NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

July - 2025

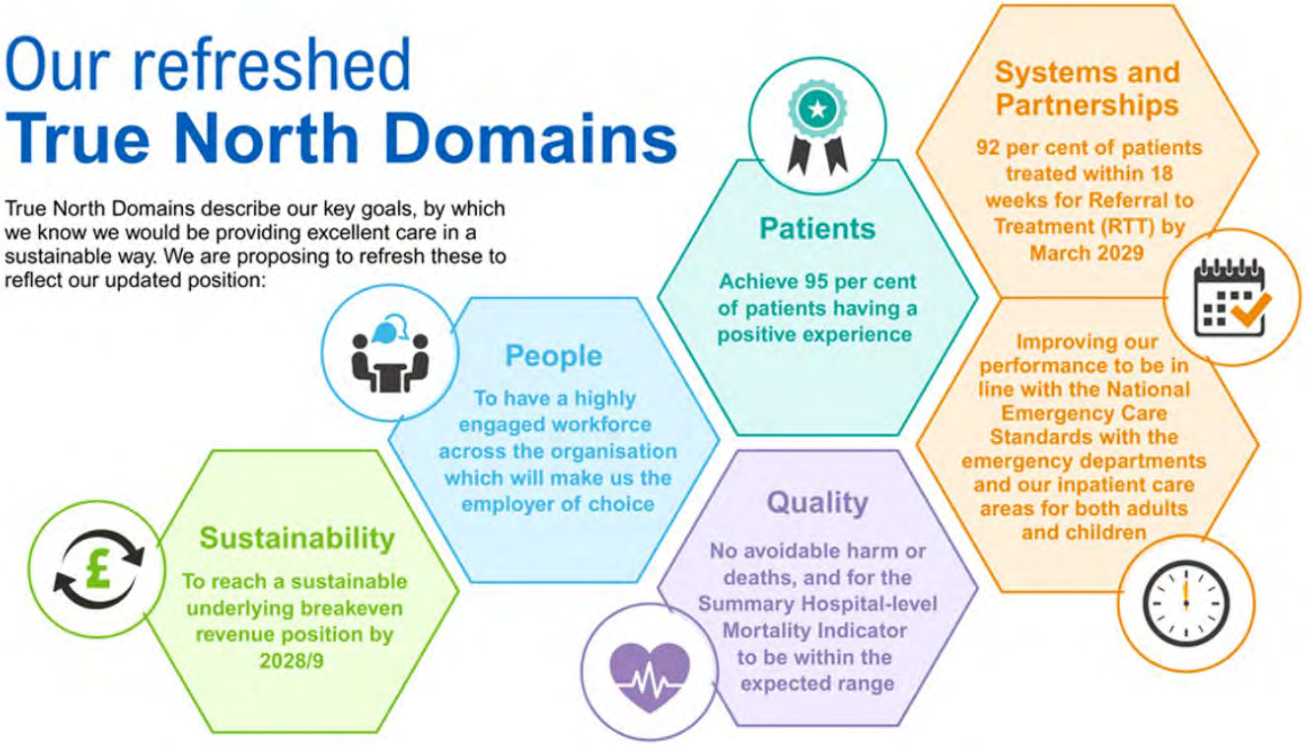
Patient FIRST

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
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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

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

Patients

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

NHS Medway NHS Foundation Trust

Steph Gorman
Chief Nursing Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Complaints	2	3	1	0	1	1
PALS	3	2	0	0	1	0
FFT	2	6	2	3	0	2
Patient Experience	0	1	0	1	0	0
PHSO	4	1	0	0	0	0

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

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

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

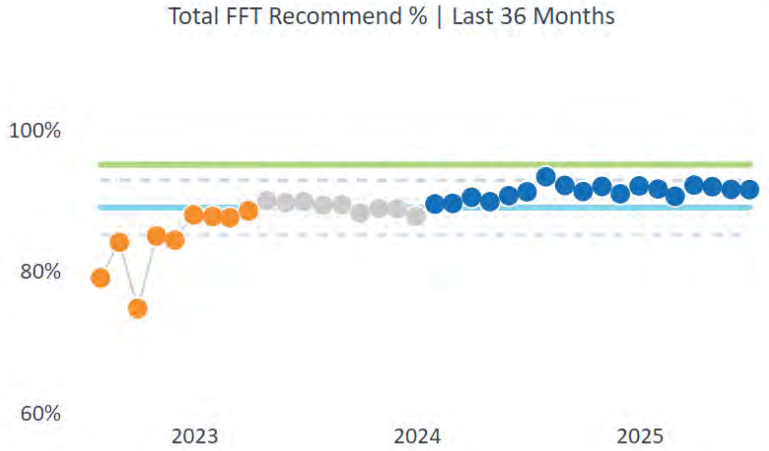
True North Domain: **Patients**

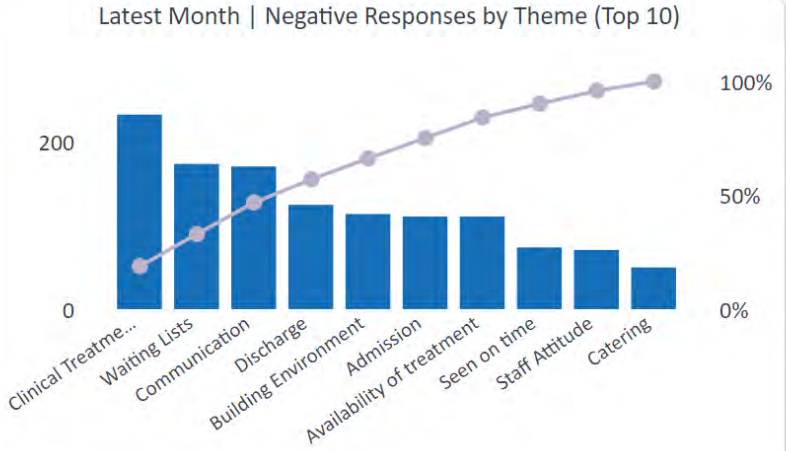
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

2	2	0	0	6





Key Messages

- Overall, positive experiences of care remain at 91.5% trust wide
- Positive experiences of care for ED reduced by 1 percentage point in the last month, many patients reported longer waiting times. This is likely attributed to the recent industrial action.
- As a celebration, maternity and inpatient areas remain above the target of 95% positive experiences of care for the 5th consecutive month
- Negative feedback in relation to staff attitude have dropped in the last 2 reporting periods which is positive.

Issues, Concerns & Gaps

- Car parking remains a contributor to poor experience overall in outpatient areas which is a challenge.
- Patients have reported a number of issues related to appointments, times and locations
- Noise and sleep has been noted as a rising contributor in the last reporting period in some clinical areas.

Actions & Improvements

- The patient experience team are working with Comms and Engagement team to manage patient expectations when coming to the site for an appointment. Messages to the public via social media are published to inform the public in relation to parking.
- The elective reform corporate project are continuing to work at pace to provide standard template letters that are sent to patients to ensure they are informed of where they are required to attend their appointment.
- The clinical teams have reinvigorated the ' noise at night' project, a new poster has been developed with the surgery and comms team to ensure patients get a restful nights sleep where possible.

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Patients	FFT			Emergency Care FFT Recommend %	80.0%			Driver is red for 2 reporting periods	75.3%	73.7%	79.4%	75.7%	74.2%	73.6%
				Outpatient FFT Recommend %	95.0%			Driver is red for 2 reporting periods	92.6%	91.2%	92.2%	92.6%	92.4%	92.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0			Watch is red for 4 reporting periods	13	5	28	24	30	25
	Complaints			Complaints Breached %	5.0%			Watch is red for 4 reporting periods	20.0%	16.2%	14.3%	7.7%	12.0%	16.1%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.5%	90.5%	92.1%	91.9%	91.5%	91.5%
				Emergency Care FFT Recommend %	80.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	75.3%	73.7%	79.4%	75.7%	74.2%	73.6%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.9%	94.7%	95.2%	95.6%	95.6%	94.9%
				Maternity FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.5%	95.2%	96.5%	96.3%	98.4%	97.0%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	46.6%	47.7%	49.9%	48.0%	46.3%	45.6%
				Maternity FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	72.6%	48.2%	59.2%	65.9%	74.5%	98.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	13	5	28	24	30	25
	Complaints			Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	72	67	59	52	59	53
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	20.0%	16.2%	14.3%	7.7%	12.0%	16.1%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	87	92	91	84	75	65
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

Key Messages

- 100% complaints acknowledged; 0 PALS converted to complaints
- Complaint themes include, delays & dissatisfaction with medical treatment, dissatisfaction with nursing care & attention, incorrect diagnosis and delay in diagnosis.
- PALS themes include; queries and delays with appointments, lack of communication/response from departments, delays in medication being provided, enquires regarding personal records & delays in receiving results. 30 compliments were received.
- No new PHSO cases.
- 3 complaints re-opened (1 Specialist Medicine, 1 Frailty & 1 ED)
- 84% of complaints responded to within Trust target time of 40 working days.
- MSA breaches remain low, however the number of incidents in July is attributed to delays in ICU And HDU steps downs to the wards.

Issues, Concerns & Gaps

- 16 PALS re-opened (5 – Surgical Services, 4 – Specialist Medicine, 2 – AEM, 2 – Frailty, 2 – WC, 1 – Theatres & Anaesthetics) due to patients/relatives not being contacted by relevant department/member of staff regarding enquiry as requested.
- There continues to be a high number of enquires to PALS due to queries from patients regarding outpatient appointments, experiencing difficulties in getting through to relevant departments by telephone to enquire about appointments and results.
- PALS vacancy and annual leave within the team will impact the responsiveness of the team.
- MSA reporting remains a manual process, reliant on the Patient Experience Team.

Actions & Improvements

Concern: Patient admitted to an elderly care ward with dressings in place and concerns raised that due to nursing staff's lack of knowledge and abilities to change compression dressings, there were delays in this being performed leading to discomfort and concern to the patient. Actions: Nursing staff have sought expert advice from the Tissue Viability Team for patients who are admitted with dressings or require wound care and additional refresher training on wound management has been arranged for nursing staff on the Frailty wards. Tissue viability QIP actions noted on ward,

Concern: Delay in nursing staff escalating a deteriorating patient on a medical ward. Actions: Registered Nurses on the ward have been enrolled onto the ALERT course to update their knowledge and practice on recognising and responding to the deteriorating patients. Compliance and escalation of deteriorating patients is being monitored at ward level with support from the Matron. Early recognition of deteriorating patient work continues Trust wide.

The national teletracking team have installed the necessary module for automated MSA reporting, this will be live in late September / early October 2025. this will fully mitigate risk number 1647 once complete.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Patients	FFT			Total FFT Recommend %	95.0%	H	F	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%	92.1%	91.9%	91.5%	91.5%
				Emergency Care FFT Recommend %	80.0%	H	?	79.9%	74.0%	72.8%	75.1%	71.2%	74.6%	75.3%	73.7%	79.4%	75.7%	74.2%	73.6%
				Outpatient FFT Recommend %	95.0%		F	94.7%	92.8%	93.1%	93.2%	92.3%	93.3%	92.6%	91.2%	92.2%	92.6%	92.4%	92.8%
				Inpatients FFT Recommend %	95.0%	H	?	95.3%	95.6%	93.8%	95.1%	94.7%	94.9%	94.9%	94.7%	95.2%	95.6%	95.6%	94.9%
				Maternity FFT Recommend %	95.0%	H	?	92.6%	94.8%	96.5%	98.3%	97.3%	97.9%	94.5%	95.2%	96.5%	96.3%	98.4%	97.0%
				Total FFT Response Rate %	-			16.3%	15.5%	15.4%	14.0%	13.0%	13.3%	13.3%	13.3%	13.1%	14.0%	12.2%	11.9%
				Emergency Care FFT Response Rate %	-	L		7.6%	6.7%	7.7%	7.6%	6.9%	7.6%	7.6%	7.8%	7.1%	7.1%	7.2%	6.9%
				Outpatient FFT Response Rate %	-	L		11.5%	10.7%	10.5%	9.7%	9.2%	9.7%	9.3%	9.2%	8.7%	10.4%	8.0%	7.5%
				Inpatients FFT Response Rate %	-	H		56.7%	55.9%	54.2%	50.3%	43.9%	44.1%	46.6%	47.7%	49.9%	48.0%	46.3%	45.6%
				Maternity FFT Response Rate %	-	H		42.3%	70.6%	76.0%	70.1%	72.3%	72.0%	72.6%	48.2%	59.2%	65.9%	74.5%	98.8%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	12	12	10	6	17	2	13	5	28	24	30	25
	Complaints			Complaints	-			30	22	43	19	20	37	36	27	24	19	37	21
				Complaints Closed	-	L		20	27	24	30	26	22	29	32	32	26	30	27
				Complaints Open - Month End	-	L		53	48	67	56	50	65	72	67	59	52	59	53

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Patients	Complaints			Complaints Re-Opened	-			1	4	10	2	2	1	7	0	1	3	2	3
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	P	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	0.0%	30.8%	20.0%	21.2%	16.7%	33.3%	20.0%	16.2%	14.3%	7.7%	12.0%	16.1%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			421	521	439	515	463	470	447	321	453	460	475	533
				PALS Closed	-			402	530	441	503	464	471	455	317	454	467	484	543
				PALS Open - Month End	-	L		96	87	85	97	96	95	87	92	91	84	75	65
				PALS Converted to Complaints	-	L		1	0	0	0	0	0	0	0	0	0	0	0
				PALS Re-Opened	47		P	18	56	19	34	29	20	27	19	19	23	17	15
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	L		2	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Partially Upheld	-					1	1	1						1	
				PHSO Cases Closed - No Investigation Required	-					1	1								

Quality

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

NHS Medway NHS Foundation Trust

Steph Gorman
Chief Nursing Officer

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
IPC	5	3	1	1	2	0
Incident Management	13	2	6	2	1	2
Medicines	1	0	1	0	1	0
Mortality	11	3	5	5	1	2
Falls	7	0	0	3	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	6	1	1	0	0	0
Pressure Ulcer	4	0	1	1	0	0
Risk & Policy	1	2	1	0	0	0
VTE	0	1	0	1	0	0

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

Committees:
Quality Assurance Committee (QAC)

Quality

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

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	95.0%	L	P	99.2%	99.0%	99.1%	99.1%	99.1%	98.7%	99.2%	99.3%	98.9%	99.1%	99.4%	98.2%

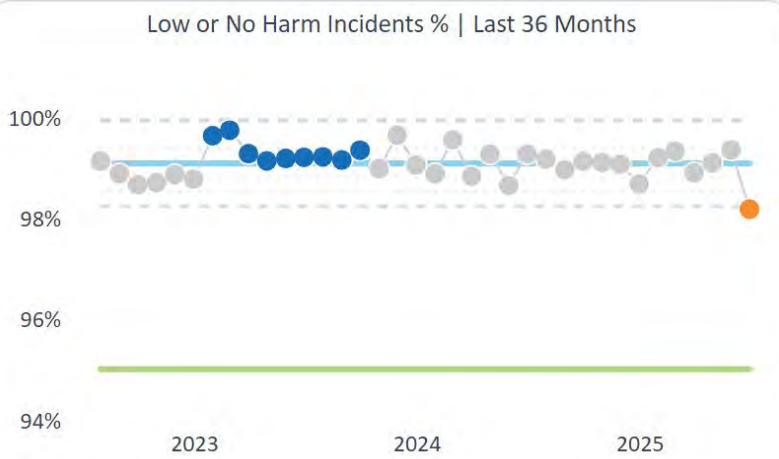
True North Domain: Quality

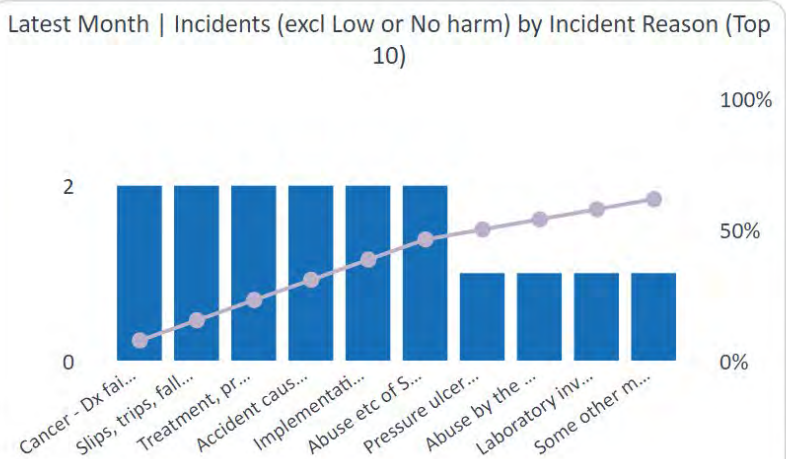
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

	L	H	L	H
13	2	4	1	1





Key Messages

- 98.2% of all incidents reported resulted in low or no harm.
- 21 incidents in July caused moderate harm or above (11 validated).
- Incidents include Falls with harm, missed medications, missed findings on imaging, delayed recognition of deterioration, sepsis management gaps, delays in cancer diagnosis and VTE prophylaxis gaps.

Issues, Concerns & Gaps

- Patients not receiving timely VTE prophylaxis is becoming a theme. Improved reporting of VTE incidents following improvement project.
- Medication management incidents remain a theme inc. not administering time critical meds or gaps in PRN meds. • Poor sepsis management is an emerging theme in 2 cases.
- Developing concern around alerts, requests and/or responses to test/imaging results (e.g. histology, imaging, bloods)
- EOLC decision making gaps remain - improvement project has demonstrated improvements in a number of areas.

Actions & Improvements

- Developing Nutrition, VTE, EOLC and Diabetes QIPs.
- SWARM training and PSIRF educational sessions provided.
- Actions taken to expedite lung MDM referrals.
- Simulation sessions held for cardiac arrest with pulmonary embolism
- KCH access to MFT PACS enabling direct access to MFT imaging to support clinical decision making.

Quality

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

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	1.30%			1.35%	1.30%	1.27%	1.51%	1.80%	2.31%	1.90%	1.57%	1.46%	1.42%	1.12%	1.20%

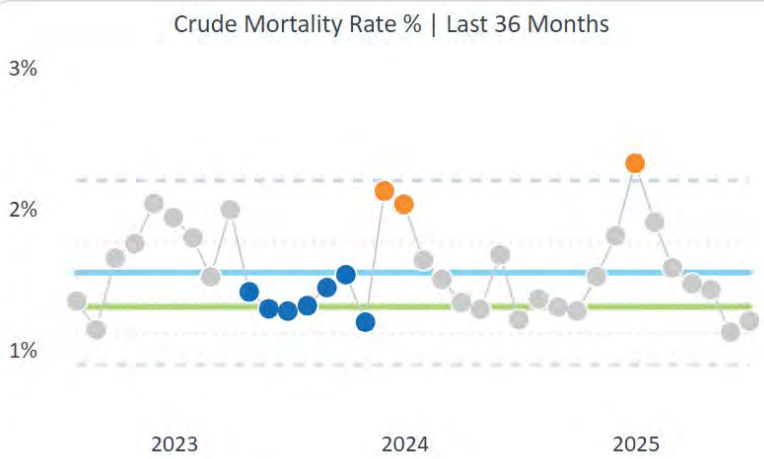
True North Domain: Quality

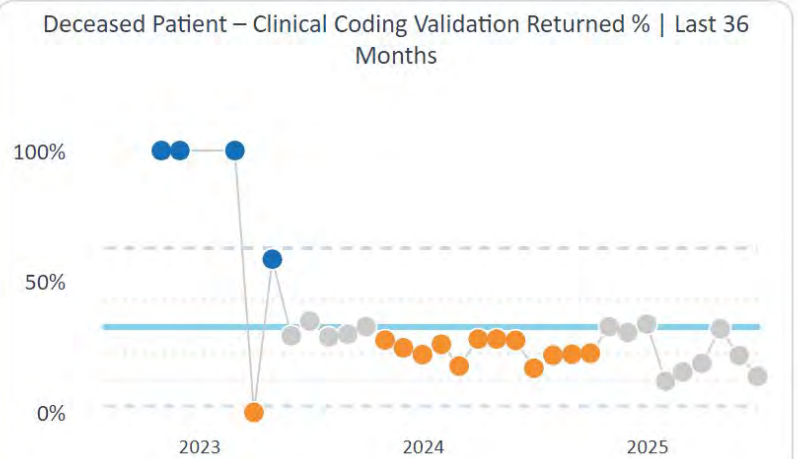
KPI Threshold: 1.30%

Sub Domain KPIs: 19

Variation Summary:

	L	H	L	H
11	0	5	1	2





Key Messages

- HSMR for the period of Apr 24- March 25 is 98.1 and 'within expected'
- SHMI for the period of Mar 24- Feb 25 is 1.25 and higher than expected
- UTI and Pneumonia are outlying diagnosis groups and are currently undergoing a deep dive process
- 21% of deaths were completed at Stage 1 SJR review which is an increase from last month. No avoidable deaths were identified.
- 16 specialities submitted a record of M&M meeting discussions for July.

Issues, Concerns & Gaps

- SHMI continues to increase and now reporting as 1.25 and higher than expected
- UTI and Pneumonia continue to alert as outlying diagnosis groups. These are significant as they feature in the top 10 diagnosis groups in the SHMI data which have the most impact on in hospital deaths.
- Returns for validation of deaths continues to remain low.
- MMRG attendance remains low. An A3 will be undertaken to inform improvements in attendance.

Actions & Improvements

- The SJR completion has improved. All licences have been fulfilled taking the total number of reviewers to 18 and consists of a mix of medical and nursing staff.
- Audit of unspecified pneumonia deaths and deep dive into UTI deaths has been commenced.
- A new M&M meeting template and action log has been created to support the specialities with their M&Ms and to drive meaningful improvement actions.
- A3 validations of death in progress. This forms part of the BO Quality Huddle. Support identified for MEC Division.
- Education on coding and Mortality data continues to be presented at specialty level.
- Medical Examiner and LFD Team working together on a deep dive into readmissions and discharge themes.

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0	H	F	Watch is red for 4 reporting periods	9	7	11	10	8	21
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	80.2%	79.8%	80.8%	80.1%	81.9%	83.0%
				Violence & Aggression Incidents	126	H	?	Watch is red for 4 reporting periods	172	247	220	167	237	221
	Mortality			SHMI (12m)	1	H	F	Watch is red for 4 reporting periods	1.25					
				Fractured NOF Within 36 Hours	92.0%		?	Watch is red for 4 reporting periods	60.9%	70.0%	48.7%	71.9%	78.8%	

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Incident Management			Never Events	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	80.2%	79.8%	80.8%	80.1%	81.9%	83.0%
	IPC			IPC Incidents	-	L	Special cause of improving nature or lower pressure due to (L)ower values	46	50	40	13	12	13
	Mortality			Deceased Patient – Clinical Coding Validation Sent %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	96.7%	97.3%	99.0%	95.9%	93.2%	90.6%
				HSMR (12m)	100	L	Special cause of improving nature or lower pressure due to (L)ower values	98.07	98.14				
				SJRs Completed %	12.5%	H	Special cause of improving nature or lower pressure due to (H)igher values	7.2%	14.6%	14.3%	11.9%	14.1%	19.6%
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	97.6%	94.5%	99.5%	96.9%	96.1%	97.8%
	Maternity			Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Risk & Policy			Risks Open - Moderate (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	20	18	18	15	15	15
				Risks Open - Extreme (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	6	8	8	9	10	10
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	84.0%	83.7%	83.5%	85.0%	83.5%	84.0%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.0%	85.3%	85.6%	86.2%	86.8%	86.4%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

- VTE - VTE risk assessment compliance remains consistently above 95%
- Falls - To note there was a fall to fracture resulting in severe harm in the last reporting period.
- Overall there has been a reduction in the number of falls in the last 4 months which is positive
- HAPU - A slight reduction in HAPU's overall and a significant reduction in G3 pressure ulcers noted in the last month; 13 clinical areas achieved above 90% in the ASSKING care bundle in July which is a celebration; Waterlow assessment tool has been removed and all areas are successfully using the new purpose T risk assessment tool
- FNoF/NAFF - Total NAFF admissions: 48 (Hip-fracture cohort: 41, Non-hip fragility fractures: 7); Operated within 36 hours: 23 / 48 (47.9%); Breaches (>36 hours): 25 / 48 (52.1%); Time to surgery (hours): mean 54.24, median 38.37, max 279.47; Time-to-surgery distribution (all NAFF): ≤24h: 9, 24–36h: 14, 36–48h: 7, 48–72h: 13, >72h: 5

Issues, Concerns & Gaps

- VTE - Delays prescribing and administering VTE prophylaxis remains an issue; VTE training is not mandatory for staff
- Falls - Intensive support has been provided to the top contributing areas - Arethusa, Pembroke, Keats, McCulloch, Will Adams, Milton and Lister; Low stocks available of falls bed and chair alarms
- HAPU - Issues have been identified in recent investigations that patients are not being turned regularly in accordance with policy, which contributes to higher incidences of HAPU
- FNoF/NAFF - We continue to perform RCA for all breaches; the July data (timings only) shows operational signals to consider: Weekday vs weekend performance: Weekday: 36 patients; 41.7% within 36h; 21 breaches / Weekend: 12 patients; 66.7% within 36h; 4 breaches / Signal: lower weekday compliance suggests daytime theatre access are key contributors, especially with specialised trauma as upper limb surgery in Theatre 8. Time-of-day at presentation: 00:00–07:59: 14 patients; 64.3% within 36h / 08:00–16:59: 17 patients; 35.3% within 36h (worst-performing band) / 17:00–23:59: 17 patients; 47.1% within 36h / Signal: the 08:00–16:59 cohort underperforms, consistent with daytime theatre pressure. Case mix: NOF fractures (all types): 42 patients; 50.0% within 36h / Non-NOF fragility fractures: 6 patients; 33.3% within 36h / Signal: non-NOF/complex fragility cases are more likely to breach; subspecialty access and optimisation needed are the limiting factors. Breach tail: 13 patients waited 48–72h; 5 patients waited >72h / Signal: a meaningful long-tail persists and warrants targeted escalation triggers after 24 and 36 hours. Summary: Of 25 breaches, the majority occurred after weekday, daytime presentations, with a notable tail of 48 hours. Patterns are most consistent with theatre capacity constraints and complex case pathways (subspecialty input and medical optimisation).

Actions & Improvements

- VTE - The VTE policy has been drafted and circulated for comments; The VTE CNS is working closely with the top 3 contributing areas to support compliance, this will be during board rounds to capture the most staff; Mandatory training package has been identified and will be supported for use through the HoN and OD team
- Falls - The falls team are providing comprehensive ward based training in relation to falls, prevention and documentation; Integral falls alarms, provided by Oska who supplied the new mattresses will be available by the end of August 2025 this will mitigate issue number.
- HAPU - Intensive support is being provided to re-educate, train and remind staff of the importance of regular turning for pressure relief and to reduce harm. Wards supported are sapphire, McCulloch, Harvey and Milton
- FNoF/NAFF - Immediate (next 4 weeks): 1.Ring-fenced daytime trauma capacity (Mon–Fri): reserve at least one daily trauma slot specifically for NAFF/hip fracture from 8:00 to 12:00 protect it from encroachment. 2. Daily 08:15 NAFF huddle (orthopaedics, anaesthetics, ortho-geriatrics, theatres): confirm priority order, fitness for anaesthesia, and kit/implant needs; allocate the ring-fenced slot. 3. >24h / >36h escalation protocol: automated E-Trauma flags to trauma anaesthetist, trauma coordinator, and on-call consultant; mandate senior sign-off for any continuation beyond 36 hours. Short–medium term (within 8–12 weeks): 4. Evening and weekend trauma lists: expand capacity where July performance was poor; formalise one additional evening list mid-week and one weekend day list during peak demand. 5. Subspecialty cover for complex NAFF: define rota for periprosthetic and complex hip cases; implement a "call-in" window to reduce breach, the new expansion in the LL team should help. 6. NAFF prioritisation in theatre scheduling: incorporate a visible NAFF priority tier in the scheduling and should not competing with other trauma. Next steps & assurance: RCAs for all 25 breaches; themes and actions will be presented at the September M&M.

Maternity

Key Messages

Perinatal Quality – Incidents: 144 datix (↓)reported for maternity; 0 Patient Incidents in maternity rated Moderate harm or above; 0 new MNSI referrals; 1 MNSI Report received in July – MDT meeting to take place to agree actions; 1 HIE grade 1 – cooled as part of Comet Trial, MRI normal; 1 Neonatal Death in community following inutero transfer from neighbouring Trust. Neighbouring Trust to lead on investigations; 28 (-) relating to PPH >1000mls; 3 (-) relating to 3rd/4th degree tears (11 in April, 4 in May, 3 June); 2 instrumental deliveries, 1 SVD; 25 (↑) Incidents in NICU, 6 (-) relating to medication. All incidents low harm **Staffing:** 8.96 (↑) WTE Band 5/6 vacancy available to advertise. **Perinatal Quality – PMRT:** Perinatal Losses (MRRACE reportable & PMRT): 1 Neonatal Death (23+0); 1 Stillbirth (27+5); 6 PMRT Meetings held in July; Maternity Led Graded at A,A and A,A; Neonatal led Graded at A,B,A. and B,A,B; Joint Maternity and Neonatal meeting for a twin pregnancy loss; Maternity grading – A,A Neonatal grading A,B,A; CNST standard C not met for 2 cases - currently at 92.3% (require 95%) **Listening to Women and Families – Service Users and MNVP:** Significant risk to the continuation of MNVP services at MFT due to ICB not renewing MNVP fixed term contract from end of September 2025; The ICB has also not increased the MNVP service provision to meet the additional requirements of CNST. This issue needs to be resolved by March 2026 or CNST Year 8 will be compromised; Patient Experience Midwife continues to work alongside MNVP to undertake in-reach work into community groups to ensure all voices are heard. **Staff Feedback:** Percentage of midwives would agree or strongly agree that they would recommend MFT as a place to work. For both agree and strongly agree midwives rank above the Trust and national average.- 2024 Survey – 78.64%; Proportion of speciality trainees in obstetrics and gynaecology responding with "excellent" or "good" on how they would rate the quality of clinical supervision out of hours (reported annually). 2025 GMC Survey – 82.22%. **Training:** Regional Labour Ward Coordinator training completed by Labour Ward Coordinators with positive feedback received. **External:** Awaiting feedback from Q4 25/26 Saving Babies Lives (SBL) Submission; National Investigation into Maternity and Neonatal Services launched with 5 key areas for immediate review identified. Report shared with Trust Board in July providing overall assurance and identifying ongoing work to achieve requirements.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: Key areas for improvement following return of MNSI report: [Need for ongoing holistic risk assessment at every antenatal contact; Alerting all staff to patient risk factors and ensuring senior oversight and care planning in accordance to guidance takes place]; Audit of 12 months PPH data >1500mls noted a trend towards black ethnicities and the lowest 5 multiple deprivation decile (MDD) **Staffing:** 4 leavers (3.25 WTE) expected in next 2 months due to personal reasons/relocation; Maternity leave rate currently 7.85 with additional 5.03 WTE due to go off over the next few months. **Risk:** 2510 (Awaiting approval) score 15 – Failure of ICB to extend contracts of MNVP Lead; 2487 Score 16 - Midwifery Workforce Budget 2025 - Non-compliance with Birth-rate Plus Recommendations – action plan agreed by Trust Board required to achieve compliance with CNST> **Perinatal Quality - PMRT**: Need to devise system to ensure Neonatal Representation at Maternity PMRT meetings; Difficulty in obtaining interpreting services, particularly over night. (recurrent); Thermal Control, documentation (recurrent); Organ donation. **Listening to Women and Families – Service Users and MNVP:** ICB unable to confirm continuation of current MNVP service provision. MNVP contract ends in September. Without the MNVP lead in post, MFT will not be compliant with CNST Year 7 which will lead to financial and reputational damage for the Trust. Without an MNVP lead in post MFT will also not be complaint with the 3 Year Delivery Plan for Maternity and Neonatal Services or be able to meet the ambitions of the 10 Year plan or the requirements of the National Review into Maternity and Neonatal Services. **Staff Feedback:** Students felt that they would like feedback at more regular intervals during their placement block, particularly in community. **Training:** Continue to balance clinical need with training requirements. **External:** If MNVP role is not supported by the ICB and Trust, the Trust will not be compliant with the preliminary requirements of the National Investigation; Awaiting formal feedback from NHSR to confirm that ICB revised structure will meet CNST requirements.

Actions & Improvements

Perinatal Quality: Audit of current system of risk assessment via EuroKing at all contacts to ensure patients are being risk assessed to correct level; Development of proforma to support Community Midwives to ensure all risk factors are considered at birth planning appointment; Centiles added to all fetal medicine scans immediately following incident to ensure all staff are alerted to any change in growth velocity; Developing a working group to review alert system on Maternity Information System with a view to utilise widely to communicate risks; Plan for a working group to review all PPHs by ethnicity, MDD, risk factors, delivery and management with a view to develop focused improvement work. **Staffing:** VCP approval received for external recruitment. To advertise for vacant posts; Support students with graduate guarantees to complete qualification in time for September start. **Risk:** 2510 – Escalating through QAC and Trust Board as part of compliance reporting. Options appraisal completed. Awaiting outcome from ICB; 2487 Escalating through QAC and Trust Board as part of compliance reporting. Working with finance BP to identify exact number of roles removed from budget. If posts cannot be returned to budget, an action plan with timelines to restore the budget will need to be agreed by Trust Board in order to be compliance with CNST Year 7. **Perinatal Quality – PMRT:** Maternity - Ensure that all families who require an interpreter if English isn't a first language receive this service as a routine and not as an option. Do not use family members to interpret Datix when interpreter is unavailable; Use hospital staff if available if no interpreter available. **Escalated** – Trust is investigating new avenues with combined LMNS in relation to interpreting services. **Neonatal:** Ensure all documentation is contemporaneous, fully completed and legible; Thermal regulation training; Organ discussion to be discussed with all eligible parents. **Listening to Women and Families – Service Users and MNVP:** Service user video to be shared as part of staff training on 3rd and 4th degree tears and as part of upcoming audit meeting; Work with ICB to attempt to resolve MNVP contractual concerns; Development of cultural experience survey for service users to be rolled out in coming months. **Staff Feedback:** Education lead to discuss as part of PROMPT training and Student lead to feedback via monthly updates and walk-arounds; Positive response to GMC speciality trainee survey, overall response rate at 73% and Obstetric & Gynaecology team receiving a highly commended award. **Training:** Anaesthetic staff all booked/mapped to training; Planned rotational O&G staff for October mapped to training sessions. **External**: Planning for NHSE Insight visit commenced, collation of evidence underway and key stakeholders invited to join; Commence auditing against SBL 3.2 from Q1 25/26; PQSM well embedded at MFT. Minimum dataset and reporting requirements in place to maintain compliance with PQOM. Local SOP to be updated to reflect new terminology and changes regarding removal of LMNS as a separate function within the ICB.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Incident Management			Low or No Harm Incidents %	95.0%	L	P	99.2%	99.0%	99.1%	99.1%	99.1%	98.7%	99.2%	99.3%	98.9%	99.1%	99.4%	98.2%
				Total Incidents Reported	-			1,199	1,055	1,139	1,112	1,068	1,207	1,245	1,334	1,359	1,326	1,386	1,424
				Clinical Incidents with Harm (Moderate and above)	0	H	F	7	10	9	8	7	11	9	7	11	10	8	21
				Incidents Open - Month End	-			2,214	2,216	1,969	1,691	1,782	1,727	1,751	1,827	1,610	1,600	1,662	1,702
				Incidents Overdue - Month End	-			1,261	1,258	1,132	778	819	788	700	760	595	558	618	666
				Patient Safety Incident Investigations (PSII) Declared	-					2			1	1	1		2		2
				Patient Safety Incident Investigations (PSII) Closed	-			1	1	1	2								
				Patient Safety Incident Investigations (PSII) Open - Month End	-	H		2	1	2			1	2	3	3	5	5	7
				After Action Review (AAR) Declared	-				4		7	2	6	5	1	4	5	4	4
				After Action Review (AAR) Closed	-			3	2	2	1	3	2	4	6	3	1	3	4
				After Action Review (AAR) Open - Month End	-	H		2	4	2	8	7	11	12	8	9	13	14	14
				Never Events	0	L	?	0	0	2	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	L		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	20.0%
				Duty of Candour Compliance Stage 2 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Incident Management			RIDDOR Incidents	-				3	3	3	1		2		4	1	1	
				RIDDOR Compliance %	-			-	100.0%	66.7%	100.0%	100.0%	-	50.0%	-	100.0%	100.0%	100.0%	-
				Health & Safety Incidents	-			55	45	65	55	45	53	46	45	45	52	70	68
				Sharps Injuries	-			13	10	6	13	7	9	5	7	6	9	10	5
				EDNs Completed Within 24hrs %	90.0%	H	F	84.1%	82.6%	84.6%	85.3%	84.7%	82.9%	80.2%	79.8%	80.8%	80.1%	81.9%	83.0%
				Violence & Aggression Incidents	126	H	?	139	108	119	99	123	116	172	247	220	167	237	221
				Assaults - Patient on Staff	-			60	40	62	35	53	57	66	73	48	48	65	72
	Falls			Low or No Harm Falls %	95.0%		?	98.8%	97.8%	98.0%	100.0%	100.0%	98.2%	100.0%	100.0%	98.6%	98.0%	98.6%	97.4%
				Falls - Total	-			82	92	102	74	83	114	90	70	69	98	71	77
				Falls - Low Harm	-			21	29	33	27	21	34	35	30	20	35	27	22
				Falls - Moderate Harm	-			0	1	2	0	0	1	0	0	1	1	0	1
				Falls - Severe Harm	0		?	0	1	0	0	0	1	0	0	0	0	1	1
				Falls Resulting in Death	0		?	1	0	0	0	0	0	0	0	0	1	0	0
				Falls per 1,000 Bed days	-			5.10	5.85	6.26	4.63	5.08	6.69	5.94	4.24	4.45	6.02	4.46	4.65

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Falls			Falls per 1,000 Bed days	-			5.10	5.85	6.26	4.63	5.08	6.69	5.94	4.24	4.45	6.02	4.46	4.65
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	23	22	31	17	26	34	39	30	22	23	28	21
				Pressure Ulcers - Grade 2	-			18	15	24	9	15	20	19	9	12	10	12	16
				Pressure Ulcers - Grade 3	-			4	7	6	7	11	13	18	19	9	12	14	4
				Pressure Ulcers - Grade 4	-	H		1	0	1	1	0	1	2	2	1	1	2	1
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.43	1.40	1.90	1.06	1.59	1.99	2.57	1.82	1.42	1.41	1.76	1.27
	Medicines			Medicine Errors - Total	-			94	68	89	92	73	74	66	97	80	102	94	106
				Low or No Harm Medicine Errors %	95.0%	L	P	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	98.5%	100.0%	98.8%	99.0%	97.9%	97.2%
	IPC			IPC Incidents	-	L		108	49	59	55	53	51	46	50	40	13	12	13
				C-Diff Cases - Hospital Acquired Total	-			7	11	5	6	5	6	4	6	3	3	7	6
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			21	32	37	43	48	54	58	64	3	6	13	19
				C-Diff Cases - Hospital Acquired (HOHA)	-			4	4	5	4	1	6	4	4	3	2	5	4
				E.coli Cases - Hospital Acquired	-			9	2	5	8	2	2	7	4	4	2	3	4
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			29	31	36	44	46	48	55	59	4	6	9	13

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	IPC			MRSA Cases - Hospital Acquired	0	H	?	0	0	0	0	2	0	0	0	0	0	0	1
				MSSA Cases - Hospital Acquired	-			3	4	1	1	3	2	4	1	1	1	1	3
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			8	12	13	14	17	19	23	24	1	2	3	6
	Mortality			Crude Mortality Rate %	1.30%		?	1.35%	1.30%	1.27%	1.51%	1.80%	2.31%	1.90%	1.57%	1.46%	1.42%	1.12%	1.20%
				Deceased Patient – Clinical Coding Validation Returned %	-			21.8%	22.2%	22.6%	32.7%	30.5%	33.8%	11.9%	15.5%	18.8%	31.9%	21.7%	13.8%
				Deceased Patient – Clinical Coding Validation Sent %	-	H		96.7%	98.9%	100.0%	97.2%	98.3%	93.3%	96.7%	97.3%	99.0%	95.9%	93.2%	90.6%
				Deceased Patient – Clinical Coding Amendments %	-			36.8%	15.0%	19.0%	44.1%	25.0%	28.8%	28.6%	17.6%	27.8%	23.3%	33.3%	50.0%
				Avoidable 2222 Calls – Cardiac Arrest	1		?					2	1	1	1		2	1	
				Avoidable 2222 Calls – Peri-Arrests	3		?	2	2	1	2	6	3	2	1	5	1	3	2
				Avoidable 2222 Calls	16		P	2	2	2	2	8	4	3	2	5	3	4	2
				HSMR (12m)	100	L	F	98.36	98.74	97.55	99.94	98.52	99.01	98.07	98.14				
				HSMR Expected Death Rate (12m)	-	H		5.2%	5.2%	5.2%	5.3%	5.3%	5.3%	5.4%	5.5%				
				HSMR Expected Death Rate (Month)	-	H		5.5%	4.9%	4.6%	5.7%	6.3%	5.9%	6.8%	6.3%				
				SHMI (12m)	1	H	F	1.20	1.20	1.20	1.21	1.21	1.23	1.25					

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Mortality			SHMI Expected Death Rate (12m)	-			3.1%	3.1%	3.1%	3.2%	3.2%	3.3%	3.3%					
				SHMI Crude Death Rate (12m)	-			3.7%	3.7%	3.7%	3.8%	3.9%	4.0%	4.1%					
				Fractured NOF Within 36 Hours	92.0%			74.1%	66.6%	66.6%	76.2%	83.3%	70.7%	60.9%	70.0%	48.7%	71.9%	78.8%	
				Number of Deaths Reviewed via SJR	-			5	16	16	18	14	13	10	18	15	13	12	19
				SJRs Completed %	12.5%			4.1%	13.1%	12.1%	11.9%	9.2%	6.5%	7.2%	14.6%	14.3%	11.9%	14.1%	19.6%
				Total Number of Deaths Due to Failings in Care	-			0	0	0	1	0	1	0	2	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	0	0	4	0	0	1	4	0	0	1	0
				Total Number of LD Deaths Due to Failings in Care	-						0			0	0			0	
	VTE			VTE Risk Assessment Completed %	95.0%			99.0%	99.2%	99.7%	99.8%	99.1%	98.9%	97.6%	94.5%	99.5%	96.9%	96.1%	97.8%
	Maternity			Caesarean Section %	-			49.4%	49.2%	51.0%	48.4%	48.1%	46.5%	51.1%	45.1%	53.0%	50.1%	48.7%	50.0%
				Elective C-Section %	-			20.0%	19.4%	19.8%	19.5%	21.8%	19.8%	22.3%	21.2%	22.3%	20.4%	20.3%	23.9%
				Emergency C-Section %	-			29.4%	29.8%	31.1%	28.9%	26.3%	26.6%	28.7%	23.9%	30.7%	29.7%	28.4%	26.1%
				PPH greater than or equal to 1500mls	-			20	12	14	16	20	18	12	15	18	12	14	17
				Total Number of Still Births Greater Than 24 weeks Gestation	-			1	2	0	0	0	2	2	2	1	2	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Quality	Maternity			Neonatal Deaths	-			2	1	0	2	2	3	3	3	1	2	2	1
				Maternity and Newborn Safety Investigations (MNSI) Declared	-			0	0	1	0	0	2	1	0	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-	L		1	1	0	0	1	0	0	0	0	0	0	0
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-						1	1	1	1	3	3	2	2	2
				Risks Open - Moderate (Month End Snapshot)	-	L		25	24	23	21	21	23	20	18	18	15	15	15
				Risks Open - High (Month End Snapshot)	-	H		47	47	46	42	48	46	48	49	51	54	57	58
				Risks Open - Extreme (Month End Snapshot)	-	L		11	11	7	6	5	5	6	8	8	9	10	10
	Health & Safety			Resuscitation Training Compliance %	-	H		83.6%	82.9%	82.9%	84.2%	84.5%	84.0%	84.0%	83.7%	83.5%	85.0%	83.5%	84.0%
				Mental Capacity Act Training Compliance %	-	H		86.6%	85.5%	86.3%	87.0%	86.9%	86.1%	86.0%	85.3%	85.6%	86.2%	86.8%	86.4%
	Legal & Information Governance			Inquests Received	-			10	7	7	12	8	15	8	8	6	7	3	11
				Inquest Hearings	-			12	3	5	5	6	7	5	6	7	8	5	3
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

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

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	13	6	8	15	1	5
Emergency Care	6	5	1	3	1	4

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

Committees:
Finance & Performance Committee

Systems & Partnerships

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

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	60.0%			50.2%	51.4%	51.1%	50.9%	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%

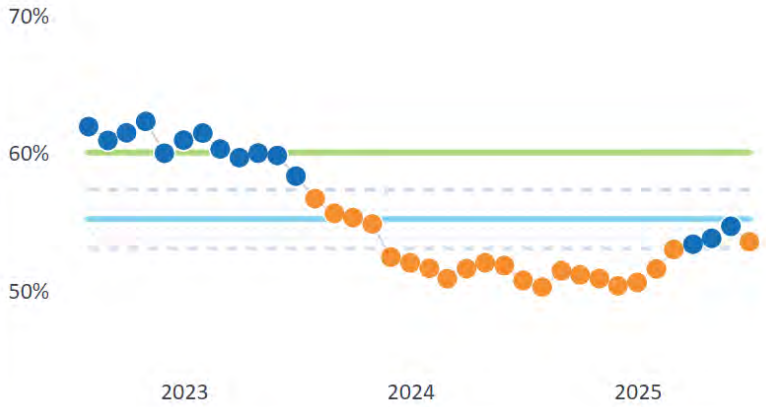
True North Domain: **Systems & Partnerships**

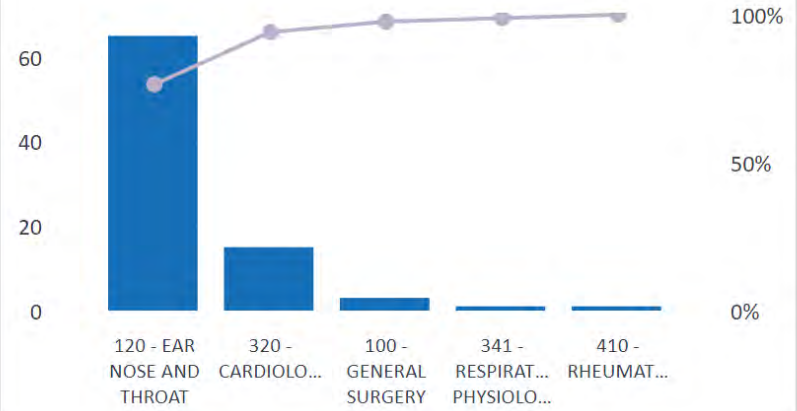
KPI Threshold: 60.0%

Sub Domain KPIs: 27

Variation Summary:

13	3	5	4	2





Key Messages

Incomplete performance has decreased in month to 53.5%, against 54.4% plan. Attributable to increased number of referrals received in March 2025 and the impact of industrial action and reduced activity.

The number of patients waiting >52wks at end of July is 1784 against a trajectory of 1730.

Overall waiting list size stands at 39,696 against a plan of 41,249

Issues, Concerns & Gaps

65 week position currently at 92 at end of July, however this is an unvalidated position and predict this will come down to 80 patients –

- 44 patient choice delays
- 25 ENT – capacity
- 6 - Cardiology (4 cons r/v, 2 MPS)
- 3 – General Surgery (2 BRAVO, 1 capacity)
- 1 – Rheumatology (late con to con ref)
- 1 – Sleep (capacity)

Actions & Improvements

- Weekly Tier 1 meetings in place with NHSE and ICB to monitor elective performance and provide any necessary support
- Action plan has been developed following the Elective Care Intensive Support Team recommendations. Progress against the actions will be monitored through the Elective Reform Programme Board.
- Developing 52 week trajectories.
- Working with BI to create forecasting reports for each specialty.

Systems & Partnerships

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

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	80.0%	H	?	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%

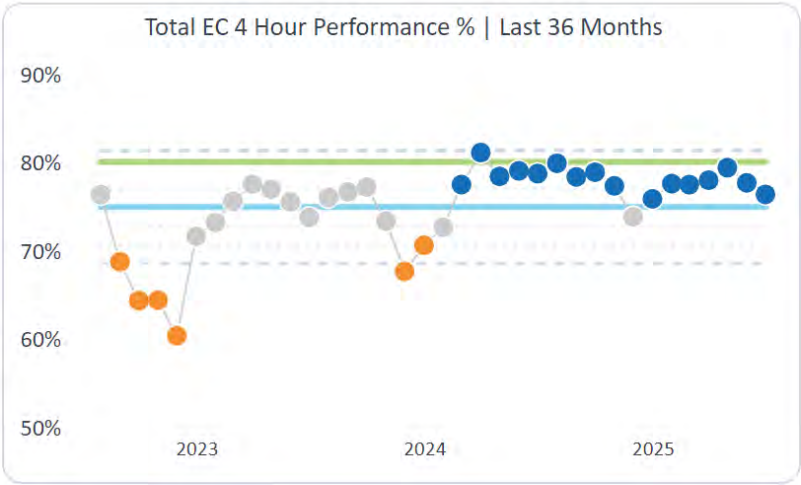
True North Domain: Systems & Partnerships

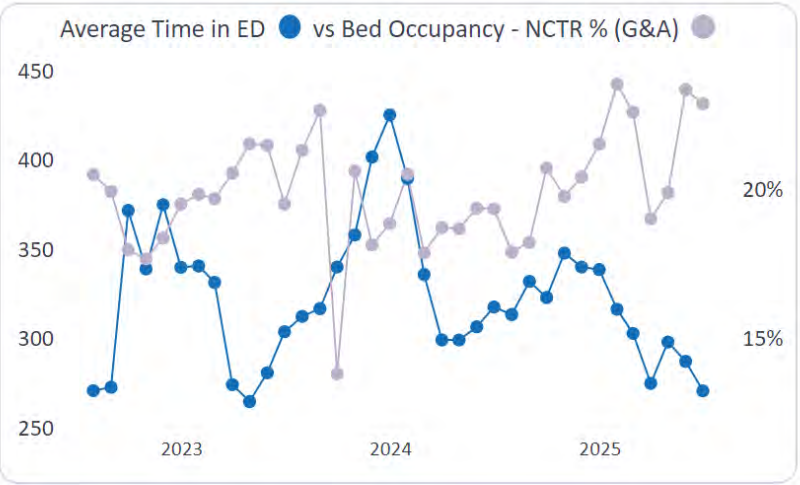
KPI Threshold: 80.0%

Sub Domain KPIs: 12

Variation Summary:

	L	H	L	H
6	0	1	2	3





Key Messages

Staff wellbeing remains a priority, with increased incidences of incivility within AEM addressed on a case-by-case basis in line with the conflict resolution policy. Collaborative progress continues on the new Mental Health and Safe Haven ED building with KMPT and MFT. SDEC overnight stays have risen slightly in July to 67. Strong joint working between MIU and AEM leadership is embedding well, with daily operational meetings, weekly rostering reviews, monthly site visits, and inclusion of MIU in CGB meetings to strengthen workforce integration. The five-day junior doctor strike (25–29 July) created late-notice staffing challenges, but senior consultants responded flexibly to maintain departmental cover.

Issues, Concerns & Gaps

July's 4-hour performance was 77.76%, with only 4 days exceeding the 80% target, impacted in part by the five-day junior doctor strike. The highest daily performance was 82.59%, leaving 27 days below target. 12 breaches continue to be driven primarily by delays in initial assessment, delays until seen by ED, and medical specialty delays, most frequently occurring in Areas 2, 3, and Majors. Initial assessment performance has declined over the past three months, with July at 53.4% despite earlier improvements since February 2025. CDU usage improved to 324 patients in July but remains underutilised; a dedicated improvement plan for CDU is being incorporated into the wider performance improvement plan to streamline efforts.

Actions & Improvements

Current priorities include enhancing night-time performance, optimising patient flow, and improving breach prevention through targeted roster reviews, real-time patient tracking at 3, 9, and 11 hours, and strengthened escalation processes with specialties. Positive FFT feedback is increasing and being celebrated across the Acute and Emergency workforce. Appraisal rates for AEM have improved, a 24-hour mental health triage service is now live in UTC, and sickness rates in medical teams remain below Trust targets. Lister and Pembroke are operating within budget, buzzer response times have reduced, and recruitment efforts across medical, nursing, and operational roles have progressed to address establishment gaps.

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	L	F	Driver is red for 2 reporting periods	181	80	86	111	101	80
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	1,767	1,695	1,718	1,777	1,735	1,767
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	121.03	120.62	115.75	117.64	119.51	122.42
				Outpatient DNA Rate %	5.0%	L	F	Watch is red for 4 reporting periods	5.2%	5.7%	6.1%	6.0%	6.3%	5.9%
				Cancer USC Performance %	93.0%		?	Watch is red for 4 reporting periods	82.4%	77.4%	77.7%	69.2%	87.5%	
				Cancer USC Performance - Breast Symptomatic %	93.0%		?	Watch is red for 4 reporting periods	14.4%	25.6%	48.0%	25.6%	76.0%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	Watch is red for 4 reporting periods	62.9%	60.8%	65.6%	55.1%	49.7%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	Watch is red for 4 reporting periods	69.6%	79.2%	64.7%	67.9%	71.4%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	Watch is red for 4 reporting periods	69.4%	67.9%	59.9%	56.6%	66.5%	
				Critical Care Discharge Delays > 4Hrs	35.0%		?	Watch is red for 4 reporting periods	46.5%	52.5%	54.3%	43.9%	45.8%	51.0%
	Emergency Care			Type 1 LOS > 12 Hours in EC %	6.0%		F	Driver is red for 2 reporting periods	14.2%	13.2%	10.6%	10.6%	10.1%	11.5%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	Watch is red for 4 reporting periods	82.9%	83.3%	83.8%	84.9%	82.7%	81.6%
				Type 1 EC 4 Hour Performance %	75.0%		F	Watch is red for 4 reporting periods	64.7%	65.8%	67.0%	67.5%	67.1%	65.7%

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Emergency Care			Total EC 12 Hour DTAs	0		F	Watch is red for 4 reporting periods	706	688	412	533	454	614
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	Watch is red for 4 reporting periods	315.84	302.27	274.29	297.46	286.62	270.10

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	L	Special cause of improving nature or lower pressure due to (L)ower values	181	80	86	111	101	80
				Outpatient DNA Rate %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	5.2%	5.7%	6.1%	6.0%	6.3%	5.9%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.76	1.69	1.79	1.77	1.72	1.75
				Urgent Operations Cancelled for 2nd Time	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	1	1	0	1
				Day Case Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.3%	88.0%	88.7%	88.1%	87.8%	87.1%
				DM01 Performance %	73.1%	H	Special cause of improving nature or lower pressure due to (H)igher values	87.4%	91.1%	87.6%	85.7%	86.8%	86.0%
	Emergency Care			Total EC 4 Hour Performance %	80.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	82.9%	83.3%	83.8%	84.9%	82.7%	81.6%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	20.0%	21.3%	18.5%	19.1%	19.1%	21.1%
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	1	0	3	1	0	2
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	7.9%	8.1%	7.1%	8.2%	8.4%	7.7%

Access

Key Messages

Incomplete performance has decreased in month to 53.5%, against 54.4% plan. Attributable to increased number of referrals received in March 2025 and the impact of industrial action and reduced activity.

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Actions & Improvements

- Weekly Tier 1 meetings in place with NHSE and ICB to monitor elective performance and provide any necessary support
- Action plan has been developed following the Elective Care Intensive Support Team recommendations. Progress against the actions will be monitored through the Elective Reform Programme Board.
- Developing 52 week trajectories.
- Working with BI to create forecasting reports for each specialty.

Emergency Care

Key Messages

- Staff Wellbeing – Staff morale and communications between workforce teams has highlighted strained relationships and incivilities. Case by case addressed on individual basis with appropriate management team in line with conflict resolution policy. Increase in incivilities within AEM.
- Mental Health Unit – Discussions and collaborative work between KMPT and MFT has commenced with design work for the new Mental Health and Safe Haven ED Building structure.
- SDEC Overnight Stays – Overnight stays have slightly increased in July sitting at 67.
- Sheppey and Sittingbourne Minor Injury Units – Continued collaborative working between MIU and AEM Leadership is working well. Currently daily meetings are carried out in the morning with Care Group Leaders and MIU staff to establish the day ahead staffing and any issue's. Weekly meetings with rostering colleagues and HR are held to highlight concerns. Monthly visits are completed by Care Group Leaders to get to know staff more personally. MIU are being included in CGB meetings and foundations are being set to collaborate the two workforces.
- Doctor Strikes (5 Days) - 25th – 29th July strike for junior doctors, caused some strain on the department planning due to late notice and availability of senior staff. Senior consultants adapted well to support the department with cover

Issues, Concerns & Gaps

- 4 Hour performance – Achieving 77.76% for July. July has experienced real struggles in performance, while it has not been identified that any one influence is currently responsible for the overall dip, an important factor to highlight is the 5 day doctor strike. The highest daily performance reached 82.59% with only four days exceeding the 80% target leaving unfortunately 27 days where 80% performance was not achieved.

- 12 Hour Breaches – Breach reasons remain a focus for ED, data shows the 3 main reasons being Initial Assessment, Delay until seen by ED and Speciality Delay Medical. Areas where the most breaches occur are Area 3, Area 2 and Majors.

- Initial Assessment – Despite an increase in initial assessments since Feb 25 there has been a gradual in the last 3 months July sitting at 53.4%.

- CDU Usage – Although July has seen an improvement in CDU numbers to 324 this unit is still underutilised and can see more patients through the area. ED Leadership team commenced a separated action plan specifically for the area(see imbedded attachment). This improvement plan is now being worked into the performance improvement plan to not duplicate work.

Actions & Improvements

- ED Care Group team have constructed an ED Performance Improvement plan that is currently broken down to 4 Hour Performance, Time to Treat, Non-Admitted Performance, CDU Usage and 12 Hour Breaches. A data driven plan which is Clinically and Operationally Led to drive sustainable, realistic and achievable changes and improvements in the department. Current actions are focused around night time performance and patient management. Starting actions sit with the Clinical Lead to deep dive Emergency Physician In Charge Allocations nightly and review productiveness in reviews, discharges and breaches to identify positive actions. This work is in conjunction with roster reviews. Meetings to be scheduled with BI partners for confirmation on data. Matron and Service Manager to complete work with their respective teams around the imperative duty of chasing at 3, 9 and 11 hours of patients being in the department. Conversations have been had with specialty General Managers about Sitrep attendance for support with escalations around plans for patients in the department. A copy of the full and current improvement plan is imbedded into the document.
- Increase in positive FFT with named individuals across both Acute and Emergency workforces – All feedback has been given to individuals, shared with management and celebrated at improvement huddles.
- Appraisal rate for AEM improved.
- 24 hour mental health triage service now live in UTC.
- Sickness rates in Medical teams are under Trust targets of 4%.
- Lister and Pembroke within budgets.
- Lister and Pembroke buzzer answer times reduction.
- Recruitment Drive – Medical, Nursing and Operational vacancies have been driven, moved and interviewed to fill gaps in establishments.

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Access			RTT Incompletes Performance %	60.0%	L	F	50.2%	51.4%	51.1%	50.9%	50.3%	50.6%	51.5%	53.0%	53.3%	53.8%	54.6%	53.7%
				RTT 65+ Week Waiters	0	L	F	539	358	277	180	192	249	181	80	86	111	101	80
				RTT 40+ Week Waiters	-	H		6,517	6,004	5,636	5,484	5,659	5,492	5,353	5,273	5,583	5,859	5,558	5,477
				RTT Waiting List Size	-			43,388	42,498	42,135	41,355	40,697	39,894	39,959	39,949	40,171	40,086	39,993	39,516
				RTT 52 Week Breaches	1,250	H	?	2,558	2,236	2,108	1,935	1,754	1,807	1,767	1,695	1,718	1,777	1,735	1,767
				OP Average Time to First Appointment (days)	60	H	F	109.04	117.62	111.18	116.53	107.58	118.15	121.03	120.62	115.75	117.64	119.51	122.42
				Outpatient DNA Rate %	5.0%	L	F	6.2%	6.2%	6.0%	5.5%	6.4%	5.5%	5.2%	5.7%	6.1%	6.0%	6.3%	5.9%
				OP First to Follow Up Ratio	-	L		1.64	1.74	1.72	1.66	1.76	1.77	1.76	1.69	1.79	1.77	1.72	1.75
				Operations Cancelled by Hospital on Day	13		?	18	11	12	15	8	17	10	4	5	4	14	10
				Urgent Operations Cancelled for 2nd Time	0	L	?	1	0	1	2	1	1	0	0	1	1	0	1
				Day Case Rate %	-	H		83.9%	86.5%	86.0%	87.5%	88.7%	86.2%	86.3%	88.0%	88.7%	88.1%	87.8%	87.1%
				Average Elective Length of Stay (days)	3		?	2.31	2.65	2.62	2.21	2.86	2.57	2.08	2.16	2.14	2.19	3.05	3.21
				Average Non-Elective Length of Stay (days)	10	H	P	6.11	6.16	6.46	6.61	6.30	6.43	6.60	6.43	6.36	6.47	6.01	6.49

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Access			104 Day Cancer Waits	-			14	12	16	21	9	18	11	17	17	12	20	
				Cancer USC Performance %	93.0%			72.7%	93.6%	96.2%	94.9%	94.0%	82.2%	82.4%	77.4%	77.7%	69.2%	87.5%	
				Cancer USC Performance - Breast Symptomatic %	93.0%			38.6%	84.6%	97.9%	95.2%	90.6%	56.0%	14.4%	25.6%	48.0%	25.6%	76.0%	
				Cancer 31 Day First Treatment Performance %	98.2%			96.2%	97.2%	93.5%	96.5%	100.0%	91.0%	100.0%	98.5%	98.4%	99.3%	97.5%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%			100.0%	100.0%	97.3%	90.0%	94.7%	85.2%	96.4%	87.5%	86.7%	100.0%	96.2%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%			100.0%	93.9%	97.4%	100.0%	100.0%	97.3%	100.0%	100.0%	84.4%	93.1%	91.2%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	67.2%	64.3%	58.1%	65.0%	63.7%	55.9%	62.9%	60.8%	65.6%	55.1%	49.7%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%			79.2%	87.2%	82.4%	79.4%	67.9%	77.6%	82.0%	85.5%	70.4%	72.5%	76.5%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%			66.7%	90.6%	28.6%	84.2%	70.0%	44.4%	69.6%	79.2%	64.7%	67.9%	71.4%	
				Cancer 28 Day Faster Diagnosis %	77.0%			76.4%	76.5%	76.1%	71.7%	70.5%	68.4%	69.4%	67.9%	59.9%	56.6%	66.5%	
				Cancer 28 Day Faster Diagnosis Screening %	-	L		45.5%	68.1%	65.3%	66.4%	50.5%	31.2%	49.0%	43.3%	37.9%	33.3%	41.8%	
				DM01 Performance %	73.1%	H		63.6%	68.4%	72.3%	78.4%	78.3%	82.5%	87.4%	91.1%	87.6%	85.7%	86.8%	86.0%
				Critical Care Admission Delays > 4Hrs	5.0%			0.9%	2.5%	7.8%	7.8%	6.8%	7.6%	9.4%	4.0%	1.1%	0.9%	3.2%	3.6%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Systems & Partnerships	Access			Critical Care Discharge Delays > 4Hrs	35.0%		?	45.8%	45.4%	64.7%	43.2%	57.1%	41.3%	46.5%	52.5%	54.3%	43.9%	45.8%	51.0%
	Emergency Care			Total EC 4 Hour Performance %	80.0%	H	?	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%	77.9%	79.4%	77.6%	76.3%
				Type 1 LOS > 12 Hours in EC %	6.0%		F	12.9%	12.4%	12.4%	13.3%	15.2%	15.9%	14.2%	13.2%	10.6%	10.6%	10.1%	11.5%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	85.9%	83.9%	85.0%	82.2%	79.2%	81.5%	82.9%	83.3%	83.8%	84.9%	82.7%	81.6%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H		17.1%	18.3%	20.6%	21.5%	17.6%	21.1%	20.0%	21.3%	18.5%	19.1%	19.1%	21.1%
				Type 1 EC 4 Hour Performance %	75.0%		F	67.6%	64.9%	67.8%	65.8%	58.3%	61.1%	64.7%	65.8%	67.0%	67.5%	67.1%	65.7%
				Total EC 12 Hour DTAs	0		F	576	644	693	771	771	756	706	688	412	533	454	614
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	312.83	331.38	322.36	347.27	339.45	338.03	315.84	302.27	274.29	297.46	286.62	270.10
				Number of ED Arrivals by Ambulance	-			2,820	2,887	3,020	3,051	3,248	3,210	2,722	3,021	2,977	3,022	2,947	3,120
				Ambulance Handover Delays (> 30 mins)	-			46	77	77	76	145	137	86	77	48	49	28	47
				Ambulance Handover Delays (> 60 mins)	0	L	?	1	5	2	6	10	8	1	0	3	1	0	2
				Bed Occupancy - NCTR % (G&A)	-	H		17.9%	18.2%	20.7%	19.7%	20.4%	21.5%	23.5%	22.6%	19.0%	19.9%	23.3%	22.9%
				30 Day Readmission Rate	13.0%	L	P	8.4%	7.4%	7.1%	7.4%	7.8%	7.4%	7.9%	8.1%	7.1%	8.2%	8.4%	7.7%

People

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

NHS Medway NHS Foundation Trust

Sheridan Flavin
Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	6	24	2	6	16	10
Workforce	7	7	3	8	2	3
Compliance	0	1	1	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	2	1	0	2	0	0

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

Committees:
People Committee

People

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

Workforce

National Staff Engagement Score

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

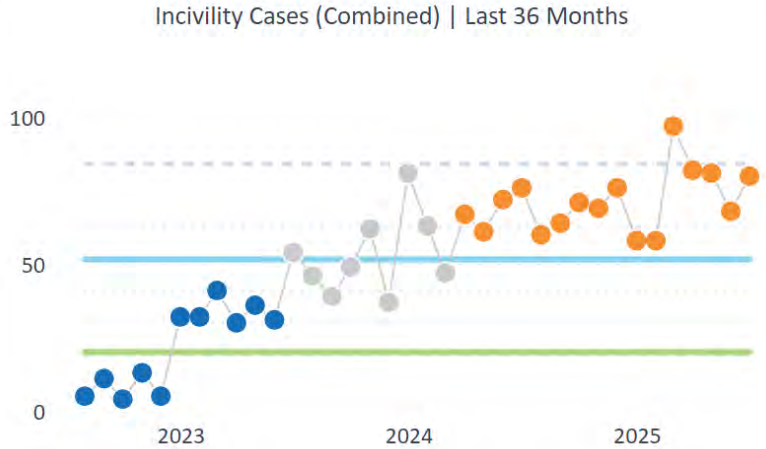
True North Domain: People

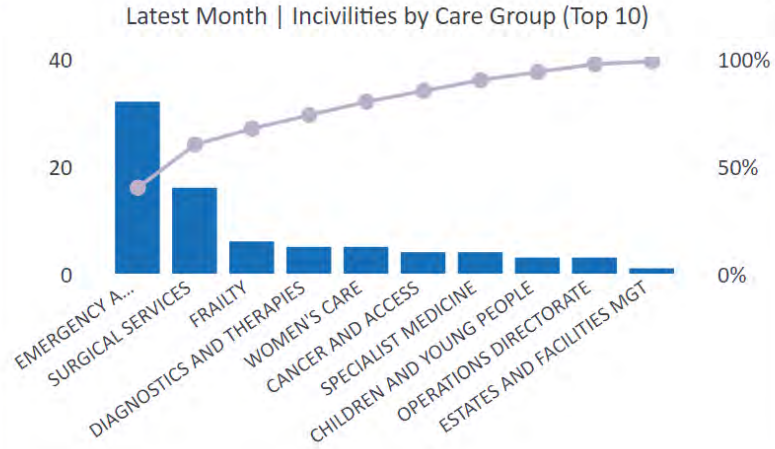
KPI Threshold: 6.93

Sub Domain KPIs: 17

Variation Summary:

7	2	1	5	2





Key Messages

The number of incivilities reported in July through Friends and Family Test (FFT) and Datix is 80 which is slight increase on 68 reported in June. Reported cases have steadily increased, reflecting greater awareness and confidence in reporting behaviours. This trend highlights the need for sustained action and reinforces the Trust's commitment to addressing incivility as a systemic issue impacting team cohesion, psychological safety, and overall organisational culture

Issues, Concerns & Gaps

- The level of incivilities being reported is a concern.
- High demand in the hospital is causing pressure on staff.
- Staff on staff rudeness, lack of courtesy to one another and taking time to communicate effectively with colleagues is a key area of incivility reported
- Incivility by reception staff to patients is also an area of concern.

Actions & Improvements

- Effective management of annual leave to ensure adequate staffing to relive pressure
- Customer services training for reception staff
- All incivilities reported are followed up and staff discussions are completed to provide feedback and implement improvements

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	Workforce			Incivility Cases (Combined)	20			Driver is red for 2 reporting periods	58	97	82	81	68	80
				Sickness Absence Rate - Total %	4.0%			Watch is red for 4 reporting periods	5.1%	4.5%	4.6%	4.5%	4.7%	4.8%
				Sickness Absence Rate - Long Term %	2.0%			Watch is red for 4 reporting periods	2.5%	2.4%	2.4%	2.5%	2.6%	2.5%
				Time to Hire - AfC	42			Watch is red for 4 reporting periods	63.80	54.90	64.40	55.05	56.50	49.10
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%			Watch is red for 4 reporting periods	78.3%	79.4%	78.4%	76.2%	75.1%	76.7%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%			Watch is red for 4 reporting periods	54.6%	54.2%	55.3%	56.0%	57.1%	53.9%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%			Watch is red for 4 reporting periods	82.2%	82.0%	82.9%	83.5%	83.6%	83.5%
				StatMan: Advanced Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	79.1%	83.4%	82.8%	83.3%	84.6%	83.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	82.1%	81.2%	80.9%	82.8%	80.9%	82.0%
				StatMan: Adult Immediate Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	77.9%	80.6%	78.0%	83.0%	81.2%	84.8%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	80.0%	80.3%	75.8%	80.6%	79.4%	81.5%
				StatMan: Mental Health Liaison Service Compliance %	85.0%			Watch is red for 4 reporting periods	83.6%	81.9%	81.5%	78.5%	76.5%	76.2%
				StatMan: New Born Life Support Compliance %	85.0%			Watch is red for 4 reporting periods	76.1%	74.6%	75.2%	78.4%	76.7%	77.2%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	StatMan			StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	78.6%	77.3%	77.2%	79.2%	77.0%	77.3%
	Compliance			DBS Compliance %	100.0%	H	F	Watch is red for 4 reporting periods	99.5%	99.7%	99.7%	99.7%	99.8%	99.9%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	Workforce			National Staff Engagement Score	6.93	H	Special cause of improving nature or lower pressure due to (H)igher values	6.74					
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,177.93	5,205.36	5,214.64	5,202.49	5,213.90	5,256.37
				Staff Leavers (FTE)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	43.72	58.67	43.88	37.61	40.16	46.47
				Vacancy Rate %	9.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.7%	6.2%	0.7%	4.4%	4.3%	4.1%
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.4%	8.3%	8.4%	8.2%	8.1%	7.9%
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	1.1%	0.6%	1.2%	1.2%	0.9%	0.8%
				Bank Spend %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.7%	6.6%	8.8%	8.2%	9.1%	9.8%
	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	90.0%	92.5%	91.6%	89.4%	88.9%	88.4%
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	43.5%	43.7%	44.1%	44.3%	44.6%	44.7%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	28.6%	28.6%	30.8%	33.3%	33.3%	33.3%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.1%	89.1%	89.9%	89.7%	89.5%	89.8%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.9%	94.8%	95.3%	95.6%	95.8%	96.0%
				StatMan: EDI Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	96.1%	96.0%	96.2%	96.3%	96.2%	96.3%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	StatMan			StatMan: Fire Safety Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	87.8%	86.7%	87.9%	88.6%	89.5%	87.9%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	96.7%	96.9%	97.1%	97.6%	97.6%	96.9%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.7%	95.8%	95.7%	96.9%	96.1%	95.4%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.8%	91.5%	92.0%	92.0%	92.0%	91.2%
				StatMan: Infection Prevention L2 Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.6%	89.9%	89.8%	90.5%	91.0%	90.3%
				StatMan: Information Governance Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.5%	91.7%	91.8%	91.8%	91.9%	91.7%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.7%	95.6%	96.0%	96.4%	96.2%	95.8%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	54.6%	54.2%	55.3%	56.0%	57.1%	53.9%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.4%	93.6%	94.3%	94.7%	94.5%	94.0%
				StatMan: Basic Prevent Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	97.1%	97.3%	97.7%	97.4%	97.4%	96.6%
				StatMan: Prevent WRAP Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.2%	91.6%	92.2%	93.4%	93.7%	93.8%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	94.4%	95.0%	95.8%	95.9%	96.3%	96.2%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	88.9%	89.9%	91.5%	93.1%	93.4%	94.0%

People

Key Messages

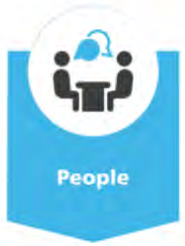
- KPI improvements can be seen in Vacancy rate, voluntary turnover, agency spend and bank spend, although the latter is only 0.2 percentage points below the Trust KPI
- Incivility cases reported in July have increased to 80, however whilst this is of concern, we also regard this as positive as it demonstrates that staff are feeling safe to raise their concerns.
- There are an increasing number of LTS cases that require employee relations support due to their complexity

Issues, Concerns & Gaps

- Sickness absence rate continues to be above the Trust target of 4%, with long term sickness at 2.5% that require employee relations support due to the complexity and length of absence.
- Moving and handling stat/mand training is below the Trust target with level 2 being of most concern at only 53.9% compliance, which has seen a continual decline since February 2025
- Appraisal rate has declined for the 4 month in a row, standing at 88.2% (2 of the months in this period were above the 90% Trust KPI level).

Actions & Improvements

- Managers and staff are being reminded to complete all relevant stat/mand training to ensure compliance.
- Appraisal training has been provided throughout July with 101 staff members attending the training and only 8 staff members did not attend.
- Managers are attending the mandated Management Essentials (ME) training and advanced ME training. Current compliance levels are; ME 44% (191 staff trained) and Advanced ME 38% (78 staff trained



People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	Workforce			National Staff Engagement Score	6.93	H	F	6.74	6.74	6.74	6.74	6.74	6.74	6.74					
				Incivility Cases (Combined)	20	H	?	60	64	71	69	76	58	58	97	82	81	68	80
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.6%	1.2%	1.1%	0.7%	0.8%	1.9%	1.0%	1.4%	1.2%	0.8%	0.9%	1.0%
				Staff Appraisal Rate %	90.0%	L	?	90.6%	89.9%	89.1%	89.0%	90.4%	90.4%	89.8%	89.6%	90.2%	90.2%	89.5%	88.2%
				Staff in Post (FTE)	-	H		5,091.91	5,066.18	5,115.91	5,128.44	5,145.30	5,152.71	5,177.93	5,205.36	5,214.64	5,202.49	5,213.90	5,256.37
				Staff Leavers (FTE)	-	L		145.58	67.67	70.68	49.26	39.32	48.84	43.72	58.67	43.88	37.61	40.16	46.47
				Staff Starters (FTE)	-	L		131.18	117.73	88.98	55.63	29.25	69.71	64.80	72.37	42.84	31.25	64.29	54.56
				Vacancy Rate %	9.0%	L	P	6.8%	7.3%	6.6%	6.5%	6.2%	7.1%	6.7%	6.2%	0.7%	4.4%	4.3%	4.1%
				Voluntary Turnover %	8.0%	L	F	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%	8.4%	8.2%	8.1%	7.9%
				Voluntary Turnover (ICS) %	-			1.4%	1.0%	0.9%	1.0%	0.7%	1.0%	0.7%	1.0%	0.8%	0.7%	0.8%	0.9%
				Sickness Absence Rate - Total %	4.0%		?	4.9%	5.3%	5.3%	5.3%	5.3%	5.6%	5.1%	4.5%	4.6%	4.5%	4.7%	4.8%
				Sickness Absence Rate - Short Term %	2.0%		?	1.8%	2.3%	2.5%	2.6%	2.7%	3.2%	2.6%	2.1%	2.2%	2.0%	2.0%	2.3%
				Sickness Absence Rate - Long Term %	2.0%		F	3.1%	2.9%	2.8%	2.6%	2.6%	2.4%	2.5%	2.4%	2.4%	2.5%	2.6%	2.5%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	Workforce			Time to Hire - AfC	42			55.90	56	60	58.30	45.40	55.60	63.80	54.90	64.40	55.05	56.50	49.10
				Time to Hire - Medical	70			86.50	51	78	69.90	60.90	61.70	65.90	58.10	56.90	68	76.70	85.40
				Agency Spend %	3.7%	L	P	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%	1.1%	0.6%	1.2%	1.2%	0.9%	0.8%
				Bank Spend %	10.0%	L		10.2%	10.5%	9.0%	8.2%	9.6%	9.9%	9.7%	6.6%	8.8%	8.2%	9.1%	9.8%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			87.2%	86.4%	86.3%	98.1%	85.2%	85.5%	87.4%	91.1%	91.3%	89.6%	87.6%	87.5%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		89.3%	90.3%	91.1%	94.9%	88.1%	88.6%	90.0%	92.5%	91.6%	89.4%	88.9%	88.4%
				Care Hours per Patient Day (CHPPD)	9.50			9.59	9.42	9.61	9.42	9.20	8.76	8.99	9.18	9.64	9.46	9.35	9.29
	Diversity			Diversity of Workforce %	-	H		42.2%	42.2%	42.7%	43.0%	43.3%	43.3%	43.5%	43.7%	44.1%	44.3%	44.6%	44.7%
				Diversity of Board %	-	H		25.0%	25.0%	30.8%	30.8%	30.8%	28.6%	28.6%	28.6%	30.8%	33.3%	33.3%	33.3%
	StatMan			StatMan Training Compliance %	85.0%	H	P	89.6%	89.0%	87.2%	87.5%	87.9%	88.9%	89.1%	89.1%	89.9%	89.7%	89.5%	89.8%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	95.4%	94.9%	95.0%	95.2%	95.1%	94.9%	94.9%	94.8%	95.3%	95.6%	95.8%	96.0%
				StatMan: EDI Compliance %	85.0%	H	P	96.2%	95.8%	96.1%	96.2%	96.2%	96.0%	96.1%	96.0%	96.2%	96.3%	96.2%	96.3%
				StatMan: Fire Safety Compliance %	85.0%	H		84.5%	83.8%	85.7%	86.5%	87.7%	88.0%	87.8%	86.7%	87.9%	88.6%	89.5%	87.9%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	96.0%	95.9%	96.0%	96.2%	96.5%	96.6%	96.7%	96.9%	97.1%	97.6%	97.6%	96.9%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	93.4%	94.2%	94.3%	94.2%	95.2%	94.8%	94.7%	95.8%	95.7%	96.9%	96.1%	95.4%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	91.6%	91.1%	92.4%	92.6%	92.7%	92.3%	91.8%	91.5%	92.0%	92.0%	92.0%	91.2%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	96.1%	95.6%	96.0%	96.1%	96.1%	96.4%	95.2%	95.6%	96.0%	95.4%	96.2%	95.0%
				StatMan: Infection Prevention L2 Compliance %	85.0%	H	P	89.5%	88.9%	89.1%	90.3%	90.3%	89.7%	89.6%	89.9%	89.8%	90.5%	91.0%	90.3%
				StatMan: Information Governance Compliance %	85.0%	H	P	90.8%	90.3%	90.7%	90.9%	91.9%	91.4%	91.5%	91.7%	91.8%	91.8%	91.9%	91.7%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	94.2%	94.3%	94.8%	95.1%	95.4%	95.6%	95.7%	95.6%	96.0%	96.4%	96.2%	95.8%
				StatMan: Moving and Handling L2 Compliance %	85.0%	L	F	79.7%	79.8%	80.7%	80.1%	79.4%	79.3%	78.3%	79.4%	78.4%	76.2%	75.1%	76.7%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%	54.6%	54.2%	55.3%	56.0%	57.1%	53.9%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	91.7%	90.7%	91.3%	92.0%	92.6%	93.3%	93.4%	93.6%	94.3%	94.7%	94.5%	94.0%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	95.8%	95.6%	96.1%	96.5%	96.7%	96.7%	97.1%	97.3%	97.7%	97.4%	97.4%	96.6%
				StatMan: Prevent WRAP Compliance %	85.0%	H	P	89.7%	89.1%	89.8%	90.2%	91.1%	90.5%	91.2%	91.6%	92.2%	93.4%	93.7%	93.8%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	StatMan			StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	95.7%	95.3%	95.8%	95.7%	95.7%	95.9%	94.4%	95.0%	95.8%	95.9%	96.3%	96.2%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	H	P	91.8%	90.2%	87.9%	88.5%	89.0%	88.1%	88.9%	89.9%	91.5%	93.1%	93.4%	94.0%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%	82.2%	82.0%	82.9%	83.5%	83.6%	83.5%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		P	96.3%	96.4%	96.5%	96.5%	94.6%	95.5%	95.0%	95.2%	95.6%	95.7%	96.5%	95.2%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%		P	87.2%	85.8%	86.1%	86.2%	85.3%	85.7%	86.3%	86.1%	86.9%	86.9%	87.3%	86.6%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	H	?	81.5%	80.7%	82.2%	84.2%	80.3%	81.7%	84.3%	85.4%	85.6%	85.5%	84.7%	85.6%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%	79.1%	83.4%	82.8%	83.3%	84.6%	83.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%	82.1%	81.2%	80.9%	82.8%	80.9%	82.0%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	80.0%	78.6%	78.3%	76.7%	77.6%	78.1%	77.9%	80.6%	78.0%	83.0%	81.2%	84.8%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	91.7%	91.8%	92.1%	93.2%	93.1%	93.5%	94.1%	94.3%	94.6%	94.9%	94.7%	94.0%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	80.6%	83.0%	76.3%	77.3%	79.7%	82.2%	80.0%	80.3%	75.8%	80.6%	79.4%	81.5%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	L	F	81.1%	80.6%	81.2%	84.2%	82.1%	83.8%	83.6%	81.9%	81.5%	78.5%	76.5%	76.2%
				StatMan: New Born Life Support Compliance %	85.0%		F	78.7%	75.9%	79.5%	83.3%	82.5%	79.2%	76.1%	74.6%	75.2%	78.4%	76.7%	77.2%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
People	StatMan			StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	77.9%	77.5%	75.9%	77.5%	78.5%	78.2%	78.6%	77.3%	77.2%	79.2%	77.0%	77.3%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	80.8%	77.7%	78.4%	81.4%	79.1%	77.2%	77.6%	84.1%	86.7%	86.7%	84.1%	83.5%
	Compliance			Professional Registration Compliance %	100.0%	L	?	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%
				DBS Compliance %	100.0%	H	F	99.4%	99.5%	99.0%	98.9%	99.5%	99.3%	99.5%	99.7%	99.7%	99.7%	99.8%	99.9%

Sustainability

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

Simon Wombwell
Chief Finance Officer

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

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

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

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

Financial Position

(Surplus) / Deficit (£)

Type	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
	£0.00m			-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m	-4.24m	3.48m	-0.59m	-1.74m	-1.86m	-2.96m

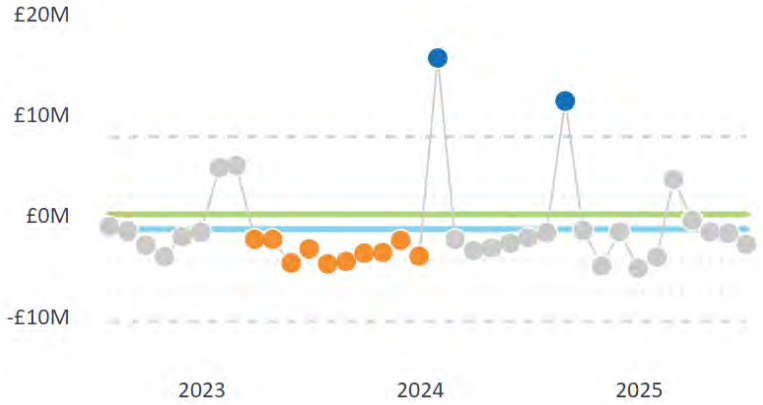
True North Domain: **Sustainability**

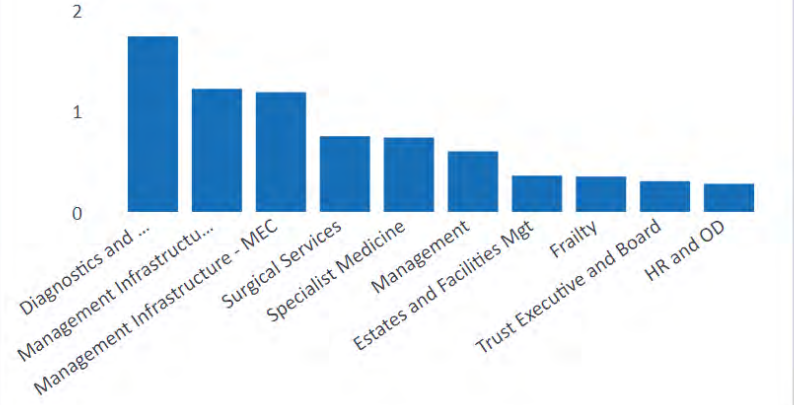
KPI Threshold: £0.00m

Sub Domain KPIs: 16

Variation Summary:

12	0	2	2	0





Key Messages

The Trust reports a YTD deficit at month 4 (July 2025) of £7.9m; this is adverse to plan by £1.9m. The key drivers causing us to move away from Plan are:

1. Our savings plans remain below target
2. We have experienced some unexpected pressures on our spending linked to (a) industrial action by Resident Doctors and (b) the breakdown of the Combined Heat and Power (CHP) plant.

We continue to report Income largely to Plan, however, we have held CDC income at last months level because activity is significantly below Plan.

Issues, Concerns & Gaps

Key risks to delivering the financial plan include:

1. Delivery of the efficiencies programme
2. CDC activity underperformance
3. ENT backlog works required (and funding source)
4. Outcome of the Brockenhurst VAT claim at the Supreme Court
5. Uncertainty and impact from potential organisation form/structure

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

Actions & Improvements

Our efficiencies programme YTD is meeting less than 30% of the target (£1.7m vs £6.2m target). Supported by PA Consulting, we need to see accelerated and increased reductions in our cost base.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Sustainability	Financial Position			Actual Worked FTE	5,155			Driver is red for 2 reporting periods	5,618.26	5,705.64	5,576.22	5,533.26	5,616.48	5,697.79
				Breakeven Revenue Budget (£)	£0.00m			Watch is red for 4 reporting periods	-4.62m	1.37m	-2.03m	-1.40m	-1.95m	-3.62m
				Total Pay Spend (£) vs Budget	£0.00m			Driver is red for 2 reporting periods	1.68m	19.85m	0.24m	-0.16m	0.88m	1.01m
				Actual Worked FTE vs Budget	0			Driver is red for 2 reporting periods	60.59	157.89	329.36	93.18	171.36	216.61

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Sustainability	Financial Position			Total Temporary Staffing Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**3.01m**	**3.31m**	**2.97m**	**2.72m**	**2.89m**	**3.20m**
				Agency Spend (£)	-		Special cause of improving nature or lower pressure due to (L)ower values	**0.31m**	**0.30m**	**0.37m**	**0.36m**	**0.26m**	**0.25m**

Sustainability

Key Messages

The Trust reports a YTD deficit at month 4 (July 2025) of £7.9m; this is adverse to plan by £1.9m. The key drivers causing us to move away from Plan are:

1. Our savings plans remain below target
2. We have experienced some unexpected pressures on our spending linked to (a) industrial action by Resident Doctors and (b) the breakdown of the Combined Heat and Power (CHP) plant.

We continue to report Income largely to Plan, however, we have held CDC income at last months level because activity is significantly below Plan.

Issues, Concerns & Gaps

Key risks to delivering the financial plan include:

1. Delivery of the efficiencies programme
2. CDC activity underperformance
3. ENT backlog works required (and funding source)
4. Outcome of the Brockenhurst VAT claim at the Supreme Court
5. Uncertainty and impact from potential organisation form/structure

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

Actions & Improvements

Our efficiencies programme YTD is meeting less than 30% of the target (£1.7m vs £6.2m target). Supported by PA Consulting, we need to see accelerated and increased reductions in our cost base.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Sustainability	Financial Position			(Surplus) / Deficit (£)	£0.00m			-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m	-4.24m	3.48m	-0.59m	-1.74m	-1.86m	-2.96m
				Total Pay Spend (£)	-			26.22m	26.23m	32.75m	30.64m	27.20m	27.72m	27.70m	46.04m	29.66m	28.94m	29.00m	30.08m
				Actual Worked FTE	5,155			5,480.86	5,528.07	5,579.90	5,505.10	5,556.27	5,552.05	5,618.26	5,705.64	5,576.22	5,533.26	5,616.48	5,697.79
				Breakeven Revenue Budget (£)	£0.00m			0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m	-4.62m	1.37m	-2.03m	-1.40m	-1.95m	-3.62m
				Total Pay Spend (£) vs Budget	£0.00m			2.64m	1.29m	0.43m	3.81m	0.74m	1.68m	1.68m	19.85m	0.24m	-0.16m	0.88m	1.01m
				Actual Worked FTE vs Budget	0			5.09	50.05	81.09	4.96	52.83	-1.98	60.59	157.89	329.36	93.18	171.36	216.61
				Total Temporary Staffing Spend (£)	-			3.16m	3.34m	3.46m	2.93m	2.94m	3.02m	3.01m	3.31m	2.97m	2.72m	2.89m	3.20m
				Total Temporary Staffing Worked FTE	-			618.47	655.16	655.05	565.62	582.46	584.79	610.15	687.55	557.06	508.99	589.93	622.10
				Bank Spend (£)	-			2.66m	2.77m	2.95m	2.51m	2.62m	2.76m	2.70m	3.02m	2.60m	2.36m	2.63m	2.95m
				Actual Worked FTE - Bank	-			572.35	593.69	612.30	519.35	542.36	551.78	572.88	631.57	511.55	457.14	541.27	576.02
				Agency Spend (£)	-			0.50m	0.57m	0.50m	0.42m	0.32m	0.26m	0.31m	0.30m	0.37m	0.36m	0.26m	0.25m
				Actual Worked FTE - Agency	-			46.12	61.47	42.75	46.27	40.10	33.01	37.27	55.98	45.51	51.85	48.66	46.08
				Income (£)	-			38.21m	52.45m	47.61m	41.37m	41.38m	39.35m	38.33m	63.01m	45.65m	43.61m	43.32m	44.20m
				Income (£) vs Budget	£0.00m			1.27m	1.40m	0.86m	-0.28m	0.18m	-1.73m	-1.55m	22.13m	-0.21m	-0.50m	0.44m	-0.65m

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Sustainability	Financial Position			Total Non-Pay Spend (£)	-			11.91m	12.47m	14.29m	13.91m	15.04m	14.21m	12.64m	14.35m	14.23m	14.35m	13.79m	15.05m
				Total Non-Pay Spend (£) vs Budget	£0.00m			-1.06m	1.22m	2.19m	1.45m	2.60m	1.46m	1.19m	1.96m	-0.40m	-0.64m	-0.56m	0.31m

Maternity (and perinatal) Incentive Scheme – Year 7 Update Report July 2025

MNSCAG 4 August 2025
Trust Board July 2025

Executive Summary

- CNST Year 7 Published 2 April 2025 with reporting period ending 30 November and submission due 3 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.

CNST Year 7 Self-Assessment

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

Medway NHS Foundation Trust

Completed
At Risk
Off Track with actions to deliver
On Track

True North: Quality

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

Eligible for CNST standards	Working days to notify (average)		Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report published	External member present
31	0.83	Not Met	0	0	0	2	0	0
		Met	31	29	29	26	14	20
		Not Yet Met		2	2	1	15	9
		N/A				2	2	2
		Compliance Current	100%	94%	94%	90%	48%	69%
		Compliance Trajectory	100%	100%	100%	93%	100%	100%
		Target	100%	95%	95%	95%	75%	50%

Key Messages:

- On track to meet all standards required for CNST Year 7.
- All perinatal losses and actions are shared monthly with Maternity and Board level Safety Champions via MNSCAG.
- Quarterly reports to be discussed with Maternity Safety and Board level Safety champions in January 2025, June 2025, August 2025, October 2025, February 2026.
- Quarterly reports submitted to Trust Board in March, July, September and November 2025 and March 2026 with details of all losses and action plans included.

Issues, Concerns, Gaps:

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

Actions and Improvements:

- All Maternity Bereavement staff now trained on how to input and commence reviews on PMRT.
- All key dates for PMRT deadlines now alert to all members of bereavement team for failsafe in case of annual leave or sickness.
- MNVP to support sourcing new service user representation at PMRT Meetings.
- Options appraisal currently with ICB to support additional resource to allow MNVP to attend PMRT and other required governance meetings.
- Ward level Safety Champion (Matron) to join PMRT meetings for fresh eyes review.

True North: Quality

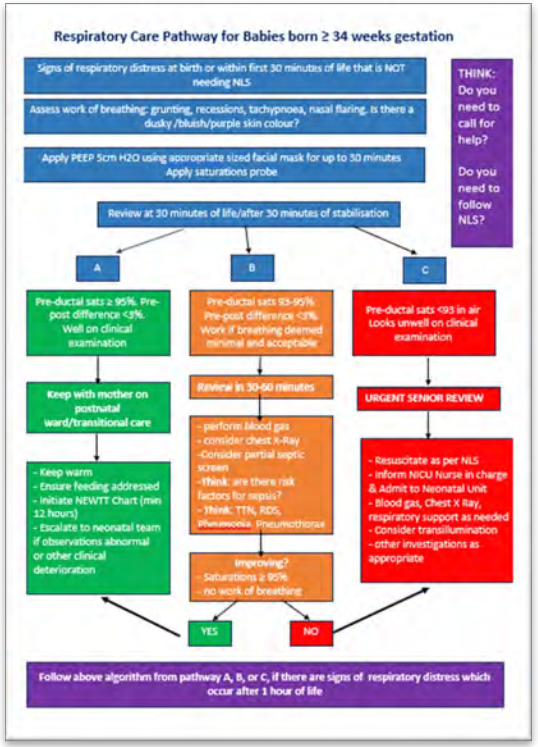
Safety Action 3 - ATAIN Q1 2025/26 Year 7 – On track

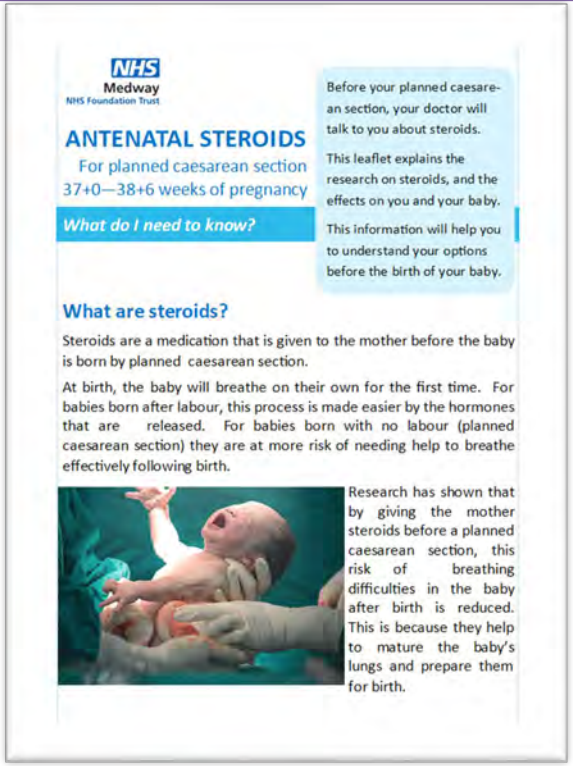
Ambition: Preventing avoidable admissions to the Neonatal Unit by supporting mothers and babies on the Transitional Care Pathway.

Goal: Ensure robust review of all Term Admissions to identify opportunities for learning and preventing avoidable admissions.

Key Messages: Q1 Year 7

- New respiratory pathway has been fully implemented for all babies born after 34 weeks gestation
- NICU auditing of RDS admissions show a reduction in the number of days babies are requiring respiratory support and total days of admission to NICU
- The FWB Midwives have implemented the new patient leaflet for Antenatal Steroids prior to planned CS at 37-39 weeks gestation
- The FWB Midwives have presented at Obstetric Audit meeting, trainee doctors teaching and midwifery essential skills regarding the introduction of the leaflet
- The leaflet is now available on Q-Pulse and as a paper copy in each antenatal care area in the trust




NHS Medway NHS Foundation Trust

ANTENATAL STEROIDS

For planned caesarean section 37+0—38+6 weeks of pregnancy

What do I need to know?

Before your planned caesarean section, your doctor will talk to you about steroids.

This leaflet explains the research on steroids, and the effects on you and your baby.

This information will help you to understand your options before the birth of your baby.

What are steroids?

Steroids are a medication that is given to the mother before the baby is born by planned caesarean section.

At birth, the baby will breathe on their own for the first time. For babies born after labour, this process is made easier by the hormones that are released. For babies born with no labour (planned caesarean section) they are at more risk of needing help to breathe effectively following birth.

Research has shown that by giving the mother steroids before a planned caesarean section, this risk of breathing difficulties in the baby after birth is reduced. This is because they help to mature the baby's lungs and prepare them for birth.

Issues, Concerns & Gaps:

- The overall admissions for RDS following planned CS has not changed
- There was a 2 month delay in the release of the leaflet, therefore audit information is not currently available to analyse

Actions & Improvements:

- ATAIN action plan ongoing and collating evidence continues
- Staff training is continuing across the obstetric and maternity teams
- FWB and NN team are continuing to collect data on all term admissions for RDS following planned CS, with uptake of antenatal steroids
- ATAIN specialist midwife now in post to continue ongoing and new QI projects

True North: People

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

NHS Medway NHS Foundation Trust

Key Messages:

- Data gathering and audit underway for compliance with RCOG guidance for short and long-term locum. Plan to audit February to July 2025. Anticipate continued compliance.
- Audit of Consultant attendance against the RCOG must/should attendance guidance planned for the summer, to be shared at:
  - Women's Audit
  - Labour Ward Forum
- The position against RCOG Must/Should attend guidance has also been shared with:
  - Trust Board via CNST reports – September 2025
  - LMNS CNST Peer Assurance Group – October 2025
- NICU nursing vacancy reduced to 1.0 WTE Band 6.
- NICU QIS 67.7% anticipated compliance (70%) by September 2025.
- Ongoing compliance with anaesthetist on-call with dedicated obstetric on-call rota.
- Ongoing compliance with BAPM requirements for neonatal medical staffing, will formally present to Trust Board in September/November for Minuting.

Issues, Concerns & Gaps:

- NICU nursing staffing not meeting BAPM QIS standards.

Actions & Improvements

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

True North: People

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

Medway NHS Foundation Trust

Key Messages:

- Midwifery staffing oversight reports have been shared with the Trust Board Bi-Annual on an ongoing basis, with reports being shared in January 2025 and July 2025, with a further report planned for January 2026.
- CNST Year 7 continues the requirement that:
  - In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
  - Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

Issues, Concerns & Gaps:

- Removal of funded posts from Midwifery budget based on vacancy rate of Month 8 has resulted in the funded establishment no longer meeting the recommendations of the BirthRate+ report from 2023 or the table top exercise completed by the Maternity team in 2024. This has been added to the Women's risk register:

- **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.

Actions & Improvements

- 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.

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

Medway NHS Foundation Trust

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

Saving Babies Lives Care Bundle v. 3.2 – On track

Key Messages:

- Q4 25/26 awaiting LMNS validation. Review and Quality Improvement meeting to be held in August.
- 3 quarterly QI meetings to be held within CNST Year 7 period to meet requirements.
- Working with leads to develop audits to review outcomes alongside interventions.
- SBL 3.2 launched April 2025 to be utilised for Q1 2025/26 submission.

Issues, Concerns & Gaps

- Quit date targets for element 1 remain challenging across the LMNS and remains partially complaint for MFT.
- Funding and resource for Hybrid Closed Loop has been commissioned nationally but as yet unable to understand where funding is sitting and how to access it to begin implementation of HCL as per element 6. Currently non-compliant with this requirement of 3.2

Actions & Improvements:

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

True North: Patients

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

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

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

Key Messages:

- The MNVP lead is a key member of the maternity and neonatal services, seeking and supporting service users to contribute their views to drive service improvements, co-producing pathways, action plans, guidelines, and improvement projects. The ICB has not renewed the fixed term contract of the MFT MNVP lead due to restrictions in place as a result of Change 25.
- Without the appropriate resource for the current MNVP provision MFT is at risk of failing CNST Year 7, and without the ongoing and adequate resourcing of the role to the requirements outlined in CNST, MFT will also be at risk of failing CNST Year 8.

Issues, Concerns, Gaps:

- Due to a clerical error, the MNVP lead at MFT is on a fixed term contract with the ICB, due to expire 30/9/25. 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.

Actions & Improvements:

- 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.

True North: People

NHS Medway NHS Foundation Trust

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

Key Messages:

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

Issues, Concerns, Gaps:

- Anaesthetic staff now mapped. All must attend to maintain compliance.

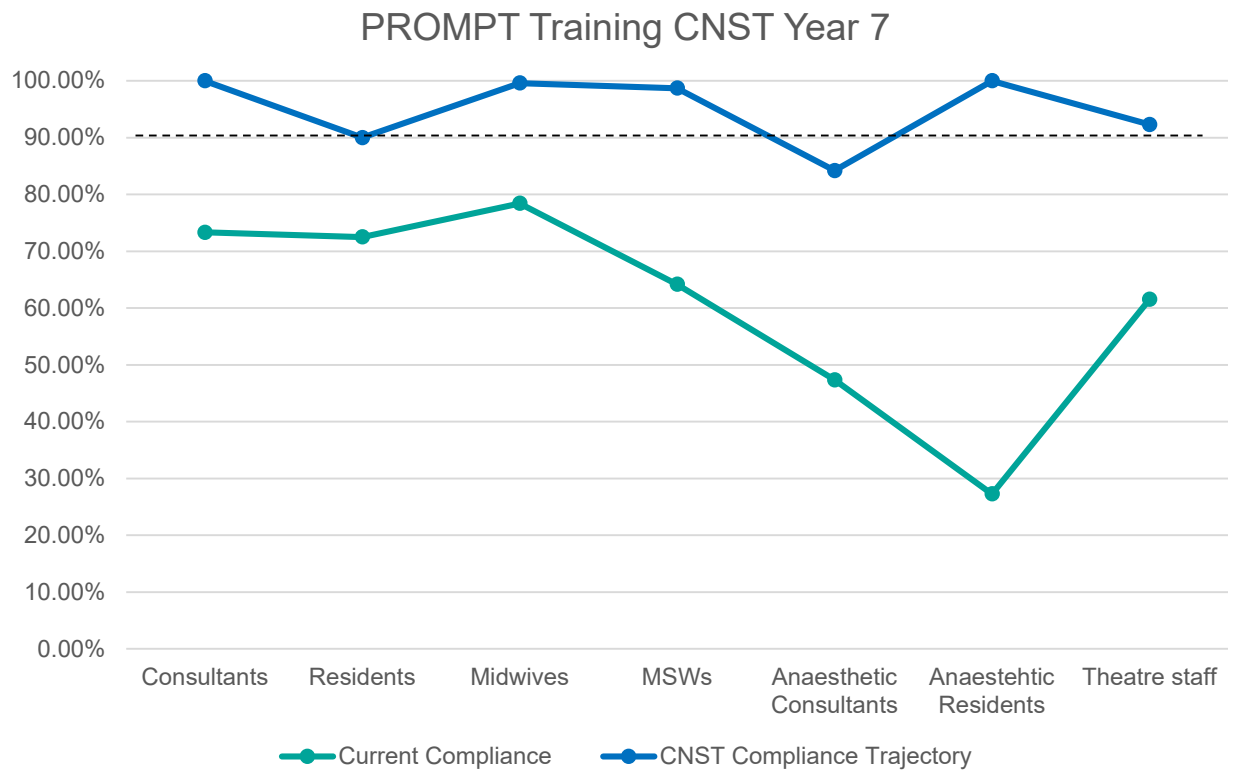
Actions & Improvements:

- Managerial oversight of all training spreadsheets and trajectories to reduce risk of cancellations impacting compliance close to submission.
- Continue to work with service managers to ensure all staff are allocated to training and appropriate study leave/cover is arranged for medical staff.
- Neonatal team to have ensured advanced NLS course training dates are accessible centrally.
- Work with anaesthetic lead and service manager to ensure all eligible anaesthetic staff are booked in ahead of deadline.
- All rotating resident doctors to be booked onto Fetal monitoring and PROMPT training in October and November 2025.
- Neonatal Resident doctors to rotate in September. 13 new starters will complete NBLS during induction and will present NLS training certificate on starting and database will be updated.

True North: People

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

Staff Group	Current Compliance	CNST Compliance Trajectory
Consultants	73.33%	100.00%
Residents	72.50%	90.00%
Midwives	78.42%	99.60%
MSWs	64.18%	98.70%
Anaesthetic Consultants	47.37%	84.21%
Anaestehtic Residents	27.27%	100.00%
Theatre staff	61.54%	92.31%



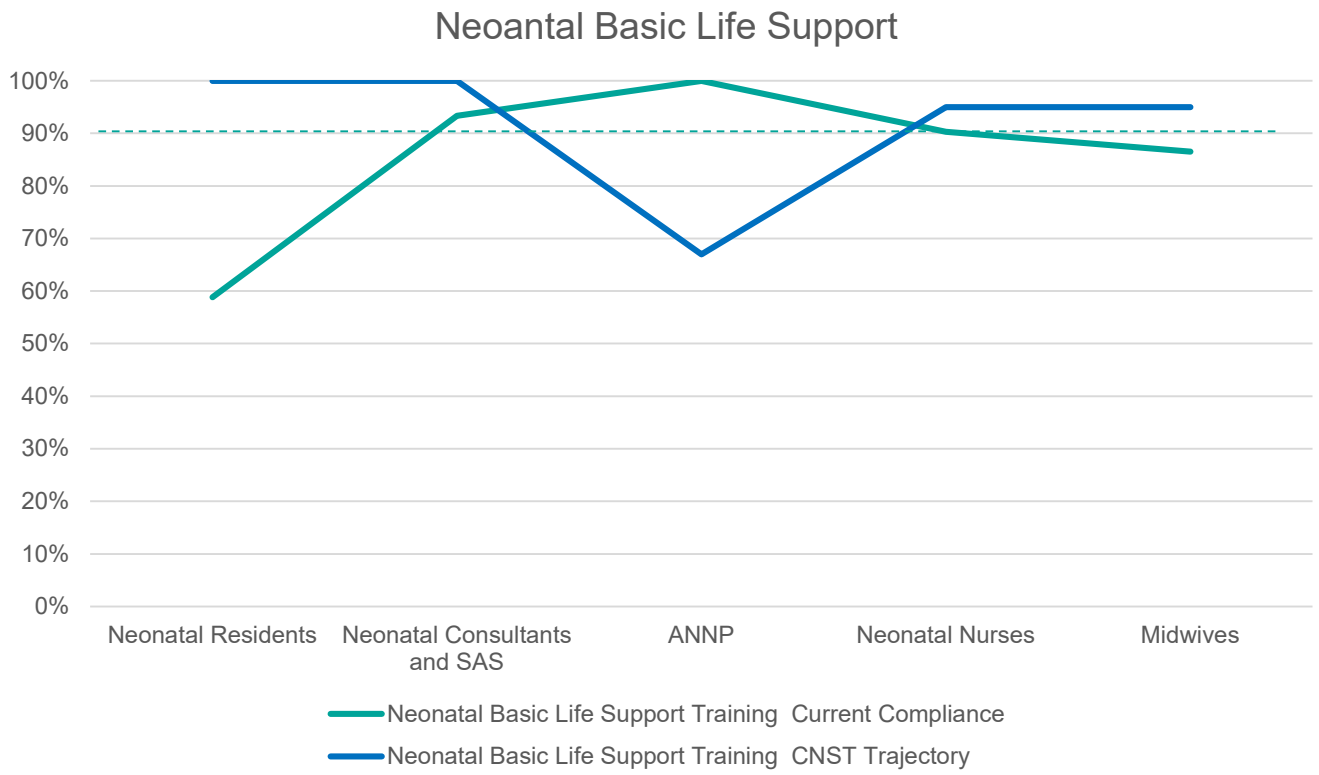
Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	**100.00%**	**100.00%**	**95.19%**
CNST Trajectory	**100.00%**	**100.00%**	**97.62%**

True North: People

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

Neonatal Basic Life Support Training		
Staff Group	Current Compliance – May 2025	CNST Trajectory
Neonatal Residents	59%	100%
Neonatal Consultants and SAS	92.86%	100%
ANNP	100%	67%
Neonatal Nurses	90.32%	95%
Midwives	87%	95%
MSWS	80%	90%

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



Actions and Next Steps

- Onwards reporting to Trust Board in September 2025
- Continue with monthly monitoring and reporting to MNSCAG and updates on IQPR slides.
- Continue to monitor training monthly and escalate any dips in compliance appropriately.
- Complete all required audits ahead of reporting schedule.
- Work with anaesthetic team to ensure all eligible anaesthetic staff are booked onto appropriate course.
- Escalate Midwifery workforce and MNVP resourcing to Trust Board.
- Continue to engage with LMNS peer assurance group to ensure all LMNS reporting is undertaken within the required timescale.
- Continue update report to each Trust Board to ensure all key elements are presented to Trust Board in line with the reporting schedule.

Perinatal Quality Surveillance and Leadership Quarterly Report Q1 25/26

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

MNSCAG –August 2025
Trust Board – September 2025

Executive Summary

- CNST Year 7 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality 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 25/26and includes the following:
  - Incidents
  - Investigations
  - PMRT
  - Complaints
  - Claims Scorecard
  - Staff and Service User Feedback
  - Perinatal Leadership
  - Safeguarding

Perinatal Quality:

Incidents

PSIRF/Investigations

PMRT

Complaints

Claims

True North: Quality

Perinatal Surveillance Tool: Quarterly Report - Q1 25/26
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

- Increase in number of incidents reported in maternity in Q1 – with 448 –increased from 399 in Q4.
- > 99% of incidents reported are no or low harm.
- 4 incidents reported as Moderate Harm or above
    - Complications following forceps delivery – readmitted 9 days postnatally with fistula. – CRIG review
    - PPH 1.7L, ARDS and Type 1 respiratory failure following TOP requiring ITU admission. – CRIG Review
    - 2 incidents relating to instrumental delivery, including consent for procedure, 3b tear and brachial plexus injury for baby – AAR.
- 83 (↑) (68 in Q4) Incidents related to a Post-partum haemorrhage over 1000mls/
- 25 (↑) (23 in Q4) related to term babies admitted to the neonatal unit.
- 15 (↓) (17 in Q4) related to 3rd or 4th degree tears.

Issues, concerns, gaps:

- Management of fluid and blood products during PPH.
- Appropriate process for consenting patients.
- PPH and 3rd and 4th degree tear rates.

Actions & Improvements:

- MDT case review identified administration of multiple blood products and fluids, combined with elevated lactate levels in the case where patient required ITU admission. Targeted interventions being implemented including increasing awareness of high-risk patients and Obstetric Emergency Simulation Training for Obstetric anaesthetists.
- MDT AAR to review cased including timing of consent.
- Ongoing work on PPH management and 3rd and 4th degree tears – overall improvement in rates noted as training becomes embedded into practice.

True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q 25/26

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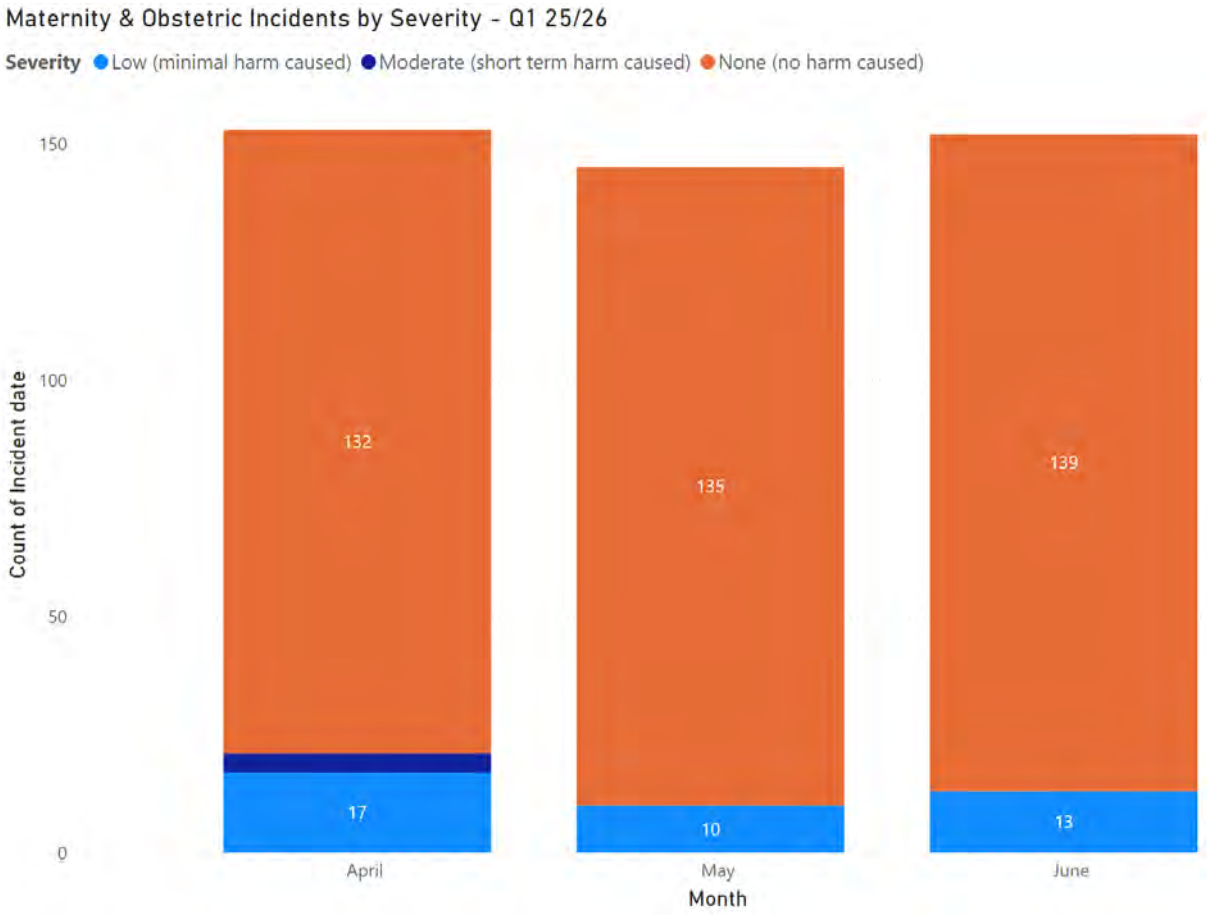
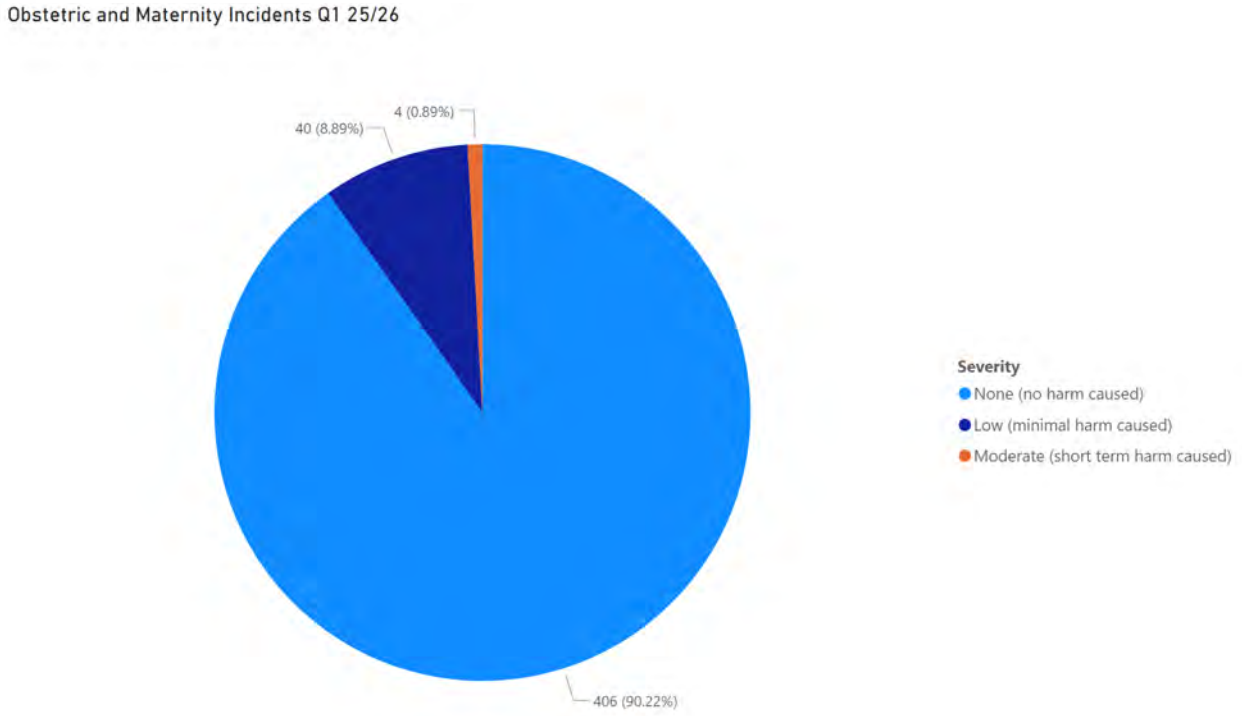
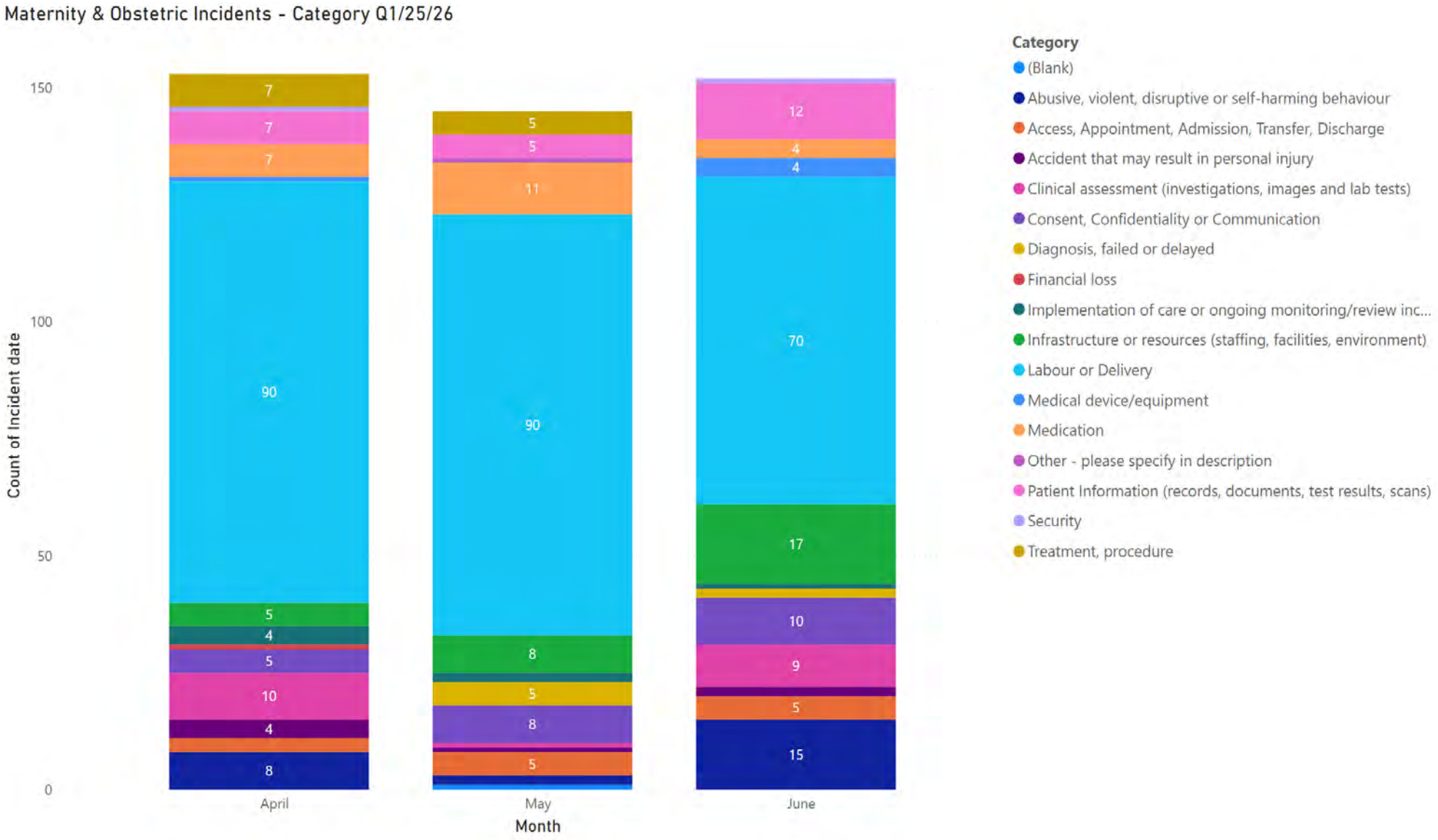




True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q1 25/26



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

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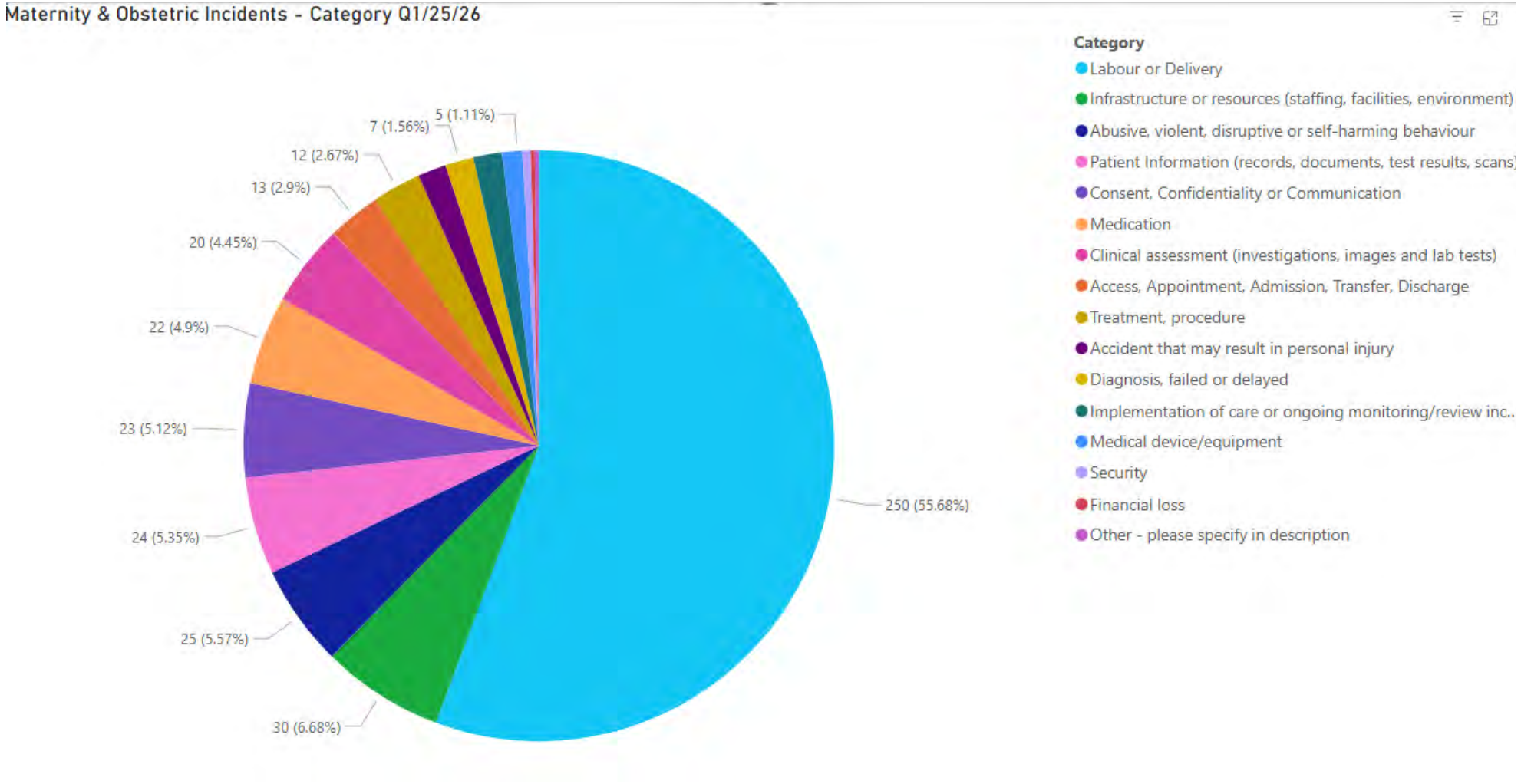
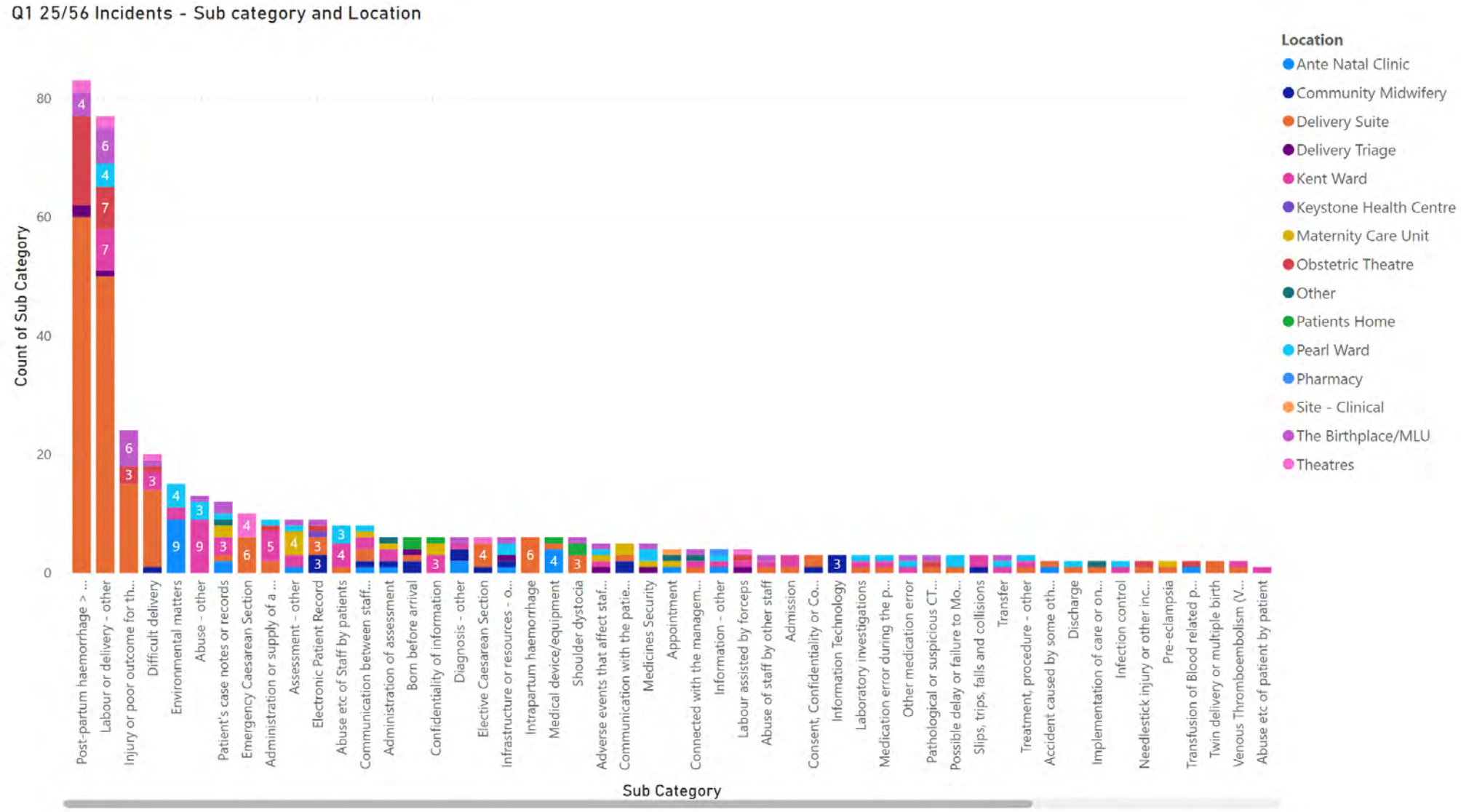


True North: Quality - Perinatal Surveillance Tool: Quarterly Report - Q1 25/26

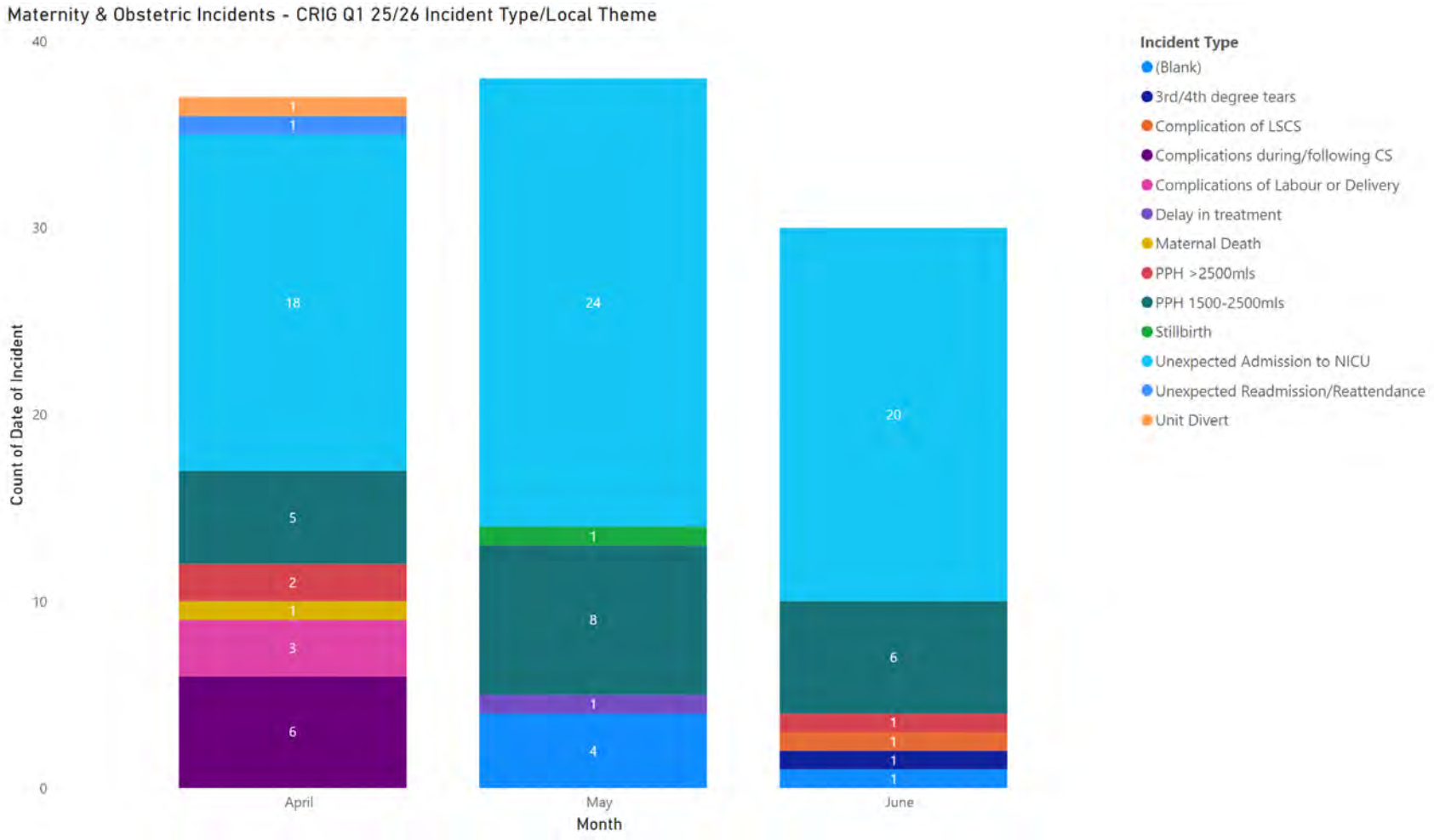


True North: Quality – Q1 PSIRF

Medway NHS Foundation Trust

Key Messages :

- 2 AARs declared in Q1 25/26
- 2 MNSI referrals
- 87/399 (3.5%) incidents in Q4 required review at CRIG.
- PMRT reviews not included in chart as reviewed outside of CRIG.



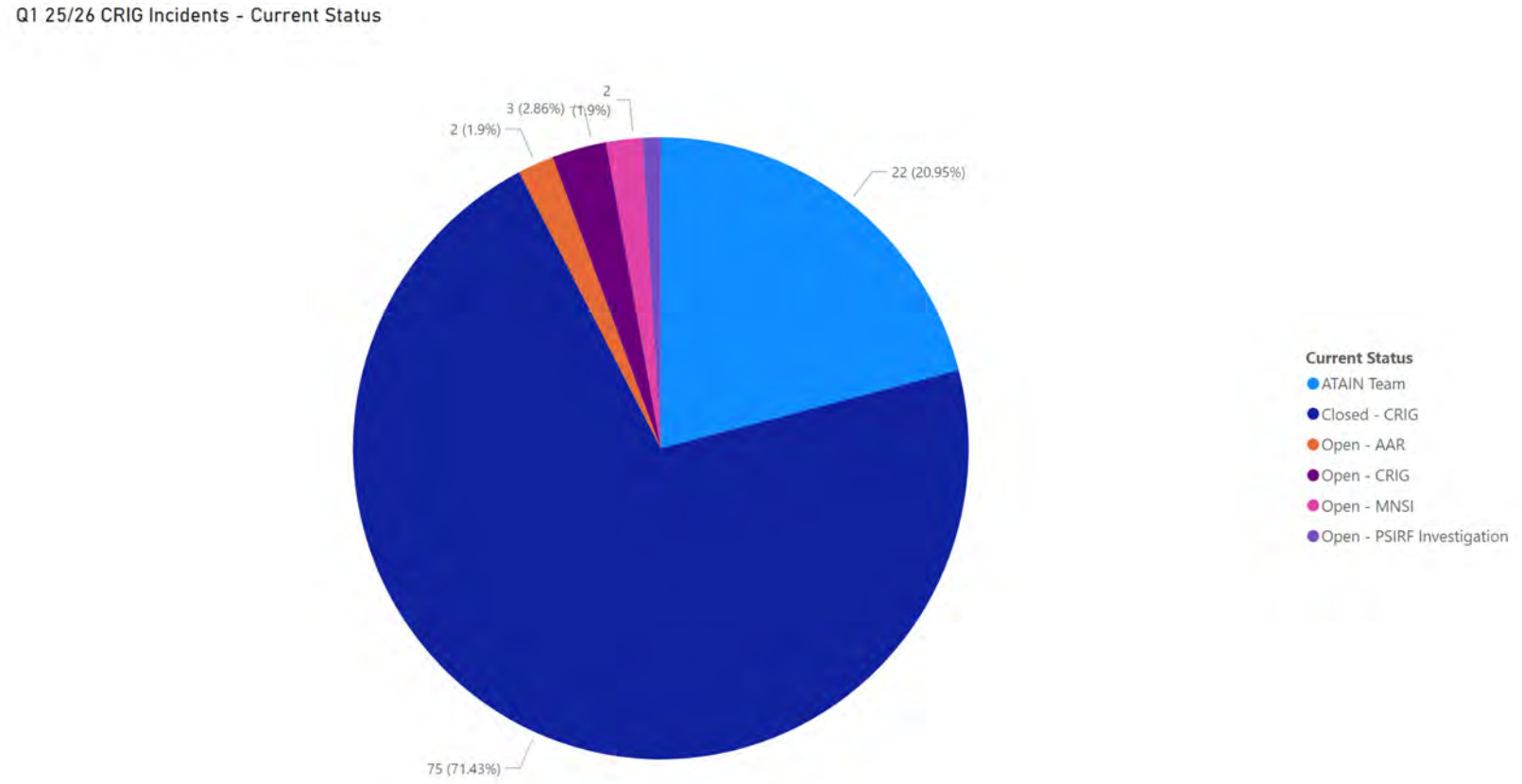
True North: Quality – Q1 PSIRF

Key Messages :

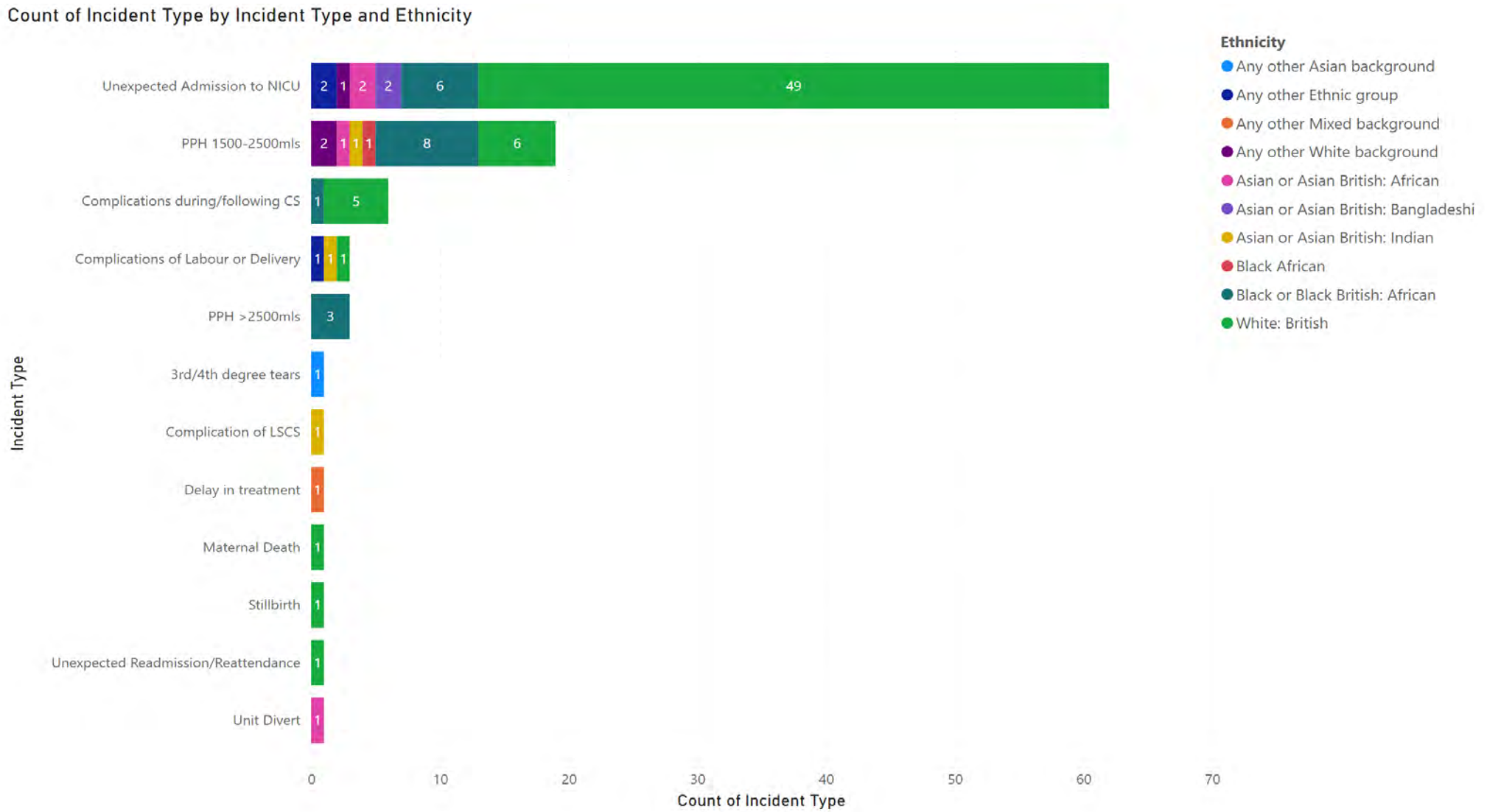
- 2 MNSI referrals in Q1:
  - Antenatal Maternal Death and Stillbirth following major APH.
  - HIE grade I – cooled as part of Comet Trial
- 2 AAR
  - Readmission day 9 postnatal with fistula
  - Complications following forceps delivery including 3b tear, process of consent and BPI injury to baby.
- 1 PSIRF investigation
  - PPH, SB, NND 23 weeks.

Actions & Improvements :

- Reviewed and standardised perimortem section packs and obstetric emergency grab bags to ensure all essential equipment present for emergency use and staff awareness.
- Review and updated Obstetric Emergency escalation call list.
- Complete AAR and develop any SMART action plans as required.
- Review parent information provided for babies included in the Comet trial.



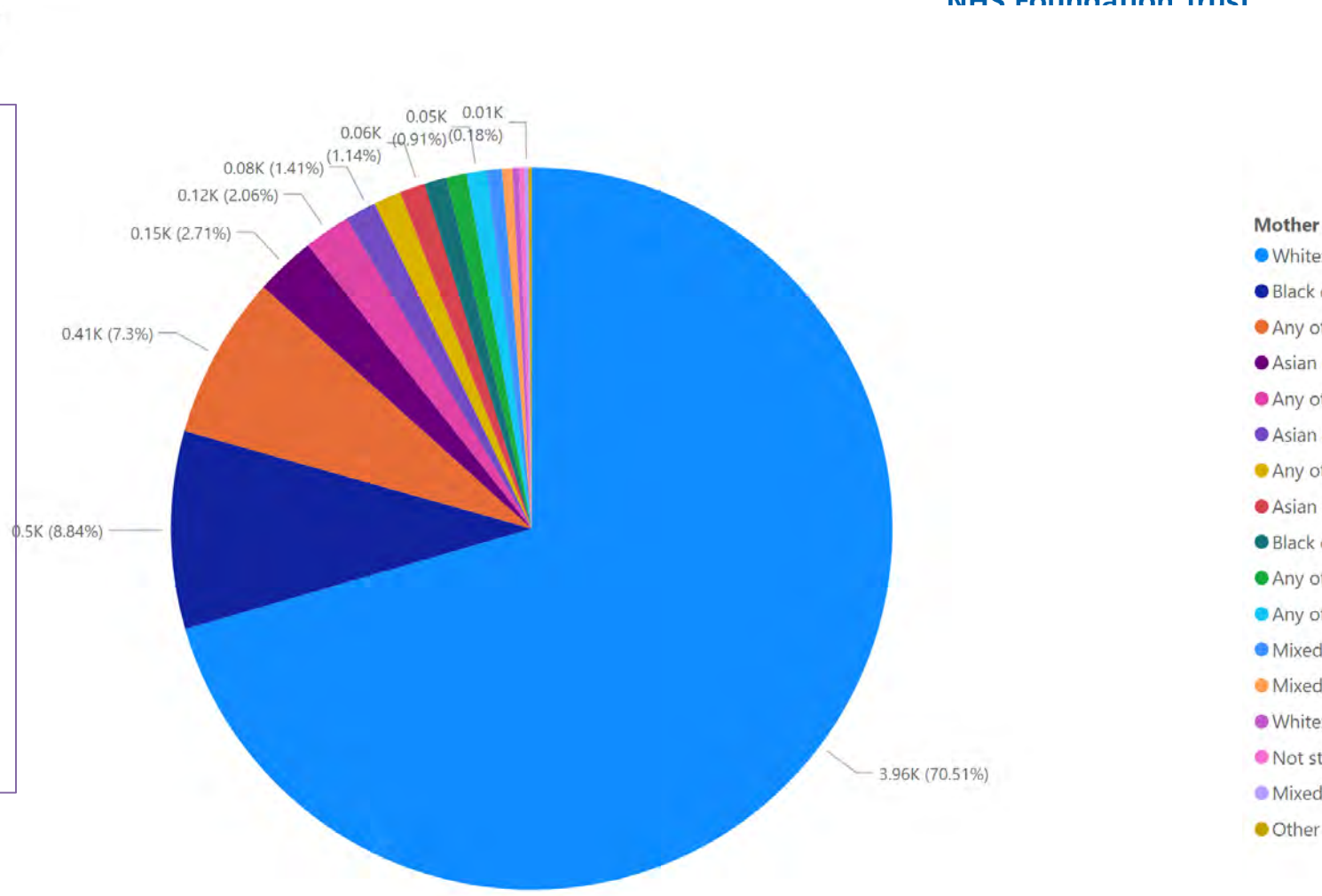
True North: Quality – Q1 PSIRF – Ethnicity Review



True North: Quality – Q1 PSIRF – Ethnicity Review

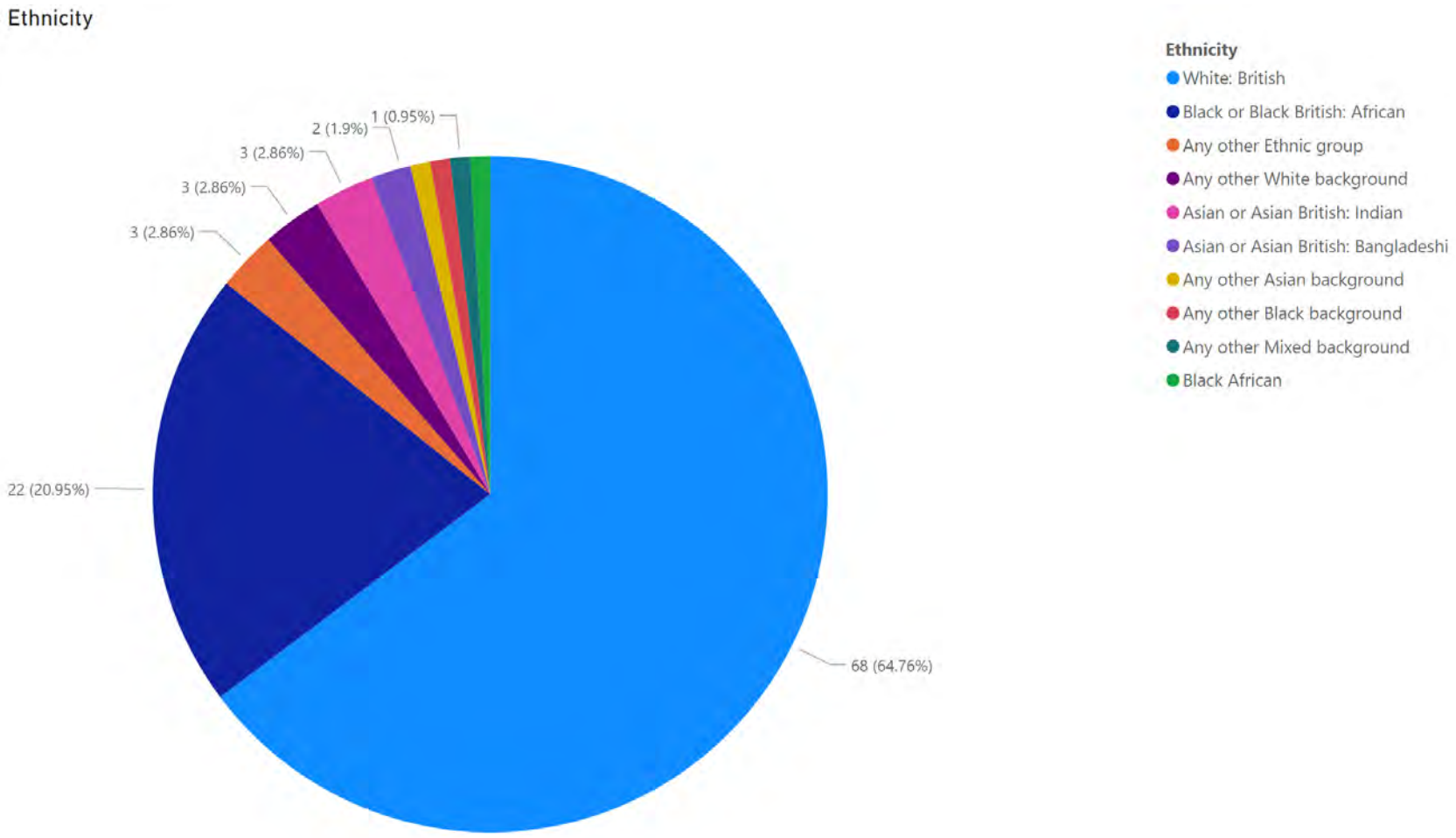
2024/2025 Bookings – Ethnicity

- Review of bookings from 2024/25 showed current MFT maternity patients demographics as follows:
  - White British – 70.5%
  - Black or Black British (incl. African, Black Caribbean, Any other Black background) - 9.93% - an increase of almost 1% from 2023/24 data.
  - Asian or Asian British (inc. Indian, Bangladeshi, Pakistani, any other Asian background) – 7.32% - An increase of 1.32% from 23/34 data



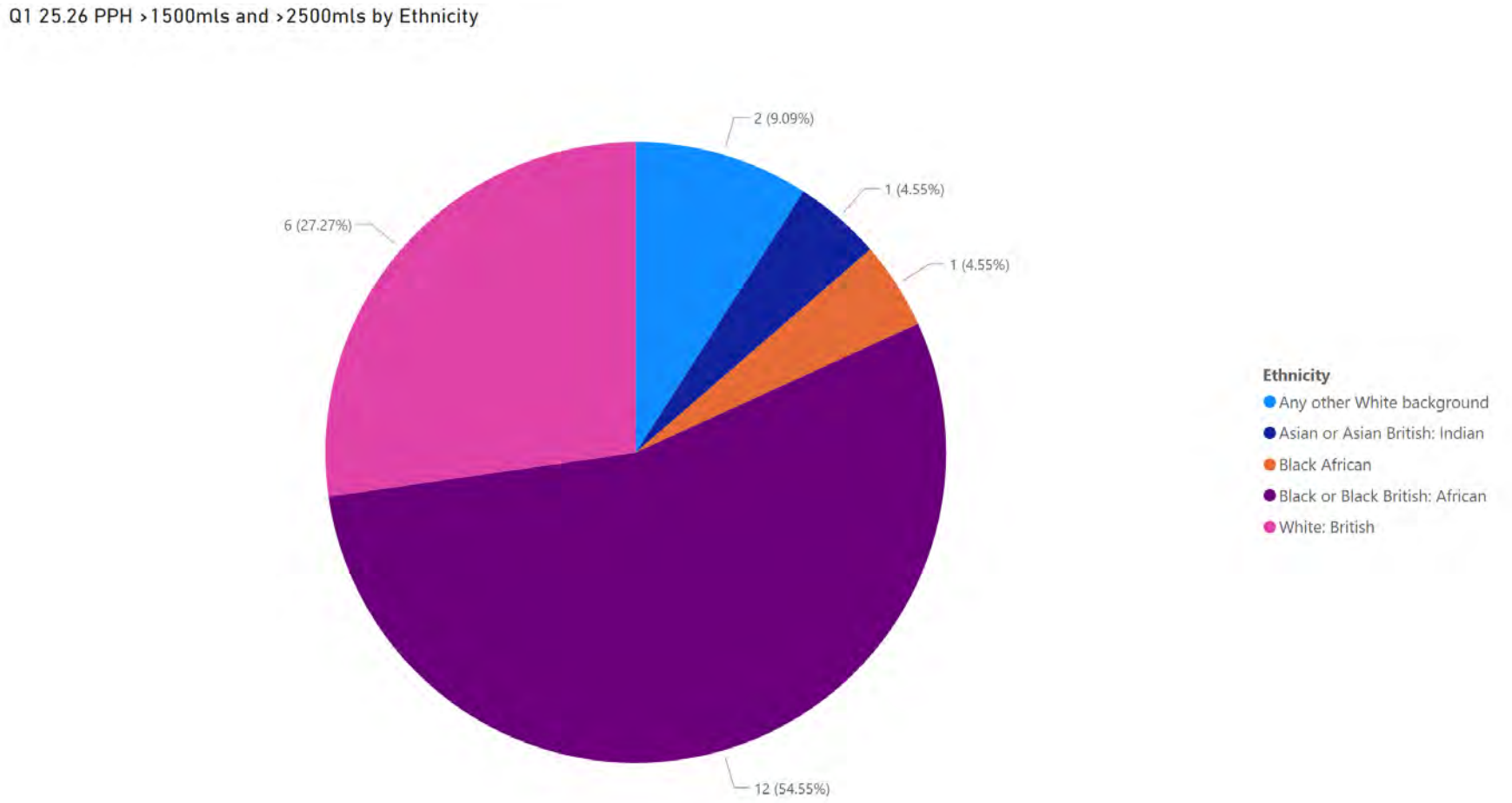
True North: Quality – Q1 PSIRF – Ethnicity Review

- Review of incidents reviewed at CRIG in Q1 25/26 shows:
  - 64% White British (70% birth-rate)
  - 22.8% Black or Black British including African, and any other black background (9.93% of birth-rate)
  - 8.57% Asian or Asian British, including Indian, Bangladeshi and any other Asian background 9 (7.23% birth-rate)

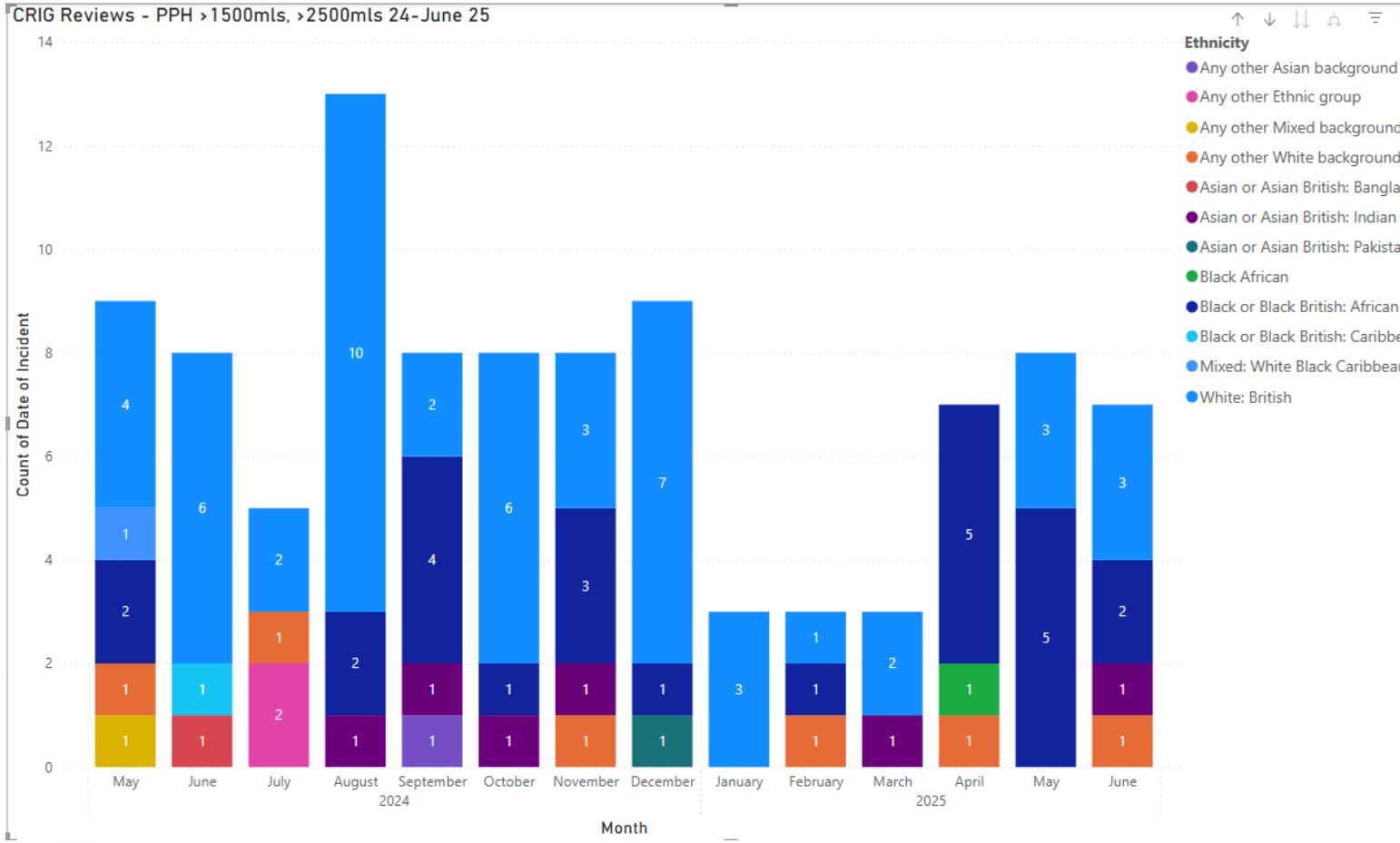


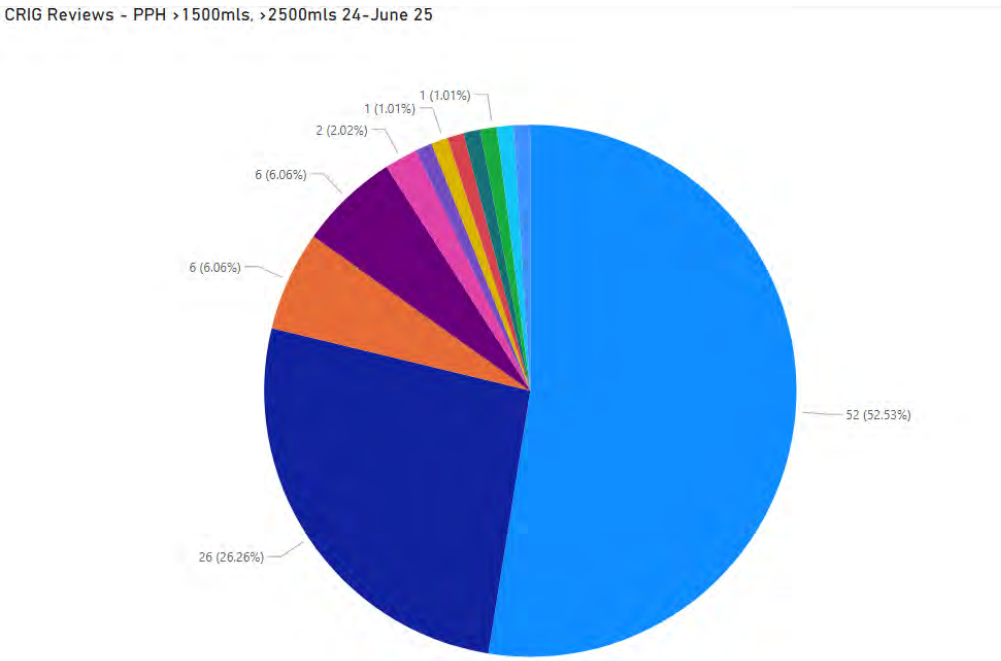
True North: Quality – Q1 PSIRF – Ethnicity Review - PPH

- Review of the PPHs that were reviewed at CRIG >1500mls and >2500mls in Q1 - **59%** of the mothers experiencing PPH were black.
- In Q1 there were 19 PPH >1500mls reviewed at CRIG. 8 of these were experienced by black mothers.
- In Q1 there were 3 PPH >2500mls. These were all experienced by black mothers.
- This is a significant disproportion from their 9.93% contribution to the Birth-rate.
- If we review the past year, the rate of PPH by ethnicity for the past 12 months – this shows **29.29%** of the PPH's reviewed at CRIG were experienced by black mothers.



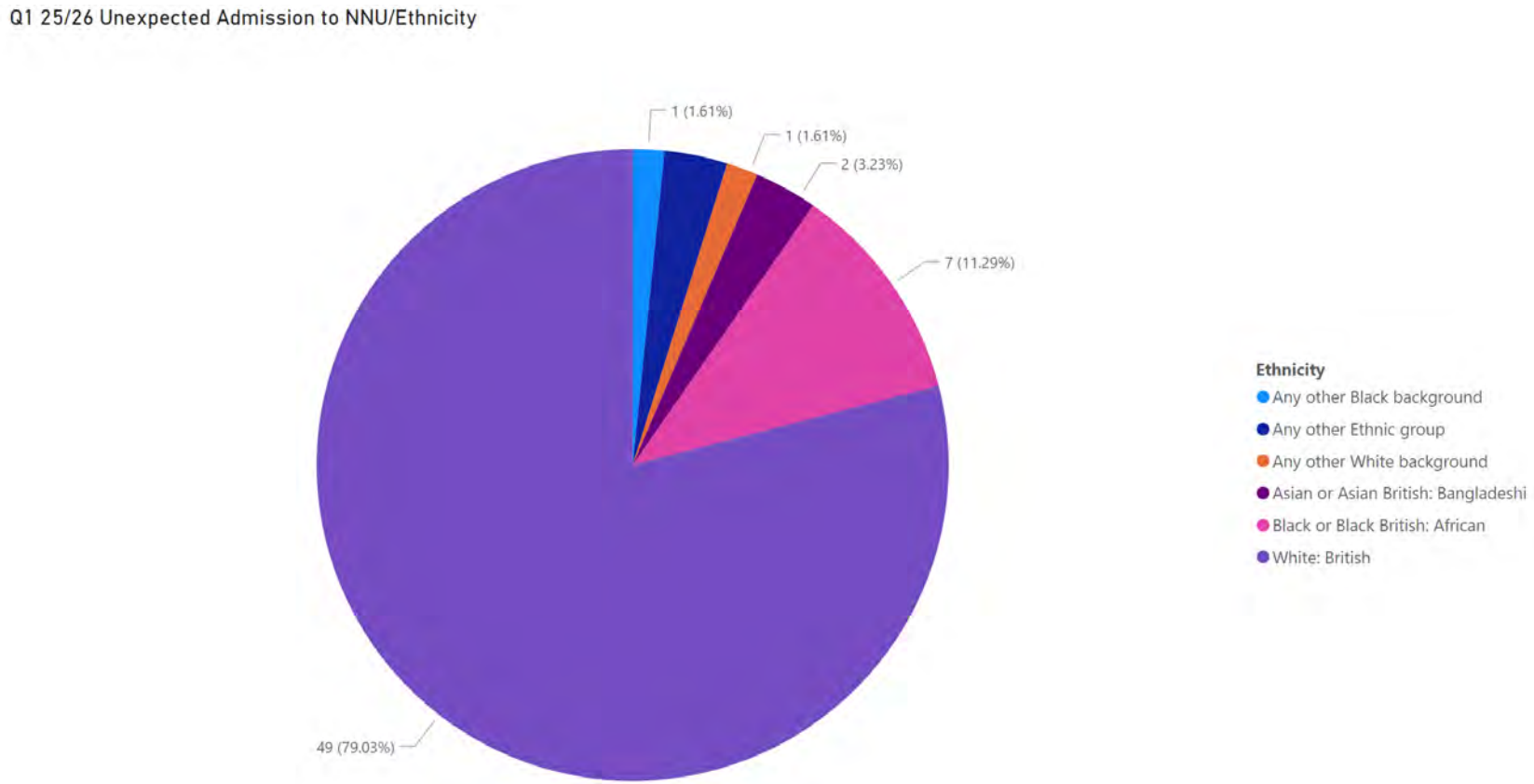
True North: Quality – Q1 PSIRF – Ethnicity Review - PPH





True North: Quality – Q1 PSIRF – Ethnicity Review – ATAIN

- Review of the Term admissions to the neonatal unit by ethnicity showed
  - White British – 79% (70% Birth-rate)
  - Black or Black British, Any other black background – 13% (9.93% of birth rate)



True North: Quality – Q1 PSIRF – Deprivation Score

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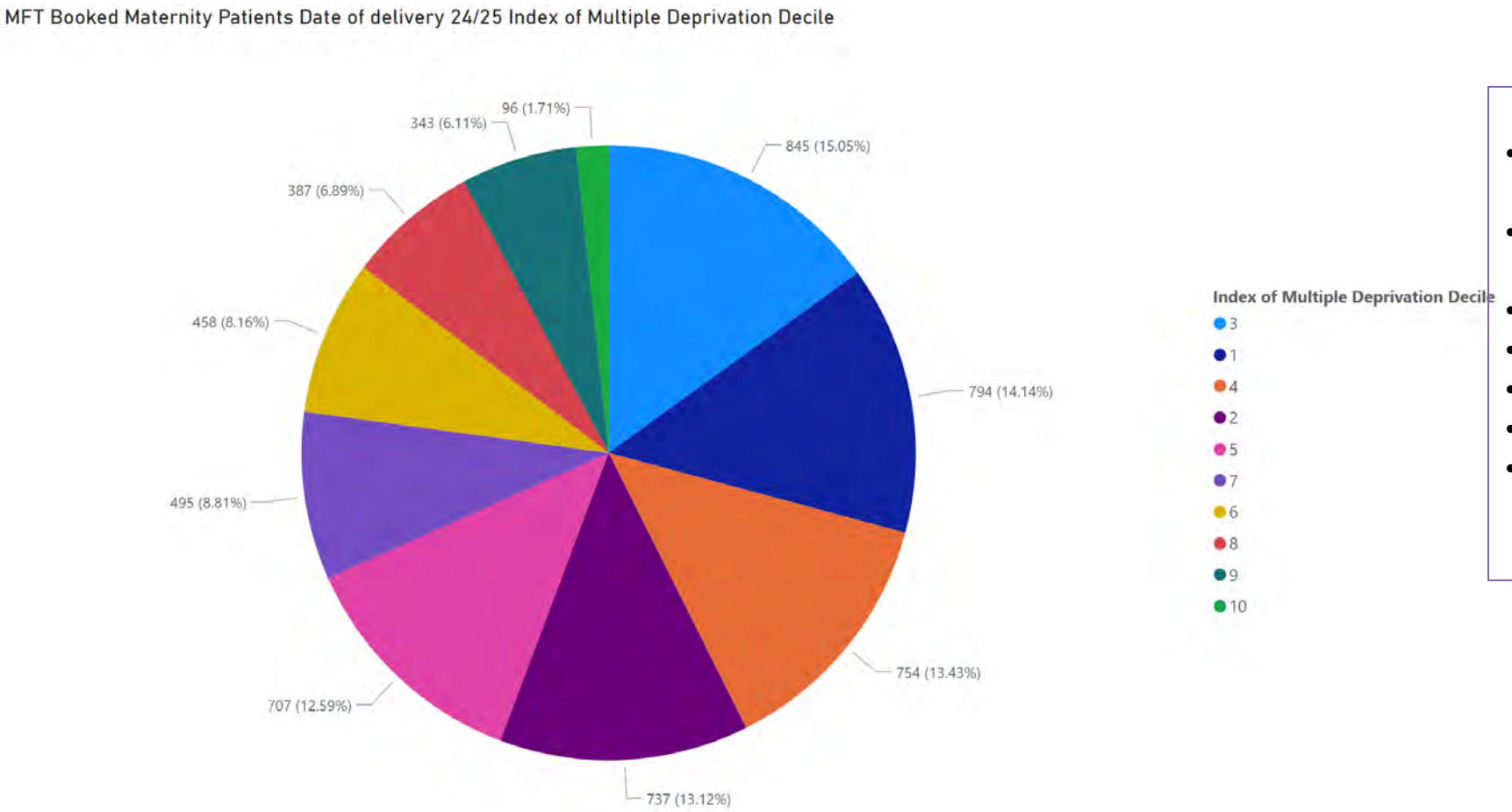
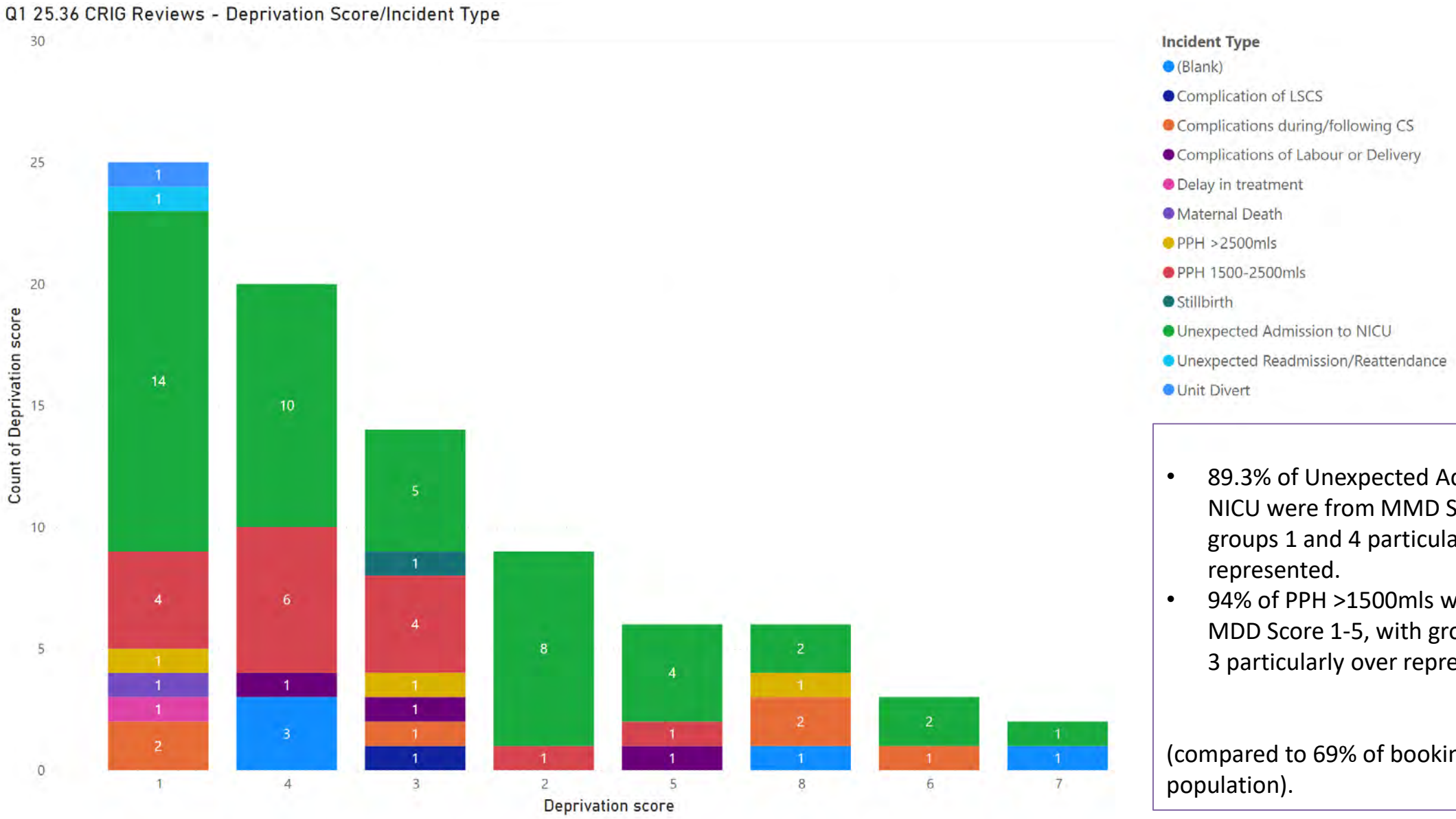


- On review of the booking population with EDD in 2024/2025
- 14% in Multiple Deprivation Decile (MDD) 1
- 13% in MDD 2
- 15% in MDD 3
- 13% in MDD 4
- 13% in MDD 5
- **69% of booking population in lowest 5 centiles.**

True North: Quality – Q1 PSIRF – Deprivation Score

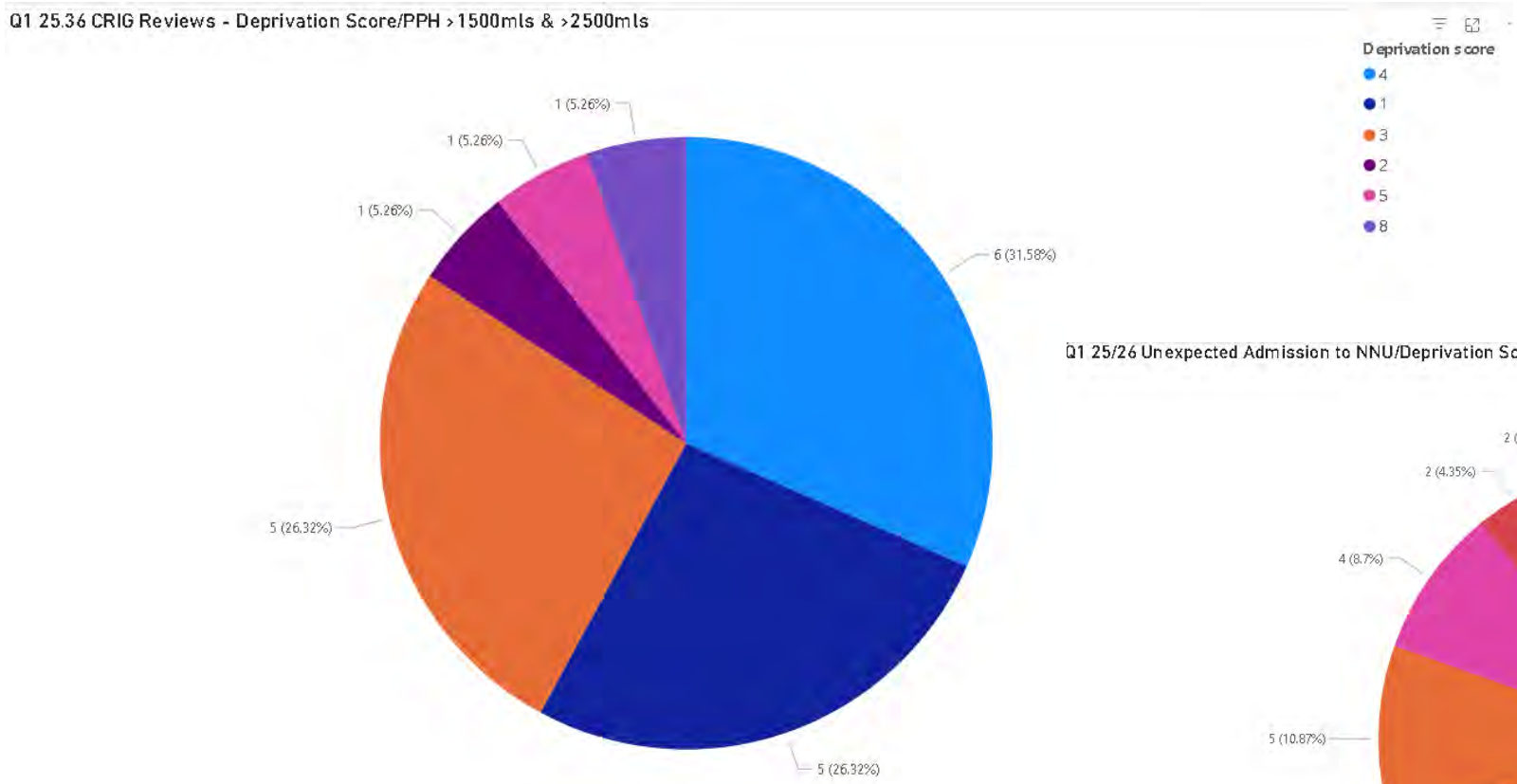


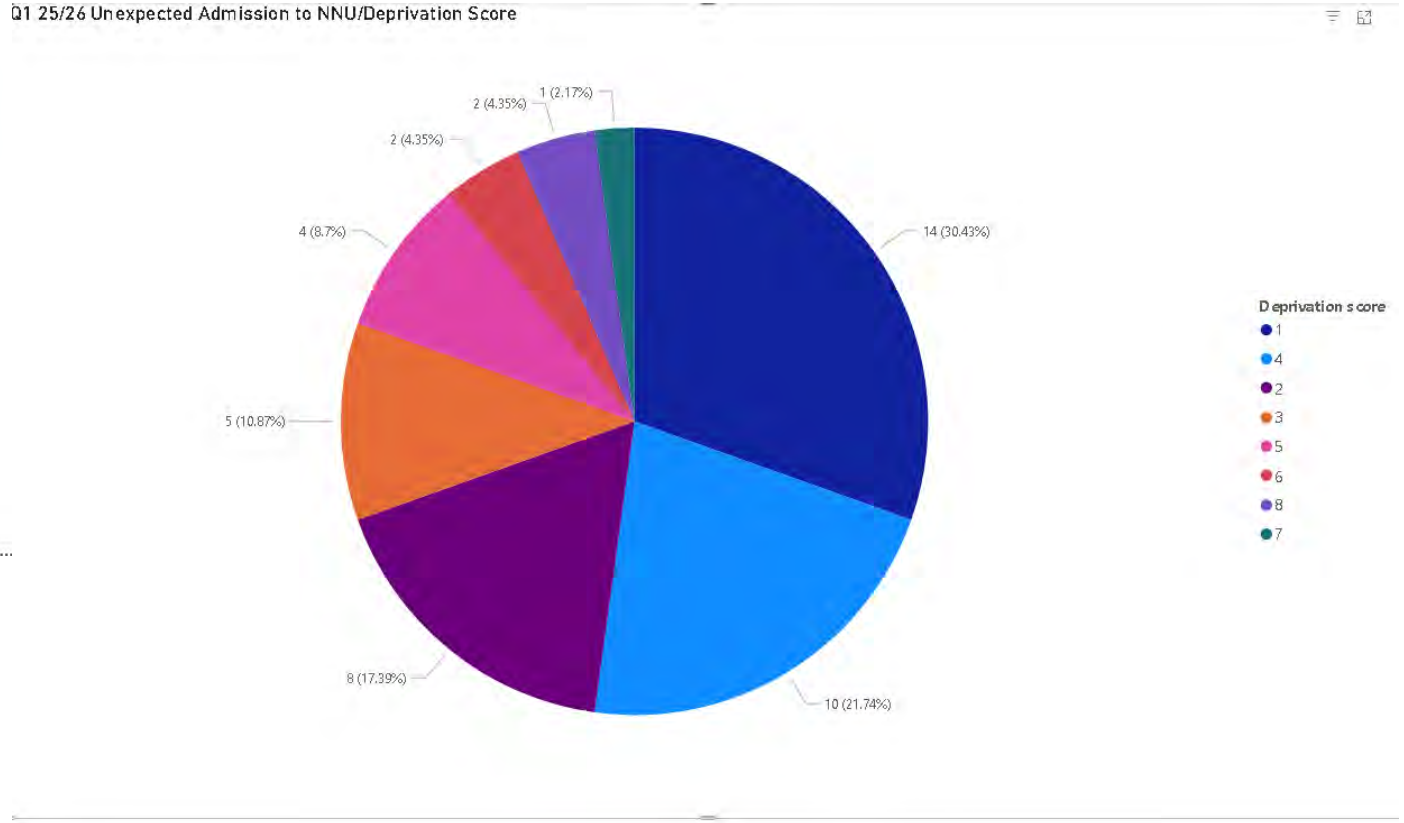
- 89.3% of Unexpected Admissions to NICU were from MMD Score 1-5, with groups 1 and 4 particularly over represented.
- 94% of PPH >1500mls were from MDD Score 1-5, with groups 1, 4 and 3 particularly over represented.

(compared to 69% of booking population).

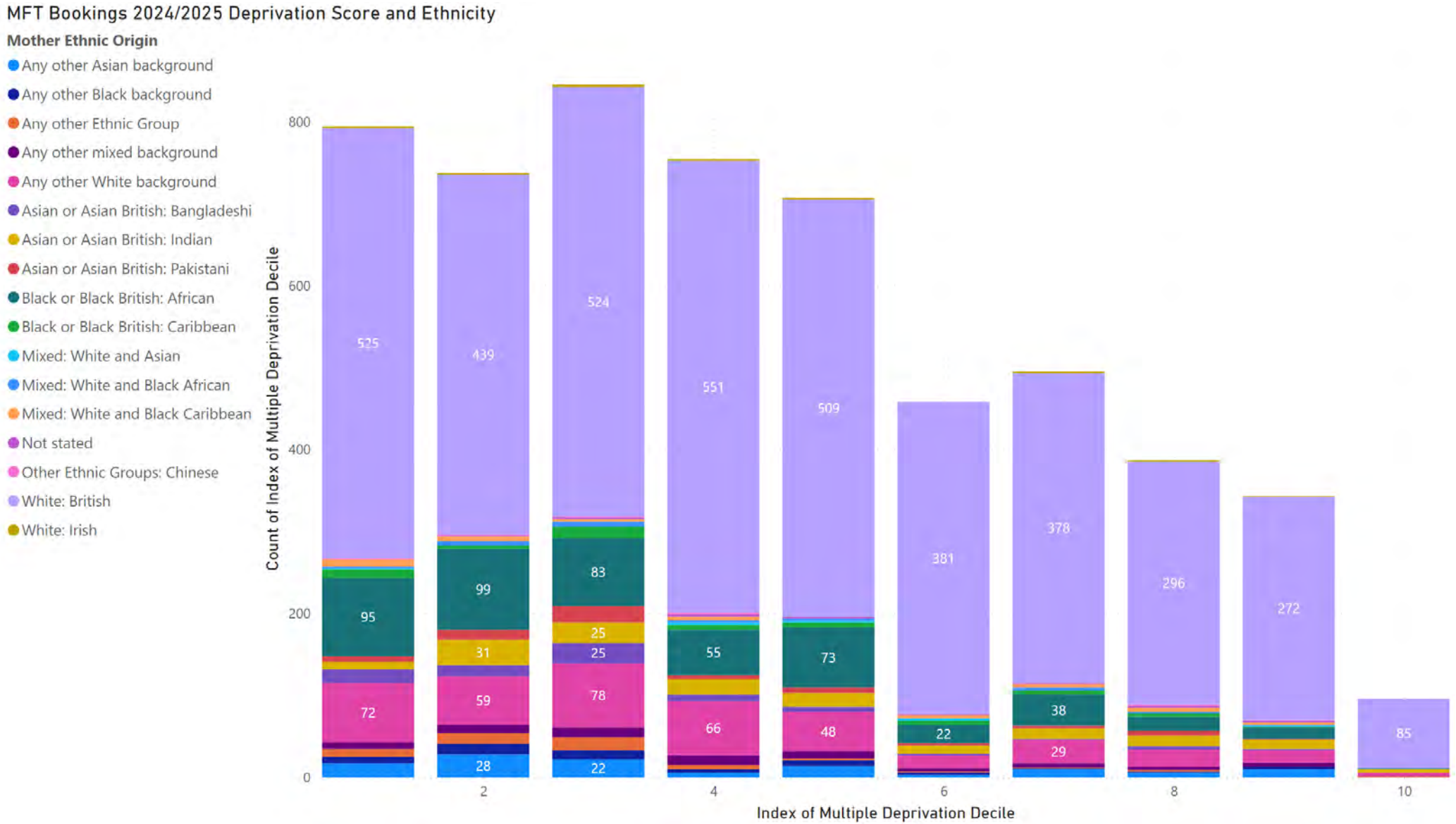
True North: Quality – Q1 PSIRF – Deprivation Score

Medway NHS Foundation Trust





True North: Quality – Q1 PSIRF – Deprivation Score



True North: Quality – Q1 PSIRF – Findings and Next Steps

Medway NHS Foundation Trust

Findings

- There is a significant theme of a disproportionate number of black women experiencing PPH >1500mls and >2500mls in Q1 (59%), a trend which is also present in the previous 12 months of data (29%)- 9.93% of booking population.
- Based on Q1 data, those living in MDD score 1-5 represent 94% of the PPH's reviewed at CRIG.
- 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.

Next Steps

- Deep dive review of PPH data for past 12 months, looking at ethnicity, deprivation score, mode of delivery, management, risk status.
- Once clear understanding of larger data set, present findings to audit meeting and labour ward forum for consideration of targeted management pathway eg. Prophylaxisis.
- 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.

True North: Quality – Complaints and PALS

Key Messages:

- Downward trend of complaints over past 12 months.
- Staff attitude is not a recurrent theme, complications during labour and delivery and lack of medical care and attention are the dominant themes for past 12 months. This is in contrast to positive feedback received regarding care and attention in Families and Friends tests.
- Lowest MDD scores (1-5) account for 86.72% of complaints received in Q1.
- Review of ethnicities of complaints shows that no complaints were received in Q1 from black families, with 1 complaint received from an Asian family (14.29%) and the remaining complaints from white British(57.14%) or other White backgrounds (28.57%)

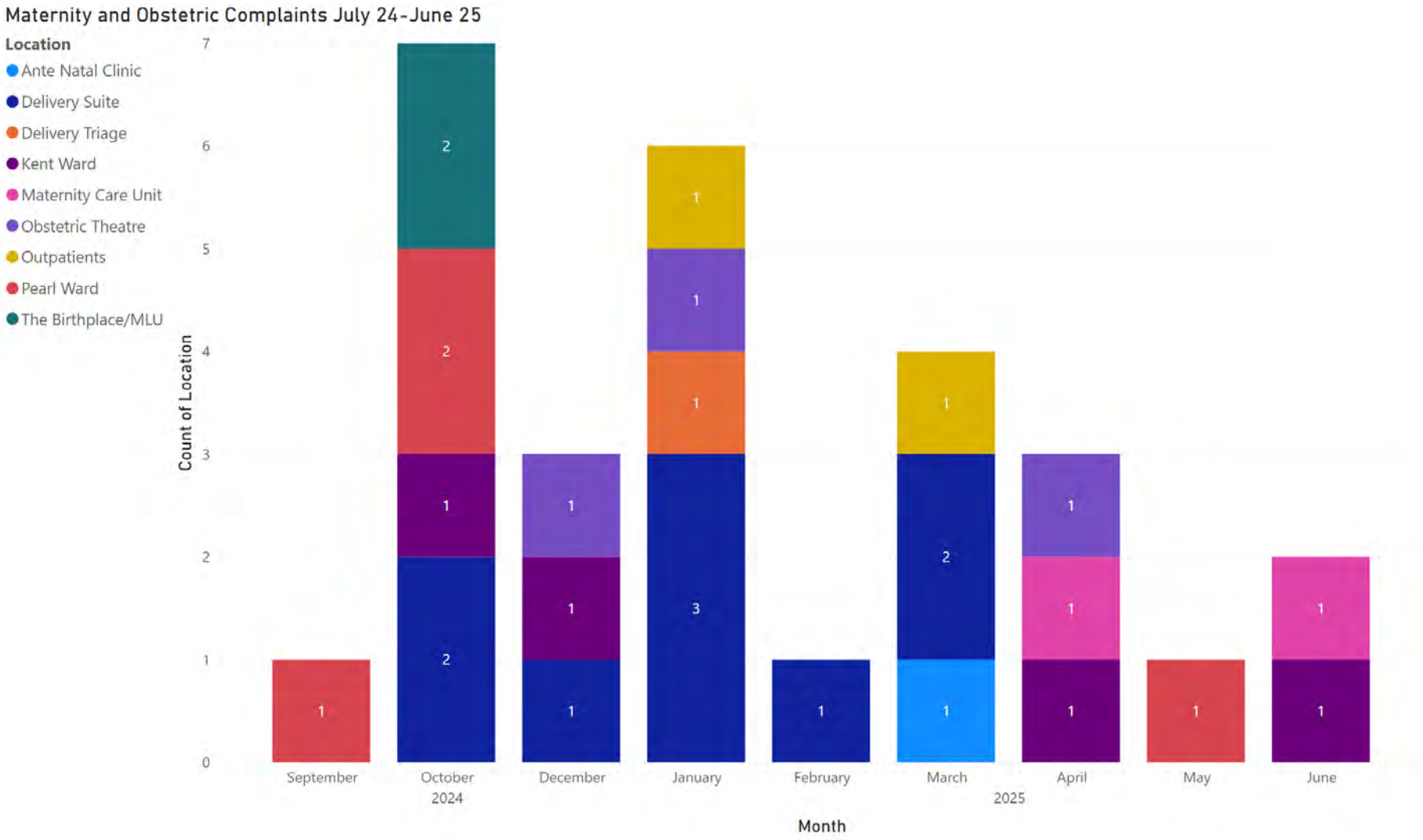
Issues, concerns, gaps:

- Lack of medical and nursing care and attention
- Over representation of lowest MDD scores in complaints.
- Under representation of Black families in complaints.

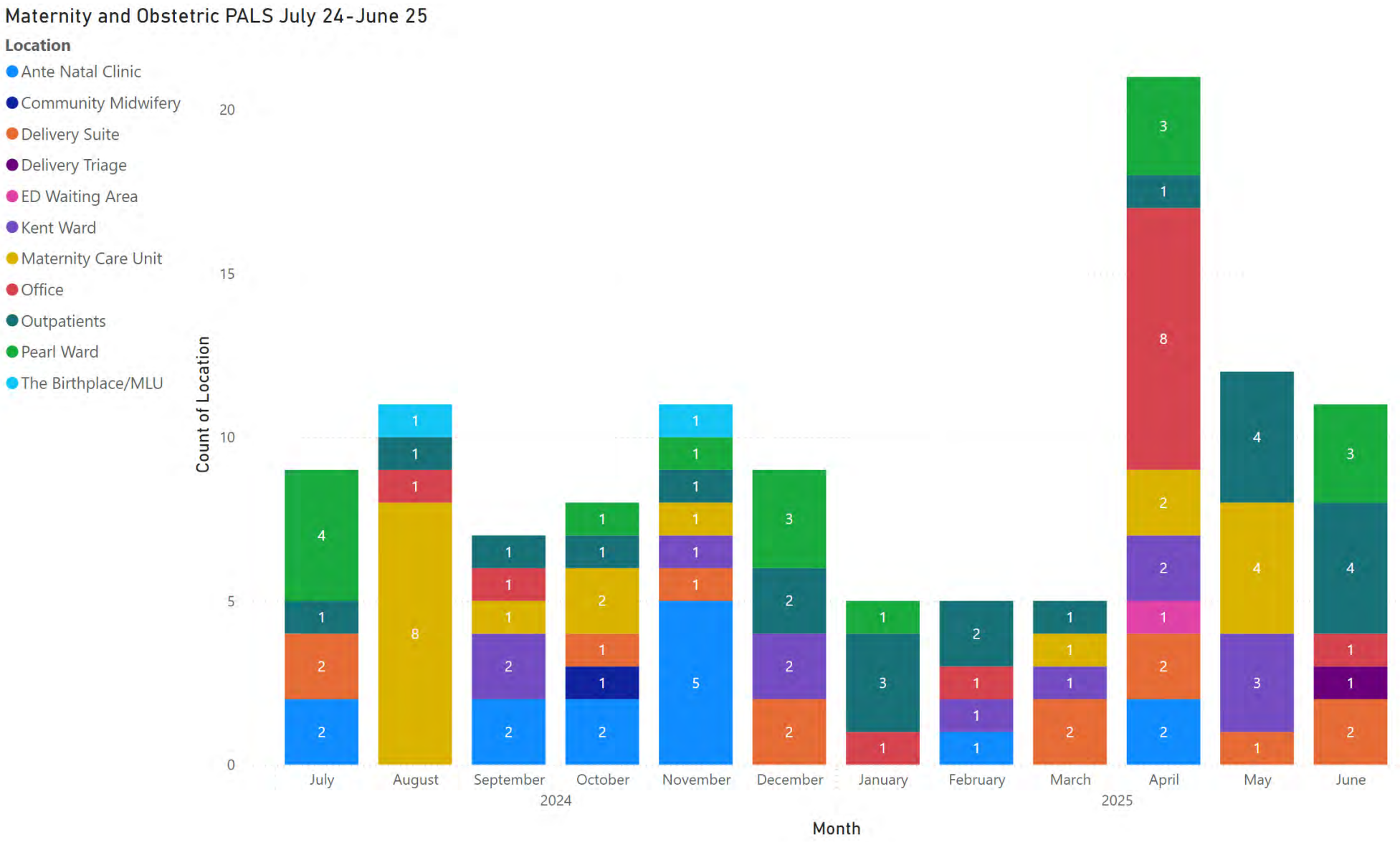
Actions & Improvements:

- Actions identified as part of CQC Picker Survey Action Plan seek to address concerns regarding medical and nursing care and attention in particular:
    - Co-produced Regional Communication project to support staff and service users to communicate needs, expectations, risk and decision making.
    - Focus on improving patient information, particularly in postnatal ward areas with clear expectations for staff, service users and visitors as well as work to improve patient experience including medication rounds, welcome posters and additional information and resources.
- Continue to review complaint data with ethnicity and deprivation score to see better trends over time and correlate themes and learning from individual complaints. Consider focused work with MNVP lead, Patient Experience and EDI midwife to support service users from lowest MDD.
- Review work completed as part of the inpatient debrief pilot and PMA debrief service to identify further opportunities to improve service user experience.

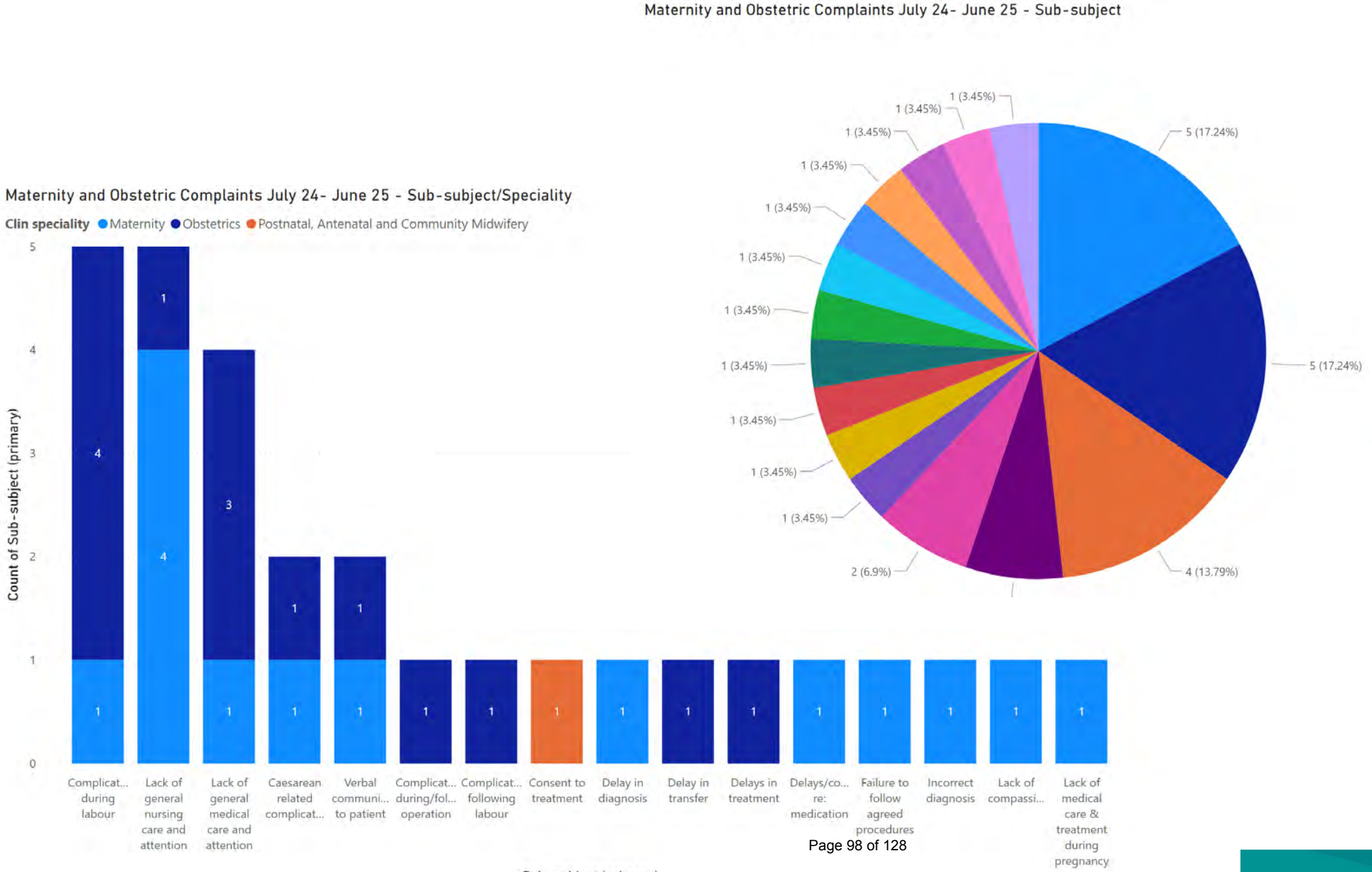
True North: Quality – Complaints & PALS



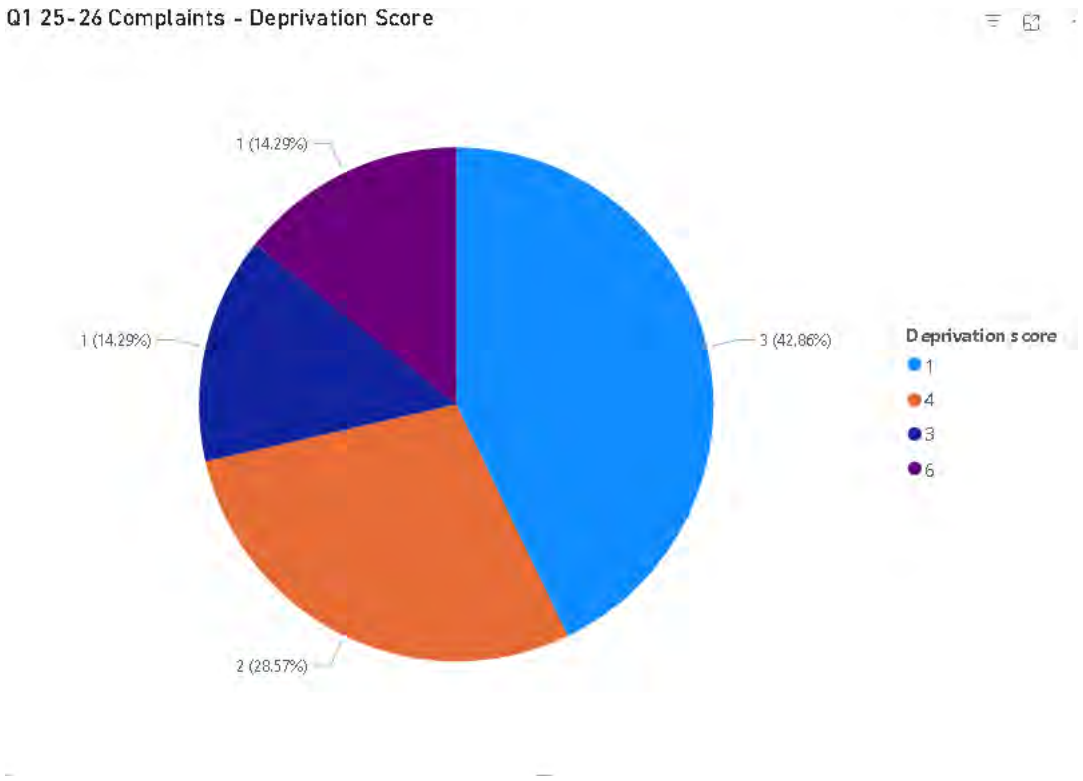
True North: Quality – Complaints & PALS

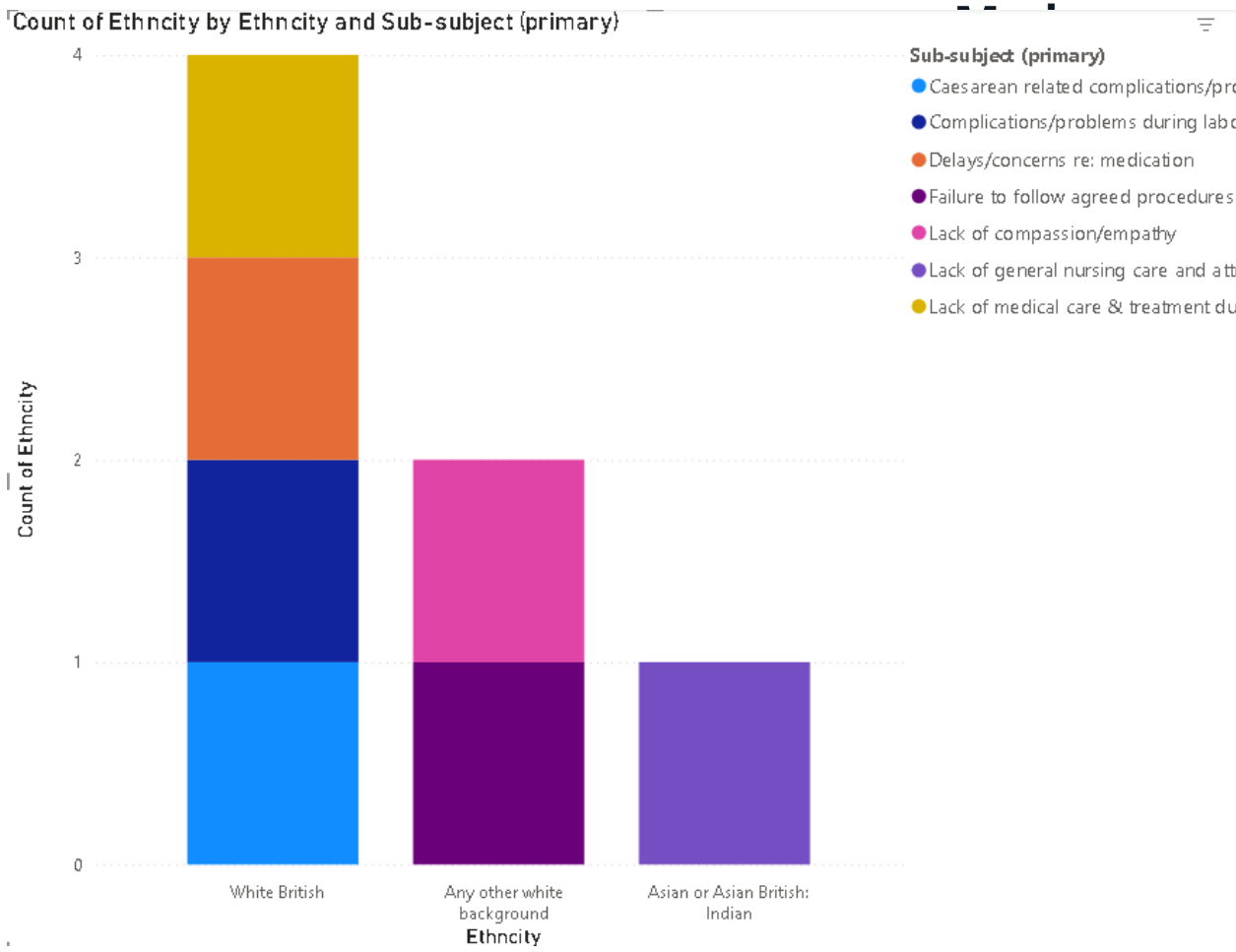


True North: Quality – Complaints & PALS



True North: Quality – Complaints – Deprivation Score & Ethnicity Q1





True North: Quality – Claims

Key Messages:

- New scorecard due to be published in September 2025.
- Deprivation score added to current scorecard to strengthen analysis based on inequalities.
    - 64.29% of claims were made by families in MDD 1-5 (69% of birth rate)
    - No clear correlation between low MDD and type of incident or theme, with a range of deprivation scores spread across each category.
- Ethnicity data remains unchanged from last report with:
    - 0% of claims from black families.
    - 13.57% claims from Asian families (7.23% of birth rate)

Issues, concerns, gaps:

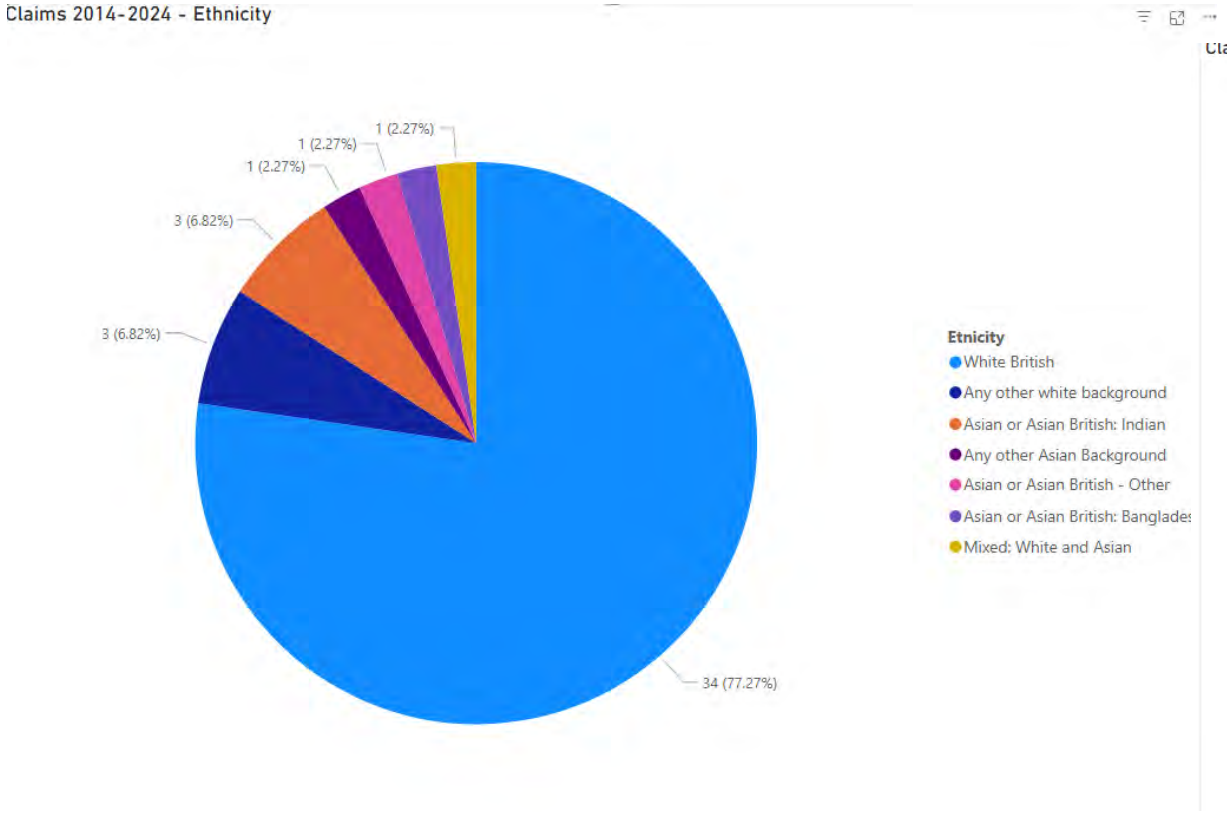
- Black families continue to be underrepresented in claims, both in terms of proportionate to their birth-rate and the % of incidents experienced by this group.
- Asian families continue to be overrepresented.

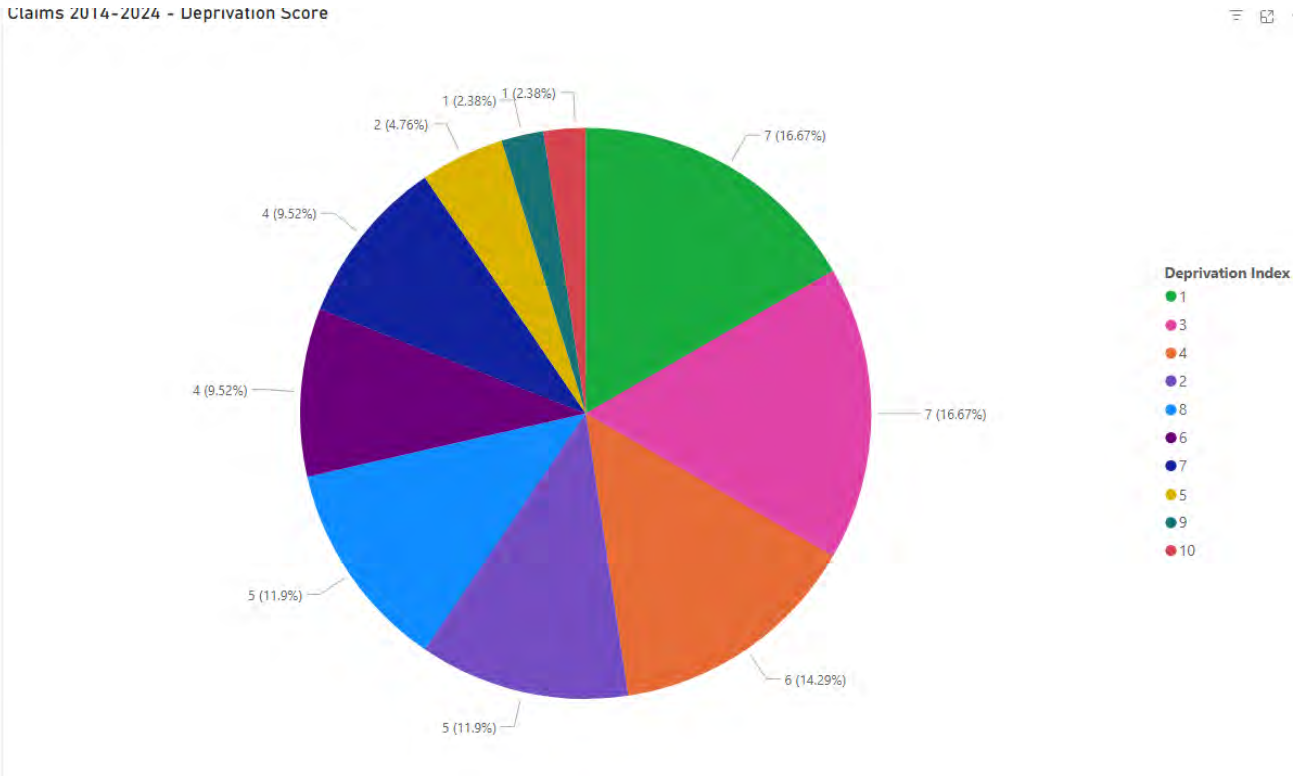
Actions & Improvements:

- Ongoing community in-reach work with Black communities by PE & EDI midwife and MNVP to encourage service users from this group to come forward and share their feedback to direct service improvement. It may take several years for this to translate into a claim, but it is important to continue listening to the voices of these women and families to ensure their experiences can help improve services.
- Continue to review all audit data through an equality and diversity lens to identify opportunities for improvement, even when no direct feedback from service users.
- Gather information on service user communication barriers (eg. Interpreter required) via CRIG and Early Notification database to ensure all families have access to the information and support they need throughout their pregnancy and into the postnatal period.

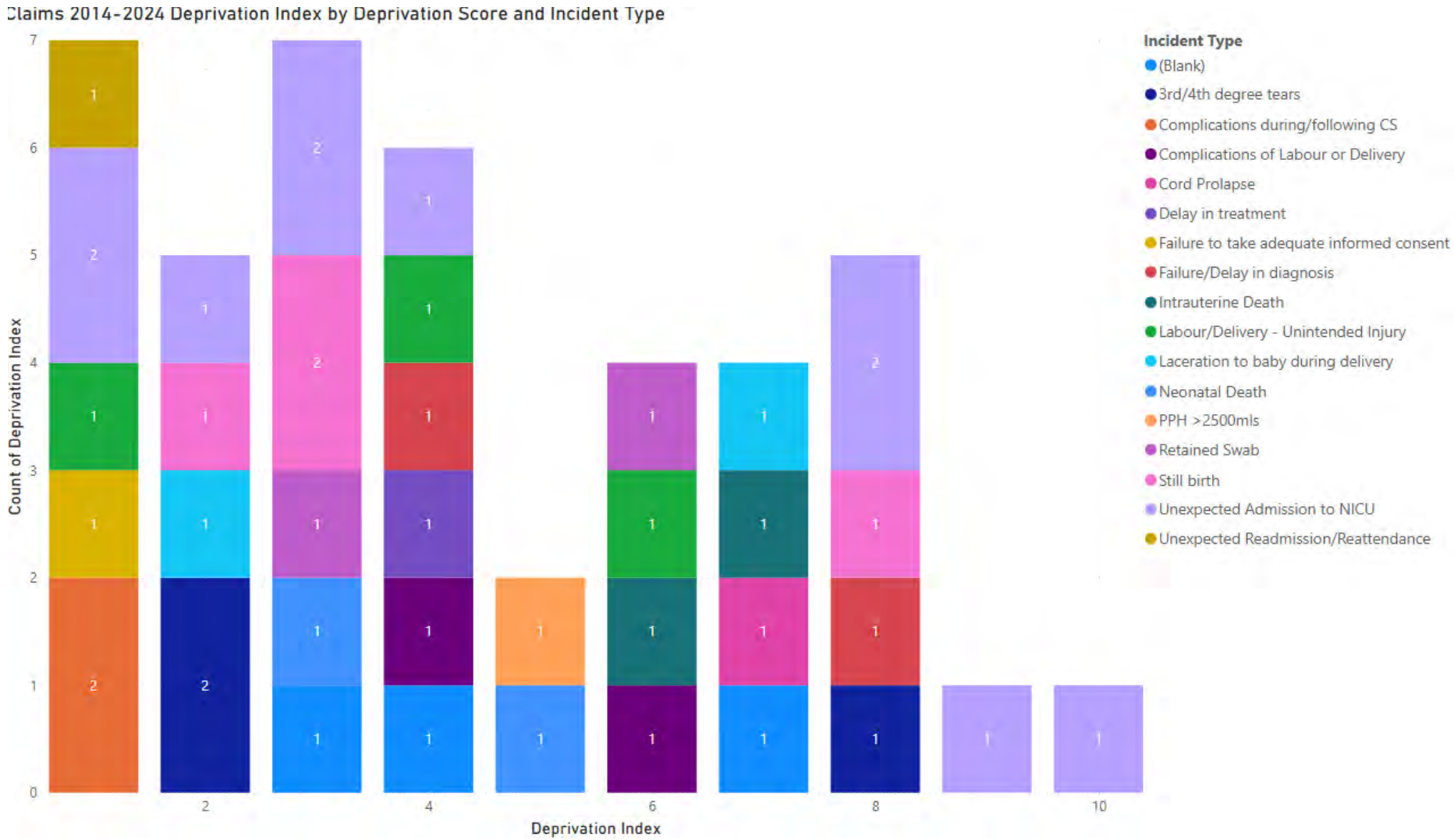
True North: Quality – Claims

Medway NHS Foundation Trust

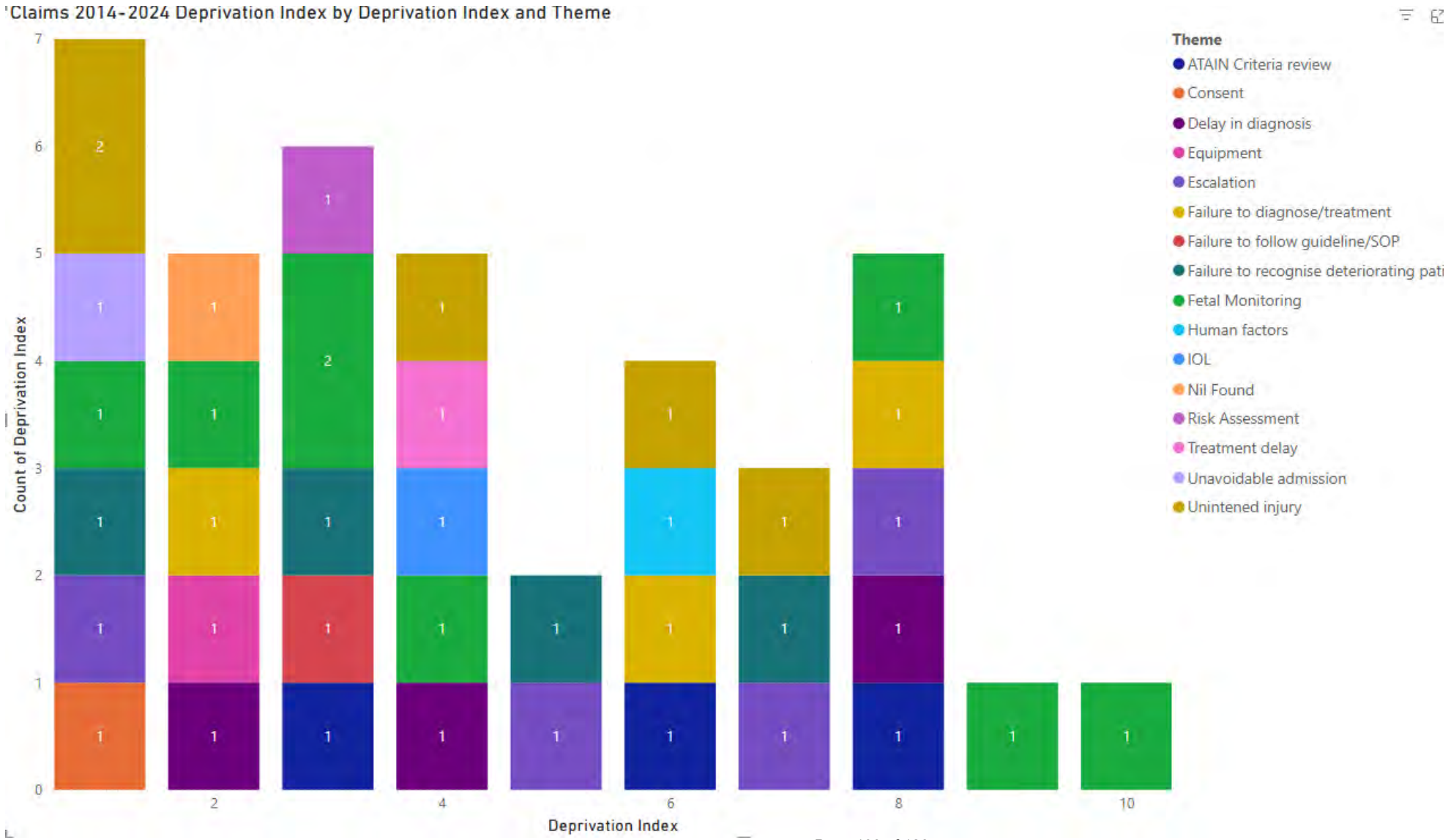




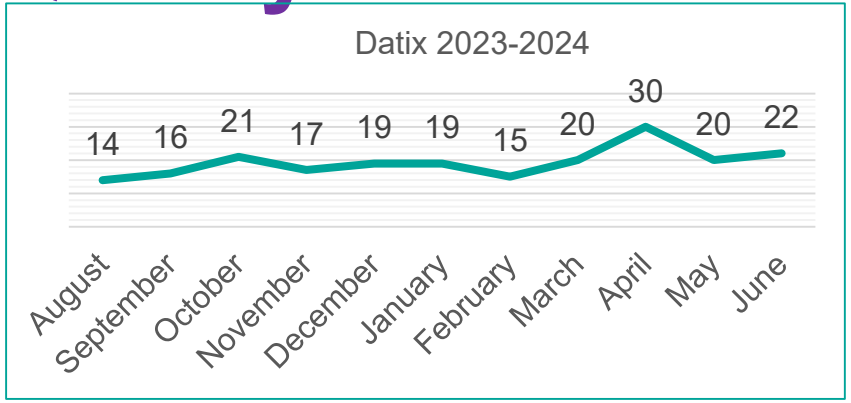
True North: Quality – Claims

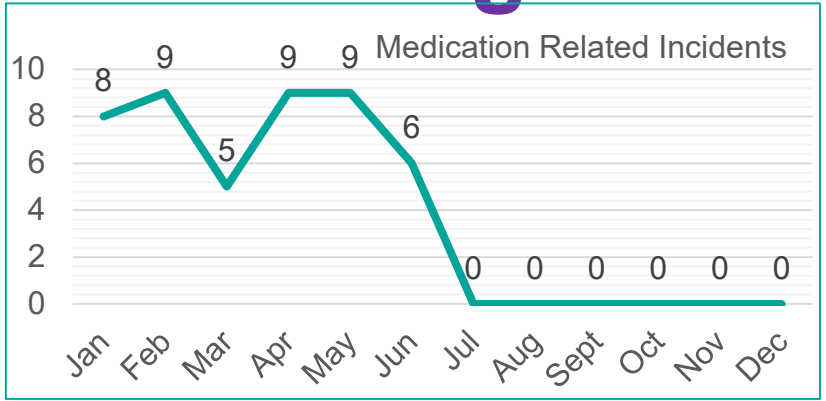


True North: Quality – Claims



Quality: Success and Challenges in NICU





NHS Medway NHS Foundation Trust

Key Messages:

- 22 reported incidents for June 2025
- Common theme:
  - Medication Incidents
    - Slight reduction in numbers of medication incident for June
    - All reported incidents are graded as “no harm”
    - We are seeing effects of action implemented last month – standardised timing for oral supplements
  - Reports of Abuse/Disruptive Behaviour from parents
  - Accident – staff fell to the floor as she was sitting down
- Safety Alerts/National Reminders:
  - New immunisation schedule effective 1st of July
- Formal Reviews/Learning Response:
  - SWARM – 1 – Wrong breast milk given
  - Local SEIPS - 1 – Frozen milk of different baby found in bag
- Unit activity- 0 closures

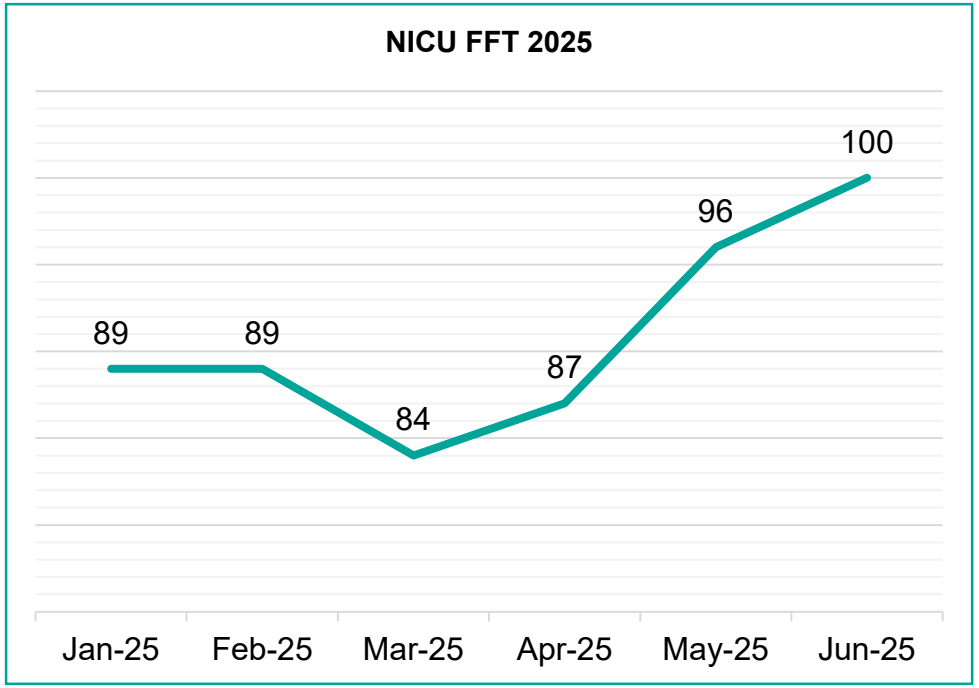
Issues/Concerns/Gaps:

- Medication Datix:
  - Prescription errors – near misses; some medication not represcribed properly; wrong sticker used
- Other Datix:
  - Disruptive behaviour – one parent issued with yellow card
  - Accident – castor wheels in chairs does not have breaks
- SWARM/SEIPS:
  - Issues with organisation of fridge/freezer is prone to errors and makes it difficult for easy milk identification
  - Checking of freezers not regularly done by staff. Only fridge part is regularly checked.
  - Milk not double checked prior to administration.
- Safety Alerts/National Reminders:
  - Changes in immunisation involving 2nd and 3rd

Actions/Improvements/ Next Steps:

- Medication incidents
  - To launch standardised (and simplified way) of prescribing and preparing fluids with additives
  - Designing new fluid and prescription charts based on staff recommendation from survey
  - Continued review of actions with pharmacy lead.
  - Care-group meetings to look into medication incidents
- Accident – HoN for CYP looking into replacing castor wheels with brakes in chairs
- SWARM/SEIPS
  - Re-organisation of fridge and freezer using dividers and zipper bags
  - Emphasis on double checking
- Immunisation
  - New standardised stickers ordered
  - New infographic and reminders to be printed and laminated

NICU- FFT and Complaints



Issues/Concerns/Gaps:

- Complaint
- Newborn fed another mothers' breastmilk

- FFT:
- Some areas of improvements identified, including 'Table cleaning after meal' ' Air conditioning as the unit is very hot' ' clearer information with regards to plans of care

Actions/Improvements/ Next Steps:

- Encourage everyone to complete FFT prior to discharge
- Complaint-
  - SWARM done- actions identified
- FFT-
  - Continue to work with families as partners in care.
  - During the hot weather, ensuring parents are comfortable, offering cold drinks

Key Messages:

- 1 Complaint received for June 2025

- FFT 100% , 22 responses
  - Improvement from previous months
  - Some very positive feedback surrounding friendly and supportive staff, showing great communication skills

Quality

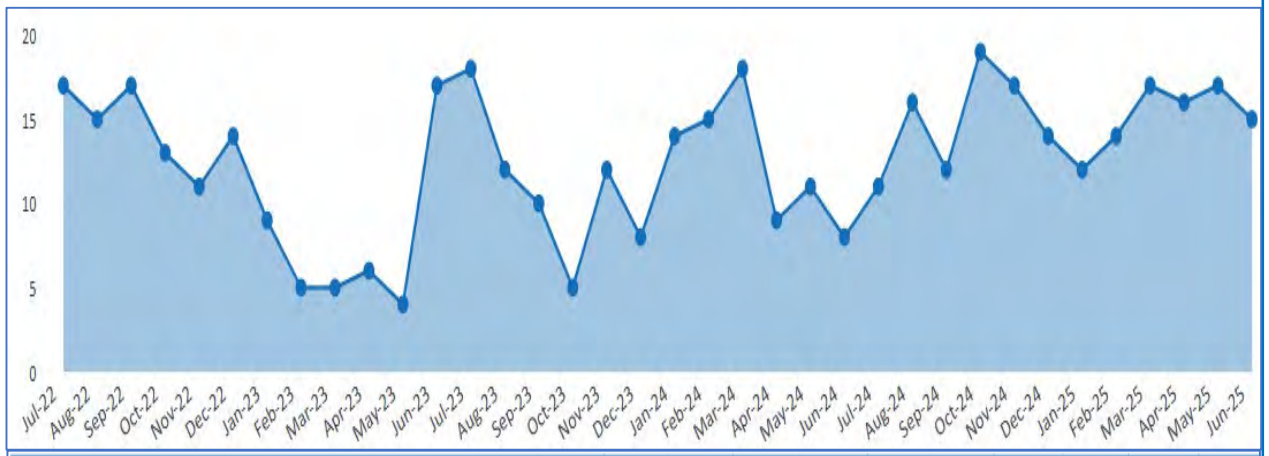
Owner: Sachin Patil

Metric: Reduction of medication errors

Target: 4 (TBR)

Current Month: 15 Trend: Positive

1. Historic Trend Data



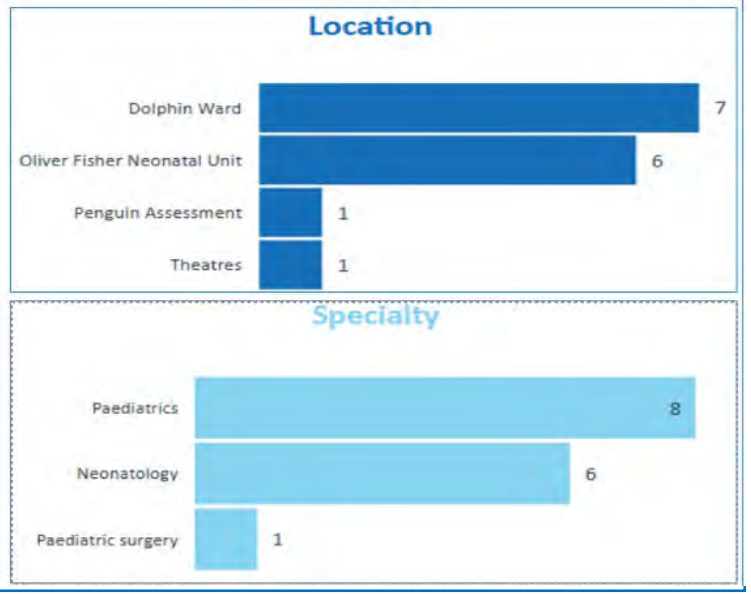
Care Group	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
CHILDREN AND YOUNG PEOPLE	11	16	12	19	17	14	12	14	17	16	17	15

2. Stratified Data – May 2025

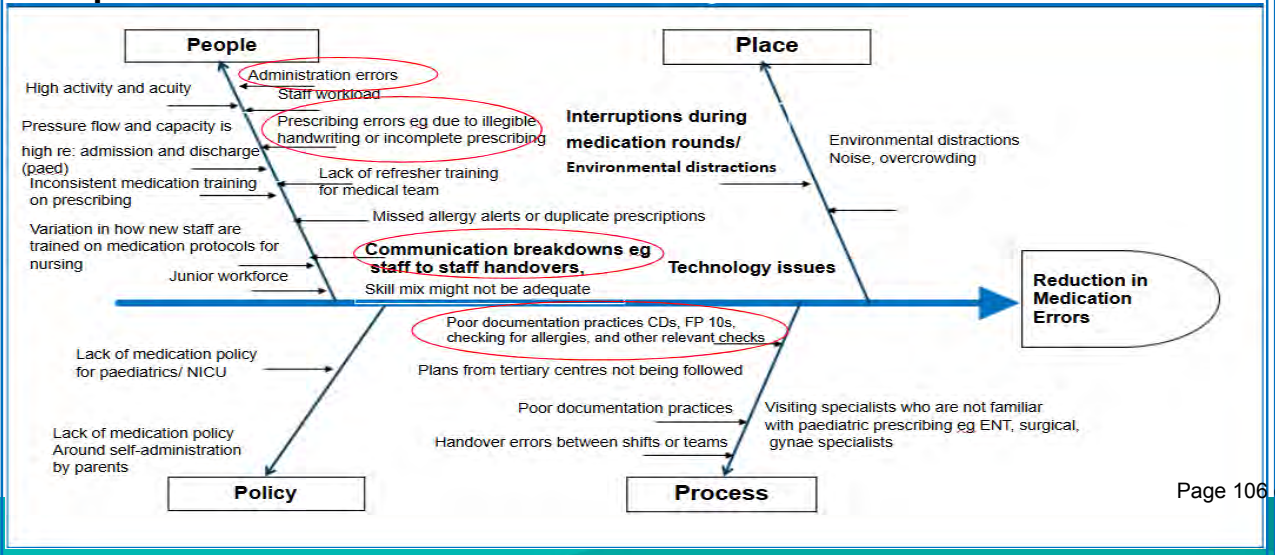
JUNE 2025

CHILDREN AND YOUNG PEOPLE

15



3. Top Contributors



4. Countermeasures – Next 30 days

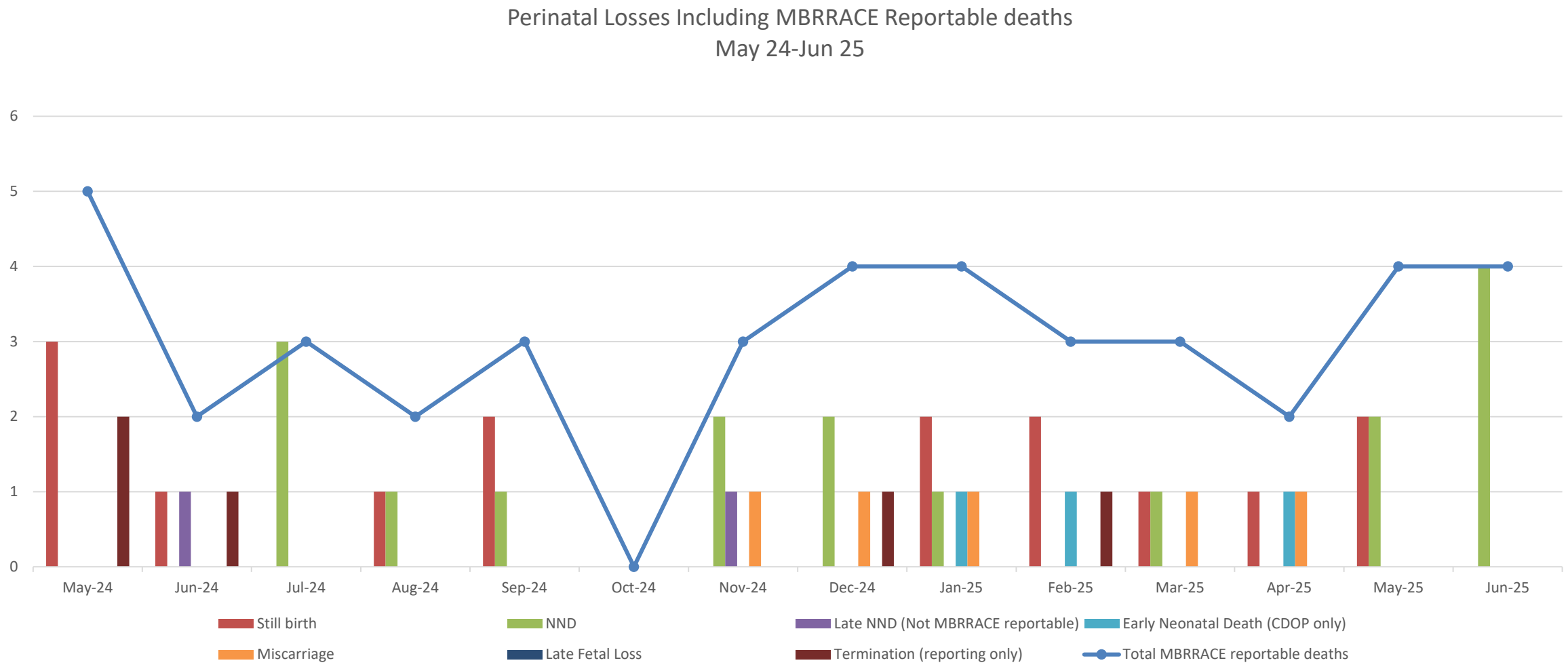
Concern	Cause	Countermeasures to be completed	Owner
High turnover, complex patients, insufficient staffing, skill mix	Administration errors	1. Explore awareness around a more detailed filling of the medication error datixs to understand where the issues are coming from 2. Explore possibility of lead pharmacist contributing to medication training for nurses 3. Explore involving parents in the medication administration information required for safety checks 4. Review guidance around double checking for paediatric medications 5. Arrange a collaboration meeting with TT to explore a RCA session for medication administration errors	Sumiah/ Claire Eastwood
CYP are prescribed medications incorrectly	Prescribing errors eg due to illegible handwriting or incomplete prescribing etc	1. Send out comms as reminder of GMC guidelines 2. Engage colleagues from relevant specialist through education and reminding colleagues when they come to review patients in the paediatric ward about 3. Encourage specialists to discuss prescription with paediatric registrars after before prescription 4. Explore communications around prescribing and discharges as part of their induction 5. Explore support for paediatric registrars with prescription queries 6. Pharmacy huddles to share learning around medication errors 7. Explore model used in NICU around prescribing checks to be transferred to Paediatrics	Sachin Patil/ Felicity Brokke
Interdisciplinary communications are not robust enough in relation to transfer of information around medication	Communication breakdowns	1. Review the use of handover template for handovers from other clinical areas 2. Explore reasons why staff are not using the existing handover template 3. Explore the SBAR handover type and incorporate medication into it 4. Ogranise a listening events around medication errors	Sachin/ Matrons/ Amanda/ TT
GMC, NMC and local policies are not being followed	Poor documentation practices CDs, FP 10s, checking for allergies, and other relevant checks	1. Review FP10 policies for better clarity 2. Review existing training around medication documentation 3. Provide support sessions for staff around medication documentations 4. Do a data deep dive around the use of FP10/ paediatric prescriptions for historic data collection	Sumiah A Claire E/ Suzanne T Asleigh B

Perinatal Surveillance Tool Q1 25/26– Perinatal Mortality Review Tool

Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust



Perinatal Surveillance Tool Q3 2024/25– Perinatal Mortality Review Tool

Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight

Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- 10 (-) MBRRACE reportable cases in Q1
- 7 Neonatal deaths – all extreme prematurity or expected. Mortality review slides to follow.
- CNST standard C (PMRT review commenced within 2 months of loss) not commenced for 2 cases, 1 due to staff sickness and 1 due to non-return of booking/antenatal care factual questions by booking Trust within required timeframe. Currently at 93% compliance for standard C (95% required).
- 10 PMRT reviews completed in Q1

Issues, Concerns & Gaps:

- High number of neonatal deaths in Quarter.
- Current non-compliance with standard C.
- Sensitive communication with parents regarding religious requests in NICU Documentation of Neonatal resuscitation.
- Delayed identification or escalation of candida risk.
- Delayed cord clamping not instituted although this was indicated.
- Management of IUGR pathway.
- Management of placenta for histology.
- Use of interpreting services.
- Neonatal documentation.
- No interface between EPAC and maternity systems.
- Neonatal Medical input for maternity PMRT reviews.

Actions & Improvements

- Non-compliance with standard C raised with MBRRACE and delayed return of factual questions by neighbouring Trust to be considered in assessment of return.
- .NICU to ensure chaplaincy and cultural liaison service is utilised when required. Individual reflective practice for staff involved and reflective discussion during MDT meetings to ensure learning from case is shared.
- Improve timeliness and visibility of placental microbiology results, including routine, direct communication to neonatal team when pathogens are identified. Implement an MDT Microbiology/Maternity/Neonatal handover, especially when results are pending from maternal or placental cultures.
- Develop or revise twin delivery protocols, especially for cases involving suspected IUD, to include clear identification processes. Ensure cord clamping decisions are explicitly documented pre-delivery with clarity around which twin is expected to be viable. Conduct Simulation training in complex twin deliveries involving one demised twin, to improve communication, team roles and labelling accuracy.
- Share learning from IUGR case at Fetal medicine forum and audit. Full action plan to be developed by MDT on receipt of MNSI report.
- Interpreters to be used for all families where the mother does not speak/has limited English. Family members should not be used. Seek member of staff who speaks the language to support if interpreter not available.
- AAR completed for placenta sent to incorrect pathologist and awaiting sign-off. Changes to workbook completed to prevent reoccurrence.
- Community Midwives to ask patients if EPAC scan undertaken and document any variance to dates.

Overview of Neonatal Deaths – Q1 2025

Case Summary

A total of 7 neonatal deaths were recorded in Q1. One of these, Baby Adereti, was born at 20 weeks' gestation—below the threshold of viability

These cases were primarily linked to extreme prematurity, multiple births, and severe intrauterine conditions, highlighting the complex challenges faced.

Most cases were anticipated losses due to severe clinical presentations, allowing for focused and compassionate end-of-life care planning with families.

Clinical Patterns

The gestational age of 5 out of the 7 babies ranged from 20 to 23 weeks, emphasizing the vulnerability of extremely premature infants.

5 of 7 cases involved multiple pregnancies (twins/triplets), indicating a higher risk profile associated with these complex gestations.

Prominent complications observed included Intrauterine Growth Restriction (IUGR), Hypoxic-Ischemic Encephalopathy (HIE), Intraventricular Hemorrhage (IVH), and Twin-Twin Transfusion Syndrome (TTTS). These severe conditions often presented significant challenges to survival.

Case Management

All cases have been scheduled for comprehensive Perinatal Mortality Review Tool (PMRT) review, with clear timelines established to ensure thorough investigation and learning.

Two cases necessitated transfer to Kings Hospital for specialist intervention, demonstrating the need for collaboration with higher-level care facilities for complex surgical or medical needs.

The detailed table below provides a concise overview of each individual case, summarizing gestational age, critical clinical factors, and the scheduled dates for their respective PMRT reviews.

Patient	Gestation	Clinical Factors	PMRT Date
1	34+2 weeks	FGR, twin pregnancy	21/08/2025
2	26+0 weeks	Severe HIE, bilateral IVH	19/08/2025
3 – Triplet 3	23+3 weeks	Severe IUGR post-TTTS laser	21/08/2025
4- (Triplet 2)	23+3 weeks	Surgical case at Kings	By Kings
5 -Triplet 1	23+3 weeks	Surgical case, died at Kings	By Kings
6 -	23+2 weeks	Pneumothorax, suspected chorioamnionitis	16/09/2025
7 -	Below the threshold of viability		27/04/2025

Assurance, Actions & Next Steps

Our multidisciplinary team conducts structured reviews to identify potential areas for improvement in complex neonatal cases.

Structured Review

PMRT scheduled for 5 cases; 2 coordinated with Kings specialist unit

Learning Integration

Internal learning events established

Cross-unit discussions to share insights from complex cases

Risk Management

Comprehensive review of care pathways for extreme preterm births

Enhanced protocols for managing complex multiple pregnancies

Benchmarking & Continuous Improvement

Medway NHS Foundation Trust

Peer Benchmarking

- Establishing data-sharing partnerships with comparable tertiary units
- Comparing outcomes for extremely preterm and multiple births
- Identifying potential areas for practice enhancement

Enhanced Monitoring

- Refining antenatal surveillance protocols for high-risk pregnancies

Trust Assurance

- Quarterly reporting of all PMRT findings to Clinical Governance Committee
- Transparent tracking of implemented improvements
- Regular staff training on updated protocols and guidelines

The clinical profile of these cases reflects the inherent challenges in managing extremely preterm infants (particularly in multiple pregnancies). While outcomes were difficult to alter given the clinical presentations, our robust review processes and continuous improvement initiatives demonstrate our commitment to optimising care in these complex scenarios.

MBRRACE Reportable Loses Q4

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
4	1	Stillbirth	30+2	Unexplained	PMRT	C,B - Communication - poor communication around clinical condition and options and continuity of care - no joined up consultant rounds. - Escalated to HOM and Clinical Director - to be discussed at consultant meeting and Labour Ward Forum.
4	2	Miscarriage	23+0	Unexplained	PMRT	BC, Concerns regarding management of blood pressure and lack of follow-up – Maternal Medicine consultant follow up and plan in place for patient management.
4	3	Neonatal death	23+0	Extreme prematurity	MBBRACE, PMRT	(antenatal care at other Trust outside LMNS) A, B, A – Concerns regarding documentation, including Apgars and saturations and communication with parents. Also concerns regarding thermal management. Staff education and training to address concerns.
4	4	Neonatal death	25+1	Extreme prematurity	MBRRACE, PMRT	(Antenatal care at another trust outside LMNS). Graded A, B, A - Communication, thermal management - Staff education and training to address concerns.
4	5	Neonatal death	24+1	Exutero Transfer -	MBRRACE reportable for birthing Trust, PMRT	Extreme prem and grade 4 intraventricular haemorrhage (IVH)
4	6	Stillbirth	40+9	Unexplained	PMRT, MNSI	MNSI - PMRT Graded C, C. IUGR at birth, identified antenatally and management not appropriate. - Share at Maternal Fetal Medicine Governance Meeting for Learning/Audit. Full action plan from MNSI report to be agreed by MDT.
4	7	Neonatal death	25+0	Extreme Prematuirty	MBRRACE, PMRT	C, A, A HIE, Extreme prematurity, Minimal nursing notes documented. Education and training regarding documentation.
4	8	Stillbirth	25+4	Unxeplained	PMRT	B,B Placenta sent to incorrect pathologist. Retrieved and sent to correct organisation. HTARI Completed. AAR Completed. Awaiting sign-off. Changes to workbooks completed.
4	9	Stillbirth	31+3	Unxeplained	PMRT	C, A - Poor English and not using interpreting services - changes to practice to ensure that interpreters are used, not family members. Not reviewed or discussed with a senior clinician when she requested discharge - recommendation that anyone declines admission when advised should be escalated to senior reg/consultant for review.

MBRRACE Reportable Loses Q4

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
4	10	Miscarriage	23+1	Unxeplained	PMRT, MBRRACE	A, A EPAC scan dated her early - no interface between viewpoint gynae and viewpoint maternity. No IT solution. Pregnant people to inform community midwives if EPAC scan shows variance to dates.
4	11	Stillbirth	25+2	Unexplained	PMRT, MBRRACE	Baby 2: A, A
4	12	Neonatal death	26+0	Extreme Prematurity	PMRT, MBRRACE	Baby 1: A,B,A Delayed cord clamping not undertaken due to misidentification of twins, presumed demised. - Improve processes to ensure correct identification and clinical management including cord-clamping. Policy and SIM
4	13	Neonatal Death	26+1	Extreme Prematurity	PMRT, MBRRACE	A, B, A Neonatal - Not possible to assess from the notes whether the parents were seen by a consultant. NICU action for education and training.
4	14	Neonatal death	23+1	Extreme Prematurity	PMRT, MBRRACE	B,A, A Communication and interpreting. Ensure interpreter is used.

MBRRACE Reportable Loses Q1

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
1	1	Neonatal Death	20+2	Extreme Prematuirty	CDOP Only	Comfort care only.
1	2	Neonatal Death	34+2	Expected loss, paliative care, FGR, Twins	PMRT, MBRRACE	palliative care only.
1	3	Neonatal death	26+0	Unexplained	PMRT, MBRRACE	
1	4	Stillbirth	26+0	Unexplained	PMRT, MBRRACE	
1	5	Stillbirth	30+0	Eclampsia, Unbooked	PMRT, MBRRACE	
1	6	Neonatal death	23+3	Triplet 3, extremely IUGR following laser	PMRT, MBRRACE	Triplet 3, died at MFT.
1	7	Neonatal death	23+3	Triplet 2, Born MFT, transferred to Kings for Surgery.	PMRT, MBRRACE	Triplet 2 died - June - Kings
1	8	Neonatal death	23+3	Triplet 1, transferred to Kings for Surgery.	PMRT, MBRRACE	Triplet 1 - died Kings July.
1	9	Neonatal death	23+2	Extreme Prematurity	PMRT, MBRRACE	
1	10	Stillbirth	31+2	Antepartum haemorrhage,	PMRT, MBRRACE, MNSI	Reviewed and standardised perimortem section packs and obstetric emergency grab bags to ensure all essential equipment present for emergency use and staff awareness. Review and updated Obstetric Emergency escalation call list.
1	11	Miscarriage	22+4	Unexplained	PMRT, MRRACE	

CNST Year 7 – Eligible MBRRACE Reportable Losses (PMRT Generated Report)

Case ID	Surveillance case status	Date surveillance first closed	Review status	Eligible for CNST standards	Working days to notify	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report published	Standard c published deadline	External member present
96619	Surveillance complete	27/12/2024	Review complete	Yes	0	Yes	Met	Met	Met	Met	26/06/2025	Met
96501	Surveillance complete	27/12/2024	Review complete	Yes	1	Yes	Met	Met	Met	Met	17/06/2025	Met
96440	Surveillance complete	27/12/2024	Review complete	Yes	1	Yes	Met	Met	Met	Met	11/06/2025	Met
96791	Surveillance complete	16/01/2025	Review complete	Yes	2	Yes	Met	Met	Met	Met	06/07/2025	Met
96790	Surveillance complete	16/01/2025	Review complete	Yes	2	Yes	Met	Met	Met	Met	06/07/2025	Met
96922	Surveillance complete	17/01/2025	Review complete	Yes	1	Yes	Met	Met	Not met	Met	14/07/2025	Met
97041	Surveillance complete	20/02/2025	Review complete	Yes	0	Yes	Met	Met	Met	Met	23/07/2025	Met
97358	Surveillance complete	21/02/2025	Review complete	Yes	1	Yes	Met	Met	Met	Met	17/08/2025	Met
97285	Surveillance complete	21/02/2025	Review complete	Yes	1	Yes	Met	Met	Met	Met	11/08/2025	Met
97711	Surveillance complete	18/03/2025	Writing report	Yes	1	Yes	Met	Met	Met	Not yet met	11/09/2025	Met
97457	Surveillance complete	25/03/2025	Review pre-published	Yes	0	Yes	Met	Met	Baby born in different trust so n/a	Baby born in different trust so n/a	Not applicable	Baby born in different trust so n/a
97854	Surveillance complete	29/03/2025	Reviewing	Yes	2	Yes	Met	Met	Met	Met	30/09/2025	Met
97854	Surveillance complete	29/03/2025	Writing report	Yes	2	Yes	Met	Met	Met	Not yet met	19/09/2025	Met
97622	Surveillance complete	29/03/2025	Review complete	Yes	1	Yes	Met	Met	Met	Met	04/09/2025	Met
97573	Surveillance complete	29/03/2025	Writing report	Yes	0	Yes	Met	Met	Met	Not yet met	01/09/2025	Met

CNST Year 7 – Eligible MBRRACE Reportable Losses (PMRT Generated Report)

Case ID	Surveillance case status	Date surveillance first closed	Review status	Eligible for CNST standards	Working days to notify	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c report published	Standard c published deadline	External member present
97566	Surveillance complete	29/03/2025	Writing report	Yes	0	Yes	Met	Met	Met	Not yet met	28/08/2025	Met
97057	Surveillance complete	02/04/2025	Review complete	Yes	1	Yes	Met	Met	Not met	Met	23/07/2025	Met
98080	Surveillance complete	09/04/2025	Reviewing	Yes	1	Yes	Met	Met	Met	Not yet met	07/10/2025	Met
98199	Surveillance complete	17/04/2025	Writing report	Yes	0	Yes	Met	Met	Met	Not yet met	17/10/2025	Met
98682	Surveillance complete	21/05/2025	Reviewing	Yes	2	Yes	Met	Met	Met	Not yet met	22/11/2025	Not yet met
98682	Surveillance complete	21/05/2025	Reviewing	Yes	2	Yes	Met	Met	Met	Not yet met	18/11/2025	Not yet met
98712	Surveillance complete	23/05/2025	Reviewing	Yes	0	Yes	Met	Met	Met	Not yet met	23/11/2025	Not yet met
98500	Surveillance complete	02/06/2025	Reviewing	Yes	0	Yes	Met	Met	Met	Not yet met	09/11/2025	Not yet met
98899	Surveillance complete	21/06/2025	Reviewing	Yes	0	Yes	Met	Met	Met	Not yet met	06/12/2025	Not yet met
99041	Surveillance complete	10/07/2025	Ready for review	Yes	0	Yes	Not yet met	Not yet met	Not yet met	Not yet met	18/12/2025	Not yet met
99439	Surveillance complete	17/07/2025	Reviewing	Yes	1	Yes	Met	Met	Met	Not yet met	16/01/2026	Not yet met
99362	Surveillance complete	19/07/2025	Reviewing	Yes	0	Yes	Met	Met	Met	Not yet met	12/01/2026	Not yet met
99331	Surveillance complete	19/07/2025	Reviewing	Yes	1	Yes	Met	Met	Met	Not yet met	08/01/2026	Not yet met
99372	Surveillance complete	29/07/2025	Reviewing	Yes	1	Yes	Not yet met	Not yet met	Baby born in different trust so n/a	Baby born in different trust so n/a	Not applicable	Baby born in different trust so n/a

NHS
Medway
NHS Foundation Trust

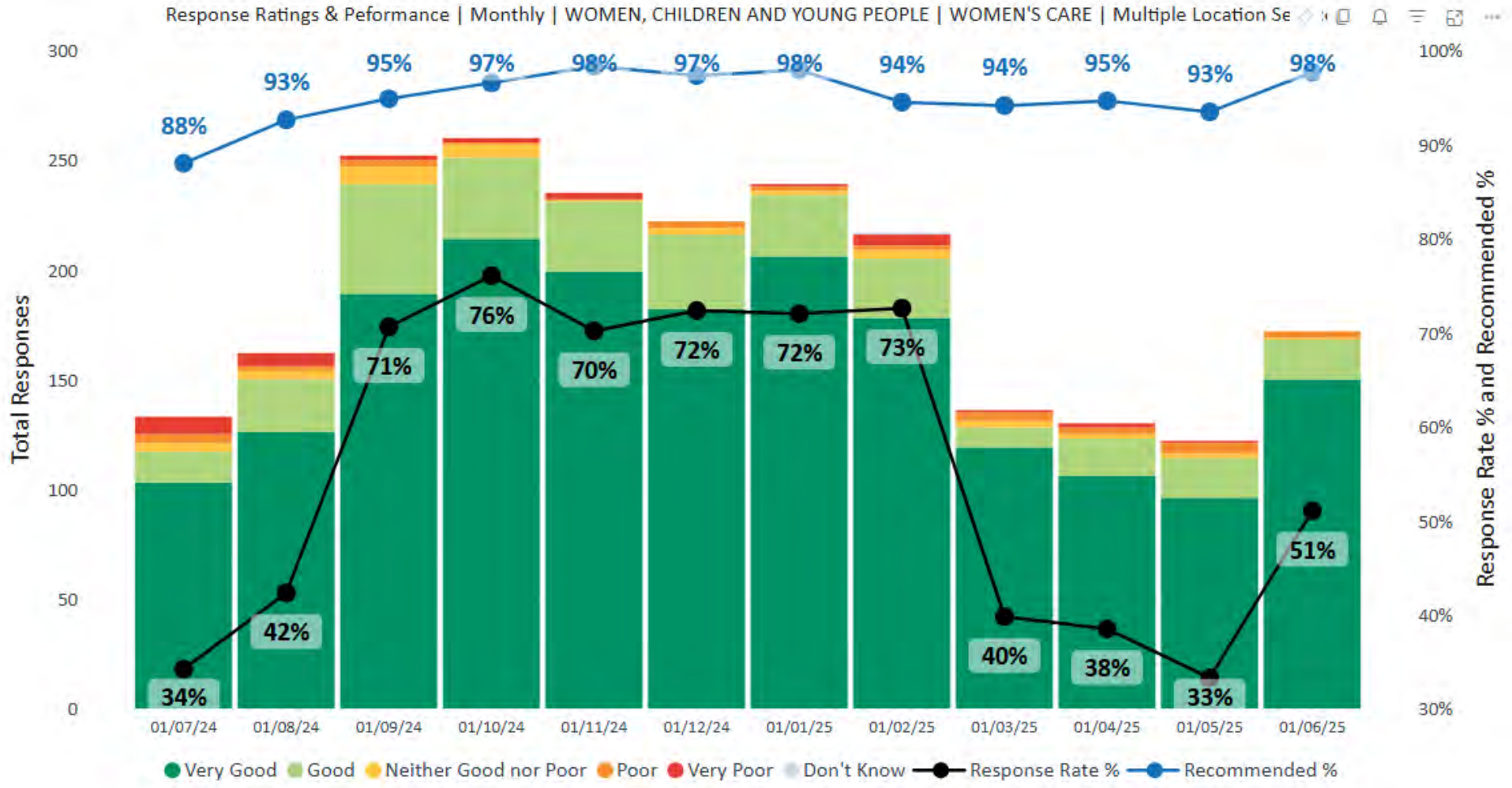
Service User, MNVP and Staff Feedback Perinatal Leadership

Patient FIRST

Perinatal Surveillance Tool Data Q1 2023/24– Service User Feedback – Maternity FFT

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

Medway NHS Foundation Trust



Perinatal Surveillance Tool Data q1 25/26– Service User Feedback

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

Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

Family and Friends Test Comments - Q1 25/26

NHS Medway NHS Foundation Trust

Antenatal Community

"From the beginning, throughout my pregnancy and both during and after birth the all saints midwife team have been an amazing support. Any questions or concerns they listened to and helped me navigate. They took the time to get to know me and I felt comfortable in their care. Special mention for both Jayne and Amy who are a credit to their job and the team. They made me feel so at ease throughout this entire journey and generally showed they cared about me and my baby. I shall miss seeing them often but already know that if I was to have another baby I would want them as my midwives again"

Pearl Ward:

"Everyone was very kind and helpful, no question was made to feel silly for asking. Both mum dad and baby was looked after and spoken too with respect. Amazing staff who go out of their way to make you feel comfortable and safe and all exactly on time with when the next meditation times they come round so they kept on the roll so everyone knew what they was doing. It was also such a calm relaxing and quiet ward which perfect in order for mum and baby to get better."

Delivery Suite:

I have a rare genetic condition that requires complex medical treatment, my condition is unknown to many medical professionals but the team liaise well with my specialists in another county to ensure my medical needs are met.

Fetal Medicine

The staff are just so helpful and considerate, every single time and every single other member of staff we come across never fail to make you feel as welcome and comfortable as possible. I don't feel no matter how praised they are it would ever be enough. Thank you to everyone single one of you

Kent Ward:

"I felt listened to by everyone who i encountered during my care. The team explained the risks and benefits to every aspect of my care and reminded me often of my choices whilst still providing clinical guidance and advice. I thought the team worked well together, particularly in the event of an emergency. We were blown away by everyone's response when the birth required immediate intervention. The team remained calm, professional and dedicated to saving my baby and I. Everyone was compassionate and kind."

The Birth Place:

"Midwife who delivered baby and whole team were incredibly kind caring and compassionate. Completely listened to me and my needs. So happy I delivered here and could praise the ward enough."

"Everything. From the minute we arrived to being discharged was brilliant. I was guided through my labour and birth and told everything that was happening afterwards from being sutured to mine and my new-borns checks."

Perinatal Surveillance Tool Data Q1 25/26– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

Key Messages:

- Very positive family and friends responses, with positive comments, increased response and recommend rate.
- Positive improvements noted:
  - Praise for care on postnatal ward.
  - Care planning for complex patients
  - Families felt they were listened to, their concerns were heard and acted upon and they felt involved in their care planning.
  - Positive feedback for women on additional scanning pathways in fetal medicine.
  - Positive feedback for community midwives and excellent antenatal care provision.
  - Positive feedback from bereaved families regarding compassionate care, supporting them with their emotional needs and emergent medical concerns.
  - Positive feedback from patients receiving care across multiple teams.

Issues, concerns, gaps:

- Lack of continuity between consultants resulting in conflicting plans of care
- Concerns raised regarding cleanliness, particularly of bathrooms.
- Temperature on the wards and waiting areas uncomfortably hot.
- Delays in discharge process.
- Incorrect information regarding appointments causing delays in care or follow ups
- Long waiting times in MCU/Antenatal Clinic

Actions and improvements

- Consultant ward rounds on antenatal ward now ring-fenced to support consultant attendance and feedback shared with consultants to ensure awareness of care planning and communication to patients.
- Improvement to bathrooms included in estates work being undertaken across hospital.
- Review of appointment information provided to service users alongside MNVP to ensure patients are aware what the appointment will entail, any procedures that may need to take place as well as clear information regarding time and place.
- Ensure waiting time boards in Antenatal clinic are updated with waiting times.
- Review of MCU clinical as part of MCU/Triage QI project. Separate pathway now in place for planned MCU attendance and emergency/unplanned attendances.

Perinatal Surveillance Tool Data Q4 2024/25– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

MEDWAY Maternity Voices
Working in partnership to improve maternity services

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
  - Maternity Triage/MCU QI Project
  - Co-production of CQC Picker Survey Action plan.
  - Working with EDI & PE Midwife to engage with BAME and other diverse service users.
  - Ongoing work on Communications project.
  - Birth After caesarean section pathway.
- Service user representative on LMNS Equity and Equalities stakeholder group.
- Ongoing review of Patient information leaflets.
- MNVP lead on MNSCAB bi-monthly for service user feedback update.
- Positive service user feedback received regarding:
  - Community midwives
  - The Birth Place – “wonderful and calm”
  - “Great antenatal classes, really informative and enjoyable”
  - “Clear communication about induction”
  - Kindness and compassion of staff.

Issues, concerns, gaps:

- ICB currently unable to fund additional MNVP role (0.5WTE Band 7 Governance lead) to meet requirements of CNST Year 7 and Year 8 with regards to supporting MNVP quoracy at key Maternity and Neonatal Trust level meetings.
- MNVP lead role at risk at MFT due to incorrectly being on fixed term contract. Contract extended to September. Awaiting outcome of ICB Strategic Commissioning Group for next steps.

Actions and improvements

- MNVP resourcing added to MFT risk register to highlight and escalate risk to organisation should the ICB not continue to support the required resource.
- Senior team working with ICB colleagues to develop options appraisal to be taken to ICB Strategic Commissioning Group.
- MNVP supported service user to attend MNSCAG in Q1 to share long-term impact of perineal injury. Video to be used to support training and learning for all staff.
- MNVP to support Insight visit in September.

Perinatal Surveillance Tool Data Q1 25/26– Staff Feedback & Perinatal Leadership

Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

Goal: To ensure staff feedback forms and integral part of service improvement

Key Messages:

- Board Level Safety Champion Walk Arounds ongoing, including virtual and face to face sessions. Positive feedback in session held in quarter, with staff feeling well supported by leadership team, with clear routes of escalation and approachability.
- Teams Talks Continue monthly – ADOM and DOM provide updates on actions and concerns previously raised, along with key updates on service and staffing developments for staff. Staff are given the opportunity to share both positive and negative feedback and actions are derived from these discussions as required.
- "You said, We listened" posters updated June 2025 and displayed across unit and shared via Maternity Matters to update staff on actions taken following concerns raised including:
    - Update to diabetes care flow charts following staff feedback that they were difficult to follow.
    - Review of IOL pathway following admission based on staff and service user feedback that the process could be delayed once a patient commenced the IOL process. Change of agent for induction being introduced with training videos developed by IOL midwife and consultant midwife.
    - K2 taster sessions and system video made available to all staff to review prior to entering procurement process.
- Student feedback – felt well supported by the education team. Safe learning environment charter (SLEC) focus group held.

Issues, concerns, gaps:

- Students reported via SLEC focus group that practice supervisors needed more training to better support their learning needs. .
- Longstanding concerns regarding Maternity Information system from staff.
- Staff concerns regarding estates including condition of flooring, equipment and temperature.
- Staff acknowledge challenging skill mix across department currently and need to support newly qualified staff.
- Unable to recruit to vacancy in line with Trust external recruitment freeze.

Actions and improvements

- Practice supervisor training and PS/PA updates provided by Canterbury Christchurch university available for all midwives to attend.
- Student Midwife Practice Development Midwife holding monthly PS/PA drop in sessions for training.
- Education team developed communications for all staff on key ways to support students and encourage learning and patient safety.
- Supported by Board Level Safety champions to process request for external recruitment for midwifery staff. This has now been approved and future vacancies can be advertised without delay.

Perinatal Surveillance Tool Data Q1
25/26– Staff Feedback & Perinatal Leadership

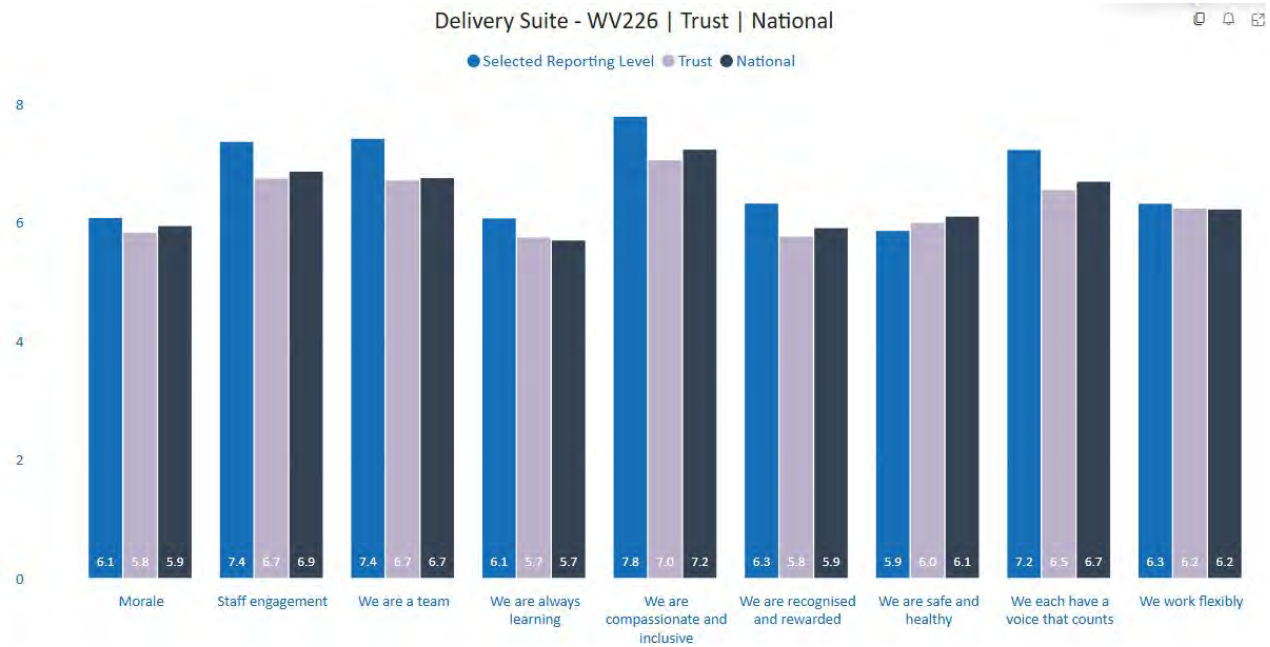
Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

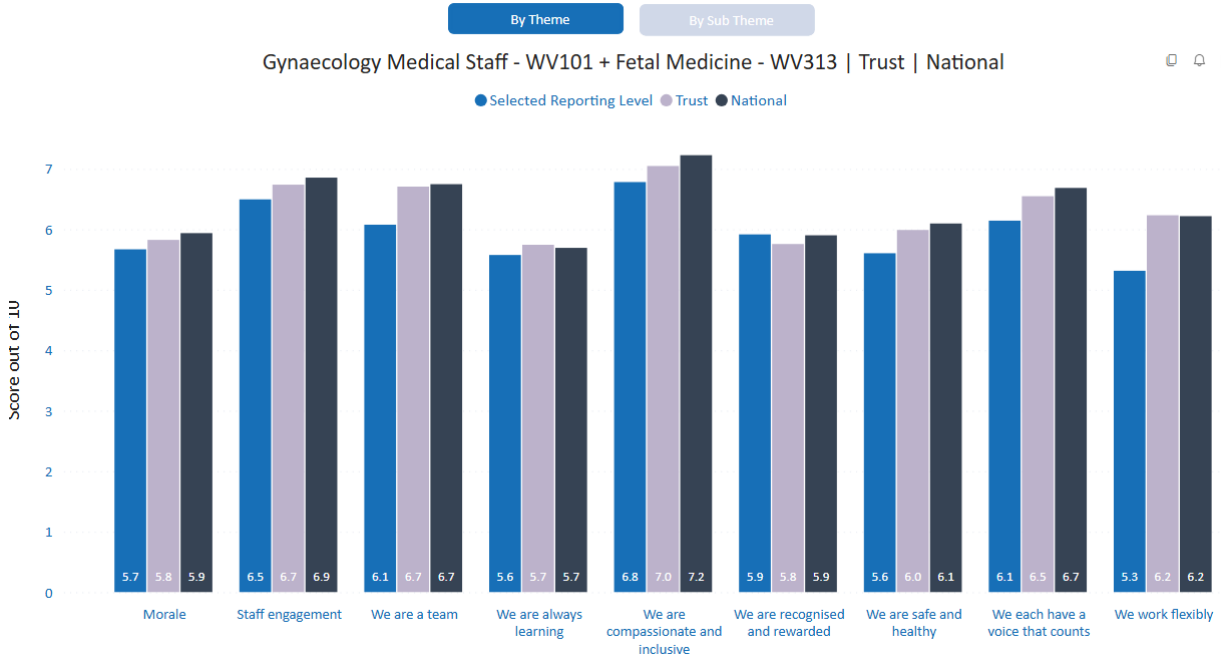
Goal: To ensure staff feedback forms and integral part of service improvement

Medway NHS Foundation Trust

Key Messages:

- Board Level Safety Champion Walk Arounds ongoing, including virtual and face to face sessions.
- Positive staff survey results with midwifery staff responding more positively across 8/9 themes than both Trust and national average. Medical staff fell below Trust and national average for 8/9 questions. Clinical Director with the support of speciality leads to review actions to ensure targeted work in place.
- Divisional driver in place to reduce incivility – monitored weekly.





Perinatal Surveillance Tool Data Q1
25/26– Staff Feedback & Perinatal Leadership

Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.

Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway NHS Foundation Trust

Key Messages:

- The perinatal quality oversight model requires annual reporting on the following:
  - Percentage of midwives would agree or strongly agree that they would recommend MFT as a place to work. For both agree and strongly agree midwives rank above the Trust and national average.- **2024 Survey – 78.64%**
  - Percentage of midwives who would recommend the organisation to family or friends who require treatment. Again this ranks above the Trust and national average- **2024 Survey 77.59%**
  - Proportion of speciality trainees in obstetrics and gynaecology responding with “excellent” or “good” on how they would rate the quality of clinical supervision out of hours (reported annually). **2025 GMC Survey – 82.22%.** This is a positive response and above the IQR. Overall response rate for the survey was also positive, at 73%. . Obstetric and Gynaecology team also received a Highly Commended award from RCOG for their training.


Royal College of Obstetricians & Gynaecologists

Certificate

This is to certify that

Medway Maritime Hospital

has been recognised in the TEF 2025 results as

Highly commended for the Gynaecology and Obstetrics award in the Medium-sized hospitals category

by the

Royal College of Obstetricians and Gynaecologists

Dr Ian Scudamore
Vice President, Education

Dr Ranee Thakar
President

Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London, SE1 1SZ

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		Survey Year	2022		2023		2024		2025	
Trust/board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Medway NHS Foundation Trust - RPA	Medway Maritime Hospital - RPA02	Clinical Supervision out of hours	84.38	Within IQR	81.15	Below	82.64	Within IQR	82.22	Within IQR

Actions and next steps :

- 2025 GMC survey published in July 2025. All responses with IQR.
- College tutor to share results with consultants and work alongside clinical leads to develop an action plan for any areas that require improvement.
- To report to Trust Board as part of medical education reporting.

Safeguarding

NHS Medway NHS Foundation Trust

Patient FIRST

Safeguarding – Maternity

Key Messages:

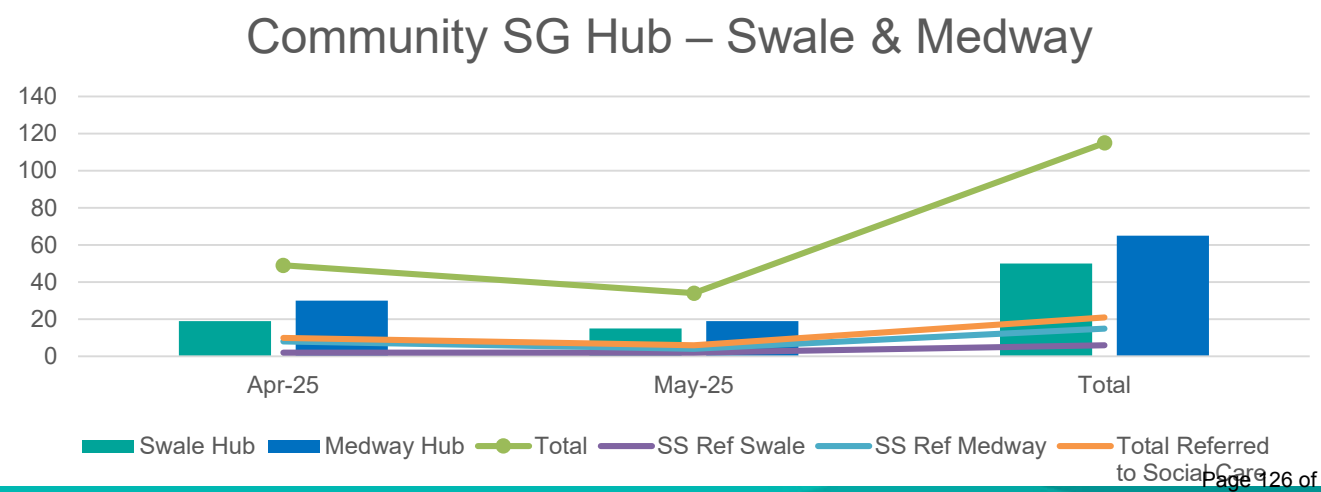
- The Maternity Safeguarding Team continue to be more visual on the wards with face to face ward rounds and facilitating of meetings. With the continuation of attending Community Teams meetings with updates of relevant safeguarding issues and for any questions the teams may have. There is a hope that Social Care will attend each team meeting for some bespoke training regarding making referrals and highlighting concerns. The team also continues to work closely with Team Connect to ensure that the Safeguarding service and care we provide is effective and always developing.

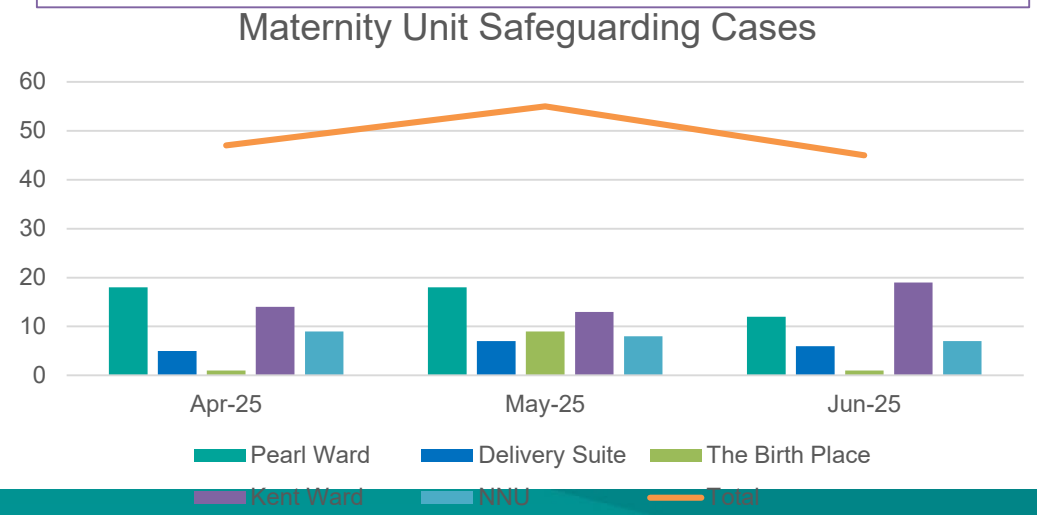
Issues, Concerns & Gaps:

- The number of referrals to our Midwifery hub has slightly increased in this quarter. Requesting information from Social Care remains an obstacle to our midwifery teams. However, contact has been made with the MASH team Manager Sarah Featherstone to see how we can work together as a service in order to aid this issue. If they are able to facilitate the bespoke training as discussed above this should have a positive impact in the hub referrals being received. The safeguarding team continue to work closely with Team Connect with regards to the referrals and transfer of care

Actions/Improvements :

- The Did Not Attend (DNA) audit for six months has been completed within the first quarter. The Maternity compliance of the policy has improved with 71% of DNA checklists bring completed, this is a 53% increase from the previous audit findings. With a total of 15% of DNA checklists not commenced. Work remains on going, and the maternity safeguarding team continue to re-iterate the importance of following the DNA pathway.
- Adults Level 3 Safeguarding training is at 87.86%.
- Children's Level 3 Safeguarding training has increased to 86.78%.
- The re-audit for safe sleeping documentation has been conducted, the results have shown great improvement. The Maternity Safeguarding Team continue to discuss this within essential skills, supervision and the Maternity matters publication to ensure all staff are aware of their responsibilities with sharing safe sleeping information. A re-audit is due in August 2025.

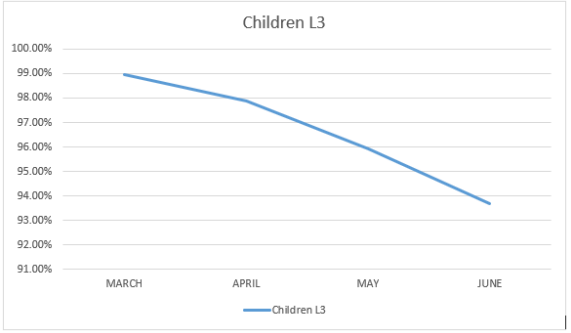




SIOR - Patients

Successful Deliverables

- 4 inpatients with safeguarding concerns (June)
- Safe guarding Level 3 staff statman compliance 93.68%
- Safeguarding guidelines all updated



Next Steps

SG L3 compliance:
MARCH 98.94%
APRIL 97.87%
MAY 95.92%
JUNE 93.68%

Identified Challenges

- Reduction in staff compliance - 8 nurses expired – 3 are new recruits
- Neonatal Abstinence Syndrome – Documentation on Finnegan Scoring training for nursing team
- Accurate nursing documentation in one set place for all safeguarding patients, including accurate details of all visitors including full name, relation to the family, visiting times and interactions.
- Afternoon court hearings (2-4pm,) for babies is delaying the discharge process with social care to foster/baby family placements

Next Steps

- Continue to work in partnership with NICUs within ODN
- Create a work schedule to ensure guideline are reviewed and updated as required
- Medway Social Care have met with Judges – Judges agreed to baby court hearings to be heard in the mornings to reduce any delays in discharge

Opportunities

- Provide NICU specific Safeguarding training twice a year on NICU Medical Team new doctors induction from March 2025 to share the importance of accurate documentation and consent.
- Collate data of safeguarding babies to determine how many days babies are remaining on the unit between being medically it for discharge and discharged with social care involvement.
- NAS training for nursing team to be arranged with Neonatal Consultant with speciality.

Next Steps

- Continue to work closely with the multi professional team, ensure SS are aware of when a baby is medically fit for discharge
- Continue to support team to complete training
- Safeguarding team to provide safeguarding supervision on nursing team days throughout the year

Risks

- Gaps in training for foster carers and Mother and Baby Units in terms of infant feeding advice once baby leaves the NICU.
- Risk Visitor forms not being completed correctly.
- Risk visitor forms to be shared with Security once baby admitted to NICU

Next Steps

- Ensure full and concise information sharing within the MDT
- Work with social workers as well as families as partners in care
- Ensure the security team are aware of any families of concern
- Audit documentation

Conclusions and Next Steps

- This quarter has demonstrated continued progress in our commitment to delivering safe, high-quality perinatal care.
- Key improvements in clinical outcomes, compliance with national standards, and service user feedback reflect the dedication of our multidisciplinary teams.
- Multidisciplinary reviews of key incidents continue within the quarter and work to identify learning and actions at the time of incidents, demonstrating our commitment to learning and continuous improvement.
- Review of data with regards to Ethnicity and deprivation scores has identified further work in particular with regards to rate of PPH experienced by black women and those in the lowest MDD, and the proportion of families in lowest MDD who have an unexpected term admission to the neonatal unit.
- Gaps in compliance with CNST Safety Action 1 have been addressed and compliance with this standard is anticipated by the end of CNST Year 7.
- All eligible MBRRACE reportable/PMRT cases have been included in the report, including details of actions and learning, including a deep dive review of Neonatal Deaths in Q1.
- Service user and staff feedback continue to drive service improvement and development.
- Staff survey results and GMC survey results as required by PQOM showed positive responses from both midwives and obstetric trainnes.
- Continue with monthly reporting to MNSCAG and Trust Board via the IPQR slides which contain all the key information required as part of the PQOM minimum data set.
- Report for onward reporting to Trust Board as per CNST year 7 requirements.

Medway NHS Foundation Trust

Cultural Review

Prepared by:
Sylvia Stevenson
Director, Absolute Diversity

September, 2025
Updated Timetable

> Transformation is not about becoming something new. It's about becoming true to values we claim, but have yet to live.

SYLVIA STEVENSON

Timing is about choosing the right moment to act - whether that's starting, stopping, or finishing something - to get the best result. In today's organisations, timing can be the difference between success and failure. It's about being ready and aware of the bigger picture.

The ancient Greeks had two words for time: ***Chronos*** - measured and data-driven, and ***Kairos*** - focused on meaning and urgency. Chronos counts minutes; Kairos captures moments. One plans what's important, the other acts when it really matters.

In a world shaped by political shifts, financial pressures, rising expectations, and workforce challenges, timing is more important than ever. These aren't just background issues - they are the environment in which change must take place. Within this landscape, Kairos moments emerge - those windows of opportunity where bold choices and cultural shifts can create lasting change.

It's been a real pleasure partnering with Medway NHS Foundation Trust in this first part of their Cultural Transformation journey. Having worked with private sector organisations across the UK and globally, I've come to appreciate even more the vital service the Trust provides to thousands each day. It's been a meaningful and eye-opening experience engaging with staff and leaders, and gaining deeper insight into the complexities of patient care.

This is a key moment for Medway NHS Foundation Trust to respond to the changing needs of its people and services. The challenge is: will the Trust adapt gradually (Chronos), or step boldly into meaningful cultural transformation (Kairos)?

I trust this report will help shape the top priorities and guide the next phase of the Cultural Transformation Programme.

Sylvia Stevenson

Certified Diversity Practitioner/Consultant

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Introduction

A cultural review gives us more than answers – it gives us insight. In a time where expectations around inclusion, fairness, and wellbeing are rising, it's easy to assume we're doing enough. But culture is often shaped by what goes unspoken, unnoticed, or unquestioned. That's why this review matters.

By stepping back and listening carefully, we can see not just how things work on paper, but how they feel in practice. A cultural review creates space to explore what's really driving behaviours, where barriers still exist, and what needs to shift for everyone to thrive. It's not about blame — it's about clarity, growth, and the courage to do better.

This review doesn't aim to repeat what's already been said. It aims to spark honest reflection and challenge comfort zones. It calls on leaders to think differently: not just about policies and programmes, but about the hidden dynamics that reward sameness, overlook difference, and resist change. It invites us to build something more enduring — a culture where inclusion is not the goal, but the way we do things.

Medway Maritime Hospital is one of the largest and busiest hospitals in Kent, serving a local population of over 500,000 people across Medway and Swale. As part of Medway NHS Foundation Trust, the hospital provides a wide range of acute and specialist services, delivered by over 4,000 staff from a rich mix of backgrounds and cultures. This diversity strengthens the hospital's ability to meet the varied needs of its patients, both in densely populated urban areas and in more rural communities.

Medway is part of the Kent and Medway Integrated Care System, working with partners to deliver joined-up health and care. As demands grow and expectations change, the Trust recognises that real cultural transformation is essential - not just in what it says, but in what it does every day. Inclusive values, staff wellbeing, and long-term sustainability are all part of this shift. The cultural review is an important step in identifying what needs to change, enabling the Trust to build a workplace culture where everyone can thrive and deliver even better care to patients.

Why Culture Matters

Culture has long been listed as a 'priority' across health and social care, yet too often, it's treated as an abstract concept - discussed at conferences, measured in surveys, and then quietly sidelined when operational pressures take centre stage. But culture isn't a "nice to have" or a staff engagement tick-box. In today's world, it's the invisible force that decides whether we sink or swim.

Culture isn't defined by what's written on the walls, but by what happens in the corridors, in the clinics, and behind closed doors. What does culture really mean in a post-pandemic, digitally accelerated, increasingly intersectional NHS workforce?

- **Culture is the silent architect of safety and risk:** In a high-pressure system like the NHS, it's culture - not process - that determines whether people speak up or stay silent. Whether they escalate or self-censor. Whether they cut corners or ask for help. We've seen time and again that well-written protocols don't protect patients. Cultures that practice psychological safety do.
- **It shapes behaviour, but it's measured by belonging**: In a rapidly diversifying workforce and patient population, 'culture fit' is no longer a valid goal. We need cultures of belonging where people don't feel they have to mask parts of themselves to be accepted. This means engaging meaningfully with issues like racial trauma, neurodivergence, gender identity, lived experience, and systemic power imbalances - not through surface-level initiatives, but through sustained, honest, and embedded practice.

" Culture change is not an initiative. It is the outcome of sustained leadership, consistency, and trust."
Professor Michael West
The King's Fund

- **Culture determines whether people stay or leave:** Retention is now a survival issue. It's not just about pay or workload - it's about how people feel when they come to work. Are they heard? Are they safe? Are they trusted? Are they allowed to challenge constructively? A culture that drives out the most passionate staff isn't broken - it's working exactly as designed.
- **Culture is a mirror and a magnifier:** What people say in private about the Trust says more than strategy documents ever will. Culture is reflected in the stories staff tell, the 'norms' they follow, and the unwritten rules they obey. It magnifies what leadership tolerates - not what it claims to value. If exclusion, blame, or burnout go unchecked, they become accepted practices.
- **Culture reflects how leadership responds or reacts**: In moments of pressure, challenge, or dissent, culture is revealed in how leaders choose to respond. Do they listen, acknowledge, and take meaningful action, or do they deflect, delay, or deny? A poor culture enables avoidance, defensiveness, or silence. A healthy culture equips leaders to face discomfort with courage and transparency. Ultimately, the way leaders react sets the tone for whether trust is built or broken across the organisation.

Medway NHS Foundation Trust's Cultural Transformation Programme is a 3–5-year plan to improve workplace culture by addressing deep-rooted issues such as violence, aggression, racism, and inequality. It also aims to ensure policies and processes are applied fairly and consistently across the Trust, while improving the Equality, Diversity, and Inclusion (EDI) strategy to support lasting, meaningful change.

Phase 1 of the programme focused on gaining a clear understanding of the current culture within the organisation. This involved listening to staff across all levels, running a bespoke diversity survey, and supporting the Board to take part in a cultural competence self-assessment. This work helped leaders reflect on how they lead diverse and dynamic teams and provided vital insights to guide the next stage of the programme.

Phase 1 was shaped by two key problem statements:

- **Problem Statement 1**: There is a growing perception within the Trust of an increase in incidents involving violence and aggression towards staff from patients and their relatives. The programme aims to create a safer working environment by addressing root causes and putting in place sustainable measures to support staff wellbeing - especially for those in patient-facing roles.
- **Problem Statement 2:** Despite some improvement in the Trust's Workforce Race Equality Standard (WRES) profile, significant concerns remain about the overall organisational culture. Staff have raised concerns about the inconsistent and sometimes inequitable way policies, (such as those related to recruitment, performance, disciplinary processes, and flexible working), are understood, interpreted, and applied. These concerns extend beyond race and touch on a range of protected characteristics, highlighting the need for broader cultural change across the organisation.

These problems formed the basis of engaging the workforce through feedback, lived experiences, and data, creating a strong foundation for the next phase of cultural improvement.

Why Data Matters

Data doesn't just count people - it reveals patterns, blind spots, and missed opportunities. When used well, it helps organisations see what's really happening beneath the surface of their workplace culture. It highlights where talent may be held back, where processes are not applied fairly, and where valuable staff may be lost without clear reasons.

This goes beyond fairness and extends to how well the organisation functions. Inequity often leads to inefficiency. When certain groups face barriers that others do not, it can result in higher costs, increased turnover, and lower staff engagement. By examining data across key areas like recruitment, promotion,

complaints, and retention, organisations can better understand where inequalities and inefficiencies intersect.

Strong data leads to stronger decisions. It helps leaders move beyond assumptions and target action where it matters most - not only to improve inclusion, but to build a more effective, accountable, and financially sustainable organisation.

Case Study: How Poor Culture Is Costing the NHS Millions

A 2023 study by Liverpool John Moores University looked at how much poor workplace culture, including violence, harassment, and abuse, is costing the NHS. The research focused on England during 2021/22 and found major financial losses linked to how staff are treated at work. [Source: Liverpool John Moores University Report

Key findings:

- **£1.36 Billion Lost in One Year:** Violence, harassment, and poor treatment at work cost the NHS around £1.36 billion in 2021/22. This includes money lost from people taking time off, being less productive, or leaving their jobs.
- **£332 Million from Staff Off Sick:** Time off taken by staff due to poor workplace behaviour and stress led to a loss of over £330 million. A culture that harms staff health also harms the bottom line.
- **£148 Million Lost to Turnover:** When staff leave because of poor culture, it costs the NHS more money in recruitment, training, and the loss of experience — adding up to nearly £150 million.

This research shows that poor culture doesn't just affect people, it affects performance. A safe, respectful workplace isn't a "nice to have"; it's essential for keeping good staff, delivering high-quality care, and protecting NHS budgets. When workplace culture breaks down, the financial consequences are real and measurable - from sickness absence and low morale to staff turnover and service disruption.

For today's NHS leaders, this means adopting a more business-savvy approach to workforce and culture. Leading with compassion must go hand in hand with operating with business acumen. Understanding the financial impact of poor culture is essential to making smarter decisions, setting clearer priorities, and investing in what really matters – people!

In a system under financial pressure, culture is not a soft issue, it's a strategic one. Leaders who recognise this will not only create better places to work but also drive better outcomes for patients and long-term value for the organisation.

Methodology

The Cultural Transformation Steering Group

The Cultural Transformation Steering Group (CTSG) was established to support the progression of the Cultural Transformation Programme, acting as the voice of the workforce and helping to shape and refine actions through meaningful engagement and feedback. The group has been meeting every two weeks since September 2024 and is made up of representatives from staff networks, clinical and support services, and subject matter experts from across the organisation.

The CTSG plays a vital role in responding to the key problem statements identified in Phase 1 of the programme - including the rise in violence and aggression towards staff and the inconsistent, and sometimes inequitable, way in which organisational policies are understood and applied. By listening to lived experiences and reflecting a broad range of perspectives, the CTSG seeks to ensure that the programme remains grounded in reality and responsive to the needs of staff. As champions for change, CTSG members help build trust, improve accountability, and keep staff voices at the heart of cultural change and transformation.

Phase 1: Data Analysis

The first phase of the Cultural Transformation Programme focused on gathering insight through a range of data sources to better understand staff experiences, views, and the current state of organisational culture. This helped build a clearer picture of what was working well, where there were opportunities for improvement, and where change needed to be prioritised.

Three key engagement activities were carried out to involve staff across the organisation:

1. **A Diversity MOT Cultural Competence Self-Assessment**: This assessment was completed by Executive Leaders, Non-Executive Directors, and Council Governors. Phase 2 will extend the assessment to approximately 55 Senior Leaders across the Clinical Divisions. The first cohort focused on key areas including cultural awareness, inclusion, diversity, diligence, and competence, alongside board-specific questions exploring ownership of their role in shaping and supporting an inclusive culture. The process began in October 2024 and ran through to March 2025. The outcome was a Board-specific development plan, created as part of the Trust's commitment to continual improvement.

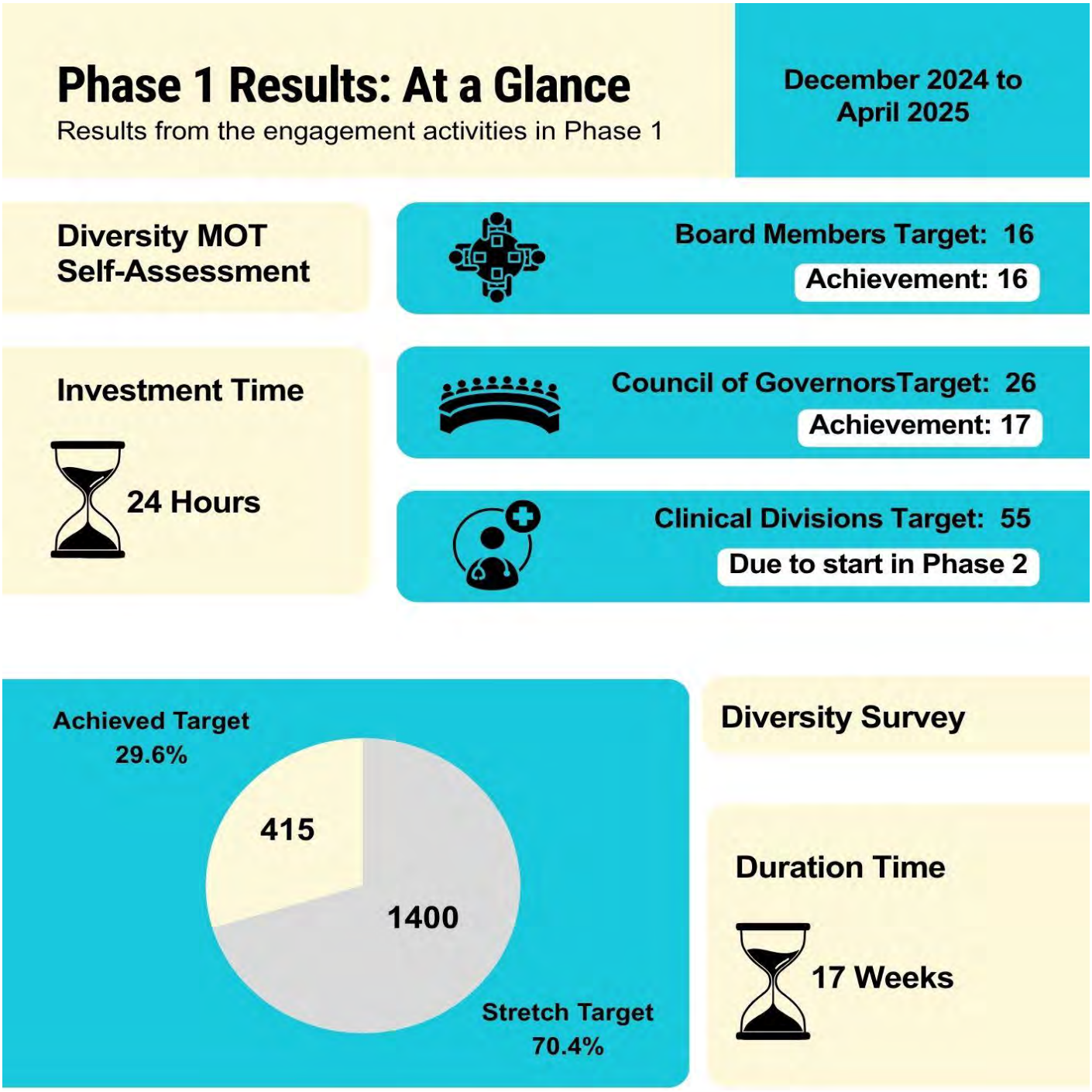
2. **Listening Sessions**: From 10 December 2024 to 30 April 2025, up to 800 staff members from all levels across the organisation were invited to take part in peer-to-peer, one-to-one (1:1), and focus-based listening sessions. These were facilitated by Absolute Diversity Ltd (AD) and delivered both online and in person. The original end date of March 2025 was extended to 30 April due to a positive increase in staff engagement.

   The sessions hosted by AD were anonymous. Where listening took place within team meetings, confidentiality was strongly emphasised to support ongoing efforts to create psychologically safe spaces — allowing staff to share openly without fear of repercussion.

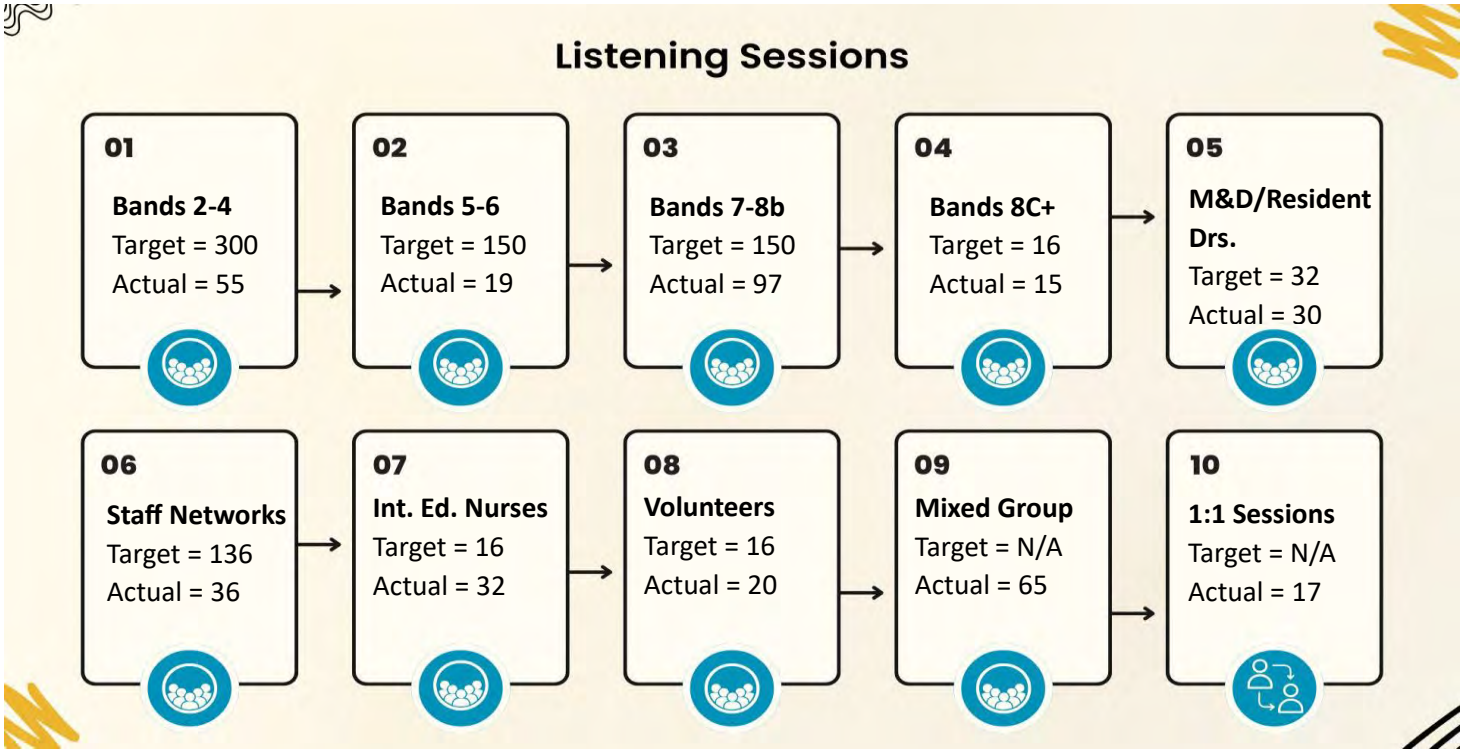
3. **Bespoke Diversity Survey:** Open to all staff, this survey ran from 6 January 2025 to 30 April 2025. It gathered a wide range of views and lived experiences from across the organisation, directly linked to the goals of the Cultural Transformation Programme.

This combined approach ensured that the data gathered reflected voices from across the organisation, including those who are often less heard. It formed the foundation for meaningful analysis and future planning.

Statistical Data Results



The agreed target for listening sessions was a minimum of 800 individuals.



Final Total of individuals who attended a listening session = **386**
Total Sessions= **76**
Actual Investment Time = **100 hrs and 28 mins.**

Please note:

The survey deadline was extended from the end of March to the end of April to give more people a chance to take part.

The Listening Sessions were first planned as a mix of face-to-face and online peer-group sessions, with the option to book private 1:1 sessions. By mid-January, sign-ups were low. It was felt that growing pressure from the ongoing quademic, staff absence, and a definite fear of speaking out were key reasons why fewer people attended, with fear seen as the major contributing factor. Working with the Cultural Transformation Steering Group (CTSG) and Executive leaders, we changed how we ran the engagement sessions. Based on staff feedback, we added more dates and linked some sessions to regular team meetings. This made it easier for staff to take part during their normal working hours.

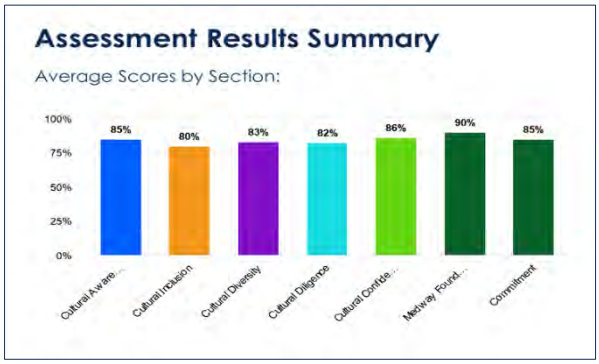
In early March, staff shared that they wanted more opportunity to speak openly with senior leaders. In response, 'Listening with the Board' sessions were introduced for all staff groups and ran from February to April. These sessions gave staff a safe space to share their views and experiences directly with Board members. There is a strong perception that this approach is helping to build trust with staff feeling more heard and a growing interest in continuing the sessions beyond Phase One of the Cultural Transformation Programme.

Analysis

The Diversity MOT Board Insights

Overview

The Board participated in a self-assessment related to Cultural Competence call The Diversity MOT. It was used as a mirror - not to shame, but to reflect. Leaders took time to honestly assess how they think, lead, and engage with difference at a personal, team and organisation-wide perspective.

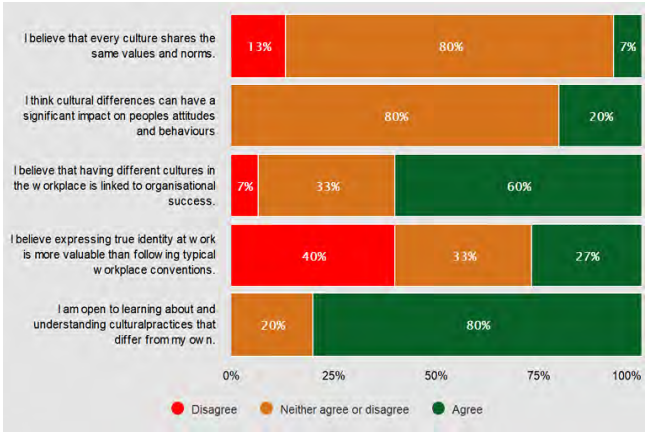


The process was intentionally split between Executive and Non-Executive Board members, allowing for personal and group insights to discussed in an open, honest and safe space.

The Board rated itself most confident in Cultural Confidence (86%), Commitment (85%), and overall leadership behaviours specific to Medway Foundation Trust (90%). Cultural Awareness also scored strongly (85%), showing a belief that cultural differences are well recognised and respected. Slightly lower scores in Cultural Inclusion (80%) and Cultural Diligence (82%) suggest areas where the team sees more room for growth, particularly in creating consistently inclusive environments and using data effectively.

While these scores reflect positive intent and self-belief, it's important to regularly check that perception matches what's really happening day to day. This is where deeper insight from each section helps uncover what's working well and where greater attention may be needed.

Cultural Awareness Team Context Rating: 85%



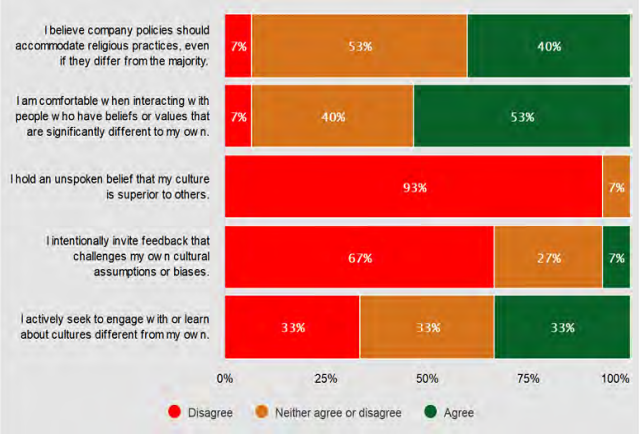
Perception: The team sees itself as having strong cultural awareness.

Example Gap: While the overall score is high, not all respondents felt confident recognising when their own cultural assumptions might influence how they interpret others' behaviour. This suggests room for deeper personal reflection, despite a generally positive self-view.

Why it matters: Without recognising our own blind spots, we risk making decisions that unintentionally exclude or misjudge the people we aim to support.

> "In a world where you can be anything, be inclusive!"

Cultural Inclusion Team Context Rating: 80%

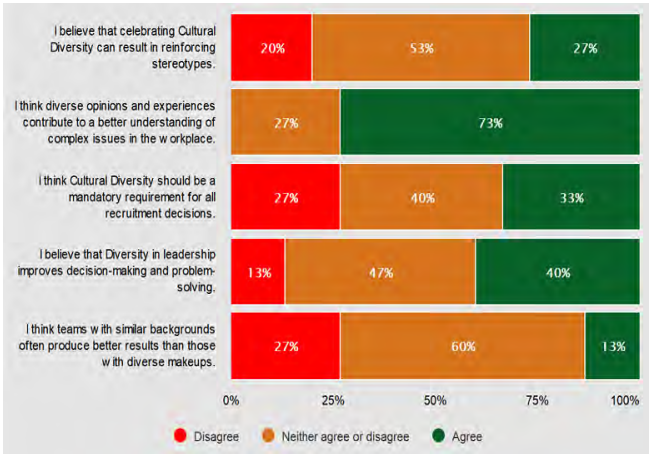


Perception: Leaders believe they are creating inclusive spaces for all.

Example Gap: Some responses showed uncertainty about whether all team members genuinely feel safe to challenge ideas or raise concerns. This highlights that inclusion may be experienced unevenly, even if leaders intend to create a welcoming environment.

Why it matters: If people don't feel safe to speak up, valuable insight stays hidden—and early warning signs may be missed.

Cultural Diversity Team Context Rating: 83%

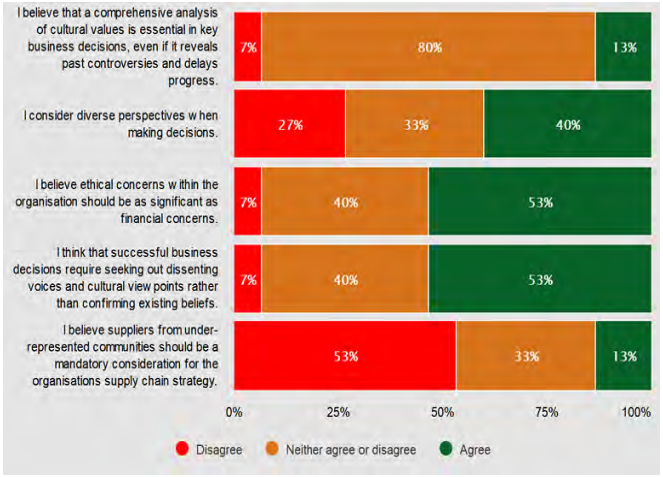


Perception: There is strong value placed on diversity in principle.

Example Gap: Not all leaders felt confident about how to involve diverse perspectives in early decision-making processes. This points to a gap between valuing diversity and actively using it to shape organisational choices.

Why it matters: Decisions made without enough perspective can overlook key risks or needs, even with the best of intentions.

Cultural Diligence Team Context Rating: 82%

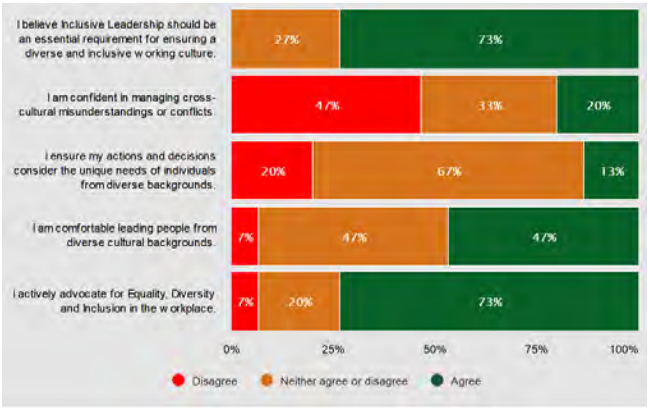


Perception: The team recognises the importance of using data to support fairness.

Example Gap: Responses indicated that while leaders agree with using data, not all are regularly reviewing it to identify patterns or guide action. This shows a potential area for strengthening the habit of using data in everyday leadership, including areas like workforce planning, service delivery, and financial decision-making.

Why it matters: What we don't track, we don't see; and what we don't see, we can't fix, including risks that may quietly impact performance or budgets.

Cultural Confidence Team Context Rating Score: 86%

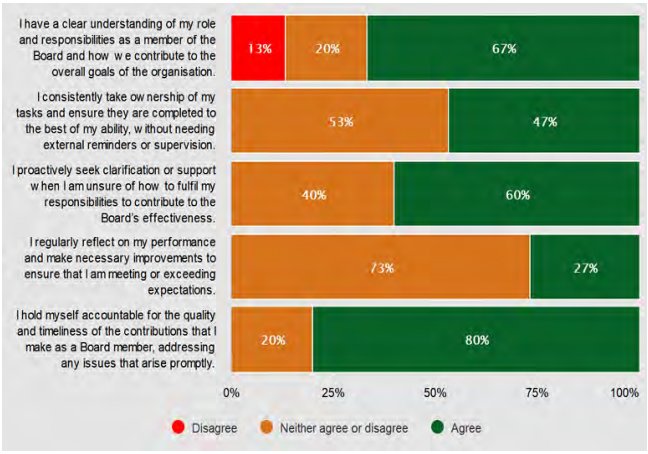


Perception: Most leaders feel confident managing diverse teams.

Example Gap: A closer look reveals that some leaders are less certain about how to handle cultural disagreement or misunderstandings when they arise. This shows that confidence may be situational, rather than consistent across all areas.

Why it matters: When challenges are handled well, trust grows; when they're not, it quietly erodes.

Board-Specific Leadership Team Context Rating Score: 90%



Perception: The Board sees itself as highly committed and accountable.

Example Gap: While commitment is strong, some responses suggest that not all leaders consistently challenge others when fairness or inclusion may be at risk. This suggests an opportunity to turn intent into more consistent action.

Why it matters: Silence at the top can signal that certain issues aren't important - even when leaders care deeply.

The Board's Cultural Competence Rating

The leadership team assessed itself as operating across three stages of cultural competence: **Polarisation, Minimisation, and Acceptance**. This mix shows that while some progress has been made, there are still areas where cultural difference may be misunderstood, downplayed, or only partly acted upon. Each stage presents different risks and opportunities, for patient care, staff experience, and organisational performance. Reaching Acceptance isn't about saying the right things - it's about whether people's lived experiences match what leaders believe is happening. It asks whether different views genuinely shape decisions, or whether they're just noted and moved on from. The real test is whether the organisation can keep learning, stay uncomfortable when needed, and act before issues become patterns. Staying still might feel safe, but it quietly allows old habits to carry on unchecked.

Outcome

The Board agreed on a development plan as follows:

- **Bias Awareness Workshop**: A workshop has taken place, and as a result, four Board members have volunteered to become Executive Inclusion Champions (EICs) and are currently being trained. EICs will help ensure that Equity, Diversity and Inclusion (EDI) shapes every discussion and decision. Their role is to support the Board in leading fairly, reflecting the people it serves, and improving the quality of decisions. One key tool they will use is the NHS EDI Impact Assessment, which supports more inclusive and informed decision-making across the organisation.
- **An Inclusive Leadership Toolkit**: This will be developed during phase two of the programme, following the Diversity MOT rollout to Clinical Leaders. These leaders will be expected to support and upskill their teams by modelling inclusive leadership and management. Leadership is about setting the tone, creating safe environments, and inspiring others through example. Management is about making inclusion part of everyday systems, how people are supported, developed, and held to account. The toolkit will include practical examples of inclusive behaviours for both, helping teams know what good looks like and making it easier to build accountability into daily practice.
- **One-to-One Coaching for Leaders**: Most Executive leaders have now taken part in a one-to-one session with Absolute Diversity. These sessions are helping leaders update and improve their personal and team EDI objectives, in line with the NHS Healthcare Inequalities Improvement (HIA) approach. Ongoing support is available where leaders request it, ensuring tailored guidance continues as needed. This support will remain in place under the current contract, with a view to transitioning into business as usual - where appropriate - once the contract comes to an end.
- **Monthly progress reviews** are now built into Board meetings to ensure updates on the Cultural Transformation Programme are visible, tracked, and regularly discussed. This helps keep the improvement actions front and centre as one of the Trust's top priorities.

The Board Development plan is not about fixing people. It's about noticing patterns, listening well, and being willing to change course. The Diversity MOT shows that the Trust is ready to move from awareness to action—through reflection, responsibility, and results.

The Diversity Survey Insights

A Diversity Survey was launched in January 2025 and closed in April 2025. It was open to all employees across Medway NHS Foundation Trust. The aim was to better understand the make-up of the workforce, what's working well, and where there may be gaps or unfair experiences. The survey also helped the Trust identify actions for improvement. A key focus of the survey was understanding how well the organisation recognises and values people's different backgrounds, experiences, and views—not just in policy, but in everyday working life. This included whether staff feel respected, heard, and treated fairly, regardless of their identity or role. It also explored how cultural differences are acknowledged within teams and leadership. This focus was

especially important in identifying practical ways to reduce incidents of racism, violence, and aggression, by listening directly to staff experiences and learning where support, training, or change may be needed.

The survey included 35 questions in total. Of these: -

- 7 focused on demographic details such as age, gender identity, sexual identity, ethnicity, religion, and disability.
- 20 explored employees' lived experiences in the workplace, grouped into 3 main areas of organisational culture, EDI, and leadership.
- 5 questions covered key issues, asking whether respondents had witnessed or experienced racism, bullying or harassment, sexual harassment, or violence and aggression within inpatient settings. Where respondents said an incident had occurred, they were then asked whether they believed the organisation had responded appropriately.

A total of 415 people completed the survey. While this was lower than expected, it reflects wider challenges in encouraging staff to engage with online surveys - especially during times of operational pressure and when there are concerns about the safety of speaking up.

Staff across different departments and roles were invited to share their thoughts between December 2024 and April 2025. This feedback comes directly from staff through open-ended responses, giving an unfiltered view of how some people are feeling day to day. The feedback was not gathered through structured prompts, which makes the themes that emerged even more important to take seriously. Some of the comments were difficult to read. While there were moments of pride and positivity, much of what was shared focused on discomfort, inconsistency, or a lack of trust in how people are treated.

At the same time, there were signs of hope. Many staff spoke with pride about their teams, about colleagues who genuinely care, and about their commitment to patients. A few mentioned changes starting to happen—like cultural events being celebrated, or some leaders beginning to listen more closely. These pockets of progress may be small, but they're meaningful, especially in a system under constant pressure. This balance between what hurts and what helps, is at the heart of this feedback.

Important: Signs of Growing Cultural Tension

Some comments in the feedback reflect a growing discomfort with the Trust's equity efforts - particularly around race. A small but noticeable number of staff feel that initiatives aimed at addressing inequality are tipping into what they perceive as unfair treatment of others. One quote described this as "*being told to treat some staff better just because of their skin colour*." This kind of statement points to a deeper belief that inclusion work may be creating new divides, rather than fixing existing ones.

These views, though uncomfortable, should not be ignored. They echo broader political shifts seen across Kent and Medway, where conversations about fairness, identity, and 'who belongs' are becoming more charged. This isn't about agreement or disagreement but more about

recognising that resentment can grow quietly, and if left unchecked, it risks turning staff against each other or against leadership altogether. Leaders should ask:

- How do we explain equity in a way that feels fair to everyone?
- How do we challenge myths without shutting people down?
- And how do we keep the focus on behaviour and values, not just policy?

Summary of Diversity Survey: Top 5 Recurring Themes

Each theme is drawn directly from staff voice. While these are not formal complaints, they reflect real perceptions and lived experiences, and they deserve to be taken seriously. The order reflects frequency and intensity of mention.

1. Bullying, Toxic Behaviour & Lack of Consequence: Negative Theme

Staff spoke openly about bullying - often linked to power imbalances, poor leadership, or team dynamics that go unchecked. There were examples of staff feeling pushed out, ignored, or even retaliated against when raising concerns. Some said poor behaviour was overlooked when it came from people in favour or seniority.

Insight: This isn't just about isolated bad behaviour, but about patterns and protection. When staff feel that some people are 'untouchable,' trust in the whole system breaks down.

Implication: A culture that is even perceived to tolerate bullying can lead to good staff quietly leaving, while others stop speaking up. This creates serious risks, not just for retention, but also for safety, learning, and credibility.

2. Unequal Treatment Across Bands and Teams: Negative Theme

Staff shared concerns about how fairness seems to work differently depending on grade or team. People in lower bands or support roles felt more heavily scrutinised, with less access to development and less flexibility. There was a recurring perception that senior staff or close-knit groups got more opportunities or more leniency.

Insight: This is not just a grievance about opportunity; it's about dignity. When staff notice patterns in how rules or rewards are applied, it raises questions about who is valued and why.

Implication: If people stop believing the system is fair, they stop investing in it. The sense of being overlooked or held to a different standard is not just bad for morale; it creates invisible divisions that affect teamwork, loyalty, and growth.

3. Communication and Leadership Visibility: Negative Theme

Many described leadership as distant, inconsistent, or difficult to engage with meaningfully. Some said they didn't hear back after raising concerns. Others said they only saw leaders during walkarounds or in formal settings, and felt there was little real understanding of frontline pressures.

Insight: People notice when leadership only shows up in moments of pressure or performance. And they remember when their words are met with silence.

Implication: Being seen and being heard are not the same - but both matter. If staff don't believe their experiences shape decisions, they will stop offering them. This weakens the culture of openness and makes change harder to deliver.

4. Discrimination, Segregation and Cultural Discomfort: Negative Theme

A range of concerns came up concerning race, language, team dynamics, and cultural division. Some described feeling isolated, either because they were in the minority or because they feared being misunderstood or targeted. A few staff suggested that inclusion efforts had made things more tense or 'politicised.'

Insight: This reflects both discomfort and a sense of deeper fragility in the organisational culture. When inclusion feels performative or only for some, resentment grows on all sides.

Implication: The aim isn't to keep everyone comfortable, but to keep people connected. If some groups feel left behind and others feel misunderstood, the whole culture starts to fragment. This is a time that asks leaders to lead with openness, not avoidance.

5. Pride in Teams and Patient Focus: Positive Theme

Despite the challenges, many staff expressed pride in their teams and in the care they deliver. Some said their teams were the main reason they stayed. A few spoke of progress in team culture, such as more visible leadership, flexible working, or celebration of cultural events.

Insight: The workplace isn't broken - it's uneven. There are pockets of positivity that show what's possible when values and behaviour align.

Implication: Protecting what works is just as important as fixing what doesn't. If the good stories aren't lifted up, it's easy to believe none exist, and that belief will shape how staff show up.

Hearing What's Hard to Hear

These reflections haven't been easy to read, and they weren't easy for staff to share. The concerns about bullying, unfair treatment, silence, and cultural tension shows that while many care deeply about their work and teams, there are real cracks in trust and fairness that need attention.

But there is hope in the honesty. Staff are becoming more willing to speak up, even when it's difficult, which means they still care. The pride in patient care and strong team bonds shows that the foundations are there. What's needed now is not perfection, but visible and consistent action. Listening must lead to learning, and learning must lead to change - especially from the top. That means checking what's really happening on the ground, acting where gaps are clear, and being open when things need to improve. Change will take time, but trust starts to rebuild when people can see that something is being done.

Insights from the Listening Sessions

Summary of Listening Sessions: Top 5 Recurring Themes

Listening That Makes a Difference

Creating a space where people feel able to speak honestly is not just about having a meeting - it's about trust. For someone to open up about what's really going on, they need to feel safe, respected, and that their experiences matter. That means more than just "being heard". It's about people believing their voice will count. Listening in this way helps bring out the things that usually go unsaid, especially when the topic is uncomfortable.

Medway NHS Foundation Trust, is learning that unless they properly understand how people are feeling, what's frustrating them, and what support they actually need, they can't offer the right help. Without that, even the best intentions may miss the mark. Good listening doesn't just support staff; it can unlock solutions to bigger organisational problems.

The Listening Sessions ran across the Trust and ended on 30 April 2025. In each session, staff were invited to share their personal experiences, guided by six key questions that were co-designed with members of the Cultural Transformation Steering Group (CTSG):

1. **What's one thing you love about working here?**
2. **How would you describe the culture to someone new?**
3. **Have you ever witnessed or experienced sexual harassment, racism, or violence or aggression at work? And if so, how was it handled?**
4. **How do people usually interact in your team—including things like jokes or banter? Are boundaries respected?**
5. **How safe and confident do you feel raising concerns?**
6. **What one thing would you change to improve the culture, and why?**

In hosting the Listening Sessions, we were intentional about creating space for both positive and developmental feedback. Staff were encouraged to share what was working well, as well as what needed to improve. The following Top 5 themes reflect the most common feedback from staff between December 2024 and April 2025. While there were some positives, most of what people shared focused on challenges they are facing in their day-to-day working lives. These themes should be treated as a reflection of the working environment during that time - not as a full judgement of the organisation, but as a snapshot of how it feels for many staff right now.

1. Discrimination & Racism: Negative Themes

This was the most reported negative theme, with over 40 mentions. Staff shared experiences of racism, cultural bias, and unequal treatment - with many pointing to the lack of ethnic minority representation in senior leadership. Some felt that leadership did not reflect the diversity of the wider workforce, which made it harder to feel seen or fully included. The absence of visible role models from different backgrounds was mentioned as a barrier to both trust and aspiration. Worryingly, some individuals described formal grievances or job threats

after reporting discrimination. The fear of speaking out was described not as hypothetical—but as lived reality for some.

Insight: These accounts reveal more than just policy gaps - they reflect a lack of trust in systems meant to protect staff. For leadership, this isn't just an HR issue; it's a signal that some staff believe fairness and safety are not guaranteed.

Implication: In an environment where resources are tight and every role matters, failing to address these experiences risks silencing talent, losing trust, and increasing attrition. Tackling this area will take more than awareness sessions - it requires visible action, safe feedback channels, and regular real accountability checks.

2. Leadership & Management – Mixed Themes

Leadership was mentioned often, with mostly negative views. Staff talked about leaders not being visible enough, not always being held accountable, and decisions being made without clear communication. When staff spoke about "leadership," they were mostly thinking of Bands 7 to 8b roles in clinical teams, and those in less senior banded positions in support areas. This shows that many people experience leadership through middle managers rather than senior leaders. Some said their managers are under pressure and doing too much, while others felt they didn't get enough support.

Insight: The message here is not that leaders need to do more, but that how leadership is experienced varies too widely across the organisation.

Implication: In a period of financial pressure, people will have a higher level of tolerance if they feel leadership is fair, present, and transparent. Inconsistent leadership risks disengagement at a time when staff buy-in is essential for service continuity.

3. Career Progression & Development – Mixed Themes

Many staff expressed uncertainty or disappointment about their development prospects. While some praised training opportunities, others felt overlooked or stuck - especially if they didn't "fit the mould" or lacked the right networks. The theme of "who gets seen" came through clearly.

Insight: This is less about entitlement to promotion, and more about clarity, fairness, and visibility in how people are supported to grow.

Implication: When development is unclear, talented staff look elsewhere or stop trying. In times of high workload, it's tempting to delay investment in people - but the long-term cost of stagnation or disengagement is far higher.

4. Speaking Up & Psychological Safety – Negative Themes

Staff shared fears about speaking openly - whether about inappropriate behaviour, safety concerns, or even raising suggestions. Some described retaliation or inaction when they had tried to escalate issues, including after reporting discrimination or aggression.

Insight: The issue isn't just whether staff are "allowed" to speak up, but whether they believe they will be protected, taken seriously, or ignored.

Implication: In any system under strain, silence can be dangerous. If issues are not raised, problems don't just stay hidden - they grow. Leaders must ask whether current processes are trusted, not just whether they exist.

5. Workplace Culture – Mixed Themes

Culture came up repeatedly - mostly linked to team dynamics, behaviour, and how people are treated day-to-day. Some teams were described as warm, supportive, and like "a family," while others experienced cliques, banter crossing the line, or unfair expectations relating to workload depending on who you were.

Insight: Culture is not uniform across the organisation, and where it breaks down, it often happens quietly.

Implication: In times of great challenge, strong culture is what helps teams pull together. But if it feels unfair or unsafe in pockets, staff will disengage quietly. Leaders must focus not just on raising standards - but on levelling out the experience across teams.

These themes reflect a workforce that still cares, but is cautious. Staff are not simply complaining; they are indicating where trust is worn thin and systems aren't working as they should. With resources under pressure, staff engagement is no longer a nice to have, it is one of the few levers left to protect retention, service quality, and resilience. The most uncomfortable findings are also the most valuable because they show exactly where leadership attention is most needed.

What Staff say is working well

[Based on feedback from Listening Sessions and Diversity Survey]

Despite ongoing pressures, many staff see areas where the organisation is making genuine progress. These strengths are often localised or inconsistent, but they show what's possible when people feel supported, valued, and listened to. Below is a summary of key areas where staff said the organisation is doing well:

- **Team Spirit and Support:** Many staff spoke positively about the way their teams work together, especially in tough situations. Strong day-to-day support from colleagues helps keep services running and makes the job feel more manageable, even when things are stretched.
- **Focus on Patient Care:** Despite the challenges, a strong focus on patient care remains clear. Staff continue to put patients first and take pride in providing a good standard of care, including in sensitive areas like end-of-life support.
- **Efforts to Improve:** Staff have noticed signs that the organisation is trying to move forward. Whether through visible leaders, new initiatives or more open conversations, people recognise the intention to improve, even if results are mixed.
- **Communication is Improving:** Communication across the organisation is getting better. Updates are more regular and easier to find, particularly for staff with digital access. People are starting to feel more informed about what's going on.

- **Diverse Workforce and Inclusive Culture:** Working in teams made up of different backgrounds is something many people value. Some staff also appreciate the support groups and events in place to help everyone feel involved and part of the wider organisation.
- **Training and Career Development:** There are examples of staff getting good access to training and learning opportunities. Apprenticeships, funding for further study and national programmes like Patient First are helping some people develop in their roles.
- **Innovation and Practical Changes:** Some visible improvements are making a difference to day-to-day work. Refurbished areas, digital tools and better ways of working like improvement huddles are helping to make progress feel more real.
- **Support for Wellbeing:** Where it's available, support for wellbeing is appreciated. Occupational health and dedicated wellbeing teams have had a good impact for some, though not everyone finds it easy to access or knows what's available.
- **Good Local Management:** In some areas, local managers are making a real difference. Staff describe them as supportive, fair, and easy to talk to - especially when they support their teams and take time to understand what's really going on.
- **Pride and Staying Power:** Even in difficult circumstances, many staff still feel proud of their work. Their determination to carry on and put patients first shows a strong sense of purpose and commitment to public service.

Top Issues Staff Want Fixed

[Based on feedback from Listening Sessions and Diversity Survey]

Staff across the organisation have shared open and honest feedback about what would make it a better place to work. The key messages are clear: people want to be treated fairly, respected for the work they do, and supported by leaders who listen and take action. This summary outlines the top 10 issues raised by staff, based on real experiences. It highlights areas where change is needed and where leadership has a chance to rebuild trust through clear, practical action. The aim is not to create new systems or programmes, but to strengthen what may already be in place and ensure it works better for staff at all levels across the organisation.

1. Show Up and Lead Well

What staff said:

- Senior leaders feel far away from everyday work
- Some managers don't treat people well or fairly
- Staff want leaders to be visible, listen, and take action

Why it matters: When leaders ignore problems or stay out of sight, people stop speaking up. Good staff leave and poor behaviour continues.

2. Treat Everyone Fairly

What staff said:

- Some staff, especially managers, get special treatment
- Rules for home working, time off and complaints aren't applied the same
- Investigations are slow or don't lead to change

Why it matters: When people are treated differently, it causes frustration, weakens teams, and breaks trust in the organisation.

3. Fix Staffing and Reduce Pressure

What staff said:

- Not enough people to do the job safely
- Breaks are missed and staff are burnt out
- Night shifts and busy wards are often overlooked
- Too many in management, not enough on the front line

Why it matters: Too much pressure leads to mistakes, stress and people leaving. It also puts patients at risk.

4. Treat People With Respect

What staff said:

- Some staff are rude or dismissive towards others
- Certain teams are looked down on
- Managers can be condescending or do not listen
- Staff want to be treated like adults

Why it matters: When respect is missing, teamwork suffers, and morale drops. People stop caring and communication breaks down.

5. Value Everyone's Work

What staff said:

- Support staff feel ignored or underappreciated
- Some managers take credit for others' work
- Effort is only noticed in senior or clinical roles

Why it matters: If people feel invisible, they lose motivation. Every role matters and helps patient care in some way.

6. Communicate Clearly and Honestly

What staff said:

- Decisions are made without asking those doing the work
- Managers don't explain changes or share updates
- Communication feels one-sided or secretive

Why it matters: Poor communication creates confusion, stress and mistakes. It also stops teams from feeling part of the bigger picture.

7. Improve Workplaces and Equipment

What staff said:

- Some buildings are dirty, damaged or unfit
- Admin teams are scattered and can't work together properly
- Parking and access are major sources of stress

Why it matters: Working in poor conditions feels unfair and unsafe. It also slows people down and lowers morale.

8. Break Down Team Divides

What staff said:

- Clinical and admin teams feel disconnected
- Some groups get more support and attention than others
- Bank and part-time staff feel left out

Why it matters: When staff feel divided or forgotten, morale suffers. Working together well means everyone feels included.

9. Build Skills and Support Learning

What staff said:

- New starters don't always get proper training
- Some managers don't know how to support their teams
- Staff want training that helps them do their job well

Why it matters: Without the right skills, staff feel unsure, mistakes happen, and teams can't grow.

10. Live the Values Every Day

What staff said:

- Some managers say one thing but do another
- Senior staff aren't always held to the same standards
- Staff are tired of hearing promises with no follow through

Why it matters: If values aren't lived out in daily actions, staff stop believing in them. This leads to frustration and poor behaviour being accepted.

Why This Matters Now

Staff have been honest about what needs to change, and they've made it clear what matters most. These 10 issues are not new, but they are urgent. In a system already under pressure, the cost of not acting is high: more staff will leave, morale will drop further, and patient care will suffer. People aren't asking for perfection - they're asking to be treated fairly, heard clearly, supported properly, and given the tools to do their job well. Trust will only be rebuilt through action that's visible, consistent, and felt on the ground. If leaders focus on getting these basics right, the organisation will be in a far stronger place to face the future.

Improvement Actions already taking place in Medway NHS Foundation Trust

Workplace Culture & Psychological Safety

- **Online Prayer & Schwartz Rounds**: Safe spaces for staff to reflect and share clinical experiences.
- **Acceptable Behaviour Policy**: Updated with staff input to better manage violence and aggression.
- **Visitors Charter**: Draft being revised to set clear expectations for visitor behaviour.
- **Zero Tolerance Campaigns**:
    - "Not In A Day's Work" posters tackling abuse and racism.
    - Posters protecting staff from violence, aggression, and discrimination.

Support Systems & Reporting

- **Guardian Service**: 24/7 confidential support for reporting bullying, harassment, or safety concerns.
- **Anti-Bullying and Harassment Group**: Reviews trends and investigations to suggest improvements.
- **Dignity at Work Advisors**: Offer private support and advice on workplace issues.
- **Civility and Respect Toolkit**: Resources to help teams build a respectful culture.

Values, Training & Inclusion

- **BEST Values & Staff Compact**: Promoting positive behaviours.

being updated to include examples of negative behaviour.

- **Inclusion by Design Training**: In-person sessions for leaders on equality, diversity, and inclusion.
- **Sexual Safety e-Learning**: Mandatory training to address misconduct and support sensitive conversations.
- **Updated Policies**:
    - Bullying, Harassment, Discrimination & Conflict Resolution
    - NHS Sexual Safety in Healthcare Charter

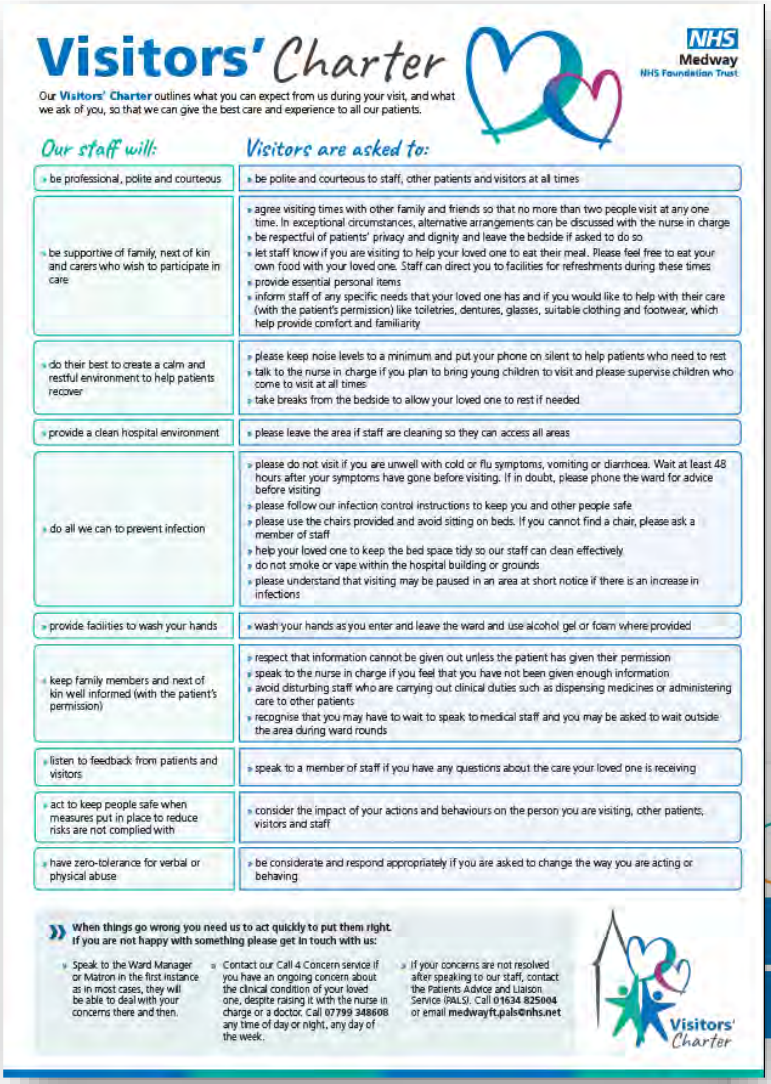
Monitoring, Recognition & Engagement

- **Incivility Reduction Objective**: Targeting a 50% drop in bullying and incivility using new reporting tools.
- **Staff Feedback**: Through NHS Staff Survey, People Pulse, and Friends and Family Test.
- **Awards & Recognition**: Monthly and annual awards, long service celebrations, and volunteer events.
- **Awareness Campaigns**: Highlighting initiatives and celebrating staff contributions.

Other Initiatives

- **Body Camera Trial**: Testing in key areas to improve safety.
- **Staff Networks**: Supporting diverse groups including BAME, LGBTQIA+, Faiths, Women's, Armed Forces, and DAWN (Disability and Wellbeing Network).

Posters are visible throughout the buildings to empower staff to speak up and reminds the public that abusive behaviour can lead to refusal of treatment and further action.



Visitors' Charter

NHS Medway NHS Foundation Trust

Our **Visitors' Charter** outlines what you can expect from us during your visit, and what we ask of you, so that we can give the best care and experience to all our patients.

Our staff will:	Visitors are asked to:
be professional, polite and courteous	be polite and courteous to staff, other patients and visitors at all times
be supportive of family, next of kin and carers who wish to participate in care	agree visiting times with other family and friends so that no more than two people visit at any one time. In exceptional circumstances, alternative arrangements can be discussed with the nurse in charge be respectful of patients' privacy and dignity and leave the bedside if asked to do so let staff know if you are visiting to help your loved one to eat their meal. Please feel free to eat your own food with your loved one. Staff can direct you to facilities for refreshments during these times provide essential personal items inform staff of any specific needs that your loved one has and if you would like to help with their care (with the patient's permission) like toiletries, dentures, glasses, suitable clothing and footwear, which help provide comfort and familiarity
do their best to create a calm and restful environment to help patients recover	please keep noise levels to a minimum and put your phone on silent to help patients who need to rest talk to the nurse in charge if you plan to bring young children to visit and please supervise children who come to visit at all times take breaks from the bedside to allow your loved one to rest if needed
provide a clean hospital environment	please leave the area if staff are cleaning so they can access all areas
do all we can to prevent infection	please do not visit if you are unwell with cold or flu symptoms, vomiting or diarrhoea. Wait at least 48 hours after your symptoms have gone before visiting. If in doubt, please phone the ward for advice before visiting please follow our infection control instructions to keep you and other people safe please use the chairs provided and avoid sitting on beds. If you cannot find a chair, please ask a member of staff help your loved one to keep the bed space tidy so our staff can clean effectively do not smoke or vape within the hospital building or grounds please understand that visiting may be paused in an area at short notice if there is an increase in infections
provide facilities to wash your hands	wash your hands as you enter and leave the ward and use alcohol gel or foam where provided
keep family members and next of kin well informed (with the patient's permission)	respect that information cannot be given out unless the patient has given their permission speak to the nurse in charge if you feel that you have not been given enough information avoid disturbing staff who are carrying out clinical duties such as dispensing medicines or administering care to other patients recognise that you may have to wait to speak to medical staff and you may be asked to wait outside the area during ward rounds
listen to feedback from patients and visitors	speak to a member of staff if you have any questions about the care your loved one is receiving
act to keep people safe when measures put in place to reduce risks are not complied with	consider the impact of your actions and behaviours on the person you are visiting, other patients, visitors and staff
have zero-tolerance for verbal or physical abuse	be considerate and respond appropriately if you are asked to change the way you are acting or behaving

When things go wrong you need us to act quickly to put them right. If you are not happy with something please get in touch with us:

- Speak to the Ward Manager or Matron in the first instance as in most cases, they will be able to deal with your concerns there and then.
- Contact our Call 4 Concern service if you have an ongoing concern about the clinical condition of your loved one, despite raising it with the nurse in charge or a doctor. Call **07799 348608** any time of day or night, any day of the week.
- If your concerns are not resolved after speaking to our staff, contact the Patients Advice and Liaison Service (PALS). Call **01634 825004** or email **medwayft.pals@nhs.net**

Visitors' Charter

Posters remind the public that there is an expectation that they conduct themselves in a respectable manner

NHS Medway NHS Foundation Trust

Protecting our staff, patients and visitors

from violence, aggression and discrimination.

As an anti-discrimination organisation, the Trust and our workforce will challenge, prevent and take action against illegal discrimination towards our staff, patients and members of the public. For example racism, homophobia, sexism or harassment of any kind.

In addition, as part of our zero tolerance policy, the Trust will use all means possible, including legal options and refusing treatment, to protect our staff, patients and members of the public from any form of violence, abusive or aggressive behaviour or intimidation.

Scan the QR code or visit:
www.medway.nhs.uk

Please respect our staff and each other.

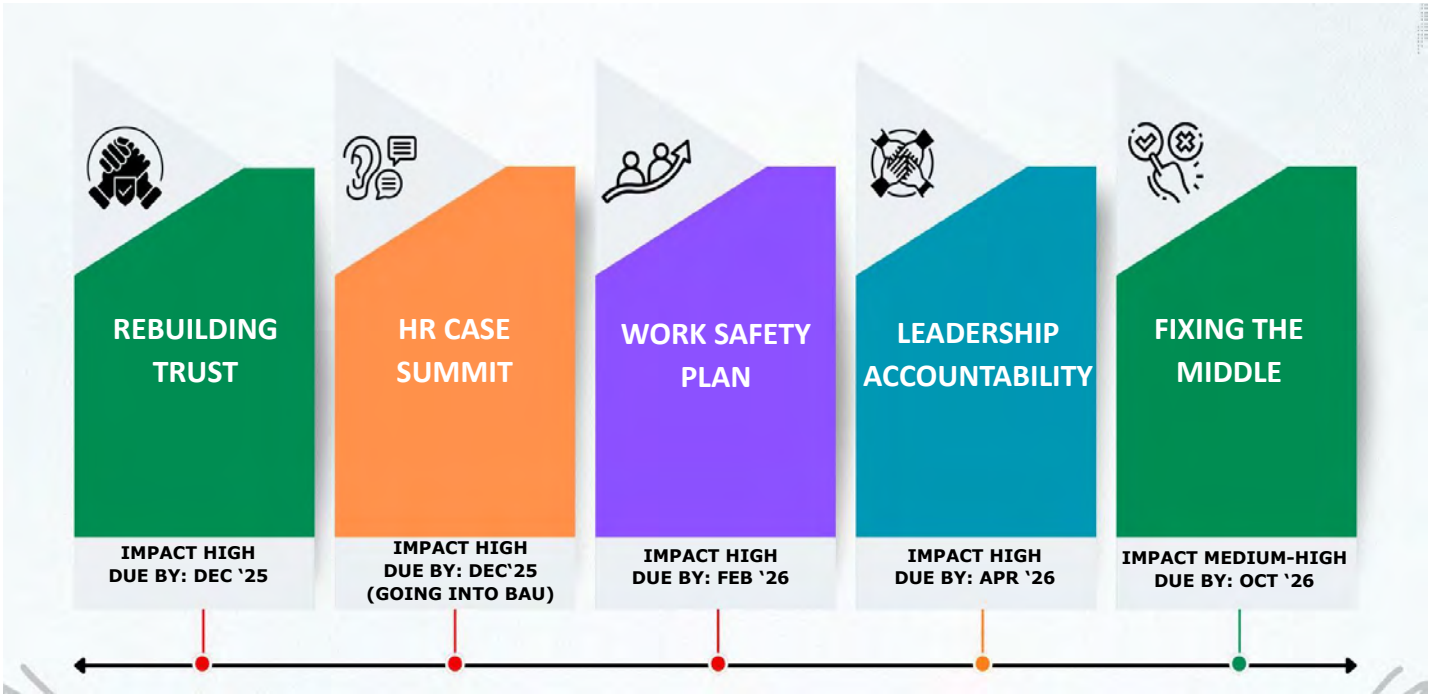
Scan the QR code for more information about our zero tolerance policy and our commitment to being an anti-discrimination organisation.

Best of care Best of people

Patient FIRST

Recommendations

Following powerful staff feedback from the Diversity Survey, Listening Sessions, and the Diversity MOT with Board Members, five practical priorities have been identified to improve trust, fairness, and leadership consistency at Medway NHS Foundation Trust, without requiring significant additional cost or new programmes. These insights reflect not just what staff are saying, but how leaders are 'showing up', especially under pressure. The priorities below are designed to move from listening to visible, values-driven action.



Work under each of these pillars has already commenced.

1. Rebuilding Trust: Making It Safe to Speak Up

SMART GOAL: By December 2025, establish a clear Trust wide roadmap of listening events for all staff groups, linking these with existing channels such as Freedom to Speak Up (FTSU). Make it easy for staff to:

- Know when and where sessions will happen.
- Share feedback openly or anonymously.
- Identify and contact their divisional advocate.
- Access regular updates on what action has been taken.

Why it matters: This supports the Board's objective to shift from reactive to proactive leadership. A clear and visible listening plan shows that staff voice is not just invited during crises, but is built into how the Trust listens, learns and leads every day.

Why it's Top Priority: Fear of speaking out, especially around racism or bullying, is silencing staff and creating risk.

Impact High: Improves psychological safety and early problem-solving.

Feasibility Medium: Builds on existing listening approach and FTSU structure with minimal tech or cost.

2. HR Case Summit: Staff Experience Review

SMART GOAL: By December 2025, complete a full review of the end-to-end staff experience in Employee Relations processes (e.g. grievance, bullying, and harassment), building on work started in phase 1 through the HR Case Summit. The review will:

- Map key process stages and decision points.
- Identify themes around fairness, communication, delay, and outcomes.
- Pay particular attention to perceived impact on minority ethnic staff.
- Deliver a detailed report of findings and practical recommendations, with clear actions for improvement, ownership, and timeline for delivery.

Why it matters: While the number of formal ER cases is small, the perception that the process is unfair is widespread. Staff say it's slow, confusing or unsafe. Many believe colleagues from minority ethnic backgrounds are treated worse. Even if those views aren't always backed by data, what people believe shapes trust more than facts alone. If staff feel unsupported or treated unfairly, they lose trust, or leave.

Impact High: Makes the process clearer, fairer and safer for everyone. Helps retain good staff, reduce formal cases and demonstrates the organisation's commitment to fair and inclusive values.

Feasibility High: The review is already in progress and is due to finish by December 2025. It will be delivered through our agreement with Absolute Diversity, with support from partner Trusts. Time and resources have already been set aside for this work. This phase covers the review only and does not include the implementation of the recommendations.

Board Link: Delivers on the Board's aim to embed inclusive leadership and reduce bias. Shows clear action is being taken to make sure all staff are treated fairly, whatever their background or role.

3. Work Safety Plan: Making the Organisation Safer for Everyone

SMART GOAL: By February 2026, develop a clear plan to reduce violence, aggression, and racism on wards and across the organisation, with a focus on protecting frontline staff - especially those from minority ethnic backgrounds and internationally educated staff. The plan should include:

- Regular tracking of incidents by team, ward, and staff group.
- Clear and early ways for staff to raise concerns, using the Freedom to Speak Up service more actively.
- Better use of Equality Impact Assessments to identify and respond to risks
- Stronger and more consistent use of the yellow/red card policy for unacceptable behaviour from patients or visitors.
- Working with other Trusts or through the Kent and Medway system to build on the regional objective.

Why it matters:

Aggression towards frontline staff is rising, especially in inpatient care. Staff from minority ethnic backgrounds are often targeted more, and many internationally educated staff work in these areas. They've come a long way to support the NHS and deserve to feel safe and supported.

In Kent and Medway, this is happening alongside political shifts and growing workplace pressure. If the organisation doesn't respond clearly and consistently, more staff will leave or stop speaking up.

Impact High: Protects staff, improves morale, and sends a strong message that racism violence and aggression are not part of the job.

Feasibility Medium: Can be delivered using existing tools and policies. Support from other Trusts or the wider Kent and Medway system may help, but joining a central initiative could slow progress. Identifying quick local actions that can be put in place immediately is strongly advised to build trust and show early commitment.

Board Link: Directly supports the Board's aim of addressing and reducing bias by protecting those most at risk, using existing tools more effectively, and creating safer working conditions for everyone.

4. Leadership Accountability & Clarity Framework

SMART GOAL: By April 2026, either introduce a clear and practical Leadership Accountability and Clarity Framework across all bands if one does not currently exist, or strengthen and improve any existing framework to ensure it is consistent, fair, and understood across the Trust. The framework should:

- Set clear expectations for leadership behaviours and inclusive decision-making.
- Link those behaviours directly to appraisals, recognition, and formal consequences.
- Apply equally from Band 7 upwards, with visible outcomes across all divisions.
- Be supported by HR, OD, and governance teams, with ownership and accountability held by the Board and Senior Leadership, and regular oversight and reporting.

Why it matters: Inconsistent leadership undermines staff confidence, team culture, and fairness; it also costs the organisation money. Poor leadership contributes to higher turnover, increased sickness absence, disengagement, and recruitment strain. A visible framework helps set and uphold standards, ensuring poor behaviour is addressed and values-led leadership is recognised.

Impact High: Rebuilds trust, improves fairness, reduces avoidable cost, and strengthens the leadership culture.

Feasibility High: Can be delivered through existing appraisal and governance processes if HR is properly resourced and senior leaders—particularly in clinical divisions—are fully integrated into the accountability model.

Board Link: Directly supports the Board's commitment to embedding inclusive leadership and reducing bias by making expectations clear, consequences fair, and accountability consistent at the highest level.

5. Fixing the Middle: Building Fair and Confident Teams

SMART GOAL: By October 2026, 80% of Band 7 to 8b managers will have completed a Trust-specific training programme that supports fair leadership, good people management, and stronger teams. The programme will:

- Use real examples from Medway, based on common team issues.
- Be delivered in short, simple sessions that work around busy workloads.
- Help managers deal with problems early, treat people fairly, and build trust.

- Include feedback from staff, self-reflection, and peer support.

This training should be based on the results of the Diversity MOT, which is being rolled out to Clinical Divisional Leaders. Those results will help shape what topics matter most and where to focus first.

Why it matters: Most staff say their experience at work is shaped by their manager. When things feel unfair or unclear, it affects how people work and their level of engagement. Helping managers build the right skills improves how teams work every day.

Impact Medium to High: Helps fix day-to-day issues and improves how people feel at work.

Feasibility Medium: Can be delivered using internal trainers and short sessions, but will need protected time for managers to take part and coordination support to run well. It will also require consistency and clear governance for tracking, so it doesn't lose momentum over time, especially as the impact of the investment may take time to show.

Board Link: Supports the Trust's aim to make work fairer for everyone by giving managers the tools they need to lead well.

Repositioning Staff Networks at Medway Foundation Trust

Staff networks are often seen as side conversations or support groups, but when done well, they are far more than that. They can be a powerful voice for change, a radar for what's really going on beneath the surface, and a source of energy and ideas for moving the organisation forward.

At Medway Foundation Trust (MFT), six staff networks currently operate:

- **Faiths and Beliefs Network [FABs]**
- **BAME Network**
- **Women's Network**
- **Disability and Wellness Network (DAWN)**
- **LGBTQIA+ Network**
- **Neurodiverse Staff Network**

There's agreement among staff, network leads, and senior leaders that now is the time to refresh how these networks work - both in terms of purpose and structure. They should not sit on the edges of the organisation but be part of the way the organisation listens, learns, and leads change - especially in supporting the implementation of the Cultural Transformation Programme.

Why This Matters Now

Staff networks can help organisations notice problems earlier, test ideas, and offer insight into what staff really need. When they are connected into the wider organisation, they can shape better decisions and improve how people feel at work. Research from NHS England shows that well-supported staff networks:

- Give staff a safe and trusted space to speak up.
- Help leaders make better decisions.
- Build stronger teams and reduce turnover.

- Improve the working environment for everyone.

"Staff networks provide insight, challenge and lived experience that can help create better services and a better NHS." - NHS England, 2023. The latest NHS Staff Survey (2024) shows why this work matters. While some areas have improved, concerns around physical violence and discrimination have increased:

- 14.4% of NHS staff faced physical violence from patients or the public.
- 9.25% reported discrimination at work—the highest level in five years.

This makes it clear that staff networks aren't just helpful – they are necessary. They play a key role in building a safer, more respectful workplace.

What We've Heard

As part of the Phase 1 listening and engagement work, staff, network members, and senior leaders across the organisation shared their views on how staff networks are working at MFT. Several clear themes came through:

- The purpose of networks is unclear – are they support spaces, change agents, or both?
- They feel disconnected from the organisation's main strategies and teams
- They want more access to senior leaders and decision-making conversations
- They need support to deliver change—not just energy from volunteers
- There is burnout risk, especially as network leads juggle this work with their day jobs

This feedback shows the need for a fresh, practical strategy that builds on what's working and addresses what isn't.

Three Key Recommendations for Refreshing the Networks

1. **Make Networks a Core Part of Decision-Making**
   Position staff networks as trusted sources of insight and foresight. Invite them into early discussions on strategy, policy, and service design - especially when changes might impact staff experience.

   How:
   - Involve network reps in key meetings and project boards.
   - Set up quarterly check-ins between networks and executive team.
   - Use networks to test new ideas and raise risks early.

   Benefits:
   - Brings real-life staff experience into planning.
   - Builds trust and accountability.
   - Helps avoid unintended consequences of decisions.

   Considerations:
   - Needs time and senior commitment.
   - Risk of networks becoming too formal or losing their safe-space feel.

2. **Connect Networks to Onboarding and Learning**
   Build networks into the way people join and grow at MFT - from Day 1 through their entire career.

   How
   - Include network signposting in staff induction.
   - Invite networks to share short stories or sessions in training.
   - Mention networks in development plans and appraisal conversations.

   Benefits
   - Normalises staff network involvement.
   - Builds early connection and sense of belonging.
   - Helps spot and grow future leaders from all backgrounds.

   Considerations
   - Needs coordination across HR, Comms, and OD.
   - Content must feel real and useful—not box-ticking.

3. **Show the Impact of Network Work**
   Create a simple, light-touch way to track and show how networks are making a difference.

   How
   - Co-design an impact dashboard with network leads.
   - Include indicators like: changes influenced, feedback collected, and visibility across the Trust.
   - Link outcomes directly to the Cultural Transformation Programme.

   Benefits
   - Shows how networks contribute to culture and change.
   - Makes the case for continued investment.
   - Builds pride and purpose for those involved.

   Considerations
   - Avoid making this too numbers-heavy.
   - Allow space for stories, experiences, and lessons learned—not just data.

Next Steps

A half-day Staff Network Strategy Workshop to be planned in the near future to:

- Revisit what each network is here to do.
- Define shared goals and ways of working.
- Agree how networks will support the wider Cultural Transformation Programme.
- Draft a practical and forward-thinking network strategy.

The workshop will lead to a proposal for the People Committee and Board (date to be confirmed). In challenging times, staff culture matters. Networks aren't an extra they are part of how MFT listens, leads, and improves. It's time to bring them to the centre. Let them lead.

Closing Statement & Next Steps

Absolute Diversity would like to thank the Board of Medway NHS Foundation Trust, the Cultural Transformation Steering Group (CTSG), and every staff member who took part in this work. Whether through surveys, listening sessions, or team discussions, your honesty, openness, and willingness to share have helped shape this report into a meaningful reflection of current culture. Every voice mattered and every contribution is valued.

Now is the time to act. With rising costs, increasing pressure on services, and a workforce that continues to look to leadership for direction, there is no space for delay. Culture is not a side issue, it is central to how organisations function. It affects how people feel at work, how care is delivered, and how money is spent.

A poor culture pushes good people away, damages morale, and drives up sickness and turnover. It also drains energy, increases risk, and weakens trust. On the other hand, a better culture not only saves money - it keeps talented staff, improves patient outcomes, and builds the kind of organisation people want to be part of.

Medway's core values offer a strong and credible foundation for this change:

- **Bold:** Now is the time for strong, clear action. Staff have spoken. They are watching and waiting to see what happens next. Leaders need to lead visibly and consistently - not just when it's easy, but when it matters.
- **Every Person Counts:** Everyone deserves to feel safe, respected, and treated fairly at work. This is how teams stay strong, and how staff stay committed. When fairness is felt, loyalty follows.
- **Sharing and Open:** Talking and listening must lead to action. Being transparent about progress, setbacks, and learning helps rebuild trust and shows that change is real.
- **Together:** Change works best when it is shared. Staff, leaders, networks, and services must move forward side by side, building solutions that last and keeping each other accountable.

The next step begins with a joint planning meeting between the CTSG and the Board. This is an important opportunity to align intentions with action, agree clear priorities, and build momentum into the next phase.

This programme is not about being perfect. It's about doing the right thing consistently, even when it's difficult. Staff have been clear about what matters most. The challenge now is to act with courage, humility, and purpose - and to keep going.

"***Commitment means staying loyal to what we said we were going to do, long after the mood we said it in has left us***." Absolute Diversity remains committed to supporting Medway NHS Foundation Trust as it continues to build a better, safer, and fairer place to work, for every member of staff, and every patient served.