Ashford and St. Peter's Hospitals NHS Foundation Trust

Report title:	**Integrated Performance Report**		
Report to:	**Council of Governors**		
Date of meeting:	**Tuesday 2 June**	**Agenda item:**	6.2
Report summary:	This report was shared with Trust Board on 25 March 2026.		
Recommendation:	To note		
Report lead:	Chief Nursing Officer, Chief Medical Officer, Chief Operating Officer, Chief People Officer		
Report author:	Director of Performance, Deputy Chief Operating Officer, Associate Director of performance, Head of Quality and Regulation, Mortality Improvement Lead, Associate Director of Workforce - Planning & System Working		

Purpose of report:	**For Noting**	**For Decision**	**For Assurance** x

Assurance level:	**Significant** High level of confidence / evidence in delivery	**Acceptable** x General confidence / evidence in delivery	**Partial** ☐ Some confidence / evidence in delivery	**No Assurance** ☐ No confidence / evidence in delivery

Link to Strategic Objectives:	All strategic objectives
Link to CQC Domains:	All CQC domains
Link to BAF risk:	
Potential impact on stakeholders:	
Next steps	To note
Appendices:	

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Report title:	Integrated Performance Report		
Report to:	**Public meeting of the Trust Board**		
Date of meeting:	Wednesday, 25 March 2026	**Agenda item:**	1.8
Report summary:	*Quality* This report presents the performance against the quality and safety metrics for January and February 2026. Complaint responsiveness suffered some detriment during peak winter pressures but remains a core focus for Divisions with good work in SSMSK relating to a trail of SWARMS for new complaints. Good progress has been made to clear the 2025 backlog and revised processes are in place to oversee continued improvement for the responses due in February and March. This is reflected in the continuation of the improvement objective in the 2026/27 quality priorities. Common cause variation seen in relation to pressure ulcers and falls over this period. Continuous improvement work is still ongoing in identifying the interventions to address the root causes and to reduce the likelihood of recurrence related to practice. Hand hygiene audit data shows more work to be done with a targeted campaign for 3-months beginning in April. Good assurances that, after mitigation, a greater than 90% staff fill rate was achieved across our inpatient wards. There is a worsening backlog in relation to patient safety investigations of all grades, compounded by the winter operational pressures, with a significant deterioration in completion rates for verbal and written duty of candour in February. A Patient Safety Governance meeting is being established by the CMO to drive progress in this area through a shared approach with divisions. Deteriorating patient clinical lead and Martha's Rule Clinical Project Lead have been appointed. *Performance* **Urgent Care** February's A&E All type performance was 73.6% and achieved the trajectory set for the month. Ambulance handover delays over 45 minutes remained high at 11.9%, and 17.8% of patients spent more than 12 hours in ED. Non-elective length of stay increased to 8.4 days. Paediatric A&E performance remained challenged at 67.4% (Type 1). Flow was affected by infection control issues in some wards resulting in temporary bed closures. Discharge lounge was bedded 14 nights and		

SDEC 3 nights throughout February adversely impacting flow and performance the following days.

Elective Recovery Programme
February RTT performance is forecast at 60.1% against a plan of 65.7%. Performance remains constrained by the prolonged closure of theatres following critical ventilation and electrical failures, significantly reducing capacity across key surgical specialties.

Divisions have implemented a coordinated package of RTT recovery actions, including expanded weekend and Sunday clinics, additional consultant capacity, increased Saturday theatre lists, and targeted outsourcing across key specialties. External funding has facilitated further use of the independent sector to support the Trust's RTT position by the end of March.

Diagnostics (DM01)
Diagnostic performance is (estimated) to marginally improve to 88.3% in February, although was primarily impacted by reduced non-obstetric ultrasound and Endoscopy capacity. To mitigate this, the Trust is outsourcing both these modalities.

Cancer Performance
Cancer performance for February is forecast to meet all three national standards, supported by strengthened oversight through weekly PTL meetings, tumour-group breach reviews and targeted specialty-level improvement actions. Pathway progression continues to be affected by diagnostic and reporting delays, workforce constraints and tertiary-provider dependencies, particularly impacting the 62-day standard.

While a small number of patients are expected to exceed 104 days, the Trust remains confident in delivering its 2025/26 cancer performance commitments.

Workforce

Temporary staffing
Despite significant improvement when compared to our position last year, bank and agency usage remain above the Trust plan and national target level for percentage of total pay. Registered Mental Health Nurse agency continues to be a significant driver of agency usage, and operational pressures and activity performance recovery continue to drive both bank and agency usage. Workforce reviews in targeted areas are being taken forward to identify solutions where temporary staffing has been driven by long standing recruitment issues.

Ongoing monitoring of temporary staffing use continues through the Medical Scrutiny panel and Workforce Control panel processes. A review is underway of workforce control processes and other temporary staffing controls to identify further opportunities to support reductions.

	Sickness absence Sickness absence increased in line with seasonal variation but continues to be an area for improvement, having been over target for the last five months. A sickness absence improvement plan has been developed, focused on developing local health and wellbeing improvement plans. Opportunities for Group programmes of work have also been identified. **Turnover** Turnover and stability continue to be areas of positive performance within workforce metrics, in line with national trend data.
Recommendation:	Board to receive the report for assurance.
Report lead:	Chief Nursing Officer, Chief Medical Officer, Chief Operating Officer, Chief People Officer,
Report authors:	Director of Performance, Deputy Chief Operating Officer, Associate Director of performance, Head of Quality and Regulation, Mortality Improvement Lead, Associate Director of Workforce - Planning & System Working

Purpose of report:	**For Noting** ☐	**For Decision** ☐	**For Assurance** ☒

Assurance level:	**Significant** ☐ High level of confidence / evidence in delivery	**Acceptable** ☒ General confidence / evidence in delivery	**Partial** ☐ Some confidence / evidence in delivery	**No Assurance** ☐ No confidence / evidence in delivery

Link to Strategic Objectives:	All strategic objectives
Link to CQC Domains:	All CQC domains
Link to BAF risk:	SR4: There is a risk of failure to embed a culture of continuous improvement, and to deliver safe and effective care, impacting our ability to consistently deliver sustainable improvements SR4.1: The inability to effectively capture and act upon the patient voice, leading to missed opportunities to improve service quality, patient care, and experience... SR6: We are unable to recruit and retain the workforce with the skills that we need to deliver excellent patient experience
Potential impact on stakeholders:	Public interest and potential for increased regulatory scrutiny as part of routine quality and safety oversight.

Next steps	N/A
Appendices:	None

Ashford and St. Peter's Hospitals
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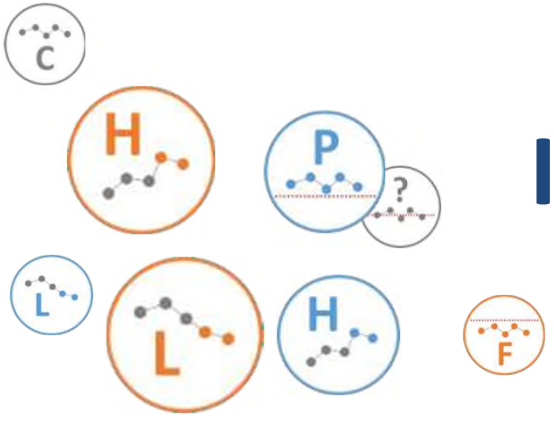
Ashford & St Peter's Hospitals NHS FT



Trust Board
Integrated Performance Report

Reporting Month: January/February 2026

The NHS England website has a range of resources to support Boards using the Making Data Count methodology.
This includes a number of videos explaining the approach (with case studies) and can be accessed here > https://www.england.nhs.uk/publication/making-data-count/

Statistical Process Control (SPC) & Icons

This scorecard incorporates Statistical Process Control (SPC) graphs.

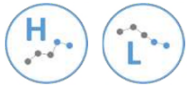
On each graph, data is plotted against a centre line (the average). The Upper Control Limit (UCL) and Lower Control Limit (LCL) are defined by the variability of the data.
It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify and consider how likely it is that the target will be achieved.

Variation Icons

> Are we improving, declining or staying the same?

Common cause variation – No significant change

Special cause of concerning nature or higher pressure due to **H**igher or **L**ower values



Special cause of improving nature or lower pressure due to **H**igher or **L**ower values

CC - Common cause variation describes variation that is expected & predictable.
SC - Special cause variation describes variation that is unusual or unexpected.

Assurance Icons

> Can we reliably hit the target?

Variation indicates 'hit and miss' variation, inconsistency passing and failing the target

Variation indicates consistently **P**assing the target

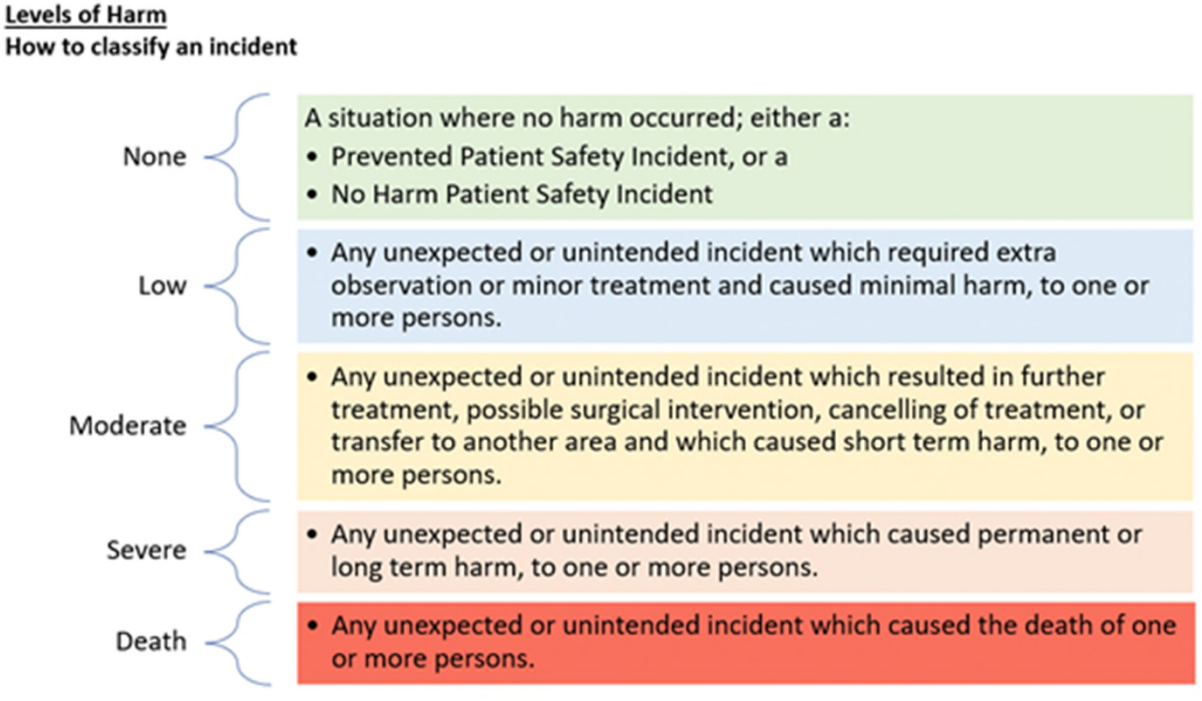
Variation indicates consistently **F**alling short of the target

Assurance Level Icons

> A level of assurance has been assigned to each of the key metrics in this report, the 4 levels are;

Assurance Levels			
No Assurance	**Partial**	**Acceptable**	**Significant**
No confidence or evidence in delivery	Some confidence and evidence in delivery of existing mechanisms and objectives	General confidence and evidence in delivery of existing mechanisms and objectives	High level of confidence and evidence in delivery of existing mechanisms and objectives

Levels of Harm

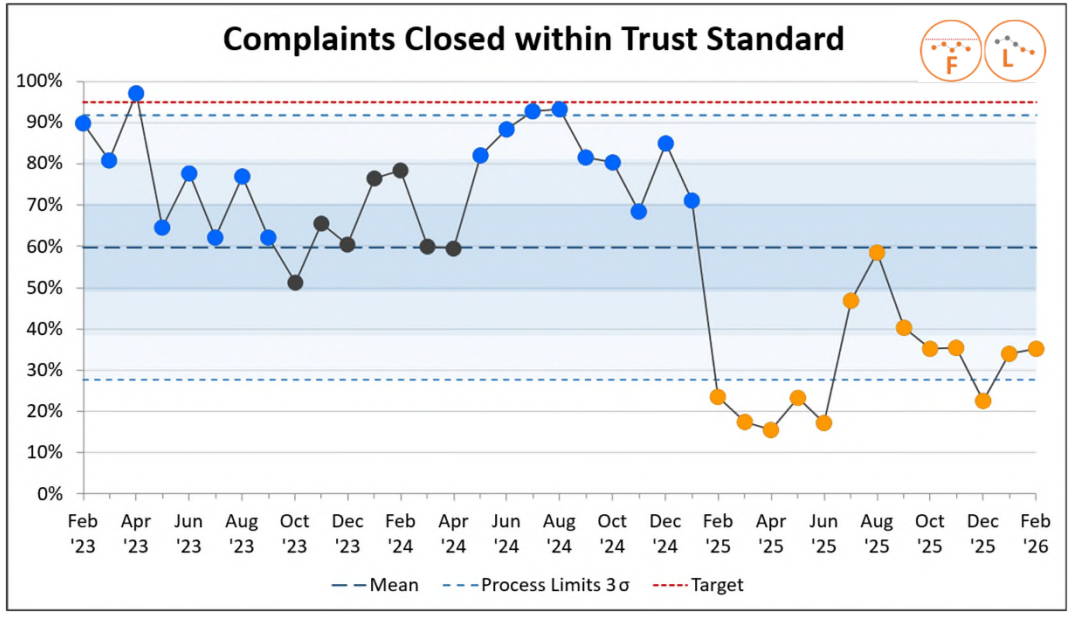


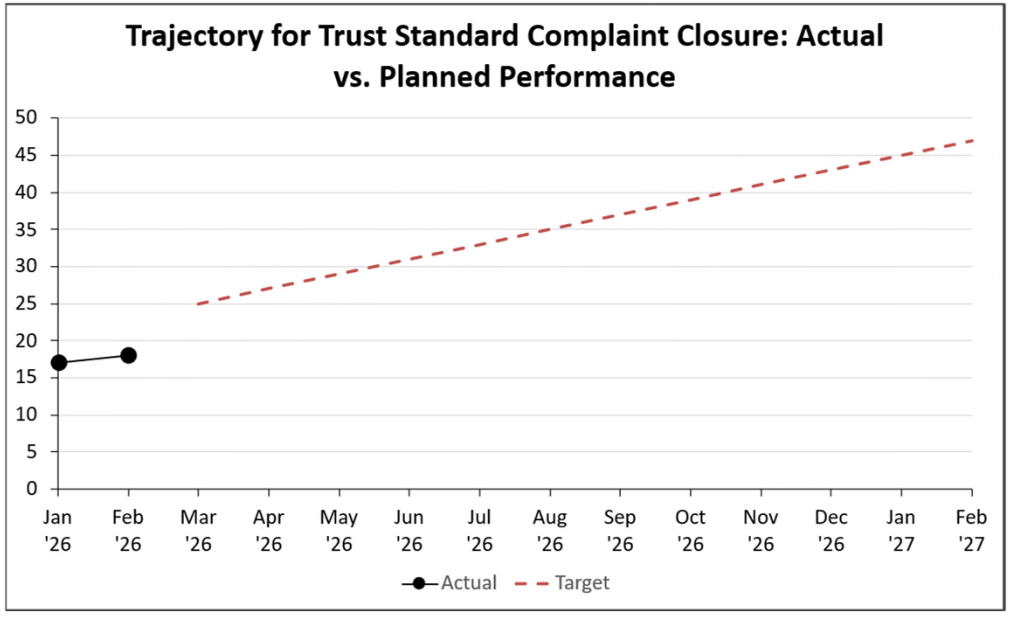
Patient Experience

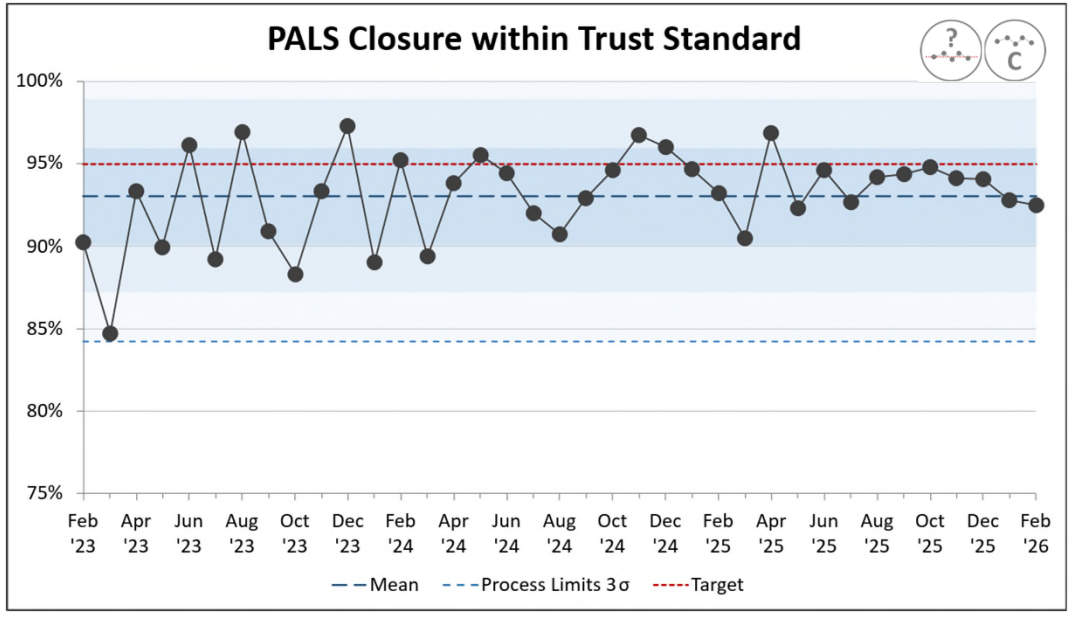
Reporting Period

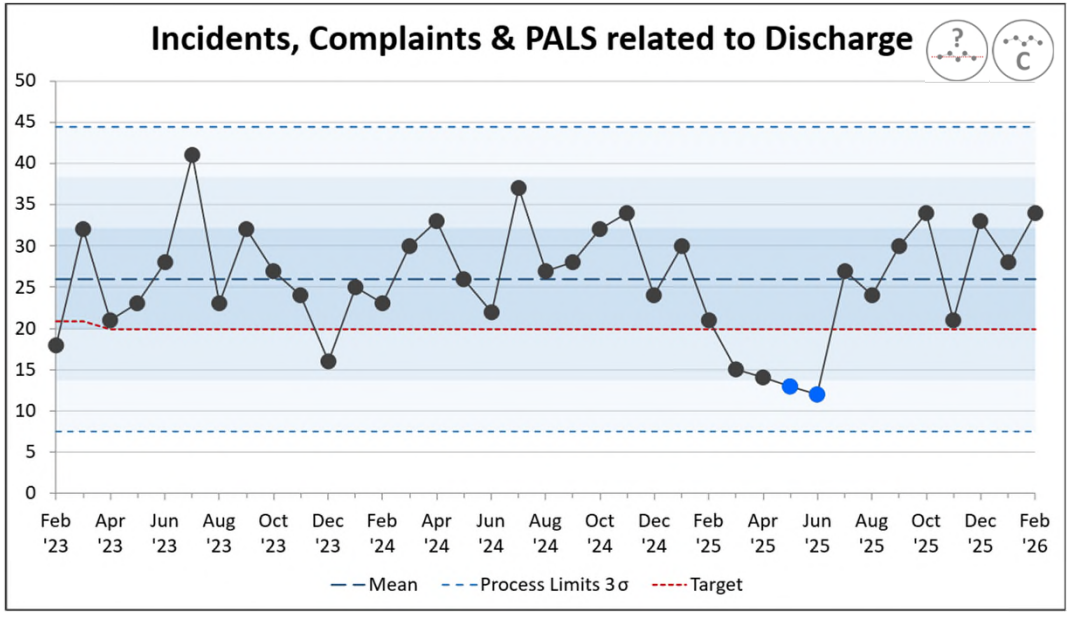
Monthly | January/February 2026

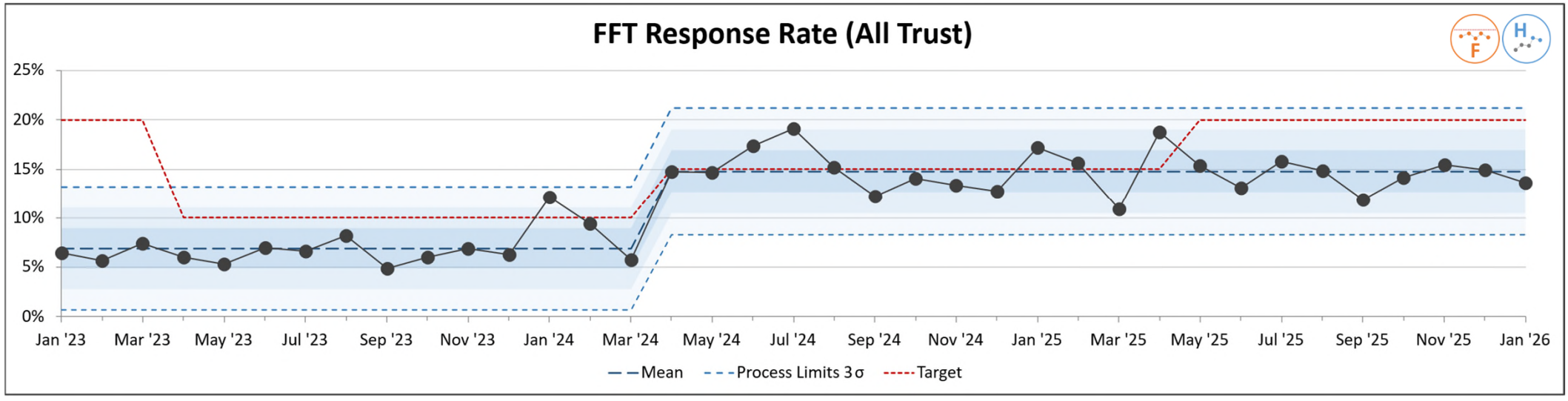
Complaints and PALS

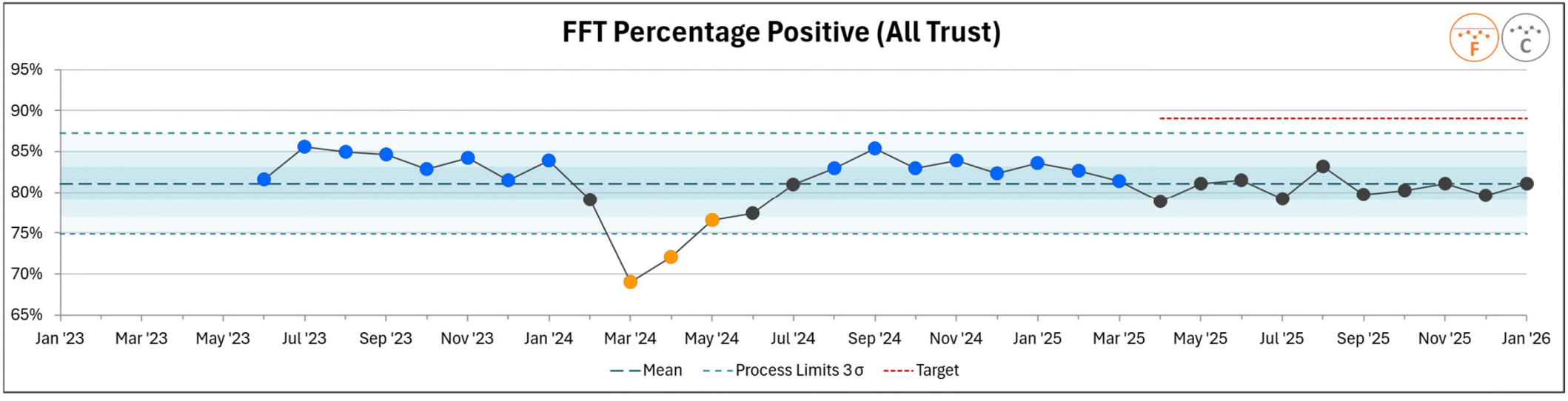












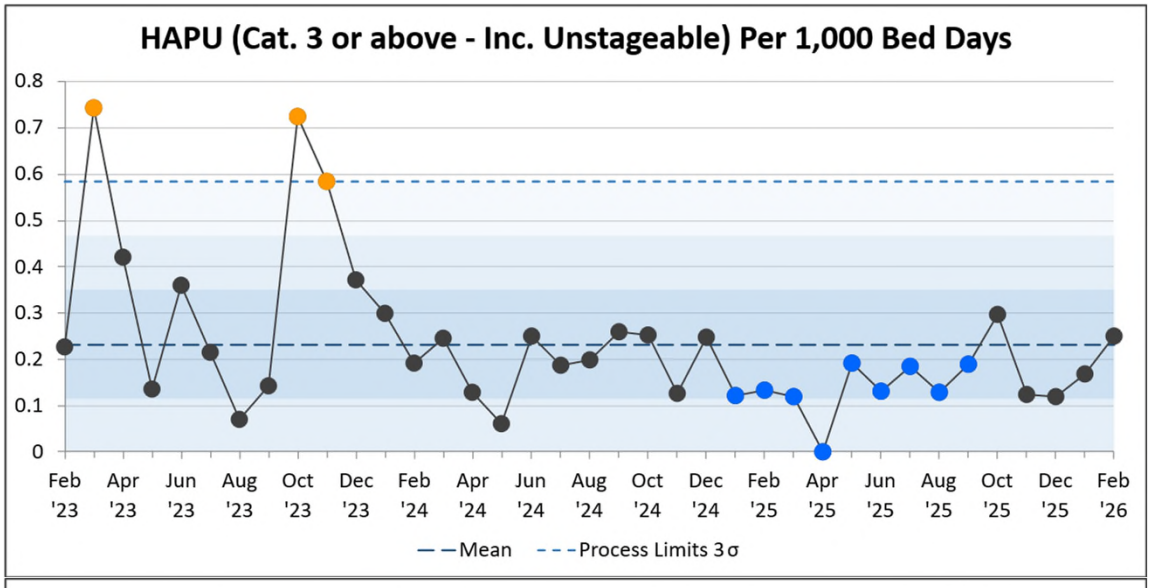
ViewPoint FFT Response Rates Split and Percentage Positive (January 2026)

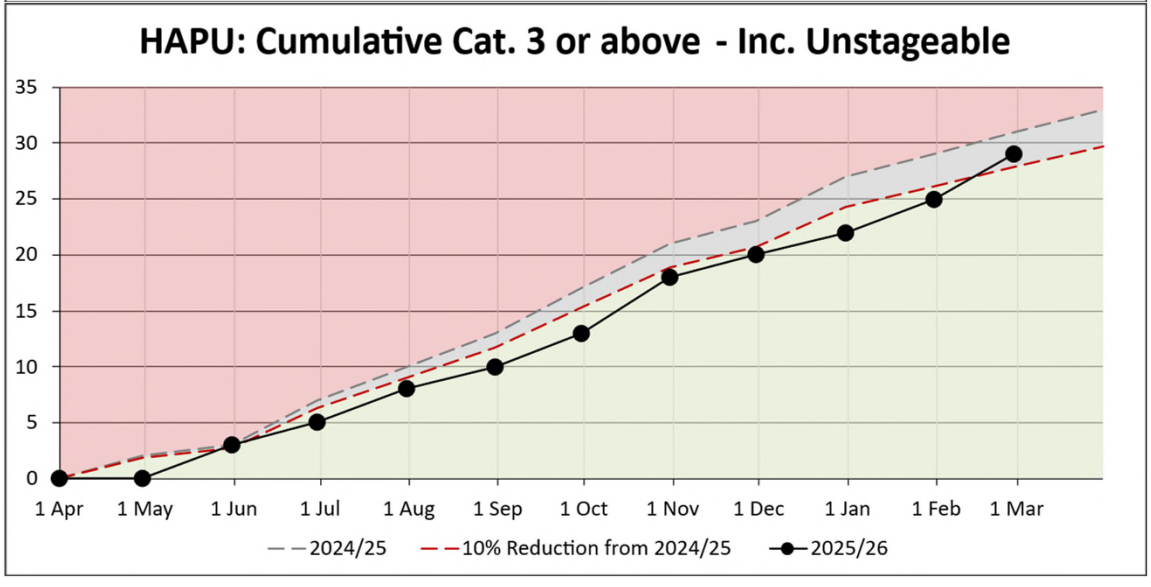
Emergency Department (ED)		Inpatients		Maternity		Outpatients	
	Positive	Response Rate	Positive	Response Rate	Positive	Response Rate	
7.5%	72.2% (up from 65%)	16.6%% (up from 15.8%)	77.4% (up from 75.6%)	63.1%	82.2%	16.3%	

Patient Experience	Reporting Period		FFT/PALS/Complaints
	Monthly	January/February 2026	

What is impacting current performance?	**Friends and Family Test (FFT);** Partial assurance • Although positive feedback increased in several areas, overall performance remains inconsistent due to low response rates linked to limited divisional engagement. **Complaints and PALS;** Partial assurance • Activity continued to be related to communication with clinical teams, appointments, and delays in diagnostic testing and results, and uncertainty regarding treatment provision. Patients often report a lack of clear information or updates regarding their care pathway, leading to requests for clarification and an increase in the number of complaints being reopened due to responses not fully addressing patient concerns. • Discharge themes continue to be driven by concerns about fitness for discharge, clarity of discharge planning, and post-discharge support / onward care. **Parliamentary and Health Service Ombudsman (PHSO);** Acceptable assurance • Activity was driven by a small number of complaints progressing to PHSO following unsuccessful local resolution attempts. One case was resolved in February through early resolution and remedy payment of £1,200 as advised by the PHSO. There are no overdue action plans. **National Surveys** • In 2026, national surveys will include Urgent and Emergency Care, Maternity and Children and Young People's. The Adult Inpatient Survey continues annually, with the 2025 survey fieldwork taking place in early 2026 and results expected in summer 2026.
What actions are being taken to improve?	• Period of enhanced oversight of improvement and performance at Divisional Governance Board meetings and Divisional Performance Review meetings. Improved complaint triage, allocation, and governance through increased collaboration with the Patient Experience Team. • Better use of Datix to support complaint management. • Staff development, including civility training, to address recurring themes. • Operational improvements: SWARM reviews, updated patient information, and "You Said, We Did" displays. • Co-design a complaints satisfaction survey with complainants to better capture their voice and understand their experience of the complaints process. • Monthly touchpoints with PHSO caseworkers ensure timely case management and effective oversight. • Results from national surveys will inform divisional improvement plans, with targeted shadow surveys developed to address the lowest-scoring areas • Standardised LfPE templates to monitor actions arising from National Patient Survey findings.
What are the timelines?	• The FFT Improvement trajectories will be mapped in the next report. • A target has been set to close two additional complaints within the Trust Standard month on month within the Trust (see chart on page 4). While this will gradually increase the total number of timely closures, the percentage achieved may fluctuate significantly because the number of complaints due to close each month varies. • Implementation of Standardised LfPE templates in Q1 2026/7 • Complaints satisfaction survey to be piloted by end Q1 2026/7
Key risks and quality impact to the trust?	• Poor patient Experience, reduced assurance on care quality, and increased regulatory and reputational risk for the Trust.

A 10% reduction in Category 3 and above hospital acquired pressure ulcers (HAPU) including unstageable, based on the 2024-2025 outturn	Reporting Period		Pressure Ulcers
	Monthly	January/February 2026	





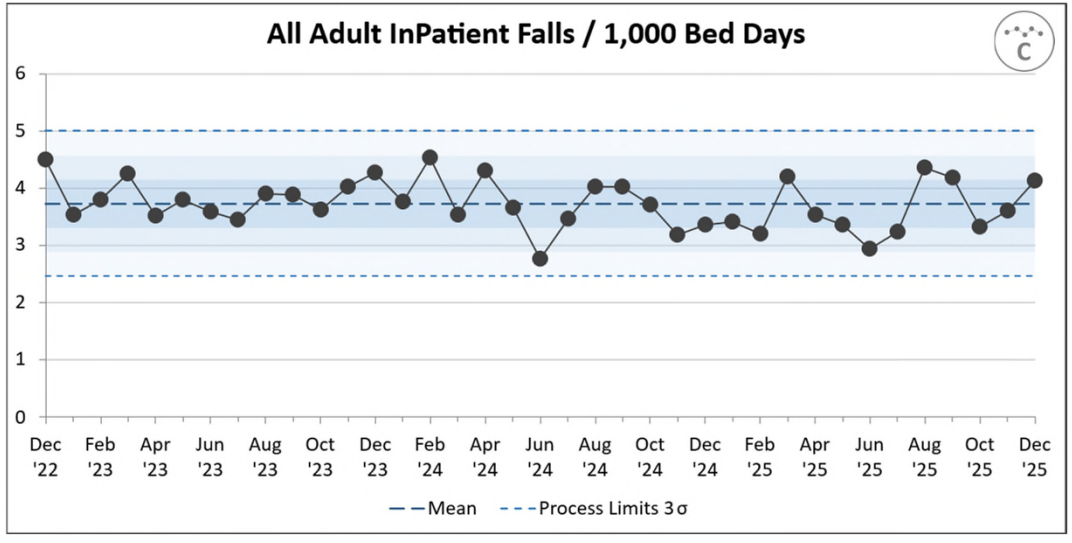
	Target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Cat3 u/s HAPU	29	0	3	2	3	2	3	5	2	2	3	2		27

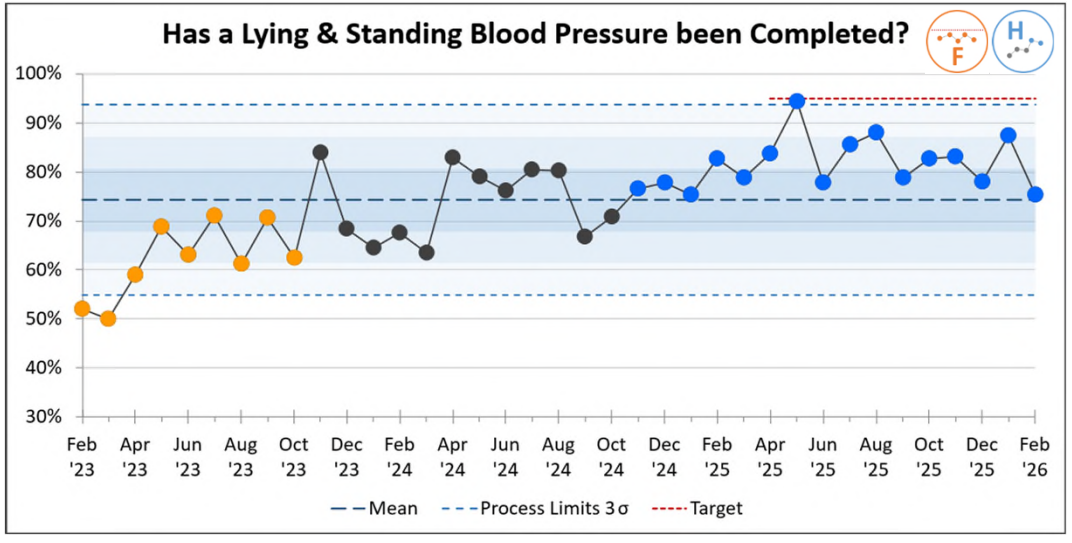
A 10% reduction in all inpatient falls based on the 2024-2025 outturn; 95-98% Lying and standing BP compliance for all ward areas

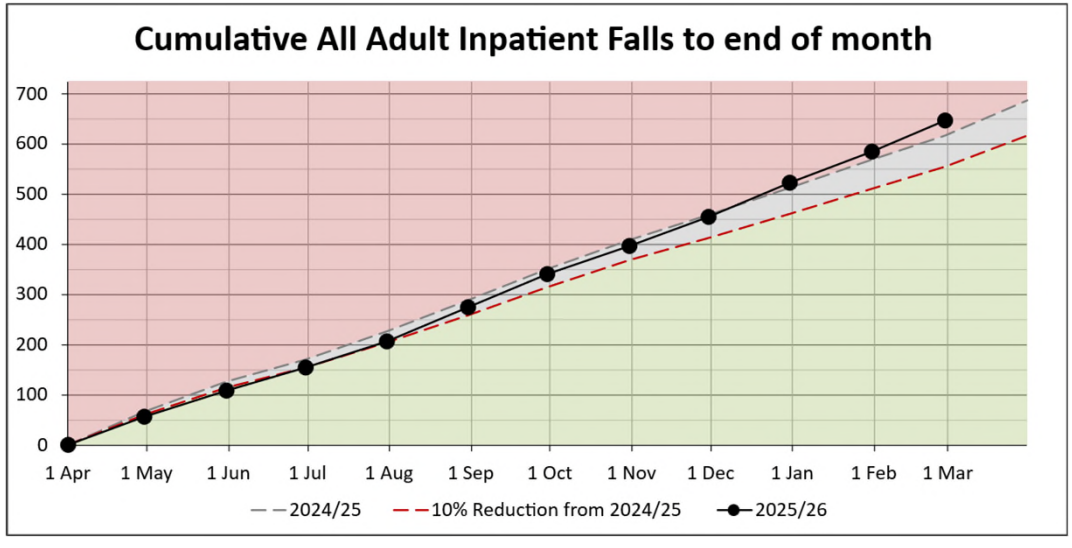
Reporting Period

Monthly | January/February 2026

Falls



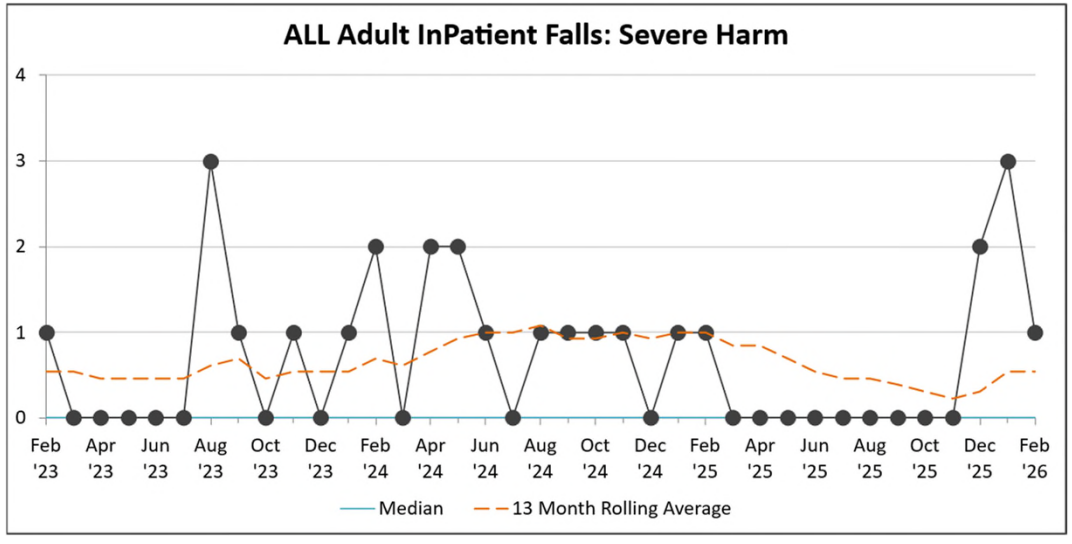


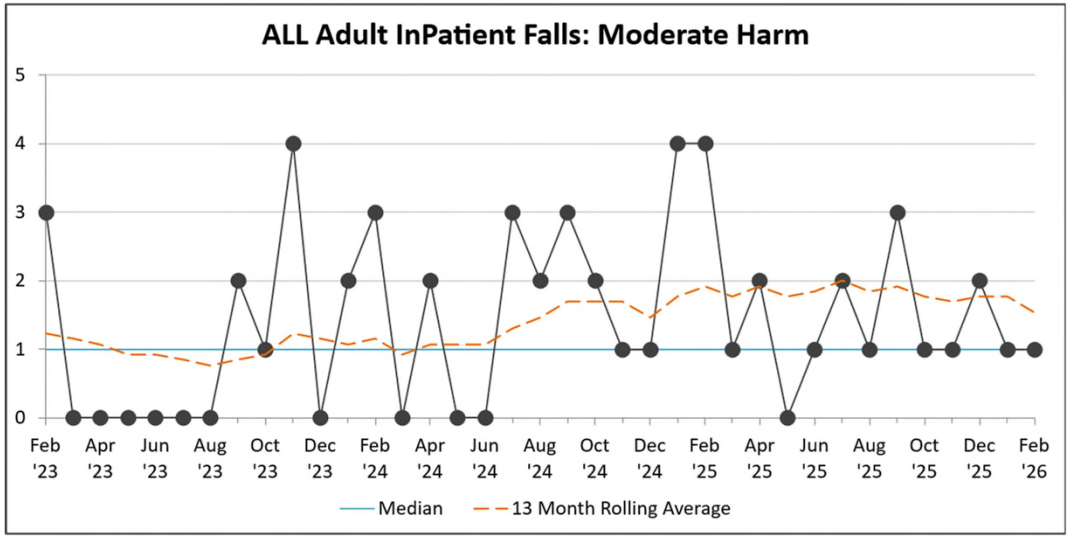


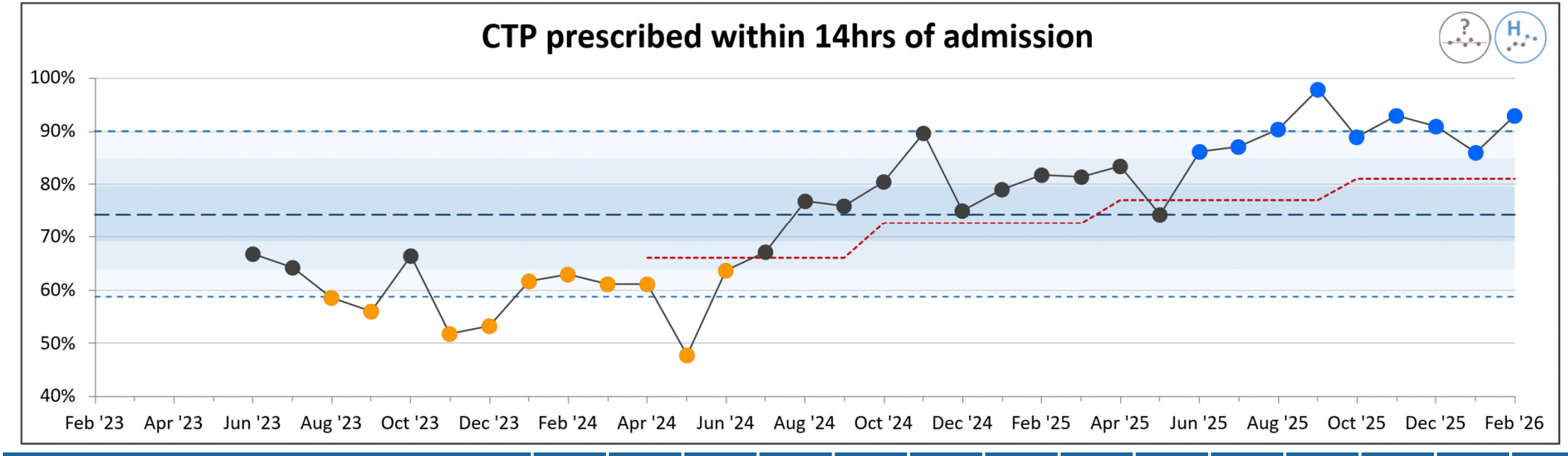
* result pending	Target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
All Falls		56	53	45	53	68	66	56	58	69	61	63		648
Mod/severe														
L & S BP compliance														

Ashford and St. Peter's Hospitals NHS Foundation Trust

5% increase in patients prescribed chemical thromboprophylaxis (CTP) within 14 hours of admission in the first 6 months of 2025-2026 from a baseline of	Reporting Period		Falls / CTP
	Monthly	January/February 2026	







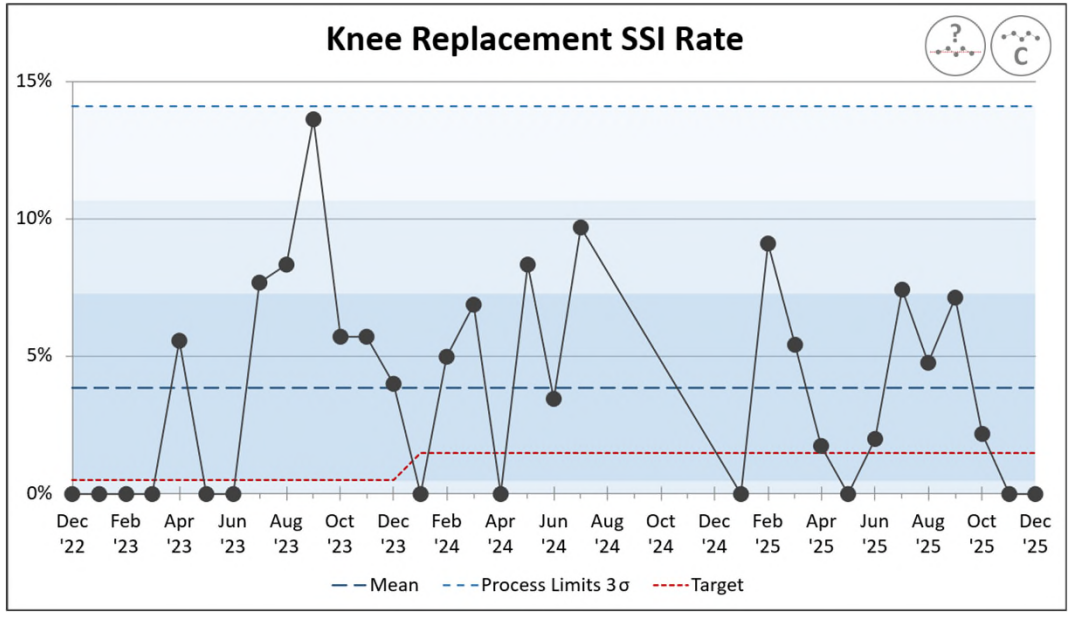
CTP PRIORITY MILESTONES	Target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Q1 and Q2 CTP prescribed within 14 hours of admission	77%	83.4%	74.4%	86.2%	87.1%	90.4%	97.9%							
Q3 and Q4 CTP prescribed within 14 hours of admission	81%							89.0%	93.0%	91.0%	86.0%	93.0%		

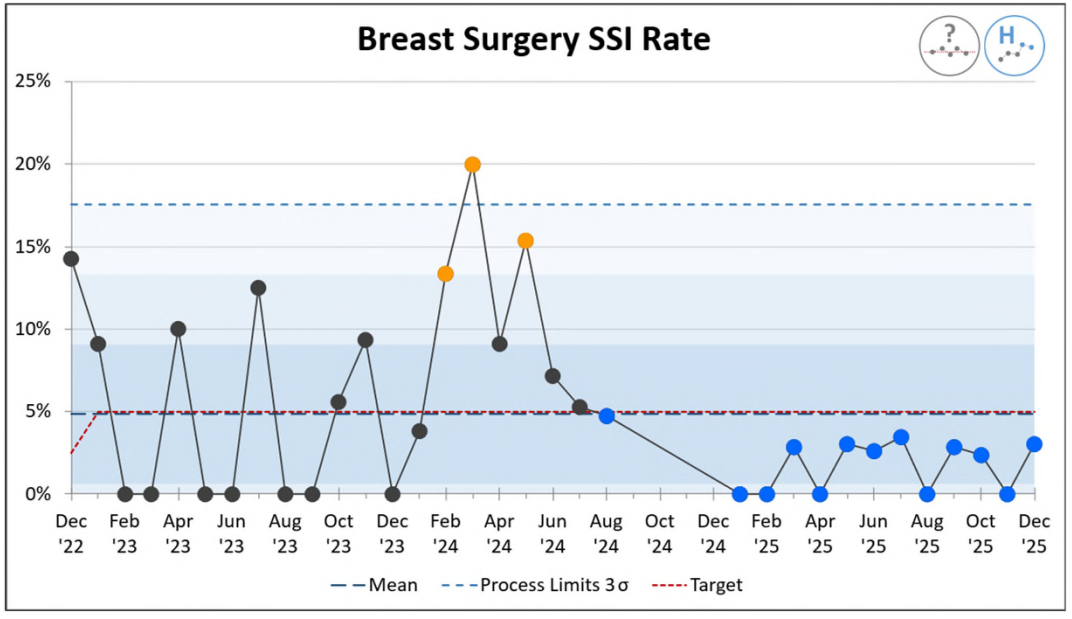
Ashford and St. Peter's Hospitals NHS Foundation Trust

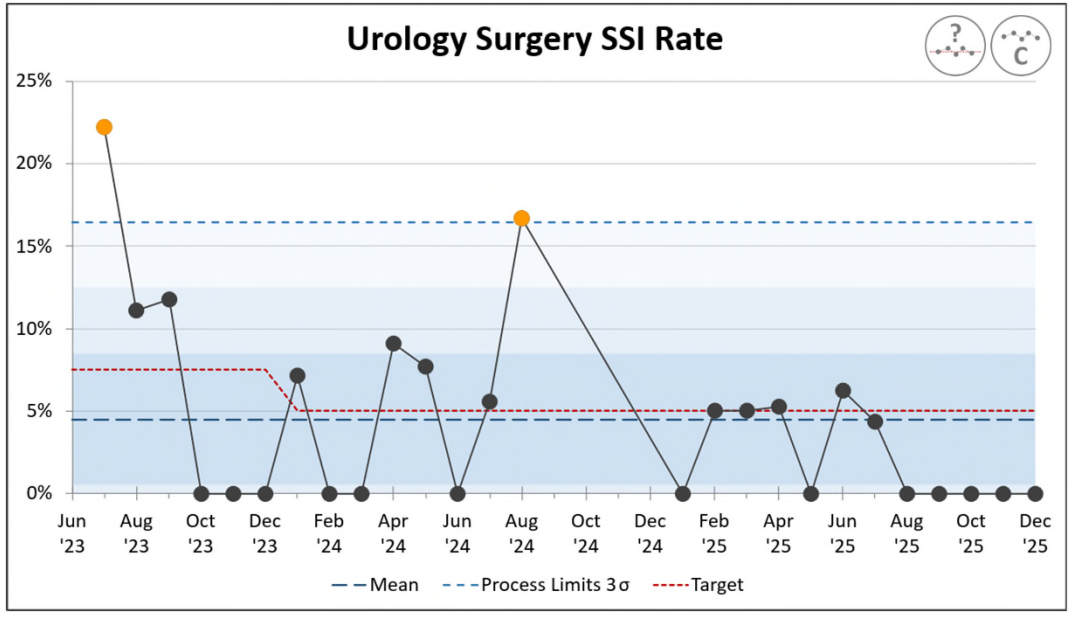
Harms Free Care	Reporting Period		PUs/FALLS/CTP
	Monthly	January/February 2026	

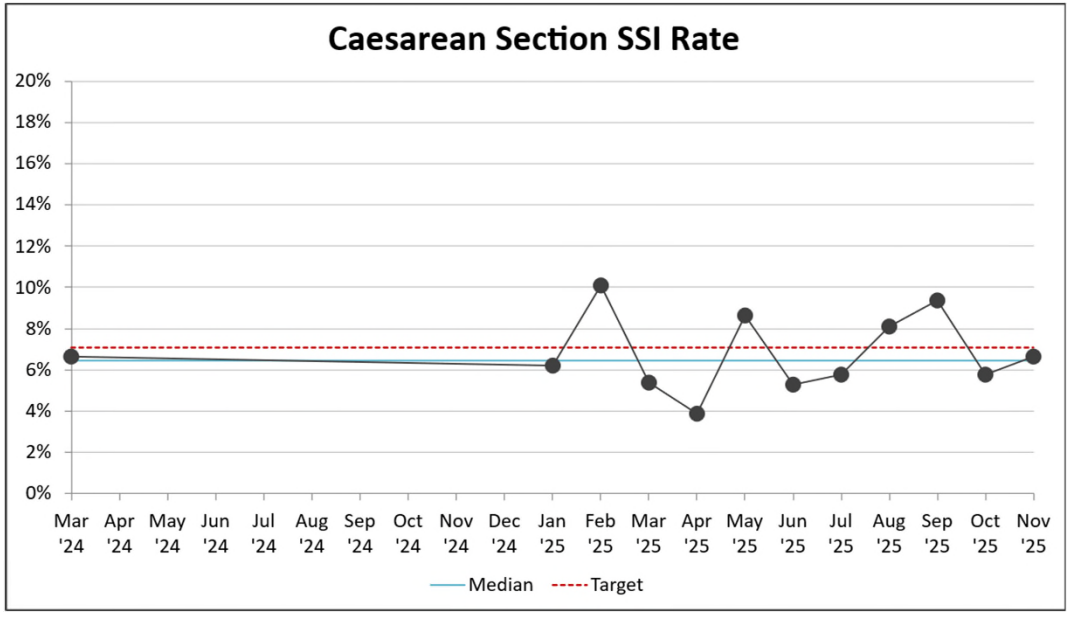
What is impacting current performance?	**Pressure Ulcers (PU);** Acceptable assurance • Key drivers include equipment shortages, inconsistent and inaccurate pressure ulcer assessments (particularly in patients with darker skin tones), missed categorisation and escalation, patient refusal linked to sub-optimal pain management, and significant operational pressures during OPEL 4 periods, all contributing to delays and gaps in harm-prevention practices. **Falls;** Partial assurance • The data reflects Trust-wide variability in applying agreed falls-prevention actions, ineffective measures for patients with complex needs, and low compliance with prevention practices—exacerbated by operational pressures. Falls with moderate and severe harm did not relate to bathrooms or lying and standing blood pressure checks, and bathroom-related falls continued to decline. **Chemical Thromboprophylaxis (CTP);** Significant assurance • Performance remains strong, driven by consistently high prescribing of chemical thromboprophylaxis within 14 hours and the full embedding of previous improvement actions. All planned actions are now complete, supporting sustained results.
What actions are being taken to improve?	• Improved 'escalation' arrangements with mattress provider to increase alternating air mattress availability • Ward spot checks monitoring quality of patient assessments; staff are required to escalate ineffectual repositioning, pain issues, or equipment needs to ensure timely review and optimisation of care. • Ward-based training by Clinical Practice Educators, using improved resources including; PU categorisation cards representing darker skin tones and wound-care models. • Ongoing recognition scheme to celebrate wards achieving zero Category 2+ HAPU, reinforcing good practice and shared learning. • Outstanding After-Action Reviews • The delivery plan for the inpatient falls deep dive is now complete, and audit scheduling will follow. • A corporate Trust-wide Falls Improvement Plan will be implemented, with progress monitored via the Safety and Quality Meeting for accountability and delivery. • Clinical areas with two or more hospital-associated harms are reviewed at the weekly Harms Free Care Team meeting, followed by delivery of ward-based, face-to-face bite-size training sessions to address identified themes, concerns, and learning needs to support staff, strengthen awareness, and implement actions that reduce the risk of further harms. • Harms Free Grand Rounds continue to share learning, discuss challenges, and agree actions related to harm prevention.
What are the timelines?	• Escalation arrangements, ward spot checks, training, harms reviews, recognition scheme, and Bi-monthly multidisciplinary Harms Free Grand Round are in place. • After Action Reviews to be completed by wards within 1 month of identified harm • Audit and falls improvement plan expected date TBC.
Key risks and quality impact to the trust?	• Increased patient harm and reduced care quality: Higher incidence of pressure ulcers leads to pain, infection risk, prolonged recovery, and reduced patient experience. • Increased external scrutiny, damage to public confidence, and affect Trust ratings. • Operational and financial impact:, with potential for longer lengths of stay, additional treatment costs, and increased staff workload, reduced efficiency and diverting resources from other priorities.

To implement the UKHSA surgical site infection programme, including post-discharge surveillance, where possible	Reporting Period		IPC
	Monthly	November/December 2025	

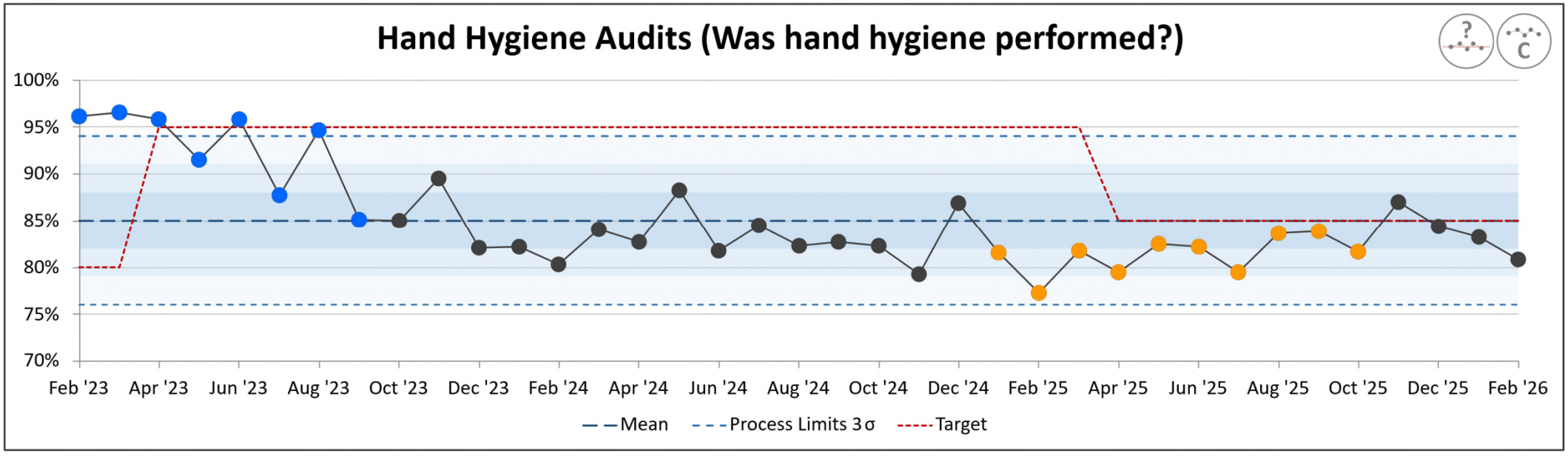


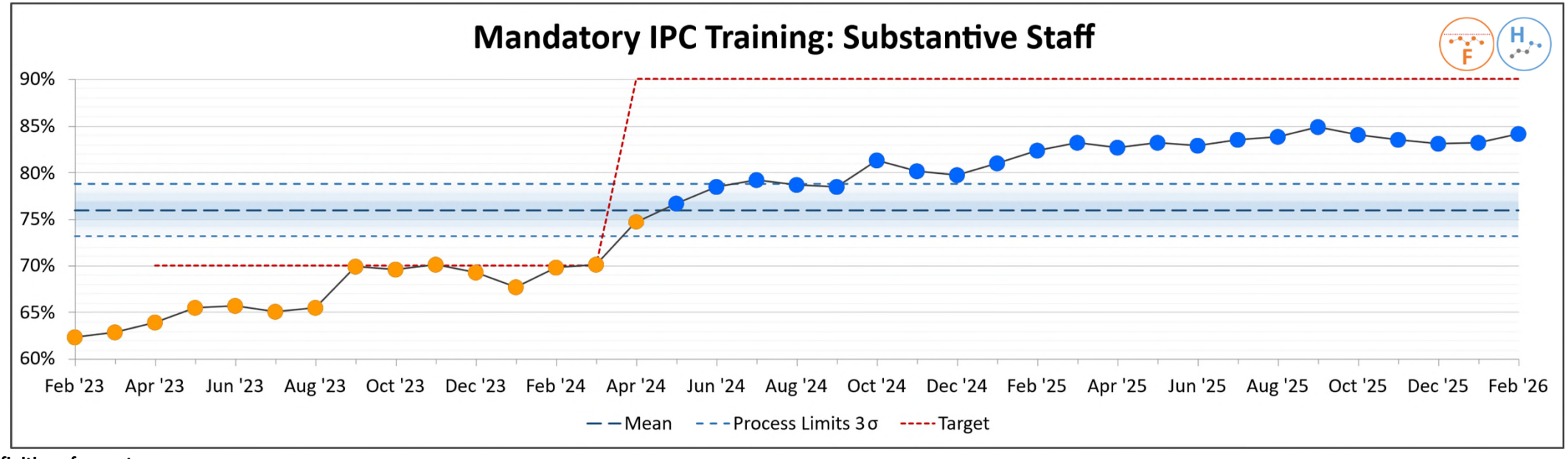






To achieve or exceed 85% compliance with the 5 moments for hand hygiene; 90% of staff will have completed IPC mandatory training by the end of 25/26	Reporting Period		IPC
	Monthly	January/February 2026	





Definitions for next page

- Hospital-onset, healthcare associated (**HOHA**) ≥3 days after admission (where day of admission is day 1)
- Community-onset healthcare-associated (**COHA**) ≤ 2 days after admission and the patient was admitted in the 28 days prior to the current episode (where day 1 is date of discharge);

Infection Prevention and Control

Reporting Period		IPC
Monthly	January/February 2026	

What is impacting current performance?	**Infection Prevention and Control (IPC);** Acceptable assurance • Two bloodstream infections (E.coli and Klebsiella spp) were assessed as likely avoidable. The source for E.coli was unclear and peripheral cannula identified as the Klebsiella spp source. Gaps were identified in catheter care documentation and cannula care practices. • The Trust exceeded its Clostridioides difficile threshold with six Trust apportioned cases in January and two in February. Of the cases reviewed all were unavoidable and three cases are still under review. • A diarrhoea and vomiting outbreak occurred, with Norovirus confirmed in several patients with early opportunities for isolation missed due to delays in recognising symptoms, notifying the nurse-in-charge, and initiating appropriate precautions. Ward learning from their previous outbreak was not embedded in practice. **Surgical Site Infections (SSIs);** Acceptable assurance • Most infections are patient-reported, identified, and treated within community settings, and are captured through the robust surveillance programme. • During the last quarter, all reported SSIs were superficial (no deep or organ/space infections, or cases returned to theatre), indicating low overall SSI severity. • The data is a positive indicator that SSI prevention strategies are being effectively implemented and utilised. • One isolated readmission occurred following a caesarean section; the SSI care bundle was completed, and the patient had higher-risk clinical factors. The patient was successfully discharged on oral antibiotics, back into community care following a 5-day readmission for intra venous (IV) antibiotics. • Knee SSI rates have stabilised with rates sustained below both the Trust target and the national United Kingdon Health Security Agency (UKHSA) benchmark. • Incidentally, variation in post-operative wound care advice across community services was identified.
What actions are being taken to improve?	• Learning is being reinforced through PSIRF swarms, targeted Aseptic Non-Touch Technique (ANTT) and IPC training, routine ward-round oversight for infection risks, and focused ward support to strengthen early recognition of diarrhoea and timely implementation of IPC precautions. • A Trust Wide Hand Hygiene Campaign will be launching in April for 3-months. • The SSI Oversight Committee was postponed due to key stakeholder availability, with plans to set objectives for the new financial year at the next meeting. • The January SSI focus group was not quorate therefore the maternity organ infection will be presented at the next meeting. • Work on the internal SSI surveillance dashboard remains paused pending release of the upgraded UKHSA database. • The Surrey Heartlands Tissue Viability Team have issued guidance internally and through the Surrey Heartlands Newsletter to improve awareness and standardise care pathways.
What are the timelines?	• PSIRF swarms, ANTT and IPC training and IPC Team ward-rounds are in place. • The next SSI Oversight Committee will be in March 2026 • The next SSI focus group will be in April 2026. • The timeline for the revised release of the UKHSA database is awaited following a system issue.
Key risks and quality impact to the trust?	• Low compliance and reduced early identification and management of infection risks an increase in healthcare-associated infections, compromised patient safety, reduced organisational compliance with national IPC requirements, and potential regulatory scrutiny. • SSIs adversely affect patient outcomes, increase length of stay and drive additional clinical and financial pressures.

Trust deploy sufficient suitably qualified competent skilled and experienced staff to meet care/treatment needs safely and effectively

Reporting Period: Monthly | February 2026

Safe Staffing

Ward name	Day								Night								Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day		Night	
	Registered Nurses/Midwives		Non registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non registered Nursing Associates		Registered Nurses/Midwives		Non registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non registered Nursing Associates			Registered Nurses/Midwives	Non registered Nurses/Midwives	Registered Nursing Associates	Non registered Nursing Associates	Registered allied health professionals	Non registered allied health professionals	Overall	Average fill rate Registered Nurses/Midwives (%)	Average fill rate Non registered Nurses/Midwives (care staff) (%)	Average fill rate Registered Nurses/Midwives (%)	Average fill rate Non registered Nurses/Midwives (care staff) (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Total	**50,015**	**47,824**	**27,647**	**27,110**	**0**	**1,070**	**1,426**	**932**	**38,808**	**38,464**	**21,135**	**25,257**	**0**	**140**	**667**	**591**	**16,833**	**5.1**	**3.1**	**0.1**	**0.1**	**0.0**	**0.0**	**8.4**	**96%**	**98%**	**99%**	**120%**
Dickens	1,380.00	1,219.00	1,035.00	1,380.00	0.00	0.00	0.00	11.50	645.00	1,128.75	322.50	1,462.00	0.00	10.75	0.00	10.75	674.00	3.5	4.2	0.0	0.0	0.0	0.0	7.7	88%	133%	175%	453%
Eliot	644.00	724.50	322.00	575.00	0.00	0.00	0.00	0.00	602.00	612.75	301.00	344.00	0.00	0.00	0.00	10.75	232.00	5.8	4.0	0.0	0.0	0.0	0.0	9.8	113%	179%	102%	114%
Aspen	2,852.00	2,633.50	1,069.50	1,219.00	0.00	0.00	0.00	0.00	2,332.75	2,107.00	999.75	1,419.00	0.00	0.00	0.00	0.00	976.00	4.9	2.7	0.0	0.0	0.0	0.0	7.6	92%	114%	90%	142%
BACU	2,495.50	2,277.00	356.50	368.00	0.00	0.00	0.00	0.00	1,999.50	1,838.25	333.25	548.25	0.00	0.00	0.00	0.00	622.00	6.6	1.5	0.0	0.0	0.0	0.0	8.1	91%	103%	92%	165%
BRAD	713.00	897.00	1,426.00	1,161.50	0.00	356.50	0.00	0.00	666.50	666.50	666.50	666.50	0.00	0.00	0.00	0.00	620.00	2.5	2.9	0.6	0.0	0.0	0.0	6.0	126%	81%	100%	100%
Cedar	1,782.50	1,794.00	1,426.00	1,253.50	0.00	0.00	0.00	0.00	999.75	1,118.00	1,333.00	1,365.25	0.00	0.00	0.00	0.00	638.00	4.6	4.1	0.0	0.0	0.0	0.0	8.7	101%	88%	112%	102%
Chestnut	2,852.00	2,633.50	2,139.00	1,897.50	0.00	11.50	0.00	0.00	2,332.75	2,128.50	1,666.25	1,827.50	0.00	0.00	0.00	0.00	1,016.00	4.7	3.7	0.0	0.0	0.0	0.0	8.4	92%	89%	91%	110%
Falcon	1,782.50	1,725.00	1,782.50	1,529.50	0.00	0.00	0.00	0.00	1,333.00	1,333.00	999.75	1,107.25	0.00	0.00	0.00	0.00	956.00	3.2	2.8	0.0	0.0	0.0	0.0	6.0	97%	86%	100%	111%
Holly	1,782.50	1,684.75	1,426.00	1,489.25	0.00	103.50	0.00	0.00	999.75	999.75	1,333.00	1,483.50	0.00	0.00	0.00	0.00	845.00	3.2	3.5	0.1	0.0	0.0	0.0	6.8	95%	104%	100%	111%
Kingfisher	1,782.50	2,323.00	1,782.50	1,541.00	0.00	0.00	0.00	0.00	1,333.00	1,838.25	999.75	1,032.00	0.00	0.00	0.00	0.00	969.00	4.3	2.7	0.0	0.0	0.0	0.0	6.9	130%	86%	138%	103%
Maple	1,782.50	2,104.50	1,426.00	1,495.00	0.00	0.00	0.00	0.00	1,333.00	1,343.75	1,333.00	1,440.50	0.00	0.00	0.00	0.00	903.00	3.8	3.3	0.0	0.0	0.0	0.0	7.1	118%	105%	101%	108%
May	1,426.00	1,219.00	1,069.50	1,035.00	0.00	161.00	0.00	0.00	999.75	978.25	999.75	978.25	0.00	0.00	0.00	0.00	589.00	3.7	3.4	0.3	0.0	0.0	0.0	7.4	85%	97%	98%	98%
Robin (SAU)	1,322.50	1,265.00	506.00	437.00	0.00	0.00	0.00	0.00	666.50	655.75	333.25	333.25	0.00	0.00	0.00	0.00	494.00	3.9	1.6	0.0	0.0	0.0	0.0	5.4	96%	86%	98%	100%
Swan	2,495.50	2,426.50	1,782.50	1,891.75	0.00	11.50	0.00	0.00	1,666.25	1,666.25	1,666.25	2,010.25	0.00	10.75	0.00	0.00	1,084.00	3.8	3.6	0.0	0.0	0.0	0.0	7.4	97%	106%	100%	121%
Ash	1,782.50	2,116.00	0.00	356.50	0.00	0.00	0.00	0.00	1,333.00	1,816.75	0.00	354.75	0.00	0.00	0.00	0.00	465.00	8.5	1.5	0.0	0.0	0.0	0.0	10.0	119%	-	136%	-
Joan Booker	1,426.00	1,337.50	1,069.50	978.00	0.00	0.00	0.00	0.00	1,333.00	1,193.25	333.25	634.25	0.00	0.00	0.00	0.00	665.00	3.8	2.4	0.0	0.0	0.0	0.0	6.2	94%	91%	90%	190%
Labour	3,208.50	3,287.00	713.00	650.50	0.00	0.00	0.00	0.00	2,999.25	3,182.00	666.50	639.63	0.00	0.00	0.00	0.00	303.00	21.3	4.3	0.0	0.0	0.0	0.0	25.6	102%	91%	106%	96%
Abbey Birth Centre	713.00	598.00	0.00	327.75	0.00	0.00	0.00	0.00	666.50	634.25	0.00	333.25	0.00	0.00	0.00	0.00	21.00	58.7	31.5	0.0	0.0	0.0	0.0	90.2	84%	-	95%	-
ITU	3,772.00	3,806.50	713.00	230.00	0.00	11.50	0.00	0.00	3,569.00	3,612.00	333.25	268.75	0.00	10.75	0.00	0.00	308.00	24.1	1.6	0.1	0.0	0.0	0.0	25.8	101%	32%	101%	81%
NICU	4,634.50	3,346.50	0.00	0.00	0.00	0.00	1,426.00	920.00	4,332.25	3,171.25	0.00	0.00	0.00	0.00	666.50	569.75	494.00	13.2	0.0	0.0	3.0	0.0	0.0	16.2	72%	-	73%	-
Swift	1,782.50	1,552.50	1,426.00	1,334.00	0.00	80.50	0.00	0.00	999.75	989.00	1,333.00	1,408.25	0.00	0.00	0.00	0.00	806.00	3.2	3.4	0.1	0.0	0.0	0.0	6.7	87%	94%	99%	106%
Cherry	1,782.50	1,460.50	1,426.00	1,288.00	0.00	115.00	0.00	0.00	999.75	999.75	1,333.00	1,494.25	0.00	0.00	0.00	0.00	682.00	3.6	4.1	0.2	0.0	0.0	0.0	7.9	82%	90%	100%	112%
CAU (AMU)	2,495.50	2,265.50	2,139.00	2,104.50	0.00	161.00	0.00	0.00	2,332.75	2,193.00	1,999.50	1,999.50	0.00	96.75	0.00	0.00	969.00	4.6	4.2	0.3	0.0	0.0	0.0	9.1	91%	98%	94%	100%
Heron	1,185.75	1,173.00	1,185.75	1,141.25	0.00	0.00	0.00	0.00	666.50	677.25	849.25	1,010.50	0.00	0.00	0.00	0.00	468.00	4.0	4.6	0.0	0.0	0.0	0.0	8.6	99%	96%	102%	119%
Willow	2,139.00	1,955.00	1,426.00	1,426.00	0.00	57.50	0.00	0.00	1,666.25	1,580.25	999.75	1,096.50	0.00	10.75	0.00	0.00	1,034.00	3.4	2.4	0.1	0.0	0.0	0.0	5.9	91%	100%	95%	110%

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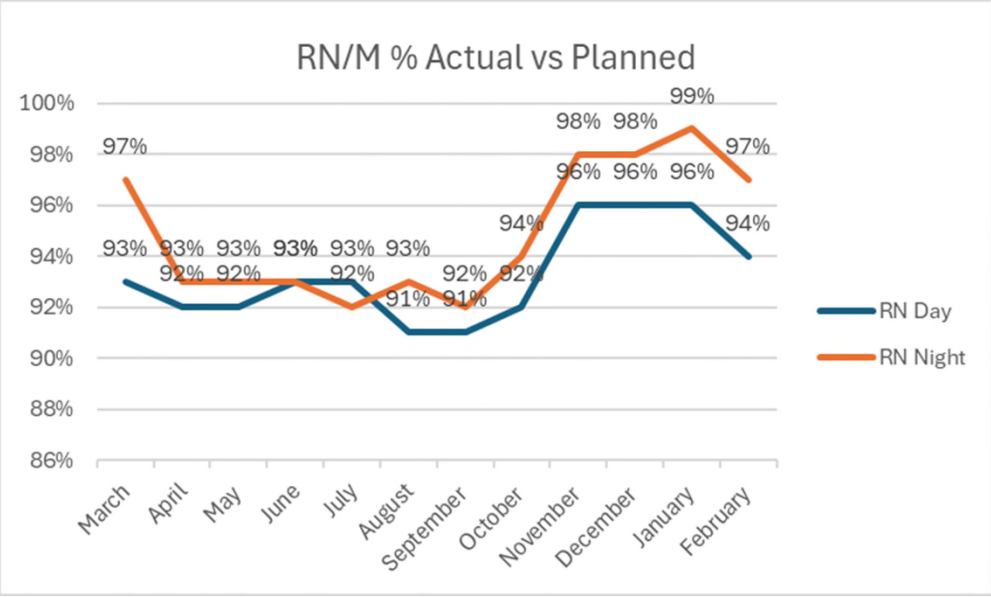
Safe Staffing

Ward name	Day								Night								Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day		Night	
	Registered Nurses/Midwives		Non registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non registered Nursing Associates		Registered Nurses/Midwives		Non registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non registered Nursing Associates			Registered Nurses/Midwives	Non registered Nurses/Midwives	Registered Nursing Associates	Non registered Nursing Associates	Registered allied health professionals	Non registered allied health professionals	Overall	Average fill rate Registered Nurses/Midwives (%)	Average fill rate Non registered Nurses/Midwives (care staff) (%)	Average fill rate Registered Nurses/Midwives (%)	Average fill rate Non registered Nurses/Midwives (care staff) (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Total	**45,070**	**42,145**	**24,922**	**23,297**	**0**	**1,104**	**1,288**	**679**	**34,959**	**33,782**	**19,049**	**21,925**	**0**	**97**	**602**	**602**	**14,904**	**5.1**	**3.0**	**0.1**	**0.1**	**0.0**	**0.0**	**8.3**	**94%**	**93%**	**97%**	**115%**
Dickens	1,242.00	805.00	931.50	667.00	0.00	0.00	0.00	23.00	580.50	526.75	290.25	440.75	0.00	0.00	0.00	0.00	217.00	6.1	5.1	0.0	0.1	0.0	0.0	11.3	65%	72%	91%	152%
Eliot	483.00	517.50	241.50	362.25	0.00	0.00	0.00	0.00	451.50	408.50	225.75	290.25	0.00	0.00	0.00	0.00	130.00	7.1	5.0	0.0	0.0	0.0	0.0	12.1	107%	150%	90%	129%
Aspen	2,576.00	2,328.75	966.00	1,092.50	0.00	0.00	0.00	0.00	2,107.00	1,773.75	903.00	1,225.50	0.00	0.00	0.00	0.00	890.00	4.6	2.6	0.0	0.0	0.0	0.0	7.2	90%	113%	84%	136%
BACU	2,254.00	2,012.50	322.00	333.50	0.00	0.00	0.00	0.00	1,806.00	1,709.25	301.00	462.25	0.00	0.00	0.00	0.00	562.00	6.6	1.4	0.0	0.0	0.0	0.0	8.0	89%	104%	95%	154%
BRAD	644.00	713.00	1,288.00	943.00	0.00	310.50	0.00	0.00	602.00	612.75	602.00	612.75	0.00	0.00	0.00	0.00	560.00	2.4	2.8	0.6	0.0	0.0	0.0	5.7	111%	73%	102%	102%
Cedar	1,610.00	1,552.50	1,288.00	1,092.50	0.00	0.00	0.00	0.00	903.00	946.00	1,204.00	1,214.75	0.00	0.00	0.00	0.00	628.00	4.0	3.7	0.0	0.0	0.0	0.0	7.7	96%	85%	105%	101%
Chestnut	2,576.00	2,369.00	1,932.00	1,863.00	0.00	23.00	0.00	0.00	2,107.00	2,128.50	1,505.00	1,763.00	0.00	10.75	0.00	0.00	910.00	4.9	4.0	0.0	0.0	0.0	0.0	9.0	92%	96%	101%	117%
Falcon	1,610.00	1,529.50	1,610.00	1,506.50	0.00	0.00	0.00	0.00	1,204.00	1,193.25	903.00	1,032.00	0.00	0.00	0.00	0.00	859.00	3.2	3.0	0.0	0.0	0.0	0.0	6.1	95%	94%	99%	114%
Holly	1,610.00	1,742.25	1,288.00	1,288.00	0.00	115.00	0.00	0.00	903.00	1,182.50	1,204.00	1,397.50	0.00	0.00	0.00	0.00	749.00	3.9	3.6	0.2	0.0	0.0	0.0	7.6	108%	100%	131%	116%
Kingfisher	1,610.00	1,610.00	1,610.00	1,529.50	0.00	0.00	0.00	0.00	1,204.00	1,333.00	903.00	1,075.00	0.00	0.00	0.00	0.00	871.00	3.4	3.0	0.0	0.0	0.0	0.0	6.4	100%	95%	111%	119%
Maple	1,610.00	1,897.50	1,288.00	1,345.50	0.00	0.00	0.00	0.00	1,204.00	1,150.25	1,204.00	1,397.50	0.00	0.00	0.00	0.00	811.00	3.8	3.4	0.0	0.0	0.0	0.0	7.1	118%	104%	96%	116%
May	1,288.00	1,173.00	966.00	989.00	0.00	115.00	0.00	0.00	903.00	903.00	903.00	989.00	0.00	0.00	0.00	0.00	532.00	3.9	3.7	0.2	0.0	0.0	0.0	7.8	91%	102%	100%	110%
Robin (SAU)	1,196.00	1,173.00	460.00	402.50	0.00	0.00	0.00	0.00	602.00	602.00	301.00	301.00	0.00	0.00	0.00	0.00	473.00	3.8	1.5	0.0	0.0	0.0	0.0	5.2	98%	88%	100%	100%
Swan	2,254.00	2,162.00	1,610.00	1,414.50	0.00	23.00	0.00	0.00	1,505.00	1,494.25	1,505.00	1,526.50	0.00	0.00	0.00	0.00	977.00	3.7	3.0	0.0	0.0	0.0	0.0	6.8	96%	88%	99%	101%
Ash	1,610.00	1,886.00	0.00	299.00	0.00	0.00	0.00	0.00	1,204.00	1,526.50	0.00	322.50	0.00	0.00	0.00	0.00	432.00	7.9	1.4	0.0	0.0	0.0	0.0	9.3	117%	-	127%	-
Joan Booker	1,288.00	1,196.50	966.00	755.00	0.00	0.00	0.00	0.00	1,204.00	1,161.00	301.00	585.88	0.00	0.00	0.00	0.00	668.00	3.5	2.0	0.0	0.0	0.0	0.0	5.5	93%	78%	96%	195%
Labour	2,898.00	2,930.50	644.00	571.00	0.00	0.00	0.00	0.00	2,709.00	2,778.88	602.00	591.25	0.00	0.00	0.00	0.00	306.00	18.7	3.8	0.0	0.0	0.0	0.0	22.5	101%	89%	103%	98%
Abbey Birth Centre	644.00	598.00	0.00	253.00	0.00	0.00	0.00	0.00	602.00	505.25	0.00	301.00	0.00	0.00	0.00	0.00	18.00	61.3	30.8	0.0	0.0	0.0	0.0	92.1	93%	-	84%	-
ITU	3,404.00	3,105.00	644.00	161.00	0.00	0.00	0.00	0.00	3,225.00	2,924.00	301.00	193.50	0.00	0.00	0.00	0.00	235.00	25.7	1.5	0.0	0.0	0.0	0.0	27.2	91%	25%	91%	64%
NICU	4,186.00	2,932.50	0.00	0.00	0.00	0.00	1,288.00	655.50	3,913.00	2,762.75	0.00	0.00	0.00	0.00	602.00	602.00	456.00	12.5	0.0	0.0	2.8	0.0	0.0	15.2	70%	-	71%	-
Swift	1,610.00	1,357.00	1,288.00	1,207.50	0.00	195.50	0.00	0.00	903.00	903.00	1,204.00	1,182.50	0.00	0.00	0.00	0.00	728.00	3.1	3.3	0.3	0.0	0.0	0.0	6.7	84%	94%	100%	98%
Cherry	1,610.00	1,299.50	1,288.00	1,046.50	0.00	172.50	0.00	0.00	903.00	903.00	1,204.00	1,247.00	0.00	0.00	0.00	0.00	636.00	3.5	3.6	0.3	0.0	0.0	0.0	7.3	81%	81%	100%	104%
CAU (AMU)	2,254.00	2,035.50	1,932.00	1,840.00	0.00	149.50	0.00	0.00	2,107.00	1,999.50	1,806.00	1,773.75	0.00	86.00	0.00	0.00	875.00	4.6	4.1	0.3	0.0	0.0	0.0	9.0	90%	95%	95%	98%
Heron	1,071.00	1,045.50	1,071.00	1,001.00	0.00	0.00	0.00	0.00	602.00	602.00	774.00	903.00	0.00	0.00	0.00	0.00	443.00	3.7	4.3	0.0	0.0	0.0	0.0	8.0	98%	93%	100%	117%
Willow	1,932.00	2,173.50	1,288.00	1,334.00	0.00	0.00	0.00	0.00	1,505.00	1,752.25	903.00	1,096.50	0.00	0.00	0.00	0.00	938.00	4.2	2.6	0.0	0.0	0.0	0.0	6.8	113%	104%	116%	121%

Trust deploy sufficient suitably qualified competent skilled and experienced staff to meet care/treatment needs safely and effectively	Reporting Period		Safe Staffing
	Monthly	January/February 2026	



NICU Clinical Areas	December		January		February	
	Day	Night	Day	Night	Day	Night
NICU – RN target >80% fill rate	76%	73%	72%	73%	70%	71%
Sickness rates	5.5%		4.1%		Unavailable	
Safe Staffing Related Datix	0		0		0	

BAPM Guideline for NICU Nurse Staffing	Ratio	Cot numbers agreed at Network	BAPM RN Staffing requirement (100% Occupancy)
ITU	1:1 (QIS Band 5 or 6)	8	9
HDU	1:2 (Non-QIS Band 5's)	8	4
SCBU	1:4 (B4 and 5's)	12	3

Maternity Clinical Areas	January		February	
	Day	Night	Day	Night
Joan Booker (antenatal/postnatal ward)	94%	90%	93%	96%
Labour Ward/Triage	102%	106%	101%	103%
Abbey Birth Centre	84%	95%	93%	84%

NICU	Establishment	WTE	Vacancy
Band 5	17.17	23.05	+5.88 wte (34%)
Band 6	41.04	28.65	12.39 wte (30%)
Band 7	12.29	10.79	1.5wte (12%)

1:1 Care in active labour – Target 100%

Description	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
# instances - Any occasion when one midwife is not able to provide continuous one-to-one care and su	0	0	0	0	0	0	0	0	0	0	0	0
Total number of instances	155	160	162	161	167	167	164	156	159	141	148	120
% of instances - Any occasion when one midwife is not able to provide continuous one-to-one care and s	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

Labour ward coordinator with supernumerary status – 100%

Description	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
# instances - Labour Ward Co-ordinator not supernumerary	0	0	0	0	0	0	0	0	0	0	0	0
Total number of instances	158	160	161	161	167	167	164	156	159	141	148	120
% of instances - Labour Ward Co-ordinator not supernumerary	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Trust deploy sufficient suitably qualified competent skilled and experienced staff to meet care/treatment needs safely and effectively	Reporting Period		Safer Staffing
	Monthly	January/February 2026	

The data presents care hours per patient day, average percentage fill rates against planned and where these vary from acceptable KPIs an exception report narrated by the DCNs. This submission sets out to support evidence of planning, right skills and detection of red flags.
Key KPIs drawn out in the exception report include CPPD less than 6 hours, percentage fill rate less than 90% (of concern), percentage fill rate of less than 80% (requires focussed action).

What is impacting current performance?	**Safe Staffing;** Acceptable assurance • In January only one area reported planned to actual fill rates of <80%. NICU continues to be challenged with fill rates. • In February, excluding NICU, only one area reported a planned-to-actual fill rate below 80%. • Dickens Ward functioned as an escalation area during the month, and staffing levels were appropriate for the acuity and dependency of the patients. • Overall staffing fill rates exceeded 90% after mitigation. However, attention is drawn to specific areas where fill rates fell below 80%. The winter period has had significant challenges, with additional care areas opened and substantive staff requiring re-deployment to ensure areas were safe. • Sickness absence levels in January were not a concern, with most areas reporting rates below 3%. Hotspots identified as NICU, Cherry, and SDEC, though these are showing improvement and continue to be monitored through the NMAHP scrutiny meeting. This comparison uses December data, as February figures are not yet available. While some areas are still rated red, overall sickness levels are declining, indicating a positive improving trend. • Red flag reporting demonstrated ongoing improvement throughout January and February, with the DCN review confirming no associated harm incidents in both months. <u>Of note</u>, the following areas reported reduced HCSW/MSW fill rates: • ITU - HCSW staffing is allocated based on patient numbers and the acuity and dependency levels within the unit. • Bradley unit - currently over-established for RN posts, resulting in an additional RN being rostered on shifts in place of an HCA. • Joan Booker - MSWs are in the ABC template, this is under review.
What actions are being taken to improve?	• Merger of Dickens and Eliot templates • Drive 95 initiative aimed at achieving a substantive fill rate of over 95% in ward areas; is being monitored through the NMAHP Workforce Scrutiny process. • Areas reporting fill rates above 100% are reviewed through the Workforce Scrutiny meeting. These higher levels generally relate to Enhanced Care, for which a business case is in place to support the development of a substantive workforce. • Review of the implementation Safer Staffing policy. • PM safer staffing huddles are now established, though consistent attendance still requires targeted attention and will be overseen via the NMAHP Workforce Scrutiny Meeting. • Transition to Allocate twill support more timely data capture and provide accurate acuity and dependency information to inform twice-daily staffing discussion.
What are the timelines?	• Work is progressing well with full implementation of Allocate is planned for August. • Merger of Dickens and Eliot templates will occur as part of budget setting therefore we will not see this change until April 2026. • Safer Staffing policy Review scheduled for this month.
Key risks and quality impact to the trust?	• If the Trust is unable to deploy sufficient, suitably qualified, competent, skilled and experienced staff, there is an increased risk of unsafe or delayed care, reduced service effectiveness, and potential harm to patients.

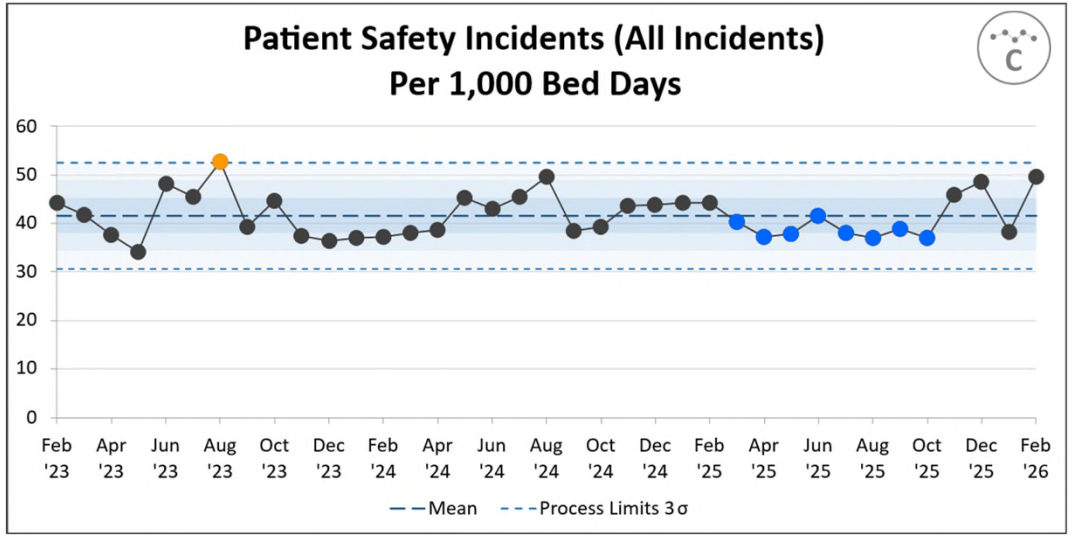
Trust deploy sufficient suitably qualified competent skilled and experienced staff to meet care/treatment needs safely and effectively	Reporting Period		Maternity
	Monthly	January/February 2026	

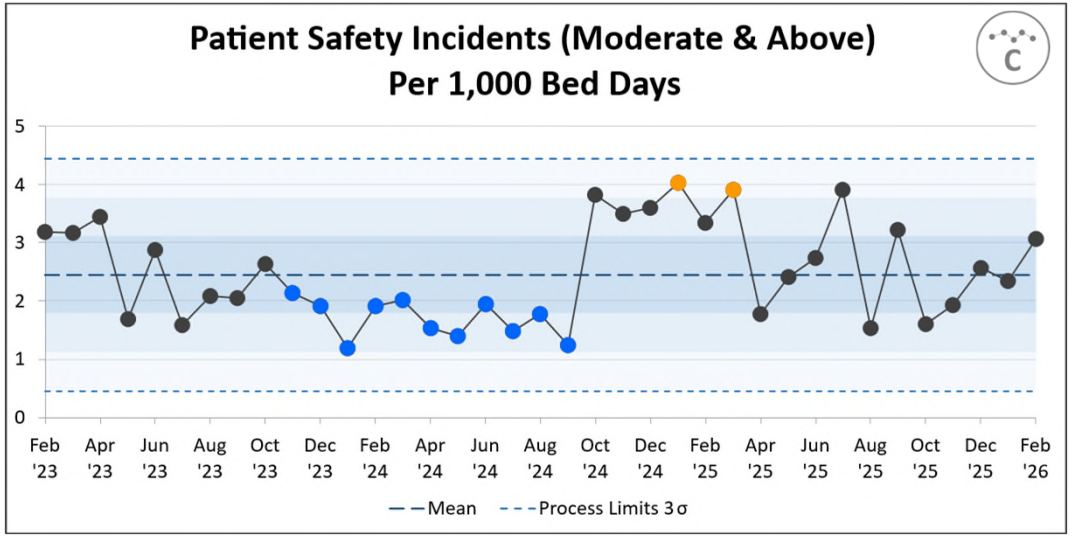
What is impacting current Maternity performance?	**Maternity Safe Staffing;** : High level assurance with ongoing mitigations • Rosters are completed in accordance with the Trust Roster Policy. • Labour ward is currently showing a fill rate of over 100%. • The second Band 7 (Maternity Operations Coordinator) role was previously supernumerary. However, since November 2025, this role has been incorporated into the clinical midwifery numbers. • A Birthrate Plus review is currently underway to inform the required midwifery establishment. Until this work is completed in March 2026, the labour ward template will continue to reflect a fill rate of >100% when the second Band 7 is on duty. • The Abbey Birth Centre (ABC) is showing a fill rate of < 90% for the day shift in Jan and the night shift in Feb. • ABC is a midwifery led unit caring for low-risk women and there are not always women suitable for admission. • During periods of high acuity elsewhere and low activity on ABC midwives are redeployed to support other areas. However, when a suitable woman presents, a midwife is allocated most of the time to provide care on ABC. Any instance where a suitable woman is unable to access ABC is reported via Datix and investigated. Until the ongoing work to increase births and improve birth centre utilisation is realised (anticipated by August 2026), this approach will continue.
What actions are being taken to improve?	• Daily staffing review via the 09:30 Maternity Safety Huddle with dynamic redeployment and escalation arrangements to maintain safe care delivery. • Quality indicators compliance are expected to be maintained, including 100% 1:1 care in established labour and 100% Labour Ward Co-ordinator supernumerary status with a reduction in staffing red flags events. • Improved consistency in fill rates is expected from May 2026 following completion of the Birth Rate Plus assessment by 31 March 2026
NICU Safe Staffing	**Alert:** • Vacancy factor of Band 6 QIS nurses affecting substantive fill rate. **Advise:** • NICU OPEL Score Guideline is used to guide safe staffing and occupancy of the unit. Average unit occupancy runs at 60% • Qualified In Speciality (QIS) trained nurses are band 6 & above caring for intensive care level patients – largest vacancy rate includes non direct care roles. • Agency nurses increase fill rate and support safer staffing across ITU and HDU. • Sickness rate is for the whole of NICU, not nursing specific. **Assure:** • Safe staffing levels reviewed at daily Trust Safety huddle and again at start of night shift. • Nursing Staff are re-deployed from Ash ward to cover activity where possible, with non-clinical staff supporting and supplementing clinical numbers when needed. • Improved fill rates have been achieved by escalating shifts from bank to agency. Recent agreement to approve this up to 4 weeks in advance. • Rosters continue to be completed as per roster policy • Active over recruitment at band 5 to 'grow our own' and 3 Band 5's promoted to Band 6 post as from February 2026. • Maximum number of QIS students (6) supported to complete ITU course every year. • Unit safe-staffing process followed when there are gaps in BAPM recommendations and fill rate, and a triangulation spreadsheet is in progress to monitor BAPM compliance, unit status according to OPEL score, and refusal of in-utero and ex-utero transfers (IUTs/EUTs). • All ASPH woman were delivered at ASPH and not transferred out for care elsewhere.

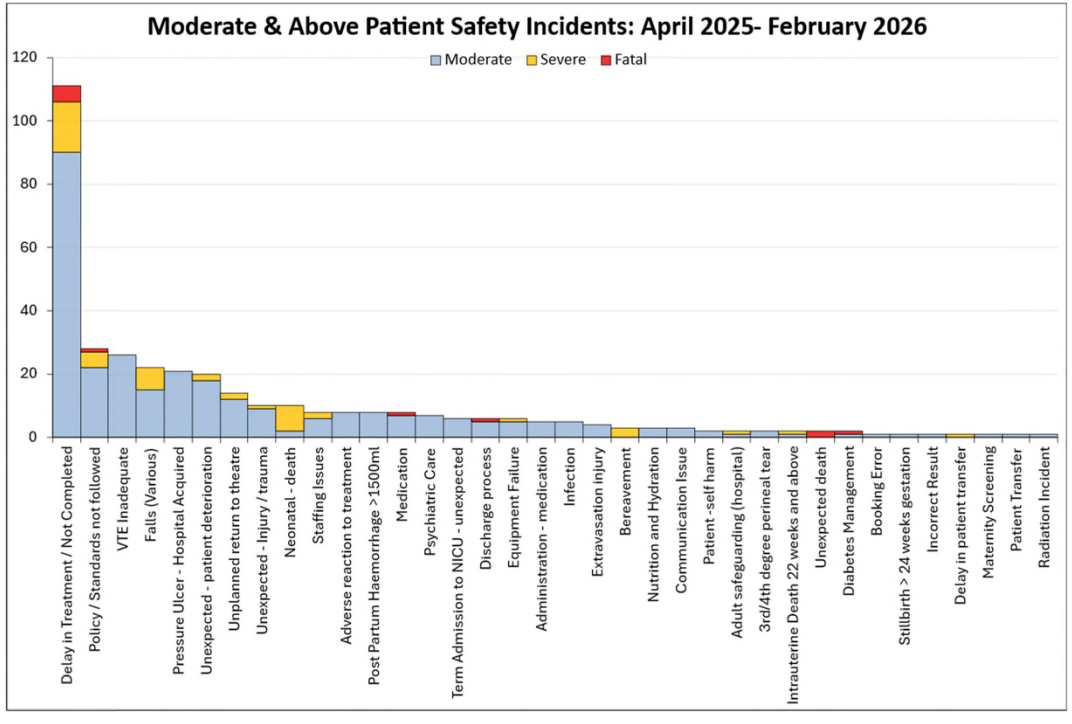
Reported Patient Safety Incidents – Moderate and Above Harm (see also Mat/Neo Report for WHP)

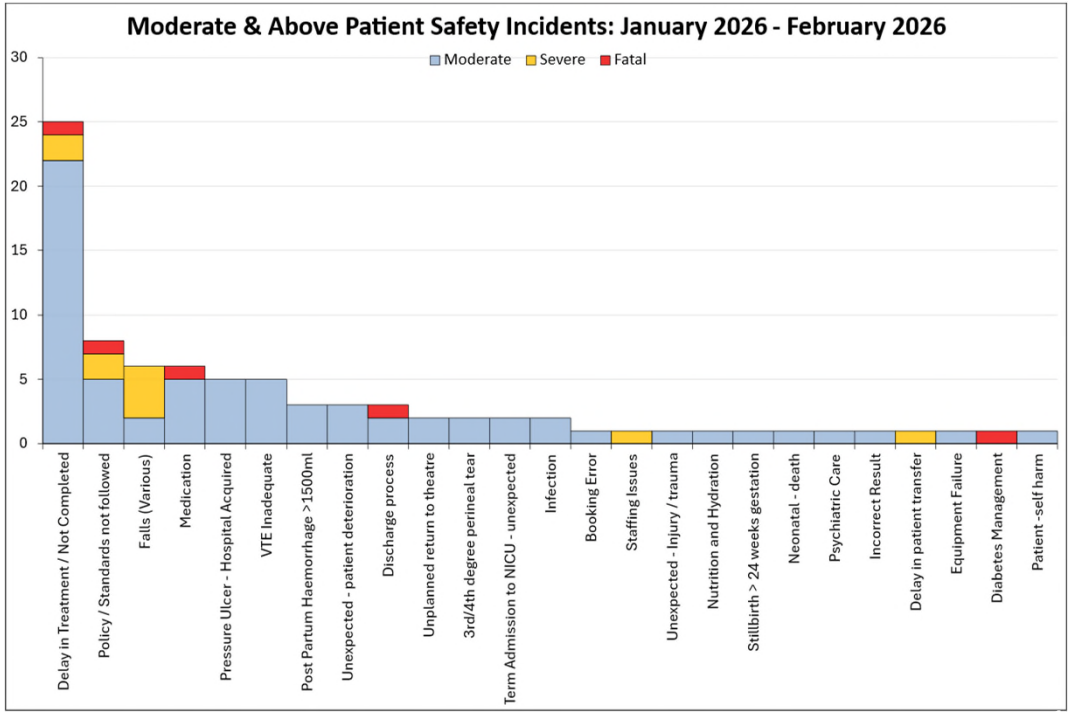
Reporting Period	
Monthly	January/February 2026

Patient Safety









NB: Cumulative charts do not include incident reports relating to ED Care in Escalation Areas. The volume of incidents from escalation areas (e.g., corridor care) is disproportionately high and would skew the data, masking other trends. Data relating to ED escalation areas is presented separately in other reports.

Reported Patient Safety Incidents – Moderate and Above Harm (see also Mat/Neo Report for WHP)	Reporting Period		Patient Safety
	Monthly	January/February 2026	

What is impacting current performance? What actions are being taken to improve?

Assurance level: Partial Assurance

73 incidents graded as moderate or above harm (January and February 2026)

Never Event

A stylet was not removed from a vascath and was left in the patient. No harm was caused to the patient and this incident's level of harm will likely be downgraded following completion of the learning response. After action review to be completed.

Fatal Harm Incidents - Seven incidents (involving eight patients) were reported and are under investigation.

Four relate to care in UEC, two relate to care in GSACT and one relates to care in SSMSK.

One patient died following complications of an elective procedure. Three patients had a potential treatment delay / incorrect treatment whilst in ED (under different specialities). Two patients died shortly after discharge from ED – potential unsafe discharges and missed diagnosis. Two patients died following step down from ITU, with potential inappropriate step down and delayed recognition and management of deterioration.

Severe Harm Incidents – six incidents were reported and five under investigation and one has been completed.

Four relate to patient falls in GSM (n=3) and UEC (n=1). Two patient sustained a fractured neck of femur, and one sustained a subarachnoid haemorrhage. One sustained a trochanteric fracture and has sadly since died. A coroner's referral has been made for this case and learning response completed. The learning response identified several learning points and associated safety actions including:

- Unfilled one to one supervision should be escalated and mitigated with ward staff and/or Baywatch. Baywatch principles must be followed correctly - ward based teaching on falls prevention and the principles of bay watch.
- The correct post fall procedure was not followed – ward-based teaching on post fall procedures
- The patient was medically optimised for discharge but remained in hospital for a significant period awaiting an appropriate community package of care - Implementation of weekly MDT discussion of complex long stay patients and identification of an escalation process for complex patients refused by multiple care homes.

Moderate Harm Incidents – themes

Treatment issues were the most reported – all under investigation. One patient, who was transferred to Ashford during the critical incident in January 2026, deteriorated and required transfer to St George's Hospital for neurosurgery. Five patients experienced treatment delays which resulted in a deterioration in their condition requiring further interventions – two of these patients experienced delays in the Emergency Department.

Missed/delayed diagnosis and Post Partum Haemorrhage (PPH) were the second most reported.

Three missed/delayed diagnosis incidents occurred within UEC, one in GSM and one in WHP – all under investigation. Two cases related to missed/delayed cancer diagnosis.

Five incidents of PPH over 1500mls were reported – all under investigation.

Reported Patient Safety Incidents – Low and No Harm

Reporting Period	
Monthly	January/February 2026

Patient Safety

What is impacting current performance? What actions are being taken to improve?

Assurance level: Partial Assurance

- 1382 incidents reported as no/low harm in January and February 2026, accounting for 95% of the safety incidents reported
- January saw a decrease in total reporting of no and low harm incidents, followed by an increase in February. February also saw an increase in reported incidents per 1000 bed days; these are likely linked to an increase in incident reports for prolonged stays in ED and corridor care.

Themes in low and no harm (for hospital acquired pressure ulcers and falls, please see harms free care pages)**:**

Treatment Issues – 107 incidents

- 33 patients experienced treatment delays. This was most reported in WHP (n=13), GSM (N=10) and UEC (n=10). No themes/trends noted across these areas.
- 49 patients had treatment which did not follow the correct policy / pathway. This was most reported in WHP (n=22), GSM (N=11) and SSMSK (n=6). No themes/trends noted across these areas.

Medicine Administration – 39 incidents

- These incidents mostly occurred in GSM – three incidents occurred on the infusion suite, two of which were reactions to medicines administered. No other themes or trends noted.

Challenging Behaviour – 38 incidents

- These incidents mostly occurred in SSMSK (n=13), with eight on Heron ward all relating to one patient, and five on Swan ward with three relating to one patient.

Equipment issues – 30 incidents. No themes or trends identified.

Prescribing – 29 incidents.

- 9 patients had incorrect prescriptions at the time of their discharge. No other themes or trends identified.

Patient Transfer Delays – 28 incidents

- These incidents predominantly relate to delays in admitting patients to a ward bed from ED, Recovery and Cardiac Catheter Laboratory during the sustained period of OPEL 4 and critical incident.

Psychiatric Care – 28 incidents

- All these incidents were reported in UEC, and themes include challenging behaviour of patients awaiting psychiatric assessment and patients absconding/leaving the department ahead of psychiatric assessment.

Emerging Risks: Cervical Screening Samples

- Since 2022, 214 cervical screening samples which have been taken at GP practices have never been received at the BSPS Cytology laboratory. These samples are from across the entire HPV primary screening patch which extends from Kent - Dorset and Hampshire/IOW up to Oxfordshire. It has not been possible to identify the reasons for the lost samples in over half of the cases. SIAFs (Screening Incident Assessment Forms) were raised and submitted to NHSE, at the time each incident was identified and actions worked through with the GP practices and laboratory. There is no sample tracking in place therefore it was not possible to confirm if the samples ever left the GP practice, if they were received at the hub hospitals (for onward transfer to BSPS Cytology lab) or arrived at the BSPS cytology lab.

National and Local Safety Priorities, and Learning Responses - PSIIs

Reporting Period	
Monthly	January/February 2026

Patient Safety

Datix Ref	Criteria	Division	Due Date	Update
W118251	Failure to recognise or escalate a deteriorating patient	WHP	23/04/2025	Overdue – awaiting divisional approval and then to be reviewed at EPSIP.
W124825	Failure to recognise or escalate a deteriorating patient	WHP	22/09/2025	Overdue – ongoing investigation
W125420	Death thought more likely than not due to problems in care or service delivery	GSACT	1/10/25	Overdue – ongoing investigation with external reviewer input. Interim report to EPSIP 13 th March 2026
W127412	Emerging Risks Treatment delays	GSACT	20/11/2025	Overdue – draft report with patient and clinical teams.
W129303	Never Event - Incorrect implant	GSACT / SSMSK	16/01/2026	Overdue – draft report with clinical teams
W121226	Emerging Risks Treatment delays – cord compression	UEC / GSM / SSMSK	21/01/2026	Overdue – ongoing investigation
W131129	Death thought more likely than not due to problems in care or service delivery	GSM	5/3/26	Overdue – ongoing investigation
W132268	Never Event - – Wrong patient given intravitreal injection	SSMSK	20/04/2026	Ongoing – within timescale
W133127	Never Event – retained guidewire	GSACT	07/05/2026	Ongoing – within timescale

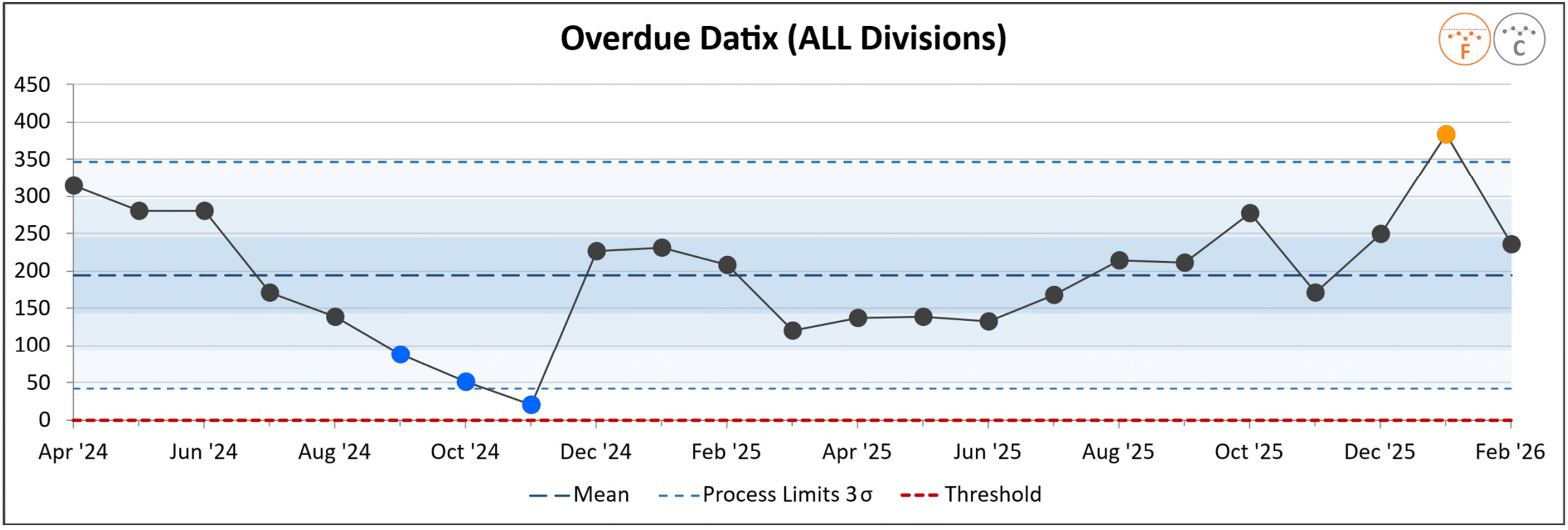
Month	Number of PSIIs commenced	Number of PSIIs signed off
Apr	0	0
May	0	0
Jun	4	1
Jul	0	1
Aug	1	0
Sep	0	1
Oct	2	1
Nov	1	1
Dec	0	0
Jan	2	0
Feb	0	0

What is impacting current performance?	**Assurance level: Partial Assurance** • One Patient Safety Incident Investigation (PSII) was commenced in January 2026 for a never event of a retained guide wire • No PSIIs were completed during this period. No PSIIs were completed due to inconsistent divisional engagement, difficulty securing panel members, and reduced Patient Safety Team capacity following unfilled posts and lost planned resource. These gaps severely limited timely PSIRF investigations.
What actions are being taken to improve?	• PSII investigations should be completed within 60 working days, as set out in the Trust's PSIR Plan 2024-2026, which is under review. NHSE does not mandate a national timescale, but recommend no longer than 6 months. • Improved timeliness requires strengthened divisional ownership earlier identification of panel members, securing protected time for clinical staff. and reviewing workload/prioritisation within the Patient Safety Team.

Overdue Patient Safety Incidents

Reporting Period	
Monthly	January/February 2026

Patient Safety



What is impacting current performance? What actions are being taken to improve?	**Overdue Patient Safety Incidents;** Partial Assurance

- The numbers of overdue incidents across all divisions remains high except for UEC who are below their target (see the next page for Divisional charts).
- All divisions (except SSMSK) have made good progress in reducing their overdue incidents in February 2026.
- GSM have reduced their overdue incidents by over 50% in February following the commencement of the Quality and Safety Matron.
- UEC overdue incidents increased significantly in January 2026 due to the redeployment of their Quality and Safety matron to provide support during the protracted period of OPEL 4 and critical incident within the department. However, they have successfully reduced these by 50% in February 2026 and are back below their target threshold.
- WHP have reduced their overdue incidents by 40% in February 2026. However, continue to have the highest number of overdue incidents across the Trust.
- GSACT have reduced their overdue incidents by over 30% and DTC have reduced their overdue incidents by over 23%. Both following a concerted effort from the divisions to review, investigate and close incidents in a timely manner, supported by the central safety team.
- SSMSK have the lowest number in total of overdue incidents across the Trust but has seen this continually increased since November 2026. The division intends to focus on reducing this throughout March 2026.

PSIRF safety priorities and transition plan 25/26

Reporting Period: Monthly | January/February 2026

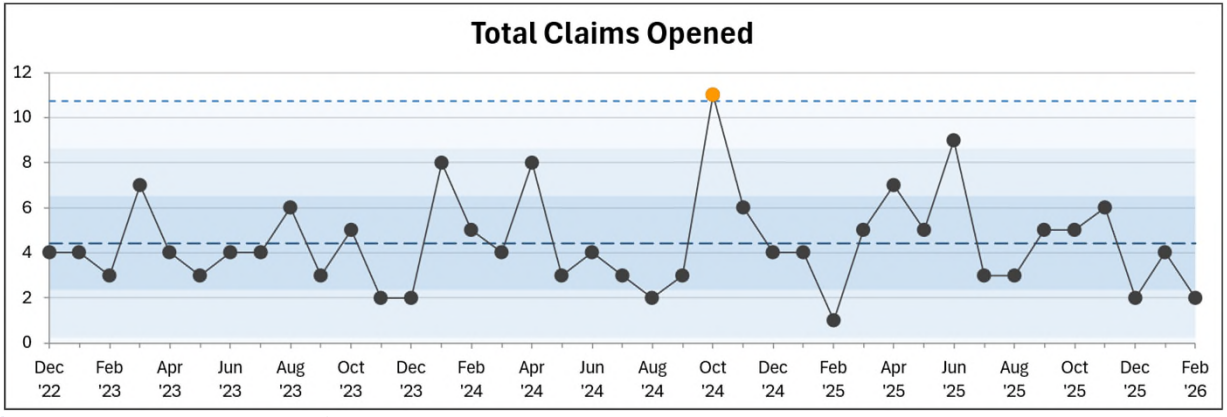
Patient Safety

PSIRF TRANSITION KPIs 2025-26	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Verbal Duty of Candour (DoC) completed for moderate and above harm incidents (By month incident reported)	100%	100	100	94	100	92	100	100	100	89	79	73
Number of verbal DoC outstanding		0	0	GSM: 1	0	DTC: 1		0	0	DTC: 2 GSACT: 1	GSACT:2 SSMSK: 1 UEC: 1 WHP:1	GSACT: 6 UEC: 3 WHP: 1
Written DoC completed for moderate and above harm incidents (By month incident reported)	100%	100	83	70	100	83	86	71	100	63	**50**	**18**
Written DoC completed within 10 days of identification of moderate and above harm incidents. (By month incident reported)	100%	**20**	**23**	**38**	**24**	**33**	**10**	**29**	**0**	**30**	**25**	**9**
Feedback to those affected (patients/families) within 10 days of a completed learning response for moderate and above harm incidents (by month completed) (completed responses only) *all incidents closed	95%	**80***	**50***	**40**	**53**	**38**	**59**	**50**	71	**50**	100	100
Final amendments of PSII reports within 10 working days of EPSIP approval (by month of approval)	100%	N/A	N/A	100	100	N/A	100	100	100	N/A	N/A	N/A
Level 1 Safety Syllabus compliance Trust wide	95%	83	84	84	86	86.5	87	87	87.5	87.5	86	86
PSII investigation actions include a test of effectiveness (where appropriate) (by month of approval at EPSIP)	100%	N/A	N/A	100	100	N/A	100	100	100	N/A	N/A	N/A
PSII safety actions not completed within the agreed timescale (by month due for completion)	0	0	0	0	0	0	2	0	0	2	0	0
PSII investigations have a named engagement lead (newly commenced PSIIs)	100%	N/A	N/A	100	N/A	100	N/A	100	100	N/A	100	N/A
PSII investigations have patient/family support needs documented at the time of agreeing ToR (by month PSII commenced)	100%	N/A	N/A	100	N/A	100	N/A	100	100	N/A	100	N/A

What is impacting current performance?	**Duty of Candour (DoC);** Partial assurance • Completion of verbal and written DoC has been significantly impacted by the sustained operational pressures experienced and high volume of moderate and above safety incidents reported in Dec 2025 (n= 30), Jan (n=29) and Feb 2026 (n=40). (April –Nov 2025 averaged 15 moderate and above safety incidents per month). • GSM has made good progress in reducing their overdue DoCs since the Quality and Safety Matron commenced in post. **Level 1 Safety Syllabus;** Partial assurance • Mandatory safety syllabus training had been slowly increasing towards the target but has unfortunately dropped slightly in January and February 2026. Of those non-compliant, medical and dental staff are the largest group (n=256) with 93 being locum staff and 32 being substantive consultants. Estates accounts for 154 staff who are non-complaint, and administrative staff account for 129 non-compliant staff. 92 nursing and midwifery staff are non-compliant with 28 of these being bank staff, and 33 being from WHP Division. • L1 Safety Syllabus is available for all staff as e-leaning, as well as being offered face to face at Trust Induction and update days. Face to face training has also been offered for individual teams who may have difficulty accessing these. **PSIRF Update;** Partial assurance • The Trust Patient Safety Incident Response Plan (PSIRP) and Policy is currently under review, and is due for publication in April 2026, outlining the Trust's safety priorities for 2026-2028. • The PSIRF gap analysis is being updated and will be published alongside the PSIRP 2026-2028. • Duty of Candour Masterclasses have been offered Trustwide, as well as bespoke sessions for induvial services and teams. • The PSIRF gap analysis is being updated and will be published alongside the PSIRP 2026-2028. • Learning response templates have been updated and circulated. • Datix has been upgraded to taxonomy 6 of Learning from Patient Safety Events (LfPSE) **Martha's rule;** Partial Assurance • Deteriorating Patient Clinical Lead appointed and due to commence in post in April 2026. • Martha's Rule Clinical Project Lead appointed – start date to be confirmed. • Patient Wellness Questionnaire trialled on Heron ward. • Patient Wellness Questionnaire (PWQ) recording in the Electronic Patient Record (EPR)–developed with RSCH
What actions are being taken to improve?	• PSIRF training needs analysis for 2026-2028 to be written • Work to commence on feedback from incidents • Further Datix optimisation ongoing and joint procurement project for an integrated governance system with RSCH. • PWQ trial roll out to other wards • PWQ recording in EPR to be trialled • Escalation by patient, family and staff – pathways to be developed

Clinical Claims and Learning From Inquests

Reporting Period		Patient Safety
Monthly	January/February 2026	



What is impacting current performance? What actions are being taken to improve?

Clinical Claims; Partial assurance

- Six new letters of clinical claims were received in January and February 2026.
- (2 are high value, 4 are low value). Both high value claims received follows a patient safety incident and related to GSM Division.
- Five letters of notification of claim were received. Three have been rejected by NHSR as they do not meet their reporting requirements. One medium value case has been accepted by NHSR and relates to a patient safety incident in UEC division. One low value case is awaiting a decision from NHSR and relates to care in WHP Division (no associated incident or complaint).

Closed claims

The launch of NHS Resolution's (NHSR) new case management system has limited the Trust's access to detailed information on closed claims, as the system does not yet provide the level of granular data required for reporting. The Trust is waiting for NHSR to develop internal processes to be able to share the data required. They have not provided a timescale for this.

Inquests; Significant assurance

- Four inquests were concluded in January and February 2026.
- No Prevention of Future Deaths Reports were received by the Trust.
- Two inquests were closed with no learning or actions for the Trust.
- Two inquests were closed with learning and actions for the Trust.

Case Summary and Coroner's Conclusion	Learning identified and action taken
A patient undergoing total hip revision surgery experienced a delay in recognising significant blood loss, later developed a bowel perforation, and died 10 days post-operatively. The Coroner concluded that the death was contributed to by neglect.	• Internal review of trauma unit guidelines for periprosthetic fracture management was undertaken. • Historical cases of periprosthetic fractures were reviewed. • A new Peri-Prosthetic Fracture Pathway was developed with clinical and safety improvements. • The new pathway has been embedded into the surgical pathway.
A patient undergoing a Percutaneous Coronary Intervention became hypotensive and bradycardic, sustained a cardiac arrest, and sadly did not survive despite prolonged resuscitation. The Coroner concluded that the death resulted from a rare but recognised complication of a necessary elective cardiac procedure.	• The Coroner raised concerns that the patient had not received written information about the procedure and its risks. • The cardiology team developed a patient information leaflet for coronary angiogram and angioplasty, explaining the purpose, benefits and risks of the procedures, which will be provided at the patient's initial cardiology consultation.

Open National Patient Safety Alerts

Reporting Period		Patient Safety
Monthly	January/February 2026	

NatPSA/2023/013/MHRA: Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. Due to the known significant risk of serious harm to a baby after exposure to valproate in pregnancy, these measures aim to ensure valproate is only used if other treatments are ineffective or not tolerated. **Alert closure due 31/01/2024**	
Actions and Assurance	• Surrey Heartlands Valproate Implementation Group progressing system wide action plan. • Alert cannot be closed until all identified patients reviewed with a robust recall system. • National and local barriers remain due to multi-agency complexity, workforce constraints, and patient-level factors. • Strong mitigations are in place, but further work is needed to embed recall, documentation, and two-specialist review processes
NatPSA/2025/006/NHSPS: Harm from incorrect recording of a penicillin allergy as a penicillamine allergy. There are reports of healthcare staff recording a patient's penicillin allergy as a penicillamine allergy in electronic prescribing systems. **Alert closure due 20/11/2026**	
Actions and Assurance	• Alert shared trust-wide with actions led by Pharmacy and supported by Digital. • All identified patients reviewed, except one currently on a community palliative care pathway. • The remaining patient's documented penicillamine allergy predates electronic prescribing/records.
NatPSA/2025/005/NHSPS: Harm from delayed administration of rasburicase for tumour lysis syndrome. Tumour lysis syndrome (TLS) is a life-threatening complication of cancer or it's treatment. Rasburicase is indicated for the treatment and prophylaxis of acute hyperuricaemia in adults, children and adolescents with haematological malignancy, a high tumour burden and at risk of rapid tumour lysis or shrinkage at initial of chemotherapy. It is recommended as prophylaxis for patients at high risk of TLS, those at intermediate risk who can not take alternative therapy, and those who need immediate therapy and pre-existing urate levels are high.	
Actions and Assurance	• Patients with haematological malignancies require a documented risk assessment before treatment, including Rasburicase dose and monitoring needs. • Rasburicase administered only by trained, competent staff. • Specialist teams must ensure correct EPR prescribing and stock if used outside routine areas. • Confirmation of nursing staff competency and training is still awaited. **Alert closure due 09/03/2026**
NatPSA/2025/008/NHSPS – Risk associated with adult breathing circuits lacking a patent exhalation route Each year, around 236,500 adults and children admitted to hospital require invasive or non-invasive ventilatory (NIV) support. As patients' conditions change, some will receive respiratory support in areas such as emergency departments or base wards. Setting up or modifying a breathing circuit is a complex process, and effective ventilation depends on a correctly assembled circuit that allows both inhalation and a safe exhalation route. The National Patient Safety Team has identified incidents where patients were harmed or placed at risk due to incorrectly assembled breathing circuits. **Alert closure due 12/06/2026**	
Actions and Assurance	• Alert has been shared with the Chief Medical Officer, ITU Lead, and Respiratory Lead. • Actions include a review of local guidance, incorporating checklists and visual aids, and ensuring clear communication of any changes to guidance or practice

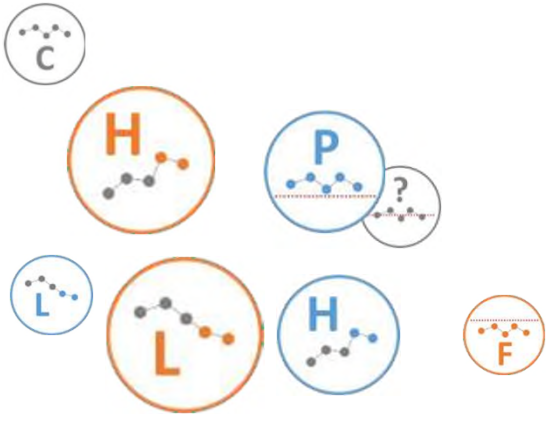
Closed National Patient Safety Alerts

Reporting Period		Patient Safety
Monthly	January/February 2026	

NatPSA/2026/002/DHSC: Recall of Quetiapine Oral Suspension (unlicensed medicine), manufactured by Eaststone Limited due to a potential for overdosing. Alert opened 29/01/2026 Eaststone Limited have informed that the formula they have used to manufacture all batches of quetiapine oral suspension products is incorrect. The active content is twice the amount that it should be which could lead to overdosing. **Executive Sponsor:** Chief Medical Officer/Chief Nurse	
Actions and Assurance	• Medicine Safety Officer confirmed that the Trust does not use this provider or affected products. **Alert closed**
NatPSA/2026/001/DHSC: Steriflex No. 109(1L) and No. 171 (2): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags. Alert opened 14/01/2026 Manufacturer Fresenius Kabi, are transitioning their Steriflex® range of licensed and unlicensed IV fluid bags to DEHPfree IV fluid bags in line with changes to reach regulations and have experienced a shortage during this change due to increased demands and lack of availability of raw materials. **Executive Sponsor:** Chief Medical Officer/Chief Nurse.	
Actions and Assurance	• Medicine Safety Officer confirmed that the Trust does not use this provider or affected products. **Alert closed 15/01/2026**

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Ashford & St Peter's Hospitals NHS FT



Trust Board Performance Scorecard

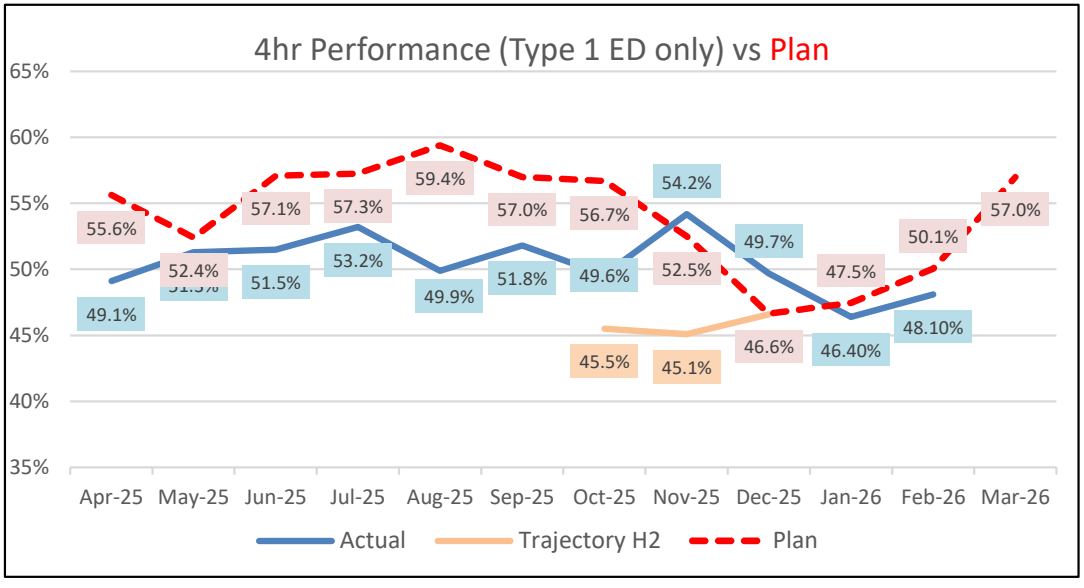
Reporting Month: February 2026

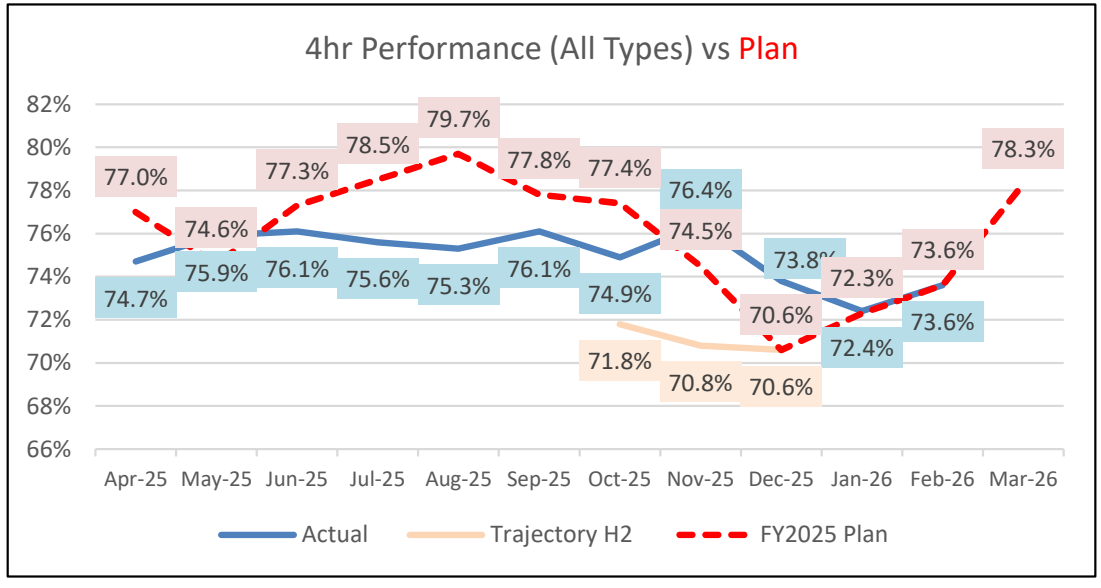
The NHS England website has a range of resources to support Boards using the Making Data Count methodology.
This includes a number of videos explaining the approach (with case studies) and can be accessed here > https://www.england.nhs.uk/publication/making-data-count/

A&E 4 Hour Performance

Reporting Period: Monthly | February 2026

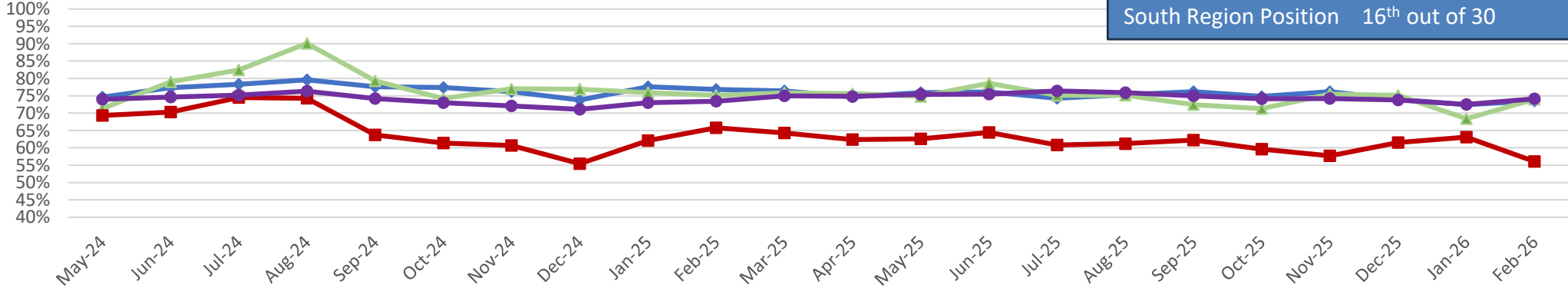
Emergency Care





Monthly A&E Performance (NHSI All Types)

National Position 66th out of 123 providers
South Region Position 16th out of 30



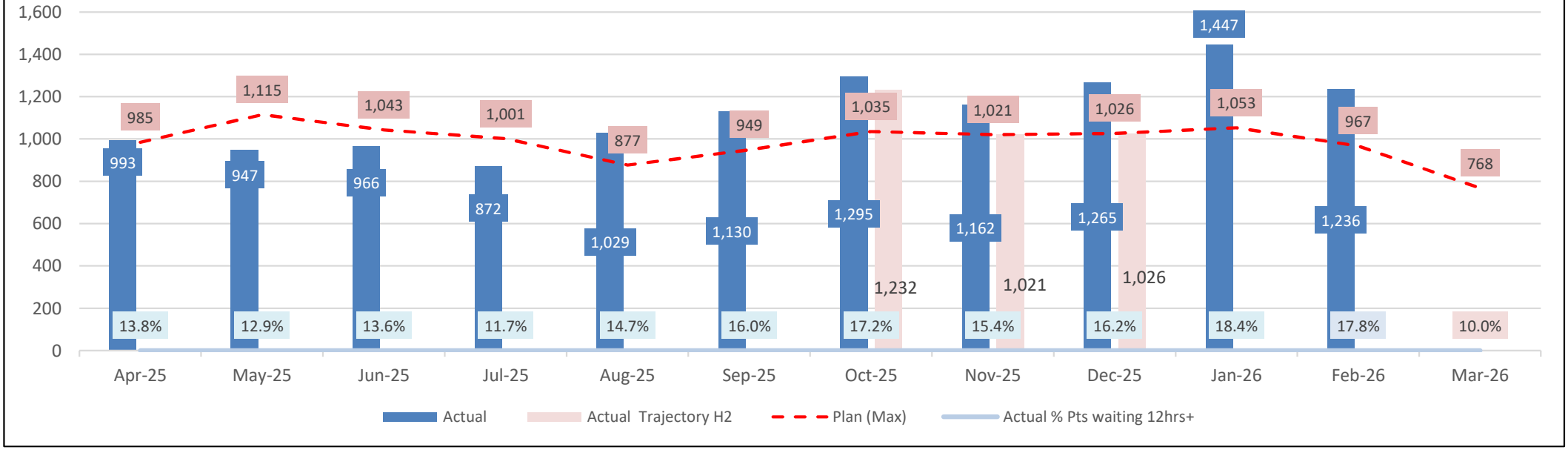
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
ASPH	74.60%	77.3%	78.3%	79.6%	77.6%	77.4%	76.2%	73.8%	77.6%	76.8%	76.4%	74.7%	75.9%	76.1%	74.3%	75.3%	76.2%	74.8%	76.2%	73.9%	72.4%	73.5%
RSH	71.30%	79.0%	82.4%	90.1%	79.3%	74.2%	77.0%	76.9%	75.9%	75.1%	75.8%	75.6%	74.8%	78.6%	75.1%	75.1%	72.4%	71.3%	75.5%	75.1%	68.4%	74.0%
SASH	69.30%	70.3%	74.5%	74.3%	63.7%	61.4%	60.7%	55.4%	62.1%	65.8%	64.3%	62.4%	62.6%	64.4%	60.8%	61.2%	62.2%	59.6%	57.7%	61.5%	63.1%	56.1%
England	74.00%	74.6%	75.2%	76.3%	74.2%	73.0%	72.1%	71.1%	73.0%	73.4%	75.0%	74.8%	75.4%	75.5%	76.4%	75.9%	75.0%	74.1%	74.2%	73.8%	72.5%	74.1%

A&E Performance

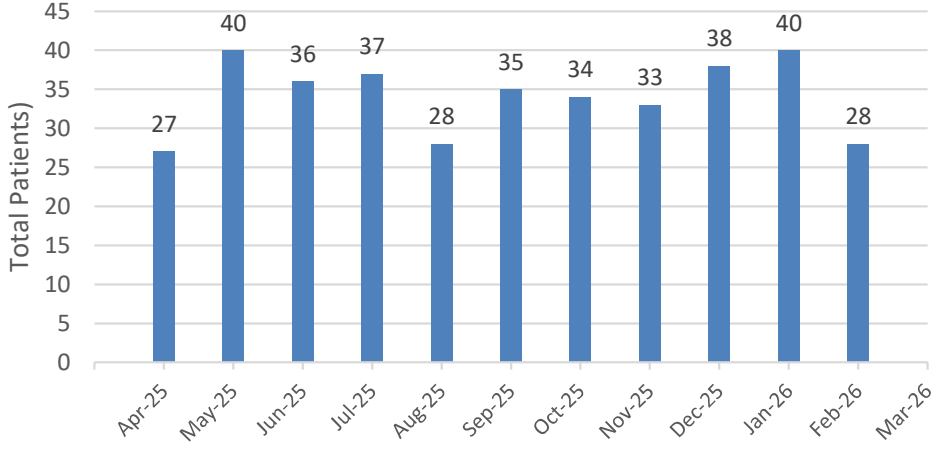
Reporting Period: Monthly | February 2026

Emergency Care

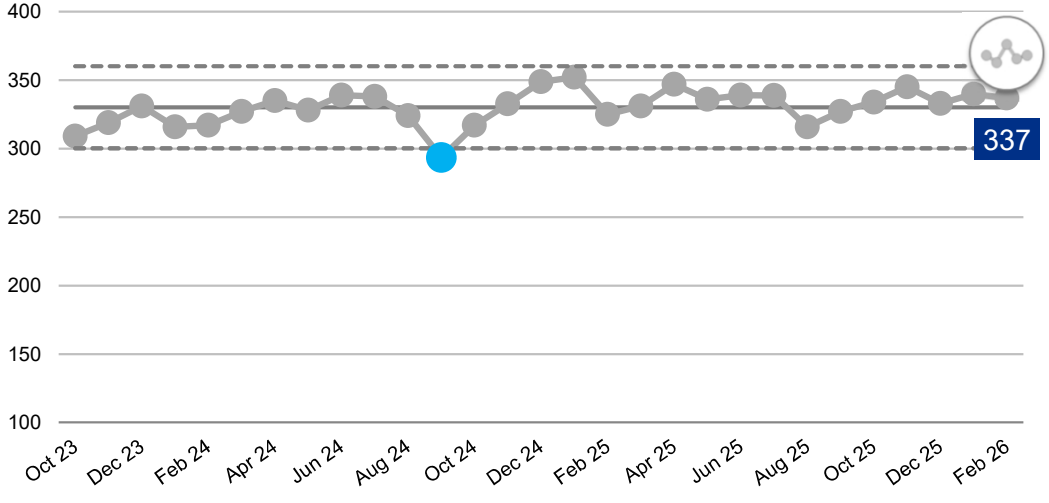
No. & % of Patients Spending Longer Than 12hrs in ED vs Plan



Number of Mental Health Patients Staying >24Hrs in ED (16 years +)



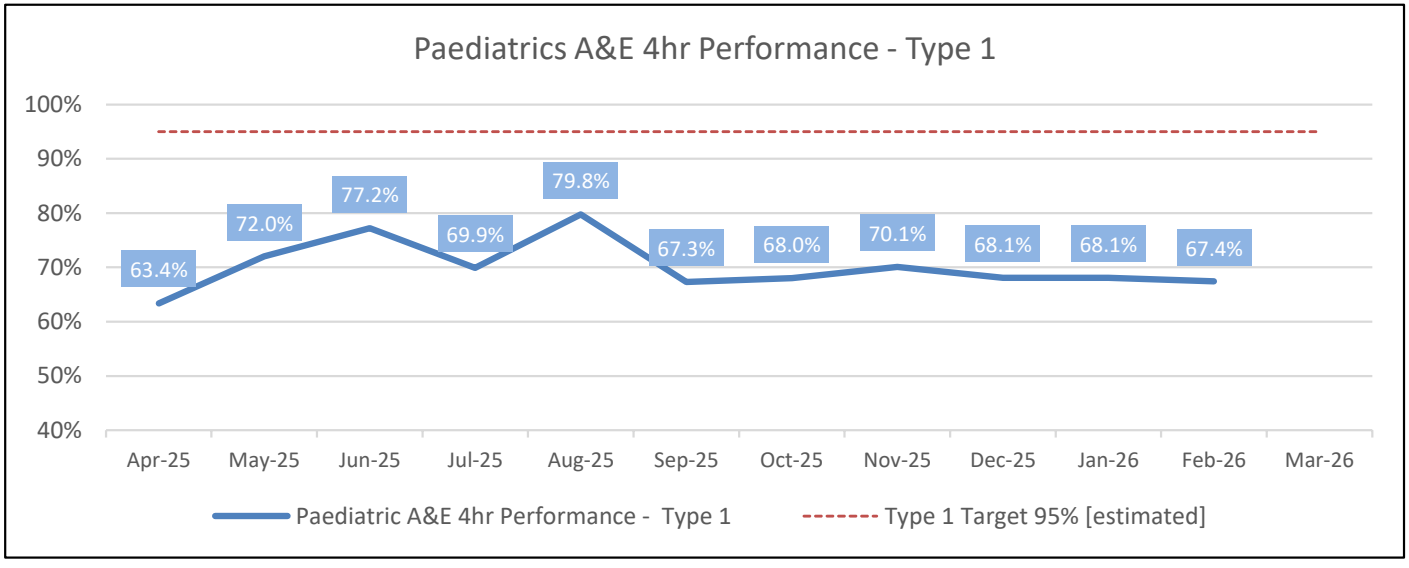
A&E Monthly Average Daily Attendances (SPH)

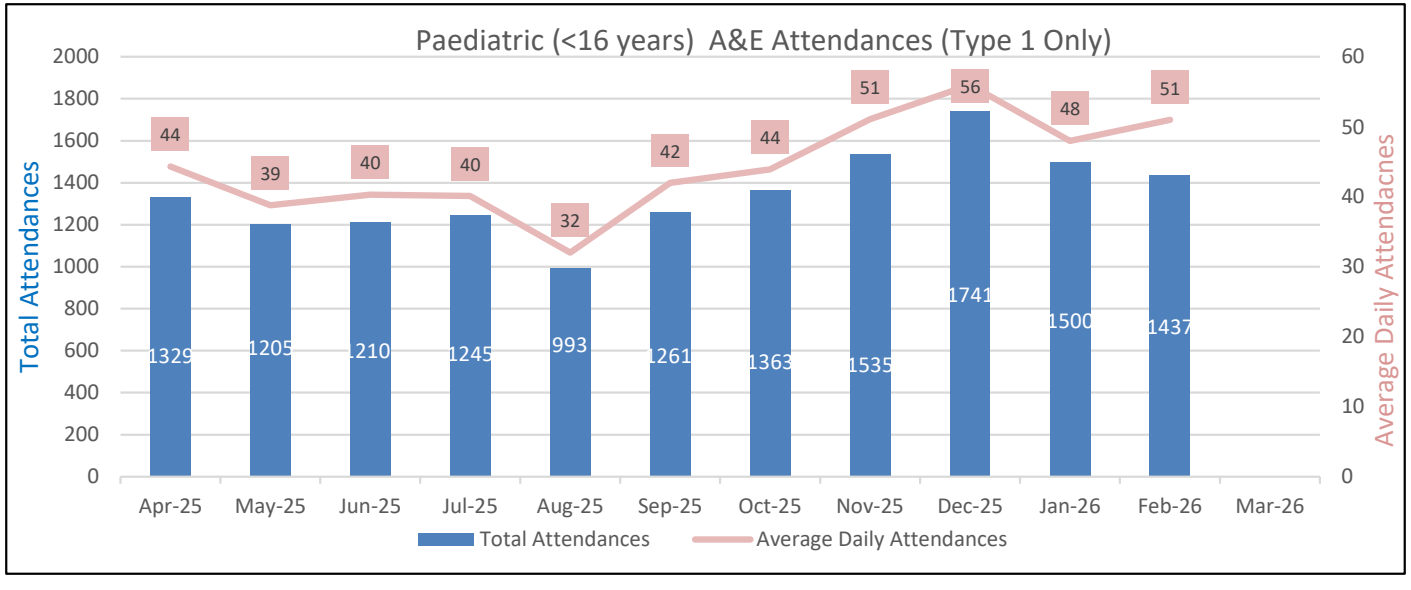


Paediatric A&E 4 Hour Performance (<16 Years)

Reporting Period: Monthly | February 2026

Emergency Care





Paediatrics

Following the NHSE Regional Clinical Advisor visit in February 2026, a new clinical pathway has been agreed jointly between the Paediatric and ED teams to improve use of the existing Paediatric SDEC (4 spaces) within the Children's and Young People's ED footprint. This aims to further support the management of patients suitable for same day emergency care within a dedicated area of the department. A change to how data is recorded is also being piloted as a temporary measure to help clinicians to safely improve use of this area whilst maintaining clinical visibility and oversight.

A supernumerary nurse in charge pilot is underway to support improving and identification of delays in speciality response times.

A pilot is being run to provide additional ED consultant support to CYP ED during twilight periods on the two busiest days of the week, to support flow. The ED consultant team have also agreed that when possible and there is no ED consultant on shift, they will increase the seniority of ED medical staff allocated to Paediatric ED during evening periods.

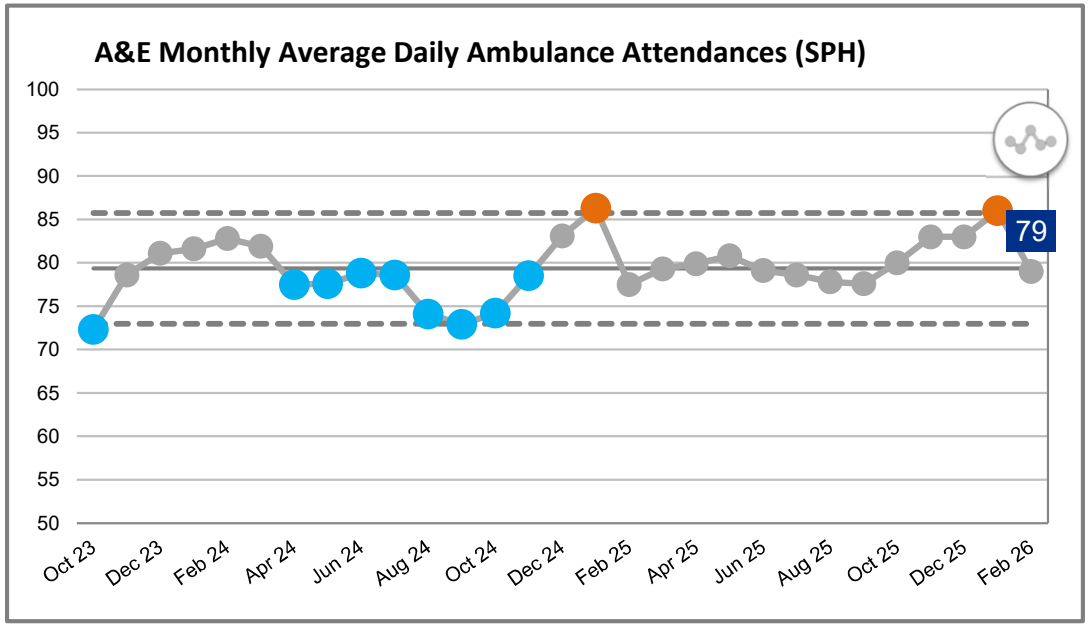
Early indications are that March performance is improving since these changes were made.

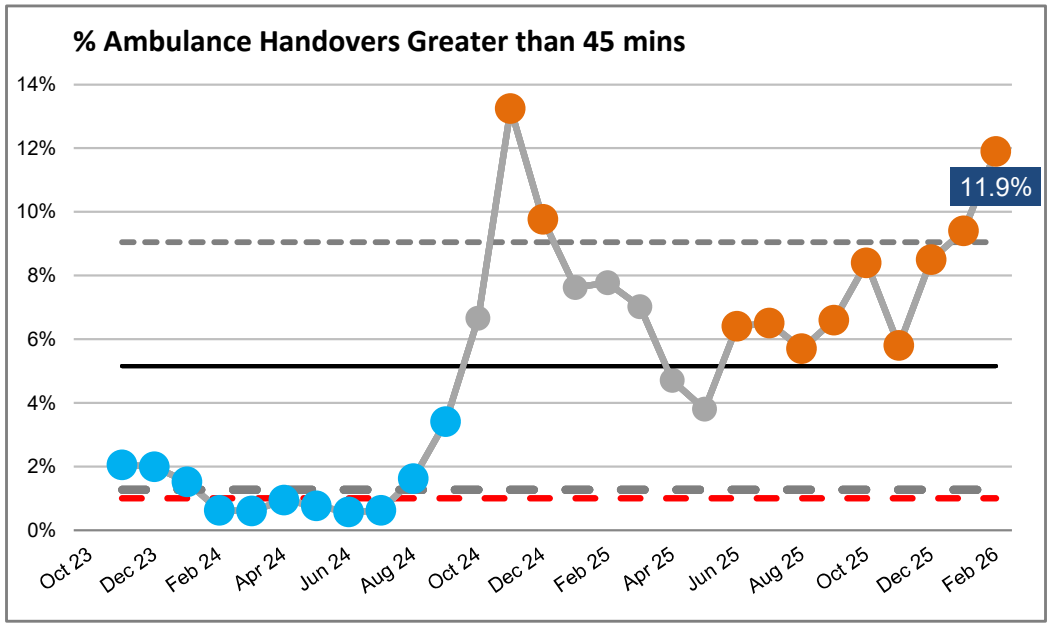
Mental Health Patients Staying >24Hrs in ED (<16 Years)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Number of Patients	0	0	0	0	0	1	1	0	2	1	0	

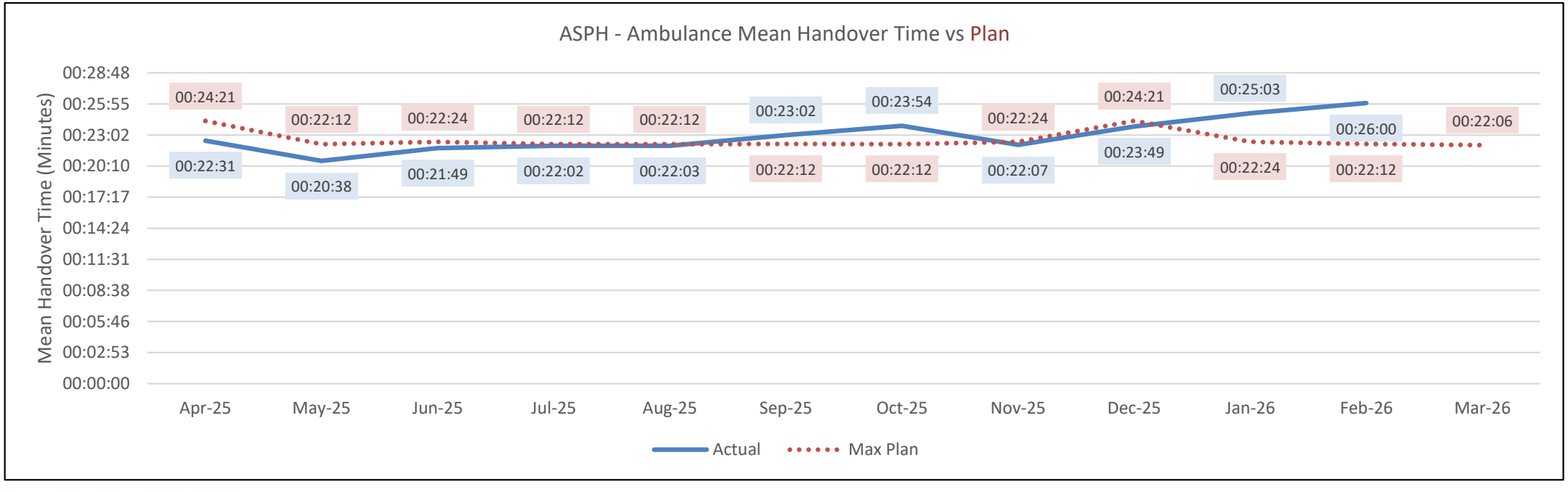
Ambulance Performance

Reporting Period: Monthly | February 2026

Emergency Care







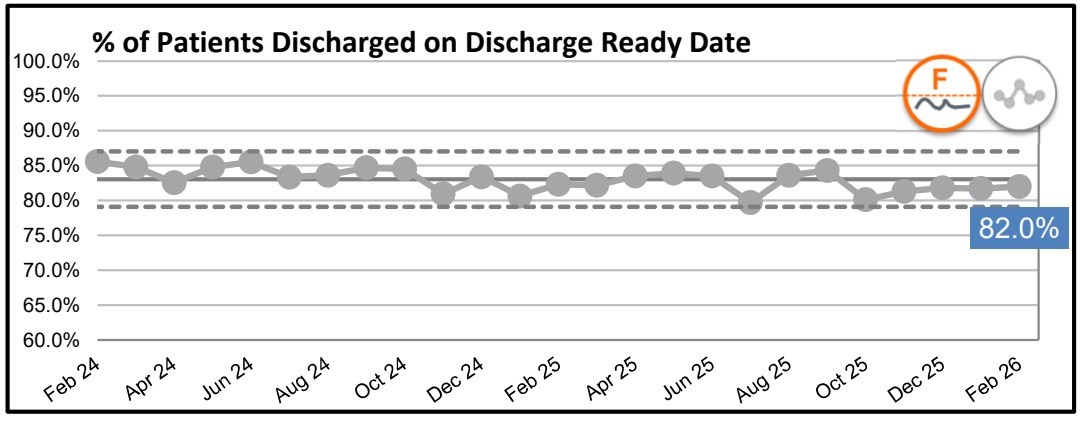
Ashford and St. Peter's Hospitals NHS Foundation Trust

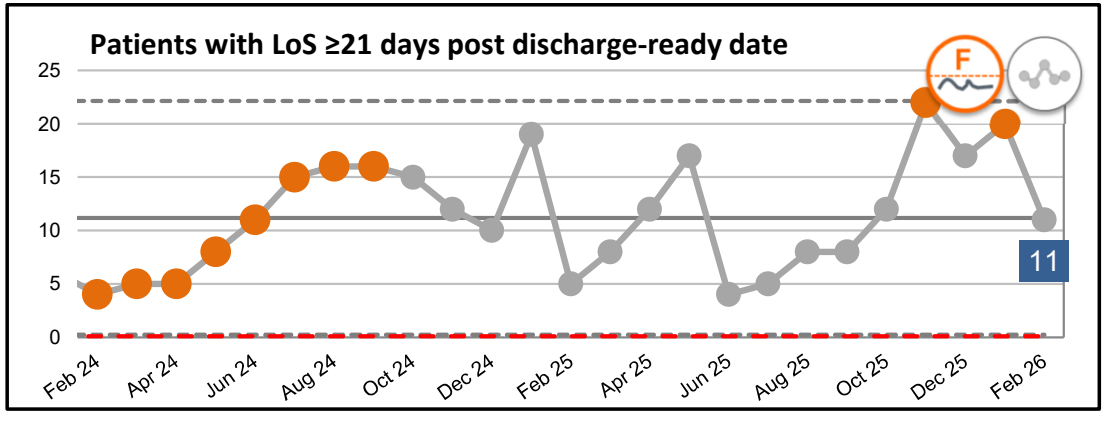
A&E | Flow | Stroke | Recovery | Diagnostics | Cancer

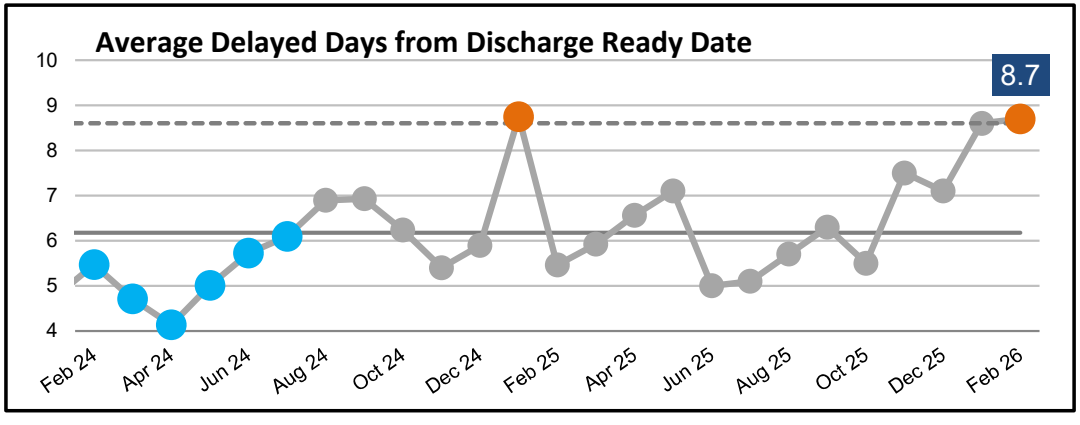
Hospital Flow

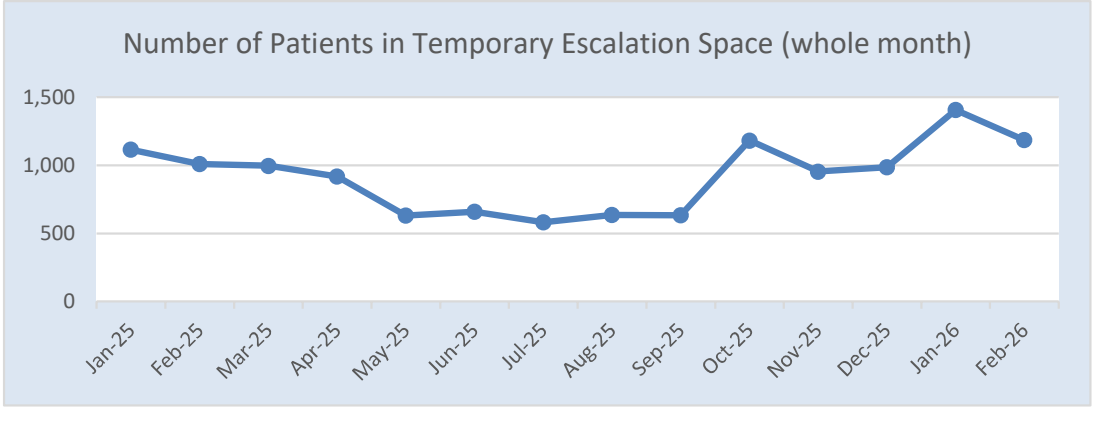
Reporting Period: Monthly | February 2026

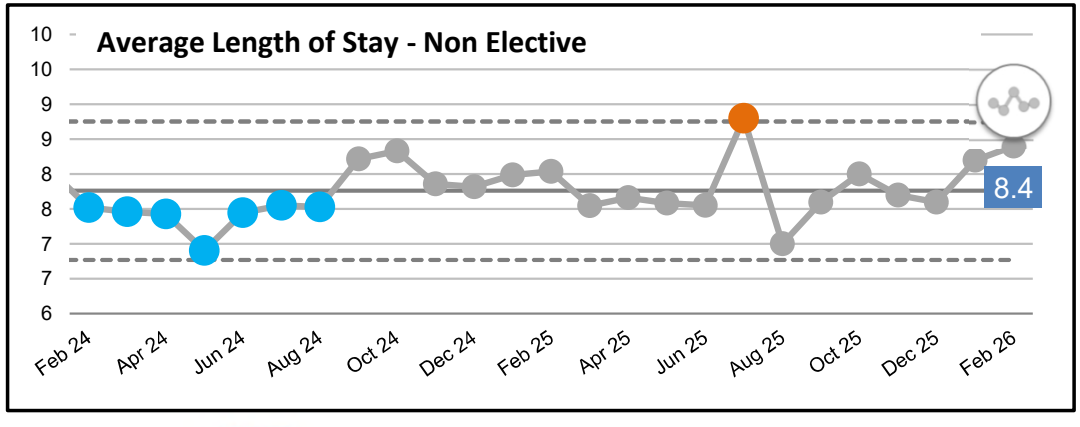
Emergency Care

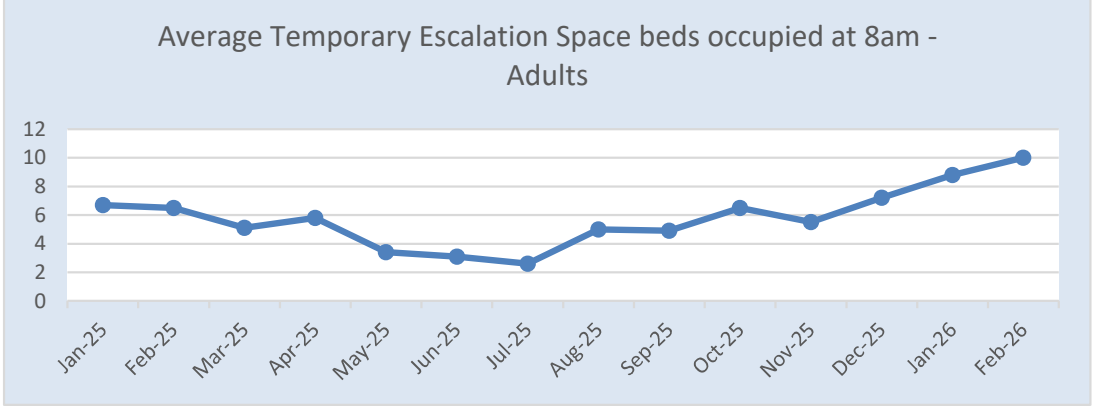


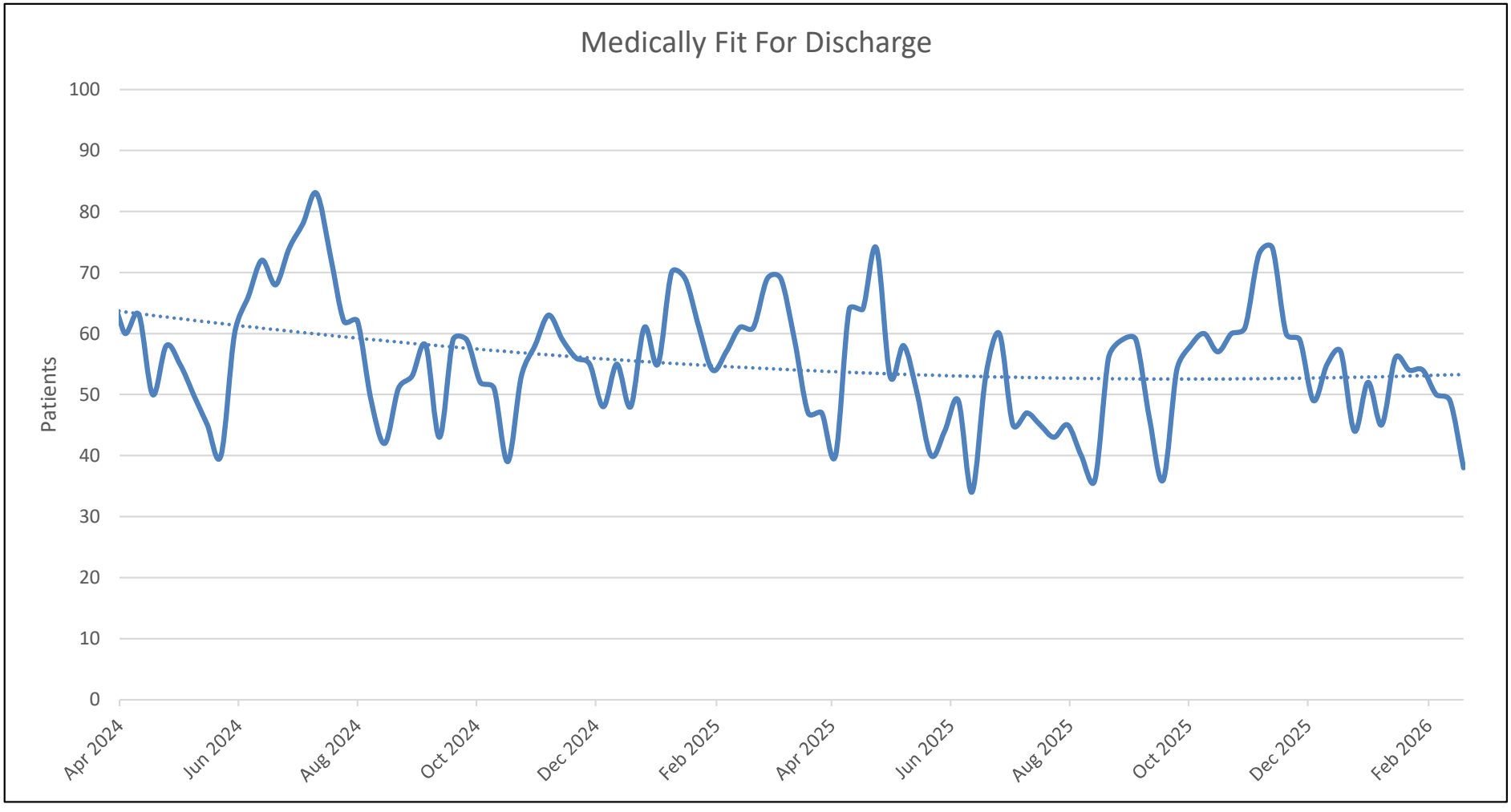











Medically Fit For Discharge
Patients
100
90
80
70
60
50
40
30
20
10
0
Apr 2024
Jun 2024
Aug 2024
Oct 2024
Dec 2024
Feb 2025
Apr 2025
Jun 2025
Aug 2025
Oct 2025
Dec 2025
Feb 2026

Urgent Care Performance / Flow

Reporting Period: Monthly | February 2026

Emergency Care

What is impacting current performance?	February Type 1 performance corresponds to the following: • Improving, but still high volume of specialty patients in ED >12hrs • Discharge lounge and SDEC bedded during periods of high escalation (14 nights in Discharge lounge, 3 nights in SDEC) • Infection controls in some ward areas (e.g. for Flu A, norovirus), leading to temporary bed closures
What actions are being taken to improve?	• SDEC and ED chairs – increase utilisation through alteration in digital process commenced week commencing 2/3/26 • Modification of ED operational, bronze and flow coordinator roles, NHS England GIRFT Team on site 16 March 26. • Plan re ED model hospital trial from April 26. • Pathway 1 team focussed on eliminating delays in P1 • Flow Co's joining with the TOCH – commence 3/3/26 • Weekend discharge team with consultant / discharge coordinator – commenced weekend 28/2 • Over 21 days LLOS meeting with Deputy Tri moving to CMO in April 26. • Therapy senior oversight of caseload • Rehab pathway improvement • Increase virtual ward referrals from CAU
What are the timelines?	Considerable focus is on improving March performance with actions in place aimed at supporting improvement in both admitted and non-admitted pathways
Key risks and quality impact to the trust?	• Capacity pressures: Significant use of escalation beds has been required Trust-wide to manage sustained high demand. Corridor care continues, with an increased risk of ambulance handover delays and the need to manage periods of immediate handover when capacity is constrained. • Flow constraints: High numbers of mental health patients awaiting inpatient beds, alongside patients with no criteria to reside, are adversely impacting patient flow. • Demand and staffing: Peaks in attendance continue to challenge safe staffing levels, requiring careful balancing of quality, performance, and financial constraints, including control of locum and bank spend. • ED overcrowding: Reduced flow through the system results in overcrowding within ED, limiting clinical space to see and treat patients and increasing waiting times.

Stroke and TIA Performance Dashboard [February 2026]

General Performance

Metric	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	RollingYear
Number of Admissions during the month	36	53	38	39	27	53	29	42	56	28	67	45	57	53	55	744
Number of Discharges during the month	36	33	32	39	35	33	36	39	47	35	42	37	42	48	38	624

Metric	Target		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	RollingYear
Proportion of stroke patients scanned within one hour of hospital arrival	50%	Y	20	24	24	26	27	25	20	33	33	22	25	25	30	32	27	420
		Total	36	33	32	39	35	33	35	39	47	35	42	37	42	48	38	623
		%	55.6%	72.7%	75.0%	66.7%	77.1%	75.8%	57.1%	84.6%	70.2%	62.9%	59.5%	67.6%	71.4%	66.7%	71.1%	67.4%
Proportion of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	90%	Y	10	7	8	9	11	12	16	15	17	11	10	19	13	13	13	194
		Total	36	30	32	36	30	27	35	37	45	32	40	35	38	42	33	570
		%	28%	23%	25%	25%	37%	44%	46%	41%	38%	34%	25%	54%	34%	31%	39%	34%
Proportion of stroke patients spending 90% of their stay on a stroke ward	90%	Y	21	27	21	22	25	24	27	31	29	25	29	29	28	36	24	417
		Total	34	32	32	37	32	25	35	37	37	32	39	34	38	42	33	561
		%	62%	84%	66%	59%	78%	96%	77%	84%	78%	78%	74%	85%	74%	86%	73%	74%
Proportion of stroke patients reviewed by a Stroke specialist consultant within 14hours	n/a	Y	18	20	17	22	20	14	24	27	29	31	31	27	27	28	22	382
		Total	36	33	32	39	35	19	35	29	45	35	42	37	42	48	38	597
		%	50%	61%	53%	56%	57%	74%	69%	69%	69%	89%	74%	73%	64%	58%	58%	10
Proportion of stroke patients reviewed by a Stroke specialist consultant within 24hours	95%	Y	24	28	25	34	27	25	29	33	33	33	37	37	35	40	28	503
		Total	36	33	32	39	35	33	35	39	45	35	42	37	42	48	38	621
		%	66.7%	84.8%	78.1%	87.2%	77.1%	75.8%	82.9%	84.6%	73.3%	94.3%	88.1%	100.0%	83.3%	83.3%	73.7%	81.0%
Proportion of stroke patients reviewed by a specialist stroke nurse within 24 hours	95%	Y	33	33	28	36	34	33	30	28	42	34	42	35	30	44	35	564
		Total	36	33	32	39	35	33	35	31	45	35	42	37	35	48	38	606
		%	91.7%	100%	87.5%	92.3%	97.1%	100%	86%	90%	93%	97%	100.0%	94.6%	85.7%	91.7%	92.1%	93.1%

February 2026

Direct admission to the stroke unit within four hours slight increased to 39%, remaining significantly below the 90% target. There was improvement in early care, most notably brain imaging within 1 hour, which increased from 66.7% (Jan) to 71.1% (Feb).

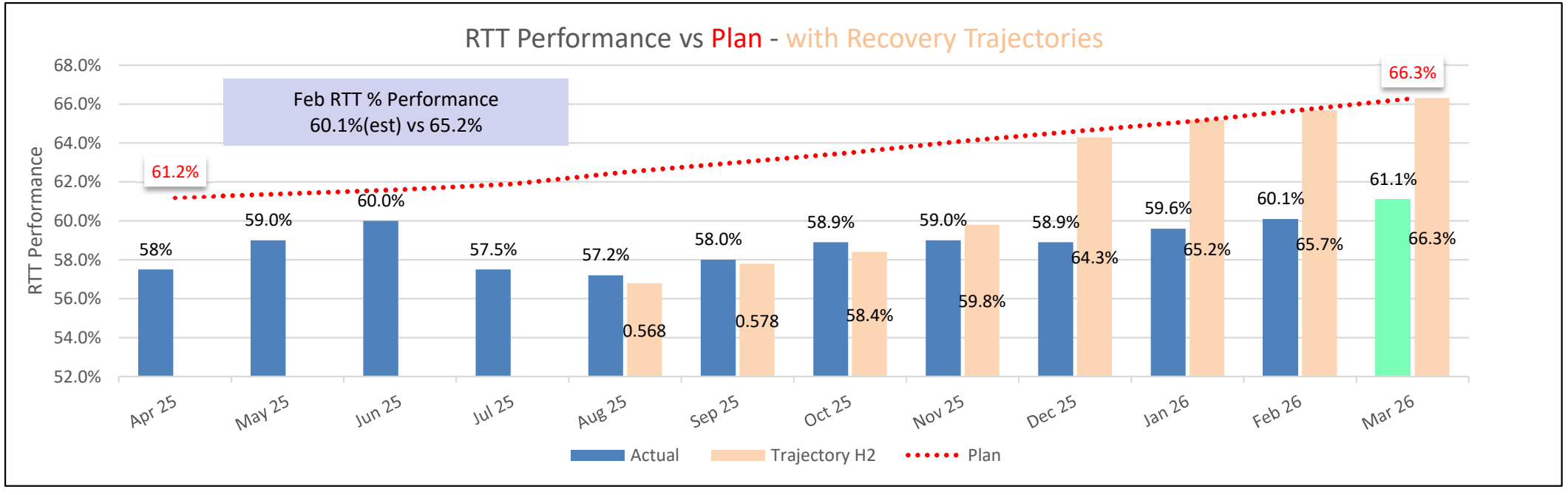
Stroke Improvement Plan

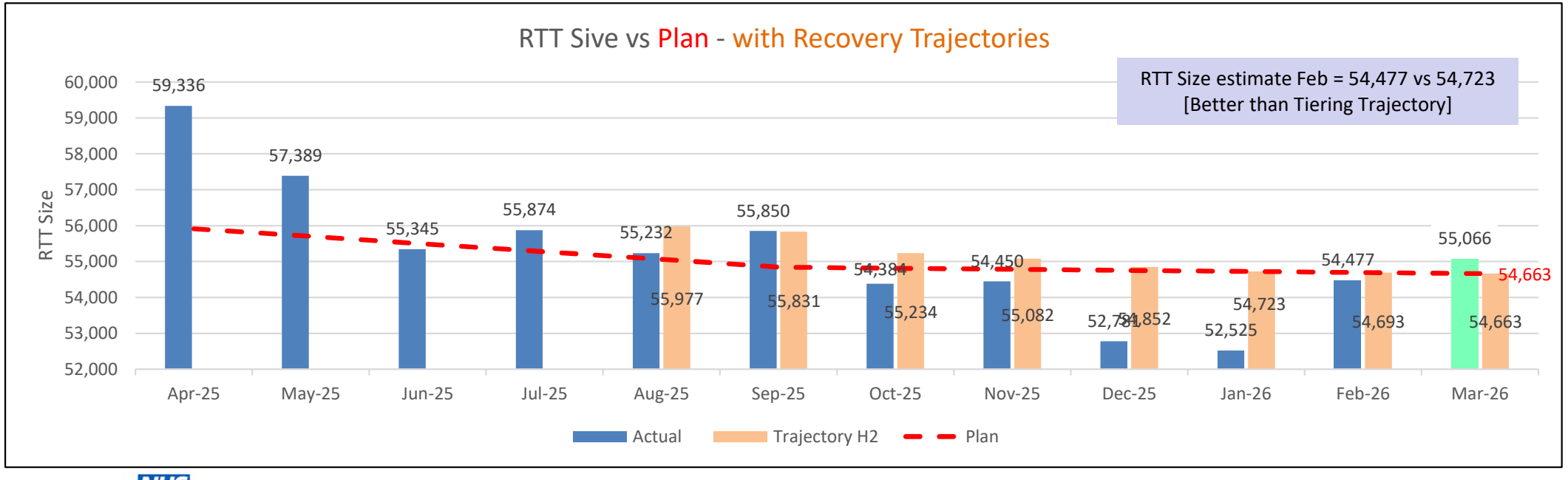
- Regional peer review by ISDN network on 23rd Feb 2026 where the pathway was discussed in detail and any immediate actions will be sent in the next few weeks as part of the report.
- Pre-hospital Video Triage paper approved at divisional board and will be rolled out in the next few weeks.
- Working with Radiology to set up lysis cupboard in the CT area to reduce the time between imaging and Thrombolysis.
- Working with informatics on a daily report to enable real time analysis of 4 hour breaches.
- Recently set up collaborative and regular meetings with UEC division to discuss and improve pathways (stroke clinical lead and UEC divisional chief nurse)

Referral to Treatment (RTT) Performance

Reporting Period	
Monthly	February 2026 [est]

Elective Care

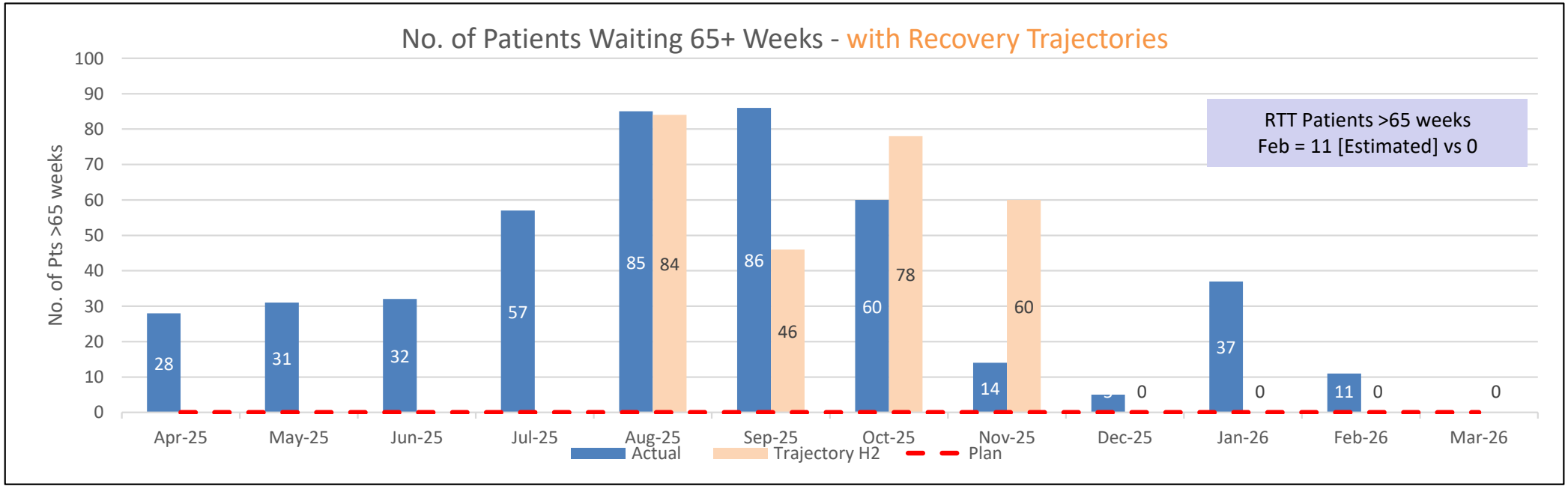


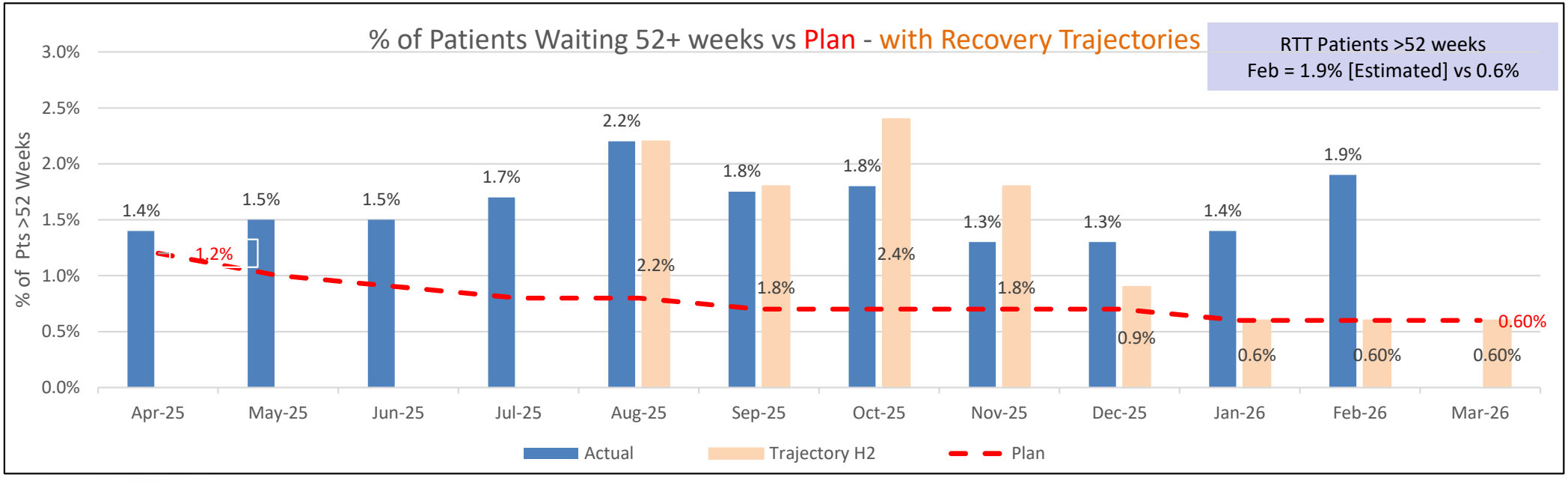


Referral to Treatment (RTT) Performance

Reporting Period: Monthly | February 2026 [est]

Elective Care



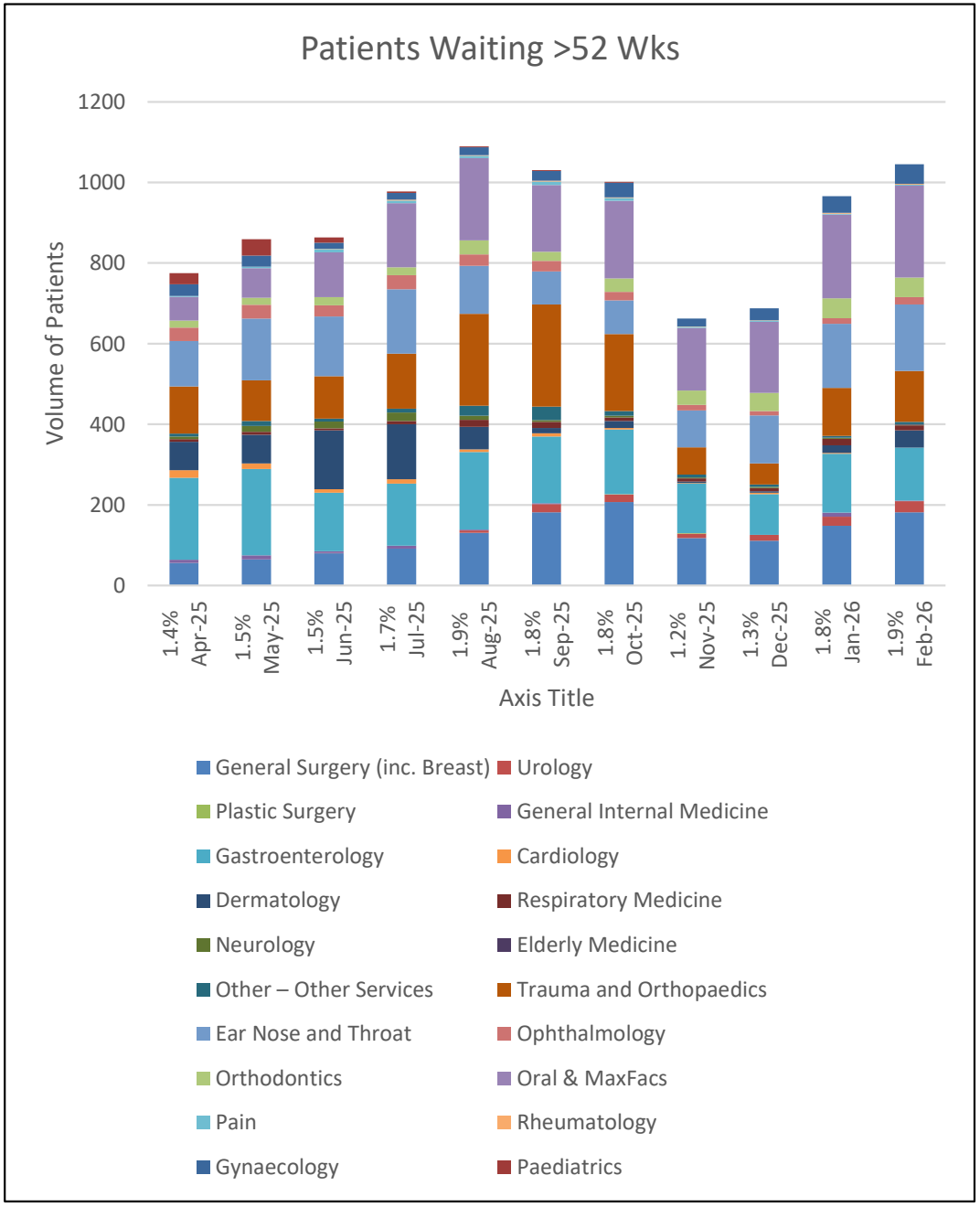


Referral to Treatment (RTT) Performance

Reporting Period: Monthly | February 2026 [Est]

Elective Care

		Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% Patients Waiting >52 wks [Plan <=0.6% max]		1.2%	1.4%	1.5%	1.5%	1.7%	1.9%	1.8%	1.8%	1.2%	1.3%	1.8%	1.9%
GS-ACT	General Surgery (inc. Breast)	52	56	65	80	92	131	182	207	118	111	148	182
	Urology	0	0	0	1	0	6	20	19	11	15	23	27
	Plastic Surgery	0	0	0	0	0	0	0	1	1	0	0	0
GSM	General Internal Medicine	12	8	10	4	7	2	2	0	0	0	10	2
	Gastroenterology	138	203	214	145	154	192	166	160	123	101	146	131
	Cardiology	12	19	14	9	11	7	8	4	1	3	2	0
	Dermatology	25	71	71	146	136	56	13	17	4	4	19	43
	Respiratory Medicine	9	6	7	5	8	17	15	9	8	8	16	12
	Neurology	4	7	15	17	21	10	4	4	2	3	2	2
	Elderly Medicine	0	0	0	0	0	0	0	0	0	0	1	1
	Other – Other Services	13	7	12	7	10	25	34	12	7	6	4	6
iMSK & SS	Trauma and Orthopaedics	117	117	101	105	136	228	253	191	68	52	119	126
	Ear Nose and Throat	93	112	153	148	160	119	82	83	91	119	159	165
	Ophthalmology	58	34	34	28	35	28	26	21	14	11	14	18
	Orthodontics	14	17	18	20	19	35	23	34	36	45	49	49
	Oral & MaxFacs	69	59	73	111	159	204	165	192	155	176	208	228
	Pain	3	2	4	8	7	6	9	7	3	3	2	2
	Rheumatology	0	0	0	1	2	1	2	2	1	1	2	2
WH&P	Gynaecology	35	29	27	15	17	20	24	36	19	30	42	49
	Paediatrics	17	28	41	13	3	2	2	2	0	0	0	0

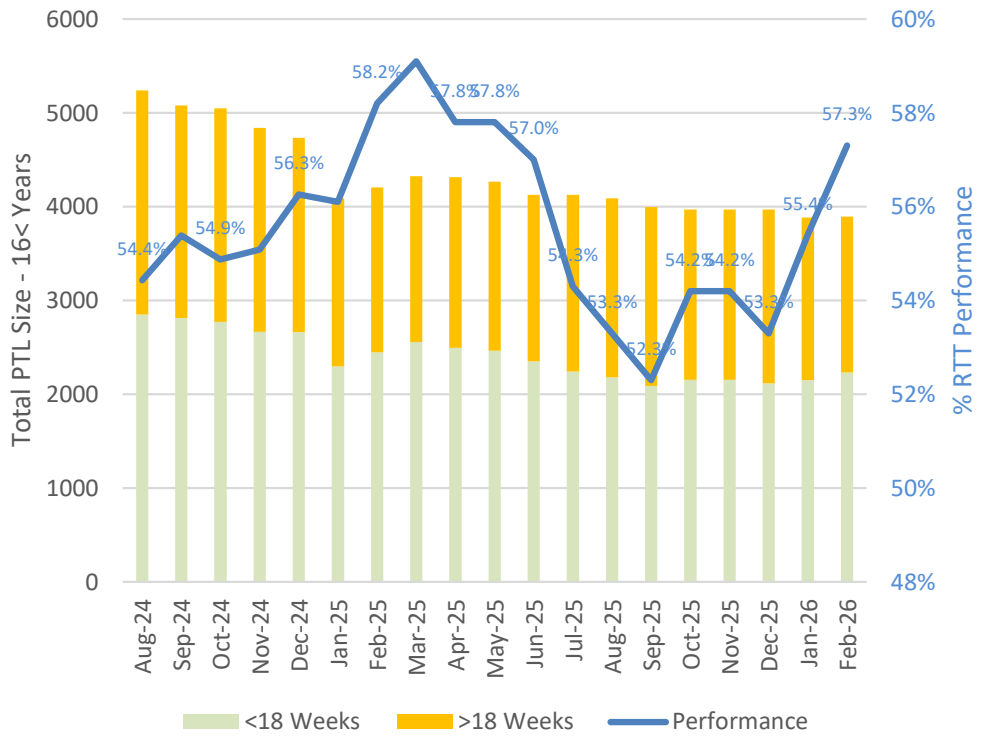


Referral to Treatment Performance – Paediatrics

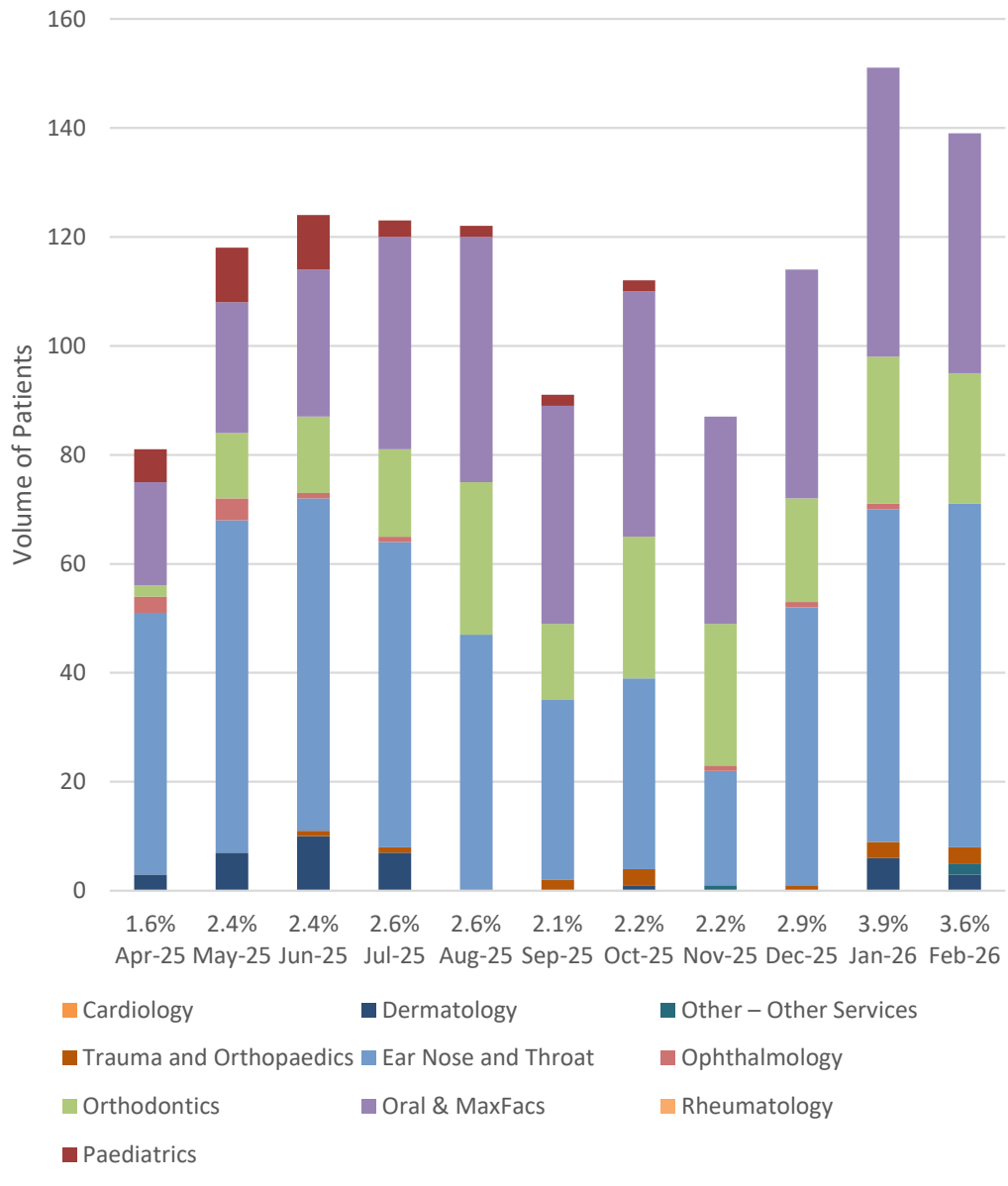
Reporting Period: Monthly | February 2026 [Est]

Elective Care

Patients <16 Years RTT Performance



Paediatric Patients Waiting >52 Wks



Paediatrics Patients

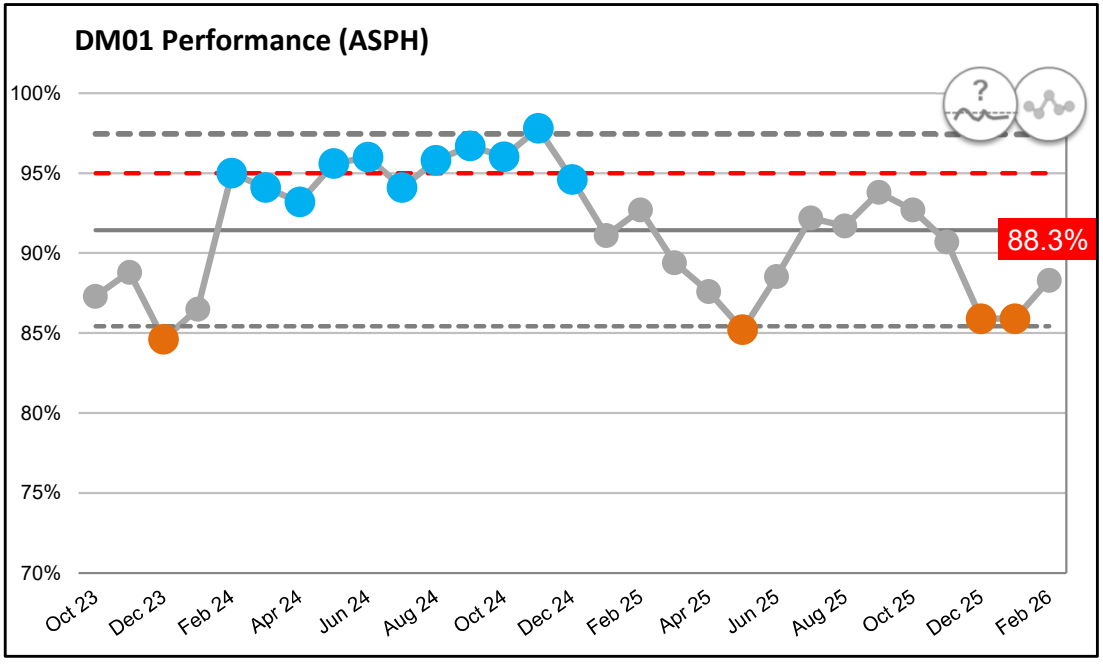
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% Patients Waiting >52 wks	**1.6%**	**2.4%**	**2.4%**	**2.6%**	**2.6%**	**2.1%**	**2.2%**	**2.2%**	**2.9%**	**3.9%**	**3.6%**
Urology	0	0	0	0	0	0	0	0	0	1	1
Dermatology	3	7	10	7	0	0	1	0	0	6	3
Other – Other Services	0	0	0	0	0	0	0	1	0	0	2
Trauma and Orthopaedics	0	0	1	1	0	2	3	0	1	3	3
Ear Nose and Throat	48	61	61	56	47	33	35	21	51	61	63
Ophthalmology	3	4	1	1	0	0	0	1	1	1	0
Orthodontics	2	12	14	16	28	14	26	26	19	27	24
Oral & MaxFacs	19	24	27	39	45	40	45	38	42	53	44
Paediatrics	6	10	10	3	2	2	2	0	0	0	0

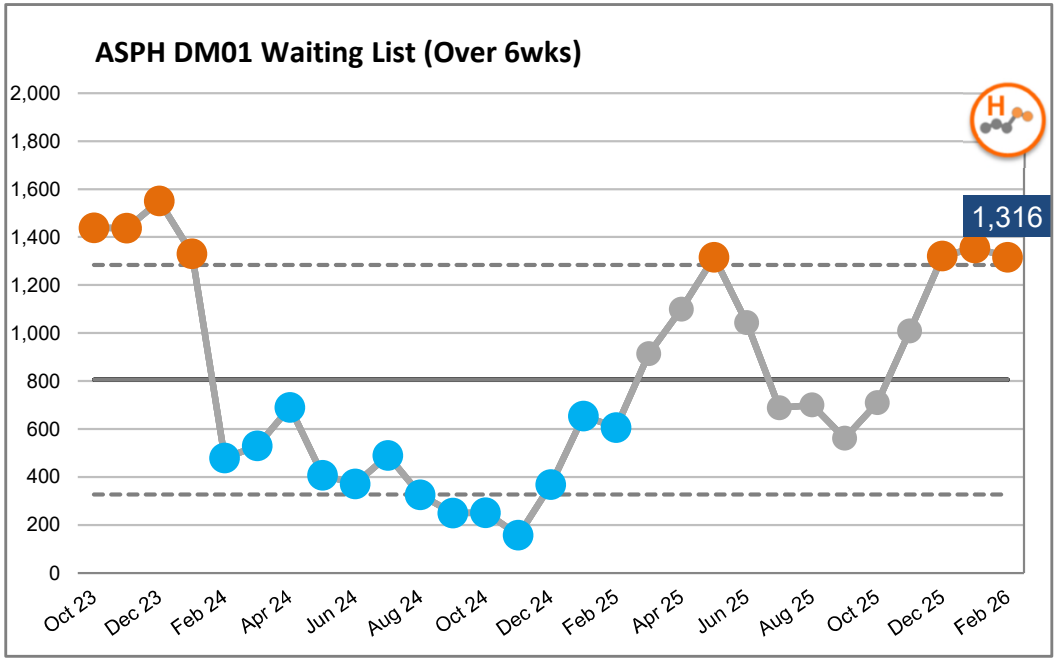
What is the impact on current performance?	February RTT performance is estimated at 60.1% against a plan of 65.7%, reflecting sustained operational pressures. Additional internal and Independent Sector capacity coming online in March is expected to lift performance slightly to around 61.1%. Performance has also been constrained by the extended closure of four inpatient theatres and one day-surgery theatre due to ventilation and electrical failures, significantly affecting Orthopaedics, Ophthalmology, and Specialist Surgery. These infrastructure challenges, coupled with resourcing and workforce constraints, have further limited planned activity and delayed performance recovery.
What actions are being taken to improve?	**RTT Recovery** Divisions have implemented a range of targeted recovery actions to strengthen RTT performance, including: • Expanded weekend and Sunday clinics in ENT • Reinstated weekend activity and new consultant capacity in OMFS • Additional Saturday theatre lists and selective outsourcing in Orthopaedics • Increased Dermatology and Gastroenterology capacity through weekend clinics, straight-to-test pathways, and independent sector support. • General Surgery has also increased activity through continued outsourcing and in-house delivery. These coordinated actions, form the Trust's recovery trajectory are aimed at improving RTT performance. • External funding has been accessed to increased our use of the independent sector to support our RTT position by the end of March.
What are the timelines?	The Trust set out a trajectory of recovery which is currently behind due to the issues mentioned above. The RTT position by the end of March is projected to be 61.1 against the 66.3%, required to meet the Trust plan.
Key risks and quality impact to the trust?	Financial risk and impacting on patient experience. Not delivering RTT performance in line with the National standard would see a deterioration in National Oversight Framework segmentation and in position in new national league tables. Performance tiering could be increased through further NHSE intervention and oversight. RTT position at 2025/26 year end could significantly affect 2026/27 improvement requirement.

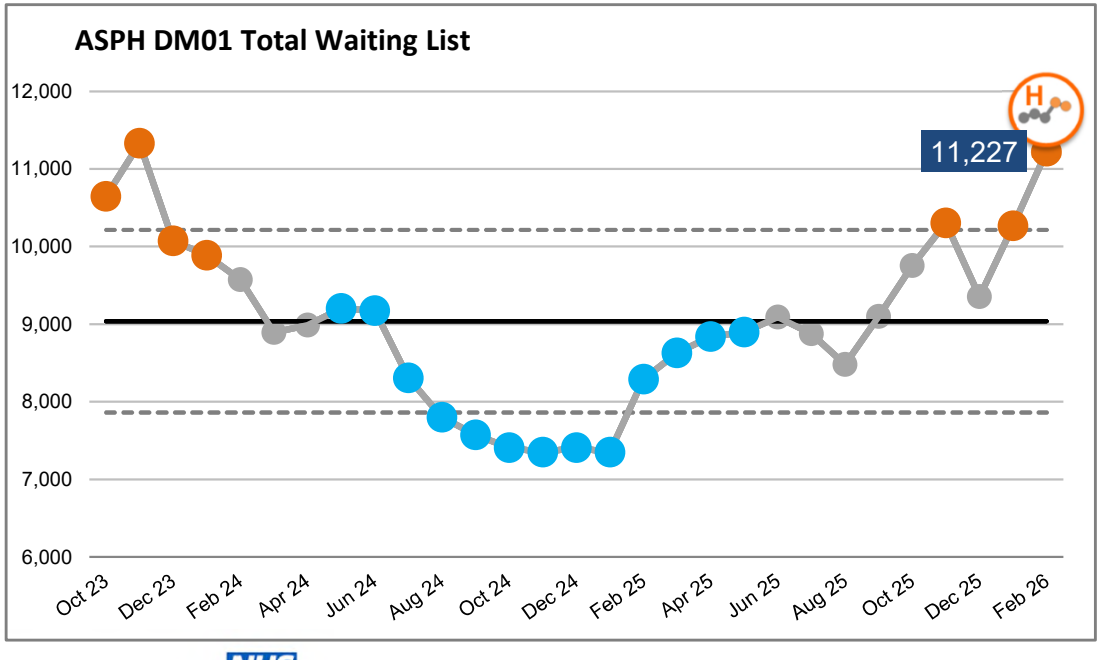
Diagnostics (DM01)

Reporting Period: Monthly | February 2026 [Est]

Elective Care





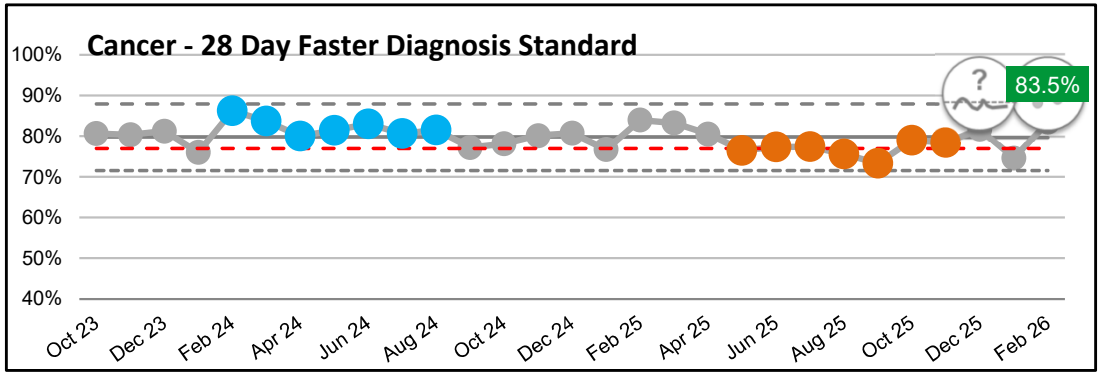


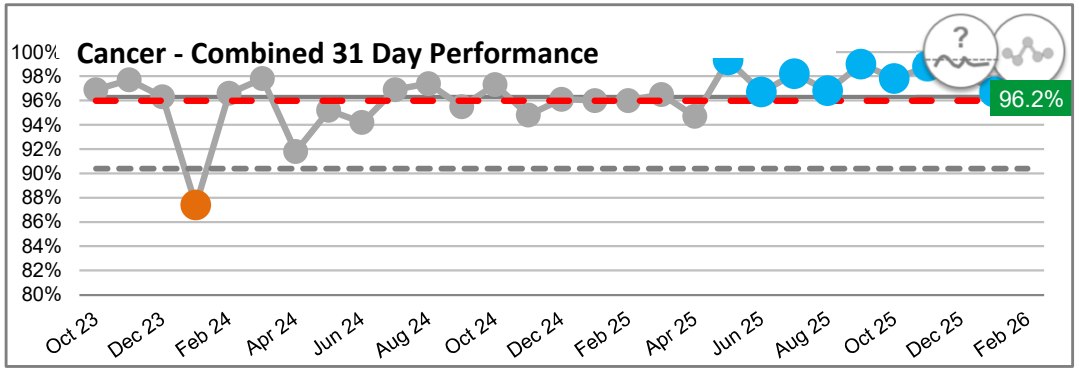
What is impacting current performance?	**Ultrasound (US)** – Backlog pressures are driven by unplanned staff shortages, a reduction in weekend lists, and ongoing difficulties recruiting sonographers **Endoscopy –** High demand to schedule RTT long-waiters continues to displace routine activity, resulting in extended waiting times for routine scopes. Outsourcing OGDS is ongoing throughout March.
What actions are being undertaken to improve performance?	**CT** – Improving each month. Average waiting times are 3.5 weeks now. The reporting backlog has also improved following additional cancer funding to support both outsourcing and insourcing arrangements. **Ultrasound (US)** – Due to ongoing national recruitment challenges of sonographers, we remain in a difficult position regarding our workforce. We have engaged with in a insourcing company in order to mitigate the risk to our waitlist and to ensure long waiters are being seen. **Endoscopy** – Support for RTT long-waiters has required displacement of some routine activity, though the unit continues to achieve an average list fill of 92% and utilisation of 90%. Due to the hospital pressures Endoscopy has lost the use of ESAC at weekends increasing the DM01 waits **Urodynamics** – Operational pressures persist due to an ongoing mismatch between demand and capacity following the cessation of the waiting list initiative. An improvement plan is underway.
When will the position be recovered?	We should see a noticeable improvement to Ultrasound performance by the end of May 26.
What are the key risks?	The risk of harm arising from delays in endoscopy is recorded on the Trust's risk register, with mitigating controls in place. The endoscopy team works closely with the Trust cancer team through daily meetings to ensure enhanced monitoring of patients on cancer pathways. Inpatient endoscopy capacity is reviewed daily through joint clinical and administrative meetings. Prioritisation of TWR referrals continues to displace routine and urgent activity, contributing to growth in those waiting lists. Following the reinstatement of Sunday lists, the surveillance backlog is now reducing; however, ongoing prioritisation of TWR bookings continues to place pressure on surveillance capacity.

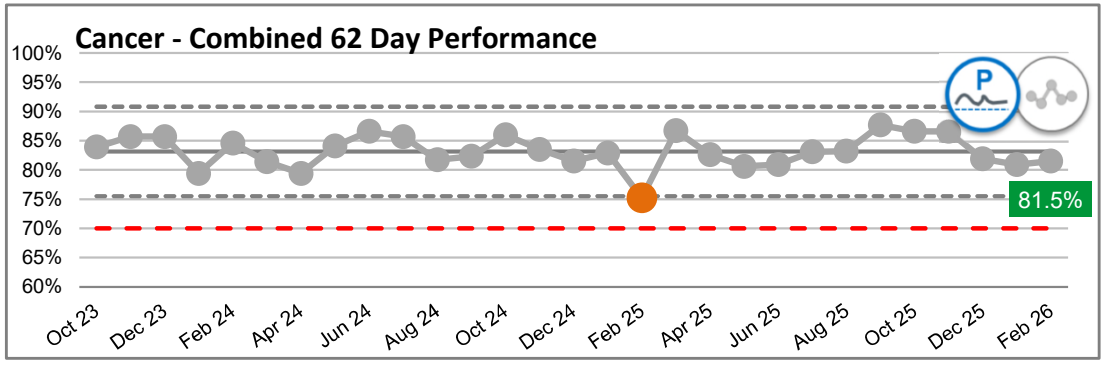
Cancer

Reporting Period: Monthly | February 2026 (prov)

Elective Care







Division	Measure	Domain	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Trend
Cancer - Patients Waiting Ov		Overall	0	15	14	12	24	28	18	
GS-ACT	Colorectal	>104 days	0	2	2	1	2	5	2	
	Urology	>104 days	0	0	0	1	1	3	2	
GSM	Brain	>104 days	0	0	0	0	0	0	0	
	Dermatology	>104 days	0	4	5	2	2	2	2	
	Haematology	>104 days	0	0	0	0	2	0	0	
	Lung	>104 days	0	0	0	2	2	5	2	
	Upper GI	>104 days	0	0	0	1	4	4	1	
iMSK & SS	Breast	>104 days	0	4	1	2	4	3	4	
	Breast Symptomatic	>104 days	0	1	2	0	0	0	0	
	H&N	>104 days	0	2	3	2	6	5	5	
WH&P	Gynaecology	>104 days	0	2	1	1	1	1	0	
	Paediatrics	>104 days	0	0	0	0	0	0	0	

What is the impact on current performance?

Delays in scheduling diagnostic imaging after MDT discussions, along with extended reporting turnaround times, have slowed pathway progression. Capacity constraints and reduced staffing have also impacted the timely scheduling of first appointments, resulting in some 14-day breaches. In addition, later tertiary referrals continue to affect 62-day performance, driving a strengthened focus on reducing the number of patients approaching or exceeding 62 days

What actions are being taken to improve performance?

To support improved performance, weekly imaging meetings are used to prioritise long-waiting patients for booking and reporting. A weekly cancer performance meeting, supported by daily operational reviews between the appointments centre and specialties, ensures demand is matched to available meet capacity. Pathway reviews are underway for specialties referring to tertiary providers to strengthen resilience, and specialty-level 62-day improvement plans are being progressed through pathway-mapping meetings. In addition, Alliance-led pathway workshops have taken place for nationally targeted tumour groups (Breast and Lung), with corresponding action plans due in the coming weeks.

What are the timelines?

These actions are already in progress and form part of the Trust's ongoing improvement programme. Strengthening diagnostic resilience and enhancing collaboration with tertiary providers are expected to support sustained performance improvement and delivery against national standards. Key Risks and Quality Impacts. Key risks include ongoing capacity constraints and fluctuations in demand, workforce availability, and imaging capacity—particularly reporting turnaround times. Histopathology reporting delays, including molecular results for oncology pathways, also continue to present timeliness risks.

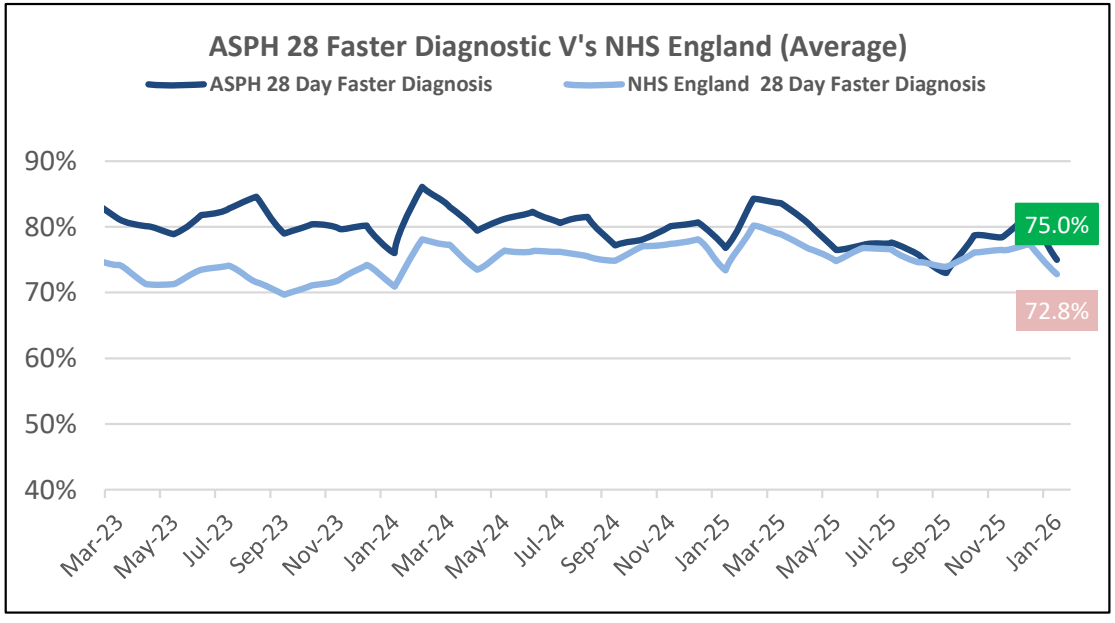
Patients waiting 104+ days

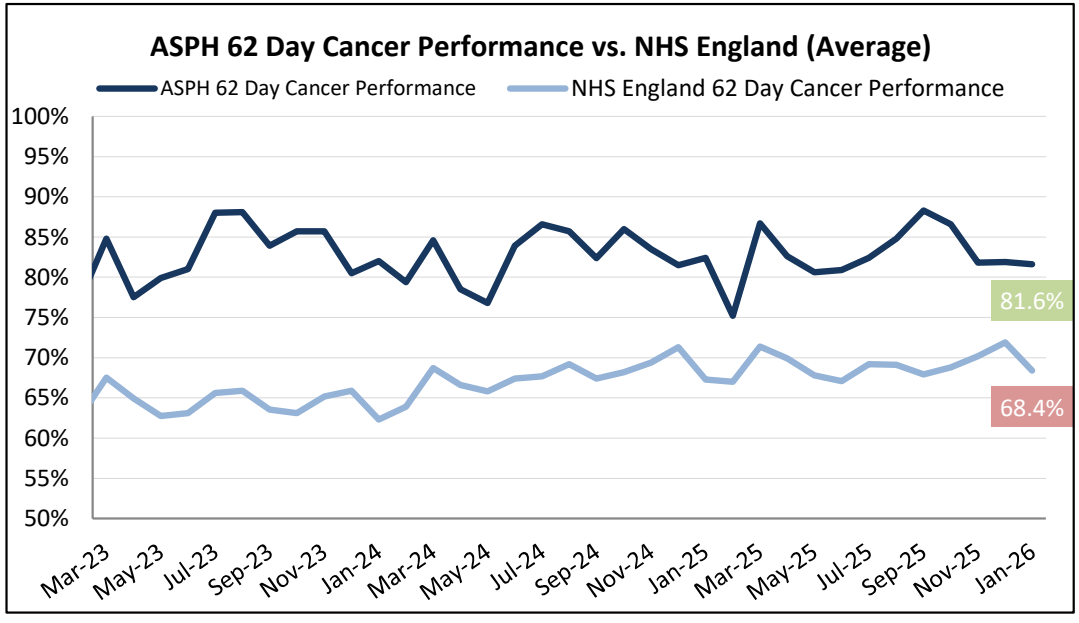
It is predicted that approximately 18 patients will wait more than 104 days for diagnosis or treatment. These cases largely relate to patients who are medically unfit, require multiple specialty diagnostics, or have been unavailable to attend appointments.

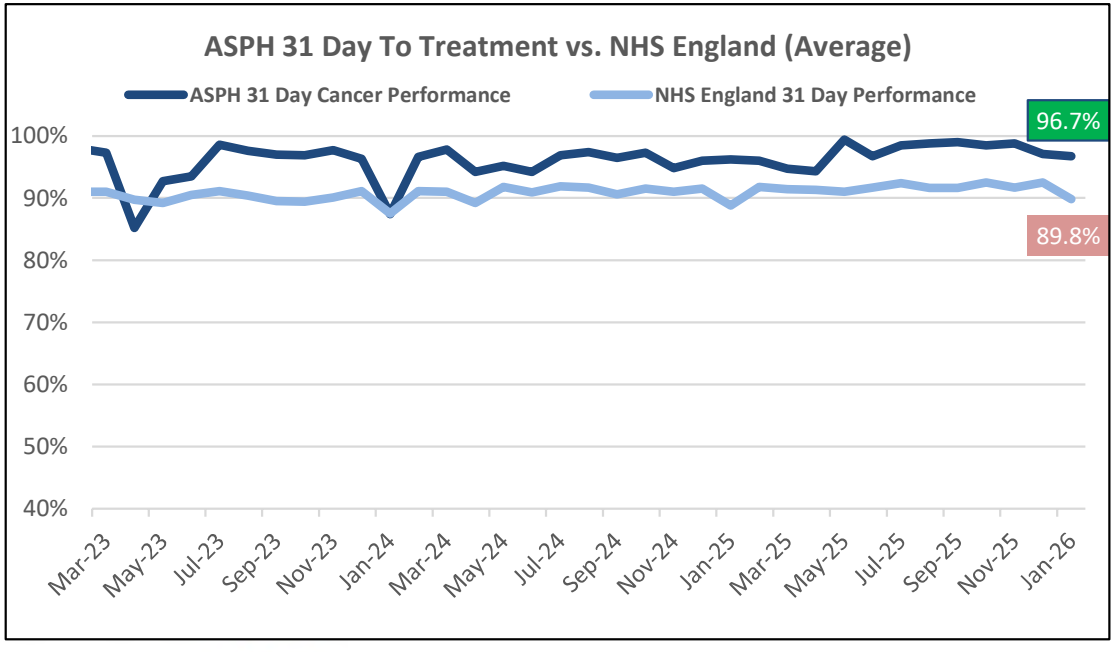
Cancer – Published Performance

Reporting Period	
Monthly	January 26 (latest data)

Elective Care





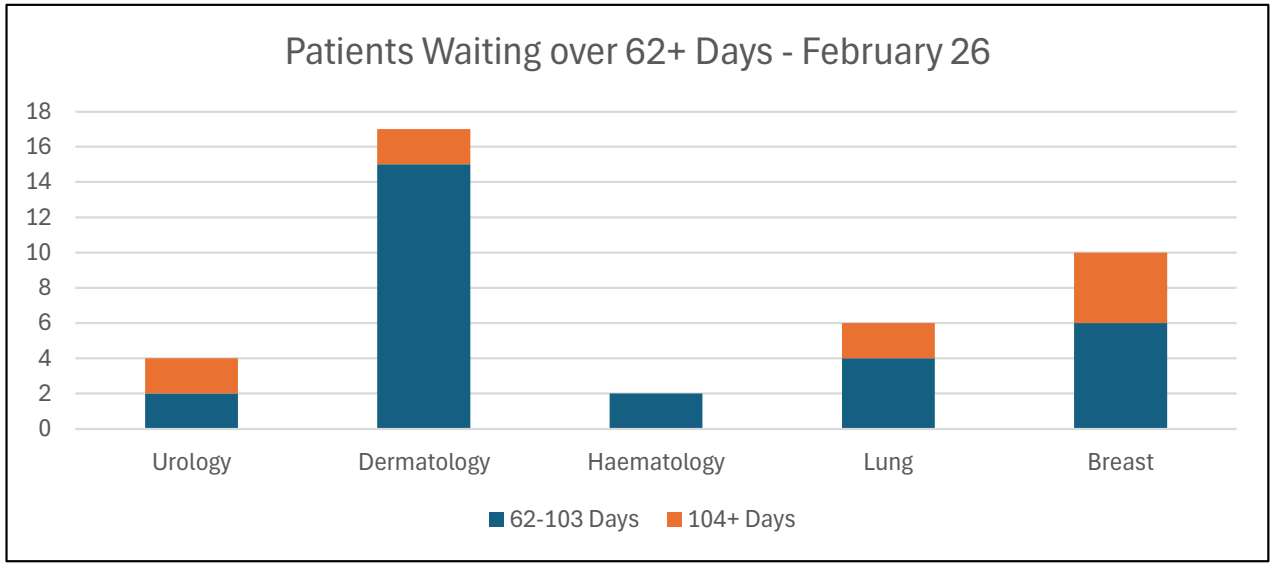


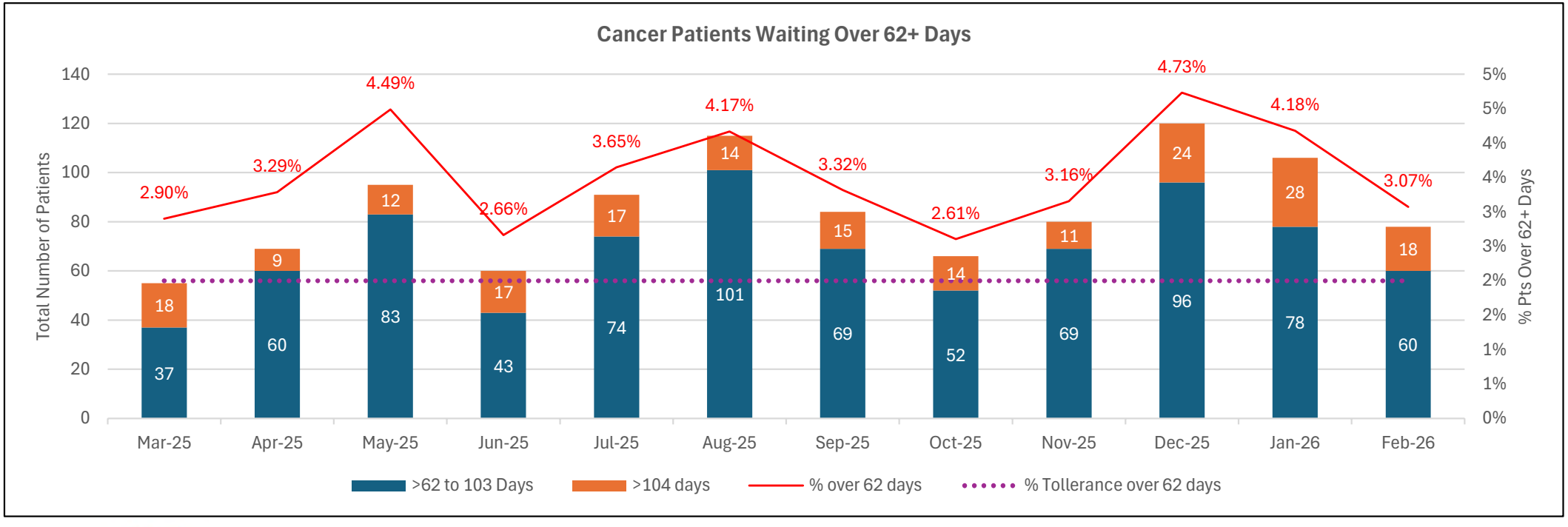
Operational Performance - NHS Planning Guidance [Mar-26 Plan]

Division	Measure	Domain	Target	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Trend
Operational Performance			Mar-26							
Cancer - 28 Day Faster Diagnosis *		**Overall**	**80%**	73.3%	79.0%	78.4%	81.8%	74.5%	83.1%	
GS-ACT	Colorectal	28 FDS	80%	74.2%	77.0%	80.9%	83.6%	76.6%	81.2%	
	Urology	28 FDS	80%	76.7%	75.3%	73.2%	76.4%	69.8%	81.6%	
GSM	Brain	28 FDS	80%	88.9%	100%	71.4%	80.0%	86.7%	77.8%	
	Dermatology	28 FDS	80%	74.4%	87.0%	82.7%	88.9%	75.7%	90.1%	
	Haematology	28 FDS	80%	44.4%	40.0%	57.1%	25.0%	66.7%	42.9%	
	Lung	28 FDS	80%	93.3%	90.0%	88.9%	100%	80.0%	79.1%	
	Upper GI	28 FDS	80%	61.1%	59.3%	66.2%	48.1%	34.1%	59.6%	
iMSK & SS	Breast	28 FDS	80%	80.3%	78.8%	84.5%	82.9%	87.4%	87.8%	
	Breast Symptomatic	28 FDS	80%	73.1%	81.4%	81.5%	90.9%	89.5%	81.0%	
	H&N	28 FDS	80%	64.4%	81.0%	71.6%	80.5%	71.1%	74.0%	
WH&P	Gynaecology	28 FDS	80%	67.7%	65.0%	69.9%	79.2%	70.2%	85.6%	
	Paediatrics	28 FDS	80%	100%	100%	50.0%	100%	100.0%	100.0%	

***Feb data provisional**

Cancer - 62 Day Combined Performance		**Overall**	**75%**	87.7%	84.4%	83.5%	87.2%	80.9%	81.5%	
GS-ACT	Colorectal	62 Day	75%	96.8%	68.2%	73.3%	100%	73.8%	100.0%	
	Urology	62 Day	75%	86.6%	86.7%	93.8%	88.4%	86.7%	90.3%	
GSM	Brain	62 Day	75%	100%	100%	100%	100%	100%	100%	
	Dermatology	62 Day	75%	95.5%	99.2%	91.3%	94.3%	92.5%	94.3%	
	Haematology	62 Day	75%	82.8%	75.0%	85.7%	73.3%	83.3%	60.7%	
	Lung	62 Day	75%	71.4%	62.5%	83.3%	73.7%	72.7%	47.1%	
	Upper GI	62 Day	75%	100%	88.9%	82.4%	96.6%	69.5%	60.0%	
iMSK & SS	Breast	62 Day	75%	64.7%	63.6%	63.2%	77.1%	67.8%	77.8%	
	Breast Symptomatic	62 Day	75%	60.0%	100%	33.3%	50.0%	0%	0%	
	H&N	62 Day	75%	66.7%	33.3%	42.9%	33.3%	12.5%	45.5%	
WH&P	Gynaecology	62 Day	75%	83.3%	75.0%	71.4%	50.0%	70.5%	50.0%	
	Paediatrics	62 Day	75%	100%	100%	100%	100%	100.0%	100.0%	


Patients Waiting over 62+ Days - February 26
18
16
14
12
10
8
6
4
2
0
Urology
Dermatology
Haematology
Lung
Breast
62-103 Days
104+ Days


Cancer Patients Waiting Over 62+ Days
Total Number of Patients
% Pts Over 62+ Days
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
2.90%
3.29%
4.49%
2.66%
3.65%
4.17%
3.32%
2.61%
3.16%
4.73%
4.18%
3.07%
37
18
60
9
83
12
43
17
74
17
101
14
69
15
52
14
69
11
96
24
78
28
60
18
>62 to 103 Days
>104 days
% over 62 days
% Tollerance over 62 days

NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

Ashford & St Peter's Hospitals NHS FT

Workforce Performance

Reporting Month: February 2026

NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

Trust Balanced Scorecard

Reporting Period		Trust Data
Monthly	February 2026	

Measure	Apr Actual	May Actual	Jun Actual	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Variation	Assurance
Agency Staff use (WTE)	107	99	85	109	123	116	125	134	146	126	137	H	-
Agency Spend as %age of Total Pay	2.4%	2.2%	1.8%	2.3%	2.6%	2.3%	2.5%	2.4%	2.6%	2.4%	2.4%	L	?
Bank Staff use (WTE)	515	427	392	413	401	389	416	492	429	436	493	L	-
Bank Spend as %age of Total Pay	11.8%	9.6%	9.2%	9.7%	9.4%	8.4%	9.8%	11.7%	9.8%	10.6%	10.4%	L	F
Vacancy Rate (%)	6.2%	6.4%	5.5%	5.5%	5.1%	4.9%	4.0%	4.3%	5.1%	5.6%	6.0%		?
Staff turnover rate	11.3%	10.9%	10.7%	10.7%	10.4%	10.1%	10.0%	9.9%	9.8%	9.9%	9.8%	L	P
Stability	89.6%	89.8%	90.0%	89.5%	89.8%	89.9%	90.0%	90.0%	90.1%	89.8%	89.9%	H	P
Sickness absence	2.76%	3.4%	3.4%	3.6%	3.7%	3.5%	3.6%	3.5%	4.2%	3.9%	3.9%		?
Staff Appraisals	78.3%	78.5%	78.8%	79.1%	77.0%	78.1%	78.4%	77.3%	76.4%	77.8%	76.7%	H	F
Statutory and Mandatory Training	87.2%	87.8%	88.0%	88.5%	88.5%	88.9%	88.3%	87.9%	87.1%	87.5%	87.9%	H	F

Above are the Trust Balanced scorecard metrics with support of statistical processes control variation and assurance measures. The variation measure is a 24-month trend and assurance is measured vs the Trust in year targets.

KPI/Measure - April 2025/26	Target
Vacancies (%)	<5%
Agency % of Pay Bill	<2%
Bank % of Pay Bill	<6.30%
Turnover (%)	<13%
Stability of workforce (%)	>88%
Sickness (%)	<3.5%
Appraisal (%)	>90%
Mandatory Training (%)	>95%

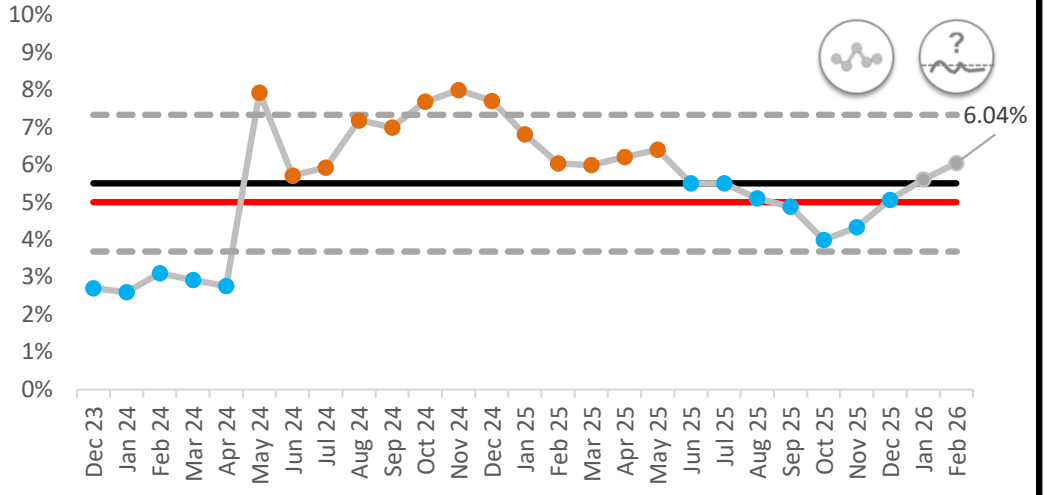
Ashford and St. Peter's Hospitals
NHS Foundation Trust

Focus Metrics

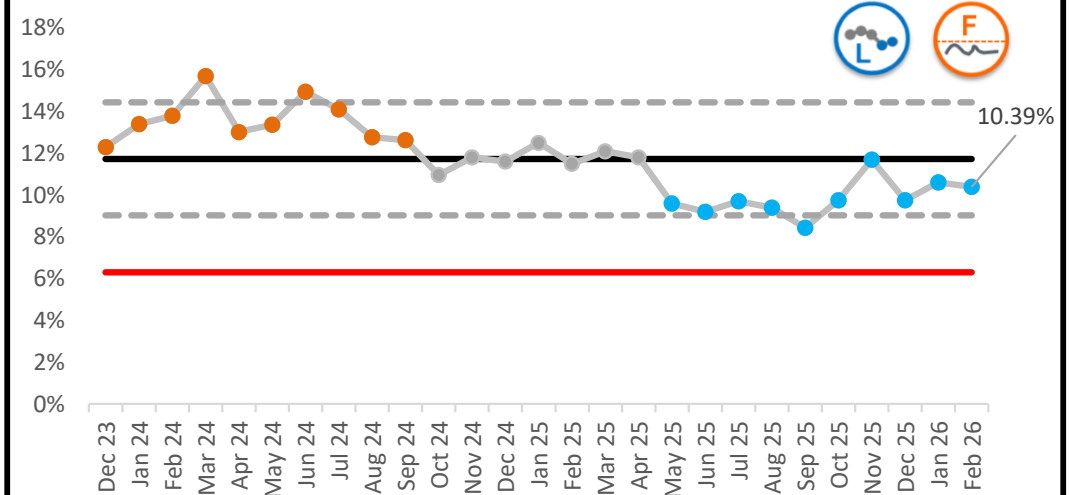
Reporting Period	
Monthly	February 2026

Trust Data

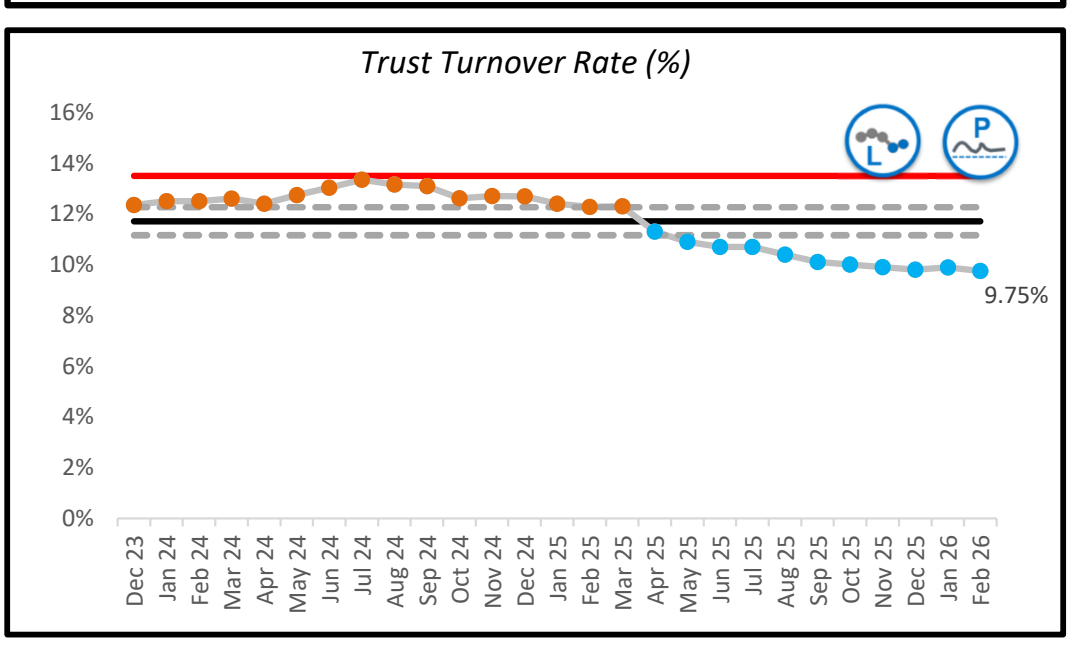
Trust Vacancy Rate (%)



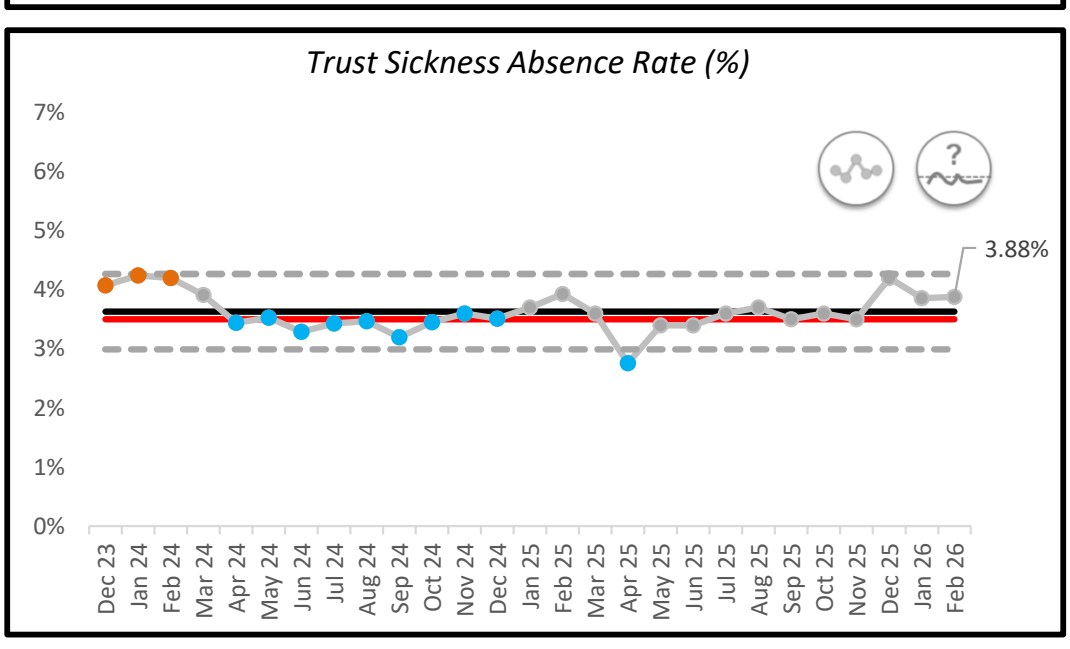
Bank Spend as a Percentage of Total Pay (%)



Trust Turnover Rate (%)



Trust Sickness Absence Rate (%)



Workforce Performance

Reporting Period		Trust Data
Monthly	February 2026	

What are the priority root causes we are seeking to address?	- Temporary staffing usage and spend have risen since Q2 through the seasonal period. Both agency and bank usage are above target. RMN agency continues to be a significant driver for agency use alongside operational pressures and activity performance recovery which drives both bank and agency usage. - Vacancy rates have increased in month and are above Trust target - Sickness absence has demonstrated a seasonal rise and has been above target for the last 5 months. - Appraisal and mandatory training rates are below target levels.
What progress has been made in the last reporting period?	- Completion of the workforce review of inpatient therapies, resultant in a 78% reduction in agency staffing in this area compared to Apr25. Focused work around Cancer workforce is underway, with dermatology being scoped. - First Programme Board update provided on implementation of new rostering system for Agenda for Change staff, confirming programme is on track within identified timelines. - Baseline survey undertaken again to assess compliance against the 10-point improving resident doctors working lives programme, shows we have moved to 82% compliant, 10th in SE Region. - Sickness absence improvement plan developed and approved by Trust Executive Board in March 2026, including opportunities for some areas of Group work and a focus on health and wellbeing interventions. - Turnover and stability continue to perform above target levels. - Pilot "Building safe and respectful teams" programme running in March, focusing on civility and respect in the workplace.
What progress is planned for the next reporting period?	- Implementation of the Trusts Sickness Absence Improvement Plan. - Improved process for Workforce Control Panel to ensure opportunities for workforce opportunities are well considered. - Roll out of first cohort of staff using Allocate Optima for E-Rostering, seeking to optimise the deployment of our workforce resources and minimise unnecessary temporary staffing use. - Options appraisal of 2026/27 Workforce CIP opportunities. - Triangulation on cultural indicators including workforce data, ER data, FTSU concerns and staff survey data to support targeted interventions.
What are the key risks?	- Improving staff engagement and satisfaction alongside progressing Workforce CIP opportunities. - Maintaining safe staffing levels while reducing temporary staffing spend, mitigated by robust safer staffing processes across the clinical workforce.