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

Thu 30 October 2025, 09:15 - 14:00

Marie South and Alan Pentecost Rooms, Academic Centre, Maidstone Hospital

Agenda

09:15 - 09:16
1 min

10-1
To receive apologies for absence

Annette Doherty

09:16 - 09:16
0 min

10-2
To declare interests relevant to agenda items

Annette Doherty

09:16 - 09:20
4 min

10-3
To note progress with previous actions

Annette Doherty

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

Patient Experience

09:20 - 09:45
25 min

10-4
Patient Experience story

Jocelyn Moore and Tina Cooper

N.B. This item is scheduled for 09.20am

- Board cover page Experience of Care patient GS.KMRJdocx (1).pdf (3 pages)
- Surgery Div January RJ 2025 patient story RG (002).pdf (3 pages)

Reports from the Chair of the Trust Board and Chief Executive

09:45 - 09:50
5 min

10-5
Report from the Chair of the Trust Board

Annette Doherty

- Report from the Chair of the Trust Board - October 2025 - FINAL APPROVED.pdf (3 pages)

09:50 - 09:55
5 min

10-6
Report from the Chief Executive

Miles Scott

- Chief Executive's report October 2025 - FINAL APPROVED.pdf (4 pages)
- Medium Term Planning Framework - delivering change together 2026 27 to 2028 29.pdf (40 pages)

Reports from Trust Board sub-committees

09:55 - 10:05
10 min

10-7
Quality Committee, 29/10/25

Maureen Choong

N.B. Report to follow after the meeting on 29/10/25.

- Summary of Quality Committee 29.10.25.pdf (4 pages)

10:05 - 10:15
10 min

10-8
Finance and Performance Committee, 28/10/25

Neil Griffiths

N.B. Report to follow after the meeting on 28/10/25.

- Summary of Finance and Performance C'ttee 28.10.25 v2.pdf (4 pages)

10:15 - 10:25
10 min

10-9
People and Organisational Development Committee, 24/10/25

Richard Finn

- Summary of People and Organisational Development Cttee 24.10.25.pdf (3 pages)

Integrated Performance Report

10:25 - 10:55
30 min

10-10
Integrated Performance Report (IPR) for September 2025

Miles Scott and colleagues

- IPR cover.pdf (1 pages)
- Finalised Integrated Performance Report September 251023.pdf (43 pages)
- Trust Board Month 6 Finance OverviewV1.pdf (4 pages)
- Trust Board M6 Finance Report V1.pdf (2 pages)
- Safe staffing.pdf (1 pages)

Quality items

10:55 - 11:05
10 min

10-11
Maternity Report relating to the Perinatal Quality Oversight Model

Joanna Haworth

- Board cover page for October 2025 Trust Board.pdf (3 pages)

11:05 - 11:15
10 min

10-12
MTW Mental Health Strategy 2025-2030

Joanna Haworth

- Board cover page - MH Strategy 25-30.pdf (2 pages)
- 1092_Mental_Health_Strategy_V1.pdf (28 pages)

11:15 - 11:30
15 min

BREAK

11:30 - 11:40

10-13

10 min

Findings of the national inpatient survey 2024

Joanna Haworth

- 2024 Inpatient CQC survey results MTW.pdf (2 pages)
- Trust Board Adult Inpatient Survey 2024 updated24.10.25.pdf (15 pages)

People and Organisational Development issues

11:40 - 11:50
10 min

10-14
Six-monthly update on the implementation of the sexual safety in healthcare charter

Helen Palmer

- Six-monthly update on the implementation of the sexual safety in healthcare charter.pdf (2 pages)
- Sexual Safety Update POD & Trust Board 0925 final.pdf (8 pages)

Systems and Place

11:50 - 12:00
10 min

10-15
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

- Oct HCP update front sheet.pdf (1 pages)
- HCP update Oct 25.pdf (4 pages)

Assurance and policy

12:00 - 12:10
10 min

10-16
Quarterly report from the Freedom to Speak Up Guardian

Helen Palmer

- FTSU Quarterly ETM Report - October 2025 (1).pdf (5 pages)

Other matters

12:10 - 12:10
0 min

10-17
To consider any other business

Annette Doherty

12:10 - 12:10
0 min

10-18
To respond to any questions from members of the public

Annette Doherty

12:10 - 12:10
0 min

10-19
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

Annette Doherty

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
N/A	N/A	N/A	N/A	N/A

Actions not yet due (and still 'open')

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

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

Title of report	**Experience of Care Patient Story**					
Board / Committee	**Trust Board**					
Date of meeting	October 2025					
Agenda item no.	10-4					
Executive lead	Joanna Haworth, Chief Nurse					
Presenter	Joceyln Moore, Matron for General Surgery					
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 patient story will provide feedback on the experience of care of a patient who had an emergency laparotomy for an impending bowel perforation at MTW. Key areas that impact experience of care are: • Management of insulin dependent Diabetes following VRII • Communication with the patient and family • Communication between teams		
Any items for formal escalation / decision	The Board is asked to consider and discuss the experience of care and related actions.		
Appendices attached	• Appendix A – Experience of care patient story.		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
Nursing, Midwifery, Allied Health Professionals and Pharmacy Board		October 2025	Progress noted against the risk and action points

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR4- Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation.
Links to Trust Risk Register (TRR)	Nil
Compliance / Regulatory	Nil

Implications	

NHS
Maidstone and Tunbridge Wells NHS Trust

Patient Story

Name: RJ	
Date of care experienced: **October 2025**	**Services/wards experienced:** **Diabetic Clinical Nurse Specialist** **Ward 11** **Surgical team** **Ward 12** **High Dependency Unit** **Physiotherapist/Occupational Therapist**

Outline of experience:

For the purposes of this story, the patient will be referred to as RJ. The patient and his wife consented to have his story told in the interest of learning for staff within MTW.

RJ was admitted to the Trust with a history of abdominal pain, general decline in mobility, bilateral pulmonary embolisms, urinary tract infection and acute kidney injury. This was with a past medical history of Multiple Sclerosis and Insulin Dependent Diabetes. Prior to admission RJ, had been mobile with a stick and driving.

RJ was initially admitted to ward 12 under the care of the medical team as they felt there was no surgical intervention needed at this point and the abdominal pain was thought to be due to faecal impaction.

On the 21 June 2025 the Surgeons were asked to review RJ as his abdominal pain was increasing and his general condition worsening. A CT scan showed that RJ had a small bowel obstruction and was consented for theatre. The discussion with RJ and the family highlighted the risks of this surgery. RJ went to theatre and had a Low Hartmann's procedure to remove the obstruction and was then transferred to the High Dependency Unit (HDU) for organ support post operatively.

RJ's recovery was further complicated when he developed an Ileus which is a common post bowel surgery complication. Additionally, the abdominal wound began oozing serous fluid as the balance of managing the anticoagulant therapy and risks of haemorrhage was important in maintaining a therapeutic does.

On the 2 July 2025 whilst on HDU the family activated Martha's rule as they had concerns with RJ's general care when he was on WD12, poor family communication while in HDU, and they also felt RJ could have been transferred to the main ward when he was not well enough for general ward care. In response to the concerns raised the Nurse in charge called RJ's wife to discuss the concerns the family had.
On the 4 July 2025 RJ was transferred to ward 11 from the HDU for the on-going care post-surgery which seemed to progress slowly due the general deconditioning which occurs with prolonged illness. RJ's family visited daily, and they were actively involved with RJ's care.

On the 24 July 2025 the family of RJ contacted the Patient Liaison Service to raise concerns regarding his care on ward 12 and ward 11, at this time the Head of Nursing asked the senior nursing staff to meet with the family to discuss their concerns. On the 28 July the Head of Nursing was on ward 11 and met the family of RJ who were quite distressed and frustrated with communication and felt staff were not listening. The main issues highlighted:

- Medication left on the patient table which RJ could not reach or take without help
- Pressure damage to the sacrum
- Concerns with Insulin administration as this is time critical
- Concerns how this was being drawn up from a Pen cartridge
- General staff attitude/ no name badges and not introducing themselves
- Staff not listening to concerns raised about RJ's care
- Lack of continuity of care from the surgical team
- Inadequate cleaning of RJ's room

Following this family meeting there were some immediate actions which the Head of Nursing asked the ward staff to undertake, to reduce the risks around the medications and measurement of the blood glucose. The Head of Nursing apologised to the family and asked them to contact her directly if there were any further concerns. Daily meetings with the family on the ward were also organised by the Head of Nursing to assess progress.

Action plan from the family meeting meeting:

- The ward team to seek advice/training from the Diabetic Nurse specialist
- Additional training with the Practice Development team on time critical medications and the importance of observing patients taking their medications
- Additional support and training from the Diabetic team
- Discussion with the surgical Consultant regarding continuity of care and communication with the family
- RJ to be encouraged to be more mobile in the bed and to sit out of bed for longer periods
- Documentation (chart to be completed) to establish time spent out in the chair to support the Occupational therapy team and Physiotherapy team in understanding RJ's rehabilitation potential along with goal setting
- New name badges for ward staff had already been ordered to ensure all team members had name badges
- Discussed with the team the importance of communication with families
- Staff reminded about introducing themselves to patient and families
- Domestic supervisor contacted
- Daily family meetings to give updates

On the 13 August 2025 RJ's wife emailed to raise her concerns in a formal complaint regarding the on-going management of the Diabetes care, which has been forwarded to the complaints team and ward 11 to investigate.

The care continued and RJ was discharged home on the 1 September 2025. RJ's wife was keen that their story was shared for learning and training.

Positive points to highlight:	**Areas for improvement:**
• RJ's family were keen to highlight that the ward had some amazing staff who were engaged and good with communication. • The family feedback that they were happier following the meeting with the Head of Nursing as they felt listened to as they were then having regular conversations and contact.	• The general management of a Patient with type 1 Diabetes within the Trust not only Ward 11(as reported by patient's wife). Especially around dietary advice and portion control within the hospital meals. • Poor communication with the family. • Surgical team lack of continuity when talking to family highlighting, they had not read the communications from the day before • Staff attitude • General cleaning of the room while on ward 11.

Ongoing actions with case:

- On going formal complaint which the ward team - completed
- After-action review to encourage the ward staff to learn from this experience - completed
- Poster in the ward areas highlighting Do's and Don't with Insulin administration as a visual aid - completed
- Patient safety alert raised regarding the insulin cartridge usage and shared within the Division - completed
- Liaise with the Medicine and Emergency Care division on current actions relating to diabetes care across clinical areas - completed
- Discussion regarding themes with complaints team - ongoing
- Review Friends and family feedback to monitor if the above themes/ trends will reoccur - ongoing

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board**					
Date of meeting	Thursday 30 October					
Agenda item no.	10-5					
Executive lead	Annette Doherty, Chair					
Presenter	Annette Doherty, Chair					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

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

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

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

I was delighted to attend the official opening of the Undergraduate Medical Building earlier this month at Tunbridge Wells Hospital. We were joined at the event by former MP for Tunbridge Wells, The Rt Hon Greg Clark PC, Founding Dean of the Kent and Medway Medical School and Consultant in Intensive Care Medicine, Professor Chris Holland, and members of our Medical Education team, who oversaw the project. The new facility, which provides accommodation to medical students on clinical placements at our hospitals, highlights the Trust's commitment in supporting the next generation of healthcare professionals in the region while also strengthening our role as a teaching trust.

In addition to attending the Kent and Medway Joint NHS Committee held on 8 October, where we addressed a number of strategic topics including next steps for the Acute Provider Collaborative, I also joined the Trust's Chief Executive, Miles Scott, at the South East Learning Improvement Network Event in Brighton on 13 October. Hosted by NHS England, the event covered themes including productivity improvements, referral to treatment targets, and new standards in Urgent and Emergency Care. There was also a talk by Professor Mark Britnell, from the Global Business School for Health at University College London, on integrated care organisations around the world and the learnings in providing integrated types of primary, community and secondary care to patients. The talk had a significant focus on system partnership and collaboration, and ways to deliver more integrated patient care across the NHS as part of the 10-year strategic plan.

Miles and I also recently met with the new Chief Executive of NHS Kent and Medway Integrated Care Board, Adam Doyle. Together we discussed partnership working across the Kent and Medway system, as well as innovations and improvements that will ensure patients in our communities continue to receive fast, safe and high-quality care.

I am continuing to visit wards and departments across our hospitals to speak with staff about the services we provide. This month I had the pleasure of meeting colleagues in the Haematology-Oncology Day Unit at Tunbridge Wells Hospital, where we discussed their work in caring for our cancer patients, the treatments they deliver and the vital contribution they make in ensuring MTW's Kent Oncology Centre is one of the best performing cancer centres in the country. I visited the Estates and Facilities Management team at Maidstone Hospital, who are responsible for managing and maintaining the fabric of our sites and buildings so that we can continue to deliver our services. I also had the opportunity to meet our Integrated Discharge teams, who play a vital role in improving flow across our hospitals by getting patients back home, or to the right place for their ongoing care, as quickly and safely as possible. My thanks to all the teams I have met this month for sharing their experiences with me and giving me invaluable insight into the work they do in caring for our patients and keeping our services running efficiently.

Finally, I would like to end my report by recognising the incredible work of two of our Non-Executive Directors (NEDs), Maureen Choong and Richard Finn, who will be stepping down from their roles in mid-November.

Maureen came to MTW in 2017 following a long career in the NHS which spanned a variety of roles including Executive Director of Nursing in acute hospital trusts and specialist advisor to the Care Quality Commission (CQC). She has continued to hold a number of positions since joining the Trust, including Chair of the Quality Committee and Maternity Safety Champion, where she supported the maternity service at Tunbridge Wells Hospital to be upgraded by two CQC ratings in just 14 months. Maureen has dedicated her time and support to MTW throughout her tenure and is a familiar face across the hospitals, regularly meeting with staff and using her expertise to deliver advice and insights to all aspects of Trust activities.

Richard joined the Board in 2019, having previously worked as a consultant in a number of global companies advising on change management, people strategy, HR function transformation and leadership development. He has held a number of roles at MTW, including Lead NED for Canterbury Oncology, Member of the Finance and Performance Committee, and Deputy Chair of the People and Organisation Committee. Richard has been a highly engaged NED throughout his tenure and a champion for qualitative data. His expertise and experience in organisational

development and leadership have been vital in strengthening the people agenda at the Trust and he has provided invaluable support to the organisation through the Transformation programme.

On behalf of the Board, I would like to express our sincere gratitude to Maureen and Richard for the significant contributions they have made to the Trust during their tenures, and for the dedication and commitment they have shown in helping MTW continue to provide outstanding care to patients in our local communities.

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?
22/09/2025	Consultant Neurologist	Omar	Almasri	Neuro	January 2026	Replacement
22/09/2025	Consultant Neurologist	Angelo	Dawson	Neuro	27th Oct 25	Replacement

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	Thursday 30 October 2025					
Agenda item no.	10-6					
Executive lead	Miles Scott, Chief Executive					
Presenter	Miles Scott, Chief Executive					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Chief Executive Report for the October Trust Board meeting, summarising Trust developments and achievements over the last month.		
Any items for formal escalation / decision	N/A		
Appendices attached	NHS England- Medium Term Planning Framework		
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:

- We celebrated important milestones this month for developments which have enabled the Trust to enhance its services, care for more patients across the system and support the development of new clinical staff:

  - The Kent and Medway Orthopaedic Centre (KMOC) is being officially opened this afternoon during a ministerial visit by Karin Smyth MP, Minister of State at the Department of Health and Social Care. KMOC celebrated its first anniversary last month and has treated over 3,000 patients over the past year, supporting them to regain their mobility and independence through planned orthopaedic surgery. The Centre, which is located at Maidstone Hospital and provides three state-of-the-art operating theatres, has also obtained NHS England Getting It Right First Time (GIRFT) surgical hub accreditation. Surgical hubs focus on non-emergency surgery and bring together the skills and expertise of staff under one roof, helping to deliver shorter waits for surgery.

  - The Undergraduate Medical Building at Tunbridge Wells Hospital was also officially opened this month. The new facility enables the Trust to host up to 173 medical students and trainee doctors each year. MTW provides clinical placements for medical students studying at the Kent and Medway Medical School, King's College London and City St George's University of London. The Undergraduate Medical Building means these students can now live close to their placement at the hospital, giving them direct access to medical and surgical services to complete their studies. The six-storey building, which achieved a Building Research Establishment Environmental Assessment Method 'Excellent' rating, will help the Trust to attract, train and retain future generations of doctors to the region.

  - We marked the one-year anniversary of Fordcombe Hospital joining the Trust. Located near Tunbridge Wells, Fordcombe Hospital provides care across a range of specialties, including diagnostics, general surgery and gastroenterology, and holds two operating theatres, 28 inpatient and day care beds, and several consultation spaces. The extra capacity provided by Fordcombe Hospital has enabled the Trust to support the wider NHS across Kent and Medway. Over 26,000 appointments and treatments have been delivered at Fordcombe Hospital in the last year, and an additional 2,000 of the longest-waiting NHS patients from across the system have also been transferred to the Trust.

- As NHS trusts across the country continue to navigate a challenging financial landscape, the Trust is managing a significant period of transformation as we work to ensure long-term sustainability and create the foundations for continued improvement and innovation. Living within our means and delivering a Cost Improvement Programme for 2025/26, which totals £49 million, is central to this effort. Of this, £36.5 million must be achieved through workforce-related savings. Encouragingly, the first half of the year saw us reduce pay spend and introduce robust vacancy controls to maintain this trajectory as we near the end of the first phase of this work and go into the second phase, which focusses on the clinical divisions. Bank and temporary staffing costs have also reduced and remain an ongoing focus as we move into the latter part of the financial year. Work on developing improvement plans that will enable us to work more efficiently and enhance patient experience is also continuing and includes a number of digital solutions. In our outpatient departments, for example, we are implementing a dynamic new scheduling system that provides real-time visibility of clinic and room availability, streamlining booking processes and reducing administrative time. A new outpatient prescription dispensing pathway is also being piloted, designed to alleviate pressure on our pharmacy teams and offer patients faster, more convenient prescription services, including home delivery options.

  As we enter a more challenging second half of the year, our focus remains firmly on delivering our financial plan while providing the highest standards of care for patients and supporting the wellbeing of our staff.

- The Trust's patient portal has been updated and now provides online access to radiology results, including x-rays, CT scans and MRIs. Over 200,000 patients already use the portal, which is a secure, free and easy-to-use tool that keeps them informed about their health, without waiting for the post or calling our teams. The platform, called Patients Know Best, enables patients to access important documents such as appointment details, clinic letters, and now radiology

imaging results, which will appear in their portal 28 days after clinical review - any findings from new imaging results will be shared with a patient before they are made available to view. The portal also provides a number of other benefits including amending or cancelling outpatient appointments and reminders of upcoming appointments.

- A new national Community of Practice to enhance emergency stroke care was recently launched at Maidstone Hospital. Chaired by MTW's Lead Stroke Nurse, the purpose of the group is to bring together healthcare professionals from around the UK to share knowledge and best practice to support stroke services with emergency stroke care. During the inaugural meeting, the Trust's Stroke Unit spoke about the Stroke Assessment Bay, where suspected stroke admissions can be brought directly on arrival to Maidstone Hospital. This means patients don't need to go through the Emergency Department first and can quickly receive the care they need in the right place at the right time. With the number of stroke cases increasing every year, the new collaborative group will support stroke services across the country to develop same day emergency care in their own organisations, leading to better outcomes for stroke survivors.

- ITV Meridian featured our Ophthalmology teams in a special news report this month to raise awareness of cornea donation. ITV interviewed Consultant Ophthalmologist, Miss Sundas Maqsood, who spoke about the shortage of cornea donors and the 6,000 people who are currently awaiting a transplant in the UK. The crew also spoke with patients who have received a cornea transplant, and the impact that improved vision has had on their lives. On behalf of the Board, I would like to thank Miss Maqsood, her team and her patients for taking part in this special report, which encouraged more people to register their decision to donate corneal tissue.

- The Trust celebrated Black History Month in October, which aims to educate people on the history, achievements and contributions of Black people, and highlight the challenges the African and Caribbean communities face in the UK and across the world. This year's theme was 'Standing Firm in Power and Pride', and the Trust's Cultural and Ethnic Minorities Network supported a number of events, including Nigerian Independence Day on 1 October. Colleagues gathered in the restaurants at Maidstone and Tunbridge Wells hospitals to enjoy a special Nigerian menu, with many wearing traditional dress in adire fabric, specially made for the celebrations. A system-wide virtual event was also held across Kent and Medway, with the theme 'Powering Through the Storm', celebrating resilience, unity and pride. A vast multicultural workforce works across the Trust and the wider NHS, and Black History Month has provided the opportunity for us to celebrate the rich diversity of our healthcare services and communities.

- Colleagues formally collected the Gold Defence Employer Recognition Scheme award from the Ministry of Defence during a ceremony held at the Army Flying Museum in Hampshire this month. The award, which we achieved in July, recognises the Trust's outstanding commitment to assisting veterans, reservists, cadet force adult volunteers, and the families of those currently serving. The award was presented by HM Lord-Lieutenant of Hampshire, Mr Nigel Atkinson, and highlights MTW's commitment to supporting our Armed Forces community staff and advancing initiatives that strengthen the Trust's position as a Forces-friendly organisation.

- The Trust's Catering team have won gold at the Awards for Excellence in Waste Management for NHS Trusts in England. The team received the top prize in the Best Reduction of Food Waste of the Year category for their work in segregating food waste from wards and restaurants. The initiative aligns with NHS England's standards for healthcare food and drink, which require NHS trusts to monitor and reduce food waste. The national focus on reducing waste also supports broader Net Zero goals, as food waste is a major contributor to carbon emissions. The team's project introduced a comprehensive approach to food waste reduction, including training for staff, portion control, meal planning, engagement with suppliers to reduce packaging and data-driven insights. In just five months, the team achieved an 18% reduction in food waste while also boosting the Trust's recycling rate by 17%, with the aim to eliminate over 15 tons of food waste annually.

- Congratulations to the joint winners of the Trust's Employee of the Month award for September, Consultant Anaesthetists Helen Burdett and Kate Stannard. Helen and Kate are the founders of Women in Medicine International (WIMIN), an organisation they run in their spare time to promote women in medicine and support charities. The annual WIMIN conference attracts renown international speakers and has significantly contributed to the development of female

clinical leaders. Chanse Fyffe, F1 Resident Doctor on Ward 21 at Tunbridge Wells Hospital, also received the Highly Commended Awarded for developing a process that ensures priority discharges are completed in a timely and efficient manner.

NHS England

Medium Term Planning Framework –

delivering change together 2026/27 to 2028/29

Contents

Foreword

Dear colleague,

Today we are publishing the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 – marking the beginning of a new way of working in the NHS.

It **signals the end of the short-termism** that has held the local NHS back for so long, providing local leadership teams and boards with the opportunity to break the cycle of 'just about managing' by creating the environment and headroom to fix the fundamental problems we face, while in parallel improving care in the immediate term.

It further **closes the gap between the national centre and service**: the fact that much of what is contained within this document has been co-produced with hundreds of leaders from primary care, acute, mental health, ambulance and community services is testimony to the collective desire to genuinely embrace the change the public told us all they wanted, and drive improvement in every part of the country.

But most importantly, **it marks the return of locally-led ambition** in the NHS – creating the platform for NHS boards and leaders to truly listen to their communities and drive the change they want and need.

And we're already seeing the early impact that new-found ambition is having: for the first time in years, elective waiting lists have started to fall, access to primary care is improving with more people saying it's easier to contact their GP than a year ago, corridor care incidents have fallen sharply and 12 hour waits are down year-on-year for the first time since the pandemic. We've even seen a sharper uptake in flu vaccinations across staff and the public in the early part of this year's campaign.

The same commitment to accelerating improvement is going to need to be seen right across the NHS as we go into the next few months: we need to deliver a strong and safe winter, continue our drive to improve elective performance and maintain our firm grip on the money as this is what unlocks future freedoms.

Just a few short months ago we published the 10 Year Health Plan: today's publication shows how that reform agenda will drive faster delivery of care now while creating a platform for sustained improvement in the future. It completely rewires how the NHS works, setting out how a new operating model and financial regime will rightly return freedom and innovation to the frontline of the NHS.

Resetting these foundations will enable the NHS to accelerate the delivery of neighbourhood health services, radically transform its approach to quality, and finally embrace the opportunities of digital health to drive improvements in every aspect of its work.

All of this means that the NHS is now able to commit to even more ambitious delivery targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry. At the same time, the Planning Framework sees a return to some of the basics that have taken a back seat over the last decade: ensuring providers take the time to better understand what their patients and staff are telling them, and making sure they take action when they fall short.

In short, this is the most ambitious plan the NHS has published in a generation. Over the next 3 years it will return the NHS to much better health – with waiting times dramatically reduced, access to local care restored to the level patients and communities expect, and unnecessary bureaucracy slashed so that savings are poured back into frontline services and staff.

None of what is set out in this Framework is going to be easy to deliver – but the emerging energy for change generated through the 10 Year Health Plan has started to create new optimism in the NHS.

We will continue to challenge ourselves when we fall short of what patients and communities need. Equally, we give you a clear commitment to break down any unnecessary barriers in your way – as we hope we have started to demonstrate over the course of this year.

Our collective challenge goes well beyond improving the care we provide our patients – it's about ensuring we are the community of staff and leaders that seize the opportunity to put the NHS on a sustainable footing: safeguarding it for generations to come, winning back the public's faith, and most importantly saving, extending and improving many more lives.

Thank you to all of you who have committed time and effort this year – either through contributing to the 10 Year Health Plan or helping shape this new approach to delivery. Keep up the hard work – it's very much appreciated.

Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care

Sir James Mackey, Chief Executive, NHS England

Introduction

The NHS is undergoing the biggest change process since its inception: moving away from an era where unparalleled levels of bureaucracy, complicated rules and unnecessary processes have constrained and restricted transformation to a new way of working where local leaders are empowered to drive the change their patients, communities and staff want, and need, to see.

Six months ago, despite a £22 billion injection of additional funding made available through the Autumn Statement, the NHS was predicting a deficit of £6.6 billion for the current financial year, the Public Attitudes Survey showed record-low public confidence in the NHS, staff surveys reflected worrying levels of dissatisfaction among our workforce, and the variation gap between the best and worst performers in the NHS had never been bigger.

In short, service confidence to deliver the commitments the NHS has made to improve access to care and reduce waiting times during this parliament was at an all-time low: due, in part, to a growing disconnect between the centre and the service and an operating model that had become overly bureaucratic and that stifled local innovation and change.

Yet, given the opportunity to contribute to the development of the 10 Year Health Plan, local health and care staff and NHS leaders talked with genuine optimism about what the future could look like – but only if we dramatically changed course on how the NHS is run: empowering local leaders to take more control and moving away from the annual cycle of short-term, centrally directed planning and finance that made it hard to drive real change over the medium and long term.

The 3 strategic shifts and wider transformation areas of the 10 Year Health Plan offer a blueprint for reimagining services, unlocking productivity and redirecting resources to where they can deliver the greatest impact. By embracing this approach, systems and trusts can cut waiting times, improve performance against constitutional standards, and deliver better outcomes for individuals.

The proposed abolition of NHS England is already helping to fundamentally re-set the relationship between the centre and the service, so that local NHS leaders can be more supported and empowered to drive accelerated change and improvement on behalf of their patients and staff.

Reviving an ambitious NHS

The early response from local NHS leaders has been fantastic. There's been a significant, system-wide and disciplined effort to get a better grip of the money, meaning we could start the financial year with plans that projected balance – collectively recognising some of the challenges that lie ahead in fulfilling that ambition. So far this year, these plans are being held in aggregate and for most of the NHS.

The leadership community has also stepped up to the opportunity to shape the way in which we operate in future: ICB leaders have collectively drafted the Model ICB and have redrawn the map of ICBs to create the platform through which we can do much more effective strategic commissioning going forward, drive greater productivity and better target our resources.

The broader leadership community from acute, mental health, ambulance, community and primary care has worked together throughout the summer developing plans that will see us accelerate delivery of the 10 Year Health Plan. That work forms the basis of many of the commitments set out in this document.

At the same time as more effectively planning for the broader changes we need to see, the NHS has delivered overall improvements in the rate of elective recovery on both referral to treatment waiting times and reducing waiting lists, significant reductions in spending on inefficient use of agency staff, and improvements in access to primary care.

That early progress gives us the foundation to accelerate the pace of reform. The 3-year revenue and 4-year capital Spending Review 2025 (SR25) settlement gives us both the opportunity to move away from annual financial and delivery planning cycles and a real terms increase in funding. Revenue funding will increase by 3% in real-terms over the SR25 period up to £226 billion in 2028/29, and capital spending will increase from £13.6 billion in 2025/26 to £14.6 billion in 2029/30 – equivalent to a 3.2% average real-terms growth across the full SR25 period. This represents a 31.4% and 50% real-terms funding growth in revenue and capital, respectively, since 2019/20.

Regaining public confidence in the NHS is dependent on delivering change that local communities can see and experience – better access to urgent care when they need it; reduced waiting times for elective care; and more convenient access to primary care – all of which can only be delivered and accelerated if we manage our finances well.

But it goes beyond winning back the confidence of the public: improving access to care and reducing waiting has a clear impact on future economic growth. Improving population health and tackling sickness in a more productive way directly impacts on reducing the drivers of health related inactivity, which in turn can make us more productive as a nation. It's from that economic growth that future investments in the NHS will come. On a macro scale, we can also act as a catalyst for stimulating demand for innovative health technologies, creating a robust market for UK life sciences businesses, and supporting research and development that accelerate product development and commercialisation.

The NHS has signed up to some challenging delivery commitments between now and the end of 2028/29, including:

Elective, cancer and diagnostics

- Elective (including diagnostic) reform and activity to deliver 92% 18-week referral to treatment by the end of 2028/29.
- Improve performance against key cancer standards: Maintaining performance against the 28-day Faster Diagnosis Standard (FDS) at 80% and improving 31 and 62 day standards to 96% and 85% respectively.
- Improve performance for diagnostic waiting times so that the rate of those waiting over 6 weeks is 1% (DM01 measure).

Urgent and emergency care

- Improve A&E waiting times, so that 85% of patients wait no more than 4 hours, as well as reducing the number who wait over 12 hours.
- Improve Ambulance Category 2 performance to an average of 18 minutes.

Primary care and community services

- Improve access to primary care, including reducing unwarranted variation in access. Ensure 90% of clinically urgent patients are seen on the same day. We will consult with the profession on this new ambition and approach.
- Maintain the additional 700,000 urgent dental appointments per year.
- At least 80% of community health service activity occurring within 18 weeks.
- Community pharmacy: maximise pharmacy first and roll out new services (emergency contraceptives and HPV vaccination).

Mental health, learning disabilities and autism

- 73,500 people accessing individual placement and support and providing 915,000 courses of NHS Talking Therapies treatment.
- 94% coverage of mental health support teams in schools and colleges, reaching 100% by 2029.
- Reduce the number of inappropriate out of area placements.
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction.

Delivering all these priorities between now and 2028/29 will only be achievable if we change the way we work together.

This document sets out how we are moving to a new operating model, resetting the financial framework and creating much greater opportunity for local autonomy through the new neighbourhood health approach, a new foundation trust model and the creation of integrated health organisations. It also sets out the early progress being made on reforming our approach to quality, workforce and neighbourhood health, while setting the scene for embracing a crucial new principle that services should be delivered digitally as the default wherever possible. All the work to date has been supported and developed by leaders from across the NHS and much of it is being published in draft this autumn so that the broader health and care leadership community can contribute to these important policy developments.

Using the reform agenda to fix today while building a more sustainable future

For too long, the delivery and reform agendas have been seen as separate conversations in the NHS.

The lack of progress in recovering delivery since the pandemic and the urgent need to dramatically change the NHS operating model to return freedoms and innovation back to local NHS organisations means **our central leadership challenge over the next 3 years is how we use the reform agenda to accelerate delivery in the short-term while creating new ways of working** that provide the platform for much more sustainable, locally-driven improvement in the future.

The Medium Term Planning Framework provides us with the road-map to achieving this. The reforms to the financial regime set out in this document can help us to accelerate the long-overdue changes to the delivery of outpatient care. Taken together, they can have a substantial impact on waiting lists in the immediate and medium term.

The changes we have set out to reform the NHS App will improve direct communication with patients who are waiting for their care – helping us to reduce 'did not attend' rates, which can have a big impact on reducing waiting lists.

Similarly, embracing interoperable technology supports better communication between acute and primary care providers – enhancing how we can use Advice and Guidance, which allows us to provide more appropriate care and reduce waiting times for our patients.

Accelerating the delivery of neighbourhood services – supported in this document by changes to the operating model and the financial regime – can have a dramatic impact on urgent and emergency care performance, simply by reducing the number of frail patients that require hospital beds, freeing up more capacity and increasing the amount of elective work we can deliver.

To support this, the Medium Term Planning Framework sets out the priority deliverables and the reform opportunities that ICBs and providers need to deliver for the next 3 years and the broader strategic aims that will need to be reflected in 5-year plans developed by each organisation.

The priorities in this document are deliberately high-level. We are setting a clear direction on the top priorities the NHS needs to deliver, while allowing local autonomy to meet the needs of local populations. Strategic aims are set out in section 2. Headline targets and multi-year performance expectations are set out in section 3. Supporting publications will provide further detail on the key actions and interventions.

To support a shared understanding of the expected pace of progress, ICBs and providers must develop robust and realistic 5-year plans that outline improvement against these priorities, based on the principles outlined in this guidance.

1 Incentivising delivery and creating the conditions to transform care

1.1 Financial context and discipline

The multi-year settlement provides the foundation on which we can move away from annual to medium-term financial and delivery planning cycles.

Provider and system finance directors and CEOs have been working with the national finance team to develop a new approach that enables:

- **better alignment of incentives to enable more robust delivery** – payment schemes, best-practice tariffs, deconstructing fixed payment and UEC payment model
- **a move to fairer distribution of funding across the NHS** – ICB allocations will move toward the fair sharing of resources and reflect funding streams established in recent years to cover deficits and pay for additional elective activity. Careful consideration will be given to the pace with which we achieve this move. In parallel, a review is underway of components of the broader NHS funding formula to identify any improvements that can further enhance the calculation of fair funding. A review of the Carr-Hill formula for general practice is also under way
- **longer-term planning** – to support more robust delivery and improved decision-making locally
- **a new approach to capital** – maximising value from increased public and private capital through a reformed capital regime

This new approach will be underpinned by far greater transparency of increasingly granular financial data – with NHS England committing to publish trust-level productivity statistics on a routine basis to provide transparency on performance. Costing dashboards will also be made available to drill down into provider costs to better understand cost variation.

NHS England will bring together existing tools (including, Patient-Level Information and Costing Systems (PLICS) dashboards, Model Health System, and Health Expenditure Benchmarking), so they are more consistent and coherent. This will increase and simplify the information available, enabling providers and others to interrogate more granular cost data and support more informed spending decisions.

Existing measures of productivity recognise technical efficiency gains (unit cost reductions, shorter lengths of stay, and increased activity per WTE). We are also designing a different approach that identifies and incentivises left shift, prevention, and the use of technology to ensure that productivity measures do not penalise trusts for moving lower-complexity activity into more appropriate settings.

In support of better alignment of incentives and to enable more robust delivery, we plan to dismantle block contracts and are proposing to:

- introduce a new UEC payment model for 2026/27, comprising a fixed element (based on price x activity) and a 20% variable payment
- develop an incentive element of the UEC payment model with clinical, financial and operational groups

Findings from the dismantling block contracts work will inform future planning requirements, including the pace of change.

New best practice tariffs will be proposed as part of the 2026/27 Payment Scheme to incentivise a shift to day cases, outpatients, and more efficient ways of working, including the use of technology and alignment with the GIRFT 'Right Procedure, Right Place' approach. A consultation on these proposals will take place later this autumn.

The proposed new payment model for UEC is also designed to help unlock funding for neighbourhood health as demand for acute services reduces. A financial / incentive model is currently being developed with pilot sites, available for adoption in 2026/27.

A review of the broader funding formula for the NHS is underway to ensure funding is allocated fairly across the system. The use of funding streams such as deficit support funding and elective recovery funding have become so widespread over the last few years that careful consideration needs to be given to the pace with which we achieve the move to a fair shares model. The conclusions of this work will be detailed in the financial allocations and supporting technical guidance.

Allocations for capital will also be released this autumn, alongside updated guidance on new delegated limits. Business case templates will also be made available through NHS England regional teams to support planning and delivery.

Full details of changes to the financial framework, including multi-year revenue and capital allocations, and updated assumptions will be set out in the accompanying technical guidance published as part of the Medium Term Planning Framework package.

ICBs and providers must now take responsibility for implementation of these changes as part of their work to develop multi-year plans. All ICBs and providers will be expected to deliver a balanced or surplus financial position in all years of the planning period. Plans should incorporate:

- delivery of the 2% annual productivity ambition, as a minimum
- delivery of a break-even financial position without deficit support funding by the end of this planning horizon, other than where, exceptionally, a different expectation is agreed with NHS England
- adherence to other requirements, including guidance on managing provider/commissioner funding changes and a new board risk assessment process

Where deficit support funding (DSF) is in place, non-DSF financial positions should be reported transparently to boards.

Taken together, these measures represent the biggest shake-up of the NHS financial regime in more than a decade – with the aim of significantly strengthening local decision-making, enabling boards to plan much more effectively, and providing local leaders with a rules based transparent framework to drive transformation, not only in their own organisations but as part of their broader system.

1.2 Productivity

In 2024/25, acute hospital productivity grew by 2.7%, and this positive trend has continued into 2025/26, with 2.4% growth in Q1. Despite this, productivity is still below pre-COVID levels. Since 2019/20, the NHS workforce has grown much faster than activity, highlighting the need to decouple workforce growth from service delivery growth. Reversing this trend is essential for long-term sustainability.

While recent productivity gains are encouraging, significant inefficiencies and unwarranted variation persist across the system. There must now be sustained and targeted action to drive further improvements in productivity throughout the remainder of this financial year and over the next 3 years.

This effort has 2 components. **First, we must get the basics right** – reducing inpatient length of stay, improving theatre productivity, and returning to pre-COVID levels of activity per whole-time equivalent (WTE). **Second, we must seize the major opportunities** offered by technology, service transformation, and tackling unwarranted cost variation. This includes accelerating the shift to a digital-by-default approach and embedding more efficient models of care across the NHS. This focus must extend across all parts of the NHS, including acute, community, mental health, learning disabilities and autism services, and primary care, to ensure we deliver maximum value for every pound spent.

SR25's revenue settlement locks in a requirement to deliver a sustained 2% year-on-year improvement in productivity over the next 3 years. Achieving this as a minimum target is essential to restoring the NHS to its pre-pandemic productivity levels and is a prerequisite for financial sustainability and future efficiency gains.

To support delivery, NHS England will share improved and updated productivity and efficiency opportunity packs, with analysis of these opportunities for all NHS providers. NHS providers and commissioners should use this analysis to identify the local improvement actions they can take over the full planning horizon.

Trust-level productivity measures will also be published monthly as official statistics in development and will be incorporated into the NHS Oversight Framework, supporting transparency and accountability.

Delivering the productivity transformation at scale is fundamental to the plan. It will enable the NHS to reform and respond to growing demand, improve patient outcomes, and maintain long-term financial sustainability.

As part of the wider productivity and transformation agenda, systems are expected to make demonstrable progress on 2 long-term shifts in the models:

1. UEC: transition to digital-first and clinically prioritised access

ICBs and providers should accelerate the shift to a more structured, digital-first UEC model, using clinical prioritisation and scheduling to improve patient experience and reduce avoidable demand.

This shift involves moving away from traditional walk-in demand to models that support patients to access the right care, in the right setting, at the right time, based on clinical urgency and individual need. This includes:

- expanding digital and telephony-based triage and booking mechanisms
- increasing access to same-day or next-day scheduled care where clinically appropriate

This will help protect emergency departments for the most unwell patients and address crowding – one of the greatest safety risks in UEC.

Organisations should set out in their plans how these approaches will be scaled during 2026/27, including through collaboration with primary care, 111, and community urgent care providers.

2. Outpatients: shift to a digital-first, patient-led model

ICBs and providers must continue to progress towards a digitally enabled, patient-led outpatient model that improves access, efficiency, and patient experience. Priorities include:

- expanding the use of Advice and Guidance and digital triage tools
- empowering patients with greater choice and control over their follow-up care – including access to patient initiated follow up (PIFU), remote consultations and digital monitoring

This transformation should result in a sustained reduction in unnecessary outpatient follow-up activity (OPFU), freeing up capacity to reduce long waits.

Given the variation in baseline position, a uniform national target will not apply. Instead, providers and commissioners must:

- model the level of OPFU opportunity and compare it against the reduction required locally to accelerate delivery of referral to treatment and long-wait recovery objectives
- develop plans that reflect local opportunity and ambition, aligned to the scale of change required

Plans are expected to be suitably ambitious and progress will be assessed as part of routine oversight arrangements, specifically recognising the evidence that a significant proportion of follow-ups may be clinically unnecessary or avoidable through better use of digital tools and pathways.

2 Resetting the foundations: a new operating model

Over the course of the last few months, we have created the foundations of a radically different way of working: a clearer operating model, a consistent set of rules, and a service more confident in its ability to deliver reform.

The 10 Year Health Plan provides the vision: a system in which care should happen as locally as it can, be digital by default, and be in a patient's home if possible, in a neighbourhood health centre when needed, or in a hospital if necessary. The operating model now being embedded provides the vehicle to get there.

This new approach is rooted in simplicity and discipline: the NHS is moving to a rules-based system where everyone knows what is expected and what follows.

Success will be rewarded with greater freedom; challenge will be met with real support; and persistent failure will be confronted fairly but firmly. By replacing duplication with clarity and bureaucracy with guardrails, we want to enable leaders to act with ambition and staff to focus on what matters most: better care for patients and communities.

Every part of the system has a clear role:

- **the Centre sets national outcomes**, codifies standards, builds shared platforms once and well, and removes barriers
- **regions are the leadership interface**, with a single line of sight across performance, finance, workforce and quality, responsible both for grip and for support
- **ICBs are becoming strategic commissioners**, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost)
- **providers**, through a revitalised foundation trust process, are responsible for collaboration, productivity and quality, with earned freedoms for those who deliver and proportionate intervention where standards slip
- where integration adds most value, **integrated health organisation contracts** will enable end-to-end redesigning of pathways, with efficiencies reinvested into better and more effective ways of working
- at the frontline, **neighbourhood teams** will be established to support our communities. Working with social care colleagues, they will deliver proactive support for people with frailty and long-term conditions. They will provide urgent and acute community services, rehabilitation and prevention – and support improved access to care, especially general practice. Their work will be enabled by digital tools and shared care records

The NHS Oversight Framework is the backbone of this system. It will bring fairness, proportionality, consistency, transparency and predictability, measuring access, quality, finance, people, productivity and delivery of the 3 shifts: presenting this information clearly in league tables to ensure that everyone – including for the first time the public – can see how organisations are performing relative to their peers, and what comes next. Boards will be expected to use this to drive improvement.

This model will be supported and enabled at all levels by service transformation through technology, with a default preference that patients interact with services digitally, wherever possible and clinically appropriate.

A suite of documents will sit alongside the Medium Term Planning Framework to bring this to life and to support ICBs and providers to develop 5-year plans that will allow them to transform their services. They are designed to create the conditions for the NHS to start implementing the ambitions of the 10 Year Health Plan.

- **Model Region and ICB blueprints** are now published, with the **Model Neighbourhood Framework** expected in November.
- **The Strategic Commissioning Framework**, which will be shared in October, builds on the Model ICB blueprint to provide commissioners a clear scope for their evolved role.
- A draft **foundation trust framework**, which will be published for consultation in November as well as **a system archetypes blueprint** explaining the interplay of the new contract models set out in the 10 Year Health Plan (integrated health organisations, multi-neighbourhood provider contracts and single neighbourhood provider contracts) and a draft integrated health organisation blueprint.

The new Strategic Commissioning Framework will enable the NHS – led by the ICBs – to create a much greater focus on outcomes and to incentivise systems and providers to prioritise

investment where the impact on patients' lives has the greatest potential to be transformative.

Working with ICBs, we will commit to developing a shadow set of outcome measures for 2026/27 building on the NHS Outcomes Framework and international best practice, supporting ICBs to drive better patient outcomes in their commissioning of both internal and commercial contracts.

The NHS Oversight Framework will continue to bring consistency and transparency to performance management and will be updated to include a comprehensive set of metrics to account for different organisations.

Commissioning responsibility for **vaccination and screening** will move to ICBs – likely from April 2027, subject to the passage of legislation. In 2026/27, NHS England will continue to develop the commissioning and contracting framework that will support ICBs with their new responsibilities for vaccinations and will expand our digital service systems to other providers and vaccinations, in line with the 10 Year Health Plan. Furthermore, subject to consultation on changes to the Human Medicines Regulations, NHS England will enable community pharmacy to deliver vaccinations off-premises, where commissioned.

Providers must continue to deliver regional public health programmes in 2026/27, in line with programme standards, guidance, service specifications and quality assurance requirements.

2.1 Unleashing local potential – a foundation trust framework; integrated health organisations; and oversight of trusts and system models

The publication of the 10 Year Health Plan has unleashed real enthusiasm for re-empowering boards, with early design work on the new foundation trust model being based on excellent governance, organisational self-awareness and transparency: where providers must demonstrate how they will deliver high-quality, efficient services and provide evidence of being good at participating within collaboratives as well as leading their own organisation.

A draft foundation trust framework will be published for consultation in November.

A draft system archetypes document will be published in the same timeframe, setting out how integrated health organisations (IHOs) will be a contract-based delivery method, not a new organisational form, and will explain how IHO contracts work alongside multi-neighbourhood and single-neighbourhood contracts. IHOs will work with the wider provider landscape to deliver high-quality care efficiently, including through sub-contracting arrangements and, where appropriate, delegation of commissioning. We will issue further detailed guidance in a Model IHO blueprint document later this year.

While the draft model is still being designed, early consideration is being given to how:

- NHS England will assess provider capability to take on an IHO contract, with contracts commissioned by ICBs
- IHO contract holders will work to deliver the shift of resources from hospital to community through an integrated and preventative delivery model aligned to neighbourhood health working
- IHO contracts will be responsible for a defined population, building on existing working to improve population health outcomes, allocative efficiency, access and quality. More detail will be given in the model system archetypes publication expected in the autumn

These draft models are being developed in tandem with the design of new oversight arrangements, including reviewing the current oversight model, metrics and provider capability.

The new approach to oversight is being driven by 3 core principles:

- **oversight should drive improvement**, not bureaucracy
- **peer support and tailored interventions**, which are sufficiently aspirational and valued, especially when organisations acknowledge their own challenges

- **oversight metrics must reflect system-minded behaviours**, including addressing inequalities and left shift

We will continue to work with providers and ICBs to refine the NHS Oversight Framework so that it genuinely supports improvement. We will also amend the NHS Oversight Framework to expand to a more comprehensive set of metrics and to account for new models for provision of services, in addition to governance and transaction adjustments for 2026/27, while ensuring alignment with the Care Quality Commission on provider capability.

2.2 Delivering neighbourhood health at pace

Delivering neighbourhood health at pace is central to returning patient and community trust in the NHS, breaking down siloed working among our staff and finally getting control of improving urgent care by providing more convenient and appropriate services in every neighbourhood in the country.

An NHS that isn't consumed by a near continuous cycle of 'just about managing' to deliver urgent care services is realisable – but only if we put our collective leadership effort into making neighbourhood care a reality. The impact on patient and staff morale will be exponential. The delivery of neighbourhood care has to be a priority for every leader in the NHS because it will create more space to do elective work, reduce waiting times, improve the quality of care and make headroom for leaders to focus on innovation.

Most care is already delivered in our communities and neighbourhoods, and many community-based services will continue as they are today. But for those patients that are using multiple services – or are referred from one service to another – we can make a big difference to the individual, as well as to staff, quality of care and productivity, if we can join up or integrate services and teams better. There are also opportunities to improve care through the provision of digital services, empowering patients to manage their own care or to receive digitally-enabled treatment in their own home, complementing community-based services.

The impact we can have by organising ourselves better around the patient on priority long-term conditions such as cardiovascular disease and diabetes won't just transform how patients get their care, it will dramatically improve productivity in how we deliver services going forward.

This is not just about NHS services working more closely together but also about improved joining up of care across NHS, local authority and voluntary and charitable sector services. By doing this, we will keep more care in people's

neighbourhoods and use our hospitals only for patients who truly need to be treated in them.

There are examples of neighbourhood health working across the country and in every ICB. The evidence from these examples shows they have a significant impact, not just on making services more convenient to access, but supporting improvements in urgent and emergency care, access to primary care and improving patients' satisfaction. Starting now and accelerating over the next 3 years, we want to deliver even more care in our neighbourhoods, providing more joined up care for high-priority cohorts through integrated neighbourhood teams (INTs), and make a material difference to patient experience and hospital demand.

In implementing neighbourhood health, the immediate focus must be on:

- improving and tackling unwarranted variation in GP access for the whole population
- reducing unnecessary non-elective admissions and bed days from high priority cohorts – people who have moderate to severe frailty, people living in a care home, people who are housebound or at the end of life
- enabling patients requiring planned care to receive specialised support closer to home

Starting this year, we will bring forward a roadmap for the delivery of the NHS App functions as described in the 10 Year Health Plan:

High-functioning systems will want to go further and faster and should be looking to set up integrated teams and services for other cohorts, in areas such as children and young people and mental health and learning disability, autism and ADHD.

To support moving at pace, we will produce:

- a draft **model neighbourhood framework**, which will set out the definitions, goals and scope of neighbourhood health, along with priority actions for 2026/27
- a **national neighbourhood health planning framework**, co-produced with the Local Government Association and local authority colleagues, setting out how the NHS, working in active partnership with local authorities and others, can plan for the delivery of the broader set of neighbourhood goals
- **model system archetypes**, which will outline different archetypes for the commissioning and provision of neighbourhood health services, including the 3 new contract types: single and multi-neighbourhood provider contracts, and integrated health organisation contracts
- **model neighbourhood health centres archetypes**, which will describe different archetypes of provision of neighbourhood health services that can be used to inform the better utilisation and enhancement of existing estates, together with new-build solutions, where appropriate

From April 2026, ICBs and relevant NHS providers should:

- identify GP practices where demand is above capacity and create a plan to help decompress or support to improve access and reduce unwarranted variation
- ensure an understanding of current and projected total service utilisation and costs for high priority cohorts of those with moderate to severe frailty, living in care homes, housebound or at the end of life
- create an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions. These plans should be consistent with national standards for urgent community response services, which require 7-day availability and rapid response. Systems should ensure funding and commissioning covers a minimum 12 hour "community urgent care" offer, supervised by senior clinical decision-makers and operating at a multi-neighbourhood level. Local ICBs must confirm how this will be resourced and delivered

Plans should also include establishing integrated neighbourhood teams, ideally contract-based, working with local authorities and starting in areas of highest need. Further details will be set out in the Model Neighbourhood Framework.

However, providers and systems should not wait for guidance to be finalised where there are local opportunities to rapidly create an approach to neighbourhood delivery that will improve delivery of services this winter. Local leaders are strongly encouraged to work collaboratively to identify these opportunities where they are confident of delivering immediate impact – supporting improved access to urgent and emergency care now.

2.3 Shifting from sickness to prevention

The 10 Year Health Plan is clear that we need to shift from an NHS that focuses on treating patients to one that improves the lives of the population by preventing ill health or slowing the exacerbation of ill health. This approach will improve the outcomes and experiences of patients and improve the management of demand for general practice and acute care services.

ICBs must ensure their 5-year plans support the following preventative goals:

- a significant focus on tackling obesity. Specifically:
  - in 2026/27, to be making demonstrable progress in delivery of new obesity service models to improve advice and support, access to treatment, and effective management of obesity, including providing access to weight loss medications and strengthening specialist provision, including complications of excess weight clinics for children and young people
  - by the end of June 2028, to have provided access to National Institute for Health and Care Excellence (NICE) approved weight loss treatments for an initial eligible cohort of around 220,000 adults
  - by the end of March 2029, to be making 250,000 referrals to the NHS Digital Weight Management Programme a year
- supporting the target of a 25% reduction in CVD-related premature mortality over the next 10 years, including working in partnership with local authorities to test the new NHS Health Check online service and to scale it across the country
- implementing opt-out models of tobacco dependence in routine care
- reducing exposure to antibiotics to meet thresholds set in recent guidance and addressing problematic polypharmacy to reduce avoidable harm
- demonstrating how they will reduce health inequalities in the exercise of their functions

Further detail on emerging national standards and legislation related to prevention will follow.

2.4 Doing digital differently

The 10 Year Health Plan sets out how we will take the NHS from the 20th century technological laggard it is today to the 21st century leader it has the potential to be.

The health service must become one that is digital-by-default, a principle widely established across government and private services worldwide, but one the NHS has not embraced. A core element of this is giving patients a 'doctor in their pocket', available through the NHS App.

Starting this year, we will bring forward a roadmap for the delivery of the NHS App functions as described in the 10 Year Health Plan:

1. **Delivering My NHS GP** - using AI-assisted triage models and data-driven pathways to guide people to the service they need quickly and provide those who need an appointment with the ability to book one.
2. **Transforming Planned Care** – putting patients in control of their treatment pathways by giving them one place to manage all their appointments, referrals and interactions – while bringing efficiencies that reduce referral-to-treatment times.
3. **Managing My Health** – empowering people to manage their health and the health of their dependants by giving them targeted access to prevention services – helping to reduce future demand before sickness develops or worsens.

Through these features, the NHS App has the potential to transform how NHS services are delivered and unlock a range of benefits, including:

- reducing future demand by intervening before sickness develops or worsens
- getting patients to the right service, first time
- reducing the cost of delivering NHS services
- streamlining patient journeys to deliver better outcomes with fewer interactions
- meeting patient needs as efficiently as possible through automation and effective capacity management
- improving the experience of NHS services

Getting this right doesn't just mean making appointments and other transactional services available online. It means fundamentally rethinking our care models to make the best possible use of technology and innovation and to deliver a high-quality care model at scale accessed through the NHS App, wherever possible.

But we will need to go further, looking beyond the digitisation of transactional and administrative services and more fundamentally rethink care pathways. Modern technology and innovation provide new opportunities to empower patients to manage their own care and receive treatment digitally, rather than face-to-face, wherever clinically safe and accessible for the patient. This enables better care, better health outcomes, a better patient experience and lower cost. We will set out the implementation of this approach through the modern service frameworks, ensuring the clinically-led design of ambitious, affordable and clinically safe digital-first pathways. This shift will free up capacity for those who need it, while making a material contribution to financial sustainability.

To expand the range of options available to patients, work will continue to establish NHS Online – a new 'online hospital' to digitally connect patients to expert clinicians anywhere in England from 2027. Using the NHS App, patients will have the option of being referred to the online hospital for their specialist care following a GP appointment. This new model of care will enhance patient choice and control, while helping to reduce patient waiting times.

Those providers leaning heavily into the digital agenda are already achieving substantial performance improvements and cash-releasing productivity benefits. For example, acute trusts leveraging the NHS Federated Data Platform have achieved an average increase of 114 elective surgeries per month per trust and a 35% reduction in delayed discharge days.

Providers and commissioners must therefore prioritise adopting and embedding a modern infrastructure to continue realising these benefits. From April 2026, the NHS must begin to:

- fully adopt all existing NHS App capabilities as a priority, including making at least 95% of appointments available after appropriate triage via the NHS App across all care settings. More widely, providers should ensure full

coverage of patients' abilities to manage their medicines, to view waiting times and contact information, to receive and complete pre- and post-appointment questionnaires, and to implement digital PIFU in line with GIRFT guidance. This should be in place no later than the end of 2028/29

- ensure all providers in acute, community, and mental health sectors are onboarded to the NHS Federated Data Platform (FDP) and using its core products to support elective recovery, cancer, and UEC. Trusts should use the FDP for data warehousing and implement the canonical data model. ICBs should use the population health management suite of tools from the FDP for strategic commissioning and adopt the FDP System Coordination Centre and other performance management tools. This should be achieved by 2028/29
- move all direct-to-patient communication services to NHS Notify, terminating local arrangements, and exploit NHS App-based 'push' notifications as the preferred method of contact. Transitions should start in 2026/27, with providers completing migration by the end of 2028/29
- move to a unified access model, using AI-assisted triage, that can effectively guide patients to self-care or to the appropriate care setting, through a single user interface delivered via the NHS App but with an integrated telephony and in-person offering
- achieve full compliance with the minimum standards set out in the Digital Capabilities Framework, including ensuring 100% coverage of electronic patient record systems as soon as possible
- implement all core national products and services specified in the forthcoming national product adoption dashboard by the end of 2027/28, prioritising: deploying the Electronic Prescription Service; deploying the Electronic Referral Service APIs; consolidating NHS. Net Connect into the national collaboration service; and integrating all existing NHS App capabilities. This applies to acute, community and mental health providers
- providers should deploy ambient voice technology (AVT) at pace, with due regard to the national AVT registry, and adopt the latest in digital therapeutics for both supportive and wrap-around care (and for direct clinical delivery where services have the appropriate regulatory approvals – typically Class IIa)

2.5 Transforming our approach to quality

The publication of the 10 Year Health Plan ushered in a new era of transparency, driving higher quality care across the NHS. Over the summer, we have worked with system leaders to develop plans to deliver some of the core commitments within the plan, including:

- developing the purpose and scope for a new National Quality Board (NQB) **Quality Strategy** to be published by the end of March 2026. Following initial discussion with the NQB, wider stakeholder engagement is now taking place to inform the vision and implementation approach that the strategy will set out
- establishing the approach to introducing **modern service frameworks** (MSFs), which will support more consistent delivery of high-quality, evidence-based, **digital-by-default** care in conditions where there is potential for rapid and significant improvements in both quality and productivity. The criteria and methodology are being tested through the development of a first set of 3 MSFs, focused on CVD, serious mental illness and sepsis, with further MSFs on dementia and frailty to follow. Task and finish groups are being set up for each, and the frameworks will be co-designed in partnership with clinicians, people with lived experience and system partners

We are also progressing a set of immediate priorities to improve care quality:

- **National Care Delivery Standards** are currently being developed to ensure the consistent delivery of high-quality and equitable care every day of the week. In November, we will confirm the scope of the new standards and publish them in March 2026
- the **Emergency Department Paediatric Early Warning System** (PEWS) will be launched in 2026. All hospitals will be expected to ensure a change plan is in place to add PEWs to their transition and complete this transition by April 2028
- a **Single National Formulary** will be introduced within the next 2 years

All ICBs and providers must continue to implement the NHS Patient Safety Strategy, including embedding the Patient Safety Incident Response Framework to support a systems-based approach to safety and ensuring patient safety specialists are appointed and trained and that patient safety partners contribute to safety-related governance committees. It also involves ensuring full implementation of all 3 components of Martha's Rule in all acute inpatient settings, as set out in the new NHS Standard Contract requirement.

From April 2026, and as guidance is published, ICBs and providers are also expected to:

- use the new NQB quality strategy to guide local action to improve the quality of care in the highest priority areas for their population and service users
- implement modern service frameworks as they are launched
- implement the National Care Delivery Standards to ensure consistent high-quality care across the week
- plan for the introduction of a Single National Formulary, prioritising the following efficiency savings in 2026/27 to create headroom for adopting innovations: use of best value Direct Acting Oral Anticoagulants, SGLT-2 medicines and the wet AMD Medical Retinal Treatment Pathway
- continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation while meeting statutory NHS Continuing Healthcare duties. ICBs should prepare for full transition to AACC Data Set v2.0 and its digital infrastructure by March 2027, replacing the current quarterly collection to improve monitoring
- undertake local process and workflow re-engineering to make sure all colleagues are using digital systems and to remove duplicate paper-based processes, ensuring maximal use of the NHS Federated Data Platform
- for all hospitals with a paediatric inpatient setting, implement the Paediatric Early Warning System by April 2027

Improving the quality of our maternity services

In June 2025, the Secretary of State announced an independent investigation into maternity and neonatal care and a taskforce to agree and oversee the resulting action plan.

Ahead of the action plan being finalised, all ICBs and providers are expected to take immediate action to improve care and ensure women are listened to. This includes:

- implementing best practice resources as they are launched, such as the forthcoming maternal care bundle, new approaches to avoiding brain injury in childbirth, the specification for maternity triage, and the Sands National Bereavement Care Pathway for stillbirth and neonatal death
- using the national Maternity and Neonatal Inequalities Data Dashboard to identify variation in practice and put in place interventions for improvement
- participating in the Perinatal Equity and Anti-Discrimination Programme to support leadership teams to improve culture and practice

The **Maternity Outcomes Signal System** (MOSS) will be implemented across all NHS trusts by November 2025, enabling the use of near real-time data to monitor key safety indicators such as stillbirth, neonatal death, and brain injury rates. Signals in MOSS prompt a local safety check to prevent further harm and maintain high quality care.

This near real-time data, the maternity and neonatal performance dashboard and the new inequalities dashboard mentioned above, alongside gathering patient experience information and active staff engagement, gives teams, leadership and boards vital insight into the quality of their services. They should stay continuously curious, actively using this information to understand how their services are performing and whether they are meeting the expectations of the women and families they serve. Where there are incidents or things go wrong, they should engage proactively with families, be honest and open, seeking to learn and to implement changes quickly to prevent incidents in future.

2.6 Understanding and improving the patient experience

The British Social Attitudes survey published early this year showed that satisfaction rates are at a record low and continuing to drop. We all have a collective responsibility to address this with absolute urgency.

The progress we're making in improving access and reducing waits – providing care in a faster and more convenient way – will help with this, but there's more we can be doing now to better understand why some patients are dissatisfied with the service they receive.

A number of NHS organisations already run inpatient surveys and capture patient experiences in real time. This helps boards better understand the issues patients face and helps local teams identify the changes they need to make to improve the experience of care.

Between now and the end of 2025/26, all NHS trusts will be expected to:

- complete at least one full survey cycle to capture the experience of people waiting for care: Have they had cancellations? Has anyone been in touch? What do they think has got worse since they have been on the waiting list? What information do they need to manage their condition well? This should support delivery teams to improve the experience of waiting and, where necessary, re-prioritise patients who may need to be treated faster
- capture near real time experiences with a renewed focus on ensuring effective discharge processes. Trusts should triangulate inpatient survey results, relevant Friends and Family Test feedback and PALS complaints data to identify areas where improvement is needed. A resource pack will be published on NHS England's website in November to support organisations to do this

Improving experience of care will be a central feature of the Quality Strategy, due to be published in 2026. This will include cross-cutting improvement priorities which will enhance everyone's outcomes and experiences.

2.7 Reconnecting with our workforce, and renewing and strengthening leadership and management

Delivering the 10 Year Health Plan will require an engaged and empowered workforce. Creating that means truly listening to what our staff tell us are the barriers they face and acting to address those concerns.

Earlier this year we published a 10 Point Plan to improve the working lives of resident doctors: tackling those non-pay issues that we've long since known about but not committed to fully resolving.

It sets a new standard: we need to be unwavering in our commitment to understanding the challenges our local staff face and to fixing those issues.

The annual Staff Survey provides a rich source of data for every organisation, but too often the findings it generates don't elicit the organisational response our staff and teams want and need.

Over the course of the last few years, the use of national pulse surveys alongside annual staff surveys has sometimes created a confused picture of what staff are trying to tell us. We will commit to working with staff experience leads from the NHS to revise our approach to how we use these tools to better support local boards to be more innovative in how they measure and improve staff experience. We will conclude this ahead of the publication of the latest staff survey results.

In the meantime, every NHS board will be expected to use the 2025/26 staff survey findings to commit to:

- a full and detailed analysis of all free text comments generated through their staff survey
- identifying, as a minimum, 3 areas where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within their organisation and developing detailed action plans to resolve those issues within year wherever possible

Calling out all forms of discrimination

Discrimination, racism, antisemitism, Islamophobia and aggression have no place in the NHS: during the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stand against racism.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome, and in particular where racism, antisemitism, Islamophobia and discrimination are not tolerated.

We also expect organisations to continue to tackle sexual misconduct, including regularly assessing progress on the Sexual Safety Charter, in line with the letter of 20 August.

Leadership

Successive reports – most recently from General Sir Gordon Messenger and Dame Linda Pollard – have made clear the vital role of high quality leadership in the NHS, and this has never been more important than it will be in the coming years.

While leadership is everyone's responsibility, our very senior leaders (chairs, CEOs and executive directors) carry specific accountabilities and impact. They must set the tone, standards, and direction that enable colleagues across the health and care system to lead and deliver effectively, improve how services are delivered, and support the vision of the 3 shifts.

The reforms to the NHS operating model set out in Chapter 2 are designed to create the space for leaders to lead, incentivise those who do it well, and support those who need it.

The regulation of managers – widely welcomed across the NHS leadership community – will, when enacted, provide additional clarity on the standards expected and accountability for upholding them, just as is in place for clinicians and other professionals within the NHS.

But the high expectations we rightly have of our leaders must come with the tools and support needed for success – something which has been severely lacking in recent years.

As a first step, we will publish the new **Management and Leadership Framework** during the autumn, setting a code of practice and standards and competencies for clinical and non-clinical leaders and managers at 5 levels, from entry level to board. ICBs and providers should embed this Framework into recruitment and appraisal practices, with all leaders and managers self-assessing against the Code and standards and senior leaders obtaining 360 degree feedback. Digital tools will be provided during 2026/27 to facilitate this.

Going further, over 2026/27 we will continue progress to establish a new **College of Executive and Clinical Leadership**. A national curriculum and interactive online modules will be published in 2026/27, offering time-efficient leadership and management development at each level.

National leadership programmes will also be updated, and ICBs and providers should incorporate these national offers as part of personalised development pathways for leaders and managers, linked to agreed development needs and career plans and our new appraisal system.

This new consistent and standards-based approach will help the leaders of today both improve their own practice, and identify and support the leaders of tomorrow.

Finally, it is vital that the benefits of excellent leadership are retained within, and well-spread across, the NHS. Regional teams will work with national colleagues to develop a talent database of our strongest leaders to guide challenged systems and organisations.

2.8 Genomics, life sciences and research

Research in the NHS is vital for generating the next generation of treatments and improving health outcomes, and clinical trials can provide a significant benefit to participating patients by giving early access to new treatments and technologies.

All NHS providers must meet the site-specific timeframes of the government's 150 day clinical trial set-up target. To support embedding research as part of everyday care, research activity and income should be reported to boards on a 6-monthly basis. This should include details of study set-up performance, how they are meeting the terms of research contracts outside the NHS HM Treasury allocations, commercial research income and how capacity building elements of commercial contract income are used, as set out in the research finance guidance.

From April 2026:

- ICBs should ensure clinical trials are proactively supported, including by reducing the time they take to set up, by following standards and guidance set out in Managing research finance in the NHS
- providers are expected to deliver services in line with the NHS Genomic Medicine Service service specification, including the delivery of genomic testing services and testing strategies as well as clinical functions for cancer, rare disease and population health and the new genomics population health service

3 Trajectories for operational performance and transformation

As outlined earlier, 2026/27 marks the beginning of a new method of planning, with priority targets set for the SR25 period and ambitions covering the first 5 years of the 10 Year Health Plan. Achieving these targets is the bedrock of delivering the shifts outlined in this framework. Without progress, we will fail to realise the ambitions in the 10 Year Health Plan and lose any progress we have made in stabilising the NHS for the future.

Alongside meeting these key targets, the NHS must develop plans that enable systems to deliver healthcare that follows best practice standards and meets the needs of local populations. The NHS Oversight Framework will allow monitoring of performance against plans, while also tracking delivery across a broader range of standards.

Performance improvement has slowed in 2025/26, but we cannot allow this to continue if we are going to capitalise on the opportunity the 10 Year Health Plan and SR25 has created. These targets will be supplemented with appendices on the key actions and interventions that will drive our success.

3.1 Elective, cancer and diagnostics

We are committed to returning to the constitutional standard of 92% of people waiting less than 18 weeks for treatment, and to continuing to improve performance against the 3 cancer standards for 28-day diagnosis, 31-day treatment and 62-day referral to treatment. We have made significant progress over the past year and need to build on this momentum, driving further radical transformation, including introducing a new model for planned care that meets the 10 Year Health Plan commitment of "ending outpatient care as we know it".

This plan is rightly ambitious and will require a significant shift in the way trusts work, but also how ICBs, trusts and primary care work together to change the way most patients access planned care in the future. Our aim is for patients to receive more specialised support closer to home – that means working with GPs, community and neighbourhood teams and being digitally enabled where appropriate.

The key priorities will be:

- general practice is asked to continue prioritising the use of Advice and Guidance prior to, or instead of, a planned care referral where clinically appropriate (excluding referrals for urgent suspected cancer). There should be a move to all referrals going via Advice and Guidance for the 10 specialties at provider level which have the most potential for this model to be effective. We expect ICBs to support this, and bring it to life, through their strategic commissioning for 2026/27
- to support this increased use of Advice and Guidance, we encourage systems to ensure all referrals receive appropriate clinical triage, which we expect to flow through a single point of access. This will ensure more patients wait less time to receive a diagnosis and start an appropriate form of treatment
- to move toward the e-Referral Service (e-RS) being used for all Advice and Guidance requests from primary care, with effect from July 2026, where these requests are managed within the e-RS user interface, and from October 2026 where a third-party service is used. We will work with regions and providers to ensure rapid but manageable roll-out supported by appropriate platforms, including improvements to the functionality of e-RS
- to start to plan with ICBs and primary care how greater access to specialist advice and direct access to diagnostics for specific specialties, when aligned to neighbourhoods, could support GPs to manage more patients without the need for referral. Further details will be set out in the Model Neighbourhood Framework

Further details on how ICBs, trusts and general practice should work together to plan for this new neighbourhood health approach for elective pathways will be set out in the model neighbourhood framework.

For those patients who do require specialist outpatient care, we expect providers to continue identifying and acting on opportunities to improve productivity and ensure timely access. This includes:

- significantly reducing the number of routine, clinically low-value follow-up appointments. This will be supported by GIRFT's specialty-level good practice guides and the first group of these will be available in December, with

other pathways to follow. We are exploring whether further changes are required to the payment for follow-up activity and will advise of this in due course. Where there is greatest variation in the management of follow-ups, there will be rigorous performance management. By releasing capacity from clinically low-value follow ups, we will allow new patients to be seen and diagnosed

- conducting comprehensive reviews of clinic templates and standardising these in line with GIRFT's specialty-level good practice and job planning guides
- expanding 'straight to test' pathways and one-stop clinics where clinically appropriate, starting with the 10 largest specialties by volume and expanding, with the aim of including all clinically appropriate specialties by March 2029

Further guidance in productivity opportunities relating to outpatient care are set out in the productivity section of this document. Delivering improved referral to treatment performance is closely correlated with reducing waiting lists at national and provider level. Nationally, we expect to see the waiting list reduce during 2026/27 and while the local requirement will vary by provider, reductions in waiting list sizes will be expected at all trusts.

As well as ensuring patients are treated in order of clinical priority, providers and ICBs should appropriately manage their waiting lists, including through thorough validation and the application of referral to treatment guidance and local access policies to assure themselves of their data quality. This is particularly important in carefully managing any service changes that may affect reporting, such as EPR installations and upgrades. There is a growing range of digital tools available to support data quality and address other issues, and all providers will be expected to use the NHS Federated Data Platform or equivalent technology to deliver these improvements.

Children and young people (CYP) continue to face longer waiting times for planned care, despite the disproportionate impact of long waits on their development and longer-term outcomes. Systems and providers are required to put in place targeted actions to increase activity and improve performance for their CYP population. This should include developing ringfenced CYP capacity within the ICB footprint using existing NHS estate by running regular dedicated paediatric surgery days in either a day surgery or hub setting, with an aim to increase CYP activity delivered through surgical hubs.

Management attention needs to be maintained on meeting cancer standards and securing further improvements to early diagnosis. This should include the continued prioritisation of diagnostic (including CDC) and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways to the USC pathway and diverting lower-risk people to more appropriate access routes for their condition. Cancer alliances will continue to be a source of expert performance improvement advice and support to providers, ICBs and wider system partners. Regions will continue to encourage close working and co-ordinated support across alliances and diagnostic networks to tackle the key performance challenges across their areas.

Diagnostic activity will need to increase to support delivery of both planned care and cancer standards. All systems have already been provided with activity and performance targets that need to be achieved by March 2029, and significant progress is expected in 2026/27. To support this, CDC capacity should be fully utilised and operating hours extended where possible to deliver the activity that has been commissioned, and – as neighbourhood health teams mature – organisations should consider how CDC capacity can be made available to neighbourhood teams as well as providers. Systems should ensure that these targets are achieved through a mix of capital-funded capacity increases, improved productivity (digital and services throughput) and demand optimisation that reduces the use of tests with limited patient benefit. This should include implementation of decision support tools like i-Refer-CDS. To support demand optimisation, NHS England and the royal colleges are launching a campaign this autumn – Right Test, Right Time – which encourages clinicians to focus on test referrals that add most value to patient care.

Working with local providers, ICBs will continue to hold responsibility for commissioning levels of activity for providers to deliver the performance requirements set out in this guidance. They will need to take steps in-year to mitigate demand growth in excess of agreed growth assumptions. This will require close working between primary and secondary care, with neighbourhood health teams playing an increasing role over time.

Given the interdependence between referral to treatment and diagnostic performance, we are taking a consistent approach in setting individual targets at provider level (for example, a percentage improvement as well as a performance floor). This will support planning locally by giving a clear and consistent message about performance improvement requirements on a like-for-like basis across delivery areas.

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment
Improve performance against cancer constitutional standards	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	
	Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards by March 2027	Maintain performance against the 31-day standard at 96% and 62-day standard at 85%
Improve performance against the DM01 diagnostics 6-week wait standard	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test

3.2 Urgent and emergency care

It has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less to be seen, treated and discharged from A&E.

During that time, in parts of the NHS, we have normalised asking our staff to deliver sub-optimal care, and some of our patients have all but given up hope of expecting a reliable service in urgent care.

This document sets out expectations for next year and beyond, but we are also taking immediate steps to improve performance and service quality throughout this winter. This will include a major focus on reducing crowding in our emergency departments, ensuring that patients unlikely to require admission are seen in urgent treatment centres (UTCs), same day emergency care and other suitable points of delivery and that children are seen within 4 hours. This will allow our emergency departments to start focusing on the sickest patients and reduce the risks associated with crowding that have become normalised in recent years.

Throughout 2026/27, this will result in a service that is UTC-first and by default for patients who are less likely to require admission, and pathways for children that support more rapid assessment and treatment, with the aim that these cohorts of patients are treated within the 95% standard again. We will work with NHS providers and the relevant professional bodies (RCEM, RCPH, RCP etc) to develop this approach over the coming weeks and ask how we can best improve standards of care for the sickest and most unwell patients.

The priority will then be to improve core operational performance against constitutional standards each year by developing services and pathways that align with the neighbourhood health model, while continuing to improve clinical and operational processes inside hospitals. This will allow acute emergency care to be safeguarded for those who will benefit from it most, while unified and more efficient urgent care can be delivered in the community.

To achieve this:

- ICBs and providers must ensure patients are directed or conveyed to the most appropriate care for their urgent or emergency care needs, reducing avoidable ambulance conveyances to hospital. This will require fully utilising core services such as 111 and increasing the rate of impactful interventions such as 'hear and treat'

- ICBs and providers must deliver more urgent care in the community by expanding neighbourhood health services, aiming to reduce total non-elective admissions and bed days, with a specific focus on frail older people, given rising demand pressures. ICBs and providers must have robust ways to measure the impact of neighbourhood health, and take remedial action if non-elective demand in this population group continues to increase
- ICBs should specifically assess total resources spent on those living with frailty and shift a proportion of those resources to better community provision, to ensure safe and effective care away from an acute hospital setting wherever possible, and to short-stay frailty attuned care when people do require admission
- ambulance services must continue to be planned in accordance with the published ambulance service specification. This includes acute trusts and ambulance services working collaboratively to reduce ambulance handover times toward the 15-minute standard
- acute trusts should embrace new standards and guidance on how to achieve our ambitious 4-hour performance target and use these to drive the necessary step-change, aligning with the soon to be published Model Emergency Department and clinical operational standards for the first 72 hours in hospital
- providers must have a renewed and rigorous focus on ensuring that patients who are less likely to require admission are directed to a UTC by default, and that there are agreed clinical and operational processes for non-admitted patients to be seen, treated and discharged within 4 hours to reduce overcrowding in departments and improve safety
- providers must also continue to improve emergency department paediatric performance, with the expectation of returning to 95% over the coming months. Current data indicates this is more than possible if paediatric assessment units are effectively utilised and the issue is properly addressed
- to improve our ability to respond to patients in mental health crisis and ensure the needs of mental health patients are met in an appropriate environment, we will establish mental health emergency centres in Type 1 emergency departments
- we need a whole-system effort to continue to reduce discharge delays. This should include improving in-hospital discharge processes, making best use of community beds, and increasing home-based intermediate care capacity
- ICBs and providers must ensure early action to improve flu vaccination uptake among staff and the public, helping to keep patients and colleagues safe
- systems should accelerate the transition towards a more structured, digital-first UEC model, with appointments and scheduling according to clinical prioritisation and ultimately a better patient experience (see section on productivity)

Success measure	2026/27 target	2028/29 target
4-hour A&E performance	Every trust to maintain or improve to 82% by March 2027	National target of 85% as the average for the year
12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
Category 2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes

3.3 Primary care

Central to the broader reforms we are delivering is continuing to focus on improving access to **general practice** – this is critical to not only managing wider system pressures but also rebuilding the public's faith in its NHS. Building on existing general practice action plans, in 2026/27 all ICBs must:

- ensure practices are delivering the 2025/26 GP contract (including recent 1 October changes) and the 2026/27 GP contract from April, including improving and providing good access whether by phone, online or walk in throughout core hours. This includes all patients knowing on the day how their request will be managed, and increasing the number of people who can see their preferred healthcare professional
- put in place action plans to continue to improve contract oversight, commissioning and transformation for primary care, and tackle unwarranted variation, including identifying and planning how to support those struggling to deliver access or other elements of the GP contract
- ensure additional capacity is commissioned to meet demand out-of-hours and over surge periods including bank holidays and weekends
- support primary care providers to deploy ambient voice technologies, ensuring the time freed up is used to see additional patients

Success measure	Target for all years 2026/27 to 2028/29
Same day appointments for all clinically urgent patients (face to face, phone or online)	90% We will consult with the profession on this new ambition
Improved patient experience of access to general practice (ONS Health Insights Survey)	Year-on-year improvement

To support primary care access and increase the role of **community pharmacy**, ICBs must:

- embed pharmacy-first approaches, ensuring that local commissioning discussions utilise available pharmacy capacity to support primary care pressures
- continue developing the relationships between general practice and community pharmacy to support access to pharmacy services
- introduce prescribing-based services into community pharmacies during 2026/27
- expand access to emergency contraception through community pharmacies
- maximise use of the Discharge Medicines Service to reduce medicines harm and reduce readmissions
- make HPV vaccination available at pharmacies for women and young people who missed out on vaccination at school
- ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App
- ensure all primary care services enable patients to request and manage their medicines online
- transition all messaging to NHS Notify, using NHS App-based 'push' notifications as the default option

For **dental services**, the government has set out a manifesto commitment to deliver 700,000 additional urgent care dental appointments against a pre-election baseline in every year of the parliament. Additional capacity has been put in place in 2025/26 to ensure an urgent care safety net is in place. ICBs will be asked to continue to secure necessary capacity, including working to implement dental contract reforms that are expected to be taken forward from April 2026 following consultation in summer 2025. In 2026/27, all ICBs must:

- deliver their contribution to the government's commitment to deliver an additional 700,000 urgent dental appointments in England against the July 2023 to June 2024 baseline period
- successfully implement dental reforms to ensure the additional manifesto target is incorporated into contractual activity (subject to consultation)
- implement locally driven quality improvement approaches for dentistry, ensuring clinical leadership and communities of practice are in place to support improved access and the introduction of new pathways for high needs and complex patients

Success measure	Target for all years 2026/27 to 2028/29
Deliver 700,000 additional urgent dental appointments against the July 2023 to June 2024 baseline period	Each ICB to deliver their share of the urgent dental appointment target every year (2026/27 to 2028/29)

3.4 Community health services

Timely and effective community health services will be critical to shifting care out of hospital and into the community to deliver our ambitions for neighbourhood health. Community health services deliver both planned and reactive provision, often for the most complex patients. Variation in capacity, provision and long waiting times have existed for too long in community health services.

In 2026/27, all ICBs and community health services providers must:

- increase community health service capacity to meet growth in demand, expected to be approximately 3% nationally per year
- actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits

- identify and act on productivity opportunities, including ensuring teams have the digital tools and equipment they need to connect remotely to health systems and patients, and expanding point-of-care testing in the community. To support this, community health service productivity metrics will be published later this financial year
- continue to standardise core service provision as defined in Standardising community health service
- consider where digital therapeutics, such as for MSK treatment, could be deployed at pace where those therapeutics have appropriate regulatory approval

Success measure	2026/27 target	2028/29 target
Address long waiting times for community health services	At least 78% of community health service activity occurring within 18 weeks	At least 80% of community health service activity occurring within 18 weeks

3.5 Mental health

Mental health care isn't just important to the service users who rely on care and support being available when they need it; it is critical to the smooth running of health economies right across the NHS.

We all accept that more must be done to improve the mental health of the nation. The quality of mental health services and the ability to access them – especially for those in crisis and children and young people – must improve to address current unmet needs and reduce the risk of future harm.

There are also significant opportunities to improve quality and productivity in mental health services. There is unwarranted variation in the direct and indirect contacts per whole time equivalent hours worked within children and young people's community mental health services and this contributes to long waiting times. We must also reduce average lengths of stay in adult acute mental health beds and complete the job on 3-year plans to localise care, reduce out-of-area placements and end the commissioning of locked rehabilitation inpatient services.

Achieving these improvements will take leadership at every level. Nationally, we will commit to working with local NHS mental health providers to set a new approach for mental health in 2026, including through the upcoming MSF for serious mental illness, led by a new national lead for mental health alongside the mental health NHS leadership community.

In 2026/27, all ICBs and mental health providers must:

- continue to expand coverage of mental health support teams in schools and colleges ahead of the ask for full national coverage by 2029
- develop a plan for delivering their local approach to establishing mental health emergency departments co-located with or close to at least half of Type 1 emergency departments by 2029
- use ring-fenced funding to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity through access to Individual Placement and Support for people with severe mental illness
- reduce inappropriate out-of-area placements and locked rehabilitation inpatient services. From 2027/28 onwards, ICBs should only commission mental health inpatient services for adults and older adults that align with the NHS Commissioning Framework
- reduce longest waits for CYP community mental health services by improving productivity, and reducing local inequalities and unwarranted variation in access
- identify and act on productivity opportunities including, in children and young people's community mental health services, increasing the number of direct and indirect contacts per whole time equivalent hours worked, and reducing the average length of stay in adult acute mental health beds

- ensure mental health practitioners across all providers undertake training and deliver care in line with the Staying safe from suicide guidance, which sets out the latest evidence in understanding and managing suicide

Success measure	2026/27 target	2028/29 target
Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	77% coverage of operational mental health support teams and teams in training	94% coverage, reaching 100% by 2029 (operational mental health support teams and teams in training)
Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	63,500 accessing Individual Placement and Support by the end of 2026/27 805,000 courses of NHS Talking Therapies by the end of 2026/27 with 51% reliable recovery rate and 69% reliable improvement rate	73,500 accessing Individual Placement and Support by the end of 2028/29 915,000 courses of NHS Talking Therapies by the end of 2028/29 with 53% reliable recovery rate and 71% reliable improvement rate
Eliminating inappropriate out-of-area placements	Reducing the number of inappropriate out of area placements by end of March 2027	Reducing or maintaining at zero the number of inappropriate out of area placements

3.6 Learning disabilities, autism and ADHD

People with a learning disability and autistic people too often experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. To improve health outcomes and access to and experience of care, in 2026/27 all ICBs and providers must:

- reduce the very longest lengths of stay in mental health hospitals
- reduce admission rates to mental health hospitals for people with a learning disability and autistic people
- optimise existing resources to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published

The government will publish plans for the reform of SEND in due course. We expect ICBs and providers to work with NHS England and the Department of Health and Social Care to respond to those reform plans once published, and to continue to meet their statutory duties in the meantime.

Success measure	2028/29 target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	Deliver a minimum 10% reduction year-on-year

3.7 Workforce

The ambitions outlined in the 10 Year Health Plan will require a fundamental shift in the way the NHS deploys, retains and trains its workforce. The forthcoming 10 Year Workforce Plan will set out how. In advance of this, providers' plans should set out the workforce assumptions to deliver the shifts from hospital to community and sickness to prevention, while taking full advantage of productivity improvements, for example, from the shift from analogue to digital. **Workforce plans must triangulate with finance and activity plans**. Providers must also:

- **fully implement** the 10 Point Plan to improve resident doctors' working lives, with action plans informed by feedback and national survey results, and progress reported publicly
- **demonstrate progress in reducing sickness absence rates**, which are higher in the NHS (5.1%) than in other industries and are a significant driver of expensive temporary staffing use. Providers must set out how they intend to support the 10 Year Health Plan ambition to reduce sickness absence rates to the lowest recorded national average level (approximately 4.1%)
- **continue to reduce agency staffing usage** in support of the ambition to eliminate this by August 2029
- **implement the reformed statutory / mandatory training framework due for publication in March 2026**, alongside a new approach to staff safety management
- **implement the reforms to consultant job-planning** to improve productivity and staff satisfaction (specifically, a trust-wide process for demand and capacity planning linked into service-level activity plans). Effective service-level job planning is essential to delivering innovation, education and training because it ensures clinical capacity is aligned to both service and education and training needs, providing transparency for funding allocation. Providers must:
  - for each year, ensure that 95% of medical job plans are signed-off in line with the business cycle, underpinned by service-level demand and capacity planning
  - by the end of 2026/27, ensure a system for monitoring and assurance is in place for tracking job planned activity
  - by the end of 2027/28, achieve tracking of job planned activity for the full year
  - by the end of 2028/29, ensure multiprofessional service level activity and job planning are in place

Success measure	2026/27 target	2028/29 target
Reduce use of bank and agency staffing	Trusts to reduce agency and bank use in-line with individual trust limits, as set out in planning templates, working towards zero spend on agency by 2029/30 Annual limits will be set individually for trusts, based on a national target of a 30% reduction in agency use in 2026/27, and a 10% year-on-year reduction in spend on bank staffing	

4 Next steps and plan submission

The 10 Year Health Plan stipulates that organisations should develop 5-year strategic plans that set out how they will deliver the 3 shifts and improve productivity of their services. These 5-year plans will need to be supported by 3-year numerical returns that describe what the organisation will deliver from 2026 to 2029. This timetable sets out the key outputs expected from the NHS and describes the planning process across the 3 phases.

The planning timetable - expectations for phase 2

Organisations will be expected to submit their 3 year plans as part of their first submission. This will be reviewed and assured by NHS England regional teams. Regional teams will provide feedback on the plans, and organisations will resubmit, alongside their 5-year strategic plans.

	Phase 1: Foundational		Phase 2: Plan development		Plan acceptance	
National planning timetable	July: Engagement with regional/ ICB leadership	August: Medium-term planning framework cascaded	September	October: Planning framework updated with ambitions and expectations	November	December: First submissions	January	February: Full plan submissions	March: Final plan acceptance
Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs			Risk-based planning support to ICBs and providers		Review of first submission, provide feedback to organisations, discussions of areas for improvement including support from national directors		Plan assurance and acceptance	
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers		Integrated planning		Respond to regional feedback, finalise plans and board sign-off		Respond to outcome of plan assurance	Prepare to implement plans
Provider activities	Set up process, governance and build robust evidence	Complete foundational work		Integrated planning		Respond to regional feedback, finalise plans and board sign-off			
Outputs		Underlying financial position Block contract reviews		First submission = numerical plans (3-year workforce, finance and performance) Board assurance statements		Full submission: 5-year plans Updated numerical plans Board assurance statements			

Providers and ICBs will be expected to return the following plans to NHS England:

Submission	Requirement
First submission	• 3-year revenue and 4-year capital plan return • 3-year workforce return • 3-year operational performance and activity return • integrated planning template showing triangulation and alignment of plans • board assurance statements confirming oversight of process
Full plan submission	• updated 3-year revenue and 4-year capital plan return • updated 3-year workforce return • updated 3-year operational performance and activity return • integrated planning template showing triangulation and alignment of plans • 5-year narrative plan • board assurance statements confirming oversight and endorsement of the totality of the plans

The phase 2 planning process

Each NHS organisation is expected to develop their own integrated plans that set out:

- their strategic ambitions
- how they will meet their local population health needs. Plans should reflect the needs of all age groups and explicitly children and young people
- their transformation ambitions, demonstrating how they will implement the 3 shifts set out in the 10 Year Health Plan while improving productivity
- evidence of partnership working and co-operation with other NHS organisations, local authorities and the voluntary, community, faith and social enterprise sector
- how they will meet the standards set out in this document

These plans should be developed in collaboration with their NHS partners and in discussion with NHS England regional teams. Although system plans are no longer required, it is still important that plans are based on cooperation and partnership-working.

Organisations' boards should be engaged in the development of plans and are expected to complete board assurance statements demonstrating that they are satisfied that plans are robust and deliverable. Organisations will be required to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in-year, which must be assured by the board as part of the final plan submission process. To support the management of in-year risk, NHS providers and commissioners should identify specific and timely actions that could be taken to reprioritise existing budgets to address unforeseen pressures, guided by the principles in HM Treasury's 'Consolidated Budgeting Guidance'.

We will ask for the first submission of plans before Christmas. This will include the 3-year numerical plans covering workforce, finance and performance trajectories, as well as board assurance statements. This first submission does not include the narrative plans. Final plans will be expected in early February, including refreshed numerical plans, 5-year plans and updated board assurance statements. Neighbourhood health plan requirements will be set out in the Neighbourhood Health Framework and these will not need to be submitted to NHS England as part of this planning round.

Plans will be assured by NHS England regional teams who will provide specific support to those organisations who face the biggest challenges in meeting our collective ambitions. NHS England national programme teams will also provide support where required and ensure that transformation expertise is targeted and aligned.

We will share further guidance on what should be included within the 5-year narrative plans. ICBs should ensure that their 5-year strategic commissioning plans encompass the statutory requirement for joint forward plans (JFPs) agreed by the ICB and their partner trusts.

Title of report	**Summary report from the Quality Committee, 29/10/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th October 2025					
Agenda item no.	10-7					
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 29th October 2025 (a ‘‘deep dive’’ meeting). The Committee considered the following topics: The BAF risks overseen by the Quality Committee; an update on the management of Diabetes at the Trust; an update on the improvement plan for Elective Care Pathway Management; and a review of the live reporting and the Patient Safety Incident Response Plan (PSIRP). The Committee noted that the reports presented, demonstrate that controls relating to Principal Risks 2, 3, and 4 of the Board Assurance Framework demonstrate partial assurance.
Any items for formal escalation / decision	N/A
Appendices attached	There are no appendices to this report.

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

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

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

The Quality Committee met (in-person / face-to-face) on 29th October 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 noted that the 'Patient Access'; Patient Safety and Clinical Effectiveness' and 'Patient Experience' Principal risks, were all being reviewed and updated regularly.
- The Clinical Lead for the Diabetes service, presented an **update on the management of Diabetes at the Trust,** where in the Committee heard that a number of changes in staff and team structure had taken place since the team last presented to the Committee. The Committee were presented with detail of all aspects of diabetes care provided, for in and outpatients and heard that the team were undertaking a number of audits to monitor their patient's outcomes. The team informed the Committee that the Model Hospital data was used to benchmark the service and identify areas of focus or improvement. The Committee were informed of the issues and opportunities to the provision of a number of aspects of the Diabetes service and noted the areas of opportunity, which included: patient initiated follow up clinics, virtual monitoring systems and reducing the rate at which patients do not attend their appointment. The Committee discussed challenges with delivering the use of hybrid closed loop systems for managing blood glucose levels in patients with type 1 diabetes. Hybrid closed loop systems use a continuous glucose monitor and an insulin pump, connected by a computer algorithm, to automatically adjust insulin delivery for people with type 1 diabetes. The Committee noted the improvements in the service, made by the team.
    - ❖ The Committee noted that this demonstrated limited assurance of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2, 3 and 4.
- The Deputy Chief Operating Officer then presented an update on **the improvement plan for Elective Care Pathway Management**, which provided an overview of the reasons behind the improvement plan being developed, which included the implementation of a task and finish group to oversee completion of the plan. The Committee heard that during the last 10 months there was an incident rate of 0.009% of total outpatient activity, of incidents which involved patients who either did not receive their results or experienced a delay in follow-up appointments. All incidents had been reviewed an no harm identified. The Committee heard that the process of managing referrals had been amended to reduce the risk of duplicate referrals and reduce the use of paper. It was noted that regular waiting list validation would maintain waiting list oversight.
    - ❖ The Committee noted that this demonstrated adequate assurance of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 3.
- The Patient Safety Manager then presented the **review of live reporting and the Patient Safety Incident Response Plan (PSIRP) dashboard,** where in the Committee heard that since the implementation of the Patient Safety Incident Response Framework (PSIRF), there had been: improvements in the quality of investigations and associated reports; increased patient and family engagement and PSII reports being more person-centred than serious incident reports. It was noted that there was continued high levels of compliance with the mandatory patient safety syllabus training across the Trust and the team had retained patient safety partners (PSP). It was noted that an internal audit had given an opinion of reasonable assurance. The Committee heard that an updated version of the PSIRP was launched in April and the Committee were presented with the different types and frequency of learning response undertaken, compared to last year. The Committee heard that the team were tracking operational activity of learning responses commissioned and supporting with live oversight of themes and trends against the PSIRP plan. It was noted that the electronic system had an incident action tracker built in, which allowed tracking and reporting of action activity by action type and by filtering of safety theme across the Trust. It was noted that the incident reporting category codes had been amended to support identification of themes and trends, which had enabled the team to undertake themed reviews for falls, Pressure Damage and Venous Thromboembolism, with the themes and trends feeding into live thematic dashboards on the InPhase system. It was noted that MTW Patient Safety Team won an award for innovation for use of the dashboards at the InPhase user group in 2024 and won a HSJ award for use of digital technology to support patient safety improvements in September 2025.
- The Committee heard that the Patient Safety team collaborated with the Care Coordination Centre, who oversee the patient flow logistics across the organisation, to set up live oversight of

key quality issues that would help to support the operational patient flow and bed management processes, such as live oversight of inpatient falls, violence, aggression and self-harming incident data.

- The Committee received a demonstration of the live dashboard, accessible by all staff and review by speciality, division and location. The Committee saw that staff were able to review themes of good care and areas of improvement identified, from previous learning responses, which could be tracked over time and compared to similar periods of time in previous years. It was also noted that the dashboard could be adapted to identify themes across a variety of data sets and had greatly reduced the time taken to produce reports, identify themes, trends and share learning.
    - ❖ The Committee noted that this demonstrated adequate assurance of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2 and 4.
- The items for scrutiny at future Quality Committee 'deep dive' meetings were discussed, and the Chair then conducted an **evaluation of the meeting**.

Title of report	**Summary report from the Finance and Performance Committee**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th October 2025					
Agenda item no.	10-8					
Executive lead	Neil Griffiths, Non-Executive Director					
Presenter	Neil Griffiths, Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Finance and Performance Committee met (virtually) on 28th October 2025. The Committee considered the following topics: 1) To consider the BAF risks 2) The patient access strategic theme metrics for September 2025 3) The financial performance for month 6, 2025/26, including an update on the Financial Improvement Plan 4) Maternity Information System Business Case 5) Out of Hours GP Service 6) Quarterly update on the Business Case benefits realisation 7) Histopathology Business Case – update 8) Quarterly productivity report 9) An update on Fordcombe Hospital 10) Quarterly analysis of consultancy use 11) Annual Review of the Procurement Strategy 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 28th October 2025, virtually.

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 Director of IT attended to present the **Quarterly update on the implementation of the Digital and Data Strategy** wherein the Committee were presented with an overview of ongoing digital transformation projects, the results of the digital maturity self-assessment, noting a score above national and regional averages, but lower scores in 'empowering people' and 'safe practice,' prompting plans for a deep dive and peer review to understand and address these areas. The Committee discussed the governance and implementation of artificial intelligence, with a focus on quantifying benefits, addressing assessment discrepancies, and ensuring innovation was not hindered by policy development.
- The **Maternity Information System Business Case** was presented to the Committee, which outlined the need to replace the current maternity information system due to a national patient safety alert and expiring contract, with a collaborative procurement through the Kent and Medway System to ensure safety and cost-effectiveness. The Committee approved the business case. It was noted this will require a review of the capital programme for 2026/27.
- The Director of Planning, Strategy and Partnerships presented the **Out of Hours GP Service** Business Case, wherein the Committee discussed the provision of the GP out of hours service highlighting risks and financial implications.
- The **Quarterly update on the Business Case benefits realisation** was then presented, which included the process and outcomes of business case benefits evaluation, highlighting improvements in post-project review, lessons learned, and the handling of specific cases with implementation delays. The Committee acknowledged this was a very good analysis and helpful as we think about business case approvals and risk.
- The Committee then heard an **update on the Histopathology Business Case,** where it was noted that there was a need to align service costs with partner payments, manage cash flow risks, and improve demand management and internal cost allocation. The Committee approved the business case.
- The **Patient Access strategic theme** metrics for September were reviewed, and it was highlighted that the RTT waiting list has grown to 48-50,000 due to reduced high-volume outpatient activity, with a recovery plan in place to improve productivity and efficiency, and a revised trajectory submitted to NHSC aiming for a waiting list of 44,000 by March. It was noted that performance against four-hour and 12-hour emergency targets, as well as 62-day and 28-day cancer targets, remained below trajectory, with recovery plans focused on reducing length of stay, improving community pathways and future plans to implement digital triage, with single point of access hubs for high-demand specialties, using Patient Knows Best integration to improve referral management, reduce unnecessary appointments, and enhance patient experience.
- The **financial performance month 6, 2025/26** was then presented by the Deputy Chief Executive / Chief Finance Officer, which included that the Trust was £0.1m in surplus in the month which was £0.1m favourable to the plan. Year to date the Trust was £12.5m in deficit which was breakeven to plan, requiring improved run rates, delivery of cost improvement plans and management of significant risks related to undelivered System savings. The Committee discussed the shortfall in System savings, with the implementation of stricter workforce controls, engaging divisions in cost reduction, and considering additional schemes and income generation opportunities to close the gap.
- An update on **Fordcombe Hospital** was provided, which included that there was improved capacity and income generation at Wells Health, with ongoing initiatives including expanding robotic and orthopaedic cases, developing relationships with insurers, and enhancing marketing efforts. This updated plan addresses the previous year end shortfall, although needs to be fully delivered.
- The Divisional Director of Operations, Core Clinical Services then provided the **quarterly productivity report,** and highlighted the improvements in implied productivity, driven by cost reductions while maintaining activity levels, and noted ongoing efforts to replicate national metrics locally for better real-time analysis. The Committee heard that the implementation of vitals charts and data-driven improvement methods in diagnostics, had led to reduced wait

times, better capacity management, and enhanced reporting accuracy. The Committees thanked the team for a very good report and presentation.

- The Committee then received the **annual review of the Procurement Strategy**, wherein the three-year procurement strategy was outlined, emphasising the need to maximise existing systems, improve data quality, implement scan for safety, and establish a category-led work plan with regular product reviews. The Committee heard that the Procurement Act requires procurement teams to take on contract management for major contracts, with the role being merged with sustainability responsibilities to optimise resources. The Committee discussed the System-wide collaboration on procurement savings, citing the absence of a central leader and standardised processes, with a proposal being developed to address this gap.
- The Committee noted the **quarterly analysis of consultancy use, the summary report from the from the September 2025 People and Organisational Development Committee;** and the **forward programme**.
- The Committee **considered the assurance provided at the meeting relating to the Board Assurance Framework** and noted that the information presented, demonstrated that controls relating to Principal Risks 3,5 and 6 of the Board Assurance Framework are demonstrating effectiveness.

Title of report	**Summary report from the People and Organisational Development Committee, 24/10/25**					
Board / Committee	**Trust Board 'Part 1' Meeting**					
Date of meeting	30th October 2025					
Agenda item no.	10-9					
Executive lead	Richard Finn, Associate Non-Executive Director					
Presenter	Richard Finn, Associate Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The People and Organisational Development Committee met (virtually, via webconference) on 24th October 2025 (a ''deep dive' meeting). The Committee considered the following topics: 1) The People BAF risk 2) Monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR) 3) Six-monthly update on the implementation of the sexual safety in healthcare charter 4) Update from the Director of Medical Education (DME) (6-monthly report) 5) Review of the Trust's People related risks 6) Lifestyle Medicine Programme 7) People Transformation update 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 24th October 2025 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed.
- The Committee noted the **People Board Assurance Framework (BAF) risk** and it was outlined that the Principal risk was being updated, following feedback from the Committee at the last meeting, which would reflect the current area of focus for the People and Organisational Development team and would be presented to the next Committee.
- The Committee conducted a **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**, wherein it was reported that the number of substantive staff in post had reduced for the second month in a row and there was a reduction in recruitment activity, where it was noted that the vacancy rate had increased. It was noted that, the impact of Phase 1 had begun to materialise and would become more evident as the key timelines for Phase 1 were reached.
    - The Committee considered that this demonstrated the controls articulated in the Board Assurance Framework, Principal Risk 6 regarding reduction in temporary staff spend.
- The Chief People Officer provided the Committee with the **Six-monthly update on the implementation of the sexual safety in healthcare** charter which included an overview of the Sexual Safety Charter, which was published by NHS England in July 2023, with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace and identified a need for regular board assurance to be established. It was noted that a number of key actions were agreed to be in place by July 2024 of which MTW was 100% compliant and the activities to ensure compliance were presented. The Committee heard that the reporting of sexual misconduct in the workplace had increased, which could reflect a healthy reporting culture and safety in speaking up, but it was noted that the numbers did not match with the National Staff survey data. The Committee heard that the team would be looking at a range of information from a number of areas to develop a more comprehensive action plan and noted that assurance was gained that the Trust was meeting and acting on what was required to meet the standards.
- An **Update from the Director of Medical Education** was presented to the group, and it was outlined that a summary of the results of the GMC National Training Survey was provided, noting a lower response rate and a trend of decreasing red flags but also fewer green flags. Four areas required actions in response to the survey and were noted to be: histopathology; intensive care medicine; foundation medicine (F2) and Surgery (F1) and it was noted that Trust was not expecting a formal visit. The Committee discussed challenges in offering training posts to doctors.
- The group reviewed the **Trust's People related risks** wherein it was recognised that that there was a decrease in open people risks from 43 to 39, with four rated as red which included: including financial challenges; medical device training; occupational health space and industrial action. Most risks were amber, and the overall risk landscape remained dynamic due to ongoing transformation work.
- The Head of Occupational Health attended to present the **Lifestyle Medicine Programme**, which included that the initiative had been made possible with the support of the MTW Charity and aimed to empower staff to take control of their own health through evidence-based lifestyle interventions. The Committee heard that the pilot supported MTW's commitment to prevention, wellbeing, and a culture of health creation within its workforce, by reducing sickness levels and that there was a potential to roll the program out to patient cohorts. The Committee heard the initiative came through the well-being group, noted the importance of preventative medicine for our staff in order for them to support our patients and congratulated the team on setting the program up, the good feedback received so far and that the Trust was the only one in the country undertaking this work.
- The Chief People Officer provided a **People Transformation update**, where the group heard that Phase 1 of the program was coming to a close and Phase 2 had begun. The Committee heard that Phase 2 began with a 45-day consultation, split into trust-wide and local changes, targeting

headcount reduction, skill mix reviews, and working practice improvements. The process incorporated the lessons from phase one, with more targeted and agile engagement to minimise disruption.

- The Committee considered the assurance provided relating to the People BAF risk, and the Chair conducted an evaluation of the meeting.
- The Committee noted the **forward programme.**

Title of report	**Integrated Performance Report (IPR) for September 2025**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th October 2025					
Agenda item no.	10-10					
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 September 2025 is enclosed.		
Any items for formal escalation / decision			
Appendices attached			
Report previously presented to:			
Committee / Group		Date	Outcome/Action
n/a			

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

September 2025

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

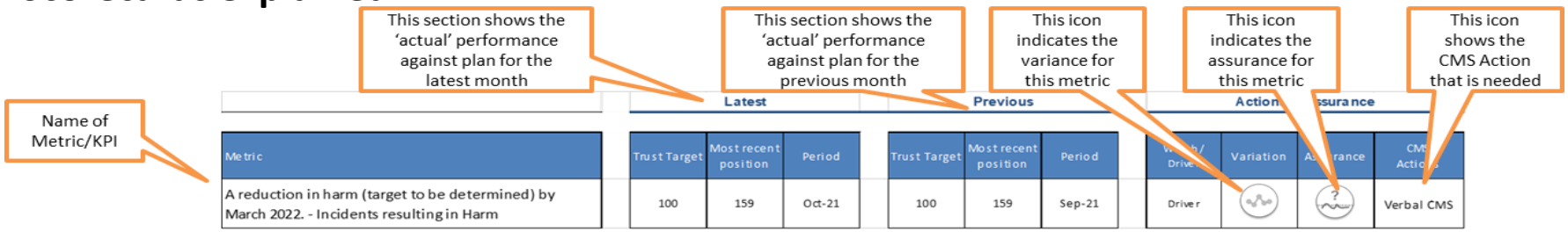
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

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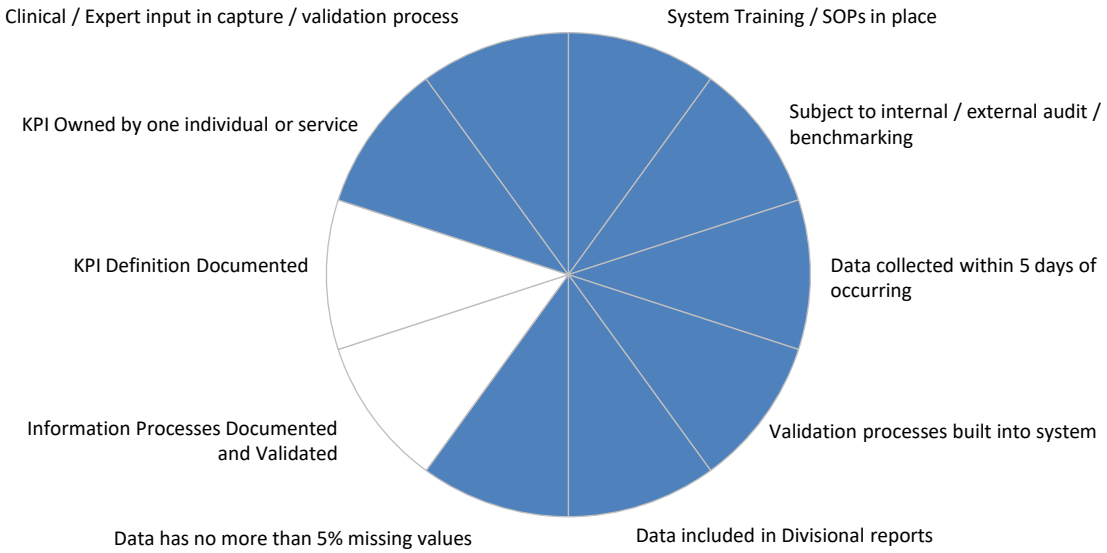
Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The 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 six 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 is consistently achieving the target. Sickness levels is now experiencing special cause variation of an improving nature 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 failing the target for 6+ months. The number of incidents of moderate+ harms due to potential mismanagement of deteriorating patients is experiencing common cause variation and variable achievement of the target. Both the Rates of E.Coli and C.Diff continue to experience common cause variation and variable achievement of the target. 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 continues to experience special cause variation of an improving nature and passing the target for more than six months. VTE performance was above the 95% target in August (data runs one month behind) and is experiencing common cause variation and 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 September 25 of 74.1% at 70.25% (Excluding SYS) which was 1.5% below the internal recovery trajectory. Nationally we reported 70.19% (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 September 25. The number of patients having waited more than 40 weeks (Excluding SYS) is now experiencing common cause variation but has failed the target for 6+ months. The "Reduction in weeks wait for first Outpatient Appointment" indicator is experiencing common cause variation and 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 3% above the new trajectory target for September 25 at 91.4%. 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 1.8% below the new trajectory target for September at 81.1% and has now failed the target for 6+months. The new NPAF Indicator for A&E 4hrs (an Aggregated Quarterly Position) is consistently passing the NPAF target of 78% . 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 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. September 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 common cause variation 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 now experiencing special cause variation of a concerning nature and variable achievement of the target. Diagnostic Imaging activity levels were above plan in September and this indicator is now experiencing special cause variation of an improving nature 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 14.8%. The target for this is currently being worked up. Complaints responded to within the target date passed the target again in September, at 78%, 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 special cause variation of an improving nature and variable achievement of the target.

Sustainability: The Trust was £0.1m in surplus in the month which was £0.1m favourable to plan in the month. Year to Date the Trust is £12.5m in deficit which is on plan.

Maternity: Both of the indicators for Women waiting for Induction of Labour continue to experience common cause variation and consistently 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 special cause variation of an improving nature and variable achievement of the target.

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)
- % 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 outpatient appointment (Average) (P.19)
- 10% Reduction in Non-Elective LOS (P.20)
- Outpatient Calls answered <1 minute (P20)
- Ambulance Handovers < 30 mins (P.20)
- % Capped Theatre Utilisation (P.20)
- Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - monthly *NPAF Metric* (P.21)
- Percentage of emergency department attendances admitted, transferred or discharged within 12 hours – Quarterly *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

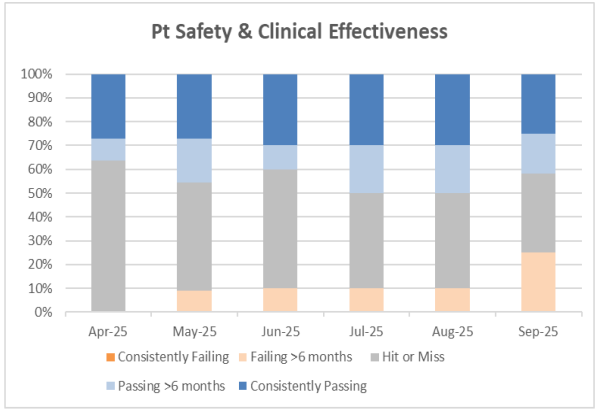
Patient Safety & Clinical Effectiveness:
- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.15)
- 12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* (P.16)
- 12 month rolling count of C. difficile cases as a proportion of trust threshold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

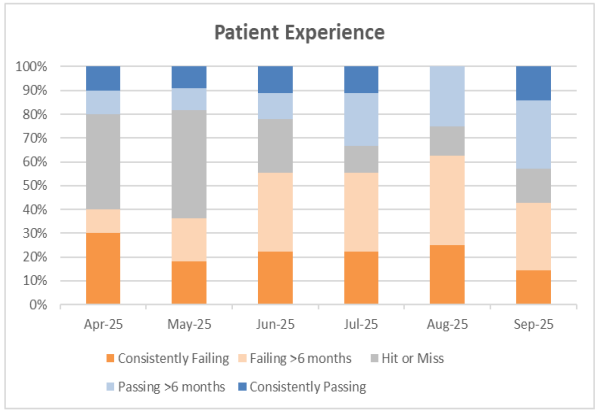
Patient Experience:
- New Complaints Received (P.23)
- FT Response Rates: All areas (P.24)

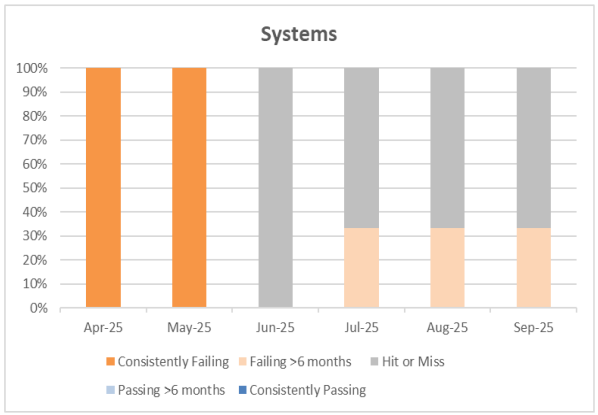
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.30)
- Women waiting for Induction of Labour <4 Hrs (P.30)

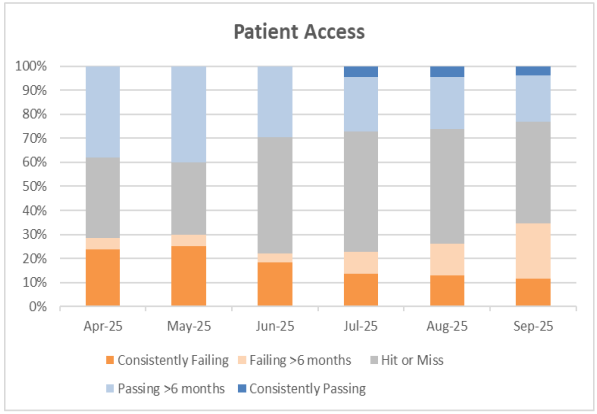
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

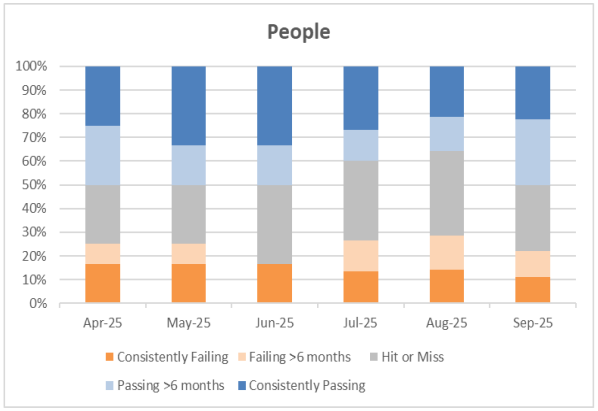
Assurance Stacked Bar Charts by Strategic Theme

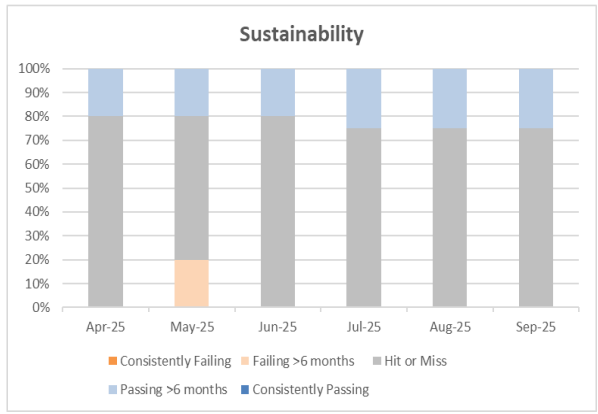












Matrix Summary

September 2025		Assurance				
		Pass ★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement	Reduce Turnover Rate to 12% Percentage of AfC 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% Sickness Absence *NPAF Metric* 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 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	Friends and Family (FFT) % Response Rate: Maternity	12 month rolling count of MRSA cases *NPAF Metric*
	Common Cause	Statutory and Mandatory Training Percentage of AfC 8c and above that are Female % VTE Risk Assessment (one month behind) **Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - Quarter Position Aggregated *NPAF Metric* *Cancer - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric* Safe Staffing Levels (Nursing)	Achievement of Bank Element of Workforce Plan (WTEs) Achievement of Agency Element of Workforce Plan (WTEs) Conversion rate from ED (Excluding Type 5 and including Direct Admissions) Friends and Family (FFT) % Response Rate: A&E Cash Balance (£k)	Staff Leavers within 12 months Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) Never Events IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric* To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally Access to Diagnostics (<6weeks standard) Cancer - 62 Day (New Combined Standard) data runs one month behind Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) Transformation: % of Patients Discharged to a PIFU Pathways To achieve the planned levels of new outpatients 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. Friends and Family (FFT) % Response Rate: Inpatients 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 Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) A&E 4 hr Performance Percentage of emergency department attendances spending over 12 hours in the department - Quarter Position Aggregated *NPAF Metric* *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) 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 AfC 8c and above that are BAME RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways) Transformation: CAU Calls answered <1 minute % Capped Theatre utilisation. Friends and Family (FFT) % Response Rate: Outpatients
	Special Cause - Concern			Transformation: % OP Clinics Utilised (slots) Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) Complaints Rate per 1,000 occupied beddays	Achievement of Workforce Plan (WTEs) Achievement of Substantive Element of Workforce Plan (WTEs) Staff Leavers within 24 months 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	

Strategic Theme: People

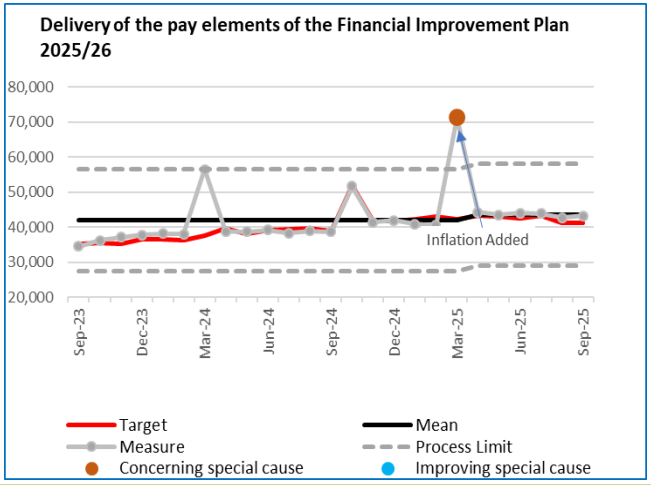
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Well Led	Delivery of the pay elements of the Financial Improvement Plan 2025/26		41,218	43,230	Sep-25	41,280	42,772	Aug-25	Driver			Full CMS			
Breakthrough Objective	Well Led	Achievement of Workforce Plan (WTEs)		7966	8305	Sep-25	7983	8332	Aug-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Well Led	Achievement of Substantive Element of Workforce Plan (WTEs)		7298	7702	Sep-25	7313	7707	Aug-25	Driver			Escalation			
	Well Led	Achievement of Bank Element of Workforce Plan (WTEs)		579	534	Sep-25	581	578	Aug-25	Driver			Not Escalated			
	Well Led	Achievement of Agency Element of Workforce Plan (WTEs)		89	69	Sep-25	90	69	Aug-25	Driver			Not Escalated			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	1.2%	Sep-25	3.2%	0.8%	Aug-25	Driver			Not Escalated			
	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	5.8%	Sep-25	8.0%	5.7%	Aug-25	Driver			Not Escalated	5.5%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.0%	Sep-25	12.0%	10.4%	Aug-25	Driver			Not Escalated	9.7%		
	Well Led	Sickness Absence *NPAF Metric*		4.5%	4.0%	Aug-25	4.5%	3.8%	Jul-25	Driver			Not Escalated	4.0%		
	Well Led	Statutory and Mandatory Training		85.0%	90.9%	Sep-25	85.0%	91.8%	Aug-25	Driver			Not Escalated	91.0%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	73.7%	Sep-25	66.0%	73.3%	Aug-25	Driver			Not Escalated	74.95%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	11.2%	Sep-25	4.0%	9.3%	Aug-25	Driver			Not Escalated	11.14%		
	Well Led	Percentage of AfC 8c and above that are BAME		13.5%	6.6%	Sep-25	13.1%	6.7%	Aug-25	Driver			Escalation	6.78%		
	Well Led	Staff Leavers within 12 months		15.3	21	Sep-25	15.3	21	Aug-25	Driver			Not Escalated	19		
	Well Led	Staff Leavers within 24 months		28	34	Sep-25	27.8	35	Aug-25	Driver			Escalation	35		

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



Sep-25
42,230
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	39,257	36,544	- 2,713	7,701	7,298	- 403
Bank	3,306	3,455	149	534	579	45
Agency	498	673	175	69	90	21
Other	180	166	- 14	-	-	-
Total Pay	**43,241**	**40,838**	**- 2,403**	**8,304**	**7,967**	**- 337**

	Year to Date '£000			Year to Date WTE		
	Submitted			Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	236,493	224,338	- 12,155	46,361	44,103	- 2,258
Bank	21,184	22,135	951	3,337	3,646	309
Agency	3,015	4,703	1,688	410	618	208
Other	1,044	946	- 98	-	-	-
Total Pay	**261,736**	**252,122**	**- 9,614**	**50,108**	**48,367**	**- 1,741**

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

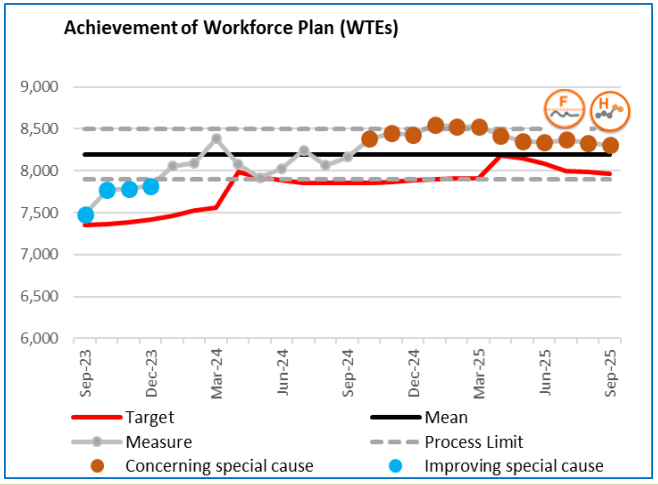
Workstreams	Actions	When	Who
Programme Delivery	Workforce Transformation Programme Phase 1 consultation closes	Sept 2025	Chief People Officer
	Workforce Transformation Programme Phase 2 consultation proposal launches	Oct 2025	Chief People Officer
Rostering Performance	Ongoing programme to establish e-rostering for all HCP teams (into 3rd phase with no major issues)	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 – in place	Sept 2025	Deputy Chief Nurse
Data analysis	Project team reviewing data to identify root causes of variance of WTE to plan	Ongoing	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)

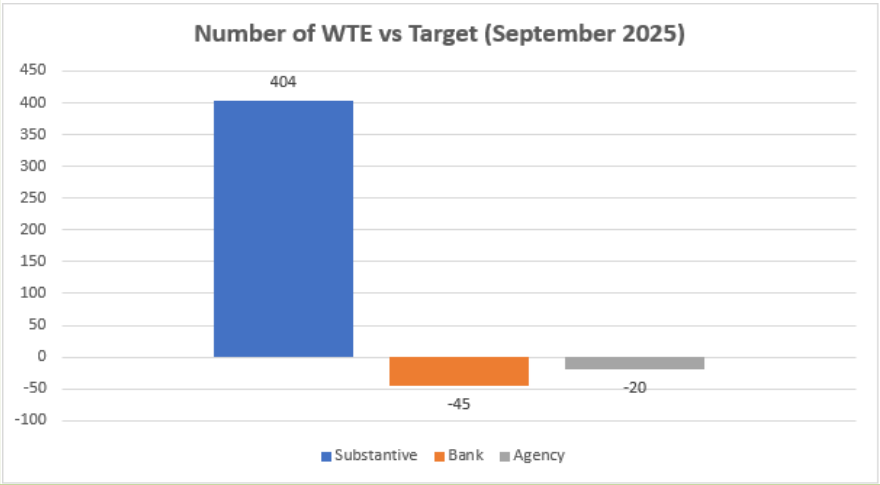
Owner: Chief People Officer
Metric: Achievement of Workforce Plan (WTEs)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Sep-25
8,305
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
7,965
Business Rule
Full Escalation as has failed the target for 6+ months

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)

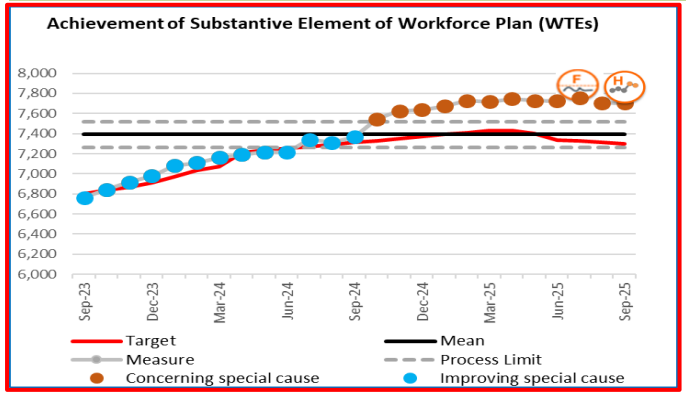
Risks:

- 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.

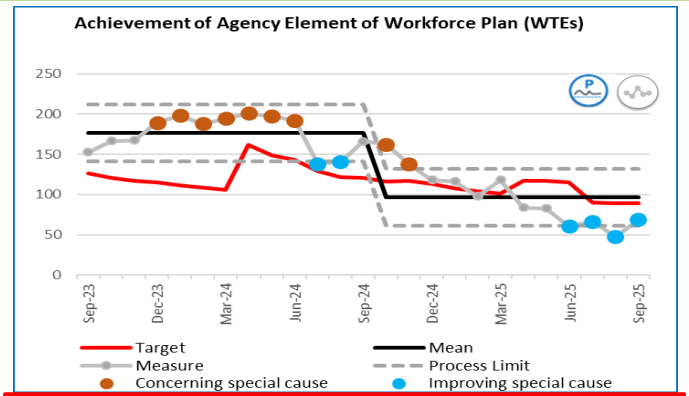
4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Project Charter	Project Charter Developed	Sept 25	Project Team
	Project Charter awaiting sign off	Oct 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)	Oct 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

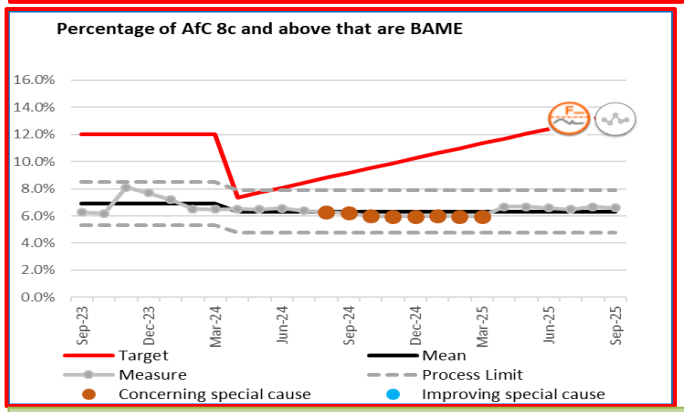
People – Workforce: CQC: Well-Led



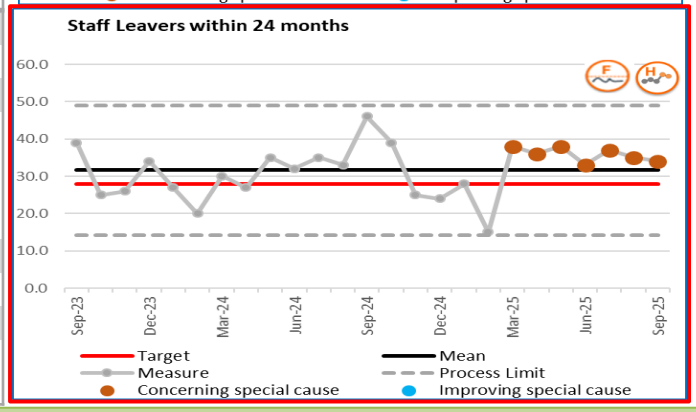
Sep-25
7,702
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
7,298
Business Rule
Full Escalation



Sep-25
69
Variance / Assurance
Metric is currently experiencing common cause variation and has passed the target for 6+ months
Target (Internal)
89
Business Rule
Full Escalation



Sep-25
6.6%
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
13.5%
Business Rule
Full Escalation



Sep-25
34
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Target (Internal)
28
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 common cause variation and has passed the target for 6+ months

% 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.

Achievement of Agency Element of the Workforce Plan: Usage continues to drop, with focus turning to final remaining 7 medical agency posts and hotspot areas (e.g. enhanced care) for Q3

% of AfC 8c and above that are BAME:
As a result of the latest WRES and WDES data, we will be drafting a mandatory manager's induction programme that will provide managers with a comprehensive range of skills including MTW culture and values, people management fundamentals, communication and engagement, leadership development and finance and resource management.

Staff Leavers within 24 months: We will undertake a review in Q3 25/26 following Phase 1 conclusion

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:
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

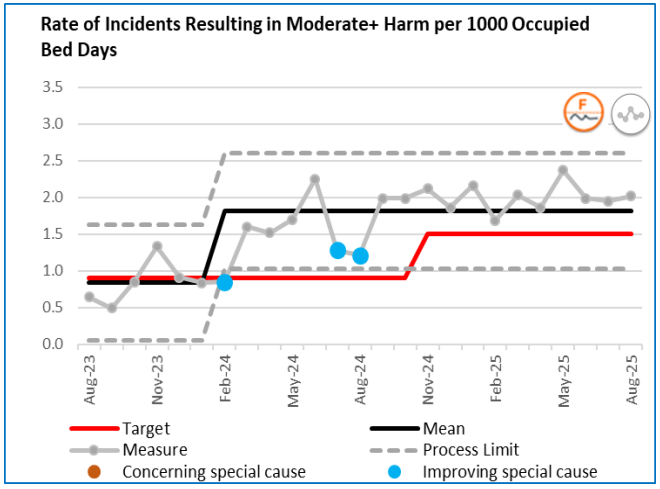
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	2.02	Aug-25	1.50	1.95	Jul-25	Driver			Full CMS	2.38		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	5	Aug-25	2.1	3	Jul-25	Driver			Verbal CMS	3		
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	8	Sep-25	TBC	3	Aug-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	2	Sep-25	TBC	0	Aug-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	Sep-25	TBC	0	Aug-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	82.5	Jun-25	100.0	83.1	May-25	Driver			Not Escalated	81.9		
	Safe	Summary Hospital-level Mortality Indicator (SHMI) *NPAF Metric*		100.0	88.2	Jun-25	100.0	88.0	May-25	Driver			Not Escalated	87.1		
	Safe	Never Events		0	0	Sep-25	0	1	Aug-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	43.7	Sep-25	32.6	21.9	Aug-25	Driver			Not Escalated	41.5		
	Safe	12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric*		1.0%	1.52%	Sep-25	1.0%	1.50%	Aug-25	Driver			Escalation			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.3	43.7	Sep-25	44.3	43.3	Aug-25	Driver			Not Escalated	56.7		
	Safe	12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric*		1.0%	1.19%	Sep-25	1.0%	1.15%	Aug-25	Driver			Escalation			
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Sep-25	0	0	Aug-25	Driver			Not Escalated	0		
	Safe	12 month rolling count of MRSA cases *NPAF Metric*		0	2	Sep-25	0	0	Aug-25	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	4.0	Sep-25	6.4	4.1	Aug-25	Driver			Not Escalated	3.9		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	97.4%	Aug-25	95.0%	98.0%	Jul-25	Driver			Not Escalated	98.1%		

Vision: Counter Measure Summary

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

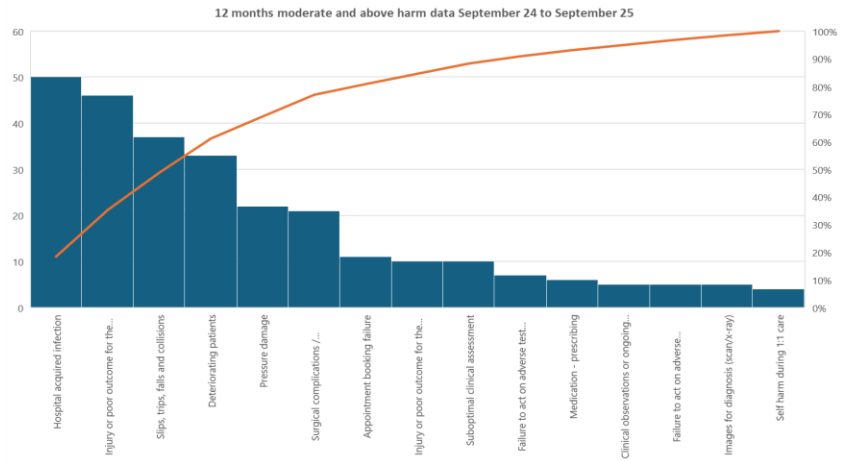
Owner: Chief Medical Officer
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

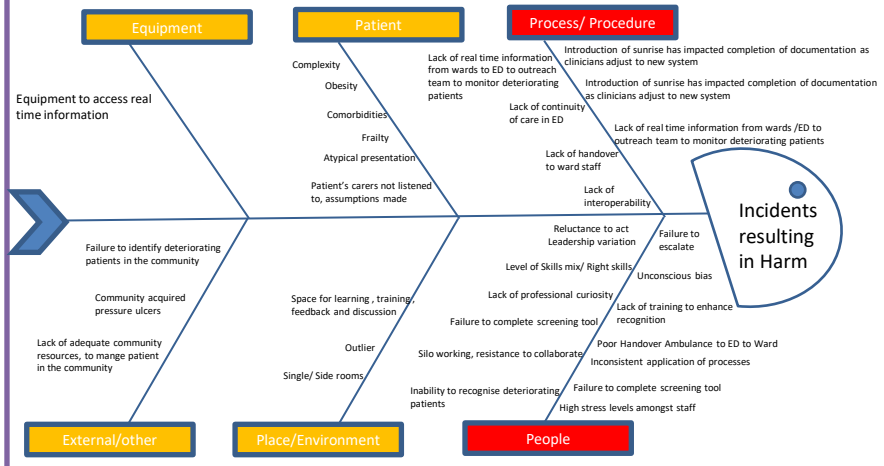


Aug-25 (1 month arr)
2.02
Variance Type
Metric is currently experiencing common cause variation
Maximum Limit (Internal)
1.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



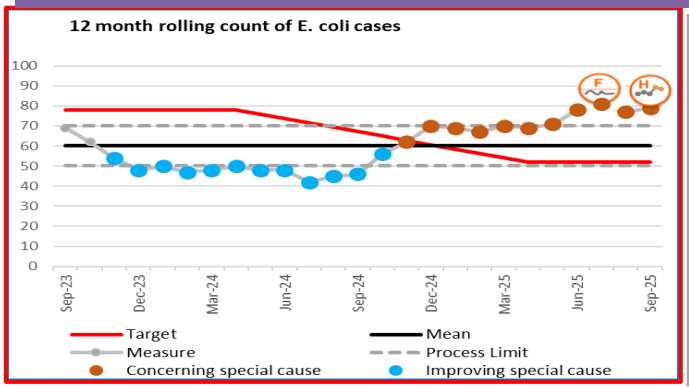
3. Top Contributors



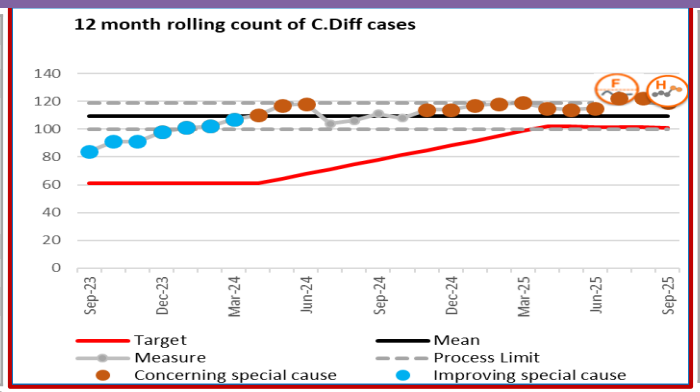
4. Action Plan

Actions	Leads	Due by
Deteriorating Patients		
10 @ 10 Training roll out	JB	Aug-26
Determine staffing for who will deliver local induction training	JB	Dec-25
Pilot 2am huddle meeting as an alternative to H@N	JJ	Jan-26
Piloting of deteriorating patient document (SBAR)	JB/MH	Jan-26
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

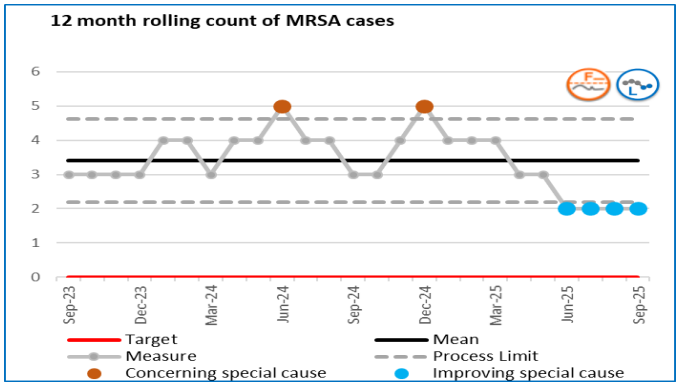
Patient Safety & Clinical Effectiveness: CQC: Safe



Sep-25
79
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



Sep-25
119
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



Sep-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 commenced 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
- Trial of alternative cleaning agent for environment and equipment
- Enhanced bed and mattress cleaning
- Deep cleaning programme for high-risk areas due to start (Ward 11 due 14/10/25)

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

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three month Forecast	Variation	Assurance
Vision	Responsive	To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric*		74.1%	70.25%	Sep-25	73.8%	69.1%	Aug-25	Driver			Verbal CMS	72.6%		
Breakthrough Objective	Responsive	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways)		16.0	19.5	Sep-25	16.5	17.9	Aug-25	Driver			Full CMS	19.0		
Constitutional Standards and Key Metrics	Responsive	To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally		74.1%	70.19%	Sep-25	73.8%	69.0%	Aug-25	Driver			Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		729	889	Sep-25	732	1020	Aug-25	Driver			Escalation	709		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	6	Sep-25	N/A	5	Aug-25	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally *NPAF Metric*		N/A	0	Sep-25	N/A	0	Aug-25	Driver	No SPC	No SPC	Not Escalated			
	Responsive	Access to Diagnostics (<6weeks standard)		88.3%	91.4%	Sep-25	88.5%	88.9%	Aug-25	Driver			Not Escalated	90.6%		
	Responsive	A&E 4 hr Performance		82.9%	81.2%	Sep-25	85.1%	80.2%	Aug-25	Driver			Escalation	81.0%		
	Responsive	**Percentage of emergency department attendances admitted, transferred or discharged within 4 hours - Quarter Position Aggregated *NPAF Metric*		78.0%	82.0%	Sep-25	78.0%	81.9%	Jun-25	Driver			Not Escalated			
	Responsive	Percentage of emergency department attendances spending over 12 hours in the department - Quarter Position Aggregated *NPAF Metric*		5.0%	6.4%	Sep-25	5.0%	7.2%	Jun-25	Driver			Escalation			
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	99.2%	Aug-25	96.0%	99.2%	Jul-25	Driver			Not Escalated	100.1%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	87.5%	Aug-25	85.0%	82.2%	Jul-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%	75.9%	Aug-25	75.0%	75.1%	Jul-25	Driver			Not Escalated	76.0%		
		*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%	88.1%	Aug-25	90.0%	88.7%	Jun-25	Driver			Not Escalated	88.3%		

* 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)

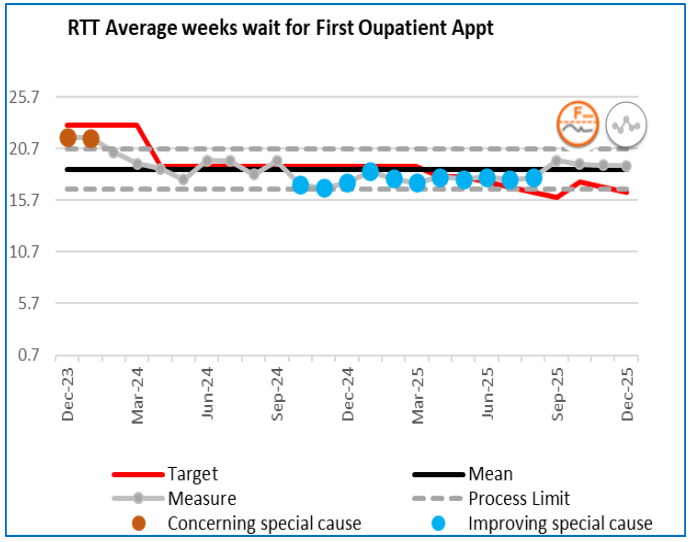
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	80.1%	Sep-25	85.0%	83.7%	Aug-25	Driver	L	?	Not Escalated	82.3%		F
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		5.6%	6.2%	Sep-25	6.0%	5.6%	Aug-25	Driver		?	Not Escalated	6.7%		P
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	85.2%	Sep-25	90.0%	86.9%	Aug-25	Driver		F	Escalation	85.6%	H	F
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.0%	Sep-25	5.0%	6.0%	Aug-25	Driver		F	Escalation	6.3%		F
	Effective	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward)		5.9	6.4	Sep-25	5.9	6.5	Aug-25	Driver		F	Escalation			
	Effective	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	13.2%	Sep-25	16.0%	13.5%	Aug-25	Driver		P	Not Escalated			
	Effective	To achieve the planned levels of new outpatients activity		24,397	22,711	Sep-25	22,174	20,005	Aug-25	Driver		?	Not Escalated	23,270		?
	Effective	To achieve the planned levels of elective (DC and IP combined) activity		6,323	6,332	Sep-25	5,769	5,837	Aug-25	Driver	H	?	Not Escalated	6,030		?
	Effective	% Capped Theatre utilisation.		85.0%	81.0%	Sep-25	85.0%	81.9%	Aug-25	Driver		F	Escalation			
	Effective	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	47.0%	Sep-25	49.0%	48.8%	Aug-25	Driver	L	?	Not Escalated	46.9	L	?
	Effective	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity		19,622	18,956	Sep-25	17,916	18,366	Jul-25	Driver	H	?	Not Escalated	19,168	H	?

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 is weeks wait to first outpatient appointment (Average)
Desired Trend: 7 consecutive data points below the mean

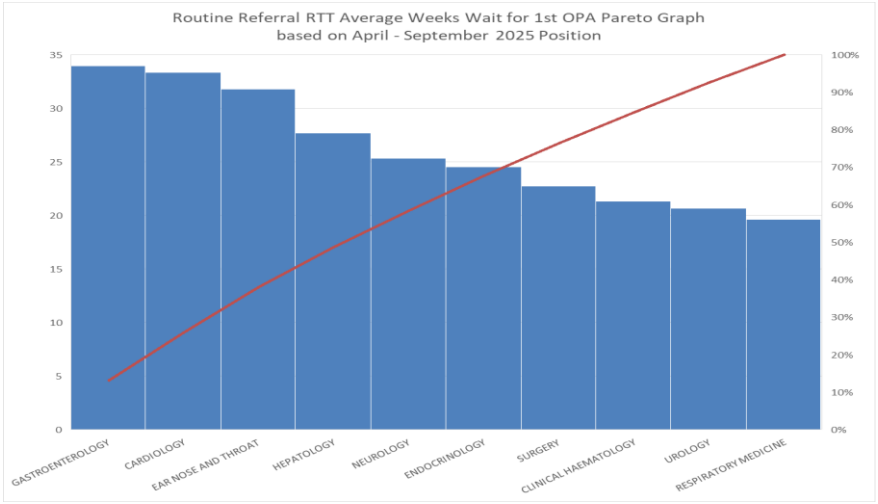
1. Historic Trend Data



Sep-25
18.5
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
16.0
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)

Further data reviews underway to determine root causes in each specialty listed above.

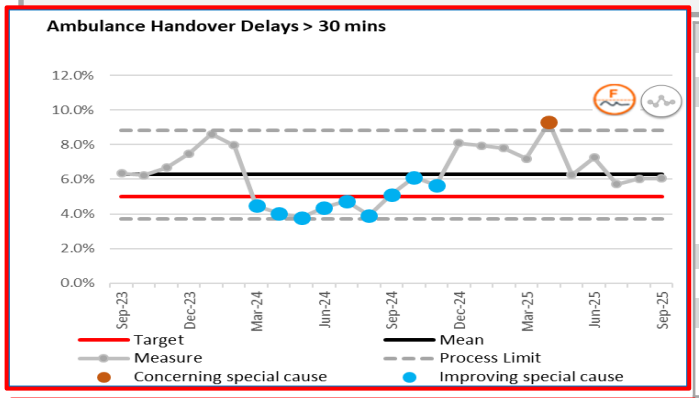
Key Risks:
- System capacity challenges
- Cancelled activity due to industrial action may impact performance
- Financial constraints could impact ability to deliver activity levels
- Clinical engagement to transform pathways

4. Action Plan

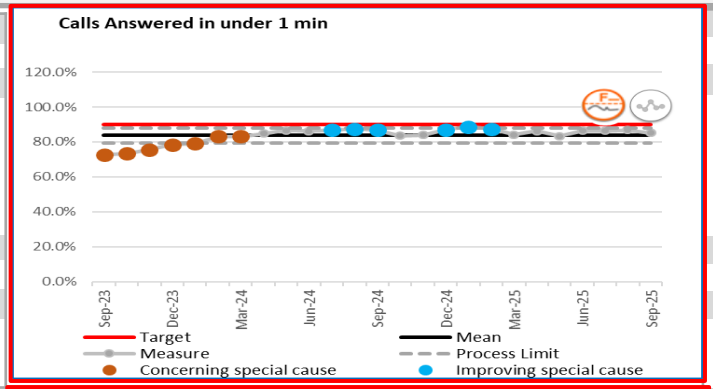
Action	When
Review data and develop multiple cancellation report	Oct 25 ✓
Analysis and root cause of a sample of 40 week breaches (excluding system data) for top 3 contributors	Oct 25
Triangulate all data against top specialty contributors	Ongoing
Complete root cause analysis for each pathway	Ongoing

ENT- Contributors	Counter-measures	When
Follow-up appointments need capacity – reducing availability for New outpatients	Booking team in ENT CAU instructed not to book follow up appointments in NEW slot from September	Oct
Appointment cancellation and DNA's	Appointments only booked 6 week in advance	Oct
Appointment cancellation and DNA's	Adherence to annual leave policy for all staff to reduce hospital cancellations	Oct

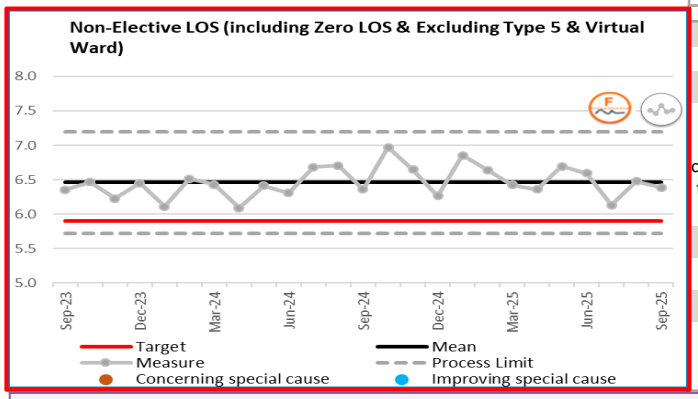
Patient Access: CQC: Responsive



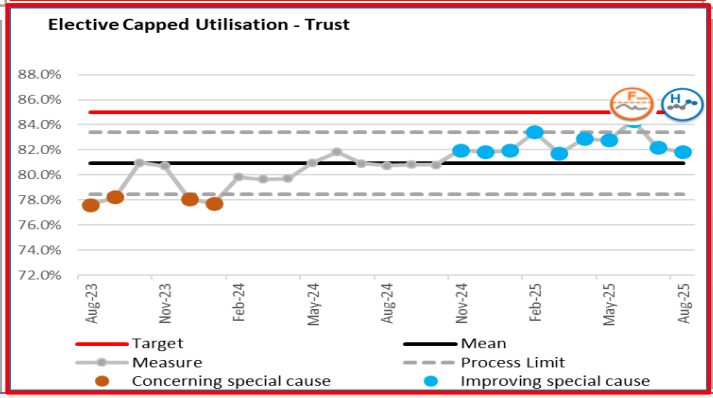
Sep-25
6.0%
Variance / ,Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Limit (Internal)
5%
Business Rule
Full Escalation as has failed the target for 6+months



Sep-25
85.2%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as is consistently failing the target



Sep-25
6.4
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



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 common cause variation 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.

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

Actions:

Ambulance Handover delays <30mins: Continuous reviews of inbound ambulances.

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
- 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. Opening TWH mega rap has improved flow.

Calls Answered within 1 minute in the CAUs:. Total calls answered in September was 31,730 which was 2,682 more calls than the previous month. Performance is steady at 86% despite known vacancies within our CAU teams.

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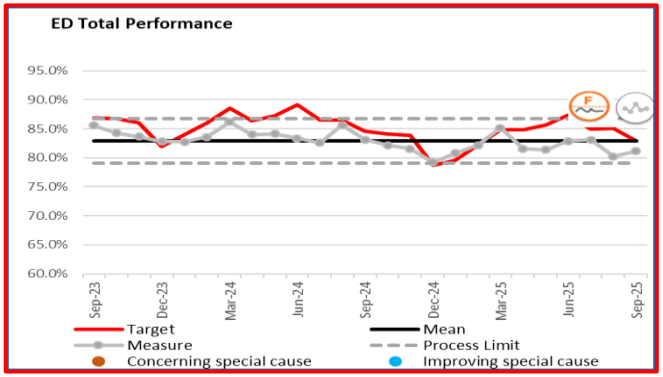
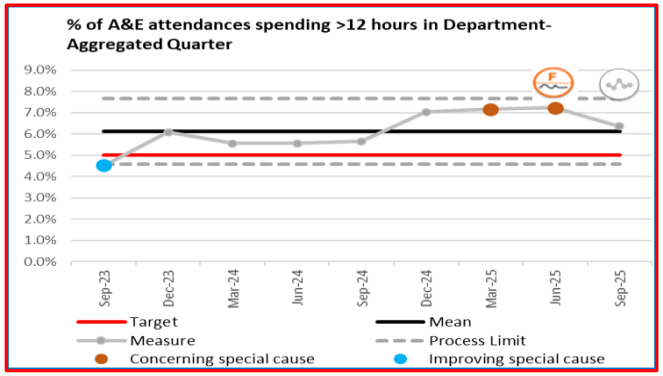
Non-Elective LOS: This is the operation flow financial theme project and is reported on a fortnightly and monthly basis through the Financial Improvement Programme Board, up through F&P and to Trust board. Also aligned to the Better use of Beds system programme of work.

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

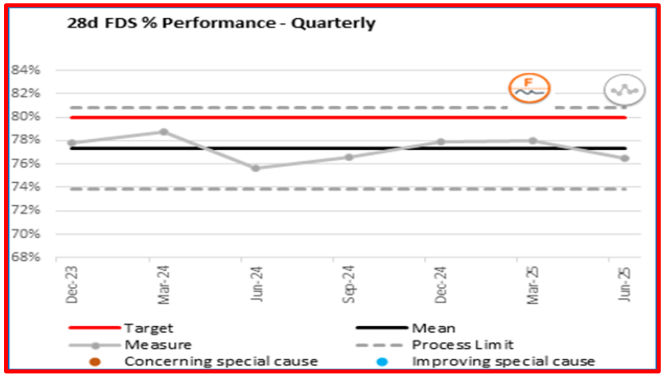
Patient Access: CQC: Responsive



Sep-25
81.15%
Variance / Assurance
Metric is currently experiencing common case variation
Target (Bus. Plan)
82.9%
Business Rule
Full Escalation as has failed the target for 6+months



Sep-25
6.4%
Variance / Assurance
Metric is currently experiencing common case variation
Max Limit (NPAF)
5%
Business Rule
Full Escalation as has failed the target for 6+months



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:

A&E 4 hrs (Monthly) & A&E >12 hrs (Quarterly NPAF): Both these metrics are experiencing common cause variation and have failed the target for 6+ months

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).

Actions:

A&E 4 hrs (Monthly) & A&E >12 hrs (Quarterly NPAF): ED improvement Action Plan formulate and submitted.

Key actions :

- Consultant front door streaming and consultant allocations enacted
- Super RAP implementation to improve flow
- CDU optimisation workstream
- SOP for Minors/GP Surge
- UTC 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

Assurance & Timescales for Improvement:

A&E 4 hrs (Monthly) & A&E >12 hrs (Quarterly NPAF): Improve to 84% in September and realign with submitted trajectory thereafter

28 Day Faster Diagnosis:

Plan formulated on triangulation of data completeness, diagnosis (Yes/No) and overall compliance.

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.

Strategic Theme: Patient Experience

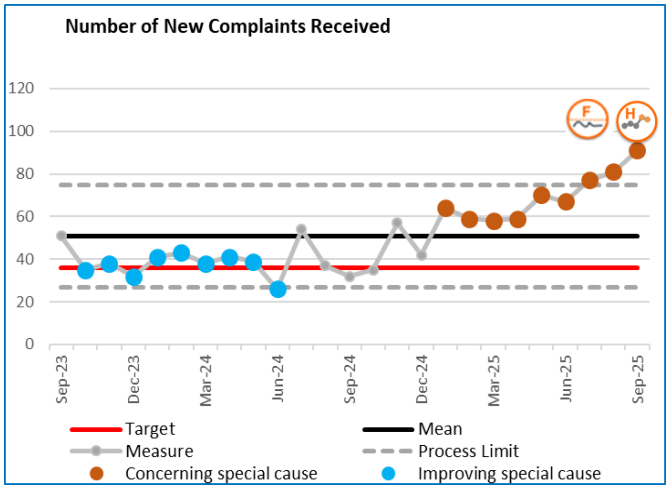
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		36	91	Sep-25	36	81	Aug-25	Driver			Full CMS	102		
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	14.8%	Sep-25	TBC	9.0%	Aug-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	36	Sep-25	24	18	Aug-25	Driver			Not Escalated	26		
	Caring	Complaints Rate per 1,000 occupied beddays		3.9	5.2	Sep-25	3.9	4.4	Mar-24	Driver			Not Escalated	5.8		
	Caring	% complaints responded to within target		75.0%	78.0%	Sep-25	75.0%	85.0%	Aug-25	Driver			Not Escalated	75.0%		
	Caring	Complaints Backlog – Older than 4 months		0	0.01	Sep-25	0	1	Aug-25	Driver			Not Escalated			
	Caring	Complaints Closed in Month		38	69	Sep-25	38	54	Aug-25	Driver			Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	99.0%	Sep-25	95.0%	94.0%	Aug-25	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		21.4%	18.1%	Sep-25	21.4%	16.1%	Aug-25	Driver			Not Escalated	25.14%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		9.9%	11.5%	Sep-25	9.9%	12.8%	Aug-25	Driver			Not Escalated	12.95%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		12.1%	10.5%	Sep-25	12.1%	9.2%	Aug-25	Driver			Escalation	11.83%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		15.9%	13.3%	Sep-25	15.9%	13.3%	Aug-25	Driver			Escalation	14.96%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	99.1%	Sep-25	93.5%	98.3%	Aug-25	Driver			Not Escalated	99.7%		

Breakthrough: Counter Measure Summary

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

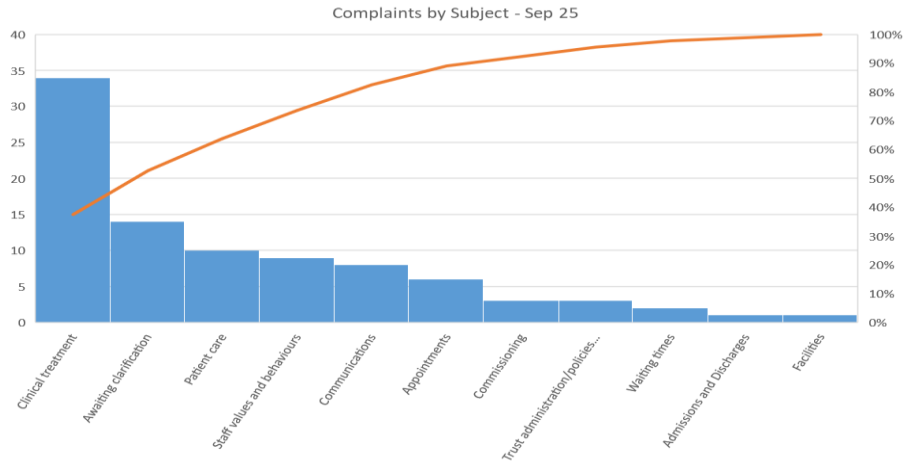
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Sep-25
91
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.

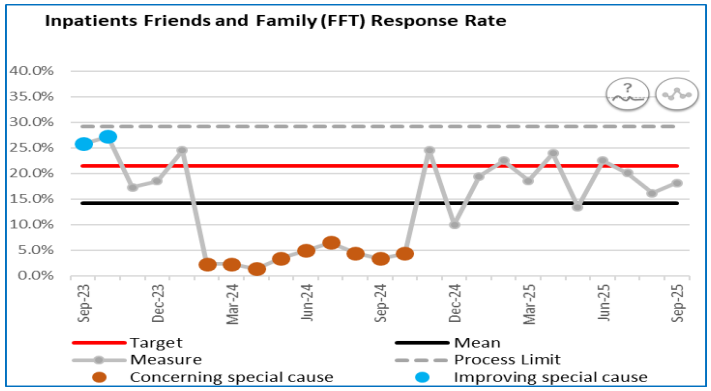
Key Risks:

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	Complaints Team requesting, through their training packages around complaints, departments and services try to de-escalate concerns rather than signposting straight to formal complaints route – ongoing	Patient Complaints Lead
Trust-wide / core team	Review new complaints coming in to determine the themes and trends, to determine if any remedial actions are possible – ongoing	Patient Complaints Lead
Breakthrough Objective Actions		
Trust-wide / core team	Undertake stakeholder engagement event for new A3 in Nov-25	Patient Experience Team
Trust-wide / core team	Establish target for the number of complaints locally resolved, using trend data	Patient Experience Team

Patient Experience: CQC: Caring



Sep-25

18.1%

Variance / Assurance

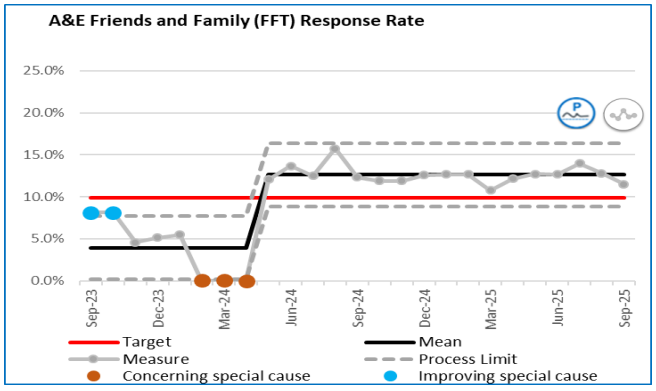
Metric is currently experiencing common cause variation and variable achievement of the target

Target (Ave. National)

21.4%

Business Rule

For illustrative purposes after target revision



Sep-25

11.5%

Variance / Assurance

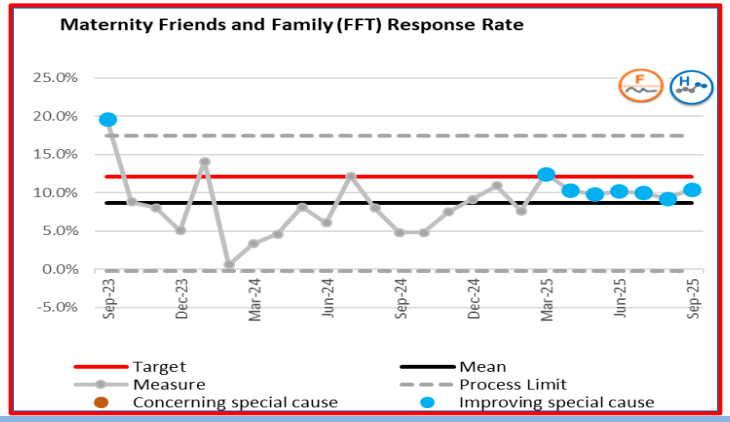
Metric is currently experiencing common cause variation and has passed the target for 6+ months

Target (Ave. National)

9.9%

Business Rule

For illustrative purposes after target revision the target



Sep-25

10.5%

Variance / Assurance

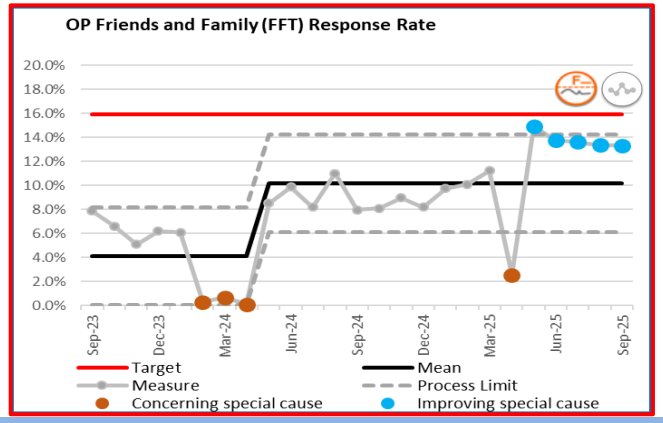
Metric is currently experiencing special cause variation of an improving nature but has failed the target for 6+ months

Target (Ave. National)

12.1%

Business Rule

Full Escalation as failed target for 6+ months



Sep-25

13.3%

Variance / Assurance

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

Target (Ave. National)

15.9%

Business Rule

Full escalation as is consistently failing the target

Summary:

Friends and Family Response Rate – Inpatients: is currently experiencing common cause variation and variable achievement of the target
National Response – 20.0%
Trust Recommended Rate is 94.0%
Friends and Family Response Rate - A&E: is currently experiencing common cause variation and has passed the target for 6+ months
National Response – 9.9%
Trust Recommended Rate is 78.3%
Friends and Family Response Rate - Maternity: : is currently experiencing special cause variation of an improving nature but has failed the target for 6+ months
National Response – 12.6%
Trust Recommended Rate is 100%
Friends and Family Response Rate - Outpatients: Is experiencing common cause variation and is consistently failing the target
National Response – 16.9%
Trust Recommended Rate is 93.9%

Actions:

Inpatients: The response rate for September has increased slightly from August. Although the majority of feedback is in response to SMS text requests feedback via hardcopy means continues to be popular mode 31% (292/936) for the completion of inpatient feedback. 94% 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 (21/794) but areas for focus include staff attitude, implementation of care and environment.
A&E: In contrast to inpatients, the vast majority of feedback for ED continues to be as a result of SMS text requests with 99% (2531/2559). Positive themes remain consistent on staff attitude; implementation of care, waiting time has emerged as a theme this month replacing environment – limited/shorter than anticipated waiting time correlates closely with overall patient satisfaction. Kindness, courtesy and professionalism were terms used frequently within the feedback. Themes identified for improvement again this month include staff attitude, waiting time and environment. Negative comments relating to time taken for triage to take place and a lack of/incorrect information about waiting times were consistent points of feedback again this month.
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: communication, staff attitude and implementation of care.
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. 88% (7645/8701) were via this means despite the likely impact of the survey fatigue filter applied for SMS text requests. Top themes continue to be 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 or changes to appointment modes or timings which weren't communicated in a timely manner.
FFT Response All: Feedback received in September has been reasonably consistent overall. 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.

Assurance & Timescales for Improvement:

Friends and Family (FFT) Response Rates:
The transcription of hard copy cards is now being undertaken in-house resulting in more timely upload of data.

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 and more widely to understand the different systems in use and potential options.

Strategic Theme: Systems

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision	Effective	To support the system financial recovery plan through the better use of beds programme - Daily Average In-Hospital Non-Elective Overnight Beddays (excluding Virtual Ward) *		524	548	Sep-25	524	534	Aug-25	Driver		F	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	38	Sep-25	57	45	Aug-25	Driver		F	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	10.1	Aug-25	12.0	11.4	Jul-25	Driver	L	?	Not Escalated			

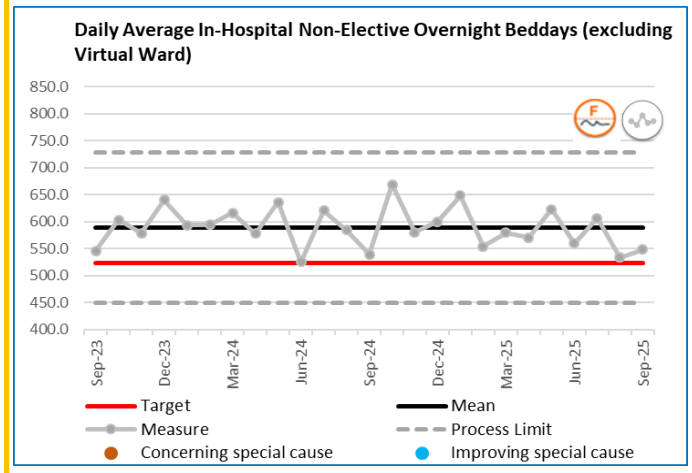
*This strategic theme is focussing on contributors to the overall non-elective length of stay that are part of the Better Use of Beds programme.
Please note that the target for the Vision metric is a 10% reduction which represents the Trust's internal stretch target.

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)

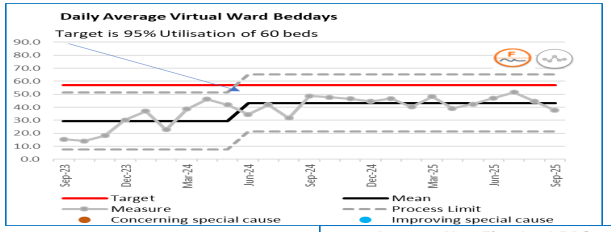
Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average In-hospital non-elective Beddays
Desired Trend: 7 consecutive data points below the mean

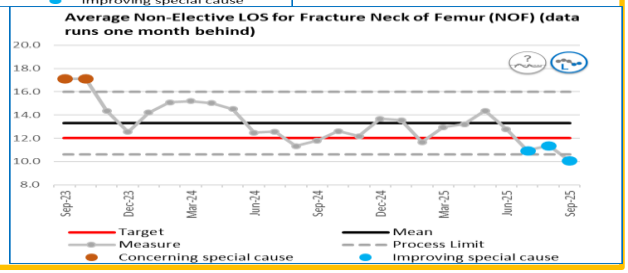
1. Historic Trend Data



Sep-25
548
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

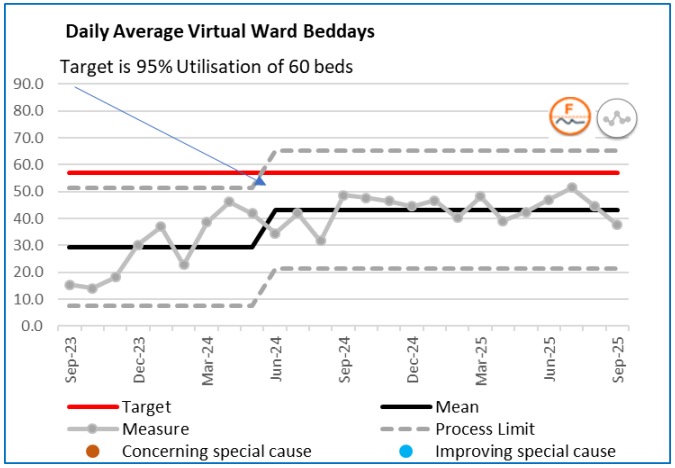
Workstreams	Actions	When	Who
Strategic Theme – Vision Metric	Review target for Vision Metric	Complete	Project Team
	SRO to discuss interdependency of vision metric with LOS Metric with COO.	complete	SRO
VW Beddays	Project Charter being developed and scope being defined and timeline for A3 development 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

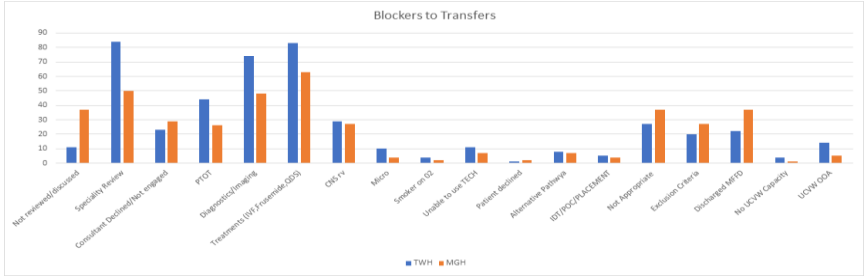
Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average Virtual Ward Beddays - Target is 95% of 60 beds
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Sep-25
38
Variance Type
Metric is currently experiencing Common Cause Variation
Target (Internal)
57 (95% of 60 beds)
Target Achievement
Metric has failed the target for 6+ months

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
	Agree improvement trajectory	End October	SRO with BI
	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

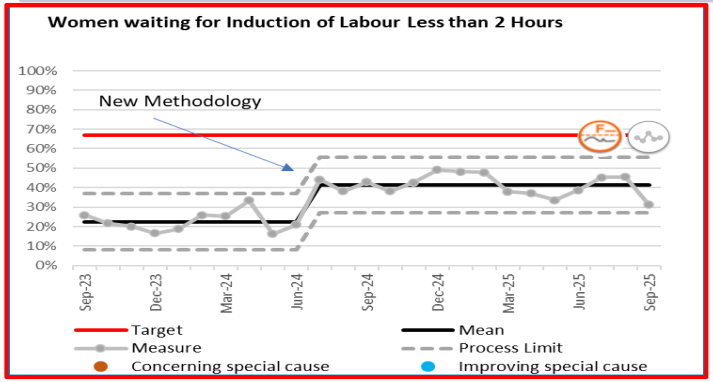
Strategic Theme: Sustainability

				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***		-23	105	Sep-25	-1,614	-1,603	Aug-25	Driver			Verbal CMS	-3,271		
Breakthrough Objectives	Well Led	Reduce non-pay spend		21,911	22,042	Sep-25	22,055	21,514	Aug-25	Driver			Verbal CMS	21,741		
Constitutional Standards and Key Metrics	Well Led	CIP		5,413	4,159	Sep-25	5,173	3,665	Aug-25	Driver	No SPC	No SPC	Not Escalated	7,781	No SPC	No SPC
	Well Led	Cash Balance (£k)		6,695	13,699	Sep-25	6,469	24,969	Aug-25	Driver			Not Escalated	7,986		
	Well Led	Capital Expenditure (£k)		576	467	Sep-25	390	2,975	Aug-25	Driver			Not Escalated	309		

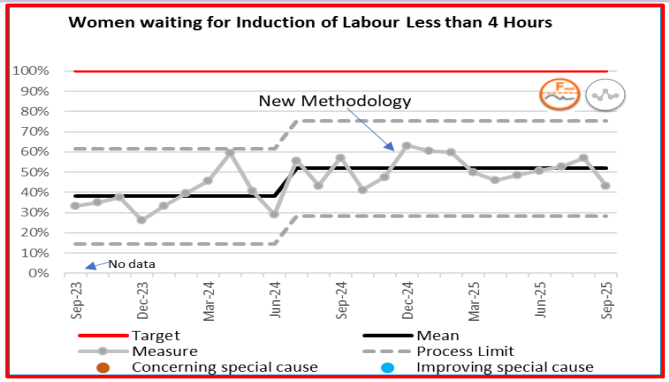
Maternity Metrics

				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	490	Sep-25	470	461	Aug-25	Driver		No target	Not Escalated	457		No SPC
	Maternity Metric	Antenatal bookings		No target	541	Sep-25	545	483	Aug-25	Driver		No target	Not Escalated	524		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	20.5%	Sep-25	No target	20.6%	Aug-25	Driver		No target	Not Escalated	22.2%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	23.2%	Sep-25	No target	29.2%	Aug-25	Driver		No target	Not Escalated	24.2%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.0%	Sep-25	36.0%	28.1%	Aug-25	Driver			Not Escalated	26.1%		
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	31.1%	Sep-25	67.0%	45.5%	Aug-25	Driver			Escalation	47.1%		
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	43.4%	Sep-25	100.0%	57.0%	Aug-25	Driver			Escalation	54.4%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	5.9%	Sep-25	6.0%	6.5%	Aug-25	Driver			Not Escalated	6.8%		
	Maternity Metric	Unexpected term admissions to NNU (data runs one month behind)		4.0%	4.7%	Sep-25	4.0%	6.7%	Aug-25	Driver			Not Escalated	5.2%		
	Maternity Metric	Stillbirth rate		0.4%	0.4%	Sep-25	0.4%	0.2%	Aug-25	Driver			Not Escalated	0.2%		
	Maternity Metric	PPH >=1500% Rate		3.0%	3.1%	Sep-25	3.0%	4.2%	Aug-25	Driver			Not Escalated	2.8%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	2.5%	Sep-25	2.5%	2.2%	Aug-25	Driver			Not Escalated	2.7%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	84.5%	Sep-25	75.0%	79.0%	Aug-25	Driver			Not Escalated	80.9%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	92.3%	Sep-25	95.0%	100.0%	Aug-25	Driver			Not Escalated	102.0%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	89.4%	Sep-25	95.0%	88.5%	Aug-25	Driver			Not Escalated	91.3%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Sep-25	100.0%	100.0%	Aug-25	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Sep-25	100.0%	100.0%	Aug-25	Driver			Not Escalated	100.0%		

Maternity Metrics



Sep-25
31.1%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as consistently failing the target



Sep-25
43.4%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target

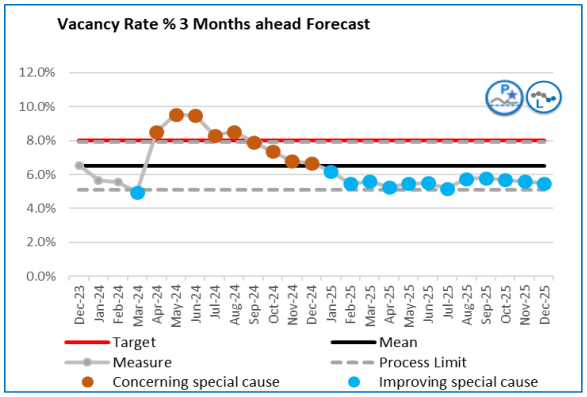
Summary:	Actions:	Assurance & Timescales for Improvement:
Women waiting for Induction of Labour less than 2: is experiencing common cause variation and consistently failing the target. **Women waiting for Induction of Labour less than 4 Hours:** is experiencing common cause variation and consistently failing the target.	A3 in progress to address flow throughout the service which impacts transfer for ongoing induction of labour. IOL project group is proposing the allocation of an IOL midwife on Triage and delivery suite to support flow through pathway.	**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, prioritisation and escalation 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 Ward was thought to be the main bottle neck. However, Delivery Suite staffing and practices have a significant impact. Timescales for improvement will be dependent on the outcome of the flow project and any actions required as a result.

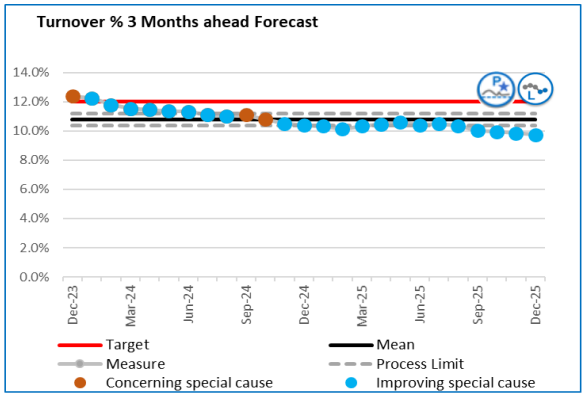
NHS
Maidstone and Tunbridge Wells NHS Trust

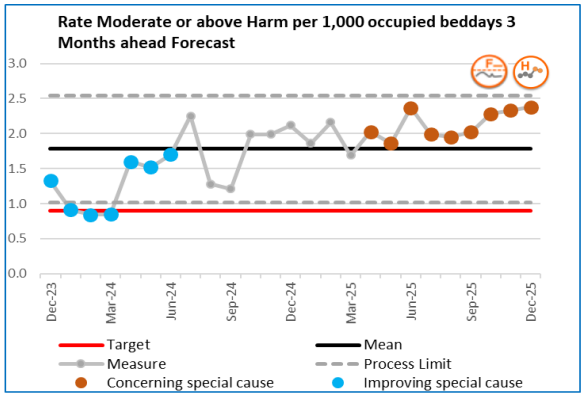
Appendices

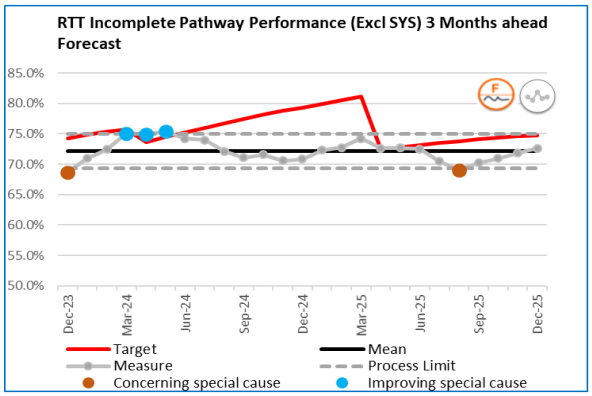
MTW
exceptional people, outstanding care

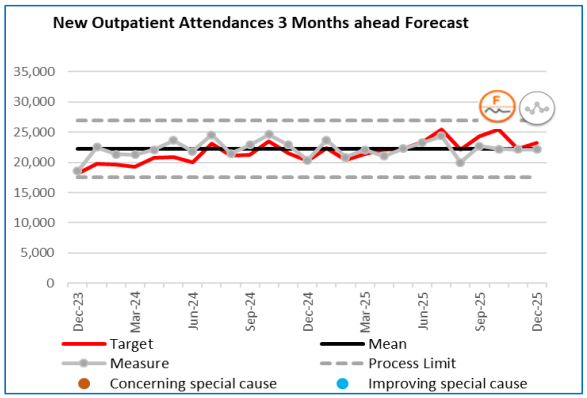
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

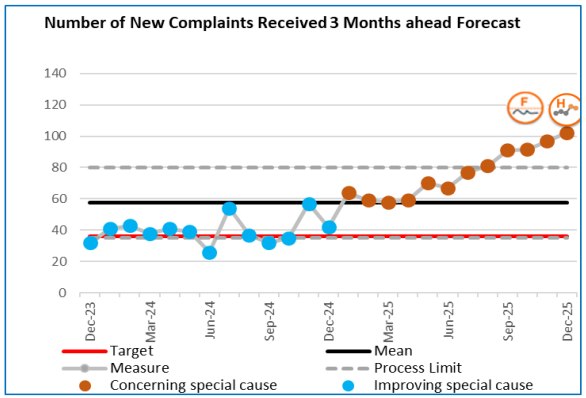


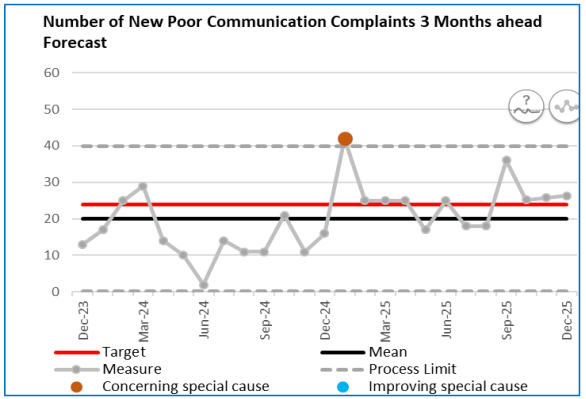


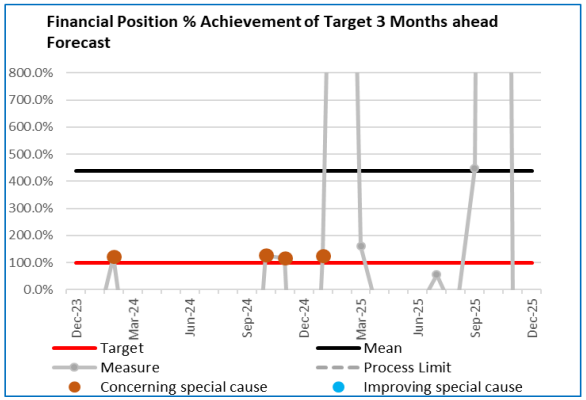


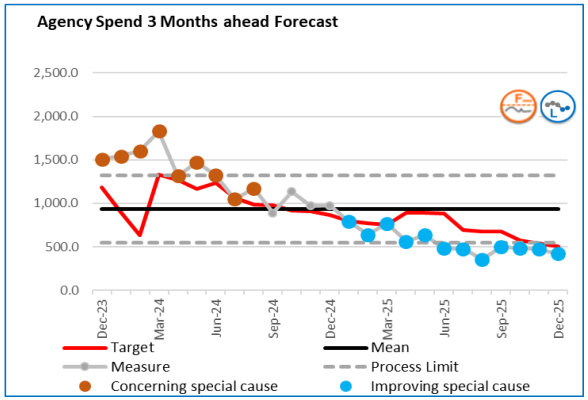




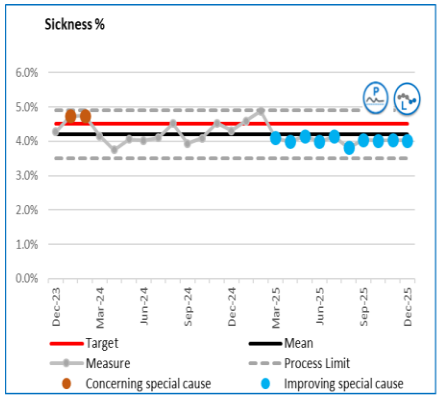


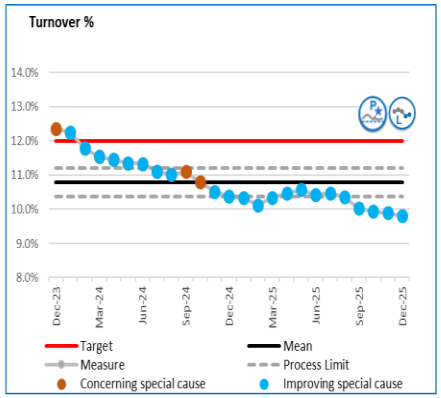


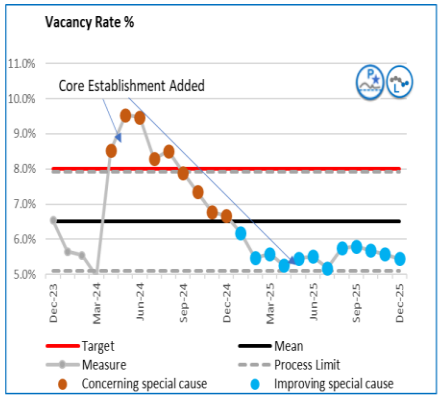


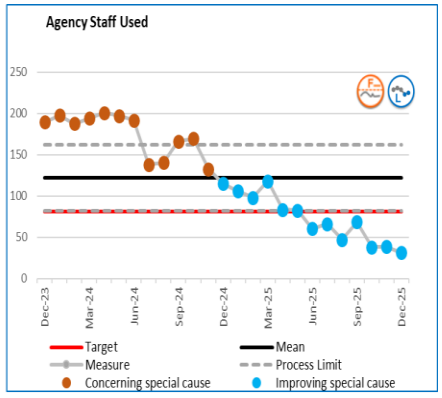


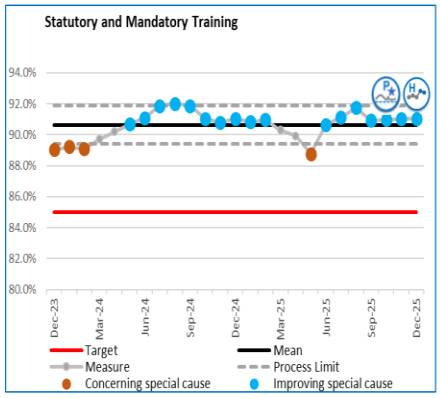
Forecast SPCs (3 month forward view) for People Indicators

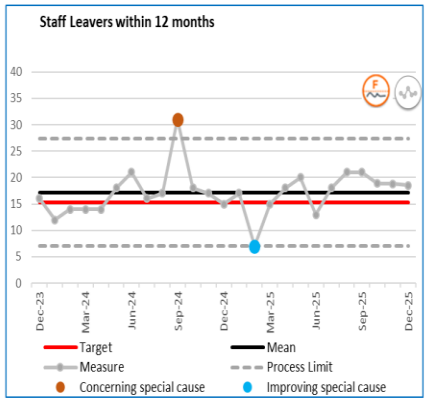


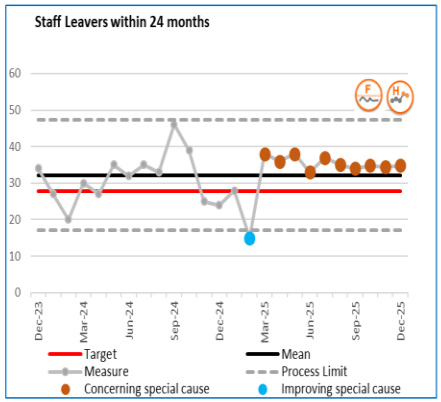


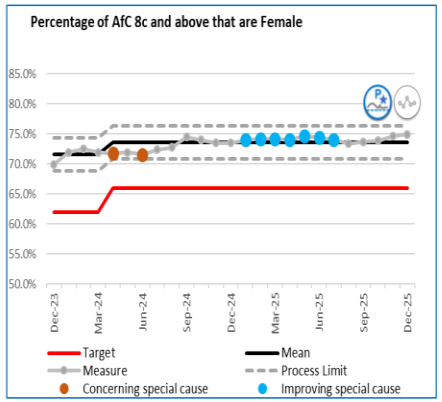


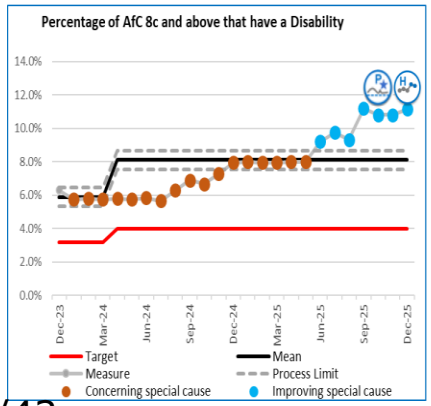


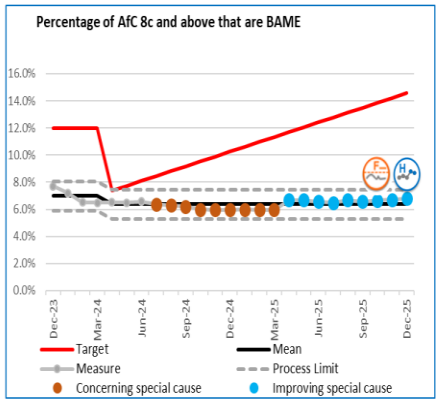


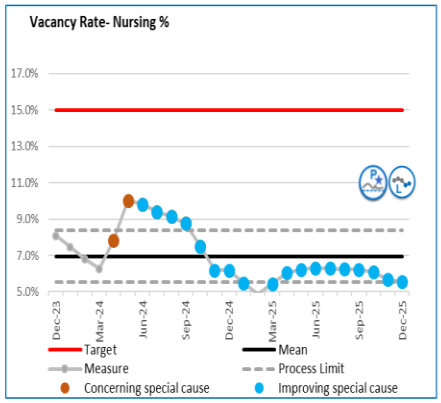




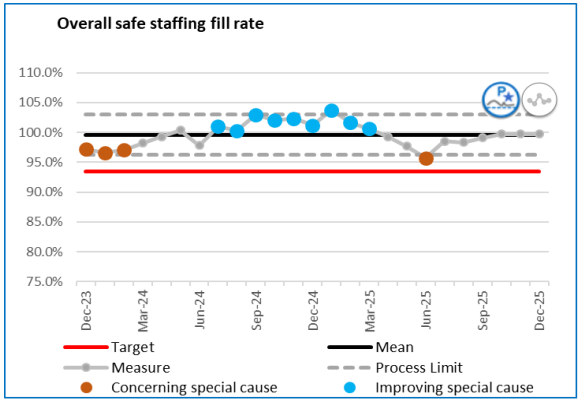


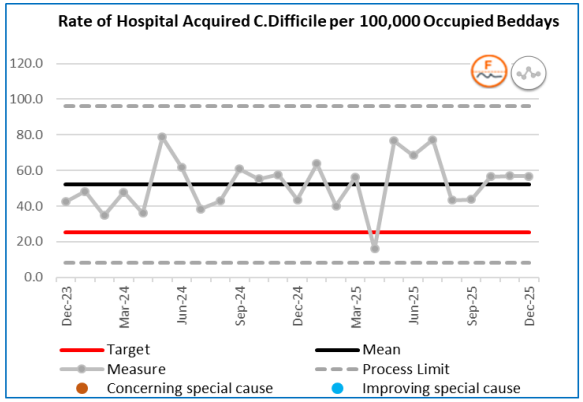


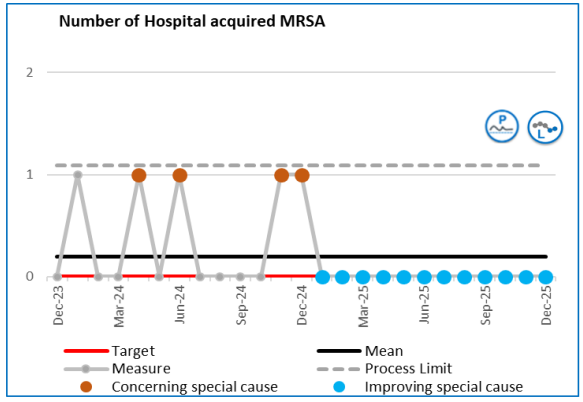


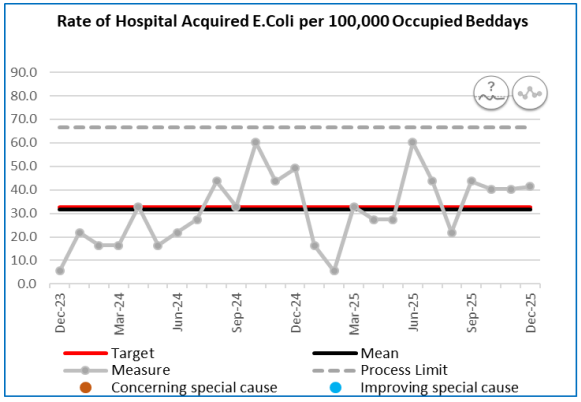


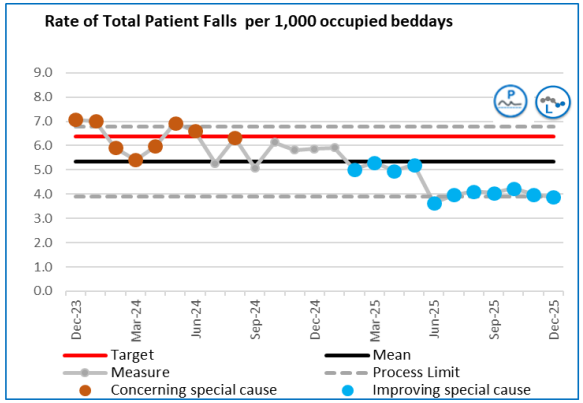
Forecast SPCs (3 month forward view) for Patient Safety Indicators

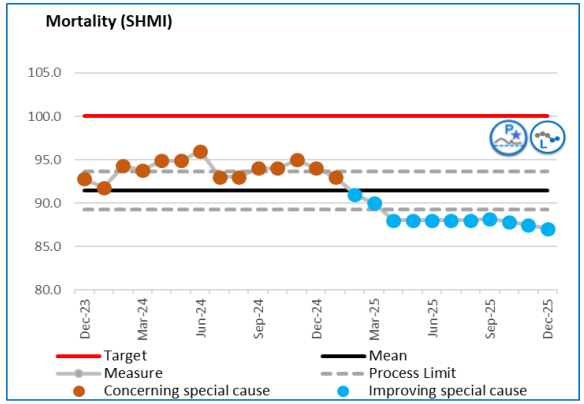


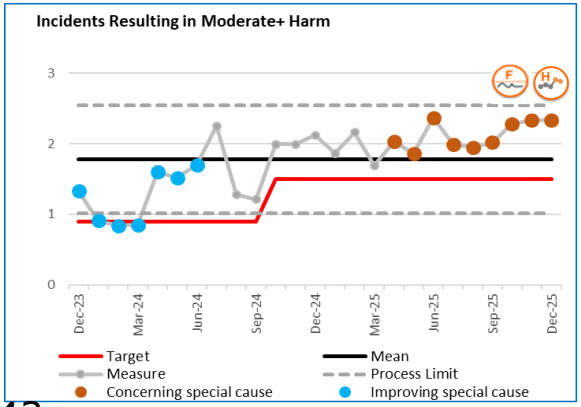


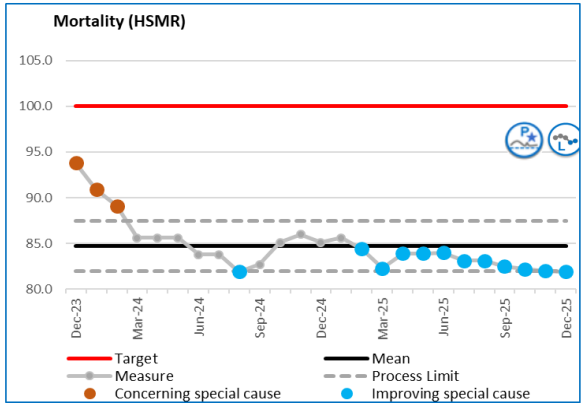




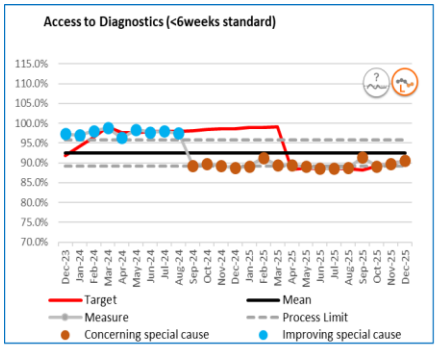


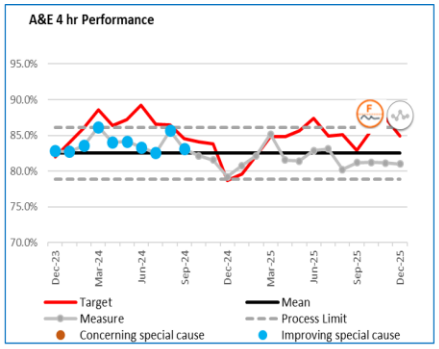


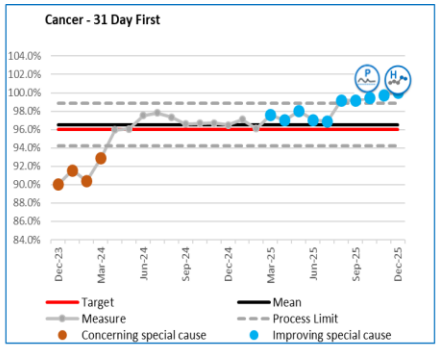


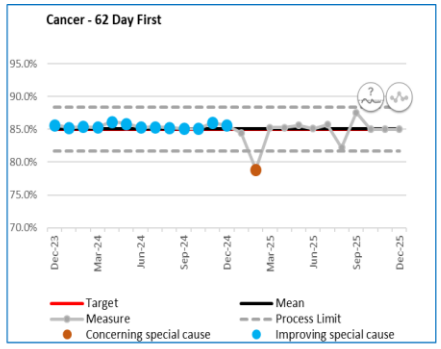


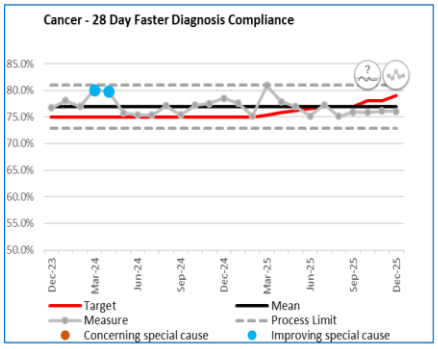
Forecast SPCs (3 month forward view) for Patient Access Indicators

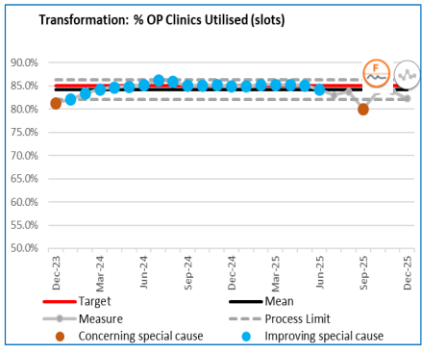


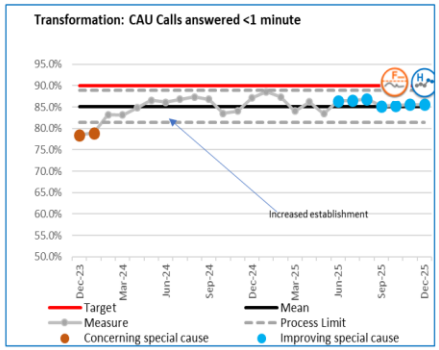


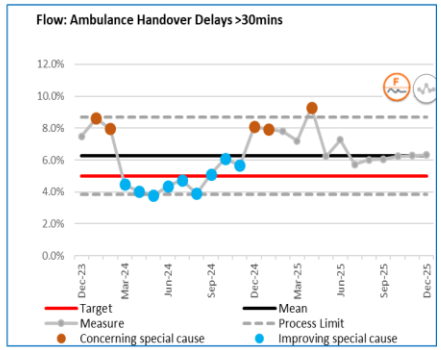


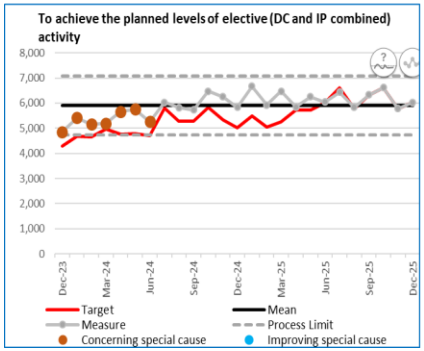


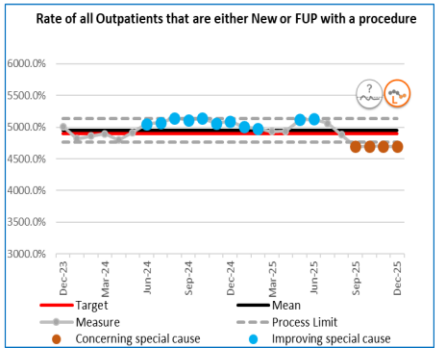


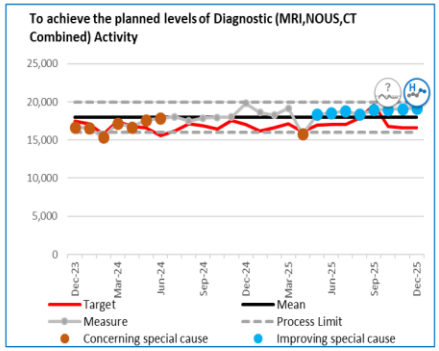


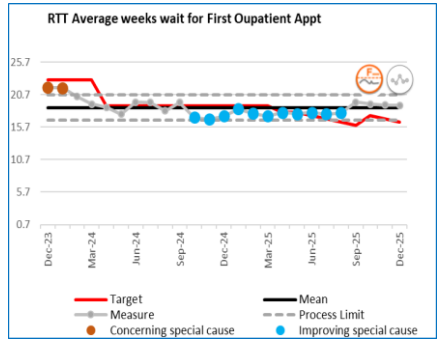




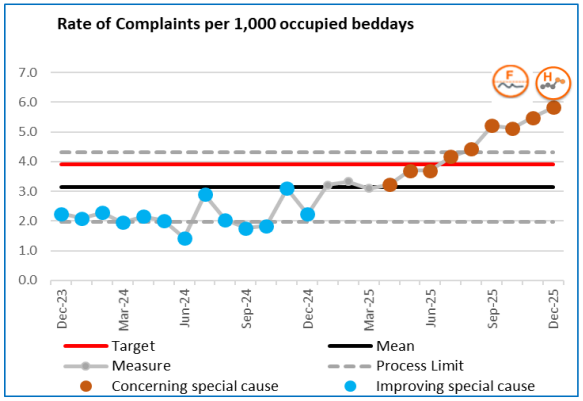


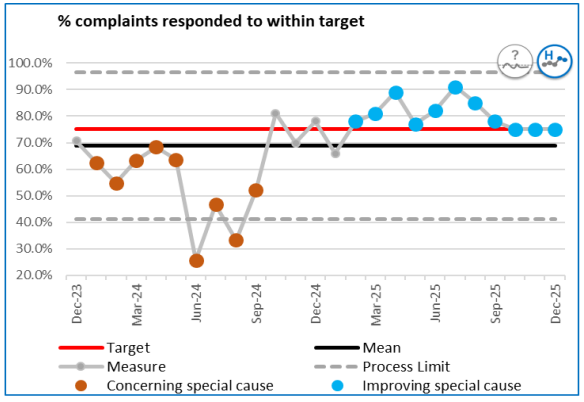


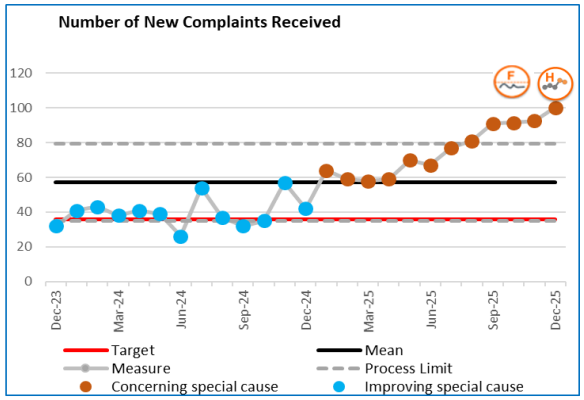


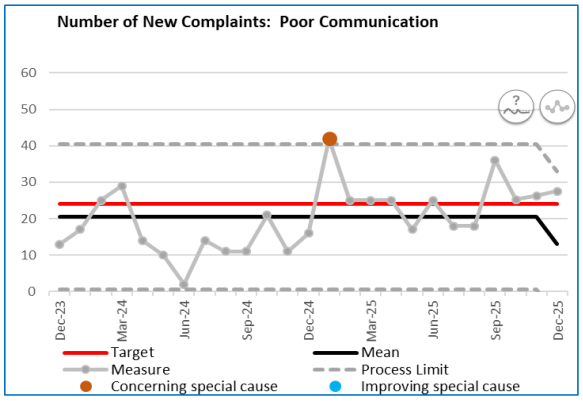


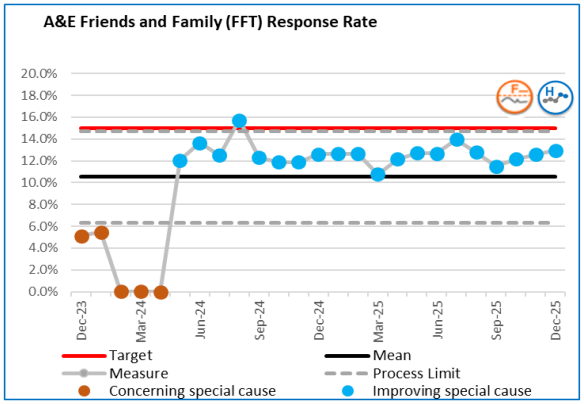
Forecast SPCs (3 month forward view) for Patient Experience Indicators

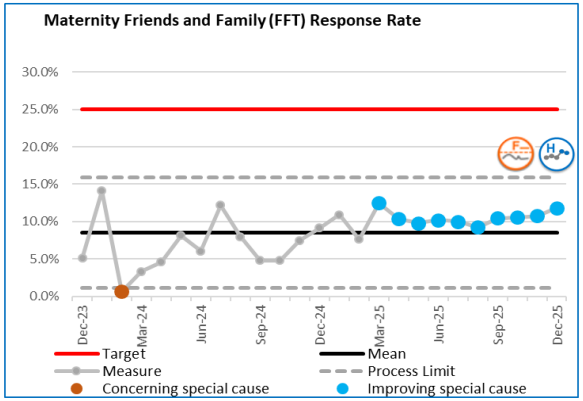


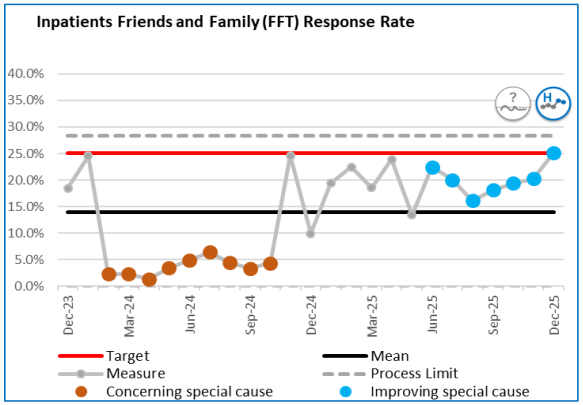


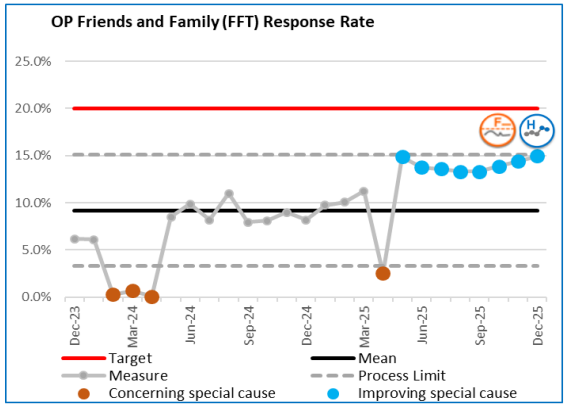


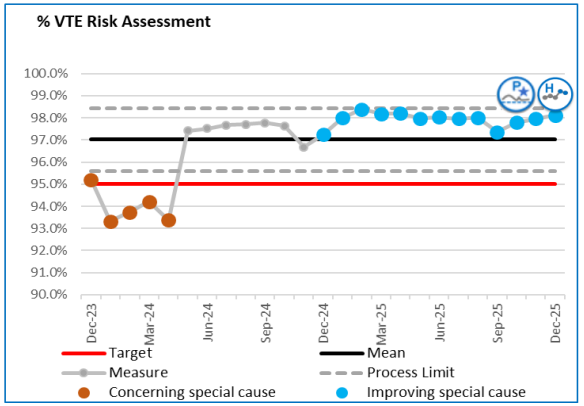




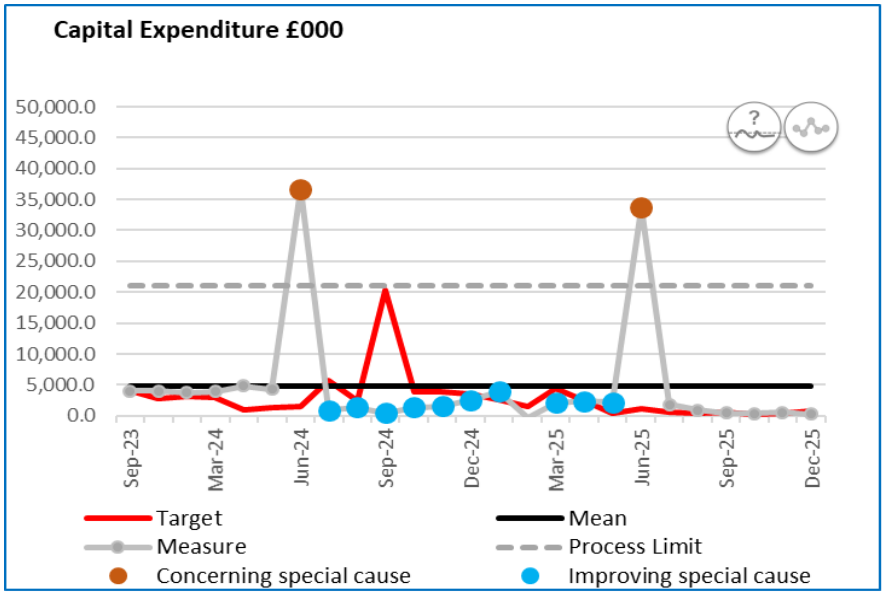


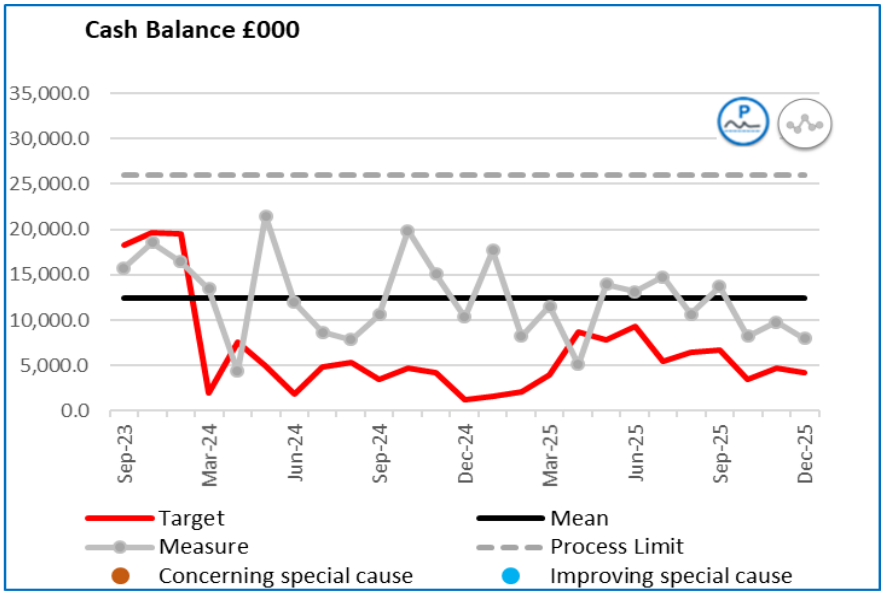


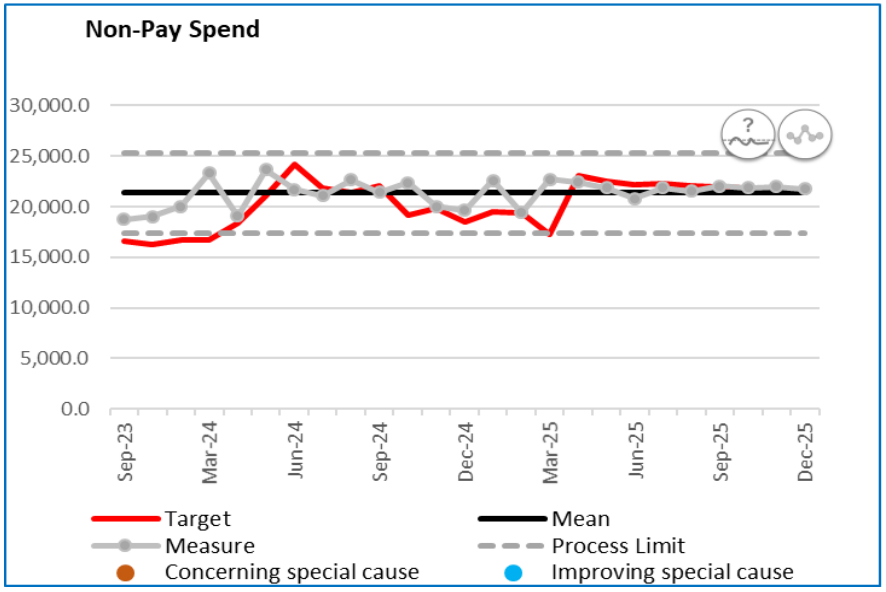




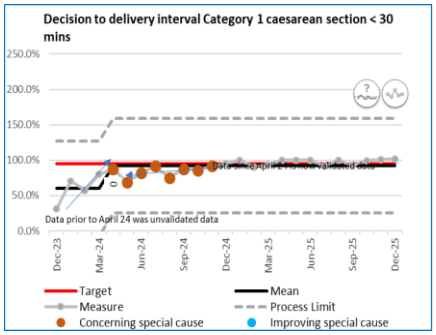
Forecast SPCs (3 month forward view) for Sustainability Indicators

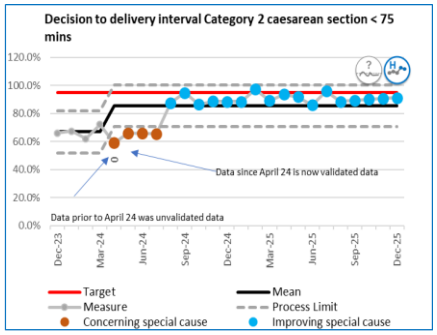


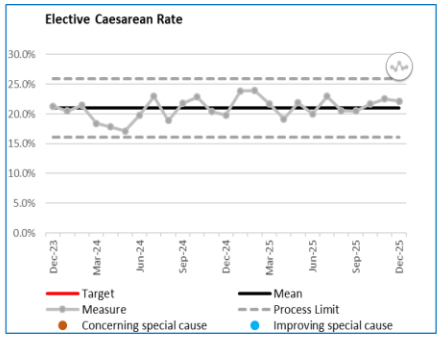


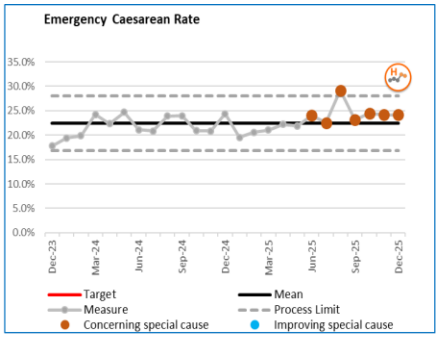


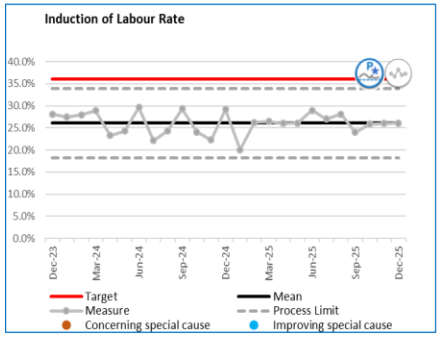
Forecast SPCs (3 month forward view) for Maternity Indicators

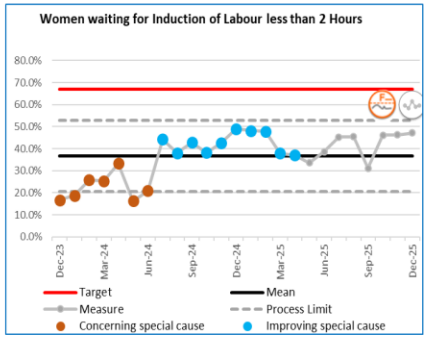


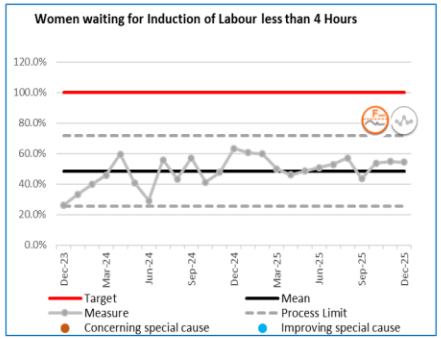


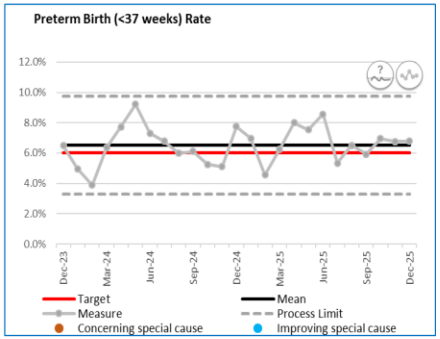


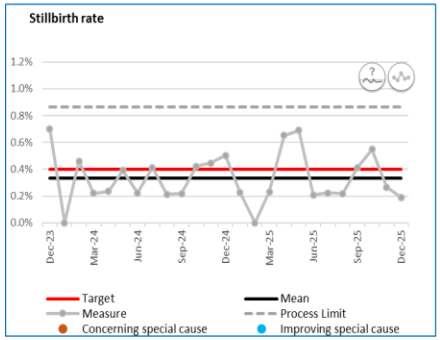


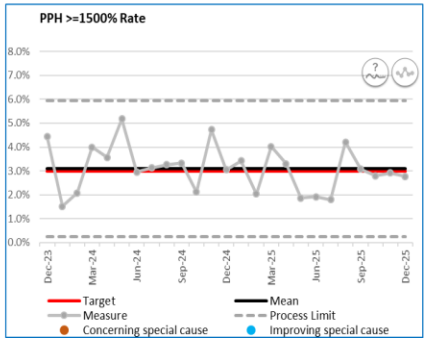


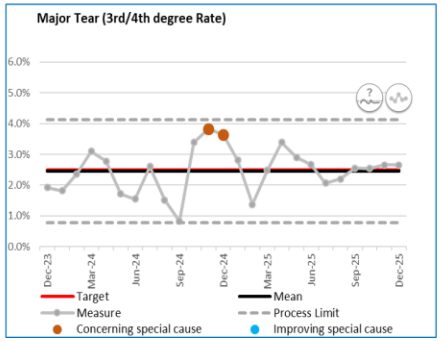


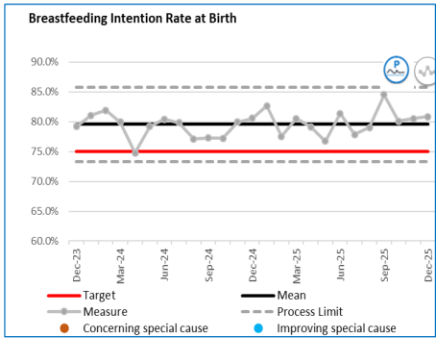






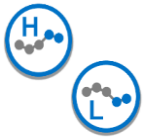






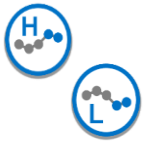
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

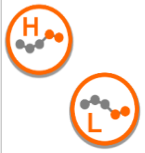
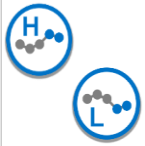
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

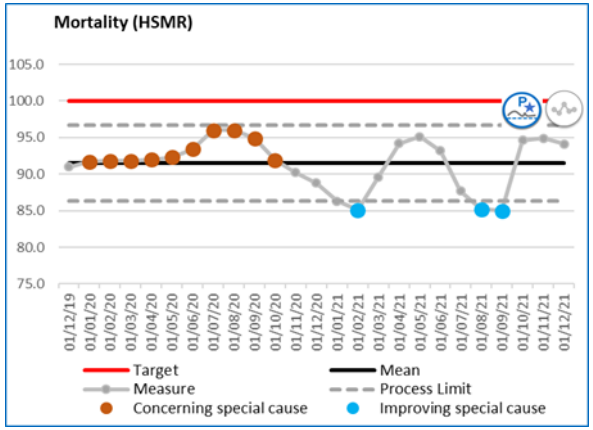
The **target** line **between** the **upper** and **lower** control limit for all metric types

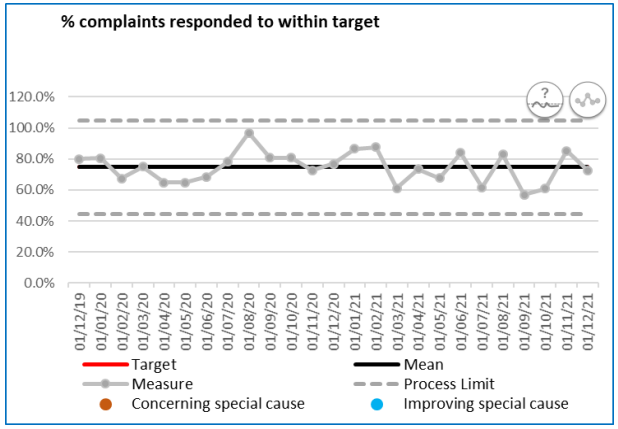
Metrics that consistently **fail** have:

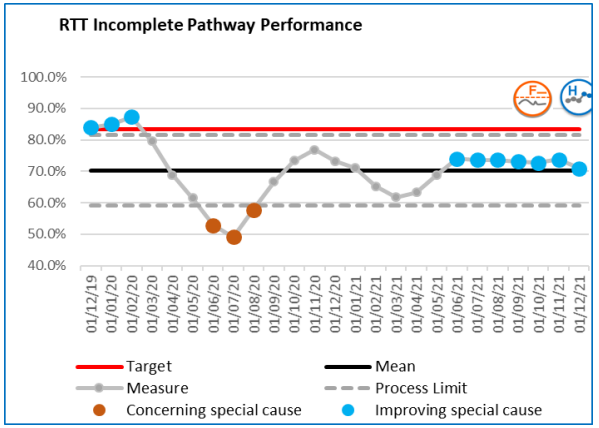
The **lower** control limit **above** the target line for metrics that need to be **below the target**

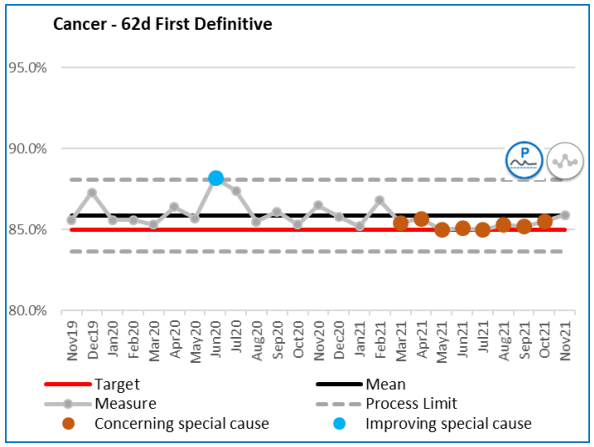
The **upper** control limit **below** the target line for metrics that need to be **above the target**

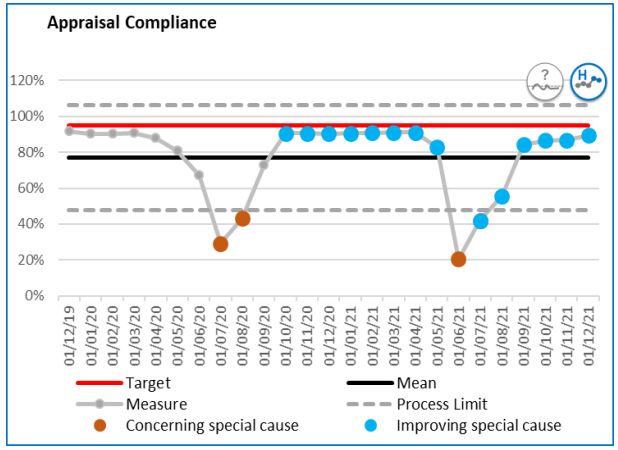
A metric not achieving the target for 6 months or more will be flagged as failing

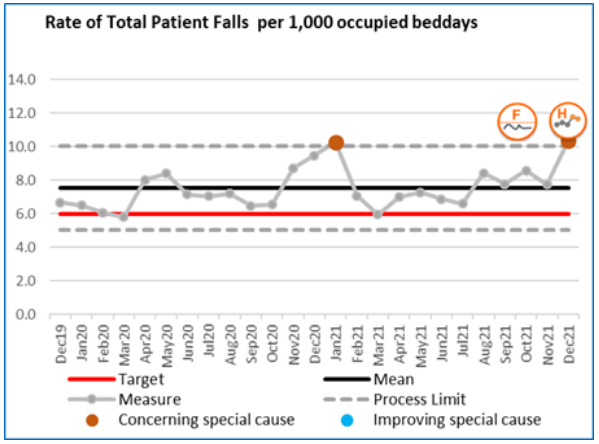












Maternity Metrics Definitions

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

Executive Summary

- The Trust was £0.1m in surplus in the month which was £0.1m favourable to the plan. Year to date the Trust is £12.5m in deficit which is breakeven to plan.
- The key year to date pressures are: System savings slippage (£5.5m) and Fordcombe slippage to plan (£1.2m). These pressures were offset by additional clinical income above contract baseline (£2.6m), additional Pathology income (£1.1m), reduction in outsourcing (£1.2m) and non-recurrent benefits (£1.8m)
- The Trust has a £72.1m CIP savings target in 2025/26 which is split between Internal (£49m), System (£22.6m), national savings expectation (£1.3m) less £0.8m stretch. The Trust is forecasting to deliver £49.7m which is £22.4m adverse to plan. The main slippage relates to system savings which is £21.8m adverse to plan
- In October the Trust has applied to National NHSE for a Revenue Support PDC (working capital top-up) facility, this is one off cash funding of £13m which if successful the Trust will receive the funding in November.
- The Trust is forecasting to deliver the year-end financial plan (breakeven) however recovery actions / CIP delivery of £37.2m are required to be delivered.

Current Month Financial Position

- The Trust was £0.1m in surplus which was £0.1m favourable to the plan.
- **Key Adverse variances in month are:**
    - System savings slippage (£1.8m). The Trust was £1.8m adverse to plan in the month associated with the system saving target.
    - Fordcombe hospital slippage to plan (£0.4m)
    - Drugs (£0.3m). The Trust overspent within drugs by £0.3m (excluding passthrough related costs), the main area of pressure in the month related to Cancer (£0.2m) and Medicine (£0.1m).
    - Other key overspends include CIP support (£0.1m) and increase in injury cost recovery debt (£0.1m)
- **Key Favourable variances in month are:**
    - Additional Clinical Income above contract baseline (£1.9m) which includes £1.7m for 2025/26 depreciation funding in line with national guidance and £0.2m associated with 50% risk share of growth in debt from 31st March 2025.
    - Pathology Income (£0.4m). A review of pathology services identified services for Molecular pathology had not been historically charged. The increase in September (£0.4m) represents a back dated charge to April 2025 and mainly impact other Kent and Medway providers.
    - Other benefits in the month included a revenue top capital adjustment of £0.4m and backdated CoS VAT review (£0.2m)

Year to Date Financial Position

- The Trust is £12.5m in deficit which is breakeven to plan
- **Key Adverse variances are:**
    - System savings slippage (£5.5m). The Trust was £5.5m adverse to plan associated with the system saving target.

- Fordcombe hospital slippage to plan (£1.2m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £1.2m adverse to plan.

- **Key Favourable variances are:**
  - Additional Clinical Income above contract baseline (£2.6m) which includes £1.7m for 2025/26 depreciation funding inline with national guidance, Radiotherapy income (£0.4m), COVID Medicine Delivery Unit (£0.3m) and £0.2m associated with 50% risk share of growth in debt from 31st March 2025.
  - Pathology Income (£1.1m). A review of pathology services identified services for Molecular pathology had not been historically charged and the Trust has introduced a new revised charges for Histopathology. Overall this has benefitted the position by £1.1m.
  - Reduction in outsourcing (£1.2m). The Trust has underspent against the plan by £1.2m, the main areas underspent against plan are: Medicine and Emergency (£0.7m) and Surgery Division (£0.5m)
  - Non recurrent benefits (£1.8m). The Trust has benefited by £1.8m through non recurrent items.

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 September the Trust has saved £4.2m which was £1.3m adverse to plan mainly due to a slippage associated with the system wide savings target (£1.8m)
- Year to date the Trust has saved £21.2m which is £0.4m 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 £49.7m of savings in 2025/26 which is £22.4m adverse to plan. The main slippage relates to the system wide savings target (£21.8m adverse)
- The Trust is forecasting to deliver £60m 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 2024 requiring a response by 31st December 2024 which have been submitted. Mitigation actions are using our VAT advisers to dispute the process undertaken and to counter challenge the basis of the HMRC position when it is clarified.
- **Brockenhurst Car parking VAT claim (net £0.9m)** - 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.
- **CIP delivery** - The Trust is forecasting to deliver £49.7m which is £22.4m adverse to plan. The main slippage relates to system savings which is £21.8m adverse to plan
- **Redundancy Costs (Phase 2)** – The Trust might incur c£4.1m 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
- **2025/26 Outstanding Contract issues** - The Trust has included £5.3m into the YTD position / forecast for items above baseline contract. These items include: 2025/26 depreciation funding (£3.3m), COVID Medicine Delivery Unit (CMDU = £1.2m), additional Radiotherapy income (£0.8m). Contract discussions are ongoing with commissioners.

Cashflow position:

- The closing cash balance at the end of September was £13.7m, which is higher than the plan value by £7m. The main reason for the increase is primarily due to monthly activity invoices for periods 1-5 for the Roche managed service contract extension agreement of c.£5m; the Trust is expecting to pay these in October.
- 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 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 fortnightly cash meeting which the Trust actively participates in. The Trust now sends a 12 month cash flow to show a 13 week cash flow as well as a debtor/creditor position of the local patch. The ICB are encouraging organisations to pay other NHS organisations and not withhold payments as in previous years. The Trust is engaging well with EKHUFT, 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 September the Trust's percentages were: Trade in value: 68.7% (M5 75.3%) and by quantity: 65.6% (M5 75.9%) for NHS by value: 87.4% (M5 88.9%) and by quantity: 62.1% (M5 72.16%)

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 have been prioritised and agreed at ETM, business cases are now in development.
    - Freedoms & Flexibilities - The Trust has been notified by NHSE that an additional £161k of internal funding has been agreed in M6, relating to the Trust surplus in 2024/25 - this is not cash-backed.

- **Month 6 Actuals (excluding IFRS16)**

The YTD spend at month 6 is £6.8m against a YTD budget of £5.5m. 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 6 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. Estates Safety schemes are in the design and ordering stages, there is a risk of long lead-in times, which may impact year-end timescales. The timings and expenditure for Cardiology ward refurbishment scheme are being reviewed in the light of slippage on the FBC approval from the ICB (including the IFRS 16 funding for the cardiac catheter laboratory). This is likely to mean slippage on the scheme in 2025/26.
  - 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 internally and by NHSE
  - Linac replacement at K&C - The machine was delivered to site at the end of July and will be commissioned over the next few months, before going into clinical use before end of December.
  - 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. The Forecast outturn is now fully committed so there is no available funding for any new IFRS16 schemes.
  -

Year end Forecast

- The Trust is forecasting to deliver the planned breakeven position however recovery actions of £37.2m are required to be delivered.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 6
2025/26

Maidstone and Tunbridge Wells NHS

Summary

September 2025/26

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	70.5	68.1	2.4	0.2	2.2	409.8	405.8	4.0	0.4	3.6
Expenditure	(65.3)	(63.1)	(2.1)	(0.2)	(2.0)	(392.2)	(388.3)	(3.9)	(0.4)	(3.5)
EBITDA (Income less Expenditure)	5.2	5.0	0.2	0.0	0.2	17.6	17.5	0.1	0.0	0.1
Financing Costs	(4.5)	(4.4)	(0.1)	0.0	(0.1)	(35.8)	(35.9)	0.2	0.0	0.2
Technical Adjustments	(0.6)	(0.6)	(0.0)	0.0	(0.0)	5.7	5.9	(0.3)	0.0	(0.3)
Net Surplus / Deficit	**0.1**	**(0.0)**	**0.1**	**0.0**	**0.1**	**(12.5)**	**(12.5)**	**0.0**	**0.0**	**0.0**
Cash Balance	13.7	3.4	10.3		10.3	13.7	3.4	10.3		10.3
Capital Expenditure (Incl Donated Assets and IFRS16)	0.5	0.6	0.1		0.1	6.8	5.5	1.2		1.2
Cost Improvement Plan	4.2	5.4	(1.3)		(1.3)	21.2	20.7	0.4		0.4

Summary Current Month:

- The Trust was £0.1m in surplus in the month which was £0.1m favourable to plan. The Trusts key variances to the plan are:

Adverse Variances:

- System savings slippage (£1.8m). The Trust was £1.8m adverse to plan in the month associated with the system saving target.
- Fordcombe hospital slippage to plan (£0.4m)
- Drugs (£0.3m). The Trust overspent within drugs by £0.3m (excluding passthrough related costs), the main area of pressure in the month related to Cancer (£0.2m) and Medicine (£0.1m).
- Other key overspends include: CIP support (£0.1m) and increase in injury cost recovery debt (£0.1m)

Favourable Variances

- Additional Clinical Income above contract baseline (£1.9m) which includes £1.7m for 2025/26 depreciation funding inline with national guidance and £0.2m associated with 50% risk share of growth in debt from 31st March 2025.
- Pathology Income (£0.4m). A review of pathology services identified services for Molecular pathology had not been historically charged. The increase in September (£0.4m) represents a back dated charge to April 2025 and mainly impact other Kent and Medway providers.
- Other benefits in the month included a revenue top capital adjustment of £0.4m and backdated CoS VAT review (£0.2m)

Year to date overview:

- The Trust is £12.5m in deficit which is breakeven to plan. The Trusts key variances to the plan are:

Adverse Variances:

- System savings slippage (£5.5m). The Trust was £5.5m adverse to plan associated with the system saving target.
- Fordcombe hospital slippage to plan (£1.2m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £1.2m adverse to plan.

Favourable Variances

- Additional Clinical Income above contract baseline (£2.6m) which includes £1.7m for 2025/26 depreciation funding inline with national gu idance, Radiotherapy income (£0.4m), COVID Medicine Delivery Unit (£0.3m) and £0.2m associated with 50% risk share of growth in debt from 31st March 2025.
- Pathology Income (£1.1m). A review of pathology services identified services for Molecular pathology had not been historically charged and the Trust has introduced a new revised charges for Histopathology. Overall this has benefitted the position by £1.1m.
- Reduction in outsourcing (£1.2m). The Trust has underspent against the plan by £1.2m, the main areas underspent against plan are: Medicine and Emergency (£0.7m) and Surgery Division (£0.5m)
- Non recurrent benefits (£1.8m). The Trust has benefited by £1.8m through non recurrent items.

CIP (Savings)

- The Trust has a £72.1m savings target in 2025/26. This is composed of £49m internal target, £22.6m system savings target, £1.3m national savings expectations less £0.8m stretch target. In September the Trust delivered £4.2m savings which was £1.3m adverse to plan. The main slippage in the month relates to system wide savings which is £1.8m adverse to plan. Year to date the Trust has delivered £21.2m of savings which is £0.4m favourable to plan.

Year End Forecast

- The Trust is forecasting to deliver the planned breakeven position however recovery actions of c£37.2m are required to be delivered.

Sep-25			DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RN/N (number of shifts)	Occupied Beds	Planned CHPPD	Actual CHPPD	CHPPD by reg/unregisterd		Nurse Sensitive Indicators					Financial review		
Hospital Site name	Ward name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing							CHPPD Registered Nurses and Midwives	CHPPD Non registered Care staff	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Staffing red flags raised	Comments	Budget £	Actual £	Variance £ (overspend)
Maidstone	Acute Assessment Unit (M)	Acute Medical Unit (M) - NG551	87.5%	125.1%	-	-	100.0%	147.0%	-	-	34.2%	37.6%	87	6.02	17	472	10	11.1	6.1	5.0	-	-	2	0	3	50 Enhanced care shifts	222,487	241,341	(18,854)
Maidstone	Stroke Unit	Stroke Unit (M) - NK551	102.0%	82.1%	-	100.0%	104.0%	86.1%	-	-	20.8%	1.3%	76	5.19	12	935	9	8.5	4.3	3.9	55.6%	100.0%	4	0	2	1 Enhanced care shifts	328,790	293,281	35,509
Maidstone	Hyperacute Stroke Unit	HASU (34) - NK552	92.3%	103.1%	-	-	100.0%	103.3%	-	-	27.3%	3.5%	123	8.64	17	389	12	11.4	9.6	1.8	30.4%	85.7%	1	1	3	1 Enhanced care shifts	198,240	180,998	17,242
Maidstone	Cornwallis	Cornwallis - NS251	91.5%	102.2%	-	-	97.8%	101.7%	-	100.0%	16.4%	3.7%	34	2.39	6	506	8	7.4	3.9	3.5	63.4%	95.6%	1	0	2	2 Enhanced care shifts	136,186	131,469	4,717
Maidstone	Culpepper and CCU	Culpepper Ward (M) - NS551	97.5%	92.7%	-	-	100.0%	106.7%	-	-	20.3%	0.0%	10	0.68	1	382	8	7.4	5.1	2.4	75.0%	100.0%	2	0	3	2 Enhanced care shifts	144,347	161,295	(16,948)
Maidstone	Culpepper and CCU	CCU (M) - NS551	98.1%	-	-	-	100.0%	-	-	-	7.9%	0.0%	10	0.67	0	177	8	7.7			140.0%	100.0%		0	0		0	0	0
Maidstone	Edith Cavell	Edith Cavell - NS459	127.1%	160.9%	-	100.0%	120.3%	197.9%	-	-	69.0%	61.8%	71	4.86	1	367	10	14.8	7.0	6.9	22.7%	80.0%	0	0	0	143 Enhanced care shifts	116,764	167,789	(51,025)
Maidstone	Foster Clarke	Foster Clark - NR359	98.6%	133.9%	-	-	100.0%	143.3%	-	-	36.1%	27.8%	46	3.15	1	816	6	7.5	3.4	4.1	33.3%	93.3%	2	3	2	84 Enhanced care shifts	197,951	166,458	31,493
Maidstone	John Day	John Day Respiratory Ward (M) - NT151	88.5%	104.8%	-	100.0%	99.4%	93.9%	-	-	17.7%	19.1%	79	5.48	23	824	8	7.6	4.3	3.3	74.3%	100.0%	5	1	3	29 Enhanced care shifts	214,333	210,672	3,661
Maidstone	Intensive Care (M)	Intensive Care (M) - NA251	100.7%	92.0%	-	-	97.7%	81.6%	-	-	3.8%	0.0%	19	1.27	0	92	62	60.2	53.5	6.8	200.0%	100.0%	0	2	0		260,715	231,885	28,830
Maidstone	Lord North	Lord North Ward (M) - NF651	91.7%	72.2%	-	-	96.7%	100.0%	-	-	6.1%	0.0%	32	2.06	14	444	8	7.4	5.3	2.1	66.7%	100.0%	1	0	7		120,030	130,135	(10,105)
Maidstone	Mercer	Mercer Ward (M) - NJ251	100.5%	102.2%	-	100.0%	100.3%	125.6%	-	-	30.0%	21.2%	30	2.08	0	766	6	6.7	3.2	3.5	20.0%	100.0%	3	0	2	37 Enhanced care shifts	217,627	150,661	66,966
Maidstone	Peale	Peale Ward COVID - ND451	95.0%	101.7%	-	-	99.0%	100.5%	-	-	27.7%	7.9%	68	4.52	7	395	8	7.8	5.1	2.7	29.6%	75.0%	1	0	5	2 Enhanced care shifts	94,542	103,190	(8,648)
Maidstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - NE751	97.5%	91.5%	-	-	89.7%	70.7%	-	-	0.8%	0.0%	1	0.07	0	53	46	39.7	29.3	10.4	0.0%	99.5%	0	0	0		76,122	65,928	10,194
Maidstone	Whatman	Whatman Ward - NK959	94.1%	100.6%	-	-	98.9%	114.1%	-	-	28.3%	14.8%	61	4.18	16	597	10	9.5	4.9	4.6	96.0%	100.0%	4	0	7	23 Enhanced care shifts	202,038	188,308	13,730
Maidstone	Maidstone Birth Centre	Maidstone Birth Centre - NP751	83.3%	83.6%	-	-	103.6%	93.7%	-	-	18.6%	0.0%	34	1.75	0	60	37	33.4	23.3	10.1	0.0%	-	0	0	0		66,450	99,906	(33,456)
TWH	Acute Medical Unit (TW)	Acute Medical Unit (TW) - NA901	89.4%	102.3%	-	100.0%	96.1%	117.1%	-	-	23.8%	16.6%	115	8.28	31	787	9	8.6	5.3	3.3	-	-	11	0	4	23 Enhanced care shifts	316,926	265,214	51,712
TWH	Coronary Care Unit (TW)	Coronary Care Unit (TW) - NP301	97.5%	84.0%	-	-	100.0%	-	-	-	22.7%	0.0%	41	2.79	3	206	12	11.4	9.9	1.5	-	-	0	0	0		66,391	81,966	(15,575)
TWH	Hedgehog Ward	Hedgehog Ward (TW) - ND702	88.5%	26.7%	-	-	86.7%	23.1%	-	-	15.1%	26.8%	91	6.52	24	413	14	10.3	9.5	0.8	-	-	0	0	0	1 Enhanced care shifts	221,802	206,555	15,247
TWH	Intensive Care (TW)	Intensive Care (TW) - NA201	103.7%	98.3%	-	-	99.8%	99.9%	-	-	0.8%	0.0%	11	0.56	0	360	31	31.0	27.0	3.9	-	-	0	0	0		418,653	441,083	(22,430)
TWH	Wells Day Unit	Private Patient Unit (TW) - NR702	95.3%	83.5%	-	-	88.1%	86.7%	-	-	0.0%	-	-	-	-	67	36	32.2	18.9	13.2	50.0%	100.0%	0	0	0		83,071	81,488	1,583
TWH	Ward 2	Ward 2 (TW) - NG442	93.0%	123.4%	-	100.0%	75.8%	141.8%	-	100.0%	32.7%	45.9%	50	3.38	10	769	8	8.2	3.2	4.9	33.3%	85.7%	8	1	3	91 Enhanced care shifts	254,483	218,456	36,027
TWH	Ward 11	Ward 11 (TW) - NG131	94.7%	109.8%	-	-	97.5%	79.8%	-	-	18.7%	0.9%	58	4.06	7	801	8	7.5	4.2	3.3	25.9%	86.7%	6	0	0	11 Enhanced care shifts	191,157	188,960	2,197
TWH	Ward 12	Ward 12 (TW) - NG132	87.5%	126.2%	-	-	96.4%	134.2%	-	-	50.5%	36.3%	114	7.56	21	881	7	7.3	3.2	4.1	14.9%	85.7%	8	2	11	97 Enhanced care shifts	210,135	201,298	8,837
TWH	Ward 20	Ward 20 (TW) - NG230	90.6%	134.5%	-	-	100.0%	138.2%	-	-	41.2%	38.9%	91	6.09	13	888	7	7.6	3.3	4.2	38.8%	89.5%	3	1	1	91 Enhanced care shifts	221,267	216,608	4,660
TWH	Ward 21	Ward 21 (TW) - NG231	88.1%	118.9%	-	-	94.7%	138.9%	-	-	31.7%	35.4%	69	4.55	23	884	7	7.5	4.0	3.5	5.7%	100.0%	4	1	3	70 Enhanced care shifts	188,917	222,595	(33,678)
TWH	Ward 22	Ward 22 (TW) - NG332	98.7%	119.9%	-	-	99.2%	129.1%	-	-	25.7%	20.5%	55	3.65	3	947	6	6.9	3.3	3.6	65.5%	94.7%	4	0	5	61 Enhanced care shifts	233,308	209,711	23,597
TWH	Ward 30	Ward 30 (TW) - NG330	95.2%	112.1%	-	100.0%	98.3%	101.8%	-	100.0%	24.0%	0.0%	117	7.03	15	857	7	7.0	3.6	3.1	11.6%	60.0%	10	4	11	9 Enhanced care shifts	183,345	183,588	(243)
TWH	Ward 31	Ward 31 (TW) - NG331	91.9%	114.1%	-	100.0%	95.8%	118.3%	-	-	15.0%	0.0%	74	4.49	20	864	7	7.2	3.5	3.6	13.8%	100.0%	2	0	16	27 Enhanced care shifts	185,915	188,300	(2,385)
TWH	Ward 32	Ward 32 (TW) - NG130	93.5%	95.7%	-	100.0%	96.7%	96.6%	-	100.0%	17.1%	0.0%	28	1.90	7	503	9	9.0	5.1	3.6	0.0%	100.0%	3	0	0		166,909	155,452	11,457
TWH	Gynae Ward	Ward 33 (Gynae) (TW) - ND302	102.7%	107.2%	-	-	96.7%	100.0%	-	-	29.1%	0.0%	17	0.95	0	272	8	8.0	5.1	2.9	22.6%	89.5%	0	0	0		114,394	123,600	(9,206)
TWH	SCBU	NICU (TW) - NA102	89.5%	-	-	-	84.3%	-	-	-	27.9%	17.8%	144	9.27	9	383	15	14.4	13.2	3.3	-	-	0	0	0		265,192	260,720	4,472
TWH	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - NE901	94.0%	74.0%	-	100.0%	118.3%	100.0%	-	100.0%	11.7%	0.0%	25	1.74	0	272	14	13.4	9.7	3.3	10.6%	100.0%	0	0	0		113,556	102,750	10,806
TWH	Surgical Assessment Unit	Surgical Assessment Unit (TW) - NE701	100.0%	87.5%	-	100.0%	95.0%	111.1%	-	100.0%	5.5%	0.0%	8	0.54	0	124	20	19.3	13.8	4.8	9.2%	100.0%	0	0	0		82,025	83,281	(1,256)
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	91.7%	86.7%	-	-	91.6%	64.6%	-	-	18.9%	12.1%	154	9.91	45	1123	8	6.8			-	-	0	0	0		268,073	408,248	(140,175)
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	93.7%	81.3%	-	-	96.9%	83.3%	-	-	38.3%	4.5%	90	5.58	8	366	8	6.9	6.6	2.1	-	-	0	0	0		80,238	120,240	(40,002)
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	129.3%	88.1%	-	-	119.2%	93.4%	-	-	27.9%	0.8%	170	9.67	23	604	9	10.4			-	-	0	0	0		173,479	233,097	(59,618)
Crowborough	Crowborough Birth Centre	Crowborough Birth Centre (CBC) - NP775	48.3%	64.8%	-	-	35.0%	50.0%	-	-	0.0%	-	-	-	-	16	140	65.8	41.1	24.8	-	-	0	0	0	Crowborough birth centre currently closed	67,402	53,758	13,644
Maidstone	A&E (M)	Accident & Emergency (M) - NA351	99.6%	131.9%	-	100.0%	99.4%	136.2%	-	-	31.3%	22.2%	213	14.39	1	0	-	-	-	-	0.0%	79.6%	0	0	0	66 Enhanced care shifts	523,471	470,744	52,727
TWH	A&E (TW)	Accident & Emergency (TW) - NA301	100.8%	89.5%	-	100.0%	103.5%	98.1%	-	100.0%	33.1%	13.5%	243	16.82	5	0	-	-	-	-	11.3%	76.8%	0	0	0	7 Enhanced care shifts	479,464	508,912	(29,448)
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	60.6%	-	-	-	-	-	-	-	4.1%	0.0%	3	0.17	0	0	-	-	-	-	-	-	0	0	0		0	0	0
TWH	Community Midwifery Services (TW)	Community Midwifery Services - TW/Eden/Ton/PW/Hawk - NJ160	88.2%	89.3%	-	-	-	-	-	-	7.1%	0.0%	29	1.43	2	0	-	-	-	-	-	-	0	0	0		0	0	0
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	89.3%	0.0%	-	-	-	-	-	-	0.0%	-	-	-	-	0	-	-	-	-	-	-	0	0	0		0	0	0
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Seven/Mallings - NJ160	96.1%	-	-	-	-	-	-	-	0.0%	-	-	-	-	0	-	-	-	-	-	-	0	0	0		0	0	0
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Maidstone/Leeds - NJ160	75.9%	56.3%	-	-	-	-	-	-	8.7%	0.0%	35	1.65	6	0	-	-	-	-	-	-	0	0	0		0	0	0
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	82.6%	69.6%	-	-	-	-	-	-	16.7%	0.0%	22	1.10	2	0	-	-	-	-	-	-	0	0	0		0	0	0
		Midwifery TW (four IP rosters)	102.3%	86.7%	-	-	99.0%	82.1%	-	-	25.1%	6.0%	414	25.17	76								0	0	0		0	0	0
		Midwifery TW Community (six comm. rosters)	83.7%	60.8%	-	-	-	-	-	-	6.5%	0.0%	260	15.25	31								0	0	0		348,540	323,927	24,613
		Midwifery TW (all fourteen rosters)	83.7%	81.2%	-	-	99.2%	82.1%	-	-	13.5%	5.2%	473	29.65	32								0	0	0		0	0	0
Maidstone	K&M Orth Centre - Inpatient Ward	K&M Orth Centre - Inpatient Ward - TK153	84.6%	96.9%	-	100.0%	71.1%	95.1%	-	100.0%	0.0%	-	-	-	-	197	28	24.1	13.7	8.2	#N/A	#N/A	1	0	0		167370	145279.99	22090.01
Fordcombe	Fordcombe Ward	Fordcombe Ward (AFC) - NU901	85.4%	75.8%	-	-	98.7%	-	-	-	12.7%	0.0%	30	1.84	0	52	48	42.4	36.4	6.0	#N/A	#N/A	0	0	0		83097	79149.43	3947.57

Total Established Wards			**8,474,909**	**8,450,330**	**24,579**
Additional Capacity beds	Cath Labs		58,855	54,057	4,798
	Whatman		0	0	0
Other associated nursing costs			6,166,152	6,419,130	-252,978
Total			14,699,916	14,923,517	(223,601)

Green: equal to or greater than 90% but less than 110%
Amber Less than 90% OR equal to or greater than 110%
Red equal to or less than 80% OR equal to or greater than 130%

Title of report	**Maternity Report relating to the Perinatal Quality Oversight Model**					
Board / Committee	**Trust Board**					
Date of meeting	30 October 2025					
Agenda item no.	10-11					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Jo Haworth, Chief Nurse					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	PQOM Overview 1. To ensure effective Board oversight in Year 7 of the Maternity Incentive Scheme, it is recommended that the monthly Perinatal Quality Oversight Model (PQOM) report (Appendix 1) is available at every Trust Board, which includes the minimum dataset required by Safety Action 9. A member of the perinatal leadership team will be available to provide supporting context (as specifically required by Safety Action 9). Note that the PQOM replaced the Perinatal Quality Surveillance Model report (PQSM) in August 2025. 2. Trust safety champions (including the Non-Executive Director) already see this data monthly, which enables early action to be taken and support to be provided should the data identify an area of concern or need. The Board's review of this data provides assurance of effective ward to Board reporting, and reassures the Board of the check and challenge applied by the safety champions. 3. Items to be escalated were identified via the Maternity and Neonatal Care Oversight Group Meeting on 15 October 2025 and are summarised below. 4. Areas of improvement noted: 4.1. Improvement in the availably of Neonatal Coordinators. 4.2. A reduction in the vacancies and turnover within the Midwifery workforce. 4.3. Work is under way to improve communication and emergency experience for patients. 4.4. PPH thematic review is ongoing and to note, Patient Safety is supporting. 4.5. Swab count audit now part of monthly Matron's checklist audits report. 4.6. Neonatal team has a process in place to ensure guidelines are up to date; they are now showing a significant improvement.

	5. Areas of Concern; assurance provided but not performing well: 5.1. Safeguarding - domestic abuse questions not being consistently asked at every contact point. MDT review required to identify any core issues and if any harm. 5.2. Future MIS system to be designed to enable effective audit of safeguarding enquiries. The ICB to raise at next Board meeting. 5.3. An increase in emergency caesarean sections during August; reduced to 23% during September. 5.4. EDI data accessed and acknowledging that the data the service has reflects the national position. Work is underway to address healthcare inequalities; this will be reported back to MNCOG going forward. 5.5. Ongoing capacity issues in the Neonatal Unit. 5.6. Concerns raised around non compliance with Maternity resus checklists; an action plan is in place; to be reported to MNCOG going forward. 5.7. An increase in vacancy rate in the Neonatal Unit however new starters are in the pipeline. 5.8. MIS training compliance required to achieve CNST compliance by CNST deadline; all obstetric consultants and anaesthetists must attend when booked between now and 30 November 2025 to achieve compliance. 5.9. An action plan to be put in place to improve process for access to translation services; this will part of a Trust wide plan. 5.10. Ongoing national shortage of QIS nurses for the Neonatal Unit to meet BAPM standards. 6. Commissioned Work: 6.1. Review of roles and responsibilities used in ED to understand if this can be translated into Maternity emergencies. 6.2. <u>Actions to ensure implementation of NHSE Guidance July 2025 Report</u> 7. In June 2025 NHSE announced a national inquiry into maternity services. Local NHS Boards are asked to focus on five key areas whilst the inquiry is ongoing. 8. The Board is reassured that these five key areas of focus are being addressed through existing improvement work, with a clear improvement plan in place. The Report at Appendix 2 was presented to Board Level Safety Champions via MNCOG on 16 August 2025 and is shared for information.
Any items for formal escalation / decision	1. In relation to PQOM the Board is invited to: a. review the October (August data) 2025 PQOM report and the summary of items for escalation set out above for information and assurance; b. confirm in the minutes of this meeting that it has reviewed and discussed the PQOM report to undertake a review of maternity and neonatal quality and safety; c. decide if any further information, action and/or assurance is required.
Appendices attached	Documents are available to review in Admincontrol; Part 1 meeting Folder; Reading Room; Appendices to Maternity Report 1. Appendix 1 - October (August data) 2025 PQOM report 2. Appendix 2 - Actions to ensure implementation of NHSE Guidance July 2025 Report

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	16 August and 15 October 2025	For referral to Trust Board

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

Title of report	**Mental Health Strategy 2025-2030**					
Board / Committee	**Trust Board**					
Date of meeting	30th October 2025					
Agenda item no.	10-12					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Jo Haworth, Chief Nurse					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	☐

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	Please find attached the proposed new Mental Health Strategy 2025-2030 for approval. This is the first of its kind at MTW and represents the culmination of 12 month's worth of internal and external engagement including focus group with Mental health Resource charity in Tunbridge Wells. We identify 5 priority areas of focus and expand on our plans to achieve this over the coming five years. These priorities are: 1. Safe emergency and inpatient care (with a commitment to Deliver timely, compassionate, and effective care in environments designed to protect the physical and psychological safety of individuals experiencing acute mental health crises) 2. Preventative outpatient care (with a commitment to Provide outpatient services and pathways designed to identify, support, and manage mental health needs early—before they escalate into crises or require emergency or inpatient care) 3. Digital and innovation (with a commitment to Use digital tools and data-driven approaches to enhance the accessibility, effectiveness, efficiency, and personalisation of mental health support within MTW) 4. Skilled people (That the workforce will possess the knowledge, practical competencies and confidence to deliver safe, compassionate, and evidence-based care to individuals experiencing mental ill health) 5. Strong partnerships (with a commitment to Ensure effective, collaborative relationships between mental health services and MTW to ensure integrated, person-centred care for patients with mental health needs who access or are treated within our services)
Any items for formal escalation / decision	None
Appendices attached	• Appendix A – pdf of the Mental Health Strategy 2025-2030

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Mental Health Committee	01/09/25	Draft version circulated for comments
Non-executive director group	10/10/25	Draft version circulated for comments
ETM	14/10/25	Approved

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	n/a
Links to Trust Risk Register (TRR)	n/a
Compliance / Regulatory Implications	n/a

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Mental Health Strategy
2025-2030

Contents

"In A&E they showed compassion and worry for our young person's needs"

Parent

"I'm in desperate need of support as my health is deteriorating"

Outpatient with a mental health condition

Foreword

> Mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community. It has intrinsic and instrumental value and is a basic human right. Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm.

World Health Organisation (WHO) definition

Mental health conditions pose a significant contemporary health issue, with substantial implications individually and for broader society. It currently represents 23% of ill health in the UK and is the largest single cause of disability.

The NHS aspires to improve mental healthcare provision across England, working with local communities, voluntary sector organisations and key service partners. Maidstone and Tunbridge Wells NHS Trust is supporting this agenda through this Mental Health Strategy and its implementation plans for the next five years.

Challenging the stigma around mental health is crucial for fostering the right environment for mental health care. There is an increasing acceptance of mental health discussions, but people still face challenges in getting the right help in the right place and at the right time.

We are truly grateful to all those individuals and groups who have contributed to this document. We are wholly committed to making this strategy a reality in the coming years.

Amy Daniels Head of Mental Health

Jo Haworth Chief Nurse

Executive summary

Mental health is a national and local priority, with the demand for mental health services continuing to exceed provision because of growing demand and significant gaps in care. NHS England has called for stronger crisis services, improved access to community support, and a focus on at-risk groups such as young persons and pregnant people.

Despite progress, population need remains high. One in four adults experiences a mental health issue, but only half receive support. Suicide remains a major concern, with 17 deaths per day in the UK.

Maternal mental health is especially impacted by inequality, with higher suicide rates in deprived areas and LGBTQIA communities. Locally, Kent and Medway face a number of challenges. Hospital admissions for self-harm for 10–24 year-olds remain high. Veterans are more likely to seek treatment for alcohol misuse than other substances. Between 2020 and 2023, 67% of local suicide deaths involved people not known to secondary mental health services, underlining the need for better early intervention.

This Mental Health Strategy 2025-2030 recognises and responds to these challenges. As an acute care provider we are setting out five priority areas of focus into 2030 to ensure we are improving outcomes, reducing inequalities, and embedding mental health as a core part of our care to patients with mental health needs.

1. Safe emergency and inpatient care

2. Preventative outpatient care

3. Digital and innovation

4. Skilled people

5. Strong partnerships

National picture

Mental health is a national priority, with NHS England highlighting the importance of strengthening crisis and acute pathways, improving access to community-based support, and supporting at-risk populations. The need for action is pressing and despite progress in expanding services, the scale of unmet need remains high.

The Centre for Mental Health reports that 23% of adults now experience a common mental health difficulty, yet only half receive the help and support they require.

Services continue to face sustained demand, and many people still struggle to access care in a timely or convenient way. This gap carries serious consequences. Every day, 17 people die by suicide in the UK, including five who were in contact with mental health services at the time of their death. Those at greatest risk nationally include young persons, people who have self-harmed and new parents. Furthermore, suicide rates are closely linked to inequality, with higher rates for people in the most deprived areas or from the LGBTQIA community.

Statutory mental health services alone cannot meet this level of demand. In 2020, the Care Quality Commission reviewed the assessment of mental health care in acute trusts and found that patients with mental health needs are not always treated with the same importance as those with physical health needs. The CQC recommended acute trust-level changes, including stronger governance of mental health care and investment in upskilling the workforce to ensure staff have the skills and confidence to meet people's mental health needs.

This strategy responds to these challenges. It sets out how we will work collectively across systems and providers to address national priorities, reduce inequalities, and ensure mental health is given equal weight to physical health in every part of care.

Parity of esteem

is the principle by which mental health must be given equal priority to physical health. It was protected by law in the Health and Social Care Act 2012.

The importance of ‘parity of esteem’

We are committed to ensuring patients’ mental health needs are supported alongside their physical health needs. Parity of esteem is central to this approach; when holistic, person-centred care is provided, patients experience better outcomes and higher-quality care.

In preparing for this strategy, our engagement with patients, carers, staff and partners has highlighted areas where improvements are needed:

- Physical health needs are not always addressed alongside mental health needs.
- There is a lack of consistent information about waiting times or onward care.
- Staff do not always have the right skills to understand mental health needs or deliver care to those in crisis.
- Environments are not always optimal for delivering high-quality mental health care.

Physical health needs are not always addressed alongside mental health needs

In response, and in line with the three shifts within Fit for the Future: 10-Year Health Plan for England, we are committed to:

1. **Working with partners** to reduce the length of time people spend in hospital, ensuring timely, safe discharge and access to specialist care as needed.
2. **Ensuring the right digital tools** and resources are in place to target improvements, learning, and resources at the right time and in the right areas.
3. **Reviewing outpatient pathways** and links to primary care providers to enable preventative support and signposting, reducing the likelihood of people reaching crisis.
4. **Ensuring staff have the necessary skills** and resources.

Local picture

The picture in Kent and Medway reflects these national challenges, with local data highlighting both areas of progress and persistent concerns.

Hospital admissions for self-harm among 10–24-year-olds have shown a slight reduction (479 per 100,000), but rates remain higher than in other health and care partnerships in Kent (Kent JSNA, 2025).

The prevalence of mental health conditions locally is broadly in line with national rates. However, among veterans, distinct patterns are evident: in Kent, veterans are more likely to seek treatment for alcohol misuse than for opiates or non-opiates compared to non-veterans. Between 2020 and 2023, there were seven recorded suicides among serving personnel and veterans (Kent JSNA, 2025).

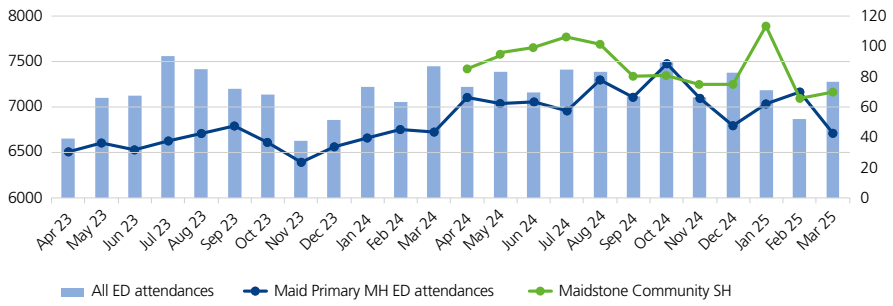
Suicide remains a significant local public health concern. Between 2020 and 2023, 67% of people who died by suicide in Kent and Medway were not known to secondary mental health services, though many had been in contact with primary care. This highlights the importance of early identification and intervention in frontline and community settings (Kent JSNA, 2025).

Young people are particularly at risk. The Kent Public Health Observatory identified suicide as a leading cause of death for 10–35-year-olds, causing a disproportionate number of ´years of life lost´. The Kent and Medway Multi-Agency Suicide Prevention Strategy (2020–25) recognised this as a major public health issue and prioritised collaborative action to reduce risks.

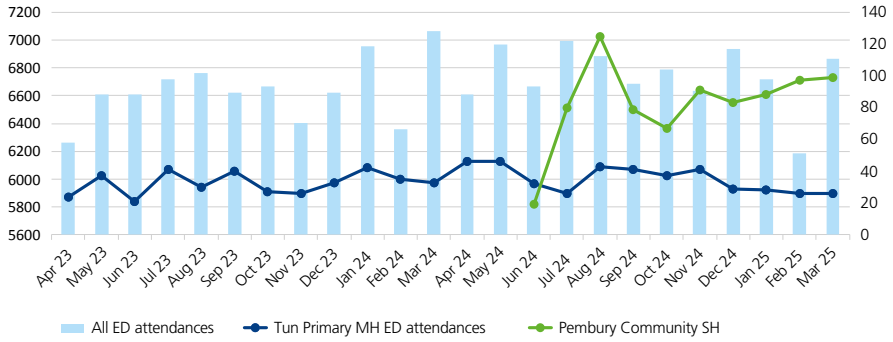
Emergency Department (ED) mental health attendances and Safe Haven presentations

18 years and older

Maidstone Hospital and Maidstone Community Safe Haven presentations



Tunbridge Wells Hospital and Pembury Community Safe Haven presentations



Data source: Lightfoot
Secondary Uses Service (SUS) dataset | Emergency Care dataset (ECDS) | Accident & Emergency dataset
Mental Health Matters (safe Haven)

Maidstone and Tunbridge Wells NHS Trust saw a reduction in total mental health attendance for people aged 18 and over until 24/25, where there has been an increase to over 1000 between April and February. There has been a steady rise in primary mental health ED attendances at Maidstone Hospital since April 2023.

Primary mental health ED attendances at Tunbridge Wells Hospital have remained consistent, reducing slightly from October 2024 with increased footfall to the Pembury Community Safe Haven. Across the system, work continues on flow to crisis alternatives to reduce the need for people to present to ED. We are committed to working collaboratively with system partners.

Total mental health attendances	21/22	22/23	23/245	24/25 (Apr-Feb)
East Kent Hospitals University NHS Foundation Trust	5,456	4,990	4,860	6,060
Medway NHS Foundation Trust	2,195	2,125	1,475	715
Maidstone and Tunbridge Wells NHS Trust	1,650	730	695	1,015
Dartford and Gravesham NHS Trust	785	930	950	765

Data source: ECDS

All referrals via the crisis/A&E pathway for children and young people (CYP)

Presenting 2+ times in a 90-day period therefore considered a high-intensity user, aged up to and including 17 years

Kent and Medway High-Intensity User Service Review

during 90-day period (05/9/2024- 03/12/2024)

Kent – of 61 young people:

2.6
average referrals recorded

72%
had safeguarding concerns

85%
were known to social services

23%
looked after / cared for child

21%
lived in residential placement

18%
had gender identity concerns

ASD
25%
had a known diagnosis of Autistic Spectrum Disorder (ASD), with a further 30% awaiting assessment

ADHD
26%
had a known diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), with a further 25% awaiting assessment

Data source:
CAMHS High Intensity User (HIU) Review

Age	No. seen by age	% seen by age
9yr	0	0%
10yr	0	0%
11yr	0	0%
12yr	4	7%
13yr	4	7%
14yr	9	15%
15yr	15	25%
16yr	15	25%
17yr	14	23%
18yr	0	0%
Total	**61**	**100%**

Kent admissions classified as a high-intensity user during a 90 day period

Our vision

It is our intention with this strategy to set out a 5-year plan to support patients of all ages experiencing mental health difficulties at any point in their care with us. This includes the individuals themselves, and their network of support.

- We will ensure the care we deliver to people experiencing mental health difficulties is in the **right place**, and at the **right time**.
- We will support people to get **better** or prevent things from getting **worse**.
- We will make sure our environments are **safe**.
- We will make sure our staff have the **right skills**.
- Lastly, we will make sure we work as part of the whole health and social care **system**.

"We are committed to providing outstanding, patient-centred care, meeting the needs of physical health alongside mental health.

It is crucial that our patients feel safe, listened to and have confidence in the knowledge and skills of our staff."

Our priorities for the next five years

We have identified **five key priorities** for our strategy, each with a specific commitment to support continuous improvements in care across all ages.

1

Safe emergency and inpatient care

Deliver timely, compassionate, and effective care in environments designed to protect the physical and psychological safety of individuals experiencing acute mental health crises.

2

Preventative outpatient care

Provide outpatient services and pathways designed to identify, support and manage mental health needs early – before they escalate into crises or require emergency or inpatient care.

3

Digital and innovation

Use digital tools and data-driven approaches to enhance the accessibility, effectiveness, efficiency and personalisation of mental health support.

4

Skilled people

The workforce will possess the knowledge, practical competencies and confidence to deliver safe, compassionate and evidence-based care to individuals experiencing mental ill health.

5

Strong partnerships

Ensure effective, collaborative relationships between mental health services and MTW to ensure integrated, person-centred care for patients with mental health needs who access or are treated within our services.

Priority 1: Safe emergency and inpatient care

Our commitment: Deliver timely, compassionate, and effective care in environments designed to protect the physical and psychological safety of individuals experiencing acute mental health crises.

Objective 1
Provide a safe, therapeutic environment for all ages of patients and their carers.

Objective 3
Use experience feedback to improve services.

Objective 2
Ensure there are clear and structured processes for clinical escalation and staff support.

Objective 4
Embed tools that help identify and manage risk in a more holistic, person-centred, and collaborative approach.

What we are doing already:

- We have a designated Lead for Mental Health and have established a Mental Health Committee with responsibility for the delivery of quality mental health care.
- There is a new hub for staff to access resources when caring for patients with mental health conditions, and tools in place such as the MRT or new escalation procedures to support decisions in care.
- A dedicated Enhanced Therapeutic Observations and Care team (ETOC) has been introduced to help care for our most at-risk patients, and a complex case panel has been set up to coordinate complicated discharge plans [more information on page 25].
- We have operating models in place for all ages and are working with national improvement initiatives such as the NHS Confederation programme including social care partners, the police, SECAmb and charitable organisations.
- We monitor experience of care scores, noting strong performance in mental health care. We are engaged with and integrating Kent and Medway system initiatives such as the new 'Sit & Wait' service.

In 2024 the following was observed in the population of west Kent.

479
Patients aged 10-24 years admitted to hospital due to self harm (per 100,000)*

*worse than the national picture

11
Suicide rate (per 100,000) **

**similar to the national picture

	The improvements we want to make:	What this will look like:	By when
Year 1	Review of out of hours support and decisions to admit for patients in mental health crisis.	24/7 operational support for mental health patients.	2026
	Effective transfer of care for children within MTW moving into adult services at 16 years old.	Anticipatory care planning with partner organisations, and in support of the all-age mental health approach within the system.	2026
	Establish a system for monitoring the safety of patients in our care through minimising the use of restrictive practice and reducing the number of adverse events.	Specific objectives agreed and added to the digital dashboard for tracking and learning outcomes shared, identifying specific trends in relation to health inequalities.	2026
	An all-age Complex Case Panel to support the care planning and management of those with complex needs.	An agreed process for patients of any age requiring complex care planning and management.	2026
	Consistent application of the internal transfer policy to ensure at-risk patients are not left unattended when moving around the site.	Effective communication between ward and other internal locations (e.g. radiology) in monitoring at-risk patients when off the ward.	2026
Year 2-3	Having the capacity to identify needs and appoint specialist support staff for at-risk patients on admission, adopting a therapeutic approach to minimise the use of security services.	Effective use of a suitably skilled ETOC team and reducing use of security staff to reactive manage challenging behaviours.	2027/28
	Ready access to and capacity to share medical history with partner organisations at handover and transfer points.	Information readily available across data platforms at handover or transfer, with multidisciplinary colleagues able to enter own contacts.	2027/28
	Improving feedback processes and reviewing operational and legal processes to ensure patients are safe.	Specific experience of care feedback at directorate level and up to date operating policies and procedures.	2027/28
	Correct identification processes on admission, with suitable carryover of prescribed medications, but also an awareness of diagnostic overshadowing.	Early identification and reference to known mental health conditions on admission.	2027/28
	Communicating timescales and processes while patients wait in our Emergency Departments, encouraging kindness and understanding of others.	Visible signage of triaging processes and cultural kindness messaging.	2027/28
Year 4-5	Evaluating our waiting room provision to create safe spaces for patients awaiting care.	A list of safe spaces across all sites and creating additional spaces where none exist.	2029/30
	Compliance with emerging national objectives.	Recognition of and work towards all emerging national objectives.	2029/30

Priority 2: Preventative outpatient care

Our commitment: Provide outpatient services and pathways designed to identify, support, and manage mental health needs early – before they escalate into crises or require emergency or inpatient care.

Objective 1
Identify, develop and implement clear outpatient pathways for those requiring mental health care and support both in a crisis or when an early need is identified.

Objective 3
Understand the educational needs of outpatient staff, and formulate an ongoing plan to provide access to high-quality learning and development to influence the wider organisational culture.

Objective 5
Ensure links and maintain key relationships with external providers and campaigns to feed back into the trust.

Objective 2
Scope what is currently being collected in all outpatient settings regarding wellbeing and mental health information, and then aggregate and validate data to understand the bigger picture.

Objective 4
Ensure patients and carers are involved in work to improve services, reduce stigma and share learning.

What we are doing already:

- Successful implementation of insight experiences and adapted approaches for patients struggling to attend typical appointments (e.g. phlebotomy). Has been well received by patients, with suggestions for rolling out into to other areas of the trust to overcome barriers to care.
- Recognising our role in the wider patient journey, acting as advocate for partner services and signposting accordingly.
- Dedicated psychological resource for mental health care such as those accessing Cancer or Maternity services and living with long-term condition.

From Sickness to Prevention is a core focus of the new NHS "Fit for the Future" 10-year Health plan.

The intention is to move away from solely treating illness towards a model that prevents it, ensuring health services are intervening earlier and promoting healthy choices. By ensuring we have this as a priority area of focus, we are well-placed to support delivery of the 10-year plan.

	The improvements we want to make:	What this will look like:	By when
Year 1	Clarify the current approach being taken to ensure all patients and/or their carers are asked about their mental health, and identify where there are gaps in onward referral and/or signposting processes.	A standard operating procedure in place for recognising mental health need across all outpatient settings, leading to appropriate onward referral and/or signposting.	2026
	Ensuring there is a clear response to patients disclosing potential mental health concerns with onward referral to Talking Therapies among other options as appropriate.	Evidence of an active response to all patient disclosures.	2026
	Actively playing a role in the signposting to safe havens and in sharing information to primary care in avoiding ED.	Safe havens and alternative treatment options are well-communicated to patients or referrers in contact with our outpatient services.	2026
Year 2-3	Ensuring there are processes in place to flag the early warning signs of crisis for patients with long-term or complex conditions (e.g. cancer, cardiology, maternity).	Clear identification and escalation of patients flagging as in crisis when in our care.	2027/28
	Patients or their carers are offered the opportunity to discuss reasonable adjustments in support of their outpatient appointment(s), recognising there are inequalities in accessing care.	Patient or their carers feel they were asked about reasonable adjustments in support of their outpatient appointment.	2027/28
Year 4-5	Evaluating digital platforms to ensure consistency in the mechanism for encouraging disclosures, so that those booking through a digital portal are equally screened.	Consistency of screening mechanisms across all booking systems.	2029/30
	Ensuring our outpatient teams are aware of and are avoiding diagnostic overshadowing for patients with mental health conditions.	Staff will receive awareness training and embed this knowledge in clinical practice.	2029/30
	Conduct an audit of the care for patients with long term conditions and their mental wellness throughout treatment.	Audit completed with an analysis of mental wellness during treatment for a specific long-term condition e.g. cancer.	2029/30

Priority 3: Digital and innovation

Our commitment: Use digital tools and data-driven approaches to enhance the accessibility, effectiveness, efficiency, and personalisation of mental health support.

Objective 1
Ensure ownership and action related to mental health data by divisions and partners.

Objective 3
Improve data validity by reducing duplication and streamlining data collection.

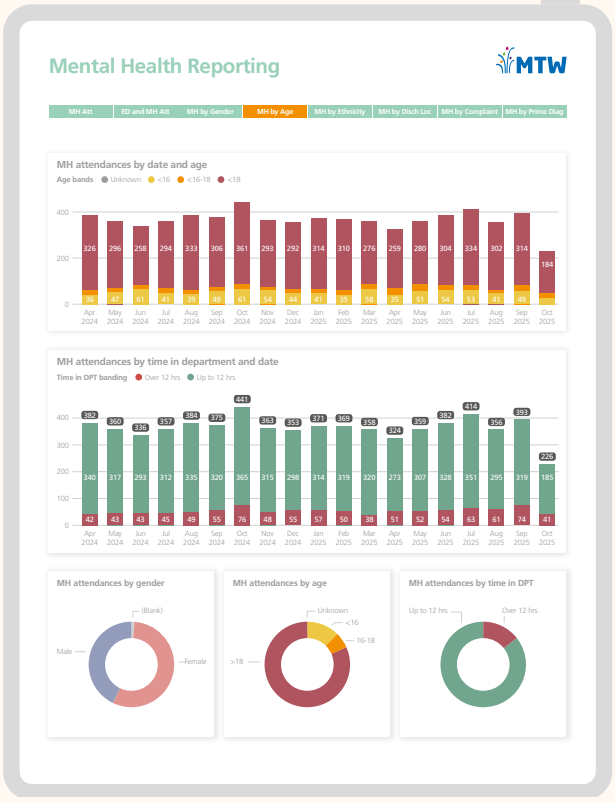
Objective 5
Harness technology to ensure patients are treated in the right place, and that we have the right information at the right time.

Objective 2
Use digital systems to improve clinical care and experience.

Objective 4
Investigate and seek to invest in innovative concepts to improve future services.

What we are doing already:

- Internal alerting and identification systems have been strengthened particularly in the Emergency Department.
- There is a digital dashboard to have oversight of patients across sites (see right) and an intranet Mental Health hub with resources to support staff in their care of patients.
- Reporting incidents has been simplified with agreement of an 'approved user' list to ensure non-MTW staff can also input.
- Automated handovers have been introduced in Maternity.
- Digital feedback mechanisms are in place to capture insights on experience of care.
- A new e-referral system is used to access liaison psychiatry.
- There is a dedicated section in the electronic note record for high-intensity user plans.
- Validation processes are triangulated with data captured, and all new developments are digitally-based in a move away from analogue processes.



	The improvements we want to make:	What this will look like:	By when
Year 1	Use of integrated digital platforms to free up direct clinical time (e.g. Teletracking to Sunrise)	Lean digital processes that create clinical capacity.	2026
	Regular reporting on the outputs of the digital dashboard to governance groups and divisions.	A minimum of quarterly reporting on the outputs of the dashboard from ward to board.	2026
	Extracting themes and trends from data to improve clinical care and experience of patients.	Service improvements that reflect the need identified from the data, and monitoring of experience.	2026
	Improve the user awareness of system availability and accessibility (e.g. KMCR).	Communications to be shared across the trust and relevant external agencies.	2026
Year 2-3	Approved data sharing agreements between MTW and key partners (KCHFT, KMMHT, KCC).	Data sharing agreements installed and effective.	2027/28
	Data outputs to be routinely screened for duplication and accuracy.	Data will be cleansed and offer greater reliability to users.	2027/28
	Implementation of innovative approaches moving away from restrictive practice.	Minimal use of restrictive practice and a 'therapeutic first' culture of care.	2027/28
Year 4-5	Introduction of relevant AI and remote technologies to analyse the soft signs in patient data and predict further mental health care needs.	Integrated AI processes in specialist care as aligned with the Digital Transformation Programme Board.	2029/30
	Eliminating all paper-based touchpoints in the mental health pathway.	Purely digital interface across the pathway.	2029/30
	Optimal integration between key digital systems across the system.	Digital systems will interface optimally in the sharing of key patient data.	2029/30

Priority 4: Skilled people

Our commitment: The multiprofessional workforce will possess the knowledge, practical competencies and confidence to deliver safe, compassionate, and evidence-based care to individuals experiencing mental ill health.

Objective 1
Educate all staff to know how to access vital resources and support to signpost patients to the right services.

Objective 3
Design and implement evidence-based training to upskill the workforce.

Objective 5
Commit to ensuring patient stories are shared and heard to improve care and services.

Objective 2
To support staff to develop practical skills to support patients and carers more effectively.

Objective 4
Ensure there is shared learning from things that went well and things that did not go so well.

What we are doing already:

- Dedicated workforce through ETOC team and recognised mental health leads.
- A focus on preceptorship pathways and embedding routine mental health care (e.g. through case studies).
- Annual Learning Needs Assessment ensures funding available for investing in mental health.
- Continued promotion of the role of a MH first aider.
- Widespread use of patient stories to share lived experiences.
- External education support from specialist partner agencies (e.g. KMMHT psychiatry liaison teams commissioned).
- Syllabus changes to reflect more holistic mental and physical health.
- A culture that is motivated to improve mental health care.

	The improvements we want to make:	What this will look like:	By when
Year 1	Follow through on the learning from incidents and patient stories to embed this into practice.	A closed learning loop of continuous improvement where identified changes are brought in the future practice.	2026
	Provision of a comprehensive specialist 'on-the-floor' training from liaison psychiatry colleagues.	Regular provision of this specialist training.	2026
	Ensuring safe staffing levels when there are high volumes of complex patients and at-risk patients with mental health needs.	Effective rostering practice and use of the ETOC referral pathway.	2026
Year 2-3	Provision of comprehensive mental health training for all professional groups (e.g. doctors, nurses, health care professionals) and including non-clinical staff (e.g. Switchboard) where appropriate. This is to be based on a clear foundation of mental health law and application in practice.	Wide ranging, inclusive offer of mental health awareness training.	2027/28
	Continued move away from temporary workforce to bank or substantive staff in caring for mental health conditions.	Predominately substantive or bank staff involved in care, who have had comprehensive training, feel valued and chose to remain within the organisation.	2027/28
	Introduction of simulation-based learning or partner shadowing opportunities.	Creation of bespoke programmes to be delivered through Learning and Development.	2027/28
	Comprehensive wellbeing and safety resources for all staff managing complex behaviours.	Support available to all staff.	2027/28
Year 4-5	Introduction of bespoke training programmes to minimise diagnostic overshadowing.	A training programme specific to overcoming diagnostic overshadowing is available to staff.	2029/30
	Embedding preventative mental health care for long-term conditions in line with the 10 year Health plan.	Shared models of care across long-term condition pathways (e.g. bariatrics, cancer, neonatal) that embody a preventative approach to mental health care.	2029/30

Priority 5: Strong partnerships

Our commitment: Ensure effective, collaborative relationships between mental health services and MTW to ensure integrated, person-centred care for patients with mental health needs who access or are treated within our services.

Objective 1
Ensure there is multi-agency working in the care of patients with mental health needs and actively contribute as a mental health system partner.

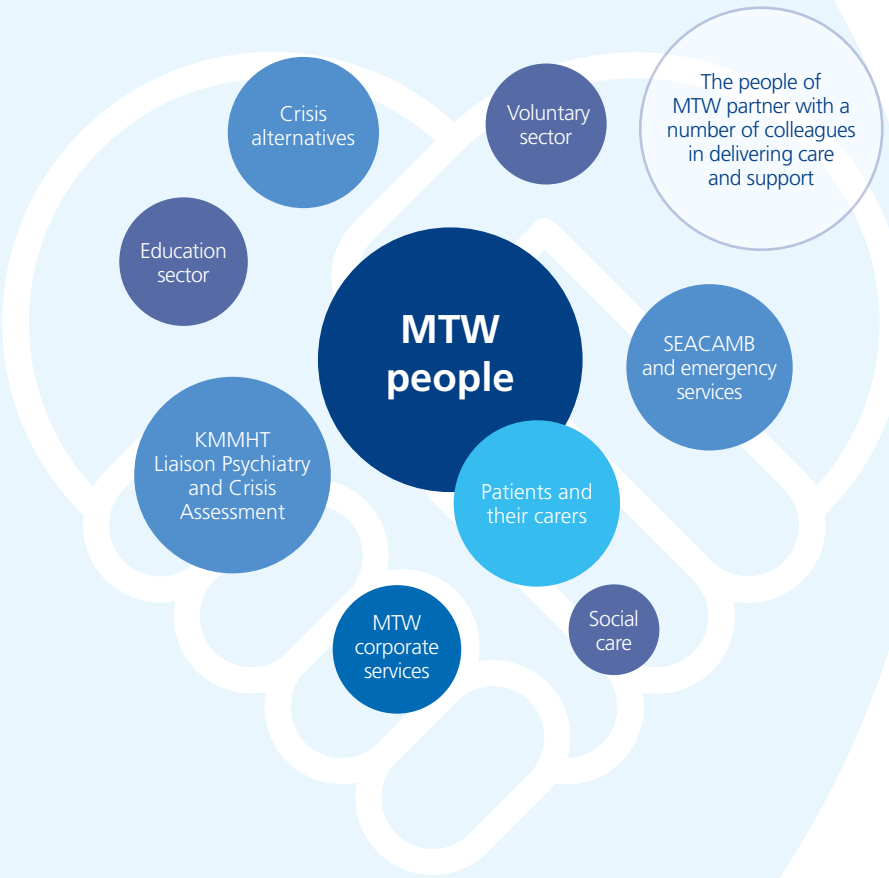
Objective 3
Work collaboratively with patients as 'experts by experience' to inform how we deliver and improve our services.

Objective 2
Review working relationships and embed strong oversight and governance to improve engagement and equity of care provided.

Objective 4
Be clear how particular roles and responsibilities are defined in relation to providing good quality care working with carers, service users, volunteers, staff and partners.

What we are doing already:

- Close working with internal security services to move away from involvement in caring for at-risk patients.
- Working within the system to share good practice and signing up the relevant national programmes (e.g. NHS confederation).
- Adopting an 'all age' vertical approach to care, and working collaboratively when patients move across region to ensure continuity.
- Introduction of a complex case panel (see page 22 for more information).
- Improved governance and interface meetings established and effective.
- Links with partners for Right Care Right Place implementation, and other voluntary sector agencies.
- Work with local education providers on undergraduate programme content.



	The improvements we want to make:	What this will look like:	By when
Year 1	Working with primary care colleagues to avoid Emergency Department admissions when alternative locations more suitable (e.g. crisis alternatives).	A reduction in unnecessary admissions to the Emergency Department.	2026
	Improving internal and external partnerships to ensure consistency in care.	Collaborative working across agencies.	2026
	Refining escalation pathways and communicating same.	Effective escalation decision-making and experience of care for patients	2026
Year 2-3	Improving the transition for patients between children and adult services.	Improved communication and awareness in the period leading up to and during the transition phase.	2027/28
	Ensuring patients have access to specialist advice (e.g. drug and alcohol services).	Effective collaboration with specialist services.	2027/28
	Introducing a number of 'experts by experience' to contribute to service developments into the future.	Co-production with experts with lived experience of wide-ranging mental health conditions.	2027/28
Year 4-5	Continuing to contribute to system-wide efforts on creating a positive mental health culture, acknowledging the 10-year health plan's focus on prevention.	Regular attendance at system meeting addressing broader public health approaches.	2029/30
	Ensuring our work culture continues to represent our PRIDE values.	A strong culture embodying the trust's values.	2029/30

Complex Case Panel *Please be advised this page comes with a trigger warning*

One of our achievements in 2024 and as part of the the build up to this strategy, has been the introduction of a Complex Case Panel.

This innovative process is currently used to support the care planning and management of those 16 years and older with complex mental health needs alongside a diagnosed or undiagnosed neurodiversity need and/or physical health challenges, who may not always have a clear or safe discharge destination.

It involves the meeting of a widespread group of healthcare professionals and partner agencies, the patient or their representatives and local community providers. The aim is ´To work collaboratively in response to a person in crisis to provide a timely and clear action plan to avoid extended stays in hospital.´

A patient account involving the Complex Case Panel:

Miss D is an 18-year-old patient who was admitted to MTW from Cygnet House in Maidstone. She has Emotionally Unstable Personality Disorder and disordered eating. She used to be a cheerleader and felt pressured to look slim with weekly weighing at the club. She recently had undergone a complex transition to adult services and been receiving specialist care in the community for four and a half years. Prior to this admission, she had been an inpatient in Maidstone Hospital and discharged only two days previously. However, having had minimal food in this time she required readmission for dehydration.

In the Emergency Department she was reviewed by an Approved Mental Health Professional and placed under Section 3. The plan was to start tube feeding through her nose and support her return to Cygnet House once fit for discharge. A feeding regime was put in place and Miss D was deemed medically ready for discharge. She was seen by Psychiatry regularly and referred to a specialist eating disorders team for ongoing care. But following assessment this service declined the referral due to her acutely disordered eating. As her initial discharge plan and destination had changed Miss D was referred to a social worker for discharge planning. Multiple other agencies were also involved, and she remained under the collaborative care of the Psychiatry Liaison team and medical team while an inpatient at the hospital.

On the medical ward where she stayed, there was mixed experience in the staff to provide the complex care Miss D required. Mandatory weight monitoring was a constant source of conflict and stress, and Miss D would exercise excessively to burn off her consumed calories. Although Miss D weighed 48.9kg on admission, her self-imposed goal weight was 30kgs. She was often combative during feeding times necessitating security restraint her for wellbeing. This was particularly distressing for her but also the staff.

Miss D continued to lose weight and after several weeks, a full Complex Case Panel was initiated, paving the way for weekly meetings to coordinate care, overseen by the Trust's Head of Mental Health. Eventually Miss D was successfully referred to the specialist centre, ultimately leading to a return to her original destination.

What we reflect on from this account

Positives

- Good collaborative working with MDT and multiple agencies to plan care and discharge.
- Inclusion of the medical team in the MDT meeting to ensure physical and mental parity.
- An individualised care plan was successfully put in place, including a feeding plan that meant Miss D did not have to be told about her weight, and could observe all feeds being prepared.
- Miss D was kept up to date on progress and hurdles in her discharge planning.
- Appropriate use of trained personnel to restrain Miss D during feed times when required.
- Further ward-based training for staff on ad hoc physical intervention was explored.

Negatives

- The identification and management of mealtime distress was not as timely and effective as we would have liked. For example, Miss D later reported that continued talking about her weight gain had a negative impact.
- There were limited alternatives to the use of security staff in restrictive practice with Miss D, which caused not only widespread distress but occasional delays to care.
- The initiation of the complex case panel could have taken place earlier and led to a swifter discharge.
- Other referral centres could have been explored sooner.
- The mixed experience of the staff on a busy medical ward for Miss D's complex needs led to additional challenges.

Takeaway learning and actions:

- Ongoing individualised MDT care plans for complex patients.
- Development of a policy to manage the transition of children with complex needs into adult services.
- Weekly complex case panel discussions for patients with complex needs to manage care and discharge plan.
- Tactical commanders to escalate delays in complex patients via daily system calls.

Our sincere thanks to Miss D for permission to share this story.

Summary

Delivering the Mental Health Strategy 2025-2030 will improve the experience of care for people of all ages using our services, and for the teams delivering their care.

The delivery of this strategy will be monitored through our Mental Health Committee and separate workstreams for each of the priority areas. We will formally review our progress annually to ensure our actions stay on track.

Our thanks once again to everyone who has contributed to the writing of this document.

If you would like this document in an alternative format or language, then please contact the Patient Experience Team at mtw-tr.ppe@nhs.net

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Glossary – useful terms in the reading of this strategy

Analogue	The use of traditionally paper-based systems or processes in healthcare.
Anticipatory care	Involves proactively working with individuals, particularly those with frailty or complex conditions, to plan for their future care needs and preferences.
Challenging behaviours	Any behaviour that poses a risk to the individual or others, significantly reduces quality of life, or interferes with daily activities and social interactions.
Clinical practice	The provision of health or mental health services to patients through the application of medical knowledge, skills, and professional judgment to diagnose, treat, and manage patient care.
Continuous improvement	The ongoing effort to enhance care and services through small, incremental changes to achieve greater quality and efficiency over time.
Dashboard	An information management tool that receives data from linked databases to provide data visualisations.
Data platform	Technology that allows organisations to collect, store, manage, process, and analyse data from various sources, enabling them to extract insights and make data-driven decisions.
Diagnostic overshadowing	The tendency for healthcare professionals to mistakenly attribute a person's physical symptoms or new behaviours to an existing diagnosis, such as a learning disability or mental health condition, rather than considering them as symptoms of an unrelated or co-occurring medical problem.
Digital	Computer and technology-based systems or processes in healthcare.
Directorate	A management or administrative unit within the hospital, responsible for a specific clinical specialty (like surgery or women's services) or support function (such as HR).
Disclosure	The action of making new or secret information known.
Division	The grouping of hospital services and directorates into larger units to manage and deliver care.
Duplication	When an action or process is repeated more than once for no obvious reason or benefit.
Emergency	A serious, unexpected, and often dangerous situation requiring immediate action.
E-referral	An electronic booking and referral system that allows patients and healthcare professionals to manage appointments for care.
Expert by experience	An individual with firsthand, personal knowledge of using, or caring for someone who has used health, mental health, or social care services.
External	Not directly linked to the hospital and based outside of the physical footprint.
Feedback	Helpful information or criticism that is received to inform what can be done to improve a performance, services etc.
Governance	The systems and processes an organisation uses to direct and control itself effectively, ensuring high standards of care, patient safety, and legal compliance.
Handover	The formal transfer of professional responsibility and accountability for a patient's care from one healthcare professional or group to another, either on a temporary or permanent basis.
Health inequalities	The unfair and avoidable differences in health outcomes between groups of people or populations, which can be seen in factors like life expectancy, health conditions, and access to or quality of care.
Incidents	Any unintended or unexpected event or occurrence that has caused or could have caused harm to patients, staff, visitors, or the organisation itself.
Inclusive	Fostering a culture and providing services where everyone, including staff and patients, feel valued, are treated fairly, and have equal access to opportunities and resources, regardless of their background or protected characteristics like age, race, or disability.
Inpatient	A patient who is admitted to a hospital for treatment and needs to stay overnight or for one or more nights.
Internal	From within the physical footprint or directly linked to the hospital.
Long-term condition	A health problem that is not curable at present but can be managed with medication or other treatments, requiring ongoing management over months, years, or even decades.
Maternity	The entire period of pregnancy, including antenatal care, the process of labour and childbirth, and the postnatal care for both mother and baby.
Medication	Prescribed medicines to treat health conditions.
Mental or physical	Describes the state and function of the mind or body.
MRT 'Managing Risk Tool'	A tool to support health and social care practitioners to assess a patient's level of risk and the level of supervision required. It also guides staff as to when Police should be contacted.

National	Relating to or characteristic of a nation; common to a whole nation.
Objectives	Specific, measurable, and time-bound (SMART) goals that define what the organisation, teams, or individuals aim to achieve to deliver high-quality, safe patient care.
Outpatient	A patient who receives healthcare services at a hospital or clinic, such as for a consultation, test, or procedure, but does not require an overnight stay.
Oversight	Assessing performance to ensure public accountability, identify support needs, and drive improvement.
Parity of esteem	The principle of valuing mental health equally to physical health, ensuring that people with mental health needs receive the same priority, access to care, quality of treatment, and respect as those with physical health conditions.
Pathway	The defined route a patient takes through a healthcare service, from initial contact to treatment and beyond.
Patient stories	Personal, detailed accounts of individuals' experiences with healthcare services, capturing both positive and negative aspects of their journey.
Perinatal	The time from conception through to about 12 months after giving birth.
Policy	A mandatory, written statement of intent from a Trust or organisation that sets out a broad approach or principle for a particular issue, guiding staff in their decisions and actions to ensure consistency, compliance with legislation and best practice.
Postpartum	The time immediately following childbirth.
Preceptorship	a structured support period for healthcare professionals as they transition from student to autonomous practitioner.
Procedure	Clinical intervention or a standardised series of actions performed by a care professional on a patient to prevent, cure, relieve, or diagnose disease.
Provider	Any organisation that delivers health and care services to patients, such as NHS trusts, GP practices, and independent hospitals.
Psychiatric	Relates to psychiatry, the medical field focused on the diagnosis, treatment, and prevention of mental health conditions, particularly severe ones.
Psychosis	Relates to psychiatry, the medical field focused on the diagnosis, treatment, and prevention of mental health conditions, particularly severe ones.

Reasonable adjustments	A change to a service, policy, or physical environment that removes or reduces a disadvantage for a person with a disability, ensuring they have equal access to healthcare.
Restrictive practice	Any intervention or practice that restricts a person's movement or freedom to act, to control a dangerous situation where there is a risk of harm to the person or others.
Safe haven	A dedicated facility offering out-of-hours support for people with mental health crises, providing a safe alternative to A&E.
Safe space	A supportive space within the hospital footprint.
Soft signs	Subtle, early indicators that a patient may be becoming unwell or deteriorating in health before more obvious physiological changes are observed.
Stigma	The devaluation and discrediting of an individual due to a health condition, mental illness, or social attribute. It involves negative attitudes, labels, and social exclusion that can lead to discrimination, causing people to feel shame, low self-esteem, and reluctance to seek help.
Streamlining	The movement of patients through the different stages of required hospital care and considers whether they are subject to unnecessary delay.
Syllabus	The basis for the preparation of detailed training modules.
System	A collection of providers and groups that work together towards a shared purpose such as patient care or improving public health.
Temporary workforce	Staff employed to fill short-term gaps in permanent roles.
Transfer	The physical movement of a patient from one care setting or specialty to another.
Transition	A planned and gradual process that supports young people to move from children's services to adult services and become more independent in managing their healthcare needs.
Triage	The process of assessing a patient's condition or request to determine the urgency of their need and the most appropriate clinical pathway or clinician for their care.
Triangulation	The process of combining data from multiple, diverse sources to gain a more complete and accurate understanding of a complex situation, issue, or performance.
Validation	Confirmation that patients waiting for appointments still require the appointment.

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

Fordcombe Hospital
Fordcombe
Tunbridge Wells
Kent, TN3 0RD

01892 740047

10.2025 – 1092 V1

Title of report	**2024 Adult Inpatient Survey**					
Board / Committee	**Trust Board Meeting (Part 1)**					
Date of meeting	30October 2025					
Agenda item no.	10-13					
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)					
					
✓	☐	☐	✓	✓	✓

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The report outlines the Adult Inpatient Survey undertaken by Picker Institute for Maidstone and Tunbridge Wells NHS Trust (MTW) for the Care Quality Commission (CQC) in 2024. A sample was collected of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. 537 completed questionnaires were returned from the sample of 1250 for MTW (46% final response rate for the Trust). The report provides a summary of Trust findings from the survey compared to national average for all Trusts in England. Benchmark report is not available at time of this meeting. Therefore, comparison between local hospitals and regions is not available.
Any items for formal escalation / decision	5 new recommendations have been identified for the Trust. • Individual needs: Staff taking into account patients' individual needs; Religious needs • Individual needs: Staff taking into account patients' individual needs; cultural needs • Individual needs: Staff taking into account patients' individual needs; language needs • Leaving hospital: Family/ Carers being involved in discussions about leaving hospital • Leaving hospital: Patients being involved in discussions about them leaving hospital
Appendices attached	Summary Slides attached

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

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 outcome. PR4- Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation. PR5- If we do not work effectively as a system, patients that are no longer fit to reside will remain within MTW for longer which may result in deterioration and poor clinical outcomes
Links to Trust Risk Register (TRR)	1301- Failure to meet national targets for complaints performance
Compliance / Regulatory Implications	Nil

Executive Team Meeting (ETM)

Adult Inpatient Survey 2024 results update.

Reason/s for submission to the ETM (delete the tick for any that do not apply):

Decision	
Discussion	✓
Information	✓
Other (state)	

Link to corporate breakthrough objective/s (delete the tick for any that do not apply):

Reduce complaints re poor communication		Increase discharges by 12pm	
Reduce patient falls to 6.5 per 1000 OBD		Reduce premium workforce expenditure	
Achieve planned levels of new outpatient activity		Reduce staff turnover to 12%	

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

This report details the findings of the 2024 Adult Inpatient Survey and the associated actions and ongoing oversight and monitoring.

The national adult inpatient survey is held annually and captures the experience of patients over the age of 16 who have spent at least one night in hospital. This excludes patients who are admitted to maternity units or psychiatric units.

For 2024 the sample of patients was taken from patients discharged during November 2024

537 completed questionnaires were returned from the sample of 1250 for MTW (46% final response rate for the Trust). This was an increase compared to 43% response rate in 2023 and 41% in 2022.

Survey results show that patient **experience was best** in the following areas:

1. Patients being able to sleep at night
2. Availability of food outside of set mealtimes
3. Effective communication regarding ward moves

Areas where patient **experience could improve** are:

1. Staff taking into account patients' individual needs, including religious, cultural and language needs
2. Involvement of patients and families in decision and discussions about the patient leaving hospital

Who took part in the survey for MTW?

NHS Maidstone and Tunbridge Wells NHS Trust

1250 invited to take part

537 completed

68% urgent/emergency admission

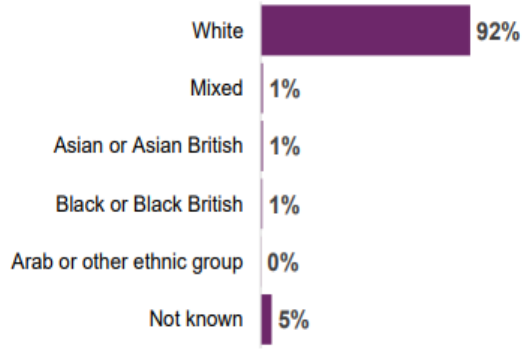
32% planned admission

46% response rate

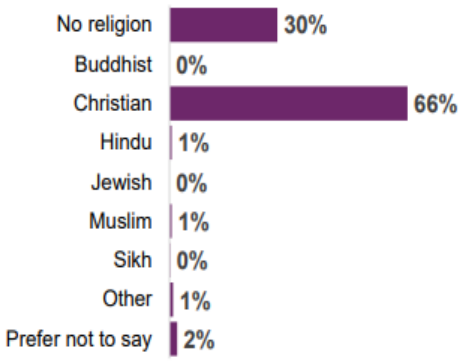
41% average response rate for all trusts

43% response rate for your trust last year

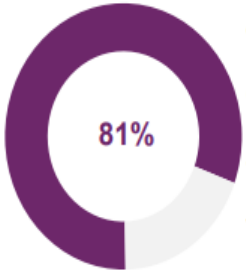
Ethnicity



Religion



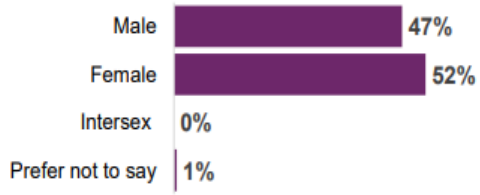
Long-term conditions



of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

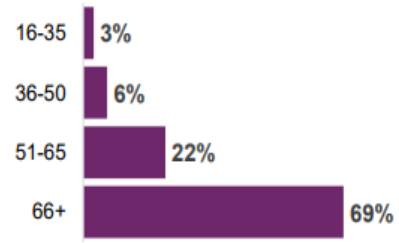
Sex

At birth were you assigned as...



1% of patients said their **gender is different from the sex they were assigned with at birth.**

Age



Headline results for MTW: Summary areas of good practices and areas to improve for MTW.

Where patient experience is best

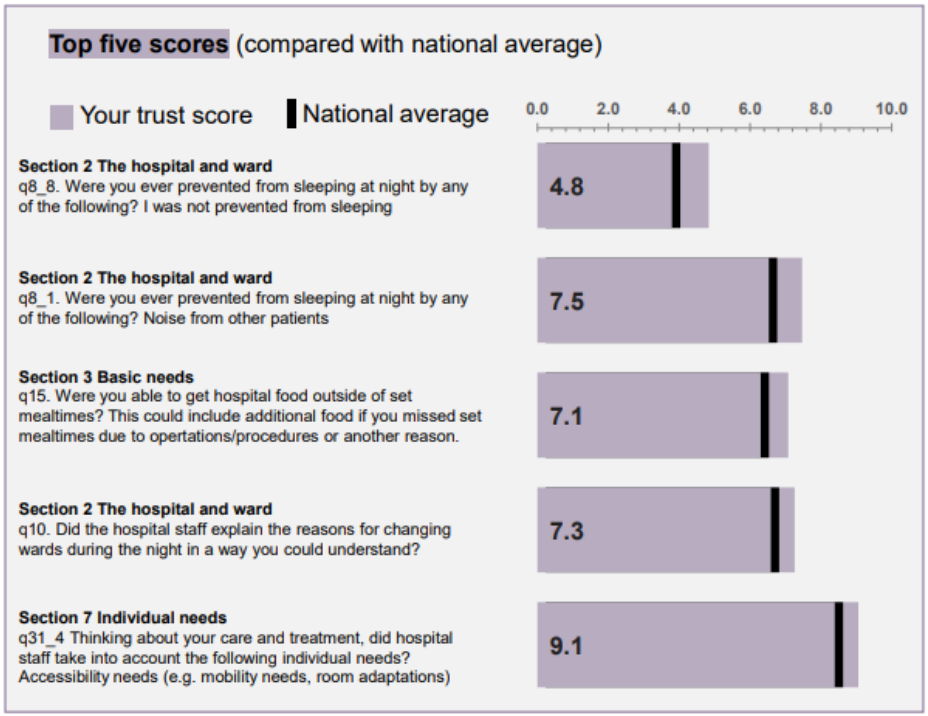
- ✓ **Sleeping:** Patients not being prevented from sleeping at night
- ✓ **Sleeping:** Patients being prevented from sleeping at night due to noise from other patients
- ✓ **Food:** Patients being able to get hospital food outside of set mealtimes
- ✓ **Explaining change of wards:** Reasons for changing wards explained in a way they can understand
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Accessibility needs

Where patient experience could improve

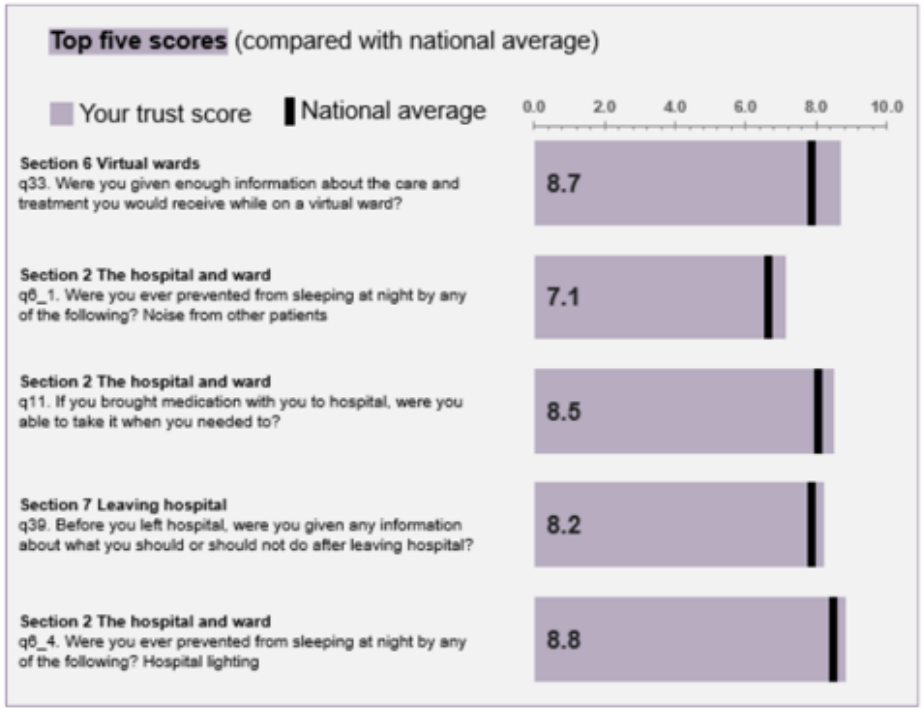
- **Individual needs:** Staff taking into account patients' individual needs: Religious needs
- **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- **Individual needs:** Staff taking into account patients' individual needs: Language needs
- **Leaving hospital:** Family / carers being involved in discussions about the patient leaving hospital
- **Leaving hospital:** Patients being involved in decisions about them leaving hospital

MTW top five scores (compared with national average)

2024 top five scores



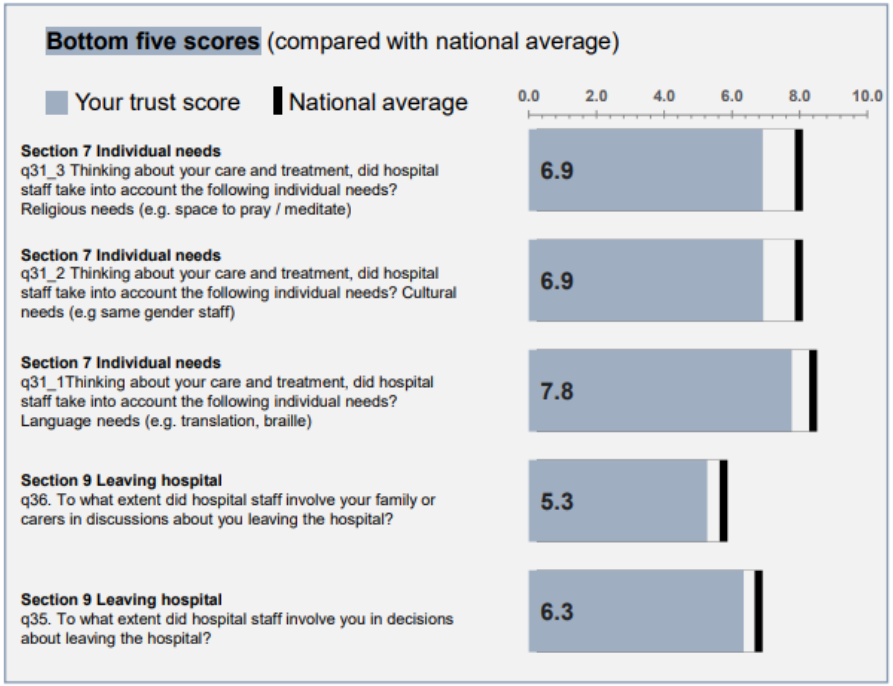
2023 top five scores



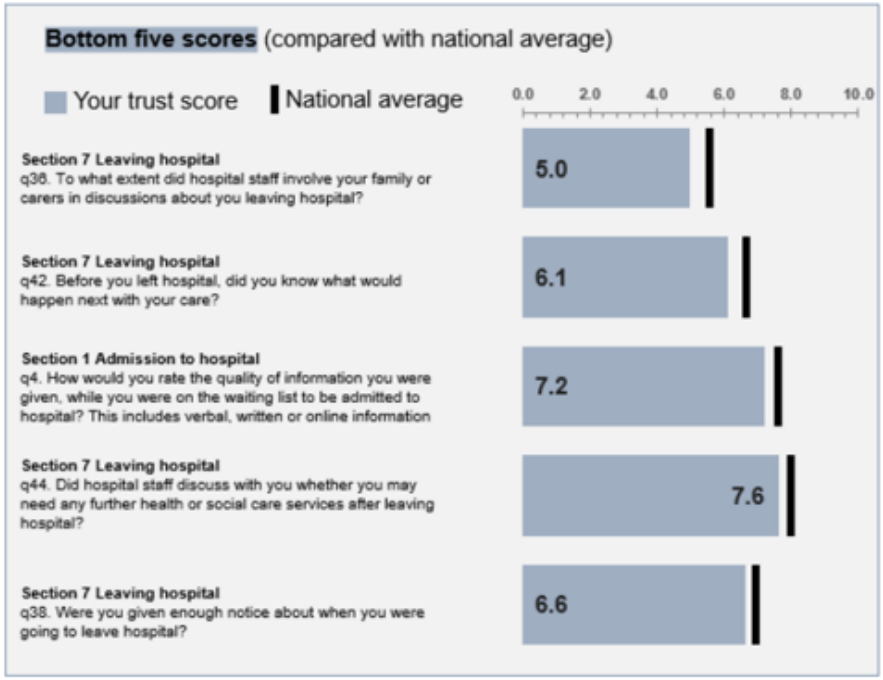
Adult Inpatient Survey 2023 | RWF | Maidstone and Tunbridge Wells NHS Trust

MTW bottom five scores (compared with national average)

2024 bottom five scores



2023 bottom five scores

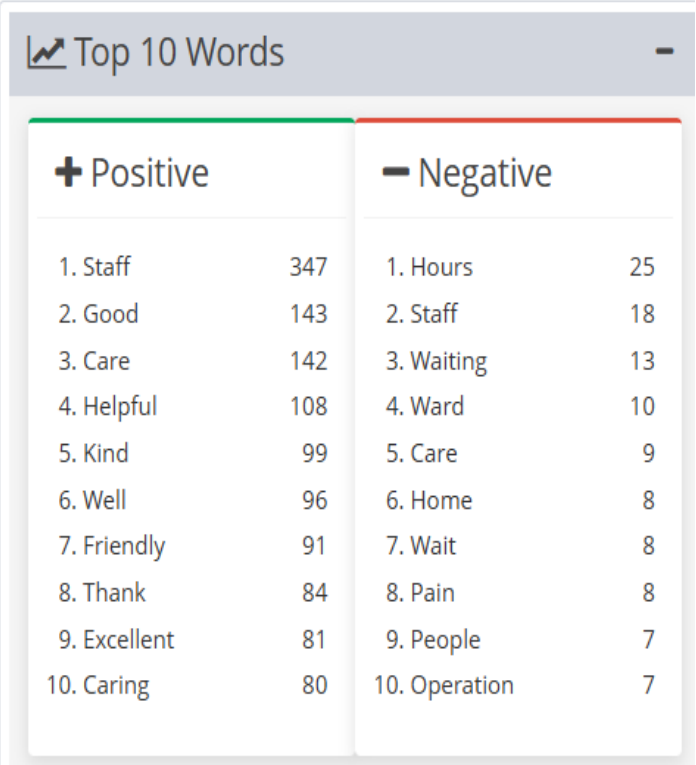


See appendix for detailed responses and comparisons

2024 Findings

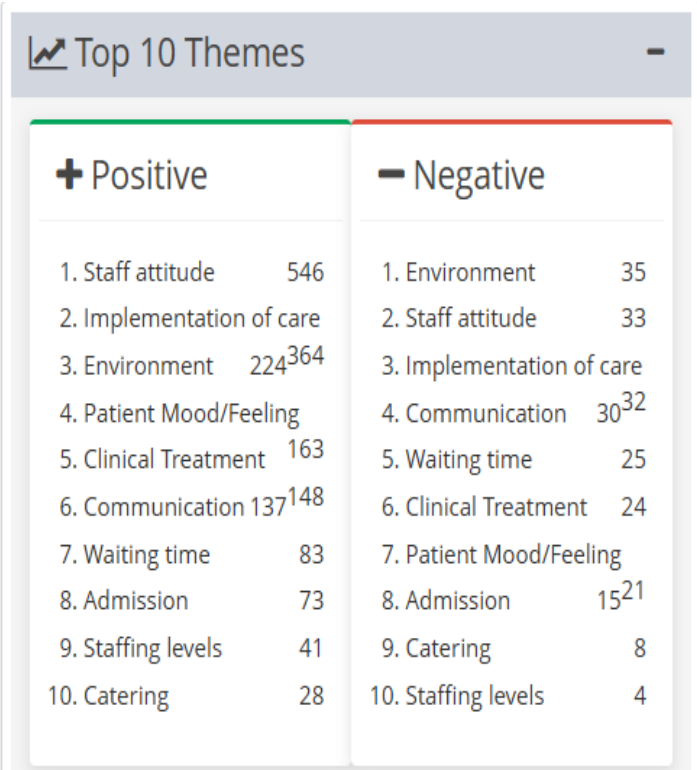
- Improvement in the opportunities available to patients and families to give feedback
- Continued positive experience regarding sleeping at night
- Availability of food has improved in comparison to previous years results.
- Actions related to communication about discharge have not translated to an improvement in the way patients and families feel about involvement in discharge planning

Triangulation with Friends and Family Test (FFT) feedback received November 2024.



Top 10 Words

Positive		Negative	
1. Staff	347	1. Hours	25
2. Good	143	2. Staff	18
3. Care	142	3. Waiting	13
4. Helpful	108	4. Ward	10
5. Kind	99	5. Care	9
6. Well	96	6. Home	8
7. Friendly	91	7. Wait	8
8. Thank	84	8. Pain	8
9. Excellent	81	9. People	7
10. Caring	80	10. Operation	7



Top 10 Themes

Positive		Negative	
1. Staff attitude	546	1. Environment	35
2. Implementation of care		2. Staff attitude	33
3. Environment	224[364]	3. Implementation of care	
4. Patient Mood/Feeling		4. Communication	30[32]
5. Clinical Treatment	163	5. Waiting time	25
6. Communication	137[148]	6. Clinical Treatment	24
7. Waiting time	83	7. Patient Mood/Feeling	
8. Admission	73	8. Admission	15[21]
9. Staffing levels	41	9. Catering	8
10. Catering	28	10. Staffing levels	4

Whilst FFT does not ask the exact same questions as the inpatient survey there is alignment in what this data is also reporting e.g. environment, catering and communication

Next Steps

- Triangulation of findings with FFT, complaints, PALS, other national surveys and PLACE results
- Evaluate findings against Trust Experience of Care strategy
- Development of initial action plan in response to findings
- Coordinate existing work streams relating to discharge
- Continue to capture patient feedback via multiple routes
- Monitor and report via Experience of Care Oversight Group and Quality Committee

Action Plan

Next Steps: Recommendations	Actions- Assurance provided at the Experience of Care Oversight Group which reports to the Quality Committee	Timeline	Monitoring group	Lead(s)
Individual needs: Staff taking into account patients' individual needs: **Religious needs.** How: Co-production and partnership with different communities, staff and faith leaders	The spiritual and religious care policy is being updated. Trust is now able to run a paginated report on different religions to enable targeted patients visit by chaplains and volunteers. Referrals to chaplaincy team can now be tracked via sunrise. Partnering with community and faith leaders to support diverse groups	March 2026	End of Life Care Steering Committee	Lead Chaplain
Individual needs: Staff taking into account patients' individual needs: **Cultural needs.** How: Co-production and partnership with different communities, staff and faith leaders	Staff training and awareness in culturally sensitive care Provision of diverse meal options Adapting treatment to personal belief e.g. blood transfusion Partnering with community and faith leaders to support diverse groups to identify what patients, carers and relatives want incorporated in daily care planning...	Ongoing as part of staff education In place Ongoing	Practice development team meetings. Nutrition and Hydration committee Patient Experience Steering group	Divisional & Educational teams Catering teams Divisional teams Experience of Care Team
Individual needs: Staff taking into account patients' individual needs: **Language needs.**	Review of the translation and interpretation services is currently ongoing... Translation and interpretation policy has been updated. Completion of the self-assessment against the NHS improvement framework: community language translation and interpreting services	Dec 2025 Completed March 2026	Patient Experience Steering group	Experience of Care lead

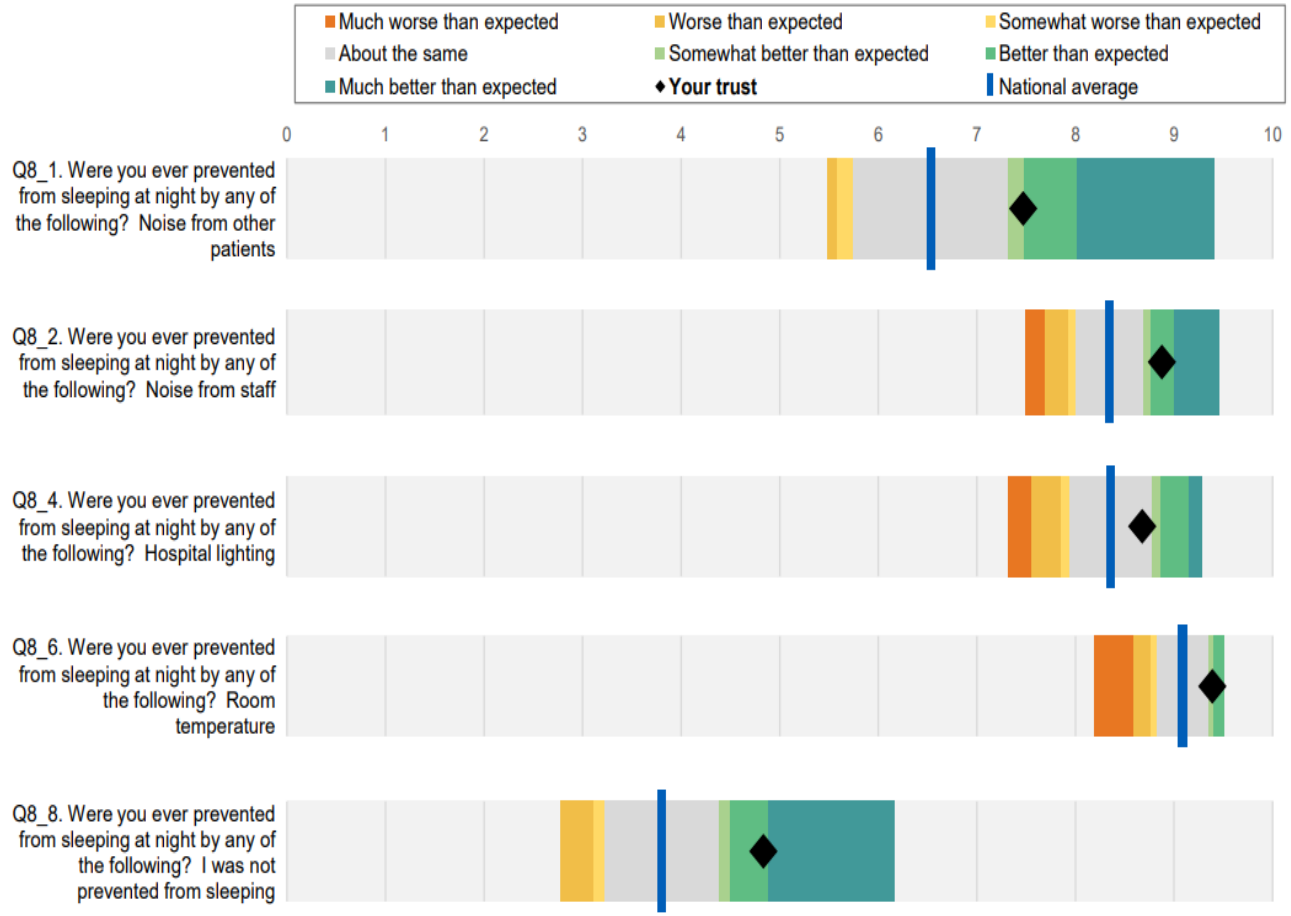
Action Plan

Next Steps: Recommendations	Actions- Assurance provided at the Experience of Care Oversight Group which reports to the Quality Committee	Timeline	Monitoring group	Lead(s)
Leaving hospital: Family / carers being involved in discussions about the patient leaving hospital	This is an existing action from the 2023 survey... Wherever possible endeavour to establish a single point of contact amongst families to act as liaison... For complex discharges consider instigating meetings to include families/carers thereby ensuring that it is a collaborative process wherever possible.	Ongoing improvement programmes of work.	Operational flow directorate meeting group	Divisional/ Complaints and PALS teams Divisional/ Complex Case Panels
	Focus on virtual wards/ hospital at home and discharge pathways. Transfer of Care Hub to plan timely and safe discharges.			Flow team (Deputy Chief Operating Officer)
Leaving hospital: Patients being involved in decisions about them leaving hospital	This is an existing action from the 2023 survey. Ensure that patients are informed of discharge plans at the earliest opportunity. 'Better use of beds' programme in collaboration with KCHFT- management and discharge pathways for orthopaedic and mental health patients Transfer of Care Hub to plan timely and safe discharges	Ongoing improvement programme of work.	Operational flow meeting group	Flow team (Deputy Chief Operating Officer)

APPENDIX

Headline results for MTW: Results and comparison for areas of good practice where patient experience is best.

Hospital and Ward- Sleeping



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Somewhat better than expected: 527	7.5	6.5	5.5	9.4
Better than expected: 527	8.9	8.3	7.5	9.5
About the same: 527	8.7	8.4	7.3	9.3
Somewhat better than expected: 527	9.4	9.1	8.2	9.5
Better than expected: 527	4.8	3.8	2.8	6.2

Headline results for MTW:
Results and comparison for areas of good practice where patient experience is best.
Hospital and Ward- Change of wards

About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
65	7.3	6.6	5.2	9.0

Basic needs- Obtaining food outside of set mealtimes

About the same

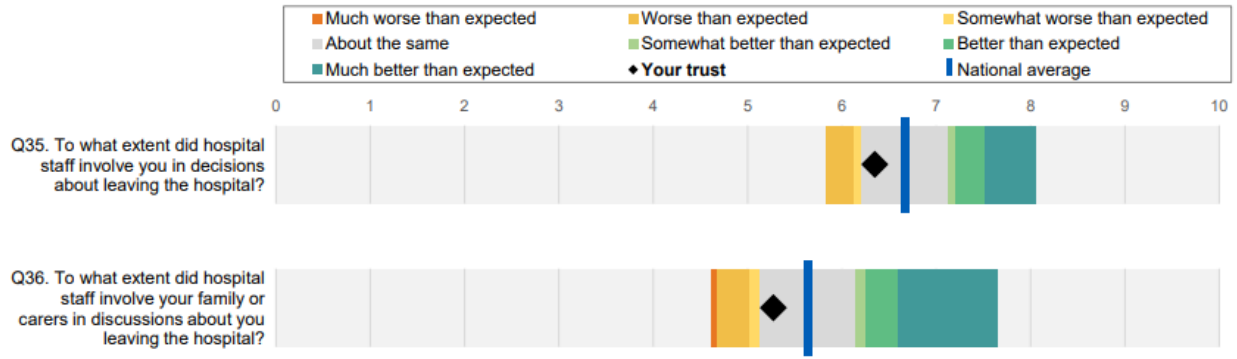
237	7.1	6.3	4.6	8.5

Headline results for MTW:

Results and comparison for areas where patient experience could improve: Individual needs

Question scores

	Number of respondents	Your trust
Q31_1. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)	50	7.77
Q31_2. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Cultural needs (e.g. same gender staff)	56	6.93
Q31_3. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)	42	6.91



		Number of respondents	Your trust	All trusts in England: National average	All trusts in England: Lowest score	All trusts in England: Highest score
Q35. To what extent did hospital staff involve you in decisions about leaving the hospital?	About the same	514	6.4	6.7	5.8	8.1
Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving the hospital?	About the same	371	5.3	5.6	4.6	7.7

Title of report	**Six-monthly update on the implementation of the sexual safety in healthcare charter**					
Board / Committee	**Trust Board**					
Date of meeting	30th October 2025					
Agenda item no.	10-14					
Executive lead	Helen Palmer, Chief People Officer, Jo Haworth, Chief Nurse					
Presenter	Helen Palmer, Chief People Officer, 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)	This report details the relevant updates in relation to the implementation of the sexual safety in healthcare charter since the last report.		
Any items for formal escalation / decision	None		
Appendices attached	None		
Report previously presented to:			
Committee / Group		Date	Outcome/Action

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employer • PR2: If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 1200 – Potential for harm as a result of trauma – impact on wellbeing • 3371 – Risk that usage of temporary staffing above targeted levels in the NHSE 2025/26 operational planning guidance could impact on financial sustainability, as there is a cost implication that could also affect staff and patient experience
Compliance / Regulatory	Please list any compliance or regulatory matters raised or addressed by this report

Implications	• Annual sexual safety risk assessment • Worker Protection (Amendment of Equality Act 2010) Act 2023

Sexual Safety Update

19th September 2025

Helen Palmer - Chief People Officer

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Summary of Report

- In September 2023, the Sexual Safety Charter was published by NHS England with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace and identified a need for regular board assurance to be established reporting jointly by the CPO and CNO, every NHS trust and ICB has signed up to the charter.
- Whilst no major concerns are highlighted in our risk assessment and reported cases are very low there is a gap in reporting of sexual harassment identified through the staff survey with approx. 336 staff saying they experienced some form of unwanted sexual behaviour versus 7 reported cases in last 6 months.
- While more cases have been reported in the last 6 months (7) than the first 6 months of signing the charter (4) there is a need to clarify and proactively communicate how to report harassment and what happens to demystify the process and reduce fears about speaking up.
- We need to be mindful of those staff that maybe more at risk or vulnerable and ensure targeted engagement working with our established staff networks.
- Sexual Safety cases in the workplace are often extremely sensitive and can be complex so it is vital our ER team and Investigating Managers are properly trained and supported in handling of these cases when they occur, this training was delivered in May 2025 from our employment lawyers
- Regularly monitoring and assurance has now been established and a range of actions identified and agreed including education, support and practice engagement and communication
- There is commitment from the System for ongoing sharing of knowledge and resources-recognising our Mental Health and Community colleagues who often deal with more cases and have specialist roles, training and skills well established

Sexual Safety Charter-Update from Feb 2025

- On the 4th September 2023 NHS England published its first sexual safety charter. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this.
- Trusts were asked to review and sign up and this was agreed by the MTW Trust Board
- CPO & CNO then wrote to all MTW staff on the introduction to the charter
- A number of key actions were agreed to be in place by July 2024 of which MTW was 100% compliant
- This included looking at the data from New questions in the 2023 National Staff Survey about staff experience of sexual harassment from patients and colleagues which was shared and discussed with ETM and JCF
- On October 26, 2024, the Worker Protection (Amendment of Equality Act 2010) Act 2023 came into effect, placing new obligations on employers to prevent sexual harassment in the workplace, to coincide with this NHS England shared a number of resources to support providers including training, policy templates and guidance
- A Risk Assessment was completed by a MDT including Employee Relations and Safeguarding to ensure we are actively managing risk appropriately-this will be a reviewed annually
- An ICS group has been established and is meeting to share resources and support-acknowledging that colleagues in Mental Health and Community have deeper experience that the whole system can benefit from

Sexual Safety Charter-Update from NHSE

- On the 20th August 2025 NHSE wrote to all Trusts and ICBs asking them to take further actions to identify and act against potentials perpetrators of sexual misconduct this included:
  - Completing a self-assessment against the NHSE assurance framework
  - Encouraging staff to complete the e-learning on sexual misconduct
  - Complete specialist training for ER/HR teams
  - Review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers / hosts
    - Including investigation findings DBS information, patterns of behaviour
    - Misconduct through a patient safety lens as well as an HR process
  - Ensure ESR is up to date with ongoing and complete investigations
  - Review chaperoning policies
  - Engage EPR suppliers to monitor unusual access to patient records

Sexual Safety Data

National Staff Survey Data-2024

	24	23	Change	Comparator group avge
In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public?	6.4% (1 or more times) 219 staff	7.0%	Marginal positive improvement	7.9%
In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues?	3.4% (1 or more times) 117 staff	4.2%	Marginal positive improvement	3.7%

Employee Relations Data-last 6 months March – Sept 25

Division	Cases in last 12 months	Patient/Visitor/Staff	Outcome
Cancer	0		
Medicine	1	Staff to Patient	No case to answer
Women's	0		
Core Clinical	1	Staff to Staff	Upheld
Surgery	0		
Corporate inc BSS	2 (1 employee)	Staff to Patient Staff to Staff	Final Written Under investigation
Estates and Facilities	3	Staff to Patient x2 Staff to Staff	2 resignations Complaint withdrawn
Wells Health	0		

Sexual Safety-Analysis

- Reported ER cases and Inphases are very low, however Staff Survey responses highlight a greater number of sexual harassment incidents occurring from both staff and patients going unreported through our formal channels. Divisionally this was most prevalent in Medicine and Emergency and Therapies from patients and public and Estates and Specialist Surgery from staff

- The MDT risk assessment was conducted by Safeguarding and ER and agreed with wider range of supporting colleagues highlighted no current unmitigated risks at MTW on the set criteria

- Those with protected characteristics of being gay and lesbian and those from a mixed or multiple ethnic background report higher instances of harassment in the staff survey particularly from service users and members of the public, highlighting the role of bystanders, colleagues and managers is especially important in creating preventative team and organisational cultures.

- Through the People Promise Civility and Respect project data from all available data sources was triangulated. Whilst numbers were low, this further backed up the view that many instances of unwanted sexual behaviour go unreported and fear of speaking up, shame and lack of understanding on how and when to report contributes to this.

- Although not a lot of communication and engagement regarding sexual safety has been done previously at MTW to evaluate, what has delivered has been well received. Eg-Personal safety sessions delivered by the conflict resolution team. Recently female staff have posted on the Facebook group regarding feeling vulnerable on the grounds at night.

- In looking at sexual safety, staff have also raised issues relating to feeling safe from allegations of a sexual nature when delivering patient care and there is some inconsistency in how this is addressed in different services.

Sexual Safety Charter-Action Plan

	Governance & Reporting	Education & Support	Engagement & Comms
Completed	Establish a by annual reporting structure for Board Assurance jointly from CPO/CNO Annual risk assessment led by ER & Safeguarding K&M ICS working group established	National E learning on Sexual Safety available to all via MTW Learning Sexual Safety added to EDI Bystander/Upstander training Specialist External Wellbeing support sourced for signposting and direct referral Specialist training sourced and delivered for ER team then rolled to Investigating Managers-Procurement stage Sharing of resources and training across K&M ICS-Ongoing	Sexual Safety Charter signed and communicated to all staff Discussion and reporting of staff survey questions at ETM JCF (2023 results) Updated Specialist Wellbeing signposting and resources on intranet
Under way / Ongoing	Triangulation of data from Staff Survey, Inphase, ER & FTSU as part of Civility & Respect project-Completion Delayed November 2025 Review reporting process and timeline for staff reporting sexual harassment Review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers / hosts Review chaperoning policies Engage EPR suppliers to monitor unusual access to patient records	Sharing of resources and training across K&M ICS-Ongoing Leadership Masterclasses on addressing unwanted behaviours/banter at work	Sensitive proactive communications via PPE project & Wellbeing & Safety-Ongoing Sharing and codesigning actions with senior leaders and staff impact council – Delayed November 2025 Work with staff & peer networks to identify intersectional and vulnerable groups-targeted proactive interventions Regular touch points triangulation of data, themes and actions (People/Quality & Safety/Security etc) – Bi annually

Conclusion and Recommendations

- Whilst no major concerns are highlighted there is a gap in reporting of unwanted sexual behaviours, the changes in the law also put an obligation for employers to be proactive in preventing sexual harassment at work.
- There is a need to clarify and proactively communicate how to report sexual harassment at work and what happens to demystify the process and reduce fears about speaking up.
- We need to be mindful of those staff that maybe more at risk or vulnerable and ensure targeted engagement and support.
- Sexual Safety cases in the workplace are often extremely sensitive and can be complex so it is vital our ER team and Investigating Managers are properly trained and supported in handling of these cases when they occur.
- Focused preventative work will be undertaken in areas where there is under reporting but research shows are likely to be places where sexually inappropriate behaviour (e.g. what may be considered 'banter') is more likely to occur.
- Research shows that there is a significant impact on all parties when accusations of a sexual nature are raised and investigated. Although support of offered to all those involved, this will be looked at again and adjustments made where necessary.
- Trust induction covers elements of behaviour but these will be looked at in the context of sexual safety.
- Regular monitoring and assurance has now been established and a range of actions identified and agreed for delivery this year.

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**					
Date of meeting	30th October 2025					
Agenda item no.	10-15					
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)					
					
✓	✓	✓	✓	✓	✓

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. Across the ICB change is taking place to streamline governance and reset several meeting forums. Further work is expected on this and will be guided by the ICB executive team led by Adam Doyle, the new CEO.
Any items for formal escalation / decision	None
Appendices attached	ICB/HCP slide pack West Kent HCP work programme update report System Partnership review

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

ICB and West Kent HCP update

October 2025

Exceptional people, outstanding care

ICB/ System news

- The new ICB CEO, Adam Doyle, has now taken up his post. He joins us from NHS Sussex, where he has been the CEO for nine years and most recently, been on secondment to NHS England as the National Director for System Development.
- We have responded, as a group of providers, to an opportunity to comment on the local government reorganisation. In summary, we have strongly supported a Local Authority reorganisation that prioritises boundary alignment with HCP areas to deliver sustainable, person-centred services and advance NHS shifts in delivery.
- The provider collaboratives have been reset with the community and mental health/LD collaboratives coming together to form the new Sustainable Community Care Board. This re-launched at the end of August with a workshop and the first Care Board took place on 20th October. The Board is chaired by Mairead McCormick and Sheila Stenson. The acute provider collaborative is now being led by Tracey Fletcher. Both will report into the CEO group and the now established K&M Joint Committee.

West Kent HCP

- The last West Kent Development Board took place on 16th October with the most recent executive meeting on 9th October.

- The Development Board considered a number of items including the Better Care Fund, Better Use of Beds including the impact of the reduction of the Additional Capacity Fund (ACF), the WK delivery plan progress (attached) and the System Partnership Review outcome (attached).

- Examples of progress are the continued roll out of the digital front door in primary care which is now live in Tunbridge Wells, Malling, The Ridge & Athena PCNs and delivery in progress in all other WK PCNs. Reactive Frailty INT's are now in place in The Ridge PCN, Tonbridge PCN and Sevenoaks PCN Care Home Huddles live in 4/5 care homes. A Proactive Frailty INT was commenced in the ABC PCN in September.

Risks and challenges

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

Title of report	**Freedom To Speak Up Guardian Report Q2 (July – September 2025)**					
Board / Committee	**Trust Board**					
Date of meeting	30th October 2025					
Agenda item no.	10-16					
Executive lead	Helen Palmer, Chief People Officer					
Presenter	Helen Palmer / Wayne Wright, 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)	This is the quarterly report for the period July 2025 to September 2025, presented to ETM by the Freedom To Speak Up Guardian (FTSU). The purpose of this report is to identify trends, address issues, and provide a progress update on the Freedom to Speak Up function. During this quarter, 59 concerns were raised. The most reported location was Maidstone, followed by Tunbridge Wells. Divisional breakdown highlights Unknown (due to anonymity) and MEC as the divisions with the highest number of cases. Concerns were received through various routes, including direct contact with the FTSUG, anonymous portal logs, safe space champions, and staff side conversations. This report provides a detailed analysis of these concerns and associated trends.
Any items for formal escalation / decision	
Appendices attached	• There are no appendices in this report

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

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR1: Failure to attract and retain a culturally diverse workforce may prevent the organisation from achieving its ambition to be an inclusive employe
Links to Trust	993 – Continued dependency on bank and agency staff following

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

Introduction

This quarter has seen a sustained escalation in concern across the Trust, with a total of 59 Freedom to Speak Up (FTSU) cases, compared to 63 last quarter.

Reporting patterns have been notably turbulent, reflecting the ongoing transformation programme. Periods of limited contact have been followed by sudden spikes in activity, which appear to correlate with major all-staff announcements. Reporting often dips immediately after communications about organisational change, suggesting a wider sense of unease as the Trust transitions from Phase 1 into the formal consultation period of Phase 2.

Despite this volatility, the FTSU service has remained proactive and strategically engaged. Targeted outreach has supported high-pressure teams to develop bespoke listening initiatives and local support plans. In parallel, FTSU has collaborated closely with the Employee Experience and Transformation workstreams to co-develop accessible educational content designed to promote transparency and awareness.

At a national level, MTW's cost-saving FTSU model was shared via NHS Elect as part of wider system learning.

Q2 2025 Data Collection

Q2 2025 Data Collection

Total Concerns Logged: 59

Theme	Number
Bullying and Harassment	16
Health and Safety	15
Other	19

Patient Safety	9
Fraud	0
Total	**59**
Tranformation	**23**

Reporting Patterns

A notable increase in anonymous reporting was observed this quarter. While not unexpected during periods of organisational change, it is indicative of reduced psychological safety. Staff clearly wish to be heard, but some remain uncertain about whether they will be protected or supported.

It remains important to clarify that protection from detriment applies only where it can be evidenced that an individual's treatment or employment has been negatively affected *because of* their disclosure. It does not provide protection from wider strategic changes or organisational restructuring.

Despite the increase in volume and complexity, most cases were managed and closed within one month of receipt, demonstrating a robust and responsive case-handling process. At the time of reporting, eight cases remain open, comprising:

- One historic case undergoing longer-term review.
- Three cases under surveillance, with FTSU supporting new managers through resolution and learning.
- Three active cases with leadership oversight.
- One case managing the consequences of detriment.

Breakdown by Theme

Behaviour and Civility

Concerns relating to bullying, undermining, belittling, and exclusionary behaviour remain the largest thematic category this quarter. The intensity and complexity of these cases have increased in tone since the start of the transformation. Several reports reflect a decline in local resolution confidence, highlighting the continued importance of Kindness and Civility initiatives and leadership modelling of respectful behaviour.

Transformation

Concerns linked to the Transformation Programme were raised consistently. Themes included the emotional impact of uncertainty, perceived unfairness, inconsistent information flow, and a lack of clarity around Phase 2 consultation processes.

Staff feedback reflects a shift from initial uncertainty (Q1) to fatigue, mistrust, and frustration. There remains limited confidence in leadership transparency, particularly around redeployment and communication timing.

Process and Governance Concerns

Concerns have been raised about governance and its impact on key services. Due to the amount of transformation happening lots of services are changing. There have been lots of reports of individuals who feel their job description does not match the extent of the work they do, meaning when redeployment, or automatic slotting has taken place, they are unable to attain the full breadth of skills. There are acting up arrangements without formal documentation, concerns around disciplinary processes feeling inconsistent and finally recruitment irregularities as they move into redeployment.

Equality, Diversity and Inclusion

There has been a small rise in reports of discriminatory or racist language, from both staff and public-facing roles. Concerns also included non-inclusive job descriptions and reports of nationalist slogans being used in some areas, leaving members of our global majority staff feeling intimidated.

While numerical frequency has reduced since last quarter, the emotional intensity and seriousness of these cases have increased. Some staff continue to express limited confidence in management's ability to handle EDI breaches objectively.

Patient Safety

Concerns were raised about clinical safety within transformation, specifically relating to decisions made by leaders who may lack full clinical context in extremely nuanced areas. Staff also reported anxiety about patients being admitted to inappropriate wards due to bed pressures, such as low-risk patients in high-intensity wards or mental-health patients in unsuitable environments.

Outreach and Proactive Work

Despite the unpredictable reporting pattern, several key pieces of strategic work have progressed this quarter:

- **Targeted Outreach:** Capacity was used to engage with specific teams under pressure, resulting in the development of tailored listening initiatives and staff action plans.
- **Transformation Collaboration:** FTSU has worked closely with the transformation workstream to support staff, including the creation of short, accessible videos explaining available services and the role of elected staff representatives.
- **National Sharing of Best Practice:** MTW's cost-saving model for FTSU was shared via NHS Elect, contributing to wider system learning and supporting other Trusts to embed culture change within financial constraints.

- **Future Communications Planning:** In response to the recent announcement regarding the closure of the National Guardian's Office, preparatory work has begun on internal messaging to reassure staff and maintain continuity of the speaking up service.
