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

Thu 18 December 2025, 09:15 - 12:00

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

Agenda

09:15 - 09:16
1 min

12-1
To receive apologies for absence

Annette Doherty

09:16 - 09:16
0 min

12-2
To declare interests relevant to agenda items

Annette Doherty

09:16 - 09:16
0 min

12-3
To note progress with previous actions

Annette Doherty

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

Patient Experience

09:16 - 09:41
25 min

12-4
Patient Experience story

Charley Kinsella

N.B. This item is scheduled for 09.20am

Patient Story- Experience of Care MEC Division Dec 2025.pdf (1 pages)
Patient Story DW July RG MG Final (3).pdf (3 pages)

Reports from the Chair of the Trust Board and Chief Executive

09:41 - 09:46
5 min

12-5
Report from the Chair of the Trust Board

Annette Doherty

Report from the Chair of the Trust Board - December 2025 - FINAL APPROVED.pdf (2 pages)

09:46 - 09:51
5 min

12-6
Report from the Chief Executive (incl. a quarterly update on the Patient First Improvement System (PFIS))

Miles Scott

Chief Executive's report December 2025 - FINAL APPROVED.pdf (4 pages)

Reports from Trust Board sub-committees

09:51 - 09:56
5 min

12-7
Quality Committee, 10/12/25

Joanna Webber

- Summary of Quality Committee 10.12.25.pdf (3 pages)

09:56 - 10:01
5 min

12-8
Finance and Performance Committee, 16/12/25

Neil Griffiths

N.B. Report to follow after the meeting on 16/12/25.

- Summary of Finance and Performance C'ttee 16.12.25.pdf (3 pages)

Integrated Performance Report

10:01 - 11:01
60 min

12-9
Integrated Performance Report (IPR) for November 2025

Miles Scott and colleagues

- IPR cover.pdf (1 pages)
- Finalised Integrated Performance Report November 12122025.pdf (44 pages)
- Trust Board Month 8 Finance OverviewV1.pdf (4 pages)
- Trust Board Finance Report M8 V1.pdf (2 pages)
- Safe staffing report.pdf (1 pages)

11:01 - 11:15
14 min

12-10
Break

Quality items

11:15 - 11:25
10 min

12-11
Maternity Update (Minimum dataset from PQSM)

Rachel Thomas and Sarah Flint

N.B. Please note that the appendices are saved in the documents section on admincontrol.

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

11:25 - 11:35
10 min

12-12
Quarterly Learning from Deaths report

Sara Mumford

- December 2025 LfD Board Cover Sheet_.pdf (1 pages)
- December 2025 LfD Board Report.pdf (8 pages)

Other matters

11:35 - 11:35
0 min

12-13
To consider any other business

Annette Doherty

11:35 - 11:35
0 min

12-14
To respond to any questions from members of the public

Annette Doherty

11:35 - 11:35
0 min

12-15
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.

NHS Maidstone and Tunbridge Wells NHS Trust

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]
10-4b	Agree a time for PSIRF training to be delivered to the Trust Board	Louise Thatcher and Sara Mumford	Dec 25	

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-4a	Review if a notification of Martha's rule being activated on InPhase, can be sent to senior nursing staff	Sara Mumford	Nov 25	The ability to notify the matron, Head of Nursing and DDNQ have been added

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	18th December 2025					
Agenda item no.	12-4					
Executive lead	Joanna Haworth, Chief Nurse					
Presenter	Charlene Kinsella (Charley), Head of Nursing for Emergency Medicine and Urgent Treatment Centres					
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 attached story represents poor experience of care of a patient and his wife who received his care in a corridor at the Tunbridge Wells Emergency Department. The principles for providing patient care in corridors were recently updated and published by NHSE on 11th December 2025.		
Any items for formal escalation / decision	The Trust board members are asked to note 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	

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR2: If we do not reduce the number of significant avoidable events our patients are at risk of poor clinical outcome. 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)	3419– Risk that the regulatory action against the Trust if areas on non-compliance are found with service delivery. 3579- Risk that patients do not receive care an treatment in line with best practice.
Compliance / Regulatory Implications	N/A

NHS
Maidstone and Tunbridge Wells NHS Trust

Patient Story

Name: Mr J	
Date of care experienced: October 2025	**Services/wards experienced:** Emergency Department Tunbridge Wells Hospital

Outline of experience:

Mr J attended the Emergency Department (ED) via ambulance, after a mechanical fall at home in October 2025, reporting pain in his hip and wrist. His wife had attempted to mobilise him after the fall but was unable to and came to hospital with him, staying throughout his stay in ED and his later admission to the hospital.

To note, Mr J. has provided consent to his experience in ED to be shared.

The department was experiencing a high influx of ambulances with high acuity. Therefore, a decision was made to open a temporary escalation area in a corridor to support the department with the additional pressure. The decision on corridor care is made in conjunction with ED leadership and management team, Trust senior leadership and system wide intelligence about number of ambulances and patients being conveyed or waiting to be assessed by ambulance crews.

There are several considerations that need to be made prior to corridor care being enacted. Some of these considerations include ensuring that there is timely release for paramedic crews waiting in the department so that they can respond to emergency calls for patients in the community, who remain at high risk. Secondly, the ED team need to ensure that the department has sufficient space to provide good quality care whilst maintaining privacy and dignity and any associated risks and challenges identified for each patient.

After approximately two hours in the ambulance handover area, Mr J was allocated to the temporary escalation corridor whilst he was waiting to be seen by an ED senior doctor. This decision was made on the basis that Mr. J had his observations taken, bloods samples and a tracing of the heart completed prior to the move, all noted as being within normal limits. The nurse had also administered pain relief, and Mr J's wife reported that his pain had initially improved. However, Mr J. was still waiting for his for an X-Ray of his wrist and hip which was completed shortly after being moved to the corridor.

There was an allocated nurse in the area, and she continued to provide care and to monitor Mr J. for any pain or discomfort. Mr. J had not attempted to mobilise as instructed by the nursing teams until the X-ray was reported. His pain, particularly in his hip, appeared to be getting worse. He was given more additional pain relief but with minimal improvement. His wife had asked a number of times when the X-ray would be completed and if he would be allocated a

more private space. Unfortunately, Mrs J. didn't feel that she was being listened to and later expressed that she felt that the staff had forgotten them.

Mrs J saw a poster in the department, which advises on the process for escalating concerns if a patient and/ or relative is unhappy with the care being provided. Mrs J. followed the steps provided and spoke to the nurse in charge (NIC). She expressed that the main concern was that Mr J was in too much pain to stand and needed to use the bathroom. When the senior nurse overheard the conversation and the concerns being raised, she further enquired about the problem and quickly identified that Mr J, did not meet the criteria to be allocated for corridor care as he had a history of a fall and was not mobile. This meant that Mr J would be unable to use the bathroom without compromising his dignity. The senior nurse was able to identify a different patient for corridor care and a designated treatment side room allocated to Mr J. Shortly after, Mr J went to X-ray and was confirmed as having a fracture in his pelvis.

Learning was identified for the NIC. All patients, who in extremis, may end up having their care on the corridor must be reviewed by the NIC, prior to the decision being made. The criteria for care of the 'Undesignated patient' was re-circulated to the Nursing teams via the Weekly Governance brief. A record of the incident was raised to enable a discussion with the wider team and to review if Mr J had come to any harm. Fortunately, Mrs. J was always in the ED with her husband and was able to advocate on his behalf. Following on from further review, Mr J did not come to any physical harm but did experience some psychological harm due to the poor experience of care, together with his wife.

Once the senior nurse had explained the pressures the department were under, Mr & Mrs J. understood why the decision had been made. They thanked the staff for their care and later sent a thank you card to the department.

The ED department recognises that corridor care is far from ideal and the aspirations of the department is that they will be able to irradicate all corridor care. By always looking for new strategies to manage our patients and the use of Same Day Emergency Care (SDEC's), Urgent Treatment Centre's (UTC's), Single Point of Access (SPOA) is vital to offload pressures from ED. Patient care and experience remains a top priority for the ED team. The Head of Nursing (HoN) recently attended the Corridor Care Conference, where teams shared their experiences and those of patients and their relatives. It was also acknowledged that nationally, clinical teams were doing everything they could to promote patient safety, maintain good patient experience with a joint vision of eradicating the use of corridor care in the NHS.

Positive points to highlight:	Negative points to highlight:
- Pain relief: Audited monthly to review compliance of pain assessment and analgesia given to patients. - 'Speak up' posters in ED's (cross-site): Allowed Mrs J. to identify how to escalate concerns relating to her husband's care. These were developed on the Martha's rule principle to enable patient's and their relatives to advocate for their care. - Use of incident recording system: Incident raised to ensure a review of harm level could be undertaken.	- Corridor care criteria: Learning of Mr J's experience in ED and the 'Undesignated care' patient standard Operating Procedure (SOP) shared. - Communication with patients: Failure to acknowledge the patients / relatives' concerns.

Ongoing actions with case:

- Review of undesignated care SOP is being followed: Role of the NIC is vital to ensure that this is undertaken throughout the day. 'Walking handover' implemented as a trial on the 15/12/2025, where all patients being cared for in an ED corridor is spoken to during the NIC handover.
- On-going review of Incidents relating to corridor care by the ED leadership and management team.
- HoN engaged in on-going NHS sessions to identify learning and improvements that can be shared with the teams.

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board**					
Date of meeting	Thursday 18 December					
Agenda item no.	12-5					
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 December 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 honoured to be invited to speak at the latest Women's Network event recently held at Maidstone Hospital. The network is designed to support women in their careers and professional development, widen perspectives and provide an opportunity for women across the Trust to connect. Themed 'Surviving to thriving', the session discussed how women can overcome challenges, build resilience and explore personal growth. I shared my own experiences alongside fellow guest speakers Helen Palmer, Chief People Officer, and Eleanor Doherty, Clinical Lead Physiotherapist in the Stroke Unit.

At this month's Kent and Medway NHS Joint Committee, hosted by the Kent and Medway Integrated Care Board, we discussed the system's financial position for 2025/26 and received a progress update on the system improvement plan.

I conducted informal mid-year review discussions with the Trust's Non-Executive Directors at the end of last month as part of NHS England's Board member appraisal process, to support ongoing dialogue about performance and development objectives in line with organisational priorities.

The Trust Board Away Day was held on 11 December, where we focussed on the provider assessment submission and undertook further work on developing the Trust's strategy. We also reviewed the first commissioning proposals and decisions made by the Integrated Care Board, and implications for our three-year plan aligned to the NHS long term plan.

With the festive season upon us, the Trust hosted celebratory Christmas lunches for our volunteers at Maidstone and Tunbridge Wells hospitals, to thank them for the invaluable work they do. MTW currently has over 250 volunteers, who contribute on average in excess of 30,000 hours per year. Volunteers are a vital part of life in our hospitals, helping people find their way around, keeping patients company and sitting with them during treatments, supporting hospital radio and our chaplaincy teams, and also working with the League of Friends at Maidstone and Tunbridge Wells hospitals. They also support staff by acting as an extra pair of hands and freeing them up to prioritise clinical care. On behalf of the Board, I would like to thank all our volunteers for the incredible support they provide to our staff and patients.

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
28/11/2025	Consultant Gastroenterologist-IBD	Mohammad Aamir	Saifuddin	Gastroenterology	TBC	New

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	Thursday 18th December 2025					
Agenda item no.	12-6					
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 December Trust Board meeting, summarising Trust developments and achievements over the last month.		
Any items for formal escalation / decision	N/A		
Appendices attached	There are no appendices to this report.		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
N/A		N/A	N/A

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

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

- National Industrial action by the British Medical Association began yesterday, 17 December, and resident doctors will be taking action until 22 December. Detailed plans were put in place ahead of the action to ensure staff rosters were filled. Senior clinical managers are also providing additional support at our hospitals. In common with the rest of the NHS, we expect some disruption to normal services, including postponements to outpatient appointments and elective procedures, however our teams are working hard to ensure urgent and emergency services, maternity and cancer are provided, and to ensure patient safety. Any patients who are affected by postponements to appointments are being contacted and re-booked for the next possible date.

- This latest industrial action has coincided with one of our most challenging periods due to winter pressures, with over 20,000 people attending ED across our sites in November for the second month running. As part of our winter planning, we have reviewed all areas of activity to identify any potential gaps or risks while focusing on increased capacity, working with local partners and ensuring we support the wellbeing of both patients and staff during the winter months. Part of this work has included our winter vaccination programme, which aims to protect as many staff as possible. Over 4,500 of staff have now had their flu vaccine. Static and roving clinics continue across our sites – including for night staff – to make it as easy as possible for colleagues to get vaccinated. We are now entering the peak of flu season. Numbers of flu cases appear to be increasing sharply in London and we expect this to ripple outwards. As the risk of transmission in hospitals increases, our Infection Prevention and Control team are monitoring numbers of respiratory illness.

- The Trust remains in Segment 1 of the NHS England National Oversight Framework (NOF) following the publication of the performance results for Q2 last week. This places MTW 16th out of 134 acute trusts in England. The NOF assessment covers a wide range of metrics including patient experience and safety, waiting times for operations, cancer treatment and A&E time. We are pleased to remain near the top of Segment 1, which reflects the continued hard work of our teams across the Trust. While there has been no significant change this quarter, we know performance can vary over the year, and so our focus is on maintaining the highest standards of care for our patients.

- We recently had a mid-year review with NHS England (NHSE), which is aligned with the NHS Oversight Framework. NHSE commended the Trust's performance in a number of areas and additional actions were agreed in areas where our operational performance is under pressure. Following the mid-year review, our key focus areas include:
    - Elective Care: improving outpatient scheduling, reducing follow-ups via Patient Initiated Follow-Ups, increasing virtual ward use and supporting specialty transformation pathways.
    - Urgent and Emergency Care: optimising same day emergency care pathways, supporting community and social care capacity, opening escalation areas, and reducing length of stay in community beds to improve flow.
    - Cancer: recovery actions across Urology, Breast, Gynaecology, Head and Neck, Colorectal, and screening services, focused on pathway optimisation.

- Work continues on our transformation programme, which is designed to support long-term sustainability while maintaining strong operational performance and a clear focus on patient safety. A central element of this programme is the 2025/26 Cost Improvement Plan, which requires significant workforce-related savings. The first phase of this work, involving Corporate and Estates and Facilities teams, is now in its final stages and we are supporting colleagues as changes are implemented and continue to adapt our support offer in response to feedback. The second phase, which focuses on clinical divisions, has completed its consultation period.

  The Trust has made encouraging progress in reducing temporary staffing costs and non-pay expenditure. While the financial environment has become more challenging, we are beginning to see early benefits from the initial phase of workforce transformation, with underlying pay expenditure showing improvement and Bank staffing use at its lowest level for some time. As we

move into the latter part of the year, maintaining focus on cost control remains essential.

- The work of the top-performing West Kent Community Diagnostic Centre (CDC) was recently recognised on the ITV Meridian news programme. The report celebrated the service provided by the CDC, which has delivered over 230,000 tests since it opened in 2023, helping to shorten waiting times, reduce pressure on hospital services and transform patients' experience of care. The feature included interviews with MTW clinicians and several patients, one of whom described the service provided at the CDC as "the NHS at its very, very best."

- Consultant Ophthalmologist and Deputy Clinical Director for Head and Neck, Mr Mohamed Elalfy, has been elected President of the Royal College of Ophthalmologists. The College represents the ophthalmology profession in the UK and also supports overseas members in low and middle income countries, building a global community to influence eye health policy and to share standards, professional learning and development. Mr Elalfy is currently serving as Honorary Treasurer of the College – the first colleague from MTW to do so – and was the first to stand for the role of President. He will take up his new role in May for a three-year term. On behalf of the Board, I would like to congratulate Mr Elalfy on this prestigious appointment, which reflects his commitment to shaping the future of ophthalmology care in the UK.

- The Patient First Improvement System (PFIS) is celebrating its third anniversary this month. Launched in 2022, PFIS trains teams to identify issues in their areas and work together to implement solutions that will improve services, benefiting both patients and staff. PFIS is now also being embedded into directorate governance, enabling leaders to align improvements in their areas with the Trust's strategic themes. This means continuous improvement can happen across a directorate, from frontline teams to Board members. Over the last three years, more than 660 colleagues spanning 117 teams have been PFIS trained, completing 1,800 tickets to date with more being completed each day. Staff have reported that PFIS has empowered them to make changes that directly improve the patient experience and united their teams by enabling a collective response to problem-solving. PFIS tickets raised and implemented over the past three years cover a broad range of teams and services across the Trust, and have included:
    - New dissection benches in laboratories to help sample turnaround times.
    - Out of hours FP10 prescription forms in the Surgical Assessment Unit, enabling patients to go home sooner.
    - Out of hours sample collections in the Rubin Clinic, meaning sexual health clinics can run later.
    - New process of capturing and uploading clear screenshots of surface and skin rendering by the Radiotherapy team at Canterbury, assisting with treatment delivery.
    - All steps of the referral process for the Virtual Ward now being digitised, saving time and resources.

- The Trust recently hosted the inaugural conference for nursing, midwifery and allied health professional educators in the Kent and Medway region. Titled 'Break down the barriers – improving the patient experience through multi-professional education', the conference was opened by Chief Nurse, Jo Haworth, and welcomed educators from further education colleges, higher education institutions and other NHS providers. Guest speakers covered a range of topics including multi-professional restorative clinical supervision and T-levels in Kent and Medway. The conference also featured panels on preceptorship and post-registration challenges, with audience members able to ask questions to educators from organisations across Kent and Medway, including Medway NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust and Canterbury Christ Church University. I would like to personally thank Practice Development Nurses Georgie Devaney and Emma Farmer for organising this event, which gave attendees the opportunity to shares ideas and discuss future collaborations, with the aim of further developing multi-professional education across the region.

- Our teams have achieved national recognition over the past month across a number of areas:
    - The Myeloma team and the wider Cancer division at Maidstone Hospital have been presented with the Myeloma UK Clinical Service Excellence Programme (CSEP) Award, honouring the team's outstanding dedication to improving the lives of people with myeloma and their commitment to compassionate, patient-centred care. Myeloma is an incurable blood cancer that affects more than 33,000 people in the UK. Most cases are treatable and can have periods of remission, but diagnosis can be challenging as

symptoms can be mistaken for other conditions. The team at Maidstone Hospital are the first in Kent to be recognised with the award, with the judging panel praising our staff for their focus on enhancing quality of life and for their willingness to listen and respond to patients' needs. The achievement was recognised by ITV Meridian who filmed a news feature in the Kent Oncology Centre at Maidstone Hospital earlier this month. The ITV team spoke to Dr Fathi Al-Jehani, Clinical Director for Haematology, and Claire Herbert, Myeloma Clinical Nurse Specialist, about their roles and how we help patients such as Richard Gurton from Kings Hill, whose early diagnosis of myeloma proved crucial, and who was interviewed about his care and support from our clinical teams. On behalf of the Board, I'd like to thank our colleagues and Richard for taking part in this news broadcast.
    - The Virtual Ward team has won Best Employer for Staff Recognition and Engagement at the Nursing Times Workforce Awards 2025 for its exceptional culture of valuing and empowering staff. Launched in 2022, the Virtual Ward enables nurses and clinicians to monitor and support patients at home with hospital-level care. The team has so far supported more than 2,000 patients across 11 clinical pathways, including frailty, surgery and orthopaedics, saving over 7,200 bed days. Nurses working on the Virtual Ward report high levels of satisfaction and retention, gaining advanced digital and clinical skills while also leading governance and improvement projects.
    - The Cellular Pathology team at Maidstone Hospital have received a formal compliment by UKAS, the UK's accrediting body for laboratories. Medical laboratories deliver tests such as biopsies and blood tests, providing results that inform treatment decisions and health outcomes. UKAS accreditation recognises the quality of laboratories by verifying their integrity, impartiality and competence, undertaking assessments to ensure they meet the relevant requirements. Following a recent assessment visit, UKAS raised the formal compliment in recognition of the Cellular Pathology team's work on their quality management system, and their proactive approach to risk management. The compliment also named two of the team's staff members, Hayley Williams, Pathology Quality Manager and Rosebud Rusike, Senior Biomedical Scientist and Quality Lead, for their knowledge, skills and dedication to continuous improvement.

- Congratulations to the winner of the Trust's Employee of the Month award for November, Dr Alex Ashley in the Emergency Department (ED). Dr Ashley was nominated for the award for his work in designing an innovative real-time business continuing solution to improve patient visibility and safety in ED, while also supporting the Care Coordination Centre and site teams. His initiative demonstrated exceptional commitment to improving the experiences of patients and staff. Raji Radhakrishnan, Ward Manager in Ward 22, also received the Highly Commended Award for introducing improvement initiatives such as a 'Relative Clinic', which has enhanced transparency and improved communications with families.

Title of report	**Summary report from the Quality Committee, 10/12/25**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	18th December 2025					
Agenda item no.	12-7					
Executive lead	Jo Haworth, Chief Nurse; Sarah Davis, Chief Operating Officer; Sara Mumford, Chief Medical Officer and DIPC					
Presenter	Jo Webber, Associate Non-Executive Director					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***	☐	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The Quality Committee met in person on 10th December 2025 (a ‘‘deep dive’’ meeting). The Committee considered the following topics: The BAF risks overseen by the Quality Committee; Review of the emerging risks within the Trust’s risk register and PSIRP dashboard, and agree priorities for future deep dive reviews; Review of Infection Prevention and Control at the Trust; and Review of the guidance for Service-based ‘deep dive’ reports. 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	Please list any risks on the Trust Risk Register to which this report

(TRR)	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 10th December 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 regularly.
- The Trust Patient Safety Specialist presented a **review of the emerging risks within the Trust's risk register and PSIRP dashboard, and agree priorities for future deep dive reviews,** wherein the Committee heard that the weekly Incident Review Group was identifying emerging patient safety themes and gaps. Current priorities included hospital-acquired C.difficile (CDI), serious inpatient falls, patients lost to follow-up, and failure to rescue deteriorating patients. It was noted that the learning from deaths Patient Safety Incident Investigations highlighted that five Never Events occurred across Orthopaedics, Ophthalmology, Gynaecology, and Interventional Radiology. Recent incident trends included maternal injury, surgical complications, incomplete phlebotomy requests, and absconding patients. The Committee heard that Maternity and Newborn Safety Investigations (MNSI) themes for 2025/26 would focus on clinical assessment and fetal monitoring. It was highlighted that 14 new risks had been identified under Patient Safety Strategic Themes, with nine of these being red risks. It was recognised that patient discharges were becoming and worsening picture, and that review into the drivers behind this would be beneficial. The Committee noted that deep dives would be scheduled on patient discharges (February 2026), 12-hour breaches and mortality (April 2026), Clinical Admin Units quality impacts, and the national trend of Never Events (post-Easter 2026). It was heard that falls and pressure ulcers were improving but require ongoing review.
    - ❖ 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 Chief Medical Officer / Director of Infection Prevention and Control then presented a **review of Infection Prevention and Control (IPC) at the Trust**, which included that the Trust was currently breaching national trajectories for CDI and E. coli, though recent interventions had reduced CDI cases to three in November and improved performance for E. coli and MRSA. The Committee heard that governance structures were being amended so the IPC Committee would receive reports from directorates and key teams, escalating to the IPC Oversight Group and then Quality Main for oversight. Assurance measures included a revised stool sampling pathway, re-commenced deep cleaning (Ward 10 completed, Ward 11 in progress, and Ward 32 planned), a disinfectant trial planned for January, and successful tap replacement confirming contamination was localised at outlets. The Committee noted that winter viruses, including RSV and flu, were the next priority, with five flu cases currently across both sites and segregation processes in place. Covid-19 cases were gradually decreasing. Paediatric flu cases were rising as expected and were being managed. The Committee was assured that risks were under control and the Trust response remained proactive and well-supported.
    - ❖ The Committee noted that this demonstrated adequate assurance of the effectiveness of controls for the Board Assurance Framework, Principal Risks 2, 3 and 4.
- The Committee then reviewed **the guidance for Service-based 'deep dive' reports,** wherein the it was agreed to trial this for upcoming deep dives reviews to assess whether it was useful in getting to the route cause of the issues and discussing the relevant actions.
- 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	18th December 2025					
Agenda item no.	12-8					
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 16th December 2025. The Committee considered the following topics: 1) To consider the BAF risks 2) The patient access strategic theme metrics for November 2025 3) The financial performance for month 8, 2025/26 4) An update on the Financial Improvement Plan 5) Annual review on the capacity and effectiveness of the finance function 6) Annual update on the Estates Strategy 7) The Medium Term Plan 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 16th December 2025, virtually via webconference.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were noted.
- The group considered and reviewed the Board Assurance Framework (BAF) risks relating to the Committee.
- The **Patient Access strategic theme** metrics for November were reviewed, and it was highlighted that regarding performance, the Trust continued to be a system supporter and ranked among the best performers nationally. The Committee heard that the 28-day cancer standard was achieved in October, meeting the National Performance Assessment framework target of 80%. It was noted that cancer waiting times had improved for the 62-day standard, although the target of 80% was missed, it was noted that recovery remained on track. It was noted that the diagnostic waiting times target standard had achieved 96.4% in October, which was above the national target, but below the trust's internal target of 99%. The Committee heard that the four-hour Emergency Department (ED) performance fell below target due to challenges at initial entry points, space constraints, and issues with patient discharges, it was noted that the recovery plan has been revisited. It was noted that the team had plans in place to manage activity during the Industrial Action by Resident Doctors, which was planned to commence at 7am on the 17 December and last until 7am on the 22 December, noting there was potential for further activity loss compared to the previous period of Industrial Action.
- The **financial performance month 8, 2025/26** was then presented by the Chief Finance Officer, which included that the Trust was £2.9m in deficit in month against a plan of £1.7m in surplus. The Committee discussed ongoing cash challenges, the trajectory towards the 2% productivity target, supplier payment risks, payroll trends, and the impact of redundancy costs. The Committee discussed the year-end forecast, the risks and challenges to achieving it, and noted it would continue to be closely monitored.
- The **monthly update on the Trust's Financial Improvement Plan** was provided, and the Committee reviewed the financial improvement plan, workforce controls, discussed delivery of savings, headcount management, divisional performance, and the pipeline of cost improvement schemes, with a focus on the need for further controls and accurate tracking. It was noted that that the majority of savings schemes were on track, with £28.6 million delivered year-to-date and a forecast of £47.5 million by year-end.
- The Chief Finance Officer presented the **annual report on the capacity and effectiveness of the finance function**, wherein the group were presented with the annual review of the finance function, detailing team structure, recent improvements, benchmarking, digital initiatives, and future skills needs; to be linked to productivity and efficiency and support for system projects and innovation.
- The **annual update on the Estates Strategy** was presented, which included structural changes to the team to drive efficiencies and productivity, compliance with reporting, asset management, cleaning and catering performance, and sustainability initiatives, with a focus on continuous improvement, accurate reporting, and future space utilisation.
- The Director of Strategy, Planning and Partnerships presented the **Mid Term Plan** which included that the plan, which was discussed at a Trust Board Away Day, had been developed and was due to be submitted on 17 October.
- The Committee noted the **summary report from the from the November 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	**Integrated Performance Report (IPR) for November 2025**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	18th December 2025					
Agenda item no.	12-9					
Executive lead	Chief Executive / Executive Directors					
Presenter	Chief Executive / Executive Directors					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

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

November 2025

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

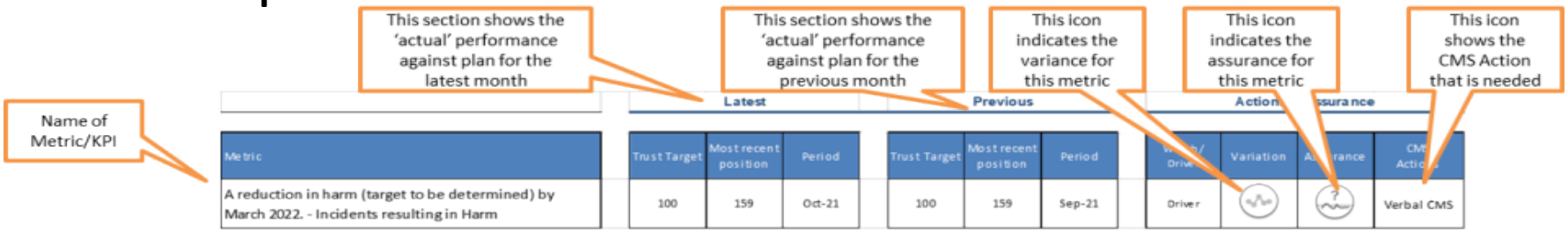
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

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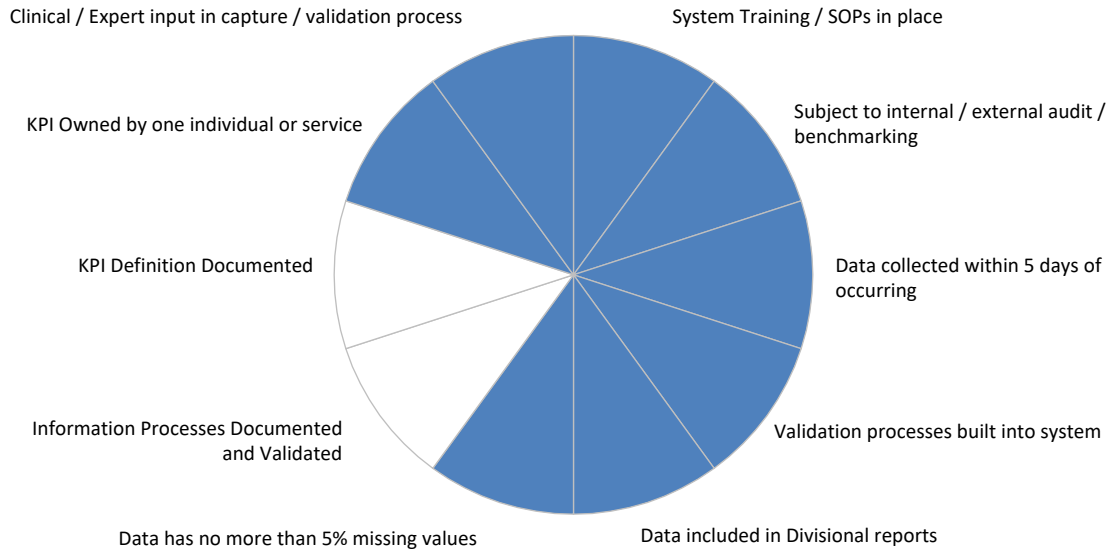
Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The 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 is consistently failing the target, with the substantive staff element 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 is now consistently passing the target. 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 and 24 months are no both in variable achievement of the target. The Nursing Safe Staffing levels is consistently achieving the target. 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 has moved to special cause variation of an improving nature but is consistently failing the target. The Trust continues to implement several actions to improve performance.

Patient Safety & Clinical Effectiveness: The rate of incidents causing patients moderate or higher harm has returned to common cause variation but is 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. 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 October (data runs one month behind) but is experiencing special cause variation of a concerning nature while 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 November 25 of 74.6% at 69.8% (Excluding SYS) which was 4.8% below the internal recovery trajectory. Nationally we reported 69.7% (including SYS). This indicator is experiencing common cause variation and has now failed the target for 6 months. 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 November 25. The number of patients having waited more than 40 weeks (Excluding SYS) is now experiencing common cause variation and variable achievement of the target. 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 6.6% above the trajectory target for November 25 at 96.4%. This indicator is experiencing special cause variation of an improving nature and has now passed the target for 6+ months. The overall Diagnostics target has also now changed nationally from 99% to 95% currently.

Executive Summary (continued)

Patient Access (Continued): The Trust's performance for A&E 4hrs was 2.6% below the trajectory target for November at 79.6% and is failing 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 has moved to special cause variation of an improving nature and has achieved the target for 6+months. The Trust continues to achieve 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. November performance will improve as cashing up of clinics continues. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute remains in common cause variation and is consistently failing the target. Performance for First Outpatients activity was above the trajectory target for November 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 November 2025 and remains in common cause variation 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, remains in special cause variation of a concerning nature and variable achievement of the target. Diagnostic Imaging activity levels were above plan in October, and this indicator remains in 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 revised 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 in common cause variation and variable achievement of the new target of 15.7%. Complaints responded to within the target date passed the target again in November, at 75%, and continues to experience special cause variation of an improving nature. Maternity & Outpatients 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 and virtual ward beddays has 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) has returned to common cause variation and variable achievement of the target.

Sustainability: The Trust was £2.9m in deficit in the month which was £4.6m adverse to plan in the month. Year to Date the Trust is £18.2m in deficit which is £10.5m adverse to plan. The most recent Implied Productivity NPAF Metric is experiencing common cause variation and has failed the target for 6+months.

Maternity: Both 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 indicators for Decision to delivery interval (Category 1 & Category 2) caesarean sections. The Decision to delivery interval (Category 2) caesarean section indicator is now experiencing special cause variation of an improving nature but consistently failing 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)

Patient Access:
- Achieve a 5% improvement in RTT Incomplete Pathway Performance (P.19)
- RTT - Reduction in weeks wait to first outpatient appointment (Average) (P.20)
- Ambulance Handovers < 30 mins (P.21)
- 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)
- 10% Reduction in Non-Elective LOS (P.22)
- Outpatient Calls answered <1 minute (P.22)
- % Capped Theatre Utilisation (P.22)
- RTT Waiting List (Excl SYS) (P.22)

Systems:
- Daily Average Virtual Ward Beddays (P.28)

Sustainability:
- Implied Productivity YTD vs Previous Year (P.30)

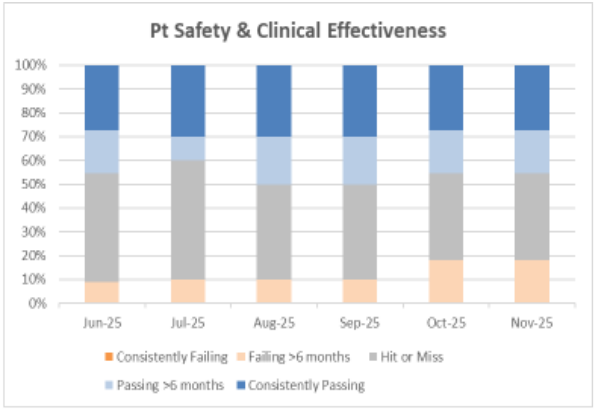
Patient Safety & Clinical Effectiveness:
- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.15)
- 12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* (P.16)
- 12 month rolling count of C. difficile cases as a proportion of trust threshold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

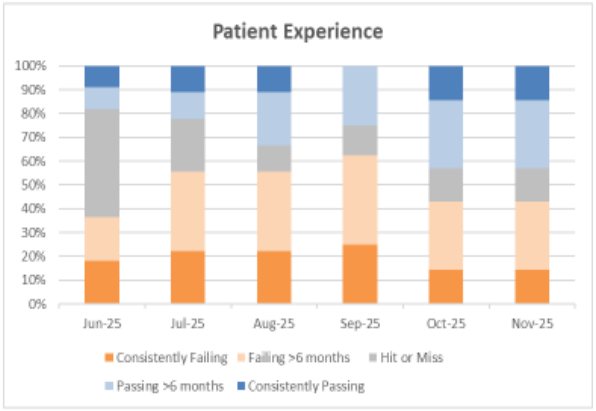
Patient Experience:
- New Complaints Received (P.24)
- FT Response Rates: Maternity (P.25)
- FT Response Rates: Outpatients (P.25)

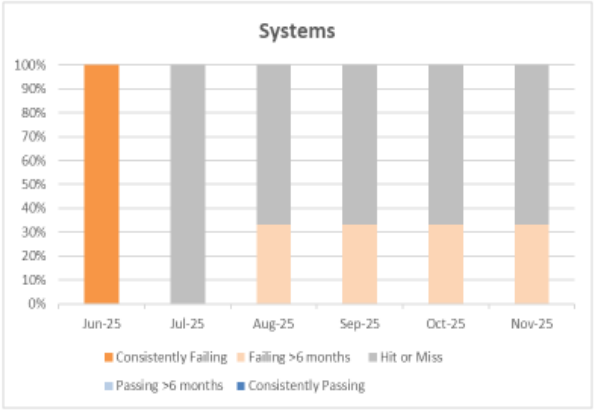
Maternity Metrics:
- Women waiting for Induction of Labour <2 Hrs (P.32)
- Women waiting for Induction of Labour <4 Hrs (P.32)
- Decision to delivery interval (Cat 2) caesarean section (P.32)

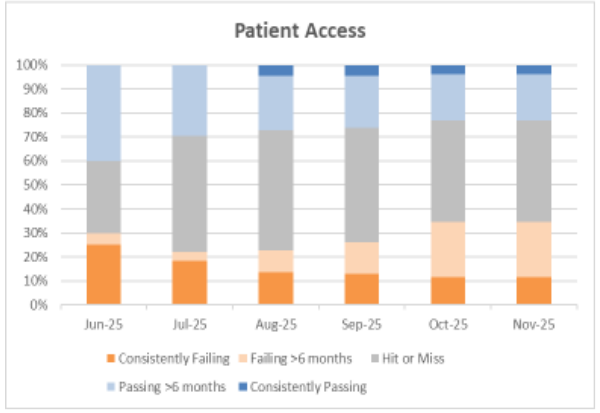
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

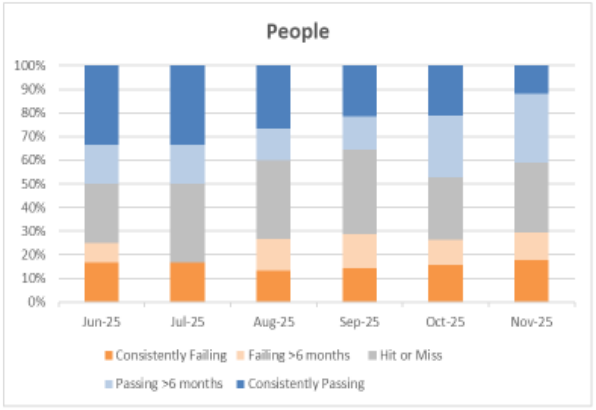
Assurance Stacked Bar Charts by Strategic Theme

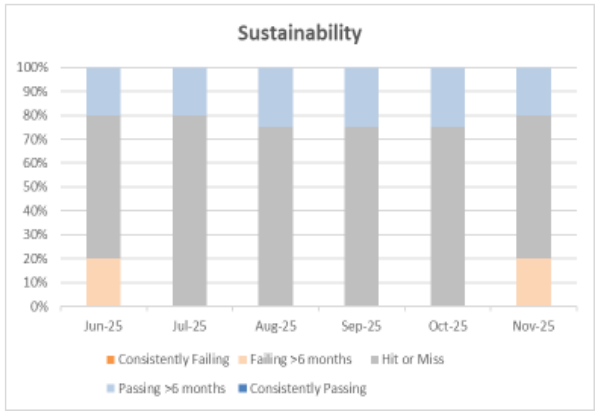












Matrix Summary

November 2025

Variance	Assurance: Pass ★	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail	Assurance: Fail -
Special Cause - Improvement	Agency Spend as a % of spend – target of 3.2% Reduce Turnover Rate to 12% Percentage of AfC 8c and above that have a Disability Summary Hospital-level Mortality Indicator (SHMI) *NPAF Metric* Standardised Mortality HSMR Conversion rate from ED (Excluding Type 5 and including Direct Admissions)	Achievement of Agency Element of Workforce Plan (WTEs) Reduce the Trust wide vacancy rate to 8% IC - Number of Hospital acquired MRSA Bacteraemia Rate of patient falls per 1000 occupied bed days Access to Diagnostics (<6weeks standard)	Achievement of Bank Element of Workforce Plan (WTEs) Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind) % complaints responded to within target Capital Expenditure (£k)	Friends and Family (FFT) % Response Rate: Maternity	Percentage of AfC 8c and above that are BAME 12 month rolling count of MRSA cases *NPAF Metric* Friends and Family (FFT) % Response Rate: Outpatients
Common Cause	Statutory and Mandatory Training Percentage of AfC 8c and above that are Female **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*	Cancer - 31 Day First (New Combined Standard) - data runs one month behind Friends and Family (FFT) % Response Rate: A&E Cash Balance (£k)	Sickness Absence *NPAF Metric* Staff Leavers within 12 months Staff Leavers within 24 months Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) Never Events IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Transformation: % of Patients Discharged to a PIFU Pathways To achieve the planned levels of new outpatients activity To achieve the planned levels of elective (DC and IP combined) activity To increase the number of complaints that are closed through an initial conversation or local resolution - shown as a percentage of all complaints closed 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 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 financial plan, inc. operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) *NPAF Metric* Reduce non-pay spend	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) To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric* 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* To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally A&E 4 hr Performance Flow: Ambulance Handover Delays >30mins To reduce the overall number of complaints or concerns each month Friends and Family (FFT) % Response Rate: Maternity Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays - Target is 95% of 60 beds Implied Productivity Growth (YTD compared to previous year)	12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric* RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways) Transformation: CAU Calls answered <1 minute Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward) % Capped Theatre utilisation.
Special Cause - Concern	% VTE Risk Assessment (one month behind) Safe Staffing Levels (Nursing)		Cancer - 62 Day (New Combined Standard) data runs one month behind 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) RTT Total Waiting List (Excl SYS)

Strategic Theme: People

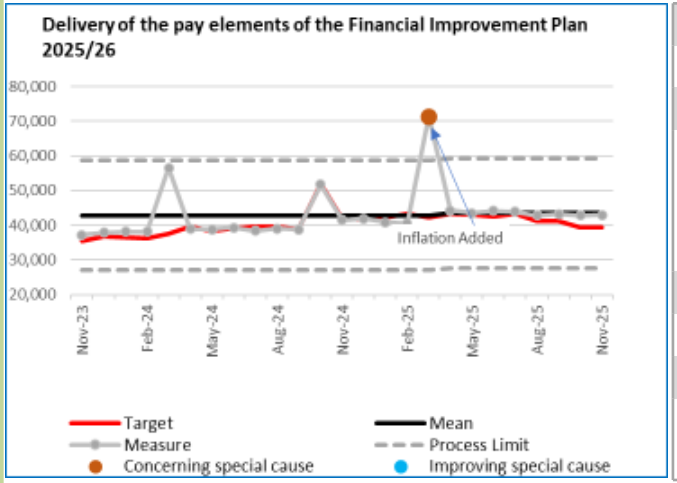
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Well Led	Delivery of the pay elements of the Financial Improvement Plan 2025/26		39,254	42,914	Nov-25	39,382	42,759	Oct-25	Driver			Full CMS			
Breakthrough Objective	Well Led	Achievement of Workforce Plan (WTEs)		7799	8258	Nov-25	7859	8288	Oct-25	Driver			Full CMS			
NHS Performance Assessment Framework (NPAF) Metrics	Well Led	Sickness Absence *NPAF Metric*		4.5%	4.8%	Oct-25	4.5%	4.4%	Sep-25	Driver			Not Escalated	4.2%		
Constitutional Standards and Key Metrics	Well Led	Achievement of Substantive Element of Workforce Plan (WTEs)		7173	7630	Nov-25	7233	7680	Oct-25	Driver			Escalation			
	Well Led	Achievement of Bank Element of Workforce Plan (WTEs)		552	567	Nov-25	552	545	Oct-25	Driver			Not Escalated			
	Well Led	Achievement of Agency Element of Workforce Plan (WTEs)		74	61	Nov-25	74	61	Oct-25	Driver			Not Escalated			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	0.8%	Nov-25	3.2%	1.3%	Oct-25	Driver			Not Escalated			
	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	6.4%	Nov-25	8.0%	6.1%	Oct-25	Driver			Not Escalated	5.7%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	10.9%	Nov-25	12.0%	10.5%	Oct-25	Driver			Not Escalated	9.9%		
	Well Led	Statutory and Mandatory Training		85.0%	91.3%	Nov-25	85.0%	91.1%	Oct-25	Driver			Not Escalated	91.1%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	72.0%	Nov-25	66.0%	72.5%	Oct-25	Driver			Not Escalated	74.72%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	10.7%	Nov-25	4.0%	11.1%	Oct-25	Driver			Not Escalated	11.54%		
	Well Led	Percentage of AfC 8c and above that are BAME		14.2%	8.7%	Nov-25	13.9%	7.2%	Oct-25	Driver			Escalation	7.11%		
	Well Led	Staff Leavers within 12 months		15.3	13	Nov-25	15.3	21	Oct-25	Driver			Not Escalated	19		
	Well Led	Staff Leavers within 24 months		28	24	Nov-25	27.8	40	Oct-25	Driver			Not Escalated	36		

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



Nov-25
42,914
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Limit (Internal)
39,254
Business Rule
Full Escalation as has failed the target for 6+ months

2. Stratified Data

	Current Month ' £000			Current Month WTE		
	Submitted			Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	38,821	35,399	-3,422	7,630	7,173	-457
Bank	3,580	3,159	-421	567	552	-16
Agency	340	534	194	61	74	14
Other	172	162	-10	0	0	0
Total Pay	**42,914**	**39,254**	**-3,660**	**8,258**	**7,799**	**-459**

	Year to Date £000			Year to Date WTE		
	Submitted			Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	314,118	297,502	-16,616	61,673	58,508	-3,165
Bank	28,010	28,462	452	4,450	4,750	300
Agency	3,891	5,775	1,884	533	767	234
Other	1,388	1,266	-122	0	0	0
Total Pay	**347,408**	**333,005**	**-14,403**	**66,656**	**64,025**	**-2,631**

3. Top Contributors & Risks

Top Contributors:

- Historic substantive recruitment above plan
- Inconsistent rostering practices and approvals 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 to an even greater extent with tighter substantive vacancy control
- 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

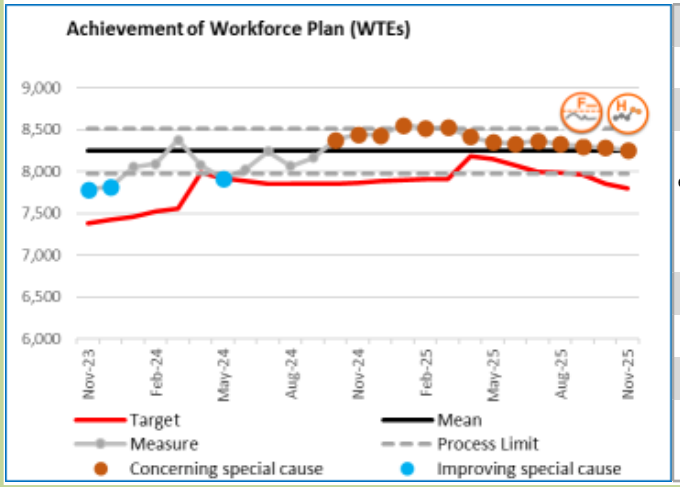
Workstreams	Actions	When	Who
Rostering Performance	Ongoing programme to establish e-rostering for all HCP teams (into 3rd phase with no major issues)	Ongoing	Head of Temporary Staffing
	Regular review of nursing rostering KPIs with Divisions	Ongoing	Deputy Chief Nurse
Vacancy and Pay Controls	Review of responsibility allowances and how to increase grip and control	Jan 2026	Chief People Officer
	Exec Vacancy Control Panel – challenging recruitment requests and holding roles for redeployment opportunities	Ongoing	Chief People Officer
Bank pay	Weekly review of temporary staffing use across all staff groups and divisions	Ongoing	Workforce Workstream Leads
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
Temporary Staffing	Divisional targets set by Executives to reduce temporary staffing spend by 50%	Dec 25-Mar 2026	Divisional Leads

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Achievement of Workforce Plan (WTEs)

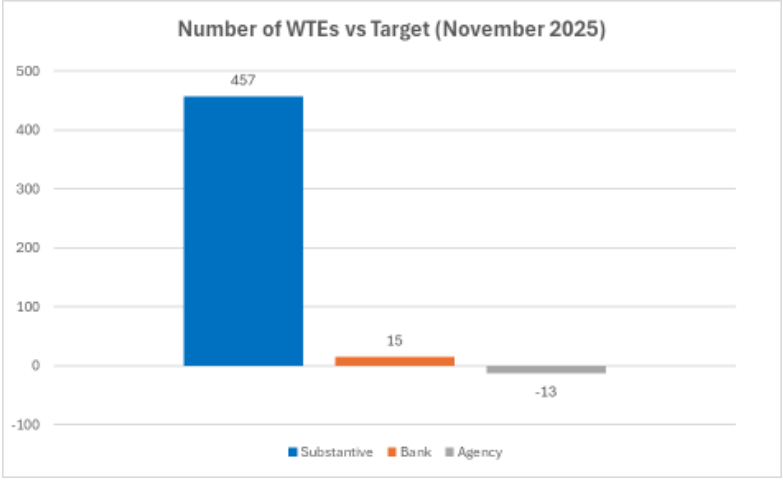
Owner: Chief People Officer
Metric: Achievement of Workforce Plan (WTEs)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Nov-25
8,258
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
7,799
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)
- Turnover remains low

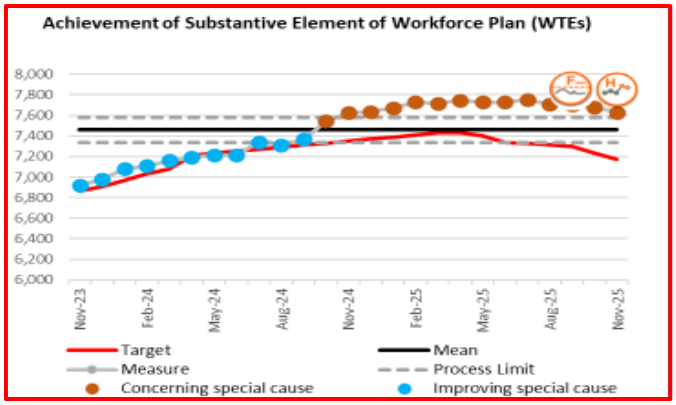
Risks:

- 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.
- There is a risk that workforce is reviewed in isolation i.e. substantive or bank and should be reviewed holistically as workforce with triangulated control.

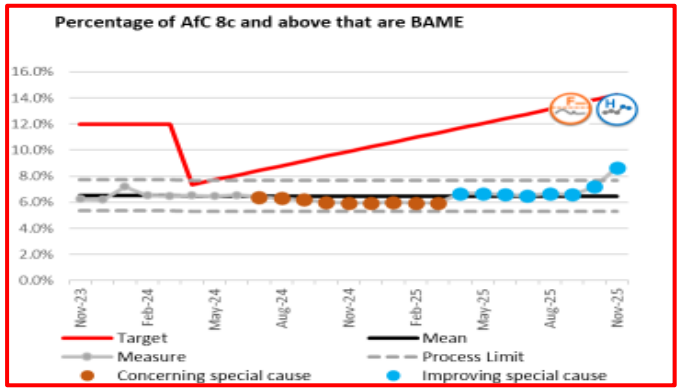
4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Programme Delivery	Workforce Transformation Programme Phase 1 redeployment and notice period for leavers	Jan 2026	Chief People Officer
	Workforce Transformation Programme Phase 2 consultation outcomes communicated	Dec 2025	Chief People Officer
Data analysis	Project team reviewing data to identify root causes of variance of WTE to plan (ETM SDR Request)	Ongoing	Project team
Workforce Pay Controls	PWC supporting pay workstreams and Divisions to identify and implement further pay reduction schemes	Jan 2026	PWC / Workstream & Divisional Leads

People – Workforce: CQC: Well-Led



Nov-25
7,630
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
7,173
Business Rule
Full Escalation



Nov-25
8.7%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target (Internal)
13.9%
Business Rule
Full Escalation

Summary:	Actions:	Assurance & Timescales for Improvement:
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 **% of AfC 8c and above that are BAME:** This metric is special cause variation of an improving nature and consistently failing the target.	**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. **% 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. Impact of the transformation programme to be analysed, full report completed by Q1 2026/27	**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) **% 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

Strategic Theme: Patient Safety & Clinical Effectiveness

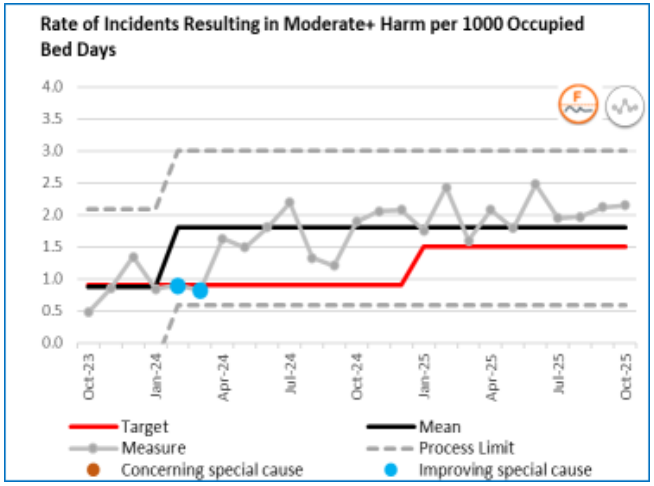
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	2.15	Oct-25	1.50	2.12	Sep-25	Driver			Full CMS	2.49		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	4	Oct-25	2.1	2	Sep-25	Driver			Verbal CMS	2		
NHS Performance Assessment Framework (NPAF) Metrics	Safe	Summary Hospital-level Mortality Indicator (SHMI) ***NPAF Metric***		100.0	87.6	Aug-25	100.0	87.9	Jul-25	Driver			Not Escalated	86.6		
	Safe	12 month rolling count of E. coli cases as a proportion of trust threshold ***NPAF Metric***		1.0%	1.35%	Nov-25	1.0%	1.50%	Oct-25	Driver			Escalation			
	Safe	12 month rolling count of C. difficile cases as a proportion of trust threshold ***NPAF Metric***		1.0%	1.11%	Nov-25	1.0%	1.15%	Oct-25	Driver			Escalation			
	Safe	12 month rolling count of MRSA cases ***NPAF Metric***		0	1	Nov-25	0	2	Oct-25	Driver			Not Escalated			
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	7	Nov-25	TBC	7	Oct-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	0	Nov-25	TBC	1	Oct-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	Nov-25	TBC	0	Oct-25	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	81.0	Aug-25	100.0	83.6	Jul-25	Driver			Not Escalated	82.9		
	Safe	Never Events		0	1	Nov-25	0	1	Oct-25	Driver			Not Escalated	0		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	27.4	Nov-25	32.6	27.4	Oct-25	Driver			Not Escalated	35.2		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.3	16.4	Nov-25	44.3	53.6	Oct-25	Driver			Not Escalated	51.6		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Nov-25	0	0	Oct-25	Driver			Not Escalated	0		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	4.7	Nov-25	6.4	3.7	Oct-25	Driver			Not Escalated	3.5		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	95.2%	Oct-25	95.0%	97.1%	Sep-25	Driver			Not Escalated	97.5%		

Vision: Counter Measure Summary

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

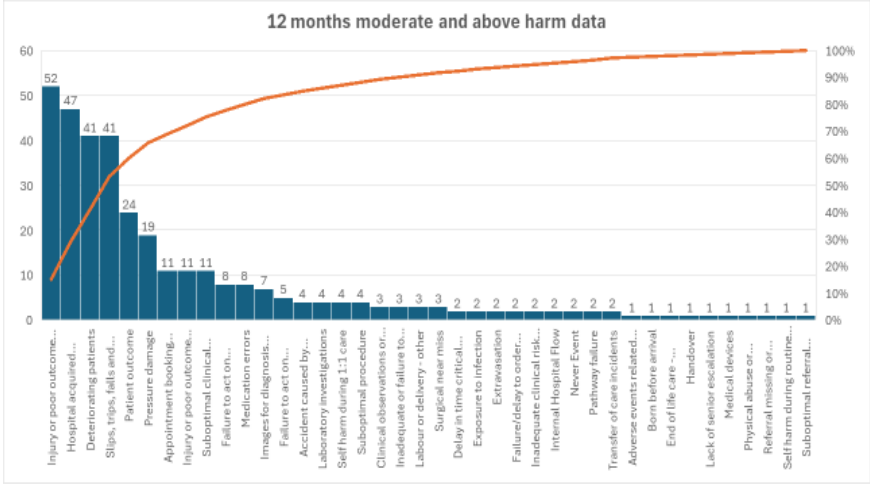
Owner: Chief Medical Officer
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

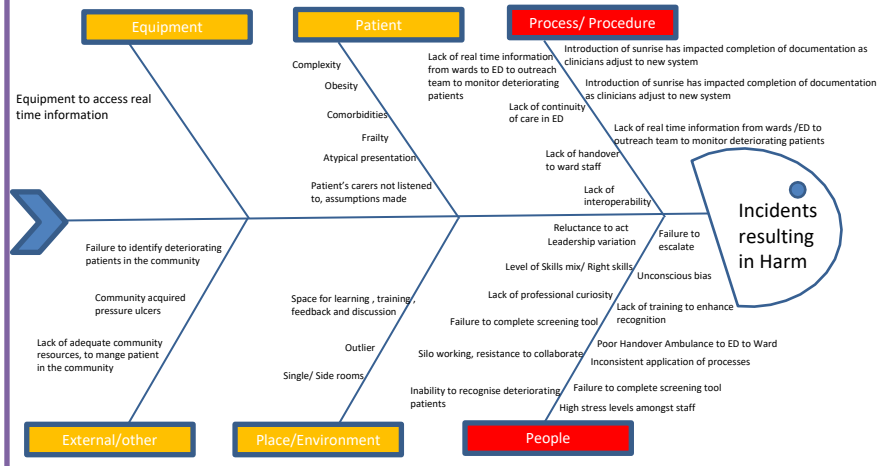


Oct-25 (1 month arr)
2.15
Variance Type
Metric is currently experiencing common cause variation
Maximum Limit (Internal)
1.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



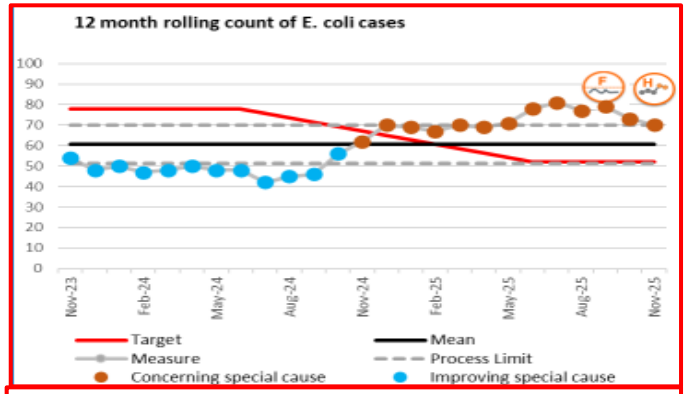
3. Top Contributors



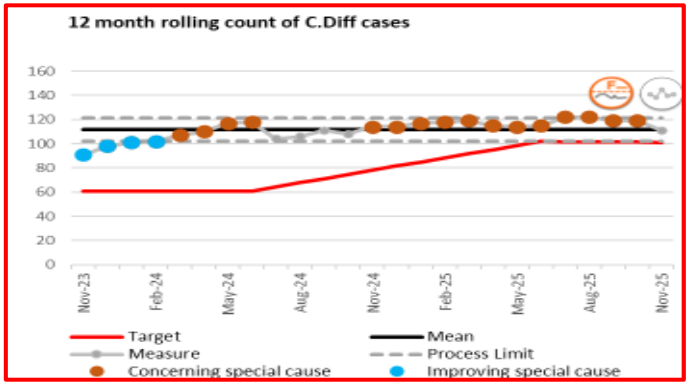
4. Action Plan

Actions	Leads	Due by
Deteriorating Patients		
10 @ 10 Training roll out	JB	Aug-26
Collation of Peri Arrest Data by Chief Registrars	JB	Jan-26
Pilot 2am huddle meeting as an alternative to H@N	YJ	Jan-26
Piloting of deteriorating patient document (SBAR)	JB/MH	Jan-26
Promote Friday review of TEP/DNR	JB/HB	Ongoing
Establish alerting system on Sunrise	JK	Ongoing
Develop Deteriorating patients training package	JB	Mar-26

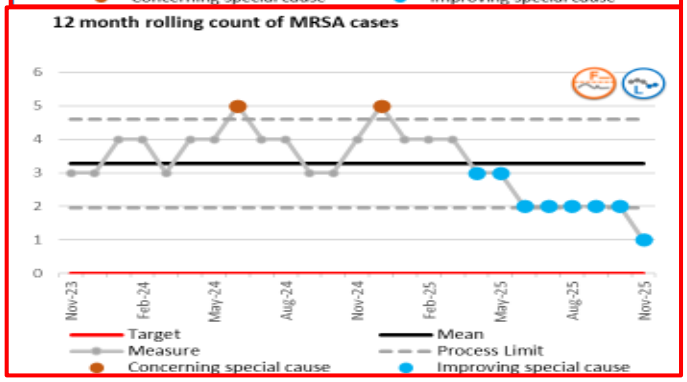
Patient Safety & Clinical Effectiveness: CQC: Safe



Nov-25
70
Variance / ,Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months
Target (Threshold)
50
Business Rule
Full Escalation as has failed the target for 6+months



Nov-25
111
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (Threshold)
90%
Business Rule
Full Escalation as has failed the target for 6+months



Nov-25
1
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 of 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 common cause variation 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, regular audits are carried out on:

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

A review of disinfectants and a trial of chlorine-based disinfectants completed. Implementation of change will be rolled out over next month. Mattresses are cleaned at the time of linen changes with sporicidal wipes

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
- Implementation of chlorine-based disinfectant from January 26
- Enhanced bed and mattress cleaning
- Deep cleaning programme for high-risk areas in place

MRSA - The Trusts continues to review all cases and share learning where appropriate. No hospital attributable cases since February 2025. 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. November saw a positive impact from the action plan, improving to a common cause variation

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*		74.6%	69.8%	Nov-25	74.3%	70.1%	Oct-25	Driver			Full CMS	71.8%		
Breakthrough Objective	Responsive	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways)		15.0	19.6	Nov-25	15.5	19.0	Oct-25	Driver			Full CMS	19.5		
NHS Performance Assessment Framework (NPAF) Metrics	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally *NPAF Metric*		N/A	3	Nov-25	N/A	0	Oct-25	Driver	No SPC	No SPC	Not Escalated			
	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 - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric*		85.0%	85.4%	Sep-25	85.0%	85.4%	Jun-25	Driver			Not Escalated			
	Responsive	*Cancer - 28 Day Faster Diagnosis Compliance (one month behind) - Quarter Position Aggregated *NPAF Metric*		80.0%	76.5%	Sep-25	80.0%	76.5%	Jun-25	Driver			Escalation			
Constitutional Standards and Key Metrics	Responsive	RTT Total Waiting List (Excl SYS)		41681	49309	Nov-25	41971	49808	Oct-25	Driver			Escalation			
	Responsive	To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally		74.6%	69.18%	Nov-25	74.3%	70.1%	Oct-25	Driver			Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		740	609	Nov-25	747	626	Oct-25	Driver			Not Escalated	705		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	7	Nov-25	N/A	2	Oct-25	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		89.8%	96.4%	Nov-25	89.1%	91.4%	Oct-25	Driver			Not Escalated	99.0%		
	Responsive	A&E 4 hr Performance		82.2%	79.6%	Nov-25	82.7%	80.2%	Oct-25	Driver			Escalation	80.2%		
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.8%	Oct-25	96.0%	98.7%	Sep-25	Driver			Not Escalated	98.5%		
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	80.6%	Oct-25	85.0%	86.6%	Sep-25	Driver			Not Escalated	85.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	82.9%	Oct-25	75.0%	78.5%	Sep-25	Driver			Not Escalated	80.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	93.3%	Oct-25	90.0%	96.2%	Sep-25	Driver			Not Escalated	92.4%		

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

- CWT metrics are the Provisional reported monthly positions, but the position hasn't been fully validated yet. Finalised reports will be available after the 6 monthly refresh and the position is expected to improve.

Strategic Theme: Patient Access (continued)

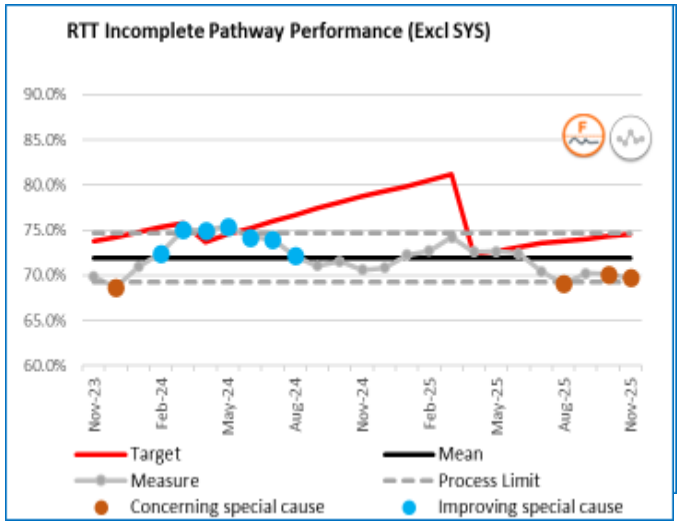
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	81.6%	Nov-25	85.0%	82.7%	Oct-25	Driver			Not Escalated	81.9%		
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		6.2%	5.8%	Nov-25	5.4%	5.6%	Oct-25	Driver			Not Escalated	5.3%		
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	83.0%	Nov-25	90.0%	85.0%	Oct-25	Driver			Escalation	83.5%		
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.7%	Nov-25	5.0%	7.2%	Oct-25	Driver			Escalation	7.1%		
	Effective	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward)		5.9	6.5	Nov-25	5.9	7.3	Oct-25	Driver			Escalation			
	Effective	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	4.4%	Nov-25	16.0%	4.7%	Oct-25	Driver			Not Escalated			
	Effective	To achieve the planned levels of new outpatients activity		22,186	22,661	Nov-25	25,501	23,881	Oct-25	Driver			Not Escalated	22,436		
	Effective	To achieve the planned levels of elective (DC and IP combined) activity		5,780	6,103	Nov-25	6,611	6,969	Oct-25	Driver			Not Escalated	5,755		
	Effective	% Capped Theatre utilisation.		85.0%	81.9%	Nov-25	85.0%	81.0%	Oct-25	Driver			Escalation			
	Effective	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	47.2%	Nov-25	49.0%	46.6%	Oct-25	Driver			Not Escalated	47.1		
	Effective	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity		17,063	18,368	Nov-25	19,622	19,147	Oct-25	Driver			Not Escalated	18,991		

Vision: Counter Measure Summary

Project/Metric Name – RTT – Achieve a 5% improvement in RTT Incomplete Pathway Performance

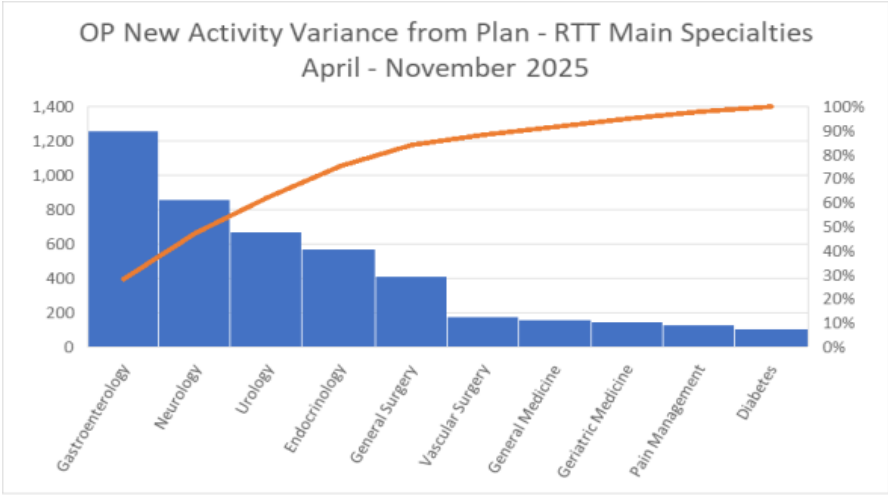
Owner: Chief Operating Officer
Metric: RTT – 5% improvement in performance)
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Nov-25
69.8%
Variance Type
Metric is currently experiencing common cause variation and has failed the target for 6+months
Target (Internal)
74.6%
Target Achievement
Full Escalation as has failed the target for 6+months

2. Stratified Data



Excludes non-RTT specialties such as Therapies & Maternity

3. Top Contributors

- Increase in clock start
- Total waiting list increased
- DNA rates
- Outpatient utilisation
- Reduction in Productivity
- Activity below submitted activity plan for 25/26-New outpatient activity due to reduction in outsourcing and WLI activity
- Consultant vacancy hotspots and sickness

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

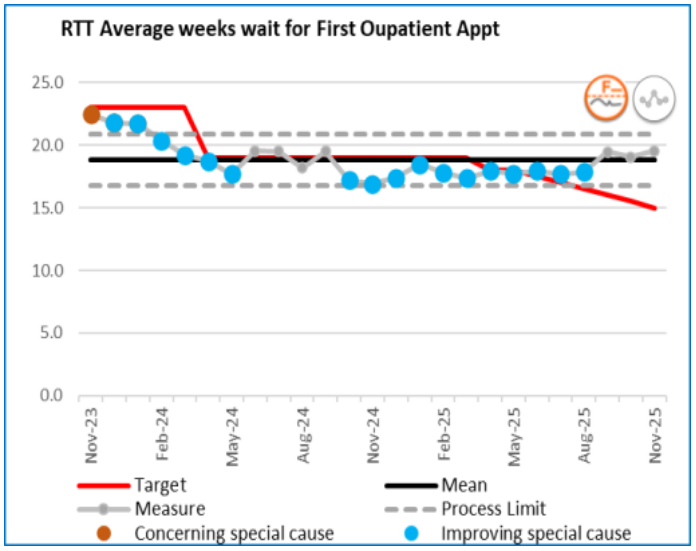
Action	When
Speciality recovery action plans developed which includes productivity and efficiency gains	Commenced
Increase monitoring of action plans through DDOs and performance meetings	Commenced
Trust wide project for referral triage system- Pilot ENT/Hepatology	Dec
Patient Access Team planned validation audits – outcome of audits to be reviewed and next steps agreed.	Dec

Breakthrough Objective: Counter Measure Summary

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

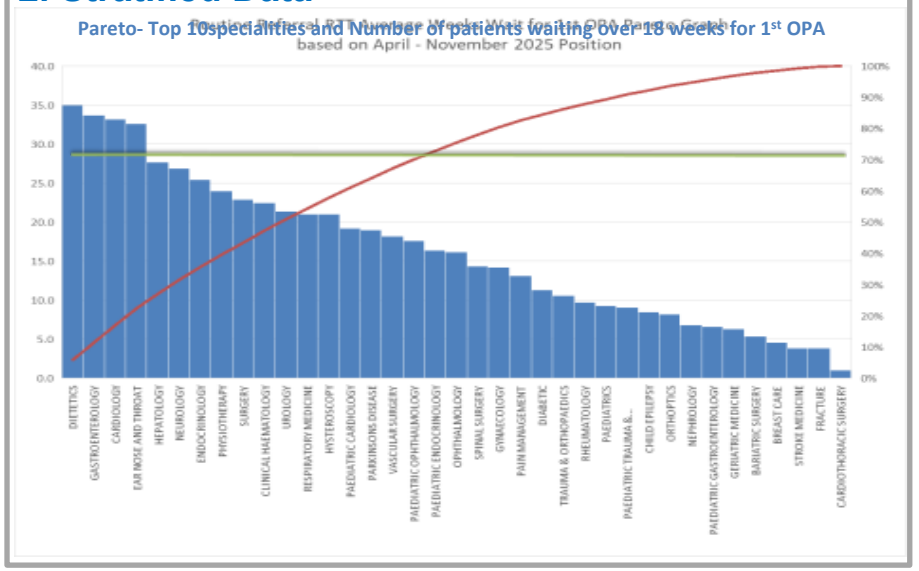
Owner: Chief Operating Officer
Metric: RTT – Reduction is weeks wait to first outpatient appointment (Average)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Nov-25
19.6
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
15.2
Target Achievement
Metric is consistently failing the target

2. Stratified Data



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.

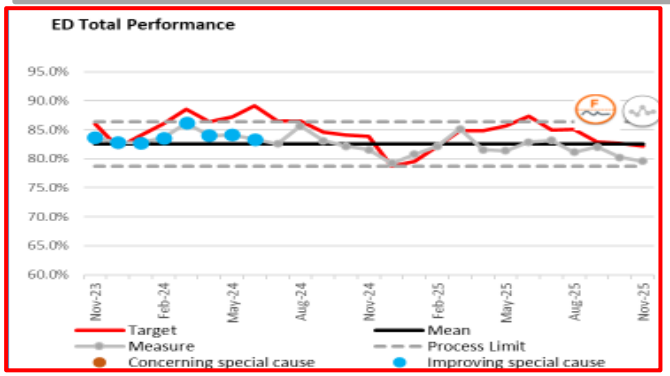
Key Risks:

- 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

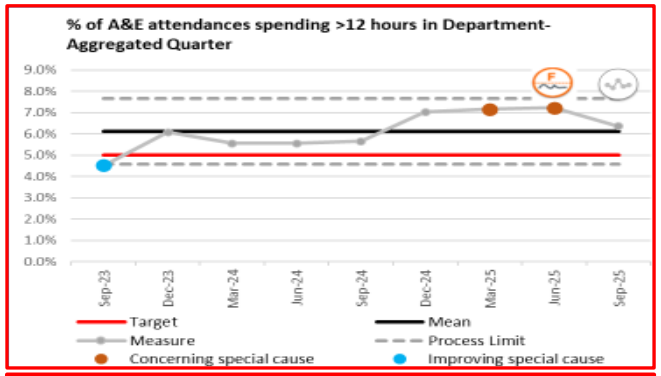
4. Action Plan

Action	When
Pathway mapping and Time and Motion Study completed for Hepatology and new pathway triage trial to commence in December 25	Dec 25
Triangulate all data against top specialty contributors	Ongoing
Complete root cause analysis for each pathway	Ongoing
ENT CAU process- Gemba completed and initial findings going through review with Speciality	Dec 25
Capacity of audiology- Clinic realignment and improved monitoring in progress	Ongoing
ENT- Review demand and capacity variation in subspecialities	Dec 25
Gastro and Cardio- Divisional Improvement work and A3 development in progress	Ongoing

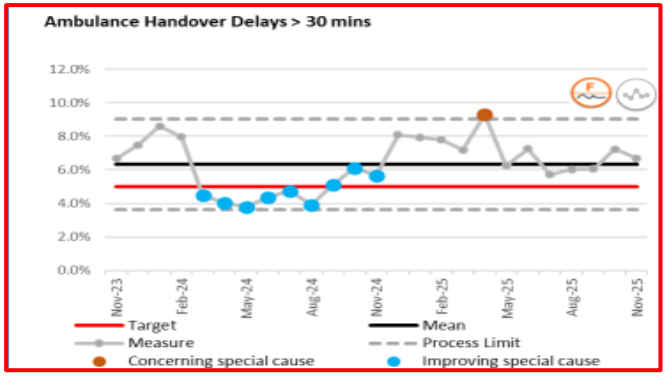
Patient Access: CQC: Responsive



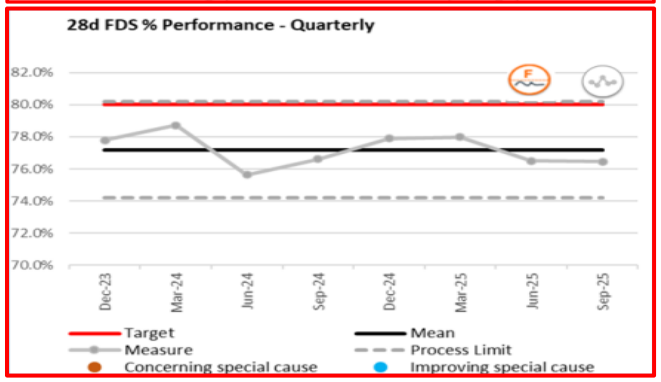
Nov-25
79.6%
Variance / Assurance
Metric is currently experiencing common case variation
Target (Bus. Plan)
82.2%
Business Rule
Full Escalation as has failed the target for 6+months



Jul - 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



Nov-25
6.7%
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
76.5%
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

Ambulance Handover delays <30mins: is experiencing common cause variation and has 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): Continuous review of the data and reactively and proactively. Focused work and pilots underway. Current challenges remain flow during winter.

Ambulance Handover delays <30mins: New RAP flow in TWH has improved offload ability. Review of available trolleys underway to ensure appropriate equipment available to offload in a timely fashion.

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): Step change expected after implementation of SDEC transformation

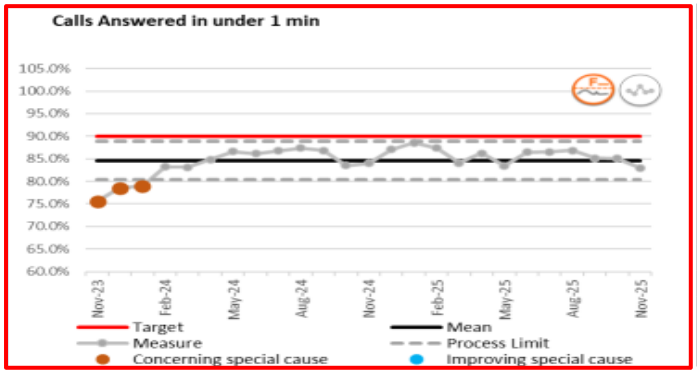
Ambulance Handover delays <30mins: Improved communication with SECAMB to review immediate offload and getting patients assessed whilst awaiting for hospital trolleys to safety offload. Monthly review with SECAmb of all inphases on both ends to improve efficiency and break down any blockers.

28 Day Faster Diagnosis: Plan formulated on triangulation of data completeness, diagnosis (Yes/No) and overall compliance.

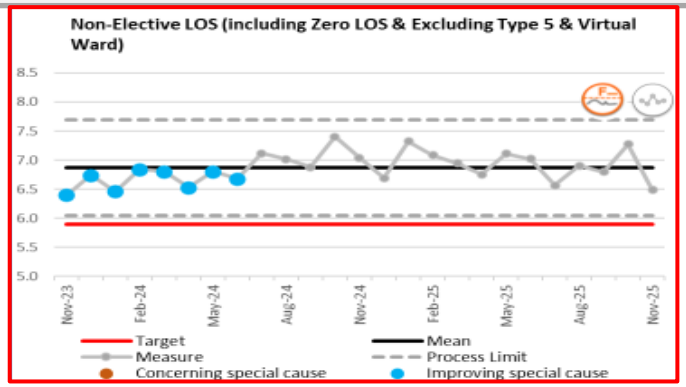
Performance is benchmarked against the national target as per the 25/26 Operating Plan (80% for 28 days), rather than achieving 80% at yearend as per previous guidance.

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.

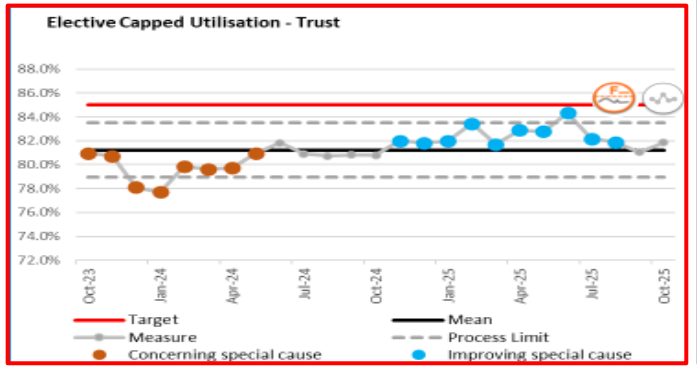
Patient Access: CQC: Responsive



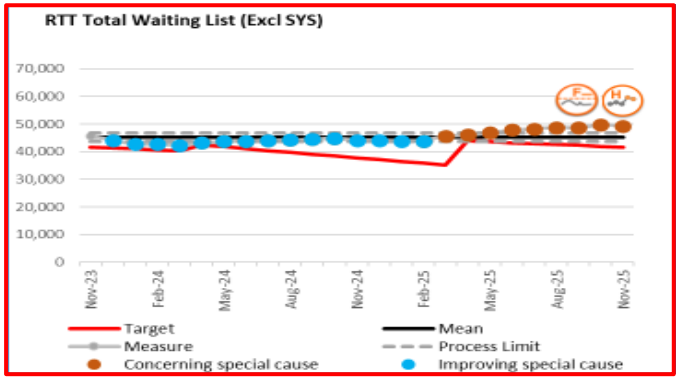
Nov-25
83%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as is consistently failing the target



Nov-25
6.5
Variance Type
Metric is currently experiencing common cause variation consistently failing the target
Target (Internal)
5.9
Target Achievement
Full Escalation as is consistently failing the target



Oct- 25
81.9%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target.



Nov-25
49,286
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target
Target (Internal)
41,681
Business Rule
Full Escalation as is consistently failing the target

Summary:

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.

.

Elective Capped Theatre Utilisation: is experiencing common cause variation and consistently failing the target.

RTT Total Waiting List (Excl SYS): is experiencing Special Cause Variation of a Concerning nature and consistently failing the target

Actions:

Performance against the under 1 minute 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:

Calls Answered within 1 minute in the CAUs:. Total calls answered in October was 26,922 which was 4,808 less calls than the previous month. Performance is steady at 85% despite known vacancies within our CAU teams.

Non-Elective LOS: This is the operation flow financial theme project, reported through the Financial Improvement Programme Board.

Elective Capped Theatre Utilisation: Smart scheduling in Ophthalmology, Trauma & Orthopaedics and Gynaecology is ongoing.

RTT Total Waiting List (Excluding Sys): Please see RTT CMS.

Strategic Theme: Patient Experience

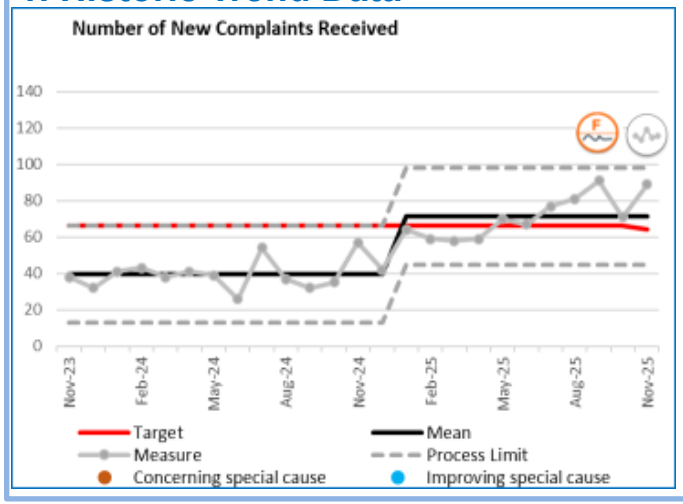
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		64	89	Nov-25	66	71	Oct-25	Driver			Full CMS	90		
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		15.7%	11.0%	Nov-25	15.7%	24.3%	Oct-25	Driver			Verbal CMS			
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	26	Nov-25	24	36	Oct-25	Driver			Not Escalated	26		
	Caring	Complaints Rate per 1,000 occupied beddays		3.9	4.9	Nov-25	3.9	3.8	Mar-24	Driver			Not Escalated	4.9		
	Caring	% complaints responded to within target		75.0%	75.0%	Nov-25	75.0%	76.0%	Oct-25	Driver			Not Escalated	75.0%		
	Caring	Complaints Backlog – Older than 4 months		0	7	Nov-25	0	2	Oct-25	Driver			Not Escalated			
	Caring	Complaints Closed in Month		38	66	Nov-25	38	90	Oct-25	Driver			Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	98.0%	Nov-25	95.0%	100.0%	Oct-25	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		21.4%	15.8%	Nov-25	21.4%	17.1%	Oct-25	Driver			Not Escalated	24.73%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		9.9%	10.2%	Nov-25	9.9%	10.5%	Oct-25	Driver			Not Escalated	11.60%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		12.1%	7.7%	Nov-25	12.1%	8.3%	Oct-25	Driver			Escalation	10.57%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		15.9%	13.5%	Nov-25	15.9%	12.7%	Oct-25	Driver			Escalation	14.93%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	99.4%	Nov-25	93.5%	96.6%	Oct-25	Driver			Not Escalated	96.1%		

Vision: Counter Measure Summary

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

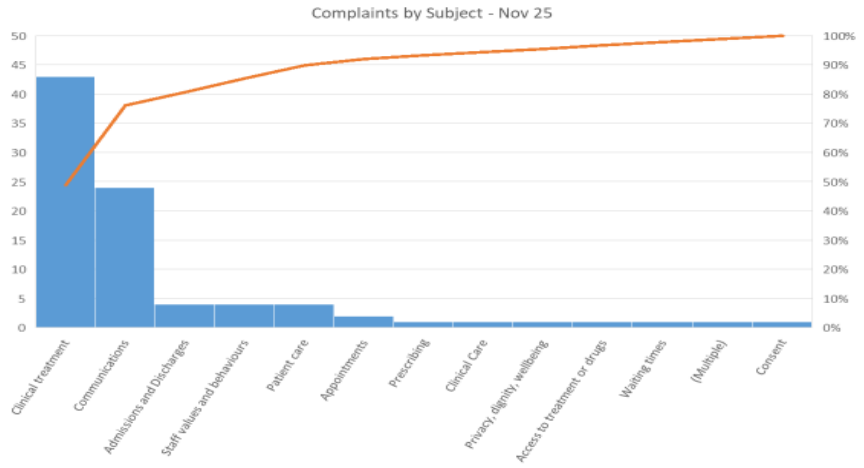
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Nov-25
89
Variance Type
Metric is currently experiencing Special Cause Variation of a Concerning Nature
Max Limit (Internal)
64
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.

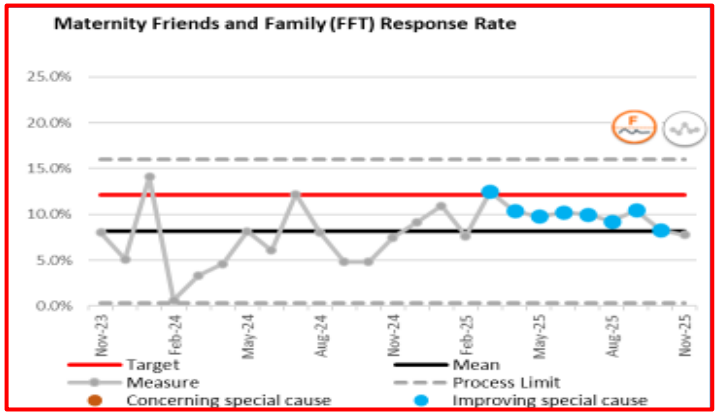
Key Risks:

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.

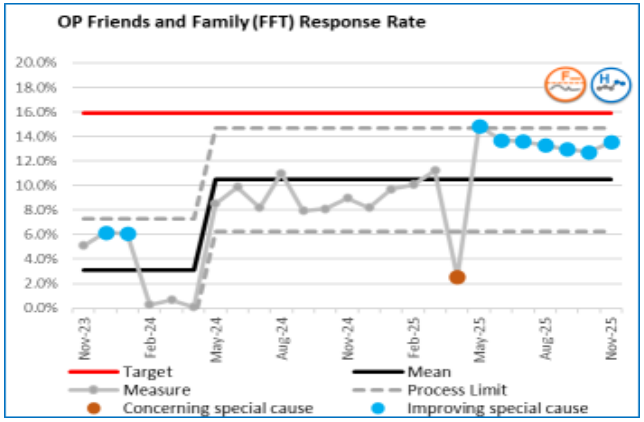
4. Action Plan of the Vision Objective:

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
Trust-wide / core team	Promotion of telephone resolution (early resolution) & meetings (family meetings - name changes to local listening meeting in new policy	Patient Complaints Lead
Trust-wide / core team	PALS team is now fully staffed and will be de-escalating complaints were appropriate	Patient Complaints Lead
Trust-wide / core team	Additional training around de-escalation as part of the roll out of the new policy	Patient Complaints Lead

Patient Experience: CQC: Caring



Oct-25
7.7%
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



Oct-25
13.5%
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 - Maternity: is currently common cause variation and has failed the target for 6+ months
National Response – 12.6%
Trust Recommended Rate is 100%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of an improving nature, butis consistently failing the target
National Response – 16.9%
Trust Recommended Rate is 93.9%

Actions:

Maternity: The response rate has dropped in comparison to recent months. Whilst the quantity of feedback remains low, the positivity ratings remain high with staff attitude, implementation of care and patient mood/feeling again the top 3 themes, the care and kindness of midwives and other staff is commonly referred to. Similarly, the top 3 negative themes communication, environment and implementation of care, environment is a consistent them over past months. Comments reflecting poor communication between patient and staff as well as between staff formed the majority of negative feedback, no comments were provided with a high proportion of negative ratings.
No feedback was received for the postnatal community team in November, this has been highlighted to the patient experience midwife in maternity.
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. 91% (7/8) were via this means despite the likely impact of the survey fatigue filter applied for SMS text requests which is likely to have the most significant impact on outpatient feedback. 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 – notably there are comments in relation to multiple grades of staff and professional groups. Much of the positive feedback is associated with core clinical services and/or the CDC with patients repeatedly commenting on appointment times being maintained. Areas for improvement continue to be: staff attitude, environment and waiting time – a number of comments are associated with poor experience/dissatisfaction with remote appointments, there are multiple references to consultations running extremely later than appointed times.
FFT Response All: Feedback received in November has dropped slightly. 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.
Transcription of responses received by hard copy has now been taken in-house, it's noted that whilst this mode of response remains limited there has been a noticeable decrease (approx. 50%) in responses via this means over the last 2 months.
Formal notice of the cessation of provision of patient experience services by HCC at the end of August 2026 has been received.

Assurance & Timescales for Improvement:

Friends and Family (FFT) Response Rates:
The transcription of hard copy cards is now being undertaken in a more timely manner, teams have been encouraged to ensure that cards are being made available on a regular basis to support in-month reporting wherever possible. It's noted that responses via this means have dropped over the last two months despite this. Consideration is being given to undertaking regular engagement in main outpatient areas to promote FFT feedback.
An alternate provider for FFT is now being sought.

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	513	Nov-25	524	626	Oct-25	Driver			Verbal 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	35	Nov-25	57	47	Oct-25	Driver			Full CMS			
Constitutional Standards and Key Metrics	Effective	Delivery of the better use of beds programme for MTW - Average Non-Elective LOS for Fracture Neck of Femur (NOF) - Data runs one month behind		12.0	11.8	Oct-25	12.0	11.9	Sep-25	Driver			Not Escalated			

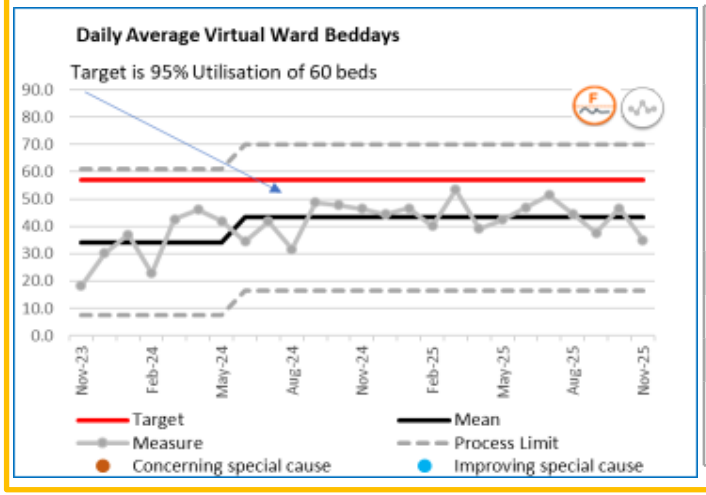
*This strategic theme is focussing on contributors to the overall non-elective length of stay that are part of the Better Use of Beds programme.
Please note that the target for the Vision metric is a 10% reduction which represents the Trust's internal stretch target.

Breakthrough Objective: Counter Measure Summary

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

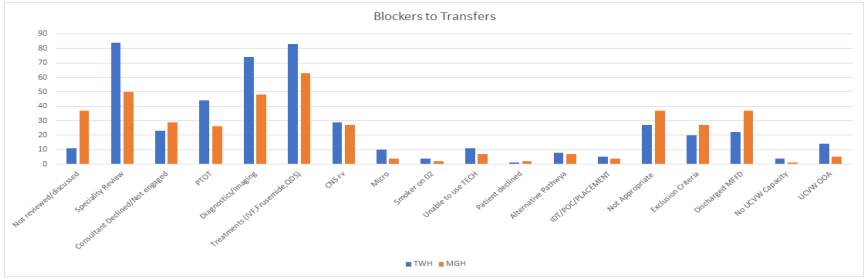
Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average Virtual Ward Beddays - Target is 95% of 60 beds
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Nov-25
35
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.

There is an issue with the way we record inpatients who transferred to Virtual Ward on our PAS system, the team are waiting for national coding to make the change in recording.
There is issue with clinical staff availability which is delaying go live in Gynaecology

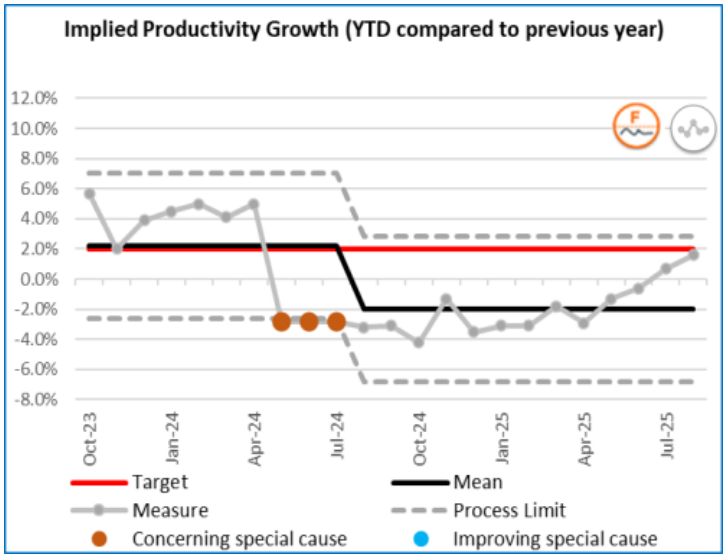
4. Action Plan

Workstreams	Actions	When	Who
Coding	Meeting to agree process for recording LTC Pathways	14/11/2025	VW, Coding, CSMT
Pathways	**Update on new pathways**		**FJ and VW team**
Gynae & Hyperemesis	Meeting to confirm pathways and go live date	Dec	VW Team/Gynae
Urology	Stone, Acute Urology, TWOC Pathways in development date of meeting to be agreed	TBC	VW Team/Urology
Gastro	IBD meeting to agree pathway	25/11/2025	VW Team/Gastro
Maternity	Meeting to agree go live for C-Section wound care	14/11/2025	VW Team/Maternity
ENT	Two pathways in development meeting to agree next steps	TBC	VW Team/ENT
Surgery Pathways	CD and COS to identify pathway for General Surgery	Dec 25	

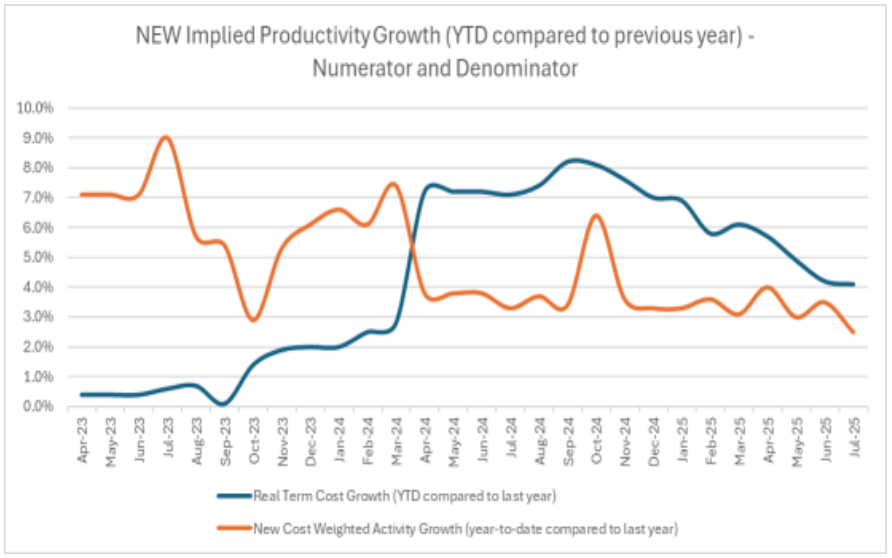
Strategic Theme: Sustainability

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Three Month Forecast	Variation	Assurance
Vision	Well Led	Delivery of financial plan, inc. operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) *NPAF Metric*		1,708	-2,906	Nov-25	3,108	-2,805	Oct-25	Driver			Verbal CMS	-5,304		
Breakthrough Objectives	Well Led	Reduce non-pay spend		21,554	21,516	Nov-25	21,815	23,302	Oct-25	Driver			Verbal CMS	22,313		
NHS Performance Assessment Framework (NPAF) Metrics	Productivity & Efficiency Metric	Implied Productivity Growth (YTD compared to previous year)		2.0%	1.6%	Jul-25	2.0%	0.7%	Jun-25	Driver			Escalation			
Constitutional Standards and Key Metrics	Well Led	CIP		8,042	3,994	Nov-25	7,864	4,071	Oct-25	Driver	No SPC	No SPC	Not Escalated	4,983	No SPC	No SPC
	Well Led	Cash Balance (£k)		7,572	16,466	Nov-25	8,649	17,734	Oct-25	Driver			Not Escalated	8,419		
	Well Led	Capital Expenditure (£k)		459	243	Nov-25	309	439	Oct-25	Driver			Not Escalated	309		

Sustainability



Jul-25
1.6%
Variance / Assurance
Metric is currently experiencing common cause variation and is failing the target
Target (National)
2.0%
Business Rule
Escalated as failed target for 6+ months

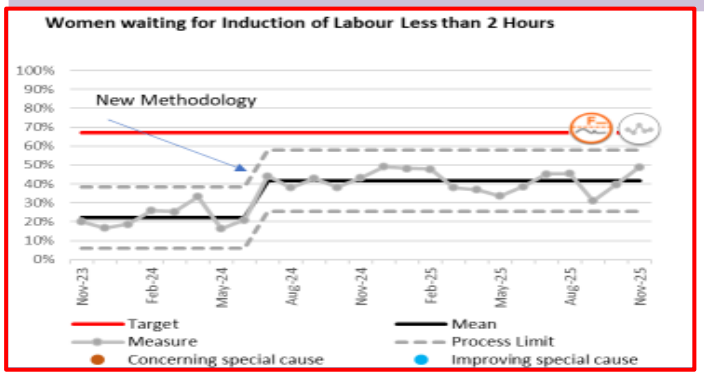


Summary:	Actions:	Assurance & Timescales for Improvement:
This metric is now showing a positive value (1.6%) but in line with our business rules remains escalated. In the last NPAF publication this value would have attracted a NOF score of 3.17, so despite this improvement, MTW would remain in segment 3 if our improvement is relative to our peers. The national median is 2.2% for Month 4. The blue line on the second SPC chart illustrates the increase in costs from April 2024, which has not been matched by a corresponding rise in cost-weighted activity (shown by the orange line). However, costs have reduced from a peak in October 2024, with this downward trend continuing into 2025/26. This aligns with the reduction in both temporary and substantive staffing costs achieved during the same period. As previously noted, several significant organisational changes occurred during 2024/25 — including the opening of KMOC and the transition of Fordcombe Hospital — which led to additional expenditure without the anticipated corresponding increase in activity.	There are various transformation programmes are in place to improve our position including within Outpatients, Patient Flow and Theatres. The GIRFT programme is also being used to identify areas for improvement and to action these. The Financial Improvement and Workforce Transformation programmes are also key in controlling and reducing costs, in line with our finance and business plans. Performance in terms of our activity against plan for the different points of delivery across our divisions is managed via the operational management governance but is also within the scope of the SDR process – with Exec oversight and scrutiny. Various productivity and efficiency metrics are also part of the SDR process for our divisions and are also included at Trust-level in the IPR.	Productivity and efficiency reports produced quarterly for EMT and Finance and Performance Committee, with deep-dives into each division on rotation. Robust governance in place for the transformation programmes listed, overseen by the Executive Management Team and Board.

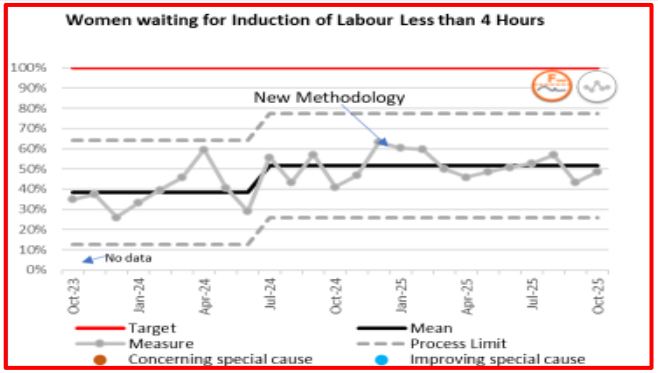
Maternity Metrics

				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	459	Nov-25	470	465	Oct-25	Driver		No target	Not Escalated	454		No SPC
	Maternity Metric	Antenatal bookings		No target	597	Nov-25	545	589	Oct-25	Driver		No target	Not Escalated	539		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	23.7%	Nov-25	No target	24.0%	Oct-25	Driver		No target	Not Escalated	21.7%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	28.5%	Nov-25	No target	24.8%	Oct-25	Driver		No target	Not Escalated	25.5%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.8%	Nov-25	36.0%	28.1%	Oct-25	Driver		P	Not Escalated	26.8%		P
	Maternity Metric	Women waiting for Induction of Labour less than 2 Hours		67.0%	49.0%	Nov-25	67.0%	39.8%	Oct-25	Driver		F	Escalation	47.9%		F
	Maternity Metric	Women waiting for Induction of Labour less than 4 Hours		100.0%	61.0%	Nov-25	100.0%	48.7%	Oct-25	Driver		F	Escalation	45.3%		F
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	4.6%	Nov-25	6.0%	7.1%	Oct-25	Driver		?	Not Escalated	5.6%		?
	Maternity Metric	Unexpected term admissions to NNU (data runs one month behind)		4.0%	4.3%	Oct-25	4.0%	4.7%	Sep-25	Driver		?	Not Escalated	5.0%		F
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Nov-25	0.4%	0.4%	Oct-25	Driver		?	Not Escalated	0.5%		?
	Maternity Metric	PPH >=1500% Rate		3.0%	2.7%	Nov-25	3.0%	2.2%	Oct-25	Driver		?	Not Escalated	2.2%		?
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	3.2%	Nov-25	2.5%	1.7%	Oct-25	Driver		?	Not Escalated	2.7%		?
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	80.0%	Nov-25	75.0%	80.8%	Oct-25	Driver		P	Not Escalated	81.3%		P
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins		95.0%	100.0%	Nov-25	95.0%	100.0%	Oct-25	Driver	H	?	Not Escalated	60.5%	H	?
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins		95.0%	86.3%	Nov-25	95.0%	89.3%	Oct-25	Driver	H	F	Escalation	7.4%	L	F
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Nov-25	100.0%	100.0%	Oct-25	Driver		P	Not Escalated	100.0%		P
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Nov-25	100.0%	100.0%	Oct-25	Driver		P	Not Escalated	100.0%		P

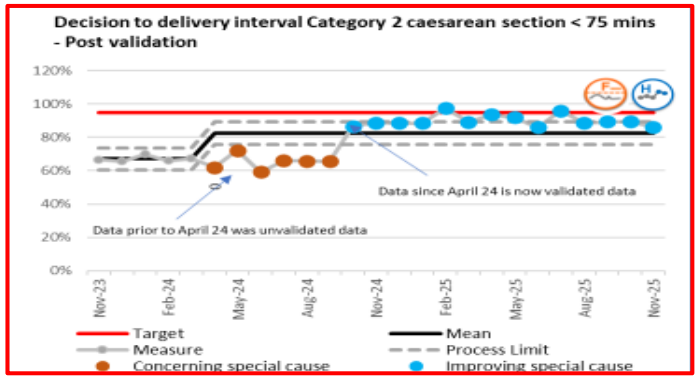
Maternity Metrics



Nov-25
49%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
67%
Business Rule
Full escalation as consistently failing the target



Nov-25
61%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target



Nov-25
86.3%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature
Target (Internal)
95%
Business Rule
Full escalation as consistently failing the target

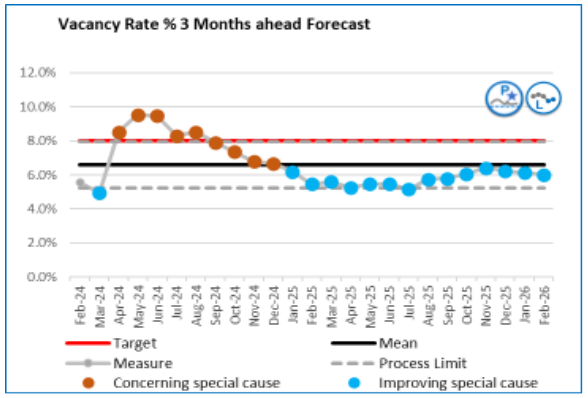
Summary:	Actions:	Assurance & Timescales for Improvement:
Women waiting for Induction of Labour less than 2: is experiencing common cause variation and consistently failing the target. **Women waiting for Induction of Labour less than 4 Hours:** is experiencing common cause variation and consistently failing the target. **Decision to delivery interval Category 2 caesarean section <75mins:** is experiencing special cause variation of an improving nature but 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. **Decision to delivery interval Category 2 caesarean section <75mins:** Each category 2 C-sections are reviewed clinically and any harm escalated to risk team, the vast majority do not cause any harm and there is oversight via MNCOG	**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. **Decision to delivery interval Category 2 caesarean section <75mins:** The team continue to share learning from each review

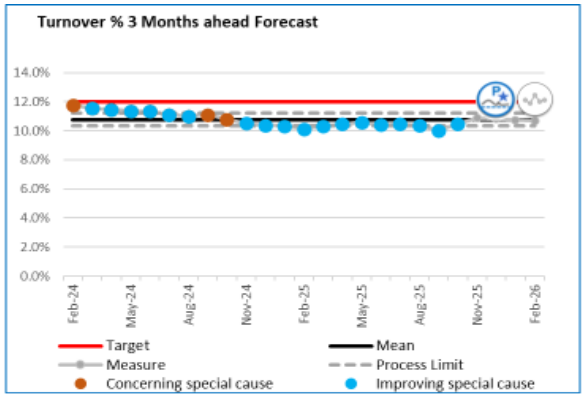
NHS
Maidstone and Tunbridge Wells NHS Trust

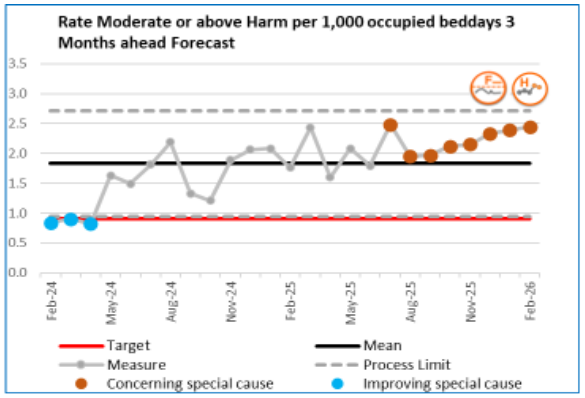
Appendices

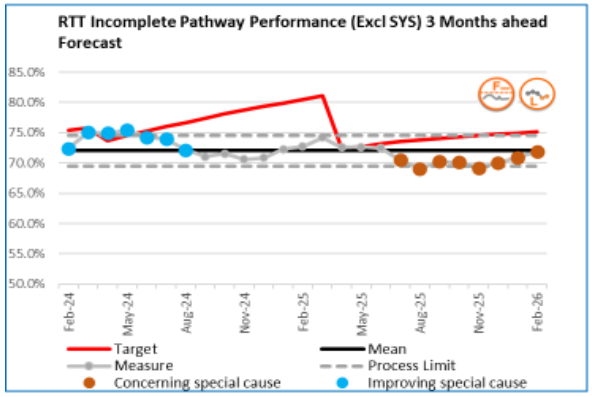
MTW
exceptional people, outstanding care

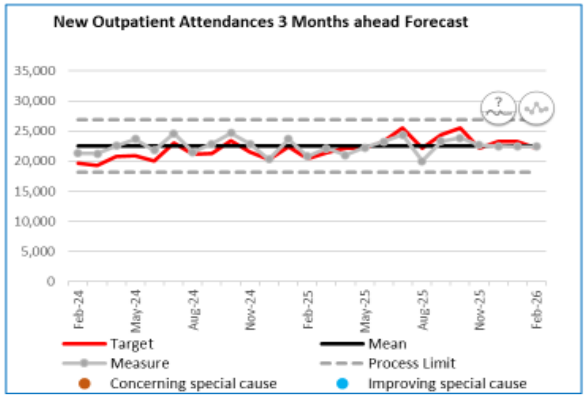
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

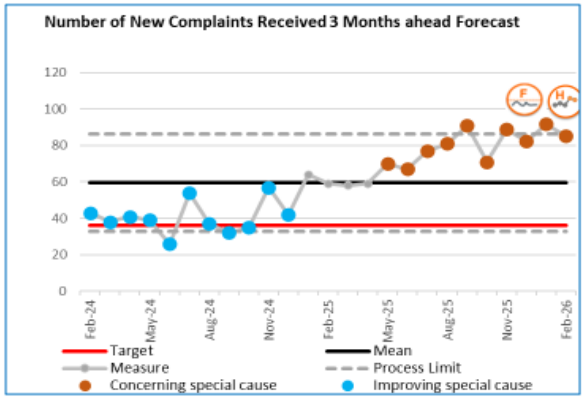


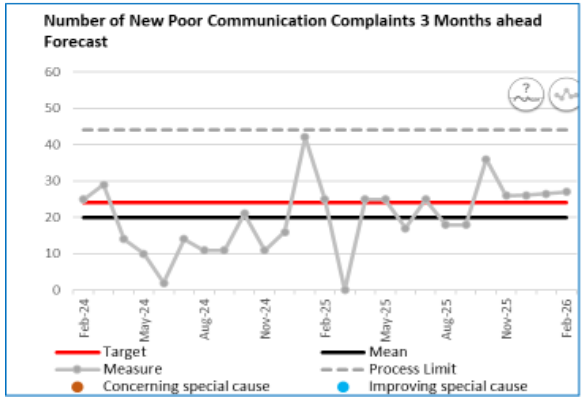


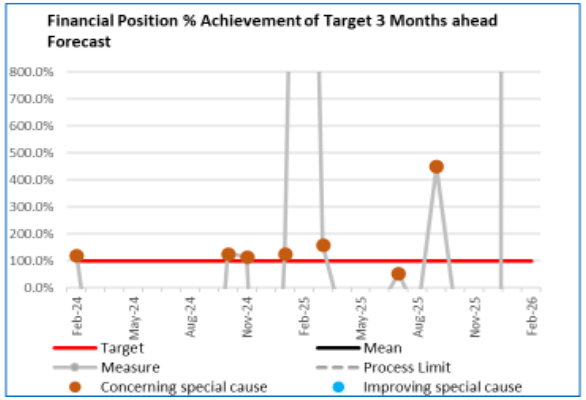


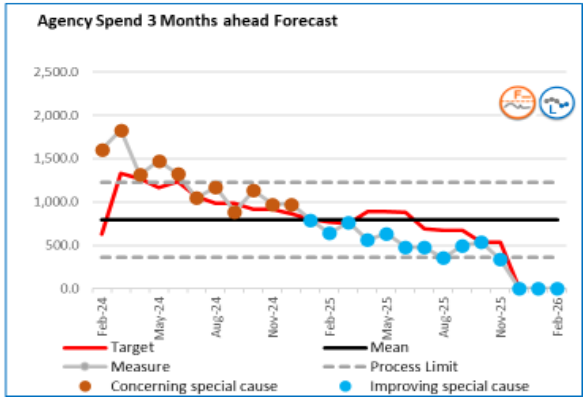




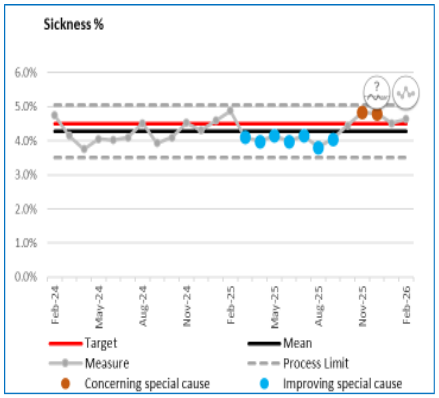


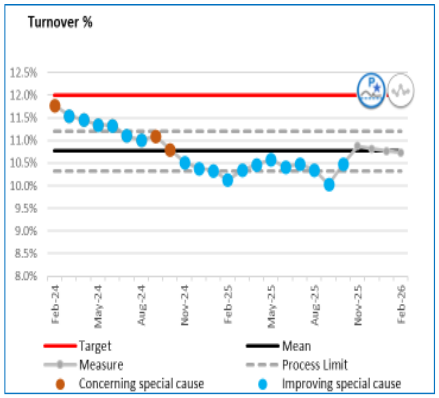


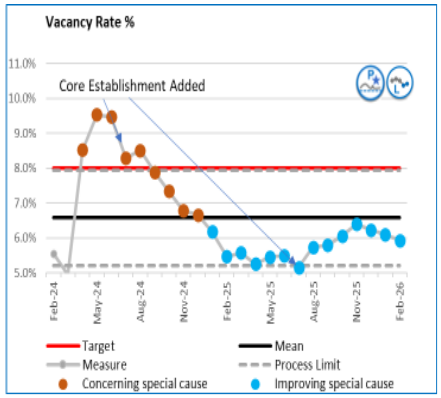


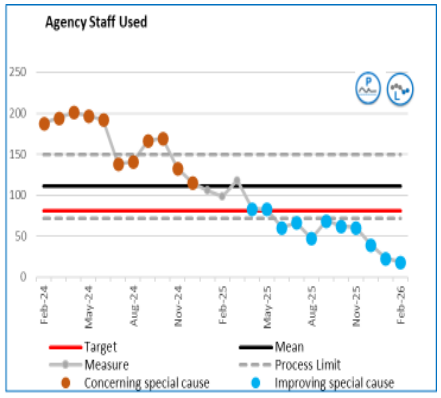


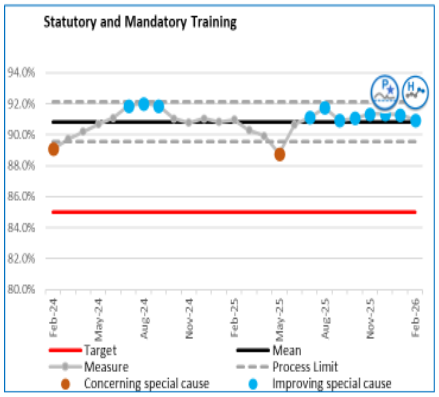
Forecast SPCs (3 month forward view) for People Indicators

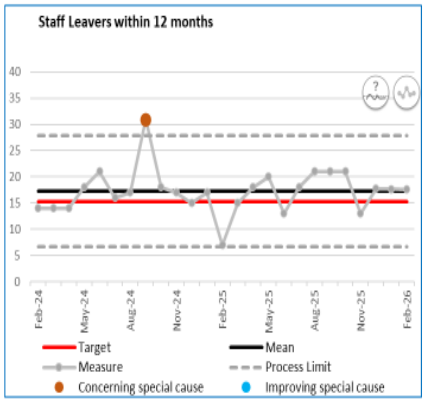


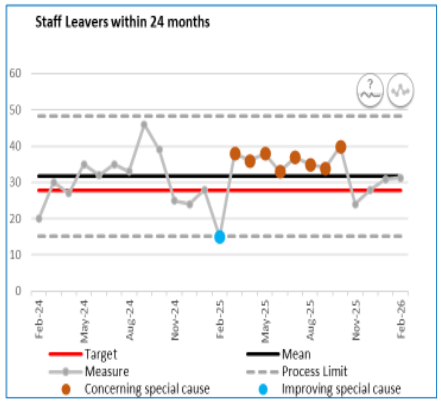


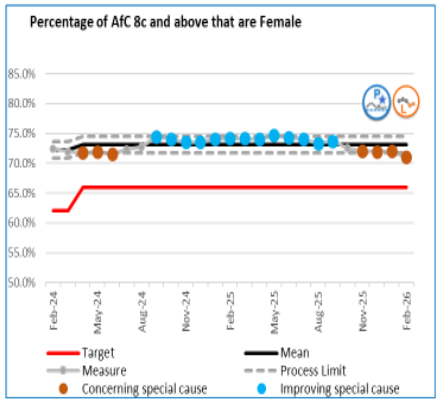


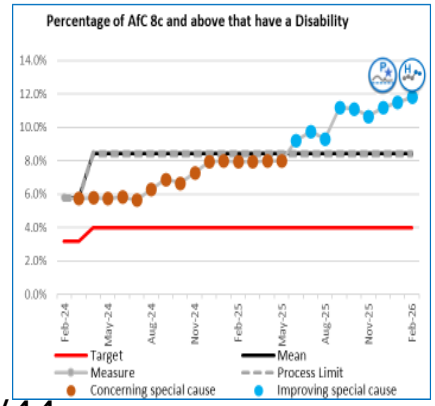


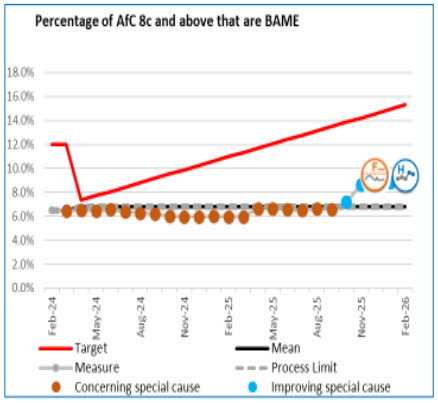


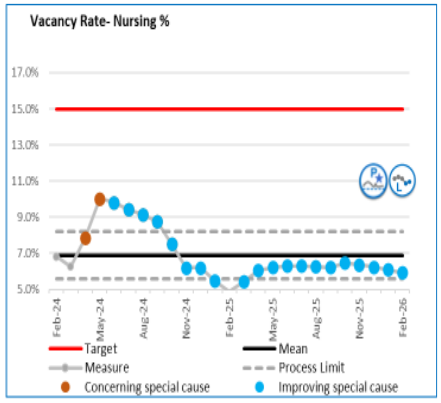




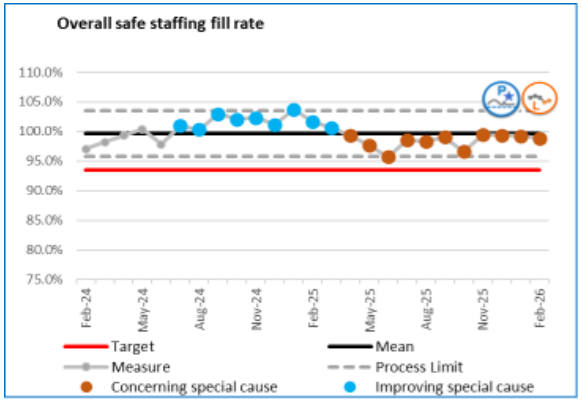


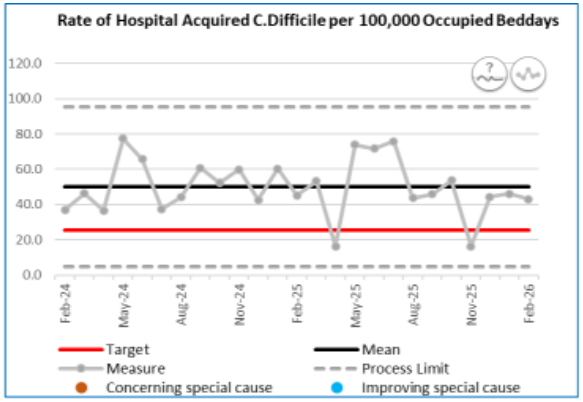


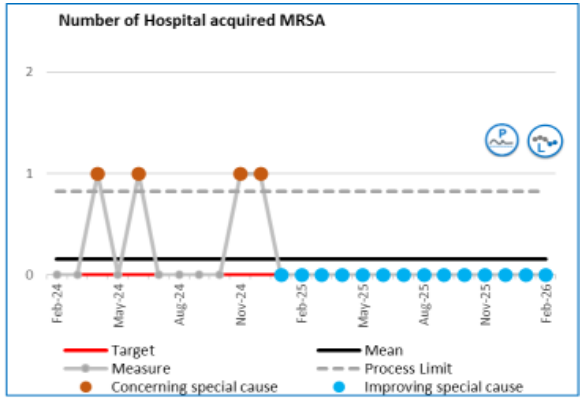


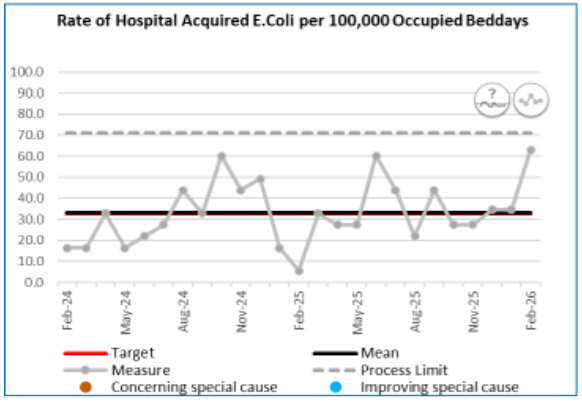


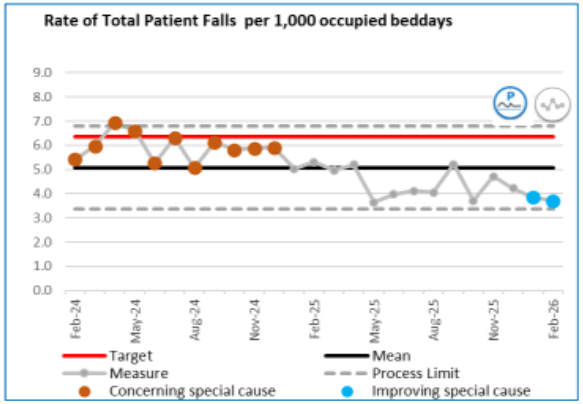
Forecast SPCs (3 month forward view) for Patient Safety Indicators

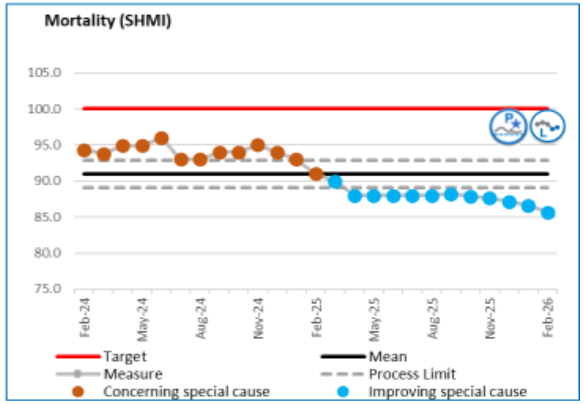


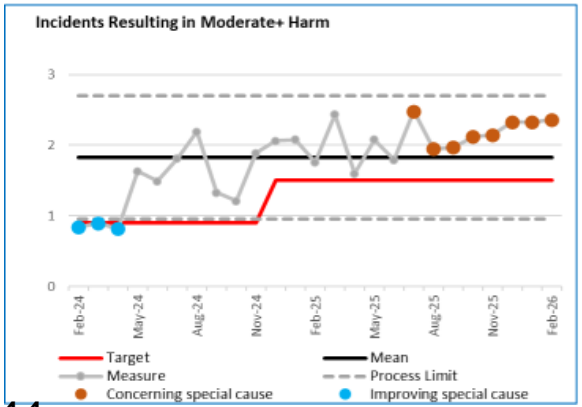


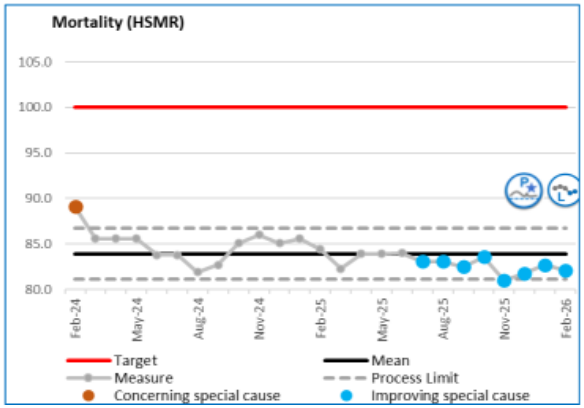




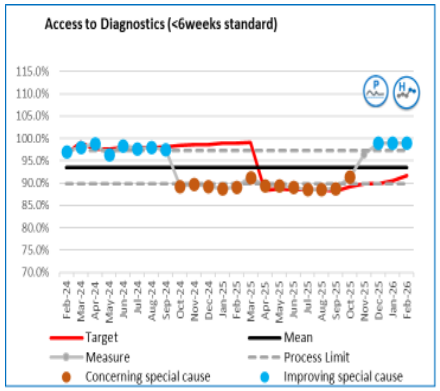


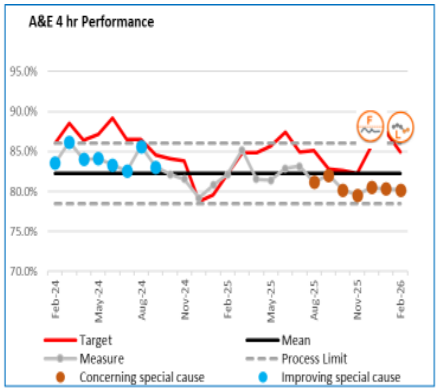


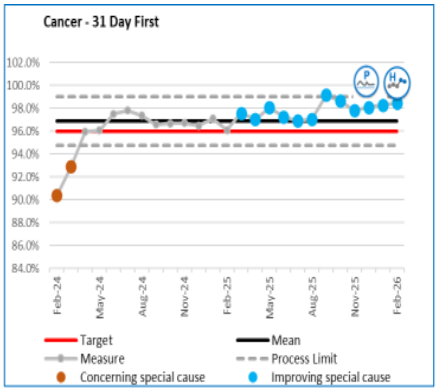


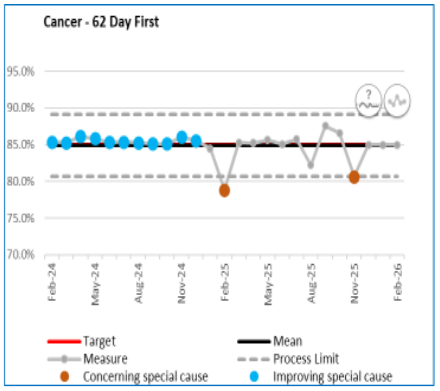


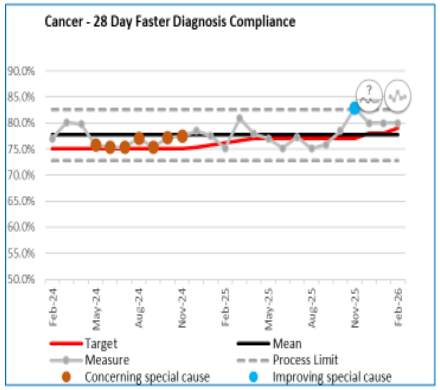
Forecast SPCs (3 month forward view) for Patient Access Indicators

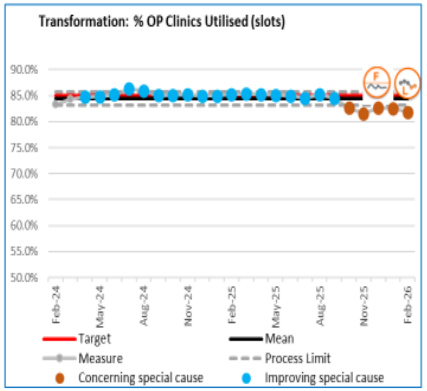


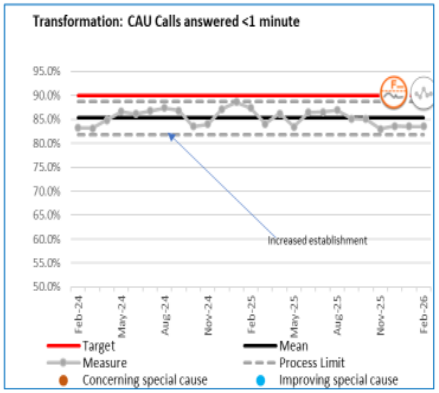


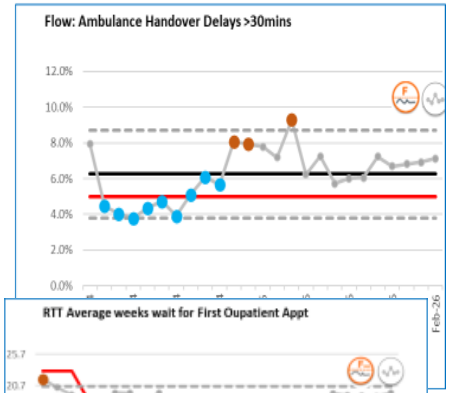


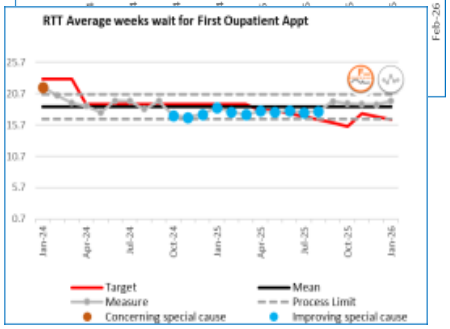


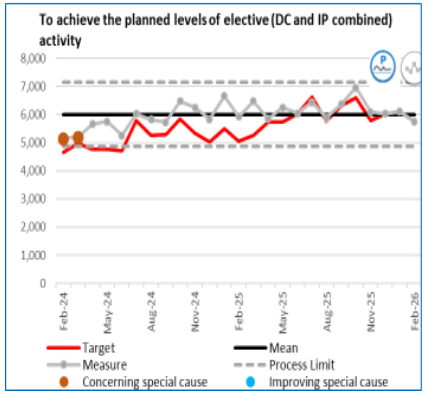


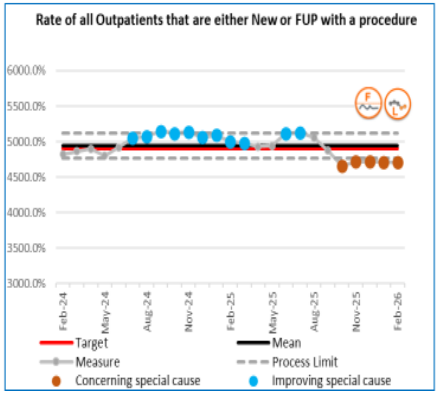


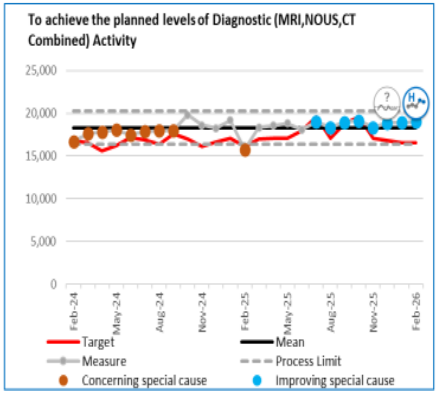




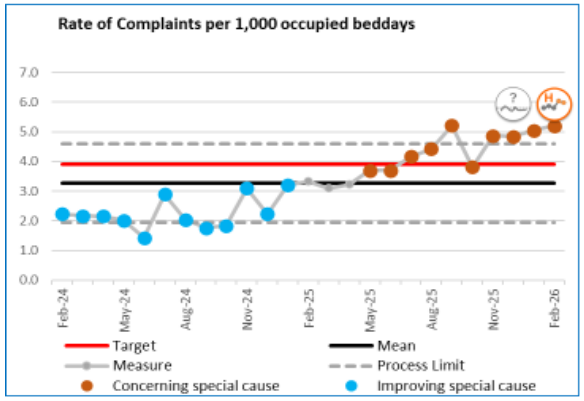


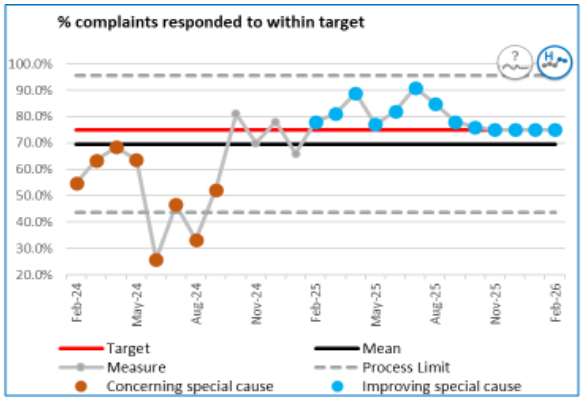


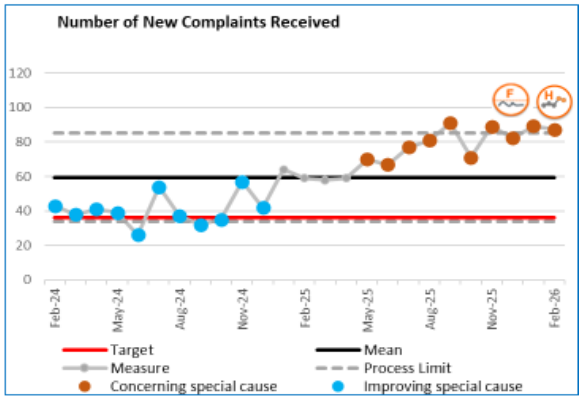


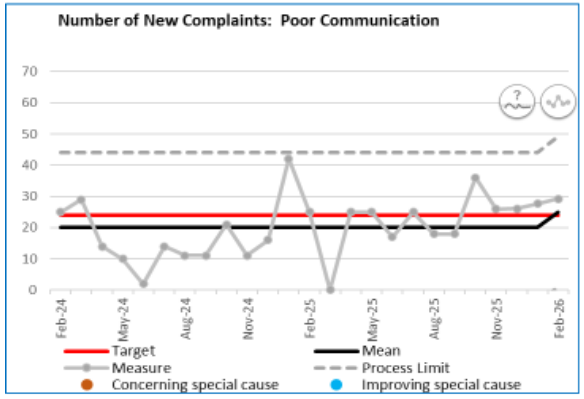


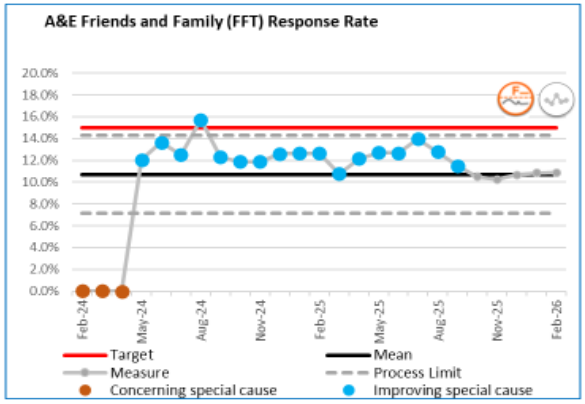
Forecast SPCs (3 month forward view) for Patient Experience Indicators

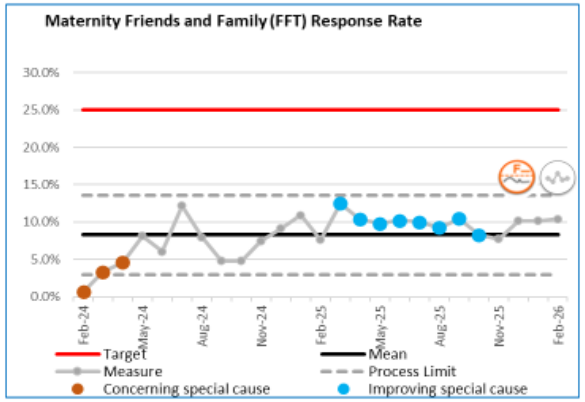


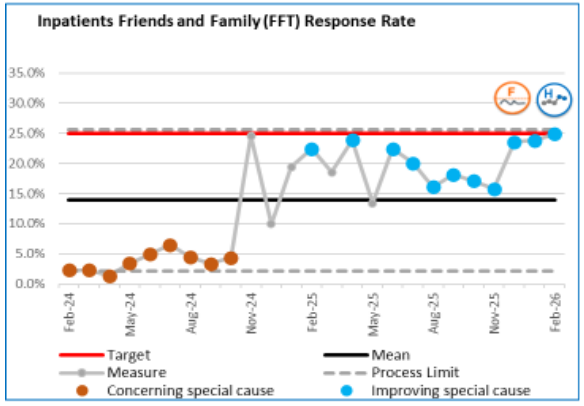


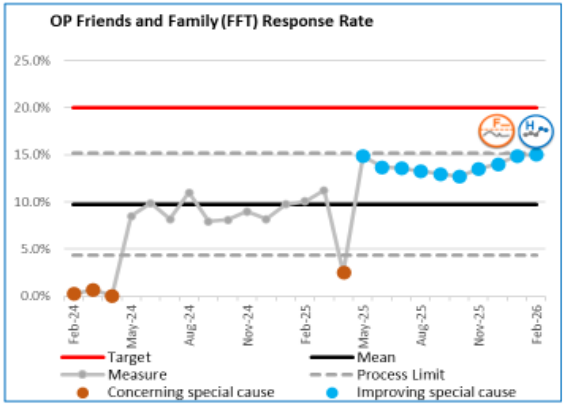


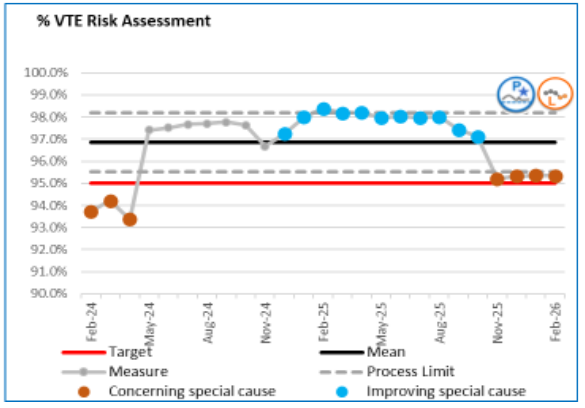












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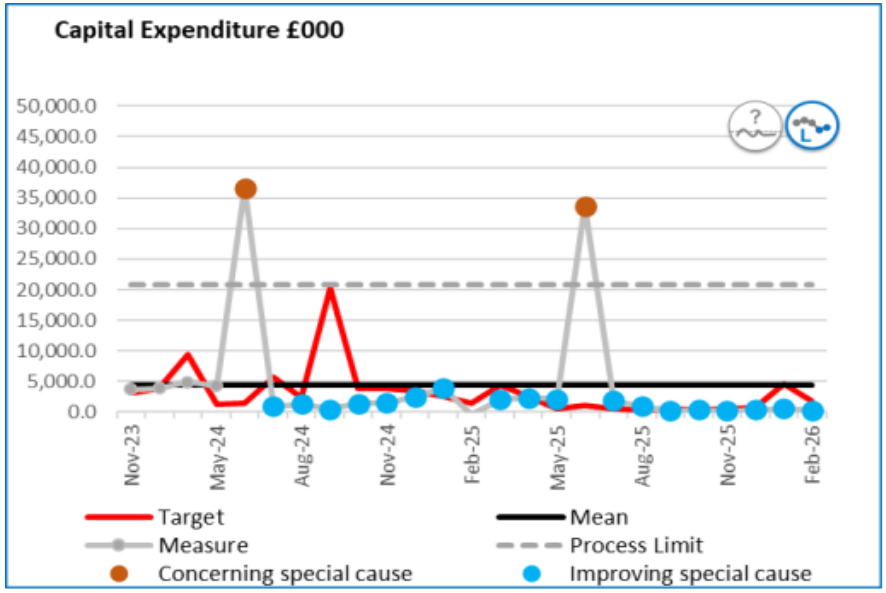
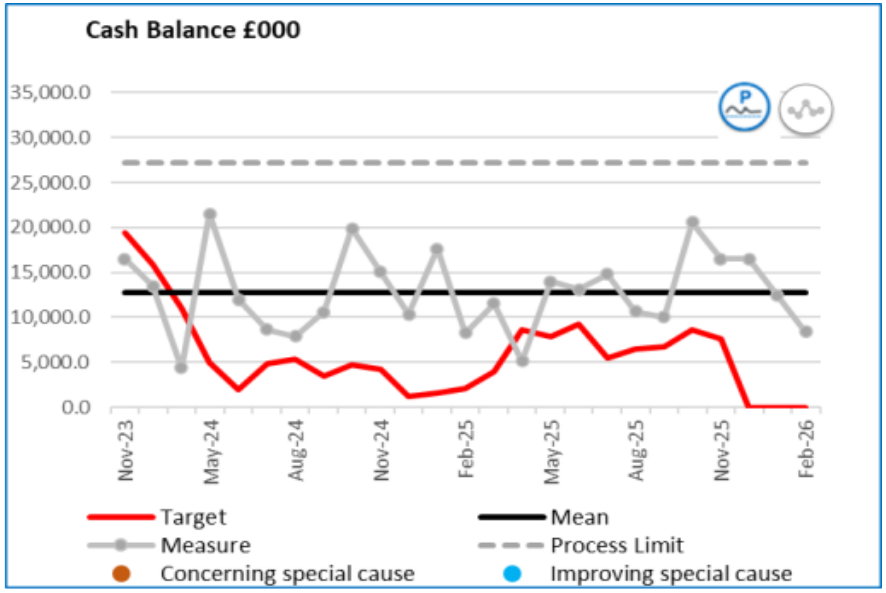
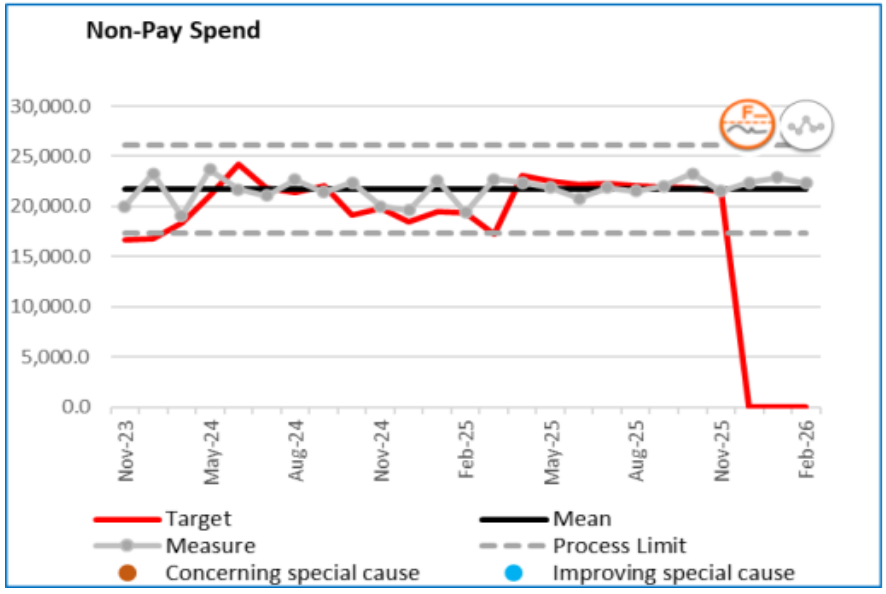
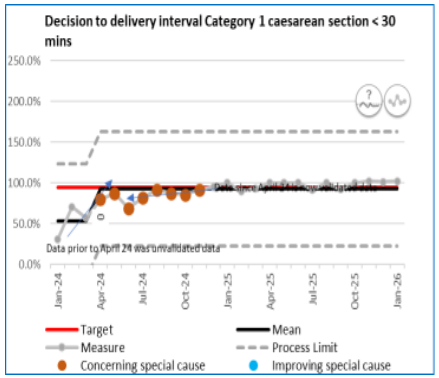
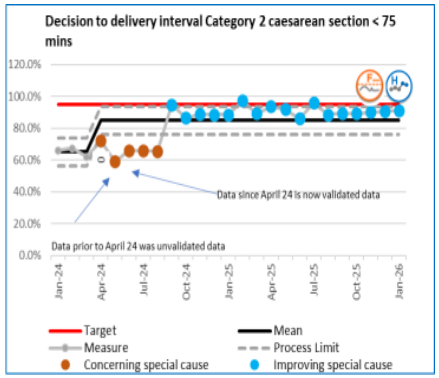


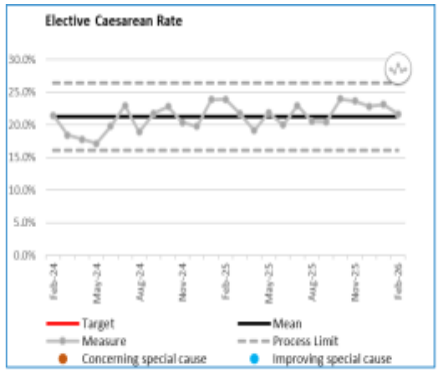


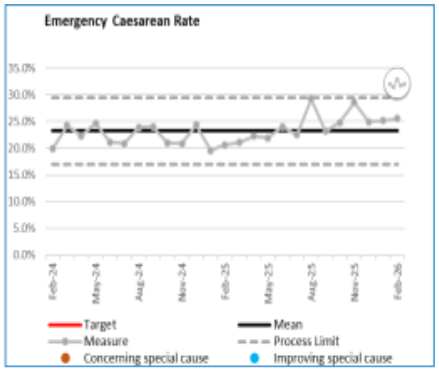


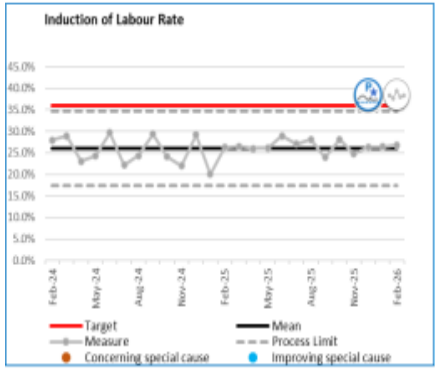
Forecast SPCs (3 month forward view) for Maternity Indicators

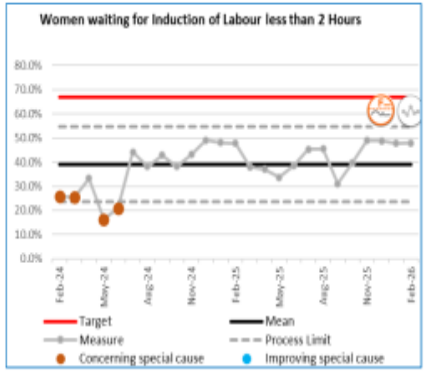


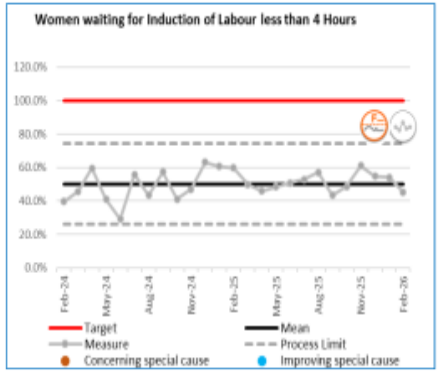


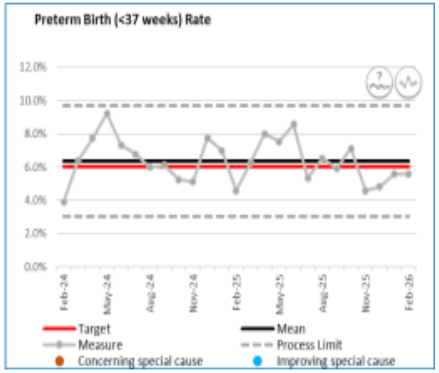


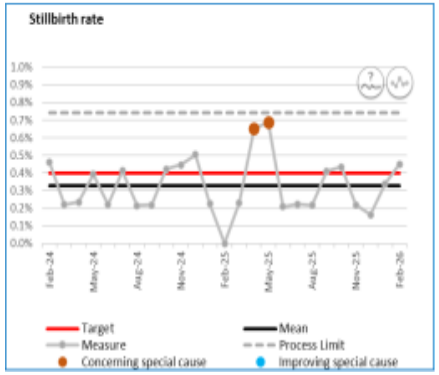


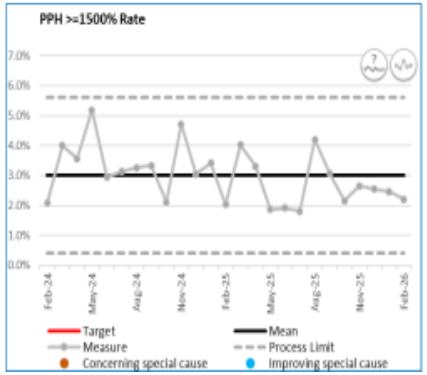


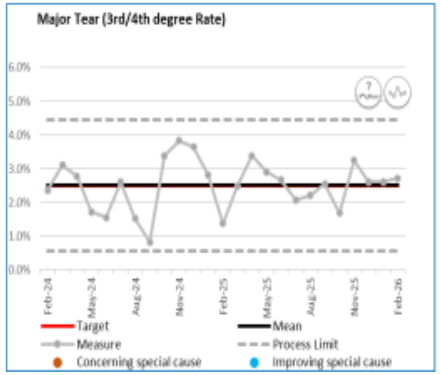


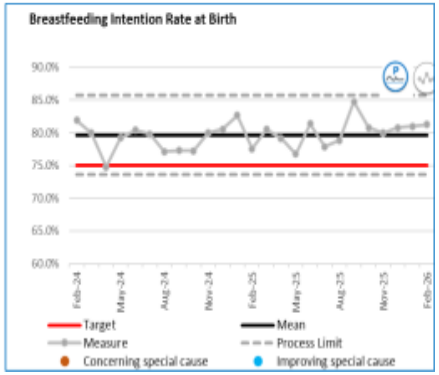






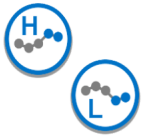






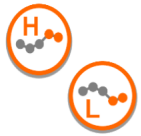
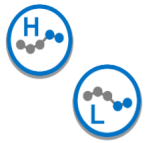
SDR Business Rules Driven by the SPC Icons

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

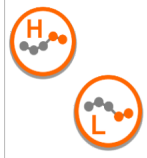
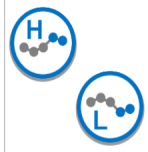
SDR Business Rules Driven by the SPC Icons

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:

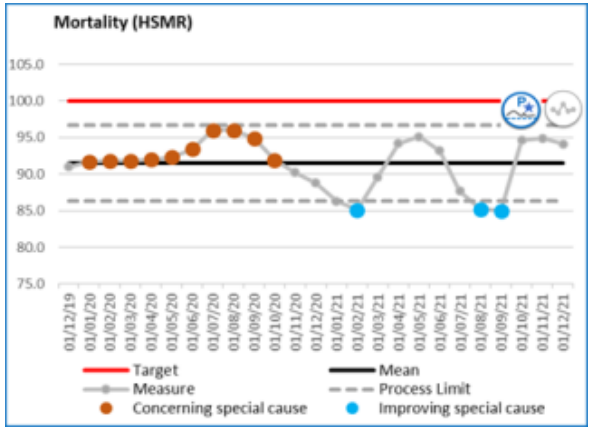
The **target** line **between** the **upper** and **lower** control limit for all metric types

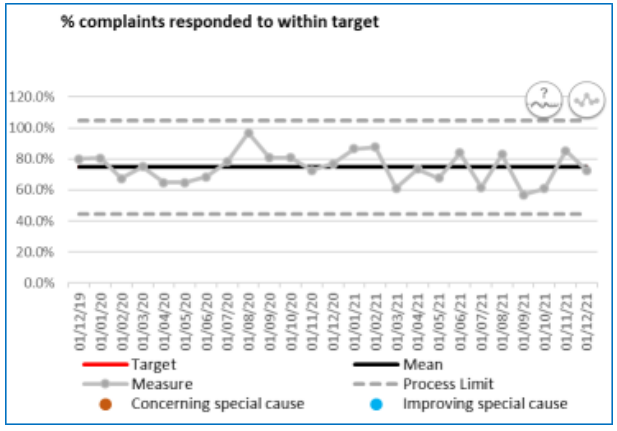
Metrics that consistently **fail** have:

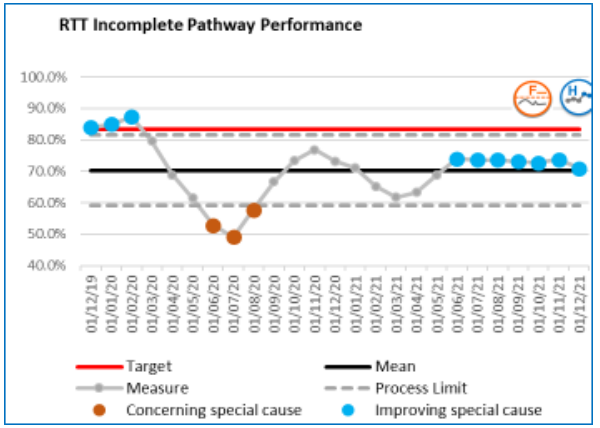
The **lower** control limit **above** the target line for metrics that need to be **below the target**

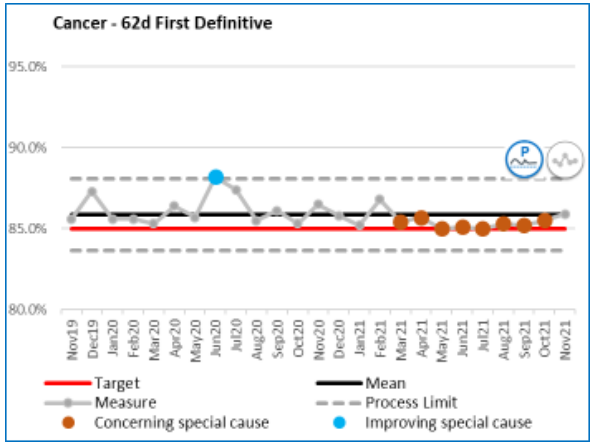
The **upper** control limit **below** the target line for metrics that need to be **above the target**

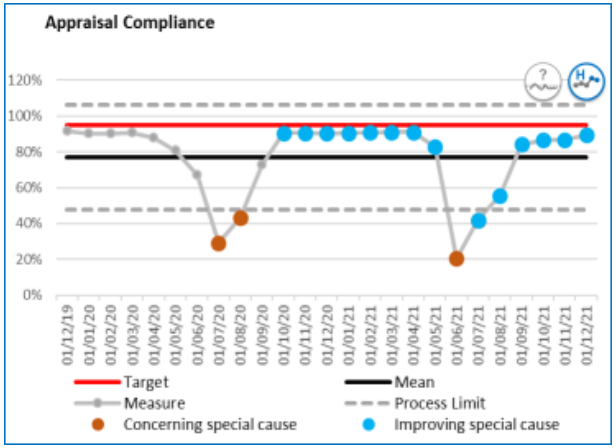
A metric not achieving the target for 6 months or more will be flagged as failing

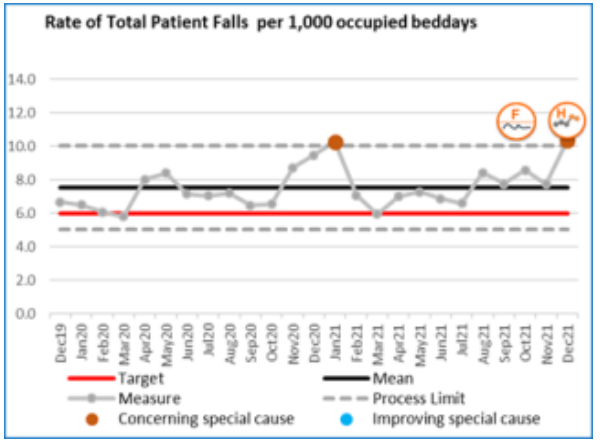












Maternity Metrics Definitions

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 £2.9m in deficit in the month which was £4.6m adverse to the plan. Year to date the Trust is £18.2m in deficit which is £10.5m adverse to plan.
- The key year to date pressures are: System savings slippage (£10.5m), 2024/25 clinical income contract adjustment (£4.3m), Fordcombe slippage to plan (£1.4m), Increase in doubtful debt (£1m), Brockenhurst Car Park VAT adjustment (£0.8m), CIP consultancy support costs (£0.7m) and industrial action (£0.2m). These pressures were offset by additional clinical income above contract baseline (£2.9m), additional Pathology income (£1.2m), reduction in outsourcing (£1.8m) and non-recurrent benefits (£2.5m)
- The Trust has a £72.1m CIP savings target in 2025/26 which is split between Internal (£49m), System (£22.6m), national savings expectation (£1.3m) less £0.8m stretch. The Trust is forecasting to deliver £48.5m which is £23.6m adverse to plan. The main slippage relates to system savings which is £22.6m adverse to plan
- The Trust applied in October to National NHSE for a Revenue Support PDC (working capital top-up) facility, this is one off cash funding of £13m, following the National NHSE team's review and assessment the Trust was awarded £1.7m which was received in November. The Trust is currently in discussions with the Regional NHSE team as the Trust is applying for Revenue Support PDC – Unplanned Cash Support facility of £19.4m with the expectation of the PDC being received in January.
- The Trust is forecasting to deliver the year-end financial plan (breakeven) however the Trusts current forecast trajectory including recovery actions is a deficit of £18.4m

Current Month Financial Position

- The Trust was £2.9m in deficit which was £4.6m adverse to the plan.
- **Key Adverse variances in month are:**
    - System savings slippage including national expectations (£2.6m).
    - Clinical Income pressures (£1.6m). The pressures in the month include £2.7m pressures relating to 2024/25 which were partly offset by additional income above contract (£1.1m)
    - Internal CIP shortfall (£1.4m)
    - Redundancy costs associated with Phase 1 workforce transformation (£0.3m)
- **Key Favourable variances in month are:**
    - Non recurrent benefit in the month (£0.4m)

Year to Date Financial Position

- The Trust is £18.2m in deficit which is £10.5m adverse to plan
- **Key Adverse variances are:**
    - System savings slippage including national expectations (£10.7m).
    - 2024/25 clinical income contract adjustment (£4.3m)
    - Fordcombe hospital slippage to plan (£1.4m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £1.4m adverse to plan.
    - Brockenhurst Car park VAT adjustment (£0.8m)
    - Increase in doubtful debt (£1m), CIP consultancy support costs (£0.7m) and industrial action (£0.2m)

- **Key Favourable variances are:**
    - Additional Clinical Income above contract baseline (£2.9m) which includes £2.2m for 2025/26 depreciation funding in line with national guidance and Radiotherapy income (£0.7m)
    - Pathology Income (£1.2m). 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 £1.2m.
    - Reduction in outsourcing (£1.8m). The Trust has underspent against the plan by £1.8m, the main areas underspent against plan are: Medicine and Emergency (£1.1m) and Surgery Division (£0.7m)
    - Non recurrent benefits (£2.5m). The Trust has benefited by £2.5m 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 November the Trust has saved £4m which was £4m adverse to plan
- Year to date the Trust has saved £29.2m which is £7.4m adverse 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 £48.5m of savings in 2025/26 which is £23.6m adverse to plan. The main slippage relates to the system wide savings/national savings expectations target (£22.6m adverse)
- The Trust is forecasting to deliver £52m 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.
- **CIP delivery** - The Trust is forecasting to deliver £48.5m which is £23.6m adverse to plan. The main slippage relates to system wide savings/national savings expectations which is £22.6m adverse to plan
- **Redundancy Costs (Phase 2)** – The Trust might incur c£2.7m of redundancy costs associated with the pay transformation plan. The forecast assumes £0.7m could be mitigated through redeployment.
- **2025/26 Outstanding Contract issues** - The Trust has included £5.4m into the YTD position / forecast for items above baseline contract. These items include: 2025/26 depreciation funding (£3.3m), COVID Medicine Delivery Unit (CMDU = £1m), additional Radiotherapy income (£1.1m). Contract discussions are ongoing with commissioners.

Cashflow position:

- The closing cash balance at the end of November was £16.5m, which is higher than the plan value by £9.0m. The two main reasons for the increase is due to 1) monthly activity invoices for periods 1-7 for the Roche managed service contract extension agreement of c.£6.9m; the Trust is expecting to pay these in early January; 2) Two months of activity invoices for Cardiology Medtronic managed service contract for £1.3m, these are expected to be paid in late December.

- 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 Trust actively participates in the fortnightly ICS cash working group. The Trust sends a 12 month cash flow that is similar to the version that is included within the finance pack, a 13 week cash flow as well as a debtor/creditor position of the local patch monthly to the ICB. 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, Kent and Medway Mental Health NHS Trust 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 November the Trust's percentages were - Trade in value: 61.1% (M7 64.3%) and by quantity: 55.3% (M7 60.1%) for NHS by value: 81.6% (M7 86.1%) and by quantity: 52.6% (M7 57.3%).

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 £534k as part of the Constitutional Standards allocation for MTW
  - Linac Replacement at Kent and Canterbury Hospital £2.6m (equipment) and £300k (enabling works)
  - Addition to Plan:
  - Estates Safety schemes - £3.46m as part of the Critical Infrastructure Strategy allocation for MTW
  - Histopathology Equipment - £421k as part of the Digital Histopathology Modernisation Funding
  - Cyber Security - £158k as part of the Cyber Improvement Programme
  - NHS Wayfinder (Patient Portal) - £207k relating to NHS Apps for Referrals and Appointments.
  - Estates Safety Phase 2 - £445k relating to Ward fire door replacements.
  - Digital Pathology Schemes - 2 bids to NHSE via KMPN have been approved in principle for £679k and £658k, relating to various equipment and staffing costs. MOUs are expected in M9.
  - System Capital Support: The Trust has also been awarded £2m relating to the Urgent and Emergency Care (UEC) Performance Award in recognition of achieving A&E targets in 24/25. This is additional to Plan. Schemes have been prioritised and agreed at ETM. Schemes are now progressing.

- Freedoms & Flexibilities: The Trust has been notified by NHSE that an additional £161k of internal funding, relating to a surplus in 24/25 - this is not cash-backed. Schemes are currently being identified by ICT.

- **Month 8 Actuals (excluding IFRS16)**

  The Trust has been notified by NHSE that an additional £161k of internal funding, relating to a surplus in 24/25 - this is not cash-backed. Schemes are currently being identified by ICT.

- **Forecast**
- At Month 8 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 the Cardiology ward refurbishment scheme has been reviewed and there is slippage on the FBC approval from the ICB (including the IFRS 16 funding for the cardiac catheter laboratory). This means there will be a significant slippage on expenditure in 2025/26, so other Trust priorities are being reviewed and agreed.
- 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; orders are being placed.
- Linac replacement at K&C - The machine went into clinical use on 27th November.
- 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 YTD variance relates a reduction in the MLS lease renewal which was less than originally planned; other new leases e.g. consumables and Park and Ride bus Maidstone, have either not been required or have been secured under a different funding stream. These funds have now been diverted to cover the lease modification of Springwood Road Block A site which has been refurbished recently which results in an increase in rental charges from January, with a further annual rental uplift in March. The lease modification was significantly more than planned so the unused funds have been diverted to cover these costs. Funds are also been held within the ”slippage” element of the main line capital of £676k to fund this modification and a further new lease previously not planned. 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 year-end financial plan (breakeven) however the Trusts current forecast trajectory including recovery actions is a deficit of £18.4m

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 8
2025/26

Maidstone and Tunbridge Wells NHS

Summary

November 2025/26

	Current Month					Year to Date				
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	66.5	67.5	(1.0)	0.0	(1.1)	544.5	542.6	1.9	1.1	0.8
Expenditure	(64.4)	(60.8)	(3.6)	(0.0)	(3.6)	(522.7)	(510.4)	(12.4)	(1.1)	(11.3)
EBITDA (Income less Expenditure)	2.0	6.7	(4.6)	0.0	(4.6)	21.8	32.3	(10.5)	0.0	(10.5)
Financing Costs	(4.2)	(4.4)	0.2	0.0	0.2	(44.3)	(44.7)	0.4	0.0	0.4
Technical Adjustments	(0.7)	(0.6)	(0.1)	0.0	(0.1)	4.3	4.7	(0.4)	0.0	(0.4)
Net Surplus / Deficit	**(2.9)**	**1.7**	**(4.6)**	**0.0**	**(4.6)**	**(18.2)**	**(7.7)**	**(10.5)**	**0.0**	**(10.5)**
Cash Balance	16.5	4.2	12.2		12.2	16.5	4.2	12.2		12.2
Capital Expenditure (Incl Donated Assets and IFRS16)	0.2	0.5	0.2		0.2	7.5	6.3	1.1		1.1
Cost Improvement Plan	4.0	8.0	(4.0)		(4.0)	29.2	36.7	(7.4)		(7.4)

Summary Current Month:

- The Trust was £2.9m in deficit in the month which was £4.6m adverse to plan. The Trusts key variances to the plan are:

Adverse Variances:

- System savings and national saving expectation slippage (£2.6m).
- Clinical Income pressures (£1.6m). The pressures in the month include £2.7m pressures relating to 2024/25 which were partly offset by additional income above contract (£1.1m)
- Internal CIP shortfall (£1.4m)
- Redundancy costs (£0.3m)

Favourable Variances

- Non recurrent benefit in month (£0.4m), Pathology Income overperformance (£0.3m), backdated education income (£0.2m),Revenue Capital (£0.2m) and underspend against depreciation (£0.1m)

Year to date overview:

- The Trust is £18.2m in deficit which is £10.5m adverse to plan. The Trusts key variances to the plan are:

Adverse Variances:

- System savings and national saving expectation slippage (£10.7m).
- 2024/25 clinical income contract adjustment (£4.3m)
- Fordcombe hospital slippage to plan (£1.4m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £1.4m adverse to plan.
- Increase in doubtful debt (£1m), Brockenhurst Car Park VAT adjustment (£0.8m), CIP consultancy support costs (£0.7m) and industrial action (£0.2m)

Favourable Variances

- Additional Clinical Income above contract baseline (£2.9m) which includes £2.2m for 2025/26 depreciation funding inline with national guidance and Radiotherapy income (£0.7m).
- Pathology Income (£1.2m). 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 £1.2m.
- Reduction in outsourcing (£1.8m). The Trust has underspent against the plan by £1.8m, the main areas underspent against plan are: Medicine and Emergency (£1.1m) and Surgery Division (£0.7m)
- Non recurrent benefits (£2.5m). The Trust has benefited by £2.5m 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 November the Trust delivered £4m savings which was £4m adverse to plan. The main slippage in the month relates to system wide savings which is £2.6m adverse to plan and slippage against internal schemes (£1.4m).

Year End Forecast

- The Trust is forecasting to deliver the year-end financial plan (breakeven) however the Trusts current forecast trajectory including recovery actions is a deficit of £18.4m

Nov-25			DAY				NIGHT				Temporary Staffing						CHPPD by reg/unregistered			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 Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Occupied Beds	Planned CHPPD	Actual Care Hours per pt day	CHPPD Registered Nurses and Midwives	CHPPD Non registered Care staff	CHPPD Non registered Nursing associates	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Number of Enhanced Care shifts	Comments	Budget £	Actual £	Variance £ (overspend)
Maidstone	Acute Assessment Unit (M)	Acute Medical Unit (M) - NG551	90.6%	114.7%	-	-	98.3%	138.4%	-	-	104	7.56	30	504	10	10.2	5.8	4.3	0.0	-	-	3	0	43	enhanced care and escalation on unit	265,014	228,744	36,270
Maidstone	Stroke Unit	Stroke Unit (M) - NK551	111.4%	109.3%	-	100.0%	115.0%	123.3%	-	-	112	8.14	18	1007	8	8.6	4.2	4.3	0.1	23.1%	33.3%	3	2	21		310,899	296,126	14,773
Maidstone	Hyperacute Stroke Unit	HASU (34) - NK552	101.5%	112.5%	-	-	104.4%	103.3%	-	-	96	6.83	9	412	11	11.5	9.7	1.8	0.0	30.4%	85.7%	0	0	1	escalation into assessment bay	201,153	175,968	25,185
Maidstone	Cornwallis	Cornwallis - NS251	98.9%	91.1%	-	-	100.0%	98.4%	-	-	44	3.16	0	510	7	7.2	4.0	3.2	0.0	16.4%	81.8%	4	1	0		130,194	116,818	13,376
Maidstone	Culpepper and CCU	Culpepper Ward (M) - NS551	104.5%	99.0%	-	-	100.0%	159.6%	-	-	7	0.54	0	383	7	8.0	5.1	2.9	0.0	69.6%	100.0%	1	0	20		141,848	145,619	(3,771)
Maidstone	Culpepper and CCU	CCU (M) - NS551	99.8%	-	-	-	100.0%	-	-	-	11	0.80	0	173	8	8.0				100.0%	100.0%	0	0	0		0	0	0
Maidstone	Edith Cavell	Edith Cavell - NS459	122.6%	114.0%	-	100.0%	105.6%	153.0%	-	-	48	12.55	2	646	6	7.1	3.7	3.1	0.3	5.9%	100.0%	0	0	66		113,640	160,861	(47,221)
Maidstone	Foster Clarke	Foster Clark - NR359	98.8%	125.5%	-	-	99.2%	170.1%	-	-	62	4.49	2	803	7	7.8	3.4	4.4	0.0	14.0%	100.0%	4	0	99		198,141	187,937	10,204
Maidstone	John Day	John Day Respiratory Ward (M) - NT151	93.6%	114.6%	-	-	98.7%	103.3%	-	-	55	3.89	14	875	7	7.6	4.1	3.4	0.0	38.5%	100.0%	5	1	61		214,333	220,228	(5,895)
Maidstone	Intensive Care (M)	Intensive Care (M) - NA251	93.4%	86.1%	-	-	96.7%	78.4%	-	-	14	0.88	0	143	43	39.7	34.7	5.0	0.0	75.0%	100.0%	0	0	0		250,334	225,349	24,985
Maidstone	Lord North	Lord North Ward (M) - NF651	95.6%	90.0%	-	-	97.8%	100.0%	-	-	31	1.88	10	469	8	7.4	5.2	2.1	0.0	17.4%	100.0%	3	0	0		120,030	133,331	(13,301)
Maidstone	Mercer	Mercer Ward (M) - NJ251	99.6%	105.9%	-	-	100.0%	137.2%	-	-	41	2.98	3	771	6	6.8	3.1	3.7	0.0	33.3%	88.9%	2	0	46		164,696	154,232	10,464
Maidstone	Peale	Peale Ward COVID - ND451	94.4%	105.5%	-	-	99.0%	146.7%	-	-	45	3.11	6	395	8	8.2	5.0	3.2	0.0	22.2%	100.0%	2	1	24		102,910	118,103	(15,193)
Maidstone	Short Stay Surgery Unit (M)	Short Stay Surgical Unit (M) - NE751	97.3%	96.5%	-	-	98.5%	120.0%	-	-	3	0.18	1	57	39	35.5	25.5	9.9	0.0	0.0%	100.0%	0	0	0		76,122	71,095	5,027
Maidstone	Whatman	Whatman Ward - NK959	89.8%	110.7%	-	-	100.0%	123.9%	-	100.0%	65	4.58	14	612	8	8.5	4.0	4.4	0.0	53.8%	100.0%	4	1	42	escalation into assessment bay	193,179	197,561	(4,382)
Maidstone	Maidstone Birth Centre	Maidstone Birth Centre - NP751	80.8%	84.7%	-	-	100.0%	90.0%	-	-	33	1.79	2	14	156	138.2	26.4	11.5	0.0	0.0%	-	0	0	0		83,580	93,602	(10,022)
TWH	Acute Medical Unit (TW)	Acute Medical Unit (TW) - NA901	97.2%	102.5%	-	100.0%	100.0%	108.8%	-	-	110	8.08	10	838	9	8.7	5.3	3.4	0.1	-	-	4	0	27	escalation into SDEC areas	316,926	301,225	15,701
TWH	Coronary Care Unit (TW)	Coronary Care Unit (TW) - NP301	97.3%	76.0%	-	-	100.0%	-	-	-	57	4.02	3	204	12	11.4	10.0	1.3	0.0	-	-	0	0	0		83,305	83,025	280
TWH	Hedgehog Ward	Hedgehog Ward (TW) - ND702	111.4%	26.1%	-	-	114.3%	20.0%	-	-	63	18.13	13	510	11	10.5	9.9	0.6	0.0	0.4%	100.0%	0	0	60	increase in enhanced care seen due to patient need - data anomoly for HCSW - for deep dive	221,803	202,521	19,282
TWH	Intensive Care (TW)	Intensive Care (TW) - NA201	96.5%	70.1%	-	-	97.1%	110.2%	-	-	5	0.23	0	186	64	60.6	27.3	4.1	0.0	-	-	0	1	11		405,834	418,181	(12,347)
TWH	Wells Day Unit	Private Patient Unit (TW) - NR702	82.6%	57.7%	-	-	70.2%	47.1%	-	-	No Demand	No Demand	No Demand	54	45	30.1	19.6	10.6	0.0	12.5%	100.0%	0	0	0	decreased fill rate due to reduce activity	83,071	74,818	8,253
TWH	Ward 2	Ward 2 (TW) - NG442	94.2%	99.4%	-	100.0%	90.8%	121.7%	-	-	54	3.69	8	796	7	7.4	3.4	4.0	0.0	64.3%	77.8%	5	0	39	escalation into assessment bay	254,529	210,148	44,381
TWH	Ward 11	Ward 11 (TW) - NG131	91.0%	107.4%	-	-	99.1%	94.1%	-	-	88	6.48	8	875	7	6.9	3.7	3.2	0.0	100.0%	75.0%	0	0	4		191,157	189,902	1,255
TWH	Ward 12	Ward 12 (TW) - NG132	89.6%	112.1%	-	-	97.5%	115.8%	-	-	125	8.72	20	901	7	6.7	3.2	3.5	0.0	13.5%	90.0%	7	1	45		251,283	177,349	73,934
TWH	Ward 20	Ward 20 (TW) - NG230	92.2%	128.7%	-	-	100.0%	129.8%	-	-	75	4.95	13	886	7	7.4	3.4	4.1	0.0	9.8%	-	3	0	78		222,588	200,426	22,162
TWH	Ward 21	Ward 21 (TW) - NG231	94.7%	90.8%	-	-	97.3%	104.4%	-	-	49	3.32	15	905	7	6.7	4.0	2.6	0.0	23.9%	90.9%	5	2	14		189,490	177,017	12,473
TWH	Ward 22	Ward 22 (TW) - NG332	90.8%	130.1%	-	-	97.5%	138.3%	-	-	74	5.40	17	934	6	7.1	3.1	4.0	0.0	66.7%	88.9%	5	3	86		213,397	218,378	(4,981)
TWH	Ward 30	Ward 30 (TW) - NG330	96.6%	122.1%	-	100.0%	99.2%	117.8%	-	100.0%	70	5.04	4	904	6	6.9	3.3	3.4	0.2	10.0%	100.0%	11	1	31		183,345	189,315	(5,970)
TWH	Ward 31	Ward 31 (TW) - NG331	94.7%	115.2%	-	100.0%	98.3%	124.2%	-	-	101	6.43	16	876	7	7.3	3.5	3.7	0.1	10.8%	100.0%	0	0	37		185,915	192,260	(6,345)
TWH	Ward 32	Ward 32 (TW) - NG130	101.5%	100.2%	-	-	99.0%	102.8%	-	100.0%	26	1.81	3	555	8	7.9	4.5	3.3	0.0	0.0%	71.4%	1	0	0		166,909	144,377	22,532
TWH	Gynae Ward	Ward 33 (Gynae) (TW) - ND302	102.7%	106.5%	-	-	100.0%	93.3%	-	-	22	1.40	2	289	8	7.6	4.9	2.7	0.0	17.3%	100.0%	1	0	1	Escalation into assessment bay	114,395	116,877	(2,482)
TWH	SCBU	NICU (TW) - NA102	84.7%	-	-	-	83.1%	-	-	-	102	6.29	11	293	20	18.1	16.8	1.3	0.0	11.1%	100.0%	0	0	0		264,277	231,857	32,420
TWH	Short Stay Surgical Unit (TW)	Short Stay Surgical Unit (TW) - NE901	110.2%	88.1%	-	100.0%	142.8%	123.3%	-	-	45	3.26	1	346	10	11.3	7.9	3.0	0.3	7.3%	100.0%	0	0	0		113,556	111,879	1,677
TWH	Surgical Assessment Unit	Surgical Assessment Unit (TW) - NE701	97.8%	94.1%	-	-	100.0%	100.0%	-	-	17	1.24	1	152	16	15.7	11.3	4.4	0.0	3.8%	93.3%	0	0	0		82,025	91,222	(9,197)
Maidstone	K&M Orth Centre - Inpatient Ward	K&M Orth Centre - Inpatient Ward - TK153	85.2%	77.8%	-	100.0%	66.0%	73.9%	-	100.0%	No Demand	No Demand	No Demand	171	33	25.4	15.3	8.1	1.9	65.5%	92.9%	1	0	0	decreased fill rate due to reduce activity	167,370	140,403	26,967
Fordcombe	Fordcombe Ward	Fordcombe Ward (AFC) - NU901	135.1%	69.0%	-	-	100.0%	-	-	-	28	1.82	0	53	35	40.4	37.2	3.2	0.0	-	-	0	0	0		83,097	57,767	25,330
Maidstone	A&E (M)	Accident & Emergency (M) - NA351	99.7%	151.2%	-	100.0%	102.7%	176.2%	-	100.0%	238	38.81	15	0	-	-	-	-	-	0.0%	79.8%	0	0	74		445,204	484,406	(39,202)
TWH	A&E (TW)	Accident & Emergency (TW) - NA301	104.3%	97.0%	-	100.0%	106.5%	103.0%	-	100.0%	225	38.52	19	0	-	-	-	-	-	11.2%	79.4%	0	0	18		473,975	519,083	(45,108)
TWH	Delivery Suite	Midwifery Services - Delivery Suite - NF102	85.5%	87.8%	-	-	84.2%	76.3%	-	-	174	11.07	44	1931	4	3.6				-	-	0	0	0	for deep dive into CHPPD data	334,943	367,771	(32,828)
TWH	Antenatal Ward	Midwifery Services - Antenatal Ward - NF122	93.2%	98.7%	-	-	95.7%	96.7%	-	-	67	3.87	15	314	9	8.3	6.3	2.1	0.0	-	-	0	0	0		98,638	120,847	(22,209)
TWH	Postnatal Ward	Midwifery Services - Postnatal Ward - NF132	106.8%	86.2%	-	-	98.7%	94.5%	-	-	121	6.99	2	635	11	10.5				-	-	0	0	6		234,167	231,709	2,458
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Team Leads - NJ160	70.3%	-	-	-	-	-	-	-	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	0	0	-		95,577	116,515	(20,938)
TWH	Community Midwifery Services (TW)	Community Midwifery Services - TW/Eden/Ton/PW/Hawk - NJ160	91.9%	89.1%	-	-	-	-	-	-	18	0.98	2	0	-	-	-	-	-	-	-	0	0	-		68,081	68,249	(168)
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Phoenix Team - NJ160	73.1%	0.0%	-	-	-	-	-	-	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	0	0	-		-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Seven/Mallings - NJ160	102.8%	-	-	-	-	-	-	-	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	0	0	-		-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Maidstone/Leeds - NJ160	79.6%	79.2%	-	-	-	-	-	-	28	1.32	2	0	-	-	-	-	-	-	-	0	0	-		-	-	-
TWH	Community Midwifery Services (TW)	Community Midwifery Services - Crowborough - NJ160	97.7%	78.0%	-	-	-	-	-	-	9	0.48	0	0	-	-	-	-	-	-	-	0	0	-		67,403	-234	67,637
		Midwifery TW (four IP rosters)	94.1%	88.3%	-	-	90.1%	88.8%	-	-	362	21.93	61	-	-	-	-	-	-	-	-	-	-	-		-	-	-
		Midwifery TW Community (six comm. rosters)	87.4%	71.2%	-	-	-	-	-	-	188	10.86	17	-	-	-	-	-	-	-	-	-	-	-		-	-	-
		Midwifery TW (all fourteen rosters)	83.0%	85.3%	-	-	90.6%	88.8%	-	-	426	49.67	32	-	-	-	-	-	-	-	-	-	-	-		-	-	-

Total Established Wards			**8,526,872**	**8,296,406**	**230,466**
Additional Capacity beds	Cath Labs		58,855	55,415	3,440
	Whatman		-	-	-
Other associated nursing costs			5,225,935	6,407,057	-1,181,122
Total			**13,811,662**	**14,758,878**	(947,216)

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	18 December 2025					
Agenda item no.	12-10					
Executive lead	Jo Haworth					
Presenter	Rachel Thomas and Sarah Flint					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

Links to Strategic Themes (Please ☑ as appropriate)					
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)	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 9 December 2025 and are summarised below. 4. Areas of improvement; assurance provided: 4.1. 94% of guidelines in Neonates have been updated and are not overdue for review. 4.2. Triage dashboard is now in place although some work still be done to optimise. 4.3. Year 7 MIS compliance to be declared for all ten safety actions. Board Notification Form to be presented to Trust Board in January to enable the declaration to be finalised in advance of the 3 March 2026 deadline. 4.4. EDI improvement work appears to be progressing well.

	5. Areas of Concern; assurance provided but not performing well: 5.1. NICU surge and capacity issues – T&F group being set up to explore gaining funding for additional cot. 5.2. Induction of labour bottlenecks / flow issues – team reviewing next steps for T&F group. 5.3. Run of Pneumothorax cases in Neonates – currently being reviewed by MDT and to be presented at next MNCOG in January 2026. 6. Areas of Concern; requires assurance: 6.1. Increase in MNSI activity October – currently under review and update to be presented in January 2026. 6.2. Maternity sickness rates increasing. 6.3. Whilst Year 7 MIS has met compliance, there are further challenges that are expected to affect Year 8 of MIS which will require action. 6.4. The need to address AHP issues in Neonates. <u>Claims Scorecard Q2 Report</u> 7. In accordance with Safety Action 9 of the Scheme, the Trust Board is invited to review and note the Q2 Claims Scorecard Report (July-September 2025) (Appendix 2), which triangulates the claims scorecard against incident and complaint data. 8. The Board is reassured that, in accordance with the Scheme, this Claims Scorecard report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 9 December 2025.
Any items for formal escalation / decision	1. In relation to PQOM the Board is invited to: a. review the attached December (October 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	1. Appendix 1 - December (October data) 2025 PQOM report 2. Appendix 2 - Q2 Claims Scorecard Report (July-September 2025)

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	9 December 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	Please list any risks on the Trust Risk Register to which this report relates

Risk Register (TRR)	•
Compliance / Regulatory Implications	Please list any compliance or regulatory matters raised or addressed by this report Fulfils requirements for Maternity Incentive Scheme

Title of report	**Learning from Deaths Report**					
Board / Committee	**Trust Board**					
Date of meeting	18th December 2025					
Agenda item no.	12-11					
Executive lead	Sara Mumford, Chief Medical Officer					
Presenter	Sara Mumford, Chief Medical Officer					
Report Purpose (Please ☑ one)	***Action/Approval***	☐	***Discussion***		***Information***	✓

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

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

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

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

Quarterly Learning from Deaths Report December 2025

1. Learning from Deaths Group (LfDG)

The Learning from Deaths Group meets monthly to provide assurance that all hospital deaths are proactively monitored, reviewed, reported and where necessary referred to the Patient Safety team for further investigation. A further responsibility of the group is to ensure learning from mortality reviews are shared with clinical teams to learn from omissions in care and to highlight good practice.

1.1 Structured Judgement Review (SJR)

When a concern is raised by the Medical Examiner Service regarding a death (according to one of nine nationally standardised and validated categories), a trained clinician will undertake an SJR. The SJR reviewer makes explicit comments about phases of care with scores (excellent, good, adequate, poor, or very poor) attributed to each phase and the overall care received. The overall score is agreed by the LfDG at a monthly meeting. SJRs are currently not shared with families. A turnaround time of 28 working days from receiving the SJR request to completion is the expectation. There are currently no cases in the backlog.

Up to ten cases are discussed at each monthly LfDG.

1.2 SJR Outcomes and Discussion

In the last quarter, there were ten cases referred for an SJR in September, ten in October, and seven in November. SJRs discussed at MTW's LfDG can be raised for deaths in hospital and for community deaths within 30 days of hospital discharge. It is expected that 10-15% of deaths will be referred for an SJR. Figure 1 highlights all SJRs allocated and completed since 1st March 2025 (to correspond to the ME data in section 2) to 30 November 2025.

Figure 1: SJR outcomes (April 2025 – November 2025)

Month	Very Poor care	Poor care	Adequate care	Good care	Excellent care	Total
March 2025	2	2	3	2	0	9
April 2025	1	2	3	2	2	10
May 2025	0	3	2	1	3	9
June 2025	0	2	2	6	1	11
July 2025	0	1	0	6	3	10
August 2025	0	2	2	4	2	10
September 2025	0	1	1	7	1	10
October 2025	0	2	6	2	0	10
November 2025	0	1	2	3	1	7
Total	**3**	**16**	**21**	**33**	**13**	**86**

1.3 Actions from ‘Poor Care’ and ‘Very Poor Care’ SJR Reviews

Over the past three months, four cases assessed as ‘Poor Care’ were discussed at the Learning from Deaths Group meeting. Each case has had associated actions identified.

All cases have been further discussed at clinical governance meetings. One case was referred to the Patient Safety team and has been commissioned as a full PSII under the deteriorating patient and learning disability categories.

1.4 Themes highlighted from LfDG

1.4.1 Areas of Concern

- **Clinical Assessment and Recognition of Deterioration:** There were repeated delays or missed opportunities to recognise deterioration, review abnormal observations, or blood results, and escalate care appropriately.
- **Timeliness of Investigations and Interventions:** Several investigations, imaging, and treatments were delayed or not performed, affecting the speed and accuracy of clinical decision-making.
- **Quality of Documentation and Communication:** Documentation was often unclear or incomplete, hindering understanding of clinical decisions, handover information, and communication with families.
- **Decision-Making and Senior Oversight**: Some key decisions lacked senior involvement, clear justification, or alignment with the patient’s condition and goals of care.
- **End-of-Life Care Recognition and Planning:** End-of-life needs were often identified late, with delayed palliative care referral and incomplete documentation of personalised EOL plans.
- **Multidisciplinary and System Coordination:** Engagement of specialist teams, timely transfer between sites, and coordination across services were inconsistent and at times contributed to delays.
- **Inadequate documented assessment of capacity and use of Mental Capacity Act**

1.4.2 Areas of Good Practice

- **Assessment & Early Management:** Patients received a prompt, thorough admission assessment with timely speciality referrals and immediate consultant-led management, including rapid transfer to specialist care.
- **Recognition of Deterioration & Escalation:** Deterioration was identified early, leading to rapid senior review, appropriate escalation, a sensible ceiling-of-care decision with effective involvement from critical care outreach.
- **Multidisciplinary Team Working**: Strong collaboration between MDT including palliative care, nursing, and therapy teams ensured a personalised, well-coordinated plan involving the family.

- **Communication & Documentation**: Communication with the family was consistently professional and respectful, supported by clear, thorough documentation across all teams, including ITU.
- **End-of-Life Care**: The dying phase was appropriately recognised, and end-of-life care was delivered promptly and compassionately with high palliative care involvement and good communication throughout with the family.

1.5 Sharing of Learning

- Quarterly Safety Grand Rounds commenced in August 2025 with first theme of Sepsis. The second theme will be learning disabilities.
- Individual discussions and reflection with team members where appropriate.
- Learning from poor care and good practices highlighted from cases reviewed at the LfDG continue to be shared with directorates via presentation at monthly Clinical Governance meetings.
- Learning is also being shared via the Learning from Deaths Section in the Patient Safety Learning Hub on the intranet.
- Divisional mortality reports, including mortality indicators and learning from SJRs are now provided to divisions to be presented at monthly Clinical Governance meetings monthly.
- Excellent care is recognised with communication to individuals and/or teams involved.

1.6 Planned Actions

- Following the migration of completed SJR cases into the InPhase module, testing will now begin on the reporting functionality to ensure relevant data can be retrieved and analysed to support the Learning from Deaths process.
- Addition of themes identified from SJRs to direct thematic reviews and targeted sharing and action plans.
- Continue quarterly Safety Grand Rounds on each site with all staff welcome.
- Appoint a Learning from Deaths lead within Medicine and Emergency Care to attend the Learning from Deaths Group (LfDG) and present cases at Clinical Governance (CG) and Safety Grand Rounds.
- A Safety Chief Registrar has been appointed with a key remit to focus on sharing of learning with resident doctors and learning from deaths across the trust. Work is ongoing to create a Patient Safety newsletter in next financial year.
- LfDG Chair to attend Medical Examiner Clinical Governance meetings to encourage consistency of referral for SJRs.

2. <u>Medical Examiner Service (Hosted by MTW)</u>

The number of deaths sadly occurring in the Trust in September, October and November 2025 were 124, 128, and 116 respectively, which is shown in Figure 2 and is consistent with previous years.

Figure 2: MTW 2021-2025 Deaths (September – November)

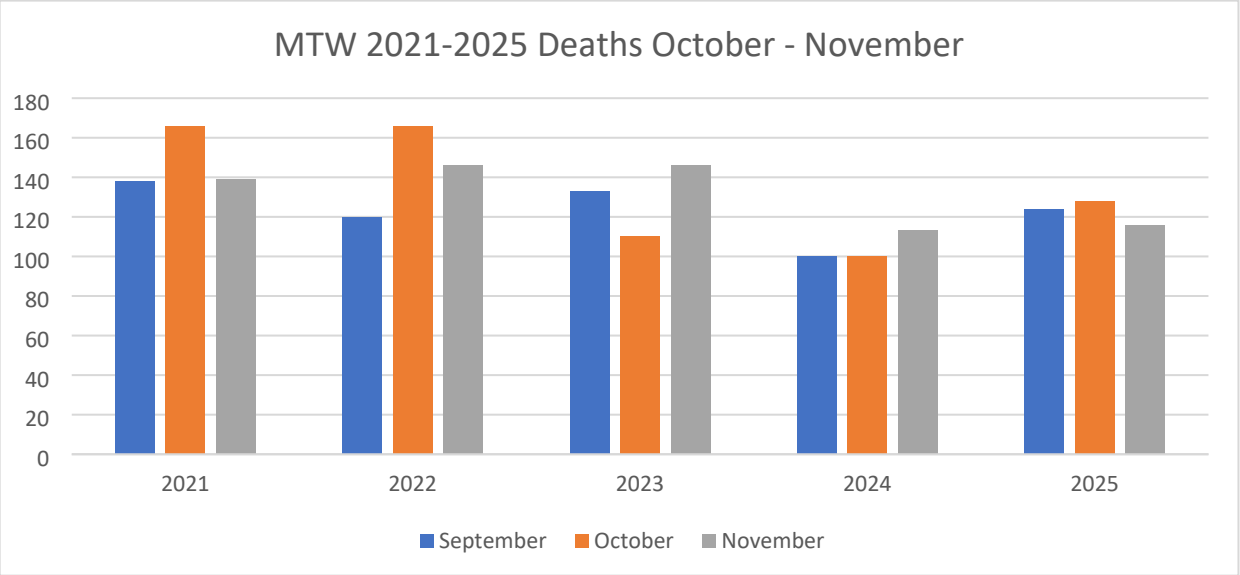
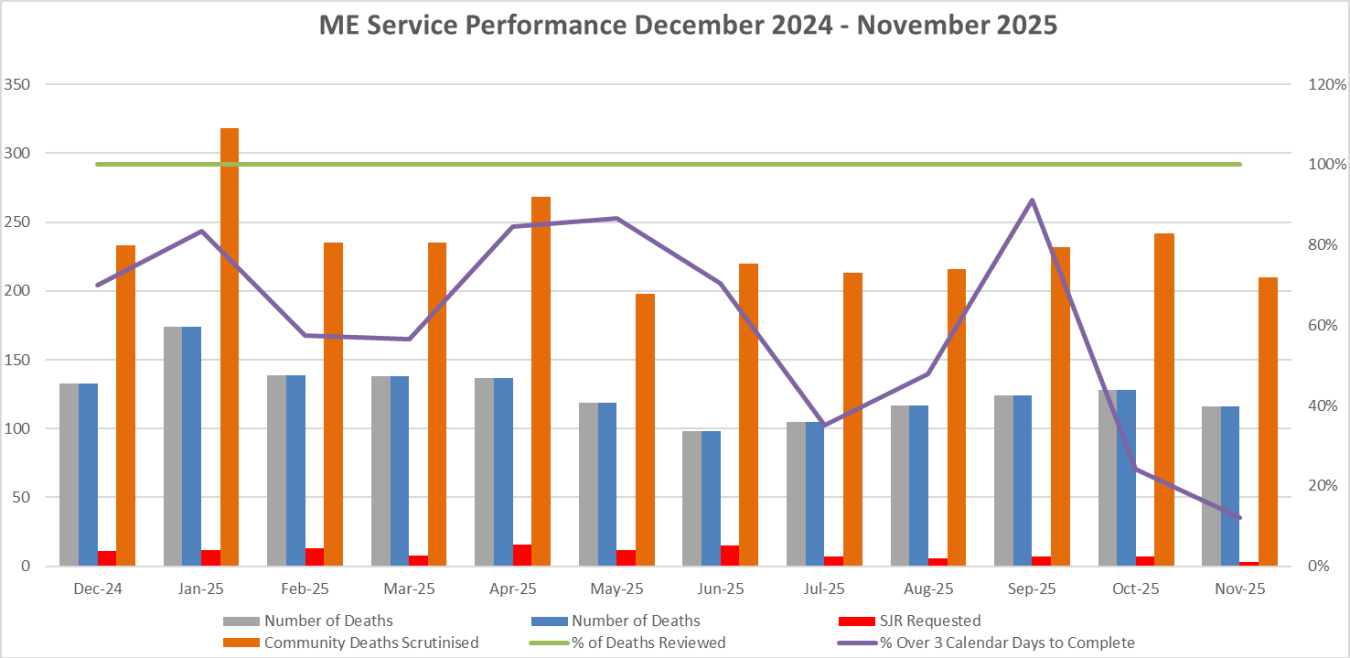


Figure 3: ME Scrutiny Vs Deaths and SJRs Raised



In September, October, and November 2025, the percentage of cases that exceeded the three-workday performance target was 91%, 24% and 12%, respectively. The increased workload from community deaths under review and staffing challenges continue to impact on ability of the Medical Examiner Service to complete reviews within three working days, however, marked improvement has been seen in October and November.

3. Mortality Data

The reporting period for this report covers hospital inpatient admissions from Aug 2024 to July 2025. It provides an overview and benchmarking of mortality using the Hospital Standardised Mortality Ratio plus (HSMR+) and the Standardised Mortality Ratio (SMR) provided in November 2025 by Telstra Health. The Monthly Standardised Hospital Mortality Index (SHMI) data is updated monthly from NHS Digital's Indicator Portal. SHMI for the period Jul-24 to Jun-25 is 87.59 and 'as expected'.

HSMR+ for Jul-25 is 63.29 and "lower than expected", based on 3679 super-spells and 73 deaths (crude rate 1.98%). HSMR+ for the period Aug-24 to Jul-25 is 79.78 and "lower-than-expected", based on 41,763 super-spells and 1104 deaths (crude rate 2.64%), (see Figure 5).
The Trust continues to perform well with statistically significantly lower HSMR when compared to regional and national peers.

Figure 4: Summary of Data for Aug 2024 – Jul 2025

Metric	Result
HSMR	79.78 (lower-than-expected) (75.14 – 84.63)
HSMR position vs. peers	Regional (acute, non-specialist) peer group = 18 trusts: 8 lower-than-expected. 8 within expected 2 higher-than-expected. Peer group = 96.4 (lower-than-expected) (95.2 – 97.7)
All Diagnosis SMR	75.8 (lower-than-expected)
Significant Diagnosis Groups	• Acquired foot deformities (184 superspells; 1 death) • Other endocrine disorders (501 superspells; 8 deaths)
CUSUM breaches	N/A
Emergency Weekend HSMR	84.5 (lower-than-expected)
Emergency Weekday HSMR	77.9 (lower-than-expected)
SHMI position	(Jul-24 to Jun-25) 87.59 (as expected)

SHMI data for the time period Jul-24 to Jun-25 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

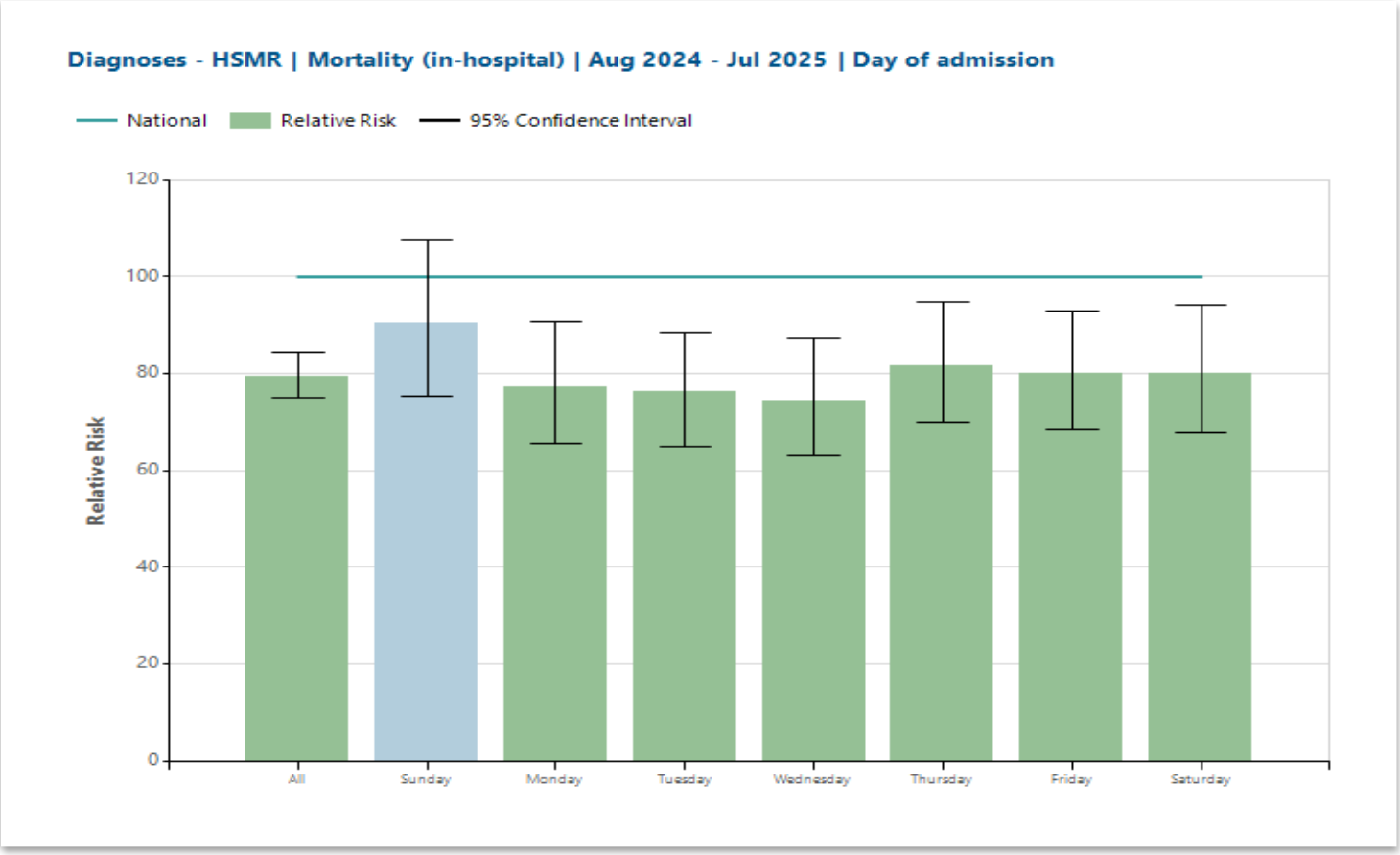
3.2 Significant Diagnosis Groups

There are no new significant diagnosis group outliers this month. There are two diagnosis group outliers, ‘acquired foot deformities’ and ‘Other endocrine disorders. These outliers are not new to appear and are not presenting new deaths or new themes that require further investigation.

3.3 CUSUM Breaches

There are no CUSUM alerts this month.

Figure 5: HSMR Day of admission (Emergency only)



The variation in HSMR based on a day of admission comparison shows that whilst we remain below the national mean for all days of the week, admissions on Sunday still have a high associated mortality and further work is required to resolve this.


MTW
exceptional people, outstanding care