lead – Megan Fradgley	Actions/Mitigations:
1a	Alert (Include actions taken and mitigation)	Safety Action 6: Q7 and Q8 have been assessed by the LMNS and an improvement trajectory confirmed. Q9 submissions are being prepared ready for submission in September 2025. Elements 1, 2, 3 and 5 all have areas where there is the potential for reduced, or at the least delayed, implementation. Key challenges surrounding sonography provision. 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: Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Safety Action 8: In addition it is noted that, in previous years of the scheme, training compliance is strong throughout the year, but falls in the lead up to the 30 November MIS deadline due to increased numbers of staff going out of date. The Practice Development Team have prepared compliance projections to enable close monitoring.	Review of USS service currently underway but with challenges. Mitigation in place regarding the use of CTG's when next working day USS not available (EI 3.2b), but reduced compliance in recent audit – learning to be shared with triage and medical teams. Discussed at Trust Board in May 2025. For more detailed discussions with ICB to develop plan, with further Trust Board discussion planned. Plan in place to improve training compliance in July, awaiting updated data. Funding in place to ensure funded teaching time to improve compliance. Bookings have been made for all staff who require training. Attendance when booked is vital to ensure sustained compliance rates. Obstetric and anaesthetic leads aware and will support staff to attend training.

Maternity Incentive Scheme Year 7 Progress Report

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

Report date: August 2025		Report Lead: MIS Lead – Megan Fradgley	Actions/Mitigations:
1b	Assurance	Safety Actions 1, 2, 3, 4, 5 and 10 all progressing and expected to declare compliance. Safety Action 9: Perinatal leadership team progressing with culture improvement plan and bi-monthly meetings. Safety Champions meeting monthly. Improved sharing of PFIS actions to include maternity specific PFIS Spotlights. Safety Action 8: New starter medical staff who commenced work after 1 July 2025 will not be included in training compliance figures for the purposes of MIS compliance as long as an action plan is in place to recover their compliance within 6 months of starting work with the Trust. The Trust Board must approve this action plan.	Due to careful planning by the Practice Development team, the number of new starters who have not completed training by the MIS Year 7 deadline is expected to be minimal. For any who are non-compliant a commitment is in place to rectify this within 6 months of their start date (or sooner). Steps taken will include: 1. Booking staff onto the next available training date 2. Ensuring their rota enables attendance
1c	Advise	Safety Action 3: Improvement with data collection been made and MDT reviews taking place, but challenges arise as the MDT are not all available at the same time. Safety Action 9: In process of moving from PQSM to PQOM for reporting.	Ongoing project looking at coding to improve quality of ward attender data.

Maternity Incentive Scheme – Year 7 RAG rating

Changes from last month

- SA6 green to amber due to potential reductions in improvement trajectory in Q9.

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?			20			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?			3	1		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?			19	3		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.

Progress in achieving Maternity Incentive Scheme 10 Safety Actions

	RAG	Current Position
SA1 – Perinatal mortality reporting		Quarterly PMRT reports demonstrate compliance against safety action.
SA2: Digital / data		Safety action expected to meet compliance with MSDS data submission.
SA3: Transitional care		Data collection processes improved, but ATAIN processes still require improvement and streamlining. New QIP relating to early identification of jaundice in non-white babies to be undertaken.
SA4: Medical staffing		Medical workforce audits relating to locums, compensatory rest, and consultant attendance take place monthly and reported in PQSM/PQOM. To be presented in November workforce report to Board.
SA5: Midwifery staffing		Bi-annual workforce report presented to Trust Board in June, with next due November.
SA6: NHS England Saving Babies' Lives care bundle		Continued improvement trajectory seen in Q7 and Q8. Q9 submission currently being prepared and some reductions in compliance noted, particularly Element 3.2b. Key challenges relating to USS capacity will prevent full compliance with SBLCB and could threaten future improvement work.
SA7: Maternal and neonatal voices		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. Discussed at Trust Board in May.
SA8: Training		Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Also drop in training compliance for neonatal consultants and doctors. Plan in place to capture consultants and Trust doctors in July to improve compliance. Education team provided training compliance projections in the lead up to MIS 30 November deadline. Commitment in place to ensure training compliance of any new starter medical staff who commenced with the Trust after 1 July 2025.
SA9: Board reporting, escalation and oversight		Safety Action 9: Perinatal leadership team progressing with culture improvement plan, bi-monthly meetings with Board Safety Champions taking place. Board Safety Champions meet monthly for walkabouts with additional listening events. New PQOM format being introduced.
SA10: MNSI and EN reporting		Oversight provided to Trust Board of compliance with this Safety Action through incorporation into PQOM.

Saving Babies Lives - overview of progress towards implementation



	Compliance Q7	Compliance Q8	Progress / action	Responsible (role)	By when
El 1: Smoking in pregnancy	70%	70%	1.4 – Compliance for opt out referrals for smokers is increasing and approaching target value. 1.6 – Quit targets continue to be challenging, action plan in place. 1.9 – Staff training for VBA below minimum requirement of 90%.	Smoking in pregnancy midwife	
El 2: Fetal growth	90%	95%	Element 2.7 not implemented – Uterine artery dopplers not in current pathway. Review of USS capacity ongoing.	Fetal wellbeing midwife	
El 3: Reduced fetal movement	100%	100%	Fully implemented with mitigation for next working day USS for RFM. Initial data for Q9 shows reduction in compliance with mitigation for El 3.2b which could affect future assessment. Continued work required to improve USS provision.	Fetal wellbeing midwives	
El 4: Fetal monitoring	60%	80%	Projecting 100% compliance next quarter.	Fetal monitoring midwife	
El 5: Pre-term births	93%	96%	5.6 – Multiple pregnancy guideline does not currently include cervical length screening.	Pre-term lead midwife	
El 6: diabetes in pregnancy	83%	83%	6.2 – Requirement for named diabetes consultant and named diabetes nurse who are trained to onboard women with HCL, with plans in place to ensure that relevant members of diabetes MDT are also competent to onboard women with HCL. Action plan required.	Diabetes in pregnancy midwives	
Total	86%	90%	Q9 submission due September 2025.	Saving Babies Lives Lead midwife	

Maternity & Neonatal Trust Board Safety Report

Board report

Presented by Perinatal Leadership team

Assure

What has improved to acceptable standards

1	MIS Year 7 Safety Action 5: Bi-annual workforce report presented to Trust Board in June. Safety Action 6: Q8 submission to ICB in June. Improvement in overall implementation projected, subject to ICB verification. The ICB continues to oversee quality improvement work and progress towards implementation for all elements, at quarterly meetings. Safety Action 9: Perinatal leadership team progressing with culture improvement plan. Bi-monthly meetings with Board Safety Champions taking place. Safety Action 10: Oversight provided to Trust Board of compliance with this Safety Action through incorporation into PQOM.
2	Incident management • 0 PSII/ MNSI commissioned • 100% compliance on DOC • 100% Compliant for perinatal mortality reviews including an external reviewer
3	Operational: 1:1 care in labour and Delivery Suite Co-Ordinator Supernumerary Status remained 100%
4	FFT Increase in FFT responses. Majority of comments received from FFT remain overwhelming positive regarding staff and their birth experiences

What needs to be escalated?

	Issue	Current Mitigation	What support is needed
1	MIS Year 7 - Safety Action 3: Inconsistencies in ATAIN data not yet fully resolved. - 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: Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Also drop in training compliance for neonatal consultants and doctors.	ATAIN Q1 now finalised following manual data checking by ATAIN lead and neonatal data lead. However, consistent process for data collection still requires agreement, Q2 report due next month. Discussed at Trust Board in May 2025. For more detailed discussions with ICB to develop plan, with further Trust Board discussion to follow BAPM Basic Airway compliant assessment now drafted and going through internal governance processes. Plan in place to capture consultants and Trust doctors in July to improve compliance.	Nil
2	Risk Register - There is one red risk on the register (1182) relating to 'Delay in progress with IOLs may result in a poor clinical outcome and poor patient and staff experience.' - New risk to the register: 3511-Lack of Immediate Newborn Saturation Monitoring Equipment on Antenatal Ward and Triage-12 3510-Insufficient Establishment Uplift for Training and Staffing in Maternity Services-10 3512-Unavailability of dedicated bladder scanner impacting patient safety in Maternity-9	Oversight through working group that is occurring monthly	None
3	Incident reporting 16 inphases for moderate harm following MDT review 7 remained moderate harm 3 AARs commissioned, one relating to a drug error, one regarding management of a PPH & one relating to a drug error	Investigation ongoing, immediate actions taken and addressed with staff	
4	Training Compliance was not met for NLS annual update for Neonatal Consultants (50%) and registrars (75%). Non-compliance will affect CNST declaration if it is not met by 30 November 2025. Mandatory training compliance was not met for; Saving Babies Lives Care Bundle, Equality/ equity and personalised care (3-yr Programme) (MU Day 1), Care during labour and immediate post-natal period (3-yr programme) (MU Day 1)	Actions: - Sick and redeployed staff have been re booked for next available space - Staff are being emailed of booking when made	Additional funded has been agreed for NLS, not further support currently needed.
5	Operational: There were a total of 39 suspension of service reported in month: - Crowborough Birth Centre suspensions-11 Nights and 13 Full day- 13 Patients affected – 2 attend MBC instead & 1 Postnatal patient transferred for feeding support 12 Home birth suspensions - 4 day and 8 nights - All due to community staffing. - Maidstone birth centre- 2 day and 1 night – none	Nil	Nil
6	Complaints 6 new complaints in month 1breached complaints in month	New complaints on track to respond on time/LRM organised.	Nil

Advise

What is a challenge but currently manageable

	Issue	Mitigation	Resolution date
1	MIS Year 7 • Safety Action 3: New QIP relating to early identification of jaundice in non-white babies to be undertaken. • Safety Action 4: Now rag rated green as progress shown against BAPM staffing action plans for neonatal staff.	• To be presented to LMNS in August, with update on progress by 30 November. • Progress against action plan included in Workforce Report and presented to Trust Board in June. Further progress will need to be monitored throughout Year 7, with reassessment if consultant budget not agreed at 1:7.	30 November
2	Incident management • 3 AAR's are closed in June • 0 published PSII/MNSI reports	Learning shared with teams and being disseminated with teams	Undertaken
3	Safety Champions • There is a disparity between the MSW duties in the birth centres to those who work on Delivery Suite. MSWs feel very useful at the birth centres and think that delivery suite MSWs could have their roles enhanced. • Staff feedback that there are more and more stickers and additional paperwork introduced when there is a safety recommendation	• Workforce lead to send out a survey to MSWs to gauge retention data & DOM to take to delivery suite matron for consideration • Establish on average number of stickers used and additional proformas	

Data measures – perinatal quality oversight tool

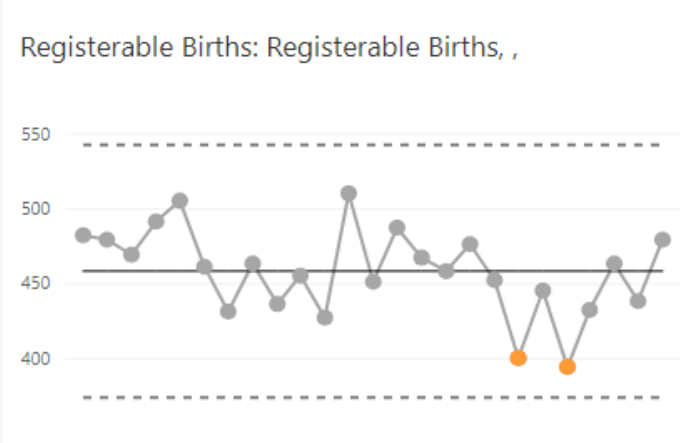


Slide No.	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
9	1. Findings of review of all perinatal deaths using the real time data monitoring tool													
10	2. Findings of review of all cases eligible for referral to MNSI (split rolling number)													
		0	0	0	1	1	0							
11	2a. The number of patient safety incidents logged and what actions are being taken													
	Number	0	0	2	1	1	0							
27	2b. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training													
29	2c. 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													
39	3. Service user voice feedback - themes													
35	4. Staff feedback from frontline champion and walk-about - themes													
19	5. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust													
19	6. Coroner Reg 28 made directly to Trust													
	7. Progress in achievement of CNST 10 safety actions													
	8. Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported annually												63%
	9. Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'Excellent' or 'Good' on how they would rate the quality of clinical supervision out of hours	Reported annually												38%

Maternity Overview

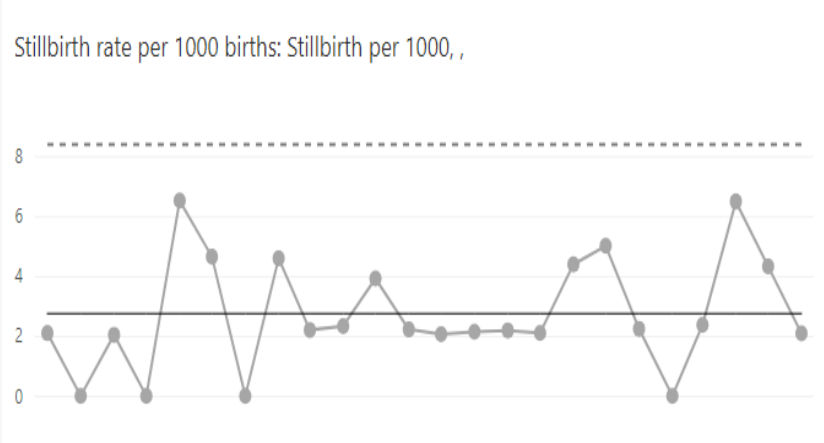
June
Number of births
479

No significant change



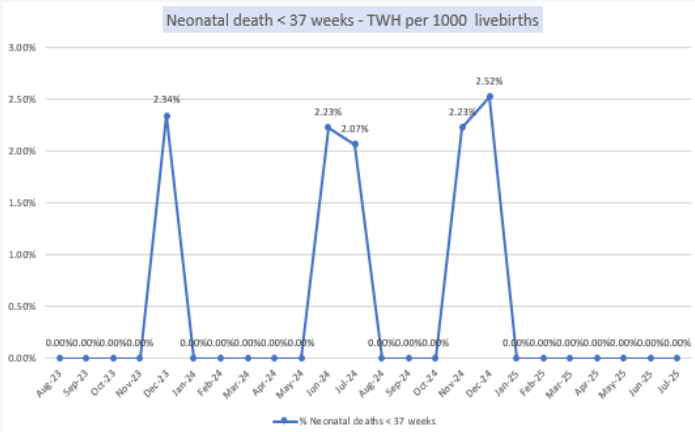
June
Still birth rate/1000
0.02

No significant change



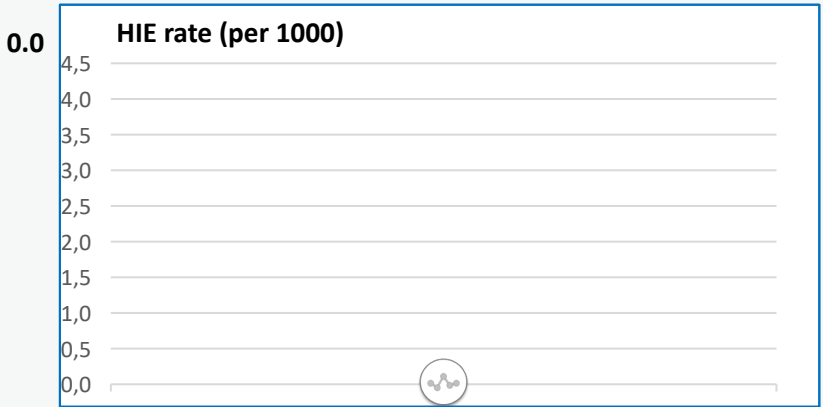
June
Neonatal Death
rate/1000
0.0

No significant change



Latest month
HIE rate/1000
0.0

No significant change

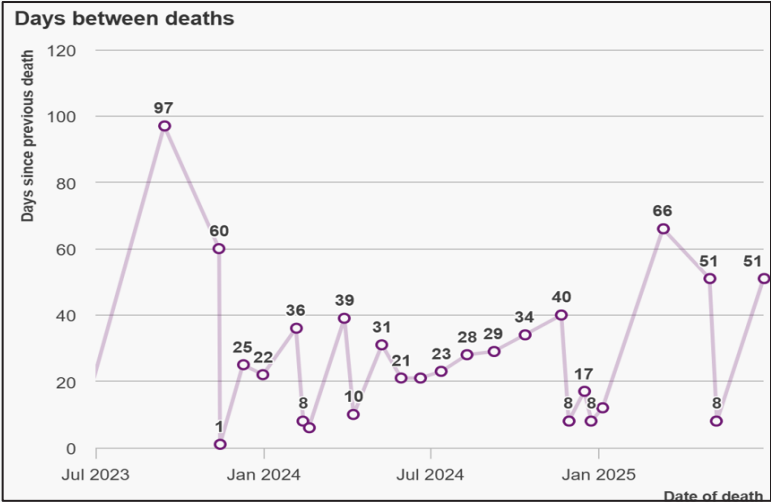


Maternity Overview

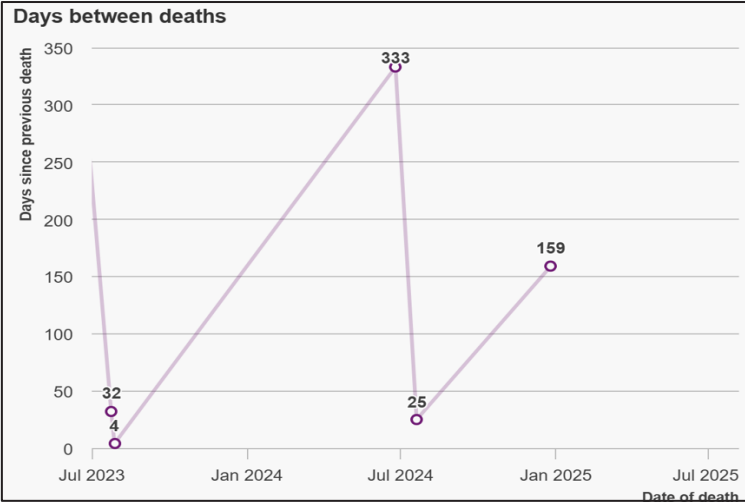
Date of last stillbirth
30/06/2025

Average days
between stillbirths 28

No significant change



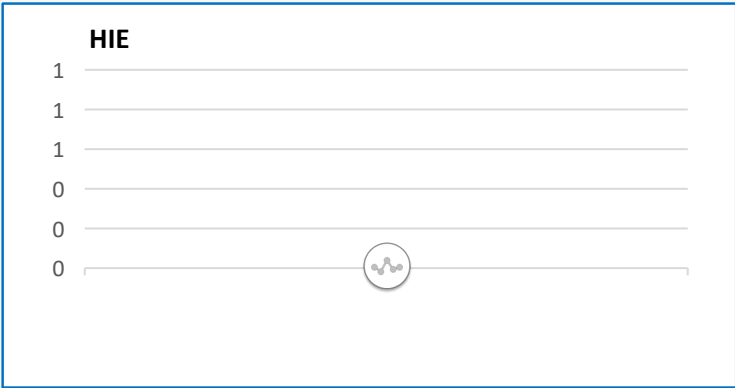
Date of last neonatal
death: 26/12/2024
Average days
between deaths 111



Date of last HIE

Average days
between HIE

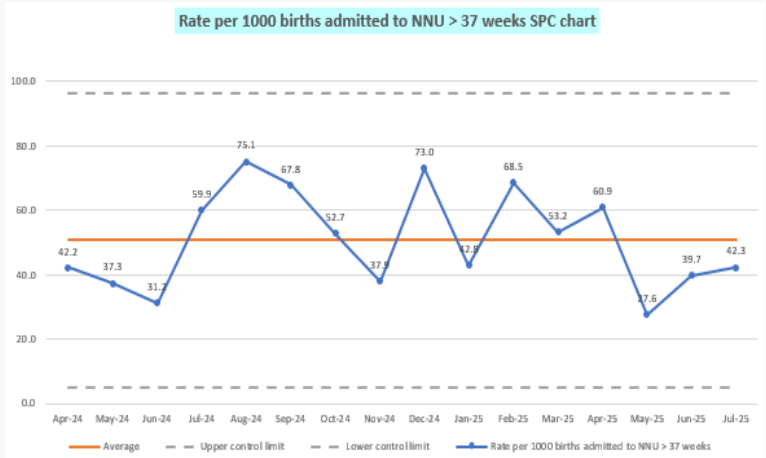
No significant change



Latest month
Unexpected
admissions to NNU

0.0

No significant change

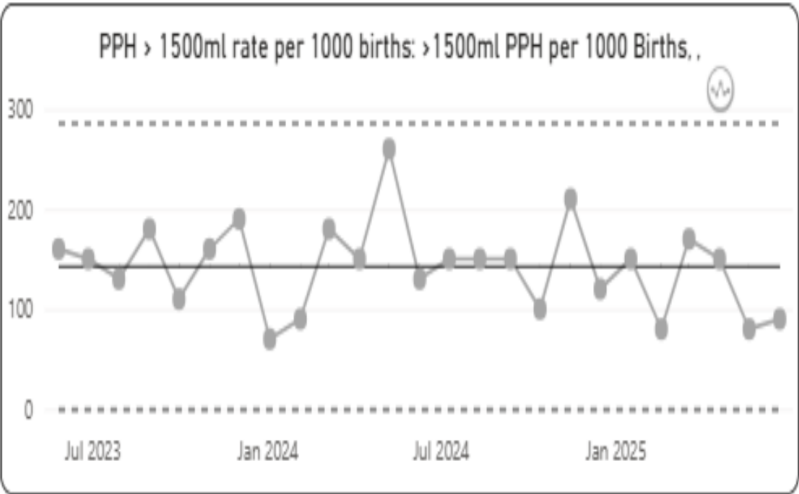


Maternity Overview

June PPH > 1500ml
rate per 1000 births

18.8

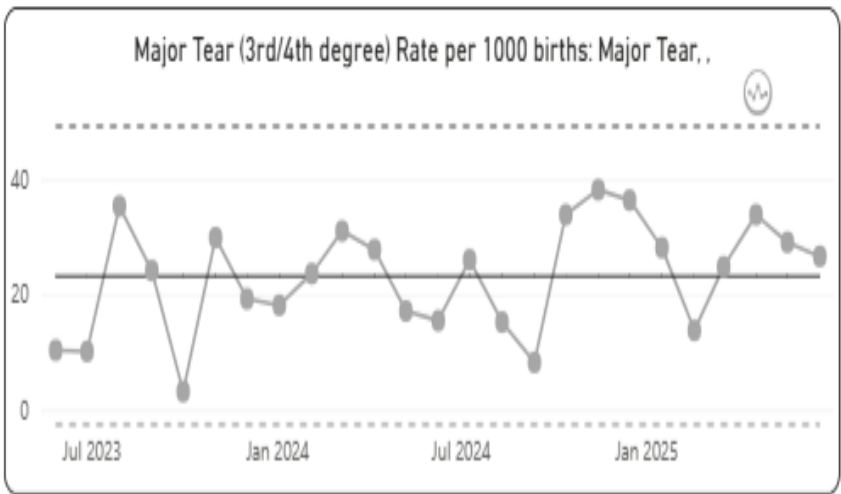
No significant change



June 3rd /4th
degree tear rate
per 1000 births

26.6

No significant change



Latest month
Safer staffing fill rate

No significant change



Latest month
Proportion of staff
with concerns about
safety

No significant change



1. Perinatal Mortality rate

The graphs above demonstrate how the Trust is performing against the national safety ambition.

Datix No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
/	/	/	/	/

1.1 .Learning from PMRT reviews

InPhase	Description	Initial learning from rapid review
#45267	IUD at 34+3	Escalated to PSIRG for review and PSII commissioned in July Learning points • Apart from booking appointment no midwifery care • Incorrectly assessed as low risk VTE at booking • Smoker and due to no midwifery care and large volume of virtual appointments, the opportunity for CO monitoring was missed • No ASF created in pregnancy, missed opportunity for support • No reasonable adjustments made due to vulnerabilities • Not offered alternative to GTT

2.0 Maternity and Newborn Safety Investigation Programme (MNSI)

2.1 Investigation progress update

MNSI Ref	Month	Reason for referral	Date of confirmed investigation	Family Informed	Duty of candour complete Y/N	Early notification, external notifications and other investigations
MI - 041333	April	Baby transferred for cooling following Category 1 LSCS (maternal cardiac arrest, suspected amniotic fluid embolism) at 39 ⁺⁰	Date referred 14/04/2025 Consent for investigation 06/05/2025	Yes	Yes	ENS referral complete 29/05/25
MI- 042048 MI- 042184	May	Baby transferred for cooling following SVD, passed away day 6 of life after care withdrawn following MRI results and clinical examination of severe brain injury	Date referred 15/05/2025 Consent for investigation 21/05/2025	Yes	Yes	ENS referral complete 29/05/25 Informed of inquest 19/06/2025

2.2 .Learning from MNSI Investigations

None published in June

2.3 Maternity Patient Safety Incidents (PSI)

Maternity Patient Safety Incidents during the period June:

- 0 PSII's closed in June
- 0 PSII commissioned in June
- 6 PSII ongoing

Month	InPhase	Description	Maternal ethnicity
November	#28793	Mother experienced late miscarriage at 21+0, missed referral for cervical length screening.	Black or Black British: African
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
May	#42165	Cat 1 EMCS for bradycardia of twin 1 (35+5) Confirmed HIE	White: British

Maternity **After Action Reviews (AARs)** during the period June:

- 3 AAR's closed in June
- 3 AAR's commissioned in June

Month	InPhase	Description	Maternal ethnicity
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
March	#38022	Mother with Type 1 Diabetes experienced hypoglycaemia and seizure	White British
June	#43156	Wrong dose Terbutaline given	White British
June	#43362	Baby suffered humeral fracture during EMCS	White British
June	#43725	2900ml PPH transfer from MBC with ongoing PPH	White British

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2.4 Moderate Harm incidents

16 inphases initially graded as moderate harm on Inphase 7 downgraded to low harm after MDT review

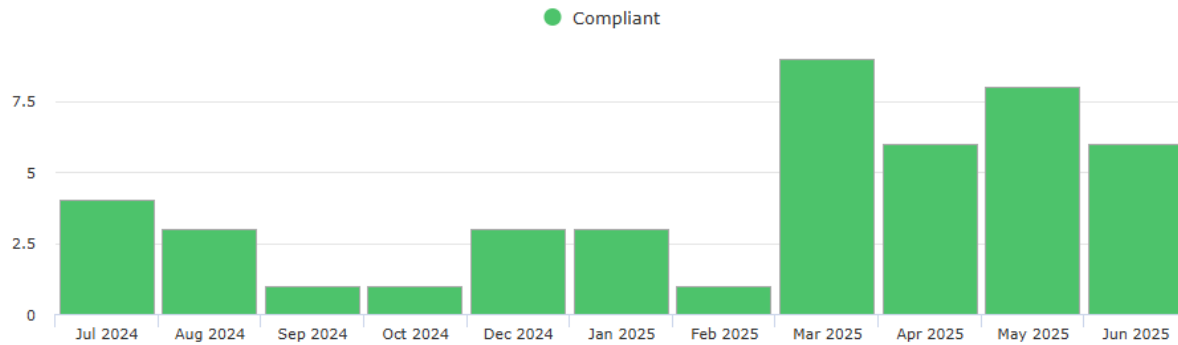
ID	Incident Summary	Actions/Learning	Date of review & outcome
#43675 Incident: 30/5/2025 Reported: 31/5/2025	Shoulder Dystocia on Triage with 2 nd degree tear Logged as moderate physical	- Shoulder Dystocia proforma completed, parents debriefed. No signs of arm weakness or potential fracture. Baby did not required admission to NNU -	MDT review 3/6/25 No care issues identified review group happy to downgrade to Low Harm and closed.
#42546 Incident: 12/5/2025 Reported: 12/5/2025	2200ml PPH forceps. Red tag unaccounted for post delivery swab count. Moderate physical harm as PPH >2000mls	- No PPH bloods taken and PPH proforma not fully complete - Moderate due to volume and red tag	MDT Review 13/5/25 then escalated to PSIRG Awaiting final closure from central patient safety team as moderate.
#42558 Incident: 27/5/2024 Reported: 12/5/2025	ED admission one year post EMCS with offensive PV loss, cerclage material found in vagina Logged as moderate physical	- Cerclage removal noted to be difficult at time of delivery - Appropriate transfer to theatre to have adequate environment and lighting - All correct procedures followed	MDT Review 20/5/25 escalated to PSIRG Remained as moderate physical following review. Awaiting central patient safety closure.
#43230 Incident: 23/5/2025 Reported: 23/5/2025	OASI - 3c tear Logged as moderate physical	- 2 hour delay in perineal repair - Documentation not clear regarding delay – TBC with care midwife	MDT Review 3/6/25 No care issues identified review group happy to downgrade to Low Harm and closed.
#43362 Incident: 25/6/2025 Reported: 26/05/2025	Baby sustained a humeral fracture during EMCS Logged as moderate physical	- Communication difficulties in theatre notes between MDT - Management of fracture and aftercare noted to be no care issues identified	MDT Review 3/6/25 To be discussed at PSIRG 12/06/25

ID	Incident Summary	Actions/Learning	Date of review & outcome
#42319 Incident: 8/5/25 Reported: 9/5/25	Bladder injury after LSCS at full dilatation Logged as moderate physical	- Injury was before the baby was delivered - Decision for LSCS by Consultant who then leaves the unit - LSCS performed by oncoming ST3 with no handover, should have been supervised due to patient being previous section, fully dilated and poor progress - There is potential that the Injury could have been avoided if senior obstetrician had been present to supervise - ST3 also noted to not have had appropriate handover prior to LSCS	MDT Review 13/5/25 Remained moderate and closed. Did not meet PSIRG criteria. Feedback provided to Consultant and Registrar providing care.
#42067 Incident: 4/5/25 Reported: 5/5/25	3c tear and 1200ml PPH Logged as moderate physical	- OASI well managed and repaired appropriately - No PPH proforma - No PPH Bloods taken - Inadequate documentation, email sent to midwives involved (Handover at time of PPH)	MDT Review 13/5/25 No significant care issues identified review group happy to downgrade to Low Harm and closed
#42022 Incident: 3/5/2025 Reported: 3/5/2025	Fetal Bradycardia following spinal with low gases but no NNU admission Logged as moderate psychological	- Low gas reviewed - Cat 2 for slow progress. Upgraded to Cat 1 due to the bradycardia. No care issues found. Cord gas repeated- all normal. - No admission to NNU, good condition at birth.	MDT Review 13/5/25 No care issues identified review group happy to downgrade to Low Harm and closed
#42882 Incident: 17/5/2025 Reported: 18/5/2025	1700ml PPH Logged as moderate physical	- Learning around bloods not being taken at the time of PPH, GLOW circulated	MDT Review 20/5/25 No significant care issues identified review group happy to downgrade to Low Harm and closed
#42983 Incident: 20/5/25 Reported: 20/5/2025	2100ml PPH following BBA Moderate physical harm as PPH >2000mls	- Well managed PPH on arrival to TWH Delivery Suite	MDT Review 20/5/25 No learning or care issues identified, remained moderate due to PPH volume. Awaiting final closure by central patient safety team.
#43062 Incident: 20/5/25 Reported: 20/5/25	Baby sustained scalpel laceration to right cheek during LSCS Logged as moderate physical	- Known complication of LSCS and forms part of the consent process. - Well managed on recognition and neonatal review obtained. - No bleeding and no steri-strips required Superficial injury.	MDT Review 23/5/25 No care issues identified review group happy to downgrade to Low Harm and closed

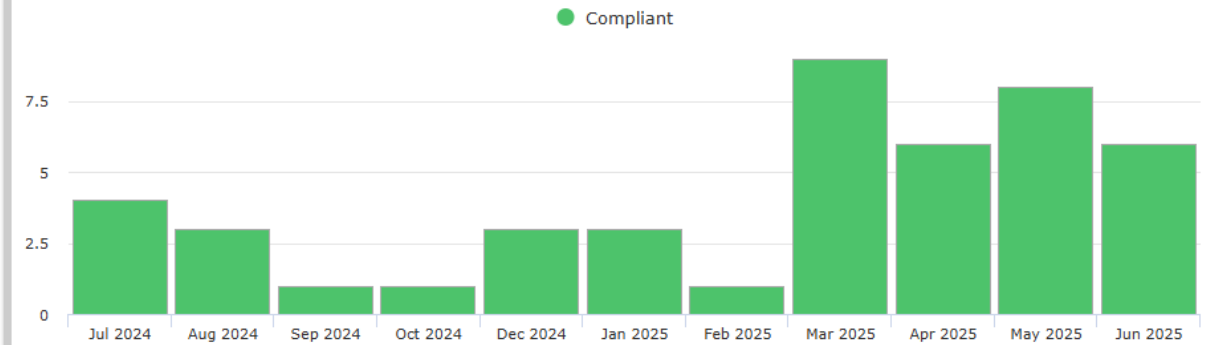
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2.5Duty of Candour Compliance Maternity

Verbal DOC Compliance - LFPSE - Rolling 12 Months



First Letter DOC Compliance - Rolling 12 Months



DOC remains 100% compliant for verbal and first DOC

2.6 Learning from closed investigations in June (MNSI,PSII,AAR)

#37542	Area for improvement	Safety action description (SMART)	Safety action owner (role, team directorate)	Targeted date for implementation	Date Implemented
Investigation: AAR 3.3L oral fluid intake in labour resulting in hyponatraemia	If a patient is not passing urine as expected or there are concerns over ketone levels, a fluid balance chart should be used.	Fluid balance charts are now commenced on all women when they are admitted and confirmed in labour	Community Matrons Sally Sadler		Complete 1 st March 2025
	Staff and patients are being educated on the importance of drinking to thirst rather than aiming for a specific volume.	Information shared with community teams regarding education.	Community Matrons Sally Sadler		2 nd April 2025
		Inclusion within latent phase of labour patient information leaflet	Kelly Everdell AN ward manager	1 st August 2025	
		Discussed with women at birth choices appointment	Community Matrons Sally Sadler		2 nd April 2025
		This forms part of the trust parent education classes	Community Matrons Sally Sadler		1 st May 2025
	There is no guideline on how to manage potential hyponatremia.	There is no national guidance for the management and hyponatremia within maternity care. The service is currently scoping guidelines with the LMNS to understand the local guidance that has been adopted to aide in the trust developing their own. Draft collated potential guideline from LMNS to go out for comment in August.	Gemma Mizon, Consultant obstetrician, risk lead and lead for maternal medicine.	09.08.2025	
	Transferred patients must always be admitted to delivery suite not triage.	Transfer of care guidance being reviewed with new process defining admission requirements on transfer and approved through guideline group.	Angela Clarke, Guideline lead	1 st September 2025	
	Obstetric review must happen within 1 hour of arrival following transfer.	Transfer of care guidance being reviewed with new process defining admission requirements on transfer.	Angela Clarke, Guideline lead	1 st September 2025	
	Blood results must be reviewed in a timely manner.	SBAR tool to be updated to ensure oversight of pending bloods are highlighted	Angela Clarke, Guideline lead	1 st September 2025	

#32197	Area for improvement	Safety action description (SMART)	Safety action owner (role, team directorate)	Targeted date for implementation	Date Implemented
Investigation: AAR 3L PPH. Twin birth 1 SVD and Twin 2 LSCS	Staff need to be aware of what's been given in theatre- staff need to communicate details of the action taken so the scribe can document it clearly.	Theatre team to document on white board in Obstetric Theatre all uterotonics given, blood products and timings. Learning to be shared with team.	Theatre Lead (Tina Purland)	30 th March 2025	
		Reminder to all staff via GLOW to ensure that PPH drugs and actions are clearly stated in theatre for scribe	Hannah Sydee (Patient safety team)	30 th March 2025	
		PROMPT already discuss communication during emergencies	Practice development team	Ongoing	Ongoing
		New obstetric lead for simulation to complete in situ theatre PPH's focusing on communication. MECU and theatre lead when appointed to work on this.	Rahul Gore (Simulation lead)	31 st July 2025	
	PPH proformas are not in theatre, staff must bring them with them from the delivery room and staff report they are not user friendly.	PPH proformas confirmed by DS managers are in place in theatres. However, managers will ensure they are stocked	Tanya Freeman and Tracy Thresher (Delivery suite management)	30 th March 2025	March 2025
		Take 5 to educate staff where they are located in theatre	Tanya Freeman and Tracy Thresher (Delivery suite management)	30 th March 2025	March 2025
	The PPH proforma is considered user friendly by staff.	To review the current PPH proforma utilised and trial a new proforma with staff	Tracy Thresher, Oliver Wildman		1 st April 2025
	Obstetric consultant not informed and therefore did not attend-staff appear to be unclear as to when the consultant should be informed of a PPH-policy states 1500mls and ongoing.	Consultants and PPH >1500mls (Consultant to attend in person at >1500ml when on-site. When off-site Consultant to be informed at >1500ml and to attend at >2000)	Mahnaz Akunjee Gemma Mizon	30 th April 2025	1 st April 2025
	Delay in placing CODE RED	CODE red learning has already been shared via take 5 and glow since this incident. To continue to monitor through PPH reviews	Hannah Sydee (Patient safety team)	20 th January 2025	20 th January 2025
	Obstetric consultant not informed and therefore did not attend-staff appear to be unclear as to when the consultant should be informed of a PPH-policy states 1500mls and ongoing.	There is already an existing mandatory escalation pathway, requiring direct senior Consultant attendance (> 1500ml, when Consultant on-site, > 2000ml when Consultant off-site)	Labour Ward Lead (Oli Wildman)	1 st June 2025	
		Prompt in the PPH Proforma Clearly stated in local PPH and Roles and Responsibilities of On-Call Consultant Guideline/SOP documents			
		Monthly Audit of Consultant Attendance as per RCOG requirement (and shared at Clinical Governance			

#34013	Area for improvement	Safety action description (SMART)	Safety action owner (role, team directorate)	Targeted date for implementation	Date Implemented
Investigation: AAR 1.6L PPH – CBC transferred to TWH	There needs to be early recognition of emergency situations and the escalation process must be followed.	Skills drills with this focus at birth centres	CBC managers/matrons and Practice Development (PD) team	Ongoing	January 2025
		Taught on PROMPT already	PD team	Ongoing	January 2025
	The emergency and transfer must be a priority when the emergency is recognised.	Skills drills with this focus at birth centres	CBC managers/matrons and PD team	Ongoing	January 2025
		Taught on PROMPT already	PD team	Ongoing	January 2025
	Communication needs improving amongst staff, staff must communicate clearly during emergencies and inform seniors before going home.	Skills drills with this focus at birth centres	CBC managers/matrons and PD team	30 th March 2025	March 2025
		Take 5 for birth centres and to discuss at team meeting	CBC matron	30 th March 2025	March 2025
	On call staff need to be called in to assist when support is needed.	Take 5 for birth centres and to discuss at team meeting	CBC matron	30 th June 2025	
	Ensure the perineum has been examined promptly after delivery to reduce the risk of PPH.	Feedback to staff involved	CBC matron	30 th June 2025	
	Ensure rapid cannulation once PPH recognised.	Take 5 for both birth centres and for community bulletin	CBC managers/matrons	30 th July 2025	
	To implement a thematic review of PPH cases.	Ongoing thematic review questions that are already part of their proforma to be built into InPhase. This would then be reported through the maternity governance framework for oversight.	head of maternity governance	1 st Sept 2025	



2.4 Coroners' reports

Outstanding report due

Identifier	Date listed	Summary
Nil	Nil	Nil

Regulation 28 report issued

Identifier	Action required	Progress	Responsible (role)	By when
Nil	Nil	Nil	Nil	Nil

2.5 Review of NHS Resolution Scorecard

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

Themes identified from Claims Scorecard (10 years)	Themes identified from Complaints (current)
• Top injuries by volume reveal key trends in incidents. It is of note that additional/unnecessary operations and psychological harm are reported as often as brain injury, yet brain injury contributes 45% of the total claim value. • Top causes by volume demonstrates the prevalent theme of fail/delay in treatment, with fail/delay diagnoses and fail to recognise deterioration coming second and third respectively. • Top injuries by value account for 90% of total claim costs, despite representing just 27% of cases. These findings highlight the need to prioritise prevention, early intervention, and escalation in high risk maternity cases. • Top causes by value demonstrates the prevalent theme of fail/delay in treatment.	• Communication remains the leading theme in complaints (55%) • Pain management and patient autonomy (respecting birth plans and preferences) are recurring issues. • Several complaints cite postnatal discharge and follow-up care as inadequate.
Themes identified from Maternity Patient Safety Incidents	Themes identified from other sources (e.g. staff feedback, family feedback, FSU etc)
- Handover of care and the use of SBAR - Fetal monitoring - Esculation	FFT/MNVP feedback themes: Negative: • Poor and inconsistent communication • Staff not aware of history/reading notes • Discharge process Positive: • Kind, knowledgeable, considerate and experienced staff • Good breastfeeding support • Recognition of personalised care

Review of NHS Resolution Scorecard



Themes	Linked themes	Actions
1. Documentation	a. Partograms – maternal pulse b. Handover	SBAR documentation amended. GLOW sent out reminding of need to monitor maternal pulse in second stage, with learning shared with individual staff members where issues noted on review. GLOW sent out regarding measuring blood loss, learning also shared at prompt.
2. Fetal monitoring	a. IIA b. Interpretation c. Frequency d. Guidelines e. Equipment f. Loss of contact	Fetal monitoring study day designed to embed learning from incidents. Learning outcomes include (but are not limited to): • Human factors contributing to delays in recognising and responding to loss of contact. • Escalation processes in the context of fetal wellbeing and emergency response. • Correct use of equipment, with emphasis on: • Ensuring appropriate devices are available and functional. • Awareness that CTG machine attachments are not interchangeable, and using the correct one is essential.
3. Communication	a. Between staff – handovers – escalation b. Quality and consistency of advice to patients c. Informed consent regarding options of treatment/delivery/risks d. Staff attitude and behaviour	Review of processes underway relating to women accessing unscheduled advice during pregnancy. Consent and personalised care training within mandatory training day, service user voice within PROMPT training and at all meetings. Work ongoing regarding 2222 categories to ensure correct teams attends.
4. Delayed diagnosis/treatment	a. Staffing issues b. Recognition of complications of treatment c. Continuity of care d. Equipment failures e. Insufficient pain relief in labour	Audit of supervision of junior members of staff, including supervision and psychological safety. All PPH's over 1500ml with significant care issues identified continue to be reviewed at PSIRG to ensure themes and learning identified. New drapes purchased which clearly measure blood loss whilst suturing.
5. Poor clinical care	a. Education/training/skills	GLOW sent out relating to postnatal observations. Review of guideline relating to neonatal observations following a difficult birth. Patient safety team Virtual Board established to share learning. Training at prompt on fluid balance and hyponatraemia.



3.0 Maternity Outcomes Safety Signals System (MOSS)

When available - Number and action taken on national / local flags

N/A yet



4.0 Safety Improvement Plan

Progress updates from National reports / MSSP action plans / CQC / Thematic review action plans as required.

Include actions relating to a local improvement plan utilising the patient safety incident response framework (PSIRF) and ensure they are reflected in the minutes of Board, LMNS, ICS, Local and regional learning systems.

4.0 Maternity Improvement Plan

Maternity CQC action plan	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Comments
29A Warning Notice and CQC Report “Must” and “Should” Activities – progress																						
Complete	2	15	17	35	54	82	96	100	108	126	132	144	151	168	175	175	175	176	183	185	185	• Work continues on the remaining actions: ➤ Workforce recruitment and retention planning and reporting to be finalised ➤ Training strategy and reporting to be completed ➤ Review of Risk and Governance Strategy to be completed ➤ Maternity strategy development in progress
On track and on time	23	11	3	153	113	99	89	33	22	37	34	27	30	15	12	11	14	10	7	6	6	
Breached but progressing	1	0	6	0	23	9	5	57	60	24	26	21	15	13	9	10	7	10	6	5	5	
Breached at risk	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	
Milestone Actions completed for the Delivery Areas: • Reduction in harm associated with PPH • C-section undertaken within appropriate time frame • Safe systems for Triage • Robust Medicines Management • Birth Centre Booking Processes • Birth Centre Risk Assessment • Safe Clinical Environments and Processes • Workforce Recruitment and Role Specific Training																						Ongoing monitoring and oversight has been established for these delivery areas and the workstream activity has transitioned to business as usual
CQC report following inspection in October 2024 was published 31 July 2025 • Overall rating: Good • Safe: Requires improvement • Effective: Good • Caring: Good • Responsive: Good • Well-led: Good Action planning is in progress to advise CQC of actions to meet the breach of regulations relating to medical review of patients waiting for induction of labour, by end of August 2025 A full review of the report will identify any further actions for improvement which will be incorporated into the Maternity Improvement Programme with the objective of achieving a rating of outstanding in the future																						

5.0 Three Year delivery plan

Theme	Objective	Red	Amber	Green	Blue	Total
Theme 1: Listening to Women	Objective 1: Care that is personalised	0	0	3	1	4
	Objective 2: Improve equity for mothers and babies	0	0	4	0	4
	Objective 3: Work with service users to improve care	0	0	1	0	1
Theme 2: Workforce	Objective 4: Grow our workforce	0	0	3	0	3
	Objective 5: Value and retain our workforce	0	0	7	0	7
	Objective 6: Invest in skills	0	0	4	0	4
Theme 3: Culture and Leadership	Objective 7: Develop a positive safety culture	0	0	3	2	5
	Objective 8: Learn and improve	0	0	2	4	6
	Objective 9: Support and oversight	0	1	1	3	5
Theme 4: Standards	Objective 10: Standards to ensure best practice	0	0	2	2	4
	Objective 11: Data to inform learning	0	0	2	0	2
	Objective 12: Make better use of digital technology in maternity and neonatal services	0	0	2	1	3
Total		0	1	34	13	48
- Three year delivery plan actions have been added to the overarching Maternity Improvement Plan - Any further improvement actions identified from review of the newly published CQC report will be benchmarked against the themes and actions of the Three year delivery plan - The maternity team have developed a response to an open letter published by Sir Jim Mackey and Duncan Barton of NHS England on 23 June 2025 – see next slide						

5.0 Three Year delivery plan – Five areas of focus

- On 23 June 2025 Sir Jim Mackey and Duncan Barton of NHS England published an open letter setting out plans for an independent investigation into maternity and neonatal services across the country
- An independent taskforce will also be established, alongside immediate actions to improve care
- Local NHS Boards are asked to focus on five key areas whilst the inquiry is ongoing:
 - Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.*
 - Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.*
 - Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.*
 - Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.*
 - Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.*
- MTW maternity services have an established action plan to meet the requirements of the Three year plan and the NHSE benchmarking tool. The areas of focus above have been mapped against the existing actions to provide assurance that these areas are being addressed

Benchmarking areas of focus against existing action plans	Red	Amber	Green	Blue	Total
• Focus area 1	0	0	2	2	4
• Focus area 2	0	1	2	1	4
• Focus area 3	0	0	4	1	5
• Focus area 4	0	0	2	4	6
• Focus area 5	0	0	6	0	6
Total	0	1	16	8	25

6. Training compliance

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

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle	59% (MU Day 2)	Do not attend	55% (MU Day 2)	Do not attend		
Fetal monitoring and surveillance (MU Day 4)	96%	90% / 92%	Do not attend	Do not attend	Do not attend	Do not attend
Multi professional Maternity Emergencies training (MU Day 3)	95%	100% / 100%	93%	100%	Do not attend	Do not attend
Equality/ equity and personalised care (3-yr Programme) (MU Day 1)	93%	Do not attend	78%	Do not attend	Do not attend	Do not attend
Care during labour and immediate post-natal period (3-yr programme) (MU Day 1)	93%	Do not attend	78%	Do not attend	Do not attend	Do not attend
Neonatal resus training	95%	100% / 100%	93%	100%		
MAST	Directorate overall compliance for June = 86.6%					



Training update

Compliance was not met for:

- Saving Babies Lives Care Bundle
- Equality/ equity and personalised care (3-yr Programme) (MU Day 1)
- Care during labour and immediate post-natal period (3-yr programme) (MU Day 1)

Themes of why compliance has not been met:

- Staff sickness
- Staff being pulled to support the clinical work
- Staff not turning up to booking

Actions:

- Sick and redeployed staff have been re booked for next available space
- Staff are being emailed of booking when made

7.0. Safe Maternity staffing

Fill rates – planned versus actual

Jun-25			DAY				NIGHT			
Hospital Site name	Ward name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	93.7%	85.5%	-	-	88.7%	75.9%	-	-
TWH	Delivery Suite	Midwifery Services - MSW (2022) - NF102	-	5.8%	-	-	-	6.4%	-	-
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	92.4%	85.4%	-	-	91.3%	81.8%	-	-
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	92.7%	92.7%	-	-	83.3%	83.3%	-	-
Crowborough	Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	74.8%	70.0%	-	-	69.5%	63.3%	-	-
TWH	Specialist Midwives	Midwifery Services - Specialist Midwives - NF152	101.4%	-	-	-	98.5%	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	77.3%	-	-	-	-	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - TW/Ton/PW/Hawkhurst - NJ160	-	-	-	-	-	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	85.4%	96.7%	-	-	-	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Eden/Seven/Mallings - NJ160	-	-	-	-	-	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Maidstone/Leeds - NJ160	76.9%	54.8%	-	-	-	-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	105.5%	58.6%	-	-	-	-	-	-
Midwifery TW (four IP rosters)			103.6%	49.8%	-	-	95.9%	43.6%	-	-
Midwifery TW Community (six comm. rosters)			83.5%	64.3%	-	-	-	-	-	-
Midwifery TW (all fourteen rosters)			93.8%	60.1%	-	-	96.1%	43.6%	-	-



Safe Maternity staffing

Further narrative found in the work force report for this month

7.2 Staffing Vacancy rates

Staff group	Vacancy rate
Midwifery	6.44 WTE
Midwife Support workers	7.08 WTE
Obstetric consultants Resident doctors	
Neonatal Nurses	*to be included from Sept meeting
ANNP	
Neonatology consultants Resident doctors	
Obstetric anaesthetists Resident doctors	

7.3 Midwifery Red flags, actions and mitigations

- Antenatal Ward – Compliance 83.33%
 - Delay in IOL
- Delivery Suite – Compliance 87.22%
 - IOL waiting for transfer
- Postnatal – Compliance 85%
 - Time critical activity
- Ongoing work regarding flow within the acute service including IOL
- Work to be completed on the accuracy of data being inputted

7.4 Other perinatal staff exception reporting

Operational Performance

Impact of operational change

	Occurrence	Impact of Operational Change
Diverts out of Trust	None	
Crowborough Birth Centre suspensions	13 x Day – Unit Staffing and acuity 11 x Night – Unit Staffing and acuity	13 Patients affected – 2 attend MBC instead 1 Postnatal patient transferred for feeding support
Maidstone Birth Centre suspensions	2 x Day – Unit Staffing 1 x Night – unit Staffing	None
Home birth suspensions	4 x Day - 2 for community acuity, 2 for Community staffing 8 x Night – 6 for community staffing, 1 for unit acuity and 1 for community acuity	No Patients affected

1:1 Care in Labour

1:1 Care in Labour (target 100%)	
Month	Achieved (%)
January	100%
February	100%
March	100%
April	100%
May	100%
June	100%
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)

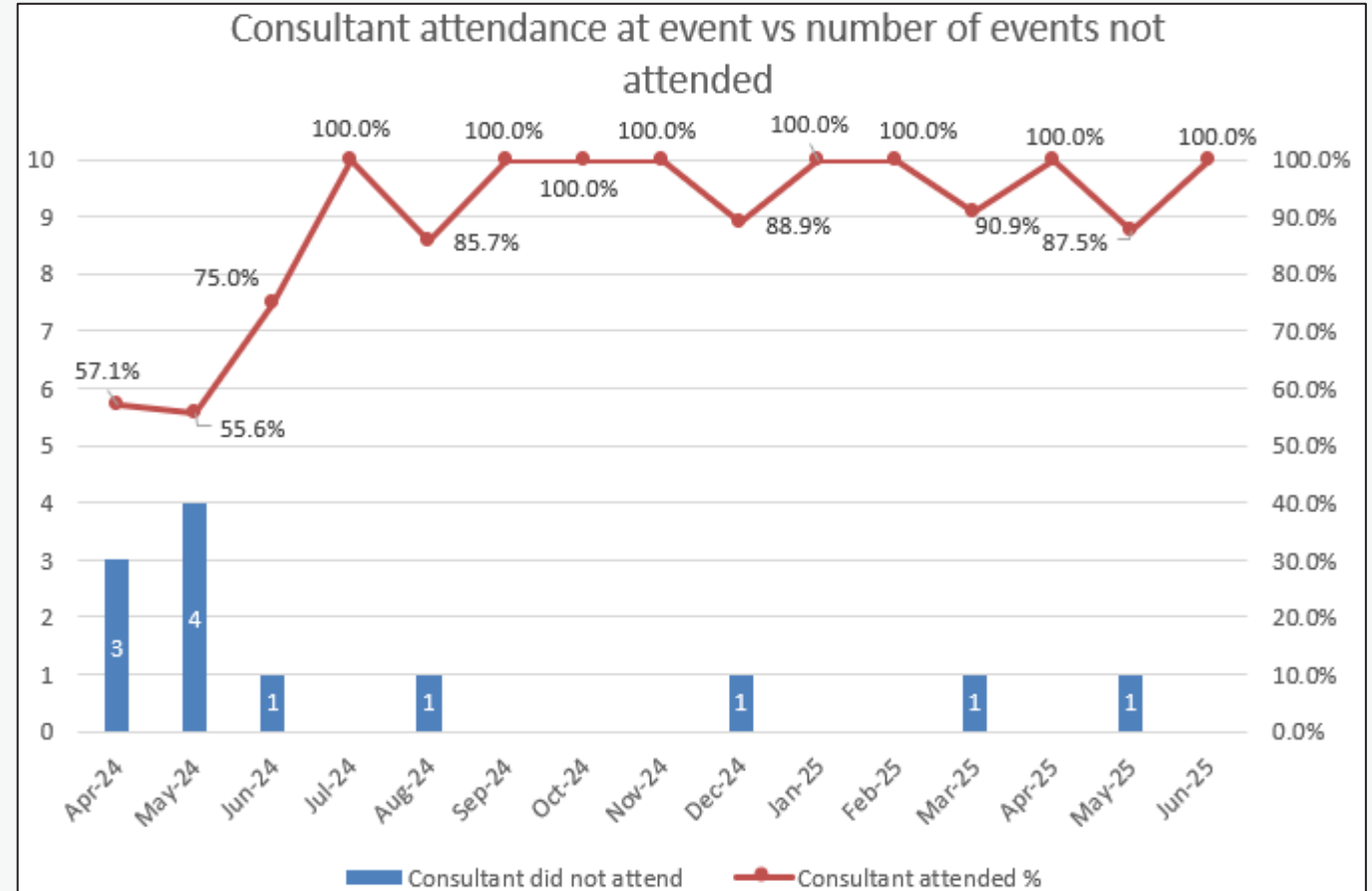
Delivery Suite Co-Ordinator Supernumerary Status

Supernumerary Maintained (target 100%)	
Month	Achieved (%)
January	100%
February	100%
March	100%
April	100%
May	100%
June	100%
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.

Consultant Attendance at Intrapartum event

June Data shows a 100% compliance for when a consultant MUST attend an intrapartum event.



8. Safety Champions meeting

8.1 Meeting Log

Date	Role	Attendance
02/07/2025	Maureen Choong- Board Safety Champion	Yes
	Jo Haworth Board Safety champion	Yes
	Wunmi OGUNNOIKI, Perinatal Obstetric Lead	Yes
	Rachel Thomas, Perinatal Midwifery lead/Perinatal management lead	Yes
	Lou Mair, Perinatal neonatal lead	No
	MNVP lead	No

8.2 Safety Champions feedback

Feedback raised by staff	Action and progress
Culture on delivery suite feels very different to the birth centres. There is a disparity between the MSW duties in the birth centres to those who work on Delivery Suite. MSWs feel very useful at the birth centres and think that delivery suite MSWs could have their roles enhanced.	Workforce lead to send out a survey to MSWs to gauge retention data & DOM to take to delivery suite matron for consideration
Staff feedback that there are more and more stickers and additional paperwork introduced when there is a safety recommendation	Establish on average number of stickers used and additional proformas
Feedback raised by service users	Action and progress
Nil	Nil
Nil	Nil
Additional safety champions intelligence	Action and progress
Nil	Nil

Themes and progress with Cultural surveys or equivalent

Bi-monthly meetings between Board Safety Champions and Perinatal Leadership Team taking place. Meetings took place on 22 April 2025 and 27 June 2025, at which the Perinatal Culture Leadership Team shared the Culture Improvement Plan that has been developed in response to staff feedback. A summary of progress against this plan is shared below.

Theme/Vision	Progress	Support requirements
To ensure that all perinatal staff understand the roles responsibilities and interrelationships of the perinatal leadership group, directorate and divisional triumvirates and roles.	1. Development of communication materials 2. Increase visibility of leadership 3. Reinforce understanding and engagement	None identified at present
Leaders communicate clearly so staff understand how and why decisions are made. Staff feel able to share ideas and be involved in change.	1. Continue to gather feedback from staff surveys and walkabouts 2. Implementation of congratulation and success stories within division 3. Standardise take 5 format 4. Implementation of PFIS in NICU and birth centres 5. Divisional A3 project underway to improve information sharing	None identified at present
Focusing on fostering a positive and inclusive workplace culture by promoting respectful communication, understanding diverse perspectives, increase awareness and its impact on staff, staff feel empowered to challenge inappropriate or uncivil behaviour, tools and how to access them.	1. Develop clear statement of expectations for respectful behaviour and inclusivity. 2. Deliver training and launch internal campaign on civility in the workplace. 3. Ensure clear reporting structures for inappropriate behaviour. 4. Establishment of peer champions or respect ambassadors to model positive behaviour and provide peer support.	None identified at present

9. Insights from service users and Maternity & Neonatal Voices Partnership Co-production

Engagement Activity	Co-Production Activity
• Monthly MNVP status meetings in place with MNVP Lead and PT EX Lead for Maternity. The aim of the meetings is to review Feedback Log themes, agree actions and review overall MNVP business and progress • 15 Steps visit at TWH (ANC and PN Ward) carried out with MNVP • MNVP committee meeting held – updates from various areas, including Patient Experience.	• Respectful Vaginal Examination (VE) project - re-launched in response to patient feedback concerning VEs and the process of informed consent. New posters designed with feedback from MNVP. Aim to be published end of July '25. • 15 Steps visit at TWH (ANC and PN Ward) carried out with MNVP.

9.1 CQC national maternity survey action plan 2024/5

Theme	Progress	Support requirements
Ensure service users feel their concerns in Triage are taken seriously and addressed	- Standardise processes for handling patient concerns raised during triage, ensuring consistent responses. (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Ensure complaints are addressed on time and that key learnings are identified and implemented. (ongoing)	Input from Obstetric team required to implement regular training for Doctors.
To ensure service users feel supported and informed about their labour and birth, including pain management, both immediately after birth and during recovery.	- Provide service users with opportunities to ask questions about their birth experience, ensuring they feel informed, supported, and listened to. (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Adequate and Equitable Pain Management (ongoing) - Information and Accessibility (ongoing)	Lack of midwifery led debrief service to be added to Risk Register
Ensure feeding choices are respected and supported	- Strengthen Feeding Support (ongoing) - Guideline review (complete) - Communication & Advocacy (ongoing)	None identified
Improve feeding support and ensure service users feel heard by midwifery staff	- Strengthen Feeding Support (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Feedback & Continuous Improvement (ongoing) - Provide service users with opportunities to ask questions about their birth experience, ensuring they feel informed, supported, and listened to. (ongoing)	None identified

9.2 Additional Service User feedback

Debriefs / Birth Afterthoughts	Action and progress
No midwifery led debrief service	
Friends and Family test	Action and progress
Negative: - Poor and inconsistent communication - Staff not aware of history/reading notes - Discharge process	- Feedback from the Friends and Family Test (FFT) have been shared with ward managers and frontline staff. Ongoing improvement actions are aligned with the MNVP work plan and the MTW Maternity service user improvement plan. - Monthly MNVP status meetings are now in place, led jointly by the MNVP Lead and the Patient Experience Lead for Maternity. These meetings focus on reviewing feedback log themes, agreeing priority actions, and tracking progress against MNVP workplan and maternity service user improvement plan. - Staff training to enhance communication and personalised care began for midwives in January 2025. Doctors received targeted training on personalised care and consent in March 2025. A quarterly training model is currently being scoped in collaboration with the obstetric link. – Teaching to Theatre staff carried out in June '25.
Positive: - Kind, knowledgeable, considerate and experienced staff - Good breastfeeding support	
Complaints and Compliments	Action and progress
Number In month: 6 Number open: 13 Breached: 1 Themes: - Clinical treatment/not adhering to birth plan - Communication/lack of or inconsistent information	New complaints on track to respond on time/LRM organised.

10. Saving Babies Lives v3.2

	Compliance Q7	Progress / action	Responsible (role)	By when
El 1: Smoking in pregnancy	70%	Training compliance below target affecting implementation. Issues with data collection and accuracy now improved with plan in place to improve compliance.	Smoking in pregnancy midwife	
El 2: Fetal growth	90%	Element 2.6 and 2.14 progressing toward implementation – delays in electronic BP monitor purchasing and training. Element 2.7 not implemented – Uterine artery dopplers not in current pathway. Review of USS capacity ongoing.	Fetal wellbeing midwife	
El 3: Reduced fetal movement	100%	Fully implemented with mitigation for next working day USS for RFM.	Fetal wellbeing midwives	
El 4: Fetal monitoring	60%	Version 3.2 removed audit requirement for fresh eyes and hourly review. However these audits will continue to ensure continued oversight. Implementation of Element 4 expected to improve substantially at next review.	Fetal monitoring midwife	
El 5: Pre-term births	93%	Self assessment for Q8 is of full implementation, awaiting LMNS review.	Pre-term lead midwife	
El 6: diabetes in pregnancy	83%	Version 3.2 has changed previous training requirements. SBL Lead and diabetes in pregnancy midwives scoping new requirements to develop plan to improve training compliance.	Diabetes in pregnancy midwives	
Total	86%	Improvement from 83% in Q7. LMNS assessment for Q8 due August 2025, improvement projected at provisional assessment.		

11. Progress in achievement of Maternity Incentive Scheme 10 safety actions

	RAG	Current Position
SA1 – Perinatal mortality reporting	Green	Quarterly PMRT reports demonstrate compliance against safety action.
SA2: Digital / data	Green	Safety action expected to meet compliance with MSDS data submission.
SA3: Transitional care	Green	New QIP relating to early identification of jaundice in non-white babies to be undertaken.
SA4: Medical staffing	Green	RAG improvement amber to green following progress made against neonatal staffing action plans.
SA5: Midwifery staffing	Green	Bi-annual workforce report presented to Trust Board last month.
SA6: NHS England Saving Babies' Lives care bundle	Green	Continued improvement trajectory seen in Q7.
SA7: Maternal and neonatal voices	Yellow	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. Discussed at Trust Board in May.
SA8: Training	Yellow	Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Also drop in training compliance for neonatal consultants and doctors. Plan in place to capture consultants and Trust doctors in July to improve compliance.
SA9: Board reporting, escalation and oversight	Green	Safety Action 9: Perinatal leadership team progressing with culture improvement plan. Bi-monthly meetings with Board Safety Champions taking place.
SA10: MNSI and EN reporting	Green	Oversight provided to Trust Board of compliance with this Safety Action through incorporation into PQOM.



12.0 Trust transitional care

If not already compliant, add in evidence of progress with action plan to move to the transitional care pathway based on BAPM framework for babies from 34+0. Timescales for implementation and progress.

We are compliant with SA3 and adhere to BAPM framework



13. Maternity Risk Register

(Extracted from risk register, rated 8 and above)

Closed

Nil

New Risks

3511-Lack of Immediate Newborn Saturation Monitoring Equipment on Antenatal Ward and Triage-12

3510-Insufficient Establishment Uplift for Training and Staffing in Maternity Services-10

3512-Unavailability of dedicated bladder scanner impacting patient safety in Maternity-9

Amended risk scoring following review

Nil

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	31.07.2025
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
3429	A fully functioning and commissioned MNVP (Maternity and Neonatal Voices Partnership) may not be in place by Year 7 of the Maternity Incentive Scheme.	15	10	5	07.05.2025	31.03.2026
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	07.10.2025	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. *CLOSED*	12	8	4	23.02.2024	31.05.2025



14. Recommendation

Please refer to 3A.

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

Neonatal Safety Report

Aug 2025 (June 2025 data)



Maidstone and
Tunbridge Wells
NHS Trust

Neonatal Safety Report

Neonatal Safety Report Key Issues Report			
Report Date: Aug 2025 (June 2025 data)		Report lead: Neonatal Matron/Senior Nurse Neonatal Quality & Risk	Actions:
1a	Alert	- There was 1 baby who was not able to access speech and language therapy input in a timely way, due to a gap in service provision - Compliance for Medical Staff attending annual neonatal life support updates for trust doctors and consultants has not improved and additional resources requested - Consultants 50% for annual update , 100% for Resus council NLS - Registrars 75% compliance for annual update - SHOs 100% compliance for annual update 96%	- There are ongoing discussions to outsource the SALT service however therapist now available on the staff bank Documentation via InPhase to assess/monitor impact Risk rating increased on risk register - Funding now in place to support 10 x 2 hour sessions a year for medical staff, competency document in place , consultant lead identified , all inductions for August and September have staff allocated and we are now planning 4 Consultant led sessions in August to ensure that all Consultants and Trust Doctors are up to date. - Competency document approved for use following pilot for all annual updates and GMC led instructor providing training and assessment for all medical staff including doctor inductions.
1b	Assurance	New risk added to the risk register as NNU have 21% of guidelines out of date and being reviewed.	- There is a plan to improve staggering of guideline expiry for the future - Team working hard to improve compliance
1c	Advise	- There were 23 InPhase submissions this month, 3 were referred on to maternity and 3 to other departments - Continuing neonatal theme with marks from Sa02 monitor skin probes - There were 3 submissions to Tracking Trends (1 collapse secondary to pneumothorax, 2 medication overdoses)	- 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. - MDT review of cases. Learning shared via neonatal risk report. - Individual reflections for medication incidents.

Neonatal Safety Metrics: InPhase LFPSE and Tracking Trends

Total incidents reported on InPhase this month: 20

Breakdown of the number of incidents under investigation:

Related to NNU: 19

Referred to Maternity: 1

Referred to another department outside of perinatal service: 0

Tracking Trends Submissions this month: 3

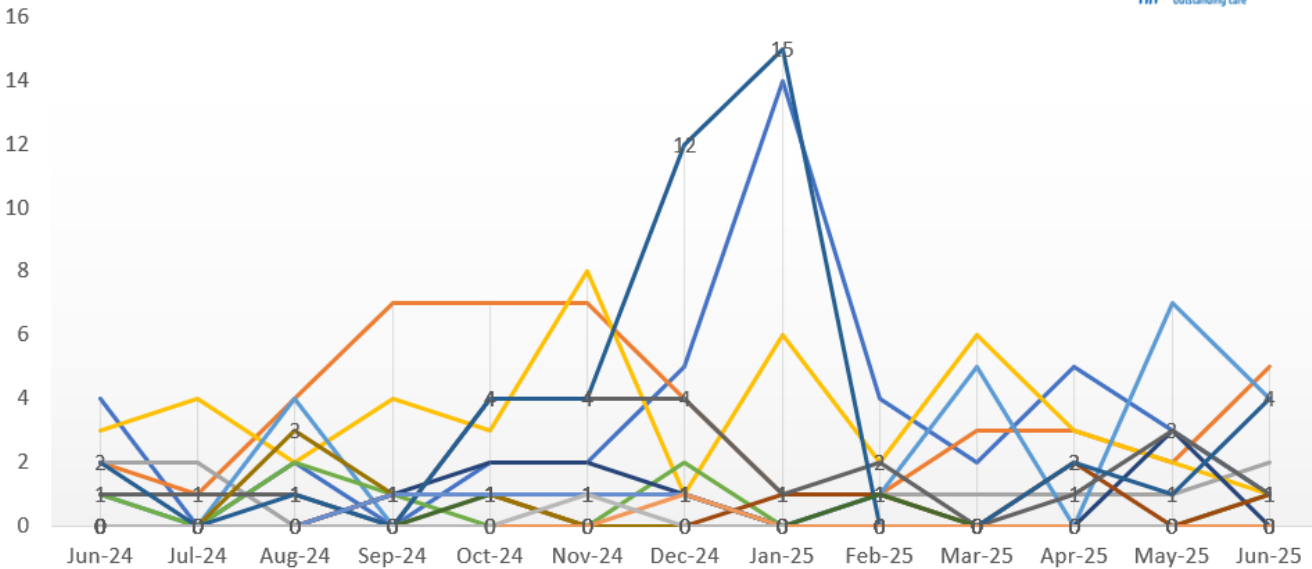
2 medication overdoses (prescribed and administered)

1 deterioration secondary to pneumothorax

New referrals to PSIRG this month – 0



Monthly Trends



Clinical Assessment Medication Communication Procedures Patient Incident
Staff Incident Trust incident Public incident Data Medical Device
Escalation Equipment Fall Security supplies

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



Cases referred to maternity for further investigation

- Avoidable delay in repeating SBR level (20hrs) – joint review with NNU

Themes & immediate learning from NNU investigations:

- Medication incidents – incorrect prescribing, failure of safety netting to prevent prescription errors resulting in administration errors, poor documentation at administration
- SBR result not plotted correctly – in line with new guidance all results must be checked and countersigned
- Data breach – NIPE printout given to wrong patient – need for careful checking
- There was 1 baby who required specialist input for Speech and Language Therapy who was not able to access this in a timely way
- Good practice noted with escalation of the unit (acuity/staffing)

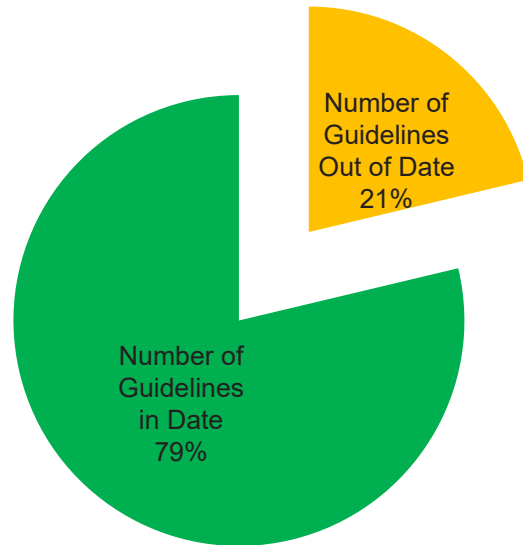
There were no neonatal deaths on the neonatal unit during this time period

Neonatal Tracking Trends Submissions

As a level 2 LNU, MTW provides a multidisciplinary reviewed exception report to the Neonatal ODN for each case reaching the criteria outlined below.

Submissions for June 2025		
Category	Case details	Significant Learning/Comments
Badger ID APD27F Criteria Met: Sudden deterioration secondary to pneumothorax	Twin 2, 37+2. Baby required neonatal admission shortly after birth due to respiratory distress. Developed a spontaneous right sided pneumothorax on day 2 of life, requiring intubation & ventilation, chest drain and central access. Transferred on day 2 to Medway Maritime Hospital for continuing intensive care. Returned to MTW after 4 days and now discharged home.	Detailed MDT review in progress – no immediate significant learning identified.
Badger ID ABU34F Criteria Met: Medication overdose	Sodium Chloride 30% prescribed in mls rather than mmols, resulting in approximately 4x overdose/dose.	No harm to patient. Individual nursing and medical reflections completed. Importance of robust checking of prescriptions to provide safety netting and prevent harm to patient
Badger ID ATXK9F Criteria Met: Medication overdose	Baby received 2.5mg/kg dose, instead of recommended 2mg/kg/dose	No harm to patient. Individual nursing and medical reflections completed. Need for careful checking of prescriptions in line with guidance reinforced. Further doses reduced accordingly to ensure baby did not receive dosage >maximum recommended daily dosage

Neonatal Guidelines – June 2025



A number of guidelines delayed in ratification due to directorate meeting changes.

This number out of date will improve substantially for next report

Plan in place to group guidelines into themes to ensure that there is an even spread of reviews over the year

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 – June 2025

Risk	Grading May 2025	Current Grading	Actions/Comments
Lack of speech and language therapy provision for neonatal and paediatric areas	16	12	KCHFT withdrew support in April 2025. Discussion under way with EKHUFT for collaborative service. All issues to be logged on InPhase. SLT now available on staff bank to mitigate some risk allowing reduction in risk rating from July
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, with one line of work recently recruited to. Risk will be closed in July and replaced with new risk (neonatal unit not compliant with BAPM standards)
Inadequate governance provision & policies and guidelines out of date/requiring review Joint risk with paediatrics	12	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. There is only dedicated neonatal governance cover for 7.5hrs per week and no one substantively within paediatrics
Lack of psychology support for families/staff on NNU	9	9	Bank post recruited to for 2 days per week, start date confirmed Need for substantive post to be added to BAPM business case
There is a shortage of non-invasive respiratory support equipment (vapotherm)	9	9	Equipment funded by emergency capital funding bid and league of friends. Awaiting device to arrive in Trust.

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

Aug 2025 (June 2025 data)



Maidstone and
Tunbridge Wells
NHS Trust

Neonatal Patient Experience Report

Key Issues Report Neonatal Patient Experience			
Report Date: Aug 2025 (June 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 has now been recruited to, to provide some mitigation in the meantime - Remains on risk register
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 - Audit and data – interviewing July
1c	Advise	- Maternity EDI lead recruitment now in post and offering support across perinatal service - Successful appointment to further neonatal quality roles (discharge planning, transitional care, risk & governance)	Anticipated start date June 2025

Maternity & Neonatal Trust Board Safety Report

Board report

Presented by Perinatal Leadership team

Assure

What has improved to acceptable standards

1 MIS	• Safety Actions 1, 2, 3, 4, 5 and 10 all progressing and expected to declare compliance. • Safety Action 9: Perinatal leadership team progressing with culture improvement plan and bi-monthly meetings. Safety Champions meeting monthly. Improved sharing of PFIS actions to include maternity specific PFIS Spotlights. • Safety Action 8: New starter medical staff who commenced work after 1 July 2025 will not be included in training compliance figures for the purposes of MIS compliance as long as an action plan is in place to recover their compliance within 6 months of starting work with the Trust. The Trust Board must approve this action plan.
2 Patient Safety- Maternity	• 0 MNSI referrals and no reports published in month • 0 PMRT referrals in month • 0 PSII/AARS commissioned in July • 100% complaint for DOC
3 Operational and staffing	• 100% complaint for 1:1 care in labour • 100% complaint Del suite coordinator status
4 Risk Register	No New or amended risk in month, one closed risk- 3072- The current interpreting service provided by the Trust does not fulfil the needs of the maternity services at MTW.

What needs to be escalated?

	Issue	Current Mitigation	What support is needed
1 Neonatal	- The neonatal unit was running at >80% occupancy (maximum recommended by BAPM) for 25/31 days (80% of the time) and the combined ITU/HDU was greater than 80% for 27 out of 31 days (87% of the time). - There were also 17 out of 31 days when the ITU/HDU occupancy was greater than 100%, creating the risk that a cot would not be available for a critically ill baby or care could be impacted for other patients. - This is the eleventh month in a row that the neonatal unit has spent prolonged periods of time in escalation	- Escalation as per guidelines, with regular multidisciplinary safety huddles including leadership, maternity, neonatal operational delivery network to mitigate risk/prioritise need - Escalation task and finish group in progress. To bring report of findings to MNCOG once finalised - New risk to be added to risk register	- Additional support from the neonatal ODN/SpecCom to review cot commissioning. - The neonatal staffing and occupancy tool has consistently highlighted that HRG2 cots (HDU) need to increase by 2 and HRG3 cots (SCBU) should be decreased by 1 based on occupancy over the past 2 years.
2 Neonatal	- As NNU does not currently have any funded transitional care cots, this data is not captured on Badgernet. - This has a workforce impact for both neonatal medical and nursing staff	- Babies receiving antibiotics are logged onto badgernet, but this process requires improvement (A specialist Co-Ordinator role with interest in data has recently been appointed to – start date pending)	- Time to explore ways to capture this data on badgernet using minimum dataset to ensure that the data is representative of the work being performed and to review governance pathways for transitional care patients. - Additional administration support may be required.
3 Neonatal	- Challenges with recruitment and retention of experienced nurses. - There is a national shortage of qualified in speciality (QIS) nurses. - MTW currently has 55.9% of staff QIS against a BAPM recommended target of 70%. - An additional 15 WTE clinical nurses are required to reach this target based on current activity/occupancy. - MTW also has the highest birth rate in the network. Continued need for bank and agency usage due to shortage of QIS nurses/19% vacancy rate	- MTW have adopted a 'grow your own' approach - Ongoing external recruitment with dual clinical and specialist roles to boost interest from experienced nurses – final posts now recruited to with start dates pending - robust processes to triage high risk antenatal admissions during periods of high acuity to minimise risk - Lines of work approved	- Additional financial investment – 1) Business planning to increase workforce 2) Consideration for financial incentives to encourage external applicants and to retain staff following QIS training
4 Neonatal	- MTW have only one substantively funded Allied Health Professional role to support the neonatal service. Without substantive funding in psychology, the units BLISS platinum accreditation is at risk. - Recommended provision based on current cots - Psychology, Occupational Therapy, Speech and Language Therapy (SLT) and Physiotherapy = 0.9WTE each - Dietetics = 0.8WTE - Pharmacy = 0.36WTE	- Short term shared funding secured for physiotherapy - Recent application for extended funding from KCC for psychology was unsuccessful. Further business case in progress. - Bank recruitment currently in progress for psychology and SLT - Remains on the risk register, with quarterly report submitted to the neonatal ODN for external oversight	- Financial investment as per business case - Additional support from neonatal ODN
5 Neonatal	Concerns escalated by maternity team regarding high workload of resident doctors at weekends and that this has impacted on timeliness of reviews/discharges on postnatal ward	Raised with clinical lead to allow discussions at management meeting and increased consultant oversight during periods of high acuity	Review currently underway by General Manager

What needs to be escalated?

	Issue	Current Mitigation	What support is needed
6 Neonatal	Compliance for Medical Staff attending annual neonatal life support updates is suboptimal	- Funding now in place to support 10 x 2 hour sessions a year for medical staff, - Competency document in place , - Consultant lead identified , all inductions for August and September have staff allocated and we are now planning 4 Consultant led sessions in August to ensure that all Consultants and Trust Doctors are up to date. - Whilst suboptimal, with the plan in place, compliance is now on an upward trajectory.	
7 MIS	Safety Action 6: Q7 and Q8 have been assessed by the LMNS and an improvement trajectory confirmed. Q9 submissions are being prepared ready for submission in September 2025. Elements 1, 2, 3 and 5 all have areas where there is the potential for reduced, or at the least delayed, implementation in the future. Key challenges surrounding sonography provision. 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: Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Safety Action 8: In addition it is noted that, in previous years of the scheme, training compliance is strong throughout the year, but falls in the lead up to the 30 November MIS deadline due to increased numbers of staff going out of date. The Practice Development Team have prepared compliance projections to enable close monitoring.	Review of USS service currently underway but with challenges. Mitigation in place regarding the use of CTG's when next working day USS not available (EI 3.2b), but reduced compliance in recent audit – learning to be shared with triage and medical teams. Discussed at Trust Board in May 2025. For more detailed discussions with ICB to develop plan, with further Trust Board discussion planned. Plan in place to improve training compliance in July, awaiting updated data. Funding in place to ensure funded teaching time to improve compliance. Bookings have been made for all staff who require training. Attendance when booked is vital to ensure sustained compliance rates. Obstetric and anaesthetic leads aware and will support staff to attend training.	
8 Patient Safety	3 PSII commissioned in month 2 inquest commissioned	Staff are being supported through inquest by both the midwifery and legal teams	
9 Training	Non compliance for neonatal resus is still an issue, the consultant training sits at 62.5% and the other doctors at 70%	An action plan is in place , however if numbers do not improve then this will affect CNST declaration.	
10 Operational	July Data shows a 80% compliance for when a consultant MUST attend an intrapartum event	1 missed case. 4 th degree tear in the night. Feedback given.	

Advise

What is a challenge but currently manageable

	Issue	Mitigation	Resolution date
1 Neonatal	- MTW is one of only two neonatal services in Kent that does not have a neonatal outreach service. - It is likely that commissioning of an outreach service would significantly impact length of stay, which may reduce the number of days in escalation.	Two specialist co-ordinators have recently been appointed to increase support to families in preparation for discharge (family integrated care and discharge planning)	It will not be possible to resolve this until a service is commissioned
2 Neonatal	The % of shifts covered with a supernumerary shift leader (to maintain operational oversight) is currently lower than in other level 2 neonatal units nationally (49.98 vs 70.1%, but on an upward trajectory)	5.4 WTE specialist band 7 posts are now recruited to (following additional finance from business planning)	All posts will be operational by October 2025 (additional funding would be required to increase compliance in line with national average)
3 MIS	Safety Action 3: Improvement with data collection been made and MDT reviews taking place, but challenges arise as the MDT are not all available at the same time. Safety Action 9: In process of moving from PQSM to PQOM for reporting.	Ongoing project looking at coding to improve quality of ward attender data.	
4 Operational and staffing	A total of 23 suspensions of service, 2 women were affected	Suspensions were undertaken due to staffing to maintain safe service with senior oversight	

Data measures – perinatal quality oversight tool

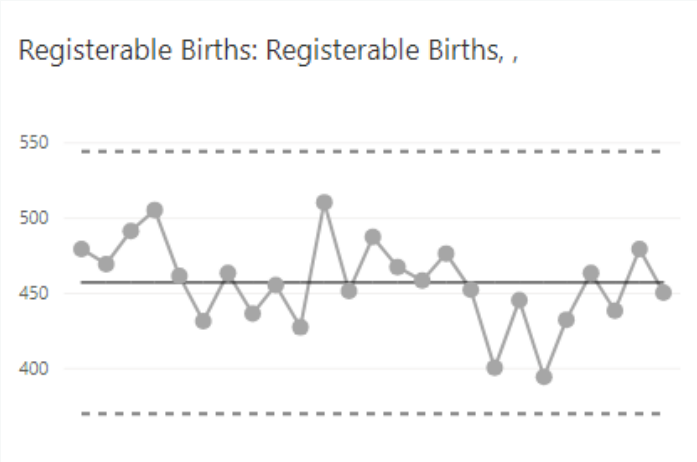


Slide No.	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
9	1. Findings of review of all perinatal deaths using the real time data monitoring tool													
10	2. Findings of review of all cases eligible for referral to MNSI (split rolling number)													
		0	0	0	1	1	0	0						
11	2a. The number of patient safety incidents logged and what actions are being taken													
	Number	0	0	2	1	1	0	3						
27	2b. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training													
29	2c. 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													
39	3. Service user voice feedback - themes													
35	4. Staff feedback from frontline champion and walk-about - themes													
19	5. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust													
19	6. Coroner Reg 28 made directly to Trust													
	7. Progress in achievement of CNST 10 safety actions													
	8. Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported annually												63%
	9. Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'Excellent' or 'Good' on how they would rate the quality of clinical supervision out of hours	Reported annually												38%

Maternity Overview

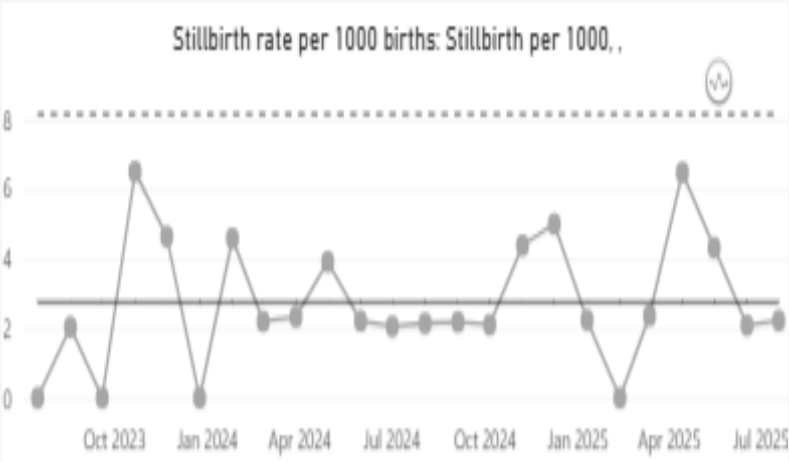
July
Number of births
450

No significant change



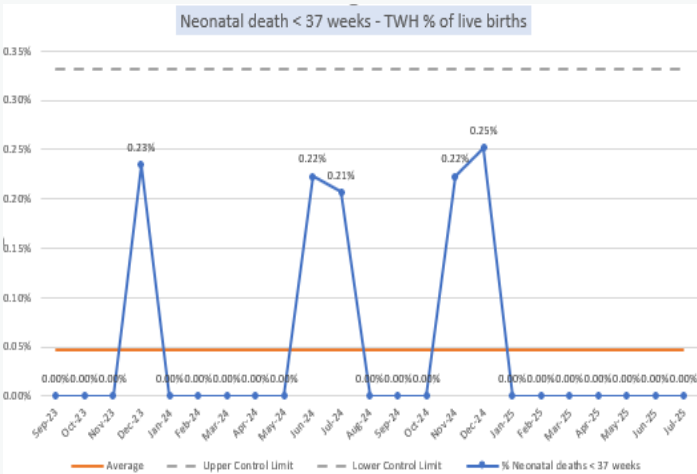
July
Still birth rate/1000
2.2

No significant change



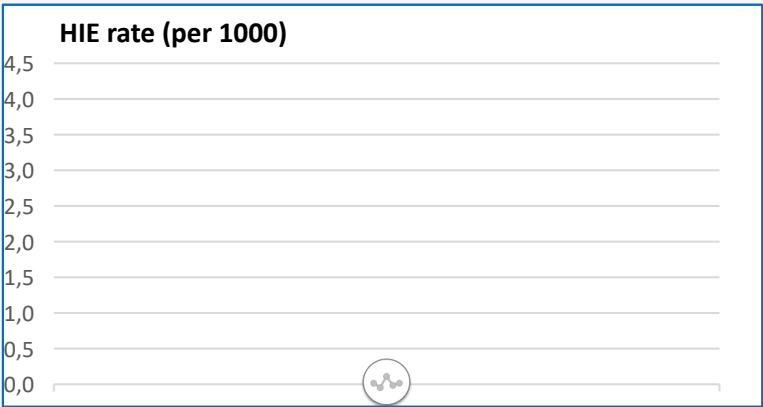
June
Neonatal Death
rate/1000
0.0

No significant change



Latest month
HIE rate/1000: 1.12

No significant change
Incidence = 1 in July 2025

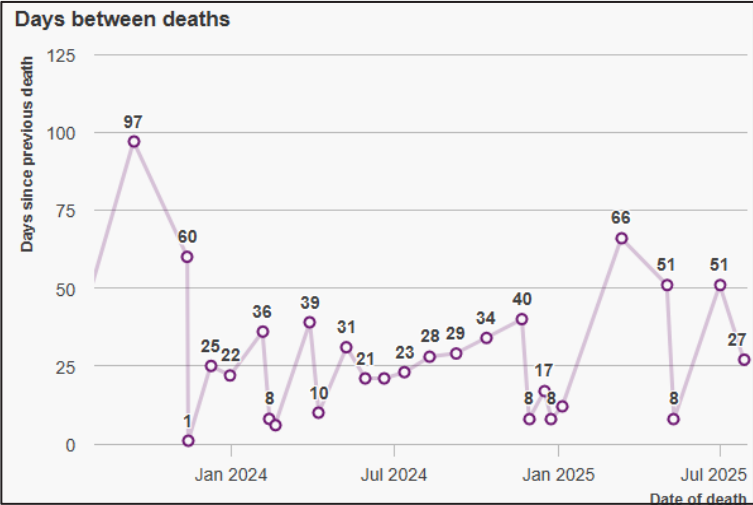


Maternity Overview

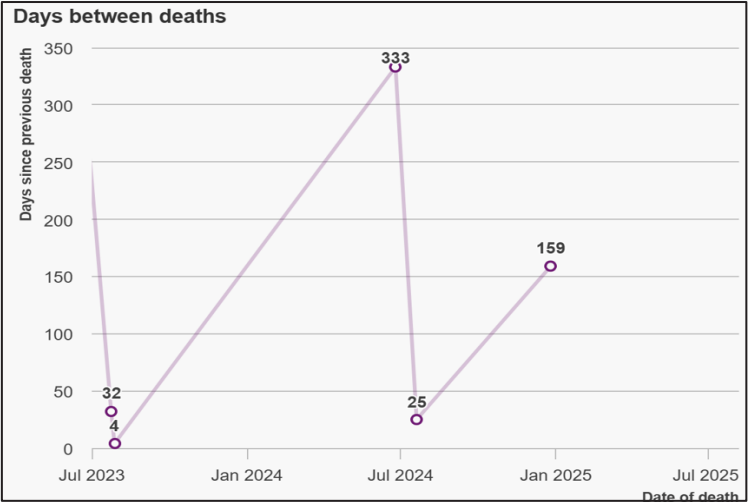
Date of last stillbirth
30/06/2025

Average days
between stillbirths 28

No significant change



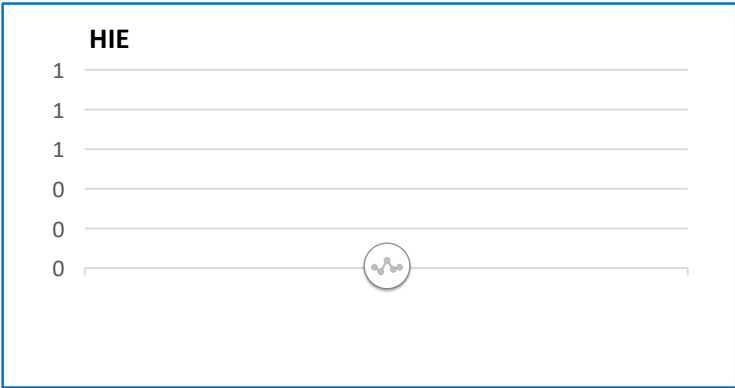
Date of last neonatal
death: 26/12/2024
Average days
between deaths 111



Date of last HIE

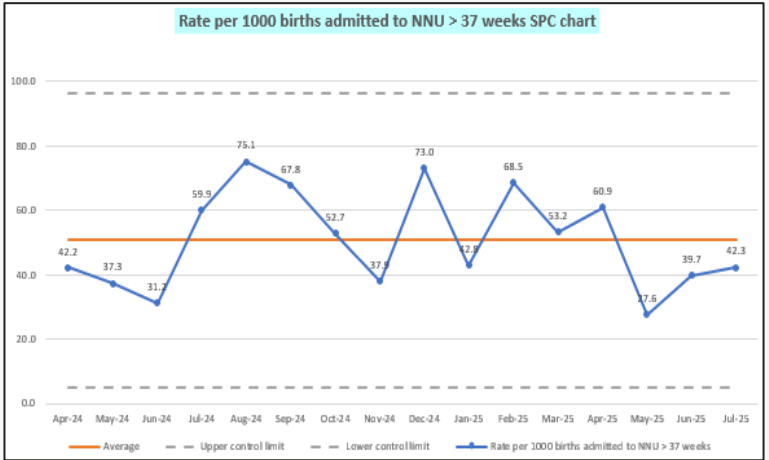
Date of last HIE
01/07/2025

Average days
between HIE: 51



July
HIE rate/1000: 1.12

No significant change
Incidence = 1 in July 2025

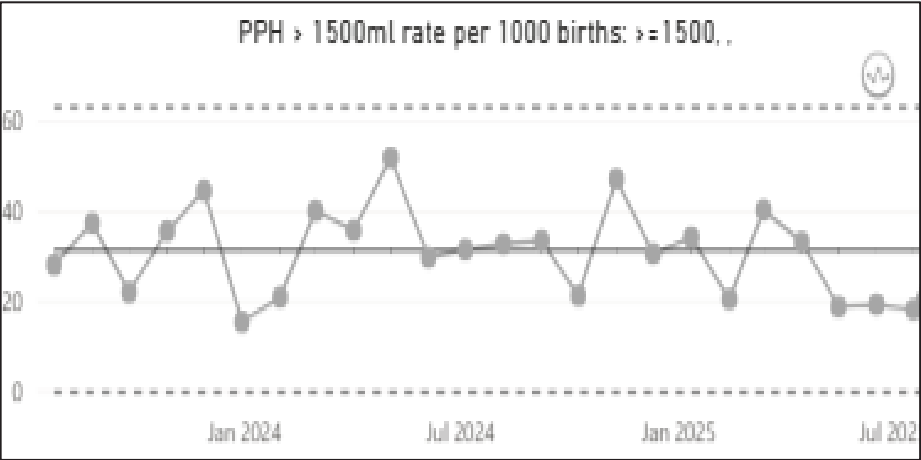


Maternity Overview

July PPH > 1500ml
rate per 1000 births

18.0

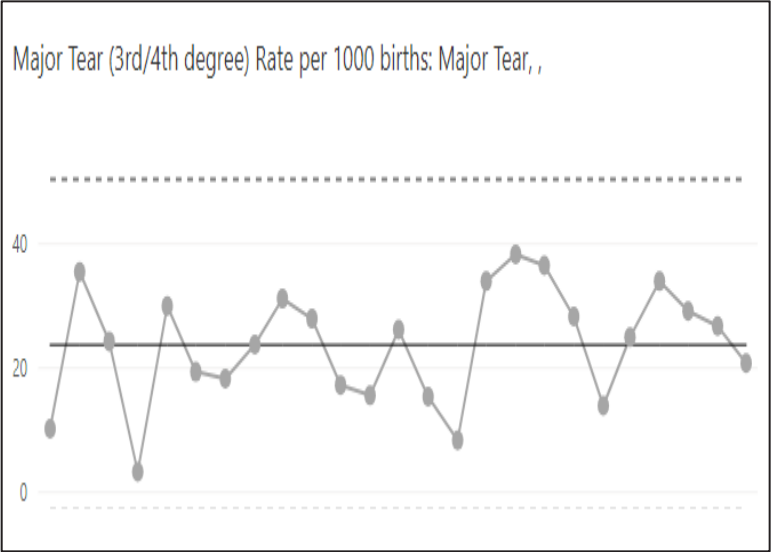
No significant change



July 3rd /4th
degree tear rate
per 1000 births

20.7

No significant change



Latest month
Safer staffing fill rate

No significant change



Latest month
Proportion of staff
with concerns about
safety

No significant change



1. Perinatal Mortality rate

The graphs above demonstrate how the Trust is performing against the national safety ambition.

Datix No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
/	/	/	/	/

1.1 .Learning from PMRT reviews

InPhase	Description	Learning from published review
42281	Mother experienced IUD at 33+2	Grading B and B Learning: CMW at 16/40 was missed due to capacity in clinic No consultant obstetrician input after diagnosis of IUD on triage or on management of IOL Actions: Now additional clinic and appointment capacity at this venue to ensure appointments are timely Feedback to registrar and consultant

2.0 Maternity and Newborn Safety Investigation Programme (MNSI)

2.1 Investigation progress update

MNSI Ref	Month	Reason for referral	Date of confirmed investigation	Family Informed	Duty of candour complete Y/N	Early notification, external notifications and other investigations
MI-041333	April	Baby transferred for cooling following Category 1 LSCS (maternal cardiac arrest, suspected amniotic fluid embolism) at 39 ⁺⁰	Date referred 14/04/2025 Consent for investigation 06/05/2025	Yes	Yes	ENS referral complete 29/05/25
MI-042048 MI-042184	May	Baby transferred for cooling following SVD, passed away day 6 of life after care withdrawn following MRI results and clinical examination of severe brain injury	Date referred 15/05/2025 Consent for investigation 21/05/2025	Yes	Yes	ENS referral complete 29/05/25 PMRT notification Informed of inquest 19/06/2025
MI-044726	July	Mother experienced intrapartum stillbirth at 40 ⁺¹	Date referred 29/07/2025 Consent for investigation 01/08/2025	Yes	Yes	PMRT notification 30/07/2025
MI-043753	July	Baby transferred for cooling following Category 2 LSCS (for CTG concerns) at 39 ⁺⁵	Date referred 03/07/2025 Consent for investigation 14/08/2025	Yes	Yes	ENS referral complete 03/07/2025

2.2 .Learning from MNSI Investigations

None published in July

2.3 Maternity Patient Safety Incidents (PSI)

Maternity Patient Safety Incidents during the period July:

- 0 PSII's closed in July
- 3 PSII commissioned in July
- 9 PSII ongoing

Month	InPhase	Description	Maternal ethnicity
November	#28793	Mother experienced late miscarriage at 21+0, missed referral for cervical length screening.	Black or Black British: African
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
May	#42165	Cat 1 EMCS for bradycardia of twin 1 (35+5) Confirmed HIE	White: British
Jul	45267	Mother experienced stillbirth at 34 ⁺³	White: British
Jul	46810	Mother sustained bowel and uterine perforation at surgical management of retained products of conception	White: British
Jul	46775 48837	Mother experienced pre-term birth at 23 ⁺⁰ , neonatal death at 4 days	Any other White background

Maternity **After Action Reviews (AARs)** during the period June:

- 0 AAR's closed in July
- 0 AAR's commissioned in June

Month	InPhase	Description	Maternal ethnicity
March	#38022	Mother with Type 1 Diabetes experienced hypoglycaemia and seizure	White British
June	#43156	Wrong dose Terbutaline given	White British
June	#43362	Baby suffered humeral fracture during EMCS	White British
June	#43725	2900ml PPH transfer from MBC with ongoing PPH	White British

2.4 Moderate Harm incidents

- 8 inphases initially graded as moderate harm on Inphase
- 1 downgraded to low harm after MDT review
- 2 upgraded to moderate harm after review
- 6 remained moderate harm after review

ID	Incident Summary	Actions/Learning	Date of review & outcome
Incident 02/07/25 46501 & 46502	Transfer from MBC MROP fell to floor hit head during transfer from stretcher to bed. PPH 1800mls Graded moderate psychological harm	• Carbetocin used out of guidance (MROP and perineal repair) • No observations performed prior to transfer • G+S bottles labelled incorrectly with NHS number • Lateral transfer should have been used	Reviewed by MDT 09/07/25 Remains at moderate harm
Incident 5/7/2025 46705	Neonatal collapse at 23minutes of age. 2222 admitted to NNU Graded moderate psychological harm	- Unavoidable admission to NNU - NN Consultant action as no CXR	Reviewed by MDT 10/07/25 and then presented at weekly PS review – downgraded to low harm Closed
Incident 15/7/25 47219	4th degree tear following forceps.	- Good escalation to from ST3 to SAS doctor - On call Consultant did not attend (out of hours) was called but decision was made that Registrar was signed off and competent. RCOG states Consultant must attend for repair of 4th degree tears.	Reviewed by MDT Remained moderate harm Closed
Incident 17/7/25 47445	2300ml PPH and 3rd degree tear Graded moderate physical harm	- Obstetric review should have occurred in person when mother was found to not be fully dilated. Band 5 midwife VE support provided by education team. - No second cannula sited, learning shared via GLOW	Reviewed by MDT Remained moderate harm Closed
Incident 21/7/25 47722	Return to theatre 14 days post LSCS Graded moderate psychological and physical harm	- Earlier opportunity to have referred to triage noted - Review group acknowledged that SOP for MEWS to be used for outpatient community care. Under review to update escalation pathway from community setting and make amendment to SOP to reflect this.	Reviewed by MDT 29/07/25 remains moderate physical To close once DOC sent
Incident 23/7/25 47734	PPH 3800mls	- No escalation made to Gynae Consultant when Obstetric Consultant was not available due to being in theatre already - Both theatres in use for elective cases – review into decision making around this ongoing.	Reviewed by MDT 29/07/25 remains moderate physical To close once actions complete and DOC sent

2.4 Moderate Harm incidents cont.

ID	Incident Summary	Actions/Learning	Date of review & outcome
Incident 01/07/2025 46430	Baby transferred out for cooling Graded moderate physical harm	- Lack of fetal monitoring in latent phase - CTGs not classified - Lack of holistic assessment, lack of escalation as a result, MEWS not calculated - NLS not followed initially – Delay in inflation breaths, should have been a NN Registrar present - EMCS should have been Cat 1 rather than Cat 2	Reviewed by MDT 03/07/25 Remains moderate harm. Escalated to PSIRG- For MNSI
Incident 07/07/25 46810 Joint with Gynae	Bowel perforation at surgical management of retained products of conception. Admission to ITU. Graded severe physical and severe psychological	- Clear guidance needed for early PN patients needing ERPC - Consultants running scanning sessions on EGAU should be involved and have input on plan - Need for clear escalation pathways for SSSU - Importance of not using acronyms when working alongside other departments	Reviewed by MDT 10/07/2025 Downgraded to moderate harm. Escalated to PSIRG- For PSII
Incident 07/07/2025 48837	23/40 delivery, transfer to Medway NND 11/7/25 Initial graded low harm, upgraded by MDT	- Missed opportunity for Partosure to be offered at 22+5 - Mobile resuscitaire not working correctly and did not have daily check completed so resuscitation started from cold - Incorrect oxygen cylinder brought to room - Consideration to be given to heated mattresses for resuscitaires escalated	Reviewed by MDT 29/07/2025 Upgraded to moderate Escalated to PSIRG for PSII and PMRT
Incident 27/06/2025 45267	34 Week IUD Initial graded low harm, upgraded by MDT	- No community midwife appointments aside from booking appointment. Had obstetric input but midwifery appointments were not booked. - Lack of recognition of vulnerabilities the family faced - No alternative to GTT offered when unable to have GTT due to eating/drinking on day of test	Reviewed by MDT 29/07/2025 Upgraded to moderate Escalated to PSIRG for PSII and PMRT

Neonatal Patient Safety Incidents

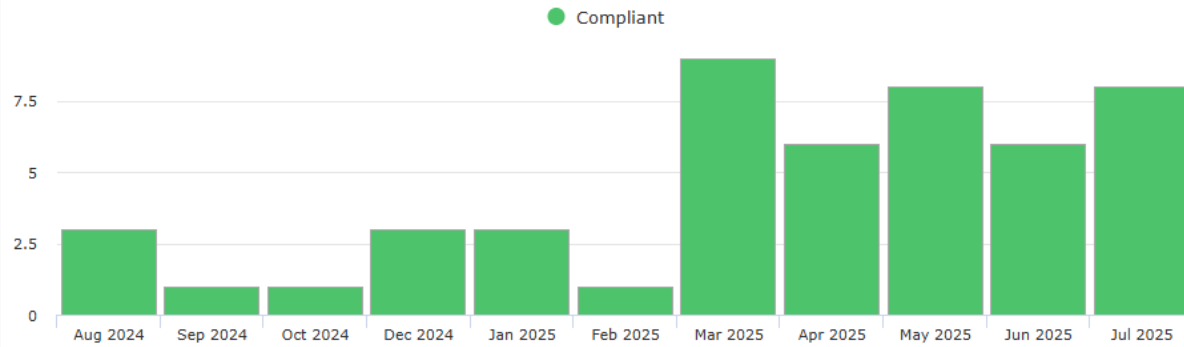
Neonatal Patient Safety Incidents during the period June:

- 1 joint PSII commissioned with maternity in month
- 0 AAR commissioned
- 0 AA/PSII closed in month

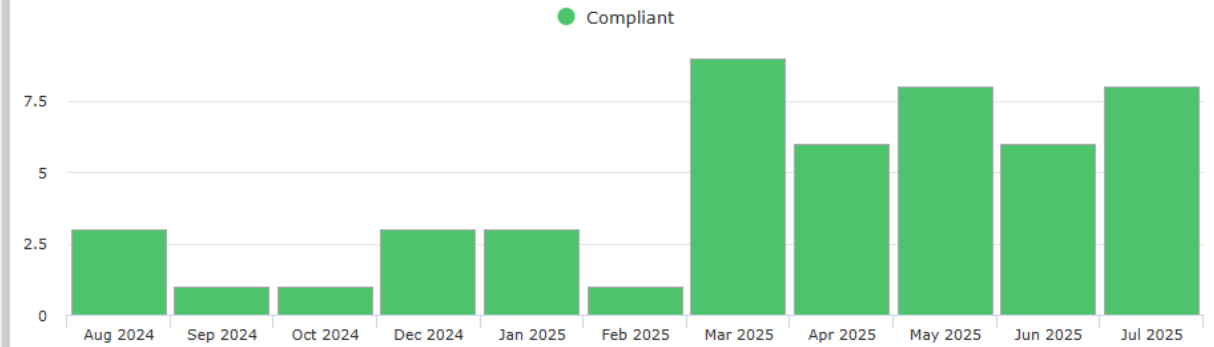
Month	InPhase	Type of investigation	Description	Ethnicity / Social Deprivation
July 2025	48837/46775	PSII Led by maternity with neonatal input as incident occurred in delivery suite	Baby born at 23+0 weeks gestation. Equipment failure of resuscitaire – baby hypothermic. Graded as moderate harm. Baby died on day 4 following ex-utero transfer to level 3 centre with complications associated with extreme prematurity. Case under Coronal Review.	Ethnicity – white/other IMD = 3

2.5 Duty of Candour Compliance Maternity

Verbal DOC Compliance - LFPSE - Rolling 12 Months



First Letter DOC Compliance - Rolling 12 Months



DOC remains 100% compliant for verbal and first DOC

Neonatal

DOC remains 100% compliant for verbal and first DOC

2.6 Learning from closed investigations in April- not presented as yet

#4252 and #34224	Area for improvement	Safety action description (SMART)	Safety action owner (role, team directorate)	Targeted date for implementation	Date Implemented
Investigation: AAR Joint AAR of two cases on same night shift Mother experienced 3b tear and 2000ml PPH	PPH bloods were not taken	There is PPH order set that has been created on Sunrise: Remind staff of sending PPH bloods using the Sunrise order set at the time of PPH: - GLOW - PROMPT Mandatory Training - Clinical Governance	Maternity Patient Safety Team (Hannah Sydee, Gemma Mizon, Emily Hartingdon, Sian Hersey-Walker)	30th April 2025	
	In theatre, there is an ongoing theme of poor communication of the ongoing measurements of blood loss	New obstetric lead for simulation to complete in situ theatre PPH's focusing on communication. MECU and theatre lead when appointed to work on this.	Simulation Lead (Rahul Gore)	31 st July 2025	
		Reinforce the message via: - Individual Team Feedback - PROMPT - PPH Simulation Training - Take 5 - GLOW - Clinical Governance	Ward managers, practice development and patient safety team	1 st May 2025	
		Utilise the real-time blood loss documentation board in theatre, ensuring loss is recorded and updated every 5 minutes. Train midwives, doctors, theatre staff on its use.	Theatre Lead (Tina Purland)	1 st May 2025	
		Obstetric consultant not informed and therefore did not attend-staff appear to be unclear as to when the consultant should be informed of a PPH-policy states 1500mls and ongoing.	Labour Ward Lead (Oli Wildman)	1 st June 2025	
	Code red stood down prior to final MBL/end of procedure	Implement a structured verbal announcement protocol in theatre, requiring staff to audibly state to the up-to-date MBL and clarification that bleeding has settled before standing down Code Red	Simulation Lead (Rahul Gore) Theatre Lead (Tina Purland) Practice Development Team (Laura Coleman)	1st May 2025	

2.6 Learning from closed investigations in June- not presented as yet



#33959	Area for improvement	Safety action description (SMART)	Safety action owner (role, team directorate)	Targeted date for implementation	Date Implemented
Investigation: AAR Mother developed PE and DVT postnatally, - incorrect assessment on VTE form – no Fragmin recommended	VTE assessments are to be checked on each shift. Staff taking over patient care should thoroughly check the VTE assessment to ensure that human error does not take place.	Conduct spot audits weekly on postnatal and delivery suite wards to verify completion of VTE assessments at shift changes, targeting a compliance rate of 100%	Ward managers	June 2025	
		Handover project currently auditing and reviewing SBAR and clinical handovers with aims to improve and standardise	Grace Anderson Audit and project Midwife	30th December 2025	
		Risk of having digital and paper records in maternity and issues relating to this is on the risk register.	Jessica O'Reilly Head of Maternity Governance	Ongoing	
	We acknowledge that staff felt the shift was busy, which they felt impacted their review of the patient's clinical notes; however, escalation protocols were not followed.	1:1 discussions with midwives involved to reflect	Laura Knauf PN manager/ acting matron	30 th June 2025	
	Multiple cases of assessment errors and VTE in maternity recognised as a theme	VTE lead and PN manager to work together to improve maternity	Laura Knauf PN manager/ acting matron Tutu VTE lead	30 th September 2025	
		PN manager (Previous VTE lead) to attend the Thrombosis Committee	Laura Knauf PN manager/ acting matron	30 th September 2025	

2.7 Coroners' reports

Outstanding report due

Identifier	Date listed	Summary
I.O	18/06/2025	Inquest called Baby transferred for cooling following SVD, passed away day 6 of life after care withdrawn following MRI results and clinical examination of severe brain injury Update: Statements in final drafts
H.B	08/08/2025	Overview and statements requested 23 week delivery, baby transferred and passed away day 4 of life Update: Statements requested for first draft

Regulation 28 report issued

Identifier	Action required	Progress	Responsible (role)	By when
Nil	Nil	Nil	Nil	Nil

2.8 Review of NHS Resolution Scorecard

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

Not due until October



3.0 Maternity Outcomes Safety Signals System (MOSS)

When available - Number and action taken on national / local flags

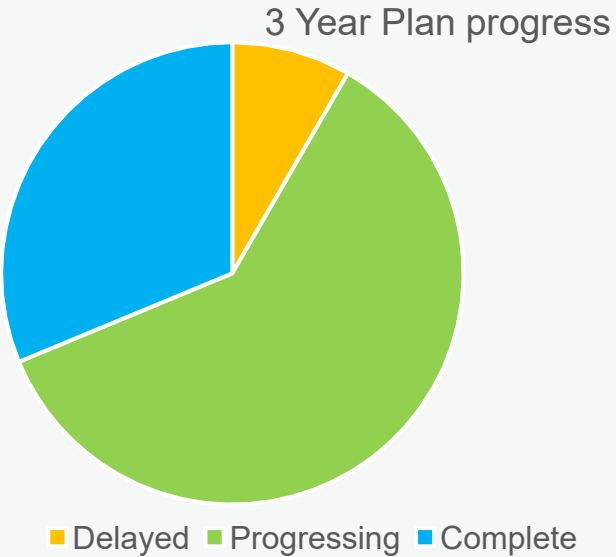
N/A yet

4.0 Maternity Improvement Plan

Maternity CQC action plan	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Comments
29A Warning Notice and CQC Report “Must” and “Should” Activities – progress																							
Complete	2	15	17	35	54	82	96	100	108	126	132	144	151	168	175	175	175	176	183	185	185	185	• Work continues on the remaining actions: ➤ Workforce recruitment and retention plan to be completed ➤ Training strategy to be completed ➤ Review of Risk and Governance Strategy to be completed ➤ Maternity strategy development in progress
On track and on time	23	11	3	153	113	99	89	33	22	37	34	27	30	15	12	11	14	10	7	6	6	1	
Breached but progressing	1	0	6	0	23	9	5	57	60	24	26	21	15	13	9	10	7	10	6	5	5	10	
Breached at risk	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	
Milestone Actions completed for the Delivery Areas: • Reduction in harm associated with PPH • C-section undertaken within appropriate time frame • Safe systems for Triage • Robust Medicines Management • Birth Centre Booking Processes • Birth Centre Risk Assessment • Safe Clinical Environments and Processes • Workforce Recruitment and Role Specific Training																							Ongoing monitoring and oversight has been established for these delivery areas and the workstream activity has transitioned to business as usual
CQC report following inspection in October 2024 was published 31 July 2025 • Overall rating: Good • Safe: Requires improvement • Effective: Good • Caring: Good • Responsive: Good • Well-led: Good An action plan has been submitted to advise CQC of actions taken and planned to meet the breach of regulations relating to review of patients waiting for induction of labour, 28 August 2025 The Induction of Labour Improvement working group is coordination the actions to improve flow through the maternity service and ensure appropriate medical and midwifery staffing to ensure timely reviews of women waiting for induction of labour A further review of the report will identify any further actions for improvement which will be incorporated into the Maternity Improvement Programme with the objective of achieving a rating of outstanding in the future																							

5.0 Three Year delivery plan

Theme	Objective	Red	Amber	Green	Blue	Total
Theme 1: Listening to Women	Objective 1: Care that is personalised	0	0	4	0	4
	Objective 2: Improve equity for mothers and babies	0	1	3	0	4
	Objective 3: Work with service users to improve care	0	0	1	0	1
Theme 2: Workforce	Objective 4: Grow our workforce	0	0	3	0	3
	Objective 5: Value and retain our workforce	0	1	5	1	7
	Objective 6: Invest in skills	0	0	4	0	4
Theme 3: Culture and Leadership	Objective 7: Develop a positive safety culture	0	0	2	3	5
	Objective 8: Learn and improve	0	0	2	4	6
	Objective 9: Support and oversight	0	0	1	4	5
Theme 4: Standards	Objective 10: Standards to ensure best practice	0	1	1	2	4
	Objective 11: Data to inform learning	0	1	1	0	2
	Objective 12: Make better use of digital technology in maternity and neonatal services	0	0	2	1	3
Total		0	4	29	15	48
- Three year delivery plan actions have been added to the overarching Maternity Improvement Plan - Improvement actions identified from review of the recent CQC report have been benchmarked against the themes and actions of the Three year delivery plan						



6. Training compliance

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

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists	Neonatal medics (split by consultant/ other Dr) Annual Update	Neonatal nurses (Nrs/ ANNP) Annual Update
Saving Babies Lives Care Bundle Data now cross referenced with VBA training in 2024	94%	Do not attend	81%	Do not attend	Do not attend	Do not attend
Fetal monitoring and surveillance (MU Day 4)	96%	100% / 92%	Do not attend	Do not attend	Do not attend	Do not attend
Multi professional Maternity Emergencies training (MU Day 3)	96%	95% / 100%	95%	98%	Do not attend	Do not attend
Equality/ equity and personalised care (3-yr Programme) (MU Day 1)	95%	Do not attend	86%	Do not attend	Do not attend	Do not attend
Care during labour and immediate post-natal period (3-yr programme) (MU Day 1)	95%	Do not attend	86%	Do not attend	Do not attend	Do not attend
Neonatal resuscitation training	96%	95% / 100%	95%	Do not attend	Consultant:62.5% Formal plan in place	ANNP (ACP) 100%
			81%	Do not attend	ST/Permanent NNU Doctors: 70% Formal plan in place	
			Do not attend	Do not attend	Foundation/GP 96%	

MAST Womens Directorate overall compliance for July = 87.2%



Training update

Compliance was not met for:

- Saving Babies Lives Care Bundle (MU Day 2) for MSWs
- Equality/ equity and personalised care (3-yr Programme) (MU Day 1) for MSWs
- Care during labour and immediate post-natal period (3-yr programme) (MU Day 1) for MSWs
- Neonatal Resuscitation annual update (senior neonatal medical staff)

Themes of why compliance has not been met:

- Staff sickness creating a 'bottleneck' and therefore a capacity issue due to need to rebook ++
- Neonatal life support update – training availability

Actions:

- Sick and redeployed staff have been re booked for next available space
- Additional dates have been added for Day 1, Day 2 and Day 3 to increase capacity during October and early November.
- Staff reminded of bookings and rosters checked
- Neonatal Resuscitation Annual Update: 1) Funding now in place to support 10 x 2 hour sessions a year for medical staff 2) competency document in place 3) consultant lead identified 4) all inductions for August and September have staff allocated and we are now planning 5) Consultant led sessions in August to ensure that all Consultants and Trust Doctors are up to date. Whilst suboptimal, with the plan in place, compliance is now on an upward trajectory.

7.0. Safe Maternity staffing

Fill rates – planned versus actual

Inpatient area	Planned CHPPD	Actual CHPPD	Variance
Maidstone Birth Centre - NP751	52	44.5	↓
NICU (TW) - NA102	13	12.1	↓
Midwifery Services - Delivery Suite - NF102	12	7.0	↓
Midwifery Services - Antenatal Ward - NF122	9	8.3	↓
Midwifery Services - Postnatal Ward - NF132	9	9.9	↑
Crowborough Birth Centre (CBC) - NP775	116	100.2	↓

Ward Staffing levels above 130%

Trust Ward Name	Below 80% of agreed unregistered establishment staffing level		Comment
	Day	Night	
Postnatal Ward	134.8%	121.1%	Overfill was seen on both days and night shifts due to an increase in establishment following recommendations of the CQC. This is currently funded at risk; however, the approval of the Maternity Business Case will result in additional staff becoming part of the Postnatal establishment.

In July there was high levels of temporary staffing used within Maternity services due to increase sickness and high acuity.

Trust Ward Name	Temporary staffing hours			Number Enhanced Care additional duties	Periodically Escalated overnight
	Bank hours	Agency hours	WTE temporary demand		
Maidstone Birth Centre	426.83	0.00	1.83	6	No
NICU	1,241.00	90.00	8.33	0	Yes, extended cot base when needed
Delivery Suite	1,574.75	117.00	11.67	0	No
Antenatal Ward	886.42	23.50	4.61	0	No
Postnatal Ward	1,596.65	44.25	9.11	0	No
Crowborough Birth Centre	392.75	0.00	2.12	0	No

7.1 Staffing Vacancy rates

Staff group	Vacancy rate
Midwifery	5.6 WTE
Midwife Support workers	9.99 WTE
Obstetric consultants	-0.24 WTE
Resident doctors	-7.28 WTE
Neonatal Nurses	9.0 WTE
ANNP	0 WTE
Neonatal AHP	Non-compliant with current recommendations in all groups
Neonatology consultants	0
Neonatal Resident doctors	
Reg	
SHO	
*inclusive of paediatrics	
Obstetric anaesthetists	*to be included from October meeting
Resident doctors	

7.2 Midwifery Red flags, actions and mitigations

Antenatal Ward – Compliance 89.52%

- Delay or cancelled time critical activity 16
- Missed or delayed care 10
- Delay between admission for induction & beginning of process 2
- Occasion when midwife is not able to provide one to one care 1

Delivery Suite – Compliance 87.63%

- Delay in being transferred to DS from Triage – 4
- Induction waiting to come in from ANW – 37
- Missed observations - 1

Postnatal – Compliance 87.10%

- Delayed or cancelled time critical activity – 4
- Missed or delayed care - 2
- Ongoing work regarding flow within the acute service including IOL
- Work to be completed on the accuracy of data being inputted
- Note one red flag for no one to one care in labour on the antenatal ward. This incident was investigated and found to be a recording error. Guidance provided to staff on the completion of red flags on BR+.

7.3 Other perinatal staff exception reporting

Operational Performance

Impact of operational change

	Occurrence	Impact of Operational Change
Diverts out of Trust	None	
Crowborough Birth Centre suspensions	2 x Day – Unit Staffing and acuity 11 x Night – Community Staffing	2 Patients unable to delivery due to closures
Maidstone Birth Centre suspensions	1 x Day – Unit Staffing 2 x Night – unit Staffing	None
Home birth suspensions	2 x Day – Community Staffing 5 x Night – Community Staffing	No Patients affected

7.4 1:1 Care in Labour

1:1 Care in Labour (target 100%)	
Month	Achieved (%)
January	100%
February	100%
March	100%
April	100%
May	100%
June	100%
July	100%
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)

7.5 Delivery Suite Co-Ordinator Supernumerary Status

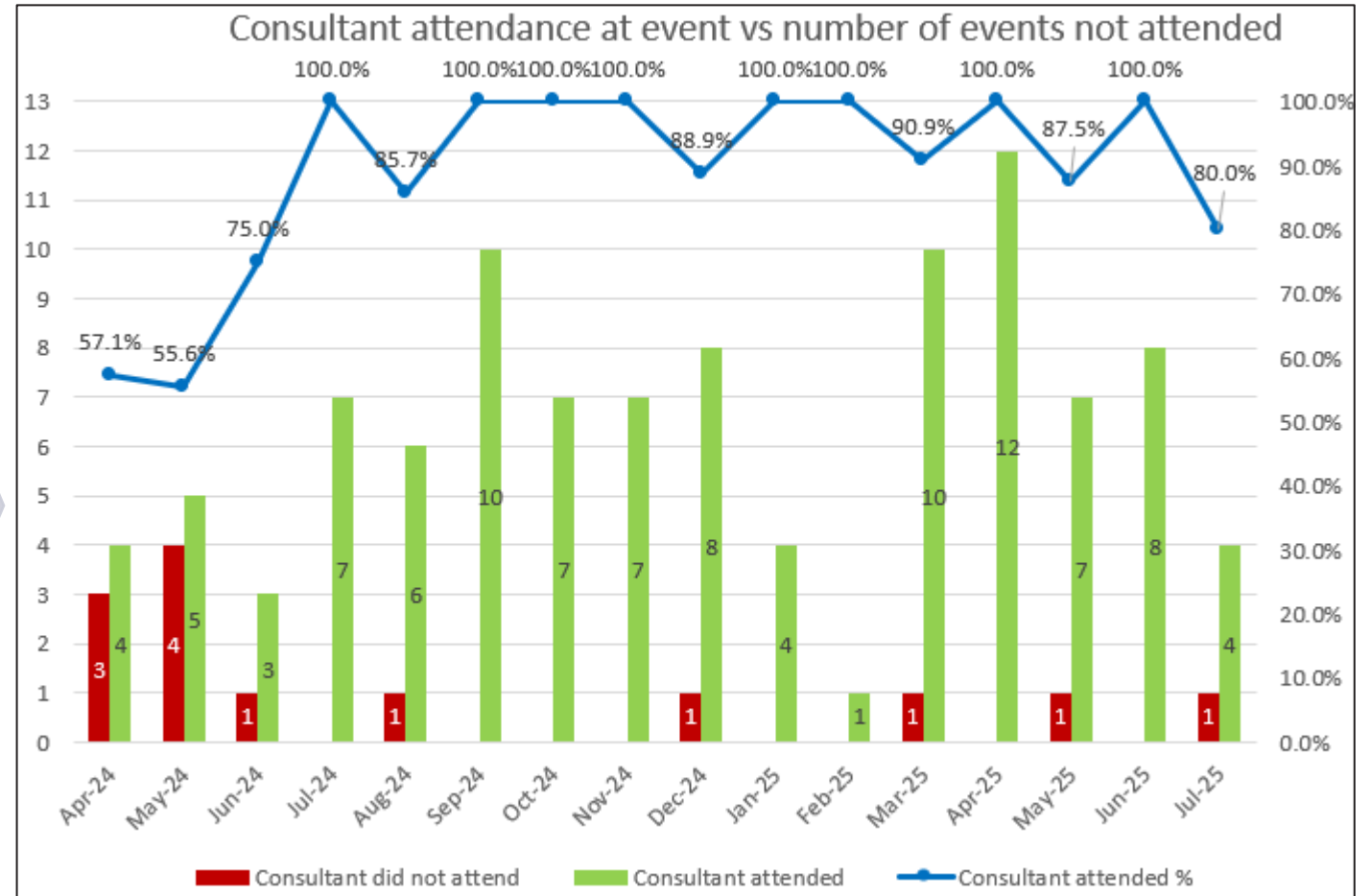
Supernumerary Maintained (target 100%)	
Month	Achieved (%)
January	100%
February	100%
March	100%
April	100%
May	100%
June	100%
July	100%
August	
September	
October	
November	
December	

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.

7.6 Consultant Attendance at Intrapartum event

July Data shows a 80% compliance for when a consultant MUST attend an intrapartum event.

1 missed case. 4th degree tear in the night. Feedback given.



7.7 Neonatal Unit Commissioned Cots & Nurse Staffing

July 2025 – registered and non registered nurses (including management/non clinical roles)

Staff group	Budget (WTE)	Staff in Post (WTE)	Vacancy (WTE)	Vacancy Rate %	Starters (WTE)	Leavers (WTE)	Staff Turnover %	Sickness Rate %
Nursing	51.5	42.5↑	9.0↓	17.5%↓	2.0↑	0↓	4.4% ↓	6.0% ↑

Care Location	NNU Unit Designation	Commissioned Intensive Care (IC) Cots	Commissioned High Dependency (HD) Cots	Commissioned Special Care (SC) Cots	Commissioned Transitional Care (TC) Cots
The Tunbridge Wells Hospital at Pembury	LNU (level 2)	2	4	12	0
Total	18cots	2	4	12	0

Quarter 4 Neonatal Staffing Tool (Submission May 2025)

Agreed Standard:
QIS nurses required to meet BAPM recommendations: 70%

Current position to meet activity at 80% capacity:
Requirement vs in post – variance is -12.24

Neonatal Commissioned Cots:
Advised increase of 2 HDU cots and reduction in 1 SC cot based on activity.

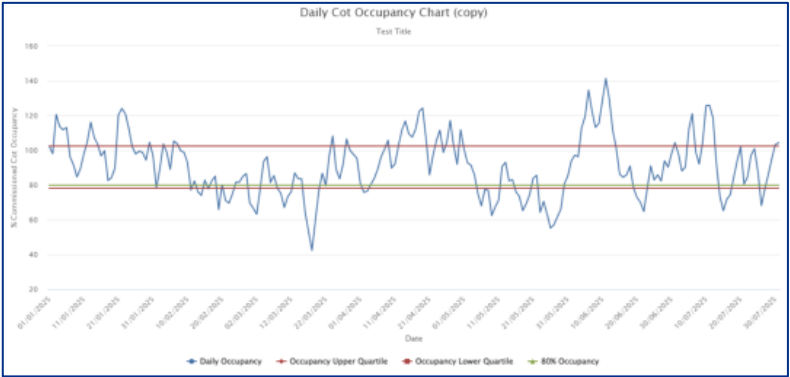
7.8 Neonatal Unit Nurse Staffing – by month

Month (2025)	% shifts with supernumerary shift leader		% shifts staffed to BAPM recommendations		% shifts covered by bank		Additional shifts required to make all shifts BAPM compliant
	MTW	National (level 2)	MTW	National (level 2)	MTW	National (level 2)	MTW
January	11.1	66.1	75.93	86.52	14.32	7.88	11.3
February	7.32	66.71	100	82.48	9.12	8.73	0
March	17.74	66.23	74.19	85.26	13.82	9.14	11.4
April	28.57	67.98	76.19	87.27	13.85	7.33	10.8
May	36.17	69.9	95.74	88.86	6.17	7.48	0.6
June	33.96	71.44	77.36	85.17	16.09	7.61	5.9
July	48.98	71.27	81.63	85.01	18.97	7.19	4.2
August							
September							
October							
November							
December							

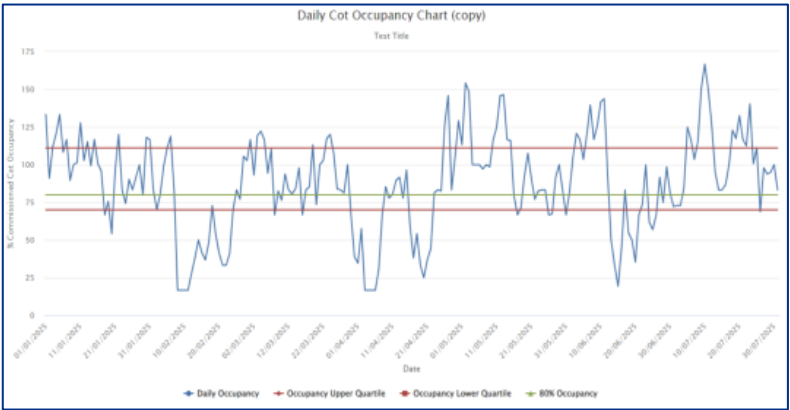
7.9 Neonatal Unit Occupancy

Month (2025)	No of days when unit occupancy exceeded 80% (maximum recommendation)		No of days when unit occupancy exceeded 100%	
	NOPEL RED		NOPEL BLACK	
	All cots	ITU/HDU	All cots	ITU/HDU
January	31/31	28/31	15/31	17/31
February	19/28	9/28	3/28	10/28
March	18/31	25/31	2/31	12/31
April	28/31	12/31	17/31	4/31
May	11/31	24/31	1/31	15/31
June	25/30	16/30	11/30	11/30
July	25/31	27/31	11/31	17/31
August				
September				
October				
November				
December				

Occupancy 1st Jan 2025 – 31st July 2025 – All cots



Occupancy 1st Jan 2025 – 31st July 2025
ICU/HDU cots



8. Safety Champions meeting

8.1 Meeting Log

Date	Role	Attendance
02/07/2025	Maureen Choong- Board Safety Champion	Yes
	Jo Haworth Board Safety champion	Yes
	Wunmi OGUNNOIKI, Perinatal Obstetric Lead	Yes
	Rachel Thomas, Perinatal Midwifery lead/Perinatal management lead	Yes
	Lou Mair, Perinatal neonatal lead	No
	MNVP lead	No

8.2 Safety Champions feedback

Feedback raised by staff	Action and progress
Culture on delivery suite feels very different to the birth centres. There is a disparity between the MSW duties in the birth centres to those who work on Delivery Suite. MSWs feel very useful at the birth centres and think that delivery suite MSWs could have their roles enhanced.	Workforce lead to send out a survey to MSWs to gauge retention data & DOM to take to delivery suite matron for consideration
Staff feedback that there are more and more stickers and additional paperwork introduced when there is a safety recommendation	Establish on average number of stickers used and additional proformas
Feedback raised by service users	Action and progress
Nil	Nil
Nil	Nil
Additional safety champions intelligence	Action and progress
Nil	Nil

8.3 Themes and progress with Cultural surveys or equivalent

Bi-monthly meetings between Board Safety Champions and Perinatal Leadership Team taking place. Meetings took place on 22 April 2025 and 27 June 2025, at which the Perinatal Culture Leadership Team shared the Culture Improvement Plan that has been developed in response to staff feedback. A summary of progress against this plan is shared below.

Theme/Vision	Progress	Support requirements
To ensure that all perinatal staff understand the roles responsibilities and interrelationships of the perinatal leadership group, directorate and divisional triumvirates and roles.	1. Development of communication materials 2. Increase visibility of leadership 3. Reinforce understanding and engagement	None identified at present
Leaders communicate clearly so staff understand how and why decisions are made. Staff feel able to share ideas and be involved in change.	1. Continue to gather feedback from staff surveys and walkabouts 2. Implementation of congratulation and success stories within division 3. Standardise take 5 format 4. Implementation of PFIS in NICU and birth centres 5. Divisional A3 project underway to improve information sharing	None identified at present
Focusing on fostering a positive and inclusive workplace culture by promoting respectful communication, understanding diverse perspectives, increase awareness and its impact on staff, staff feel empowered to challenge inappropriate or uncivil behaviour, tools and how to access them.	1. Develop clear statement of expectations for respectful behaviour and inclusivity. 2. Deliver training and launch internal campaign on civility in the workplace. 3. Ensure clear reporting structures for inappropriate behaviour. 4. Establishment of peer champions or respect ambassadors to model positive behaviour and provide peer support.	None identified at present

9. Insights from service users and Maternity & Neonatal Voices Partnership 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 - Communication and Personalised Care A training session strengthen staff communication and embed personalised care principles commenced in January 2025 for midwifery teams. Doctors and theatre teams have received tailored training on consent and personalised care, with a focus on respectful communication. A quarterly training delivery model is currently being scoped in collaboration with the obstetric link to ensure ongoing access and consistency across staff groups. To further support these efforts, a set of new infographics has been introduced across maternity settings. These visual tools are designed to aid conversations between staff and service users, reinforce key personalised care principles, and support informed decision-making and consent. They complement clinical discussions by presenting complex information in an accessible, user-friendly format.
Lack of clarity in decision-making	Identified a need to support service users in understanding choices and implications	Enhanced Decision-Making Support To improve clarity in decision-making, we are using infographics to visually present complex clinical information, available options, and associated outcomes. These tools help patients better understand their care pathway and make informed choices. Staff training now includes a focus on shared decision-making and active listening to ensure that service users feel fully informed and involved.
Discharge logistics	Identified inefficiencies in flow and communication during discharge processes	Flow and Discharge Improvement Work is ongoing to improve patient flow and discharge processes within maternity services. This includes targeted action to address delays, ensure timely communication, and enhance continuity of care during transitions between departments and services.

9.1 CQC national maternity survey action plan 2024/5

Theme	Progress	Support requirements
Ensure service users feel their concerns in Triage are taken seriously and addressed	- Standardise processes for handling patient concerns raised during triage, ensuring consistent responses. (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Ensure complaints are addressed on time and that key learnings are identified and implemented. (ongoing)	Input from Obstetric team required to implement regular training for Doctors.
To ensure service users feel supported and informed about their labour and birth, including pain management, both immediately after birth and during recovery.	- Provide service users with opportunities to ask questions about their birth experience, ensuring they feel informed, supported, and listened to. (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Adequate and Equitable Pain Management (ongoing) - Information and Accessibility (ongoing)	Lack of midwifery led debrief service to be added to Risk Register
Ensure feeding choices are respected and supported	- Strengthen Feeding Support (ongoing) - Guideline review (complete) - Communication & Advocacy (ongoing)	None identified
Improve feeding support and ensure service users feel heard by midwifery staff	- Strengthen Feeding Support (ongoing) - Implement training for staff on active listening and empathetic communication (ongoing) - Feedback & Continuous Improvement (ongoing) - Provide service users with opportunities to ask questions about their birth experience, ensuring they feel informed, supported, and listened to. (ongoing)	None identified

9.2 Additional Service User feedback- Maternity

Debriefs / Birth Afterthoughts	Action and progress
No midwifery led debrief service	
Friends and Family test	Action and progress
Negative: - Poor and inconsistent communication - Continuity of care - Clarity in decision-making - Discharge logistics. Positive: - Outstanding care - Supportive and compassionate staff - Clean facilities - Effective feeding support - Good partner inclusion.	- Feedback from FFT continues to be shared with ward managers and frontline maternity staff. This ensures that both positive comments and areas for improvement are visible and actionable at service level. Ongoing improvement initiatives are aligned with both the MNVP workplan and the MTW Maternity Service User Improvement Plan, ensuring a joined-up approach to patient experience and service quality. BRAINS Poster Rollout/Infographics - Supporting Informed Decision-Making The BRAINS decision-making framework has been visually promoted through new ward posters. These were co-designed with service users and MNVP representatives to support more informed and collaborative discussions between patients and clinical staff. Rollout is underway across all maternity sites. Staff Training - Communication and Personalised Care A training programme to strengthen staff communication and embed personalised care principles commenced in January 2025 for midwifery teams. Doctors and theatre teams have received tailored training on consent and personalised care, with a focus on respectful communication. A quarterly training delivery model is currently being scoped in collaboration with the obstetric link to ensure ongoing access and consistency across staff groups. Flow and Discharge Improvement Work is ongoing to improve patient flow and discharge processes within maternity services. This includes targeted action to address delays, ensure timely communication, and improve continuity of care during transitions between departments and services.
Complaints and Compliments	Action and progress
Number In month: 7 Number open: 20 Breached: 1 Themes: - Clinical treatment/poor standard of care - Incorrect/inappropriate advice	On track to respond on time/LRM organised.

9.3 Additional Service User feedback – Neonatal

Friends and Family test	Action and progress
Not in use	
Neonatal ODN Parent Experience Survey	Action and progress
“The staff we encountered during our stay were fantastic. We still talk about them now and the positive impact they had on a traumatic time for our whole family.” “As silly as this sounds, the staff encouraged us to be our son’s parents-they were there for medical needs or any questions we had, but they were happy, once they had shown us how to set up feeds on the NG tube etc, to let us do everything for ourselves and learn about our son as best we could”.	Positive feedback shared with team
Complaints and Compliments	Action and progress
Number In month: 0 Number open: 0 Breached: 0 Themes: N/A	

10. Saving Babies Lives v3.2



	Compliance Q7	Compliance Q8	Progress / action	Responsible (role)	By when
El 1: Smoking in pregnancy	70%	70%	1.4 – Compliance for opt out referrals for smokers is increasing and approaching target value. 1.6 – Quit targets continue to be challenging, action plan in place. 1.9 – Staff training for VBA below minimum requirement of 90%.	Smoking in pregnancy midwife	
El 2: Fetal growth	90%	95%	Element 2.7 not implemented – Uterine artery dopplers not in current pathway. Review of USS capacity ongoing.	Fetal wellbeing midwife	
El 3: Reduced fetal movement	100%	100%	Fully implemented with mitigation for next working day USS for RFM. Initial data for Q9 shows reduction in compliance with mitigation for El 3.2b which could affect future assessment. Continued work required to improve USS provision.	Fetal wellbeing midwives	
El 4: Fetal monitoring	60%	80%	Projecting 100% compliance next quarter.	Fetal monitoring midwife	
El 5: Pre-term births	93%	96%	5.6 – Multiple pregnancy guideline does not currently include cervical length screening.	Pre-term lead midwife	
El 6: diabetes in pregnancy	83%	83%	6.2 – Requirement for named diabetes consultant and named diabetes nurse who are trained to onboard women with HCL, with plans in place to ensure that relevant members of diabetes MDT are also competent to onboard women with HCL. Action plan required.	Diabetes in pregnancy midwives	
Total	86%	90%	Q9 submission due September 2025.		

11. Progress in achievement of Maternity Incentive Scheme 10 safety actions

	RAG	Current Position
SA1 – Perinatal mortality reporting		Quarterly PMRT reports demonstrate compliance against safety action.
SA2: Digital / data		Safety action expected to meet compliance with MSDS data submission.
SA3: Transitional care		Data collection processes improved, but ATAIN processes still require improvement and streamlining. New QIP relating to early identification of jaundice in non-white babies to be undertaken.
SA4: Medical staffing		Medical workforce audits relating to locums, compensatory rest, and consultant attendance take place monthly and reported in PQSM/PQOM. To be presented in November workforce report to Board.
SA5: Midwifery staffing		Bi-annual workforce report presented to Trust Board in June, with next due November.
SA6: NHS England Saving Babies' Lives care bundle		Continued improvement trajectory seen in Q7 and Q8. Q9 submission currently being prepared and some reductions in compliance noted, particularly Element 3.2b. Key challenges relating to USS capacity will prevent full compliance with SBLCB and could threaten future improvement work.
SA7: Maternal and neonatal voices		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. Discussed at Trust Board in May.
SA8: Training		Neonatal team not delivered NLS training including BAPM compliant assessment since the start of the relevant period. Also drop in training compliance for neonatal consultants and doctors. Plan in place to capture consultants and Trust doctors in July to improve compliance. Education team provided training compliance projections in the lead up to MIS 30 November deadline. Commitment in place to ensure training compliance of any new starter medical staff who commenced with the Trust after 1 July 2025.
SA9: Board reporting, escalation and oversight		Safety Action 9: Perinatal leadership team progressing with culture improvement plan, bi-monthly meetings with Board Safety Champions taking place. Board Safety Champions meet monthly for walkabouts with additional listening events. New PQOM format being introduced.



12.0 Trust transitional care

If not already compliant, add in evidence of progress with action plan to move to the transitional care pathway based on BAPM framework for babies from 34+0. Timescales for implementation and progress.

We are compliant with SA3 and adhere to BAPM framework



13. Maternity Risk Register

(Extracted from risk register, rated 8 and above)

Closed

3072- The current interpreting service provided by the Trust does not fulfil the needs of the maternity services at MTW.

New Risks

Nil

Amended risk scoring following review

Nil

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	31.07.2025
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	16	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
3429	A fully functioning and commissioned MNVP (Maternity and Neonatal Voices Partnership) may not be in place by Year 7 of the Maternity Incentive Scheme.	15	10	5	07.05.2025	31.03.2026
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	07.10.2025	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

13. Neonatal Risk Register

(Extracted from risk register, rated 8 and above)

Risk	Grading June 2025	Current Grading	Actions/Comments
Lack of speech and language therapy provision for neonatal and paediatric areas	16	12	KCHFT withdrew support in April 2025. Discussion under way with EKHUFT for collaborative service. All issues to be logged on <u>InPhase</u> . SLT now available on staff bank to mitigate some risk allowing reduction in risk rating
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, with one line of work recently recruited to. Risk will be closed in July and replaced with new risk (neonatal unit not compliant with BAPM standards)
Inadequate governance provision & policies and guidelines out of date/requiring review	12	12	Risk increased last month as the compliance had 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. There is only dedicated neonatal governance cover for 7.5hrs per week.
Lack of psychology support for families/staff on NNU	9	9	Bank post recruited to for 2 days per week, but awaiting start date Need for substantive post to be added to BAPM business case Risk will be closed in July and replaced with new risk (neonatal unit not compliant with BAPM standards)
There is a shortage of non-invasive respiratory support equipment (<u>vapo</u> therm)	9	9	Equipment funded by emergency capital funding bid and league of friends. Awaiting device to arrive in Trust.

Closed:

New Risks:

Nil

**Amended risk
scoring following
review:**

Nil



14. Recommendation

Please refer to 3A.

Claims Score Card

Q1

Report date: July 2025		Report Lead: Jessica O'Reilly	Actions:
1a	Alert (Include actions taken and mitigation)	Claims data 4 claims were closed with damages awarded under the categories of : Failure to perform earlier CTG monitoring, Failure to diagnose and repair a 3rd or 4th degree tear, Failure / missed opportunity to review the "GAP/GROW" and Failure to identify and repair labial tear 0 inquests were closed Complaints - There was an increase in the volume of complaints in May 2025 (11 complaints) with 21 across Q1. Key themes of communication failures, clinical treatment concerns, and staff behaviours. Investigations closed and reports published 6 Investigations closed in Q1 (5 AAA's and 1 Reflective Discussion) 2 MNSI Reports published in Q1 8 PMRT Reports published in Q1 Triangulation of themes - Fail/delays to treatment consistency highest cause in claims data. Links to themes of fetal monitoring and communication. - Fetal monitoring issues included loss of contact, equipment issues, failure to review and failure to escalate. - Communication an ongoing theme through claim and complaint data. Relates to communication with women (lack of/inconsistent information, not listening) and with staff (handover, escalation).	Claims data Complaints 9 Complaints closed, 12 under review - Of the closed complaints: 1 complaint upheld, 1 apology given, 1 not upheld but learning identified. Investigations closed and reports published - Action plans produced Triangulation of themes - Fetal monitoring training has been updated to reflect themes identified, including human factors, escalation processes and correct use of equipment. - Mandatory training updated to include consent, communication, civility, with service user voice threaded through learning, - Changes made to SBAR handover documentation, additional training arranged for birth centre staff relating to emergencies and transfers. - Audit of psychological safety of junior staff and clear guidance on when senior input required.

Claims Score Card

Q1

Report date: July 2025		Report Lead: Jessica O'Reilly	Actions:
1b	Assurance	Plans in place to review ethnicity and social deprivation as part of triangulation in next report.	
1c	Advise	Investigations commissioned and claims opened 2 PSII's and 3 AAR's commissioned 2 MNSI Referrals 3 PMRT Cases reported to MBRRACE 2 claims opened 1 Inquest opened	Investigations commissioned and claims opened Initial review indicates theme of MDT communication in AAR's. PSII immediate actions undertaken, including assurance that SECAMB to ensure all ambulances stock transwarmers. Communication sent to staff reminding of need to document maternal pulse in second stage.

Triangulation of complaints, claims and serious incidents against the Claims Scorecard

Executive Summary

This report is a review of maternity complaints, serious incidents and claims data from 1 April 2025 – 30 June 2025, against the Trust's Claims Scorecard. The aim is to examine themes and trends identified, and any actions taken to reduce the risk of re-occurrence, improve patient safety and reduce the cost of litigation. For discussion by Board Level Safety Champions at a Trust level, to give assurance that safety issues are being addressed.

Overview of findings

Key theme of communication apparent throughout incident and complaint data. Linked themes include handovers and escalation, consistency of advice, and civility. Key theme of fetal monitoring apparent throughout claim and complaint data. Linked themes include timely review, quality of monitoring, and escalation.

Actions Identified

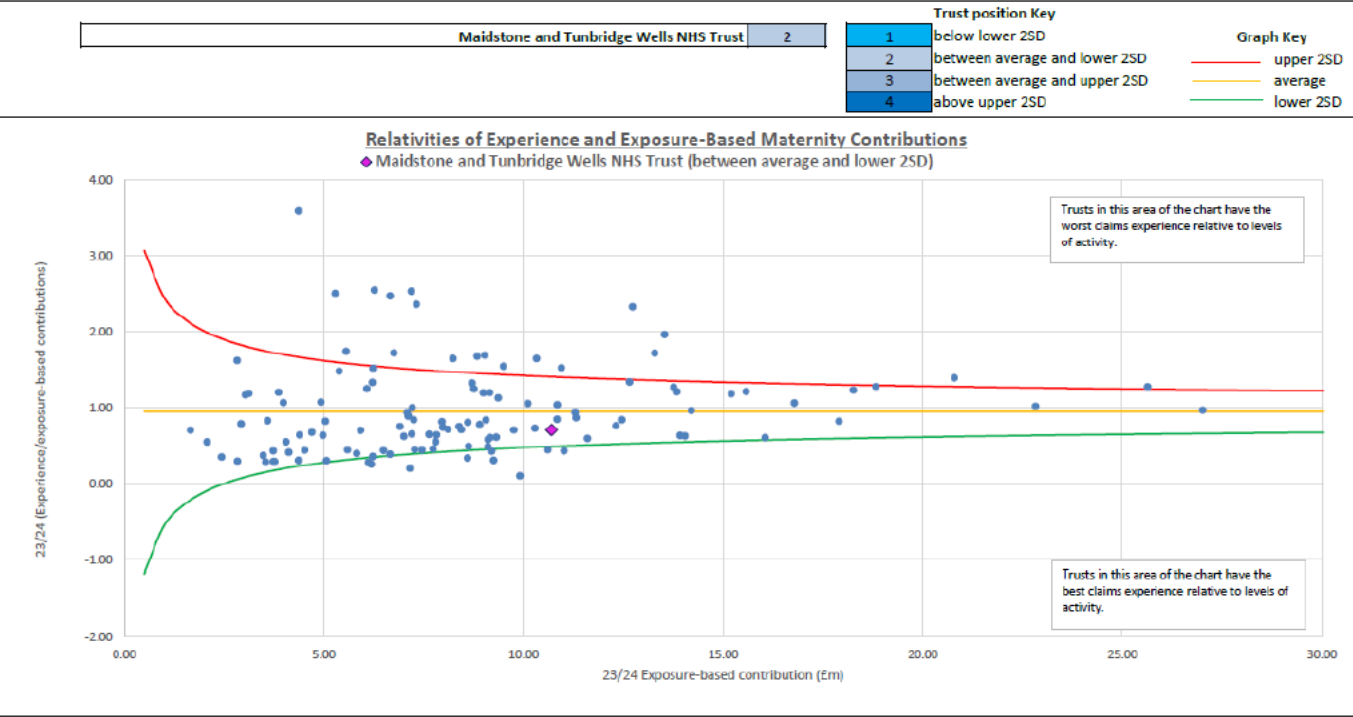
Fetal monitoring training updated to reflect themes identified, including understanding and response when there is a loss of contact or difficulty auscultating the fetal heart. Immediate learning was shared, with longer term learning ensured through incorporation into annual training. The learning outcomes address human factors, escalation processes and correct use of equipment. Mandatory training updated to include consent, communication, civility, with service user voice threaded through learning. Changes made to SBAR handover documentation, additional training arranged for birth centre staff relating to emergencies and transfers. Audit of psychological safety of junior staff and clear guidance on when senior input required.

Next steps

Data regarding ethnicity and social deprivation currently being triangulated will be published in next report.

Top injuries by volume: - Stillborn (9) - Additional/Unnecessary Operations (6) - Brain injury (6) - Psychological Harm (6) - Unnecessary Pain (5)	Top injuries by value: - Brain injury (6) - Cerebral Palsy (3) - Hypoglycaemia (2) - Multiple Injuries (2) - Unnecessary Pain (5)
Top causes by volume: - Fail/Delay Treatment (16) - Fail/Delay Diagnosis (7) - Fail to Recog. Complication of (5) - Not Specified (4) - Fail Antenatal Screening (3)	Top causes by value: - Fail/Delay Treatment (16) - Delay in Performing Operation (2) - Fail/Delay Admitting to Hospital (1) - Failure/Delay Diagnosis (7) - Fail Antenatal Screening (3)

Maternity



A vertical axis value of the experience/exposure-based contributions close to 0 indicates that the trust's claims experience is in line with expectations given the level of activity (in this case the number of births) for the trust. A positive value suggests that the trust has had a worse claims experience than expected given its level of activity, while a negative value suggests that the trust has had a better claims experience than expected given its level of activity.

Claims scorecard 10 Year Data Overview

This chart demonstrates top five claims based on injuries, causes, volume and value.

- Top injuries by volume reveal key trends in incidents. It is of note that additional/unnecessary operations and psychological harm are reported as often as brain injury, yet brain injury contributes 45% of the total claim value.
- Top causes by volume demonstrates the prevalent theme of fail/delay in treatment, with fail/delay diagnoses and fail to recognise deterioration coming second and third respectively.
- Top injuries by value account for 90% of total claim costs, despite representing just 27% of cases. These findings highlight the need to prioritise prevention, early intervention, and escalation in high risk maternity cases.
- Top causes by value demonstrates the prevalent theme of fail/delay in treatment.

This chart provides a benchmarking analysis of Maidstone and Tunbridge Wells NHS Trust’s maternity claims against other trusts in the NHS.

Maidstone and Tunbridge Wells NHS Trust is highlighted in purple on the chart. The Trust’s maternity services are positioned between the average and lower 2SD lines, indicating performance that is better than average relative to the level of activity. This suggests that the Trust has experienced fewer or less severe maternity claims than would be expected, based on the volume of births and overall activity.

This favourable position reflects strong performance in maternity risk management and is a positive indicator of clinical safety, governance, and overall quality of care.

Claims opened and closed in Q1

	No.	Damages paid (claims closed)	Themes/categories
Claims opened	1	-	
Inquests opened	1	-	
Claims closed	4	Yes	1. Theme: Failure to perform earlier CTG monitoring 2. Theme: Failure to diagnose and repair a 3rd or 4th degree tear 3. Theme: Failure / missed opportunity to review the "GAP/GROW" 4. Theme: Failure to identify and repair labial tear
Inquests closed	0	-	-

Learning from closed investigations in May (PSII and AARs)

#	Description	Ethnicity	Postcode deprivation decile	Learning and actions
#30030	Investigation: PSII downgraded to AAR 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	8	There is confusion amongst staff who is responsible for checking blood results on the antenatal ward Antenatal handover sheet to have section added for blood tests – in use
#30190	Investigation: Reflective discussion Mother experienced 3b tear and 1700ml PPH. Forceps performed by a ST2 supervised by an ST3	White: British	10	- To make it clear to all doctors in training that the supervision of a junior doctor can only be performed by and ST5 and above. This will be implemented through reinforcement in clinical governance meeting, directorate email and supervision policies being added to the departmental handbook. - To try and standardise the approach that a senior registrar (ST5+) will always be present (if acuity allows) during deliveries in theatre to support the psychological safety of the junior doctor and to be ready to support if required. Audit of percentage of theatre deliveries where an ST5+ was present, survey feedback from junior doctors on perceived supervision and psychological safety.
#34331	Investigation: AAR Baby found to have skull fracture and experienced seizures following emergency LSCS.	Any other mixed background	7	- Staff do not feel confident in what to expect or monitor for if there is a risk of a skull fracture Case to be presented at Clinical Governance - Handover should include more details of the patient's birth especially if it was considered difficult- it was not reportedly handed over that the birth was difficult SBAR handover to be enhanced - Seizures in newborns are difficult to recognise and staff do not feel confident in recognising them and wish for training or simulations in how to recognise seizures in newborns To add recognition of neonatal seizures to mandatory training - Staff suggested a new practice of newborns having 24 hours of observations if they have experienced a difficult birth such as this. To review guideline

Learning from closed investigations in June (PSII and AARs)

#	Description	Ethnicity	Postcode deprivation decile	Learning and actions
#37542	Investigation: AAR 3.3L oral fluid intake in labour resulting in hyponatraemia	White: British	6	- If a patient is not passing urine as expected or there are concerns over ketone levels, a fluid balance chart should be used. Fluid balance charts are now commenced on all women when they are admitted and confirmed in labour - Staff and patients are being educated on the importance of drinking to thirst rather than aiming for a specific volume. Information shared with community teams regarding education. Inclusion within latent phase of labour patient information leaflet. Discussed with women at birth choices appointment and parent education classes. - There is no guideline on how to manage potential hyponatremia. There is no national guidance for the management and hyponatremia within maternity care. Currently scoping with LMNS. - Transferred patients must always be admitted to delivery suite not triage. - Obstetric review must happen within 1 hour of arrival following transfer. - Blood results must be reviewed in a timely manner. Transfer of care guidance being reviewed, SBAR tool
#32197	Investigation: AAR 3L PPH. Twin birth 1 SVD and Twin 2 LSCS	White: British	1	- Limited updates of ongoing measured blood loss Theatre team to document on white board in Obstetric Theatre all uterotonics given, blood products and timings. Learning to be shared with team. - Delay in Code Red - No timely escalation to on-call consultant - Staff need to be aware of what's being given in theatre. Theatre staff to communicate actions for scribing - PPH proformas are not in theatre and staff reported they are not user friendly - Staff to have more rapid access to blood issued Learning shared through GLOW, PROMPT Training, PPH Guideline updated to clarify requirement for Consultant attendance (> 1500ml, when Consultant on-site, > 2000ml when Consultant off-site).
#34013	Investigation: AAR 1.6L PPH – CBC transferred to TWH	White: British	4	- Highlight the need for early recognition of emergency situations and process to follow - Emergency transfer must be the priority on recognition of emergency - Improvement in communication, staff to clearly communicate during incidents and before leaving shift - On call staff to be called in to assist when support is required - Need for early cannulation and perineal check to reduce delays Skills drills with this focus at birth centres, PROMPT Training, feedback to staff involved, learning with wider team via Take 5.

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?

PMRT Reports Published Q1

Summary of case	Grading of care	Issues	Actions
Intrapartum IUD @ 38+1 Antenatal diagnosis of anencephaly at dating scan	B- Until baby up until the point the baby died A- 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)	GLOW sent out Individual learning to booking midwife
Antenatal IUD @ 27+6 of one twin Routine USS @ 27+6 showed IUD of one twin, pregnancy continued until labour @ 30+0	B- Until baby up until the point the baby died A- 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	Quality improvement project started with community, antenatal clinic, fetal wellbeing and patient safety to review process and improve care
Antenatal IUD @ 29+5 Admitted via ambulance with abdominal pain and IUD confirmed on USS	B- Until baby up until the point the baby died A- 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.	Fetal wellbeing team are auditing this monthly and reporting through SBL
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	A- Until baby up until the point of birth A- Until baby up until the point the baby died A- Following confirmation of the death of her baby	None	N/A

PMRT Reports Published Q1

Summary of case	Grading of care	Issues	Actions
Antenatal IUD @ 34+6 Attended triage with abdominal pain and IUD confirmed on USS	B- Until baby up until the point the baby died A- 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 This mother had gestational diabetes but it was not managed appropriately	Glow sent to all staff Diabetes team are reviewing processes for non English speaking women with GDM
Antenatal IUD @ 38+4 RFM at 38+4 when IUD was diagnosed	B- Until baby up until the point the baby died A- 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.	Bereavement guideline being updated and will include clear guidance of scanning for confirmation
Antenatal IUD @ 24+3 Anomaly USS showed HC <5 th centile. Repeat USS in 4 weeks showed IUD	A- Until baby up until the point the baby died A- Following confirmation of the death of her baby	No learning	N/A
22+0 IUD	B- Until baby up until the point the baby died A- Following confirmation of the death of her baby	This mother lives with family members who smoke but they were not offered referral to smoking cessation services	Fetal wellbeing team to send out a reminder to all staff to ensure they discuss and document VBA for smoking households and referral pathway for family members who smoke

Complaints – Q1 2025 Review

Between April and June 2025, a total of 21 maternity service complaints were logged, reopened, or progressed. Complaints predominantly relate to **communication failures, clinical treatment concerns, and staff behaviours**. The majority of cases highlight issues around:

- Lack of information or inconsistent communication with patients.
- Poor pain management and obstetric care standards.
- Perceived lack of respect for patient preferences, including failure to follow birth plans.

Status at time of writing report: 9 complaints closed, 12 remain open or under review (local resolution meetings or directorate actions pending).

Common Patterns in Themes

- Communication remains the leading theme in complaints (55%)
- Pain management and patient autonomy (respecting birth plans and preferences) are recurring issues.
- Several complaints cite postnatal discharge and follow-up care as inadequate.

Top Complaint Issues Raised (from coded data):

Subject	Sub-subject	Frequency
Communication	Lack of information (patient-specific)	6
	Patient/relative not listened to	3
	Inconsistent or conflicting information	2
	Breakdown in communication	1
Clinical Treatment	Poor standard of obstetric care	5
	Inadequate pain management	2
	Infection risk/infection control	1
	Delayed treatment	1
	Poorly coordinated care/lack of continuity	1
Staff Behaviour	Staff attitude (nursing/midwifery)	2

Thematic Review of Complaint Descriptions

Based on qualitative analysis of complaint description, the following key themes were identified:

Theme	Key Examples	Frequency
Communication Failures	Discharge without clear advice, lack of consent for procedures, inconsistent messages.	9
Pain Management Issues	Insufficient pain relief during labour, concerns over speed of delivery.	3
Respect for SU Choice	Birth plans not followed, patient preferences ignored.	3
Staff Attitude and Behaviour	Abrupt tone, unsupportive midwives, dismissive interactions.	2
Clinical Standards	Poor obstetric care, infection risk, delays in diagnosis or treatment.	5

Complaints – Q1 2025 Review

Review of EDI data:

- All 21 complainants identified as female
- Age range: 23–42. Most common age group: 30–39 years (13 out of 21)
- **White British** representation: **71%** (15 out of 21)
- Over 50% of entries list language as "unknown", which limits meaningful analysis
- Almost no data captured on religion (1 Buddhist, 20 Unknown)
- Mental health-related conditions were disclosed in 14 out of 21 cases (67%)

Ethnicity	Count
White British	15
Any other White background	2
White Irish	1
Caribbean	1
Chinese	1
Indian	1

Condition	Count
Anxiety disorder	7
Depression (incl. mixed with anxiety)	5
EUPD (Emotionally Unstable Personality Disorder)	1
OCD	1
None	7

Language	Count
English	10
Unknown	11

IMD Decile	Frequency
1 (Most deprived)	1
4	5
5	1
6	4
7	3
8	2
9	3
10 (Least deprived)	1

Review of Index of Multiple Deprivation (IMD) Deciles

- Majority in Mid-Range: Most areas fall within deciles 4–7, suggesting a concentration in the mid-range of deprivation.
- Higher Deprivation Outlier: One postcode falls into decile 1, placing it among the most deprived 10% of neighbourhoods nationally.
- Higher Affluence: Three postcodes rank in deciles 9–10, indicating low levels of deprivation.
- Most Common Decile: Decile 4 appears most frequently (5 times), suggesting a cluster of slightly below-average conditions in terms of deprivation.

Complaint timing

- Recent and timely complaints: Most complaints (about 60%) were raised within 1-2 months of the care episode.
- The 2022 and 2023 cases (debrief and reopened complaint) - not upheld.

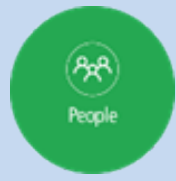
As of 29/07/25:

- **12** complaints remain ongoing or with the directorate, mainly involving delayed treatment, home birth protocols, and poor obstetric care.
- **1** complaint was upheld concerning a midwife's attitude during an ambulance handover.
- **2** complaints were not upheld, relating to gestational diabetes criteria and discharge advice.
- **1** complaint resulted in an apology for lack of advice on blood thinning injections.
- **4** complaints were closed after providing information, including debrief requests and explanations about infections.
- **1** complaint was closed due to insufficient evidence, but learning was taken forward regarding pain relief and partner presence during labour.

Triangulation of complaints, claims and serious incidents against the Claims Scorecard

Themes	Linked themes	Actions
1. Documentation	a. Partograms – maternal pulse b. Handover	SBAR documentation amended. GLOW sent out reminding of need to monitor maternal pulse in second stage, with learning shared with individual staff members where issues noted on review. GLOW sent out regarding measuring blood loss, learning also shared at prompt.
2. Fetal monitoring	a. IIA b. Interpretation c. Frequency d. Guidelines e. Equipment f. Loss of contact	Fetal monitoring study day designed to embed learning from incidents. Learning outcomes include (but are not limited to): • Human factors contributing to delays in recognising and responding to loss of contact. • Escalation processes in the context of fetal wellbeing and emergency response. • Correct use of equipment, with emphasis on: • Ensuring appropriate devices are available and functional. • Awareness that CTG machine attachments are not interchangeable, and using the correct one is essential.
3. Communication	a. Between staff – handovers – escalation b. Quality and consistency of advice to patients c. Informed consent regarding options of treatment/delivery/risks d. Staff attitude and behaviour	Review of processes underway relating to women accessing unscheduled advice during pregnancy. Consent and personalised care training within mandatory training day, service user voice within PROMPT training and at all meetings. Work ongoing regarding 2222 categories to ensure correct teams attends.
4. Delayed diagnosis/ treatment	a. Staffing issues b. Recognition of complications of treatment c. Continuity of care d. Equipment failures e. Insufficient pain relief in labour	Audit of supervision of junior members of staff, including supervision and psychological safety. All PPH's over 1500ml with significant care issues identified continue to be reviewed at PSIRG to ensure themes and learning identified. New drapes purchased which clearly measure blood loss whilst suturing.
5. Poor clinical care	a. Education/training/skills	GLOW sent out relating to postnatal observations. Review of guideline relating to neonatal observations following a difficult birth. Patient safety team Virtual Board established to share learning. Training at prompt on fluid balance and hyponatraemia.

Title of report	Learning from Deaths Report				
Board / Committee	Trust Board				
Date of meeting	25 September 2025				
Agenda item no.	09-17				
Executive lead	Sara Mumford				
Presenter	Sara Mumford				
Report Purpose (Please ☒ one)	Action/Approval	☐	Discussion	☐	Information ☒

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

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This paper focuses on national benchmarking mortality data at the Trust, statutory scrutiny by Medical Examiner service and the work of the Learning from Deaths Group.	
Any items for formal escalation / decision	No new concerns identified from National benchmarking data	
Appendices attached	None	
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 September 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 the outcomes of Mortality reviews are shared with clinical teams to learn from omissions in care and to highlight good 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 1), 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 currently not shared with families.

The current situation of completed and outstanding SJRs is shown in Figure 1. The table highlights all SJRs allocated and completed within the financial year 1 April 2025 – 16 June 2025 when this report was produced. Figure 1 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. There are currently no cases in the backlog.

Figure 1: Current SJR Position

LfDG SJR 25/26 Snapshot Position	Overdue for completion	Cases <4 Weeks under Review	Unallocated Cases	Total Caseload within SJR Process	Number of Completed Cases in 2025/26
September 2025	5	6	0	11	21

1.2 SJR Outcomes and Discussion

There were 11 cases referred for Structured Judgement Reviews (SJRs) in June, 10 in July, and another 10 in August. SJRs can now be raised for community deaths within 30 days of hospital discharge; there was one community death referred for an SJR discussed at the July LfDG meeting.

Figure 2: SJR outcomes (April 2025 - August 2025)

Month	Very Poor care	Poor care	Adequate care	Good care	Excellent care	Total
Apr-25	1	2	3	2	2	10
May-25	0	3	2	1	3	9
June-25	0	2	2	6	1	11
July-25	0	1	0	6	3	10
Aug-25	0	2	2	4	2	10
Total	1	10	9	19	11	50

1.3 Good Practice Identified

- **Mental Capacity and Communication:** Appropriate consideration was given to the Mental Capacity Act, with good communication maintained with the patient's relatives/next of kin (NOK).
- **Family Discussions and End-of-Life Care:** Good discussions were documented with the family regarding the patient's poor prognosis and the plan for palliation.
- **Involvement of Family and Carers:** Evidence of staff recognising the importance of, and actively involving, family members and carers to facilitate patient care.
- **Multidisciplinary Team (MDT) Decision-Making:** Excellent and timely decision-making demonstrated by all members of the MDT, including the Learning Disabilities Nurse, Outreach Team, and Palliative Care Team.
- **Senior Clinical Oversight and Escalation:** The patient received consistent senior review, with daily input from consultants and registrars. There was appropriate and timely escalation of care to ITU when the patient's condition deteriorated.
- **Early Treatment Escalation Planning:** An early decision was made regarding the treatment escalation plan, including ward-based care and a DNACPR order, reflecting good clinical decision-making and care.
- **Timely Comprehensive Geriatric Assessment:** A comprehensive geriatric assessment was carried out in a timely manner, resulting in a sensible and well-considered care plan, supported by excellent palliative care input.

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

Over the past three months, five cases were assessed as 'Poor Care' were discussed at the LfDG. Each case has had associated actions identified. One of these cases was referred to the Patient Safety team to determine whether it meets the PSIRF criteria for further investigation.

At the June LfDG meeting two cases rated as 'Poor Care' were discussed. These cases have been discussed at the Safety Grand Round and at directorate Clinical Governance.

In July, there was one case assessed as 'Poor Care' discussed at the LfDG meeting. This case related to a patient who died in the community within 30 days of discharge from MTW. Learning from this case is be shared across the Trust as there were themes affecting several directorates.

At the August LfDG meeting, two cases assessed as 'Poor Care' were discussed. The first case was referred to the patient safety team to determine if it met the PSIRF requirements for further investigation. In addition, sharing learning included, cases presentation at Grand Round and Clinical Governance meetings. In addition, staff involved in the patient's care have been contacted to support learning, and a review of the current policy on patient transfers will be undertaken to update it in line with the lessons learned from this case.

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

- Feedback to directorates through case presentation at Ground Rounds and Clinical Governance meetings to aid learning.
- Learning from poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates via discussion from Learning from Death 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.
- Excellent care is recognised with communication to individual and/or teams involved

1.6 Areas of concern

In total there were five SJRs rated 'Poor Care' discussed at the LfDG meetings over the last three months.

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
- 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 Completed Actions

- A survey was conducted among resident doctors to assess how safety messages are currently shared with them and gather their preferred options for learning. Although the response rate was low, with only 28 replies, key preferences emerged. The residents expressed a strong interest in learning through Grand Rounds, Safety Events, and a Safety Newsletter.
- Three additional SJR reviewers have now been recruited, bringing the total number of reviewers to full capacity.
- The InPhase SJR system is now live, with three cases allocated to reviewers through the new platform. Ongoing testing is being conducted to identify and resolve any issues as they arise. Additionally, data reports have been developed on the module dashboard to replace existing spreadsheets for storing and managing SJR information.
- The data analysis of sepsis cases from November 2023 to November 2024 was presented at the Medical Grand Round at TWH in August.
- Safety Grand Rounds are in place quarterly across each site.
- One of the Chief Registrars starting in October will be supporting Patient safety including Learning from Deaths Group.

1.8 Planned Actions

- A phased approach will commence to backfill manually completed SJRs since April 2025 into the InPhase SJR module. This process aims to ensure that accurate data is available within the system to support further testing of the reporting functionality.
- Safety Ground Round presentation of sepsis cases from November 2023 to November 2024 at the Medical Grand Round at MGH and the joint Surgical Clinical Governance meeting.
- Appoint a Learning from Deaths lead within Medicine and Emergency Care Division to attend the Learning from Deaths Group (LfDG) and present cases at Clinical Governance (CG) and Safety Rounds.

- A trust-wide learning toolkit is being created and to support ongoing education and improvement from the learning from deaths initiative.
- Next Safety Grand Rounds in January 2026 will be a review of patients with Learning Disabilities who have died at MTW.

2. Medical Examiner Service (Hosted by MTW)

The number of deaths sadly occurring in the Trust in March, April and May 2025 were 98, 105 and 117 deaths. Figure 3 compares death in the summer months of 2025 to the previous five years.

Figure 3: MTW 2021-2025 Deaths (May – August)

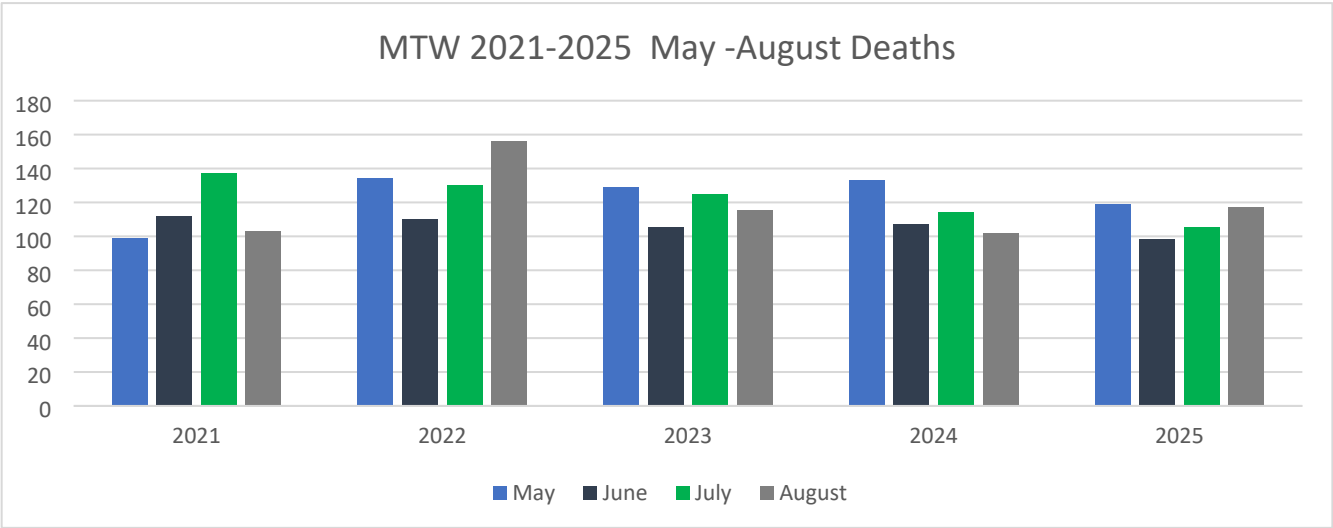


Figure 4: ME Scrutiny Vs Deaths and SJRs Raised

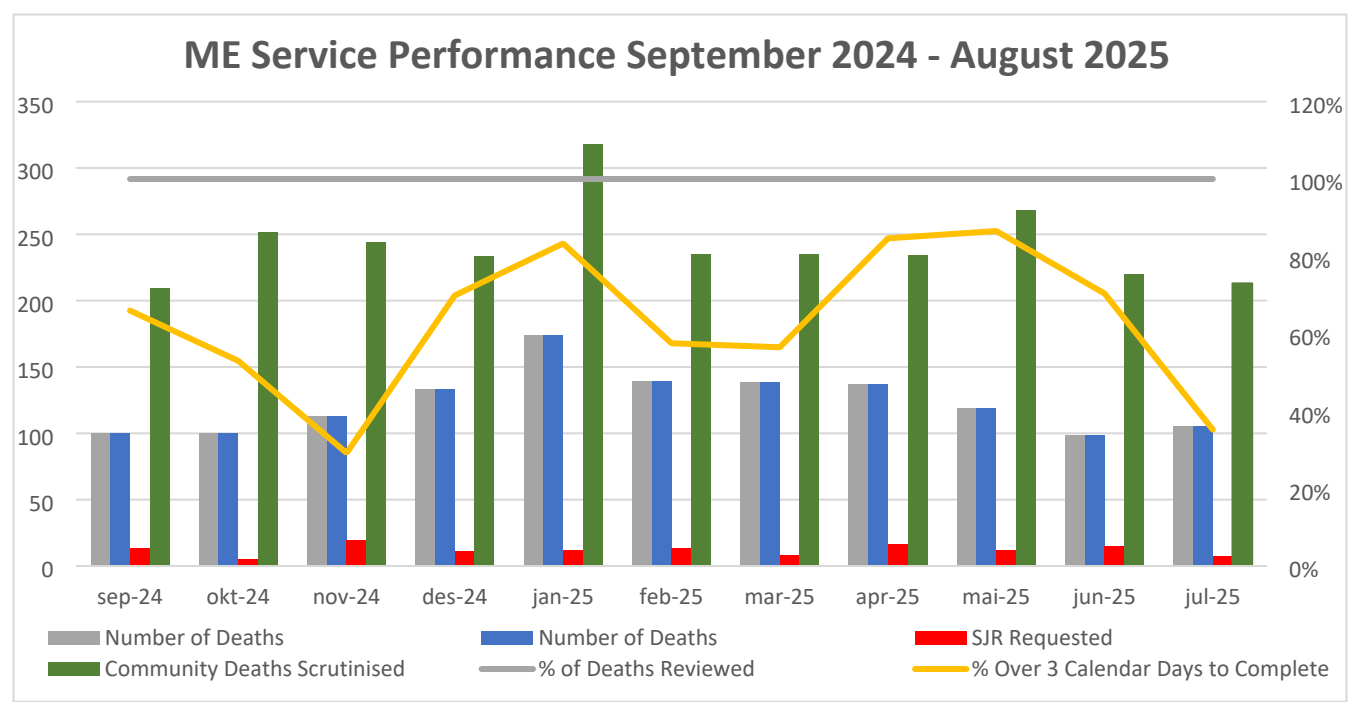


Figure 5: Deaths and ME data at MTW Mar 2025 - Aug 2025

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
Mar-25	138	138	100%	78	57%
Apr-25	137	137	100%	116	85%
May-25	119	119	100%	103	87%
Jun-25	98	98	100%	69	70%
Jul-25	105	105	100%	37	35%
Aug-25	117	117	100%	56	48%

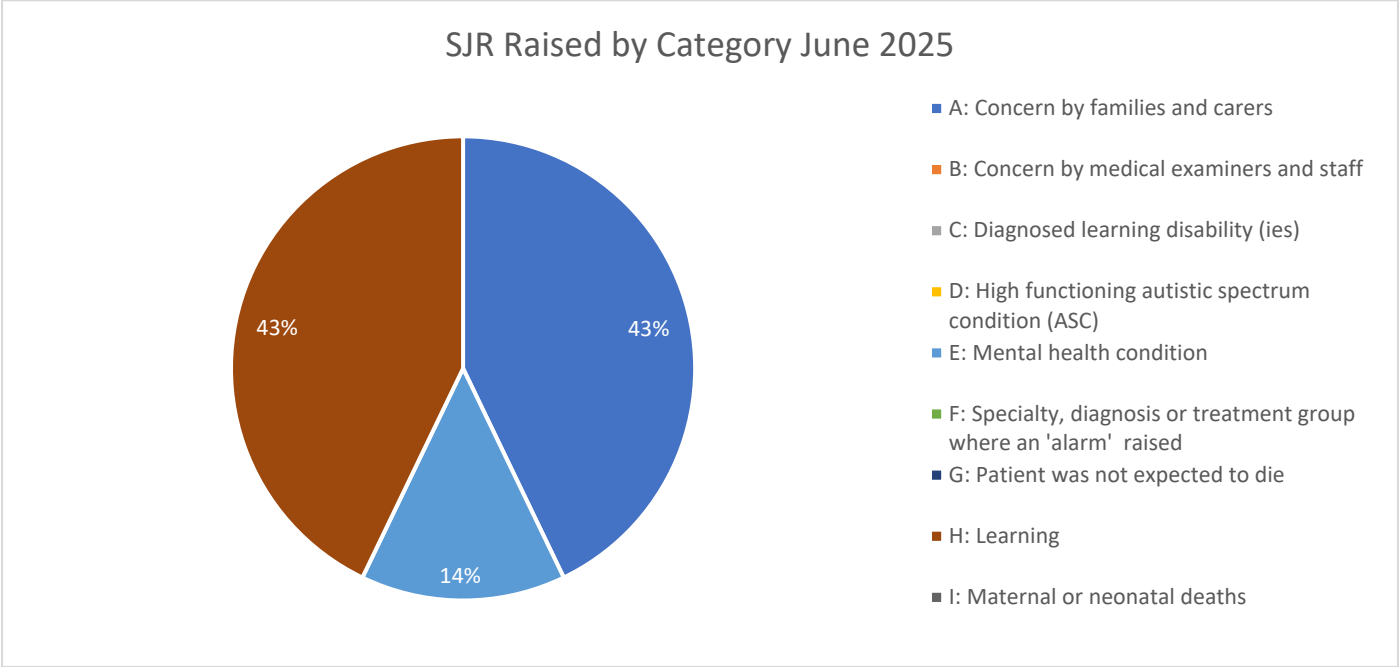
2.1 Medical Examiner (ME) Service Update

In June, July and August 2025, the percentage of cases which exceeded the three-workday performance target were 70%, 35% and 48% 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 three working days. However, the Service is experiencing a reduction in hospital referrals.

2.2 SJR Categories raised by ME Service

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

Figure 6: SJR Raised by Category



3. Benchmarking Mortality Data

The reporting period for this report covers hospital in-patient admissions from May 2024 to April 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 September 2025 by Telstra Health.

Figure 7: Summary of Data for May 2024 – April 2025

The Monthly Standardised Hospital Mortality Index (SHMI) data is updated monthly from NHS Digital's Indicator Portal. SHMI for the period Apr-24 to Mar-25 is 87.53 and 'as expected' (see Appendix 2)

Metric	Result
HSMR	83.06 (lower-than-expected) (78.31 – 88.03)
HSMR position vs. peers	Regional (acute, non-specialist) peer group = 18 trusts: 6 lower-than-expected 9 within expected 3 higher-than-expected Peer group = 97.8 (lower-than-expected) (96.5 – 99.1)
All Diagnosis SMR	79.2 (lower-than-expected)
Significant Diagnosis Groups	Acquired foot deformities (194 superspells; 1 death)
CUSUM breaches	Cancer of bone and other connective tissue disease (Jul-24)
Emergency Weekend HSMR	88.5 (lower-than-expected)
Emergency Weekday HSMR	81.0 (lower-than-expected)
SHMI position	(Apr-24 to Mar-25) 87.53 (as expected)

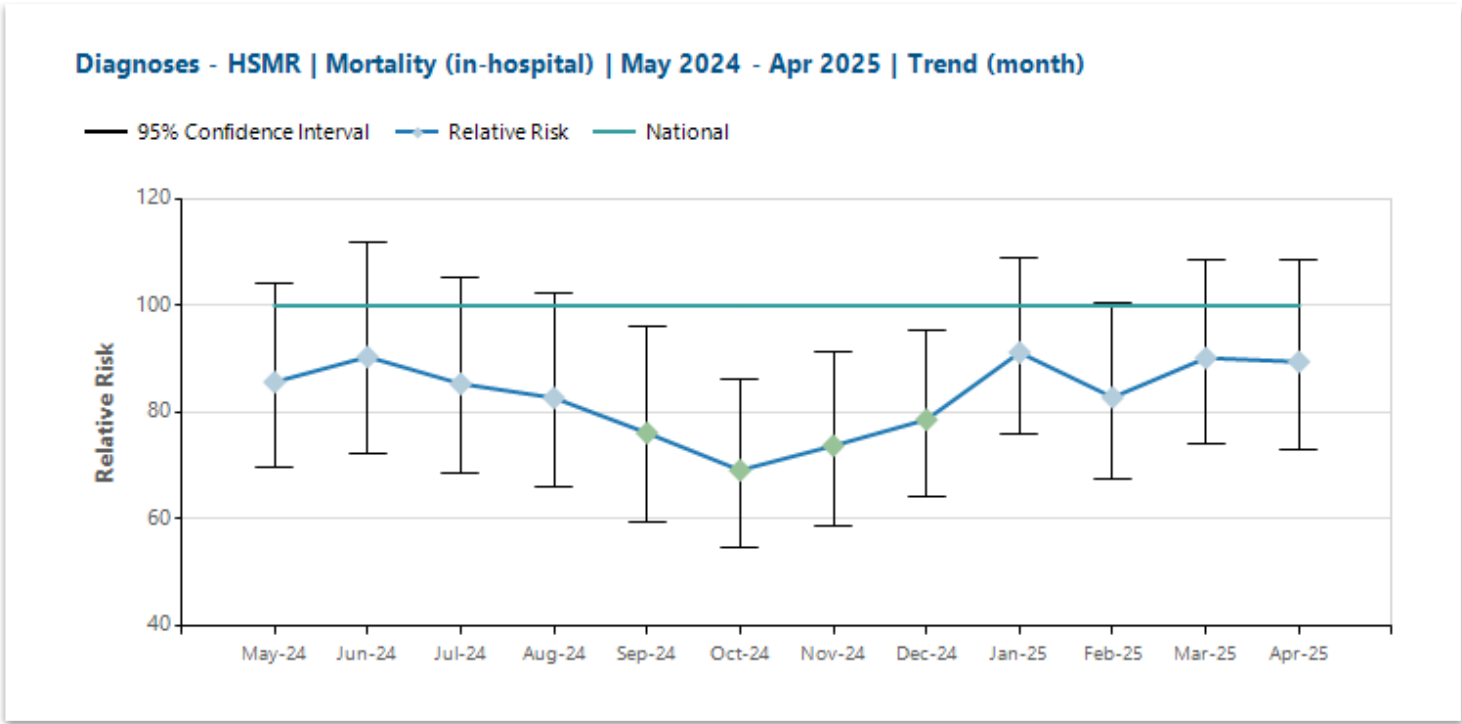
3.1 Hospital Standardised Mortality Ratio + Summary

HSMR+ for Apr-25 is 89.48 and “within expected”, based on 3029 superspells and 102 deaths (crude rate 3.37%).

HSMR+ for the period May-24 to Apr-25 is 83.06 and “lower-than-expected”, based on 42,335 superspells and 1139 deaths (crude rate 2.69%). There has been a slight reduction this month in HSMR+ activity.

The Trust continues to perform statistically significantly lower when compared to regional and national peers

Figure 8: HSMR Monthly Trend



3.2 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 198 superspells and one death.

3.3 CUSUM Breaches

There is one remaining CUSUM alert for ‘cancer of bone and connective tissue disease’, which was first reported to the Trust in November 2024. This is the result of a single death in July 2024. It is anticipated that this alert will cease to flag over the next three months.

Figure 9: HSMR Day of admission (Emergency only)

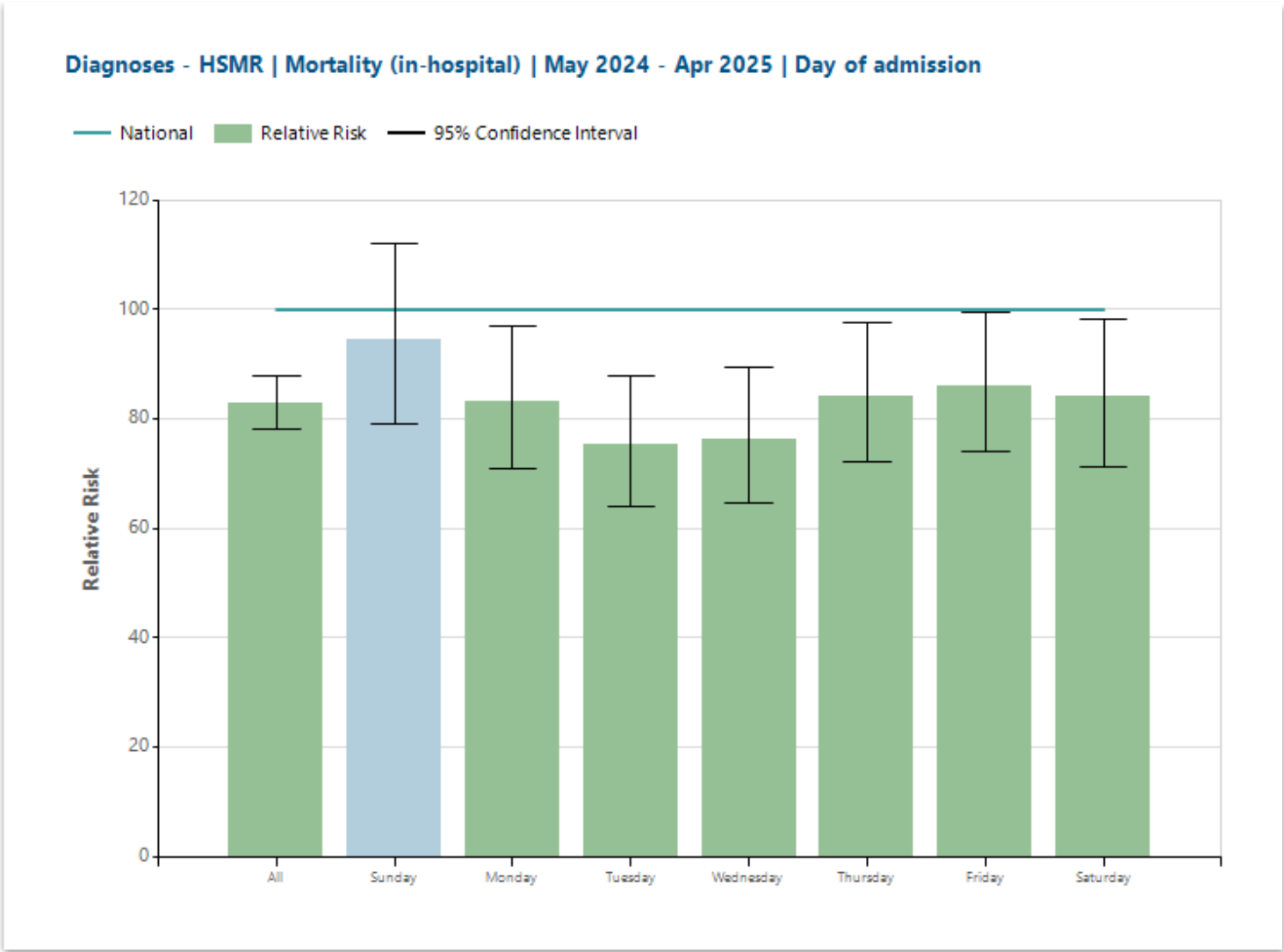
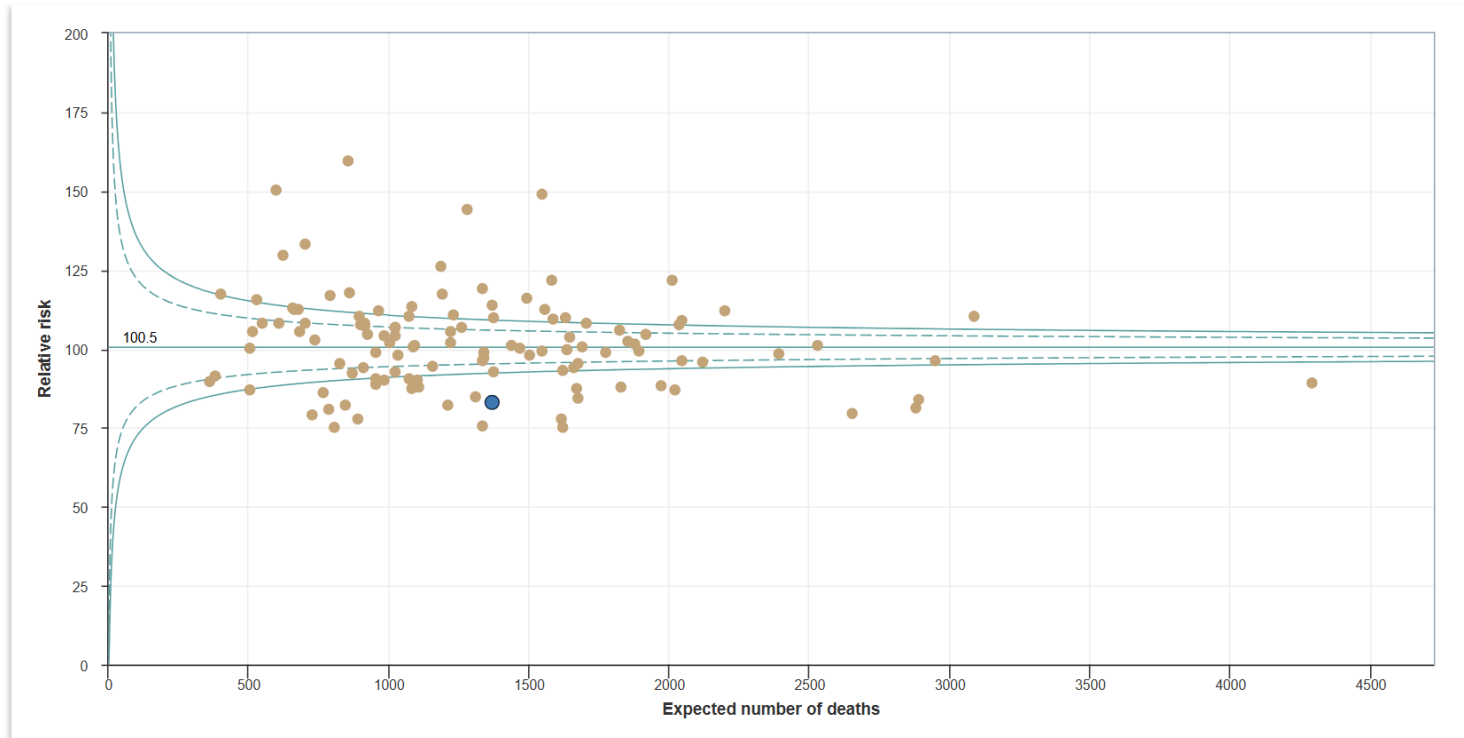


Figure 10: HSMR+ National Peer Comparison (Last 12 Months)

For the period May-24 to Apr -25 MTW performs statistically significantly better than national peers.

(MTW = blue; all other acute, non-specialist Trusts = brown)



Title of report	Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)					
Board / Committee	Trust Board Meeting					
Date of meeting	25 th September 2025					
Agenda item no.	09-19					
Executive lead	Rachel Jones. Director of Strategy, Planning and Partnerships					
Presenter	Rachel Jones. Director of Strategy, Planning and Partnerships					
Report Purpose (Please ☒ one)	Action/Approval	☒	Discussion	☐	Information	☐

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

Executive Summary		
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This is the monthly update on the activities and focus within the Integrated Care Board and West Kent Health Care Partnership. The slides focus on the current position and risk around the lack of clarity and challenge to the in-year additional capacity fund.	
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 •

ICB and West Kent HCP update

September 2025

ICB/ System news

- Cedi Frederick will remain in post as the Chair of the ICB for a further 3 years.
- The ICB Annual General meeting will take place online on Wednesday, 17 September 2025
- The ICB has awarded Kent and Medway NHS and Social Care Partnership Trust (KMPT) a single integrated contract for adult, children and adolescent mental health services.
- The new contract, which includes the all-age eating disorder service, is for services covering all of Kent and Medway and will involve a transfer of staff from the current service provider for a go-live of 1st April 2026.
- NHSE published a planning framework for England on 8th September 2025. Providers will be required to submit integrated 5 year plans which meet national and local priorities and demonstrate how financial sustainability will be secured over the medium term.

West Kent HCP

- The last West Kent Development Board took place on 21st August with the most recent executive meeting on 11th September.
- We are working in collaboration with the ICB and Darent Valley on the redesign of HCP functions in response to national request to reconfigure ICBs.
- The work (Change 25) is now delayed until 2026 as the ICB works with the regional and national teams in the future blueprint requirements. The HCP team will no longer be part of phase 2 of our transformation programme and continue to be funded by the ICB.
- The most significant issue the HCP is working on with the ICB is the in-year provision of the Additional Capacity Fund. Schemes from this fund span a number of providers including ourselves, KCHFT and the voluntary sector.

ACF funding allocations – West Kent overview

WK ACF allocations for last 3 years	WK funding allocation	Percentage reduction for WK HCP	Funding reduction for WK HCP
2023/24 actual allocation	£6,410m	-	-
2024/25 actual allocation	£4,862m	32% reduction on the 2023/24 actual allocation	£1,548k on the 2023/24 actual allocation
2025/26 allocation Assumed allocation based on HCP and ICB communication stating a 5% reduction on 2024/25 funding levels. Proposal submitted by WK HCP to KM ICB on 29 April 2025	£4,619m	5% reduction on the 2024/25 actual allocation	£243k on the 2024/25 actual allocation
2025/26 allocation On 16th June 2025, KM ICB sent a letter to HCPs, informing HCPs of their allocations. Revised submission submitted by WK HCP to KM ICB on 03 July 2025, full detail per quarter sent by WK HCP to KM ICB on 16 July 2025	£3,753m	23% reduction on the 2024/25 actual allocation	£1,109m on the 2024/25 actual allocation

IMPLICATIONS OF STOPPING WK 2025/26 ACF PROPOSALS MID YEAR

Scheme Name	Partner/s delivering	ACF value last year, 2024/25	Proposed ACF value this year, 2025/26	Amount embedded in current delivery	Implications/risks of stopping
1. Transfer of Care Hub	KCHFT	£460k	£205k	£205k, 100%	If stopped WK TOCH will not comply with national expectations such as: 7-day working and expanding the scope of current teams to include all discharge pathways, inclusive of discharges from community hospital or live system data requirements.
2. Bed brokerage	XYLA via MTW/KCC	£648k	£390k	£390k, 100%	XYLA contract ends 30/09/25, original WK proposal was based on KCHFT costings, which are 46% lower than KCC BB costs.
3. KEaH+ mitigation	ECFY via P3/CSU	£150k	£100k	£100k, 100%	Potential risk of flow issues as a result of KEaH contract not delivering full ICB commissioned service. There are ongoing concerns with KEaH+, and WK is already seeing an impact on MTW flow which has traditionally performed well and supported other parts of the system (particularly Medway and Ashford) during Winter.
4. Take Home and Settle	Age UK	£55k	£51k	£51k, 100%	Staff in post require 3 months notice, stopping/reducing would impact on flow in mid winter months.
5. Acute Virtual Ward	MTW/KCHFT	£1,900m	£1,702m	£1,702m, 100%	Staff in post, 6 months contractual notice required - stopping/reducing would not occur until next financial year. Impacts flow if reduced.
6. Frailty Virtual Ward	KCHFT	£700k	£700k	£700k, 100%	Staffing in post, 6 months contractual notice required - stopping/reducing would not occur until next financial year. Impacts flow if reduced.
7. Single Point of Access	MTW/KCHFT	£400k	£400k	£400k, 100%	Staffing in post, 6 months contractual notice required - stopping/reducing would not occur until next financial year. Impacts flow if reduced.
8. Frailty and Complex Care INTs	Primary care/KCHFT	£140k	£205k	£205k, 100%	First PCN work in progress, others gearing up to start in September. Significant negative impact on relationships and commitment to undertake the neighbourhood working. Impacts on flow if stopped. 6 months notice assumed depending on ICB contracts/MOU as paid direct.
9. P2 Reablement beds at Hawkurst House	Graham Group	£300k (part year)	£0k	£0k, 0%	None – this scheme has stopped.
10. RBLI Accommodation	RBLI	£109k (part year)	£0k	£0k, 0%	None – this scheme has stopped.
Total		£4,862m On budget	£3.753m On budget	£3,753m On budget	MTW ED performance will be negatively impacted if any schemes were to stop.

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	Cover sheet – KMPN Joint Venture Contract
Date	September 2025
Meeting	For Partner Trust Boards – MTW, EKHUFT, MFT and DGT September or October 2025
Author	Francesca Trundle, KMPN Managing Director

Introduction

Following approval by all Partner Trust Boards earlier in 2025 to the KMPN Joint Venture Case for Change and the initial joint committee meeting, we are now bringing the detailed documentation (the KMPN Joint Venture Contract) for board sign-off. This cover sheet highlights the key provisions in the contract that boards will be delegating to the KMPN joint committee and what will be retained by Trust boards as well as reminding boards of the financial principles, scope of KMPN and the phased approach to implementation. Many of the provisions in the joint venture contract will be completed or updated over the coming year before the joint venture reaches its final form (Phase 3). Approving this documentation now, however, ensures each partner is aware of its obligations and liabilities through Phase 2.

The contract has been reviewed by a series of different groups with representatives from each organisation. The finance and investment group have reviewed the finance schedule and the joint committee has reviewed the terms of reference. A corporate governance task and finish group has overseen the development, with advice from workforce and governance specialists from DAC Beachcroft, our appointed lawyers. DAC Beachcroft lawyers presented to that group on two separate occasions and it met monthly from October 2024 – January 2025 and then again in June 2025 to finally review, with comments and queries picked up outside the meeting.

The first meeting of the KMPN joint committee took place on 1st August and introduced members to KMPN services and the programme of work required over the next two years' which the committee will support. It included presentations on cellular pathology and microbiology services. The group also discussed the terms of reference and principles of delegated responsibility to the committee.

Delegated responsibilities to the joint committee

This contract (and the joint committee terms of reference included within it) delegates the following responsibilities to the joint committee:

- **Approving** contracts with a total value of less than £1m or approving the commitment of resources up to £1m
- **Recommending** single KMPN business cases with values above £1m directly to Trust boards for approval
- **Recommending** the final form for Stage 3 of the Kent and Medway Joint Venture (the full consolidation of pathology staff and budgets into a host Trust) to the Trusts boards;
- **Approving** changes in the location of or provision of pathology services, including but not limited to the consolidation of any sub-specialties onto certain sites within KMPN

As well as the approvals above, the following responsibilities remain with each individual Trust board:

- **Approving** the annual KMPN budget and approving spending above the agreed KMPN budget;
- **Approving** material variations to scope of activity delivered through the KMPN;
- **Varying** the KMPN JV Agreement including, in particular, the financial principles;
- **Joining** a new NHS body to the KMPN or collaborating with any other pathology network;
- **Entering into**, renewing or extending any land transaction or loan agreement;
- **Disaggregating** the Committee;
- **Committing** any Trust to a reconfiguration of services which could engage the statutory duties of any Trust such as public consultation or TUPE consultation;
- **Tendering** for and entering into a new contract with any integrated care board for the delivery of Services through the KMPN;
- **Pooling** the budgets of the Trusts;
- **Resolving** to form a legal entity such as an LLP or company limited by shares to deliver some or all of the activities of KMPN;

Financial principles

With respect to Phase 2 of the Joint Venture the following cost apportionment percentages will apply in line with previous agreements:

	MTW	EKHUFT	NKPS
Network Costs	25%	25%	50%
Membership Shares	MTW as per the percentage split set out in 2.2.2 below	EKHUFT as per the percentage split set out in 2.2.2 below	NKPS as per the percentage split set out in 2.2.2 below
LIMS	33%	34%	33%
MSC	As incurred	As incurred	As incurred
Outturn	The Partners will finalise the risk sharing profile in respect of any Surplus and/or Deficit in the budget as part of the Mobilisation Plan for Stage 2 and Stage 3. The proposal is that any surplus or deficit will be shared amongst partner organisations. Any variations shall be implemented in accordance with the Change Control Procedure.		

The initial KMPN Membership Shares, using the recurrent 23/24 In-Scope Services pathology expenditure, are as follows:

	EKHUFT	MTW	NKPS	DGT	MFT	Total
	Actual					
	£k	£k	£k	£k	£k	£k
Recurrent costs less intercompany costs	36,699	27,248	19,282	5,006	3,501	91,736
Percentage of total recurrent costs	40%	30%	21%	5%	4%	100%

Scope of KMPN Joint Venture

The KMPN Joint Venture will include:

- All blood sciences, microbiology, cellular pathology, blood transfusion (including transfusion practitioners) and point of care services within each Trust
 - Phlebotomy services at East Kent

The KMPN Joint Venture will not include:

- Mortuary services
 - Phlebotomy services at Maidstone and Tunbridge Wells, Dartford and Gravesham and Medway
 - The direct employment of and accountability for medical staff (funding for clinical leadership PAs will be included)

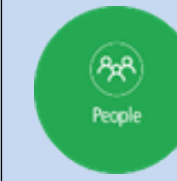
Phased approach to implementation

As set out previously, KMPN will move to the joint governance and management approach via the joint committee in Phase 2. It is likely that this will be delayed by three months from October 2025 to January 2026 to align with other local Trust workforce changes but the majority of the preparatory actions for Phase 2 have now been completed and this is being overseen by the existing KMPN Board.

The Joint Venture contract sets out that if there is a delay to moving to Phase 3 (final form of the hosted joint venture), KMPN will remain in Phase 2, unless the partners agree otherwise. During Phase 2, the joint committee will recommend to Trust boards which organisation will be the JV host for Phase 3.

Following approval of this documentation the next updates to Trust boards are likely to be on the proposed award of a network MES contract in Autumn 2025.

Title of report	Review of the Draft Winter plan for 2025/26					
Board / Committee	Trust Board					
Date of meeting	25 th September 2025					
Agenda item no.	09-25					
Executive lead	Sarah Davis, COO					
Presenter	Sarah Davis, COO					
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 Trust Board report seeks assurance that the Board Assurance Statement (appendix 1) can be approved. The paper includes risks and a QIA. Key objectives: a. This paper details the bed modelling and demand predictions for winter 25/26, along with the identified capacity gap and mitigation to ensure patient safety. b. It summarises the national assurance winter framework and best practice emergency care framework, to provide assurance to ETM on 26/8/25, F&P Committee 23/9/25 and to MTW Trust Board on 25/9/25 of the state of readiness for winter 2025/26. c. It is requested that Board Assurance paperwork is reviewed and approved. d. It highlights financial risks while understanding that there is no winter funding resource.	
Any items for formal escalation / decision	Board Assurance paperwork	
Appendices attached	• Appendix 1 – Board Assurance Statement – NHS Trust • Appendix 2 – UEC plan/ GIRFT Best Practice Standards • Appendix 3 – QIA • Appendix 4 – IPC guidance and cohorting guidelines • Appendix 5 – Full capacity protocol	
Report previously presented to:		
Committee / Group	Date	Outcome/Action
ETM F&P	22.8.25 23.9.25	Proceed to Board/ F&P with some additions outlined by COO tbc

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 •

Purpose of Report: MTW Winter Plan 2025/26 and Board Assurance sign off

Date: 19/09/25

From: Deputy Director of Operational Flow, Corporate Services

Summary of contents

- 1. Background**
 - 2. Demand and capacity modelling winter 25/26**
 - 3. Actions in place to support winter**
 - 3.1 Schemes for mitigation
 - 3.2 Further schemes being considered
 - 3.3 Best Practice & Metrics
 - 3.4 Infection prevention (incl. respiratory paediatric surge) and staff vaccination programme
 - 3.5 Winter Weather/ Wellbeing plan
 - 4. Trust Board Assurance**
 - 4.1 Risk log & QIA
 - 4.2 NHSE Governance covering NHSE/ System/ Trust/ Division
 - 4.3 Winter Dashboard KPI's
 - 5. Conclusion**
-

1. Background/ Action required

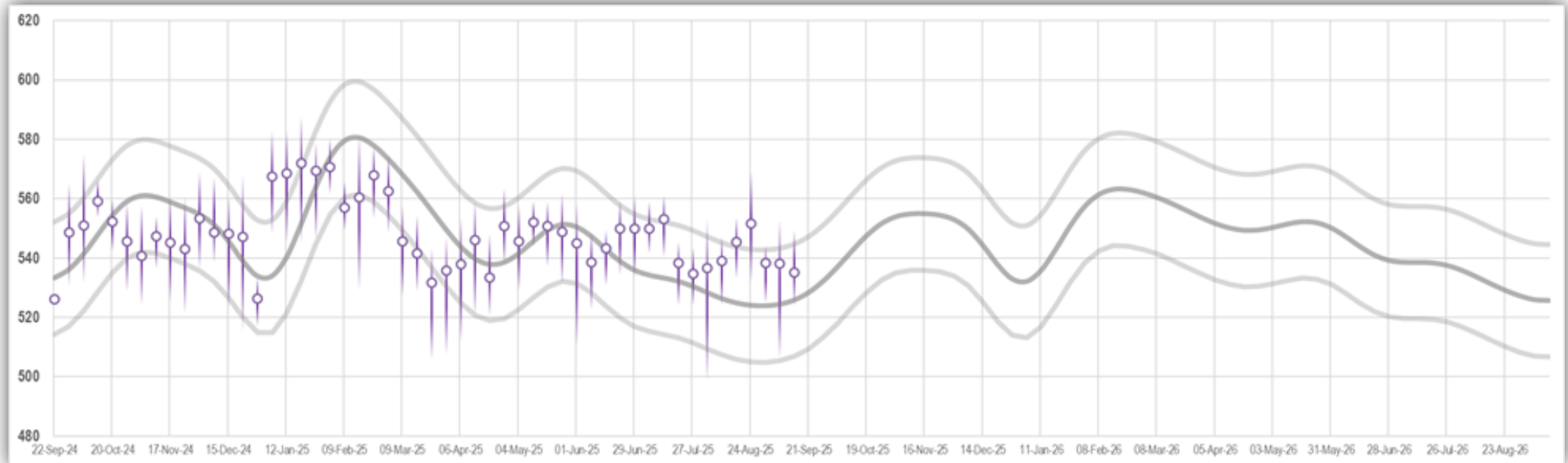
- This paper details the bed modelling and demand predictions for winter 25/26, along with the identified capacity gap and mitigation to ensure patient safety.
- It summarises the national assurance winter framework and best practice emergency care framework, to provide assurance to ETM on 26/8/25, F&P Committee 23/9/25 and to MTW Trust Board on 25/9/25 of the state of readiness for winter 2025/26.
- It is requested that Board Assurance paperwork is reviewed and approved.
- It highlights financial risks while understanding that there is no winter funding resource.

2. Demand and capacity modelling winter 25/26

- Ongoing system wide programmes of work have already resulted in reduction of escalated areas, maintaining the closed wards on both sites, the reduction of SDEC escalation and closing of 10 PP beds.
- The winter bed modelling for 25/26 indicates that winter occupancy will require between 563 to 582 beds (graph 1) with the peak of 582 modelled in February 2026. Working at 92% occupancy the peak is scaled up to 633.

- Capacity is calculated at 567 (slide 2)
- These figures do not include Maternity or Paediatrics which maintain their own bed base.
- **There is currently a maximum gap of 66 beds at the peak.**

Graph 1 – winter 25/26 bed modelling (MTW BI) excl. Paeds & Maternity and excl. pathways which do not use the bed base in Slide 2



Core Medical/ Haem Beds				Core Surgical/ Gynae Beds			
Tunbridge Wells		Maidstone		Tunbridge Wells		Maidstone	
AMU	28	John Day	30	W11	30	Cornwallis	19
CCU	7	Culpepper	13	W32	20		
W2	26	CCU	6	W30*	30		
W12	30	Mercer	26	W31	30		
W20	30	Foster Clarke	28	W33	10		
W21	30	AAU	18				
W22	32	Stroke Unit	49				
		Whatman	21				
		Edith Cavell	22				
		Peale	14				
		Lord North*	18				
TOTAL BEDS	183	TOTAL BEDS	245	TOTAL BEDS	120	TOTAL BEDS	19

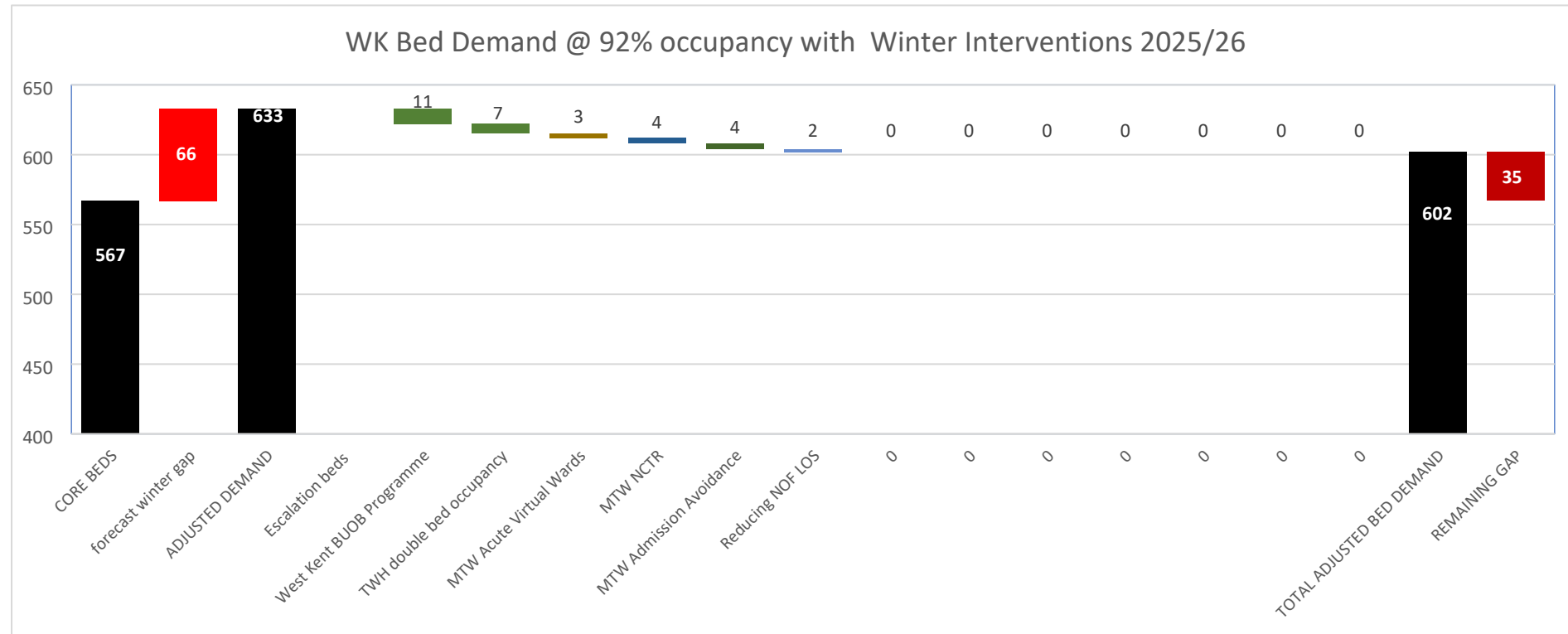
3. Actions in place to support winter

3.1 Schemes in place for mitigation

Working with partners, there are mitigations in place to support the gap by 31 beds, reducing the identified gap of 66 to 35 beds.

(See below slide 3 waterfall chart developed by the West Kent HCP in collaboration with system partners)

Slide 3: West Kent HCP Waterfall at 92% occupancy to mitigate the gap



- Better Use of Beds (WK) offers 11 beds (SPOA/ Community Virtual Ward/ P2 community hospital flow/ P3 assessment & process)
- Double occupancy rooms available TW to support (x 7 beds)
- Virtual Ward is funded to 60 beds with an A3 improvement project to further optimise this capacity, specifically Surgery/ Ortho (up to 3 beds)
- No Criteria to Reside (NCTR)/ Admission Avoidance – a programme of work is underway to reduce the number of NCTR, including improved system working led by Single Coordinator role, Discharge to Assess for E Sussex patients (already in place for W Kent), improved LOS for #NOF as part of Better Use of Beds, reduction in conveyances & admissions as part of Single Point of Access (SPOA), PO daily meetings, Care Coordination Centre driven discharge focus, increased weekend discharges. A LOS opportunity of a minimum of 4 beds has been identified.
- Admission avoidance schemes offering up to 4 beds:

- Working on improved DTA Board Round post take (MEC) to optimise alternative pathways
- Ongoing education of all staff around alternative pathways across clinical/ administrative workforces
- “Perfect Week” for Pathway 1 planned in collaboration with community partners plus ongoing MADE events
- Community virtual ward supporting further admission avoidance
- Ringfenced #NOF bed W30 in place from 1.9.25 and improved processes offering 2 beds
- Flexing capacity:
 - up to 6 beds on Lord North for medical patients when available
 - short-term SSSU for specific cohorts of surgical patients if appropriate and if elective plans permit

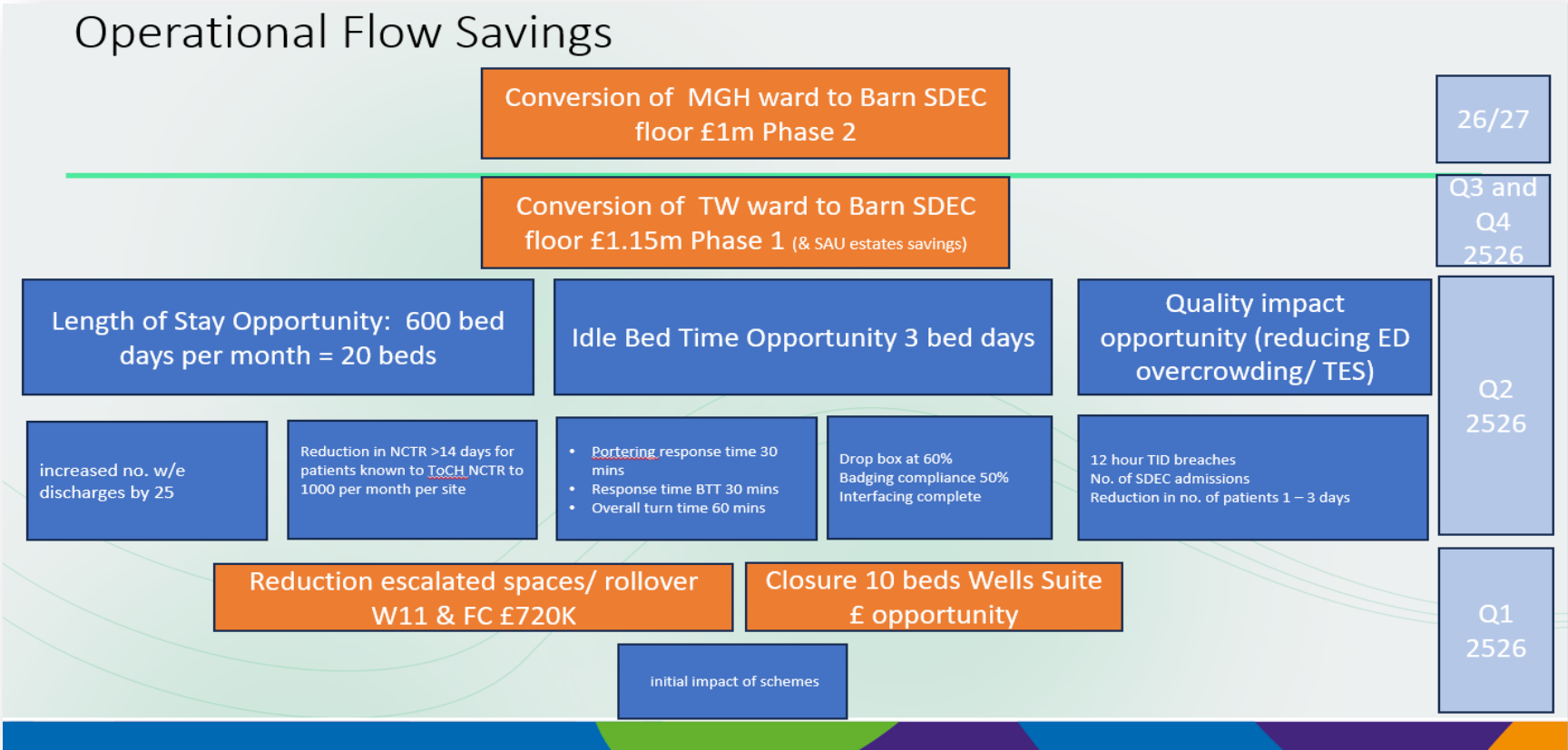
3.2 Further schemes being considered

There are additional schemes to continue to mitigate the gap as below:

Additional clinical pathway improvement (see slide 3) to reduce LOS/ overnight admissions (with no additional funding) ● “Red line” project within MEC to ensure Trust-wide SDEC not escalated overnight, to optimise SDEC activity/ pull from ED from 0800 ● Retain 1 ringfenced bed on W33 from late afternoon (from the last elective discharge) to enable EGAU (SDEC) to close from 6pm, allowing SDEC activity to continue through this bed overnight ● Ringfenced KMOC Orthopaedic elective activity in place ● ITU A3 improvement project to support transfer of ward fit patients in development
Further large-scale transformation work ● Options paper being developed to provide capacity to “bridge” stable NCTR patients or develop a Neuro HSP service to provide earlier discharge dates for neuro rehab (P2b/a) NCTR patients. No guarantee of external funding at this stage. Paper to be presented to COO and Chief Nurse for further discussion. ● An SDEC paper is being presented separately to ETM increasing the overall number of patients through SDEC through increased risk appetite/ culture of “SDEC FIRST” and reducing admission of >1 - 5 day patients. If funding required, will be requested separately ● TeleTracking enablers to drive improvement including interfacing EPR/ TT, introduction of increased data reporting on discharge attributes, review and potential rollout of further Endoscopy solution to support elective, embedding of Maternity TT processes, optimisation of porter/ BTT processes (see slide 4)
Focus on Winter: 1st Jan to 15th Feb ● The data shows that the 6 weeks from 2nd Jan will be the most pressurised. ● Work is underway to identify increased resilience in the form of additional schemes, battle rhythm such as weekly MADE events, potential cohorting of patients, senior clinical decision making in key areas, increased actions with partners.
Elective/ Cancer RTT ● Mitigation for elective care to ensure RTT is met, as well as creating sufficient headroom in Q2 and Q3 to mitigate the impacts of likely winter demand ● Programme of works to improve productivity and efficiency in progress
Further mitigation if funding becomes available: ● Enabling Care for You (private provider) mitigation for Pathway 1 following introduction of KEAH+ Sept 24 to reduce LOS (cost per case) – currently in discussion with ICB and KCC to support external funding of this. To support TW discharges and also w/e and front door discharges

4 Stroke Beds MGH (nursing staffing) (the additional 4 beds on Stroke are currently working towards substantive funding and will form part of core Stroke ward)
Further Divisional schemes to be advised incl. additional support in ED & Medicine eg GP in ED, additional Respiratory consultants plus TES nursing in ED

Slide 4 – Operational Flow Theme CIP (SRO Deputy Chief Operating Officer)



3.3 Best Practice & Metrics

The Winter Plan is being mapped against the GIRFT Clinical Operational Standards for Emergency Care Pathways (published July 2024 and 2025). See Appendix 2 for GIRFT standards/ UEC plan. Key themes are optimising hospital avoidance, strengthening the SDEC offer, using digital tools to join up pathways, reviewing in-hospital standards and supporting discharge processes. The standards for acute providers are being mapped against current SOP’s within MTW through a task and finish group led by the Deputy Chief Operating Officer. Areas for further development in the GIRFT standards include the following:

- Acute Care Standards: (1) Urgent cross sectional (CT/MRI) imaging should be reported within 4 hours of request – Clinical Director for Radiology working on key principles with clinical colleagues to reduce demand in Surgery/ ED, aiming to complete by end Oct
- Acute Care Standards: (7) Patients transferring out of critical care units should be prioritised for inpatient bed allocation above other requests for available beds – A3 project within Surgery Division to roll out Trustwide
- Acute Care Standards: (9) Twice daily consultant ward rounds is the optimal model and should be delivered in higher acuity areas eg ICU, AMU, SSW, SAU CCU and other medical wards if possible – no current plans to develop this year but focussing on twice daily Board Rounds

The UEC plan identifies the following metrics:

UEC plan June 25 key metrics

UEC plan 2025 Themes	National Target
High quality emergency care	Reduce ambulance wait times for Cat 2 patients to 30 mins
	Meet the maximum 45 minute ambulance handover time standard
Improving flow through hospitals	4 hour standard at 78%
	Improve the 4 hour performance for children
Ending 12 hour waits in corridors for a bed	12 hour standard for patients in ED (time in department) to a maximum of 10%
Mental health teams leading from the front	Reduce the number of patients over 24 hours in ED waiting for a mental health admission
A whole system approach to improving patient discharge	Increasing urgent care in primary, community and mental health settings including UCR teams and virtual wards
From analogue to digital: using data and digital investment to improve flow	
Vaccination for staff	Improve staff vaccination rates by 5%

3.4 Infection prevention (including respiratory paediatric surge) and staff vaccination programmes

Flu Vaccination (Occupational Health)

- The Flu vaccination programme will commence in October 2025.
- Booking and recording of update by Vaccination Track
- Clinics running across 3 main sites (MGH, TW and Fordcombe, including the Roundall)
- Weekend and evening clinics as well as core shift hours
- Peer Vaccinators as well as bank staff
- Focus on all cohorts including frontline health care staff
- Immuno-compromised staff can receive Covid vaccination via GP

IPC

- Guidance attached detailing cohorting and IPC controls (see Appendix 4)

- Training to be scheduled from IPC team for CCC/ Site Practitioner/ Tactical Commander team and guidelines circulated to managers on call

Paediatric respiratory surge plan

- Winter surge plan for paediatrics which incorporates respiratory conditions which is shared with the ICB and incorporates information on all hospitals in the sector.
- POPEL plan for escalation of bed capacity which reviews ED, ambulatory, day surgery and inpatient capacity and staffing
- If there is a specific type of surge a plan is implementing for the specific requirement i.e. whooping cough, strep A, measles
- Notification and Respiratory training is supported by the South Thames Paediatric Network with additional study sessions and support
- STPN dashboard in place which is updated twice a day by MTW, this provides PICU bed availability, beds at other hospitals across the STPN network.
- OCC surge meetings increase from weekly to daily if required according to requirement with the ICB

3.5 Winter Weather/ Wellbeing Plan 25/26

The Emergency Planning team continue to support staff with business continuity plans and plan for severe weather. Plans are already underway to ensure staff can reach site over the bank holiday period. The Occupational Health team is focussing on staff vaccination programmes for winter alongside the extensive and year-round wellbeing approach. 47% of staff were vaccinated in 24/25 with a target for 25/26 to increase this by 5%.

Staff Psychological Support

- Mental Health First Aid Training, supervision and co-ordination
- Support signposting resource development and accessible drop ins
- Psycho-educational training and relapse prevention support for self-care and stress management
- Assessment and specialist CBT and EMDR treatment for workplace traumas
- Post potentially traumatic workplace incident debriefs

Health and Wellbeing

- Our Lifestyle Medicine project intends launching the 'Know Your Numbers' campaign in late September (Occupational Health)
- Listening Ear (one-to-one) wellbeing conversations and onward signposting to external support services.
- Health and Wellbeing Conversations (resources, tools and templates for supporting individual and team wellbeing).
- Physical Wellbeing resources, including NHS Health Checks (over 40's), physiotherapy self-referral, stop smoking and lifestyle medicine.
- Financial Wellbeing resources, including; one-to-one Money Guider sessions, Pensions, Retirement and Financial Wellbeing seminars and webinars, Blue Light card, Wagestream, Food Pantry and free fruit from staff canteens.
- Citizen's Advice Bureau onsite bookable appointments (Maidstone Hospital) for support with debt, housing, legal matters, relationship breakdown, consumer issues etc.
- Winter Wellbeing themed communications and engagement, including; weekly Wellbeing Wednesday, monthly Wellbeing Update, Wellbeing events calendar, engagement stands, in-reach sessions, Student Café, IEN Listening Events and promoting NHSE national winter campaigns.
- Workplace Community initiatives to support connection and prevent loneliness and homesickness, including; mindfulness, Film Club, Crafternoons, Book Club and Staff Choir.
- Peer Support Groups and Staff Networks, providing emotional and practical support, including but not limited to; Living with Cancer, Parent, Menopause, Men's Health, Neurodiversity and Carer's groups.

- Support through Transformation: an extensive support offer including, but not limited to; Wellbeing Workshops, Transformation Masterclasses, manager peer support sessions and one-to-one coaching sessions (with a qualified coach) for navigating organisational change, resources for managing stress and supporting mental health, individual and team wellbeing action plans etc.
- Flexible Working – informed by the successful Flex Appeal pilot, and building on the People Promise Exemplar programme, the flexible working initiative will be implemented across the entire Trust, commencing in early autumn.

4. Trust Board Assurance

4.1 Risk log and QIA

The following quality and financial risks have been identified as below. The QIA/ EQIA has been approved at panel (see appendix 3) by the Medical Director and Chief Nursing representative.

Risks	Status	What we will do to address it
Increased acuity/ increased IPC issues eg RSV, Covid, flu leading to higher activity		Surge beds, cohorting* protocols, site team aware/ directed through CCC, admission avoidance schemes, system wide response & sitreps, staff prepared for respiratory illnesses** * A patient cohorting plan including risk-based escalation is in place (see appendix 4), led by the Head of the CCC and the IPC Nursing Lead to be understood by site management teams, ready to be activated as needed. ** A fit testing programme continues to be in place. Approximately 50% of patient facing staff are fit tested, with the focus on the highest risk areas such as ED and respiratory wards. It is now BAU and documented on ESR and also MTW learning so managers can address at appraisal if non-compliant. Fit testing leads liaise with procurement regularly where they discuss PPE stock level and highlight any areas in need. This can be upscaled quickly in response to increasing numbers of respiratory viruses.
Financial risk to Trust if further escalation required without funding or if SDEC escalated		ensure processes in place to allow early and safe discharges, clear 4pm plan documented for site team/ manager on call by Tactical Commander, reduction of NCTR patients
Lack of capacity in community/ adult social care/ mental health to support discharges in timely way		Work closely with external partners to ensure pathways in place including w/e and front door pathways, early notification of discharges, right patient right place, patient centred care
Moral injury to staff across system undergoing Transformation programme resulting in low morale		Clear leadership and personal visibility. Staff wellbeing support, clear messaging and communication, 1-2-1 and team meetings in place, support for senior leaders to cascade information (see section 5 Winter Wellbeing Plan). Exec leadership including ward & department visits/ tea rounds
Lack of capacity may lead to increased no. of patients waiting more than 12 hours in ED		Monitoring of quality impact, working in partnership to identify increased capacity, focus on admission avoidance with partners, availability of beds/ hot meals/ patient screens if required

department which will impact on quality (linked to TES)		
Further Industrial Action episodes, leading to financial risk and possible staff relationship issues		Work with resident doctor forum, robust IA planning

4.2 NHSE Governance covering NHSE/ System/ Trust/ Division

NHSE

- Board Assurance Statement is attached (see Appendix 1). This paper requests that this statement is signed off by both the CEO and Chair at Trust Board and required to be submitted to NHSE by 30 Sept 2025.

System

- The Winter Plans has been reviewed through a regionally led winter exercise on 8th September 2025 with MTW attendance.
- Daily system wide calls will be in place led by the Operational Command Centre (OCC) at K&MICB who will also coordinate system industrial action response
- Work is underway to align the action cards responding to OPEL levels between the acute and community trust.

Trust

- The MTW Winter Plan is led by the Chief Operating Officer as SRO, who will remain the Executive accountable for winter.
- Trust level exercises which are taking place in September and October 25, led by Head of the CCC and Director for Emergency Planning & Response, covering full hospital capacity, escalation, overcrowded ED and snow/ staffing infection outbreaks.
- During periods of pressure, OPEL escalation level action cards will be used at Directorate/ department level. These are included in the Full Capacity Protocol (see appendix 5) which was updated in May 2025.

Division

- IPC colleagues are engaged in the plan development providing patient cohorting plans in consultation with the CCC. There is a plan to achieve a 5% improvement on staff vaccination. Fit testing is BAU and recorded on ESR with stock levels maintained.
- Divisional mitigation as laid out in the Board Assurance Framework:
 - Rotas are being reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends and bank holidays, led by the Deputy DDO's in all Divisions. This will include provision for senior clinical decision makers at times of increased pressure
 - Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.
 - MADE event scheduled to reduce bed occupancy pre-Christmas with system support, working towards a reduction to below 80%

- Elective and cancer delivery plans are in place to create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services – this is part of Divisional BAU and ongoing.
- On call arrangements are in place as business as usual with quality and flow being driven through the Care Coordination Centre. The Tactical Commander will monitor the OPEL framework and participate in system wide calls, requesting or responding to mutual aid in specific areas, reporting to the Site Director. Critical incidents will only be used for short periods within clear guidelines.
- Increased visibility from leaders across all Divisions including Exec team, with increased tea rounds on the wards/ departments across all sites, team meetings, huddles and continuing with the monthly Team Brief led by the Chief Executive. This will support personal visibility and leadership to support staff.
- Surgery interventions include:
 - 5 Ambulatory trauma/day surgery TW / Robotic Day case pathways
 - 6 Improved use of virtual ward
 - 7 Non ambulatory Fragility Fractures pathway – Ring fenced beds and fast track to theatres
 - 8 Smart Scheduling theatre meetings for TW
 - 9 Maximise Maidstone and Fordcombe activity

4.3 Winter Dashboard KPI's

A Winter Dashboard has been developed (see table 4 below), reflecting that national metrics from the Urgent and Emergency Care Plan published on 6th June 2025. There is considerable focus on the 12 hours in department.

Table 4 – Winter Dashboard (updated 17.9.25)

	Financial Year	April	May	June	July	August	September	October	November	December	January	February	March
ED All Type 4hr Performance	2022/2023	79.9%	84.0%	87.4%	84.0%	86.4%	84.8%	84.1%	83.4%	76.6%	86.1%	88.7%	85.4%
Target 78%	2023/2024	89.6%	87.2%	88.2%	86.7%	84.7%	85.6%	84.2%	83.7%	82.8%	82.7%	83.6%	86.2%
	2024/2025	84.0%	84.1%	83.3%	82.6%	85.7%	83.1%	82.1%	81.5%	79.2%	80.8%	82.1%	85.2%
	2025/2026	81.5%	81.4%	82.9%	83.1%	80.2%	81.2%	-	-	-	-	-	-
	Variance	-2.5%	-2.7%	-0.5%	0.5%	-5.4%	-1.9%	-	-	-	-	-	-
ED Paeds 4hr Performance	2022/2023	96.5%	97.4%	97.4%	97.3%	97.6%	97.7%	96.4%	96.1%	92.7%	97.9%	97.1%	96.3%
	2023/2024	97.4%	97.5%	97.9%	97.9%	98.0%	97.0%	96.0%	95.1%	95.7%	96.0%	97.0%	96.9%
	2024/2025	96.2%	95.7%	95.7%	96.5%	98.0%	96.5%	96.4%	93.9%	93.1%	95.9%	96.0%	97.3%
	2025/2026	97.5%	96.9%	97.4%	97.1%	97.3%	93.5%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%
	Variance	1.3%	1.2%	1.7%	0.7%	-0.7%	-3.0%						
>12 in Department	2022/2023	6.8%	3.9%	2.7%	4.5%	2.8%	5.2%	5.2%	4.5%	7.1%	3.8%	2.0%	3.3%
Target <10%	2023/2024	2.0%	3.3%	3.3%	4.1%	4.7%	4.7%	5.6%	6.8%	5.8%	6.7%	6.2%	3.9%
	2024/2025	5.5%	5.3%	5.9%	6.5%	4.1%	6.3%	7.1%	6.6%	7.4%	8.6%	7.5%	5.5%
	2025/2026	7.2%	6.9%	7.6%	5.6%	6.8%	5.9%	-	-	-	-	-	-
12hr DTAs	2022/2023	78	10	10	17	2	40	85	16	114	51	7	22
	2023/2024	0	4	0	2	0	47	42	105	34	47	29	12
	2024/2025	9	27	29	35	12	66	131	80	171	274	189	25
	2025/2026	185	111	172	62	134	18	-	-	-	-	-	-
	Variance	176	84	143	27	122	-48	-	-	-	-	-	-
12hr DTA %	2022/2023	0.4%	0.0%	0.1%	0.1%	0.0%	0.2%	0.4%	0.1%	0.6%	0.3%	0.0%	0.1%
Calculation DTA/Total attendances	2023/2024	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.5%	0.2%	0.2%	0.1%	0.1%
	2024/2025	0.0%	0.1%	0.1%	0.2%	0.1%	0.3%	0.6%	0.4%	0.8%	1.4%	1.0%	0.1%
	2025/2026	0.9%	0.5%	0.8%	0.3%	0.6%	0.2%	-	-	-	-	-	-
	Variance	0.9%	0.4%	0.7%	0.1%	0.6%	-0.2%	-	-	-	-	-	-
Vaccination Rates	2024/2025	47.0%											
Improve by 5% - Target 52%	2025/2026												

5.Conclusion

Key metrics have been set out nationally to be delivered to ensure safe and timely patient flow, within a framework of the UEC 2025 plan. National best practice is laid out in the GIRFT Emergency Care Standards. Following local bed modelling, there is currently a gap between predicted demand and capacity. Some mitigation is in place with no additional funding. Further work is underway to reduce LOS through a number of enablers within the Divisional and Flow programmes of work, which has already delivered de-escalation in 2025. There will be a further focus on winter to deescalate pre-Christmas and for the 6 weeks from 2nd January 2026.

Appendices

Appendix 1 – Board Assurance Statement



Board Assurance
Statement - NHS Tru

Appendix 2 – GIRFT Best Practice Standards and UEC plan – 2025

[NHS England » Urgent and emergency care plan 2025/26](#)

[PowerPoint Presentation](#)



GIRFT Clinical
Operational Standai

Appendix 3 – QIA/ EQIA



QIA -
Winter25_v3.approve

Appendix 4 – IPC guidance and cohorting guidelines



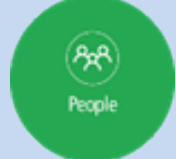
MTW winter
respiratory viruses gu

Appendix 5 – Full Capacity protocol (incl. action cards)



Full capacity
protocol [RWF-COR

Title of report	Responsible Officer's Annual Report					
Board / Committee	Trust Board					
Date of meeting	25 th September 2025					
Agenda item no.	09-27					
Executive lead	Sara Mumford, Chief Medical Officer					
Presenter	Sara Mumford					
Report Purpose (Please ☒ one)	Action/Approval	☒	Discussion	☒	Information	☒

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Medical appraisal is a process by which doctors can demonstrate that they are honest, delivering high quality care, reviewing their activity and outcomes through the Trust clinical governance processes, undertaking research, being educators to all colleagues, and celebrating their success and reflecting on both positive and negative experiences working as a doctor in our Trust. Completion of appraisal is an annual requirement and an opportunity for a doctor to reflect on their personal and professional development, demonstrating clinical effectiveness, managing patients safely and creating a positive patient experience, maintaining their skills and knowledge and keeping focussed on their wellbeing and personal support systems as well as providing evidence on how they are learning continuously from both positive and negative patient experiences. Engaging in the process and completing quality appraisals are part of maintaining high professional standards and working within the domains of GMC Good medical practice 2024. No doctors required a referral to the GMC for non-engagement in this process essential for GMC revalidation. 652 appraisals were completed which is the highest ever undertaken by the Trust representing a completion rate of 97.5% of all eligible doctors. Appraisals not undertaken were due to appropriate reasons and 1 doctor missed their appraisal without approval and the doctor is being supported by the RO and on track to complete this. The purpose of an appraisal is for a doctor to reflect on their progress, be challenged on their development and create an annual PDP that is personal to them as a result of a supportive appraisal meeting. 100% of doctors felt supported and challenged during their appraisal and 100% felt that the PDP created was personal to their development needs. This report includes the General Medical Council Annual Return which is required to be reviewed by the Trust Board prior to submission.

Any items for formal escalation / decision	The Board is asked to approve the report for submission to the GMC		
Appendices attached	• Appendix A – MTW appraisal data 2024-2025 •		
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: • None
Links to Corporate Risk Register (CRR)	Please list any risks on the Corporate Risk Register to which this report relates • None
Compliance / Regulatory Implications	• All doctors practising at MTW must be registered with the GMC and hold a licence to practice. This report addresses the process by which this is achieved at MTW.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of Maidstone and Tunbridge Wells NHS Trust (MTW) can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Dr Sara Mumford was appointed as Chief Medical Officer at MTW and is an appropriately trained medical practitioner who fulfils the requirements of a Responsible Officer. Dr Mumford was appointed as Responsible Officer in January 2024.
Comments:	No changes so continue as above.

Action for next year:	No changes expected so continue as above.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	To monitor and maintain the number of appraisers. To move to an appraiser allocation available on the L2P system to evenly distribute Drs medical appraisal between all appraisers.
Comments:	There were 652 appraisals completed between 1st April 2024 and 31st March 2025 (17% increase in appraisals compared to 23/24) We had 103 medical appraisers during 24/25 appraisal year (85 Consultants and 18 Speciality doctors). 12 new appraisers joined the medical appraisers list in the 24/25 appraisal year 57% of appraisals were submitted on time (standard is submission within 1 month of the appraisal meeting). All medical appraisers have provision in their job plan to undertake this work Appraiser allocation planning during 24/25 enabled MTW to commence allocation on 1st April 2025
Action for next year:	Review of appraiser allocation system for 25/26 • acceptance of appraiser vs appeals • submission of appraisals on time • feedback from Drs and appraisers Maintain doctor to appraiser ratio to support increasing numbers of doctors joining MTW as a designated body

	Introduction of appraisals for Physicians Assistants and Physician Assistants in Anaesthesia due to commence December 2025.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	None.
Comments:	The Responsible Officer, Medical Appraisal and Revalidation Lead, Medical Appraisal and Revalidation Manager and the Coordinator regularly update and review all Drs joining and leaving MTW, ensuring they are appropriately connected and disconnected from MTW. All have password access to secure GMC connect website for updating this data. The introduction of job plans onto L2P has identified opportunities for the medical staffing team to onboard new Consultants and SAS Drs onto the L2P system enabling more efficient identification of new starters who will be need appraisals. A review of the New Doctor form by the appraisal team was undertaken this year to ensure only relevant information was requested in order to add a doctor to the appraisal system Development of a similar form for PAAs/PAs has been developed to onboard this group on to the L2P appraisal system.
Action for next year:	Continue as above

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	The medical appraisal policy has been updated together with a Medical Appraisal Quality Assurance Document and a role description for medical appraisers. The documents are awaiting final approval.

Comments:	None
Action for next year	Approve documents as above in next 3 months.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	To continue with the two-tier process of checking appraisal completion and revalidation approval process. To complete the GMC Self-assessment tool on 'Effective clinical governance to support revalidation' To identify where, in the forward external audit calendar, audit of the medical appraisal system can be carried out.
Comments:	Internal peer review of our Appraisal and Revalidation (A&RV) process is internal and within the A&RV team. This involves a two-stage process for reviewing all completed appraisals and referring back any appraisals that are incomplete or missing key documents that provide assurance that Drs are working safely eg Medical Indemnity, Private Practice Provider Governance Form. All appraisals are reviewed by the Medical Appraisal Coordinator and then again by the Medical Appraisal and Revalidation lead for final approval. Any appraisals undertaken by the Medical Appraisal and Revalidation lead are approved by the Responsible Officer. A revalidation summary document is prepared by the Medical Appraisal and Revalidation Lead for all Drs under notice for revalidation each month and distributed to the RO/CMO, Chiefs of Service, and Deputy Medical Directors to review and discuss any concerns, and written approval for recommendation is obtained. The summary has had additional detail added this year to ensure information provided is relevant to support approval for a revalidation recommendation. Doctors are invited to complete a feedback questionnaire about the appraisal process every time they complete an appraisal via the L2P medical appraisal system. Data is

	regularly reviewed by the Medical Appraisal Manager and Medical Appraisal and Revalidation Lead. The RO, Medical Appraisal Manager and Medical Appraisal and Revalidation Lead attend the Southeast Higher-Level RO (HLRO) team regional network meetings where updates on changes are shared and receive South East HLRO information updates electronically. A GMC document on 'Effective clinical governance to support revalidation' was developed for organisations to internally review governance processes without report. Effective processes are in place already within MTW NHS trust that can ensure Drs can maintain their revalidation through MTW as a designated body. The tool highlights the need to ensure the addition of PAAs and PAs into this process. Independent audit of medical appraisals is due to be undertaken in 2027/28 (5-year cycle) External peer review has not been undertaken this year but contacts have been made with two local Trusts to review how this can be achieved within the boundaries of information governance.
Action for next year:	Establish all PAs/PAA's onto the L2P appraisal system for the purpose of appraisal and revalidation. Implement any additional recommendations regarding the appraisal process and standards expected in December 2025. Achieve agreement with local Trusts on external peer review

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Maintain annual New Doctor appraisal and revalidation training. Maintain the Appraisal and Revalidation Pages in the Medics Hub.
Comments:	Information on the Appraisal and Revalidation Process is available on the Trust Intranet Medics Hub.

	All doctors who connect to MTW as their designated body are invited to attend a New Doctor appraisal training session to familiarise themselves with the appraisal process. All doctors working at MTW will be provided with the access to IT facilities, library facilities, or study leave to attend conferences and courses to support Continuing Professional Development. All doctors can attend or watch directorate Clinical Governance meetings and are encouraged to be involved in Quality Improvement activities. All are expected to discuss any patient safety events, and complaints that they are involved in within their appraisal with their designated body for revalidation. MTW will provide a governance form that summarises if the doctor has, or has not been involved in any specific incidents and their participation in clinical governance upon request to any doctors with a designated body outside our organisation (e.g agency locums), to those with private practice privileges in the independent sector, or to those who also practice elsewhere in the NHS.
Action for next year	Continue as above Update information regarding appraisal and revalidation for PAAs/PAs on the Appraisal and Revalidation web page following publication of guidance by the GMC (expected in December 2025) Offer separate training for PAAs/PAs once requirements for appraisal are shared by the GMC due December 2025 Offer appropriate training for appraisers of PAs/PAAAs once requirements are known Develop a series of short videos on the various requirements for medical appraisal to increase awareness of the process of appraisal and revalidation.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Monitor satisfactory completion of appraisal documentation. Monitor completion of the L2P MSF in time for revalidation
Comments:	The L2P appraisal includes a requirement to discuss the doctor's whole practice and takes into account all of the relevant information The L2P appraisal Multisource Feedback was introduced in March 2024, and is working well. Doctors are prompted to complete the MSF in Year 3 of a revalidation cycle in time for discussion at the Year 4 appraisal in preparation for revalidation. L2P allows for electronic colleague feedback as well as both paper and electronic patient feedback. Feedback is collated as two reports available on L2p to be reviewed by both Doctor and appraiser. A new Medical and Appraisal Revalidation Manager took up post in April 2024 following the retirement of the previous manager. The two-tier process for reviewing medical appraisals was continued and the standards of completion were also updated as part of introducing the Medical Appraisal Guide 2022
Action for next year:	Continue as above.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Monitor satisfactory completion of the appraisal documentation in line with NHSE MAG 2022 standards – referred back rates and reasons for this to be shared with RO and doctors via the Appraisal Newsletter.
Comments:	This has been introduced via the L2P system and within the appraisal check list undertaken by the Medical Appraisal Coordinator. Failure to provide enough evidence, or complete an appraisal satisfactorily is referred to the Medical Appraisal and Revalidation Lead, and escalated to the RO if non-engagement was the reason.
Action for next year:	Specific appraisal document for PAs/AAs will be required and is in progress by L2P in time for start of revalidation due to start in December 2025.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Obtain ratification of updated Medical Appraisal Policy.
Comments:	None
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Y/N	Yes
Action from last year:	Arrange one additional accredited New Appraiser training session
Comments:	Additional 12 appraisers were trained in March 2025.
Action for next year:	Maintain annual training of new appraisers to ensure we can appraise all Drs who require this through MTW Appraisers are job planned to complete either 6 or 12 appraisals in a year, dependant on the previous year's performance

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Provide annual appraiser updates in 24/25 (booked for October and November 24) and share feedback Monitor Drs feedback and include training identified to support appraisers in maintaining quality appraisals
Comments :	67% appraisers attended update training in 24-25.

Feedback – Appraisal Process overview



97% feel appraisal process is satisfactory

96% can access all necessary forms

5% doctors say cannot always access some supporting information easily eg Mandatory training, activity data, log books

Exceptional people,
outstanding care

Appraisal Overview Feedback

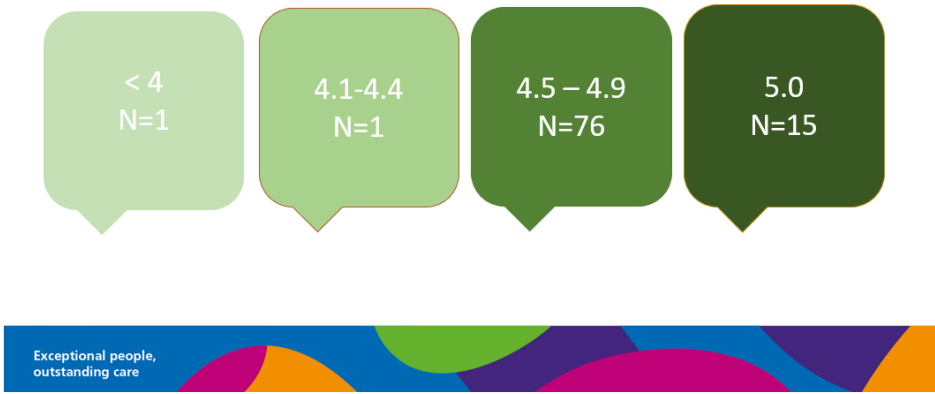


Exceptional people,
outstanding care

Clinician Overview Feedback



Exceptional people,
outstanding care

	Feedback – n= 93 Appraiser ratings 1-5  Exceptional people, outstanding care
Action for next year:	Continue Review lower rated appraisers as priority for additional support

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Undertake an audit of completed appraisals using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT) as a measure of quality
Comments:	ASPAT (appraisal summary and audit tool) is used to ensure Drs appraiser's appraisal outputs (summaries and personal development plans (PDPs)) of the appraisals are in keeping with quality standards Appraisals that do not meet the recommended standards are referred back to the appraiser for further completion with an explanation of what is required to meet the standard
Action for next year:	Continue as above and arrange peer review

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	MTW will continue to refer doctors where there are fitness to practice concerns in line with GMC requirements. The Medical Appraisal Lead will continue to review all doctors under notice for revalidation each month by reviewing appraisals and the valid MSF and provide a recommendation summary document for revalidation approval. These recommendations are then ratified by the Chiefs of service, Chief Medical Officer and Responsible Officer.
Action for next year:	No changes expected

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	The Medical Appraisal and Revalidation Manager ensures that recommendations are made to the GMC in a timely manner. All doctors for whom a deferral is recommended are contacted by the Medical Appraisal and Revalidation Lead by letter explaining the reason for the deferral and the Lead works with the doctor to ensure that a positive recommendation can be made by the end of the deferral period. Non-engagement is escalated to the Chief Medical Officer (Responsible Officer) for further action and referral to the GMC when necessary. There were no 'non-engagement' recommendations made in 24/25.

Action for next year:	No new changes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	Clinical governance is a system through which MTW are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish". It involves monitoring systems and processes to provide assurance of patient safety and quality of care across the organisation. Clinical governance meetings are held monthly except in August, in all specialties Monitoring doctors' performance and development is a key contributor to delivering effective clinical governance. Quality includes patient experience, safety and clinical effectiveness and is a key marker of operational performance. Appraisal is an opportunity to discuss on how a doctor is contributing as an individual in both positive ways and to reflect honestly on incidents where things went less well and learn from such events so that they can prevent future mistakes and reduce risk of harm. All doctors are working in managed departments to help make changes that are less likely to cause harm, and processes are in place to help understand why things go wrong. Any involvement in After Action Reviews, Patient Safety Incident investigations, Coroners' inquests and SJRs should be discussed and reflected upon at appraisal and included within the appraisal document. The GMC guidance on Supporting Information for Appraisal Jan 2024 provides differing types of information that doctors can provide as evidence for their appraisal that reflects on how they are working within good clinical governance focussing on CPD and how to record this, acceptable evidence of Quality Improvement activities, and maintaining professional standards as set out in the GMC guidance on

	Good Medical Practice 2024. These are available as documents on the Trust intranet, All doctors are able to engage in regular clinical governance meetings, audits and research and are supported by audit and research and development departments. Doctors are now able to produce a table of attendance at CG meetings and reflect on learning where appropriate in the appraisal. A log book of activity of work can be a challenge to produce for some doctors but other forms of evidence such as patient outcome data, and mortality and morbidity meetings etc are available for doctors to discuss their performance. A doctor can be asked to discuss any specific issue at their appraisal by the RO when relevant.
Action for next year:	No changes expected

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	Doctors are expected to discuss conduct and performance at their appraisal including any Maintaining High Professional Standards (MHPS) issues where relevant. Involvement in patient safety incidents, SJR reviews, performance issues, complaints and any incidents that caused harm should be discussed at the appraisal and reflection on the learning from these events. SJR meetings will now inform the appraisal team if specific information is required to be discussed by a doctor at the next appraisal The Medical Appraisal team will check this has been discussed and reflected on when the appraisal is submitted.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	The L2P system is an electronic appraisal system, including the MSF tool
Action for next year:	L2P will also start to host the doctors job plan later this year

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	There is a clear process for responding to concerns about a doctor at MTW. Medical appraiser training includes discussion on managing a doctor who is found to be breaching professional standards and how this must be escalated to the RO in a timely way dependent on the nature of the concern. MTW follows the NHS practical guidance on responding to concerns: • Patients must be protected. • Clinicians too must be safeguarded. • All action must be based on reliable evidence. • The process must be clearly defined and open to scrutiny. • The process should demonstrate equality and fairness. • All information must be safeguarded. • Support must be provided to all those involved.

Action for next year:	No changes expected

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	None
Comments:	MTW expects all doctors to maintain high professional standards and acts to manage and resolve performance concerns. The Responsible Officer responds to concerns raised regarding doctor's fitness to practice whether through complaints, contact from the GMC, or concerns raised by others. The Responsible Officer has regular meetings with the Practitioner Performance Advisory Service and with the local Employer Liaison Adviser for the GMC. The disciplinary process for doctors is in line with GMC guidance, Maintaining High Professional Standards and the Doctor's Conduct and Performance Policy and Procedure can be found on the Trust intranet. Disciplinary procedures including MHPS investigations will be instigated as necessary where fitness to practice concerns exist, however other processes including coaching, remediation and additional training are also used to support doctors of concern. Doctors in distress for any reason will also be supported to return to full practice as appropriate. Non-executive directors are appointed to support MHPS investigations The Practitioner Performance Advice Service collects data on the cases referred to them for advice.
Action for next year:	No changes expected

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	Doctors working at MTW with concerns but connected to another designated body, or working at another organisation while connected to MTW can have information shared from RO to RO. Written information can be transferred via the Medical Practice Information Transfer (MPIT) form. MPIT forms are also requested on new doctors joining MTW from their previous Responsible Officer MTW receives HPAN, or Healthcare Professional Alert Notice, a system used by NHS Resolution to issue notices to NHS organisations about healthcare professionals who may pose a significant risk of harm, acting as a safeguard during investigations by regulatory bodies.
Action for next year:	No changes expected

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	None
Comments:	MTW is committed to dealing firmly and fairly with doctors whose fitness to practise is in doubt. Response to concerns must be based on reliable evidence, and should demonstrate equality and fairness. All information must be safeguarded. Support must be provided to all those involved as they proceed through any internal or external investigation.

	MTW follows procedures free from bias and discrimination and works together with the Practitioner Performance Advice service, General Medical Council and the Medical Practitioners Tribunal service to seek a resolution.
Action for next year:	No changes expected

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue with PSIRF
Comments:	Patient Safety Incident Response Framework (PSIRF) has been implemented since April 2024 at MTW. This NHSE framework sets out how to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Action for next year:	No changes expected

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Further development of Clinical Director training programme. Development of leadership framework for consultants
Comments:	The leadership program is available for all staff who wish to develop their leadership skills. The leadership framework is under development
Action for next year:	Continue

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	All doctors are required to undertake mandatory pre-employment checks with the Medical Staffing team before they can start working at MTW to ensure that doctors are GMC licenced medical practitioners with appropriate verified qualifications and clinically experienced for their role. All doctors joining MTW will be checked for Healthcare Professional Alert Notices (HPAN) by medical staffing MPIT forms will be requested by Medical Staffing for all doctors in non-training grades on commencement.
Action for next year:	Continue as above

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	The MTW Equality, Equity, Diversity and Inclusion strategy (Jan 2023) ensures that we aim to bring EDI to the heart of everything we do. Our NHS People Promise has a focus on flexible working, kindness and respect and employee listening

	Our Senior Leadership program included a focus on compassionate leadership and Kindness in Action when raising a concern. The L2P system is a better system for appraisal and feedback has been very positive. The introduction of the MSF component now means that we have brought all of the documentation needed for revalidation into one system. The MSF report not only provides feedback on doctors but also shows that the doctor is receiving feedback from their wider multi-disciplinary team (admin, nursing, allied HCP and medical) An additional MSF for educators has also become available for doctors who are educational and clinical supervisors
Action for next year:	No changes expected

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	Trust PRIDE values Active EDI and OD team to promote inclusivity Exceptional leaders programme centred on compassionate leadership
Action for next year:	No changes expected

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None

Comments:	Freedom to speak up guardian ensuring the safety and well-being of both our patients and staff. PSIRF implemented with learning panels and shared learning across organisation. Learning from deaths group provides learning summaries for clinical governance across the organisation Revised governance structure with enhanced executive oversight of patient safety, patient outcomes, and patient experience
Action for next year:	Continue as above

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None
Comments:	Local processes for managing informal complaints. Formal complaints procedure in place. Complaints and patient safety incidents discussed at appraisal
Action for next year:	Continue as above

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	None
Comments:	Formal complaints procedure EDI policy

Action for next year:	Continue as above

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Network with other Trust Appraisal and Revalidation teams
Comments:	South East HLRO quarterly meetings South East HLRO Self-assessment tool to help all organisations demonstrate its clinical governance processes to support revalidation Advice from PPAS/NHS Resolution Regular meetings between the RO and local GMC ELA. The new Appraisal and Revalidation Manager has been invited to attend Appraisal/Revalidation Managers Network with local trusts. These will commence in September 25 and will be made a regular event.
Action for next year:	Feedback on network events and any impact or changes as a result of attending these for the medical appraisal services at MTW

Section 2 – metrics

Year covered by this report and statement: 1st April 2024 – 31st March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review (31 st March 2025)	766
Total number of appraisals completed	676 (MTW) 3 (HOKH) 4 (HITW)
Total number of appraisals approved missed	16 (MTW) 1 (HOKH) 2 (HITW)
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	189
Total number of late recommendations	0
Total number of positive recommendations	163
Total number of deferrals made	26
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	23
Total number of trained case managers	9
Total number of concerns received by the Responsible Officer ²	25
Total number of concerns processes completed	17
Longest duration of concerns process of those open on 31 March (working days)	3 years 3 months

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Median duration of concerns processes closed (working days) ³	2 months
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	4 (one by MTW and 3 by other)
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	168
Total number of new employment checks completed before commencement of employment	100%
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Dr Sara Mumford continued as Responsible Officer Lizzie Kendrick joined as Trust Medical Appraisal Manager Trained 12 new appraisers
Actions still outstanding
Policies to be approved: Medical Appraisal Policy Medical Appraisal Quality Assurance Medical Appraiser Role description Current issues To monitor and maintain an appropriate appraiser: doctor ratio

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Continue to provide New Dr appraisal and revalidation training
Continue to provide annual appraiser updates in 25/26
Continue to monitor Drs feedback and reflect on how to include training to support appraisers in maintaining quality appraisals

To continue with the two-tier process of checking appraisal completion and revalidation approval process

Monitor satisfactory completion of appraisal documentation, appraisals referred back, and completion of the MSF in time for revalidation

Maintain the Appraisal and Revalidation Pages in the Medics Hub and create a series of short on line training videos for the Medics Hub to facilitate appraisal training for new doctors

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Undertake an audit of completed appraisals using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT) as a measure of quality as part of peer review with local Trusts.

Network with local Appraisal and Revalidation Leads

Review allocation of appraiser process with feedback from appraisers, doctors and medical appraisal team

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

24/25 has been another successful year for appraisal and revalidation at MTW.

As an organisation we aim to be exceptional people delivering outstanding care and our medical staff are an important in this vision.

The highest number of medical appraisals (652) were completed this year at MTW.

Medical staff at MTW are required to be patient focussed, respectful, innovative, and deliver on excellent care.

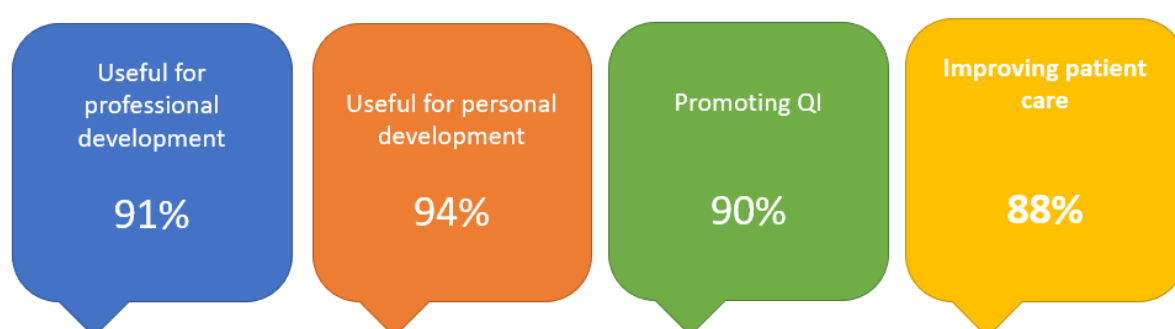
Medical appraisal is a process by which doctors can demonstrate that they are honest, delivering high quality care, reviewing their activity and outcomes through the Trust clinical governance processes, undertaking research, being educators to all colleagues, and celebrating their success and reflecting on both positive and negative experiences working as a doctor in our Trust.

Completion of appraisal is an annual requirement and an opportunity for a doctor to reflect on their personal and professional development, demonstrating clinical effectiveness, managing patients safely and creating a positive patient experience, maintaining their skills and knowledge and keeping focussed on their wellbeing and personal support systems as well as providing evidence on how they are learning continuously from both positive and negative patient experiences. Engaging in the process and completing quality appraisals are part of maintaining high professional

standards and working within the domains of GMC Good medical practice 2024. No doctors required a referral to the GMC for non-engagement in this process essential for GMC revalidation.

652 appraisals were completed which is the highest ever undertaken by the Trust representing a completion rate of 97.5% of all eligible doctors. Appraisals not undertaken were due to appropriate reasons and 1 doctor missed their appraisal without approval and the doctor is being supported by the RO and on track to complete this.

Doctors have fed back that they do feel that appraisers are making a difference and rated 97.8% of appraisers as a 4.5 / 5 or higher.



The purpose of an appraisal is for a doctor to reflect on their progress, be challenged on their development and create an annual PDP that is personal to them as a result of a supportive appraisal meeting.

100% of doctors felt supported and challenged during their appraisal and 100% felt that the PDP created was personal to their development needs.

Annual training of appraisers is undertaken to support their ongoing education and offer an opportunity to discuss unusual situations as well as maintain their skills and knowledge of the appraisal process. Appraisers are also encouraged to contact the RO at any time for discussion if any clinical or wellbeing concern should be shared. Doctors with low wellbeing scores of < 5 are highlighted to the appraisal lead and knowledge of internal and external support is offered.

A multisource feedback (MSF) is required once every 5 years and non-completion of this was highlighted as one of the more frequent reasons for deferral of revalidation so introduction of the MSF into the L2P system is expected to improve this as the doctor only needs to use one appraisal and MSF system.

The access to an educator MSF is also now available for use within a 5 year cycle for all clinical and educational supervisors.

43% of appraisals were completed later than expected and difficulties with finding an appraiser has been recognised and allocation of appraisers started on 1st April 2025. It is too early to know if this has been successful but will be reviewed next year. Allocation has the potential to make appraisal discussion more diverse and for some to

undertake more appraisals than previously completed. In addition, this may be more challenging for an appraiser to see a wider range of doctors from other specialties and this may highlight those appraisers who need additional support in the process and will be monitored.

Planned changes for this year include:

- Including all MTW based Physician Assistants and Physician Assistants in Anaesthesia on the L2P appraisal system and arranging training for this new group of professionals who will require GMC revalidation.
- Integration of job planning into L2P and prompt addition of doctors onto the L2P system via medical staffing
- Review of L2P onboarding forms for new doctors to complete
- Creation of specific reports by L2P to support appraisal reviews and measure outcomes for MTW.
- Real time monitoring of appraisal completion to reduce late appraisals and identify doctors who may have left the Trust and no longer require an appraisal through MTW
- Delivering another new medical appraiser training in 25/26
- Allocation of medical appraisers to doctors from April 2025
- Focussed support on more reflection before and during the appraisal by doctors
- Digital videos explaining the appraisal process for new doctors

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

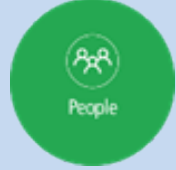
Signed on behalf of the designated body

Official name of the designated body:	Maidstone and Tunbridge Wells NHS Trust

Name:	Miles Scott
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Dr Lesley Navaratne
Email address:	lesleynavaratne@nhs.net

Title of report	Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment				
Board / Committee	Trust Board Meeting				
Date of meeting	25 th September 2025				
Agenda item no.	09-27				
Executive lead	Sarah Davis, Chief Operating Officer				
Presenter	Sarah Davis, Chief Operating Officer				
Report Purpose (Please ☒ one)	Action/Approval	☒	Discussion	☐	Information
					☐

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The enclosed report provides information on the Trust’s statement of compliance with NHS England Core Standards on Emergency Planning Response & Recovery for 2025. The Trust is fully compliant with all 62 of the Core Standards. The Trust has submitted evidence for all standards via the secure Resilience Direct System. The Trust Board is requested to approve the submission of the Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment for 2025 to the Kent and Medway ICB. N.B. the Trust is not required to complete the “Interoperable Capabilities” section. The Board are asked to note the significant amount of work carried out to achieve this.
Any items for formal escalation / decision	
Appendices attached	
Report previously presented to:	
Committee / Group	Date
Trust Resilience Committee	
Executive Team Meeting	

1 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England and Improvement has published NHS Core Standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met

2 Statement of Compliance

As part of the national EPRR assurance process for this year Maidstone & Tunbridge Wells NHS Trust has been required to assess itself against these core standards. The outcome of this self- assessment shows that against 62 of the core standards which are applicable to the organisation the trust is fully compliant with 62 of these core standards

The overall rating is: Fully Complaint

NHS England EPRR Assurance Compliance Ratings:

To support a standardised approach to assessing an organisation's **overall preparedness rating**.

NHS England and Improvement have set the following criteria:

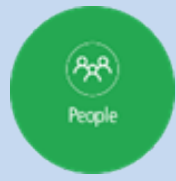
Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

3 Conclusion

The Trust's Emergency Preparedness remains strong and is an essential part of the organisation.

It is imperative that during a period of transformation that resilience is kept high on the agenda ensuring that risks are mitigated as far as practicable through effective planning and exercising. The need to horizon scan on a regular basis has never been more important.

Title of report	Board Assurance Framework					
Board / Committee	Trust Board meeting (Part 1)					
Date of meeting	25 th September 2025					
Agenda item no.	09-29					
Executive lead	Annette Doherty, Chair of the Trust Board					
Presenter	Executive Colleagues					
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	

	Strategic Objective	Senior Risk Owner	Overseeing Committee			1	2	3	4	5	6	8	9	10	12	15	16	20	25	Risk appetite	SRO Level of assurance
People	Reduction in total pay spend	Chief People Officer	People and Organisational Development	Q1	12															Open	Limited ↔
				Q2																	
				Q3																	
				Q4																	
Patient Safety and clinical effectiveness:	Number of moderate +harms attributed to the potential management of Deteriorating patients	Chief Medical Officer	Quality	Q1	15										 ↗					Cautious	Limited ↔
				Q2																	
				Q3																	
				Q4																	
Patient Access	Reduction in weeks wait to first outpatient appointment	Chief Operating Officer	Finance and Performance	Q1	10								 ↘								Adequate ↗
				Q2																	
				Q3																	
				Q4																	
Patient Experience:	To increase the number of complaints that are closed through an initial conversation or local resolution meeting	Chief Nurse	Quality	Q1	9															Cautious	Adequate ↗
				Q2																	
				Q3																	
				Q4																	
Systems and Partnerships	Delivery of the better use of beds program for MTW	Director of Strategy, Planning and Partnerships	Finance and Performance	Q1	15																Limited ↔
				Q2																	
				Q3																	
				Q4																	
Sustainability:	Reduce non-pay spend	Chief Finance Officer	Finance and Performance	Q1	16																Open ↔
				Q2																	
				Q3																	
				Q4																	

Key



Target



No change in Assurance



Current



Increase in Assurance rating



Decrease in Assurance rating

Key

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

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

5 x 5 Matrix

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

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

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

