Appendices Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 23 July 2025 at 12:00 – 15:30 - Trust Board Room, Gundulph Offices and via MS Teams

Item	Subject	Presenter		Time	Action
3. Opening Matters					
3.5	Standing Financial Instructions and Scheme of Delegation **APPENDIX 1**	Chief Finance Officer	3		Approve
4. Sustainability					
4.1	Finance Report (Month 2) **APPENDIX 2**	Chief Finance Officer	87		Discuss
4.3	Integrated Quality Performance Report **APPENDIX 3**	Deputy Chief Executive	95		Assurance
5. Quality, Safety and Patients					
5.1	Learning from Deaths – Quarterly Report **APPENDIX 4**	Chief Medical Officer	148		Approve
5.3	Maternity (and Perinatal) Incentive Scheme – Year 7 Update **APPENDIX 5**	Chief Nursing Officer	164		Assurance
5.4	Claims, Incidents and Complaints Triangulation Report – Q4 2024/25 **APPENDIX 6**		182		
5.5	Perinatal Quality Surveillance and Leadership Quarterly Report: Q4 2024/25 **APPENDIX 7**		195		
5.6	Bi-annual Midwifery Workforce Report **APPENDIX 8**		223		
5.7	IPC Annual Report **APPENDIX 9**	Chief Nursing Officer	244		Approve
5.8	Health and Safety Annual Report **APPENDIX 10**	Director of Integrated Governance and Quality	296		Approve
6. Items for Approval - none					
7. Items for Note					
7.1	Freedom to Speak Up – Annual Report **APPENDIX 13**	Chief People Officer	320		Note

Appendices Agenda

7.6	Engagement and Involvement Framework 2025-2028 **APPENDIX 14**	Director of Communications and Engagement	331		Approve

Standing Financial Instructions and Scheme of Reservation and Delegation

Authors:	Director of Strategy and Partnerships/Company Secretary Deputy Chief Financial Officer Strategy and Partnerships Strategy Development Officer
Document Owner:	Chief Financial Officer
Revision Number:	V 6.9
Document ID Number:	
Approved By:	The Trust Board
Go Live:	July 2025
Date of Next Review:	March 2026

Document Control / History

Revision Number	Reason for change
V 6.9	Trust agreed refresh including revisions for new procurement legislation.

Consultation

TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS

Contents

FOREWORD

These Standing Financial Instructions (SFIs), together with the Trust's Constitution which contains the Standing Orders (SO's), provide a business and financial framework within which all executive directors, non-executive directors and staff of the Trust will be expected to work. All executive and non-executive directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These documents fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The SFI's have been formally adopted by the Board.

Any queries should be referred to the Chief Financial Officer (CFO) or their Deputy as appropriate.

1. INTRODUCTION

1.1 GENERAL

1.1.1 These SFI's shall have effect as if incorporated in the Constitution - SO's of the Trust.

1.1.2 These SFI's detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and the requirements of the independent regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These SFI's identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the CFO.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFI's then advice MUST BE SOUGHT BEFORE ACTING. The user of these SFI's should also be familiar with and comply with the provisions of the Trust's Constitution and Standing Orders.

Failure to comply with the Trust SFI's is a disciplinary matter which could result in dismissal.

TERMINOLOGY

1.1.5 Any expression to which a meaning is given in the Health Service Act 2006, or in the Financial Directions made under the 2006 Act shall have the same meaning in these instructions and in addition:

- "**the Act**" means the National Health Service Act 2006;
- **"Agenda for Change"** (AfC) refers to the grading and pay system for NHS staff. It harmonises pay scales and career progression arrangements across traditionally separate pay groups.
- **"Audit and Risk Committee"** (ARC) is the committee which supports the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment, the integrity of financial statements and the annual report.
- **"Bankers' Automated Clearing Services"** (BACS) is an electronic payment system used for bank-to-bank transfers;
- **"Bribery"** means an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage.
- **"Board of Directors"** and (unless the context otherwise requires) "Board", means the executive and non-executive directors of the Trust, including the Chairman, collectively as a body;
- "**Budget**" means a resource, expressed in financial terms, proposed by the Trust *(Board)* for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
- "**Budget Holder**" means the director or staff with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;
- **"Care Quality Commission"** (CQC) is the independent regulator of health and adult social care in England. The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety;
- **"Charitable Funds Committee"** (CFC) is a separate legal entity, and is the primary committee for the management and monitoring of charitable funds within the regulations provided by the Charities Commission and is chaired by the Chairman of the Board;
- "**Chair"** is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole.

- **“Chief Delivery Officer”** (CDO) is the post responsible for ensuring that a company’s products and services are delivered efficiently, on time, and within budget. They oversee project management, resource allocation, and customer satisfaction, ensuring high-quality delivery and continuous improvement.

- "**Chief Executive Officer**" (CEO) is the highest-ranking executive. Their responsibilities include making major corporate decisions, driving towards strategic goals, and acting as the main point of communication between the board of directors and operations.

- **"Chief Financial Officer"** (CFO) this post is a statutory requirement, and the CFO must be a professionally qualified accountant. The main responsibility is to ensure the Trust adheres to financial regulations and ensures Trust finances are recorded and reported in accordance with Accounting standards as adopted by the NHS.

- **“Chief Medical Officer”** (CMO) is the senior executive responsible for providing vision, professional leadership and strategic direction in the delivery of the Trust's ambitions in the provision of care, learning and research;

- **“Chief Nursing Officer”** (CNO) is the senior executive responsible for organisational, administrative, and nurse leadership duties while setting standards of nursing care and establish the policies and protocols for achieving those standards;

- **“Chief People Officer”** (CPO) is the senior executive responsible for managing human resources. They use their qualifications and experience to ensure the Trust uses its personnel effectively to achieve its goals.

- “**Committee**” refers to the committee of the Board of Directors;

- “**Constitution**” describes the constitution of the Trust which sets out rights for patients, public and staff. It outlines commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the Trust operates fairly and effectively.

- “**Council of Governors**” is the collective body through which executive and non-executive directors explain and justify their actions. It works closely with the Trust Board to make sure services are meeting the needs of the local community.

- **“Corruption”** means the abuse of power or position for personal gain which can manifest as favouritism, nepotism, or unethical practices that harm patient care and misallocate resources.

- **“Department of Health and Social Care”** (DHSC) is a ministerial department support ministers in leading the nation’s health and social care to help people live more independent, healthier lives for longer.

- **“Finance Planning and Performance Committee”** (FPPC) is responsible for

ensuring the Trust has a robust financial strategy, planning framework and overseeing system planning and broader financial management responsibilities;

- **"Financial Recovery Plan"** (FRP) is an integral part of the financial planning process. Its aim is to demonstrate a well-structured, well planned and practical way forward that will achieve financial stability and sustainability.

- **"Fraud"** means deception carried out for personal gain, usually for money, depriving someone of something by deceit. Fraud can also involve the abuse of a position of Trust.

- **"Freedom of Information"** (FoI) is the Act 2000 which gives the public a right of access to information held by public authorities. It also obliges authorities to publish certain information about their activities. The act covers any recorded information held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland.

- "**Funds held on trust**" means those funds which the Trust held at its date of incorporation or subsequently has chosen to accept;

- **"Health Research Authority"** (HRA) is an 'arm's length' body of the Department of Health and Social Care (DHSC) in England. It provides a unified national system for the governance of health research. Its main job is to look after the interests of the general public in health and social care research.

- "**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice;

  "**Member of the Board**" means an executive or Non-Executive Director (Member of the Board in relation to the Board of Directors includes its Chairman.)

- **"Non-Executive Director"** refers to members of the Board of Directors. They are not involved in the day to day running of the business but are guardians of the governance process and monitor the Executive Directors' activity as well as contributing to the development of strategy. They have four specific areas of responsibility: strategy; performance; risk; and people and provide independent views on resources, appointments and standards of conduct.

- "**NHS England" (NHSE)** is the name of the regulator governing NHS Foundation Trusts. Any reference to documents, guidance or direction issues by NHSE will refer to either this body or its predecessor body;

- "**Nominated Staff** means staff charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

- "**Non-Executive Director**" (NED) refers to a Member of the Board of Directors who does not hold an executive office of the Trust;

- **"Public Dividends Capital"** (PDC) represents taxpayers' equity in the NHS trust.

- **"Regulator"** means independent regulators for all health and social care services in England.

- **"Research ethics committees"** (REC's) considers the ethical implications of research and promoting research integrity more generally.

- "**Staff**" means a member of staff of the Trust;

- **"Standing Financial Instructions"** (SFI's) has the purpose of providing control of the Trust's financial and related activities. SFI's identify the financial responsibilities that apply to everyone working for the Trust;

- **"Standing Orders"** (SO's) are a requirement by law and they regulate the way in which the proceedings and business of the Trust are conducted.

- **"Scheme of Reservation and Delegation"** (SoRD) outlines the decisions that are reserved for the Board of Directors, and the levels of delegation the Board provides to employees and committees

- "**Trust**" means Medway NHS Foundation Trust.

- **"Trust Investment and Delivery Group"** (TIDG) is designed to provide a quality assurance role for business cases/investment proposals before onwards submission (to Trust Executives/FPPC/Trust Board) for approval. It also monitors delivery of the schemes through implementation and post implementation.

- **"Ultra Vires"** means acting beyond one's legal power or authority

- **"Vacancy Control Panel"** (VCP) is the committee responsible for overseeing and approving the recruitment and filling of vacant positions within the Trust. It ensures that vacancies are managed efficiently and align with budgetary constraints and organisational needs.

1.1.6 Wherever the titles CEO, CFO, or other nominated staff are used in these instructions, it shall be deemed to include such other director or staff who have been duly authorised to represent them.

1.1.7 Wherever the term "staff" is used and where the context permits it shall be deemed to include staff of third parties contracted to the Trust when acting on behalf of the Trust.

1.1.8 All references in the instructions to gender shall be read as equally applicable to all genders, including male, female, non-binary and all others.

1.2 RESPONSIBILITIES AND DELEGATION

1.2.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Trust's Constitution - Standing Orders for the Board of Directors.

1.2.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation which forms part of the SFI's.

1.2.3 The CEO has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 The CEO and CFO will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.2.5 It is a duty of the CEO to ensure that existing directors and staff and all new appointees are notified of and understand their responsibilities within these Instructions.

1.2.6 All staff, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of the Trust's Constitution - Standing Orders and Standing Financial Instructions.

1.2.7 Any contractor or staff of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the CEO to ensure that such persons are made aware of this.

1.2.8 For any and all directors and staff who carry out a financial function, the form in which financial records are kept and the manner in which directors and staff discharge their duties must be to the satisfaction of the Chief Financial Officer.

2. AUDIT

The Trust is required to go through internal and external statutory, independent auditing to ensure the organisation is accountable and well-governed, and to deliver quality services.

External auditors provide independent assurance that the Trust is spending and accounting for public money properly. The annual external audit is a key statutory requirement for NHS organisations that should provide important and valuable insight into the financial governance of the organisation.

An internal audit as directed by Trust Management can provide a review on operations and processes that can also benefit cost savings, and ensure policies, procedures and activities of the Trust are working efficiently.

2.1 AUDIT AND RISK COMMITTEE

2.1.1 External audits are a legal requirement and must be independent.

2.1.2 Internal audits are directed by Trust Management to ensure policies, procedures and activities of the Trust are working efficiently.

2.1.3 In accordance with Standing Orders (and as set out in the Audit Code for NHS Foundation Trusts, issued by NHSE) the Board shall establish a committee of non-executive directors as an ARC, with formal terms of reference, which will provide an independent and objective view of internal control.

2.1.4 Where ARC feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of ARC should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS Resolution.

2.1.5 It is the responsibility of the CFO to ensure an adequate internal audit service is provided and ARC shall be involved in the selection process when an internal audit service provider is changed.

2.1.6 There is an independent Statutory Audit which is legal requirement to ensure the Trusts accounts are a true and fair view of its financial activities and in accordance with International Financial Reporting Standards (IFRS) as adopted in HM Treasury's 'Financial Reporting Manual' (FReM), subject to any agreed divergences for the DHSC group, or through subordination to the Companies Act 2006.

2.2 BRIBERY, FRAUD, MONEY LAUNDERING, AND CORRUPTION

2.2.1 In line with their responsibilities, the CEO and CFO shall monitor and ensure compliance with the following guidance issued on bribery, fraud, money laundering and corruption:

A. the Proceeds of Crime Act 2002 (POCA) (as amended by the Serious Organised Crime and Police Act 2005 (SOCPA)),

B. the Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 (MLR 2017) and

C. the Terrorism Act 2000 (TA 2000) (as amended by the Anti-Terrorism, Crime and Security Act 2001 (ATCSA 2001) and the Terrorism Act 2006 (TA 2006)

2.2.2 The CFO is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, will ensure that the Trust cooperates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

2.2.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by the NHS Counter Fraud Authority.

2.2.4 The CFO will ensure that the Trust's Local Counter Fraud Specialist has received appropriate training in connection with counter fraud measures and are accredited by the Counter Fraud Professional Accreditation Board.

2.2.5 Where the Trust appoints a Local Counter Fraud Specialist whose services are provided to the Trust by an outside organisation, the CFO must be satisfied that the terms on which those services are provided are such to enable the Local Counter Fraud Specialist to carry out their functions effectively and efficiently and, in particular, that they will be able to devote sufficient time to the Trust.

2.2.5 The Local Counter Fraud Specialist shall report to the Trust CFO and shall work with NHS Counter Fraud Authority as required.

2.2.6 The Local Counter Fraud Specialist and the CFO will, at the beginning of each financial year, prepare a written work plan outlining the Local Counter Fraud Specialist's projected work for that financial year.

2.2.7 The Local Counter Fraud Specialist shall be afforded the opportunity to attend Audit and Risk Committee meetings and other meetings of the Board of Directors, or its committees, as required.

2.2.8 The CFO will ensure that the Local Counter Fraud Specialist:

(a) keeps full and accurate records of any instances of fraud and suspected fraud;

(b) reports to the Board any weaknesses in fraud-related systems and any

other matters which may have fraud-related implications for the Trust;

(c) has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;

(d) receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and

(e) participates as appropriate in activities which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

2.2.9 The CFO must, subject to any contractual or legal constraints, require all Staff to co-operate with the Local Counter Fraud Specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

2.2.10 The CFO must also prepare an Anti-Fraud, Bribery and Corruption Procedure/Policy that sets out the action to be taken both by persons detecting a suspected fraud and the local counter fraud specialist, who is responsible for investigating it.

2.2.11 Any Staff discovering or suspecting a loss of any kind must either immediately inform the CEO and the CFO or the Local Counter Fraud Specialist, who will then inform the CEO and the CFO. Where a criminal offence is suspected, the CFO must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the Local Counter Fraud Specialist.

2.2.12 The CFO is responsible for maintaining an accessible Losses and Special Payments policy to be followed by the Trust for the reporting of transactions.

2.2.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the CFO must immediately notify:

(a) the Board of Directors; and

(b) the internal auditor

2.3 CHIEF FINANCIAL OFFICER

2.3.1 The CFO is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(c) ensuring that an annual internal audit report is prepared for the consideration of ARC. The report must cover:

(i) a statement on the effectiveness of internal control;
(ii) major internal control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.3.2 The CFO and appointed auditors (both internal and external) are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or staff of the Trust;

(c) the production of any cash, stores or other property of the Trust under staff control; and

(d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of or risk associated with, relevant established policies, plans and procedures;

(b) the adequacy, efficiency and application of financial and other related management controls;

(c) the suitability and effective usage of financial and other related management information and data;

(d) the extent to which the Trust assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

2.4.2 Whenever any matter arises which involves, or is thought to involve,

irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

2.4.3 The Head of Internal Audit will normally attend ARC meetings and has a right of access to all ARC members, the Chair and Chief Executive of the Trust.

2.4.4 The Head of Internal Audit shall be accountable to the CFO. The reporting system for internal audit shall be agreed between the CFO, ARC and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

2.5. EXTERNAL AUDIT

2.5.1 It is for the COG to appoint or remove the external auditors at a general meeting of the COG.

2.5.2 The Trust must ensure that the external auditor appointed by the COG meets the criteria included by NHSE within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

2.5.3 External Audit responsibilities (in compliance with the requirements of NHSE and Schedule 10 of the 2006 NHS Act as amended) are:

(a) to be satisfied that the accounts comply with the directions provided in the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).

(b) to be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts;

(c) to be satisfied that proper practices have been observed in compiling the accounts;

(d) to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

(e) to comply with any directions given by NHSE as to the standards, procedures and techniques to be adopted, i.e., to comply with the Audit Code for Foundation Trusts;

(f) to consider the issue of a public interest report;

(g) to certify the completion of the audit;

(h) to express an opinion on the accounts and all schedules:

- Annual Financial accounts

- Annual Quality Account
- The Annual Report

(i) to refer the matter to NHSE if the Trust, or staff or director of the Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

2.5.4 External Auditors will ensure that there is a minimum of duplication of effort between themselves, Internal Audit and NHSE. The auditors will discharge this responsibility by:

(a) reviewing the statement made by the CEO as part of the Statement on Internal Control and making a negative statement within the audit opinion if the Statement on Internal Control is not consistent with their knowledge of the Trust;

(b) reviewing the results of the work of relevant assurers, for example the Care Quality Commission (CQC), to determine if the results of the work have an impact on their responsibilities;

(c) undertaking any other work that they feel necessary to discharge their responsibilities.

2.5.5 The Trust will provide the external auditor with every facility and all information which it may reasonably require for the purposes of its functions under Schedule 10 of the Act.

2.5.6 The Trust shall forward a report to NHSE within 30 days (or such shorter period as NHSE may specify) of the External Auditor issuing a public interest report. The report shall include details of the Trust's response to the issues raised within the public interest report.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The CEO and Chief Delivery Officer (CDO) will compile and submit to the Board an annual business plan. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 The Trust will give information as to its forward planning in respect of each financial year to NHSE. This information will be prepared by the Directors, who must have regard to the views of the COG gathered through dedicated agenda items on quarterly council of governor meetings.

3.1.3 At the start of the financial year the CFO will, on behalf of the CEO, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Trust Finance plan;

(b) be in accordance with any Financial Recovery Plans (FRP) or instructions from an appropriate authority;

(c) accord with activity and workforce plans;

(d) be produced following discussion with appropriate budget holders;

(e) be prepared within the limits of available funds available to the Trust; and

(f) identify potential risks.

3.1.4 The CFO shall monitor financial performance against budget and business plan, periodically review them and report to the Board.

3.1.5 Staff shall provide the CFO with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts.

3.1.6 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The CEO on the advice of the CFO may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

3.2.2 The CEO and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CEO, subject to any authorised use of virement.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The CFO will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) financial reports to the Board in a form approved by the Board containing:

(i) the Statement of Comprehensive Income to date showing trends and forecast year-end position;

(ii) summary cash flow and forecast year-end position;

(iii) Statement of Financial Position;

(iv) movements in working capital;

(v) capital project spends and projected outturn against plan;

(vi) explanations of material variances that explain any movements from the planned retained surplus/deficit position at the end of the current month;

(vii) performance against any permissible borrowing or covenants;

(viii) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 The Financial reports shall be received monthly by the Trust Executive and the Finance, Performance and Planning Committee (FPPC) and bi-monthly by the Board.

3.3.3 Budget Holders are responsible for ensuring that:

i. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the CFO or nominated delegate.

ii. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

iii. no permanent staff are appointed without the approval of the VCP.

iv. the systems of budgetary control established by the CFO are complied with fully;

v. any business or investment cases for further funding of budgets both capital or revenue or that may have indirect impacts on budgets need to follow an approved process,

vi. there is "check and challenge" of practices with regards to efficiencies.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All items of capital expenditure must be referred to the CFO for inclusion in the capital planning and approval processes (including leases).

3.5 MONITORING RETURNS (Foundation Trust Acute License Duties)

3.5.1 The CEO is responsible for ensuring that:

(a) Financial performance measures have been defined and are monitored;

(b) Reasonable targets have been identified for these measures;

(c) A robust system is in place for managing performance against the targets;

(d) Reporting lines are in place to ensure overall performance is managed;

(e) Arrangements are in place to manage/respond to adverse performance.

4. ANNUAL ACCOUNTS AND REPORTS

4.1.1 The CEO is responsible for the preparation and submission of annual accounts in respect of each financial year in such form as NHSE may require. The annual accounts are approved prior to submission to NHSE by those deemed by the Board to be 'charged with governance'.

4.1.2 The Trust's Audited Annual Accounts will be presented to the Board for approval and received by the Council of Governors at a public meeting. A copy will be laid before Parliament and copies forwarded to NHSE.

5. BANK ACCOUNTS

5.1 GENERAL

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK ACCOUNTS

5.2.1 The CFO is responsible for:

(a) Oversight and management of bank accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.3 BANKING PROCEDURES

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) the limit to be applied to any overdraft;

(c) those authorised to sign cheques or other orders and payments drawn through any medium on the Trust accounts and the limitation on single signatory payments.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 All funds shall be held in accounts in the name of the Trust. No staff, other than the CFO, shall open any bank account in the name of the Trust or of its hospitals/wards that otherwise imply these are operated by the Trust.

5.4 TENDERING AND REVIEW

5.4.1 The CFO will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all income due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.1.3 The Trust will carry on activities for the purpose of making additional income available in order to better carry on the Trust's principal purpose, subject to any restrictions in NHSE's authorisation and as stated in the Constitution.

6.2 FEES AND CHARGES

6.2.1 The CFO is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice will be taken as necessary.

6.2.2 All staff must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 DEBT RECOVERY

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts and holds a co-responsibility for salary overpayments with the Human Resources team.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The CFO is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery or electronic records;

(c) the provision of adequate facilities and systems for staff whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment

of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the CFO.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Where cash collection is undertaken by an external organisation this shall be subject to such security and other conditions as required by the CFO.

6.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. Any loss or surplus of cash should be immediately reported to the CFO.

6.4.7 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS), or by crossed cheque and drawn in accordance with these instructions, except with the agreement of the CFO, as appropriate, who shall be satisfied about security arrangements. Uncrossed cheques shall be regarded as cash.

7. CONTRACTS WITH COMMISSIONERS

7.1 Following engagement and scrutiny by the Head of Contracts and the Associate Director of Income and Contracts, the CFO is ultimately responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the Business Plan, as per the NHS Standard Contract 2024/25. These must be approved and signed by the CEO.

7.2 In carrying out these functions, the CEO should consider the advice of the CFO regarding:

(a) costing and pricing of services;

(b) payment terms and conditions;

(c) billing systems and cash flow management;

(d) any other matters of a financial nature;

(e) the contract negotiation process and timetable;

(f) the provision of contract data;

(g) amendments to contracts.

7.2 Contracts with commissioners shall comply with best practice and shall be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation’s liabilities under the terms of the contract, should be considered.

7.3 The CFO shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

7.4 The Trust will maintain a public and up-to-date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services.

8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND STAFF

8.1 REMUNERATION AND TERMS OF SERVICE

8.1.1 In accordance with the Constitution the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

8.2 FUNDED ESTABLISHMENT

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Vacancy Control Panel (VCP) excepting in cases where there is no additional cost demonstrated.

8.3 STAFF APPOINTMENTS

8.3.1 No director or staff may engage, re-engage, or regrade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the VCP.

8.3.2 The Board will approve procedures presented by the CEO for the determination of commencing pay rates, condition of service, etc., for those staff outside of Agenda for Change (AfC).

8.3.3 A signed copy of the contract/appointment form and other such documents as they may require shall be sent to the Chief People Officer (CPO) within one week of the staff commencing duty.

8.3.4 A termination of employment form and such other documents as the CPO may require shall be submitted in the prescribed form immediately upon the effective date of a member of staff's resignation, retirement or termination being known. Where staff fails to report for duty in circumstances which suggest that he has left without notice the CPO shall be informed immediately.

8.3.5 The CPO shall be notified immediately upon the effective date of any change in state of employment or personal circumstances of any staff being known.

8.3.6 All-time records, pay sheets, and other pay records and notifications shall be in a form approved by the CPO and shall be certified and submitted in accordance with the relevant instructions.

8.4 PROCESSING OF PAYROLL

8.4.1 The CPO is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay;

(c) making payment on agreed dates;

(d) agreeing method of payment.

8.4.2 The CPO will issue instructions regarding the conditions upon which the following will apply. The CFO has ultimate responsibility regarding the process for actually enacting points 'g', 'h', and 'l':

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of staff. All staff shall be paid by bank credit transfer, unless otherwise agreed by the CPO;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of staff;

(h) procedures for payment by cheque, bank credit, or cash to staff;

(i) procedures for the recall of cheques and bank credits;

(j) overpayments, pay advances and their recovery;

(k) separation of duties of preparing records and handling cash;

(l) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 The CFO will issue instructions regarding the maintenance of regular and independent reconciliation of pay control accounts.

8.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the CPO's instructions and in the form prescribed by the CPO.

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of resignation, termination or retirement. Where staff fail to report for duty in circumstances that suggest they have left without notice, the CPO must be informed immediately.

8.4.5 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.6 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

8.4.7 Adjustments to pay due to Salary Sacrifice Schemes (season tickets, fleet cars, and bicycle purchase scheme) will be actioned through payroll.

8.4.8 The circumstances under which the Trust reimburse expenses incurred by staff carrying out business activity, as well as other categories of expense, are set out in the respective business travel and expenses policies and guidance on QPulse. Budget holders should ensure they are familiar with such policies and guidance.

8.5 STAFF EXPENSES

8.5.1 The Chief Financial Officer and Chief People Officer are jointly responsible for establishing procedures for the management of expense claims submitted by Trust employees.

They shall arrange for duly approved expense claims, which are in accordance with the Trust's expense policy, to be processed through the Trust's payroll system Expense claims shall be authorised in accordance with the Scheme of Delegation.

8.5.2 The Chief Financial Officer and Chief People Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Chief Financial Officer shall liaise with the Chief Executive where appropriate.

8.6 CONTRACTS OF EMPLOYMENT

8.6.1 The CPO is responsible to the Trust Board for:

(a) ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

(c) The CPO will be responsible for ensuring the Trust has processes and procedures in place that ensure compliance with HM Treasury Guidance on

Public Sector Exit Payments.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the CEO will determine the level of delegation to budget managers.

9.1.2 The CEO will set out in the Scheme of Delegation:

(a) the list of requisitioners who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The CEO shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The Trust's Associate Director of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

9.2.2 The CFO will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts due. The system shall provide for:

(i) A list of directors/staff authorised to certify requisitions, orders, goods receipts or invoices.

(ii) Certification by either hard copy or electronic means that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to staff regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) ensure compliance with NHSE guidance on use of non-clinical agency and consultancy spend

9.2.3 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits;

(b) the appropriate person must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the CFO will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate person if problems are encountered.

9.2.4 Official Orders, either hard-copy or electronically generated, must:

(a) be uniquely and consecutively numbered;

(b) be in a form approved by the CFO;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the CEO

9.2.5 Managers and budget holders must ensure that they comply fully with the guidance and limits specified by the CFO and that:

(a) all contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO advance of any commitment being made;

(b) contracts above specified thresholds are notified, advertised and awarded in accordance with current legislation on public procurement;

(c) no order shall be issued for any item or items to any supplier that has made an offer of gifts, reward or benefit to directors or staff, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(iii) where the CEO has approved the order, in writing, being satisfied that the supplier represents the most appropriate choice.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the CEO through a Trust investment governance process;

(f) all goods, services, or works are ordered on an official order, either in hard copy or electronic media, except works and services executed in accordance with a contract or purchases from petty cash and purchases using a purchasing card;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/staff authorised to certify invoices are notified to the CFO;

(j) purchases from petty cash and via Trust credit card are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

(k) petty cash records are maintained in a form as determined by the CFO.

9.2.6 The CFO shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Executive Director or Director.

9.3 LEGALLY BINDING AGREEMENTS (e.g. leases)

9.3.1 Any documents pertaining to leases or rental agreements must be vetted by the Trust investment governance process to enable insurance issues and technical accounting treatment to be determined.

9.3.2 All lease agreements must be signed on behalf of the Trust by an Executive Director in addition to being accompanied by the usual order and duly authorised in accordance with SFI's.

9.4 EXPENDITURE ON DRUGS

9.4.1 All drugs should be purchased by Pharmacy and not direct with suppliers by service teams.

9.4.2 The clinical criteria for the introduction of new drugs must be in accordance with the Trust's clinical policies and procedures.

9.4.3 The introduction of new drugs costing less than £25,000 per annum (full year effect) may be authorised by the Medicines Management Group through submission of a financial assessment, providing such costs can be met from within existing budget. Between £25,000 and £100,000 can be approved by the

CMO, providing such costs can be met from within existing budget. Above these amounts or outside of budget, a business case needs to be made to the Trust Investment Group (TIG). Any expenditure on drugs e.g. those off the Formulary, and High Cost drugs commissioned externally outside of these limits without prior approval is not authorised and is a contravention of the SFI's.

10. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND INVESTMENTS

The CFO will be responsible for the management of the Trust's cash flow.

10.1 EXTERNAL BORROWING

10.1.1 The Trust can access financial assistance through mechanisms as outlined in the Secretary of State's guidance under section 42A of the National Health Service Act 2006.

10.1.2 The Trust will secure the most preferential interest rates for borrowing.

10.1.3 The CFO will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing. The CFO is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts and associated interest.

10.1.4 The CFO shall be responsible for advising the Trust Board regarding the Trust's ability to repay Public Dividend Capital (PDC) and long-term loan principal together with the payment of dividends on PDC and interest on such borrowings. The CFO shall also be responsible for reporting periodically to the Trust Board concerning all loans or short-term borrowings.

10.1.5 Any application for new borrowing will only be made by the CFO or by staff so delegated by the Board.

10.1.6 In accordance with the Trust Articles of Association the CFO must prepare detailed procedural instructions as per NHSE procedure, concerning applications for new borrowing which comply with instructions issued by the Independent Regulator.

10.1.7 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

10.1.8 All long-term borrowing must be consistent with the plans outlined in the current 5-year strategic plan or an appropriately approved FRP.

10.1.9 Assets protected under the authorisation agreement with the Independent Regulator shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

10.2 INVESTMENTS

10.2.1 The Trust is not permitted to invest when in deficit and in receipt of support.

10.2.2 Temporary cash surpluses must be held only in such investments and with such

financial institutions as approved by the Board and within the terms of guidance issued by the Independent Regulator.

10.2.3 The CFO is responsible for advising the Board on investment strategy and shall report periodically to the Board concerning the performance of investments held.

10.3 FOREIGN EXCHANGE CONTRACTS

10.3.1 Foreign exchange contracts can only be entered into for the purpose of obtaining best value for money when contracts are taken out in foreign currencies. Foreign exchange contracts will not be entered into for the purpose of trading for profit in foreign currencies.

10.3.2 Foreign exchange contracts can only be entered into with the direct knowledge and authorisation of the CFO. All contracts must be signed on behalf of the Trust by the CFO (or in his absence his delegated colleague). The goods or services which are being purchased with the foreign exchange currency will have the appropriate order and duly authorised in accordance with SFI's.

10.3.3 The Board will be informed of any such foreign exchange contracts entered into.

11. CAPITAL INVESTMENT, ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The CEO:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 Every capital expenditure proposal must be taken through the Trust investment governance processes, in accordance with the Trust business case policy:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements;

(b) that the CFO has certified professionally to the costs and revenue consequences detailed in the business case;

(c) that the CEO has certified to indicate endorsement of the operational assumptions.

(d) that the business case is submitted and approved in accordance with delegated powers.

(e) that all proposals to lease, hire or rent fixed assets have been subject to appraisal of their impact on the Trust's ability to achieve its financial targets and subject to legal advice, from the Trust's legal adviser, on the terms of the proposed contract.

11.1.3 For capital schemes where the contracts stipulate stage payments, the CEO will issue procedures for their management.

11.1.4 The CFO shall issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.

11.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

11.1.6 The CEO shall by delegation issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.1.7 The CEO will issue a scheme of delegation for capital investment and the Trust's Standing Orders.

11.1.8 The CFO shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 ASSET REGISTERS

11.2.1 The CEO or nominated delegate, is responsible for the maintenance of registers of assets, taking account of the advice of the CFO concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Trust shall maintain a publicly available property register recording protected property, in accordance with the guidance issued by the Independent Regulator.

11.2.3 The Trust may not dispose of any protected property without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The CFO shall approve procedures for reconciling balances on protected property accounts in ledgers against balances on protected property registers.

Non-protected assets may be used to raise funds for the development of services.

11.3 SECURITY OF ASSETS

11.3.1 The overall control of all assets is the responsibility of the CEO.

11.3.2 Asset control procedures (including protected property, non-protected assets, cash, cheques, negotiable instruments and donated assets) must be approved by the CFO. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

11.3.3 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the CFO.

11.3.4 Whilst staff has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior staff in all disciplines to apply such appropriate routine security practices in relation to property of the Trust as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

11.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by staff in accordance with the procedure for reporting losses.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Private use of the Trust's assets

Use may only be made of the Trust's assets in the pursuance of the Trust's business unless use of the assets for private or other business is explicitly approved in writing. No such use is implied by previous practice. Approval to use the Trust's assets shall be granted as appropriate by the relevant line

manager or a member of senior management of the Trust, dependent upon the value of the asset and the use requested.

12. STORES AND RECEIPT OF GOODS

12.1 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of stores shall be delegated to staff by the CEO. The day-to-day responsibility may be delegated by him to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical staff; the control of fuel oil of a designated estates manager.

12.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be defined in writing by the designated manager/pharmaceutical staff in the Trust Medicines Management SOP regarding responsibility and custody. Wherever practicable, stocks should be marked as property of the Trust.

12.3 The CFO shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns and losses.

12.4 Stocktaking arrangements shall be agreed with the CFO and there shall be an appropriate physical check at least once a year.

12.5 The designated manager/pharmaceutical staff shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

This section must be read in conjunction with the "Losses and Special Payments Procedure" on QPulse.

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The CFO shall prepare detailed procedures for the disposal of assets including condemnations, scrap materials and items surplus to requirements and ensure that these are notified to managers. The Trust may not dispose of any protected property without the approval of the Independent Regulator. These procedures shall comply with all appropriate Standing Orders and SFI's in addition to the requirements specified in the Trust's Policies and Procedures.

13.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by staff authorised for that purpose by the CFO;

(b) recorded by the condemning staff in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second staff member authorised for the purpose by the CFO.

13.1.4 The condemning staff shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

13.2.2 Any staff discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately, or without any undue delay depending on the seriousness of the loss, inform the CEO and the CFO. Where a criminal offence is suspected, the CFO must immediately inform the Local Security Management Specialist and the police.

13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross

carelessness, the CFO must immediately notify:

(a) the Board, and

(b) the Local Counter Fraud Manager and

(c) the Local Security Management Specialist.

13.2.4 Within limits established by the Trust Board, or ARC through its delegated authority, may consider and if thought fit, shall approve the writing-off of losses.

13.2.5 The CFO shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.6 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

13.2.7 The CFO shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14. INFORMATION TECHNOLOGY

14.1 The CDO, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management audit trail exists through the computerised systems (including those obtained by external agency arrangements) and that such computer audit reviews as he/she may consider necessary are being carried out.

(e) ensure the Trust has a Data Protection lead

14.2 The CFO shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

14.5 Where computer systems have an impact on corporate financial systems the CEO shall satisfy themselves that:

(a) systems acquisition, development and maintenance are in line with corporate policies and documents such as a Digital Data and Technology Strategy (DDaT);

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) CFO staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out;

(e) any changes to such systems shall be notified to and approved by the CFO and the CDO;

(f) appropriate disaster recovery and contingency arrangements are in place to ensure continuity in execution of the Trust's business.

14.5 The CDO is responsible to the Board for setting the Trust DDaT Strategy and monitoring progress towards implementing that strategy.

14.6 All new systems must be approved by DDaT Group as to their suitability, value for money and compliance with any set strategy. For the avoidance of doubt, this approval is also required for new systems (or upgrades) acquired by any subsidiary or related party where they will be hosted on or be interoperable with the Trust's digital infrastructure

15. PATIENT PROPERTY

15.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The CEO is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

The Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The CNO in consultation with the CFO must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16. CHARITABLE FUNDS - FUNDS HELD ON TRUST

16.1 INTRODUCTION

16.1.1 The discharge of the Charitable Fund's corporate trustee responsibilities is distinct from its responsibilities for corporate funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. In particular, the purchasing rules and delegated financial limits that apply to Trust purchasing also apply to charitable funds purchasing. Trustee responsibilities cover both charitable and non-charitable purposes. The CFO shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

16.1.2 This Section of the SFI's shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

16.1.3 The Board hereby nominates the CFO to have primary responsibility to the Board for ensuring that these SFI's are applied.

16.1.4 The Charitable Funds Committee (CFC) is a Committee of the Corporate Trustee of the Charitable Funds (the Trust's Board of Directors). Its purpose is to undertake the routine management of the Charitable Funds and to give additional assurance to the Trustee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales. The CFC on behalf of the Charitable Trustee is responsible for fundraising in compliance with all statutes and regulations. The Directors with responsibility for Fundraising and Finance will advise the CFC.

16.2 EXISTING CHARITABLE FUNDS

16.2.1 The CFO shall arrange for the administration of all existing charitable funds and shall ensure that a governing instrument exists for every charitable fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and staff. Such guidelines shall identify the restricted nature of certain funds where applicable.

16.2.2 The CFC as part of its remit review the funds in existence and make recommendations to the Charitable Fund's corporate trustees regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The CFC may recommend an increase in the number of funds where this is consistent with the Charitable Funds corporate trustee policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific wards or departments.

16.3 NEW CHARITABLE FUNDS

16.3.1 The CFO shall arrange for the creation of a new charitable fund where funds and/or other assets, received in accordance with the Charitable Funds corporate

trustee's policies, cannot adequately be managed as part of an existing fund.

16.3.2 Where no fund matches a donor's specific purpose the advice of the CFC should be sought to establish if a new fund is required or whether the donation should be rejected if the donor's wishes cannot be accommodated.

16.4 SOURCES OF NEW FUNDS

16.4.1 In respect of Donations, the CFO shall:

(a) provide guidelines to the Charitable Fund corporate trustees as to how to proceed when offered funds. These to include:

(i) the identification of the donors' intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice;
(v) treatment of offers for personal gifts.

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Charitable Funds and that the donor's intentions have been noted and accepted.

16.4.2 In respect of Legacies and Bequests, the CFO shall:

(a) provide guidelines to staff of the Charitable Funds covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Charitable Funds are the beneficiary;

(c) be empowered, on behalf of the Charitable Funds corporate trustees, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

(d) be directly responsible for the appropriate treatment of all legacies and bequests;

(e) be kept informed of all enquiries regarding legacies and keep an appropriate record. After the death of a testator all correspondence

concerning a legacy shall be dealt with on behalf of the Trust by the Chief Financial Officer, who alone shall be empowered to give an executor a good discharge.

16.4.3 In respect of Fund-raising, the Charity and Fundraising Manager of the Medway Hospital Charity will:

(a) deal with all arrangements for fund-raising by and/or on behalf of the Charitable Funds and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Director of Communication and Engagement shall be the only staff empowered to give approval for such fund- raising subject to the overriding direction of the Board;

(c) be responsible for alerting the Board to any irregularities regarding the use of the Charitable Fund's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

(e) be required to advise the Board on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

16.4.4 In respect of Charitable Fund's Trading Income, the CFO shall:

(a) be primarily responsible, along with other designated staff, for any trading undertaken by the Charitable Fund's as corporate trustee;

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

16.4.5 In respect of Investment Income, the CFO shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5 **INVESTMENT MANAGEMENT**

16.5.1 The CFO shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which they shall be required to provide advice to the Charitable Fund's corporate trustees shall include:

(a) the formulation of investment policy within the powers of the Charitable

Funds under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the reporting of investment performance

16.6 **DISPOSITION MANAGEMENT**

16.6.1 The exercise of the Charitable Funds dispositive discretion shall be managed by the Charitable Trustees in conjunction with the Charitable Funds corporate trustees. In so doing he shall be aware of the following:

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of Trust funds to discharge Charitable Fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Trust shall be discharged by Charitable Funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Funds;

(f) the definitions of "charitable purposes" as agreed with the Charity Commission.

16.7 **BANKING SERVICES**

16.7.1 The CFO shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Charitable Funds as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 **ASSET MANAGEMENT**

16.8.1 Assets in the ownership of or used by the Charitable Funds as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Charitable Fund. The Chief Financial Officer shall ensure:

(a) that appropriate records of all assets owned by the Charitable Fund as corporate trustee are maintained and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets.

These to include decisions regarding insurance, inventory control and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for.

16.9 **REPORTING**

16.9.1 The CFO shall ensure that regular reports are made to the Charitable Funds corporate trustees with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

16.9.2 The CFO shall prepare annual accounts in the required manner which shall be submitted to the Charitable Funds corporate trustees within agreed timescales.

16.9.3 The Charity and Fundraising Manager shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and the Charity Commission for adoption by the Charitable Funds corporate trustees.

16.10 **ACCOUNTING AND AUDIT**

16.10.1 The CFO shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 The CFO shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year and will liaise with external audit and provide them with all necessary information.

16.10.3 The Charitable Funds corporate trustees shall be advised by the CFO on the outcome of the Charitable Funds annual audit. The CEO shall submit the Management Letter to the Charitable Funds corporate trustees.

16.11 **ADMINISTRATION COSTS**

16.11.1 The CFO shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Finance, shall charge such costs to the appropriate trust accounts.

16.12 **TAXATION AND EXCISE DUTY**

16.12.1 The CFO shall ensure that the Charitable Funds liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. INDUCEMENTS and DECLARATION OF INTERESTS

17.1 ACCEPTANCE OF GIFTS AND HOSPITALITY

17.1.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. Staff must comply with national guidance 'Standards of Business Conduct for NHS Staff and any guidance and directions issued by the Independent Regulator.

17.1.2 All staff will be responsible for notifying the Company Secretary who will record in writing, any gift, hospitality or sponsorship accepted (or refused) by staff on behalf of the Trust.

17.1.3 Any offers for gifts, hospitality or sponsorship that do not comply with the Trust's Standard of Business Conduct Policy, should be courteously but firmly refused and the firm or individual notified of the Trust's procedures and standards

17.2 DECLARATION OF INTERESTS

17.2.1 The Company Secretary shall be advised of declared pecuniary interests of members of the Board for recording in a register they will maintain for that purpose.

17.2.2 All other staff should declare any relevant interest in accordance with the standards of Business Conduct which should be updated annually.

17.3 PRIVATE TRANSACTIONS

17.3.1 Staff having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favor or preference as regards price or otherwise which is not generally available should be sought or accepted.

18. RETENTION OF DOCUMENTS

18.1 The CEO or nominated delegate shall be responsible for defining retention periods and maintaining archives for all documents required to be retained as directed by law, where applicable.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents so held shall only be destroyed at the express instigation of the CEO or their nominated delegate; records shall be maintained of documents so destroyed.

18.4 The Trust's arrangements for disclosure under the Freedom of Information (FoI) Act shall be maintained by the CMO.

19. RISK MANAGEMENT & INSURANCE

19.1 The CEO shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board and the ARC.

19.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit; clinical audit; health and safety review;

(f) decisions on which risks shall be insured through arrangements with either the NHS Resolution Pooling Schemes or commercial insurers;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts.

19.3 The CEO in consultation with his designated staff shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

APPENDIX 1. PURCHASING AND TENDERING

1 Quotations: Competitive and non-competitive

1.1.1 General Position on quotations

Competitive quotations are required where the intended expenditure or income during the total period of the contract is reasonably expected to exceed £12,000. Competitive quotations must be obtained via the Procurement department to ensure that all obligations under the Procurement Act 2023 are met.

1.1.2 Competitive Quotations

(a) Written Quotations or Tenders as appropriate should be obtained from at least 3 suppliers from £24,999 to the threshold as stated in Procurement Law 2023 for Goods and Services based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) For minor works written Quotations or Tenders as appropriate should be obtained from at least 3 suppliers from £50,000 to the threshold as stated in Procurement law, based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(c) Quotations should be in writing on company letter headed paper, from a company email address or via the e-tendering platform

(d) All quotations should be treated as confidential and should be retained for inspection.

(e) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

1.1.3 Non-Competitive Quotations

Non-competitive quotations in writing may be only be obtained as allowed for in the Procurement Act 2023. The fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee at each meeting.

1.1.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive, Deputy Chief Executive or Chief Financial Officer.

APPENDIX 2. HIERARCHY OF DELEGATED BUDGETARY AUTHORITY

Budgets Authorised	(£) Limit	Minimum level of Staff
Virement between non- pay budget lines within same cost-centre.	£all	Budget holder or appropriate delegated budget manager(s) together with authorisation from Head of Management Accounts or equivalent
Virement between non-pay lines across divisions.	£all	Mutual agreement of budget holders or budget manager(s) together with authorisation from Head of Management Accounts or equivalent
Any virement involving pay lines	£all	Budget holder or appropriate delegated budget manager(s) together with authorisation from Head of Management Accounts or equivalent; any establishment change to be authorised by the Chief Financial Officer

Pay Expenditure Delegated Limits

Budgets Authorised	(£) Limit	Minimum level of Staff
Commitment to incur costs as a result of a contract of employment (including temporary contracts), existing post	£all	Vacancy Control Panel (VCP)
Commitment to incur costs as a result of a contract of employment (including temporary contracts), new post	£all	CFO and CEO and CPO (by authorising change to establishment)
Commitment to incur costs via agency, consultancy or other means, for any continuous period fulfilling same duties, even if undertaken by different individuals.	£all	Executive VCP upon receipt of request authorised by the Budget holder

APPENDIX 3. SUMMARY OF DELEGATED APPROVAL LIMITS

Table 1. Contractual approvals required to commence and commit Trust expenditure

Authority	Expenditure				Contracts	Disposal / write-off of assets	Write-off of debt	Losses and special payments
	General		Business cases					
	PO/Inventory	Non-PO	Capital	Revenue				
Trust Board	£500,000+	£500,000+	£1,000,000+	£500,000+	£500,000+	£500,000+	£500,000+	£500,000+
Trust Investment and Delivery Group			£1,000,000	£500,000				
CEO	£500,000	£500,000	£1,000,000*	£500,000*	£500,000	£500,000	£500,000	£500,000
CFO	£500,000	£500,000	£1,000,000*	£500,000*	£500,000	£500,000	£500,000	£500,000
Associate Director of Procurement	£500,000	£50,000			£50,000			
Chief Operating Officer	£150,000	£25,000			£50,000			
All other voting Executive members of the Trust Board	£100,000	£10,000			£50,000			
All other Executive Directors	£50,000	£10,000						
Divisional Directors	£50,000	£10,000						£10,000
Chief Pharmacist	£50,000	£10,000						
Director of Estates & Facilities	£50,000	£50,000	£50,000*					
Deputy CFO	£50,000	£50,000	£50,000*	£50,000*	£50,000	£50,000	£50,000	£50,000
Deputy Director of HR & OD	£50,000	£5,000						
Deputy Director of Nursing	£50,000	£5,000						
Heads of Service / General Managers	£20,000	£5,000				£5,000		£5,000
Company Secretary	£10,000	£5,000						
Other budget holders and qualified pharmacy buyers	£10,000							
Financial Controller	£5,000	£5,000				£5,000	£5,000	£5,000

Notes:

*Capital approval limits of individuals are subject to approval of the investment proposal through the relevant governance structure, e.g. Trust Investment and Delivery Group and Trust Board. The chair of each relevant governance committee has delegated authority to approve additional contingency to a project, following approval ,at the lesser of 10% of the approved scheme value or their delegated capital authority.

The CEO and CFO are authorised to provide assurance and therefore approval for all items that have been agreed by the Trust Board.

PO/Stock relates to all goods and services ordered through Trust approved procurement and stock replenishment systems (finance, pharmacy and temporary staffing systems) including goods supplied by NHS Supply Chain.

Non-PO purchases are exceptional purchases approved with Finance. Purchase commitments made in this way without Finance approval will be reported as a breach of SFI's.

Where evidence of the correct governance process and a valid contract signed by those delegated to do so in the SFIs is attached to a purchase order requisition the Director Of Procurement is delegated authority to provide system approval to issue the official purchase order.

The Clinical Negligence Scheme premium is approved annually by the CFO and is outside of the Trust Purchasing Ordering process

Limits can be delegated downwards during periods of absence by completing SFI forms at the end of this document.

Limits can be delegated upwards or sideways by using vacation rules in the Finance ledger.

Table 2. Approvals required to commit Trust expenditure – Charitable Funds

Financial Limits	**Charitable Funds**
Charitable Funds Committee	**More than £15,000**
Chief Executive/Chair of the Charitable Funds Committee	**£3,000 - £15,000**
Charity and Fundraising Manager	**Up to £3,000**

APPENDIX 4. SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

TABLE 1

SFI REF	DELEGATION	DUTIES DELEGATED
	CEO or Deputy CEO	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
	CFO	Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using Resources and conforming to Standing Orders, Financial Instructions and financial procedures.
	CFO	Form and adequacy of financial records of all departments.
	Audit and Risk Committee	Provide independent and objective view on internal control and probity.
	CFO	Carry out all work to counter fraud and corruption in accordance with NHSE directions.
	CFO	Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption in accordance with NHSEI Directions.
	Head of Internal Audit	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
	Audit and Risk Committee	Ensure cost-effective external audit.
	CDO	Overall responsibility for business plans and budgets. Delegate budget to budget holders and submit monitoring returns. Ensuring compliance with NHSEI requirements and ensuring adequate system of monitoring. Submit budgets.

		Monitor performance against budget, submit to Board financial estimates and forecasts. Devise and maintain systems of budgetary control.
	CFO	Annual accounts and reports.
	CFO	Banking arrangements.
	CFO	Income systems.
	CFO	Negotiating contracts for provision of patient services. Negotiating NHS contracts Regular reports of actual and forecast contract income.
	Board CEO / Deputy CEO or CFO Nomination and Remuneration Committee	Agree terms of reference of Nomination and Remuneration Committee Variation to funded establishment of any department. Report in writing to the Board its advice and its basis about remuneration and terms of service of directors and senior employees.
	CPO	Payroll form and adequacy of payroll records and processes
	CEO	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
	CFO	Prompt payment of accounts.
	CEO	Authorise who may use and be issued with official orders.
	CFO	Agree terms of reference of Performance and Remuneration Committee Variation to funded establishment of any department. Report in writing to the Board its advice and its basis about remuneration and terms of service of directors and senior employees.
	CFO	Payroll form and adequacy of payroll records and processes
	CEO	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
	CFO	Prompt payment of accounts.
	CEO	Authorise who may use and be issued with official orders.
	CFO	Maintenance of asset registers.
	Line or senior managers	Use of Trust assets for private use.
	CEO	Overall responsibility for fixed assets.
	All senior staff	Responsibility for security of Trust assets

		including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
	CFO	Responsible for systems of control over stores and receipt of goods.
	CEO	Identify persons authorised to requisition and accept goods from Supplies stores.
	CFO	Prepare procedures for recording and accounting for losses and special payments
	CEO	Responsible for accuracy and security of computerised data.
	CEO	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
	CFO	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee if any).
	CEO	Retention of document procedures
	CEO CFO	Risk management programme Insurance arrangements

APPENDIX 5. MEDWAY NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the CEO and Deputy CEO.

The delegation shown below is the lowest level to which authority is delegated.

Delegation to lower levels is only permitted with written approval of the CEO or Deputy CEO who will, before authorising such delegation, consult with other senior staff as appropriate.

All items concerning Finance must be carried out in accordance with SFI's and Standing Orders.

In all cases in the absence of the CEO the Deputy CEO or CFO may deputise. In the absence of the CFO the deputy CFO may deputise for the CFO.

TABLE 1

Delegated Matter	Authority Delegated To	Reference Documents
Management of Budgets Responsibility of keeping expenditure within budgets At individual budget level (Pay and Non-Pay) At service level For the totality of services covered by Clinical / Executive Director For all other areas:	Budget Manager Associate Director/ Head of Service Clinical/Executive Director or Deputy CEO CFO or appropriate delegated manager	
Maintenance / Operation of Bank Accounts	CFO	

delegated powers of virement. (Subject to the limits specified above in (a)) Orders exceeding 12-month period All contracts for goods & services and subsequent variations to contracts	 As (a) above for whole life of contract	
Capital Schemes Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations Financial monitoring and reporting on all capital scheme expenditure Granting and termination of leases Contract Variations to capital projects	 Director of Estates and Facilities CFO or nominated deputy CFO	
Quotation, Tendering & Contract Procedures Waiving of Tenders on competitive quotations subject to SFI's below £500,000 £500,000 to £1m £1m to 3m Over £5m	 CFO CEO Trust Leadership Team Trust Board	
Setting of Fees and Charges Private Patient, Overseas Visitors, Income Generation and other patient related services. Price of NHS Contracts	 CFO CFO	

Engagement of Staff Not on the Establishment. Engagement of Trust's Solicitors Authorising engagement of Bank or Agency Staff Medical Locums Nursing Clerical	Executive VCP / CFO CFO / Deputy CEO / CEO Nominated Executive Director Divisional Director and above / Head of Service / Budget Manager Divisional Director and above / Head of Service / Budget Manager Divisional Director and above / Head of Service	
Expenditure on Charitable and Endowment Funds - Up to £10,000 - £10,001 to £25,000 - £25,000 to £100,000	Fund Holder Deputy CFO and Charity and Fundraising Manager CFO / CPO	SFI's Section 16
- £100,001 to £500,000 - £500,001 upwards	Charitable Funds Committee Trustees	
Agreements/Licenses Preparation and signature of all tenancy agreements/licenses with staff subject to Trust Policy on accommodation for staff Agreements with landlords on behalf of the Trust Extensions to existing leases Letting of premises to outside organisations Approval of rent based on professional	Accommodation Manager CFO CFO	

assessment		
Condemning & Disposal Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively with current/estimated purchase price <£50 with current purchase new price >£50 disposal of x-ray films (subject to estimated income of £1,000 per sale) disposal of x-ray films (subject to estimated income exceeding £1,000 per sale) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale) any disposals >£5k	Head of Service Associate Director Head of Radiology Head of Radiology and AD Director of Estates Director of Estates Executive Directors inc Director of Estates	

Losses, Write-off & Compensation		
Losses and Cash due to theft, fraud, overpayment & others Up to £5000	Financial Controller Deputy CFO	
Losses and Cash due to theft, fraud, overpayment & others £5000 - £50,000	CFO or Deputy CEO	
Losses and Cash due to theft, fraud, overpayment & others £50,000 - £500,000	Trust Board	
Losses and Cash due to theft, fraud, overpayment & others over £500,000	As above	
Fruitless Payments (including abandoned Capital Schemes over £50,000)	As above	
Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other		
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other.		

Compensation payments made under legal obligation, or ex gratia payments for clinical negligence in line with legal advice Extra Contractual payments to contractors Up to £50,000 Ex-Gratia Payments (except clinical negligence in line with legal advice) Patients and staff for loss of personal effects For clinical negligence up to NHS RESOLUTION Excess Limit (negotiated settlement) in line with legal advice. For personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to NHS RESOLUTION Excess Limit Other, except cases of maladministration where there was no financial loss by claimant Up to £50,000 (i) Special severance payment applications which are below £100,000 and/or where the employee earns more than £150,000	CFO CFO As above CFO CFO CFO CPO	
(ii) Special severance payment applications which are at or above £100,000 and/or where the employee earns more than £150,000	Ministerial Approval	
Reporting of Fraud Incidents to the Police Where a fraud is involved	CFO or nominated Local Counter Fraud Specialist (LCFS)	

Petty Cash Disbursements Expenditure up to £50 per item Reimbursement of patients' monies		
Receiving Hospitality Applies to both individual and collective hospitality receipt items. In excess of £50.00 per item offered and received.	Declaration required in Trust's Hospitality Register	
Implementation of Internal and External Audit Recommendations	Appropriate Executive Director	
Maintenance & Update on Trust Financial Procedures	CFO	
Investment of Funds (including Charitable & Endowment Funds)	CFO	
Human Resources & Pay Authority to fill funded post on the establishment with permanent staff. Authority to appoint staff to post not on the formal establishment. Additional Increments	Divisional Director/Heads of Service CEO / CFO / CPO / Divisional Director	

The granting of additional increments to staff within budget	CPO or deputy	
Upgrading & Regrading All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure	CPO or deputy	
Investments	CEO / Deputy CEO/ CFO / CPO	
Additional staff to the agreed establishment with specifically allocated finance.	CEO / Deputy CEO / CFO / CPO	
Additional staff to the agreed establishment without specifically allocated finance.		
Pay		
Authority to complete standing data forms effecting pay, new starters, variations and leavers	HR Advisor	
Authority to complete and authorise positive reporting forms	Associate Director/Head of Service	
Authority to authorise overtime	Associate Director/Head of Service	
Authority to authorise travel & subsistence expenses	Associate Director/Head of Service/Budget Manager	
Approval of Performance Related Pay Assessment (not Executive Directors)	Executive Directors / Chief Executive	

Leave Approval of annual leave Annual leave - if exceptional circumstances prevent an employee taking their full entitlement, approval to carry forward up to maximum of one working week. Special leave arrangements	 Line/Departmental Manager Line/Departmental Manager Line/Departmental Manager	
Sick Leave Extension of sick leave on half pay up to three months Return to work part-time on full pay to assist recovery Extension of sick leave on full pay	 Line Manager in conjunction with HR Business Partner Line Manager in conjunction with HR Business Partner Line Manager in conjunction with HR Business Partner	
Study-Leave Study-leave outside of the UK All other study-leave (UK)	 Deputy CEO General Manager/Head of Service/Executive Director	

Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Human Resources staff must be sought when the grievance reaches the level of General Manager	CPO	
Entering into Fixed Term Contract	CPO or their deputy	
Staff Retirement Medical staff Non-Medical	 CMO Line Manager	
Redundancy All staff	 Nominations and Remunerations Committee	
Dismissal	CPO	
Authorisation of New Drugs if Budgeted Estimated total yearly cost up to £25,000 Estimated total yearly cost between £25,001 and £100,000	 Medicines Management Group Medical Director	
Authorisation of Sponsorship deals		
Authorisation of Research Projects	CEO, Deputy CEO, CMO or CFO / Research and Innovation Governance Group (RIGG) / Research Operational Group (ROG) the research having already been approved by the	

	Health Research Authority (HRA) and NHS Research Ethics Committee (REC's) as appropriate (national/regional bodies)	
Authorisation of Clinical Trials	CEO, Deputy CEO CMO, RIGG / ROG, the trial having already been approved by HRA and NHS REC's as appropriate (national/regional bodies)	
Insurance Policies and Risk Management	CEO, Deputy CEO and CFO	
Patients & Relatives Complaints Overall responsibility for ensuring that all complaints are dealt with effectively Responsibility for ensuring complaints relating to a directorate are investigated thoroughly.	CNO Director of Quality and Patient Safety	
Medico - Legal Complaints Coordination of their management.	Associate Director/Head of Service/Executive Director	
Relationships with Press Non-Emergency General Enquiries Within Hours Outside Hours Emergency Within Hours Outside Hours	 Communications and Engagement team Admin on Call or Executive Director CEO, Deputy CEO or Executive Director Admin on Call or Executive Director	

Infectious Diseases & Notifiable Outbreaks	Admin on Call or Infection, Prevention and Control Lead	
Extended Role Activities Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	CEO, Deputy CEO or Chief of Nursing & Midwifery	
Patient Services Variation of operating and clinic sessions within existing numbers Outpatients Theatres Other All proposed changes in bed allocation and use Temporary Change Permanent Change Contract monitoring & reporting	CEO, Deputy CEO or CMO	
Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts & Insurance of Medical Staff. Work experience students	CPO CPO	
Review of fire precautions	Director of Estates & Facilities	
Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Head of Facilities/CFO	

Review of Medicines Inspectorate Regulations	CNO	
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	CMO / CFO	
Review of Trust's compliance with the Data Protection Act	CEO, Deputy CEO	
Monitor proposals for contractual arrangements between the Trust and outside bodies	CEO, Deputy CEO	
Review the Trust's compliance with the Access to Records and Freedom of Information Acts	CEO, Deputy CEO	
Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven"	CEO, Deputy CEO	
The keeping of the Register of Directors' Interests.	Company Secretary	
Attestation of sealings in accordance with Standing Orders	CEO, Deputy CEO	
The keeping of a register of documents sealed.	Company Secretary	
The keeping of the Hospitality Register.	CEO, Deputy CEO	
Retention of Records	CEO, Deputy CEO	

Clinical Audit	CEO, Deputy CEO	

APPENDIX 6. HM Treasury Guidance on Public Sector Exit Payments: Use of Special Severance Payments

The May 2021 guidance sets out the criteria the Trust must consider before making special severance payments, the control process and the transparency requirements.

SPECIAL_SEVERANCE_GUIDANCE_v3_FINAL.pdf (publishing.service.gov.uk)

Payments

Special Severance Payments are any payments on termination of employment which do not correspond to an established contractual, statutory or other right (for example, statutory and contractual redundancy pay or untaken annual leave). Some examples of the types of payment which are likely to constitute special severance payments include any payment reached under a settlement agreement, write-offs of outstanding loans and special leave such as gardening leave.

Control

Special severance payments should be exceptional rather than routine. The CPO or Deputy will be responsible for ensuring that all relevant internal policies and procedures have been followed and all alternative actions have been fully explored and documented before an application is made for a special severance payment. They must also ensure that arrangements for special severance payments are fair, proportionate and lawful.

The process for applying for a special severance payment to HM Treasury is as follows:

- The CPO or Deputy (the sponsor) will be responsible for ensuring the Annex A proforma in the HM Treasury guidance is completed.
- The CPO or Deputy (the sponsor) will submit the completed proforma to the CFO or Deputy for approval.
- Upon approval, the CPO or Deputy will send proforma to the HM Treasury spending team for assessment.
- HM Treasury spending team will notify the sponsor of the outcome in writing.

Ministerial approval will be sought for Special Severance Payments where an exit package which includes a Special Severance Payment is at, or above, £100,000 and/or where the employee earns over £150,000. This is because payments of this nature are a significant payment out of public funds. In these cases, the CEO or

Chair will be the sponsor, with support of CPO or Deputy as required.

No offers of special severance payments should be made before HM Treasury approval is received in writing. Notification on the outcome of the case will be made in writing to the sponsoring department.

Any payment proposed as part of a settlement agreement in excess of contractual, statutory and other entitlements is a Special Severance Payment and authorisation must be given in writing by HM Treasury before such a settlement is agreed. 3.27 Where there is a dispute between the employer and employee or ex-employee, employers should consider, at an early stage, the likelihood of an employment tribunal or other claim and seek legal advice on potential costs involved. Employers must first consider non-financial avenues to resolve disputes in collaboration with the parties involved. The Government's default approach is not to settle, and HM Treasury will closely scrutinise any such cases to ensure Special Severance Payments are only made in exceptional circumstances and represent value for money for the Government as a whole.

Transparency

Employers should continue to follow existing relevant guidance on reporting exit payments and Special Severance Payments. Employers are required to disclose in their annual accounts information about all exit payments paid during the financial year. This disclosure includes details about the number of exit payments paid in bands from £0-£25,000, £25,001-£50,000, £50,001-£100,000, £100,001-£150,000 and £150,000+. Additionally, public sector authorities should also publish details of all Special Severance Payments in their annual accounts. Evidence to support all exits should be collected and stored, so it is easily accessible and clear to understand.

NHS Medway NHS Foundation Trust

NHSE Guidance on Special Payments

On 19th April 2021, NHSE/I instructed Trusts to provide detail of any special payments which are above £95,000 and/or which could be considered as novel, contentious or could cause repercussions elsewhere in the public sector ('NCR'). See the letter below. The detail of the special payments should be submitted to ENGLAND.assurance@nhs.net prior to payment being made. The Chief People Officer or Deputy should send details of the payment to NHSE when the Annex A proforma is issued to HM Treasury spending team.

Classification: Official

Publication approval reference: PAR510

To:

- CCG accountable officers
- NHS trust accountable officers
- NHS foundation trust accounting officers

Dear Colleagues,

Adrian Snarr Director of Financial Control
Skipton House 80 London Road
London SE1 6LH

England.Assurance@nhs.net

19th April 2021

Collection exercise of special payments relating to 2020/2021

In late 2020, HM Treasury (HMT) issued a change to the delegated special payment limits, which requires all special payments above £95k within the Department of Health and Social Care (DHSC) group to be submitted to HM Treasury for approval. As a result DHSC has asked that all commissioner and provider organisations provide detail of all such special payments above £95k for which the Department does not have delegated approval for the financial year 2020/21.

This retrospective data collection applies to special payments made in 2020-21. For 2021-22 and beyond HM Treasury approval will need to be sought for any special payment above the threshold prospectively. Therefore, you should submit special payments over £95k prior to payment being made to: ENGLAND.assurance@nhs.net.

For clarity, the relevant special payments are those:

- over £95k in value, and/or
- classified as novel, contentious or could cause repercussions elsewhere in the public sector ('NCR').

The term 'approvals' encompasses cases approved (whether paid or outstanding) by the local approving bodies.

Any special payment above £95k or classified as NCR that has been incurred by clinical commissioning groups (CCGs), NHS trusts or NHS foundation trusts without HMT approval will be considered irregular.

You should be aware of the settlement reached in respect of what is known as the Flowers employment case. This has been deemed a special payment, but a submission will be made to HMT jointly by NHS England and NHS Improvement to seek approval for the whole payment, rather than asking individual organisations to request approval. You do not need to include those payments in this return, as we will seek approval for that.

We are aware that you may have previously submitted special severance payments for HMT approval, but we ask you to include them in this return so that we have a complete record. For those cases we do not require all the backup documentation.

CCGs, NHS trusts and NHS foundation trusts should complete and submit the template below to the NHS England and NHS Improvement assurance mailbox – England.Assurance@nhs.net.

We are aware of the time and resources constraints facing your finance teams; however, we need to submit the requested information to regularise all the special payments following the revised arrangements announced by HMT.

Please may I request that the special payment templates **(including nil returns)** are submitted to the assurance mailbox by **close of play on Friday, 30th April 2021**.

If you have any questions, please email the assurance mailbox as noted above.

Yours sincerely,

A Snarr

Adrian Snarr
Director of Financial Control
NHS England and NHS

2020/21 special payments notification form

Please return this completed form to England.Assurance@nhs.net, including all the supporting documents used when the payment was approved.

Name of organisation	
Contact details: Name, email and telephone number of person submitting the form	
Is approval required prospective or retrospective: Include date of payment	
Amount of special payment: in £s	
Nature and circumstance of case:	
Legal advice if appropriate:	
Management procedures followed:	
Assessment of value for money of the case:	
Do the circumstances give indication of any wider impact:	

APPENDIX 7. Delegation forms

Executive Delegation Form (SFIa2)

Executive Director Temporary Delegation Form

I hereby confirm that:

Name:

Director Title:

In their absence from the Trust delegates authority to:

Name:

Director Title:

Will act in the capacity of the named person with full designated powers, delegation, responsibility and accountability.

This designated authority will take effect from:

Date:
Time:

Which expires at:

Date:
Time:
The designated Authority can be revoked in writing in advance of the expiration date under the authority of the Chief Executive Officer, Jayne Black.

Signed:	**Signed:**
Name:	**Name:**
Director Title:	**Deputy Title:**
Date:	**Date:**

Scheme of Delegation Temporary Transfer Form
(SFIa3)

Absence/Leave Delegation Form

I hereby confirm that:

Name:

Designation:

In their absence from the Trust delegates authority to:

Name:

Designation:

Will act in the capacity of the named person with full designated powers, delegation, responsibility and accountability.

This designated authority will take effect from:

Date:
Time:

Which expires at:

Date:
Time:
The designated Authority can be revoked in writing in advance of the expiration date under the authority of the Chief Executive Officer, Jayne Black.

Signed:	**Signed:**
Name:	**Name:**
Designation:	**Designation:**
Date:	**Date:**

Trust References

Clinical Strategy
Patient First Strategy
Patient Experience Strategy
Anti-Fraud and Bribery policy
Business case policy
Budget holder guidance
Business planning guidance
CORP-FIN-POL-4 - Business Case Policy (QPulse)

External References

The Fraud Act 2006
Proceeds of Crime Act 2002 (POCA) (as amended by the Serious Organised Crime and Police Act 2005 (SOCPA))
Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 (MLR 2017)
Terrorism Act 2000 (TA 2000) (as amended by the Anti-Terrorism, Crime and Security Act 2001 (ATCSA 2001) and the Terrorism Act 2006 (TA 2006)

END OF DOCUMENT

Finance Report

For the period ending 31st May 2025 (M2)

Contents

1. Executive Summary – Trust level

The financial results to May 2025 (Month 2) are set out below. Performance is measured against the Plan agreed with NHSE, this being a £4.9m control total deficit for the year 2025/26.

£m	Plan	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month reported	(0.3)	(1.7)	(1.4)	In month the Trust reports a £0.2m favourable variance to control total and 'on plan' year to date (YTD), this being in line with the YTD £2.1m deficit control total at M2.
Tech. adjustments	(2.0)	(0.4)	1.6	ERF clinical income is reported up to the local commissioner cap; in addition to this, £4.0m planned Deficit Support Funding has been recognised in May, bringing the total DSF to £10.4m YTD. Efficiency delivery in-month is £0.4m against a target delivery of £1.1m; the YTD delivery is £0.7m against a plan total of £1.6m. This continues to be the main contributor to the overall adverse pay position. External support is being procured to accelerate the efficiencies programme.
In-month vs **Plan**	**(2.3)**	**(2.1)**	**0.2**	
YTD total	**(2.8)**	**(2.8)**	**0.0**	
Forecast outturn	**(4.9)**	**(4.9)**	**-**	The Trust expects to deliver the overall £4.9m deficit for the year but this is high risk.
Efficiencies Programme				
In-month	1.1	0.4	(0.7)	The efficiency programme target for the year is £45m, including £18m of system efficiencies and the remaining £27m assigned to the Divisions. The Trust's progress towards identifying schemes remains off plan leaving a significant gap to both the Divisional and System targets.
YTD	1.6	0.7	(0.9)	
Cash				
Month end	12.7	13.9	0.6	Cash is ahead of plan, principally as a result of the slow start to the capital programme. Delivery of a cash-releasing efficiency programme, as noted above, will be crucial to the Trust in being able to balance its cash position and commitments during the financial year.
Capital				
YTD				The slow start to Capital expenditure is to help cash and finalise plans given the need to reprioritise and accommodate risks. The forecast spend has reduced compared to plan at this time; this relates to the Electronic Patient Records project which was anticipating funds via Public Dividend Capital but which we understand will no longer be available. Note: recent announcements of three new allocations are not included in M2 figures: • £4.7m to support the Estates Strategy • £1.5m to support Constitutional Standards • £1.0m UEC incentive scheme for being in the top 10 highest 4-hour performers in 2024/25.
Capex	6.6	1.5	(5.1)	
Leases	0	0	0	
Total	**6.6**	**1.5**	**(5.1)**	
FORECAST				
Forecast	**42.8**	**40.5**	**(2.3)**	

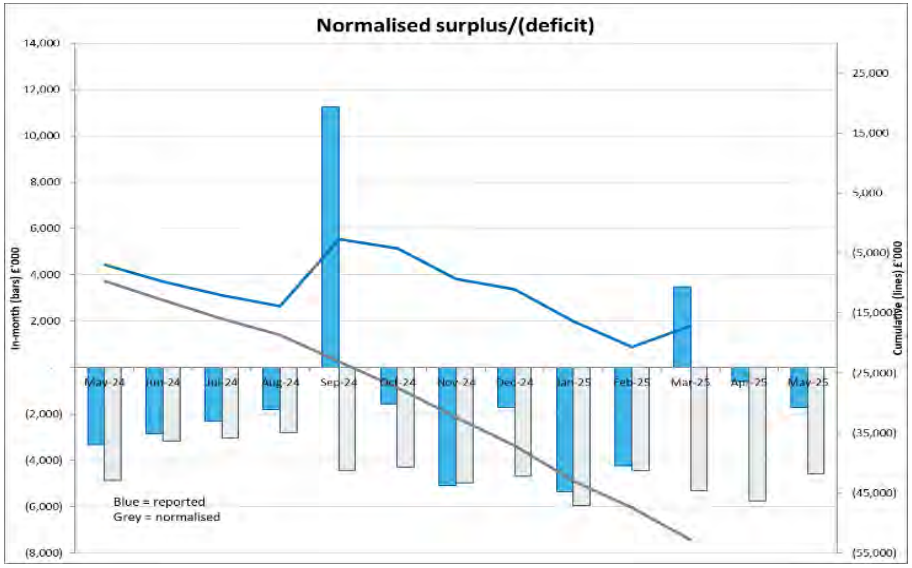
2. Income and Expenditure (I&E) vs Plan

£m	In-month			Year to date			Commentary
	Plan	Actual	Var.	Plan	Actual	Var.	
Clinical income	38.7	38.6	(0.1)	79.4	79.0	(0.3)	Clinical income has been reported on plan in month, up to but not exceeding the commissioner contract/ERF cap. £4m Deficit Support Funding (DSF) has been recognised, totalling £10.4m (25%) year to date. The adverse variance relates to the cost and volume drugs and devices variable element of the contract (counter-balanced by underspends in non-pay). Donated asset adjustment relates to the Salix decarbonisation grant for capital works and is a timing issue related to the capital works; this is excluded for the purpose of performance against the control total.
High cost drugs	2.5	2.1	(0.4)	4.8	4.5	(0.4)	
Donated assets	2.0	0.4	(1.6)	3.9	0.5	(3.4)	
Other income	2.9	2.8	0.0	5.8	5.7	(0.0)	
Total income	**46.1**	**44.0**	**(2.1)**	**93.9**	**89.8**	**(4.1)**	
Nursing	(11.4)	(11.5)	(0.1)	(22.8)	(23.1)	(0.3)	The nursing pay overspend largely relates to the MEC division, driven by recruitment in Q4; budget / reserve adjustment is under review. The small underspend on medical staff is due to some costs now being incurred through non-pay rather through the payroll. Pay inflation of £1.5m has been accrued YTD. Not all efficiency targets have been transacted through the divisions into individual budget lines – this is a timing issue each month and will be actioned shortly after schemes are approved.
Medical	(9.0)	(8.9)	0.1	(18.2)	(18.0)	0.2	
Other	(9.0)	(8.5)	0.5	(18.1)	(17.4)	0.7	
Efficiency target	0.4	-	(0.4)	0.7	-	(0.7)	
Total pay	**(29.1)**	**(28.9)**	**0.2**	**(58.5)**	**(58.6)**	**(0.1)**	
Clinical supplies	(5.3)	(5.1)	0.2	(10.2)	(9.8)	0.4	The clinical supplies underspend reflects lower than planned devices funded through variable income (noted in income above). The 'Other' category underspend is due to Trust reserves (some will balance the pay overspending). The £27m efficiency target is allocated to Divisions, but as stated in pay above, not all of these have been transacted into individual budget lines. The £18m System Savings target is being held centrally, pending development of detailed plans.
Drugs	(1.2)	(1.2)	0.1	(2.4)	(2.1)	0.3	
High cost drugs	(2.5)	(2.3)	0.2	(4.8)	(4.7)	0.1	
Other	(6.2)	(5.8)	0.4	(12.6)	(11.9)	0.6	
Efficiency target	0.3	-	(0.3)	0.4	-	(0.4)	
Total non-pay	**(15.0)**	**(14.3)**	**0.6**	**(29.6)**	**(28.6)**	**1.0**	
EBITDA	**2.0**	**0.7**	**(1.3)**	**5.8**	**2.6**	**(3.2)**	
Non-operating exp.	(2.3)	(2.5)	(0.1)	(4.7)	(4.9)	(0.3)	Depreciation budgets continue to be reviewed following the year end revaluation and capitalisation of assets.
Surplus/(deficit)	**(0.3)**	**(1.7)**	**(1.4)**	**1.1**	**(2.3)**	**(3.4)**	
Tech. adj.	(2.0)	(0.4)	1.6	(3.9)	(0.5)	3.4	Timing of the Salix grant (decarbonisation project) as noted in income above.
Control total	**(2.3)**	**(2.1)**	**0.2**	**(2.8)**	**(2.8)**	**0.0**	The Trust is expected to meet its annual plan; however, the key risks to this are: • Delivery of a ~£45m efficiency programme (both Trust and System identified plans are currently below target). • Loss of DSF – failing to achieve Plan (at system level) could lead to reductions in DSF. • Capping of the ERF income and activity/costs are above the capped level. • Receivable and payable risks e.g. NKPS, MCH and Car Park VAT. • Cash; risk increases if DSF is reduced.
DSF (incl. Clin Inc)	(4.0)	(4.0)	-	(10.4)	(10.4)	-	
Performance excluding DSF	**(6.9)**	**(7.1)**	**(0.2)**	**(6.9)**	**(7.1)**	**(0.2)**	

3. Normalised performance

The table below adjusts the reported I&E position for technical and other non-recurrent items to give a 'normalised' view of the financial position, i.e. the position we would expect to report operating on a normal, ongoing basis.

£'000	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Apr-25
Reported surplus/(deficit)	**(3,328)**	**(2,852)**	**(2,310)**	**(1,807)**	**11,241**	**(1,568)**	**(5,099)**	**(1,718)**	**(5,347)**	**(4,242)**	**3,482**	**(590)**	**(1,735)**
Technical adjustments	12	(173)	25	(178)	(275)	(267)	(475)	(1,188)	424	(200)	(3,032)	(96)	(378)
Control total surplus/(deficit)	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**10,966**	**(1,835)**	**(5,574)**	**(2,906)**	**(4,923)**	**(4,442)**	**450**	**(686)**	**(2,113)**
Deficit support funding	-	-	-	-	(14,247)	(1,973)	(1,776)	(2,306)	(2,191)	(989)	(1,948)	(6,412)	(3,996)
Control total surplus/(deficit) before deficit support funding	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**(3,281)**	**(3,808)**	**(7,350)**	**(5,212)**	**(7,115)**	**(5,431)**	**(1,498)**	**(7,098)**	**(6,109)**
Normalisation adjustments:													
Non-recurrent adjustments	(429)	(131)	(52)	(589)	(224)	537	320	833	1,214	1,140	(295)	1,351	1,178
Industrial action costs	-	447	130	-	-	-	-	-	-	-	-	-	-
Industrial action income	-	-	-	-	(542)	-	-	-	-	-	-	-	-
Annual leave accrual cost	-	-	-	(465)	-	-	-	-	-	-	147	-	-
Pension 9.4% Costs	-	-	-	-	-	-	-	-	-	-	17,984	-	-
Pension 9.4% Income	-	-	-	-	-	-	-	-	-	-	(17,984)	-	-
Pay Award	(1,268)	(1,268)	(1,267)	(949)	(1,205)	5,239	3,109	-	-	-	-	-	-
Pay Award Income	960	960	960	961	961	(6,103)	(906)	-	-	-	-	-	-
NHS Property Services Credit Note	(667)	-	-	-	-	-	-	-	-	-	-	-	-
Car Parking VAT - Claim Recognised											(3,508)		
Additional Sessions Accrual	-	-	(379)	379	-	-	-	-	-	-	-	-	-
Recurrent surplus/(deficit)	**(4,720)**	**(3,017)**	**(2,893)**	**(2,650)**	**(4,292)**	**(4,134)**	**(4,826)**	**(4,379)**	**(5,901)**	**(4,291)**	**(5,154)**	**(5,747)**	**(4,931)**
Recurrent surplus/(deficit) - cumulative in-year	*(9,385)*	*(12,402)*	*(15,295)*	*(17,945)*	*(22,236)*	*(26,371)*	*(31,197)*	*(35,575)*	*(41,476)*	*(45,767)*	*(50,922)*	*(5,747)*	*(10,678)*



Commentary:

- The normalised/recurrent position removes technical items, e.g. income and spend relating to charitable donations and one-off impacts such as industrial action.
- The normalised reporting in-month I&E position (£4.9m) shows an improvement in month to the recurrent deficit by £0.8m; mainly due to the reduction of pay expenditure, helped by the vacancy controls.
- Based on the month 2 run-rate, the annualised performance would be ~£59m, i.e. a deterioration of ~£6m on 24/25. This arises from the full year effect of growth in nursing and midwifery staff in A&E and maternity respectively (mainly during Q4 24/25), together with the full year effect of the mobile endoscopy unit, whilst clarity is being sought from commissioners over ERF income that could be derived from this mobile unit.
- Enhanced vacancy controls have been extended to the end of September 2025

4. Statement of Financial Position

31 March 2025	£m	Month end Actual	Movement vs Prior Year
289.7	**Non-current assets**	**287.8**	**(1.9)**
6.7	Inventory	6.8	0.1
38.6	Trade and other receivables	41.2	2.5
0.4	Assets held for sale	0.4	0.0
13.3	Cash	13.9	0.6
59.0	**Current assets**	**62.3**	**3.2**
(0.2)	Borrowings	(0.2)	0.0
(61.0)	Trade and other payables	(62.6)	(1.6)
(1.1)	Other liabilities	(3.3)	(2.2)
(62.3)	**Current liabilities**	**(66.1)**	**(3.8)**
(2.8)	Borrowings	(2.7)	0.1
(1.3)	Other liabilities	(1.3)	0.0
(4.1)	**Non-current liabilities**	**(4.0)**	**0.1**
282.3	**Net assets employed**	**280.0**	**(2.3)**
511.2	Public dividend capital	511.2	0.0
(292.5)	Retained earnings	(294.8)	2.3
63.6	Revaluation reserve	63.6	0.0
282.3	**Total taxpayers' equity**	**281.7**	**(2.3)**

Key messages:

Non-current assets are £1.9m lower than year end, being the net impact of £1.5m investment expenditure and £3.4m depreciation.

Net current assets (*Current Assets less Current Liabilities*). In May the Trust has net current liabilities of £3.8m.

- **Trade and other receivables** are £41.2m (88% of one month's income) and has improved (reduced) by ~£3m since prior month.
- **Cash** as at 30 April is £13.9m, representing an increase of £2.4m in month; the increase relates to the slow start on the capital programme, education income received in advance and DSF payment.
- **Trade and other payables** are £62.6m (133% of one month's expenditure) and have shown a small (£0.8m / 1.3%) increase compared to the prior month.
- **Other liabilities** relate to deferred income; this has increased due to receipt of Education Income in April, received one quarter in advance.

Public dividend capital remains at £511.2m.

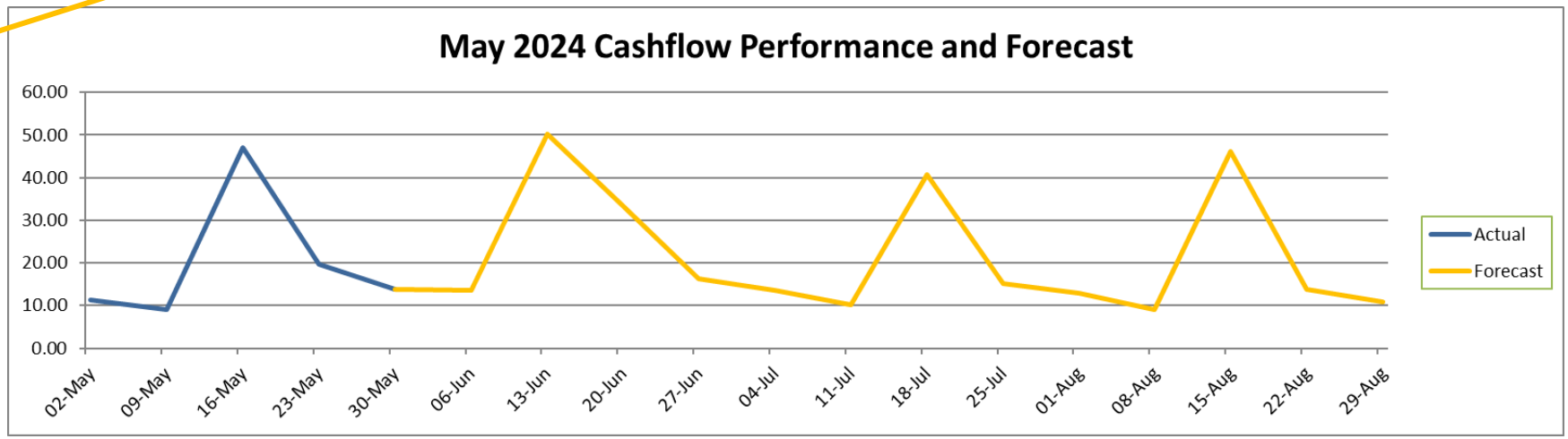
Revaluation reserve remains at £63.6m and is not expected to change until the annual revaluation in March 2026.

5. Cash

13-week cash forecast

£m	w/e Actual 02/05/25	09/05/25	16/05/25	23/05/25	30/05/25	Forecast 06/06/25	13/06/25	20/06/25	27/06/25	04/07/25	11/07/25	18/07/25	25/07/25	01/08/25	08/08/25	15/08/25	22/08/25	29/08/25
BANK BALANCE B/FWD	**16.2**	**11.4**	**9.1**	**46.9**	**19.6**	**13.8**	**13.6**	**50.1**	**33.6**	**16.2**	**13.5**	**10.3**	**40.6**	**15.3**	**13.0**	**9.1**	**46.2**	**13.9**
Receipts																		
NHS Contract Income	0.4	0.0	43.6	0.8	0.0	0.1	40.9	0.0	0.0	0.0	0.0	45.2	0.0	0.0	0.0	44.0	0.0	0.0
Other	0.2	0.2	0.3	0.5	0.1	0.7	0.6	0.2	0.5	0.3	0.3	0.5	0.5	0.2	0.3	0.6	0.2	0.5
Total receipts	**0.6**	**0.2**	**43.9**	**1.3**	**0.2**	**0.9**	**41.4**	**0.2**	**0.5**	**0.3**	**0.3**	**45.7**	**0.5**	**0.2**	**0.3**	**44.5**	**0.2**	**0.5**
Payments																		
Pay Expenditure (excl. Agency)	(0.4)	(0.4)	(0.4)	(26.6)	(0.4)	(0.4)	(0.4)	(12.3)	(14.9)	(0.5)	(0.5)	(4.1)	(22.9)	(0.5)	(0.5)	(0.5)	(30.5)	(0.5)
Non Pay Expenditure	(2.0)	(2.2)	(5.4)	(2.0)	(5.6)	(0.7)	(3.3)	(6.0)	(3.0)	(2.5)	(3.0)	(10.4)	(3.0)	(2.0)	(3.3)	(6.5)	(2.0)	(3.0)
Capital Expenditure	(3.0)	0.0	(0.3)	(0.0)	(2.0)	0.0	(1.1)	(2.4)	0.0	0.0	0.0	(2.9)	0.0	0.0	(2.4)	(0.5)	0.0	0.0
Total payments	**(5.4)**	**(2.6)**	**(6.0)**	**(28.5)**	**(7.9)**	**(1.1)**	**(4.9)**	**(20.7)**	**(17.9)**	**(3.0)**	**(3.5)**	**(17.4)**	**(25.9)**	**(2.5)**	**(6.1)**	**(7.5)**	**(32.5)**	**(3.5)**
Net Receipts/ (Payments)	**(4.8)**	**(2.3)**	**37.9**	**(27.3)**	**(7.8)**	**(0.3)**	**36.5**	**(20.5)**	**(17.4)**	**(2.7)**	**(3.2)**	**28.4**	**(25.4)**	**(2.3)**	**(5.8)**	**37.0**	**(32.3)**	**(3.0)**
Funding Flows																		
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working Capital Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grant Capital	0.0	0.0	0.0	0.0	2.0	0.0	0.0	3.9	0.0	0.0	0.0	2.0	0.0	0.0	2.0	0.0	0.0	0.0
Loan Repayment/Interest payable	0.0	0.0	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dividend payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**0.0**	**0.0**	**0.0**	**(0.1)**	**2.0**	**0.0**	**0.0**	**3.9**	**0.0**	**0.0**	**0.0**	**2.0**	**0.0**	**0.0**	**2.0**	**0.0**	**0.0**	**0.0**
BANK BALANCE C/FWD	**11.4**	**9.1**	**46.9**	**19.6**	**13.8**	**13.6**	**50.1**	**33.6**	**16.2**	**13.5**	**10.3**	**40.6**	**15.3**	**13.0**	**9.1**	**46.2**	**13.9**	**10.9**
ICB revenue support based on £30m as advised																		
Revised Cash balance with support based on 24/25	**11.4**	**9.1**	**46.9**	**19.6**	**13.8**	**13.6**	**50.1**	**33.6**	**16.2**	**13.5**	**10.3**	**40.6**	**15.3**	**13.0**	**9.1**	**46.2**	**13.9**	**10.9**

Why does this say 24/25? Do we need the row that says ICB revenue support based on £30m advised?



- Closing cash at the end of May was £13.9m, which is a £2.4m increase since the prior month. This increase relates to the payment of DSF during May for the first two months of the financial year.
- The rolling 13-week forecast assumes cash delivers in-line with the planned I&E position and does not therefore forecast cash shortfalls.
- Forecasting cash in-line with the income and expenditure plan carries **significant risk** as this relies on the delivery of significant cash-releasing cost improvements across the financial year. Should efficiencies not deliver or not be cash-releasing, mitigations will be required – this could include stretching creditors and/or an application to DHSC for support cash. The position will be monitored carefully and risks flagged as the earliest opportunity.

6. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance, which is on Plan Year-to-Date (Plan of £2.8m deficit). To achieve this, we reported an in-month (May) of £0.2m favourable to Plan.

However, there remains a number of emerging **risks** to delivery of the annual plan; namely:

- **Savings**: Plan phasing of cash releasing efficiency schemes grows gradually from month 1/April to month 5/ August; there is a notable step change in July and again in October as “Local” and "System" schemes respectively are required to deliver. The Trust cost base must therefore reduce accordingly, with particular focus required on pay and headcount.
- **Income**:
    - The ICB has effectively capped the ERF income, which is lower than the expected value of activity plans to achieve 60% RTT at 18 weeks. Delivery of the activity plan may therefore not be reimbursed and/or be delivered at additional, unplanned cost (unless this can be achieved through productivity gains). Conversations continue in respect of the cap and this will be made explicit in a letter to the ICB accompanying our signed contract. The lead commissioner has indicated that provided ERF monies are not clawed back by NHSE then it does not intend on paying less ERF income than contracted if our activity levels (variable income) are below agreed activity plans (but RTT targets may not be delivered).
    - The guidance issued in May 2025 sets the condition [to hit Plan] now placed on DSF means failure to meet Plan each quarter (and NHSE assurance over full year delivery) could result in lost DSF/income. This creates a form of ‘double jeopardy’ in that **our** DSF could be lost due to our failure and/or the failure of others, and **our** failure could result in loss of DSF income for others. Delivery at Month 2 is positive for DSF receipt in Q2.
- **Cash**: Firstly, failure to address CIP targets (and control costs) means we will have insufficient cash to meet payments falling due. Consequently, this leads to a failure to meet I&E plan with an expected result of a loss of DSF (noted above) and that cash-backed income too will be forgone.
- **Old Year**: The Board have been apprised of the 2024/25 risks around MCH invoicing, NKPS charges and Car Park VAT reclaim.

The risk to delivery of the 2025/26 Plan is high-significant. Our current spend run-rate remains too high relative to the future expenditure Plan (~£4m all things remaining the same). To address the position, we have put the following actions in place (in addition to continued effort to create cost reduction plans):

1. Vacancy controls, limiting external recruitment to essential posts only. This has been extended from the end of May 2025 to the end of September 2025 and will be assessed again closer to that date; a further extension may be put in place until expenditure is at a level consistent with planned income.
2. At the time of writing, a tender process is concluding for third party support and expertise to accelerate the identification and delivery of unidentified savings plans.
3. Cash review meetings are being established on a weekly basis; including development of working capital action planning. There are now weekly system cash working group meetings and monthly South East region cash meetings.
4. Further consideration will need to be given to the governance and accountability structures to accelerate cost reductions, including grip and controls.

Simon Wombwell
Chief Finance Officer
June 2025

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

June - 2025

Patient FIRST

Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Complaints	2	3	1	0	1	1
PALS	2	2	1	0	1	0
FFT	5	4	1	3	0	2
Patient Experience	0	1	0	1	0	0
PHSO	0	3	2	0	0	0

Patient FIRST

Operational Leads:
Wayne Blowers - *Director of Quality & Patient Safety*
Nicola Lewis - *Associate Director of Patient Experience*

Committees:
Quality Assurance Committee (QAC)

Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

FFT

Total FFT Recommend %

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	95.0%	H	F	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%

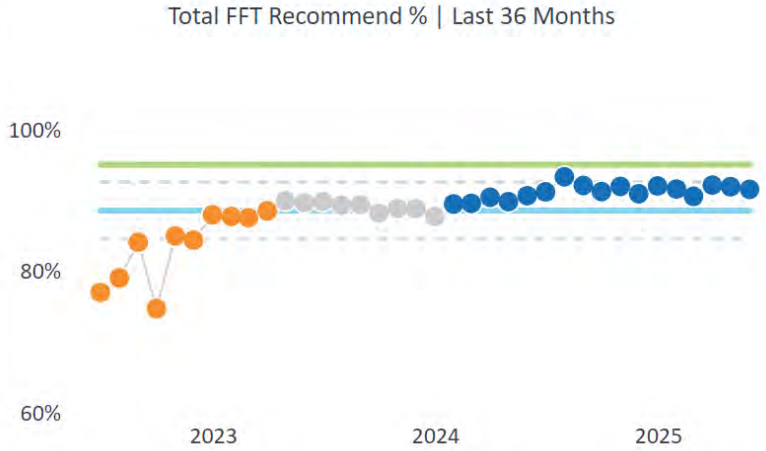
True North Domain: **Patients**

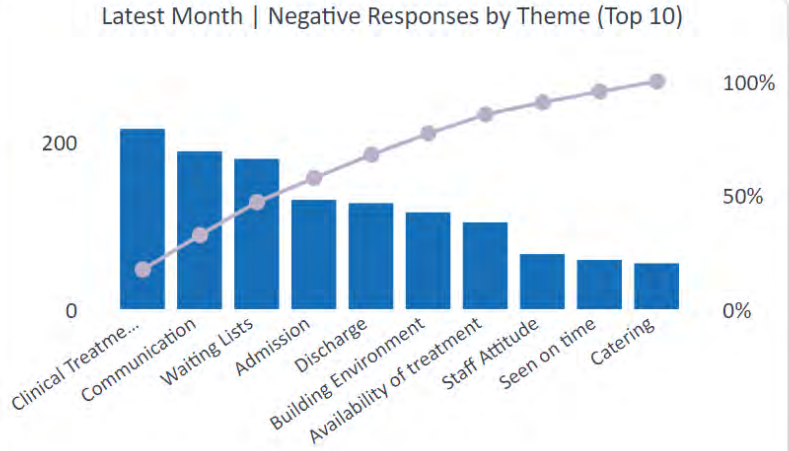
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

	L	H	L	H
5	1	0	0	4





Key Messages

- Inpatients and Maternity positive FFT thresholds were met, Inpatient areas have met trajectory for 3 consecutive months.
- Work continues to achieve 80% in ED and 95% in outpatient areas
- Consistent challenges remain with patients reporting car parking as a negative experience.
- Patients report that our staff are the most positive part of their overall experience which is a celebration.

Issues, Concerns & Gaps

- There have been a rising number of concerns from patients regarding cleanliness in bathrooms around outpatient and ward areas
- The catering team are receiving feedback in greater detail regarding food and the associated areas for improvement

Actions & Improvements

- A full review of all bathrooms and washrooms is underway with the H&S and IPC team
- Nursing staff are completing regular checks in all outpatient area toilets and escalating concerns outside of cleaning times
- The catering team have successfully sourced a new provider for patient sandwiches
- Further work is underway to improve the mealtime experience and availability of hostesses with a review of working hours and availability of hostesses

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Patients	FFT			Emergency Care FFT Recommend %	80.0%			Driver is red for 2 reporting periods	74.6%	75.3%	73.7%	79.4%	75.7%	74.2%
				Outpatient FFT Recommend %	95.0%		F	Driver is red for 2 reporting periods	93.3%	92.6%	91.3%	92.3%	92.7%	92.7%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L		Watch is red for 4 reporting periods	2	13	5	28	24	30
	Complaints			Complaints Breached %	5.0%	L	F	Watch is red for 4 reporting periods	33.3%	20.0%	16.2%	14.3%	7.7%	12.0%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.9%	94.9%	94.7%	95.2%	95.6%	95.6%
				Maternity FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	97.9%	94.5%	94.1%	94.6%	93.4%	97.7%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	43.8%	46.9%	47.3%	51.0%	48.4%	49.3%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	2	13	5	28	24	30
	Complaints			Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	64	71	65	57	49	55
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	33.3%	20.0%	16.2%	14.3%	7.7%	12.0%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	102	94	99	99	95	90
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				PHSO Cases Closed - Upheld	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				PHSO Cases Closed - Not Upheld	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

Key Messages

- MSA breaches remain low, however the number of incidents in June is contributed to delays in ICU And HDU steps downs to the wards.
- 100% complaints acknowledged
- 0 PALS converted to complaints
- Complaint themes include, dissatisfaction with medical care & treatment, delays in medical treatment & diagnosis, complications during or following an operation.
- PALS themes include; queries and delays with appointments, lack of communication/response from departments, delays in medical and nursing care, delays in medication being provided, enquires regarding personal records & delays in receiving results. 27 compliments were received
- One PHSO case was closed from a care episode on 2021 - partially upheld due to poor communication with family and delay in referral to specialist centre
- 1 complaint re-opened for resolution meeting (Specialist Medicine.)
- 88% of complaints responded to within Trust target time of 40 working days.
- 12% of complaints breached KPI (2) – Care Group staff annual leave has impacted this.

Issues, Concerns & Gaps

- Accurate reporting on Teletracking remains a consistent issue, it is reliant upon manual reporting
- 15 PALS re-opened (4 – Specialist Medicine, 4 – Surgical Services, 3 – AEM, 2 – Frailty, 1 – C&YP & 1 – C&CSS) due to patients/relatives not being contacted by relevant department/member of staff regarding enquiry as requested.
- There continues to be a high number of enquires to PALS due to queries from patients regarding outpatient appointments, experiencing difficulties in getting through to relevant departments by telephone to enquire about appointments and results.
- A member of the PALS Team is leaving the Trust at the end of July, this will impact the service the Team are able to provide and may result in delays in enquires being addressed and potentially lead to an increase in formal complaints

Actions & Improvements

- Further escalation has been actioned to the national Teletracking team to rectify this, an automated approach to reporting is awaited. The company have not offered a timeframe for resolution. Risk number 1647.
- A patient believed that the doctor mistakenly requested a CT scan with contrast when the patient had previously had a reaction to contrast. Actions: The importance of clearly documenting all the details of all consultations with patients within the letter to the GP has also been highlighted to the doctor involved, an incident report has been filed for Trust wide learning, the entire ENT medical team have discussed the case in their monthly Patient Safety and Governance meeting so that the patient's case, the discussions around maintaining vigilance, the outcomes and learning points are recorded.
- Relatives of an elderly care patient felt that the wound care from nursing staff on an elderly care ward was lacking and felt they were not adequately trained to deal with the patient's wounds. Action: The TVN team have provided additional training and education on wound management and refresher aseptic non-touch technique competency for nursing staff.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Patients	FFT			Total FFT Recommend %	95.0%	H	F	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%
				Emergency Care FFT Recommend %	80.0%		?	73.0%	79.9%	74.0%	72.8%	75.1%	71.2%	74.6%	75.3%	73.7%	79.4%	75.7%	74.2%
				Outpatient FFT Recommend %	95.0%		F	93.0%	94.7%	92.8%	93.0%	93.1%	92.3%	93.3%	92.6%	91.3%	92.3%	92.7%	92.7%
				Inpatients FFT Recommend %	95.0%	H	?	94.5%	95.3%	95.6%	93.9%	95.2%	94.7%	94.9%	94.9%	94.7%	95.2%	95.6%	95.6%
				Maternity FFT Recommend %	95.0%	H	?	88.0%	92.6%	94.8%	96.5%	98.3%	97.3%	97.9%	94.5%	94.1%	94.6%	93.4%	97.7%
				Total FFT Response Rate %	-			14.8%	16.3%	15.4%	15.3%	13.9%	12.9%	13.2%	13.1%	13.2%	13.0%	13.9%	12.3%
				Emergency Care FFT Response Rate %	-	L		7.5%	7.6%	6.7%	7.7%	7.6%	6.9%	7.6%	7.6%	7.8%	7.0%	7.0%	7.1%
				Outpatient FFT Response Rate %	-			9.9%	11.4%	10.6%	10.3%	9.5%	9.2%	9.6%	9.1%	9.2%	8.5%	10.5%	8.2%
				Inpatients FFT Response Rate %	-	H		56.6%	56.4%	55.6%	54.8%	50.5%	43.6%	43.8%	46.9%	47.3%	51.0%	48.4%	49.3%
				Maternity FFT Response Rate %	-			34.2%	42.3%	70.6%	76.0%	70.1%	72.3%	72.0%	72.6%	39.8%	38.5%	33.2%	51.0%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	26	12	12	10	6	17	2	13	5	28	24	30
	Complaints			Complaints	-			21	30	22	43	19	20	37	36	27	24	19	37
				Complaints Closed	-	L		38	20	27	24	30	26	22	29	33	32	27	31
				Complaints Open - Month End	-	L		42	52	47	66	55	49	64	71	65	57	49	55

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Patients	Complaints			Complaints Re-Opened	-			4	1	4	10	2	2	1	7	0	1	3	1
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	P	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	3.6%	0.0%	30.8%	20.0%	21.2%	16.7%	33.3%	20.0%	16.2%	14.3%	7.7%	12.0%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			499	421	521	439	515	463	470	447	321	453	460	475
				PALS Closed	-			540	402	527	441	503	464	469	455	317	453	464	480
				PALS Open - Month End	-	L		79	98	92	90	102	101	102	94	99	99	95	90
				PALS Converted to Complaints	-	L		0	1	0	0	0	0	0	0	0	0	0	0
				PALS Re-Opened	47	H	P	32	18	56	19	34	30	20	27	19	19	23	17
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	L		2	2	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Partially Upheld	-	H		0	0	0	1	1	1	0	0	0	0	0	1
				PHSO Cases Closed - Upheld	-	L		1	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-	L		0	0	0	1	1	0	0	0	0	0	0	0

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
IPC	6	3	0	1	2	0
Incident Management	14	3	4	2	1	2
Medicines	2	0	0	0	1	0
Falls	6	1	0	3	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	7	0	1	0	0	0
Mortality	10	4	5	6	0	2
Pressure Ulcer	3	0	2	1	0	0
Risk & Policy	1	3	0	0	0	0
VTE	0	1	0	1	0	0

Operational Leads:
Wayne Blowers - *Director of Quality & Patient Safety*
James Alegbeleye - *Medical Director for Quality & Safety*

Committees:
Quality Assurance Committee (QAC)

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	95.0%		P	99.3%	99.2%	99.0%	99.1%	99.1%	99.0%	98.7%	99.2%	99.3%	98.9%	98.8%	98.9%

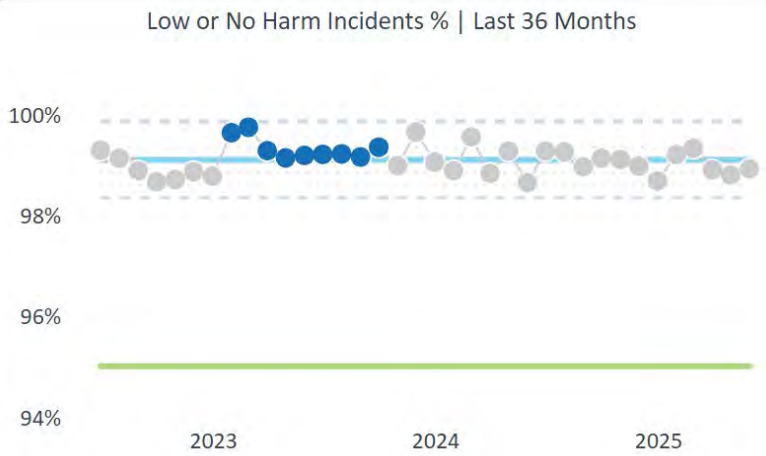
True North Domain: Quality

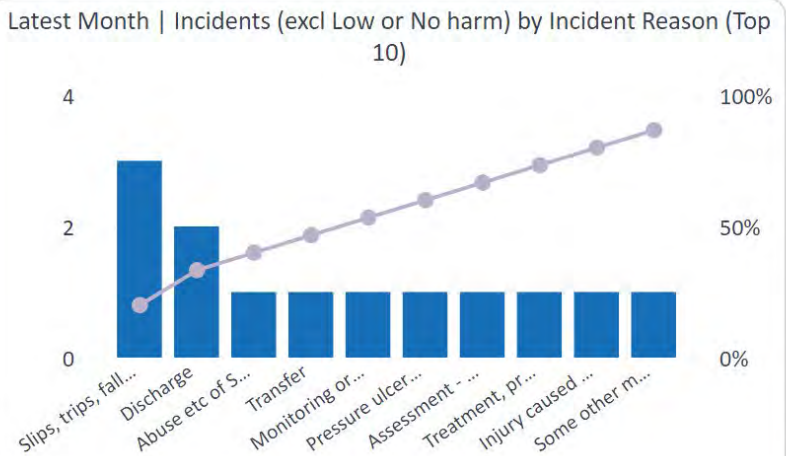
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

	L	H	L	H
14	1	3	1	2





Key Messages

- 98.9% of all incidents reported resulted in low or no harm.
- Clinical incidents with harm as moderate or above has decreased by 23% compared to May.
- 10 incidents in June caused moderate harm or above. At time of writing, 5 have been validated via IRG, specialty or Care Group
- 5 Incidents caused moderate harm: VTE; fall; poor EDN (tbc); no BM monitoring (tbc); delay in transfer (tbc)
- 3 incidents caused severe harm: high lactate (tbc); inadequate anticoagulation (tbc); fall.
- 1 incident was fatal: No VTE prophylaxis (validated)

Issues, Concerns & Gaps

- VTE prophylaxis is a theme and concern across 3 incidents with harm this month. There is however improved reporting so cannot confirm if this is an emerging theme or if there is better recognition at this stage.
- Systems downtime was a factor in the fatal incident. Additional datix regarding these issues to be explored at IRG.
- High lactates remain an issue. Recent MDT QI meeting determined the policy needs to be reviewed. VBG and ABGs to be added to EPR in September.
- Diabetes monitoring remains an issue, addressed by working groups and QIP once created.

Actions & Improvements

- Providing support to create nutrition, medications, VTE and diabetes QIP.
- Immediate review of all oxygen tubing in all rooms to ensure tubing reaches furthest point of all rooms. Continue ongoing Trust audit of emergency equipment checks. Oxygen cylinder part to be part of daily checklist and only checked by clinical staff (band 3 or above). Evidence of adequate tubing in each room, checklists and audits completed.
- NG ESR E-Learning created for staff which gives them theoretical knowledge on types of NG tubes, difference of the tube used for feeding and drainage purposes, safe insertion techniques and its management.
- Trauma summit identified multiple key learning points, actions in progress and a further summit to be scheduled.

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	1.30%			1.21%	1.35%	1.30%	1.27%	1.51%	1.80%	2.31%	1.90%	1.58%	1.46%	1.42%	1.18%

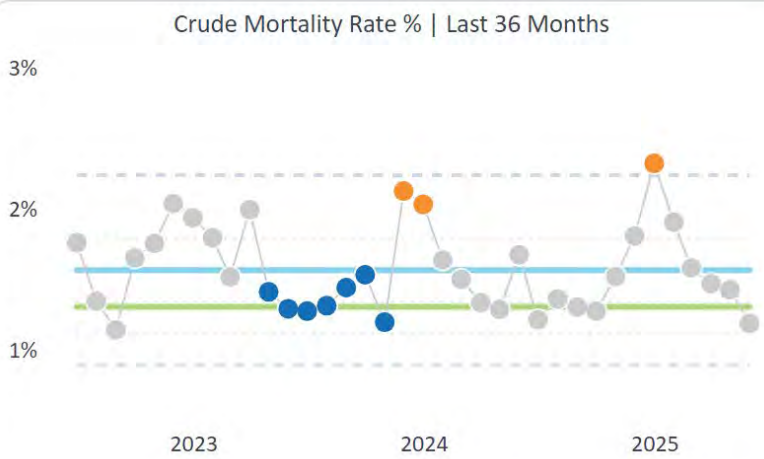
True North Domain: Quality

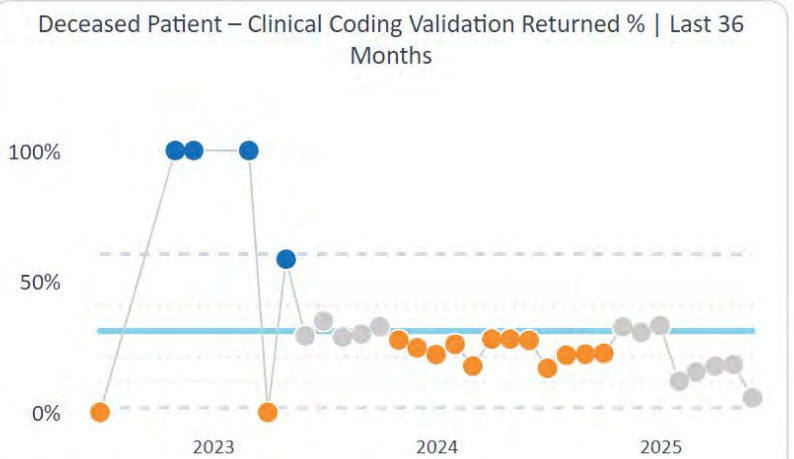
KPI Threshold: 1.30%

Sub Domain KPIs: 19

Variation Summary:

	L	H	L	H
10	0	5	1	3





Key Messages

- HSMR for the period of Mar 24- Feb 25 is 97.4 and 'within expected'
- SHMI for the period of Mar 24- Feb 25 is 1.25 and higher than expected
- 14.1% of deaths were completed at Stage 1 SJR review which is an increase from last month. No avoidable deaths were identified.
- 15/19 specialities submitted M&M minute for June.

Issues, Concerns & Gaps

- SHMI continues to increase and now reporting as 1.25 and higher than expected
- Returns for validation of deaths continues to remain low.
- There has been an increase in referrals from the Medical Examiner for readmissions and previous discharge issues. This issue is being further explored at the MMSG in July with data being provided at speciality level to explore further investigation opportunities.

Actions & Improvements

- There are no new diagnosis group outliers or alerts to bring to the Trust's attention in the HSMR data. Furthermore, a long-time outlier for COPD has ceased to appear in HSMR data this month. This may be significant if matched within the SHMI model.
- LFD and clinical coding have continued to present at specialities across the Trust on the importance of clinical documentation and the impact this has on coding and mortality. The Trust continue to have improved performance in 'trend in doing' metrics which are performing better than regional and national peers.
- The learning from deaths audit continues to provide an added layer of scrutiny to hospital deaths. The data will be presented at Resuscitation and Deterioration Group (RADG)

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0		F	Watch is red for 4 reporting periods	11	9	7	11	13	12
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	82.9%	82.2%	82.9%	84.4%	84.5%	86.2%
				Violence & Aggression Incidents	126	H	?	Watch is red for 4 reporting periods	116	172	247	220	167	237
	Mortality			SHMI (12m)	1	H	F	Watch is red for 4 reporting periods	1.23	1.25				
				Fractured NOF Within 36 Hours	92.0%		?	Watch is red for 4 reporting periods	70.7%	60.9%	70.0%	48.7%	71.9%	

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Incident Management			After Action Review (AAR) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	2	4	6	3	1	3
				Never Events	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	82.9%	82.2%	82.9%	84.4%	84.5%	86.2%
	Falls			Falls Resulting in Death	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	IPC			IPC Incidents	-	L	Special cause of improving nature or lower pressure due to (L)ower values	51	46	50	40	13	12
	Mortality			Deceased Patient – Clinical Coding Validation Sent %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	93.3%	96.7%	97.3%	99.0%	94.9%	100.0%
				Deceased Patient – Clinical Coding Amendments %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	29.4%	28.6%	17.6%	23.5%	29.4%	100.0%
				HSMR (12m)	100	L	Special cause of improving nature or lower pressure due to (L)ower values	98.34	97.41				
				SJRs Completed %	12.5%	H	Special cause of improving nature or lower pressure due to (H)igher values	6.5%	7.2%	14.6%	14.3%	11.9%	14.1%
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	98.9%	97.5%	94.5%	99.5%	96.8%	96.0%
	Risk & Policy			Risks Open - Moderate (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	23	20	18	18	15	15
				Risks Open - High (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	46	48	49	51	54	57
				Risks Open - Extreme (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	5	6	8	8	9	10

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	84.0%	84.0%	83.7%	83.5%	85.0%	83.5%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.1%	86.0%	85.3%	85.6%	86.2%	86.8%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

- FNoF - During the month of June, we admitted a total of **31 patients** with Non-Ambulatory Fragility Fractures (NAFF). 25 patients (**80.6%**) were operated on within the 36-hour target timeframe. **6** patients (19.4%) breached the 36-hour target for surgery. This represents a compliance rate of 80.6%, which is a modest improvement compared to previous months
- VTE - Risk assessment compliance is above trajectory; Compliance in W&C division has improved significantly
- Falls - Falls CNS's are leading improvement work in the top 3 contributing areas in line with QIP; Engagement from clinical areas has improved significantly since the new CNS's have commenced in post
- HAPU - TVN team have provided Intensive support to Keats, Byron and Emerald as the top contributing areas; The final phase of the trust wide mattress replacement is almost complete; During the month of June, we admitted a total of 31 patients with Non-Ambulatory Fragility Fractures (NAFF). 25 patients (80.6%) were operated on within the 36-hour target timeframe. 6 patients (19.4%) breached the 36-hour target for surgery. This represents a compliance rate of 80.6%, which is a modest improvement compared to previous months
- SHMI for the period of Mar 24- Feb 25 is 1.25 and higher than expected

Issues, Concerns & Gaps

- FNoF - We continue to carry out detailed root cause analyses (RCA) for all breach cases. Surgical breach times are now clearly recorded on E-trauma. **Medical Optimisation Delays: Three** patients breached due **to medical reasons** that required optimisation prior to surgery: One patient with a neck of femur (NOF) fracture had sepsis, with a temperature of 38.3°C and a lactate of 2.1. Surgery was deferred until medically safe. One patient with NOF fracture developed Type 2 Respiratory Failure and was admitted to HDU. Non-invasive ventilation was initiated, and the patient was jointly managed by the medical and anaesthetic teams. One patient with a NOF fracture suffered a stroke on admission and required medical optimisation before being deemed fit for surgery. **Specialist Surgeon Availability: Three** patients experienced delays due to the need for input from **Lower Limb surgeons**: One patient with a peri-prosthetic fracture required the expertise of a hip surgeon before surgery could proceed. Two patients with peri-prosthetic femur fractures required lower limb arthroplasty surgeons to perform surgery, which contributed to the breach in target timeframe. In total, 4 of the 6 breaches involved neck of femur fractures and 2 involved peri-prosthetic fractures.
- VTE - Delays in prescribing mechanical prophylaxis following a VTE assessment; Positive CTPA and VQ scans are being reported manually
- Falls - Themes from unwitnessed falls include toileting, inadequate bay tagging and not allowing patient autonomy
- HAPU - To note there have been a rising number hospital acquired pressure damage associated harm
- Medical Optimisation Delays - Three patients breached due to medical reasons that required optimisation prior to surgery: One patient with a neck of femur (NOF) fracture had sepsis, with a temperature of 38.3°C and a lactate of 2.1. Surgery was deferred until medically safe. One patient with NOF fracture developed Type 2 Respiratory Failure and was admitted to HDU. Non-invasive ventilation was initiated, and the patient was jointly managed by the medical and anaesthetic teams. One patient with a NOF fracture suffered a stroke on admission and required medical optimisation before being deemed fit for surgery. Specialist Surgeon Availability: Three patients experienced delays due to the need for input from Lower Limb surgeons: One patient with a peri-prosthetic fracture required the expertise of a hip surgeon before surgery could proceed. Two patients with peri-prosthetic femur fractures required lower limb arthroplasty surgeons to perform surgery, which contributed to the breach in target timeframe. In total, 4 of the 6 breaches involved neck of femur fractures and 2 involved peri-prosthetic fractures.

Actions & Improvements

- FNoF - We continue to work closely with our anaesthetic, medical, and ortho-geriatric teams to streamline pre-operative optimisation for complex patients. All breach cases undergo root cause analysis and are reviewed at departmental M&M meetings to drive shared learning and continuous improvement, the outcome from last meeting highlighted above. The ongoing need for timely access to specialist hip and lower limb surgeons has been escalated to operational and clinical leads, with efforts underway to improve weekend and out-of-hours support.
- VTE - A3 group leading on a QIP project alongside pharmacy to comply with thromboprophylaxis. VTE dashboard to be complete by early Autumn 2025
- Falls - Daily visits to the top contributing areas to support education, documentation processes and support decision making; Staff and patient education, and attending safety huddles
- HAPU - Inadequate turning was a theme related to the increased HAPU harm. The team have increased their intense support and monitoring in the top contributing areas to improve patient care; We continue to work closely with our anaesthetic, medical, and ortho-geriatric teams to streamline pre-operative optimisation for complex patients. All breach cases undergo root cause analysis and are reviewed at departmental M&M meetings to drive shared learning and continuous improvement, the outcome from last meeting highlighted above. The ongoing need for timely access to specialist hip and lower limb surgeons has been escalated to operational and clinical leads, with efforts underway to improve weekend and out-of-hours support.

Maternity

Key Messages

Perinatal Quality – Incidents: 152 datix (↑)reported for maternity; 0 Incidents in maternity rated Moderate harm or above; 0 new MNSI referrals. ; 1 PSII completed in June – Missed hip scan follow up for breech babies – all babies contacted with the exception of 1 who has moved out of area. Further attempt to contact the family will be made. All babies scanned have returned normal results; 28 (-) relating to PPH >1000mls; 3 (↓) relating to 3rd/4th degree tears (11 in April, 4 in May); 22 (↑) Incidents in NICU, 6 (↓) relating to medication. All incidents low harm. **Staffing**: 7.88 (↑) WTE Band 5/6 vacancy available to advertise. **Perinatal Quality – PMRT**: Neonatal deaths – Early Neonatal Death 23+2; Early Neonatal death 23+2 (triplet 3); 3 PMRTs; Maternity led PMRT – 2 held in May, graded C,A and A, A; Neonatal Led Graded at A,B,A; CNST standard C not met for 2 cases - currently at 92.3% (require 95%). **Listening to Women and Families – Service Users and MNVP** : Positive co-production work continuing regarding improving communication and developing a communication tool for staff and service users; Positive feedback for The Birth Place and communication around induction. Praise for community midwives; Sharing powerful service user story regarding life-long impact of unrepaired 4th degree tear (historic). **Staff Feedback - June:** Reducing incivility now a Divisional Driver; Student feedback – felt well supported by the Education team. In response to the Safe Learning Environment Charter (SLEC) focus groups, students reported that practice supervisors needed more training. **Training**: Positive trajectory for CNST Training compliance for year 7. Successful Simulations held across unit. **External**: NHSE Insight visit postponed until September 2025; Shared learning and methodology regarding Claims, Incidents and Complaints Triangulation, with a focus on Inequalities, at NHS Resolution Conference; NHS England issued letter to all Trusts that provide maternity and Neonatal services announcing a national investigation and outlining 5 key areas of focus for all Trusts; Perinatal Quality Surveillance Model (PQSM) to be replaced by Perinatal Quality Oversight Model (PQOM)

Issues, Concerns & Gaps

Perinatal Quality – Incidents : Training and process gaps identified following PSII. **Staffing:** 3 leavers (2.25 WTE) expected in next 2 months due to personal reasons/relocation; Maternity leave rate currently 6.85 with additional 5.03 WTE due to go off over the next few months. **Risk**: 2510 (Awaiting approval) score 15 – Failure of ICB to extend contracts of MNVP Lead; 2487 (Approved care group) score 20 - Midwifery Workforce Budget 2025 - Non-compliance with Birth-rate Plus Recommendations. **Perinatal Quality - PMRT :** 3 PMRT reviews held in June and areas for improvement included: Use of interpreter/parents declining interpreter, Lack of escalation to senior doctor, Documentation of senior doctor review (neonatal). **Listening to Women and Families – Service Users and MNVP** : ICB unable to confirm continuation of current MNVP service provision. MNVP contract ends in August. Without the MNVP lead in post, MFT will not be compliant with CNST Year 7 which will lead to financial and reputational damage for the Trust. Without an MNVP lead in post MFT will also not be complaint with the 3 Year Delivery Plan for Maternity and Neonatal Services or be able to meet the ambitions of the 10 Year plan or the requirements of the National Review into Maternity and Neonatal Services. **Staff Feedback**: Students felt that practice supervisors needed more training to support their learning needs; **Training:** Anaesthetic team need to be mapped and booked for PROMPT training. **External**: Changes within ICB and removal of "LMNS" role may pose risk to CNST compliance; If MNVP role is not supported by the ICB and Trust, the Trust will not be compliant with the preliminary requirements of the National Investigation.

Actions & Improvements

Perinatal Quality: Additional failsafe's put in place for NIPE screening pathway to ensure all breech deliveries >28 weeks are referred for hip ultrasound scan by 6 weeks including: Weekly cross check for breech presentations & enhanced training for NIPE practitioners, Position at birth to be added to neonatal yellow card; Medication incidents now a Divisional Driver with A3 projects underway; Good MDT working in the development of SMART action plans following MNSI reports. **Staffing**: VCP approval received for external recruitment. To advertise for vacant posts; Support students with graduate guarantees to complete qualification in time for September start. **Risk** : 2510 – Escalating through QAC and Trust Board as part of compliance reporting. Working with ICB to review options appraisal; Escalating through QAC and Trust Board as part of compliance reporting. Working with finance BP to identify exact number of roles removed from budget. **Perinatal Quality – PMRT:** MBRRACE advised non-return by neighbouring Trust would be considered when reviewing MFT compliance with standard C; Use of interpreters to be routine for all families who require one. Family members not to be used. Datix to be completed if no interpreter available; Neonatal team to ensure all documentation is contemporaneous, fully completed and legible. **Listening to Women and Families – Service Users and MNVP**: Service user video to be shared as part of staff training on 3rd and 4th degree tears and as part of upcoming audit meeting; Work with ICB to attempt to resolve MNVP contractual concerns. **Staff Feedback:** Practice supervisor training and PS/PA updates provided by Canterbury Christchurch for all midwives to attend; Student Midwife Practice Development Midwife holding monthly PS/PA drop in sessions for training. **Training:** Continue to monitor staff training compliance and work with Trust leads to consider a modular approach to Safeguarding Training; Work with anaesthetic team to ensure all required staff are booked. **External** : ICB to approach NHSR to confirm that ICB revised structure will meet CNST requirements; Planning for NHSE Insight visit commenced, collation of evidence underway and key stakeholders invited to join; Continue to audit against SBL v3 standards and commence 3.2 from Q1 25/26; PQSM well embedded at MFT. Minimum dataset and reporting requirements in place to maintain compliance with PQOM. Local SOP to be updated to reflect new terminology and changes regarding removal of LMNS as a separate function within the ICB.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.3%	99.2%	99.0%	99.1%	99.1%	99.0%	98.7%	99.2%	99.3%	98.9%	98.8%	98.9%
				Total Incidents Reported	-			1,229	1,199	1,055	1,139	1,112	1,068	1,207	1,245	1,334	1,359	1,326	1,386
				Clinical Incidents with Harm (Moderate and above)	0		F	3	6	10	9	8	8	11	9	7	11	13	12
				Incidents Open - Month End	-			2,050	2,215	2,217	1,970	1,692	1,782	1,728	1,752	1,828	1,610	1,600	1,663
				Incidents Overdue - Month End	-			1,101	1,262	1,259	1,133	779	819	788	701	761	595	558	618
				Patient Safety Incident Investigations (PSII) Declared	-			0	0	0	2	0	0	1	1	1	0	2	0
				Patient Safety Incident Investigations (PSII) Closed	-	L		0	1	1	1	2	0	0	0	0	0	0	0
				Patient Safety Incident Investigations (PSII) Open - Month End	-	H		3	2	1	2	0	0	1	2	3	3	5	5
				After Action Review (AAR) Declared	-			2	0	4	0	7	2	6	5	1	4	5	4
				After Action Review (AAR) Closed	-	H		2	3	2	2	1	3	2	4	6	3	1	3
				After Action Review (AAR) Open - Month End	-	H		5	2	4	2	8	7	11	12	8	9	13	14
				Never Events	0	L	?	0	0	0	2	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	80.0%
				Duty of Candour Compliance Stage 2 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Incident Management			RIDDOR Incidents	-			1	0	3	3	3	1	0	2	0	4	1	1
				RIDDOR Compliance %	-			100.0%	-	100.0%	66.7%	100.0%	100.0%	-	50.0%	-	100.0%	100.0%	100.0%
				Health & Safety Incidents	-			97	55	43	64	54	45	53	46	45	45	52	68
				Sharps Injuries	-			12	13	10	6	13	7	9	5	7	6	9	10
				EDNs Completed Within 24hrs %	90.0%	H	F	83.0%	84.1%	82.6%	84.6%	85.3%	84.7%	82.9%	82.2%	82.9%	84.4%	84.5%	86.2%
				Violence & Aggression Incidents	126	H	?	157	139	108	119	99	123	116	172	247	220	167	237
				Assaults - Patient on Staff	-			71	60	40	62	35	53	57	66	73	48	48	65
	Falls			Low or No Harm Falls %	95.0%		?	100.0%	98.8%	97.8%	98.0%	100.0%	100.0%	98.2%	100.0%	100.0%	98.6%	98.0%	98.6%
				Falls - Total	-			93	82	92	102	74	83	114	90	70	69	98	71
				Falls - Low Harm	-			29	21	29	33	27	21	34	35	30	20	35	27
				Falls - Moderate Harm	-			0	0	1	2	0	0	1	0	0	1	2	0
				Falls - Severe Harm	0		?	0	0	1	0	0	0	1	0	0	0	0	1
				Falls Resulting in Death	0	L	?	0	1	0	0	0	0	0	0	0	0	0	0
				Falls per 1,000 Bed days	-			5.77	5.10	5.85	6.26	4.63	5.08	6.69	5.94	4.24	4.45	6.02	4.46

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Falls			Falls per 1,000 Bed days	-			5.77	5.10	5.85	6.26	4.63	5.08	6.69	5.94	4.24	4.45	6.02	4.46
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	19	23	22	31	17	26	34	39	30	21	22	28
				Pressure Ulcers - Grade 2	-	H		8	18	15	24	9	15	20	19	9	11	10	12
				Pressure Ulcers - Grade 3	-	H		10	4	7	6	7	11	13	18	19	9	11	14
				Pressure Ulcers - Grade 4	-			1	1	0	1	1	0	1	2	2	1	1	2
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.18	1.43	1.40	1.90	1.06	1.59	1.99	2.57	1.82	1.35	1.35	1.76
	Medicines			Medicine Errors - Total	-			99	94	68	89	92	73	74	67	97	81	107	97
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	98.5%	100.0%	98.8%	99.1%	97.9%
	IPC			IPC Incidents	-	L		66	108	49	59	55	53	51	46	50	40	13	12
				C-Diff Cases - Hospital Acquired Total	-			4	7	11	5	6	5	6	4	6	3	3	7
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			14	21	32	37	43	48	54	58	64	3	6	13
				C-Diff Cases - Hospital Acquired (HOHA)	-			4	4	4	5	4	1	6	4	4	3	2	5
				E.coli Cases - Hospital Acquired	-			6	9	2	5	8	2	2	7	4	4	2	3
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			20	29	31	36	44	46	48	55	59	4	6	9

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	IPC			MRSA Cases - Hospital Acquired	0			0	0	0	0	0	2	0	0	0	0	0	0
				MSSA Cases - Hospital Acquired	-			0	3	4	1	1	3	2	4	1	1	1	1
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			5	8	12	13	14	17	19	23	24	1	2	3
	Mortality			Crude Mortality Rate %	1.30%			1.21%	1.35%	1.30%	1.27%	1.51%	1.80%	2.31%	1.90%	1.58%	1.46%	1.42%	1.18%
				Deceased Patient – Clinical Coding Validation Returned %	-			16.9%	21.8%	22.2%	22.6%	32.7%	30.5%	33.1%	11.9%	15.5%	17.7%	18.3%	5.6%
				Deceased Patient – Clinical Coding Validation Sent %	-			92.8%	96.7%	98.9%	100.0%	97.2%	98.3%	93.3%	96.7%	97.3%	99.0%	94.9%	100.0%
				Deceased Patient – Clinical Coding Amendments %	-			23.1%	36.8%	15.0%	19.0%	44.1%	25.0%	29.4%	28.6%	17.6%	23.5%	29.4%	100.0%
				Avoidable 2222 Calls – Cardiac Arrest	1			2	0	0	0	0	2	1	1	1	0	2	1
				Avoidable 2222 Calls – Peri-Arrests	3			5	2	2	1	2	6	3	2	1	5	1	3
				Avoidable 2222 Calls	4			7	2	2	2	2	8	4	3	2	5	3	4
				HSMR (12m)	100			98.82	98.12	98.49	97.31	99.69	98.33	98.34	97.41				
				HSMR Expected Death Rate (12m)	-			5.2%	5.2%	5.2%	5.2%	5.3%	5.3%	5.3%	5.4%				
				HSMR Expected Death Rate (Month)	-			4.9%	5.5%	4.9%	4.6%	5.7%	6.3%	6.1%	6.9%				
				SHMI (12m)	1			1.20	1.20	1.20	1.20	1.21	1.21	1.23	1.25				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Mortality			SHMI Expected Death Rate (12m)	-	H		3.1%	3.1%	3.1%	3.1%	3.2%	3.2%	3.3%	3.3%				
				SHMI Crude Death Rate (12m)	-	H		3.7%	3.7%	3.7%	3.7%	3.8%	3.9%	4.0%	4.1%				
				Fractured NOF Within 36 Hours	92.0%		?	56.5%	74.1%	66.6%	66.6%	76.2%	83.3%	70.7%	60.9%	70.0%	48.7%	71.9%	
				Number of Deaths Reviewed via SJR	-			13	5	16	16	18	14	13	10	18	15	13	12
				SJRs Completed %	12.5%	H	?	11.2%	4.1%	13.1%	12.1%	11.9%	9.2%	6.5%	7.2%	14.6%	14.3%	11.9%	14.1%
				Total Number of Deaths Due to Failings in Care	-			0	0	0	0	1	0	1	0	2	0	0	0
				Number of LD Deaths Reviewed via SJR	-			1	0	0	0	4	0	0	1	4	0	0	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	?	99.8%	99.0%	99.2%	99.7%	99.8%	99.1%	98.9%	97.5%	94.5%	99.5%	96.8%	96.0%
	Maternity			Caesarean Section %	-			42.5%	49.4%	49.2%	51.0%	48.4%	48.1%	46.5%	51.1%	45.1%	53.0%	50.1%	48.7%
				Elective C-Section %	-	H		17.3%	20.0%	19.4%	19.8%	19.5%	21.8%	19.8%	22.3%	21.2%	22.3%	20.4%	20.3%
				Emergency C-Section %	-			25.2%	29.4%	29.8%	31.1%	28.9%	26.3%	26.6%	28.7%	23.9%	30.7%	29.7%	28.4%
				PPH greater than or equal to 1500mls	-			12	20	12	14	16	20	18	12	15	18	12	14
				Total Number of Still Births Greater Than 24 weeks Gestation	-			0	1	2	0	0	0	2	2	2	1	2	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Quality	Maternity			Neonatal Deaths	-			2	2	1	0	2	2	3	3	3	1	2	2
				Maternity and Newborn Safety Investigations (MNSI) Declared	-			0	0	0	1	0	0	2	1	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			1	1	1	0	0	1	0	0	0	0	0	0
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-			1				1	1	1	1	3	3	2	2
				Risks Open - Moderate (Month End Snapshot)	-	L		34	25	24	23	21	21	23	20	18	18	15	15
				Risks Open - High (Month End Snapshot)	-	L		82	47	47	46	42	48	46	48	49	51	54	57
				Risks Open - Extreme (Month End Snapshot)	-	L		12	11	11	7	6	5	5	6	8	8	9	10
	Health & Safety			Resuscitation Training Compliance %	-	H		83.6%	83.6%	82.9%	82.9%	84.2%	84.5%	84.0%	84.0%	83.7%	83.5%	85.0%	83.5%
				Mental Capacity Act Training Compliance %	-	H		85.6%	86.6%	85.5%	86.3%	87.0%	86.9%	86.1%	86.0%	85.3%	85.6%	86.2%	86.8%
	Legal & Information Governance			Inquests Received	-			15	10	7	7	12	8	15	8	8	6	7	3
				Inquest Hearings	-			10	12	3	5	5	6	7	5	6	7	8	6
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	11	7	9	15	2	4
Emergency Care	7	5	0	3	1	4

Operational Leads:
Stewart Nisbet - *Director, Surgery and Anaesthetics*
Nicola Cooper - *Director, Medicine and Emergency Care*
Sam Chapman - *Director, Cancer and Core Clinical Services*
Nadia Stevens - *Director, Women, Children and Young People*

Committees:
Finance & Performance Committee

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	54.0%			50.7%	50.2%	51.4%	51.1%	50.9%	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%

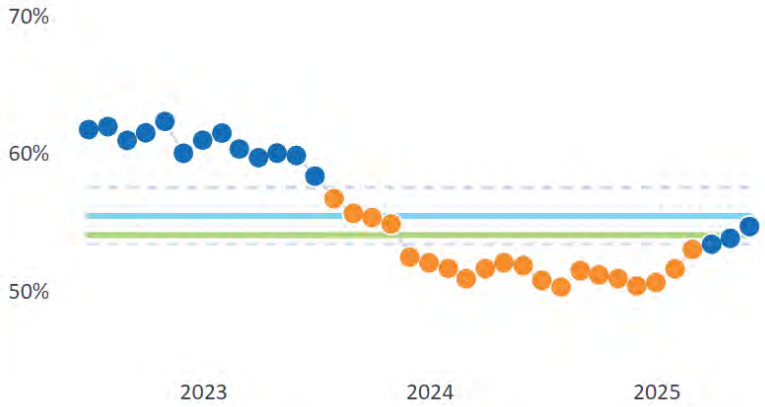
True North Domain: **Systems & Partnerships**

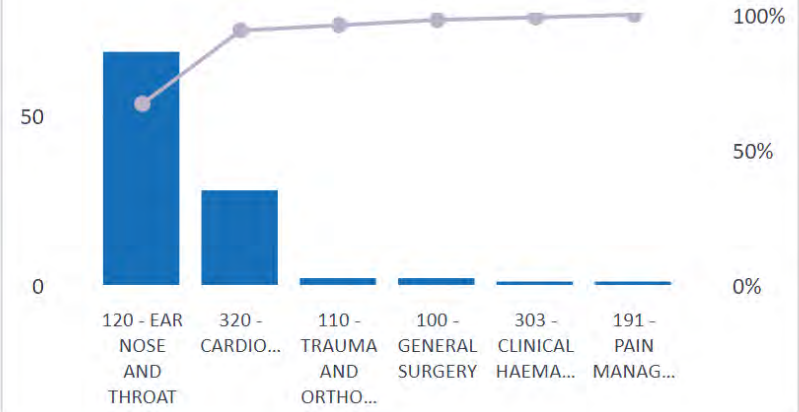
KPI Threshold: 54.0%

Sub Domain KPIs: 27

Variation Summary:

11	4	5	4	3





Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	80.0%			78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%

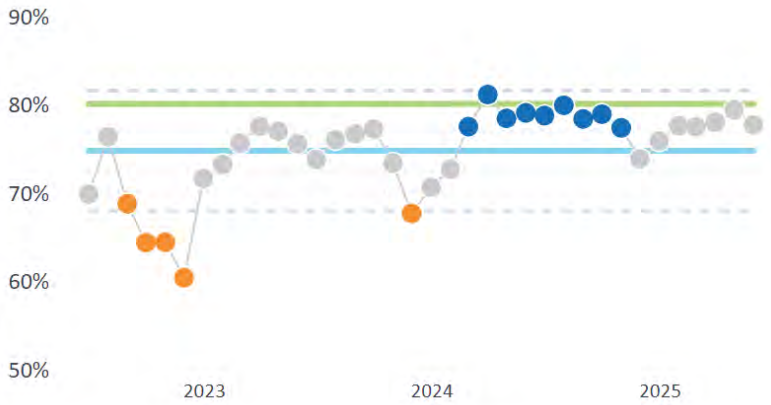
True North Domain: Systems & Partnerships

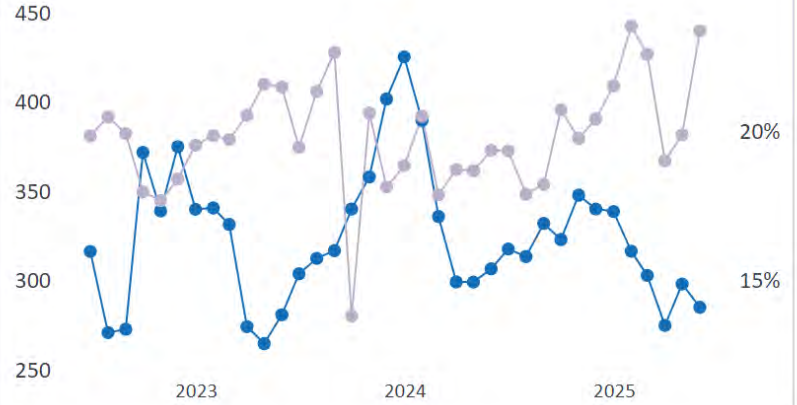
KPI Threshold: 80.0%

Sub Domain KPIs: 12

Variation Summary:

7	0	0	3	2





Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	L	F	Driver is red for 2 reporting periods	249	181	80	86	111	103
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	1,807	1,767	1,695	1,718	1,777	1,736
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	118.15	121.04	120.61	115.79	117.73	119.69
				Cancer USC Performance %	93.0%	L	?	Watch is red for 4 reporting periods	82.2%	82.4%	77.4%	77.7%	69.2%	
				Cancer USC Performance - Breast Symptomatic %	93.0%		?	Watch is red for 4 reporting periods	56.0%	14.4%	25.6%	48.0%	25.6%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	Watch is red for 4 reporting periods	55.9%	62.9%	60.8%	65.6%	55.1%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	Watch is red for 4 reporting periods	44.4%	69.6%	79.2%	64.7%	67.9%	
				Cancer 28 Day Faster Diagnosis %	77.0%	L	?	Watch is red for 4 reporting periods	68.4%	69.4%	67.9%	59.9%	56.6%	
				Critical Care Discharge Delays > 4Hrs	7.1%		F	Watch is red for 4 reporting periods	41.3%	46.5%	52.5%	54.3%	43.9%	45.8%
	Emergency Care			Type 1 LOS > 12 Hours in EC %	6.0%	L	F	Driver is red for 2 reporting periods	13.0%	11.7%	11.3%	10.3%	10.6%	10.0%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	Watch is red for 4 reporting periods	83.6%	85.0%	84.9%	84.2%	84.9%	82.7%
				Type 1 EC 4 Hour Performance %	75.0%		F	Watch is red for 4 reporting periods	61.1%	64.7%	65.8%	67.0%	67.5%	67.1%
				Total EC 12 Hour DTAs	0		F	Watch is red for 4 reporting periods	756	706	688	412	533	454

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Emergency Care			Average Time in EC Department - Excl. Type 5 (mins)	240			Watch is red for 4 reporting periods	338.07	315.84	302.27	274.27	297.46	284.41

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%
				RTT 65+ Week Waiters	0	L	Special cause of improving nature or lower pressure due to (L)ower values	249	181	80	86	111	103
				Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	5.5%	5.2%	5.7%	6.1%	6.0%	6.4%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.77	1.76	1.69	1.79	1.77	1.68
				Urgent Operations Cancelled for 2nd Time	0	L	Special cause of improving nature or lower pressure due to (L)ower values	1	0	0	1	1	0
				Day Case Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.2%	86.3%	88.0%	88.7%	87.9%	87.0%
				DM01 Performance %	73.1%	H	Special cause of improving nature or lower pressure due to (H)igher values	82.5%	87.4%	91.1%	87.6%	85.7%	86.8%
	Emergency Care			Type 1 LOS > 12 Hours in EC %	6.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	13.0%	11.7%	11.3%	10.3%	10.6%	10.0%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	83.6%	85.0%	84.9%	84.2%	84.9%	82.7%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	21.1%	20.0%	21.3%	18.5%	19.1%	19.3%
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	8	1	0	3	1	0
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	7.4%	7.9%	8.1%	7.1%	8.0%	6.8%

Access

Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

Emergency Care

Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	H	?	50.7%	50.2%	51.4%	51.1%	50.9%	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%
				RTT 65+ Week Waiters	0	L	F	608	539	358	277	180	192	249	181	80	86	111	103
				RTT 40+ Week Waiters	-	H		6,497	6,517	6,004	5,636	5,484	5,659	5,492	5,353	5,273	5,583	5,859	5,566
				RTT Waiting List Size	-	H		43,722	43,388	42,498	42,135	41,355	40,697	39,894	39,959	39,949	40,171	40,086	40,064
				RTT 52 Week Breaches	1,250	H	?	2,782	2,558	2,236	2,108	1,935	1,754	1,807	1,767	1,695	1,718	1,777	1,736
				OP Average Time to First Appointment (days)	60	H	F	104.25	109.06	117.62	111.19	116.56	107.58	118.15	121.04	120.61	115.79	117.73	119.69
				Outpatient DNA Rate %	10.0%	L	P	6.3%	6.2%	6.2%	6.0%	5.5%	6.4%	5.5%	5.2%	5.7%	6.1%	6.0%	6.4%
				OP First to Follow Up Ratio	-	L		1.74	1.64	1.74	1.72	1.66	1.76	1.77	1.76	1.69	1.79	1.77	1.68
				Operations Cancelled by Hospital on Day	13		?	15	18	11	12	15	8	17	10	4	5	4	13
				Urgent Operations Cancelled for 2nd Time	0	L	?	0	1	0	1	2	1	1	0	0	1	1	0
				Day Case Rate %	-	H		84.4%	83.9%	86.5%	86.0%	87.5%	88.7%	86.2%	86.3%	88.0%	88.7%	87.9%	87.0%
				Average Elective Length of Stay (days)	3		?	2.73	2.31	2.65	2.62	2.21	2.86	2.57	2.08	2.16	2.14	2.19	3.07
				Average Non-Elective Length of Stay (days)	10	H	P	6.06	6.11	6.16	6.46	6.61	6.30	6.43	6.60	6.43	6.36	6.47	6.01

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Access			104 Day Cancer Waits	-			17	14	12	16	21	9	18	11	17	17	12	
				Cancer USC Performance %	93.0%	L	?	70.6%	72.7%	93.6%	96.2%	94.9%	94.0%	82.2%	82.4%	77.4%	77.7%	69.2%	
				Cancer USC Performance - Breast Symptomatic %	93.0%		?	9.7%	38.6%	84.6%	97.9%	95.2%	90.6%	56.0%	14.4%	25.6%	48.0%	25.6%	
				Cancer 31 Day First Treatment Performance %	98.2%		?	96.4%	96.2%	97.2%	93.5%	96.5%	100.0%	91.0%	100.0%	98.5%	98.4%	99.3%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%		?	100.0%	100.0%	100.0%	97.3%	90.0%	94.7%	85.2%	96.4%	87.5%	86.7%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%		?	96.4%	100.0%	93.9%	97.4%	100.0%	100.0%	97.3%	100.0%	100.0%	84.4%	93.1%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	67.7%	67.2%	64.3%	58.1%	65.0%	63.7%	55.9%	62.9%	60.8%	65.6%	55.1%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%		?	85.7%	79.2%	87.2%	82.4%	79.4%	67.9%	77.6%	82.0%	85.5%	70.4%	72.5%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	84.6%	66.7%	90.6%	28.6%	84.2%	70.0%	44.4%	69.6%	79.2%	64.7%	67.9%	
				Cancer 28 Day Faster Diagnosis %	77.0%	L	?	67.9%	76.4%	76.5%	76.1%	71.7%	70.5%	68.4%	69.4%	67.9%	59.9%	56.6%	
				Cancer 28 Day Faster Diagnosis Screening %	-	L		62.9%	45.5%	68.1%	65.3%	66.4%	50.5%	31.2%	49.0%	43.3%	37.9%	33.3%	
				DM01 Performance %	73.1%	H	?	67.6%	63.6%	68.4%	72.3%	78.4%	78.3%	82.5%	87.4%	91.1%	87.6%	85.7%	86.8%
				Critical Care Admission Delays > 4Hrs	6.2%		?	7.2%	0.9%	2.5%	7.8%	7.8%	6.8%	7.6%	9.4%	4.0%	1.1%	0.9%	3.2%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Systems & Partnerships	Access			Critical Care Discharge Delays > 4Hrs	7.1%		F	49.6%	45.8%	45.4%	64.7%	43.2%	57.1%	41.3%	46.5%	52.5%	54.3%	43.9%	45.8%
	Emergency Care			Total EC 4 Hour Performance %	80.0%		?	78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%
				Type 1 LOS > 12 Hours in EC %	6.0%	L	F	12.3%	12.9%	12.4%	12.4%	13.2%	12.5%	13.0%	11.7%	11.3%	10.3%	10.6%	10.0%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	84.1%	85.9%	83.9%	85.0%	82.2%	81.2%	83.6%	85.0%	84.9%	84.2%	84.9%	82.7%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H		16.6%	17.1%	18.3%	20.6%	21.5%	17.6%	21.1%	20.0%	21.3%	18.5%	19.1%	19.3%
				Type 1 EC 4 Hour Performance %	75.0%		F	68.5%	67.6%	64.9%	67.8%	65.8%	58.3%	61.1%	64.7%	65.8%	67.0%	67.5%	67.1%
				Total EC 12 Hour DTAs	0		F	663	576	644	693	771	771	756	706	688	412	533	454
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	317.04	312.83	331.38	322.36	347.25	339.45	338.07	315.84	302.27	274.27	297.46	284.41
				Number of ED Arrivals by Ambulance	-			2,919	2,820	2,887	3,020	3,051	3,248	3,210	2,722	3,021	2,977	3,022	2,947
				Ambulance Handover Delays (> 30 mins)	-			59	46	77	77	76	145	137	86	77	48	49	28
				Ambulance Handover Delays (> 60 mins)	0	L	?	2	1	5	2	6	10	8	1	0	3	1	0
				Bed Occupancy - NCTR % (G&A)	-			19.3%	17.9%	18.2%	20.7%	19.7%	20.4%	21.5%	23.5%	22.6%	19.0%	19.9%	23.4%
				30 Day Readmission Rate	13.0%	L	P	8.5%	8.4%	7.4%	7.1%	7.4%	7.8%	7.4%	7.9%	8.1%	7.1%	8.0%	6.8%

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

NHS Medway NHS Foundation Trust

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	6	25	1	6	16	10
Workforce	7	8	2	8	2	3
Compliance	1	0	1	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	1	2	0	1	0	1

Operational Leads:
Dominika Kimber - *Deputy Director of HR & Organisational Development*

Committees:
People Committee

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	6.93	H	F	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74

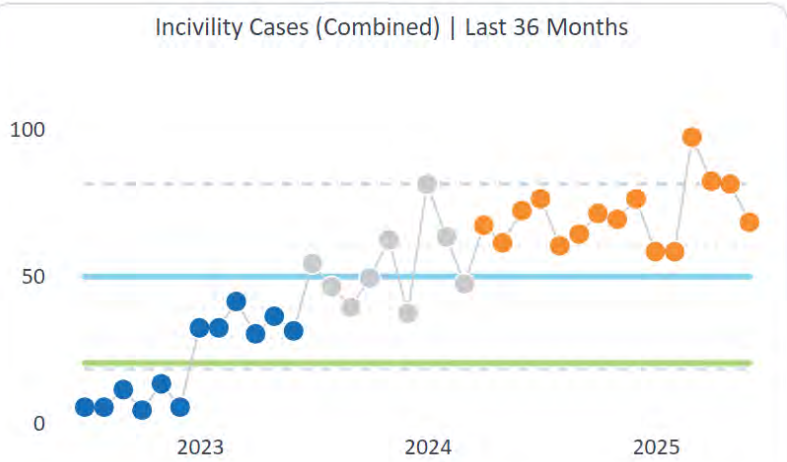
True North Domain: People

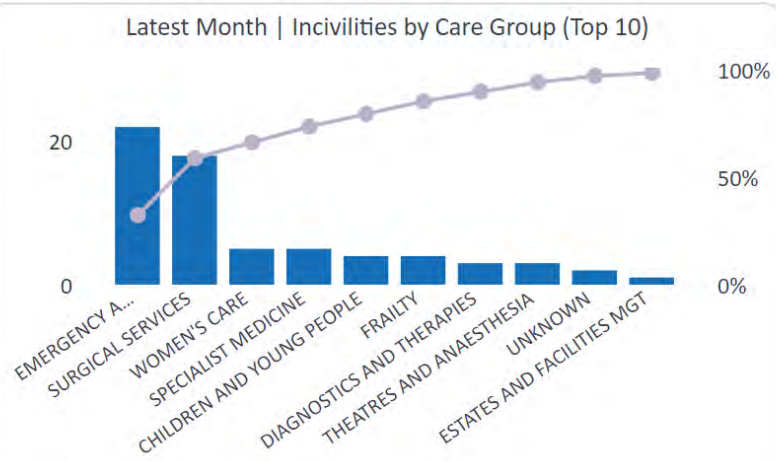
KPI Threshold: 6.93

Sub Domain KPIs: 17

Variation Summary:

	L	H	L	H
7	1	1	6	2





Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	Workforce			Incivility Cases (Combined)	20	H	?	Driver is red for 2 reporting periods	58	58	97	82	81	68
				Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	8.4%	8.4%	8.3%	8.4%	8.2%	8.1%
				Sickness Absence Rate - Total %	4.0%		?	Watch is red for 4 reporting periods	5.6%	5.1%	4.5%	4.6%	4.5%	4.6%
				Sickness Absence Rate - Long Term %	2.0%		F	Watch is red for 4 reporting periods	2.4%	2.5%	2.4%	2.4%	2.5%	2.3%
				Time to Hire - AfC	42		?	Watch is red for 4 reporting periods	55.60	63.80	54.90	64.40	55.05	56.50
	Safe Staffing			Care Hours per Patient Day (CHPPD)	9.50	H	F	Watch is red for 4 reporting periods	8.58	8.80	8.98	9.43	9.19	9.13
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%	L	F	Watch is red for 4 reporting periods	79.3%	78.3%	79.4%	78.4%	76.2%	75.1%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	Watch is red for 4 reporting periods	53.7%	54.6%	54.2%	55.3%	56.0%	57.1%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	84.8%	82.2%	82.0%	82.9%	83.5%	83.6%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.1%	79.1%	83.4%	82.8%	83.3%	84.6%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	81.8%	82.1%	81.2%	80.9%	82.8%	80.9%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	78.1%	77.9%	80.6%	78.0%	83.0%	81.2%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.2%	80.0%	80.3%	75.8%	80.6%	79.4%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	StatMan			StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	83.8%	83.6%	81.9%	81.5%	78.5%	76.5%
				StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.2%	76.1%	74.6%	75.2%	78.4%	76.7%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	78.2%	78.6%	77.3%	77.2%	79.2%	77.0%
	Compliance			DBS Compliance %	100.0%		F	Watch is red for 4 reporting periods	99.3%	99.5%	99.7%	99.7%	99.7%	99.8%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	Workforce			National Staff Engagement Score	6.93	H	Special cause of improving nature or lower pressure due to (H)igher values	6.74	6.74				
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,152.10	5,177.93	5,205.36	5,215.52	5,202.57	5,212.01
				Staff Leavers (FTE)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	48.84	43.72	58.67	42.88	37.61	36.56
				Vacancy Rate %	9.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	7.2%	6.7%	6.2%	0.6%	4.4%	4.3%
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.4%	8.4%	8.3%	8.4%	8.2%	8.1%
				Time to Hire - Medical	70	L	Special cause of improving nature or lower pressure due to (L)ower values	61.70	65.90	58.10	56.90	68	76.70
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	0.9%	1.1%	0.6%	1.2%	1.2%	0.9%
				Bank Spend %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.9%	9.7%	6.6%	8.8%	8.2%	9.1%
	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	88.6%	90.0%	92.5%	91.6%	89.4%	88.9%
				Care Hours per Patient Day (CHPPD)	9.50	H	Special cause of improving nature or lower pressure due to (H)igher values	8.58	8.80	8.98	9.43	9.19	9.13
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	43.3%	43.5%	43.7%	44.1%	44.3%	44.6%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	28.6%	28.6%	28.6%	30.8%	33.3%	33.3%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	88.9%	89.1%	89.1%	89.9%	89.7%	89.5%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	StatMan			StatMan: Conflict Resolution Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.9%	94.9%	94.8%	95.3%	95.6%	95.8%
				StatMan: EDI Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.0%	96.1%	96.0%	96.2%	96.3%	96.2%
				StatMan: Fire Safety Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	88.0%	87.8%	86.7%	87.9%	88.6%	89.5%
				StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.6%	96.7%	96.9%	97.1%	97.6%	97.6%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.8%	94.7%	95.8%	95.7%	96.9%	96.1%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	92.3%	91.8%	91.5%	92.0%	92.0%	92.0%
				StatMan: Infection Prevention L2 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.7%	89.6%	89.9%	89.8%	90.5%	91.0%
				StatMan: Information Governance Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.4%	91.5%	91.7%	91.8%	91.8%	91.9%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.6%	95.7%	95.6%	96.0%	96.4%	96.2%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	53.7%	54.6%	54.2%	55.3%	56.0%	57.1%
				StatMan: Patient Safety L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	93.3%	93.4%	93.6%	94.3%	94.7%	94.5%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.7%	97.1%	97.3%	97.7%	97.4%	97.4%
				StatMan: Prevent WRAP Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.5%	91.2%	91.6%	92.2%	93.4%	93.7%

People

Key Messages

Please add your commentary here

Issues, Concerns & Gaps

Please add your commentary here

Actions & Improvements

Please add your commentary here

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	Workforce			National Staff Engagement Score	6.93	H	F	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74				
				Incivility Cases (Combined)	20	H	?	76	60	64	71	69	76	58	58	97	82	81	68
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.9%	1.6%	1.2%	1.1%	0.7%	0.8%	1.9%	1.0%	1.4%	1.2%	0.8%	0.9%
				Staff Appraisal Rate %	90.0%		?	90.2%	90.6%	89.9%	89.0%	89.0%	90.4%	90.4%	89.8%	89.6%	90.2%	89.9%	89.0%
				Staff in Post (FTE)	-	H		5,030.84	5,091.91	5,066.18	5,115.91	5,128.44	5,145.30	5,152.10	5,177.93	5,205.36	5,215.52	5,202.57	5,212.01
				Staff Leavers (FTE)	-	L		62.65	145.58	67.67	70.68	49.26	39.32	48.84	43.72	58.67	42.88	37.61	36.56
				Staff Starters (FTE)	-	L		55.36	131.18	117.73	88.98	55.63	29.25	69.71	64.80	72.37	42.84	31.25	54.29
				Vacancy Rate %	9.0%	L	P	7.8%	6.8%	7.3%	6.6%	6.5%	6.2%	7.2%	6.7%	6.2%	0.6%	4.4%	4.3%
				Voluntary Turnover %	8.0%	L	F	8.7%	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%	8.4%	8.2%	8.1%
				Voluntary Turnover (ICS) %	-			1.2%	1.4%	1.0%	0.9%	1.0%	0.7%	1.0%	0.7%	1.0%	0.8%	0.7%	0.7%
				Sickness Absence Rate - Total %	4.0%		?	5.0%	4.9%	5.3%	5.3%	5.3%	5.3%	5.6%	5.1%	4.5%	4.6%	4.5%	4.6%
				Sickness Absence Rate - Short Term %	2.0%		?	2.1%	1.8%	2.3%	2.5%	2.6%	2.7%	3.2%	2.6%	2.1%	2.2%	2.0%	2.3%
				Sickness Absence Rate - Long Term %	2.0%		F	2.8%	3.1%	2.9%	2.8%	2.6%	2.6%	2.4%	2.5%	2.4%	2.4%	2.5%	2.3%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	Workforce			Time to Hire - AfC	42			54	55.90	56	60	58.30	45.40	55.60	63.80	54.90	64.40	55.05	56.50
				Time to Hire - Medical	70			42.60	86.50	51	78	69.90	60.90	61.70	65.90	58.10	56.90	68	76.70
				Agency Spend %	3.7%			1.7%	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%	1.1%	0.6%	1.2%	1.2%	0.9%
				Bank Spend %	10.0%			12.1%	10.2%	10.5%	9.0%	8.2%	9.6%	9.9%	9.7%	6.6%	8.8%	8.2%	9.1%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			95.7%	87.3%	85.8%	85.4%	99.4%	85.9%	85.5%	87.4%	91.1%	91.3%	89.6%	87.6%
				Staff Fill Rate % (Total) - Registered Nurse	-			90.1%	89.6%	89.7%	90.1%	96.1%	89.2%	88.6%	90.0%	92.5%	91.6%	89.4%	88.9%
				Care Hours per Patient Day (CHPPD)	9.50			8.47	8.57	8.51	8.71	8.55	8.62	8.58	8.80	8.98	9.43	9.19	9.13
	Diversity			Diversity of Workforce %	-			42.0%	42.2%	42.2%	42.7%	43.0%	43.3%	43.3%	43.5%	43.7%	44.1%	44.3%	44.6%
				Diversity of Board %	-			21.4%	25.0%	25.0%	30.8%	30.8%	30.8%	28.6%	28.6%	28.6%	30.8%	33.3%	33.3%
	StatMan			StatMan Training Compliance %	85.0%			89.2%	89.6%	89.0%	87.2%	87.5%	87.9%	88.9%	89.1%	89.1%	89.9%	89.7%	89.5%
				StatMan: Conflict Resolution Compliance %	85.0%			95.0%	95.4%	94.9%	95.0%	95.2%	95.1%	94.9%	94.9%	94.8%	95.3%	95.6%	95.8%
				StatMan: EDI Compliance %	85.0%			95.9%	96.2%	95.8%	96.1%	96.2%	96.2%	96.0%	96.1%	96.0%	96.2%	96.3%	96.2%
				StatMan: Fire Safety Compliance %	85.0%			85.6%	84.5%	83.8%	85.7%	86.5%	87.7%	88.0%	87.8%	86.7%	87.9%	88.6%	89.5%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	95.4%	96.0%	95.9%	96.0%	96.2%	96.5%	96.6%	96.7%	96.9%	97.1%	97.6%	97.6%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	92.2%	93.4%	94.2%	94.3%	94.2%	95.2%	94.8%	94.7%	95.8%	95.7%	96.9%	96.1%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	90.8%	91.6%	91.1%	92.4%	92.6%	92.7%	92.3%	91.8%	91.5%	92.0%	92.0%	92.0%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	96.7%	96.1%	95.6%	96.0%	96.1%	96.1%	96.4%	95.2%	95.6%	96.0%	95.4%	96.2%
				StatMan: Infection Prevention L2 Compliance %	85.0%	H	P	88.6%	89.5%	88.9%	89.1%	90.3%	90.3%	89.7%	89.6%	89.9%	89.8%	90.5%	91.0%
				StatMan: Information Governance Compliance %	85.0%	H	P	89.9%	90.8%	90.3%	90.7%	90.9%	91.9%	91.4%	91.5%	91.7%	91.8%	91.8%	91.9%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	93.2%	94.2%	94.3%	94.8%	95.1%	95.4%	95.6%	95.7%	95.6%	96.0%	96.4%	96.2%
				StatMan: Moving and Handling L2 Compliance %	85.0%	L	F	79.8%	79.7%	79.8%	80.7%	80.1%	79.4%	79.3%	78.3%	79.4%	78.4%	76.2%	75.1%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	48.0%	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%	54.6%	54.2%	55.3%	56.0%	57.1%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	91.3%	91.7%	90.7%	91.3%	92.0%	92.6%	93.3%	93.4%	93.6%	94.3%	94.7%	94.5%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	96.0%	95.8%	95.6%	96.1%	96.5%	96.7%	96.7%	97.1%	97.3%	97.7%	97.4%	97.4%
				StatMan: Prevent WRAP Compliance %	85.0%	H	P	89.0%	89.7%	89.1%	89.8%	90.2%	91.1%	90.5%	91.2%	91.6%	92.2%	93.4%	93.7%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	StatMan			StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	96.2%	95.7%	95.3%	95.8%	95.7%	95.7%	95.9%	94.4%	95.0%	95.8%	95.9%	96.3%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	H	P	91.8%	91.8%	90.2%	87.9%	88.5%	89.0%	88.1%	88.9%	89.9%	91.5%	93.1%	93.4%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	72.6%	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%	82.2%	82.0%	82.9%	83.5%	83.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		P	96.4%	96.3%	96.4%	96.5%	96.5%	94.6%	95.5%	95.0%	95.2%	95.6%	95.7%	96.5%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%		P	87.2%	87.2%	85.8%	86.1%	86.2%	85.3%	85.7%	86.3%	86.1%	86.9%	86.9%	87.3%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	H	?	81.9%	81.5%	80.7%	82.2%	84.2%	80.3%	81.7%	84.3%	85.4%	85.6%	85.5%	84.7%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	85.1%	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%	79.1%	83.4%	82.8%	83.3%	84.6%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	81.9%	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%	82.1%	81.2%	80.9%	82.8%	80.9%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	80.5%	80.0%	78.6%	78.3%	76.7%	77.6%	78.1%	77.9%	80.6%	78.0%	83.0%	81.2%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	90.8%	91.7%	91.8%	92.1%	93.2%	93.1%	93.5%	94.1%	94.3%	94.6%	94.9%	94.7%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	85.9%	80.6%	83.0%	76.3%	77.3%	79.7%	82.2%	80.0%	80.3%	75.8%	80.6%	79.4%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	82.3%	81.1%	80.6%	81.2%	84.2%	82.1%	83.8%	83.6%	81.9%	81.5%	78.5%	76.5%
				StatMan: New Born Life Support Compliance %	85.0%		F	79.9%	78.7%	75.9%	79.5%	83.3%	82.5%	79.2%	76.1%	74.6%	75.2%	78.4%	76.7%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
People	StatMan			StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	78.0%	77.9%	77.5%	75.9%	77.5%	78.5%	78.2%	78.6%	77.3%	77.2%	79.2%	77.0%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	85.9%	80.8%	77.7%	78.4%	81.4%	79.1%	77.2%	77.6%	84.1%	86.7%	86.7%	84.1%
	Compliance			Professional Registration Compliance %	100.0%	L	?	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
				DBS Compliance %	100.0%		F	99.8%	99.4%	99.5%	99.0%	98.9%	99.5%	99.3%	99.5%	99.7%	99.7%	99.7%	99.8%

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Simon Wombwell
Chief Finance Officer

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	12	2	2	6	0	1

Operational Leads:
Paul Kimber - *Deputy Chief Finance Officer*

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Financial Position

(Surplus) / Deficit (£)

Type	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
	£0.00m			-2.31m	-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m	-4.24m	3.48m	-0.59m	-1.74m	-1.86m

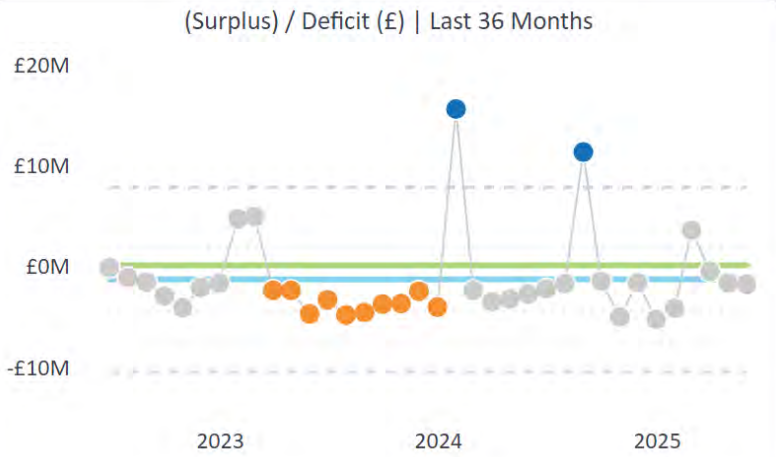
True North Domain: **Sustainability**

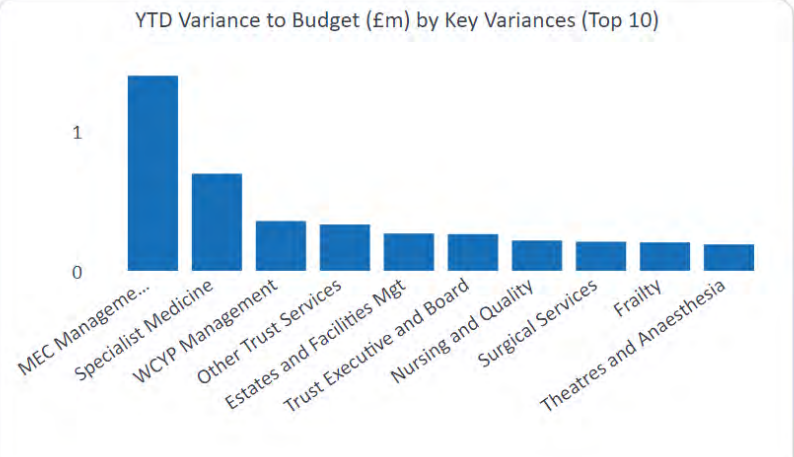
KPI Threshold: £0.00m

Sub Domain KPIs: 16

Variation Summary:

12	0	2	2	0





Key Messages

The Trust reports a deficit at Month 3 YTD of £4.2m, adjusted to a control total deficit of £4.7m; this is in line with plan.
ERF and CCD income is reported to plan; £14.4m of Deficit Support Funding has also been recognised per Plan YTD.
Pay costs have increased month-on-month, including an increase to worked WTEs.
Delivery of the efficiencies programme remains the key concern; the delivery target continues to increase each month with a notable step change from July, meaning the expenditure run-rate in cash terms must reduce accordingly.

Issues, Concerns & Gaps

Profiling of the efficiencies plan to provide time to develop savings means the Pay budget in Q2 will be ~£27m versus a Pay cost today of £29m.
The ERF and CDC income is reported to plan but there is a potential £1.8m risk if underperformance against activity is clawed back by commissioners.
There remain risks around MCH invoicing, NKPS charges and Car Park VAT reclaim. We may also have risks around Deficit Support Funding if we and our system partners do not deliver to Plan.
Cash remains an area of focus to ensure the Trust can meet its commitments, especially if CIPs do not deliver.

Actions & Improvements

Identification and delivery of savings is the most urgent financial objective.
The Trust has engaged PA Consulting to aid the Trust for this purpose.
We need to assess roster controls, particularly in Nursing.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability	Financial Position			Actual Worked FTE	5,155			Driver is red for 2 reporting periods	5,552.05	5,618.26	5,705.64	5,576.22	5,533.26	5,616.48
				Actual Worked FTE vs Budget	0			Watch is red for 4 reporting periods	-1.98	60.59	157.89	329.36	93.18	171.36

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability	Financial Position			Total Temporary Staffing Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**3.02m**	**3.01m**	**3.31m**	**2.97m**	**2.72m**	**2.89m**
				Agency Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**0.26m**	**0.31m**	**0.30m**	**0.37m**	**0.36m**	**0.26m**

Sustainability

Key Messages

The Trust reports a deficit at Month 3 YTD of £4.2m, adjusted to a control total deficit of £4.7m; this is in line with plan.

ERF and CCD income is reported to plan; £14.4m of Deficit Support Funding has also been recognised per Plan YTD.

Pay costs have increased month-on-month, including an increase to worked WTEs.

Delivery of the efficiencies programme remains the key concern; the delivery target continues to increase each month with a notable step change from July, meaning the expenditure run-rate in cash terms must reduce accordingly.

Issues, Concerns & Gaps

Profiling of the efficiencies plan to provide time to develop savings means the Pay budget in Q2 will be ~£27m versus a Pay cost today of £29m.

The ERF and CDC income is reported to plan but there is a potential £1.8m risk if underperformance against activity is clawed back by commissioners. Conversely, the ICB has currently capped the ERF income, which is lower than the value of activity plans. Delivery of the activity plan may therefore not be reimbursed and/or be delivered at additional, unplanned cost.

There remain risks around MCH invoicing, NKPS charges and Car Park VAT reclaim. We may also have risks around Deficit Support Funding if we and our system partners do not deliver to Plan.

Cash remains an area of focus to ensure the Trust can meet its commitments, especially if CIPs do not deliver.

Actions & Improvements

Identification and delivery of savings is the most urgent financial objective. The Trust has engaged PA Consulting to aid the Trust for this purpose.

We need to assess roster controls, particularly in Nursing.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability	Financial Position			(Surplus) / Deficit (£)	£0.00m			-2.31m	-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m	-4.24m	3.48m	-0.59m	-1.74m	-1.86m
				Total Pay Spend (£)	-			26.13m	26.22m	26.23m	32.75m	30.64m	27.20m	27.72m	27.70m	46.04m	29.66m	28.94m	29.00m
				Actual Worked FTE	5,155			5,531.73	5,480.86	5,528.07	5,579.90	5,505.10	5,556.27	5,552.05	5,618.26	5,705.64	5,576.22	5,533.26	5,616.48
				Breakeven Revenue Budget (£)	£0.00m			0.07m	0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m	-4.62m	1.37m	-2.03m	-1.40m	-1.95m
				Total Pay Spend (£) vs Budget	£0.00m			0.03m	2.64m	1.29m	0.43m	3.81m	0.74m	1.68m	1.68m	19.85m	0.24m	-0.16m	0.88m
				Actual Worked FTE vs Budget	0			50.36	5.09	50.05	81.09	4.96	52.83	-1.98	60.59	157.89	329.36	93.18	171.36
				Total Temporary Staffing Spend (£)	-			3.60m	3.16m	3.34m	3.46m	2.93m	2.94m	3.02m	3.01m	3.31m	2.97m	2.72m	2.89m
				Total Temporary Staffing Worked FTE	-			682.59	618.47	655.16	655.05	565.62	582.46	584.79	610.15	687.55	557.06	508.99	589.93
				Bank Spend (£)	-			3.16m	2.66m	2.77m	2.95m	2.51m	2.62m	2.76m	2.70m	3.02m	2.60m	2.36m	2.63m
				Actual Worked FTE - Bank	-			631.54	572.35	593.69	612.30	519.35	542.36	551.78	572.88	631.57	511.55	457.14	541.27
				Agency Spend (£)	-			0.44m	0.50m	0.57m	0.50m	0.42m	0.32m	0.26m	0.31m	0.30m	0.37m	0.36m	0.26m
				Actual Worked FTE - Agency	-			51.05	46.12	61.47	42.75	46.27	40.10	33.01	37.27	55.98	45.51	51.85	48.66
				Income (£)	-			39.81m	38.21m	52.45m	47.61m	41.37m	41.38m	39.35m	38.33m	63.01m	45.65m	43.61m	43.32m
				Income (£) vs Budget	£0.00m			0.93m	1.27m	1.40m	0.86m	-0.28m	0.18m	-1.73m	-1.55m	22.13m	-0.21m	-0.50m	0.44m

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability	Financial Position			Total Non-Pay Spend (£)	-			13.56m	11.91m	12.47m	14.29m	13.91m	15.04m	14.21m	12.64m	14.35m	14.23m	14.35m	13.79m
				Total Non-Pay Spend (£) vs Budget	£0.00m			0.91m	-1.06m	1.22m	2.19m	1.45m	2.60m	1.46m	1.19m	1.96m	-0.40m	-0.64m	-0.56m

1. Executive Summary

Reducing mortality and preventing avoidable deaths is the Quality True North and breakthrough objective for Medway NHS Foundation Trust. This report presents Quarter 4 outcomes from the Trust's mortality review programme, including progress on structured judgement reviews (SJRs), thematic learning, and ongoing quality improvement initiatives. This report is submitted in accordance with the National Learning from Deaths (LfD) Guidance, which requires Trusts to regularly collect, analyse, and publish key mortality data through quarterly public Board reports.

During Quarter 4 (Q4) 2024–25, Medway Maritime Hospital reported 456 adult inpatient and Emergency Department (ED) deaths. Of these, 41 (9%) underwent a Stage 1 SJR review. Although this was below the aspirational 12.5% target, focused improvement activity has led to the March figure achieving 14.8% review compliance. This progress followed the implementation of an A3 improvement initiative, supported by reviewer reallocation and active recruitment, with three of five reviewer vacancies now filled. The remaining posts will be recruited following the Aqua Learning from Deaths and SJR Workshop in April 2025.

The five primary learning themes identified from the SJR process are:

- Communication and multidisciplinary care coordination issues
- Delayed recognition and response to clinical deterioration
- Inadequate end-of-life care planning
- Medication and treatment failures
- Poor adherence to pathway policies and documentation

Significant improvement work has been started, including initiation of the Sepsis 6 A3 programme, strengthening of the joint ED and Critical Care Mortality and Morbidity process, and ongoing development in palliative and end-of-life care provision.

The Hospital Standardised Mortality Ratio (HSMR+) for December 2023 to November 2024 stands at 99.6, categorised as "within expected". Conversely, the Summary Hospital-level Mortality Indicator (SHMI) for November 2023 to October 2024 is 1.20, categorised as "higher than expected". SHMI analysis attributes this to a reduction in expected deaths, potentially linked to data shifts related to Same Day Emergency Care (SDEC) activity. Furthermore, increasing palliative care activity and extended lengths of stay are contributing factors. These findings are being explored in the ongoing Mortality Refresh Programme, part of the Trust's Quality Breakthrough objective.

2. Learning from Deaths

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality metrics, medical examiner scrutiny, structured judgement reviews (SJR), patient safety incident investigation outcomes, together with detail from quality and clinical governance processes. This report seeks to outline key relevant activity.

Between 01 January 25 to 31 March 25, for quarter 4 of the financial year 2024/2025, the Trust recorded 456 inpatient adult deaths. A total of 41 (9%) of deaths were reviewed using the Structured Judgement Review (SJR) method. The cases reviewed included 24 referrals from the Medical Examiner, 10 randomly selected, 5 involving patients with learning disabilities, and 2 prompted by family complaints regarding care.

An overview of the Trust's current position with regards to mortality is presented below.

Figure 1: Q4 2024-25: Overview of deaths

	January 25	February 25	March 25	Total
Total no. of deaths (adult inpatient & ED)	196	138	122	456
Total number of deaths returned by SJR (stage 1)	13	10	18	41
% of deaths reviewed by SJR.	6.5%	7.0%	14.2%	9%
Total number of deaths judged as probably preventable (>50:50)	1	0	2	3
Total number of LD deaths reviewed	0	1	4	5
Total number of LD deaths judged as probably preventable (>50: 50)	0	0	0	0

3. Structured Judgement Reviews (SJR)

Review Activity

From the data in quarter 4, we can see that:

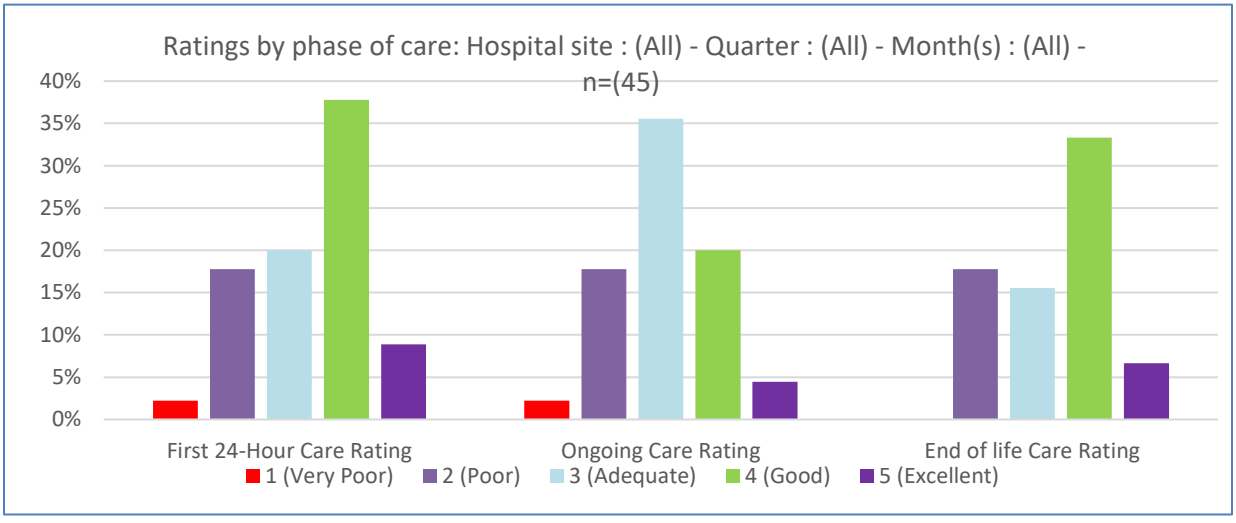
- The majority of the patients we review are aged over 90 (31.6%)
- The majority of deaths reviewed are definitely not avoidable (84.2%)
- The majority of patients reviewed have a length of stay of between 1-6 days (42%)

A total of 41 (9%) deaths were subject to SJR review during quarter 4 (24/25). Any cases which are judged as potentially avoidable, or have an overall care score as 'poor' or 'very poor', are escalated to the stage 2 SJR panel. If the panel agrees that the death was preventable (more than 50:50) these are escalated to the Incident Review Group (IRG) for further discussion and consideration if a further investigation under the PSIRF framework is required.

SJR phases of care scores

The SJR format allows reviewers to comment on each phase of care. The phases of care are the first 24 hours of admission, ongoing care, care during a procedure, final days and overall care. The reviewer is asked to score the phases from (i) very poor, (ii) poor, (iii) adequate (iv) good (v) excellent. This allows us to see where the poor or excellent care is during the admission. SJRs that have identified learning are shared with the specialities to discuss at the Mortality and Morbidity (M&M) meetings. The phases of care scores for quarter 4 are included in figure 2 below:

Figure 2: Q4 24-25 Phases of care scores- SJR



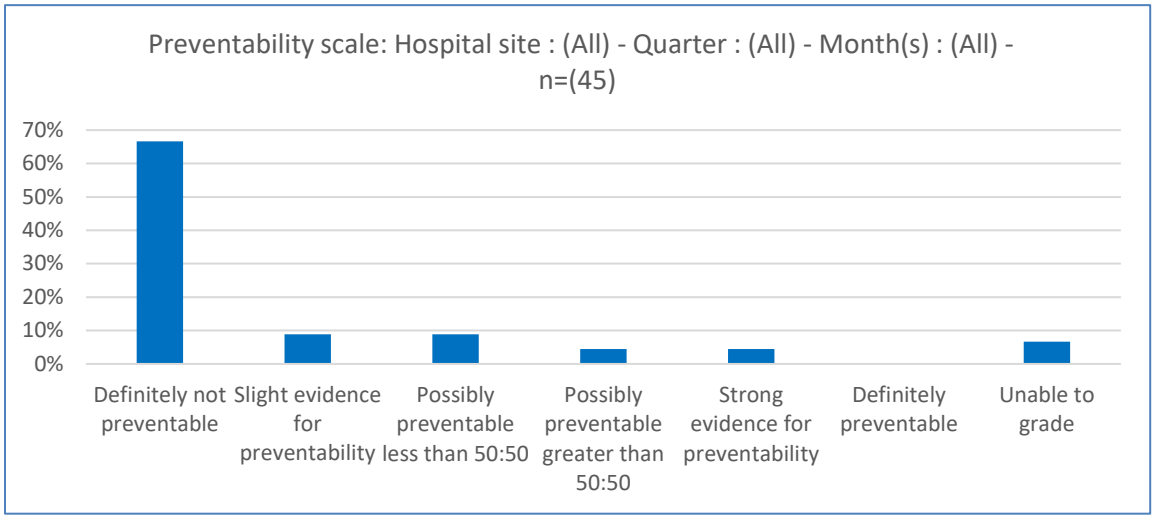
The purpose of conducting SJRs is to identify concerns and opportunities to improve. In particular, there are three 'triggers' within an SJR that lead to escalation to the stage 2 panel and for consideration of a patient safety incident:

(i) Where overall care is considered poor/very poor,

(ii) Where a problem in care led to harm,

(iii) Where the reviewer considered there to be evidence that the death may have been preventable. This approach ensures further scrutiny of these cases.

Figure 3: Q4 24-25 SJR scores on preventability



Of the 41 cases reviewed at by the single SJR reviewer at stage 1, 11 cases were referred for the stage 2 panel for the reasons above. Some the actions following the stage 2 SJR panel were:

- One case where the death was judged as 'strong evidence of preventability' was escalated to the Patient Safety Team and is currently undergoing the process of a Patient Safety Incident Investigation (PSII)
- One case judged as 'strong evidence of preventability underwent a SWARM review and a joint mortality and morbidity meeting between ED and Critical Care. The meeting was very well attended by both teams and some of the actions include:
  (i) Consultant to consultant referrals between ED and critical care to be completed using a standard form and phone call. Audits will be carried out to monitor compliance
  (ii) Inter-department simulation between ED, critical care and Acute Medicine to examine complex patient cases and explore potential human factors

(iii) Non invasive ventilation (NIV) policy to be reviewed in line with British Thoracic Society (BTS) guidelines

One case was judged as possibly preventable (less than 50%). The original concern was that endocarditis was not considered as a primary diagnosis for a patient which could have led to a potentially different pathway of care for the patient. Upon further review, it was discovered that blood cultures revealed no growth, and therefore it was reasonable not to suspect endocarditis when the patient was admitted. This case was downgraded to low harm and is currently undergoing a local investigation overseen by the Patient Safety Team.

To maximise the use and value of the whole of the SJR dataset, all individually completed SJRs with learning identified are discussed at the relevant Mortality and Morbidity (M&M) meeting for the teams to reflect on the learning and embed actions that are improvement driven where necessary.

The process of escalation of cases judged as poor for overall care, slight evidence of preventability or possibly preventable (less than 50%) is currently under review to ensure that there is a robust review system once these cases have been highlighted via the SJR process.

Learning from excellence and poor care

Some of the themes of positive learning from SJRs for Quarter 4 24/25 were as follows:

Timely and appropriate decision making

- Early identification of clinical deterioration and timely escalation of care
- Prompt decision making regarding end of life care, including completion of Treatment Escalation Plans (TEP) and Do Not Resuscitate Forms (DNAR)
- Appropriate and timely referrals to specialist and tertiary centers
- Thorough clear documentation of care decisions, patient progress and end of life discussions

Patient centered and compassionate care

- Clear and consistent communication and with families and next of kin
- Sensitive and thoughtful discussions around prognosis and care decisions

- Careful consideration of patient and family wishes with excellent involvement with chaplaincy addressing cultural needs
- Tailored care addressing individual needs including nutrition, comfort measures and symptom control

Team working

- Excellent coordination between teams including physiotherapists, dieticians, speech and language therapists, respiratory teams and palliative care.
- Active involvement of ART and other specialist teams in patient care, ensuring comprehensive support.
- Good examples of collaboration between departments ensuring seamless transitions in care (ED to specialty wards and ICU involvement).

4. Key themes from SJRs

Delayed recognition and response to patient deterioration 	There were repeated delays in recognising and responding to patients who were clinically deteriorating. These included long waits in the Emergency Department (12+, 30+ hours), long wait for ward transfers, delayed reviews, missed signs of infection and inadequate responses to worsening conditions (e.g hyperkalaemia, pressure ulcers and sepsis). There appears to be a culture of waiting for senior reviews for specialist input, even when patients are clearly deteriorating.
Insufficient end of life care planning 	End of life care was often poorly timed or inconsistently applied. Treatment Escalation Plans (TEP) and Do Not Attempt Resuscitation (DNAR) decisions were made very late (sometimes hours before death) and anticipatory medications were either missed or under dosed. There was also a lack of early involvement from End of life Care (EOLC)/palliative teams, resulting in missed opportunities to improve patient comfort and support families. Documentation gaps around capacity assessment and Deprivation of Liberty (DoLs) further compromised care.

	Delays or inadequate planning for end of life care (discussion with families, DNAR and TEP forms not completed). Whilst some of these are discussed on admission, it was not always followed up with families, leading to unclear treatment goals.
Medication and treatment failures 	There were several examples of prescribing errors; missed medications and delays in treatment often due to poor systems or lack of follow through. In several cases, critical medications like antibiotics, steroids, or anticoagulants were delayed or stopped without clear clinical justification. Additionally, there were issues with medication availability and incomplete assessments which run the risk of compromising care.
Poor adherence to pathway polices and documentation 	Fundamental care processes like risk assessments, documentation of observations and pathway adherence (e.g Venous Thromboembolism (VTE), NEWS2, stroke pathway) were inconsistently applied or not completed. Inaccurate documentation of pressure areas, lack off escalation when scores were high and copy and pasting nursing notes. In some cases, these contributed to delayed diagnosis and interventions.
Communication and coordination issues within multidisciplinary teams 	There were widespread issues with breakdown in communication between clinical teams. Poor handover, beeps not responded, conflicting documentation and lack of follow up with tertiary centres which resulted in disjointed care. This affected timely interventions and led to confusions around roles and responsibilities, particularly in complex cases requiring coordinated decision making. There were examples of misallocation of critical care step downs with patients placed as an outlier on surgical wards.

Several themes identified through the SJR process align with ongoing improvement initiatives overseen by the Patient Safety Team. Below is a summary of key improvements and actions linked to these themes:

Deteriorating Patient

- The real-time Deteriorating Patient Dashboard is now live, providing up-to-date data on inpatients who are deteriorating. A series of A3 improvement projects are underway in wards with low compliance.
- Continuous efforts are being made to enhance awareness and improve escalation procedures related to patient deterioration.
- A review of competencies and training regarding the NEWS2 escalation criteria for nurses is in progress.

Medication Safety

- The Omitted Doses Working Group has been reinstated to address missed doses of time-critical medications, including those for Parkinson's and antiepileptic drugs.
- The Medication Quality Improvement Plan is being implemented to address concerns related to medication incidents.
- Exploring the potential for alerts on the Electronic Prescribing and Medicines Administration (EPMA) system to notify when duplicate drugs are administered.

Documentation

- Regular reminders are being issued regarding the avoidance of the 'copy and paste' function in documentation. This message is also reinforced in presentations by Clinical Coding and Learning from Deaths teams.
- Senior leadership is actively engaging in delivering documentation training to junior staff.

Communication Between Clinical Teams

The Internal Professional Standards have now been agreed and have been discussed at governance and education meetings across the Trust. The formal launch is planned for mid-July 2025. These standards will address the shift from the mindset of "it's not my patient" to "It's our

Medway patient" and is line with the Trust's cultural transformation programme as well as "Civility Saves Lives".

5. Action and improvement work for Q4 2024-25

Sepsis 6 working group

Over the last three quarters, SJRs that were randomly selected with a focus on sepsis related deaths highlighted some key issues with sepsis management across the Trust. The SJR reviews revealed that there were examples of delayed recognition and diagnosis of sepsis, delayed treatment initiation or adjustments, failure to escalate care on deterioration, care and continuity gaps, systemic challenges contributed by bed shortages and prolonged ED stays and patterns of incomplete sepsis management. This prompted joined up working with the Acute Response Team who have set up the sepsis 6 working group. The group runs monthly, with the first meeting having taken place on the 18th March 2025. The Transformation team will be supporting with this work. The group is using the A3 Patient First methodology to identify the problem areas and countermeasures. Some of the issues identified by the group that will be addressed through the A3 improvement work are:

- No identifiable sepsis medical lead for the Trust
- No NICE Quality Standard to adhere to (previous ones were withdrawn in 2024 and have not been updated)
- No sepsis policy for the Trust

The improvement work in relation to sepsis is being overseen by The Patient Safety Group. Feedback from monthly meetings and progress will be monitored by Patient Safety.

Joint ED and Critical Care mortality and morbidity meeting (M&M)

A case referred by the Medical Examiner (ME) due to a delay in critical care intervention in the patient's management stated that the patient required intubation but was not prioritised by the ITU team. Initially the team suggested a coroner referral as the patient had not been diagnosed as an asthmatic, but the ME noted that she was difficult to ventilate using an Ambu® bag, which supports the diagnosis of asthma, and therefore felt that it was reasonable to offer this as a cause of death. This case prompted the start of regular joint multidisciplinary meetings between ED and Critical care. The meeting was very well attended and the feedback from attendees was positive.

- SJR completed - strong evidence of avoidance

- Case presented at the Quality Huddle- instruction for Divisional Medical Director to identify actions for shared learning- joint M&M between critical care and ED instructed.

Learning identified:

- Leadership thought the case fell short of what was expected
- Communication failures
- NIV Policy contraindicated plan of care set / unclear about process and plan
- Interdepartmental communication failures

Actions

- Consultant to Consultant Referral between ED & Critical care, Use of Referral form to critical care for traceability as well as phone call, audit for compliance
- Inter-department simulation between ED, Critical care and AEM looking at complex patients deteriorating and explore human factors and communication
- NIV Policy to be reviewed in Line with BTS guidelines

Issues, gaps and concerns to escalate from the meeting were that Critical care beds with wadable patients are preventing swift admission to critical care.

Palliative and End of Life care (EOL)

The Clinical Nurse Specialist is leading a programme of work to increase education and awareness, in collaboration with the palliative care team, they are delivering training to nurses, junior doctors and consultants each month

An A3 approach using the Patient First methodology is underway to improve the completion of the RESPECT document, this is being led by the End Of Life (EOL) team.

- EoL team moving to a 6-day working week, likely to come to fruition in late summer which will help with out of hours and weekend decision making delays
- This workstream feeds into the Breakthrough Objective for mortality and is part of the Quality Huddle
- EOLC are working with SECAMB to look at the root causes for delays into hospital at the end of life

Issues/concerns.

There are issues with completing fast tracks discharges. The fast track discharge process is for patients who have a rapidly deteriorating condition or are likely to rapidly deteriorate and are

approaching the last weeks to months of life. The aim is to provide a safe transition to the preferred place of care. The process for fast tracking a patient was changed at short notice resulting in only two staff being trained to complete fast tracks. This has been escalated up through to exec, and to the ICB via the Associate Director of Patient experience.

As a consequence, the Trust are experiencing delays with patients being discharged home to die. It is anticipated the training programme to be extended to the EoL team in April, and MFT have requested the business continuity plans to be in place by the Palliative Care Team and Integrated Care Board as soon as possible. This workstream will be monitored via the Patient Experience Group and the Mortality breakthrough objectives.

6. Summary and Next Steps

This quarter demonstrates continued Trust-wide engagement in mortality reviews, reflective learning, and actions. Targeted improvements in sepsis management, EOL care, and multidisciplinary working are key to reducing avoidable harm and ensuring patients receive safe, high-quality care.

Next steps include:

- Full recruitment to the SJR reviewer team post-April workshop to ensure review compliance achieves the consistent target of 12.5% of deaths reviewed each month.
- Continued analysis of SHMI trends and coding impacts. Coding presentation and the impact of clinical documentation on coding, finance and mortality indicators continue to be delivered to specialties across the Trust.
- Embedding learning from themes via M&M meetings and Quality Governance processes.

The Trust remains committed to learning from deaths to improve clinical practice, fostering a culture of openness and learning, and delivering better outcomes for patients and families.

7. Specialty Mortality and Morbidity Meetings (M&M)

Since the implementation of the new escalation process for mortality and morbidity reviews, there has been a notable improvement in response from the teams. Seventeen of the nineteen specialties shared minutes from their M&M meetings. The outstanding specialties include Ear, Nose and Throat (ENT) and Hematology. For both specialties, the process of appointing new governance leads is in progress to ensure compliance with requirements.

Figure 4: Q4 2024-25: M&M tracker

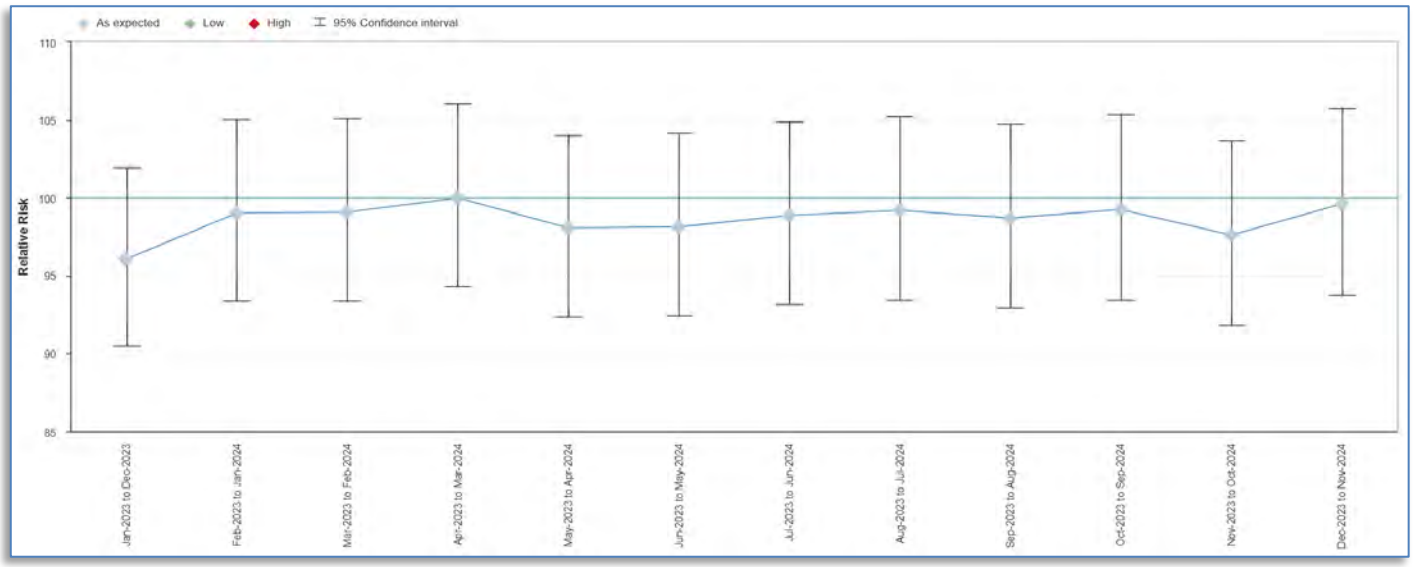
Speciality 2024/2025	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Acute Medicine	Cancelled	15th	7th	12th	30th	27-Sep	cancelled	29th	13th	31st	26th	28th
Acute Paediatrics	4th	2nd	6th & 20th	18th	15th	5th	3rd & 17th	7th	Rescheduled to 23/01	23rd	20th	
Anaethetics					11th		9th			2nd		
Cardiology	23rd	28th	25th	30th		24th	Cancelled	26th	Meething cancelled	Meeting cancelled rescheduled to 11/02	11th	
Critical Care - ICU/HDU	No Meeting	No Meeting	No Meeting	15th	21st	12th	23rd	13th	12th	Cancelled	5th & 26th	26th
Diabetes and Endocrinology	17th	No Meeting held	No meeting held	17th	No meeting held	Cancelled	16th	20th	Cancelled	15th		5th
ED	24th	22nd	26th	24th	28th	25th	23rd	27th	Cancelled	29th	26th	26th
Elderly Care	25th	23rd	20th		1st	26th	31st		Cancelled	30th	20th	27th
ENT **LOW MORTALITY GROUP		9th	24th	No meeting held	No meeting held		14th Nov	14th				
Gastroenterology	22nd	20th	24th	29th	No meeting held	30th	28th	23rd Dec	13th Jan	27th		17th
General Medicine									Cancelled	24th	14th	28th
General Surgery		9th	No meeting held		No meeting held	11th	9th	14th	12th	14th	12th	19th
Haematology **LOW MORTALITY GROUP	19th	24th			No meeting held		1st Nov	27th Dec	27th Dec	Cancelled	14th	
Neonatology		28th			No meetting held		8th					
Maternity/still births					No meeting held	chased 08/10						
Gynaecology ** LOW MORTALITY GROUP	26th		7th	5th	21st	26th	14th	18th	16th		24th	31st
Trauma & Orthopaedics			No meeting held	Cancelled	No meeting held	11th	9th	14th	12th	14th	12th	19th
Respiratory	19th	17th	21st	No meeting held	No meeting held	20th	11th	22nd	20th	17th		Meeting held-awaiitng minutes
Urology	17th	9th	No update	9th	No meeting held	11th	9th	14th	12th	14th	12th	19th

8. Mortality

Hospital Standardised Mortlaity Ratio (HSMR+)

The Hospital Standardised Mortality Ratio (HSMR+) for the reporting period of December 2023 to November 2024 is 99.6, which is classified as ‘within expected’. The Trust continues to report a stable value for HSMR+, with no statistically significant variation.

Figure 5 HSMR+ Decmeber 2023- November 2024 12 month rolling trend



Acute Cerebrovascular Disease has been flagged as an outlying diagnosis group in both SHMI and HSMR+. Detailed analysis reveals the following:

- Approximately one-third of deaths occur in patients aged 15–64, a group typically associated with lower mortality risk
- The data suggests a disproportionate number of deaths in younger patients
- Medway reports a higher-than-national average number of deaths among patients aged 15–64 with cerebrovascular disease
- In contrast, the over 85 age group, usually associated with higher risk, represents a lower proportion of admissions

Additional data shows:

- Around 50% of cerebrovascular-related deaths occur in patients with Charlson Comorbidity Index scores between 4–19
- 22% of these patients have a Charlson score of zero, contributing to 12.1% of deaths, which is broadly in line with national data
- However, Medway reports deaths in patients with low to mid-range Charlson scores (1, 4, 6–9), a trend not observed nationally

As a result, the Trust will undertake deep-dive case reviews to:

- Verify the accuracy of clinical coding
- Examine the quality of care provided
- Identify any recurring themes or learning opportunities

Summary Hospital- Level Mortality Indicator (SHMI)

SHMI for the period November 23 to October 2024 is 1.20 and “higher-than-expected”. This is another slight deterioration on last month. There has been an increase in crude rate, and an increase in the difference between crude and expected rate.

Figure 6: Medway SHMI trend

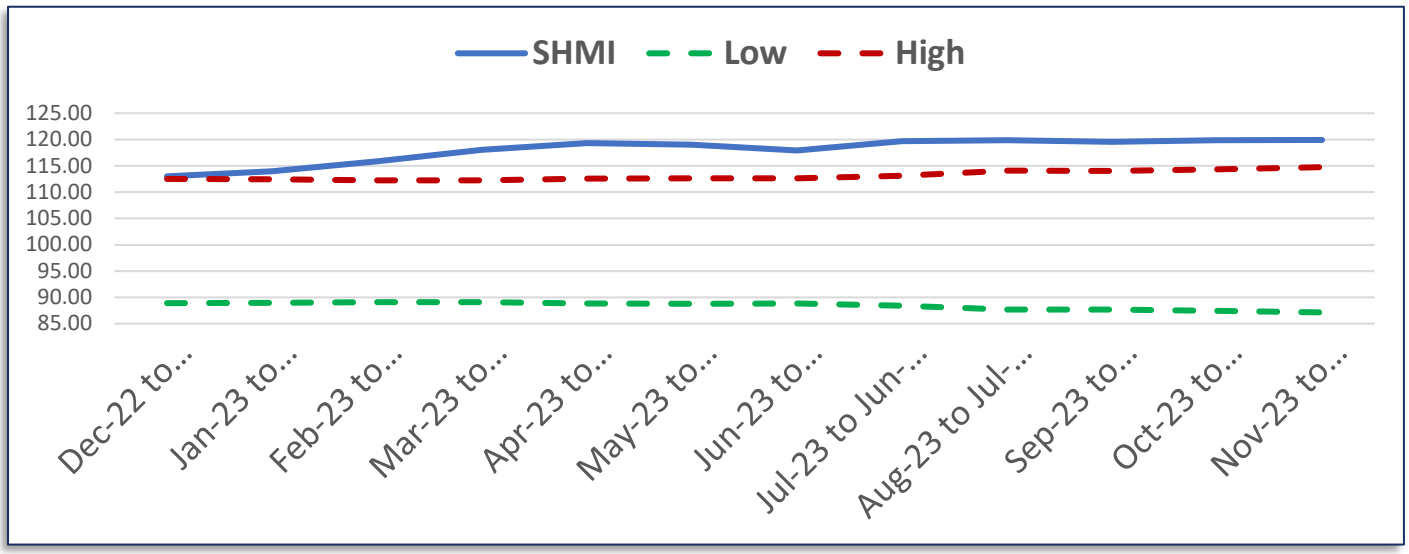
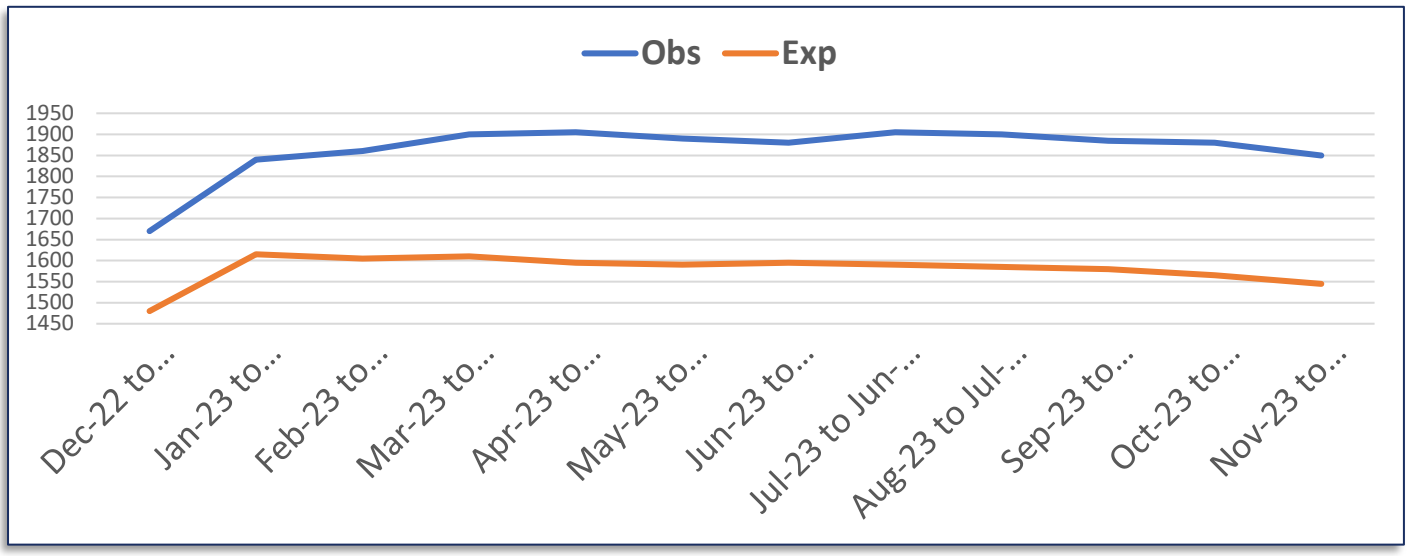


Figure 7: SHMI crude rate (blue) vs expected rate (orange)



One potential reason for the decreased expected rate may be due to the Same Day Emergency Care (SDEC) data migration from admitted to emergency data sets. Whilst this has minimal to no impact on the observed deaths, it may result in a minor drop in expected deaths. Other potential impacts explored over Quarter 4 were long lengths of stays noted for palliative patients. Medway shows a growing trend of longer length of stays among palliative patients, now longer than national peers. This trend correlates with higher-than-expected SHMI values. This

Next steps

Along with the current ongoing A3 mortality workstream, which aims to address potential influences on the causes for the rise in SHMI, the Trust continues to address causes for outlying diagnosis groups.

These examples, along with regular presentations from the clinical coding department and the learning from deaths teams, are delivered regularly to specialities to evidence the importance of clinical documentation and the impact this has on coding, finance and mortality statistics for the Trust.

NHS
Medway
NHS Foundation Trust

Maternity (and Perinatal) Incentive Scheme – Year 7 Update Report June 2025

Patient FIRST

Executive Summary

- CNST Year 7 Published 2 April 2025 with reporting period ending 30 November and submission due 3 March 2026.
- Received confirmation from NHSR of compliance with CNST Year 6.
- Request escalation to Trust Board for MNVP service provision:

as a CNST

"At this time the ICB are unable to provide adequate MNVP Lead time to enable MNVP attendance quorate member at the required Trust assurance and Governance meetings as set out in year 7 guidance. All risks with not providing this much necessary resource to the MNVP have been clearly communicated throughout the LMNS and ICB and we continue to champion the need for this role."

- Review of standards for CNST Year 7 ongoing with action leads, but anticipate no significant challenges to achieving compliance in year 7.
- Trust Board and LMNS reporting requirements remain consistent with year 6, and currently working with LMNS colleagues to schedule external reporting in line with local reporting and governance requirements.

CNST Year 7 Self-Assessment

True North	Safety Action	Description	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Quality	Safety Action 1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?							
Systems + Partnership	Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?							
Patients	Safety Action 3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?							
People	Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?							
People	Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?							
Quality	Safety Action 6	Can you demonstrate that you are on track to compliance with all the elements of saving Babies' Lives Care Bundle Version Three?							
Patients	Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users							
People	Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?							
Quality	Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?							
Quality	Safety Action 10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?							

True North: Quality

Safety Action 1: PMRT
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

- Currently meeting the majority of reporting requirements for CNST year 7 with appropriate processes in place to maintain compliance.
    - All eligible perinatal deaths reported within 1 day.
    - Parents were informed of review and their perspectives sought and their questions and concerns were incorporated into the PMRT review process in 100% of eligible cases.
    - 91% of reviews were commenced within 2 months of death. (Target 95%)
    - 100% of reports were published within 6 months of death.
    - 100% of PMRT reviews had an external member present (target 50%)
- All perinatal losses and actions are shared monthly with Maternity and Board level Safety Champions via MNSCAG.
- Quarterly reports to be discussed with Maternity Safety and Board level Safety champions in January 2025, June 2025, August 2025, October 2025, February 2026.
- Quarterly reports have been submitted to Trust Board in March, July, September and November 2025 and March 2026 with details of all losses and action plans included.

Issues, Concerns, Gaps:

- Non-compliance with 2c- all reviews commenced within 2 months. 2 eligible cases missed deadline, however one case due to non-return of factual questions from booking/antenatal care providing Trust.
- Current MNVP funding does not support MNVP attendance at PMRT meetings.

Actions and Improvements:

- All Maternity Bereavement staff now trained on how to input and commence reviews on PMRT.
- All key dates for PMRT deadlines now alert to all members of bereavement team for failsafe in case of annual leave or sickness.
- Escalating to MBRRACE to exclude one case from figures as we were unable to commence review without return of factual questions.
- Ward level Safety Champion (Matron) to join PMRT meetings for fresh eyes review.
- MFT support MNVP attendance at PMRT meetings when funding allocation allows for MNVP time to attend.

True North: Patients

Safety Action 3: Transitional Care and ATAIN
Ambition: Review the provision of transitional care pathway and ATAIN data to ensure admissions to NNU are unavoidable
Goal: To reduce unnecessary separation of mothers and babies

NHS Medway NHS Foundation Trust

Key Messages:

- Transitional Care (TC) service established since 2017.
- Neonatal team involved in decision making and care planning for all babies in TC.
- All term admissions to Neonatal Unit reviewed by an MDT including Neonatal Consultant ATAIN Lead, NICU Governance Lead, Fetal Wellbeing leads and Obstetric Lead.
- Quarterly audits ongoing.
- All findings reported via MNSCAG and shared with the LMNS via Neonatal Subgroup.
- Action plan in place for findings from ATAIN reviews
- Respiratory Distress is most common reason for admission at MFT, a significant contributory factor for these these admissions were from no-labour CS. Therefore QI project focusing on reducing term admissions with revision of respiratory pathway and prenatal counselling for families continues from CNST Year 6.
- Update on project to shared with LMNS in July 2025 and quarterly with Safety Champions. (April and May 2025)
- Progress with the project shared with Safety Champions and LMNS in November 2025.

Issues, Concerns, Gaps:

- No issues identified with compliance.
- Awaiting full audit of revised respiratory pathway from NICU to fully assess impact of QI project.

Actions, & Improvements:

- Preliminary data from QI data suggests that numbers of admissions has not been reduced, but that length-of-stay has been reduced and therefore reunited with their mothers sooner.
- Revised pre-term optimisation guideline due to launch in June/July 2025.
- Co-produced patient information leaflet to support counselling for use of antenatal corticosteroids to be launched June/July 2025.

True North: People

Safety Action 4: Clinical Workforce
Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard

NHS Medway NHS Foundation Trust

Key Messages:

- Data gathering and audit underway for compliance with RCOG guidance for short and long-term locum. Plan to audit February to July 2025. Anticipate continued compliance.
- Audit of Consultant attendance against the RCOG must/should attendance guidance planned for the summer, to be shared at:
  - Women's Audit
  - Labour Ward Fourm
- The position against RCOG Must/Should attend guidance has also been shared with:
  - Trust Board via CNST reports – September 2025
  - LMNS CNST Peer Assurance Group – October 2025
- NICU nursing vacancy reduced to 1.56 WTE Band 6.
- NICU QIS 67.7% anticipated compliance by September 2025.
- Ongoing compliance with anaesthetist on-call with dedicated obstetric on-call rota.
- Ongoing compliance with BAPM requirements for neonatal medical staffing, will formally present to Trust Board in September/November for Minuting.

Issues, Concerns & Gaps:

- NICU nursing staffing not meeting BAPM QIS standards.

Actions & Improvements

- 6 NICU nurses due to qualify in speciality in September 2025 which will bring QIS compliance >70%
- QIS staffing added to Issues log as per CNST Year 7 requirement.

True North: People

Safety Action 5: Midwifery Workforce
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Medway NHS Foundation Trust

Key Messages:

- Midwifery staffing oversight reports have been shared with the Trust Board Bi-Annual on an ongoing basis, with reports being shared in January 2025 and July 2025, with a further report planned for January 2026.
- Maternity has provided updates to the Trust Board on points required by CNST including:
  - Staffing and establishment in line with Birth-rate Plus review in 2023 and table-top exercise in 2024.
  - Ongoing oversight of staffing levels and mitigations/action plans to improve recruitment and retention.
  - 100% compliance with Supernumerary Status of Labour Ward Coordinator at start of every shift, and throughout the shift.
  - 100% compliance with 1:1 Care in Labour.

Issues, Concerns & Gaps:

- Formal staffing assessment required in 2026 for all Trusts in LMNS. Current financial position within ICB and Trust may present challenge to ongoing compliance.

Actions & Improvements

- Preceptor midwife in post to support newly qualified band 5 midwives.
- Trust engaged in MOPEL/SHREWD dashboard across LMNS. Operational and compliance staff working with provider to see if system can meet both operational and reporting requirements.

CNST Year 6
Elements within Safety Action 6 - Saving Babies Lives Care Bundle 3

Medway NHS Foundation Trust

True North	Elements within Safety Action 6	Description	BRAG April 2024	BRAG May 2024	BRAG June 2024	BRAG July 2024	BRAG September 2024	BRAG October 2024	BRAG November 2024	BRAG May 2025
Quality	Element 1	Reducing smoking in pregnancy								
	Element 2	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction								
	Element 3	Raising awareness of reduced fetal movement								
	Element 4	Effective fetal monitoring during labour								
	Element 5	Reducing preterm births								
	Element 6	Management of pre-existing Diabetes in Pregnancy								

Saving Babies Lives Care Bundle v. 3

Key Messages:

- LMNS validated and assessed 99% overall compliance across the 6 elements
- 3 quarterly QI meetings to be held within CNST Year 7 period to meet requirements.
- Focus on QI across all elements, with evidence of QI work to be included in submission for Q2 2024/25
- SBL 3.2 launched April 2025.

Issues, Concerns & Gaps

- Quit date targets for element 1 remain challenging across the LMNS.
- Awaiting national implementation tool to commence auditing against SBL 3.2

Actions & Improvements:

- Audit of 35-36 week scan and evaluation of 39-40 week scan on FGR pathway.
- Audit of pregnancies at risk of placental insufficiency.
- Midwifery-led parent events planned for 2025 to support evaluation of preterm clinic services and develop improvements.
- Additional education for maternity staffing from preterm leads.
- Preterm and Fetal Medicine QI and audit activity to be shared at Women's audit twice yearly.
- Regular sharing at LMNS learning and sharing forums.
- Collaborative working with neonatal colleagues to support preterm optimisation pathway and post-natal risk assessment.
- Working with LMNS to identify training gaps across region, including agency staff.

True North: Patients

NHS Medway NHS Foundation Trust

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP)

Ambition Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Goal: Mechanisms in place for gathering service user feedback, and work with service users, through the MNVP to coproduce local maternity services.

Key Messages:

- MNVP continues to engage with local community groups and charities throughout CNST Year 7, prioritising hearing from those experiencing the worst outcomes.
- MNVP is a listed member (non-voting) of MNSCAG which includes engagement with Safety Champions (front-line and Board Level), discussion of safety and incidents, workforce, PMRT, audit and compliance.
- MFT is committed to making the MNVP lead a quorate members of all meetings as outlined by CNST Year 7 requirements once the additional hours/post is in place to support this activity.
- Action plan from the 2024 Picker CQC Maternity survey, including free-text, was co-produced with the MNVP lead in November 2024 and progress against the plan was shared via MNSCAG and Maternity and Board Level Safety Champions as well as with the LMNS

Issues, Concerns, Gaps:

- MNVP Governance lead post has been recruited to but process paused due to financial restrictions. Awaiting approval.

Actions & Improvements:

- Co-production and engagement work continues and is embedded in practice across Maternity & Neonatal Services .
- 15 Steps Challenge to be held in February 2024 and actions being completed.
- Continue to work through CQC 2024 action plan.
- MNVP work plan for 2025/26 to drive work across the service.

True North: People

NHS Medway NHS Foundation Trust

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2024 – 30th November 2025)

Key Messages:

- Working to achieve >90% compliance for all staff groups including new starters for all required training
    - PROMPT
    - CTG
    - NBLS
- All neonatal medical staff are trained to the minimum required NLS training The British Association of Perinatal Medicine Neonatal Airway Safety Standard.
- As a level 3 until, this is covered in doctors induction, therefore currently 100% compliant with this requirement.

Issues, Concerns, Gaps:

- Anaesthetic staff need to be mapped.
- Resident obstetric doctors currently below trajectory for fetal monitoring training due to rotation in October 2025.

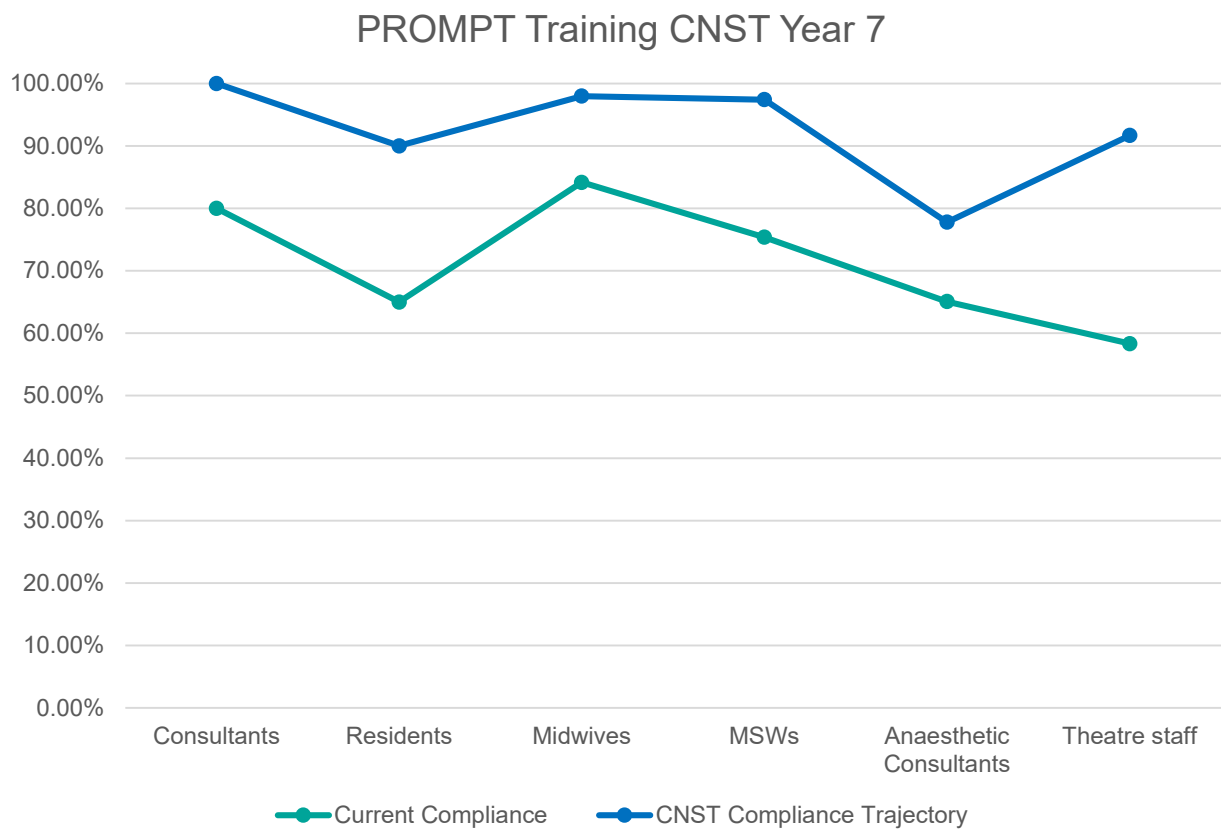
Actions & Improvements:

- Managerial oversight of all training spreadsheets and trajectories to reduce risk of cancellations impacting compliance close to submission.
- Continue to work with service managers to ensure all staff are allocated to training and appropriate study leave/cover is arranged for medical staff.
- Neonatal team to have ensured advanced NLS course training dates are accessible centrally.
- PROMPT to be added to ESR to support compliance/oversight.
- Work with anaesthetic lead and service manager to ensure all eligible anaesthetic staff are booked in ahead of deadline.
- All rotating resident doctors to be booked onto Fetal monitoring training in October and November 2025.

True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2024 – 30th November 2025)

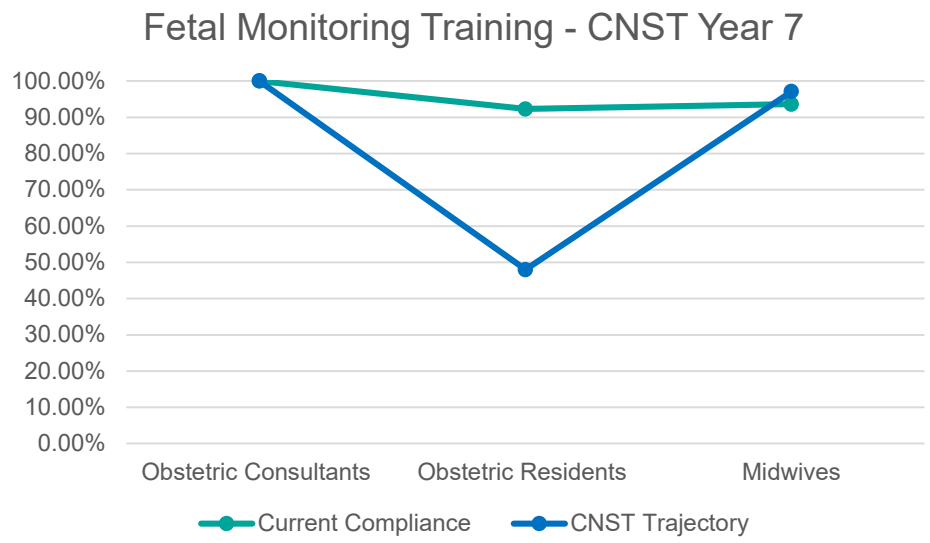
PROMPT Training		
Staff Group	Current Compliance (May 2025)	CNST Compliance Trajectory
Consultants	80.00%	100.00%
Residents	65.00%	90.00%
Midwives	84.17%	97.97%
MSWs	75.38%	97.40%
Anaesthetic Consultants	65.08%	77.78%
Theatre staff	58.33%	91.67%



True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2023 – 30th November 2024)

Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	100.00%	92.31%	93.60%
CNST Trajectory	100.00%	48.00%	97.12%

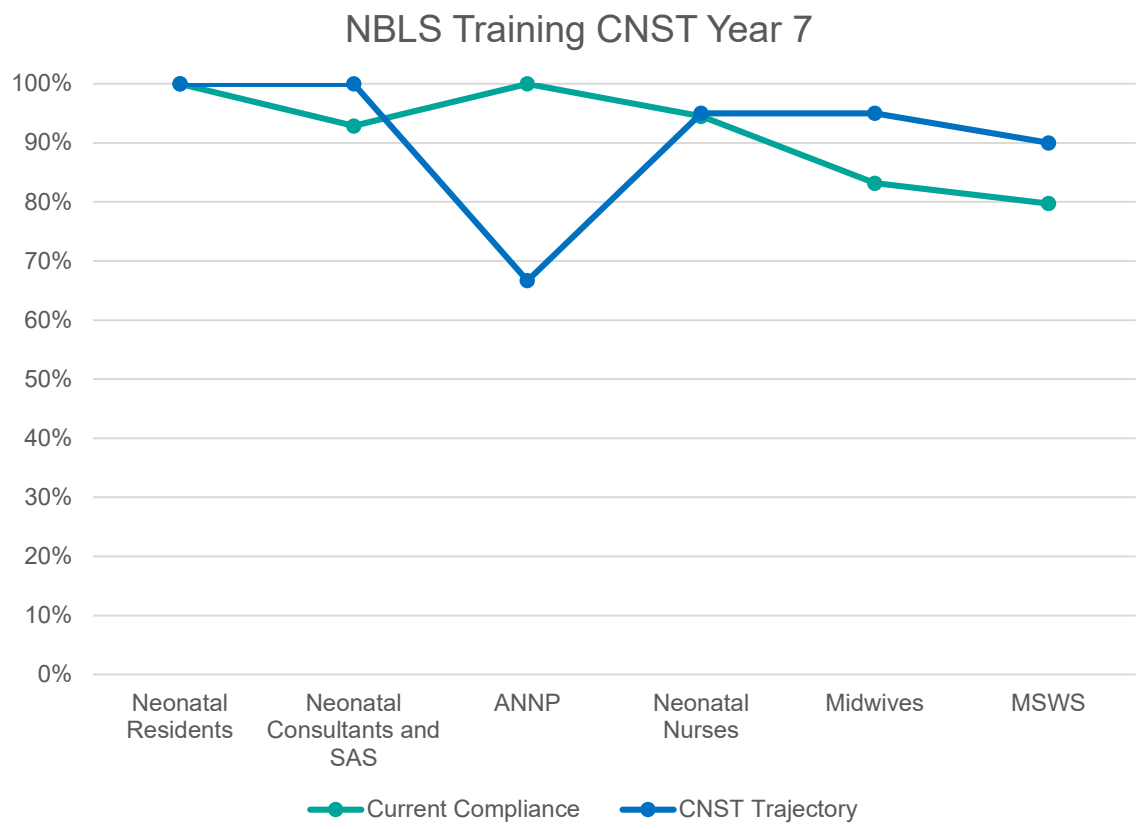


True North: People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2024 – 30th November 2025)

Neonatal Basic Life Support Training		
Staff Group	Current Compliance – May 2025	CNST Trajectory
Neonatal Residents	100%	100%
Neonatal Consultants and SAS	92.86%	100%
ANNP	100%	67%
Neonatal Nurses	95%	95%
Midwives	83%	95%
MSWS	80%	90%

Neonatal Life Support Training – Unsupervised first responders		
Staff Group	Current Compliance – May 2025	CNST Trajectory
Neonatal Residents	100%	100%
Neonatal Consultants and SAS	100%	100%
ANNP	67%	67%
Total compliance	97.5%	97.5%



True North: Quality

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.

Goal: Ensure there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.

Key Messages:

- The Trust has embedded the perinatal quality surveillance model (PQSM) with monthly reporting via MNSCAG and to every Trust Board.
- Detailed quarterly PQSM report to Trust Board to identify themes, trends and actions.
- Concerns raised by staff, service users and safety intelligence are reflected through MNSCAG and up to Trust Board
- The Board Safety Champions support the perinatal leadership team and meet with them monthly via MNSCAG.
- A Non-executive director (NED) is working with the Board safety champion and complete monthly staff engagement sessions (face to face and virtual)
- The Trust Claims scorecard is triangulated against incidents and complaints and this is reported via MNSCAG and onwards to Trust Board on a quarterly basis.
- Ongoing engagement with Perinatal Leadership Programme and quarterly reporting in place to MNSCAG and onwards to Trust Board.
- All required elements of SA9 to be minuted by Trust Board in September 2025 meeting.

Issues, Gaps & Concerns:

- Local SCORE survey not completed.
- Awaiting national update to PQSM

Actions & Improvements :

- IQPR slides contain all PQSM information for Trust Board under appropriate headings and are supported by quarterly reports.
- Engage with Trust workstreams for culture work and action plans based on staff surveys to avoid “survey fatigue”.
- To continue to engage with the LMNS for regional shared learning via Quality Performance meeting and ensure reflective learning within MFT from other Trusts identified concerns/issues and to adopt a system wide understanding of PQSM
- Strong working relationships with Board Level Safety Champions, supportive in escalating risks and provide supportive challenge.

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting

Ambition: Ensure all eligible cases are investigated to the highest standard and receive appropriate external review.

Goal: Ensure all eligible cases are reported to Maternity and Neonatal Safety Investigation (MNSI) and NHSR's Early notification scheme.

Key Messages:

- Continue business as usual to ensure:
  - All eligible cases reported to MNSI and NHSR EN as required from 8 December 2024 to 30 November 2025.
  - 100% of families received information regarding the role of MNSI and NHSR EN.
  - 100% of cases had appropriate DOC.
  - Trust Board have oversight of all MNSI cases via the monthly IQPR slides and quarterly PQSM report along with outcomes, learning and actions.
  - 100% of cases had the appropriate field on claims wizard completed.
  - All relevant information required to be presented to Trust Board is included in the next slide and this will be presented to Trust Board in January 2026.

Issues, Gaps & Concerns:

- Additional requirement to ensure all families have access to the information regarding NHSREN and MNSI in accessible formats.

Actions & Improvements :

- Work with risk midwives to update database to ensure accessible information requirements and offer are recorded.
- Review existing NHSR and MNSI resources and identify any gaps in provision of accessible information based on local population.
- Work with LMNS to share and develop additional resources.
- Link with PE&EDI midwife and Trust Accessible Information Group to address any challenges.
- Develop action plan if gaps or issues identified to achieve compliance.

Actions and Next Steps

NHS Medway NHS Foundation Trust

- Onwards reporting to Trust Board in July 2025.
- Continue with monthly monitoring and reporting to MNSCAG and updates on IQPR slides.
- Continue to monitor training monthly and escalate any dips in compliance appropriately.
- Complete all required audits ahead of reporting schedule.
- Work with anaesthetic team to ensure all eligible anaesthetic staff are booked onto appropriate course.
- Senior team to work with all Safety Action Leads to ensure ongoing compliance and early escalation of any concerns.
- Continue to engage with LMNS peer assurance group to ensure all LMNS reporting is undertaken within the required timescale.
- Continue update report to each Trust Board to ensure all key elements are presented to Trust Board in line with the reporting schedule.

NHS
Medway
NHS Foundation Trust

Claims, Incidents and Complaints Triangulation Report

Kate Harris, Associate Director of Midwifery
Ellen Salmon, Maternity CNST and Compliance Manager

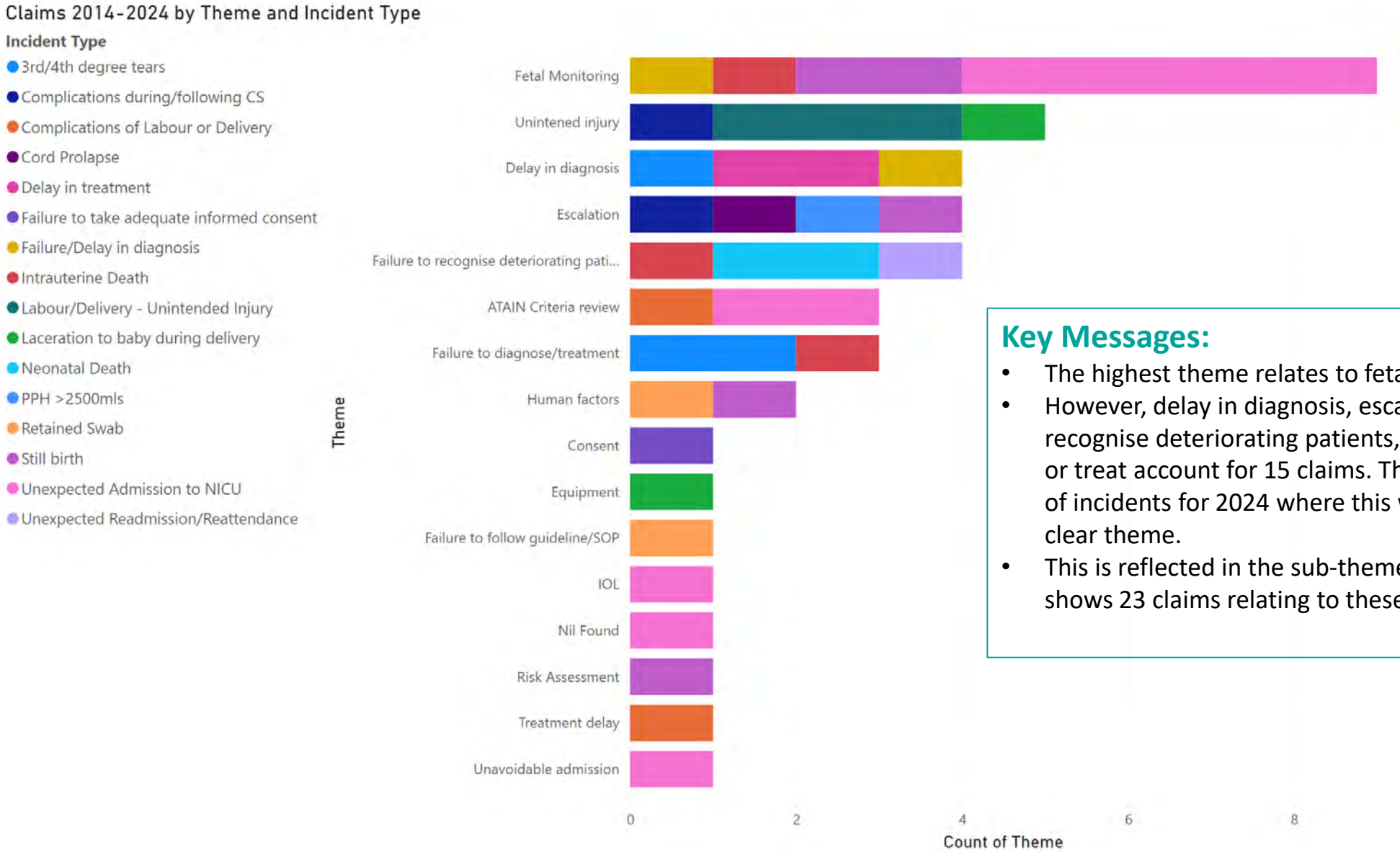
Patient FIRST

Executive Summary

- 2014-2024 Claims Scorecard published in October 2025.
  - 52 Maternity Claims
    - 36 Closed
    - 12 Open
    - 4 Incident
- 8 additional claims added to the Scorecard from July 2023-June 2024

- Report will review claims, alongside incidents reviewed at CRIG and complaints.
- Report also will review actions from a previous MNSI case which has now progressed to a claim.

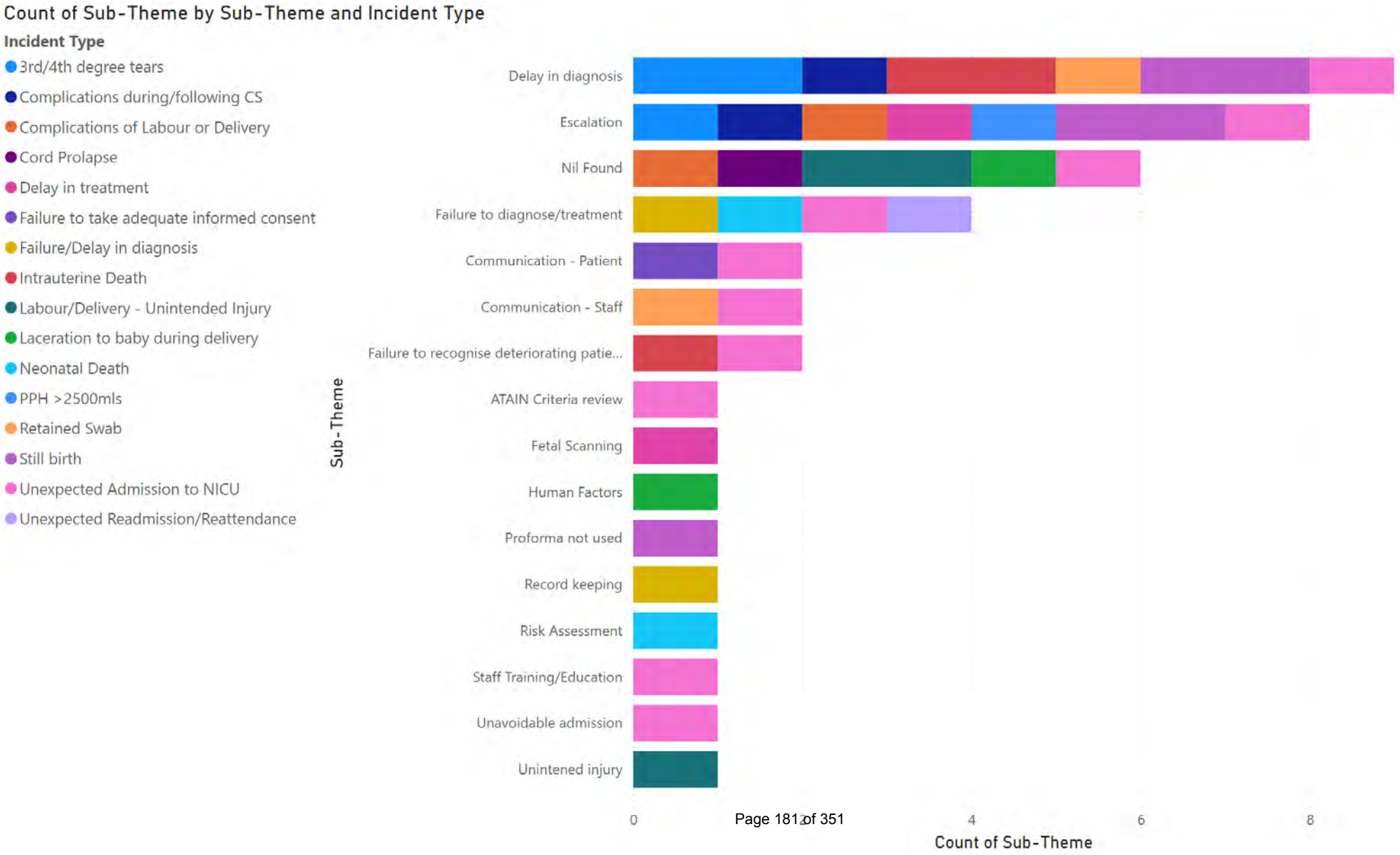
Claims -2014-2024 – Themes



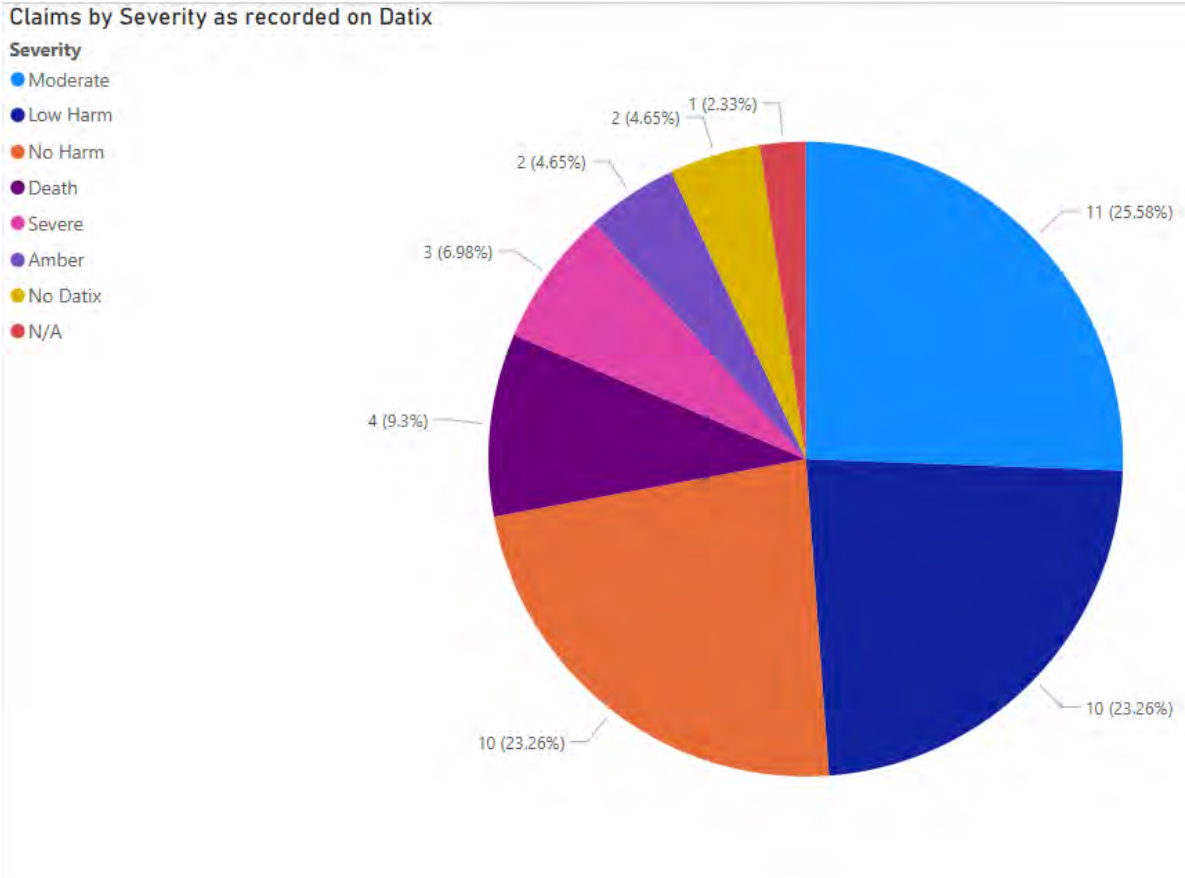
Key Messages:

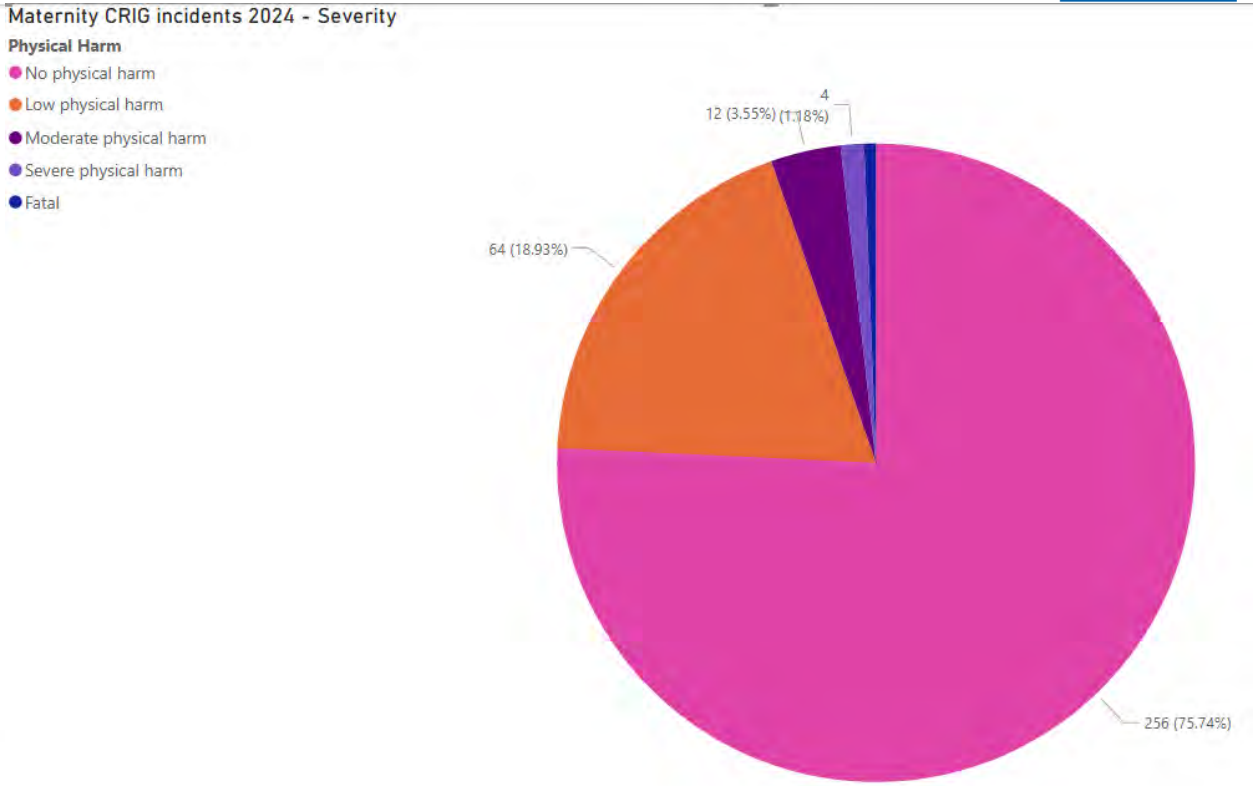
- The highest theme relates to fetal monitoring (9) claims.
- However, delay in diagnosis, escalation, failure to recognise deteriorating patients, failure/delay to diagnose or treat account for 15 claims. This is aligned to the review of incidents for 2024 where this was also collectively a clear theme.
- This is reflected in the sub-themes on the next slide which shows 23 claims relating to these areas.

Claims -2014-2024 – Themes



Claims -2014-2024/CRIG Incidents 2024 – Severity

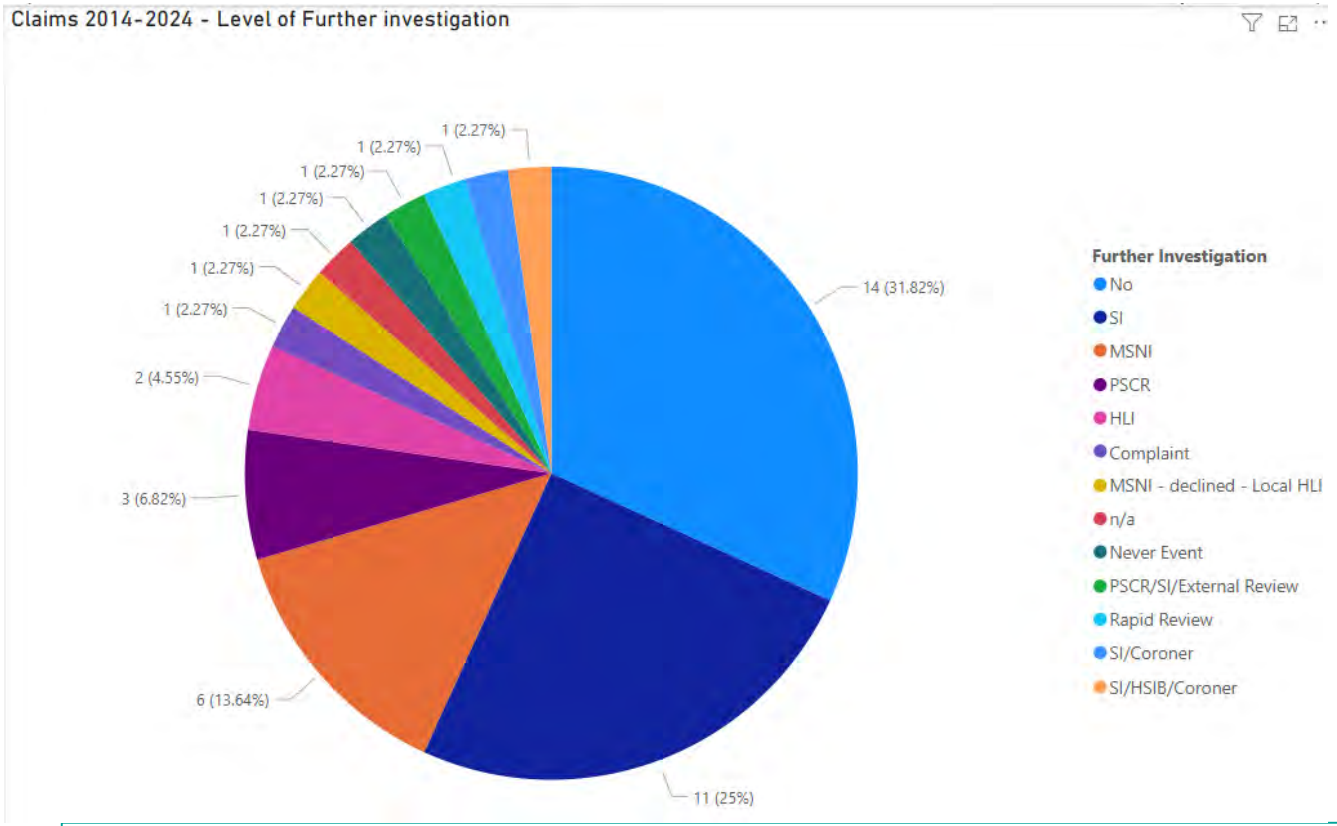


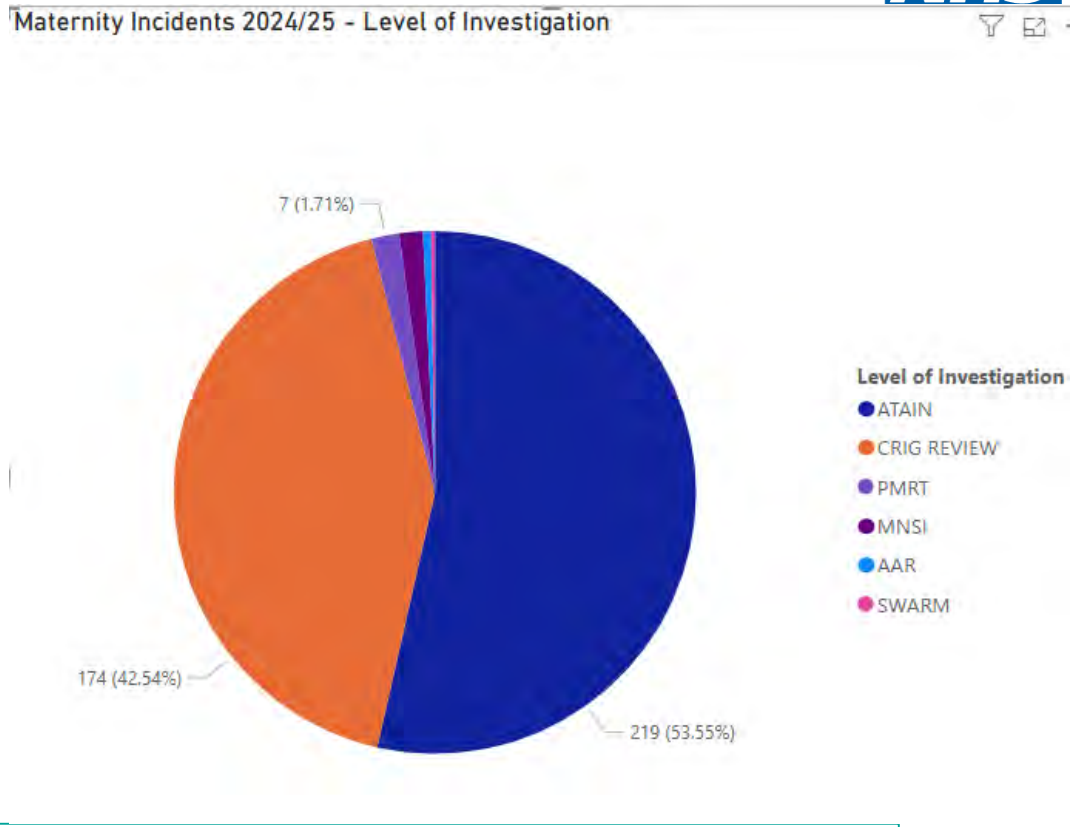


Key Messages:

- 41.4% of claims were datixed at moderate harm or above.
- 5.32% (18) of incidents reviewed at CRIG in 2024 were agreed as having moderate harm or above.

Claims -2014-2024/CRIG 2024 –Level of Investigation

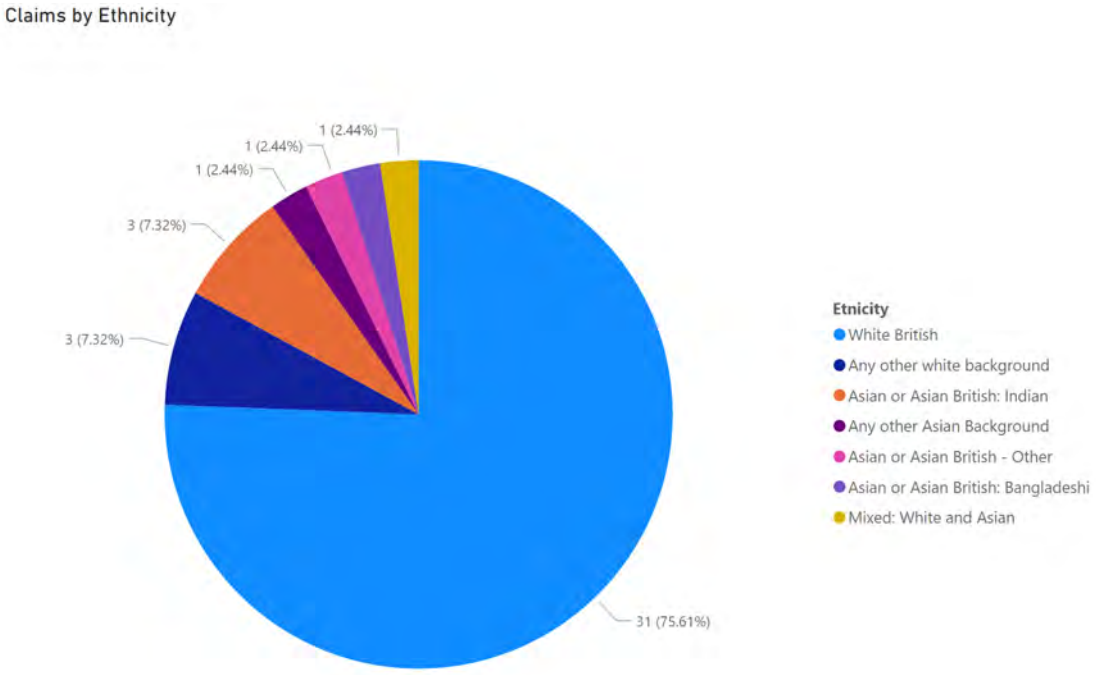


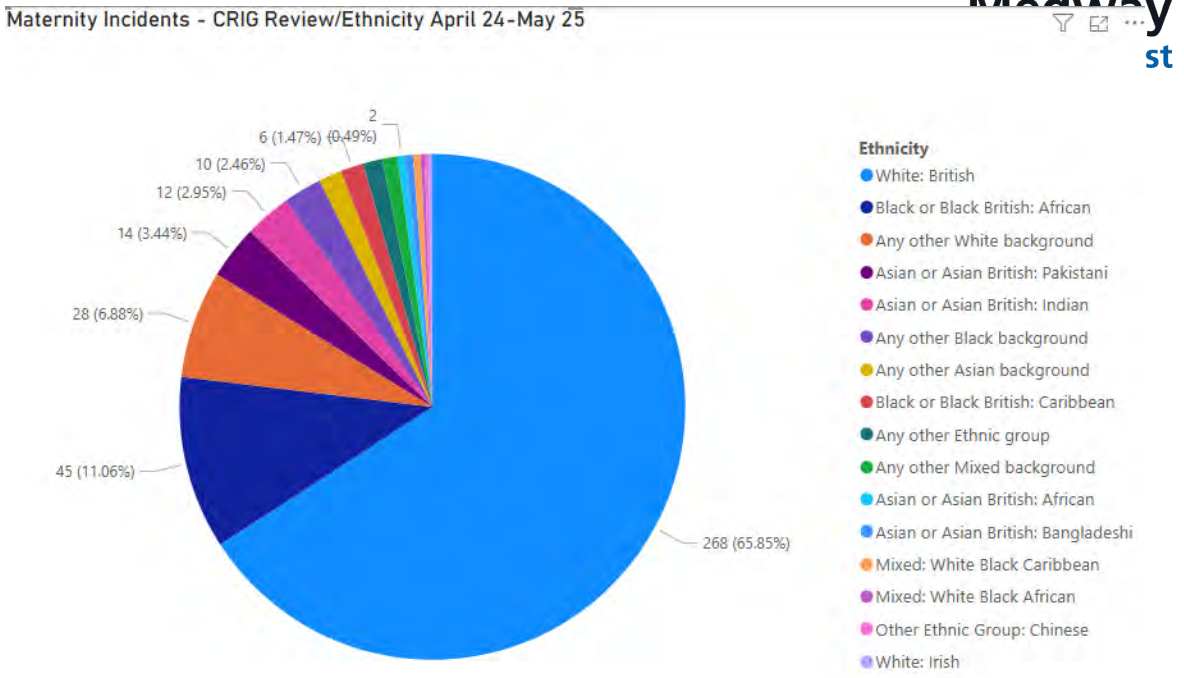


Key Messages:

- 63% of claims had a higher level of investigation.
  - >25% having an SI investigation
  - 18% were referred to MNSI/HSIB
- Only 2.2% of Maternity incidents reviewed at CRIG in 2024/25 received a higher level of investigation:
  - 1.34% MNSI (6)
  - 0.49% AAR (2)
  - 0.24% SWARM (1)
- 53.53% (219) had an MDT ATAIN review.

Claims -2014-2024/CRIG Incidents 2024 – Ethnicity





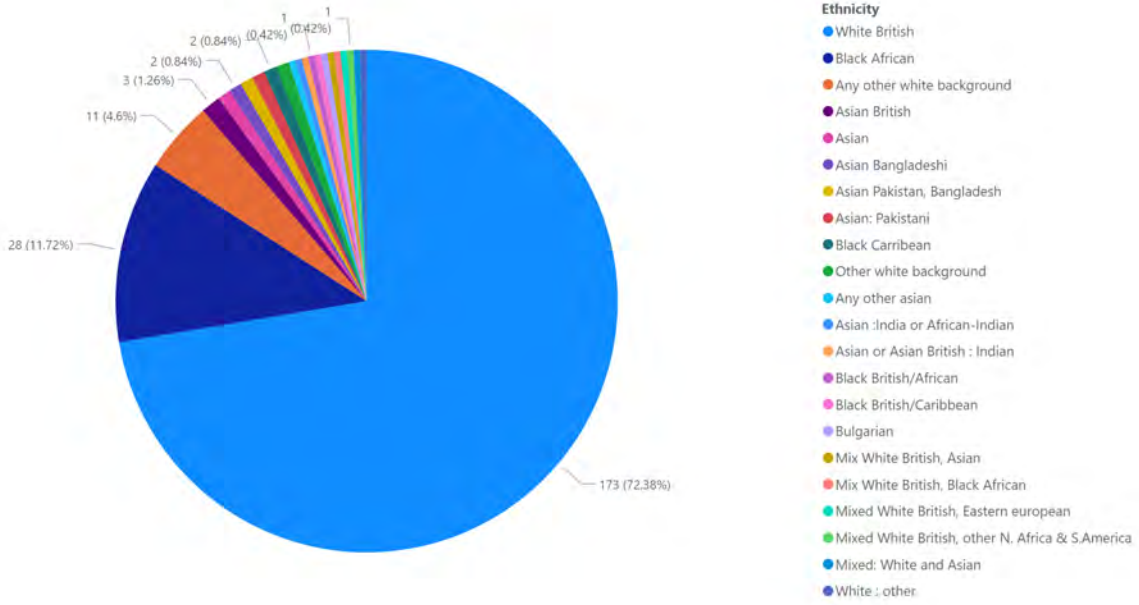
Key Messages:

- 75% of claims are from White British Families reduced from 77.5% for the 2013-2024 Scorecard. (65% of incidents reviewed at CRIG in 2024/25)
- 14.64 % of claims are from families of Asian background (reduced from 17.5%). This remains disproportionately high against the 6% of total births at MFT from Asian women. (7.86%% of incidents reviewed at CRIG in 2024/25)
- 7.32% or 3 claims are from any other white background (6.8% of incidents reviewed at CRIG in 2024/25)
- 0 claims from Black families despite accounting for over 7% of the total births at MFT and 15.48% of incidents reviewed at CRIG in 2024/25

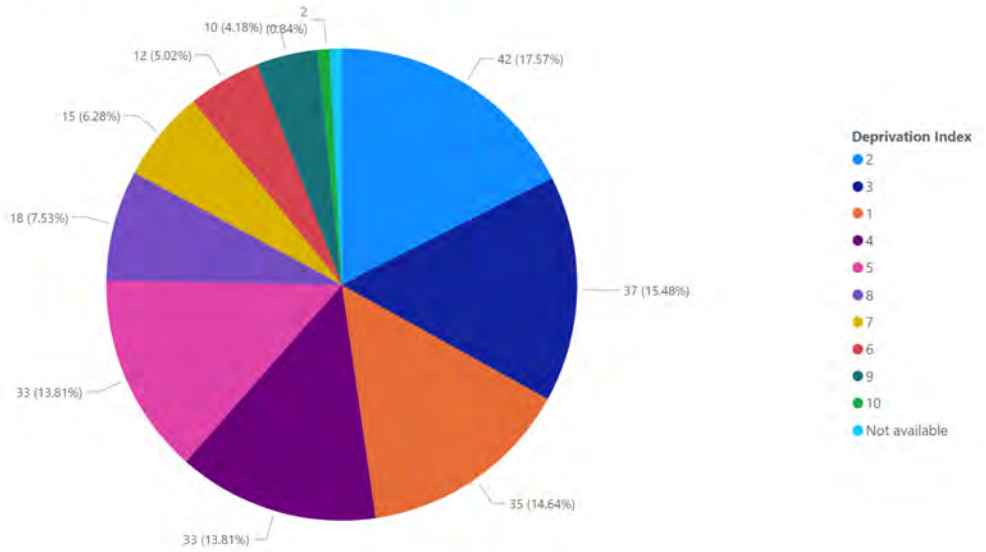
ATAIN Cases 24/25 – Ethnicity

Medway NHS Foundation Trust

ATAIN Admissions - 24/25 by Ethnicity



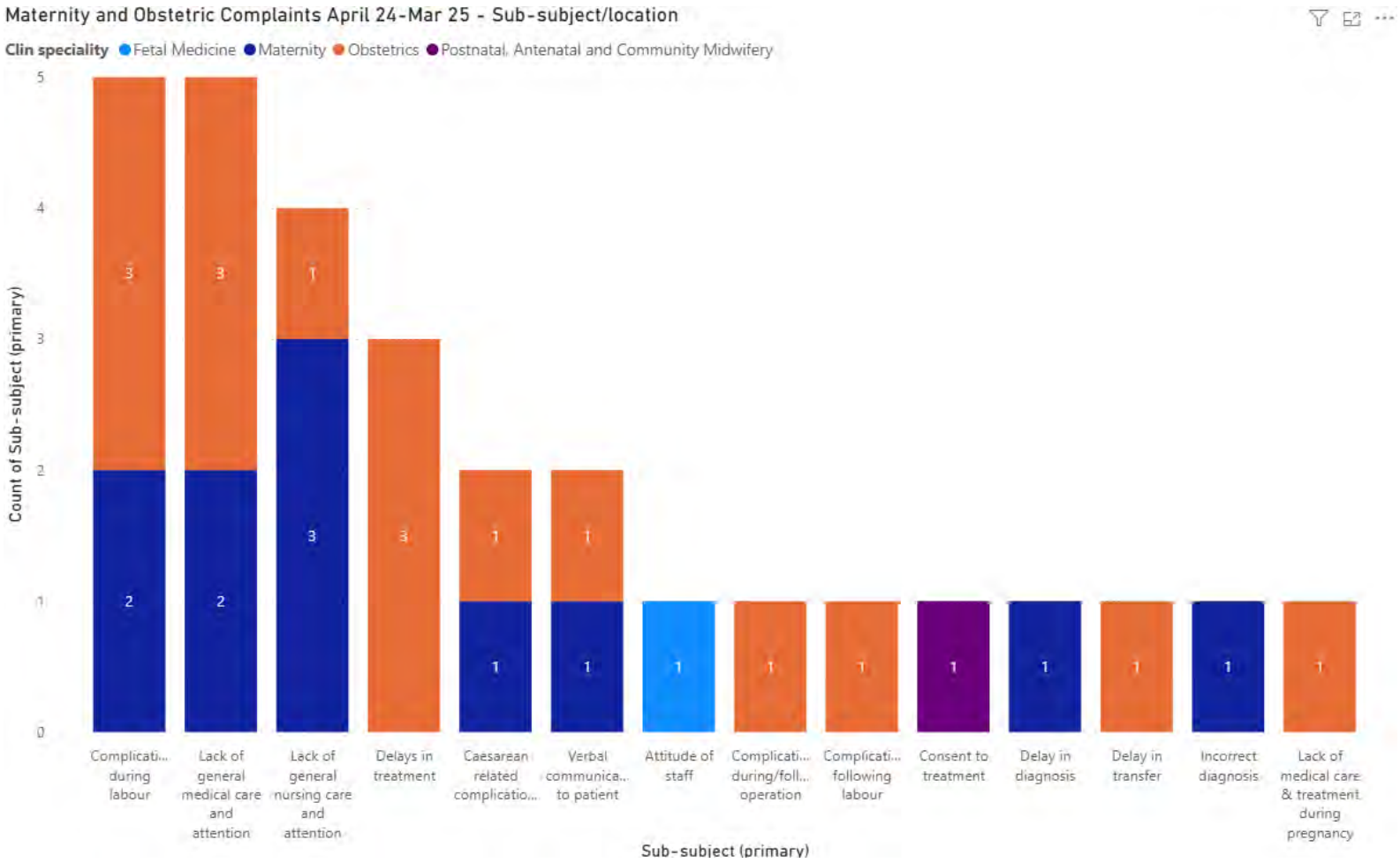
ATAIN Admissions 24/25 - Deprivation Index



Key Messages:

- ATAIN data for 24/25 doesn't show any marked disproportionate representation between ethnic groups admitted to neonatal unit and overall birthing population.
- Deprivation scores show that approximately 75% of admissions are in the 5 most deprived areas, but further work on understanding the birthing population needs to be undertaken to draw any conclusions from this data.

Complaints 2024/25



Key Messages:

- The majority of claims received in 2024/25 relate to complications during labour (5), Lack of Medical/nursing care and attention (9), delays in treatment/diagnosis/incorrect diagnosis (6).
- It is unlikely the “lack of medical/nursing care and attention” complaints will develop into claims, but those regarding delays in treatment or diagnosis have the potential to become litigious.
- Care planning and communication continues to be a recurrent theme in complaints. Work is ongoing across the department, including a focus on how we develop, agree and communicate care plans throughout pregnancy.
- Cultural Coaches being trained within the department to be champions inclusive communication.

Learning from Claims – Neonatal Death 2022

- In 2022 there was a neonatal death with key concerns being delay in the IOL process/decision to proceed to section and delay in transferring the baby to the neonatal unit to receive antibiotics. The case was investigated as an HSBI/MNSI investigation and is now also a claim.

Ref	HSIB Recommendation	Action	Outcome
1	The Trust to support staff to listen carefully, hear and take seriously mothers' concerns about their and their babies' health at all stages of their pregnancy journey. (Ockenden, 2020).	Memo to be sent to all staff to remind them to ensure an obstetric review is requested and responded to in line with clinical guidance. Audit of 30 cases to be completed for delivery suite & Pearl ward	Audit completed and need for consultant ward rounds re-emphasised with all staff.
2	The Trust to support staff to listen carefully, hear and take seriously mothers' concerns about their and their babies' health at all stages of their pregnancy journey. (Ockenden, 2020).	The trust to re-energise the listen to me campaign and audit patient experience of staff response to prevent concerns. PMA's to incorporate feedback as part of the debrief service. Feedback to all staff in the mandatory training.	Relaunch listen-to-me campaign, incorporate service user feedback into all training.
3	The Trust to ensure that when mothers present with altered fetal movements at term, a dynamic, holistic assessment and discussion about a plan of care, is completed by a senior obstetrician.	Review Fetal monitoring policy to ensure pathway is robust and obstetric led decision making underpins care planning.	Risk Assessment tool launched in 2023.
4	The Trust to ensure that staff are supported to apply national and local guidance in relation to the discussion to options available to mothers who experience pre-labour rupture of membranes.	Review of pre-labour of rupture of membranes guideline to ensure reflective of NICE guidance. In particularly in relation to immediate augmentation. Any revision to guidance to be shared with staff by mandatory training and the maternity Friday newsletter.	Pre-PROM guideline updated.
5	The Trust to ensure that there is a robust process which supports dynamic risk assessment of mothers undergoing IOL including face to face information sharing to support decision making.	Audit to be completed of 30 cases to ensure that all women who are undergoing IOL on Pearl ward are reviewed daily by the obstetrician and that this review includes face-to-face review and shared decision making.	IOL guideline updated. Since this time, an A3 QIP project has been undertaken to improve the IOL pathway, including a dedicated midwife to manage the pathway.
6	The Trust to support the obstetric team to achieve clinical oversight of the antenatal ward so that risk assessments are reviewed and care plans for mothers are individualised.	As above	Consultant ward rounds on antenatal ward continue to be monitored and any concerns regarding non-attendance are escalated.
7	The Trust to ensure that mothers under obstetric led care receive a holistic review, dynamic risk assessment and a documented plan of care by the obstetric team.	Audit to be completed of 30 cases to ensure that all women who are undergoing IOL on Delivery Suite are reviewed daily by the obstetrician and that this review includes face-to-face review and shared decision making.	Consultant ward rounds/attendance on delivery suite monitored via daily bedstate and from EuroKing against the RCOG guidelines.
8	The Trust to support neonatal staff to recognise the need for escalation to senior clinicians to review and have oversight of babies requiring admission to the neonatal unit. This should include education and training along with robust systems in the clinical setting.	• Continue in situ NICU simulations • In situ simulations using the key elements of this case as learning (to write simulation with appropriate learning outcomes) • Safety huddle to ensure appropriate team allocation as well as awareness of who to escalate to	Training and education completed.
9	The Trust to ensure that when it has been recognised that a baby requires IV antibiotics for suspected sepsis, administration is completed within 1 hour (NICE, neonatal infection 2021c).	Audit the time antibiotics are given for all admissions across ITU/HDU/SCBU and postnatal ward. Auditing 01.09.22 – 01.12.22. To review the times & reasons for delays. • Once audited, if delays, to review systems in place and implement sustainable changes. • Flowchart for expected actions once decision to admit a baby – to ensure that all care is actioned regardless of location	Admission/antibiotics flow chart completed and embedded across the unit.

Actions and Improvements Q4 24/25

- All ATAIN reviews include ethnicity and social deprivation data as part of the review and thematic analysis.
- All CRIG reviews consider ethnicity and PE&EDI midwife joins CRIG to provide additional check and challenge, particularly for areas where BAME groups are over represented (e.g. PPH).
- Co-production on CQC Picker Survey action plan included MNVP, PE&EDI lead and other key stakeholders to ensure we are taking robust and responsive action to service user feedback.
- Patient Survey underway for all service users, with particular focus on how ethnicity and culture impacted experience of care.
- “Listening Clinics” to be developed to gather feedback and address patient concerns in real time.
- Introduce communication cards (both in top languages and visually) to support communication of routine tasks/examinations.
- Sharing service user stories and videos at training and audit days to highlight impact of poor outcomes on patient lives.
- In depth review of complaint letters, responses and actions, to share with staff the service user voice and our actions/responses.
- Development of PE&EDI Midwife Goals for 2025/26 aligns with improvement work identified from the triangulation reports, with a goal to support staff and service users deliver and access a service that is equitable and where they all have a voice
    1. Improve Engagement with Ethnic Minority Communities and those from deprived areas.
    2. Deliver cultural sensitivity training for staff.
    3. Address Health Inequalities.
    4. Promote inclusive leadership
    5. Enhance patient Experience.

Next Steps

- Continue to report Claims, Incidents and Triangulation reports to MNSCAG and Trust Board quarterly in line with CNST requirements. Next report due to Trust Board in July 2025.
- Work collaboratively with LMNS colleagues to identify themes and trends in claims/incidents/complaints across the region to support proactive quality improvement work.
- Work with BI/Digital Midwife to develop report to pull social deprivation and ethnicity for entire booking/birthing population to support ongoing benchmarking and analysis of outcomes for particular groups.
- Continue quarterly reporting to MNSCAG/Trust Board updating against current incidents/complaints and themes.
- Share methodology with NHSR Conference.

Perinatal Quality Surveillance and Leadership Quarterly Report Q4 2024-25

Kate Harris, Associate Director of Midwifery
Ellen Salmon, Maternity CNST and Compliance Manager

Executive Summary

- CNST Year 7 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9)
- Monthly updates aligned with the minimum dataset of the PQSM are submitted monthly to QPSCC and QAC along with to every Trust Board.
- This report provides quarterly oversight for 4 2024/25 and includes the following:
  - Incidents
  - Investigations
  - PMRT
  - Staff and Service User Feedback
  - Perinatal Leadership
  - Safeguarding

Incidents, investigations and PMRT

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q4 24/25
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

- Increase in number of incidents reported in Q4 – with 399 –increased from 365 in Q3.
- 99% of incidents reported are no or low harm.
- 3 incidents reported as Moderate Harm or above
    - Maternal death at 5 weeks PN following ITU admission for central saddle pulmonary embolism and hypoxic brain injury. – MNSI Investigation Underway.
    - Intrauterine death following attendance with Reduced Fetal Movements and Tightening's. – MNSI investigation underway.
    - Complications following forceps delivery with second degree tear and episiotomy – Reviewed and deemed appropriate management and referral to perineal clinic.
- 68 Incidents related to a Post-partum haemorrhage over 1000mls/
- 23 related to term babies admitted to the neonatal unit.
- 17 related to 3rd or 4th degree tears.

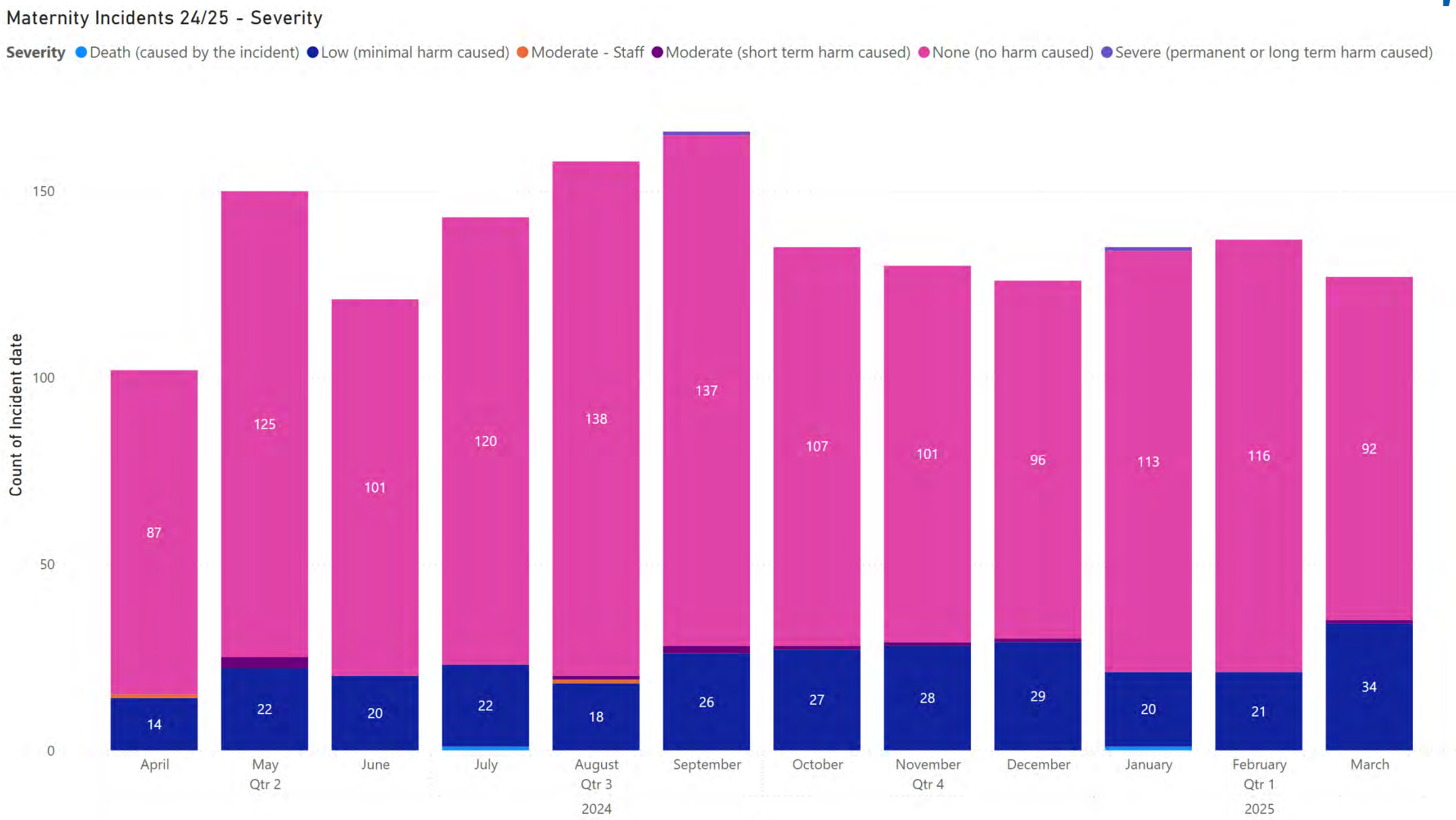
Issues, concerns, gaps:

- Increased numbers of maternal deaths noted across the region.
- Patient understanding of the importance of anticoagulant prophylaxis in pregnancy and postnatal period.
- PPH and 3rd and 4th degree tear rates.

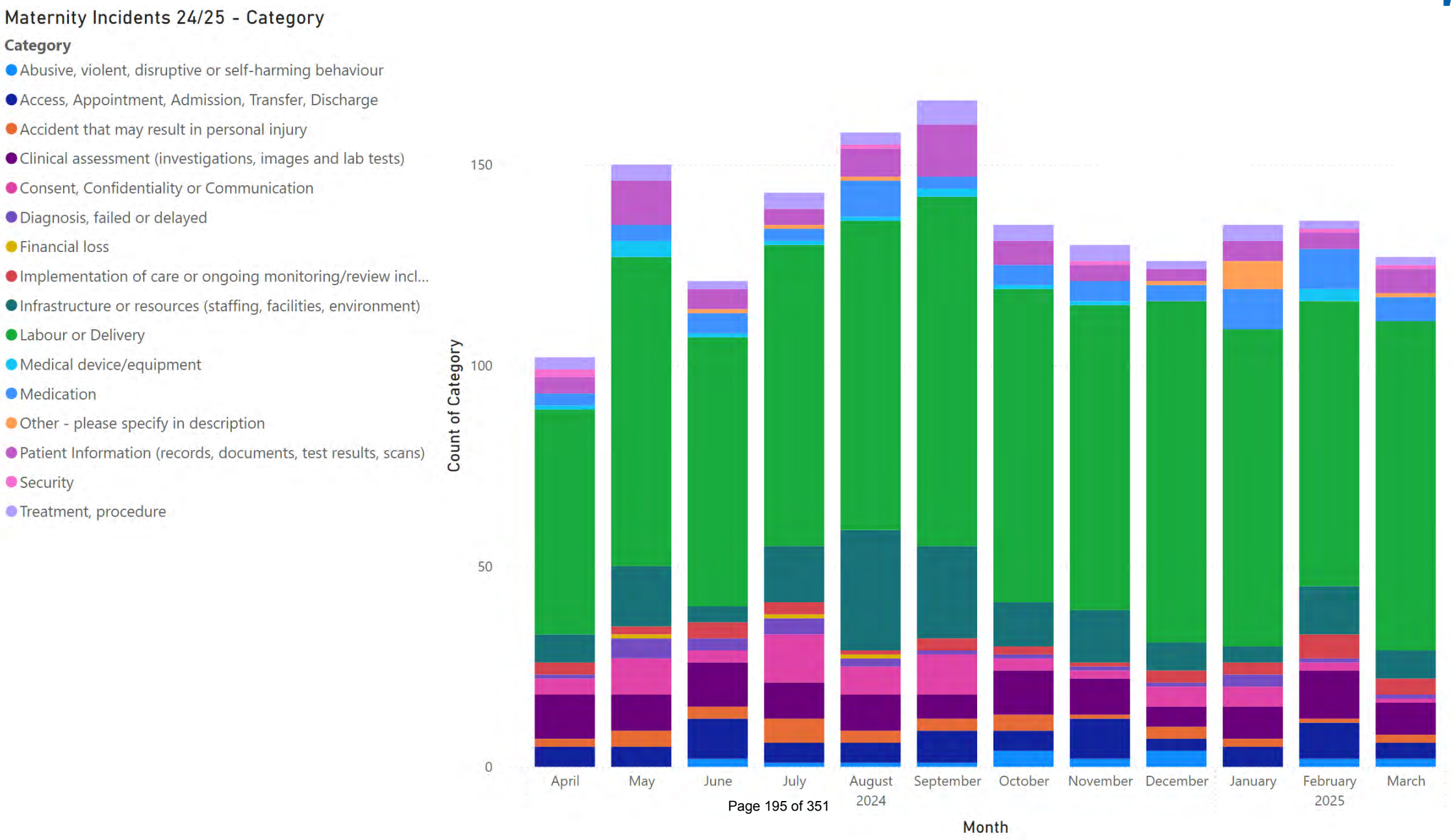
Actions & Improvements:

- LMNS-led regional review of maternal deaths. Governance leads engaged in new LMNS group to review incidents and PSIRF themes across region.
- Audit of PPH rates >1500mls demonstrated that Trust is not an outlier for PPH rates in 2024. Work ongoing to review care against local guidelines to ensure appropriate management of all PPHs in line with local guidance. Weekly review at CRIG of all eligible cases.
- OASI-2 bundle launched in Q4 across maternity unit, with training by education team, consultant midwife and obstetrician. Training to continue for all staff and new OASI-2 guideline to launch in coming months.
- Immediate review and relaunch of patient information leaflet regarding anticoagulant prophylaxis

True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q4 24/25

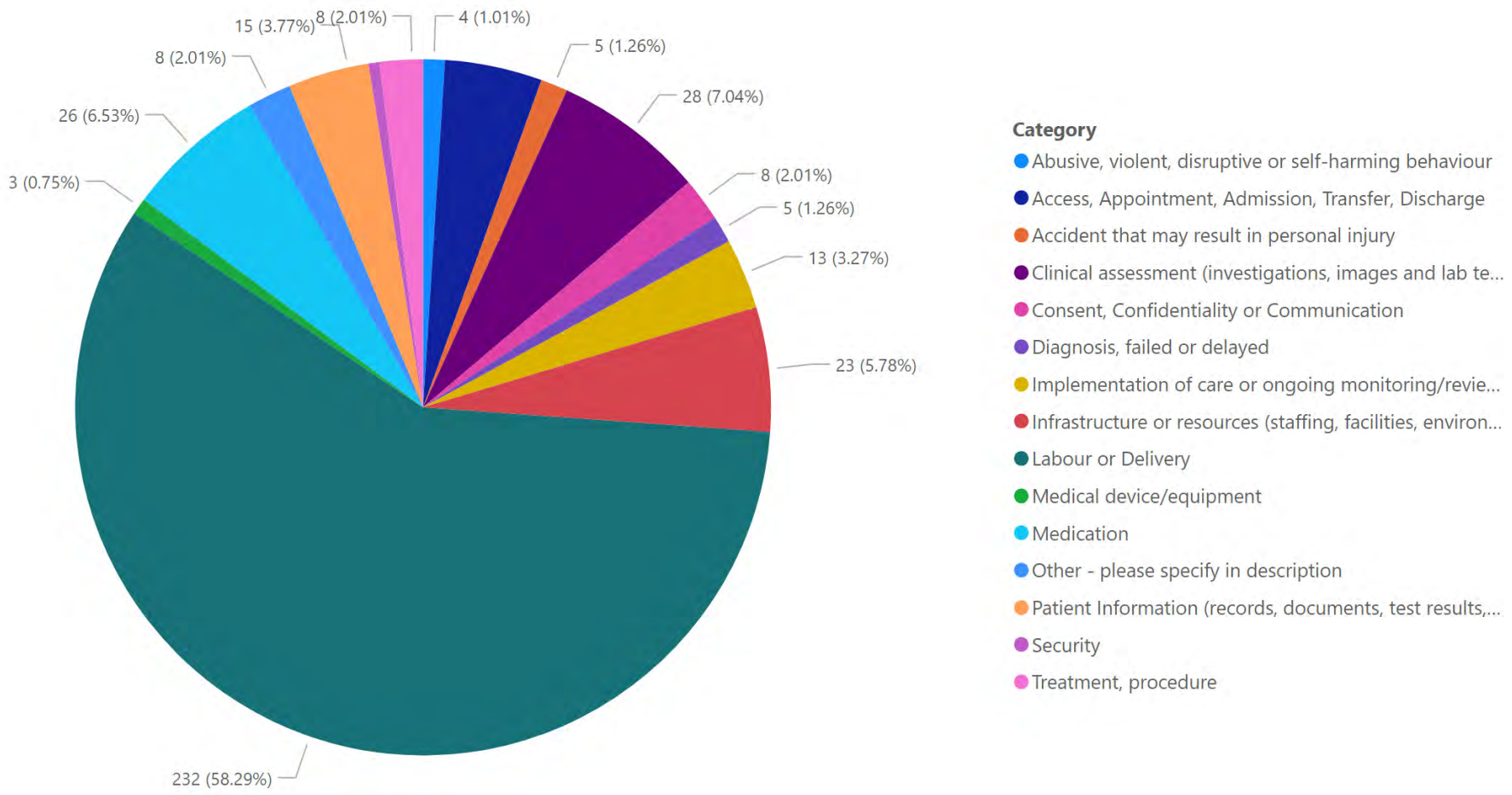


True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q4 24/25



True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q4 24/25

Maternity Incidents Q4 24/25 Category

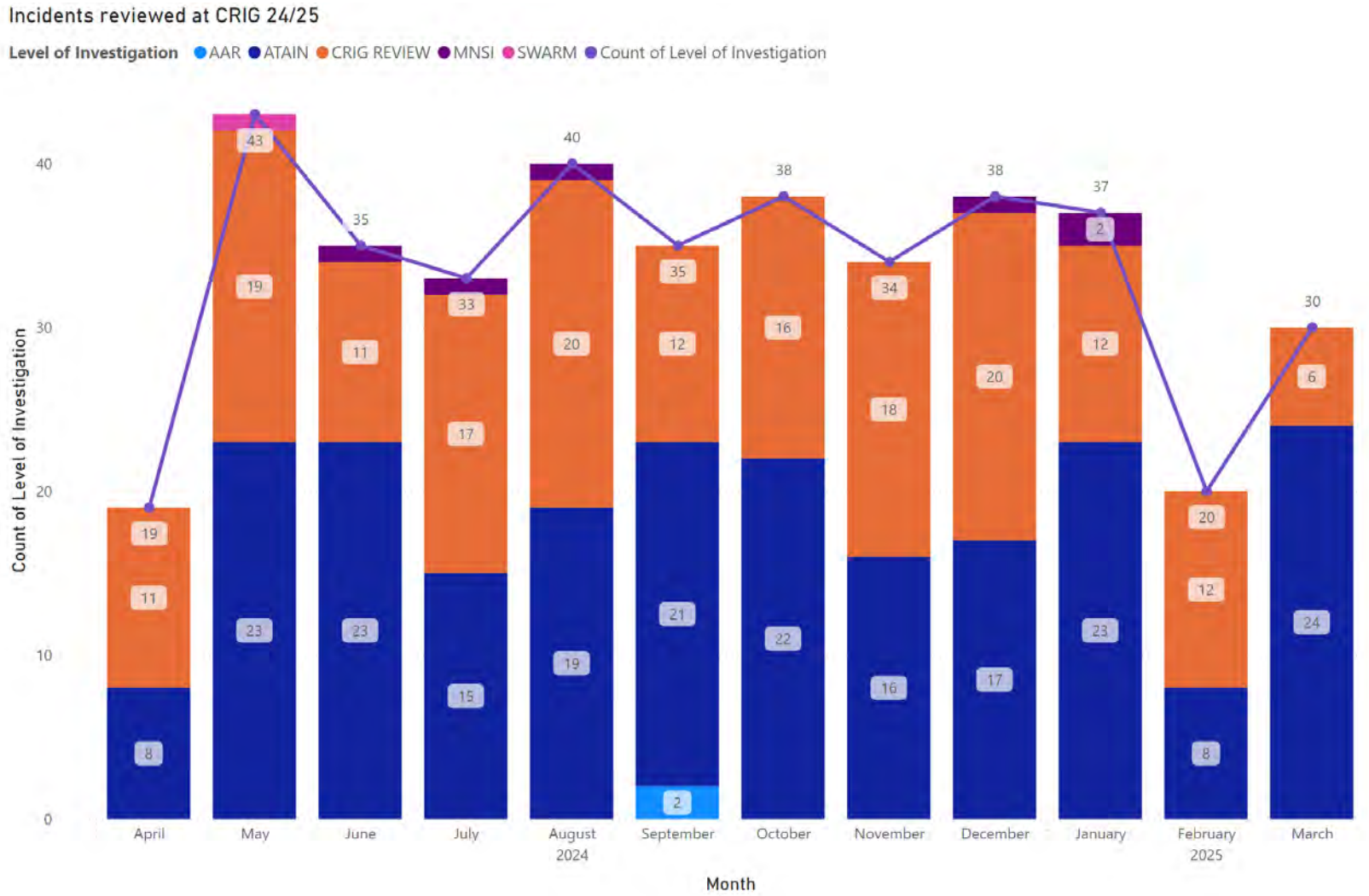


True North: Quality – Q4 PSIRF

NHS Medway NHS Foundation Trust

Key Messages :

- Database commenced March 2024.
- 0 AAR declared in Q4 2024./25
- 2 MNSI referrals
- 87/399 (3.5%) incidents in Q4 required review at CRIG.
- PMRT reviews not included in chart as reviewed outside of CRIG.



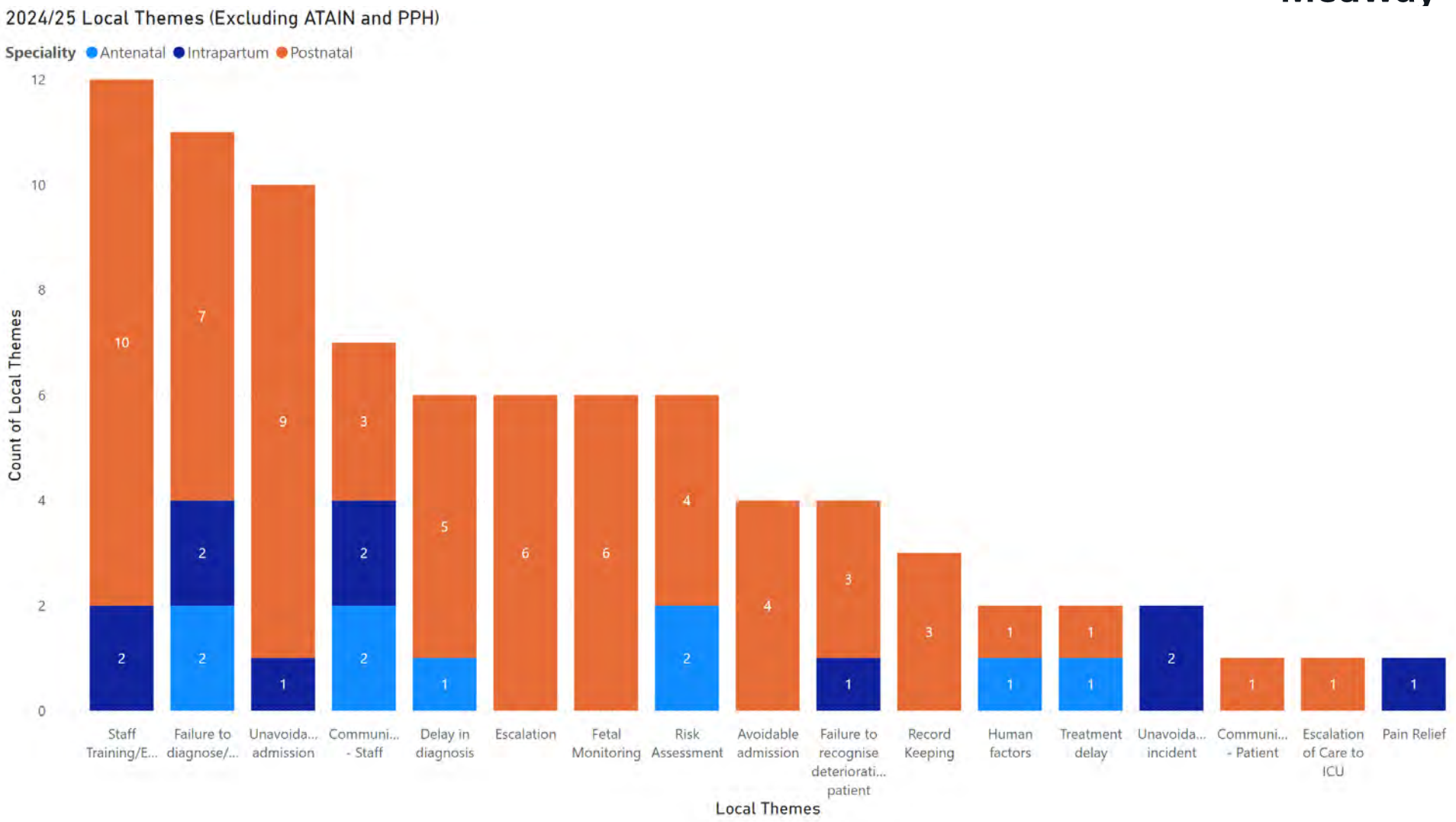
True North: Quality – Q4 PSIRF

Key Messages :

- Failure/delay in diagnosis and treatment remains the most prominent theme for incidents (excluding ATAIN and PPH meeting CRIG criteria) with 17 incidents relating to failure/delay in diagnosis
- For 12 reviews the key theme was around education and training.

Actions & Improvements :

- Align audit plan for 2025/26 and Maternity Patient Safety Incident Response Plan to key themes from 2024/2025 incidents.
- All actions/learning from CRIG are captured on Action log and learning disseminated.
- Review of new/significantly updated guidelines to ensure recommended audit requirements are being met to determine compliance with guidelines. Compliance manager to join guideline group to capture audit plans in real time and add to schedule.



True North: Quality – Q3 PSIRF

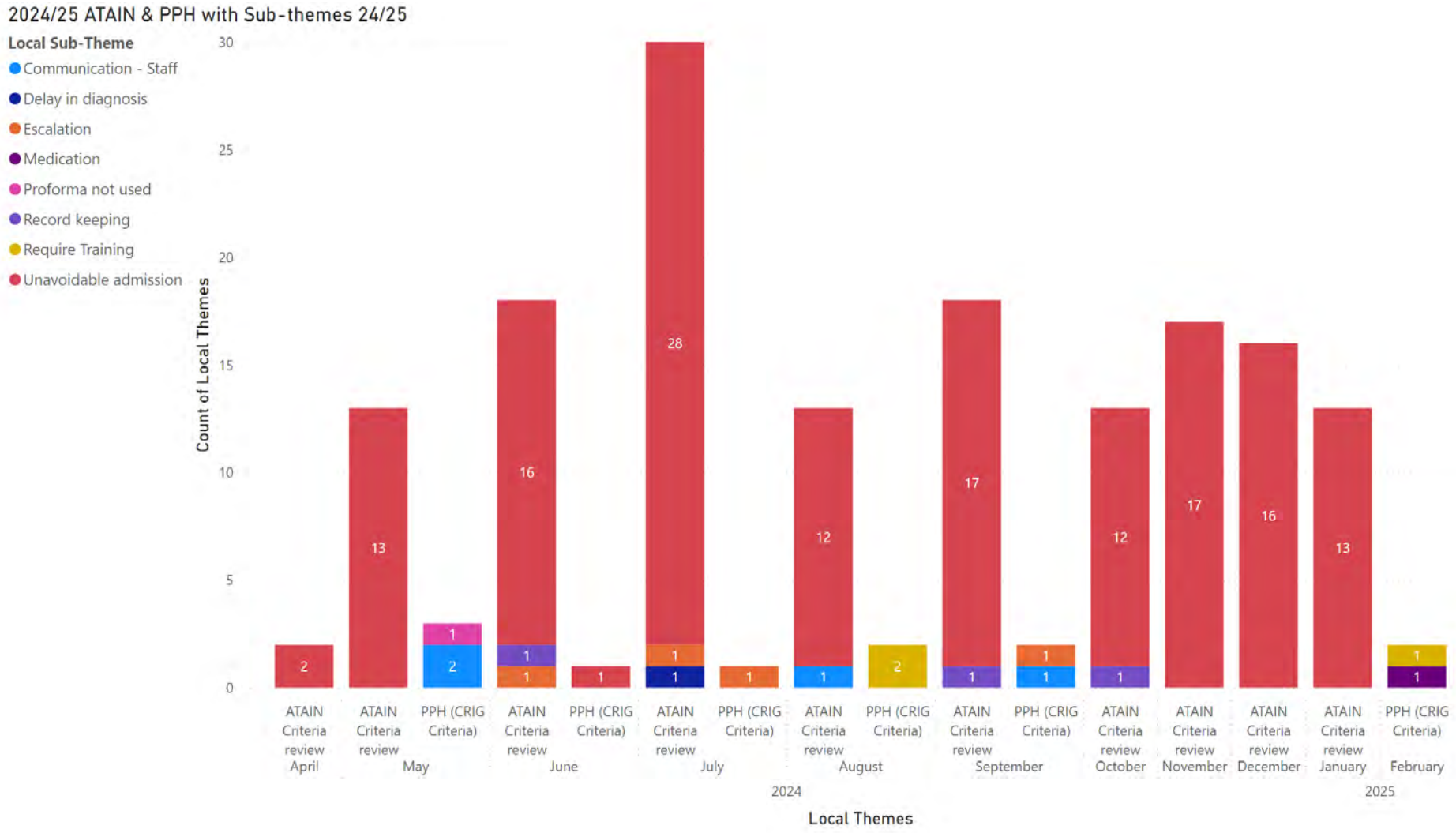
Medway NHS Foundation Trust

Key Messages :

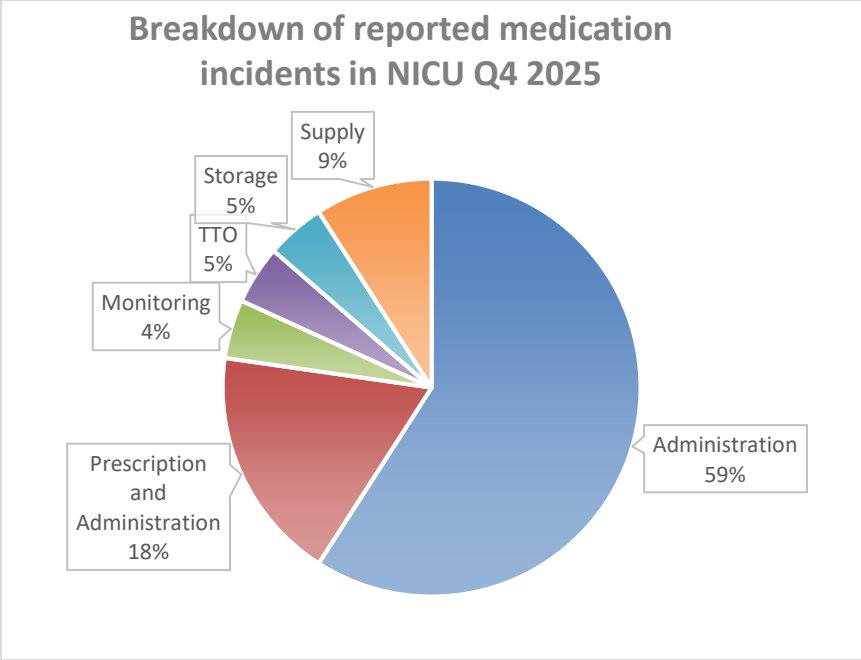
- The majority of all ATAIN cases were deemed as unavoidable admissions with no other themes detected during MDT review throughout 24/25.
- Additional themes included:
  - Escalation (1)
  - Record Keeping (3)
  - Delay in diagnosis (1)
  - Communication staff (1)
- For PPH meeting CRIG criteria the key themes across 24/25 were
  - Communication – staff (3)
  - Training required (3)
  - Medication (1)
  - Proforma not used (1)

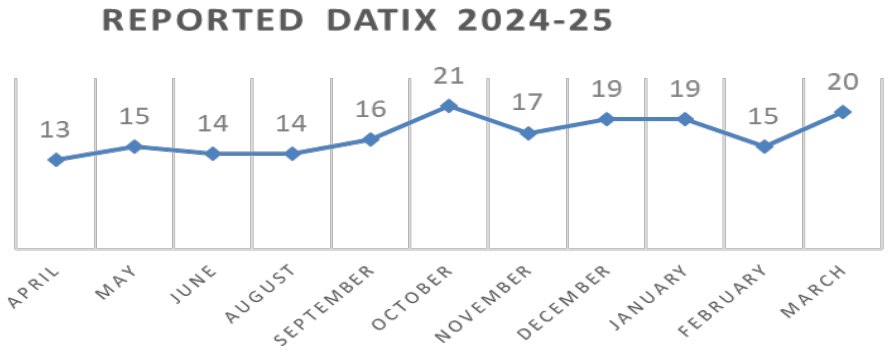
Actions & Improvements

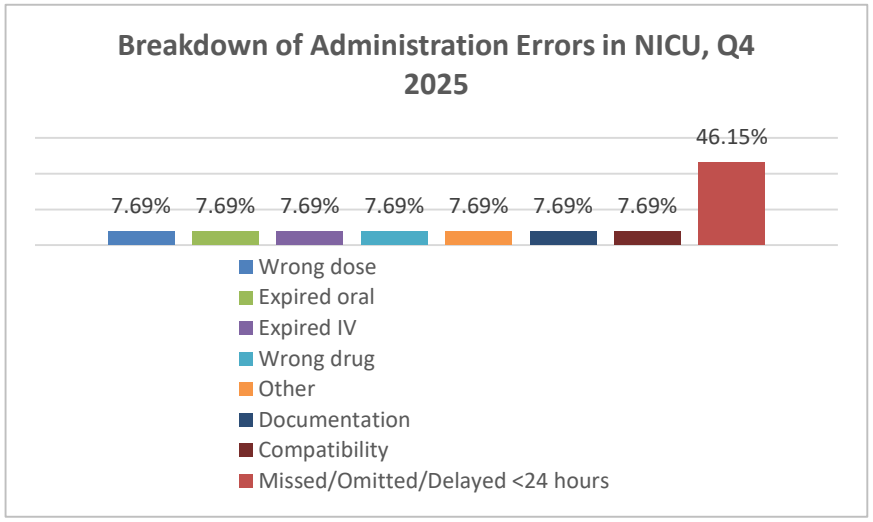
- Quarterly MDT audit report of all ATAIN cases ongoing – in depth review and thematic analysis.
- Ongoing audit of PPH management according to guidance to identify where additional staff training may be required.
- PPH research trial findings to be presented at audit meeting.
- Staff communication in emergencies key component of Obstetric Emergency training for all staff, with PPH being utilised as part of simulation.



NICU-Medication related incidents for Q4 2025







Summary:

- 22 (42%) medication related incidents from January to March 2025. Last year's number of incidents in the same time period is 20.
- Administration error is the most reported category for medication incident. Missed/omitted/delayed drugs are the most common.
- Combined prescription and administration error is the second leading category.
- All incidents reported led to "no harm".

Main gaps/issues/barriers for Q4:

- For missed drugs
  - Majority of incidents involved oral supplements
  - Majority of missed drugs are between 18h00-06h00
- Some information in drug monographs are not up to date and is not complete.
- **Lack of pharmacy support** to provide:
  - Oversight and review prescribed medications
  - Review monographs
  - Review and create action plans for incidents
- Paper medication administration record relies on individual checks. This is subject to confirmation bias and external factors.
- Incomplete details of TTO in discharge letters.

Other gaps/issues/barriers:

- The paper fluid prescription chart and medication administration chart needs updating.
- Process on adding electrolytes in IV fluids and milk needs changing to ensure safe practice.

Actions/Improvements/ Next Steps:

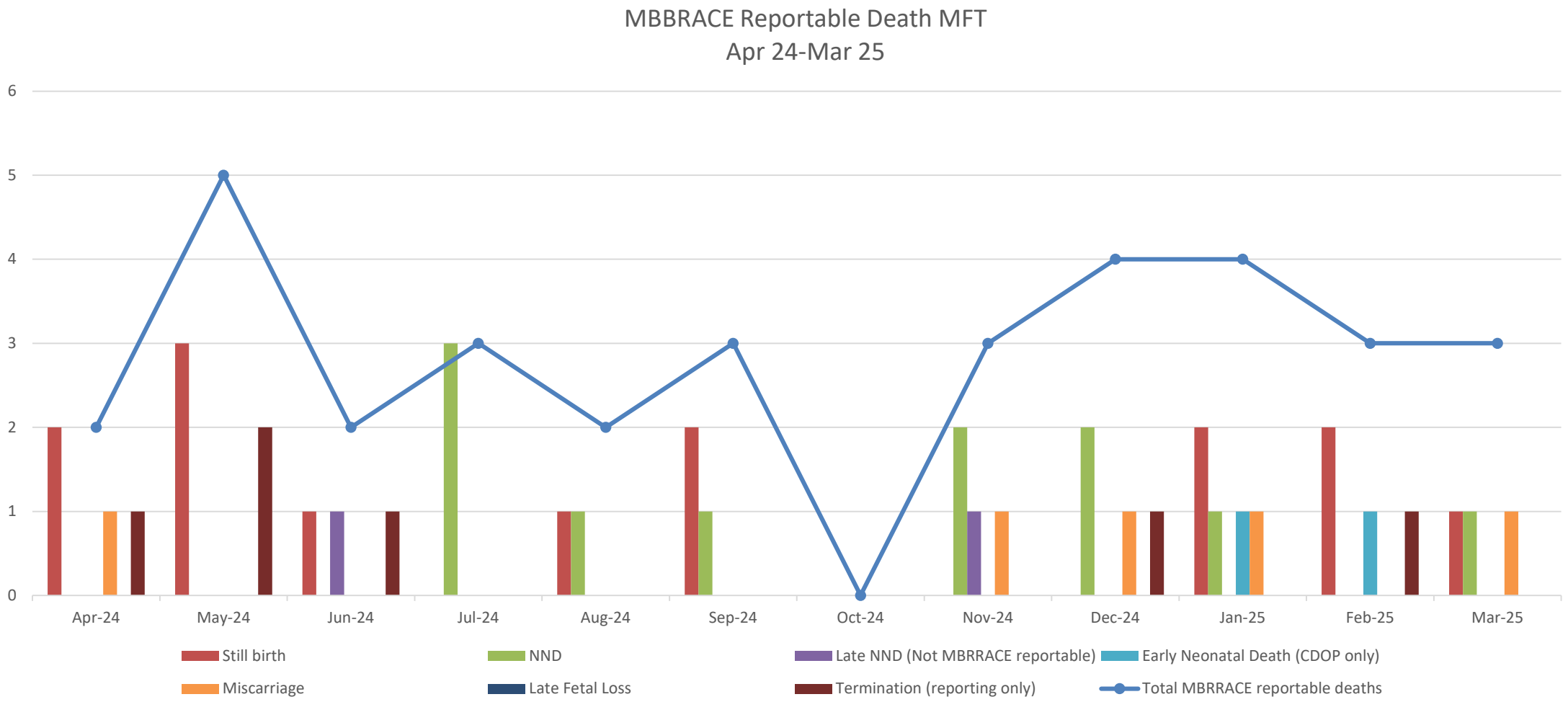
- Standardized timings of oral supplements to be launched.
- Identifying and prioritizing medications that needs updating in the drug monograph formulary.
- Reviewing process on writing medications in the discharge letter.
- Update processes in mixing electrolytes in milk and fluids.
- **Escalating the need for additional pharmacy staff** to provide oversight in the whole medication process and review in NICU.
- Explore possibility of **electronic prescribing** in NICU. In the absence of EPMA- to review and update the prescription charts.
- Conducting survey amongst staff on understanding of current medication issues in the unit.

Perinatal Surveillance Tool Q4 2024/25– Perinatal Mortality Review Tool

Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust



Perinatal Surveillance Tool Q3 2024/25– Perinatal Mortality Review Tool

Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- 10 (↑) MBRRACE reportable cases in Q4
- CNST standard C (PMRT review commenced within 2 months of loss) not commenced for 2 cases, 1 due to staff sickness and 1 due to non-return of booking/antenatal care factual questions by booking Trust within required timeframe. Currently at 90.9% compliance for standard C (95% required).
- 6 PMRT reviews completed in Q4
- Communication with parents regarding care plans continue to be theme for improvement along with documentation and thermal management.

Issues, Concerns & Gaps:

- Current non-compliance with standard C.
- Communication and care planning between medical staff and families.
- Documentation of Neonatal resuscitation.
- Thermal and hypoglycaemic management of extreme pre-term infants.
- Trust dashboard does not align with MBRRACE reporting requirements.

Actions & Improvements

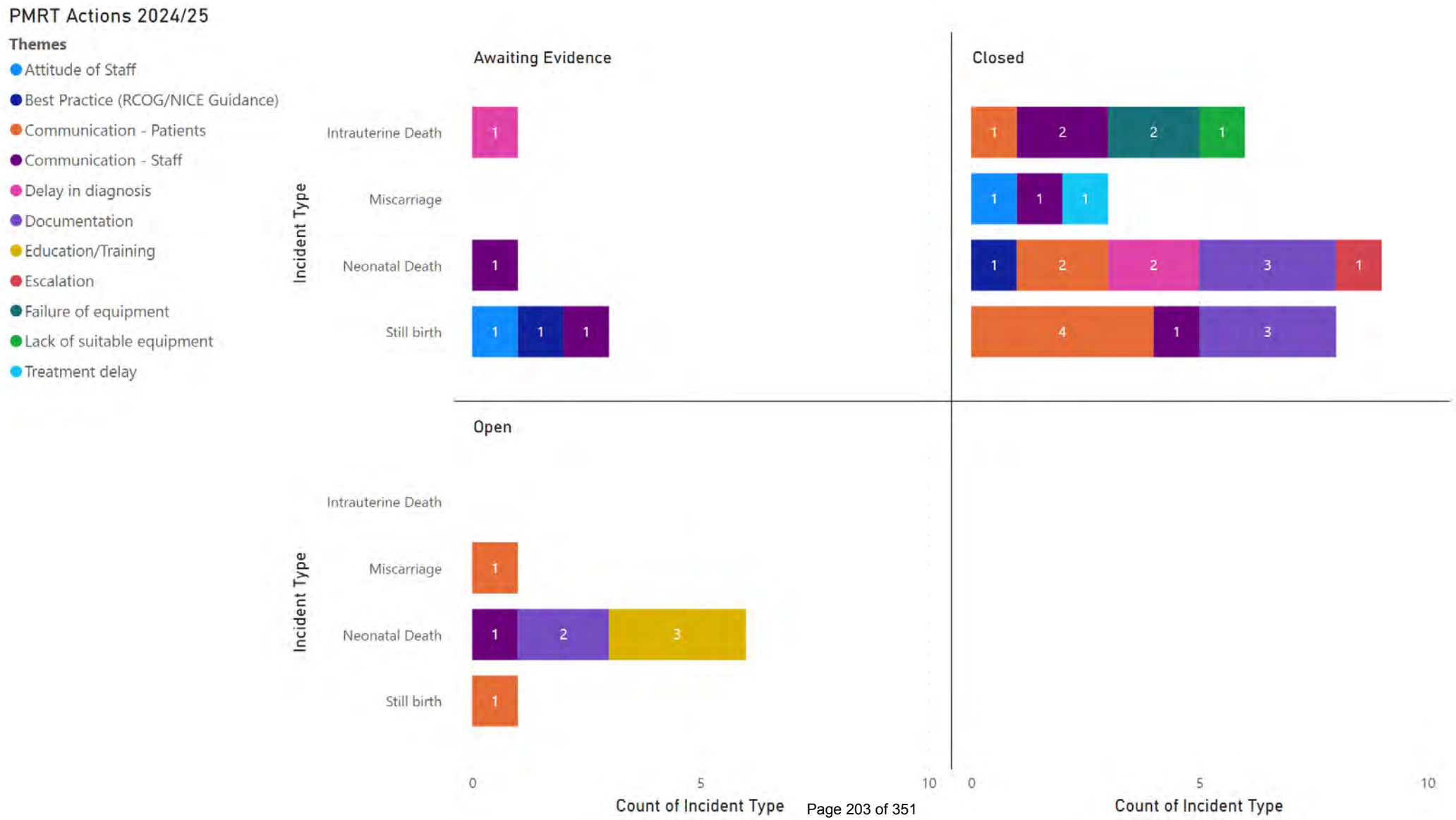
- Failsafe put in place to ensure to ensure PMRT review is commenced within 2 months including additional staff trained and additional flagging for outstanding cases.
- 26 PMRT actions now closed, 12 open/awaiting evidence.
- Discuss concerns for sustained compliance with revised CNST targets with LMNS team to consider system-wide position and escalation.
- Neonatal Training Action plan for both documentation and communication to ensure that clinical care is documented in a timely fashion with a documentation checklist in place to support this.
- Education and training for neonatal staff on thermal and hypoglycaemic management of extreme preterm infants.
- Reduction in actions regarding delay in diagnosis and attitude of staff.
- Concerns raised around continuity of care from obstetric team, communication and care planning to be shared at consultant meeting and labour ward forum for further actions to be developed.
- Protected time for consultant ward rounds on antenatal ward to be ring-fenced.
- Co-produced information booklet to be published and shared with families to support them through bereavement journey.
- Consider aligning Trust dashboard with MBRRACE reporting requirements.

Perinatal Surveillance Tool Q4 2024/25– Perinatal Mortality Review Tool

Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway Foundation Trust



MBRRACE Reportable Loses Q3

Medway NHS Foundation Trust

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
3	1	Miscarriage	22+4	Unexplained	PMRT	A,A, parents raised no concerns with care.
3	2	Neonatal Death	23+4	Extreme prematurity	PMRT	A,A, parents raised no concerns with care.
3	3	Neonatal death	26+5	Extreme prematurity tension pneumothorax	PMRT	A,A,A
3	4	Post-neonatal death	26+0	Extreme prematruity	passed away at 53 days. Use PMRT tool for review - not for CNST.	A,B,A Learning identified around neonatal resuscitation documentation and hypoglycaemic management – Documentation training for all staff attending resuscitations along with documentation checklist to be introduced. Hypoglycaemic management training for all relevant NICU staff.
3	5	Neonatal death	39+0	HIE - Maternal Abruption	MNSI, Coroner, PMRT	D,A,A Patient booked with neighbouring Trust. Actions assigned to them regarding referral and management of high-risk patient. Delay in decision making by ambulance crew on most appropriate hospital to transfer patient to – Direct line being established with go-live in May 2025 between SECAMB and Maternity to ensure timely risk assessment and advice for patients with acute obstetric emergencies in community.
3	6	TOP	30+4	Fetal Abmormality	MBRRACE Reportable only	
3	7	Neonatal death	32+6	HIE - Maternal Abruption	PMRT	A,A,A, Patient attended by ambulance and was taken directly to theatre for Cat 1 section – care managed appropriately.
3	8	Miscarriage	23+6	Unexplained	PMRT	B,D Concerns regarding continuity of care from obstetric team and listening to patients views regarding care planning. To be discussed at Consultant meeting and Labour Ward forum for further actions to be agreed.

MBRRACE Reportable Loses Q4

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
4	1	Stillbirth	30+2	Unexplained	PMRT	C,B - Communication - poor communication around clinical condition and options and continuity of care - no joined up consultant rounds. - Escalated to HOM and Clinical Director - to be discussed at consultant meeting and Labour Ward Forum.
4	2	Miscarriage	23+0	Unexplained	PMRT	BC, Concerns regarding management of blood pressure and lack of follow-up – Maternal Medicine consultant follow up and plan in place for patient management.
4	3	Neonatal death	23+0	Extreme prematurity	MBBRACE, PMRT	(antenatal care at other Trust outside LMNS) A, B, A – Concerns regarding documentation, including Apgars and saturations and communication with parents. Also concerns regarding thermal management. Staff education and training to address concerns.
4	4	Neonatal death	25+1	Extreme prematurity	MBRRACE, PMRT	(Antenatal care at another trust outside LMNS). Graded A, B, A - Communication, thermal management - Staff education and training to address concerns.
4	5	Neonatal death	24+1	Exutero Transfer -	MBRRACE reportable for birthing Trust, PMRT	Extreme prem and grade 4 intraventricular haemorrhage (IVH)
4	6	Stillbirth	40+9	Unexplained	PMRT, MNSI	MNSI Case underway, PMRT for May 2025.
4	7	Neonatal death	25+0	Extreme Prematuirty	MBRRACE, PMRT	PMRT May
4	8	Stillbirth	25+4	Unxeplained	PMRT	PMRT due May
4	9	Stillbirth	31+3	Unxeplained	PMRT	PMRT June
4	10	Miscarriage	23+1	Unxeplained	PMRT, MBRRACE	PMRT June
4	11	Stillbirth	25+2	Unxeplained	PMRT, MBRRACE	PMRT July
4	12	Neonatal death	26+1	Extreme Prematurity	PMRT, MBRRACE	PMRT TBC

CNST Year 7 – Eligible MBRRACE Reportable Losses (PMRT Generated Report)

Case ID	Surveillance case status	Date surveillance first closed	Review status	Eligible for CNST standards	Working days to notify	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c started deadline	Standard c report published	Standard c published deadline	External member present
96440	Surveillance complete	27/12/2024	Review complete	Yes	1	Yes	Met	Met	Met	45699	Met	45819	Met
96501	Surveillance complete	27/12/2024	Review complete	Yes	1	Yes	Met	Met	Met	45705	Met	45825	Met
96619	Surveillance complete	27/12/2024	Review complete	Yes	0	Yes	Met	Met	Met	45714	Met	45834	Met
96791	Surveillance complete	16/01/2025	Review complete	Yes	2	Yes	Met	Met	Met	45722	Met	45844	Met
96790	Surveillance complete	16/01/2025	Review complete	Yes	2	Yes	Met	Met	Met	45722	Met	45844	Met
96922	Surveillance complete	17/01/2025	Reviewing	Yes	1	Yes	Met	Met	Not met	45730	Not yet met	45852	Met
97057	Surveillance complete	02/04/2025	Reviewing	Yes	1	Yes	Met	Met	Not met	45739	Not yet met	45861	Met
97041	Surveillance complete	20/02/2025	Reviewing	Yes	0	Yes	Met	Met	Met	45739	Not yet met	45861	Pre-standard announcement date
97285	Surveillance complete	21/02/2025	Reviewing	Yes	1	Yes	Met	Met	Met	45758	Not yet met	45880	Pre-standard announcement date
97358	Surveillance complete	21/02/2025	Reviewing	Yes	1	Yes	Met	Met	Met	45764	Not yet met	45886	Pre-standard announcement date
97457	Surveillance complete	25/03/2025	Reviewing	Yes	0	Yes	Met	Met	Baby born in different trust so n/a	Not applicable	Baby born in different trust so n/a	Not applicable	Baby born in different trust so n/a

CNST Year 7 – Eligible MBRRACE Reportable Losses (PMRT Generated Report)

Case ID	Surveillance case status	Date surveillance first closed	Review status	Eligible for CNST standards	Working days to notify	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c started deadline	Standard c report published	Standard c published deadline	External member present
97566	Surveillance complete	29/03/2025	Reviewing	Yes	0	Yes	Met	Met	Met	45775	Not yet met	45897	Pre-standard announcement date
97573	Surveillance complete	29/03/2025	Reviewing	Yes	0	Yes	Met	Met	Met	45778	Not yet met	45901	Pre-standard announcement date
97622	Surveillance complete	29/03/2025	Reviewing	Yes	1	Yes	Met	Met	Met	45781	Not yet met	45904	Pre-standard announcement date
97711	Surveillance complete	18/03/2025	Reviewing	Yes	1	Yes	Met	Met	Met	45788	Not yet met	45911	Pre-standard announcement date
97854	Surveillance complete	29/03/2025	Reviewing	Yes	2	Yes	Met	Met	Met	45796	Not yet met	45919	Pre-standard announcement date
97854	Surveillance complete	29/03/2025	Reviewing	Yes	2	Yes	Met	Met	Met	45808	Not yet met	45930	Pre-standard announcement date
98080	Surveillance complete	09/04/2025	Reviewing	Yes	1	Yes	Met	Met	Met	45815	Not yet met	45937	Not yet met
98199	Surveillance complete	17/04/2025	Reviewing	Yes	0	Yes	Met	Not yet met	Met	45825	Not yet met	45947	Not yet met
98316	Surveillance complete	27/04/2025	Review not supported	Yes	0	Not suitable for review							
98500	Surveillance not started	Not set	Ready for review	Yes	0	Yes	Not yet met	Not yet met	Not yet met	45847	Not yet met	45970	Not yet met

NHS
Medway
NHS Foundation Trust

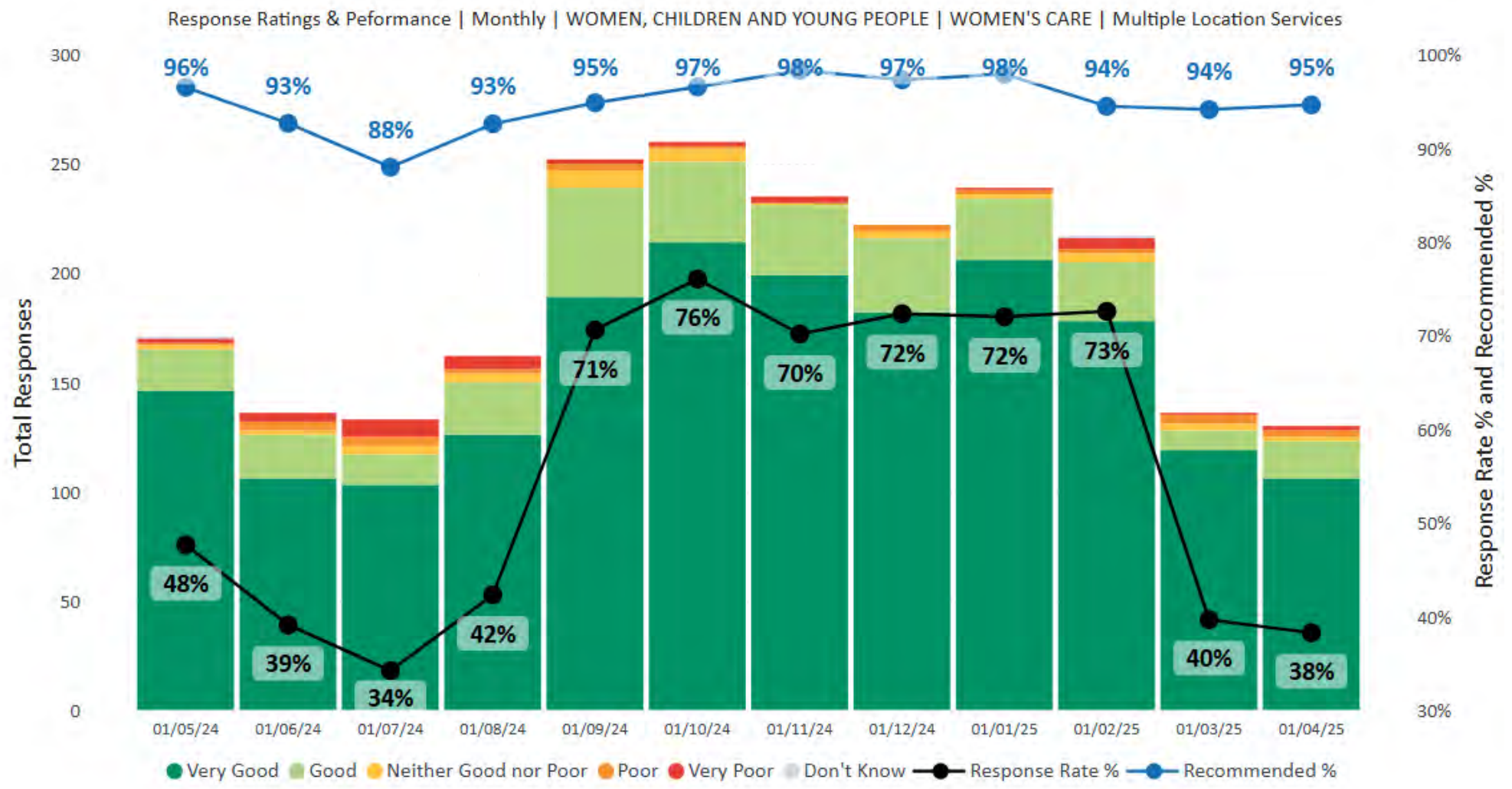
Service User, MNVP and Staff Feedback Perinatal Leadership

Patient FIRST

Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Goal: To embed service user feedback into service development and improvement.



Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

We was so looked after from the moment we came in to the moment we left, every member of staff we dealt with made our experience so memorable, i really cannot complain about anything, the first member of staff we dealt with ... was absolutely lovely, ... our next star member ... we spent the whole shift with from the moment she took us over to the moment she left was an absolute star, she helped me as a first time mum understand everything that was happening and helped me go from 1cm to 9cm dilation the support that she had provided both me and my partner throughout the day was very welcoming, she made our experience so memorable, we found the fresh eyes system such a relief as their was always a second opinion on the babys heart rate and obs, our last star members were the midwife and the theatre team who helped bring our beautiful son into the world and removed all the stress of going into theatre for an emergency c section

My midwives ...understood my wishes for the type of birth I wanted. They kept us informed and explained the benefits and risks of procedures that were required as my labour progressed. We built a great rapport with them and they were a fantastic support throughout. They included my partner and made us both feel in control of the decisions we were making. They stayed with us whilst my options for theatres were discussed and advocated for me in situations that we were unsure of.

Following my birth, it was required for me to transfer from the birth place to the delivery suite to assess the need for stitches by the doctors. I think my options could have been explained better by the doctors and I was grateful to have my midwives with us who were able to help navigate the decision

The staff were extremely helpful and supportive. We really liked how we had different teams of people (infant feeding team, TC nurses, midwives) who all offered their professional support and knowledge in a friendly, approachable manner. We felt confident and ready to leave the hospital with our newborn baby by the end of our 5 days in Pearl Ward. We'd particularly... all the midwives - all so attentive and couldn't have cared more.

I feel having more support for birthing partners. I know the focus is on mother and baby but my husband struggled to support me during the birthing process as he felt he was getting in the way of the nurses and he felt very scared for me as we had to deviate from the original birth plan but he was unaware why.

Perinatal Surveillance Tool Data Q4 2024/25– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

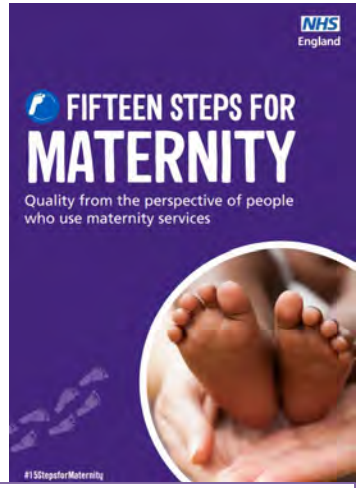
NHS Medway NHS Foundation Trust

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
  - Maternity Triage/MCU QI Project
  - Co-production of CQC Picker Survey Action plan.
  - Working with EDI & PE Midwife to engage with BAME and other diverse service users.
- 15 Steps challenge held in February 2025 – Led by MNVP chair with a number service users, visited Maternity and Neonatal Units. Visit was very positive, with service users reporting friendly and approachable staff, calm ward environments, and satisfied patients. Some minor actions environmental actions noted and these are being actioned by the area leads.
- MNVP lead on MNSCAB bi-monthly for service user feedback update.
- Slight dip in recommend rate and response rate in quarter, however overall response are rated “Very good” or Good”.
- Survey completed with staff and service users regarding amenity rooms.

Issues, concerns, gaps:

- ICB currently unable to fund additional MNVP role (0.5WTE Band 7 Governance lead) to meet requirements of CNST Year 6 with regards to supporting MNVP quoracy at key Maternity and Neonatal Trust level meetings.
- Care planning and communication are recurrent themes across service user feedback, including complaints and FTT responses.
- Negative service user feedback received regarding Amenity Rooms on postnatal wards.



Actions and improvements

- Review of the Birth after caesarean section pathway ongoing after service user feedback group. Service user feedback shared at audit meeting and positive discussions had, including the development of a proforma to support service users make informed choices.
- Continued emphasis on communication and care planning across all training forums, including PROMPT, CTG, doctors induction and Midwifery Essential skills.
- Audit programme to include feedback from service users and where possible service user videos.
- Feedback from complaints shared with individual staff members and teams.
- Use of Amenity Rooms paused.

Perinatal Surveillance Tool Data Q4 2024/2025– Staff Feedback & Perinatal Leadership

Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway

Key Messages:

- Board Level Safety Champion Walk Arounds ongoing, including virtual and face to face sessions.
- Teams Talks Continue monthly – ADOM and DOM provide updates on actions and concerns previously raised, along with key updates on service and staffing developments for staff. Staff are given the opportunity to share both positive and negative feedback and actions are derived from these discussions as required.
- Positive progression pathway feedback to CNO, from Band 2 “New to Care” through midwifery apprenticeship programme to being a substantive midwife.
- Student feedback sought regularly via student forum.
- Improved midwifery staffing position reflecting positively in morale and staff wellbeing across the unit.
- National staff survey results received – actions being developed in line with Trust and Departmental priorities.
- Perinatal Culture and Leadership programme is ongoing with support for cultural training for staff agreed.
- Quarterly Regional Perinatal Leadership Teams’ Newtork meeting established to share ideas, discuss concern, receive support on ongoing cultural development work.
- Futures page set up for all Perinatal Leadership Teams to share resources and act as a support page for leadership teams.

Issues, concerns, gaps:

- Students raised concerns regarding outstanding births required to achieve their qualifications.
- Longstanding concerns regarding Maternity Information system from staff.
- Incivility amongst staff noted as a trend on datix and is a focus of staff survey action plans for 24/25
- Staff concerns regarding estates including condition of flooring, equipment and temperature.
- Staff acknowledge challenging skill mix across department currently and need to support newly qualified staff.

Actions and improvements

- Issues log now reflects staff concerns regarding flooring, fetal medicine equipment and lack of air conditioning. Senior team escalating through appropriate forums.
- Working with CNO, Infection Control and Estates as part of Trust wide review of estates to support site-wide prioritisation of estates work.
- Patient Safety Collaborative to provide outcome measures to support Trusts to align the work of the PCLP to the requirements of CNST Safety Action 9.
- NHSE removed the “quad” element of the PCLP – with Trusts now able to determine the numbers and roles included in their Perinatal Leadership Team.
- Working with Chief People Officer to address incivility amongst staff.
- Dedicated midwife in post to support newly qualified staff through their preceptorship. Working a range of clinical shifts to provide support.
- PMA team proactively engaging with preceptees to ensure they are able to access PMA support.
- Senior team working to support all staff through regular team meetings, “open door” policy and visibility across unit.

Safeguarding

NHS Medway NHS Foundation Trust

Patient FIRST

Safeguarding – Maternity

NHS Medway NHS Foundation Trust

Key Messages:

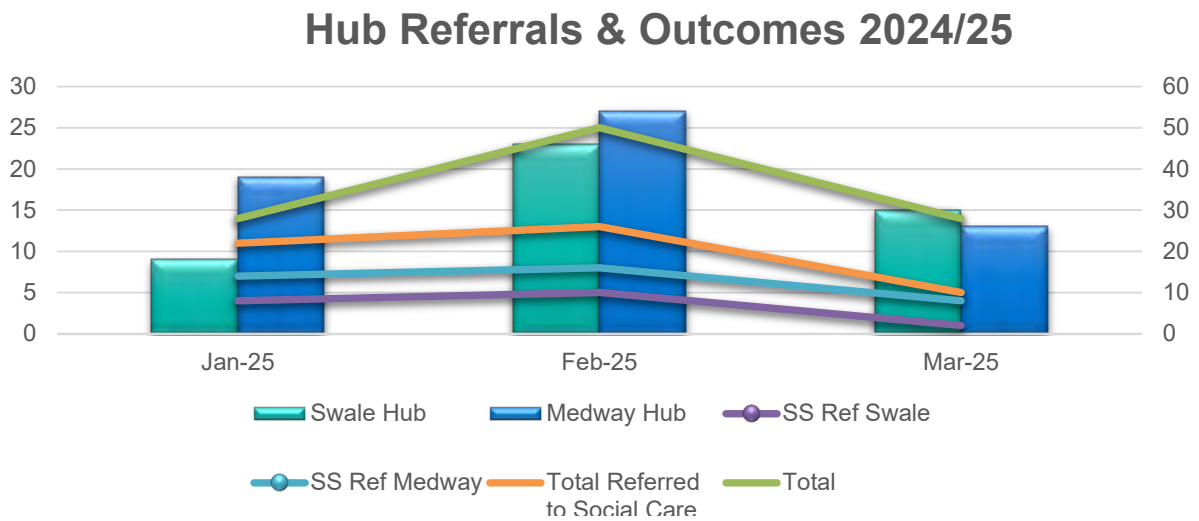
- Maternity Safeguarding team continue to have a visual presence on the wards, with face to face ward rounds and facilitation of meetings.
- Reduction in number of referrals to midwifery hub, reflecting the effectiveness of the training and TOR for the hub to ensure only appropriate referrals are made.

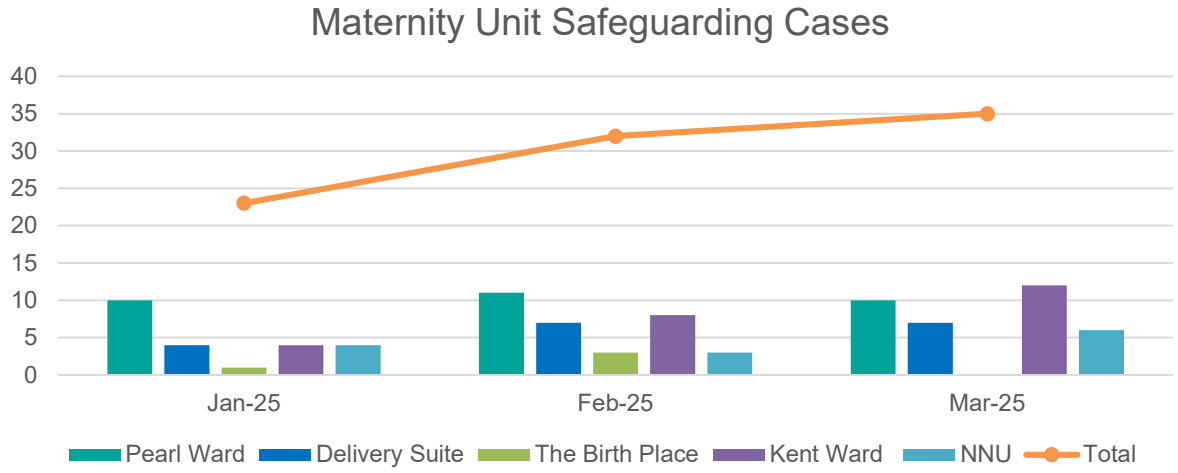
Issues, Concerns & Gaps:

- Safe sleeping audit showed poor compliance around visualisation of sleep space during first postnatal home visit. Inconsistent compliance across all 5 teams in regards to SIDs prevention advice.
- Inconsistent compliance across inpatient areas for CP-IS review for all admissions.
- Antenatal toxicology data review outstanding from 2024

Actions/Improvements :

- Maternity Safeguarding team to join Community team meetings quarterly.
- Maternity Safeguarding Team have been providing bespoke sessions to the community teams mainly face to face to discuss any concerns or questions they have around the advice that should be given. Updates have also been provided in the Maternity Matters publication to ensure all staff are aware of their responsibilities with sharing safe sleeping information. A re-audit is in the process of being completed.
- .The “Maternity Defaulters Standard Operating Procedure” has been reviewed and simplified to be more “user friendly”. The “How to complete a DNA Checklist” video guide has been circulated to all community midwives, and the Senior Sisters remain to have oversight of the DNA checklist on the monthly safeguarding returns
- Children’s Level 3 Safeguarding training has increased to 85.71%.

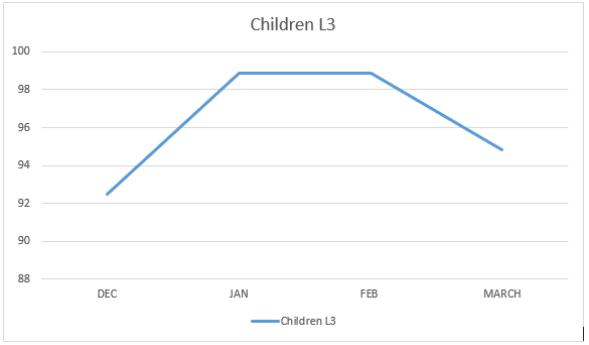




Safeguarding – NICU

Successful Deliverables

- 8 inpatients with safeguarding concerns (March)
- Safe guarding Level 3 staff statman compliance 94.85%
- Safeguarding guidelines all updated



Next Steps

SG L3 compliance:
DEC 92.47%
JAN 98.9%
FEB 98.9%
MARCH 94.85%

Identified Challenges

- NICU Nursing Team supervision
- Improved communication between NICUs within the Network is required to ensure seamless transfers of care
- Ensure guidelines are kept updated
- ESR, timely system updates

Next Steps

- Continue to work in partnership with NICUs within ODN
- Create a work schedule to ensure guideline are reviewed and updated as required

Opportunities

- Provide NICU specific Safeguarding Training twice a year on NICU Medical Team new doctors induction from March 2025 to share the importance of accurate documentation and consent.
- Collate data of safeguarding babies to determine how many days babies are remaining on the unit between being medically it for discharge and discharged with social care involvement.

Next Steps

- Continue to work closely with the multi professional team, ensure SS are aware of when a baby is medically fit for discharge
- Continue to support team to complete training
- Safeguarding team to provide safeguarding supervision on nursing team days throughout the year

Risks

- Gaps in training for foster carers and Mother and Baby Units in terms of infant feeding advice once baby leaves the NICU.
- Risk visitor forms to be shared with Security once baby admitted to NICU

Next Steps

- Ensure full and concise information sharing within the MDT
- Work with social workers as well as families as partners in care
- Ensure the security team are aware of any families of concern

Conclusions and Next Steps

- This quarter has demonstrated continued progress in our commitment to delivering safe, high-quality perinatal care.
- Key improvements in clinical outcomes, compliance with national standards, and service user feedback reflect the dedication of our multidisciplinary teams.
- Multidisciplinary reviews of key incidents continue within the quarter and work to identify learning and actions at the time of incidents, demonstrating our commitment to learning and continuous improvement.
- Gaps in compliance with CNST Safety Action 1 have been addressed and compliance with this standard is anticipated by the end of CNST Year 7.
- All eligible MBRRACE reportable/PMRT cases have been included in the report, including details of actions and learning.
- Service user and staff feedback continue to drive service improvement and development.
- Continue with monthly reporting to MNSCAG and Trust Board via the IPQR slides which contain all the key information required as part of the PQSM minimum data set.
- Report for onward reporting to Trust Board as per CNST year 7 requirements.

NHS
Medway
NHS Foundation Trust

Maternity Bi-Annual Workforce Report

MNSCAG June 2025

Trust Board July 2025

LMNS July 2025

Patient FIRST

Executive Summary

- CNST Year 7 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board.
  - The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels.
  - This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
  - The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in January 2025.
  - Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- Monthly monitoring of workforce embedded into practice
- New starter/preceptorship package is now in place with dedicated member of the education to support.
- Current vacancy of 5.56 WTE (April 2025) Band 5/6 Midwives
- The maternity service currently has a 22% uplift to cover sick leave, annual leave and mandatory training. A PID for an increased uplift to 25% to support additional training requirements was included in business planning for 25/26, but was not agreed by the Trust.
- NMC panel interviews completed for CCCU reaccreditation.
- Midwifery turnover rates improved across region.
- Stress and anxiety absence reviewed by senior team and improvement strategies implemented, including standardised reporting, collaboration with occupational health and return to work process.
- Menopause support focus groups run across the Trust to help staff manage symptoms and reduce potential absences.
- Award and recognition activities celebrating key members of maternity staff within the Trust and the LMNS.
- Recruited to enhanced COC Support worker post.
- Work ongoing to gather information from internationally educated and midwives from BAME backgrounds to identify actions and next steps.
- Planned NHSE Insight visit for September 2025. Staff focus group scheduled for all midwifery groups (Band 7 and below), consultants and resident doctors, with separate sessions for band 5 and internationally educated midwives. Workforce action plan for 25/26 to be developed based on the feedback from these sessions alongside workforce intelligence data.
- The Delivery Suite acuity tool data shows that unit was adequately staffed 70% of the time, which is a significant improvement on the previous 6 months which showed adequate staffing 58% of the time. Negative acuity of up to two midwives short also improved in the reporting period, reducing from 36% to 27% and 2 or more midwives short reduced from 6% to 3%. This is an extremely positive picture and it is anticipated this rate will improve and hopefully reach the 85% target in the next reporting period as the benefit of significantly reduced vacancy is seen across the unit.

True North: People
Planned vs Actual Midwifery Staffing levels

NHS Medway NHS Foundation Trust

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

Measure	Goal	Mar 24	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 25	Feb	Mar	Apr 24
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	0:125	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio		1:30	1:31	1:32	01:29	01:29	01:32	1:31	1:29	1:30	1:29	1:30	01:27	01:29	1:30

	Establishment	In post	Recruited to but not in post	On secondment	Contractual Vacancy
Clinical Band 7 Midwives	22.00	21.27	0	0	0.73
Clinical Band 5 and 6 RM/RN	159.64	147.92	4.52	1.64	5.56
MSW's Band 3	33.76	29.57	1.8	2.28	0.11
Total	215.4	198.76	6.32	3.92	6.4

True North: People
Planned vs Actual Midwifery Staffing levels

NHS Medway NHS Foundation Trust

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

Key Messages:

- Midwifery band 5/6 vacancy has reduced to 5.56 in April 2025.
- Large junior workforce being supported in practice by dedicated clinical skills facilitator.
- Exit interviews demonstrate staff leaving for personal reasons or promotion and not due to work place dissatisfaction but service has overall good retention rates.
- Engaged in LMNS live MOPEL scoring to support shared awareness of unit's capacity across LMNS in real time in the event that mutual aid is required.

Issues, Concerns & Gaps:

- Full Birth-rate plus assessment due in 2026 (as per CNST requirements) across LMNS. Due to financial position of Trust and ICB limited scope for funding.
- Trust-wide recruitment freeze delaying process of recruitment for critical patient safety roles.
- Awaiting funding confirmation for NHSE/LMNS Retention/Recruitment post will continue to be funded for 25/26.
- Unable to secure 25% uplift request for training which will present a challenge when factoring in significant training requirements within the Core Competency Framework.

Actions & Improvements:

- Include Birth-rate plus assessment in business planning for 26/27 and escalate through ICB/LMNS.
- Escalate through CNO for support to progress advertising/recruitment to safety critical roles.
- Escalate through LMNS for confirmation of recruitment/retention midwife post funding for 25/26.
- Identifying mental health first-aiders within care group to complete training and be a source of support for staff absent with anxiety and stress.
- Reviewing training requirements and deploying a variety of learning methods, including videos and e-learning.

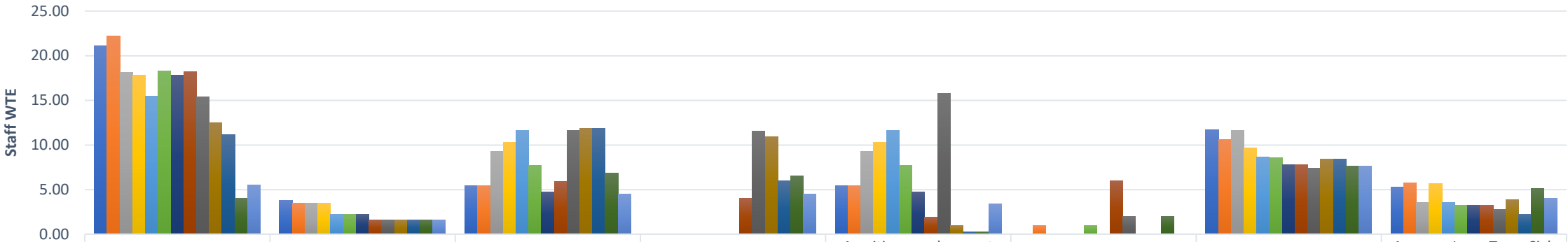
True North: People
Workforce Data April 24-April 25

NHS Medway NHS Foundation Trust

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

Midwifery Staffing April 24-April 25



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Apr-24	21.12	3.77	5.42	0.00	5.42	0.00	11.72	5.32
May-24	22.23	3.48	5.42	0	5.42	1	10.64	5.72
Jun-24	18.16	3.48	9.26	0	9.26	0	11.64	3.6
Jul-24	17.86	3.48	10.34	0	10.34	0	9.64	5.68
Aug-24	15.48	2.24	11.63	0	11.63	0	8.68	3.55
Sep-24	18.28	2.24	7.72	0	7.72	1	8.56	3.23
Oct-24	17.81	2.24	4.72	0	4.72	0	7.76	3.23
Nov-24	18.24	1.64	5.92	4	1.92	6	7.76	3.23
Dec-24	15.37	1.64	11.68	11.57	15.8	2	7.4	2.78
Jan-25	12.51	1.64	11.88	10.92	0.96	0	8.44	3.87
Feb-25	11.15	1.64	11.88	6	0.32	0	8.44	2.26
Mar-25	4.03	1.64	6.84	6.52	0.32	2	7.64	5.16
Apr-25	5.56	1.64	4.52	4.52	3.36	0	7.6	3.99

Growing the Workforce:

Midwifery Workforce Pipeline Modelling Tool

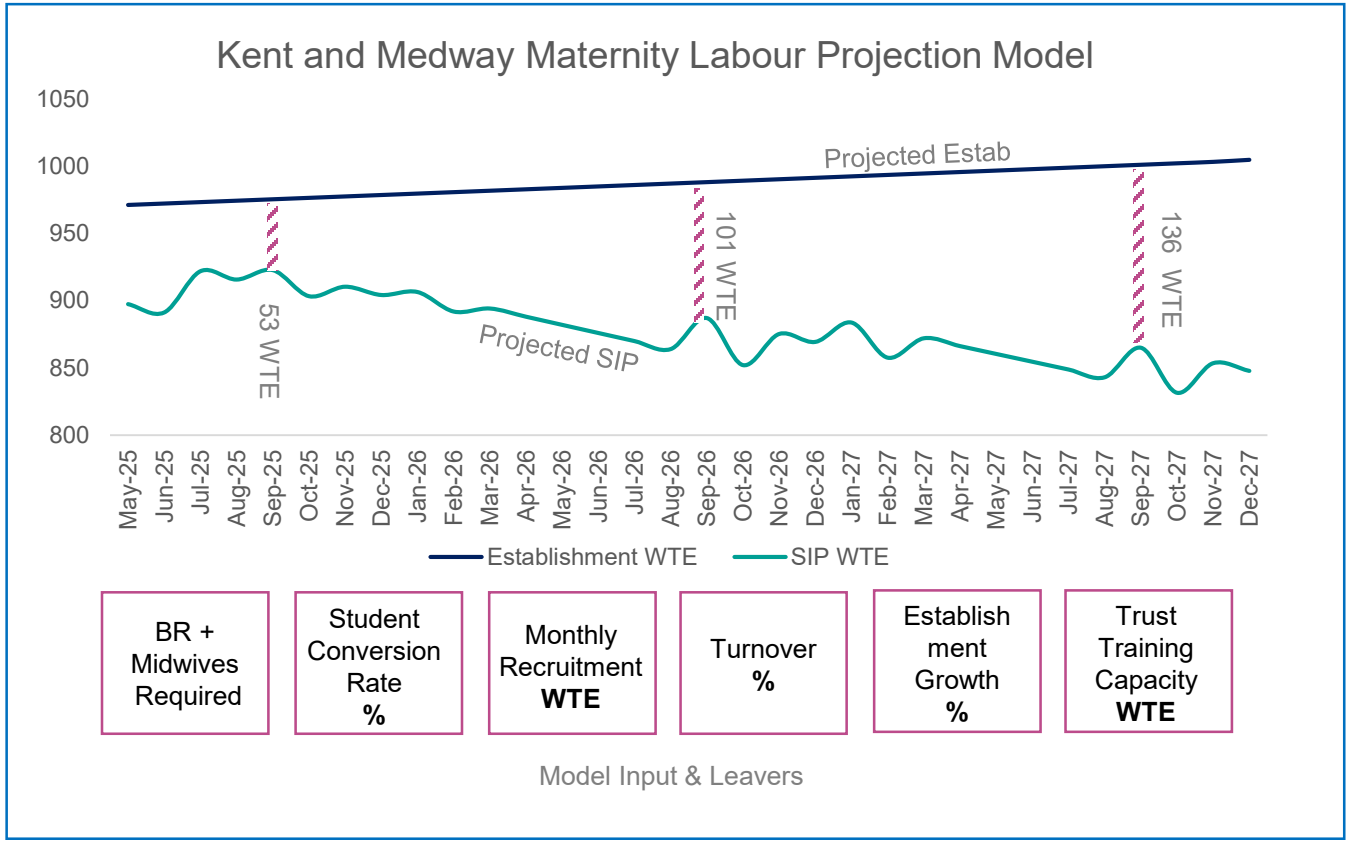
Kent and Medway Local Maternity and Neonatal System

NHS Medway NHS Foundation Trust

The Maternity projection model is designed to forecast workforce requirements over time, by analysing inputs such as monthly recruitment, turnover percentage, Birthrate + service levels, student conversion rates in combination with historic performance of recruitment and retention activity ranging from student intake to general annual recruitment.

A key focus of the model is to determine how many students, or additional staffing will be required to support future demand. By incorporating student conversion rates, the model is intended to predict the number of students transitioning into the workforce, while measuring the drop out rate to enable early conversations with our higher education providers on the student volume requirements and ensuring capacity planning within the trust education and operation areas to ensure proficiencies are maintained and ensuring birthing numbers per student requirements are adhered to.

The model is in the early test stage with live data run throughs and prediction scenarios being conducted.



Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Key Messages:

- Positive retention noted, with minimal leavers over past 6 months.
- The service is currently working with the HEE Midwifery Apprentice Programme and have 2 recently qualified and 5 ongoing apprentices.
- T-Levels pilot to support young people to complete health qualifications within the hospital setting has been completed. Service keen to actively engage in the future of the programme.
- 1 RN on the RN to midwifery shortened course programme (18mth).
- Sickness and absence now below Trust target.
- Bank shift renumeration incentive has been reduced, with no apparent impact on fill rate.
- Underpinning for Midwifery Continuity of Carer commenced with recruitment of COC MSW.
- Ongoing work to gather information and feedback from Internationally educated and BAME midwives in order to develop an action plan to improve their experience across the unit.
- Actively engaged in Trust-wide work on incivility, with all datix incidents reported reviewed by senior team and addressed.
- Working with Trust to support ongoing culture work.

Issues, Concerns & Gaps:

- Anxiety/stress/depression/other psychiatric illness highest reason for absence.
- Funding for recruitment and retention midwife continued for 2024/25. Waiting for confirmation of extension for 2025/26
- 100% of the Midwifery workforce are female and over 80% of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups
- Concerns raised regarding University of Greenwich student recruitment, onboarding and placement support.

Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Actions & Improvements:

- Targeted work by senior team to ensure consistent management of sickness and absence for stress and anxiety.
- Flexible working opportunities facilitated across the service wherever possible.
- Mental Heath First-Aiders identified across service to support staff with anxiety/stress.
- 2 members of staff (Labour Ward Coordinator and NICU Nurse) to attend Civility training and will support driving improvements in attitudes and behaviours in the clinical areas.
- Monthly Maternity forum chaired by the DoM to to facilitate feedback to staff and provide staff with the opportunity to raise any concerns and celebrate achievements.
- Monthly safety walk rounds by Local and Board Level Safety Champions to talk to teams on shift, and anonymous safety champion feedback form now in place.
- Successful funding achieved from Trust CPD budget to support all professional development requests.
- Regular update for colleagues on progress around recruitment and actions taken as a result of the midwifery forum and safety walk arounds.
- Positive engagement with University of Greenwich with CNO and HOM. Action plan in place to address concerns regarding recruitment, onboarding and placement.
- Staff survey analysed to support development of action plan in line with departmental and Trust priorities and target areas.
- All staff feedback collated on feedback log and actions allocated and outcomes fed back to staff. Actions to be grouped by theme and added to BAF to ensure appropriate oversight.
- Ongoing engagement with Trust and LMNS quality and diversity workstreams.
- Continue to embed inclusive recruitment process for band 7 and above to ensure that our interview panels are diverse.
- Talent management undertaken with senior band 6s being supported to complete management training.
- Band 2 New to Care MSW post retained within service alongside uplift of MSW/CSW roles across the Trust to provide a continued route for “home-grown” staff.
- Efficient use of E-rostering to ensure adequate and appropriate staffing cover across unit.
- Continue to support culture and improvement work, including recognising and celebrating staff achievements “Star of the Month!”, LMNS recognition awards, Trust Nursing and Midwifery Awards and Hospital Hero Awards.
- Planned NHSE Insight visit for August 2025. Staff focus group scheduled for all midwifery groups (Band 7 and below), consultants and resident doctors, with separate sessions for band 5 and internationally educated midwives. Workforce action plan for 25/26 to be developed based on the feedback from these sessions alongside workforce intelligence data.

True North: People
Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- The pie chart shows Acuity RAG status for May 2024-October 2024 and November 2024 to April 2024.
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity.
- A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite acuity tool data shows that unit was adequately staffed 70% of the time, which is a significant improvement on the previous 6 months which showed adequate staffing 58% of the time. Negative acuity of up to two midwives short also improved in the reporting period, reducing from 36% to 27% and 2 or more midwives short reduced from 6% to 3%. This is an extremely positive picture and it is anticipated this rate will improve and hopefully reach the 85% target in the next reporting period as the benefit of significantly reduced vacancy is seen across the unit.

Issues, Concerns & Gaps:

- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this may create red flags in these areas
- Web-based acuity tool for antenatal and postnatal wards is still in testing due to technical issues from provider.

Actions & Improvements:

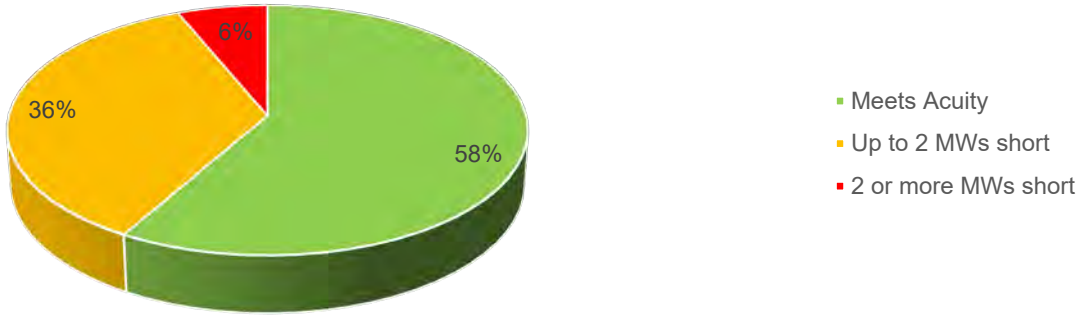
- A clear and robust escalation policy is in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored. Early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service
- Working with LMNS to further develop the live-MOPEL reporting/SHREWD dashboard to enable all required reporting to be gathered from this system, removing the need for duplication of work and financial commitment to two systems.

True North: People
Birthrate Plus 4- hourly acuity tool

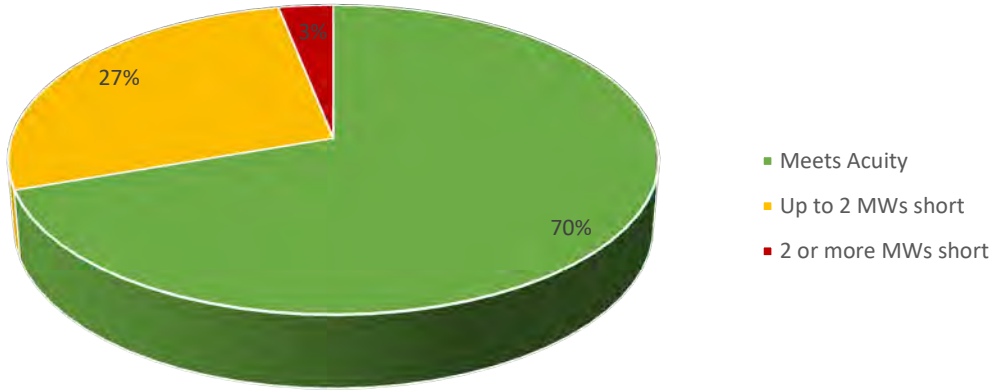
Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Delivery Suite Staffing/Acuity May 24-Oct 24



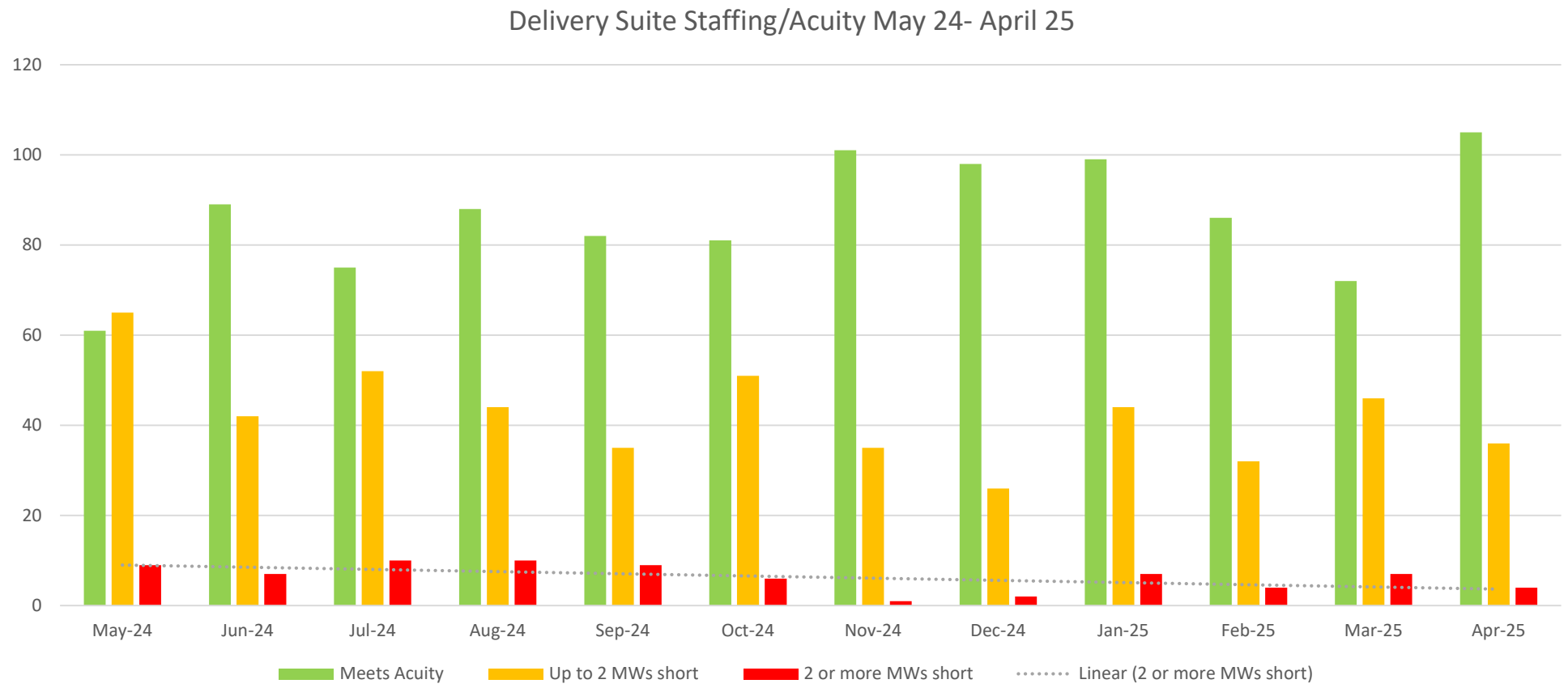
Delviery Suite Acuity/Staffing - Nov 24-April 25



True North: People
Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

NHS Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- Red flags are recorded every 4 hours by the delivery suite coordinator on the birth-rate plus acuity tool. The same red flag may be recorded multiple times per shift (eg. Delay in induction of labour).
- The pie chart shows that for the last two reporting periods, the red flags for delay in commencing IOL have remained consistent at 74/73%.
- 22% of red flags relate to delay or cancelled time critical actives, which is consistent with the previous reporting period.
- Minimal delays in accepting transfers or delaying elective sections for >24 hours throughout the past 12 months.
- 10% of the red flags were declining in-utero transfers, which is a slight reduction from the previous 6 months (11%) and is a necessary action to ensure safety of patients already admitted into our maternity service.
- 1 red flag raised for inability to provide 1:1 care in labour, however, however, this was immediately mitigated by staffing factors and the mother had continuous 1:1 care in established labour. This is also confirmed via the maternity dashboard.

Issues, Concerns & Gaps:

- IOL delays continue to raise red flags, but this data does not quantify the number of women affected or the length of delay.

Actions & Improvements:

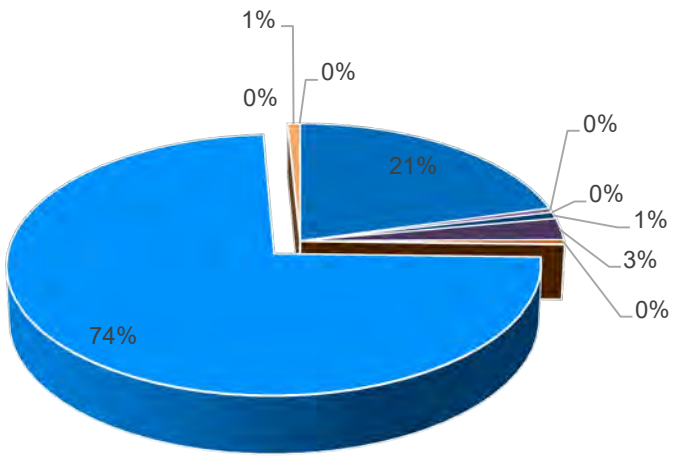
- Despite continued red flags for IOL delays, the number of instances where a clinical action was taken over the reporting period to delay an IOL has decreased significantly (almost halved), with 102 instances in May 2024 reduced to 55 instances in April 2025.
- Ongoing QI work progressing regarding the IOL pathway, with a new induction agent being commenced in June/July 2025 which it hopes will reduce the length-of-stay for mothers on the antenatal ward and improve flow through the IOL pathway. Training videos for staff have been prepared and guideline to be launched at the upcoming audit meeting and shared widely across the unit.
- Staffing factors contributing to red flags/acuity have also significantly improved over the previous 12 months, of particular note, inability to fill vacant shifts has reduced from 87 in May 2024 to 17 in April 2025.

True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust

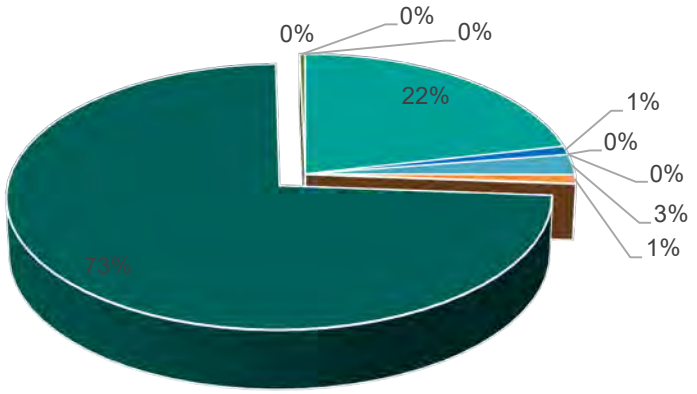
Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Maternity Red Flags June -November 2024



- Delayed or cancelled time critical activity
- Missed or delayed care (for example delay of 60 minutes or more in washing and suturing
- Missed medication during admission to hospital or MLU
- Delay in providing pain relief
- Delay between presentation and triage
- full clinical examinaination not carried out when preseting in labour
- Delay between admission for induction and beginning of process
- delayed recognition of and action on abnormal vital signs.

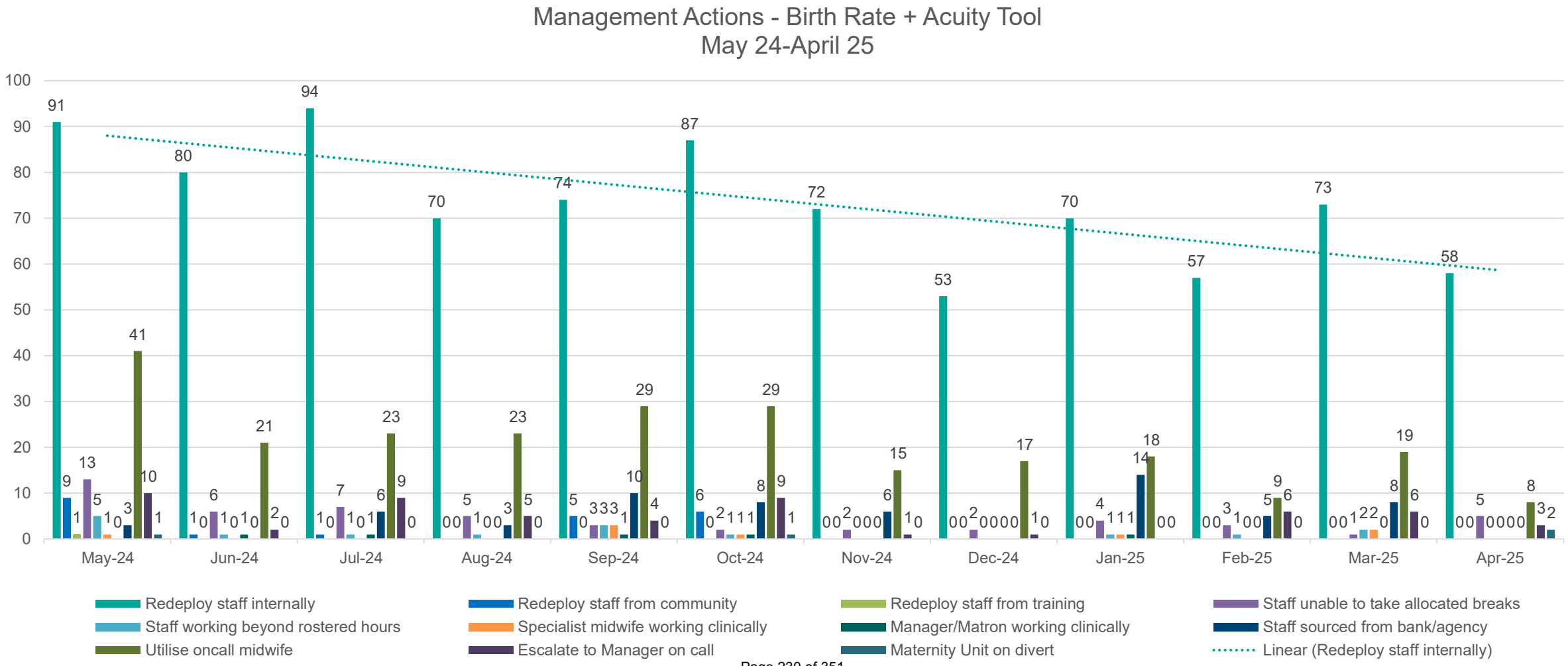
Maternity Red Flags - Dec 24-April 2025



- Delayed or cancelled time critical activity
- Missed or delayed care (for example delay of 60 minutes or more in washing and suturing
- Missed medication during admission to hospital or MLU
- Delay in providing pain relief
- Delay between presentation and triage
- full clinical examinaination not carried out when preseting in labour
- Delay between admission for induction and beginning of process
- delayed recognition of and action on abnormal vital signs.

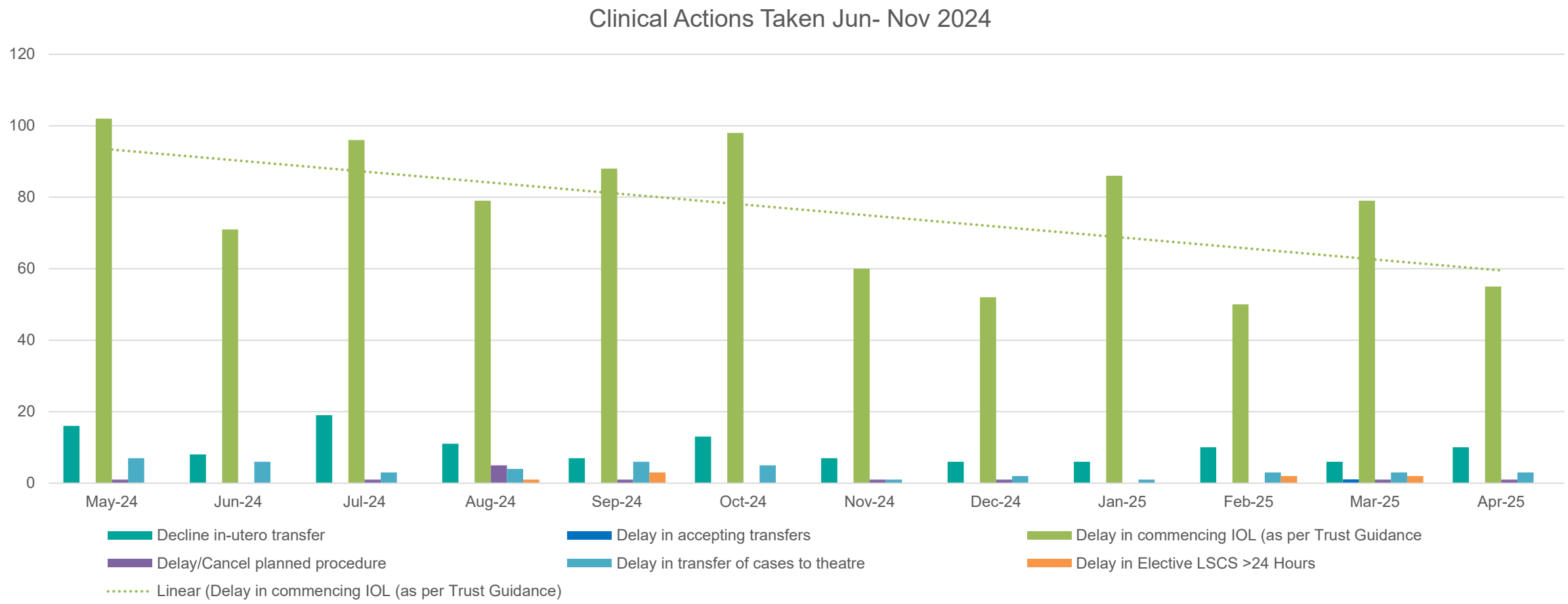
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



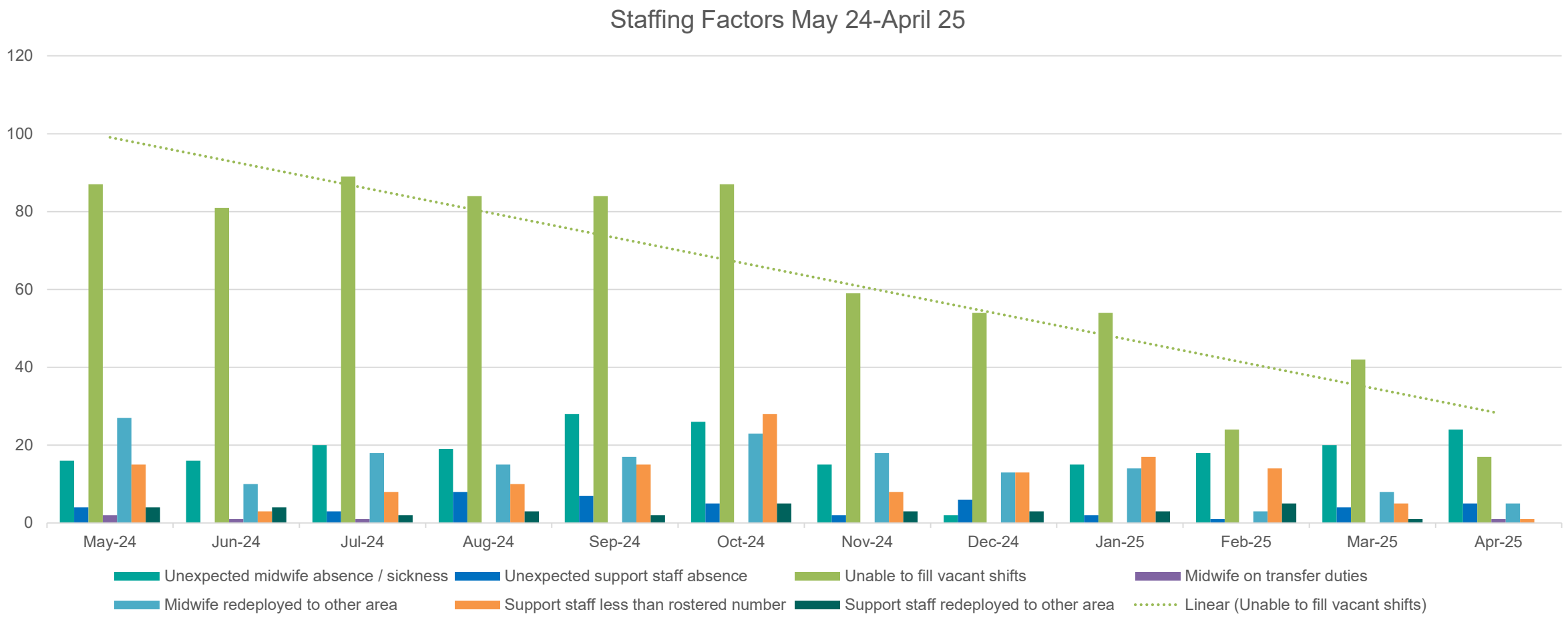
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



True North: People
Delivery Suite Co-ordinator supernumerary status

Ambition: To ensure supernumerary status of the delivery suite co-ordinator.
Goal: To monitor compliance of supernumerary status and ensure there is an action plan in place of how the maternity service intends to achieve this .

	Compliance with Supernumerary status of coordinator as per CNST Guideance	Complaince with 1:1 Care in Labour as per CNST Guidance
Nov 24	100%	100%
Dec 24	100%	100%
Jan 25	100%	100%
Feb 25	100%	100%
Mar 25	100%	100%
April 25	100%	100%

Key Messages:

- Delivery suite supernumerary status is a core element of CNST Safety Action 5.
- In year 7, the requirement has changed to ensure that the coordinator is supernumerary on the rota and that the shift commences
- The twice daily bed state monitors the supernumerary status of the delivery suite co-ordinator to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status for more than 1 hour, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary have been reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite, and therefore meet the requirements of CNST allowing the service to declare 100% compliance with supernumerary status.
- Compliance with 1:1 care in labour remains at 100%.

Training –

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

NHS Medway NHS Foundation Trust

PROMPT Training		
Staff Group	Current Compliance (May 2025)	CNST Compliance Trajectory
Consultants	80.00%	100.00%
Residents	65.00%	90.00%
Midwives	84.17%	97.97%
MSWs	75.38%	97.40%
Anaesthetic Consultants	65.08%	77.78%
Theatre staff	58.33%	91.67%

Neonatal Basic Life Support Training		
Staff Group	Current Compliance – May 2025	CNST Trajectory
Neonatal Residents	100%	100%
Neonatal Consultants and SAS	92.86%	100%
ANNP	100%	67%
Neonatal Nurses	95%	95%
Midwives	83%	95%
MSWS	80%	90%

Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	**100.00%**	**92.31%**	**93.60%**
CNST Trajectory	**100.00%**	**48.00%**	**97.12%**

Key Messages:

Working to achieve >90% compliance for all staff groups including new starters for all required training
- PROMPT
- CTG
- NBLS

- All neonatal medical staff are trained to the minimum required NLS training The British Association of Perinatal Medicine Neonatal Airway Safety Standard. As a level 3 until, this is covered in doctors induction, therefore currently 100% compliant with this requirement.
- >85% compliance achieved across all staff groups for Safeguarding Adults Level 3 training.

Issues, Concerns, Gaps:

- Anaesthetic staff need to be mapped.
- Resident obstetric doctors currently below trajectory for fetal monitoring training due to rotation in October 2025.
- Moving and handling training L2 significantly below the Trust target.

Actions & Improvements:

- Managerial oversight of all training spreadsheets and trajectories to reduce risk of cancellations impacting compliance close to submission.
- Continue to work with service managers to ensure all staff are allocated to training and appropriate study leave/cover is arranged for medical staff.
- Neonatal team to have ensured advanced NLS course training dates are accessible centrally.
- PROMPT to be added to ESR to support compliance/oversight.
- Work with anaesthetic lead and service manager to ensure all eligible anaesthetic staff are booked in ahead of deadline.
- All rotating resident doctors to be booked onto Fetal monitoring training in October and November 2025.
- Midwifery-led moving and handling training included in pick'n'mix training to improve compliance with annual training.
- Work with ward managers and medical leads to identify issues with attending 2/3 yearly Moving and handling training and consider opportunities for this to be brought in house/included on induction.

Training –

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

ALL TRAINING REQUIREMENTS

STATUTORY SUBJECTS	Compliance		Compliance (%)	
	Yes	No	Yes	No
ABLS L2	286	54	84.12%	15.88%
Conflict Resolution	310	15	95.38%	4.62%
Equality, Diversity & Human Rights	331	15	95.66%	4.34%
Fire Safety	301	45	86.99%	13.01%
Health, Safety & Welfare	320	26	92.49%	7.51%
Infection Prevention L2	314	27	92.08%	7.92%
Information Governance	325	21	93.93%	6.07%
MCA	289	51	85.00%	15.00%
Moving & Handling L1	340	6	98.27%	1.73%
Moving & Handling L2 (2yr)	194	88	68.79%	31.21%
Moving & Handling L2 (3yr)	28	27	50.91%	49.09%
Safeguarding Adults L3	227	31	87.98%	12.02%
Safeguarding Children L3	240	48	83.33%	16.67%

MANDATORY SUBJECTS	Compliance		Compliance (%)	
	Yes	No	Yes	No
Anaphylaxis	257	9	96.62%	3.38%
Blood, Prescription, Admin & Sampling	156	23	87.15%	12.85%
Blood, Prescription, Admin & Sampling - Medical Staff	29	0	100.00%	0.00%
Cultural Competence	213	40	84.19%	15.81%
Freedom to Speak Up (All)	340	6	98.27%	1.73%
Freedom to Speak Up (Managers)	3	0	100.00%	0.00%
Insulin Safety	240	25	90.57%	9.43%
Local Induction	321	25	92.77%	7.23%
Maternal Smoking	311	28	91.74%	8.26%
NEWS2	197	33	85.65%	14.35%
Patient Safety L1	334	12	96.53%	3.47%
Prevent WRAP	312	25	92.58%	7.42%
Reducing Antimicrobial Resistance	53	3	94.64%	5.36%
Sepsis	278	35	88.82%	11.18%
The Oliver McGowan Mandatory Training P1	328	18	94.80%	5.20%
Understanding sexual misconduct in the workplace	315	31	91.04%	8.96%

Next Steps:

- Continue to support staff development through apprenticeship schemes and RN to RM courses.
- Continue to monitor red flags and supernumerary and 1:1 care in labour.
- Continue to engage with LMNS workforce groups.
- Continue to seek staff feedback and provide staff with regular updates on outcomes following actions.
- Request Board support for formal Birthrate+ establishment review in 2026 (3 yearly requirement), PID to be completed.
- Develop 25/26 workforce action plan following NHSE Insight visit in September 2025.
- Share report with Trust Board and LMNS in compliance with CNST Year 7 requirements.

NHS
Medway
NHS Foundation Trust

Infection Prevention & Control Annual Report 2024/25

Michelle Clarke
IPC Matron (Acting)

Mona Keren
IPC Clinical Nurse Specialist (Acting)

Elizabeth Salisu
IPC Nurse

Deborah Esan
IPC Nurse

Best of care
Best of people

Contents

Tables and figures

Glossary

Glossary Term	Meaning
ADIPC	Associate Director of IPC
AMS/AMR	Antimicrobial Stewardship/Resistance
AMSG	Antimicrobial Stewardship Group
BAF	Board Assurance Framework
CPE	Carbapenemase Resistant Enterobacteriaceae
DIPC	Director of IPC
DDoN	Divisional Director of Nursing
FFT	Friends and Family Test
GNBSI's	Gram negative bacteraemia Infections
Gthr	Trust audit tool
HoIPC	Head of IPC
HoN	Head of Nursing
HR	High Risk
ICB	Integrated Care Board
IPCT	Infection Prevention and Control Team
IPC	Infection Prevention and Control
PII	Period of increased incidence
POCC	Peri-op and Critical care
PIR	Post Infection Review
PPE	Personal Protective Equipment
QIP	Quality Improvement Plan
RSV	Respiratory Syncytial Virus
SSIS	Surgical Site Infection Surveillance
SMART	Surgical, Medical and Acute Response Team
UKHSA	United Kingdom Health Security Agency
VHR	Very High Risk

1 DIRECTOR OF IPC INTRODUCTION

1.1 This annual report covers a summary record of all activities relating to practices in Infection Prevention and Control (IPC) at Medway NHS Foundation Trust during the period April 2024 – March 2025.

1.2 As Chief Nursing Officer and the Director of Infection Prevention and Control, it is a privilege and a proud moment to present Medway NHS Foundation Trust's Annual Infection Prevention and Control Report. The last year has continued to build on previous years improvements:

- Staff across the Trust work closely with the IPC Team to ensure that during the busy winter period IPC standards are consistently maintained to ensure patient safety and experience with clear processes for infection management embedded.
- Embedding PSIRF methodology within reviews of all Hospital Acquired Infections using learning to develop first IPC Quality Improvement Plan
- Continued development of simulation training to support wards that have hospital acquired infections and implementing intensive support for wards on Periods of Increased Incidence
- Working with the EPR team to add the Diarrhoea Assessment Tool as part of stool documentation on EPR to ensure patients are being sampled appropriately
- The second annual link practitioner showcase.
- Created an IPC condensed audit on Gthr.

1.3 The report shows how the Trust continues to make improvements around IPC, and that it is still high on our agenda. Our challenges this year have been not meeting our targets around Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. diff) for the 3rd year. This continues to reflect the national picture and the IPC team have been an integral part of the Kent and Medway System Collaborative identifying actions to reduce these infections in 2025/26. We continue to work hard to make sure we reduce infections which is a key part of keeping our patients safe and ensuring they have a positive experience while in our care.

Kind regards

Sarah

Sarah Vaux
Interim Chief Nursing Officer and Director of Infection Prevention and Control (IPC)
Medway NHS Foundation Trust

2 BACKGROUND

2.1 The code of practice for the prevention of infections, 2015 uses 10 criterion (Figure 1) by which a registered provider will be monitored and judged on how it complies with the registration requirements placed upon them for cleanliness and infection control within an organisation.

2.2 The code stipulates the importance of the Director of Infection Prevention and Control (DIPC) to regularly report to the board of directors. This includes the formation of an annual written report summarising the work undertaken by the Infection Prevention and Control Team (IPCT) over the year, reports on key Infection Prevention and Control (IPC) issues and progress around the Trust's annual IPC work programme.

2.3 The IPCT's annual work programme for 2024-25 was based on Health and Social Care Act 2008: *Code of Practice on the prevention and control of infections and related guidance* and would cover complete remit of the IPCT in controlling and managing infections throughout the Trust.

2.4 There was continued work on the IPC Board Assurance Framework (BAF) from the last financial year which was then reviewed in May 2024 following an updated version being published.

Figure 1: Compliance Criterion of The Code of Practice on the prevention and control of infections and related guidance

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

3 THE IPC TEAM AND STRUCTURE

3.1 Delivery of Infection Prevention and Control sits within all departments and clinical services since it is fundamental to patient care. To enable this delivery, the Trust has an organisational structure which oversees required actions. These are outlined in the Trust Governance structure (Figure 2) and the IPC team reporting structure (Figure 3).

Figure 2: Trust Governance Structure

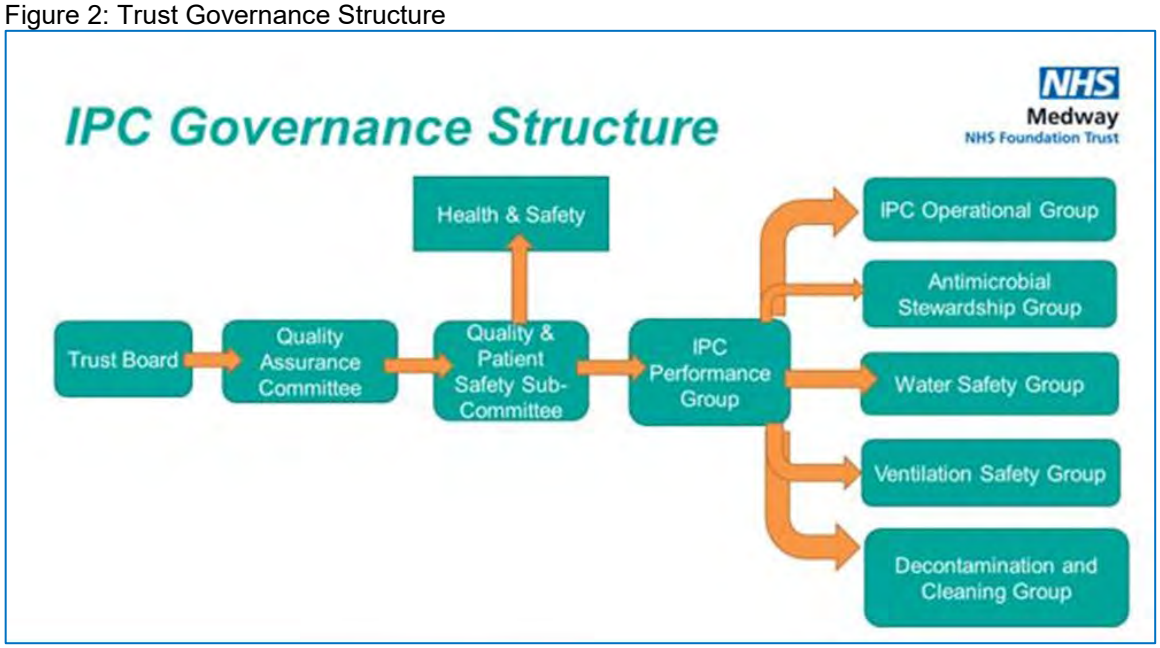
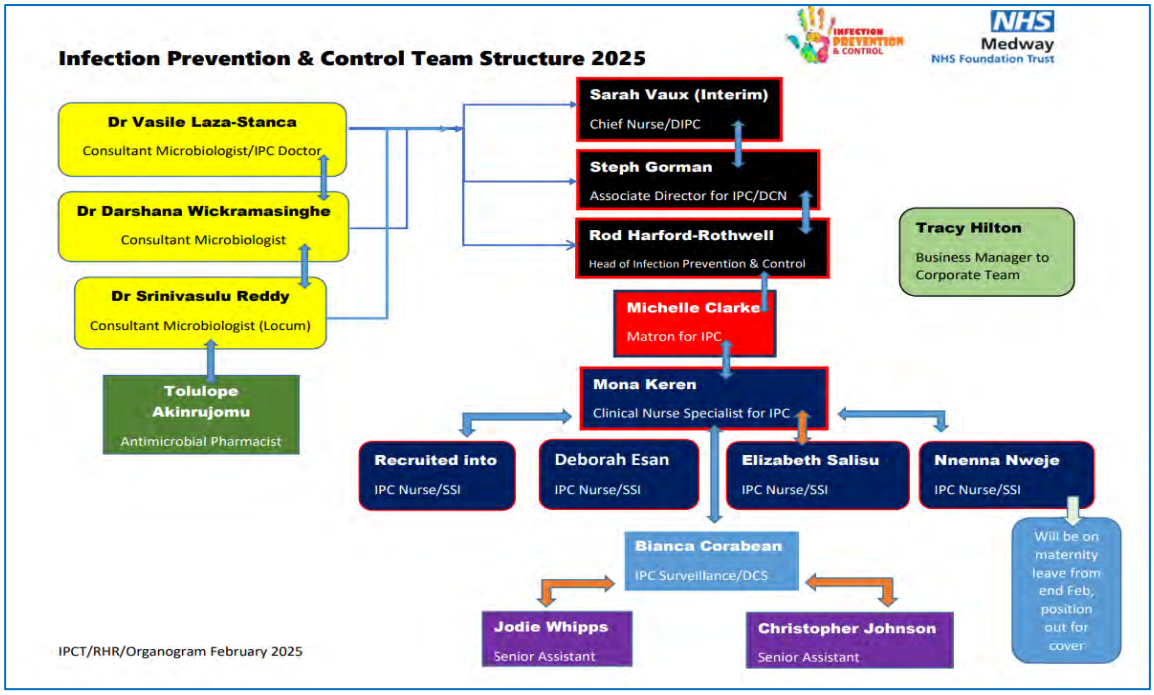


Figure 3 - The IPC team Structure



3.2 The team had been fully recruited into in early 2022-23 but following some internal promotions within the Trust opportunities presented for members of the team to act into more senior roles.

3.3 With the promotion of the ADIPC to act as the Deputy Chief Nursing Officer in a dual role capacity this created opportunities for some internal secondment placements. Firstly the previous Matron became the Head of Service, the IPC CNS to Matron, then IPC Nurse to IPC CNS, with the IPC Nurse vacancy being filled by an internal Trust seconded position.

3.4 IPC Team continued to expand and develop their knowledge base by attending the courses listed below during 2024/25 (Figure 4).

Figure 4 – IPC Team Continuous Professional Development

Role	Course	Completion date
IPC Clinical Nurse Specialist	Mary Seacole Programme	May 2025
IPC Nurse	RCN Infection Prevention & Control Programme	July 2024
IPC Nurse	RCN Infection Prevention & Control Programme	October 2024
IPC Nurse	UKHSA Surgical Site Surveillance	June 2024
IPC Nurse	UKHSA Surgical Site Surveillance	September 2024

IPC Surveillance Nurse	UKHSA Surgical Site Surveillance	December 2024
IPC Surveillance Nurse	DipHE Infection Control	February 2025
IPC Nurses	IPS Conference – Liverpool	September 2024
IPC Senior CSW	Trainee Nursing Associate	Due to complete August 2025

3.5 The IPC Strategic Assurance Group (IPCSAG) name changed to become the IPC Programme Group (IPCPG) and continues to meet monthly with a slightly altered structure to reflect alternative reporting of full report or data reporting only. The change does not affect how it reports to the Quality and Patient Safety Sub-Committee (QPSSC) chaired by the Chief Nursing Officer and the Chief Medical Officer. This then is reported to the Trust's Quality Assurance Committee (QAC).

3.6 With the divisional restructure to create 4 divisions the IPC team is no longer split into 2 teams to cater for the Planned and Unplanned divisions. The IPC Matron and IPC Clinical Nurse Specialist continue to represent and report at Divisional Governance meetings for divisions split between them.

3.7 Clinical audit of the care environment is a good indication of quality, and all IPC audits are uploaded to the live data system Gthr. The data system is used by the Trust to capture and highlight good practice and where improvements are needed to help plan and guide additional resource. All wards have access to all their audit information and reported on within their respective care groups and again at Trust level.

3.8 The IPC operational group (IPCOG) was developed from a need to have a better understanding of the issues facing ward leaders/|Matrons enabling them to understand their audit data better, identify themes and trends in an open forum, sharing best practice through peer support and helping to drive-up standards across the Trust to keep our patients safe whilst in our care. The IPCOG, although paused for a few months, in order to review and ensure that it was delivering what it set out to do, is always well attended and has proved a useful tool to engage staff. This group reports bi-monthly to the IPCPG.

3.9 The Antimicrobial Stewardship Group (AMSG) is chaired by a medical consultant and supported by a consultant microbiologist, the IPCT are frequent attenders and participants at these meetings but attendance not been consistent by divisional members. A bi-monthly antimicrobial report is presented at IPCPG.

3.10 The decontamination group is chaired by the Head of IPC following successful completion of a City and Guilds Decontamination Leads course at Eastwood Park training centre. The Approved Engineer for Decontamination (AED) conducts annual audits on site offering assurance. The decontamination group was

changed to reflect the incorporation of the cleaning group following implementation of the National Cleaning Standards of Healthcare Cleanliness and reports to the IPCPG.

3.11 Following the relaunch of the water safety group a renewed focus on establishing all water safety requirements across the Trust and better reporting of issues has occurred. The appointment of an Approved Engineer for Water (AEW) has strengthened this group and reports back to the IPCPG and the Health and Safety and Security Group (HSSG) and up to board level.

3.12 The relaunch of the Ventilation group has occurred following the need to re-look at the Trust's estate to ensure that current ventilation systems are adequate or where improvements can be made. Where no mechanical ventilation systems are in place the procurement of suitable air-flow systems can be discussed and effectively planned for. This group reports to the IPCPG and the HSSG.

4 BOARD ASSURANCE FRAMEWORK

4.1 The Board Assurance Framework template was produced in June 2020 by NHSE/I to all NHS providers to help aid compliance with the Health and Social Care Act 2008, *Code of Practice* and compliance with the then national COVID-19 strategies, policies and guidelines.

4.2 Following several NHSE & Clinical Commissioning Group (CCG) now Integrated Care Board (ICB) visits in 2020/21 the DIPC had initiated and led on a collaborative discussion to combine the previous 4 previous improvement plans into one single plan aligning it to the BAF.

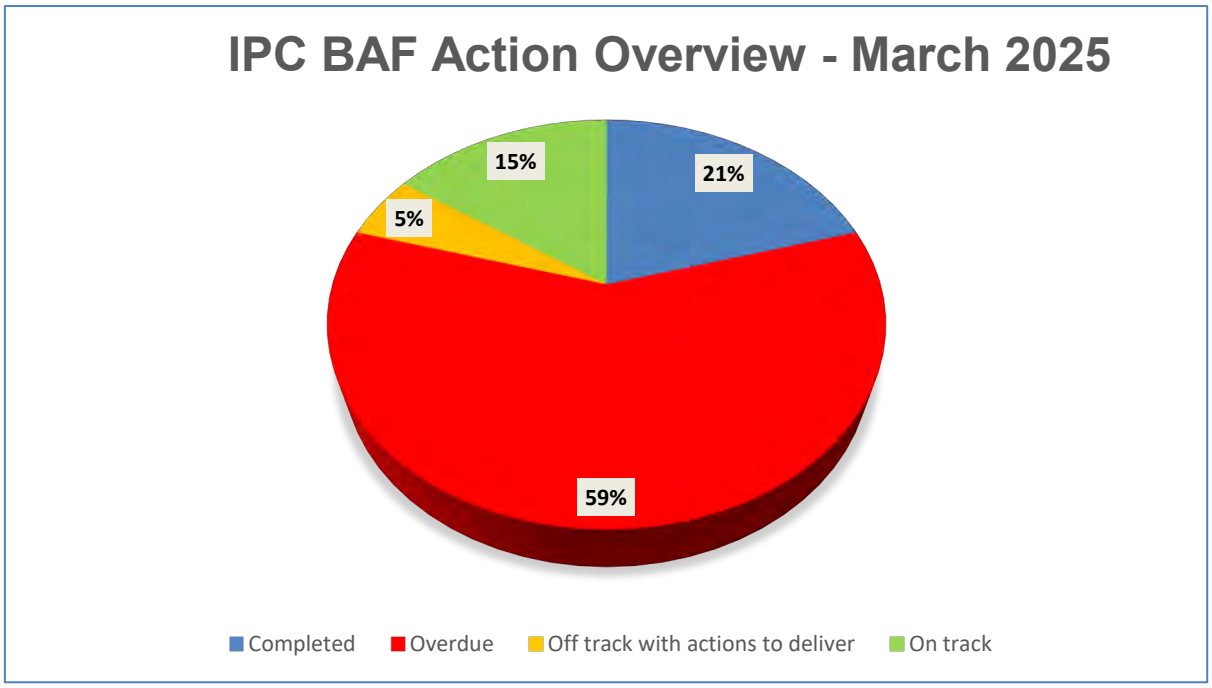
4.3 Originally 216 actions were identified within the Trust's 2021 IPC BAF improvement plan. This reduced to 145 actions by September 2023 and an action plan developed.

4.4 The board assurance framework (BAF) action plan has reported bi-monthly and enabled an update on the number of actions closed within month, the number of actions on track for delivery, the number that are off track and then those that are overdue awaiting completion.

4.5 The latest version of the BAF (May 2024) is our last as it becomes amalgamated into the Trust's Quality Improvement Plan (QIP).

4.6 The remaining actions will be closed down and transferred to the corresponding IPC related meeting action logs or the IPC QIP. On closing down the BAF, Figure 5 shows the status of the actions that are Completed, On Track, Off Track, and Overdue.

Figure 5: Overview of BAF actions.



5 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)- A NEW APPROACH TO RESPONDING TO PATIENT SAFETY INCIDENTS.

5.1 The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

5.2 The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

5.3 Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and removes the 'Serious Incidents' classification and the threshold for it. Instead, it recognises that things do not always go to plan and supports a patient safety culture by focusing on understanding how incidents happen, including the impact of systems and human factors which contribute to them, rather than attributing blame or liability to a person.

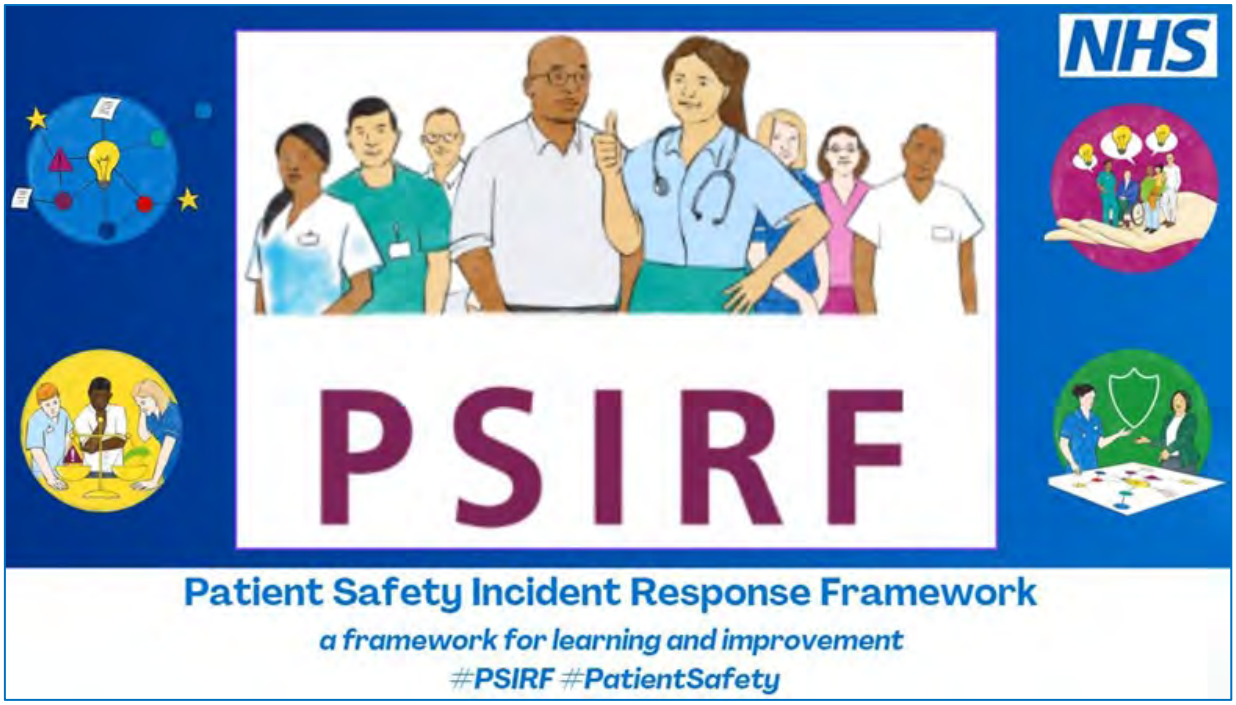
5.4 This allows for more effective learning, and improvement, and ultimately safer care for patients. PSRIF also ensures greater involvement, support, and compassion for patients, families and staff involved in, and affected by, patient safety incidents.

5.5 Although there will be fewer formal investigations of incidents, colleagues are more likely to be involved in a learning response so they can learn from incidents and improve patient safety in their area of work.

5.6 PSIRF promotes the use of various learning response approaches instead of formal investigations:

- Local investigation: Involves collecting accounts of those involved and identifying improvements.
- SWARM: A facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

- After Action Review (AAR): A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event an understanding of why the outcome differed from that expected, and generates learning to assist improvement. It focuses on four key questions with everyone involved given an equal ability to contribute.
- Patient Safety Incident Investigation (PSII): An in-depth investigation that could take up to six months to complete. They will be targeted at areas of known concern in the organisation where contributory factors to an incident are not fully understood. Those leading patient safety investigations will be offered training by the Patient Safety Team.
- Some other types of review may occur such as thematic reviews for groups of cases, and a Structured Judgement Review (SJR) for deaths.



5.7 Integration into IPC: The IPCT has adopted the PSIRF methodology within its QIP. A move away from traditional Root Cause Analyses (RCA) allows for a more holistic systems-based approach. All actions arising from PSIRF-aligned reviews initiated from June 2024 onwards are systematically recorded and monitored within the QIP.

6 METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

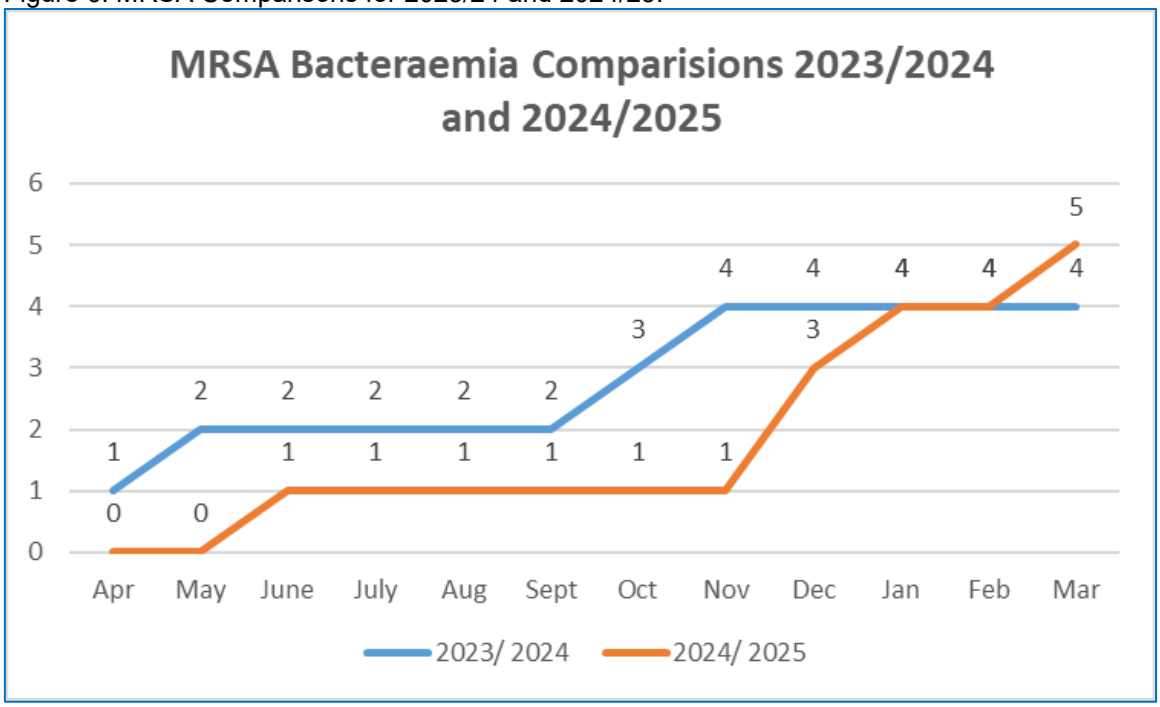
6.1 Since April 2018, cases of MRSA bacteraemia have been reported based on the timing of infection onset in relation to hospital admission. These cases are classified and recorded by the UK Health and Safety Agency (UKHSA) through

the Healthcare- Associated Infection (HCAI) Data Capture System (DCS) as follows:

- hospital-apportioned where the infection onset is >2 days after admission
- Community-apportioned where the infection onset / blood culture collection is < 2 days after admission

6.2 In 2024/2025 reporting period, the Trust reported 2 cases of HOHA and 3 cases of COHA MRSA bacteraemia against a national zero tolerance policy for such infections. This represents an increase from the 4 total cases reported in the previous year (2023/2024) as seen in Figure 6.

Figure 6: MRSA Comparisons for 2023/24 and 2024/25.



6.3 AARs were conducted to investigate the acquisition of MRSA bacteraemia cases. Of the 2 HOHA cases reported in December 2024, one was linked to lower UTI. The second case had an unidentified source as patient presented with multiple wounds, was wearing a neck brace, and there were concerns regarding the efficacy of decolonisation due to complexity of the case.

6.4 AAR was undertaken for 3 COHAs reported in June, January and March, the cases were linked to upper and lower UTIs, while the third had an unidentified source. Although a direct cause of bacteraemia could not be established in that case, inadequate documentation regarding cannula and catheter care raised concerns about compliance with best practice.

6.5 MRSA acquisitions, where MRSA is detected in patients on admission or through weekly screening, is recorded and overseen by the IPC team. Admission screening is usually swabbing of the nose and groin but should also include any wounds, cannula sites that look infected and pressure sores. A urine sample should also be obtained from a catheter if also identified at time of admission.

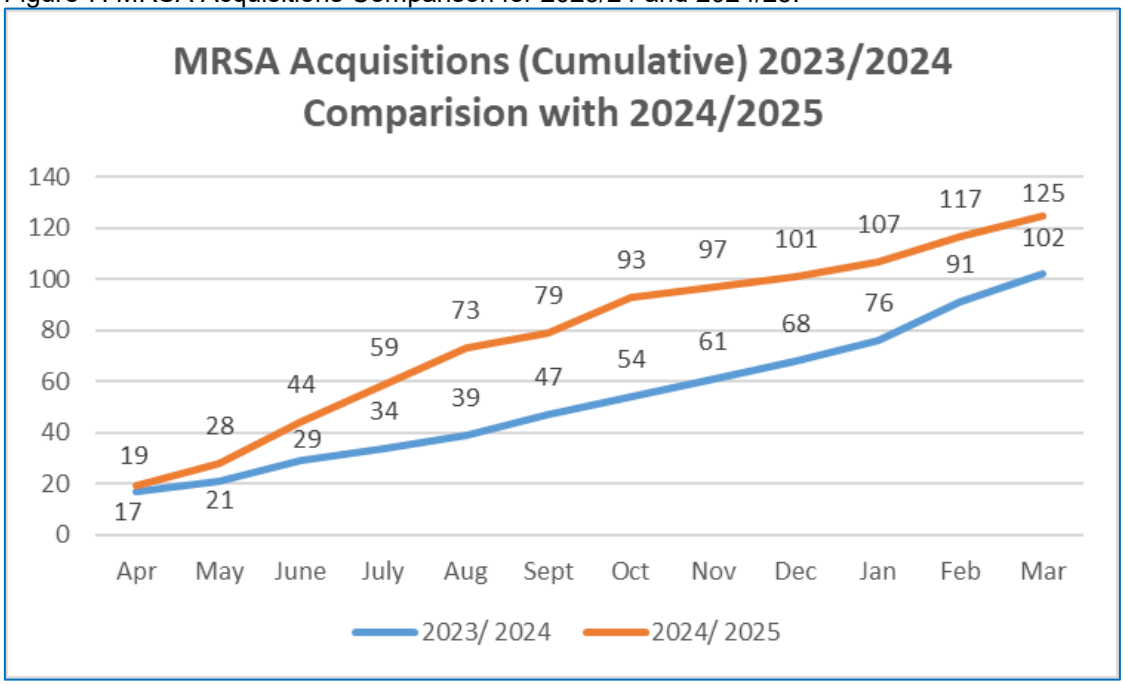
6.6 There is no national reporting process regarding the acquisition of MRSA within the clinical areas therefore there is no national threshold set by NHSE.

6.7 MRSA acquisition equates to a near miss scenario for MRSA bacteraemia as acquisition increases the risk of developing a bacteraemia through poor hand hygiene compliance at the point of care (especially when managing invasive devices), incorrect use of Personal Protective Equipment (PPE) and cleanliness of equipment and the environment.

6.8 The Trust has not set any objectives for the reduction of MRSA acquisitions for 2024/25, but the IPC Team continue to monitor acquisition numbers and ward locations throughout the year and has a set target outlined in the QIP.

6.9 The number of Hospital MRSA acquisitions has been collated across the year as cumulative in the graph below (Figure 7).

Figure 7: MRSA Acquisitions Comparison for 2023/24 and 2024/25.



6.10 The data collected in 2024/25 will be reviewed in the upcoming year to identify potential reductions in MRSA bacteraemia acquisition, and to determine areas where increase in acquisition have been seen, prompting remedial action.

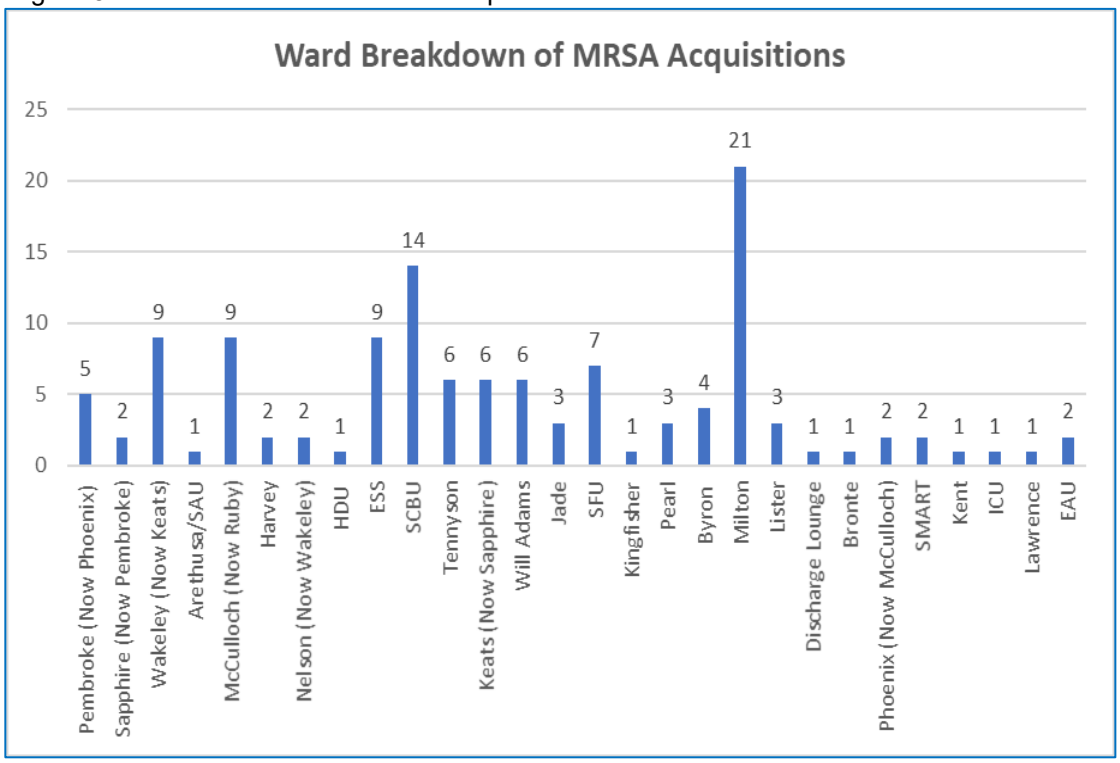
6.11 Any ward reporting three or more cases within a rolling 28-day period will be placed under a Period of Increased Incidence (PII), provided there is evidence of cross-contamination. Under a PII, the clinical area is placed on enhanced

monitoring, including focused audits, weekly visits by the Infection Prevention and Control team, and simulation-based training sessions. A targeted action plan is also developed to support the ward or department in achieving full IPC compliance.

6.12 The graph above illustrates an increase in MRSA acquisitions, rising to 125 cases in 2024/2025, which exceeds the 102 cases recorded in 2023/2024. Most detections were made through routine nose and groin screening, while the remaining cases were identified from wound swabs, sputum, endotracheal tube secretions, line swabs, conjunctival samples, and serous fluid collections.

6.13 The data collected has also enabled a comprehensive review and monitoring of acquisition locations, with further analysis to determine the percentages by Division and by individual care group.

Figure 8: Ward Breakdown of MRSA Acquisitions.



6.14 The graph above (Figure 8) shows the distribution of MRSA acquisitions by ward during the 2024/25 period. The highest number of acquisitions occurred on Milton Ward between July and October, during which an outbreak was declared. Key findings from the outbreak review included:

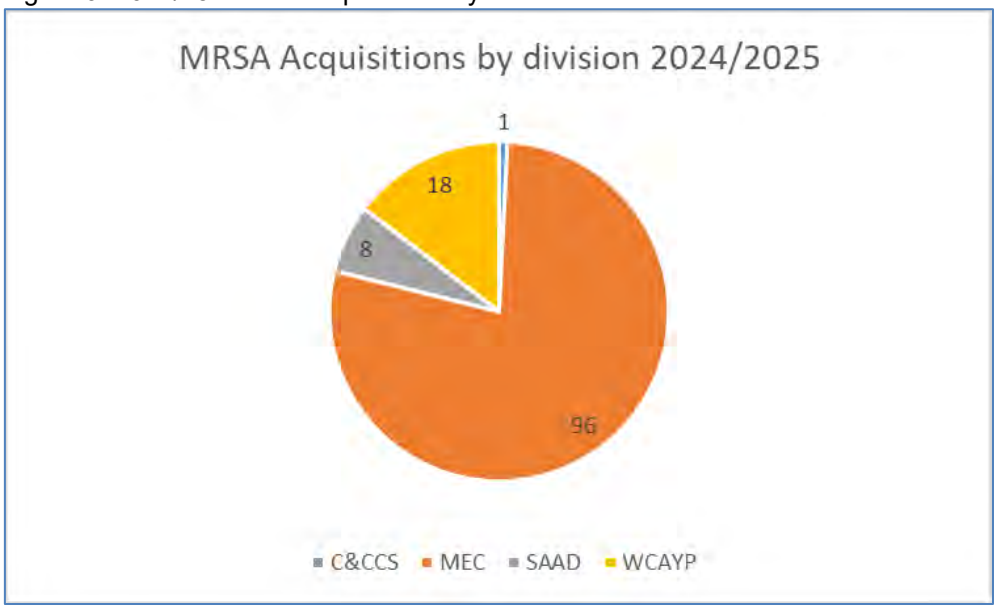
- A delay in laboratory reporting of results (exceeding 48 hours), which was subsequently added to the risk register.

- Changes to the enhanced cleaning process, which the IPC Team had not been made aware of.

- Environmental issues, including clutter and insufficient storage space, contributing to IPC non-compliance.
- Gaps in the IPC internal reporting process, highlighting areas for improvement in communication and escalation.

6.15 Figure 9 shows the percentage of acquisitions by divisions across the Trust.

Figure 9: 2024/25 MRSA Acquisitions by Divisions.



6.16 The highest number of MRSA acquisitions occurred within the Medicine and Emergency Division (MEC), reflecting the complex nature of the services provided within this group. Milton Ward and the frailty bed base recorded the highest acquisition rates, with many patients identified through weekly screening and lacking clear criteria to reside. The IPC team will continue to monitor these areas closely throughout the forthcoming year to support ongoing improvement in MRSA screening compliance. Results are reviewed and discussed monthly at both the IPCOG and the IPC PG meetings to inform ongoing monitoring and improvement efforts.

6.17 Below (Figure 10) shows the MRSA screening audit compliance for each Division, compared to Trust wide.

Figure 10: 2024/25 MRSA Screening Divisional Breakdown.

Cancer and core clinical services (C&CCS)											
Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
46	57	53	No data	77	96	81	No data	77	65	57	33
Medicine and Emergency Care (MEC)											
Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
93	90	85	90	84	90	92	90	89	93	87	86
Surgery and Anaesthetics (SAA)											
Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
90	85	89	89	84	94	92	80	93	85	89	86
Women, Children and Young People (WYCP)											
Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
51	13	49	100	60	No data	22	86	100	No data	93	91
Overall Trust Compliance Scores											
Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
88	87	84	90	83	93	89	87	90	90	87	87

6.18 Throughout the year, this 90% MRSA screening compliance target was not consistently achieved. The MEC division demonstrated relatively stable compliance, while the CCCS Division only met the target in September. There is a review of the questions for WCYP division as they are non-compliant on questions about documentation and there is an action plan for CCCS to ensure completion of screening audit. The divisions continue to report to IPCPG with an update on their data. The IPC Operational Group continue to review the main issues for non-compliance around swabbing of wounds and IV devices.

6.19 To address these gaps, the IPC Team will provide ongoing education and support across clinical areas, with assistance from IPC link practitioners.

7 METHICILLIN SENSITIVE STAPHYLOCOCCUS AUREUS (MSSA)

7.1 There is no national threshold for MSSA bacteraemia.

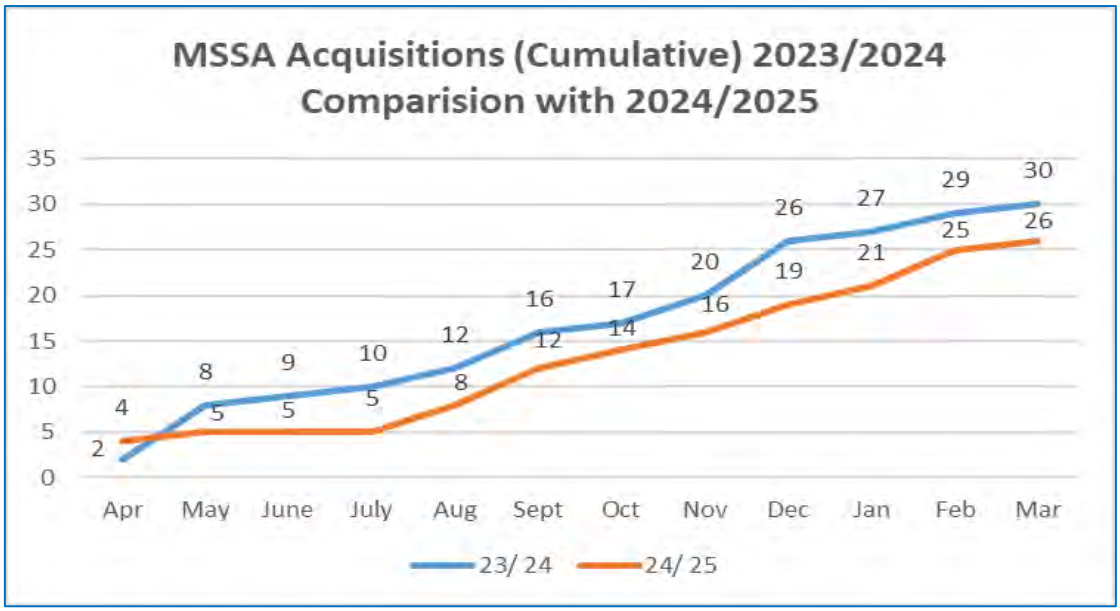
7.2 In 2024/25 the Trust reported 26 cases during this operational year. This was a decrease of 9 cases on the previous year's total of 35. The percentage of reduction is 26% in comparison to the previous financial year.

7.3 Figures 11 and 12 show a comparison of MSSA infections for 2023/24 and 2024/25.

Figure 11: 2023/24 and 2024/25 MSSA infection comparison.

Year	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
23/24	2	8	9	10	12	16	17	20	26	27	29	30
24/25	4	5	5	5	8	12	14	16	19	21	25	26

Figure 12: 2023/24 and 2024/25 MSSA infection comparison.



7.4 A new review process for Gram Negative Blood Stream Infections (GNBSI's) including MSSA was implemented in November 2023 and has been in place since introduced and this includes MSSA. This process involves a rapid case review to identify common themes, contributory factors, and key learning points.

7.5 As the Trust now holds a full year's worth of data, the process is currently under review to assess how it can be made more effective and beneficial. This includes determining how best to utilise the data collected to drive improvement. As a result, new key objectives have been incorporated into the IPC Quality Improvement Plan.

7.6 The IPC team expanded the Period of Increased Incidence (PII) criteria to include any ward with two GNBSI acquisitions from the same source, or three acquisitions from different sources, including MSSA cases. When these thresholds are met, the ward is provided with intensive support, including targeted simulation-based training focused on addressing the key themes and emerging trends identified through case reviews.

8 *CLOSTRIDIOIDES (CLOSTRIDIUM) DIFFICILE*

8.1 *Clostridoides difficile* infection (CDI) is classified under 4 headings.

- **Hospital onset / healthcare associated (HOHA):** onset > 48 hours of admission (>2 days). These cases are Trust-apportioned
- **Community onset / healthcare associated (COHA)**: cases that occur in the community (or within 2 days of admission) but have been an in-patient in the previous 4 weeks. These cases are Trust-apportioned.
- **Community onset / Indeterminate acquisition (COIA):** cases reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting

organisation within 83 days prior to the current specimen date (where date of discharge is day 1).

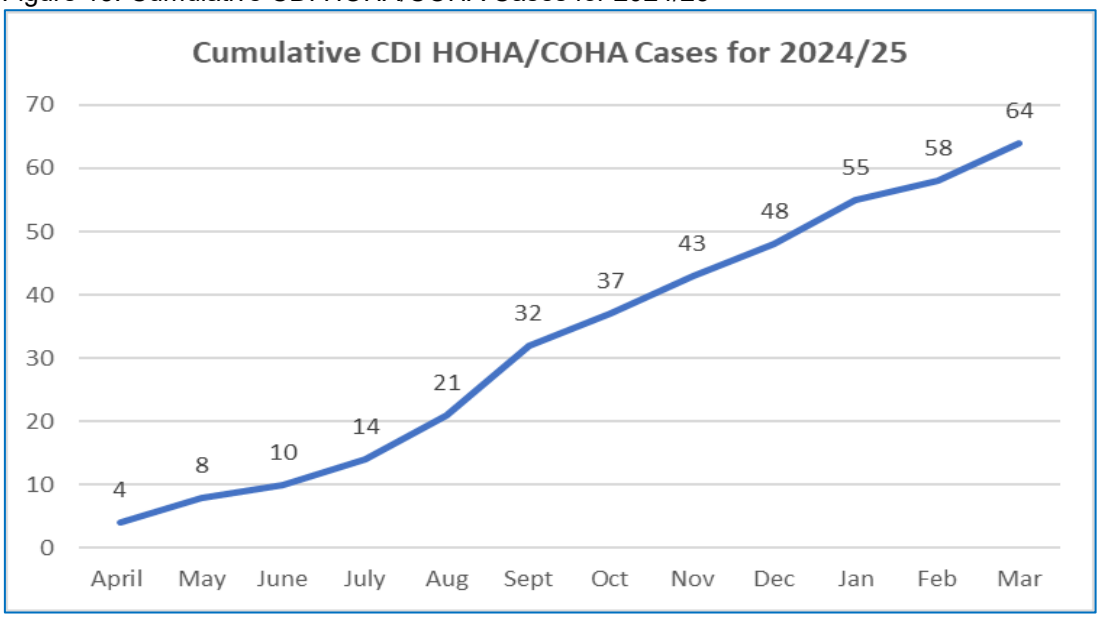
- **Community onset, community associated (COCA)**: cases that occur in the community (or within 2 days of admission) when the patient has not been an inpatient in hospital in the previous 12 weeks. These cases are apportioned to the Integrated Care Board (ICB) formally the CCG.

8.2 From 2021/22 Trust level thresholds include all healthcare associated cases (ie HOHA and COHA).

8.3 Nationally there has been a surge in hospital acquired infections with many acute Trusts nationally breaching their thresholds.

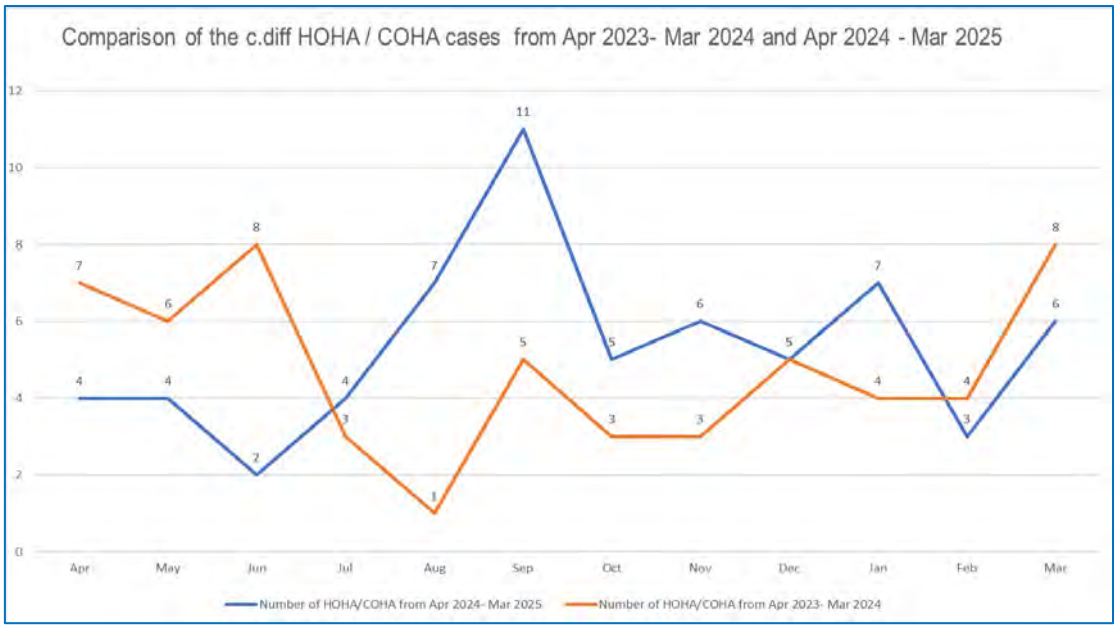
8.4 The Trusts threshold for 2024/25 was 53 cases with a breach of 11, ending the financial year with 64 cases. As seen in figure 13, the Trust breached the threshold in January 2025. The Trust saw a 21% breach on our threshold and a 34% increase on last year.

Figure 13: Cumulative CDI HOHA/COHA Cases for 2024/25



8.5 Comparing the cases from 2024/25 with 2023/24 (figure 14), there is no clear correlation with the time of year for cases.

Figure 14: 2023/24 and 2024/25 CDI case comparison.



8.6 A breakdown of the Wards (Figure 15), Care Groups (Figure 16) and Divisions (Figure 17) can be found below. Due to ward movements throughout the year, there may be discrepancies with the attributions of the cases, however the total number is accurate.

Figure 15: Ward breakdown of CDI cases for 2024/25.

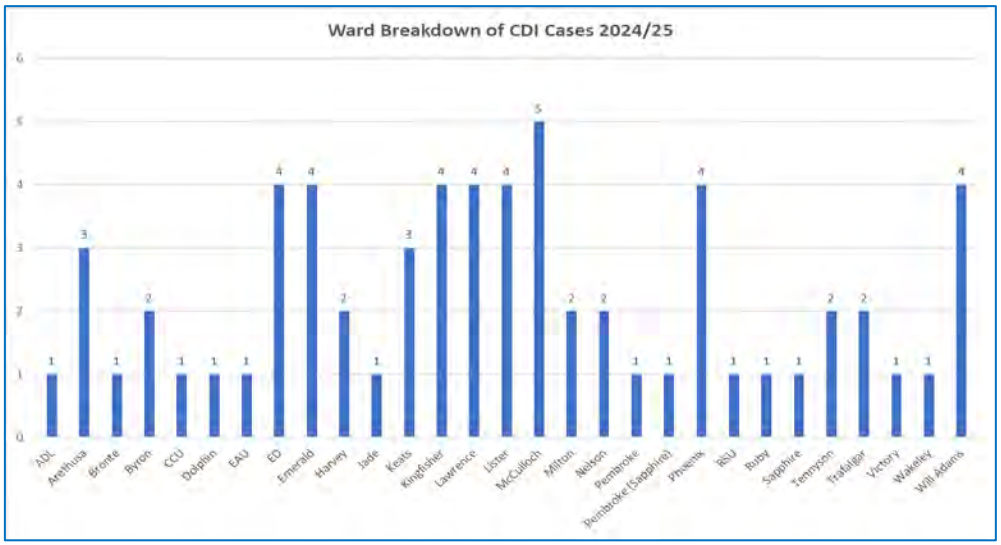


Figure 16: Care Group breakdown of CDI cases for 2024/25.

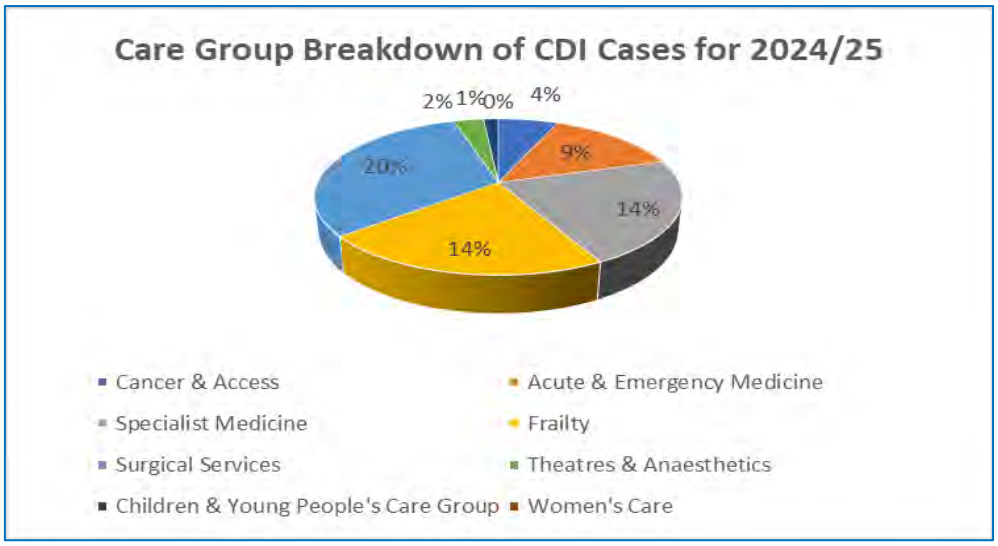
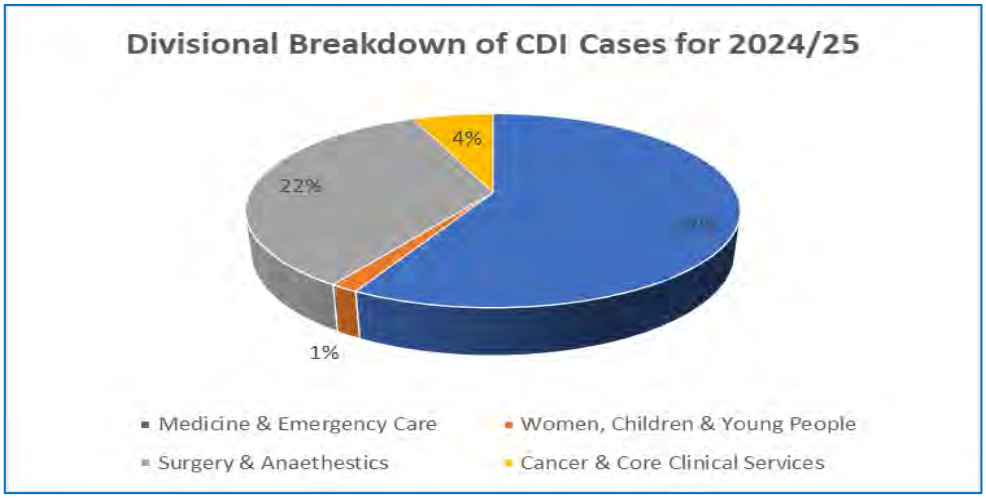


Figure 17: Divisional breakdown of CDI cases for 2024/25.



8.7 Mini Post Infection Reviews (PIR)/SWARMS were carried out for HAI cases throughout the year between the IPC team and Consultant Microbiologist.

8.8 For cases that needed further investigation or where major learning was found, a SWARM is completed. An invitation to attend the meeting goes to the ward manager, consultant overseeing the care, Microbiology Consultant, Matron, HoN, IPC team and ICB colleagues.

8.9 Following the completion of the investigations for 2024/25 only 1 of these cases was avoidable, which is a reduction on previous years. This was due to inappropriate sampling in ED. Of those determined HOHA 6 cases may have been community acquired if they had been sampled earlier. The remainder were unavoidable as these patients had complex medical or surgical issues with a need for antimicrobials or no sources found.

8.10 Although the cases were largely unavoidable, some lapses in care were established from case reviews, which did not impact their positive result, but will have led to discomfort, isolation and potentially extended lengths of stay. These have added to the actions within the IPC Quality Improvement Plan for 2025/26.

8.11 The most frequent lapses in care were to do with sampling, isolation, stool chart, treatment and antimicrobial duration or usage.

8.12 On review of the Stool Chart Documentation audit (Figure 18), it showed clear gaps in compliance for completing the documentation as seen in the data below for 2024/25.

Figure 18: 2024/25 Trustwide Stool Chart Documentation Audit.

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
66	61	66	74	69	79	76	72	80	79	83	74

8.12 Actions taken in the year to improve on the previous year's results are

- Working with AMSG to ensure antimicrobial stewardship remains a top priority for the organisation.
- Intense Support, for wards with the infection, where the IPC team go round to all patients with the nurse in charge and review associated documentation to ensure completion is compliant, which includes stool documentation.
- The addition of the Diarrhoea Assessment Tool into the stool chart on EPR to aid in assessing patients as to whether a stool sample is required.
- Continue to hold SWARMs to ensure learning is understood for any lapses of care and omissions led by ADIPC or IPC Matron.
- Monthly IPCOG Gthr & PIR learning discussion: led by HON & HoIPC.
- Continued roll out one standardised easy clean commode for inpatient areas.
- Commode cleaning competencies developed for all frontline staff
- *C.difficile* numbers & PIR outcomes to DIPC and DDoN's of new cases for oversight.
- Continued implementation of CDI ward rounds weekly with microbiologist and IPC team reviewing all cases of C.difficiles and new Glutamate dehydrogenase (GDH) positive result.
- Simulation training led by IPC team for wards on a Period of Increased Incidence.

8.13 The IPC team worked closely with system partners within Kent and Medway and are part of the CDI collaborative led by the ICB IPC team looking at actions from all Trusts to learn from each other. What was reassuring was that as a system we were reporting similar themes and trends and were doing many of the same initiatives.

8.14 MFT are currently working on the Green Card scheme to capture patients who are GDH +ve and therefore high-risk patients for a CDI, at the earliest opportunity and ensure that they receive the appropriate antibiotics where needed. In addition, we are looking at rapid enteric testing for the upcoming winter as a system.

9 GRAM NEGATIVE BACTERAEMIA INFECTIONS (GNBI'S)

9.1 *Escherichia coli (E. coli),* Klebsiella and Pseudomonas are all gram-negative bacteraemia and are now required to be reported nationally through the data capture system (DCS). All these organisms have a significant impact on the health of the patient and affect Kent and Medway Healthcare systems.

9.2 During 2024/25, the IPC team raised a Datix for all HCAI GNBSI, completed documentation of care regarding the case using a structured rapid review document. Following this, the case was reviewed with the Consultant Microbiologist and IPC nurses to find out the root cause, source of infection and common themes and trends (See Figure 19).

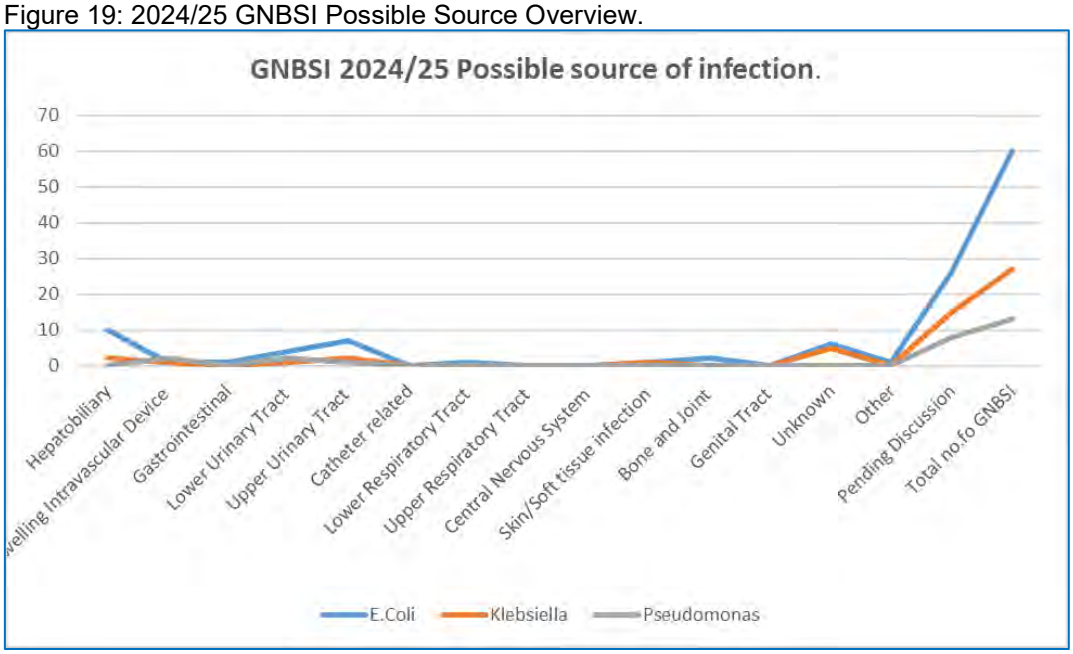
9.3 The completed document is attached to the Datix for the ward manager to review and action the identified learning for improvement.

9.4 In November 2024, the IPC team introduced a decision checklist for reviewing patients with HCAI GNBSIs. Using this document, the IPC nurses reviewed the patient with the Consultant Microbiologist, and decided if the case required a SWARM meeting involving the ward manager, managing consultant and the ward IPC link practitioner. Following this, the form is attached to the Datix for the final approval by the IPC CNS or Matron.

9.5 Any identified actions from the reviews were added to the IPC Quality Improvement Plan.

9.6 Figure 19 shows the identified possible source of infection for the HCAI GNBSIs in 2024/25. Although, half of this cases are yet to be discussed.

Figure 19: 2024/25 GNBSI Possible Source Overview.



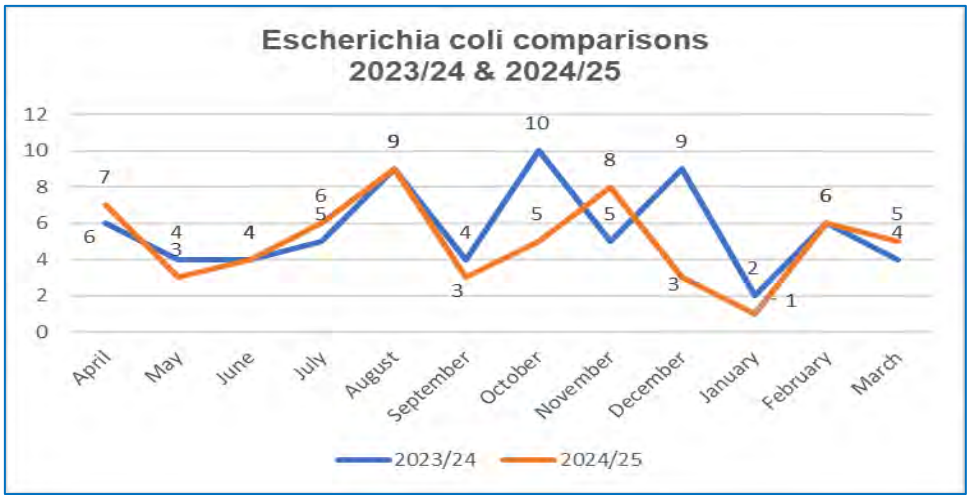
9.7 Of the 3 main GNBSI organisms only E. coli achieved a reduction on the previous year's total by 24.97%. Klebsiella increased by 5 cases and Pseudomonas by 2 cases. However, they are all within the allocated threshold for the year 2024/25.

9.8 *E. coli* – (figure 20) ended 2024/25 with 60 cases against a threshold of 88 resulting in a 31.82% reduction below the trajectory while 2023/24 ended 6.85% below the set trajectory of 73.

9.9 Although the two years remained within the set threshold, the percentage improvement in 2024/25 shows significant progress in reducing E. coli bacteraemia.

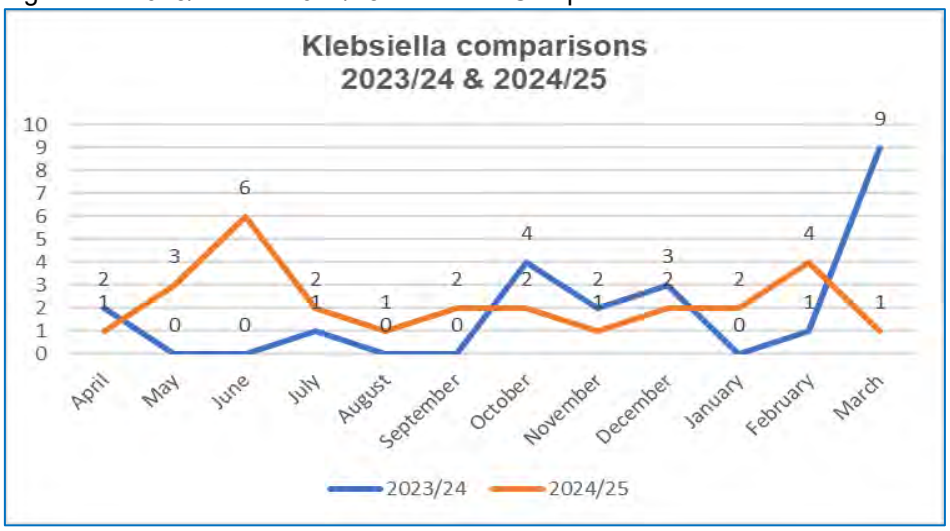
9.10 Medicine and Emergency division accounts for the 55% of these cases in 2024/25.

Figure 20: 2023/24 and 2024/25 Escherichia Coli Comparison data.



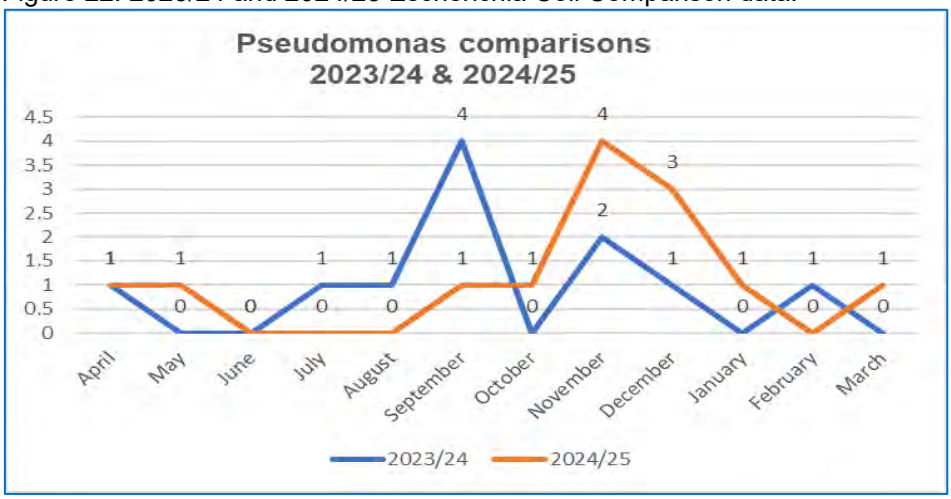
9.11 Klebsiella – (figure 21) there was a total of 27 cases in 2024/25 against a threshold of 27 which surpassed 2023/24 by 5 cases.

Figure 21: 2023/24 and 2024/25 Klebsiella Comparison data.



9.12 2024/25 data for Pseudomonas showed that we ended the year with 13 cases against a threshold of 15 cases which is 13.33% below trajectory while 2023/24 ended the year with 8.33% below trajectory having 11 cases against the threshold of 12. A comparison against the previous year can be found in Figure 22.

Figure 22: 2023/24 and 2024/25 Escherichia Coli Comparison data.



9.13 The Trusts IPC strategy aimed to reduction of Hospital Acquired Infections in year. The year 1 deliverable was to maintain the status quo which was partially achieved with a reduction in GNBSI's, but also looked to understand the lapses and the learning. The year 2 deliverable for 2024/25 was to reduce GNBSI's by 5%. This 5% reduction was achieved only in E. coli cases. However, the team will continue to utilise the Quality Improvement Plan and the ward teams to achieve reduction in the Trust GNBSI's cases further.

9.14 A new process for monitoring GNBSI's for 2024/25 was introduced mid financial year. The criteria set was if a ward had 2 or more cases within a 28-day period, they required an immediate review by the IPC nurses to ascertain the source of the bacteraemia, any delays and to ensure appropriate management.

9.15 Additionally, these cases will also trigger the ward to be placed on Period of Increased Incidence (PII).

10 RESPIRATORY INFECTIONS (COVID-19/INFLUENZA/RSV)

10.1 COVID-19 had presented a significant challenge to the delivery of health services and the Trust over the recent pandemic, but we have now returned to business as usual since the removal of all COVID restrictions.

10.2 Current epidemiology suggests that the virus although still circulating in the community is associated with less mortality and morbidity because of an increase immunity in the population following the mass vaccination programme and the development of therapeutic interventions.

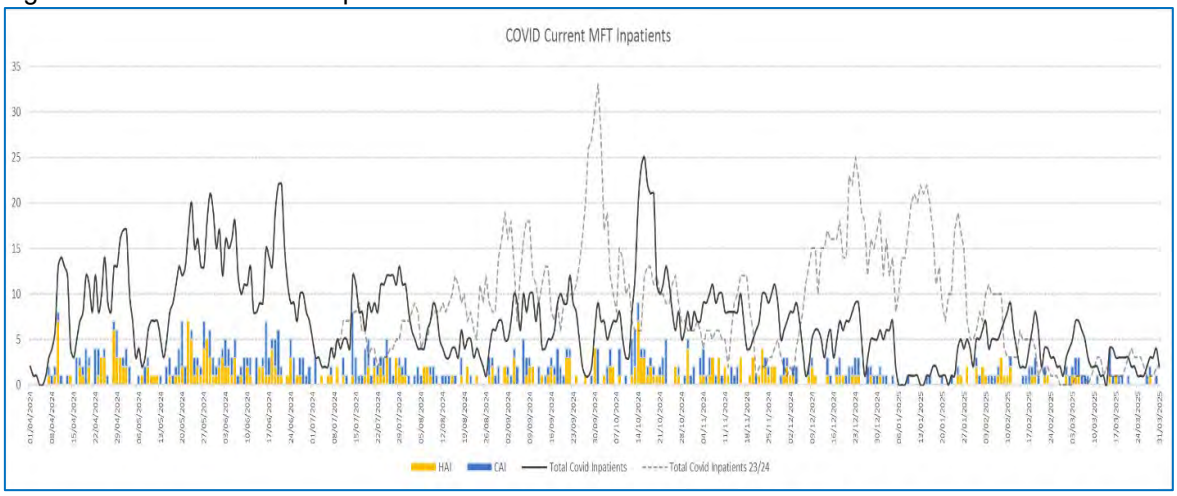
10.3 Although cases reduced considerably, the IPC team continued to review each COVID-19 case to determine if they are Trust attributed. in addition, any COVID-19 related deaths required an internal infection review. Determination of hospital acquired transmission was as below

Hospital Acquired Infection (HAI) - Patients swabbed for COVID-19 8 days from admission to the Trust. Other respiratory infections would be classed as post 48 hours from admission to the Trust.

Community Acquired Infection (CAI)- Patients swabbed within 7 days of admission to the Trust. Other respiratory infections would be classed as cases swabbed within 48 hours from admission to the Trust.

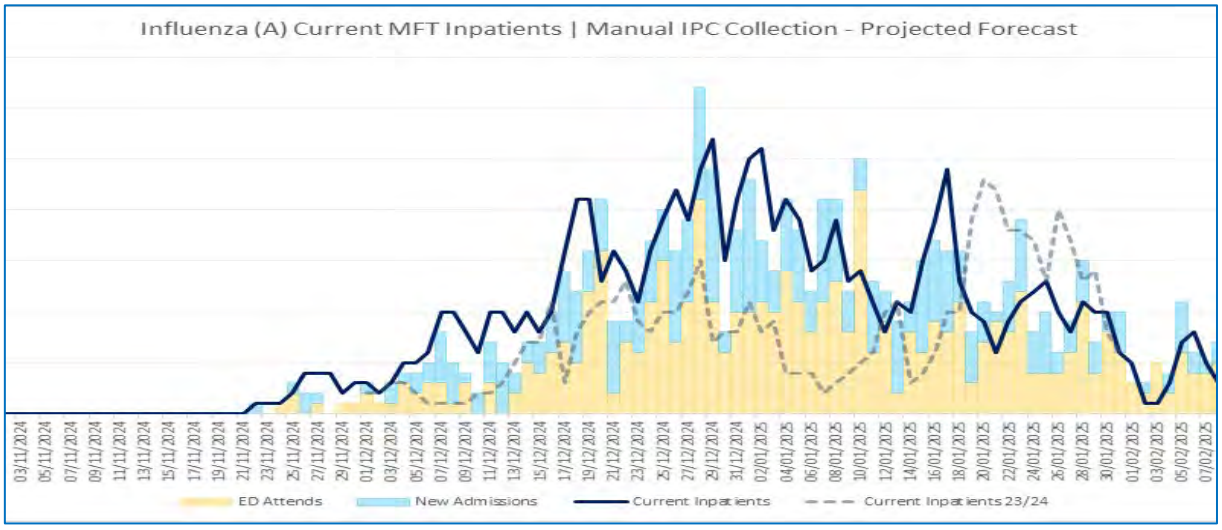
10.4 Figure 23 below shows the total number of COVID-19 cases per month and demonstrates peaks in April, May, June and October for positive results and a clear reduction in July 2024 and January 2025.

Figure 23: MFT COVID-19 inpatient cases for 2024/25.



10.5 An overview of Influenza A cases for Winter 2024/25 can be seen in figure 24. Cases appeared to spike in December 2024 and January 2025, which is in line with the flu season.

Figure 24: MFT Influenza inpatient cases for Winter 2024/25.



10.6 For Winter 2024/25 the Trust continued to use its established respiratory pathways for both paediatric and adult patients to ensure patient safety by correctly cohorting patients with respiratory symptoms and therefore reducing the risk of a nosocomial transmission and outbreaks.

10.7 The pathways are supported by the Rapid Testing Service who provided the Polymerase Chain Reaction (PCR) testing to identify four main respiratory infections, COVID-19, RSV (paediatrics), influenza A and influenza B, which means that swabs are tested on site for a faster turnaround.

10.8 The IPC team attend the daily morning site team call 7 days a week and report on any COVID-19, Influenza A, Influenza B and RSV cases. Additionally, highlighting any of these patients who have not already been isolated, and where potential side rooms are.

10.9 The data is also sent to the Business Intelligence team who collate the information and report externally as required.

10.10 A monthly overview of the respiratory figures is found below, with November to January being the months with the most cases overall (Figure 25 and Figure 26).

Figure 25: MFT Influenza B inpatient cases for Winter 2024/25.

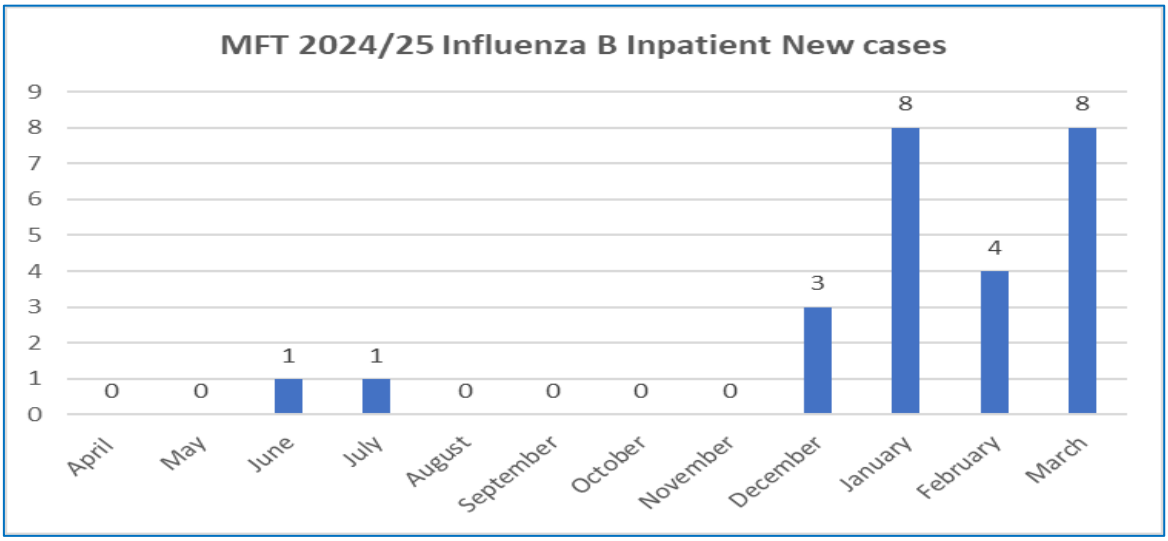
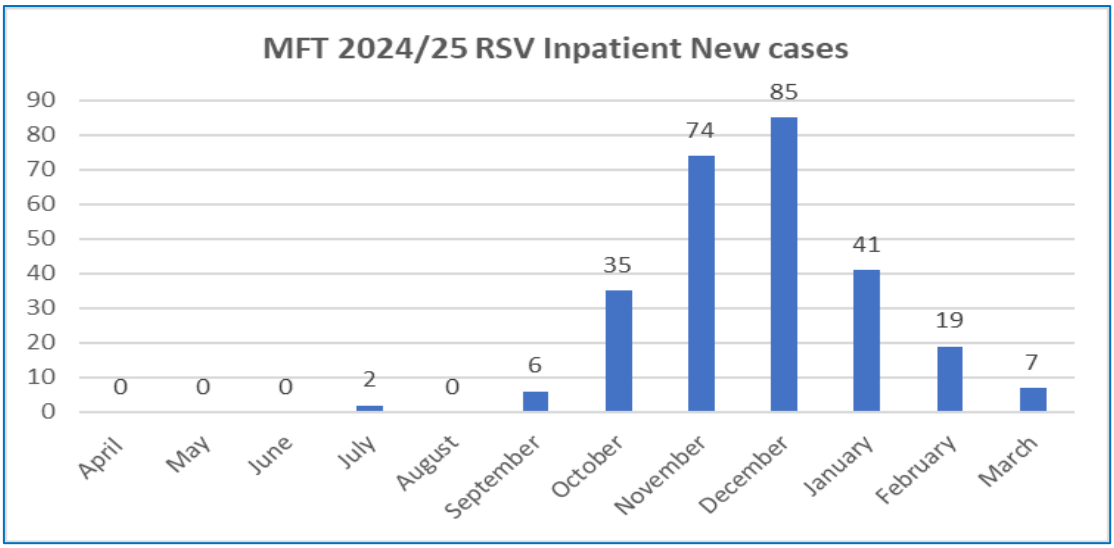


Figure 26: MFT RSV inpatient cases for Winter 2024/25.



10.11 This data shows that both Influenza and RSV peaked in line with national data. This had an impact on the use of side rooms within the hospital over the winter period which at times restricted flow within the Trust. The IPC team supported the site team with appropriate use of side rooms across 7 days..

10.12 The Trust symptom checker document was added to the Electronic Patient Record over the last year, making it easier for staff to access. The purpose of the document is to enable staff to identify and document daily if a patient has developed any respiratory symptoms, and ensure they can be effectively managed to prevent the disruption of vital services.

10.13 Compliance with the completion of the symptom checker has continued to be an issue but has improved over the financial year. A comparison of compliance through the symptom checker audit for 2023/24 and 2024/25 can be found in figure 27.

Figure 27: MFT Symptom Checker Audit Compliance Comparison.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	80.2	85.5	89.2	89.3	88.8	90	89.8	90	92.2	84	89.7	89.7
2025/26	86.9	91.8	84.6	85.9	85.1	83.2	85.4	88.6	83.3	87.4	87.9	84.7

10.14 Patients who trigger are sampled and isolated in a timely manner whilst awaiting a result, remaining in isolation for 5 days if positive.

11 Period of Increased Incidence

11.1 Placing a ward on a period of increased incidence is triggered by a criteria set by the IPC team.

11.2 It is an opportunity to give the ward tailored and focussed support in order to ascertain the perceived lapses in documentation or hand hygiene compliance for example, and supporting staff to improve in these areas.

11.3 A breakdown of the criteria for a PII and the support given is shown below.

CDI:

- One case with new learning. The ward will be placed on PII.
- If two cases within 28 days then the ward is automatically placed on PII.
- 4 weeks of audits to be carried out in full then step down based on the performance of the Ward.

GDH:

- Two cases within 28 days with significant learning. The Ward will be placed on PII.
- Continue audits for 2 weeks and then step down based on the performance of the Ward.

MRSA (colonisation):

- If there are 3 cases within 28 days, we then ask the following questions:
  1. Are there signs of clear cross contamination?
  2. Are we really concerned about these infections?
- If yes to the above questions, then the ward is placed on PII. If not, we continue to monitor for further cases.

MRSA (Bacteraemia):

- If one case, then the ward is automatically placed on a period of increased incidence for 4 weeks.
- The ward can be stepped down based on the performance after 4 weeks

MSSA:

- If there are 2 cases within 28 days the ward is placed on PII.
- Continue audits for 2 weeks and then step down based on the performance of the Ward.

GNBSIs:

- If 2 cases within 28 days with the same source of infection, then the ward is placed on PII
- If different sources, then threshold of 3 is allowed before a ward is placed on PII.
- Audits to be carried out 1st and 3rd week. If significant concerns, then this will be modified.

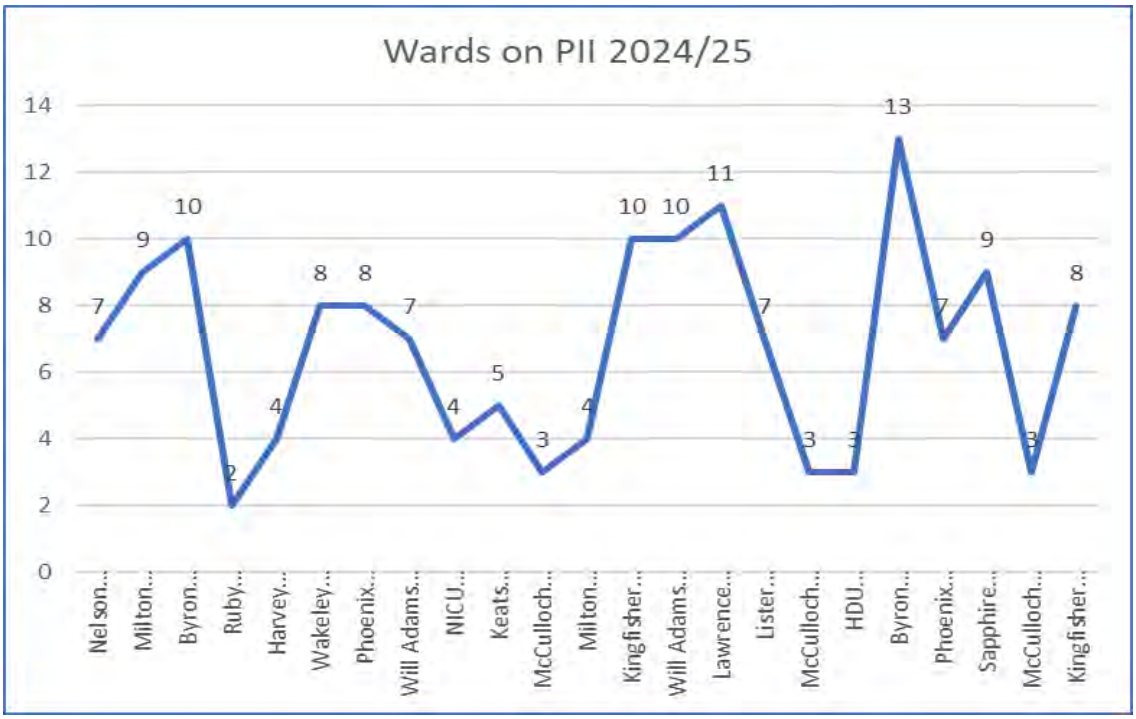
11.4 The audit scores are reviewed weekly and an email notification with recommendations for improvement, sent to the ward manager, matron and Head on Nursing.

11.5 Following this stage, the ward is provided with intensive support by the IPC team in collaboration with the ward manager and the Nurse in charge, for 4 weeks with the objective of sustainable improvement.

11.6 Figure 28 shows a weekly overview of the wards that were placed on a PII within the 2024/25 financial year. While Ruby ward was on PII for 2 weeks due to good compliance and audit scores, Byron ward was on PII for 13 weeks due to poor compliance.

11.7 Sapphire ward continues to be on a PII into the new financial year, as the audit scores are still not at an acceptable level for hand hygiene.

Figure 28: 2024/25 Overview of Wards on a Period of Increased Incidence.



11.8 Figure 29 shows the list of wards with acquired infections that qualified them to be placed on PII. Byron, McCulloch, Phoenix, Will Adams, Milton wards have all been on PII on two different occasions due acquiring more than one infection in different month.

Figure 29: MFT Influenza inpatient cases for Winter 2024/25.

Wards	Themes
Byron	ESBL, MRSA Bacteraemia
Harvey	ESBL,
HDU	C. Diff
Keats	GDH
Kingfisher	C. Diff, MRSA Bacteraemia
Lawrence	GDH
Lister	C.Diff
McCulloch	C. Diff, ESBL
Milton	GDH, C. Diff, MRSA, E. coli, Klebsiella

Nelson	C. Diff, ESBL
NICU	MRSA colonisation
Phoenix	MRSA Bacteraemia, GDH, C. Diff
Ruby	MRSA Colonisation
Sapphire	MRSA Bacteraemia
Wakeley	MRSA Colonisation
Will Adams	MRSA Colonisation, GDH, C. Diff

12 OUTBREAKS

11.1 During 2024/25 the Trust had 3 outbreaks for COVID-19, CPE and MRSA colonisation.

11.2 Throughout Winter 2024/25 reporting period MFT was and remained under pressure which saw most of that period escalating at Opel level 3 or 4. Entering into business continuity only once, to support flow through the hospital, which impacted on side room availability.

11.3 Any ward where an outbreak was declared, the IPC team started enhanced cleaning measures, a PII, Intense support and an outbreak meeting was convened to identify learning and where improvements can be made.

11.4 On 6th April 2024 there was a CPE outbreak on Sapphire Ward involving 4 direct patients. The incidence occurred through the index case, who was repatriated internationally, and not appropriately isolated on the ward due to unawareness of policy although highlighted by the nurse in charge.

11.5 Learning from the CPE incidence set in motion an increase in education surrounding this organism. The IPC team have incorporated it into any teaching sessions delivered, and further work was carried out with EPR to establish and move the location of the Infection Admission Assessment to highlight patients with a history of an infection or high-risk patients.

11.6 In addition, a reliance on the need for contact tracing was highlighted further due to Extramed being removed, which makes it difficult to trace which patients have been in contact with an index case during their inpatient journey. this has been added to the risk register as an issue, pending work by the Teletracking team.

11.7 On 8th April 2024 there was a COVID outbreak on Will Adams Ward involving 14 patients, 8 who became positive. The index case was positive on 1 day, followed by the remaining 7 patients testing positive the next day, as they were symptomatic. No further cases tested positive after this date, and the outbreak

was closed after 20 days as per policy. At the time of this testing, national guidelines advised that contact tracing was not required.

11.8 On 25th July 2024 we had an MRSA Colonisation outbreak on Milton Ward, involving 19 patients. Delays were found in lab results coming back and was added to the Risk Register. The outbreak was linked to a wandering index patient and poor cleaning practices. Improvements have since occurred and positive outcomes seen.

11.9 As part of the outbreak actions a deep clean was implemented using UVc, the bays were decanted one at a time into Christina Rosetti. Through good collaboration with ward, IPC, estates and facilities along with the clean the estates team were able to replace the old sinks in each bay to new ones with correct taps and bowl drainage.

11.9 Actions plans were devised and monitored through the outbreak meetings to reduce the effect outbreaks have on the patient, the clinical areas and also the organisation to aid flow.

13 SURGICAL SITE INFECTION SURVEILLANCE (SSIS)

13.1 The IPC Team took over the administration of the mandatory SSI surveillance monitoring from the Surgical, Medical and Acute Response Team (SMART) in July 2022

13.2 SSI data for mandatory hip and knee reporting is submitted once a quarter to the United Kingdom Health Security Agency (UKHSA) data capture system (DCS) and the minimum requirement is one submission per year. The original aim of the IPC Team was to continuously monitor hip and knee surveillance and report for the whole year has been achieved with 4 submissions a year.

13.3 While the goal is to implement surveillance monitoring across all surgical sites, the initial focus was on elective hip and knee surgeries. This approach allowed the team to establish a robust surveillance system, which has since been successfully expanded to include the Colorectal service. Data for Quarter 3 of 2024–25 (October–December 2024) has been fully submitted, and the submission for Quarter 4 (January–March 2025) is currently in progress.

13.4 Below shows the data for the number of patients on the list for surveillance, and the number of surgical site infections (SSI) noted per quarter for both elective THR/TKR (Figure 30) and colorectal (Figure 31) procedures.

Figure 30: 2024/25 Q1-Q3 Overview of TKR/THR cases and the number of SSI's.

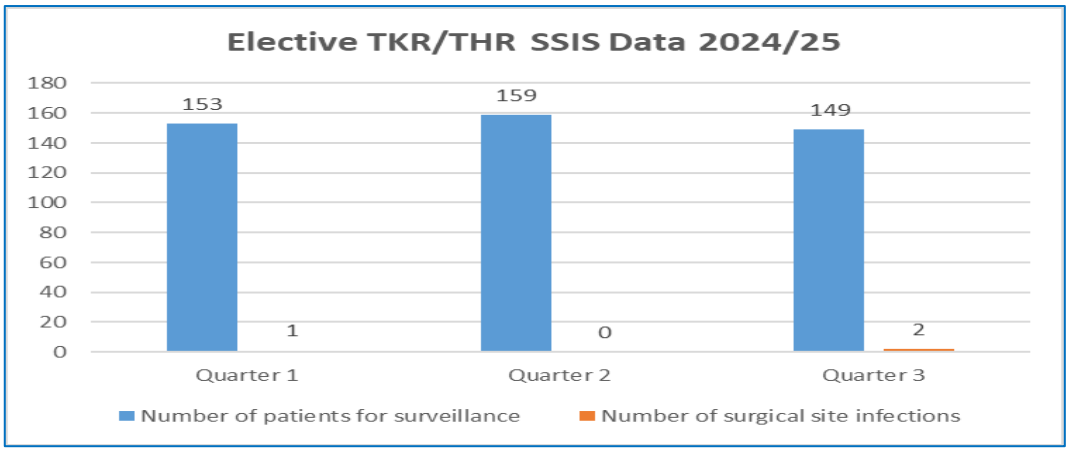
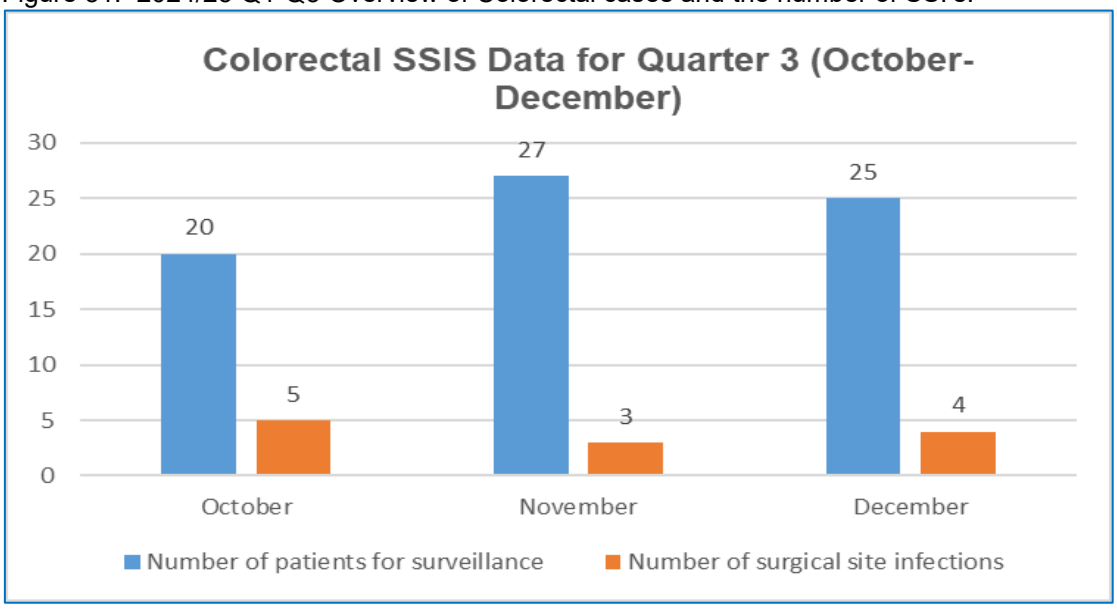


Figure 31: 2024/25 Q1-Q3 Overview of Colorectal cases and the number of SSI's.



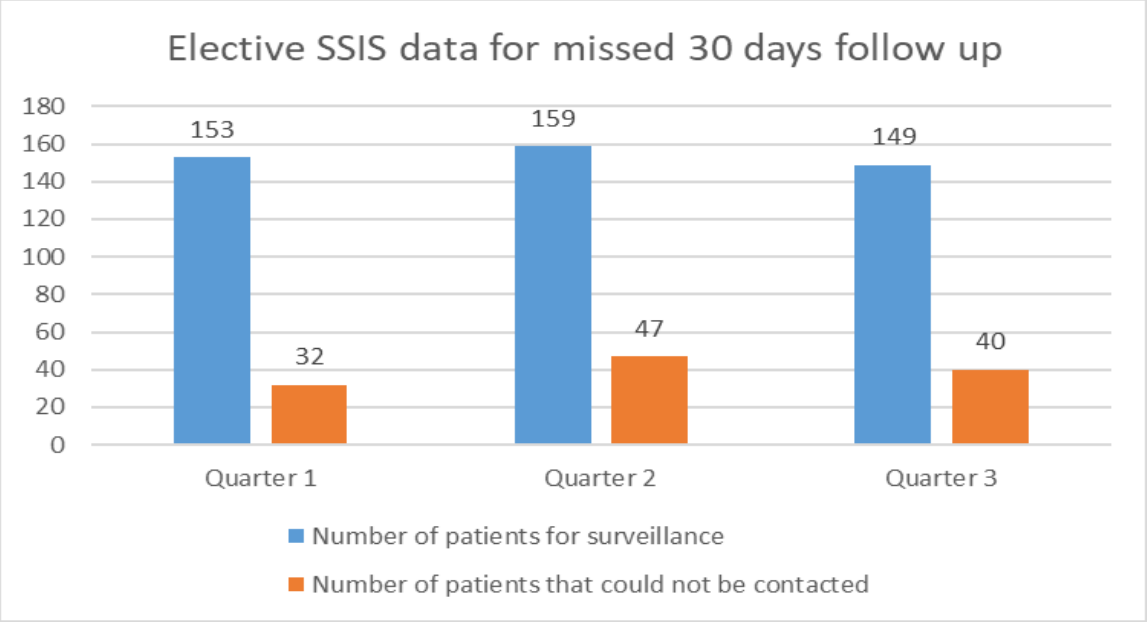
13.5 Part of the surveillance programme is to contact patients at 30 days post procedure via telephone to determine if after discharge there was any infection at the surgical site.

13.6 The team continues to face challenges in contacting patients for the 30-day follow-up, as some do not answer their phones, making it difficult to assess post-operative concerns. This is reflected in the national Data Capture System.Graph below shows the total number of patients per quarter and the number of patient that did not answer the phone for elective SSIS.

13.7 The graph below (Figure 32) illustrates the total number of patients per quarter alongside the number of patients who did not answer phone calls regarding elective SSIS. To minimise missed contacts, a second attempt is made if the initial call goes unanswered. For patients who are readmitted, the IPC Team conducts ward visits to complete the PDQs. Additionally, SMART Team notes are

reviewed to ensure that patients who were missed for PDQs did not develop an infection during their time in the community under SMART care.

Figure 32: 2024/25 Q1-Q3 Overview of TKR/THR cases and number of missed follow-ups.



13.8 Version 2 of the Elective SSIS pathway has been created, and collaborative discussions are ongoing. Given the similarities with the Trauma Orthopaedic pathway, efforts are being made to integrate common steps and processes with support from the Transformational Team. The IPC and Transformational Team are working together to finalise the pathway.

13.9 A document has been created to review deep and organ-space SSIs. It has been shared with the Team and consultants for feedback and amendments before implementation.

14 IPC Gthr AUDITS

14.1 The Gthr system was adopted by the Trust to capture all audit data from February 2022 where wards can input see and access their results in real time whilst offering assurance on compliance to the board.

14.2 The IPC dash board on Gthr has allowed specific questions to be devised and tailored looking at the ward environment; hand hygiene; bare below the elbows and also includes the Friends and Family Test (FFT) cleanliness data.

14.3 Hand hygiene compliance scores have remained consistent over 2024/25 – Figure 33 and 34)

Figure 33 -Hand Hygiene Compliance Score (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar

95	95.4	92.2	95.7	94.1	95.3	93.9	94.5	96.8	95.2	95.2	95.8

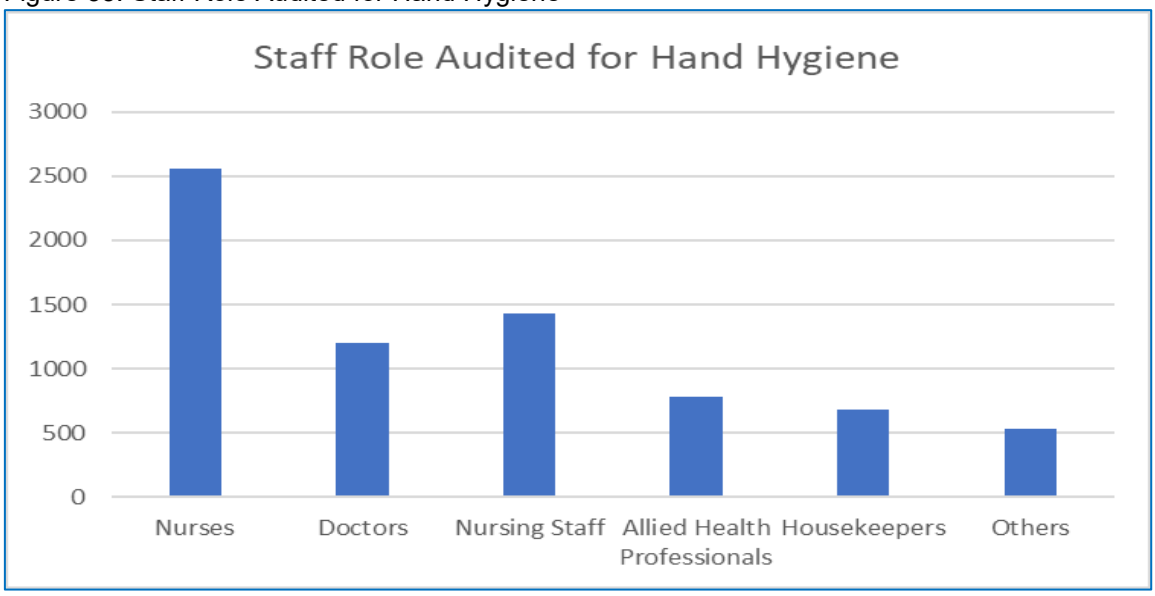
Figure 34 – Hand Hygiene Facilities Audit Compliance (Trustwide).

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
97.7	98.4	98	99.3	96.6	98.7	95	99.1	96.9	94.4	97.7	97.7

The information listed above in the two metrics show that hand hygiene compliance is good across the organisation generally, but challenges still remain with some compliance around bare below the elbows within some clinical areas this is further examined in the bare below the elbows compliance section of this report.

14.4 A breakdown of staff observed for hand hygiene over 2024/25 can be found in Figure 35.

Figure 35: Staff Role Audited for Hand Hygiene



14.5 In addition to the data captured from assessing hand hygiene compliance, bare below the elbows within the clinical environment is another key metric that has remained consistent throughout 2024/25 as seen in Figure 36 and Figure 37.

Figure 36: Bare Below the Elbows Overall Compliance Data (Trustwide)

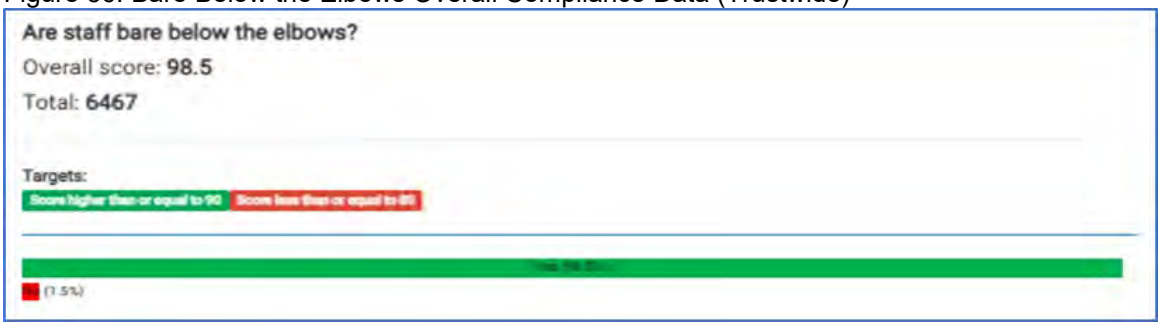


Figure 37: Bare Below the Elbows Compliance Breakdown Data (Trustwide)

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
98.8	98.7	98.2	97.8	99.3	97.7	98	98.9	98.5	98.3	98.9	98.8

14.6 The IPC team continues to challenge practice that falls below the standard expected when seen and offers support and guidance to staff so that they understand the importance complying with the hand hygiene and bare below the elbow's when in the care environment.

14.7 In 2024/25 the IPC team promoted World Hand Hygiene Day on 5th May by carrying out trolley dashes across the hospital and putting on displays in the main entrance of the hospital. The IPC team used visual aids, handing out information, doing light box refresher sessions, using games and challenges to educate staff about the importance of hand hygiene in keeping patient's safe and reducing the risk of cross-contamination to others across the organisation by refocusing attention through a less formal route. These sessions are always well attended not only by staff but have helped to remind visitors to the Trust of the important part they also play in minimising infection.

14.8 Following the commode audit in 2023 the Trust significantly invested in replacing it's varying commode types for one single 'easy clean' variant. Since the roll out, the Trust has seen a noticeable improvement in GTHR audits scores.

14.9 The commode and sluice facilities audit continues to show consistent positive results as seen in Figure 38.

Figure 38: Commode and Sluice Facilities Audit (Trustwide)

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
96.4	92.8	94.1	97.6	96.5	97.1	98.8	99	99	98.8	97.7	98.4

13.10 Peripheral cannula audits have been consistently under the Trust standard during 2024/25 but show an improvement on the previous financial year as shown in Figure 39. From IPC audits it has demonstrated that some falls in compliance is down to not dating IV devices post insertion and also not completing Saving Lives documentation. The IPC Team have addressed these issues with the respective clinical areas to prevent re-occurrence.

Figure 39: Trustwide Peripheral Cannula Audits 2023/24 and 2024/25 comparison

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
23/24	88.8	87.6	85.5	85.1	87.4	81.7	81.7	80.5	79.6	81.9	85.4	84.2
24/25	83.6	83.8	78	87.2	89.4	88.2	87.5	88.6	90.4	89.3	87.8	92

Also through auditing it showed that planned date for removal and lack of documentation on continued need for the cannula was missing. The IPC team continues to work with EPR team to resolve these issues.

13.11 Gthr has also become an integral part of the reporting by wards and departments to the IPC operational group. Wards have to present their areas of challenge to

allow for discussion from other areas who have good practice. This is a forum for sharing ideas and solutions.

13.12 Over the last year, a task and finish group was held in order to review the audits that ward managers undertake. The group initially focussed on IPC audits which saw 10 audits being reduced to 3 for inpatient areas and ED. The remaining audits that these areas were expected to complete are Hand Hygiene and Commodes weekly, and then Environmental audit on a monthly basis.

13.13 In March 2025, the IPC team absorbed the remaining audits into a condensed audit for inpatient areas and a separate one for the Emergency department which is to be conducted monthly by the IPC team.

13.14 Going forward these audits will be presented by the IPC team at Divisional meetings, IPCOG and IPCPG, which will feed into board level meetings.

15 HOSPITAL CLEANLINESS

15.1 In April 2021 the NHS published the *National Standards of Healthcare Cleanliness* which would apply to all healthcare environments and replaced the *National specifications for cleanliness in the NHS* 2007

15.2 These standards have now been fully implemented across the Trust as healthcare providers must clearly demonstrate how and what standard should be achieved by setting out clear accountability and responsibilities for cleaning the clinical environment

15.3 Regular discussion at the Decontamination Group and the IPC Programme Group meetings highlight that cleaning staff needed further training which is currently in the process of pre roll out.

15.4 In recent months, the IPC team have been working more closely with the senior housekeeping team to close the gap on any issues raised during the cleaning audits. Alongside this collaborate working to produce training for both housekeeping and department staff which will be introduced in the new financial year.

15.5 The Friends and Family Test Gthr scores are an indicator for where further work is needed as it focuses on how clean the patients found the location where they were being cared for. The overall monthly scores for the Trust can be found below in Figure 40. An ongoing theme in these audits is the cleanliness of the toilets.

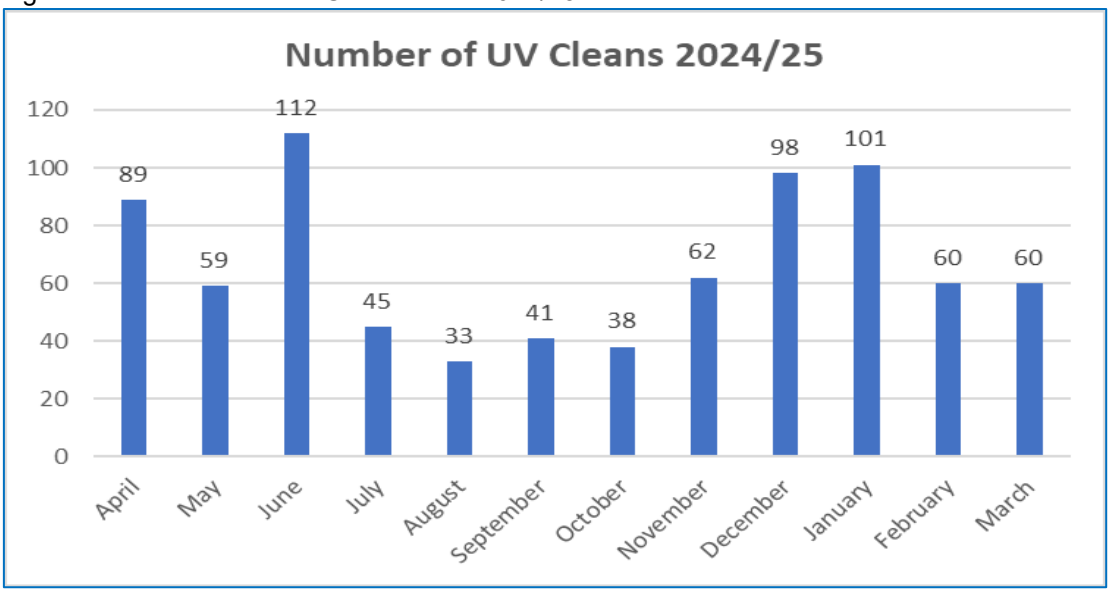
Figure 40 – Friend and Family Test Cleanliness Scores (Trustwide).

April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
86%	85%	87%	88%	89%	88%	87%	87%	87%	86%	87%	87%

15.6 UV cleans continue to be the Trusts chosen method for decontaminating patient areas that have been exposed to infections. However, this method is only used in areas that can be completely sealed off, therefore will not be carried out in open Nightingale wards or nurses' stations.

15.7 As seen in the graph in Figure 41, the UV cleans decrease during the summer months, which is in line with the winter escalation period when we see more cases of COVID-19 and diarrhoea related infections.

Figure 41 – The number of UV cleans in 2024/25.



16 DECONTAMINATION

16.1 The purpose of the Decontamination group is:

- To implement and monitor compliance with the decontamination policy as defined in Health Technical Memorandum (HTM) 0101 Management and decontamination of surgical instruments (medical devices) used in acute care (Part A: Management and Provision), and the Health and Social Care Act 2008.
- To ensure there are appropriate systems and processes in place for effective decontamination of patient environment and all patient equipment.
- To monitor compliance with assessing risks against the Health and Safety at Work regulations for Trust employees and service users.
- To ensure compliance with the Control of Substances Hazardous to Health (COSHH) regulations
- To action UKCA/EU directives regarding medical devices
- Review all audit data metric and actions in a timely manner

16.2 The Decontamination group meets monthly and is chaired by the HoIPC. It reports into the IPCPG bi-monthly. The aim of the group is to move to bi-monthly meetings but after a prolonged period of monitoring to assure compliance.

16.3 The core membership of the group is chaired by the Head of IPC and includes housekeeping lead, facilities team, ward managers, Matron's, department managers and HoN's.

16.4 The group discusses the cleaning audit results for each clinical area, the participation scores for each area with ward staff supporting the audit alongside the housekeeping team and then any areas of concern.

16.5 The Friends and Family Test Gthr scores are also discussed during this meeting, focussing on how clean the patients found the location where they were being nursed. This helps triangulate the audit data with the information patients are providing.

16.6 The Trust appointed an Approved Engineer for Decontamination (AED) who liaises closely with the Decontamination Lead and authorising engineer on all matters relating to testing and verification of results. The AED also conducts an annual audit of the decontamination service to ensure it meets the required IHEEM standards.

16.7 A continued programme of audit is planned throughout the forthcoming year using an audit tool looking at standards of cleaning and sterilization of equipment used within the hospital. These audits will provide valuable data to be reviewed at the group.

16.8 The laundry department reports into this meeting, updating members on the number of washes carried out, issues with the machines and risks highlighted within the department. Numerous episodes of items being found in laundry including dentures, pads and needles has also been highlighted.

16.9 For theatre equipment there have been issues throughout the year with sterile procedure trays holes or tears and therefore the sterility breached, however there were minimal reported by the latter part of 2024/25.

16.10 Waste is an essential component of this meeting, which refers to the 2022 edition of the HTM 07-01: Safe and sustainable management of healthcare waste. Waste leads highlight that the effective segregation of waste is essential to ensure both statutory compliance (by preventing the mis-consigning of waste) and also to prevent waste from being treated using expensive processes when not required. The current TWM contracts prices per tonne for waste disposal are:

Dry mixed recycling: £55.00 + VAT per tonne
General waste: £130.63 + VAT per tonne
Offensive waste: £345.87 + VAT per Tonne
Infectious waste: £422.73 + VAT per Tonne

High Temp Incineration waste: £661.00 + VAT per tonne

16.11 A trial has taken place this year with SharpSmart in a bid to reduce the number of sharps injuries and look at potentially fully roll it out across the Trust.

16.12 The Water Safety Group also feeds into this meeting and updates members on the regular legionella testing trust wide, where we have positive results and updates on further readings. Shower head changes are also discussed in this meeting, and areas within the Trust that due to inactive use of showers or taps, require regular flushing. They also reported on water temperatures and ensure that they meet the high and low levels.

17 COMMODE AUDITS

17.1 Audits provides assurance to the Trust on the cleanliness, suitability, safety and durability of a device. Uploading audit data to Gthr enables effective review and monitoring of all data captured.

17.2 A Trust wide commode audit was completed by the IPC team in June 2024 which showed continued improvement in the commode cleanliness compliance from its previous state.

17.3 As of 2023, there were six different commode designs which posed various cleaning issues and technical concerns.

17.4 In June 2024, 82 commodes were audited and a total of 25 commodes were identified to require replacements due to damages to lids, arms, seats, rusting of frames, commode liners holder, flaky paints etc.

17.5 The 'Clinell easy-clean' commode is becoming the primary model across the Trust, with only a small number of older units in circulation. These remaining units are being phased out and replaced as part of ongoing equipment upgrades.

17.6 Since the introduction of the new commodes, the following actions have been implemented:

- Ward/Department Managers are responsible for regular review of commode cleanliness within their clinical areas to ensure thorough cleaning and raise staff awareness of the potential IPC risks associated with soiled commodes.
- Commode training was delivered to all staff on the ward, with link practitioners empowered to act as IPC champions, cascading key messages and reinforcing best practices.
- Majority of the broken, damaged and outdated commodes have been replaced in line with the Trust's standards as planned. The new models (Clinell) are easier to clean supporting efforts to reduce mismanagement and faecal pathogen growth.

- Regular unannounced commode audits are carried out by the IPC team.
- The "Commode Cleaning: 10 Point Plan" posters are also clearly displayed in all ward / department sluice(s), with Ward Managers responsible for ensuring their visibility and upkeep.

17.7 As of 2024, there are 82 commodes in use across the Trust, following a reduction and standardisation process which began in 2023. The commode cleanliness scores have since steadily improved, supported by targeted interventions and continued IPC support as evidenced in Figure 42.

Figure 42 – 2023/24 & 2024/25 Commode Cleanliness Audit Comparison (Trustwide)

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
24/25	96.3	87.4	88	94.7	93.9	95.3	93.8	93.5	98.2	93	95.7	96.8
23/24	81	78.8	87.7	90.4	86.2	89	92.5	84.8	95.1	94.4	91.5	93.3

18 EDUCATION AND TRAINING

18.1 The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

'That relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients' care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

18.2 Level 1 training, delivered via e-learning, is completed by non-clinical staff, while Level 2 training is required for all clinical and patient-facing staff.

18.3 Training compliance by division has been reviewed at both IPCPG and Divisional Governance Care Group meetings, and the information has been incorporated into the divisional reports. Figure 43 shows the compliance data for all staff group as of the end of the 2024/25 period.

Figure 43: 2024/25 Overview of Trust IPC Training Compliance.

	Column Labels			
	Compliant		**Compliance (%)**	
Staff Group / Subject	Yes	No	Yes	No
Add Prof Scientific and Technic	127	**23**	84.67%	**15.33%**
Infection Prevention L1	9	1	90.00%	10.00%
Infection Prevention L2	118	22	84.29%	15.71%
Additional Clinical Services	942	**72**	92.90%	**7.10%**
Infection Prevention L1	15	2	88.24%	11.76%

Infection Prevention L2	927	70	92.98%	7.02%
Administrative and Clerical	994	**57**	94.58%	**5.42%**
Infection Prevention L1	980	51	95.05%	4.95%
Infection Prevention L2	14	6	70.00%	30.00%
Allied Health Professionals	218	**20**	91.60%	**8.40%**
Infection Prevention L1	2	0	100.00%	0.00%
Infection Prevention L2	216	20	91.53%	8.47%
Estates and Ancillary	470	**17**	96.51%	**3.49%**
Infection Prevention L1	458	15	96.83%	3.17%
Infection Prevention L2	12	2	85.71%	14.29%
Healthcare Scientists	3	**2**	60.00%	**40.00%**
Infection Prevention L1	2	1	66.67%	33.33%
Infection Prevention L2	1	1	50.00%	50.00%
Medical and Dental	560	**175**	76.19%	**23.81%**
Infection Prevention L1	1	0	100.00%	0.00%
Infection Prevention L2	559	175	76.16%	23.84%
Nursing and Midwifery Registered	1498	**87**	94.51%	**5.49%**
Infection Prevention L1	2	0	100.00%	0.00%
Infection Prevention L2	1496	87	94.50%	5.50%
OVERALL SUMMARY	4812	**453**	91.40%	**8.60%**

18.4 The IPC team provides placements for student nurses and Student Nurse Associates (SNAs), lasting between 4 to 8 weeks. These placements have proven to be highly valuable in enhancing students' understanding of infection prevention and control, as well as the broader management practices essential for maintaining safe and effective hospital services.

18.5 The team continues to make ongoing improvements to enhance the student experience, guided by feedback from previous placements. A welcome booklet has been developed and is sent out prior to the students' arrival. It includes key information such as working hours, team contact details, and an overview of what to expect during the placement.

18.6 Students placed with the IPC Team are allotted time with various members of the team to understand the depth and wealth of the work undertaken by the IPC Team. They are also given opportunities to shadow professionals from the wider

multidisciplinary team, both those directly and indirectly involved in IPC, to gain a well-rounded understanding of collaborative approaches in clinical practice.

18.7 The IPC Team delivers Hand Hygiene training every Wednesday as part of the Trust induction program. This session uses a combination of simulation and discussion-based teaching methods to engage staff effectively.

18.8 The IPC Team has been included in the annual doctors' induction each August. During the session, simulation and observational methods are employed to focus on the principles of infection control.

18.9 The IPC Team has also provided additional training to Year 12 students and students at Mid-Kent College, focusing on the fundamentals of infection prevention and control.

18.10 During the 2024/25 financial year, the IPC Team delivered simulation-based training across 10 wards, with a primary focus on the Medicine and Emergency divisions. The sessions were attended by a multidisciplinary group of staff, including nurses, doctors, phlebotomists, and clinical support workers (CSWs), with a total of 279 participants. The training covered key infection prevention topics such as MRSA colonisation, GDH, *Clostridioides difficile* (C. difficile), and Carbapenemase-Producing Enterobacteriaceae (CPE).

19 IPC LINK PRACTITIONERS

19.1 IPC Link practitioner training was re-established in July 2022. IPC Link practitioners are required to attend regular updates provided by the IPC Team and be an active participant at these meetings.

19.2 Each ward and department have signed up to provide a minimum of one practitioner (Trained or Untrained) who will represent their respective clinical area attending at least 75% of these sessions, which run for a half day quarterly throughout the year.

19.3 IPC Link sessions are chaired by the IPC Matron and external speakers also provide content and support delivering additional updates on products being used or planned for introduction into the hospital. Housekeeping have a fix slot every meeting.

19.4 Subjects covered can include but not limited to:

- The Infection Admission Assessment becoming mandatory.
- Checking results on iLab and not relying on the IPC team for notifications.
- Re-iteration on how to use the Diarrhoea Assessment Tool.
- Correct sharps bin use and Sharps safety.
- Cannula care across the Trust, checking devices, completing documentation daily and removing devices that are not needed.

- What Antimicrobial Stewardship is, its importance and whether they want to become AMS Champions.
- What IPC Standard Precautions are, their importance and what is happening within the Trust regarding these standards.
- What CPE is and all the components around it.
- The latest housekeeping issues and updates across the Trust
- A reflection on the upcoming Links Annual Showcase in October and what to expect.

19.5 The Kent and Medway ICB IPC conference runs annually and offers places for IPC Link Practitioners throughout Kent and Medway to attend in addition to the education sessions provided by the Trust.

19.6 In October 2024 the IPC team presented its second IPC Link Practitioners showcase, which concludes the annual Infection Prevention week. The links were asked to prepare a presentation of an improvement that they had implemented or tried to implement within their work area. The event was attended by 19 link practitioners with 10 wards presenting on the day. The presentations were judged by a panel of the Deputy Chief Nursing Officer/Associate Director for IPC and a member of the NHSE IPC team.

19.7 Awards were given for 1st, joint 2nd, and 3rd and for presentations demonstrating innovation and passion. A breakdown can be seen below.

Award	Link Practitioner	Ward	Project Description
1st Place	Irish Carandang	SDEC	The improvement project was called 'If You Care, Clean the Chair'. The department introduced a sliding sign above each patient chair space to indicate whether it had been cleaned, and proved to be a successful intervention.
2nd Place	Issac Motte	Kingfisher	'Appropriate Usage of Personal Protective Equipment' This project looked at re-educating the staff on the ward on what PPE to wear, when to wear it and how to DON and DOFF it. They used the slogan 'See it, Say it, Sort it'.
2nd Place	Eduardo Vargas	Main Theatres	The focus of this project was more wide spread within the department, and looked at where they are in relation to IPC and what they aim to do going forward to make further improvements. They looked at Hand hygiene, Dress code, Appropriate waste segregation and tidying up their waste disposal area, with positive improvements.

			In addition, they looked at a potential IPC safety audit available.
3rd Place	Paul Oldak	Phoenix	'Safer Environment Safer Care' General issues on the ward were explored and improvements were made as follows: • Removal of clean linen off of the cupboard floor and more shelves built in. • 2 hourly toilet checklist to ensure they are clean and in good working order.

- The Ward with the Longest Infection Free Period – Awarded to Emerald Assessment Unit.
- Most Improved Ward – Awarded to McCulloch Ward.
- Most Engaged Department – Awarded to Sheppey Frailty Unit.
- Long service as a link practitioner – Awarded to Nuala Brady-Murphy.

19.8 The day was well received by all including ward and care group teams who attended to support.

19.9 The IPC team are planning to continue to make this an annual event and have already started planning for this year.

20 FIT TESTING

20.1 FFP 3 Fit-testing principles for Acute Hospital Trusts introduced in June 2021 became mandatory and forms part of EPRR Core standard 12 and being a legal requirement in August 2022. The Trust must have arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including high consequence infectious diseases (HCIDs).

20.2 Initially, 3,209 hospital workers were required to undergo FIT testing as part of their training profile during the pandemic. However, with the relaxation of COVID-19 guidelines and a decrease in COVID cases, a review of the staff numbers was conducted, reducing the total to nearly 1,600. A further review of the staff groups requiring FIT testing is currently underway.

20.3 The IPC Team continue to manage the mandatory fit-testing programme following Ashfield's departure from the Trust and the IPC Team were all re-trained to undertake qualitative fit testing using either a bitter or sweet fit testing solution. Face2fit undertook the training for all IPC team members and sessions were rostered for all staff identified following a staffing review.

20.4 The procurement team has worked alongside the IPC Team in the development of mask procurement to ensure that they are UK sourced and that the Trust has adequate stocks of all mask types within the clinical areas.

20.5 Currently, staff undergo FIT testing with an FFP3 mask from the approved product range. In instances where staff are unable to pass the fit test due to factors such as altered facial features, beards for religious reasons, or sensitivity to the masks, the IPC Team offers specialised training on the use of half masks as an alternative.

20.6 The graphs below (Figure 44 and Figure 45) present data on the total number of staff trained, DNA (Did Not Attend) rates, and the fit mask testing across different staff groups The DNA rates for the last financial year was 45%. Out of the 674 sessions that were offered only 368 attended the Fit Testing sessions.

Figure 44: 2024/25 Overview of Fit Testing sessions and DNAs.

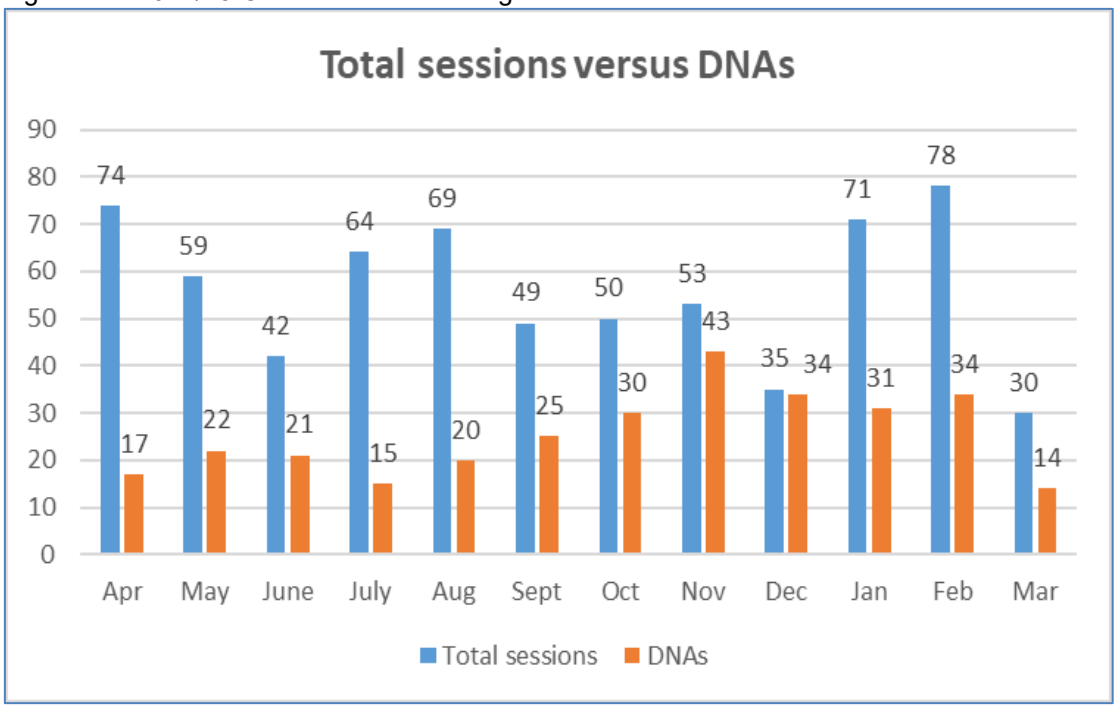
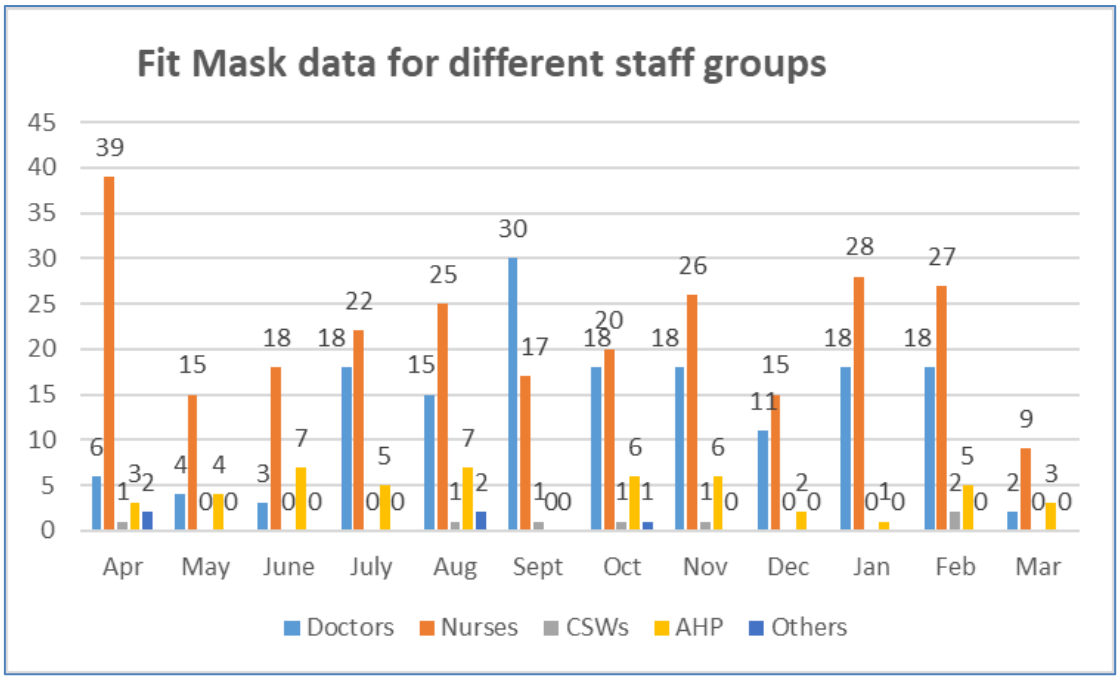


Figure 45: 2024/25 Fit Tested Staff Breakdown.



20.7 The IPC Team has procured a Porta Count machine to reduce dependence on traditional fit testing solutions, which were often found to be unpleasant by staff. Team members are scheduled to undergo training in its use within the forthcoming year.

21 ESTATES/IPC/HOUSEKEEPING WALK ABOUTS

21.1 The joint IPC/Housekeeping and Facilities bi weekly walkabouts sought to address and remedy estates and cleaning issues.

21.2 The programme began in June 2022 and consisted of representatives from Estates team (Director), ADIPC or IPC Matron, an estates team representative, Building, Electrical, Ventilation/water, Housekeeping/Hotel services, and then as needed Fire and Health and safety, Ward Manager/Matron.

21.3 Fast forward to 2024/25 and the walkabouts are now carried out by the IPC Matron, a Housekeeping team leader/supervisor or associate manager and a member of the Senior Estates team. Information is then cascaded back to the corresponding teams in relation to any minor work that needs completing.

21.4 These walkabouts have been successful in highlighting and addressing the problems within the Trust's estate generating a lot of actions.

21.5 The latest ward to be refurbished was Ruby Ward in April 2024, when the Trust took it over in 2024.

21.6 It enables the teams involved to look at the fabric of the estate and seek to put right any issues or damage seen making the environment cleaner and safer for patients.

21.7 To facilitate the visits, the IPC team developed an audit schedule to highlight the areas that need reviewing and ensure that all areas are covered. The information collected is then uploaded to Gthr.

21.8 The previous year focused on the inpatient areas. In 2024/25 we changed to assessment and review of all outpatient areas and other areas across the Trust including stairwells and corridors.

21.9 The flooring across the Trust has been highlighted as a major job that needs reviewing to ascertain what areas are most in need of replacement as due to budget constraints not all areas can be remedied straight away.

21.10 A plan is in place to do a toilet Gemba across the Trust in 2025/26, as this is a theme highlighted in the Trust Friends and Family test feed back

22 NEXT STEPS

21.1 Finalisation of Process Mapping: The process mapping for Elective Total Hip Replacement (THR) and Total Knee Replacement (TKR) will be finalised to standardise procedures and ensure consistency across the pathway.

21.2 Collaboration with BD: A joint initiative with BD will be undertaken to develop a Practice Versus Guidance (PVG) review. This will inform ongoing improvement efforts, culminating in the development of a case study to support shared learning and best practice dissemination.

21.3 Quality Improvement: Transmission-Based Precautions: A quality improvement project is underway to address staff understanding of transmission-based precautions. Following a recent staff survey piloted on Harvey Ward, education and training initiatives are being developed to address identified knowledge gaps.

21.4 Targeted Training on Clostridioides difficile (C. diff): Focused teaching sessions on C. diff have commenced, including the identification of 'C. diff Champions' to drive adherence to IPC standards. This initiative, which began in March, is currently focused on frailty wards where incidence rates have been highest.

21.5 CAUTI Reduction Project: Engagement with Urology Specialist Nurses is planned to explore strategies for reducing catheter-associated urinary tract infections (CAUTIs), with potential for a dedicated project aimed at further reduction.

21.6 Train the IPC team on the new Porter Count machine in order to continue supplying a FIT Testing service to the Trust and increase the number of Fit Testers within the team.

21.7 Developing an IPC web page with links to all of the surveillance data, organism of the month and key messages with learning from SWARMs and AARs.

21.8 Continue to work with the housekeeping team to ensure Standards of Cleanliness are met. In addition, collaborate on a teaching toolbox for Day Surgery and Diagnostics to enable them to competently clean patient spaces between a fast-paced patient turnover reducing the need for the bed turnaround team, which will free them up to attend to inpatient discharges resulting in faster paced bed availability.

23 CONCLUDING REMARKS

23.1 This year like most others have had its challenges and the IPC Team have risen to the challenge by continuing to build and forge great links with all clinical teams across throughout the organisation including working well with Estates and Facilities make changes to both cleanliness and the fabric of the Trust's estate.

23.2 The IPC team have achieved a great deal in 2024/25 by further building and developing the FIT testing service so that it meets the needs of our regulatory responsibilities and the organisation as a whole.

23.3 SSIS has continued to grow and has ensured closer working relationships with the surgical team in gathering information to ensure safer surgery in particular the orthopaedic team. The IPC team took on colorectal SSI data collection, but it paused intermittently to allow for staff recruitment and will continue as able,

23.4 The team remain committed to delivering a robust and adaptable IPC service to the Trust and are fully integrated into the divisions and care groups with an IPC team member regularly in attendance at these meetings. We are also very visible within the clinical areas supporting, nurturing and advising all grades of staff working for the Trust and for the benefit of our patients using our services.

23.5 The team are fully committed to working collaboratively incorporating facilities, clinical and procurement teams in trialling new products, reviewing practices and implementing new processes in the fight against infection.

23.6 A successful relaunched IPC link practitioner programme was rolled out 3 years ago and continues with good participation from staff around the Trust. This year we ended the International IPC week with our 2nd Annual Link Practitioner Showcase event to celebrate and reward the vital support work that they do. The showcase event also saw link practitioners present a project that they implemented or attempted to, with information shared about barriers met. We had external stakeholders at this event where prizes were awarded to the most innovative subject. We thank Jackie Dalton from NHSE/I IPC team and our Deputy Chief Nurse/Associate Director for IPC for their time and helping to judge this event.

23.7 Due to the increase in Clostridioides difficile cases nationally the IPC team have devised a simulation training programme which is additional to our usual supportive processes which aims to make staff stop, think and focus on what measures should be taken, these sessions used the simulation training room

when it was available, to mock a scenario to focus minds on best practice thus trying to avoid needless harm to patients and a disruption of our services. Primary feedback from teams proved encouraging and our progress is being followed by NHSE/I for possible national rollout.

23.8 The IPC service continues over 7 days to further support the vital work of our nursing and clinical colleagues. Since its inception staff have really embraced this service and we hope to build on what we can offer the teams moving forward. However, due to staff vacancies the weekends have only been covered in the mornings until further notice.

23.9 Although the use of the Quality Improvement Plan was fairly new to us this year, we have developed it from key themes and trends from investigations in 2024/25 to drive improvements across the Trust and to support delivery of the IPC strategy.

ENDS.

Health and Safety Annual Report 2024/25

Blessing Oduntan
Health and Safety Manager

NHS Medway NHS Foundation Trust

CONTENTS

1 Executive Summary

1.1 The purpose of this report is to provide assurance on compliance with legislation and Trust policies to the Health, Safety & Security Group and the Trust Board.

1.2 The report highlighted statistical analysis and key information regarding Health & Safety (H&S) activity, audit programme and progress, training compliance, reported incidents, RIDDOR and investigation outcomes across Medway NHS Foundation Trust, together with monitoring and responding to the health and safety needs of the Trust.

1.3 This is the sixth Health and Safety annual report produced. The report and its purpose conform to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.

1.4 5 of the 8 objectives set for 2024/25 were achieved, as set out in Section 4 of the report. Aside 1 training plan that was not completed, the incompletion of objectives was due to the long-term absence of the moving and handling lead (whose expertise are required for actions) coupled with the team not having a health and safety manager in role for more than 6 months in the year. The incomplete actions have been incorporated in the 2025/26 objectives.

1.5 Regardless of the two challenges highlighted above, the health and safety team did make significant strides in other areas such as:

- Delivery of >736 hours of moving and handling training and numerous supports to promote good handling practices and prevent injury, in spite of the long-term absence of moving and handling subject matter experts (SME).
- Thorough investigation of past incidents and sharing lesson points through educational engagement which has led to 50% reduction in 2024/25 from previous year RIDDOR reportable incidents to Health and Safety Executive.
- Working with maternity units to address overexposure risk from Nitrous Oxide.
- Development of a Health Surveillance programme for occupational health monitoring within areas not previously captured by the Trust.
- Formulation of a Health and Safety Strategy to guide the overall direction of the Trust's health and safety management.

2 Introduction

2.1 This Health & Safety annual report covers the period 1st April 2024 to 31st March 2025. The report outlines key developments and the work that has been undertaken during this reporting period, and is an opportunity to consider work planned, and the objectives for the year ahead.

2.2 It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the Trust premises and activities to:

• Comply with health and safety legislation;

• Implement health and safety arrangements;

• Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;

• Develop partnership working and to ensure health and safety arrangements are maintained for all

• To ensure that the health and safety agenda is not only embedded, but embraced throughout the Trust using a variety of monitoring methods.

3 Overview of Legal Compliance

3.1 The table below outlines the main health & safety legislation and identifies the proactive and reactive work that the Trust has carried out in order to ensure compliance.

Legislation	**Description of Actions/Level of Compliance**	
Health & Safety at Work Act 1974	1. The Corporate Health & Safety Policy has been incorporated in to version 1 Health & Safety Handbook 2. Competent persons in place to provide advice. 3. Health, Safety & Security Group held monthly 4. Established Sharps Group	

	5. Established Violence & Aggression Group	
Management of Health & Safety at Work Regulations 1999	1. Annual H&S Audit programme completed in full for all areas of the Trust. 2. H&S Improvement Plan & HSE Action plan completed. 3. Workplace Health & Safety Standards audit completed and action plan derived.	
Manual Handling Operations Regulations 1992	1. Training delivered by competent person 2. Some training now aligned to National Back Exchange Standards 3. Outstanding actions for Manual Handling on HSE action plan	
Display Screen Equipment Regulations 1992	1. DSE SOP within H&S handbook and accompanying self-assessment tool updated. 2. Health & Safety Team conduct 1:1 assessment and provide advice on request	
Personal Protective Equipment Regulations 2022	1.PPE SOP incorporated in to version 1 Health & Safety Handbook	
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	1. Investigations have been implemented for all RIDDOR incidents and the findings are shared with the Health, Safety & Security Group. 2. RIDDOR reporting compliance at 94%	

Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	1. Terms of reference have been reviewed for the Health, Safety & Security Group. 2. H&S Trade union H&S Reps in place 3. Attendance to the Health, Safety & Security Group is Good. 5. Reports received on audits, action plan progress, KPIs and risk register 6. Health, Safety & Security Group acts as consultative committee for H&S policies	
Control of Substances Hazardous to Health 2002	1. COSHH audits completed weekly by departments 2. Adhoc spot checks completed by Health & Safety Team 3. H&S engage with departments as requested for product selection and risk assessment.	

4 2024/25 Health & Safety Objective Update

4.1 The achievement of the primary health and safety objectives for the year 2024/2025 are summarised below:

No.	Objective	What was achieved	
1.	To successfully deliver the Stage 1 Moving & Handling training improvement plan to address backlog of staff's training	Induction and Clinical Refresher Training was delivered; however, Keyworker training and Manager Awareness Training was not delivered as the Moving and handling Lead who is competent to deliver	

		training was on long term absence.	
2.	To complete all actions from the National Back Exchange Gap Analysis that align to the Stage 1 Moving & Handling training improvement plan	Long Term absence of the Moving and Handling lead affected completion of action.	
3.	To establish and roll-out a Health & Safety training programme for all persons who have managerial responsibilities across the Trust	Discussion have taken place to use articulate to create training programme. Training programme is currently being drafted and action will be completed in 2025/26.	
4.	To expand the use of digital technology, to enable the Health & Safety team to better respond to queries, including space utilisation and display screen equipment (DSE).	Action completed.	
5.	To work with clinical colleagues to develop and distribute a suite of risk assessments for all in-patient wards and their activities.	Action completed	
6.	To re-audit against the Workplace Health & Safety Standards Audit on a monthly rolling programme, with all audit sections being complete by March-2025.	All sections of Workplace Standard Audit completed.	

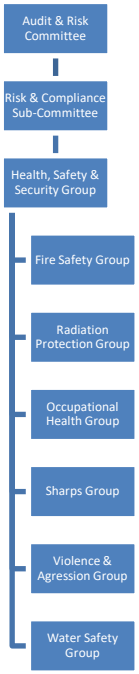
7.	To complete departmental audits against priority areas rated 2, 3 and 4, following the successful completion of Priority 1 audits in 2023/24.	Priority 2, 3 and 4 Audits completed in 2024/25.	
8.	To review and redesign the Trust's audit tools where required and to undertake audits for specific high-risk areas.	Action completed.	

5 Governance Arrangements

5.1 The Director with delegated responsibility for Health & Safety within the Trust is the Interim Chief Nursing Officer.

5.2 The Health, Safety & Security Group is established on the authority of the Risk &Compliance Sub-Committee to assist the Trust Board in fulfilling its responsibilities in relation to the Health and Safety at Work. It will fulfil its purpose by having responsibility for:

- Oversight of the systems and controls governing fire, security and health & safety, reviewing key performance indicators to assess their adequacy, and identifying where improvements need to be made.
- Establishing and maintaining standards of health and safety and welfare in keeping with legal requirement and in accordance with Trust policy.
- Providing the Trust with an overarching view of health and safety and to provide assurance that non-clinical risks are effectively manage on behalf of the Trust.



5.3 The Health, Safety & Security Group has 6 established sub-groups, from which assurance and escalation reports are received, these include:

1. Violence & Aggression Group
2. Radiation Protection Group
3. Fire Safety Group
4. Water Safety Group
5. Occupational Health Group
6. Sharps Group

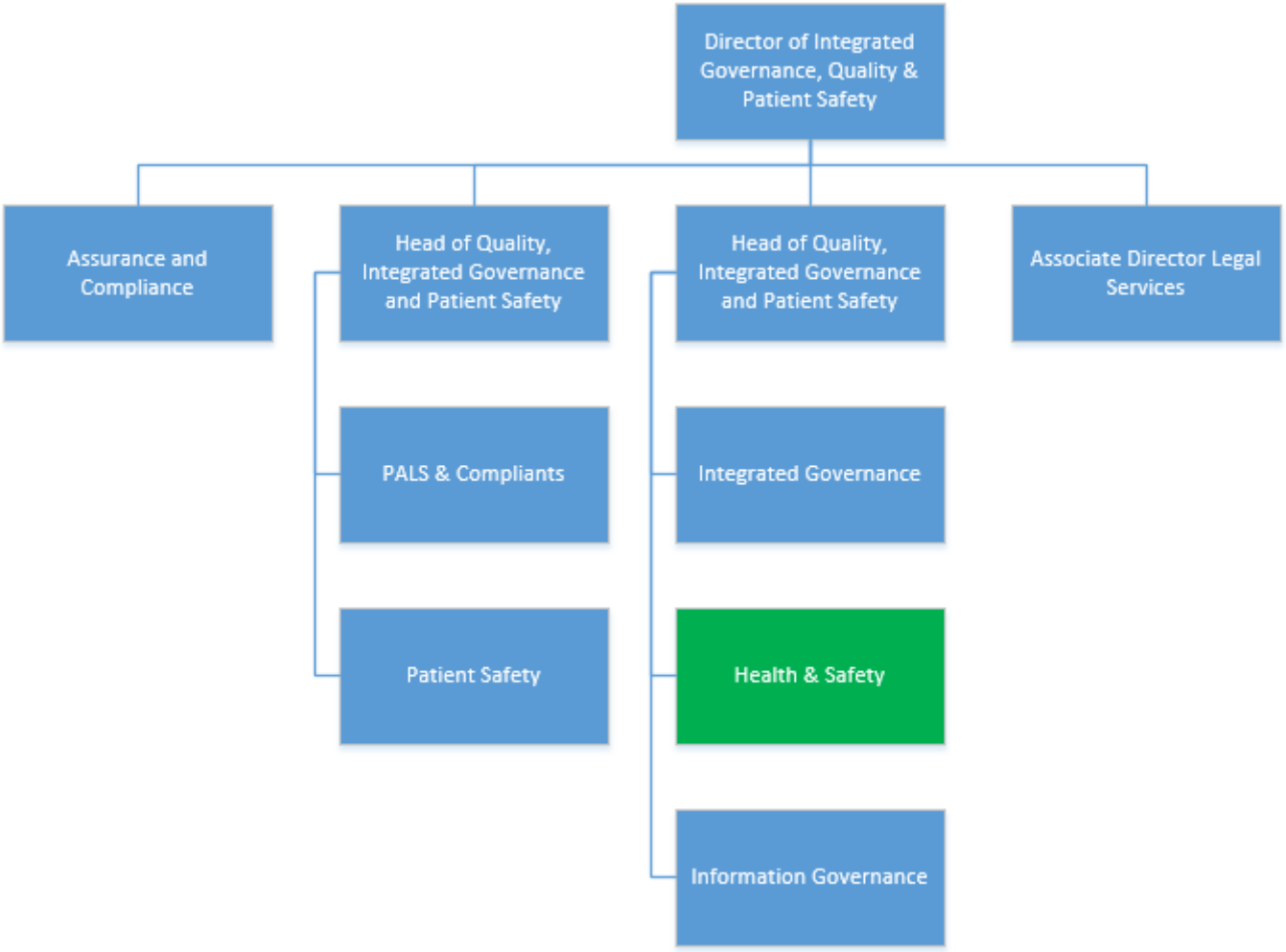
5.4 In addition to receiving reports from established sub-groups, the Health, Safety & Security Group also receives regular reports on topics including:

1. Estates & Facilities compliance (including waste management)
2. Employer liability and public liability claims
3. Wellbeing reports
4. Infection prevention & control

6 Competent Health & Safety Advice

6.1 The Health and Safety Team reports to the Head of Quality & Safety.

6.2 Both the Health & Safety Manager and Head of Quality & Safety hold Chartered Memberships with the Institute of Safety & Health (IOSH).



The Health and Safety Team consists of:

- One Health & Safety Manager
- One Health and Safety Lead
- One Moving & Handling Lead (Long Term Absence)
- Two Health and Safety Officers
- One Health & Safety Administrator

7.3 Regulation 7 of the Management of Health and Safety at Work Regulations 1999 requires organisations to have competent health and safety advice. The organisation has many health and safety risks and regulations that are managed across the organisation. These

risks are monitored through the Health, Safety & Security Group, or other appropriate monitoring arrangements.

7.4 The Health and Safety Team are responsible for advising and guiding the Trust to ensure that it is meeting, or working towards meeting, its legislative requirements. They also provide health and safety competent advice either verbally, via email or as part of an inspection/audit.

7.5 During this period 811 Datix incidents indicated as H&S factors were monitored by the H&S Team with H&S advice given in all incidents. This is a 15% reduction in reported H&S incidents from previous year. This may be due to less incidents created by increase in number of health and safety team which has led to increased support and engagement across the trust, or may be a result of under-reporting. This reduction in reported incidents should be monitored.

7 Policies

7.1 Policies and standard operating procedures (SOPs) that were consulted on and approved by the Health, Safety & Security Group include:

- TOR-MMH-IMG-RPG-12: Annual Review of Terms of Reference for Radiation protection Group
- CORP-EFA-GUD-1: Guidance for Security Officers attending a ward or clinical area
- CORP-H&S-TOR-2: Annual Review of Terms of Reference for Sharp Group
- CORP-EFA-TOR-1: Update for the Terms of Reference of Fire Safety Steering group
- CORP-EAF-GUD-2: Management of Risk Posed by Sex and/or Violent Offenders whilst on Medway Maritime Hospital Site Guideline
- Fundraising Stall Standard Operating Procedure
- Health and Safety Strategy (To be brought back for Implementation Plan)
- Acceptable Behaviour Standard Policy

7.2 The following policies and standard operating procedures (SOPs) were consulted on and incorporated in to version 1 of the Health & Safety Handbook, which was approved by the members of the Health, Safety & Security Group

- DSE Assessment integration into Gthr (digital platform)

7.3 No new policies or standard operating procedures (SOPs) were incorporated into version 1 of the Moving & Handling Handbook in 2024/25 due to long term absence of the moving and handling lead, however a consultation was held in the Health, Safety & Security Group

in June 2024 with regards to altering the moving and handling training programme provided to Doctors. The follow up action will be implemented once long-term absence is resolved.

8 Enforcement Notices and Improvement Plans

8.1 The Health & Safety Executive (HSE) is the regulatory body for Health & Safety legislation for all organisations across UK.

8.2 The Trust did not receive any enforcement or improvement notice from the HSE in 2024/25.

8.3 A singular health and safety incident was queried by the Health and Safety Executive. This incident involved a contact of the Health and Safety Executive by a member of the public who reported that staff were seen standing on chair to change curtain/s (unsafe work at height). No further query from HSE received following the Trusts response.

9 Changes to Legislation

9.1 The Health & Safety team is responsible for communicating any relevant legislative changes to the Trust Board and staff via the approved governance routes.

9.2 The Health and Safety Executive (HSE) is committed to helping business and other stakeholders adapt to changes in occupational health and safety law and practice in line with Government policy on 'Common Commencement Dates' which are:

- 6th April (the start of the tax year); and
- 1 October.

9.3 The Health & Safety team continue to monitor upcoming legislative changes in order to ensure the Trust remains compliant. Any changes to legislation will be escalated via the Health & Safety governance route.

9.4 The following are the legislative changes that have come into effect in 2024/25 which will impact the Trust.

- Carer's leave act was introduced in 6 April 2024, to introduce a new statutory unpaid leave entitlement for employees with caring responsibilities. Individuals will be able to take up to one week of unpaid carer's leave in any 12-month period.
- The Employment Relations (Flexible Working) Act was also introduced on 6 April 2024, to allow employees and other workers to request variations to terms and conditions of employment, including working hours, times and locations.

- In September 2024, the Workers (predictable Terms and Conditions) Act 2023 came into force which introduces a new statutory right to request a more predicable working pattern. It applies to workers whose existing working patterns lack certainty in terms of hours or times they work. It also applies to agency workers.
- From October 2024, Worker Protection (Amendment of Equality Act 2010) Act 2023 (Worker Protection Act) came into effect, introducing a "preventative duty" on employers to take proactive steps to prevent sexual harassment in their workplaces.

10 Incident Reporting

10.1 Health and Safety Incidents are reported via the incident management system; Datix. The graphs below (Figure 1) outline the health and safety incidents from April 2024 to March 2025.

10.2 There were 811 incidents indicated as H&S factors in this period, with only 398 near miss incidents. More work is required to increase reporting of near miss incidents as they are opportunities to prevent further H&S incidents, and a key indicator of a positive health and safety culture.

10.3 The 811 incidents (excluding violence and aggression) is a 3.44% of the 23,609 notifications reported on Datix during the period of April 1st 2024 to March 31st 2025. This reported H&S incidents has similar trajectory to other annual incidents. See figure 2.

Figure 1; Health & Safety Incidents by Month

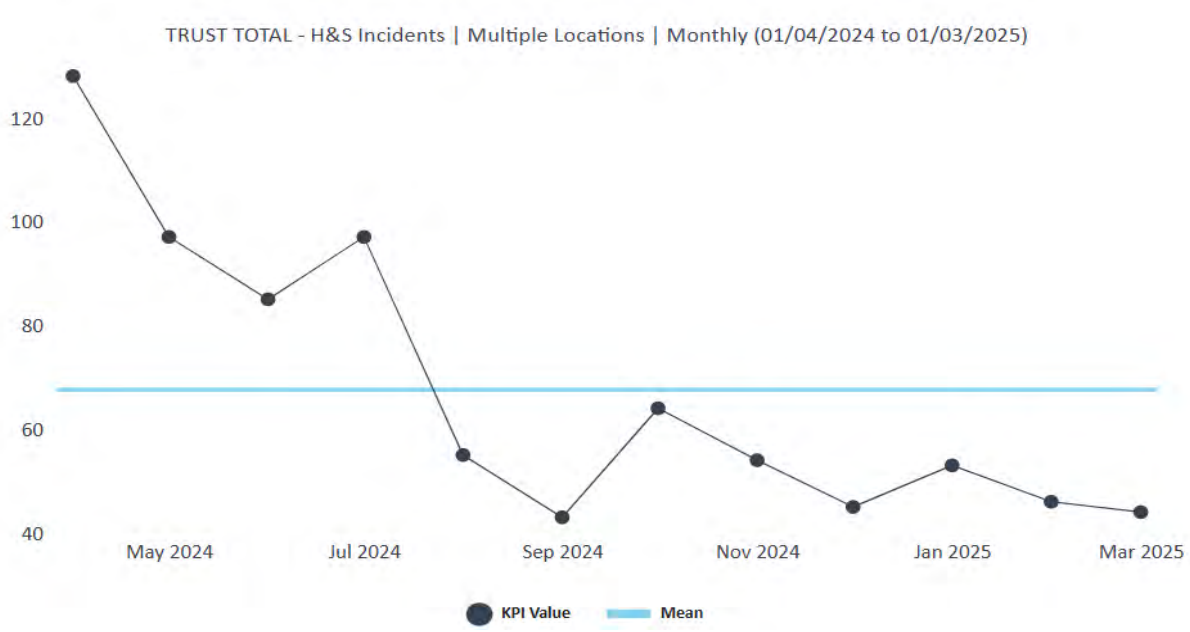
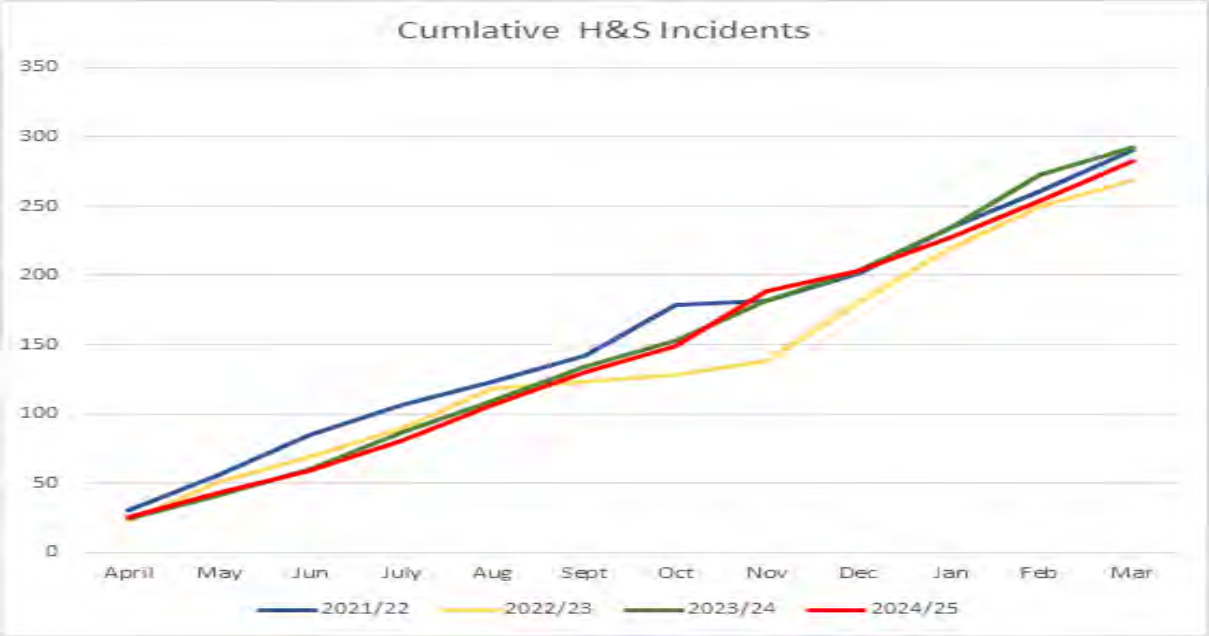


Figure 2; Annual Cumulative Health & Safety Incidents Trend



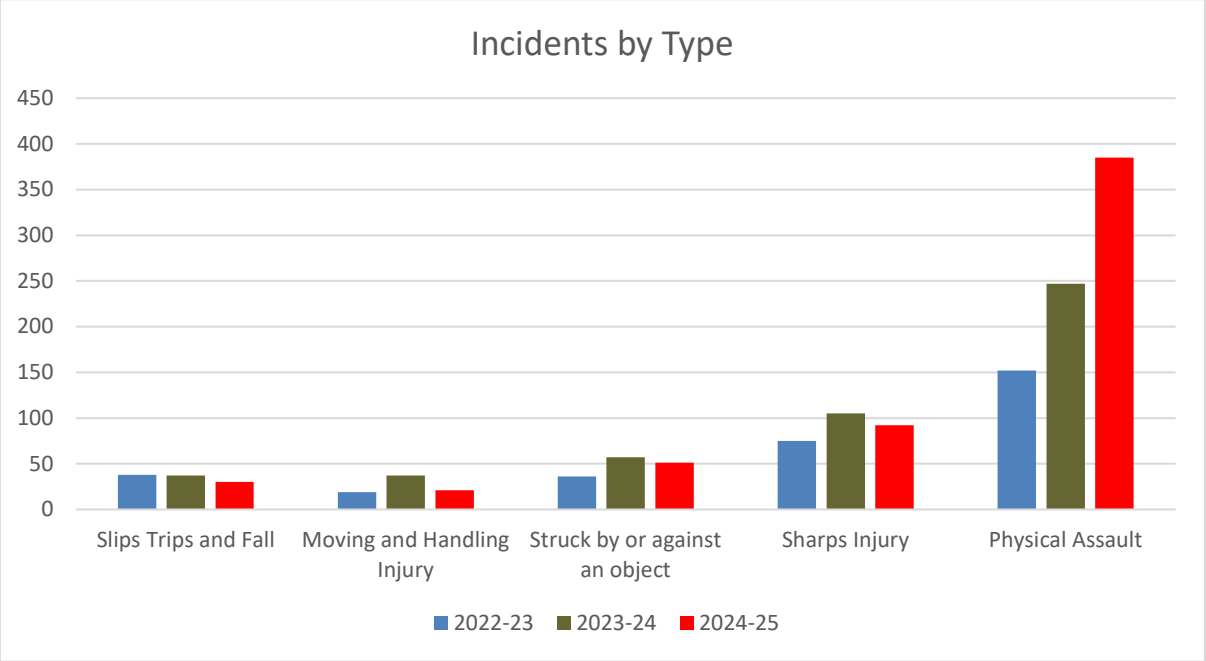
10.4 The Trust uses the Datix system to act as its digital 'accident book'. The accident book is an essential document for employers and employees, who are required by law to record and report details of specified work-related injuries and incidents. It enables organisations to comply with legal requirements under social security and health and safety legislation, including Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements.

10.5 Historically, reporting of health and safety incidents via Datix has been poor, with a lack of awareness of the importance of reporting incidents, and anecdotal feedback from staff citing inadequate locations and time consuming processes as reasons for not reporting. The Patient Safety team has worked on improving the system by making it easier to log incidents, and creating additional categories to help identify incident types, including health and safety and potential RIDDOR incidents, more readily. In addition, daily data cleanses by the Health & Safety team is identifying incidents where there is a health and safety dimension – for instance, a staff member receiving an injury whilst preventing a patient fall would be missed if it was only considered as a 'patient fall' incident.

10.6 The Health & Safety team recently reviewed the Datix reporting process and has taken steps to incorporate a streamlined process for the reporting of Safety Incidents.

10.7 The following data provides a breakdown of the type and cause of health and safety related incidents that have been reported in 2024/25. The previous year's figures are included for comparison.

Figure 3; H&S Incidents by Type



10.8 The top two categories of incidents have not changed since the previous report; they remain physical assaults (see section 14) and injury from sharps.

10.9 The 2024/25 incident data showed a significant increase in the numbers of physical assault incidents, and thus require significant focus and action (see section 14 for more details).

10.10 Ward and Departmental Managers are required to investigate incidents, supported by specialists when required, and any trends are reported to the Health and Safety Team who then report to Health, Safety & Security Group. Any learning is incorporated into H&S audits, advice and training.

10.11 The ongoing challenge is to get the ward and departmental managers to investigate incidents within their area as they are sometimes engaged with other activities or have the assumption that incident investigation is purely the responsibility of the health and safety team. The Health and Safety Team is continually highlighting benefit to managers to be involved in incident investigation, especially those within their area of control.

11 Sharps Safety

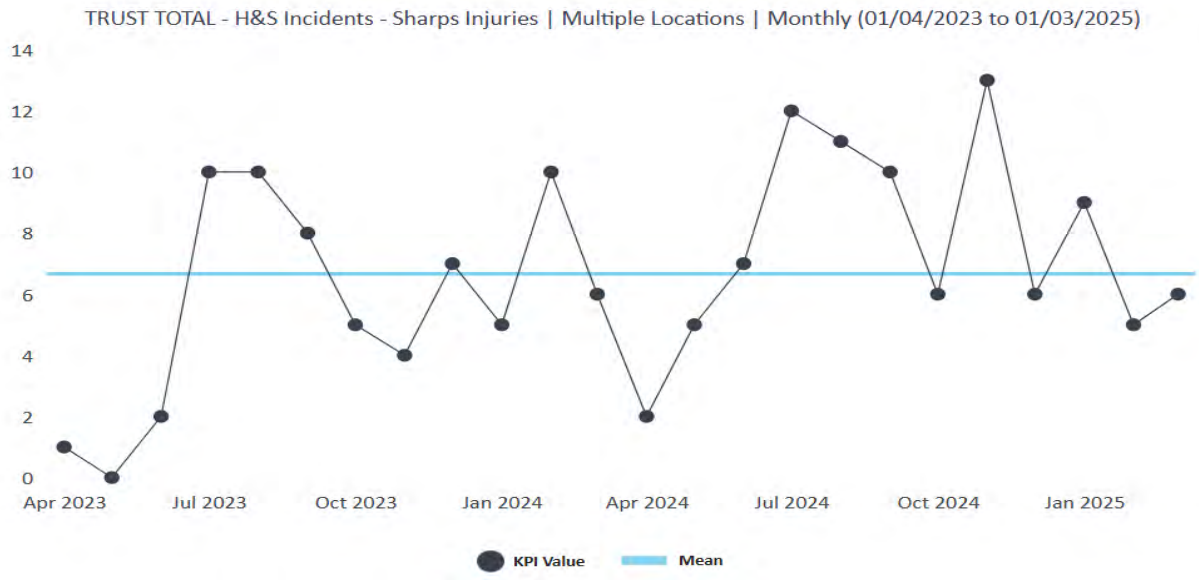
11.1 The number of injuries caused by sharps devices showed similar trend in 2024/25 to that

recorded in 2023/24 (92 in 2024/25; 105 in 2023/24).

11.2 Blood borne risk associated with sharp injuries put this injury in the categories of those that require significant attention regardless of numbers recorded. Sharps and contamination injuries are a significant risk in healthcare settings, and the topic is a current area of interest for the HSE who have included it in their hospital inspection programme.

11.3 Measures to avoid occupational exposure to blood borne viruses including prevention of sharps injuries must include; the safe handling and disposal of sharps. This require the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff. This is a requirement of the 'Code of Practice on the prevention & control of infections' and 'Sharps Instruments in Healthcare Regulations 2013'.

Figure 2; Sharps injuries by month (April 2023 – March 2025)



11.4 The Health & Safety team have been working in collaboration with the Infection, Prevention & Control (IPC) team to review the number and types of sharps used across the Trust, with an aim to both streamline the number of devices (circa 6000) used, whilst ensuring the Trust is compliant with the Health & Safety (Sharps Instruments in Healthcare) Regulations 2013. Departments have been asked to review their unsafe sharps and move to safer alternatives or present risk assessments to the Sharps Group for decision.

11.5 The move to using safer sharps, and ensuring risk assessments are in place for non-safe sharps, are part of the process of reducing the frequency of sharps injuries. However,

training and supervision is of equal importance as the safer sharp alternatives, are only safer if used correctly, and staff follow the correct procedures when disposing of them.

11.6 A Sharps Group was formally established in early 2024. The purpose of the group is to ensure there are robust governance arrangements in place for Sharps Management and providing assurance onto the Health, Safety & Security Group. There is now a greater analysis of data in order to inform where the H&S and IPC resources should be focused.

12 Slips, Trips & Falls

12.1 Slips, trips and falls of staff or other users of the site (excluding patients) is the second lowest occurring health and safety incident type within the Trust, however, in the past 2 years it accounted for the highest numbers of incidents reported as RIDDOR to HSE mostly due to prolonged absence from work following injury.

12.2 There are three primary causes of slips trips and falls:

1. Tripping over an object – this relates to the tidiness of workspaces and ward areas. Injuries occur from tripping over boxes, furniture and other obstructions in the working environment.
2. Falls from chairs – this relates primarily to chairs which move as people go to sit on them. This is attributed to incorrect castor specifications for the flooring. The use of computers on wheels in ward areas may be a factor in that more staff are working at computers in the wards as opposed to offices.
3. Slipping on wet/slippery surfaces – this includes both wet and dusty environments due to cleaning or maintenance work, as well as areas that become slippery due to inclement weather.

Figure 3; Slips, Trips & Falls by year

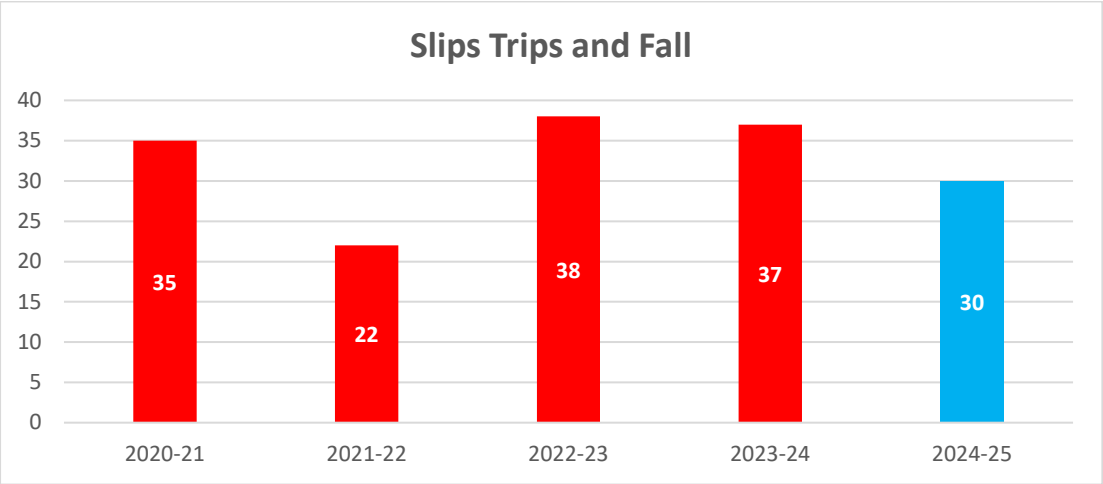
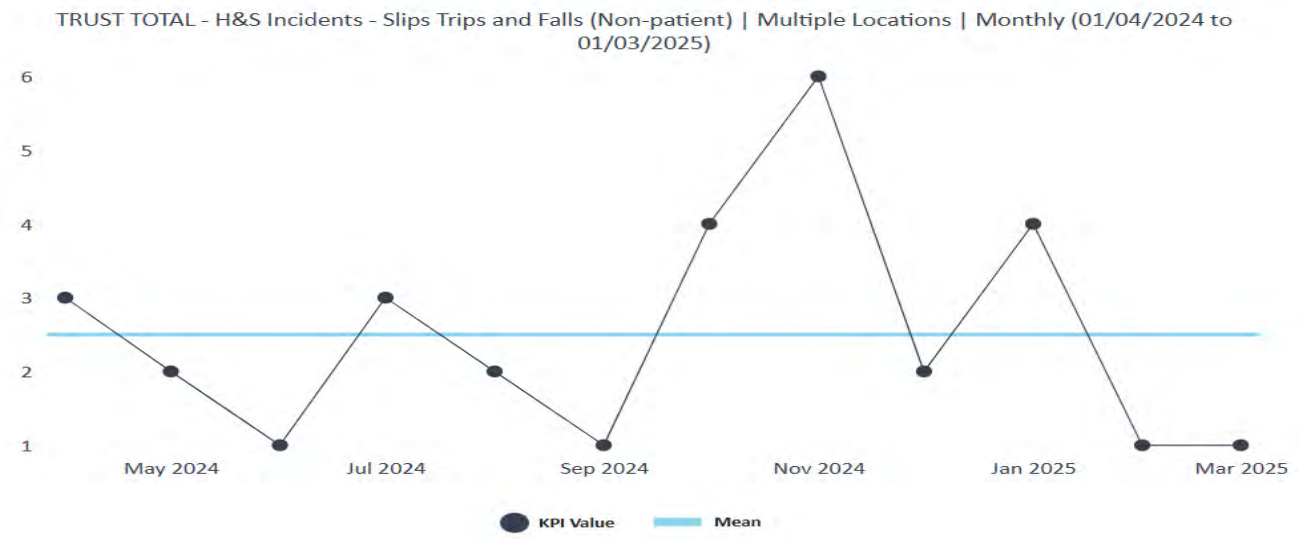


Figure 4; Slips, Trips & Falls by month



12.3 There have been improvements made across the site with flooring repairs and replacements being undertaken and resurfacing works. Individual teams are responsible for keeping their work area tidy and reporting faults to the Estates Hotline.

12.4 IPC and H&S audits flag work areas that are cluttered and pose trip hazards. The Health & Safety team continue to work with the Procurement Department to ensure that chair castors are specified for the type of flooring they will be used on, and H&S audits include checking existing chair castors.

12.5 Each slip, trip and fall incident is reviewed by the H&S team to ensure the handler has undertaken remedial measures to prevent a recurrence.

13 Moving & Handling

13.1 Moving and handling is recognised as a significant risk within healthcare settings. The challenges for safely moving patients by staff without risk of injury relate to ensuring that the staff are trained in correct moving and handling techniques, and have access to appropriate equipment for the task. Moving and handling risks also extend to non-patient moving and handling activities, as the hospital is reliant on the movement of significant quantities of waste, laundry, consumables and equipment in and around the site.

13.2 Moving & Handling matters at the Trust are overseen by the Health & Safety Team, specifically by the Trusts Moving & Handling Lead.

13.3 The Moving & Handling function have a designated training room from which all training is delivered.

13.4 The Moving & Handling Lead is responsible for investigating all incidents that include a factor of manual handling, alongside providing advice and guidance on equipment provision. The moving and handling lead was on long term absence from the Trust for the majority of 2024-25 which resulted in some of the provision of training and advice not being met. The Health and Safety team took up this duty and provided training, support and advice within their capacity.

13.5 Regardless of the challenges created by the long-term absence of Moving and Handling Lead in 2024/25, there was a 43% reduction in reported moving and handling incidents (Twenty-one (21) Moving and Handling incidents were reported, a decrease of sixteen (16) from the previous year). Also, only two of the reported twenty-one incidents met a requirement to be reported to the HSE under the RIDDOR regulations, this is an 83 % reduction from RIDDOR reported moving and handling incidents of 2023/24 (see section 15).

Figure 5; Moving & Handling Incidents by Year

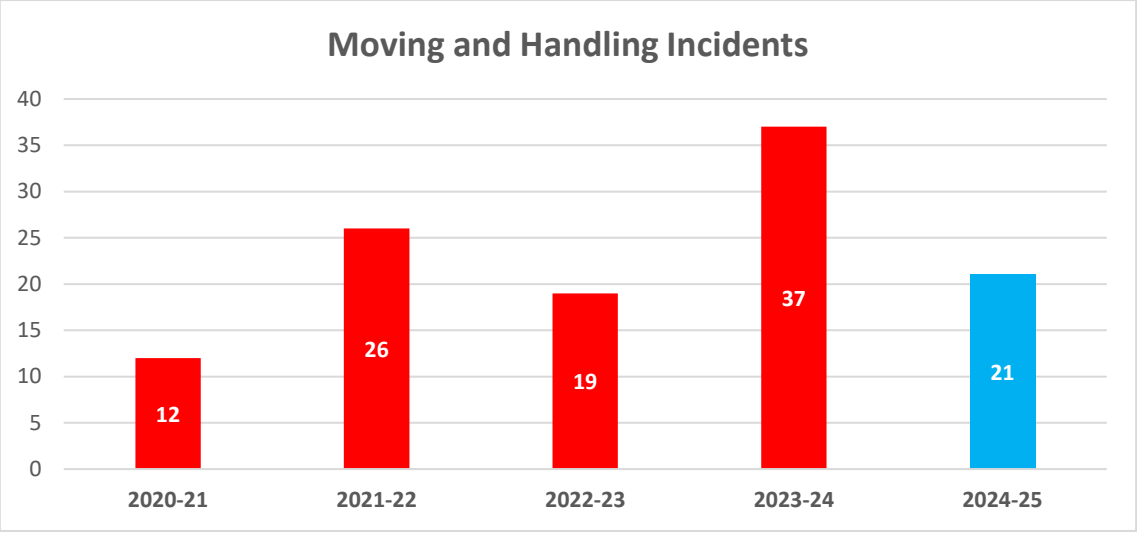
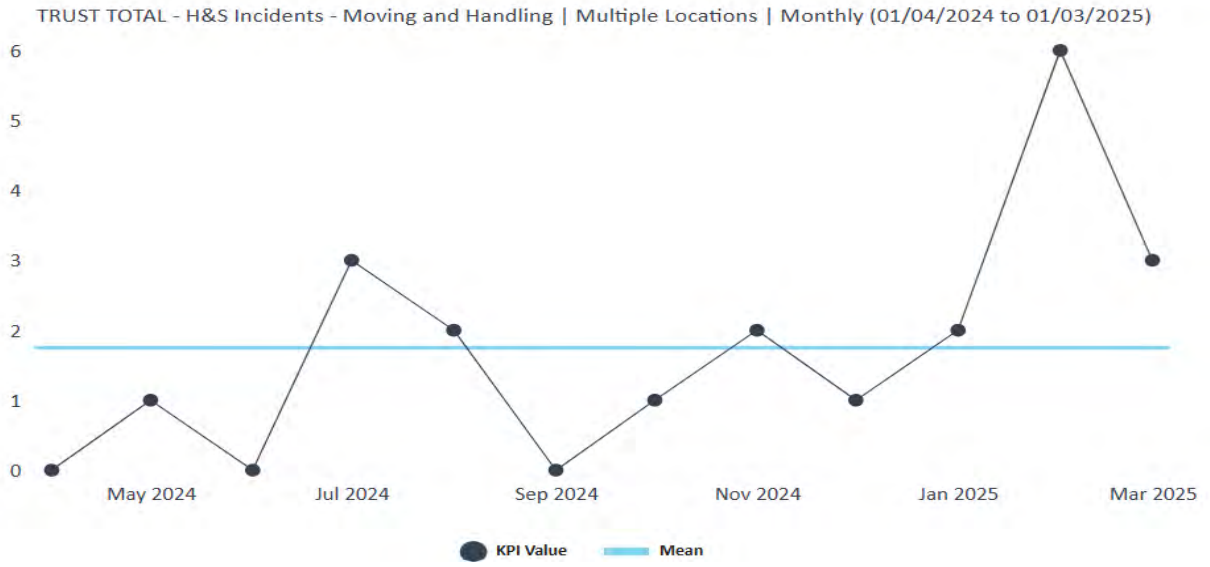


Figure 8; Moving & Handling Incidents in 2024/25



13.6 There has been a significant increase in the number of musculoskeletal referrals (both work-related and non-work related) from the previous year. The work-related referrals can be associated to the need for more support for staff which is currently missing due to long term absence of the moving and handling lead.

Table 1; Moving & Handling Incidents in 2024/25

MSK Referrals	Work related	Non work related	Total
1/4/23 - 31/3/24	50	211	261
1/4/24 - 31/3/25	73	287	360

13.7 Key to preventing moving and handling injuries is to ensure that staff are fit to perform the task; have been sufficiently trained; have the right equipment; and follow the correct process. Training and observing staff in the workplace are essential in ensuring good practice, as staff will not always follow their training within a busy work environment. A significant threshold in the reporting of incidents under RIDDOR is the over 7-day injury which is the responsible factor for reported Moving and Handling RIDDOR in 2024/25.

13.8 There is more work to be done to ensure the Trust complies with the legislative responsibilities in moving and handling of patients, and ensure practice of safe handling by

staff. The Trust to continue to work to reduce moving and handling incidents, ensuring that risk assessments are suitable and sufficient, and that provided training is tailored to staff groups. M&H Key Worker training need to be reintroduced to bolster availability of local M&H advice within wards and departments.

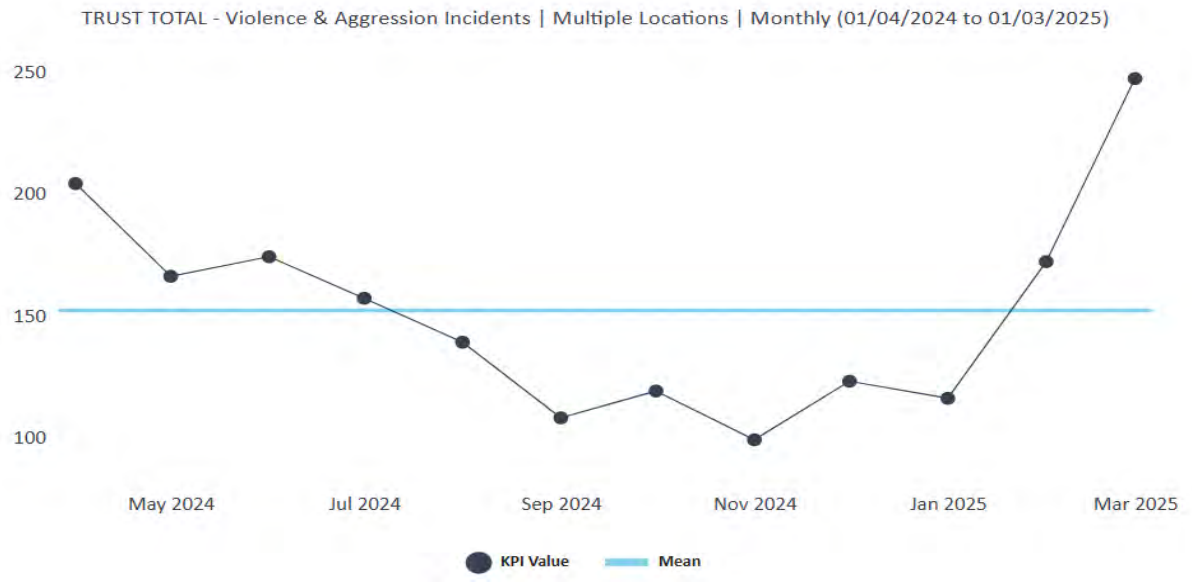
13.9 The Trust will benefit significantly by addressing the current gap created by the moving and handling lead so that tailored training can be put into place for staff, as well as support for patients especially those who require bespoke M&H risk assessment, as the current gap is creating non-compliance to Manual Handling Regulation, and the Trust is unable to provide assurance in relation to Moving and Handling.

14 Security (Violence & Aggression)

14.1 Violence and aggression continue to be an area of interest, particularly within the Medicine and Emergency Care Division which has seen an increase in incidents since last year, with 152 physical assault incidents notified this year, compared to 120 incidents notified last year, an increase of 27%.

14.2 Overall 900 incidents of Violence and aggression were recorded this year, that is an equivalent of almost 3 incidents per day. However, the Trust recorded reduction in numbers of violence and aggression incidents reaching threshold of RIDDOR with four incidents this year meeting RIDDOR criteria as opposed to seven meeting RIDDOR criteria last year. This may be associated to increase in security personnel to manage and de-escalate incidents.

Figure 9; Physical Assault Incidents trend within the Trust



14.3 Physical assault is still the highest occurring health and safety incident category reported via DATIX. Reported numbers have steadily increased across the years (See the graph below). A total of three hundred and eighty-five (385) physical assault was recorded on the DATIX reporting system of the Trust in 2024/25. This is a significant 36% increase (138) from the total of two hundred and forty-seven (247) physical assaults recorded in 2023-24, and more than double the number reported in 2022/23.

Figure 10; Physical Assault Incidents trend within the Trust

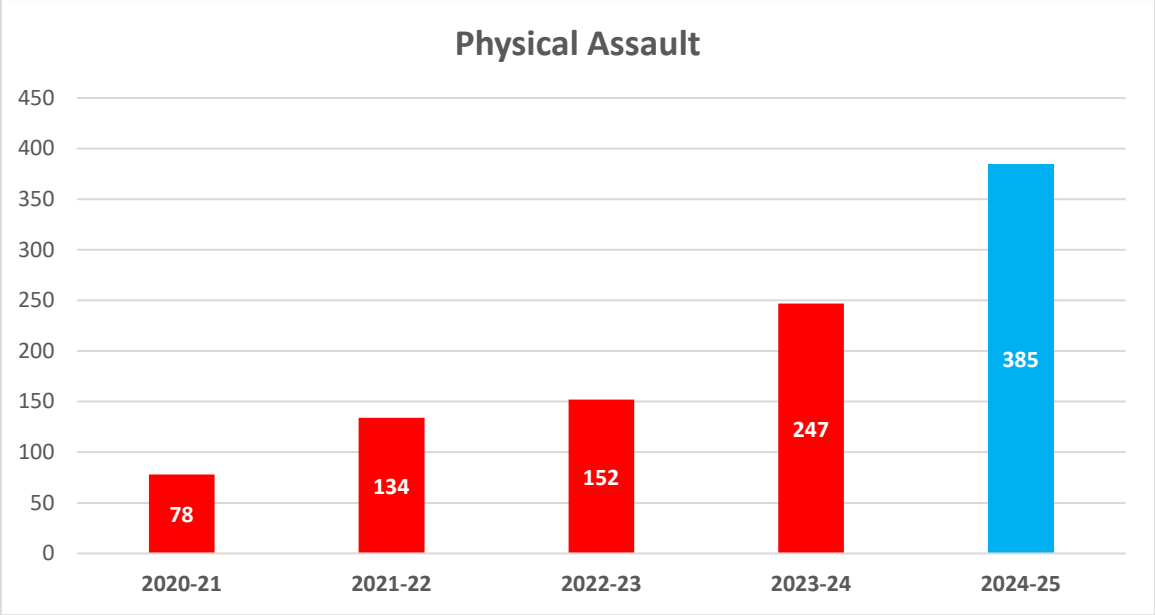
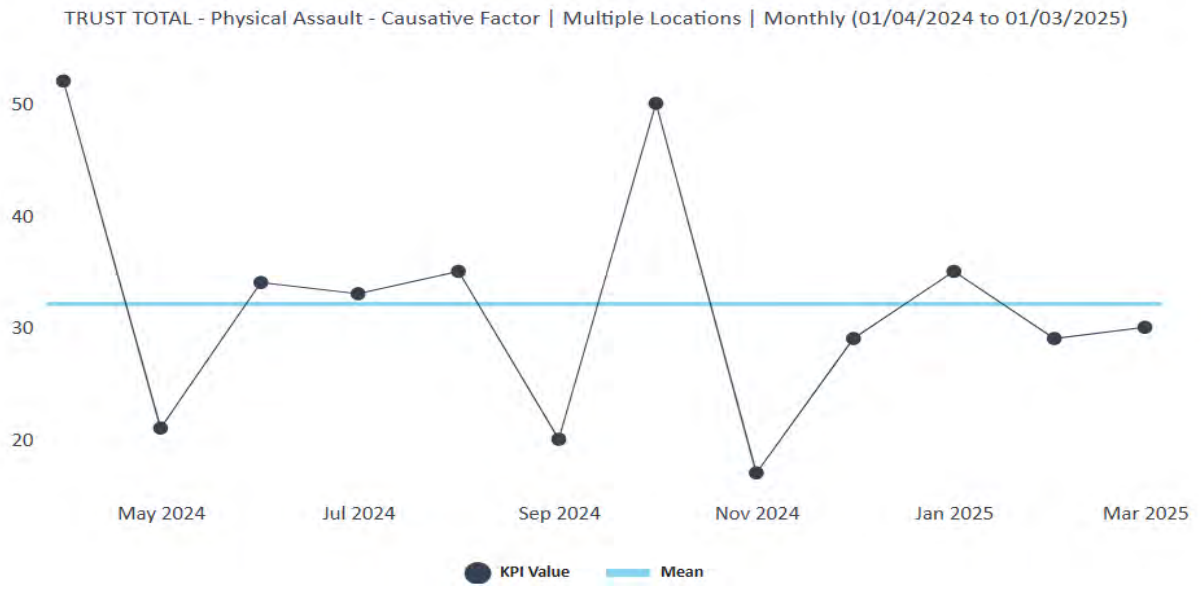


Figure 11; Total physical assaults by year SPC chart (2024/25)



14.4 Following an assault, staff are advised to attend ED for assessment and treatment. They are also encouraged to attend Occupational Health where support and further guidance is offered, and to report the assault to the Police. The Security Manager is available to support staff who are part of a criminal case, and he meets regularly with an allocated Inspector from Medway Police to discuss criminal activity at the hospital. In 2024/25, 4 patients received custodial sentences for staff assault, 1 patient received community order while 3 cases are pending (sentencing dates to be confirmed).

14.5 The Prevention and Management of Violence and Aggression (PMVA) training is available to all staff and the Security Manager is working with violence and aggression prevalent departments, such as the Emergency Department, to identify targeted strategies to manage violence and aggression, as well as ensuring that the Sanctions and Redress Policy is applied to patients who physically or verbally assault staff. A priority of the Violence, Aggression and Security Steering Group will be to expand the Policy to a Violence and Aggression Reduction Strategy for 2025/26.

14.6 One of the strategies in place to support staff to deal with Violence and aggression is the provision of Prevention and Management of Violence and Aggression (PMVA) training programme. This is in addition to the conflict resolution training programme provided on the Trusts internal training platform. A total of 895 staff completed PMVA training, with 545 DNA (did not attend – mostly due to workload or sickness). There is a need to address significant numbers of DNA considering how limited spaces for this training are.

14.7 The security team is continually pushing for incidents to be reported by departments onto Datix for follow up. A Yellow and Red card system is implemented for repeat offenders with 72 yellow cards and 17 red cards being issued to service users this year.

14.8 During the year, the Security Management Specialist has reviewed security risk assessments, violence and aggression risk assessments and made recommendations to clinical staff and Estates and Facilities Department where changes can be made to the environment and alterations to the premises.

14.9 The Security Management Specialist continues to attend multi-disciplinary meetings and advise multiple staff groups on Violence and Aggression, crime reduction and lone working.

14.10 The Trust remains committed to the delivery of a secure environment for those who use or work in the Trust so that the highest possible standard of care can be delivered; to this end security remains a key priority within the development and delivery of health services. The Trust plan to further increase the capacity of the in-house security team and stationed

security personnel in prevalent area of violence and aggression such as the accident and emergency unit. The Trust has also commenced trialing the use of body cameras in prevalent clinical areas.

15 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

15.1 Under RIDDOR, certain work place accidents, incidents, ill-health and certain near miss events must be recorded, depending on the severity and nature of the injury. The Trust has a legal duty to report this data to the Health and Safety Executive.

15.2 There were 16 notifiable incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) in 2024/25, a significant 50% decrease from 32 of 2023/24 and joint lowest with 2019/20.

15.3 One of the recorded 16 notifiable incident related to a patient, with the 15 others associated to staff (mostly due to being off work for more than 7 days following injury).

15.4 This significant decrease in RIDDOR incidents can be associated to the work committed to investigating past RIDDOR incidents and sharing lesson learnt from incidents to prevent recurrence.

Figure 12; RIDDOR submissions by Year

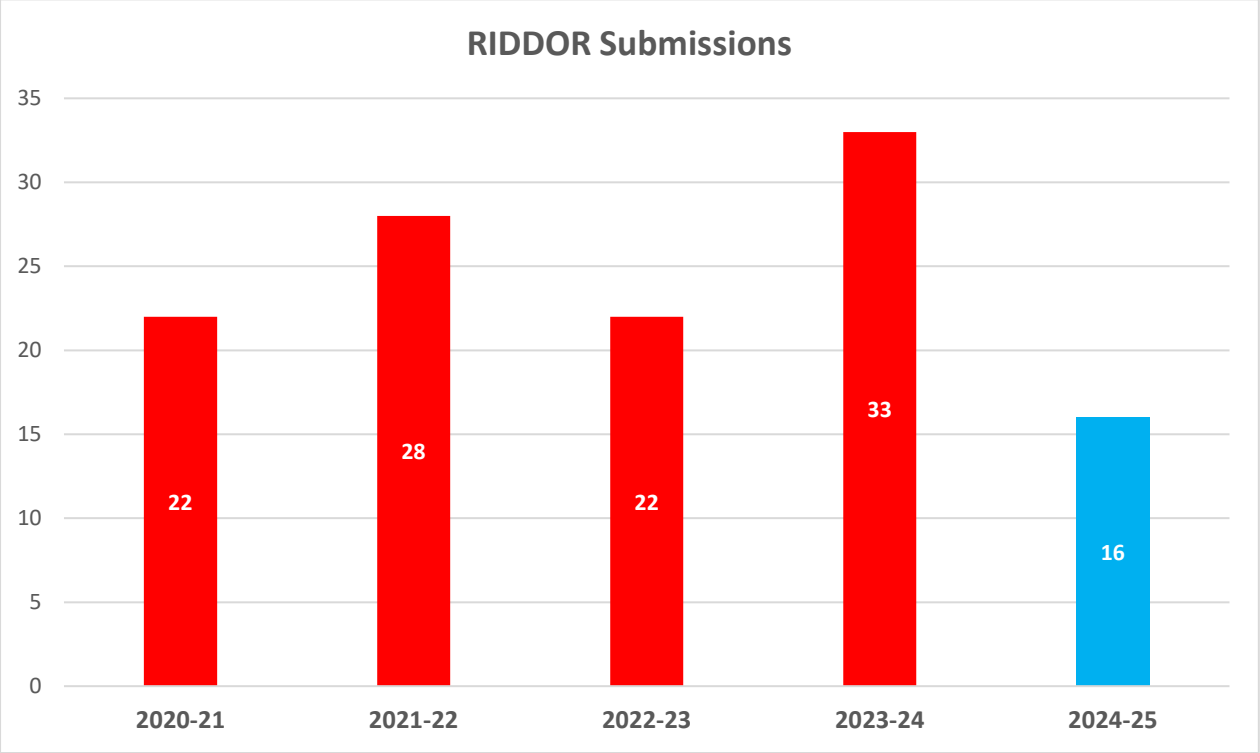


Figure 13; RIDDOR Submission by Incident Type

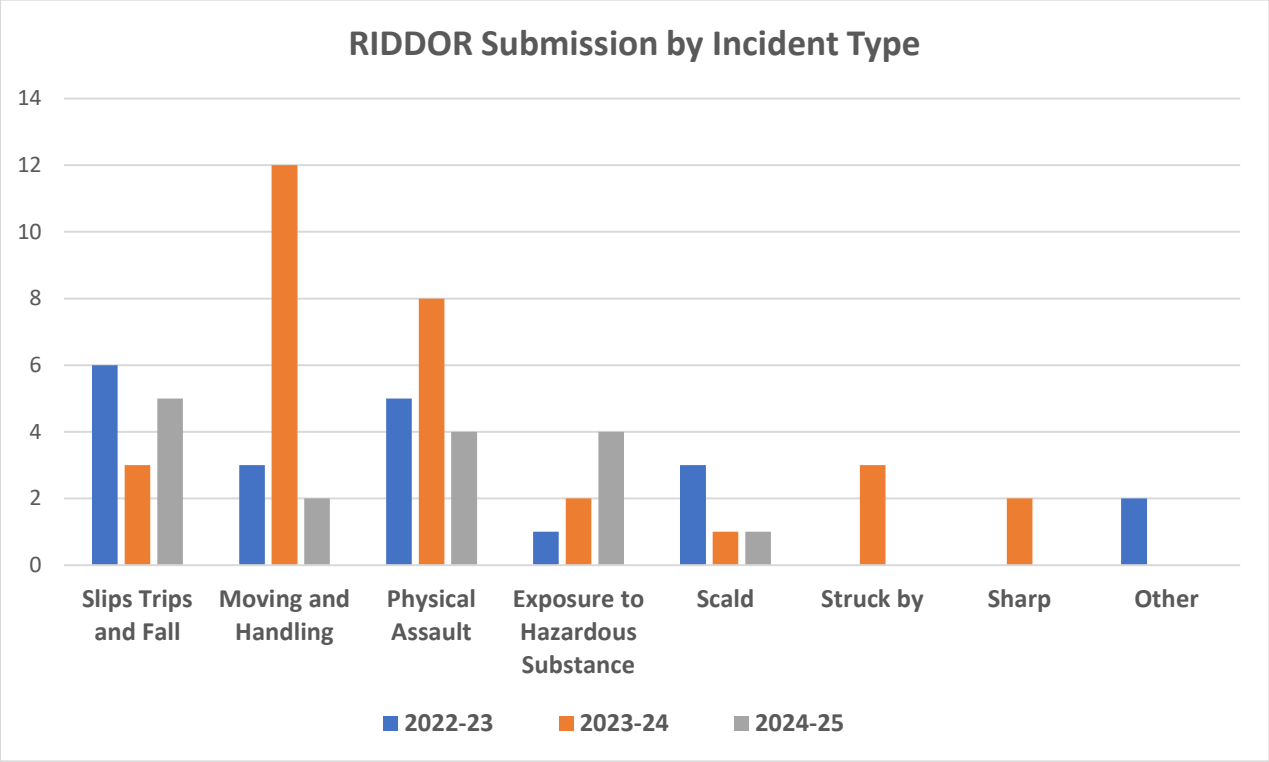


Figure 14; Monthly RIDDOR Submission of 2024/25

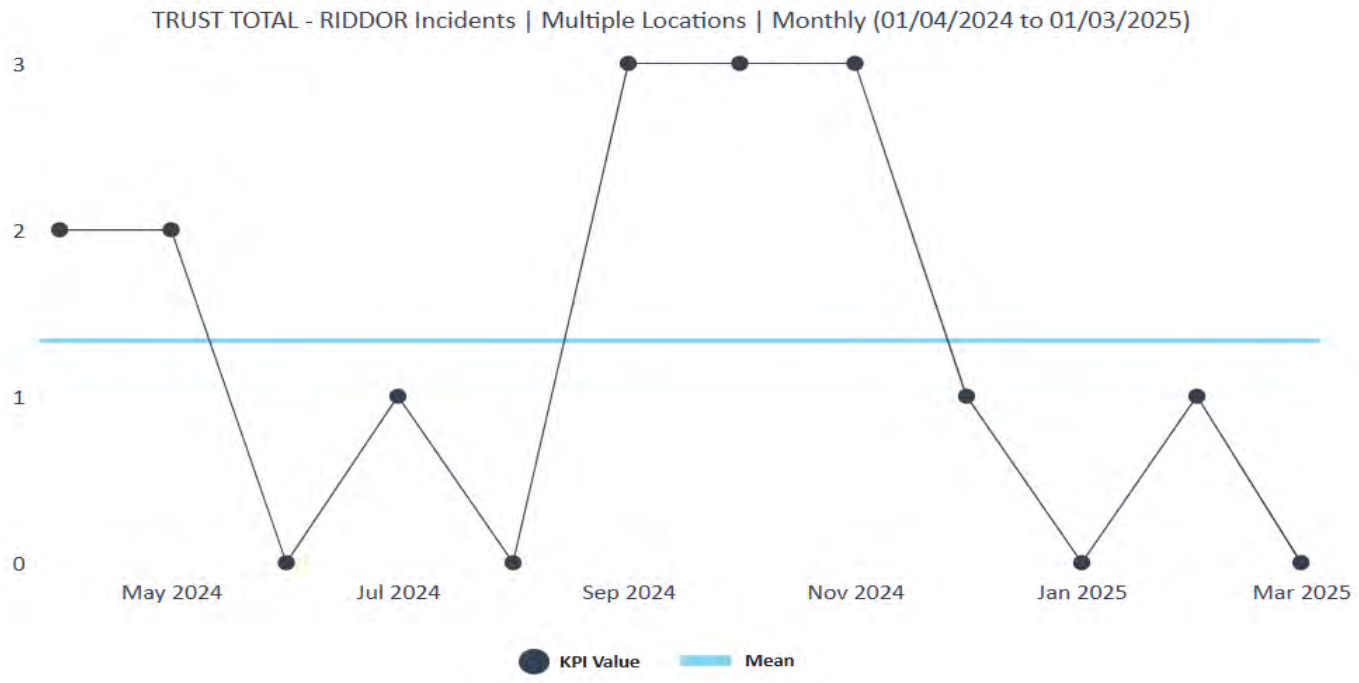
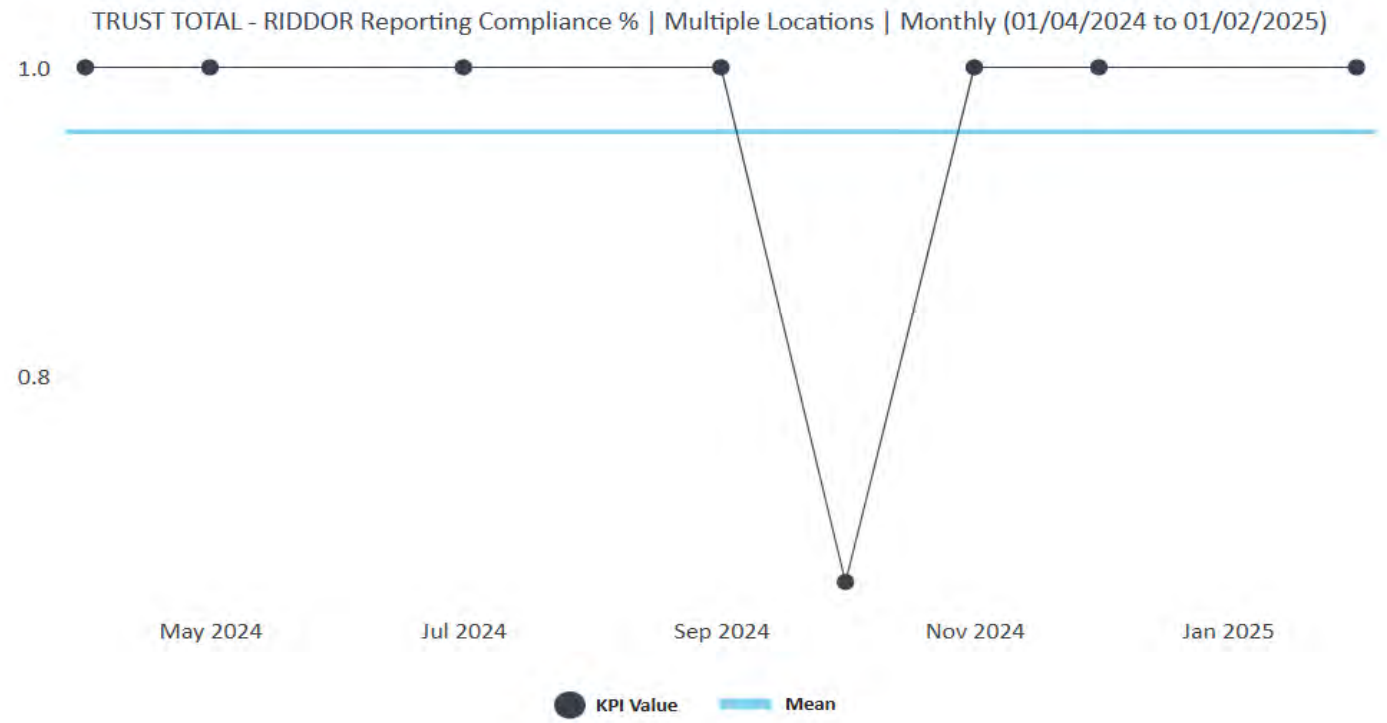


Figure 15; RIDDOR Reporting compliance for 2024/25



15.5 The Trust has historically performed poorly when reporting RIDDOR incidents within the regulatory timescales, however, this year saw a significant jump in compliance rate to 94%, up from 70% from 2023-24. The improved compliance is an indicator that staff and managers are better aware of need for flagging potential RIDDOR incidents early, as well as the good work put in by the health and safety team to chase up potential reportable incidents.

15.6 The top three areas for RIDDOR reportable injuries in 2024/25 are Slip trip and fall, physical assault and COSHH. This is a similar trend to previous years. There is need for more action to address root causes of injuries.

15.7 All RIDDOR incidents reflect a level of harm that is impactful on the individual as well as the organization. The Trust must set an ambitious target to reduce the number of these incidents to as low as is reasonably practicable and certainly within line with similar organizations which would mean only seven RIDDOR incidents or less per year.

15.8 The annual work plans need to focus on the high-risk areas within the Trust and ensure there are sufficient resources in place to progress improvements quickly.

16 Training

16.1 Mandated Health & Safety training within the Trust currently consists of 2 levels of training:

1. **Health, Safety and Welfare**; completed at induction with a renewal period of 3 years. Training is available via a national e-learning package.

16.2 Mandated Moving & Handling training within the Trust currently consists of 3 levels of training:

1. **M&H Level 1 (theory);** completed at induction by all staff, renewal every 2 years, available as e-learning module of face to face.
2. **M&H Level 2**, is a practical session for all clinicians and non-clinical roles where manual handling is required. Renewal every 2 years, face to face only.
3. **M&H Level 3**, is a practical session for Doctors only with a renewal period of 3 years.

16.3 The training compliance rate for individual departments is set at 85% across all statutory and mandatory subject areas by the Trusts organisational development team.

16.4 Compliance levels at the end of the year for Health, Safety & Welfare, and Moving and Handling Level 1 were above 90% (See table 1).

16.5 A gap analysis against NBE (National Back Exchange) standards was completed that re-mapped the training to meet NBE standards in relation to duration and ratio perspective. The Safety Team also introduced additional training materials such as Sara-Steady, Hoist slings etc. A 2-year improvement plan was compiled and is being progressed with monthly monitoring via the M&H report within the HSSG meeting. Keyworker training for non-clinical staff in high risk areas was introduced, however the training for many of these keyworkers has lapsed due to long term absence of the moving and handling lead.

16.6 Compliance levels for Moving and Handling Levels 2 and 3 were well below the 85% target at the end of 2024/25. Moving and Handling Training compliance is being severely impacted by the DNA (did not attend) rate with an average over the last quarter over 54%, a key factor being the release of personnel to attend training by their line managers. The DNA rate is being monitored via the Statutory and Mandatory Training Group meeting.

16.7 In addition to statutory and mandatory training, additional training is required to be undertaken by staff who use ladders as part of their daily job. The requirements for ladder safety training are set out by the Working at Height Policy.

- Level 1 Access Equipment Training (E-learning module via ESR) – renewed every 3 years.
- Level 2 Access Equipment Training (1/2 day face to face session) – renewed every 5 years.

Level 2 training is only required to be undertaken by staff who undertake working at height for the purpose of activities such as maintenance (I.e. Estates staff). All other staff required to work at height, should complete Level 1 training. The compliance levels for Level 1 training and reported on monthly by the Workforce Team. Records of compliance for Level 2 training should be held by the individual department in which the individual works.

Table 2; Training Compliance

	TRAINING COMPLIANCE				
TRAINING	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Health and Safety Welfare	90%	89%	89%	89%	**91%**
Moving and Handling Level 1	90%	87%	87%	91%	**93%**
Moving and Handling Level 2	83%	77%	77%	78%	**79%**
Moving and Handling Level 3 (Doctors)	68%	51%	51%	45%	**54%**

16.8 Compliance rates continue to fall below the target figure of 85%, this is likely due to the fact. Without mandating key safety subjects, compliance is likely to remain low.

16.9 The Health & Safety Team also facilitates 1-day emergency first-aid training for departments who have identified via a risk assessment, that first aid provision is required. The nominal target for the Trust is currently being assessed, although this needs to be reviewed against the actual risk assessment for each area. There are currently (36) first-aiders, although registered nurses can also fulfil the role. The locations of the first-aiders will be dependent on the risk level of individual departments.

16.10 Other departmental-specific safety training such as confined space, radiation safety etc. is currently arranged and managed locally at departmental level, and as such, the Health & Safety team does not have a broad-picture of compliance across all aspects.

17 Audit

17.1 Auditing is a key function of the Health & Safety Team, and is supported by the Management of Health & Safety at Work Regulations 1999, HSG65 (Plan, Do, Check, Act) and is a core component of the Trusts Health & Safety Management Arrangements.

17.1 In 2024/25, the Trust audit itself against the NHS Employers Workplace Health and Safety Standards. A separate action plan was created in line with the audit findings. At the time of

reporting the action plan from the audit have been collated and being discussed with action owner.

17.2 The Health and Safety audit programme was developed for 2024/25 with the intention to audit all Trust departments before year-end.

17.3 The order of audits was based on the risk-profile of each department, with departments being given a priority level of 1-4. 1 being highest priority and 4 being the lowest priority. E.g. Inpatient wards have been issued a level 1 priority.

17.4 Due to the fact that Priority 1 was audited between January and March 2024, the focus in April 2024 to March 2025 was to audit priority 2,3 and 4. 100% of audits were completed against plan, by the end of the 2024-25 financial year.

17.5 The audits were completed using Gthr (a data collection and analysis tool) to make the process more efficient.

17.6 Wards and departments are required to undertake local audits and inspections on a regular basis, on matters pertinent to health & safety, inclusive of:

- Window restrictor checks - conducted weekly
- COSHH (Control of substances hazardous to health) checks – completed weekly
- Workplace Inspections – Completed quarterly

These audits are currently completed by either the Health & Safety Keyworker or the departmental manager, with copies of audits shared via email, and data recorded in a spreadsheet.

17.7 To improve efficiency of completing the audits, and to enable data analytics, the suite of local audit tools has been integrated into Gthr and the results compiled for analysis.

18 Risk Assessments

18.1 The Health & Safety Team support the completion of risk assessments as required. The management on control measures from such risk assessments sit under ownership of the departmental manager/s.

18.2 In addition, several risk assessment pro-forma with associated guidance notes are available for staff to complete as required, including:

1. General Risk Assessment
2. COSHH Risk Assessment
3. Display Screen Equipment Self-Assessment
4. First Aid Needs Assessment

5. Lone Worker Risk Assessment
6. New and Expectant Mothers Risk Assessment

18.3 From the audits completed, the lack of suitable and sufficient risk assessments is apparent and so the affected departments will be contacted to arrange a support visit where the incomplete assessments will be reviewed with the Safety Team.

18.4 The Health and Safety Team is working towards creating a platform of completed COSHH Assessment for clinical units and develop risk assessment training programme for managers to aid completion of suitable and sufficient risk assessment.

19 Conclusion

19.1 Improvements in health and safety are on-going across the Trust. The Health & Safety Team are working with the Trust's Clinical Divisions to increase compliance of local audits. Improvements in this area will show a greater level of legal compliance generally across the Trust.

19.2 Both the audit programmes and incident reporting are fundamental to the Trust being able to identify, analyse and address its high-risk areas. This relies on the involvement of all staff and managers and the Health & Safety Team are working Trust-wide to deliver on this. Reconfigurations made to Datix continues to improve the efficiency of reporting for staff and should also improve the follow up and investigation of incidents by managers.

19.3 The Trust will benefit significantly by addressing the current gap created by the moving and handling lead so that tailored training can be put into place for staff, as well as support for patients especially those who require bespoke M&H risk assessment, as the current gap is creating non-compliance to Manual Handling Regulation, and the Trust is unable to provide assurance in relation to Moving and Handling.

20 Health & Safety Objectives 2025/26

The key objectives for the Health & Safety team for 2025/26 are set out below.

20.1 To produce Health and Safety Strategy document to demonstrate that the Trust has securing compliance with health and safety legislation as a core requirement of strategy led by the board.

- Strategy document to set out overarching Health and Safety action plan (3 year) and implementation of plan.

- Strategy document to be approved by the board and made available on the intranet.

20.2 To ensure effective compliance monitoring with all relevant health and safety legislation and safety standards that relate to Medway Trust Foundation activities.

- Health and Safety Team to carry out regular H&S Audits to help demonstrate compliance and provide quarterly compliance reports to the HSSG.
- All wards/departments regularly monitoring and assessing their work environment using spot inspection visits. Also supported by Health and Safety Team.
- The Trust maintaining records of evidence to support compliance with the above requirements
- Provision of legal updates to the HSSG
- Development of a register of H&S Legislation

20.3 To work with the Integrated Governance Team to improve staff's completion of DATIX so as to ensure timely gathering of vital information of health and safety related accident/incident/near miss data, which feed into investigation process.

- Questions within the DATIX form to be expanded to facilitate better input.
- Acceptable completed model form to be developed and communicated to staff.
- Timely Investigation of accidents, incidents and near miss.
- Identified Root causes and any reasonably practicable required changes communicated back to the appropriate team for consideration.

20.4 To address shortfall in Moving and Handling Training (keyworker Training and Manager Awareness Training); and align Moving and Handling training programme to National back exchange through the completion of outstanding actions from the National Back Exchange Gap Analysis:

- Resolve the issue of M&H Lead on Long Term absence.
- Consider resilience for the role for long term need (upskill or support)
- Completion of a risk assessment for M&H training facilities and equipment.
- Alignment of M&H training programme to NBE Standards.
- Provide Keyworker Training and Manager Awareness Training.
- Create a means to provide structured feedback to managers where concerns relating to staff training are highlighted.

20.5 To review current audit programme to create audit plan that focuses on risk/need of the Trust.

- The revised audit programme to ensure high risk areas are regularly audited.
- To ensure actions identified from audits are followed up through to completion with support provided by the H&S Team.

20.6 To provide appropriate training and guidance for managers and staff that enables them to safely undertake their work activities and become more aware of risk and risk control.

- This will include induction training, training on risk assessment, training on COSHH assessment, training in Moving and Handling and other training needs in line with the Trusts Health & Safety Handbook.

20.7 To reduce the number of health and safety related accidents and incidents (10% reduction from total number reported in 2024/25) reportable under the Reporting of Injuries, Diseases and dangerous Occurrences Regulations 2013. Implementing all the other 7 objectives (i.e. regular spot checks, monitoring and audit, training, investigation and shared lesson learnt) will act as drivers for the targeted reduction.

- Tracking RIDDOR reports monthly (type, frequency etc)
- Educating and supporting units to change practice or equipment based on lessons learnt.

NHS Medway NHS Foundation Trust

The Guardian Service
Here to listen

CLIENT Medway

Annual Report
23 September 2024 to 31 March 2025

Circulation:

Main point of contact

Leon Hinton Chief People Officer

Dominika Kimber Deputy Director of HR & OD

Prepared by:
Guardian name(s)

Natasha Barrett Salvador April 2025

Guardians
The Guardian Service Ltd.

Date:

Contents

1. Executive summary

The 12-month reporting period typically spans from 1st April 2024 – 31st March 2025. However, this report exclusively addresses the interval from 23rd September 2024, the service implementation date, to 31 March 2025. During this period, 63 new concerns were raised to the Guardian service. Through the following methods: telephone, electronic mail, or in-person meetings.

The measures implemented by the Trust in addressing the concerns raised and in advocating for the Freedom to Speak Up Guardian (FTSUG) initiative throughout the organisation, alongside the continued positive influence of The Guardian Service, have resulted in a notable impact in staff members participating in the incitive. A high significant number of staff members have opted to engage with The Guardian Service due to their ongoing perception that their concerns would not be appropriately addressed, along with a fear of potential repercussions.

The four staff groups expressing the most significant concerns were Nursing and Midwifery (15), Estate and Ancillary (11), Medical and Dental (11), and Additional Clinical Services (8).

The four most prevalent themes identified in new cases were Bullying and Harassment (14), Patient Safety and Staff Harm (11), Discrimination and Inequality (11), and Management Issues (11).

Bullying and harassment are predominant themes; however, the Trust has demonstrated a high level of receptiveness and proactivity in addressing the concerns raised by the Guardian. The Trust and the board have responded in a timely and effective manner to all issues presented to date. The Guardian Services has monthly meetings working in partnership with the FTSUG executive lead to review all cases any Bullying and Harassment cases, are included in the trust internal reporting structure.

2. Purpose of the paper

The objective of this paper is to provide an analysis of the progress and development of the service, as well as a summary of the themes emerging from the cases received by the Freedom to Speak Up (FTSUG.) This report encompasses the period from 23rd September 2024- 31st March 2025. It adheres to the guidelines established by the National Guardian Office (NGO) concerning the content that FTSUG should include in their reports to the Board.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSUG) The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSUG workshops, regional network meetings and FTSUG conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in The Medway Maritime NHS trust on the 23rd September 2024 .

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

For the period covered by this report, specifically from 23rd September 2024 - 31 March 2025, a total of 63 concerns have been raised. This figure corresponds to a projected average by the NGO of 63 cases per quarter. For a trust of this size.

The NGO indicates that Freedom to Speak Up (FTSUG) has experienced a consistent annual increase in the number of staff members raising concerns through FTSUG across the National Health Service (NHS). The Guardian Service is beginning to be effectively integrated within the Medway NHS Trust. Staff frequently express to the Guardian that the independent nature of the Guardian Service has contributed to their sense of psychological safety and has further motivated them to speak up and their raise concerns. This aspect has proven particularly significant for those wishing to maintain anonymity while expressing their concerns. These elements, in conjunction with ongoing promotional activities and working in partnership with teams across the trust, may be contributing to the positive trend in the number of concerns being raised.

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	13	20.63%
Permission to escalate with names	14	22.22%
Permission to escalate anonymously	36	57.14%
Total	**63**	**100%**

9. Themes

Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	11
B Management Issue	11
C System Process	6
D Bullying and Harassment	14
E Discrimination / Inequality	11
F Behavioural / Relationship	8
G Other (Describe)	1
H Worker Safety	1
Grand Total	**63**

10. Trends in Cases

Given the brief duration for which The Guardian Service has been active within the Medway Maritime NHS Trust, it is challenging to ascertain any discernible trends. This difficulty stems from the absence of prior data sets for comparative analysis. Nevertheless, the primary areas indicating the potential for rapidly emerging trends appear to pertain to bullying and harassment related to patient safety concerns, as well as discrimination and inequality. Additionally, the data sample from the past eight months is limited; hence, any identified trends would likely rely on assumptions rather than being grounded in data at this juncture.

11. Assessment of Cases

There has been a steady increase in Red concerns (10), all of which were initially raised to the Chief Executive as requested and subsequently filtered to the appropriate level. Additionally, there have been Amber concerns (19), Green concerns (32) White (2) raised during the initial period of The Guardian Service's operation within the Trust, all of which have been addressed expeditiously. Notably, no concerns have been escalated to the board at this time. All concerns have been recorded using the RAG system, categorizing them as Red, Amber, and Green.

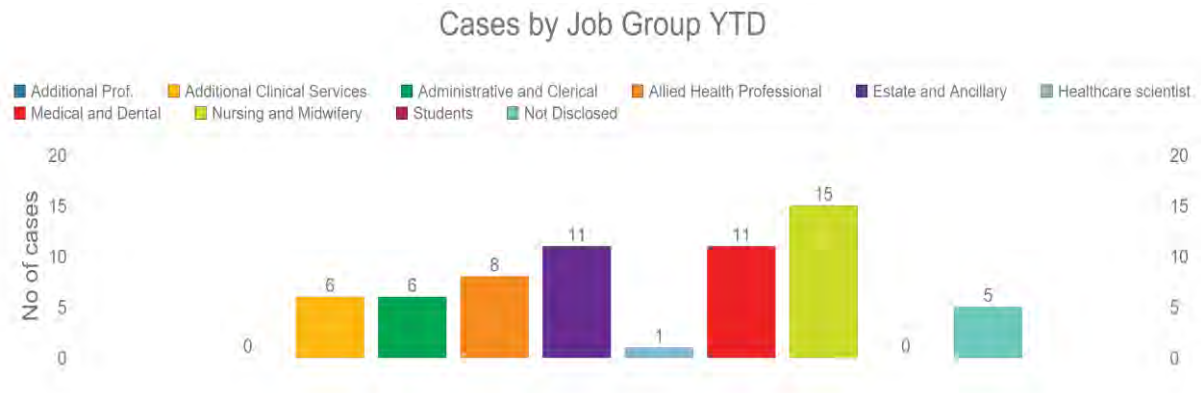
A total of 14 primary themes related to bullying and harassment have been identified. These predominantly reflect the concerns of staff members who have experienced elements of what may be perceived as micromanagement, repeated and persistent elevated voices, and extreme temperament. Such an environment has led to feelings of inadequacy among staff, prompting them to question their own abilities to complete required tasks. It appears that there is a lack of professional communication, often compounded by situations that undermines staff morale and places them under high-stress conditions.

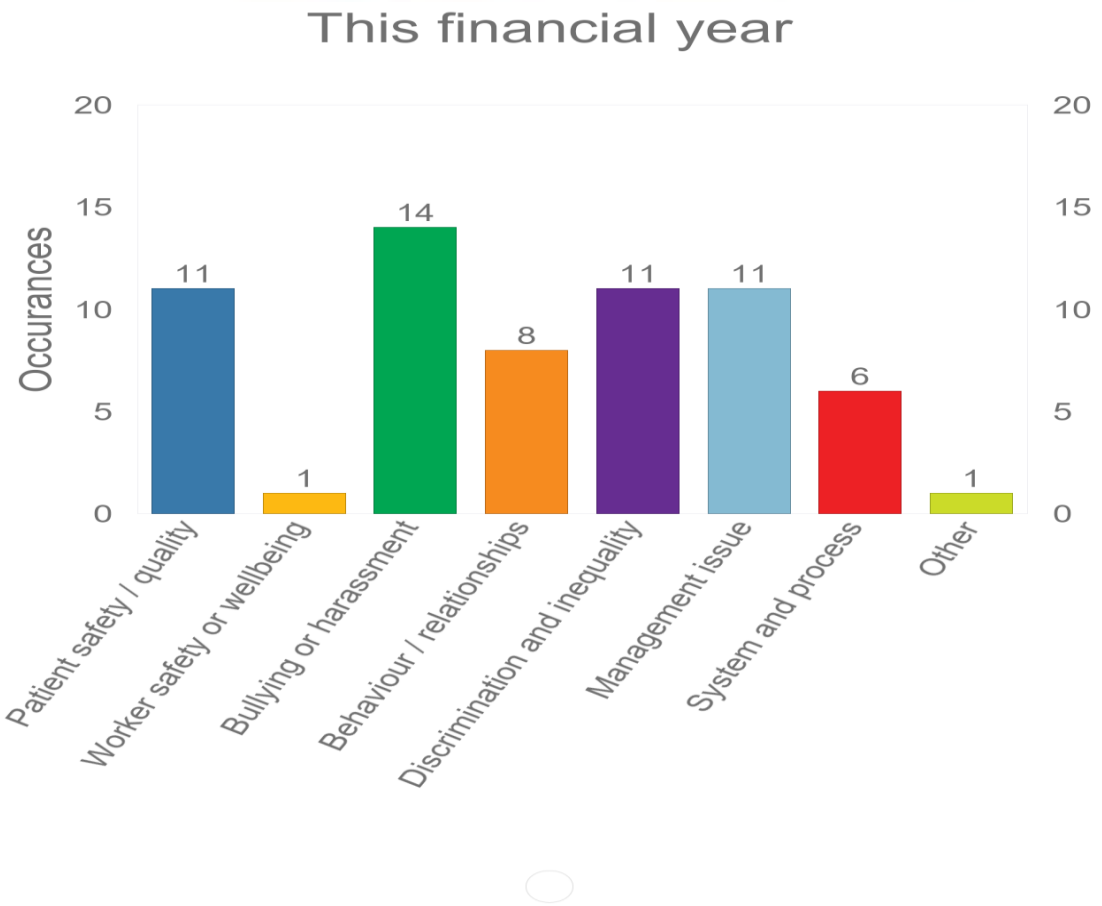
Furthermore, staff members often express a reluctance to raise their concerns with their direct line managers for fear that nothing will be done or of potential retaliation. Consequently, many resort to the Freedom to Speak Up (FTSUG) services as a first option rather than as a last resort. Additionally, staff frequently feel an added pressure to conduct appraisals and other sensitive meetings in the on-site restaurant.

There have also been reports of discrimination and unequal treatment, with concerns primarily arising from experiences of unfair treatment and communication issues among staff and management. Staff have expressed they feel much of this discontent has been attributed to individuals' ethnicity, gender, or other protected characteristics. The trust endeavour to address matters in a timely manner, however, this is not always the case, sometimes investigations into the matters have been conducted, but the results are not communicated back to the staff member. Therefore, many staff members have left the trust without having their concerns resolved.

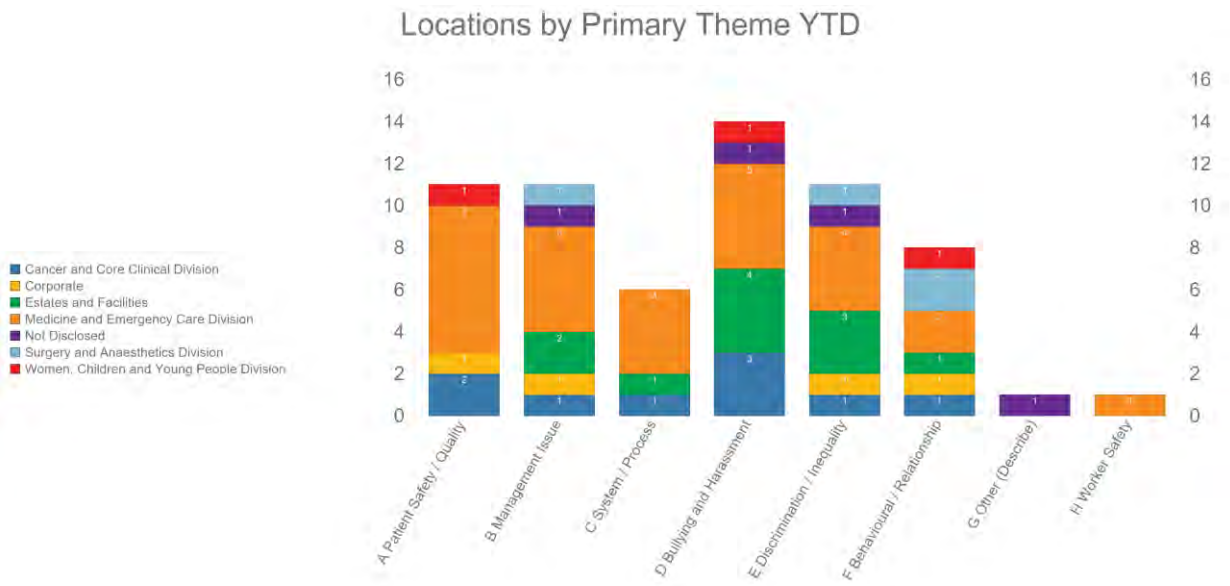
12. Statistical Graphs

Concerns raised by Directorate

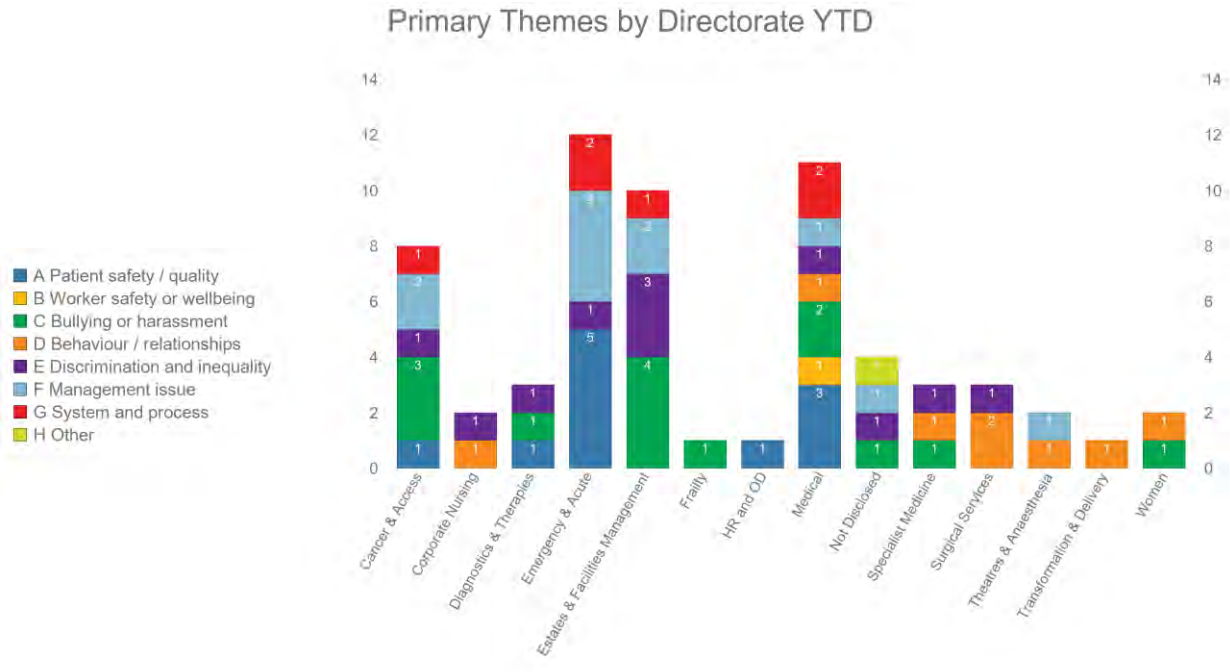




Concerns raised by Location



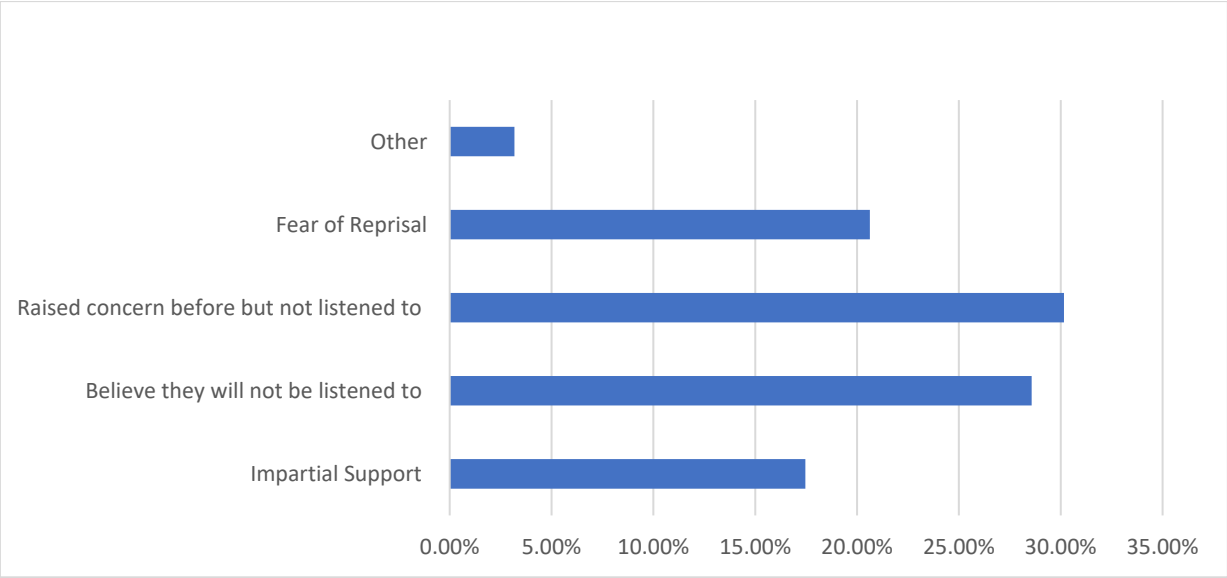
Concerns raised by Job Group



13. Why do staff use The Guardian Service?

Staff members reach out to the service for unbiased guidance and support. The availability of an impartial and independent individual, external to the Trust, who can attentively listen to concerns without judgment or adverse consequences, can often suffice for the individual expressing the concern. Engaging confidentially with the FTSUG can afford staff a certain level of reassurance and assistance. The FTSUG Guardian is equipped to present options for the staff member to contemplate as they decide how best to address their concern.

Obstacles to voicing concerns, such as apprehension regarding retaliation and diminished confidence among staff, were less significant factors in contacting the Guardian Service.



14. Detriment

No detriment has been reported during this period. The Guardian Service actively encourages staff to voice their concerns. The FTSUG dedicates considerable time to engaging with staff members, fostering a psychologically safe environment that enables them to freely share their experiences. The FTSUG also reassures staff that should they feel they have faced any detriment; it is imperative that they report this matter to the FTSUG promptly. The matter would be taken very seriously, and the Guardian would work closely with the Trust to ensure this was investigated. This process instils confidence in the staff that they will continue to receive necessary support. Concerns regarding detriment are significant and have a profound impact on the culture surrounding speaking up within the organization.

15. Action taken to improve the Freedom to Speak Up Culture

- The FTSUG actively listens, coaches, and encourages staff to express their concerns. Often, simply providing a listening ear is sufficient, and suggestions regarding the utilization of existing tools, such as team meetings and supervision, can assist individuals in achieving a resolution.
- Additionally, the FTSUG supports staff by offering the option of a facilitated meeting, which provides an opportunity for both parties to engage in a candid and constructive dialogue.
- In certain cases, staff members involved in a formal process may reach out to the FTSUG. The FTSUG will clarify that while it can offer emotional support, it is unable to partake in the formal proceedings.
- The Trust has exhibited its dedication to cultivating a robust speak-up culture and has endorsed the establishment of The Guardian Service within the Medway Trust.
- The Trust has executed a prompt response to all concerns raised through the Guardian Service.
- The service has been promoted on the staff intranet, with posters and postcards disseminated across various locations.
- The FTSUG participates in meetings and events both on-site and via MS Teams, to inform staff about the service and to foster a culture of open communication.

The role of the FTSUG is intricate, and the operational context is continually evolving; therefore, to ensure adherence to best practices, the FTSU completes annual refresher training provided by the NGO to support ongoing learning and development in relation to changes within the field.

16. Learning and Improvements

- Monthly meetings have been held with the Chief People Officer and the Deputy Director of HR & OD to review the monthly activity reports, outcome of cases, emerging themes and learning points are discussed, whilst maintaining the confidentiality of all individuals.
- The FTSUG service also attend meetings with the following:
    - HR Business partners for the respected division,
    - Sexual health meetings,
    - Brake through objectives,
    - Gemba meetings focusing on areas which are experiencing changes and could see an increase in concerns.
    - Staff survey results and actions plan
    - Occupational Health
    - People committee meetings.

- The FTSUG attends fortnightly "Listen and Learn" meetings with other FTSUG within the Guardian Service, where complex concerns are raised and discussed, and learning is embedded via shared good practices. Reflecting on practice informs continual learning.
- The FTSUG attends Southeast Regional meetings, workshops, events and conferences organised by the NGO. This, in addition to the NGO Bulletins, enables Guardians to keep abreast of developments in the field which support the effective handling of concerns and continuous improvement.

17. Comments & Recommendations:

Medway NHS Trust has introduced the Guardian Service and designated it as the provider for Freedom to Speak Up. Data indicates that the implementation of this service has been positively received.

To date, communication with the Trust has been constructive, and it is a recommendation that this approach continues. Ongoing communication with staff regarding the Trust's commitment to addressing their concerns and nurturing a culture of openness is essential.

Furthermore, it is recommended that the Board engage with and provide guidance to middle management to ensure their awareness of, and support for, a culture that encourages employees to speak up. To facilitate this, management should be encouraged to include the Freedom to Speak Up Guardians in meetings and briefings, thereby normalizing the practice of voicing concerns.

In addition to the aforementioned recommendations, further considerations should be given to not only support staff within an open culture but also to enhance the provision of supportive services for management regarding unconscious bias and ongoing management training—specifically pertaining to the support of staff in mitigating incidents of incivility.

18. Staff Feedback

Feedback received from staff members who have raised concerns has been positive about the Guardian Service since the launch at Medway NHS trust:

Given your experience would you speak up again?

Only to Guardians. My problem has been going on for over a year and this is the first time I have felt confident in talking to someone about it.

I felt Tasha actively listened to my concerns and validated the way I was feeling which helped with the way i had been feeling.

I probably would but only if I could have similar support from Natasha or Stewart again.

I would speak up again in confidence if i felt i needed to do so depending on the outcome.

Yes i felt listened to

I feel that my concerns were addressed satisfactorily

Any additional comments:

I was in a very unique situation and had no one to turn too. If it hadn't been for the Guardian Service I would have had no way to blow the whistle.

incredibly helpful experts.

Natasha is extremely helpful and I felt listened to so thank you for being a listening ear and trying to solve my problems.

Excellent handling of my concerns

NHS
Medway
NHS Foundation Trust

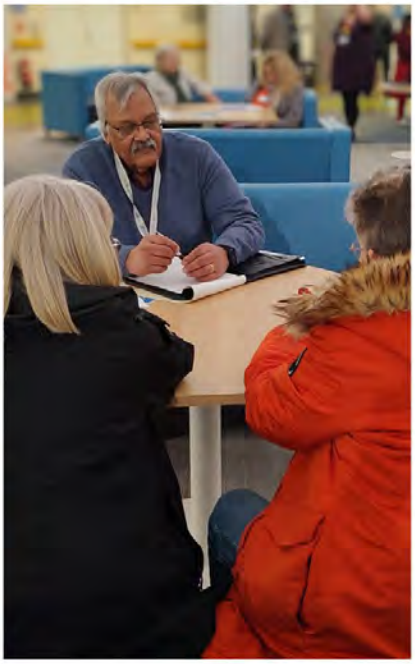
ENGAGEMENT AND INVOLVEMENT FRAMEWORK

2025 to 2028

Best of care
Best of people

Patient FIRST

NHS
Medway
NHS Foundation Trust



GOVERNOR ENGAGEMENT PLAN

Governor Engagement Plan

1. Introduction

1.1 This Governor engagement plan outlines the vision and methods for building an effective, responsive and representative Council of Governors (CoG) that is well equipped to carry out its engagement function with constituents.

1.2 The Governors hold the Non-Executive Directors (NEDs) to account for the performance of the Trust Board. The Trust Board is responsible for the strategy, operational management and decision-making of the Trust and must take into account the Governors' views when setting the strategy for the organisation. The CoG contributes to the strategic direction of the Trust.

1.3 Governors provide an important link between the Trust and the community it serves – its members, patients, partners, carers, families, volunteers, local population and staff – ensuring patients and public have a voice within the organisation. This helps strengthen accountability and is reflected in our commitment to our improvement programme Patient First, which puts the patient at the heart of everything we do.

1.4 Governors also represent the views of their constituents and provide an objective oversight of how the Board is meeting its strategic objectives and the requirements of the regulator.

1.5 In order for Governors to fulfil their role, the Trust must support them in their involvement, identifying appropriate opportunities for Governors to be engaged and to engage with their constituents, so that they can identify concerns to be raised at the Board.

1.6 Staff Governors need to be supported by their managers to carry out their role, including allowing time during working hours where needed.

1.7 How the Governors carry out their role is not defined in legislation and is therefore open to interpretation at a local level. At Medway it is considered to be about:

- acting as ambassadors for the Trust
- being a link between the Trust and the community it serves
- for staff Governors, being a link with staff
- feeding back to the Trust on the views of members and staff. This can be through formal channels such as raising questions at Board meetings through the Governor Board representative, or through the Patient Experience Group, or more informally with the support of the Trust's Engagement Team or the Patient Advice and Liaison Service (PALs)
- sharing information on performance and service improvements and/or changes with members and staff.
- receiving information on the Trust's performance, changes and plans, and gaining assurance on how the Non-Executive Directors are carrying out their roles.

The role description for Governors is appended to this document.

2. Objectives

2.1 This plan outlines what the Trust needs to do to ensure effective involvement of Governors, make best use of their skills, knowledge and expertise, and to support them to engage effectively.

2.2 The aim of the plan is to:

- support the Council of Governors in its engagement and involvement
- ensure Governors' skills, knowledge, expertise and interests are taken into account
- ensure their feedback is properly channelled back into the Trust for improvement and decision-making.

3. Providing Governors with assurance

3.1 At the heart of the NHS Foundation Trust model is local accountability in relation to which Governors play a pivotal role. Governors are elected individuals who represent members and service users, and appointed individuals who represent other stakeholder organisations. Together they form the Council of Governors.

3.2 Although Governors do not have an operational role, it is important that they are able to see services in action and to meet staff, so that they can perform their role with a level of insight.

3.3 They do not have a right to inspect services or hospital areas, or to conduct quality reviews. However, the Trust will ensure programmes of activity are in place to:

- support Governors in gaining assurance about the role and performance of Non-Executive Directors.
- help Governors understand the context within which the Trust operates so they are equipped to contribute to the Trust's strategic direction.
- ensure Governors are able to support communication and engagement with members.

4. Links with other strategies and documents

4.1 The Governor involvement plan links with and takes account of the following documents:

- NHS and Trust Constitutions
- Governor Code of Conduct
- Membership Engagement Strategy
- Community Engagement Strategy
- Communications and Engagement Strategy
- Patient First Strategy
- Patient Experience Strategy
- Quality Strategy

- Volunteering
- Trust's charitable fundraising strategy
- People Strategy
- Equality and Diversity Strategy

5. The involvement cycle

5.1 The diagram below illustrates the Governor involvement cycle. This demonstrates how Governors gather feedback from patients, staff or from their own observations, which they then feed into the Trust. They, in turn, are provided with information and assurance which they then communicate to patients and members.

5.2 The following are examples of how the Governors can develop their own knowledge:

- Receipt of Trust activity reports, trends and performance metrics
- Support the development of operational/strategic plans
- Attendance as designated members or observers at Trust committees/groups
- Observing Board meetings held in public
- Discussion of Patient First strategies and plans
- Attend the weekly Patient First: In the Spotlight sessions
- Discussion of the Quality Account Priorities
- Attendance at the annual Quality Priorities public event
- Engagement in the quality agenda, including Patient-Led Assessments of the Care Environment (PLACE) and preparations for Care Quality Commission (CQC) inspection

- Involvement in the Ward Accreditation programme
- Supporting the Friends and Family Test process, by encouraging service users and carers to provide their feedback
- Understanding the service user experience
- Regular organised interface with Trust staff in clinical areas, where possible
- Regular attendance at Council of Governor meetings and the Annual Members' Meeting

The Trust will also:

- involve Governors in planning communications and engagement with members
- provide updates through reports, briefings, newsletters and presentations
- facilitate information sharing with the community through briefings, events, magazines, website and social media
- support Governors to build knowledge and gain assurance through observation of meetings, participation in walkabouts and shadowing, and participation in involvement programmes.
- facilitate training and development
- highlight external engagement and networking opportunities
- manage the generic governor email account: medwayft.governors@nhs.net and handle inquiries and questions appropriately

How Governors can actively engage

- Attend Governor Coffee and Chat sessions organised by the Engagement Team where they can directly meet with and talk to patients and visitors for the purpose of gathering feedback in order to help them to better represent their views
- Attend community engagement events and stands both on-site and in the community
- Attend regular Patient First improvement huddles and driver meetings (with prior agreement)

6. Evaluation

6.1 In order to determine whether the methodologies outlined in the plan are working, progress against the framework will be discussed and reviewed annually by the Council of Governors.

Appendix 1: Governor Role Description

Title: Public, Staff and Partner Governor for Medway NHS Foundation Trust

Accountable to: Medway NHS Foundation Trust and its members

Remuneration: Governors are not paid a salary, but are entitled to claim reasonable travel expenses

Key Working Relationships

Members of the Trust, Chair of the Trust, the Board of Directors, the Senior Independent Director, the Chief Executive and the Company Secretary, Communications and Engagement staff.

Key Duties and Responsibilities

Statutory

As part of the Council of Governors for Medway NHS Foundation Trust you will have a number of statutory duties which include:

1. Representing the interests and views of members of Medway NHS Foundation Trust and the local communities
2. To appoint and if appropriate remove the Chair and Non-Executive Directors
3. To decide the remuneration, allowances and conditions of employment for the Chair and Non-Executive Directors
4. To approve (or not) the appointment of the Chief Executive
5. To appoint and if appropriate remove Medway NHS Foundation Trust's external auditors in conjunction with the Integrated Audit Committee
6. To receive the Trust's annual report and accounts and auditor's report
7. To hold the Non-Executive Directors to account for the performance of the Board
8. To approve significant transactions
9. To approve any application by Medway NHS Foundation Trust to enter into a merger, acquisition, separation to dissolution
10. To approve amendments to the Trust's Constitution
11. To encourage members of the local communities to become members of Medway NHS Foundation Trust
12. To oversee the Medway NHS Foundation Trust's Membership Strategy
13. To attend the Council of Governors meetings, Annual Members Meeting and training/development days
14. To actively engage with Medway NHS Foundation Trust members and local communities – including attending some of the regular engagement activities

and events arranged by the Engagement Team

15. (for Partner Governors) To represent the interests of and report back to the appointing organisation

Additional Duties

As part of the Council of Governors for Medway NHS Foundation Trust you would also have a number of individual duties and responsibilities to fulfil, which include:

1. To abide by the Governors' Code of Conduct
2. To abide by the Trust's Constitution
3. To uphold the values of the Trust
4. To comply with the Trust's policies and procedures

As part of the role of Governor for Medway NHS Foundation Trust, the following time commitments apply:

1. Attending the quarterly Council of Governors meetings, the Annual Members' Meeting, and any extraordinary Council of Governors meetings that are called
2. To attend any Board Committees or Interest Groups to which you are a designated attendee
3. To attend any training or development days
4. Attending engagement events and activities organised by the Engagement Team

There are also some limitations to the role of Governor for Medway NHS Foundation Trust, which include:

1. The Council of Governors cannot veto or over-rule a decision made by the Board of Directors other than as defined in paragraphs 8 and 9 above
2. The Council of Governors will not be involved in the day to day running of the Trust, setting budgets, staff pay or other operational matters
3. The Council of Governors has no role in considering the appointment or dismissal, appraisal, pay levels or conditions of services of Executive Directors
4. Governors do not raise complaints or act as advocates on behalf of individuals.

Appendix 2: Methodologies

Governor involvement – methodologies	Ambassadorial role	Receiving information on performance/changes and gaining assurance on the performance of the NEDs	Sharing information on performance and changes with members	Feedback to the Trust on members' views
Having an input into Trust objectives and strategy				
Input into the development of the operational/strategic plan through the Council of Governors		X		
Attendance as designated attendees or observers at Trust committees/groups		X		
Input into the Quality Account Priorities		X		
Involvement in the community engagement agenda	X		X	X
Input into the Governor Engagement Plan		X	X	
Involvement in the Membership Engagement Strategy	X			
Engagement in the quality agenda, including Patient-Led Assessments of the Care Environment (PLACE) and preparations for Care Quality Commission (CQC) inspection		X		
Supporting the Friends and Family Test process, by encouraging service users and carers to provide their feedback	X			X
Understanding the service user experience	X			X
Receiving regular information				
Receipt of Trust activity reports, trends and performance metrics		X		
Reading performance Board reports		X		

External reports such as from the CQC and associated action plans		X		
Chief Executive's weekly email		X		
News updates from the Chair and Lead Governor		X		
Board feedback via the Governor Board representative		X		
News at Medway		X		
Training and development		X		
Engagement and sharing information				
Annual Members' Meeting			X	
Member events	X		X	
Governor and member recruitment sessions	X		X	
Regular organised interface with Trust staff in clinical areas.				X
Involvement in the planning of patient events such as open days and charity fairs	X		X	
Taking part in engagement events organised by other health and care organisations across Medway and Swale	X		X	X
Connecting with the community through Governors' own networks	X		X	X
Forging links with Governors in other Trusts to adopt best practice	X		X	
Forming relationships with Healthwatch	X		X	X
Presenting to local voluntary and community groups to share information about the Trust and gain feedback	X		X	X
Taking part in service redesign groups			X	X
Governors developing building their own knowledge, gaining assurance and providing feedback				

Preparing for Council of Governor meetings by reading background reports		X		
Observing Board meetings held in public		X		
Attending Board sub-committees as members and observers		X		
Participating in Trust events	X		X	
Buddying with Executive Directors to participate in walkabouts		X		
Taking part in CQC mock inspections		X		
Taking part in PLACE assessments		X		
Building links with volunteers	X		X	X

NHS
Medway
NHS Foundation Trust

MEMBERSHIP STRATEGY

Membership Strategy

1. About the strategy

The purpose of our Membership Strategy is to outline how Medway NHS Foundation Trust will build on membership recruitment and engagement activities, and how we will support, sustain and communicate with our membership and involve members as far as possible in our activities, to give them meaningful opportunities to engage with the hospital. This strategy builds on the success of membership recruitment and engagement to date and outlines the Trust's membership plans over the period 2025 to 2028.

The strategy outlines the Trust's three areas of focus:

1. **Recruiting and retaining members**
2. **Communicating with members**
3. **Engaging with members**

2. Membership

Why do we have members?

All foundation trusts have a duty to engage with their local communities and encourage local people to become members of the organisation (ensuring that membership is representative of the communities that they serve). Annex A details the demographic information of our community and membership.

Becoming a member provides the opportunity to get involved, by sharing views and opinions which contribute to and support service improvement at the Trust. The Trust values its members and keeps them involved through regular updates, and by inviting members to take part in various groups, surveys, consultations and events. Members are also invited to put themselves forward as candidates when vacancies arise on the Council of Governors and to vote for representatives on the Council of Governors when elections are held.

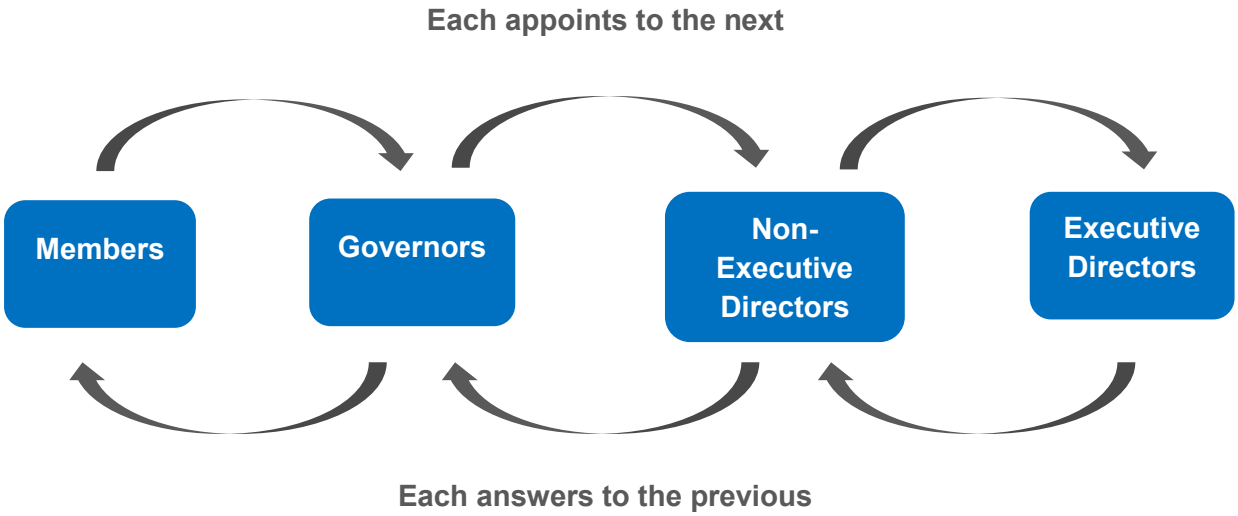
Medway NHS Foundation Trust enjoys a high level of membership. Under our constitution we are required to have a minimum of 400 members. Our membership stands at more than 11,000 and includes public and staff members, therefore representing a healthy position.

We also have an increasing number of young members, thanks to proactive efforts to target this cohort in membership recruitment, for example through renewed links with Medway Youth Council and attendance at university freshers' fairs.

More important than the number of members, is the level of engagement. We have greatly increased the engagement with our members through regular email updates and outreach activity.

Governor elections

Members elect the majority of representatives on the Trust's 'Council of Governors', which in turn appoints the Chair and other non-Executive Directors to the Board of Directors. The Council of Governors' job is to formally represent the interests of the membership and the wider public and to hold the Trust's Non-Executive Directors to account for the performance of the Trust's Board of Directors.



A representative and engaged membership will help our Trust to continue to maximise its potential as a foundation trust and is an important objective for the Council of Governors.

Public governors have a responsibility to represent the interests of the trust members who elected them as well as other members of the public. Public Governors provide an important link between the hospital and the local community, enabling us to gather views from local people and to feed back what is happening within the Trust. They reflect members' interests and work on their behalf to improve health services for the future. By passing on ideas and suggestions members also can help Governors carry out their role effectively.

Staff governors have the same role as public governors in that they are responsible for holding the non-executive directors, individually and collectively, to account for the performance of the board of directors, and for representing the members of the staff constituency and the members of the trust as a whole. As employees of the trust, staff governors bring a unique understanding of the issues faced by an NHS foundation trust.

Partner governors are appointed by the bodies they represent – these include charities, local councils and local universities.

What membership means to us

Membership enables people to gain access to information, allows people to acquire knowledge and understanding about new and future developments and offers a way to influence services by providing feedback.

Membership provides a way for the trust to connect with patients, carers and the public and gives us the opportunity to communicate with those who are interested in our work. It means we can keep people up to date with the latest events and developments and can reach out directly to the membership if we are looking for patient input into service change; for example, a patient representative was recruited in this way to support the redesign of our Frailty unit.

We recognise people want different things from membership, depending on their needs and reason they became members. Many want to be informed, others more involved, and some want to take a lead.

We categorise the different levels of membership as follows:

- **Informed** - Receive regular newsletters, information and updates.
- **Involved** - Informed as well as consulted on the Trust's plans and invited to participate in events, surveys, focus groups
- **Taking a lead** - Informed and involved as well as standing for election as a governor, participating in formal service user representative forums, volunteering or attending special feedback groups

3. Recruiting and retaining our members

Becoming a member

Recruitment of members is currently achieved through membership recruitment stands, public events, social media and our Trust website, and individual recruitment by Governors. We have also added details of Trust membership to the end of the Friends and Family Test which has greatly increased membership take up. It is also mentioned on our clinic letters, and advertised in each edition of The Net magazine. Posters are also displayed around the hospital.

We will continue to organise recruitment stands within the hospital and at external venues and continue our efforts to maintain the current level of membership. Our recruitment activities will be published on the membership section of the website (https://www.medway.nhs.uk/membership/), in our Community Engagement newsletter and promoted through social media.

Next steps:

- We will look to identify opportunities in new locations where potential membership may be attracted (for example healthy lifestyle related clubs)

- We will continue to encourage people to sign up online through our application form, whilst having paper forms available where needed to enable us to sign up as many members as possible

- Since transferring to a new membership database in May 2023, we are now able to track the referral methods by which we recruit new members. The table below shows our main referral methods by which new members have been recruited.

Referral Source	Members
Engagement Stands	104
Friends and Family Test	61
Hospital Letter	56
Trust website	53

Please note – these figures only include members who named a referral source and are still active members.

Retaining our membership

We will aim to retain existing members by continuing to communicate and engage through the activities described in the following sections and, importantly, communicating how member engagement has had an impact.

- A comparison of public membership figures since 2023 shows an overall decrease of 3,498 members. This is mainly due to a data quality project in 2023 which identified a large number of members who had moved away from their given address. They were subsequently removed from the system as we had no way of contacting them. A number of members are also removed following elections when letters are returned as undelivered, meaning they no longer reside at their given address.

- A small number of members are regularly removed as they have passed away (around six per month), and some ask to be removed as they are no longer interested in membership. An average of 1.8 people unsubscribe following each email to members. Members receive an average of 2.6 emails per month.

- The potential current reach by email to public members stands at 43 per cent (previously 25 per cent). The absence of email addresses for many members relates to historic recruitment. New members are strongly encouraged to provide an email address as this is the main form of communication. A number of historical members with no email address remain, but a large number were removed from the database during the data cleanse. This has contributed to the significant increase in percentage of members with email addresses.

Through this strategy:

- We will look to streamline the routes of engagement between members, staff and the Trust, members and Governors and Governors and the Trust to avoid duplication and to ensure issues are addressed in a timely manner

- We will ensure a consistent service in responding to communication from members through whatever route they raise issues, ensuring the most appropriate team responds to the enquiry

- We will find ways to highlight where issues raised by members have been addressed and the impact this has had

- We will continue to increase opportunities for Staff Governor engagement and communication with staff members.

Eligibility for membership

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. Members are invited to "opt in" by completing a paper or electronic application form. Members are required to abide by the Trust's code of conduct and public service values, and members may be disqualified if they do not comply [1].

We are keen to involve our current and past patients and their families, carers and other members of our local community. We are also keen to involve those who live outside our community and who wish to become involved because they live within easy travelling distance, have some current or past connection with the Trust or may use health care services provided by the Trust.

Staff Membership – individuals are eligible to become members of the Staff constituency if they have a permanent contract, a 12 month or longer fixed term contract, have an honorary contract, or exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust and have done continuously for at least 12 months (for example, Trust volunteers). Employed individuals will automatically become members unless they opt out.

4. Communicating with members

- **News at Medway**
  The Trust distributes a quarterly magazine, News at Medway.
- **Community Engagement magazine**
  Members receive the regular Community Engagement newsletter by email.
- **Message from the Chair**
  Members also receive a regular e-bulletin from the Trust Chair.
- **Member newsletters**
  Regular updates are sent to members who have provided email addresses. Data from the last year (1 April 2024 to 31 March 2025) indicates that the average open rate for all emails to members is 36.3 (36.3 per cent of recipients opened the email at least once).
- **News updates and invitations**
  The Trust will share any news updates and also send invitations to take part in engagement opportunities and events.
- **Website**

[1] Public Members may be disqualified if

- They have perpetrated a serious incident or violence in the past five years, towards any hospital or healthcare facilities or against any of the Trust's , Non-Executive Directors, Council of Governors, in accordance with the relevant Trust's policy for withholding treatment from violent/aggressive behaviour
- They have been confirmed as a "persistent complainant" in accordance with the relevant Trust's policy
- Breached the Trust's code of conduct

Staff members may be disqualified on the same basis as public members. In addition a staff member may be asked to temporarily cease membership activities during any period of suspension under the Trust's code of conduct and associated staff policies and professional codes.

We have a membership section on our Trust website https://www.medway.nhs.uk/get-involved/become-a-member/ and members are able to contact us through the membership office by phone or email.

- **Social media**
  We will continue to use all our social media channels to promote members' activities and opportunities to engage.

5. Engaging with members

Member engagement is currently undertaken through the Annual Members' Meeting and a series of public events throughout the year, often involving our Governors and teams from across the Trust.

The Annual Members' Meeting provides an opportunity for members to meet governors (their representatives) and senior staff of the Trust. It provides a good opportunity for the trust to promote itself to increase membership.

A number of public events take place throughout the year, the purpose of which is to inform, consult and engage with members, patient, stakeholders and local people. These may be held at the hospital in person or virtually, or in the community.

In addition, the Trust offers opportunities for members to get involved in service change or development.

New for this strategy

- In response to member feedback, we have started to hold tours in parts of the hospital to give members an opportunity to see 'behind the scenes.' These have proved very popular and will remain a key part of our event calendar
- Our Summer Fun Day is now a regular event on the calendar, bringing in families and local people to the hospital grounds. It is also very popular with staff.
- We will continue to work towards advertising events well ahead of time. We continue to find new avenues through which to advertise our events.

6. Community Engagement

Aligned with our vision and values and our aim to deliver the best of care, our community engagement approach is focused on listening to the people who use and care about our services. We want to better understand their diverse health needs, respond to what matters to them, and by harnessing their information, intelligence and expertise, plan, design and deliver improved services for a better patient experience.

Our Engagement Team and Governors will continue to proactively engage with our local community. Through this work we continue to build strong trusting relationships and establish a presence within charitable and voluntary sector organisations, youth and carer groups, schools, as well with Black, Asian and Minority Ethnic (BAME) communities, LGBTQIA+ groups and religious groups.

7. Evaluating and reviewing our work with members

A quarterly report is submitted for the Public Council of Governors meetings, providing a summary of engagement and governor activities. Governors are invited to suggest future engagement activities and ways in which we can improve engagement and membership uptake.

8. Membership support

The trust has a responsibility to communicate with members. To this end the trust and its Council of Governors will champion and promote membership as widely as possible.

We need to adequately resource our membership function and to ensure that it is appropriately integrated within the organisation. This requires a commitment to providing membership services over the long term, developing them as required and supporting skills development.

The trust has a Membership Office, staffed by the Engagement Team.

Annex A – Membership Data

Who our members are – local demographics

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. We are eager to involve our current and past patients and their families, carers and other members of our local community. We would also like to involve those who live outside our community and who wish to become involved because they live within easy travelling distance, have some current or past connection with the Trust or may use health care services provided by the Trust.

Distribution of current membership

	Membership as at April 2023	**Membership as at April 2025**
Medway Swale Rest of England and Wales	6,128 1,614 2,098	4,137 1038 1,167
Total Public	**9,840**	**6,342**
Staff	4,055	5,063
Total	**13,895**	**11,405**

Profile of current membership compared to local area

Please note – demographic data is not always provided; this analysis is based on the following percentage of members for each category:

Age – 76.3 per cent
Gender – 99.99 per cent
Ethnicity – 78.9 per cent

	% of Membership	**% of local area (Medway)**	**Difference (%)**
Age			
16-19	0.4	3.7	-3.3
20-29	4.4	12.3	**-7.9**
30-39	15.7	14.2	+1.5
40-49	13.4	12.9	+0.5
50-59	16.9	13.6	+3.3
60-69	15.9	10.2	+5.7
70-79	17.7	7.8	+9.9

	% of Membership	% of local area (Medway)	Difference (%)
80+	15.6	4.0	+11.6
Gender			
Male	31.7	49.0	**-17.3**
Female	68.3	51.0	+17.3
Ethnicity (broad)			
Asian	7.4	5.9	+1.5
Black	6.1	5.6	+0.5
Mixed	1.4	2.8	-1.4
Other	0.3	1.4	-1.1
White	84.7	84.3	+0.4

Analysis of the data indicates that our membership base is older than the local average and represents females by almost 18 per cent more than the local population.

People aged 16-29 are slightly under-represented, and people aged 60 upwards are increasingly over-represented as the age bracket increases. We are aware of this and have been working to improve uptake of membership by young people over the past few years.

Member ethnicity profile matches the local population to within 1.5 per cent in all categories, indicating that all ethnicities are appropriately represented.

Approved by Council of Governors – 22 May 2025
Approved by Trust Board –
Review date: April 2025
Next review date: April 2028