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

Thu 30 April 2026, 09:15 - 13:00

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

Agenda

09:15 - 09:16
1 min

04-1
To receive apologies for absence

Annette Doherty

09:16 - 09:16
0 min

04-2
To declare interests relevant to agenda items

Annette Doherty

09:16 - 09:20
4 min

04-3
To note progress with previous actions

Annette Doherty

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

Patient Experience

09:20 - 09:45
25 min

04-4
Patient Experience story

Catarina Cunha and Gemma Viner

N.B. This item is scheduled for 09.20am

N.B. Report to follow.

Patient Story Trust Board Medicine and Emergency Care Division April 26 Cover pageRG.pdf (1 pages)
Medicine and Emergency Care patient story April 26RG.pdf (2 pages)

Reports from the Chair of the Trust Board and Chief Executive

09:45 - 09:50
5 min

04-5
Report from the Chair of the Trust Board

Annette Doherty

Report from Chair.pdf (3 pages)

09:50 - 09:55
5 min

04-6
Report from the Chief Executive

Miles Scott

Report from CEO.pdf (3 pages)

Reports from Trust Board sub-committees

09:55 - 10:05
10 min

04-7
Quality Committee, 15/04/26

Vivek Srivastava

- Summary of Quality Committee 15.04.26.pdf (2 pages)

10:05 - 10:15
10 min

04-8
Finance and Performance Committee, 28/04/26

Neil Griffiths

N.B. Report to follow.

- Summary of Finance and Performance C'ttee 28.04.26.pdf (3 pages)

Integrated Performance Report

10:15 - 11:00
45 min

04-9
Integrated Performance Report (IPR) for March 2026

Miles Scott and colleagues

- IPR cover.pdf (1 pages)
- Finalised Integrated Performance Report March 24042026.pdf (36 pages)
- Trust Board Month 12 Finance OverviewV1.pdf (3 pages)
- Trust Board M12 Finance Report.pdf (2 pages)
- Safe staffing report.pdf (1 pages)

11:00 - 11:15
15 min

Break

Quality items

11:15 - 11:25
10 min

04-10
National Guidance on Corridor Care

Sarah Davis

- Trust Board cover page_Corridor Care_30.4.26.pdf (1 pages)
- Trust Board April 26 v2_final.pdf (8 pages)
- NHS England » Principles for providing patient care in corridors.pdf (13 pages)

11:25 - 11:35
10 min

04-11
Maternity Update

Rachel Thomas

N.B. The appendices are saved in the documents section on admincontrol.

- Maternity update.pdf (3 pages)

Systems and Place

11:35 - 11:45
10 min

04-12
Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

HCP and ICB update.pdf (6 pages)

Other matters

11:45 - 11:45
0 min

04-13
To consider any other business

Annette Doherty

11:45 - 11:45
0 min

04-14
To respond to any questions from members of the public

Annette Doherty

11:45 - 11:45
0 min

04-15
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]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

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

Actions not yet due (and still 'open')

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

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

Title of report	**PATIENT STORY- Medicine and Emergency Care Division**					
Board / Committee	**TRUST BOARD**					
Date of meeting	30th April 2026					
Agenda item no.	04-4					
Executive lead	Jo Haworth, Chief Nurse					
Presenter	Catarina Cunha, Head of Nursing Acute Medicine and Geriatrics					
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 experience of care looks at and elaborates on the care of a young person (Master F) who attended the Emergency Department and required admission to support a safe discharge plan. This necessitated a multi – professional approach with external partners and ongoing actions that ensured that F's best interests were met and safety was maintained.		
Any items for formal escalation / decision	N/A		
Appendices attached	• Appendix A –Patient Story		
Report previously presented to:			
Committee / Group		Date	Outcome/Action
Nursing and Midwifery Board		21 April	

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisatio
Links to Trust Risk Register (TRR)	3419-Risk that regulatory action against the Trust if areas of non compliance are found with service delivery. 3502-Risk that adequate feedback mechanisms are not in place to improve patient experience
Compliance / Regulatory Implications	N/A

NHS
Maidstone and Tunbridge Wells NHS Trust

Experience of Care: Medicine and Emergency Care

Name: Master F (not his real name)	**Services/wards experienced**: Two medical wards at Maidstone Hospital

Outline of experience:

F is a young adult who has mild learning disabilities and autism, he is able to manage his activities of daily living independently. He attends a local school that supports individuals with additional needs. This story relates to his attendance to the Emergency Department (ED) in early October 2025 and we would like to thank F and his family for allowing us to share their experience.

F attended ED with a close relative having taken an overdose of their prescribed medication. In ED, the close relative disclosed that he was finding it difficult to keep F safe at home. Both were struggling with the loss of close family members including F's primary carer.

Investigations in ED determined that there was no medical treatment required for the overdose however it was recognised that an admission was required to support a safe plan to discharge given the concerns raised by the relative.

The team in ED discussed with the Child and Adolescent Mental Health Services (CAMHS) on call Psychiatrist who advised that a Multi - Professional Meeting (MPM) should take place including colleagues from the Local Authority to facilitate a safe discharge plan.

F was therefore admitted to a medical ward at Maidstone Hospital. The first MPM was arranged two days after the admission date however did not progress as one of the external stakeholders was not able to attend. A subsequent MPM was arranged for the following day. During this meeting it became apparent that his primary carer who had parental responsibility for him under a Special Guardianship Order (SGO) had passed away the previous year. The SGO had expired on her death, and it was uncertain who retained Parental Responsibility.

The Local Authority responsible for F had had a long history of care responsibility for F before his birth having taken responsibility for his siblings. F had been placed in care soon after he was born with responsibility given to a close relative who became F's primary carer. The close relative who attended ED with F also lived in the same house. Following the death of F's primary carer concerns had been raised about the suitability of the living arrangements as it remained unclear what support F was receiving at home.

During the MPM it was acknowledged that F had attended ED 6 times since September 2024 to September 2025 for various concerns. However, information regarding who had parental responsibility for F was not consistently recorded or explored in detail. The Local Authority sought legal advice to facilitate a safe discharge and clarity on who held parental responsibility.

A follow up MPM was convened at the end of October 2025. The Local Authority had met with F and the extended family. They were keen to have F back at home and had sufficient interests in providing care to F.

F was discharged to a new family relative with agreement from all involved. Since discharge, F attendances to ED are much easier due to the level of information available to support informed decision making and admission avoidance where possible.

In conclusion, F's story highlights

- Role of the MPM and collaborative working with internal and external stakeholders at the earliest opportunity.
- Think family approach in adult and children safeguarding.

Positive points to highlight:	**Negative points to highlight:**
• Early referral from ED to MTW Safeguarding • Support from ward team to ensure MPM were held in a timely manner. • Nursing support in gathering relevant individuals' roles in F's life. • New next of kin identified giving respite and shared responsibility.	• Lack of professional curiosity in ED during previous attendances • Lack of collaborative information sharing following the death of the primary carer with parental responsibility • Period of time with uncertainty around parental responsibility for F.

Actions to take from this:

- To ascertain at early stage who has parental responsibility for any child/young adult.
- To involve external partners in decisions for best supportive outcome.
- To follow-up with Local Authority Partners if SGO is being completed and by whom.
- Early Multi Professional meetings to bring all professionals involved in care of patients where they may be complexities around discharge.

Title of report	**Report from the Chair of the Trust Board**					
Board / Committee	**Trust Board**					
Date of meeting	30th April 2026					
Agenda item no.	04-5					
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 April 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:

Chief Executive, Miles Scott, and I attended a session with local Members of Parliament last week alongside other NHS leaders to discuss the Kent and Medway Integrated Care Board system strategy, which aligns with delivering the Government's NHS 10-Year Plan. As part of this strategy, a Provider Alliance will be developed comprising two Provider Collaboratives: community and acute. This will be led by Chief Executives and all organisations will have shared accountability for system outcomes.

The progress of the Acute Provider Collaborative was discussed at a separate meeting held by the Kent and Medway ICB for Chairs and Chief Executives. Together, we discussed how to develop and embed a Provider Alliance across Kent and Medway, with acutes working in partnership to deliver the aims of the Acute Provider Collaborative.

At the South East Regional Senior Leaders (Chairs) meeting this month, we covered topics including progress in performance and elective care across the region, the industrial action held by the British Medical Association at Easter, and the National Quality Strategy, which is due to be published in May.

I then joined Miles Scott at the NHS England (NHSE) South East Regional Roadshow this week, which was hosted by NHSE's Regional Director and Regional Chair, and attended by Sir Jim Mackey, NHSE's Chief Executive. The event brought together Trust Chairs and CEOs, and ICB Chairs, and we reflected on the progress from the last financial year. We then set shared priorities for 2026/27 and discussed how these will be delivered together across the region.

We were delighted to welcome His Majesty's Lord Lieutenant of Kent, Lady Annabel Colgrain, to Maidstone Hospital earlier this month. Lady Colgrain formally presented the King's Award for Voluntary Service to Vickie Gadd, Lead Clinical Nurse Specialist for Gynae Oncology Genetics and Family History at the Trust. Vickie was recognised for her long-standing voluntary work with BRCA Kent, a group which supports women across the county who are living with a faulty BRCA gene.

Lady Colgrain commended Vickie and her fellow volunteers in BRCA Kent for their dedication to providing support and guidance to those who have been diagnosed with a genetic mutation, and for raising awareness among healthcare professionals and members of the public across the community.

The visit also highlighted the importance of research in improving outcomes for patients. MTW continues to play an active role in clinical research, working collaboratively with partners across the country to embed research into services and ensure patients benefit from the latest evidence and innovation.

One recent example is the LiVD-ACL study, a pioneering clinical trial in which MTW is the only trust in the UK offering this innovative approach to ACL reconstruction in children. Early results have shown excellent outcomes, with the first cohort of patients returning to sport at their previous level. The results were recently presented at the British Association for Surgery of the Knee conference, where Consultant Orthopaedic Surgeon Mr Nicholas Bowman and Orthopaedic and Research Physiotherapist Helen Sankey were awarded best podium presentation. On behalf of the Board, I would like to congratulate Nicholas and Helen on this achievement and thank them for their contribution to research at the Trust.

Finally, I would like to welcome our new Associate Non-Executive Director, Elizabeth (Liz) Woolman, who joined the Board earlier this month to replace Richard Finn, who stood down last November. Liz is a qualified executive coach and marketeer, with over 25 years' experience in a FTSE 100 organisation in the global technology sector. She has held senior positions in a wide range of areas including human resources, sales, strategy and communication product management. Liz's vast experience in implementing new systems and technology platforms, as well as digital transformation, will be an invaluable asset to our team.

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?
31st March 2026	Consultant Histopathologist	Elsie	Wessels	Histopathology	TBC	Replacement.

Title of report	**Report from the Chief Executive**					
Board / Committee	**Trust Board**					
Date of meeting	30th April 2026					
Agenda item no.	04-5					
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 April 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:

- The British Medical Association held industrial action earlier this month. The national action by resident doctors presented additional challenges as it coincided with the Easter bank holiday weekend and a period of increased staff annual leave. Despite the difficulties this presented, we maintained safe services and ensured all critical treatments went ahead. Ahead of the national action, detailed plans were put in place across the Trust to ensure staff rosters had been filled to minimise the impact on our patients. Clinical and operational leaders worked closely with colleagues to support staff and our services, and to reduce any impact on patients as we focussed on maintaining our activity for oncology patients and new patients, as well as providing safe, timely emergency care. In line with the rest of the NHS, there was some disruption to elective activity and outpatient appointments, with affected patients contacted in advance to re-schedule for the next available date.

- NHS England has confirmed the Trust's Medium-Term Plan (2026/27–2028/29) and Five-Year Integrated Delivery Plan meet the requirements of the national planning framework. This marks an important milestone and reflects the extensive work undertaken across the organisation and with system partners to develop robust, multi-year plans aligned to national priorities for sustaining performance, service transformation and long-term sustainability. The focus has now moved from plan submission to delivery, with ongoing engagement with NHS England through established regional oversight arrangements, and close working with Kent and Medway ICB in its role as commissioner to support implementation of agreed system priorities.

- In this new financial year, our focus remains on maintaining safe services through ongoing operational pressures while delivering our priorities for 2026/27. These include improving activity and performance, maintaining an affordable establishment, controlling discretionary non-pay spend, reducing time spent in hospital and optimising inpatient capacity, and reducing variable pay. Alongside this, we continue to work with partners across Kent and Medway on shared priorities where system collaboration strengthens patient care and flow.

- The Kent Oncology Centre is providing some of the quickest access to cancer treatment in the country - achieving the 62-day target consistently for more than six years. Recent developments include:
    - The Trust's radiotherapy services at the Kent Oncology Centre's Canterbury site have received highly positive feedback by the Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), with no recommendations or improvement notices, and no action plan required. The IR(ME)R inspection highlighted multiple areas of good practice, including governance, quality assurance, peer review and staff training, with one element (the radiotherapy treatment imaging training package) recommended as exemplary for wider adoption.
    - Oncology services have also recently introduced new advanced radiotherapy techniques to further enhance patient care. Volumetric Modulated Arc Therapy (VMAT), delivered in combination with Simultaneous Integrated Boost (SIB), is now in use for breast cancer patients, enabling more precise, personalised treatment. This approach allows different dose levels to be delivered to multiple target areas in a single session, improving treatment accuracy, reducing exposure to healthy tissue and shortening overall treatment times. The first patient was successfully treated last month, marking a significant step forward in improving outcomes and patient experience across Kent and Medway.

- MTW has been confirmed as compliant with the Year 7 requirements of the Maternity (Perinatal) Incentive Scheme (MIS), following publication of the national results by NHS Resolution. The MIS is a scheme run by NHS Resolution, which sets out a series of safety actions designed to improve outcomes for women and babies and to provide assurance around maternity safety, governance and learning from incidents. This compliance reflects the continued focus on safety, governance and learning across Maternity services, and the work colleagues do every day to support families by meeting the safety actions set out in the scheme.

- The Patient First Improvement System training programme was recently awarded Continuous Professional Development (CPD) accreditation. PFIS training provides teams with the skills to identify areas for improvement in their departments and implement changes that will benefit patients and staff. CPD accreditation means staff members who successfully complete the course are now awarded 12 hours of accredited learning. Since launching in 2022, 685 staff members have received PFIS training, across 120 teams. As well as face-to-face improvement huddles, virtual improvement boards

have also been introduced to support remote working and staff working across different sites. Over 2,015 improvement tickets have been completed since PFIS was introduced, with recent improvement projects including:

  - Implementation of real-time monitoring in the Sexual Health walk-in clinic, ensuring the maximum number of patients can be seen.
  - Introduction of a document template for GPs referring patients to the cancer lower gastrointestinal pathway, ensuring the required referral information is provided for the patient to enter the pathway in a timely manner.

- Chief Nurse, Jo Haworth, has been appointed Visiting Professor by Canterbury Christ Church University in the School of Nursing, Midwifery, Allied and Public Health. As a Visiting Professor, Jo will support strategic academic development, contribute to teaching and curriculum innovation, and offer expert insight into contemporary clinical leadership and workforce priorities. She will also act as a role model for students, offering insight into career routes and what senior leadership looks like in today's healthcare system. The appointment will enhance the student experience by ensuring teaching remains practice-informed, relevant and aligned with current NHS priorities, while supporting continued collaboration to improve health outcomes across Kent and beyond. Jo has already played a key role in supporting the University, contributing to the redesign of nursing programmes and the development of a new midwifery course.

- I represented the Trust at two events earlier this month, highlighting innovative ways of working at MTW that have transformed the care we provide:
  - At the HSJ Provider Summit I spoke on optimising patient flow through the use of real time data. I highlighted the Trust's whole organisation approach to improving flow, including the introduction of an electronic bed management systemin our Care Coordination Centre. This data system provides real-time visibility of available beds and has significantly reduced the amount of time a bed is empty and reduced the time a patient spends in the Emergency Department (ED) before they are transferred to a ward (from one hour 40 minutes to 40 minutes). This ensures patients arriving in ambulances are quickly moved into the ED. The system has enabled the Trust to increase the number of planned operations while enabling nursing and ward teams to spend more time on direct patient care.
  - I was invited to speak at the Pembury Society's spring public meeting, where I talked about the development of Tunbridge Wells Hospital and the Trust's role in the local health system. I gave a brief history of the original site and shared key achievements from across the Trust over the past two years. These included the opening of the Kent and Medway Orthopaedic Centre, the development of the West Kent Community Diagnostic Centre and the introduction of robot-assisted surgery, highlighting our continued focus on innovation and improving care for local communities.

- Congratulations to the winner of the Trust's Employee of the Month award for March, Julia Collings, Junior Sister on Ward 21 at Tunbridge Wells Hospital. Julia was nominated by a patient's daughter for the outstanding care she provided her mother, who is living with dementia, during her hospital stay. The nomination described Julia as "the very best of what nursing can be" and detailed how she placed the patient's wellbeing at the heart of every decision, treated the patient with dignity and respect, and adapted her communication style to suit their needs.

Title of report	**Summary report from the Quality Committee, 15/04/26**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th April 2026					
Agenda item no.	04-7					
Executive lead	Jo Haworth, Chief Nurse; Sarah Davis, Chief Operating Officer; Sara Mumford, Chief Medical Officer and DIPC					
Presenter	Vivek Srivastava, 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 15th April 2026 (a ''deep dive'' meeting). The Committee considered the following topics: The BAF risks overseen by the Quality Committee; Review of patient discharges at the Trust, and an update on the Trust's Mental Health Strategy. The Committee noted that the reports presented, demonstrate that controls relating to Principal Risks 2, 3, and 4 of the Board Assurance Framework demonstrate partial assurance.
Any items for formal escalation / decision	N/A
Appendices attached	There are no appendices to this report.

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

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	PR:2 If we do not reduce the number of significant avoidable harm events our patients are at risk of poor clinical outcomes PR 3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage PR 4: Failure to provide compassionate, effective, responsive and safe care may negatively impact the experience of care for patients, their families and carers and may affect the reputation of the organisation.
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 3417 - Risk of Significant physical and/or psychological harm to patients as a result of prolonged Histology turnaround times • 3096 - Risk of increased staff turnover/ sickness/ negative impact

	on wellbeing across Cellular Pathology- all roles.
Compliance / Regulatory Implications	N/A

The Quality Committee met (in-person / face-to-face) on 15th April 2026 (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 group discussed the submitted report and the ongoing revision of the BAF, noting that a full update was being prepared for Trust Board sign-off. Members considered the impact of financial constraints, particularly on patient experience, and noted that the People section of the BAF was likely to increase due to emerging risks. The group also noted that people-related risks were being appropriately escalated to Executive level and highlighted the importance of addressing both immediate and underlying risks.
- The Chief Nurse and Director of Quality Governance presented a report on the **monitoring of quality during financial challenge.** The presentation included the key quality impacts associated with NHS financial turnaround in acute trusts, particularly the consequences of staffing constraints, operational pressures and reduced capacity, which had the potential to adversely affect patient safety, flow, governance, workforce morale and patient experience. The group discussed the potential quality risks arising from vacancy controls, skill-mix changes and workforce reductions, and reflected on past experiences within the Trust and learning from other organisations that had successfully recovered from financial difficulty. Members highlighted concerns about staff capacity, reduced clinical governance resource and the challenge of maintaining service quality while delivering financial savings. The importance of clearly defined and measurable quality metrics was emphasised, alongside the need to consolidate assurance through dashboards and existing oversight processes. Non-Executive Directors sought assurance that quality was not deteriorating as a result of financial pressures, and it was agreed that further work would be undertaken to refine the presentation, strengthen the focus on the 'so what', and share key messages and recommendations with the wider teams.
    - ❖ 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 items for scrutiny at future Quality Committee 'deep dive' meetings were discussed.

Title of report	**Summary report from the Finance and Performance Committee**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th April 2026					
Agenda item no.	04-8					
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 (Including the Cash Committee) met (virtually) on 28th April 2026. The Finance and Performance Committee considered the following topics: 1) To consider the BAF risks 2) The patient access strategic theme metrics for March 2026 3) The financial performance for month 12, 2025/26 and an update on the Trust's Financial Improvement Plan 4) Kent and Medway FIP weekly report 5) Forecast Q1 mitigations 6) Quarterly analysis of consultancy use 7) Capital Plan 8) Follow up from Drivers of the Deficit work 9) To approve the Trust's Green Plan Refresh 10) NHSE Acceptance of final medium-term plan for 2026/27–2028/29 and your five-year Integrated Delivery Plan 11) ID1064 – Out of Hours GP Business Case 12) Diagnostics digital capability business case addendum 13) Submission for Cash Application 14) Approval of Terms of Reference of the Cash Committee The Committee noted the notification of the use of the Trust Seal. The Cash Committee consider an Update on the Trust's cash position 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, but the risks remained.
Any items for formal escalation / decision	
Appendices attached	N/A

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

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	• PR3: If the Trust does not meet its constitutional patient access standards there may be delays in care for our patients, financial implications and reputational damage • PR5: If we do not work effectively as a system patients that are no longer fit to reside will remain within MTW for longer which may result in poorer clinical outcomes and reduced flow through our hospitals • PR6: Failure to deliver the Trust financial plan resulting from the system being in financial recovery
Links to Trust Risk Register (TRR)	Please list any risks on the Trust Risk Register to which this report relates • 791 – Failure to meet Referral to Treatment Targets (RTT) • 3109 – Failure to deliver Financial Plan including recurrent cost improvement programmes for 2024/25 • 3113 – There is a risk that the Trust will not have enough cash to meet its commitments resulting in suppliers not being paid and the Trust not meeting its BPPC (Better Payment Practice Code) • 3130 – There is a risk that the Trust will not be able to deliver it's financial efficiency plan (CIP)
Compliance / Regulatory Implications	N/A

The Finance and Performance Committee met on 28th April 2026, 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.
- **Patient Access strategic theme** metrics for March were reviewed, and the Committee heard that the Emergency Department (ED) achieved just over 80%, slightly below the internal target of 83%. It was noted that the National Assessment Performance Framework (NPAF) indicator for A&E 4hrs consistently passed the target of 78% and the Committee heard that performance remained one of the highest nationally. The Committee heard that cancer standards were met or exceeded, with 28-day at 84%, 31-day at 97.8%, and 62-day at 86.1%. It was noted that the diagnostic waiting times performance was 97.9%, above the revised national target of 95% and the Referral to Treatment Times (RTT) performance reached 76.2% against a target of 75.4%, with the waiting list just over 46,000 patients.
- The **financial performance month 12, 2025/26** was then presented by the Chief Finance Officer, which included that the draft accounts were submitted ahead of the deadline, reflecting a £16.6m deficit, in line with forecasts. The Committee heard that the organisation delivered a Cost Improvement Plan (CIPs) of over £50m, a record for the Trust. It was noted that the new financial year required £54.6 million in CIP, with a focus on identifying and maturing schemes.
- The **Kent and Medway FIP weekly report** was noted by the Committee.
- The Director of Finance presented the **Forecast Q1 mitigations** which included three scenarios; the base case (month 12 run rate), the best case (full CIP delivery), and worst case (higher mitigations required). The Committee heard that the forecast for Q1 was £9.8 million, requiring an additional £2.1 million in mitigations to reach the £11.9 million target.
- The **Quarterly analysis of consultancy use** was noted by the Committee.
- The Director of Finance presented the **Capital Plan** and outlined allocations, the importance of timely capital spend and the strategic alignment with system objectives.
- The Chief Transformation Officer provided the Committee with the **follow-up from Drivers of the Deficit work** wherein the group heard that the EY modelling report identified opportunities aligned with the Trust's existing plans, with some additional potential in pathway optimisation. It was noted that delivery of the Trust's plans was through five executive-led delivery groups covering affordable establishment, variable pay, length of stay, activity and performance, and non-pay, all reporting to a weekly delivery board and supported by a project management office.
- The Committee approved the **Trust's Green Plan Refresh.**
- The Chief Finance Officer presented the **NHSE Acceptance of final medium-term plan for 2026/27–2028/29 and your five-year Integrated Delivery Plan.** It was noted that plans had been accepted with the conditions set by NHS England regarding CIP identification and weekly reporting to the ICB and the region. The shift in performance management from the ICB to NHSE's regional team was noted.
- The Director of Strategy, Planning & Partnerships presented the **Out of Hours GP Business Case** and **Diagnostics digital capability business case addendum** which were both approved by the Committee and the Out of Hours GP business case was referred to the Trust Board for approval.
- The **notification of the use of the Trust Seal** and the **forward programme** were noted by the group.
- 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 were demonstrating effectiveness.

The Cash Committee met on 28th April 2026, virtually via webconference.

The key matters considered at the meeting were as follows:

- The Committee received and **Update on the Trusts' Cash Position** and the Committee received an update on the Trust's cash position, year-end balances, disputed debts, cash recovery strategies, and the importance of resolving outstanding issues.

Title of report	**Integrated Performance Report (IPR) for March 2026**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th April 2026					
Agenda item no.	04-9					
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)					
Patient experience	Patient access	Sustainability	People	Systems and partnerships	Patient safety and clinical effectiveness
☐	☐	✓	✓	✓	☐

Executive Summary			
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	The IPR for March 2026 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

March 2026

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

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

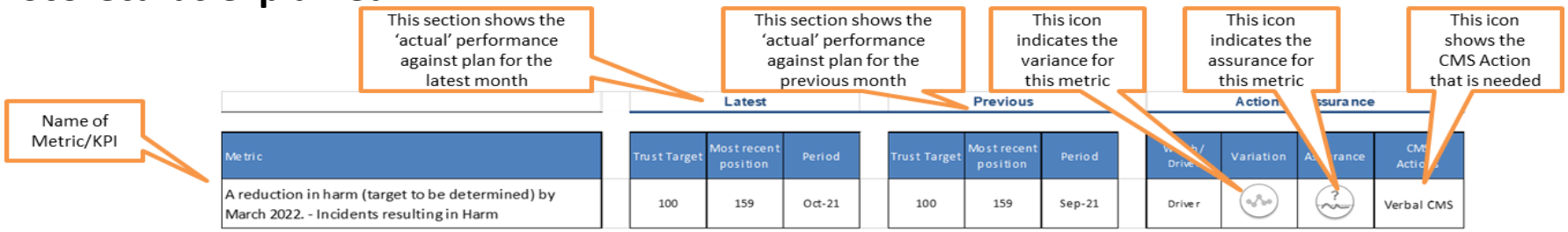
Escalation Pages:

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

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

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

Scorecards explained



Further Reading / other resources

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

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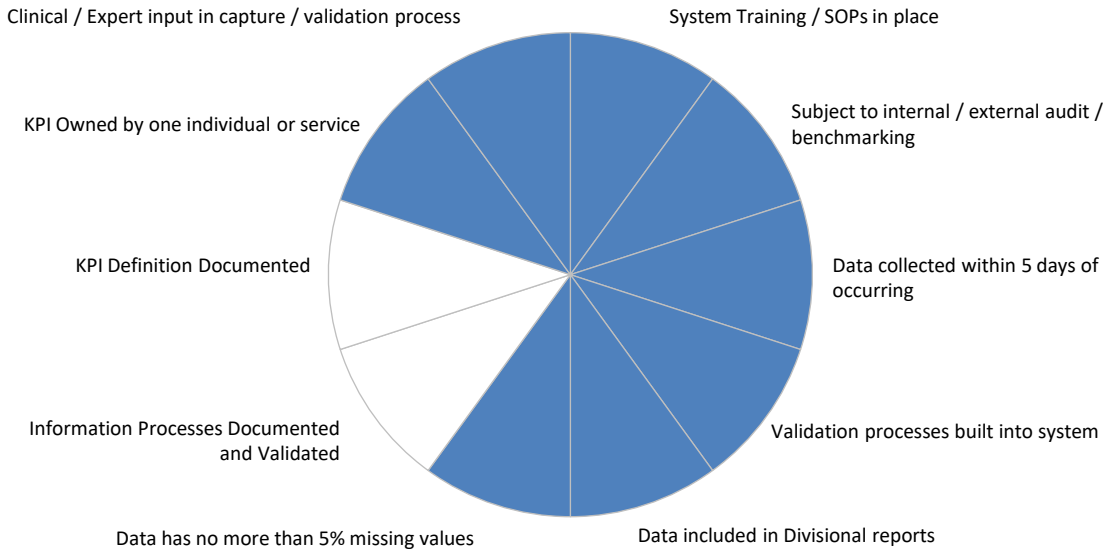
Forecasts

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

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

Data Quality Kite Marks



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

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

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

The implementation of this is an audit recommendation.

Executive Summary

Executive Summary:

The Strategy Deployment Review (SDR) governance structure and Improvement process has been reviewed for the new financial year and the new Vision and Breakthrough Objectives for each of the six strategic themes have been agreed. The new objectives are therefore reflected in this report. These Key Performance Indicators are at an early stage and will continue to be developed as the improvement programme continues. Any indicators that are part of the National Performance Assessment Framework (NPAF) have been highlighted or added if they were not already included in the report.

People: Delivery of the pay elements of the Financial Improvement Plan 25/26 indicator is experiencing common cause variation continues to fail the target for 6+ months. The breakthrough objective of achievement of the workforce plan in WTEs remains in common cause variation, and consistently failing the target, with the substantive staff element of this also currently escalated. Agency staff spend as a proportion of the total pay spend continues to experience special cause variation of an improving nature and is in variable achievement of the target. Vacancy Rate has moved to special cause variation of a concerning nature and variable achievement of the target with the March position at 8.5%. Turnover Rate has moved to special cause variation of a concerning nature but continues to consistently pass the target. The number of staff that leave within 12 and 24 months are now 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 remains in 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 continues to be in special cause variation of a concerning nature and failing the target for 6+ months. The number of incidents of moderate+ harms due to potential mismanagement of deteriorating patients is experiencing common cause variation and variable achievement of the target. Both the Rates of E.Coli and C.Diff continue to experience common cause variation and variable achievement of the target. However, the new NPAF Indicators which monitor a 12-month rolling count of cases as a proportion of the Trust Threshold for MRSA, E.Coli and C.Difficile are currently escalated. For 25/26 there were 104 cases of C.Difficile against the target of 100 and 73 cases of E.Coli against the target of 52. There were 3 cases of MRSA. The rate of falls remains in common cause variation and continues to pass the target for more than six months. VTE performance was above the 95% target in February (data runs one-month behind) and is in common cause variation while passing the target each month throughout 25/26.

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 achieved the trajectory target for March 26 of 75.4% at 76.2% (Excluding SYS). Nationally we reported 76.06% (including SYS). We remain one of the best performing trusts in the country for longer waiters. Nationally we have reported 24 52-week breaches at the end of March 26, mainly due to mutual aid provided to peer organisations. The "Reduction in weeks wait for first Outpatient Appointment" indicator is experiencing common cause variation and consistently failing the target. The average weeks wait for first outpatient appointment as at the end of March 26 was 17.9 weeks against the internal trajectory target of 13 weeks

Diagnostic Waiting Times performance was 2.9% above the trajectory target for March 26 at 97.9%. This indicator is experiencing common cause variation and has now passed the target for 6+ months. The overall Diagnostics target has also now changed nationally from 99% to 95%. Diagnostic Imaging activity levels were above plan in March 26 and were above target for 25/26. This indicator remains in common cause variation and variable achievement of the target.

Executive Summary (continued)

Patient Access (Continued): The Trust's performance for A&E 4hrs was 5.3% below the trajectory target for March at 78.5% and has failed the target for 6+months. The Trust is expected to achieve 80.1% for the year against the Trust target of 83%. 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 Nationally. The NPAF Indicator for A&E 12hr waits (an Aggregated Quarterly Position) has failed the target for Quarter 4 25/26. The average in-hospital non-elective length of stay indicator is experiencing common cause variation but is consistently failing the target. The conversion rate from A&E to inpatient admission remains in common cause variation and has passed the target for 6+ months. Ambulance Handover within 30 minutes continues to experience common cause variation and has failed 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 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 has now achieved the 80% target for Quarter 3 at 82.3%, with February 26 performance achieving 84%.

Outpatient utilisation has achieved the 85% target in March, as well as for the 25/26 year overall. This indicator is now experiencing common cause variation and variable achievement of the target. The percentage of Clinical Admin Unit (CAU) Calls answered within 1 minute remains in special cause variation of a concerning nature and consistently failing the target. Performance for First Outpatients activity was above the trajectory target for March (this is likely to improve further as cashing up of clinics take place). Whilst the activity levels are expected to be slightly below target for 25/26, the activity levels in the last Quarter of the year were significantly higher than the submitted plan as part of the Trust's Recovery Plan. This indicator is experiencing common cause variation and variable achievement of the target. Elective Activity (Inpatients and Day Case combined) was above plan for March and achieved the plan for 25/26. Theatre Utilisation is experiencing common cause variation but is consistently failing the target. The rate of Outpatients that are either a new appointment, or a follow up appointment with a procedure, remains in common cause variation and variable achievement of the target.

Patient Experience: The number of overall complaints remains in common cause variation but 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 March, at 78%, and has passed the target throughout 25/26. This indicator continues to experience special cause variation of an improving nature and variable achievement of the target. Maternity, Inpatients & Outpatients Friends and Family Response rates remain in common cause variation and have failed the target for six consecutive months or are consistently failing. A&E Friends and Family Response rate passed the target in March and has passed the target for 6+months.

Systems: The daily average in-hospital non-elective beddays (Excluding Virtual Ward) is experiencing common cause variation but has failed the target for 6+months. Both the daily average virtual ward beddays and the Average Non-Elective LOS for Fracture Neck of Femur (NOF) remain in common cause variation and variable achievement of the target. The target for the Virtual Ward beddays has been increased to 95% of the 60 beds.

Sustainability: The Trust was £0.8 in surplus in the month which was £3.2m adverse to plan in the month. Year to Date the Trust is £16.6m in deficit which is £16.6m adverse to plan. The most recent Implied Productivity NPAF Metric is experiencing special cause variation of an improving nature and variable achievement of the target.

Maternity: The indicator for Women waiting for Induction of Labour within 6 hours continues 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.

Executive Summary (continued)

Escalations by Strategic Theme:

People:
- Delivery of the Pay Elements of the Financial Improvement plan (P.11)
- Achievement of Workforce Plan (WTEs) (P.12)
- Achievement of Substantive Element of Workforce Plan (WTEs) (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)
- 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 in-hospital non-elective beddays (Excluding Virtual Ward) (P.27)

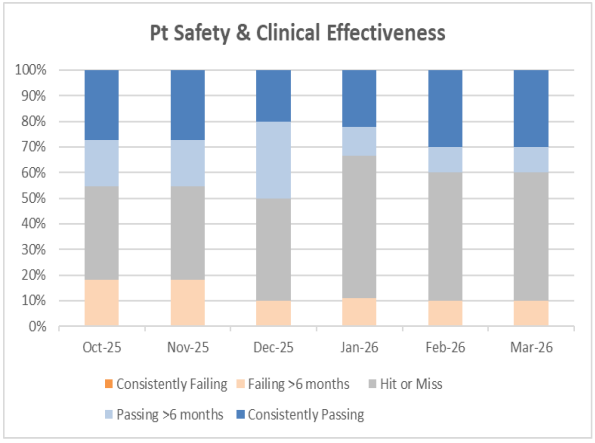
Patient Safety & Clinical Effectiveness:
- Rate of Incidents resulting in moderate harm per 1,000 occupied beddays (P.15)
- 12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* (P.16)
- 12 month rolling count of C. difficile cases as a proportion of trust threshold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

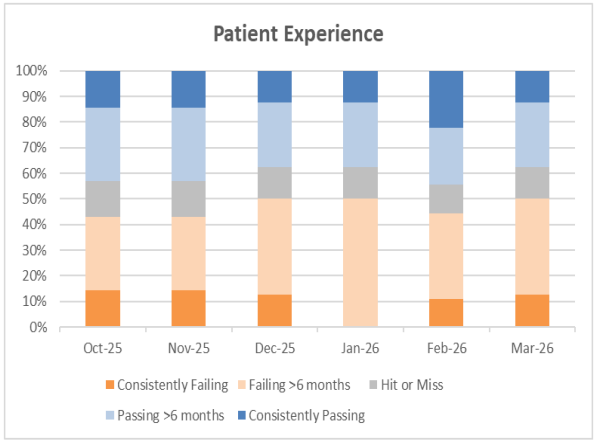
Patient Experience:
- New Complaints Received (P.24)
- FT Response Rates: Maternity (P.25)
- FT Response Rates: Outpatients (P.25)
- FT Response Rates: Inpatients (P.25)

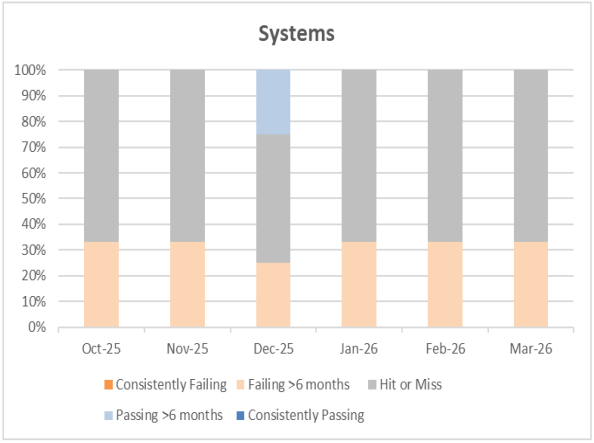
Maternity Metrics:
- Women waiting for Induction of Labour <6 Hrs (P.29)

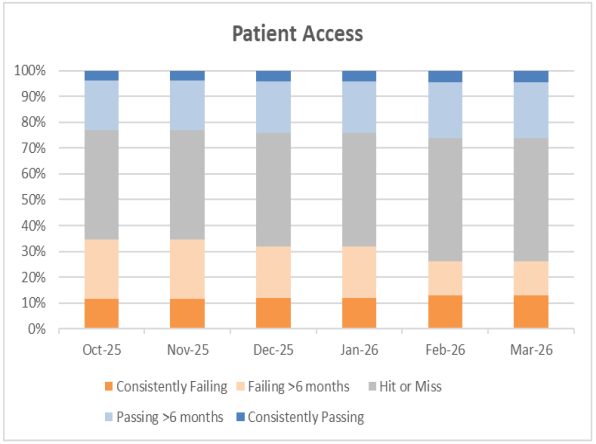
**Escalated due to the rule for being in Hit or Miss for more than six months being applied*

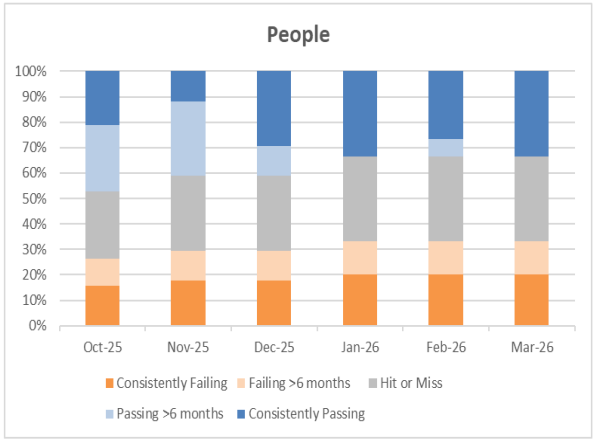
Assurance Stacked Bar Charts by Strategic Theme

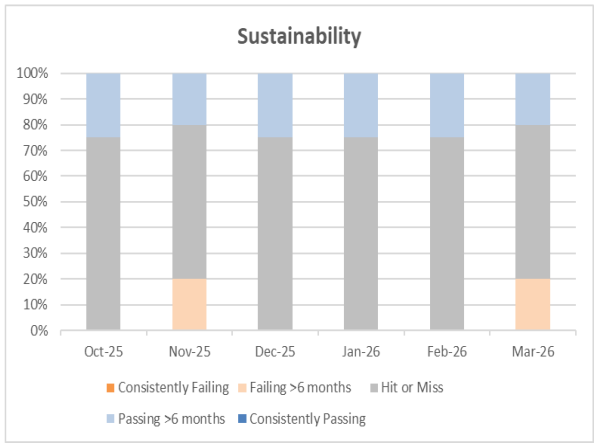












Matrix Summary

March 2026

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% Percentage of AfC 8c and above that have a Disability	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)	Achievement of Agency Element of Workforce Plan (WTEs) % complaints responded to within target Implied Productivity Growth (YTD compared to previous year)		Percentage of AfC 8c and above that are BAME 12 month rolling count of C. difficile cases as a proportion of trust threshold *NPAF Metric* 12 month rolling count of MRSA cases *NPAF Metric* To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric* To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally Friends and Family (FFT) % Response Rate: Outpatients
Common Cause	Statutory and Mandatory Training Percentage of AfC 8c and above that are Female Summary Hospital-level Mortality Indicator (SHMI) *NPAF Metric* *Cancer - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric* Safe Staffing Levels (Nursing)	Rate of patient falls per 1000 occupied bed days Access to Diagnostics (<6weeks standard) Cancer - 31 Day First (New Combined Standard) - data runs one month behind Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind) Conversion rate from ED (Excluding Type 5 and including Direct Admissions) Friends and Family (FFT) % Response Rate: A&E Cash Balance (£k)	Sickness Absence *NPAF Metric* Achievement of Bank Element of Workforce Plan (WTEs) Staff Leavers within 12 months Staff Leavers within 24 months Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind) Never Events IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Bacteraemia *Cancer - 28 Day Faster Diagnosis Compliance (one month behind) - Quarter Position Aggregated *NPAF Metric* RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support) Cancer - 62 Day (New Combined Standard) data runs one month behind %Outpatient Clinic Utilised (slots) To achieve the planned levels of new outpatients activity To achieve the planned levels of elective (DC and IP combined) activity Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%) To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity To 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. Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays - Target is 95%of 60 beds 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 Reduce non-pay spend Capital Expenditure (£k)	Delivery of the pay elements of the Financial Improvement Plan 2025/26 Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) A&E 4 hr Performance Ambulance Handover Delays >30mins To reduce the overall number of complaints or concerns each month Friends and Family (FFT) % Response Rate: Inpatients Friends and Family (FFT) % Response Rate: Maternity 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*	Achievement of Workforce Plan (WTEs) RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways) RTT Total Waiting List (Excl SYS) Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward) % Capped Theatre utilisation.
Special Cause - Concern	Reduce Turnover Rate to 12% Standardised Mortality HSMR		% of Patients Discharged to a PIFU Pathways Complaints Rate per 1,000 occupied beddays	Percentage of emergency department attendances spending over 12 hours in the department - Quarter Position Aggregated *NPAF Metric*	12 month rolling count of E. coli cases as a proportion of trust threshold *NPAF Metric* CAU Calls answered <1 minute

Strategic Theme: People

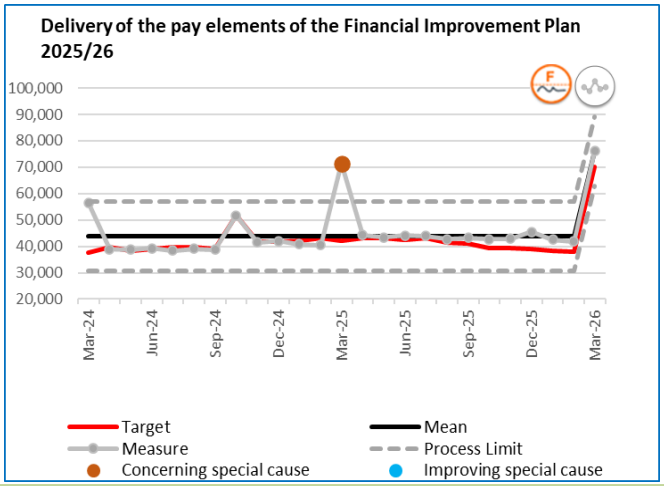
				Latest			Previous			Actions & Assurance				Year End Position		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Position	Variation	Assurance
Vision	Well Led	Delivery of the pay elements of the Financial Improvement Plan 2025/26		70,245	76,054	Mar-26	37,898	41,920	Feb-26	Driver			Full CMS			
Breakthrough Objective	Well Led	Achievement of Workforce Plan (WTEs)		7642	8137	Mar-26	7677	8177	Feb-26	Driver			Full CMS			
NHS Performance Assessment Framework (NPAF) Metrics	Well Led	Sickness Absence *NPAF Metric*		4.5%	4.8%	Feb-26	4.5%	5.2%	Jan-26	Driver			Not Escalated	4.6%		
Constitutional Standards and Key Metrics	Well Led	Achievement of Substantive Element of Workforce Plan (WTEs)		7015	7457	Mar-26	7050	7483	Feb-26	Driver			Escalation			
	Well Led	Achievement of Bank Element of Workforce Plan (WTEs)		552	636	Mar-26	552	641	Feb-26	Driver			Not Escalated			
	Well Led	Achievement of Agency Element of Workforce Plan (WTEs)		74	44	Mar-26	74	54	Feb-26	Driver			Not Escalated			
	Well Led	Agency Spend as a % of spend – target of 3.2%		3.2%	0.5%	Mar-26	3.2%	0.4%	Feb-26	Driver			Not Escalated			
	Well Led	Reduce the Trust wide vacancy rate to 8%		8.0%	8.5%	Mar-26	8.0%	8.7%	Feb-26	Driver			Not Escalated	8.2%		
	Well Led	Reduce Turnover Rate to 12%		12.0%	11.7%	Mar-26	12.0%	11.8%	Feb-26	Driver			Not Escalated	11.7%		
	Well Led	Statutory and Mandatory Training		85.0%	89.7%	Mar-26	85.0%	90.5%	Feb-26	Driver			Not Escalated	90.5%		
	Well Led	Percentage of AfC 8c and above that are Female		66.0%	72.2%	Mar-26	66.0%	72.4%	Feb-26	Driver			Not Escalated	72.32%		
	Well Led	Percentage of AfC 8c and above that have a Disability		4.0%	11.1%	Mar-26	4.0%	11.0%	Feb-26	Driver			Not Escalated	12.66%		
	Well Led	Percentage of AfC 8c and above that are BAME		15.7%	8.3%	Mar-26	15.3%	8.3%	Feb-26	Driver			Not Escalated	9.39%		
	Well Led	Staff Leavers within 12 months		15.3	6	Mar-26	15.3	8	Feb-26	Driver			Not Escalated	13		
	Well Led	Staff Leavers within 24 months		28	20	Mar-26	27.8	18	Feb-26	Driver			Not Escalated	27		

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



Mar-26

76,054

Variance / Assurance

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

Max Limit (Internal)

70,245

Business Rule

Full Escalation as has failed the target for 6+ months

2. Stratified Data

	Current Month ' £000			Current Month WTE		
				Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	40,302	37,492	-2,810	7,457	7,015	-442
Bank	3,477	1,647	-1,830	636	552	-84
Agency	231	282	51	44	74	31
Other	32,044	30,824	-1,220	0	0	0
Total Pay	**76,054**	**70,245**	**-5,809**	**8,136**	**7,642**	**-495**

	Year to Date £000			Year to Date WTE		
				Submitted		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	473,704	469,187	-4,517	91,675	86,757	-4,918
Bank	41,844	21,577	-20,266	6,861	6,958	97
Agency	3,845	4,541	696	760	1,065	305
Other	33,943	23,375	-10,568	0	0	0
Total Pay	**553,336**	**518,680**	**-34,655**	**99,295**	**94,779**	**-4,516**

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 vacancy freeze
- 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

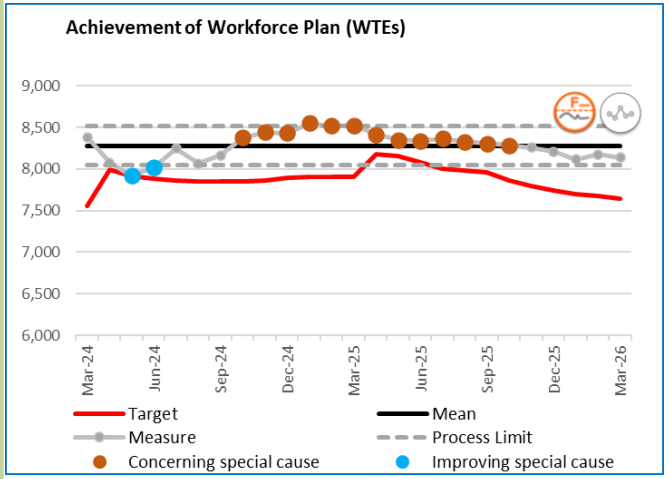
Workstreams	Actions	When	Who
Rostering Performance	Ongoing programme to establish e-rostering for all HCP teams (into 3rd phase with no major issues)	Ongoing	Head of Temporary Staffing
	Regular review of nursing rostering KPIs with Divisions	Ongoing	Deputy Chief Nurse
Affordable Establishment	Establishment review to ensure budget, establishment and WTE are consistent across whole Trust	May 2026	Chief Nurse / Chief Medical Officer
	Recruitment freeze implemented	June 2026	Chief People Officer
Variable Pay	Variable Pay Rapid improvement event and ongoing data analysis and planning completed	March 2026	Chief People Officer
	Variable pay launch event held with immediate actions agreed to reduce spend	March 2026	
	Rapid improvement events both organisationally and divisionally led	March 2026	
Medical Staffing	System-wide harmonisation of pay rates Roll-out of Patchwork/rostering and revised job planning approaches.	May 2026	Chief Medical Officer/ Chief People Officer

Financial Breakthrough Objective: Counter Measure Summary

Metric Name – Achievement of Workforce Plan (WTEs)

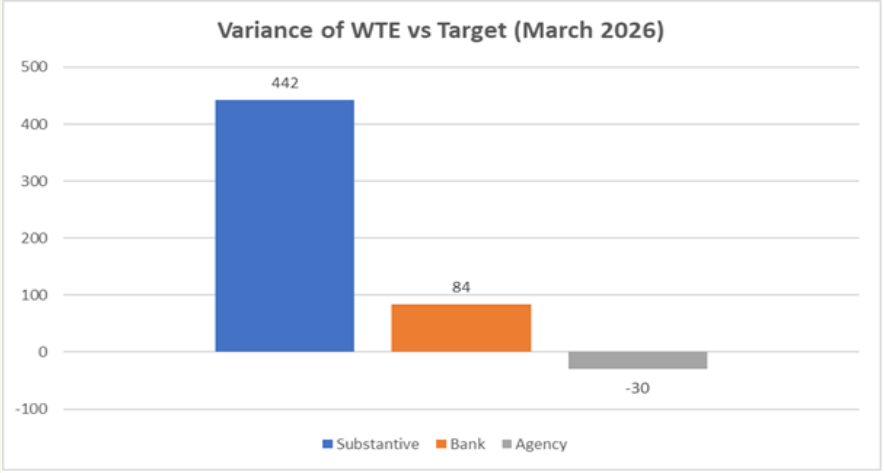
Owner: Chief People Officer
Metric: Achievement of Workforce Plan (WTEs)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-26
8,049
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Max Limit (Internal)
7,642
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

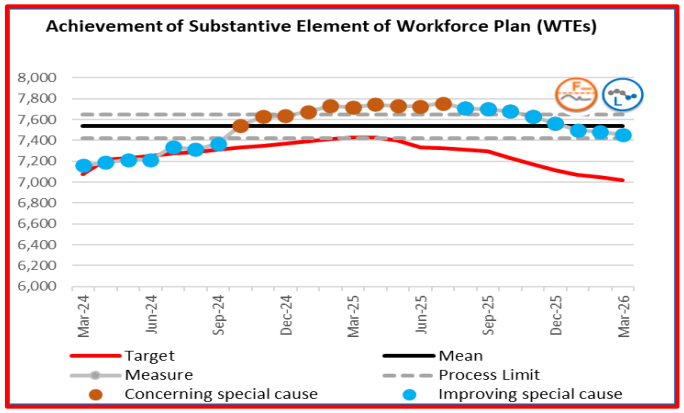
Risks:

- There is a risk that recruitment freeze will drive higher variable pay spend
- There is a risk that staff morale and wellbeing will decline
- 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.

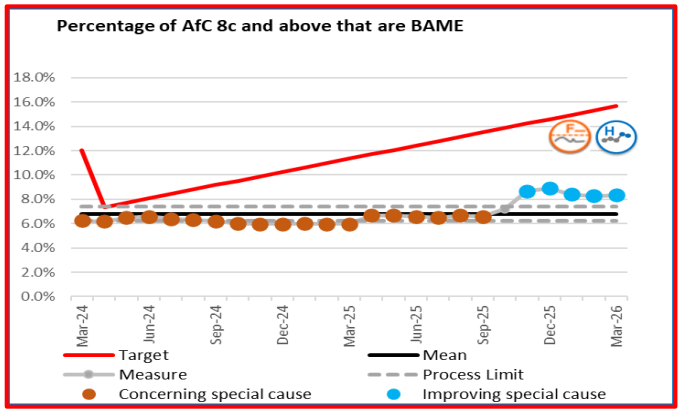
4. Action Plan of the Breakthrough Objective

Workstreams	Actions	When	Who
Workforce Transformation phase 2	Workforce Transformation Programme Phase 2 redeployment and notice period for leavers	Jan – Mar 2026	Chief People Officer
Variable pay	Variable pay delivery group established and rapid improvement event planned for w/c 16/3	Mar	Project team
Affordable Establishment	Recruitment freeze in place to be reviewed in line with establishment reviews	June	Chief People Officer
	Affordable Establishment delivery group set up – coordinating trust wide establishment reviews to bring substantive staffing numbers in line with affordable budgets	May 2026	Project Team

People – Workforce: CQC: Well-Led



Mar-26
7,457
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature but is consistently failing the target
Max Limit (Internal)
7,015
Business Rule
Full Escalation



Mar-26
8.3%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target (Internal)
15.7%
Business Rule
Full Escalation

Summary:	Actions:	Assurance & Timescales for Improvement:
Achievement of Substantive Element of the Workforce Plan: is experiencing special cause variation of an improving nature but is consistently failing the target **% of AfC 8c and above that are BAME:** This metric is 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 posts is in place and monitored by executive colleagues. Substantive numbers are steadily dropping, as is the use of variable resource (both bank and agency), overseen by the Variable Pay project, although further improvement work is required to meet the 26/27 targets **% of AfC 8c and above that are BAME:**	**Achievement of Substantive Element of the Workforce Plan:** • A recruitment freeze has been implemented with a robust exception process monitored by Executives (in place and ongoing) • Impact of Phase 2 (expected March - May 2026) • Financial Improvement Delivery Groups established and ongoing monitoring of progress through weekly Delivery Board, primarily through the Variable Pay and Affordable Establishment projects **% of AfC 8c and above that are BAME:**

Strategic Theme: Patient Safety & Clinical Effectiveness

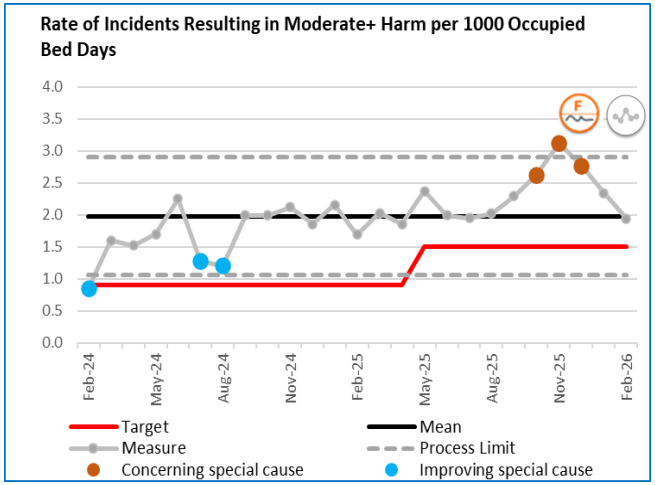
				Latest			Previous			Actions & Assurance				Year End Position		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Position	Variation	Assurance
Vision	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		1.50	1.94	Feb-26	1.50	2.34	Jan-26	Driver			Full CMS	2.53		
Breakthrough Objective	Safe	Number Moderate+ Harms Attributed to the Potential Mismanagement of Deteriorating Patients (data runs one month behind)		2.1	4	Feb-26	2.1	2	Jan-26	Driver			Verbal CMS	35		
NHS Performance Assessment Framework (NPAF) Metrics	Safe	Summary Hospital-level Mortality Indicator (SHMI) ***NPAF Metric***		100.0	91.2	Dec-25	100.0	88.5	Nov-25	Driver			Not Escalated	91.2		
	Safe	12 month rolling count of E. coli cases as a proportion of trust threshold ***NPAF Metric***		1.0%	1.40%	Mar-26	1.0%	1.50%	Feb-26	Driver			Escalation			
	Safe	12 month rolling count of C. difficile cases as a proportion of trust threshold ***NPAF Metric***		1.0%	1.04%	Mar-26	1.0%	1.15%	Feb-26	Driver			Escalation			
	Safe	12 month rolling count of MRSA cases ***NPAF Metric***		0	3	Mar-26	0	3	Feb-26	Driver			Not Escalated			
Constitutional Standards and Key Metrics	Safe	Number of new Patient Safety Incident Investigations (PSIIs) commissioned in month		TBC	1	Mar-26	TBC	2	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new After Action Reviews (AARs), commissioned in month		TBC	1	Mar-26	TBC	2	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Safe	Number of new SWARMs commissioned in month		TBC	0	Mar-26	TBC	0	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	87.1	Dec-25	100.0	84.8	Nov-25	Driver			Not Escalated	87.1		
	Safe	Never Events		0	0	Mar-26	0	0	Feb-26	Driver			Not Escalated	4		
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays		32.6	43.9	Mar-26	32.6	27.4	Feb-26	Driver			Not Escalated	33.1		
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays		44.3	43.9	Mar-26	44.3	40.0	Feb-26	Driver			Not Escalated	47.1		
	Safe	IC - Number of Hospital acquired MRSA Bacteraemia		0	0	Mar-26	0	2	Feb-26	Driver			Not Escalated	3		
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	4.6	Mar-26	6.4	3.5	Feb-26	Driver			Not Escalated	4.3		
	Caring	% VTE Risk Assessment (one month behind)		95.0%	96.5%	Feb-26	95.0%	96.2%	Jan-26	Driver			Not Escalated	97.1%		

Vision: Counter Measure Summary

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

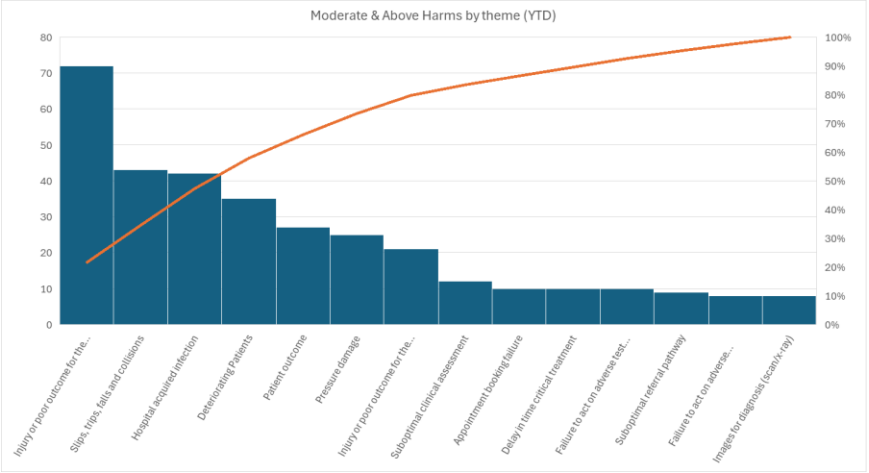
Owner: Chief Medical Officer
Metric: Incidents resulting in moderate+ harm per 1000 bed days
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

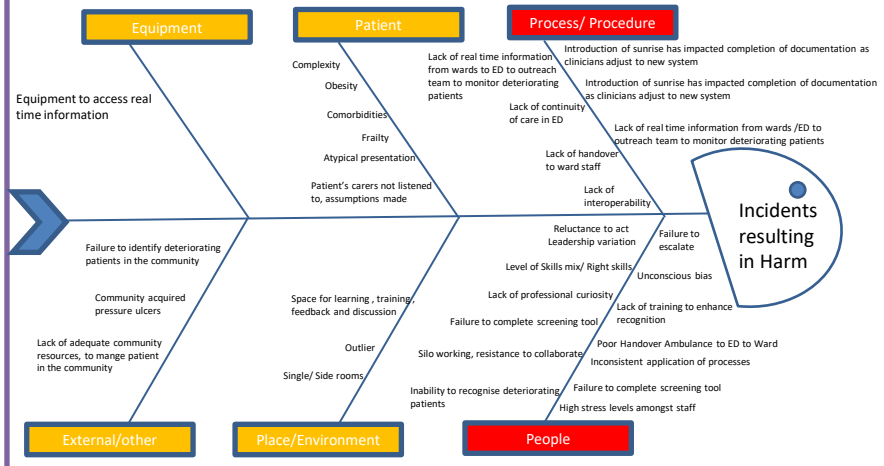


Feb-26 (1-month arr)
1.94
Variance Type
Metric is currently experiencing common cause variation
Maximum Limit (Internal)
1.5
Target Achievement
Metric has failed the target for 6+ months

2. Stratified Data



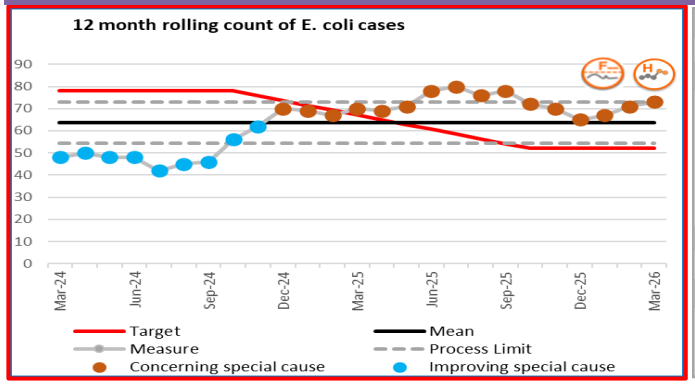
3. Top Contributors



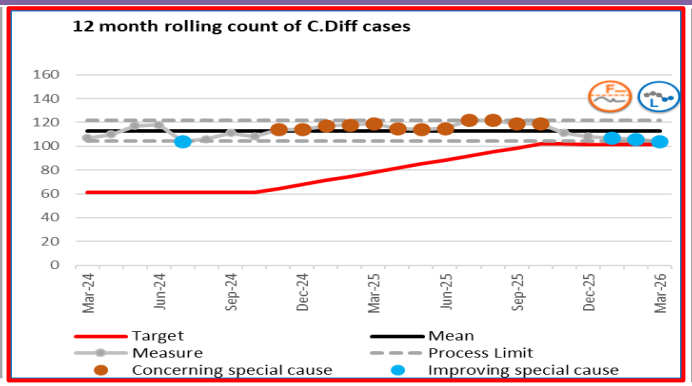
4. Action Plan

Actions	Leads	Due by
Deteriorating Patients		
Develop Deteriorating Patient Trust wide mandatory training	JB	May-26
Upskilling resident doctors in the deteriorating patient pathway clinical review document	YJ/MM/JB	Apr-26
Analysis of Peri arrest data on InPhase	JB/RS	Apr-26
Setting up Deteriorating Patient Committee	SM/JB	Jun-26

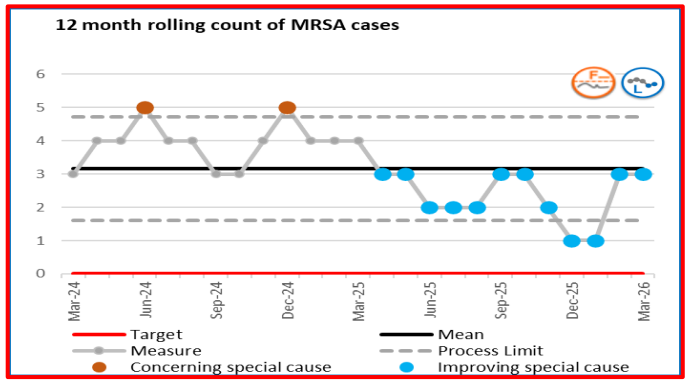
Patient Safety & Clinical Effectiveness: CQC: Safe



Mar-26
73
Variance / ,Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target
Target (Threshold)
50
Business Rule
Full Escalation as has failed the target for 6+months



Mar-26
104
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Threshold)
90%
Business Rule
Full Escalation as has failed the target for 6+months



Mar-26
3
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 is consistently failing the target

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 special cause variation of an improving nature but is consistently failing the target

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:- IPT newsletters, ad hoc department training sessions, regular audits are carried out on:

- Catheter care/ daily documentation of catheter care
- Hydration week is in March 2026 with a focus on hydration stations
- IV care and documentation
- Hand hygiene

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
- Appropriate personal protective equipment in place
- Increased training on infection prevention and antimicrobial stewardship for divisions/ clinicians
- Weekly consultant microbiologist/IPC ward rounds
- Deep cleaning programme for high-risk areas – ward 10, 11 and 32 completed
- Chlorine-based disinfectant for environmental and patient equipment has been rolled out
- Continued support regarding patient placement/ risk assessment
- New diarrhoea pathway launched in October 2025/ now on Sunrise – education ongoing
- Cleaning of mattresses implemented at every linen change using sporicidal wipes

MRSA - The Trusts continues to review all cases and share learning where appropriate. The ICB is notified as per schedule 4 of any cases for their investigation and actions. The Trust reported two hospital attributable MRSA bacteraemia for February 2026; one case was unavoidable in a patient who was colonised with MRSA, the other case also deemed unavoidable in a complex urology patient.

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 an ongoing working action plan which is regularly updated and taken to the IPCC for overview. November and December saw a positive impact from changes implemented by the action plan.

MRSA: We have a screening programme in place for MRSA on acute admissions meeting a risk criteria, and for those undergoing certain elective procedures. Last case of MRSA was in February 2026.

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

Overall: The Infection prevention team continue to monitor and escalate where infection and nosocomial rates are rising, rapid review scrutiny will continue for alert organisms including E.Coli and C.Difficile, with the aim of seeing a month-on-month reduction in cases.
Feedback from rapid reviews is provided to teams and governance meetings.

Strategic Theme: Patient Access

	CQC Domain	Metric	DQ Kite Mark	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions	Year End Positon: Year End Position	Year End Positon: Variation	Year End Positon: Assurance
Vision	Responsive	To achieve a 5% improvement in RTT (Excluding SYS) as per the Trust Trajectory *NPAF Metric*		75.4%	76.2%	Mar-26	75.2%	70.7%	Feb-26	Driver	H	F	Full CMS	76.2%	H	F
Breakthrough Objective	Responsive	RTT - Reduction in weeks wait to first out patient appointment (Average weeks wait excluding cancer pathways)		13.0	17.9	Mar-26	13.5	19.3	Feb-26	Driver		F	Full CMS	17.9		F
NHS Performance Assessment Framework (NPAF) Metrics	Responsive	RTT Patients waiting longer than 52 weeks for treatment - Reported Nationally *NPAF Metric*		N/A	24	Mar-26	N/A	37	Feb-26	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%	77.4%	Mar-26	78.0%	78.7%	Dec-25	Driver	L	P	Not Escalated			
	Responsive	Percentage of emergency department attendances spending over 12 hours in the department - Quarter Position Aggregated *NPAF Metric*		5.0%	8.6%	Mar-26	5.0%	8.3%	Dec-25	Driver	H	F	Escalation			
	Responsive	*Cancer - 62 Day (one month behind) - Quarter Position Aggregated *NPAF Metric*		85.0%	85.8%	Dec-25	85.0%	85.7%	Sep-25	Driver		P	Not Escalated			
	Responsive	*Cancer - 28 Day Faster Diagnosis Compliance (one month behind) - Quarter Position Aggregated *NPAF Metric*		80.0%	82.3%	Dec-25	80.0%	76.6%	Sep-25	Driver			Not Escalated			
Constitutional Standards and Key Metrics	Responsive	RTT Total Waiting List (Excl SYS)		44,258	46,057	Mar-26	44,945	50,111	Feb-26	Driver		F	Escalation			
	Responsive	To achieve a 5% improvement in RTT (Including SYS) - Reported Nationally		75.4%	76.06%	Mar-26	75.2%	70.6%	Feb-26	Driver	H	F	Business Rules not applied (for info only)			
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (Excluding System Support)		691	928	Mar-26	752	924	Feb-26	Driver			Not Escalated	928		
	Responsive	RTT Patients waiting longer than 40 weeks for treatment (System Support only)		N/A	65	Mar-26	N/A	54	Feb-26	Driver	No SPC	No SPC	Business Rules not applied (for info only)			
	Responsive	Access to Diagnostics (<6weeks standard)		95.0%	97.9%	Mar-26	93.2%	97.9%	Feb-26	Driver		P	Not Escalated	97.9%	H	P
	Responsive	A&E 4 hr Performance		83.8%	78.5%	Mar-26	80.9%	78.0%	Feb-26	Driver		F	Escalation	80.1%		F
	Responsive	Cancer - 31 Day First (New Combined Standard) - data runs one month behind		96.0%	97.8%	Feb-26	96.0%	96.5%	Jul-25	Driver		P	Not Escalated	96.0%		P
	Responsive	Cancer - 62 Day (New Combined Standard) data runs one month behind		85.0%	86.1%	Feb-26	85.0%	87.5%	Jan-26	Driver			Not Escalated	85.0%		
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance (data runs one month behind)		75.0%	84.0%	Feb-26	75.0%	81.1%	Jan-26	Driver	H	P	Not Escalated	80.0%	H	P
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness (data runs one month behind)		90.0%	91.1%	Feb-26	90.0%	92.0%	Jan-26	Driver		P	Not Escalated	90.0%		P

* 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)

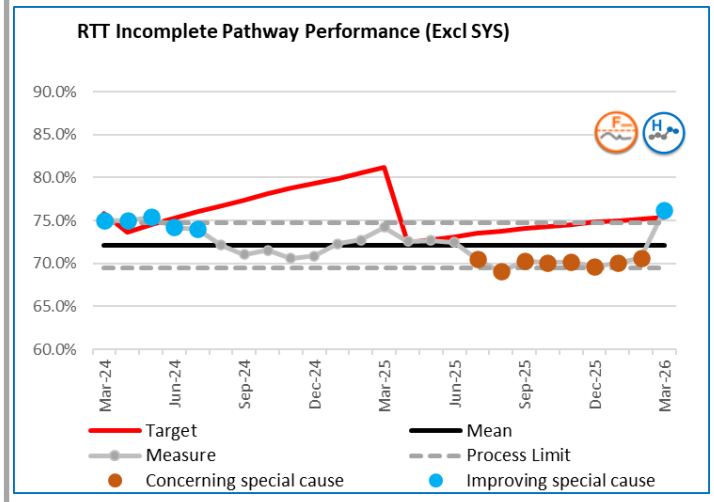
				Latest			Previous			Actions & Assurance				Year End Position		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Position	Variation	Assurance
Constitutional Standards and Key Metrics	Effective	% Outpatient Clinic Utilised (slots)		85.0%	85.3%	Mar-26	85.0%	85.5%	Feb-26	Driver			Not Escalated	85%		
	Effective	% of Patients Discharged to a PIFU Pathways		6.0%	5.9%	Mar-26	6.5%	5.5%	Feb-26	Driver			Not Escalated	5.8%		
	Effective	CAU Calls answered <1 minute		90.0%	79.5%	Mar-26	90.0%	80.7%	Feb-26	Driver			Escalation	84.1%		
	Effective	Ambulance Handover Delays >30mins	TBC	5.0%	7.9%	Mar-26	5.0%	5.9%	Feb-26	Driver			Escalation	7.7%		
	Effective	Achieve 10% Reduction in Non-Elective LOS (including Zero LOS & Excluding Type 5 and Virtual Ward)		5.9	7.0	Mar-26	5.9	7.3	Feb-26	Driver			Escalation			
	Effective	Conversion rate from ED (Excluding Type 5 and including Direct Admissions)		16.0%	13.6%	Mar-26	16.0%	15.3%	Feb-26	Driver			Not Escalated			
	Effective	To achieve the planned levels of new outpatients activity		24,378	26,698	Mar-26	22,169	23,159	Feb-26	Driver			Not Escalated	26,698		
	Effective	To achieve the planned levels of elective (DC and IP combined) activity		6,325	6,417	Mar-26	5,755	5,776	Feb-26	Driver			Not Escalated	6,417		
	Effective	% Capped Theatre utilisation.		85.0%	81.4%	Mar-26	85.0%	81.2%	Feb-26	Driver			Escalation			
	Effective	Rate of all Outpatients that are either New or FUP with a procedure (Nat Target min 49%)		49.0%	51.6%	Mar-26	49.0%	49.9%	Feb-26	Driver			Not Escalated	49.0%		
	Effective	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity		17,063	19,038	Mar-26	17,916	17,403	Jul-25	Driver			Not Escalated	19,038		

Vision: Counter Measure Summary

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

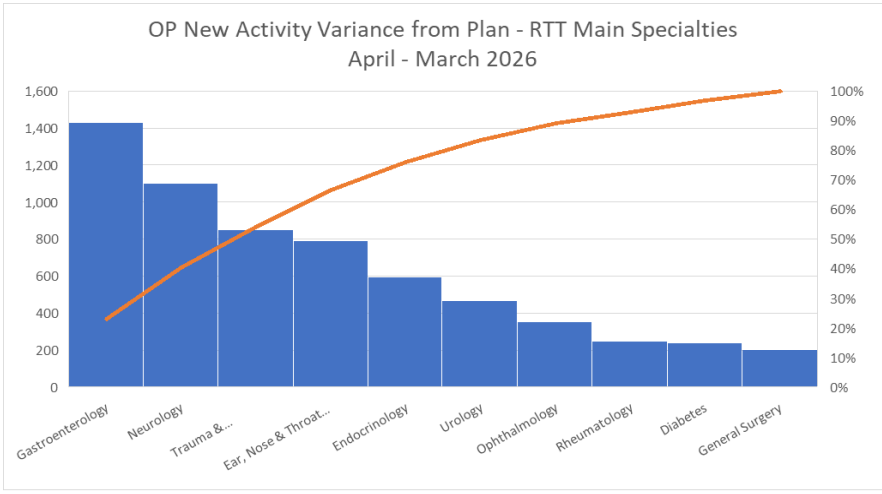
Owner: Chief Operating Officer
Metric: RTT – 5% improvement in performance)
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Mar-26
76.2%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature and is consistently failing the target
Target (Internal)
75.4%
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

- DNA rates
- Outpatient utilisation
- Consultant vacancy hotspots and sickness

Key Risks:

- Mutual aid
- 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

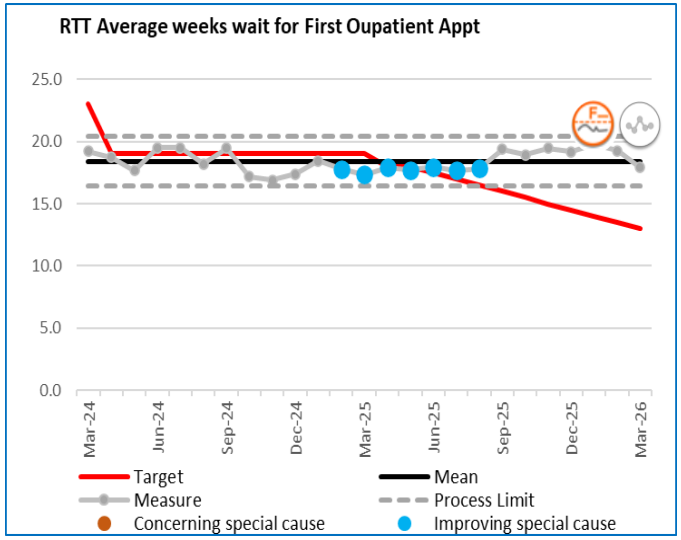
Action	When
Speciality recovery action plans developed which includes productivity and efficiency gains.	Ongoing
Increase monitoring of action plans through DDOs and performance meetings.	Ongoing
Trust wide project for referral triage system- Pilot ENT/Hepatology	Ongoing
Patient Access Team planned validation audits – outcome of audits to be reviewed and next steps agreed.	Ongoing
RTT Sprint WB 16.03.2026 – objective to monitor and improve activity and performance	Ongoing

Breakthrough Objective: Counter Measure Summary

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

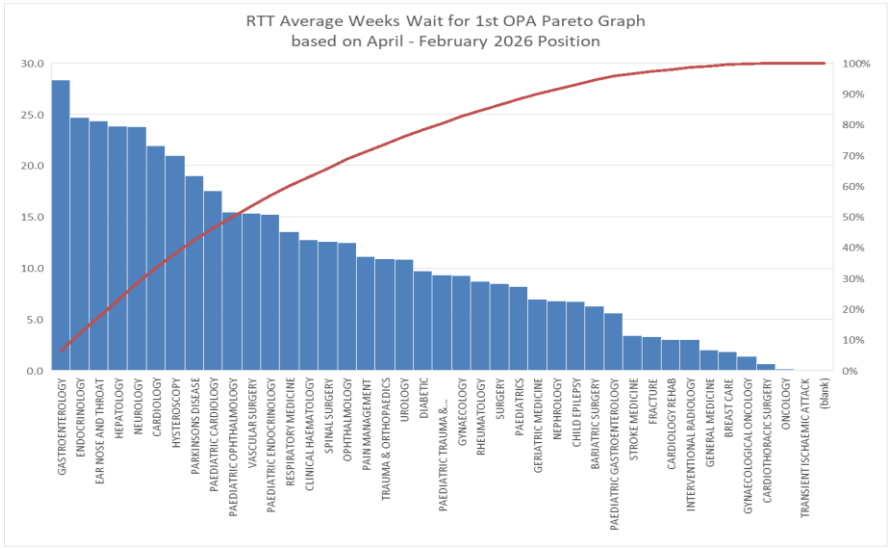
Owner: Chief Operating Officer
Metric: RTT – Reduction is weeks wait to first outpatient appointment (Average)
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-26
17.9
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
13.0
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 being booked in for New activity

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

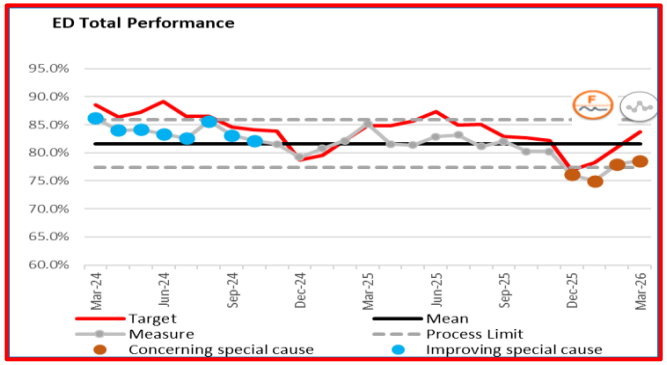
Key Risks:

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

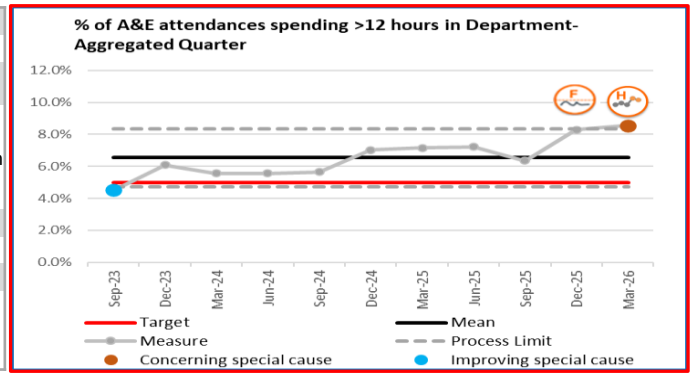
4. Action Plan

Action	When
Triangulate all data against top specialty contributors – Completed for ENT	Mar 26-Complete
Complete root cause analysis for each pathway- Completed for ENT, Ongoing for Cardio and Gastro	Mar 26-Ongoing
ENT CAU process- Training and Education to reduce rework	Mar 26-Complete
Capacity of audiology- Clinic realignment and improved monitoring in progress.	Feb 26-Ongoing
ENT- Review demand and capacity variation in subspecialities	Mar 26-Complete
Gastro -Work is in progress with Northumbria to establish a Gastroenterology Single Point of Access;	Complete
Gastro –Clinical Guidelines for SPOA have been developed	Mar 26-Ongoing
Clinical Champions to be agreed for each pathway and sign off	May 26
Go live to be confirmed	May 26

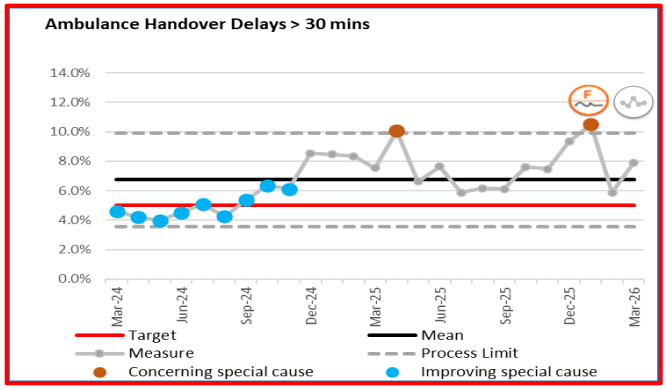
Patient Access: CQC: Responsive



Mar-26
78.5%
Variance / Assurance
Metric is currently experiencing common cause variation
Target (Bus. Plan)
83.8%
Business Rule
Full Escalation as has failed the target for 6+months



Jan - Mar-26
8.6%
Variance / Assurance
Metric is currently experiencing Special case variation of a concerning nature
Max Limit (NPAF)
5%
Business Rule
Full Escalation as has failed the target for 6+months



Mar-26
7.9%
Variance / ,Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Max Limit (Internal)
5%
Business Rule
Full Escalation as has failed the target for 6+months

Summary:

A&E 4 hrs (Monthly): is experiencing common cause variation and has failed the target for 6+ months

A&E >12 hrs (Quarterly NPAF): is experiencing special cause variation of a concerning nature and has failed the target for 6+ months

Ambulance Handover delays <30mins: is experiencing common cause variation and has failed the target for 6+months

Actions:

A&E 4 hrs (Monthly) & A&E >12 hrs (Quarterly NPAF):
Escalation process in place for an increase in triage wait and the time a patient is waiting in ED for a diagnostic test.
LOS project has been implemented across the organisation
Both ED's are being benchmarked against the Model ED standards.

Ambulance Handover delays <30mins:. Delays due to escalated areas.
ED improvement Action Plan in progress.
Key actions :
- Consultant front door streaming at TWH
- Super RAP implementation
- CDU optimisation workstream
- SOP for Minors Surge
- UTC utilization focus work

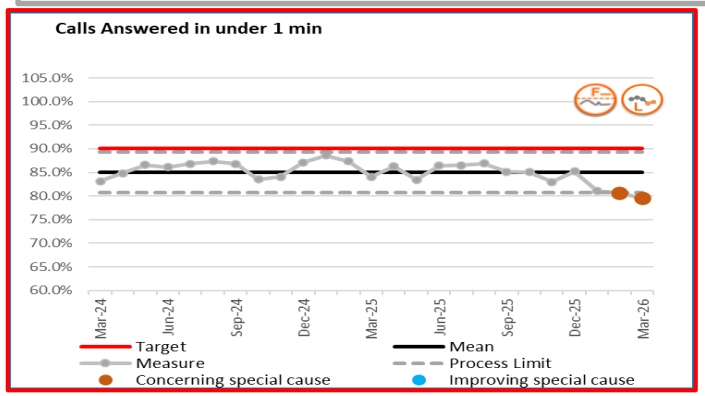
SDEC transformational work in progress

Assurance & Timescales for Improvement:

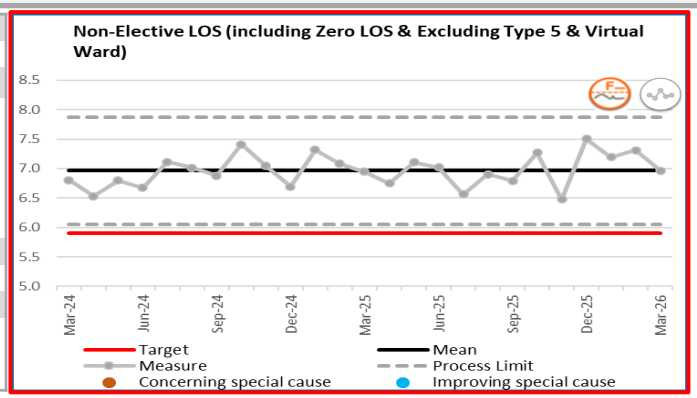
A&E 4 hrs (Monthly) & A&E >12 hrs (Quarterly NPAF): UCDU capacity reviewed and space changes made to increase capacity. Implementation of EEMAC as per national guidance is in progress. LOS project is part of the Financial Delivery pillars.

Ambulance Handover delays <30mins: Collaboration with SECAMb and the Care Coordination Centre (CCC) to create capacity to offload ambulances

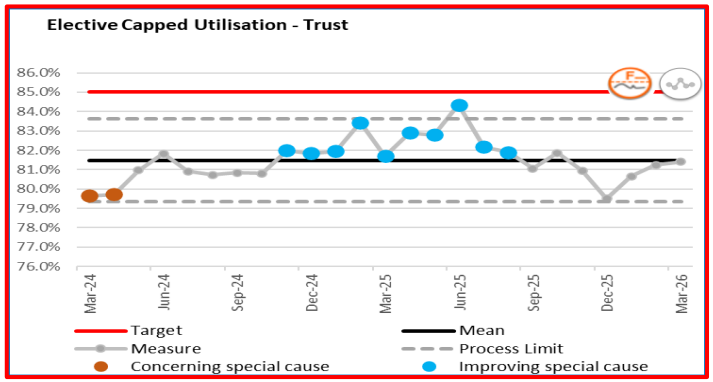
Patient Access: CQC: Responsive



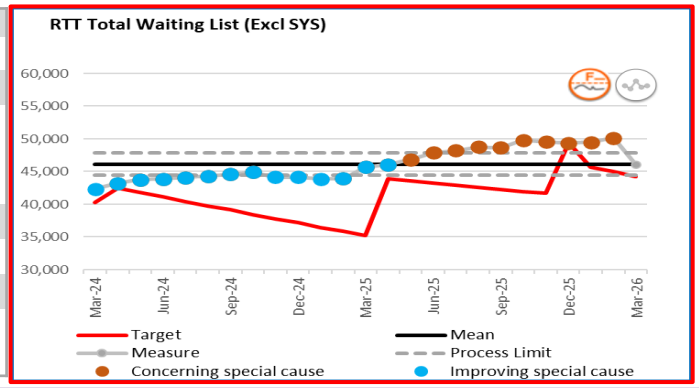
Mar-26
79.5%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation as is consistently failing the target



Mar-26
7.0
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



Mar- 26
81.4%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target.



Mar-26
46,057
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target (Internal)
44,258
Business Rule
Full Escalation as is consistently failing the target

Summary:

Calls Answered <1 min: is experiencing special cause variation of a concerning nature and is 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 is consistently failing the target.

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

RTT Total Waiting List: is experiencing common cause variation and is consistently failing the target.

Actions:

Performance against the under 1 minute 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

RTT Total Waiting List: Validation remains in progress

Assurance & Timescales for Improvement:

Calls Answered within 1 minute in the CAUs: Call performance has shown a slight decline; however overall delivery remains stable at average performance of 80% demonstrating a continued focus on service delivery.

Non-Elective LOS: This is the Length of Stay Delivery Group project.

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

Increased monitoring of adherence to Theatre Toolkit at consultant level to identify areas of opportunity for improvement

Improved awareness of theatre KPIs in theatres and CAUs

RTT Waiting List: New pathways implemented are in the process of being monitored for outcome delivery.

Strategic Theme: Patient Experience

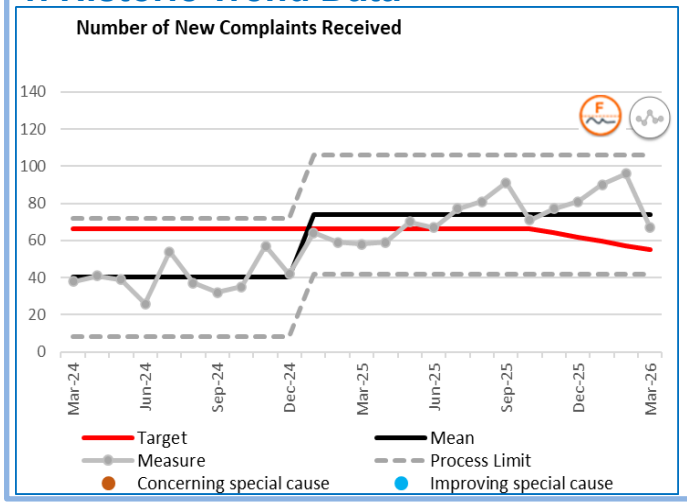
				Latest			Previous			Actions & Assurance				Year End Position		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	Year End Position	Variation	Assurance
Vision	Caring	To reduce the overall number of complaints or concerns each month		55	67	Mar-26	57	96	Feb-26	Driver			Full CMS	927		
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%	17.3%	Mar-26	15.7%	9.1%	Feb-26	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	39	Mar-26	24	36	Feb-26	Driver			Not Escalated	318		
	Caring	Complaints Rate per 1,000 occupied beddays		3.9	3.7	Mar-26	3.9	5.5	Feb-26	Driver			Not Escalated	4.2		
	Caring	% complaints responded to within target		75.0%	78.0%	Mar-26	75.0%	75.0%	Feb-26	Driver			Not Escalated	78.0%		
	Caring	Complaints Backlog – Older than 4 months		0	0	Mar-26	0	6	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints Closed in Month		38	93	Mar-26	38	57	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Caring	Complaints - 3 Day acknowledgement		95.0%	95.0%	Mar-26	95.0%	96.0%	Feb-26	Driver	No SPC	No SPC	Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		21.4%	19.2%	Mar-26	21.4%	20.1%	Feb-26	Driver			Escalation	17.80%		
	Caring	Friends and Family (FFT) % Response Rate: A&E		9.9%	10.7%	Mar-26	9.9%	11.5%	Feb-26	Driver			Not Escalated	11.80%		
	Caring	Friends and Family (FFT) % Response Rate: Maternity		12.1%	10.2%	Mar-26	12.1%	8.1%	Feb-26	Driver			Escalation	9.40%		
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		15.9%	12.7%	Mar-26	15.9%	12.7%	Feb-26	Driver			Escalation	12.20%		
	Safe	Safe Staffing Levels (Nursing)		93.5%	99.3%	Mar-26	93.5%	99.9%	Feb-26	Driver			Not Escalated	98.5%		

Vision: Counter Measure Summary

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

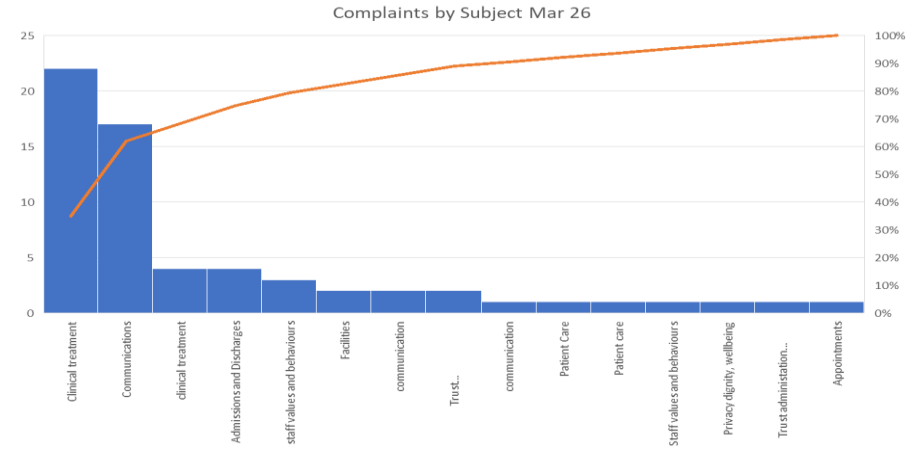
Owner: Chief Nurse
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Mar-26
67
Variance Type
Metric is currently experiencing common cause variation
Max Limit (Internal)
62
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.

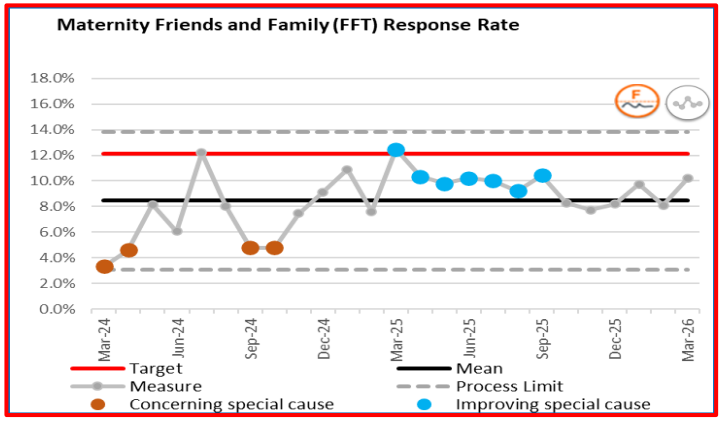
Key Risks:

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.

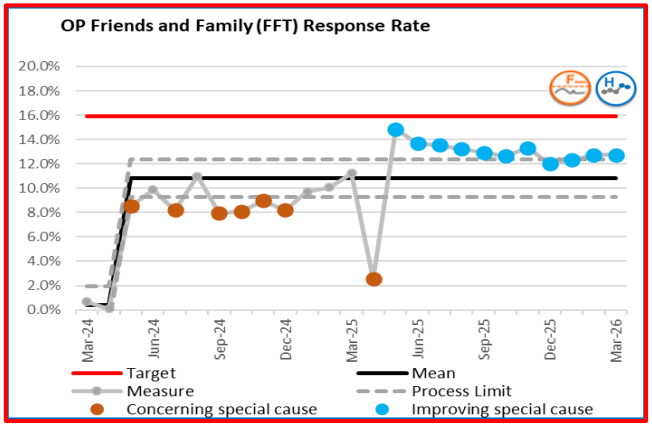
4. Action Plan of the Vision Objective:

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

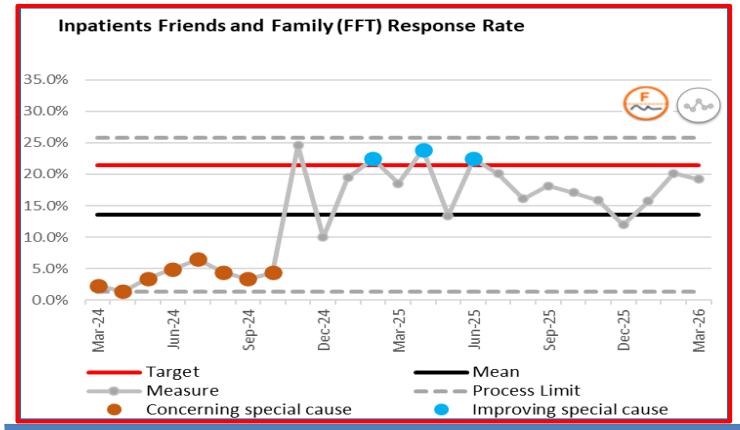
Patient Experience: CQC: Caring



Mar-26
10.2%
Variance / Assurance
Metric is currently experiencing common cause variation but has failed the target for 6+ months
Target (Ave. National)
12.1%
Business Rule
Full Escalation as failed target for 6+ months



Mar-26
12.7%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature but is consistently failing the target
Target (Ave. National)
15.9%
Business Rule
Full escalation as is consistently failing the target



Mar-26
19.2%
Variance / Assurance
Metric is currently experiencing common cause variation and has failed the target for 6+ months
Target (Ave. National)
21.4%
Business Rule
Full Escalation as failed target for 6+ months

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, butt is consistently failing the target.
National Response – 16.9%
Trust Recommended Rate is 93.9%

Friends and Family Response Rate - Inpatients: Is experiencing common cause variation and has failed the target for 6+ months.
National Response – 21.4%
Trust Recommended Rate is 92.2%

Actions:

Maternity: The response rate has fallen further and remains below target. While feedback volumes are low, positivity remains high, particularly around staff attitude and implementation of care. Negative feedback is limited in volume but highly critical, focusing on environment, staff attitude and waiting times, with concerns about communication, being listened to, and confidence in care.
Outpatients: The response rate remains stable, with most responses generated via SMS, although survey fatigue significantly limits distribution and paper returns remain minimal. Positive feedback continues to centre on staff attitude, kindness, implementation of care and environment, while areas for improvement remain staff attitude, environment and waiting times.
Inpatients: Response rates remain below target, though paper survey use has stabilised following engagement with ward managers and returns are increasingly within the reporting period. Feedback remains predominantly positive, particularly for staff attitude, implementation of care and environment. Negative themes are unchanged and focus on staff attitude, environment and implementation of care, with issues most often linked to communication, especially around discharge.

Assurance & Timescales for Improvement:

FFT Response All: Overall, response rates in March remain below target. 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 is now completed in-house, it's noted that whilst this mode of response remains limited the proportion via this means has stabilised and submission within month has increased.
Friends and Family (FFT) Response Rates:
Communication with ward managers encouraging the prompt return (in month) of paper responses and messages circulated in staff communications have continued. Requests for paper forms continue to be fulfilled within a 48hour window. Paper forms are consistently uploaded within 48hrs of receipt despite reduced staffing. Whilst visits to numerous wards to engage with staff and gain feedback were undertaken last month and appear to have been beneficial in promoting FFT reduced staffing levels have meant that it has not been feasible to repeat this in March. Work to engage a new FFT provider is now underway.

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	567	Mar-26	524	583	Feb-26	Driver			Full CMS			
Breakthrough Objective	Effective	Delivery of the better use of beds programme for MTW - Daily Average Virtual Ward Beddays - Target is 95% of 60 beds		57	48	Mar-26	57	48	Feb-26	Driver			Verbal CMS			
Constitutional Standards and Key Metrics	Effective	Delivery of the better use of beds programme for MTW - Average Non-Elective LOS for Fracture Neck of Femur (NOF) - Data runs one month behind		12.0	13.1	Feb-26	12.0	13.6	Jan-26	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 and system business cases.

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

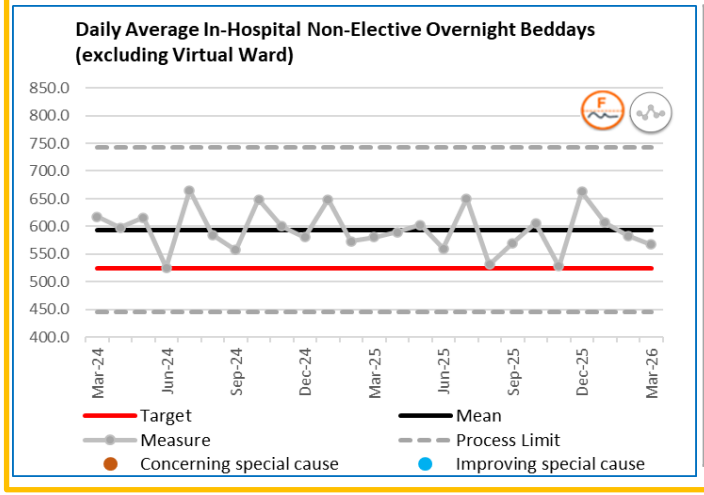
Please note that virtual wards beds includes an element of patients in the process of transferring to the virtual ward

Vision Objective: Counter Measure Summary

Project/Metric Name – Daily Average In-Hospital Non-Elective Overnight Beddays (excluding Virtual Ward)

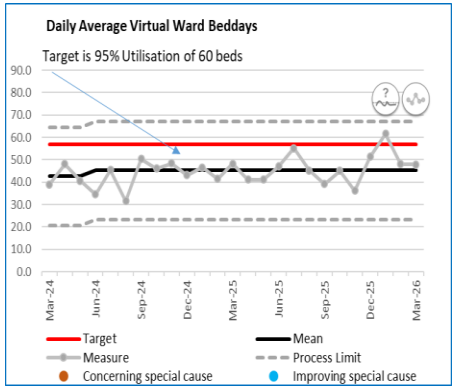
Owner: Director Strategy, Planning & Partnerships
Metric: Daily Average In-Hospital Non-Elective Overnight Beddays (excluding Virtual Ward)
Desired Trend: 7 consecutive data points above the mean

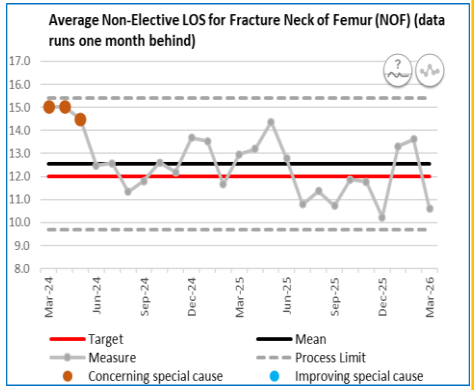
1. Historic Trend Data



Mar-26
567
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





3. Top Contributors and Key Risks

Top Contributors:
Areas where pathway utilisation could be improved are:

- Respiratory (weekend)
- Gastroenterology
- Orthopaedics
- Diabetes
- Women's

Key Risks/Issues:
Clinician engagement and support for the virtual ward pathways
Time for new pathways to be agreed and implemented
Adherence to agreed pathways

4. Action Plan

Workstreams	Actions	When	Who
VW Beddays	Women's pathway to be implemented	April	Project Team
	Respiratory and orthopaedic pathways to be developed	May	Project Team
	To make virtual ward the default model of care for agreed pathways	June	Project Team
	To link with bed reduction work to utilise virtual ward as an enabler	May	Project Team
	Align recording of VW activity to wider NHS, discharging patient and admitting to VW rather than transfer (risk mitigation)	Complete	VW Team
Pathway 0 discharges	To develop a measurable record of pathway 0 discharges – currently under development using new teletracking data feed	June	BI/project team

Strategic Theme: Sustainability

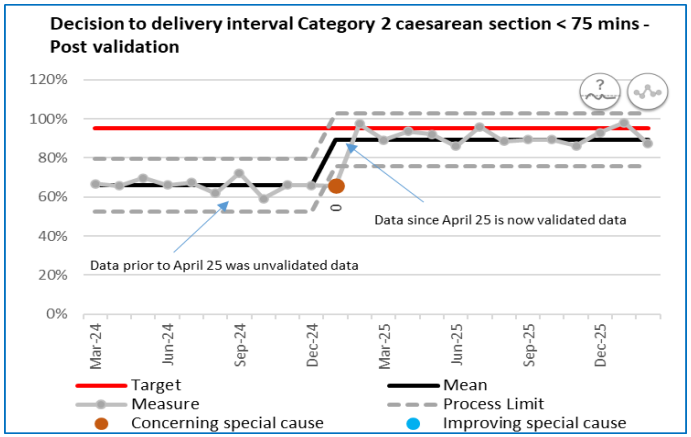
				Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision	Well Led	Delivery of financial plan, inc. operational delivery of capital investment plan (net surplus(-)/net deficit (+) £000) ***NPAF Metric***		4,029	819	Mar-26	2,828	1,263	Feb-26	Driver			Full CMS
Breakthrough Objectives	Well Led	Reduce non-pay spend		22,080	20,796	Mar-26	21,390	20,414	Feb-26	Driver			Verbal CMS
NHS Performance Assessment Framework (NPAF) Metrics	Productivity & Efficiency Metric	Implied Productivity Growth (YTD compared to previous year)		2.0%	2.8%	Dec-25	2.0%	2.3%	Nov-25	Driver			Not Escalated
Constitutional Standards and Key Metrics	Well Led	CIP		9,172	5,724	Mar-26	9,051	6,187	Feb-26	Driver			Not Escalated
	Well Led	Cash Balance (£k)		4,000	13,063	Mar-26	2,761	25,548	Feb-26	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)		4,930	15,703	Mar-26	1,827	3,064	Feb-26	Driver			Not Escalated

*Forecasts for 2026/2027 are currently being worked up

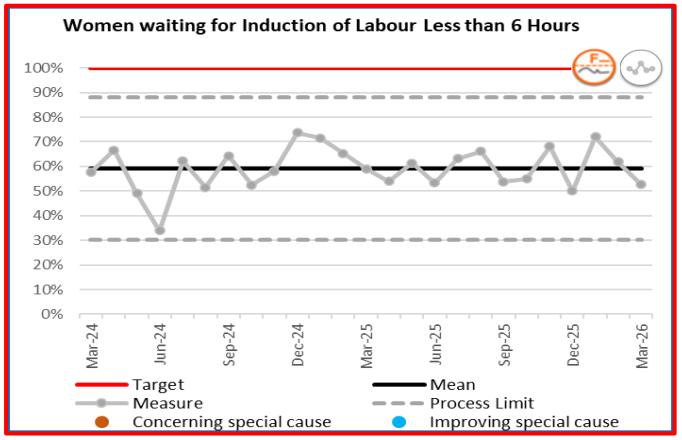
Maternity Metrics

				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	474	Mar-26	470	398	Feb-26	Driver		No target	Not Escalated	424		No SPC
	Maternity Metric	Antenatal bookings		No target	529	Mar-26	545	516	Feb-26	Driver		No target	Not Escalated	564		No SPC
	Maternity Metric	Elective Caesarean Rate		No target	23.4%	Mar-26	No target	24.2%	Feb-26	Driver		No target	Not Escalated	24.1%		No SPC
	Maternity Metric	Emergency Caesarean Rate		No target	26.4%	Mar-26	No target	21.4%	Feb-26	Driver		No target	Not Escalated	24.8%		No SPC
	Maternity Metric	Induction of Labour Rate		36.0%	24.0%	Mar-26	36.0%	26.5%	Feb-26	Driver			Not Escalated	27.2%		
	Maternity Metric	Preterm Birth (<37 weeks) Rate		6.0%	6.8%	Mar-26	6.0%	6.3%	Feb-26	Driver			Not Escalated	6.4%		
	Maternity Metric	Unexpected term admissions to NNU (data runs one month behind)		4.0%	3.8%	Feb-26	4.0%	4.8%	Jan-26	Driver			Not Escalated	4.4%		
	Maternity Metric	Stillbirth rate		0.4%	0.2%	Mar-26	0.4%	0.0%	Feb-26	Driver			Not Escalated	0.1%		
	Maternity Metric	PPH >=1500% Rate		3.0%	2.1%	Mar-26	3.0%	2.5%	Feb-26	Driver			Not Escalated	2.6%		
	Maternity Metric	Major Tear (3rd/4th degree Rate)		2.5%	3.4%	Mar-26	2.5%	3.3%	Feb-26	Driver			Not Escalated	3.1%		
	Maternity Metric	Breastfeeding Intention Rate at Birth		75.0%	80.2%	Mar-26	75.0%	81.4%	Feb-26	Driver			Not Escalated	81.4%		
	Maternity Metric	Decision to delivery interval Category 1 caesarean section < 30 mins - one month in arrears		95.0%	87.5%	Feb-26	95.0%	90.9%	Jan-26	Driver			Not Escalated	43.7%		
	Maternity Metric	Decision to delivery interval Category 2 caesarean section < 75 mins - one month in arrears		95.0%	87.2%	Feb-26	95.0%	98.0%	Jan-26	Driver			Not Escalated	0.4%		
	Maternity Metric	One to one care in labour - % of women who are diagnosed in labour		100.0%	100.0%	Mar-26	100.0%	100.0%	Feb-26	Driver			Not Escalated	100.0%		
	Maternity Metric	% of shifts for which Delivery Suitte coordinator is supernumerary (MOPEL)		100.0%	100.0%	Mar-26	100.0%	100.0%	Feb-26	Driver			Not Escalated	100.0%		
	Maternity Metric	Women waiting for Induction of Labour less than 6 Hours		100.0%	52.6%	Mar-26	100.0%	61.8%	Feb-26	Driver			Escalation			

Maternity Metrics



Feb-26
87.2%
Variance / Assurance
Metric is currently experiencing common cause variation
Target (Internal)
95%
Business Rule
No Escalation – for info



Mar-26
52.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation
Target (Internal)
100%
Business Rule
Full escalation as consistently failing the target

Summary:	Actions:	Assurance & Timescales for Improvement:
Women waiting for Induction of Labour less than 6 Hours: is experiencing common cause variation and consistently failing the target.	A3 completed to address patient flow in the unit. IOL project group proposing the allocation of an IOL midwife on Triage and delivery suite to support flow through pathway. Risk assessments for patients waiting for IOL now being captured electronically on inPhase. Power BI dashboard to be developed so that areas of improvement can be more easily identified. Proposal to shorten IOL process by 1 step to be considered at April Clinical Governance (would shorten wait times). **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 6 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 timing of IOL. 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

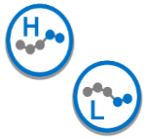
NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

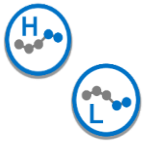
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

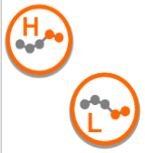
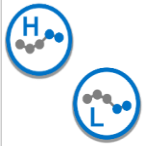
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

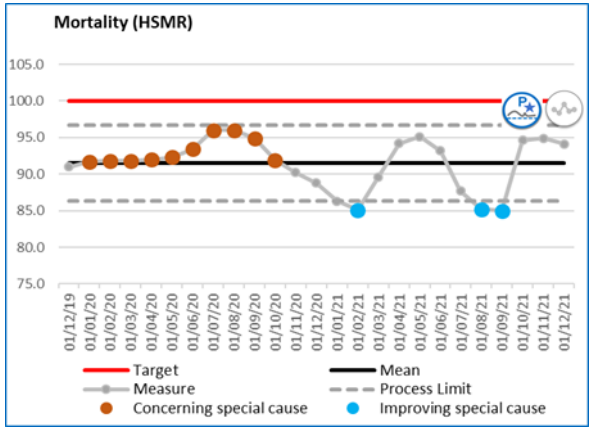
The **target** line **between** the **upper** and **lower** control limit for all metric types

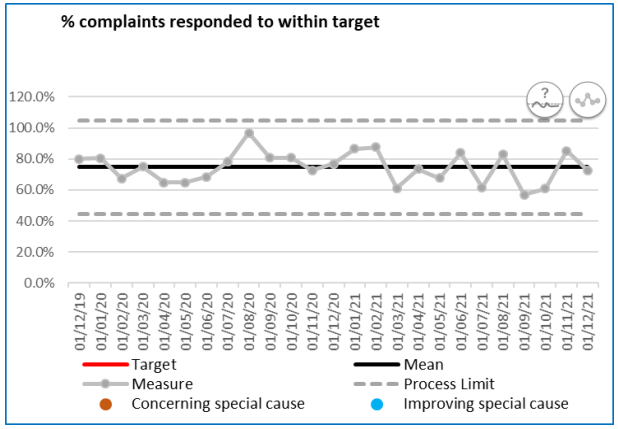
Metrics that consistently **fail** have:

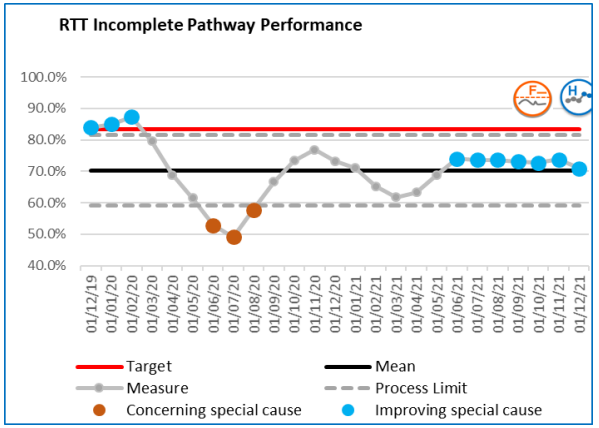
The **lower** control limit **above** the target line for metrics that need to be **below the target**

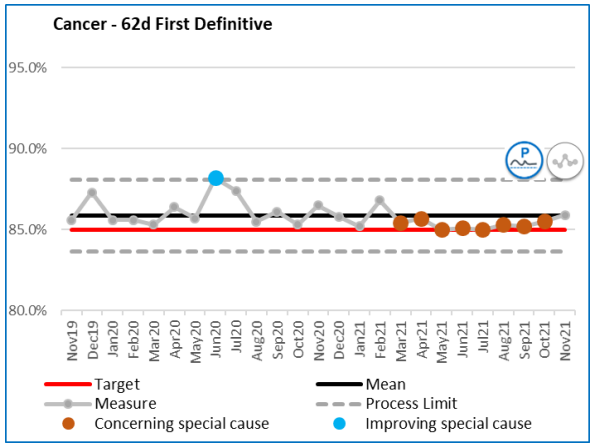
The **upper** control limit **below** the target line for metrics that need to be **above the target**

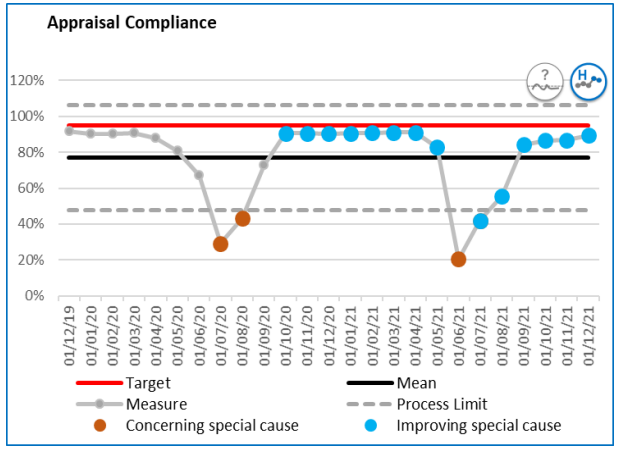
A metric not achieving the target for 6 months or more will be flagged as failing

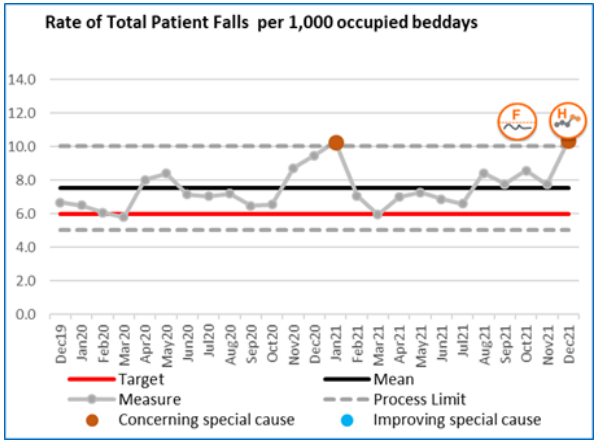












Maternity Metrics Definitions

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

Executive Summary

- The Trust was £0.8m in surplus in the month which was £3.2m adverse to the plan. Year to date the Trust is £16.6m in deficit which is £16.6m adverse to plan.
- The key year to date pressures are: System savings slippage (£22.6m), Redundancy costs (£6.5m), Fordcombe slippage to plan (£2.4m), CIP consultancy support costs (£1.4m), Brockenhurst Car Park VAT adjustment (£0.8m) and Increase in doubtful debt (£0.6m). These pressures were offset by additional clinical income above contract baseline (£7.4m), industrial action funding net of costs (£2.2m), additional Pathology income (£2m), non-recurrent benefits (£2.8m), recharge of patient transport costs (£1.1m) and underspend in PDC (£1m).
- The Trust has a £72.1m CIP savings target in 2025/26 which is split between Internal (£49m), System (£22.6m), national savings expectation (£1.3m) less £0.8m stretch. The Trust has delivered £50.9m which is £21.2m adverse to plan. The main slippage relates to system savings which is £22.6m adverse to plan
- The Trust's adjusted application for PDC Revenue Cash Support of £9.044m was approved by NHSE and received on April 20th. NHSE have made £2.4m of this repayable as working capital support, related to redundancy payments.

Current Month Financial Position

- The Trust was £0.8m in surplus which was £3.2m adverse to the plan. The level of wte worked in the month was 8,136 which was an reduction of 33wte between months and was the lowest this financial year. Substantive wte reduced between months by 26wte to 7,457wte which is the lowest since September 2024.

- **Key Adverse variances in month are:**
    - System savings slippage including national expectations (£3.1m).
    - Redundancy costs associated with phase 1 and 2 workforce transformational (£2.4m)
- **Key Favourable variances in month are:**
    - Public Dividend Capital (PDC) was £1m lower than plan, this reflects the March 2026 valuation.
    - Drugs underspend to plan of £0.7m and review of dilapidations (£0.4m)

Year to Date Financial Position

- The Trust is £16.6 in deficit which is £16.6m adverse to plan
- **Key Adverse variances are:**
    - System savings slippage including national expectations (£22.6m).
    - Redundancy costs associated with workforce transformational (£6.5m)
    - Fordcombe hospital slippage to plan (£2.4m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £2.4m adverse to plan.
    - Brockenhurst Car park VAT adjustment (£0.8m)
    - CIP consultancy support costs (£1.4m) and Increase in doubtful debt (£0.6m)
- **Key Favourable variances are:**
    - Additional Clinical Income above contract baseline (£7.4m) excluding passthrough costs and net of 2024/25 pressures.

- Industrial action (£2.2m). The Trust has received £2.4m for the impact of industrial action
- Pathology Income (£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 £2m.
- Non recurrent benefits (£2.8m). The Trust has benefited by £2.8m through non recurrent items.
- Public Dividend Capital (PDC) was £1m lower than plan, this reflects the March 2026 valuation.

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 March the Trust has saved £5.7m which was £3.4m adverse to plan
- The Trust has saved £50.9m in 2025/26 which is £21.2m adverse plan.
- The Trust is forecasting to deliver £53.8m 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.

Cashflow position:

- The closing cash balance at the end of March was £13.06m, which is higher than the plan value by £9.0m. The variance relates to the following items; 1) the Trust received significant funding in the last quarter relating to both National and System Capital bids; some of the cash payments for these fall into 2026/27; 2) the Trust retained cash ahead of the decision by NHSE on its latest cash application in case that was not awarded and we had to manage liquidity before the monthly ICB SLA payment on or around 15th of the month
- The Trust was successful with the February PDC Revenue Cash Support application and received £9.044m in April.
- 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. Where other organisations are not replying in a prompt manner this has been escalated to the senior finance team to support resolution.

- 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%. The Trust's BPPC at the end of March 2026 was - Trade in value: 60.7% (M11 56.9%) and by quantity: 48.5% (M11 46.2%) for NHS by value: 76.1% (M11 76.9%) and by quantity: 47.8% (M11 43.2%).

Capital Position

- **Capital Plan**
  - The Trust's capital plan for 2025/26 was **£18.282m**.
  - The Trust's planned share of the K&M ICS control total is **£12.262m** for 2025/26. This includes both purchased capital funding and IFRS 16 leased capital funding, as both are now managed at system level. The Trust also received National funding of **£3.45m** for the following:
  - Return to Constitutional Standards - **£0.5m**
  - Linac Replacement (LA1C) - **£2.9m**

  - The Trust received **additional funding** during the year from both National and System sources, see below:

  - **National Funding in addition to Plan - Total £11.632m**
    - Estates Safety schemes - £3.46m
    - Cyber Security - £158k
    - NHS Wayfinder (Patient Portal) - £207k
    - Estates Safety Phase 2 - £445k
    - Digital Histopathology Schemes - £1.8m
    - Frontline Digitisation - £800k
    - Maternity Services - £48k
    - Bowel Screening Programme - £1.03m
    - Linac Replacement (LA2C) - £2.6m
    - Trans Nasal Endoscopy (TNE) - £1.06m

  - **System Capital Support in addition to Plan - Total £2.161m**
    - Urgent and Emergency Care (UEC) Performance Award - £2m
    - Freedoms & Flexibilities - £161k (not cash-backed)

- **Year-end Outturn**
  - The Trust reported **£31.7m** spend at year-end, M12 alone saw a significant spend value of over £15m. The Linac LA2C is being held on the Trust's behalf offsite, with the enabling and installation work taking place in 26/27.
  - The ICS Control Total was £12.262m and an additional £2.161m was awarded in-year, making the revised Control Total £14.423. The overall spend at year-end was £14.335m which resulted in an £88k underspend.
  - The National PDC funding totalled £15.1m, all the funding was fully spent at the year-end, with over £6m only being agreed in the last few weeks of the year.

- **Other Capital funding**
  - The PFI Lifecycle (IFRIC 12) final spend of **£1.77m** was slightly lower than the Plan figure.
  - The donated schemes totalled **£550k** for the year.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 12
2025/26

Maidstone and Tunbridge Wells NHS

Summary

March 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	101.6	101.6	0.0	0.6	(0.6)	857.5	842.6	15.0	2.6	12.3
Expenditure	(96.8)	(92.3)	(4.5)	(0.6)	(3.9)	(814.9)	(782.4)	(32.5)	(2.6)	(29.9)
EBITDA (Income less Expenditure)	4.8	9.3	(4.4)	0.0	(4.4)	42.6	60.2	(17.6)	0.0	(17.6)
Financing Costs	(5.5)	(14.3)	8.8	0.0	8.8	(62.9)	(72.1)	9.2	0.0	9.2
Technical Adjustments	1.4	9.0	(7.6)	0.0	(7.6)	3.7	11.9	(8.2)	0.0	(8.2)
Net Surplus / Deficit	**0.8**	**4.0**	**(3.2)**	**0.0**	**(3.2)**	**(16.6)**	**0.0**	**(16.6)**	**0.0**	**(16.6)**
Cash Balance	13.1	4.0	9.1		9.1	13.1	4.0	9.1		9.1
Capital Expenditure (Incl Donated Assets and IFRS16)	15.7	4.9	(10.8)		(10.8)	31.8	18.3	13.5		13.5
Cost Improvement Plan	5.7	9.2	(3.4)		(3.4)	50.9	72.1	(21.2)		(21.2)

Note: These figures are draft accounts and subject to audit approval

Summary Current Month:

- The Trust was £0.8m in surplus in the month which was £3.2m adverse to plan. The Trusts key variances to the plan are:

Adverse Variances:

- System savings and national saving expectation slippage (£3.1m).
- Redundancy costs (£2.4m)
- Clinical Income overperformance net of passthrough costs £1m adverse to plan.

Favourable Variances

- Public Dividend Capital (PDC) was £1m lower than plan, this reflects the March 2026 valuation.
- Drugs underspend to plan of £0.7m and review of dilapidations (£0.4m)

Year to date overview:

- The Trust is £16.6m in deficit which is £16.6m adverse to plan but in line with the Trusts resubmitted forecast to NHSE. The Trusts key variances to the plan are:

Adverse Variances:

- System savings and national saving expectation slippage (£22.6m).
- Redundancy costs (£6.5m)
- Fordcombe hospital slippage to plan (£2.4m). The Trust set an improvement target of £2.8m for 2025/26, year to date the division is £2.4m adverse to plan.
- CIP consultancy support costs (£1.4m) , Brockenhurst Car Park VAT adjustment (£0.8m) and Increase in doubtful debt (£0.6m)

Favourable Variances

- Additional Clinical Income above contract baseline (£7.4m) excluding passthrough costs net of 2024/25 pressures.
- Industrial action (£2.2m).
- Pathology Income (£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 £2m.
- Non recurrent benefits (£2.8m). The Trust has benefited by £2.8m through non recurrent items.
- Public Dividend Capital (PDC) was £1m lower than plan, this reflects the March 2026 valuation.

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 March the Trust delivered £5.7m savings which was £3.4m adverse to plan. The main slippage in the month relates to system wide savings which is £3.1m adverse to plan. Year to date the Trust has saved £50.9m which is £21.2m adverse to plan. The main slippage relates to system wide and national saving expectations (£22.6m) which has been partly offset over overperformance against Trust wide schemes (£1.4m)

Mar-26		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/Nt (number of shifts)	WTE Temporary demand RN/Nt	Temporary Demand Unfilled - RN/N (number of shifts)	Occupied Beds	Planned CHPPD	Actual Care Hours per pt day	CHPPD by reg/unregistered			Nurse Sensitive Indicators								Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing							CHPPD Registered Nurses and Midwives	CHPPD Non registered Care staff	CHPPD Non registered Nursing associates	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Filled Enhanced care shifts	Staffing Red flags raised	Inphase Staffing Incidents raised	Comments	Budget £	Actual £	Variance £ (overspend)
Maidstone	Acute Medical Unit (M) - NG551	88.3%	119.5%	-	-	99.9%	172.3%	-	-	29.0%	1.0%	88	6.04	17	504	10	11.0	5.9	5.0	0.0	-	-	4	0	74	2	0	67 Enhanced care shifts - mental health, 6 Enhanced care shifts for dementia/delirium, 1 for risk of falls.	219,217	219,676	(459)
Maidstone	Stroke Unit (M) - NK551	100.4%	113.4%	-	100.0%	103.8%	125.9%	-	-	30.9%	0.0%	78	5.19	14	927	8	9.4	4.3	4.9	0.2	10.0%	100.0%	1	1	46	3	0	2 Enhanced care - mental health, 2 Enhanced care - Dementia/Delirium, 42 Enhanced care - other	278,465	279,030	(565)
Maidstone	HASU (34) - NK552	93.7%	89.1%	-	-	100.0%	106.5%	-	-	18.6%	0.0%	90	6.02	16	373	13	12.2	10.4	1.9	0.0	30.4%	85.7%	0	0	4	0	0	4 Enhanced care - Dementia/Delirium	203,690	178,113	25,487
Maidstone	Cornwallis - NS251	94.3%	88.7%	-	-	97.8%	92.0%	-	-	15.5%	0.0%	27	1.70	3	529	8	7.3	4.2	3.1	0.0	72.4%	94.5%	1	0	0	4	0		122,877	128,857	(5,980)
Maidstone	Culpepper Ward (M) - NS551	99.5%	90.0%	-	-	99.1%	103.2%	-	-	15.7%	0.0%	17	1.05	0	383	8	7.5	5.2	2.4	0.0	145.0%	93.1%	3	0	2	0	0	2 Enhanced care - Dementia/Delirium	141,448	146,033	(4,585)
Maidstone	CCU (M) - NS551	100.0%	-	-	-	100.0%	-	-	-	20.2%	0.0%	26	1.77	0	181	8	7.9	-	-	-	140.0%	100.0%	0	0	0	0	0				
Maidstone	Edith Cavell - NS459	101.3%	135.4%	-	100.0%	99.0%	195.9%	-	-	46.3%	0.6%	39	2.56	1	676	6	7.3	3.2	3.8	0.3	36.4%	75.0%	5	2	99	4	0	58 Enhanced care - mental health, 36 enhanced care Dementia/Delirium, 5 Enhanced care LD/Autism	113,220	164,101	(50,881)
Maidstone	Foster Clark - NR359	99.0%	115.2%	-	-	100.4%	151.5%	-	-	36.5%	1.3%	83	5.59	2	831	6	7.3	3.4	3.9	0.0	37.5%	33.3%	2	2	75	6	0	54 Enhanced care - dementia/delirium, 21 Enhanced care - mental health.	200,301	182,596	17,705
Maidstone	John Day Respiratory Ward (M) - NT151	93.5%	111.1%	-	-	103.3%	100.2%	-	-	26.4%	0.7%	136	8.90	19	918	7	7.5	4.2	3.3	0.0	61.8%	100.0%	3	3	48	2	0	21 Enhanced care - dementia/delirium, 14 Enhanced care LD/Autism, 13 Enhanced care - Mental health	221,718	240,290	(18,572)
Maidstone	Intensive Care (M) - NA251	90.0%	81.9%	-	-	95.1%	93.9%	-	-	4.8%	0.0%	24	1.62	0	83	66	60.9	50.0	10.9	0.0	333.3%	100.0%	0	0	0	0	0		260,587	233,931	46,656
Maidstone	Lord North Ward (M) - NF551	96.1%	95.2%	-	-	100.0%	98.8%	-	-	9.8%	0.0%	22	1.46	7	499	7	7.1	5.0	2.1	0.0	92.3%	100.0%	0	0	0	1	0		120,030	126,077	(6,047)
Maidstone	Mercer Ward (M) - NJ251	98.2%	138.2%	-	100.0%	100.2%	154.8%	-	-	38.5%	3.7%	37	2.52	2	806	6	7.6	3.1	4.5	0.0	45.0%	100.0%	5	0	102	1	0	101 Enhanced care - dementia/delirium, 1 Enhanced care mental health	166,963	172,053	(5,090)
Maidstone	Peale Ward COVID - ND451	98.5%	153.6%	-	-	100.0%	193.8%	-	-	33.2%	2.0%	52	3.23	3	389	8	10.9	5.4	5.5	0.0	71.8%	96.4%	1	0	96	3	0	64 Enhanced care - mental health, 20 Enhanced care LD/autism, 7 Enhanced care - dementia/delirium, 5 enhanced care - risk of falls.	102,431	129,632	(27,201)
Maidstone	Short Stay Surgical Unit (M) - NE751	96.0%	92.7%	-	-	89.6%	71.0%	-	-	6.2%	0.0%	12	0.80	1	43	57	48.0	35.7	12.3	0.0	0.0%	-	0	0	0	0	0		73,419	74,703	(1,284)
Maidstone	Whatman Ward - NK959	90.2%	107.9%	-	-	100.0%	113.8%	-	-	35.0%	2.4%	75	5.20	16	640	7	6.9	3.2	3.7	0.0	105.9%	100.0%	4	1	29	8	0	28 Enhanced Care - Dementia/delirium, 1 Enhanced care - mental health	195,076	182,015	13,061
Maidstone	Maidstone Birth Centre - NP751	80.6%	88.1%	-	-	101.8%	96.8%	-	-	25.9%	0.0%	53	2.87	0	19	120	108.4	-	-	-	0.0%	-	0	0	0	0	0		83,580	99,874	(16,294)
TWH	Acute Medical Unit (TW) - NA901	94.1%	116.2%	-	100.0%	99.5%	128.7%	-	-	29.0%	8.5%	88	6.20	12	840	9	9.5	5.3	4.1	0.1	-	-	9	2	54	5	0	35 Enhanced Care - dementia/delirium, 19 Enhanced care - mental health	318,301	303,519	14,782
TWH	Coronary Care Unit (TW) - NP301	97.3%	68.0%	-	-	99.9%	-	-	-	33.8%	0.0%	68	4.54	3	210	12	11.6	10.3	1.2	0.0	-	-	0	0	0	1	0		83,137	84,260	(1,123)
TWH	Hedgehog Ward (TW) - NV702	88.3%	57.6%	-	-	84.7%	53.6%	-	-	10.9%	5.2%	87	5.90	24	516	12	8.5	7.7	0.8	0.0	31.1%	100.0%	0	0	0	2	0		221,803	185,974	35,829
TWH	Intensive Care (TW) - NA201	99.0%	50.1%	-	-	95.6%	83.7%	-	-	1.0%	0.0%	14	0.89	2	192	63	58.1	-	-	-	69.2%	100.0%	0	2	0	0	1		408,866	405,978	2,888
TWH	Private Patient Unit (TW) - NR702	102.5%	71.8%	-	-	91.5%	93.5%	-	-	1.1%	0.0%	3	0.22	0	62	41	35.0	22.5	12.6	0.0	69.2%	100.0%	0	0	0	0	0		83,071	74,326	8,745
Pembroke	Pembroke Ward (A/C) - NJ301	110.3%	114.9%	-	-	100.1%	-	-	-	16.7%	0.0%	31	2.06	0	77	28	29.6	25.3	4.3	0.0	-	-	0	0	0	0	1		84,527	76,411	8,116
TWH	Ward 2 (TW) - NG442	97.1%	132.2%	-	-	99.2%	144.4%	-	-	35.8%	12.0%	111	7.48	16	832	7	8.5	3.5	5.0	0.0	78.8%	96.2%	7	0	110	3	0	109 Enhanced Care - Dementia/Delirium, 1 Enhanced care Mental health	256,848	230,262	26,586
TWH	Ward 10 (TW) - NG130	94.0%	112.0%	-	100.0%	101.6%	133.8%	-	100.0%	32.6%	0.0%	73.00	5.10	12.00	722	7.4	8.0	4.3	3.5	0.1	-	-	3	3	11	7	0	6 Enhanced care - Mental Health, 3 Enhanced care Dementia/Delirium, 2 Enhanced care - risk of falls. Overfill in care staff on a night due to roster being aligned following new establishment template following ward move.	199,219	195,087	4,132
TWH	Ward 11 (TW) - NG131	91.1%	101.7%	-	-	96.8%	100.0%	-	-	22.0%	0.8%	98	6.71	7	832	8	7.5	4.0	3.5	0.0	22.7%	88.2%	6	0	0	1	0		212,764	197,776	14,988
TWH	Ward 12 (TW) - NG132	93.9%	111.8%	-	-	97.6%	116.9%	-	-	36.3%	11.5%	119	7.70	13	938	6	6.8	3.3	3.5	0.0	20.3%	91.7%	4	1	65	7	0	51 Enhanced care - mental health, 8 enhanced care - Dementia/delirium, 6 enhanced care LD/autism	224,900	198,072	26,828
TWH	Ward 20 (TW) - NG230	96.4%	123.3%	-	-	100.0%	123.4%	-	-	21.6%	8.1%	58	3.34	4	906	7	7.4	3.5	3.9	0.0	57.5%	91.3%	1	0	59	2	0	33 Enhanced care - mental health, 26 Enhanced care - dementia/delirium	190,680	201,504	(10,824)
TWH	Ward 21 (TW) - NG231	97.1%	89.9%	-	-	99.4%	109.7%	-	-	19.0%	2.8%	74	4.57	9	942	7	6.7	4.1	2.6	0.0	29.8%	92.9%	4	0	20	3	0	11 Enhanced care - mental health, 8 Enhanced care - dementia/delirium, 1 enhanced care - risk of falls.	215,660	231,556	(15,890)
TWH	Ward 22 (TW) - NG332	98.8%	103.3%	-	-	98.4%	170.1%	-	-	29.3%	21.2%	59	3.85	6	981	6	8.1	3.2	4.8	0.0	77.3%	94.1%	5	1	174	7	0	169 Enhanced care - Dementia/Delirium, 5 Enhanced care Mental Health	139,402	149,536	(10,134)
TWH	Ward 31 (TW) - NG331	99.7%	102.3%	-	100.0%	99.2%	97.6%	-	-	15.8%	0.0%	73	4.27	5	930	7	6.6	3.5	3.1	0.1	3.7%	100.0%	5	2	2	12	0	1 Enhanced care - dementia/delirium, 1 Enhanced care mental health	192,504	200,234	(7,730)
TWH	Ward 32 (TW) - NG330	82.7%	77.2%	-	100.0%	72.6%	74.8%	-	100.0%	1.0%	0.0%	6	0.38	2	623	10	7.6	4.1	3.3	0.2	-	-	2	2	0	2	0	Underfill due to realignment of Healthrooster following ward move.	194,418	166,943	27,475
Maidstone	K&M Orth Centre - Inpatient Ward - TK153	88.2%	68.7%	-	100.0%	73.0%	81.0%	-	100.0%	0.0%	No hours	No Demand	No Demand	No Demand	173	30	24.1	15.5	6.3	2.4	65.5%	96.4%	0	0	0	0	0		167,257	134,858	32,399
TWH	Ward 33 (Gynae) (TW) - NS302	107.7%	129.7%	-	-	100.0%	100.0%	-	-	30.4%	0.0%	23	1.55	0	272	8	8.6	5.4	3.3	0.0	69.1%	96.4%	1	0	0	0	0		114,396	111,247	3,149
TWH	NICU (TW) - NA102	94.8%	-	-	-	81.1%	-	-	-	20.8%	0.0%	137	8.01	16	258	23	20.4	18.8	1.5	0.0	-	-	0	0	0	0	1		264,276	242,263	22,013
TWH	Short Stay Surgical Unit (TW) - NE901	108.5%	54.2%	-	100.0%	103.2%	100.0%	-	-	14.8%	0.0%	6	0.39	1	237	15	14.9	11.0	3.3	0.6	-	-	0	0	0	0	0		111,409	102,265	9,144
TWH	Surgical Assessment Unit (TW) - NE701	97.2%	93.3%	-	-	100.0%	100.0%	-	-	16.4%	0.0%	31	2.00	2	99	25	24.7	17.9	6.9	0.0	-	-	0	0	0	0	0		89,813	91,233	(1,420)
TWH	Midwifery Services - Delivery Suite - NF102	89.6%	93.9%	-	-	79.5%	82.3%	-	-	14.1%	1.8%	181	10.15	70	1939	-	-	-	-	-	-	-	0	0			0		134,943	186,082	(51,139)
TWH	Midwifery Services - Antenatal Ward - NF122	96.9%	94.6%	-	-	94.8%	87.1%	-	-	18.7%	0.0%	53	2.90	11	364	-	-	-	-	-	-	-	0	0			0		96,479	108,203	(11,724)
TWH	Midwifery Services - Postnatal Ward - NF132	104.2%	79.0%	-	-	92.5%	90.1%	-	-	25.0%	0.0%	184	10.32	24	616	-	-	-	-	-	-	-	0	0			0		234,170	223,802	10,368
Maidstone	Accident & Emergency (M) - NA351	99.0%	113.4%	-	100.0%	99.4%	180.1%	-	-	37.9%	2.3%	324	20.03	21	0	-	-	-	-	-	0.0%	77.1%	-	0	69		2	69 Enhanced care - mental health	438,024	507,906	(69,882)
TWH	Accident & Emergency (TW) - NA301	99.7%	87.8%	-	100.0%	101.4%	100.5%	-	100.0%	28.6%	2.0%	247	16.45	14	0	-	-	-	-	-	10.7%	73.6%	-	0	20		2	20 enhanced care - mental health	465,735	494,064	(28,329)
TWH	Community Midwifery Services - Team Leads - NJ160	76.5%	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	-	0			0				
TWH	Community Midwifery Services - TW/Eden/Ton/PW/Hawk - NJ160	84.1%	70.7%	-	-	-	-	-	-	3.6%	0.0%	17	0.64	0	0	-	-	-	-	-	-	-	-	0			0				
TWH	Community Midwifery Services - Phoenix Team - NJ160	86.9%	0.0%	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	-	0			0				
TWH	Community Midwifery Services - Seven/Mallings - NJ160	115.8%	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0	-	-	-	-	-	-	-	-	0			0				
TWH	Community Midwifery Services - Maidstone/Leeds - NJ160	74.9%	74.5%	-	-	-	-	-	-	8.6%	0.0%	29	1.40	0	0	-	-	-	-	-	-	-	-	0			0				
TWH	Community Midwifery Services - Crowborough - NJ160	83.7%	88.5%	-	-	-	-	-	-	2.2%	0.0%	3	0.13	0	0	-	-	-	-	-	-	-	-	0			0				
TWH	Crowborough Birth Centre (CBC) - NP775	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0		67,403	156	67,247
TWH	Midwifery Services - Specialist Midwives - NF152	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0		95,579	131,815	(36,236)
TWH	Midwifery Services - Antenatal Outpatient Clinic - NF142	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0		70,240	65,068	5,172
	Midwifery TW (four 9F rosters)	95.8%	82.2%	-	-	85.8%	87.0%	-	-	19.1%	0.6%	418	23.38	105													0				
	Midwifery TW Community (six comm. rosters)	86.5%	65.8%	-	-	-	-	-	-	3.7%	0.0%	237	13.22	35													0				
	Midwifery TW (all fourteen rosters)	85.9%	73.5%	-	-	86.7%	87.0%	-	-	10.8%	0.5%	561	33.25	56													0				

Total Established Words		8,427,301	8,379,444	47,857
Additional Capacity beds	Cath Labs	58,873	54,419	4,454
	Whatman	0	0	0
Other associated nursing costs		5,371,744	6,081,460	(709,716)
Total		13,857,918	14,515,322	(657,404)

Even though closed from Oct 25 - May 26 costs here haven't been distributed to other areas - Costs now mostly moved - Budget remains

This cost centre incurred a cost in M12

This cost centre incurred a cost in M12

RAG Key

Under fill / Overfill

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	**Corridor Care**					
Board / Committee	**Trust Board Meeting (Part 1)**					
Date of meeting	30th April 2026					
Agenda item no.	04-10					
Executive lead	Sarah Davis, COO and Jo Haworth, Chief Nurse					
Presenter	Sarah Davis, COO and Jo Haworth Chief Nurse					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	This Trust Board report provides details on corridor care within MTW. The slide pack includes: • NHSE guidance for corridor care • How MTW has responded from a governance, quality and safety point of view for patients and staff • If incidents have taken place, what has been the impact from Jan to March 2026 • Next steps from the learning and ongoing governance
Any items for formal escalation / decision	
Appendices attached	

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

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

MTW Care Coordination Centre

Corridor Care Update

April 2026 Trust Board

Sarah Davis, Chief Operating Office
Jo Haworth, Chief Nurse

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

What is the national guidance? (NHSE, December 25)

1. **Assessment and mitigation of risk** for potential harm, including staff and patients
2. **Escalation**- must adhere to organisational governance processes and use of OPEL framework
3. **Quality of care -** must uphold the equitable high standards of care if in corridor or not
4. **Data collection** and measuring harm
5. **Feedback loop** - raising concerns and reporting incidents
6. **De-escalation –** appropriate and timely

Oversight and MTW response to guidance

NHSE guidance defines corridor care as additional beds/spaces in a bay, room or area above its capacity. This represents care being delivered in a room/area not intended for clinical use pr beds outside of the bedhead count in this category.

At MTW our objective is to include our double occupancy rooms (TW) and Surgical Assessment Unit (TW) to ensure full visibility of patients cared for in areas with reduced facilities. This additional reporting supports patient experience and quality of care with the aim to de-escalate at the earliest opportunity.

The principles of corridor care exclude children, as the NHSE guidance deems this 'never acceptable'. Additional consideration should be given when planning where to place patients admitted due to mental health or enhanced care needs, patients who are severely frail, patients who are at end of life, patients who are pregnant or breastfeeding, any patient with a National Early Warning Score (NEWS) 2 score over 5, confirmed or suspected of being infectious, patients with physical disabilities and patients with learning disabilities, neurodivergence or autistic patients .

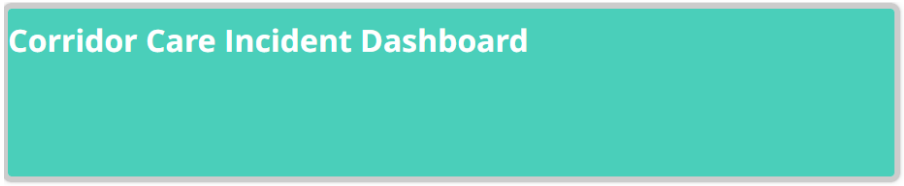
MTW has ensured that the implementation of policy focusses on vulnerable patients

One of the 6 core principles set out by NHSE is having Trust assurance that there is data collection, oversight and the measuring of harm for patients being cared for in corridor spaces.

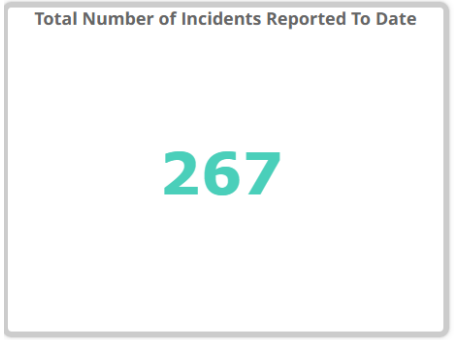
MTW has created live dashboards and reviews incidents within a robust governance framework and has participated in NHSE-led self assessment.

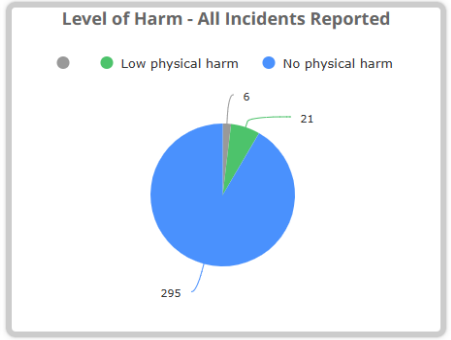
- **Slide 4 shows live dashboard created for MTW and Slide 5 corridor care incident report.**
- **Slide 6 shows self assessment for HSSIB investigation report on patient care in temporary care environments – Jan 26.**

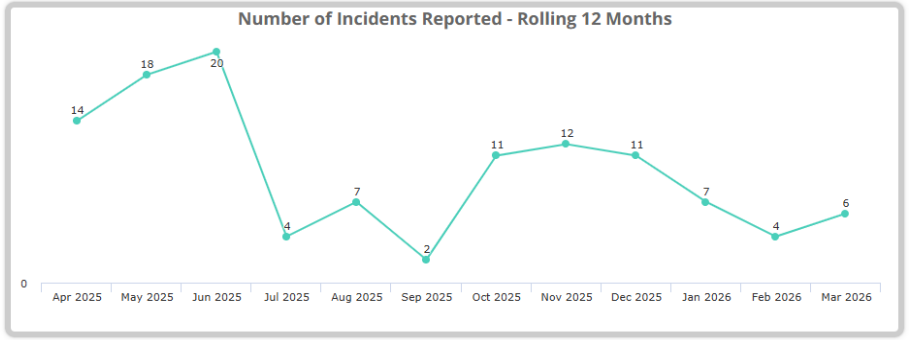
Data collection and measuring harm – development of Corridor Care Incident report (Inphase)

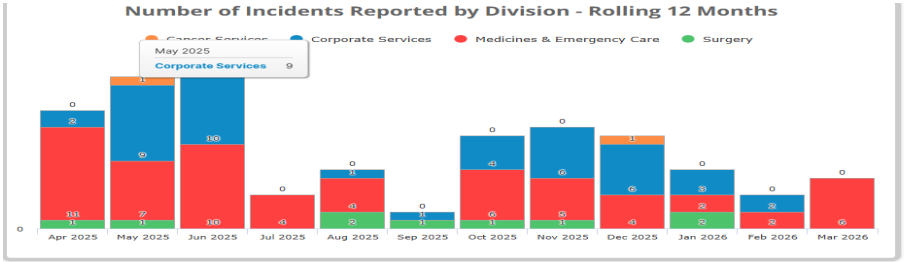


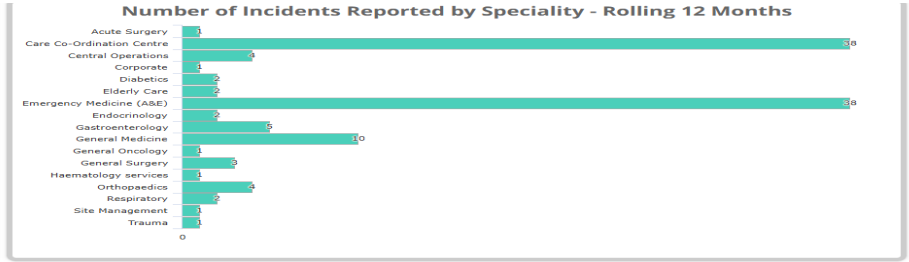
MTW
Exceptional people, outstanding care

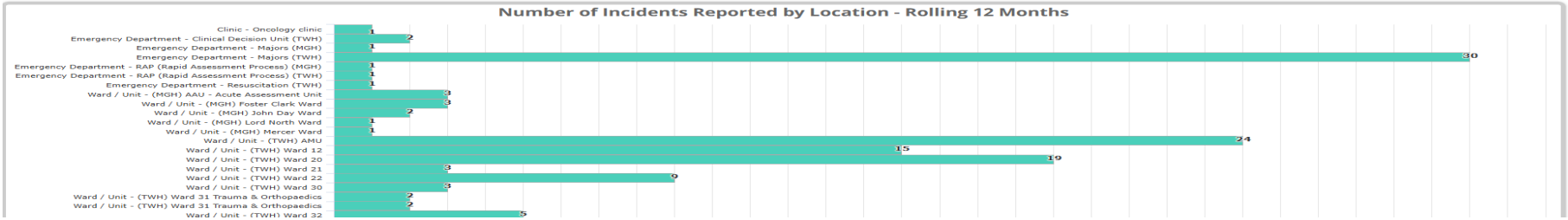












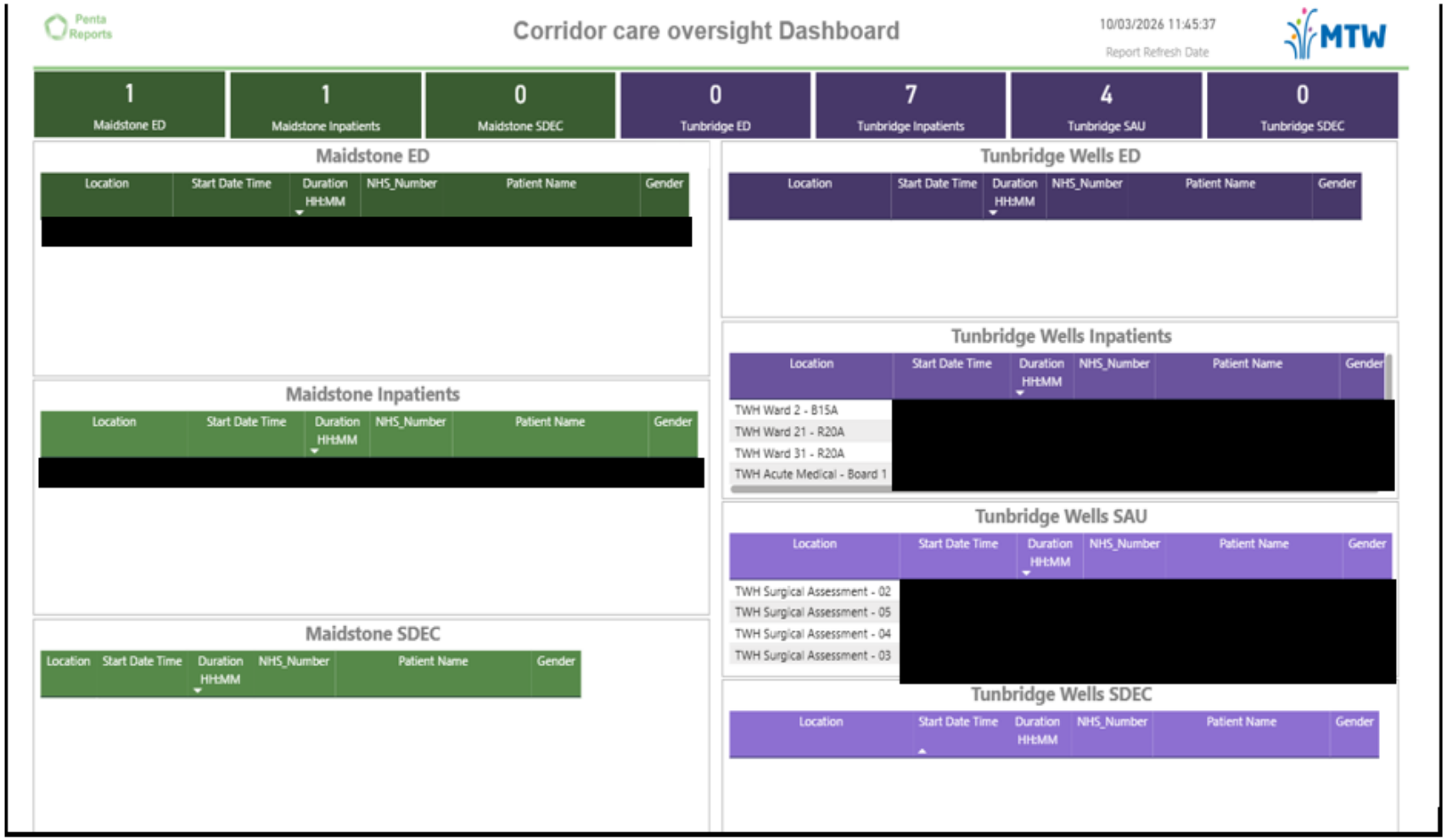
What is this report?

- Feedback loop to support key themes to contribute to improvement plan
- Report measures number of incidents by Division and location (rolling 12 mths)
- Red is MEC, green is Surgery

What does this show?

- Hot spots ED/ AMU at TW as expected due to flow
- Reduction Jan to March overall but March saw increase in MEC (Medicine/ Emergency Care) and reduction in Surgery.

De-escalation – development of Corridor Care Oversight Dashboard



What is the purpose of this report?

- Supports de-escalation
- Visibility in Care Coordination Centre (command centre with central oversight)

What does it show?

- how long each patient has boarded on ward
- number of beds open/ gender
- visibility of ED boarding

How has MTW self-assessed? (NHSE regional, January 26)

Organisation have a policy that governs the use of temporary care environments that includes potential risk mitigation strategies.	
Use a multidisciplinary team to assist risk-based decisions on where to situate temporary care environments and make decisions on which patients are appropriate to be placed in them	
Consider the staffing ratios needed to manage temporary care environments, including numbers, skill mix, experience and competencies	
Organisation nominated and assigned an individual healthcare professional to oversee corridor care. In progress	
Have aligned processes across different departments, including the availability of specialty services to help facilitate the movement of patients to the right place of care as soon as possible	
Organisation made adaptations to temporary care environment spaces that include having essential equipment nearby	
Have a means of tracking individual patients who are in a temporary care environment to support their clinical observations, understanding their needs and a process by which they document the length of time they have been in the temporary care environment.	
Have a way of displaying clinical information and observations of patients in a temporary care environment to all relevant staff, so that trends or deterioration in a patient's condition can be identified.	
Organisation provide information to patients about the use of temporary care environments and to inform them that any patient may be placed in one if there is a clinical need to provide a space for other patients In progress	
Organisation gather information about the use of temporary care environments	
Ensure that patients in temporary care environments are regularly engaged with to ensure that they have food, water, are comfortable, understand what is happening to them and what the plan is going forward	

Quality and Safety actions in place

Governance/ Quality of Care

- Corridor spaces reviewed
- Risk assessments completed for each corridor space by senior nursing leads
- Temporary escalation guidance reviewed (updated to corridor care and new NHSE guidance)
- Review of quality rounds and named nurse processes
- Review of patient's privacy and dignity and equipment requirements
- Staffing review and oversight when additional patients on wards
- Governance oversight by Chief Nurse incl. Experience of Care Oversight Committee/ Patient Safety Oversight Group, reports into Quality Committee

Documentation / Quality of care

- Standard operating procedure (SOP) in ED
- Plus one Guidance
- Caring for patients in temporary escalation spaces

Patient and Staff Comms

- corridor care letter for patients
- Staff intranet page built to ensure staff have one-stop access to all guidance
- Script for nurses to support
- Additional guidance to managers on call for out of hours

Reporting oversight

- Corridor care oversight dashboard – BI
- Corridor care reporting tool – BI Risk assessments – N drive

How has NHSE guidance developed beyond initial guidance and how has MTW responded?

NHSE: Increased standards to include patients who spend at least 45 mins awaiting diagnostic testS

MTW:

- Development of TeleTracking report for 45 min diagnostic delays
- Highlighted at site meetings
- Ongoing review at Experience of Care Oversight Group, Patient Safety oversight group, reports into quality committee

NHSE: Increased requirement of daily Sit rep collection from 6.3.26, publication from May 26 on NHSE website

MTW:

- compliant

Date published: 11 December, 2025
Date last updated: 11 December, 2025

Principles for providing patient care in corridors

This guidance replaces the Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces, published on 16 September 2024.

Publication (/publication)

Content

The term ‘corridor care’ is inclusive of any non-designated clinical space. The term ‘temporary escalation space’ (TES), as used in previous guidance, has been removed.

Introduction

Our aim is always to deliver high standards of care for patients in the right place and at the right time. NHS England’s position is that corridor care is unacceptable and must not be normalised.

We are committed to the total eradication of corridor care, recognising it as a clinical and moral imperative.

NHS England considers the delivery of corridor care in departments or wards experiencing patient crowding to be unacceptable and should never be considered standard. Patients should only be placed in corridors in extremis and for the shortest possible duration, to ensure the time patients are cared for in this environment is kept to a minimum

Care should be person-centred, focusing on the needs of the individual and ensuring that privacy and dignity are maintained, to the best ability, given environmental constraints.

Decisions about corridor care must be made transparently, with clear governance and oversight. Trust boards, quality committees and senior clinical leaders must be actively involved in both escalation and de-escalation processes. It is essential that trust executives and boards are fully sighted on the scope and scale of corridor care within their organisations, ensuring they understand the associated risks and challenges. Decisions on corridor care require strategic leadership and system-wide co-ordination.

Where corridor care is unavoidable, trusts should have active plans to eliminate its use entirely. Published evidence examining patient safety and crowding in emergency departments and wards reports worse clinical outcomes and poorer experiences for patients, their loved ones and healthcare staff.

Delivering care in corridor areas can be physically and emotionally challenging for staff. A survey and subsequent report by the Royal College of Nursing (RCN) (https://www.rcn.org.uk/Professional-Development/publications/corridor-care-unsafe-undignified-unacceptable-uk-pub-011-635) highlighted the detrimental impact of this care setting on patients and staff and calls for total eradication. In these settings, sustaining infection prevention and control (IPC) practice, privacy, dignity and a good patient experience become even more difficult, further amplifying the risk to patient and staff safety.

In addition to the RCN report, a statement published by the Royal College of Emergency Medicine (https://rcem.ac.uk/wp-content/uploads/2024/12/Care-in-Temporary-Escalation-Spaces-RCEM-Position-Statement-1.pdf) said it is not possible to provide safe and good quality care in temporary care environments. A statement by the Royal College of Physicians (https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/a-snapshot-of-uk-doctors-delivering-care-in-a-temporary-environment/) called for an end to corridor care, as it deems it unsafe and unacceptable for both patients and staff.

The following principles have been developed to support point-of-care staff in delivering the safest and highest quality care possible when corridor care has been deemed unavoidable.

Overarching corridor care principles

These principles should be applied alongside any local standard operating procedures and arrangements governing flow pathways, IPC, and safe and effective staffing. Risk sharing should be considered against the entire hospital flow pathways to minimise risk at every stage.

Corridor care does not include clinical spaces opened as part of winter pressure planning and refers to care given in any unplanned setting. However, the current healthcare landscape means that some providers are using corridor care more regularly – and this use is no longer in extremis.

The use of corridor care is never acceptable and must be avoided when caring for the following patient groups:

- children
- mental health patients
- patients with learning disabilities, neurodivergence or autistic patients
- patients with physical disabilities
- patients who have dementia, confusion or delirium
- patients who are confirmed or suspected of being infectious
- any patient with a National Early Warning Score (NEWS) 2 score over 5
- patients who are pregnant or breastfeeding
- patients who are severely frail
- patients who are at end of life

This is not an exhaustive list, and each patient must be assessed before being placed in corridor care. An equality impact assessment should be undertaken whenever corridor care is being considered for a patient.

The core principles

The core principles for corridor care for patients are:

1. Assessment and mitigation of risk
2. Escalation
3. Quality of care
4. Raising concerns and reporting incidents
5. Data collection and measuring harm
6. De-escalation

1. Assessment and mitigation of risk

Patients should, where possible, be seen, assessed and treated within a clinically appropriate trolley, bed or chair space. Care delivered outside of these clinically appropriate spaces should only be used when all other capacity and escalation options have been exhausted.

It is essential that local health and safety policies can be adhered to for the safety of patients and staff.

It is imperative that all healthcare partners across the system and patient pathway, from pre-hospital care to point of discharge, work collaboratively to share and manage risk, ensuring safe and effective patient flow. They must have clear, open lines of communication and have processes for the escalation of concerns. Clear lines of accountability must be established to ensure that each patient in a corridor is under the oversight of a designated healthcare professional who is responsible for their care.

Assessments of risk for potential harm and safety for staff and patients who are being considered for corridor care must be completed, and organisational governance processes and full capacity protocols must be followed. Local patient safety checklists should be used to ensure the patient can be safely cared for in this setting. This should include an inclusion and exclusion checklist.

Providers should refer to NHS England's Emergency care improvement support team (ECIST) guidance (https://future.nhs.uk/connect.ti/ECISTnetwork/groupHome) (FutureNHS login required), which details best practice measures, principles, tools and evidence to support decision-making that balances patient and organisational risk across a system in extremis.

IPC is a key component of the risk assessment. Corridor care environments often limit the ability to adhere to fundamental IPC practices (such as patient isolation, hand hygiene compliance and environmental and equipment cleaning), increasing the risk of healthcare-associated infections (HCAIs) transmission. Therefore, ensuring adherence to local IPC policies and national IPC guidance is mandatory before placing any patient in a corridor.

The Care Quality Commission's (CQC) fundamental standards (https://www.cqc.org.uk/about-us/fundamental-standards) should be adhered to.

Further considerations and requirements

- The clinical, psychological and functional suitability of the patient.

- A clear clinical plan for each patient must be in place, where all patients must have a named consultant and an identified responsible clinical team.
- Appropriate staffing and skillsets that ensure the safe monitoring of patients and the ability to recognise deterioration.
- Induction and training on caring for patients in corridors should be given to staff and must include strict IPC practices, such as hand hygiene, personal protective equipment (PPE) use and waste disposal.
- Only permanent staff or those temporary employees who are familiar with the environment and IPC risk controls should be allocated to deliver care in corridors.
- Staff are not to be routinely and continually allocated to work in corridor care environments.
- The provision of daily senior nurse quality rounds and safety huddles should include a review of the staffing requirements for the additional patients and their individual needs, in line with expectation 3 of the National Quality Board (NQB) guidance: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016) (https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/).
- Access for staff to use observation charts and medication charts at the 'bedside' and have full access to patient records and electronic systems.
- The ability for staff to secure storage and safe handling of medicines.
- Access for staff to use oxygen, air, suction and resuscitation equipment and the ability to provide safe quality care and an emergency response within it.
- Adherence to local IPC policies.
- Staff providing care and treatment should have clear visibility of their patients' location (patient tracking).
- The ability for patients, families and care partners to summon assistance easily, without delay.
- Allow for patient visitors in line with local policies.
- Executive leadership and senior accountable clinical staff must be visible and actively support decisions about corridor care, including governance.
- Work as multi-professional teams with other departments to assess, manage and transfer patients efficiently, in line with expected discharge and admission times and rates.
- The level and profile of risks will continually change and will need to be assessed using a dynamic risk assessment (DRA) approach. This assessment should also consider risk across the pathway or system, recognising that increasing a risk in one area may reduce a risk in another part of the pathway, which may be the 'least worst' scenario.

System-wide risk considerations

- **Integrated care boards (ICBs)** must adopt a risk-sharing approach that includes IPC as a critical quality and safety domain.
- Providers and systems can use tools such as the **GIRFT Summary Emergency Department Indicator Table (SEDIT) dashboard** to assess demand, capacity, flow, IPC risks and outcome metrics, helping to reduce reliance on corridor care.

2. Escalation

All providers must have established working escalation models in place and follow organisational governance and reporting structures at all stages of patient care, including episodes of corridor care. The escalation process must prioritise patient safety, including adherence to IPC protocols, to minimise risks associated with increased occupancy (crowding) and corridor care environments.

Local policies on internal escalation should be triggered once a patient has been allocated to receive corridor care. This should include the senior clinical and management teams (triumvirate) responsible for the department, as well as the trust executive team, who should escalate to the board.

Escalations should adhere to organisational governance processes. Providers should follow any local policies regarding patient flow and safe staffing.

Providers should escalate to system quality groups and use the NHS England Operational pressures escalation levels (OPEL) framework (https://www.england.nhs.uk/long-read/integrated-opel-framework-2024-to-2026/) to allow systems to have a clear vision of urgent and emergency care pressures and awareness of the potential risks and harm. Systems will be able to escalate to regions, who will escalate to the national team accordingly. Providers must also report the number of patients receiving corridor care in emergency departments or wards via the daily sitrep.

3. Quality of care

Corridor care areas must uphold the same high standards of care for patients as those in planned clinical non-corridor settings.

It is essential to maintain the delivery of high-quality care throughout the entire episode of corridor care, ensuring patients receive the same standard of care as those in allocated clinical spaces.

The following principles should be followed:

- patient safety is paramount: all patients being considered for corridor care must be assessed using a safety checklist that includes IPC risk factors such as infectious status and vulnerability to cross-contamination
- patients should be registered on local IT systems or the Electronic Patient Record (EPR) to ensure access to all relevant electronic systems to record their care
- while it is recognised that patient experience will not be optimal, it is important to always maintain privacy and dignity during their episode of care; this should include screens, when requested or required, and access to a fully private area for confidential discussions or certain examinations
- it is recognised that maintaining patient confidentiality is challenging. However, trusts must ensure that all staff are supported to uphold these standards to meet all legal and ethical standards despite the challenges that corridor care presents
- ensuring IPC practices are followed rigorously is essential, as these environments often present heightened risks of HCAIs. It is imperative that IPC principles are integrated into the delivery of care, ensuring the safety and wellbeing of patients, staff and the broader healthcare environment
- all care should be person-centred, ensuring that the focus is on the needs of the individual and ensuring that the patient's preferences and values guide any clinical decisions
- patients should be informed of why they are being cared for in a corridor and reassured that they will still receive safe and essential clinical care. Appendix 1 provides an example of a patient information leaflet; this should be available in multiple languages or explained via a translator
- trusts should ensure adherence to the Accessible Information Standard (https://www.england.nhs.uk/long-read/accessible-information-standard-requirements-dapb1605/) in all communications with patients; National Voices offers guidance on community languages, translations and interpreting services (https://www.nationalvoices.org.uk/publication/community-languages-translation-and-interpreting-services/)
- patients should be allowed visitors in line with local visiting policies in the area where they are being cared for
- patients should be orientated to the area where they are being cared for, and efforts should be made to create a risk-controlled environment in the corridor, including easy access to hand hygiene stations, PPE and clinical waste disposal
- patients should be instructed on how to alert staff to their needs
- easy access to bathrooms should be maintained, and hourly comfort rounds should be undertaken. Personal hygiene requirements should be identified
- patients should have access to nutrition, including hot meals and hydration. Reasonable adjustments should be made for any patients identified as

requiring support
- patients should have space for personal possessions and private items
- if appropriate, patients should be supported to move around regularly if they are in a corridor care area for more than a few hours
- good quality sleep is important for patient recovery, and efforts should be made to create a sleep-friendly environment, minimising disruptions
- regular communication with patients, families and care partners is essential, with transparent updates on the patient's treatment plan, condition and expected transition to a more suitable clinical area
- patients and families should be encouraged to raise concerns or complaints in real time. Feedback should include concerns related to infection risks or patient safety, and appropriate IPC actions should be taken as part of any response
- clinical staff should maintain regular reviews, observations and NEWS2 scoring of a patient's condition to identify early any changes or deterioration that may require the patient to be moved out of corridor care areas and into another area of the emergency department. Medications should be given as per the prescription plan and should be monitored
- appropriate discharge planning should always be focused on reducing corridor care. This includes ensuring patients are not delayed unnecessarily and that discharge processes are safe, efficient and person-centred

4. Raising concerns

In high-pressure environments like corridor care, maintaining a strong culture of speaking up is essential to patient safety, infection prevention and staff wellbeing.

Staff must abide by their code of practice and, if this feels undermined, they should raise concerns. It is imperative that staff delivering corridor care have a voice and feel heard. Staff should be encouraged to raise concerns immediately, and these concerns should be dealt with in a timely manner.

Staff should always feel safe to report and raise concerns and be reassured that these are being taken seriously. Staff should not be fearful of raising concerns and reporting complaints.

Staff should have access to the freedom to speak up (FTSU) guardians and be aware of the FTSU process to raise concerns. Senior management teams should promote this and embed it in their organisation's culture.

Staff should have the opportunity to debrief and discuss areas of concern further.

Staff need to be heard and supported. Areas should have mechanisms to support staff psychological and welfare needs, for example, open door policies, staff forums, drop-in sessions, visible senior staff support and debrief sessions after a patient safety event. Local staff surveys can also be used.

Patient experience must be monitored, and patients, families or care partners should be given the opportunity to raise concerns and complaints in real time. Local policies on raising concerns and complaints should be followed.

Patient welfare must be measured. This can be done using surveys (such as the Friends and Family Test) or a trust might develop a specific survey about their corridor care.

5. Data collection and measuring harm

All trusts need to formally measure and report corridor care data for emergency departments and wards. This should be reported using the metrics on the national daily sitreps, including instances where no corridor care is being provided (nil returns).

It is important that the executive team and trust boards have visibility of the numbers of patients being cared for in the corridor and the actions to eradicate this.

Trusts need to monitor the risks of potential harm, the actual harm that has occurred, and the impact on patients and staff of the use of corridor care. This should include, but not be limited to, complaints, ‘duty of candour’ incidents and information from external sources such as patient and staff surveys.

Real-time quantitative and qualitative harm data should be visible to senior clinical and management teams, trust executives and boards. Providers should apply their own processes and incident reporting systems. These can be used to escalate concerns to system, regional and national colleagues.

There must be mechanisms in place to evaluate any harm caused (for example, after-action reviews). These mechanisms should allow learning to be fed back to frontline staff and to trust executives.

The SEDIT dashboard (https://gettingitrightfirsttime.co.uk/sedit/) can also support analysis of demand, capacity, estates space and outcomes to evaluate potential harm and realised harm.

The Summary Acute Medicine Indicator Table (SAMIT) dashboard (https://gettingitrightfirsttime.co.uk/samit/) can also provide valuable insights into patient flow, safety and performance across systems.

De-escalation

It is essential that providers and systems have robust de-escalation models.

De-escalation should mirror escalation plans in reverse and use the dynamic risk assessment approach. The same communication channels used for escalation should be used for de-escalation. Situation reports should be provided for senior teams, trust executives and system leadership.

The chief executive or executive team should oversee de-escalation and ensure care is delivered in appropriate areas immediately. The trust board's quality committee should also be sighted, given the risk that the provider could potentially breach CQC registration by using corridor care.

There should be a process in place to debrief staff, identify lessons and review internal standard operating procedures, policies and processes.

These principles are intended to support point-of-care staff in delivering the safest and highest quality care possible in situations where corridor care has been deemed unavoidable. Corridor care should only be used in extremis and must not be considered an acceptable or sustainable model of care.

Appendix 1: example patient information leaflet

Your care in our hospital today

Right now, you are being cared for in a corridor or another temporary space.

This is because the emergency department/hospital ward (delete as appropriate) is extremely busy.

We apologise and realise that this isn't an ideal environment. We want you to know that your safety, wellbeing, privacy and comfort remain our top priority.

You will still receive safe, high-quality care, and we are following all measures to protect you and others from infection.

Below are answers to some common questions. If you have any other concerns, please speak to a member of staff nearby – we're here to help.

Why am I being cared for in this space?

The hospital is very busy. Because of high numbers of patients, there are currently not enough cubicles or beds available.

To make sure everyone gets the care they need, we sometimes use alternative spaces temporarily. You will still receive safe, high-quality care, and we are following all measures to protect you and others from infection.

How long will I be here?

It’s hard to give an exact time. Staff are checking patients all the time and will move you to a bed, room or more suitable space as soon as one becomes available.

Your team will let you know as soon as this happens.

How will my dignity and privacy be protected?

We understand this is not the ideal environment, and we are doing everything we can to make sure you have privacy. Screens may be used to make sure you feel as comfortable as possible during assessments and care.

Will I still be seen by a doctor as quickly as other patients?

Yes. You will be seen based on how urgent your care needs are – not where you are.

Being in a corridor or other temporary space does not delay your treatment.

Will I still get food and drink?

Yes. If it is safe for you to eat and drink, meals will be provided at set times.

Please tell staff if you have any allergies, dietary needs, or if you need food or drink outside these times.

Can I use the toilet and washing facilities?

Yes. There are toilets and washing areas nearby.

Staff will show you where they are or help you if you need it.

Do I have an allocated nurse?

Yes. You will have your own nurse who will tell you their name.

They will help you with your medicines and care.

If you have any worries or questions, please speak to them.

Can I get staff attention if I need help?

Yes. Staff are always nearby and will check on you often.

Your nurse will explain how to get help if you need anything or if you start to feel worse.

Can I have visitors?

Yes. Please try to keep visitors to a small number because this area can be busy and it helps us keep people safe and comfortable.

[Add more details about local arrangements]

All visitors must clean their hands and follow hospital safety rules.

Who will talk to my family or carers?

Your nurse, doctor or therapist can share information with your family or carers if you wish.

If I need to be admitted to a ward, will this delay me?

No. If you need to go to a ward, your bed will be arranged as soon as one is ready.

Your care will continue while you wait.

How can I give feedback about my care?

If you have any questions or worries, please speak to a member of staff.

We welcome your feedback. You can also contact our Patient Advice and Liaison Service (PALS) on: [Insert phone number] or [Insert email address].

Publication reference: PRN01967

Date published: 11 December, 2025
Date last updated: 11 December, 2025
▲Back to top

Title of report	**Maternity Report relating to the Perinatal Quality Oversight Model**					
Board / Committee	**Trust Board Meeting**					
Date of meeting	30th April 2026					
Agenda item no.	04-11					
Executive lead	Jo Haworth					
Presenter	Rachel Thomas					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	✓	***Information***	✓

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	<u>PQOM Overview</u> 1. To ensure effective Board oversight in Year 8 of the Maternity Incentive Scheme, it is recommended that the monthly Perinatal Quality Oversight Model (PQOM) reports (Appendix 1) are available at Trust Board on a quarterly basis. This represents a change from last year, where PQOM data was sent monthly to Board. A member of the perinatal leadership team will be available to provide supporting context. 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. Appendix 1 provides a summary of Q3 PQOM data which was discussed at the Maternity and Neonatal Care Oversight Meetings on 9 December, 14 January and 11 February. As the Board has already received December and January escalations, the items to be escalated from the February meeting are detailed below. 4. Following the publication of Maternity Incentive Scheme Year 8 guidance on 31 March 2026 the Board reporting requirements of the Scheme have been mapped against the MIS year. Subject to Board approval it is proposed that Q4 PQOM data be presented in May, Q1 in September and Q2 in November to ensure timely and regular reporting throughout the year. <u>MNCOG 11 February 2026</u>

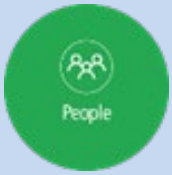
	5. Matters of concern/key risks for escalation 5.1. Letter of concern received from MNSI relating to EDI issues reported during an investigation. Immediate actions underway. 5.2. Ongoing risks relating to the over occupancy of the neonatal unit. 5.3. Neonatal unit staffing on a downward trajectory. 6. Improvements/Positive Assurance 6.1. 3rd and 4th degree tear rates below national rates. 6.2. No harm caused by any C Section delays. 6.3. No themes arising on PPH dashboard data. 6.4. MIS Year 7 compliance to be submitted by 3 March 2026. 6.5. MNSI cluster review did not identify any themes. Recognised work to do relating to EDI in response to MNSI Letter of concern. 7. Major actions commissioned/improvement work underway 7.1. Review metrics that are presented to Board in relation to IOL delays to ensure consistency with National metrics. 7.2. Neonatal team to work with patient safety team to establish if incident rates are affected by current over occupancy issues. 7.3. Thematic review of consultant non-attendance at emergency events to be carried out. 7.4. Annual review of PSII's and MNSI's to be performed to look for learning themes. 7.5. Risks relating to epidural infusion changes to be added to the risk register. 7.6. Project to improve accuracy of classification of C Sections to be undertaken. 7.7. To liaise with ICB regarding running a test process in advance of the new MOSS system's introduction. PMRT Q2 Report 8. In accordance with Safety Action C of the Scheme, the Trust Board is invited to review and note the quarterly PMRT Report (January 2026, Q3 data October to December 25) (Appendix 4) which includes details that the PMRT has been used to review eligible perinatal deaths, that required standards have been met and consequent action plans. 9. The Board is reassured that, in accordance with the Scheme, this PMRT report has been discussed by the Trust Maternity Safety and Board Level Safety Champions via MNCOG on 11 February 2026.
Any items for formal escalation / decision	1. In relation to PQOM the Board is invited to: a. review the attached 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 – Q3 (Nov to Dec 2025 data) PQOM Report 2. Appendix 2 – PMRT Report (January 2026, Q3 data October to December 25)

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Maternity and Neonatal Care Oversight Group	11 February 2026	For referral to Trust Board

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

Title of report	**Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)**					
Board / Committee	**Trust Board**					
Date of meeting	30th April 2026					
Agenda item no.	04-12					
Executive lead	Rachel Jones. Director of Strategy, Planning and Partnerships					
Presenter	Rachel Jones. Director of Strategy, Planning and Partnerships					
Report Purpose (Please ☑ one)	***Action/Approval***	✓	***Discussion***	☐	***Information***	☐

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

Executive Summary	
Executive summary of key matters/areas for consideration (incl. key risks, recommendations and external approvals)	**Summary:** The attached slides outline the latest system developments, health care partnership status and revised work program and the 26/27 approach to contracting.
Any items for formal escalation / decision	No
Appendices attached	System and HCP slides

Report previously presented to:		
Committee / Group	Date	Outcome/Action
Neighborhood Heath Programme Board	16th December	Approved

Assurance and Regulatory Standards	
Links to Board Assurance Framework (BAF)	Please list any BAF Principal Risks to which this report relates: • Strategy and Partnership risk linked to system working
Links to Corporate Risk Register (CRR)	Please list any risks on the Corporate 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

Maidstone and Tunbridge Wells NHS Trust

University Hospitals Sussex NHS Foundation Trust

ICB and West Kent HCP update

April 2026

Exceptional people, outstanding care

System

- Children and young people's mental health services transferred from NEFLT to KMMH on 1st April.
- The Cancer Alliance and Endoscopy/Imaging networks have transferred from the ICB to MTW from 1st April.
- A Provider Alliance is being established which will meet once per month, report to the Joint Committee and will oversee the system improvement team.
- The Provider Collaboratives have been consolidated into the Acute and Community provider collaboratives and will report to the newly forming Provider Alliance.
- This will be CEO led and be supported and driven by the system delivery director.

System

- Alongside the Provider Alliance will be a CEO System Leadership Group which will meet monthly and replaces the current CEO System Improvement Group.
- The new structure will be implemented from May.
- The contract for 26/27 has now been signed and a work plan is being developed both internally and across K&M where applicable.
- This is a shadow year for monitoring and will be overseen with a shared governance approach. This will include

West Kent HCP

- The HCP staff will transfer to KMMH as part of the system improvement team, and we expect this to be for 1st July.
- The staff of the HCP are continuing with the parts of the work plan which align with the system improvement work, particularly on neighbourhood health, urgent and emergency flows and health & well-being.
- We have stood many of the regular meetings down and are planning a celebration close meeting for the HCP, likely to be in June, once a date of transfer is confirmed.
- The staff continue to be supported by MTW.

Contracting approach

- The contract for 26/27 has now been signed and a work plan is being developed both internally and across K&M, where applicable.
- This is a shadow year for monitoring and will be overseen by the ICB with a shared governance approach with an emphasis on structured, evidence-based contract oversight
- This will include a new monthly Contract Management Committee supported by sub-groups.
- A contractual priority for 2026/27 will be the quality, consistency and reliability of data and reporting, for which providers hold primary responsibility.