Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 10 September 2025 at 10:00 - 13:30

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	10:00	-
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 23 July 2025	Chair	3	10:03	Approve
2.2	Action Log		13		-
3.	**Opening Matters**				
3.1	Chief Executive Officer Update	Chief Executive	14	10:07	-
3.2	Revised Undertakings NHSE		16	10:10	Briefing
3.3	Cultural Transformation Report		**Appendix 4.0**	10:20	-
3.4	Council of Governors Report	Lead Governor	Verbal	10:35	-
3.5	Trust Risk and Issue Report	Chief Nursing Officer and Dir Strategy and Partnertship	25	10:40	-
3.6	Board Assurance Framework		37	10:50	Assurance
	Board Committee Assurance Reports:				
3.7	a) Quality Assurance (Aug) b) People (July) c) Finance, Planning and Performance (Aug)	Committee Chair	41 44 48	11:00	Assurance
	Board Story Presentation				
3.8	Ward Accreditation Programme	Associate Director of Patient Experience	52	11:15	Note
4.	**Sustainability**				
4.1	Finance Report (Month 04)	Chief Finance Officer	61	11:40	Note
4.2	Integrated Quality Performance Report **APPENDIX 1.0**	Deputy Chief Executive	69	11:50	Assurance
~ Wellbeing Break for 10 minutes ~					

Agenda

NHS Medway NHS Foundation Trust

5. Quality, Safety and Patients					
5.1	Maternity and Perinatal Incentive Scheme – Year 7 Update Report July 2025 – CNST **APPENDIX 2.0**	Director of Midwifery	74	12:10	Briefing
5.2	Perinatal Quality Quarterly Report – Q1 2025/26 **APPENDIX 3.0**	Director of Midwifery	77	12:20	Briefing
5.3	Guardian of Safe Working – Annual Report	Chief Medical Officer	79	12:30	-
5.4	Medical Appraisal and Revalidation - Annual Report	Chief Medical Officer	86	12:40	Approve
5.5	Safer Staffing - Mid-Point Review	Chief Nursing Officer	116	12:50	Briefing
6. Items for Approval					
6.1	Safeguarding - Annual Report	Chief Nursing Officer	130	13:00	Approve
6.2	Virtual Ward	Chief Operating Officer	182	13:10	Approve
6.3	KMPN Contract Signing	Director of Strategy and Partnerships	228	13:20	Approve
7. Supplementary Items					
	Nothing for September				
8. Closing Matters					
8.1	Questions from the Council of Governors and Public	Chair	Verbal	13:30	Note
8.2	Escalations to the Council of Governors				
8.3	Any Other Business and Reflections				
	Date and time of next meeting: Wednesday, 12 November 2025				

Minutes of the Trust Board Meeting in Public

Wednesday, 23 July 2025 at 12:00 – 15:30

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
	Helen Wiseman	Non-Executive Director
	Jenny Chong	Non-Executive Director/Senior Independent Director
	Jon Wade	Chief Executive Officer (Interim)
	Mojgan Sani	Non-Executive Director
	Peter Conway	Non-Executive Director
	Sheridan Flavin	Chief People Officer (Interim)
	Simon Wombwell	Chief Finance Officer (Interim)
	Siobhan Callanan	Deputy Chief Executive
	Steph Gorman	Chief Nursing Officer (Interim)
Attendees:	Alana Marie Almond	Deputy Company Secretary (Minutes)
	Anan Shetty	Governor
	Angela Harrison	Governor
	Glynis Alexander	Director of Communications and Engagement
	Hari Aggarwal	Governor
	Jignesh Patel	Deputy Lead Governor (Interim)
	Karen Fegan	Governor
	Katie Goodwin	NHSE Improvement Director
	Martina Rowe	Lead Governor (Interim)
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Natasha Barrett Salvador	Freedom to Speak Up Guardian, The Guardian Service Ltd
	Teresa Murray	Governor
	Wayne Blowers	Director of Integrated Governance and Quality

	Yushreen Vadamootoo	Governor
Observing:	Alex Liggins	Vanguard Healthcare Solutions
	Andrea Paris	Service Manager for Children and Young People
	Charles Uche	IG Lead
	Hayley Pierre	Communications Team at MFT
	Katrina Ashton	Swale Resident and Patient of MFT
	Russell Edwards	The Surgical Consortium
Apologies:	Chris Parokkaran	Divisional Medical Director of Medicine and Emergency Care
	Christine Palmer	Governor
	Ghada Ramadan	Medical Director, Children's and Young People Services
	Jane Perry	Academic Non-Executive Director
	Joy Onuoha	Governor
	Matthew Taiano	Staff Governor and Staff Story
	Natasha Turner	Governor
	Nick Sinclair	Chief Operating Officer (deputised by Darren Palmer)
	Nikki Lewis	Associate Director of Patient Experience
	Paulette Lewis	Non-Executive Director

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair welcomed all present and apologies were noted as above. The following highlights were given by the Chair:

a) Chair introduced the new members of the Board; Sheridan Flavin (CPO) and Steph Gorman (CNO) in addition to Martina Rowe, Lead Governor (Interim) with Jay Patel as her Deputy.
b) Chair thanked Glynis Alexander for her time at the Trust as this was her last Board meeting.
c) Chair apologised on behalf of the Trust and Board for the delays in the Ears Nose and Throat service. More information on ENT will be given in the Chief Executive's Update.
d) David Fuller Report – Chair and CMO visited the Mortuary Services and were very impressed in terms of their response.
e) The Governments 'Ten Year Plan' will be reflected in the work the Trust does going forward. The Trust has appointed an external company 'Carnall Farrar' who are leading an external review in regards to potential collaboration, between the Trust and DGT.

1.2 Quorum

The meeting was confirmed as quorate.

1.3 Declarations of Interest

There were no declarations of interest

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

2.1 The minutes of the meeting held on 14 May 2025 were **APPROVED** as a true and accurate record.

2.2 Action Log

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

3 Opening Matters

3.1 Chief Executive Officer Update

Jon Wade presented the update for noting, highlighting the following key points:

a) Jon apologised for the delay in the Ear, Nose and Throat (ENT) service which has affected approximately 9,000 patients. It is an issue taken seriously by the Trust and the Board and confirmed there will be internal and external investigations into causality. There will be feedback given from these investigations. There is a significant major recovery operation in place, with a target of March 2026. The concern for the Trust is around harm to patients, so there are harm reviews are in place by ENT Clinicians. Every patient has been attempted to be contacted, if this has not happened, the public have been encouraged to get in touch and book their appointment.
b) Industrial action
c) Review to consider partnership working and the work Carnall Farrar is doing with the Trust and Dartford and Gravesham Trust (DGT)

The Board **NOTED** the update.

3.2 Council of Governors Report

Martine Rowe presented to the Board for noting from the Council of Governors (COG), with the following highlights:

- Announcement of the interim Lead (Martina Rowe) and Deputy Lead (Jignesh Patel) Governor elections.
- Public Governor Elections - terms begin on 01 August 2025.
- Governor events and activities
- Lead Governor message will be presented to members at the Annual Members' Meeting on 23 September.

Check and Challenge

a) Chair – thanked Martina and the Board congratulated her and Jignesh on their successful appointment.

The Board **NOTED** the update

3.3 Trust Risk Register and Issue Report

Steph Gorman presented the report providing an oversight of the highest rated risks and issues, and current mitigations in place to reduce the consequence and likelihood of the risks/issues occurring.

Check and Challenge

a) Gary – the scoring of Pembroke Ward refurbishment and the two new lifts scoring, should this come under business as usual? Steph – will take this away and return with response.
b) Mojgan – questioned the Metavision upgrade. Alison – will take this and come back with a response.

c) Peter – how confident is the team that the risk will hit the mitigation dates? Steph – the risk owners update regularly and on a yearly basis. Matt – confirmed risk owners had recently reviewed each risk. Peter – was not assured that the target positions will be met at this stage. Jon – questioned what is the accountability framework as the team need to be clear about the process with the Audit and Risk Committee and how to give accurate assurance to the Board. Chair – the committee escalations to the Board should include how long the Trust can tolerate an extreme risk. The oversight of the majority of risks is mainly for the QAC.
ACTION NO: TB/2025/017 - The Trust Risk Register and Issues Log will be submitted to the Audit and Risk Committee, then back to Board – Matt Capper and Steph Gorman.

The Board **NOTED** the reports

3.4 Board Assurance Framework (BAF)
Matt Capper presented the BAF for assurance.

Check and Challenge
a) Jenny – BAF5 – new wording around organisational culture; the risk wording needs to be tighter and will discuss at the People Committee. Matt – agreed.
b) Jenny BAF6 – why has the risk rating increased from 12 to 20? Matt – explained this is due to the findings from the work that has emerged from the Cultural Transformation Programme.
c) Chair – one risk is at 25, which means it is certain to happen with catastrophic impact. Can the risks be made clear as to what they link to and add an agenda item to discuss the high scoring risks. Matt – agreed.

The Board **NOTED** the BAF

3.5 Standing Financial Instructions and Scheme of Delegation
Simon Wombwell presented the report for formal adoption by the Board, to be reviewed in March 2026. There have been no amendments since the Audit and Risk Committee.

Check and Challenge
a) Chair – raised the formatting of the document.
b) Chair – consider the Kent and Medway Joint Committee Terms of Reference and check as a result of this, does anything need changing in SFI or SORD. Matt – yes, the documents need updating.
ACTION NO: TB/2025/018 – SFI and SORD to be updated.

The Board **APPROVED** the SFI and SORD.

4. Sustainability
4.1 Finance Report (Month 2)
Simon Wombwell presented the report highlighting the following key points:
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.
3) £0.4m of efficiencies have been delivered against a plan of £1.1m in the month, the total YTD delivery is £0.7m.

4) Cash is reasonably stable at present largely due to the capital programme.
5) Identification and delivery of savings is the most urgent financial objective.
6) The Trust has appointed PA Consulting to help with the recovery work.

Check and Challenge

a) Chair – how can the Trust recover from being off plan in Month 04? The trajectory to the year end is crucial. Simon – agreed that the following would be reported; cash position will be reported to July Finance Planning and Performance Committee (FPPC), risk mitigation and trajectory at August FPPC, then to Board for September.

The Board **NOTED** the report

4.2 Review of Financial Governance (January 2025) Update

Simon Wombwell presented the report, which was taken as read. The recommendations were summarised into three themes

1) Trust Board and Governance
2) Capacity and Capability
3) Financial Controls

Check and Challenge

a) Peter – Item 13 'quality and safety measures'; if they are in place can Simon demonstrate where they are in the IQPR? Simon – this will be discussed at FPPC in July 2025, with a combined paper on contracts and how they impact on performance. The challenge is to triangulate the four or five metrics. Siobhan – the focus is to reduce the key metrics and triangulate.
ACTION NO: TB/2025/009 and TB/2025/012 – these actions cover this work.
ACTION NO: summary of current position on IQPR refresh to the ARC – Siobhan Callanan

The Board **NOTED** the report

4.3 Integrated Quality Performance Report

Siobhan Callanan presented the report for assurance. Apologised for the gaps in the Executive Summary. The refresh means the report will move away from over-reporting and will concentrate on areas which are absolutely key to patient safety, experience and outcomes.

Check and Challenge

a) Jenny – data issue with TeleTracking, this has been an item for a long period of time – what is the Trust going to do with this? Steph – the Trust is not far from a resolution, figures are correct but it is a manual process currently.
b) Jenny – VTE – reporting is improved. Steph – the numbers will now start to reduce.
c) Jenny – RTT – has the ENT Backlog been added to these figures? Darren – no numbers have not been included yet, need to agree with Jon how this is included. Jon – working on validation with the national team and national statistics, will be agreed by end of September 2025.
d) Jenny – what is the reason around cancer rate variation? Darren – confirmed this was to do with doctor sickness rates.
e) Chair – what is the trajectory to reduce patients waiting over 65 weeks? Darren – confirmed this will be by the end of September 2025.

The Board were **ASSURED** by the report

5.1 Learning from Deaths – Quarterly Report

Alison Davis presented the report highlighting the following:

1) 456 Adult inpatient and Emergency Department deaths – 9% underwent stage 1 SJR reviews.
2) Initiation of the Sepsis 6 A4 programme.
3) HSMR+ at 99.6
4) SHMI at 1.20

Check and Challenge

a) Mojgan – in regard to the issues with coding. Alison – external expertise assisted to generate an action plan which has now been completed, it does not mean that data reflects patients, so the data is being reviewed again.
b) Mojgan – queried the dichotomy with the Doctor Foster team. Alison - Doctor Foster, come to every Mortality Surveillance Group, with a subject matter expert who produces a detailed report. If the Board require any further information from Doctor Foster to let Alison know.
c) Peter – the data in the appendix is quite old, the report details up to October 2024. Alison – this is in error and will update outside of Board.

The Board **APPROVED** the report

5.2 NHSE Maternity and Neonatal Review - Update

Kate Harris presented the report highlighting actions to improve care from the Secretary of State for Health and Social Care review. To note:

1) MFT was not one of the named Trusts
2) The maternity and neonatal services assure the Board processes are in place to address the ask of the National investigation.
3) Minor gap identified, and next steps put into place.

Check and Challenge

a) Jenny – thanked Kate for the mitigation points and it would be good to see focus in other areas and divisions.
b) Siobhan – concerns in regard to the funding for the MVP post. Kate – ICB is about to confirm that the post will continue to be hosted by the ICB, otherwise the funding can be sent to the organisations and the Trust would fund internally. Siobhan – need to be mindful as it is a CNST compliance item.
c) Chair – link in to the overall Trust Cultural Transformation Programme work, link in with Steph Gorman and Sylvia Stevenson. Kate – agreed
d) Gary – what is the update on the primary feedback for the premium CNST costs, that had increased? Matt – will report back on the CNST though the QAC. Matt – explained that there were a number of reasons why the premiums have increased including; SHMI and Legal Services input but the Trust. Maternity is where it should be.

The Board **NOTED** the report

5.3 Maternity (and Perinatal) Incentive Scheme – Year 7 Update

Kate Harris presented the report.

1) CNST Year 7 Published 2 April 2025 with reporting period ending 30 November and submission due 03 March 2026.

2) Received confirmation from NHSR of compliance with CNST Year 6.
3) Request escalation to Trust Board for MNVP service provision
4) Review of standards for CNST Year 7 ongoing with action leads, but anticipate no significant challenges to achieving compliance in year 7.
5) 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.

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

5.4 Claims, Incidents and Complaints Triangulation Report – Q4 2024/25

Kate Harris presented the report

1) 2014 to 2025 Claims Scorecard published in October 2025.
2) 52 Maternity Claims: 12 Open, 36 Closed, 4 Incident
3) 8 additional claims added to the Scorecard from July 2023 to June 2024
4) Report will review claims, alongside incidents reviewed at CRIG and complaints.
5) Report also will review actions from a previous MNSI case which has now progressed to a claim.

Check and Challenge

a) Peter – page 54 – identified risks; does this mean there are none? Kate – there are none to escalate to the Board but there are risks.
b) Siobhan – must keep close eye on claims and subject access requests. Kate – yes, and there has been an increase on freedom of information requests.

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

5.5 Perinatal Quality Surveillance and Leadership Quarterly Report: Q4 2024/25

Kate Harris presented the report which included key improvements in clinical outcomes, compliance with national standards, and service user feedback reflect the dedication of our multidisciplinary teams.

Check and Challenge

a) Simon – have you got everything you need to be able to build the improvement? Kate – yes but it is always a challenge. Will need support with the Birth Rate Plus and it is due.
b) Peter – are there any risks that need escalating to the Board? Kate – no risks are needed to escalate.
c) Peter – well done on the Christchurch work.

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

5.6 Bi-annual Midwifery Workforce Report

Kate Harris presented the report for assurance and noting.

Check and Challenge

a) Chair – thanked Kate and the team for their work and such a great standard of service, keep up the good work.

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

5.7 IPC Annual Report

Steph Gorman presented the report detailing the 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.

Check and Challenge

a) Siobhan – congratulated Steph and the team.
b) Mojgan – how confident are we around the anti-microbial stewardship? Steph – gave assurance around processes in place for basics including hand hygiene.
c) Chair – when the Micro Biologist reports, Chair would like to attend the meeting.
d) Chair – PA Consulting to pick up the fact the Trust are paying over the national average for antibiotics.
ACTION NO: Address the cost of antibiotics with PA Consulting – Simon Wombwell

The Board **APPROVED** the report

~ The Board took a 15-minute Wellbeing Break~

5.8 Health and Safety Annual Report

Wayne Blowers presented the report to provide assurance of the Trust's compliance against health and safety legislation requirements, as well as analysis and key performance information of health and safety activities.

Check and Challenge

a) Gary – successful prosecutions, did we share this with colleagues? Glynis – yes there were communications around this.
b) Chair – 385 instances of violence; this is an enormous number of physical assaults. One of the key actions from the Cultural Transformation work going forward is about the Trust being a "safe place to work". The Trust is working on how to help colleagues, making it safe and dramatically reducing this number.
c) Sheridan – there are 545 'did not attends' at the training for staff, it is crucial that staff attend training. Steph – this is being addressed at the Safety and Security Group.
d) Matt – this report will be submitted to the Governors in August 2025.

The Board **APPROVED** the report

6 Items for Approval

6.1 Data Security Protection Toolkit

Siobhan Callanan presented the report documenting the full submission of the 2024/2025 CAF-DSPT, with Standards Met, occurring 30 June 2025. Details on benchmarking and future submissions are included in the report.

Check and Challenge

a) Jenny – queried the items marked as 'not achieved'. Charles – will need to discuss cyber security in a meeting outside of Board, to protect the Trusts cyber security. There are some outcomes marked as not achieved or partially achieved, that is the minimum standard from NHSE. There is an improvement plan with the Director/Head of IT. KPMG are to perform a benchmarking audit to see how the Trust performed compared to other organisations. This audit will be presented to the Audit and Risk Committee, potentially in September 2025.

The Board **APPROVED** the DSPT

7 Items for Note

7.1 Freedom to Speak Up – Annual Report

Natasha Barrett-Salvador/Sheridan Flavin presented the report providing analysis of the FTSUG service at the Trust, covering the period 23 September 2024 to 31 March 2025.

1) 63 new concerns were raised to the Guardian service.
2) 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).
3) 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).

Check and Challenge

a) Chair – thanked Natasha and the team.
b) Simon – can we understand the relevant performance. How do our numbers compare to other organisations and over time? Is the Trust improving? Natasha – agreed to include in future reporting.
c) Matt – this report will be submitted to the Governors in August 2025.

The Board **NOTED** the report

7.2 Quality Assurance Committee (June and July meetings)

Alison Davis/Mojgan Sani presented the report for assurance.

The Board were **ASSURED** by the report

7.3 People Committee (May meeting)

Jenny Chong/Sheridan Flavin presented the report for assurance.

The Board were **ASSURED** by the report

7.4 Finance, Planning and Performance Committee (May and June meetings)

Helen Wiseman/Simon Wombwell presented the report for assurance.

The Board were **ASSURED** by the report

7.5 Audit and Risk Committee (June meeting)

Mojgan Sani/Simon Wombwell presented the report for assurance. Mojgan presented the report as she deputised for Peter Conway at the June meeting.

ACTION NO: TB/2025/020 - Estates Backlog to be submitted to the September Audit and Risk Committee

The Board were **ASSURED** by the report

7.6 Engagement and Involvement Framework 2025-2028

Glynis Alexander presented the report updating the Board on the Governor Engagement Plan, and the Membership Strategy. This has been submitted to the Governors and is a live document.

The Board **APPROVED** the report

8 Closing Matters

8.1 Questions from the Council of Governors and Public

1) Martina/Governors - The X-ray machine at the Memorial Hospital, Sittingbourne; this has been inoperative for some time. Darren – the machine was old and unsafe so it was closed alongside the service. As part of the capital planning there is a new machine purchased, it is in storage but there are some enabling works to be completed with the Estates team such as heightening the ceiling etc. Anticipated to start by end of August 2025 completion by end of October 2025.
2) Martina/Governors - Smoking on the hospital site, including staff in scrubs. Alison – is now the Executive lead, there are a series of actions in place to work through with Fire Safety Officer and the non-smoking group should be established in September. The safety element of smoking on site is being raised by Fire Safety Officer. Will take away the action of addressing staff smoking on site for the group to consider.
3) Martina/Governors - Governor training. Matt – there is a budget and training pieces are in place. Matt was waiting to hear what was in the ten-year plan, so will proceed with the training.
4) Teresa Murray – ethic minority mothers and maternity – is there anything more the Trust can do? There is a successful Council run course in Medway called 'Blooming Bumps'. Teresa is happy to link in with Public Health team to support. Steph – will take this back to the Maternity team and be in touch.

8.2 Escalations to the Council of Governors (COG)

There were no escalations to the COG.

8.3 Any Other Business and Reflections

The Board may switch the Board Day scheduling but will keep everyone informed.

There were no further matters of any other business or reflections.

8.4 Date and time of next meeting

Wednesday, 10 September 2025

The meeting closed at 15:15

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 23 July 2025

Signed by the Chair …… Date:

Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
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
23.07.25	**TB/2025/017**	**Trust Risk Register and Issue Report** - The Trust Risk Register and Issues Log will be submitted to the Audit and Risk Committee, then back to Board	10.09.25	Matt Capper, Director of Strategy and Partnership/Company Secretary Steph Gorman, Chief Nursing Officer (Interim)	**PROPOSE TO CLOSE** - delegated to the Audit and Risk Committee. Ongoing work on the refresh of the risk register, BAF and its reporting.	Green
23.07.25	**TB/2025/018**	**Standing Financial Instructions and Scheme of Delegation:** to be reviewed and amended following the establishment of the Kent and Medway Joint Committee.	12.11.25	Matt Capper, Director of Strategy and Partnership/Company Secretary	**NOT DUE UNTIL NOVEMBER 2025**	White
23.07.25	**TB/2025/019**	**Review of Financial Governance (January 2025) Update**: summary of current position on IQPR refresh to the ARC	10.09.25	Siobhan Callanan, Deputy Chief Executive	**PROPOSE TO CLOSE** - delegated to the Audit and Risk Committee	Green
23.07.25	**TB/2025/020**	**Audit and Risk Committee Assurance Report:** Estates Backlog to be submitted to the September Audit and Risk Committee	10.09.25	Nick Sinclair, Chief Operating Officer	**PROPOSE TO CLOSE** - delegated to the Audit and Risk Committee	Green

Chief Executive's report: September 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.

NHS Ten Year Plan

The Government's 10 Year Health Plan, launched in July, sets out a transformational vision and clear direction that will guide our decision-making and development of our services.

The plan's three shifts to make the NHS fit the future – hospital to community, analogue to digital, and sickness to prevention – are reflected in work underway at the Trust and in our Clinical Strategy.

The plan's ambition to end the 'hospital by default' requires care to be delivered as locally as possible through digital-first approaches, home-based care where feasible, neighbourhood health centres when needed, and hospital care only when necessary.

We continue to make more care available locally by expanding the range of diagnostic services at our Community Diagnostic Centres in Sheppey and Rochester.

We are seeking to substantially expand our virtual hospital services. By using technology to monitor the condition of patient remotely, which can alert the hospital team if it is necessary to increase the level of care, this enables people to stay in the comfort of their own homes, making best use of hospital beds.

We will be reviewing our strategy in line with this ambitious national plan so that we can continue to focus our efforts on providing local people with the right care in the right place at the right time.

Industrial action

Since my last report we have seen further strike action take place, which has placed additional pressure on our services. I would like to sincerely thank colleagues' who demonstrated exceptional professionalism, teamwork and commitment to patient care during five days of action by Resident Doctors in late July.

Our priority was to ensure that we continued to safely care for patients who needed it, particularly across urgent and emergency services, while also minimising the impact on elective care. For some patients however, this did mean that their non-urgent appointment or procedure was postponed, for which I am sorry and grateful for their understanding.

NHS Oversight Framework

The NHS Oversight Framework for 2025/26 sets out how NHS England will assess providers and integrated care boards (ICBs), alongside a range of agreed metrics, promoting improvement and helping to identify quickly where organisations need support.

As the Trust is currently in the Recovery Support Programme (RSP), we are automatically placed in segment 5. This reflects the scale of the operational and financial challenges that we are working hard to address, so that we can reduce waiting times for our patients, meet our £45 million savings target this year, and improve our long-term financial sustainability.

Ear Nose and Throat (ENT) delays

Progress is being made in addressing a significant backlog of patients whose referrals to the ENT service were not correctly managed in line with NHS waiting time standards. We have contacted these patients to apologise for this unnecessary delay to their care and are seeing patients in clinic, prioritising the longest waits. We are also working with partners to make more appointments available so that we can see all patients as soon as possible.

This service is provided by the Trust at Medway Maritime Hospital and Darent Valley Hospital, with those impacted predominantly in the Dartford, Gravesham, Swanley, Bexley and Greenwich areas. When these referrals were first received, they were reviewed by a clinician and assessed as routine, meaning that no urgent concerns, such as cancer, were identified at the time.

We have made changes to ensure referrals to this service are correctly managed. An independent investigation is underway to understand how this error occurred and if anyone has come to harm. We are committed to learning from this error and making changes so that this does not happen again.

New Palliative and End of Life Care Service

I'm pleased to report that our End of Life Care Team and the Palliative Care Team at Medway Community Healthcare (MCH) have joined forces to form a single Palliative End of Life Care Service.

As a result, we're able to offer a more consistent, patient-centred approach which includes a unified referral system, coordinated visits for patients transitioning between stages, enhanced discharge pathways and a joint educational programme.

Award recognition for Maternity and Breast Care teams

Two Trust teams have recently been recognised for best practise in national awards.

Team Lotus, our Perinatal Mental Health Maternity Team, has been shortlisted as a finalist for the Mental Health Awards 2025 in the 'Innovative proactive wellbeing activity' category. They were nominated for the Helping You Grow Stronger (HUGS) service which they recently helped roll out at neighbouring trusts. HUGS supports women and birthing people who are experiencing difficulties with their emotional wellbeing, by helping them develop the tools to identify and manage their needs.

A project led by our Breast Care Unit entitled 'Breast Surgery Goes Wireless' has been shortlisted in the 'Performance Recovery' category of this year's HSJ Awards. The unit was the first in the region to adopt radiofrequency identification (RFID) tags for preoperative localisation of breast tumours. This replaced same-day wire-guided localisation, reduced patient anxiety, improved scheduling, and enhanced surgical precision.

Welcoming new Governors

Finally, I'd like to extend a warm welcome to Emma Gostling and Paul Green, who joined our Council of Governors in August, representing Medway and the Rest of England and Wales respectively. My thanks to Anan Shetty, who has been re-elected to represent Medway. My thanks also to all Trust members who voted and all candidates who stood for election. A breakdown of the results can be found on our website.

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	x	X	x	x	x
Title of Report	**NHS England's Enforcement Undertakings for Medway NHS Foundation Trust**		**Agenda Item**		
Author and Job Title	Matt Capper, Dir Strategy & Partnership and Company Secretary.				
Lead Executive	Jon Wade, Chief Executive Officer				
Executive Summary	Approval		Briefing	x	Noting

Background
NHS England has accepted new Enforcement Undertakings from Medway NHS Foundation Trust ("the Licensee" / "the Trust"), replacing and superseding previous undertakings from December 2021 and October 2023. This action is taken because the older undertakings are considered outdated due to the passage of time and intervening events. The Trust holds a license under section 87 of the Health and Social Care Act 2012.

Grounds for Action (Suspected Breaches of Licence Conditions)
The following licence conditions are cited by NHS England NHS England as areas of breach (NHS2(2); NHS2(4)(a)(b)(c); NHS2(5)(a)(b)(d)(e)(f); NHS2(7)).
A detailed description of the key concerns is contained in the undertakings letter (appended). The main areas of concern are:

- **Leadership, Culture, and Governance**:
  - Emerging concerns with leadership, governance, and capability to deliver financial and operational performance
- **Financial Sustainability**:
  - The Trust failed to deliver its £2.4m deficit plan for 2024/25, ending the year with a £22.4m deficit, which was £20.0m adverse to plan.
  - There is a lack of confidence in the Licensee's capability to deliver its £4.9m deficit plan for 2025/26.
  - The Trust reports an underlying deficit position of £57m for 2025/26, with insufficient evidence that the drivers of this deficit are being addressed effectively.
  - The Trust's exit from the Recovery Support Programme (RSP), entered in July 2021, was extended for the third time in March 2025. This extension was due to a lack of oversight and collective responsibility for financial delivery by the Board and an evident lack of financial governance.

NHS England believes the undertakings are necessary to secure that the identified breaches do not continue or recur. By agreeing the undertakings, the Trust has agreed to the following commitments:

- **Leadership, Well-Led and Governance**:
  - Implement robust quality governance systems and processes to meet CQC registration standards and ensure a stable Executive team with robust organisation-wide governance, supported by a Board development programme.
- **Financial Management**:

<table>
<tr><td></td><td colspan="4">

Reduce the current deficit and achieve financial sustainability.

Programme Management:

Implement sufficient programme management and governance arrangements for oversight, understanding of risks, and accountability in delivering these undertakings.

General:

Take all reasonable steps to meet the Recovery Support Programme (RSP) Transition Criteria.

Consequences of Non-Compliance
Failure to comply with these undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act or revocation of its licence under section 89 of the Act. Providing inaccurate, misleading, or incomplete information may also be treated as a failure to comply.

These undertakings were signed on behalf of the Licensee by Jonathan Wade, Chief Executive, and on behalf of NHS England by Anne Eden, Regional Director, SE Region NHS England.
</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="4">To note the detail and commitments within the agreed undertakings letter.</td></tr>
<tr><td><u>Governance Route</u>
Meeting:
Date submitted:</td><td colspan="4">N/A</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="4">As detailed in the letter.</td></tr>
<tr><td>Resource implications:</td><td colspan="4">As detailed in the letter.</td></tr>
<tr><td>Sustainability and/or Public and patient engagement considerations:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Integrated Impact assessment (please mark):</td><td>Yes</td><td colspan="2">No</td><td>N/A</td></tr>
<tr><td></td><td colspan="2"></td><td>x</td></tr>
<tr><td>Appendices:</td><td colspan="4">

Medway NHS FT Undertakings letter.

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<tr><td>Freedom of Information status (please mark):</td><td>Disclosable</td><td>X</td><td>Exempt</td><td></td></tr>
<tr><td>For further information please contact:</td><td colspan="4">Jon Wade. Chief executive Officer</td></tr>
</table>

REPLACEMENT ENFORCEMENT UNDERTAKINGS

LICENSEE:

Medway NHS Foundation Trust
Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

BACKGROUND

NHS England accepted undertakings under section 106 of the Health and Social Care Act 2012 ("the Act") from Medway NHS Foundation Trust ("the Licensee" / "the Trust") on 08 December 2021 which were varied on 10 October 2023. Due to the passage of time, and intervening events, some of those undertakings are deemed to be outdated.

These Enforcement Undertakings replace and supersede the variations from October 2023.

DECISION

On the basis of the grounds set out below, and having regard to its Enforcement Guidance, NHS England has decided to accept additional undertakings from the Licensee and to replace existing undertakings for the reasons set out below. These undertakings will supersede the undertakings agreed on 08 December 2021 and varied on 10 October 2023 which will cease to have effect from the date of these undertakings.

GROUNDS

1. Licence

1.1 The Licensee is the holder of a licence granted under section 87 of the Act.

2. Breaches

2.1. NHS England has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: NHS2(2); NHS2(4)(a)(b)(c); NHS2(5)(a)(b)(d)(e)(f); NHS2(7).

2.2. In particular:

Leadership, Culture and Governance

2.2.1. An interim Chief Executive (joint with neighbouring Dartford and Gravesham NHS Trust) took up post in April 2025 for an initial period of six months. There are emerging concerns with leadership, governance and capability to deliver the financial plan and operational performance. An independent leadership review is being commissioned to consider organisational leadership options;

2.2.2. The Licensee's substantive Finance Director retired at the end of December 2024 and an interim replacement is now in post. A finance governance review was undertaken in December 2024, with the formal report shared in January 2025. Further review work was recently undertaken by the NHS England Recovery Support Programme in February and March 2025. Many of the concerns and recommendations were similar to those made in previous reviews;

Financial Sustainability

2.2.3. The Licensee failed to deliver its £2.4m deficit plan in 2024/25; the year end deficit was £22.4m, £20.0m adverse to plan;

2.2.4. In M9 2024/25 the Licensee reported a deterioration in their forecast deficit position of c£23m over their agreed deficit plan and the Licensee formally revised its forecast outturn position at M10 to reflect a £20.6m variance to plan. This position had not been shared with the Trust Board, with Kent & Medway Integrated Care Board or NHS England in advance and was unexpected;

2.2.5. The Licensee has submitted a £4.9m deficit plan for 2025/26. The plan is predicated on the delivery of a £45.4m efficiency programme (equating to 7.9% of operating expenses) which is significantly greater that savings achieved in previous years;

2.2.6. There is a lack of confidence in the Licensee's capability to deliver their 2025/26 financial plan given the limited identification of cost improvement programme schemes and limited evidence of collective Board oversight and a robust financial controls environment;

2.2.7. For 2025/26 the Licensee reports an underlying deficit position of £57m. Whilst the Licensee has developed a medium-term financial recovery plan, there is not sufficient evidence that the drivers of the deficit are being addressed or that the Licensee's underlying position will sufficiently improve;

2.2.8. The Licensee entered the Recovery Support Programme (RSP) in July 2021 by virtue of being placed in segment 4 of the NHS Oversight Framework. The exit date was extended for the third time in March 2025 due to the lack of oversight and collective responsibility for financial delivery by the Licensee's Board and evident lack of financial governance. The Licensee is unable to be approved for exit until they can demonstrate achievement of a financially balanced plan that does not compromise on quality and value for money.

3. Need for action

NHS England believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

4. Appropriateness of Undertaking

In considering the appropriateness of accepting in this case the undertakings set out below, NHS England has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

LICENSEE:

Medway NHS Foundation Trust
Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

UNDERTAKINGS

NHS England has agreed to accept and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:

1. Leadership, Well-Led and Governance

1.1 The Licensee will take all reasonable steps to put in place principles, systems and standards of governance which would reasonably be regarded as appropriate for a supplier of healthcare services to the NHS. In particular:

1.1.1 The Licensee will take all reasonable steps to ensure that robust quality governance systems and processes are in place to maintain the required standards to meet the conditions of their CQC registration.

1.1.2 The Licensee will provide evidence by Q1 2026/27 of effective Trust leadership and governance structures and ensure that processes and robust controls are in place to deliver and sustain essential improvements in financial delivery and the quality of services ensuring sustainability and a continuous quality improvement focus in the Trust.

1.2 The Licensee will ensure that the undertakings in this document will be delivered whilst maintaining or improving the quality of services.

1.3 The Licensee will ensure that there is a stable Executive team with clear and robust organisation wide governance in place, supported by a Board development programme to be in place by the end of Q1 2026/27 that has been agreed with NHS England.

1.4 The Licensee will ensure cross-professional Board ownership for the delivery of the 2025/26 and beyond. This is to be balanced across all aspects of hospital management – quality, workforce, performance, activity and finance.

2. Financial Management

2.1 The Licensee will take all reasonable actions to reduce the current deficit and achieve financial sustainability.

2.2 In meeting the requirements of paragraph 1.1., the Licensee will:

2.2.1. By a date to be agreed with NHS England, refresh and submit to NHS England a Financial Recovery Plan ("FRP") that adheres to the latest available NHS planning guidance and sets out realistic actions over an appropriate timescale, to stabilise and improve the Licensee's financial position;

2.2.2. Ensure that the FRP is agreed by the Licensee's Trust Board, Kent & Medway Integrated Care Board (ICB) and NHS England and maintained to adhere to the latest available NHS planning guidance;

2.2.3. Ensure that the plan addresses the underlying drivers of the deficit and improves the underlying recurrent financial position;

2.2.4. In refreshing and implementing the FRP, the Licensee should engage effectively with key stakeholders including Kent and Medway Integrated Care System (ICS) and Integrated Care Board (ICB) and ensure the FRP is aligned with wider system financial planning and key strategies;

2.2.5. The Licensee will deliver the FRP in accordance with the timescale outlined in that plan, or such dates to be agreed with NHS England. As a milestone towards delivering the FRP, the Licensee will meet its 2025/26 Financial Plan as agreed with the Kent and Medway Integrated Care Board (ICB) as part of an overall ICS plan for 2025/26.

2.3. The Licensee will ensure that robust financial controls, processes (including financial reporting and forecasting), and governance, including Board accountability, is in place to ensure effective use of resources and best value for money.

2.4. The Licensee will cooperate and actively participate in any Kent and Medway ICB financial sustainability and efficiency programmes.

3. Programme Management

3.1 The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

3.2 Such programme management and governance arrangements must enable the board to:

3.2.1 obtain clear oversight over the process in delivering these undertakings;

3.2.2 obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and

3.2.3 hold individuals to account for the delivery of the undertakings.

4. General

4.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Transition Criteria as set out and agreed by the South East Regional Support Group (RSG) and National Quality and Performance Committee (QPC) in partnership with the Licensee.

4.2 The Licensee will review progress against meeting the RSP Transition Criteria and these undertakings, updating NHS England regularly at Oversight Meetings and inputting into reports when requested.

4.3 In line with the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address regulatory concerns.

5. Reporting

5.1 In line with the above and in any event, the Licensee will provide regular reports to NHS England on its progress in complying with the undertakings set out above and will attend meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. These meetings will take place once a month unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England.

5.2 Upon request, the Licensee will provide NHS England with the evidence, reports or other information relied on by its Board in relation in assessing its progress in delivering these undertakings.

5.3 The Licensee will comply with any additional reporting or information requests made by NHS England.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence,

including any additional licence condition imposed under section 111 of the Act and those conditions relating to:

- **compliance with the health care standards binding on the Licensee; and**
- **compliance with all requirements concerning quality of care.**

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS England may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

Signed on behalf of Licensee

Name: Jonathan Wade
Position: Chief Executive

Signature: 

Signed on behalf of NHS England

Name: Anne Eden
Position: Regional Director, SE Region NHS England

Signature: 

Meeting of the Trust Board in Public

Wednesday, 10 September 2025

NHS Medway NHS Foundation Trust

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
				X	
Title of Report	**Trust Risk Register and Issues Log Report**			**Agenda Item**	3.5
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 05 August 2025.				
Proposal and/or key recommendation:	There are 83 approved risks on the Trust Risk Register of which, 10 are rated Extreme (scoring 15 and above). 3 new risks were approved in July of which, 2 are rated extreme. 1 risk was closed in July. 3 risks have had their score reduced. **Extreme Risks** 1. SHMI mortality indicator being higher than expected 2. Limitations of EPR/EPMA system functionality 3. Backlog maintenance impacting on the infrastructure and clinical safety 4. 16 and 17 year olds at risk of not receiving optimal inpatient care 5. Women, Children, and Young People's Division inability to meet the financial efficiency target for 2025/26 6. Organisation being the target of a Cyber Attack 7. Existing Metavision version facing challenges with reported bugs and compatibility issues with the current IT systems, requiring an urgent upgrade 8. Non-Compliance with HTM 05-01 Managing Healthcare Fire Safety 9. Patients who lack capacity potentially coming to harm by absconding from the hospital site 10. Lack of clear and embedded ligature risk management processes within paediatrics There are 207 approved Issues on the Trust Log of which, 1 is rated Significant. 9 new issues were approved in July. 4 issues were closed in July. **Significant Issue** 1. Trust is not currently culling or destroying patient records in line with records management code of practice.				
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

1. Summary of Approved Risk Scores

There are 83 approved risks on the Trust Risk Register, of which, 10 are rated Extreme (scoring 15 and above), 57 are rated High (scoring 8-12), 15 are rated Moderate (scoring 4-6) and 1 rated Low (scoring 1-3).

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			10	5	
3 - Possible	1	5	22	20	5
2 - Unlikely		2	6	4	1
1 - Rare				1	1

Consequence

2. 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 score of 16 - Consequence 4 (Major) x Likelihood 4 (Likely).

The risk has been refreshed and updated to include mitigations in line with the Quality Breakthrough Objective, these include:

1) Variability of SJR process - over medicalised, process not in line with RCP guidance, lack of centralised database- process is now aligned with RCP guidance, reviewers and both medical and nursing backgrounds and SJR+app used to hold SJR data and reviews.
2) Limited LFD visibility at Board level - LFD report monthly to QAC and quarterly to Trust Board. LFD reports are shared with specialities and included in Quality Care Group and Divisional level reporting
3) M&M Process - structural issues, absence of responsibility to report M&M outcomes, lack of engagement and compliance. Teaching provided to specialties and best practice guide with minute template and action log circulated to all teams. Escalation process in place to ensure compliance. Mortality and Morbidity Review Group (MMRG) for specialties to report on M&M themes and trends.
4) Validations of deaths process variable and not fully optimised - job planning/PA for MEC specialty with higher volume of deaths. Responsibility for Patient Safety Leads/Mortality leads in lower

volume specialties to review all deaths. Business case developed to resource the process. VCP to be approved and target of respiratory related deaths to be implemented.

5) Medical staff not clear on EOL escalation as no criteria for deterioration in the notes. Decisions being made but not communicated to teams. Medical staff not making EOL decisions in the day or out of hours and decisions not supported by consultants. Specialty teams to clarify criteria for deterioration in order to commence EOL care for out of hours. Medical handover of deteriorating patients highlighting those most likely EOL and highlighted to ART/RESUS to improve communication. Roll out education plan and reclarify the EOLC process for medical teams and EPR recording- create a robust rota for out of hours.

An action plan has also been agreed by Task and Finish Group to include:

1) Clear working diagnosis on EPR, correct named consultants, ongoing comorbidities in initial FCE of each admission, in a way that is visible to healthcare colleagues and coding team.
2) Coding review by responsible consultant to check facts are correct and all comorbidities captured and coded.
3) Ensure all patients who should be placed on palliative care pathways are seen without delay by the palliative care team, and the decision is recorded in a way that is visible to coding.
4) Continue to monitor compliance with TEP form completion above 95%.
5) Where there are concerns regarding excess deaths in a specialty, or individual deaths, ensure deep dives / SJR's are carried out in a timely fashion.
6) Ensure that there are internal and external resources to support the validation of diagnosis on EPR accuracy and coding.
7) In order to support improvements in understanding and reducing mortality, appoint clinical learning from deaths lead.
8) Future investment in a mortality database which is fit for purpose.

Extreme Risk 2 (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).

Actions continue to be monitored and are within timeframe for completion.
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. Covered in Blood Training – Prescription and Administration which is mandatory for all staff who are involved in the transfusion process.
- POCT Database correctly records results (incorrect capillary blood glucose ranges on EPR).

- 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. For Gentamicin for Endocarditis, the dose range is stated within the order set.
- Working with the vendor to update the system to support dose range limits on EPMA.
- Removed the inpatient discharge summary from the ED in light of EPMA order reconciliation manager not transferring between ED and inpatient.

Extreme Risk 3 (Ref 2158) was raised July 2024 and describes ***backlog maintenance impacting on the infrastructure and clinical safety***. The maintenance 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.
This has a current risk score of 16 - Consequence 4 (Major) x Likelihood 4 (Likely).

Extreme Risk 4 (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.
This has a current risk score of 16 – Consequence 4 (Major) x Likelihood 4 (Likely).

Extreme Risk 5 (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).

Extreme Risk 6 (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. 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.
This has a current risk score of 15 - Consequence 5 (Catastrophic) x Likelihood 3 (Possible).

Extreme Risk 7 (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. 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.

This has a current risk score of 15 - Consequence 5 (Catastrophic) x Likelihood 3 (Possible). A project plan is in draft and the team are in the process of setting a 'Demo' date. Business change are working to understand the workflows that will need to be built so that 'to be maps' can be generated. Training on configurtion of the system will start September 2025 with go-live for the upgrade and transition of care will be March 2026 with a view to a mobile module going live in April.

Extreme Risk 8 (Ref 2166) was raised August 2024 and describes ***Non-Compliance with HTM 05-01 Managing Healthcare Fire Safety.*** 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

This has a current risk score of 15 - Consequence 5 (Catastrophic) x Likelihood 3 (Possible). The risk owner provides assurnance that the Fire Capital Program is now underway and is monitored via the Fire Safety Group.

Extreme Risk 9 (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. 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.
This has a current risk score of 15 - Consequence 5 (Catastrophic) x Likelihood 3 (Possible).

Extreme Risk 10 (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.

This has a current risk score of 15 - Consequence 5 (Catastrophic) x Likelihood 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.

3. Risk Movement

There has been no increase in risk scores during the month of July but 3 have had their score reduced.

1) Tiny Tugs Nursery Environment (Ref 2438) was raised with an initial risk score of 16 - Consequence 4 (Major) x Likelihood 4 (Likely) but, upon review by the Estates Group this score has been reduced to 6 - Consequence 2 (Minor) x Likelihood 3 (Possible). There have been no reported incidents relating to the nursery environment and all areas are still in use.

2) Paediatric Oncology Shared Care Unit (POSCU) Transformation Project (Ref 2476) describes that following the recommendations from NHSE for transformation of children's oncology services, Medway POSCU to increase services to give infusional chemotherapy in addition to current service. The concerns have arisen from the proposed funding vs outlay to provide the service at the recommended safe level. There is a significant shortfall in the recurrent payment identified, to that calculated by team at Medway to provide the service. If this service development does not occur, this would result in the Medway POSCU losing service provision. The oncology service provided locally for children living in Medway, Swale and Gravesend would be substantially less, resulting in patients from 0-18 living with an oncology condition within the area, travelling to alternative treatment centres.

   This was raised with an initial risk score of 16 - Consequence 4 (Major) x Likelihood 4 (Likely) but, upon review by the Divisional Board the score has been reduced to 12 - Consequence 4 (Major) x Likelihood 3 (Possible) due to the current controls in place to manage the risk.

   The owner provide assurance in that financial discussions are taking place with NHSE and the challenges around adequate funding to provide the service. Meetings are ongoing to clarify processes, tariffs and potential for alternative services for aseptic pharmacy services.

3) Access Control (Ref 1901) uses a system of cards and readers to unlock doors. Access Control management was weak allowing access by staff to areas where they are not authorised. Following a

review at the Estates Group the risk score was reduced from 8 - Consequence 4 (Major) x Likelihood 2 (Unlikely) to the target score of 4 - Consequence 4 (Major) x Likelihood 1 (Rare). Access is now well managed across the Trust with no reported incidents. Consideration is being given to the closure of this risk.

4. New Risks

The following risks were approved at the relevant groups and committee's in July:

1) Tiny Tugs Nursery Environment (Ref 2438) as detailed above in section 3. Risk Movement ref 1).
2) Paediatric Oncology Shared Care Unit (POSCU) Transformation Project (Ref 2476) as detailed above in section 3. Risk Movement ref 2).
3) PALS Staffing Levels (Ref 2497) was approved by the Patient Experience Group with a score of 12 – Consequence 3 (Moderate) x 4 (Likely). If replacement of the outgoing PALS Facilitator is not approved then there is a risk that the PALS service will have to move to reduced operating hours leading to an increase in complaints, patients experiencing dealings and a poor service user experience.

5. Closed Risks

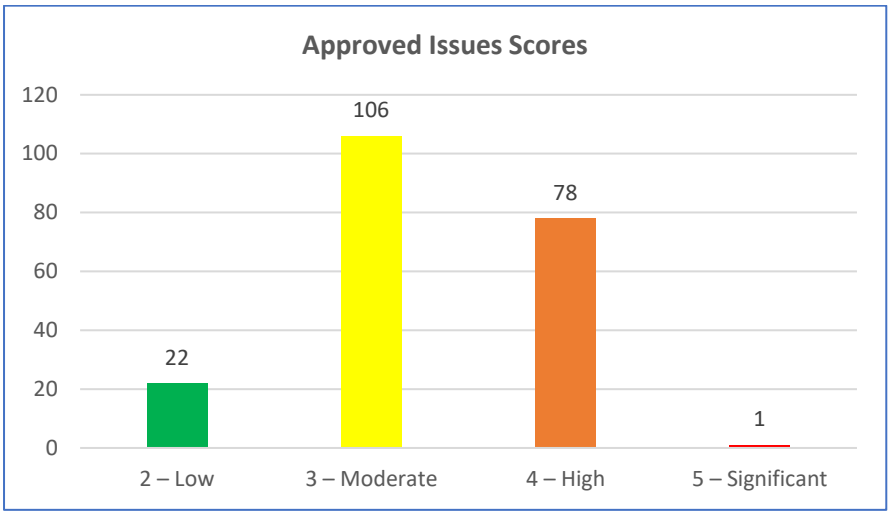
The following risks were closed in July 2025:

1) ERF / Elective Activity Plans (Ref 2055)
   This risk was confirmed for closure by the Deputy Chief Financial Officer as this refers to 24/25 activity plans with consideration for a new risk to be raised.

Issues Log

1. Summary of Approved Issues

There are 207 approved Issues on the Trust Issues Log, of which, 1 is rated Significant.



2. Significant Issues

The Significant Issue of ***the Trust not currently culling or destroying patient records*** (Ref 2083) was raised in May 2024. This describes that due to the lack of resources available, the Trust is not able to cull or destroy 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.

3. New Issues

The following issues were approved at the relevant groups and committee's in July:

1) Due to the number of vacancies within the Palliative Care Team the number of referrals received for discharge planning in particular completion of Fast tracks to discharge patients out of MFT with either POC/NH has been vastly restricted. Increasing LOS for Palliative and EOLC and increasing HSMR/SHIMI.
   Priority Rating 4 - High

2) Mental Health Administration and Legal Services Provision at Medway. Patients who are admitted to Medway that require detaining under the mental health act are at risk of not having this carried out adequately. Staff at MFT are not aware or trained adequately to administer their section papers or read their legal rights. There is are no staff who can accurately upload the section paperwork to the relevant national body. If the patient were to appeal their section under the mental health act, MFT do not have the adequate legal expertise to conduct this hearing. As a consequence, patient care would be at significant risk. The trust would be at risk from a legal perspective. Staff are not receiving the appropriate training for when patients are being detained in our care.
   Priority Rating 4 – High.

3) Lack of Antimicrobial Pharmacist due to 12 month career break. The department has advertised unsuccessfully for a suitably experienced temporary member of staff to fulfil the role. MFT is an outlier in its high use of antimicrobials, and preference to use antibiotics in the Watch category rather than the Access category. This results in a higher risk of the development of Clostridium Difficile infection and antibiotic resistance.
   Priority Rating 4 – High

4) In outpatients Magpies, none of the consultant chairs are infection control compliant as all have breaks and/or splits in the wipeable surface. This is also the case with the examination couches in all consulting rooms (totalling 7 chairs and 7 couches). There is potential for equipment to be condemned resulting in no furniture to provide a safe service.
   Priority Rating 4 – High

5) Cross-Trust Antenatal Care and Delivery Planning. Increasing numbers of women are booking to deliver their babies at other NHS Trusts while receiving antenatal care at our Trust. This creates clinical risk due to differing guidelines, care pathways, and documentation systems between Trusts. Our midwives may be unaware of the delivery Trust's protocols, potentially leading to inconsistent care and increased risk of adverse perinatal outcomes.
   Priority Rating 4 – High

6) Reduced staffing in the Chaplaincy Team
   Priority Rating 3 – Moderate

7) Mixed Sex Breaches - Jade Ward
   Priority Rating 3 – Moderate

8) BCG Vaccinations. A recent review of the service showed only 18% compliance with the 28 day target for vaccinating new-born babies.
   Priority Rating 3 – Moderate

9) Ongoing issue with Rodents on Will Adams ward
   Priority Rating 3 – Moderate

4. Closed Issues

The following Issues were closed in July:

1) Obsolete Paediatric Ventilators
   This issue was rated 5 – Significant and was agreed for closure as new ventilators have arrived and training is underway.

2) Pathology Results in incorrect Chronological Order
   Agreed for closure, EPR Team confirmed that this has been resolved.

3) Lack of CSPL Admin to Support National Cervical Cancer Audit
   Agreed for closure as post appointed to and member of staff has now started.

4) ENT PTL and Waiting Times Information – DVH
   Agreed at Surgical Divisional Board for closure as this Issue has been superseded by a new issue raised ENT Backlog which sets out the RTT position. This is also linked to the ENT Backlog risk.

MFT Board Assurance Framework **Aug-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, CIP and cash reserves resulting in the non delivery of the agreed in year control totals.	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) • Trust finance stability plan	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. **August 25 -** Month 3 and 4 move to off plan position as predicted a result of slow delivery of effeciency savings and slow change in pay profile.	5	5	25	-	←		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 8-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. **August 25 -** Estates prioritisation submission made to ICB and NHSE with backlog maintenance rated highly. Business cases for national fundig are being submitted where possible andCILs funding is being explored in line with medway and swale local development plans.	5	4	20	-	1		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. **August 25 -** It has been confrmed that the trust has been moved into an enhanced oversight framework. The trust is rapidly developing a stability plan.	4	4	20	↑	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 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. **August 25 -** Position being monitired through Board Committees.	5	4	20	-	1		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. **August 25 -** Deficit payment regime clarified and monitored. monthly finnace reports and fiannce committee focus.	5	4	20	-	1		Being mapped

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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 programe (likely as an A3).	4	5	20	↑	0		Being mapped
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		
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.

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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.

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
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, 10 September 2025

Title of Report	Quality Assurance Committee Monday, 11 August 2025		**Agenda Item**	3.7a
Executive Lead	Alison Davis, Chief Medical Officer Steph Gorman, Chief Nursing Officer (Interim)			
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, 11 August 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 Steph Gorman, Chief Nursing Officer (Interim) stephanie.gorman@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
3	3	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

Escalations to note:

- Microbiology – capacity and example of antibiotic use at Dartford
- Ultrasound scanners – lack of scanners
- Trauma summit in September, report to committee in October, capacity remains an issue.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
1. Terms of Reference The Committee agreed Divisional representation should be considered going forward, to be included within the ToR. To include Safeguarding, IPC and Pharmacy.	Assurance
2. Assurance and Escalation Report from QPSSC The Committee noted the report, recommending a more detailed approach to reporting within the Executive Summary. The Committee noted the ongoing work with Carnell Farrar. The Committee noted higher risk within Datix are reviewed by the central team.	Assurance with minor improvements needed.
3. Safeguarding Annual Report The Committee noted the report requesting a deep dive in Safeguarding for the November meeting.	Assurance
4. Learning from Deaths The Committee noted the report, requesting further details on the impact of actions.	Partial Assurance
5. Accreditations Assurance Report The Committee noted the report requesting the next report, in December, includes an action ownership oversight, stating which actions require immediate attention.	Assurance with minor improvements needed.
6. Anti-Microbial Stewardship The Committee noted the report suggesting a review of Dartford's use of antibiotics (which is 20% lower than MFT), as a cost cutting exercise. PA Consultancy to lead.	Assurance

Staff capacity remains an issue, impacting Antimicrobial Stewardship Group meetings, ward rounds and data collection.	
7. IIA and QIA Process The Committee suggested PA Consultancy have oversight of the process. The Committee **NOTED** the report for sign off of the process.	Assurance
8. ENT Backlog The Committee requested details of a suggested 'alternative pathway' suggested by an ENT consultant for outstanding appointments. The Committee **NOTED** the report	Assurance
9. NHSI Maternity Self-Assessment The Committee **NOTED** the report	Assurance
10. Maternity and Neonatal Safety Champion Assurance and Escalation Report The Committee **NOTED** the report	Assurance
11. Clinical Strategy The Committee noted elements could change due to Carnall Farrar review. The Committee **APPROVED** the Strategy	Assurance
12. Information Governance Implementation Plan The Committee **NOTED** the Implementation Plan	Assurance
13. PSIRF Investigation Highlights Report The Committee **NOTED** the report	Assurance

Meeting of the People Committee
Tuesday, 10 September 2024

Title of Report	People Committee Assurance and Escalation Report to Trust Board		**Agenda Item**	3.7
Executive Lead	Sheridan Flavin, Chief People Officer			
Committee Chair	Jenny Chong, Non-Executive Director			
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:	Not applicable			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted and date of meeting:	People Committee – 31 July 2025			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients)	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	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:	Sheridan Flavin, Chief People Officer s.flavin1@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
3	1	x	

Declarations of Interest Made

No additional declarations in relation to agenda items.

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

Item	Group, Subcommittee, Committee	Date
Not at this meeting		

Reports not received as per the annual workplan and action required

N/A

Items/risks/issues for escalation

None to report from this meeting

Implications for the corporate risk register or Board Assurance Framework

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. Risk and Issue Register The Committee requested further updates in relation to Risk 1409, due to the recent escalation of the risk. The Committee agreed the Risk Register needs to have view of the most recent data, for review of the amber and red risks only. All columns are to be completed including the target date. The Committee **NOTED** the report	
2. Board Assurance Framework The Committee discussed BAF 5 and were assured of mitigations in place. The Committee **NOTED** the report	
3. Integrated Quality Performance Report The Committee were **ASSURED** by the narrative, and will welcome the refreshed version.	
4. Anti-Bullying and Harassment Group Assurance Report Regular monthly meetings of the Anti-Bullying and Harassment group have been paused as the divisional response to the allegations of incivility, which include bullying or harassment, take place as part of the weekly People Breakthrough Objective huddles.	

• Divisions drive discussions and actions through their care groups, Anti-Bullying and Harassment Group will meet quarterly, to focus on the trends and additional support to the divisions. The Committee agreed the reporting within the assurance report. The Committee requested an Executive Summary going forward. The Committee were **ASSURED** by the report	
5. HR and OD Performance Group Assurance Report Key highlights were: • Medical Staffing and AfC Teams continue to struggle with ongoing staffing issues and vacant roles. This results in the Head of Service covering for lower bands and not able to lead on strategic projects such as Values based recruitment, Recruitment training for hiring managers and Job Descriptions refresh. For this reason, there has been no notable progress with the DBS project for a number of weeks The Committee commented on Appraisals – compliance needs to be improved. The Committee were **ASSURED** by the report	
6. Stat Mand Training Group Assurance Report The Committee discussed training prior to appraisals – the committee were assured by processes being put into place. The Committee were **ASSURED** by the report	
7. Health and Wellbeing Guardian Assurance Report Key highlight: The National Health and Wellbeing (HWB) Framework dashboard, alongside key performance indicators from NHS Staff Survey and metrics from contracted services, combine to provide an overview of progress against the Trust People Strategy. The Committee **ASSURED** by the report	
8. People Strategy Refresh The strategy will be refreshed for March 2026 The Committee **APPROVED** the Strategy	
9. Freedom to Speak Up Implementation Plan The Committee **APPROVED** the Implementation Plan	
10. Policies and Terms of Reference for NOTING: • Apprenticeship Policy • Positive Action Policy • Equality and Inclusion Steering Group – Terms of Reference	
11. Staff Survey The report provided an update on progress of the planned work in response to the 2024 National Staff Survey results; and provides an overview of approach to the 2025 National Staff Survey, in particular aligning the action plan/improvement approach to the Patient First process and methodology. This aims to increase Divisions oversight and accountability The Committee **NOTED** the report	

12. Mandated EDI Reports The report brings together the mandated data reports for the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES). The key challenges are increased likelihood of white staff being successful from shortlist to appointment, and under-representation of staff from 'Other Ethnic Groups' in senior positions in the workforce; and the under-representation of disabled people throughout the workforce, compared to the UK population The Committee **NOTED** the report	
13. Medical Appraisal and Revalidation Annual Report The Committee discussed the issues with identify doctors on Datix The Committee **APPROVED** and **NOTED** the report for onward ratification at Board	

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Title of Report	Finance, Planning and Performance Committee Wednesday, 27 August 2025		**Agenda Item**	3.7c
Executive Lead	Simon Wombwell, Chief Finance Officer (Interim)			
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, 27 August 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
6	0	X	

Declarations of Interest Made

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
Financial Report Month 04 1. Deficit of £7.9m (£1.9m adverse to plan) 2. Continued underperformance against the savings targets 3. Income reductions for low activity in the CDCs 4. A small set of unexpected cost impacts, notably: industrial action costs, the breakdown of the Combined Heat and Power (CHP) plant (cost of repairs plus pushing up our utilities costs) and an increase in haematology drugs spend. 5. Cash issues potentially for November/December 2025. The process will result in a deeper level of level of scrutiny. The forecast is being reviewed weekly, we will need to make decision on working capital by end of the autumn. Assuming we will receive deficit support funding. A huge risk. 6. Mutually Agreed Resignation Scheme (MARS) targeted for 15 September 7. Business Case for Virtual Wards The Committee **NOTED** the report.	Partial Assurance
PA Consultancy 1. Moving at pace to prioritise grip and control, tightening processes. 2. Activity plan triangulation, what is the balance and risk. 3. Additional resource being brought in to support 4, Divisional ongoing opportunities ensuring review of mitigation actions in place 5. Through validation will start delivery The Committee **NOTED** the report	Partial Assurance
Performance Monitoring (Triangulating Finance, Activity and Performance) 1. The 2025/26 plan includes metrics and performance measures across a range of performance areas. 2. Financial performance, year to date, £7.9m deficit, which £1.9m adverse to plan. £660k attributable to industrial action. 3. Month 4 a decline across several trajectories, except DM01 and 31-day cancer standard	Assured

4. Updates to continue on a monthly basis, with activity levels and performance. The Committee were **ASSURD** by the report	
Medway Community Healthcare 1. Trust has an overdue receivable balance with MCH of £2.77m. £1.55m relates to triage. 2. Previous efforts to resolve have been unsuccessful. 3. Re-escalation to the commissioner for "arbitration" and ICB. The Committee were **ASSURED** and **NOTED** the ongoing work to retrieve funds.	Assured
Critical Infrastructure Backlog 1. Infrastructure failure due to collapse or malfunction of critical systems. 2. Failures arise from age related deterioration, inadequate maintenance, design flaws, or not replacing aged assets. The Committee were **ASSURED** by the report but felt the paper was not within the gift of the FPPC, a report for the Trust Board	Partial Assurance
Workforce Spend and Increase in WTE 1. The Trust has experienced significant establishment growth since Covid, combined with a loss in productivity. 2. Growth has been agreed through a governance process, part of a national programme or has a funding source 3. There are governance arrangements in place to address, track and escalate various workstreams designed to reduce worked WTEs; however, further work is required to identify and realise reductions. The Committee **NOTED** the report, requesting further updates to be bought back to FPPC	Partial Assurance
Risk and Board Assurance Framework The Committee **NOTED** the reports.	Assured
Virtual Wards Business Case 1. The Virtual Hospital Programme offers a transformative solution to systemic pressures on patient flow, discharge capacity, and inpatient efficiency. 2. Building on the success of MFT's SMART acute virtual ward, the business case proposes a step-change: scaling from 80 to 200 virtual beds - including high-acuity care - while activating 24/7 coverage and integrated admission avoidance pathways. 3. The model will enable the closure or repurposing of up to three inpatient wards, freeing up 91 beds, and delivering a strong return on investment within 9-12 months. The Committee expressed their appreciation of the impressive work, and **APPROVED** the business case for onward ratification at the Trust Board.	Assured
Contact Renewal Register 1. Trusts Contract Management Database, Atamis. 2. Compare AP and PO records against contracts database to highlight any major contract purchases that may have been initiated outside Trust SFIs. 3. Consider the benefit of Including NHS-to-NHS and income contracts onto the Contracts Database. 4. Regular reminders and procurement training to support greater compliance to Trust SFIs. The Committee **NOTED** the report	Assured

Medicines Efficiency Programme and High Cost Drugs 1) The Trust spends over £40 million annually on medicines 2) Through the Medicines Efficiency Programme, the pharmacy department has delivered savings of approximately £1 million per year for the last three years. 3) Year to date delivery for the 2025/26 programme is £562,000 against a plan of £334,000. 4) National medicines inflation (7.14%) and underfunding in the ICB block payment present an ongoing risk. The Committee were **ASSURED** by the report	Assured
National Cost Collection Planning and Submission and Results NCCI Score 1) The Trust has submitted its National Cost Collection for 2024/25 in-line with national requirements. 2) The National Cost Collection Index score is estimated to be between 95 and 98 based on inflated NCC 2023-24 data. NHSE will release the actual scores in October 2025, using all provider returns. The Committee **NOTED** the report	Assured
Green Plan The NHS England Green Plan Guidance, updated on February 4, 2025, providing a framework for NHS organisations to develop and refresh their green plans to support excellent patient care, save money, reduce waste, and achieve net zero emissions by 2040. The Committee **NOTED** the plan, requesting if comes back to the Committee giving a clear outline on what the Committee is being asked to review, in terms of investment.	Assured

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
			X		
Title of Report	**Story to Board - Ward Accreditation Programme**			**Agenda Item**	3.8
Author and Job Title	Nikki Lewis, Associate Director of Patient Experience				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				
Executive Summary	Approval		Briefing	Noting	X
	This paper will provide an outline of the work achieved within the ward accreditation process at Medway NHS Foundation Trust. This programme of work commenced a year ago; three clinical areas have achieved gold award status.				
Proposal and/or key recommendation:	Nil				
Governance Route Meeting: Date submitted:	Quality Assurance Committee - 08 September 2025				
Identified Risks, issues and mitigations:	Nil				
Resource implications:	Nil				
Sustainability and/or Public and patient engagement considerations:	Nil				
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:					

NHS Medway NHS Foundation Trust

Story to Board

Staff story and experience – Ward Accreditation

10 September 2025

Nikki Lewis, Associate Director of Patient Experience

Patient FIRST

Ward Accreditation

NHS Medway NHS Foundation Trust

Background

Ward accreditation is a way for MFT to ensure that we deliver consistently high quality care and good patient experience, improving collaboration between teams to champion their strengths and achievements and to make improvements.

The scheme looks at a range of important indicators around patient care and ward practice – such as good infection control practice, patient nutrition and minimising the occurrence of pressure ulcers – along with a number of other measures.

Wards are peer reviewed by staff that work in other departments and are supported by the Integrated Governance Team.

Ward Accreditation

NHS Medway NHS Foundation Trust

The accreditation category each ward can achieve ranges from Gold to Silver, Bronze and White and is aligned to the Care Quality Commission's (CQC) standards of Outstanding, Good, Requires Improvement or Inadequate.

What makes a ward GOOD?	
Safe	Patients and staff are protected from bullying, harassment, avoidable harm and abuse. The ward has an open culture on reporting and learning from mistakes, prompt responses to safeguarding concerns and thorough investigations. There is good management of medication and accurate record keeping.
Effective	Patient's needs are consistently met by staff who have the right skills, qualifications and knowledge. The ward keeps up-to-date with new research, guidance and developments in the sector. Patients are always asked to give their consent to their care, treatment and support.
Caring	Patients are consistently positive about the caring attitude of staff. Patients receive care from staff who know and understand their history, likes and goals. End-of-life care is compassionate and supportive, with patient being supported to make decisions about their preferences.
Responsive	Patients receive patient-centred care and are involved in identifying their needs and how these should be met. Patients have a choice about who provides their personal care.
Well-led	Patients, their family and friends are regularly involved with the ward in a meaningful way. Staff have the confidence to question practice and report concerns. The ward has a clear vision and set of values that include honesty, respect and safety.

Delivery Suite

Some examples of how the team achieved their GOLD rating;

- scoring 100% in 18 out of 20 assessments
- achieving at total of 98% overall score
- amazing feedback from families about their care and experience
- excellent standards met on all aspects of care and management.

Victory Ward

Some examples of how the team achieved their GOLD rating;

- scored 100% (outstanding) in 14 out of 19 assessments
- excellent feedback from staff who feel supported, valued, respected and appreciated.
- great communication between teams and all documentation required was found complete
- all information present and up to date on all information boards
- early warning dashboard reports green across the board.

Critical Care

Some examples of how the team achieved their GOLD rating;

- excellent evidence of multi-disciplinary team (MDT) working
- 100% with information governance and complaints, listening and learning and cognitive/sensory environment
- environment was calm, clean, clutter free and organised
- hand hygiene was good and all equipment cleaned between patients
- quality safety boards, patient information and 'What Matters to Me' boards completed
- Early warning dashboard audits all rated as green.

Accreditation Cycle

Medway NHS Foundation Trust

Ward / Area	Care Group	Division	Outcome Rating	%
Tennyson	Frailty	MEC	Silver	86%
Jade	Specialist Medicine	MEC	Silver	87%
Wakeley	Specialist Medicine	MEC	Bronze	73%
Lister	Emergency & Acute Medicine	MEC	Bronze	83%
Arethusa	Surgical Services	SA	Bronze	84%
Bronte	Specialist Medicine	MEC	Silver	92%
Kingfisher	Surgical Services	SA	Silver	91%
Byron	Frailty	MEC	Bronze	82%
Critical care	Theatres and Anaesthesia	SA	Gold	95%
Emerald	Frailty	MEC	Silver	87%
Will Adams	Specialist Medicine	MEC	Silver	90%
Harvey	Surgical Services	SA	Bronze	84%
Sapphire	Specialist Medicine	MEC	Bronze	84%
Ruby	Specialist Medicine	MEC	Silver	87%
Lawrence	Cancer & Core Clinical Service	SA	Bronze	78%
Milton	Frailty	MEC	Silver	88%
Keats	Specialist Medicine	WCYP	Bronze	74%
Pembroke	Emergency & Acute Medicine	MEC	Silver	91%
McCulloch	Surgical Services	SA	Silver	93%
Victory	Surgical Services	SA	Gold	95%
Phoenix	Surgical Services	SA	Silver	88%
Ocelot	Surgical Services	SA	Silver	91%
Pearl	Women's	WCYP	Silver	90%
Delivery Suite	Women's	WCYP	Gold	98%
Dolphin	Women's	WCYP	Silver	90%

Accreditation Rating	Criteria for attainment	Timescale for Re-Assessment
Exemplar*	Retained Gold Status for 2 consecutive years	24 Months - Unless deterioration over 2 consecutive months highlighted on the Early Warning dashboard
Gold	3 or more CQC domains rated 'Outstanding'	18 Months - Unless indicated through ongoing monitoring
Silver	3 or more CQC domains rated 'Good'	12 Months - Unless indicated through ongoing monitoring
Bronze	3 or more CQC domains rated 'Requires Improvement'	6 Months
White	3 or more CQC domains rated 'Inadequate'	1 Month

Next Steps

NHS Medway NHS Foundation Trust

- Although the accreditation has begun on our wards it will soon include specialist areas such as outpatients, critical care and our Emergency Department, with all of our clinical areas being able to benefit from the scheme in due course.
- We will continue to support the ward areas that have achieved bronze and silver to get to gold!
- Review the cycle of ward accreditation processes as we move through the next phases of audit, we have five areas left to complete a full cycle.

Meeting of the Trust Board
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	X				
Title of Report	**Finance Report – Year to July 2025 (Month 4)**			**Agenda Item**	4.1
Author and Job Title	Paul Kimber, Deputy CFO				
Lead Executive	Simon Wombwell, Chief Finance Officer				
Executive Summary	Approval		Briefing	Noting	X
	At the end of July 2025, the Trust is reporting a deficit of £7.9m (£1.9m adverse to Plan). This position is the result of: i. Continued underperformance against the savings targets (a rising target as the System target is now being phased in, as per plan); ii. Income reductions for low activity in the CDCs; and iii. A small set of unexpected cost impacts, notably: industrial action costs, the breakdown of the Combined Heat and Power (CHP) plant (cost of repairs plus pushing up our utilities costs) and an increase in haematology drugs spend. Action to improve our savings planning and delivery is critical to reversing the I&E imbalance. Further, this impacts adversely on our cash position, and compounds our risks as Deficit Support Funding is expected to be withdrawn id the I&E plan is not met.				
Proposal and/or key recommendation:	For discussion				
Governance Route Meeting: Date submitted:	Finance, Planning and Performance Committee 27 August 2025				
Identified Risks, issues and mitigations:	As described				
Resource implications:	No new investments are required as a direct result of this paper.				
Sustainability and/or Public and patient engagement considerations:	As described.				
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:	simon.wombwell@nhs.net				

Finance Report

For the period ending 31st July 2025 (M4)

Contents

1. Executive Summary
2. Income and Expenditure
3. Normalised performance
4. Statement of Financial Position
5. Cash
6. Conclusions

1. Executive Summary – Trust level

The financial results to July 2025 (Month 4) are set out below. Performance is measured against the Plan agreed with NHSE, this being a £4.9m control total deficit for the year to 31st March 2026.

£m	Plan	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month reported	0.7	(2.9)	(3.6)	The July (in-month) position is a £3.2m deficit; £7.9m deficit year to date (YTD), this is adverse to plan for July and YTD by £1.9m. ERF clinical activity has improved in-month and reporting to plan. CDC income is reporting £0.7m adverse to plan, this is due to under performance as well as phasing of budgets equally over the year rather than gradual increase as more activity is delivered. £3.4m Deficit Support Funding (DSF) has been recognised in-month (as per Plan), reduced from £4m reported last month. Efficiency delivery in-month is £0.6m against a target of £2.9m (incl. £0.7m system target; YTD this is £1.7m/30% vs £6.2m Plan. This continues to be the main contributor to the adverse position. The Trust expects to deliver the overall £4.9m deficit for the year, but this is high risk... delivery of cost reduction remains the most urgent financial objective.
Tech. adjustments	(2.0)	(0.3)	1.7	
In-month vs **Plan**	**(1.3)**	**(3.2)**	**(1.9)**	
YTD total	**(6.0)**	**(7.9)**	**(1.9)**	
Forecast outturn	**(4.9)**	**(4.9)**	**-**	
Efficiencies Programme				
In-month	1.6	0.4	(0.7)	The annual savings target is £45.4m, made up of a £27.2m Trust target and £18.2m of System efficiencies. Phasing of the "Trust" schemes grows gradually from April to August; with a notable step change in July as the System target is added, and then grows until October. The Trust's progress towards identifying schemes remains off plan leaving a significant gap to both the Divisional and System targets.
YTD	3.3	1.1	(2.2)	
Cash				
Month end	16.5	20.0	3.5	Cash continues to be favourable as the capital programme is behind plan & an advanced payment on Education income (paid quarterly in advance).
Capital				
YTD				The capital programme is £10.2m behind the NHSE reported plan in July. The main issue relates to year 2 of the £30.1m Trust decarbonisation project, 87% funded by a Salix grant. Access to the grant being dependent on completion of works by 31st March 2026. £6.6m of works completed in 2024/25 with a further £23.5m planned for 2025/26. To date these works are £7.2m behind plan with a material risk being highlighted to the overall delivery and therefore access to the remaining grant. Estates are liaising with Salix, procurement and contractors to provide a full assessment and recommendations as a priority. Until this is fully understood the annual forecast is to return to Plan.
Capex	11.3	3.2	(8.1)	
Leases	2.1	-	(2.1)	
Total	**13.4**	**3.2**	**(10.2)**	
FORECAST				
Forecast	**50.0**	**47.7**	**(2.3)**	

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

£m	In-month			Year to date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	39.4	38.6	(0.8)	156.8	155.8	(1.0)
High cost drugs	2.5	2.7	0.2	9.3	9.4	0.1
Donated assets	2.0	0.3	(1.7)	7.9	0.9	(7.0)
Other income	3.0	2.9	-	11.6	11.6	(0.0)
Total income	**46.8**	**44.4**	**(2.3)**	**185.6**	**177.7**	**(8.0)**
Nursing	(11.6)	(11.8)	(0.3)	(45.7)	(46.7)	(1.0)
Medical	(9.0)	(9.5)	(0.5)	(35.8)	(36.4)	(0.6)
Other	(10.2)	(8.8)	1.4	(37.3)	(34.6)	2.7
Efficiency target	1.6	-	(1.6)	3.1	-	(3.1)
Total pay	**(29.1)**	**(30.1)**	**(1.0)**	**(115.7)**	**(117.7)**	**(2.0)**
Clinical supplies	(5.8)	(7.3)	(1.5)	(21.7)	(23.0)	(1.4)
Drugs	(1.3)	(1.6)	(0.3)	(4.9)	(5.3)	(0.4)
High cost drugs	(2.5)	(2.4)	0.1	(9.3)	(9.2)	0.1
Other	(5.7)	(3.8)	1.9	(24.2)	(19.9)	4.4
Efficiency target	0.5	-	(0.5)	1.4	-	(1.4)
Total non-pay	**(14.7)**	**(15.0)**	**(0.3)**	**(58.7)**	**(57.4)**	**1.3**
EBITDA	**3.0**	**(0.6)**	**(3.6)**	**11.2**	**2.6**	**(8.7)**
Non-operating exp.	(2.4)	(2.4)	-	(9.4)	(9.7)	(0.3)
Surplus/(deficit)	**0.7**	**(2.9)**	**(3.6)**	**1.9**	**(7.1)**	**(9.0)**
Tech. adj.	(2.0)	(0.3)	1.7	(7.9)	(0.8)	7.1
Control total	**(1.3)**	**(3.2)**	**(1.9)**	**(6.0)**	**(7.9)**	**(1.9)**
DSF (incl. Clin Inc)	(3.4)	(3.4)	-	(17.8)	(17.8)	-
Performance excluding DSF	**(4.7)**	**(6.6)**	**(1.9)**	**(23.8)**	**(25.7)**	**(1.9)**

Commentary

Clinical income adverse performance is mostly due to £0.7m of CDC underperformance YTD recognised in-month; ERF income has been accrued to the commissioner contract/ERF cap value. £3.4m Deficit Support Funding (DSF) is included, totalling £17.8m (43%) year to date (as per the Plan). The adverse variance relates to the cost and volume drugs and devices variable element of the contract (counter-balanced by underspends in non-pay). The Donated asset adjustment relates to the Salix Decarbonisation Grant supporting capital works; this is a timing issue, matching income to progress; this is excluded for the purpose of performance against the control total.

The nursing pay overspend largely relates to the MEC Division, driven by recruitment in Q4 and increased requirement for temporary cover of staff absences. The overspend on medical staff includes part of £0.6m of cover during the recent five days of industrial action. Pay award estimate of £3.0m has been accrued YTD, this is £0.1m more than the funding to July. Not all efficiency targets have been transacted through the divisions into individual budget lines due to timing issues following the month closedown.

The clinical supplies overspend recognises a £1.6m accrual for NKPS historic debt. The position also includes devices funded through variable income (noted in income above). The 'Other' category underspend relates budgets held centrally. The £27m efficiency target is allocated to Divisions, but as stated in pay above, not all of targets have been transacted into individual budget lines.
The £18m System Savings target is being held centrally, pending development of detailed plans (phased from July (this month) onwards).

Depreciation budgets continue to be reviewed following the year end revaluation and capitalisation of assets.

Timing of the Salix grant (Decarbonisation project) as noted in income above.

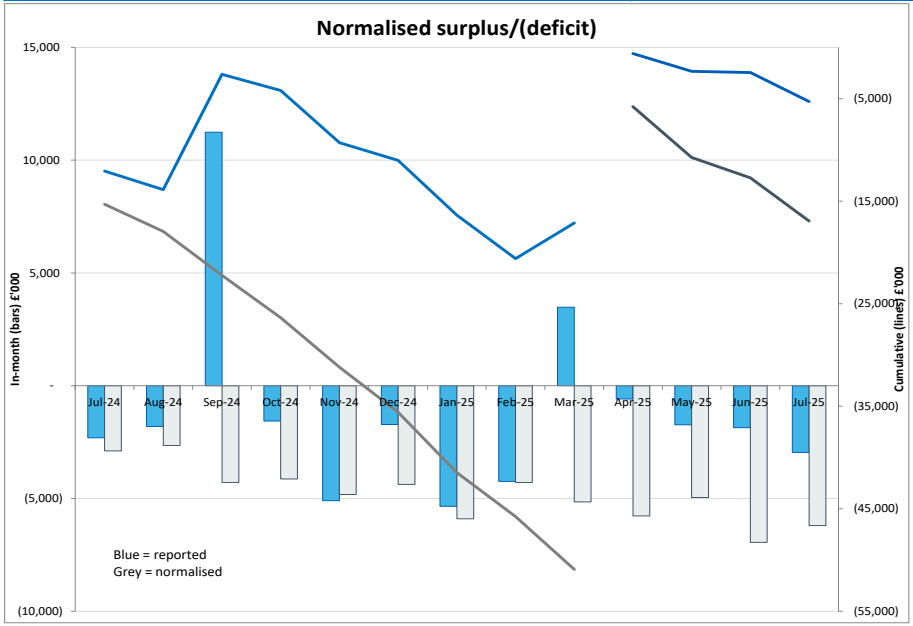
The Trust is expected to meet its annual plan; however, the key risks to this are:

- Delivery of a ~£45m efficiency programme (both Trust and System identified plans are below target with an increasing target trajectory to address from July).
- Loss of DSF – failing to achieve Plan (at system level) will lead to a DSF reduction.
- Loss of ERF income and activity/costs are above the capped level.
- Receivable and payable risks e.g. MCH and Car Park VAT; ENT backlog costs.
- Cash risk increases if DSF is reduced.

3. Normalised performance

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

£'000	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Reported surplus/(deficit)	**(2,310)**	**(1,807)**	**11,241**	**(1,568)**	**(5,099)**	**(1,718)**	**(5,347)**	**(4,242)**	**3,482**	**(590)**	**(1,735)**	**(1,861)**	**(2,956)**
Technical adjustments	25	(178)	(275)	(267)	(475)	(1,188)	424	(200)	(3,032)	(96)	(378)	(48)	(48)
Control total surplus/(deficit)	**(2,285)**	**(1,985)**	**10,966**	**(1,835)**	**(5,574)**	**(2,906)**	**(4,923)**	**(4,442)**	**450**	**(686)**	**(2,113)**	**(1,909)**	**(3,004)**
Deficit support funding	-	-	(14,247)	(1,973)	(1,776)	(2,306)	(2,191)	(989)	(1,948)	(6,412)	(3,996)	(3,996)	(3,996)
Control total surplus/(deficit) before deficit support funding	**(2,285)**	**(1,985)**	**(3,281)**	**(3,808)**	**(7,350)**	**(5,212)**	**(7,115)**	**(5,431)**	**(1,498)**	**(7,098)**	**(6,109)**	**(5,905)**	**(7,000)**
Normalisation adjustments:													
Non-recurrent adjustments	(52)	(589)	(224)	537	320	833	1,214	1,140	(295)	-	-	-	-
NKPS Debt provision										1,351	1,176	(1,010)	161
Industrial action costs	130	-	-	-	-	-	-	-	-	-	-	-	555
Industrial action income	-	-	(542)	-	-	-	-	-	-	-	-	-	-
Annual leave accrual cost	-	(465)	-	-	-	-	-	-	147	-	-	-	-
Pension 9.4% Costs	-	-	-	-	-	-	-	-	17,984	-	-	-	-
Pension 9.4% Income	-	-	-	-	-	-	-	-	(17,984)	-	-	-	-
Pay Award	(1,267)	(949)	(1,205)	5,239	3,109	-	-	-	-	(212)	(212)	(212)	635
Pay Award Income	960	961	961	(6,103)	(906)	-	-	-	-	184	184	184	(552)
Car Parking VAT - Claim Recognised									(3,508)				
Additional Sessions Accrual	(379)	379	-	-	-	-	-	-	-	-	-	-	-
Recurrent surplus/(deficit)	**(2,893)**	**(2,650)**	**(4,292)**	**(4,134)**	**(4,826)**	**(4,379)**	**(5,901)**	**(4,291)**	**(5,154)**	**(5,774)**	**(4,961)**	**(6,943)**	**(6,202)**
Recurrent surplus/(deficit) - cumulative in-year	*(15,297)*	*(17,946)*	*(22,238)*	*(26,372)*	*(31,199)*	*(35,577)*	*(41,478)*	*(45,769)*	*(50,923)*	*(5,774)*	*(10,735)*	*(17,677)*	*(23,879)*



Commentary:

- The normalised/recurrent position removes technical items, e.g. income and spend relating to charitable donations and one-off impacts such as industrial action.
- The July normalised I&E position (£6.2m) is an improvement of the in-month recurrent deficit by ~£0.7m, reflecting £0.4m from planned income phasing after adjusting for the pay award funding, and £0.3m clinical supplies consumable reduction after accounting for historic NKPS debt provision.
- Based on the average run-rate YTD, the annualised performance would be ~£71m, i.e. a deterioration of ~£20m on 24/25. This arises from the continued growth in nursing and midwifery staff in A&E and maternity respectively (following decisions made in mid-24/25), together with the full year effect of the mobile endoscopy unit; clarity is being sought from commissioners over ERF income that could be derived from this mobile unit.
- Enhanced vacancy controls have been extended to the end of September 2025.

4. Statement of Financial Position

31 March 2025	£m	Month end Actual	Movement vs Prior Year
289.7	**Non-current assets**	**286.2**	**(3.5)**
6.7	Inventory	6.9	0.1
38.6	Trade and other receivables	42.9	3.5
0.4	Assets held for sale	0.0	0.0
13.3	Cash	20.0	1.6
59.0	**Current assets**	**69.8**	**5.3**
(0.2)	Borrowings	(0.2)	0.0
(61.0)	Trade and other payables	(71.8)	(10.8)
(1.1)	Other liabilities	(4.7)	(3.6)
(62.3)	**Current liabilities**	**(76.7)**	**(14.4)**
(2.8)	Borrowings	(2.8)	0.1
(1.3)	Other liabilities	(1.3)	0.0
(4.1)	**Non-current liabilities**	**(4.1)**	**0.1**
282.3	**Net assets employed**	**275.2**	**(7.1)**
511.2	Public dividend capital	511.2	0.0
(292.5)	Retained earnings	(299.6)	(7.1)
63.6	Revaluation reserve	63.6	0.0
282.3	**Total taxpayers' equity**	**275.2**	**(7.1)**

Key messages:

Non-current assets are £3.5m lower than year end, being the net impact of £3.2m investment expenditure and £6.7m depreciation.

Net current liabilities (*Current Assets less Current Liabilities*). In July the Trust has net current liabilities of £6.9m.

- **Trade and other receivables** are £42.9m (97% of one-month's income)
- **Assets held for sale**, in July 3 accommodation properties with an NBV of £0.4m were sold by auction for £0.5m; £0.1m profit on disposal. However, it should be noted these properties were impaired by £0.2m in 2024/25 before reclassification.
- **Cash** as at 30 June is £14.9m, representing an increase (+) of £1.6m (+£1m MoM) due to a variety of movements in working balances i.e. deferred income/prepayments etc.
- **Trade and other payables** are £71.8m (162% of one month's expenditure). This is a £5.4m increase on the prior month due to an increase in NKPS payables and the effect of the agreed pay award being fully accrued.
- **Other liabilities** relate to deferred income; materially for education income paid quarterly in advance.

Public dividend capital remains at £511.2m.

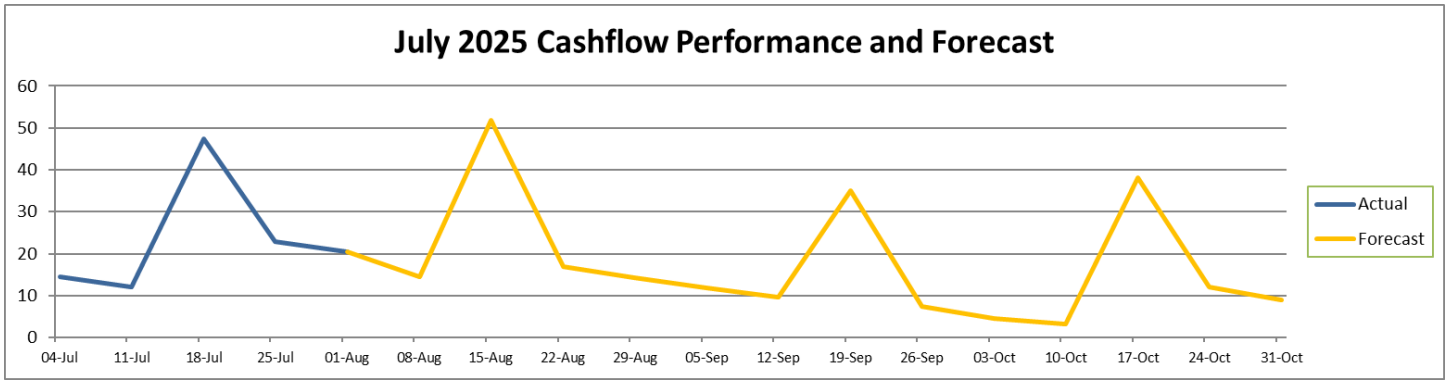
Revaluation reserve remains at £63.6m and is not expected to change until the annual revaluation in March 2026.

Overall, the balance sheet remains largely consistent with the year end albeit with a degradation reflecting the deficit. Future months cash and payables are expected to reduce as long-standing disputes are settled, the effect of which will significantly worsen the overall position if cash releasing efficiencies do not deliver as planned.

5. Cash

13-week cash forecast

	w/e																	
	Actual					Forecast												
£m	04/07/25	11/07/25	18/07/25	25/07/25	01/08/25	08/08/25	15/08/25	22/08/25	29/08/25	05/09/25	12/09/25	19/09/25	26/09/25	03/10/25	10/10/25	17/10/25	24/10/25	31/10/25
BANK BALANCE B/FWD	**17.3**	**14.4**	**12.0**	**47.5**	**22.9**	**20.4**	**14.5**	**51.7**	**16.9**	**14.2**	**11.9**	**9.6**	**35.0**	**7.5**	**4.5**	**3.2**	**38.2**	**12.0**
Receipts																		
NHS Contract Income	0.7	0.8	44.3	0.6	0.5	0.2	45.9	2.4	0.0	0.0	0.0	40.9	0.0	0.0	0.0	48.4	0.0	0.0
Other	0.2	0.1	0.3	0.1	0.7	0.2	0.9	0.2	0.5	0.3	0.3	0.5	0.5	0.2	0.3	0.6	0.5	0.2
Total receipts	**0.9**	**1.0**	**44.6**	**0.7**	**1.2**	**0.4**	**46.8**	**2.7**	**0.5**	**0.3**	**0.3**	**41.4**	**0.5**	**0.2**	**0.3**	**49.0**	**0.5**	**0.2**
Payments																		
Pay Expenditure (excl. Agency)	(0.5)	(0.4)	(4.2)	(22.8)	(0.4)	(0.5)	(0.5)	(31.1)	(0.5)	(0.5)	(0.5)	(4.1)	(25.3)	(0.5)	(0.5)	(4.1)	(24.0)	(0.5)
Non Pay Expenditure	(3.4)	(2.9)	(4.9)	(2.2)	(2.9)	(5.7)	(8.5)	(6.1)	(2.6)	(2.0)	(2.0)	(7.2)	(2.6)	(2.6)	(1.0)	(9.3)	(2.6)	(2.6)
Capital Expenditure	(0.0)	(0.0)	(0.1)	(0.3)	(0.3)	(0.1)	(0.5)	(0.3)	(0.1)	(0.1)	(0.1)	(0.5)	(0.1)	(0.1)	(0.1)	(1.6)	(0.1)	(0.1)
Total payments	**(3.8)**	**(3.4)**	**(9.2)**	**(25.3)**	**(3.7)**	**(6.3)**	**(9.6)**	**(37.5)**	**(3.2)**	**(2.6)**	**(2.6)**	**(11.7)**	**(28.0)**	**(3.2)**	**(1.6)**	**(15.0)**	**(26.7)**	**(3.2)**
Net Receipts/ (Payments)	**(2.9)**	**(2.4)**	**35.4**	**(24.5)**	**(2.5)**	**(5.9)**	**37.2**	**(34.9)**	**(2.7)**	**(2.3)**	**(2.3)**	**29.7**	**(27.5)**	**(3.0)**	**(1.3)**	**34.0**	**(26.2)**	**(3.0)**
Funding Flows																		
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Working Capital Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grant Capital	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	1.0	0.0	0.0
Loan Repayment/Interest payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dividend payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(4.7)	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**0.0**	**0.0**	**0.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(4.4)**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**0.0**
BANK BALANCE C/FWD	**14.4**	**12.0**	**47.5**	**22.9**	**20.4**	**14.5**	**51.7**	**16.9**	**14.2**	**11.9**	**9.6**	**35.0**	**7.5**	**4.5**	**3.2**	**38.2**	**12.0**	**9.0**



- Closing cash at the end of July was £20.0m, which is a £5.1m increase month-on-month; this is helped by the quarterly payment in advance of Education income.
- The rolling 13-week forecast is based on real cash i.e. expected transactions rather than the I&E forecast; for prudence it assumes little to no efficiencies are delivered. At the current rate of spend, without increased savings delivery we will require intervention / cash support in December 2025.
- Should I&E forecasts become reality (i.e. improved [genuine] savings delivery) this cash position would be impacted positively.

6. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance at the end of July 2024 (Month 4), which is £1.9m adverse to plan in-month and year-to-date (MFT is £7.9m in deficit against a planned £6m deficit).

However, as reported last month, there remains a number of key **risks** to delivery of the annual plan; namely:

- **Savings**: Plan phasing of savings schemes grows gradually from month 1/April to month 5/August; there is a notable step change in July and again in October as "Local" and "System" schemes respectively are required to deliver. The Trust's cost base must therefore reduce accordingly, with particular focus required on pay and headcount. The start of PA Consulting means greater effort on CIPs has begun, but this will take time to manifest.
- **Income**:
    - The ICB has effectively capped the ERF income, which is lower than the expected value of activity plans to achieve 60% RTT at 18 weeks. Delivery of the activity plan may therefore not be reimbursed and/or be delivered at additional, unplanned cost (unless this can be achieved through productivity gains). The lead commissioner has indicated that provided ERF monies are not clawed back by NHSE then it does not intend on paying less ERF income than contracted even if our activity levels (variable income) are below agreed activity plans. CDC income levels are below plan and we have adjusted YTD income assumptions to match lower activity delivered.
    - The guidance (May 2025) sets the condition [to hit Plan] means failure to meet I&E Plan each quarter (and NHSE assurance over full year delivery) could result in lost DSF income. This creates a form of 'double jeopardy' in that **our** DSF could be lost due to our failure and/or the failure of others, and **our** failure could result in loss of DSF income for others. Whilst we have secured DSF for Q1 and Q2, we have a risk of losing £16m for H2. At the end of July, MFT is the only Trust in K&M with an adverse variance which means our System partners may lose their DSF too.
- **Cash**: Firstly, failure to address CIP targets (and control costs) means we will have insufficient cash to meet payments falling due. i.e. CIP shortfall leads to a failure to meet I&E plan (adverse expenditure), which means an expected loss of DSF (adverse income). We are squeezed in "I" and "E".
- **Old Year**: The Board have been apprised of the 2024/25 risks around MCH invoicing, Car Park VAT reclaim and cost of recovering the ENT backlog.

The risk to delivery of the 25/26 Plan remains high-significant. Our current spend run-rate is too high relative to the future expenditure Plan (~£4m all things remaining the same). To address the position, we continue with the following actions in place (in addition to continued effort to create cost reduction plans):

1. Vacancy controls, limiting external recruitment to essential posts only. This has been extended to the end of Sept 25 and will be assessed again closer to that date; a further extension may be put in place until expenditure is at a level consistent with planned income.
2. The process to accelerate savings delivery is underway with PA Consulting; focus on Corporate, clinical productivity and grip and controls.
3. Cash review meetings are operating on a weekly basis; including development of working capital action planning. There are now weekly system cash working group meetings and monthly South East region cash meetings.
4. The fortnightly Sustainability Recovery Group, chaired by the DCEO is now operational.

Simon Wombwell
Chief Finance Officer
August 2025

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

July - 2025

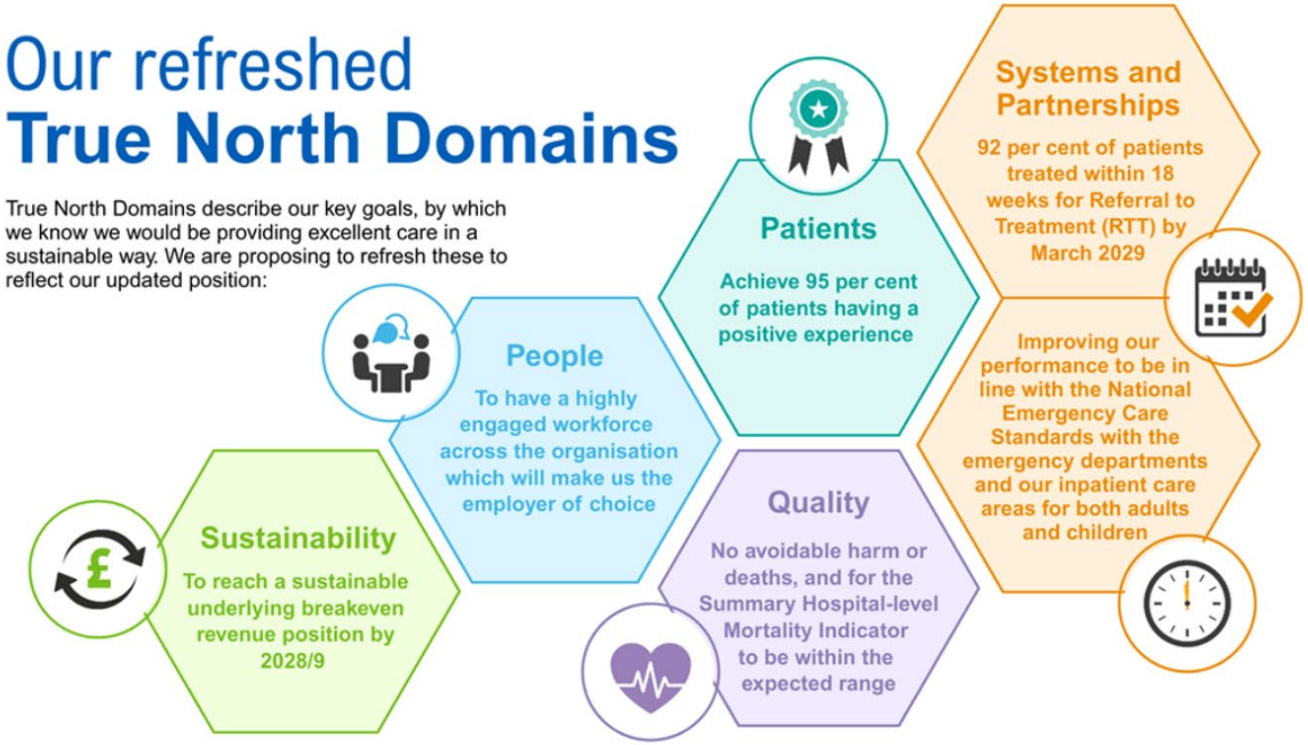
Patient FIRST

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	35	6	17	18	14
Quality	50	15	16	13	5	4
Patients	11	13	3	4	2	3
Systems & Partnerships	19	11	9	18	2	9
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
- Total Pay Spend (£) vs Budget
- Actual Worked FTE vs Budget

Executive Summary

Strategic Initiatives

Culture, Leadership and Behaviours
SRO - Sheridan Flavin, CPO

It's important that staff feel safe to speak up about concerns at work and line managers have a vital role in this. Therefore ensuring that managers are competent and skilled to support colleagues with concerns.

To upskill managers, we are providing mandated Management Essentials (ME) training and advanced ME training.

Current compliance levels are:
- ME 44% (191 staff trained)
- Advanced ME 38% (78 staff trained

Cultural Transformation programme has moved into the second phase of the work to identify deliverables to tackle the issues identified in phase 1 in relation to culture and violence and aggression against staff.

Patient First Improvement Programme
SRO - Siobhan Callanan, Deputy CEO

As part of our ongoing commitment to Patient First and delivery of our True North ambitions, we are undertaking a strategic review of organisational metrics.
Executive leaders review to identify essential metrics to retain and propose any new ones. Divisional leadership for validation, refinement, and the addition or removal of metrics where appropriate.

To strengthen clarity and purpose:
"**Driver metrics**" will remain, representing those that directly support our strategic objectives.
Watch metrics will be renamed to performance metrics, including agreed key operational indicators across the organisation.

Refined Reporting Structures
Performance Review Meetings (PRMs):
Divisional teams will report using a focused, exception-based model to prioritise escalation, accountability, and support.
Trust Leadership Team (TLT):
Executive Leads will present high-level progress using breakthrough objective A3s.
This revised model strengthens strategic alignment, enhances clarity in performance reporting, and reinforces our collective improvement focus.

Clinical Strategy
SRO - Alison Davis, CMO

Review and update following Year One of the Clinical Strategy has been approved by our Quality Assurance Committee. The update will be submitted to Board for approval in October.

This update highlights our celebrations as well as our new ways of working and aligning closely to the System Strategy, other local partners and the 2025 NHS 10 year plan

Access and Flow Productivity
SRO - Nick Sinclair, COO

RTT improvement work continues with improvements in most areas. Overall PTL size has reduced which impacts the overall performance percentage and we had impact from IA. 65 weeks continues to reduce and is now 85

ED Performance continues to decline with non-admitted performance declining. A recovery plan has been requested from the department
Ongoing work on flow continues with improvements in discharge

Digital, Data and Technology (DDaT)
SRO - tbc

Refreshed DDaT Strategy due for sign off. Successful delivery of the Strategy align to actions and progress against the main components.

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

Executive Summary

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Corporate Projects

Elective Reform

SRO - Nick Sinclair, COO

Key Deliverables:

- Continued improvement seen across all workstreams which brings the overall RTT position nearer to 55%
- Key highlights show significant improvements are being made
- training figures in validation are having an impact on the PTL
- Improved use of NHS APP by patients (92%)
- Focused work on patient experience whilst waiting to be seen
- Focused improvements in PSC with call abandonment rates

Previous 30 Days Focus:

- Continue to work towards the 60% RTT performance (55% funded)
- Key highlights show
- Daily PTL meetings within care groups reducing delays in decision making
- Twice weekly PTL focus with Divisional leads further improving performance
- Neon data and workstream progression with Clinical Leads
- IST Action Plan being developed

Next 30 Days Focus:

- Continue to work towards the 60% RTT performance (55% funded)
- Key highlights
- NEON now integrated into the Corporate Project workstream to present at TLT
- Each specialty to work through NEON data and clinically validate activity
- Prepare next steps for IST Action Plan

Reducing Length of Stay

SRO - tbc

Key Deliverables:

- Reduce to 6% type 1 12 hour waits in ED
- Improve to 80% ED total performance
- AMU LOS at 72 hours
- Improved decision making at board rounds to <LOS
- Improved Discharge Lounge population
- Improve EDN / TTO rejection rates and turn around times
- TeleTracking Optimisation focus on Occupied timer

Previous 30 Days Focus:

- Project discussed at TLT – Agreement that Nick Sinclair would take over as Exec Sponsor and refresh programme for H2
- Frailty SDEC paper discussions and escalations made within the Division to start review from ground up and utilise this process effectively going forward.
- Policy and SOP documents collated to support Criteria-Led Discharge implementation.
- EPR team engaged and discussions held on integrating CLD form into the system.
- Action Plan in development with PA Consulting

Next 30 Days Focus:

- Agree project plan and objectives with Nick Sinclair
- Finalise Actions with PA Consulting
- COO meeting with ED Care Group for recovery plan an trajectory

Medical Productivity

SRO - Alison Davis, CMO

Key Deliverables:

Job planning - Definition: Annual agreement on consultant/SAS doctor hours and activities (DCC, SPA, ANR, external duties).
Target: 95% job planning completion by March 2026 (NHSE directive)
Rostering and Rotas
Robust rostering and rotas for all levels of medical staff
Recruitment and Retention
Challenges: Difficulty attracting qualified doctors; reliance on locums and bank staff.

Previous 30 Days Focus:

Job planning – Completion of team job plans with review at consistency panel. Apportion PA target efficiencies to each clinical division
Rostering – review S&A rotas; presentations from e-rostering providers
Recruitment and Retention – Continue development of employee value proposition based on survey insights. Specific focus on consultant recruitment for hard to fill posts. Support for doctors pursuing specialist registration via Portfolio pathway as BAU. Review of support and training for locally employed doctors with Medical Education Department

Next 30 Days Focus:

Job planning - Complete apportioning pf PA target efficiencies to each clinical division. Work with PA consultancy to deliver efficiencies
Rostering – continuing review of S&A rotas; presentations from e-rostering providers. Work with PA consultancy to ensure all opportunities are identified.
Recruitment and Retention - Specific focus on consultant recruitment for hard to fill posts. Review of support and training for locally employed doctors with Medical Education Department

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X	X	X	
Title of Report	**Maternity and Perinatal Incentive Scheme – Year 7 Update Report July 2025**			**Agenda Item**	5.1
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
	• CNST Year 7 Published 02 April 2025 with reporting period ending 30 November and submission due 03 March 2026. • The following Safety actions are off track or at risk: • Safety Action 1 – remains off track with actions to deliver. Currently at 93% for Standard C due to non-return of factual information from another Trust. Anticipate will reach compliance in Q2 and Safety action will return to on track. • Safety Action 5 – At risk (2487 – Midwifery Workforce budget 2025 – Non-compliance with Birth-rate plus recommendations. (Score 16). • Safety Action 7 – Off track (2510 - Failure of ICB to extend the fixed term contract of the Maternity and Neonatal Voices Partnership Lead (Score 15). Awaiting outcome of ICB Strategic Commissioning Board review of options appraisal due to take place 31 July 2025. • All remaining safety actions are on track with reporting scheduled as per CNST requirements				
Proposal and/or key recommendation:	For noting - quarterly reporting is a core requirement for Safety Action 9				
Governance Route Meeting: Date submitted:	Maternity and Neonatal Safety Champion Assurance Board, 04 August 2025				
Identified Risks, issues and mitigations:	Risk: **2487 – Midwifery Workforce budget 2025 – Non-compliance with Birth-rate plus recommendations. (Score 16)** • This shortfall poses a significant risk to patient safety, quality of care, and compliance with national standards including the NHS Resolution Maternity Incentive Scheme (which would also have a significant financial and reputational impact on the Trust) and the Ockenden Review recommendations **Cause:** • Insufficient budget allocation for midwifery staffing. • Rising birth rates and increasing acuity of maternity cases. • Lack of alignment with Birthrate Plus® workforce planning tool. **Consequence:** • Increased likelihood of Red Flag events (e.g., loss of supernumerary status of Labour Suite coordinator). • Potential for delays in care, missed clinical deterioration, and adverse maternal or neonatal outcomes.				

	• Non-compliance with national safety and quality standards, including financial implications (non-refund of CNST premium in line with CNST Maternity Incentive Scheme) • Reputational damage and increased litigation risk. <u>Mitigations:</u> • Escalate to Board Level Safety Champions and Trust Board. • Raise risk on risk register • ADOM and Matrons to review workforce strategy and recruitment plans to support filling all existing vacancies, including external recruitment. • ADOM and Matrons to work with finance BP to review how to address WTE posts that were established in 2024/25 but are missing from 25/26 Budget. • Ensure safe staffing levels are maintained and utilise bank staff to mitigate any gaps. • Continue to staff to Birthrate Plus recommendations as a Divisional Overspend. • Work with Trust Board and Executive Team to develop an agreed plan to address the shortfall and establish the previously agreed budget. <u>Risk:</u> **(2510 - Failure of ICB to extend the fixed term contract of the Maternity and Neonatal Voices Partnership Lead (Score 15).** • Due to a clerical error, the Maternity and Neonatal Voices Partnership (MNVP) lead at MFT is on a fixed term contract with the ICB, due to expire 30 September 2025. Without a lead MNVP chair in post, MFT will not have a functioning MNVP and this will result in: • Failure to listen to the voice of the service user which may impact on the improvements, quality and safety of services, inability to triangulate service user experience with patient safety issues. • Failure to coproduce maternity and neonatal services. • Failure to meet the immediate responsibilities outlined in the letter from NHSE to Trusts in June 2025 in light of National Investigation into Maternity and Neonatal Services. • Failure to meet Safety Action 7 for CNST Year 7, resulting in overall failure of the incentive scheme. • Failure to meet the CNST Incentive scheme will mean the Trust does not receive a rebate on its CNST premium (10% of premium) • Reputational damage and loss of confidence from families. • Failure to meet MNVP national guidance. • Failure to meet requirements of theme 1 of the 3-year delivery plan. • Failure to deliver Kent and Medway equity and equalities action plan, therefore failing to improve the population health of those most disadvantaged. • Failure to meet the ambition of the 10-year plan. <u>Mitigations</u> • Escalate to Board Level Safety Champions, Trust Board and Executives. • Work with ICB colleagues to develop options appraisal paper to be presented to ICB Strategic Commissioning Group on 31 July 2025. Preferred option of all Trusts and Maternity and Neonatal Team within ICB is to maintain ICB as hosts of MNVP across the region.
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:	Perinatal Quality Quarterly Report – Q1 2025/26				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	k.harris4@nhs.net				

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X	X	X	
Title of Report	**Perinatal Quality Quarterly Report – Q1 2025/26**			**Agenda Item**	5.2
Author and Job Title	Kate Harris, Associate Director of Midwifery				
Lead Executive	Chief Nursing Officer				
Executive Summary	Approval		Briefing	X	Noting X

	• 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 Oversight Model (PQOM). (Safety Action 1 and Safety Action 9)
	• Monthly updates aligned with the minimum dataset of the PQOM are submitted monthly to QPSCC and QAC along with to every Trust Board.
	• This report provides quarterly oversight for 1 2025/26 and includes the following:
	  • Incidents
	  • Investigations
	  • PMRT
	  • Complaints
	  • Claims Scorecard
	  • Staff and Service User Feedback
	  • Perinatal Leadership
	  • Safeguarding				

Proposal and/or key recommendation:	For noting - quarterly reporting is a core requirement for Safety Action 9				
Governance Route Meeting: Date submitted:	Maternity and Neonatal Safety Champion Assurance Board, 04 August 2025				
Identified Risks, issues and mitigations:	Issues: • There is a significant theme of a disproportionate number of black women experiencing Postpartum haemorrhage (PPH) >1500mls and >2500mls in Q1 (59%), a trend which is also present in the previous 12 months of data (29%) – (Black women make up 9.93% of booking population). • Based on Q1 data, those living in Multiple Deprivation Decile Score (MDD) 1-5 represent 94% of the PPH's reviewed at Clinical Review Incident Group (GRIG) • Based on Q1 data, those living in MDD score 1-5 represent 89% of Term Admissions to the neonatal unit – 69% of booking population. • Based on Q1 data, 79% of Term Admissions are from White British families (70% of booking population) and 13% from black families. Mitigations: • Deep dive review of PPH data for past 12 months, looking at ethnicity, deprivation score, mode of delivery, management, risk status.				

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• Once clear understanding of larger data set, present findings to audit meeting and labour ward forum for consideration of targeted management pathway eg: Prophylaxis.
• Share findings with ATAIN team and review data to understand other contributory factors, eg: Mode of delivery, maternal co-morbidities, risk status, gestation. Develop actions according to findings.

<u>Issues:</u>
• Medication incidents continue to be a theme across the Neonatal Unit.

<u>Mitigations</u>
• Reducing medication errors is a Divisional Driver, with a significant number of counter measures in place to address concerns, with a downwards trend noted.

<u>Issues:</u>
• 7 neonatal deaths in quarter, including 2 babies who died at other Trusts.

<u>Mitigations:</u>
• Review of all cases by multidisciplinary Perinatal Mortality Review Tool (PMRT).
• 5 out of 7 cases from multiple pregnancies and 6 out of 7 <26 weeks gestation. 1 baby was below the threshold for viability.
• Internal learning events established and cross unit discussions to share insight from complex cases.
• Comprehensive review of care pathways for extreme preterm births and develop enhanced protocols for managing complex multiple pregnancies.
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<tr><td>Resource implications:</td><td colspan="4">N/A</td></tr>
<tr><td>Sustainability and/or Public and patient engagement considerations:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Integrated Impact assessment (please mark):</td><td>Yes</td><td colspan="2">No</td><td>N/A</td></tr>
<tr><td></td><td colspan="2"></td><td>X</td></tr>
<tr><td>Appendices:</td><td colspan="4">Perinatal Quality Quarterly Report – Q1 2025/26</td></tr>
<tr><td>Freedom of Information status (please mark):</td><td>Disclosable</td><td>X</td><td>Exempt</td><td></td></tr>
<tr><td>For further information please contact:</td><td colspan="4">k.harris4@nhs.net</td></tr>
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Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X			
Title of Report	**Guardian of Safe-working Hours Annual Report**			**Agenda Item**	5.3
Author and Job Title	Dr Shrawan Agrawal, Guardian of Safe-working Hours (GSWH) and Consultant Rheumatologist Anumesh Chandra, GSWH administrator				
Lead Executive	Alison Davis, Chief Medical Officer				
Executive Summary	Approval		Briefing	Noting	x
	The new Junior Doctor contract which was introduced in 2016 required all NHS Trusts to appoint a Guardian of Safe Working Hours (GSWH). The GSWH is independent of trust management structures with a specific remit to ensure that safe working practices for Post Graduate Doctors in Training are embedded. There is an annual requirement to provide a report on compliance with the contract to the Trust Board. The GSWH keeps the engagement from the Post Graduate Doctors in Training representatives at the highest possible level, the GSWH receives regular feedback and communication from the representatives. This is achieved by the GSWH contacting representatives as many as possible to hold regular discussions in post graduate doctor's forum meeting. These are held every 3 months, where various issues from post graduate doctors are being discussed. Resolutions are suggested in the same meeting or action logs are created and discussed in the next meeting. The GSWH has also been actively involved in the induction of new post graduate doctors where post graduate doctors get training on exception reporting. So far, no major issues have been noticed in the exception reporting and majority of small issues have been discussed and resolved, when they were raised in the postgraduate doctors' meetings. At post graduate doctor's forum, all post graduate doctors' representatives are invited and various issues raised by them have been tackled on a regular basis. We get the chance to discuss the number of exception reports in the previous 3-4 months periods. We discuss all the exception reports with immediate safety concern in details. Accordingly, appropriate actions are being taken with DATIX where needed				
Proposal and/or key recommendation:	N/A				
Governance Route Meeting: Date submitted:	Quality Assurance Committee – 08 September 2025				
Identified Risks, issues and mitigations:	None				
Resource implications:	N/A				

Sustainability and/or Public and patient engagement considerations:	None		
Integrated Impact assessment (please mark):	Yes	No	N/A
	X		
Appendices:	N/A		
Freedom of Information status (please mark):	Disclosable		Exempt	
For further information please contact:	Dr Shrawan Agrawal, GSWH, Guardian of Safe-working Hours and Consultant Rheumatologist shrawanagrawal1@nhs.net		

1 Executive Overview

1.1 The new Junior Doctor contract which was introduced in 2016 required all NHS Trusts to appoint a Guardian of Safe Working Hours (GSWH). The GSWH is independent of Trust management structures with a specific remit to ensure that safe working practices for Post Graduate Doctors in Training are embedded. There is an annual requirement to provide a report on compliance with the contract to the Trust Board.

2 Exception Reports

2.1 Exception reporting is a process that replaces the old “diary card exercise”, exception reports are submitted by a Post Graduate Doctor in training and Non-training Doctors, when their day-to-day work varies significantly from their agreed work schedule. The exception report is reviewed by the Doctor’s Educational Supervisor or by the GSWH, who decides whether to award Lieu or Overtime to the Doctor. If the Doctor wishes to have overtime payment, the Exception report must be logged within seven days. If the Doctor wishes to have ‘time off in lieu’ the report must be logged within fourteen days.

2.2 Exception Reports are recorded using an e-Rota system, provided by Medway NHS foundation trust. The report can relate to variations in hours worked, the pattern of work, missed educational or learning opportunities or lack of support available to the Doctor whilst at work. The Doctor has the option to flag up as an immediate safety concern if they wish.

2.3 During the period 01 August 2023 to 30 June 2025, the trust has received a total of 485 exception reports. The breakdown is below.

Exception Reports (ER) over past years		
Reference period of report	**01/08/22 – 31/07/23**	**1/8/23 – 30/6/25**
Total number of exception reports received	291	485
Number relating to immediate patient safety issues	8	10
Number relating to hours of working	241	411
Number relating to pattern of work	13	16
Number relating to educational opportunities	34	56
Number relating to service support available to the doctor	3	2

Resolution of exception reports		
Reference period of report	**01/08/22 – 31/07/23**	**1/8/23 – 30/6/25**
Total number of exceptions where TOIL was granted	104	220
Total number of overtime payments	84	203
Total number of work schedule reviews	12	15
Total number of reports resulting in no action	91	24
Total number of organisation changes	0	0
Compensation	0	0
Unresolved	9	10

Reasons for ER over past years by specialty			
ER relating to:	**Specialty**	**Reference period of report**	
		01/08/22 – 31/07/23	**1/8/23 – 30/6/25**
Immediate patient safety issues	General medicine	5	8
	Paediatrics	1	0
	Urology	2	0
	Cardiology	0	1
	Gen Surgery	0	1
Total		**8**	**10**
ER relating to:	**Specialty**	**Reference period of report**	
		01/08/22 – 31/07/23	**1/8/23 – 30/6/25**
No. relating to hours/pattern	General medicine	116	200
	Acute medicine	5	0
	General Surgery	76	91
	Haematology	0	1
	Obstetrics and gynaecology	8	14
	Otolaryngology (ENT)	10	4
	Paediatrics	11	26
	Respiratory Medicine	0	3
	Trauma & Orthopaedic Surgery	17	33
	Urology	4	7
	Geriatric Medicine	6	4
	Accident & Emergency	3	12
	Cardiology	1	28
	Anaesthetics	1	1
	Neonatology	1	0
	General Practice	0	3
Total		**259**	**427**

No. relating to educational opportunities	Acute Medicine	0	0
	Anaesthetics	0	0
	General Medicine	17	40
	General Surgery	6	11
	Geriatric Medicine	1	0
	Obstetrics and gynaecology	5	0
	Trauma & Orthopaedic Surgery	0	4
	Urology	0	1
	Paediatrics	4	0
	Accident & Emergency	1	0
Total		**34**	**56**

No. relating to service support available	General Medicine	3	1
	General Surgery	0	1
Total		**3**	**2**

Reasons for ER over past years as per grades				
ER relating to:	**Specialty**	**Reference period of report**		
		Grade	**01/08/22 – 31/07/23**	**01/08/22 – 31/07/23**
Immediate patient safety issues	General medicine	FY1	3	3
	General medicine	FY2	0	1
	General medicine	CT1	0	1
	General medicine	CT3	1	3
	General medicine	ST4	1	0
	Paediatrics	FY1	0	0
	Paediatrics	FY2	1	0
	Urology	FY1	1	0
	Urology	FY2	1	0
	Cardiology	FY1	0	1
	General Surgery	FY1	0	1
Total			**8**	**10**

No. relating to hours/pattern	General medicine	CT1	10	29
	General medicine	CT2	7	8
	General medicine	CT3	2	2
	General medicine	FY1	90	145
	General medicine	FY2	2	10
	General medicine	ST1	0	2
	General medicine	ST4	0	4
	General surgery	CT1	0	2
	General surgery	FY1	63	68
	General surgery	FY2	13	21

	Geriatric medicine	CT2	0	1
	Geriatric medicine	FY1	6	3

ER relating to:	Specialty	Grade	01/08/22 – 31/07/23	01/08/22 – 31/07/23
No. relating to hours/pattern	Obstetrics and gynaecology	FY2	0	4
	Obstetrics and gynaecology	ST1	2	5
	Obstetrics and gynaecology	ST2	0	1
	Otolaryngology (ENT)	FY2	4	4
	Otolaryngology (ENT)	ST1	6	0
	Paediatrics	FY1	7	15
	Paediatrics	FY2	1	5
	Paediatrics	ST1	2	1
	Paediatrics	ST2	0	4
	Paediatrics	ST7	1	0
	Paediatrics	ST8	0	1
	Respiratory Medicine	FY1	0	2
	Respiratory Medicine	FY2	0	1
	Trauma & Orthopaedic	FY1	12	8
	Trauma & Orthopaedics	FY2	5	25
	Urology	FY1	4	4
	Urology	FY2	0	3
	Accident & Emergency	FY1	1	0
	Accident & Emergency	FY2	0	10
	Accident & Emergency	ST1	1	2
	Accident & Emergency	ST2	1	0
	Acute medicine	FY1	5	0
	Anaesthetics	FY2	0	1
	Anaesthetics	ST2	1	0
	Cardiology	FY1	0	28
	Cardiology	ST3	1	0
Total			**254**	**427**

ER relating to:	Specialty	Grade	01/08/22 – 31/07/23	01/08/22 – 31/07/23
No. relating to educational opportunities	General medicine	CT1	1	0
	General medicine	CT2	1	0
	General medicine	CT3	2	0
	General medicine	FY1	12	28
	General medicine	FY2	1	11
	General medicine	ST1	0	1
	General surgery	FY1	3	6
	General surgery	FY2	2	5
	General surgery	CT2	1	0

	Geriatric medicine	FY1	1	0
	Obstetrics and gynaecology	ST1	5	0
	Paediatrics	FY2	1	0
	Paediatrics	ST1	3	0
	Trauma & Orthopaedic	FY2	0	4
	Urology	FY1	0	1
Total			**34**	**56**
No. relating to service support available	General medicine	FY1	1	0
	General medicine	CT3	0	1
	General medicine	ST4	2	0
	General surgery	FY1	0	1
Total			**3**	**2**

2.4 The trust received a total of twelve Exception Reports which were recorded with 'Immediate Safety concern'. Upon review, not all reports were with immediate Safety concerns. Majority of these were due to lack of enough staffing on that day. All were reviewed and an outcome was provided in each case. In one case, DATIX was completed to investigate this in detail. This was investigated by the 'interim divisional governance lead in medicine and emergency medicine'. Fortunately, none of the patients came to harm as per his investigation. In another case, it was discussed how to get locum cover out of hours, in last moment sickness.

3 'POST GRADUATE DOCTORS IN TRAINING' FORUM

3.1 The GSWH has continued to hold regular 'Post Graduate Doctors in Training' Forums. These generally occur quarterly. The attendance of these meetings consists of the Chief Medical Officer, Medical Staffing leads, Medical Education Leads, a representative from the BMA, Post Graduate Doctors in Training Representatives. During the meeting, the GSWH raises any concerns if reported within an exception report.

3.2 The Post Graduate Doctors in Training representatives also raise any concerns that their training colleagues have shared with them. This can range from short notice of rotas being distributed or educational issues. If these are raised during the forum, a resolution is provided or added to the action log to be discussed at the next forum. Despite attendance, the forum minutes and action log is shared with all invited for this meeting, so that all can stay up to date with issues.

3.3 Since COVID-19 pandemic the meeting has been held virtually. This has benefited the 'Post Graduate Doctors in Training' as they are able to attend from any location.

3.4 Currently, exception reports can only be submitted by post graduate doctors in training. Some hospitals have now also included LEDs (Locally employed doctors) who can submit exception reports, and some hospitals are in process of doing so. It was discussed in the residents' doctors meeting at MFT few months ago. MFT is also planning, how LEDs can submit exception reports. This will hopefully help in maintaining the safe hours for all our resident doctors, as well as maintaining patients' safety.

3.5 There are some changes in exception reporting going to happen this year called 'Exception reporting reforms. This must be implemented by 12th September 2025 by all the NHS trusts in England. We are planning beforehand, so that it can be implemented fully here at MFT.

4 Engagement of 'Post Graduate Doctors in Training'

4.1 Currently the trust has a good level of engagement from various trainee representatives who participate actively in bringing up various issues, if our post graduate doctors are facing. They attend and participate in 'residents doctor meeting' held every 3 months.

5 Engagement of Educational Supervisors

5.1 Engagement of educational supervisors has been generally mixed, but with the new 'exception reporting reforms', there will not be much direct involvement of educational supervisors in authorisation of exception reports.

6. Conclusion and Next Steps

6.1 The GSWH will keep the engagement from the Post Graduate Doctors in Training representatives at the highest possible level. The GSWH receives regular feedback and communication from the representatives. This is achieved by the GSWH arranging quarterly postgraduate doctors meeting, where various issues are raised by post graduate doctor's representatives, faced by various trainees. The GSWH also deals and escalates any issues faced by the trainees, if come to notice.

6.2 MFT is looking into steps, so that LEDs can also submit exception reports. We are looking into the process and the cost involved. We welcome this step, so that we can monitor the safe hours for our LEDs and for patient safety.

6.3 MFT is looking into the steps we should take, so that the new 'exception reporting reforms' can be implemented fully from September this year.

Trust Board Meeting in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X			
Title of Report	**Medical Appraisal and Revalidation Annual Report**			**Agenda Item**	5.4
Author and Job Title	Jeremy Davis, Deputy Responsible Officer Janet Bradford, Interim Revalidation Manager				
Lead Executive	Alison Davis, Chief Medical Officer and Responsible Officer				

Executive Summary	Approval	X	Briefing	X	Noting	X

This annual report outlines Medway NHS Foundation Trust's performance and compliance with statutory requirements for medical appraisal and revalidation for the year ending 31 March 2025.

Assurance Statement:
The Trust remains fully compliant with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013), and continues to strengthen its governance and assurance processes. Subject to board approval of this report, a positive statement of assurance will be submitted to NHS England in October 2025.

Key Leadership Updates:
- Interim Chief Executive Officer appointed – April 2025
- Interim Chief People Officer appointed – July 2025
- A second Deputy Chief Medical Officer was appointed in May 2025, enabling the existing DCMO to provide greater support to appraisal and revalidation functions.

Revalidation Summary:
- **122** submissions made to GMC
- **111** positive recommendations
- **11** deferrals (9: insufficient evidence, 2: ongoing processes)
- The **9%** rolling deferral rate was lower than the NHS Acute Trust average of 14%.

Appraisal Summary:
- Appraisal compliance remains strong:
- **587 appraisals** were completed on time.
- **4 appraisals** were missed with prior approval (e.g. maternity leave, sabbatical).
- **4 appraisals** were delayed without prior approval but completed in April 2025.
- This marks an improvement from the previous year's **11 unapproved missed appraisals**, reflecting better monitoring and follow-up.

Governance and Oversight:
- The **Chief Medical Officer Decision-Making Group** meets bi-weekly to manage concerns under MHPS, liaising with NHS Resolution and the GMC.

	• External Quality Assurance was conducted by Miad Healthcare (Jan–Mar 2025), with recommendations now being actioned. **Training and Development** • Appraiser training delivered to 40 doctors (new and refresher sessions) • Responsible Officer newsletter and MS Teams Appraiser Forums introduced • Ongoing coaching for doctors with incomplete appraisal histories **Completed 2024–25 Actions:** • Appraiser training (new and refresher) delivered in 2024/25 • External Quality Assurance review by Miad Healthcare completed in March 2025 • Strengthened internal communications through appraiser forums and bi-annual newsletter • Appraisal delays followed up more robustly with improved compliance • Team strengthened: new DCMO, appraisal administrator, and senior appraiser roles now embedded **Ongoing / Carried Forward Actions for 2025-2026** • Improved mechanisms for governance to identify doctors in SI/PSIRF/legal claims- action plan in place • Continuous appraiser training and capacity review – funding approved and training booked for October/November 2025 • Implementation Miad QA recommendations – Action Plan established and progressing well • Review HR processes for bias/discrimination -data review from workforce and GMC for our Designated Body (appendix 1 - *1DV)* • Enhance MHPS NED support capacity via additional NED training • Implement GMC regulations for Physician and Anaesthetic Associates **Conclusion:** The Trust has demonstrated strong engagement from its medical workforce and continues to enhance its medical appraisal and revalidation systems.
Proposal and/or key recommendation:	The Board / executive management team of ***Medway NHS Foundation Trust*** is required to review content of this report in order to confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). The Board is asked to review and confirm compliance with regulatory requirements.
Governance Route Meeting: **Date submitted:**	People Committee 22 July 2025 Trust Board 10 September 2025
Identified Risks, issues and mitigations:	No risks have been identified.
Resource implications:	No additional resources required.

Sustainability and/or Public and patient engagement considerations:	N/A				
Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2024 - 25				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Name: Janet Bradford Job Title: Revalidation/CMO Team Email: met-tr.Revalidationmedway@nhs.net				

1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2024-2025 reporting year. This report is a required item of assurance, and we are also required to submit a compliance statement, signed off by or on behalf of the Board. We are able to positively respond to all assurance statements, as we are compliant with all regulatory requirements.

For noting there is a newly appointed interim Chief Executive Officer from April 2025 and Interim Chief People Officer from July 2025.

2 Background

The GMC's aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body that monitors and assures their practice. MFT is a Designated Body for circa 586 doctors (varies throughout the year because of leavers/joiners) and this report is about them. This report does not cover doctors who are deanery resident trainees as their designated body is Health Education England, and their RO is the HE KSS Postgraduate dean.

3 List of Attached Documents

Appendix 1 – Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2024 - 25. This Framework is used across all designated bodies to enable a consistent approach for Boards to Quality Assure their appraisal and revalidation systems. Each section in the appendix relates to specific items set out in the Responsible Officer regulations 2010 amended 2013.

4 Revalidation

For the year ending 31 March 2025, a total of 122 revalidation submissions were made, out of which 111 positive revalidation recommendations were sent to the GMC during the reporting year. 11 deferral recommendations were sent. Of the 11 deferral recommendations submitted 9 were for insufficient evidence and 2 were as a result of an ongoing process. The insufficient evidence group includes Dr's who have has career breaks, or who have had periods working outside the UK.

5 Appraisal

The overall appraisal rate at MFT remains stable:

- 587 appraisals were completed on time.
- Of those which were missed, they are divided into approved missed (agreed in advance that the appraisal would not take place in the year covered in the report) and unapproved where the appraisal was late. In most unapproved instances the appraisal was two or three months late, but this delay was enough to take the completion into the 25/26 reporting year.

- 4 appraisals were approved missed appraisals:
    - 1 Closed as overseas sabbatical
    - 3 Closed as a result maternity leave.
- 4 had unapproved missed appraisals during the reporting period which were eventually completed in April 2025.

The number of unapproved appraisals for this reporting year has improved from the last reporting period of 2023-2024 which was 11. This reflect changes in the way delayed completion of appraisals are monitored and followed up.

General review of last year's actions

Completed Actions: The following actions were completed from the Board Report 2022-2023

- Funding was made available to complete a new appraiser training session in September 2024 to replace those who have retired or who wish to step down as an appraiser.
- SOP for MPIT RO to RO transfer of Information was competed in January 2025
- Reviews of appraisals have identified some new connected doctors do not always have robust appraisal history from previous organisations and sometimes key elements are not completed to the standards set at MFT. Further support is provided to these doctors through 1-1 coaching and mentoring and this will continue in 2025 -2026.
- Provision of New Appraiser Training for 20 doctors in September 2024 (and another 20 in April 2025)
- Provision of Appraiser refresher training for 40 doctors -for organisational reasons this was delivered in May 2025
- External Quality Assurance review was carried out by Miad Healthcare January - March 2025 (see Appendix 1 for summary of recommendations)
- An additional Deputy Chief Medical Officer (DCMO) was appointed May 2025, allowing the Deputy RO (DCMO) to concentrate on revalidation and appraisal
- Introduction of a regular Responsible Officer newsletter with the support of the Trust communications team
- Implementation of Appraiser Forums on MS Teams twice yearly

Incomplete Issues

- The process for identifying doctors in SI reports / PSIRF reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal.

Current Staffing:

- An incoming Head of Chief Medical Officer Service & Senior Workforce Manager was appointed full time in September 2024 to replace previous post holder who retired
- The Medical Revalidation Manager left in June 2025 following maternity leave, therefore, a review of administrative staffing establishment is currently taking place
- A B6 Interim Manager who has been in the team since February 2023 covering for the period of maternity leave for up to 22.5 hours per week and from June 2025 7.5 hours per week
- A B4 full time Medical Appraisal Support Administrator was recruited and joined the team in April 2024 primarily for appraisal and revalidation but also offering support for the CMO office and is now well established in the team
- 2 Senior Appraisers have been in place since 2023/24, are well established and have both undertaken Responsible Officer training

Actions Carried Forward:

- The process for identifying doctors in SI reports/PSIRF, Datix, and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and

legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal.

New Actions/Ongoing:

- To provide training for new appraisers – as a continuum .
- Provide appraiser refresher training for existing appraisers – as a continuum .
- Ongoing monitoring and review of resources to be regularly undertaken.
- Work further ahead with Revalidation preparation, ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by the GMC.
- To review the number of Non-Executive Directors NED's able to support Maintaining High Professional Standards (MHPS) investigations, working with the Trust secretary re this. Once new NED's able to support MHPS have been identified, we will provide appropriate training.
- To review the ROAG and CMO team HR processes to ensure that there is assurance that these are free from bias and discrimination.
- Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances e.g. maternity leave).
- To provide a detailed action log and plan for the recommendations following the Miad Healthcare Quality Assurance review January – March 2025
- To implement new regulations regarding the registration of Physician and Anaesthetic Associates (PA & AA) and any subsequent appraisal and revalidation processes - currently we have 8 PA's in post

Overall conclusion:

We have continued to strengthen our appraisal and revalidation process, and the governance of medical staff. This has further been supported by the external Quality Assurance conducted by Miad Healthcare January - March 2025 (see Appendix 1 for summary of recommendations)

There is overall good engagement from our doctors.

Appendix 1

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

1A – General The board/executive management team of Medway NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	**Continue to Review Resources for the RO team**
Comments:	Alison Davis remains as Responsible Officer with Jeremy Davis remaining as Deputy Responsible officer. Both are trained licensed medical practitioners. We have 2 senior appraisers in post since 2023/24 and are well established. Both have undertaken Responsible Officer training. For noting there is a newly appointed interim Chief Executive Officer from April 2025, and an interim Chief People Officer from July 2025.
Action for next year:	To provide ongoing support and review and evaluate the correct ratio of senior appraisers to number of doctors on our Designated Body

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Comments:	Yes
Action from last year:	To provide current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them. To ensure that the administrative team is optimally resourced to manage the increased demands/task associated with the increase in the number of prescribed connections (586+) excluding Dentists
Comments:	**Completed:** One New Appraiser Training session took place in April and September 2024 and another session is planned for later in April 2025. An Appraiser Refresher Training session took place in October 2024 and more training planned for May 2025

Action for next year:	To provide current appraisers with Refresher training, this will be delivered by e-learning modules to ensure that the Appraisers can complete the modules at a time convenient for them. Funding will be available to complete a new appraiser training session in 2025/26 to replace those who have retired or who wish to step down as an appraiser.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None Identified
Comments:	The Human Resources Department/Medical Staffing provides the Chief Medical Officer's office with a weekly list of all new non-training grade doctors, together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC connection list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. Doctor's in training (Resident) do not have a prescribed connection with MFT. When the weekly staff in post list is received, this is cross-checked with the Appraisal system to ensure that no Doctors have been missed.
Action for next year:	To continue as before.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	The Medical Practice Information Transfer (MPIT) Standard Operating Procedure (SOP)
Comments:	**Completed:** SOP ratified in January 2025 and now published on Trust policy system
Action for next year:	To review efficacy by checking that all MPIT requests sent to other organisations were received back and that in the case of any delays the agreed escalations were followed

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	A review of this action by the Responsible Officer will take place during 2023-2024 to determine best practice moving forward.
Comments:	**Completed:** originally planned for 23/24 this was completed in 24/25.

	External Quality Assurance review conducted by Miad Healthcare January – March 2025 (see Appendix 1 for summary of recommendations)
Action for next year:	To develop an action plan and implement recommendations following the review.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Ongoing monitoring and review of resources to be regularly undertaken.
Comments:	**Completed:** The appraisal platform L2P has the relevant information to help completion of appraisal under the resources section. Non-training grade Trust doctors and doctors working on MFT employment bank undertake an Annual appraisal. All doctors with a prescribed connection to MFT as Designated body are connected on GMC Connect and added to MFT appraisal system L2P. New doctors are invited to the appraisal training and are sent all the necessary information for them to carry out an appraisal. Regular appraisee training sessions have been provided by Deputy Responsible Officer, Senior Appraiser and Revalidation team including one to one coaching, to all doctors new to UK and any doctor who is new to the appraisal system. Revalidation team also offer all the support needed for completion of appraisals, including facilitating collection of patient and colleague feedback. The Revalidation Team receives a weekly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role.
Action for next year	Ongoing.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Review of existing process and agreement to identify which Doctors are associated with specific SI's, with appropriate governance teams for improving the process has been identified as a key improvement needed for 2023 - 2024. MFT Governance team

	are introducing a new DATIX Style system which may help assist with appraisal complaints.
Comments:	**Partially completed:** The process for identifying doctors in SI /PSIRF/ Datix reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal. All Doctors are required to complete an appraisal every year containing supporting evidence on their full scope of work. If a doctor works outside MFT in any capacity as a medical doctor, the doctor is required to complete an Annual Declaration form duly signed and confirmed by RO/hospital Director from the Private Hospital or other organisations where they practice. We provide 'Dr Foster' reports on request that can be included into appraisals
Action for next year:	The process for identifying doctors in SI reports and those involved in legal claims and passing this information to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	None
Comments:	There is a monthly process of reviewing delayed appraisals with the Deputy RO and if required taking direct action with GMC REV6 early concerns submissions. This has demonstrated tangible improvements with appraisal compliance
Action for next year:	Continue with this process

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	None
Comments:	**Completed:**

	Policy approved by the Trust Executive Board in November 2023 and now active and has been reviewed for relevance to legislation and practice
Action for next year:	Ensure it remains relevant to current practice and NHSE/GMC guidance

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	1) To provide two dates of New Appraiser training for 20 doctors each session. 2) Review of current appraiser list to a) Clarify which appraisers are job planned for this activity b) Clarify inactive/low activity appraisers (those who have undertaken less than three appraisals in the past year) with a view to removing these from the appraisal list (unless due to reasonable circumstances e.g. maternity leave).
Comments:	**Completed:** The Trust had 143 trained appraisers including 2 external appraisers trained appraisers on 31st March 2025. Not all are job planned to undertake appraisals, and of those that are the majority of our appraisers complete 5 appraisals on a rolling annual basis and generally no more than one per month.
Actions for next year:	Ongoing

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2023-2024 year.
Comments:	**Not Completed:** The new appointment of an additional DCMO will free up capacity for the Deputy RO to work with the senior appraisal team to conduct this review

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	The Lead Appraisers are trained at Responsible Officer training events to garner a full understanding of their role. The RO, Deputy RO and managerial support team attend regional appraisal network events at least once per year. Following on from the recommendation from the External Q&A we will use the PROGRESS QA Template audit tool.  PROGRESS QA template.pdf
Action for next year:	Deputy Responsible Officer and Senior Appraisers will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 20% of appraisers within the trust for the 2025-2026 year.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To continue presenting yearly report to Board for compliance.
Comments:	**Completed:** There is an ongoing process to support revalidation including the Responsible Officer Advisory Group meetings and the HR Decision Making process to ensure appraisal and revalidation is operationally supported throughout the year. The Trust Policy has been reviewed to ensure it is following best practice. There is an annual report which goes to the People Committee and then the Board to provide assurance that revalidation processes are safe and effective.
Action for next year:	To continue presenting yearly report to Board for compliance.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	To review policy to incorporate identified changes.

Comments:	**Completed:** For 2024 – 2025 we continue to adhere to the changes (2022) for under notice period for Recommendations, monthly Responsible Officer Advisory Groups (ROAG) meetings have taken place, in which Doctors under notice are reviewed to ensure GMC requirements are adhered to.
Action for next year:	Work further ahead with Revalidation preparation ensuring all Doctors within the 12 months under notice period are discussed as soon as they are placed under notice by GMC.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	To continue with the correct processes in place to support Revalidation Recommendations.
Comments:	**Completed** The Responsible Officer Advisory Group (ROAG) provides a structure for reviewing all revalidation recommendations and ensures all recommendations and deferral recommendations are complete in good time.
Action for next year:	To continue with the correct processes in place to support Revalidation Recommendations.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal.
Comments:	**Partially Completed:** The revalidation team continues to monitor information on complaints/SI/PSIRF/ Datix for inclusion in medical appraisal. Key aspects of clinical governance for the RO are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems. The process for identifying doctors in SI reports and those involved in legal claims coming to the revalidation office is still a concern. The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal.

	All Consultants, Specialty Doctors and doctors (not in a formal training programme) are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a regular basis by the Revalidation team to ensure that progress in meeting these deadlines is being maintained.
Action for next year:	The Trust governance structure and legal claim structures do not currently support identification of individual clinicians in a form that can be shared with the appraisal team. Other Trusts are in a similar position but this remains an action for 2025/26 to allow an A3 process to pursue this goal.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	To continue biweekly decision-making group meetings to discuss and action any conduct/capability issues of doctors. To update the terms of reference for the decision-making group.
Comments:	**Completed:** Conduct and performance issues are reviewed at the biweekly Decision-Making Group. This includes triangulating information received from HR processes, complaints/SIs/Never Events and regular weekly meetings of Chief Medical Officer with Deputy Chief Medical Officer and Divisional Medical Directors. Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. This is monitored and there is an escalation process to ensure MPIT references are received and reviewed. The team receives regular requests from Independent sector providers to complete practicing privileges references and share relevant information to the RO of the organisation where Dr's undertake work in the independent sector. All doctors are required to include reports of any SIs/Datix/Complaints in which they were involved during the appraisal year, with appropriate reflections and learning. All doctors are required to undergo formal Multisource feedback both from Colleagues and Patients once in the 5 yearly revalidation cycle. All doctors are encouraged to share and reflect any compliments received (including thank you cards and feedback received from patient experience team) during every appraisal discussion.

	Training grade Doctors (Resident) have a Postgraduate Dean at NHSE KSS Deanery (Kent, Surrey and Sussex) as their Responsible Officer. While they are working in MFT, the Doctors have regular work placed based assessments by their named Educational and Clinical supervisors and their performance discussed and documented in the quarterly Local Faculty Group and Local Academic Board meetings. Any identified concerns are flagged up to NHSE KSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at NHSE KSS.
Action for next year:	Ensure that for deanery trainees educational supervisors are assigned in keeping with specialty job plans, and for Trust CTF's and MTI's educational supervisors are also assigned in keeping with specialty job plans

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None required as ongoing.
Comments:	We have used L2P appraisal system since 2012 and are able to ensure the system incorporates any requested updates to comply with Good Medical Practice 2024 or any local requests to ensure the system is user friendly.
Action for next year:	Ongoing.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	The number of Case Investigators is insufficient for MHPS Investigations. **Completed:** we now have a total of 20 Case Investigators and additional 6 were trained in 2024/25.

Comments:	**Action Completed:** The Chief Medical Officer / Responsible Officer chairs the Decision-Making Group, which meets bi-weekly to review all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the GMC as required in each case. The Deputy Responsible Officer, Head of Medical Director Services and a member from HR attend this meeting. Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified, these are then managed under the appropriate Trust policy. Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy. Concerns raised via the Freedom to speak up Guardian service are also included in this process. The Trust now has 20 trained Case Investigators and 11 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed. All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance. As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate.
Action for next year:	The Trust will train 3 more Case Managers and are planning to provide training in conjunction with NHS Resolution Service (formerly the National Clinical Assessment Service) and other local Kent NHS organisations.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Nil

A senior team including the Chief Medical Officer (RO), Deputy Chief Medical Officer, Head of Employee Relations and Head of MD services meets on a biweekly basis to review concerns about doctors and decide on appropriate actions. Investigations where required, are undertaken under MHPS guidelines, using appropriately trained Case Manager and Case Investigators, following discussion with NHS Resolution Practitioner Performance Advice (PPA).

Deanery doctors in training posts are connected to Health Education Kent, Surrey and Sussex (HE KSS) and their RO is the Postgraduate Dean of HE KSS. Any concerns are flagged via the Director of Medical Education at MFT.

The following table outlines the number and outcome of cases reviewed by the Decision-Making Group (non-training doctors connected to MFT Designated Body) in the reporting year. *Figures in brackets show percentage*

2024 – 2025 – issues managed within the CMO Decision-Making Group	White	BAME	Male	Female	Total
Outcome					
Reviewed and no case to answer 2024 - 25	1 (14)	6 (86)	6 (86)	1 (14)	7
2023 - 24	0 (0)	9 (100)	9 (100)	0 (0)	9
Reviewed and advice given regarding future conduct 2024-25	2 (22)	7 (78)	9 (100)	0 (0)	9
2023 - 24	2 (40)	3 (60)	5 (100)	0 (0)	5
Reviewed and advice given regarding improving performance (capability) 2024-25	0 (0)	1 (100)	1 (100)	0 (0)	1
2023-24	–	–	–	–	0
Reviewed and managed by other HR policy (grievance, Dignity at work, sickness) 2024-25	0 (0)	1 (100)	1 (100)	0 (0)	1
2023-24	5 (38)	8 (62)	11 (85)	2 (15)	13
Formal MHPS investigation 2024-25	1 (14)	6 (86)	5 (71)	2 (29)	**7**
2023-24	0 (0)	2 (100)	2 (100)	0 (0)	**2**
Total 2024-25	4 (16)	23 (84)	23 (88)	3 (12)	**25**
2023-24	7 (24)	22(76)	27(93)	2 (7)	**29**

2024-25 issues managed within the CMO Decision-Making Group	UK	EEA	Other IMG
Country of original medical qualification			

GMC Connect, the main GMC reporting system used by the revalidation team, does not provide detail on ethnicity but does provide detail on country of primary medical qualification. Medway NHS FT has a higher proportion of non-UK graduates (excluding deanery doctors in training who are excluded from these figures as their RO connection is with the deanery) than the average for all NHS acute trusts (GMC figures, July 2025).

Medway	UK	EEA	Other IMG
Medway Number	59	106	421
Medway Percentage	**10%**	**18%**	**72%**
All NHS Acute Trusts – Percentage	**46%**	**10%**	**44%**

Background Workforce data produced October 2024 mid reporting year for ALL Medical Staff MFT. We have not been able to obtain data excluding deanery trainees.

ETHNICITY

	Cons		Non-consultant		Medical Trainees		TOTAL
.	contract	bank	contract	bank	contract	bank	
White - British	16.3%	16.3%	11.3%	21.1%	5.8%	14.8%	**12.1%**
White - Irish	0.4%	0.0%	0.0%	5.3%	0.5%	1.5%	**0.9%**
Any Other White Background	9.8%	4.1%	10.6%	7.0%	4.0%	5.1%	**6.3%**
Any Other Mixed Background	5.7%	2.0%	2.0%	3.5%	3.5%	3.8%	**3.8%**
Any Other Asian Background	44.1%	49.0%	31.1%	26.3%	34.2%	22.3%	**32.4%**
Any Other Black Background	4.9%	0.0%	20.5%	21.1%	15.1%	17.9%	**14.4%**
Any Other Ethnic Background	8.2%	6.1%	6.0%	5.3%	6.3%	5.4%	**6.3%**
unknown/unspecified	10.6%	22.4%	18.5%	10.5%	30.7%	29.2%	**24.0%**
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

GENDER

	Cons		Non-consultant		Medical Trainees		TOTAL
.	contract	bank	contract	bank	contract	bank	
Male	72.2%	73.5%	58.9%	68.4%	45.3%	45.5%	**54.0%**
Female	27.8%	26.5%	41.1%	31.6%	54.7%	54.5%	**46.0%**
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Summary of Data for Medical workforce where Ethnicity recorded	White	BAME (inc. mixed background)	Unknown ethnicity	Male	Female
All Medical workforce	19.3	56.7	24.0	54.0	46.0
All Medical workforce excluding unknown	25.4	74.6	(Excluded)	54.0	46.0

Action for next year:	To include in the analysis of Dr's reviewed in the CMO Decision Making Group an analysis of country of medical qualification. To work with the Head of equality and Inclusion to clarify the data excluding deanery trainees. To work with the Head of Equality and Inclusion to understand why individuals from some protected characteristic groups are more likely to be reviewed, and consider how this can be mitigated.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	To continue with the current process set in place.
Comments:	Upon connecting a Doctor to the designated body, a RO to RO reference request is sent to the previous designated body. Dependent on the information shared, more details may be requested which can result in a RO to RO conversation to elaborate further. All doctors who work in other places are required yearly to produce a signed form from RO/Hospital Director of the other organisation (s) about their practice and any concerns regarding their practice. This form is uploaded to their medical appraisal every year. For doctors connected elsewhere but working in MFT fall under two categories: Training grade doctors are regularly monitored by their educational supervisors and any concerns raised are dealt with through the Local faculty groups chaired by the specialty College Tutors and the Local Academic Board chaired by the Director of Medical Education and escalated to RO of HEKSS and the RO at MFT is updated immediately for any necessary actions. Other groups of doctors who may work in MFT could be bank doctors or contracted through agencies and have their own RO. The Revalidation team would contact their designated body if any concern arises. The Medical Practice Information Transfer (MPIT) Standard Operating Procedure (SOP) was ratified in January 2025
Action for next year:	To continue with the current process set in place.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Nil

Comments:	All processes for responding to concerns are managed according to our Trust Policy Maintaining High Professional Standards Policy. This policy was renewed in 2024 and included specific assurance that the Case Manager will use The NHS England 'Just Culture Guide' as part of the decision-making process where the concern relates to a patient safety incident. The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events are conducted where needed to clarify whether causes are more broadly based and can be attributed to systems or organisational failures or demonstrate that there were untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each incident will require appropriate investigation and remedial actions. The Trust actively promotes an open and fair culture, which encourages practitioners and other NHS staff to report adverse incidents and other near misses. To support Case Managers the Trust has trained Case Investigators to ensure appropriate processes. Whilst care is taken to avoid potential bias and discrimination when cases are considered by our Senior Team, it is recognised this process could be strengthened. Historically there was NED involvement in the ROAG process, but that has lapsed.
Action for next year:	Review of the ROAG and biweekly CMO HR processes to strengthen assurance that processes are free from potential bias and discrimination, by working with the Trust Head of Equality and Inclusion to plan this work

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Nil.
Comments:	The Trust has a robust educational infrastructure in place including weekly Grand Rounds. Appraisers are supported in ensuring that Personal Development Plan (PDP's) are relevant, challenging and specific. Quality Improvement Activities (QIA) remain an integral part of the appraisal process and reviewing external and national data encouraged. Doctors are encouraged to provide clinical performance evidence for various external facilities such as Dr Fosters or similar.

	The Trust operates a Patient First philosophy which is fundamental to the Trust strategy/culture and is reflected in appraisal discussions/outputs.
Action for next year:	Ongoing.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil.
Comments:	1. *Targeted interventions on collaborative leadership and organisational values* Applying our *Bold* Trust values with *Patient First* principles the organisation leadership teams work collaboratively and actively to demonstrate this with a variety of interventions open to all staff such as monthly briefings and weekly Spotlight huddles. 2. *Positive equality, diversity and inclusion (EDI) action* Equal opportunities and diversity are fundamental not just in the statutory training programmes but embedded in all Trust events and forums. The trust delivers a cultural intelligence programme. There are a variety of active staff network programmes including: BAME, Women, Armed Forces, LGBTQA+ There is gender imbalance in the medical leadership and senior medical workforce, with women being under represented, and the CMO and RO team encourage opportunities to address this. The senior medical leaders in the Trust represent a range of diverse ethnicity. 3. *Consistent management standards delivered through accredited training* The Trust runs a variety of multi-disciplinary leadership programmes many aligned to our local university which has an extensive healthcare and management portfolio. (Canterbury Christ Church University) 4. *A simplified, standard appraisal system for the NHS* The Trust has a very robust generic appraisal system for non-medical/dental staff. This is monitored Trust wide on a weekly basis with relevant follow ups as required. The Trust appraisal dashboard incorporates medical and dental appraisal metrics. 5. *A new career and talent management function for managers*

	There are structured and informal management and leadership development opportunities in all areas of the Trust. This can be demonstrated by the positive retention of key staff who have transitioned into more senior roles and sometimes through training/development into different areas. 6. *Effective recruitment and development of non-executive directors (NEDs)* The Trust has a full complement of Non-Executive Directors (NEDs) from a range of backgrounds with regular review/renewal processes. 7. *Encouraging top talent into challenged parts of the system* This is ongoing but there have been several new operational initiatives during 2024/25 that have required different people structures and new roles.
Action for next year:	To review the number of Non-Executive Directors NED's as they are required to support the MHPS investigations, working with the Trust secretary re this. Once new NED's have been identified, we will provide appropriate training.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	To continue to monitor compliance.
Comments:	All doctors employed by MFT are subject to NHS mandatory recruitment pre-employment checks. To ensure compliance with pre-employment checks, a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non-training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT. The references for all substantive consultants are reviewed by the RO / Deputy Ro before confirmation of employment.
Action for next year:	To continue to monitor compliance and liaise actively with the medical and temporary staffing teams as appropriate.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil.
Comments:	The Trust has been engaged in Patient First since 2022. This is interlinked with the Trust strategy and all non-clinical and clinical process are aligned to an all-inclusive culture for patients and staff.
Action for next year:	Ongoing.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Nil
Comments:	There are monthly staff briefings both face to face or Teams and all staff are encouraged to attend. At every event the right to 'Speak Up' is supportively emphasised. The Trust has Human Resources /People teams with a range of roles that openly supports fairness and mutual respect. Diversity underpins all Trust polices. Trust values reflect this. The Trust has started a Culture Transformation programme in 2024/24
Action for next year:	Ongoing.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistle-blowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Nil
Comments:	There is an active Whistle blowing policy in place that is regularly reviewed. There is a in depth and proactive safeguarding system in place that is supportive of both staff and patients with robust training programmes.
Action for next year:	Ongoing

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Nil

Comments:	The Trust has an active staff survey and outcomes are communicated at staff briefings with relevant action plans as required. Opportunity for feedback from /with medical and dental staff is actively encouraged and supported through the Junior Doctor forum and Local Negotiating Committee as well as more informal routes. The Trust adheres to an MHPS/Grievance/Complaints and disciplinary procedures
Action for next year:	Ongoing

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Nil
Comments:	The Trust actively employs International Medical Graduates (IMG's) though robust recruitment processes. The Trust runs regular 'Welcome to UK Practice' face to face/team sessions bi-annually (January and September) The MHPS and investigative processes are managed through the Chief Medical Officer's (CMO) service in conjunction with HR teams. The processes are non-discriminatory and monitored to ensure parity. From April 2024 to March 2025 MFT had 55 IMG's commence employment who were new to the UK
Action for next year:	As part of the implementation of the new MHPS policy, the Joint Local Negotiation Committee have agreed to review the implementation of the new policy during 2024-2025. This will include an assessment of the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	HLRO review/Peer review.
Comments:	The CMO/RO and revalidation administrative teams regularly attend on the HLRO meetings and workshops and participate in a local peer group forum for informal feedback and discussion. This is about process and the sharing of best practice and not about individual doctors or cases.
Action for next year:	Continue as before

- **Section 2 – metrics**

Year covered by this report and statement: 1 April 2023 - 31March 2024 . All data points are in reference to this period unless stated otherwise.

2A General
The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	586

2B – Appraisal
The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	587
Total number of appraisals approved missed	4
Total number of unapproved missed	4

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	122
Total number of late recommendations	0
Total number of positive recommendations	111
Total number of deferrals made	11
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	464

2D – Governance

Total number of trained case investigators	20
Total number of trained case managers	11
Total number of new concerns MHPS registered	6
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March 25	12 months

Median duration of concerns processes closed	1 month
Total number of doctors excluded/suspended/restrictions applied	3
Total number of doctors referred to GMC	1
Total number of doctors under review, or discussed with GMC (including the 1 above)	7

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	121
Number of new employment checks completed before commencement of employment	121 *(Leavers 99)*

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	Ongoing
Total number of appeals against the designated body's professional standards processes made by doctors	N/A
Number of these appeals upheld	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report. *Please refer to page 3 of the main report.*

- **Section 4 – Statement of Compliance**

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Medway NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	2025

APPENDIX 1:

Summary of Recommendations from External Quality Assurance (Miad Healthcare)

https://miadhealthcare.com/

1. Appraisees	**Portfolio Review:** **Appraisee improvement opportunity recommendations: -** • Ensure that Appraisees include detail of their private practice and include a statement of good standing from the manager. • CPD reflection requires focussed development. Consider Appraisee/Appraiser training using, for example, the "What, so what, now what" model of refection • It was noted that there were some senior educator appraisals with poor reflection and reflection on logbook data is variable – Appraisees need to be reminded of the importance of reflective activity. • Provide guidance on the use of AI generated reflective activity in medical appraisal • Review and reflection of compliments received is key evidence for inclusion across the GMP 2024 elements. Appraisees need to be aware that they should include both compliments and considered reflection to comply with the standards • If not already in place, consider sharing the many examples of excellent QIA across the Trust to celebrate the work and share the learning.
2. Appraisers	**Portfolio Review:** **Appraiser improvement opportunity recommendations: -** **Scope of practice** - not summarised well by most Appraisers which is in direct contrast to the exceptional high standard seen in the Appraisee input. This should be addressed with Appraisers.

	Gaps - this element requires a more focussed approached by Appraisers. **Reviews supporting information and lessons learned** - It would support the Appraisers focus if there was a reminder of the output the RO requires in this element. **RO review** of what needs to be included in the end summary section going forward.
3. Organisation	**Policies** The recommendations and suggestions for the two key medical appraisal and revalidation policies can be found in detail in Appendix A (i & ii) – Recommendations and suggestions. Links to relevant references are included
	Infrastructure **Appraisers** • Development of a formal screening process for Appraiser recruitment which is more dynamic without putting obstacles in the way of becoming an Appraiser • If the above point is accepted, then include in the Appraisal and Revalidation policy **General:** **Medium Risk** - It is recommended that the Administrative Team resource be expanded to mitigate the risk of not meeting the regulatory requirements of the expanding connections, the lack of experienced management leadership continuity due to the resignation of the Revalidation Manager and to support the implementation of the recommendations made by this review. • Integration of the Datix system with medical appraisal so that there is assurance that all incidents and complaints are included

	• Trust-wide communication to provide clarity that Job Planning and Medical Appraisal are different entities • Additional processes' need to be in place to further enhance the support provided to doctors and others from ethnic minority groups to ensure there are consistent and equitable opportunities for the development and maintenance of skills • Enhancement of the Appraisal feedback mechanism, including Appraisee and Appraiser experience. Once the additional DCMO is in place it would be beneficial for the Senior Appraisers and the DCMO's to conduct a detailed internal QA review considering 1/3rd of the connected doctors each year • PA's and AA's GMC regulation will require additional administrative resource and training to be in place to meet the current and future needs of the group, which will include Appraiser skills update • Close monitoring of Appraiser capacity especially where there are high number of Appraisees and low Appraiser availability to smooth demand in under-represented specialities • Continue to monitor the timeliness of appraisal meetings to keep the backlog to a minimum • Implement the GMC Effective clinical governance to support revalidation: A self-assessment tool • Full engagement in Mandatory Training is required but the compliance rate needs to be improved • Maintain the Appraiser network meetings

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
		X			
Title of Report	Safe Staffing - Mid-Point Review			**Agenda Item**	5.5
Author and Job Title	Ryan Kendall, Nursing Workforce Lead Steph Gorman, Chief Nursing Officer (Interim)				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				
Executive Summary	Approval		Briefing		Noting X
	It is a requirement that every board of directors receives an annual establishment report with a further review on a biannual basis (National Quality Board, 2016). This paper meets the requirements of the biannual update. It is important to be clear were this report is in the cycle and whilst there has been data collection there has not been any establishment meetings or professional judgement at this mid-point. This report will provide an update on registered nurse and midwifery staffing and will provide assurance of compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards, Developing Workforce Safeguards (NHSE)., providing an overview of safe staffing in relation to the establishment including vacancies and turnover, planned Vs actual staffing levels and care hours per patient day (CHPPD) over the past six months. There is an update on temporary spend, safe staffing incidents and staffing issues and risks. There are key items for noting for the board especially with regards the national changes in the job profiles for nursing and midwifery roles band 4-7, work for future pipeline, planning for future graduates in accordance with the letter in August for guaranteed places and the potential risk for an uplift to staffing within paediatrics for 26/27.				
Proposal and/or key recommendation:	Recommendation is for Divisional and corporate teams to be aware of this data to form part of their business planning 25/26				
Governance Route Meeting: Date submitted:	This paper will be going to the Recruitment Retention and Education Group (RRED) Will be submitted to People Committee 25 September 2025				
Identified Risks, issues and mitigations:	Risks are identified within the paper				
Resource implications:	Following the uplift in establishments in April 2024 to meet the previous recommendations all further uplifts will form part of Divisional Business Planning				
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:	Steph Gorman, Chief Nursing Officer (Interim) stephanie.gorman@nhs.net				

NHS
Medway
NHS Foundation Trust

Mid Point Establishment Review

Steph Gorman – Acting Chief Nursing Officer
Caroline Mpita – Head of Clinical Workforce
Ryan Kendall – Nursing Workforce Lead

Patient FIRST

Executive Summary

NHS Medway NHS Foundation Trust

- The National Quality Board (NQB 2016) requires an annual safer staffing report and the monitoring of sustainable safe staffing levels on inpatient wards to be presented to provider Trust Boards. This is also aligned to the Royal College of Nursing (RCN) Nursing Workforce Standards (2021). Boards and Executive teams have responsibility and accountability for setting, reviewing and taking decisions and action on staffing levels and skill mix and should receive an annual establishment report with a further review on a biannual basis.
- This paper meets the requirements of the biannual update, providing an overview of safe staffing in relation to the establishment including vacancies and turnover, planned Vs actual staffing levels and care hours per patient day (CHPPD) over the past six months
- This paper complies with a good governance process and will be presented at Committees and Board to provide the Executive team and Trust Board assurance that staffing levels are safe at mid point during the year and highlight any areas of risk prior to the full report at year end.
- This paper is the bi-annual safe staffing review and is taking into consideration the safety of the patients and staff.
- This report asks the committee to note the findings which divisions will build into business planning.
- The overall finding is that staffing levels across the Trust meet the requirements of safe staffing with a strong recruitment pipeline and clear plans to support retention

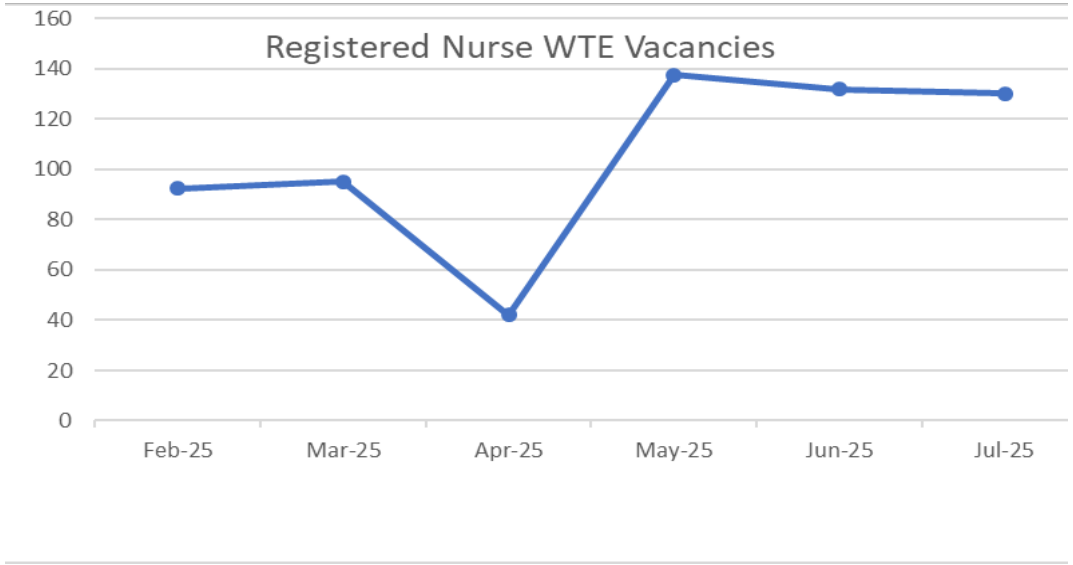
Introduction

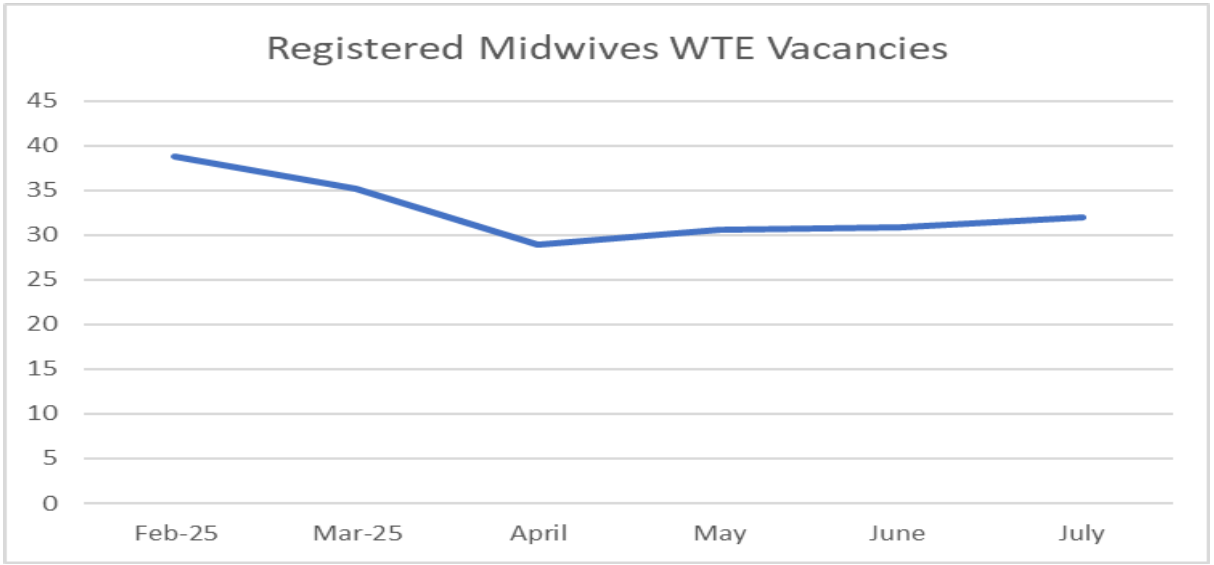
- All Trust Boards have a duty to ensure that safe staffing levels are in place and that patients are cared for by appropriately qualified and experienced staff in a safe environment. They should oversee workforce issues and identify any risks to safe and high-quality care whilst ensuring that their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing (NHSEI, 2018).
- In addition, the Nursing & Midwifery Council (NMC) set out nursing and midwifery responsibilities in relation to safe staffing levels. Demonstrating safe staffing is also one of the standards that all healthcare providers must meet to comply with Care Quality Commission (CQC) regulations to ensure the delivery of safe and effective health and care. Evidence demonstrates that appropriate staffing levels and skill mix positively influence patient outcomes whereas increases in patient harm resulting in an increased length of stay and incurred financial costs to the provider are attributable to poor nurse staffing levels.
- An annual establishment review was carried out in November 2024 and reported to the trust board in March 2025, this is the mid-point review following on from that and is the first time this has been completed.
- Nurse and Midwifery staffing levels and skill mix are associated with the quality and safety of care in hospital wards (NHSE,2021). Demonstrating sufficient staffing is one of the essential standards that all health care providers need to comply with Care Quality Commission (CQC) regulation (CQC, 2024).
- There are currently 25,632 nursing and midwifery vacancies in England as at March 2025 (NHS England - Digital, 2025). This is a vacancy rate of 6.0% and a decrease from the same period the previous year when the vacancy rate was 7.5% (31,294 vacancies).

Current registered staffing position July 2025

WTE Summary	ESR Establishment	Vacancy
Registered Nurses and Midwives	1874.37	162.14

Of the 162.14 Registered Vacancies 82.61 of these are at band 5 for both Nursing and Midwifery. All vacancies are regularly being reviewed every two months at the Recruitment, Retention and Education Meeting (RRED). Most wards within the trust currently have a limited amount of vacancies.



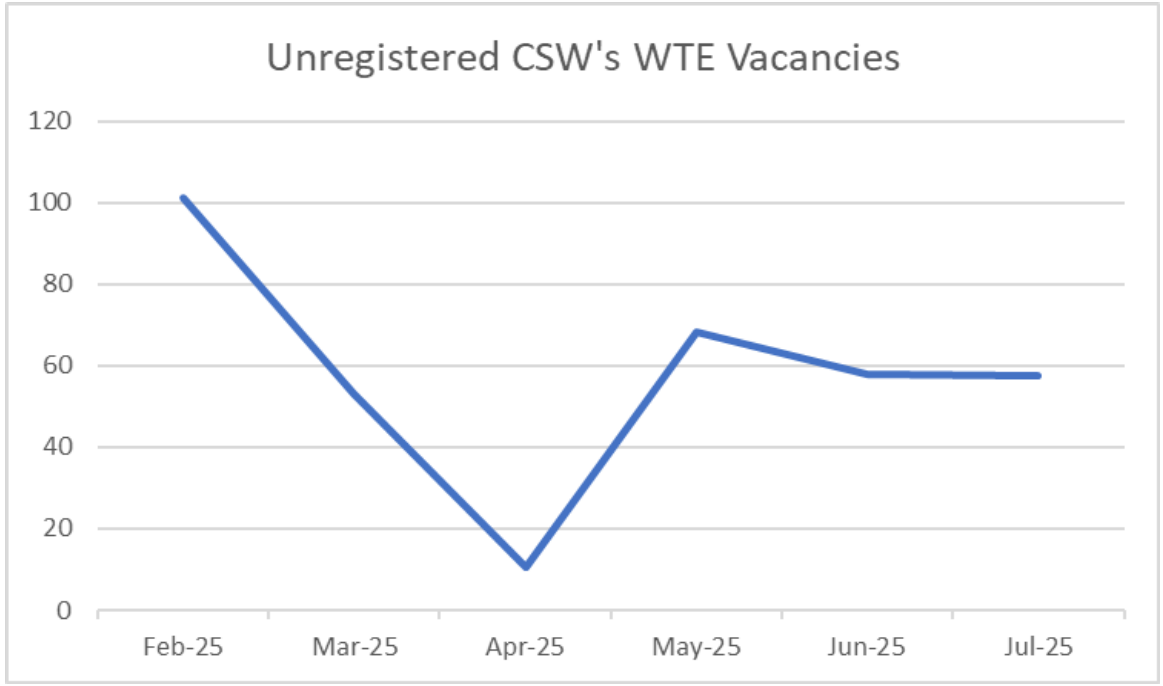


We have a healthy pipeline of Registered Nurses, 26 of our internal Nursing students who were successful in interview have been placed onto wards. There are plans in place to re-interview unsuccessful candidates with 6 international Nurses who have a pin number and are currently working as clinical support workers.

Within Midwifery including current pipeline there will be 2.2 registered vacancies and 0 Unregistered Vacancies in August 2025.

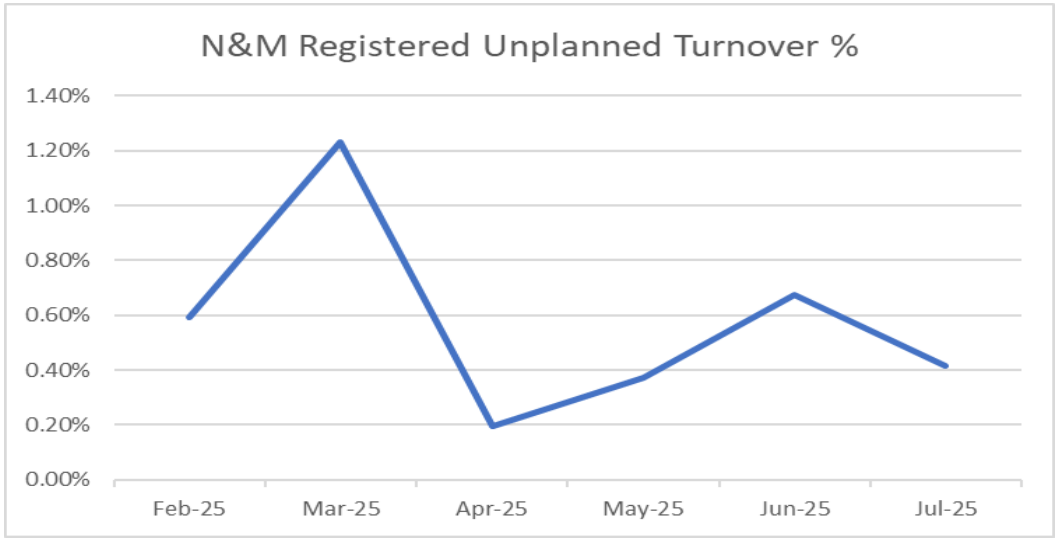
Current unregistered staffing position July 2025

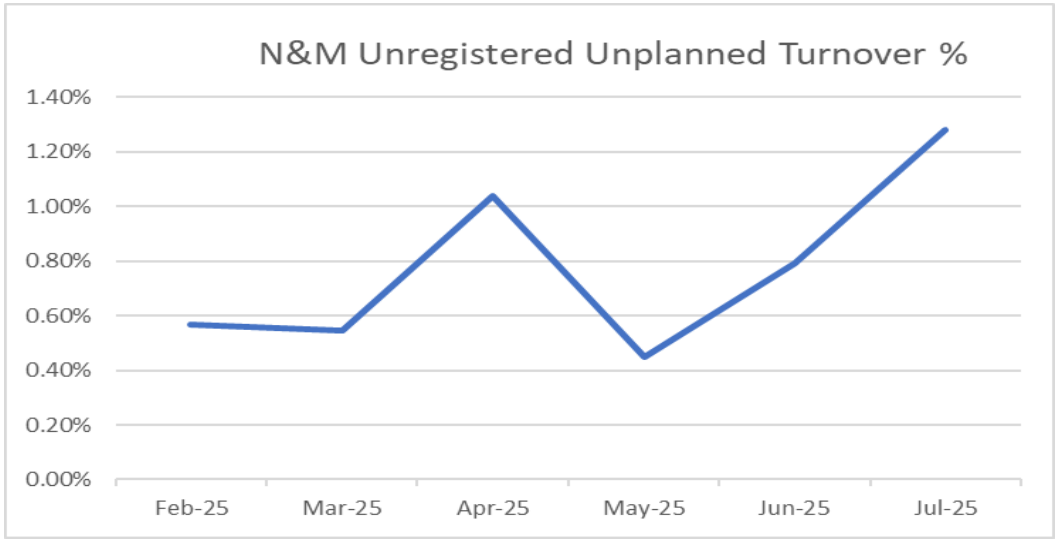
WTE Summary	ESR Establishment	Vacancy
CSW's and MSW's	962.58	57.68



- This is a reduction from November 2024 where vacancies were 116.78
- Wards also currently have a limited number of CSW vacancies. As from the graph above you can see that the vacancies have remained steady.
- Certificate of Sponsorship has had an impact on both the retention of CSW's and recruitment of CSW's. A staff member has to earn a minimum of £25,000 per annum from their substantive employment which has been set by UKVI. This equates to the staff working at the top of band 3. This means that staff who are at the bottom of the band 3 salary are not eligible for sponsorship therefore some CSW's are in the process of leaving.
- Of the staff that are eligible for sponsorship they need to be working full time hours and some are working 20 hours a week. Ongoing work is being done with divisions to find the fairest way of offering the full-time contracts.
- In the previous 6 months we have employed new to care staff where the trust recruits' staff who have had no experience in care and provides a robust induction which has helped are pipeline.

Turnover and retention

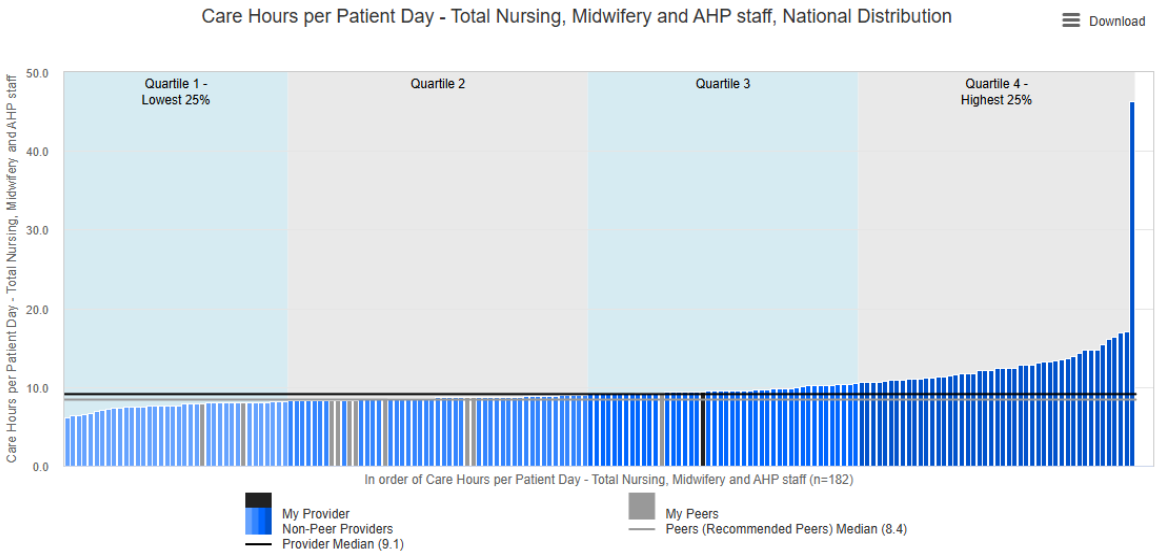




- The primary reasons for staff leaving the organisation in July 2025 is for personal development followed by work life balance. The secondary reasons are promotion advancement and not feeling recognised.
- 94% of our clinical leavers did not say stress was the reason for leaving and 88% stated they would recommend the trust to friends and family. The majority of the leavers have moved to other NHS trusts.
- Clinical Workforce have appointed a new Clinical Workforce Facilitator where part of their workstream is to focus on pastoral care for new recruits. Since the contract has ended with SBS (Shared Business services) they are also following up with staff who are leaving to find the reasons to improve knowledge at ward level and at trust level.
- The clinical workforce team are currently focusing on career conversations, trolley dash's and advocating trusts wellbeing services to promote retention.
- PNA/ PMA service (professional Nurse Advocate/ Professional Midwifery Advocate) service has had a re-launch in May 2025. This service is used to support clinical workforce well-being and retention by providing restorative supervision.
- It is also worth taking note of our leavers rate found in Model Hospital. This is the percentage of Registered Nurses that have left the NHS over the previous 12 months. As of August 2025, this is 3.3% which is the best in the South East and within the lowest quartile in nationally. For CSW's this is 8% which is in the 2nd lowest quartile for the South East and Regionally. For Midwives this is 1.6% which is the best in the South East and in the lowest quartile nationally.

Care Hours per Patient Day (CHPPD)

- Care hours per patient day (CHPPD) is the total number of hours worked on the roster divided by the bed state captured at 23.59 each day. NHS England have devised this to show staffing levels in relation to patient numbers on an inpatient ward.
- CHPPD data gives ward managers, nurse leaders and senior leaders a picture of how staff are deployed and how productively.
- Currently our data shows that our CHPPD is 9.36 hours per patient per day. As of April 2025, the national average for CHPPD is 9.64 hours per patient per day.
- There is work ongoing with BI to streamline the date set prior to submission to model hospital. This increased figure relates prolonged stays on acute admissions units and increased enhanced care requests



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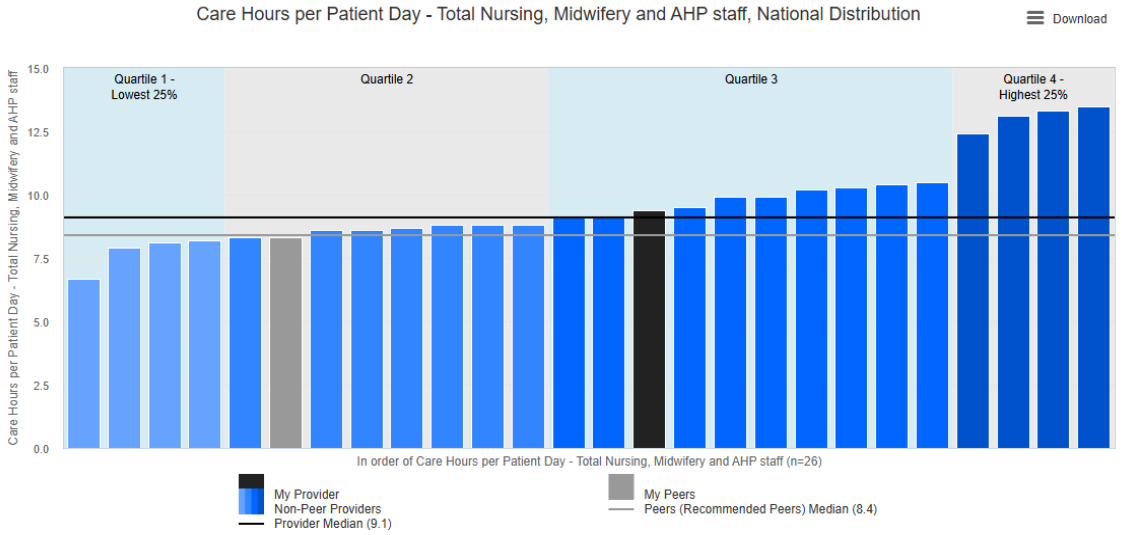

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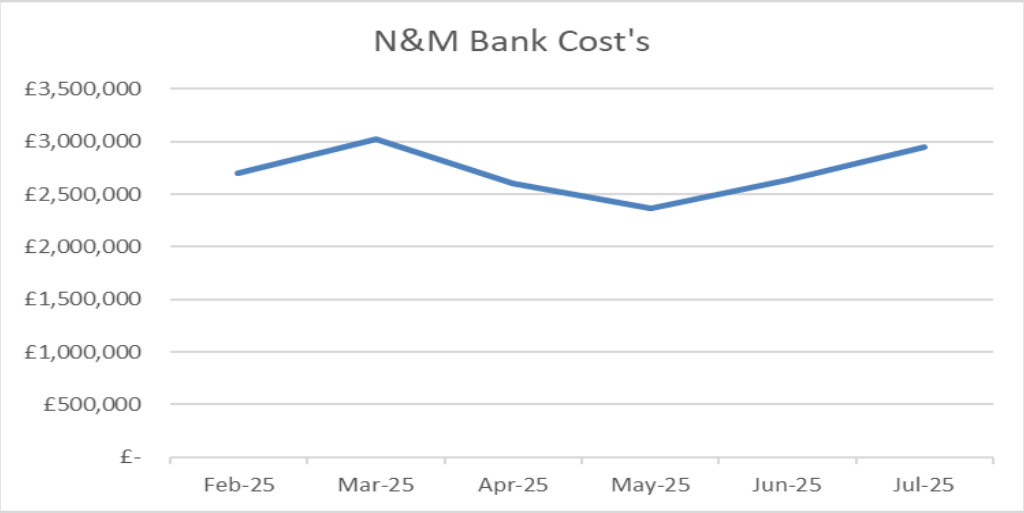
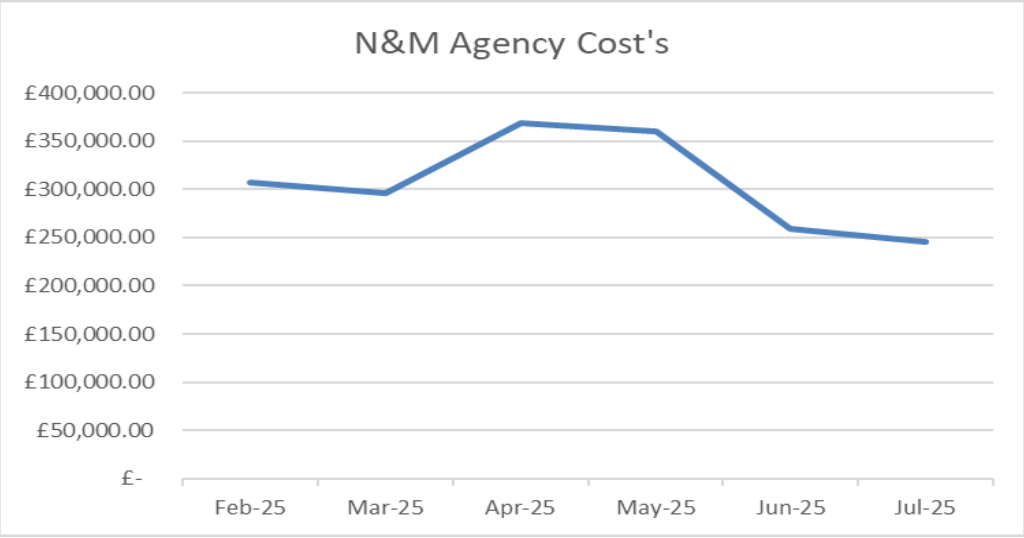
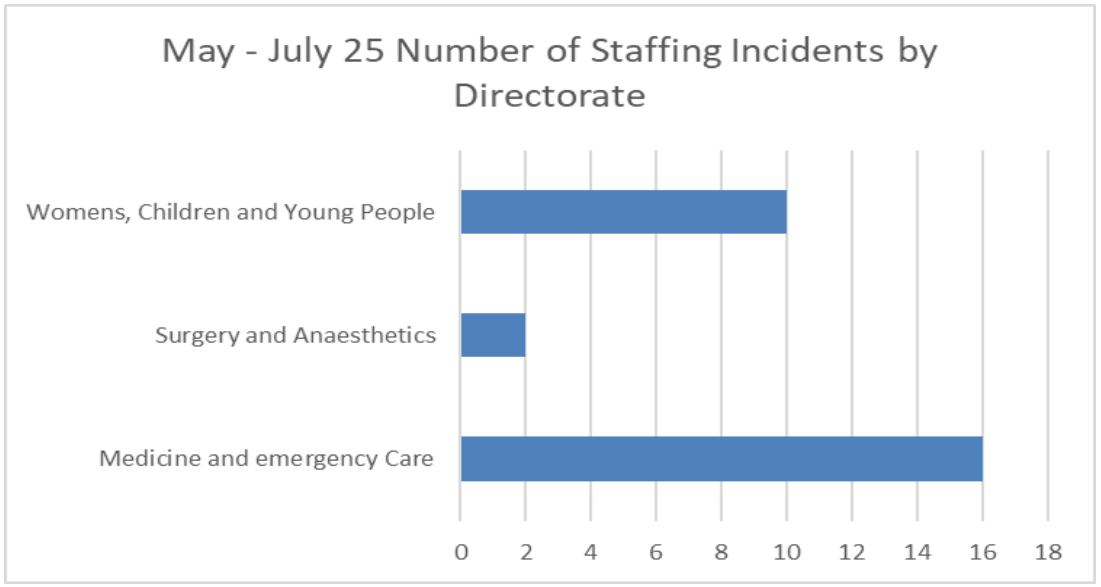
Temporary Staffing

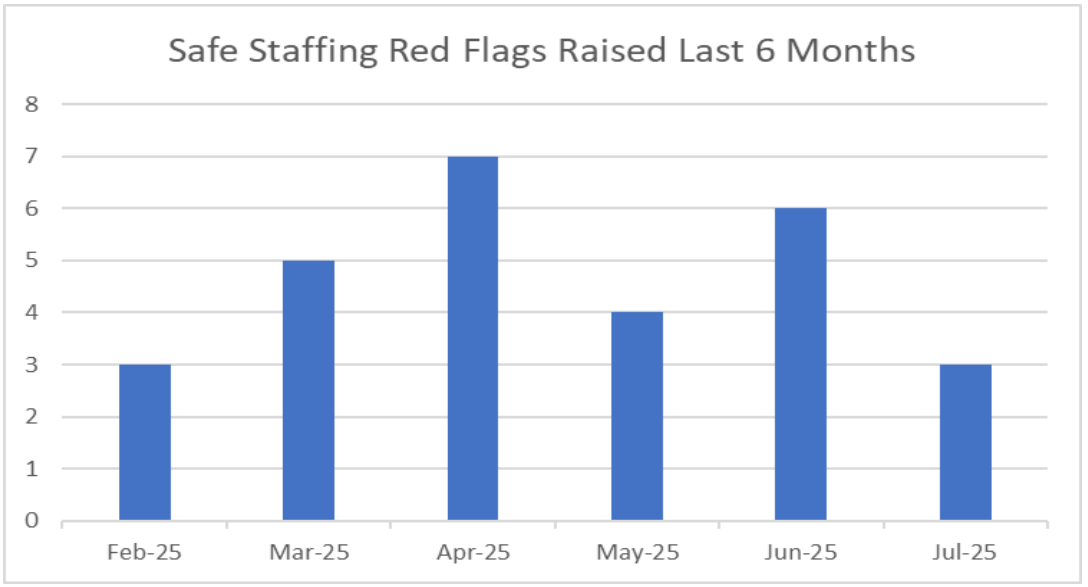




- Agency spend would relate to the use of RMN's which saw a peak in April and May but has decreased over the last 2 months. ED are recruiting RMN's which will reduce this cost further
- There has been no reduction in bank spend over the last 6 months which includes enhanced care costs, cover for areas with high sickness and secondment cover at the base ward
- There is a constant review of Nursing and Midwifery pay spend locally at ward level, divisionally and at trust level.
- Within RRED the bank and agency spend is consistently reviewed every meeting to ensure plans are in place to reduce bank and agency spending where possible.
- Eroster monthly Support Meetings paused at the beginning of the financial year to review KPI's, update the nursing dashboard and ensure roster templates aligned with the budgets. These will be reinstated in September to give support to wards on their health roster which includes going through the health roster metrics. The idea of these meetings is to give support to the wards as well as looking at ways of improving their metrics including bank and agency spend.
- Continued work to reduce numbers of staff being paid at grade rather than the requirement for the shift with a significant reduction since March

Safe Staffing Red Flags and Incidents





Directorate	Key Themes For Staffing Incidents
Medicine and Emergency Care	ED Overcrowded - more staffing required Higher acuity of patients
Surgery and Anaesthetics	Minimum number of staffing not met as per guidance Bank staff not having access to EPR
Women Children and Young People	Sickness Lack of appropriately trained staff for a specific area

Staffing Issues and Risks

The Risk Register has 34 approved issues and 5 risks relating to nursing, midwifery and AHP staffing in total. This is an increase from our annual staffing paper in March when there were 14 issues at a maximum medium priority and no risks:

- There are no significant issues
- There are 9 issues with a high score of 4
- There are 22 issues which score a 3 and are medium priority.
- The remaining issues are a low priority

- There are no extreme staffing risks
- 3 risks score 12
- The remaining 2 risks score 9 and 8

All issues and risks are reviewed regularly at the Recruitment, Retention, Education and Development Meeting (RRED)

Next Steps and Recommendations

- The board of Directors is asked to note:
  - National profiles for Nursing & Midwifery roles bands 4-7 have been published in June 2025. The roles are currently being reviewed with the aim of have standard job descriptions in line with the national profiles.
  - Due to the current financial situation of the trust we are only recruiting where necessary. However, we are ensuring we are investing in our future pipeline by scheduling career events with local schools and colleges to ensure they are aware of all the roles within Medway NHS Foundation trust with the next one scheduled for October 2025.
  - Future planning student Nurses and Midwives. Student Nurses and Midwives who have their placement with Medway NHS Foundation trust will be given support and guidance on how to get a job at the trust. The clinical workforce will attend student surgery's to also ensure they are adequately prepared for the application process. If the students are successful they will be given a conditional offer
  - 9 out of 11 of the student nurse associates have been offered jobs within the trust. The other two have found roles within the community. We currently do not have further Nursing Associates cohorts however a business case is currently being written as it is important to consider future pipeline.
  - To ensure our ESR vacancies align with the wards.
  - SNCT figures look similar for the last two years of reporting 2023 and 2024 however to note that further review of staffing within paediatrics means there may be a need to increase this, this coming year.
  - Reviews will be undertaken for the first time within the Surgical Assessment Unit (SAU) and Penguin using the ECIST tool.
  - Specialist Nurses will be included in the annual report along with theatres and outpatients.

Appendices (A)

No.	Title	Link (double-click)
Appendix 1	Ward Profiles	Microsoft PowerPoint Presentat
Appendix 2	Safe Care Matrix	Microsoft Edge PDF Document Microsoft Edge PDF Document Microsoft Edge PDF Document
Appendix 3	What Have We Achieved	Microsoft PowerPoint Presentat
Appendix 4	Planned Vs Actual Staffing	Microsoft PowerPoint Presentat
Appendix 5	Leavers rates	Microsoft PowerPoint Presentat
Appendix 6	RN pay at grade	Microsoft PowerPoint Presentat
Appendix 7	Issues and risks Log	Microsoft Excel Worksheet Microsoft Excel Worksheet

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
			X	X	
Title of Report	Safeguarding Annual Report			**Agenda Item**	6.1
Author and Job Title	Bridget Fordham, Head of Safeguarding				
Lead Executive	Steph Gorman, Chief Nursing Officer (Interim)				
Executive Summary	Approval	X	Briefing		Noting
	This annual report is to inform the committee of the continued delivery of statutory and regulatory safeguarding duties placed upon the Trust. The Trust has met all of the standards required to provide the Local Safeguarding Children's Partnerships (LSCP's) and the Kent and Medway Safeguarding Adults Board (KMSAB) with assurance that there are robust processes in place with appropriate polices to support the safeguarding of those using the trust services. The report details the activity undertaken internally and externally in order to meet these responsibilities. Delivery of safeguarding training at level 3 for adults and children has been a challenge however the training compliance has been maintained at KPI targets. MCA training compliance has now been removed from the risk register due to sustained achievement for 8 months. Maternity safeguarding has achieved the key performance indicators to 100%. Learning Disabilities training – Oliver McGowan was introduced as an eLearning with next steps progressing to face to face tier 1 and tier 2 training.				
Proposal and/or key recommendation:	For Board approval				
Governance Route Meeting: Date submitted:	Safeguarding Assurance Group, 28.07.25 Quality Assurance Committee, 11.08.25				
Identified Risks, issues and mitigations:	No major risks identified. Previous identified risk 2122 Breaching of Urgent Authorisations of Deprivation of Liberty Safeguards remains in place. Risk identified for 2025-2026 is the delivery of the Oliver McGowan mandatory training tiers 1 and 2.				
Resource implications:	Funding to deliver Oliver McGowan Training. This is a system wide risk.				
Sustainability and/or Public and patient engagement considerations:	N/A				

Integrated Impact assessment (please mark):	Yes		No		N/A
					X
Appendices:	Appendix 1 – Kent and Medway Safeguarding Adults Board Self-Assessment Framework Appendix 2 – Kent and Medway Section 11 audit.				
Freedom of Information status (please mark):	Disclosable	X	Exempt		
For further information please contact:	Bridget Fordham, Head of Safeguarding b.fordham@nhs.net				

NHS
Medway
NHS Foundation Trust

Trust Safeguarding Annual Report

Head of Safeguarding

06 JUNE 2025

Best of care
Best of people

NHS
Medway
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Contents

1 EXECUTIVE SUMMARY 2

2 SAFEGUARDING CHILDREN 3

3 MATERNITY SAFEGUARDING 17

4 LEARNING DISABILITIES 27

5 MENTAL CAPACITY 34

6 SAFEGUARDING ADULTS 41

7 SAFEGUARDING SUPERVISION 46

8 SAFEGUARDING TRAINING ..... ERROR! BOOKMARK NOT DEFINED.

9 NEXT STEPS 48

1 EXECUTIVE SUMMARY

1.1 Statutory safeguarding activity has remained relatively stable throughout 2024/25. This report details how the Trust all age safeguarding team have supported safeguarding activity across the Trust whilst ensuring that external statutory safeguarding duties were met.

1.2 The Statutory Safeguarding Children's Section 11 audit was submitted and reviewed by the Local Safeguarding Children's Partnerships (LSCP) and statutory partners peer review panel, with no further actions identified. As a result, only one outstanding action remained relating to the Trust DBS project being undertaken by the recruitment team with support from safeguarding. This has now been completed and presented at the Kent and Medway Health Reference Group (HRG) due to the significant work and assurance provided from this.

1.3 The Self-Assessment Framework (SAF) for the Kent and Medway Safeguarding Adults Board assurance was completed and underwent peer review. All standards were approved by the peer review panel as having been met with no further actions required.

1.4 There was an overall increase in the number of strategy meeting invitations; however, Q3 saw a significant 68% decrease in requests following Medway Community Health (MCH) entering business continuity from 5th December 2024 to 20th January 2025. On 20th January 2025, the MCH strategy meeting team resumed coordination of strategy meetings, leading to a gradual return to normal request volumes.

1.5 In 2024/25, the number of children referred for a Child Protection (CP) Medical decreased to 84, compared to 110 in 2023/24. Of the referrals received, 32 children were not seen, primarily due to the absence of visible injuries, cancellations by social workers, or incorrect referrals for neglect assessments, which are commissioned by MCH services.

1.6 Referrals to children's social care have increased compared to previous years. In response, the safeguarding team is implementing new approaches to enhance the quality of referrals, including the development of an easily accessible, artificial intelligence-powered step-by-step instructional video.

1.7 The Trust has achieved KPI compliance in Safeguarding Children Levels 1, 2, and 3 for 2024/25, supported by increased engagement from medical staff.

1.8 MCA training has been above the 85% KPI for 10 consecutive months and Adult safeguarding has maintained between 81% and 85% throughout the year.

1.9 Maternity safeguarding key performance indicators have been fully met in 2024/2025; there remains 100% compliance with Child Protection Case-holder supervision, 100% compliance in pre-birth planning completed.

1.10 Oliver McGowan eLearning, (Part one for tier 1 and tier 2 Oliver McGowan mandatory training (OMMT)) was initiated and has achieved the KPI of 85%.

2 SAFEGUARDING CHILDREN

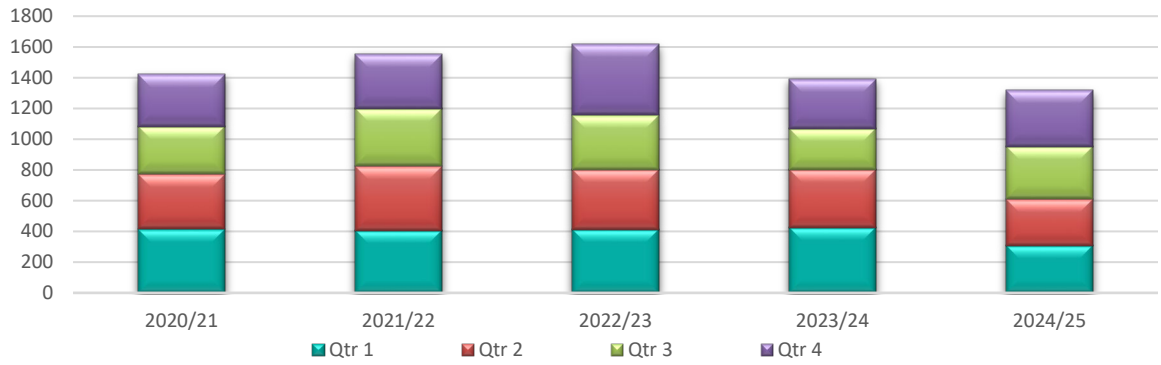
Multi-Agency Safeguarding Hub

2.1 Medway NHS Foundation Trust (MFT) plays a crucial role in safeguarding children and families by collaborating with the Multi-agency Safeguarding Hub (MASH). This partnership involves sharing health-related information and analysing previous attendances to ensure appropriate support for families referred to children's services.

2.2 MFT ensures strong safeguarding practices by having key professionals actively involved in MASH meetings. The Named Practitioner for Safeguarding Children participates in regular operational meetings, while the Head of Safeguarding attends the strategic board. These engagements help maintain coordinated efforts and ensure MFT fulfils its statutory duty to provide timely and proportionate information when concerns arise.

2.3 There were 1316 MASH requests for information in the year 2024/25, with 4656 individual records accessed and analysed for relevant information. However, as discussed in the quarter 3 (Q3) report, Medway Community Health (MCH) faced IT system failures starting on 5th December 2024, leading to a business continuity phase that lasted until 20th January 2025. This disruption likely contributed to the gradual downward trend in MASH requests over the past two years.

Total No. MASH Requests

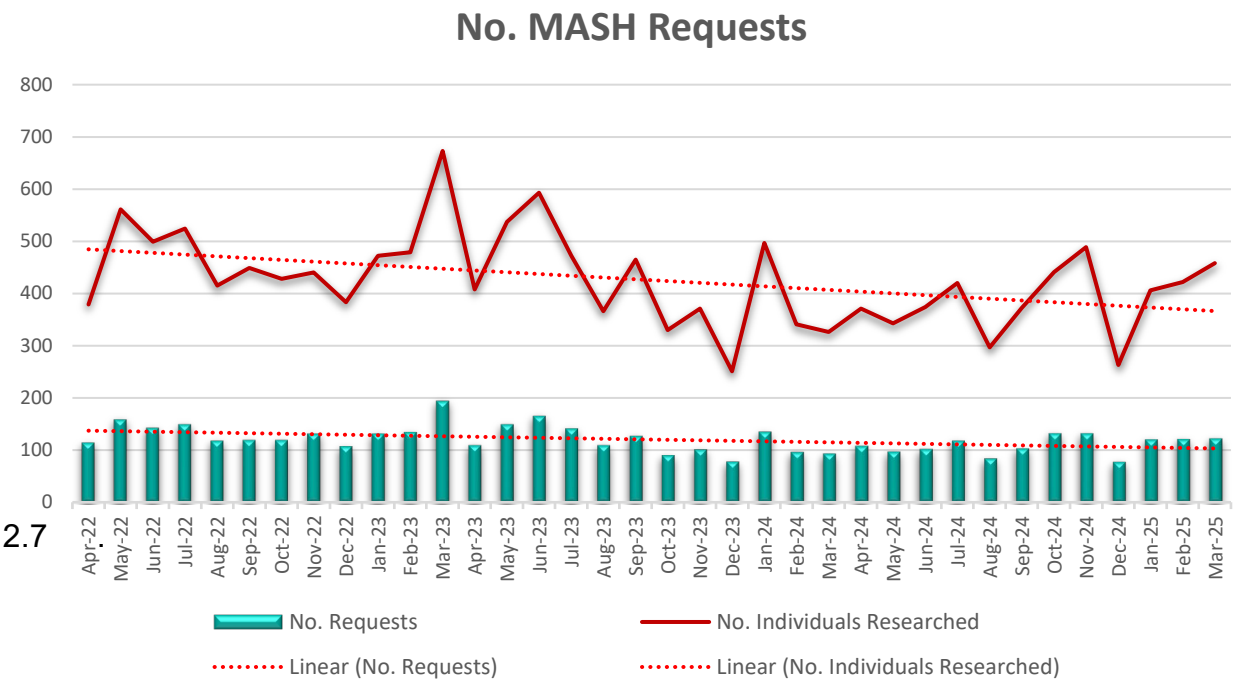


2.4 Figure 2 further illustrates the overall downward trend in the number of MASH requests received since April 2022 to date. It is unclear what the reason is for this change, but is likely due to the quality of referrals received. MASH operational meetings are reflecting that the number of referrals that do not meet threshold are high. To note, these referrals are those received across the partnership and from members of the public and therefore does not sit directly with MFT. Staff are

supported with making quality referrals when needed and the threshold guidance and making good quality referrals are included within training. Links to the threshold guidance are listed on the safeguarding page on the Clock Tower and also on the safeguarding children's virtual noticeboard (Padlet).

2.5 The safeguarding team have been actively working on safeguarding initiatives, including the use of artificial intelligence (AI) videos. Through the use of AI, the safeguarding team aim to support consistency in assessments, reduce errors in referrals, and provide accessible training materials for staff. Furthermore, Incorporating AI into training aligns with broader NHS efforts to integrate technology into healthcare education.

2.6 **Figure 2** - No. MASH Requests



2.7

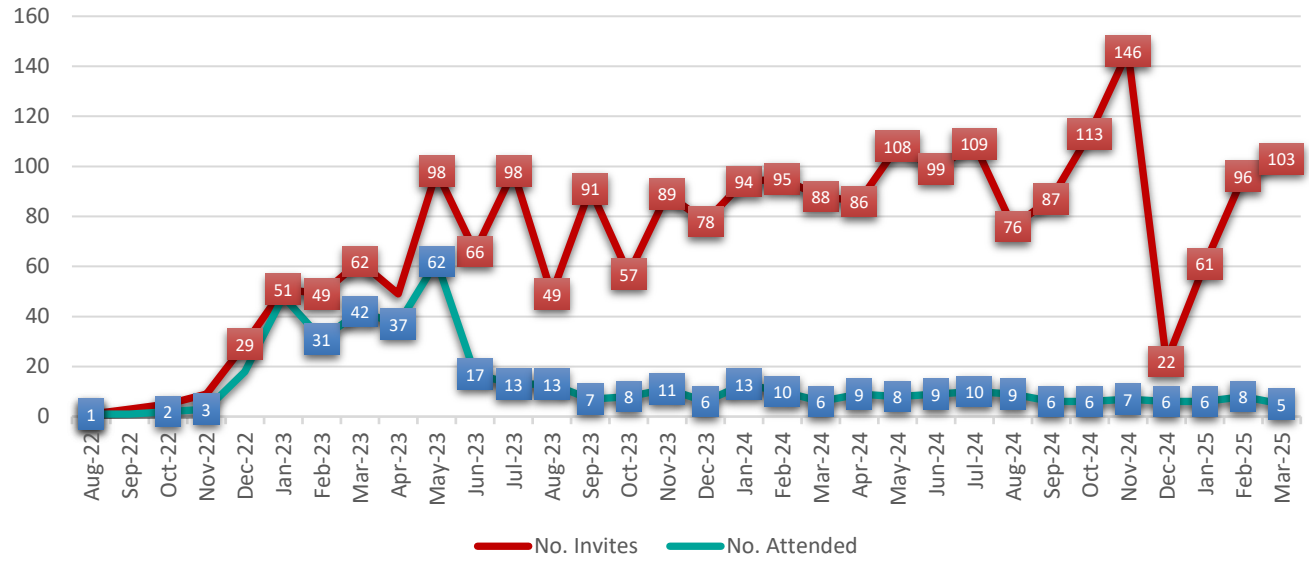
Strategy Meetings

2.8 The increase in strategy meeting invitations from 952 in 2023/24 to 1106 in 2024/25 reflects a growing need for multi-agency collaboration. However, the number of meetings attended was significantly lower due to the implementation of a team supporting health attendance coordination and representation by MCH.

2.9 MFT now only attends strategy meetings where there has been recent significant contact with the family. However, MCH's business continuity phase in December 2024 led to a sharp decline in requests, dropping from 146 in November to just 22 in December. While MFT's attendance remained stable, the reduction in invitations meant that critical information held by MFT was not shared to support risk assessments.

2.10 This issue was raised in multiple multi-agency meetings by various partner agencies, due to its impact on safeguarding children and was subsequently added to the Medway Safeguarding Children Partnership (MSCP) risk register.

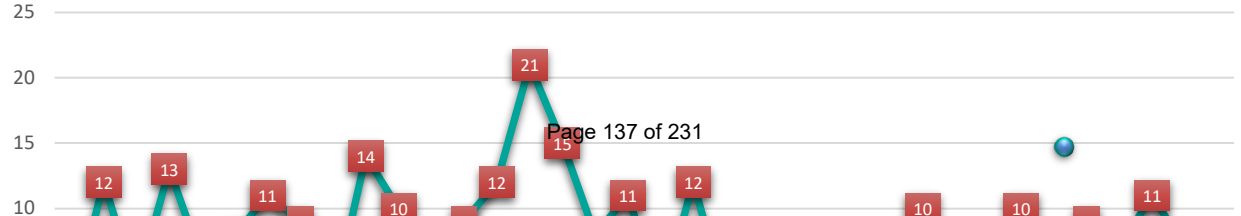
No. Strategy Meeting Invitations v. No. Meetings Attended



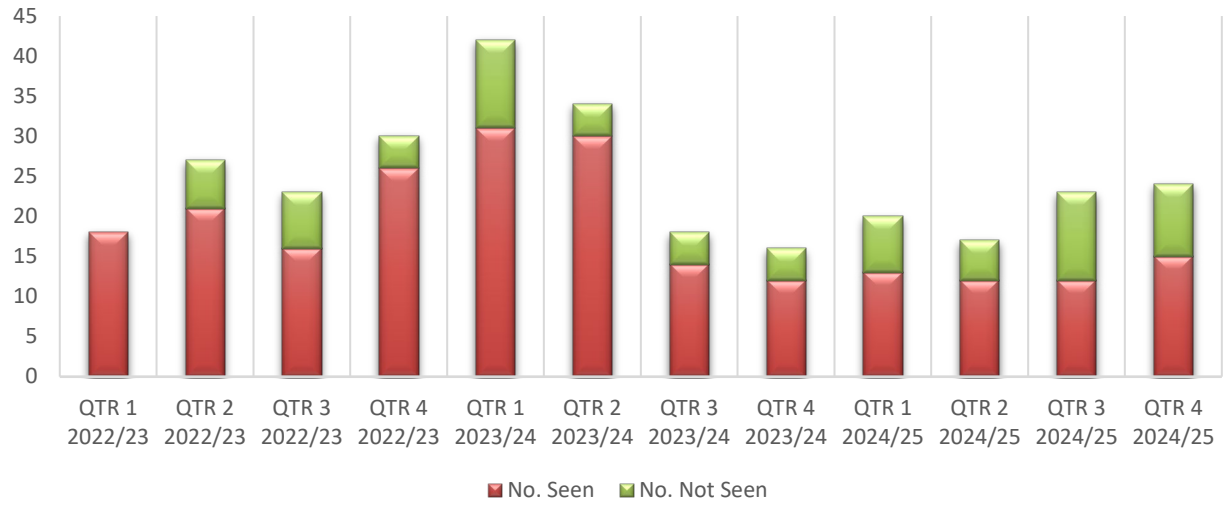
Child Protection/Non-Accidental Injury (NAI) Medicals

2.11 The number of child protection/NAI medical requests has decreased over the past two years, from 110 in 2022/23 to 98 in 2023/24, and now 84 in 2024/25. However, due to the unpredictable nature of CP medical referrals, future numbers cannot be accurately forecasted.

2.12 NAI medicals are critical assessments conducted when there are concerns about potential abuse or neglect, helping professionals determine the cause of injuries and ensure appropriate safeguarding measures. Given the complexity of these cases, referral rates can fluctuate based on various factors, including awareness, reporting practices, and multi-agency coordination.

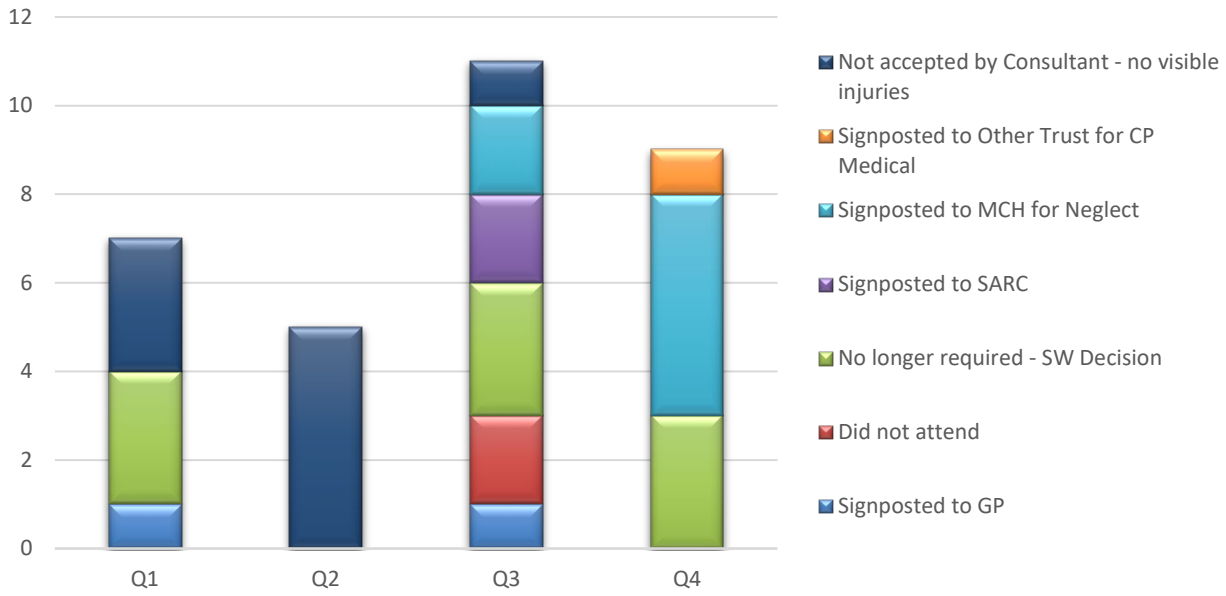


2.13 The below chart illustrates the number of referrals received and the number of children that were seen/not seen. These numbers have remained relatively consistent with previous data.



2.14 The data indicates that the majority of children not seen following a CP Medical referral were due to no injuries being present, or following cancellations by social workers. However, there has been a rise in referrals for CP neglect medicals, prompting a need for clearer guidance on referral pathways.

Reason Children Not Seen following CP Medical Referral



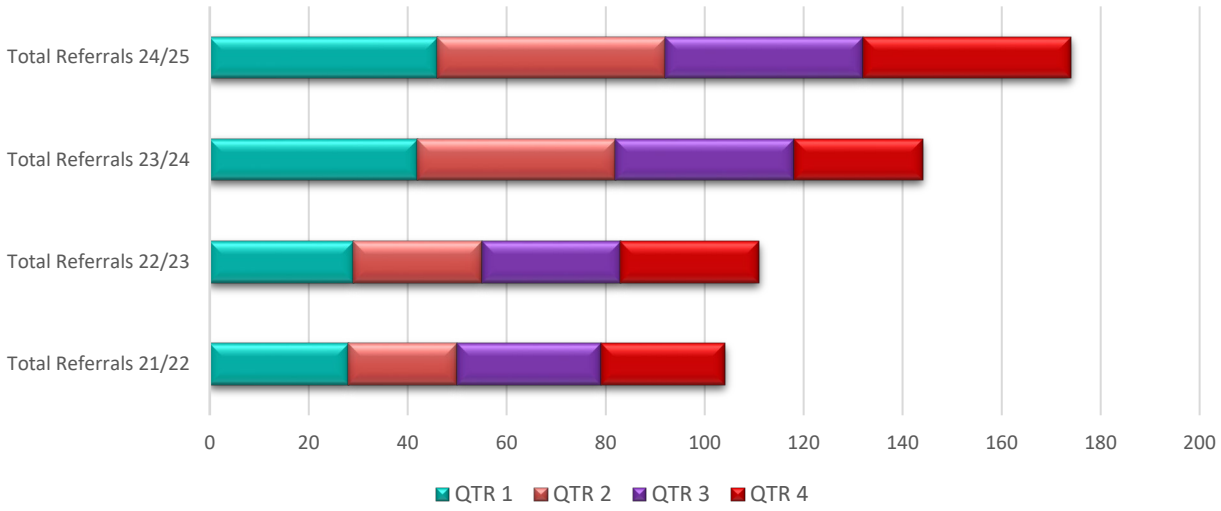
2.15

2.16 The new CP Medicals process, set to launch in Q1 2025/26, introduces two dedicated one-hour appointment slots from Monday to Friday (12:00 – 14:00) for children to be assessed by a Paediatric Assessment Unit (PAU) Consultant. This change aims to reduce pressure on the ward consultant, particularly during periods of high patient acuity, ensuring more efficient and focused assessments.

2.17 This adjustment aligns with broader NHS efforts to streamline paediatric care and improve accessibility for safeguarding assessments.

Referrals to Children's Social Care

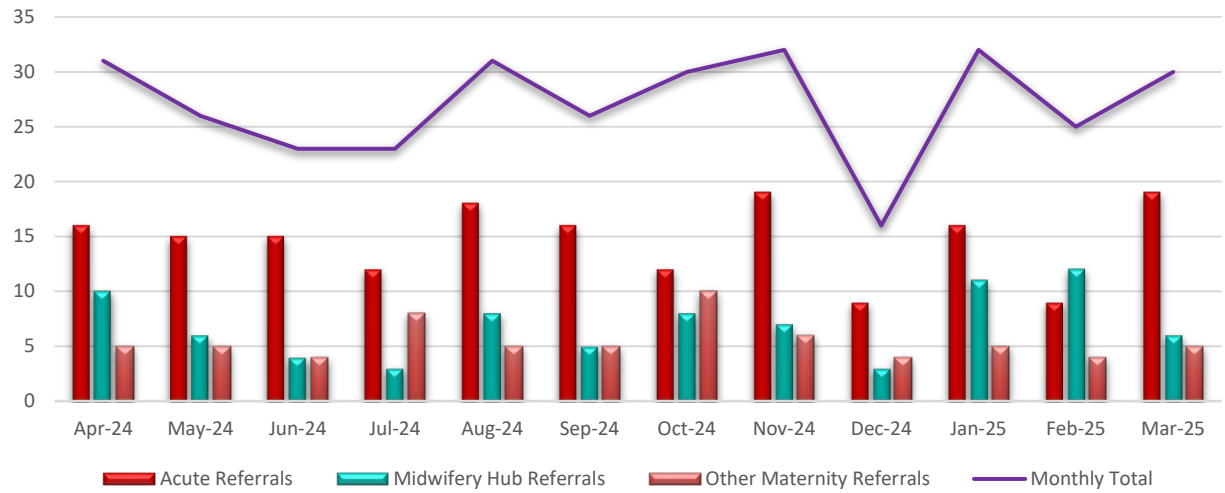
2.18 The increase in acute referrals to children's social care, rising to 174 in 2024/25, could be linked to improved staff awareness through training or growing social complexities among children and young people accessing healthcare from MFT. However, the true scale of referrals remains unclear, as staff are not consistently sharing referrals with the safeguarding team, despite guidance provided in training, supervision, and ad hoc support. This lack of oversight means that the data only reflects referrals known to the safeguarding team, rather than the full picture.



2.19 It is hoped that the new referral training videos will provide staff with clearer guidance, helping reinforce communication and compliance in referral-sharing protocols. This will ensure greater accuracy in safeguarding assessments, ultimately leading to more effective interventions for vulnerable children and families.

2.20 The below graph presents a detailed breakdown of the monthly referrals from both acute and maternity services, totalling 325 for the year. December 2024 recorded the lowest number of referrals, likely influenced by the Christmas period, during which families are less inclined to seek medical attention for non-urgent concerns

No. Social Care Referrals for CYP/Unborn – Acute and Maternity



Audits

2.21 The Safeguarding team continues to support the local Safeguarding Children Partnership through quarterly multi-agency audits. Case file audits serve as a collaborative approach to evaluating practices and outcomes for children and young people, identifying gaps, and deriving lessons from both single and multi-agency perspectives. The Case File Audit Group (CFAG) convened in June, September, and November 2024 to review five families per meeting, focusing on themes such as physical abuse, pre-birth assessment, and contextual safeguarding. Several cases were classified as 'requires improvement'; however, with one exception, no actions were required from MFT. Appropriate measures were taken for families who engaged with Trust services. The single case requiring action for MFT pertained to pre-birth assessment, with learning shared with maternity safeguarding. A plan is in place for the maternity team to review and implement necessary actions.

2.22 The Safeguarding team conducts monthly MASH audits to support the quality assurance of actions and assessments. In the 2024/25 period, a total of 22 MASH referrals were audited and shared with social care. These audits did not pertain to referrals made by MFT, and no shared learning was identified.

2.23 Section 11 of the Children Act (2004) mandates that Local Children Safeguarding Partnerships conduct a self-assessment audit to evaluate how organisations and services adhere to safeguarding standards for children and young people. The audit was submitted in September 2024, with the scrutiny panel convening in Q3 to review agency submissions. Several questions were raised regarding the MFT audit, all of which have been addressed. The final submission in November 2024 confirmed that 33 standards were met, 1 standard was partially met, and 1 action was identified.

2.24 The partially met standard relates to the organisation's arrangements for monitoring and reviewing recruitment and selection policies in accordance with national guidance, including the Disclosure and Barring Service (DBS).

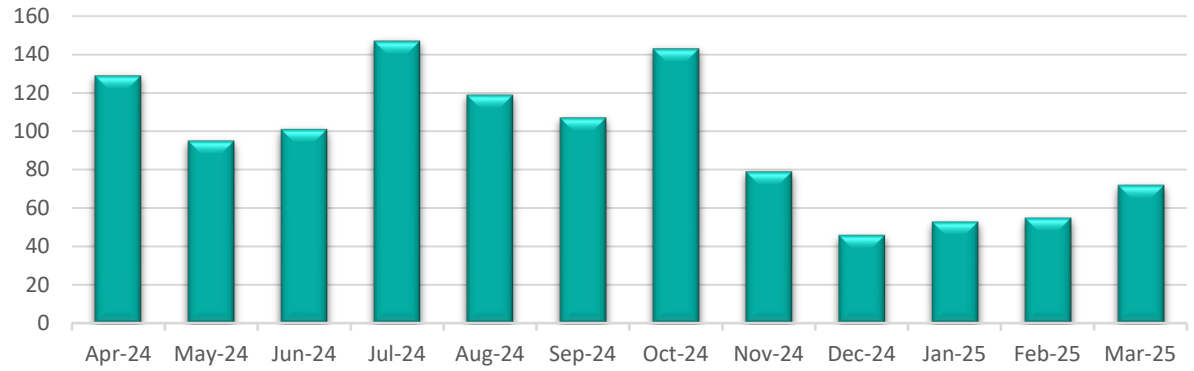
2.25 A project led by Recruitment and Safeguarding is currently in progress to ensure that all staff have the appropriate level of DBS clearance. Originally scheduled for completion by 31 December 2024, the deadline has been extended to 31 March 2025 due to resource constraints.

2.26 The Safeguarding team remains a key member of the Medway Children's and Young People's Contextual Safeguarding Panel, supporting the sharing of information where children are identified to be at risk of exploitation.

Notifications

2.27 MFT continues to receive a daily 'missing list' of children reported missing in Medway, with alerts being added in line with previous reports. These alerts support risk management and ensure the completion of appropriate safeguarding actions should a missing child present at the hospital.

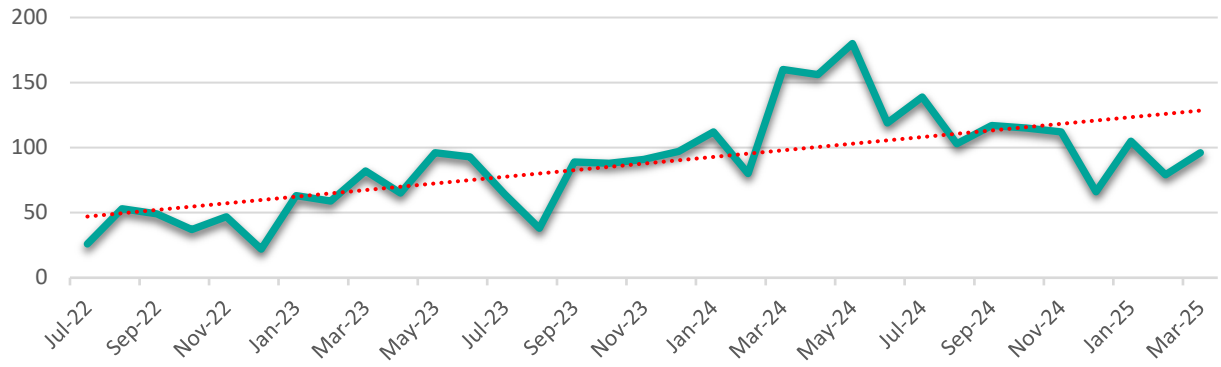
No. Missing Child Notifications



2.28 When safeguarding concerns are identified for patients attending the hospital, staff can submit a 'safeguarding notification' via Sunrise/EPR or the intranet. These notifications are sent via email to the safeguarding team, facilitating information sharing, staff support, and the follow-up of necessary safeguarding actions.

2.29 In 2024/25, the safeguarding team received a total of 1,387 notifications. While an initial upward trend was observed following the launch of this function, notifications have generally declined throughout the year. The reasons for this decrease remain unclear and require further investigation.

No. Safeguarding Notifications Received



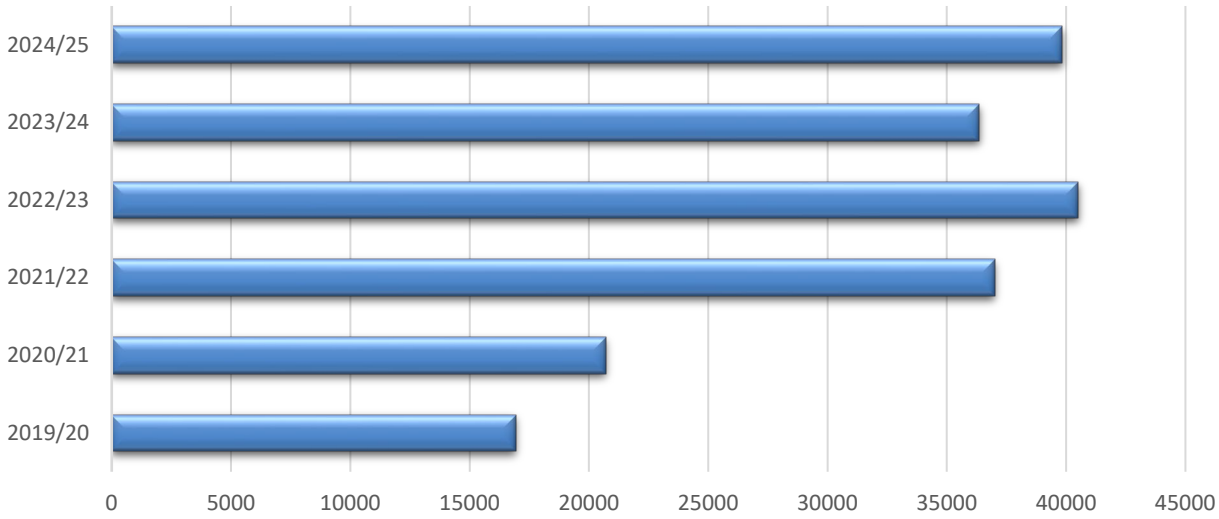
Children's Emergency Department (ChED)

2.30 The Safeguarding team continues to provide daily oversight and monitoring of attendances at the Children's Emergency Department (ChED). In accordance with 'Facing the Future: Standards for Children in Emergency Care Settings (2018),' robust systems are required to ensure that primary care teams are

informed of each child's emergency department attendance. This includes General Practitioners (GPs), Midwifery, Health Visitors, and School Nurses.

2.31 GP discharge notifications are automatically generated via the Electronic Patient Record (EPR) system and uploaded to the Kent and Medway Care Record (KMCR). All ChED attendances are screened using a rag-rating system to identify potential safeguarding concerns. The safeguarding team aims to share all attendances electronically with the appropriate health partners via secure email on the next working day.

2.32 In 2024/25, the Children's Emergency Department (ChED) recorded a total of 39,832 attendances, representing a slight increase from 36,452 in 2023/24. While this annual rise is modest, attendances have more than doubled since the pandemic. Several factors may have contributed to this substantial increase, including a rise in mental health-related attendances and ongoing challenges in accessing local GP services.



Comparison of total No. attendances to ChED per year

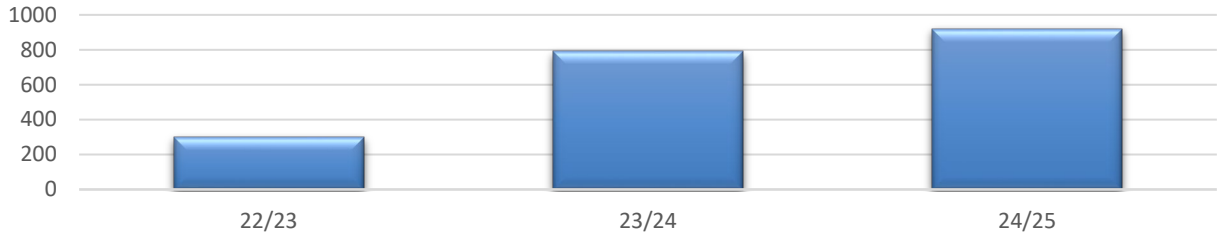
2.33 Of the 39,832 attendances 3243 were aged 16-17 years of age, the highest number within this age bracket to date. This is likely linked to the vast increase in mental health attendances we are seeing, reflected in the mental health data.

2.34 All children and young people accessing unplanned healthcare through the Children's Emergency Department (ChED) and Penguin Assessment Unit are checked against the National Spine using the Child Protection Information System (CP-IS). This system is designed to identify children and young people with existing child protection plans or those in care who may be transient or unwilling to disclose information to professionals, thereby facilitating information sharing in accordance with Working Together to Safeguard Children (2023).

2.35 In 2024/25, 1,870 children were identified as out-of-area attendances to ChED. With CP-IS fully embedded in practice, the Trust ensures that, should a child be subject to a Child Protection Plan (CP Plan) or classified as a Looked After Child

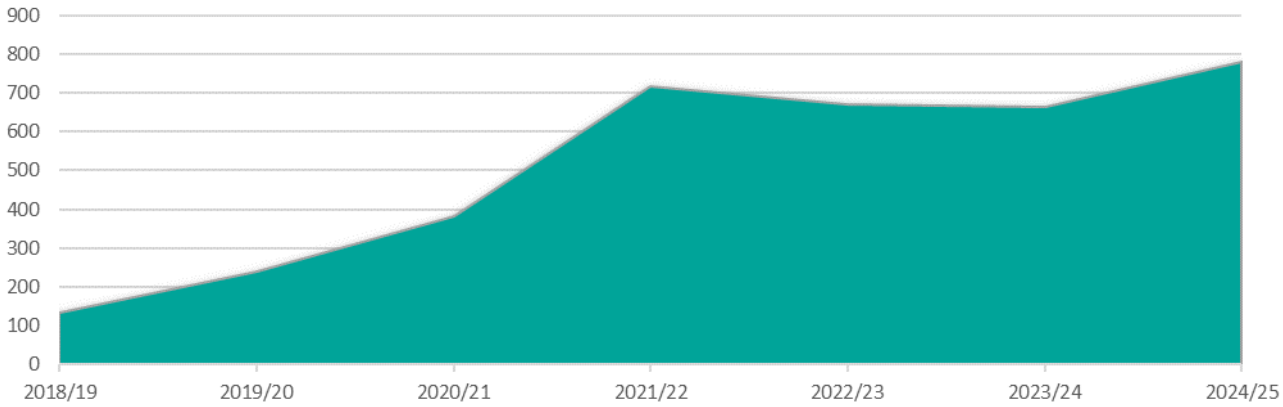
(LAC), their social worker is notified of their attendance, irrespective of their usual place of residence within the UK.

2.36 In 2024/25, a total of 920 CP-IS alerts were identified for children and young people (CYP) accessing emergency care at MFT. This figure remained relatively stable compared to the previous year but remains significantly higher than historical records.



Paediatric Mental Health

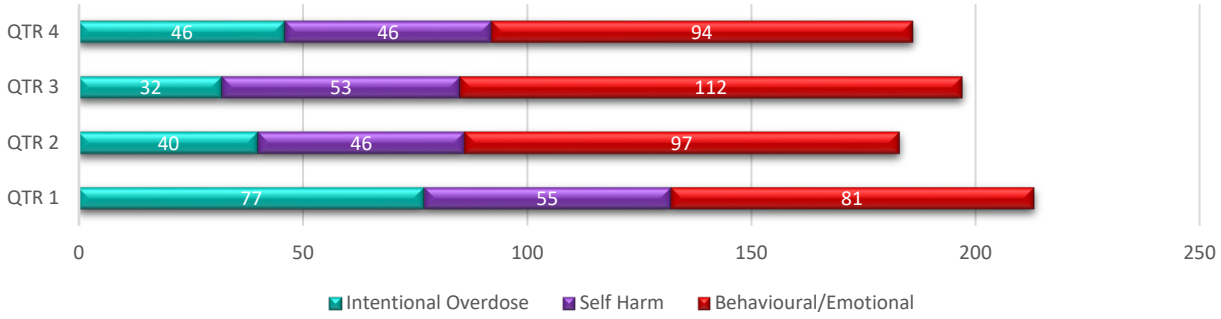
2.37 Mental health presentations continue to place significant pressure on the ChED with 779 attendances related to mental health concerns recorded in 2024/25—the highest figure to date and representing a more than 300% increase compared to pre-pandemic levels (Figure 15). This ongoing demand continues to place significant pressure on both the ChED and the Children's Ward, particularly for children and young people (CYP) awaiting a social placement or a Tier 4 bed.



Mental Health Presentations to ChED

2.38 Close collaboration remains in place between the Emergency Department team and the Child and Adolescent Mental Health Services (CAMHS) crisis team to ensure that all children and young people receive appropriate care and are discharged with a comprehensive safety plan. As a result, 644 referrals were made to the CAMHS crisis team throughout the year.

2.39 Behaviour that challenges and emotional mental health presentations continue to account for the highest number of attendances, with self-harm presentations remaining consistent throughout the year. In Q1, there was a notable increase in attendances related to intentional overdose; however, the underlying cause of this spike remains unclear.



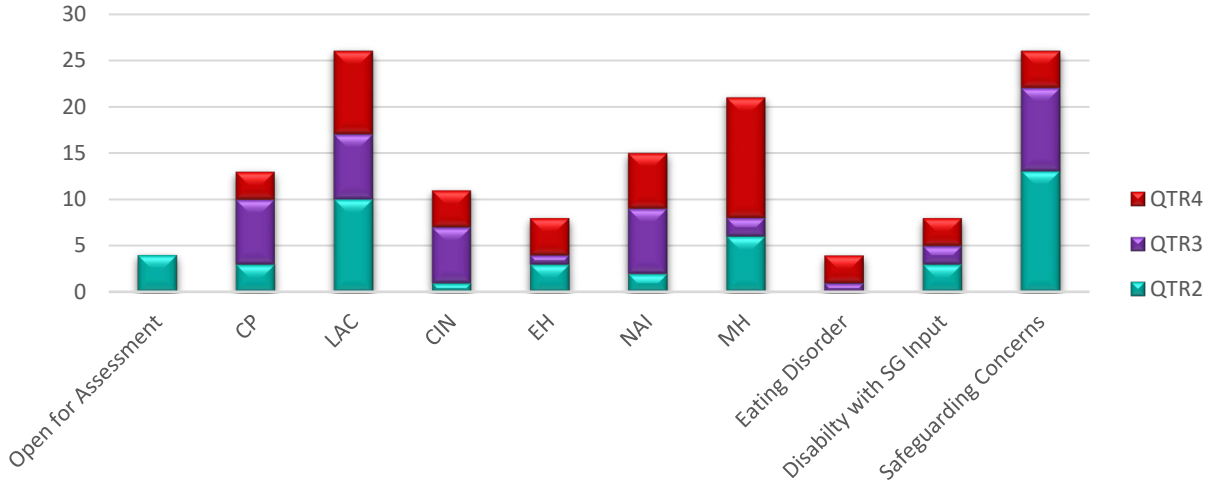
Inpatient Activity

2.40 A Safeguarding Practitioner continues to provide daily support to both the Children's Emergency Department (ChED) and the children's inpatient areas. Additionally, they participate in the weekly children's multidisciplinary team (MDT) meeting, ensuring effective collaboration and safeguarding supervision of inpatient activity. The combination of daily engagement and MDT participation strengthens joined-up working and enhances safeguarding oversight across inpatient services.

2.41 Throughout the year, the children's ward has faced complex admissions involving young people with significant social challenges. The safeguarding team maintains close collaboration with the ward, supporting the coordination of social care input and facilitating safe discharge planning.

2.42 The below graph illustrates the safeguarding concerns identified among these admissions, highlighting a substantial number of children subject to Child Protection (CP) plans, potential non-accidental injuries (NAI), and other general safeguarding concerns. A number of these children experienced extended stays on the ward.

It is important to note that improved data collection was implemented in Q2; therefore, Q1 data is not included in the analysis

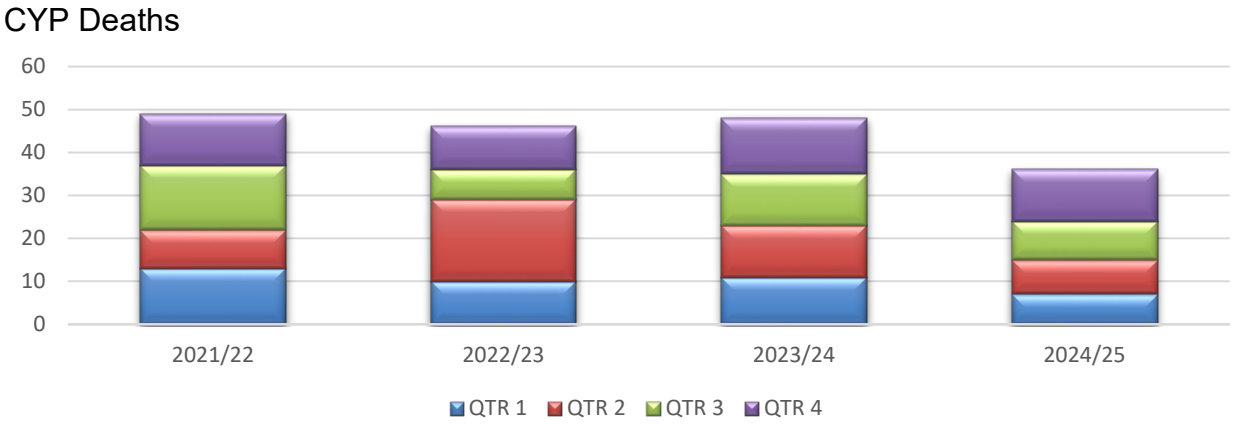


Type of Safeguarding Concern (Ward Admissions)

Child Death

2.43 The Safeguarding team continues to collaborate closely with the child death review panel. Sadly, in 2024/25, a total of 36 deaths of babies and children known to MFT were recorded, with 18 occurring in the neonatal period and 18 involving children.

2.44 For unexpected deaths, 10 Joint Agency Response (JAR) meetings were conducted. Additionally, local safeguarding practice reviews (LCSPR) have been initiated for three cases—two involving neonatal deaths in the community and one concerning chronic neglect of twins, with one twin sadly passing away.



Safeguarding Supervision

2.45 Safeguarding supervision is a structured, accountable process designed to support, assure, and enhance the knowledge, skills, and values of individuals, groups, and teams. Reflective and restorative supervision aims to improve the

quality of a practitioner's work, ensuring the achievement of agreed objectives and outcomes. Ultimately, it promotes high standards of practice, enabling professionals to make sound judgements that safeguard and protect children and young people from harm.

2.46 Staff responsible for child protection caseloads have achieved 100% compliance with supervision requirements, which is scheduled quarterly.

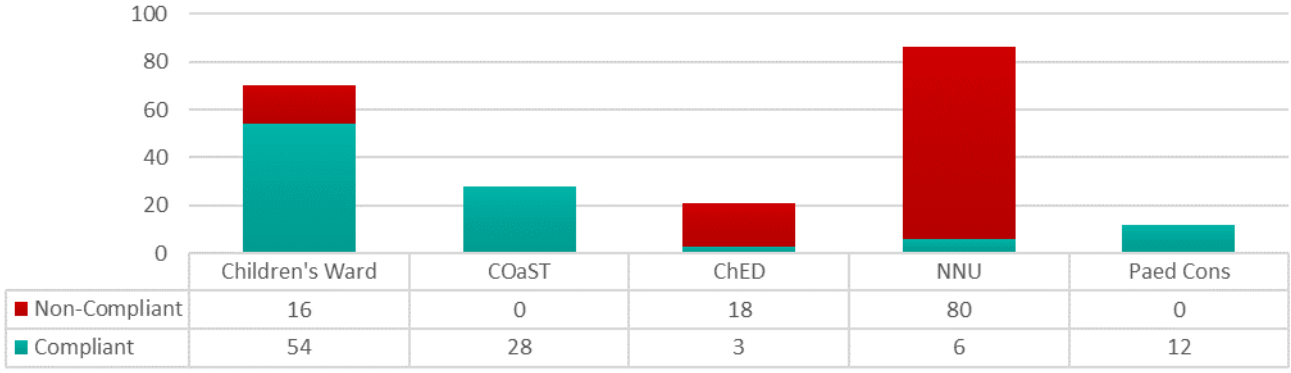
2.47 The Safeguarding team maintains close collaboration with the Community Outreach and Specialist Team (COaST), enabling staff to access ad hoc supervision as needed for individual cases or newly identified safeguarding concerns. This is provided alongside their regular group supervision, ensuring ongoing professional support and effective safeguarding practice.

2.48 For staff who do not hold a caseload, the recommended frequency for supervision is twice per year. Engagement in non-caseholder supervision has presented challenges, though compliance reached its highest level in Q3 at 57% since recording began. However, following an influx of new staff, compliance has since declined to 47%.

2.49 To enhance engagement, supervision dates have been scheduled for 2025/26. While progress in improving compliance has been slow, low uptake from the wider neonatal team and ChED staff is reflected in the data. Liaison with the neonatal professional development nurse (PDN) is ongoing to support compliance efforts, and time on neonatal training days was requested. Unfortunately, no space was available in the training schedule, but attendance at a neonatal team meeting in May 2025 has been confirmed. ChED staff have been invited to participate in ward supervision sessions to support learning and strengthen collaborative working. However, uptake has been limited.

2.50 It should be noted that the Neonatal Outreach Team, responsible for managing safeguarding cases within the neonatal unit, receive weekly supervision from the Safeguarding Team, alongside ad hoc one-to-one supervision as needed. This structured approach ensures ongoing support and oversight for babies known to children's social care or identified as being at risk of harm

Safeguarding Supervision Compliance



	Children's Ward	COaST	ChED	NNU	Paed Cons
Non-Compliant	16	0	18	80	0
Compliant	54	28	3	6	12

Local Safeguarding Child Practice Reviews (LSCPR)

2.51 There has been one new request for LSCPR in 2024/25. This has now been published under the pseudonym of 'Ruby and Daisy' and relates to a child suicide from 2023. In addition to this, 'Laura' was published in February 2025, which was a LCSPR initiated in 2023/24 following an unexpected neonatal death.

Key themes identified within the 'Ruby and Daisy' review:

The child's voice and parental narratives

Think family

Child sexual abuse

Equality, equity, diversity and inclusion

Families declining support

Support levels guidance, requests for support and professional escalation

Risk assessing, safety planning and sharing and triangulating information

Multi-agency response to child suicide.

2.52 The actions identified relate to multi-agency working and MFT will continue to support with this going forward.

2.53 Key findings identified within the 'Laura' review:

- The impact of multiple house moves and homelessness on children's wellbeing and education
- The challenges of cross borough working to safeguard children experiencing chronic neglect
- The identification, referral and assessment of need and risk in pregnancy
- Assessing the needs of the children (including the unborn) and their lived experience

2.54 The review identified specific actions for MFT, with the maternity safeguarding team overseeing the corresponding action plan. As of the publication date, maternity services had already commenced audits on several key areas, including the provision of safe sleeping information, a review of the maternity hub terms of reference, and the process for identifying risk when appointments are not attended.

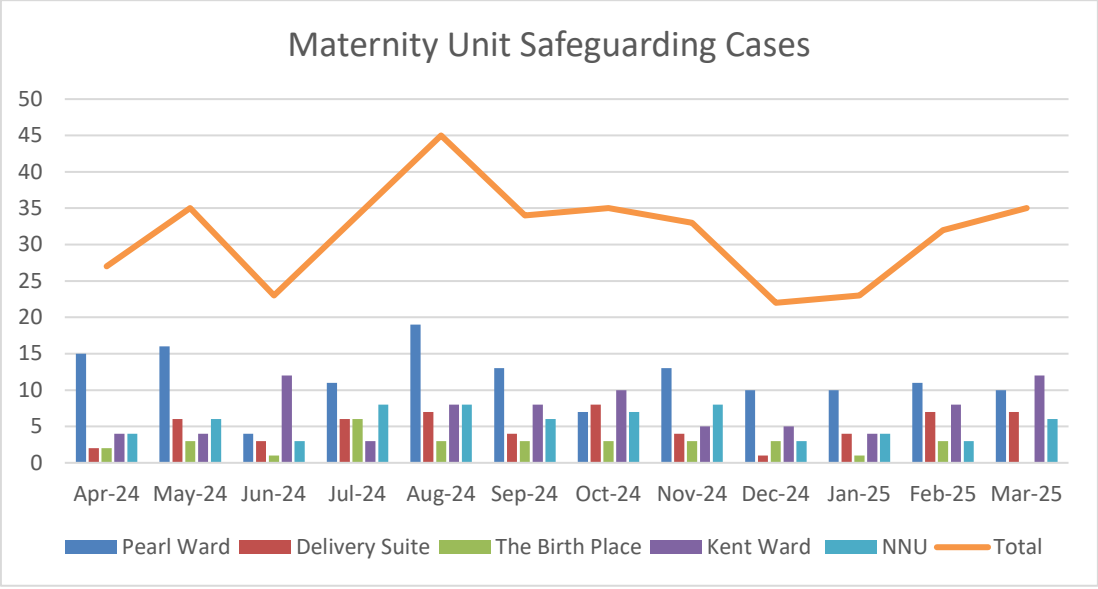
2.55 Over the past year, there have been eight requests for agency summaries, with MFT involved in four cases. All four cases have been referred for LCSPR's and will require agency reports to be completed and shared with the author of the reviews.

3 MATERNITY SAFEGUARDING

3.1 The Maternity Safeguarding Service consists of one whole time equivalent Band 7 Interim Named Midwife for Safeguarding, and a Band 6 Interim Deputy Named Midwife for Safeguarding. The responsibility of the Maternity Safeguarding Team is to provide oversight, co-ordination, and take responsibility of the day-to-day safeguarding of all unborn and new-born babies within the care of Medway NHS Foundation Trust (MFT), within both the hospital and community settings.

Maternity Unit Safeguarding Cases

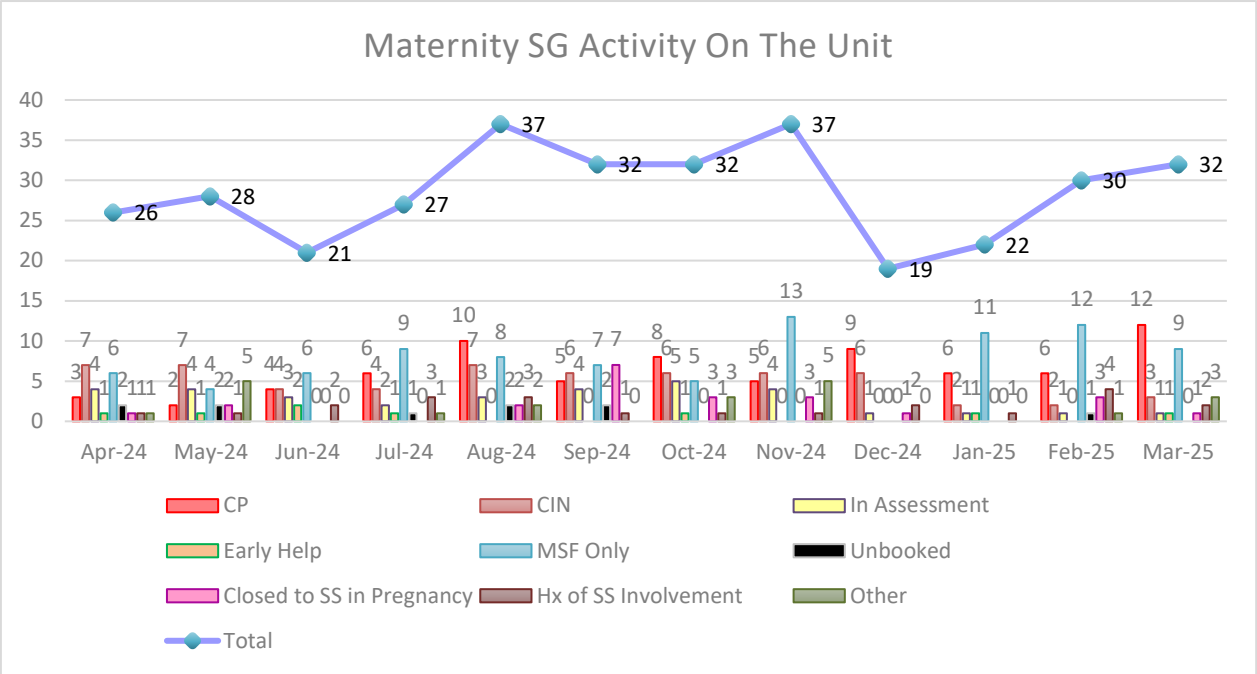
3.2 Pearl Ward and Kent Ward remain the areas that have the highest amount of safeguarding cases raised to the Maternity Safeguarding Team, with the Delivery Suite following. The daily ward round continues and remain a mixture of face to face and over the telephone, and the Maternity Safeguarding Team continue to have early oversight of admissions. This aids communication with the teams and ensures that care plans are up to date and followed, and early contact with social care (if required) can be facilitated to aid in reducing a prolonged stay for families for social reasons.



3.3

3.4 The safeguarding activity on the maternity unit is increasing month by month, with increasingly complex cases. The Maternity safeguarding team have had oversight of 76 Child Protection cases over the year of 2024/2025 which will include but not limited to: facilitating pre-discharge meetings, Court dates, potential baby removal from the parents, supporting the midwives on the wards with potentially volatile situations and care planning.

3.5



Team Connect

3.6 Team Connect and the Maternity Safeguarding Team work alongside each other, the team comprises of one Band 7 Senior Sister, four Midwives and one Midwifery Support Worker (MSW). A Maternity Team Assistant (MTA) also supports Team Connect for one day a week due to maternity leave.

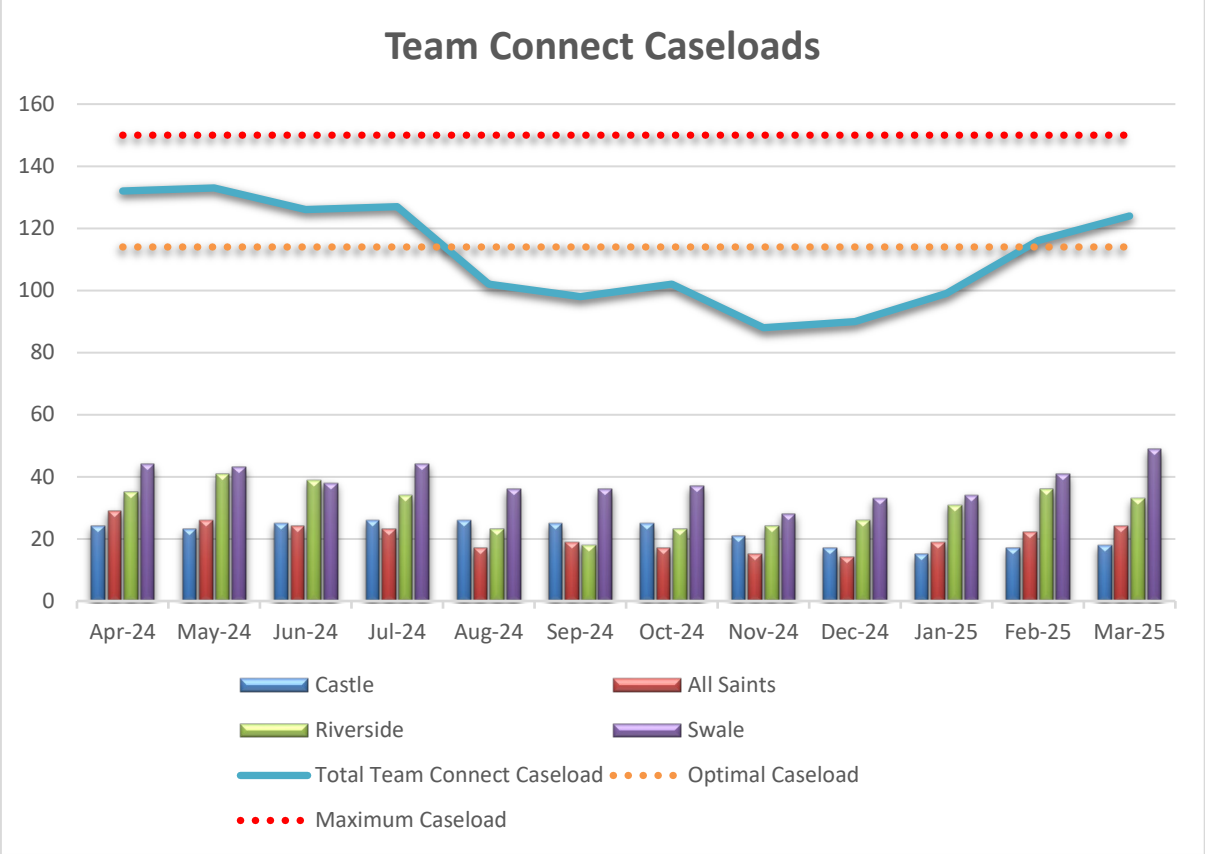
3.7 Team Connect provide holistic care to vulnerable families in the community, in both the antenatal and postnatal periods. In addition to providing maternity care, the team work closely with other health care providers, Children's services and agencies supporting the family. The MSW for the team provides bespoke parent preparation visits for families, and undertakes appropriate clinical work to support the team and families.

3.8 The Senior Sister for Team Connect works closely with the Interim Named Midwife for Safeguarding for continued improvement of the service and increased oversight of the safeguarding practices within the team. There are elements of cross- cover between roles at a management level in times of leave to ensure there is always an identified person to escalate and have oversight of safeguarding.

3.9 The Senior Sister continues to have responsibility of the Windmill Clinic (Drug and Alcohol Misuse Multi-Disciplinary Team Meeting), the completion of Mother and Baby forms, and supports when needed to review policy and processes for the team and wider safeguarding practices.

3.10 Team Connect caseloads saw a decrease between July – November 2024, and have remained under the maximum caseloads expected from the team; there has been a noticeable increase since December and now are just above the optimum level. The Swale area continues to be consistently high across the year with

Riverside remaining at a high caseload in the last quarter. The Senior Sister continues to hold a small caseload in the Swale area.

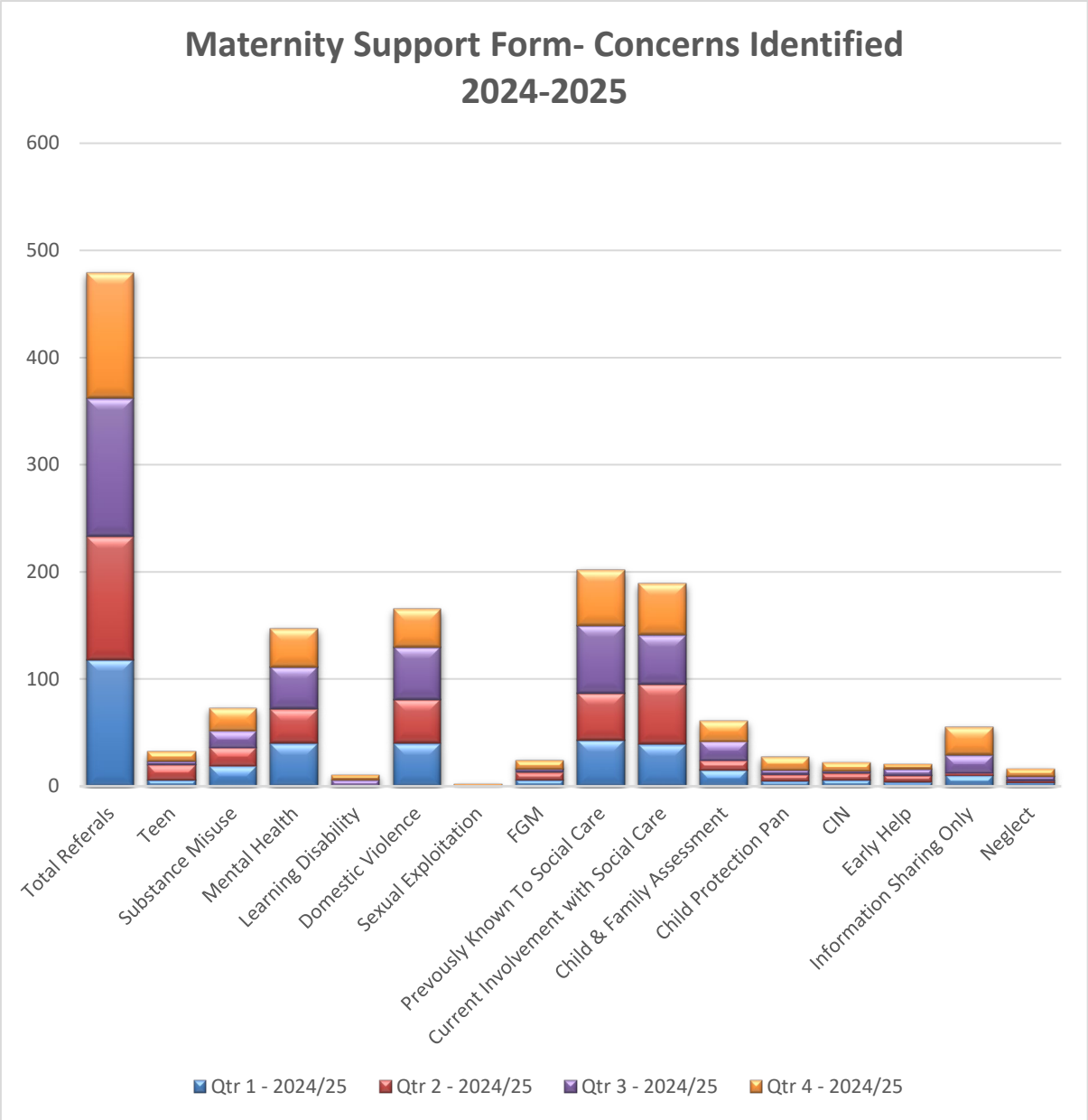


Maternity Safeguarding Activity

3.11 Maternity Support Forms (MSF), continue to be used across the community and hospital settings to clearly document safeguarding concerns or high-risk vulnerabilities, actions taken, and the plans agreed with the families and professionals. MSF's are a communication tool between trust professionals, but also with external health agencies such as Health Visitors and General Practitioners (GP's).

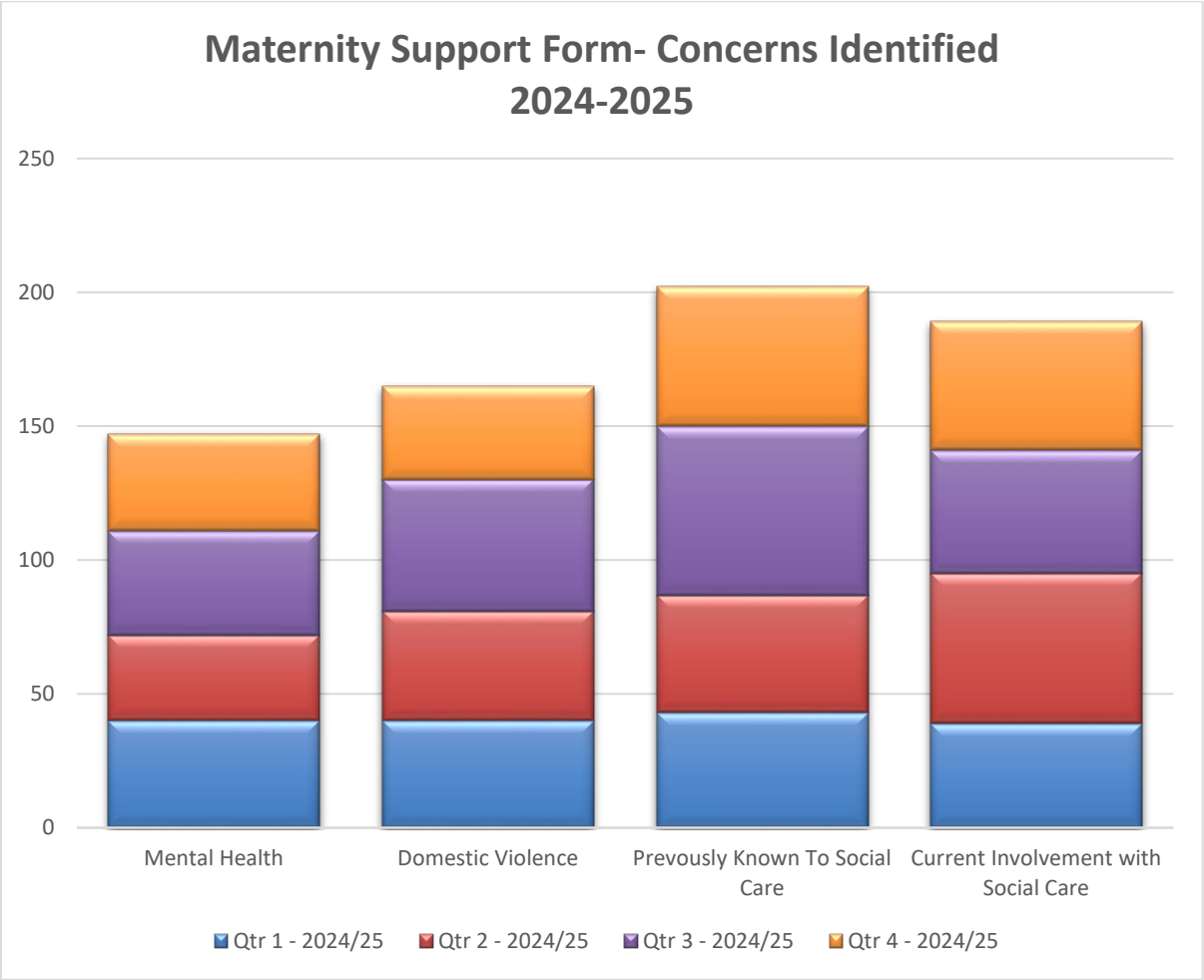
3.12 These forms are also useful when sharing information between trusts if there is a transfer of care. The forms allow for a reduction of delays in discharge due to clear plans being visible to staff to follow, it also ensures that professionals are aware of the concerns in all maternity areas to encourage professional curiosity and timely escalation of concerns. The forms allow data to be collected on the types of vulnerabilities we are supporting families with, and if there are any trends or significant areas of concerns to focus on.

3.13 The graph below shows the risks/concerns identified on MSF's over the period of 2024-2025 and is broken down into quarters for ease of comparison (please note that each individual MSF referred may have multiple concerns included):



3.14 There have been 479 MSF's raised in 2024/2025, in comparison to 521 for the previous year, this is a reduction of 42 MSF's raised. The decrease of raising an MSF could reflect the education of the teams in relevant information sharing. Ongoing work has been completed with all community maternity teams who hold the responsibility of commencing and updating the MSF's, in relation to appropriate documentation and effective care planning. All MSF's continue to be reviewed by the Maternity Safeguarding team to ensure that they are being used appropriately, all relevant contact details are completed if any further professionals are involved and that there are clear and concise plans if required for contacting relevant teams.

3.15 The highest area of concerns identified are: Family's previously known to social care, Current Involvement with Social care, Mental Health and Domestic Abuse. The concerns remain to be consistent from previous years.



3.16 There have been 165 families identified with Domestic abuse as a concern in 2024/25 in comparison to 203 families in 2023/24, this is a noticeable decrease from last year however still remains as a top concern for the safeguarding team. To ensure maternity staff are appropriately trained to identify, understand and support families where domestic abuse is a factor, it is included in both Adult and Children Level 3 Mandatory Safeguarding Training, as well as essential skills maternity specific training. Maternity have a close working relationship with the Hospital Independent Domestic Violence advisors (HIDVA), who are able to support both staff and service users and have provided bespoke training and increased visibility to maternity staff both in the hospital and community settings. This level of training and support will need to continue to ensure a robust and safe service is provided, and to encourage multi-agency working.

3.17 This year has seen 147 families with mental health as a concerning factor which is a decrease from last year's 161 families. The specialist mental health maternity

team, Team Lotus, take responsibility for the oversight of the care planning for families with mental health complexities and also attend the Maternity Safeguarding hub's and Neonatal weekly safeguarding meeting to ensure specialist advice is shared with the Multi-disciplinary team to aid in care planning and improve communication between teams.

3.18 Joint working between the Maternity Safeguarding Team and Team Lotus remains ongoing, and is crucial to ensure prompt and necessary early intervention and support.

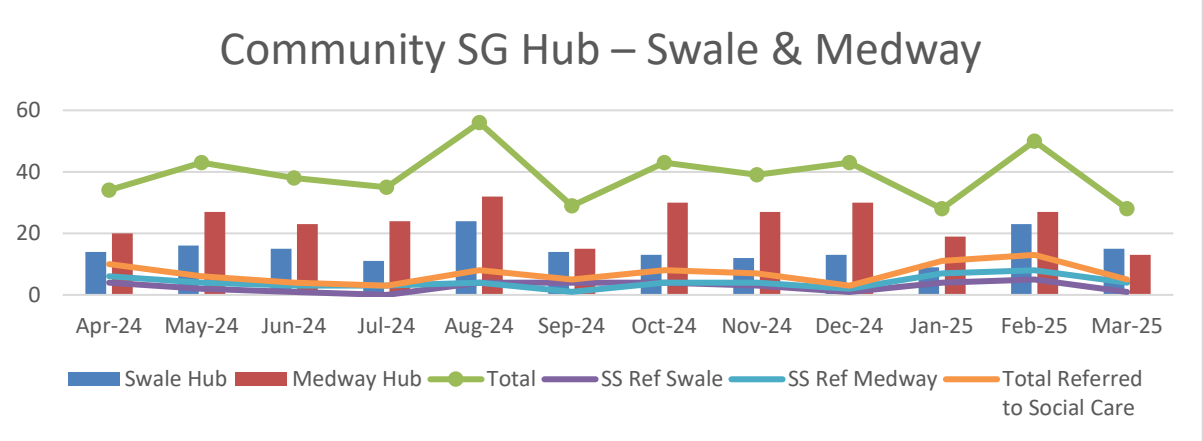
Medway and Swale Maternity Safeguarding Hubs

3.19 Following the Local Safeguarding Practice Reviews of 'RH' and 'KH' and learning lessons review of 'XW', recommendations were made for a full review of the maternity safeguarding hub process, specifically to review the terms of reference referral criteria and associated referral forms.

3.20 This has been completed with the Maternity Safeguarding team alongside the team manager for SPA and Mash at Medway Children's Services, with input from Matrons, Senior Sisters, the Medway Safeguarding Children's Partnership (MSCP) and hub members. The new terms of reference and referral forms went live in quarter three, with ongoing reviews of the processes.

3.21 There have been 466 families referred to the Maternity Safeguarding HUB (including both Medway and Swale), in 2024/2025; In comparison to 445 heard the previous year. This is a small increase of 21 families heard. However, there has already been a decrease since the introduction of the new terms of reference and referral forms, there should be a more noticeable and positive impact going forward.

3.22

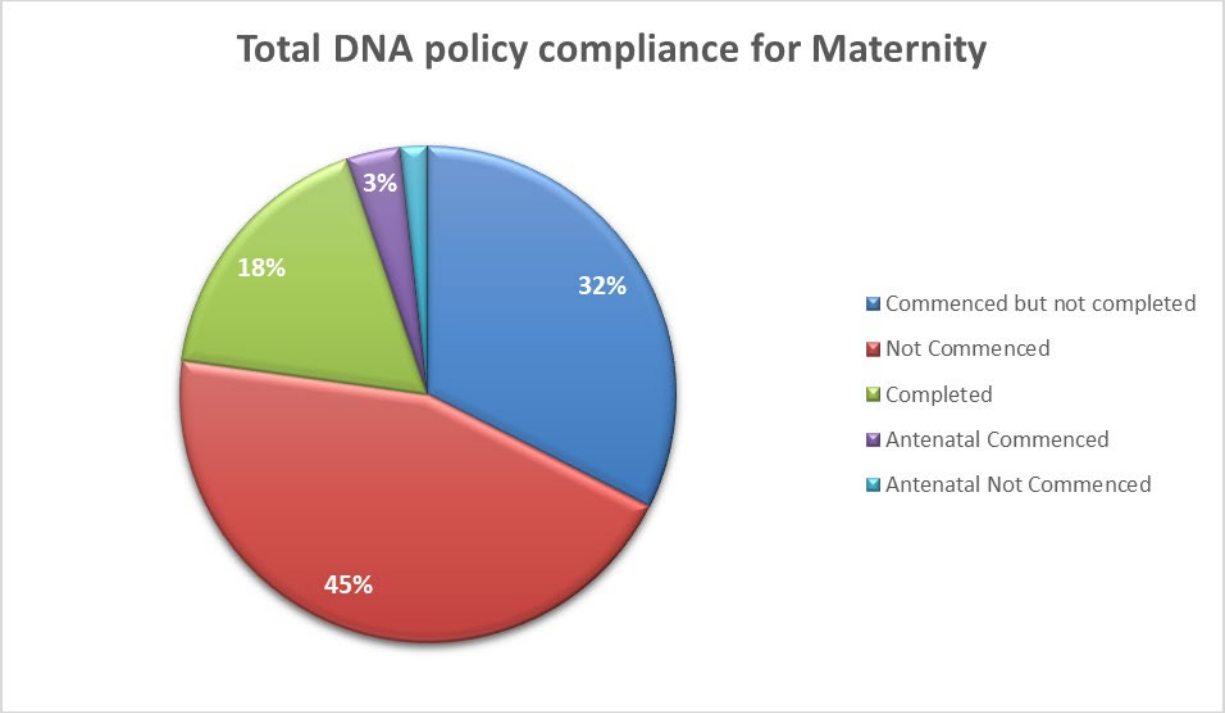


Did Not Attend (DNA) processes and audit

3.23 In 2024/25 some LCSPR's have highlighted a concern that maternity were not appropriately following our defaulter's guideline and due to this there has been missed opportunities for professional curiosity, early intervention, and safeguarding practices to be followed.

3.24 A full DNA audit was completed this year for the period of 01st October 2023 – 30th September 2024 to investigate areas of compliance, improvement required and ways to better support maternity staff to identify and support families who may need additional support.

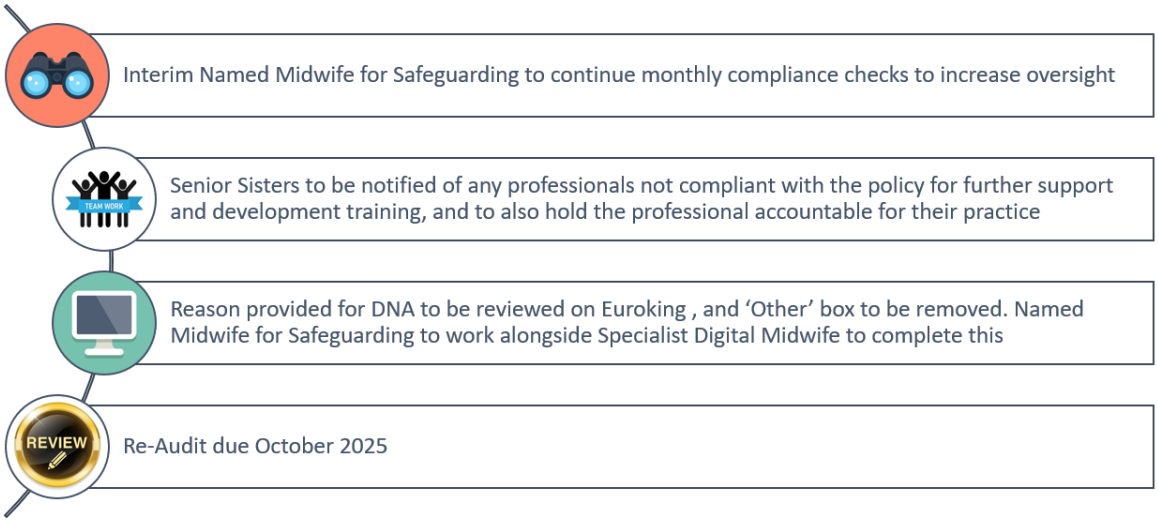
3.25 The outcome of this audit demonstrated that despite robust changes to the Defaulters Guideline and Missed contacts checklist during the audit period, compliance with this policy has remained low with only 18% of the 228 services users requiring a Missed contacts checklist being completed in full, and 32% not commenced at all.



3.26 Similar to last year there were also concerns of the quality of documentation and the need for significant improvement in this area. Overall, it was identified that compliance with this policy was a practice issue rather than a process issue, and additional oversight from senior sisters and the maternity safeguarding team is still required.

3.27 An action plan was created in agreement with senior maternity management as follows below. All actions have now been completed, it was deemed that due to the non-compliance that another audit should be completed before the year. Therefore, it was agreed to collect data to the end of April 2025.

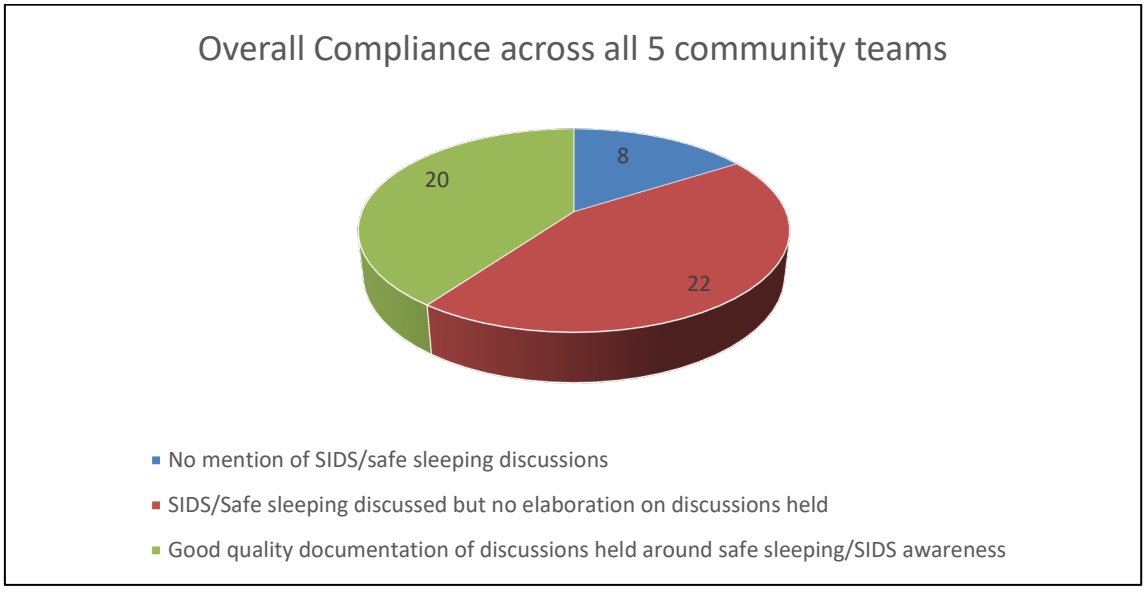
3.28 The new audit is in the process of being completed.



3.29 The maternity safeguarding team continue to review each missed contact checklist when received and are sending back to the community midwife with the appropriate senior sister copied in if not completed properly.

Safe Sleeping Audit

3.30 The Local Child Practice Review of "KH" prompted a review of practice around Sudden Infant Death Syndrome (SID'S) prevention advice provision within maternity care. Following this advice, a full review of documentation for postnatal visits completed with the family demonstrated that safe sleeping advice was shared by the way of a tick against the topic at each contact. However, it was found that not all contacts recorded the nature and depth of the discussion that had been had and there was no evidence that staff members had visualised the safe-sleep environment that was in place for baby. The graph below demonstrates the compliance across all five of the community teams for the month of October 2024.



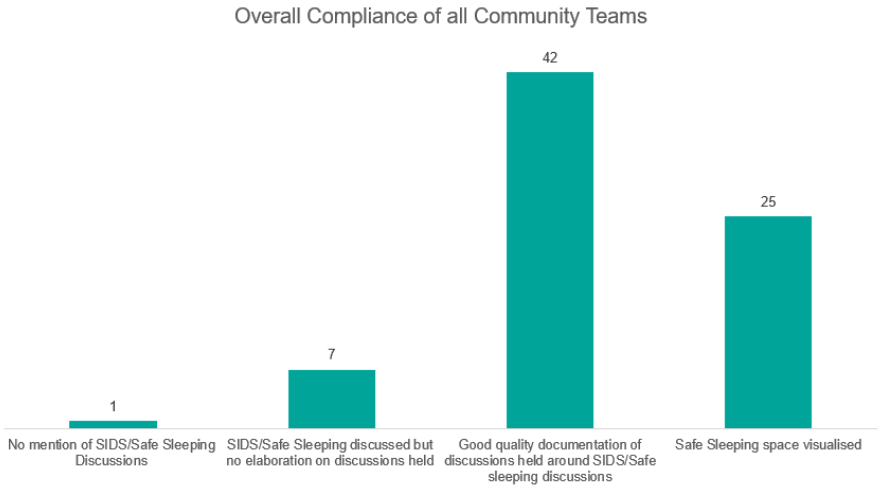
3.31

3.32 The summary of findings was the inconsistency noted across all five of the community teams in the level of documentation on SID's prevention and safe sleeping advice provision.

3.33 There was only evidence of 1 incidence of documentation of visualising the sleeping space with the home of the 50 contacts reviewed. This demonstrated that this practice was not embedded within the community teams as routine for first day visits or any subsequent contacts.

3.34 Upon discussion with team leaders it was also evident that practice is not embedded within the team for consistent availability of Lullaby Trust information cards, however positively a QR code signposting parents to the Lullaby Trust website is included on postnatal visits leaflet given to all women on their first postnatal home visit.

3.35 Following the completion of this action plan, a re-audit has been completed for March 2025 and as seen from the graph below there has been significant improvement across all five community teams within the documentation.



3.36

3.37 Further work will continue to be ongoing to ensure that improvements continue within the safe sleeping provision provided by midwifery.

Service Performance Indicators

Key performance indicator's (KPI) specific to Maternity Safeguarding at MFT are:

- 100% Safeguarding Supervision for all Child Protection (CP) cases
- Pre-Birth Planning for 100% of babies' subjects to a CP plan

Safeguarding Supervision

3.38 Clinical safeguarding supervision is mandatory for all Child Protection case holders in Maternity, with a statutory requirement to complete one session each quarter. The Named Midwife for Safeguarding oversees supervision in maternity.

3.39 While Team Connect manages most Child Protection cases, there are instances where general community teams handle families under a child protection plan due to concerns arising in late gestation. Throughout, 2024/2-25, we have met our statutory responsibilities and achieved 100% compliance rate for safeguarding supervision for all child protection case holders.

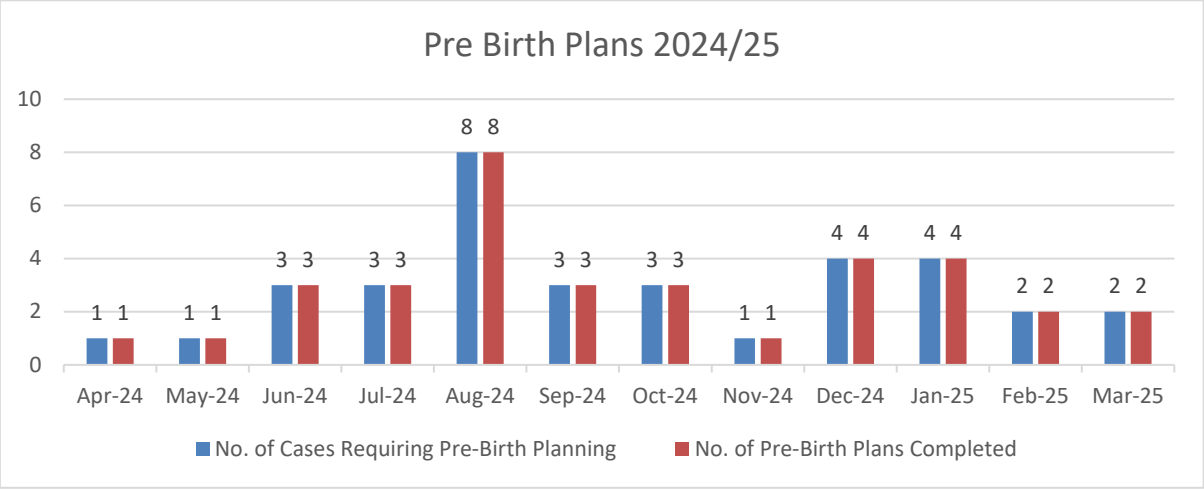
3.40 Supervision for non-Child Protection case holders has continued this year; all maternity teams are aware that they are required to complete safeguarding supervision a minimum of twice per year. Maternity Safeguarding Supervision sessions are available to staff via teams. There has been increased compliance from the community midwives.

3.41 Senior sisters continue to have oversight of their team's compliance with supervision. There has been good compliance seen throughout the year and at the end of this year compliance was 75%.

Pre Birth Plans

3.42 Pre-Birth planning is required for all CP cases within maternity; it enhances communication between Midwifery, Social Care and the Families to ensure clarity of expected outcomes, reduction in length of stay, and transparency between services and service users. Pre-Birth Planning Meetings are required to be held by 36 weeks gestation, or 34 weeks if they have factors for pre-term delivery, and is led by the maternity teams.

3.43 In 2024/2025, 35 families required a pre-birth plan to be completed. The KPI for Pre-Birth Plans is 100%, and positively there has been 100% compliance.



Service Development

3.44 The following audits are in the process of being completed and will provide evidence of embedded practice across the maternity service:

- Did Not Attend (DNA)

- Child Protection Information Sharing (CP-IS)

3.45 Antenatal Toxicology is in the process of being explored by the Interim Named Midwife for Safeguarding. The initial data has been collected, it is in the process of being analysed. A meeting will take place with Matron for Community, Interim Named Midwife for Safeguarding and the Head of Midwifery to discuss the findings and for evidence to be provided if this is something that can be trialed within the maternity setting.

4 LEARNING DISABILITIES

4.1 The Trust employs two registered Learning Disability (LD) nurses within the corporate safeguarding team. The Lead Learning Disability Nurse returned from maternity leave in July 2024. Maternity leave cover from a registered nurse was not possible due to the National shortage of registered Learning Disability Nurses, and the team backfilled the post with a senior clinical support worker with a keen interest in supporting people with learning disabilities.

Oliver McGowan Mandatory Training

4.2 The Health and Care Act 2022 introduced a statutory requirement that CQC registered providers must ensure their staff receive learning disability and autism training appropriate to their role.

4.3 Oliver McGowan training is the governments preferred LD training and this supports the NHS Long Term Workforce Plan ambition by upskilling the wider health and care workforce. Its goal is to provide appropriately adjusted care for people with a learning disability and autistic people to reduce health inequality.

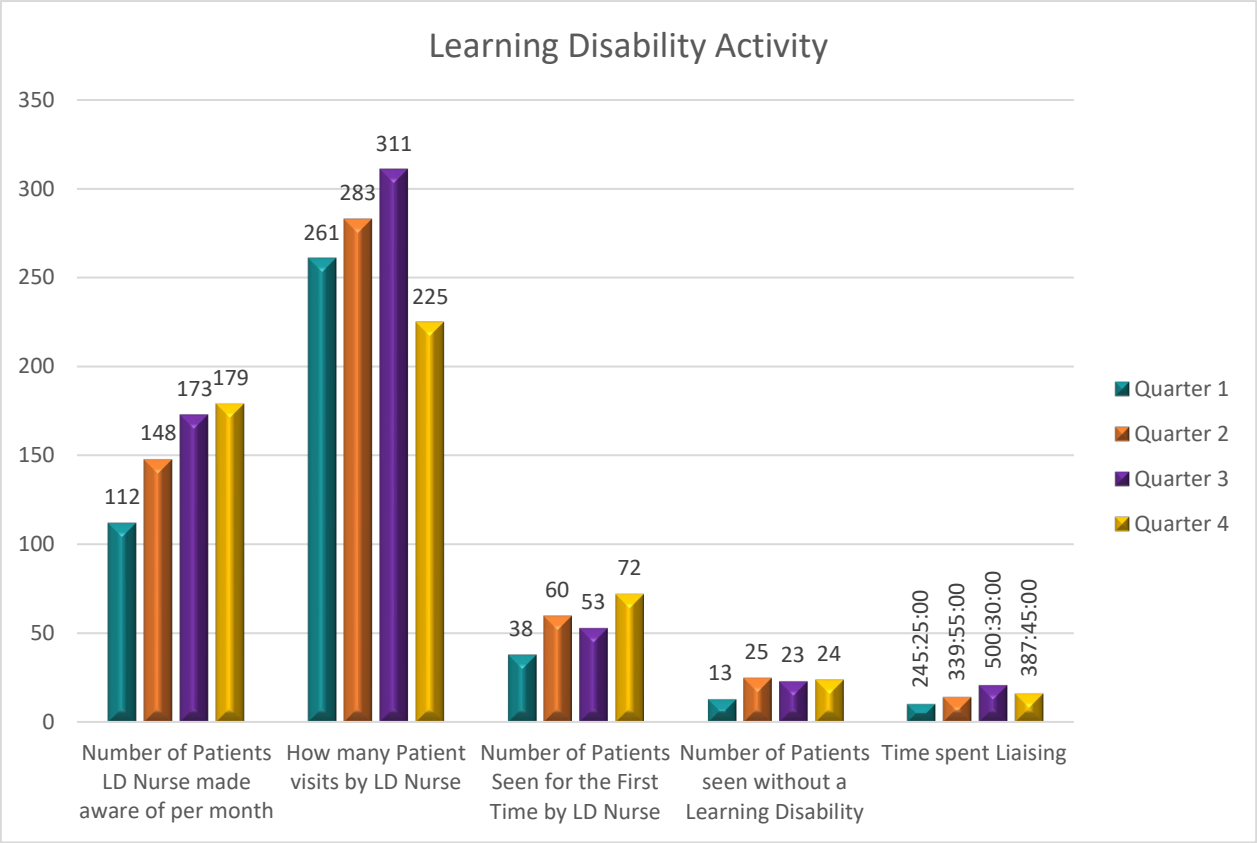
4.4 The ICB has commissioned external provider Bemix to deliver this training. There are challenges for all Trusts to support this roll out.

- This will be a full day's training for all patient facing staff.
- There are limited training rooms and venues available.
- The facilitators include those with lived experience and rooms must be accessible with a maximum of 30 participants.
- There is a cost implication in the longer term as there is only partial funding for training delivery.

4.5 All staff must first complete the eLearning to support this training. The Trust compliance of the Oliver McGowan eLearning training (part 1) is currently at 93%.

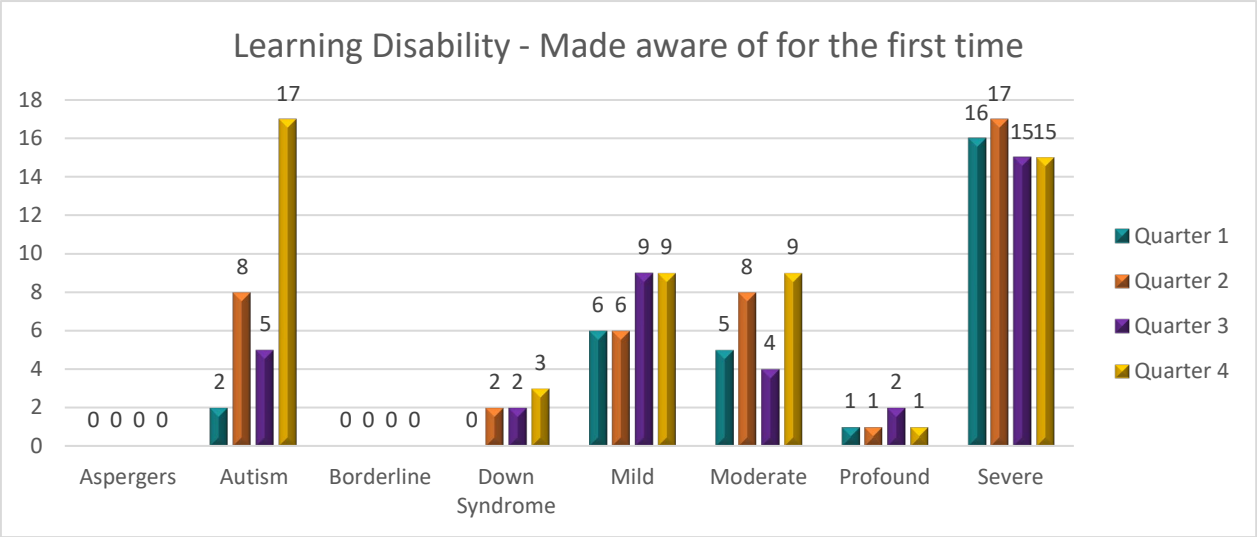
Learning Disability Activity

4.6 The graph below demonstrates the number of patient reviews undertaken by the LD nurses over the past year.

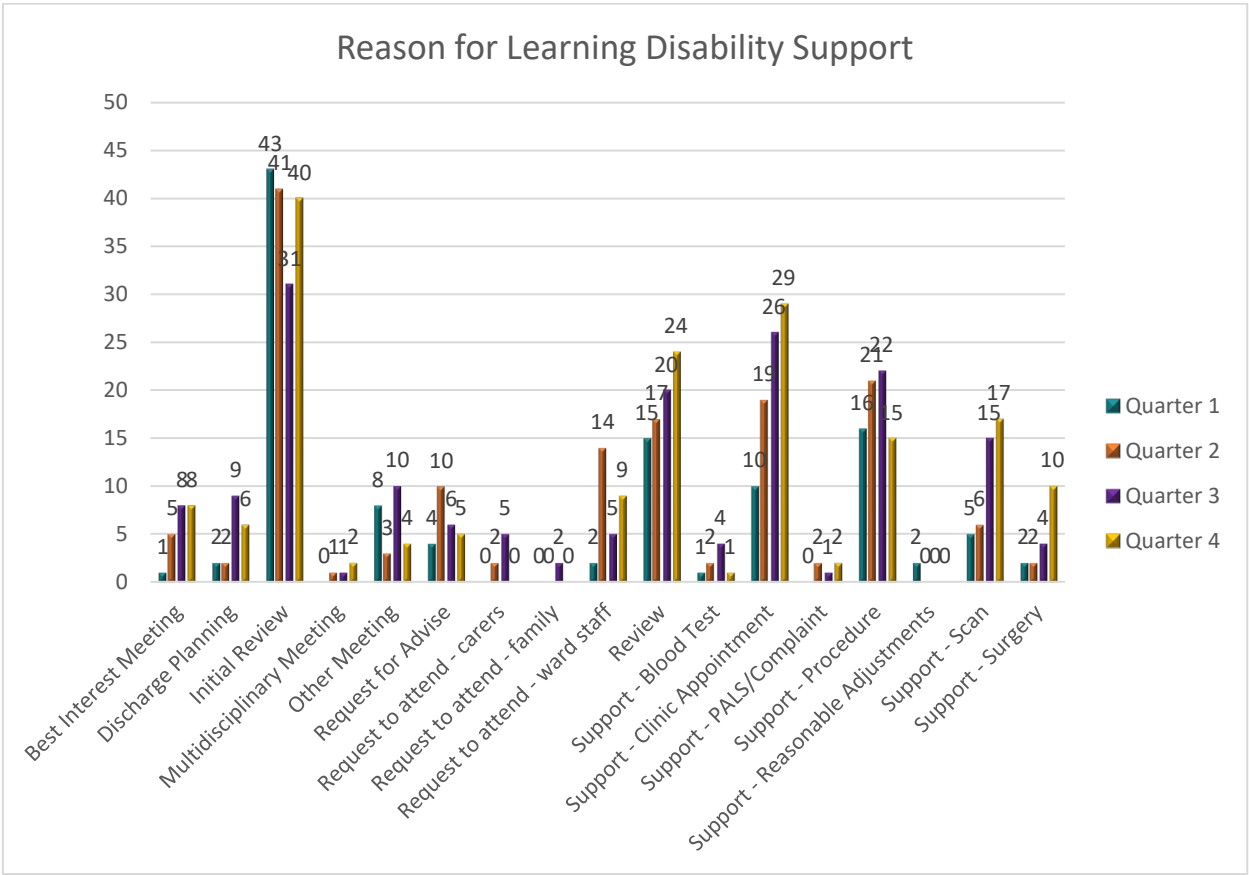


The number of new patients seen by the team for the first time doubled from Q1 to Q4. Medway and Swale have a high number of supported living environments and care homes specialising in supporting those with learning disabilities, autism and complex disabilities. In addition there are many parents caring for their adult children with learning disabilities, we have experienced a growing number where the parent is struggling or unable to continue to care for them due to their own ageing and health issues.

The type of learning disability that the patients who are seen for the first time is shown below.



4.7 The reasons for referral to the LD nurses can be seen below.



Achievements.

4.8 **VIP Pathway –** The VIP pathway has continued to be successful with the hospital providing blood tests, Flu and Covid vaccinations, scans, podiatry, haircut, dental treatment, bowel screening, breast screening and gynaecology investigations under one general anaesthetic. A mother gave positive feedback stating how streamlined the service was with minimal distress to her son. Due to the patient's

challenging behaviours the Learning Disability Nurses held a briefing in theatre before the patient and carers arrived so all involved were aware of the plan. The Learning Disability Nurses then met patient, family and carers with a wheelchair in the carpark to escort him straight to the anaesthetic room for minimal distress.

4.9 Learning Disability Nurse and CEPOD Lead and Coordinator gave a Spotlight presentation on the VIP pathway on the 25th April 2024. This pathway has become embedded and has an established pathway is in place to support patients requiring multiple procedures or sedation and anaesthetic for investigations and treatment.

4.10 The Learning Disability Nurses and colleagues for surgery and anesthetics were finalists in the Nursing Times Awards Night for the Learning Disability award. We were runners up and commended for the collaborative work undertaken to provide reasonable adjustments for so many of our patients in line with the (Equality Act 2010).

4.11 The Learning Disability Nurses where asked to speak at the Community of Practice event held at the Canterbury Christ Church University in December 2024 about the success of the VIP Pathway.

Awards

4.12 Tony Hunt, Learning Disability nurse was nominated for a Medway Star Award in the Equality and Inclusion category for his continued support for people with learning disabilities.

4.13 Jodie Holt, Bank Learning Disability Clinical Support Worker won a star award and is a finalist at the Trust annual awards for her commitment and initiative when covering maternity leave in the Safeguarding and Learning Disability team. Jodie stepped into a new role that she excelled in.

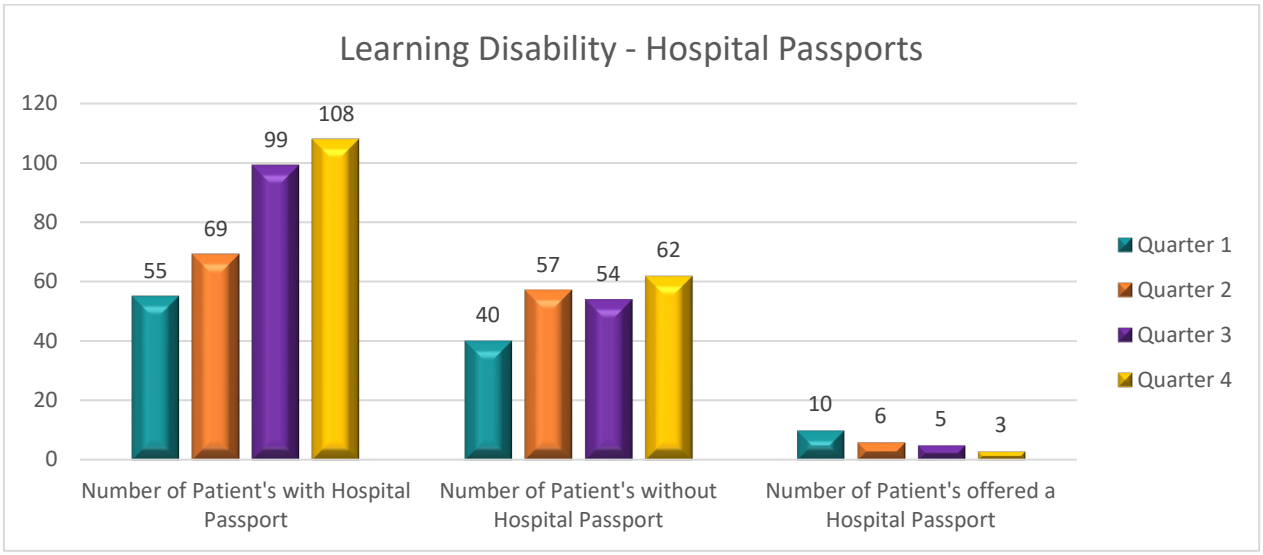
4.14 **Learning Disability Awareness week 2024 – Mencap's theme Do you see me.** About people with a learning disability being seen, heard and valued. Proud Pac, a dance and drama group of those with learning disabilities and autism gave a performance in the Atrium which received a huge response and support from the public and staff alike.

4.15

Consent has been gained for these photos to be shared.

4.16 Disability History Month, Learning Disability Nurses supported the Equality and Inclusion team with a stand in the staff restaurant. This was to promote the Changing Places Facility, use of Hospital Passports and other resources.

4.17



Learning disability passports are a vital communication aid and a supportive tool to break down barriers for those with Learning Disabilities in hospital settings.

4.18 **Reasonable adjustments** – The VIP Pathway is an excellent example of a reasonable adjustment. Examples of basic reasonable adjustments include

reading Hospital Passports, listen to carers and families, adapt communication - simple clear language and pictures can be used.

4.19 The Learning Disability nurses have introduced desensitising visits for patients with learning disabilities and autism to familiarise themselves with where they will be admitted and what is likely to happen. This has included taking the patient on a walk around of departments ahead of day surgery. Patients can attend POCU, Sunderland and theatres including the anaesthetic room, as well as meeting the teams when available. This has shown to reduce anxieties ensuring, that the patient and their family/carers have a good experience.

4.20 The Learning Disability Nurses are able to offer a gender informed support approach, as having a male and female Learning Disability Nurses we have been able to provide support i.e. for breast screening, gynaecology and urology investigations. This has worked well where some patients with learning disabilities may feel uncomfortable with a male staff member if they have previously suffered trauma.

Transition

4.21 Historically transition from children's services to adults has been a challenging time for many families and carers of those caring for someone with complex health issues, increasing those challenges when they have a learning disability with impaired capacity. The Lead Learning Disability Nurse is working collaboratively with a number of specialist services including Acute Medicine, Respiratory and Gastroenterology in adult services. Paediatric consultants making referrals onto Speciality teams within MFT i.e. Respiratory and Gastroenterology as the key health related issues that people with learning disabilities.

4.22 The Lead Learning Disability nurse is working with the transition lead nurse from Demelza hospice, Medway Community Healthcare children's learning disability team, Children's Outreach and Specialist Teams (COaST) to improve processes and pathways locally and nationally.

4.23 There is a well-established pathway for transition to Diabetes services and Neurology are following a similar process. Respiratory clinicians are happy to accept referrals within their remit but will monitor the volume of referrals to caseload management and appointment waiting times.

Learning from Deaths.

4.24 **LeDeR** mortality review programme is a service improvement initiative commissioned by NHS England since 2017, the aim is to improve care for people with a learning disability and autistic people, reduce health inequalities and

prevent people with a learning disability and autistic people from dying unnecessarily early.

4.25 We have referred 12 patients with learning disabilities to LeDeR from April 24-March 25. All these patients have had a Structured Judgement Review (SJR) which is shared with the LeDeR reviewer. 9 of these deaths were attributable to Pneumonia / Chest Sepsis. This is the most common cause of death for people with learning disabilities.

4.26 Poor communication with those that know the patient best and failure to make a referral to the learning disability nurses in a timely manner have been highlighted within 2 reviews as learning points to share. These have been taken directly back to the tams involved in the care of the patients.

4.27 Feedback from a patient's family was received following her death in September 2024. The family were so grateful for the care and treatment received they donated £4000 from her trust fund to be shared with the Therapy dogs and Lawrence ward. This was presented at a memorial photoshoot event for her family and friends, nursing teams, therapy dogs and their owners. This was published in the Trust magazine in spring 2025, highlighting the vital connection therapy dogs make to support patients with learning disabilities and autism.

Audits

4.28 **The learning disability improvement standards for NHS trusts -** measures the quality of care provided to people with learning disabilities, autism or both. The standards have been developed with a number of outcomes created by people and families. By taking this approach to quality improvement, it places patient and carer experience as the primary objective, as well as recognising the importance of how the NHS listens, learns and responds in order to improve care.

4.29 The four elements are:

- Trust Overview
- respecting and protecting rights,
- inclusion and engagement
- workforce.

The Audit is usually undertaken in 3 parts

- Organisational data collection
- Staff Surveys
- Patient surveys

This year the data collection was focused on Data collection and staff surveys.

The staff survey response remains weak with only **39** responses received The aim was for 150 responses.

4.30 Some of the standards we have not been able to meet year on year remain consistent.

LD and Autism specific data such as;

- The number of complaints received regarding care and treatment of people with a learning disability during 2023-4.
- Do you compare the outcomes and experiences of patients with a learning disability from different ethnic background groupings?
- Are you readily able to identify children, young people and adults with a learning disability and/or autistic patients, who are on waiting lists for assessment and/or treatment?
- Do you monitor/compare the emergency readmission rates for children, young people and adults with a learning disability, with those of people without learning disabilities?
- Do you have a dedicated post/position for a person(s) with a learning disability or their family carers on your Trust council of governors and/or any of your Trust Board sub-committees?
- Triage processes which prioritise people with a learning disability, or autistic people
- A low stimulus area / waiting area

5 MENTAL CAPACITY ACT

5.1 The primary purposes of the MCA include the promotion of autonomy ('No decision about me without me.' Liberating the NHS 2012), to safeguard those estimated 2 million vulnerable individuals that lack capacity in England and Wales, to plan ahead and to always ensure that any decisions made for someone who lacks capacity must be in their best interests and restrict their rights as little as possible.

5.2 In addition to the legislation the purpose of a Mental Capacity Act assessment is to determine whether an individual has the mental capacity to make a specific decision at a particular time.

5.3 The MCA Lead Nurse plays a crucial role in ensuring that the principles of the Mental Capacity Act 2005 are upheld by providing expertise, advocacy, policy development and by delivering training and education.

5.4 Training is essential to ensure that staff understand not only their legal responsibilities but can effectively support those who lack capacity. Training can be accessed either face to face or eLearning.

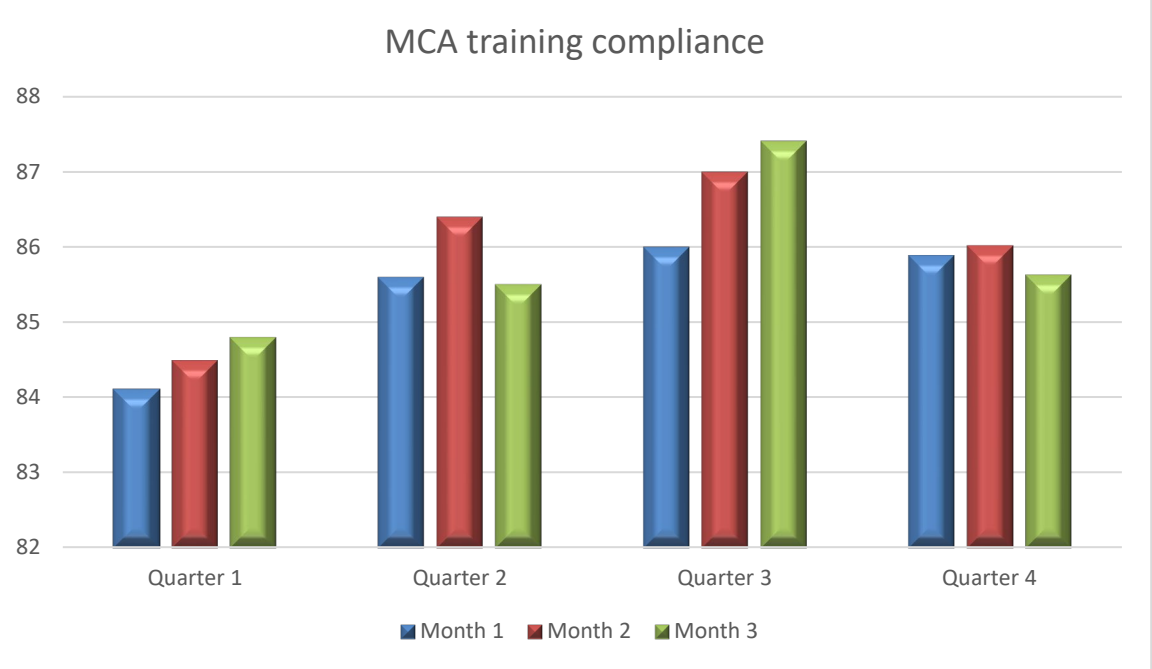
Training Compliance

5.5 Compliance for mandatory MCA training has been within the expected KPI (key performance indicator) of 85% for over six months leading it to be removed from the risk register, however, monitoring of this remains continuous via monthly performance reports which are shared both internally and externally.

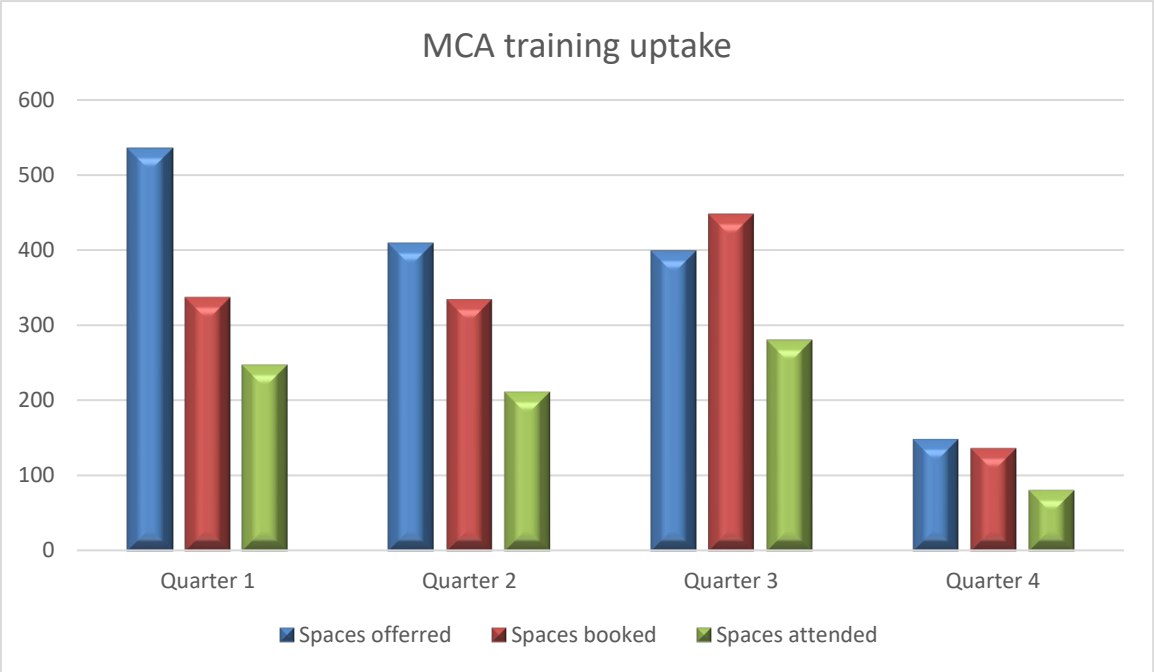
5.6 Supplementary workshops are offered with the aim of enhancing knowledge and skills with a focus on form filling, particularly for professionals who need to complete legal documentation correctly. The workshops have been offered throughout the year but are difficult to recruit to given that they are optional despite professionals being able to use the learning towards their professional development log.

5.7 The MCA Lead Nurse in conjunction with the clinical practice facilitators (CPF's) has developed an MCA competency package that will initially be incorporated into a new starter booklet then cascaded out amongst the wider workforce.

5.8 It is envisaged that those competencies will be assessed on both the wards by the CPF's who have had train the trainer sessions and the MCA Lead Nurse; the competencies were ratified in March 2025 and will be in circulation for signing off from April 2025 onwards.



5.9 To year end, 1493 training spaces were made available; a slight decrease on the year 2023 / 2024, however the MCA Lead Nurse monitored the compliance monthly to ensure conformity. From the places offered 1255 were booked with 819 actually attending equating to 55% of places being utilised despite reminders being sent to candidates up to 48 hours prior to the session.



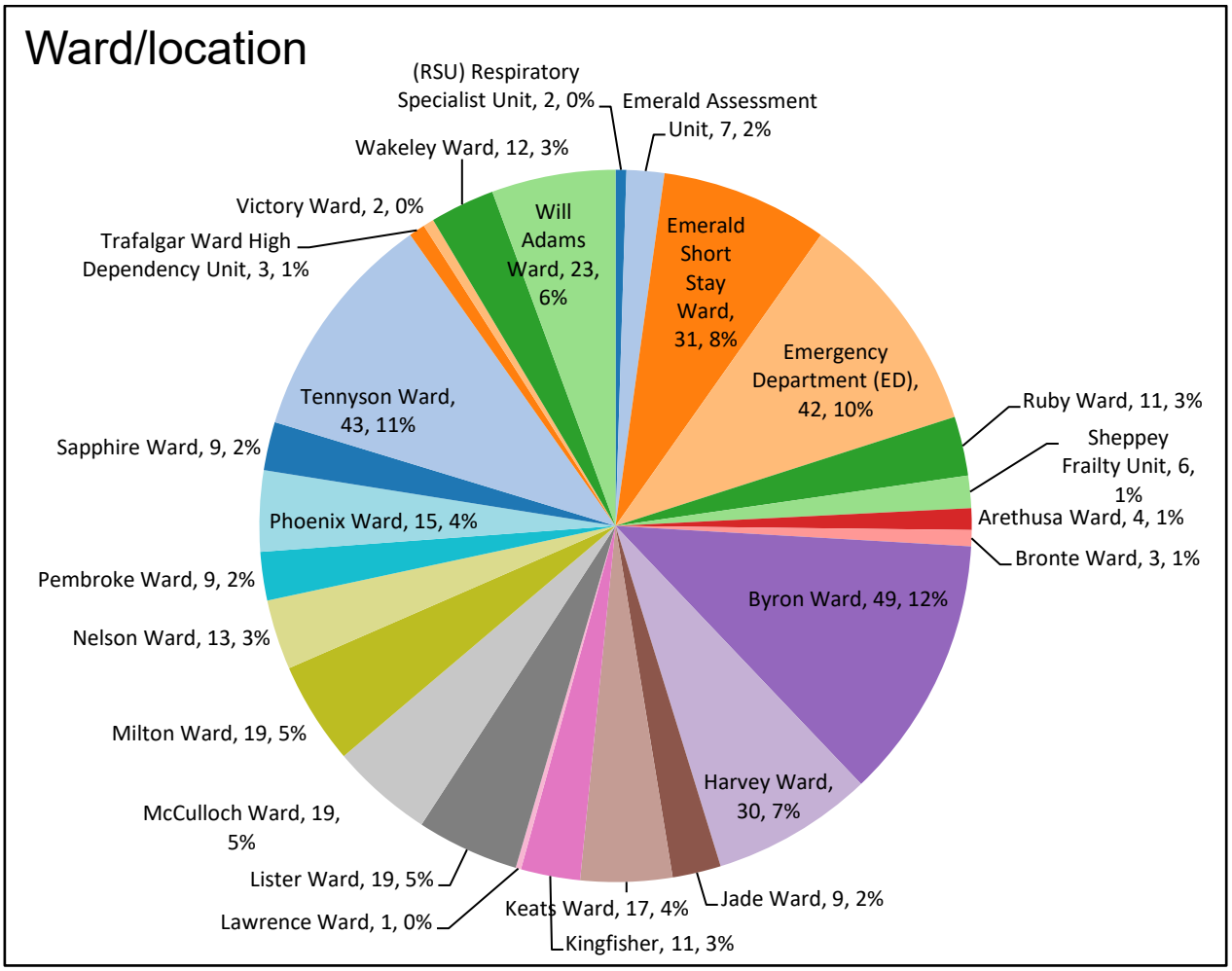
Whilst compliance of medical and dental colleagues remains the lowest and below the KPI it is increasing month on month: Q1 = 67%, Q2 = 70% and Q3 71% Q4 = 71%

MCA Audits

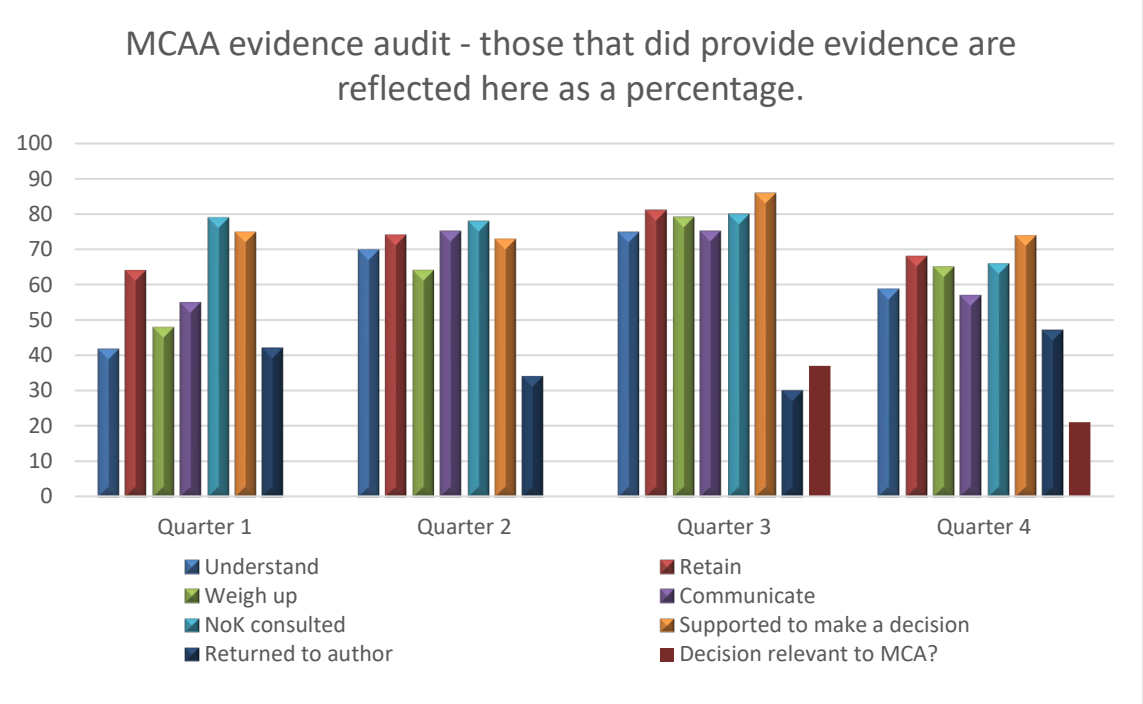
5.10 The MCA Lead Nurse reviews and audits 50% of those mental capacity assessments monthly that are submitted with DoLS applications to ensure that the assessment was conducted fairly, accurately and in line with legal and ethical guidelines: The Mental Capacity Act (2005).

5.11 409 MCAA's were audited throughout the year, the majority of which came from medicine and emergency care. This is appropriate given the number of patients in their care that have a cognitive impairment. However, given that several wards have been reconfigured this year it is difficult to give exact information.

5.12



5.13 The quality of assessments has improved since the start of the audit and for the majority of this year suggesting that colleagues are adhering to the five principles of the Mental Capacity Act and are able to apply both the functional and diagnostic tests accurately.



5.14 From Quarter 2 onwards, an extra field was added to the audit focussing as to whether the decision to be made on the assessment toolkit is actually relevant to the MCA. Given that the initial findings are that compliance to this is low the MCA Lead Nurse has added in extra time at the mandatory training to discuss the importance of the decision to be made and the difference between 'care and treatment' and 'care and treatment arrangements which is the reason why the majority of the assessments are returned.

5.15 Whilst the MCA does not necessarily define best interests the best interest principle states that any action taken for a person that lacks capacity should be made in their best interest. This person is usually a person handling day to day decisions; it is therefore positive to see an increase on those with an interest in a person's welfare being contacted.

Independent Mental Capacity Advocate (IMCA)

5.16 An Independent Mental Capacity Advocate (IMCA) plays a vital role in safeguarding the rights of individuals who lack the capacity to make specific decisions and have no one else to advocate for them. IMCAs provide essential support in cases involving serious medical treatment, long-term accommodation moves, or decisions under DoLS.

5.17 The local advocacy service undertakes a 'duty' service for Trust patients and while numbers are fairly small (39 to year end 2024 -2025), having the service on site ensures that advocacy is readily accessible for those who need it most. Unfortunately, there has been a decrease in referrals since the dedicated IMCA left post in January with the service now being undertaken on a rotational basis.

The MCA Lead Nurse will continue to work with the service provider to explore strategies to increase awareness.

5.18 The Medway commissioned IMCA provider Libra is expanding the IMCA drop-in service to another contracted service, building on the success of the pilot at MFT.

Deprivation of Liberty (DoLS)

5.19 Deprivation of Liberty Safeguards (DoLS) is a legal framework in England and Wales designed to protect individuals who lack the mental capacity to make decisions about their care and treatment. It is part of the Mental Capacity Act 2005 and applies to people in care homes and hospitals who may be deprived of their liberty for their own safety.

5.20 The Deprivation of Liberty Safeguards (DoLS) process includes different types of authorisations and assessments to ensure individuals who lack mental capacity are protected.

5.21 The authorisation relevant to the Trust are known as urgent or standard. authorisations. Urgent DoLS authorisations can last up to 7 days and are initially granted by the hospital, known as the 'managing authority'.

5.22 If needed, urgent authorisations can be extended for a further 7 days. This type of authorisation can be used if a person urgently needs to be deprived of their liberty before they have had a full assessment; an application is usually made to the local authority for a standard authorisation at the same time that an urgent authorisation is given.

5.23 Along with the administration team, The MCA Lead Nurse plays a key part in overseeing the processes that support vulnerable individuals, making sure that staff follow legal and ethical guidelines while maintaining accurate records and care plans.

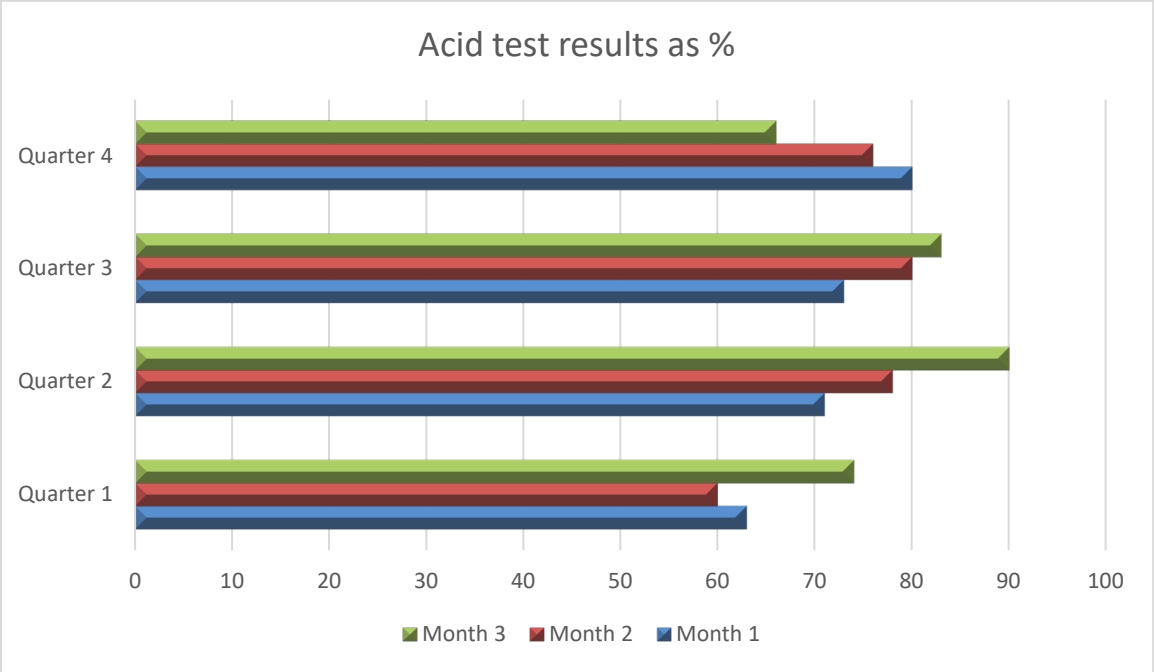
Number of DoLS Applications Raised to the Local Authority								
	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Total DoLS applications	**621**	**610**	**846**	**1071**	**1211**	**952**	**861**	**823**
Breached 14 days DoLS								**455**

5.24 The number of urgent DoLS applications has decreased in the latest reporting period which can be attributed to several reasons: there have been many long stay patients with no criteria to reside, staff are still struggling with the paperwork, some working areas have not fully embedded the process into their systems and there is a lack of awareness around the acid test.

5.25 Three standard authorisations were granted during this period from 455 breached authorisations, with patients, their families and Ward managers being informed along with any conditions attached. While it's positive that patients, families, and ward managers were informed, the high number of breaches highlights ongoing challenges in the process. **Risk 2122** - Breaching of urgent authorisations of Deprivation of Liberty Safeguards (DoLS).

5.26 Given the decrease in applications an, “Acid Test” audit is conducted to assess whether those in hospital are meeting the legal criteria for deprivation of liberty and are in receipt of the necessary safeguards.

5.27



5.28 In order to ensure that individuals lacking in capacity receive appropriate consideration, patient records are scrutinised, along with the incident recruiting system (Datix) and the enhanced care and frailty lists daily.

5.29 By maintaining regular communication with local authorities, the MCA Lead Nurse helps highlight vulnerable individuals who lack capacity and are actively objecting to their placement, or pose a risk of absconding. Where restraint is in use to prevent harm to self or others, escalation is necessary to ensure the local authority prioritise assessments appropriately.

Restraint

5.30 By regularly reviewing incidents on the Datix system, the MCA Lead Nurse can help ensure that individuals with impaired decision-making receive the appropriate support and interventions they need. The comment section is often used along with the electronic patient record to highlight regulatory guidelines and need for legal framework.

5.31 Incidents involving restraint are carefully recorded and monitored to ensure that interventions are always necessary, proportionate, and in the best interests of the patient. Weekly liaison meetings between safeguarding and security teams provide an opportunity for informal discussions to help identify trends, and improve practices around restraint.

5.32 For this reporting year there have been approximately 82 incidences in relation to 49 patients reported via Datix. These cases are noted as security have raised the Datix when supporting the ward with the safety of the patient. This figure is very low compared to the number of DoLS applications made and demonstrates that restraint is under reported.

5.33 Reporting on restraint is an area of weakness across the Trust, staff do not recognize restraint well and do not report this. This is an area for improvement in the coming year.

6 SAFEGUARDING ADULTS

Safeguarding Activity

6.1 A Section 42 enquiry is initiated when there are reasonable grounds to believe that abuse or neglect is occurring or may occur. The local authority assesses whether an enquiry is necessary to determine appropriate safeguarding actions and support for the individual at risk.

	Q4:2025	Q3: 2024	Q2: 2024	Q1:2024
Referrals About Care & Treatment at MFT	16	18	20	28
Referrals Raised by MFT Externally	38	42	34	27

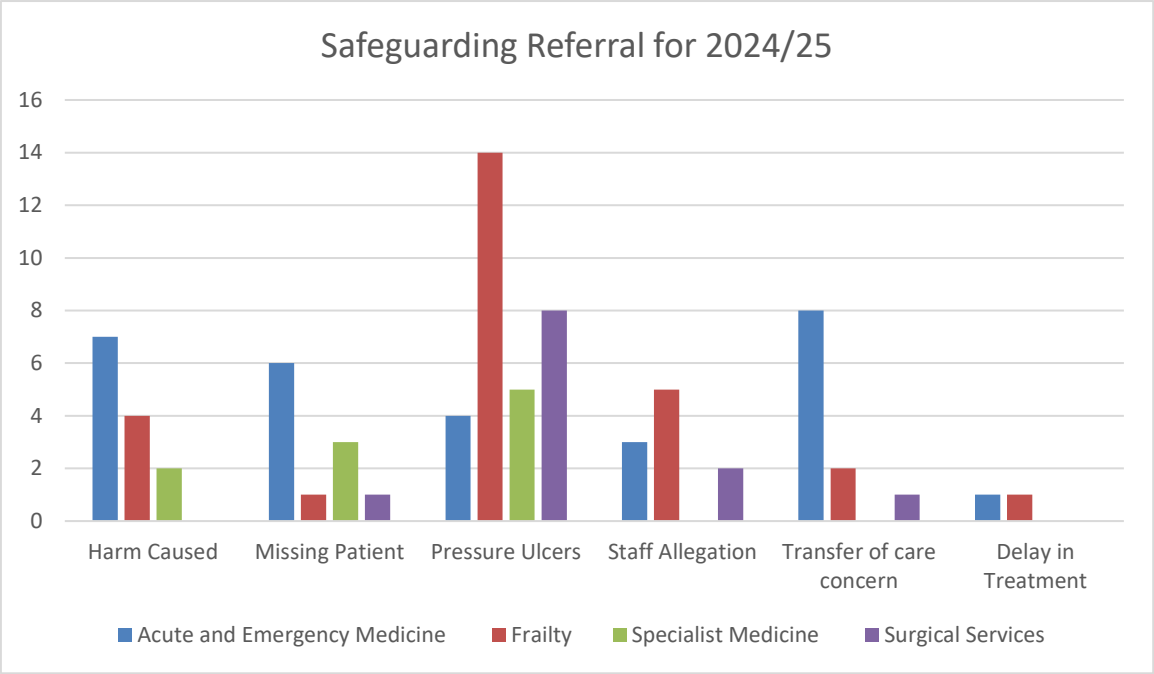
6.2 There have been 82 safeguarding referrals raised about care and treatment provided at the Trust during 2024-25.

The primary safeguarding concern category used was neglect or acts of omission in treatment received while under the Trust's care.

The referrals included:

- 31 cases of pressure ulcer acquisition compared to 23 cases in 2023/4
- 11 cases of transfer of care concerns compared to 17 cases in 2023/4

6.3



6.4 Whilst neglects and acts of omission are a primary category of abuse, there are subheadings under each category. Often a safeguarding concern involves several categories and therefore the dominant category is selected.

6.5 There have been 2 cases of alleged sexual abuse that fall under the staff allegations category. A separate report on staff allegations is being prepared for 2024/25.

6.6 24 cases have been investigated and closed by adult social care this year, 18 were found to have no fault attributed to the Trust.

6.7 6 cases involving staff allegations were found to have no case to answer. Of the concerns related to the acquisition of pressure ulcers, 23 cases were closed, with 6 substantiated against the Trust under the category of neglect.

6.8 The safeguarding case closures for 2024/25 remain consistent with those from 2023/24, with a 2/3 of cases unsubstantiated.

6.9 The number of unsubstantiated safeguarding referrals suggests that individuals and other agencies may have been directed to the safeguarding pathway instead of the complaints route, potentially due to a lack of clarity in differentiating the two processes.

6.10 A lack of understanding and the lack of communication to the hospital means that they are not in receipt of the full facts. expectations around safeguarding investigations may also contribute to referrals that fail to meet the attributable harm criteria.

6.11 The data however indicates that pressure ulcer acquisition has been a dominant issue amongst substantiated safeguarding cases in 2024/25. This is being addressed through auditing, teaching and support given to the wards from the Tissue Viability nurses. There has been new equipment purchased and the introduction of the QIP and ward accreditation programmes which include reduction and eradication of acquired pressure ulcers as a metric.

6.12 Outcomes and closures of safeguarding enquiries can take significant time for a number of reasons. Where a police investigation is ongoing the enquiry will remain open, when there is an internal investigation such as an AAR or PSII the local authority will await the Trust sign off before reaching a conclusion and there is often drift and delay on both sides due to staffing continuity, competing priorities and volume of workload.

6.13 There has been a restructure at the local authority and the introduction of a central safeguarding team within adult social care. Processes are being introduced to ensure that information and enquiry responses are swifter to allow for more effective learning and removal of risk where appropriate, takes place.

6.14 In response to this and to meet the statutory time frames we have introduced a 30 day turn around target for all initial safeguarding responses.

6.15 The Trust raised at least 141 safeguarding adult referrals to the local authorities in the past year. The true figure is uncertain as both Kent and Medway authorities introduced an online referral mechanism and we are not always made aware of the referrals being made.

6.16 The rise in self-neglect referrals demonstrates the impact of learning from training but also the shared learning from cases at meetings such as the Nursing, Midwifery and Allied health professionals' group.

6.17

Category of Abuse Raised By the Trust for external safeguarding	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Domestic Violence or Abuse	9	13	10	11	43
Financial or Material	2	1	4	1	8
Neglect or Acts of Omission	5	5	3	6	19
Physical	0	1	2	2	5
Psychological or Emotional	3	2	2	6	13
Self-Neglect	7	10	20	13	50
Sexual	1	2	0	0	3
Total	**27**	**34**	**41**	**39**	**141**

Domestic Abuse

6.18 We work closely with our Hospital Independent Domestic Violence Advisors (HIDVA) to support staff and patients with concerns or disclosures made about domestic abuse. We recognise that domestic abuse impact the whole family and as such the team consider the victim, perpetrator, children and any vulnerable adults. The domestic abuse audit shows that staff are aware of their service and make referrals for their support.

6.19 The proportion of HIDVA clients, compared to the other Medway Services, is 3 times higher for clients from Eastern European background, nearly 10 times higher for clients from Pakistan, and even 39 times higher for clients from any other Black, African and/or Caribbean background.

Ethnicity		
White		
British	**39**	**65%**
Gypsy or Irish Traveller	1	2%

Eastern European	5	8%
Mixed / Multiple Ethnic Background		
Any other Mixed / Multiple ethnic background, please describe	1	2%
Asian / Asian British		
Indian	1	2%
Pakistani	3	5%
Any other Asian background, please describe	2	3%
Black / African / Caribbean / Black British		
African	4	7%
Any other Black / African / Caribbean background, please describe	4	7%

6.20 Of the patients supported by the HIDVA at the Trust their reasons for attending hospital are seldom for disclosure. It takes professional curiosity to recognise and ask the questions through a safe enquiry route.

Reasons for attending hospital		
Total completed	45	
Accident at home	3	7%
Alcohol	3	7%
Birth	1	2%
Complications in pregnancy	4	9%
Domestic abuse	17	38%
Drug overdose	1	2%
Injury from accident	3	7%
Mental health	7	16%
Other	**20**	**44%**
Physical injury	7	16%
Self-harm	1	2%
Suicidal ideation	3	7%
Suicide attempt	5	11%

6.21 The HIDVA and Safeguarding team are supporting ED by attending daily where possible to explore some of the patients attending and to see if they can support with exploring how injuries occurred and whether safeguarding or HIDVA support is required.

Domestic Homicide Reviews (DHR)

6.22 The safeguarding team have continued to support the community safety partnership by sharing information to enable decision making as to whether a Domestic Homicide Reviews should be undertaken.

6.23 The actions from published DHR's are forming part of the overarching action plan from safeguarding reviews.

6.24 Due to changes in legislation the criteria for a DHR – now to be known as Domestic Abuse Related Death Review (DARDR), the scope of these investigations is widening to include suicides and substance related deaths where Domestic Abuse may be a feature.

Safeguarding Adult Reviews (SAR's) Section 44.

6.25 Learning from SAR's has been a key feature of the internal safeguarding work this year. We have specifically focussed on the following learning to improve practice.

6.26 Legal literacy – MCA training compliance has been above the KPI of 85% for over 6 months and is now off of the risk register. 50% of all patients on a DoLS have their MCA's audited every month and the results show improving quality month on month.

6.27 Self-neglect - referrals have increased and quality of recognition and referrals has improved.

6.28 Safe Discharge – IDT (MCH) and MFT discharge liaison nurse are now all working in the same team, working to same process. This aids communication and information sharing.

6.29 Multi- agency working - The ED High Intensity User meeting has been re-established and allows a multi-disciplinary oversight of risks and concerns of some of the most frequent attending patients with complex presentations.

6.30 Carers – The learning of the impact of caring responsibilities on carers has continued to be highlighted throughout training and meetings. Staff are now seen to be having conversations with carers and documenting the conversation. They offer referral for carers assessment and leaflet is emailed to ward staff to give to the relative to inform them of their rights and how to request a carers assessment. Even if they decline they are given signposting should they change their mind.

6.31 Alcohol / cooccurring conditions – the promotion of the Mental Capacity Act Assessments, ensuring clinicians consider executive functioning when seeing repeat attenders who do not wait to be seen but then reattend has been significant throughout the year as this patient group can be very complicated for a busy unit or environment to manage. By using the Addenbrookes Cognitive Exam (ACE3) we have been able to support clinicians in assessing and managing these patients in a more holistic way.

6.32 The team have raised 3 Section 44 SAR referrals to the Kent and Medway Safeguarding Adults Board this year. One of these did not progress to a SAR as is an active homicide investigation. One is due for publication shortly and the

other is in progress related to discharge of a prisoner to the ED as a place of safety.

6.33 6 IMR's have been undertaken for section 44 SAR's in the past 12 months.

6.34 The Kent and Medway Safeguarding Adults Board have published many reviews over the past 12 months, the majority of those published did not involve MFT, however the identified learning is transferrable to other agencies and we are working on embedding the actions and providing assurance.

Prevent

6.35 The Trust has raised 2 Prevent referrals in the past year where there have been concerns for staff members.

6.36 The team have continued to support the Prevent work by sharing information to allow the Prevent Team to make decisions as to whether someone meets the criteria for support through the Channel pane.

6.37 Following the Southport attacks the Prevent team have been expanding the criteria of those to review and explore support options available.

6.38 We have ensured our quarterly returns to the Prevent duty data collection have been submitted in a timely way.

6.39 Training levels are consistently above the KPI for both Basic Prevent Awareness and WRAP 3 Prevent.

6.40 The current Prevent Policy has been reviewed and approved.

7 SAFEGUARDING TRAINING

Safeguarding Children's Training

7.1 The Trust achieved KPI compliance with Safeguarding Children Level 3 in Q3, following extensive efforts to engage staff in training throughout 2023/24, with a particular focus on medical staff. However, a remapping exercise conducted in October 2024 reassigned several positions to Level 3, including maternity support workers (MSWs), which had a subsequent impact on compliance rates.

7.2 In January 2025, compliance dropped to 81% (Figure 22), likely due to the MSW remapping and the recruitment of a significant number of newly qualified midwives. A revised trajectory was established to achieve 85% compliance by the end of April 2025. However, through effective staff engagement, this target was successfully reached ahead of schedule.

7.3 Staff can access additional training through local Safeguarding Children's Partnerships. Information on available training sessions, including booking details, is shared with staff and accessible via the Safeguarding Children's Padlet. However, this training is not automatically recorded in the internal staff record unless forwarded to the safeguarding team for manual upload. Work has been commenced in coloration with the Organisational Development team to support the capture of staff learning outside of the classroom.

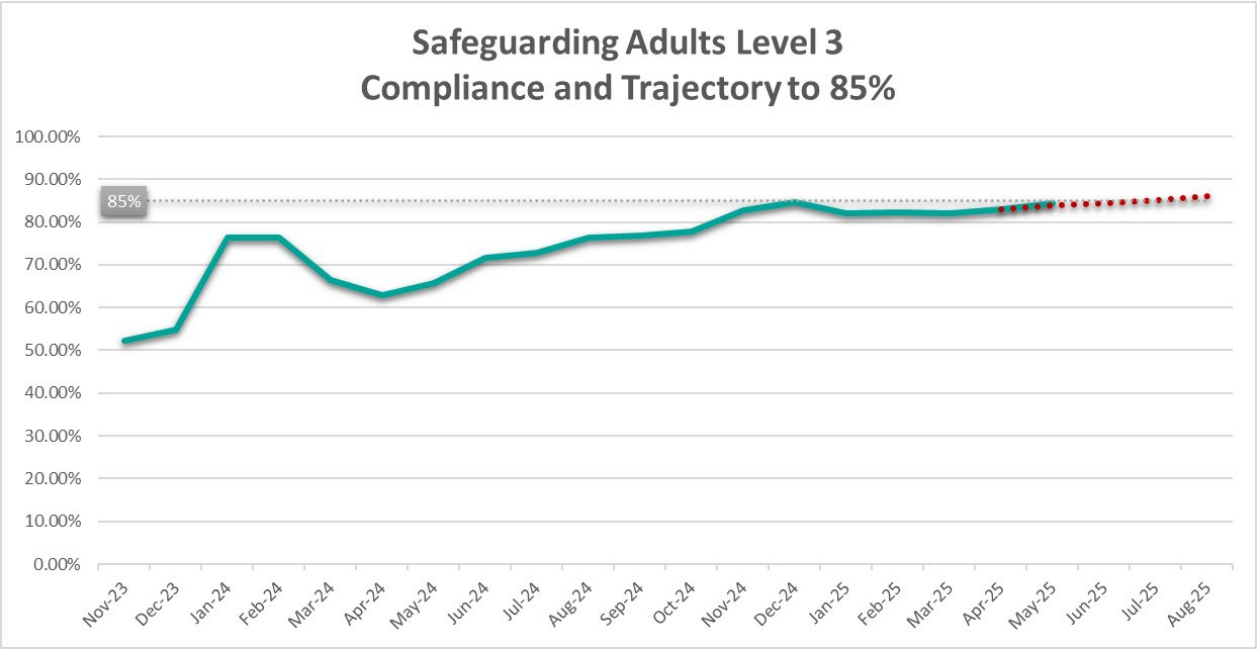
Safeguarding Adults Training

7.4 Safeguarding Adults level 3 training is just below the KPI of 85% however training continues to be promoted and delivered face to face to meet the requirements of the intercollegiate document.

7.5 There is a plan to introduce modular learning for level 3 to support embedded learning from safeguarding adult reviews.

	Quarter 4 2025	Training number of staff compliance previously to current	Training number of staff by of non-compliance
	Compliant Percentage		
Safeguarding Adults Level 1	96.16%	1379 to 1353	26
Safeguarding Adults Level 2	87.93%	1566 to 1552	14
Safeguarding Adults Level 3	84.80%	1294 to 1451	260

7.6



8 NEXT STEPS

8.1 Maintain compliance with Safeguarding Children and Adults Level 3 training throughout
2025/26.

8.2 Continue developing new training provisions, including bite-sized case study modules.

8.3 Complete the Was Not Brought (WNB) audit, incorporating analysis of cancellations and rescheduled appointments.

8.4 Sustain liaison with the neonatal unit and ChED to enhance engagement in safeguarding supervision.

8.5 To ensure vulnerable individuals receive timely and effective intervention, safeguarding referrals must be precise, well-contextualized, and supported by relevant information. Strengthening referral processes and enhancing professional development in safeguarding practices are essential steps in addressing these concerns. The team are looking to developing an AI generated video guide for staff to support best practice.

8.6 To collaborate with teams to improve reporting on restraint and ensure that compliance with legislation is upheld.

8.7 The Learning Disabilities Nurses to support the Trust in the role out of the statutory Oliver McGowen learning disabilities and autism training in line with National requirements.

8.8 The Lead Learning Disability nurse alongside the Head of safeguarding to develop data collection in line with National Learning Disability Improvement Standards and learning from LeDeR.

8.9 **Dr Conway sensory box** providing resources as part of improvements in the Emergency Department for patients with Learning Disability and Autism. This box will include resources that can be used in the Emergency Department to help reduce anxiety, stress and behaviours that challenge that may be due to being in an unfamiliar environment that is over stimulating.
This box is named in memory of Dr Brendan Conway who was a fantastic advocate and Learning Disability Champion for people and patients with learning disabilities and autism.

Appendix 1.

Kent and Medway Safeguarding Adults Board – Self Assessment Framework.

Medway NHS Trust
SAF October peer rev

Appendix 2.

Final Audit Response
Medway Foundation T

Kent and Medway Section 11 2024-2026

Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
					X
Title of Report	**Virtual Ward**			**Agenda Item**	6.2
Author and Job Title	Tracy Stocker, Director of Operations, Flow and Integration				
Lead Executive	Darren Palmer, Chief Operating Officer (Interim)				
Executive Summary	Approval	X	Briefing		Noting

The Virtual Hospital programme offers a transformative solution to systemic pressures on patient flow, discharge capacity, and inpatient efficiency. Building on the success of MFT's SMART acute virtual ward, the business case proposes a step-change: scaling from 80 to 200 virtual beds - including high-acuity care - while activating 24/7 coverage and integrated admission avoidance pathways. This model will enable the closure or repurposing of up to three inpatient wards, freeing up 91 beds, and delivering a strong return on investment within 9-12 months.

The economic analysis performed estimates that: (1) the implementation of the model requires £0.7M in investment over the first 3 months (£0.3M CAPEX and £0.4M OPEX); (2) net cash inflow of £0.5M by Mar-26 (i.e. returned investment and generated positive inflow); (3) net cash inflow of £5.2M in FY 2026/2027.

More than a capacity intervention, this is a strategic reimagining of acute care - bringing hospital-level services into patients' homes, enhancing safety, accelerating recovery, and reducing the risk of readmissions or hospital-acquired harm. By embedding virtual pathways across early discharge, alternative to admission, as well as integrated pathways for referrals from care homes, primary care, and community services, the programme addresses both inflow and outflow bottlenecks, aligning seamlessly with NHS England's Ten-Year Plan, virtual ward priorities, GIRFT recommendations, and Kent & Medway ICB's transformation agenda.

Importantly, this is a clinically robust, patient-centred, and scalable model of acute care delivered outside the hospital walls.

Proposal and/or key recommendation:	Seeking approval from the Trust Board for the implementation of the full virtual hospital (option 3) This option delivers the complete Virtual Hospital model as proposed in this business case. It includes NCTR reablement units, full 24/7 SMART team expansion, 260-bed virtual capacity, and the Alternative to ED care coordination pathway. It enables the closure of up to three wards and positions MFT as a leading site for ICS-wide scaling of digitally enabled acute care. This is not a speculative initiative. The model builds on proven digital infrastructure already in place across Medway and Kent and will be delivered through a phased, risk-managed approach with strong governance and stakeholder engagement. It positions Medway as a regional leader in digitally enabled care - ready to scale its expertise across the ICS and beyond. The proposal delivers: • **Operational benefits**: reduced NCTR burden, improved patient flow, and significant physical estate release. • **Clinical and workforce gains**: safer, more personalised care; flexible working models; and strengthened staff retention. • **Financial returns**: a minimum benefit-cost ratio of 3.6x, driven by reducing need for resourcing physical estate, additional capacity for revenue generating from electives or a regional virtual hub service. Our approach to implementing the virtual hospital has four main pillars: 1. **Optimising the management of NCTR patients in hospital–** Repurposing two care of the elderly wards to cohort NCTR patients will free up staffing and infrastructure to support a 24/7 260-beds virtual model, while improving discharge flow and patient outcomes through more targeted, lower-intensity reablement care. 2. **24/7 Virtual Ward Service –** Activating round-the-clock coverage will allow safe virtual management of higher-acuity patients, particularly from Care of the Elderly, Acute, and Oncology wards - transforming the service into a true alternative to non-elective inpatient care. 3. **Admission Avoidance Pathway –** By enabling direct virtual referrals from care homes and primary care, the Virtual Hospital can manage acute episodes early, avoiding ED attendances and non-elective admissions. 4. **Scaling Virtual Bed Capacity -** Expanding to 200 virtual beds, including 100 high-acuity, will free up 91 inpatient beds over 12 months. This scale enables referrals from all wards and direct admission avoidance from ED, SDEC, care homes, primary care, and prisons - maximising system efficiency.
Governance Route Meeting: **Date submitted:**	Trust Leadership Team – 29 July 2025 Finance, Planning and Performance Committee – 27 August 2025

Identified Risks, issues and mitigations:	Risks and issues are listed in the main document				
Resource implications:	Additional clinical and admin staff will be required to run the service				
Sustainability and/or Public and patient engagement considerations:	This is an expansion of a current service				
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:	Tracy Stocker - Director of Operations tracy.stocker1@nhs.net				

Business Case: Virtual Hospital at Medway Foundation Trust: Improving Productivity, Efficiency and Patient Flow

Executive Summary

Medway Foundation Trust (MFT) faces sustained and systemic pressures on patient flow, discharge capacity, and inpatient efficiency - challenges that threaten the Trust's financial sustainability, operational resilience, and clinical outcomes.

The **Virtual Hospital programme** offers a transformative solution to these pressures. Building on the success of MFT's SMART virtual ward, the business case proposes a step-change: scaling to 260 virtual beds - including high-acuity care - while activating 24/7 coverage and integrated admission avoidance pathways. This model will enable the closure or repurposing of up to three inpatient wards, **freeing 91 beds**, and delivering a strong return on investment within 9-12 months.

The economic analysis performed estimates that: (1) the implementation of the model requires £0.7M in investment over the first 3 months (£0.3M CAPEX and £0.4M OPEX); (2) net cash inflow of £0.5M by Mar-26 (i.e. returned investment and generated positive inflow); (3) net cash inflow of £5.2M in FY 2026/2027.

More than a capacity intervention, this is a strategic reimagining of acute care -bringing hospital-level services into patients' homes, enhancing safety, accelerating recovery, and reducing the risk of readmissions or hospital-acquired harm. By embedding virtual pathways across early discharge, alternative to admission, as well as integrated pathways for referrals from care homes, primary care, and community services, the programme addresses both inflow and outflow bottlenecks, aligning seamlessly with NHS England's virtual ward priorities, GIRFT recommendations, and Kent & Medway ICB's transformation agenda.

A short video illustrating the SMART Virtual Ward model today and the opportunities of the Virtual Hospital can be found here (MFT-specific version available from 2nd Sep 2025):

https://docsend.com/view/25h7zxxc4khd2udm

1. Background

1.1. Current Service Conditions

Medway Foundation Trust (MFT) faces sustained and systemic challenges in managing flow, discharges, and capacity. As of 30 May 2025[1], the hospital had 561 inpatients. Of these, **136 (24%) had no criteria to reside (NCTR)**, with 90 awaiting discharge arrangements and 160 pending assessment. A further **65 patients had a length of stay exceeding 21 days**, and one patient had remained in hospital for over 170 days. These figures illustrate a serious efficiency bottleneck. A core driver of this inefficiency is the rising number of patients with complex, chronic conditions - often older adults with multiple comorbidities – with ICB pop health data illustrating this in detail in Annex 3.

More broadly, similar inefficiencies are replicated across the inpatient footprint. MFT currently manages a large proportion of patients in high-cost physical settings who could be cared for more safely, more appropriately, and more affordably through virtual or digitally enabled models.

1.2. Our Vision for the Virtual Hospital at Medway FT

The Virtual Hospital (VH) is Medway Foundation Trust's strategic model for delivering acute-level hospital care in patients' homes, enabled by validated digital technology and a dedicated multi-disciplinary clinical team. It is designed as an extension of the hospital environment, providing the same clinical governance, escalation protocols, and quality assurance expected of an inpatient ward.

This approach aligns directly with NHS England's *Virtual Wards and Hospital at Home: Guidance for Integrated Care Systems* (NHSE, 2023), which defines virtual wards as models that "support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home."

National evaluations demonstrate that virtual wards can:

- **Reduce average hospital length of stay by up to 30%**, particularly for frailty and respiratory patients (NHSE, 2023a).
- **Avoid 20–40% of admissions** among high-risk, complex patients when proactive pathways are in place (Bardsley et al., 2022).
- **Improve patient experience**, with >80% of patients preferring to be treated at home rather than in hospital (NHSE, 2023b).

Our vision is therefore not simply to expand remote monitoring capacity, but to **reimagine the model of acute care, delivering it in the most appropriate, safe, and patient-centred setting**.

[1] Medway FT Internal Hospital Data, June 2025

1.3. What the Virtual Hospital is Not

The Virtual Hospital is **not**:

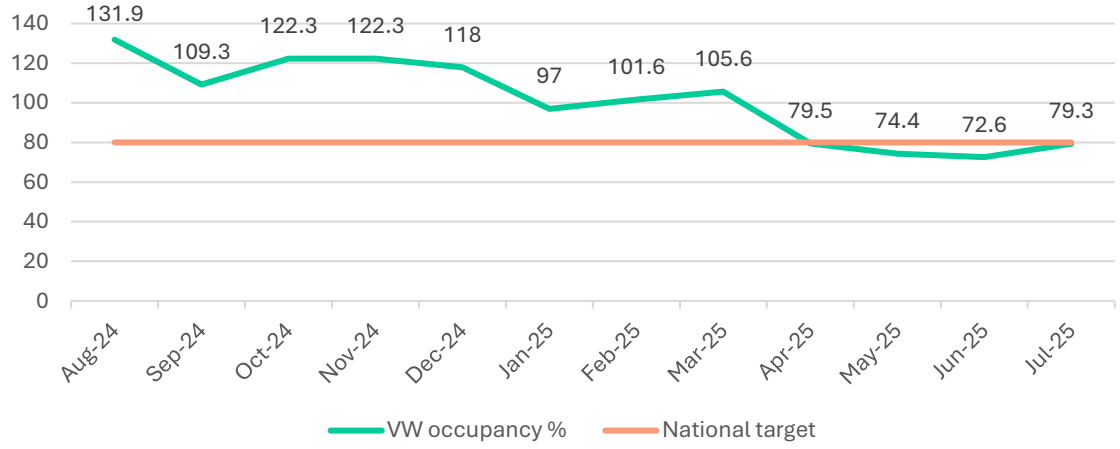
- **Community "Healthcare at Home"** – which delivers sub-acute care and reablement but does not operate with hospital-level medical oversight or escalation capacity.
- **Stand-alone remote monitoring** – which captures patient observations but does not integrate them into an acute clinical model with daily reviews, clinical decision-making, and rapid escalation.

Instead, the Virtual Hospital is a **clinically governed hospital service operating outside the hospital estate**, integrating clinical-grade data captured in the home, including continuous monitoring where required, daily virtual ward rounds and oversight, and targeted in-person visits.

1.4. What We Do Today and How We Intend to Scale

Our **SMART Virtual Ward** currently has capacity for 80 patients at any one time but exceeds >100 patients during some of the busiest months of the year (Figure 1Figure 8). The service has demonstrated that patients with significant medical needs can be effectively managed at home. Patient experience feedback confirms the value of being cared for at home, with reduced stress, faster recovery, and a lower risk of hospital-acquired complications such as infections and deconditioning (NHS England, 2023b; Lewis et al., 2022).

Figure 1: SMART Virtual Ward – monthly admissions and utilisation data (Aug-24 – Jul-25)



However, the current service has limitations:

- It operates between 08:00 and 20:00, restricting its ability to manage higher-acuity patients.
- It primarily supports early discharge, with limited capacity for admission avoidance or direct referral pathways, especially for patients experiencing frequent admissions (e.g. care home patients).

The Virtual Hospital programme seeks to **scale and transform this model** by:

1. **Expanding to 260 virtual beds**, including at least 60 high-acuity beds, enabling the safe management of complex medical, oncology, and frailty patients at home.
2. **Activating 24/7 clinical coverage**, ensuring that acute patients can be managed with the same confidence and responsiveness as on an inpatient ward.
3. **Embedding admission avoidance pathways**, so that referrals from ED, SDEC, primary care, care homes, and community services can be directed straight to the Virtual Hospital, avoiding unnecessary admissions.

National evidence suggests that up to **30% of admissions for frail and complex patients** could be safely avoided with integrated, digitally enabled alternatives (NHS England Virtual Ward Evidence Review, 2022; Bardsley et al., 2022). By implementing these enhancements, Medway FT will be able to release up to **91 inpatient beds (equivalent to three wards) within 12 months**, **improving patient flow**, **reducing "no criteria to reside" occupancy**, and **contributing to the Trust's financial recovery**.

This expansion positions MFT as a leader in the Kent & Medway system, with a model that is clinically robust, evidence-based, and aligned with national strategic priorities.

2. Clinical Model

2.1. Overview of the Clinical Model

The Virtual Hospital will operate as a **fully governed clinical service**, building upon the existing SMART clinical model. Patients admitted receive:

- Daily **virtual ward rounds** including a multi-disciplinary clinical team.
- **Continuous or intermittent remote monitoring** (depending on acuity), providing regular and comprehensive patient information.
- **Escalation protocols** enabling urgent in-person review or hospital transfer where clinically indicated.
- **In-person visits** from nursing or therapy staff where required.

2.2. Criteria for Patient Admission

Clinical effectiveness and patient safety is one of the Critical Success Factors for the expansion of the SMART virtual ward and underpins the assessment of each patient admitted to the ward. For every patient referral, a comprehensive risk assessment takes place by the medical team that includes an evaluation of:

- Age
- Is the patient stable and safe to go home? Up to referring / triaging clinicians
- NEWS Score
- Clinical Frailty Score
- Home Safety Assessment incl. family at home
- Staff Safety Assessment (alternatives available if staff are not safe to visit patient at home)

Overview of patient eligibility criteria for each tier of monitoring on the virtual hospital is included in Annex 2. These will be further finessed through additional consultations with clinicians as part of project mobilisation.

2.3. The Evidence Base

2.3.1. Suitability of Current Patients

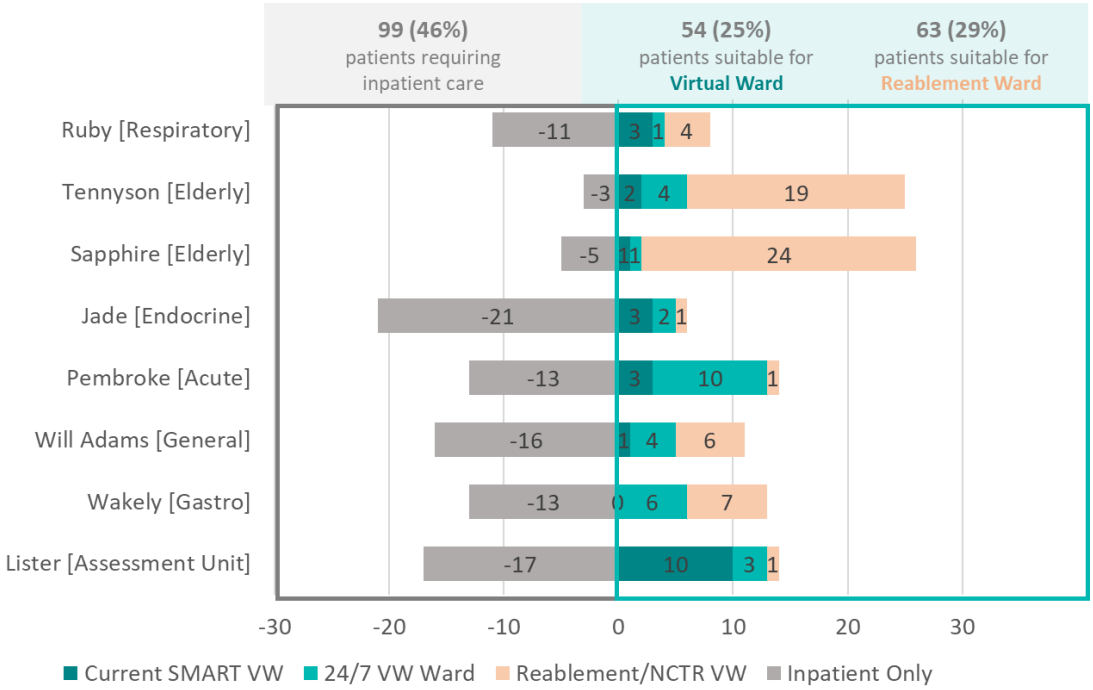
Analysis of Medway inpatient activity (May 2025) showed that **24% of inpatients had no criteria to reside (NCTR)** — equating to ~136 patients at any one time. A further 65 patients had been in hospital for >21 days, with a subset clinically stable but awaiting discharge arrangements. National evidence suggests that **20–30% of frailty and complex long-stay patients** could be safely managed through virtual wards (NHSE, 2023a; Bardsley et al., 2022).

In August 2025, an audit was carried out by clinicians within the Trust, to assess the proportion of patients currently in the hospital, who could be managed by the virtual hospital. In-patients were categorised across:

a) Patients could be managed on the current SMART 12-hour virtual ward (with increased capacity)
b) Patients could be managed on virtual ward, if service was expanded to 24 hours (as they require continuous 24/7 monitoring)
c) Patients could be managed by a reablement/NCTR ward (dependent on relevant assessment of reablement suitability).

Results are summarised in Figure 2. Just within these 8 wards (~30% of wards, 40% of bed capacity), 54% of patients were suitable for the virtual hospital, including: **63 patients suitable for the NCTR reablement ward** and **54 patients suitable for virtual ward**, if the 24/7 component is activated. **Scaled across all wards, this suggest: >180 patients suitable for a reablement ward** and **>160 patients suitable for virtual ward** (from inpatients alone).

Figure 2: Audit Outcomes (216 patients across 8 wards) – Breakdown of patient suitability for the different services of the virtual hospital



2.3.2. Outcomes Compared to Inpatient Care

Multiple evaluations have shown that patients cared for in virtual wards experience:

- **Safe service, no service-associated adverse effects**, no negative impact on mortality rate (Pugmire et al.,2025)
- **Reduced average length of stay by 20–30%** (NHSE Impact Report, 2023a).
- **Admission avoidance rates of 30–40%** in frailty and care home cohorts (Lewis et al., 2022).
- **Lower risk of hospital-acquired infection and deconditioning** compared with inpatient stays (GIRFT, 2022).
- **Equal or improved patient satisfaction**: >80% of patients prefer home-based care to hospital admission (NHSE, 2023b).

A full evaluation of outcomes and benefits will be conducted alongside the service implementation, in line with the NICE EVA process (which our current technology supplier has been approved for). This will be structured as a formal service evaluation, with the aim to publish results in a peer reviewed journal.

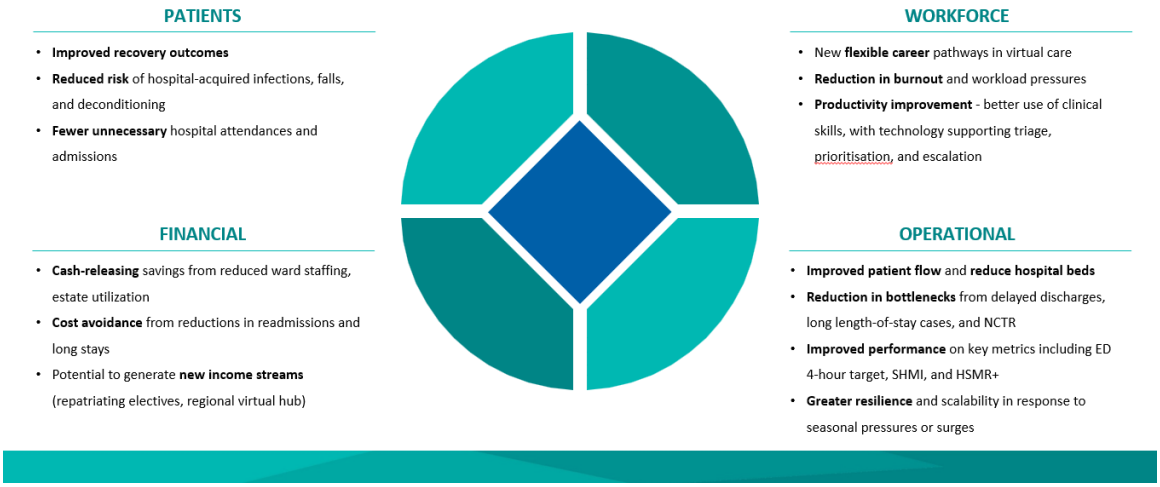
2.4. Number of Patients Expected to Benefit

- Initial expansion to **260 virtual beds** will allow ~70,000 virtual bed days annually (equivalent to 91 inpatient beds released).
- Target groups include ~400 patients/month between referrals from inpatients, ED and admission avoidance pathways, plus ~60 NCTR patients at any one time.
- Overall, at least **5,000 patients annually** will directly benefit from Virtual Hospital care, with indirect benefits (flow, reduced cancellations, elective recovery) reaching thousands more.

2.5. Benefits

The proposed virtual hospital will generate benefits for patients, the workforce, the operational capacity and efficiency of the hospital, and the financial sustainability of the hospital. This includes productivity gains and cash-releasing opportunities from the closure of 91 beds. An overview of the benefits is presented in Figure 3.

Figure 3: Benefits Overview



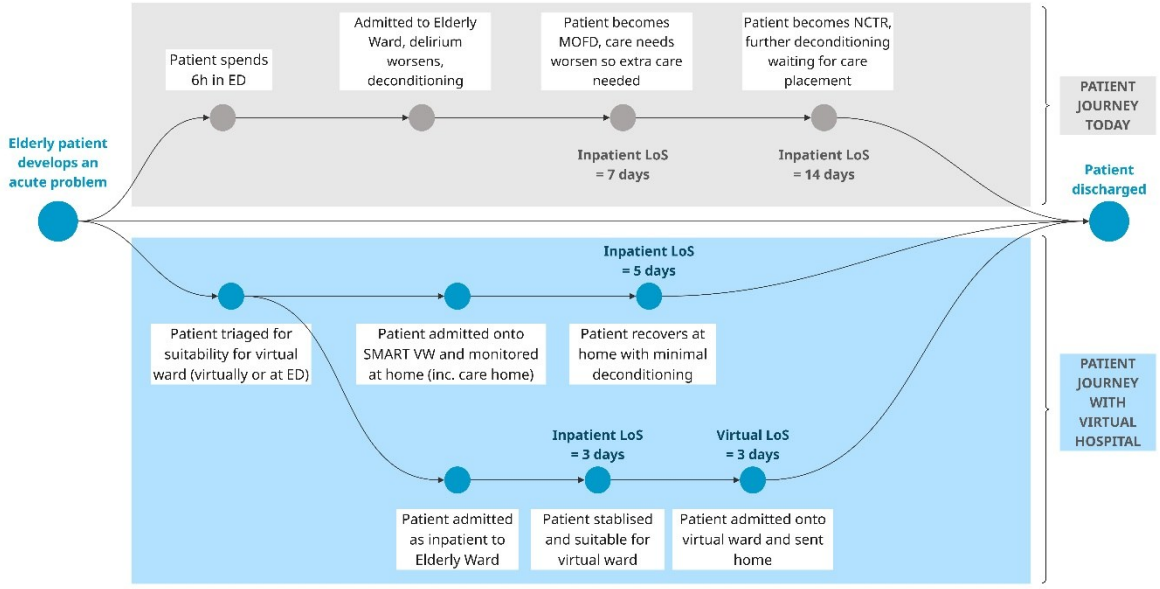
2.6. Clinical and Patient Risk Assessment & Mitigations

A risk analysis has been performed (details in Annex 1), in line with NHSE national guidance and with mitigations mirror those used successfully in other NHS virtual ward rollouts (NHSE, 2023a).

2.7. Practical Example of Virtual Hospital in Action

An example of the patient journey, with and without the virtual hospital, is included in Figure 4. Additionally, illustrative patient case studies are provided below, putting the patient journey into the context of two representative patient stories.

Figure 4: Patient journey overview with and without the virtual hospital



Case Study: Cardiac Pathway in the Virtual Hospital

Patient story (Cardiac pathway):
Mr B, a 64-year-old with a history of ischaemic heart disease and hypertension, attended ED with chest discomfort and palpitations. Investigations excluded acute coronary syndrome, but telemetry revealed episodes of atrial fibrillation with rapid ventricular response. He was stabilised in the Acute Medical Unit over 24 hours with rate-controlling therapy. Traditionally, Mr B would have remained in hospital for ongoing observation and dose titration, occupying a cardiology bed for 5–7 days.
Instead, he was admitted to the **Virtual Hospital**. A home monitoring kit was issued, including an ECG patch linked to the digital platform, a blood pressure monitor, and pulse oximeter. Data were streamed continuously to the Virtual Hospital hub.

- **Daily consultant cardiology review** was conducted virtually, reviewing rhythm traces and symptoms.
- **Nursing input** included scheduled phone calls and one home visit to provide education on anticoagulation and lifestyle advice.
- **Pharmacist review** ensured safe optimisation of his medication and prompt delivery from the hospital pharmacy.

On day 5, Mr B's ECG data showed intermittent breakthrough arrhythmia. This was flagged by the digital platform, and the consultant adjusted his medication remotely. No readmission

was required. By day 7, he was in stable sinus rhythm and discharged back to his GP with a comprehensive care summary.

Clinical impact:

- Avoided 5–7 days of inpatient cardiology bed use.
- Safe rhythm monitoring and medication titration achieved at home.
- One potential deterioration detected early and managed virtually.

Patient impact:

- Reported high satisfaction, noting he could "recover in comfort" while knowing he was being monitored continuously.
- Avoided disruption to work and family life.
- Gained confidence in managing his condition through proactive education and regular clinician contact.

Case Study: Care Home Admission Avoidance

Patient story (Care home pathway):
Mrs C, a 78-year-old resident of a nursing home with advanced COPD and type 2 diabetes, developed increased shortness of breath and low-grade fever. Ordinarily, she would have been conveyed by ambulance to the Emergency Department, likely resulting in an admission for observation, intravenous antibiotics, and oxygen therapy.
Instead, the care home team used their **digital monitoring kit (Feebris platform)** to capture vital signs and lung sounds. These flagged abnormalities (oxygen saturation 89%, raised respiratory rate, crackles on auscultation) which were reviewed by the Virtual Hospital hub.

She was admitted directly onto the **Virtual Hospital** under the respiratory pathway.

- **Consultant review** was undertaken the same day via video link, confirming the diagnosis of infective exacerbation of COPD.
- **Immediate treatment** was commenced in the care home: oral antibiotics, steroids, and supplemental oxygen, with clear escalation instructions.
- **Daily remote reviews** of observations and lung sounds were conducted, supplemented by one nurse home visit.
- A **pharmacist review** ensured safe medicines reconciliation and delivery of antibiotics to the care home within hours.

Within five days, Mrs C stabilised without requiring hospital admission. She remained in the care home environment, supported by familiar staff and surroundings.

Clinical impact:

- Avoided an acute admission (estimated 7–10 inpatient bed days).
- Treated safely in the care home setting with specialist oversight.
- Reduced risk of hospital-acquired infection and deconditioning.

Patient impact:

- Maintained independence and comfort in her usual environment.
- Reduced distress associated with ambulance transfer and unfamiliar hospital setting.
- Family and care staff reported greater confidence in her care, supported by 24/7 virtual oversight.

3. Implementation

3.1. Implementation Approach

The proposed virtual hospital has four main implementation components, as summarised in Table 1 and described in detail in Annex 4.

Table 1: Overview of Virtual Hospital Components

Component	Details
A. Designated reablement wards for NCTR patients	By consolidating up to 60 NCTR patients at a time into two purpose-designed reablement wards, the Trust can improve flow, deliver better outcomes through targeted reablement, and reduce costs by freeing up medica staff.
B. 24/7 Service	By enabling 24/7 clinical cover for patients on the virtual ward, we can support higher acuity patients around the clock. This is essential to decompressing high-pressure wards, preventing avoidable admissions, and enabling a wider range of patients to be cared for in their own homes with confidence.
C. Attendance and Admission Prevention for High Service Utilisers	By activating integrated pathways with other services in the system (care homes and primary care) we ensure that when high service utilisers develop acute episodes, they can be managed primarily virtually. This will reduce pressure on ED and inflow of admissions for patients who can be managed virtually to free up additional bed capacity.
D. Greater Capacity	Scaling the capacity to 260 beds – to cover referrals from all wards in the Trust as well as from ED, SDEC, care homes, primary care and prisons - will free up 91 hospital beds over 12 months.

3.2. Implementation Plan

3.2.1. Objectives and Principles

The implementation of the Virtual Hospital will be guided by a clear set of objectives and delivery principles (listed in Annex 4), ensuring that the programme is clinically safe, operationally robust, and aligned with local and national priorities.

3.2.2. Phased Approach and Timeline

Delivery of the Virtual Hospital will be staged to ensure patient safety, operational readiness, and workforce sustainability, with inpatient beds demand (Figure 5) and wards demand (Figure 6) reducing over time, as Virtual Hospital capacity increases. The **phased approach** allows benefits to be realised quickly while managing risk and embedding learning at each stage. An alternative, slower roll-out option has been modelled as a fall-back (details in Annex 5).

Phase 1 – Mobilisation (Months 0–2)

- Establish Programme Board, workstreams, and governance arrangements.
- **Restructure the first elderly ward (Sheppy)** into a reablement ward, releasing clinical staff to support virtual capacity.
- **Activate 24/7 service** for up to 50 beds (inc. oversight for reablement ward).
- Launch **admission avoidance pathway with care homes**.

Outputs: Governance live; both mid-acuity (current SMART 8am-8pm) and high-acuity (24/7 service) live; one reablement ward reconfigured.

Phase 2 – Early Expansion (Months 2–4)

- **Increase Virtual Hospital capacity to 200 patients** (120 under 24/7 monitoring, 80 under 8am-8pm monitoring, inc. clinical oversight for 2 reablement wards).
- **Open second reablement ward**, consolidating a total of ~60 NCTR patients and releasing further clinical capacity.
- Launch **admission avoidance pathway with primary care**.
- **Free up 2 inpatient wards** (Will Adams & Wakeley) that can be closed down.

Outputs: Virtual capacity at 200 beds; two reablement wards operational; two wards closed.

Phase 3 – Optimisation (Months 5–9)

- Expand **capacity to 260 patients**.
- **Optimise efficiency of admission avoidance** pathways across ED, SDEC, primary care, care homes, and prisons.
- **Optimise LoS in reablement wards**
- **Free up third inpatient wards** (Tennyson) that can be closed down.
- Conduct interim evaluation of outcomes.

Outputs: 260 virtual beds operational; pathways optimised for patient outcomes and efficiency; third ward closed down.

Phase 4 – Stabilisation (Months 10–12)

- Full transition to business-as-usual governance and staffing.
- Capacity of ≥70,000 virtual bed days annually.
- Formal evaluation report submitted to Trust Board and ICB, documenting outcomes, cost savings, and blueprint for replication.

Outputs: Service embedded as core Trust asset; documented model for scaling across Kent & Medway.

Figure 5: Reduction in Inpatient Hospital Bed Demand over Time

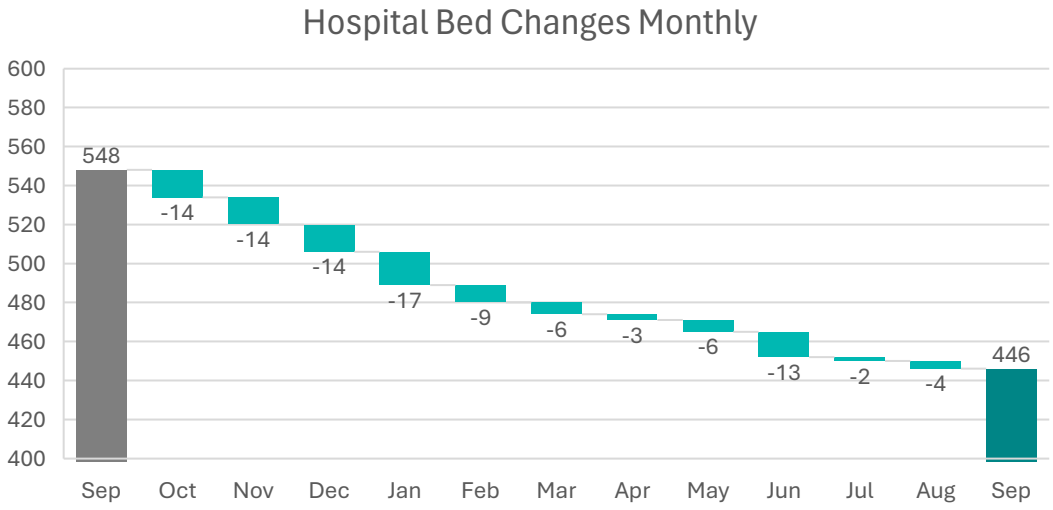
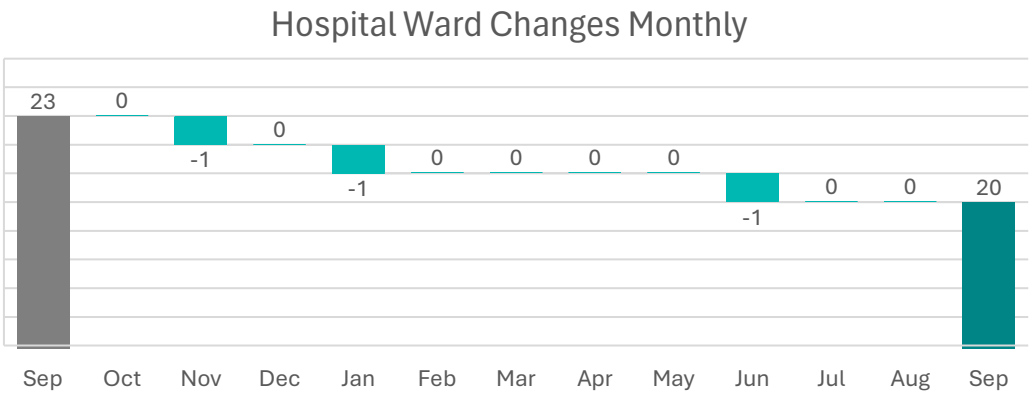


Figure 6: Reduction in Inpatient Wards over Time



3.3. Implementation Team

Delivering the Virtual Hospital at scale is a transformational undertaking that requires dedicated capacity and specialist expertise. Recognising the Trust's current workforce pressures, the implementation will be supported through a hybrid model: strong internal leadership, complemented by external change-management and digital transformation delivery resource.

3.3.1. Programme Leadership

- **Sponsor:** Provides overall strategic leadership, ensures alignment with Trust objectives, reports progress to Board.
- **Clinical Lead (Consultant):** Accountable for the safety and quality of the clinical model, escalation protocols, and governance.
- **Programme Director (SRO):** Responsible for steering the implementation programme, with day-to-day delivery support from specialist change partners.

3.3.2. Delivery Support and Project Governance

Additional operational capacity will be available from Feebris (the technology supplier who has a dedicated change-management function), including designated resource for coordinating workstreams, managing interdependencies, embedding best practice, providing specialist training for staff transitioning between physical and virtual wards. This external capacity will allow internal clinical and operational teams to focus on their core priorities, while ensuring that the Virtual Hospital programme proceeds at pace.

Each pillar of the programme - NCTR reablement wards, SMART team expansion, and the Alternative to ED pathway - will be managed as a discrete work package, with responsible leads assigned for clinical, operational, workforce, and digital domains. Weekly status reviews and monthly programme boards will ensure tight oversight of delivery progress and risk mitigation.

Robust governance will be in place to oversee delivery, risks, and outcomes. These will include:

- **Steering Group:** A cross-system board including acute, community, VCSE, and local authority representatives to provide strategic oversight and unblock barriers.
- **Operational Delivery Group:** Led by the Programme Manager, bringing together key stakeholders for weekly delivery updates, decision-making, and risk review.
- **Reporting:** Monthly progress updates to the Trust's Executive Team as required.

3.3.3. Success Monitoring

All activity will be aligned with existing Trust governance structures. Clear Critical Success Factors (CSFs) will be monitored through KPI tracking and oversight to ensure success in delivery (full list of CSFs defined in Annex 4):

3.4. Workforce Implications

The Virtual Hospital model has significant workforce implications, both in terms of creating new roles in digitally enabled care and in optimising the use of existing staff across the Trust.

3.4.1. Impact of Ward Reconfiguration and Closures

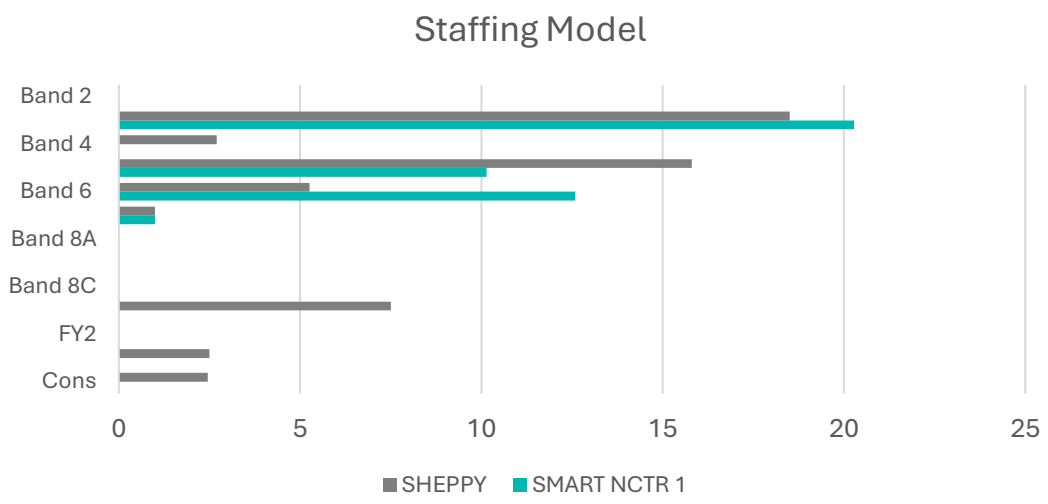
As the Virtual Hospital scales, up to three inpatient wards (91 staffed beds) will be closed over 12 months. This change will release capacity for a cohort of nurses, healthcare assistants, and medical staff. **This workforce will be absorbed into the**

Virtual Hospital service or redeployed into areas of the hospital with high temporary staffing costs.

- **Elderly wards restructured into reablement wards**: Staff currently allocated to elderly wards will transition to supporting the reablement model, with the difference in staff reallocated to Virtual Hospital posts or other posts in the hospital currently filled with bank agency (Figure 7).
- **Closed wards**: Staff will be redeployed into the Virtual Hospital hub or frontline areas of the hospital, directly reducing the Trust's reliance on bank and agency staff.

This approach ensures that the programme does not create surplus staff but instead optimises existing workforce resources, improving stability and reducing premium spend.

Figure 7: Staffing model for an elderly ward (Sheppy) today vs after restructuring into reablement ward, with clinical oversight provided by the virtual hospital



3.4.2. Process for Transition

The workforce transition will follow standard NHS organisational change processes, ensuring fairness, staff engagement, and patient safety:

- **Early Engagement**: Formal consultation with staff and trade union representatives at the outset, with clear communication of the Virtual Hospital vision and available roles.
- **Mapping of Roles**: All affected staff will have their current roles mapped against new or existing posts, with a strong emphasis on "lift and shift" redeployment rather than redundancy.
- **Preference Exercise**: Staff will be invited to express preferences for Virtual Hospital roles or other inpatient posts in line with their skills and in accordance with relevant policy.

- **Training and Upskilling**: A structured training programme (digital literacy, remote monitoring protocols, virtual consultation skills) will support staff to transition safely into Virtual Hospital posts.
- **Phased Redeployment**: As each ward is reconfigured or closed, staff will transfer in tranches, aligned to patient activity and Virtual Hospital capacity.
- **Monitoring and Support**: progress will be tracked to ensure workforce stability and morale.

3.4.3. Benefits of the Workforce Model

- **Retention**: By offering staff alternative posts in innovative models of care, the Trust reduces the risk of losing experienced clinicians.
- **Flexibility**: Redeployment creates a more flexible workforce, with skills in both physical and virtual care settings.
- **Reduced Agency Dependence**: Staff released from closed wards will be reallocated to high-demand areas, helping to reduce bank and agency usage and associated costs.
- **Career Development**: Virtual Hospital roles provide opportunities for staff to work in advanced digital care models, supporting long-term recruitment and retention.

3.5. Commercial Implications

3.5.1. Procurement and Contracting

- **Technology Platform:** The Virtual Hospital will continue to utilise and scale the **Feebris platform**, which has already been procured under the G-Cloud framework under a multi-year contract, following market engagement by the Trust in 2024. This provides a compliant route for contract expansion without the need for a new procurement exercise. The platform includes both medical kits for at-home monitoring and software; it is clinically validated, endorsed by the ICB, and already deployed across Kent and Medway, reducing adoption risk and supporting seamless system integration.
- **External Delivery Support:** Recognising the Trust's workforce constraints, external operational and change-management support will be commissioned to ensure safe mobilisation. This will done via Feebris, as a contract extention to the platform licenses, providing a rapid and compliant route to procurement. Feebris will provide dedicated resource, with decades of experience implementing transformation projects within the NHS, including scaling 24/7 virtual ward services.

3.5.2. Contract Management and Governance

All contracts will be governed under **standard NHS service-level agreements**, with appropriate KPIs. Performance will be overseen through the Virtual Hospital Programme Board, with quarterly reviews against contractual obligations and financial forecasts.

3.5.3. Commercial Benefits

- **Economies of Scale:** Consolidating virtual care technology under a single supplier avoids duplication, improves integration, and reduces per-patient costs as capacity expands.
- **Avoided Procurement Delays:** Use of existing frameworks (G-Cloud) allows rapid mobilisation and reduces the risk of service disruption.
- **Flexibility:** Framework-based contracting allows the Trust to scale volumes up or down in line with patient demand, ensuring financial sustainability.
- **System Alignment:** Leveraging platforms already adopted by care homes and primary care creates interoperability across the ICS, strengthening future regional collaboration and reduces costs.
- **Unlocking revenue opportunities:** scaling the Virtual Hospital model within a nationally recognised platform unlocks opportunities for revenue generation, where Medway FT monitoring capacity can be commissioned by other Trusts in the country who require monitoring capacity (not priced in current business case).

4. Financial Case

4.1. Investment Requirements

To deliver the virtual ward expansion, the project will **require £0.7M (£0.1M CAPEX hardware costs, and £0.6M OPEX costs to cover software, implementation and staffing costs).** Beyond the first 3 months, the benefits generated from reducing the run rate of the two NCTR wards and the reduction in bed capacity, should return this investment and outweigh any additional costs.

4.2. Benefits

The financial impact of implementing the Virtual Hospital is summarised in Table 2, unlocking up to £6.2M in cash-releasing benefits when the programme is fully operational. Repurposing two care of the elderly wards to cohort NCTR patients will free up staffing equivalent to 25% efficiency gains. Scaling the SMART virtual ward from 80 to 260 beds, and to 24/7, comes with significant cost efficiencies in the clinical staffing model (>38%). This is due to sharing of costly clinical resources across the virtual ward. The cash releasing benefits of closing a ward are estimated at £3.1M (£2.2M in nursing staff, £0.8M in medical staff, £0.1M in estate costs).

Table 2: Overview of Impact on Costs

		Pre-Implementation		*Post-Implementation*			
	Ward	**Total Beds**	**Workforce + Estate Costs**	**Total Beds**	**Workforce + Estate Costs**	**Cost Difference**	**Efficiency Gains**
1	Sheppy	22	£2,750,000	22	£2,200,000	-£550,000	25.0%
2	Elderly Ward	26	£2,750,000	26	£2,200,000	-£550,000	25.0%
3	Will Adams	28	£3,050,000	0	£0	-£3,050,000	Potential for closure
4	Wakely	28	£3,050,000	0	£0	-£3,050,000	Potential for closure
5	Tennason	28	£3,050,000	0	£0	-£3,050,000	Potential for closure
	TOTALS (Physical)		**£14,650,000**		**£4,400,000**	**-£10,250,000**	
	SMART Virtual Ward	80	£2,230,271	260	£6,279,109	£4,048,837	38.5%
	TOTALS (Virtual)		**£2,230,271**		**£6,279,109**	**£4,048,837**	
	TOTALS (Combined)		**£16,880,271**		**£10,679,109**	**-£6,201,163**	

8-8 Service 24/7 Service

Factoring in the phased deployment approach, **we estimate that the model will generate ~£0.5M in FY 2025/2026 and £5.2M in net cash inflow in FY 2026/2027** (details in Table 3; alternative implementation option in Annex 5)**.** Additionally, if cost avoidance from shortening the length of stay of NCTR patients is taken into account, the benefits are estimated to be at **£1.5M in FY 2025/2026** and **£7.5M in FY 2026/2027**.

Additional revenue generating benefits have not been modelled but include: (1) Revenue generation from repatriating electives from London trusts; (2) Revenue generation from licensing virtual service to other NHS Trusts (either for service design or clinical monitoring support).

Table 3: Project Finances

		FY 2025/26							FY 2025/26											
		2025	2025	2025	2025	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2027	2027	2027
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Capital Expenditure																				
1	Fixed assets (hardware)	-£114,814	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
2	Software	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
3	Implementation support	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
4	**Total Capital costs (CAPEX)**	**-£114,814**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Operating Expenditure																				
5	Virtual Hospital Staff Pay	-£185,856	-£313,955	-£366,281	-£418,607	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259
8	Operating software licences	-£108,900	£0	£0	£0	£0	£0	£0	-£331,368	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
10	Other operating costs	-£50,000	-£50,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
11	**Total Operating costs (OPEX)**	**-£344,756**	**-£363,955**	**-£366,281**	**-£418,607**	**-£523,259**	**-£523,259**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Total Expenditure																				
12	**Total Project Costs (CAPEX + OPEX)**	**-£459,570**	**-£363,955**	**-£366,281**	**-£418,607**	**-£523,259**	**-£523,259**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Existing Funding for SMART																				
13	Technology	£0	£0	£0	£0	£0	£0	£0	£113,568	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
14	Staff	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160
15	**Total Existing SMART Funding**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£276,728**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**
Efficiencies and Benefits																				
16	Cash-release (ward closure)	£0	£0	£254,167	£254,167	£508,333	£508,333	£508,333	£508,333	£508,333	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500
17	Cash-release (NCTR run-rate reduction)	£0	£45,833	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667
18	Cost avoidance (NCTR LoS reduction)	£0	£86,992	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800
19	**Total Efficiencies and Benefits**	**£0**	**£132,825**	**£535,633**	**£535,633**	**£789,800**	**£789,800**	**£789,800**	**£789,800**	**£789,800**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**
20	**Total cash-releasing benefits**				**£2,537,500**												**£9,741,667**			
21	**Total cash-saving benefits**				**£1,035,992**												**£2,277,600**			
Net cash inflow/(outflow)																				
22	Monthly (Incl. Cost Avoidance)	-£296,409	-£67,970	£332,512	£280,186	£429,701	£429,701	£429,701	£211,901	£429,701	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868
23	Monthly (Excl. Cost Avoidance)	-£296,409	-£154,962	£142,712	£90,386	£239,901	£239,901	£239,901	£22,101	£239,901	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068
24	**Total (Incl. Cost Avoidance)**				**£1,537,423**												**£7,480,281**			
25	**Total (Excl. Cost Avoidance)**				**£501,431**												**£5,202,681**			

Project Income Statement

Project Revenue																				
	Cash-release (ward closure)	£0	£0	£254,167	£254,167	£508,333	£508,333	£508,333	£508,333	£508,333	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500
	Cash-release (NCTR run-rate reduction)	£0	£45,833	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667
	Total Revenue	**£0**	**£45,833**	**£345,833**	**£345,833**	**£600,000**	**£600,000**	**£600,000**	**£600,000**	**£600,000**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**	**£854,167**
Project Costs																				
	Virtual Hospital Staff Pay	-£185,856	-£313,955	-£366,281	-£418,607	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259
	Software licences	£0	-£18,150	-£18,150	-£18,150	-£18,150	-£18,150	-£18,150	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614	-£27,614
	Implementation support	-£14,286	-£14,286	-£14,286	-£14,286	-£14,286	-£14,286	-£14,286	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Depreciation (Hardware, Straight line, 3Y)	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189	-£3,189
	Total Operating Expenditure	**-£203,331**	**-£349,580**	**-£401,906**	**-£454,232**	**-£558,884**	**-£558,884**	**-£558,884**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**	**-£554,062**
Project Net Income		**-£203,331**	**-£303,747**	**-£56,073**	**-£108,399**	**£41,116**	**£41,116**	**£41,116**	**£45,938**	**£45,938**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**	**£300,104**
SMART Budget																				
	Technology	£0	£0	£0	£0	£0	£0	£0	£113,568	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Staff	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160
	Total Existing SMART Funding	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£276,728**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**
SMART Net Income		**-£40,171**	**-£140,587**	**£107,087**	**£54,761**	**£204,276**	**£204,276**	**£204,276**	**£322,666**	**£209,098**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**	**£463,265**

5. Summary of All Benefits

Medway is a frontrunner, leading the way for acute care delivered in the home. With a tried and tested model, an expansion to the current virtual ward service would deliver:

- **Operational benefits**: reduced NCTR burden and improved patient flow, and significant physical estate release.
- **Clinical and workforce gains**: flexible working and professional development staff models.
- **Financial returns**: cash-releasing and cash-saving benefits. In the short term, this is driven by reducing need for resourcing physical estate and optimising efficiencies through designated reablement wards for NCTR patients. In the mid-term, this creates capacity for additional revenue generating opportunities from electives or a regional virtual hub service.
- **Improved patient experience**: safer, more personalised care - patients who currently sit in a hospital bed unnecessarily, often deconditioning, can be monitored at home amongst family and friends, recovering in familiar surroundings.

Whilst requiring some initial investment, the proposed virtual hospital will unlock capacity, workforce, and financial benefits that will improve healthcare service delivery for the Medway population. Implementation will build upon proven digital infrastructure already in place across Medway and Kent, and will be delivered through a phased, risk-managed approach with strong governance and stakeholder engagement. This proposal places Medway as a regional leader in digitally enabled care - ready to scale its expertise across the ICB and beyond.

In a climate of rising demand and constrained resources, the virtual ward is a necessary and achievable innovation. It represents a timely opportunity to improve patient outcomes, increase efficiency, and safeguard the future sustainability of the Trust. It also aligns the Trust with the recent 10-year plan for health - by delivering acute-level care in patients' homes and shifting care safely out of the hospital setting.

Annex 1: Risk Analysis and Mitigation Startegy

For both Likelihood and Impact: 1 = Low | 2 = Medium | 3 = High

Risk Category	Risk (with Description)	Likelihood (Pre)	Impact (Pre)	Score (Pre)	Mitigation	Likelihood (Post)	Impact (Post)	Score (Post)
Workforce	**Workforce capacity and readiness** – insufficient staff to safely operate the Virtual Hospital, especially 24/7 cover.	3	3	9	Phased expansion; redeployment from NCTR/closed wards; external recruitment and change-management support; flexible contracts.	2	2	4
Digital	**Digital reliability** – monitoring devices, connectivity, or platform failure could compromise patient safety.	2	3	6	Clinically validated platform (>99% uptime); dual Wi-Fi/4G; escalation phone line; daily manual checks.	1	2	2
Patient/Clinical	**Clinical deterioration at home** – unexpected deterioration without immediate physical intervention.	2	3	6	Robust inclusion/exclusion criteria; continuous monitoring for high-acuity; 24/7 escalation hub; rapid ambulance protocols.	1	2	2
Workforce	**Change management fatigue** – staff resistance to new working patterns or digital tools slows adoption.	2	2	4	Early engagement; preference exercise; digital training; clear professional pathways in virtual care.	1	1	1
System/Partnership	**External partner dependency** – care homes, GPs, or social care do not consistently refer into pathways.	2	3	6	Shared referral protocols; ICB-level champions secured (CCIO); joint training; escalation contacts.	1	2	2

Risk Category	Risk (with Description)	Likelihood (Pre)	Impact (Pre)	Score (Pre)	Mitigation	Likelihood (Post)	Impact (Post)	Score (Post)
Implementation	**Procurement and supply chain delays** – late delivery of devices or external support slows mobilisation.	2	2	4	Use extention to existing contract via G-Cloud; pre-agreed delivery timelines; maintain buffer stock.	1	1	1
Financial	**Financial sustainability** – costs exceed forecasts or benefits under-deliver, reducing ROI.	2	3	6	Phased ramp-up; benefits tracker; strict cost controls; monthly finance review; contingency budget.	1	2	2
Patient/Clinical	**Patient adherence** – patients or carers fail to comply with monitoring or treatment.	2	2	4	Simple devices; patient/carer education; daily nursing follow-up; escalation contacts.	1	1	1
Reputational	**Reputational risk** – safety incident, under-delivery, or delays reduce system/public confidence.	2	3	6	Strict quality oversight; phased rollout; robust comms; continuous KPI tracking via digital platform and reviews.	1	2	2
Digital	**Data governance/cyber security** – breach or non-compliance with DSPT/DTAC requirements.	2	3	6	Fully DTAC-compliant supplier; NHS cyber standards; regular audits; IG team oversight.	1	2	2
Patient/Clinical	**Regulatory risk** – service fails to meet CQC standards for acute-equivalent care.	2	3	6	Track record of quality in existing service. Governance parity with inpatient services; SOPs; regular audits.	1	2	2
Implementation	**Optimism bias** – implementation slower than planned, delaying benefits realisation.	2	2	4	Conservative timelines; phased expansion; slower roll-out modelled; regular Board reporting.	1	2	2
Workforce	**Staff morale/retention risk** – redeployed staff feel displaced, leading to turnover.	2	2	4	Structured consultation; preference exercise; training and OD support; recognition of new career opportunities.	1	2	2

Annex 2: Patient Acceptance Criteria

Tier 1 – Low Acuity (Step-down and stable patients) – 8AM-8PM VW

Eligibility:

- Medically optimised and clinically stable patients who no longer require inpatient monitoring but do not meet criteria for safe discharge without oversight.
- Patients with No Criteria to Reside (NCTR) who still require observation, medication titration, or rehabilitation support.
- Typical conditions: post-surgical recovery, mild infection on oral antibiotics, stable exacerbation of COPD/heart failure, wound care.

Exclusion:

- Ongoing requirement for IV therapy not safely deliverable at home.
- Oxygen >2L/min or unstable vital signs.

Monitoring:

- **Daily virtual ward round** with consultant or senior nurse.
- Intermittent remote monitoring (e.g. once or twice daily vitals).
- Home visits as clinically indicated.

Tier 2 – Mid Acuity (Active management, admission avoidance) – 8AM-8PM VW

Eligibility:

- Patients with an **acute exacerbation of a long-term condition** suitable for home-based acute treatment.
- Conditions: moderate COPD exacerbation, atrial fibrillation requiring titration, diabetic instability, oncology complications (e.g. neutropenic sepsis under close watch once initial treatment commenced).
- Patients requiring **initiation or adjustment of new treatments** that would otherwise require inpatient admission.

Exclusion:

- Rapidly deteriorating patients requiring continuous physical monitoring.
- Those needing immediate access to HDU/ICU level care.

Monitoring:

- **Twice-daily consultant/nurse reviews** (virtual).
- **Remote monitoring with automated alerts** (e.g. BP, O2 sats, ECG patch).
- Targeted in-person reviews (e.g. nurse/therapist visits 1–3x/week).
- Rapid escalation pathway to ED/SDEC if deterioration occurs.

Tier 3 – High Acuity (Continuous monitoring with 24/7 oversight)

Eligibility:

- Patients with **complex acute conditions** requiring round-the-clock observation but stable enough to remain at home with escalation protocols.

- Examples: advanced heart failure needing titration, high-risk arrhythmia monitoring, severe frailty with unstable vitals, oncology patients with high complication risk.
- Patients identified for ED admission who can be safely diverted to Virtual Hospital under senior clinical triage.

Exclusion:

- Patients requiring continuous oxygen >4L/min, IV vasopressors, or intensive care.
- Any patient with high probability of imminent crash event.

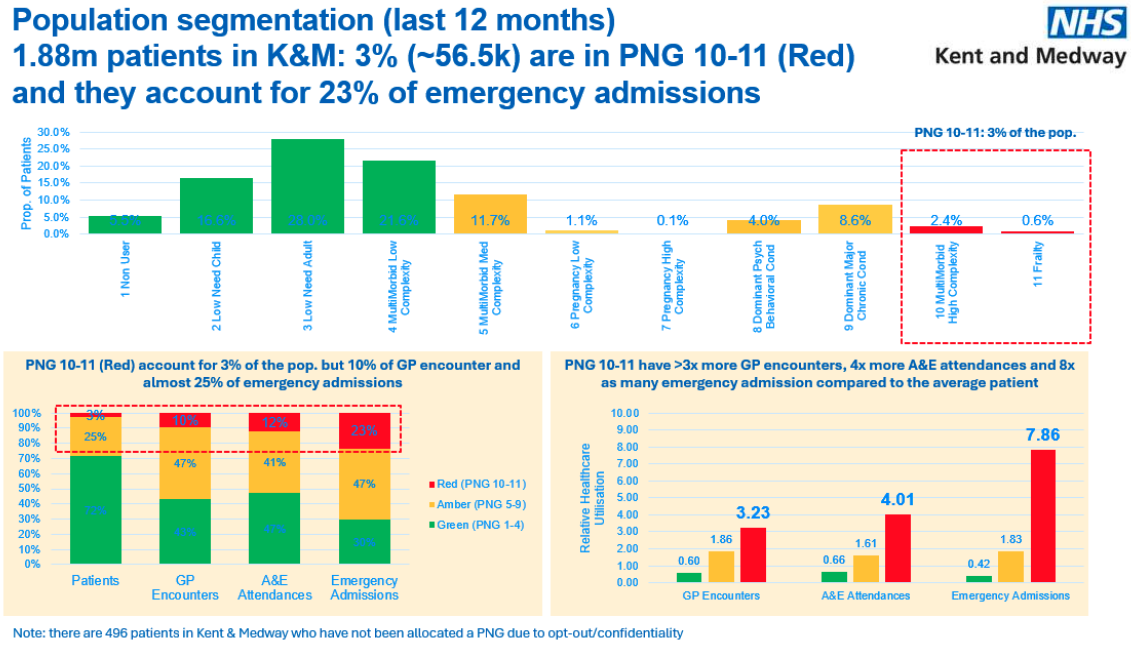
Monitoring:

- **Continuous remote monitoring** (ECG patch, O2 sats, respiratory rate, temperature) with alerts fed to the 24/7 hub.
- Consultant-led daily review, plus out-of-hours on-call rota.
- 24/7 escalation hub with **ambulance priority conveyance protocol**.
- In-person reviews by senior nurses or advanced clinical practitioners as required.

Annex 3: Population Health Challenges

A core driver of this inefficiency is the rising number of patients with complex, chronic conditions - often older adults with multiple comorbidities. The aging population in Medway and the surrounding region is growing, and with it, the intensity and duration of care needs. According to Kent and Medway ICB data[2], **just 3% of the population accounts for 12% of all ED attendances and 23% of emergency admissions** (Figure 8). These individuals often remain in hospital for extended periods and frequently transition into NCTR status, despite not requiring acute care. Their ongoing occupancy of inpatient beds presents a structural barrier to hospital flow and performance.

Figure 8: Kent & Medway Population Segmentation (Source: K&M ICB). Data for all of Kent & Medway but distribution of patients and service utilisation likely to be the same in Medway alone.



These high-need patients are not only resource-intensive but also at risk of hospital-acquired deconditioning, increased morbidity, and readmission. As such, **reducing both their inflow into the hospital** and **their length of stay** represents a prime opportunity for cost efficiency and quality improvement.

[2] Data provided by Kent & Medway ICB, June 2025

Annex 4: Implementation Details

Components of Virtual Hospital	Details
A. Designated reablement wards for NCTR patients	**Opportunity**: By consolidating up to 60 NCTR patients at a time into two purpose-designed reablement wards, the Trust can improve flow, deliver better outcomes through targeted reablement, and reduce costs by freeing up medica staff. **Approach**: As part of the Virtual Hospital programme, the Trust proposes to cohort NCTR patients into two dedicated reablement service wards, creating a more efficient and clinically appropriate model for this patient group. Currently, NCTR patients are distributed across inpatient wards and receive the same level of acute monitoring and staffing intensity as patients requiring full medical oversight - despite no longer meeting criteria for acute care.
B. 24/7 Service	**Opportunity**: By enabling 24/7 clinical cover for patients on the virtual ward, we can support higher acuity patients around the clock. This is essential to decompressing high-pressure wards, preventing avoidable admissions, and enabling a wider range of patients to be cared for in their own homes with confidence. **Approach**: Activating a 24/7 clinical cover will transform the virtual ward service from a supportive discharge service into a full alternative to inpatient care. At present, the virtual ward operates between 8am and 8pm, limiting its ability to safely manage higher-acuity patients or accept complex referrals for those requiring overnight monitoring or time-sensitive escalation. By extending to round-the-clock coverage, the service will be able to take on more clinically complex patients, support earlier discharge, and offer a genuine substitute for overnight inpatient care.
C. Attendance and Admission Prevention for High Service Utilisers	**Opportunity**: By activating integrated pathways with other services in the system (care homes and primary care) we ensure that when high service utilisers develop acute episodes, they can be managed primarily virtually. This will reduce pressure on ED and inflow of admissions for patients who can be managed virtually to free up additional bed capacity. **Approach**: Establishing an integrated pathway for Attendance and Admission Prevention is a pivotal enabler of system-wide impact for the Virtual Hospital. Across the region, care homes already participate in an ICB-commissioned proactive

	monitoring programme that helps staff detect acute deterioration before it escalates to an emergency. By leveraging this shared digital infrastructure (both the care homes and Medway use the Feebris virtual care platform) and embedding referral pathways into the Virtual Hospital, the Trust can safely accept direct referrals and manage many of these acute episodes virtually—avoiding unnecessary conveyance to hospital. In parallel, primary care teams are working with the ICB to identify individuals who are high service utilisers and at risk of frequent, avoidable hospital use. While these individuals can remain stable through targeted community interventions, they inevitably experience acute episodes. With a virtual admission avoidance pathway in place, these patients can be referred directly from primary care into the Virtual Hospital for early management - avoiding escalation to ED and reducing non-elective admissions. This pathway not reduces demand on urgent care and non-elective beds.
D. Greater Capacity	**Opportunity:** Scaling the capacity to 260 beds – to cover referrals from all wards in the Trust as well as from ED, SDEC, care homes, primary care and prisons - will free up 91 hospital beds over 12 months. **Approach:** As the model grows, its clinical versatility allows it to manage a broader spectrum of acuity, making it possible to accept referrals from all inpatient wards while also diverting patients away from the front door. With increased capacity, the Virtual Hospital can safely absorb direct referrals from ED, SDEC, care homes, primary care, and even secure environments such as prisons—bypassing traditional admission pathways and easing pressure on non-elective beds. The larger the virtual footprint, the more flexibly and efficiently the service can be deployed, delivering greater value per patient while supporting flow, resilience, and whole-system coordination.

Implementation Objectives:

A. **Restructure 2 elderly wards into reablement wards**, cohorting NCTR patients and optimising staffing to reduce cost, whilst improving patient outcomes.
B. **Implement 24/7 clinical coverage**, enabling the safe management of higher-acuity patients.
C. **Establish an Admission Avoidance pathway** to accept referrals for acute care from ED, SDEC, primary care, care homes, and secure settings.
D. **Expand virtual capacity** to 260 concurrent patients, including at least 60 high-acuity virtual beds (24/7) and 2 reablement wards, within 4 months.

E. **Reduce physical bed occupancy** by the equivalent of three wards (91 staffed beds) within 12 months, improving patient flow and inpatient capacity.
F. **Deliver measurable improvements in quality and safety**, including reduced length of stay, reduced hospital-acquired harms, and improved patient experience.
G. **Achieve financial sustainability**, with breakeven by Month 4 and cash-releasing benefits from both ward optimisation (NCTR) and ward closure.
H. **Position MFT as a regional leader**, creating a replicable blueprint for Virtual Hospital adoption across the Kent & Medway system.

Implementation Principles:

A. **Patient safety first** - all pathways will be governed to the same standard as inpatient care, with robust escalation protocols and clinical oversight.
B. **Phased, risk-managed rollout** - expansion will occur in phases, aligned with workforce readiness and digital capacity.
C. **Workforce engagement** - staff will be supported with training and engaged in the co-development of pathways and SOPs to ensure safe and sustainable delivery.
D. **Evidence-led delivery** - evaluation will be embedded from the outset, measuring outcomes, costs, and patient experience in line with NHSE guidance and NICE EVA protocols.
E. **Sustainability and scalability -** the service will be designed to transition to business-as-usual within 12–18 months and provide a platform for further replication across the region.

Success Monitoring - Critical Success Factors:

- **Clinical Effectiveness and Patient Safety**
  The model must demonstrate that it can deliver acute-level care safely outside of the hospital environment. This includes maintaining or improving outcomes such as HSMR+ and SHMI, ensuring compliance with GIRFT recommendations (particularly around frailty, complex discharge, and long length-of-stay), and integrating with the Trust's clinical governance and CQC quality systems.
- **Financial Return and Affordability**
  The investment must offer a compelling return, with clear cost-avoidance and cash-releasing savings - particularly in relation to estate, staffing, and flow-related efficiencies.
- **Capacity Release and Operational Impact**
  The proposal must directly enable the reduction in hospital bed utilisation, allowing the trust to close at least two inpatient wards this financial year. It must show how virtual capacity will augment and reduce physical beds, protect flow, and reduce delayed transfers of care, particularly for NCTR and frail patients.
- **Workforce Engagement and Deliverability**
  The success of the virtual ward depends on attracting and retaining a high-

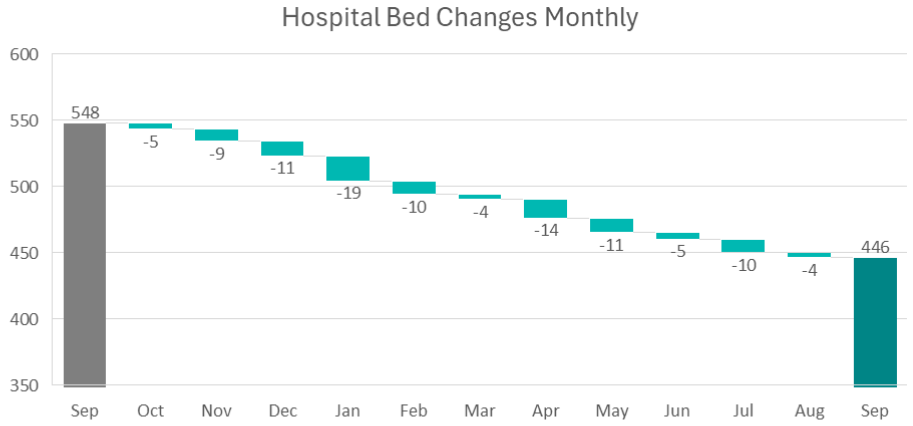
performing clinical team. The model must offer equitable, flexible working arrangements and include mechanisms to support professional development and clinical ownership. This includes pathways for training, supervision, and career progression in virtual care roles.

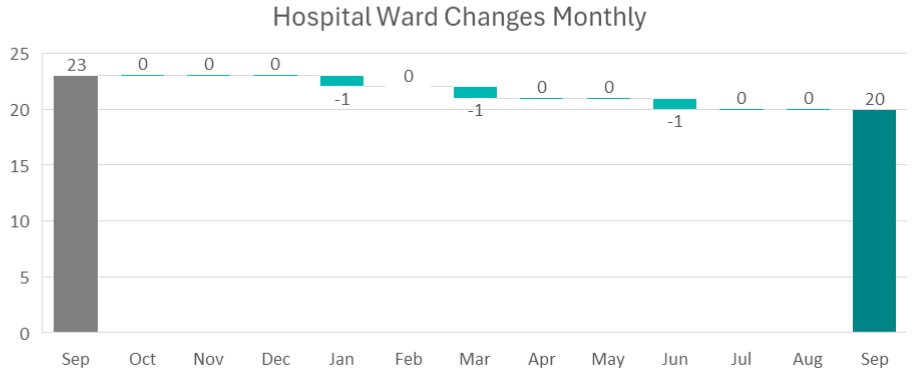
- **Contracting and Operational Oversight**
  The delivery model must be operationally sound, with clear lines of accountability for service provision, monitoring, escalation, and discharge.
- **System Alignment and Strategic Fit**
  The programme must align with wider ICB transformation goals and national directives, including NHSE's virtual ward policy, ICB hospital discharge acceleration targets, and Kent & Medway's integrated care ambitions.
- **Scalability and Replicability**
  The model must be scalable across the trust (and potentially to other trusts in the region), with clear pathways for replication, knowledge transfer, and digital consistency. Standard operating procedures, platform design, and training packages must be modular to support group-wide adoption.

Annex 5: Alternative Implementation Route (Gradual Ramp-up)

Minimise upfront investment by relying primarily on NCTR restructure to scale virtual hospital staffing. Unable to shut down a ward before Christmas.

- **Sep-Oct 2025**: **Mobilisation** – 24/7 service for 25 virtual beds.
  → First SMART NCTR ward (Sheppy) restructured.
- **Nov 2025**:
  → Second NCTR ward restructured.
- **Dec 2025**: Scale virtual bed capacity to 50 bed 24/7 and 100 beds 8-8.
- **Jan 2026**:
  → First ward (Will Adams) shut down.
- **Feb 2026:** Scale virtual bed capacity to 100 bed 24/7 and 100 beds 8-8.
- **Mar 2026:**
  → Second ward (Wakeley) shut down.
- **Apr-May 2026**: **Optimisation** – maximise efficiencies (LoS in NCTR, integrations with wider services for admission avoidance).
- **Jun 2026**:
  → Third ward (Tennyson) shut down.
- **Jul-Sep 2026**: **Stabilisation** – transition to business as usual and ensure long-term sustainability of model, with a blueprint for scaling further.





Financial Impact of Alternative Implementation Route:

Benefits: Cash releasing benefits of £1.5M in FY25/26 and £9.7M in FY26/27. Net cash inflow of £0.1M in FY25/26 and £5.2M in FY26/27.

Further cost avoidance from shortening the LoS of NCTR patients amounts to additional £1M in FY 2025/2026 and £2.3M in FY 2026/2027.

Requirements: £0.6M (£0.3M CAPEX costs to cover set-up costs, and £0.3M OPEX costs to cover virtual hospital staffing increase during Sep-Dec 2025). Beyond that point, the programme will have returned investment and be purely cash releasing.

		FY 2025/26							FY 2025/26											
		2025	2025	2025	2025	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2027	2027	2027
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Capital Expenditure																				
1	Fixed assets (hardware)	-£114,814	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
2	Software	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
3	Implementation support	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
4	**Total Capital costs (CAPEX)**	**-£114,814**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Operating Expenditure																				
5	Virtual Hospital Staff Pay	-£185,856	-£235,467	-£261,630	-£313,955	-£313,955	-£418,607	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259
8	Operating software licences	-£108,900	£0	£0	£0	£0	£0	£0	-£331,368	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
10	Other operating costs	-£50,000	£0	£0	£0	£0	-£50,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
11	**Total Operating costs (OPEX)**	**-£344,756**	**-£235,467**	**-£261,630**	**-£313,955**	**-£313,955**	**-£468,607**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Total Expenditure																				
12	**Total Project Costs (CAPEX + OPEX)**	**-£459,570**	**-£235,467**	**-£261,630**	**-£313,955**	**-£313,955**	**-£468,607**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Existing Funding for SMART																				
13	Technology	£0	£0	£0	£0	£0	£0	£0	£113,568	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
14	Staff	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160
15	**Total Existing SMART Funding**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£276,728**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**
Efficiencies and Benefits																				
16	Cash-releasing benefits	£0	£0	£0	£0	£254,167	£254,167	£508,333	£508,333	£508,333	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500
17	Run-rate reduction	£0	£45,833	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667
18	Cost avoidance	£0	£86,992	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800
19	**Total Efficiencies and Benefits**	**£0**	**£132,825**	**£281,467**	**£281,467**	**£535,633**	**£535,633**	**£789,800**	**£789,800**	**£789,800**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**
20	**Total cash-releasing benefits**				**£1,520,833**												**£9,741,667**			
21	**Total cash-saving benefits**				**£1,035,992**												**£2,277,600**			
Net cash inflow/(outflow)																				
22	Monthly (Incl. Cost Avoidance)	-£296,409	£60,519	£182,997	£130,671	£384,838	£230,186	£429,701	£211,901	£429,701	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868
23	Monthly (Excl. Cost Avoidance)	-£296,409	-£26,473	-£6,803	-£59,129	£195,038	£40,386	£239,901	£22,101	£239,901	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068
24	**Total (Incl. Cost Avoidance)**				**£1,122,504**												**£7,480,281**			
25	**Total (Excl. Cost Avoidance)**				**£86,512**												**£5,202,681**			

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NHS
Medway
NHS Foundation Trust

Business Case: Virtual Hospital at Medway Foundation Trust: Improving Productivity, Efficiency and Patient Flow

This is a summary for the full business case

12 August 2025

Proposed Model: Virtual Hospital (24/7 | 260 Beds)

NHS Medway NHS Foundation Trust

The **Virtual Hospital programme** offers a transformative solution to these pressures. Building on the success of MFT's SMART virtual ward, the business case proposes a step-change: scaling to 260 virtual beds—including high-acuity care—while activating 24/7 coverage and integrated admission avoidance pathways. Importantly, this is a clinically robust, patient-centred, and scalable model of acute care delivered outside the hospital walls.

This model will enable the closure or repurposing of up to three inpatient wards, **freeing 91 hospital beds**, and delivering a strong return on investment within 9-12 months.

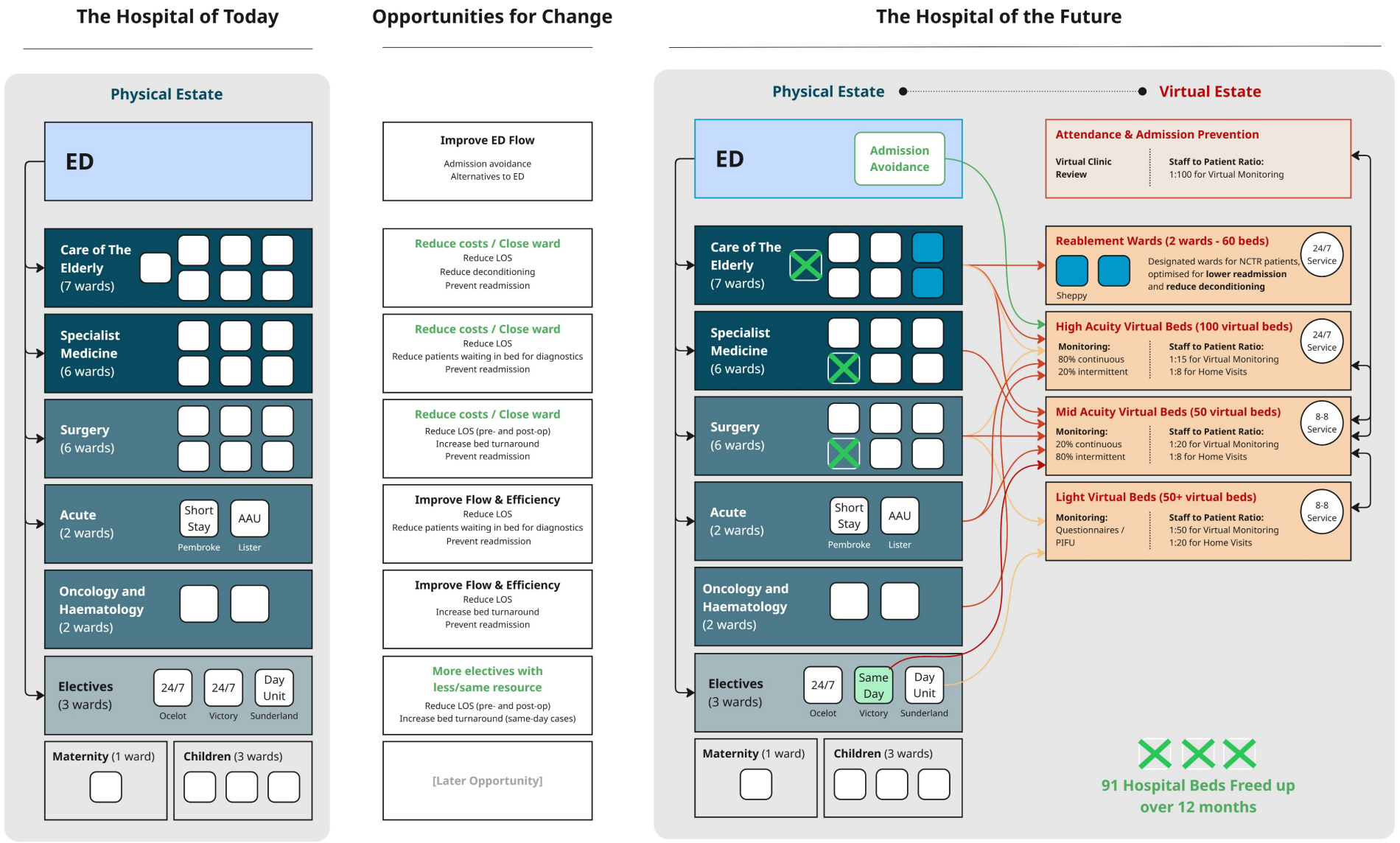
The figure on the next page illustrates:

- the current physical bed state for MFT
- the opportunities for change as outlined in the full business case
- the future state which shows the reduced physical estate and the new virtual estate

The proposal delivers:

1. **Operational benefits**: reduced burden of no criteria to reside (NCTR) patients, improved patient flow, and significant physical estate release (closure of 91 beds over 12m, equivalent to 3 wards).
2. **Clinical and workforce gains**: safer, more personalised care; flexible working models; and strengthened staff retention.
3. **Financial returns**: a minimum benefit-cost ratio of 3.6x, driven by reducing need for resourcing physical estate, additional capacity for revenue generating from electives or a regional virtual hub service. **Committing to implementing at speed from end of Sep** can deliver:

- Implementation of the model requires **£0.7M in investment** (£0.1M CAPEX and £0.6M OPEX);
- Net cash inflow of **£0.5M by Mar-26** (**i.e. returned investment and generated positive inflow**);
- Net cash inflow of **£5.2M in 2026/2027.**



NHS Medway NHS Foundation Trust

The figure illustrates the current physical bed state and the opportunities for change as outlined in the full business case, including:

- Cohorting NCTR patients into 2 reablement wards;
- Scaling virtual ward capacity to allow for the management of higher acuity patients (24/7 oversight)

The programme can free up **91 beds**, enabling the closure of **3 wards**.

The choice of wards for closure in the diagram is illustrative.

MFT Wards Audit

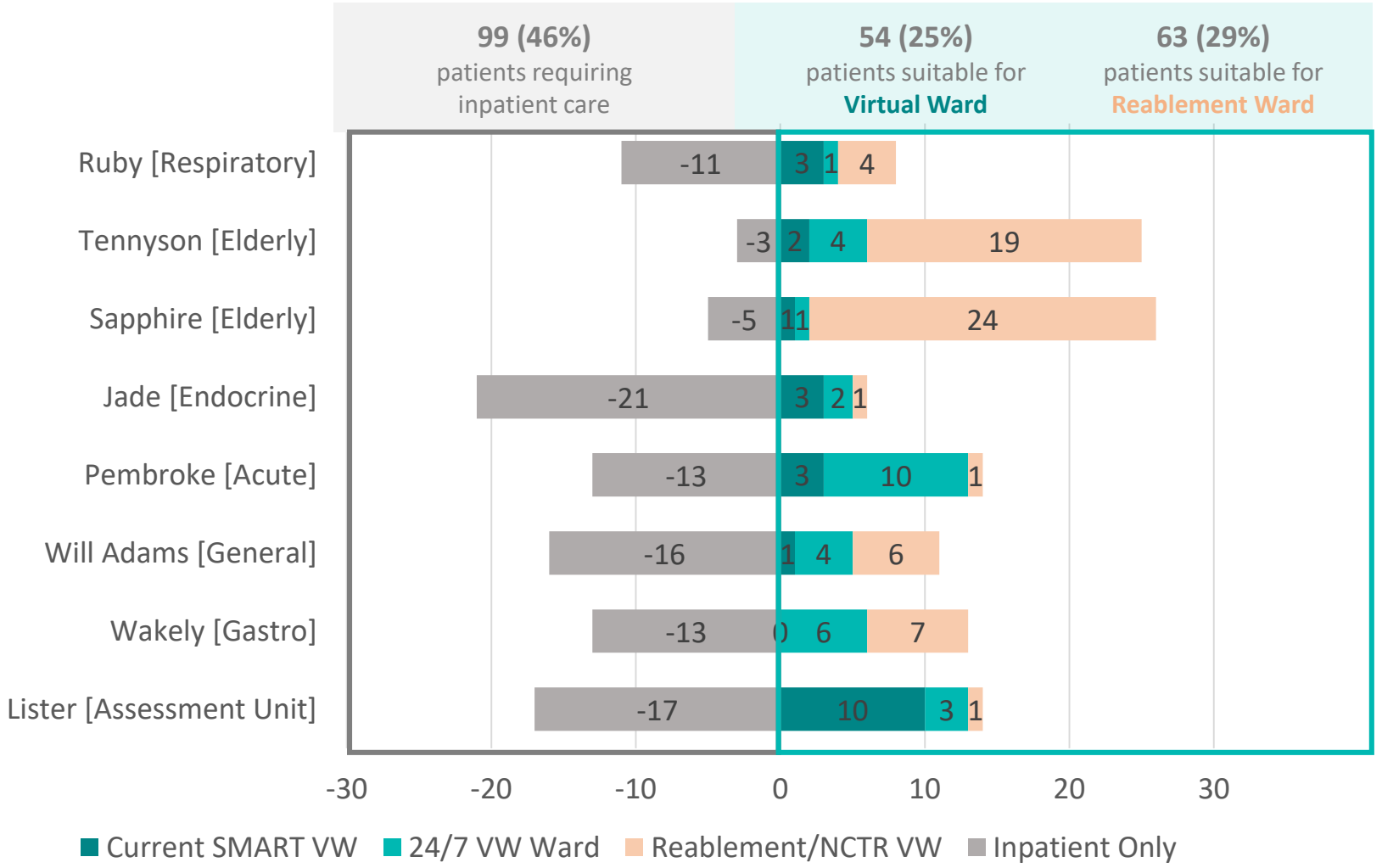
NHS Medway NHS Foundation Trust

In August 2025, an audit was carried out by clinicians within the Trust, to assess the proportion of patients currently in the hospital, who could be managed by the virtual hospital.

Just within 8 wards (~30% of wards, 40% of bed capacity):

- **54%** of patients were suitable for the virtual hospital;
- **63 patients (29%)** were suitable for the NCTR reablement ward;
- **54 patients (25%)** were suitable for virtual ward, if the 24/7 component is activated.

Scaled across all wards, this suggest: >180 patients suitable for reablement ward; >160 patients suitable for virtual ward (from inpatients alone).



Implementation Options

There are two feasible options for implementing the virtual hospital, summarised below.

NHS Medway NHS Foundation Trust

ROUTE 1: MOVING AT PACE

Commit to implementation at pace ahead of winter to maximise benefits this financial year and show we can safely and effectively close a ward before Christmas.

Impact on savings:

- **Cash-releasing: £2.5M** in 2025/2026
- **Cash-releasing: £9.7M** in 2026/2027
- **Cash-saving: £1M** in 2025/2026
- **Cash-saving: £2.3M** in 2026/2027
- **Net cash inflow: £0.5M** in 2025/2026
- **Net cash inflow: £5.2M** in 2026/2027

Impact on ward restructure/closures:

- **Elderly/NCTR Ward Restructure** in Oct-25 and Nov-25
- **Ward Closures** in Nov-25, Jan-26 and Jun-26

Required investment:

- **£0.7M** in Sep-Nov-25 → returned by Dec-25

ROUTE 2: GRADUAL RAMP-UP

Minimise upfront investment by relying primarily on NCTR restructure to scale virtual hospital staffing. Unable to shut down a ward before Christmas.

Impact on savings:

- **Cash-releasing: £1.5M** in 2025/2026
- **Cash-releasing: £9.7M** in 2026/2027
- **Cash-saving: £1M** in 2025/2026
- **Cash-saving: £2.3M** in 2026/2027
- **Net cash inflow: £0.1M** in 2025/2026
- **Net cash inflow: £5.2M** in 2026/2027

Impact on ward restructure/closures:

- **Elderly/NCTR Ward Restructure** in Oct-25 and Nov-25
- **Ward Closures** in Jan-26, Mar-26 and Jun-26

Required investment:

- **£0.6M** in Sep-Oct-25 → returned by Feb-26

Financial Impact: Option 1 (Moving at Pace)

NHS Medway NHS Foundation Trust

Benefits: **Cash releasing benefits** of **£2.7M** in FY25/26 and **£9.7M** in FY26/27. **Net cash inflow** of **£0.5M** in FY25/26 and **£5.2M** in FY26/27. Further cost avoidance from shortening the LoS of NCTR patients amounts to additional **£1M in FY 2025/2026** and **£2.3M in FY 2026/2027**.

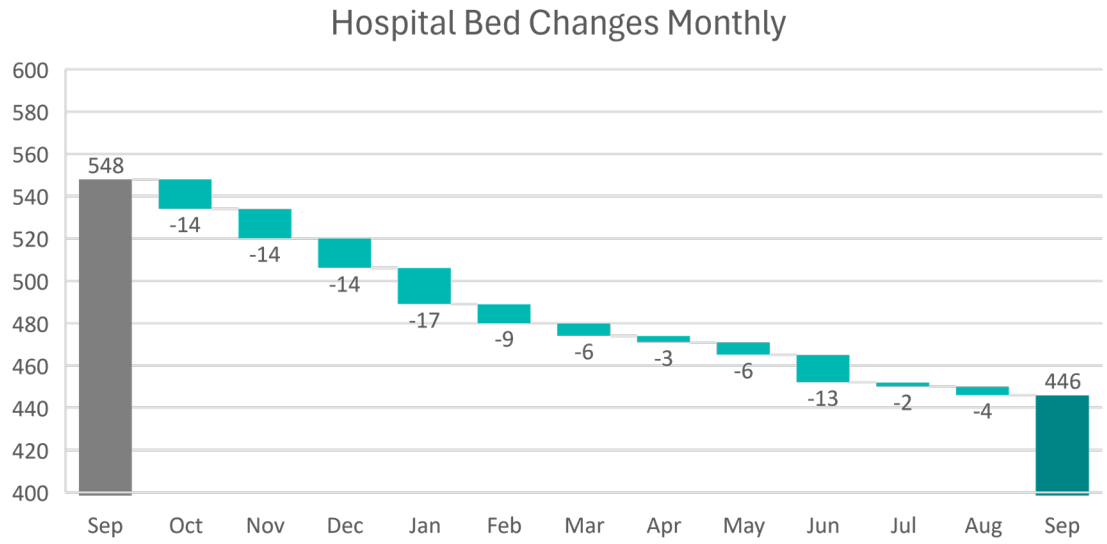
Requirements: **£0.7M** (£0.3M CAPEX costs to cover set-up costs, and £0.4M OPEX costs to cover virtual hospital staffing increase during Sep-Nov 2025). Beyond that point, the programme will have returned investment and be purely cash releasing.

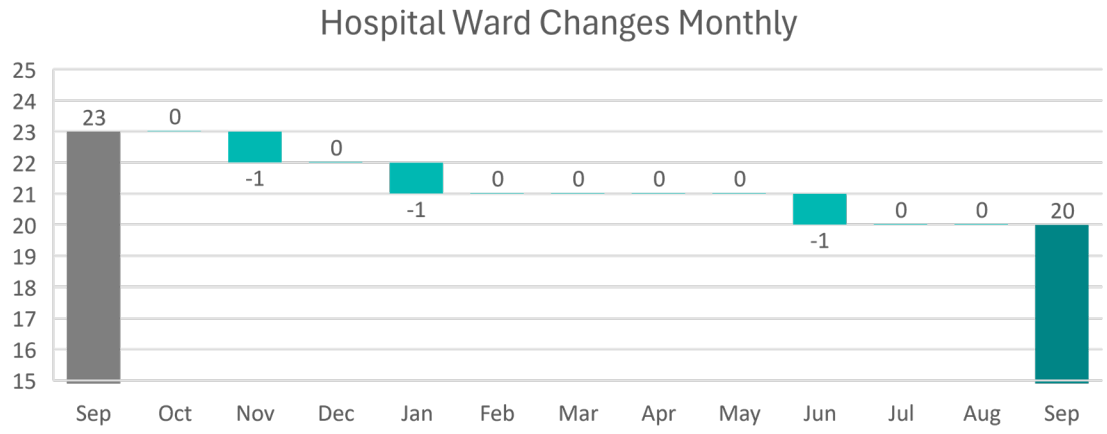
		FY 2025/26							FY 2025/26												
		2025	2025	2025	2025	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2027	2027	2027
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Capital Expenditure																				
1	Fixed assets (hardware)	-£114,814	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
2	Software	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
3	Implementation support	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
4	**Total Capital costs (CAPEX)**	**-£114,814**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Operating Expenditure																				
5	Virtual Hospital Staff Pay	-£185,856	-£313,955	-£366,281	-£418,607	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259
8	Operating software licences	-£108,900	£0	£0	£0	£0	£0	£0	-£331,368	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
10	Other operating costs	-£50,000	-£50,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
11	**Total Operating costs (OPEX)**	**-£344,756**	**-£363,955**	**-£366,281**	**-£418,607**	**-£523,259**	**-£523,259**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Total Expenditure																				
12	**Total Project Costs (CAPEX + OPEX)**	**-£459,570**	**-£363,955**	**-£366,281**	**-£418,607**	**-£523,259**	**-£523,259**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Existing Funding for SMART																				
13	Technology	£0	£0	£0	£0	£0	£0	£0	£113,568	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
14	Staff	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160
15	**Total Existing SMART Funding**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£276,728**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**
Efficiencies and Benefits																				
16	Cash-release (ward closure)	£0	£0	£254,167	£254,167	£508,333	£508,333	£508,333	£508,333	£508,333	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500
17	Cash-release (NCTR run-rate reduction)	£0	£45,833	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667
18	Cost avoidance (NCTR LoS reduction)	£0	£86,992	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800
19	**Total Efficiencies and Benefits**	**£0**	**£132,825**	**£535,633**	**£535,633**	**£789,800**	**£789,800**	**£789,800**	**£789,800**	**£789,800**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**
20	**Total cash-releasing benefits**				**£2,537,500**									**£9,741,667**						
21	**Total cash-saving benefits**				**£1,035,992**									**£2,277,600**						
Net cash inflow/(outflow)																				
22	Monthly (Incl. Cost Avoidance)	-£296,409	-£67,970	£332,512	£280,186	£429,701	£429,701	£429,701	£211,901	£429,701	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868
23	Monthly (Excl. Cost Avoidance)	-£296,409	-£154,962	£142,712	£90,386	£239,901	£239,901	£239,901	£22,101	£239,901	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068
24	**Total (Incl. Cost Avoidance)**				**£1,537,423**									**£7,480,281**						
25	**Total (Excl. Cost Avoidance)**				**£501,431**									**£5,202,681**						

Note: Additional revenue opportunities (not modelled): repatriating electives; licensing virtual hub service to other NHS Trusts.

Project Plan: Option 1 (Moving at Pace)

- **Sep-Oct 2025**: **Mobilisation** – 24/7 service for 50 virtual beds.
  → First SMART NCTR ward (Sheppy) restructured.
- **Nov 2025**:
  → First ward (Will Adams) shut down.
  → Second NCTR ward restructured.
- **Dec 2025**: Scale virtual bed capacity to 100 bed 24/7 and 100 beds 8-8.
- **Jan 2026**:
  → Second ward (Wakeley) shut down.
- **Feb-May 2026**: **Optimisation** – maximise efficiencies (LoS in NCTR, integrations with wider services for admission avoidance).
- **Jun 2026**:
  → Third ward (Tennyson) shut down.
- **Jul-Sep 2026**: **Stabilisation** – transition to business as usual and ensure long-term sustainability of model, with a blueprint for scaling further.





Financial Impact: Option 2 (Gradual Ramp-up)

NHS Medway NHS Foundation Trust

Benefits: **Cash releasing benefits** of **£1.5M** in FY25/26 and **£9.7M** in FY26/27. **Net cash inflow** of **£0.1M** in FY25/26 and **£5.2M** in FY26/27. Further cost avoidance from shortening the LoS of NCTR patients amounts to additional **£1M in FY 2025/2026** and **£2.3M in FY 2026/2027**.

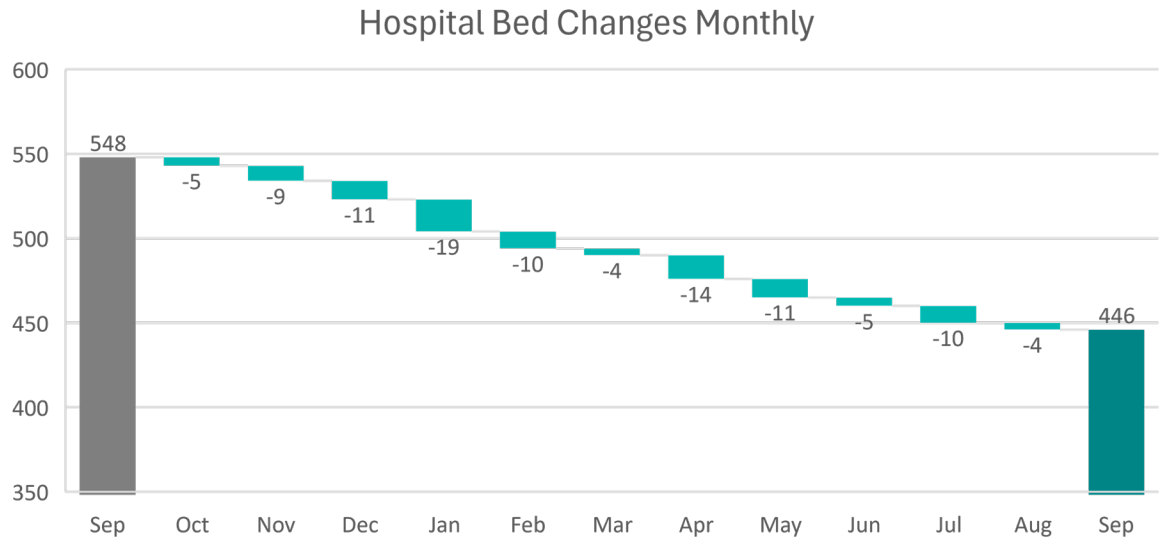
Requirements: **£0.6M** (£0.3M CAPEX costs to cover set-up costs, and £0.3M OPEX costs to cover virtual hospital staffing increase during Sep-Dec 2025). Beyond that point, the programme will have returned investment and be purely cash releasing.

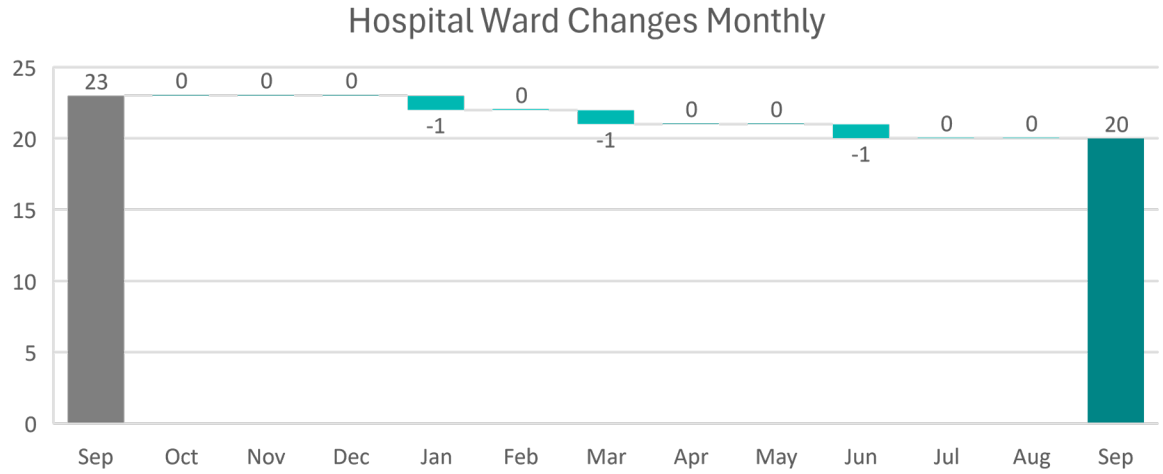
		FY 2025/26							FY 2025/26											
		2025	2025	2025	2025	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2026	2027	2027	2027
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Capital Expenditure																				
1	Fixed assets (hardware)	-£114,814	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
2	Software	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
3	Implementation support	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
4	**Total Capital costs (CAPEX)**	**-£114,814**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Operating Expenditure																				
5	Virtual Hospital Staff Pay	-£185,856	-£235,467	-£261,630	-£313,955	-£313,955	-£418,607	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259	-£523,259
8	Operating software licences	-£108,900	£0	£0	£0	£0	£0	£0	-£331,368	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
10	Other operating costs	-£50,000	£0	£0	£0	£0	-£50,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
11	**Total Operating costs (OPEX)**	**-£344,756**	**-£235,467**	**-£261,630**	**-£313,955**	**-£313,955**	**-£468,607**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Total Expenditure																				
12	**Total Project Costs (CAPEX + OPEX)**	**-£459,570**	**-£235,467**	**-£261,630**	**-£313,955**	**-£313,955**	**-£468,607**	**-£523,259**	**-£854,627**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**	**-£523,259**
Existing Funding for SMART																				
13	Technology	£0	£0	£0	£0	£0	£0	£0	£113,568	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
14	Staff	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160	£163,160
15	**Total Existing SMART Funding**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£276,728**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**	**£163,160**
Efficiencies and Benefits																				
16	Cash-releasing benefits	£0	£0	£0	£0	£254,167	£254,167	£508,333	£508,333	£508,333	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500	£762,500
17	Run-rate reduction	£0	£45,833	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667	£91,667
18	Cost avoidance	£0	£86,992	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800	£189,800
19	**Total Efficiencies and Benefits**	**£0**	**£132,825**	**£281,467**	**£281,467**	**£535,633**	**£535,633**	**£789,800**	**£789,800**	**£789,800**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**	**£1,043,967**
20	**Total cash-releasing benefits**	**£1,520,833**							**£9,741,667**											
21	**Total cash-saving benefits**	**£1,035,992**							**£2,277,600**											
Net cash inflow/(outflow)																				
22	Monthly (Incl. Cost Avoidance)	-£296,409	£60,519	£182,997	£130,671	£384,838	£230,186	£429,701	£211,901	£429,701	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868	£683,868
23	Monthly (Excl. Cost Avoidance)	-£296,409	-£26,473	-£6,803	-£59,129	£195,038	£40,386	£239,901	£22,101	£239,901	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068	£494,068
24	**Total (Incl. Cost Avoidance)**	**£1,122,504**							**£7,480,281**											
25	**Total (Excl. Cost Avoidance)**	**£86,512**							**£5,202,681**											

Note: Additional revenue opportunities (not modelled): repatriating electives; licensing virtual hub service to other NHS Trusts.

Project Plan: Option 2 (Gradual Ramp-up)

- **Sep-Oct 2025**: **Mobilisation** – 24/7 service for 25 virtual beds.
  → First SMART NCTR ward (Sheppy) restructured.
- **Nov 2025**:
  → Second NCTR ward restructured.
- **Dec 2025**: Scale virtual bed capacity to 50 bed 24/7 and 100 beds 8-8.
- **Jan 2026**:
  → First ward (Will Adams) shut down.
- **Feb 2026:** Scale virtual bed capacity to 100 bed 24/7 and 100 beds 8-8.
- **Mar 2026:**
  → Second ward (Wakeley) shut down.
- **Apr-May 2026**: **Optimisation** – maximise efficiencies (LoS in NCTR, integrations with wider services for admission avoidance).
- **Jun 2026**:
  → Third ward (Tennyson) shut down.
- **Jul-Sep 2026**: **Stabilisation** – transition to business as usual and ensure long-term sustainability of model, with a blueprint for scaling further.



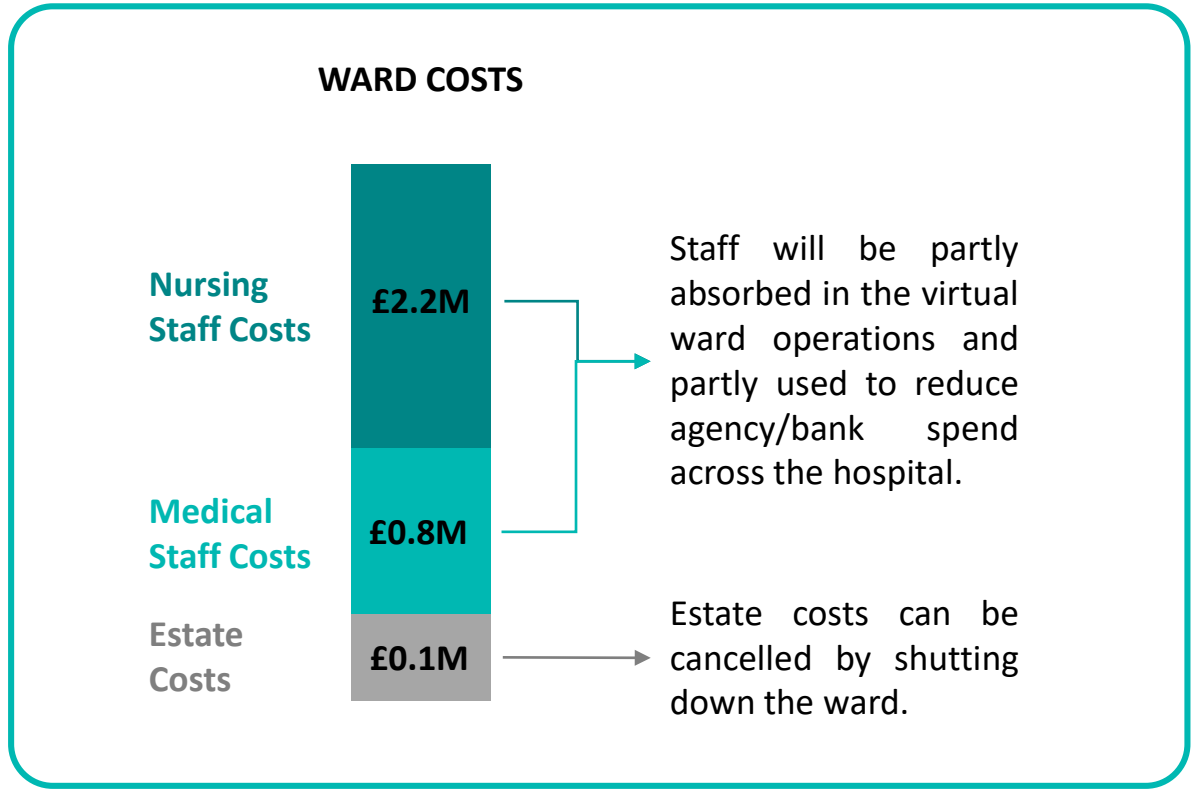


Cash-release: Closing Down Wards

Medway NHS Foundation Trust

By scaling the virtual hospital, we can free up capacity equivalent to 3 wards. Those wards can be shut down, releasing cash from both staffing and estate management, **totalling £3.05M annually per ward**, with the breakdown illustrated on the right.

The total cash-releasing benefit for the ward-closure is estimated at £9.2M.



Cash-release: NCTR Restructure

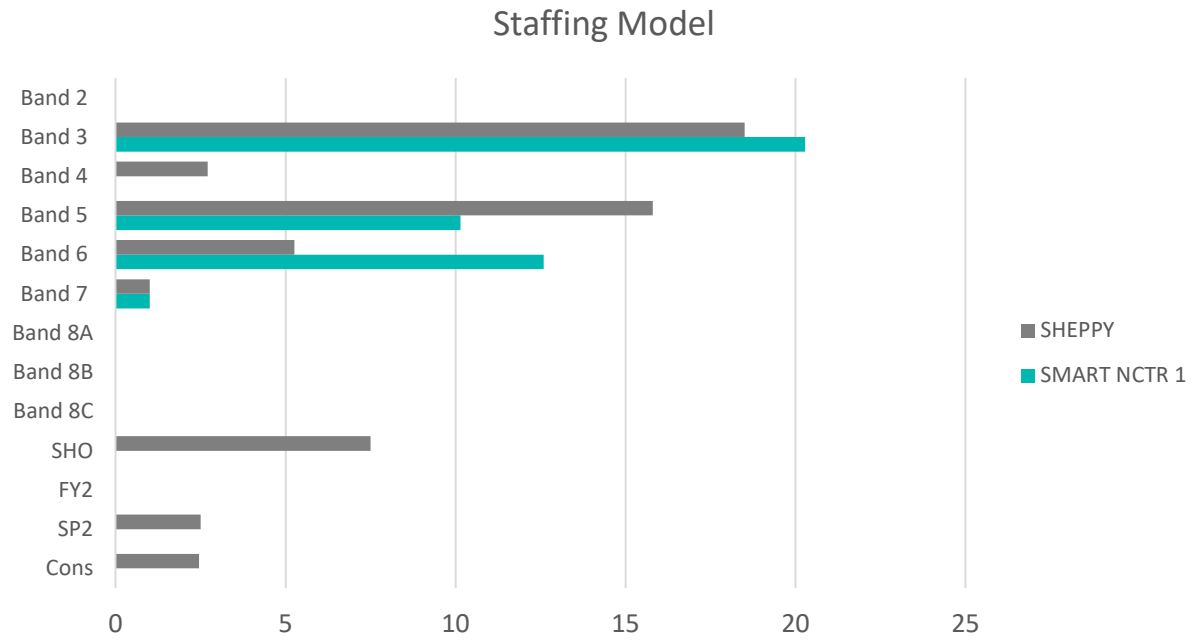
Medway NHS Foundation Trust

At any given time, up to **24% of inpatients have no criteria to reside (NCTR),** yet remain in hospital beds due to delayed pathways or lack of community-based alternatives.

Repurposing two care of the elderly wards to cohort NCTR patients and optimise their management will free up staffing and infrastructure.

The cohorted approach will allow us to **reduce the staffing costs** for these reablement wards, as illustrated with the example below.

The total cash-releasing benefit from the restructure is estimated at £1.1M.



Example: One of the elderly wards we suggest to target is Sheppy, which currently has an annual budget of £2.75M. The proposed SMART NCTR ward will require a budget of £2.2M, **reducing annual staffing costs by £0.55M**.

- The doctors from the ward will be **absorbed in the virtual hospital**, providing medical cover for any patients on the ward if required, with the rest of their capacity utilised to support a larger pool of patients managed virtually.
- The nursing staff will be restructured, with some nurses retained on the ward, and others **used to reduce agency/bank staff across the hospital.**

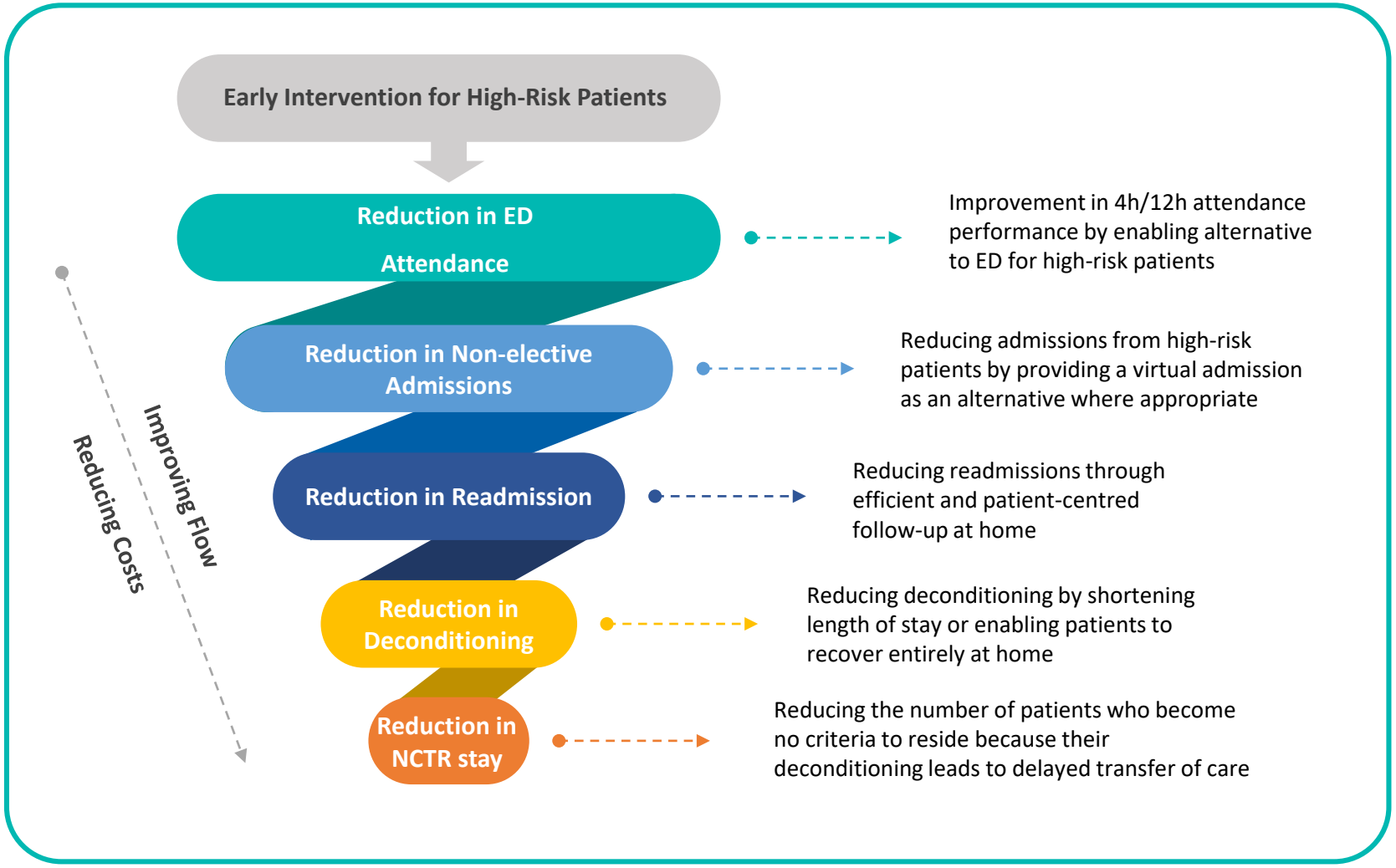
Cash-avoidance: Early Intervention + Optimisation

NHS Medway NHS Foundation Trust

In addition to the cash-releasing benefits of cohorting NCTR patients, we anticipate further downstream cost-avoidance, as illustrated by the diagram in the right.

This will lead to freeing-up additional bed capacity, estimated to be **at least 11 beds**. This can be used elsewhere to either improve cost-efficiency or deliver elective care.

The total cash-saving benefit from the downstream benefits is estimated at £2.3M.



Meeting of the Trust Board in Public
Wednesday, 10 September 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	x		x		
Title of Report	**KMPN Joint Venture Contract**			**Agenda Item**	6.3
Author and Job Title	Francesca Trundle, Managing Director KMPN				
Lead Executive	Darren Palmer, Chief Operating Officer (Interim)				
Executive Summary	Approval	x	Briefing		Noting

Following approval by all Partner Trust Boards earlier in 2025 to the KMPN Joint Venture Case for Change and the initial joint committee meeting, we are now bringing the detailed documentation (the KMPN Joint Venture Contract) for board sign-off.

This cover sheet highlights the key provisions in the contract that boards will be delegating to the KMPN joint committee and what will be retained by Trust boards as well as reminding boards of the financial principles, scope of KMPN and the phased approach to implementation.

Many of the provisions in the joint venture contract will be completed or updated over the coming year before the joint venture reaches its final form (Phase 3). Approving this documentation now, however, ensures each partner is aware of its obligations and liabilities through Phase 2.

The contract has been reviewed by a series of different groups with representatives from each organisation. The finance and investment group have reviewed the finance schedule and the joint committee has reviewed the terms of reference. A corporate governance task and finish group has overseen the development, with advice from workforce and governance specialists from DAC Beachcroft, our appointed lawyers. DAC Beachcroft lawyers presented to that group on two separate occasions and it met monthly from October 2024 – January 2025 and then again in June 2025 to finally review, with comments and queries picked up outside the meeting.

The first meeting of the KMPN joint committee took place on 1st August and introduced members to KMPN services and the programme of work required over the next two years' which the committee will support. It included presentations on cellular pathology and microbiology services. The group also discussed the terms of reference and principles of delegated responsibility to the committee.

The MFT members of the KMPN joint committee are Gary Lupton, Non-Executive Director and Matthew Capper Director of Strategy and Partnerships.

Proposal and/or key recommendation:	Approval of contract

Governance Route Meeting: Date submitted:	Medway NHS Foundation Trust Board – 12/07/2024, 13/11/2024 Kent and Medway Joint Committee (CEO and Chair) KMPN Joint Committee – 1/08/2025				
Identified Risks, issues and mitigations:	As detailed in the briefing				
Resource implications:	As detailed in the briefing				
Sustainability and/or Public and patient engagement considerations:	As detailed in the briefing				
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:	Francesca Trundle				

Delegated responsibilities to the joint committee

This contract (and the joint committee terms of reference included within it) delegates the following responsibilities to the joint committee:

- Approving contracts with a total value of less than £1m or approving the commitment of resources up to £1m
- Recommending single KMPN business cases with values above £1m directly to Trust boards for approval
- Recommending the final form for Stage 3 of the Kent and Medway Joint Venture (the full consolidation of pathology staff and budgets into a host Trust) to the Trusts boards;
- Approving changes in the location of or provision of pathology services, including but not limited to the consolidation of any sub-specialties onto certain sites within KMPN

As well as the approvals above, the following responsibilities remain with each individual Trust board:

- Approving the annual KMPN budget and approving spending above the agreed KMPN budget;
- Approving material variations to scope of activity delivered through the KMPN;
- Varying the KMPN JV Agreement including, in particular, the financial principles;
- Joining a new NHS body to the KMPN or collaborating with any other pathology network;
- Entering into, renewing or extending any land transaction or loan agreement;
- Disaggregating the Committee;
- Committing any Trust to a reconfiguration of services which could engage the statutory duties of any Trust such as public consultation or TUPE consultation;
- Tendering for and entering into a new contract with any integrated care board for the delivery of Services through the KMPN;
- Pooling the budgets of the Trusts;
- Resolving to form a legal entity such as an LLP or company limited by shares to deliver some or all of the activities of KMPN;

Financial principles

With respect to Phase 2 of the Joint Venture the following cost apportionment percentages will apply in line with previous agreements:

	MTW	EKHUFT	NKPS
Network Costs	25%	25%	50%
Membership Shares	MTW as per the percentage split set out in 2.2.2 below	EKHUFT as per the percentage split set out in 2.2.2 below	NKPS as per the percentage split set out in 2.2.2 below
LIMS	33%	34%	33%
MSC	As incurred	As incurred	As incurred
Outturn	The Partners will finalise the risk sharing profile in respect of any Surplus and/or Deficit in the budget as part of the Mobilisation Plan for Stage 2 and Stage 3. The proposal is that any surplus or deficit will be shared amongst partner organisations. Any variations shall be implemented in accordance with the Change Control Procedure.		

The initial KMPN Membership Shares, using the recurrent 23/24 In-Scope Services pathology expenditure, are as follows:

	EKHUFT	MTW	NKPS	DGT	MFT	Total
	Actual					
	£k	£k	£k	£k	£k	£k
Recurrent costs less intercompany costs	36,699	27,248	19,282	5,006	3,501	91,736
Percentage of total recurrent costs	40%	30%	21%	5%	4%	100%

The KMPN Joint Venture will include:

- All blood sciences, microbiology, cellular pathology, blood transfusion (including transfusion practitioners) and point of care services within each Trust
- Phlebotomy services at East Kent
-

The KMPN Joint Venture will not include:

- Mortuary services
- Phlebotomy services at Maidstone and Tunbridge Wells, Dartford and Gravesham and Medway
- The direct employment of and accountability for medical staff (funding for clinical leadership PAs will be included)

- **Phased approach to implementation**
  As set out previously, KMPN will move to the joint governance and management approach via the joint committee in Phase 2. It is likely that this will be delayed by three months from October 2025 to January 2026 to align with other local Trust workforce changes but the majority of the preparatory actions for Phase 2 have now been completed and this is being overseen by the existing KMPN Board.
- The Joint Venture contract sets out that if there is a delay to moving to Phase 3 (final form of the hosted joint venture), KMPN will remain in Phase 2, unless the partners agree otherwise. During Phase 2, the joint committee will recommend to Trust boards which organisation will be the JV host for Phase 3.
- Following approval of this documentation the next updates to Trust boards are likely to be on the proposed award of a network MES contract in Autumn 2025.