Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 12 November 2025 at 10:00 – 13:30 - Trust Board Room and MS Teams

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's introduction and apologies	Chair	Verbal	10:00	Note
1.2	Quorum				Note
1.3	Declarations of interest				Note
1.4	Minutes of 10 September 2025		3		Approve
1.5	Action Log		16		Note
2.	**Opening Matters**				
2.1	Chief Executive Officer Update	Chief Executive	17	10:15	Oversight
3.	**Stabilisation Plan: Page 22 - 31**				
3.1	**Integrated Quality Performance Report** Executive Summary	Chief Executive	32	10:25	Oversight
3.2	**<u>Culture</u>** a) Action 2 - Cultural Review Actions b) Action 1 - Board Strengthening c) Action 7 - Ward to Board	a) Deputy Chief Executive b) Deputy Chief Nursing Officer c) Chief People Officer	22 - 31	10:30	
3.3	**<u>Performance</u>** a) Action 4 - Delivery of Access Standards	Chief Operating Officer	Verbal	10:50	
3.4	**<u>Governance and Quality</u>** a) Action 6 - Standardised Hospital Mortality Index (Learning from Deaths – Annual Report) b) Action 10 – Decisions made on Existing Business Cases	Chief Medical Officer	44 22 - 31	11:00	
3.5	**<u>Finance</u>** a) Action 5 - Finance Plan Delivery - Month 06 Finance Report b) Action 8 - Corporate Services Improvements/Business Partner Capability c) Action 9 - Medium Term Business Plan and Financial Recovery	Chief Finance Officer	77 86 89	11:25	
4.	**Board Assurance**				
4.1	Board Assurance Statement	Company Secretary	102	11:45	Oversight

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4.2	Assurance Reports from Board Committees: a) Audit and Risk b) Quality c) People d) Finance, Planning and Performance	Committee Chair and Executive Leads	111 114 119 124	11:50	Briefing/ Assurance
4.3	Medical Examiner – Annual Report	Chief Medical Officer	128	12:10	Assurance
4.4	Paediatrics Summit Report	Chief Medical Officer	144	12:25	Briefing
4.5	Maternity CNST Compliance Assurance Report – Updates and Actions	Director of Midwifery	160	12:35	Approve
5.	**Other Board Business**				
5.1	Council of Governors Report	Lead Governor	Verbal	12:45	Assurance
5.2	Audit and Risk Committee (September 2025) - Revised Terms of Reference	Company Secretary	185	12:55	Approve
5.3	League of Friends - Annual Report	League of Friends	193	13:05	Briefing
6.	**Items to Note – Papers in Appendices Folder ***				
6.1	Medical Education - Annual Report **APPENDIX**	Chief Medical Officer	*1	13:10	Note
6.2	Infection Protection and Control Standard Contract **APPENDIX**	Chief Nursing Officer	*13	13:13	Note
6.3	Survey Results - Cancer Patient Experience and Inpatient CQC **APPENDIX**	Chief Nursing Officer	*23	13:15	Note
7.	**Closing Matters**				
7.1	Questions from the Council of Governors and Public	Chair	Verbal	13:20	Note
7.2	Escalations to the Council of Governors				
7.3	Any Other Business and Reflections				
	Date and time of next meeting: Wednesday, 14 January 2026				

Minutes of the Trust Board Meeting in Public

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

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

Gundulph Boardroom and via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust Chair
	Alison Davis	Chief Medical Officer
	Gary Lupton	Non-Executive Director
	Helen Wiseman	Non-Executive Director
	Jon Wade	Chief Executive Officer (Interim)
	Peter Conway	Non-Executive Director
	Sheridan Flavin	Chief People Officer (Interim)
	Simon Wombwell	Chief Finance Officer (Interim)
	Jenny Chong	Non-Executive Director – left the meeting at 13:00
	Steph Gorman	Chief Nursing Officer (Interim)
	Darren Palmer	Chief Operating Officer (Interim)
	Paulette Lewis	Non-Executive Director
	Jane Perry	Academic Non-Executive Director
Attendees:	Emma Tench	Assistant Company Secretary (Minutes)
	Katie Goodwin	NHSE Improvement Director
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Martina Rowe	Lead Governor
	Abby King	Director of Communications
	Rajini Sivaraman	Ward Manager (Board Story agenda item 3.8)
	Jenny Woolley	Delivery Suite Senior Sister (Board Story agenda item 3.8)
	Sylvia Stevenson	Absolute Diversity (agenda item 3.3)
	Nikki Lewis	Associate Director of Patient Experience
	Alison Herron	Director of Midwifery
Observing:	Imogen Head	NHS England
	Lauren Smith	NHS England

	Robin Barker	CEO of Can We Talk
	Alex Liggins	Vanguard Healthcare Solutions
	Christine Palmer	Swale Governor
	Hari Aggarwal	Medway Governor
	Matthew Taiano	Staff Governor
	Maya Guthrie	Strategy and Partnerships Project Manager
	Paul Riley	Swale Governor
	Jay Patel	Deputy Lead Governor
Apologies:	Siobhan Callanan	Deputy Chief Executive
	Mojgan Sani	Non-Executive Director

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

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

1) Cultural Transformation Report to be reviewed in detail, on the agenda, apologies were relayed to colleagues for the difficult read, and the behavior received by some colleagues.
2) NHS League tables issued 09 September by the government, Medway Foundation Trust (MFT) was ranked at position 130. The stabilisation report will address areas for performance, care and finances
3) The independent review for the Dartford and Gravesham Trust (DGT) and MFT collaboration will be received late September.

1.2 Quorum

The meeting was confirmed as quorate.

1.3 Declarations of Interest

There were no declarations of interest

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

2.1 The minutes of the meeting held on 23 July 2025 were **APPROVED** as a true and accurate record.

2.2 Action Log

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

3 Opening Matters

3.1 Chief Executive Officer Update

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

a) NHS Ten Year Plan
b) Industrial Action – thanks to all staff for mitigation of risk across the organisation. Apologies to the public for any disruption to services.

c) NHS oversight Framework – League tables, disappointed in the position, significant challenges across the organisation to mitigate, as well as in social care and community services.
d) Ear, Nose and Throat (ENT) Delays – making good progress, NHSE feeling assured with procedures in place. Full assessment carried out to ensure this is an isolated incident.
e) New Palliative and End of Life Care Service
f) Award recognition for Maternity and Breast Care teams
g) Welcome to new Governors

The Board **RECEIVED** and **NOTED** the update.

3.2 Revised Undertakings NHSE

Jon Wade presented the report in line with the paper submitted. Key highlights:

1) NHSE has accepted new Enforcement Undertakings from Medway Foundation Trust (MFT), necessary to secure identified breaches do not recur.
2) The Trust holds the license under section 87 of the Health and Social Care Act 2012.
3) Main areas for concern within the undertakings:
    - Leadership, Culture, and Governance
    - Financial Sustainability
4) MFT has agreed to four areas of commitment:
    - Leadership, Well-Led and Governance
    - Financial Management
    - Programme Management
    - General (Recovery Support Programme)

<u>Check and Challenge</u>

a) Helen Wiseman: The document is not dated.
John Goulston: The document was received 23 July, after the last board meeting.
b) John Goulston: Stability links to the Carnall Farrar report. The report will come back to Board once the Carnall Farrar report is published.
c) Helen Wiseman: In regards to financial undertaking, is the expectation based on the original outturn.
Simon Wombwell: Expectation is against the £4.9m. The organisation was still on plan in July.

ACTION TB/2025/021: To take forward in line with the stabilisation plan, ensuring the metrics and outcomes are in line with undertakings, the report to come back to the board.

The Board were **BRIEFED** by the update

3.3 Cultural Transformation Report

Jon Wade and Sylvia Stevenson updated the Board on the recent publication of the Cultural Transformation Phase 1 Report, published 05 September.

1) Apologies to members of staff who have been affected by negative behaviors.
2) The report, whilst honest and truthful, is a challenging read. Negative behaviors need to be tackled head on. The organisation is responding to support staff, a duty of care to everyone.
3) The Board and Council of Governors were commended for their engagement.

Check and Challenge

a) John Goulston: Stakeholders need to be ensured of a confidence response from the top down. A need to make a sustainable difference.
b) Sheridan Flavin: A need to treat everyone equally and fairly. Meeting on a weekly basis to measure incivilities. 80 reported cases, good to see the confidence in reporting. Any issues reported to the Freedom to Speak Up (FTSU) Guardian identified as 'red' are actioned within 24 to 48 hours. A paper will be coming to the Board in November
ACTION TB/2025/022: FTSU Update Report to the Board in November
ACTION TB/2025/023: Details of responsibilities for the governance route to be decided and shared.
The Board **RECEIVED** the report.

3.4 Council of Governors Report

No update for this meeting.

3.5 Trust Risk Register and Issue Report

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

1) Risk 2274 – Extreme Risk 4: *16 and 17-year old's not receiving optimal inpatient care*. This is starting to move forward at pace. The policy has been written and approved. The 'go live' date the beginning of November
2) Risk 2166 – Extreme Risk 8: *Non-Compliance with HTM 05-01 Managing Healthcare Fire Safety*. Compartmentation still not achieved. Fire Capital Program is now underway and is monitored via the Fire Safety Group.
3) Risk 2230 – Extreme Risk 9: *patients who lack capacity potentially coming to harm by absconding from the hospital site*. Significant work in place to reduce to 12.

Check and Challenge

a) Peter Conway: Consistent reporting required, not all extreme risks are within the report, for example Health and Safety.
Matt Capper: Health and Safety has been reviewed and disaggregated. This is no longer an extreme risk.
b) Peter Conway: In regards to fire safety compartmentation, this will take time, in the meantime what are the risks and who is responsible. The report does not give sight. This will need to come back to the Board. The fire safety report to Audit and Risk was not of the quality expected.
Steph Gorman: This sits with Estates. The interim COO has been sighted
ACTION TB/2025/24: Report on risks and responsibilities for Fire Safety.
c) Peter Conway: In regards to Health and Safety (H&S), has the Quality Assurance Committee (QAC) had oversight and been alerted to issues.?
Matt Capper: A number of items go through to QAC and the People Committee for H&S, we are confident with the governance route.
Paulette Lewis: QAC are reviewing the assurance process. We will now have divisional representation at the meetings. The committee are also continuing with deep dives.
Jenny Chong: The People Committee do receive reports. Main areas of focus are Stat Mand training, and safe staffing.
d) Gary Lupton: In regards to compartmentation this should remain an issue, there will never be full compliance.

e) Helen Wiseman: Risk 2304, Extreme Risk 10: *Trust not having clear and embedded ligature risk management processes within paediatrics*. What is the timeline and what level are we aiming for?
Steph Gorman: The risk is marked for closure; new blinds are expected imminently.
Jon Wade: An example of the need to refresh some governance processes, intervention was needed expediate this issue.

f) John Goulston: Risk 2453, Extreme Risk 5: *Women, Children, and Young People's Divisions inability to meet the financial efficiency target for 25/26.* Why is this the only division mentioned as an extreme risk for not hitting their financial target, are other departments confident they will reach their CIP. Who is moderating this for consistency?
Peter Wombwell: The risk and framework need a refresh. The accuracy of the wording is crucial.

g) The NEDs discussed the crispness of the reporting. Impact of actions needs to be included in the reporting.
ACTION TB/2025/025: Report to be refreshed for clarity and inclusion of impact of actions taken.

3.6 Board Assurance Framework (BAF)

Matt Capper presented the BAF for assurance.

1) Drawing out the importance of cash, now prominent and clearer
2) Feeding back comments from sub committees into the BAF, some risks have increased.

Check and Challenge

a) John Goulston: The report needs to be reviewed in line with the Stabilisation plan.
b) Helen Wiseman: BAF 4 for Sustainability, *There is a risk that if not properly managed the Trust's financial position will lead to compromises in patient safety, health and safety and staff morale.* This is a cause for concern as the risk register states under development.
Matt Capper: We are currently going through remapping in line with the Datix database. There is a broader piece of work. This will be pitched against the sustainability plan.

The Board were **ASSURED** by the BAF

Board Committee Assurance Reports

3.7a Quality Assurance Committee

Paulette Lewis presented the assurance report to the Board. Escalations included:

a) Working with Deputy CE, CNO and CMO to understand the issues and understand the impact and outcomes. Will be bringing divisional leads to the meeting for further assurance.
b) Safeguarding meeting standards
c) Maternity meeting standards
d) Deep dive into controlled drugs, escalated controlled missing drugs, to come to Board.
e) Antibiotic use – MFT are a high user, we need to review.
f) CQC report – seen areas of improvement, report to follow
g) Domestic violence and drug use – increase in reports from Medway cohort.
h) Coversheet for reporting – a refresh and training needed for improved reporting.
i) Equipment Report from Estates – not received at the Quality Committee, lack of scanners for Ultrasound. This will be requested urgently.
j) ENT – Continued work, seeing improvements. Patients have been identified for harm, any incidents have been rated as 'low'. Continued review split between adults and children. The issues discovered will be redesigned for clinical pathways to provide a better service.

k) SHMI is above the expected range. Steering groups carrying out deep dives highlighting areas for improvement. Audits are carried out against national best practice. Multi-disciplinary processes for learning from deaths. Accuracy in data, grateful to GIRTH national coding team who will be doing a deep dive.
ACTION TB/2025/026: Medicine management of controlled drugs report to come to Board.

The Board were **ASSURED** by the report

3.7b People Committee

Sheridan Flavin presented the report for assurance. The following key elements were highlighted:

a) Committee will ensure 'Line of Sight' to Board.
b) Risk 1409 – Medicals for ionisation and radiation. One person has not yet received a medical due to being off sick, this has now been arranged.
c) Anti-Bullying and Harassment Group – We are in the process of merging with the EDI group.
d) Statutory Mandatory training – Moving and Handling Level 2, issues due to trainer absence. The position has now been appointed. Continued non-attendance rates need to be addressed.
e) Cultural Transformation Programme – The committee's commitment to ensuring staff feel safe at work and when speaking out. The committee will continue to ensure we embody the right culture throughout the Trust

Check and Challenge

a) Paulette Lewis: A need to review how we are triangulating quality (QAC) with people (People Committee) and finance (FPPC).
Sheridan Flavin: Guardian of Safe Working is coming to the People Committee this month after review at QAC. The committee continue to review target for turnover, vacancies and cost, we are now triangulating.

The Board were **ASSURED** by the report

3.7c Finance, Planning and Performance Committee

Helen Wiseman presented the report for assurance.

a) Virtual Wards were approved by the committee for onward ratification by the Board
b) Need to understand our triangulation. Specialties need to understand the unpinning of main metrics.
c) Financial performance and forecasting – we are behind plan.
d) PA Consultancy – working to identify CIPS. They confirmed we are off track but where we expect to be at this point of time. PA will continue to attend FPPC meetings.
e) CIPS understanding with work force spend, a critical driver.
f) Contract renewal register – tracking for renewal dates.
g) High cost drugs – one issue concerning Haematology drug – deep dive into governance and financial controls.

The Board were **ASSURED** by the report

Board Story Presentation

3.8 Ward Accreditation Programme

Nikki Lewis, Jenny Woolley and Rajini Sivaraman joined the board, for the presentation to outline the work achieved within the ward accreditation process, at Medway NHS

Foundation Trust. The programme of work commenced a year ago; three clinical areas have achieved gold award status.

Check and Challenge

a) Jon Wade: Congratulated team. The accreditation is exceptionally important to the Trust. Keen to integrate the accreditation into all areas both at MFT and DGT. Can be used to support all areas.
b) Steph Gorman: MFT are in contact with the team at Dartford. MFT do not have a dedicated team for reviewing accreditations, welcome the Trust Board to join the team. A great first year.
c) Alison Davis: How can the experiences of best practice be used across the organisaton. Synergy would be helpful. In regards to the Cultural Transformation programme, apologies for inappropriate behaviors, however, the presentation highlights the good evidence of multi-disciplinary working, we need to link this.
d) Paulette Lewis: How does the accreditations link to divisions and their performance. How do we include in our quality standards?
Steph Gorman: When the process was put into place the previous 6 months of audits were used towards the accreditation score. This comes up through the divisions, and into QAC.
Nikki Lewis: The process has also highlighted areas for improvement, for example nutrition, a really helpful process.
e) Simon Wombwell: Is there a link to areas who are 'bronze' and financial challenges.
Nikki Lewis: Medical areas are due to complexity of patients, more profound than in clinical areas.
Simon Wombwell: We continue to spend on Bank staff, but may need specialist nurses in those areas to ensure continuity of care, we need to link together.
f) Helen Wiseman: In regards to multi-complex needs. is this in frailty.
g) Nikki Lewis: This is in general care, frailty not only covers those over 65, you can be frail and under 65. Multi complexity could be, for example, alcohol abuse etc.

The Board **NOTED** the Board Story

~ 10 Minutes Wellbeing Break ~

4. Sustainability

4.1 Finance Report (Month 4)

Simon Wombwell presented the report, the following key highlights were given:

1) Deficit of £3.9m at the end of July 2025 adverse to plan.
2) Only organisaiton in Kent who are not 'on plan' – risk loss of deficit support funding.
3) Continued underperformance against savings target.
4) Income reductions for low activity in the CDCs.
5) Cost impacts: industrial action, utility costs, and increase in haematology drug spend.
6) Impact on cash position

Check and Challenge

a) John Goulston: Does the two grants from Salix cover replacement of the heating system.
Matt Capper: The grant is related to heat pumps.
b) Helen Wiseman: What is the risk if there is a general power cut?
Gary Lupton: The hospital has backup generators, a robust system.

c) John Goulston: The Board are approaching a crucial junction. A need to be clear regarding the System Saving Package and MFT percentage of the £118m, and the risk to our internal position.
d) Jon Wade: CEO meeting on Tuesday, 16 September to prioritise work.
e) John Goulston: Month 5 to be submitted by the week end; this will direct the conversation for deficit support for the next quarter.

The Board **NOTED** the report

4.2 Integrated Quality Performance Report

Jon Wade presented the report for assurance. The report was taken as read.

Check and Challenge

a) John Goulston: The refreshed IQPR will be aligned to the Stabilisation Plan, including areas of focus and work streams for the rest of the year.
ACTION TB/2025/027: IQPR refresh in line with the Stabilisation Plan.

The Board were **ASSURED** by the report

5. Quality, Safety and Patients

5.1 Maternity and Perinatal Incentive Scheme – Year 7 Update Report July 2025 - CNST

Alison Herron presented the report in line with the paper submitted. Key highlights included:

- CNST Year 7 Published 02 April 2025 with reporting period ending 30 November and submission due 03 March 2026.
- The following Safety actions are off track or at risk:
    - Safety Action 1 – remains off track with actions to deliver. Currently at 93% for Standard C due to non-return of factual information from another Trust. Anticipate will reach compliance in Q2 and Safety action will return to on track.
    - Safety Action 5 – At risk (2487 – Midwifery Workforce budget 2025 – Non-compliance with Birth-rate plus recommendations. (Score 16). Currently safely staffed.
- 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).
- All remaining safety actions are on track with reporting scheduled as per CNST requirements

Check and Challenge

a) Paulette Lewis: Two vacancies indicated as 'red'
Alison Herron: Remains 'red' against birth rate plus, this will be shown in a different way in the next report, the red will be able to come off.
b) Paulette Lewis: Monitor of deliveries, do we have to wait to complete every 6 months?
Alison Herron: On track for 4500 deliveries, these are monitored monthly. September is the busiest time.
c) John Goulston: Is there an update on last week's visit from the Regional South East Team?
Alison Herron: An informal insight visit, a full day. Focus sessions with colleagues including the Maternity Champion. Report to be received within the next two weeks.
ACTION TB/2025/028: Update from Regional South East Team visit to the next meeting.
d) Jane Parry: Commend the maternity services on the visit.

The Board were **BRIEFED** by the report

5.2 Perinatal Quality Quarterly Report – Q1 2025/2026

Alison Herron presented the report in line with the papers submitted. Key highlights included:

1) 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).
2) Monthly updates aligned with the minimum dataset of the PQOM are submitted monthly to QPSCC and QAC along with to every Trust Board.
3) This report provides quarterly oversight for Action 1 2025/26

Check and Challenge

a) Paulette Lewis: The choices for women in maternity has changed. The package of care has now changed. We need to review to change the skill mix. Acuity and practice changes, compared to our finances. We are based on birth rate plus, the old model. This is a national issue.
Alison Herron: C-Section feeds into acuity, we do have nurses in the portfolio who are included in the birth rate plus.
Paulette Lewis: The full package of care needs to include theatres as well as nurses.
b) Simon Wombwell: The C-Section rate is 50%, the Penny Dash Report has this as a focus area.
c) John Goulston: Health and inequality (page 77), very stark that 59% of hearmorrage are black women.
d) Paulette Lewis: Looking at statistics, what are we doing to understand the demographic and their health needs. This needs to remain a focus.

The Board were **BRIEFED** by the report

5.3 Guardian of Safe Working (GSWH) – Annual Report

Alison Davis presented the report. The following was highlighted:

a) The GSWH keeps the engagement from the Post Graduate Doctors in Training representatives at the highest possible level, through regular feedback and communication from the representatives. Representatives hold quarterly discussions in post graduate doctor's forum meeting.
b) GSWH involved in the induction of new post graduate doctors. No major issues have been noticed in the exception reporting and majority of small issues have been discussed and resolved.
c) All the exception reports with immediate safety concern are discussed in detail. Accordingly, appropriate actions are taken with DATIX where needed

Check and Challenge

a) Peter Conway: This report has been to QAC. There is no narrative relating to risk and issues, what is the report asking the Board to review; this should be reflected in the coversheet.
Alison Davis: There is a robust governance process. Assurance can be given that concerns raised by residents are reviewed quickly.
Peter Conway: A need to see risk and issues around next steps. Need to review for lower costs with more productivity.
b) Sheridan Flavin: Areas of the report require focus and review: working hours, late finishes, sickness and TOIL. A need for education around opportunities.
c) Paulette Lewis: The coversheet should highlight the key issues and challenges.

5.4 Medical Appraisal and Revalidation – Annual Report

Alison Davis presented the report. The Trust remains fully compliant with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013), and continues to strengthen its governance and assurance processes. Subject to board approval of this report, a positive statement of assurance will be submitted to NHS England in October 2025. The Trust has demonstrated strong engagement from its medical workforce and continues to enhance its medical appraisal and revalidation systems.

Check and Challenge

a) John Goulston: Alongside actions would be good to have the timelines.
b) John Goulston: Benchmarking, page 103, 70% consultants are male is this the usual ratio.
Sheridan Flavin: This is within the expected range.
Jon Wade: A requirement to look at proportionality.
Peter Conway: According to GMC data, overall male consultants are 51%, we are an outlier.
John Goulston: A consideration when succession planning.

The Board were **APPROVED** the report.

5.5 Safer Staffing – Mid-Point Review

Steph Gorman presented the report. The report provides an update on registered nurse and midwifery staffing to provide assurance of compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards, Developing Workforce Safeguards (NHSE)., providing an overview of safe staffing in relation to the establishment including vacancies and turnover, planned Vs actual staffing levels and care hours per patient day (CHPPD) over the past six months. The report includes an update on:

- Temporary spend – bank spend remains consistent.
- Safe staffing incidents and staffing issues and risks – increase compared to March, around budgets.
- National changes in the job profiles for nursing and midwifery roles band 4-7. Vacancies for 2 WTE Midwives.
- Planning for future graduates in accordance with the letter in August for guaranteed places
- Potential risk for an uplift to staffing within paediatrics for 26/27.
- Reduction in turn over particularly for registered staff, best in region.
- Primary reasons for leaving are ‘better work life balance’ and ‘personal development’.
- Pediatrics – potential increase in staffing. Tool in place to gain accurate figures.
- We are providing Safe staffing across the organisation.

Check and Challenge

a) Gary Lupton: In terms of the financial position, we now need to look deeper into hours and grades, nursing and doctors are a big proportion of costs. A consideration to profile different models.
b) Jane Perry: Mid Kent college is pipeline into workforce, accepting what has been said, but we need to acknowledge this amazing achievement.
c) Peter Conway: There is an issue with budgets to not aligning to safer staffing goals. Not on the Risk Register. Can you assure us the financial budgets are embedded?
Steph Gorman: This has been reviewed, had meetings with clinical workforce and finance to ensure the right budgets were embedded.

Peter Conway: With the requirement to reduce our staffing by 400, what is the trajectory.
Simon Wombwell: When looking at Net we do not have sufficient budget, we are overspent, we cannot sustain level of staff.

d) Peter Conway: For assurance to the Board, around safety, have we locked in what we can.
Simon Wombwell: The work around safe staffing is primary. Safety is the priority. However, need to review what can we do to get it back into a balanced budget.

e) Helen Wiseman: Why is acuity looked at every 6 months instead of daily.
Steph Gorman: This is reviewed for bank requests. We have the tool for daily review, just need to start using it, using well-staffed dynamics to make sure we are adaptable and flexible.

f) Simon Wombwell: Temporary staffing spend is £2.5m a month, we need to bring this cost base down.
Steph Gorman: Temp base is enhanced care, this is under review.

The Board were **BRIEFED** by the report

6 Items for Approval

6.1 Safeguarding – Annual Report

Steph Gorman presented the report, informing the Board of the continued delivery of statutory and regulatory safeguarding duties placed upon the Trust.

1) The Trust has met all of the standards required to provide the Local Safeguarding Children's Partnerships (LSCP's) and the Kent and Medway Safeguarding Adults Board (KMSAB) with assurance that there are robust processes in place with appropriate polices to support the safeguarding of those using the trust services.
2) The report details the activity undertaken internally and externally in order to meet these responsibilities.
3) Delivery of safeguarding training at level 3 for adults and children has been a challenge however the training compliance has been maintained at KPI targets.
4) MCA training compliance has now been removed from the risk register due to sustained achievement for 8 months.
5) Maternity safeguarding has achieved the key performance indicators to 100%.
6) Learning Disabilities training – Oliver McGowan was introduced as an eLearning with next steps progressing to face to face tier 1 and tier 2 training.

The Board **APPROVED** the Safeguarding Annual Report

6.2 Virtual Ward

Tracy Stocker and Darren Palmer presented the report for ratification, after receiving approval at the Finance, Planning and Performance Committee on 27 August.
The report provided a fully comprehensive overview of the transformative solution to systemic pressures on patient flow, discharge capacity, and inpatient efficiency.

<u>Check and Challenge</u>

a) Jon Ward: An interesting piece of work, that could potentially place MFT at the forefront. Completely supported of the business case. It is high risk, not a reason not to do it, but need to be aware of support if needed.
Darren Palmer: Modeling it is theoretical.
John Goulston: The Netherlands and Denmark do have similar models

b) Jon Wade: In regards to 'winter plans' there is a forecast bed gap of -156, this plan goes a significant way to mitigate.

c) Gary Lupton: In terms of theming, include all benefits realization. There needs to be a weekly process of monitoring, needs to be measurable. Reallocation of staff and bed reduction, need to look at corporate and support costs to drive down. Need to count everything.
Darren Palmer: The report is conservative in terms of savings; the additional benefits will be captured.
d) Alison Davis: For assurance, in regards to patient acceptance, what happens if the patient deteriorates. A weekly review needs to be a focus, and measure from day one. Need to be able to pick up issues early. Benefits realisation need to be a focus.
e) Paulette Lewis: Need to consider the demographic of patients, looking at how to manage the type of patients we have.

The Board **RATIFIED** the Virtual Ward

6.3 Kent and Medway Pathology Network (KMPN) Contract Signing

Matt Capper presented the report for approval. The report highlights key provisions in the contract that boards will be delegating to the KMPN joint committee and what will be retained by Trust boards as well as reminding boards of the financial principles, scope of KMPN and the phased approach to implementation.

Check and Challenge

a) Gary Lupton: Having learnt from current contracts, we want to understand how growth is managed, is this really the key focus? The challenge is how to manage growth through efficiency. A push on education.
b) Helen Wiseman: Cannot see where recommendations and learnings for future plans within the pathology service have been addressed.
Matt Capper: The contract will be sent to the NEDS
c) Alison Davis: Driving down demand, no patient should be having a test they don't need. Specific challenge is the way success is measured when samples are sent to the lab. There are discrepancies in the current arrangements.
Matt Capper: The concerns will be raised at the Network meeting.
ACTION TB/2025/029: Update on reporting measured success when sending samples to the lab.

The Board **APPROVED** the contract signing

7 Supplementary Items

Nothing to report for this meeting.

8 Closing Matters

8.1 Questions from the Council of Governors and Public

a) Imogen Head: Triangulation of accreditation process, and cultural work. Are we seeing a higher level of incivility on wards where there is low accreditation?
b) Tina Rowe: Have adult social services been considered in the virtual ward assessment?
Darren Palmer: The virtual hospital will have 2 streams, this will include adult social services. This is theoretical. We are looking at how we can work with these services.

8.2 Escalations to the Council of Governors (COG)

- Ward accreditation
- Cultural transformation

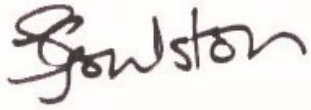
- Safeguarding report
- Stabilisation plan

8.3 Any Other Business and Reflections
There were no further matters of any other business or reflections.

8.4 Date and time of next meeting
Wednesday, 12 November 2025

The meeting closed at 13:53

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



Signed by the Chair …… Date:

Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
14.05.25	**TB/2025/009 and TB/2025/012**	**Integrated Quality Performance Report (IQPR):** develop an IQPR that dovetails into the business plan and submit significant information as opposed to copious amounts of data. **Patient First – Refresh:** a review and refresh of the methodology/strategy to be completed and submitted to Board.	10.09.25 and 20.08.25	Siobhan Callanan, Deputy Chief Executive	**10.09.25 - Jon Wade confirmed that work is ongoing** 02.07.25 - Siobhan will bring an update to August Board, with formal submission to the September Board meeting IQPR will be included on the Board agenda	Amber
23.07.25	**TB/2025/018**	**Standing Financial Instructions and Scheme of Delegation:** to be reviewed and amended following the establishment of the Kent and Medway Joint Committee.	12.11.25 ~~10.09.25~~	Matt Capper, Director of Strategy and Partnership/Company Secretary		
10.09.25	**TB/2025/021**	Undertaking NHSE - To take forward in line with the stabilisation plan, ensuring the metrics and outcomes are in line with undertakings, the report to come back to the board	12.11.25	Siobhan Callanan, Deputy Chief Executive		
10.09.25	**TB/2025/022**	Freedom To Speak Up - Update Report to the Board	12.11.25	Sheridan Flavin, Chief People Officer	**PROPOSE TO CLOSE -** FTSU Annual report circulated to the People Committee	Green
10.09.25	**TB/2025/023**	Cultural Tansformation Report - Details of responsibilities for the governance route to be decided and shared.	12.11.25	Sheridan Flavin, Chief People Officer		
10.09.25	**TB/2025/024**	Report on risks and responsibilities for Fire Safety	12.11.25	Neil McElduff, Director of Estates		
10.09.25	**TB/2025/025**	Risk Register - Report to be refreshed for clarity and inclusion of impact of actions taken.	12.11.25	Wayne Blowers - Director of Integrated Governance, Quality and Patient Safety	**NEED TO AGREE A DUE DATE - 28.10.25 - ongoing:** this work forms part of the Stabilisation Plan governance work	White
10.09.25	**TB/2025/026**	Medicine management of controlled drugs report to come to Board.	12.11.25	Steve Cook, Pharmacy Senior Manager	**PROPOSE TO CLOSE -** Update 04.11.25 - Report to QAC in September. Updates to be shared with the committee in March 2026.	Green
10.09.25	**TB/2025/027**	IQPR refresh in line with the Stabilisation Plan	12.11.25	Siobhan Callanan, Deputy Chief Executive	**NEED TO AGREE A DUE DATE**	
10.09.25	**TB/2025/028**	Maternity - Update from Regional South East Team visit to the next meeting.	14.01.26 ~~12.11.25~~	Alison Herron, Director of Midwifery	**REQUEST FOR DUE DATE CHANGE** - update to be given January 2026, team are awaiting receipt of the report form the Regional South East team. It has been chased by Ali Herron.	White
10.09.25	**TB/2025/029**	Kent and Medway Pathology Network - Update on reporting measured success when sending samples to the lab	12.11.25	Matt Capper, Director of Strategy and Partnership/Company Secretary		

Chief Executive's report: November 2025

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

Industrial action

Planning is under way to ensure that we take all necessary steps to continue to safely care for our patients during five days of industrial action by Resident doctors – expected from 7am on Friday 14 November to 7am on Wednesday 19 November – and to minimise delays and disruption to our services during this time.

Considering the benefits of closer collaboration

In recent months, independent health experts, commissioned by NHS Kent and Medway, have been engaging with staff and stakeholders to explore whether closer collaboration with Dartford and Gravesham NHS Trust, where I am also Chief Executive, could benefit patients and ensure we make better use of limited NHS resources long term.

We already work closely with Dartford in some medical and surgical specialities, and pathology services. Joint working across trusts is common as there is a recognition of the value of partnership working across the NHS, with organisations increasingly working with their neighbours in group arrangements under shared leadership.

I've been impressed by colleagues' engagement in considering the case for collaboration, sharing examples of best practice and learning from experience here and elsewhere, and the collective commitment to put patients first as we consider our potential next steps.

Stabilisation plan priorities

In September, new quarterly league tables published by NHS England placed Medway 130 out of 134 acute trusts in England, when assessed against performance and financial indicators for the first quarter of this year. The Board has submitted the Trust's provider capability self-assessment which is part of the new National Oversight Framework. In combination with the league tables, I anticipate the Trust will be placed in segment five and will fall into the new National Provider Improvement Programme (NPIP), previously the Recovery Support Programme.

This is disappointing and clearly not where we aspire to be. This position reflects the scale of the operational and financial challenges that we are working hard to address, so that we can improve access for our patients, deliver cultural improvement for our staff and deliver long-term financial sustainability.

Currently too many of our patients wait too long to be admitted to a ward, have the operation or diagnostic they need, or have cancer diagnosed or ruled out, and treatment started.

In order to provide focused attention on the areas in which we are required to improve, the Board has agreed a stabilisation plan that consists of five immediate priorities to improve our culture, governance, performance, quality of care and financial position.

1. **Culture** - this is focussed on empowering staff, creating an inclusive and fair culture, and developing managers. Key to delivery is the work already under way to act on the findings and recommendations of the independent review published in September.

2. **Governance** – this involves improving our processes so that we are working in a consistent way, that issues are escalated appropriately from ward to Board, and we can make informed decisions.

3. **Performance** – this is focussed on improving access to services for patients by achieving key elective, emergency and cancer care standards this financial year which include:

    a. **Elective care** - eliminating 65 week waits by 21 December, significantly reducing 52 week waits and treating 60 per cent of patients within 18 weeks of being referred.

    b. **Emergency care** - achieving 78 per cent four-hour emergency performance and reducing length of stay in the Emergency Department.

    c. **Cancer care** - sustaining the improving trend in cancer performance to achieve 75 per cent for 62 day waits, and 80 per cent for the 28-day faster diagnosis standard.

4. **Quality** – a downward trend in mortality indictors and improved compliance against the NICE standard for sepsis care by September 2026.

5. **Finance** – achieving this year's forecast outturn deficit position and efficiencies, and developing a realistic but challenging medium term financial (and operational) plan for the next three years.

Finance and workforce measures

The NHS in Kent and Medway is taking action to reduce spending, and protect patient care, so that our organisations and services are more sustainable in the future. All organisations in Kent and Medway are working hard on this challenge and recently all the chief executives in the county met and agreed to adopt a fair and consistent approach.

This includes significantly limiting recruitment; reducing bank and agency spend; agreeing a standardised bank rate; and everyone following the same rules and processes, including in how we measure savings.

Earlier this year we introduced strict controls on recruitment and other large costs, such as equipment and supplies, and are further reducing our use of agency and bank staff. We are also reviewing non-clinical services to identify further savings.

As part of this work, we have launched a Mutually Agreed Resignation Scheme (MARS) which is open to all staff and is designed to enable eligible colleagues, in agreement with us, to choose to leave their post voluntarily in return for a severance payment.

Our aim is to keep care safe, protect roles where we can, and make sure money is focussed on improving services for patients and communities. These steps do not mean stopping essential care or important changes, but making sure every pound is used where it's needed most.

Staff Survey

As part of our efforts to improve our culture, we are currently actively encouraging colleagues to complete this year's NHS Staff Survey, which closes on Friday 28 November. Feedback from this extensive nationally-led survey continues to drive our priorities for improving staff experience and patient care. This year, we are aiming for a 50 per cent response rate, building on last year's participation of 45 per cent. As an incentive, staff who complete the survey will be offered the opportunity to win an extra day's annual leave.

Staff vaccination

We are also encouraging all staff to have their flu vaccination this winter at one of our easy-to-access clinics currently taking place throughout the hospital. Having a jab as early as possible is an essential step in helping us protect patients, colleagues and services through the busy winter period. I'm proud of the difference our peer vaccinators make at helping to boost staff vaccination rates, by offering on-the-spot vaccinations within various teams and departments across the Trust.

Patient Portal

I am delighted that more than 220,000 Medway and Swale residents are now using our online patient portal, Patients Knows Best, to quickly and securely access information about their hospital treatment, such as appointment details and clinic letters.

The latest development of this free and easy-to-use app now provides patients with easy access to their X-ray results, which will appear in the portal 28 days after clinical review. In addition, patients undergoing a hip or knee replacement operation can now access information and videos about their surgery on the portal, and complete their preoperative questionnaire online. This benefits patients with fewer hospital visits, and reduces printing, postage, and administration costs.

We know from feedback that the portal is well received by patients, particularly the speed with which they can access details of their upcoming appointments, so they no longer have to wait for letters to arrive by post.

Medway joins major research studies

I'm proud that we are the first hospital in Kent to offer patients the opportunity to take part in the Generation Study. Led by Genomics England in partnership with NHS England, the study wants to learn if looking at the DNA of newborns can help us find and treat genetic conditions earlier. It will test for 200+ rare genetic conditions including sickle cell, cystic fibrosis and hypothyroidism that can be treated in the NHS in early childhood.

Our Research and Innovation team is also encouraging members of Black communities to participate in a pioneering new research programme aimed at tackling health inequalities and improving healthcare outcomes.

The Improving Black Health Outcomes (IBHO) programme, led by the National Institute for Health and Care Research BioResource, aims to improve understanding of how health conditions uniquely affect Black communities. Taking part is simple – participants consent to provide a blood or saliva sample and complete a health and lifestyle questionnaire.

Expanding local diagnostic services

Our Community Diagnostic Centres (CDCs) in Sheppey and Rochester help patients across Medway and Swale access important tests and scans away from Medway Maritime Hospital, and help ease pressure on diagnostic services there.

Construction at our Rochester centre is progressing well, with the installation of a new Magnetic Resonance Imaging (MRI) scanner due to open shortly – the final milestone in this important project.

Once complete, both sites will offer a wide range of tests and scans, including CT, MRI, ultrasound, and cardiology and respiratory investigations – bringing faster, more convenient diagnostic care closer to people's homes.

Children's Community Services

Our children's community services transferred to Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Health (MCH) at the end of October. The transfer follows a re-procurement process carried out last year in which the commissioners, Kent and Medway Integrated Care Board (ICB), awarded the contract for these services to KCHFT, who had bid jointly with MCH.

Going forward, all children's community services across Kent and Medway will now fall under the new partnership, led by KCHFT, which will mean greater efficiency, smoother pathways and improved outcomes for patients and their families. We thank colleagues

involved in working collaboratively over the past few months to ensure a smooth transition while continuing to provide excellent services with minimal disruption.

Investing in a greener future

Our environmental impact must underpin the long-term efficiency, resilience and quality of the services we provide. Our Green Plan represents a significant step forward in our commitment to delivering sustainable healthcare for our local communities.

We are committed to embedding sustainability into every aspect of our work and have already begun making meaningful changes. Thanks to £25.9 million of funding from the Public Sector Decarbonisation Scheme, we have started investing in a greener future by installing solar panels, replacing aging boilers with modern heat pumps, and installing energy efficient light emitting diode (LED) lights and double glazing.

This will help us in our aim to achieve our full net-zero target in 2040, and we will continue to build on this progress. From reducing our carbon footprint, to improving energy efficiency and promoting greener practices, our efforts are ongoing and evolving.

Charity's 30th anniversary campaign

Finally, I would like to acknowledge thirty years of support from The Medway Hospital Charity. To mark this significant milestone, the Charity has launched the Thirty at 30 campaign to raise £30,000 to buy 30 new wheelchairs for the hospital.

Wheelchairs, which cost £1,000 each, make a huge difference in helping patients get to appointments comfortably and on time.

Earlier this year, the charity funded 30 chairs after feedback showed a shortage was causing delays for patients and their loved ones. But with rising demand and a bustling hospital environment more wheelchairs are needed at more entrances across the site so patients can access them easily.

Every donation helps the Charity move closer to their goal and improve the experience of our patients and visitors.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board Meeting in Public
Date: Wednesday, 12 November 2025 at 10:00 – 13:30
Trust Board Room and via MS Teams

Title of Report	Stabilisation Plan			**Agenda Items**	3.1-3.5
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
	X	X	X	X	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
Author and Job Title	Jennifer Butler – cPMO Programme Manager Jacqui Leslie – Head of Transformation				
Lead Executive	Siobhan Callanan				
Purpose	**Approval**		**Briefing** **X**		**Noting**
Proposal and/or key recommendation:	The Board is asked to note this report, which provides an update on the current status of the Stabilisation Plan and its associated programmes. This paper is presented for noting only and does not require approval or discussion at this stage. Its purpose is to formally inform the Board of programme progress, current risks, and the actions underway to strengthen delivery foundations across all workstreams.				
Executive Summary	All programmes within the Stabilisation Plan are currently rated Amber or Red, reflecting the ongoing challenges relating to organisational pace and operational pressures. Work is actively underway to strengthen delivery foundations across every programme. Each workstream is now developing detailed programme plan which they can be measured against A comprehensive communications plan is also in development to support the next phase of the stabilisation programme.				
Issues for the Board/Committee Attention:	The Executive Summary at the commencement of this submission details the areas of focus and the key performance position of the stabilisation plan.				
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Content in this paper – in the areas of Culture, Performance and Finance, have been discussed at: Trust Board (Cultural Transformation) FPPC (Performance, Finance) QAC (Quality)				

Board Assurance Framework/Risk Register:	TBC			
Financial Implications:	Please see summary in the Finance area of the Stabilisation Plan.			
Equality Impact Assessment and/or patient experience implications	There are no significant equality or patient experience implications to report at this stage. The Stabilisation Plan is currently focused on strengthening programme governance, planning, and delivery processes. Impact on Patient Experience - No direct impact has been identified. Any downstream service changes arising from future phases of the programme will be subject to appropriate quality and equality assessments. Controls in Place - Existing Trust governance processes, including Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), will be applied to any future changes to ensure no adverse impact on patients, staff, or protected groups. Consideration of Health Inequalities - Health inequalities have been considered; however, no specific impacts have been identified at this early stage of programme planning. Health Inequalities Potentially Impacted - None identified at this stage. Controls to Prevent Adverse or Unintended Implications - All programme workstreams will continue to review equality and health inequality implications as proposals develop. Any changes with potential impact will be escalated through the Trust's governance framework for assessment and mitigation.			
Freedom of Information status:	Disclosable		Exempt	

NHS
Medway
NHS Foundation Trust

Medway Foundation Trust's – Stabilisation Plan

(first stage of our Integrated Improvement Plan)

12th November 2025

Patient FIRST

Executive Summary

NHS Medway NHS Foundation Trust

Current Position

- All programmes are rated Amber or Red.
- Key challenges remain - organisational pace, operational pressures, and limited delivery capacity.

Work Underway

- Structured activity plans being developed for each workstream, setting out:
  - Key actions
  - Ownership
  - Milestones
  - Interdependencies
- This will improve oversight, support earlier risk identification, and give clearer visibility to executives.

Strengthening Governance & Communications

- Governance is being strengthened to improve clarity and alignment across programmes.
- A coordinated communications approach is in development to ensure:
  - Consistent messaging
  - Better staff understanding of stabilisation priorities
  - Greater transparency on progress

Overall Assessment

- The Stabilisation Plan remains deliverable.
- Progress depends on sustained organisational focus and increased pace of delivery.
- Strengthened planning, governance, and communications will support movement from Amber/Red towards greater stability.

Programme	RAG
Culture	
Governance	
Quality	
Performance	
Finance	

We would welcome the Board's views on what they would find most helpful in terms of reporting. We are also reviewing our wider reporting and governance processes to ensure they remain robust and fit for purpose. This paper has been produced at pace to provide an initial view, and further work is underway to strengthen both reporting and governance arrangements.

Executive Summary

Exec Group has set the vision for the organisation for the next 17 months to ensure delivery of our agreed Integrated Improvement Plan. We have adopted a portfolio approach to delivery, focusing on three distinct phases:

Culture Programme

Programme: Culture

Exec Lead(s): CEO / DCEO / CPO

Programme RAG Status

Description	
1	Executive team and unitary Board strengthening
2	Deliver the Cultural Transformation Programme - phase 2
3	Addressing the employee relations backlog and strengthening process / managerial capability to prevent recurrence

RAG Justification

Report and recommendations commissioned by the ICB is being considered by Trust Board and Council of Governors.
Phase 2 of the Trust-wide Cultural Transformation programme has been established under a six-workstream structure and is moving into mobilisation stage. Three of four plannned workstreams have commenced activity with two of these rated green and one rated amber. One workstream has not yet started. Last month's Board update desribed the established governance and the key milestones . Three centrally shared Programme roles are required and are yet to be filled.
ER backlog status report is included in Board papers for 12/11/25 and presented as a separate report.

Milestones Completed this Period

First session of the revised board development programme completed on 3rd November

National submission on board level succession planning submitted

ER backlog remedial actions are underway - updated position has been advised via a separate report

Milestones to be Completed next Period

Take receipt of Board and Council of Governors feedback on recommendations from ICB-commissioned report re: closer collaboration with Dartord and Gravesham NHS Trust.

Complete programme mobilisation on WS1 and 3 of the Cultural Transformation Programme and take key actions to ensure WS 1 moves back on track for first 30 day delivery actions. Complete other key workstream actions identified in the October Board update as planned.

Current measures of performance		Oct-25 Latest	Oct-25 Plan
1	Core roles within the Executive Team are substantively recruited to (Lead: CEO)	TBC	TBC
2	80% of middle managers completing the TLT development programme (Advanced Management Essentials for B8a and above / Management Essentials for B7) (Lead: DECO / CPO)	51.6% (AME) 51.7% (ME)	TBC
3	Deliver to the six workstream timescales linked to Phase 2 of the Cultural Transformation Programme (completion of Phase 2 by October 2026)	Three w/streams active	Four w/streams active
4	100% of backlog cases in Employee Relation (ER) have been reviewed and outcomed (Lead: CPO)	100% of cases allocated	100% of cases allocated
5	Improvement in performance related to disciplinary and grievance investigations completed within 6 weeks (non MHPS)	TBC	TBC
6	Improvement in performance related to disciplinary and grievance hearings held within 3 weeks of the report being submitted (non MHPS)	TBC	TBC

Performance - KPI Profile

	30-Sep Delivered	30-Sep Plan	31-Oct Delivered	31-Oct Plan	30-Nov Delivered	30-Nov Plan	31-Dec Delivered	31-Dec Plan	31-Jan Delivered	31-Jan Plan	28-Feb Delivered	28-Feb Plan	31-Mar Delivered	31-Mar Plan
1	TBC	TBC	TBC											100%
2	43% (AME) 46.7% (ME)	TBC	51.6% (AME) 51.7% (ME)					85% (ME)						80% (AME)
3	N/A	N/A	3	4										
4	100% allocated	100%	TBC	TBC				100%						
5	TBC	TBC	TBC	TBC		TBC		TBC		TBC		TBC		TBC
6	TBC	TBC	TBC	TBC		TBC		TBC		TBC		TBC		TBC

Key Barriers to success	
1	Attracting talent to the organisation to fill key roles (Linked to timings of recruitment and organisational reputation)

Key Risks	
1	Organisational Development (OD) capacity to deliver training (Management Essentials) will be impacted by impending leadership gaps (Head of OD) and the proposed re-structuring of the OD team
2	Delayed launch of Phase 2 of the Cultural Transformation Programme

Escalations to Board

Outline Project Plan:

	Description / Action	Deadline	Lead
1	Delivery of the unitary board strengthening programme in line with the findings of the Margaret Pratt review supported by the Independent Board Advisor (Fiona Wise)	TBC	CEO
2	Executive level core roles are defined and recruitment pipeline timetabled (in collaboration with any supporting providers)	TBC	CEO / CPO
3	Progression of TLT development programme linked to the delivery of Management Essentials and Advanced Management Essentials for all relevant staff	AME- 31/03/26 ME - 31/12/25	CPO
4	Establish governance and delivery structure for phases of the Cultural Transformation Programme	mid-Oct 2025	CPO
5	Management of ER backlog cases with external support	31/12/25	CPO

Interdependencies:

1 ICB commissioned report related re: closer collaboration with Dartord and Gravesham NHS Trust.

Governance Programme

Programme: Governance **Lead(s):** CNO / CMO **Programme RAG Status**

Description:	
1	Developing a ward to board "golden thread" of governance and accountability throughout the organisation
2	Decision made on existing business cases (i.e. cath lab and theatre robot)
3	Corporate support service improvement (supporting the above) and business partner capability; triangulation

RAG Justification
TBC

Milestones Completed this Period
Decision made on Elective Business Case
Cath Lab - Taken to TLT request for funding going through system funding.
Theatre Robot further work needed on the Business Case
IIA panel members agreed and launch Nov 5th

Milestones to be Completed next Period
Executive led meeting to discuss HR Business Partner Capability
Agreement to revise business case approval process
Cath Lab - Taken to TLT request for funding going through system funding.
Theatre Robot further work needed on the Business Case

Current Measures of Performance:	Oct-25 Latest	Oct-25 Plan
1 % of performance reporting mapped correctly to Board / committee routes (CNO)		
2 % of divisions using revised IQPR and escalation routes (CNO)		
3 Development of IIA panel and number of IIAs completed and approved (CNO)		
4 A unitary Board decision taken on all three business cases (DCEO/CFO)		
5 Business partner model developed and implemented by Mar 26 (CPO/CFO)		

Performance - KPI Profile

	30-Sep Delivered	30-Sep Plan	31-Oct Delivered	31-Oct Plan	30-Nov Delivered	30-Nov Plan	31-Dec Delivered	31-Dec Plan	31-Jan Delivered	31-Jan Plan	28-Feb Delivered	28-Feb Plan	31-Mar Delivered	31-Mar Plan
1												100%		
2								100%						
3								100%						
4								100%						
5														100%

Key Barriers to Success:
1 Fragmented reporting structures that do not align ward to board for key information sharing

Key Risks:
1 Capacity & resourcing
2 Capacity of implementation of stabilisation plan will be impacted if CQC report is re
3 Risk in business cases - Risk of Decision not being made, on time, with the right stak

Outline Project Plan:

	Description / Action	Deadline	Lead
1	An agreed accountability and assurance performance review meeting framework embedded within the organisation.	28-Feb	CNO
2	% of divisions using revised IQPR and escalation routes	31-Dec	CNO
3	Development of IIA panel and number of IIAs completed and approved (CNO)	31-Dec	CNO
4	Ensuring existing business cases are taken to the appropriate governance forum for timely decision-making, providing clear accountability and alignment with strategic priorities	31-Dec	DCEO/CFO
5	Develop an accountability and assurance framework for BI/HR/Finance	31-Mar	DCEO/CFO

Interdependencies:	
1	Dependency on the framework and risk to current BP retention.
2	Interdependent with Culture area - Exec board strengthening work

Quality Programme

Programme: Quality | **Lead(s):** CNO / CMO | **Programme RAG Status**

Description:
1 Bringing SHMI back into the expected range (mortality)

RAG Justification
The Trust SHMI is outside the expected range and is showing an upward trajectory. This is due to patients admitted as emergencies. Areas of concerns are those clinical pathways were Trust is an outlier: pneumonia and urinary tract infection (UTI); addressing issues related to palliative and end of life care, both within the hospital and with providers; patient delays in our emergency department; poor patient flow in the hospital (which is influenced and impacted by the high number of patients who do not meet the criteria to reside in hospital) and the current processes.

Milestones Completed this Period
1. Deep dives of high mortality groups completed (Pneumonia, UTI, CVA, Diabet
2. Published vacancy for mortality lead
3. Agreement for Patient Safety leads to complete clinical validation in medici

Milestones to be Completed next Period
1. Establish a system of clinical validation
2. Establish pneumonia pathway
3. Recruit a mortality lead

Performance - KPI Profile

Current Measures of Performance:	Oct-25 Latest	Oct-25 Plan	30-Sep Delivered	30-Sep Plan	31-Oct Delivered	31-Oct Plan	30-Nov Delivered	30-Nov Plan	31-Dec Delivered	31-Dec Plan	31-Jan Delivered	31-Jan Plan	28-Feb Delivered	28-Feb Plan	31-Mar Delivered	31-Mar Plan
1 Mortality - A downward trajectory of the Trust SHMI by September 2026. (CMO)	1.2637		1 1.26	TBC												1.15%
2 Crude mortality rate in month to be less than the same time period 12 months previously (CMO)	1.5		2 1.42	TBC												1.10%
3 100% compliance in NICE Guideline Sepsis care compliance using monthly	100%		3 0.85	TBC												90%

Key Barriers to Success:
As the SHMI data is 6 months arrears in reporting, we have the risk of the improvement not being realised before March 2026
The SHMI methodology lacks congruence with Medway patients characteris

Outline Project Plan:

	Description / Action	Deadline	Lead
1	Mortality - A downward trajectory of the Trust SHMI by September 2026.	#######	CMO

Key Risks:
1 Capacity & resourcing
2 Insufficient capacity of frontline managers in engaging their frontline team

Interdependencies:
1 Dependent on 12 hour waits in winter months

Performance Programme

Programme: Performance **Lead(s):** COO/CFO **Programme RAG Status**

Description:
1 Delivery of the access standards, as per the revised forecast outturn
2 Exiting from Tier 1 for Cancer
3 Exiting from Tier 1 for RTT

RAG Justification
Overall RAG status for the programme is **Amber with Red Risk**, based on KPI - latest month vs Plan. Red risk : In the delivery of : 95.3% of DM01 Delivery of Diagnostics within 6 weeks

Milestones Completed this Period
1. Stabilisation plan shared with divisions w/e 1st Nov
2. EM5 proposal presented to TLT and agreed
3. Development of RSP action plan
4.Reduction of no criteria to reside figures
5. Following improvement set in May, cancer performance for 28 days is on track as pe
6. 31 day Cancer continues to perform along with 62 day beginning to recover in line with the plan

Milestones to be Completed next Period
1. Divisional improvment plans to be developed based on the Stabilisation plan
2. MADE Events planned of 5,6,7 November and 17-24 Dec
3. Introduction of EM5 to contributes to 4 and 12 hour performance
4. Implementation of RSP Action plan for RTT until end of March
5. Validate the October position
6. To review the RAG status for the programme

Current Measures of Performance:	Sep-25 (Validated) Latest	Sep-25 (Validated) Plan
1 Patients are seen and treated within 18 Weeks	53.4%	55.6%
2 No more than 1% of patients to be waiting >52 weeks seen & treated	5.4%	3.8%
3 ED 4hr Performance	75.7%	79.0%
4 ED >12hr LOS Type 1	11.1%	11.0%
5 95.3% of DM01 Delivery of Diagnostics within 6 weeks.	82.4%	93.0%
6 28 day FDS (80%)	76.7%	76.0%
7 62 day (75%) Cancer waits	71.0%	73.0%

Performance - KPI Profile

	30-Sep		31-Oct		30-Nov		31-Dec		31-Jan		28-Feb		31-Mar	
	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan	Delivered	Plan
1	53.4%	55.6%	Unvalidated	49.8%		50.4%		52.0%		52.7%		53.6%		56.0%
2	5.4%	3.8%		7.5%		6.9%		5.8%		5.4%		4.8%		4.0%
3	75.7%	79.0%		75.0%		74.0%		76.0%		74.0%		78.0%		80.0%
4	11.1%	11.0%		11.0%		11.0%		13.0%		13.0%		12.0%		9.0%
5	82.4%	93.0%		94.6%		4.7%		95.0%		94.9%		95.3%		95.3%
6	76.7%	76.0%		76.1%		77.0%		77.0%		77.4%		78.6%		80.1%
7	71.0%	73.0%		74.5%		74.7%		73.0%		71.6%		74.2%		75.0%

Key Barriers to Success:
1 Lack of community provision - impacting increased attendances to ED and rising NCTR and limited system response
2 Potential Medics Industrial Action

Outline Project Plan:

	Description / Action	Deadline	Lead
1	Awaiting NHSE signoff for RTT action plan	30/11/2025	COO
2	Action plan for Cancer developed and in monitoring phase	30/11/2025	COO
3	UEC board plan in development	30/11/2025	COO

Key Risks:
1 Risk to RTT delivery due to ENT backlog and cost to deliver recovery
2 Risk to delivery of diagnostics due to limited Imaging reporting capacity
3 Risk to programme delivery due to potential winter cancellations illustrated by seas
4 Increase in ED attendances (due to seasonal variance - winter)

Interdependencies:
1 Winter planning is integral to all the above programmes
2 Dependency on the level of industrial action during this period
3 Reduction of sessions (for Medics) have a interdependency with achieving Performance
4 Interdependency based on the Virtual hospital occupancy for patient flow

Finance Programme

Programme: Finance **Lead(s):** CEO / CFO **Programme RAG Status**

Description:
1 Financial Plan delivery, as per 2025/26 Plan adjusted for in-year performance
2 Developing the Medium Term Plan (MTP) and Financial Recovery Plan for 2026/27 onwards

RAG Justification

The YTD risk adjusted forecast outturn ("RAFOT") performance has been delivered as at month 6 (September).
However, following a recent supreme court ruling the Trust must now crystallise a £3.5m VAT risk (this had been assumed as high risk but a system approach to maintain in the RAFOT was taken).

Milestones Completed this Period
1. Month 6 (September) risk adjusted forecast outturn ("RAFOT") position delive
2. Internal planning guidance drafted
3. National 'Medium Term Planning Framework' released

Milestones to be Completed next Period
1. Deliver Month 7 (October) RAFOT
2. Delivery of efficiency programme to meet RAFOT
3. First cut divisional business plans for 26/27 to be presented

Performance - KPI Profile October financial position to be finalised by w/c 10/11 - Verbal update in Board meeting

Current Measures of Performance:	Latest	Plan		30-Sep Delivered	30-Sep Plan	31-Oct Delivered	31-Oct Plan	30-Nov Delivered	30-Nov Plan	31-Dec Delivered	31-Dec Plan	31-Jan Delivered	31-Jan Plan	28-Feb Delivered	28-Feb Plan	31-Mar Delivered	31-Mar Plan
1 2025/26 In Year Plan	(£44m)	(£4.9m)	1	(£13.6m)	(£13.6m)		(19.1m)		(20.0m)		(28.8m)		(33.3m)		(37.5m)		(43.8m)
2 2025/26 CIP Target (excluding share of System-wide savings target)	£16.1m	£27m	2	£2.9m	£3.1m		4.3m		6.2m		**8.4m**		10.8m		13.5m		**16.1m**
3 2025/26 CIP Target (including share of System-wide savings target (£18m))	£17.8m	£45m	3	£2.9m	£3.1m		4.3m		6.4m		8.9m		11.7m		14.8m		17.8m
4 Board sign-off, with updates and direction for Board each Month	17-Dec	17-Dec	4	02-Oct	02-Oct		22/10/2025		12/11/2025		**17/12/2025**						
5 Submission to national timetable (TBC)	31-Dec	31-Dec	5	-	-		-		-		31/12/2025						

Key Barriers to Success:
1 Delay in recognition by NHSE for in-year adverse performance
2 Winter pressures & / or Industrial Action
3 Agreement of control total vs Board view on 'deliverability' (consistent with triangulation & system)

Outline Project Plan:

	Description / Action	Deadline	Lead
1	Update DSF & forecast with ICB and NHSE in prep for national review meeting	15-Oct	CFO / CEO
2	Review forecast & CIP tracker values against profile to £44m deficit	29-Oct	CFO>FPPC
3	Draft Plan with balance between capacity/resource, activity & performance	29-Nov	CFO>FPPC
4	Board to sign off Medium Term Plan for submission to NHSE (TBC)	17-Dec	CFO>FPPC
5	Forecast Update with expectation of revised control total for 2025/26 OT	31-Jan	CFO / CEO

Key Risks:
1 MFT is required to invest in performance targets over financial balance
2 Safety priorities constrain financial improvement e.g. capacity requires safe
3 Pace of financial improvement is constrained by lack of restructuring or inves

	Interdependencies:
1	Balancing financial objectives with operational and safety targets
2	Change & improvement will require some level of joint strategic working e.g. System level change
3	Capital - technological and infrastructure investment to improve productivity

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

September - 2025

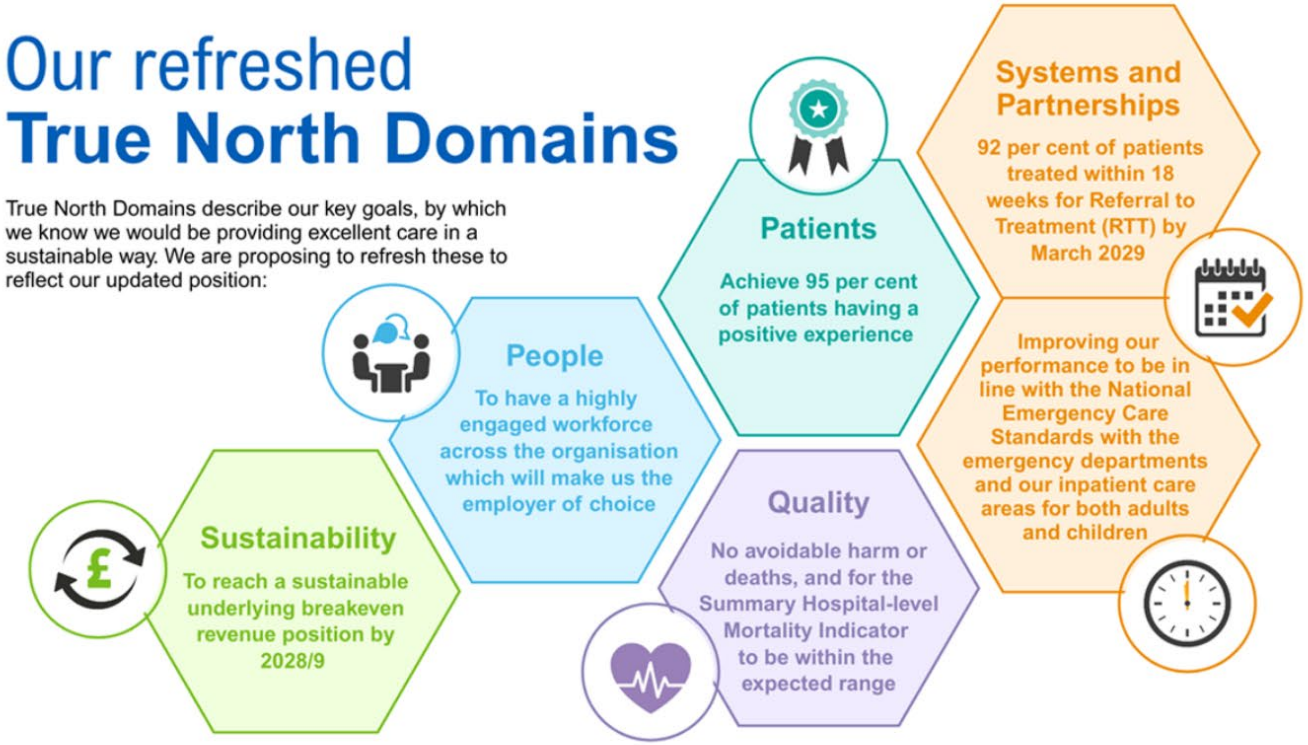
Patient FIRST

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	9	8	2	10	4	4
Quality	21	12	11	9	2	3
Systems & Partnerships	14	10	8	11	2	11
Patients	6	6	0	4	0	3
Sustainability	6	1	2	5	0	2

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

Assurance

True North & Driver KPIs
All Domains

Variation	P – KPI consistently passing the threshold	? – KPI Inconsistently hitting, passing and falling short of the threshold	F – KPI consistently falling short of the threshold	No threshold Set for KPI
H / L – Improving Variation		Emergency Care FFT Recommend %	National Staff Engagement Score Total FFT Recommend % Type 1 LOS > 12 Hours in EC %	
No Significant Change		Crude Mortality Rate % Total EC 4 Hour Performance % Total Pay Spend (£) vs Budget WTE Actual vs Plan	Outpatient FFT Recommend %	
H / L – Concerning Variation	Low or No Harm Incidents %		Incivility Cases (Combined) RTT 65+ Week Waiters RTT Incompletes Performance % Variance to CIP Target (£)	Deceased Patient – Clinical Coding Validation...

Executive Summary

True North Strategy and Supporting Breakthrough Objectives

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

People

Ambition:

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

Vision:

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

Breakthrough Objective:

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

Performance:

- National Staff Engagement Score
- Incivility Cases (Combined)

Patients

Ambition:

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

Vision:

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

Breakthrough Objective:

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

Performance:

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

Quality

Ambition:

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

Vision:

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

Breakthrough Objective:

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

Performance:

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

Systems and Partnerships

Ambition:

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

Vision:

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

Breakthrough Objective:

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

Performance:

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

Sustainability

Ambition:

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

Vision:

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

Breakthrough Objective:

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

Performance:

- Surplus / (Deficit) (£) Variance to Plan YTD
- Total Pay Spend (£) vs Budget
- WTE Actual vs Plan
- Variance to CIP Target (£)

Executive Summary

Stabilisation Plan

Culture
Sheridan Flavin, CPO

Key Messages

Cultural Transformation (CT) - findings have been communicated to all staff through an all staff comms.
Managers and staff have been asked to gather feedback from teams to feed into the Phase 2 workstream plans
Six workstreams are being developed as part of Phase 2
ER backlog – the Trust has engaged additional resource to clear ER backlog by end of 2025.
Business Partner and Investigation & Mediation Team consultation and recruitment nearing completion.

Issues, Concerns & Gaps

CT – Scoping of each workstream to be completed, including development of workplans, terms of reference and workstream members etc.
Reporting and monitoring mechanisms being developed for People Committee to provide assurance to Board.
ER work – complexity of cases and availability of relevant parties for investigation etc, slowing down progress.
Additional ER casework being received impacts capacity of team to clear backlog

Actions & Improvements

CT – Complete scoping of all phase 2 workstreams ensuring that phase 2 staff feedback is captured and fed back to staff
ER work – continue to close backlog cases
Exhaust informal approaches to resolving conflicts prior to formal processes, by using supportive mechanisms to resolve workplace disputes
Promote mandated management training to upskill managers in handling and resolving workplace disputes

Governance & Quality
Alison Davis, CMO
Steph Gorman, CNO

Key Messages

SHMI outside the expected range;
HSMR+ within the expected range

Issues, Concerns & Gaps

Workstreams
1. Patient clinical pathways
2. Learning from Deaths processes
3. Clinical Documentation and coding

Actions & Improvements

1. Deep dive into pneumonia and UTI with actions focussed on improving communication and documentation via speciality morbidity and mortality (M&M)meetings
2. Linking review of deaths output with speciality M&M meetings
3. Task and finish group to ensure accurate clinical documentation and subsequent coding

Performance
Frances Woodroffe, COO

Key Messages

Improvements are being seen in cancer performance, and the Trust is returning to the agreed plan, and is on track to come out of tiering at the end of Q3.
Elective performance is still challenged, primarily driven by the treatment of the discovered cohort of ENT patients, but is on course to recover by the end of the financial year.
UEC performance remains steady, but adverse to plan. Over October and November, the Trust and wider system are working to improve flow, reducing delays and reducing crowding in ED.

Issues, Concerns & Gaps

There is a national drive to eradicate 65 week waits by 21st December. MFT has already eliminated 65 weeks in all specialities except ENT and a small cohort of neurology patients who are referred to London.
Additional capacity has been commissioned to enable us to meet this deadline, but patient choice, late notice cancellations or sickness may affect delivery.

Actions & Improvements

There has been significant place and system engagement to improve the forecast bed deficit for winter, and establish additional schemes to support flow.
MADEs are planned for 5-7 November and 17-24 December to support the UEC improvement actions and reduce occupancy ahead of the festive break.

Recovery plans for any specialty not on track to deliver 60% RTT performance are being developed – gastroenterology, cardiology, rheumatology and ENT are the key risks

Financial Recovery Plan
Simon Wombwell, CFO

Key Messages

Initial drafting completed around the financial context and historic performance.
Iterative process of developing the Stabilisation Plan will feed into the FRP.

Issues, Concerns & Gaps

FRP requires mature savings planning for the current financial year and 2026/27; this will also need to include those medium-to-long-term strategic interventions at Trust, place and system level to be articulated, agreed and quantified.

Actions & Improvements

Completion of Dartford & Gravesham NHS Trust group model review required.

Patients

Key Messages

- 100% complaints acknowledged - Complaint themes include, delays in treatment, delay in diagnosis and failure to diagnose, general dissatisfaction with nursing and medical care, complications during/following operation delays in medication and pain relief, appropriateness of discharge, lack of communication, delays in outpatient appointments, STREAMing process.
- PALS themes include; queries on appointments, lack of communication from departments, delays in medication & pain relief being provided, dissatisfaction with medical care & treatment, delays in receiving results, appropriateness of discharge, enquires regarding personal records.
- 19 compliments registered.
- No new PHSO cases opened and two PHSO closed – one partially upheld (Specialist Medicine) and one PHSO case not upheld (Surgical Services).
- 1 complaint re-opened (AEM – ED complainant requesting some additional information following death of patient).
- 84% of complaints responded to within Trust target time of 40 working days. The challenge remains in receiving comments from staff to progress the complaint for writing
- MSA breaches remain low and are attributed to delayed step down of patients in the ICU / HDU

Issues, Concerns & Gaps

- 13 PALS re-opened (6 – Surgical Services, 2 – Children & Young People, 1 – AEM, 1 – Diagnostics & therapies, 1 – Frailty, 1 Specialist medicine), follow-up 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 appointments, results, lack of communication & information to patients and waiting times. Contact is also being received from inpatients regarding concerns they have about their current ongoing care
- Automated reporting of mixed sex breaches on tele tracking remains an issue

Actions & Improvements

- Concern: Patient's placenta was not given to the family following the delivery of their baby - family had requested this prior. (Patient's placenta was located and returned to the patient and her husband as requested later in the day)
- Actions: Staff Training and Reflection - All staff involved and the wider Maternity team have been asked to reflect on this event, to reinforce the importance of compassionate communication and cultural sensitivity.
- Documentation Improvements – Maternity Services are reviewing their documentation procedures to ensure that all personal birth preferences, especially those involving cultural or religious significance, are clearly recorded and communicated across teams
- The software to automate MSA breaching has been installed, the ADPE to work with the national team and MTW to implement the test environment prior to go live

Maternity

Key Messages

Perinatal Quality – Incidents: 137 datix (↑)reported for maternity; 0 Incidents in maternity rated Moderate harm or above; 1 HIE II/III, 1 MNSI Referral awaiting Triage. 0 Accepted referrals; 1 MNSI Report received in September 2025; PPH - 14 (↓)1500mls, 1 (↓) > 2500mls; 27 (-) relating to PPH >1000mls; 2 (↑) relating to 3rd/4th degree tears (11 in April, 4 in May, 3 June, 3 July) - 6 recorded via Maternity Dashboard; 22 (↑) Incidents in NICU, 5 (-) relating to medication. All incidents no/low harm. **Staffing**: 2.65 (↑) WTE Band 5/6 vacancy available to advertise; 5.39 WTE recruited but not yet started; 0 leavers in next 3 months. **Perinatal Quality** – PMRT: Perinatal Losses (MRRACE reportable & PMRT): 3 Neonatal Death (21, 20+4, 23+6); 1 Stillbirth (23+6); 1 Miscarriage (22+3). 2 PMRT Meetings held in September: Maternity Led Graded at A,A and A, A Neonatal C,A. **Listening to Women and Families – Service Users and MNVP**: MNVP role now permanent contract within ICB. Risk to year 7 CNST compliance now removed; MNVP service provision has not yet been increased by the ICB 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**: Community connectivity continues to be a subject of staff feedback. The issue score has been increased due to ongoing delays to broadband upgrade and concerns regarding staff and patient wellbeing; Discussions and feedback from Trust Culture Survey discussed at all team meetings. **Training**: Positive compliance position and trajectory for Midwifery and obstetric staff for PROMPT and CTG training; Awaiting 2 anaesthetic staff to be mapped for PROMPT to be compliant; All hospital midwives now mapped to Entonox training. **External**: Feedback from Q1 25/26 Saving Babies Lives (SBL) submitted; NHSE Maternity Insight Visit completed September 2025. Awaiting formal report.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: Reduction in medication incidents in NICU – work ongoing as part of Divisional Driver; Awaiting confirmation from MNSI whether HIE II/III case will be accepted. If not accepted, case will be investigated internally; Slight increase in 3rd and 4th degree tears in month. Datix not completed for all instances. Staffing: 10.04 WTE maternity leave with a further 4.47 WTE to go on maternity leave in coming months. Risk: Non-compliance with CNST Safety Action 1 (PMRT) and risk of non-compliance with Safety Action 8 – training. Perinatal Quality - PMRT: Patient first scorecard showing incorrect numbers for stillbirths and Neonatal deaths for September. Raised with BI; Need to devise system to ensure Neonatal Representation at Maternity PMRT meetings; Junior doctors need to be released to attend for learning. Themes: Delay in commencement of induction following pregnancy loss; Care of nutritional needs for babies on the NICU Unit. Listening to Women and Families – Service Users and MNVP: ICB has not increased the provision for the MNVP to meet all CNST requirements. Staff Feedback: Connectivity in the Community remains an issue due to previously allocated funds being withdrawn. This poses a clinical risk, both in terms of having relevant information available to make plans of care, but also in terms of the inability to complete contemporaneous notes; Staff raised concerns regarding expenses payments impacting on universal credit payments; Negative social media comments affecting staff wellbeing. Training: Training allocations stacked heavily in last 3 months of CNST reporting period, posing risk of non-compliance if non-attendance for any reason (eg. Sickness, clinical pressures). External: Not currently providing pregnancy specific Hybrid Closed Loop to type 1 diabetic pregnant patients. Working with ICB to identify allocated funding and MEC Division to review service provision, prioritisation and business planning. SBL compliance will reduce, as this element will now move to partially implemented.

Actions & Improvements

Perinatal Quality: MDT Action plan following MNSI report completed and approved by Trust. Key actions include review of VTE diagnosis and management pathway, patient information and resources and staff education and training; PPH now on Trust PSRP and to be added as a QI project; 3rd and 4th degree tears now a PSRP QI project; Reminder to all staff to ensure all 3rd and 4th degree tears are datixed. Staffing: Matrons undertaking a deep dive into stress and anxiety related sickness absence and ensure management in line with Trust Guidelines. Perinatal Quality – PMRT: Joint learning presentation to Trust M&M meeting. Maternity: Improve referral and communication pathways between MDT for early counselling and care planning with families. Neonatal: Ensure all documentation is contemporaneous, fully completed and legible; Pathway of notification for neonatal alert and preterm admissions is being reviewed by fetal wellbeing and neonatal teams to ensure timely review even if birth is not imminent. Listening to Women and Families – Service Users and MNVP: Development of cultural experience survey for service users to be rolled out in coming months; MNVP leading with Consultant midwife on developing communication tool across region; Picker Survey 2025 results received into organisation. Action plan to be co-produced with MNVP and key stakeholders once embargo lifted. Staff Feedback: Senior Leadership team trying to secure funding to support to progress community Broadband to improve connectivity; Plan to trial “10 at 10” style feedback sessions within Maternity; Senior team to liaise with payroll/HR as to how expenses are documented on payslip to try to avoid impacting on benefit payments; Senior team and Trust wellbeing team available to support staff if negative social media occurs. Encourage service users to raise concerns through Trust channels so this can be addressed. Training: Plan in place to map all staff to training evenly spread throughout the year. To seek support of Clinical Directors to ensure appropriate allocation. External: 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

Key Messages

- NOF (neck of femur) fractures: 46 patients, Breached >36h: 24 / 46 (52.2%)
- NAFF (non-ambulatory fragility fractures, non-hip): 4 patients; Breached >36h: 3 / 4 (75.0%)
- FNoF: Overall, more than half of NOF cases and three-quarters of NAFF cases breached the 36-hour standard in September, indicating sustained pressures in theatre capacity, medical optimisation pathways, subspecialty availability, and perioperative logistics.
- Falls - RSU, Ocelot, Ruby, Sheppey Frailty Unit and Tennyson ward achieved 100% in CRASH Bundle audit which is a celebration
- TVN – the number of reportable harms related to pressure damage has remained static in the last quarter with a reduction in stage 4 pressure damage in September.
- VTE – overall improvement in VTE Risk assessment compliance in Paediatric areas. An overall reduction in hospital acquired thrombosis in September, dropped to 11 from 25 in August

Issues, Concerns & Gaps

- FNoF: Thematic breakdown – NOF breaches (n=24) = Theatre capacity / emergency override / list overrun: 6; Medical optimisation (cardiac/respiratory/anticoagulation/bleeding): 8; Subspecialty surgeon required (THR/hip surgeon): 2; Diagnostics / imaging delays (CT planning/report; delayed diagnosis; inpatient fall work-up): 4; Equipment / theatre logistics (e.g., traction table): 1; Consent / family decision-making time: 1; Trial of mobilisation prior to listing (failed, then operated): 1; Transfusion/serology (antibodies; external cross-match): 1 | Signal: Capacity constraints and medical optimisation remain the commonest drivers. NAFF breach summary (n=3 of 4) = Theatre capacity with infection-control sequencing (ESBL) → cancellation; Subspecialty hip surgeon availability (periprosthetic); Insufficient theatre capacity (reduced session due to audit):
- Signal: Small numbers but high breach rate driven by capacity and subspecialty availability.
- Falls - Awaiting approval for mandatory bedrail training on ESR. E-Learning training package finalised. Low stocks of Falls preventive equipment.
- TVN - the team are experiencing short term staffing issues which has reduced their capacity by 75%
- VTE – training is not mandatory for medical and nursing staff. Learning has been identified from recent incidents that education is a significant gap.

Actions & Improvements

- FNoF: Additional lists: Trauma list capacity increased through converting some of the day stay list to trauma list plus targeted weekend capacity; Scheduling rules: embed a NAFF/NOF priority tier with conflict-resolution over electives; Data capture: mandatory “breach reason” coding in E-Trauma (capacity, medical, subspecialty, diagnostics, equipment, consent/decision-making); Governance: monthly thematic review at M&M
- Falls - request and chasers have been sent to expedite the training required to be added to ESR. New integrated falls alarms have been purchased with the new mattresses. These are to be networked into the call bell / alarm system which are likely to be ready for use in the next 4-6 weeks.
- TVN – support has been requested via the CNO and VCP process to mitigate the staffing issues, creative ways of working have been put forward in the short term.
- VTE – a proposal for e-learning to be mandatory for all staff is to be drafted and discussed for approval at the relevant boards.

Access

Key Messages

Access

- Incomplete performance has improved this month to 53.4%, however adverse to 55.6% plan.
- Patients waiting >52wks at end of September is 2127 against a trajectory of 1546. This is a deterioration in performance driven by the prioritisation of ENT capacity to longer waiting patients in the discovered cohort.
- Overall waiting list size stands at 39,233 against a plan of 40,583, a positive variance.

DM01

- Performance 82.4% ; Imaging 82.9%, Endoscopy 73.3% (highest performance), physiological measurements 86.1%

Cancer August (published data)

- 28D performance has increased again for August to 75.4% against 63.6% recovery trajectory (3.5% improvement from previous month). September currently tracking at 76.7%
- 31D performance was at 98.6%, MFT are in top 20. September currently tracking at 98%
- 62D performance increased to 71.6% against 72.73% plan, 6.7% improvement from previous month. September currently tracking at 70.5%
- 62D backlog position deteriorated to 11.3% , September currently tracking at 10.7%

Issues, Concerns & Gaps

Access

- 65 week position currently at 559 at end of September, which is expected to improve to 557 with validation. Of these, 547 - ENT (capacity as prioritising long waiting discovery cohort), 5 – Cardiology, 5 – Colorectal / General Surgery
- All but 8 specialities are delivering RTT performance >60%, and focus is needed on improving performance for these areas.

DM01

- Challenges with NOUS capacity and workforce continuing although improved position in September from previous month. MRI performance dipped, balancing capacity with cancer demand.

Cancer August

- 28D – Lower GI and Head & Neck/Thyroid are our tumour sites where we are focussing our efforts in improve performance; action plans are in place.
- 62D – largest opportunities to improve are in Head & Neck and Gynaecology

Actions & Improvements

Access

- Fortnightly Tier 1 meetings remain with NHSE and ICB to oversee elective and cancer performance improvement.
- Targeted recovery plans are being compiled for the 8 challenged specialities.
- Development of improved forecasting and modelling at specialty level
- Maximisation of additional ENT capacity to eradicate 65 week waits prior to 21st December

DM01

Developing targeted actions for imaging and increased weekly assurance meetings

Cancer August

- Lower GI summit meeting held 10 October 2025, to discuss performance and what further actions are required to improve performance further.
- Head & Neck pathway – challenges with timely diagnostics, working with Imaging at MFT and DGT
- Gynaecology – in process of developing targeted actions

Emergency Care

Key Messages

- September performance ended at 75.7%, improving on the previous two months. This is 2.9% adverse to the 78.6% plan for the month
- Ambulance handover delays
    - >15 min delay % sits at 27.9%. This is 7.1% favourable against the plan of 35% for September.
    - >30 min delay is 2.4% which is 2.6% favourable to the 5% plan for the month.
- Type 1 attendances >12 hours sits at 11.5%, 0.5% adverse to the plan of 11%

Issues, Concerns & Gaps

- Long waits in ED remain a challenge, with the longest waits in excess of 24 hours, focus is on reducing the longest wait, reducing total >12 hour waits, whilst improving 4 hour performance.
- 12 Hour Breaches – September recorded 1,160 breaches compared with 1,217 in August. Focus remains on the reduction of 12 hour breaches with weekly deep dives to identify trends and priority areas. Current data highlights that the majority of 12-hour breaches occur in Majors, predominantly within Frailty and Acute specialties.
- Initial assessment compliance in ED for September was 51.3%, remaining 19.7% below target and representing a further decline from recent months. Work to improve this number is included in the ED performance action plan.
- Issues remain around reduced usage of CDU due to mental health patients. Plans mobilising for new EM5 model (ED SDEC) to commence 3 November (agreed through DGMB on 15.10.2025) with a view to steaming suitable patients through CDU area to turnaround suitable patients who can be managed in alignment with a 2 hour management pathway.

Actions & Improvements

- Virtual ward to commence by end of October to support reduction in acute length of stay. Initial focus will be on admitted patients awaiting diagnostics, patients in ED who can be admitted to the VW to prevent acute hospital admission. The predicted impact is expected to show a reduction in patients waiting >12 hours in ED as an increase in patients admitted to the virtual ward will be provide capacity on the wards and will enable better flow out of ED
- MECC improvement focus in increased inreach into ED to ensure senior decision makers for specialities to support prevention of DTAs, utilisation of SDEC, implementation of EM5 model, increased board rounding. Meetings are in place with system partners around community support and how this can improve NCTR, flow and discharges
- Resetting our frailty services to deliver an SDEC multdisciplinary approach is essential for winter – work has commenced to reset the service before Christmas with support from system partners and based on good practice elsewhere in Kent and Medway
- An absolute focus internally is required to reduce hospital discharge delays, this is being worked up alongside external support to the wider system from Newton Europe.

People

Key Messages

- Incivility cases reported in September have stabilised at 72. As this high number is still of concern, it may also demonstrate that staff are feeling psychologically safe to speak up and raise concerns.
- Staff appraisal completion rate is continuing to deteriorate over the period of four months. HR BPs are raising this with staff in their areas

Issues, Concerns & Gaps

- Moving and handling stat/mand training continues to be below the Trust target with level 2 being of most concern at only 51.0% compliance, which has seen a continual decline since February 2025.
- Medway Hospital Life Support is below target and has seen a continual decline since May 2025. At only 74.39%.
- Resuscitation training programmes continues to be below Trust target (Advanced life support, Adult basic life, European Paediatric Advanced life support, Newburn life support, Paediatric life support)
- Safeguarding Level 3 continues to remain below target however this has increased to 83.39%

Actions & Improvements

- The incivility breakthrough huddle structure and approach has been reviewed and updated to enable a dedicated time for each division.
- A moving and handling trainer has been recruited to assist with the low compliance and provide a train the trainer model of delivery. The incumbent will be joining the Trust in November. Additional sessions have already been put in place for staff to book onto We are confident that compliance rate will increase.
- Life Support is presently being monitored via the Resus and Acute Deterioration Group (RADG) and work continues with divisions to improve the compliance. Monthly mapping, regular reporting at divisional and care group meetings highlighting noncompliance continues
- Safeguarding continue to overbook training to accommodate the large DNA rate. DNAs and the managers are notified

Sustainability

Key Messages

The Trust reports a YTD deficit at month 6 (September 2025) of £10.6m, adjusting to a control total deficit of £13.9m; this is adverse to plan by £8.0m.
The key driver causing us to move away from Plan is that our savings plans remain below target (adverse by £12.0m YTD).
This is having a detrimental impact on our cash (partially offset by the capital plan being behind at this time) – the Trust may will be seeking cash support and/or deploy cash management techniques which could affect supplies.

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 20% of the target (£2.9m vs £14.9m target).
Supported by PA Consulting, we need to see accelerated and increased reductions in our cost base.

Meeting of the Trust Board Meeting
Wednesday, 12 November 2025

Patient First Domain (please mark)	Sustainability	People	Patients	Quality	Systems
	x	x	x	x	x
Title of Report	**Annual Learning from Deaths Report**			**Agenda Item**	3.4a
Author and Job Title	Sofia Power, Wayne Blowers and Dr James Alegbeleye				
Lead Executive	Alison Davis				
Executive Summary	Approval		Briefing		Noting

Total deaths: 1,526 adult inpatient and ED deaths (01 April 2024 – 31 March 2025).

Reviews completed: 141 Structured Judgement Reviews (SJR) – 9.2% of deaths; 5 cases judged as possibly preventable (>50%).

External assurance: NICHE Health & Social Care Consulting review identified 11 required improvements in governance, specialty reporting, SJR processes, and family feedback. Implementation monitored via the **Mortality Breakthrough Objective**.

Key improvements this year:

- New digital SJR platform and multidisciplinary reviewer model introduced.
- Strengthened escalation of preventable deaths via Patient Safety Incident Response Framework (PSIRF).
- Enhanced governance through monthly **Mortality and Morbidity Surveillance Group (MMSG)** and divisional learning forums.

Key themes from deaths reviewed:

- Delays in recognising and escalating deteriorating patients.
- Late initiation of end-of-life care planning and documentation.
- Medication delays, omissions and prescribing errors.
- Poor documentation, handover and multidisciplinary communication.

Positive findings:

- Timely sepsis recognition and treatment in several cases.
- Compassionate end-of-life care and strong multidisciplinary collaboration.
- Good family communication and cultural/spiritual care.

Medical Examiner Service (ME):

- The Death Certification Reforms 2024 became statutory on 9 September 2024, requiring all non-coroner deaths to undergo independent Medical Examiner (ME) review.
- Throughout 2024/25, significant focus was placed on ensuring safe, effective transition to the statutory system.
- Medway continues to see a higher proportion of hospital-based deaths reviewed compared with national averages, with 51% of cases in the statutory period occurring in hospital.
- Recurring themes identified by the ME Office include:
    - Prolonged ED stays and environmental pressures

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- Poor-quality documentation and excessive copy-and-paste
- Difficulty identifying the responsible consultant
- Delayed ceiling-of-care discussions
- Limitations in recording controlled drugs on ePR
- Variable quality of mortality reviews
- Increased nosocomial infections in patients medically fit for discharge
- Inconsistent communication with families

Mortality indicators:

- **HSMR+** is within the ‘As expected’ range following national model changes in 2024 and improved clinical coding.
- **SHMI remains high (1.235)** – linked to palliative care trends, deprivation, and post-discharge deaths.

Learning culture and dissemination:

- Learning shared via Mortality Matters newsletter, divisional reports, and AQUA workshops.
- Continued expansion of training, coding education and SJR reviewer capacity.

Forward focus 2025/26:

- Reduce SHMI value to expected levels by 2026/27.
- Sustain mortality governance improvements and embed with PSIRF.
- Strengthen escalation for deteriorating patients, end-of-life care planning and documentation standards.

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<tr><td>Proposal and/or key recommendation:</td><td>Improvement in Clinical pathways especially care for sepsis, respiratory diseases and Pneumonia
Funding support for Validation of deaths</td></tr>
<tr><td><u>Governance Route</u>
Meeting:
Date submitted:</td><td>MMSG then to QAC</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td>Quality and safety risks– SHMI is a national metric and a smoke signal
Rising palliative care – Increased demand for community services
Impact of deprivation – A factor for premature mortality.</td></tr>
<tr><td>Resource implications:</td><td>Validation of deaths by Consultants (estimated 4PA)
Community supports for out of Hospital End of life care services.</td></tr>
<tr><td>Sustainability and/or Public and patient engagement considerations:</td><td>Public and Patient awareness alternative pathways rather than use of A&E for point of care</td></tr>
<tr><td>Integrated Impact assessment (please mark):</td><td>
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For further information please contact:	sofia.power@nhs.net

ANNUAL REPORT – Learning from Deaths 2024-25

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ANNUAL REPORT – Learning from Deaths 2024-25

1 EXECUTIVE SUMMARY

In 2017, the National Quality Board (NQB) published *Learning from Deaths* guidance, introducing a consistent framework for NHS trusts to review, investigate and learn from patient deaths. The aim is to strengthen accountability, ensure openness, and promote organisational learning to improve the safety and quality of care.

As part of this framework, trusts are required to operate a systematic mortality review process. This process not only identifies avoidable factors in individual cases but also highlights recurring themes, informs service improvements, and supports shared learning across the wider health system. Embedding mortality reviews within clinical governance structures ensures lessons are acted upon and that resulting improvements are monitored for effectiveness.

The introduction of the Medical Examiner (ME) service has further enhanced this process by providing independent and structured scrutiny of deaths. MEs engage with bereaved families, ensuring their concerns are addressed, while contributing to the identification of patient safety issues. This strengthens the link between mortality reviews and wider organisational learning, placing the voices of families at the centre of improvement.

This report summarises the mortality reviews conducted during the year, the themes identified, and the actions taken. It demonstrates how learning from deaths continues to drive improvements in the quality and safety of care we provide. The report is submitted in line with national guidance, which requires trusts to regularly collect, analyse, and publish key mortality data through quarterly public board reports.

2 SERVICE OVERVIEW AND IMPROVEMENTS

During the reporting period, the Trust has continued to strengthen its processes for reviewing and learning from deaths, ensuring alignment with national guidance and local governance arrangements. A key development has been an independent review conducted by NICHE Health and Social Care Consulting. NICHE supports trusts in achieving a comprehensive understanding of all aspects of Learning from Deaths governance, from reporting, through to improvement, ensuring robust and effective processes are in place to learn from deaths.

The review provided an in-depth evaluation of the Trust's current systems and practices, identifying eleven key actions for service improvement. They key focus areas and improvement actions were targeted to:

- Board and leadership
- Line of sight to the learning from deaths agenda
- Speciality reporting
- Case review and SJR activity
- Reporting to the Board
- A shift in focus from SHMI and HSMR for assurance on quality of care relating to deaths
- SJR process to move to a multi-disciplinary approach
- Team working
- Ethnicity and other protected characteristics
- Referrals for SJR in line with national guidance
- Thematic analysis and links to PSIRF
- Family feedback loop

A significant focus of the NICHE review was the Trust's Structured Judgement Review (SJR) process, ensuring it aligns with national best practice. The findings have been instrumental in shaping the Trust's improvement plan, supporting greater transparency and ensuring that learning from deaths is embedded across all care pathways.

Implementation of the recommendations is closely monitored through the Mortality Breakthrough Objective. This is a time-bound, weekly meeting designed to support the Trust's True North Objective. The meetings review progress against the Breakthrough Objective, track key metrics, discuss performance trends, identify barriers and risks, agree immediate actions, escalate concerns if necessary, and celebrate successes.

The Quality Breakthrough Objective workstream is specifically focused on preventing patient harm and avoidable deaths. Medway Foundation Trust (MFT) aims to achieve a reduction in mortality, bringing the Trust into the lowest quartile of the Summary Hospital-level Mortality Indicator (SHMI) by 2026/27. The Trust aims to reduce the gap between observed and expected mortality rates, enabling SHMI to return to the expected range. They key focus areas of the Breakthrough Objective are:

- Care continuity and speciality review for patients on the Emergency admission pathway
- SJR process and aligning with national best practice
- Accurate recording of episodes of care
- Learning from deaths process aligning with best practice
- Medical Examiner process and feedback loop
- End of life care process

Progress is reported monthly to the Mortality and Morbidity Surveillance Group (MMSG), to the Quality Assurance Committee (QAC), and quarterly to the Trust Board, providing assurance of both impact and sustainability.

3 MORTALITY REVIEW OVERVIEW

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality indicators, Medical Examiner (ME) scrutiny, structured judgement reviews (SJR), patient safety incident investigation outcomes, together with detail from quality and clinical governance processes. SJR activity includes reviews for all patients identified to have a learning disability. This report seeks to outline relevant activity.

For the financial year of 2024/25 and between 01 April 2024 to 31 March 2025, the Trust recorded 1,526 adult inpatient and Emergency Department (ED) deaths. A total of 141 (9.2%) of deaths were reviewed using the SJR method.

	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	YTD
Adult ED+ inpatient deaths	358	304	391	473	1526
No. of SJR stage 1 reviews	22	34	44	41	141
% of SJRs stage 1 completed	6.1%	11.2%	11.3%	8.7%	9.2%
No. of deaths judged possibly preventable (>50%)	1	0	1	3	5

Mortality data and learning from deaths are reported monthly to the Mortality and Morbidity Surveillance Group (MMSG). The Group, chaired with executive oversight, provides rigorous scrutiny of mortality surveillance and ensures that a systematic, evidence-based approach is applied to learning from deaths. This process supports

continuous quality improvement, strengthens accountability for patient outcomes, and ensures compliance with national expectations.

The MMSG's primary role is to provide assurance to the Trust Board on mortality outcomes and the effectiveness of learning from deaths activity, in line with the requirements of NHS England's *Learning from Deaths* framework. By reviewing both internal and external intelligence, the Group enables the Trust to demonstrate transparency, identify themes, and ensure that learning is translated into sustainable improvements in clinical practice.

The Group meets monthly and benefits from wide-ranging input from key stakeholders, including Learning Disability services, the Medical Examiner Service, Clinical Coding, and Neonatal and Fetal mortality reviews, with integration of national Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) data. This comprehensive and collaborative approach ensures that mortality surveillance is not only robust at a local level but also aligned with national reporting standards and regulatory expectations. In doing so, the MMSG provides the Trust Board with a high level of assurance that learning from deaths is embedded across services and continues to inform the Trust's wider quality and safety priorities.

The Mortality and Morbidity Review Group (MMRG) was reinstated to strengthen governance and provide a structured mechanism for specialties to feed into the Mortality and Morbidity Surveillance Group (MMSG). The Group serves as a forum for specialties to present trend and thematic data, as well as share improvement activity arising from their local mortality and morbidity meetings. Each month, a different specialty presents its quarterly data, which is then triangulated with findings from Structured Judgement Reviews (SJRs) and mortality data. This process ensures a comprehensive understanding of themes across the Trust and supports the alignment of local learning with organisational priorities.

While the Group has experienced challenges with attendance and engagement over the past year, it continues to provide an important platform for specialties to learn from one another, share good practice, and escalate issues where necessary. The Trust remains committed to maintaining this forum and is actively working to improve attendance and compliance. Looking ahead, a key aspiration for the coming year is to embed the MMRG more firmly within each specialty's governance processes, ensuring it becomes a well-established and valued component of the Trust's wider learning and assurance framework.

4 LEARNING FROM DEATHS

Structured Judgement Reviews (SJR)

In 2024, the SJR process was revised following the review by NICHE. The review highlighted the need to align the process with national best practice, strengthen the multi-disciplinary nature of reviews by involving both medical and nursing staff, and reduce reliance on Medical Examiner referrals to ensure that everyday care is also captured through randomly selected reviews.

In response, the Trust invested in a new SJR reporting platform designed to guide reviewers through each phase of care while incorporating more detailed patient demographic information to enhance inclusivity and diversity. A new Trust-wide training programme was also introduced, providing regular development opportunities in both the SJR methodology and the Learning from Deaths process. Reviewer opportunities were expanded to include nursing staff, further embedding a multi-disciplinary approach.

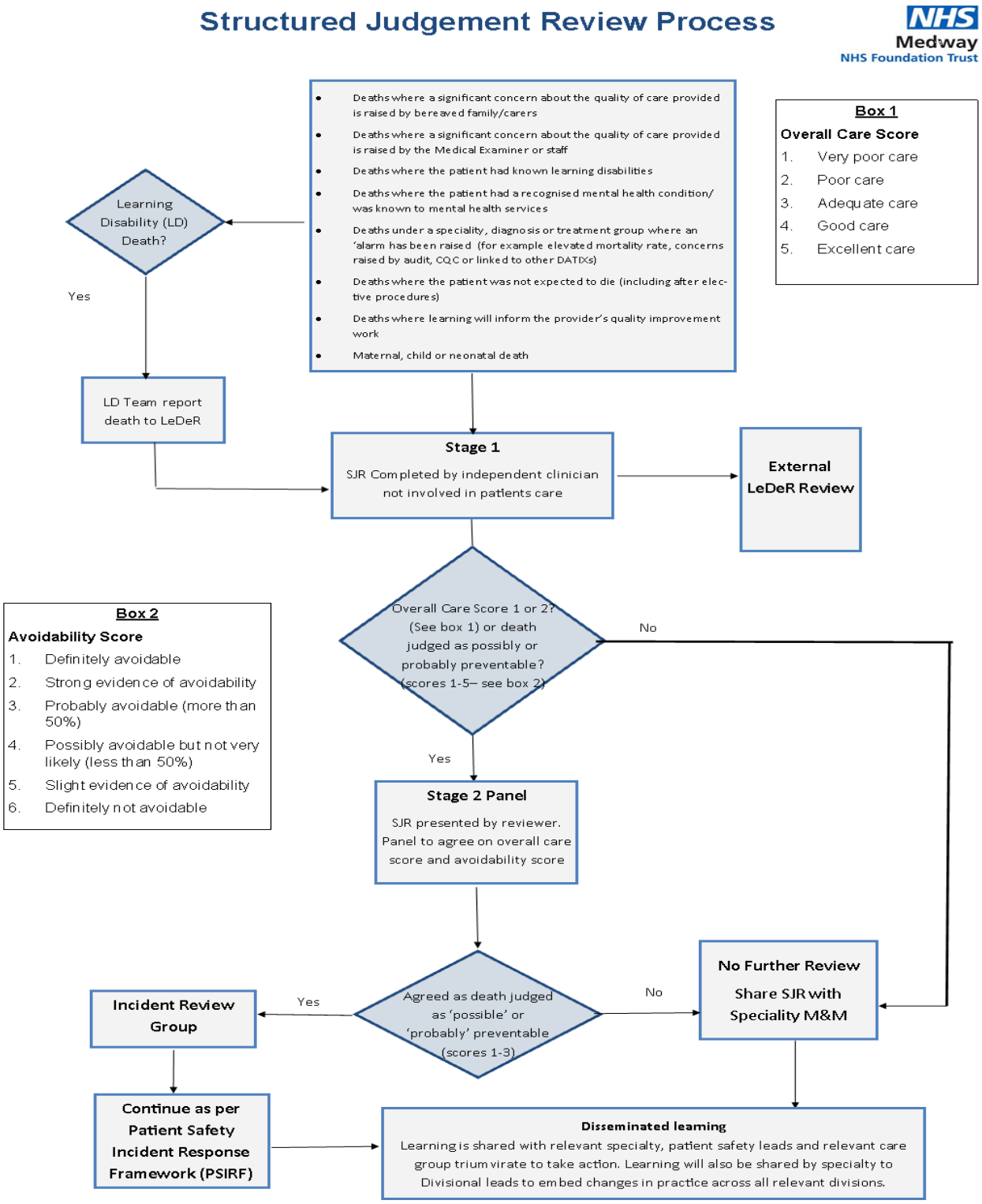
Additionally, the revised process ensures that any cases judged as potentially preventable are appropriately escalated to the Patient Safety team for investigation as potential incidents.

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

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

(i) Where overall care is considered poor/very poor,
(ii) Where a problem in care led to harm,
(iii) Where the reviewer considered there to be any evidence that the death may have been preventable. This approach ensures further scrutiny of these cases.

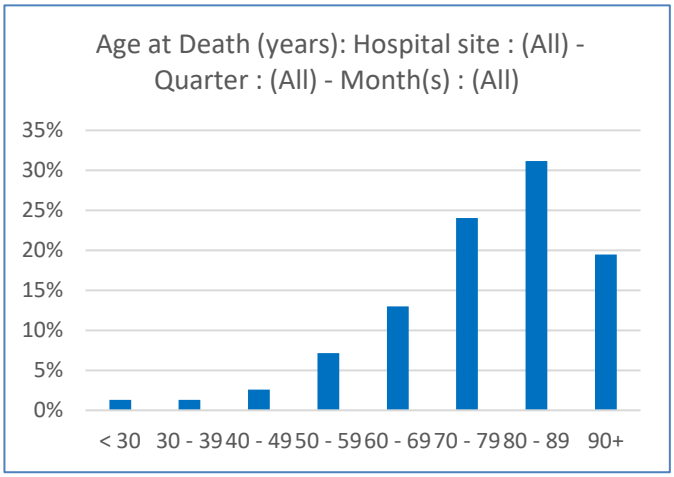
Structured Judgement Review Process

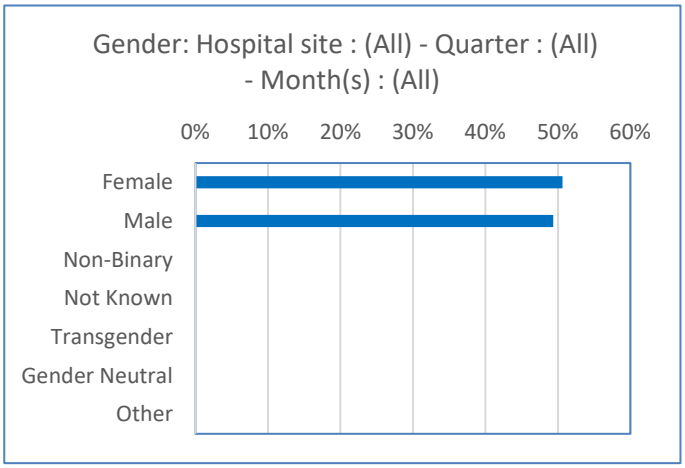


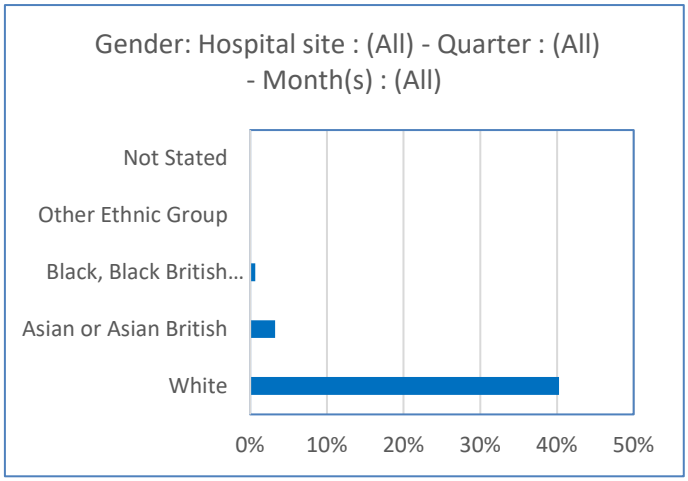
During the 2024/25 reporting period, the inclusion of protected characteristics and patient demographic information has enabled a more detailed analysis of patients reviewed through the SJR process. The findings from this data highlight the following trends:

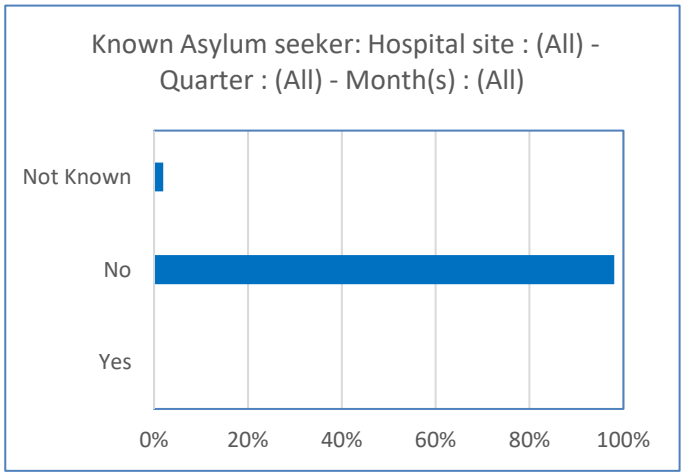
- The majority of patients reviewed were older adults, with the largest proportion falling within the 80–89 year age group (31.2%).
- A slightly higher proportion of reviews related to female patients compared with male patients (50.6%).
- Patients reviewed were predominantly from a White ethnic background, with lower representation from other ethnic groups (40.3%).
- The majority of patients reviewed do not have known asylum seeker status with a small percentage where it was not known as to their status (98.1%).

Patient demographic detail from SJRs 2024/25







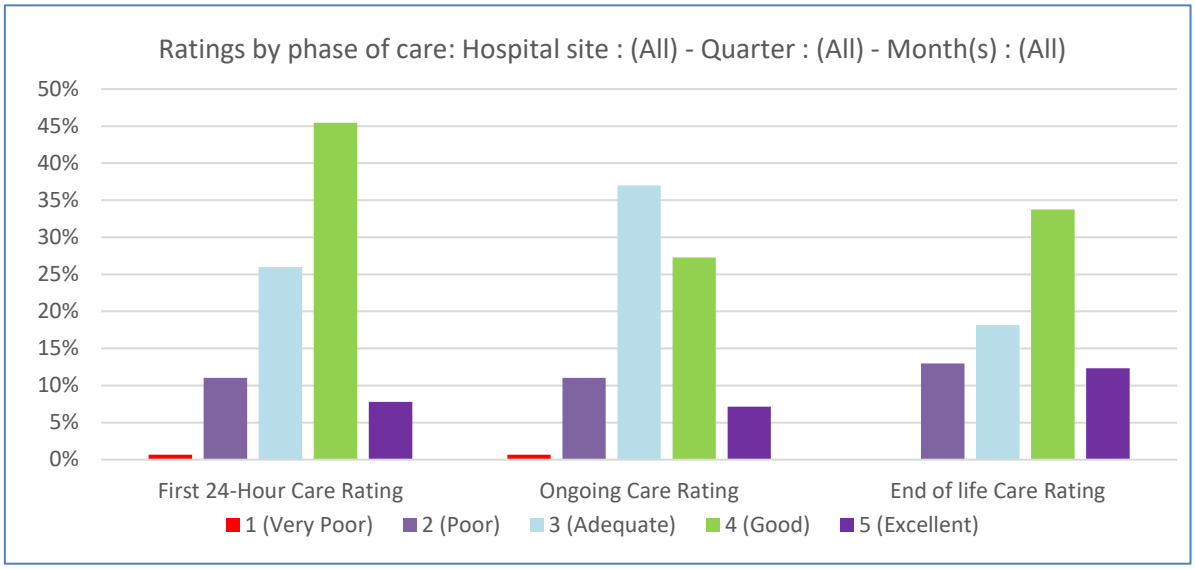


Care scores from Structured Judgement Reviews

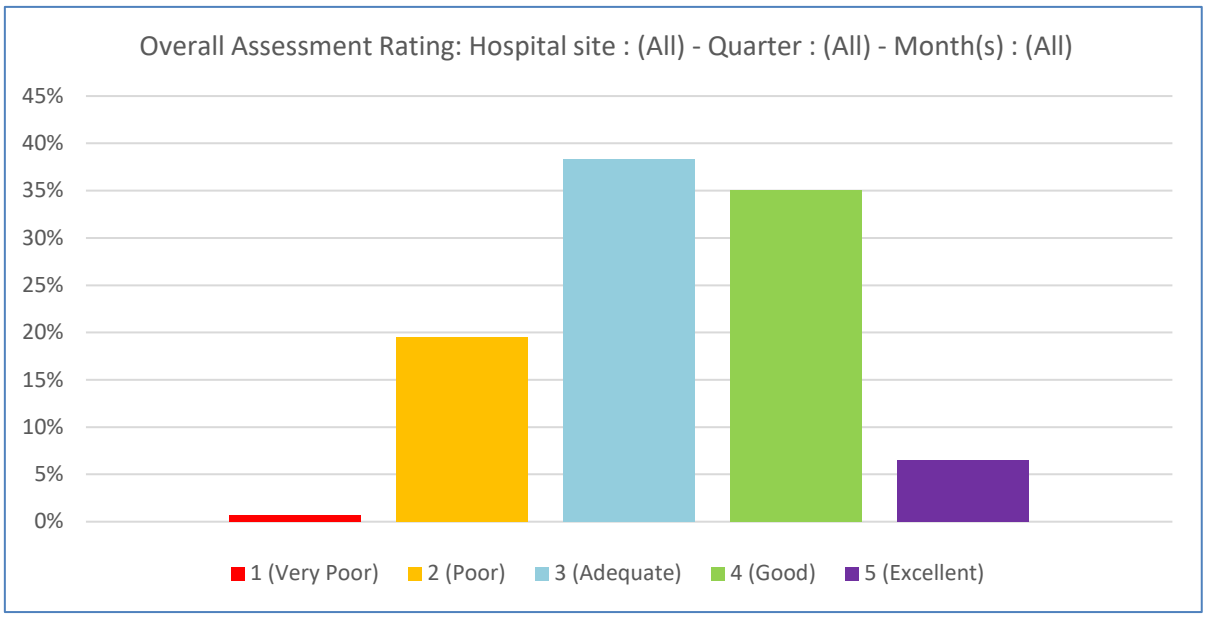
During the reporting period, analysis of care scores across each phase of care indicated that good care was most frequently identified within the first 24 hours of admission

(45.5%). The ongoing care phase was most commonly rated as adequate (37%), while good care was more frequently identified during the end-of-life phase (33.8%). As part of the SJR process, reviewers provide a holistic judgement of the overall care received by each patient. Across all reviews, overall care was most commonly rated as adequate (38.3%).

Phases of care scores from SJRs 2024/25



Overall care scores from SJRs 2024/25



Structured Judgement Reviews (SJRs) that highlight learning are presented by the Learning from Deaths Team at the relevant specialty mortality and morbidity meetings (M&M). This structured approach ensures that key lessons are shared effectively, with a strong focus on translating learning into clear, actionable improvements and identifying recurring themes across specialties.

The process is now firmly embedded within clinical governance and has played a significant role in strengthening the culture of shared learning across the organisation. It has not only promoted greater understanding of the Learning from Deaths and SJR process but has also encouraged wider engagement. Notably, many new reviewers have come forward after observing SJR presentations within their specialty, further expanding the pool of trained reviewers and reinforcing the sustainability of this important work.

In addition to identifying areas for improvement, SJRs also play a vital role in highlighting examples of good practice. Recognising where high-quality care has been delivered is an equally important aspect of the review process, as it reinforces positive behaviours, promotes consistency in clinical standards, and supports the dissemination of effective practice across specialties. By systematically capturing and sharing these examples, the Trust not only ensures that learning from deaths is balanced and constructive, but also strengthens a culture of continuous improvement by celebrating excellence in care alongside identifying opportunities for change. SJRs that have positive feedback are shared within reports to the Divisions and to the speciality.

Some of the positive learning identified over 2024/25 included:

Patient centred and compassionate care: Good communication with family and well-respected wishes with excellent involvement from chaplaincy team input respecting the Islamic faith (turning the bed to mecca and after death care). Tailored care to address individual needs.
Patients seen promptly in ED with good timely recognition of sepsis and antibiotics administered promptly.
Timely and appropriate decision making; early identification of clinical deterioration and escalation of care, prompt decisions around end of life care including completion of Treatment Escalation Plans (TEP) and Do Not Attempt Resuscitation (DNAR) forms.
Excellent team working and coordination between teams including physiotherapists, dieticians, speech and language therapists, Respiratory and palliative care teams.
Active involvement of the Acute Response Team (ART) and other specialist teams, ensuring comprehensive support
Great communication with not only family, but patient as well. They were updated regularly and management plans were updated to match the individual circumstances
Prompt administration of antibiotic and timely recognition of deterioration
Excellent recognition of sepsis with cultures and bloods taken door to needle time of less and one hour and appropriate IV fluids

Some of the learning identified from SJRs and shared with the speciality teams for the year 2024/25 included:

Sepsis 6 not often initiated promptly (cultures not taken, fluids delayed, antibiotics late or incomplete
Delays in recognising dying patients- late initiation of end of life care conversations with families
TEP and DNAR forms unclear or incomplete and signed too late in the admission
Poor handover between ED, wards, and specialist teams
Families not consistently updated on deterioration, escalation or medication changes
Bleep failures, phone issues and non-responses led to deterioration without timely review
Weekend staffing gaps contributed to long delays
Long stays in ED and frail patients not moved promptly enough to appropriate wards
Notes copied and pasted causing duplication and confusion. Poor detail in procedures, rationale for treatments decisions and capacity assessments.
Delayed imaging due to consent, reporting or referral issues
Differential diagnosis not considered at clerking.
Missed or delayed prescriptions. Drug availability issues not escalated and inappropriate prescribing without documentation to rationale
Delayed discharged planning for medically fit patients

With the introduction of the new Structured Judgement Review (SJR) reporting platform, we are now able to capture and analyse data in greater depth than ever before. For the first time, this enhanced system enables us to break down SJR findings at a Divisional level, providing tailored insights that reflect the unique context and challenges within each area of the organisation.

Moving forward, each Division will receive its own data set, accompanied by analysis and learning specific to its performance. This will allow Divisions to take focused, evidence-based actions, ensuring that improvements are both meaningful and targeted.

This initiative represents a significant step forward in our approach to learning from reviews. It is an ongoing programme of work, and the outcomes and impact of these changes will be reported in the next financial year.

Some of the actions from SJRs to speciality level include:

Speciality	Issues identified from SJRs	Learning and actions
Acute Medicine	Poor handover particularly around day 2 Emergency Department patients	Audit for Day 2 ED patients over the weekend in acute medicine to review handover.
Frailty	Documentation and clinical accuracy of primary diagnosis. When no aspiration from NG tubes identified, nurses need to wait after repositioning and try again	NG tube check policy highlighted at nursing huddles by Matron 4 monthly presentations on the new Dr rotation by clinical coding and learning from deaths tea

	before sending for chest x-rays.	highlighting the impact and importance of clinical documentation.
Critical care and ED	Interdepartmental issues between ED and critical care, NIV policy contradicted and unclear plan.	Leadership throughout the case fell short of what was expected and there were widespread communication failures. Consultant and consultant referral process between ED and critical care- using referral forms for traceability as well as phone call, audit for compliance. Inter-departmental simulation between ED, critical care and AEM (
General Medicine	Poor documentation in notes identified, delays in escalation and decision making.	Clinical coding and LFD to present documentation education.
Respiratory	Clearer documentation and hot clinics needed to rapid deterioration patients	Clinical coding and LFD to attend for documentation teaching. Hot clinic for rapid deterioration to be discussed at operations meetings.
Trauma & Orthopaedics	Heart failure and oedema not recognised	Discussed learning with the team. Review of ED observations to consider trends. Resident Dr teaching to evaluate both ED and ward admission on epR.

Preventable deaths

In the context of SJRs, the term ‘preventable death’ is used in preference to ‘avoidable death’. This terminology is considered more measured and constructive, supporting professional, learning-focused approached to patient safety and quality improvement.

With the introduction of the revised Structured Judgement Review (SJR) process, the Trust has established a clear and robust framework for reviewing deaths assessed with a degree of preventability.

All deaths graded as having any degree of preventability are reviewed at the Stage 2 multidisciplinary panel, where concerns regarding aspects of care are examined in

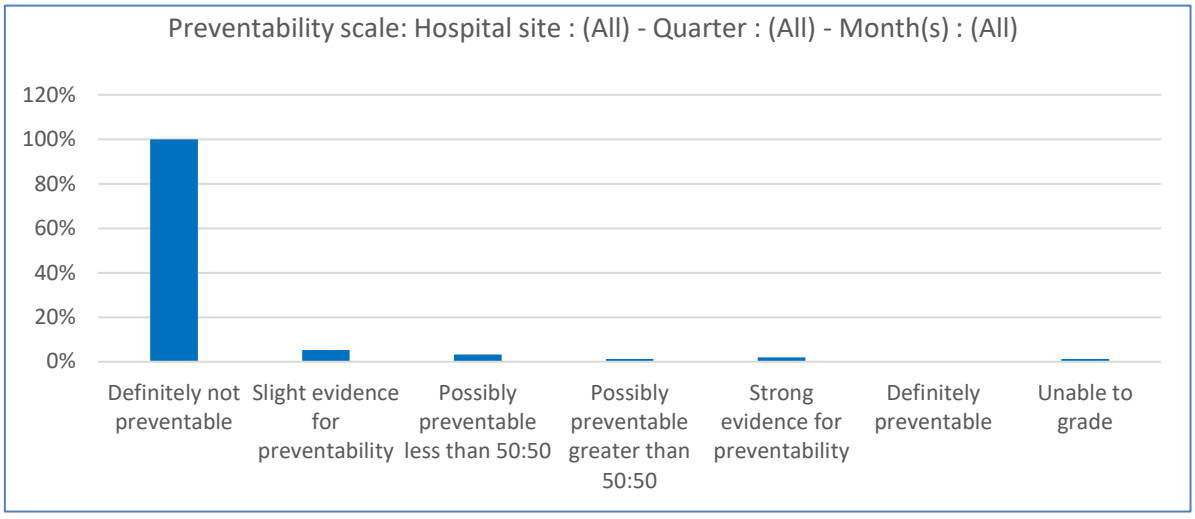
detail and a final preventability score is determined. Cases assessed as slight evidence of preventability, possibly preventable (less than 50:50), or definitely not preventable are escalated to the Divisional Governance Lead to ensure learning and appropriate actions by the relevant teams. Cases assessed as possibly preventable (greater than 50:50), strong evidence of preventability, or definitely preventable are escalated to the Incident Review Group for further investigation by the Patient Safety Team.

Prior to the introduction of the new Structured Judgement Review (SJR) process, any case assessed as having any degree of preventability was escalated to the Incident Review Group (IRG) for further investigation. During 2024/25, a total of 16 cases were referred to the IRG on this basis. Between April 24- March 25:

- Eight cases were local investigations after harm level reduced to low
- SWARM declared for 3 cases and closed.
- Three cases underwent After Action Reviews (AARs) and have been closed
- Two underwent Patient Safety Incident Investigations (PSII). One of these remains open.

As the Patient Safety Incident Response Framework (PSIRF) became more embedded within the Trust, the process was refined to align with national best practice and PSIRF guidance. Under this approach, any death identified as involving issues in care and judged to be 'more likely than not' caused by those problems will trigger a patient safety investigation.

When the new process was initiated in January 2025, three deaths were assessed as either 'possibly preventable (greater than 50:50 likelihood)' or showing 'strong evidence of preventability,' and therefore met the criteria for further review under PSIRF.



Actions from cases escalated to the Patient Safety Team included:

Key issues	Improvement actions from Division
Confusion regarding intermittent GCS scores between alert and confused.	**MEC Division**: Staff improvement re GCS scores A3 to bridge the gap between confusion and agitation and accurate NEWS score calculation led by ART and enhanced care clinical lead. Learning shared of rare short QT syndrome to specialties to spread awareness.
Missed pneumothorax diagnosis. X-ray report not reviewed prior to discharge over weekend. Missed opportunities to chase reporting findings, poor documentation.	**MEC Division and CCCS Division:** Explored options to outsource imaging to support KPI. This resulted in the backlog being cleared and wait times significantly reduced.
Poor sight of low haemoglobin, lack of registrar review, poor documentation, arterial blood gas not collected, no sepsis 6 completed, lack of escalation	**MEC Division**: Teaching day on education regarding acute bleed protocol and added to clinical trust fellow induction training programme. Questionnaire developed for patient facing staff to determine understanding on when to escalate patients. Ongoing work with deteriorating patient quality improvement plan.
Oesophago Gastro- Duodenoscopy (OGD) out of hours under general anaesthetic deemed unsuitable. No bleed on call consultant overnight	**MEC Division** Guidance document around GI bleed on call process created and circulated and made available on Trust intranet.
Delay in draining empyema. Delay in escalation to tertiary centre for specialist care. Sepsis 6 not followed	**MEC Division** Standard operating procedure for time critical tertiary referrals and rapid escalation. Audit on ED sepsis 6 compliance. Assess the requirement for additional band 7 role in pleural service. Links to Sepsis 6 A3 improvement work currently ongoing
Potentially avoidable cardiac arrest, missed communication between team during pressured site environment. Lack of escalation to respiratory care for patient with asthma and T2 RF	**S&A Division and MEC Division** - Links to quality improvement project for Avoidable 2222 calls. Joint medic and ED M&M for this case. ED guidelines reviewed regarding reducing dose of labetalol. Process review for ICU to be informed of Type 2 respiratory failure in patients with asthma.
Lack of review for step down HDU over the weekend and not added to deuteriation tracking board. Poor communication. Nebuliser and steroids not prescribed on a regular	**S&A Division**- Ongoing PSII- actions to be agreed.

basis and lack of documentation regarding matron review	

** MEC- Medicine and Emergency Care Division*
** S&A- Surgical and Anaesthetic Division*
** CCCS- Cancer and Core Clinical Services*

6 THEMES FROM STRUCTURED JUDGEMENT REVIEWS

While immediate actions arising from Structured Judgement Reviews (SJRs) are important to address specific issues promptly, focusing solely on individual cases can limit broader organisational learning. Identifying themes across multiple SJRs allows the Trust to recognise patterns, understand systemic issues, and implement improvements that have a wider and more sustainable impact.

Thematic analysis provides insights into recurring areas such as clinical practice, documentation, pathways of care, or communication issues, which may not be apparent when reviewing single cases in isolation. By addressing these underlying causes, the Trust can develop targeted interventions, revise policies or procedures, and strengthen training, ultimately improving patient safety and outcomes across the organisation.

This approach also ensures that learning is embedded at a strategic level, rather than being reactive. It supports a culture of reflection, continuous improvement, and proactive risk management, ensuring that lessons from deaths contribute to long-term, measurable improvements in care quality and patient safety.

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

	End of life Care (EOLC)/palliative teams, resulting in missed opportunities to improve patient comfort and support families. Documentation gaps around capacity assessment and Deprivation of Liberty (DoLs) further compromised care. Delays or inadequate planning for end of life care (discussion with families, DNAR and TEP forms not completed). Whilst some of these are discussed on admission, it was not always followed up with families, leading to unclear treatment goals.
Medication and treatment failures 	There were several examples of prescribing errors; missed medications and delays in treatment often due to poor systems or lack of follow through. In several cases, critical medications like antibiotics, steroids, or anticoagulants were delayed or stopped without clear clinical justification. Additionally, there were issues with medication availability and incomplete assessments which run the risk of compromising care.
Poor adherence to pathway polices and documentation 	Fundamental care processes like risk assessments, documentation of observations and pathway adherence (e.g Venous Thromboembolism (VTE), NEWS2, stroke pathway) were inconsistently applied or not completed. Inaccurate documentation of pressure areas, lack off escalation when scores were high and copy and pasting nursing notes. In some cases, these contributed to delayed diagnosis and interventions.

Communication and coordination issues within multidisciplinary teams 	There were widespread issues with breakdown in communication between clinical teams. Poor handover, beeps not responded, conflicting documentation and lack of follow up with tertiary centres which resulted in disjointed care. This affected timely interventions and led to confusions around roles and responsibilities, particularly in complex cases requiring coordinated decision making. There were examples of misallocation of critical care step downs with patients placed as an outlier on surgical wards.

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

Key issues	Improvement actions (Trust wide initiatives)
Deteriorating Patient	The real-time Deteriorating Patient Dashboard is now live, providing up-to-date data on inpatients who are deteriorating. A series of A3 improvement projects are underway in wards with low compliance. Continuous efforts are being made to enhance awareness and improve escalation procedures related to patient deterioration. A review of competencies and training regarding the NEWS2 escalation criteria for nurses is in progress.
Medication Safety	The Omitted Doses Working Group has been reinstated to address missed doses of time-critical medications, including those for Parkinson's and antiepileptic drugs. The Medication Quality Improvement Plan is being implemented to address concerns related to medication incidents. Exploring the potential for alerts on the Electronic Prescribing and Medicines Administration (EPMA) system to notify when duplicate drugs are administered.
Documentation	Regular reminders are being issued regarding the avoidance of the 'copy and paste' function in documentation. This message is also reinforced in presentations by Clinical Coding and Learning from Deaths teams. Senior leadership is actively engaging in delivering documentation training to junior staff. Continuous education provided at Speciality level by clinical coding and learning from deaths teams. Regular reminders included in the

	monthly mortality mattes newsletter. Data validation process undergoing A3 improvement work.
Communication Between Clinical Teams	The Internal Professional Standards have now been agreed and have been discussed at governance and education meetings across the Trust. The formal launch was undertaken in mid-July 2025. These standards will address the shift from the mindset of "it's not my patient" to "It's our Medway patient" and is line with the Trust's cultural transformation programme as well as "Civility Saves Lives".
Sepsis 6 pathway	Over the reporting period, SJRs that were randomly selected with a focus on sepsis related deaths highlighted some key issues with sepsis management across the Trust. The SJR reviews revealed that there were examples of delayed recognition and diagnosis of sepsis, delayed treatment initiation or adjustments, failure to escalate care on deterioration, care and continuity gaps, systemic challenges contributed by bed shortages and prolonged ED stays and patterns of incomplete sepsis management. This prompted joined up working with the Acute Response Team who have set up the sepsis 6 working group. The group runs monthly, with the first meeting having taken place on the 18th March 2025. The Transformation team are supporting with this work. The group are using the A3 Patient First methodology to identify the problem areas and countermeasures. Some of the issues identified by the group that will be addressed through the A3 improvement work are: • No identifiable sepsis medical lead for the Trust • No NICE Quality Standard to adhere to (previous ones were withdrawn in 2024 and have not been updated) • No sepsis policy for the Trust The improvement work in relation to sepsis is being overseen by The Patient Safety Group. Feedback from monthly meetings and progress will be monitored by the Patient Safety Team.
Palliative and End of Life care (EOL)	The Clinical Nurse Specialist is leading a programme of work to increase education and awareness, in collaboration with the palliative care team, they are delivering training to nurses, junior doctors and consultants each month An A3 approach using the Patient First methodology is underway to improve the completion of the RESPECT document, this is being led by the End of Life (EOL) team. • EoL team moving to a 6-day working week, likely to come to fruition in late summer which will help with out of hours and weekend decision making delays • This workstream feeds into the Breakthrough Objective for mortality and is part of the Quality Huddle • EOLC are working with SECAMB to look at the root causes for delays into hospital at the end of life There are issues with completing fast track discharges. The fast track discharge process is for patients who have a rapidly deteriorating condition or are likely to rapidly deteriorate and are approaching the last weeks to months of life. The aim is to

	provide a safe transition to the preferred place of care. The process for fast tracking a patient was changed at short notice resulting in only two staff being trained to complete fast track referrals. This has been escalated up through to executive level, and to the ICB via the Associate Director of Patient experience. As a consequence, the Trust are experiencing delays with patients being discharged home to die. It is anticipated the training programme to be extended to the EoL team in the next financial year (25/26), and MFT have requested the business continuity plans to be in place by the Palliative Care Team and Integrated Care Board as soon as possible. This workstream will be monitored via the Patient Experience Group and the Mortality breakthrough objectives.

7 LEARNING DISABILITY (LeDeR)

All patients with a learning disability and/or autism are subject to a Structured Judgement Review (SJR). Completed SJRs are submitted to the national *Learning from Lives and Deaths of People with a Learning Disability and Autism* (LeDeR) programme for review.

During the reporting period, 12 SJRs were undertaken for patients with a learning disability. Where concerns about care are identified, or cases require escalation to the Stage 2 review panel, a member of the Learning Disabilities Team participates to provide specialist input and ensure any issues are appropriately addressed.

The reviews confirmed that the majority of patients with a learning disability received good care at Medway. Two cases, however, were escalated to the Stage 2 review panel due to concerns regarding end-of-life care. Learning from these cases was shared directly with the relevant specialty by the Learning Disabilities Team. Importantly, none of the deaths reviewed were deemed preventable.

Detailed summary

	First 24-hour Care Rating	Ongoing Care Rating	End of Life Care Rating
Patient 1	Good Care	Good Care	Excellent Care
Patient 2	Good Care	Adequate Care	Adequate Care
Patient 3	Good Care	Excellent Care	Good Care
Patient 4	Good Care	Good Care	Excellent Care
Patient 5	Good Care	Good Care	Good Care
Patient 6	Adequate Care	Adequate Care	Poor Care
Patient 7	Adequate Care	Adequate Care	Adequate Care
Patient 8	Good Care	Good Care	Good Care
Patient 9	Good Care	Good Care	Good Care
Patient 10	Excellent Care	Good Care	Poor Care

Patient 11	Good Care	Excellent Care	Excellent Care
Patient 12	Good Care	Good Care	Good Care

Key points highlighted from Learning Disability reviews by LeDeR, Medway Foundation Trust and Nationally include:

- Transition of patients from paediatric to adult care- ensuring referrals are made in a timely manner and are detailed for the accepting clinical team to have a good understanding of the situation.
- Delayed discharge for patients with learning disabilities due to placement and funding. In some cases, patients become medically unwell while waiting for discharge plans to be approved.

8 MEDICAL EXAMINER SERVICE

In April 2024, Parliament approved 09 September 2024 as the commencement date for the Death Certification Reforms 2024, which made it a statutory requirement for all deaths not investigated by a coroner to be reviewed by an independent Medical Examiner. Much of the service's focus during the financial year 2024/25 was therefore on ensuring that appropriate arrangements were in place for a smooth transition to the statutory phase.

It is important to note that the primary purpose of the Medical Examiner system is to provide independent and proportionate scrutiny of care with a view to establishing an accurate cause of death, ensuring the coroner is notified of deaths meeting the criteria outlined in the Notification of Death Regulations 2019 and in highlighting cases where concerns have been raised to the relevant body. Whilst the Medical Examiner service feeds cases into the Learning from Deaths programme, it should be viewed as a safety net rather than the primary mechanism for identifying cases where learning could be obtained.

Nationally, roughly 40% of the Medical Examiner Office's caseload comes from in-hospital deaths, with 60% of deaths reviewed occurring in the community. The figures for Medway Medical Examiner Office show a higher proportion of deaths occurring in hospital compared to this average. The exact caseload split is only known for the last two quarters of 2024/25 following the implementation of the statutory system, when 51% of deaths reviewed occurred in hospital.

A breakdown of ME office activity relating to hospital deaths in 2024/25 is provided in the table below:

	Apr-Jun 25	Jul – Sep 24	Oct – Dec 25	Jan – Mar 25	Total
Number of deaths scrutinised by ME	361	401	392	478	**1632**
Number of MCCDs not completed within 3 days of death	171	173	207	331	**882**
Number of cases where coroner referral was recommended by the ME	58	84	73	96	**311**
Number of cases where the coroner's duty to investigate was triggered	48	41	26	51	**166**
Number of cases referred for review by Trust	28	23	22	23	**96**

The following themes and trends have been reported by the Medical Examiner Office in quarterly reports to NHS England:

- Prolonged stays in ED, including frail elderly patients lodging in ED for several days and associated infrastructure issues
- Poor quality documentation due to prolific use of copy and paste
- Difficulty in identifying responsible consultant
- Delay to discussion of appropriate ceiling of care
- No option on ePR to record number of tablets / volume of liquid given when issuing controlled drugs
- Poor quality mortality reviews
- Increased number of patients medically fit for discharge contracting nosocomial infections and dying after prolonged period waiting for social care placement
- Inconsistent communication with families

9 HOSPITAL STANDARDISED MORTALITY RATIO (HSMR+)

In December 2024, Telstra Health UK (formerly Dr Foster) introduced significant methodological changes to its mortality model, transitioning from HSMR to HSMR+. Prior to this update, the Trust had reported "higher than expected" HSMR values. When considered alongside the Summary Hospital-level Mortality Indicator (SHMI), this prompted the launch of a targeted improvement workstream on mortality.

Key methodological changes included:

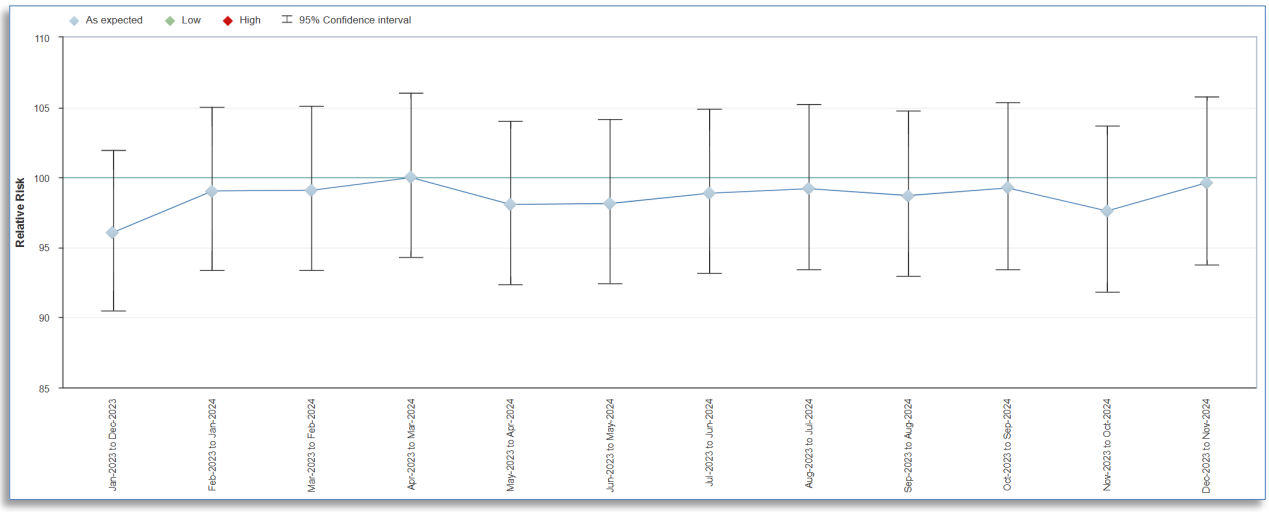
- A reduction from 56 to 41 diagnosis groups to better reflect mortality patterns.
- Exclusion of stillbirths.
- Inclusion of COVID-19, with a dedicated subgroup within viral infections to enable more accurate risk adjustment for pandemic-related impacts.

- An updated deprivation metric, providing a deeper assessment of socio-economic influences.
- An enhanced comorbidity index, moving from the Charlson Index to the Elixhauser model—a stronger predictor of mortality that incorporates a broader range of conditions.
- Addition of a global frailty measure, covering seven frailty syndromes, recognising frailty as a major predictor of mortality and enriching patient risk profiles.
- Removal of palliative care, addressing inconsistencies and reducing potential bias.

These changes had a positive effect on Medway's HSMR+ results, which improved to the "as expected" banding. Furthermore, Medway demonstrated areas of national outperformance in coding metrics, including conditions captured under the Elixhauser comorbidity index and frailty scoring for patients over 75 with a frailty condition. These strengths have contributed significantly to the Trust achieving the "as expected" banding within the HSMR+ methodology.

12 months to:	HSMR+	Crude %	Expected
Apr 24	98.8	5.0%	5.1%
May 24	98.5	5.0%	5.1%
Jun 24	98.8	5.1%	5.2%
Jul 24	98.8	5.1%	5.2%
Aug 24	98.0	5.1%	5.2%
Sept 24	98.5	5.2%	5.2%
Oct 24	97.2	5.1%	5.2%
Nov 24	99.6	5.3%	5.3%
Dec 24	98.1	5.2%	5.3%
Jan 25	98.6	5.2%	5.3%
Feb 25	97.7	5.3%	5.4%
Mar 25	98.0	5.4%	5.5%

Crude and expected rates of mortality, using the HSMR+ methodology have remained stable over the reporting period. As a result, the Trust has remained comfortably within the 'as expected' banding and are not statistically significantly different to all other acute non-specialist Trusts.



Bespoke analysis undertaken by Telstra Heath UK into the hospital datasets allows examine the type so patients treated at Medway when benchmarking. From analysis, it is evident that:

- The percentage of HSMR superspells and deaths which are from the respiratory diagnosis chapter have been increasing at Medway. Furthermore, the percentage of respiratory admissions and deaths are increasingly within geriatric medicine compared to peers.
- Respiratory HSMR activity and deaths are much more likely to be treated in geriatric medicine at Medway compared to elsewhere; whilst at peers, patients are more likely to be on a respiratory medicine pathway. 42% of respiratory deaths at Medway occur in geriatric medicine, while nationally it is 24%, regionally 22%, and among case-mix comparators it is 22%.
- A review of COPD deaths in geriatric medicine reveals a complex picture of patient acuity; whilst over-75s admitted with COPD at Medway have a higher-than-average rate of being from a more deprived quintile than elsewhere.
- Key factors associated with COPD include smoking and long-term exposure to lung irritants. While adult smoking prevalence has drastically improved over the last decade, it is interesting to note that when plotting the 10 Trusts with the highest rates of COPD admissions in the previous financial year of 23/24, there is a distinct overlap with an historic picture of major coalfields and coal mining (Medway included).

10 SUMMARY HOSPITAL LEVEL MORTALITY INDICATOR (SHMI)

The Trust's SHMI performance, in contrast to the HMSR+ data, has continued to deteriorate over the reporting period. The SHMI value for the trust remains higher than expected with data included up to March 25 as 1.235. The crude rate and in-hospital deaths have continued to increase.

12 months to:	SHMI	Provider spells	Crude %	% of death in hospital	% of deaths post discharge	Observed	Expected
Apr 24	1.19	52,930	3.9%	71.0%	29.0%	1885	1580
May 24	1.18	53,030	3.8%	72.0%	28.0%	1875	1590
Jun 24	1.20	52,485	3.9%	71.0%	29.0%	1900	1585
Jul 24	1.20	51,705	4.0%	71.0%	29.0%	1895	1580
Aug 24	1.20	51,095	4.0%	71.0%	29.0%	1880	1570
Sept 24	1.20	50,230	3.7%	71.0%	29.0%	1870	1560
Oct 24	1.20	49,445	3.7%	71.0%	29.0%	1840	1535
Nov 24	1.21	48,285	3.8%	71.0%	29.0%	1850	1525
Dec 24	1.21	47,230	3.8%	71.0%	29.0%	1825	1505
Jan 25	1.23	46,020	4.0%	71.0%	29.0%	1830	1495
Feb 25	1.25	44,910	4.1%	70.0%	30.0%	1850	1485
Mar 25	1.25	43,380	4.2%	70.0%	30.0%	1835	1470

When reviewing hospital mortality indicators, it is important to acknowledge that variation between the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR+) is not uncommon. This can present challenges in interpretation, particularly where HSMR+ demonstrates strong performance while SHMI reflects a worsening position.

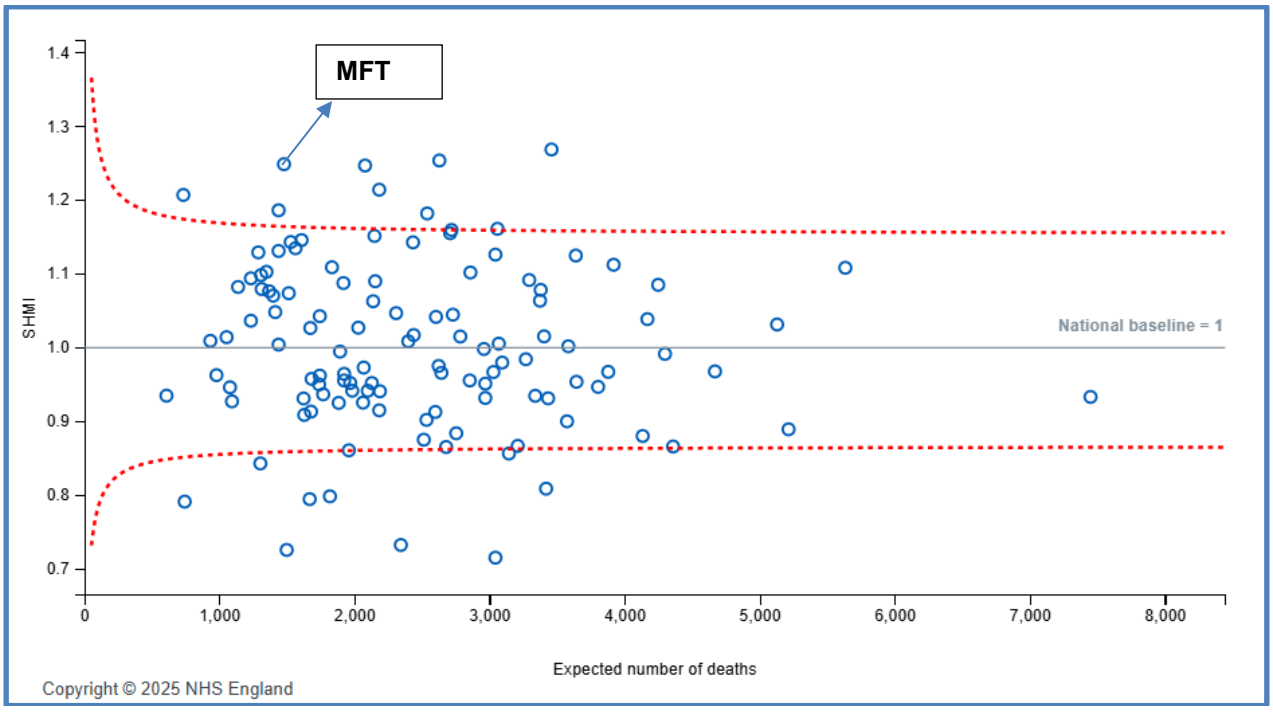
The divergence arises primarily from differences in scope and methodology. SHMI encompasses all deaths occurring either in hospital or within 30 days of discharge, whereas HSMR+ is restricted to in-hospital deaths across a defined set of diagnoses and procedures. As such, SHMI is more sensitive to factors outside the immediate inpatient episode, including discharge practices, palliative care provision, and the

effectiveness of community-based support, while HSMR+ provides a narrower reflection of acute hospital care.

Additionally, each indicator applies distinct statistical models and approaches to risk adjustment. HSMR+ adjusts for a range of variables, including age, sex, comorbidity, admission method and diagnosis group and now include frailty and deprivation, but does not cover the full breadth of hospital activity. SHMI, while broader in scope, applies a different model which may over, or under-adjust for certain patient populations. These methodological differences mean that the two measures can present contrasting pictures of performance, even when the quality of care remains consistent.

Local service configuration and patient demographics may also impact the indicators differently. For example, organisations caring for higher proportions of frail or palliative patients may observe elevated SHMI values due to post-discharge deaths, despite appropriate inpatient care. Conversely, strong HSMR+ performance may indicate effective management of acute clinical pathways but will not capture outcomes once patients leave hospital.

For these reasons, SHMI and HSMR+ should not be considered in isolation. A balanced view, triangulating both measures with structured case record reviews and clinical judgement, provides a more accurate assessment of mortality outcomes and supports meaningful learning.



Further analysis into patient type at Medway, with a focus on factors influencing the Summary Hospital-level Mortality Indicator (SHMI), highlights the following:

- **Rising palliative care rates:** Medway is experiencing an increase in palliative care cases that diverges from national trends, accompanied by longer average lengths of stay for these patients.
- **Extended stays not linked to prior palliative status:** Many patients classified as palliative at Medway have longer hospital stays, despite not having been identified as palliative prior to their final admission and death.
- **Variation in shorter stays:** Patients with prior palliative care admissions often experience shorter final stays, indicating a distinct difference in care pathways.
- **Impact of deprivation:** There is clear evidence that deprivation influences outcomes, palliative patients from more deprived backgrounds experience longer stays. This is particularly significant for Medway, which records a higher proportion of deaths among patients in deprivation quintiles 1 and 2 (the most deprived).

Outlying Diagnosis Groups

HSMR+ and SHMI data enables the Trust to identify outlying diagnosis groups, highlighting cases where the number of reported deaths exceeds the expected levels for a particular diagnosis group or where particular focus may be applied to understand some of the data. Deep dives undertaken for outlying diagnosis groups are twofold:

1. **Clinical documentation and coding**
   Reviewers need to ensure that the documentation accurately reflects the clinical presentation, and that the primary diagnosis accurately reflects the patient's condition on admission. If this changes throughout the admission, the reviewer needs to ensure the documentation accurately reflects what has changed and what is being treated as the main condition.

2. **Assurance of clinical care**
   Reviewers need to provide assurance that patients were managed appropriately in line with national and local pathways. They will need to consider both in and out of hospital deaths and reflect on whether discharge panning, follow up and safety netting were appropriate, and whether patients received suitable treatment and advice to mitigate the risk of deterioration (for post discharge deaths).

From the deep dives undertaken there are widespread issues with accuracy of documentation:

- Failure to capture comorbidity on medical clerking
- Validations requested but not completed
- Lack of clarity of presenting complaint versus comorbidity
- Model not accurately reflecting the expected mortality rates, despite coding validations completed
- Vague terminology used as primary diagnosis, leading unspecified diagnosis. This was particularly true for the Acute Bronchitis Group where lower respiratory

tract infection was erroneously applied in 8 out of 10 cases for community acquired pneumonias.

No issues in care were identified in any of the deep dives undertaken and clinicians were able to provide assurance that despite inaccuracies with primary diagnosis records, patients were treated appropriately.

Findings from deep-dive reviews are shared with relevant specialties through M&M meetings and grand round presentations. Some of the persistent outlying diagnosis groups for Acute Bronchitis and Chronic Obstructive Pulmonary Disease (COPD) have since improved.

The deaths validation process forms a key component of the Mortality Improvement Workstream and supports the Trust's breakthrough objective of establishing a robust, functioning validation system. This ensures that deaths are accurately validated and provides assurance that the associated data is reliable.

11 SHARED LEARNING

The Trust has a well-established Mortality Matters newsletter, which is circulated Trust-wide to promote shared learning and continuous improvement. Each edition features a "Case Study of the Month", drawn from Structured Judgement Reviews (SJRs). These case studies highlight key learning points and clearly set out required actions for readers, often referencing relevant policies, procedures, or best practice guidance to support implementation in clinical settings.

In addition, the newsletter provides regular updates on mortality metrics, ensuring transparency and maintaining awareness of performance across the Trust. A topic of interest is also included in each edition to reflect emerging priorities. Most recently, this has focused on clinical coding practices, specifically clarifying what can and cannot be coded from clinical documentation.1.

Previous editions have featured updates from the Medical Examiner Service, including the transition to statutory status and recent changes to the Medical Certificate of Cause of Death (MCCD). By sharing this information consistently, the newsletter supports organisational learning, encourages reflection on practice, and ensures that all staff are informed of developments relevant to patient safety and quality of care.

The Trust has also strengthened the way in which SJR data is captured, analysed, and shared. A comprehensive quarterly report is produced for all reviewers, summarising outcomes and identifying themes. This data is further broken down by division, with divisional-level presentations highlighting trends and learning directly relevant to each specialty. This ensures that improvement is both contextualised and actionable at a local level, while also contributing to organisational learning.

In parallel, the importance of accurate clinical documentation is reinforced through regular presentations delivered jointly by the Clinical Coding team and the Learning from Deaths (LfD) team. These sessions, held at specialty level, emphasise the impact of

documentation quality on coding accuracy, financial reporting, and mortality statistics. They also incorporate findings from deep-dive reviews into mortality indicator outliers, demonstrating how documentation can directly influence reported outcomes.

Since the introduction of these sessions, the Trust has seen a sustained improvement in the depth of coding and in the average Charlson comorbidity score, both of which are critical markers of coding quality. As a result, the Trust now outperforms national benchmarks on coding metrics within mortality data. This improvement has also translated into better performance in previously persistent outlying diagnosis groups, including Acute bronchitis and COPD, where results have now stabilised. The presentations continue to receive highly positive feedback and are valued across specialties, particularly during new doctor rotations, helping to embed a stronger culture of accurate and reliable clinical documentation.

To further embed learning and raise awareness of the Learning from Deaths and SJR process, the Trust runs twice-yearly workshops delivered by AQUA. These sessions focus on Learning from Deaths (LfD) and the SJR process, ensuring that learning is consistently shared across clinical teams and reinforcing a culture of reflection and continuous improvement.

12 FINAL SUMMARY

During the 2024/25 reporting period, Medway NHS Foundation Trust has made significant progress in strengthening its approach to mortality surveillance, learning from deaths, and embedding continuous improvement across clinical services. Independent external review, robust governance processes, and systematic use of Structured Judgement Reviews (SJRs) have enabled the Trust to better understand mortality outcomes and drive targeted improvements in patient care.

The Trust has demonstrated improvement in the Hospital Standardised Mortality Ratio (HSMR+), now consistently within the “as expected” range, supported by strong coding practices and enhanced recognition of comorbidity and frailty. At the same time, the Trust acknowledges ongoing challenges with the Summary Hospital-level Mortality Indicator (SHMI), which remains higher than expected. Detailed analysis has highlighted the influence of palliative care trends, deprivation, and clinical pathways, providing a clear focus for further action.

Key themes emerging from reviews include the timely recognition and management of patient deterioration, earlier planning and delivery of end-of-life care, medication safety, documentation accuracy, and effective communication across teams. Targeted improvement programmes are underway in each of these areas, supported by Trust-wide initiatives such as the Mortality Breakthrough Objective, Patient First methodology, and dedicated education and training.

Importantly, the Trust continues to strengthen learning and transparency through its Mortality and Morbidity Surveillance Group, divisional governance structures, and the Mortality Matters newsletter. By sharing lessons, celebrating examples of excellent care,

and addressing areas of concern, the Trust is fostering a culture of openness, accountability, and continuous improvement.

Looking ahead, Medway NHS Foundation Trust is committed to reducing mortality, closing the gap between observed and expected deaths, and achieving SHMI performance within the expected range by 2026/27. This will be achieved through sustained focus on patient safety, equity of care, and a continued drive to ensure that every death is reviewed, every lesson is learned, and every opportunity is taken to improve outcomes for patients and their families

Meeting of the Trust Board

Date: 12th November 2025

Title of Report	Finance Report – Year to September 2025 (M6)			**Agenda Item**	3.5a
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
				X	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
					X
Author and Job Title	Matt Chapman, Head of Financial Management Cleo Chella, Assistant Director of Income & Contracts Isla Fraser, Financial Controller Paul Kimber, Deputy Chief Financial Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Purpose	**Approval**		**Briefing**		**Noting** X
Proposal and/or key recommendation:	The Trust Board is asked to note this report. It is also requested to formally ratify the cash support application (see below) as presented to the Finance, Planning and Performance Committee.				
Executive Summary	At the end of September 2025, the Trust is reporting a control total deficit of £13.6m (£8.0m adverse to Plan). This position is the result of: i. Continued underperformance against the savings targets (£12.0m YTD underperformance against plan); ii. Income underperformance for continued low activity in the CDCs (£0.6m recognised with a further £1.1m at risk YTD); and iii. Unexpected cost impacts, notably: industrial action costs (£0.6m), the breakdown of the Combined Heat and Power (CHP) plant (cost of repairs plus utilities cost pressures) (£0.2m), consultancy costs to support the efficiency programme (£0.3m) and an increase in clinical supplies to deliver activity levels. Many of these smaller value overspends are being managed through Trust reserves and other underspends, leaving the biggest driver of adverse performance being the efficiency programme. We continue our focus on savings delivery to reverse the I&E imbalance. The Trust has worked with system partners to produce a risk adjusted forecast outturn (RAFOT); excluding DSF in Q3 and Q4 this is expected to be in the region of a £44m deficit; NHSE have indicated that significant improvement on that balance is expected.				
Issues for the Board/Committee Attention:	The adverse financial performance, compounded by loss of Deficit Support Funding (DSF) in Q3, is manifesting in cash pressures. Consequently, the Trust has prepared a **revenue cash support application** to NHSE; the application has been presented to the Finance, Planning and Performance Committee and, by the date of the Trust Board meeting itself, the formal application will have been submitted to NHSE.				

	The Trust Board should be aware of the following national guidance in respect of cash support, which is to say that an application should be a last resort and addressing the matter is the responsibility of the whole Trust/system: *"The underlying principle for the current year is that all systems have submitted balanced plans…If a system delivers its plan there should be no need for additional cash support, therefore we expect to be providing additional cash support in truly exceptional circumstances only, and providers should expect this to come with additional scrutiny.* *A trust requiring cash should first discuss requirements with the system to test whether neighbours can provide cash...* *The cash request must be supported by the CEO and Chair and set out agreed recovery actions…* *The burden of this should not fall to the finance team, the reporting of recovery actions, progress with efficiency etc. should all be coming from the PMO team led by one of the other execs…"* We can confirm that we have fully engaged system partners, however a number of those organisations are also experiencing cash constraints. The Trust therefore faces having to implement working capital strategies to manage its cash risks.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Via TLT Finance, Planning and Performance Committee – 29th October 2025			
Board Assurance Framework/Risk Register:	Board Assurance Statement – Risk 1: There is a risk that the Trust cannot effectively manage its in-year budgets, rub-rate, CIP and cash reserves, resulting in the non-delivery of the agreed in year control total. Board Assurance Statement – Risk 2: Limited capital money is impacting the Trust's ability to tackle its backlog maintenance requirements.			
Financial Implications:	As set out above.			
Equality Impact Assessment and/or patient experience implications	All efficiency opportunities are required to undertake an Integrated Impact Assessment.			
Freedom of Information status:	Disclosable	X	Exempt	

Finance Report

For the period ending 30th September 2025 (M6)

Contents

1. Executive Summary – Trust level

The financial results to September 2025 (Month 6) are set out below. Performance is measured against the Plan agreed with NHSE, this being a £4.9m control total deficit for the year to 31st March 2026.

£m	Plan	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month reported	2.6	(0.8)	(3.4)	The September (in-month) position is a £2.6m deficit (vs £3.0m deficit last month) and a £13.6m deficit year to date (YTD); this is adverse to plan for September by £3.3m and YTD by £8.0m. The in-month position includes £0.6m of net favourable non-recurrent adjustments, including favourable movements from overseas patients YTD invoicing. ERF clinical activity continues to perform on plan. CDC activity plans are not being achieved due to the delay in capacity opening and the slow take up of appointments into the new facilities; we have recognised £0.6m of the £1.7m of underperformance YTD, with the remaining £1.1m at risk. A further £3.4m of Deficit Support Funding (DSF) is recognised in-month (£24.7m YTD) as per plan. Efficiencies remain below target and the primary driver of the adverse performance to plan. The Trust is required to forecast to the £4.9m control total deficit for the year via its returns to NHSE; however, this is a significant risk and discussions are ongoing with NHSE over the balance.
Tech. adjustments	(2.0)	(1.9)	0.1	
In-month vs **Plan**	**0.6**	**(2.6)**	**(3.3)**	
YTD total	**(5.6)**	**(13.6)**	**(8.0)**	
Forecast outturn	**(4.9)**	**(4.9)**	**-**	
Efficiencies Programme				
In-month	4.5	0.6	(3.9)	The annual savings target is £45.4m, comprising £27.2m for the Trust and £18.2m for System efficiencies. The Trust's progress in identifying schemes leaves a significant gap against the overall target for both Trust and System-led programmes.
YTD	14.9	2.9	(12.0)	
Cash				
Month end	11.0	9.3	(1.7)	Cash balances are lower than plan due to the adverse I&E performance (£16.8m) excluding technical adjustments), partially mitigated by delays (£14.0m) in the capital programme. Cash support is now being sought from NHSE.
Capital				
YTD				The YTD slippage in capital is materially associated with decarbonisation works and leases; re-planning is in progress for both. Whilst an exact delivery plan is yet to be finalised, assurance has been provided that all leases are still expected to be agreed in 2025/26 and all grant funded decarbonisation works complete. Internally funded decarbonisation work is forecast to defer to 2026/27; how this impacts the grant is yet to be confirmed. The current year slippage is being offset against the £1.8m overcommitment in the original capital budgets agreed, as well as other forecast overspends. A minimal balance remains which will be assigned to reserve priorities agreed in planning, including medical equipment replacements.
Capex	19.1	7.3	(11.9)	
Leases	2.1	-	(2.1)	
Total	**21.2**	**7.3**	**(14.0)**	
FORECAST				
Forecast	**50.5**	**48.2**	**(2.3)**	

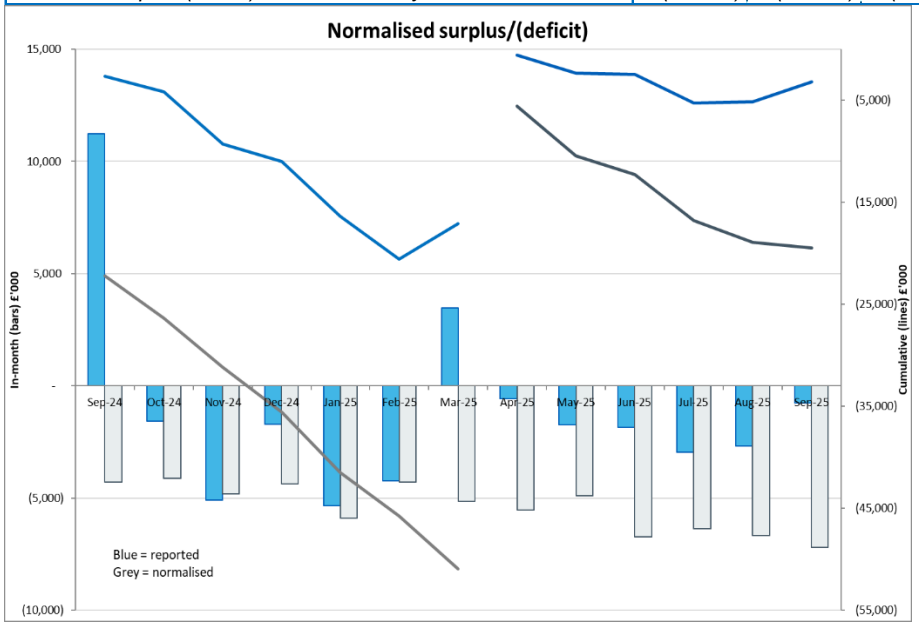
2. Income and Expenditure (I&E) vs Plan

£m	In-month			Year to date			Commentary
	Plan	Actual	Var.	Plan	Actual	Var.	
Clinical income	38.3	39.2	0.9	232.6	232.7	0.1	ERF income continues to perform in line with plan for the month, up to but not exceeding the ERF cap, and is supported by activity reports. The YTD variance reflects a £0.6m underperformance risk related to the CDC and £0.2m adverse cost and volume medical devices; this position exists due to a prior year stock adjustment. Non-recurrent income adjustments have been included this month totalling £0.6m, helping to mitigate the overall variance. Other income is below plan due to reduced car parking income, and cancer alliance below budgeted levels. Donated asset income relates to the Salix decarbonisation grant supporting capital works, which is excluded from performance against the control total. £24.7m in Deficit Support Funding has been recognised YTD.
High cost drugs	1.9	2.2	0.4	13.5	13.8	0.3	
Donated assets	2.0	1.9	(0.1)	11.9	3.1	(8.8)	
Other income	2.8	2.6	(0.2)	17.3	16.8	(0.5)	
Total income	**45.0**	**45.9**	**0.9**	**275.3**	**266.5**	**(8.8)**	
Nursing	(11.7)	(12.4)	(0.6)	(70.9)	(72.5)	(1.6)	In-month pay expenditure has increased by £0.6m, primarily driven by higher activity levels and bank holiday premium costs related to August. The nursing overspend reflects recruitment undertaken in Q4 of 2024/25, while the medical staff overspend includes £0.6m of additional costs associated with providing cover during industrial action in July. The underspend within "Other" mainly relates to centrally held pay reserves.
Medical	(9.2)	(9.3)	(0.1)	(55.5)	(56.6)	(1.1)	
Other	(8.7)	(8.0)	0.7	(51.8)	(47.3)	4.5	
Efficiency target	3.2	0.0	(3.2)	9.4	0.0	(9.4)	
Total pay	**(26.5)**	**(29.7)**	**(3.2)**	**(168.8)**	**(176.4)**	**(7.6)**	
Clinical supplies	(5.3)	(5.5)	(0.1)	(32.2)	(34.0)	(1.8)	The clinical supplies overspend recognises a £1.6m accrual for NKPS historic debt. The position includes higher insourcing costs in Surgery & Anaesthetics Pain Clinic that has restarted (£0.2m) and theatres consumables stock replenishment. The 'Other' category underspend relates to inflation and other reserves which are held centrally. The £18m System Savings target (split pay and non-pay) is being held centrally until approved schemes are confirmed.
Drugs	(1.2)	(1.2)	(0.0)	(7.3)	(7.6)	(0.3)	
High cost drugs	(1.9)	(2.4)	(0.5)	(13.5)	(13.7)	(0.2)	
Other	(5.7)	(5.4)	0.3	(35.7)	(30.7)	5.1	
Efficiency target	0.7	0.0	(0.7)	2.7	0.0	(2.7)	
Total non-pay	**(13.4)**	**(14.5)**	**(1.1)**	**(86.1)**	**(86.0)**	**0.1**	
EBITDA	**5.1**	**1.8**	**(3.3)**	**20.4**	**4.1**	**(16.3)**	
Non-operating exp.	(2.5)	(2.6)	(0.1)	(14.2)	(14.7)	(0.5)	Depreciation budgets have been reviewed, there will be a reserve transfer actioned in October to redress.
Surplus/(deficit)	**2.6**	**(0.8)**	**(3.4)**	**6.2**	**(10.6)**	**(16.8)**	
Tech. adj.	(2.0)	(1.9)	0.1	(11.8)	(3.0)	8.8	Timing of the Salix grant (decarbonisation project) as noted in income above.
Control total	**0.6**	**(2.6)**	**(3.3)**	**(5.6)**	**(13.6)**	**(8.0)**	The Trust is expected to meet its annual plan; however, the key risks to this are: • Delivery of a ~£45m efficiency programme (both Trust and System identified plans are below target with an increasing target profile as the year evolves). • Loss of DSF – failing to achieve Plan (at system level) will lead to a DSF reduction. • Loss of ERF income and/or activity/costs are above the capped level. • Receivable and payable risks e.g. MCH and Car Park VAT; ENT backlog costs. • Cash risk increases if DSF is reduced.
DSF (incl. Clin Inc)	(3.4)	(3.4)	0.0	(24.7)	(24.7)	0.0	
Performance excluding DSF	**(2.8)**	**(6.0)**	**(3.3)**	**(30.3)**	**(38.3)**	**(8.0)**	

3. Normalised performance

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

£'000	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Reported surplus/(deficit)	**11,241**	**(1,568)**	**(5,099)**	**(1,718)**	**(5,347)**	**(4,242)**	**3,482**	**(590)**	**(1,735)**	**(1,861)**	**(2,956)**	**(2,696)**	**(775)**
Technical adjustments	(275)	(267)	(475)	(1,188)	424	(200)	(3,032)	(96)	(378)	(48)	(276)	(282)	(1,872)
Control total surplus/(deficit)	**10,966**	**(1,835)**	**(5,574)**	**(2,906)**	**(4,923)**	**(4,442)**	**450**	**(686)**	**(2,113)**	**(1,909)**	**(3,232)**	**(2,978)**	**(2,647)**
Deficit support funding	(14,247)	(1,973)	(1,776)	(2,306)	(2,191)	(989)	(1,948)	(6,412)	(3,996)	(3,996)	(3,996)	(3,996)	(3,996)
Control total surplus/(deficit) before deficit support funding	**(3,281)**	**(3,808)**	**(7,350)**	**(5,212)**	**(7,115)**	**(5,431)**	**(1,498)**	**(7,098)**	**(6,109)**	**(5,905)**	**(7,228)**	**(6,974)**	**(6,643)**
Normalisation adjustments:													
Non-recurrent adjustments	(224)	537	320	833	1,214	1,140	(295)	113	36	101	18	83	(632)
NKPS Debt provision								1,464	1,212	(909)	206	144	60
Industrial action costs	-	-	-	-	-	-	-	-	-	-	555		-
Industrial action income	(542)	-	-	-	-	-	-	-	-	-	-	-	-
Annual leave accrual cost	-	-	-	-	-	-	147	-	-	-	-	-	-
Pension 9.4% Costs	-	-	-	-	-	-	17,984	-	-	-	-	-	-
Pension 9.4% Income	-	-	-	-	-	-	(17,984)	-	-	-	-	-	-
Pay Award	(1,205)	5,239	3,109	-	-	-	-	(212)	(212)	(212)	635	-	-
Pay Award Income	961	(6,103)	(906)	-	-	-	-	184	184	184	(552)	-	-
Car Parking VAT - Claim Recognised							(3,508)						
Recurrent surplus/(deficit)	**(4,292)**	**(4,134)**	**(4,826)**	**(4,379)**	**(5,901)**	**(4,291)**	**(5,154)**	**(5,549)**	**(4,890)**	**(6,739)**	**(6,367)**	**(6,747)**	**(7,214)**
Recurrent surplus/(deficit) - cumulative in-year	*(22,238)*	*(26,372)*	*(31,199)*	*(35,577)*	*(41,478)*	*(45,769)*	*(50,923)*	*(5,549)*	*(10,439)*	*(17,178)*	*(16,805)*	*(23,925)*	*(24,020)*



Commentary:

- The normalised/recurrent position removes technical items, e.g. income and spend relating to charitable donations and one-off impacts such as industrial action.
- The September normalised I&E position is a deterioration of the in-month recurrent deficit by ~£0.5m, this is mainly driven by a gradual increase in pay costs.
- Based on the year-to-date average run rate, the annualised performance is projected to be approximately **£70m**, representing a deterioration compared to 2024/25. This variance is primarily driven by:
  - Ongoing growth in nursing and midwifery staffing levels in A&E and maternity, following decisions made in mid-2024/25.
  - Non-delivery of planned efficiency measures to reduce the monthly run rate.
- Enhanced vacancy controls have been extended to the end of the financial year.

4. Statement of Financial Position

31 March 2025	£m	Month end Actual	Movement vs Prior Year
289.7	**Non-current assets**	**286.8**	**(2.9)**
6.7	Inventory	7.1	0.0
38.6	Trade and other receivables	37.3	(1.4)
0.4	Assets held for sale	0.0	(0.4)
13.3	Cash	9.3	(4.0)
59.0	**Current assets**	**53.7**	**(5.4)**
(0.2)	Borrowings	(0.2)	0.0
(61.0)	Trade and other payables	(63.0)	(2.0)
(1.1)	Other liabilities	(1.5)	(0.4)
(62.3)	**Current liabilities**	**(69.8)**	**(2.4)**
(3.3)	**Net current liabilities**	**(16.1)**	**(12.8)**
(2.8)	Borrowings	(2.8)	0.0
(1.3)	Other liabilities	(1.3)	0.0
(4.1)	**Non-current liabilities**	**(4.01)**	**0.0**
282.3	**Net assets employed**	**271.7**	**(10.7)**
511.2	Public dividend capital	511.2	0.0
(292.5)	Retained earnings	(303.1)	(10.6)
63.6	Revaluation reserve	63.6	0.0
282.3	**Total taxpayers' equity**	**271.7**	**(10.6)**

Key messages:

Non-current assets are £2.9m lower than year end, being the net impact of £7.3m investment expenditure and £10.2m depreciation.

Net current liabilities (*current assets less current liabilities*) at the end of September are £16.1m.

- **Trade and other receivables** are £37.3m (83% of one-month's income)
- **Cash** as at 30th September is £9.3m, representing a decrease of £4.0m due to the 6 month interim payment of PDC dividends (£4.3m) and the unplanned YTD revenue deficit.
- **Trade and other payables** are £63.0m (140% of one month's expenditure).
- **Other liabilities** relate to deferred income, materially being education income received quarterly in advance.

Public dividend capital remains at £511.2m, this is expected to increase by £6.3m approved for capital projects, which in turn would increase the annual revenue PDC dividend by c.£0.2m in 2026/27.

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

5. Cash

13-week cash forecast

	w/e																	
	Actual					Forecast												
£m	05/09/25	12/09/25	19/09/25	26/09/25	03/10/25	10/10/25	17/10/25	24/10/25	31/10/25	07/11/25	14/11/25	21/11/25	28/11/25	05/12/25	12/12/25	19/12/25	26/12/25	02/01/26
BANK BALANCE B/FWD	**18.1**	**17.0**	**13.7**	**40.6**	**11.4**	**8.9**	**40.1**	**41.5**	**13.5**	**10.5**	**7.6**	**39.6**	**21.7**	**5.4**	**3.9**	**3.1**	**33.3**	**6.8**
Receipts																		
NHS Contract Income	0.0	0.0	40.5	0.1	0.0	34.8	11.5	0.0	0.0	0.0	34.6	0.0	0.0	0.0	0.0	37.3	0.0	0.0
Other	0.3	0.2	0.3	0.1	0.5	0.1	0.6	0.5	0.2	0.3	0.6	0.2	0.5	0.3	0.3	0.5	0.4	0.2
Total receipts	**0.3**	**0.2**	**40.8**	**0.1**	**0.5**	**34.9**	**12.1**	**0.5**	**0.2**	**0.3**	**35.2**	**0.2**	**0.5**	**0.3**	**0.3**	**37.8**	**0.4**	**0.2**
Payments																		
Pay Expenditure (excl. Agency)	(0.5)	(0.4)	(5.0)	(25.1)	(0.4)	(0.4)	(4.6)	(24.0)	(0.5)	(0.5)	(0.5)	(13.0)	(15.5)	(0.5)	(0.5)	(4.3)	(24.2)	(0.5)
Non Pay Expenditure	(0.9)	(2.6)	(5.0)	(3.3)	(2.1)	(2.9)	(6.3)	(4.4)	(2.6)	(2.6)	(3.2)	(5.0)	(1.2)	(1.2)	(0.5)	(11.5)	(2.6)	(0.8)
Capital Expenditure	(0.0)	(0.5)	(0.0)	(0.8)	(0.5)	(0.4)	(0.3)	(0.1)	(0.1)	(0.1)	(0.7)	(1.1)	(0.1)	(0.1)	(0.1)	(3.7)	(0.1)	(0.1)
Total payments	**(1.4)**	**(3.5)**	**(10.0)**	**(29.3)**	**(3.0)**	**(3.8)**	**(11.3)**	**(28.6)**	**(3.2)**	**(3.2)**	**(4.4)**	**(19.1)**	**(16.8)**	**(1.8)**	**(1.1)**	**(19.5)**	**(26.9)**	**(1.4)**
Net Receipts/ (Payments)	**(1.1)**	**(3.3)**	**30.8**	**(29.1)**	**(2.5)**	**31.2**	**0.8**	**(28.0)**	**(3.0)**	**(2.9)**	**30.8**	**(18.9)**	**(16.3)**	**(1.5)**	**(0.8)**	**18.3**	**(26.5)**	**(1.2)**
Funding Flows																		
DH Revenue Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.2	0.0	0.0
Working Capital Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC Capital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	0.0	0.0	0.0	0.6	0.0	0.0
Grant Capital	0.0	0.0	0.4	0.0	0.0	0.0	0.6	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	3.0	0.0	0.0
Loan Repayment/Interest payable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0
Dividend payable	0.0	0.0	(4.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**0.0**	**0.0**	**(3.9)**	**0.0**	**0.0**	**0.0**	**0.6**	**0.0**	**0.0**	**0.0**	**1.2**	**0.9**	**0.0**	**0.0**	**0.0**	**11.8**	**0.0**	**0.0**
BANK BALANCE C/FWD	**17.0**	**13.7**	**40.6**	**11.4**	**8.9**	**40.1**	**41.5**	**13.5**	**10.5**	**7.6**	**39.6**	**21.7**	**5.4**	**3.9**	**3.1**	**33.3**	**6.8**	**5.6**

Closing cash at the end of September was £9.3m, which is a £8.8m decrease month-on-month due to payment of planned PDC dividends (£4.3m for the period April to September) and an unplanned deficit in the I&E position.

The rolling 13-week forecast is based on real cash, i.e. expected transactions rather than the I&E forecast; for prudence it assumes little to no efficiencies are delivered. At the current rate of spend, without increased savings delivery, we will require intervention / cash support from November 2025. This is earlier than reported in July as prior year ERF payments previously assumed receivable in October have been deferred to March in the forecast as commissioners are yet to confirm when the cash payment will be made, a delay being caused by some organisations be due payment whilst other being required to repay.

A cash-support application has been prepared with a drawdown being sought from December.

6. Conclusions

The Finance, Planning and Performance Committee is asked to note the report and financial performance at the end of September 2025 (Month 6), which is £3.3m adverse to plan in-month and £8.0m adverse YTD (MFT is £13.6m in deficit against a planned control total deficit of £5.6m). This requires the Trust to deliver a surplus of £8.7m in the second half of the year to deliver the control total.

However, as reported through this year so far, there remains a number of key **risks** to delivery of the annual plan; namely:

- **Savings**: Planned phasing of Trust savings schemes has grown gradually from April to August; there was a notable step increase in July and there is again in October System schemes are required to begin delivery. The Trust's cost base must therefore reduce accordingly, with particular focus required on pay and headcount. The start of PA Consulting means greater effort on CIPs and run-rate reduction has begun.
- **Income**:
  - The ICB has effectively capped the ERF income, which is lower than the expected value of activity plans to achieve 60% RTT at 18 weeks. Delivery of the activity plan may therefore not be reimbursed and/or be delivered at additional, unplanned cost (unless this can be achieved through productivity gains). The lead commissioner has indicated that provided ERF monies are not clawed back by NHSE then it does not intend on paying less ERF income than contracted, even if our activity levels (variable income) are below agreed activity plans. We should expect some review of this due to the ENT backlog. CDC income levels are below plan and we have adjusted YTD income assumptions, although further risk remains.
  - The guidance (May 2025) sets the condition [to hit Plan] means failure to meet I&E Plan each quarter (and NHSE assurance over full year delivery) could result in lost DSF income. This creates a form of 'double jeopardy' in that **our** DSF could be lost due to our failure and/or the failure of others, and **our** failure could result in loss of DSF income for others. Whilst we have secured DSF for Q1 and Q2, we are expecting to lose £16.5m for H2. DSF has been withdrawn from the Kent & Medway system in Q3, although technically this could be earned back in Q4.
- **Cash**: Firstly, failure to address CIP targets (and control costs) means we have insufficient cash to meet payments falling due. i.e. CIP shortfall leads to adverse expenditure, which means an expected loss of DSF (adverse income). We are squeezed in "I" and "E". We plan for support in December.
- **Old Year**: The Board have been apprised of the 2024/25 risks around MCH invoicing, Car Park VAT reclaim and cost of recovering the ENT backlog.

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

1. Vacancy controls, limiting external recruitment to essential posts only. This has been extended to the end of March 2026.
2. The process to accelerate savings delivery is underway with PA Consulting; focus on Corporate, clinical productivity and grip and controls.
3. Cash review meetings are operating on a weekly basis; including development of working capital action planning. There are fortnightly system cash working group meetings and monthly South East region cash meetings. As per guidance, FPPC will provide cash oversight.
4. The fortnightly Sustainability Recovery Group, chaired by the DCEO remains operational.

Simon Wombwell
Chief Finance Officer
October 2025

Meeting of the Trust Board in Public

Date: 12th November 2025

Title of Report	**Corporate Support Service Improvement and Business Partner Capability**			**Agenda Item**	3.5b
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			X		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
					X
Author and Job Title	Simon Wombwell, Chief Finance Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer Sheridan Flavin, Chief People Officer Siobhan Callanan, Deputy Chief Executive				
Purpose	**Approval**		**Briefing**	X	**Noting**
Proposal and/or key recommendation:	**Discussion** – The Board's view is sought on our planned approach for corporate support service improvement and business partner capability, which will feed the execution of the Stabilisation Plan.				
Executive Summary	Process for the development of business partner roles across workforce, business intelligence (BI) and finance over the next five months. This aims to meet the target set out in the Stabilisation Plan agreed by the Trust Board on 1 October 2025. The process we will follow to strengthen the strategic, analytical, and operational impact of business partnering roles, ensuring alignment between corporate services and Divisional teams in support of Trust-wide objectives for quality, sustainability, and workforce engagement.				
Issues for the Board/Committee Attention:	None				
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Trust Leadership Team, 11th November 2025				
Board Assurance Framework/Risk Register:					
Financial Implications:	None				
Equality Impact Assessment and/or patient experience implications	None				
Freedom of Information status:	Disclosable	X	Exempt		

1 Strategic Context and Rationale

1.1 The development of business partnering capability is a core requirement outlined in the Trust's Stabilisation Plan, aimed at achieving better governance and accountability through corporate support service improvement. This programme directly addresses key recommendations from the Financial Governance Report (M. Pratt, January 2025) and The Finance Function Report (K. Goodwin, March 2025). Specifically, there is a priority mandate to ensure sufficient financial business partner support, combined with HR and Business Intelligence partners, to promote improved control and deliver sustainability.

1.2 The current baseline assessment noted several critical issues, including: business partners focusing on transactional activities rather than strategic ones, providing only data instead of actionable insight, and exhibiting fragmented working between Finance, HR, and Business Intelligence (BI) partners.

1.3 The intention is to strengthen the strategic, analytical, and operational impact of business partnering roles, ensuring alignment between corporate services and divisional teams in support of Trust-wide objectives for quality, performance, workforce, and sustainability.

2 Programme Objective and Model

2.1 The initiative establishes a five-month improvement programme (November 2025 – March 2026) with the goal of creating a new business partner model, implemented by March 26.

2.2 The overriding objective is to move Business Partners (BPs) from acting merely as advisors and data providers to becoming proactive strategic enablers, embedding a collaborative, insight-driven, and accountable model.

2.3 Key goals of the programme include:

i. Enhancing strategic decision-making through unified partnering.
ii. Strengthening divisional accountability across finance, workforce, activity, and performance outcomes.
iii. Fostering a culture of co-ownership between corporate and clinical divisions.
iv. Aligning workforce, finance, and operational intelligence more closely with the Trust's revised Integrated Quality and Performance Review (IQPR) Framework.
v. A high-performing model requires BPs to be embedded within Divisional leadership, providing integrated insight across finance, people, and performance data, and using coaching and challenge to influence operational decisions towards efficiency.

3 Assurance: Progress Against Short-Term Objectives (Months 1 & 2)

3.1 The programme's initial phase (Month 1 & 2: November – December 2025) will focus on Diagnostic and Role Clarification. This short-term objective is being addressed through concrete deliverables that establish the framework for future integrated working:

i. **Role Clarity**: Current business partner responsibilities and overlaps across the three functions (Finance, HR, BI) will be mapped, and define clear role remits, reporting lines, and expected deliverables for each [divisional] partner group.

ii. **Behavioural Alignment**: A shared Business Partner Charter will be introduced. This charter defines the purpose, principles (e.g., Trusted Partnership, Strategic Influence, Collaboration), expected behaviours, and standards for cross-functional collaboration to ensure consistent, value-driven engagement across the organisation.

iii. **Divisional Engagement Framework**: Triumvirate Engagement Plans (for Finance, HR, BI) will be established for each Division. These plans define the operating framework, including meeting frequency, agenda ownership, and establish joint accountability for performance across quality, workforce, and finance.

iv. **Integrated Reporting Foundation**: Quick wins will be identified for improved meeting and reporting alignment, such as developing joint monthly divisional performance report packs and integrating them with the updated IQPR. The concept of a Performance Partnering Catch-up is being established to foster cross-functional, collaborative, real-time performance management, supporting aligned planning and action.

4 Governance and Anticipated Impact

4.1 The programme is sponsored at Executive level by the [Chief Finance Officer TBC], who will chair a dedicated project-task & finish-Group. Operational oversight is provided by Senior Business Partners and Deputy Directors from Finance, HR, and BI, with progress against milestones reviewed monthly by the Executive Team via TLT. We are also assessing the potential to use PA Consulting to provide some skills transfer as part of their work.

4.2 By March 31, 2026, the plan is expected to deliver:

i. A cohesive cross-functional business partner network with shared purpose.

ii. Business partners seen as trusted advisors within divisions.

iii. Improved decision-making through divisional leaders using integrated insight.

iv. Unified performance packs integrating financial, quality, workforce, activity, and performance metrics, providing a clear narrative evidenced by data, trends, and forecasts.

4.3 This focus on role clarity and foundational engagement in the short term is expected to ensure a structure is in place to support the subsequent phases of Capability Building and Process Integration (Months 3 & 4) leading to full implementation from April 2026.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board in Public

Date: 12th November 2025

Title of Report	**2026/27 to 2028/29 Medium Term Planning**			**Agenda Item**	3.5c
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
		X	**X**	**X**	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
					X
Author and Job Title	Simon Wombwell, Chief Finance Officer				
Lead Executive	Simon Wombwell, Chief Finance Officer				
Purpose	**Approval**		**Briefing**	**X**	**Noting**
Proposal and/or key recommendation:	Discussion – The Board is expected to assure that plans are robust and that MFT is prepared to drive the necessary change: 1. Operational capacity and capability required to balance and meet the combined quality, performance and financial target expectations. 2. Alignment of strategic direction with the national strategic shifts (treatment ⇨ prevention; hospital ⇨ community; analogue ⇨ digital) **Board to consider proposals for submission sign-offs – see para 5.**				
Executive Summary	The Medium Term Planning Framework (MTPF) marks a significant shift away from last year's short-term planning cycle towards a three-year financial and delivery cycle and a 5-year strategic planning horizon. The aim is to create the environment and headroom necessary to fix fundamental problems while improving care in the immediate term. The strategic challenges faced by Medway FT make this particularly pertinent. This report outlines the process, the priorities and, importantly, the expectations of NHSE and responsibilities of the Board in preparing and submitting the Plan for 2026/27 and planning direction to 2028/29 (broadly coterminous with the end of this parliamentary term).				
Issues for the Board/Committee Attention:	Current performance against targets (quality, performance and financial) and national expectations to improve trajectories and target delivery in 2026/27 means the Board is required to navigate an extremely challenging planning round. The proposed move to a group model with Dartford and Gravesham NHS Trust adds to the strategic challenge. The Board will want to approve a deliverable Plan ensuring our strategy is consistent with national policy, albeit accepting a degree of 'stretch' and, therefore, risk.				
Committee/ Meetings at which this paper has been	TLT, October 2025. Finance Planning and Performance Committee, October 2025. This is the first reading following formal national guidance, issued on Friday				

discussed/ approved: Date:	24th October 2025. We still await technical guidance and submission templates.
Board Assurance Framework/Risk Register:	**BAF 1**: There is a risk that the trust does not effectively manage its in-year budgets, run rate, CIP and cash reserves resulting in the non-delivery of the agreed in year control totals **BAF 4**: There is a risk that if not properly managed the Trust's financial position will lead to compromises in patient safety, health and safety and staff morale. **BAF 14**: Proposed revisions linking financial recovery to the ongoing availability of national Deficit Support Funding could further exacerbate the Trust's financial position, especially its cash position. **BAF 8**: SHMI mortality indices show that Medway Foundation Trust are outside the expected range. There is a risk that patients maybe dying unnecessarily whilst at an inpatient at Medway Foundation Trust or within 30 days of discharge. (To be reviewed once Patient First Breakthrough objective is confirmed) **BAF 9**: There is a risk that patients and their families may not receive outstanding, compassionate care every time. (link to BAF 4) **BAF 10**: High levels of 'no criteria to reside' patients and a lack of operational performance; for example, not meeting constitutional (e.g. RTT) measures has wide-ranging implications, affecting patient care, trust, finances, and overall NHS performance It's essential for trusts to address these issues promptly to maintain high-quality healthcare services. **BAF 11**: There is a risk that conflicting priorities, financial pressures and/or ineffective governance across the ICS results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care. **BAF 12**: The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity. There is a risk that the increase in patients without a criterion to reside and the low discharge profile will reduce flow through the hospital, increase the number of 12 hour delays in our ED and increase demand for bed capacity. This in turn impacts on the quality of care provided and increases the opportunity for harm to occur. In addition, this may increase overall Trust mortality as delays in ED over 5 hours correlate with increased risk of mortality. This risk also adds pressure to the financial sustainability of the trust. **BAF 13**: There is a risk that without continual investments and maintenance (including cyber security) the trust will not be able to deliver on its core responsibilities and duties as well as being able to deploy innovative systems to support the delivery of the trusts aims, objectives and strategic intentions.
Financial Implications:	As described
Equality Impact Assessment and/or patient experience implications	The development of Plans will need to consider impacts upon Equality and Patient Experience. There is potential conflict between targets e.g. productivity vs workforce experience/quality; elective performance vs system flow/capacity; financial sustainability vs performance. A key strategic ambition of the Government is a greater focus on population health, reducing inequalities and neighbourhood health services ("left shift").

Freedom of Information status:	Disclosable	**X**	Exempt	

Introduction

1. The national guidance for NHS Planning - Medium Term Planning Guidance (2026/27 to 2028/29) – was published on 24th October 2025.

2. This paper provides a Board-focussed briefing covering:

   2.1. The role of the Board in the Planning process & advice for the Board to gain assurance

   2.2. The requirements of the Trust (including MFT developed checklist of planning requirements).

3. We await further details on the technical aspects of the Planning e.g. allocations to ICBs, growth funding etc and the submission templates, but the summary below highlights the key points and the role Boards/NEDs are expected to perform in assuring and signing off the Plan(s).

4. The role of the Board is at the heart of the process of good governance, with a return to Monitor-inspired regulation - NHSE sees "the Board as the first line of regulatory defence". The Board must have a clear understanding of risks and articulate MFT's strategy alignment with national priorities and Government policy direction (e.g. the "three shifts").

5. The Medium Term Planning Framework mandates a shift away from short-termism, requiring the Board to finalise and assure highly ambitious **three-year numerical plans and a five-year strategic narrative**. As a Board member, your key role is to ensure the **robustness and deliverability** of these plans and certify them via formal **Board Assurance Statements**. Assurance will focus on three core areas:

   5.1. Financial discipline (achieving +2% productivity and break-even)

   5.2. Delivery of constitutional targets (Elective, Cancer, UEC), and

   5.3. Strategic alignment - embedding the three strategic shifts – (i) treatment to prevention (ii) hospital to community (iii) analogue to digital.

NHS Trust / Board Requirements for Plan Submission

6. The Board is explicitly required to provide two sets of assurance statements during the planning cycle (detail submission contents below):

   6.1. **First Submission (Before Christmas):** A Board Assurance Statement confirming oversight of the planning process and the 3-year numerical returns (workforce, finance, and performance trajectories). **Propose to use Board Development Day on 17th December for first submission sign-off** (subject to notification of submission date).

   6.2. **Full Plan Submission (Early February):** An updated Board Assurance Statement confirming oversight and **endorsement of the totality of the plans** (including refreshed numerical data and the 5-year narrative). **Propose to use FPPC meeting on 29th January 2026 (extended invite to all Board members) for sign-off.**

7. Overall, the Board must specifically assure the organisation's capability to manage inherent risks:

   7.1. Demonstrate a **comprehensive understanding of financial risk**.

   7.2. Ensure an **agreed approach to managing and mitigating risks in-year**.

8. Before the final plan submission (expected in early February), the Board needs to formally agree and endorse several key outputs, demonstrating their oversight; our assessment of the 'top 3' requiring Board agreement are:

   8.1. Endorsement of the **5-Year Strategic Narrative Plan**: The Board must formally agree and endorse the totality of the **5-year strategic narrative plan**, confirming it aligns with the 10-Year Health Plan vision, the three "*left shifts*", and local population needs.

8.2. **Board Assurance Statements (Final Submission)**: Formal sign-off and agreement on the **updated Board assurance statements** (we await the final templates), confirming that the plans (including updated 3-year numerical plans covering finance, workforce, and operational performance) are robust and deliverable, and that associated risks are understood and mitigated.

8.3. **Financial Trajectory and Productivity Commitment**: Agreement on the definitive financial trajectory for achieving a **break-even position without deficit support funding** by 2028/29 and the detailed organisational commitment to delivering the **minimum 2% annual productivity improvement**.

Advice for NED Assurance: Ensuring Plan robustness

9. To assure the robustness and deliverability of the plans, and confidently sign the Board Assurance Statements, the Board should scrutinise the following elements:

9.1. **Financial and Productivity Discipline (Priority 1)**

Table 1: Financial sustainability is a prerequisite for NHS transformation. NEDs must challenge the executive team on the credibility of returning to a sustainable financial position.

Area of Assurance	Assurance Question / Action Required
Financial Outcomes	Do the numerical plans commit to a **balanced or surplus financial position** in **all years** of the planning period?
Deficit Elimination	Does the plan achieve a **break-even financial position without deficit support funding** by the end of the planning horizon (2028/29), or is an exceptional agreement with NHS England required?
Transparency	If the Trust receives deficit support funding (DSF), are the non-DSF financial positions being **reported transparently to the Board**?
Productivity	Is the plan founded on delivering the **minimum 2% annual productivity ambition**? This must be addressed through targeted action like **reducing length of stay** and **improving theatre productivity**.
Risk Mitigation	Has the Board reviewed the specific and timely actions identified to **reprioritise existing budgets** to address unforeseen pressures in-year?

9.2. **Strategic Shifts and Transformation (Priority 3)**

*Table 2: The 5-year narrative plan must detail the Trust's strategic and transformation ambitions, explicitly demonstrating how they will implement the **three strategic shifts** while improving productivity.*

Area of Assurance	Assurance Question / Action Required
Digital-by-Default	Does the plan commit to **full adoption of all existing NHS App capabilities** and ensure **at least 95% of appointments** are available via the App by 2028/29?
Data Infrastructure	Is the Trust on track to be **onboarded to the NHS Federated Data Platform (FDP)** and using its core products (for elective recovery, cancer, and UEC) by 2028/29?

Pathway Redesign	How does the plan model the **reduction in clinically low-value follow-up appointments (OPFU)**, ensuring capacity released aligns with long-wait recovery objectives?
Neighbourhood Shift	Does the plan clearly outline the workforce and activity assumptions required to deliver the shift from **hospital to community** (left shift) and reduce non-elective admissions for high-priority cohorts (e.g., frail older people)?

9.3. **Delivery, Oversight, and Collaboration**

Table 3: NEDs must ensure the plans are cohesive and that required governance is embedded.

Area of Assurance	Assurance Question / Action Required
Plan Triangulation	Have the 3-year workforce, finance, and activity plans been fully **triangulated and aligned** using the integrated planning template?
Constitutional Bedrock	Do the performance targets explicitly align with the requirement to deliver 92% RTT, 85% A&E 4-hour performance, and improved cancer standards by 2028/29?
Population Needs	Do the plans reflect the needs of all age groups, explicitly including **children and young people** (CYP)?
Collaboration	Is there **evidence of partnership working and co-operation** with other NHS organisations, local authorities, and the voluntary, community, faith, and social enterprise sector?
Oversight Tools	Is the Board actively using the **NHS Oversight Framework** (including published league tables) and other tools like costing dashboards to drive improvement and understand performance relative to peers?

9.4. **Quality, Safety, and Workforce Assurance**

Table 4: The Board has specific oversight duties related to quality, safety, and staff experience.

Area of Assurance	Assurance Question / Action Required
Mandatory Safety	Have steps been taken to ensure **full implementation of all 3 components of Martha's Rule** in all acute inpatient settings, as set out in the new NHS Standard Contract requirement?
Maternity Safety	Is the Trust implementing the **Maternity Outcomes Signal System (MOSS)** by November 2025, and are quality insights being actively used by leadership and the Board?
Staff Experience	Has the Board received and committed to act upon a **full and detailed analysis of free text comments** from the staff survey, focusing on at least **3 areas of greatest staff dissatisfaction**?
Consultant Job Plans	Does the plan ensure the implementation of job-planning reforms to achieve **95% of medical job plans signed-off** in line with the business cycle?

Research Activity	Is research activity and income being **reported to the Board on a 6-monthly basis**, including details of study set-up performance against the 150-day target?

Prioritised Acute Trust Requirements Checklist (2026/27 to 2028/29).

10. Note: the priorities are our assessment for ease of assimilation of the detail. We will be expected to deliver all of these targets, unless we can negotiate and agree a dispensation. We anticipate the hardest areas to achieve any 'relaxation' will be finance and performance targets (ED, RTT, Cancer) as these are the Government Priorities, the public mandate they clearly want to protect.

10.1. **Priority 1: Financial Sustainability and Core Productivity (The Foundation)**

Table 5: These requirements are essential for restoring the NHS to better health and providing the financial headroom necessary to fund transformation.

Requirement Area	Checklist Item / Action Required	Target / Deadline
Financial Position	Deliver a sustainable financial position.	**Balanced or surplus financial position** in all years of the planning period.
Deficit Funding	Achieve a break-even financial position, unless an exceptional agreement is made.	**Without deficit support funding** by the end of this planning horizon.
Productivity	Deliver efficiency gains across the organisation (a prerequisite for financial sustainability).	**Minimum 2% annual productivity ambition**.
Efficiency Actions	Implement sustained and targeted action to drive productivity (e.g., reducing inpatient length of stay, improving theatre productivity, returning to pre-COVID levels of activity per WTE).	Ongoing throughout the planning horizon.
Agency / Bank Use	Reduce agency staffing usage.	In line with individual trust limits, **30% reduction in agency use in 26/27**, **10% reduction Year on Year in bank spending**; working toward **zero spend on agency by 2029/30**. *Bank spending is our biggest opportunity but this is linked to capacity, acuity and sickness.*

10.2. Priority 2: Constitutional Performance Targets and Operational Flow

*Table 6: These are the core delivery commitments that regain public confidence and address the urgent need to reduce waiting times, forming the **bedrock** of the overall strategy. We will need to ensure a contract value (activity plan) is sufficient to achieve these targets.*

Requirement Area	Checklist Item / Action Required	Target / Deadline
Elective (18-Week RTT)	Achieve the constitutional standard.	**92%** of patients waiting 18 weeks or less for treatment (End of 2028/29).
RTT Improvement (2026/27)	Deliver significant performance improvement in the first year.	**Minimum 7% improvement or 65%**, whichever is greater (2026/27). *This will be 65% for us. We are at ~52%*
Cancer Standards	Maintain and improve performance against key cancer standards (28/31/62 day).	Maintain 28-day Faster Diagnosis Standard (FDS) at **80%**. Improve 31-day to **96%** and 62-day to **85%** (End of 2028/29).
A&E 4-Hour Wait	Improve A&E performance towards the national target.	Achieve national target of **82% by Mar 27** up to **85%** as the average for 2028/29. *This is ~75% now*
A&E 12-Hour Wait	Reduce the number of long waits in the Emergency Department.	Achieve **year-on-year percentage increases** in patients managed within 12 hours.
Ambulance Handovers	Work collaboratively with ambulance services to reduce handover times.	Toward the **15-minute standard**.
Diagnostics (DM01)	Improve performance against the 6-week wait standard.	No more than **1%** of patients waiting over 6 weeks for a diagnostic test (End of 2028/29).

10.3. Priority 3: Foundational Reform and Quality Implementation

Table 7: These requirements involve embedding the new digital-by-default and safety models that "rewire how the NHS works" and radically transform the approach to quality.

Requirement Area	Checklist Item / Action Required	Target / Deadline
Patient Safety	Ensure full implementation of a mandatory safety measure in all acute inpatient settings.	Full implementation of all 3 components of **Martha's Rule**.
Data Platform	Be onboarded and actively use the national data platform.	Acute providers onboarded to the **NHS Federated Data Platform (FDP)** and using core products to support elective recovery, cancer, and UEC (Achieved by 2028/29).

Digital App Adoption	Fully adopt all existing NHS App capabilities.	As a priority, no later than the **end of 2028/29**.
Digital Appointments	Make appointments available after appropriate triage via the NHS App.	At least **95% of appointments** (By end of 2028/29).
Patient Communication	Migrate direct-to-patient communication services to the national platform.	Move all direct-to-patient communication services to **NHS Notify** (Complete migration by the end of 2028/29).
UEC Flow	Ensure clinical and operational processes are in place to manage non-admitted patients efficiently.	Non-admitted patients must be seen, treated, and discharged **within 4 hours** to reduce overcrowding and improve safety.
Maternity Safety	Implement the national system for monitoring safety indicators.	**Maternity Outcomes Signal System (MOSS)** implemented across all NHS trusts by November 2025.
Inpatient Safety (Paediatric)	Implement the Paediatric Early Warning System.	Implement **PEWS** in all paediatric inpatient settings by **April 2027**.

10.4. **Priority 4: Workforce, Leadership, and Planning Infrastructure**

Table 8: These actions focus on internal health, leadership accountability, and adhering to the new medium-term planning cycle.

Requirement Area	Checklist Item / Action Required	Target / Deadline
Workforce	Implement the action plan for resident doctors.	Fully implement the **10 Point Plan to improve resident doctors' working lives**.
Sickness Absence	Set out plans to reduce sickness absence rates.	Towards the lowest recorded national average level (approximately **4.1%**).
Job Planning	Ensure consultant job-planning reforms are implemented.	**95% of medical job plans signed-off** in line with the business cycle.
Staff Experience	Analyse staff feedback and develop concrete solutions.	Identify a minimum of **3 areas of greatest staff dissatisfaction** and develop detailed action plans to resolve them.
Leadership Framework	Embed the new standards for managers and leaders.	Embed the Management and Leadership Framework into recruitment and appraisal practices (Following publication in the autumn).

Plan Submission (Numerical)	Submit the required multi-year financial, workforce, and performance plans.	**First submission** (3-year numerical plans) required **before Christmas**.
Plan Submission (Strategic)	Submit the long-term strategic plan alongside updated numerical plans.	**Full submission** (including the 5-year strategic narrative plan) expected in **early February**.

11. We are building on initial preparation work and data collation to create our plans ready for iteration with the Board. The specific requirements for each return (the two submissions):

First Submission Requirements (Due before Christmas)

12. Focus on **core numerical commitments** and **initial board oversight** for the medium term.

Submission Component	Requirement Details
Numerical Plans (3-Year)	The submission must include three separate 3-year numerical returns covering: 1. **3-year revenue and 4-year capital plan return** (Finance) 2. **3-year workforce return** 3. **3-year operational performance and activity return** (RTT etc trajectories)
Integrated Planning Template	An integrated planning template must be provided, demonstrating the **triangulation and alignment of plans** across finance, workforce, and activity
Board Assurance Statement	**Board assurance statements** must be submitted, specifically confirming **oversight of the planning process**

*Note: The narrative plans are **not** included in this first submission*

Full Plan Submission Requirements (Due early February)

13. The full submission expands on the initial data, incorporating the **strategic vision and requiring a comprehensive endorsement of the plans by the Board**.

Submission Component	Requirement Details
Numerical Plan Updates (3-Year)	Updated 3-year numerical plans, including: 1. **Updated 3-year revenue and 4-year capital plan return** 2. **Updated 3-year workforce return** 3. **Updated 3-year operational performance and activity return**
Integrated Planning Template	Updated integrated planning template showing the triangulation and alignment of plans

Strategic Narrative Plan (5-Year)	A **5-year narrative plan** must be included. This strategic document must outline how the organisation will deliver the three strategic *left shifts* and improve productivity
Board Assurance Statement	Updated **board assurance statements** confirming **oversight and endorsement of the totality of the plans**. The board must also assure itself that the organisation has... 1. A **comprehensive understanding of financial risk** 2. An agreed approach to **managing and mitigating risks in-year**

Key Strategic Content Expected in the Plans

14. The plans, particularly the 5-year strategic narrative, must detail several strategic and operational assumptions, including:

- MFT's **strategic ambitions**.
- How MFT will **meet its local population health needs**, explicitly reflecting the needs of **children and young people**.
- MFT's **transformation ambitions**, demonstrating how the three strategic shifts (local care, digital by default, sickness to prevention) will be implemented while **improving productivity**.
- **Evidence of partnership working and co-operation** with other NHS organisations, local authorities, and the voluntary, community, faith, and social enterprise sector.
- How MFT will **meet the standards** set out in the Medium Term Planning Framework document.

*Note: While neighbourhood health plan requirements will be set out in the forthcoming Neighbourhood Health Framework, they do **not** need to be submitted to NHS England as part of this planning round.*

Major Risk Areas and Potential Conflicts

15. The successful delivery of targets and trajectories required for the MTPF is not going to be easy (recognising our current position(s)). The Board needs to understand and agree on the risks associated with achieving these ambitious targets (and may need to consider choices for discussion with NHSE).

15.1. **Specific Risk Areas for Board Questioning**

- **Financial Sustainability Risk:** The mandated move towards a break-even position without Deficit Support Funding (DSF) requires rigorous implementation of productivity (leading to capacity reduction) measures. The first challenge will be the management team's ability to identify schemes sufficient to meet the targets, and then the Board will need to scrutinise the assumptions underpinning the efficiency savings. Non-DSF financial positions must be reported transparently to the Board.
- **Digital Adoption Risk:** Successfully adopting a 'digital-by-default' approach, achieving 100% electronic patient record (EPR) coverage, and onboarding to the NHS Federated Data Platform (FDP) by 2028/29 relies heavily on robust infrastructure and change management (and a capital funding pipeline).
- **Workforce Productivity and Retention Risk:** Reversing the trend of workforce growth outpacing service delivery growth is essential for long-term sustainability. Failure to fully implement the 10 Point Plan for resident doctors or substantially reduce high sickness

absence rates (MFT currently 5.1%) risks morale and increases reliance on bank and agency staff.

15.2. **Potential Conflicts Between Targets**

- **Conflict 1: Productivity vs. Workforce Experience/Quality.** The requirement for a sustained **2% annual productivity improvement**, organisational change and push to eliminate temporary staffing may conflict with the concurrent need to improve staff satisfaction and reconnect with the workforce. A key issue given our cultural improvement plans. Leadership must ensure productivity efforts do not lead to staff burn-out or compromises in quality, particularly when focusing on measures like reducing length of stay or increasing activity per WTE.
- **Conflict 2: Elective Performance vs. System Flow/Capacity.** Achieving high-level operational targets (e.g., trajectory to 92% 18-week RTT and 85% 4-hour A&E) requires freeing up acute capacity. This capacity liberation is dependent on the accelerated delivery and funding of neighbourhood health services ("left shift"), which may be challenging to scale at the necessary pace. If the shift to community care is slow, we will struggle to meet both UEC and Elective constitutional standards. The contract value will need to reflect a level of activity and investment consistent with performance target delivery; productivity ("more for the same") will be expected but, as outlined above, MFT will be required to improve productivity to address financial sustainability; it is unlikely we will be able to achieve sufficient productivity improvement through both the numerator (outputs £value) and the denominator (inputs £value) of the productivity equation.
- **Conflict 3: Financial Framework Changes vs. Pace of Change.** The plan signals moving away from block contracts and introducing new Urgent and Emergency Care (UEC) payment models to incentivise transformation. However, careful consideration is needed regarding the pace of moving towards a fair shares funding model to avoid destabilising organisations currently relying on established funding streams like deficit support. Given MFT's activity is weighted towards UEC pathways and chronic care conditions (linked to our population demographic), this should have a positive impact upon our income; however, this might be diluted by a slow pace of change and any issues around the quality of our coding.

Discussion Points for Non-Executive Directors (NEDs) to consider:

16. NEDs are expected to assure that the plans are robust and that the organisation is prepared to drive the necessary change. Key areas for discussion include:

16.1. **Risk Assurance and Mitigation:** How has the Board assured itself of a comprehensive understanding of financial risk, and are the identified in-year actions (e.g., reprioritising budgets) for addressing unforeseen pressures clearly defined and appropriate? Balancing this against ambitious trajectories for RTT, Cancer, ED and diagnostic standards. What is the process for monitoring quality, safety and workforce satisfaction in real-time?

16.2. **Local Ambition and Population Needs:** Do the 5-year plans adequately reflect local population health needs, specifically for vulnerable groups such as Children and Young People (CYP), and those with learning disabilities and autism? How ambitious are the local targets for reducing unnecessary outpatient follow-up activity (OPFU) relative to the required reduction needed to accelerate RTT recovery?

16.3. **Governance and Transparency:** How is the Trust utilising the NHS Oversight Framework "league tables" and other performance data (such as monthly published trust-level productivity statistics) to drive internal improvement relative to peers? How is the Board ensuring accountability for upholding the standards set out in the new Management and Leadership Framework?

16.4. **Workforce Improvement Actions:** Has the Board critically analysed the Staff Survey free text comments, and are the detailed action plans addressing the minimum three areas of greatest staff dissatisfaction genuinely impactful and deliverable within the year?

16.5. **Shifting Resources:** What evidence is there that MFT (in collaboration with the ICB) is shifting resources into prevention and community capacity, particularly for high-priority cohorts such as those with frailty, housebound, or end-of-life patients?

16.6. **Digital:** Does the Digital strategy (and investment plan) adequately address the *analogue-to-digital shift* over the next three years?

Stabilisation Plan theme	**Finance**	Risk – 1 (mapped to BAF 1, 3, 4, 14)	Target date – March 2027
Cause		**Risk / Issue**	**Impact ∆ - top 3**
As a result of… • Historic financial deficit • Unsustainable financial model • Approach to NHS capital budget • Specialist commission landscape changes • National planning guidance constraints • Lack of grip/ Poor control of pay and non-pay budgets • Lack of delivery of productivity goals • Sluggish CIP programme		There is a risk that the trust cannot effectively manage its in-year budgets, run rate, CIP and cash reserves resulting in the non-delivery of the agreed in year control totals.	**Quality**: • Delays in cost-saving initiatives can lead to resource strain, affecting frontline service quality. **Performance**: • Regulatory intervention, reputational damage and long waits for patients. **Finance**: • Limits investment in infrastructure and technology, affecting future cost efficiency.

Risk Score	**Consequence**	**Likelihood**	**Score**
Initial score	4	3	12
Current score	5	5	25
Target score	4	3	12
Lead – Chief Finance Officer		**Appetite –** 12 (4x3)	

Controls	**Assurance on controls**
1. Finance, Performance and Planning Committee oversight. 2. Weekly sustainability recovery group. 3. Budget statements/budget holder meetings 4. NHSE Improvement Director support. 5. System finance and recovery forum (CFO attending). 6. Application of "Grip and Control" checklists and NHSE controls. 7. Self-assessment and implementation of HFMA sustainability Checklist. 8. Vacancy and enhanced non-pay controls.	1. High – Formal governance structure with clear accountability. 2. Moderate – Tactical oversight with visible outputs. 3. Low – Routine financial reporting. 4. High – On-sight oversight with strategic input. 5. Moderate – A forum for strategic alignment across ICB partners 6. High – Structured national framework with measurable compliance 7. Moderate – Reflective tool with improvement tracking 8. Moderate – Direct cost containment with governance checks
Gaps in control and assurance	**Actions to address gaps**
a. Mature stabilisation plan implementation plan. b. Mature business planning and budget setting process. c. Business partner support provision d. Set of triangulated metrics/KPIs	

Stabilisation Plan theme	**Finance**	Risk – 2 (mapped to BAF 2)	Target date – March 2027
Cause		**Risk / Issue**	**Impact ∆ - top 3**
As a result of… • Historic financial deficit • Historic capital allocations • Static national capital funding • CEDL limitations • Historic lack of grip and control on capital programming • Aged and dilapidated portions of estate		Limited capital money is impacting the Trust's ability to tackle its backlog maintenance requirements.	**Quality**: • Compromise IPC and privacy and dignity, hinder delivery of modern healthcare, reduce patient and staff experience/moral. **Performance**: • Reactive maintenance and infrastructure failures lead to cancelled clinics, delayed procedures, and reduced throughput. **Finance**: • Compounding costs and higher future liabilities lead to emergency spend at premium rates.

Risk Score	**Consequence**	**Likelihood**	**Score**
Initial score	5	4	20
Current score	5	4	20
Target score	4	3	12
Lead – Executive Director of Recovery		**Appetite –** 12 (4x3)	

Controls	**Assurance on controls**
1. Trust prioritisation matrix for estates. 2. Annual Place surveys and Ward Accreditation programme 3. Six-Facet survey recovery programme. 4. System strategic estates group (member). 5. Estates and IPC walk around	1. Moderate – Decision-making tool with traceable application. 2. High – Independent assurance of environmental quality. 3. Moderate – Structured intelligence with improvement trajectory. 4. Low – Collaborative forum with system-wide visibility. 5. High – Decision and solution mechanism.
Gaps in control and assurance	**Actions to address gaps**
a. Approved Estates and Facilities strategy. b. Mature capital planning and budget setting process. c. Estate business partner support provision to divisions d. Set of triangulated metrics/KPIs e. Annual capital programme review process (Inc. medical devices)	e Establish formal governance with oversight and audit trail.

Stabilisation Plan theme	**Culture**	Risk – 3 (mapped to BAF 5)	Target date – March 2026 (Phase 2)
Cause		**Risk / Issue**	**Impact ∆ - top 3**
As a result of… • Inconsistent handling of grievances and performance issues. • Normalised poor behaviour, including race and sex discrimination over an extended period. • Unaddressed bias and low cultural competence. • Lack of management capability. • Perceived unfairness in HR processes based on race/ethnicity		The Trust's current organisational culture will continue to negatively impact staff and patients' experience and the trusts reputation.	**Quality**: • Reduced staff morale and psychological safety compromises patient care. **Performance**: • Increased staff turnover, sickness absence, and reduced engagement affect service delivery **Finance**: • Increased legal costs, tribunal settlements, and reputational damage further strains resources

Risk Score	**Consequence**	**Likelihood**	**Score**
Initial score	3	4	12
Current score	4	4	16
Target score	3	3	9
Lead – Chief People Officer		**Appetite – 9** (3x3)	

Controls	**Assurance on controls**
1. Annual staff survey and routine Pulse surveys 2. Monthly FTSU review meetings. 3. Cultural Transformational phase 2 plan and monitoring metrics. 4. WRES/WDES indicator collection and reporting. 5. Stabilisation Plan programme.	1. High – National tool with clear feedback loops and board visibility. 2. Moderate – Embedded governance with independent oversight. 3. Moderate – Strategic programme with measurable outcomes and board-level reporting. 4. High – Nationally mandated with external scrutiny. 5. Low – Immature targeted intervention with structured governance and reporting mechanisms.
Gaps in control and assurance	**Actions to address gaps**
a. Management capability for dealing with grievances b. Not able to complete Rapid Case Review c. Sex discrimination risk assessment process	a. Dedicated investigation & resolution team to take forward complex ER cases – Established Dec 25. aa. 85% management essential (inc Advanced) trained staff (in the stabilisation plan) b. Further cases to be identified jointly with BAME network – due Oct 25 c. action plan produced to mitigate risk from the sex discrimination assessment - tbc

Stabilisation Plan theme	**Culture**	Risk – 4 (mapped to BAF 6)	Target date – December 2025
Cause		**Risk**	**Impact ∆ - top 3**
As a result of… • Pockets of strong team-based care and patient focus sit alongside hierarchical protection. • Uneven leadership behaviour. • Low psychological safety reported for some groups. • Staff preference to raise concerns through FTSU rather than local reporting. • Unembedded culture of 'just learning' Over use of formal HR processes to compensate for weak local processes.		Quality being compromised because staff do not feel confident to raise concerns with the organisation or their managers for fear of repercussions or a fear that their concerns will not be dealt with appropriately.	**Quality**: • Staff feel it's unsafe to speak up about errors, risks, or concerns, increasing the likelihood of preventable harm and reputational damage. **Performance**: • Uneven behaviour confuses expectations, accountability, and priorities, reducing operational efficiency. **Finance**: • Failure to address concerns or HR inequities can lead to increased legal costs, legal challenges or tribunal awards.

Risk Score	**Consequence**	**Likelihood**	**Score**
Initial score	4	3	12
Current score	4	4	16
Target score	4	2	9
Lead – Chief People Officer		**Appetite – 9** (3x3)	

Controls	**Assurance on controls**
1. Freedom to Speak Up service, strategy and implementation plan. 2. Cultural Transformation programme, phase two implementation. 3. Staff networks programme 4. People Strategic Initiative focussing on leadership behaviours. 5. National staff survey dashboard with local survey results links. 6. Dignity at Work Advisors roles.	1. High - a formal, protected channel for raising concerns 2. Moderate – complex programme working across a broad timescale 3. Moderate – Established groups. 4. Moderate - Strategic programme with measurable outcomes and board-level reporting 5. High - Nationally mandated with external scrutiny 6. Low – a supportive measure but not fully established.
Gaps in control and assurance	**Actions to address gaps**
a. Weak local processes to learn from events and issues. b. Varied feedback in relation to FTSU provision c. Low management capability	a. Redesigned approach to pre-disciplinary panel to reduce number of formal investigations and suspension – Oct 25 aa. Introduction of trained mediators and facilities to support local dialogue – due Dec 25 (see above) b. Continued service reflection and embedding service - tbc c. As above

Stabilisation Plan theme	Quality	Risk – 6 (mapped to BAF 8)

Cause	Risk	Impact ∆ - top 3
As a result of… • Limited community and EoL care in Medway. • Failure to learn from deaths. • Delayed or missed diagnoses in certain disease areas. • Staffing shortages and skill mix issues.	SHMI mortality indices outside the expected range therefore is a risk that patients maybe dying unnecessarily whilst an inpatient at Medway Foundation Trust or within 30 days of discharge.	**Quality**: • Compromised patient safety. **Performance**: • Poor discharge planning, inadequate follow-up, or delayed interventions strain resources. **Finance**: •Cost of remedial actions and litigation.

Risk Score	Consequence	Likelihood	Score
Initial score	5	4	20
Current score	5	4	20
Target score	4	2	8
Lead –Chief Medical Officer		**Appetite –** 8	

Controls	Assurance on controls
1. Board-level oversight of mortality through the stabilisation plan 2. Mortality surveillance dashboards. 3. Emergency Admission pathway and medical model. 4. Learning from Deaths process, End of life care pathway 5. Inpatient Deaths Review Group ToR 6. Medical Examiners process and reporting	1. Moderate - embedded in governance and linked to KPIs. 2. High – Data quality has been shown to be good by external audit. 3. Moderate – Internal pathways and still being developed. 4. Moderate – Internal processes and still embedding. 5. Moderate – Internal group scrutiny. 6. High - Independent scrutiny of deaths.
Gaps in control and assurance	**Actions to address gaps**
1. Robust links to the feedback from coroners. 2. Holistic plans with partners for patient management outside of hospital setting. 3. Immature learning from deaths processes including the SJR process. 4. Variation in level of communication with families regarding EoL. 5. Treatment of Pneumonia outlier.	1. Focus on supporting the development of robust action plans following the events and meetings of SJR group. 2. EOL team work with community providers and SECAMB to improve the clinical decision process and pathway. 3. As point 1. 4. Focussed internal programme to support the EOL decision process 5. Clinical pathway review against NCEPOD standards.

Stabilisation Plan theme	Performance	Risk – 7 (mapped to BAF 10)

Cause	Risk	Impact ∆ - top 3
As a result of… • High patient demand and seasonal surges. • Lack of out of hospital community provision. • Primary Care provision. • Reactive rather than proactive job planning. • Long follow-up rates compared to new care rates. • Disjointed clinical pathways. • Variation in Discharge Ready Date tracking	High levels of 'no criteria to reside' patients and a lack of operational performance (e.g. RTT) impacts patient care, patient experience, finances	**Quality**: • Poorer health outcomes, increased patient dissatisfaction. **Performance**: • Increased regulatory scrutiny and oversight **Finance**: • Financial penalties and barriers to access support funding.

Risk Score	Consequence	Likelihood	Score
Initial score	4	3	12
Current score	4	4	16
Target score	4	3	12
Lead – Chief Operating Officer		**Appetite – 12**	

Controls	Assurance on controls
1. Weekly internal RTT meetings. 2. Monthly reporting to TLT as part of the performance management review. 3. Acute Medical and Frailty Model 4. Trust Full Capacity Protocol and OPEL triggers and actions. 5. Waiting list maintenance and review process. 6. Patient initiated Follow-up (PIFU) initiative.	1. High – Good data quality and regular validated reporting. 2. High – Formal performance reporting with exec oversight. 3. Moderate – Effectiveness tracking requires proxy KPI's 4. Moderate – Effective policy but focuses on short term recovery. 5. High – Good data quality and reviewed by clinicians. 6. National initiative but limited take up in most areas.
Gaps in control and assurance	**Actions to address gaps**
1. EDN completion variation. 2. Clinician job planning and rostering. 3. Acute Medical Unit pathway. 4. Virtual Hospital utilisation. 5. Lack of joint care planning and provision outside of the trust. 6. Triangulation report for performance, quality and finance metrics.	1. Roll-out of the trusts LoS programme. 2. Completion of the job planning and rostering programme – Dec 25. 3. Implementing Winter Plan 2025 and embedding medical models. 4. Programme 'go-live' November 2025. 5. Implementing Winter Plan 2025 and working with new community contract service provider to identify new opportunities for out of hospital care. 6. Stabilisation plan reporting templates, IQPR and governance designed and implemented – Nov 25.

Stabilisation Plan theme	Performance	Risk – 8 (mapped to BAF 12)

Cause	Risk	Impact Δ - top 3
As a result of… • High patient demand and seasonal surges. • High acuity of presenting patients. • High bed occupancy and NCTR. • Lack of community care, social support, or placement availability. • Poor discharge coordination.	The Trust is facing sustained operational pressure, frequently escalating to OPEL 4 and Business Continuity status due to rising demand and low discharge rates. This increases 12-hour ED delays, compromises patient flow and bed pressure.	**Quality**: • Poorer health outcomes, increased patient dissatisfaction. **Performance**: • Increased regulatory scrutiny and oversight **Finance**: • Financial penalties and reactive cost pressures (additional nursing costs to staff escalation areas etc).

Risk Score	Consequence	Likelihood	Score
Initial score	4	4	16
Current score	4	4	16
Target score	3	3	9
Lead – Chief Operating Officer		**Appetite – 9**	

Controls	Assurance on controls
1. Daily site and management meetings to monitor and support progress on improving discharge processes throughout the Trust. 2. Flow and Discharge Corporate project. 3. HaCP Discharge Group, Efficiencies Group and LAEDB. 4. TeleTracking tool. 5. Virtual Ward initiatives 6. SHMI improvement programme (BAS 6)	1. Moderate – A route for escalation but limited levers for change. 2. Moderate – KPIs and defined projects but limited impact to date. 3. Moderate – Multi-agency approach but limited joint planning or KPI 4. Moderate – Tracking tool but requires staff adherence to protocol. 5. Moderate – Yet to be fully rolled out. 6. High – Highly audited data.
Gaps in control and assurance	**Actions to address gaps**
1. Length of Stay programme reporting. 2. Acute Medical Unit pathway. 3. Virtual Hospital utilisation. 4. Lack of joint care planning and provision outside of the trust.	1. Roll-out of the trusts LoS programme and monitor through TLT. 2. Implementing Winter Plan 2025 and embedding medical models. 3. Programme ‘go-live’ November 2025. 4. Implementing Winter Plan 2025 and working with new community contract service provider to identify new opportunities for out of hospital care.

Stabilisation Plan theme	Culture	Risk – 9 (mapped to BAF 14)

Cause	Risk	Impact ∆ - top 3
As a result of… • Persistent payroll errors. • Poor rota management. • Lack of rest facilities. • Repetitive mandatory training. • Fragmented accountability and oversight.	10 Point Plan to improve Resident Doctors' Working Lives: Failure to implement the 10 Point Plan could significantly undermine efforts to improve the working conditions, wellbeing, and retention of resident doctors.	**Quality**: • Reduced focus, increased errors, and lower quality of care. **Performance**: • Jeopardised long-term healthcare system and service resilience. **Finance**: • Increased sickness rates and cost of recruitment and training.

Risk Score	Consequence	Likelihood	Score
Initial score	4	3	12
Current score	4	3	12
Target score	2	3	6
Lead – Chief Medical Officer		**Appetite – 9**	

Controls	Assurance on controls
1. NHSE baseline survey monitoring.as requested by NHSE. 2. The GMC and National Education and Training survey. 3. Routine CMO and DME meetings with resident doctors. 4. Payroll control measures. 5. Stat and Man training system on ESR. 6. Health and Safety, Bullying and Harassment policies. 7. Job Planning process and annual leave policies.	1. Moderate – National process but dependent on response rate. 2. High - External validation of training quality and doctor experience. 3. High – Direct, real-time line of communication. 4. Moderate – Automated process but relies on data to be input right. 5. Moderate – A tracking system not a KPI for improving working life. 6. Moderate – A framework but requires audit of effectiveness. 7. Moderate – Job Planning programme yet to be completed.
Gaps in control and assurance	**Actions to address gaps**
1. Lack of standardised benchmarks or KPIs to measure progress across organisations. 2. Job planning may not address rota fairness, rest periods, or training access. 3. ESR and payroll systems are not integrated with onboarding processes. 4. No Formal Evaluation Framework to ascertain impact of measures.	1. Development of a scorecard to track progress on each of the 10 points – Sept 25 2. Implement digital rota tool to allow for self-rostering or shift swaps where feasible. 3. Introduce a pre-arrival onboarding checklist that includes ESR setup, IT access, and mandatory training completion. 4. Map each point to measurable indicators and assign leads – Sept 25.

Stabilisation Plan theme	Performance	Risk – 10 (mapped to BAF 13)

Cause	Risk	Impact ∆ - top 3
As a result of… • Competing operational pressures. • Availability of capital. • Fragmented digital ecosystem. • Rising threat of Ransomware and Attacks. • Lack of system direction or strategy.	Without continual investments and maintenance (including cyber security) the trust will not be able to deliver on its core responsibilities and duties as well as being able to deploy innovative systems to support the delivery of the trusts aims, objectives and strategic intentions.	**Quality**: • Cybersecurity breaches result in data loss, system outages and disrupting critical services. **Performance**: • Impedes transformation initiatives, and makes it harder to meet NHS Long Term Plan goals and digital mandates. **Finance**: • Emergency fixes, cyber incident recovery, and outdated infrastructure increase maintenance and remediation costs.

Risk Score	Consequence	Likelihood	Score
Initial score	4	4	16
Current score	4	4	16
Target score	3	3	6
Lead – Director of Strategy and Partnership		**Appetite – 6**	

Controls	Assurance on controls
1. Digital and data (DDaT) strategy and implementation plan. 2. IT investment summary (business planning item) 3. Senior level leadership and oversight. 4. Annual maintenance programme. 5. Server upgrade programme. 6. Local Cyber security audit and action plan. 7. Local and national IT partnership working (e.g. CSOC).	1. High – Aligned with national priorities and includes timelines. 2. Moderate – Not fully aligned with capital planning process. 3. High – Ensures Exec level oversight is maintained. 4. Moderate – Limited by availability of capital. 5. Moderate – reduces risks but does not eliminate them. 6. High – Identifies vulnerabilities and drives remediation. 7. Enhances threat intelligence and access to national capital funds.
Gaps in control and assurance	**Actions to address gaps**
1. Limited governance integration overseeing digital risk, cybersecurity, and innovation collectively. 2. ‘Live’ testing of response plan for ransomware, data breaches, or system outages. 3. Infrastructure, cybersecurity, and digital transformation is siloed across divisions.	1. Create a regular report for TLT – Jan 26. 2. Run table top or live simulations involving ransomware, data breach, and system outage scenarios and report findings. 3. Map all digital programmes (e.g. infrastructure upgrades, cybersecurity, innovation pilots) into a single delivery roadmap – Jan 26.

Meeting of the Board of Directors in Public
Wednesday, 12 November 2025

Title of Report	Audit and Risk Committee – 11 September 2025			**Agenda Item**	4.2a
Lead Executive	Simon Wombwell, Chief Finance Officer (Interim)				
Committee Chair	Peter Conway, Chair of Committee/Non-Executive Director				
Executive Summary	Assurance report to the Board from the Audit and Risk Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.				
Proposal and/or key recommendation:	To give the Board assurance from the Audit and Risk Committee and highlight any risks, issues or escalations.				
Purpose of the report (tick box to indicate)	Assurance	X	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	Audit and Risk Committee 11.09.25 to submit to Trust Board in Public on 12.11.25				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: X	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Audit and Risk Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Audit and Risk Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Matt Capper, Director of Strategy and Partnerships/Company Secretary: m.capper@nhs.net Simon Wombwell, Chief Finance Officer (Interim): simon.wombwell@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions		
	Partial Assurance		There are gaps in assurance		

	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

Estates: Fire Safety Assurance
The papers submitted were of insufficient quality to be considered

Items/risks/issues for escalation

Issues, Risks and Actions to note:

a) Action - Update on CNST premium to the December meeting.
b) Action - eRostering update on compliance (grip and control) to the December meeting.
c) Note - Cyber Resilience - A clear concise dashboard of the Trusts cyber risks including top risks, assurance that reasonable steps are being taken, with a focus on objectivity and benchmarking against both NHS and private sector standards.
   - The governance route to be confirmed.
   - Internal audit plan on cyber to be initiated with scope review by KPMG and Grant Thornton.
   - Top five risks to be circulated to members of the committee.
   - Cyber Fraud training attendance to be improved.
d) Action - The committee discussed salary overpayment and if payroll had been reviewed for robustness of management processes. Headline figures to be benchmarked and reported back, together with assurance that controls are in place.
e) Action - Economic Crime and Corporate Transparency Act compliance update to the December meeting.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. Board Assurance Framework The committee will review risk greater than 15 from the new Board Assurance Statement. Request the risk appetite to be developed to include realistic target dates and actions	
2. Cyber Resilience Oversight The Committee discussed assurance arrangements and emphasised the importance of third-line assurance and lack of detail provided. The committee discussed the 'exam question' from Internal Auditors' Plan perspective. A deep dive into the framework, with 9 different core topics, with input from the Executives and the committee to ensure alignment with the most significant risks.	
3. External Audit Progress Report Discussions around adequacy of coverage of high-risk areas. Noted issues with payroll overpayments (£1.4m cumulative).	
4. Internal Audit Plan Review The Committee agreed to retain flexibility in plan to respond to emerging risks. Assurance required on sustainability risks, available on the JURA system.	
5. Counter Fraud Report Key fraud risks discussed, including mandate fraud and staff working elsewhere when sick. Cultural awareness training ongoing	
6. Financial Management Key issues: pressure from CNST premium increases, capital challenges including backlog maintenance and medical equipment, and VAT recovery position. Forecasts under review. Committee emphasised need for grip and transparency	
7. Risk and Compliance Sub-Committee Assurance Report Report format to be reviewed. Concerns noted regarding lack of assurance and continuity following staff departure	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 12 November 2025

Title of Report	Quality Assurance Committee Monday, 06 October 2025			**Agenda Item**		
Executive Lead	Alison Davis, Chief Medical Officer Steph Gorman, Chief Nursing Officer (Interim)					
Committee Chair	Paulette Lewis, Chair of Committee/NED					
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee (QAC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.					
Proposal and/or key recommendation:	This report is to provide assurance to the Trust Board that the committee is operating as per its terms of reference.					
Purpose of the report (tick box to indicate)	Assurance	X	Approval			
	Noting		Discussion			
Committee/Group at which the paper has been submitted:	Quality Assurance Committee, 06 October 2025					
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:					
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X	
Relevant CQC Domain:	Tick CQC domain the report aims to support:					
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X	
Integrated Impact assessment:	Where applicable, individual considerations are provided at the QAC Committee.					
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the QAC Committee.					
Appendices:	None					
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.					
For further information or any enquires relating to this paper please contact:	Alison Davis, Chief Medical Officer Alison.davis@nhs.net					
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions				
	Partial Assurance	There are gaps in assurance				
	Assurance	Assurance with minor improvements needed.				

Best of care Best of people Patient FIRST

	Significant Assurance	There are no gaps in assurance
	Not Applicable	

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made
None

Items referred to another Group, Subcommittee and or Committee for decision or action		
Item	Group, Subcommittee, Committee	Date
None	N/A	N/A

Reports not received as per the annual workplan and action required	
None	

Items/risks/issues for escalation

Escalations to note:

- Ligature risk – blind replacement is being progressed on Dolphin Ward
- Trauma – workforce, this will be reviewed as part of the deep dive at December QAC.
- Medical devices – lack of robust reporting to QAC. The Director of Estates, or Executive lead will be invited to attend the next QAC meeting.
- Consistency of reporting – coversheets and assurance reports. This will be addressed through work with Executive Leads and the Company Secretary.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	**Assurance Level**
1. National Major Trauma Registry Backlog (NMTR) SBAR Update Urgent action is needed to address staffing, process gaps, and technological support to ensure compliance and safeguard the Trust's Trauma designation. • Review the role of the NMTR Co-ordinator • Process for management of NMTR work to be clarified, including how process should be managed in absence of NMTR admin/coordinator • Explore AI to trawl EPR for the data required for NMTR • Admin support for Trauma Steering Group to be provided by someone who is not the NMTR coordinator. The Committee requested a deep dive into Trauma for the December meeting. The Committee **NOTED** the report	Not assured
2. **Bleep System Replacement** The project seeks to replace the system with a modern, reliable two-way communication solution that will enhance both efficiency and patient safety. The upgrade will enable mass messaging, customisable responses, and persistent alerts until acknowledged, ultimately improving hospital-wide communication	Partially Assured

and emergency response efficiency. December 2025 date for completion. The Committee requested an update on clinical engagement for the meeting in November. The Committee **NOTED** the report	
3. **Assurance Report from QPSSC** a) Trauma concerns. To be addressed at the Trauma Summit on 01/10/25 b) Medical representation and PA allocation. Medical Director of Quality and Safety has identified all senior doctor programmed activities within job plans and will now align these with the job description for patient safety leads to determine what changes need to be made. c) Imaging findings and missed diagnoses. Thematic review to be completed and paper re findings to come to Quality TLT d) Standing down of QPSSC. Members of TLT agreed that QPSSC should be stood down with workstreams reporting to TLT or QAC as appropriate. e) Hospital league table implications. CMO to discuss with executive colleagues. The Committee were **Partially ASSURED** by the report, further assurance requested regarding the removal of QPSSC, committee agreed due diligence work can commence.	Partially Assured
4. **Learning from Deaths Annual Report 24/25** a) Strengthened process aligned to national guidance and local governance. b) NICHE review identified eleven key actions for improvements focusing on leadership oversight, reporting, multidisciplinary Structure Judgement Reviews (SJR), thematic analysis, and family feedback. c) Implementation is monitored through the Mortality Breakthrough Objective, a weekly forum tracking progress, key metrics, risks, and actions. d) 2024/25 – 1,498 adult inpatient and ED deaths, with 141 (9.4%) reviewed via SJR. Five deaths were judged possibly preventable. e) All patients with a learning disability and/or autism undergo an SJR, with findings submitted to the national Learning from Lives and Deaths (LeDeR) programme. No deaths were assessed as preventable. Reviews confirmed the majority of patients received good care. f) In 2024/25 51% of reviewed deaths occurred in hospital. The Medical Examiner (ME) office scrutinised 1,632 hospital deaths, identifying significant delays and quality concerns g) Hospital Standardised Mortality Ratio (HSMR+) improved following methodological changes, including updated comorbidity and frailty measures, moving the Trust into the “as expected” band. h) Summary Hospital-level Mortality Indicator (SHMI) remains higher than expected at 1.235, influenced by rising palliative care admissions, extended hospital stays, and care pathway variation The Committee requested assurance that MFT are compliant with processes for SJR reporting into the national LeDeR programme The Committee was **Partially ASSURED** by the report	Partially Assured

5. **ENT Backlog Issue Update** a) Harm review – report 917 patients, 1055 waiting over 52 weeks. Reassured, 24 patients have come to low harm. No patients came to moderate harm. b) Cohort of 464, whilst on the list, have deceased. A process is being carried out to review for causes of death. The report will be available on 17 October. The Committee were **ASSURED** by the report	Assured
6. **Women, Children and Young People Divisional Report** a) No significant issues. Risks for the division, 3 extremely high scoring. b) Delay with paediatric epilepsy service – plans in place to address, waiting for job matching. c) Incidents – deep dive into medication safety. Improvement work now seeing progress. Maternity – Incidents - revised action plans, spoken with IT for digital, from Jan 26 will be able to move over to digital reporting. Learning from deaths in paediatrics – strengthen investigation process. Ensure robust processes for internal investigations. d) PSII declared – linked to 17-year-old who had extreme violence and neglect behavior. Includes region wide divisional director of nursing work looking after young people who do not fit into a specific diagnosis. e) EDN – some duplications and system error, further EPR training for out of hours admissions. f) Medical staff communication – training introduced. g) Ward accreditations –Gold in delivery suite. Two Silver awards. Fantastic news from clinician for black and brown babies, awarded clinician of the year. The Committee requested updates on the following: 1. Patients being left on trolleys as no gynecological beds are available. 2. Ligature risk and blind replacement 3. Incivility reporting and mitigations to address The Committee were **ASSURED** by the report	Asssured
7. **Medical Devices and Equipment Update Report** The committee recommended the Director of Estates, or Executive lead attend the next meeting to provide a thorough update on the impact of care due to the quality of equipment, issues, risks and prioritisation of costs.	Not Assured
8. **IPC Standards Contract Report** a) On the 12 June 2025 the NHS Standard Contract 2025/26 was published for minimising Clostridioides difficile and GNBI's. This contract sets out the Trust's forthcoming thresholds for all alert organisms. b) Requirements support the delivery of the Antimicrobial Resistance (AMR) National Action Plan 2024/29 c) Clostridioides difficiles (C.*diff*) - if the number of cases was 10 or less the threshold would be equal to that count, for all others the threshold was reduced by 1.	Assured

d) GNBI's – For E.*coli*, Klebsiella and Pseudomonas if the number of cases was 10 or less the threshold would be equal to that count. For all others the threshold would be reduced by 5% e) MRSA Bacteraemias – not mentioned within the contract but to remain at zero tolerance The Committee an update on compliance improvement (from consistent audits) to come to the meeting in January. The Committee **NOTED** the report	
9. **Mid-Point Review** The committee NOTED that the report has already been through the governance process and to Board.	
10. **Pathology Report** a) In 2018 the pathology services at MFT and DGT entered into a joint venture, forming the North Kent Pathology Service (NKPS). As part of the venture to deliver better operational performance and efficiencies, there were also some important lessons learnt in the operationalisation of the venture, centred around six key themes: • Governance • Quality and Safety • Project Management • Communication and Stakeholder engagement • Workforce • Information and IT systems b) To note the lessons learned and to give due consideration to these when planning any joint venture The Committee NOTED the report.	Assured

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 12 November 2025

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

Best of care Best of people — Patient FIRST

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and or Risks to note:

a) Capacity issues are impacting staff morale and impacting time for training and coaching
b) TOR for Equality Steering Group and Mandatory Learning Oversight Group were discussed, changes to be made and virtually approve in order to maintain pace for progress.
c) Staff Survey, target is 50% response rate this year. Noted that we are moving to 100% survey forms, need to ensure digital literacy and accessibility is considered
d) Employee Relations to be monitored for backlog, capacity, extract learnings and manage issues by linking with cultural transformation work.
e) The Trust is not where it wants to be with data, the Committee looks forward to seeing the refreshed IQPR with better visuals and narrative
f) Resident Dr 10 Point Plan has been approved and will need to be actioned with pace
g) Compliance needs to improve for Moving and Handling L2, Medway Hospital Life Support, New Born life and Paediatric basic life support. Focus and effort required.
h) Recruitment freeze has been extended to the end of the financial year to address financial difficulties
i) Will not be uplifting bank pay rates for 2025/26

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
1. Integrated Quality Performance Report, Risk and Issues Register and Board Assurance Framework There are eight approved People risks in total of which, four are scoring High (8 – 12). There is one risk raised more than three months ago and is awaiting review and full population of controls and actions. This describes the cost of Oliver McGowan Statutory	

training and how this places risk to the organisation of not meeting the requirements. The risk has an initial rating of High. There are two risks awaiting approval that were raised more than three months ago: 1) Increase of temperature on wards and offices (Surgical Services). 2) Lack of Consequences to Incivility. There have been no People risks closed down in the last month. 100% of People risks have had no movement to their current score in the last month. Committee Chair comment: • The Risk registers do not reflect the latest accurate risks and updates. • Improvement needed on Moving and Handling L2, Medway Hospital Life Support, New Born life and Paediatric basic life support The Committee **NOTED** the IQPR, BAF and Risk Register	
2. Establishment of Equality Steering Group – Terms of Reference The report sought approval for the establishment of a new Equality Steering Group to oversee the breadth of the Trust's responsibilities for equality, diversity, inclusion and cultural development, including tackling matters of bullying harassment and discrimination. The Committee **DID NOT APPROVE** the Terms of Reference but content to accept the TOR virtually to ensure progress is made	
3. HR and OD Performance Group Report The report summarised the HR and OD teams' performance in the last two months and provided assurance to the Committee. The report highlighted: 1) Most teams report typical pressures with resources stretched due to low resilience within their teams and multiple competing priorities. In a recent away day in July, Heads of Services (HOS) identified 72 potential opportunities to improve teams' efficiency and collaboration. All of these opportunities will be reviewed alongside teams' committed actions and objectives by Sheridan Flavin (CPO), Dominika Kimber (Deputy CPO) and Lisa Webb (Associate Director OD), prior to agreeing with the HOS the workplan for the next six months until the end of the financial year. 2) A full review of all People and OD objectives is being completed to identify areas that the People Directorate will continue, pause, commence or stop to ensure that the	

directorate is efficient and effectively contributing to the Trust 10-point stabilisation plan Committee Chair comment: Employee Relations – There is a backlog and capacity issue. Extra capacity and support to be provided by NHS South, Central and West Commissioning Support Unit. The Committee were **ASSURED** by the report	
4. Mandatory Learning Oversight Group (MLOG) Report As part of a National requirement the Trust agreed to participate with NHSE Optimise, Rationalise and Redesign statutory and mandatory training programme designed to improve staff experience, deliver better outcomes and reduce time burden. The Committee was asked to approve the TOR for the MLOG. The Committee were **ASSURED** but the TOR was **NOT APPROVED**	
5. Mid-Point Staffing Review The National Quality Board (NQB2016) requires an annual safer staffing report and the monitoring of sustainable safe staffing levels on inpatient wards to be presented to provider Trust Boards. This is also aligned to the Royal College of Nursing (RCN) Nursing Work Force Standards (2021). Boards and Executive teams have responsibility and accountability for setting, reviewing and taking decisions and action on staffing levels and skill mix and should receive an annual establishment report with a further review on a biannual basis. The paper detailed the requirements of the biannual update, providing an overview of safe staffing in relation to the establishment including vacancies and turnover, planned versus actual staffing levels and care hours per patient day (CHPPD) over the past six months. The Committee **NOTED** the report	Assurance with Minor Improvements needed
6. People Implementation Plan – Update and Business Score Card The Committee **NOTED** the update	Significant Assurance
7. Guardian of Safe Working Hours The new Junior Doctor contract which was introduced in 2016 required all NHS Trusts to appoint a Guardian of Safe Working Hours (GSWH). The GSWH is independent of the Trust management structures with a specific remit to ensure that safe working practices for Post Graduate Doctors in Training are embedded. This report is submitted to the Committee as it is an annual requirement to provide detail on compliance with the contract to the Board. The Committee **NOTED** the report	Assurance with Minor Improvements needed
8. Industrial Action Update	Significant Assurance

The report provided a summary of the recent and likely future industrial action and key actions the Trust is taking in preparedness for possible industrial action, which at the local level will be managed through the EPRR route. The Committee **NOTED** the update	
9. Resident Doctor 10 Point Plan Request from NHSE The paper outlined a strategic response to NHSE directive aimed at improving the working conditions of resident doctors across NHS Trusts. Triggered by widespread concerns, ranging from payroll errors to inadequate rest facilities, the initiative is anchored in a 10-point action plan issued on 29 August 2025. Ashike and Alison gave highlights from the report and detailed the 10-points. The Committee **APPROVED** the plan	Assurance with Minor Improvements needed

Meeting of the Trust Board in Public
Wednesday, 12 November 2025

Title of Report	**ASSURANCE AND ESCALATION HIGHLIGHT REPORT** Finance, Planning and Performance Committee Wednesday, 29 October 2025	**Agenda Item**	4.2de

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
ACTION NO FC/2025/013 - Digital, Data and Technology Strategy Refresh, was delegated to the Board in Private Action Log. Matt Capper is lead for Strategy and Digital so is the action owner following Graham Wilde's departure.	To Trust Board from FPPC	29.10.25 for 12.11.25

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

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

Implications for the Risk Register or Board Assurance Framework/Statement

None recorded

Key Headlines	**Assurance Level**
Preliminary Matters **ACTION NO FC/2025/013** - *Digital, Data and Technology Strategy Refresh*, was delegated to the Board in Private Action Log. Matt Capper is lead for Strategy and Digital so is the action owner following Graham Wilde's departure. John Goulston emphasised that all Board committees should give precedence to the domains outlined in the Stabilisation Plan, ensuring that agenda items align accordingly.	There are no gaps in assurance

Agendas must be thoughtfully curated, and where appropriate, items may be reviewed or approved by the Executive team to ease the burden on committee schedules, unless an exception is made by Jon Wade or Siobhan Callanan.	
1. Deep Dive - Cash and Cash Support Simon Wombwell presented the report for approval; the application was due to be submitted the same day 29.10.25. a) The report set out further information on the application process and draft documentation for submission. b) Based upon the current cash run-rate, without Deficit Support Funding (DSF), cash support or other mitigations the Trust would go below its minimum cash holding balance (~£3m) in November 2025 and would be ~£22.6m overdrawn (~£25.6m below its minimum cash holding) at the year end. c) Baseline Forecasting has therefore now assumed loss of all DSF for the remainder of 2025/26 but assumes a successful revenue support Public Dividend Capital (PDC) application in its place. **<u>Check and Challenge</u>** 1) The application narrative being accurate and ensuring that the application gives a realistic cash forecast. 2) Ensuring creditors are paid on time. 3) That the team are actively developing contingency strategies in the event that the cash application is not approved 4) The cash funding application lacked clarity in how it triangulates performance and financial data. 5) Ensuring that the entire organisation is effectively communicated to in regard to the current financial position and cost savings required. Every member of the Executive group plays a role in managing costs and delivering savings, and this responsibility is mirrored throughout the divisions. 6) The key challenge now is how the Trust can effectively demonstrate this collective effort. The Trust must demonstrate that the organisation is actively strengthening its grip on financial management, progressing CIP initiatives, and investing significant effort in stabilisation. The Committee **APPROVED** the recommendation for submission of the application, subject to some amendments agreed post-meeting between Simon Wombwell and John Goulston.	Assurance with minor improvements needed.
2. Finance Report 06 Simon Wombwell presented the report for noting. The following was highlighted: a) At the end of September 2025, the Trust is reporting a control total deficit of £13.6m (£8.0m adverse to Plan). Smaller value overspends are being managed through Trust reserves and other underspends, leaving the biggest driver of adverse performance being the efficiency programme. b) A continued focus on savings delivery to reverse the Income and Expenditure (I&E) imbalance. Addressing the resulting cash position by gathering requirements for cash support, compounded by loss of Deficit Support Funding (DSF) in Q3. c) The Trust has worked with system partners to produce a risk adjusted forecast outturn (RAFOT); excluding DSF in Q3 and Q4 this is expected to be in the region of a £44m deficit; NHSE have indicated that significant improvement on that balance is expected. **<u>Check and Challenge</u>**	There are gaps in assurance

1) The primary focus should be on corporate services and strengthening grip and control measures, with the aim of addressing the recurring £20 million monthly pay bill. 2) Job Planning in clinical areas 3) Committee wants to see more detail in Cost Saving report; actions with deadlines. 4) Trust must focus on reducing length of stay, no criteria to reside and utilisation of bed space. Committee questioned the accuracy of data reporting in regard to bed space. The Committee **NOTED** the report.	
3. CIP Progress Report and Update from PA Consulting (PAC) Ashley MacNaughton presented the report for noting. a) PA Consulting have identified 44.4% of the target (27.9% of the target based on the risk adjustments, considering plan maturity) **Check and Challenge** 1) Suggested the Board have discussion around risk appetite. 2) The Board should develop more in collective difficult decision making 3) Asked to see the impacts of the activity and aspirations, on a phased approach up to March 2026. Detail; costs out, cost savings and what is the impact on head count? How is this translating into the income and expenditure? 4) Tasked PAC to discuss how to get the Trust to the stretched target of £17m CIP delivery (in year) with the Executive, then submit to the Board via the Sustainability Recovery Group. The Committee **NOTED** the report.	Assurance with minor improvements needed.
4. 2025/26 Capital Programme Report Simon Wombwell presented the report to brief the Committee. The Trust is not where it needs to be but with capital spending but confident that it will get back on track before year end. **Check and Challenge** 1) The Committee to conduct a deep dive at the November 2025 meeting. The Committee were **BRIEFED** by the report.	There are gaps in assurance
5. Performance Monitoring (Triangulating Finance, Activity and Performance) Gemma Brignall presented the report to brief the Committee. As at month 06 (September 2025) the Trust is £14.0m behind its planned capital expenditure. This is predominantly due to timing/plan phasing in respect of the decarbonisation works and CDC lease finalisation. **Check and Challenge** 1) Requested Performance reports place greater emphasis on the Stabilisation Plan and its key drivers, to help the Committee clearly understand the priority areas for the next six months. 2) Expect to see delivery of; reduction of ENT with 65 week wait to 0 by 21.12.25 and 1% patients waiting more than 52 week in ENT by 31.03.26. Trust also need to improve the Type 3 performance and A&E performance.	There are gaps in assurance

3) Decision to be made whether to review the Performance segment of the Stabilisation Plan should be reported to FPPC, QAC or have a Performance Committee for six months? The Committee were **BRIEFED** by the report.	
6. Mid-Year Review by NHSE South East NHSE have requested a formal financial recovery plan (FRP) document by end of November 2025. The Committee **NOTED** the update.	There are gaps in assurance
7. 2026/27 Business Planning – Progress Update Simon Wombwell presented the report to brief the Committee. The report detailed timetable and budget setting. There is more to be added in terms of activity and workforce. **Check and Challenge** 1) Ensure that Lessons Learnt are considered from 2023 onwards at the Trust and obtain learning from other organisations 2) The Committee asked for consideration around; what is the appetite for risk and the probability for success? What is the timeline three/five/ten years' time? What tough decisions do the Board need to make in terms of probability? What is realistic in terms of success? The Committee were **BRIEFED** by the report.	There are gaps in assurance
8. Board Assurance Statement (BAS) and Risk Register and Issues Log Matt Capper presented the report for assurance. **Check and Challenge** 1) The Committee would like more insight into risk by adding more commentary, the narrative must be more robust. 2) Peter Conway asked for a meeting to develop the reports further to suit. Matt Capper, Siobhan Callanan, Steph Gorman and Wayne Blowers to attend. The committee were **ASSURED** by the updated Board Assurance Statement.	There are gaps in assurance
10. Integrated Quality Performance Report (IQPR) – Executive Summary The Transformation Team are working on aligning all reporting to the Stabilisation Plan for all future meetings. The Committee **NOTED** the report.	N/A
Reflection and Any Other Business 1) Good meeting and excellent quality of discussion. 2) Focus for future meetings to be on Stabilisation Plan and areas of concern. 3) Deadlines and dates for the ongoing work, avoiding constant looping of historical conversations, get closure on items raised at Committee. 4) Big ticket item should be addressing improvements with Length of Stay.	N/A

Meeting of the Trust Board
Wednesday, 12 November 2025

Title of Report	Medway Medical Examiner Office – A Year of Statutory Service (including data from April 2024 – September 2025)	**Agenda Item**	4.3
Author	Dr Cindy Molloy, Interim Lead Medical Examiner Hayley Usmar, Lead Medical Examiner Officer		
Lead Executive Director	Miss Alison Davis, Chief Medical Officer		
Executive Summary	The Medical Examiner (ME) System is part of the government's wider Death Certification Reform Programme. From 09 September 2024, all deaths have required review either through ME scrutiny or investigation by the coroner. The role of the ME is to review cases with a view to establishing an accurate cause of death, ensuring coroner referral is made where this is appropriate and highlighting any clinical governance concerns to the relevant provider. This is achieved through case record review and discussion with both the qualified attending practitioner and the deceased's next of kin. The ME service is not limited to covering the acute Trust, Medway Medical Examiner Office is responsible for deaths occurring in Medway, Sittingbourne and Sheppey, with at least 40% of the case load occurring in the community. Between 01 April 2024 and 31 August 2025: 2936 cases were scrutinised by a Medical Examiner, of which 51% occurred in hospital 37% of referrals to ME received within one day of death 97% of cases were scrutinised within one day of referral In 98% of cases, the ME office interacted with the bereaved, providing an opportunity to discuss the cause of death and raise concerns regarding care 40% of Medical Certificates of Cause of Death (MCCD) were completed by the clinical team within 3 calendar days of death 17% of deaths reviewed were sent to coroner after scrutiny Case record review was recommended for 98 cases (3%) It is clear that delays in the death certification process are predominantly caused by the clinical team rather than the medical examiner. The ME office also highlighted the following areas for investigation: quality of SJRs, prolonged stays in ED; patients medically fit for discharge dying whilst waiting for placement; delay in discussing ceiling of care; poor documentation; electronic drug chart documentation lack of required documentation for to controlled drugs Service redesign is underway to maximise capacity and efficiency. The service is committed to providing education across the sector and has participated in a number of training sessions and events. Electronic completion of MCCDs has been trialled and is being developed further. Feedback from stakeholders and service users has been positive.		

Proposal and/or key recommendation:	Not applicable – report provided as requested			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting		Discussion	X
Governance Process: **Committee/Group and Date of Submission/approval:**	Not applicable – regular reports through Mortality, Morbidity & Safeguarding Group			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led:
Identified Risks, issues and mitigations:	N/A			
Resource implications:	N/A – Externally funded			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☑ Not applicable			
Legal and Regulatory implications:	Coroner and Justice Act 2009 Health and Care Act 2022, Section 169			
Appendices:	N/A			
Freedom of Information (FOI) status:	Tick either: ☑ This paper is disclosable under the FOI Act ☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.			
For further information please contact:	Name: Dr Cindy Molloy Job Title: Interim Lead Medical Examiner		Name: Hayley Usmar Job Title: Lead Medical Examiner Officer	

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

1. Executive summary

1.1.a The Medical Examiner System is part of the government's Death Certification Reform Programme, and will become a statutory requirement on 09 September 2024, meaning that no death will be registered unless it has been reviewed either by a Medical Examiner or through investigation by the Coroner.

1.2.a A medical examiner (ME) is a senior doctor with at least five years' experience who has undertaken specialist training in the legal and clinical elements of the death certification process. MEs are supported by Medical Examiner Officers (MEOs).

1.2.b The purpose of ME scrutiny is to establish an accurate cause of death, ensure timely and accurate referral to the coroner where required and to provide an additional opportunity for early detection and notification to the relevant provider of clinical governance issues.

1.3.a Medway Medical Examiner Office covers deaths occurring in Medway, Sittingbourne and Sheppey, working with 59 providers. The team work collaboratively with other Medical Examiner Offices for cases where care has crossed office borders.

1.4.a In the financial year 2024-25, 2689 deaths were scrutinised. 57% of scrutinised deaths occurred in hospital.

During the first year of statutory scrutiny, 2936 deaths were scrutinised, with 51% occurring in hospital.

1.4.b 97% of deaths scrutinised between April 2024 and September 2025 were scrutinised by the ME within one day of referral.

1.4.c Communicating with the designated next of kin is a key part of the scrutiny process, and occurred in 98% of cases. This discussion enables families to ask questions about care, highlight concerns and confirm their agreement with the cause of death.

1.4.d 40% of MCCDs were completed by the attending doctor within 3 calendar days of death. The new regulations remove the requirement for deaths to be registered within five days of death, but timeliness of completion of paperwork continues to be monitored.

1.6.e 241 (17%) deaths were referred to the coroner after scrutiny.

1.6.f Case record review was recommended for 98 cases (3%)

1.6.g The ME office also highlighted the following areas for investigation: quality of SJRs, prolonged stays in ED; patients medically fit for discharge dying whilst waiting for placement; delay in discussing ceiling of care; poor documentation; electronic drug chart documentation lack of required documentation for to controlled drugs

1.7.a The ME office is currently undergoing service redesign to maximise efficiency and capacity during the busier winter periods.

1.8.a Electronic completion of scanned MCCDs has been trialled and well received. This work is currently being further developed with a view to using an electronic MCCD in lieu of a referral form.

1.9.a The ME service is keen to be involved in education across both acute and non acute sectors and has been involved in a number of training sessions and events.

1.10.a The bereaved are at the heart of the ME service and have provided positive feedback regarding its impact.

3. Medway Medical Examiner Office

2.1.a A medical examiner is a senior medical practitioner trained in the legal and clinical elements of death certification processes. They provide independent scrutiny of causes of death, and will not scrutinise any case where they have been involved in the patient's care. Medical examiners (MEs), supported by medical examiner officers (MEOs) under delegation, carry out a proportionate review of medical records and give bereaved people an opportunity to ask questions and raise concerns.

2.1.b *Overview of the medical examiner scrutiny purpose and process*

	Question	Outcome	Process
	What do people die from?	Accurate cause of death	1. Proportionate review of relevant medical records 2. Interaction with the attending doctor 3. Interaction with the bereaved
	Does the death need reporting to the coroner?	Timely and accurate referral to coroner	
	Are there any clinical governance concerns?	Early detection and notification	

2.2.a On 09 September 2024, with the implementation of Death Certification reforms, it became a statutory requirement for all deaths not investigated by a coroner to be independently reviewed by a Medical Examiner – irrespective of whether they occurred in hospital or in the community.

2.2.b Medway Medical Examiner Office is responsible for deaths occurring in Medway, Sittingbourne and Sheppey. The office is working with 59 providers, broken down as follows: 1 acute hospital, 1 private hospital, 55 NHS GPs, 2 hospices.

2.3.a There are four ME Offices within the Kent and Medway Integrated Care System: Dartford & Gravesham, East Kent, Medway and West Kent. Whilst each office works with designated providers, there is a recognition that the nature of the healthcare system means that on occasion scrutiny is more appropriately carried out at an office other than the designated office for the place of death. The offices work collaboratively to ensure the most appropriate team deals with each death.

2.7.a With the support of Medway Register Office, we have been able to monitor the proportion of non-coronial deaths scrutinised by reviewing registration data. 1017 deaths were registered during this period, of which 889 were registered with an MCCD issued by a doctor. 78% of those deaths were reviewed by a Medical Examiner prior to registration.

2.7.b In reality, it is likely that this percentage is higher; the registration data does not differentiate between cases where there has been coroner involvement but the coroner has ruled that there is no need for investigation and those cases where the coroner has not been involved. The most recently published statistics relate to 2024 and show that 31% of the 2200 deaths referred to the Mid Kent and Medway Coroner during the calendar year were not taken to investigation.[1]

3.1.b The table below outlines the number of deaths scrutinised by the Medical Examiner Office since scrutiny was commenced in July 2020.

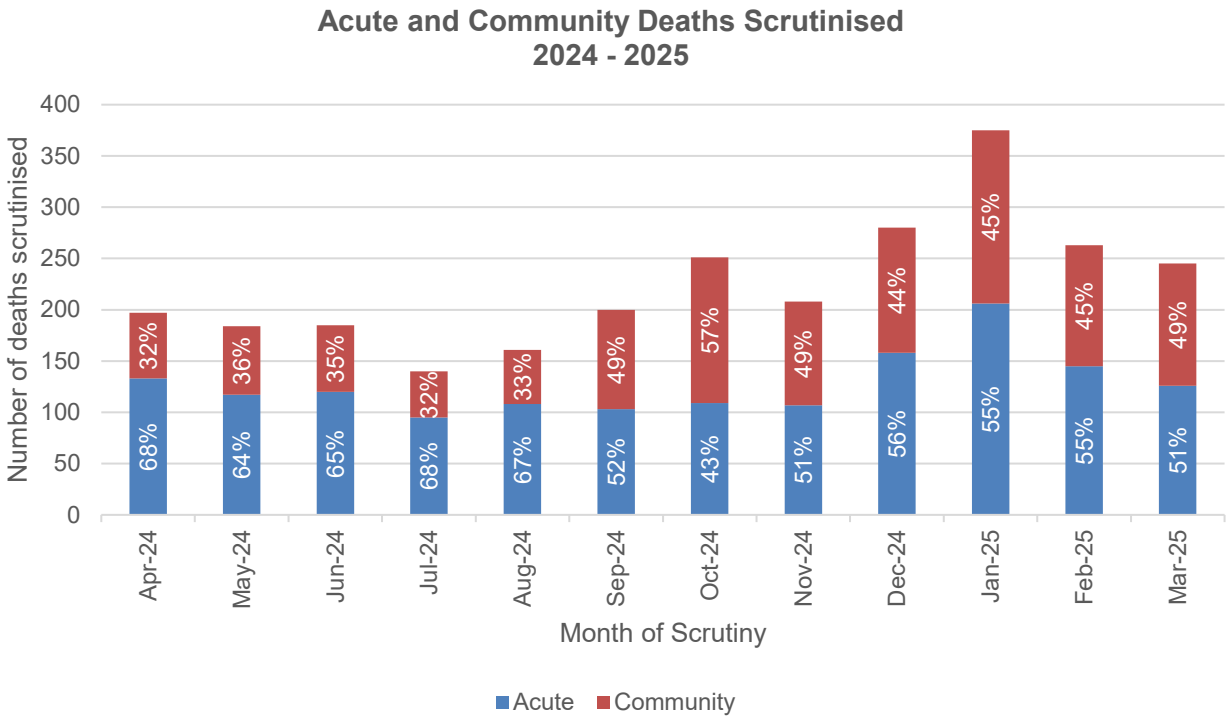
		Total number of acute deaths	Acute deaths scrutinised (% of all acute deaths)	Non-acute deaths scrutinised	Total scrutinised
2020 – 21	Apr – Jun				
	Jul - Sep	324	196 (60%)	1	197
	Oct – Dec	600	404 (67%)	2	406
	Jan – Mar	586	269 (46%)	0	269
2021 – 22	Apr – Jun	255	249 (98%)	0	249
	Jul – Sep	319	317 (99%)	4	321
	Oct – Dec	420	415 (99%)	9	424
	Jan - Mar	389	382 (98%)	2	384
2022 – 23	Apr – Jun	402	375 (93%)	15	390
	Jul – Sep	353	346 (98%)	11	357
	Oct – Dec	456	453 (99%)	69	522
	Jan - Mar	425	422 (99%)	119	541
2023 – 24	Apr – Jun	364	364 (100%)	147	511
	Jul – Sep	327	324 (99%)	158	482
	Oct – Dec	417	417 (100%)	166	583
	Jan - Mar	465	453 (97%)	159	612
2024 – 25	Apr – Jun	361	357	195	552
	Jul – Sep	299	304	195	499
	Oct – Dec	385	388	357	745
	Jan - Mar	460	483	399	882
			6918	**2008**	**8926**

3. April 2024 – March 2025: Data

3.1.a 2689 deaths were scrutinised by the Medical Examiner in the 2024/25 financial year. 1527 (57%) of these deaths occurred in the acute hospital and 1162 (43%) occurred in the community. A month by month breakdown is provided below.

3.1.b The Death Certification Reform legislation came into effect on 09 September 2024, and a corresponding increase in workload is reflected in the graph.

[1] https://coroner-stat-tool-ext.apps.live.cloud-platform.service.justice.gov.uk/



3.2.a 94% (1436) hospital cases were scrutinised by the Medical Examiner within 2 calendar days of death. Where scrutiny took longer than 24 hours, this was primarily due to weekends and bank holidays. Time to scrutiny ranged from 0 to 15 days, with a median completion time of 1 day.

3.4.a Until 09 September 2024, legislation required that death registration take place within five calendar days of the death occurring.

In order for a death to be registered without referral to coroner, a qualified attending practitioner (a doctor who has seen the patient in the last 28 days of life and is able to offer a cause of death) must complete the Medical Certificate of Cause of Death (MCCD).

Best practice is for the MCCD to be submitted to the register office as soon as possible after death, and for the purposes of monitoring, NHS England recommends that these are completed within three calendar days of the death.

In the reporting period, the MCCDs for 445 (38%) of hospital deaths were completed within three calendar days of death (counting only cases where there was no coroner involvement). Time to completion ranged from 0 to 30 days, with a median completion time of 4 days.

3.4.b The Notification of Death Regulations (2019)[2] impose a duty on medical practitioners to report deaths which meet particular criteria. Coroner referral, in and of itself, does not imply that there were any failings in care. Even when there are concerns about care, these would not necessarily have occurred during the patient's hospital attendance.

371 (24%) hospital deaths occurring during the reporting period were referred to the coroner. The most recently published coroner statistics are for 2024, when 31% of registered deaths in England and Wales were referred to coroner.

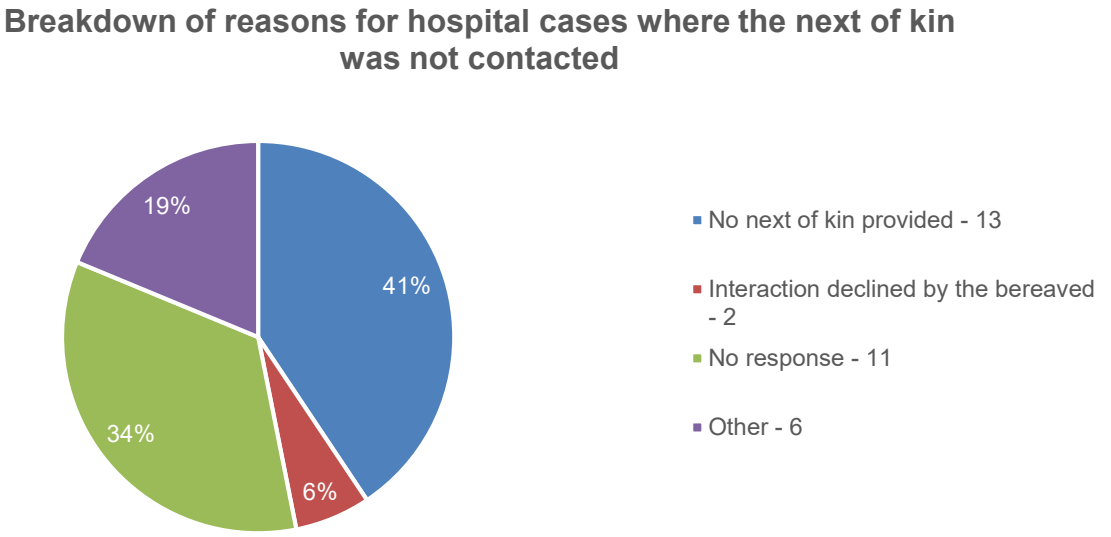
214 deaths were taken for investigation (post-mortem or inquest).

[2] https://www.legislation.gov.uk/uksi/2019/1112/made

Coroner referrals should be made as soon as possible after death. 44% of coroner referrals were made within 3 calendar days.

3.5.a A key part of the Medical Examiner process involves liaising with the next of kin of the deceased, both to ensure that they understand and are in agreement with the cause of death and to establish whether there were any concerns regarding care. By local arrangement, in coronial cases this contact may be with the coroner investigation officer instead of the medical examiner office. For the purposes of reporting, therefore, only non-coronial acute deaths are included here.

3.5.b 1156 deaths in hospital were not referred to the coroner. Of these, in only 32 (3%) cases there was no interaction with the next of kin. The reason for no interaction is broken down below:



3.5.c It is the practice of the medical examiner office to make three attempts to contact the next of kin before marking the case as having no response.

3.6.a Medical Examiners have a role in highlighting problems in care to the relevant provider for investigation. It is not within the remit of the Medical Examiner to undertake any investigation. During the reporting period, 92 (6%) of cases were referred for case record review. On average, Medical Examiner Offices in the South East refer between 5 and 10% of cases for provider review.

4. Statutory service – the first year (September 2024 – August 2025)

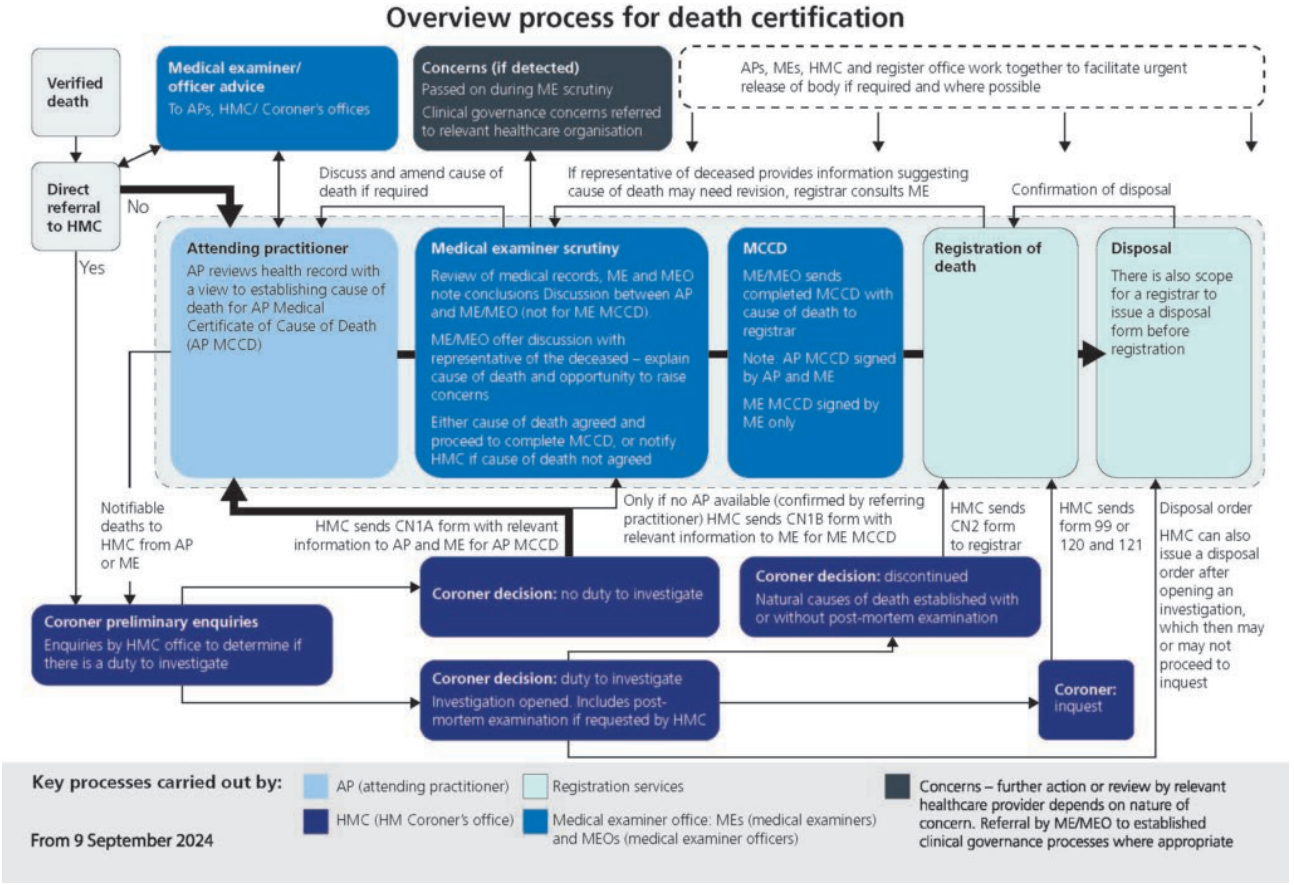
4.1.b The National Medical Examiner, Alan Fletcher, noted in his annual report that: *"Medical examiners and officers have delivered a step change in safeguards: since 9 September 2024 medical examiners have independently scrutinised every death in England and Wales not referred to a coroner and given bereaved people an opportunity to ask questions and raise any concerns with someone who had not provided care."*[3]

4.1.b In addition to this major change, the legislation also revised a number of other administrative details associated with death. Key elements included:

- Any doctor who attended to the patient during their lifetime able to issue MCCD (previously limited to those who had seen the patient in the last 28 days of life)

[3] https://www.england.nhs.uk/long-read/national-medical-examiner-report-2024/

- Revised MCCD forms with additional information fields and a requirement for countersignature by the Medical Examiner
- Ability for MEs to issue a Medical Examiner's MCCD where the cause of death is known and natural and an attending practitioner is not available, following issue of a CN1B by a coroner
- Registration required within five days of receipt of MCCD by register office, rather than within five days of death



4.2.a A total of 2936 deaths were scrutinised between 01/09/2024 and 31/08/2025 (inclusive). 1486 (51%) deaths occurred in hospital and 1450 (49%) occurred in the community.

4.2.b Of the cases scrutinised, 2900 (1456 hospital, 1444 community) deaths were of adults aged 18 or over and 36 were children under the age of 18 (30 hospital, 6 community).

4.3.a Medical Examiners work in conjunction with coroners to ensure that all deaths meet the statutory requirements for review. Medical examiners ensure that cases meeting the criteria for coroner referral outlined in the Notification of Deaths regulations 2019 are referred to the coroner, whilst coroners refer any cases where their duty to investigate under Section 1 of the Coroner and Justice Act 2009 is not engaged.

4.3.b Community deaths are more likely to be referred directly to the coroner. This is because, where a death is not expected, referral is made by the police at the time of death. Thus it is that of the 241 community cases with coroner involvement, 151 were referred prior to scrutiny, compared to 90 after ME review. Conversely, only 15 hospital deaths were referred before scrutiny, with 324 cases being referred after scrutiny.

4.3.c It is important to recognise that coroner referral does not automatically equate to a problem with care – for example, where someone dies from adhesions related to surgery performed decades

prior, the statutory requirement for coroner referral is invoked as surgery has caused or contributed to the death, but this does not mean that anyone acted improperly. In these circumstances, the coroner will issue a form CN1A to confirm that their statutory duty to investigate has not been engaged. This was the case in 47% (194) of cases referred to the coroner after ME scrutiny.

4.3.d 235 cases were accepted for investigation by the coroner, accounting for 13% of all hospital deaths referred to the ME and 3% of all community deaths referred.

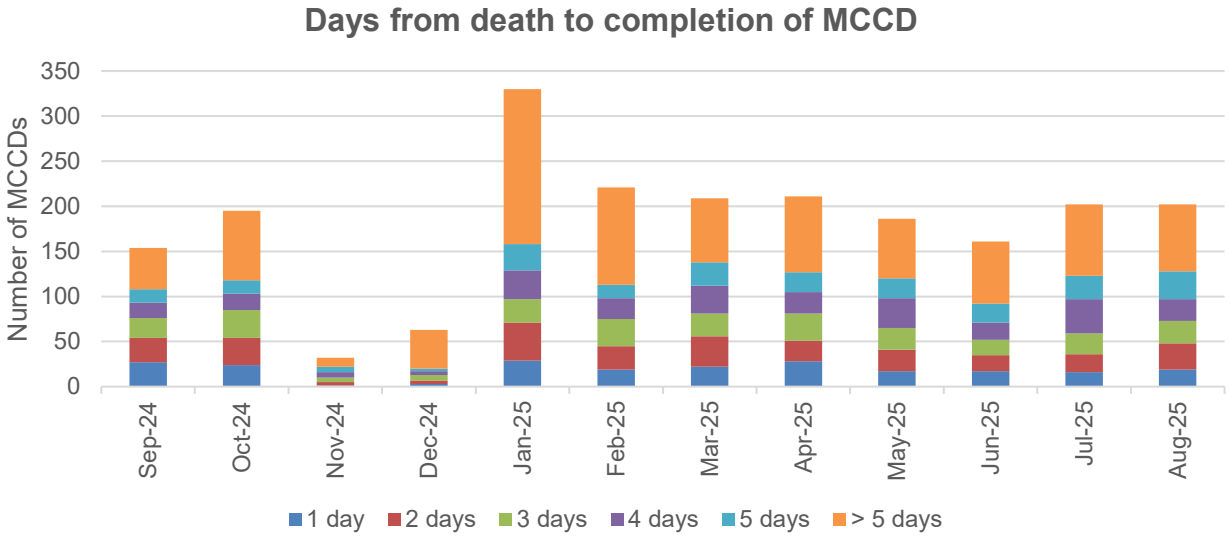
4.4.a 39 Medical Examiner Medical Certificates of Cause of Death were issued in the first year of statutory scrutiny, accounting for just 1% of all MCCDs issued through the ME Office. ME MCCDs are issued in cases where there is no doctor available to issue the MCCD, either due to the deceased not being seen or to avoid unreasonable delays as a result of sickness or annual leave. ME MCCDs are only issued when authorised by the coroner through the use of a CN1B form, and the legislation is clear that they are for use in exceptional circumstances only.

4.5.a 2662 Attending Practitioner MCCDs were issued. 1297 (48%) were for deaths occurring in hospital and 1404 (52%) for deaths in the community. It should be noted that any doctor who has attended to the deceased in life can issue an MCCD, and thus it is that hospital doctors may issue for deaths in the community and vice versa. The ME office does not collect data regarding the organisation of the doctor completing the MCCD.

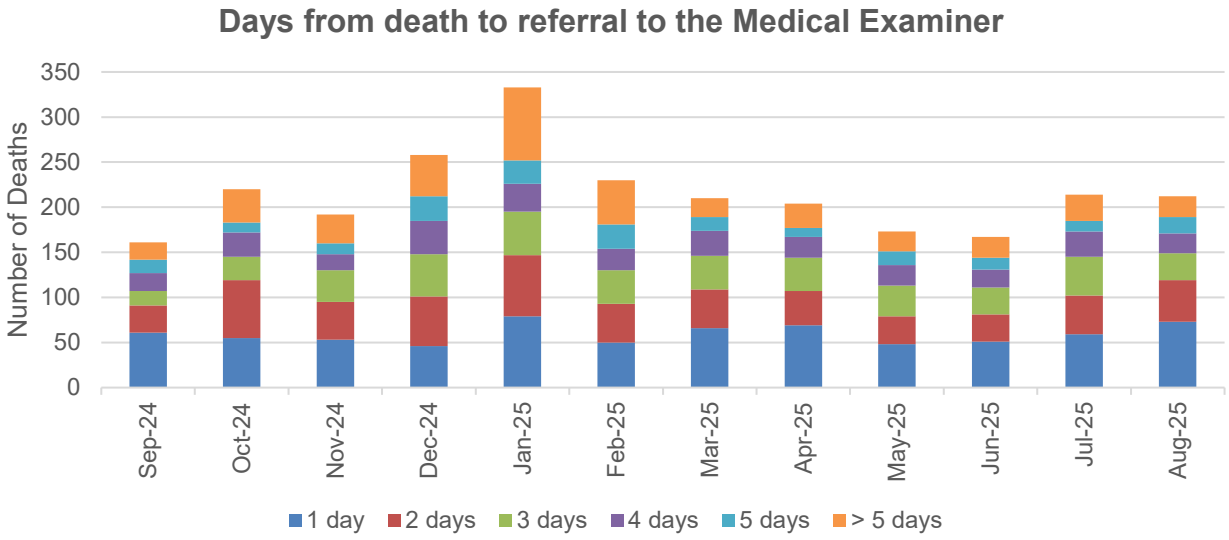
4.6.a Timely registration of death ensures that families of the deceased are able to proceed with funeral arrangements without delay. On a practical level, it also ensures flow of patients through mortuaries.

4.6.b The Death Certification Reforms have updated the previous requirement to register a death within five calendar days (the requirement now is for the death to be registered within five calendar days of the Register Office receiving the MCCD) – however, we continue to benchmark to best practice of MCCDs being issued within three calendar days of death.

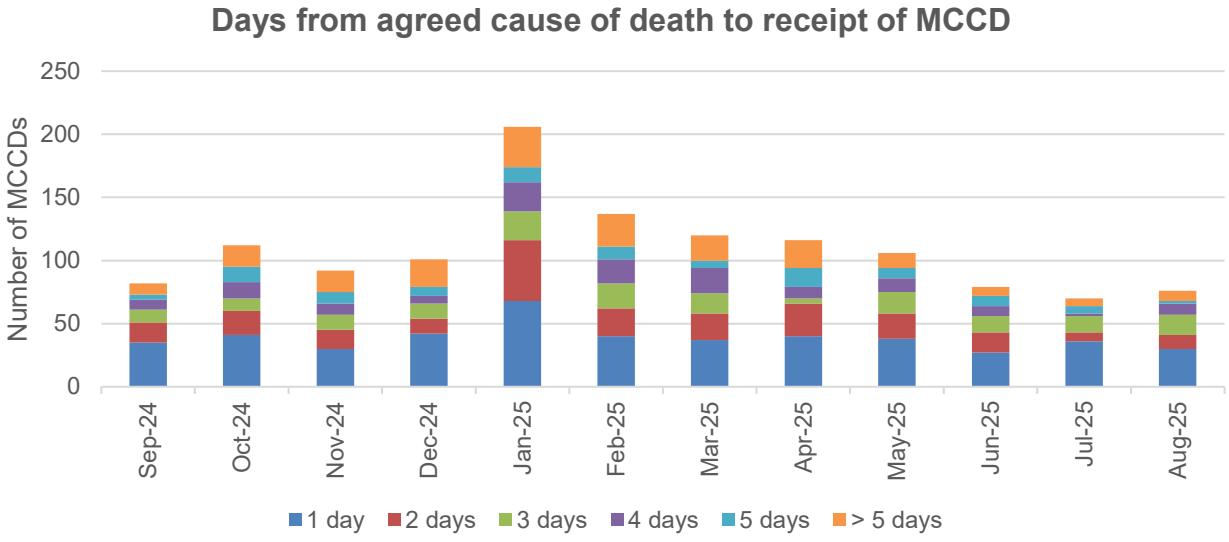
4.6.c Only 40% of MCCDs were issued within three days of death (947 out of 2369). Referral to coroner can cause delays to MCCDs being issued, but removing cases with coroner involvement from the dataset made no difference overall, with 41% (826/2024) MCCDs being issued within three days of death. The timescale for completion ranged from 0 to 62 days for all cases, and 0 to 30 days when cases where the coroner was involved were removed from the dataset.



4.6.d The delay to MCCD being issued is in part due to a prolonged referral period; only 55% of deaths were referred within two days of death occurring. This was consistent across both hospital and community deaths.



4.6.2 Delays also occur between the cause of death being agreed and the MCCD being received by the ME Office. Of 2356 non coronial cases, 175 MCCDs were sent prior to scrutiny and were subsequently accepted. Of the remaining 2181, 1222 (56%) MCCDs were received within a day of the cause of death being agreed, rising to 67% received within two days and 74% within three days. 297 (14%) MCCDs were received five or more days after agreement (11% of hospital MCCDs and 14% of community MCCDs).



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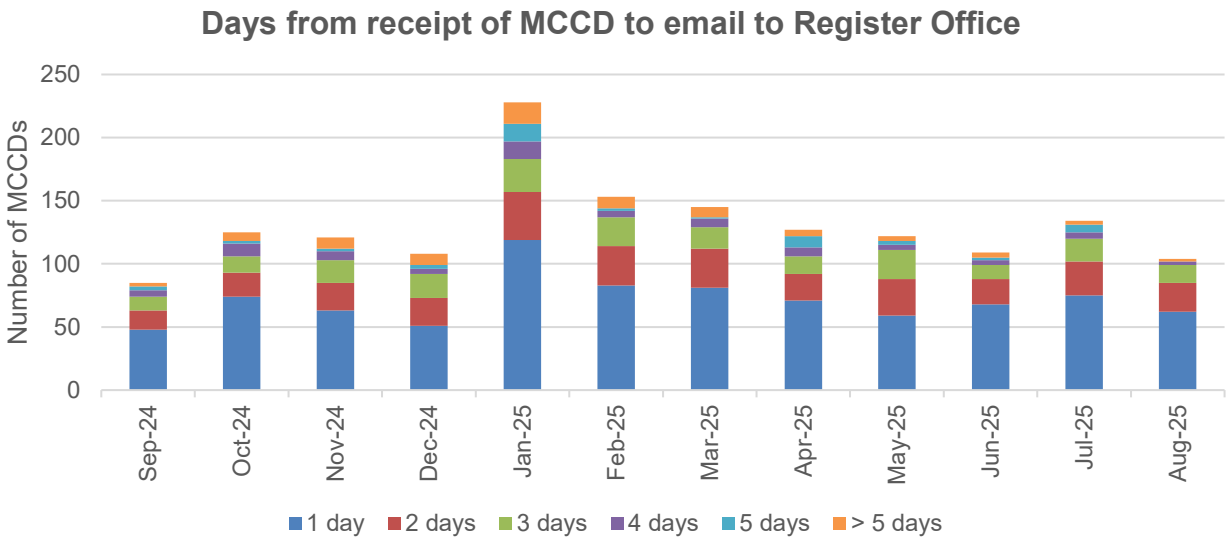
4.6.e 97% of cases were reviewed by an ME within one day of receipt of referral, but only 67% of cases had an agreed cause of death within one day of scrutiny. Unfortunately, data is not currently available to quantify where this delay occurs. Anecdotally, the delay appears to be due to delays in responding to suggestions made by the Medical Examiner.

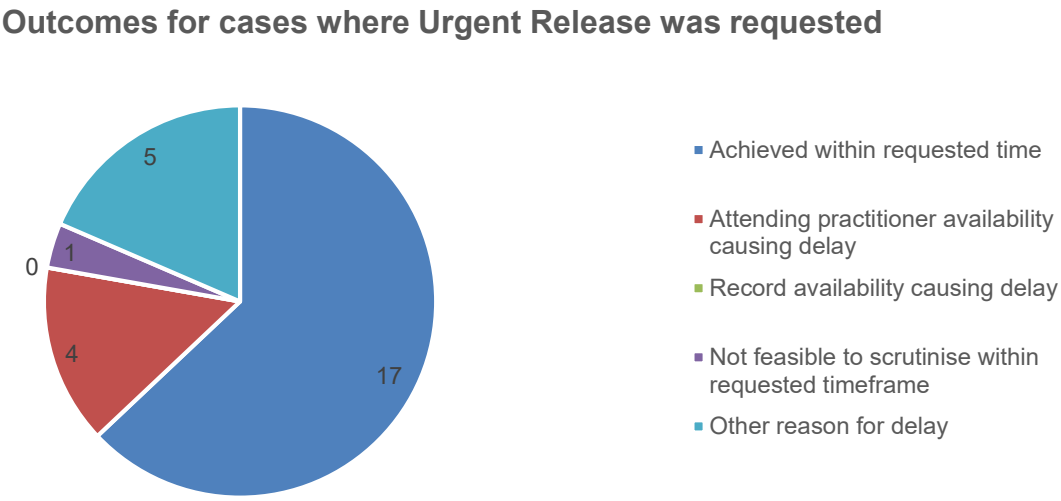
4.6.f 72% of MCCDs were countersigned and sent to the register office within a day of being received, increasing to 84% within two days and 93% within three days. It should be noted that in some cases, the MCCD served as agreement to suggestions from the Medical Examiner, and in order to

complete the office's statutory function, the next of kin was contacted after receipt of the MCCD, which may account for some of the delays in this space.



4.5.a There are some situations where urgent release of a body is required. In many instances this will be to facilitate the requirements of faith, but this can also be the case for those who are donating tissue or organs.

4.5.b During the first year of the statutory system, urgent release was requested for 27 deaths (< 1% of all deaths). Urgent release was achieved in 17 cases (63%). In 4 cases there was a delay due to the availability of the attending practitioner, in 1 case it was not feasible to scrutinise within the requested timeframe and in five cases there was another reason for delay.



4.6.a Bereaved people are at the heart of the Medical Examiner Service, and interaction with the bereaved is an important part of the scrutiny process. The purpose of the interaction is to both discuss any concerns about care and to confirm agreement with the cause of death. Where a death has been accepted for investigation by the coroner, the ME Office may not have any interaction with the next of kin, as this is undertaken by the Coroner Investigation Officer.

4.6.b Of the 2701 cases not accepted for investigation by the coroner, interaction with the bereaved occurred in 97% (2630) cases. Where interaction did not occur, it was for the following reasons:

- In 2 cases, interaction with the ME office was declined
- In 32, there was no contact person provided
- In 27 cases, there was no response from the bereaved
- in 10 cases there was another reason for no interaction

5. Clinical Governance Issues

5.1.a The Medical Examiner system has been designed to support local learning and improvement by identifying matters that require escalation to local clinical governance and other processes, aligning with and informing existing clinical governance processes.

5.2.a The issues identified in this section span the period April 2024 to September 2025 (inclusive). Whilst the Medical Examiner will flag areas of concern, it is not the responsibility of the Medical Examiner Office to investigate issues they have raised. The outcome of these investigations will be reported through other mechanisms.

5.2.b That said, where the Medical Examiner is concerned that concerns that have been raised have not been appropriately addressed, there is an expectation that these concerns will be escalated via the Regional Medical Examiner, who in turn can flag issues with the Regional Medical Director and the National Medical Examiner.

5.2.c In January 2024, when collating data for the Quarter 3 report, concerns were raised regarding the quality of mortality reviews undertaken by the trust. The reviews appeared to be focused on justifying why issues highlighted by the ME were not an issue rather than on identifying learning. These concerns were raised with the Trust at that time, by March 2024 they had not been fully addressed, and the quarter 1 2024/25 report to NHS England highlighted that ongoing support was being received from the regional team with regard to this.

5.2.d As was common across the country, the ME Office saw large numbers of patients breaching 12 hours in the Emergency Department, with some patients lodging in corridors for several days, This was something that relatives also highlighted when asked about concerns with care.

A particular concern was the number of frail elderly patients who spent prolonged periods in corridors (up to three days) before dying there.

Infrastructure issues were identified with alarms not working and sub-optimal staffing levels contributing to patients becoming ‘lost’ in the system.

5.2.e It was also noted that a number of patients who were awaiting placement spent a prolonged period in hospital medically fit for discharge before contracted a hospital associated condition and dying. Again, this was recognised as an issue at a national as well as local level.

5.2.f Delays in advance care planning were also an issue, with discussions about appropriate ceilings of care being delayed and resulting in resident doctors having to make these decisions out of hours.

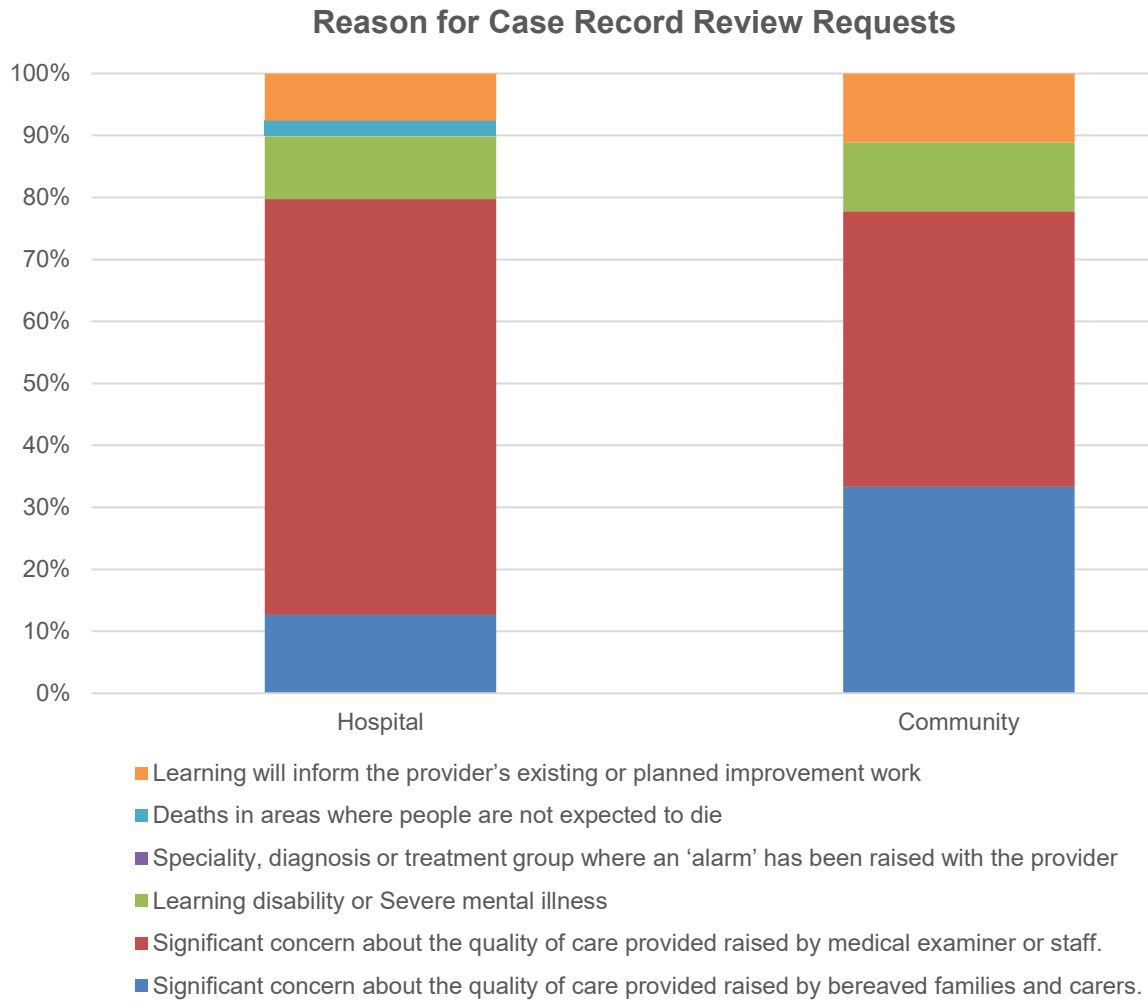
5.2.g The continued use of copy and paste in electronic patient records continued to cause problems, with key information not being recorded. It was also difficult to identify the responsible consultant from the documentation, which could translate to a lack of consultant involvement in proposed causes of death.

5.2.f Another concern with electronic patient records related to how administration of controlled drugs was recorded, with no option to include the number of tablets / volume of liquid administered offered on the electronic drug chart.

5.3.a Case reviews were requested for 98 patients (3% of total deaths reviewed) – 82 hospital cases (6% of all hospital cases reviewed) and 16 community cases (1% of all community deaths reviewed).

5.3.b Case specific mortality reviews were requested for 88 patients, (79 hospital, 9 community).

Reason for request	Hospital	Community	Total
Significant concern about the quality of care provided raised by bereaved families and carers.	10	3	13
Significant concern about the quality of care provided raised by medical examiner or staff.	53	4	57
Learning disability or Severe mental illness	8	1	9
Speciality, diagnosis or treatment group where an 'alarm' has been raised with the provider	0	0	0
Deaths in areas where people are not expected to die	2	0	2
	79	**9**	**88**



5.3.c 4 non-acute case reviews were requested (3 GP and 1 other provider).

5.3.d 2 deaths were referred for another hospital based clinical governance review, and four cases were notified directly as patient safety incidents following scrutiny.

5.4.a In 16 cases, the bereaved were signposted to PALS or equivalent by the medical examiner.

6. Planning for the future

6.1.a As a new service, the Medical Examiner Office continues to strive to develop processes and procedures to maximise efficiency and minimise delays for the bereaved. Many elements of the process are outside the control of the Medical Examiner Office, but support and collaboration with stakeholders is key to this aim.

6.2.a Following the statutory implementation, it has become clear that a service restructure is required. The original staffing for the ME office as suggested by NHS England was for 1.1 whole time medical examiners and 3.6 whote time equivalent medical examiner officers. Funding for the service is provided on this basis.

6.2.b It is clear that there is seasonal variation in the number of deaths that the ME office must review, with consistently higher demand between October and March compared to April to September. The service requires flexibility to ensure that capacity is maximised during busier periods.

6.2.c The service must also have provision to provide urgent scrutiny out of hours – on bank holidays and at weekends.

6.2.d We are currently engaged in a service redesign to ensure that all of these requirements can be met within the funding envelope provided by NHS England.

6.3.a Timely completion of MCCDs is a significant issue. Medway ME Office is an outlier in this regard and has been subject to scrutiny from the regional team, who have been satisfied that the delays are not as a result of processes within the office.

6.3.b At the time the statutory changes were announced, a digital MCCD was also mooted. Unfortunately, development of this seems to have stalled. Nevertheless, the ME office recognises that there is an appetite for electronic completion. To this end, the Lead MEO has developed a sophisticated scanning technique whereby an Adobe form is overlaid on a scanned MCCD which is then sent for electronic completion. This has been extremely well received, both by hospital and community doctors.

6.3.c The Lead MEO is currently working on developing this work further to allow an electronic MCCD to function as the referral form. This would enable immediate action of any cases where the cause of death is agreed.

6.4.a The Medical Examiner Office is committed to providing support and education to all stakeholders. During the pre-roll out period, face to face visits to stakeholders were offered, though uptake was variable. The team are part of the annual induction for new doctors, and also contributed to the Simway event in August 2025. The Lead ME has presented at several Grand Rounds, and the team has a good presence within the hospital education system.

6.4.b The next phase of education is to become a staple in the community education circuit. To this end, the ME Office is looking to develop links with the PCN and GP education leads.

7. Conclusion

7.1.a Establishing a new statutory service is not easy, especially when the existing system has been ingrained for more than 50 years. Nevertheless, along with other offices across the country, Medway ME Office is proud to have been part of the death certification reforms.

7.1.b Feedback from doctors in the acute and community sectors has been overwhelmingly positive, with the team being praised for responsiveness, accessibility and supportiveness.

7.1.c For the Medical Examiner Office, though, the feedback that matters the most is that of the bereaved – the people at the heart of the service. As a result of the efforts of the Medical Examiner Office team, the bereaved feel heard. There concerns are listened to and escalated. Coroner referrals are made for events that would not have been known prior to the implementation of the service. And for those whose relatives died in the community, there is a central point of support.

7.1.d It seems appropriate to finish with feedback received by email from a relative:

"I just wanted to say how helpful, compassionate and professional were in sorting out [the] death certificate … you kept me informed every step of the way.
You a credit to the medical examiner's office.
Thank you both so much for your help at this difficult time."

Meeting of the Trust Board in Public

Date: Wednesday, 12 November 2025

Title of Report	Paediatrics Summit Report - Update			**Agenda Item**	4.4
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
	X	X	X		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X	X	X		
Author and Job Title	Ghada Ramadan - Divisional Medical Director, Women and Children Services Karen Kessack - Divisional Director of Nursing				
Lead Executive	Alison Davis, Chief Medical Officer				
Purpose	**Approval**		**Briefing**	X	**Noting**
Proposal and/or key recommendation:	1) Continue collaborative working with DVH and plan an initial team workshop with staff across both sites. 2) Refine patient pathways following community tender. 3) Monitor and ensure we challenge all incivility incidents. We will address emerging themes to improve culture and staff well-being. 4) Present options paper on the feasibility of POSCU and PCC2 projects to TLT. 5) Continue to monitor complaints and PALS trends and action accordingly.				
Executive Summary	This report provides an overview of progress in General Paediatric Services from February 2025 to date. Strong performance has been demonstrated across key service indicators, reflecting continued alignment with organisational priorities with good advancement of the clinical strategy. The first collaboration meeting with DVH Paediatric Services Colleagues was on 16.10.25. It was a good introductory meeting and we discussed potential avenues for collaboration. These are mainly focused around strengthening Paediatric governance pathways, support with MRI scans, provision of psychology services and neonatal level 2 development work. TUPE of Community Paediatric Services has been completed. Full transfer of staff was on 27.10.25. Work has been completed in relation to the possible risk to the existing services provided (endocrine testing, respiratory support and home nasogastric tube feeding for babies). This has been an opportunity to review and improve the pathways that remain within MFT. Call for Concern (Martha's Rule) has been launched in Paediatrics and Neonates on 10 November 2025. STPN has been				

	complimentary of this work and is planning to use our approach as an exemplar of good practice in the region. Work is nearing completion to scope the feasibility of Paediatric Critical Care level 2 (PCC2) and Paediatric Oncology Shared Care (POSCU) Enhanced Level 2 transformation projects, ensuring we can deliver a quality and safe service, within NHSE financial envelope. The Paediatric Department continues to experience challenges relating to the paediatric epilepsy patient backlog, environmental and estates risks, patients with mental health issues or dysregulated behaviours, incivility reports and some gaps in the governance processes. These are on the risk/issues registers. Mitigations, controls and action plans are in place to address these issues. All actions are being actively monitored within the care group, with oversight provided at divisional level.			
Issues for the Board/Committee Attention:	Detailed in the relevant section of the report.			
Committee/ Meetings at which this paper has been discussed/ approved: Date:	This report has been reviewed and agreed by the Chief Medical Officer.			
Board Assurance Framework/Risk Register:	Detailed in the relevant section of the report.			
Financial Implications:	N/A			
Equality Impact Assessment and/or patient experience implications	N/A			
Freedom of Information status:	Disclosable	X	Exempt	

Introduction:

The following report provides a summary and assurance on progress of the issues discussed at Private Trust Board meeting in February 2025.

Positive Outcomes Since the Meeting:

1. Job Planning, RCPCH Facing the Future for General Paediatric Services Standards and resuscitation training compliance:

o The department is fully compliant with the RCPCH standards.

o Consultant engagement has improved significantly with many job plans signed off (69% full sign off, 8% awaiting second sign off, 8% awaiting first sign off, 15% in discussion).

o Based on demand and capacity modeling, the department continues to require an additional 1WTE Consultant Paediatrician. ICB has declined the business case for expansion which has affected our ability to manage RTT and epilepsy workload. The CFO has kindly raised this with ICB through the annual commissioning intentions correspondence.

o PBLS compliance is 91%. APLS for senior resident doctors is 89%. Plans in place to expedite training and address gaps through roster management.

2. **KSS Deanery Feedback:**
    - Significant improvements in the most recent round of GMC Trainee survey scores in General Paediatrics with no red flags raised and many areas rated as green. This is a welcome achievement.
    - A deanery visit in July 2025 led by Dr Olu Seidu and College Tutor Dr Kurre demonstrated how these scores were reached. The deanery was satisfied with the improvement in all areas. The steps taken to improve this position included:
        1. Appointing civility medical and nursing leads
        2. Civility team building and regular reporting via Datix
        3. Quick reviews of civility incidents with closed loop feedback
        4. Change in workforce lead consultant support
        5. Support with exception reporting
        6. Consultant paediatricians supporting freedom to speak up, clinical skills and buddy system
        7. Promoting team events and enhancing educational days
        8. Providing SIMs (Simulation-based learning) for doctors and nurses
        9. Changes to induction training programme
        10. Improvements in daily supervision, handover and twilight shifts.

3. **Acknowledgment for Enhanced Level A POSCU by South Thames CTYA Cancer Operational Delivery Network (ODN):**
    - This acknowledgment endorses the high standard of care provided by the Paediatric Haematology and Oncology service both in the hospital and the community setting (supported by the Children's Out-reach team (COAST).
    - Funding has been received 120k which has now been confirmed to be recurrent.
    - Gap analysis completed and submitted to the ODN. Currently awaiting a meeting with the oncology ODN team to address next steps. Main concern is the gap in pharmacy support and provision of aseptics which will be limited by the financial envelope. We are seeking some support from cancer alliance funding received by the Trust.
    - Options appraisal paper being drafted, which will be presented at TLT.

4. **Acknowledgment as designated Paediatric Critical Care Unit (PCCU) Level 2 provider by the South Thames Paediatric Network (STPN)**:
    - STPN approved Expression of Interest as designated Level 2 PCCU (submitted 2023);

- Recurrent funding of 250K received to support this development (last year and this year)
- Review of quality standards and service specifications with a gap analysis has been completed and submitted to the STPN
- Executive (CMO) and divisional SRO (DMD) identified for the project
- Engagement with STPN has progressed, however due to limited financial envelope and gaps identified an options appraisal paper has been prepared and awaiting Divisional and TLT discussion.

5. Paediatric Clinical Strategy:

Paediatric Priorities	24/25	25/26	26/27	Milestones	Status
Review the use of Penguin Assessment Unit and utilise as a short stay ward.				4 bedded area developed. Lead clinician and nurse developing PAU pathways (CHED PAU pathways)	Completed
Bolster link with paediatric general surgery, ENT and anaesthetists. Improve interdepartmental relations, patient pathways and experience.				Patients moved to Safari day-case unit. Improve theatre utilisation through effective job planning. Review GIRFT recommendations and implement changes	Completed
Paediatric Ambitions	**24/25**	**25/26**	**26/27**	**Milestones**	**Status**
Establish surgical day case model to enable capacity, reduce surgical backlog, improve patient experience and flow				Safari day-case unit fully operational.	Completed
Become Children's surgical hub for Kent.				Mutual aid for East Kent completed.	In progress
Excellence in Paediatric sub-specialties such as epilepsy				Subspecialty clinics (epilepsy, cardiology, respiratory, CF, oncology, rheumatology, diabetes. Consultants with interest and CNS are in post. Reviewing D&C	In progress
Develop PCCU2 service				Scoping completed	In progress
Develop CYP transition service				Medical transition lead in post Some transition pathways established (Diabetes, Epilepsy) Need for a nurse lead	In progress

6. **Community Paediatrics:**
    - Following Community tender process several elements of our Community services have transferred to the winning bidder, KCHFT working in collaboration with MCH.
    - Staff have now transferred and the service has moved to KCHFT on 27.10.2025.
    - This transfer has enabled us to clarify our own pathways and identify areas of our service that can be delivered in more cost effective ways whilst retaining quality. This applies as an example to the endocrine testing service, community respiratory pathways and home nasogastric tube feeding for babies.

7. **Paediatric Surgical Hub Progress:**
    - Work is under way with anaesthetic and surgical colleagues to progress this work based on GIRFT Further Faster principles,
    - This aligns with the Trust's clinical strategy ambitions for Paediatric services,
    - The department will be offering some general paediatric surgical lists to specialties more in need (Dental and ENT) to clear backlog and improve theatre utilisation metrics.

8. **Call for Concern (Martha's rule):**
    - The Trust received funding from NHSE to progress this vital work.
    - A joint working group led by the Acute Response Team (ART) resulted in the development of a policy which has been fully ratified.
    - This work covers Paediatrics and Neonatal pathways in the Trust.
    - Launch date 10th Nov 2025.

Patient Safety and Quality Metrics:

1. **Complaints and PALS**

Complaints

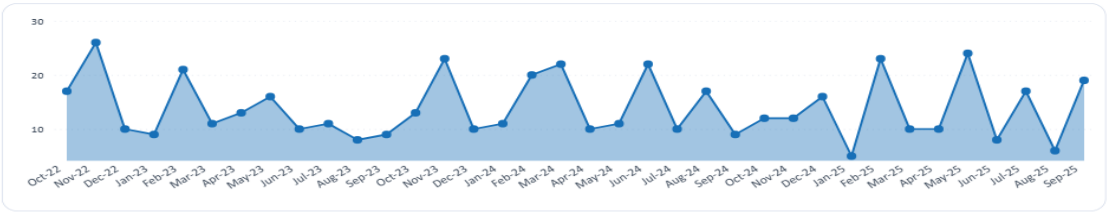
Care Group	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
CHILDREN AND YOUNG PEOPLE	0	1	0	1	3	3	2	2	3	1	1	4
Total	**0**	**1**	**0**	**1**	**3**	**3**	**2**	**2**	**3**	**1**	**1**	**4**

- An upward trend in the number of complaints received since February 2025.

- Largely themes include; all aspects of clinical treatment, delays in care, delays in pain relief, failure to diagnose and communication. Action plans have been devised to address Paediatric Assessment Unit pathways and to improve communication between professional groups.

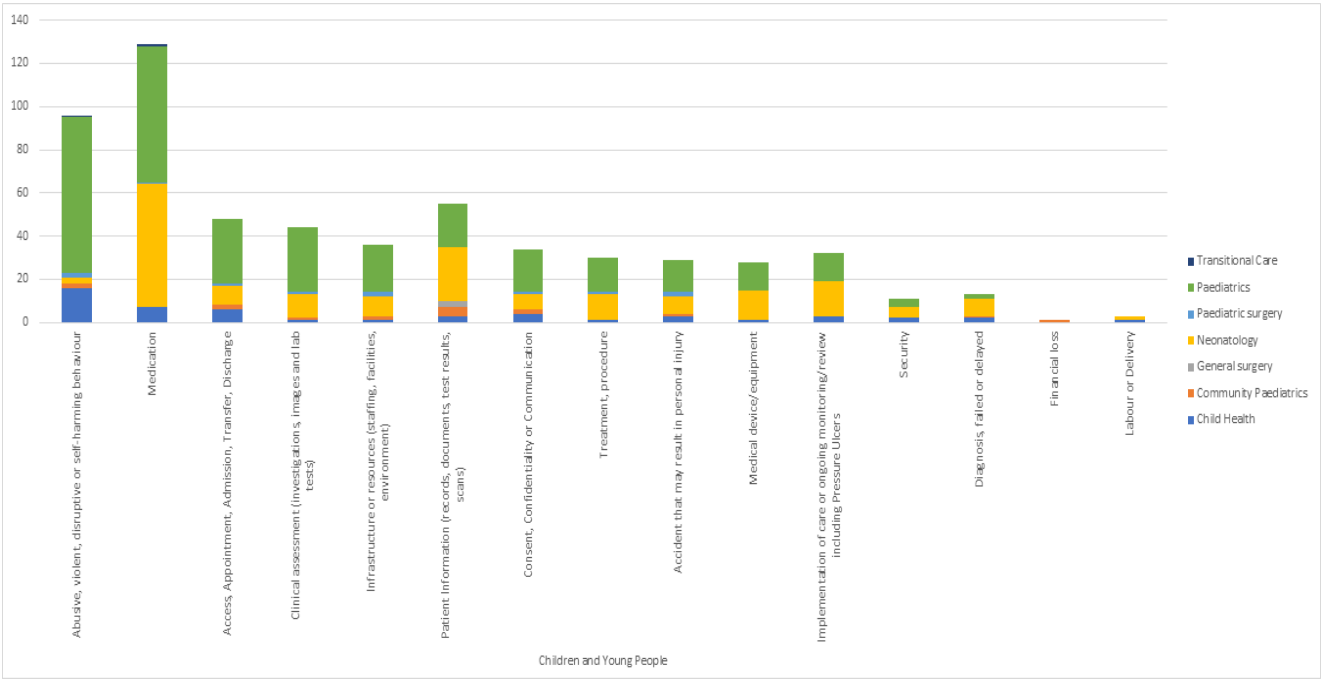
PALS

Care Group	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
CHILDREN AND YOUNG PEOPLE	12	12	16	5	23	10	10	24	8	17	6	19
Total	**12**	**12**	**16**	**5**	**23**	**10**	**10**	**24**	**8**	**17**	**6**	**19**



- Themes include, appointment queries and communication with families which we have action plans to address.

2. Incident reports



Patient Safety Incidents Investigations (PSII) and After Action Reviews (AAR's)

AAR:

Case 1: Learning: CHED resuscitation processes, leadership and team huddles (coronial inquest).

Case 2: Learning: SECAMB actions, bereavement nursing support (coronial inquest).

Case 3: Learning: communication around escalation processes (internal and external).

Case 4 (JAR): Learning: possible missed opportunity in PAU, review of nursing processes.

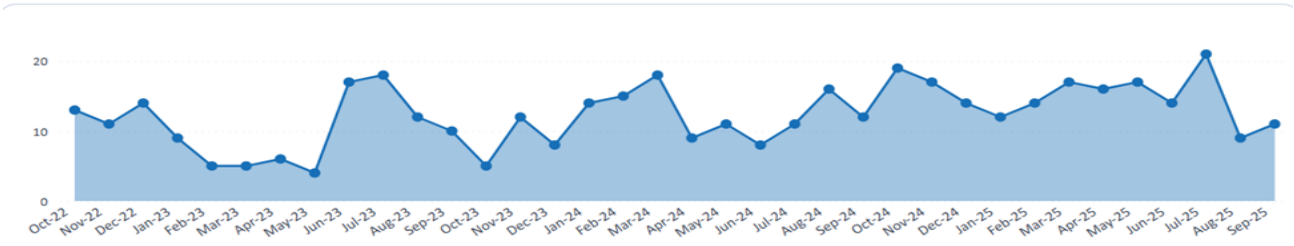
PSII:

Case 5: (multiple datixes): CAMHS patient (multiagency review).

3. Medication Safety

This is a patient first driver metric for CYP. We systematically review all medication errors and our teams of doctors and nurses are working with our pharmacy team which is showing good improvements. This is monitored regularly through the medications safety group. We are taking a PDSA approach and focus on a different area which we sprint. Trends are improving month on month. All identified incidents are no harm. Actions progressing as below.

Specialty	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Neonatology	9	6	7	8	9	5	9	9	6	6	5	4
Paediatrics	6	8	2	4	5	9	6	6	7	15	4	6
Child Health	4	3	4	0	0	3	1	2	0	0	0	0
Paediatric surgery	0	0	1	0	0	0	0	0	1	0	0	0
Transitional Care	0	0	0	0	0	0	0	0	0	0	0	1
Community Paediatrics	0	0	0	0	0	0	0	0	0	0	0	0
Total	**19**	**17**	**14**	**12**	**14**	**17**	**16**	**17**	**14**	**21**	**9**	**11**



Medication Safety Group Actions:

- Biweekly meetings and sprints to address medication errors.
- Pharmacy attend ward rounds, grand rounds and learning shared in handovers.
- Sourcing new cleaning solutions for neonatal.
- Neonatal tea meetings to share patient safety learning.

All actions below have been completed.

- All patient own medications are now to be stored in locked cupboards with nursing oversight of administration by parent (to aid 'missed doses').
- All patient own CD's are to be locked in CD cupboard and accurately recorded.
- Door bell system installed to call the nurse to the dedicated room to second check (not at the nurses desk).
- Supportive performance management for medication errors.
- Red disposable tabards being used to highlight a member of staff that is working on medications to prevent disruption.
- Reflective accounts for all medication errors.
- The 'hot topic' is now used to highlight areas with repeated errors.
- Standing agenda in the "big 4" to highlight common errors.
- FP10's now stored in CD cupboard and recorded as per CD's policy signed by SN and prescribing Doctor and checked in line with the controlled drugs policy.
- Potassium containing fluids separated in differing cupboard from NaCl fluids.
- Drug cupboards and drug room doors locked and check several times a day.
- Admission & Discharge paperwork to include drug / medication checklist.
- QR codes displayed in Drs office for easy medication links.
- Engaged with medicines safety lead.
- Generic medusa sign on requested for easy access to staff.
- QR codes now provided for staff in relation to medication administration, (awaiting PO approval from pharmacy, IV approved).
- Improved pharmacy support (new appointed)
- Induction on prescribing improved.

4. Paediatric Clinical Risks and Issues

Risks

- 2274: risk of inadequate care provision for 16 to 17 year olds -16 Extreme
- 2304: ligature risk in paediatric areas -15 Extreme
- 2476: risk of service loss at Medway POSCU due to funding shortfall from NHSE – Recommended Chemotherapy Expansion - 12 High
- 2403: Fire safety risk Paediatric Unit - 12 High
- 2334: The absence of procedures for Paediatric Assessment Unit and ChED transfers poses risk of harm to paediatric patients - 12 High
- 2309: Risk to Paediatric Diabetes Outcomes from insufficient Dietetic provision - 12 High
- 2581: Service Continuity Risk: Endocrine Testing, Allergy/Respiratory Nursing, and Infant Home NG Tube Feeding – 12 High

RISK	CONTROLS/MITIGATIONS
Risk of inadequate care provision for 16 to 17 year olds	Identifying the children that are at risk of having a delay in treatment referring as soon as possible. Consultant to consultant conversations. MDT working in early planning. For staff offering wellbeing and OH support that are affected by this cohort of patients.
Ligature risk in paediatric areas	Patient requiring a ligature free / light room, are supervised by a RMN,

	Current space is removed of any obvious ligature risk however some are unable to be removed as they are permanent estates fixtures. Staff are aware to be vigilant and escalate any support needed through the correct escalation routes. Estates raised PO 27.10.25, lead time for delivery is 6 weeks.
Risk of service loss at Medway POSCU due to funding shortfall from NHSE	Working with South Thames Network for solutions on providing local service education and provision. Regular meetings with Senior at MFT and oncology network and NHS England for funding and what the service needs to look like. SACT treatment list under review to prioritise delivery of service. Possible non-recurrent funding identified from cancel alliance.
Fire safety risk-Paediatric Unit	As a temporary mitigation, fire safety team advise that all paediatric staff will be doing on the ward fire safety training. Fire safety team agreed to do a full risk assessment/new fire plan.
The absence of procedures for Paediatric Assessment Unit and ChED transfers poses risk of harm to paediatric patients	The PAU senior team will liaise with the ChED to obtain any missing patient information. Upon arrival, the medical team will immediately assess any patient requiring urgent treatment. The Patient 1st team are facilitating joint meetings with ChED staff to develop an A3 document and action plan. This initiative aims to establish clear pathways and processes, ensuring effective collaboration between the two teams and improve the patient journey
Risk to Paediatric Diabetes Outcomes from insufficient Dietetic provision	Interview for locums have taken place, this was unsuccessful, re-advertised - awaiting applications and subsequent interviews. Trac authorisation awaited for 1 WTE dietician
Service Continuity Risk: Endocrine Testing, Allergy/Respiratory Nursing, and Infant Home NG Tube Feeding	Review the TUPE list and identify the number of nurses WTE affected by TUPE process. Review the job descriptions of the nursing staff affected by the TUPE

	process and align to the existing workload within the COAST team. Identify SOPs and Guideline's which may be impacted upon and align to the remainder of the community services with the COAST team. Identify staff working with the COAST team who could undertake some of the TUPE'd responsibilities.

Issues

- 2350: Emergency call system in Magpie Outpatient Department - 4 High
- 2251: Environmental Risk Assessment Paediatrics - 4 High
- 2169: Capacity and demand in Epilepsy Team CYP - 4 High
- 1821: Delays in diagnosis of ADHD and Autism in children - 4 High
- 2459: Outpatient Magpies Equipment and infection control - 4 High
- 2340: Pre-assessment emergency buzzer - 3 Moderate
- 2255: Day surgery / Safari trolleys - 3 Moderate
- 2347: Inadequate matron capacity within children's services - 2 Low

ISSUE	CONTROLS/MITIGATIONS
Emergency call system in Magpie Outpatient Department	17/03/2025 Ward staff aware of challenge with emergency call bells. Senior Sister provides walk arounds and regular check ins. OPD staff increased communication between themselves to highlight patients in the department. 27/10/2525 PO raised 15K.
Environmental Risk Assessment Paediatrics	Infection control: regular contact with Director of Facilities to have enhanced cleaning of the floors and environment, weekly meetings to discuss cleaning regime. Facilities supervisor now completing cleaning audit with a clinical member of senior nursing team to ensure correct documentation. Mitigations for shabby walls: all old notices and faded torn drawings removed from walls/ windows. Shabby woodwork has been reported to estates. Flooring has been reported to estates. Sensory room has now been approved for refurbishment along with parents room. Work commend 10/03/2025. 30/10/2025: repair work to start in December 2025.
Capacity and demand in Epilepsy Team CYP	Revised pathways of referrals. Weekly monitoring of service, PTL review.

	Epilepsy service has been benchmarked with MTW and DVH. TLT report presented. 27/10/2025: Band 6 CNS Epilepsy has been job matched and approved for advert.
Delays in diagnosis of ADHD and Autism in children	Triaging referrals to identify urgency. Three clinicians in post running clinics each week. Permanent full time ADHD Nurse starting soon. Undertaking nurse led clinics. Service Transferred to KCHFT and MCH on 27/10/2025.
Outpatient Magpies Equipment and infection control	Spoken with Estates to see if we are able to change any of the worse equipment for any that they may have in storage. and a quote has been requested to get them replaced. 27/10/2025: chairs ordered. Risk can be reduced. Coaches not ordered.
Pre-assessment emergency buzzer	Mitigation, Paediatric day-care staff aware of the situation to support if required and anaesthetic cover aware in order to support in an emergency. fire truck toys and any electronic toys with sirens to be removed from area to avoid confusion Adult staff in neighbouring ward also aware of challenge and support if required in placing 2222 call.
Day surgery / Safari trolleys	Current mitigation require staff to be vigilant when placing children on trollies ensuring parent carer or staff are with them at all times
Inadequate matron capacity within children's services	Current workload is being mitigated by HoN, DoN, SSR.

5. Mortality and Morbidity

Meetings continue twice per month. All cardiac arrest cases reviewed. Department strengthening the review process.

Learning identified:

- Review agenda for meetings, revise structure, invite resident doctors as well as anaesthesia and surgery to contribute.
- Consultant Paediatrician (new) now job planned to take on mortality lead.
- Safeguarding Children's Partnership to review a deceased child's care prior to death in relation to accessing and being seen by professionals.

2 On-going Challenges Facing the Paediatric Department:

16-17 Year-old Acute Admissions to Dolphin Ward:

- This policy has full approval in TLT (August 2025).
- Implementation plan under way.
- It is expected that the go live date is in March 2026.

CAMHS and patients with dysregulated behaviour:

- Concerns raised due lack of Tier 4 and PICU beds for these patients. In addition, there are limited placements for CYP with no treatable mental illness, but who present with dysregulated behaviours.
- Long hospital stay and social services support is sub-optimal.
- Impact on staff morale, physical and mental health.
- Recruitment of MH liaison nurse for CYP has failed twice due to the fixed term nature of the role.
- Recent case has been raised as a system PSII.

Paediatric Epilepsy Service:

- A separate detailed report has been presented to TLT in August 2025 indicating the challenges facing this service and the urgent need for investment.
- A band 6 nurse role has been identified from within the nursing budget to support the current CNS epilepsy. This is awaiting job matching which has been significantly delayed due to a shortage of trained job matchers.
- The pathway for referral for this service has changed accordingly to ensure timely review of referrals and offer annual reviews for existing patients.

Paediatric Cardiology Level 3 Service:

- This service continues to be supported by 2 consultants neonatologists who conduct regular weekly clinics.
- The service in addition is supported by the Evelina Paediatric Cardiology Team monthly.
- There is only 5 patients waiting to be seen in this service (40 weeks).

Environmental Risks & Infection Control:

- These issues and risks are detailed under the risks/issues section. Support from estates team has been requested for the work required. Mitigations and actions are in place.

Operational Metrics:

RTT performance

Outpatients

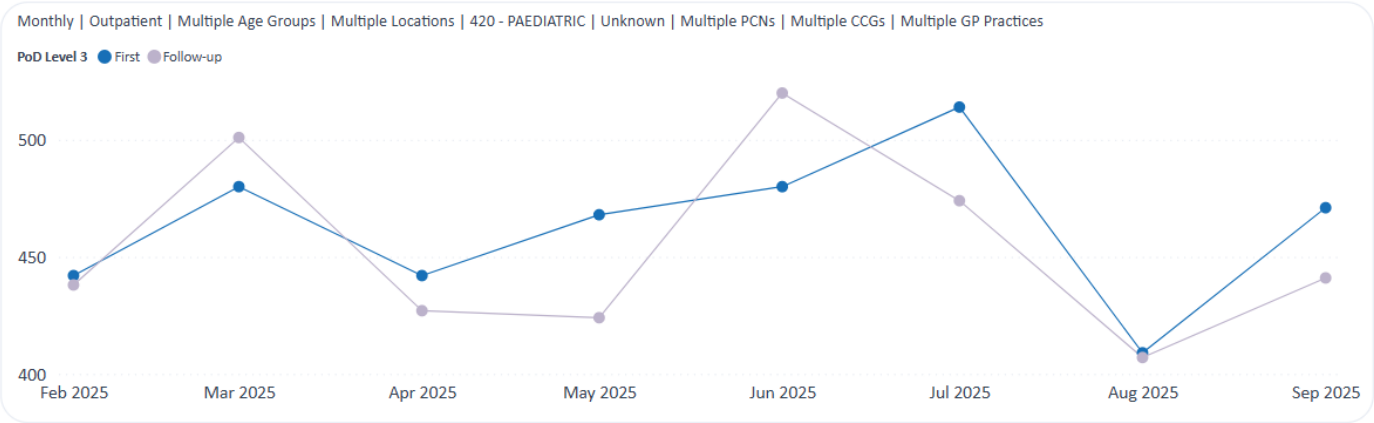
	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Out Patient New to Follow Up Ratio	**1.6**	0.97	1.01	0.95	0.86	1.06	0.85	0.90	0.90
Out Patient Clinic Utilization %	**85.0%**	94.4%	97.4%	96.6%	96.4%	95.4%	97.3%	98.2%	98.2%
Out Patient Was Not Brought (WNB) Rate %	**10.0%**	7.3%	6.3%	9.4%	10.8%	10.1%	10.6%	9.0%	9.1%
Uncashed Appointments	**0**	0	0	0	0	1	0	0	0
Elective Admissions								11	7
New Outpatient Appoint.		442	479	441	468	479	514	408	471
Follow Up Outpatient Appoint.		428	497	422	416	514	464	407	441

RTT

	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
RTT PTL Size	**1168**	1460	1385	1492	1434	1420	1360	1361	1279
RTT % Performance	**60.0%**	79.9%	83.3%	85.3%	83.9%	85.1%	81.8%	79.3%	79.3%
RTT 40+ Week Waiters	**0**	8	5	3	5	6	5	5	5
RTT 52+ Week Waiters	**0**	0	0	0	0	0	0	0	0
RTT 65+ Week Waiters	**0**	0	0	0	0	0	0	0	0
RTT 78+ Week Waiters	**0**	0	0	0	0	0	0	0	0
RTT 104+ Week Waiters	**0**	0	0	0	0	0	0	0	0
Patients waiting for 1st App 40+	**0**	2	2	1	0	1	2	2	1
Patient Initiated Follow Up %	**5.0%**	8.5%	7.5%	7.0%	7.5%	7.6%	8.2%	6.1%	7.4%

- Outpatient clinic utilisation remains above trust target.
- WNB rate was an issue from May-July 2025 following the end of six months trial period of Band 2 calling all parents before the appointment was due. The position has now recovered in August to September to below Trust target. WNB forms are completed by staff, audits and outcomes are notified to the children's safeguarding team at the Trust.
- 40+ week waiters – Paediatric Cardiology patients awaiting tertiary cardiology appointment.
- PIFU above trust target.

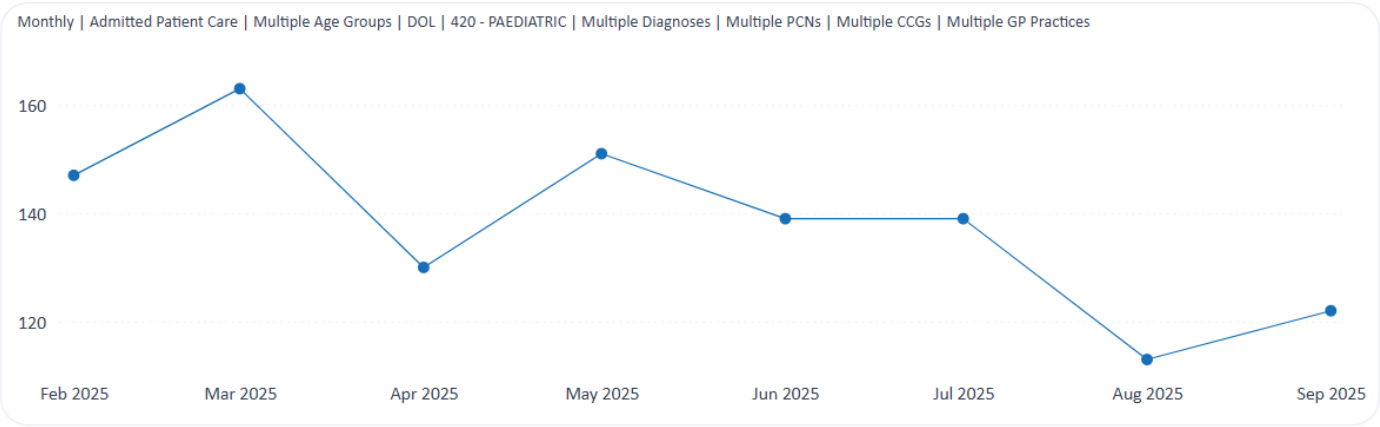
New to Follow-up Ratio



Pod Level 3	01-Feb-25	01-Mar-25	01-Apr-25	01-May-25	01-Jun-25	01-Jul-25	01-Aug-25	01-Sep-25	Total
First	442	480	442	468	480	514	409	471	**3,706**
Follow-up	438	501	427	424	520	474	407	441	**3,632**
Total	**880**	**981**	**869**	**892**	**1,000**	**988**	**816**	**912**	**7,338**

In-patients

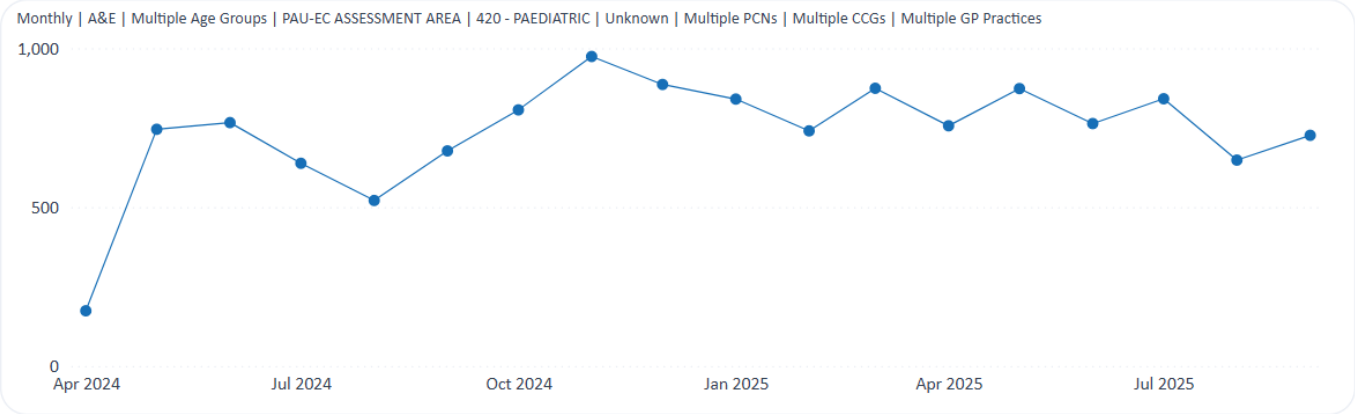
Dolphin ward addmissions



01-Feb-25	01-Mar-25	01-Apr-25	01-May-25	01-Jun-25	01-Jul-25	01-Aug-25	01-Sep-25	Total
147	163	130	151	139	139	113	122	**1,104**

- Reduction due to summer season, the addmissions are expected to increase during winter months
- Winter planning document completed for CYP services.

Penguin Assessement Unit Activity– Emergency Care Type 5 admissions



01-Apr-24	01-May-24	01-Jun-24	01-Jul-24	01-Aug-24	01-Sep-24	01-Oct-24	01-Nov-24	01-Dec-24	01-Jan-25	01-Feb-25	01-Mar-25	01-Apr-25	01-May-25	01-Jun-25	01-Jul-25	01-Aug-25	01-Sep-25
174	745	766	638	521	677	806	974	886	840	740	874	756	873	763	841	648	726

- PAU attendance slightly reduced in August 25 but it is expected to increase over autumn and winter months

Activity vs Plan

POD Group	Income	Income Plan	Variance	Chart	Activity	Activity Plan	Variance	Chart
Excess beddays Non-Elective	£105,741	£26,682	£79,059		235	52	183	
Elective Inpatient	£70,185	£0	£70,185		41	0	41	
Outpatient Procedures	£36,244	£2,125	£34,119		235	14	221	
High Cost Drugs	£46,325	£35,031	£11,294		260	170	91	
Excess beddays Elective	£11,418	£527	£10,892		20	1	19	
Elective Daycase	£2,996	£0	£2,996		4	0	4	
Outpatient Diagnostic	£19,131	£18,679	£452		164	158	6	
Accident and Emergency	£0	£0	£0		4,632	4,404	228	
Outpatient Follow-up	£466,170	£484,244	-£18,074		2,519	2,568	-49	
Outpatient Firsts	£749,830	£861,489	-£111,660		2,732	3,080	-348	
Non-Elective Inpatient	£1,748,539	£1,882,080	-£133,541		926	1,042	-116	
Total	**£3,256,580**	**£3,310,857**	**-£54,277**	**-£54,277**	**11,768**	**11,488**	**280**	**280**

- Outpatient First Attendances are currently below the year-to-date (YTD) plan, primarily reflecting the timing of plan phasing. Although the 12-month phasing incorporated expected annual leave, the actual leave patterns during the first four months of the year differed from assumptions made during planning. Consequently, activity levels are expected to increase over the next six months, with higher patient volumes anticipated relative to the original plan.

- Non-Elective inpatient activity relates to PAU and currently is 7% below plan. It is expected this activity will recover during the winter months.

Children and Young People's Services Strategic Direction

Child Health at The Centre of Decision Making

Excellence in patient safety and quality
Achieve NICE and GIRFT recommnedations for paediatric services
Progress all elements of the Paediatric Clinical Strategy until 2027

Workforce Skill, Size and Welfare

Attract resident doctors (Choose Medway Paediatrics)
Spin/Grid training for subspecilaty Paeditarics
Thrive at Medway Paediatrics
Medical leadership development and succession planning
Nursing safer staffing review and development of nursing careers

Research, Evidence and Clinical Standards

Strengthen governance processes (incidents, child death reviews, SOP's and patient pathways)
Poverty proofing training
Contribute to the Trust's R&I portfolio

Summary

Significant progress has been achieved since the last Paediatric Safety Summit across the majority of the areas discussed due to the dedication and hard work of medical, nursing and operational colleagues. The department however, continues to experience challenges relating to the epilepsy patient backlog, environmental and estates risks, and patients admitted with mental health and/or dysregulated behaviour or social issues. Mitigating actions have been implemented to address these issues, and all actions are being actively monitored within the care group, with oversight provided at the divisional level.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board in Public

Date: Wednesday, 12 November 2025

Title of Report	Maternity CNST Compliance Assurance Report – Updates and Actions			**Agenda Item**	4.5
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			X		
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X	X	X	X	X
Author and Job Title	Alison Herron, Director of Midwifery				
Lead Executive	Stephanie Gorman, Chief Nursing Officer (Interim)				
Purpose	**Approval** X	**Briefing** X	**Noting** X		

Proposal and/or key recommendation:	• Approval – The Board's formal approval is required for the following points:
	  • Safety Action 1 - Action Plan
	  • Safety Action 4 - NICU Nursing Action Plan
	  • Safety Action 8 - New starter training action plan.
	• Noting – The Board must formally minute the points highlighted in "Issues for the Board/Committee Attention"				

Executive Summary	• CNST Year 7 Published 02 April 2025 with reporting period ending 30 November and submission due 03 March 2026.
	• The following Safety actions are off track or at risk:
	  • Safety Action 1 – At Risk. Currently at 87% for Standard C – target 95%. 3/31 cases missed.
	  • Position cannot be recovered unless an additional 9 losses before 30 November and one miss case excluded by MBRRACE.
	  • Action plan in place to prevent future non-compliance.
	  • Safety Action 8 – moved to off track as not all staff groups are currently at 90% for training.
	  • Work ongoing to address gaps in compliance.
	  • Action plan in place to mitigate potential <90% compliance for any new starters.
	• Safety Action 2 has been completed as scorecard has now been published
	• All remaining safety actions are on track with reporting scheduled as per CNST requirements.				

Issues for the Board/Committee Attention:	**The Report requests the following actions from Trust Board:** • Formally record in minutes 100% compliance with RCOG guidance for short term and long- term locums. • Formally record 99% compliance with RCOG Consultant attendance guidance. • Formally record in minutes neonatal medical staffing compliance with all relevant BAPM standards.				

	• Formally record in the minutes that the Neonatal Nursing Team is currently 68.75% compliant with Qualified in Speciality and approve the action plan to achieve 70% compliance.
	• Trust Board agreement, sign-off for action plan and formal minuting of the same to ensure new starters who rotated from July 2025, in line with CNST guidance, to complete their training within 6 months of start date.
	• Note that the Non-Executive Safety Champion well established within Maternity and Neonatal Services and is a core member of Maternity and Neonatal Safety Champion Assurance Board (MNSCAG).
	• Request that the Trust Board minutes reflect that the Board Safety Champion, along with the NED are meeting with the perinatal leadership team monthly at MNSCAG and support the perinatal leadership team to escalate to Trust Board for assurance and Support.
	• Request that the Trust Board minutes reflect the ongoing work on maternity and neonatal cultural improvement as presented as part of the perinatal leadership reports to Trust Board quarterly. Current work includes:
	  • Work with absolute diversity to undertake targeted culture work within maternity and neonatal services.
	  • Undertake repeat bespoke culture survey within maternity and neonatal services
	  • Leadership team reviewing how it feeds back to staff following escalation of concerns – consider pilot of 10 at 10.
	  • The Perinatal Quality Oversight Model is fully embedded at MFT, with monthly reporting via IQPR slides and quarterly oversight report to Trust Board via Perinatal Quality Report.
	Issues:
	• Non-compliance with CNST Safety Action 1 – detailed in the report.			

Committee/ Meetings at which this paper has been approved:	Maternity and Neonatal Safety Champion Assurance Group Date: 06 October 2025 Trust Leadership Team – Quality Meeting Date: 14 October 2025			
Board Assurance Framework/Risk Register:	N/A			
Financial Implications:	Potential non-compliance with all 10 Safety Actions will have a negative impact on the total monies the Trust receives as part of the CNST Maternity Incentive Scheme			
Equality Impact Assessment and/or patient experience implications	N/A			
FOI status:	Disclosable	X	Exempt	

NHS
Medway
NHS Foundation Trust

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

Patient FIRST

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 – At Risk. Currently at 87% for Standard C – target 95%. 3/31 cases missed.
        - Position cannot be recovered unless an additional 9 losses before 30 November and one miss case excluded by MBRRACE.
        - Action plan in place to prevent future non-compliance.
    - Safety Action 8 – moved to off track as not all staff groups are currently at 90% for training.
        - Work ongoing to address gaps in compliance.
        - Action plan in place to mitigate potential <90% compliance for any new starters.
- All remaining safety actions are on track with reporting scheduled as per CNST requirements.

- Request the following actions from Trust Board:
    - Formally record in minutes 100% compliance with RCOG guidance for short term and long term locums.
    - Formally record 99% compliance with RCOG Consultant attendance guidance.
    - Formally record in minutes neonatal medical staffing compliance with all relevant BAPM standards.
    - Formally record in the minutes that the Neonatal Nursing Team is currently 68.75% compliant with Qualified in Speciality and approve the action plan to achieve 70% compliance.
    - Trust Board agreement, sign-off for action plan and formal minuting of the same to ensure new starters who rotated from July 2025, in line with CNST guidance, to complete their training within 6 months of start date.
    - Note that the Non-Executive Safety Champion well established within Maternity and Neonatal Services and is a core member of Maternity and Neonatal Safety Champion Assurance Board (MNSCAG).
    - Request that the Trust Board minutes reflect that the Board Safety Champion, along with the NED are meeting with the perinatal leadership team monthly at MNSCAG and support the perinatal leadership team to escalate to Trust Board for assurance and Support.
    - Request that the Trust Board minutes reflect the ongoing work on maternity and neonatal cultural improvement as presented as part of the perinatal leadership reports to Trust Board quarterly. Current work includes:
        - Work with absolute diversity to undertake targeted culture work within maternity and neonatal services.
        - Undertake repeat bespoke culture survey within maternity and neonatal services
        - Leadership team reviewing how it feeds back to staff following escalation of concerns – consider pilot of 10 at 10.
        - The Perinatal Quality Oversight Model is fully embedded at MFT, with monthly reporting via IQPR slides and quarterly oversight report to Trust Board via Perinatal Quality Report.

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?							

NHS Medway NHS Foundation Trust

- Completed
- At Risk
- Off Track with actions to deliver
- On Track

True North: Quality

Safety Action 1: PMRT – At Risk
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.

	Review in standard	Standard b parents informed	Standard b parents input sought	Standard c review started within 2 months	Standard c report published within 6 months	External member present
Met	47	31	31	27	16	23
Not Yet Met		4	4	1	14	7
Not Met				3	1	0
Baby born in different Trust so na				4	4	4
Eligible total	47	35	35	31	31	30
Current Compliance	100%	89%	89%	87%	52%	77%
Compliance Trajectory (current cases)	100%	100%	100%	90%	97%	100%
Target	100%	95%	95%	95%	75%	50%

Key Messages:

- 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, November 2025, February 2026.
- Quarterly reports submitted to Trust Board in March, July, September 2025 January 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.
  - 3 out of 31 eligible cases missed deadline, however one case due to non-return of factual questions from booking/antenatal care providing Trust. CNST requires 95% compliance with this standard.
- Now unlikely to achieve CNST unless exclusion of 1 missed case and an additional 9 eligible losses before close of reporting period. (Eligible losses are losses that are suitable for PMRT review, and were born and died at MFT.)
- Current MNVP funding does not support MNVP attendance at PMRT meetings.

Actions and Improvements:

- MNVP to join PMRT meetings as volunteer until ICB secure funding.

True North: Quality

Safety Action 1: PMRT – At Risk
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

Safety Action 1 Year 7
Action Plan

Overdue		
On Target		
Near Completion		
Complete		

Action No.	Recommendation	SMART Action	Update	Owner	Target Date	Completion Date	Current Position
1	Ensure robust processes in place to meet all deadlines for CNST Safety Action 1.	Establish weekly review of all losses utilising MBRRACE generated case list to monitor upcoming deadlines and escalate any barriers to completion in a timely manner. Meeting to be chaired by Compliance Manager and have representation from Maternity and NICU bereavement teams.		Compliance Manager	30/10/2025		
2		Ensure all members of the bereavement team as well as compliance manager and ADOM have full access to MBRRACE systems, including the ability to generate compliance reports.		Compliance Manager	30/11/2025		
3		Review current processes and staffing to ensure all members of team, including neonatal colleagues have been trained and are able to complete all stages of MBRRACE reporting/PMRT, .		ADOM	30/11/2025		
		Implement new reporting system (SPEN) and ensure all relevant staff (Bereavement, Risk, Management) have adequate training to report and track compliance to CNST Standards.		ADOM	30/11/2025		
4		Devise SOP clearly outlining responsibilities for reporting and maintaining compliance.		Compliance Manager	28/02/2026		
5	Recruit additional staff to support compliance process	Request funds from CNST Year 7 to employ a band 4 Compliance Support Officer to support monitoring compliance.		ADOM	30/03/2025		

True North: Quality

Safety Action 2 - MSDS – Complete

Ambition: Submit data to the Maternity Services Data Set (MSDS) to the required standard?

Key Messages:

- July 2025 Dataset meets required MSDS standards. Therefore fully compliant with this standard anticipated.
  - Valid birthweight information for at least 80% of babies born in the month.
  - Valid Ethnic category (mother) for at least 90% of women booked in month.
- Will present formal scorecard to Trust Board when published form NHS Digital.

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | **Summary** | Scores Breakdown | Metadata | Other DQ Priorities | Useful Links | FAQs

The table below summarises the number of criteria met by each maternity service provider, by month. For Safety Action 2 there are two criteria to meet in the MSDS data submission.
The final results for the CNST MIS Y7 Safety Action 2 assessment, using July 2025 data, are now available in this scorecard.

Select organisation(s)

MEDWAY NHS FOUNDATION TRUST

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Organisation	February 2025	March 2025	April 2025	May 2025	June 2025	Assessment month: July 2025
MEDWAY NHS FOUNDATION TRUST	2	2	2	2	2	2

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.

Key Messages:

- 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

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:

- 100% compliant with RCOG short-term locums with all doctors engaged in short term work (via Bank) February to August 2025. 4 doctors undertook bank shifts during this time, 3 being within the Kent, Surrey and Sussex (KSS) Deanery and 1 holding a current RCOG Locum Certificate of eligibility.
- All other doctors working bank shifts at middle-grade level hold a current posting with MFT
- No agency locums were used during this reporting period.
- All doctors on fixed term contracts are recruited through Trust recruitment processes and have all appropriate recruitment checks, clinical supervision and training in line with Trust processes and RCOG long-term locum criteria.
- All Consultants, Senior Speciality, Associate Specialist (SAS) doctors who are working as non-resident on-call out of hours have sufficient rest:
    - After 24 hours on-call, next day will be designated day off. After 48 hours of weekend on-call, Monday and Tuesday will be off days.
- 100% compliant with appropriate obstetric anaesthetic cover 24/7

	Date substantive employment at MFT ended.	Grade worked at MFT	Deanery/HEE	Short term locum passport completed	RCOG Certificate of Eligibility for Locums	Meets RCOG/CNST requirements
1	Oct-21	Registrar	Kent, Surrey, Sussex	Bank	N/A	Y
2	Aug-22	Registrar	N/A	Bank	Y	Y
3	Oct-19	Registrar	Kent, Surrey, Sussex	Bank	N/A	Y
4	Oct-19	Registrar	Kent, Surrey, Sussex	Bank	N/A	Y
5	>5 Years	SHO	NHSE Education North Central and East London	Bank	Y	Y

Issues, Concerns & Gaps:

- Temporary staffing not automatically checking RCOG certificate of eligibility for bank doctors.

Actions & Improvements

- Working with temporary staffing to add Certificate of Eligibility to e-roster skills to ensure any bank doctors from outside of KSS Deanery hold the relevant certificate.

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:

- 99% compliant with RCOG consultant attendance for must and should attend cases from April 2025-June 2025
    - 1 case of PPH >2L not escalated to the consultant.
- 1143 cases were reviewed in the audit period.
- 50 cases met the must attend criteria. 106 cases met the should attend criteria (consultants should attend if senior doctor not deemed competent for these cases)
- 8 cases did not meet the must or should attend criteria.

	Must attend	Should attend	CNST Compliant
Meets Criteria	50	106	162
Does not meet criteria	113	57	1
Total	163	163	163
% Cases meeting criteria	31%	65%	99%

Issues, Concerns & Gaps:

- Reminder to staff regarding criteria to select, in particular regarding critical deterioration as a number of cases incorrectly selected
- Individual case to be reviewed by obstetric team and shared for learning. .

Actions & Improvements

- Add “Must/should” attend criteria to CRIG form along with whether care was complaint to prompt timely MDT discussions and learning.

True North: People

Neonatal Medical Workforce

Unit name	Oliver Fisher Neonatal unit
Trust	Medway NHS foundation Trust
Network	South East Neonatal Network
Designation	NICU
Is redesignation being considered? (Y/N)	Yes
Activity FY 24/25 (HRG 2016)	
ICU (XA01Z)(HRG1)	2452
HDU (XA02Z)(HRG2)	1595
SCBU /TC(XA03Z)(HRG 3,4 and 5)	6545
Live Births	4461

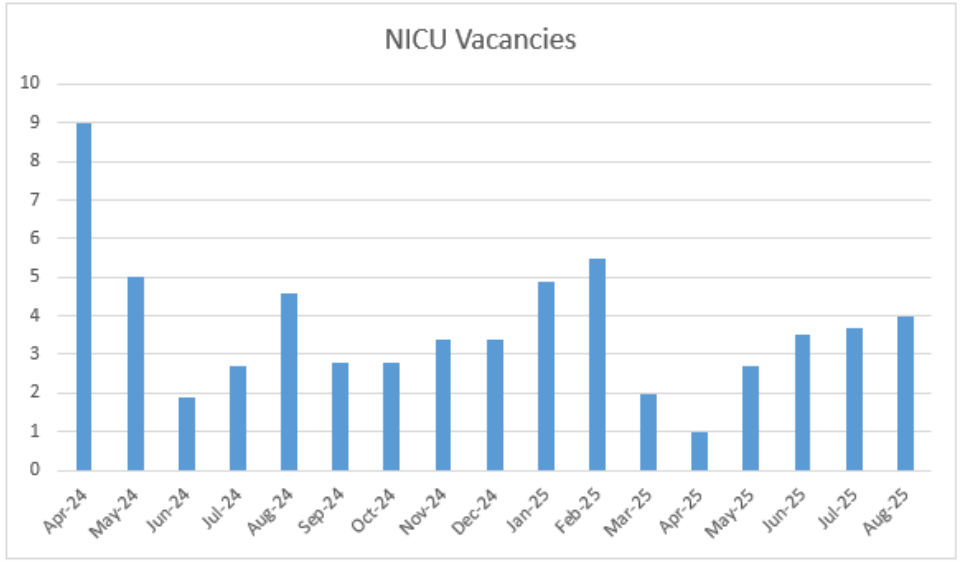
Key Messages:

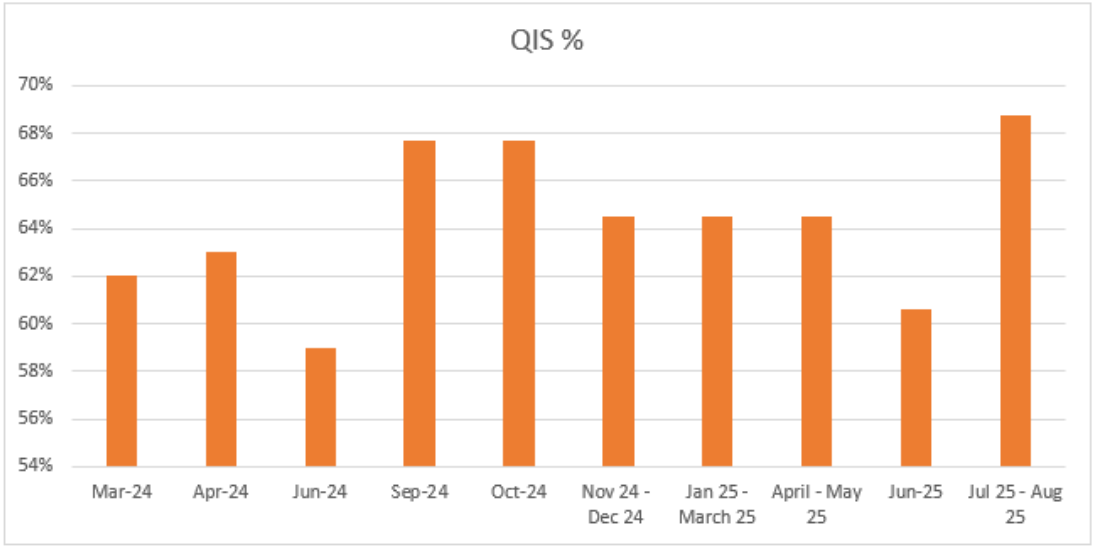
- 100% compliant with all CNST requirements with Neonatal Medical Staffing as fully compliant with all relevant BAPM Standards.
- Request Trust Board to formally record compliance in Trust Board Minutes.

	BAPM standard	Description	Assuming all budgeted posts are fully recruited to (including Deanery or Trust funded); is the unit compliant with BAPM standard?
Standards for all NICUs	All tiers separate rota compliance	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff at all times	Compliant
	Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care	Compliant
	Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport)	Compliant
	Tier 3 separate rota compliance 24/7	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit	Compliant
	Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	Compliant

True North: People

Neonatal Nursing Workforce





Key Messages:

- NICU Nursing Qualified in Speciality 68.75%.
- Rolling training programme with an additional 6 nurses commenced training September 2025.
- 0 WTE band 6 vacancies, 4 WTE band 5 vacancies
- Added to the issues log and monitored via Divisional processes
- Action plan ongoing from CNST Year 6.
- Request Trust Board approval for action plan and to formally record this in Trust Board Minutes.
- Action plan to be shared with the LMNS and ODN following Trust Board approval.

Action Plan

Recruitment						
1	Support staff to complete specialty course to support achieving > 70% QIS.	6 staff due to qualify September 2022 = 64.5% QIS 5 due to start course in September 2022 – qualify September 2023 = 66.63% 6 staff qualifying in September 2023 = 70.9% 6 more staff commenced training Sept 2023 October 2023 Staff base increased – Oct 2023 QIS currently 65%. **June 2024** - QIS currently 59% - this is due to recruitment to band 5 vacancies which increases the staff base of non-QIS trained nurses, therefore reduces the overall percentage. Currently 6 on course for 2023/24 with trajectory for September QIS being 64% with an additional 6 to start in September 2024. If no changes to current establishment >70% **18/06/25** Rolling training continues 6 nurses in current cohort. Due to complete in September 2025 - With staff movment, NICU currently at 64.5% QIS trained. The trajectory is to reach 70% in September 2025 **SEPT 2025** QIS percentage 68.75% 6 more nurse enrolled to complete the QIS course Sept 2025	NICU Matron	01/09/2026		
2	Recruit Additional QIS staff.	Continue recruitment and retention payments for QIS staff to recruit to additionally funded posts (16 WTE new QIS posts funded by network – 3 recruited to) Rolling advertisement in place for QIS Band 6. Education team increased to provided additional support induction and supervision for new staff October 2023 Current band 6 Vacancy now 7 WTE. Rolling advertisement in place for QIS Band 6. **July 2024 - Band 6 Vacancy now 0.89 WTE**	NICU Matron	01/09/2024	30/07/2024	
3	Recruit to Band 5 vacancy	Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 1 WTE Oct 2023 – current band 5 vacancy 0 June 2024 - Band 5 vacancy remains 0 - 33 band 5s in workforce **July 2024 - Band 5 vacancy 1.8WTE**	NICU Matron	30/09/2023	30/09/2023	

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Overdue		
On Target		
Near Completion		
Complete		

4	Workforce Review	Establishment review including Dinning tool which takes into consideration acuity and cot days in individual neonatal units. **Sept 2023 Workforce review completed.**	NICU Matron	30/09/2023	30/09/2023	
	Retention					
5	Support staff wellbeing with employment of clinical psychologist to support reflective practice sessions with staff.	Clinical psychologist commenced in February 2024 and is now established in post and conducting reflective practice sessions with staff (and parents).	NICU Matron	30/06/2024	01/05/2024	
6	Strengthened PDN team to support staff to undertake training and development opportunities.	PDN team now consists of 5 members of staff and support nursing staff with accessing internal and external opportunities.	NICU Matron	30/11/2024	01/12/2024	
7	Ensure there is a climate of psychological safety across unit and support staff to share feedback and concerns	SCORE survey undertaken November 2023 and to be re-surveyed in Autumn 2024. Staff developed action plan in place, with NICU specific deep dive of responses. Maternity and Neonatal Collaborative Hour Launched April 2024 to promoted shared learning and working across maternity and neonatal services and encourage staff to share both clinical and personal reflections. 06/01/2025: Psychologist now in post supporting both staff and families	NICU Matron	30/11/2024	06/01/2025	
8	Full establishment reached April 2025 - To Retain staff	Continue R&R payments. Seek staff feedback to identify training and development needs Utilise PDN team to develop training and development plans for staff. Support opportunities for staff to understand other roles within the unit to encourage career development and progression within the unit.	NICU Matron	01/09/2025	10/09/2025	
9	Band 6 fully established, currently 4 band 5 vacancies - recruit staff to these posts and retain staff	Band 5s have been promoted to band 6 roles within the NICU Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 4 WTE	NICU Matron	01/12/2025		

Overdue		
On Target		
Near Completion		
Complete		

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True North: People

Safety Action 5: Midwifery Workforce – On Track
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

NHS 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:

Actions & Improvements

- ADOM and Matrons completed mapping with finance BP and all budget reflects birth-rate plus recommendations.
- Ongoing work to ensure correct mapping of WTE against budget lines.
- Complete table-top birthrate plus exercise in October/November 2025 ahead of December workforce paper.
- Complete business case for full birth rate plus for 2026.

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	BRAG Sept 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:

- Q1 25/26 due for Submission in October.
- Review and Quality Improvement meeting to be held in November.
- SBL element leads to present QI projects and ICB learning and sharing forums in November and December 2025.
- 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 ICB 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.
- Action plan in place to address gaps in HCL initiation for pregnant patients. Working with colleagues in specialist medicine to address concerns, identify funding and develop business cases to support implementation of service.
- Additional incentive scheme for “significant others” launched to support pregnant smokers achieve a verified quit.

True North: Patients

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP) – On 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.
- 2024 CQC Action Plan Co-produced with MNVP.
- 15 Steps Challenge and Service User engagement events held.
- Co-production on QI projects, service development, patient information, patient surveys.
- Key member of Maternity and Neonatal Safety Champion Assurance Board, to become quorate member once additional resource secured.
- MNVP lead contract has now been made permanent, securing compliance with CNST year 7.

Issues, Concerns, Gaps:

- Additional resourcing for MNVP uplift not confirmed by ICB.

Actions & Improvements:

- Additional funding identified by ICB and plan to utilise to meet additional resourcing requirements to meet CNST Year 8 requirements.
- Monthly escalation to Trust Board via Perinatal Quality Oversight Model reports.
- ICB action plan in place to address gaps in resourcing.

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) **Off Track**

NHS Medway NHS Foundation Trust

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 for newly rotated doctors.
- On track to achieve 100% compliance for all neonatal first responders for NLS training.
- Exemption received from NHSR to roll training over for one anaesthetic doctor who re-joined Trust in August 2025 following a secondment. PROMPT training in date with seconded Trust. Doctor to complete training in January 2026.
- Request Trust Board agreement , sign-off for action plan and formal minuting of the same to ensure new starters who rotated from July 2025, in line with CNST guidance, to complete their training within 6 months of start date.

Issues, Concerns, Gaps:

- Challenges to get all outstanding staff booked onto remaining training sessions.
- Seeking clarification over anaesthetic consultant on call requirements (not obstetric anaesthetists). Compliance mapping to be updated accordingly.

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.
- 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 completed NBLS during induction and will present NLS training certificate on starting and database now updated.

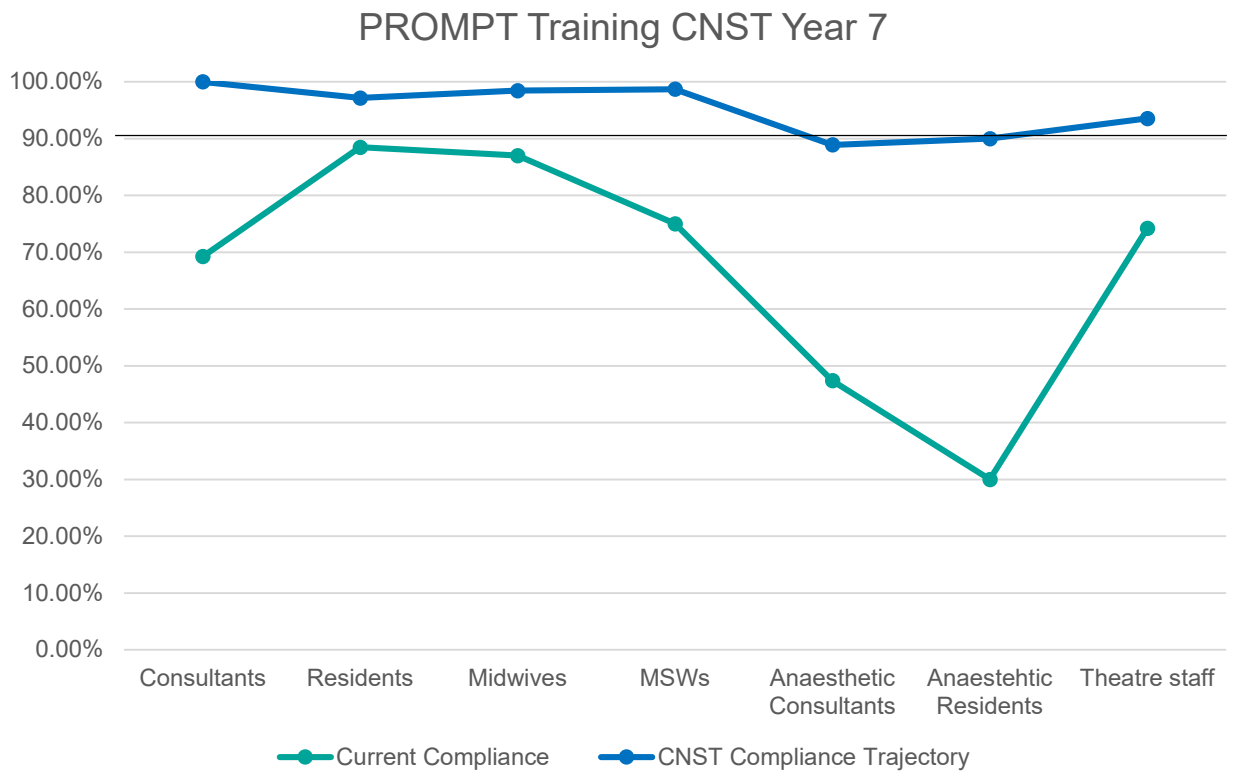
New starters Compliance Action Plan

Requirement	Action	Update	Status
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan must be approved by Trust Board and formally recorded in Trust Board minutes to ensure every staff member has attended all required training within a maximum 6-month period from their start-date with the Trust.	Any rotational medical doctors who meet the CNST criteria, not booked onto PROMPT training before 30/11/25 to be booked to attend within 6 months of start date.	Currently 2 Anaesthetic doctors subject to this action plan. Training booked for January 2026. To update Trust Board in March 2026 confirming training compliance.	On track

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	PROMPT Current Compliance	CNST Compliance Trajectory
Consultants	69.23%	100.00%
Residents	88.46%	97.14%
Midwives	87.01%	98.45%
MSWs	75.00%	98.68%
Anaesthetic Consultants	47.37%	88.89%
Anaestehtic Residents	30.00%	90.00%
Theatre staff	74.19%	93.55%



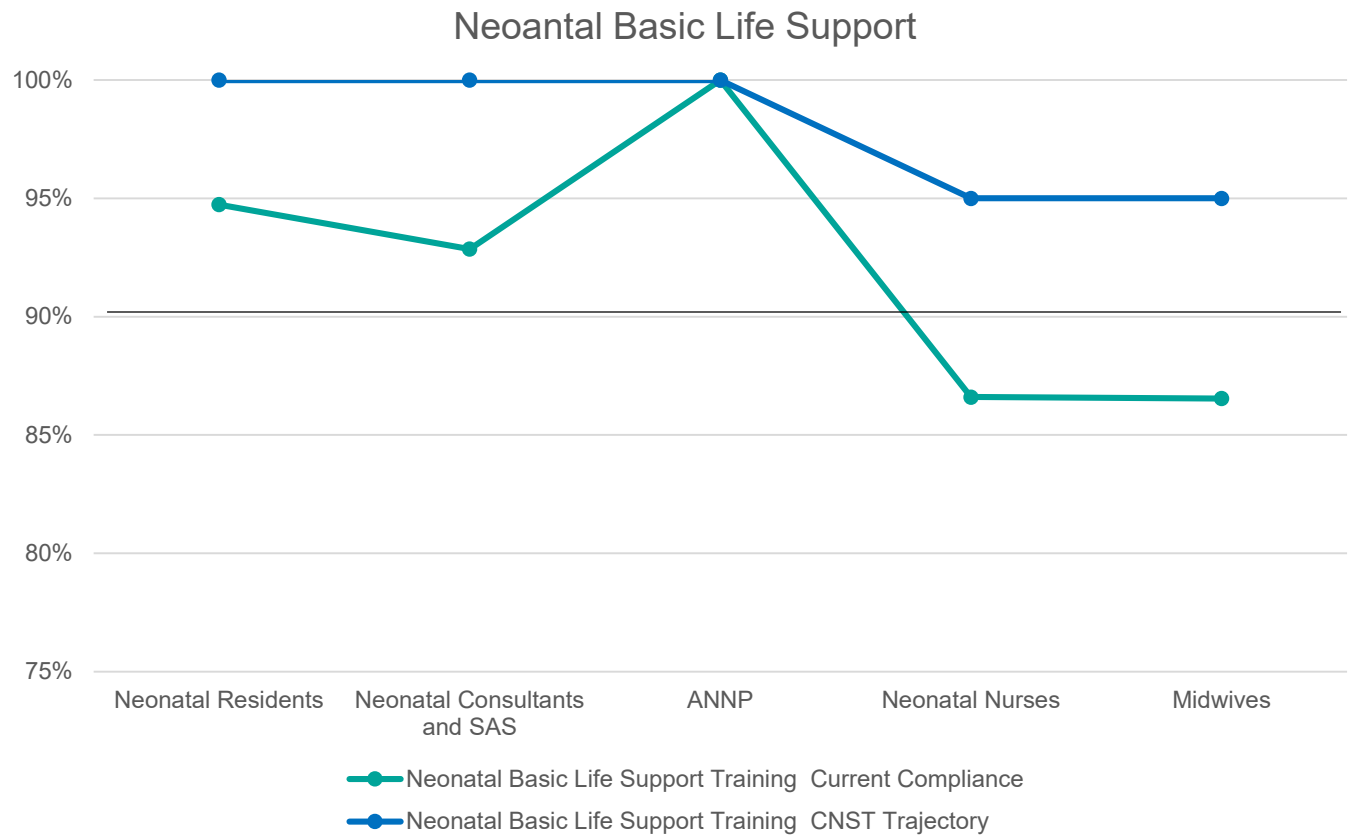
Fetal Monitoring Training and Assessment	Obstetric Consultants	Obstetric Residents	Midwives
Current Compliance	**100.00%**	**69.57%**	**94.47%**
CNST Trajectory	**93.75%**	**100.00%**	**96.33%**

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 – Sept 2025	CNST Trajectory
Neonatal Residents	95%	100%
Neonatal Consultants and SAS	92.86%	100%
ANNP	100%	100%
Neonatal Nurses	87%	95%
Midwives	87%	95%

Neonatal Life Support Training – Unsupervised first responders		
Staff Group	Current Compliance – Sept 2025	CNST Trajectory
Neonatal Residents	90%	100%
Neonatal Consultants and SAS	100%	100%
ANNP	67%	67%
Total compliance	97.5%	97.5%



True North: Quality

Safety Action 9: PMRT – On Track
Ambition: Demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Key Messages:

- Non-Executive Safety Champion well established within Maternity and Neonatal Services and is a core member of Maternity and Neonatal Safety Champion Assurance Board (MNSCAG).
- Request that the Trust Board minutes reflect that the Board Safety Champion, along with the NED are meeting with the perinatal leadership team monthly at MNSCAG and support the perinatal leadership team to escalate to Trust Board for assurance and Support.
- Request that the Trust Board minutes reflect the ongoing work on maternity and neonatal cultural improvement as presented as part of the perinatal leadership reports to Trust Board quarterly. Current work includes:
    - Work with absolute diversity to undertake targeted culture work within maternity and neonatal services.
    - Undertake repeat bespoke culture survey within maternity and neonatal services
    - Leadership team reviewing how it feeds back to staff following escalation of concerns – consider pilot of 10 at 10.
- The Perinatal Quality Oversight Model is fully embedded at MFT, with monthly reporting via IQPR slides and quarterly oversight report to Trust Board via Perinatal Quality Report. This is routinely presented by the Director of Midwifery.

Issues, Concerns, Gaps:

- Perinatal Quality reporting SOP to be updated in line with Perinatal Quality Oversight Model and current Trust reporting processes.

Actions and Improvements:

- Meeting with Trust Secretary to ensure continued efficient and effective reporting to Trust Board whilst maintaining required oversight at Trust Leadership Team (TLT) meetings.

True North: Quality

Safety Action 10: MNSI and NHSR EN reporting – On track

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

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

Key Messages:

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

Issues, Gaps & Concerns:

- Planned move to new reporting portal (SPEN) in October 2025. Awaiting allocation of user accounts and onboarding.

Actions & Improvements :

- No current gaps in accessibility identified. Continue to work with Trust Accessible Information Group, PE and EDI midwife and ICB colleagues for support should accessibility needs arrive.
- Continue to report via current systems until Trust is onboarded to SPEN.

Actions and Next Steps

NHS Medway NHS Foundation Trust

- Onwards reporting to Trust Board in November 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.
- Continue to engage with ICB peer assurance group to ensure all ICB reporting is undertaken within the required timescale.
- Continue update report to each Trust Board to ensure all key elements are presented to Trust Board in line with the reporting schedule.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board in Public

Date: Wednesday, 12 November 2025

Title of Report	Audit and Risk Committee - Terms of Reference			**Agenda Item**	5.2
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
			X	X	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X	X			
Author and Job Title	Matt Capper, Director of Strategy and Partnership/Company Secretary				
Lead Executive	Matt Capper, Director of Strategy and Partnership/Company Secretary				
Purpose	**Approval**	X	**Briefing**		**Noting**
Proposal and/or key recommendation:	The Board is asked to approve the Audit and Risk Terms of Reference, refreshed in line with HFMA model Terms of Reference.				
Executive Summary	As per the 2024 Audit Committee Handbook, the Terms of Reference have been refreshed in line with the HFMA model. The Terms of Reference has been drafted to ensure oversight of other committees.				
Issues for the Board/Committee Attention:	N/A				
Committee/ Meetings at which this paper has been discussed/ approved: Date:	Audit and Risk Committee Date: 11 September 2025				
Board Assurance Framework/Risk Register:	N/A				
Financial Implications:	None				
Equality Impact Assessment and/or patient experience implications	N/A				
Freedom of Information status:	Disclosable	X	Exempt		

List of amendments (September 2025)

Document reference	Description of amendment
V1. Re-drafted version	Revised format and content based on HFMA model Terms of Reference.
V2. Internal Audit standards	Updated to the 2025 standard (pg 4 of 7)

Medway NHS Foundation Trust
Audit and Risk Committee
Terms of Reference

1. Constitution

The board hereby resolves to establish a committee of the board to be known as the Audit and Risk Committee (the committee). The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

Any amendments to these Terms of Reference can only be approved by the Trust Board. The Terms of Reference will be reviewed annually.

2. Purpose

The committee provides assurance to the Board that governance, risk management, financial reporting and internal controls are effective across the Trust.

3. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

4. Membership

The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.

The trust secretary may attend meetings.

The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the

governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.

Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.

A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.

At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

5. Quorum

A quorum shall be two members.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's standing orders, and standards of business conduct policy.

7. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested.

The chair of the committee, board, accountable/ accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

8. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist.

9. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control
The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance, CQC Well-Led and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit
The committee shall ensure that there is an effective internal audit function that meets ~~the Public sector internal audit standards, 2017~~ the Global Internal Audit Standards as applied through the Public Sector Application Note, 2025 and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the

organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit
The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:
- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions
The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies). In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter fraud
The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management
The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting
The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

System for raising concerns
The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance regulatory compliance
The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS code of governance and the fit and proper persons test.
The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

10. Accountability and Reporting

The committee shall report to the board on how it discharges its responsibilities.

The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

11. Secretariat and Administration

The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

Meeting of the Trust Board in Public

Date: Wednesday, 12 November 2025

Title of Report	League of Friends - Annual Report			**Agenda Item**	5.3
Stabilisation Plan Domain	**Culture**	**Performance**	**Governance and Quality**	**Finance**	**Not Applicable**
				X	
CQC Reference	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-Led**
	X		X		
Author and Job Title	Janet Harsent, Chair of Trustees – League of Friends Marion Cogger, Trustee and Secretary – League of Friends				
Lead Executive	N/A				
Purpose	**Approval**		**Briefing**	X	**Noting**
Proposal and/or key recommendation:	To brief the Trust Board on the League of Friends service over the last 12 months.				
Executive Summary	This report provides detail on the equipment funded by the League of Friends to the value of £364,135 as shown within the report. When items are delivered, the League of Friends require an Impact Statement which explains the benefit of the equipment to patients in the hospital.				
Issues for the Board/Committee Attention:	N/A				
Committee/ Meetings at which this paper has been discussed/ approved: Date:	N/A				
Board Assurance Framework/Risk Register:	N/A				
Financial Implications:	N/A				
Equality Impact Assessment and/or patient experience implications	N/A				
Freedom of Information status:	Disclosable	X	Exempt		

THE MEDWAY LEAGUE OF FRIENDS
REPORT TO THE MEDWAY NHS FOUNDATION TRUST – NOVEMBER 2025

In the last 12 months, The Medway League of Friends has continued to provide a valuable service to patients, staff and visitors to Medway Maritime Hospital. Our Café and Shop are increasingly busy selling a wide range of items at all times of the day and night.

We currently have ten Trustees and recently appointed another useful contact to the Team. In addition, we have a Hospital Representative who places orders for the items we have agreed to fund and chases for delivery and invoice dates, and also a Volunteer Representative who attends our meetings to update us on any concerns raised by our volunteers.

We have 199 active volunteers across the Café and Shop, Hospital Radio Medway and our outlet in Wainscott, plus 26 paid staff across full time and part time roles.

In the 12 months since our last report, we have funded equipment to the value of £364,135 as shown below. When items are delivered, we ask the ward or department for an Impact Statement which explains the benefit of the equipment to patients in the hospital.

The full list is as follows:-

ITEMS FUNDED BY THE MEDWAY LEAGUE OF FRIENDS - NOVEMBER 2024 to OCTOBER 2025

Item	Department	Value to nearest £
IAC Monitor *	Delivery Suite	£50,557
PoCT Devices	Diabetes Department	£19,750
Foldaway bed and mattress	Lawrence Ward	£1,117
3 x Patient Monitors	Endoscopy	£16,478
4 x Sleep Study Machines	Sleep Service	£19,600
Recliner chair	Frailty Unit	£1,077
4 x Accuvein machines	Equipment Library	£17,675
Ultrasound probes	Fetal Medicine	£18,135
Resus Equipment	Theatres	£9,066
Cardiac monitors	Bronte Ward	£19,980
2 x Wheelchairs	CDC	£1,485
TULA Laser system	Urology	£10,975
Ventilators *	Paediatrics	£39,024
Various *	Defibrillators	£39,322
2 x Bladder scanners *	Equipment Library	£26,551
2 x ECG Machines	Equipment Library	£8,600
Syringe Drivers	Equipment Library	£4,324
4 x Tilt Wheelchairs	Neurotherapy	£2,628
FeNo machine	Respiratory	£2,519
Ultrasound machine	Hepatology	£19,999
Mammography Chair	Breast Screening	£3,218

Blood Gas Analyser	Frailty	£10,150
Audiology Equipment	Audiology	£8,888
Spirometer	Respiratory/Sleep Service	£8,636
Bed-end Traction Kit	Harvey Ward	£2,763
Wheelchair	Residence 9	£218
Refurbishment items	Mortuary	£1,400
	TOTAL	**£364,135**
	(November 2024	£296.762)

* CAPITAL ITEMS

We are sure you will agree this is an incredible contribution towards equipment for the treatment of patients throughout the hospital's wards and departments but we have to thank our band of volunteers, and staff, for all their hard work and for the support of all the patients, visitors and staff who visit the shop.

We regularly liaise with the Trust's Communication Department on the items we have funded and for the details to be circulated in Trust newsletters and the wider media.

In our last report, we made reference to our new on-line ordering system for patients to enable them to place an order from their bed and whilst this is not widely used, it is a facility for those patients who wish to purchase newspapers, confectionery, etc. and are either not able to visit the shop themselves or do not have relatives who visit.

A few months ago, we were asked if we would like to take over the hospital shop at Sheppey Community Hospital and having given this due consideration, we have refurbished the space and once we have recruited a few more volunteers, hope to open in November. This will provide a valuable service for the hospital site including the Medway facilities at Sheppey, i.e. Minster Ward, the CDC, Phlebotomy, MIU and OPD. We have agreed with the hospital that all funds raised on this site will be used to support bids for equipment, etc. from their wards and departments following a similar process to that used at Medway.

As part of The Medway League of Friends, Hospital Radio Medway also provides a different type of service to patients so they can listen to radio broadcasts from their bed. A group of volunteers visit wards to take requests from patients for their choice of music to be played on air. HRM's licence with Ofcom was successfully renewed back in August without any issues. HRM organised a Quiz Night in October and raised the grand sum of £553 which will be used to run their studio.

Janet Harsent (Chair of Trustees)/Marion Cogger (Trustee and Secretary)