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	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:00	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 14 May 2025	Chair	4	12:05	Approve
2.2	Action Log		13		Discuss
3.	**Opening Matters**				
3.1	Chief Executive Officer Update a) Group Working – Update	Chief Executive	14	12:10	Note
3.2	Council of Governors Report - Introduction to new Interim Lead Governor	Lead Governor	Verbal	12:20	Assurance
3.3	Trust Risk and Issue Report	Chief Nursing Officer	16	12:25	Note
3.4	Board Assurance Framework	Company Secretary	24	12:35	Assurance
3.5	Standing Financial Instructions and Scheme of Delegation **APPENDIX 1**	Chief Finance Officer	27	12:45	Approve
	Board Story Presentation				
	No Board Story for July 2025	Associate Director of Patient Experience	-	-	-
4.	**Sustainability**				
4.1	Finance Report (Month 2) **APPENDIX 2**	Chief Finance Officer	29	12:50	Note
4.2	Review of Financial Governance (January 2025) - Update	Chief Finance Officer	30		Note
4.3	Integrated Quality Performance Report **APPENDIX 3**	Deputy Chief Executive	36	13:05	Assurance
	~ Wellbeing Break for 10 minutes at 13:15 ~				
5.	**Quality, Safety and Patients**				
5.1	Learning from Deaths – Quarterly Report **APPENDIX 4**	Chief Medical Officer	40	13:25	Approve

5.2	NHSE Maternity and Neonatal Review – Update	Chief Nursing Officer	43	13:35	Note
5.3	Maternity (and Perinatal) Incentive Scheme – Year 7 Update **APPENDIX 5**	Chief Nursing Officer	50	13:40	Assurance/ Noting
5.4	Claims, Incidents and Complaints Triangulation Report – Q4 2024/25 **APPENDIX 6**		53		
5.5	Perinatal Quality Surveillance and Leadership Quarterly Report: Q4 2024/25 **APPENDIX 7**		56		
5.6	Bi-annual Midwifery Workforce Report **APPENDIX 8**		58		
5.7	IPC Annual Report **APPENDIX 9**	Chief Nursing Officer	61	14:00	Approve
5.8	Health and Safety Annual Report **APPENDIX 10**	Director of Integrated Governance and Quality	63	14:05	Approve
6. Items for Approval					
6.1	Data Security Protection Toolkit: a) Information Governance Annual Report **APPENDIX 11**	Deputy Chief Executive	66	14:10	Note
~ Wellbeing Break for 5 minutes at 14:20 ~					
7. Items for Note					
7.1	Freedom to Speak Up – Annual Report **APPENDIX 13**	Chief People Officer	69	14:25	Note
7.2	Quality Assurance Committee (June/July)	Chief Medical Officer Chief Nursing Officer Committee Chair	71	14:35	Assurance
7.3	People Committee (May)	Chief People Officer Committee Chair	77	14:45	Assurance
7.4	Finance, Planning and Performance Committee (May/June)	Chief Finance Officer Committee Chair	81	14:50	Assurance
7.5	Audit and Risk Committee (June)	Chief Finance Officer Committee Chair	87	15:00	Assurance
7.6	Engagement and Involvement Framework 2025-2028 **APPENDIX 14**	Director of Communications and Engagement	90	15:05	Approve

8. Closing Matters					
8.1	Questions from the Council of Governors and Public	Chair	Verbal	15:15	Note
8.2	Escalations to the Council of Governors			15:25	
8.3	Any Other Business and Reflections				
	Date and time of next meeting: Wednesday, 10 September 2025				

Minutes of the Trust Board Meeting in Public

Wednesday, 14 May 2025 at 12:30 – 15:00

Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Gundulph Boardroom and via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust Chair
	Alison Davis	Chief Medical Officer
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Helen Wiseman	Non-Executive Director
	Jon Wade	Chief Executive Officer (Interim)
	Leon Hinton	Chief People Officer
	Mojgan Sani	Non-Executive Director
	Nick Sinclair	Chief Operating Officer
	Sarah Vaux	Chief Nursing Officer (Interim)
	Simon Wombwell	Chief Finance Officer (Interim)
Attendees:	Abby King	Deputy Director of Communications
	Alana Marie Almond	Deputy Company Secretary (Minutes)
	Anan Shetty	Governor
	Angela Harrison	Governor (left at 14:00)
	Christine Palmer	Governor
	David Brake	Lead Governor
	Hari Aggarwal	Governor (left at 14:00)
	Jane Perry	Academic Non-Executive Director
	Joy Onuoha	Governor (left at 14:00)
	Karen Fegan	Governor
	Katie Goodwin	NHSE Improvement Director
	Lorna Gibson	Director of Development, Productivity and Efficiency
	Martina Rowe	Governor
	Matt Capper	Director of Strategy and Partnership/Company Secretary

	Matthew Taiano	Staff Governor and Staff Story (Item 3.3)
	Munirah Mazlan	Member of the Public (left at 14:30)
	Natasha Turner	Governor
	Nikki Lewis	Associate Director of Patient Experience (Item 3.3)
	Yushreen Vadamootoo	Governor (left at 14:20)
Apologies:	Glynis Alexander	Director of Communications and Engagement (Deputised by Abby King)
	Jenny Chong	Non-Executive Director/Senior Independent Director
	Paulette Lewis	Non-Executive Director
	Peter Conway	Non-Executive Director

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair welcomed all present in particular Helen Wiseman and Peter Conway to their first formal Board meeting. Apologies for absence were noted as above. Chair noted the following items:

a) Welcomed Jon Wade on his secondment as Chief Executive Officer
b) The ICB is in the process of finalising the scope for the benefits and synergies between DGT and MFT, the terms of reference will be shared with COG 22.05.25. Following this the wider organisations will be involved. The timeline will be that conclusions and recommendations will be submitted by the end of July 2025.
c) Chair and Jon attended the NHSE Recovery Support Programme meeting and received the output from the meeting on 13 May 2025. Progress report to come back to the July 2025 Board meeting.

1.2 Quorum

The meeting was confirmed as quorate.

1.3 Declarations of Interest

Amendment to John Goulston: change the statement to 'Medinet' – not medical clinical service
Amendment to Alison Davis: remove the declaration for GIRFT

There were no further declarations of interest

2. Minutes of the Last Meeting, Action Log and Governance

2.1 The minutes of the meeting held on 12 March 2025 were **APPROVED** as a true and accurate record.

2.2 Action Log

The action log was reviewed, updated and is held under separate cover.

2.3 Constitution – Annual Review

Matt Capper gave a verbal update for approval. There are no significant regulatory changes, the Council of Governors (COG) will also be informed.

The Board **APPROVED** the current position

2.4 Board and Committee Membership and Designations
Matt Capper presented to the Board for approval.

Check and Challenge

a) Mojgan - discrepancy around who chairs the committee. Matt - will confirm and amend.
b) Gary - Page 22 – additional champion roles; Gary plans to liaise with relevant individuals in regard to Security and keen to move at pace as it was mentioned by the CQC. Chair – noted that 'Security' does not include cyber security. Chair – the NEDs are there to help the Executives support the divisions.
c) Helen - Page 23 – should cyber security sit with the Audit and Risk Committee, not the Executive? Matt – yes, will amend
ACTION NO: TB/2025/008 – Matt Capper to circulate the amended document to the COG for information

The Board **APPROVED** the report with the above amends.

3 Opening Matters

3.1 Chief Executive Officer Update
Jon Wade presented the update for noting, highlighting the following key points:

1) A warm welcome
2) Improving access to diagnostics
3) Patient First
4) Visiting Charter
5) Neonatal unit accreditation success
6) Star Award finalists

The Board **NOTED** the update.

3.2 Council of Governors Report
David Brake presented to the Board for noting from the Council of Governors (COG).

a) The purdah has affected some of the local events but has not stopped the good work the Governors can do.
b) The COG had a session with Sylvia Stevenson with an organisation called Absolute Diversity. There was a good turn out but there is a wrap up session at the next COG meeting. Each Governor has completed their self-assessment and this has opened the discussion on this. David thanked Alana Almond, Gavin MacDonald and Sylvia Stevenson.
c) Thanked Simon Wombwell for his financial presentation at the last COG meeting. This opened up the request for the governors to contribute to being involved in discussions around cost savings at the Trust. David has met with Lorna to discuss this and Lorna will attend the next COG to present her work and have an opportunity for suggestions and Q&A.
d) This is David's last Board as a Governor, David thanked the Board for his time and opportunity at the Trust as a Governor. His last meeting as Lead Governor is at the COG meeting on 22 May 2025.
e) Chair it is important on behalf of the Board that David is thanked. David has been an outstanding servant to the community and thanked his time and support to the Trust.

The Board **NOTED** the update

Board Story Presentation

3.3 Staff Story: Neurodiversity with Matthew Taiano

Nikki Lewis introduced Matthew Taiano, Staff Member and Staff Governor to the Board to present the Staff Story. Matthew gave the background to his career at the Trust and neurodiversity and went on to address the challenges faced by the Trust's neurodiverse workforce, including next steps for supporting colleagues and their families.

Check and Challenge

a) Jon – thanked Matthew for his support across the organisation. What are examples of reasonable adjustments? Matthew – gave an example of fonts on systems that are not readable such as 'Times New Roman' particularly on the EPR being unreadable. The Trust have provided a font reading technology, which can be added to users PCs.
b) Gavin – any advice on how staff can identify if they have neurodiversity? Matthew – can be long and costly process to be diagnosed, can be seven years for ADHD and 10 years for autism. Matthew paid privately to expedite his diagnosis.
c) Sarah – thanked Matthew for his story, presenting to Board is a nerve-racking thing to do and thanked Matthew for sharing and supporting. Increasing rates of neurodiversity is nationally recognised. The work Matthew is doing is really important. Matthew – in order to get support at the Trust, you do not need a diagnosis.
d) Angela – thanked Matthew for the story as it was very interesting. At Swale Council the organisation have signed up to 'not every disability is visible'.

On behalf of the Board, Chair **NOTED** the Story and thanked Matthew and Nikki for their time and effort in supporting colleagues.

4. Performance, Risk and Assurance

4.1a Trust Risk and Issues Register

Matt Capper presented the report accurate as of 01 May 2025. The Register currently has 73 approved risks for the Trust of which, 8 are scored 15 and above (extreme).

Check and Challenge

a) Gary – Page 44 – should this fire risk be BAU? Page 45 – growth around staff – where will the Trust see the growth? Must ensure this is highlighted much earlier. The challenge is around the type and appropriateness of the risk. Matt – will take this away and review.
b) Mojgan – the risks around Metavision update and impact of safety on critical care – this is appearing as the same risk, is this correct? Gavin - the risk score cannot change or reduce yet; the team are researching alternative systems to use.
c) Mojgan – generally there are 71 risks with no movement in the last month, of which 46 have had no movement in six months – does this need a deep dive? Matt – gave an update on the process for reviewing risks and what will assist with mitigating the non-movement of risk; there is additional support with risk business partners and a risk training element, which should mitigate this.
d) Chair – for noting on Page 45 in 2023/24 the risk around an unfunded workforce increase of 9%, this is a driver for the deficit. What was the change in 2024/25? Leon - the increase in workforce in 2024/25 was 4.22%.

e) Chair – when did the Board agree the Risk Appetite? Matt – August 2024, this will be part of risk management framework refresh, next steps is that the framework is submitted to ARC then back to the Board when it is recalibrated.

The Board **NOTED** the report

4.1b Board Assurance Framework (BAF)

Matt Capper presented the report for assurance and noting. The draft BAF will be submitted to individual committees for scrutiny.

Check and Challenge

a) Chair – BAF 1-2025; the risk of not living within 24/25 budgets/control total, this is rated 12, this seems to under-estimate the risk as at today. Matt – this will be reviewed by the FPPC.
b) Katie - Do we measure the level of assurance over this? Should this be within the BAF? Matt – yes, this work will be done and assurance will be held separately.
c) Helen – does the forecast column give the inherent risk? Matt – the word 'forecast' needs to be removed, as this gives current position as opposed to the target.

The Board were **ASSURED** and **NOTED** the report

Board Assurance Reports

4.2 Quality Assurance Committee (QAC) – April/May 2025

Sarah Vaux presented the report for assurance.

The Board **NOTED** and were **ASSURED** by the report

4.3 People Committee (PC) – March 2025

Leon Hinton presented the report for assurance.

Check and Challenge

a) Mojgan – does the PC have an opportunity to review the impact of the outsourced Freedom to Speak Up Guardian Service? Leon – there are monitoring processes in place for the future and an update report alongside the annual report due to the PC in May 2025. The main indicator has improved slightly but is still below national average.
b) Chair – to note that Phase 1 of the Cultural Transformation Programme ends at the beginning of June 2025. The Board will meet with the Cultural Transformation Steering Group on 18 June 2025 to receive the report on phase 1 and discuss key actions for Phase 2 of the work.

The Board **NOTED** and were **ASSURED** by the report

4.4 Finance, Planning and Performance Committee (FPPC) – March/April 2025

Simon Wombwell and Gary Lupton presented the report for assurance.

Check and Challenge

a) Chair – it has been a difficult year financially. On Page 76, Chair questioned the values in the report; is there a reason for the number against the benefit of 24/25 schemes into 25/26 being crossed out in the reducing waste programme, is this an error? Lorna - the recurrent schemes from the previous year are not included in efficiencies for this year, due to budgets being set at Month 8, so that is why there is a discrepancy. This is why the non-recurrent

schemes are not appearing in this year's plan. Chair – did the Trust reduce costs by this amount. Simon – No. John – reporting must be absolutely clear when it states 'budget out' in terms of whether this has led to cost reduction.

b) Chair – thanked Gary for chairing the FPPC throughout 2024-25 and the Chair role will now be with Helen Wiseman.

The Board **NOTED** and were **ASSURED** by the report

4.5 Audit and Risk Committee (ARC) – May 2025

Simon Wombwell presented the report for assurance. Highlighted that the Trust overall has received 'partial assurance' (red/amber) so more work to do.

The Board **NOTED** and were **ASSURED** by the report

~ The Board took a 10-minute Wellbeing Break ~

4.6 Integrated Quality Performance Report (IQPR)

Gavin MacDonald presented the new style IQPR for Month 12 (March 2025) with a refreshed set of True North Domains for assurance and noting. The reports now include and Executive Summary with information as follows:

1) True North Strategy and Supporting Breakthrough Objectives
2) Strategic Initiatives
3) Corporate Projects

Check and Challenge

a) Chair – in the report it states;" The number of patients waiting over 65 weeks at the end of March was 219 including Community Paediatrics (139)" but Nick has stated that it is 80, what is accurate? Nick – 219 is an error and will be corrected through Business Intelligence.

b) Chair – trajectory for waiting over 65 weeks should be zero, when will this come to fruition? Nick –this is still being modelled.
ACTION NO: TB/2025/016 - Trajectory to reduce patients waiting over 65 weeks to May meeting of FPPC - Nick Sinclair

c) Chair – there is too much data in the IQPR. The Board needs the information on the trajectory against the business plan, current position of the Trust and expected target. The IQPR must be much more digestible. Gavin – will work this through with the working group, he will also take learning from other trusts.
ACTION NO: TB/2025/009 – Gavin to develop an IQPR that dovetails into the business plan and submit significant information as opposed to copious amounts of data.

The Board were **ASSURED** and **NOTED** the report

4.7 Finance Report (Month 12)

Simon Wombwell presented the report for noting. Key points in relation to the Month 12/March financial results:

1) In-month surplus of £3.5m to give a reported Year to Date (YTD) and full year deficit of £17.1m. Following technical adjustments, this is a full year control total deficit of £22.4m, being adverse to Plan by £20.0m.

2) Efficiency plans have delivered over £20m in-year.
3) The capital plan is underspent, as previously indicated, principally in relation to Community Diagnostic Centres (CDC) leases being unsigned.
4) Cash at the end of March was £13.3m – the cash forecast is under constant review given the forecast run-rate.
5) Audit and Risk Committee (ARC) received the annual accounts on 08 May 2025. The Auditors are in the Trust now until mid-June 2025. Audit report scheduled for ARC on 19 June 2025. Then recommendation to Board at an Extraordinary meeting, date to be confirmed. On the 25 June this is submitted to NHSE and onward to Parliament.

Check and Challenge
ACTION NO: TB/2025/010 – Matt to organise extraordinary Board to approve the Annual Report and Accounts, following him obtaining Peter Conway's availability.

The Board **NOTED** the report

4.8 Improving Financial Governance
Gavin MacDonald presented to the Board for noting. There are 44 actions of which two are fully implemented. All but five actions have passed their expected completion date and work is underway over the next month to review the expected date for completion.

Check and Challenge
a) Chair – is it accurate that 37 actions have passed their target date? This is not a good position. What is the trajectory? Gavin – more work to be completed this week on the actions and trajectories. Jon – this will be submitted to the Trust Leadership Team (TLT) meeting.
ACTION NO: TB/2025/011 – add to the TLT agenda.

The Board **NOTED** the report.

~ The Board took a 10-minute Wellbeing Break ~

5 Papers
5.1 Patient First Strategy – Refresh
Jon Wade presented to the Board. Jon confirmed that the Trust will continue with Patient First methodology but it needs work to fit the Trust better. Suggested that the strategy is pulled from the Board today and bring back formally to July 2025.

Check and Challenge
a) Chair – thinking about systems and partnerships; should this be a DGT/MFT collaboration or system collaboration? Use the June Board meeting as an opportunity for the Board to discuss a straw man then July Board for formal submission.
ACTION NO: TB/2025/012 – Gavin MacDonald to resubmit.

The Board **DID NOT APPROVE** the refresh.

5.2 2025/26 Business Planning – Progress Update
Gavin MacDonald presented to the Board for noting.

Check and Challenge

a) Gary – Key Targets; where it states "all the above to be loaded into budget"; what is the deadline that the team are working to? Simon – the budgets are already uploaded alongside the CIP targets. Team are currently working through the risks against the targets.
b) Gavin – the four areas of non-assurance as discussed at the previous Board need addressing to give the Board assurance. The four areas were:
    1) Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.
    2) A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.
    3) The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.
    4) The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.
c) Jon – on Q1 Slide; the actions are not enough to mitigate the risk
ACTION NO: TB/2025/013 – bring back assurance to the Board on the four areas of non-assurance, mitigations and how close to they get us to closing the gap, take this through the Executive group and submit to Board in July 2025.

The Board **NOTED** the report.

5.3 Emergency Preparedness, Resilience and Response – Policy
Nick Sinclair presented to the Board for approval.

The Board **APPROVED** the policy.

5.4 Green Plan – Annual Review
Nick Sinclair presented to the Board for noting. Since writing the report the Trust have received the grant for decarbonisation, this is a huge achievement and will be in a better position for the maintenance on site.

Check and Challenge
a) Chair – congratulations to the team and Nick to pass on the Board's thanks.
ACTION NO: TB/2025/014 – updated business case for Decarbonisation to come to the FPPC

The Board **NOTED** the report.

5.5 RCP Rheumatology
Alison Davis presented to the Board for approval.

Check and Challenge
a) Chair – obtain the 'lessons learnt' from both Rheumatology and Pathology departments. The Trust will need a Plan B and what does this look like, delegate to the QAC.
ACTION NO: TB/2025/015 – Alison Davis through the QAC.

The Board **APPROVED** the report.

5.6 CQC Feedback Letter
Sarah Vaux presented to the Board for noting.

Check and Challenge

a) Chair – thanked the team for all of the hard work that has gone into this and the ongoing efforts and asked for thanks from the Board to the Emergency and Urgent Care team.

The Board **NOTED** the report.

6 Closing Matters

6.1 Questions from the Council of Governors and Public

There were no questions received in advance of the meeting.

a) Martina Rowe – what does the statement mean "staffing was unchecked"? Leon – this is specifically about growth, it is about the workforce controls in place to ensure that you are not going above budgets, nothing to do with the safety of staff.
b) Martina - have the risks to staff and patients been addressed with the vacancy freeze? Leon – yes, processes have been followed and reviewed on a weekly basis.
c) Martina - what "zero assets" are there? Simon – cannot give specifics but it will be around clinical equipment, such as equipment that is expiring.
d) Martina – will the general Manager be replaced in Rheumatology? Nick – yes, this will be honoured as the position was recruited to prior to the freeze and agreed by the Executive.
e) Martina – nursing assessments were detailed in the CQC feedback, how will this be addressed? Sarah – nursing assessments were already included in the Trust's Improvement Plan and the team will continue to ensure checks are happening with an audit. The assessments also form part of the Matrons twice daily check.
f) There were no further questions.

6.2 Escalations to the Council of Governors

a) Chair – gave a final thank you to David Brake, Lead Governor.
b) Chair – Matt Capper has a number of items to bring to the Council of Governors meeting on 22 May 2025. *[Post meeting note: added to AOB at the informal COG meeting on 22.05.25]*

6.3 Any Other Business

There were no matters of any other business.

6.4 Reflection

There were no reflections to note.

6.5 Date of next meeting

Wednesday, 23 July 2025

The meeting closed at 15:05

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 14 May 2025

Signed by the Chair …… Date: Wednesday, 23 July 2025

Public Trust Board
Action Log

Off trajectory - The action is behind schedule	Due date passed and action not complete	Action complete/ propose for closure	Action not yet due

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
14.05.25	**TB/2025/008**	**Board and Committee Membership and Designations:** circulate the amended document to the COG for information	22.05.25	Matt Capper, Director of Strategy and Partnerships/Company Secretary	**PROPOSE TO CLOSE** - on COG agenda	Green
14.05.25	**TB/2025/009 and TB/2025/012**	**Integrated Quality Performance Report (IQPR):** develop an IQPR that dovetails into the business plan and submit significant information as opposed to copious amounts of data. **Patient First – Refresh:** a review and refresh of the methodology/strategy to be completed and submitted to Board.	10.09.25 and 20.08.25	Siobhan Callanan, Deputy Chief Executive	**02.07.25** - Siobhan will bring an update to August Board, with formal submission to the September Board meeting IQPR will be included on the Board agenda	Amber
14.05.25	**TB/2025/010**	**Finance Report:** Matt to coordinate an extraordinary Board to approve the Annual Report and Accounts, following him obtaining Peter Conway's availability.	18.06.25	Matt Capper, Director of Strategy and Partnerships/Company Secretary	**PROPOSE TO CLOSE** - completed	Green
14.05.25	**TB/2025/011**	**Improving Financial Governance:** add the Tracker to the Trust Leadership Team meeting agenda, ongoing item until further notice.	20.05.25	Gavin MacDonald, Chief Delivery Officer	**PROPOSE TO CLOSE** - on TLT agenda	Green
14.05.25	**TB/2025/013**	**2025/26 Business Planning – Progress Update:** bring back assurance to the Board on the four areas of non-assurance, mitigations and how close to they get us to closing the gap, take this through the TLT and submit to Board in July 2025.	23.07.25	Gavin MacDonald, Chief Delivery Officer	**PROPOSE TO CLOSE** - on Board agenda	Green
14.05.25	**TB/2025/014**	**Green Plan – Annual Review:** updated business case for Decarbonisation to come to the FPPC	25.06.25	Nick Sinclair, Chief Operating Officer	**PROPOSE TO CLOSE** - delegated to and on FPPC agenda	Green
14.05.25	**TB/2025/015**	**RCP Rheumatology:** obtain the 'lessons learnt' from both Rheumatology and Pathology departments. The Trust will need a Plan B and what is the plan?	13.06.25	Alison Davis, Chief Medical Officer	**PROPOSE TO CLOSE** - delegated to and on QAC agenda	Green
14.05.25	**TB/2025/016**	**IQPR:** Trajectory to reduce patients waiting over 65 weeks to May meeting of FPPC	28.05.25	Nick Sinclair, Chief Operating Officer	Verbal update to be given at the Board	

Chief Executive's report: July 2025

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. The Board is asked to note the content of this report.

Industrial action

Planning is under way to ensure that we take all necessary steps to safely care for our patients during five days of industrial action by Resident doctors – expected from 7am on Friday 25 July to 7am on Wednesday 30 July – and to minimise delays and disruption to our services during this time. We respect our colleagues' right to strike and appreciate that the decision to do so is not one taken lightly.

Review to consider partnership working

The Kent and Medway Integrated Care Board has commissioned a review which will explore the potential benefits and opportunities of working more closely with Dartford and Gravesham NHS Trust, where I am also Chief Executive.

The review will consider whether close working in key areas - such as particular patient pathways and some corporate services - can benefit patients and help us make best use of limited NHS resources.

It will also consider what future leadership and governance arrangements would be needed to realise any opportunities identified, of which there are various options already in place across the wider NHS.

Over the coming weeks, the review team will speak to staff and stakeholders to inform their recommendations, which we expect to receive later this year.

Investing in a greener future

Work to replace hundreds of aging windows with brand-new energy efficient alternatives is underway. This is part of our multi-million pound investment in a greener future for the site, made possible thanks to successful bids for £37.4 million of Public Sector Decarbonisation Scheme funding, to help us carbon net zero target by 2045.

This work also includes transitioning from fossil fuel reliant heating systems to low carbon alternatives by replacing old gas boilers with new air and water source heat pumps. Further work is planned to optimise the low-temperature hot water system, install solar panels on the hospital's roof, and replace fluorescent lighting with energy efficient alternatives.

IT network upgrade

In late June we undertook a major upgrade of our IT network to improve the resilience, security and performance of the systems that we all rely on every day. This upgrade is a significant step forward in our efforts to modernise our digital infrastructure to support safer, more effective care for our patients.

Taking down and restoring more than 300 vital clinical and support systems while continuing to safely care for our patients was no small feat. But thanks to meticulous planning and preparation of a large number of frontline and support colleagues and NHS partners, all systems were back online quickly as planned.

My thanks to all colleagues involved in the planning and execution of such a significant upgrade, and for the teamwork demonstrated during the downtime period.

New funding to improve building safety

Last month the Trust was successful in securing £4.7 million of national funding from the Government's Estates Safety Fund, to make some of our hospital buildings safer. This fund invests in relatively small scale but important building safety works.

This funding will help us to install new cooling equipment to prevent equipment failure, replace an on-call system to improve patient safety, replace flooring to comply to infection, prevention and control standards, and make improvements to our neonatal intensive care and maternity areas.

X-ray services at Sittingbourne Memorial Hospital

We have purchased a brand-new X-ray machine for Sittingbourne Memorial Hospital, and we are finalising plans to start the enabling works required for the new machine to be installed. Meanwhile, the X-ray service at Sittingbourne Memorial Hospital has been suspended due to the poor quality of the images as a result of the age of the current machine.

We expect the service to resume in the autumn. In the meantime, the X-ray service at our Community Diagnostic Centre at Sheppey Community Hospital has been extended and is now open from 8am to 8pm on weekdays and from 8.30am to 6.30pm on weekends.

Star Awards

Finally, I would like to recognise all the nominees and winners at last month's Medway Annual Star Awards. Our annual staff awards ceremony was a tremendous success and an excellent opportunity to celebrate colleagues who have shown great passion and commitment over the last year.

Eight of the eleven awards were nominated by colleagues, with the Team of the Year and Employee of the Year picked by a judging panel from our monthly award winners. The Hospital Hero Award received many fantastic nominations from members of the public, with five shortlisted finalists chosen by The Kent Messenger, award sponsor.

Hearing all the fantastic stories shared on the night demonstrates how we can work in partnership, guided by our Patient First improvement priorities, to deliver provide high-quality care to people living in Medway and Swale.

Meeting of the Trust Board in Public

Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
				X	
Title of Report	**Trust Risk Register and Issues Log Report**			**Agenda Item**	3.3
Author and Job Title	Claire Cowell, Integrated Governance Lead				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				

Executive Summary

Approval		Briefing		Noting	X

The Trust Risk Register and Issues Log Report provides oversight of the highest rated risks and issues and the current mitigations in place to reduce the consequence and likelihood of the risk/issue occurring.

The data provided in this report was current as of the 08 July 2025.

The Trust has 10 'extreme' risks and 3 'significant' issues, as detailed within the report below.

Extreme risks

1. *SHMI mortality indicator being higher than expected*
2. *Organisation being the target of a Cyber Attack*
3. *Existing Metavision version facing challenges with reported bugs and compatibility issues with the current IT systems, requiring an urgent upgrade*
4. *Limitations of EPR/EPMA system functionality*
5. *backlog maintenance impacting on the infrastructure and clinical safety*
6. *Non-Compliance with HTM 05-01 Managing Healthcare Fire Safety*
7. *Patients who lack capacity potentially coming to harm by absconding from the hospital site*
8. *16 and 17 year olds at risk of not receiving optimal inpatient care*
9. *Lack of clear and embedded ligature risk management processes within paediatrics*
10. *Women, Children, and Young People's Divisions inability to meet the financial efficiency target for 25/26.*

Significant issues

1. *Trust is not currently culling or destroying patient records in line with records management code of practice*
2. *Women, Children and Young People Division is experiencing significant operational disruption due to delayed recruitment*
3. *Obsolete Paediatric ventilators*

Proposal and/or key recommendation:	For assurance
Governance Route Meeting: Date submitted:	N/A
Identified Risks, issues and mitigations:	N/A

Resource implications:	N/A				
Sustainability and/or Public and patient engagement considerations:	N/A				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:					
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Wayne Blowers Director of Quality and Safety wayne.blowers@nhs.net Claire Cowell Integrated Governance Lead claire.cowell@nhs.net				

Risk Register

Summary:

There are 80 approved risks on the Trust Risk Register, of which, 10 are rated Extreme (scoring 15 and above), 55 are rated High (scoring 8-12), 14 are rated Moderate (scoring 4-6) and 1 rated Low (scoring 1-3).

There were 4 new risks approved in June with 1 being rated Extreme.

There were 2 risks closed in June.

The heat map below summarises the total number of approved risks assigned to each score.

Likelihood	1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
5 - Almost Certain					
4 - Likely			**9**	**5**	
3 - Possible	**1**	**4**	**22**	**18**	**5**
2 - Unlikely		**2**	**7**	**5**	**1**
1 - Rare					**1**

Consequence

Extreme Risks

Extreme Risk 1 (Ref 1684) was raised May 2023 and describes the Trust's ***SHMI mortality indicator being higher than expected.*** Mortality (SHMI) is calculated using an algorithm which includes the number of deaths observed vs the number of deaths expected, in the cohort of admitted patients. This has a current risk score of 16 (Consequence 4 (Major) x Likelihood 4 (Likely)). SHMI remains higher than expected and value is increasing; this has quality assurance and reputational implications for the Trust if SHMI remains high. Risk mitigations are being progressed through the BO Huddle, Mortality A3 and at the Mortality and Morbidity Surveillance Group (MMSG).

Extreme Risk 2 (Ref 1965) was raised February 2024 and highlights the risk of the ***organisation being the target of a Cyber Attack***, impacting information systems and/or IT infrastructure. This has a current risk score of 15 (Consequence 5 (Catastrophic) x Likelihood 3 (Possible)). Mitigations include the Trust progressing with the implementation of new ransomware protection and a privileged account MFA solution. Primary and Secondary servers have been built and configured user kill switches have been tested for on domain, VPN and AVD users. Staff training has been scheduled, following which a briefing paper will be circulated to agree turning on functionality. Further risk controls include monthly reporting of cyber security to Trust executives and the Information Governance Group. A gap in risk controls include firewall replacements which have yet to receive funding confirmation. The current hold on all corporate vacancies is also impacting on the ability to mitigate against this risk due to infrastructure and on-call team gaps.

Extreme Risk 3 (Ref 1979) was raised March 2024 and describes the ***existing Metavision version facing challenges with reported bugs and compatibility issues with the current IT systems, requiring an urgent upgrade***. Without this upgrade there is a risk of patient harm caused by system failure and lack of patient records being available for staff to make informed care decisions. This has a current risk score of 15 (Consequence 5 (Catastrophic) x Likelihood 3 (Possible)). The backup Electronic Data Archive (EDA) system serves as a contingency, ensuring uninterrupted access to critical patient data in the event of system or network downtime. The EDA has not worked since January 2024 and the live Metavision system stopped working in Critical Care in February 2024. Due to having no back up PC there was no access to patient medical records or drug charts from 1350 to 1630. The impact of having no electronic patient records in Critical Care led to eight drug errors as clinicians had to prescribe from memory.

The teams are controlling the risk by reverting to Business Continuity Plans and the use of paper records if the live system fails and in case of failure of the backup system printed summaries of care from Metavision are to be placed at the patient's bedside. Written paper drug charts are being updated when changes are made on Metavision and checked against Metavision on ward rounds, the ward clerks will also print the Metavision patient prescription after the daily ward round. Critical Care Audit Nurses are also checking prescriptions routinely through the week to ensure no seven-day cycle drop off. Patient prescriptions are also being printed by the Nursing staff at the end of each shift. A Business Case has been submitted to the Trust Investment Group for the Metavision upgrade.

Extreme Risk 4 (Ref 1979) was raised May 2024 and describes the ***limitations of EPR/EPMA system functionality.*** This is potentially impacting patient safety and quality of care caused by the lack of system interoperability impacting user experience of the system and workflow efficiencies. This has a current risk score of 16 (Consequence 4 (Major) x Likelihood 4 (Likely)).

Existing controls remain valid and include:

- Prescription of blood components and products NOT on EPMA: Drug charts still being used in most areas. If unable to access the drug charts, a Blood Transfusion Integrated Care Pathway is available as an alternative which can be downloaded from the Intranet QPulse.
- Prescribers are trained to know that the EPMA/EPR clinical decision support tool will only alert for interactions between medications and allergies/intolerances.

- For certain medications such as paracetamol the maximum dose limit within 24 hours is stated in the medications administration information which displays at the point of prescribing, when reviewing the prescription and when the medication is administered.
- Working with the vendor to update the system to support dose range limits on EPMA.
- Removed the inpatient discharge summary from ED in light of EPMA order reconciliation manager not transferring between ED and inpatient.
- Proposals for replacement of EPMA Pharmacist

Extreme Risk 5 (Ref 2158) was raised July 2024 and describes ***backlog maintenance impacting on the infrastructure and clinical safety***. This has a current risk score of 16 (Consequence 4 (Major) x Likelihood 4 (Likely)). The maintainance backlog is subject to balancing Capital Allocation against most urgent need. Additional funding has been made available for 25/26:

- £4.7m from the estates strategy national fund
- £1.5m for Constitutional Standards from national monies
- £1m for UEC as a result of being in the top 10 of 4-hour wait performers in 24/25

The Estates Team are bringing a paper to Board outlining the greatest estates risks and capital spend prioritisation of works.

Extreme Risk 6 (Ref 2166) was raised August 2024 and describes ***Non-Compliance with HTM 05-01 Managing Healthcare Fire Safety.*** This has a current risk score of 15 (Consequence 5 (Catastrophic) x Likelihood 3 (Possible)). A Fire Safety Paper proposing 5 key changes has been accepted and details a new approach to managing capital according to risk. The 5 key changes are:

1) Evaluate Fire Risk Assessments to provide assurance that they include the entire estate, including offsite and other external premises.
2) Increase Fire Safety Team Staffing to ensure that the functions required under HTM05 are covered.
3) Compartmentation
4) Review of the provision and content of Fire Safety Training
5) Detection

Extreme Risk 7 (Ref 2230) was raised November 2024 describing ***patients who lack capacity potentially coming to harm by absconding from the hospital site***. This risk continues to be possible due to the openness of the hospital, inability to 'lock down' certain areas and the lack of enhanced care availability to provide one to one care when needed. This has a current risk score of 15 (Consequence 5 (Catastrophic) x Likelihood 3 (Possible)). The Trust Missing Persons Policy has recently been refreshed and the Trust now also has a mental health policy. Improvement actions and incidents are being tracked by the Mental Health Working Group including progress with the roll out of the new managing risk tool on EPR. A Business Case is also being developed for 'We Can Talk' training to be implemented and work is being progressed within the ED to control exiting from certain areas.

Extreme Risk 8 (Ref 2274) was raised in December 2024 to highlight the risk that ***16 and 17 year olds may not be receiving optimal inpatient care***. This risk describes the potential for increased adverse events, including potential errors in care, delayed diagnoses, and missed opportunities for timely

interventions if optimal care and pathways are not embedded. This is partly due to the complexities of managing young people with adult pathophysiology, which may require specialised knowledge, not consistently present within paediatric teams, both medical and nursing. A system gap exists due in part to the lack of electronic prescribing in paediatrics, in addition to an understanding of adult medication protocols, which differ from paediatrics.

Controls in place include, identifying the children that are at greatest risk of potentially experiencing a treatment delay and referring these patients as soon as possible, ensuring consultant to consultant conversations take place, and improving closer MDT working in early planning of patient care. Further mitigations to lessen the risk include the implementation of a Policy for the care of 16-17 year olds which is awaiting final approval. The current risk that 16 and 17 years old will not receive optimal care is rated extreme (16) (4 (Major) x 4 (Likely)).

Extreme Risk 9 (Ref 2304) was raised January 2025 as a result of the Trust ***not having clear and embedded ligature risk management processes within paediatrics.*** The risk outlines ligature assessments not being completed, and no documented oversight of all potential ligature anchor points. Numerous ligature anchor points have been identified in paediatric areas with unclear safety processes in place to mitigate these. There have been a number of NPSA alerts and Estates and Facilities Alerts over a period of years, including EFA/2010/007: Window blinds with looped cords or chains. Looped cords and chains on window blinds can present a strangulation hazard. HAZ(SC)06/18: Showerheads: risk of use as a point of ligature. There have been frequent admissions of CAMHS patients with suicidal ideation who have attempted to tie items around their necks. This has included shower hoses, electrical cables and blind cords. This is a risk to both young people with mental health or dysregulated behaviour who may intentionally use ligature anchor points, or by CYP who may accidentally become caught in a ligature. The intentional or non-intentional ligature presents a risk of death or serious harm to a child or young person. The current risk score is rated extreme (15) (5 (Catastrophic) x 3 (Possible)).

Controls currently in place include, patients requiring a ligature free/lite room being supervised by an RMN. Clinical areas have been removed of any obvious ligature risks, however some are unable to be removed as they are permanent estates fixtures. Staff are aware to be vigilant and to escalate any support needed through the correct escalation routes. Estates introducing breakaway curtain rails and anti-ligature blinds.

Extreme Risk 10 (Ref 2453) was raised May 2025 and describes the ***Women, Children, and Young People's Divisions inability to meet the financial efficiency target for 25/26.*** There is a risk that the Division will be unable to deliver safe and high-quality patient care if the mandated £3.287 million financial efficiency target is met. The risk further describes that there has been a request to finance to ensure incorrect establishment numbers are corrected and that cost centres are being scrutinised to ensure they are correctly matched to the areas of service. This is an issue that predates the outturn budget. This will enable accurate identification of the gaps in funding linked to the outturn budgets. Until this is corrected the budget sign off cannot be completed. The current risk score is 16 (Consequence 4 (Major) x 4 (Likely)).

New Risks

The following risks were approved in June 2025:

1) Potential change to nursing profiles of bands 4,5,6 and 7 (Current Score 9 High)
2) Zero-day Cyber Vulnerability (Current Score 12 High)
3) Women, Children, and Young People's Divisions inability to meet the financial efficiency target (see Extreme Risk n.10 above)
4) Ear, Nose and Throat (Current Score 12 High)

Closed Risks

The following risks were closed in June 2025:

1) Supplier for remote monitoring is pulling out and could potentially impact patient care, service capacity and on the compliance of NHSE virtual ward service specification, expectations (all virtual wards must be Technology enabled).
   Project has now been completed and staff training has finished.

2) Reduced capacity and loss of income due to the potential discontinuation of the Lead ANP post
   The post has been approved as substantive and is within the 25/26 budget.

Issues Log

Summary

There are 203 approved Issues on the Trust Issues Log, of which, 3 are rated Significant, 73 High, 105 Moderate and 22 Low.

There were 10 new Issues approved in June with 3 being rated High.

There were 9 Issues closed in June.

Significant Issues

The first Significant Issue (Ref 2083) was raised in May 2024 and describes that due to the lack of resources available, ***the Trust is not currently culling or destroying patient records*** in line with the Public Records Act and retention schedules as set out in the Records Management Code of Practice. The impact is that organisations may be asked for evidence to demonstrate that they operate a satisfactory records management regime. There is a range of sanctions if satisfactory arrangements are not in place i.e. regulatory intervention leading to conditions being imposed upon the organisation, or monetary penalties issued by the ICO. A Health Records Handbook has been introduced that reflects the requirements of the NHS Records Management Code of Practice. A cull and destruction Business Case is also being produced for presentation at the August Information Governance Group.

The second Significant Issue (Ref 2315) was raised January 2025 and describes that the ***Women, Children and Young People Division is experiencing significant operational disruption due to the delayed recruitment for the interim General Manager vacancy***, open since December. Although there is now a start date in July the new member of staff will have no line manager when they join. This issue is compounded by the uncovered maternity leave of the Operations Director. In addition, the Director of Maternity is on extended sickness absence, and the Paediatric Medical Director is on leave with no Clinical Director for Paediatrics to deputise.

The third Significant Issue (Ref 2341) was raised February 2025 and describes ***obsolete Paediatric ventilators***. The two paediatric ventilators currently in use on Dolphin Ward are now obsolete. Although a service contract remains in place until October 2025, replacement parts for these ventilators are no longer available. As a result, if any faults arise, repairs will not be possible. Should equipment fail the controls include:

1. If a child's tidal volume is more than 60mls an Oxylog 3000+ can be used
2. Any child with a tidal volume of less than 60mls would have to be hand ventilated and may have to be moved to the operating theatres to be put onto an anaesthetic machine for ventilation purposes. This presents additional risk should the patient be too unwell to be moved.

Expected delivery date for new ventilators is 26 July.

New Issues

The following 10 Issues were approved in June:

1) Lack of a standardised process to book follow-up appointments (Priority Rating High)
2) Reduction of WTE in Critical Care staffing budget (Priority Rating High)

3) Haemofiltration equipment not fit for purpose (Priority Rating High)
4) Increased staffing costs due to unfunded escalation beds being used (Priority Rating Moderate)
5) Lack of Medical Notes for Haematology Procedures (Priority Rating Moderate)
6) Vacant Lead SACT Nurse post (Priority Rating Moderate)
7) Delay implementation Graphnet (Priority Rating Moderate)
8) Lack of Parkinson's Nurse services for Sittingbourne and Swale Patients (Priority Rating Moderate)
9) Obsolete Cardiac output equipment (Priority Rating Moderate)
10) Use of Formalin in Gynae Outpatients Department (Priority Rating Low)

Closed Issues

The following 9 Issues were closed in June 2025:

1) Safer recruitment processes not being robust, therefore resulting in breach of safeguarding statutory duties.
   All 256 roles have been reviewed and the correct DBS level set for them. Only 2 individuals are yet to start their DBS check and these have been escalated to Employee Relations.
2) Capital Allocation vs. Requirements
   Closed and linked to Backlog Maintenance Risk.
3) Reduced workforce on Keats ward impacting patient care and safety.
   Team is now fully established.
4) Lack of Defibrillator for use within the Resus Training Service
   Approved for closure as Equipment is now in situ following funding from League of Friends.
5) Medicus Outreach upgrade fault
   All issues have now been resolved.
6) Flooring integrity theatres
   New flooring completed in Recovery.
7) VTE risk assessment has not been completed for paediatric patients aged 16 and above
   Now accessible for nursing staff within EPR
8) Trust Vacancy Data not aligned with ESR and Finance
   Review with DCNO, workforce, Finance and recruitment took place on 18/06/2025
   Vacancies on ESR include maternity leave and headroom- but these are not true vacancies. Cannot be separated out. Divisions asked to bring their vacancy data to RRED meeting as this would be the most accurate version of the vacancy positions. Finance BPs to attend RRED to verify data. ESR and Finance data will not match as the systems are used for different things. Plan is to review this yearly, this was discussed at RRED on 19/06/2025.

MFT Board Assurance Framework **Jul-25**

						Initial Rating				Target Rating							Current Rating						
ID	Patient First Domain	Lead Committee	Date Added	Date closed	Full Description of Risk -	Initial Consequence	Initial Likelihood	Risk Rating	Controls	Mitigations to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date for closure	Exec Owner	Senior Manager Lead	Update position	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Number of months without movement		Corporate Risk Register / Issues log mapping
BAF1(25)	**Sustainability**	FPPC	Apr-25		There is a risk that the trust does not effectively manage its in-year budgets, run rate and CIP resulting in the non delivery of the agreed in year control total.	4	3	12	1. Finance, Performance and Planning Committee oversight. 2. Business planning and budget setting processes in place. 3. Divisional finance business partners. 4. Weekly financial recovery and CIP performance reviews linked to SDR. 5. Budget statements/budget holder meetings 6. NHSE Improvement Director support. 7. System finance and recovery forum (CFO attending) 8. Application of "Grip and Control" checklists, and "Core/Level 2-3-4" NHSE controls 9. Self-assessment and implementation of HFMA sustainability checklist 10. VCP and enhanced non-pay controls	• Medical staffing project being implemented • Trust wide recruitment freeze. • Agreed budgets at divisional level. • Greater oversight of month and forecast position • CIP programme and related governance and oversight. • Revised finance recovery strategy and implementation plan. • Revised SFI and SoRD. • Revised finance and performance governance (ToR)	4	3	12	Mar-27	CFO	Paul Kimber	**June 25** - Estimated monthly position on track against forecast . The trusts recruitment freeze has been extended to September. CIP identification continues and incorporates system expectations. **July 25 -** Month 2 performance remains on track, but with significant risk building as a result of the unidentified efficiencies against a backdrop of the growing monthly target delivery.	5	5	25	↑	0		Risk 2052: If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk. Risk 2055: ERF / Elective Activity Plans. Risk 2058: Unchecked staff growth. Risk 2126: Potential for S&A Divisional CIP target for 2024/25 not being achieved. Risk 2156: WCYP Division unable to identify efficiency schemes to meet CIP target. Risk 2172: Trust wide blood glucose and ketone contract expires 26th August, unable to extend will have a financial & operational impact.
BAF2(25)	**Sustainability**	FPPC	Apr-25		**ISSUE** - Limited capital money owing to capital monies already committed to multi-year projects and static national capital funding will impact on the Trust's ability to tackle its backlog maintenance requirements. This in turn will impact on the quality of care provided and impact the Trusts ability to meet its other statutory and recovery objectives.	5	4	20	1. Completion of Trust prioritisation matrix, including risk register entries 2. Programme review and approval by Trust Executive each financial year 3. Proposal paper drafted setting out options to address findings of the 6-Facet survey 4. Submission of capital plans and requests via the system to secure minimum fair share of operating capital allocation 5. Application for additional capital funds where available, e.g. PDC, charity, grants, etc.	• Risk based prioritisation matrix produced and being used for the capital spend discussions. • Explore strategic capital finance options. • Develop and implement Estates and Facilities Strategy • Review Medway and Swale CDEL funding availability and build into development control plan. • Member of the ICB strategic estates group (ToR). • Capital prioritisation part of Finance Committee ToR.	4	3	12	Mar-27	COO	Neil Mcelduff	**June 25** - Work on prioritising and implementing the capital programme is underway and the Trust will continue to explore opportunities for new capital funds to support projects in the capital pipeline. The current capital money does not cover all required projects **July 25 -** Further awards from national funds have been made in Q1, although not all are cash-backed.	5	4	20	↑	0		Risk 2135: Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action. Risk 2158: Backlog Maintenance impacting on the infrastructure and clinical safety.
BAF3(25)	**Sustainability**	FPPC	Jun-23		A number of independent reports into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Without addressing the culture the Trust may struggle to deliver its financial plans. Failure to address this as an issue could impact the Trust's exit from NOF4.	4	4	16	1. Budget holder meetings 2. Budget holder training (stat man) 3. Finance Training Policy 4. Mandatory objective in appraisal form 5. Sustainability work stream within Patient First 6. Communication via senior managers meetings and Trust Management Board 7. Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. 8. Better Business Case trained staff. 9. Audit tracker	• Budget holder training part of Stat and Man training. • Communication from CEO and CFO outlining staff responsibilities • Business planning and budget ownership by divisions. • Core financial policy refresh and relaunch. • Link through to the trust cultural transformation programme. • Implementation of NHSE Improvement Director report recommendations.	3	3	9	Mar-26	CFO	Exec	**June 25 -** Budget sign-off nearing completion. Focus put into the 14 Rad and Amber actions on the Finance tracker. Business Planning for 2026/27 is being scoped. SFI redraft completed **July 25 -** Budget positions now closed down and awaiting sign-off. Implementation and tracking of all recommendations is ongoing.	4	4	16	-	2		Risk 2052: If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk. Risk 2055: ERF / Elective Activity Plans. Risk 2126: Potential for S&A Divisional CIP target for 2024/25 not being achieved. Risk 2156: WCYP Division unable to identify efficiency schemes to meet CIP target.
BAF4(25)	**Sustainability**	FPPC	Apr-25		There is a risk that if not properly managed the Trust's financial position will lead to compromises in patient safety, health and safety and staff moral.	4	3	12	1. TMB (TLT) oversight and ToR 2. Finance, Performance and Planning Committee oversight. 3. Quality Assurance committee oversight. 4. Trust combined impact assessments (quality, equality and finance) included in business plan process, business cases and efficiencies. 5. IQPR dashboard 6. NHSE Improvement Director support. 7. System finance and recovery forum (CFO attending) 8. Staff surveys (National, Pulse, listening events) 9. CQC remit 10. **(-ve)** Health and Safety compliance dashboard	• Develop a Health and Safety compliance dashboard to enable tracking of impact. • Ensuring all decisions are subject to the trusts combined impact assessment process. • Implement effective business planning to ensure all risks are known and being managed.	4	2	8	Dec-25	CEO	Exec	**June 25 -** The operational risks mapped to this strategic risk have been discussed at the Quality Assurance Committee and a deep dive has been requested at the next meeting. Impact remains under review. **July 25 -** All impact assessments must be reviewed and approved by the CNO and CMO and a process is in place to ensure this happens.	5	4	20	↑	0		Under development
BAF14	**Sustainability**	FPPC	May-25		Proposed revisions linking financial recovery to the ongoing availability of national Deficit Support Funding could further exacerbate the Trust's financial position, especially its cash position.	5	3	15	1. TMB (TLT) oversight and ToR 2. Finance, Performance and Planning Committee oversight. 3. Monthly finance flash reports and cash review meetings. 4. NHSE Improvement Director support. 5. System finance and recovery forum (CFO attending). 6. Financial recovery oversight programme ToR	• CIP programme achievement. • Recovery of historic debt. • Reducing waste programme delivery including reduced spend on high spend areas. • Continued adherence with the forecast financial trajectory.	5	2	10	Oct-25	CFO	Paul Kimber	**June 25 -** Cash review meetings will be established on a weekly basis; including development of working capital action planning. **July 25 -** In addition to weekly Trust treasury meetings, finance staff are members of the K&M ICS cash working group and the South East region cash management group. We expect to hear imminently in respect of the Q2 Deficit Support Funding.	5	4	20	↑			Being mapped
BAF5(25)	**People**	People	Apr-25		The Trust has experienced issues with organisational culture which have been identified through a number of key feedback mechanisms such as annual & quarterly staff survey's, Cultural Transformation diagnostics, FTSU feedback/reports and issues raised through the incivility Breakthrough Objective. These reports describe trust culture as discriminatory on the basis of race and sex with frequent reports from staff experiencing bully harassment and/or discrimination. This results in an increased number of employee relations cases managing formal allegations of discrimination, staff suspensions from work and employment tribunal claims. There is an inconsistent approach in accountability and managing the consequences of staff behaviour.	3	4	12	1. WRES/WDES indicator collection and reporting 2. People True North objective. 3. People strategic initiative (monthly reviews and updates) incorporating phase two of the cultural transformation programme. 4. month meetings between senior HR and FTSU service to review management information reports and discuss actions.	• Improved BI data reporting providing daily information to the division on incivilities through FFT and DATIX. • Continue to make improvements to the trusts WRES/WDES indicators to bring them into line with best practice. • Weekly people breakthrough objective focused on retrospective reports from divisions providing assurance on steps taken to address reports of incivilities and discussions to identify steps to prevent incivilities from occurring in the first place. • Phase two cultural transformation programme. • Continuous work to support new FTSU service becoming imbedded and focused on trust FTSU strategic objectives (refreshed FTSU strategy)	3	3	9	Mar-26	CPO	Dominika Kimber	**May 25 -** New mindfulness sessions and menopause café initiatives being held in the wellbeing hub. Sexual harassment and abuse risk assessment learning sessions for divisions have commenced. Reporting pathways being reviewed. **July 25 -** People strategic initiative refreshed (A3) to incorporate cultural transofromation programme and new actions. People True North (A3) refreshed in June and will be presented to the TLT on 8 July. People breakthrough (A3) to be refreshed in July and august. CTSG meeting regularly to map out phase two of the programme (likely as an A3).	4	5	20	↑	0		Being mapped

ID	Patient First Domain	Lead Committee	Date Added	Date closed	Full Description of Risk -	Initial Consequence	Initial Likelihood	Risk Rating	Controls	Mitigations to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date for closure	Exec Owner	Senior Manager Lead	Update position	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Number of months without movement		Corporate Risk Register / Issues log mapping
BAF6(25)	**People**	People			There is a risk that staff do not feel confident to raise concerns with the organisation or their managers for fear of repercussions or a fear that their concerns will not be dealt with appropriatly. This has a negative impact on working relationships, trust in management taking actions and staff enagament impacting on the quality of patient care.	4	3	12	1. Freedom to Speak Up strategy and implementation plan. 2.Cultural Transformation programme progressing to phase two implementation phase. 3. Dedicated intranet page launched displaying regular updates (monthly) on actions taken following staff feedback and concerns. ("You said we did, we all have a voice") 4.Idependent external Freedom to Speak-Up service. 5. Monthly meetings between senior HR and FTSU lead to discuss performance reports and any actions. 6. People Strategic Initiative focussing on leadership behaviours. 7. National staff survey dashboard in place linking local survey results with management skills and competencies. 8. Dignity at Work Advisors.	1. FTSU strategy implementation plan is discussed in monthly meetings between senior HR and FTSU service. 2. Phase two of cultural transformation programme is going to be embedded into the people strategic initiative to track actions and report on progress. 3. Regular promotion of FTSU service to staff utilising people breakthrough objective huddles. 4. People strategic initive A3 has a number of actions to improve management capability.	4	2	8	Dec-25	CPO	Dominika Kimber	**June 25 -** Phase 2 of the Cultural Transformation programme has commenced and a findings report from phase 1 will be presented to the Board in June 25. A review of the reporting definitions is underway to ensure the quality of reporting is consistent with national expectations. A summary of the first six months of the independent FTSU service has been included in the AGS. **July 25 -** A3 for the cultural transformation to be completed by CTSG in July. People strategic initiative refreshed (A3) to incorporate cultural transformation programme and new actions.	5	4	20	↑	0		
BAF7(25)	**People**	People	Sep-23	**Jul-25**	**Amalgamated with BAF 5 - REMOVE** Should the Trust fail to deliver its strategic objectives relating to EDI, there is a risk that our people will not be able to thrive at work and that the Trust will not meet its statutory obligations to its employees. This may lead to poor employee experience and negative impact on staff wellbeing, both at work and in general. IMPACT: Failure to meet the requirements of the Equality Act 2010; increase in staff turnover; increase recruitment and retention challenges; and therefore impact negatively on quality of patient care and experience.	2	3	6	1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff. 2. Executive team and Trust Board have committed to EDI Objectives as part of their personal objectives (HIA1); although now signed off, work is required over 2024/25 to support delivery of those objectives 3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactive measures can be taken. 4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	1a. Review of the People Strategic Initiative (Leadership and Behaviours) and implementation of the agreed actions. 1b. Development of Behaviours Framework (aligned with Trust Values, incorporating all existing tools referencing behaviours e.g. Compact, Our Leadership Way, Nolan Principles) 1c. Development of examples of negative staff behaviours to be included in the Behaviours Framework 2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024 3a. Anti-bullying and harassment group to be reviewed and re-established. 3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan) 3c. New duty to protect staff from sexual harassment and actions relating to the Sexual Safety Charter will be embedded into Trust's policies and processes 4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI. 5. Cultural transformation programme.	2	3	6	Sep-25	CPO	Alister McClure	**May 25 -** NHSE plan to develop a similar Framework - we are continuing to liaise with them. All Exec objectives contain an EDI element. Cultural transformation Programme diagnostic phase has been completed and feedback is being received and analysed. **June 25 -** Phase 2 of the Cultural Transformation programme has commenced and a findings report from phase 1 will be presented to the Board in June 25. **Amalgamated with BAF 5 - REMOVE**	2	3	6	-	3 (at target)		
BAF8(25)	**Quality**	QAC	Aug-24		SHMI mortality indices show that Medway Foundation Trust are outside the expected range. There is a risk that patients maybe dying unnecessarily whilst at an inpatient at Medway Foundation Trust or within 30 days of discharge. (To be reviewed once Patient First Breakthrough objective is confirmed)	5	4	20	1. Avoidable #2222 breakthrough objective completed and now transfered to a watch metric. 2. Correct documentation and validation of death data 3. Mortality Breakthrough Objective. 4. Emergency Admission pathway and medical model. 5. Learning from Deaths process, End of life care pathway, Medical Exmainers process, 6. Revised breakthrough objective.	1. Review of the emergency admission pathways / medical model with a focus on patients admitted with respiratory disease. 2. Further embedding of learning from deaths methodology including the SJR process to utilise skills of the MDT. 3. Improving identification of end of life and communication with patients and families regarding end of life care. 4. Continue to focus on data quality improvements. 5. Include in the review of medical models. 6. Refresh the Breakthrough Objective.	5	2	10	Mar-26	CMO	James Alegbeleye	**June 25 -** 1. Review work has been completed and identified specific areas of focus (e.g. Respiratory disease) to target. Recovery actions designed. Recovery programme being rolled out. 2. **Completed** 3. **Completed** 4. Data quality continues to be comparable with national metrics. Metrics still show an adverse position SHMI. 5. Medical models being delivered and are kept under review. The next phase of this work is being designed and will form part of the Trusts business plan. 6. Mortality Breakthrough Objective established, root causes and countermeasures identified (as above). Work underway to deliver. Regular reporting to the Board (quarterly). **July 25 -** 1. Audit of clinical pathway for the treatment of pneumonia as this is an outlier group for SHMI against NCEPOD standards 2. SJR process embedded, improved morbidity	5	4	20	-	2		
BAF9(25)	**Patient**	QAC	Sep-24		There is a risk that patients and their families may not receive outstanding, compassionate care every time. (link to BAF 4)	4	3	12	1. Weekly FFT huddles to discuss top themes and trends from feedback 2. Divisional and Exec SDR to review the top contributors 3. Monitoring communication issues and managing patient expectations via the Patient Experience Group	1. Fundamentals of care programme of work. 2. The re-established ward accreditation programme. 3. Elective reform corporate project.	3	3	9	Mar-26	CNO	Nikki Lewis	**June 25 -** Performance continues improve or be held and regular reports are reviewed by TLT and relevant committees. **July 25 -** A3 refresh complete with focus on 4 top contributors. Inpatients FFT consistently meeting 95% target and moved to watch metric. ED target lowered inline with national data sets. Focus to improve OPD, ED and assessment areas FFT in the next 3-6 months	3	3	9	-	2 (at target)		Risk 1256: Lack of compliance with fundamentals of nursing care. Risk 2006: Patients awaiting G4S transport in CT.

ID	Patient First Domain	Lead Committee	Date Added	Date closed	Full Description of Risk -	Initial Consequence	Initial Likelihood	Risk Rating	Controls	Mitigations to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date for closure	Exec Owner	Senior Manager Lead	Update position	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Number of months without movement		Corporate Risk Register / Issues log mapping
BAF10(25)	**System & Partnership**	FPPC, QAC	Jun-23		High levels of 'no criteria to reside' patients and a lack of operational performance; for example not meeting constitutional (e.g. RTT) measures has wide-ranging implications, affecting patient care, trust, finances, and overall NHS performance It's essential for trusts to address these issues promptly to maintain high-quality healthcare services.	4	3	12	1. Focused work through the HARIS group 2. Weekly RTT meeting including robust review of RTT process 3. Reports direct to COO 4. Monthly reporting to TLT Focus on clinical urgent and then long waits Patient P control in operation Use of ERF monies to support increased activity	1. Revising and imbedding acute medical and frailty Model 2. Reviewing the Full capacity protocol, opel triggers and actions. 3. Develop SPOA (Pilot) and virtual wards. 4. Waiting list maintenance and review process in place. 4. Rota of Senior Operational staff on the shop floor.	4	3	12	Mar-26	COO	Divisional Directors	**June 25 -** Work continues on establishing necessary actions required to meet both internal and national targets. this includes looking at system support options. This work is in collaboration with FRP. Ability of achieving RTT % target by March 26 is driving the risk. Pead services are the exception and are working well to achieving the national target. Rostering and job planning has continued. Feedback on this area is now a standing item on the TLT agenda. **July 25 -** Focused work on improving quality of EDN completion to reduce rejection rates to achieve a timely discharge and introduction of a dedicated Acute Medical Unit to focus on reducing the LOS on those 'acute' presentations.	4	4	16	-	2		
BAF11(25)	**Systems & Partnership**	EMC, FPPC	Jun-23		There is a risk that conflicting priorities, financial pressures and/or ineffective governance across the ICS results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care.	4	4	16	1. UECDB - Oversight dashboard 2. HCP remit 3. Kent and Medway Integrated Care Partnership Joint Committee 4. Joint development of plans at ICS level 5. Kent CEOs Meeting 6. Trust-wide Flow and Discharge Corporate Project 7. Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans	1. Review of LAEDB ToR and governance framework, agenda and required reports. 2. review in-reach with clinical leads	3	3	9	Mar-26	COO	Exec	**June 25 -** work continuing as above, but risk increasing as performance is not improving. A review of mitigations and actions will take place in June. **July 25 -** UECDB reviewed priority workstreams and agreed on next actions. Corporate project continues to drive improvement in LoS. Increased pressure between partners and ICB over contractual position and funding constraints of the ACF is leading to financial risk for the ICB, escalated to the HCP Senior Leaders Group	4	4	16	-	1		
BAF12(25)	**Systems & Partnership**	EMC, FPPC, QAC	Jun-23		The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity. There is a risk that the increase in patients without a criteria to reside and the low discharge profile will reduce flow through the hospital, increase the number of 12 hour delays in our ED and increase demand for bed capacity. This in turn impacts on the quality of care provided and increases the opportunity for harm to occur. In addition this may increase overall Trust mortality as delays in ED over 5 hours correlate with increased risk of mortality. This risk also adds pressure to the financial sustainability of the trust.	4	4	16	1. Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. 2. Flow and Discharge Corporate project. 3. HCP Discharge Group, Efficiencies Group and LAEDB. 4. TeleTracking. 5. Virtual Ward initiatives 6. Linked to BAF9 improvement of SHMI	1. Create an operational plan that supports the closure of escalation beds. 2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MD. 3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS. 4. Board Round improvement as part of the reducing LoS CP.	3	3	9	Mar-26	COO	Darren Palmer	**June 25 -** work continuing as above, but risk increasing as performance is not improving. A review of mitigations and actions will take place in June. **July 25 -** Continuing to monitor and work with partners to reduce Length of stay for complex no criteria to reside pathway 1,2,3 patients.	4	4	16	-	1		Risk 2154: Harm 25/07/24.
BAF13(25)	**Corporate**	EMC	Sep-24		There is a risk that without continual investments and maintenance (including cyber security) the trust will not be able to deliver on its core responsibilities and duties as well as being able to deploy innovative systems to support the delivery of the trusts aims, objectives and strategic intentions.	4	4	16	1. Digital and data (DDaT) strategy and implementation plan. 2. IT investment summary (business planning item) 3. Board level leadership and oversight (Chief Delivery Officer). 4. Annual maintenance programme. 5. Server upgrade programme. 6. Cyber security review findings and resultant action plan. 7. Links to local and national IT initiatives and programmes (e.g. CSOC).	1. Delivering the DDaT implementation plan. 2. Improved multi-year capital programming. 3. Awareness raising and education on cyber security and associated IT risks. 4. Reviewing and producing a cyber strategy for Medway in collaboration with ICB. 5. Server upgrades programme. 6. Continuation of the trusts digitisation of 'paper case notes' project.	4	3	12	Dec-25	CDO	Adrian Billington	**June 25 -** The annual DSPT has been completed and will be reported to the Board and ARC in June. Early view is that the trust has been rated Green/Amber by internal audit which is an improvement on 23/24. The draft DDAT strategy has been approved by the trust leadership team and there is a system work programme drawing together cyber work programme. Scheduled switch infrastructure work will take place through June and July. **July 25 -** Following a number of national publications and plans the trust will be undertaling a review of the draft strategy and imple,mentation plan toi ensure that it compliments the described 'fit for the future' standards anbd practices. A paper will be submitted to TLT and Board in September.	4	4	16	-	1		Risk 1858: End of support Windows 10 25/10/25. Risk 1860: End of Support Microsoft Office 2016 & 2019 10/25. Risk 1919: Firewalls End of Support/Lifecycle Jan-25. Risk 1962: Core Network Switch Management (Increased risk of Cyber Attack). Risk 1965: There is a risk of the organisation being the target of a Cyber Attack, impacting information systems and/or IT infrastructure. Risk 2067: Deployment and Interfacing of EPR/EPMA System Impacting Patient Safety. Issue 2279: NG checklist not on EPR leading to increase in patient safety incidents.
BAF15(25)	**Quality**	QAC	Jul-25		(**New**) Multiple areas of non-compliance with H&S legislation within E&F. Following the undertaking of a H&S audit against the NHS Workplace Health & Safety Standards Audit (WHSSA) 2022 there remain a number of areas where the Trust cannot demonstrate full compliance against the Health & Safety at Work Act 1974 and the Regulations that fall under it, specifically within the remit of E&F. Failure to demonstrate compliance may result in harm and/or enforcement action from the HSE.	5	3	15	1. Governance and oversight through board sub-committee. 2. Policy and Procedure Management. 3. Risk Assessment and Audit cycle. 4. Training and Competence through mandatory training. 5. Reporting and management through trust system and learning from incidents. 6. Contractor and Supplier Control measures. 7. Leadership and Culture programmes. 9. Trust continuous improvement approach and performance monitoring regime. 10. National benchmarking.	1. Designated H&S Lead with clearly defined role. 2. Update H&S Policies and review regularly including Standard Operating Procedures. 3. Carry out and document comprehensive risk assessments for all E&F areas, with a clear action plan for addressing deficiencies and schedule frequent internal and external audits. 4. Ensure all E&F staff and contractors complete up-to-date mandatory H&S training relevant to their roles. 5. Investigate all incidents thoroughly, analyse trends, and share key lessons learned across the Trust. 6. Vet and monitor contractors to ensure full compliance with H&S standards before commencing work on Trust premises. 7. Trust Leadership Team review H&S performance regularly and champion a positive safety culture. 9. Set and monitor key performance indicators around H&S compliance (audit outcomes, incidents, action close-out rates). 10. Regularly benchmark performance against peer Trusts.	5	2	10	Dec-25	COO	Neil Mcelduff	**August 25 -** To be updated	5	3	15	new			

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	X				
Title of Report	**Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)**			**Agenda Item**	3.5
Author and Job Title	Alana Marie Almond, Deputy Company Secretary				
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Executive Summary	Approval	X	Briefing		Noting

The Trust's Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD), serves as a critical framework for the Trust. The recommendation is for the document to be formally adopted by the Board in July 2025, with the next review scheduled for March 2026. Its primary purpose is to outline the financial responsibilities, policies, and procedures to be adhered to by all executive directors, non-executive directors, and staff. These instructions are designed to ensure that the Trust's financial transactions are conducted in accordance with the law and regulatory requirements, promoting probity, accuracy, economy, efficiency, and effectiveness, while simultaneously protecting the Trust's interests and safeguarding staff from accusations of improper conduct. They are to be read in conjunction with the Trust's Constitution and Standing Orders, both of which detail decisions reserved for the Board.

Central to the Trust's financial governance, the document details the Scheme of Delegation, which empowers the Board to delegate responsibilities for the performance of its functions. The Chief Executive Officer (CEO) holds overall executive responsibility for the Trust's activities and its internal control system, while the Chief Finance Officer (CFO), a statutory post, is primarily responsible for ensuring adherence to financial regulations, accurate financial reporting, and the oversight of banking arrangements, income systems, and debt recovery. The Audit and Risk Committee (ARC), provides an independent and objective view of internal control, while the CFO is tasked with promoting counter-fraud measures and ensuring compliance with relevant legislation. The changes to the document in this refresh, reflect the requirements of the Procurement Act.

The SFI meticulously cover diverse aspects of financial management, including business planning, budgeting, budgetary control, and monitoring, with specific responsibilities for the CEO, CFO, and budget holders in preparing, approving, and overseeing financial plans. It also addresses annual accounts and reports, non-pay expenditure (including procurement and tendering guidelines), capital investment and asset management, patient property, and the administration of charitable funds. Appendices provide crucial details, such as the hierarchy of delegated budgetary authority, summary of delegated approval limits for various expenditure types, and a detailed scheme of delegation, ensuring clear lines of authority and accountability for all financial activities.

Proposal and/or key recommendation:	The Board to **APPROVE** the document, for onward publication on Q-Pulse.				
Governance Route Meeting: Date submitted:	Audit and Risk Committee – 08 May 2025 (noted for approval at Board)				
Identified Risks, issues and mitigations:	Not complying with the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) carries significant risks for the Trust, impacting its financial integrity, operational efficiency, legal standing, and the accountability of its staff.				
Resource implications:	None				
Sustainability and/or Public and patient engagement considerations:	None				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@nhs.net				

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems				
	✓								
Title of Report	Finance Report Month 2					**Agenda Item**	4.1		
Author and Job Title	Paul Kimber, Deputy Chief Financial Officer								
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)								
Executive Summary	Approval		Briefing	✓	Noting	✓			
	Key points in relation to the Month 2 / May 2025 financial results: a) The Trust reports a £0.2m favourable variance to plan, the year to date (YTD) position is in line with the submitted plan. b) ERF clinical income is reported up to the local commissioner cap; an additional £4.0m of Deficit Support Funding has also been recognised per Plan, this totals £10.4m YTD. c) £0.4m of efficiencies have been delivered against a plan of £1.1m in the month, the total YTD delivery is £0.7m. Note: Profiling of the Plan to provide time to mature savings means the Pay budget in Q2 will be ~£27m versus a Pay cost today of £29.7m (reflecting the savings target of £27m / £46m (system) respectively. Identification and delivery of savings is the most urgent financial objective.								
Proposal and/or key recommendation:	The Board is asked to note this report.								
Governance Route Meeting: Date submitted:	Overview of performance provided to Trust Leadership Team meeting 17 June 2025. Report presented at the Finance, Planning and Performance Committee on 25 June 2025.								
Identified Risks, issues and mitigations:	Non-delivery of the breakeven control total. Income and cash support, with pro-active working capital / cash management and forecasting.								
Resource implications:	The report sets out the financial resources /performance / position of the Trust								
Sustainability/engagement considerations:	N/A								
Integrated Impact assessment (please mark):	Yes		No		N/A				
					✓				
Appendices:	N/A								
Freedom of Information status (please mark):	Disclosable		X	Exempt					
For further information please contact:	Simon Wombwell								

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	X				
Title of Report	**Review of Financial Governance (January 2025) - Update**			**Agenda Item**	4.2
Author and Job Title	Simon Wombwell, Chief Finance Officer (Interim)				
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Executive Summary	Approval		Briefing		Noting X
	The *Review of Financial Governance* Report was commissioned by NHSE (South East) and K&M ICB in Update to the 2024/25 Month 8 (November) financial position and subsequent worsening of the forecast, reported in mid-December 2024 to better understand the operation and effectiveness of financial governance in Medway FT. The Review was undertaken by Margaret Pratt, Senior Financial Governance Assessor for NHSE. The recommendations can be summarised into three themes: • *Trust Board and Board Governance* – improvement in delivery of financial information to the Board, improving financial awareness and effective check and challenge and the recording of. • *Capacity and Capability* – improvement in the finance team itself, business-partner approach, better performance management and operational control processes e.g. rosters, and improved budget setting. • *Financial Controls* – Financial Recovery Planning, alignment of activity, workforce and finance, review of Patient First breakthrough objective for Sustainability and an update of SFIs.				
Proposal and/or key recommendation:	For discussion and assurance				
Governance Route Meeting: Date submitted:	The Report has been discussed at FPPC and Board since being received on 20 January 2025.				
Identified Risks, issues and mitigations:	The risk recommendations are not addressed in full, which leads to further regulatory intervention.				
Resource implications:	None				
Sustainability and/or Public and patient engagement considerations:	None				
Integrated Impact assessment (please mark):	Yes	No	N/A		
			X		

Freedom of Information status (please mark):	Disclosable		Exempt	X
For further information please contact:	Simon Wombwell			

Review of Financial Governance - update

Introduction

1 Following the worsening of the 2024/25 Month 8 (November) financial position and the forecast to 31 March 2025 (reported in mid-December 2024) a review was commissioned by NHSE (South East) and K&M ICB to better understand the operation and effectiveness of financial governance in Medway FT. The review was led by Margaret Pratt, Senior Financial Governance Assessor for NHSE.

2 The Review of Financial Governance Report was received by MFT on 20th January 2025.

3 The Report contained 15 recommendations, which are set out below together with an update to the Board on progress to address each one.

Recommendations (15) and Updates

4 The Trust reviews its financial reporting and forecasting to Board, to ensure that:

- Concerns including the forecast outturn are escalated and debated at Board, with firm recommendations for SMART actions going forward; and
- A "golden thread" is developed anchoring actions and deliverables to the delivery of sustainable finances. These actions should be tracked for effectiveness through the Board's Action log and incorporated within Trust communications. Actions should be tracked for effectiveness through the Board's Action log; and should demonstrate that there are no "orphan" activities agreed that do not have oversight from a Board Committee.
- Review outcomes should be explicitly endorsed by the CEO; lead executives and non-executive Chairs.

Completed: In the final quarter of 2024/25 a monthly profile of the forecast was provided including a reconciliation to a straight line forecast. This was discussed monthly by the Finance, Planning & Performance Committee (FPPC) and the Trust Board. The Chairs of the Trust Board and FPPC received a weekly update from the CFO on progress against material transactions and impact on the forecast. The Trust delivered a £22.4m deficit at year end, slightly better than the £22.9m deficit forecast reported in December 2024.

Proposed action: A forecast process for 2025/26 is underway, following the completion of Quarter 1. During Quarter 1 the FPPC and Board Reports clearly set out the risks to achievement of the Plan. At the end of Quarter 2 (October Meeting), it is proposed the FPPC formally discuss the forecast and approach, with feedback to the Board on the level of assurance and planned actions to address any shortfalls.

5 Consideration should be given in agenda planning to ensure that the Board considers in public its most up-to-date financial position, with associated actions; and that the Trust's communications reflect actions to address issues and risks arising. Consideration should be given to circulating to all members of the Unitary Board the reports submitted to the ICB and NHSE in the months when the Board does not meet.

Update: All Committees have agreed an annual workplan, which is reviewed periodically to incorporate changing internal and external factors. The Finance Report is received at the Board Meetings in Public, and Board Meeting takes place every month.

Proposed action: The Finance team to look at the monthly reporting timetable with a view to report the most up-to-date financial results at the Public Board. If the Board wishes financial results to be reviewed for assurance by the FPPC prior to the Board, we will need to review the

meeting timetable (Board meets mid-month, FPPC later in the end of the month). This action will be added to the Finance Team objectives for 2025/26.

6 To ensure that the Unitary Board has a clear, shared understanding of the tasks; timescales; risks; and roles, responsibilities and accountabilities for delivery, the interim CFO should be tasked with:

- reviewing and updating the financial recovery action plan including progress on the 21 actions/ recommendations made by the former financial improvement director and other reviews; and
- proposing updated monthly run-rate projections as key delivery metrics for assurance.
- This review should be considered formally by the Unitary Board by the end of January 2025, and followed up through the action log.

Update: This recommendation formed part of the work completed in Q4 2025/26.

Proposed action: The delivery of the financial plan (£4.9m deficit), risks, mitigations and actions underpinning delivery continue to be described in the monthly finance report and saving reporting. This is expected to form part of the assurance process, anticipating deep dives and recovery plan papers to provide additional assurance, as required to Board and/or sub-committees to add further assurance.

7 BAF and corporate risks; gaps in controls and gaps in assurance be reviewed for interface with the delivery of the finance recovery plan; and revised assessments and action plans developed for Committee and Board review; and active follow up of SMART action plans.

Update: Review of BAF and corporate risks is underway, led by Trust CoSec. Given this is an active part of Board and sub-committee discussions and assurance this is deemed to be normal business. Paper to Board in June regarding financial governance will dovetail into the review work.

Action: Trust CoSec and Deputy CEO completing a formal review on behalf the Board (for decision) and will link to papers and sign offs at future Board Meetings; including the same subject matter being part of the Board Development programme (See separate agenda item).

8 Check and challenge exchanges at each Board and Committee meetings are captured and included with SMART actions and reporting timelines in action logs for follow up and alignment of expectations and delivery.

Update: Check and Challenge included in the minutes across Board and sub-committees.

9 The Board and Executive Team consider commissioning as quickly as possible a Board and Team development programme to encourage strong working relations as a Unitary Board.

Update: Initial Board Development session on financial processes and Cutlural Diversity held since December 2024. Wider programme of Board development under development.

10 Financial awareness should be explicitly included in the Board development programme. All Directors should acknowledge that as Unitary Board members they are accountable for the delivery of financial plans and sustainable financial performance.

Update: Initial session held in December 2024. Further briefings and discussions with new Chairs of Audit and Risk and FPPC. Greater use of the term "Unitary Board" in both Exec and Non Executive discussions reinforcing the joint and equal responsibilities for all areas of Trust performance.

11 For assurance, a representative of the ICB be invited to attend meetings of the Finance, Planning and Performance Committee as an observer. This person also provides briefing into the monthly Oversight Meetings, chaired by the ICB.

Update: We have our nominated NHSE Improvement Director as an observor at FPPC. The ICB receive updates from the ID via the Oversight process.

12 The Trust considers revising through "Patients First" its break-through objectives to encourage focus on monthly run-rate against budget.

Update: Completed. The 2025/26 Sustainability BO is based on the financial and headcount reduction targets. Importantly, we have baselined the opening position for 2025/26 against which target delivery will be measured.

13 The Trust ensures that revised processes are implemented to ensure the Board is fully sighted on budget setting assumptions; and that mitigations to control risks and issues arising are made explicit.

Update: Board received updates on business planning and budget setting.

Action: The agreement of budgets within the context of a challenged organisation has, inevitably, led to a number of residual risks. These risks are not just financial i.e. issuing of challenging budgets to live within the agreed income envelope and meet the £4.9m deficit control total means service areas may not have sufficient budget to meet all activity and performance targets sustainably. In some instances there could be safety related risks to manage. The Board will wish to ensure that the balance of safety, activity/performance, workforce and Finance is monitored appropriately. FPPC will receive a monthly update on primary activity (are we delivering to contract?) and performance (are we meeting the constitutional targets?) alongside the financial report. The management teams will need to monitor key 'safety' metrics that allow us to investigate any unacceptable changes from the baseline position, and respond with agility where, say, the impact of operational change to support financial sustainability causes issues. This will be in addition to robust quality impact assessments conducted in the planning process. To be assured the Board should consider doing its own review of the Quality and Safety metrics to be used as 'alarm bells' during this period of major change.

14 The Executive Team take time out to reassess its appetite for change and risk to give greater emphasis, pace and urgency through their leadership to the delivery actions needed to achieve financial sustainability.

Update: The Executive team held an away day on 11th March 2025. Further sessions are being arranged by the Group CEO.

15 The Chief Executive considers and implements performance management arrangements that will demonstrate increased effectiveness in the delivery of financial control and sustainability. This could require the focussed management of individuals; and or revisions to the Patient First programme to ensure greater assurance of the delivery of financial recovery targets.

Update: This work is underway by the Deputy CEO and subject to updates to the Board and FPPC.

16 The interim CFO acts with pace and urgency to reinvigorate the finance department by setting clear expectations of professional standards; and holding both his team and colleagues to account for delivery of agreed actions.

Update: The Finance Team are working through an improvement and development programme (funded by the Recovery Support Programme). We have engaged the NHS South East Regional Academy, who have run two sessions to date. A session was completed in July which included a session on Customer Care. Improving standards will also be reflected in the 2025/26 team objectives.

17 The Trust should, as a priority, ensure that there is sufficient financial business partner support to divisions to promote improved financial control and business planning to deliver Trust financial sustainability.

Update: A Finance business partners were appointed in December and January, where there were previously gaps.

18 The Trust revisits its performance and action plans:

- Firstly, to ensure that all action plans outstanding are owned and delivered; and
- Secondly against best practice outlined in the HFMA and other checklists and agrees improvements. If appropriate the Trust should consider asking auditors KPMG to provide assurance on self-assessments and action plans for improvement as part of the Internal Audit Programme.

Update: a review of the governance and accountability structure is being led by the Deputy CEO, including Patient First, IPQR, performance meetings and management committees. The outputs will flow to the Board and sub-committees, as appropriate.

The engagement of PA Consulting will support an updated review of the Grip and Control Checklist (focussing on impactful areas e.g. rostering and workforce controls, procure-to-pay process.

Conclusion

19 The Majority of recommendations are either underway or completed. The above recommends specific actions the Board may consider (in **bold**) to capture these as part of its Action Log or Workplan, which will act as embedding the above recommendations into its work programme in the coming months.

20 Note: the Board will be aware that other Reports identified similar issues (KPMG, 2023 and NHS Improvement Director, March 2025). The Reports identified similar issues to those described above.

21 An update on the recent Finance Function Review (March 2025) will go to FPPC in August to provide assurance the recommendations are progressing.

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

June - 2025

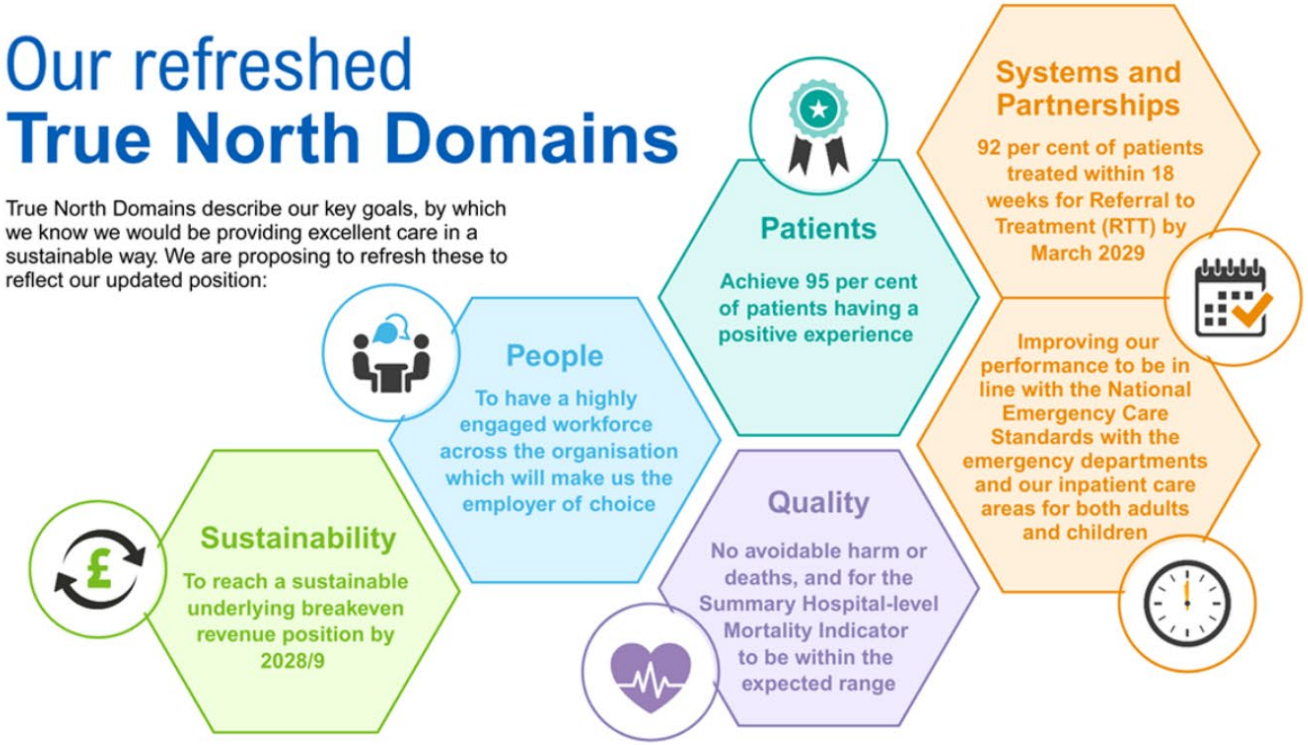
Patient FIRST

Executive Summary

Jonathan Wade
Chief Executive Officer

Our refreshed True North Domains

True North Domains describe our key goals, by which we know we would be providing excellent care in a sustainable way. We are proposing to refresh these to reflect our updated position:



True North	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
People	15	37	4	16	18	15
Quality	51	18	12	14	4	4
Systems & Partnerships	18	12	9	18	3	8
Patients	9	13	5	4	2	3
Sustainability	12	2	2	6	0	1

Variation icons:
Orange indicates concerning **special cause variation,** requiring action. **Blue** indicates where improvement appears to lie. **Grey** indicates no significant change (**common cause variation**).

Assurance icons:
Blue indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. **Grey** tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Executive Summary

True North Strategy and Supporting Breakthrough Objectives

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

People

Ambition:

To be the employer of choice and have the most highly engaged staff within the NHS.

Vision:

We will have a highly-engaged Workforce across the organisation which will make us the employer of choice. We will recruit and keep the best people by having a culture of staff-led improvement and innovation.

Breakthrough Objective:

Reduction in total number of reports relating to staff incivility & bullying or harassment reported by 50%.

Performance:

- National Staff Engagement Score
- Incivility Cases (Combined)

Patients

Ambition:

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

Vision:

Every time any of us interact with our patients, their families and carers, we should ensure our interactions are prompt and positive.

Breakthrough Objective:

To achieve a minimum of 95% positive experience of care in Outpatients and 80% for Emergency Care services.

Performance:

- Total FFT Recommend %
- Emergency Care FFT Recommend %
- Outpatient FFT Recommend %

Quality

Ambition:

Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have.

Vision:

To have no patients die when it could have been prevented. Medway NHS would like to bring the Trust in line within the lowest quartile of the HSMR funnel plot by 2025/26.

Breakthrough Objective:

Reduce number of patients coming to avoidable harm & reduce avoidable deaths in hospital of patients admitted via the emergency pathway.

Performance:

- Low or No Harm Incidents %
- Crude Mortality Rate %
- Deceased Patient – Clinical Coding Validation Returned %

Systems and Partnerships

Ambition:

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

Vision:

Medway NHS to have a stable bed occupancy of 92% by 2028. Improved timely access for patients on the Referral to Treatment (RTT) pathway.

Breakthrough Objective:

60% of patients will have their RTT pathways complete < 18 weeks by March 2026. To achieve a maximum 6% in Type 1, 12-hour LoS in ED.

Performance:

- RTT Incompletes Performance %
- RTT 65+ Week Waiters
- Total EC 4 Hour Performance %
- Type 1 LOS > 12 Hours in EC %

Sustainability

Ambition:

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

Vision:

For Medway NHS to reach a sustainable underlying breakeven position within the next 5 years (by 2028/29).

Breakthrough Objective:

Reduce our cost base by £27m to contribute towards a productive, safe, affordable workforce.

Performance:

- (Surplus) / Deficit (£)
- Total Pay Spend (£)
- Actual Worked FTE

Executive Summary

Strategic Initiatives

Culture, Leadership and Behaviours
SRO -

Please add your commentary here

Patient First Improvement Programme
SRO - tbc

The Programme continues to support the Trust's True North strategic priorities through the Transformation Team. A review commissioned by the Deputy CEO is now underway, informing a refreshed Patient First Strategy due to Board in early autumn. Key achievements include the launch of a Trust-wide TLT meeting, progress on Breakthrough Objectives—particularly on Access and RTT—and sustained growth in Improvement Huddles, with over 1,350 local improvements delivered. Staff engagement remains strong, with 2,120 trained in Patient First. Weekly Spotlights and Driver Meetings continue to highlight quality improvements, soon to feature in the new 'Ten@10' communications and bi-monthly Board sessions.

Clinical Strategy
SRO - Alison Davis, CMO

Please add your commentary here

Access and Flow Productivity
SRO - Nick Sinclair, COO

Please add your commentary here

Digital, Data and Technology (DDaT)
SRO - tbc

Refreshed DDaT Strategy due for sign on at the July Board

Health Inequalities & Population Health
SRO - tbc

Position under review

Financial Recovery Plan
SRO - Simon Wombwell, CFO

Initial drafting underway around the financial context and historic performance.
FRP requires mature 25/26 savings planning and completion of Dartford & Gravesham NHS Trust group model review before further progress can be made.

Green Sustainability Plan
SRO - Simon Wombwell, CFO

Position under review

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
			X	X	
Title of Report	**Learning from Deaths Quarter 4 (2024/25) Report**			**Agenda Item**	5.1
Author and Job Title	Sofia Power, Learning from Deaths Manager Wayne Blowers, Director for Quality and Patient Safety (Interim)				
Lead Executive	Alison Davis, Chief Medical Officer				
Executive Summary	Approval	x	Briefing		Noting x

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 Emergency Department

	(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.
Proposal and/or key recommendation:	For assurance, approval and noting
Governance Route Meeting: **Date submitted:**	Mortality and Morbidity Surveillance Group Date: 17/04/2025 Quality Assurance Committee Date: 23/05/2025
Identified Risks, issues and mitigations:	The Summary Hospital-level Mortality Indicator (SHMI) remains above the expected range and continues to be closely monitored through the Quality Breakthrough Objective and the Mortality A3 initiative. These programmes are actively exploring contributory factors and identifying countermeasures and actions to address the elevated SHMI. A robust Learning from Deaths process is firmly established to ensure comprehensive review of clinical care, enabling identification and appropriate escalation of any instances of sub-optimal practice, thereby providing assurance regarding the quality and safety of patient care. Notably, patients admitted with a primary diagnosis of respiratory disease continue to be an outlier in both SHMI and Hospital Standardised Mortality Ratio (HSMR+). To address this, a dedicated data validation project is underway. This involves detailed case reviews to ensure accuracy in clinical coding and documentation for patients with a primary respiratory diagnosis. The outcomes of this work will inform targeted quality improvement actions and support ongoing efforts to optimise patient care and outcomes.
Resource implications:	None

Sustainability and/or Public and patient engagement considerations:	N/A				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	None				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Alison Davis				

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X	X	X	X
Title of Report	**Maternity and Neonatal Care – Letter from NHSE**			**Agenda Item**	5.2
Author and Job Title	Kate Harris, Associate Director of Midwifery				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				

Executive Summary	Approval		Briefing	X	Noting	X

On 23 June 2025, the Secretary of State for Health and Social care announced a rapid independent investigation into maternity and neonatal services, along with an independent taskforce and immediate actions to improve care.

Urgent reviews of up to 10 Trusts will be conducted, (MFT is not one of the named Trusts) and all Trusts providing maternity and neonatal services have been asked to:

1. *Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.*
2. *Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.*
3. *Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership(MNVP), and local women, and families.*
4. *Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.*
5. *Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.*

In response to this the senior maternity and neonatal leadership teams met to review what we already have in place to meet this ask, consider any gaps in assurance, and any improvements that are required.

The maternity and neonatal services wish to assure the Board that they have processes in place to address the ask of the National Investigation in to Maternity and Neonatal Care launched in June 2025.

This report identifies some minor gaps and have proposed actions and improvements to address these including:

	• Continued culture work across the service with a focus on new starters and diverse groups. • Continued engagement with service user groups, the MNVP and ensuring that the service user voice is heard and drives improvements across both services. • Work with key stakeholders within the Trust and the Integrated Care Board (ICB) implement the Perinatal Surveillance Oversight Model (PQOM). • Continue to interrogate quality data with an increased focus on outcomes and experience and use this to drive improvements. • Continue to drive forward our work to reduce health inequalities and improve the experience of all service users, particularly those from BAME groups or deprived areas. Next Steps: • The maternity and neonatal services will continue to drive improvement across all these areas in line with our commitment to implement the three-Year Delivery Plan and our ongoing compliance with CNST Maternity Incentive Scheme Year and Saving Babies Lives. • The maternity and neonatal services will continue to report and escalate concerns to the Trust Board via PQOM, monthly IQPR slides, escalation reports and scheduled reporting for CNST and will continue to work with the Board Level Safety Champions to support quality care and positive outcomes and experience for all service users. • The maternity service will continue to review and develop it is Maternity Care and Triage pathways with a view to move to BSOTS (Birmingham Symptom Specific Obstetric Triage System). • Develop communication for staff to advise of Trust position and actions in response to Investigation. • Share position of review with MNVP and agree communication to be shared with service users on progress of review and Trust position. • Include MNVP on co-production of action plans as findings of investigation are released. • This report proposes to provide an update to Trust Board in six months' time, and provide further updates as the findings of the national investigation are published.
Proposal and/or key recommendation:	For information and noting
Governance Route Meeting: Date submitted:	Maternity and Neonatal Safety Champion Assurance Group, 4 July 2025
Identified Risks, issues and mitigations:	1. Be rigorous in tackling poor behaviour where it exists: Risks and Issues: • Need to ensure that all staff groups, particularly those that are internationally educated or BAME are supported and have a positive experience across maternity and neonatal services. • There is a significant number of newly qualified staff within the midwifery workforce. It will be important to seek their feedback on culture and behaviour as part of the workforce.

Mitigations:

- Work with the PE&EDI midwife to hold focused engagement session with all BAME staff to understand any concerns they may have, particularly around culture and behaviour, and develop targeted actions with the support of the Non-Executive Director and Trust Culture lead to address any concerns raised.
- Currently supporting staff to attend Culture training.
- Repeat targeted culture survey for Maternity and Neonatal Staff to understand the current cultural climate within the services and co-produce an action plan with staff and key stakeholders to address any concerns.

2. Listen directly to families that have experienced harm

Risks and Issues:

- Newly qualified staff may not have the psychological safety to raise concerns about behaviour.

Mitigations:

- Senior leadership team to continue to demonstrate a culture learning, openness and transparency and support all staff to feel safe to escalate concerns.
- Continue to monitor and respond to service user feedback and ensure that any themes and trends are managed at both service and individual practitioner level where appropriate.
- Continue to fund preceptorship midwife and student midwife lead support an ongoing feedback loop with students and newly qualified staff to support psychological safety and the importance of learning, compassion and openness.
- Continue to share learning from incidents, complaints, claims and service user feedback at relevant team and departmental meetings, including governance and audit.
- Review findings and outcomes from pre-discharge debrief pilot to consider next steps

3. Ensure you are setting the right culture:

Risks and Issues

- Funding for MNVP is required to be provided by the ICB. The current contracted hours are not adequate to support the local, regional and national ask of the MNVP. Additional funding/allocation of hours to support an additional MNVP role across the LMNS has not been achieved and the current MNVP contracted hours are at risk due to restrictions on renewing contracts as part of NHSE Change 2025 processes. This poses a risk to CNST year 7 and in particular 8 compliance, which will require the MNVP to be a quorate member of a significant number of Trust meetings.

Mitigations:

- Add MNVP funding risk to the Maternity and Neonatal Risk register.
- Continue to escalate lack of funding of additional MNVP support through Trust Board and work with ICB colleagues to support mitigation across the region.
- Continue to engage the MVNP in co-production work and remain responsive to feedback and engaged with service users and families.

- Develop communication for service users with support of MNVP in response to National Investigation report.
- Seek support of MNVP to coproduce benchmarking and actions as findings of the national investigation are published.
- Seek to hold a service user engagement event in 25/26 following success of event in 2024.

4. Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both

Risks and Issues:

- Data-driven audits (eg: Saving Babies Lives Audits (SBL) may not always consider the outcomes and experiences of service users.
- Perinatal Quality Oversight Model (PQOM) launched in draft in June 2025.
- Rates of Bronchopulmonary dysplasia (BPD) are high in NNU and there is a QI project under way to address this variation.
- Extended perinatal mortality is red at MFT. Need to understand reasons behind this variation

Mitigations:

- 99% compliant with SBL v3. Working with element leads to include more detail on service user experience and outcomes in audits, alongside compliance with outcome measures/process indicators to support further improvement work.
- Work with key stakeholders within Maternity and Neonatal services and across the Trust and ICB to ensure the full implementation of the PQOM in 2025.
- “Project Milestone” to address high BPD rates in NNU.
- Deep dive into neonatal mortality data.

5. Retain a laser focus on tackling inequalities, discrimination and racism within your services

Risks and Issues:

- Understanding of EDI data for our population has improved significantly in recent years, but this needs to be further embedded in all processes, reviews and audits
- Funding for enhanced COC MSW is only for 6 months and additional roles would require additional external funding.

Mitigations:

- Baseline data for deprivation score, ethnicity and language now available for booking/birthing population to support an understanding of outcomes for vulnerable groups compared to the whole population, and in turn drive improvement.
- Deprivation score, ethnicity and health inequality information now included on all MDT reviews to support identification of variances in outcomes and experience.
- Continue to strengthen triangulation reports.
- Fully embed the use of equality and ethnicity data in all service reviews and audit.
- MNVP and senior team to support the PE&EDI midwife to achieve objectives to ensure that EDI is integral to service delivery.

	• Poverty awareness training is being organised for all NICU staff to improve understanding and support for families affected by poverty. • Seek to extend funding for enhanced COC MSW with consideration to extend and expand pilot.				
Resource implications:	No additional resources currently identified.				
Sustainability and/or Public and patient engagement considerations:	The MNVP is a core part of Maternity and Neonatal Services engagement with service users. The national Inquiry seeks to strengthen this, but the current position of the ICB is putting this at risk.				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	a) National Investigation into Maternity and Neonatal Care Presentation – June 2025 b) Letter to CEO from NHSE				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Kate Harris k.harris4@nhs.net				

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

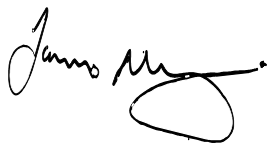
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Title of Report	Maternity (and Perinatal) Incentive Scheme – Year 7 Update Report June 2025	**Agenda Item**	5.3
Author	Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Steph Gorman, Chief Nursing Officer (Interim)		
Executive Summary	• CNST Year 7 Published 2 April 2025 with reporting period ending 30 November and submission due 03 March 2026. • Received confirmation from NHSR of compliance with CNST Year 6. • Request escalation to Trust Board for MNVP service provision: "*At this time the ICB are unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at the required Trust assurance and Governance meetings as set out in year 7 CNST 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. **Actions and Next Steps:** • 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.		
Proposal and/or key recommendation:	The Board is asked to note contents of report.		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	X
Governance Process: Committee/Group and Date of Submission/approval:	Meeting: Maternity and Neonatal Safety Champion Assurance Board Date 6 June 2025			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Risk: 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). Mitigation: • 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. • Escalate to MBRRACE				
Resource implications:	No Additional Resource Implications				
Sustainability and /or Public and patient engagement considerations:	Outline how the proposal aligns with the MFT green plan and sustainability strategy or whether any communications or medical issues have been considered (and describe these). What engagements with patients and the public has been undertaken or planned in connection with the paper.				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable X				
Legal and Regulatory implications:	Compliance with CNST Year 7, CQC				
Appendices:					
Freedom of Information (FOI) status:	Tick either: ☐ X This paper is disclosable under the FOI Act ☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.				
For further information please contact:	Name: Kate Harris Job Title: Associate Director of Midwifery Email:k.harris4@nhs.net				

Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Title of Report	Claims, Incidents and Complaints Triangulation Report – Q4 2024/25	**Agenda Item**	5.4
Author	Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Steph Gorman, Chief Nursing Officer (Interim)		

Executive Summary	• 2014-2024 Claims Scorecard published in October 2025.
	• 52 Maternity Claims
	  • 12 Open
	  • 36 Closed
	  • 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.
	• requirements.
	
	Actions and Improvements Q4 24/25
	• All ATAIN (Avoiding Term Admission to Neonatal Unit) reviews include ethnicity and social deprivation data as part of the review and thematic analysis.
	• All CRIG (Clinical Review Incident Group) reviews consider ethnicity and PE&EDI (Patient Experience and Quality and Diversity) midwife joins CRIG to provide additional check and challenge, particularly for areas where BAME groups are over represented (e.g. Post-partum haemorrhage).
	• 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		

	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.
Proposal and/or key recommendation:	The Board is asked to note contents of report.

Purpose of the report (Please mark with 'X' the box to indicate)				
	Assurance	X	Approval	
	Noting	X	Discussion	X

Governance Process: Committee/Group and Date of Submission/approval:	Meeting: Maternity and Neonatal Safety Champion Assurance Board Date: 06 June 2025

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)

Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X

Identified Risks, issues and mitigations:	N/A
Resource implications:	No Additional Resource Implications
Sustainability and /or Public and patient engagement considerations:	Outline how the proposal aligns with the MFT green plan and sustainability strategy or whether any communications or medical issues have been considered (and describe these). What engagements with patients and the public has been undertaken or planned in connection with the paper.
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	Compliance with CNST Year 7, CQC

Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Kate Harris Job Title: Associate Director of Midwifery Email: k.harris4@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Title of Report	Perinatal Quality Surveillance and Leadership Quarterly Report: Q4 2024/25	**Agenda Item**	5.5
Author	Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Steph Gorman, Chief Nursing Officer (Interim)		

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 (Perinatal Mortality Review Tool)
	  • Staff and Service User Feedback
	  • Perinatal Leadership
	  • Safeguarding
	• 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.		

Proposal and/or key recommendation:	The Board is asked to note contents of report.		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	X

Governance Process: Committee/Group and Date of Submission:	Meeting: Maternity and Neonatal Safety Champion Assurance Board Date: 06 June 2025

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1:	Priority 2:	Priority 3:	Priority 4:	Priority 5:

	(Sustainability)	(People) X	(Patients) X	(Quality) X	(Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Risk: 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). Mitigation: 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.				
Resource implications:	No Additional Resource Implications				
Sustainability and /or Public and patient engagement considerations:	N/A				
Integrated Impact assessment:	N/A				
Legal and Regulatory implications:	Compliance with CNST Year 7, CQC				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Name: Kate Harris Job Title: Associate Director of Midwifery Email: k.harris4@nhs.net				
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions		
	Partial Assurance		There are gaps in assurance		
	Assurance	X	Assurance minor improvements needed.		
	Significant Assurance		There are no gaps in assurance		
	Not Applicable		No assurance required.		

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Title of Report	Bi-annual Midwifery Workforce Report	**Agenda Item**	5.6
Author	Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Steph Gorman, Chief Nursing Officer (Interim)		

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 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.
	• 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. **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.
Proposal and/or key recommendation:	The Board is asked to note contents of report.

Purpose of the report (Please mark with 'X' the box to indicate)				
	Assurance	X	Approval	
	Noting	X	Discussion	X

Governance Process: Committee/Group and Date of Submission/approval:	Meeting: Maternity and Neonatal Safety Champion Assurance Board Date: 06 June 2025

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)

Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X

Identified Risks, issues and mitigations:	Risk: 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). Mitigation: • 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. • Escalate to MBRRACE
Resource implications:	No Additional Resource Implications
Sustainability and /or Public and patient engagement considerations:	N/A

Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	Compliance with CNST Year 7, CQC		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Kate Harris Job Title: Associate Director of Midwifery Email: k.harris4@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board in Public
Friday, 13 June 2025

Title of Report	Infection Prevention and Control (IPC) - Annual Report 2024/25	**Agenda Item**	5.7
Author	Stephanie Gorman, Chief Nursing Officer (Interim) and Associate Director of IPC		
Lead Executive Director	Stephanie Gorman, Chief Nursing Officer (Interim) and Associate Director of IPC		
Executive Summary	The IPC annual report focuses on the activities from 2024/25. The report measures IPC practices against the 10-criterion based on Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The annual report details the IPC team structure, the training of the team. It also measures the final outcome of the IPC board assurance framework and how this has been transferred to the IPC Quality Improvement Plan supporting the work of the IPC team to embed PSIRF into the management of IPC within the Trust. All of the organisms that form part of mandatory surveillance are included in this report and measures the Trusts position against thresholds, learning from Swarms and the split of infections across Divisions, care groups and ward areas. For the third year running both C.difficiles and MRSA bacteraemia's breached their threshold but the report details the work the IPC team are doing with different areas to continue to improve. This year's report is inclusive of winter respiratory viruses, FIT testing, surgical site infection surveillance, link practitioners, decontamination, hospital cleanliness, commode audit outcomes, and estates work with the addition of the new simulation training created by the IPC team to support wards with repeated hospital acquired infections.		
Proposal and/or key recommendation:	This report is for information and discussion		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	X
	Noting		Discussion	

Governance Process: Committee/Group and Date of Submission/approval:	Meeting: IPC Programme Group Date: 15 May 2025 Meeting: Quality Assurance Committee Date: 23 May 2025 and 13 June 2025

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality) X	Priority 5: (Systems)

Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective:	Caring:	Responsive:	Well-Led:
Identified Risks, issues and mitigations:	NA				
Resource implications:	NA				
Sustainability and /or Public and patient engagement considerations:	NA				
Integrated Impact assessment:	NA				
Legal and Regulatory implications:	The mandatory surveillance has a regulatory implication. No penalties for breaching last year and thresholds have been reset.				
Appendices:	NA				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Name: Rod Harford-Rothwell Job Title: Head of IPC Email: Medwayft.infectioncontrol@nhs.net				

Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X			
Title of Report	**Health and Safety Annual Report 2024/25**			**Agenda Item**	5.8
Author and Job Title	Blessing Oduntan, Health and Safety Manager				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				
Executive Summary	Approval	X	Briefing		Noting

The annual health and safety report covers the period 01 April 2024 to 31 March 2025.

The purpose of this report is to provide assurance of the trust compliance against the health and safety legislative requirements, as well as analysis and key performance information of health and safety activities.

Overview of Legal compliance:

- The Trust did not receive any enforcement or improvement notices from the Health and Safety Executive (regulatory body).
- The Trust complied with all applicable Health and Safety legislation, except Manual Handling Operations Regulations 1992.
- Reason for non-compliance to Manual Handling regulations: Subject matter expert (SME) for moving and handling, was on long term absence, role now vacant, resulting in non-delivery of critical elements of Manual Handling such as training, assessments, advisory, standard alignment etc.
- Action to address non-compliance/non-assurance: Board to approve recruitment of a moving & handling subject matter expert.

Key Performance Information:

- Trend of reported numbers of health and safety incidents remain fairly consistent for the past 5 years.
- A total of 811 health and safety incidents recorded on DATIX in 2024/25.
- Key categories of incidents based on occurrence and severity are: - Physical Assault; - Sharp Safety; - Slips, Trips & Fall.

Physical Assault

- Physical assault of staff by patients remains a significant concern. Increase of 36% from previous year (385 physical assaults).
- Staff are provided with training for managing risk and security team support staff during physical assault incidents.
- Staff are referred to occupational health team following assault.

Sharp Safety

- In 24/25, the trend of sharp incidents is similar to incidents recorded from previous years (92 sharp incidents).
- Sharp safety group meet regularly to discuss improvement actions.

	Slips, Trips and Falls • Slips, Trips and Falls accounted for the highest number of incidents reported to the health and safety executive, mostly due to prolonged absences of staff from work following injury. • The three primary causes were tripping over an object; falling from a chair; and slipping on wet/slippery surfaces. • Wards are encouraged to maintain good housekeeping and regular walk throughs are conducted to remove hazards. RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) • Under RIDDOR, the trust has a legal duty to report certain work place accidents, incidents, ill-health and certain near miss events to the Health and Safety Executive. • In 24/25, the Trust reported16 notifiable incidents, a 50% decrease from 23/24 (n=32), and lowest since 2019/20. • This significant decrease in RIDDOR incidents can be associated with the work committed to investigating past RIDDOR incidents and sharing lessons learnt from incidents to prevent recurrence. Audit • Internal health and safety audit programme and annual self-assessment against the NHS Workplace Health and Safety Standard (WHSSA) conducted • Audit highlighted full assurance not achieved in the following areas: - Board members lacking health and safety competence/training - Trust lacking moving and handling training provision, specialist advice and support - Increased incidents of violence and aggression - No risk assessments or training for some lone working teams - Inadequate arrangements to manage asbestos risks - Noise and vibration assessments not conducted Health and Safety Objectives • All objectives set for 24/25 were achieved apart from those involving moving and handling expertise. • Objectives not achieved in 24/25 have been carried forward to 25/26. • Other objectives set for 25/26 include development of health and safety strategy; improvement of incident information gathering (datix); risk assessment training for managers; internal audit of high-risk activities.
Proposal and/or key recommendation:	This report evidences the trust compliance to health and safety legislation, and key analysis of health and safety activities. The board is asked to approve the content of the report.
Governance Route Meeting: **Date submitted:**	Audit and Risk Committee 08 May 2025
Identified Risks, issues and mitigations:	The trust currently lacks a moving and handling subject matter expert, creating a risk of significant injury to patients and staff. The trust also did not comply with manual handling regulations which can result in fines and contravention by the health and safety executive. Board to approve recruitment of moving and handling subject matter expert to mitigate risk.
Resource implications:	Staff Salary for moving and handling specialist (Band 7)

Sustainability and/or Public and patient engagement considerations:	Not Applicable				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	Not Applicable				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Name: Blessing Oduntan Job Title: Health and Safety Manager Email: blessing.oduntan@nhs.net				

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
				X	
Title of Report	**Data Security Protection Toolkit (DSPT) 2024-2025**			**Agenda Item**	6.1
Author and Job Title	Charles Uche, Information Governance Lead and Data Protection Officer Craig Allen, Head of IT				
Lead Executive	Alison Davis, Caldicott Guardian, Chief Medical Officer Siobhan Callanan, Senior Information Risk Owner, Deputy Chief Executive				
Executive Summary	Approval		Briefing	Noting	X
	The report documents the full submission of the 2024-2025 CAF-DSPT, with Standards Met, occurring 30 June 2025. Details on benchmarking and future submissions are provided.				
Proposal and/or key recommendation:	Return of CAF-DSPT (2025-2026) for Board discussion of evidence requirements, areas for improvement, and items for external audit, in late Q2 / Q3.				
Governance Route **Meeting:** **Date submitted:**	Audit and Risk Committee 19 June 2025				
Identified Risks, issues and mitigations:	The Trust needs to continue improvement in two key areas: - culling and destruction of records in line with retention periods - development of data security activities These otherwise pose a risk to the Trust meeting required achievement levels of future CAF-DSPT submissions.				
Resource implications:	Investment in culling and destruction of medical records Investment in data security resource				
Sustainability and/or Public and patient engagement considerations:	Invest to save in relation to saved storage costs for medical records.				
Integrated Impact assessment (please mark):	Yes	No	N/A		
			X		
Appendices:	DSPT 2024-2025 Report				
Freedom of Information status (please mark):	Disclosable		Exempt	X	
For further information please contact:	medwayft.dpo@nhs.net				

1 Executive Overview

1.1 The following report covers the Trust's full submission of the 2024-2025 CAF-aligned Data Security Protection Toolkit (DSPT), by the required deadline of 30 June 2025.

CAF-DSPT is an annual online self-assessment tool that all NHS Trusts are required to complete, which measures performance against data protection and data security standards.

1.2 There were significant changes to the 2024-2025 DSPT for NHS Trusts, to align with some of the National Cyber Security Centre's Cyber Assessment Framework (CAF) requirements.

Overall, the evidence requirements for the prevention of cyber security attacks and information governance breaches were strengthened.

The 2024-2025 DSPT, covering 01 July 2024 – 30 June 2025, included five Objectives:

Objective A: Managing Risk
Objective B: Protecting against cyber attack and data breaches
Objective C: Detecting cyber security events
Objective D: Minimising the impact of incidents
Objective E: Using and sharing information appropriately

1.3 High level guidance for independent assessment and audit of a selection of evidence for each of the five Objectives was provided by NHS England (documents contained in appendices).

The five Objectives are formed out of 47 outcomes, comprising of 364 contributory outcomes.

High level CAF aligned DSPT independent assessment programme timeline

2 2024-2025 DSPT

2.1 In June 2025, the DPO, Information Governance Lead, Head of IT, and SIRO met to review and discuss the draft CAF-DSPT submission and plan for any areas for improvement required for the upcoming 2025-2026 and 2026-2027 submissions. This included review of:

Objective A	Objective B	Objective C	Objective D	Objective E
Managing risk	Protecting against cyber-attack and data breaches	Detecting cyber security events	Minimising the impact of incidents	Using and sharing information appropriately
7 outcomes	20 outcomes	7 outcomes	5 outcomes	8 outcomes

2.2 The SIRO completed a further sample review of evidence, and confirmed view that the Trust was ready for submission on 27 June 2025.

2.3 In our 2024-2025 submission, we achieved 'Standards Met', as we did for the previous 2023-2024.

For some outcomes in 2024-2025, the required level of achievement set out by NHS England was 'Achieved', and for others this was 'Partially Achieved' or 'Not Achieved'.

The Trust has assessed that it met each the achievement level of each outcome, and, in some cases, exceeded, hence our published overall submission achievement being 'Standards Met'.

Evidence of our 2024-2025 full submission publication on 30th June 2025 has been downloaded and retained within our DSPT records (contained in appendices).

2.4 Prior to the full 2024-2025 submission, the Trust:

a) published an interim (baseline) submission on 31 December 2024, providing an indication where further evidence or work was required.

b) arranged an external audit of 12 outcomes, as required by the CAF-DSPT, with 4 of these Board-directed to be included within the audit. The external auditor's final report found an assurance level of 'Significant assurance with minor improvement opportunities' (AMBER-GREEN), with a High confidence level in the veracity of our self-assessment and an overall risk rating of 'Moderate'.

3 Benchmarking

3.1 Benchmarking will be available in August 2025, as NHS England have paused public visibility of the publication of submission achievements for the month of July 2025. This means that the Trust's 'Standards Met' will not be available to view via https://www.dsptoolkit.nhs.uk/ until August 2025.

3.2 At the Audit and Risk Committee in June 2025, the external auditors confirmed that they would perform benchmarking for the Trust.

4 Future DSPT submissions

4.1 NHS England have confirmed that the 2025-2026 CAF-DSPT will remain the same as the 2024-2025, with the same required evidence and achievement levels. This is expected to change for 2026-2027, with areas currently 'Not Achieved' or 'Partially Achieved' rising to 'Partially Achieved' and 'Achieved' respectively.

4.2 With the expectation of gradual increase in achievement levels over the next three years, the Trust will be review areas for continued improvement, which include culling and destruction of records in line with retention periods and development of data security activities.

4.3 The Trust Board will be kept informed of areas requiring development through regular update by Information Governance and Cyber Security teams, with regular engagement with the SIRO.

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X			
Title of Report	**Freedom to Speak Up – Annual Report**			**Agenda Item**	7.1
Author and Job Title	Tasha Barrett, Freedom to Speak Up Guardian – The Guardian Service Ltd Alana Marie Almond, Deputy Company Secretary (cover sheet)				
Lead Executive	Sheridan Flavin, Chief People Officer (Interim) on behalf of Jon Wade, Chief Executive Officer				

Executive Summary	Approval		Briefing	X	Noting	X

This report from The Guardian Service Ltd, provides an analysis of the Freedom to Speak Up (FTSUG) service at the Trust, covering the period from 23 September 2024, to 31 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. The 12-month reporting period typically spans from 01 April 2024 – 31 March 2025. However, this report exclusively addresses the interval from 23 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 incentive. A 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).

	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**

	The Guardian Service's role involves actively listening, coaching, and encouraging staff, offering independent and confidential support. Staff feedback has been overwhelmingly positive, with many expressing that they felt listened to and supported. The report recommends continued constructive communication with staff about the Trust's commitment to addressing concerns and nurturing an open culture. It is also recommended that the Board engage with middle management to ensure their awareness of and support for a speak-up culture, encouraging Guardians' inclusion in meetings. Further consideration should be given to enhancing supportive services for management, including training on unconscious bias and mitigating incidents of incivility.
Proposal and/or key recommendation:	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).
Governance Route Meeting: **Date submitted:**	People Committee – 29 May 2025
Identified Risks, issues and mitigations:	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.
Resource implications:	None identified
Sustainability and/or Public and patient engagement considerations:	None identified

Integrated Impact assessment (please mark):	Yes	No	N/A
			X

Appendices:	The Guardian Service – Annual Report – September 2024 – March 2025			
Freedom of Information status (please mark):	Disclosable	X	Exempt	
For further information please contact:	Sheridan Flavin, Chief People Officer (Interim) s.flavin1@nhs.net			

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	Quality Assurance Committee Friday 13 June 2025		**Agenda Item**	7.2a
Author	Emma Tench, Assistant Company Secretary			
Committee Chair	Paulette Lewis, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee (QAC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Quality Assurance Committee, 13 June 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the QAC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the QAC Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Alison Davis, Chief Medical Officer Alison.davis@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
5	0	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and/or Risks and Items to note:

- Pharmacy for Paediatrics - gaps in impacts of workforce
- Falls
- Trial new meeting format for alternative monthly development/deep dive sessions

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
3.1 Risk and Issue Register – Quality and Safety The Committee requested updates for: • Risk to reduce with mitigations against the ligature. • Business case progression for Metavision • Update on Trauma support and backlog. The Committee were partially assured and **NOTED** the report	Partial Assurance
3.2 Board Assurance Framework (BAF) The Committee were **ASSURED** by the report	Assurance
5.1 Quality Strategy Implementation Update Report The Committee requested: • Sight of the refreshed Quality Strategy Implementation Plan for the August meeting. • PSIRF investigation highlights to be added to the QPSSC Assurance Report The Committee **NOTED** the report	
6.1 Assurance and Escalation Reports from Quality Patient and Safety Sub-Committee The Committee requested the IIA and QIA process to be presented at the August meeting. The Committee were **ASSURED** by the report	Assurance

6.2 Maternity and Neonatal Safety Champion Assurance and Escalation Report The Committee were **ASSURED** by the report	Assurance
6.3 Ear Nose and Throat The Committee received a verbal update on an emerging issue with this service.	
6.4 Learning from Deaths The Committee requested reporting on ethnicity and protected characteristics is included within the report. The Committee were **ASSURED** by the report	Assurance
7.1 Quality Account – Sign Off The report was to be APPROVED via email subject to updates.	
7.2 Infection Prevention Control Annual Report The Committee **APPROVED** the report for onward noting at the Trust Board	
7.3 Clinical Audit and NICE Annual Report The Committee APPROVED the report	
8.1 Integrated Quality Performance Report (IQPR) The Committee noted the following highlights: • Mixed Sex Accommodation • VT Risk Assessment The Committee NOTED the report	

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	Quality Assurance Committee Thursday 10 July 2025		**Agenda Item**	7.2b
Author	Emma Tench, Assistant Company Secretary			
Committee Chair	Paulette Lewis, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee (QAC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide assurance to the Trust Board that the committee is operating as per its terms of reference.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	

Committee/Group at which the paper has been submitted:	Quality Assurance Committee, 10 July 2025				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the QAC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the QAC Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Alison Davis, Chief Medical Officer Alison.davis@nhs.net				

Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.

	Significant Assurance	There are no gaps in assurance
	Not Applicable	

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	1	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None	N/A	N/A

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

Issues and/or Risks and Items to note:

As described below

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
3.1 Maternity and Neonatal Care – Letter from NHSE The Committee received a trust position update following the circulation of the national Maternity and Neonatal Care Letter from NHSE. It was noted that MFT is not among the 10 trusts described in the letter in need of urgent review. Self-directed, the trust has undertaken an internal review using the five key lines of enquiry described in the national letter to ascertain if it has any gaps in assurance. The Committee requested a further update in 6 months on this review, including an update on the internal review mapped to the NHSE actions. The Committee also discussed a risk relating to the future involvement of providing the resource for the Maternity and Neonatal Voices Partnership (MNVP) role due to funding and headcount issue at the ICB.	Assurance with minor improvements needed.
3.2 Board Story The planned patient story presentation was postponed due to patient illness.	
3.3 Ear Nose Throat The Committee received a verbal update on an emerging issue with this service.	
3.4 JAG Accreditation The Committee discussed the current accreditation status of the Endoscopy service as well as the steps for re-accreditation. Assurances were provided on the processes in place for the provision of data to the accrediting body. The Committee requested that similar Trust accreditation actions be added to the Committee workplan for review and assurance.	Partial Assurance

4.1 Deep Dive into Trust Risks The Committee undertook a 'deep dive' into risks mapped to the quality domain. The following requests/actions were issued: • Reduced availability of ultrasound machines in Theatres – the Committee requested a further update on medical device procurement plans before assuring themselves that this risk was being mitigated. • Bleep System reliability– the Committee were provided with an update on the bleep system renewal programme and timescales for delivery. A further update was requested as well as reassurance that other systems were functioning optimally. • Management of 16/17 year old cohort – the Committee were updated on the mitigations put in place to limit this risk and progress would be monitored through the deep dive process. • Paediatric Ligature Risk (window blinds) – the Committee were provided with an update on the blind replacement work. A request that the pace of delivery was increased was made. • Metavision – the mitigations for this risk were described, further updates on progress were requested to come to the Committee. • Absconding Patients – the committee were updated on the refreshed policy and protocol. The risk rating for this risk is being reduced. • Trauma Backlog – an update on the Trust action plan was described, the Committee asked for this to come back to the Committee regularly.	Assurance with minor improvements needed.

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	People Committee Thursday, 29 May 2025			**Agenda Item**	7.3
Author	Leon Hinton, Chief People Officer				
Committee Chair	Jenny Chong, Chair of Committee/NED				
Executive Summary	Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.				
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board				
Purpose of the report (tick box to indicate)	Assurance	X	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	People Committee, 29 May 2025				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the People Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Leon Hinton, Chief Finance Officer (at time of the meeting)				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	1	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and or Risks to note:
No Issues or Risk from the Committee to note.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for April 2025. The Committee were **ASSURED** by the report:	Assurance
Highlights (by exception): • True North (Staff Engagement) – [6.74, 0.09 improvement, 0.19 below target] fourth successive increase; improved to third quartile nationally (target upper quartile); Breakthrough (reducing incivilities) – [79, -16 improvement, 59 over target] • Staff appraisal – [89%, -0% no change, 1% off target] project in place to change uploading of appraisal process • Vacancy rate – [0.6%, -5.6% improvement, on target] • Voluntary turnover – [8.3%, -0.1% improvement, 0.3% off target] holding position; however forecast position to worsen in line with workforce profile reconciliation • Staff fill rates, Care Hours per Patient Day – [9.43, +0.45 improvement, 0.07 off target] • Sickness absence – [4.6%, +0.2% deterioration, 0.6% off target] three successive months of long-term sickness improvement; however, higher short-term sickness continues and deteriorate by 0.3% since March – addressing through occupational health investment and triangulation • StatMan – [89.9%, +0.8% improvement, on target] with no improvement to moving and handling level 2 for non-medical staff but improving compliance	Assurance

for medics. Inconsistent compliance progress for most resuscitation courses.	
StatMand Assurance Report The Committee received the new assurance report for StatMand providing oversight into the progress made over all StatMand compliance requirements. A detailed report highlighted the work to improve resuscitation training across the Trust ensuring sufficient capacity this included face-to-face attendance. The Committee were **ASSURED** by the report	Assurance
Board Assurance Framework (BAF) and Risk Register The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items five, six and seven. BAF 5 (incivility) required further work including control develop and actions. BAF 7 remains in development with the results of the 2024 staff survey following the commissioning of the Cultural Transformation programme. The Committee were **NOTED** the report.	Partial Assurance
Anti-bullying and harassment group assurance report The Committee received the assurance reports covering the periods since the last committee. Employee relations data reporting the relative-likelihood of white and BAME staffing at different stages of policy was discussed. The Committee were **ASSURED** by the report.	Assurance
Policies for approval The Committee **APPROVED** the following policies following comment: • Temporary workforce policy. This included assurance for working time directive monitoring.	n/a
Freedom to Speak Up Annual Report (Sep 24 to Mar 25) The Committee received the annual report for the freedom to speak up service. There had been a total of 63 cases raised from September 24 to March 2025. Four staff groups had expressed the highest number of concerns were Nursing and Midwifery, Estates and Ancillary, Medical and Dental and Additional Clinical Services. The four most prevalent themes were of bullying and harassment (c25%), patient safety and harm (c17%), discrimination and inequality (c17%) and management issues (c17%). The Committee **NOTED** the report.	Assurance
People Promise Exemplar Programme The Committee received the closure report for the programme. The report provided evidence and case studies during the life cycle of the programme which demonstrably improved staff engagement, reduced absenteeism and enhanced management practices – particularly via the team-based rostering work reducing manual rostering from 96% to 40% and halving the unfilled shift count. The Committee were **ASSURED** by the report.	Assurance
Learning from cases The Committee received an update in relation to the Supreme Court issuing a ruling around the legal definition of the word sex as used in the Equality Act 2010, and by implication the legal definition of woman and man. The Committee were informed of current NHS guidance and steps the Trust had taken to communicate that the Trust does not tolerate any form of abuse or discrimination towards staff, patients, visitors or volunteers. The Committee **NOTED** the report.	Assurance
Health and Wellbeing Guardian report – quarter 4 2024/25 The Committee received the quarterly health and wellbeing assurance report for quarter 4 2024/25. The report included and update to the number of listening ear sessions, 194 active mental health first aiders, an update on the Medway Fitness	Assurance

Hub membership and classes; and events planned for International Women's Day. The Committee **APPROVED** the report.	
HR and OD Performance The Committee were **ASSURED** of HR and OD performance against workplan.	Assurance
National Staff Survey 2024 The Committee received an update in relation to the bank staff results from the national staff survey 2024 and the consolidated implemented actions from 2024/25 and high-level actions for 2025/26. The Committee **NOTED** the update.	Assurance

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	Finance, Planning and Performance Committee Thursday, 28 May 2025		**Agenda Item**	7.4a
Author	Emma Tench, Assistant Company Secretary			
Committee Chair	Helen Wiseman, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee (FPPC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee, 28 May 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the FPPC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the FPPC Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
5	4	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and or Risks to note:
No Issues or Risk from the Committee to note.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
3.1 - Financial Report Month 01 The report updated the committee the on the current position. The committee discussed the challenges and risks in the Plan, specifically progress against the CIP target and the impact of Deficit Support Funding withdrawal would have on the I&E and cash positions. . The Committee **NOTED** the reports.	Partial Assurance
3.2 – Business Planning Update The Committee **NOTED** the report	Partial Assurance
3.3 – National Cost Collection Planning and Submission and Results/NCCI Score – pre-submission. The Committee **NOTED** the reports	Partial Assurance
3.4 – Financial Governance Tracker The committee agreed the report contents and confirmed agreement of the proposed actions. The Committee **NOTED** the report. A quarterly update report will come to the committee starting in September 2025	Partial Assurance
3.5 - Patient Led Audit for Care Environment – Assessment Results	n/a

The 2023 PLACE audits were undertaken on 04 and 05 October 2023, supported by the Patient Assessors. The results were announced 22 February 2024 and demonstrate definite improvements in the organisations performance compared to the 2022 scores. The Committee **APPROVED** the report	
4.1 – Reducing Waste and Corporate Review and Benchmarking The Committee held a lengthy review/discussion of the report. The following was raised: a) Progress was too slow and limited pipeline suggests meeting the target is high risk. b) HR processes and application of the Policy on Restructuring need to be sufficient given the focus on headcount reduction, including potential consistency across the K&M System. c) Importance of distinguishing between Trust schemes and the System-wide activity. d) Application of benchmarks and analytics to support robust opportunity generation was essential. e) The use of technology innovation and system-wide structural and strategic change is important to support targets in 2026/27 and beyond.	No Assurance
5.1 – Risk Register and Issues Log The Committee were **ASSURED** by the report	Assurance
5.2 – Board Assurance Framework The Committee noted the draft BAF; a new iteration to come to the next meeting. The Committee requested a triangulation report of evidence to submit for capital allocation (risk 2158) The Committee were **PARTIALLY ASSURED** by the report	Partial Assurance
5.3 – Ear, Nose and Throat The Committee received a verbal update on an emerging issue with this service.	
6.1 – Investment Governance and Business Case Policy and SOP The Committee **APPROVED** the updated Policy	
6.2 – Elective Hub – Operations Analysis The report provided analysis of options being carried out utilising a Five Case Model for business cases. Applying the scoring framework to the options suggests a strong preference for standalone hub models, particularly those located off the main hospital site. The committee recognised we may need to consider other options working together with D&G and the importance of commissioner support. A business case to be presented the committee. The Committee **NOTED** the report	Noted
8.2 – Any Other Business The request for external consultancy support for the identification and delivery of 25/26 CIP programme was shared with the Committee post meeting.	

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	Finance, Planning and Performance Committee Thursday, 25 June 2025		**Agenda Item**	7.4b
Author	Alana Almond, Deputy Company Secretary			
Committee Chair	Helen Wiseman, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee (FPPC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee, 25 June 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the FPPC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the FPPC Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	4	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
Ears Nose and Throat - causality to be delegated to the Audit and Risk Committee.	Audit and Risk Committee	11.09.25

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

Issues and or Risks to note:
No Issues or Risk from the Committee to note.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
3.1 - Financial Report Month 02 1) The Trust reports a £0.2m favourable variance to plan, the year to date (YTD) position is in line with the submitted plan. 2) ERF clinical income is reported up to the local commissioner cap; an additional £4.0m of Deficit Support Funding has also been recognised per Plan, this totals £10.4m YTD. DSF is a real concern. 3) £0.4m of efficiencies have been delivered against a plan of £1.1m in the month, the total YTD delivery is £0.7m. Note: Profiling of the Plan to provide time to mature savings means the Pay budget in Q2 will be ~£27m versus a Pay cost today of £29.7m (reflecting the savings target of £27m / £46m (system) respectively. 4) Identification and delivery of savings is the most urgent financial objective. 5) The CoSec was asked to review the BAF as it needs to be more realistic with the severity of the financial position. 6) The Committee asked CoSec what the plans were for Board Development with Finance and Risk. The Committee **NOTED** the report.	Partial Assurance
3.2 – Business Planning Update – Performance Monitoring The Committee asked that cancer, the backlog and PTL should be reported on. There is a need for triangulation in reporting. The Committee challenged the RTT target and whether or not the Trust has the capacity or resource to deliver. The Committee were promised a clearer position in the next month. The Committee **NOTED** the report	Assurance

4.1 - Job Planning and Medical Productivity There was detailed conversation around Programmed Activity (PA) in the Trust and the financial impact. The Committee asked for a further report on job planning and system solutions in September 2025. The Committee were partially **ASSURED** by the update	Partial Assurance
4.2 - The Reducing Waste and Improving Productivity Programme Following the update, the Committee was informed that there would be a new lead for this work after Lorna Gibson leaves. With the investment in the tracker, future reporting would be much more sophisticated. The Committee **NOTED** the update.	Partial Assurance
5.1 - Board Assurance Framework and Risk/Issue Log The Committee were advised that the Audit and Risk Committee will be reviewing the BAF and Risk Register, there will be recommendations towards improving both documents. The Committee were not assured around target ratings and the reports are not triangulating. The Committee questioned the risk around Health and Safety; although this may not be a strategic risk, it could have a reputational impact. The Board need to be equally cited on reputational impacts and risk. The Committee's recommendation to the Board will be to add reputational risks to the BAF. The Committee were **NOT ASSURED** by the report or that it is reporting the current position in the Trust.	No Assurance
5.3 – Ear Nose Throat The Committee received a verbal update on an emerging issue with this service.	
6.1 - Decarbonisation Project – Progress Update Nick Sinclair presented the report for noting. The Committee gave their congratulations to the team. The Committee **NOTED** the update.	Assurance
7.1 - Integrated Quality Performance Report (IQPR) There will be a refresh on the IQPR. The report is being reviewed and the document will articulate the finance activity and quality triangulation, there are too many KPIs and the document should give clear information on current position. The report will be submitted to future committees and Board. The Committee **NOTED** the update.	Partial Assurance
7.2 - Policy: Anti-Fraud, Bribery and Corruption The handbook was submitted for approval and there had been one change since the policy was submitted. The Committee **NOTED** the handbook but it is not for the Committee to approve.	Assurance
7.3 - Digital, Data and Technology Strategy Refresh The Committee questioned should strategy approval be at committee or Board level. The request was for the governance around all strategies to be considered/finalised and check the terms of reference as to what is expected to be submitted at what committee and what ones go direct to Board. The Committee did **NOT APPROVE** the strategy but it was **NOTED** and recommended for onward submission for Board approval.	No Assurance

Meeting of the Board of Directors in Public
Wednesday, 23 July 2025

Title of Report	Audit and Risk Committee Thursday, 19 June 2025		**Agenda Item**	7.5
Author	Emma Tench, Assistant Company Secretary			
Committee Chair	Mojgan Sani, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Audit and Risk Committee (ARC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to provide ASSURANCE to the Trust Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Audit and Risk Committee, 19 June 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the ARC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the ARC Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
2	1	X	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and or Risks to note:
No Issues or Risk from the Committee to note.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
3.1 Data Security Protection Toolkit (DSPT) and Senior Independent Risk Owner (SIRO) Report The Committee **NOTED** the report	Assurance
3.2 Freedom To Speak Up (FTSU) Effectiveness Review The Committee NOTED the report	Assurance
3.3 Maintenance Backlog Oversight Concerns over confidence of robustness of actions. The Committee **NOTED** the report	Partial Assurance
3.4 Risk Management Effectiveness Review The Committee **NOTED** the report.	Assurance
4.1 Conflicts of Interests, Gifts and Hospitality The Committee NOTED the report	Assurance
5.1 Internal Auditors – Progress Report The Committee **AGREED** the approach for KPMG report writing and **NOTED** the report	Assurance
5.2 Internal Auditors – Annual Report and Head of Internal Audit Opinion The Committee **NOTED** the report	Assurance

5.3 Counter Fraud Annual Report and Opinion 2024-25 The Committee **APPROVED** the report	Assurance
6.1 External Auditor Findings Report The Committee **DISCUSSED/NOTED** the report.	Assurance
6.2 External Auditors Annual Letter The Committee **NOTED** the report.	Assurance
7.1 Committee Work Plan – Refreshed The Committee **APPROVED** the plan.	Assurance

Meeting of the Trust Board in Public
Wednesday, 23 July 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		x	x		
Title of Report	**Engagement and Involvement Framework 2025 to 2028**			**Agenda Item**	7.6
Author and Job Title	Stella Jones, Head of Communications and Engagement				
Lead Executive	Glynis Alexander, Director of Communications and Engagement				
Executive Summary	Approval	x	Briefing		Noting
	This is an update to the existing Engagement and Involvement Framework 2023 to 2025. It consists of two sections: **Governor Engagement Plan** – this section outlines the vision and methods for supporting an effective, responsive and representative Council of Governors (CoG) that is well equipped to carry out its engagement function with constituents. **Membership Strategy** – this section outlines Medway NHS Foundation Trust's approach to membership recruitment and engagement activities, and how we will support, sustain and communicate with our membership 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. During the life of this framework we will take account of the NHS 10-year plan, as well as the Trust's own priorities.				
Proposal and/or key recommendation:	The Board is asked to approve the updated framework to be shared both internally and externally through the Clocktower and Trust website.				
Governance Route	Approved at the Council of Governors meeting on 22 May 2025				
Identified Risks, issues and mitigations:	There is a risk that due to reduced budget in future, the Trust's small engagement team may not be able to continue to support governors and members in the way set out in the framework. To mitigate this we will continue to review plans to maximise opportunities while using resources wisely.				
Resource implications:	None – supported within existing budget.				
Sustainability and/or Public and patient engagement considerations:	This framework is the document that guides our engagement through our Council of Governors and membership.				
Integrated Impact assessment (please mark):	Yes	No	N/A		
			X		
Appendices:	Included within the document				

Freedom of Information status (please mark):	Disclosable	X	Exempt	
For further information please contact:	Glynis Alexander, Director of Communications and Engagement glynis.alexander@nhs.net			